# 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, February 25, 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: 504 682 394#

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.): 3:30 p.m.**

**5. Accept Chief Executive Officer (CEO) Report.**

- Reference materials: Chief Executive Officer (CEO) Report

Pages 5-1 to 5-12

**6. Accept Alliance Financial Highlights, Balance Sheet, Income Statement and Statement of Cash Flow for the twelfth month ending December 31, 2025. – Unaudited as of 1/23/26.**

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

Pages 6-1 to 6-11

**Minutes: (7A. – 7B.):**

**7A. Approve Commission regular Meeting Minutes of January 28, 2026.**

- Reference materials: Minutes as above.

Pages 7A-1 to 7A-5

**7B. Accept Compliance Committee Meeting Minutes of December 17, 2025.**

- Reference materials: Minutes as above.

Pages 7B-1 to 7B-7

**Appointments: (8A. – 8B.)**

**8A. Approve the appointment of Ivett Vazquez to the Whole Child Model Family Advisory Committee.**

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

Page 8A-1

**8B. Approve the reappointments of Rebekah Capron to the Member Services Advisory Committee.**



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

Page 8B-1

**Reports: (9A. – 9D.)**

**9A. Authorize the Chairperson and the Chief Executive Officer (CEO) to sign the necessary implementing contract amendments and agreements to facilitate the Voluntary Rate Range Program (VRRP) for the CY 2025 rating period.**

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

Page 9A-1 to 9A-2

**9B. Approve revisions to the Member Services Advisory Committee (MSAG) Charter.**

- Reference materials:
  - Staff report and recommendation on above topic
  - Member Services Advisory Committee Charter

Pages 9B-1 to 9B-5

**9C. Approve Utilization Management (UM) Workplan – Q3 2025.**

- Reference materials:
  - Staff report and recommendation on above topic
  - Q3 2025 Utilization Management Workplan
  - UMWP: 2025, Q3 Overview and Updates

Pages 9C-1 to 9C-50

**9D. Approve 2026 Policy Priorities.**

- Reference materials:
  - Staff report and recommendation on above topic
  - 2026 Policy Priorities - DRAFT

Pages 9D-1 to 9D-4

**Regular Agenda Items: (10. – 12.): 3:35 p.m. – 5:00 p.m.**

**10. Consider and approve developing and appointing members to an Ad Hoc Committee of the Board to address specialty physician shortages. (3:35 – 4:00 p.m.)**

A. Mr. Michael Schrader, Chief Executive Officer, will review and Board will consider and approve developing and appointing members to an ad hoc Committee of the Board, consistent with Brown Act requirements, to discuss and develop recommendations to address specialty physician shortages in the Alliance service area.

- Reference materials: Staff report on above topic.

Pages 10-1 to 10-3

**11. Security Officer Report Q1 2026. (4:00 – 4:30 p.m.)**

A. Mr. Cecil Newton, Chief Information Officer, will discuss the Security Officer Report for Q1 2026.

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

Pages 11-1 to 11-2

**12. H.R.1 and Enrollment Update. (4:30 p.m. – 5:00 p.m.)**

A. Mr. Michael Schrader, Chief Executive Officer, will discuss an update on H.R.-1 and Enrollment.

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

Pages 12-1 to 12-2

**Information Items: (13A. – 13G.)**

**A. Alliance in the News** Pages 13A-1 to 13A-4

**B. Membership Enrollment Report** Page 13B-1

**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, May 14, 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, April 16, 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 February 25 meeting, unless otherwise notified.**

Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission
Wednesday, March 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:
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950 E. Blanco Road, Suite 101, Salinas, CA

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1161 San Felipe Road, Building B, Hollister, CA

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

Members of the public interested in attending should call the Alliance at (831) 430-2568 to verify

meeting date and location prior to the meeting.

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

**HEALTHY** PEOPLE. **HEALTHY** COMMUNITIES.

**DATE** February 25, 2026

**TO** Governing Commission of the Central California Alliance for Health

**FROM** Michael Schrader, Chief Executive Officer

**SUBJECT** CEO Report

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**Projected Declines in Alliance Medi-Cal Enrollment.** Alliance enrollment is projected to decline between August 2025 and December 2028 due to the end of COVID-19 unwinding flexibilities, the implementation of federal H.R. 1 requirements, and the FY2025–26 state budget. This section provides an overview of the enrollment decreases observed to date and outlines projections for the years ahead.

Updated Alliance Projection We have updated our Alliance projection for the expected decline in Medi-Cal membership over the next three years, through the end of 2028. The table below compares actual enrollment trends with three projection scenarios, including our Updated Alliance Projection. Key takeaways include:

- In 2025, actual Medi-Cal membership was lower than anticipated in our Original Alliance Projection.
- Looking ahead, our Updated Alliance Projection remains largely consistent with the Original Alliance Projection, with only minor adjustments.

| | 2025 | 2026 | 2027 | | 2028 | TOTAL |
|---|---|---|---|---|---|---|
| **Actual Alliance Experience** | **2.2%** | N/A | N/A | | N/A | N/A |
| **Original Alliance Projection** | **3.5%** | 7.8% | 8.9% | | 6.9% | 27.1% |
| **Updated Alliance Projection** | N/A | **9.5%** | **8.9%** | | **6.9%** | **27.5%** |
| **DHCS Projection** | **2.7%** | 3.4% | 2.9% | -- | -- | -- |

Additional details on each projection and the estimated annual declines are provided in the following paragraphs.

The rows show different Medi-Cal enrollment projections:

- **Actual Alliance Experience:** The real membership decline observed to date.
- **Original Alliance Projection:** The forecast developed by the Alliance in summer 2025.

- **Updated Alliance Projection:** The revised forecast developed in February 2026, incorporating new information from the Governor's January 9, 2025 State Budget.
- **DHCS Projection:** The statewide Medi-Cal caseload projection included in the State Budget. DHCS projects forward only through mid-2027. The projected decline of 2.9% is only for the first half of 2027.

The columns allow year-to-year comparisons of the projections:

- **2025**: Our Alliance membership declined by 2.2%, less than the 3.5% we had originally projected, and less than 2.7% that DHCS had projected for statewide Medi-Cal caseload.
- **2026**: Based on new information from DHCS and our actual membership declines in January and February of 2026, we are now projecting a slightly steeper decline in 2026 of 9.5% versus 7.8%.
- **2027 and 2028**: The Alliance's updated projection matches our original forecast for 2026 and 2027.
- **TOTAL**: In total, the Alliance projects a 27% decline across all four years, 2025-2028.

Three primary factors explain the differences between the Updated Alliance Projection and the DHCS projection:

- H.R. 1 affects certain eligibility groups more than others, and the Alliance case mix differs from the statewide mix. For example, individuals with UIS represent 11% of the statewide Medi-Cal caseload but account for 17% of Alliance membership.
- DHCS anticipates growth in the Seniors and Persons with Disabilities (SPD) population, while the Alliance projects a decline due to the reinstated asset limits effective January 1, 2026.
- Actual Alliance membership declines in January and February 2026, 0.85% and 0.79%, indicate a steeper downward trend than the 3.4% annual decline DHCS projects for the statewide Medi-Cal caseload.

The key drivers of enrollment declines for each year are detailed below.

- **2025**: The decline in 2025 was driven primarily by the end of COVID-19 unwinding flexibilities, which required more members to complete annual renewals rather than relying on automatic ex parte renewals.
- **2026**: Three factors will drive the anticipated 2026 decline: lingering effects of the end of COVID-19 unwinding flexibilities; a freeze on new full-scope Medi-Cal enrollments for individuals with Unsatisfactory Immigration Status

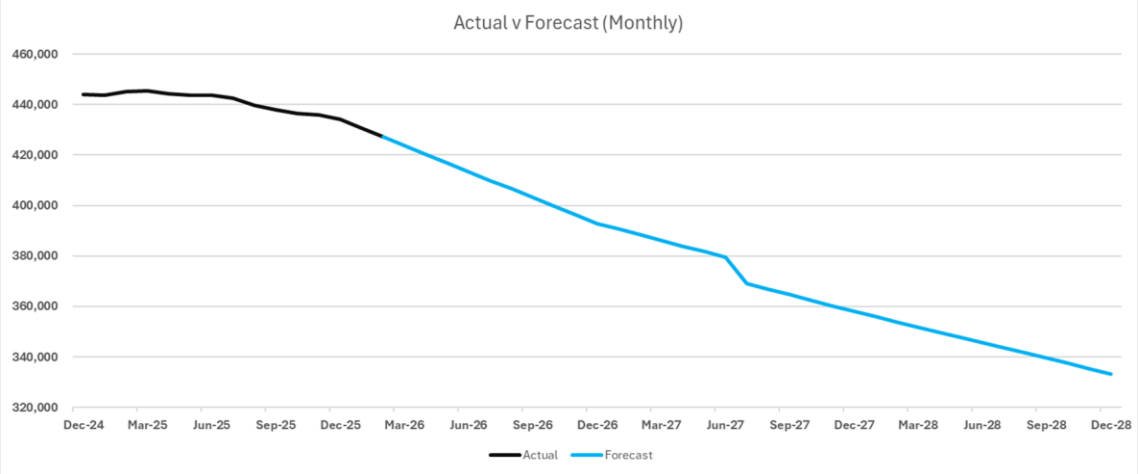
(UIS), effective January 1, 2026; and the reinstatement of Medi-Cal asset limits for long-term care applicants, also effective January 1, 2026.

- **2027**: Additional policy changes layered on top of earlier reforms will drive the 2027 decline: six-month redeterminations for Medicaid Expansion (ME) adults, new work requirements for ME adults, and a $30 monthly premium for adults with UIS.
- **2028**: One further policy change will contribute to the 2028 decline: new copayments for ME adults, building on prior policy changes.

Possible Carve Out of Medi-Cal Enrollees with UIS from Managed Care Plans. These projections do not account for the possibility that DHCS may carve out Medi-Cal enrollees with Unsatisfactory Immigration Status (UIS) from managed care and assume responsibility for their coverage directly. For the Alliance, this would mean an abrupt loss of roughly 17% of membership on January 1, 2027. On September 30, 2025, CMS issued guidance stating that monthly capitation payments for individuals with UIS do not qualify for federal financial participation for emergency Medi-Cal coverage. DHCS has not yet made a decision for how it will implement that CMS Guidance.

Tracking Actual Medi-Cal Membership Decline Against Updated Projection
The graph and table below will appear in the CEO Report each month.

The graph compares our actual membership decline with our updated projection. The black line represents our actual membership loss to date, while the blue line shows our updated projection for future decline. Going forward, if the black line tracks along the blue line, our actual trend is in line with expectations. If the black line rises above the blue line, we're losing fewer members than anticipated. If it falls below the blue line, our membership loss exceeds projections.



The table shows the actual month-to-month decline in our Alliance Medi-Cal membership for 2026 year to date.

| 2026 Month | Santa Cruz | Monterey | Merced | Mariposa | San Benito | Total MCal Enroll | % Change |
|---|---|---|---|---|---|---|---|
| Jan | 74,474 | 184,901 | 145,244 | 5,490 | 20,454 | 430,563 | -0.85% |
| Feb | 73,223 | 183,855 | 144,247 | 5,452 | 20,370 | 427,147 | -0.79% |

**Overlapping Member Outreach Campaigns**. The Alliance launched a member outreach campaign in 2025, and DHCS will in 2026.

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

- General Member Outreach. The Alliance launched its bilingual paid media campaign in late January, featuring advertisements across television, mobile platforms, radio, TikTok, social media, and billboards. The first phase of the campaign emphasizes helping members renew their Medi-Cal coverage on time through a simple three-step process. We have also created posters and handouts for provider offices and community partners, and published related articles on our website as well as in our community, provider, and member newsletters.

- Focused Member Outreach. In January, we sent text messages to more than 7,400 members who needed to complete their annual Medi-Cal renewals within the next 45 days.

- Community Partner Trainings. In collaboration with County staff, the Alliance continues to facilitate redetermination support training sessions for community partners. In February, sessions were held in Salinas, Watsonville and Merced. Training sessions were well attended and received positive feedback from participants.

- Grant Funding. A new Member Outreach and Retention funding opportunity will be launched in February for a rapid funding round (off-cycle from regular funding rounds) through the Medi-Cal Capacity Grant Program. This funding opportunity will fund trusted community partners to conduct outreach, education, and hands-on assistance that helps eligible Medi-Cal members stay enrolled.

DHCS Campaign. DHCS recently released the *Implementation Plan for New Federal Eligibility and Enrollment Changes Under H.R. 1*, outlining California's approach to meeting the new federal requirements. The plan includes a comprehensive communication strategy to help members understand the changes, using multiple delivery channels such as mail, text messages, and outbound phone calls to build awareness and support compliance with the new rules. DHCS has also developed a communications toolkit that serves as a central hub for information and resources related to these upcoming changes, with additional materials to be added as they become available.

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

Strategic Plan Development. Development of the Alliance's next three-year Strategic Plan (2027–2029) is underway. In 2025, the Alliance selected a strategic planning consultant, completed an environmental scan, and established the planning framework and timeline. Stakeholder interviews with Board members, community partners, and member representatives are now in progress to help shape priorities and direction. The Board will hold an initial discussion in April to review emerging themes, key findings, and next steps for the draft plan.

**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. To date, the TotalCare D-SNP has enrolled 510 members, and the Alliance has identified opportunities to accelerate enrollment growth including more sales and marketing resources. Staff are also working to revise the Marketing plan to

align with growth projections, with a heavy focus on monthly direct mail and social media efforts.

New Member Onboarding. One area of early success has been the capture of Health Risk Assessments (HRAs) for new TotalCare members at the point of sale. To date, the Alliance has captured HRAs for more than 74% of enrolled members at the point of sales, a performance level that aligns with a 4-Star quality threshold. This early assessment supports timely engagement as we begin developing individualized care plans for newly effective members. In addition, this process strengthens quality performance under the Medicare Star Ratings program, which CMS uses to evaluate plan quality and award quality bonus revenue. Strong Stars performance is a key lever for accelerating the path to financial sustainability while maintaining high standards of care.

Enrollee Advisory Committee (EAC). Staff have aligned the regulator-required EAC with the Alliance's existing Member Services Advisory Group (MSAG). To formalize this alignment, the consent agenda includes approval of an updated MSAG charter to add up to four (4) TotalCare member seats, ensuring dedicated input from D-SNP members. This approach enables the Alliance to meet regulatory requirements while efficiently incorporating TotalCare-specific feedback to inform program improvements and enhance the member experience.

Network Adequacy for Neurosurgery. Alliance staff are actively addressing a D-SNP network adequacy gap for Neurosurgery affecting a portion of Merced County, where CMS time and distance standards are not currently met. Consistent with challenges commonly experienced in rural service areas, this gap is being addressed through multiple contract discussions with neurosurgery groups in neighboring regions. In parallel, the Alliance is preparing for its first CMS triennial network adequacy audit, to occur in the middle of this 2026 calendar year, during which this gap will be identified. Addressing this access need remains a priority as part of our ongoing commitment to maintaining a strong, compliant provider network and ensuring appropriate access to care for D-SNP members.

**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.

State-Only Alternative Coverage Options Proposal. A coalition of safety net stakeholders, including the Local Health Plans of California, California Medical Association, California Hospital Association, California Health Executives Association

and the California Primary Care Association have come together to explore potential coverage models for individuals that will lose Medi-Cal coverage due to HR 1 requirements, other federal policy changes, and State budget constraints. Key elements to be determined include program administration, financing limitations and parameters, delivery system, eligibility and enrollment, covered benefits and cost sharing. Once further refined, the proposal will be discussed with Legislative leaders to determine if there is support to move forward.

2026 Legislative Session. The 2026 legislative session is in full swing. Staff are monitoring and tracking bills in the Board's area of legislative focus with the deadline for legislators to introduce new bills to be heard this year is February 20. Once the bill introduction deadline has passed, staff will develop a bill list which will be shared with your board.

2026-27 State Budget. Since the release of the Governor's January 2026–27 Budget proposal, discussions have continued within a framework of fiscal caution due to the more positive fiscal outlook in the Governor's proposal, while reaffirming Medi-Cal as a core programmatic priority. The January proposal reflects the stated intent to preserve Medi-Cal eligibility and benefits, even as broader budget pressures are addressed. As the budget process advances toward the May Revision, deliberations remain ongoing, but no major structural changes to Medi-Cal have been proposed to date. Of note, in late January CMS published their "*Medicaid Program: Preserving Medicaid Funding for Vulnerable Populations - Closing a Health Care-Related Tax Loophole*" final rule. Initial analysis suggests that California has been allowed a transition period through December 31, 2026, for its Managed Care Organization (MCO) tax which supports the budget assumptions included in the Governor's January budget proposal. Staff will continue to monitor developments closely and keep the Board informed of any potential implications for managed care rates, supplemental payments, or program requirements.

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

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

- Mariposa Library Health Summit, Mariposa 2/4/26
- Delhi WIC Immunization Event, Merced 2/4/26

- Department of Social Services Mobile Office Ribbon Cutting, Monterey 2/5/26
- Pathways to Early Success Resource Fair, Monterey 2/18/26
- Salvation Army Drive Through Food Distribution, San Benito 2/13/26
- Triple P Family Resource Fair, Santa Cruz 1/31/26

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

- Merced County Association of Governments RTP Roundtable, Merced 2/6/26
- Merced Maternal Wellness Coalition, Merced 2/25/26
- Greenfield Unified School District Community Collaborative, Monterey, 2/6/26
- Aging and Disability Resource Connection, Monterey 2/9/26
- Monterey Bay CHW Collaborative, Monterey 2/26/26
- Santa Cruz County Immigration Coalition Meeting, Santa Cruz 2/5/26
- Benefits Collaborative Meeting, Santa Cruz 2/10/26

Communications and Marketing. The Alliance is developing a public awareness campaign focusing on ensuring members continue to access the care they need. The campaign will begin in April and run throughout the year, focusing on encouraging members to seek care for chronic conditions, acute illnesses and remain up to date on their well-check visits and preventive screenings. We are finalizing the campaign slogan and messaging with plans to launch across all Alliance communications channels this spring. Staff completed its annual metrics review and a few key highlights include: a year-over-year 26% increase in website visitors, nearly 1.5 million Facebook views, and nearly 2 million text messages sent to members which resulted in more than 730 health screenings.

**Quality & Health Equity and Health Education**. The Alliance continues to build on its commitment to delivering high-quality care while actively addressing health disparities. Our work includes identifying and addressing barriers as they relate to our providers, members, and implementing data driven approaches to reduce disparities.

Quality & Health Equity. The Provider Partnership Program provides dedicated practice coaches who work side by side with providers to implement best practices for pediatric and care measures. This work is supplemented with Care Gap Closure grants which help fund after-hour clinic and locum providers that specifically target areas of low access and performance. Additionally, provider portal quality reports grant providers access to their members' health information data and up to date care

gap closure reports. These reports are routinely adjusted to give the most pertinent information needed to close care gaps in a timely manner.

Health Education. In our work with members, the Health Education team will continue to provide member workshops in 2026. The team has scheduled 15 workshop series/groups in Q1. Programs will be provided in English and Spanish and in multiple modalities including virtual, telephonic and in-person class options.

**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.

Community Supports. Effective March 1, 2026, Community Supports provider reimbursement rates are transitioning to the lower range of DHCS policy guidance, with the exception of Recuperative Care, Short-Term Post-Hospitalization Housing (STPHH), and Sobering Center services. This change impacts 80 Community Supports providers across the network. The Alliance has received 78 of the 80 amended Community Supports agreements, reflecting a 98% execution rate. This 98% contract execution rate reflects coverage for all counties for these impacted Community Supports. Alliance staff participated in dialogue with impacted providers to discuss the rationale for rate adjustment, answer questions, and support a collaborative transition. These conversations reinforced the strong partnership between the Alliance and our Community Supports providers. Providers demonstrated continued commitment to serving members. The Alliance remains deeply appreciative of the essential role Community Supports providers play in advancing whole-person care and addressing the complex needs of our members. We value these partnerships and look forward to continued collaboration in support of the communities we serve.

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

February Leadership Team Town Hall: The February Leadership Team Town Hall is scheduled to take place on February 12, 2026. Reflecting our commitment to the professional development of leaders throughout the Alliance, these quarterly

meetings are designed to cultivate, train, and foster connections among leaders at all organizational levels. All leadership levels (supervisor, manager, director, executive) attend these informative sessions.

February All Staff Town Hall: The February All Staff Town Hall will be held on February 17, 2026. This forum enables staff members to pose questions and participate in meaningful dialogue regarding current company initiatives, projects, and updates directly with Michael Schrader, Chief Executive Officer, the Executive Team, and other leaders. Town Halls are consistently well attended, and feedback indicates that staff value the opportunity to inquire about agenda topics. Although these Town Halls are less formal than our quarterly All Staff meetings, they serve as an effective platform for staff engagement and information sharing.

End of Year Check-ins: Leadership have completed their staff evaluation and merit allocation through the Annual Compensation Review process. Human Resources ensures that a fair and consistent process occurs across the organization as department and division leadership award staff for 2025 performance. It's also an opportunity for developmental recognition through promotional opportunities, again managed and facilitated by Human Resources for that consistent approach across the organization. Leadership will communicate staffs' end of year check-ins and merit increase no later than February 27.

**Federal Medicaid Program Integrity Focus**. In lieu of providing an update on regulatory audit activity, I am highlighting the significant federal developments related to Medicaid program integrity. Specifically, on January 27, 2026, Dr. Mehmet Oz, Administrator for the Centers for Medicare and Medicaid Services (CMS) transmitted a letter to Governor Newsom outlining federal concerns regarding the integrity and oversight of California's Medicaid program. The letter is a clear signal that CMS intends to intensify their focus on program integrity, with particular emphasis on the effectiveness of state and managed care plan controls, data integrity, and oversight of high-risk service categories. Staff have identified the following key areas of scrutiny, and where new risk areas were identified, are assessing internal operational gaps and developing a responsive action plan.

- Effectiveness of Fraud, Waste, and Abuse (FWA) Programs. We expect CMS to enhance oversight of plan FWA programs, with a focus on the efficacy of those programs, not merely their existence. Plans are expected to employ data-driven detection and monitoring capabilities, and to produce results in the form of reports to state Medicaid agencies and/or recoupments of overpaid funds.

- High-Risk Service Categories. In recent months, DHCS has flagged a number of services as high-risk for potential FWA, including hospice, home health, transportation, and applied behavioral analysis. The recent CMS communication includes additional areas of concern within the Alliance's responsibility, most notably community supports such as housing stabilization services, personal care assistance, and recuperative care.

- Encounter Data Accuracy, Completeness, and Timeliness. Like DHCS, CMS continues to emphasize encounter data as a crucial component in rate setting and overall plan oversight. DHCS recently released changes to encounter data reporting which reflect CMS' program integrity priorities in that they move encounter oversight from a largely retrospective, tolerance-based review to a more prescriptive, rules-driven framework that more thoroughly ensures completeness, accuracy, and timeliness of data.

- Provider Enrollment and Screening Controls. Provider enrollment also emerged as a significant focus area, with an emphasis on ongoing oversight and verification of provider credentials. While CMS' scrutiny is largely directed at state enrollment pathways, the expectations will flow down to managed care plans.

- Coverage of UIS population. Dr. Oz' letter underscores CMS' focus on the use of federal funds to provide Medicaid coverage to individuals with unsatisfactory insurance status, specifically referencing CMS' recovery of approximately $1.6 billion in federal matching funds nation-wide, with California receiving 88% of those funds. In addition, CMS has indicated interest in expanded access to Medicaid beneficiary eligibility and immigration-related information. While eligibility determinations rest with the State, these developments elevate compliance and financial risk associated with eligibility and capitation payment processes.

**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.

HIPAA Security Incident and Breach UPDATE. Conduent Business Services LLC (Conduent), a vendor that provides the Alliance's claims management software and related healthcare information systems, notified the Alliance on February 6, 2025, that an unknown threat actor was able to obtain access to the personal health information (PHI) of some of its clients. At the time, Conduent advised the Alliance

that its data was likely not compromised because Conduent did not host Alliance systems. In November 2025, Conduent advised the Alliance that a single complex data file containing certain PHI of approximately 1500 Alliance members, including their names, member identification numbers and diagnoses, was exfiltrated from Conduent and potentially compromised.

The Alliance informed Resilience Insurance (the Alliance's Cybersecurity insurer) of the incident and is collaborating with Conduent to verify affected members, confirm addresses, and ensure notifications are handled appropriately by Conduent.

**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 approved the MCGP 2026 Investment Plan at the January 28, 2026, Board meeting. The 2026 plan prioritizes workforce and infrastructure to expand access, support for safety net providers, community engagement for member retention, and capacity building for community-based organizations. The 2026 award target is $20 million, allocated to Board-directed strategies as follows: 50% to healthcare workforce, 30% to health care system infrastructure, and 20% to community resources and engagement. Staff are refining existing grant programs and developing new funding opportunities according to these strategies. Dates and details for new and updated funding opportunities will be phased in the first half of 2026.

Trends in the Number of Awards and Total Spend. Details of 2025 awards totaling $33M were included in the end of year impact report in the January 28, 2026, Board packet. The application deadline for the first funding round in 2026 was January 20, 2026. There are 69 eligible grant applications currently under review. Award decisions will be distributed on April 3, 2026. The next two regular funding rounds in 2026 have application deadlines on May 5 and August 18.

**DATE:** February 25, 2026

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

**FROM:** Lisa Ba, Chief Financial Officer

**SUBJECT:** Financial Highlights for the Twelfth Month Ending December 31, 2025- Unaudited as of 1/23/26

For the month ending December 31, 2025, the Alliance reported an Operating Loss of $1.2M. The Year-to-Date (YTD) Operating Loss is $64.3M with a Medical Loss Ratio (MLR) of 97.8% and an Administrative Loss Ratio (ALR) of 5.0%. The Net Loss is $26.6M after accounting for Non-Operating Income/Expenses.

The budget expected an Operating Loss of $75.2M for December YTD. The actual result is favorable to the budget by $10.9M or 14.5%, driven by rate variances.

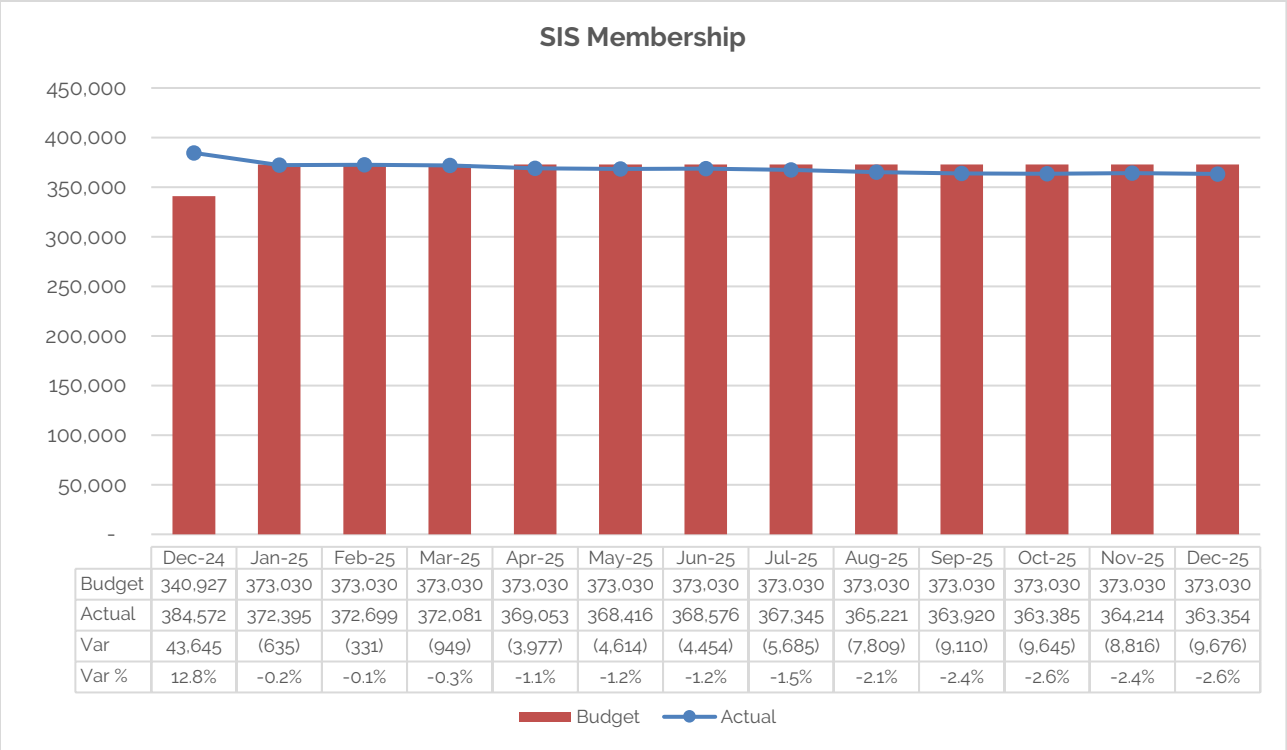
| Dec-25 MTD ($ In 000s) | | | | |
|---|---|---|---|---|
| Key Indicators | Current Actual | Current Budget | Current Variance | % Variance to Budget |
| *Membership* | *435,711* | *438,770* | *(3,059)* | *-0.7%* |
| Revenue | $188,537 | $173,830 | $14,707 | 8.5% |
| Medical Expenses | 180,412 | 171,798 | (8,614) | -5.0% |
| Administrative Expenses | 9,325 | 11,226 | 1,902 | 16.9% |
| Operating Income/(Loss) | (1,199) | (9,194) | 7,995 | 87.0% |
| Net Income | $859 | ($9,231) | $10,090 | 100.0% |
| *MLR %* | 95.7% | 98.8% | 3.1% | |
| *ALR %* | 4.9% | 6.5% | 1.5% | |
| *Operating Income %* | -0.6% | -5.3% | 4.7% | |
| *Net Income %* | 0.5% | -5.3% | 5.8% | |

| Dec-25 YTD (In $000s) | | | | |
|---|---|---|---|---|
| Key Indicators | YTD Actual | YTD Budget | YTD Variance | % Variance to Budget |
| *Member Months* | *5,304,040* | *5,265,613* | *38,427* | *0.7%* |
| Revenue | $2,266,867 | $2,085,968 | $180,899 | 8.7% |
| Medical Expenses | 2,217,734 | 2,041,559 | (176,175) | -8.6% |
| Administrative Expenses | 113,402 | 119,576 | 6,174 | 5.2% |
| Operating Income/(Loss) | (64,269) | (75,167) | 10,899 | 14.5% |
| Net Income/(Loss) | ($26,622) | ($61,314) | $34,692 | 56.6% |
| **PMPM** | | | | |
| Revenue | $427.39 | $396.15 | $31.24 | 7.9% |
| Medical Expenses | 418.12 | 387.72 | (30.41) | -7.8% |
| Administrative Expenses | 21.38 | 22.71 | 1.33 | 5.9% |
| Operating Income/(Loss) | ($12.12) | ($14.28) | $2.16 | 15.1% |
| *MLR %* | 97.8% | 97.9% | 0.1% | |
| *ALR %* | 5.0% | 5.7% | 0.7% | |
| *Operating Income %* | -2.8% | -3.6% | 0.8% | |
| *Net Income %* | -1.2% | -2.9% | 1.7% | |

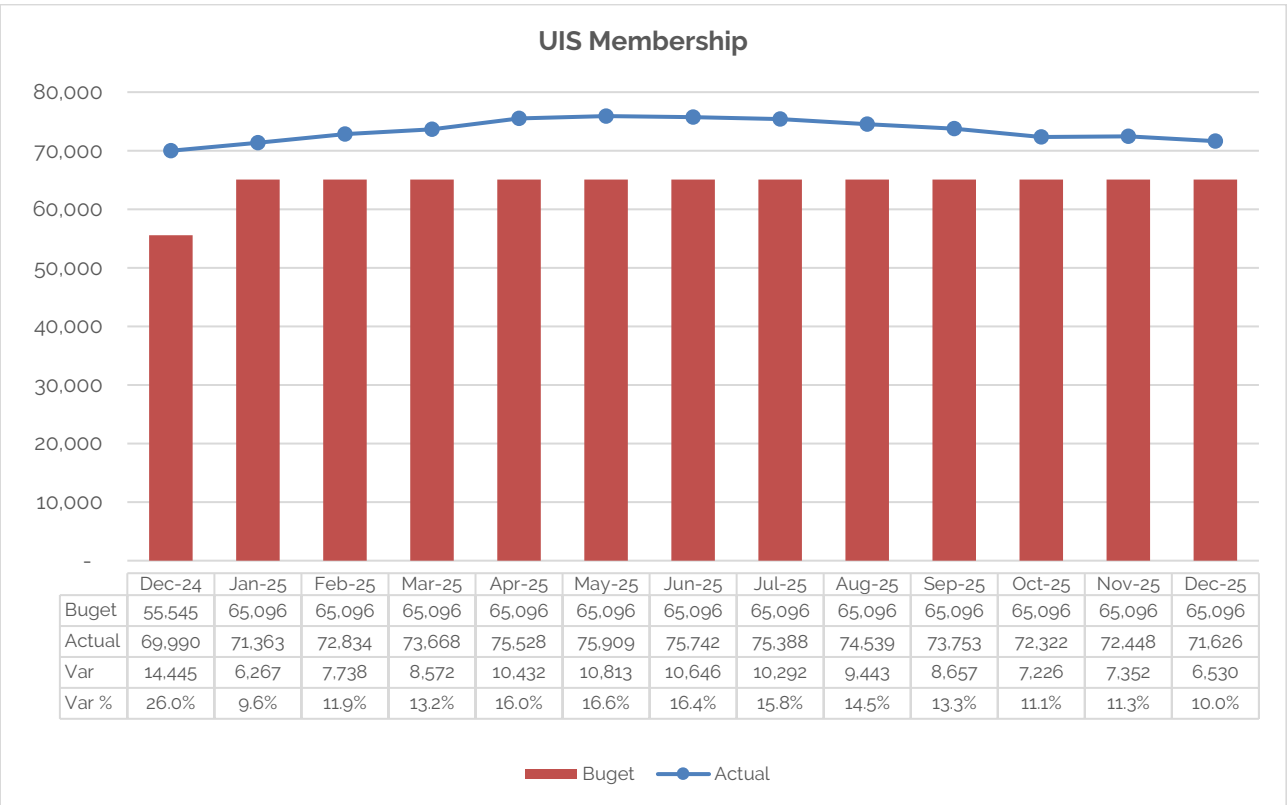
Per Member Per Month: Capitation revenue and medical expenses are variables based on enrollment fluctuations; therefore, the PMPM view offers more clarity than the total dollar amount. Conversely, administrative expenses do not usually correspond with enrollment and should be evaluated at the dollar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

At a PMPM level, revenue is $427.39, which is favorable to the budget by $31.24 or 7.9%. Medical cost PMPM is $418.12, which is unfavorable by $30.41 or 7.8%. This results in a favorable gross margin of $0.83 or 9.8% compared to the budget. The operating loss PMPM is ($12.12), compared to the budget of ($14.28).

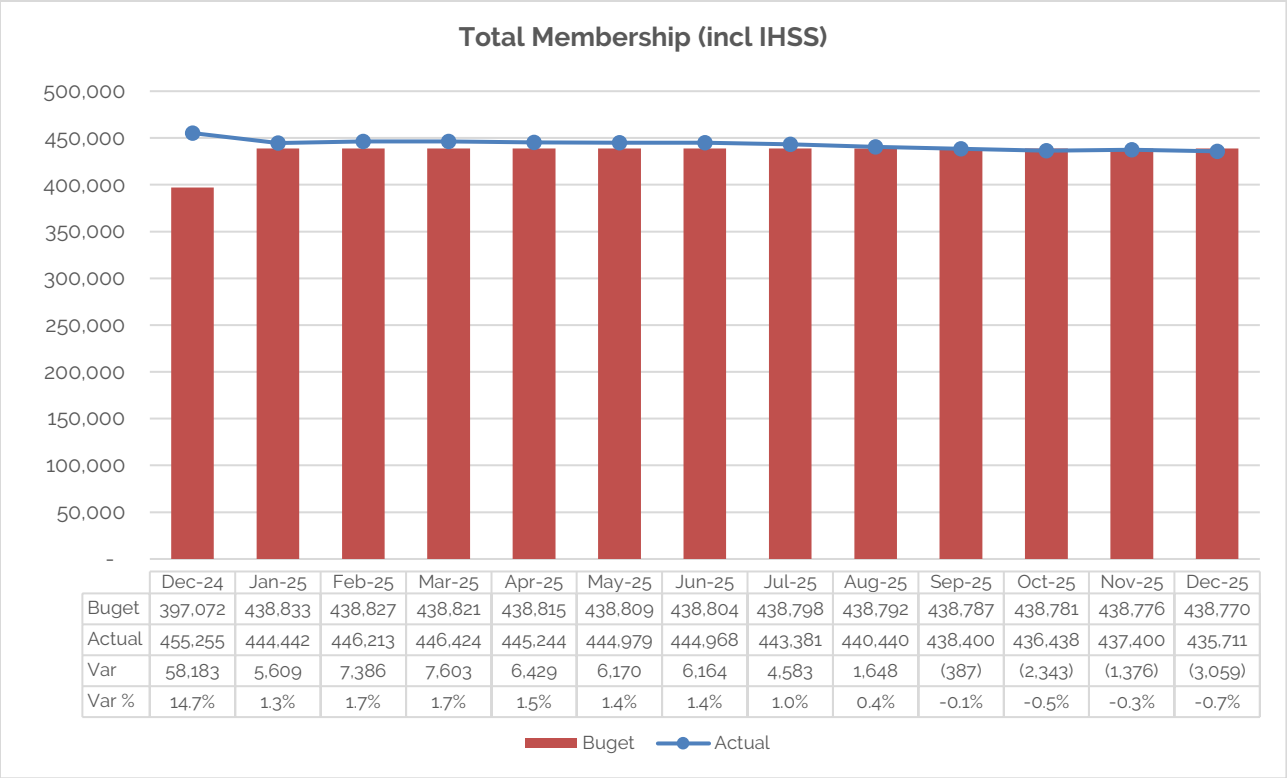
Membership: December 2025 membership is unfavorable to the budget by 0.7%. The 2025 budget assumed a flat budget with 438k members per month for all of 2025. With the ongoing redetermination process and the unwinding of COVID-19 flexibilities, both Satisfactory Immigration Status (SIS) and Unsatisfactory Immigrant Status (UIS) membership are trending downward. SIS membership continues to decline as redetermination progresses. While UIS enrollment showed growth earlier in the year, that trend began to moderate in June, followed by a slight decline in July and continued month-over-month decreases through December.




| | Dec-24 | Jan-25 | Feb-25 | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Budget | 340,927 | 373,030 | 373,030 | 373,030 | 373,030 | 373,030 | 373,030 | 373,030 | 373,030 | 373,030 | 373,030 | 373,030 | 373,030 |
| Actual | 384,572 | 372,395 | 372,699 | 372,081 | 369,053 | 368,416 | 368,576 | 367,345 | 365,221 | 363,920 | 363,385 | 364,214 | 363,354 |
| Var | 43,645 | (635) | (331) | (949) | (3,977) | (4,614) | (4,454) | (5,685) | (7,809) | (9,110) | (9,645) | (8,816) | (9,676) |
| Var % | 12.8% | -0.2% | -0.1% | -0.3% | -1.1% | -1.2% | -1.2% | -1.5% | -2.1% | -2.4% | -2.6% | -2.4% | -2.6% |




| | Dec-24 | Jan-25 | Feb-25 | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Buget | 55,545 | 65,096 | 65,096 | 65,096 | 65,096 | 65,096 | 65,096 | 65,096 | 65,096 | 65,096 | 65,096 | 65,096 | 65,096 |
| Actual | 69,990 | 71,363 | 72,834 | 73,668 | 75,528 | 75,909 | 75,742 | 75,388 | 74,539 | 73,753 | 72,322 | 72,448 | 71,626 |
| Var | 14,445 | 6,267 | 7,738 | 8,572 | 10,432 | 10,813 | 10,646 | 10,292 | 9,443 | 8,657 | 7,226 | 7,352 | 6,530 |
| Var % | 26.0% | 9.6% | 11.9% | 13.2% | 16.0% | 16.6% | 16.4% | 15.8% | 14.5% | 13.3% | 11.1% | 11.3% | 10.0% |




| | Dec-24 | Jan-25 | Feb-25 | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Buget | 397,072 | 438,833 | 438,827 | 438,821 | 438,815 | 438,809 | 438,804 | 438,798 | 438,792 | 438,787 | 438,781 | 438,776 | 438,770 |
| Actual | 455,255 | 444,442 | 446,213 | 446,424 | 445,244 | 444,979 | 444,968 | 443,381 | 440,440 | 438,400 | 436,438 | 437,400 | 435,711 |
| Var | 58,183 | 5,609 | 7,386 | 7,603 | 6,429 | 6,170 | 6,164 | 4,583 | 1,648 | (387) | (2,343) | (1,376) | (3,059) |
| Var % | 14.7% | 1.3% | 1.7% | 1.7% | 1.5% | 1.4% | 1.4% | 1.0% | 0.4% | -0.1% | -0.5% | -0.3% | -0.7% |

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.

**Dec-25 YTD Capitation Revenue Summary (In $000s)**

| Region | Actual | Budget | Variance | Variance Due to Enrollment | Variance Due to Rate |
|---|---|---|---|---|---|
| CEC SIS | $1,663,347 | $1,573,237 | $90,110 | $12,165 | $77,945 |
| CEC UIS | 470,698 | 419,068 | 51,630 | 3,491 | 48,138 |
| SBN SIS | 86,721 | 68,891 | 17,830 | 1,391 | 16,439 |
| SBN UIS | 16,920 | 19,886 | (2,966) | (2,449) | (517) |
| **Total*** | **$2,237,687** | **$2,081,083** | **$156,604** | **$14,598** | **$142,006** |

*Excludes Dec-25 In-Home Supportive Services (IHSS) premiums revenue of $5.7M, State Incentive Revenue of $4.9M, and Prior Year Revenue of $18.6M.

As of December, actuals exceeded the budget by $14.7M, representing a 8.5% positive variance. This is driven by favorable rate variances totaling $16.1M resulting from increases in prospective rates compared to the budget offsetting unfavorable enrollment of $1.4M.

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

As of December 2025 YTD, operating revenue stands at $2,266.9M, surpassing the budget by $180.9M, or 8.7%. This favorable variance includes $14.7M from increased enrollment and $166.2M 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 $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.

**Dec-25 YTD Medical Expense Summary ($ In 000s)**

| Category | Actual | Budget | Variance | Variance Due to Enrollment | Variance Due to Rate |
|---|---|---|---|---|---|
| Inpatient Hospital | $581,912 | $580,663 | ($1,250) | ($4,241) | $2,992 |
| Inpatient Services - LTC | 226,032 | 209,248 | (16,784) | (1,542) | (15,242) |
| Physician Services | 472,029 | 520,677 | 48,648 | (3,791) | 52,438 |
| Outpatient Facility | 259,657 | 224,849 | (34,808) | (1,643) | (33,165) |
| ECM | 175,351 | 111,731 | (63,620) | (813) | (62,807) |
| Community Supports | 83,797 | 41,236 | (42,562) | (300) | (42,261) |
| Behavioral Health | 94,205 | 89,786 | (4,419) | (652) | (3,767) |
| Other Medical* | 319,877 | 263,371 | (56,506) | (1,940) | (54,567) |
| State Incentives | 4,873 | - | (4,873) | - | (4,873) |
| **TOTAL COST** | $2,217,734 | $2,041,559 | ($176,175) | ($14,922) | ($161,253) |

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

December 2025 Medical Expenses of $180.4M are $8.6M or 5.0% unfavorable to the budget. December 2025 YTD Medical Expenses of $2,217.7M are above budget by $176.2M or 8.6%. Of this amount, $14.9M is due to higher enrollment, and $161.3M 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 $418.12, unfavorable by $30.41 or 7.8% compared to the budget.

| Dec-25 YTD Medical Expense by Category of Service (In PMPM) | | | | |
|---|---|---|---|---|
| Category | Actual | Budget | Variance | Variance % |
| Inpatient Services - Hospital | $109.71 | $110.27 | $0.56 | 0.5% |
| Inpatient Services - LTC | 42.62 | 39.74 | (2.88) | -7.2% |
| Physician Services | 88.99 | 98.88 | 9.89 | 10.0% |
| Outpatient Facility | 48.95 | 42.70 | (6.25) | -14.6% |
| ECM | 33.06 | 21.22 | (11.84) | -55.8% |
| Community Supports | 15.80 | 7.83 | (7.97) | -100.0% |
| Behavioral Health | 17.76 | 17.05 | (0.71) | -4.2% |
| Other Medical | 60.31 | 50.02 | (10.29) | -20.6% |
| State Incentives | 0.92 | - | (0.92) | -100.0% |
| **TOTAL MEDICAL COST** | **$418.12** | **$387.72** | **($30.41)** | **-7.8%** |

Inpatient Services: Inpatient Services are now slightly favorable to the budget, with December including a $1.5M prior period reduction. On an incurred basis, excluding prior period, the 2025 YTD PMPM is now $104.91, which is below the budgeted amount of $110.27 through December.

Inpatient Services—Long Term Care (LTC): LTC utilization is trending slightly above budget by 5%, and unit costs are also higher than planned by 4% due to the 2025 fee schedule rates coming in above budget, as well as a higher proportion of services in higher acuity LTC levels such as sub-acute facilities.

Physician Services: Favorability is influenced by lower utilization of the Targeted Rate Increase (TRI) and Provider Supplemental Payment (PSP) budgets. This favorable variance is 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 $43M to be utilized as of Dec YTD. Favorability in the Specialty PSP is 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 come in above budget due to higher utilization for all of 2025, including significantly higher utilization in January. Combined on an incurred basis, YTD PMPM actuals are $44.45 vs budgeted at $42.70, with outpatient being underbudgeted for 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 increased to 24k by December. Before adjusting for the risk corridor, ECM's YTD loss through December is $116M, slightly favorable from the initial projection of $118.8M. The risk corridor will mitigate $108, resulting in a net loss of $8M.

Community Supports: Enrollments for the Community Support (CS) program were modestly budgeted due to 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 $16.40, or 120% higher than the budget and 93% higher than the revenue PMPM of $8.51. Monthly losses increased from $1.9M in January to $7.7M in December, resulting in a YTD loss of $42M.

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 $22.9M 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 $7.3M variance, driven by higher-than-expected utilization. Additionally, Allied Health accounted for an $11.9M 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: December YTD Administrative Expenses are favorable to the budget by $6.2M or 5.2% with 5.0% ALR. Salaries are favorable by $4.2M or 5.2%, driven by savings from vacant positions, benefits, employment taxes, and PTO. Non-salary administrative expenses are favorable by $1.9M, or 5.0%, due to savings.

Non-Operating Revenue/Expenses: December YTD Net Non-Operating Income is $37.6M, which is favorable to the budget by $23.8M. The favorability is derived from the YTD Net Investment Income of $59.4M, which is $16.0M favorable to the budget due to higher interest rates. The YTD Other Revenue is $3.1M and is above budget by $0.7M. The YTD Non-Operating Expense is $24.9M from the grant distribution. This is favorable to the budget by $7.1M.

Summary of Results: Overall, the Alliance generated a YTD Net Loss of $26.6M, with an MLR of 97.8% and an ALR of 5.0%.

**CENTRAL CALIFORNIA ALLIANCE FOR HEALTH**
**Balance Sheet**
**For The Twelfth Month Ending December 31, 2025**
**(In $000s)**
**Unaudited as of 1/23/2026**

| | |
|---|---|
| **Assets** | |
| Cash | $394,722 |
| Restricted Cash | 300 |
| Short Term Investments | 807,395 |
| Receivables | 396,181 |
| Prepaid Expenses | 1,582 |
| Other Current Assets | 5,029 |
| **Total Current Assets** | **$1,605,209** |
| | |
| Building, Land, Furniture & Equipment | |
| Capital Assets | $79,537 |
| Accumulated Depreciation | (45,815) |
| CIP | 4,300 |
| Lease Receivable | 4,133 |
| Subscription Asset net Accum Depr | 13,214 |
| **Total Non-Current Assets** | **55,368** |
| **Total Assets** | **$1,660,578** |
| | |
| **Liabilities** | |
| Accounts Payable | $207,830 |
| IBNR/Claims Payable | 452,884 |
| Provider Incentives Payable | 41,109 |
| Other Current Liabilities | 9,333 |
| Due to State | 70,377 |
| **Total Current Liabilities** | **$781,533** |
| | |
| 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 | (26,622) |
| **Total Fund Balance** | **864,555** |
| **Total Liabilities & Fund Balance** | **$1,660,578** |
| | |
| **Additional Information** | |
| **Total Fund Balance** | **$864,555** |
| Board Designated Reserves Target | 560,851 |
| Strategic Reserve (DSNP) | 56,700 |
| Medi-Cal Capacity Grant Program (MCGP)* | 127,835 |
| Value Based Payments | 46,100 |
| Provider Supplemental Payments | 123,982 |
| **Total Reserves** | **915,468** |
| **Total Operating Reserve** | **($50,912)** |



Back to Agenda

**CENTRAL CALIFORNIA ALLIANCE FOR HEALTH**
**Income Statement - Actual vs. Budget**
**For The Twelfth Month Ending December 31, 2025**
**(In $000s)**
**Unaudited as of 1/23/2026**

| | MTD Actual | MTD Budget | Variance | % | YTD Actual | YTD Budget | Variance | % |
|---|---|---|---|---|---|---|---|---|
| ***Member Months*** | *435,711* | *438,770* | *(3,059)* | *-0.7%* | *5,304,040* | *5,265,613* | *38,427* | *0.7%* |
| **Capitation Revenue** | | | | | | | | |
| Capitation Revenue Medi-Cal | $185,518 | $173,441 | $12,078 | 7.0% | $2,237,687 | $2,081,083 | $156,604 | 7.5% |
| State Incentive Programs | 2,507 | - | 2,507 | 100.0% | 4,873 | - | $4,873 | 100.0% |
| Prior Year Revenue* | - | - | - | 0.0% | 18,591 | - | $18,591 | 100.0% |
| Premiums Commercial | 512 | 389 | 122 | 31.4% | 5,717 | 4,885 | 831 | 17.0% |
| **Total Operating Revenue** | **$188,537** | **$173,830** | **$14,707** | **8.5%** | **$2,266,867** | **$2,085,968** | **$180,899** | **8.7%** |
| **Medical Expenses** | | | | | | | | |
| Inpatient Services (Hospital) | $42,313 | $48,864 | $6,551 | 13.4% | $581,912 | $580,663 | ($1,250) | -0.2% |
| Inpatient Services (LTC) | 18,478 | 17,604 | (874) | -5.0% | 226,032 | 209,248 | (16,784) | -8.0% |
| Physician Services | 36,663 | 43,730 | 7,068 | 16.2% | 472,029 | 520,677 | 48,648 | 9.3% |
| Outpatient Facility | 21,241 | 18,921 | (2,320) | -12.3% | 259,657 | 224,849 | (34,808) | -15.5% |
| ECM | 15,440 | 9,403 | (6,036) | -64.2% | 175,351 | 111,731 | (63,620) | -56.9% |
| Community Supports | 7,641 | 3,470 | (4,171) | -100.0% | 83,797 | 41,236 | (42,562) | -100.0% |
| Behavioral Health | 8,579 | 7,647 | (932) | -12.2% | 94,205 | 89,786 | (4,419) | -4.9% |
| Other Medical** | 27,549 | 22,158 | (5,391) | -24.3% | 319,877 | 263,371 | (56,506) | -21.5% |
| State Incentive Programs | 2,507 | - | (2,507) | -100.0% | 4,873 | - | (4,873) | -100.0% |
| **Total Medical Expenses** | **$180,412** | **$171,798** | **($8,614)** | **-5.0%** | **$2,217,734** | **$2,041,559** | **($176,175)** | **-8.6%** |
| **Gross Margin** | **$8,125** | **$2,032** | **$6,094** | **100.0%** | **$49,133** | **$44,409** | **$4,725** | **10.6%** |
| **Administrative Expenses** | | | | | | | | |
| Salaries | $6,268 | $7,301 | $1,033 | 14.1% | $76,581 | $80,806 | $4,225 | 5.2% |
| Professional Fees | 292 | 370 | 78 | 21.1% | 4,700 | 5,210 | 510 | 9.8% |
| Purchased Services | 1,016 | 1,574 | 557 | 35.4% | 11,496 | 13,555 | 2,059 | 15.2% |
| Supplies & Other | 887 | 973 | 86 | 8.9% | 11,083 | 9,458 | (1,625) | -17.2% |
| Occupancy | 151 | 132 | (18) | -13.9% | 1,457 | 1,576 | 119 | 7.5% |
| Depreciation/Amortization | 711 | 876 | 166 | 18.9% | 8,085 | 8,971 | 886 | 9.9% |
| **Total Administrative Expenses** | **$9,325** | **$11,226** | **$1,902** | **16.9%** | **$113,402** | **$119,576** | **$6,174** | **5.2%** |
| **Operating Income** | **($1,199)** | **($9,194)** | **$7,995** | **87.0%** | **($64,269)** | **($75,167)** | **$10,899** | **14.5%** |
| **Non-Op Income/(Expense)** | | | | | | | | |
| Interest | $3,566 | $2,457 | $1,109 | 45.1% | $45,659 | $39,716 | $5,943 | 15.0% |
| Gain/(Loss) on Investments | (205) | - | (205) | -100.0% | 14,278 | 4,500 | 9,778 | 100.0% |
| Bank & Investment Fees | (61) | (62) | 0 | 0.6% | (488) | (740) | 251 | 34.0% |
| Other Revenues | 257 | 235 | 22 | 9.3% | 3,063 | 2,376 | 687 | 28.9% |
| Grants | (1,498) | (2,667) | 1,168 | 43.8% | (24,865) | (32,000) | 7,135 | 22.3% |
| Community Reinvestment | - | - | - | 0.0% | - | - | - | 0.0% |
| **Total Non-Op Income/(Expense)** | **2,058** | **(36)** | **2,095** | **100.0%** | **37,646** | **13,853** | **$23,794** | **100.0%** |
| **Net Income/(Loss)** | **$859** | **($9,231)** | **$10,090** | **100.0%** | **($26,622)** | **($61,314)** | **$34,692** | **56.6%** |
| *MLR* | *95.7%* | *98.8%* | | | *97.8%* | *97.9%* | | |
| *ALR* | *4.9%* | *6.5%* | | | *5.0%* | *5.7%* | | |
| *Operating Income* | *-0.6%* | *-5.3%* | | | *-2.8%* | *-3.6%* | | |
| *Net Income %* | *0.5%* | *-5.3%* | | | *-1.2%* | *-2.9%* | | |

**Other Medical includes Pharmacy and IHSS.



Back to Agenda

**CENTRAL CALIFORNIA ALLIANCE FOR HEALTH**
**Income Statement - Actual vs. Budget**
**For The Twelfth Month Ending December 31, 2025**
**(In PMPM)**
**Unaudited as of 1/23/2026**

| | MTD Actual | MTD Budget | Variance | % | YTD Actual | YTD Budget | Variance | % |
|---|---|---|---|---|---|---|---|---|
| ***Member Months*** | *435,711* | *438,770* | *(3,059)* | *-0.7%* | *5,304,040* | *5,265,613* | *38,427* | *0.7%* |
| **Capitation Revenue** | | | | | | | | |
| Capitation Revenue Medi-Cal | $425.78 | $395.29 | $30.49 | 7.7% | $421.88 | $395.22 | $26.66 | 6.7% |
| State Incentive Programs | 5.75 | - | 5.75 | 100.0% | 0.92 | - | 0.92 | 100.0% |
| Prior Year Revenue* | - | - | - | 0.0% | 3.51 | - | 3.51 | 100.0% |
| Premiums Commercial | 1.17 | 0.89 | 0.29 | 32.3% | 1.08 | 0.93 | 0.15 | 16.2% |
| **Total Operating Revenue** | **$432.71** | **$396.18** | **$36.54** | **9.2%** | **$427.39** | **$396.15** | **$31.24** | **7.9%** |
| **Medical Expenses** | | | | | | | | |
| Inpatient Services (Hospital) | $97.11 | $111.37 | $14.25 | 12.8% | $109.71 | $110.27 | $0.56 | 0.5% |
| Inpatient Services (LTC) | 42.41 | 40.12 | (2.29) | -5.7% | 42.62 | 39.74 | (2.88) | -7.2% |
| Physician Services | 84.14 | 99.67 | 15.52 | 15.6% | 88.99 | 98.88 | 9.89 | 10.0% |
| Outpatient Facility | 48.75 | 43.12 | (5.63) | -13.1% | 48.95 | 42.70 | (6.25) | -14.6% |
| ECM | 35.44 | 21.43 | (14.00) | -65.3% | 33.06 | 21.22 | (11.84) | -55.8% |
| Community Supports | 17.54 | 7.91 | (9.63) | -100.0% | 15.80 | 7.83 | (7.97) | -100.0% |
| Behavioral Health | 19.69 | 17.43 | (2.26) | -13.0% | 17.76 | 17.05 | (0.71) | -4.2% |
| Other Medical** | 63.23 | 50.50 | (12.73) | -25.2% | 60.31 | 50.02 | (10.29) | -20.6% |
| State Incentive Programs | 5.75 | - | (5.75) | -100.0% | 0.92 | - | (0.92) | -100.0% |
| **Total Medical Expenses** | **$414.06** | **$391.54** | **($22.52)** | **-5.8%** | **$418.12** | **$387.72** | **($30.41)** | **-7.8%** |
| **Gross Margin** | **$18.65** | **$4.63** | **$14.02** | **100.0%** | **$9.26** | **$8.43** | **$0.83** | **9.8%** |
| **Administrative Expenses** | | | | | | | | |
| Salaries | $14.39 | $16.64 | $2.25 | 13.5% | $14.44 | $15.35 | $0.91 | 5.9% |
| Professional Fees | 0.67 | 0.84 | 0.17 | 20.5% | 0.89 | 0.99 | 0.10 | 10.4% |
| Purchased Services | 2.33 | 3.59 | 1.25 | 35.0% | 2.17 | 2.57 | 0.41 | 15.8% |
| Supplies & Other | 2.04 | 2.22 | 0.18 | 8.2% | 2.09 | 1.80 | (0.29) | -16.3% |
| Occupancy | 0.35 | 0.30 | (0.04) | -14.7% | 0.27 | 0.30 | 0.02 | 8.2% |
| Depreciation/Amortization | 1.63 | 2.00 | 0.37 | 18.3% | 1.52 | 1.70 | 0.18 | 10.5% |
| **Total Administrative Expenses** | **$21.40** | **$25.59** | **$4.19** | **16.4%** | **$21.38** | **$22.71** | **$1.33** | **5.9%** |
| **Operating Income** | **($2.75)** | **($20.95)** | **$18.20** | **86.9%** | **($12.12)** | **($14.28)** | **$2.16** | **15.1%** |
| **Non-Op Income/(Expense)** | | | | | | | | |
| Interest | $8.18 | $5.60 | $2.58 | 46.1% | $8.61 | $7.54 | $1.07 | 14.1% |
| Gain/(Loss) on Investments | (0.47) | $0.00 | (0.47) | -100.0% | 2.69 | 0.85 | 1.84 | 100.0% |
| Bank & Investment Fees | (0.14) | (0.14) | (0.00) | -0.1% | (0.09) | (0.14) | 0.05 | 34.5% |
| Other Revenues | 0.59 | 0.53 | 0.05 | 10.1% | 0.58 | 0.45 | 0.13 | 28.0% |
| Grants | (3.44) | (6.08) | 2.64 | 43.4% | (4.69) | (6.08) | 1.39 | 22.9% |
| Community Reinvestment | - | $0.00 | - | 0.0% | - | - | - | 0.0% |
| **Total Non-Op Income/(Expense)** | **$4.72** | **($0.08)** | **$4.81** | **100.0%** | **$7.10** | **$2.63** | **$4.47** | **100.0%** |
| **Net Income/(Loss)** | **$1.97** | **($21.04)** | **$23.01** | **100.0%** | **($5.02)** | **($11.64)** | **$6.63** | **56.9%** |
| *MLR* | *95.7%* | *98.8%* | | | *97.8%* | 97.9% | | |
| *ALR* | *4.9%* | *6.5%* | | | *5.0%* | 5.7% | | |
| *Operating Income* | *-0.6%* | *-5.3%* | | | *-2.8%* | -3.6% | | |
| *Net Income %* | *0.5%* | *-5.3%* | | | *-1.2%* | -2.9% | | |

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



Back to Agenda

**CENTRAL CALIFORNIA ALLIANCE FOR HEALTH**
**Statement of Cash Flow**
**For The Twelfth Month Ending December 31, 2025**
**(In $000s)**
**Unaudited as of 1/23/2026**

| | MTD | YTD |
|---|---|---|
| Net Income | $859 | ($26,622) |
| Items not requiring the use of cash: Depreciation | (2,546) | (1,678) |
| Adjustments to reconcile Net Income to Net Cash provided by operating activities: | | |
| Changes to Assets: | | |
| Restricted Cash | 0 | 4 |
| Receivables | 181,376 | 28,062 |
| Prepaid Expenses | 1,058 | (747) |
| Current Assets | (853) | (1,170) |
| Subscription Asset net Accum Depr | 0 | 0 |
| **Net Changes to Assets** | **181,580** | **26,146** |
| | | |
| Changes to Payables: | | |
| Accounts Payable | (64,955) | (175,604) |
| Other Current Liabilities | 765 | (2,187) |
| Incurred But Not Reported Claims/Claims Payable | 96,425 | (24,309) |
| Provider Incentives Payable | 551 | (2,351) |
| Due to State | 1,326 | 53,707 |
| Subscription Liabilities | 0 | 0 |
| **Net Changes to Payables** | **34,111** | **(150,744)** |
| | | |
| **Net Cash Provided by (Used in) Operating Activities** | **214,004** | **(152,898)** |
| | | |
| Change in Investments | (2,586) | 231,281 |
| Other Equipment Acquisitions | 2,319 | 98 |
| **Net Cash Provided by (Used in) Investing Activities** | **(267)** | **231,378** |
| | | |
| Deferred Inflow of Resources | 0 | 0 |
| **Net Cash Provided by (Used in) Financing Activities** | **0** | **0** |
| | | |
| **Net Increase (Decrease) in Cash & Cash Equivalents** | **213,737** | **78,480** |
| **Cash & Cash Equivalents at Beginning of Period** | **180,985** | **316,238** |
| **Cash & Cash Equivalents at December 31, 2025** | **$394,722** | **$394,722** |



Back to Agenda

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

## Meeting Minutes

**Wednesday, January 28, 2026**
3:00 p.m. – 5:00 p.m.

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

**Commissioners Present**:

| | |
|---|---|
| Ms. Anita Aguirre | At Large Health Care Provider Representative |
| Dr. Ralph Armstrong | At Large Health Care Provider Representative |
| Supervisor Wendy Root Askew | County Board of Supervisor |
| Ms. Tracey Belton | County Health and Human Services Agency |
| Dr. Maximiliano Cuevas | Health Care Provider Representative |
| Supervisor Kim De Serpa | County Board of Supervisor |
| Dr. Donaldo Hernandez | Health Care Provider Representative |
| Ms. Elsa Jimenez | County Director of Health Services |
| Dr. Kristina Keheley | County Health Department Representative |
| Ms. Connie Moreno-Peraza | County Health Department Representative |

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

**Commissioners Absent:**

| | |
|---|---|
| Ms. Leslie Abasta-Cummings | At Large Health Care Provider Representative |
| Mr. Michael Molesky | Public 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 |
| Dr. Mike Wang | Chief Medical Officers |
| Ms. Anne Brereton | Deputy County Counsel, Monterey County |
| Ms. Jessie Dybdahl | Provider Services Director |
| Ms. Jessica Finney | Community Grants Director |
| Ms. Hayley Tut | Clerk of the Board |

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

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

Roll call was taken and a quorum was present.

There were no supplements or deletions to the agenda.

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.

There was no public comment.

**3. Comments and announcements by Commission members.**

Chair Pedrozo opened the floor for Commissioners to make comments. There was no comment.

**4. Comments and announcements by Chief Executive Officer.**

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

- New Alliance Board Member. Mr. Schrader welcomed Commissioner Ye Thao to his first Alliance Board meeting. In December, the Merced County Board of Supervisors appointed Mr. Thao to the Alliance Board as a public representative. Mr. Thao currently serves as a Coordinator for Merced Lao Family Community, Incorporated.
- Medicare D-SNP Program. Our Medicare D-SNP program, TotalCare, launched on January 1, 2026, with an initial enrollment of 454 members. Enrollment will continue throughout the year, as dual-eligible individuals are not limited to the Annual Enrollment Period and may switch to an Exclusively Aligned Medicare D-SNP, such as TotalCare, at any time. This includes members transitioning from a Medicare Advantage plan or from Original Medicare into our TotalCare program. In addition, we will actively engage and market to our Medi-Cal members who age into Medicare and become newly eligible for TotalCare.
- FY2026-27 State Budget. The state budget process began on January 9, 2026, when the Governor released his proposed budget for the 2026–27 fiscal year. Notably, the proposal does not introduce any new reductions to the Medi-Cal program beyond those already approved in last year's budget with future-year implementation dates. However, several risk factors remain. There is concern that the administration may be relying on overly optimistic assumptions about future tax revenues. If those projections do not materialize, the May Revision could reveal a larger budget deficit that will need to be addressed.
- Alliance 30th Anniversary. January 1, 2026 marked the Alliance's 30th anniversary. What began as a small health plan serving roughly 25,000 members in Santa Cruz County has, over three decades, grown into a five-county organization providing coverage to 430,000 members. The Alliance will commemorate this milestone by recognizing our provider partners. Mr. Schrader also acknowledged Commissioner Michael Molesky, who has served on the Board since the organization's inception three decades ago.

**Consent Agenda Items: (5.- 7E. and 8B. – 8G.): 3:17 p.m.**

**MOTION:** Commissioner Jimenez moved to approve Consent Agenda items 5-7E and 8B through 8G seconded by Commissioner Askew.

**ACTION**: The motion passed with the following vote:

Ayes: Commissioners, Armstrong, Askew, Belton, Cuevas, De Serpa, Hernandez, Jimenez, Keheley, Moreno-Peraza, Pedrozo, Radner, Sullivan and Thao

Noes: None.

Absent: Commissioners Abasta Cummings, Aguirre, Molesky and Rabago

Abstain: None.

**Consent Agenda Item: (8A):**

**MOTION:** Commissioner Sullivan moved to approve Consent Agenda item 8A seconded by Commissioner Askew.

| | |
|---|---|
| **ACTION**: | The motion passed with the following vote: |
| Ayes: | Commissioners Askew, Belton, Keheley, Pedrozo, Sullivan and Thao |
| Noes: | None. |
| Absent: | Commissioners Abasta Cummings, Aguirre, Molesky and Rabago |
| Abstain: | Commissioners Armstrong, Cuevas, De Serpa, Hernandez, Jimenez, Moreno-Peraza and Radner |

**Regular Agenda Items: (9. – 10.): 3:23 p.m.**

**9. 2022–2026 Strategic Plan Performance and 2026 Objectives. 3:23 p.m.**

Ms. Van Wong, Chief Operations Officer and Dr. Mike Wang, Chief Medial Officer, presented a comprehensive review of the Alliance's 2025 strategic plan performance, discussed pediatric and health equity measures, behavioral health insourcing, and outlined updated 2026 objectives and targets.

Ms. Wong provided an orientation to the five-year strategic plan, emphasizing health equity and person-centered system transformation, and reviewed the timeline and annual reporting process.

Dr. Wang detailed progress on pediatric MCAS measures in Merced and Mariposa counties, with improvements in well-child visits, immunizations, and lead screening, and described interventions such as workforce support, provider partnerships, and targeted outreach. The Alliance achieved significant increases in telephonic and face-to-face interpretation service utilization, with targeted member and provider engagement, and ongoing efforts to improve data granularity for language access. The Alliance successfully insourced behavioral health services in July 2025, tracked key operational metrics, and addressed increased call volumes by hiring additional staff and launching a member portal for self-service. The ECM program exceeded enrollment targets, reaching 6% of the Medi-Cal population, with ongoing efforts to improve member engagement and encounter rates.

For 2026, objectives include further improvement in pediatric measures, a new focus on member retention through culturally and linguistically appropriate outreach (MOR), enhanced behavioral health care coordination, and timely engagement of TotalCare members in case management.

Ms. Wong outlined the timeline for developing the Alliance's next strategic plan (2027-2029), including stakeholder interviews, environmental scans, and anticipated board engagement and approval milestones. El Cambio Consulting was selected to facilitate the strategic planning process, with stakeholder interviews conducted by Rafael Gomez and a draft plan to be presented in September, followed by board approval in December.

A discussion ensued among Commissioners.

[Commissioner Aguirre arrived at 3:29pm]
[Commissioner Rabago arrived at 3:51pm]

**10. 2026 Medi-Cal Capacity Grant Program Investment Plan. 4:08 p.m.**

Ms. Jessica Finney, Community Grants Director, reviewed 2025 highlights of the Medi-Cal Capacity Grant Program (MCGP) and presented the 2026 MCGP Investment Plan which recommended a $20 million award target, which the board subsequently approved.

In 2025, the Alliance awarded $33 million to 103 community partners, supporting provider recruitment, capital projects, care gap closure, community health worker and doula network development, and technology improvements. Highlights included: Provider Recruitment grants achieved a 34% decrease in wait times for appointments and high retention rates for recruited providers; improvements were achieved in care gap measures; and 18 housing fund projects are now in progress.

The 2026 plan prioritizes workforce and infrastructure to expand access, support for safety net providers, community engagement for member retention, and capacity building for community-based organizations. With no expected surpluses in the next three fiscal years to increase the MCGP available funding, the 2026 award target is set at $20 million, allocated as 50% to healthcare workforce, 30% to health care system infrastructure, and 20% to community resources and engagement.

A discussion ensued among Commissioners.

| | |
|---|---|
| **MOTION:** | Commissioner Cuevas moved to approve the staff recommendation for the 2026 Medi-Cal Grant Program Investment Plan seconded by Commissioner Aguirre. |
| **ACTION**: | The motion passed with the following vote: |
| Ayes: | Commissioners, Aguirre, Armstrong, Askew, Belton, Cuevas, De Serpa, Hernandez, Jimenez, Keheley, Moreno-Peraza, Pedrozo, Radner, Sullivan and Thao |
| Noes: | Commissioner Rabago |
| Absent: | Commissioners Abasta Cummings and Molesky |
| Abstain: | None. |

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**The Commission adjourned its meeting of January 28, 2026, at 4:25 p.m. to the regular meeting of February 25, 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.*



Back to Agenda

# COMPLIANCE COMMITTEE

**Meeting Minutes**
**Wednesday, December 17, 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 |
| **Cecil Newton** | Chief Information Officer |
| **Danita Carlson** | Government Relations Director |
| **Fabian Licerio** | Risk Adjustment Director |
| **Jenifer Mandella** (chair) | Chief Compliance Officer |
| **Jessica Finney** | Community Grants Director |
| **Jessie Dybdahl** | Provider Services Director |
| **Jill Drake** | Compliance Manager |
| **Jimmy Ho** | Accounting Director |
| **Kay Lor** | Payment Strategy Director |
| **Krishan Patel** | Data Analytics Services Director |
| **Lilia Chagolla** | Member Services Director |
| **Linda Gorman** | Communications Director |
| **Lisa Artana** | Human Resources Director |
| **Lisa Ba** | Chief Financial Officer |
| **Michael Schrader** | Chief Executive Officer |
| **Michael Wang** | Medical Director |
| **Nicole Krupp** | Regulatory Affairs Manager |
| **Ryan Inlow** | Facilities & Administrative Services Director |
| **Scott Crawford** | Medicare Program Executive Director |
| **Scott Fortner** | Chief Administrative Officer |
| **Shelly Papadopoulos** | Operations Management Director |
| **Tammy Brass** | Utilization Management Director |
| **Van Wong** | Chief Operating Officer |

**Committee Members Absent:**

| | |
|---|---|
| **Gray Clarke** | Behavioral Health Medical Director |
| **Lizette Podwalny** | Health Services Operations Manager |

**Committee Members Excused:**

| | |
|---|---|
| **Kelsey Riggs** | Care Management Director |
| **Navneet Sachdeva** | Pharmacy Director |
| **Ronita Margain** | Community Engagement Director |
| **Ryan Markley** | Compliance Director |

**Ad-Hoc Attendees:**

| | |
|---|---|
| **Anita Guevin** | Medicare Compliance Program Manager |
| **Aaron McMurray** | Information Security Manager |
| **Daljit Toor** | Regulatory Affairs Specialist |
| **Ka Vang** | Compliance Specialist |
| **Kaitlin Band** | Compliance Specialist |
| **Kat Reddell** | Compliance Specialist |
| **Margarita Shull** | Program Integrity Specialist |
| **Nicolette Shalita Vega** | NCQA Compliance Program Manager |
| **Paige Harris** | Regulatory Affairs Specialist |
| **Rebecca Seligman** | Compliance Manager |
| **Sara Halward** | Compliance Specialist |
| **Savana Ciavatta** | Associate Counsel |
| **Stephanie Vue** | Regulatory Affairs Specialist |
| **Vanessa Paz** | Community Health Program Manager |

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

Chairperson Jenifer Mandella 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 Notice of Privacy Practices**

COMMITTEE ACTION: Committee reviewed and approved Consent Agenda.

**4. Regular Agenda**

**1. HIPAA & Security Quarterly Report**

Mandella, Chief Compliance Officer, and McMurray, Information Security Analyst, presented the Q3 2025 HIPAA Privacy & Security Report.

Mandella reported on the transition of Compliance Concerns, including HIPAA and FWA reporting, to the Readily platform, as part of the broader migration of compliance work from Compliance 360 to Readily. Mandella also discussed ongoing work to support configuration changes in JIVA to better prevent the potential redisclosure of substance use disorder data

Mandella reviewed HIPAA reporting trends for the quarter, reporting an increase in referrals and noting that of the 58 referrals received, 19 were determined to be incidents

requiring state reporting, 16 were determined to be non-events, and 22 were determined to be non-reportable; there is one referral pending classification. Member impact was noted as being higher than usual; additional details were requested as to what was driving those numbers.

Mandella reviewed HIPAA program metrics included on the Alliance Dashboard noting good performance as related to timely reporting of incidents to regulators and highlighting the importance of timely reporting to Compliance and the need for ongoing education to reduce repeat incidents. Finally, Mandella reviewed root causes for disclosures, noting that incorrect selection/entry remains the top root cause, with verbal disclosures as an increasingly frequent source of reports.

McMurray, Information Security Analyst, provided an update on the assessment of cybersecurity measures related to phishing attacks for Q325, noting an increase in reporting of suspicious emails, which indicates the success of the educational phishing campaign.

McMurray also provided an update to the security remediation program noting that Network Segmentation, Privileged Access Management, HIPAA/NIST Gap Assessment and Identity and Access Management were emphasized over the quarter. Committee members expressed concern with network segmentation in particular, noting that other plans have been severely impacted by breaches as a result of limited network segmentation; McMurray was asked to provide a more detailed review of Alliance controls in this area at an upcoming Committee meeting.

COMMITTEE ACTION: Committee reviewed and approved the Q3 2025 HIPAA Privacy & Security Quarterly Report and assigned the following action items:

- Vang to provide a detailed explanation of Q325 member impacted numbers at March Committee meeting
- McMurray to include detailed review of network segmentation controls at March Committee meeting.

**2. Delegate Oversight Quarterly Report**

Drake, Compliance Manager, presented the Q3 25 Delegate Oversight Quarterly Activity Report, highlighting approved and pending reviews and additional oversight activities and upcoming activities,

Drake provided an overview of completed and pending reviews for Q1 and Q2 noting in process and outstanding documentation review and an update on 2025 Annual noting outstanding documentation and the use of CAPs for unresolved deficiencies, particularly with VSP. Staff recommended continued delegation of all Delegates.

Q1 2025 Quarterly Review
Staff recommended holding approval of the following reports received from delegated health entities

- AristaMD: Credentialing and Recredentialing
- ChildNet: Credentialing and Recredentialing

- Dignity: Credentialing and Recredentialing
- UCSF: Credentialing and Recredentialing
- VSP: Credentialing and Recredentialing

COMMITTEE ACTION: Committee approved the Q1 2025 Quarterly Review of delegated health entities and assigned the following action items:

- Staff to review documentation from AristaMD, ChildNet, Dignity, UCSF and VSP and complete Q125 quarterly reviews.

Q2 2025 Quarterly Review:
Staff recommended holding approval of the following reports received from delegated health entities:

- AristaMD: Credentialing and Recredentialing
- LPCH: Credentialing and Recredentialing
- MedImpact: UM-Pharmacy, pending receipt of revised member notice from MedImpact.
- PAMF: Credentialing and Recredentialing
- SCVMC: Credentialing and Recredentialing
- Stanford: Credentialing and Recredentialing
- UCSF: Credentialing and Recredentialing
- VSP: Call Center and Credentialing and Recredentialing

COMMITTEE ACTION: Committee approved the Q2 2025 Quarterly Review of delegated health entities and assigned the following action items:

- Staff to review documentation from AristaMD, LHPC, MedImpact, PAMF, SCVMC, Stanford, UCSF and VSP and complete Q225 quarterly reviews.

2025 Annual Review
Staff recommend approval of the following reports received from delegated health entities:

- AristaMD: Credentialing and Recredentialing
- Call the Car: Member Connections
- Carelon: Claims Processing, Provider Disputes, Member Connections, Member Grievances, Credentialing and Recredentialing, Network Management, Quality Improvement and Utilization Management
- CareNet: Member Connections
- ChildNet: Credentialing and Recredentialing
- Dignity: Credentialing and Recredentialing
- LPCH: Credentialing and Recredentialing
- SCVMC: Credentialing and Recredentialing
- Stanford: Credentialing and Recredentialing

Staff recommended holding approval of the following reports received from delegated health entities:

- MedImpact: Claims Processing, Provider Disputes, Member Connections, Credentialing and Recredentialing and Utilization Management
- PAMF: Credentialing and Recredentialing

- UCSF: Credentialing and Recredentialing
- VSP: Claims Processing, Provider Disputes, Member Connections, Member Grievances, Credentialing and Recredentialing, Network Management, Quality Improvement.

Drake reported that CAP implementation is in process for VSP due to open deficiencies related to Business Continuity, Fraud Waste and Abuse, Delegation Reporting, Provider Overpayment Reporting and Patient Rights. A response from VSP is due December 12 2025.

COMMITTEE ACTION: Committee approved 2025 Annual Reviews of delegated health entities and assigned the following action items:

- Staff to review documentation from MedImpact, PAMF and UCSF and complete 2025 annual review

Drake reported on the status of CMS Delegation and FDR Attestations noting completed and in-progress approvals.

Staff recommend approval of MedImpact for the delegated function of CMS Part D Pharmacy Benefits Management.

COMMITTEE ACTION: Committee approved the delegation of MedImpact for Pharmacy Benefits Management.

Drake reported on the transition from C360 to Readily platform for Delegate Oversight activities and noted changes to the annual assessment cycle to improve manageability.

**3. Internal Audit & Monitoring Quarterly Report**

Halward, Compliance Specialist III, presented the Q3 2025 Internal Audit and Monitoring Activity Report noting that 3 internal audits were assigned, 2 were closed and 2 are ongoing. 1 audit from Q2 is expected to move to a CAP due to lack of delegate responsiveness.
Halward reviewed outcomes of the monitoring of 34 Alliance Dashboard metrics related to regulatory requirements noting that 2 metrics failed for the monitoring period and CAPs have been initiated.

Halward reported assigned audit areas for Q4 2025 noting planned audits in the following areas:

- Case Management – Behavioral Health
- CCS Referrals
- Grievance & Appeals – Behavioral Health
- Screening & Enrollment/NPO – Behavioral Health
- UM Authorizations – Behavioral Health
- Reinstatement of Benefits Upon Overturned Appeal

Halward reported performance metrics from the Alliance Dashboard noting that Q325 efficiency metrics (timeliness of correction of identified issues) met target performance;

quality metrics (preventing recurrence of findings) are reported annually and 2024 performance is still reflected on the dashboard.

Halward finished with an update on regulatory audits noting that the 2025 DHCS Medical Audit CAP corrections have been accepted and the audit has been closed. Halward reported that the 2026 DHCS Medical Audit has been cancelled with the next audit to be scheduled in 2027 with a two-year lookback period. The DMHC follow-up survey is scheduled to take place in September 2026 with a focus on previously uncorrected findings.

COMMITTEE ACTION: Committee reviewed and approved the Q3 2025 Internal A&M Quarterly Report.

**4. CAPs Updates**

Mandella provided an informational update on various Corrective Action Plans (CAPs), highlighting CAPs that had significant updates since the previous report.

Open CAPs:

- DHCS pre-CAP: Transitional Rent Provider Network Development, which DHCS has issued to a number of plans, related to not having fully implemented the transitional rent program by January of 2026. DHCS is aware of plan concerns with the timeline and lack of guidance for the program and has indicated these CAPs are not punitive at this time.

Ongoing CAPs:

- Internal - Employee Permissions, which is nearing closure. Artana provided an update that the implementation of the software solution that was needed to identify and track consultants is nearing completion, and this concern will be resolved soon.
- Internal - ECM Community Supports, which is nearing completion via the transition of provider payment from capitated to claims-based payment and the implementation of additional UM controls and provider monitoring.
- Internal – Provider Payment Accuracy
- Internal – Timely distribution of Resolution Letters for contracted and non-contracted provider disputes
- Internal - Process improvement to gaps in management of assisted living.

Closed CAPs:

- Internal - Timeliness for Facility Site Review, which was resolved by adjusting the performance threshold, in recognition that performance is reliant on provider engagement
- Internal – ECM Encounters and Capitation Monitoring, which is nearing completion via the transition of provider payment from capitated to claims-based payment and the implementation of additional UM controls, development of reporting, and enhanced provider monitoring protocols.
- Continuity of Care, which was determined to be a reporting error and not non-compliance.

Finally, Mandella noted that additional CAPs could result from ongoing pre-delegation assessments for DSNP. Swan and Dybdahl raised questions about delegated function and oversight of the Alliance's nurse advice line vendor.

COMMITTEE ACTION: Committee assigned the following action items in response to the December 2025 CAPs Updates:

- Swan to follow up with Compliance Unit staff to obtain clarity and assess adequacy of oversight of nurse advice line vendor.

**5. Program Integrity Quarterly Report**

Seligman, Program Integrity Manager, presented the Q3 2025 Program Integrity Activity Report reporting that 161 concerns were referred to Program Integrity in the quarter (a 26% increase), 86 of which resulted in the opening of a matter under investigation (MUI). There were 141 active MUIs in the quarter. This is a record high volume for the function, and staff are exploring strategies to ensure referrals are appropriately investigated, prioritizing referrals that point to trends and schemes as opposed to individual instances of non-compliance.

Seligman reported performance of the Program Integrity performance metrics from the Q3 2025 Alliance Dashboard noting that the quality metric was above the target performance each month in the quarter and the efficiency metric was below the target performance 2 months of the quarter.

Seligman reported Q325 Program Integrity Financials reporting the total requested recoupment was $19,223.61 and completed recoupment was $7,297.44.

COMMITTEE ACTION: Committee reviewed and approved the Q3 2025 Program Integrity Report.

The meeting adjourned at 10:03 a.m.

Respectfully submitted,
Robin Sihler
Compliance Administrative and Data Reporting Assistant

**DATE:** February 25, 2026

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

**FROM:** Ronita Margain, Community Engagement Director

**SUBJECT:** Whole Child Model Family Advisory Committee: Member Appointment

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

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

Discussion. The following individual has indicated interest in participating on WCMFAC.

| Name | Affiliation | County |
|---|---|---|
| Ivett Vazquez | Community Partner | Santa Cruz |

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

Attachments. N/A

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

**DATE:** February 25, 2026

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

**FROM:** Ronita Margain, Community Engagement Director

**SUBJECT:** Member Services Advisory Group: Member Reappointment

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

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

Discussion. The following individual have indicated interest in continuing participation on MSAG.

| Name | Affiliation | County |
|---|---|---|
| Rebekah Capron | Community Partner | Merced |

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

Attachments. N/A

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

**DATE:** February 25, 2026

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

**FROM:** Michael Schrader, Chief Executive Officer

**SUBJECT:** Voluntary Rate Range Program (VRRP) for CY 2025 Rating Period

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Recommendation. Staff recommend that the Board authorize the Chairperson and the Chief Executive Officer (CEO) to sign the necessary contract amendments and agreements to facilitate the Voluntary Rate Range Program (VRRP) for the CY 2025 rating period with interested, qualified local governmental entities, as approved by DHCS, assuming that staff determines the contract language is appropriate and that revenue is sufficient to meet the Alliance's VRRP payment obligations.

Summary. The VRRP program provides an opportunity for interested, qualified local governmental entities to use local funds to draw down federal matching funds for Medi-Cal services in the Alliance's service area through increased capitation rates paid to the Alliance. Qualified entities include local government entities with taxing authority.

DHCS has released its CY 2025 VRRP Request to Medi-Cal Managed Care Plans (MCP) for proposals for the VRRP for the CY 2025 rating period. The Alliance must respond to DHCS' request with a Letter of Intent (LOI) that includes each governmental entity's level of participation.

Background. With the Board's approval, the Alliance has been facilitating supplemental payments for interested, qualified local governmental entities since FY 2009-10 through what was then called the Voluntary Intergovernmental Transfer (IGT) Rate Range Program. Provisions in the federal Medicaid Managed Care regulations restricting DHCS' ability to direct managed care payments required DHCS to make changes to the IGT program beginning in 2017-18, when DHCS renamed this payment program the VRRP.

Discussion. The VRRP includes qualified governmental funding entities voluntarily transferring funds to the State via an IGT, which, combined with federal financial participation (FFP) funds, are used to fund capitation payment increases to MCPs. DHCS estimates the available Rate Range funds within each rating region in the Alliance's service area. The Alliance determines the allocation of the rate range funds based on utilization and historical funding agreements. The interested, qualified local entities decide their requested level of financial participation up to the maximum available as estimated by DHCS.

Implementing the Voluntary Rate Range Program for Rating Period CY 2025. Upon approval by DHCS of the LOI**,** the Alliance will develop the necessary documents to implement the VRRP for the CY 2025 rating period, including, but not limited to, an amendment to the participating providers' current provider agreements.

This amendment is intended to achieve the objectives of the VRRP (i.e., provide increased funding to qualified local providers for Medi-Cal services) and includes protections for the Alliance to ensure that the Alliance is held harmless for its participation in this payment program. The provider agreement facilitates Alliance payments to the participating provider in an amount equal to the Rate Range funded capitation revenue increase. The Alliance does not retain any of the Rate Range funds. However, given the amount of staff resources required to implement the Voluntary Rate Range program, the Alliance may apply a two percent (2%) administrative fee on the governmental entities' contribution.

To implement the VRRP, DHCS calculates capitation rates for the Alliance that equal the amount of the qualified governmental entities' contribution plus the FFP. DHCS includes these capitation rate increases in the Alliance's State Medi-Cal contract. Alliance staff review the proposed rates to ensure they are sufficient to meet the Alliance's payment obligations under the VRRP agreement.

The Alliance is working with the following qualified local governmental entities to determine participation interest in the Rate Range Program for the CY 2025 rating period:

- County of Santa Cruz
- County of Monterey
- Salinas Valley Health System
- County of Merced
- San Benito Health Care District
- John C Fremont Healthcare District
- Pajaro Valley Health Care District

Action Required. It is necessary for the Board to authorize the Chairperson and the CEO to sign the LOI and implementing agreements, including amendments to the Alliance-DHCS Medi-Cal contract containing VRRP capitation rates for the CY 2025 rating period, and amendments to the participating provider agreements to enable the supplemental VRRP payments.

Fiscal Impact. There is no fiscal impact on the Alliance. VRR/IGT payments are passed through to the participating providers. The Alliance receives a two percent (2%) administrative fee which is already reflected in our financial statements.

Attachments. N/A

**DATE:** February 25, 2026

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

**FROM:** Ronita Margain, Community Engagement Director

**SUBJECT:** Member Services Advisory Group: Charter

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Recommendation. Staff recommend the Board approve Member Services Advisory Group (MSAG) Charter.

Summary. The Member Services Advisory Group (MSAG) Charter was revised to reflect changes due to the 2026 TotalCare (HMO D-SNP) Medicare Advantage Dual Eligible Special Needs Plan (D-SNP).

Background. The MSAG ensures community and member participation in establishing the Alliance's public policy in quality, health equity, disparities, population health, children services, and other ongoing plan functions. The Board reviewed and approved the initial MSAG charter for 2023. The 2026 TotalCare (HMO D-SNP) Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) has new requirements that will be met through MSAG. The revised charter reflects the new requirements and will be effective February 26, 2026.

Discussion. The MSAG Chairperson and Vice Chairperson had no comments or objections to the integration of the new TotalCare (HMO D-SNP) Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) requirements.

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

Attachments.

1. Member Services Advisory Group (MSAG) Charter.

# Member Services Advisory Group (MSAG)
# Meeting Charter

| | |
|---|---|
| **Original Date:** October 2023 | **Last Revision Date:** 02/06/2026~~01/30/2026~~~~6/5/2025~~ |
| **Approved by:** Alliance Board of Commissioners | |

| | |
|---|---|
| **Overview** | The Member Services Advisory Group (MSAG) serves as the Alliance's Community Advisory Committee.<br><br>The MSAG- serves as the Alliance's Community Advisory Committee and as the Enrollee Advisory Committee (EAC) for TotalCare Dual Eligible Special Needs Plan (D-SNP).<br><br>The MSAG provides structured, meaningful input from TotalCare Enrollees and their representatives to inform Medicare and Medi-Cal integration, care coordination, access to care, and beneficiary experience. |
| **Duties** | **Responsibilities of MSAG Members:**<br>• Review agenda and supporting documents in advance of the meeting.<br>• Attend meetings and arrive on time.<br>• Be prepared to discuss and vote on agenda items.<br>• Listen respectfully to all participants and actively engage in meeting topics.<br>• Follow the Alliance's Code of Conduct: Alliance Code of Conduct - Central California Alliance for Health.<br><br>**Responsibilities of the Chair:**<br>• Provide meeting facilitation and direct the meeting process through the agenda.<br>• Guide and lead discussion to ensure all participants are provided equal opportunity for participation.<br><br>**Responsibilities of the Vice Chair:**<br>• Preside at the meetings in absence of the Chair. |

# Member Services Advisory Group (MSAG)
# Meeting Charter

| | |
|---|---|
| | **Responsibilities of Alliance Staff:**<br>• Alliance staff will serve as support to MSAG.<br>• A coordinator will be assigned to support MSAG including but not limited to ensuring members are able effectively communicate and participate in meetings.<br>• Staff supporting MSAG can be reached at MSAG@thealliance.health.<br>• Alliance staff will ensure and monitor member and/or parent and caregiver input is considered for appropriate policies and decision-making. |
| **Composition** | **Membership**<br>• The MSAG will be comprised primarily of Alliance members or parent/guardians of Alliance members. MSAG will also include TotalCare enrollees, providers, community partners, and Alliance Commissioner(s).<br>• One member of the MSAG will serve as Chair of the MSAG and one member will serve as Vice Chair of the MSAG.<br><br>**Membership Terms**<br>• Members will be appointed by the Alliance Board.<br>• Members will be appointed to a one-year term. At the end of the term the member may be reappointed to a subsequent one-year term.<br>• Members must attend at least 50% of meetings per calendar year.<br><br>**Chair and Vice Chair Terms**<br>• The Chair and Vice Chair shall be selected by MSAG members.<br>• If both Chair and Vice Chair are absent, MSAG members present will select one member to act as Chair for the meeting. The Chair and Vice Chair shall serve renewable one-year terms. |

# Member Services Advisory Group (MSAG)
# Meeting Charter

| | |
|---|---|
| **Meeting Frequency and Locations** | • Meetings will be held quarterly.<br>• The meeting calendar for the following year shall be proposed annually at the MSAG's August meeting. The meeting calendar will be established annually by the Alliance Board.<br>• Meetings will take place in person in the Alliance offices listed below and joined together via videoconferencing.<br>  ○ Mariposa County:<br>  Mariposa County Health and Human Services<br>  5362 Lemee Lane, Mariposa, CA 95338<br>  ○ Merced County: 530 West 16th Street, Suite B, Merced, CA 95340<br>  ○ Monterey County:<br>  950 East Blanco Road, Suite 101, Salinas, CA 93901<br>  ○ San Benito County: Community Services & Workforce Development (CSWD)<br>  1161 San Felipe Road, Building B, Hollister, CA 95023<br>  ○ Santa Cruz County:<br>  1600 Green Hills Road, Suite 101, Scotts Valley, CA 95066 |
| **Agendas, Minutes, and Reporting** | • Alliance staff are responsible for agenda and meeting material production and distribution.<br>• Alliance staff will record minutes of meetings which will be approved by the MSAG members at each subsequent meeting. |
| **Advisory Group Member Support** | • The Alliance provides resources to ensure MSAG members are able to effectively participate in MSAG meetings including but not limited to providing transportation to MSAG meetings and arranging childcare as necessary.<br>• MSAG members may receive a stipend to cover travel expenses and other costs associated with in-person meeting attendance.<br>• Requests for translation and interpreter services, including sign-language interpretation or other assistive devices such as real-time captioning, note takers, reading or writing assistance and conversion of meeting materials into Braille, large print or |

| | |
|---|---|
| | computer flash drive can be made available if requested at least ten (10) business days prior to the meeting.<br>• MSAG complies with the Americans with Disabilities Act (ADA). |
| **Open and Public Meetings** | • Meetings are subject to the Brown Act, thus are open to the public.<br>• Agendas and meeting materials will be published and posted publicly at least seventy-two (72) hours prior to each meeting.<br>• Agenda packets are available by mail upon request. |
| **Review of Charter** | MSAG shall review this charter at least annually.<br><br>Any proposed changes shall be submitted to the Board for approval. |

**Revision History:**

| Date | Changes Made By | Approved By |
|---|---|---|
| October 10, 2023 | Kayla Zoliniak<br>Administrative Specialist | |
| October 26, 2023 | | Alliance Board of Commissioners |
| October 26, 2023 | Ronita Margain<br>Community Engagement Director | |
| December 6, 2023 | | Alliance Board of Commissioners |
| June 5, 2025 | Kayla Zoliniak<br>Administrative Specialist | Ronita Margain<br>Community Engagement Director |
| January 9, 2026 | Scott Crawford<br>Executive Director – Medicare Program | |

**DATE:** February 25, 2026

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

**FROM:** Tammy Brass, RN, UM Director and Health Services Executive Director

**SUBJECT:** Utilization Management Work Plan Report for Q3 2025

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Recommendation. Staff recommend the Board accept the Utilization Management Work Plan (UMWP) Report for Q3 2025.

Summary. This attached report provides details and summaries of the UMWP activities for Q3 2025.

Background. The Utilization Management Workgroup (UMWG) provides guidance and oversight to the Utilization Management (UM) Program and operates under the authority of the Quality Improvement Health Equity Committee (QIHEC). This quarterly summary highlights outcomes from the updates to the UMWP implemented in Q3 2025. Ongoing projects and initiatives carried forward from 2024, as well as newly established goals for 2025 continue to be monitored, with progress tracked against established goals.

Variances in goal achievement are documented in the quarterly UMWP, along with analysis of factors influencing outcomes. Adjustments or changes to interventions are noted and described in the quarterly recommendations.

Discussion. The Q3 2025 Utilization Management (UM) Workplan reflects ongoing improvements in care coordination, access, and service utilization across programs.

Case Management (CM)
In Q3, Pediatric CM continued to experience membership growth across all eligibility categories. Case volumes also increased under the newly aligned reporting methodology, and the team is advancing efforts to improve care plan completion through targeted member outreach. Adult CM saw enrollment declines primarily due to inability to reach members, though longer-term case activity increased and NCQA-focused quality performance continued to strengthen. A texting outreach strategy is being implemented to improve member contact, engagement, and enrollment in Case Management supports.

Enhanced Care Management (ECM) & Community Supports (CS)
ECM reporting methodology was updated in Q3, with continued quarter-over-quarter enrollment growth across all counties and no current capacity concerns, including expanded capacity in San Benito. As enrollment remains at approximately 5% of membership (goal: 3%), the team is prioritizing timely and proactive disenrollments, automation efforts, and refinement of graduation/renewal criteria in preparation for the transition to FFS payment effective 1/1/26.

Utilization & Access Trends

In Q3 2025, Medi-Cal inpatient utilization remained stable, with average length of stay (ALOS) slightly up for some populations and readmission rates generally within expected ranges. California Children's Services (CCS) and Seniors and Persons with Disabilities (SPD+Dual) members continued to benefit from weekly Interdisciplinary Team (IDT) meetings, care management, and Enhanced Care Management (ECM) collaboration, supporting transitions of care and high-risk member oversight. Avoidable emergency department (ED) visits decreased for Medi-Cal child and family populations and remained relatively unchanged for Medi-Cal Seniors and Persons with Disabilities (SPD) populations compared to prior quarters. Ambulatory Care Sensitive Admissions were stable across most counties, while Skilled Nursing Facility placements showed a small decrease in bed days and readmissions. Overall, continued focus on IDTs, transitions of care workflows, and targeted interventions is supporting utilization goals and quality outcomes.

In Q3, pharmacy and medical denials remained generally consistent with prior quarters. Top pharmacy denials continued to reflect routine patterns, with a temporary increase in dexamethasone lacrimal insert (Dextenza) requests from a single provider. Medical necessity denials were primarily for Medically Tailored Meals and related services, genetic testing (including carrier screening, oncology assays, and fetal genome tests), and varicose vein procedures. Overall trends are stable, with ongoing policy refinement, provider education, and internal clinical review supporting appropriate authorization and alignment with DHCS requirements.

Other Highlights

Since BH insourcing on July 1, 2025, over 1,000 member calls and 412 Q3 Applied Behavior Analysis (ABA) and Behavioral Health Treatment (BHT) case management activities have established baseline engagement data, with enhanced provider call tracking and targeted outreach underway to improve access and support, particularly in Mariposa County.

Behavioral Health penetration rates remain within target across all counties and age groups, with increases in ages 0–12 and 19+ and slight but in-range declines among ages 13–18 in select counties. Rates reflect BH network services only, and leadership is reviewing benchmarks to ensure continued alignment with county, state, and national standards.

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

Attachments.

1. Utilization Management Work Plan Q3 2025

# Central California Alliance for Health
# 2025 Utilization Management Work Plan and Evaluation

**I.** Projects and Initiatives
- A. Pediatric and Adult Case Management
- B. Enhanced Health Services: ECM and CS
- C. Reducing Readmissions Initiative
- D. Pharmacy Led Academic Detailing (PLAD) Program
  Naloxone Distribution Program
- E. Phone System Replacement Project
- F. BHT Provider and Caregiver Engagement

**II.** Operational Performance
- A. Routine Prior Authorization Turn Around Time
- B. Prior Authorization Request Determination Metrics
- C. Top 10 Prior Authorization Medical Necessity Denials
- D. Inter-Rater Reliability - Nurses
- E. Inter-Rater Reliability - BHT
- F. Inter-Rater Reliability - MDs
- G. Inter-Rater Reliability - Pharmacy
- H. Routine Pharmacy Turn Around Time
  Pharmacy Request Determination Metrics
  Written Notification of Pharmacy NOAs to Members and Providers
- I. Written Notification of BH NOAs to Members and Providers
- J. Written Notification of PA NOAs to Members and Providers
- K. Written Notification of CR NOAs to Members and Providers

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

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

**INITIAL WORK PLAN AND EVALUATION APPROVAL:**

Submitted and approved by UMWG Date: 3/18/2025

Submitted and approved by QIHEC Date: 3/20/2025

Submitted and approved by Board Date:

Mike Wang, MD, Medical Director Date: 3/18/2025

Omar Guzman, Chief Medical Officer Date: 3/18/2025

Tammy Brass, RN

Tammy Brass, RN, Utilization Management Director Date: 3/18/2025

**FINAL EVALUATION APPROVAL:**

Submitted and approved by UMWG Date:

Submitted and approved by QIHEC Date:

Submitted and approved by Board Date:

Mike Wang, MD, Medical Director Date:

Omar Guzman, MD, Chief Medical Officer Date:

Tammy Brass, RN, Utilization Management Director Date:



Back to Agenda

# I. Projects and Initiatives

## A.(a) Pediatric Case Manage)

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

**2025 Evaluation**

| Time Period | Total # of Eligible members by County (Per last month of quarter) | # Newly Eligible by County (Sum of each month in quarter) | # Aged Out by County (Sum of each month in quarter) | # Approved NICU/PICU by County (Sum of each month in quarter) | # High Risk NCQA Members (Tableau) | # High Risk Members (WCM) (Per last month of quarter) | # Low Risk Members (Per last month of quarter) | # ICPs (Per last month of quarter) | Comments/ Recommendations |
|---|---|---|---|---|---|---|---|---|---|
| **1st Quarter** | Santa Cruz: 1176<br>Monterey: 4083<br>Merced: 3278<br>Mariposa: 67<br>San Benito: 375 | Santa Cruz: 30<br>Monterey: 57<br>Merced: 91<br>Mariposa: 1<br>San Benito: 6 | Santa Cruz: 27<br>Monterey: 78<br>Merced: 92<br>Mariposa: 0<br>San Benito: 1 | Santa Cruz: 33<br>Monterey: 145<br>Merced: 109<br>Mariposa: 0 San Benito: 11 | **84** | **96** | **176** | **41** | **N/A** |
| **2nd Quarter** | Santa Cruz: 1232<br>Monterey: 4193<br>Merced: 3400<br>Mariposa: 69<br>San Benito: 388 | Santa Cruz: 61<br>Monterey: 83<br>Merced: 121<br>Mariposa: 2<br>San Benito: 1 | Santa Cruz: 27<br>Monterey: 89<br>Merced: 69<br>Mariposa: 0<br>San Benito: 0 | Santa Cruz: 35<br>Monterey: 131<br>Merced: 118<br>Mariposa: 1<br>San Benito: 3 | **88** | **92** | **209** | **24** | The decrease in the number of Individualized Care Plans (ICPs) is partly due to challenges in obtaining consent from high-risk members to participate in case management. Although these members have been identified as high risk, many have been unreachable or declined to engage, which has resulted in a lower number of finalized care plans compared to the total number of high-risk individuals identified. |
| **3rd Quarter** | Santa Cruz: 1267<br>Monterey: 4247<br>Merced: 3497<br>Mariposa: 71<br>San Benito: 381 | Santa Cruz: 43<br>Monterey: 52<br>Merced: 109<br>Mariposa: 8<br>San Benito: 14 | Santa Cruz: 36<br>Monterey: 102<br>Merced: 93<br>Mariposa: 0<br>San Benito: 7 | Santa Cruz: 45<br>Monterey: 157<br>Merced:109<br>Mariposa:4<br>San Benito:15 | **46** | **63** | **253** | **47** | 22% increase in newly eligible members, 5% increase in CCS eligible members and 20% increase in aged out members over Q1. Aligning with Adult CM on report methodology for greater consistency. Q2 numbers under this methodology are 32 and Q3 are 46, reporting in development for further optimization and review. In review of Q1 and Q2 updated # of ICP for Q1 is 54 and Q2 is 56. Action plan to increase ICPs: Implementing texting campaign for members who are UTC. Will cont. to monitor impacts for increased member engagement.<br>Report used https://tableau.ccah-alliance.org/#/views/DHCSWCMMonthly/AssessmentsColumnGEffectiveQ2-2023?:iid=2 |
| **4th Quarter** | Santa Cruz:<br>Monterey:<br>Merced:<br>Mariposa:<br>San Benito: | Santa Cruz:<br>Monterey:<br>Merced:<br>Mariposa:<br>San Benito: | Santa Cruz:<br>Monterey:<br>Merced:<br>Mariposa:<br>San Benito: | Santa Cruz:<br>Monterey:<br>Merced:<br>Mariposa:<br>San Benito: | | | | | |
| **Year End** | Santa Cruz:<br>Monterey:<br>Merced:<br>Mariposa:<br>San Benito: | Santa Cruz:<br>Monterey:<br>Merced:<br>Mariposa:<br>San Benito: | Santa Cruz:<br>Monterey:<br>Merced:<br>Mariposa:<br>San Benito: | Santa Cruz:<br>Monterey:<br>Merced:<br>Mariposa:<br>San Benito: | | | | | |



Back to Agenda

## A.(b) Adult Case Management

Adult Case Management Program is focused on improving the health of our Complex Case Management members. The goal is to increase the number of compliant NCQA qualifying mbrs.

**2025 Evaluation**

| Time Period | Total # of NCQA Eligible members | # Enrolled NCQA members | # NCQA members with a completed Assessment, POC and open for 60 days | Comments/ Recommendations |
|---|---|---|---|---|
| 1st Quarter | 751 | 280 | 126 | Total # of NCQA Eligible members are all members we have attempted to outreach to. We continue to try to get members engaged in CM. |
| 2nd Quarter | 539 | 134 | 48 | You may notice a decrease in overall NCQA case volume from Q1 to Q2. In Q1, our efforts were highly concentrated on NCQA in preparation for the audit. While we continue to closely review and prioritize these cases, we have also expanded our focus to include other case types. We will continue to monitor NCQA cases closely to ensure all are addressed appropriately. |
| 3rd Quarter | 575 | 124 | 60 | 25% increase from Q2 in complete cases open over 60 days; 56% decline in enrolled members over Q1 (n=124 vs280). CM focus on improving quality around NCQA and making progress toward increasing NCQA performance. Recent growth in both NCQA cases and the number of members with completed assessments, plans of care, and those open for 60 days. A slight decline in enrolled NCQA members, likely related to UTC. Team is exploring creative approaches to UTC and will soon implement member text outreach. Anticipate member texting will help boost enrollment and will cont. to monitor. |
| 4th Quarter | | | | |
| Year End | | | | |



Back to Agenda

## B. Enhanced Health Services: Enhanced Care Management (ECM) and Community Supports (CS)

| Time Period | Objective | Contracted Providers By County: Total Numbers and Capacity | Member Enrollment Totals by County | Comments/Recommendations |
|---|---|---|---|---|
| 1st Quarter | Support the ongoing development of contracted providers capacity to provide ECM core services, including for new populations of focus. | Santa Cruz: 3,351<br>Monterey: 6,988<br>Merced: 10,062<br>Mariposa: 173<br>San Benito: 684 | Santa Cruz: 3,248<br>Monterey: 6,885<br>Merced: 10,255<br>Mariposa: 182<br>San Benito: 672 | This has been demonstrated by the implementation of monthly EHS Huddles, continued monthly office hours, and including providers when necessary in IDT rounds with CR nurse and hospitals. New population of focus is the Justice Involved population. Working with CDCR, DHCS and other MCP. Attending monthly county specific CPI meetings to support providers with community collaborations and updates from the MCP. Continued quarter over quarter increases in ECM enrollment in all counties. |
| 2nd Quarter | Align with PS dept to support the contracting and development of new providers to be prepared to support the incoming pediatric populations and 2 new Community Supports (CS) services for 7/1/23. | Santa Cruz:19 - 1,584<br>Monterey: 29 - 7,692<br>Merced: 34 - 18,718<br>Mariposa: 16 - 10,337<br>San Benito: 5 - 465 | Santa Cruz: 3,748<br>Monterey: 8,412<br>Merced: 11,109<br>Mariposa: 196<br>San Benito: 723 | Continued monthly office hours, and including providers when necessary in IDT rounds with CR nurse and hospitals. New population of focus is the Justice Involved population. Working with CDCR, DHCS and other MCP. Attending monthly county specific CPI meetings to support providers with community collaborations and updates from the MCP. Continued quarter over quarter increases in ECM enrollment in all counties.<br>**Q2 Counts correct, original counts:**<br>**County: # of providers - total capacity - total enrolled**<br>**Santa Cruz: 24 - 8317 - 8804**<br>**Monterey: 33 - 10011 - 10012**<br>**Merced: 26 - 10811 - 13815**<br>**Mariposa: 13 - 6470 - 6905**<br>**San Benito: 13 - 6685 - 5694** |
| 3rd Quarter | Support the ongoing development of contracted providers capacity to provide ECM core services. | Santa Cruz: 19 - 1,460<br>Monterey: 26 - 6249<br>Merced: 35- 13,445<br>Mariposa: 21 - 10,925<br>San Benito: 7 - 3,701 | Santa Cruz: 4,261<br>Monterey: 9,639<br>Merced: 12,636<br>Mariposa: 225<br>San Benito:851 | Reporting methodology updated in Q3.<br>Continued monthly office hours, and including providers when necessary in IDT rounds with CR nurse and hospitals. Continued quarter over quarter enrollment increases in all counties. Enrollment hovers around 5% of membership with goals to reduce to 3%. ECM payment methodology is transitioning to FFS on 1/1/26, timely disenrollments have been prioritized and automation work is in process, identification of proactive disenrollment methods is in process, and further development of graduation/renewal criteria and assessments are in process.<br><br>Minimal change in capacity per county, significant increase in capacity for San Benito, no ECM capacity concerns. |
| 4th Quarter | Align with PS dept. to provide contracted and noncontracted potential ECM and CS providers with information about the new populations of focus for 2025. Support the expansion of the ECM/CS network to assist these new populations of focus in 2025. | Santa Cruz:<br>Monterey:<br>Merced:<br>Mariposa:<br>San Benito: | Santa Cruz:<br>Monterey:<br>Merced:<br>Mariposa:<br>San Benito: | |
| Year End | | | | |



Back to Agenda

## C. Reducing Readmissions Initiative

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

| 2025 Evaluation | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Time Period** | **OOA RCFE /CLF Placements** | **Total RCFE/CLF Placements** | **Merced County 30 day Readmissions** | **Monterey County 30 day Readmissions** | **Santa Cruz County 30 day Readmissions** | **Mariposa County 30 day Readmissions** | **San Benito County 30 day Readmissions** | **Total 30 day Readmission** | **Comments/ Recommendations** |
| **1st Quarter** | 5 RCFE/4 CLHF | 14 | 21% | 18% | 22% | 18% | 17% | 21% | New report for OOA RCFE/CLF in progress and will represent baseline data once complete. Q1 25 manual pull tableau/excel spreadsheet. Majority of plcmts in area, with OOA for TBI and some more complex plcmts. Currently, CM has 30 day check in with members/facilities for needs for RCFE. CLF are a PRN check in as they are considered LTC. Collaborative IDT process in development for when a member from CLF is sent to acute, facility to notify the plan for RCA. |
| **2nd Quarter** | 2 RCFE/5CLHF | 21 | 18% | 16% | 17% | 23% | 27% | 18% | Continue to wait on report to tease out CLHF/RCFE, manual report reviewed. 13 RCFE in county, 2 OOA d/t TBI. 1 CLHF in county, 5 OOA d/t bed availability and acuity. Noted decrease in overall readmission by 3%. |
| **3rd Quarter** | 0 RCFE/8 CLHF | 20 | 21% | 21% | 16% | 19% | 23% | 20% | Overall rate is slightly below Q1; SB and Mariposa with reduced rates over Q2 and SC with 6% decrease over Q1. Expect further reductions with TCS process improvements underway as part of DSNP build. Slight increase in overall readmissions for Merced, Monterey, SC. Increased focus in IDTs with CM, ECM and interdisciplinary DC planning. Tableau report available for CLHF. 8 CLHF OOA d/t bed availability for Sub-Acute LOC. RCFE manual audit. 12 RCFE in county/0 OOA RCFE. |
| **4th Quarter** | | | | | | | | | |
| **Year End** | | | | | | | | | |

## D. Pharmacy Programs

### Pharmacist-Led Academic Detailing (PLAD) Program

Using academic detailing methods, Alliance Pharmacists provide evidence-based educational sessions to clinicians in primary care settings. Currently offered for diabetes, hypertension, and asthma medication management.

| Time Period | # Providers | # Sessions | Comments |
|---|---|---|---|
| 1st Quarter | 11 | 12 | Q1 focused on hypertension and diabetes. Additional provider outreach planned in Q2 based on 2024 MCAS results. |
| 2nd Quarter | 3 | 6 | Q2 focused on asthma and completion of hypertension sessions from Q1. Decrease in response from provider outreach. Plan for additional outreach for diabetes and hypertension in Q3. |
| 3rd Quarter | 2 | 3 | Q3 focused on hypertension PLAD. Barriers to PLAD enrollment include lack of provider response/interest, and pharmacist capacity. |
| 4th Quarter | | | |
| Year End | | | |

### Naloxone Distribution Program

As part of Naloxone Distribution Project (NDP) by DHCS, the program aims to reduce opioid overdose deaths through provision of free naloxone (Narcan). Narcan is available in the Alliance offices and during community events. Focus is on Merced and Mariposa counties.

| Time Period | Total # Distributed | # Distributed (Merced/Mariposa) | # Reversals Reported (Lives Saved) | Comments |
|---|---|---|---|---|
| 1st Quarter | 146 | 128 | 2 | Majority of naloxone continues to be distributed in Merced, the county of focus. |
| 2nd Quarter | 110 | 64 | 0 | Majority of naloxone continues to be distributed in Merced. Increase in kits distributed in Santa Cruz from previous quarters. |
| 3rd Quarter | 34 | 24 | 0 | Majority of kits distributed from Merced. Significant decrease in kits given in Q3. Will continue to monitor (~77% decrease over Q1) |
| 4th Quarter | | | | |
| Year End | | | | |

## E. Phone System Replacement Project

In pursuit of the Alliance goal of work optimization and simplification, introduction of a new phone system will begin in 2025. Within 1 quarter after introduction of the new system, look for a 3% reduction in abandonment rates for all auth phone lines.

| Time Period | AuthReq Abandonment % | AuthStat Abandonment % | NEMT Abandonment % | Comments |
|---|---|---|---|---|
| 1st Quarter | 10.50% | 7.31% | 17.66% | Pre-phone system replacement #'s |
| 2nd Quarter | 4.15% | 2.84% | 15.64% | Phone system replaced 6/17/25, numbers covering 4/1-6/17 |
| 3rd Quarter | 9.34% | | 18.89% | New phone system go live resulted in call routing errors and some delays - higher abandonment rates due to change expected during this quarter. New Phone System combines auth queues - more accurate recording |
| 4th Quarter | | | | |
| Year End | | | | |

| Time Period | AuthReq Avg Wait Time | AuthStat Avg Wait Time | NEMT Avg Wait Time | Comments |
|---|---|---|---|---|
| 1st Quarter | 3:18 | 3:37 | 4:54 | Pre-phone system replacement #'s |
| 2nd Quarter | 0:50 | 0:50 | 4:07 | Phone system replaced 6/17/25, numbers covering 4/1-6/17 |
| 3rd Quarter | 2:20 | | 5:44 | Auth wait times remained low, new Phone System combines auth queues - more accurate recording. New phone system go live had call routing errors that highly impacted NEMT (all NMT calls coming to NEMT) resulting in higher wait times this quarter. |
| 4th Quarter | | | | |
| Year End | | | | |

## F. BHT Caregiver & Provider Engagement

**Effective 7/1/2025**: In pursuit of the Alliance goal of quality of care, Alliance BCBA's will provide outreach to members and providers who have been identified to have BHT-case management needs (e.g. underutilization of caregiver hours, lack of transition/discharge planning).

| Time Period | Member vs Provider Call Volume | Percentage Increased Caregiver Involvement or Progress after Intervention | Total Number Members Enrolled in BHT by County | Comments |
|---|---|---|---|---|
| **1st Quarter** | | | | |
| **2nd Quarter** | | | | |
| **3rd Quarter** | Member Calls: 1,068<br>Provider Calls: 1% of incoming calls to auth phone line | Baseline: 412 ABA/BHT CM | Mariposa: 1<br>Merced: 437<br>Monterey: 466<br>San Benito: 48<br>Santa Cruz: 178 | Member call data collected from FIVE9 phone system captured from incoming calls to ABA-BH call line. Member calls are identified for caregiver education and ABA/BHT CM needs. ABA/BHT case management needs are identified as caregiver education, review of resources related to transition/discharge planning and support identifying an ABA and/or CDE provider. From the start date of BH insourcing (July 1, 2025) 1,068 member calls have been received each call including general information regarding ABA & CDE benefit and how to access services. Q3 data reflects 412 ABA/BHT CM activates addressing needs such as utilization of hours, education on transition and discharge and support identifying ABA providers to initiate ABA services and/or transition to a new provider. This is considered baseline data as prior to insourcing delegate Carelon was not tracking Caregiver engagement/involvement percentage of increase will be assessed based on Q3 and Q4 findings. Provider incoming calls regarding education is hypothesized to occur at low and stable rates due to offered BHT office hours and pre recorded trainings offered to ABA/BHT providers, additionally general ABA/BHT auth related questions (e.g. statues updates) are encompassed in the phone system replacement data. As of 10/01/25 Clinical Analyst BCBA are logging incoming provider calls via JIVA phone log to gather additional data. Members enrolled in Mariposa county are observed to be low this is hypothesized to be due to accessibility issues, the team continues to outreach in this county and educated members on the use of telehealth services. |
| **4th Quarter** | | | | |
| **Year End** | | | | |

## II. Operational Performance

### A. Routine Prior Authorization Turn Around Time

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

| 2025 Evaluation | | | | | |
|---|---|---|---|---|---|
| **Time Period** | | **Goal** | **Results** | **Assessment & Interventions** | **Recommendation for Future** |
| **1st Quarter** | | **100%** | **99.2%** | Authorization volumes 43,937 of 44,299 auths completed timely for a turnaround (TAT) rate of 99.18% | Despite changes in staffing and multiple projects in flight, the PA team's average TAT remained near goal at 99.2%. Continued close monitoring of the daily auth volumes and proper distribution and redistribution of authorizations to monitor and aim for 100% goal. |
| **2nd Quarter** | | **100%** | **99.8%** | Authorization volumes 39,265 of 39,336 auths completed timely for a turnaround (TAT) rate of 99.82% | The PA team continues to average close to goal. As the ECM/CS auth volume continues to creep up, PA leaders have strategized to staff both PA auth queues and ECM/CS auth queues accordingly to ensure that we work towards the 100% turn-around time goal. The PA team was able to keep TAT rate up despite staffing/scheduling challenges, some of which was due to preparation for BHIP go-live. Project to implement automation and intelligent technologies to reduce manual workload and improve process efficiency is underway and will aid in achieving TAT rate goal of 100%. |
| **3rd Quarter** | | **100%** | **99.8%** | Authorization volumes 42,408 of 42,479 auths completed timely for a turnaround (TAT) rate of 99.82% | The PA team maintained strong turnaround times despite fluctuating volumes and ongoing operational demands, including continued ECM/CS growth and stabilization activities, BHIP go-live and preparation for D-SNP. PA Leaders continued proactive workload balancing and reinforced close daily monitoring of queues to ensure timely routing and resolution. Careful balance of staffing and calendaring of PTO to ensure adequate team members were in place to manage the daily volume. Ongoing collaboration between PA leadership, AC team, CIU, CM and other stakeholders (Contracts, Credentialing, Finance) to help sustain efficiency and mitigate delays. |
| **4th Quarter** | | **100%** | | | |

## A2. Routine BHT Authorization Turn Around Time - Effective 7/1/2025 post go live

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

**2025 Evaluation**

| Time Period | Goal | Results | Assessment & Interventions | Recommendation for Future |
|---|---|---|---|---|
| **1st Quarter** | **100%** | | | |
| **2nd Quarter** | **100%** | | | |
| **3rd Quarter** | **100%** | 98.0% | Authorizations volumes of 1,114 auths completed in Q3 with 98% compliance with being timely and within turnaround time (TAT) of 5 business days or less. | Data reflects an increasing trend ranging from 96%-98% of auth completion within TAT since BH insourcing. It should be noted that auths that failed to meet compliance are hypothesized to be due ABA/BHT team receiving authorizations prior to insources and auths being incorrectly routed. The team has since updated workflows, gained experience in auth types and will continue to monitor and aim for goal of 100%. |
| **4th Quarter** | **100%** | | | |



Back to Agenda

## B. Prior Authorization Request Determination Metrics

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

| 2025 Evaluation | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Time Period** | | **#PA Volume** | **# Medical Necessity Denials** | **# Appeals** | **#Appeals Upheld** | **# Overturned** | **Assessment & Interventions** |
| **1st Quarter** | | 65,657 | 1,919 | 136 | 89 | 33 | Slight increase in medical necessity denials from the usual < 2% per quarter to 2.9% this quarter. The rise in the number of Community Supports authorizations has resulted in a closer review of these benefits and review of the criteria in place for the benefits. CS authorizations account for most of the denials and appeals for PA. |
| **2nd Quarter** | | 67,223 | 628 | 111 | 83 | 23 | Continued increase in the PA volume related to increase in ECM/CS authorization requests. Denials are down to < 1% this quarter, which is lower than the average denial rate in the last few years of approx. 1 - 3%. Appeal volumes are consistent within the last 3 quarters. There is an approx. 70% upheld vs. 30% overturn rate on appeals. Appeals may increase in the coming quarters as changes to the various ECM/CS policies alter the way ECM/CS authorizations are reviewed. Trends on PA determinations will continue to be monitored. |
| **3rd Quarter** | | 71,221 | 2,021 | 152 | 91 | 22 | Q2 Correction - total # med nec denials = 1708, 2.5%<br><br>PA volume increased to 71,221, reflecting continued growth in ECM and Community Supports (CS) authorization activity. Q3 medical necessity denials = 2,021, representing approximately 2.8% of total volume. This increase is primarily tied to closer review of ECM/CS requests as policies and operational guidance continue to evolve.<br><br>Appeal volume increased to 152, consistent with the upward trend aligned with higher PA activity. The upheld vs. overturned distribution (91 upheld; 22 overturned) remains in line with historical patterns. As ECM/CS criteria continue to be adjusted and refined, additional increases in appeals may occur in future quarters.<br><br>Interventions moving forward will include:<br>-Ongoing monitoring of PA determinations for emerging patterns in ECM/CS utilization.<br>-Continued collaboration with clinical and operational teams to ensure consistent application of updated criteria.<br>-Review of denial rationales to identify areas for provider education opportunities.<br>-Continued review and refinement of CS policies to closer align with regulatory requirements and clarify requirements for providers.<br><br>Overall, Q3 metrics indicate stable processing performance and continued need for close oversight of ECM/CS benefit review trends. |
| **4th Quarter** | | | | | | | |
| **YTD/Year End** | | | | | | | |



Back to Agenda

## B2. BHT Request Determination Metrics -Effective 7/1/2025 post go live

Monitoring of BHT authorization volume, and appeals.–TAT goal NOA's: denial letters sent within 2 business days.

| 2025 Evaluation | | | | | | |
|---|---|---|---|---|---|---|
| **Time Period** | **#BHT Volume** | **# Medical Necessity Denials** | **# Appeals** | **#Appeals Upheld** | **# Overturned** | **Assessment & Interventions** |
| **1st Quarter** | | | | | | |
| **2nd Quarter** | | | | | | |
| **3rd Quarter** | 1,136 | 9 | 0 | 0 | 0 | ABA/BHT received a total of 1,136 auths in Q3, data not to include NTR code for ABA/BHT Initial assessments/FBA. 9 auths resulted in medical necessity denials for lack of sufficient clinical information to justify the request service 0.79% denials. 0 denials resulted in appeals. |
| **4th Quarter** | | | | | | |
| **YTD/Year End** | | | | | | |



Back to Agenda

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

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

| 2025 Evaluation | | | |
|---|---|---|---|
| **Time Period** | | **List Denials** | **Assessment & Interventions** |
| **1st Quarter** | | 1. Nutritional Counseling S9470 (1171)<br>2. Meals, Per Diem S9977 (991)<br>3. Home Delivered Meals S5170 (203)<br>4. Medical Nutrition Therapy 97803 (69) 5. Medical Nutrition Therapy 97802 (67)<br>6. Exome 81415 (52)<br>7. Exome 81416 (46)<br>8. Excision 15830 (20)<br>9. Genetic Testing 81443 (18)<br>10. Injection Of Sclerosan 36471 (13) | Consistent with previous quarters, Community Supports (specifically Medically Tailored Meals- MTM), genetic testing and treatment of varicose veins make up the Top 10 services denied for medical necessity. Close review of MTM and the policy utilized to review MTM authorizations to ensure that the guidance complies with regulatory requirements and clearly identify those authorizations that are to be approved for the MTM benefit. Increased provider and member outreach and education regarding MTM benefits continues.<br><br>Close monitoring and review of the genetic testing authorizations and policy to ensure that the guideline correctly reflects the reasons to approve genetic testing. Further internal review of genetic testing authorizations was prompted by NCQA audit file pull and ongoing discussions between internal and external MDs are underway.<br>The treatment of varicose veins is another benefit under review by the department after ongoing discussions from internal and external MDs. Review of the denial rate of varicose veins is in progress to assess next steps in review of varicose vein treatment, though overall denial rate remains low with only 13 cases denied in Q1. |
| **2nd Quarter** | | 1. Nutritional Counseling S9470 (835)<br>2. Meals, Per Diem S9977 (736)<br>3. Home Delivered Meals S5170 (124)<br>4. Medical Nutrition Therapy 97802 (51) 5. Medical Nutrition Therapy 97803 (51)<br>6. Exome 81415 (30)<br>7. Excision 15830 (27)<br>8. Exome 81416 (25)<br>9. Wheelchair Accessory E0973 (18)<br>10. Oncology 0340U (17), 0449U (17), 81456 (17) | Medically Tailored Meals (MTM) authorizations make up the top 5 requests that result in med nec denials, consistent with previous quarters. As seen in previous quarters, MTM providers continue to submit authorization requests for members that do not meet the criteria, resulting in med nec denials. Continued review and revisions are being made to the MTM policy in order to aptly capture appropriate criteria points and to ensure that the benefit is being reviewed according to DHCS guidelines. Also, continued provider education regarding the MTM benefit is ongoing.<br><br>Genetic testing also continues to trend in medical necessity denials as seen in the past quarters in the last few years. PA continues to receive whole genome testing requests but often do not meet medical necessity criteria. Additionally, ctDNA authorizations are being closely reviewed by CCAH MDs with many resulting in med nec denials. Continued monitoring of changes in guidance regarding genetic testing likely to result in edits to existing genetic testing policy. Input from external stakeholders considered when reviewing policy updates in forums such as QIHEC. |
| **3rd Quarter** | | 1. Nutritional Counseling S9470 (900)<br>2. Meals, Per Diem S9977 (699)<br>3. Home Delivered Meals S5170 (205)<br>4. Medical Nutrition Therapy 97802 (33) 5. Medical Nutrition Therapy 97803 (31)<br>6. Excision 15830 (30)<br>7. Carrier Screening 0449U (27)<br>8. Oncology Analysis 0340U (23)<br>9. Exome Sequence 81415 (23)<br>10. Fetal Genome Panal 81420 (23) | Medically Tailored Meals (MTM) services, including Nutritional Counseling (S9470), Meals Per Diem (S9977) and Home-Delivered Meals (S5170), continue to represent the highest volume medical necessity denials, consistent with patterns observed in previous quarters. Although MTM volumes have fluctuated, the overall trend remains stable, reaffirming the need for ongoing provider education and continued refinement of the MTM policy to ensure alignment with DHCS requirements and to clearly define eligibility criteria. PA leadership continued to work with internal stakeholders, Medical Directors and the CMO to clarify program expectations and refine internal policy. There was also increased provider outreach aimed at reducing inappropriate submissions and closer collaboration with the CIU team.<br><br>Genetic testing denials remained a recurring theme, though the types of tests appearing in the Top 10 have shifted slightly, with increased representation of carrier screening (0449U), oncology assays (0340U) and fetal genome testing (81420). These shifts reflect evolving provider ordering patterns and continued variability in meeting evidence-based criteria. PA nurses and internal MDs continued to conduct close clinical review of genetic testing requests. Policy refinement efforts remain underway to ensure guidelines reflect current standards of care. Ongoing collaboration with external stakeholders and committee review forums such as UMWG and QIHEC support these policy updates.<br><br>Varicose vein–related procedures (Excision 15830) also remain within the Top 10. While denial volumes are relatively low, continued monitoring of clinical appropriateness and benefit coverage is in progress, consistent with ongoing review of auth framework and for the auth reduction project. |
| **4th Quarter** | | | |

## D. Inter-rater Reliability Review – Nurses

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

| 2025 Evaluation | | | | |
|---|---|---|---|---|
| **Time Period** | **Goal** | | **Comments** | **Recommendation for Future** |
| **Q4 Yearly** | **100%** | **100%** | Prior auth nurses completed IRR testing in the CY 2025, each passing with a score of 90% or higher.<br><br>Newly onboarded nurses completed IRR testing prior to reviewing prior auths. | Currently using MCG IRRs.<br><br>Internally created IRR for MNT created for Registered Dietitian responsible for reviewing MNT auths. |

## E. Inter-rater Reliability Review – BCBA's (Schierlynda Brown-Gray)

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

| 2025 Evaluation | | | | |
|---|---|---|---|---|
| **Time Period** | **Goal** | | **Comments** | **Recommendation for Future** |
| **Q4 Yearly** | **100%** | | All Clinical Analyst BCBA completed IRR at 100% based on MCG IRR case studies. CASP care guidelines was not utilized due to NTR for IHSS line of business. | Future goal will be modified to remove mention of CASP guidelines. Additionally, integral audits are conducted monthly across BCBA team members to review IRR and compliance with full ABA/BHT auth review process. |

## F. Inter-rater Reliability Review – Physicians

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

| 2025 Evaluation | | | | |
|---|---|---|---|---|
| **Time Period** | **Goal** | **Results** | **Comments** | **Recommendation for Future** |
| **Q4 Yearly** | **100%** | | | |

## G. Inter-rater Reliability Review – Pharmacists

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

| 2025 Evaluation | | | | |
|---|---|---|---|---|
| **Time Period** | **Goal** | **Results** | **Comments** | **Recommendation for Future** |
| **Q4 Yearly** | **100%** | | | |

## H. Pharmacy

### Pharmacy Prior Authorization Timeliness Report

Percent of Pharmacy prior authorizations completed timely. Includes Medi-Cal and IHSS LOB.

| Time Period | Results (%) | Assessment | Interventions |
|---|---|---|---|
| 1st Quarter | 95.8% | 95.8% authorizations completed within 24 hours receipt. Small percentage of requests received during weekends or holidays. Technician PTO's and audit prep pulled staff from queues | Emphasized checking failed fax and correspondence not sent reports in multiple technician meetings as well as assigning episodes to another technician for planned PTO. Reintroduced pharmacy services coordinator role for member letter compliance |
| 2nd Quarter | 97.3% | Increase in timeliness compliance from previous quarter | Late Friday shifts for technicians continue to maintain compliance with timeliness. Training of new Pharmacy Technician started 6/16. Continued refreshers and reminders in technician and team meetings to ensure continued compliance |
| 3rd Quarter | 96.0% | Slight decrease in timeliness from prior quarter, New Technician training began in late Q2 and resumed through Q3. One technician LOA during end of Q3 | Technicians continue to work late Friday shifts, reports for correspondence and timeliness sent 3 times daily. Workflow updates to assign specific episodes to techs started 10/2025 |
| 4th Quarter | | | |
| Year End | | | |

### Pharmacy Prior Authorization Request Determination Metrics

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

| Time Period | # Auth Volume | # Denials | # Appeals | # Appeals Upheld | # Overturned | #SFH | Assessment | Interventions |
|---|---|---|---|---|---|---|---|---|
| 1st Quarter | 1912 | 52 | 2 | 1 | 1 | 0 | 6.4% PA volume increase from previous quarter however a decrease in denial rate from previous quarter at 2.7% (vs. 3.7%). For appeal, upheld denial on hyaluronan and denial overturned for ferric carboxymaltose. | Will continue to monitor. |
| 2nd Quarter | 1949 | 69 | 1 | 0 | 1 | 0 | 1.9% increase in PA volume,1% increase in denial rate from previous quarter (3.5 vs 2.7%). One appeal overturned for hyaluronan acid injection. Will continue to monitor | Will continue to monitor. |
| 3rd Quarter | 1990 | 58 | 2 | 0 | 2 | 0 | PA volume continues to increase, with 2% increase from previous quarter. Denial rate decreased (2.9 vs 3.5%). Appeal volume continues to be low. Two appeals overturned for hyaluronan acid. | Will continue to monitor. |
| 4th Quarter | | | | | | | | |
| Year End | | | | | | | (2024 avg: 1821 PAs and 4.5% denial rate) | |

### Top 5 Physician Administered Drugs that Result in Medical Necessity Denial

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

| Time Period | List of Drugs | Assessment | Interventions |
|---|---|---|---|
| 1st Quarter | 1. Denosumab<br>2. Aflibercept, Triamcinolone<br>4. Onabotulinumtoxina, Hyaluronan | Top denied drugs consistent with previous quarter | Reviewing criteria for triamcinolone for alopecia in Q2 P&T Committee, with planned provider outreach on appropriate use. Updated PA criteria for long-acting G-CSFs and anti-VEGF for eye (aflibercept). |
| 2nd Quarter | 1. Aflibercept<br>2. Denosumab, Hyaluronan<br>4. Onabotulinumtoxina<br>5. Ferric Carboxymaltose, faricimab | Top denied drugs remain consistent with previous quarter. Decrease in triamcinolone denials after provider education on PA criteria. | Updated PA criteria for triamcinolone for alopecia. Will be reviewing onabotulinumtoxin criteria for migraines in Q3 P&T Committee. |
| 3rd Quarter | 1. Dexamethasone lacrimal insert<br>2. Onabotulinumtoxina<br>3. Aflibercept<br>4. Hyaluronan, Aflibercept-Ayyh (Pavblu) | Top denied drugs remain mostly consistent with previous quarters. Increase in requests for dexamethasone lacrimal insert (Dextenza) from same provider, with majority of requests in July. Currently using Medi-Cal criteria for Dextenza. | Onabotulinumtoxin for migraines, and drugs for inflammatory ocular conditions were reviewed at Q3 P&T. PA Criteria added for Aflibercept (Eylea) biosimilars in Q2 P&T Committee. |
| 4th Quarter | | | |
| Year End | | | |



Back to Agenda

### Written Notification of Pharmacy NOAs to Members & Providers

Audit of a sample of pharmacy denial letters sent to members and providers. Focus is on individualized content: specific reason for the denial in language that is easy to understand, and reference to a criterion on which the denial decision was based.

| Time Period | Results (%) | Assessment | Interventions |
|---|---|---|---|
| 1st Quarter | 83.0% | Several member letters included technical abbreviation and diagnoses without defining. Few mistakes when copy/pasting into member letters. | New workflow introduced, Pharmacy Services Coordinator (PSC) assignment reintroduced in March 2025 for implementation in Q2, all member NOAs sent to assigned technician for additional review for completeness and accuracy of member letters. |
| 2nd Quarter | 100.0% | Letters were free of technical terms and abbreviations. All letters were complete with member-specific reason for denials | Team training on member letter requirements performed for all staff in April 2025. PSC role continues for additional letter verification prior to sending member letter. |
| 3rd Quarter | 100.0% | Letters were free of technical terms and abbreviations. All letters were complete with member-specific reason for denials | Continue NOA Second check for all member letters validating readability and accuracy |
| 4th Quarter | | | |
| Year End | | | |

### I. BHT Written Notification of NOA to Members & Providers -Effective 7/1/2025 post go live

| Time Period | Results (%) | Assessment | Interventions |
|---|---|---|---|
| 1st Quarter | | | |
| 2nd Quarter | | | |
| 3rd Quarter | 97.0% | Letters include all required information for members and providers. Member template has been created to include predetermined readability and ensure they are not to include Jargon. | NOA template was created on 8/28/25 followed by an updated training. Team continues to audit NOA for member readability and accuracy. |
| 4th Quarter | | | |
| Year End | | | |

### J. PA Written Notification of NOA to Members & Providers

Audit of a sample of PA NOA letters sent to members and providers. Focus is on individualized content: specific reason for the additional information requested in language that is easy to understand, and reference to a criterion on which the request was based.

| Time Period | Results (%) | Assessment | Interventions |
|---|---|---|---|
| 1st Quarter | 95.6% | NOA timeliness in Q1 2025 meets the Compliance threshold of 95%. The timeliness of NOAs has been identified as an area of opportunity for improvement within the PA team. | PA supervisors are working closely with Data Analytics to uncover the discrepancies between the report findings and manual review of the NOAs flagged as untimely. Errors at the beginning of the year may have also been caused by new staff who onboarded in Q3/Q4 2024 and individual coaching has taken place for those individuals. Continued close monitoring of NOA timeliness in upcoming quarters. |
| 2nd Quarter | 97.2% | A drop in NOA timeliness to members was noted in Q1 2025 after a Compliance Internal CAP was put in place.<br><br>Q2 results show an improvement in NOA timeliness to members, reaching toward the 100% goal and above the 95% threshold. | PA supervisors worked diligently alongside the Data Analytics team to identify root causes for errors on the NOA Timeliness report. Repeated testing and manual review of authorizations were conducted to validate the data from the report. Updates to the report were made and is now reflecting accurate data. Continued monitoring of the report's accuracy and ongoing audits of NOA in place. |
| 3rd Quarter | 95.5% | NOA timeliness in Q3 measured 95.5%, remaining above the Compliance threshold of 95% but slightly lower than the gains observed in Q2. The fluctuation suggests that while prior corrective actions were effective, additional variability persists in the consistency of timely NOA issuance. Preliminary review indicates that discrepancies may be due to isolated staff-level errors continuing to contribute to untimely NOAs. Continued close monitoring and training/retraining of staff. Increased cross-training of staff to review all auth types may also be influencing Q3 performance. | PA supervisors continue to closely monitor NOA reports to validate report logic, ensuring that all timeliness metrics accurately reflect operational performance. Additionally, targeted coaching continues to be provided for staff whose NOAs were identified as untimely, with emphasis on documentation requirements, system workflows, and timely completion of reviews. Increased spot-audits of NOA samples will continue throughout Q4 to verify accuracy and reinforce adherence to timeliness standards. Supervisors will also maintain weekly monitoring of NOA trends to identify any emerging issues early and implement corrective measures as needed. Interdepartmental collaboration in place to ensure compliance with turnaround times specifically for translated letters. |
| 4th Quarter | | | |
| Year End | | | |

### K. CR Written Notification of NOA to Members & Providers

Audit of a sample of CR NOA letters sent to members and providers. Focus is on individualized content: specific reason for the additional information requested in language that is easy to understand, and reference to a criterion on which the request was based.

| Time Period | | Results (%) | Assessment | Interventions |
|---|---|---|---|---|
| **1st Quarter** | | **95.4%** | NOA timeliness in Q1 2025 meets the Compliance threshold of 95%. The timeliness of NOAs has been identified as an area of opportunity for improvement within the CR team. | AC/CR supervisors are working closely with Data Analytics to uncover the discrepancies between the report findings and manual review of the NOAs flagged as untimely. Errors at the beginning of the year may have also been caused by new staff who onboarded in Q3/Q4 2024 and individual coaching/competency has taken place for those individuals. Continued close monitoring of NOA timeliness in upcoming quarters. |
| **2nd Quarter** | | **95.9%** | Slight increase from Q1 2025 noted, remains above threshold of 95%. | Continued departmental audits, training PRN. |
| **3rd Quarter** | | **94.7%** | Slight decrease from Q2 | Weekly internal audits and creation of internal NOA Library. Manual deep dive into cases reveal some variances in overall numbers. Continued monitoring of report until satisfied it is accurate and education as needed. |
| **4th Quarter** | | | | |
| **Year End** | | | | |

### L. Behavioral Health Penetration Rates-Effective 7/1/25 Post Go Live

Utilization percentage rates for children and adolescents and for adults are reported by for each county managed by CCAH. Utilization rates reflect a rolling 12 month measurement ending at the Quarter. Utilization percentage is calculated by dividing the number of unique members in each age cohort within each County into the number of members that have received NSMHS services from that same County and age cohort within each quarter (Tableau)

| Time Period | Santa Cruz | Monterey | Merced | Mariposa | San Benito | GOAL | Assessment | Interventions |
|---|---|---|---|---|---|---|---|---|
| **1st Quarter** | | | | | | | For Q1 penetration rates, see Delegate Oversight tab | |
| 0-12 | | | | | | | | |
| 13-18 | | | | | | | | |
| 19+ | | | | | | | | |
| **2nd Quarter** | | | | | | | For Q2 penetration rates, see Delegate Oversight tab | |
| 0-12 | | | | | | | | |
| 13-18 | | | | | | | | |
| 19+ | | | | | | | | |
| **3rd Quarter** | | | | | | | For all age ranges and all counties, penetration rates were within goal range. Across all counties, 0-12 and 19+ increased penetration. The 13-18 range was slightly lower in 3 of the 5 counties but still within target range. Note these percentages are only reflective of the BH network. Any interventions occurring in the physical health care space are not included in these counts for accurate representation of penetration pre and post insourcing. RM is reviewing Penetration Rate goals with Process excellence to ensure alignment with penetration goals from county, state, and national benchmarks. | As this is the first quarter BH has insourced, overall penetration rates reflect a successful transition in-house. The plan will continue to work to expand network, reduce access barriers and support increased penetration and member needs. |
| 0-12 | 7.26% | 5.38% | 3.57% | 3.55% | 4.14% | 2.5% - 4% | | |
| 13-18 | 8.84% | 7.87% | 4.63% | 2.61% | 3.46% | 2.5% - 4% | | |
| 19+ | 13.46% | 7.56% | 5.14% | 6.10% | 4.81% | 4.5% - 6.5% | | |
| **4th Quarter** | | | | | | | | |
| 0-12 | | | | | | 2.5% - 4% | | |
| 13-18 | | | | | | 2.5% - 4% | | |
| 19+ | | | | | | 4.5% - 6.5% | | |



Back to Agenda

## III. Utilization Performance

### A. Inpatient Utilization

The goals per line of business and by Medi-Cal aid category groupings were developed using Alliance historical performance, and DHCS state benchmarks. The bed-days per K/Y goal was established by utilizing historical data and state averages. The Alliance Bed Ambulatory Care Sensitive Admissions (ACSA) and 30-day Readmissions tracked per line of business and region.

| IHSS | | | | | | Goal | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Time Period | 2024 Admit/K/Y Reported | 2025 Admit/K/Y | ALOS | BD/K/Y Reported | BD/K/Y Updated | BD/K/Y | Variance | ACSA% | Readmits % | Assessment | Interventions |
| 1st Quarter | 52 | 66 | 3.0 | 201 | 314 | 200 | -0.57 | 27% | 0% | Increase in Amb Care Services. | Continued support of TCS when IHSS mbr is in Acute Hospital for any Post-Acute Care needs. Variance in updated BD r/t post service submissions. |
| 2nd Quarter | 84 | 69 | 6.6 | 450 | 193 | 200 | 0.04 | 9.1% | 9% | Increased Readmit % compared to Q1. | Increased IP CR involvement surrounding TOC/TCS, identifying high risk members and collaborating with CM/ECM to ensure member is connected to OP services appropriately. |
| 3rd Quarter | 45 | 95 | 2.2 | 211 | | 200 | 1.00 | 6.3% | 25% | Increased compared to Q1 & 2 | Increased collaboration with CR and CM, creating TOC WF, Meeting w/CM managers and sups on IDT improvement. Tracking/trending decreased CM referrals sent by CRN. CR handoff assessment to CM testing complete and in production. |
| 4th Quarter | 64 | | | | | 200 | 1.00 | | | | |
| YTD/Year End | 62 | | | | | 200 | | | | | |

| Medi-Cal Child and Family Aid Codes (OTLIC + other) | | | | | | Goal | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Time Period | 2024 Admit/K/Y Reported | 2025 Admit/K/Y | ALOS | BD/K/Y Reported | BD/K/Y Updated | BD/K/Y | Variance | % CCS | ACSA % | Readmits % | Assessment | Interventions |
| 1st Quarter | 48 | 54 | 3.7 | 198 | 186 | 170 | -9% | 25.7% | 2.7% | 5% | ALOS continues to be the same as 2024 data. | Continued support of TCS post discharge |
| 2nd Quarter | 51 | 53 | 3.5 | 188 | 205 | 170 | -21% | 24.5% | 2.8% | 4% | ALOS is slightly down compared to Q1 | Continued support of TCS post discharge |
| 3rd Quarter | 52 | 52 | 4 | 190 | | 170 | 100% | 27% | 2.4% | 5% | ALOS slightly up from Q2 | Continue to monitor, continue increased |
| 4th Quarter | 51 | | | | | 170 | 100% | | | | | |
| YTD/Year End | 49 | | | | | 170 | 100% | | | | | |



Back to Agenda

| Medi-Cal Seniors and Persons with Disabilities Aid Codes (SPD+Dual) | | | | | | Goal | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Time Period** | **2024 Admit/K/Y Reported** | **2025 Admit/K/Y** | **ALOS** | **BD/K/Y Reported** | **BD/K/Y Updated** | **BD/K/Y** | **Variance** | **% CCS** | **ACSA %** | **Readmits %** | **Assessment** | **Interventions** |
| **1st Quarter** | 239 | 248 | 6.1 | 1513 | 1426 | 1300 | -10% | 10.4% | 13.6% | 21% | ALOS continues to be the same as 2024 data. Readmissions increased slightly, expected as time of year. | Weekly IDTs for complex members including MSW, CM, ECM for short term and long term placement options. |
| **2nd Quarter** | 239 | 247 | 5.4 | 1339 | 1481 | 1300 | -14% | 11.2% | 10.6% | 17% | ALOS and readmission rates are lower compared to Q1 | Weekly IDTs for complex members including MSW, CM, ECM for short term and long term placement options. |
| **3rd Quarter** | 229 | 233 | 5 | 1267 | | 1300 | 100% | 9.1% | 10.9% | 20.0% | ALOS down compared to Q2, Readmission rate up from Q2 | Continue to monitor ALOS, Readmissions: Increase CM referrals, increased collaboration with CM for high risk members, increased oversight during IDT's. Continue building TOC WFs |
| **4th Quarter** | 216 | | | | | 1300 | 100% | | | | | |
| **YTD/Year End** | **235** | | | | | 1300 | 100% | | | | | |

| **New Medicaid Expansion Members** (i.e. former LIHP, as well as new M aid code and 7U/7W aid code members ) (ACA+Other) | | | | | | Goal | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Time Period** | **2024 Admit/K/Y Reported** | **2025 Admit/K/Y** | **ALOS** | **BD/K/Y Reported** | **BD/K/Y Updated** | **BD/K/Y** | **Variance** | **% CCS** | **ACSA %** | **Readmits %** | **Assessment** | **Interventions** |
| **1st Quarter** | 72 | 78 | 5.2 | 409 | 372 | 375 | 1% | 1.4% | 9.0% | 14% | Admit K/Y reported down from last Q, readmissions remain down. | Continue to monitor. |
| **2nd Quarter** | 70 | 74 | 4.9 | 366 | 411 | 375 | -10% | 2.0% | 6.9% | 15% | Admit K/Y and readmits increased from Q1 | Increased involvement in IDT's, capturing high risk members with potential for readmit, connecting to CM/ECM/TCS |
| **3rd Quarter** | 77 | 76 | 5 | 365 | | 375 | 100% | 1.3% | 6.6% | 15% | Remains the same compared to Q2 | Continue to monitor for trends |
| **4th Quarter** | 76 | | | | | 375 | 100% | | | | | |
| **YTD/Year End** | **72** | | | | | 375 | 100% | | | | | |

**Total Medi-Cal Inpatient Utilization:** -BD/K/Y goal based on historical data and state averages.

| | | | | | | Goal | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Time Period** | **2024 Admit/K/Y Reported** | **2025 Admit/K/Y** | **ALOS** | **BD/K/Y Reported** | **BD/K/Y Updated** | **BD/K/Y** | **Variance** | **ACSA %** | **Readmits %** | **Assessment** | **Interventions** |
| **1st Quarter** | 63 | 70 | 4.5 | 316 | 299 | 290 | -3% | 6.6 | 10% | Admit /K/Y stable and staying in line with 2024. ALOS remains the same | Ongoing IDTs, partnerships with providers/facilities, JOCs, multidisciplinary team approach with ECM/CM/MSW/TCS |
| **2nd Quarter** | 65 | 65 | 4.1 | 266 | 322 | 290 | -11% | 5.3 | 7% | Readmissions and ALOS is down compared to Q1 | Continue ongoing IDTs, partnerships with providers/facilities, JOCs, multidisciplinary team approach with ECM/CM/MSW/TCS |
| **3rd Quarter** | 65 | 68 | 4.4 | 294 | | 290 | 100% | 5.2 | 11% | ALOS slightly up compared to Q2, readmissions have increased, but relatively unchanged from Q1 | Increased collaboration with CR and CM, creating TOC WF, Meeting w/CM managers and sups on IDT improvement. Tracking/trending decreased CM referrals sent by CRN. CR handoff assessment to CM testing complete and in production. |
| **4th Quarter** | 66 | | - | | | 290 | 100% | | | | |
| **YTD/Year End** | **65** | | - | | | 290 | 100% | | | | |

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

Ambulatory Care Sensitive Admissions (ACSA) per region.

| Time Period | Santa Cruz ACSA % | Monterey ACSA % | Merced ACSA % | Mariposa ACSA % | San Benito ACSA% | Assessment | Interventions |
|---|---|---|---|---|---|---|---|
| **1st Quarter** | 5.86% | 6.38% | 6.84% | 5.33% | 5.86% | Data relatively unchanged from prior quarters. Mariposa slightly higher by 2%. | Continued interventions with ECM and providers to provide sooner access to chronic disease management, PCP post-acute visits. |
| **2nd Quarter** | 3.99% | 5.22% | 5.78% | 2.35% | 5.99% | Data relatively unchanged from prior quarter, Mariposa down, with San Bentio Co with an increase. | Continued interventions with ECM and providers to provide sooner access to chronic disease management, PCP post-acute visits. |
| **3rd Quarter** | 4.93% | 4.68% | 5.56% | 10.29% | 4.66% | Merced, Monterey, and San Benito Counties decreased from Q2.Santa Cruz and Mariposa County with increased readmission %. | Continued interventions with ECM and providers to provide sooner access to chronic disease management, PCP post-acute visits. Increased oversight for Mariposa, IDT's/TOC, over 55 population/High Risk Members. |
| **4th Quarter** | | | | | | | |
| **YTD/Year End** | | | | | | | |

**C. Readmissions (%)**

*30-day Readmissions per region

| | Santa Cruz % | | | | | Monterey % | | | | | Merced % | | | | | Mariposa% | | | | San Benito% | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Time Period | 0-18 YO | 19-55 YO | Over 55 YO | Total Readmission % | % CCS | 0-18 YO | 19-55 YO | Over 55 YO | Total Readmission % | % CCS | 0-18YO | 19-55 YO | Over 55 YO | Total Readmission % | % CCS | 0-18YO | 19-55 YO | Over 55 YO | Total Readmission % | 0-18YO | 19-55YO | Over 55 YO | Total Readmissio n % | % CCS | Assessment | Interventions |
| 1st Quarter | 7.30% | 9.73% | 14.93% | 10.89% | 0.7% | 6.29% | 8.62% | 14.15% | 9.35% | 0.8% | 8.91% | 8.45% | 14.02% | 9.68% | 0.9% | 0.00% | 7.44% | 5.08% | 6.43% | 3.37% | 9.22% | 14.84% | 9.89% | 0.1% | Overall rates continue to be within 10-15%, normal increase in numbers in older age groups. | Cont. TC support, outreach and IDTs as well as integration of ECM/CS services. |
| 2nd Quarter | 6.33% | 10.05% | 14.01% | 10.72% | 0.6% | 5.97% | 8.42% | 13.78% | 9.07% | 0.8% | 8.25% | 8.23% | 13.30% | 9.25% | 0.9% | 0.00% | 8.11% | 7.02% | 7.47% | 2.14% | 9.95% | 14.64% | 10.10% | 0.3% | Mariposa and San Benito County rates have increased, but overall rates are lower compared to Q1 | Continue TC support outreach/collaboration with CM and IDTs as well as integration of ECM/CS services w/emphasis on the county w/increased rates/older age groups. |
| 3rd Quarter | 6.44% | 10.77% | 14.91% | 11.42% | 0.60% | 6.25% | 9.39% | 14.82% | 9.96% | 0.50% | 8.20% | 8.82% | 13.98% | 9.76% | 0.80% | 0.00% | 10.04% | 8.33% | 9.09% | 2.70% | 11.10% | 14.58% | 10.97% | 0.50% | Slight overall increase for counties. | Increased collaboration with CR and CM, creating TOC WF, Meeting w/CM managers and sups on IDT improvement. Tracking/trending decreased CM referrals sent by CRN. CR handoff assessment to CM testing complete and in production. |
| 4th Quarter | | | | | | | | | | | | | | | | | | | | | | | | | | |
| YTD/Year End | | | | | | | | | | | | | | | | | | | | | | | | | | |



Back to Agenda

## D. Alternatives to Acute Inpatient Days - Skilled Nursing Facility

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

| Time Period | #SNF Bed days (Updated #) | PKPY SNF SPD (Updated #) | PKPY IPT Bed days SPD (Updated #) | Total # STR | STR Readmits After Discharge | Assessment | Interventions |
|---|---|---|---|---|---|---|---|
| **1st Quarter** | 1591 | 352 | 1406 | 250 | 47 | Increase in BD, decrease in readmits. | Continued IDTs with support of CM/ECM with difficult placements post SNF BD. |
| **2nd Quarter** | 1869 | 451 | 1485 | 246 | 71 | Increase in BD, increase in readmits. | Will monitor for trends w/ individual SNF partners, support PRN. |
| **3rd Quarter** | 1376 | 334 | 1267 | 303 | 54 | Small decrease in BD, Small decrease in Readmits | Continue to monitor for trends. Weekly IDTs with SNFs for progress & DCP. ECM/CM collaboration at time of discharge. |
| **4th Quarter** | | | | | | | |
| **YTD/Year End** | | | | | | | |

## E. Long-term Care

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

| Time Period | # of New Admissions | # of LTC | Total # of Members in LTC | Total # of Medi/Medi | Assessment | Interventions |
|---|---|---|---|---|---|---|
| **1st Quarter** | 215 | 1925 | 335 | 1590 | No change noted from 2024 | LTC members are reassessed PRN/yearly, when able to move to LLOC, support of ECM/CM back into community is utilized |
| **2nd Quarter** | 229 | 1868 | 323 | 1445 | Slight decrease in overall LTC, slight increase in new admissions | Staff are closely monitoring LTC members. Moving out of LTC into RCFE. |
| **3rd Quarter** | 296 | 2025 | 349 | 1676 | Noted increase in # admissions into LTC. Noted more mbrs transitioning to LTC from STR. | Continue to monitor for trends. |
| **4th Quarter** | | | | 0 | | |
| **YTD/Year End** | | | | | | |

## F. Emergency Department

The ED utilization goals by Medi-Cal aid category groupings were developed using Alliance historical performance, industry benchmarks (including MCG actuarial projects) and comparison to other County Organized Health Systems (COHS) data. Performance is assessed against goals based on historical data and state averages for ED visits/K/Y. Total ED visits and Avoidable ED visits tracked per line of business and region. Note: DHCS Population Aid Code Groupings may differ slightly from Tableau.

| **IHSS** | | | | **Goal** | | | | |
|---|---|---|---|---|---|---|---|---|
| **Time Period** | **Avoidable Visits %** | **Total Visits/K/Y Reported** | **Total Visits/K/Y Updated** | **Total Visits K/Y** | **Total visits: Variance** | ~~**Total Visits K/Y State Average**~~ | **Assessment** | **Interventions** |
| **1st Quarter** | 14.49% | 415 | 465 | N/A | 12% | ~~N/A~~ | No change from 2024 | Continue to monitor for trends |
| **2nd Quarter** | 13.85% | 405 | 427 | N/A | 5% | ~~N/A~~ | Rates are down compared to Q1 | Continue to monitor for trends |
| **3rd Quarter** | 13.73% | 411 | | N/A | | ~~N/A~~ | Avoidable visit % has decreased compared to Q1 and 2. | Continue to monitor for trends, internal process improvements that include increasing CM outreaches to SPD mbrs. |
| **4th Quarter** | | | | N/A | | ~~N/A~~ | | |
| **YTD/Year End** | | | | N/A | | ~~N/A~~ | | |

## F. Emergency Department (Cont.)

| Medi-Cal Child and Family | | | | Goal | | | | |
|---|---|---|---|---|---|---|---|---|
| **Time Period** | **Avoidable Visits %** | **Total Visits/K/Y Reported** | **Total Visits/K/Y Updated** | **Total Visits K/Y** | **Total visits: Variance** | **% CCS Visits** | **Assessment** | **Interventions** |
| **1st Quarter** | 17.76% | 520 | 519 | 400 | -30% | 19.26% | Avoidable visits decreased from Q4 2024 | Continued lack of PCP/Urgent care in counties represents higher utilization of ER |
| **2nd Quarter** | 17.36% | 431 | 459 | 400 | -15% | 17.36% | Avoidable visits decreased from Q1 | Continued lack of PCP/Urgent care in counties represents higher utilization of ER, Continue to monitor. |
| **3rd Quarter** | 14.29% | 478 | | 400 | | 16.43% | Avoidable visit % has decreased from Q1 and Q2 | Continue to monitor for trends, continue increased oversight, |
| **4th Quarter** | | | | 400 | | - | | |
| **YTD/Year End** | | | | 400 | | - | | |

| Medi-Cal Seniors and Persons with Disabilities | | | | Goal | | | | |
|---|---|---|---|---|---|---|---|---|
| **Time Period** | **Avoidable Visits %** | **Total Visits/K/Y Reported** | **Total Visits/K/Y Updated** | **Total Visits K/Y** | **Total visits: Variance** | **% CCS Visits** | **Assessment** | **Interventions** |
| **1st Quarter** | 11.09% | 1045 | 995 | 830 | -20% | 12.21% | Avoidable visits increased from Q4 2024., %CCS visits down. | Lack of PCP/Urgent Care in counties. ECM providers being engaged to support members more efficiently. |
| **2nd Quarter** | 9.16% | 837 | 847 | 830 | -2% | 9.77% | Avoidable visits decreased from Q1 | Continue to monitor for trends |
| **3rd Quarter** | 9.31% | 1022 | | 830 | | 9.93% | Avoidable visit % relatively unchanged from Q2, noticeable decrease compared to Q1 | Lack of PCP/Urgent Care in counties. ECM providers being engaged to support members more efficiently. Increased oversight by CR in identifying high risk members, i.e., number of ED visits, admissions, etc. Capturing and discussing these member during IDT's. |
| **4th Quarter** | | | | 830 | | - | | |
| **YTD/Year End** | | | | 830 | | - | | |

| **Medicaid Expansion** (i.e. former LIHP, as well as new M aid code and 7U/W aid code members ) | | | | Goal | | | | |
|---|---|---|---|---|---|---|---|---|
| **Time Period** | **Avoidable Visits %** | **Total Visits/K/Y Reported** | **Total Visits/K/Y Updated** | **Total Visits K/Y** | **Total visits: Variance** | **% CCS Visits** | **Assessment** | **Interventions** |
| **1st Quarter** | 10.60% | 576 | 567 | 420 | -35% | 12.64% | Metrics stable Quarter over Quarter. | Continue work as before. |
| **2nd Quarter** | 10.19% | 493 | 508 | 420 | -21% | 10.19% | Metrics stable and decreased from Q1 | Continue current work and continuous monitoring. |
| **3rd Quarter** | 10.16% | 579 | | 420 | | 10.16% | Consistent with prior quarters | Continue to monitor for trends through Q4 |
| **4th Quarter** | | | | 420 | | - | | |
| **YTD/Year End** | | | | 420 | | - | | |



Back to Agenda

| ED Visits per County | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Time Period | Santa Cruz Avoidable Visits % | Santa Cruz Total Visits/K/Y | Monterey Avoidable Visits % | Monterey Total Visits K/Y | Merced Avoidable Visits % | Merced Total Visits K/Y | Mariposa Avoidable Visits % | Mariposa Total Visits K/Y | San Benito Avoidable Visits % | San Benito Total Visits K/Y | Assessment | Interventions |
| 1st Quarter | 11.98% | 83 | 16.00% | 252 | 14.61% | 184 | 14.31% | 7 | 15.10% | 39 | Note: weighted average goal for total Medi-Cal ED visits for 2025 (in Alliance Dashboard) is 590 | N/A |
| 2nd Quarter | 12.35% | 83 | 15.99% | 245 | 12.08% | 101 | 12.25% | 6 | 14.34% | 37 | ED Visits for all counties are down compared to Q1 | |
| 3rd Quarter | 11.71% | 83 | 15.12% | 250 | 13% | 177 | 10.99% | 7 | 14.06% | 37 | Santa Cruz, Monterey, and San Benito Co rates are down compared to Q1 and 2. Merced is relatively unchanged compared to Q2 with a noticeable decreased compared to Q1 | Continue current work and monitor for trends with Merced, increased focus on TOC/ECM support. In addition to our pilot with Mercy for urgent and telehealth access to reduce admissions to the ED |
| 4th Quarter | | | | | | | | | | | | |
| YTD/Year End | | | | | | | | | | | | |



Back to Agenda

## G. Pharmacy

### Drug Utilization Review (DUR) Program

Summary of interventions performed based on DUR analyses.

| Time Period | List of DURs | Comments | Interventions |
|---|---|---|---|
| **1st Quarter** | 1. High-dose opioids (>90MME daily)<br>2. Concomitant opioids and benzodiazepines<br>3. Antidepressants in children | 1. Opioid: no concerns found on members. Low percentage of naloxone prescriptions.<br>2. Members may not be picking up naloxone due to lack of education on importance.<br>3. Considering more robust interventions after BH integration. | 1. Social media outreach on naloxone.<br>2. Opioid/BZD: collaborated with CM on member outreach about naloxone<br>For June publication:<br>1. Provider bulletin article on best practices on naloxone prescribing<br>2. Member newsletter on importance of keeping naloxone on hand<br>3. Provider bulletin article on depression treatment guidelines in children & adolescents<br><br>Provider education only:<br>1. Provider bulletin on treatment of chronic HCV infection |
| **2nd Quarter** | None | N/A | Provider education only:<br>1. Asthma management: AIR and SMART treatment |
| **3rd Quarter** | 1. Mood stabilizers and antipsychotics in children<br>2. Buprenorphine & naloxone to members at high risk | 1. Mood stabilizers and antipsychotics: No concerns. Considering more robust interventions after BH integration stabilizes.<br>2. Buprenorphine & naloxone: low utilization in members after discharge | 1. Provider educational letter on metabolic monitoring in children and adolescents on atypical antipsychotics<br>2. Provider letter on available resources, support lines, and BH contact information |
| **4th Quarter** | | | |
| **Year End** | | | |

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

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

| Time Period | Total Auths | Approvals | Denials | Voided / Canceled | Top 5 Specialty Types by County | Assessment & Interventions |
|---|---|---|---|---|---|---|
| **1st Quarter** | 1,075 | 1,072 | 3 | 0 | Merced: Other (163), Surgery Orthopedic (52), Ophthalmology (40)<br><br>Monterey: Other (50), Ophthalmology (10), Surgery General (4)<br><br>Santa Cruz: Other (18), Ophthalmology (5), Surgery (1) | An increase in OON specialty use was noted from Q4 2024 to Q1 2025.In review of the data, it appears that Q4 2024 took a 40% dip from the previous quarter. Q1 thru Q3 2024 were roughly consistent. Continued monitoring of reports after transition to Jiva to assess accuracy of the data. Close partnership with Data Analytics team to resolve any data inaccuracies identified. |
| **2nd Quarter** | 924 | 923 | 1 | 0 | Merced: Other (131), Surgery Orthopedic (22), Ophthalmology (20)<br><br>Monterey: Other (26), Ophthalmology (7), Surgery Orthopedic (5)<br><br>Santa Cruz: Other (22), Ophthalmology (2), Surgery (2)<br><br>San Benito: Other (6), Oncology (2) | OON auths stabilized in 2025 after 2024 spike from County Expansion. Jiva transition improved submission accuracy (0 voids/cancels). Continued focus on provider education, PA/CM workflow enhancement, review of high-utilization specialties and data monitoring recommended. |
| **3rd Quarter** | 978 | 967 | 11 | 0 | Merced: Other (128), Ophthalmology (34), Surgery - Orthopedic (32), Oncology (13), Surgery - General (11)<br><br>Monterey: Other (45), Ophthalmology (6), Surgery - Orthopedic (3), Surgery - General (3), Neurology (2)<br><br>Santa Cruz: Other (38), Neurology (3), Oncology (3), Surgery - Orthopedic (3), Podiatry (2)<br><br>San Benito: (Other (20), Oncology (4), Surgery - Plastic (1), Ophthalmology (1), Dermatology (1)<br><br>Mariposa: Other (24), Oncology (5), Surgery - Orthopedic (4), Pain Medicine (2), Ophthalmology (2), Neurology (2) | OON specialist utilization in Q3 increased slightly from the prior quarter, while voids/cancellations remained at zero, indicating continued accuracy in submission of auths post-Jiva transition. The denial rate of just over 1% remains consistent with historical organizational denial patterns, demonstrating ongoing appropriateness in OON referral requests and review processes.<br><br>Overall utilization remained relatively stable but some increases observed across several counties, particularly in Merced and Santa Cruz, where a broader range of specialty types appeared in the Top 5 categories. The continued prevalence of “Other” as the highest-volume category across all counties may indicate the need for further review to determine if more detailed specialty-level categorization is needed. Increases in ophthalmology, orthopedic surgery and oncology requests continue to reflect ongoing access needs that suggest localized gaps in network capacity or provider availability.<br><br>PA leadership continue close partnership with Provider Services to validate OON utilization data. Reports from PS inform that various specialties are experiencing shifts in staffing and availability. Continued review and partnership for network development and reduction in network gaps. |



Back to Agenda

**H2. Out of Area / Out of Network BHT providers Utilization Metric**

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

| Time Period | | Total Auths | Approvals | Denials | Voided / Canceled | Top 5 Specialty Types by County | Assessment & Interventions |
|---|---|---|---|---|---|---|---|
| 1st Quarter | | | | | | | |
| 2nd Quarter | | | | | | | |
| 3rd Quarter | | OOA: 27<br>OON: 18 | OOA: 10<br>OON: 18 | OOA: 0<br>OON: 0 | OOA: 17<br>OON: 0 | OON:<br>Monterey: 8<br>Mercede: 5, 1 LOA<br>Santa Cruz: 4<br>San Benito: 1<br>Mariposa: 0<br><br>OOA:<br>Mercede: 3<br>Santa Cruz: 2<br>Monterey: 5 | OON and OOA auth request are low and stable across counties for BHT services. It should be noted that data for OON providers reflect providers that were not finalized with the the credentialling process at the start of BH insourcing and all with the exception of 1 provider are now within network. OOA data typical reflect member who have specific service request (e.g. clinic services) and/or are in areas with limited ABA.BHT provider availability. |
| 4th Quarter | | | | | | | |
| YTD/Year End | | | | | | | |

## I. Under / Over Utilization Tracking and Reporting

Under-over utilization is closely monitored and UM investigates identified cases, develops interventions and works closely with other departments such as Program Integrity, QI and Provider Services. As authorization codes are waived as part of the Auth Reduction Project, we will monitor to assure there is no resulting inappropriate over utilization. Auto approved or no TAR required (NTR) utilization will be monitored when an increase/decrease of 20% from the previous reporting quarter is identified in the emerging analysis (see Section J).

| 2025 Evaluation | | | | |
|---|---|---|---|---|
| **Time Period** | **Monitored Category** | **Over or Under** | **Assessment** | **Interventions** |
| **1st Quarter** | 1.EMG<br>2. Auth Redesign Codes (As identified)<br>3. IHA<br>4. Breast Cancer Screening<br>5. Colon Cancer Screening<br>6. Lead Screening<br>7. ACE Screening<br>8. Mental Health Visits<br>9. ED Utilization | 1.Monitor for Over<br>2. Monitor for Over<br>3. Under<br>4. Under<br>5. Under<br>6. Under<br>7. Under<br>8. Under<br>9. Monitor for Over | Auth requirements for EMG/nerve conduction studies were removed in Q4 2024. Continued monitoring of these auth types after removal of auth requirements.<br><br>Screenings for breast and colon cancer, lead and ACE continue to be under utilized quarter over quarter and is consistent with last year's findings and an area of interdepartmental focus.<br><br>Mental Health Visits continue to be under utilized quarter over quarter and is also consistent with last year's trends. Behavioral health will be insourced to the Alliance next quarter and is expected to positively impact this metric. | Review of these monitored categories is underway to determine if there are additional categories whose utilization patterns should be better tracked. |
| **2nd Quarter** | 1.EMG<br>2. Auth Redesign Codes (As identified)<br>3. IHA<br>4. Breast Cancer Screening<br>5. Colon Cancer Screening<br>6. Lead Screening<br>7. ACE Screening<br>8. Mental Health Visits<br>9. ED Utilization | 1.Monitor for Over<br>2. Monitor for Over<br>3. Under<br>4. Under<br>5. Under<br>6. Under<br>7. Under<br>8. Over<br>9. Under | Q2 data shows continued underutilization trends from 2024 in cancer screening, lead screening and ACE, despite efforts across the org. EMG shifted from over to under post-auth removal, indicating impact of the Auth Redesign Project. Mental health visits notably flipped to over in Q2 2025, indicating the start of the BH insourcing which began at the end of June and officially launched on 7/1/25. | Utilization changes ≥30% will be closely tracked in Section J. |
| **3rd Quarter** | 1.EMG<br>2. Auth Redesign Codes (As identified)<br>3. IHA<br>4. Breast Cancer Screening<br>5. Colon Cancer Screening<br>6. Lead Screening<br>7. ACE Screening<br>8. Mental Health Visits (Depression Screening)<br>9. ED Utilization | 1. Monitor for Over (-29.8 %)<br>2. Monitor for Over<br>3. Monitor for Under (49%)<br>4. Monitor for Under (1.9%)<br>5. Monitor for Under (-6.86%)<br>6. Monitor for Under (1.44%)<br>7. Monitor for Under (3.86%)<br>8. Monitor for Under (-62.5%)<br>9. Monitor for Over (-3.12%) | Q3 showed continued variability across monitored utilization categories. EMG utilization remains low (previously an overutilization concern) (–29.8%) following the Auth Redesign Project, reaffirming the need for ongoing monitoring and removal of auth requirements for areas of low denial. Preventive screenings showed mixed patterns: breast cancer screening increased slightly (+1.9%), while colon cancer screening (–6.86%) and lead screening remained underutilized, consistent with long-standing trends. ACE screening shifted to modest utilization (+3.86%), reflecting increased provider activity.<br><br>Mental health visits decreased significantly (–62.5%), reversing the Q2 spike post–BH insourcing. Potential cause may be auto-approval of BH auths for in-network providers and carve out to counties for Specialty Mental Health Services (SMHS) that stabilized after initial post-BH insourcing period. ED utilization declined slightly (–3.12%), remaining within expected variation.<br><br>Overall, Q3 trends identify continued need for targeted monitoring to determine whether utilization shifts are clinically appropriate or indicative of emerging issues. Will continue to monitor Mental Health Visits. | Plan to continue to monitor these categories. Potential to review categories and make adjustments for CY 2026. |
| **4th Quarter** | 1.EMG<br>2. Auth Redesign Codes (As identified)<br>3. IHA<br>4. Breast Cancer Screening<br>5. Colon Cancer Screening<br>6. Lead Screening<br>7. ACE Screening<br>8. Mental Health Visits<br>9. ED Utilization | 1.<br>2.<br>3.<br>4.<br>5.<br>6.<br>7.<br>8.<br>9. | | |

### I2. Under / Over Utilization Tracking of BH codes -Effective 7/1/2025 post go live

Under/over utilization is closely monitored and UM investigates identified cases, develops interventions and works closely with other departments such as Program Integrity, QI and Provider Services. We will monitor to assure there is no resulting inappropriate over utilization.

| 2025 Evaluation | | | | | |
|---|---|---|---|---|---|
| **Time Period** | | **Monitored Category (BH Services)** | **Over or Under** | **Assessment** | **Interventions** |
| **1st Quarter** | | | | | |
| **2nd Quarter** | | | | | |
| **3rd Quarter** | | 1. Mental Health Assessment (H0031)<br>2. Mental Health development (H0032)<br>3. Home Care Training (S5111)<br>4. Behavior Identification Assessment (97151) | 1. Baseline<br>2. Baseline<br>3. Baseline<br>4. Baseline | Data for over utilization is based on an increase of 20% it should be noted that this increase is a refection of BH insourcing and is not currently an area of concern. Data will continue to be monitored following quarter to identify emerging trends. | No intervention needed at this time as data reflects bassline since the start of insourcing and will be compared to Q4 data to observe for any emerging trends. |
| **4th Quarter** | | | | | |

## J. Emerging Under / Over Utilization Analysis

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

| Time Period | Top 5 Over | Top 5 Under | Service / Benefit Type | Top 5 Auto Approved/NTR Codes | Assessment |
|---|---|---|---|---|---|
| **1st Quarter** | 1. G9012 OTHER SPECIFIED CASE MANAGEMENT (49,565)<br>2. 1036F CURRENT TOBACCO NON-USER (6,069)<br>3. G9920 SCREENING PERFORMED AND NEGATIVE (5,692)<br>4. 3008F BODY MASS INDEX (3,472)<br>5. T1019 PERSONAL CARE SERVICES (3,225) | 1. CHW<br>2. Dyadic Care<br>3. Doula<br>4. Street Medicine<br>5. Depression Screening | 1. Misc Non Benefit codes (supplies, pdn)<br>2. Misc. Dressings, medical supplies<br>3. Nerve Conduction tests<br>4. Z codes, EPSDT<br>5. Supervised | 1. T1000-T5999, Not valid for Medicare (773)<br>2. A6000-A6412, Dressings (571)<br>3. 95905-95913, Nerve Conduction Tests (301)<br>4. Z4300 - Z5999, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) (159)<br>5. 97010-97028 Supervised (148) | ECM/CS services continue with increased utilization, substantiated by high utilization of G9012 and 1036F. Now that members are aware of and utilizing ECM/CS benefits. organizational efforts are being made to further ensure the quality of ECM/CS services that members are receiving.<br><br>Continued trend with the top 5 under utilized services consistent with previous quarters. Continued efforts to ensure members requiring CHW and doula services are able to obtain the benefits.<br><br>No concerns regarding the top 5 auto approved and NTR codes. |
| **2nd Quarter** | 1. G9012 OTHER SPECIFIED CASE MANAGEMENT (42,141)<br>2. S9977 MEALS (26,045)<br>3. 90837 PSYCHTHERAPY, 60 MIN (18,609)<br>4. H2019 THERAPEUTIC BEHAVIORAL (12,858)<br>5. 97530 THERAPEUTIC ACTIVITIES (7,628) | 1. CHW<br>2. Dyadic Care<br>3. Doula<br>4. Street Medicine<br>5. Depression Screening | 1. Misc Non Benefit codes (supplies, pdn)<br>2. Misc. Dressings, medical supplies<br>3. Nerve Conduction tests<br>4. Application of modalities<br>5. Supervised | 1. T1000-T5999, Not valid for Medicare (767)<br>2. A6000-A6412, Dressings (559)<br>3. 95905-95913, Nerve Conduction Tests (352)<br>4. 97010-97028 Supervised (182)<br>5. 97032 - 97039, Constant Attendance (174) | Most common auth type requested continues to be ECM/CS with MTM topping the list. This trend continues from previous quarters. Continued efforts across the org for improved quality of ECM/CS utilization and ongoing ECM/CS provider education to drive the quality of ECM/CS services for members.<br><br>Uptick in BH service codes expected as the organization insources BH services. Continued monitoring of appropriate utilization of BH services into the coming quarters after insourcing.<br><br>**Top 5 Auto Approved codes updated in Q3 to limit to creation in Q2 instead of 1/1-6/30 - codes remain the same but quantities have changed** |
| **3rd Quarter** | 1. G9012 OTHER SPECIFIED CASE MANAGEMENT (95,896)<br>2. S9977 MEALS (30,606)<br>3. 90837 PSYCHTHERAPY, 60 MIN (19,029)<br>4. H2019 THERAPEUTIC BEHAVIORAL (15,039)<br>5. 83036 HEMOGLOBIN A1C (10,101) | 1. CHW<br>2. Dyadic Care<br>3. Doula<br>4. Street Medicine<br>5. Depression Screening | 1. Misc Non Benefit codes (supplies, pdn)<br>2. Misc. Dressings, medical supplies<br>3. Nerve Conduction tests<br>4. Z codes, EPSDT<br>5. Supervised | 1. T1000-T5999, Not valid for Medicare (787)<br>2. A6000-A6412, Dressings (607)<br>3. 95905-95913, Nerve Conduction Tests (338)<br>4. Z4300-Z53999 Early and Periodic Screening (EPSDT) (146)<br>5. 97032 - 97039, Constant Attendance (93) | Q3 shows continued high utilization of G9012 and ongoing increases in ECM/CS and behavioral health services, including S9977 (MTM), 90837 (psychotherapy) and H2019 (therapeutic BH). The appearance of 83036 (A1C testing) reflects increased chronic disease monitoring.<br><br>Underutilization trends remain unchanged, with CHW services, dyadic care, doula services, street medicine and depression screening still consistently low—highlighting ongoing opportunities for outreach and provider education.<br><br>Auto-approved/NTR codes remain stable with no concerns. Overall, Q3 utilization remains consistent with organizational trends, with persistent underuse in community and preventive services. |
| **4th Quarter** | 1.<br>2.<br>3. | 1.<br>2.<br>3. | 1.<br>2.<br>3. | 1.<br>2.<br>3. | |

## IV. UM Delegate Oversight

### A. UM Delegate Oversight Quarterly Report (Analysis Summary). After 7/1- (BHT reporting)*

| | | | | | |
|---|---|---|---|---|---|
| **Q4-23: Reported - Q1-24** | Carelon | 1/20/2025 | 1/17/2025 | Auth Approval Log<br>Auth Denial Log<br>Telehealth Utilization Summary<br>Admin 3 Provider OPT Utilization<br>Admin 5 Provider IPT Utilization<br>BHT Utilization Report<br>DHCS BHT Reporting Template<br>UM Summary ICE<br>UM Timeliness Report | All UM Committee meeting minutes held as required and reviewed; aligned with reports submitted and current status of CAPs during Q4 2024.<br>Clinical Criteria for UM decisions completed by Relevant staff and practitioners<br>UM decisions (approvals and denials/adverse modifications) made by appropriately qualitied professionals<br>Timeliness of UM decisions- overall, carelon reports 98.6% timeliness met for "Number Decided Within 5 Business Days" . During our Q4 UM Audit, 4 out of 10 charts did not meet timeliness, being 12-19 business days and reason of processing error noted in charts (Um5c)<br>Carelon reported already placing themselves on internal CAP for this reason, as in previous quarters, identifying root analysis, barriers and action steps This area is the area of continued improvement noted in our sample of charts reviewed quarterly but not a formal improvement plan at this time, given overall timeliness is met however sample review did not.<br>Clinical information on sample of charts consistently meets criteria<br>Denial notices-For Carelon purposes these are generally considered Adverse Determinations and/or modifications rather than true denials, however in review of sample charts of ADs, they meets requirements of documentation required to send<br>CoC-reviewed file sent and no concerns however to note this is only for BHT members on this file, only 2 members noted<br>NCQA Elements met: UM 4D, 5B, 6B, 7D, 7E, 7F |
| **Q1-25: Reported - Q2-25** | Carelon | 4/20/2025 | 4/15/2025 | Auth Approval Log<br>Auth Denial Log<br>Telehealth Utilization Summary<br>Admin 3 Provider OPT Utilization<br>Admin 5 Provider IPT Utilization<br>BHT Utilization Report<br>DHCS BHT Reporting Template<br>UM Summary ICE<br>UM Timeliness Report | All UM Committee meeting minutes held as required and reviewed; aligned with reports submitted and current status of CAPs during Q1 2025.<br>Clinical Criteria for UM decisions completed by Relevant staff and practitioners<br>UM decisions (approvals and denials/adverse modifications) made by appropriately qualitied professionals.<br>Timeliness of UM decisions- Overall, Carelon reports 99.2% timeliness met for "Number Decided Within 5 Business Days". During our Q1 UM Audit, 3 out of 11 charts did not meet timeliness, being 6-10 business days and no reason of processing error noted in charts (Um5c).<br>There is no formal improvement plan at this time due to overall timeliness being met even though the sample review did not.<br>Clinical information on sample of charts consistently meets criteria.<br>Denial notices-For Carelon purposes these are generally considered Adverse Determinations and/or modifications rather than true denials, however in review of sample charts of ADs, they meet requirements of documentation required to send. During the Q1 UM Audit 2 of the denial charts were missing the practitioner's signature although documented it was completed by appropriately qualified professional. No formal improvement plan implemented but feedback provided in the Audit Summary report.<br>CoC-Reviewed file sent and no concerns however to note this is only for BHT members on this file, only 2 members noted<br>NCQA Elements met: UM 4D, 5B, 6B, 7D, 7E, 7F |
| **Q2-25: Reported - Q3-25** | Carelon | 7/20/2025 | 7/18/2025 | Auth Approval Log<br>Auth Denial Log<br>Telehealth Utilization Summary<br>Admin 3 Provider OPT Utilization<br>Admin 5 Provider IPT Utilization<br>BHT Utilization Report<br>DHCS BHT Reporting Template<br>UM Summary ICE<br>UM Timeliness Report | All UM Committee meeting minutes held as required and reviewed aligned with reports submitted.<br>Clinical Criteria for UM decisions completed by Relevant staff and practitioners<br>UM decisions (approvals and denials/adverse modifications) made by appropriately qualitied professionals.<br>Timeliness of UM decisions- Overall, Carelon reports 99% timeliness met for "Number Decided Within 5 Business Days". During our Q2 UM Audit, 2 out of 10 charts did not meet timeliness, being 7 and 10 business days and no reason of processing error noted in charts (Um5c).<br>There is no formal improvement plan at this time due to overall timeliness being met even though the sample review did not.<br>Clinical information on sample of charts consistently meets criteria.<br>Denial notices-For Carelon these are generally considered Adverse Determinations-Modifications rather than true denials. Adverse determination sample charts met documentation requirements.<br>CoC-Reviewed file sent and no concerns. To note- this is only for BHT members on this file, and only 2 members documented. |
| **Q3-24: Reported - Q4-24** | Carelon | NA | NA | NA | NA due to insourcing |

## B. Medi-Cal Mental Health Utilization Rates

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

| Time Period | Santa Cruz | Monterey | Merced | Mariposa | San Benito | GOAL | Assessment | Interventions |
|---|---|---|---|---|---|---|---|---|
| **1st Quarter** | | | | | | | | |
| 0-12 | 7.25% | 5.08% | 3.47% | 2.73% | 3.35 | 2.5% - 4% | For 0-12 all counties met within goal, For 13-18, Mariposa was slightly below. For 19+, both Mariposa and SB were below Goal. Note this is only the BH network. Any BH interventions that occur within the physical health care space are not included here | due to insourcing 7/1, bringing in a robust BH provider network, increasing provider and member outreach, satisfaction and education is goal to increase penetration in our underserved communities. |
| 13-18 | 8.79% | 7.31% | 4.68% | 2.44 | 3.22 | 2.5% - 4% | | |
| 19+ | 11.83% | 6.77% | 4.90% | 3.99 | 3.42 | 4.5% - 6.5% | | |
| **2nd Quarter** | | | | | | | For 0-12 all counties met within goal, For 13-18, Mariposa was slightly below but did increase from last quarter For 19+, was also slightly below but increased from last quarter. All areas other than SC 0-12 increased from last quarter. Note this is only the BH network. Any BH interventions that occur within the physical health care space are not included here □ □ | due to insourcing 7/1, bringing in a robust BH provider network, increasing provider and member outreach, satisfaction and education is goal to increase penetration in our underserved communities. |
| 0-12 | 7.20% | 5.21% | 3.50% | 2.88 | 3.79 | 2.5% - 4% | | |
| 13-18 | 8.88% | 7.62% | 4.71% | 3.29 | 3.42 | 2.5% - 4% | | |
| 19+ | 12.01% | 7.03% | 4.94% | 5.11 | 4.03 | 4.5% - 6.5% | | |
| **3rd Quarter** | | | | | | | As of 7/1/25, Behavioral Health penetration is tracked on area L under Operational Performance, as this is no longer a delegate Oversight service due to insourcing BH 7/1/25. | |
| 0-12 | | | | | | 2.5% - 4% | | |
| 13-18 | | | | | | 2.5% - 4% | | |
| 19+ | | | | | | 4.5% - 6.5% | | |
| **4th Quarter** | | | | | | | As of 7/1/25, Behavioral Health penetration is tracked on area L under Operational Performance, as this is no longer a delegate Oversight service due to insourcing BH 7/1/25. | |
| 0-12 | | | | | | 2.5% - 4% | | |
| 13-18 | | | | | | 2.5% - 4% | | |
| 19+ | | | | | | 4.5% - 6.5% | | |



Back to Agenda

### C. Carelon UM File Audit*

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

| Time Period | % Compliance | Summary of Non-Compliance | Follow-up Actions |
|---|---|---|---|
| 1st Quarter | 98 | Out of the eleven reviewed charts, three charts were outside of the timeliness requirement (>5 days) for determination. The three charts determinations were 6-10 business days with no documented reason for processing delay. Also two of the denial charts were missing the signature from the reviewing practitioner | Carelon met all areas but timely response to UM decisions, which brought overall compliance from 100 down to 98%. Follow up to Carelon included: Ensure the timeliness decisions is less than 5 business days. Provide additional training on current processes as needed. Please continue to ensure Carelon staff who are pre-auditing charts internally are labeling the elements on both the approval and denial charts. Continue to clearly document within the chart the case management referral outcomes (i.e. referral submitted, not needed, etc.). Also check each chart to confirm the appropriate practitioner's signature is included. |
| 2nd Quarter | 98 | Out of the ten reviewed charts, two charts were outside of the timeliness requirement (>5 days) for determination. The two chart's determinations were 7 and10 business days with no documented reason for processing delay. | Due to insourcing we will not have UM audits for files in Q3 or Q4 and Q2 is our final. Any findings will be reported to Carelon but unlikely to have any follow up actions |
| 3rd Quarter | NA | NA due to insourcing | NA due to insourcing |
| 4th Quarter | NA | NA due to insourcing | NA due to insourcing |

### D. MedImpact Delegate Oversight

### MedImpact Pharmacy File Audit

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

| Time Period | % Compliance | Summary of Non-Compliance | Follow-up Actions |
|---|---|---|---|
| 1st Quarter | 100% | MedImpact audit passed both turnaround time (TAT) and readability. | Ongoing Corrective Action Plan (CAP) for readability of member letters for PA denial types from 2024Q4. Currently in monitoring phase. |
| 2nd Quarter | 100% | 100% passed for TAT and readability. | CAP closure in May. Collaborating with MedImpact on revision of step therapy exception and quantity exception denial language templates. |
| 3rd Quarter | 100% | 100% passed for TAT and readability. | Started monthly audits of member denial letter content for earlier detection and intervention, from letters sent in August. |
| 4th Quarter | | | |

### MedImpact Per Member Per Month (PMPM)

| Line of Business | Per Month (PMPM) Cost | | | | | | Change from 2024 |
|---|---|---|---|---|---|---|---|
| | 2024 | 2025 Q1 | 2025 Q2 | 2025 Q3 | 2025 Q4 | 2025 YTD | |
| IHSS | $258.51 | $357.87 | $374.15 | $363.80 | | $365.27 | 41.3% |

### MedImpact Medical Necessity Pharmacy Denials Per Quarter

Monitoring of Pharmacy prior authorization volume and appeals.

| Time Period | # Auth Volume | # Denials | # Appeals | # Appeals Upheld | # Overturned | Assessment |
|---|---|---|---|---|---|---|
| 1st Quarter | 42 | 8 | 1 | 1 | 0 | Auth volume 47, removed 4 PA not required and 1 withdrawn request from final PA count. Total 8 denials 4 administrative and 4 clinical necessity. 19% denial rate. |
| 2nd Quarter | 48 | 12 | 2 | 1 | 1 | Total auth # 51 (2 auths with PA not required, 1 withdrawn). High PA volume for GLP-1 agonists (T2DM and weight loss). 11 denials and 1 partial approval, 10 for medical necessity and 2 administrative. Denial rate increase to 25%. |
| 3rd Quarter | 51 | 9 | 1 | 0 | 1 | Total auth # 56 (5 PA not reqiured), High PA volume remains for GLP-1 agonists (T2DM and Weight loss). No partial approvals, 8 clinical necessity denials, 1 administrative denial. |
| 4th Quarter | | | | | | |
| Year End | | | | | | (2024 avg: 36.5 PAs, 21% denial rate) |



Back to Agenda

# UMWP: 2025, Q3

## Work Plan Overview: Q3 Updates

Tammy Brass, UM Director, Interim HSED

12/05/2025





Back to Agenda

# UMWP 2025 Q3: Data Review

## OBJECTIVES:

1. Review 2025 Q3 overall UMWP outcomes
2. Review emerging or consistent trends
3. Discuss recommendations & action items
4. Review assessments & interventions
5. Discuss future recommendations





Back to Agenda

# UMWP 2025 Q3: Areas of Focus

## AGENDA:

1. Projects and Initiatives
2. Operational Performance
3. Utilization Performance
4. Delegate Oversight

# Projects and Initiatives: **CM**

- Pediatric CM
  - 5% increase in CCS eligible members over Q1
  - 20% increase in aged out members from Q1
  - 22% increase in newly eligible members over Q1
  - Care Plans: Increases noted; member texting campaign ahead
- Adult CM
  - 25% increase from Q2 in complete cases open over 60 days
  - 56% decline in enrolled NCQA members over Q1
  - Member texting campaign to support member engagement

# Projects and Initiatives: **UM, Care Integration**

- ECM & CS
  - Continued ECM enrollment increases across all counties
  - Enrollment continued around 5% total membership – goal is 3%
  - Process improvements with audits, disenrollments + IDT engagement
- Reducing Readmissions
  - Overall 30-day readmissions remain stable at 9–11%
    - Highest rates in over-55s, with slight Q3 increases in Mariposa and San Benito.
  - Overall HR Readmits consistent w prior quarters – 20%
    - Decreases in SB (4%), Mariposa (4%) and SC (5%) counties
  - Transitional Care process development with DSNP build

# Projects and Initiatives: **Pharmacy**

- Pharmacist Led Academic Detailing Program
  - Q3 focus on hypertension PLAD
  - Barriers to PLAD enrollment noted:
    - Lack of provider response/interest
    - Pharmacist capacity
- Naloxone Distribution
  - Majority of Naloxone distributed in Merced as per prior quarters
  - Ongoing decreases noted ~77% decrease over Q1

# Operational Performance: **Prior Authorization**

**Turnaround times:** 99.82%

**PA Volumes:** +8.5% (65,657 → 71,221)

**Medical necessity denials:** +5% (1,919 → 2,021)

**Appeals:** +12% (136 → 152), 70% upheld

**Top denials:** CS/ECM authorizations

**BH (ABA/BHT):** 1136 auths Q3, 9 denials, 0 appeals

**Key actions:**

- Provider outreach & education
- Monitoring PA/appeal trends
- Refining CS policies for clarity & compliance

# Operational Performance: **Pharmacy**

**Turnaround times:** 96–97.3%

**PA Volumes:** +4% (Q1: 1,912 → Q3: 1,990)

**Denial rate:** 2.7–3.5%, trending down in Q3 (3.5 → 2.9%)

**Appeals:** Low volume, 2 overturned in Q3 (Hyaluronan)

**Top denials:**

- Dexamethasone lacrimal insert (Dextenza), Hyaluronan, Aflibercept, Onabotulinumtoxin

**Key actions:**

- Late Friday shifts, workflow updates, and tech reassignments to maintain TAT
- Ongoing tech training and member NOA letter compliance
- PA criteria updates for biosimilars and high-volume drugs

# Utilization Performance: **Inpatient Utilization**

| Metric | Q3 2025 | Trend vs Q2 | Trend vs Q1 |
|---|---|---|---|
| Admits / 1,000 Y | 68 | ↑ (65) | ↓ (70) |
| ALOS (days) | 4.4 | ↑ (4.1) | Stable (4.5) |
| Readmissions – SPD+Dual | 10.9% | ↑ (10.6%) | ↓ (13.6%) |
| Readmissions – Total Members | 11% | ↑ (7%) | Stable (10%) |
| Readmissions – Medicaid Expansion | 6.6% | Stable (6.9%) | ↓ (9%) |

**Key Actions:**

- Continue **TOC / CCM / ECM referrals** for high-risk members
- Maintain **enhanced IDT oversight** for complex cases and 55+ population
- Strengthen **provider collaboration** for chronic disease management & PCP follow-ups
- Ongoing monitoring of **readmissions, ALOS, and admit trends** for targeted interventions

# Utilization Performance:
# **Ambulatory Care Sensitive Admissions**

**ACSA % Regional Trends**

| Region | Q3 2025 | Q2 2025 | Trend |
|---|---|---|---|
| Santa Cruz | 4.93% | 3.99% | ↑ 🟢 |
| Monterey | 4.68% | 5.22% | ↓ 🔴 |
| Merced | 5.56% | 5.78% | ↓ 🔴 |
| Mariposa | 10.29% | 2.35% | ↑ 🔴 |
| San Benito | 4.66% | 5.99% | ↓ 🟢 |

**Key Actions:**

- ↑ **TOC / CCM / ECM referrals** for high-risk members
- Enhanced **IDT oversight** for complex cases, Mariposa, 55+ population
- Provider collaboration for **chronic disease management & PCP follow-ups**
- Continuous **monitoring of readmissions and ACSA trends**

# Utilization Performance: **Alternatives to Acute Inpatient**

**SNF & Short-Term Rehab (STR) Metrics – Q3:**

- **SNF Bed Days:** 1,376 ↓ from Q2 (1,869)
- **STR Readmits After Discharge:** 54 ↓ from Q2 (71)
- **Trend:** Small decrease in bed days and readmissions, indicating improved post-discharge management
- **Key Actions:** Weekly IDTs with SNFs, collaboration with ECM/CM for discharge planning and difficult placements

**Long-Term Care (LTC) Metrics – Q3:**

- **New Admissions:** 296 ↑ from Q2 (229)
- **Total Members in LTC:** 349 ↑ from Q2 (323)
- **Trend:** Increase in admissions, including transitions from STR; overall LTC population slightly rising
- **Key Actions:** Ongoing member reassessment, monitor for appropriate Title 22 placement, support ECM/CM transitions back to community where possible

# Utilization Performance: **Emergency Department** (Population Level)

| Population | Avoidable ED Visits Q3 | Trend vs Q1 | Trend vs Q2 | Total Visits Q3 | Key Notes |
|---|---|---|---|---|---|
| **IHSS** | 13.73% | ↓ | ↓ | 411 | Continuing downward trend |
| **Child & Family** | 14.29% | ↓ | ↓ | 478 | Highest avoidable visits, improvement vs Q1/Q2 |
| **Seniors & PD** | 9.31% | ↓ **vs Q1** | ↔ vs Q2 | 1022 | Stable compared to Q2, improved vs Q1 |
| **Medicaid Expansion** | 10.16% | ↔ | ↔ | 579 | Consistent with prior quarters |

# Utilization Performance: **Emergency Department** (County Level)

| County | Q3 2025 | Trend vs Q1/Q2 |
|---|---|---|
| Santa Cruz | 11.71% | ↓ |
| Monterey | 15.12% | ↓ |
| Merced | 13% | ↔ vs Q2, ↓ vs Q1 |
| Mariposa | 10.99% | ↓ |
| San Benito | 14.06% | ↓ |

**Key Actions:**

- Increase **CM/ECM outreach** to high-risk populations
- Continue **TOC/IDT coordination** to reduce post-discharge ED utilization
- Expand **urgent care and telehealth pilot programs** (e.g., Mercy collaboration)
- Monitor **county-level trends** with focus on Merced and Mariposa

# Utilization Performance: **Utilization Review**

| Category | Review | Q3 | Trend | Notes |
|---|---|---|---|---|
| **EMG / Auth Redesign Codes** | Monitor for Over | –29.8% | ↓ | Low utilization post-auth removal; monitoring continues |
| **Breast Cancer Screening** | Monitor for Under | +1.9% | ↑ | Slight improvement, but still below goal |
| **Colon Cancer Screening** | Monitor for Under | –6.86% | ↓ | Continued underutilization |
| **Lead Screening** | Monitor for Under | +1.44% | ↔ | Persistent underutilization |
| **ACE Screening** | Monitor for Under | +3.86% | ↑ | Small increase, reflects provider activity |
| **Mental Health Visits** | Monitor for Under | –62.5% | ↓ | Post-BH insourcing spike stabilized |
| **ED Utilization** | Monitor for Over | –3.12% | ↓ | Within expected variation |

# Delegate Oversight: **MedImpact**

| Quarter | Auth Volume | Denials | Denial Rate | Appeals Overturned | Notes |
|---|---|---|---|---|---|
| Q1 | 42 | 8 | 19% | 0 | 4 administrative, 4 clinical denials |
| Q2 | 48 | 12 | 25% | 1 | High volume for GLP-1 agonists; 10 clinical, 2 administrative |
| **Q3** | 51 | 9 | 16% | 1 | Continued high GLP-1 PA volume; 8 clinical, 1 administrative |

**Trends & Insights**

- GLP-1 PA requests continue to drive volume
- Denial rate decreased from Q2 peak
- **PMPM cost (IHSS) rising to $365.27 (41% increase vs 2024 $258.51)**

**Next Steps**

- Monitor GLP-1 PA volume and criteria
- Continue monthly denial letter audits
- Track cost trends against utilization patterns

# Delegate Oversight: **Carelon + BH Insourcing Utilization (7/1/25)**

**BH Penetration Rates:**

- Within Target Range for all age groups and counties
- 0–12 and 19+ showed increases
- 13–18 slightly lower in 3 of 5 counties but still on target

**Post 7/1/25 BHT Plan Data**

| Quarter | BHT Auth Volume | Denials | Denial Rate | Appeals | Notes |
|---|---|---|---|---|---|
| **Q3** | 1136 | 9 | Less than 1% | 0 | Data does not include NTR Codes for BH services |

**Assessment & Next Steps:**

- Smooth transition to in-house BH services
- Expand network and reduce access barriers
- Continue monitoring penetration and member needs

# Questions?



Back to Agenda

**DATE:** February 25, 2026

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

**FROM:** Michael Schrader, Chief Executive Officer

**SUBJECT:** 2026 Policy Priorities

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Recommendation. Approve the Alliance's 2026 Policy Priorities and authorize staff to undertake legislative, budgetary, policy and regulatory advocacy aligned with these policy priorities.

Background. Each year, your Board reviews, revises and adopts Policy Priorities reflecting your Board's priorities and principles. These Policy Priorities provide general direction for Alliance legislative, policy, and budgetary advocacy efforts in service of the Alliance's mission of accessible, quality health care guided by local innovation. The Board-approved Policy Priorities provide direction to staff to respond effectively and efficiently to proposals that could significantly impact the Alliance's strategic and operational interests.

The proposed 2026 Policy Priorities reflect the Board's strategic priorities, the current health care policy environment, and the Board's historical areas of legislative focus.

The Alliance Government Relations Director, under the direction and supervision of the Chief Executive Officer, is responsible for identifying, monitoring, tracking, and reporting on policy, legislative, and budget initiatives. Upon approval by the Board, the Government Relations Director coordinates and centralizes advocacy efforts within the parameters of the Board's Policy Priorities.

Discussion. Staff reviewed the Board's 2025 Policy Priorities within the context of today's legislative, policy, and budget environment and determined that the 2025 Policy Priorities adopted by the Board could be further augmented and strengthened considering the federal policy and legislative environment, State budget factors, and local health care delivery system realities.

The Board's approval of the 2026 Policy Priorities will enable Alliance staff to engage in activities to protect and support access to care, strengthen the local health care delivery system, advocate for adequate and appropriate financing, protect Medi-Cal eligibility and benefits, and support health equity and integrated systems of care. Activities may include legislative, regulatory, and budget advocacy throughout the year in support of the Alliance's Strategic Plan and to help advance its Mission, Vision, and Values in support of the Alliance, its members, and providers. Staff may support policies and proposals that advance these priorities and principles and may oppose policies and proposals that impede these priorities.

Staff may employ various strategies, tactics, and advocacy activities to advance the 2026 Policy Priorities, including, but not limited to, educating legislators at the federal, state, and local levels,

collaborating with vested stakeholders, building consensus, aligning messaging;, testifying at public hearings and forums, and drafting letters of support or opposition for legislative, budgetary, or policy proposals that are aligned with the Board-approved Policy Priorities.

Official Alliance legislative and regulatory positions that are not contemplated under the 2026 Policy Priorities will be brought to the Board for separate consideration and action, as needed.

Upon Board approval, staff will share a copy of the final 2026 Policy Priorities document with the Board for its information and reference.

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

Attachments. 2026 Policy Priorities – DRAFT

# 2026 Policy Priorities*

## Federal Level Priorities

- Advocate for ~~the protection of state~~ Medicaid financing policies ~~that~~ that preserve funding stability, reflect the cost of care and minimize financial risk-shifting to states, providers and plans, ~~funding from proposals that impose block grants or per member caps,~~ ensuring stable, predictable funding for Medi-Cal and preventing cuts to critical health services for low-income Californians.
- Champion the preservation of Medicaid expansion and safeguard the program's funding from federal rollback efforts that threaten health coverage for millions of low-income Californians.

## Access to Care

- ~~Increase~~ Expand and sustain provider pathways ~~to~~ that increase the availability ~~total number~~ of culturally and linguistically competent providers available to people with Medi-Cal and Medicare coverage.
- Support ~~Provide~~ immediate and long-term solutions to shortages in, or which expand the capacity of, the Medi-Cal and Medicare healthcare workforce that improve provider retention and maintain timely access to care.~~.~~
- Preserve a healthcare delivery system that supports the continued viability of independent and community-based providers alongside large integrated health systems.

## Local Innovation

- Strengthen and ~~improve~~ modernize the safety net healthcare delivery system in the context of evolving federal and state financing, oversight and compliance requirements.
- Preserve and strengthen the local health plans and the public, not-for-profit managed care model
- Support local solutions that facilitate secure, timely health information and data exchange to improve care coordination, quality and accountability

## Eligibility and Benefits

- Protect or add to the benefits available to Medi-Cal and Medicare beneficiaries by opposing cost sharing increases or benefit reductions or limitations that undermine access to care
- Protect access to publicly-sponsored health care at no or low-cost coverage for uninsured and low-income populations by minimizing administrative barriers, coverage disruptions and inappropriate disenrollment

## Financing and Rates

- ~~Demonstrate~~ Advocate for alignment between financial and programmatic

policy ~~and which~~to ensure health plan revenue is adequate to enable effective, financially viable operations

- Encourage and support provider participation in Medi-Cal and Medicare through ~~adequate~~ rates of payment that reflect the cost of care, work force pressures and quality of care
- Support funding of Medicare to enable the financial viability of a Medicare Advantage D-SNP to provide services to dual eligible members
- ~~–~~Advocate for DHCS Medi-Cal capitation rate development methodologies, including adjustment factors, that accurately reflect the full cost of care and preserve funding needed to maintain access, quality, and delivery system stability.

**Health Equity**

- Optimize health outcomes and eliminate health disparities for children and other vulnerable populations, particularly in the context of changing eligibility, benefits and financing policies
- Improve outcomes and reduce disparities between the Medi-Cal and commercially insured populations
- Increase member access to culturally and linguistically appropriate and culturally competent health care
- Prioritize allocation of resources to address disparities and to remove barriers to equitable access to high-quality services.

**Person-Centered Delivery System Transformation**

- Support integrated delivery and whole person models that ~~are designed to~~ improve quality of care and empower patients to be a partner in their own care.
- Improve the system of care for members with complex medical and social needs through coordinated, cross-sector approaches.
- ~~Aid~~ Strengthen and streamline information exchange between systems and providers to support care coordination, quality improvement and accountability.



***The Alliance supports policies and proposals which advance the above priorities and principles and may oppose those which may impede these priorities.***

**DATE:** February 25, 2026

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

**FROM:** Michael Schrader, Chief Executive Officer

**SUBJECT:** Board Ad Hoc Committee to Advise on Addressing Provider Shortages

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Recommendation. Staff recommend the Board establish and appoint the following members to an ad hoc committee of the Board, consistent with Brown Act requirements, to discuss and develop recommendations to address specialty physician shortages in the Alliance service area.

- Anita Aguirre, Chief Executive Officer, Santa Cruz Community Health
- Ralph Armstrong, DO, Hollister Women's Health
- Maximiliano Cuevas, MD, Chief Executive Officer, Clinica de Salud del Valle de Salinas
- Donaldo Hernandez, MD, Palo Alto Foundation Medical Group
- James Rabago, MD, MFA Medical Group
- Allen Radner, MD, President, CEO, Salinas Valley Health

Background. The lack of physician supply, and specialists in particular, in the Alliance service area is well-established. All five counties served by the Alliance contain federally designated Health Professional Shortage Areas (HPSAs), as identified by the U.S. Health Resources and Services Administration (HRSA). These designations apply to specific geographic areas, low-income and Medi-Cal populations, and/or designated healthcare facilities within each county, reflecting documented shortages of physicians and other healthcare providers. The presence of HPSA designations indicates persistent challenges in accessing timely primary and specialty care, particularly for Medi-Cal beneficiaries and residents of rural or underserved communities.

The Ralph M. Brown Act (Brown Act) governs the conduct for open and public meetings by "legislative bodies" of local agencies. Under the Brown Act and as established in the Board's bylaws, the Board may create subcommittees. Committees must be comprised of less than a quorum of Commissioners and are advisory in nature only. Committees that are not standing committees of the Commission with either a fixed continuing subject matter jurisdiction or a meeting schedule fixed by formal action of the Commission are not "legislative bodies" as defined by the Brown Act.

The Board may establish Ad Hoc Committees which are not standing committees to serve for a limited time to address a non-continuing subject matter.

Ad Hoc Committees are advisory only and may make recommendations to the full board.

Discussion. Staff recommends that the Board establish an ad hoc committee of the board and appoint members to address the growing shortage of specialty providers in the Alliance

service area. The Ad Hoc Committee is intended to create a structured, transparent, and time-bound process for addressing these concerns and identifying meaningful solutions.

*Purpose.*

The purpose of the ad hoc committee will be to develop feasible, actionable recommendations in response to a central question:

> *What could the Alliance do differently to attract more specialty providers to our service area and improve access for our members?*

*Scope of Work*

The Ad Hoc Committee will review and assess the effectiveness of the Alliance's current strategies, including:

- Recruitment grants
- Medicare payment rates
- Provider supplemental payments
- Incentive programs

The Committee will be asked to make recommendations for replacing or modifying these programs, to attract specialty providers to our service area and improve access for members to Alliance staff.

The committee will also consider financial and operational constraints while determining whether existing approaches should be replaced or refined. Recommendations shall be budget neutral and shall not increase overall spending.

Staff, including but not limited to the Chief Executive and Medical Officers, and committee members will work collaboratively to identify solutions which may result in recommendations to the Board.

*Duration*

The duration and meeting frequency is to be determined with the goal being several meetings to be held over a 3-4 month period with actionable recommendations to be made to the full Board upon completion. The Committee will commence in late March/early April and will conclude by June 30.

*Composition*

The Ad Hoc Committee should include individuals with experience recruiting specialty providers and/or making referrals to specialists and a demonstrated ability to develop practical, actionable recommendations.

Ideally, this will include representatives from at least three of the Alliance's five counties and include no more than six members.

Given the constraints (i.e., must be less than a quorum) and the expertise needed, staff recommends the following individuals, as listed above, as Committee participants.

- Anita Aguirre, Chief Executive Officer, Santa Cruz Community Health
- Ralph Armstrong, DO, Hollister Women's Health
- Maximiliano Cuevas, MD, Chief Executive Officer, Clinica de Salud del Valle de Salinas
- Donaldo Hernandez, MD, Palo Alto Foundation Medical Group
- James Rabago, MD, MFA Medical Group
- Allen Radner, MD, President, CEO, Salinas Valley Health

Fiscal Impact. There is no fiscal impact associated with the development of this ad hoc board committee

Attachments. N/A

**DATE:** February 25, 2026

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

**FROM:** Cecil Newton, Chief Information Officer & Information Security Officer

**SUBJECT:** Security Officer Report Q1 2026

Recommendation: This report is informational only.

Summary: The Security Officer Report for Q1 2026 provides an overview of the security measures and initiatives undertaken to protect the organization's data and systems. This update highlights the key achievements, challenges, and future plans in the realm of information security.

Background: The security initiatives were launched as part of the organization's ongoing commitment to safeguarding sensitive information and ensuring compliance with regulatory requirements. The focus has been on enhancing cybersecurity protocols, conducting regular security audits, and providing training to employees on best practices for data protection.

Discussion:

- Security/HIPAA Incident
    - 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 2025. The required regulatory reports are being filed. Member notification efforts are currently underway,
- Key Achievements:
    - Advanced Threat Detection: Deployment of CrowdStrike Falcon Shield capabilities has been completed, with onboarding now underway to improve advanced threat detection in Alliance cloud-based environments.
    - Network Segmentation: Implementation completed with enforcement now active across critical systems and environments. Initial controls focus on reducing unauthorized lateral movement across the Alliance network.

  - Privileged Access Management (PAM): The PAM infrastructure has been implemented, and onboarding engineering teams is underway.
  - HIPAA/NIST Gap Assessment: Vendor selection and gap assessments have been completed with delivery of executive summary expected by end of Q1.
  - Cybersecurity Incident Response Plan (CIRP): The Incident Response Plan has been retooled to strengthen alignment with National Institute of Standards and Technology (NIST) guidance through collaboration with Risk Management and the Service Desk teams. Playbook development focused on ransomware response readiness is underway.
  - Identity and Access Management (IAM): Phase I of the IAM initiative has been completed, Phase 2 is focused on enhancing identity lifecycle management and integration with HR systems.

- Challenges:
  - Addressing the increasing sophistication of cyber threats, including AI based attacks.
  - Monitoring 3rd parties/vendors and continually assessing their security posture.
  - Mitigating supply chain risks
  - Ensuring continuous compliance with evolving regulatory standards.
  - Managing the integration of new security technologies with existing systems.

Future Plans:

  - Expand the scope of security audits to include third-party vendors.
  - Maturation of the 3rd party risk management program through enhanced governance, standardized vendor risk assessments, and improved oversight of third-party access to organizational systems and data.
  - Continue to enhance employee training programs on cybersecurity awareness.
  - Invest in advanced security technologies to stay ahead of emerging threats.
  - Implementation of an IT Security Risk Management Program

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

Attachments: N/A

**DATE:** February 25, 2026

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

**FROM:** Michael Schrader, Chief Executive Officer

**SUBJECT:** HR 1 and Enrollment Update

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Recommendation This agenda item is informational only.

Background. HR 1, which was signed into law by the President on Julu 4, 2025, contains several significant provisions impacting Medi-Cal eligibility both that tighten eligibility and increase administrative requirements, Key changes include imposing work or community engagement requirements for many adults in the Medicaid expansion group as a condition of eligibility, requiring states to verify participation in work, community service, schooling, or similar activities to remain enrolled, and shortening eligibility redetermination cycles from once every 12 months to every six months for expansion enrollees, with more frequent documentation and verification requirements. These eligibility and enrollment-related provisions are expected to result in fewer people enrolled in Medi-Cal due to increased administrative burden and eligibility hurdles.

Discussion. On January 29, 2026, DHCS released its H.R. 1 Implementation Plan, laying out the state's strategy for operationalizing federally required changes to Medi-Cal eligibility and enrollment that begin as early as late 2026. The plan's central goal is to minimize coverage disruption through automation of eligibility verifications, streamlined six-month redeterminations, culturally responsive communications, and extensive outreach and training for counties, health plans, and community partners. These efforts are designed to help Medi-Cal members understand and comply with the new requirements and to preserve continuity of coverage for as many enrollees as possible.

The plan also acknowledges that federal changes under H.R. 1 are expected to substantially affect Medi-Cal enrollment. DHCS now estimates that about 2 million Medi-Cal members, primarily in the ACA expansion population, are at risk of losing coverage due to the new federal provisions' requirements and administrative burdens.

With the release of the Governor's January budget proposal the DHCS has updated its enrollment projections. DHCS now estimates that work and community engagement requirements alone could result in 233,000 members losing coverage by mid-2027, rising to as many as 1 million by early 2028 and 1.4 million by mid-2028 if those policies are implemented without mitigations. Estimates include an additional 289,000 individuals may lose coverage by June 2026, increasing to ~400,000 by 2029, due to the implementation of six-month eligibility redeterminations. An additional 200,000 individuals will no longer qualify for full scope federally

funded Medi-Cal as of October 1, 2026, due to HR 1 changes to the definition of Qualified Non-Citizen.

It is important to note that DHCS' projections are statewide, and projections may vary regionally because counties differ in demographic composition, employment patterns, immigration status mix, and baseline Medi-Cal enrollment levels, all of which affect how many individuals are subject to work requirements, redeterminations, or eligibility changes. Administrative capacity, outreach effectiveness, and local economic conditions (e.g., unemployment rates or seasonal work patterns) can also influence how many people successfully maintain coverage. As a result, county-level impacts may be higher or lower than DHCS's statewide averages, which are based on aggregate assumptions rather than localized conditions.

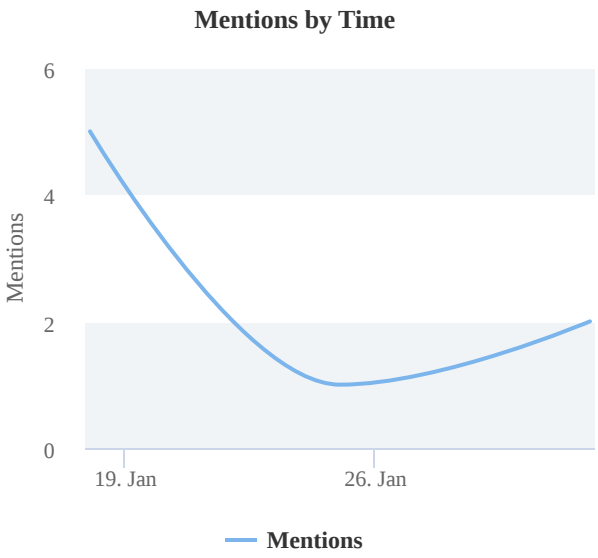
Staff have reviewed DHCS' updated estimates and assumptions and will present new plan-specific projections at the Board's February meeting.

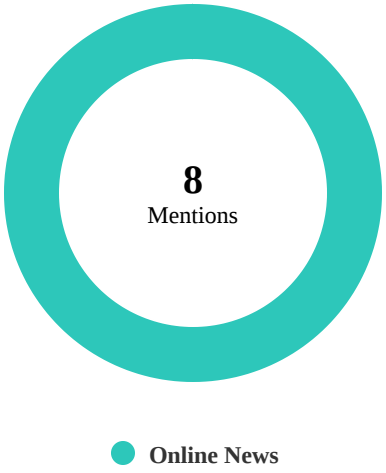
Fiscal Impact N/A.

Attachments. N/A

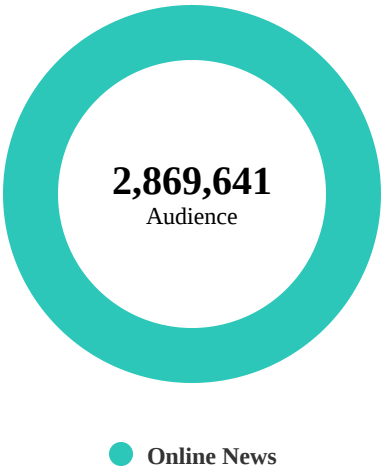
# February 2026 Board Report

## Mention Analytics



**Audience by Media Type**




**8** Total Mentions

**Mentions** 8 **Audience** 2,869,641 **Publicity** USD $61,351

**Feb 5, 2026 12:21 PM EST** Pos. **1**

### Monterey County releases 2025 Community Health Needs Assessment

**Source** Salinas Valley Tribune **Market** King City, CA **Type** Digital News **Category** Local

... do so every five years. Founded in 2022, the Monterey County Health Needs Collaborative includes the County of Monterey Health Department, Mee Memorial Healthcare System, Montage Health, Natividad, Salinas Valley Health and United Way Monterey County. California State University Monterey Bay and **Central**

**Feb 5, 2026 12:21 PM EST** Pos. **2**

### Monterey County releases 2025 Community Health Needs Assessment

**Source** King City Rustler **Market** King City, CA **Type** Digital News **Category** Local

... do so every five years. Founded in 2022, the Monterey County Health Needs Collaborative includes the County of Monterey Health Department, Mee Memorial Healthcare System, Montage Health, Natividad, Salinas Valley Health and United Way Monterey County. California State University Monterey Bay and **Central**

**Jan 27, 2026 12:59 PM EST** Neu. **3**

### La Alianza urge a los miembros de Medi-Cal a renovar para mantener su cobertura

**Source** Recordnet.com **Market** Stockton, CA **Type** Digital News **Category** Local


Ante los cambios en Medi-Cal, la Alianza busca asegurar que los miembros conserven su cobertura de cuidado de salud SCOTTS VALLEY, CA, UNITED STATES, January 21, 2026 /EINPresswire.com/ — Central California Alliance for Health (la Alianza), el plan local de Medi-Cal, urge a sus miembros a mantener su

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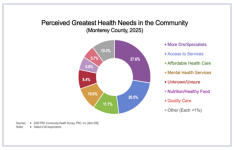
**Jan 22, 2026 12:30 PM EST** Neg. **4**

### Monterey County's latest health survey is here, with mixed results.

**Source** Monterey County Weekly **Market** United States **Type** Digital News




How healthy is Monterey County? Pam Marino here, with a few of the results of the 2025 Community Health Needs Assessment, conducted on behalf of the Monterey County Health Needs Collaborative , a partnership between the County of Monterey Health Department, all the hospitals, United Way Monterey County, CSU Monterey

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**Jan 22, 2026 10:23 AM EST** Neu. **5**

### La Alianza urge a los miembros de Medi-Cal a renovar para mantener su cobertura

**Source** GreenAgricultureReporter.com **Market** United States **Type** Digital News **Category** Trade

Ante los cambios en Medi-Cal, la Alianza busca asegurar que los miembros conserven su cobertura de cuidado de salud SCOTTS VALLEY, CA, UNITED STATES, January 21, 2026 /EINPresswire.com/ -- **Central California Alliance for Health** (la Alianza), el plan local de Medi-Cal, urge a sus miembros a mantener su

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**Jan 21, 2026 11:49 AM EST** Pos. **6**

### The Alliance urges Medi-Cal members: renew to keep coverage

**Source** EIN Presswire **Market** United States **Type** Digital News **Category** Press Wire

Amidst Medi-Cal changes, the Alliance aims to ensure members retain health coverage SCOTTS VALLEY, CA, UNITED STATES, January 21, 2026 / **Central California Alliance for Health** (the Alliance), the local Medi-Cal plan, urges its members to keep their coverage by renewing on time as statewide changes to

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**Jan 21, 2026 11:49 AM EST** Pos. **7**

### La Alianza urge a los miembros de Medi-Cal a renovar para mantener su cobertura

**Source** EIN Presswire **Market** United States **Type** Digital News **Category** Press Wire

Ante los cambios en Medi-Cal, la Alianza busca asegurar que los miembros conserven su cobertura de cuidado de salud SCOTTS VALLEY, CA, UNITED STATES, January 21, 2026 / **Central California Alliance for Health** (la Alianza), el plan local de Medi-Cal, urge a sus miembros a mantener su cobertura renovando a

Jan 21, 2026 11:36 AM EST

Neu. 8

## The Alliance urges Medi-Cal members: renew to keep coverage

**Source** APNews.com **Market** United States **Type** Digital News **Category** National

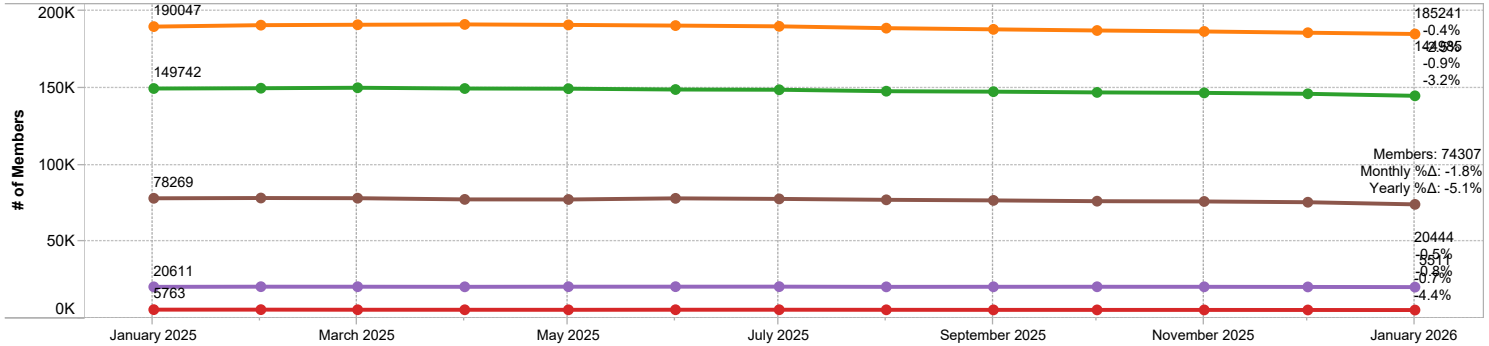
Amidst Medi-Cal changes, the Alliance aims to ensure members retain health coverage SCOTTS VALLEY, CA, UNITED STATES, January 21, 2026 / / -- **Central California Alliance for Health** (the Alliance), the local Medi-Cal plan, urges its members to keep their coverage by renewing on time as statewide changes to

# 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** |

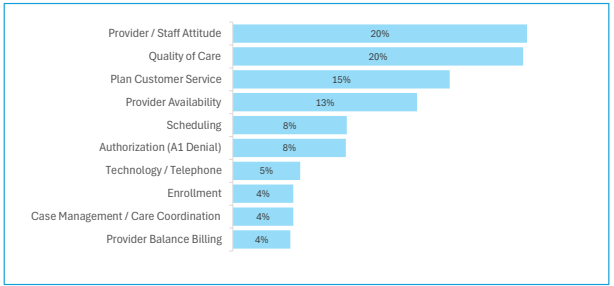
- MONTEREY
- MERCED
- SANTA CRUZ
- SAN BENITO
- MARIPOSA



Back to Agenda

**2025 Q4 Appeals and Grievances: 1772** ▲

**Appeals: 7%** ▼ 79% in favor of Plan; 21% in favor of Member
**Exempt: 12%** ▲
**Grievances: 79%** ▲
**Other: 2%** ▼ [SFH. Etc.]




**Analysis and Trends**

* Provider/Staff Attitude, QOC & Plan Customer Service remain trending categories.
* WCM: 41 for Q4 remains stable to past quarters.

**Highest Grievances Filed by County**

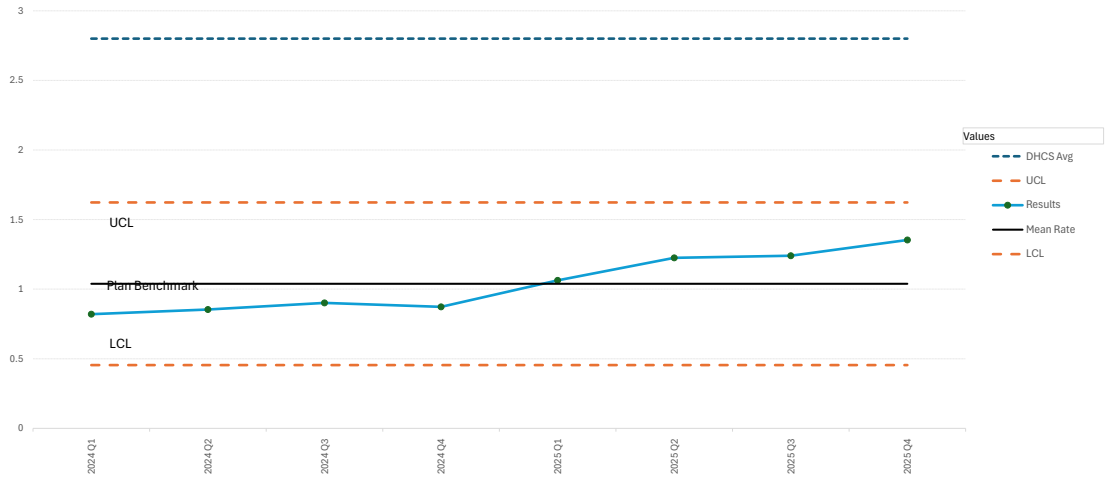
1. **Monterey:** 38%
2. **Merced:** 34%
3. **Santa Cruz:** 21%
4. **San Benito:** 4%
5. **Mariposa:** 2%

**IHSS Summary: 11**

* **Member Greivances:** 11
* **Exempt Complaints:** 0

[X] In Control
[ ] Not In Control

A lower rate demonstrates a good or positive result when compared to Upper Control Limits (UCL) and Lower Control Limits (LCL). Control limits represent three (3) standard deviations from mean or average performance.




| | | January | February | March | April | May | June | July | August | September | October | November | December |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2024 | MemberMonths | 458,093 | 456,832 | 456,657 | 455,038 | 452,106 | 450,231 | 448,719 | 447,326 | 446,009 | 444,030 | 443,064 | 444,567 |
| | Case Count | 394 | 386 | 345 | 399 | 427 | 333 | 416 | 409 | 384 | 421 | 385 | 356 |
| | Case Count Per 1000 MM | 0.86 | 0.84 | 0.76 | 0.88 | 0.94 | 0.74 | 0.93 | 0.91 | 0.86 | 0.95 | 0.87 | 0.80 |
| 2025 | MemberMonths | 444,430 | 445,841 | 446,201 | 445,076 | 444,635 | 444,467 | 443,481 | 440,590 | 439,190 | 437,547 | 436,747 | 435,163 |
| | Case Count | 404 | 438 | 579 | 626 | 501 | 508 | 472 | 540 | 629 | 657 | 521 | 594 |
| | Case Count Per 1000 MM | 0.91 | 0.98 | 1.30 | 1.41 | 1.13 | 1.14 | 1.06 | 1.23 | 1.43 | 1.50 | 1.19 | 1.37 |

*Grievances Per 1,000 Member Month



Back to Agenda

# Alliance Fact Sheet
## Q1 2026

## About the Alliance

The Central California Alliance for Health is an award-winning regional managed care health plan. The Alliance has provided trusted, no cost Medi-Cal health care from local teams to families since 1996. Using the State's County Organized Health System (COHS) model, we currently serve more than **434,047 members** in Mariposa, Merced, Monterey, San Benito and Santa Cruz counties. We have a local presence in the communities we serve, so we understand the unique needs of these communities and our members. Together with our contracted providers, we work to promote prevention, early detection and effective treatment and to improve access to quality, equitable health care. The Alliance is governed with local representation from each county on our Board of Commissioners.


## Quick Facts

**1996**
Year Established

**693**
Number of Employees

**$2.25B**[1]
Annual Revenue

**5.8%**[1]
Administrative Overhead

**$32.6M**[2]
Community Grants

## VISION

HEALTHY PEOPLE.
HEALTHY COMMUNITIES.

## MISSION

Accessible, quality health care guided by local innovation.

## VALUES

**Collaboration:**
Working together toward solutions and results.

**Equity:**
Eliminating disparity through inclusion and justice.

**Improvement:**
Continuous pursuit of quality through learning and growth.

**Integrity:**
Telling the truth and doing what we say we will do.

## What We Do

The Alliance is a local health ally for compassionate and trusted health care that supports the whole person. We ensure quality care for all ages and stages of life and for any health condition. We go beyond just providing health care, connecting our members to day-to-day resources.

## Who We Serve

Our members represent 41%[3] of the population in Mariposa, Merced, Monterey, San Benito and Santa Cruz counties. We serve seniors, persons and children with disabilities, low-income parents and their children, children who were previously uninsured, pregnant women, home care workers who are caring for the elderly and disabled and low-income, childless adults ages 19–64.

## Provider Partnerships

The Alliance partners with 100% of hospitals in our service areas and a network of approximately 14,664 providers (98% of primary care physicians and 98% of specialists within our service areas) to ensure members receive timely access to the right care, at the right time. The Alliance also partners with more than 2,395 providers to deliver behavioral health and vision services. Effective July 1, 2025, the Alliance has insourced Behavioral Health Services.

## Our Members[4]

**1 out of every 3**
Mariposa County residents.

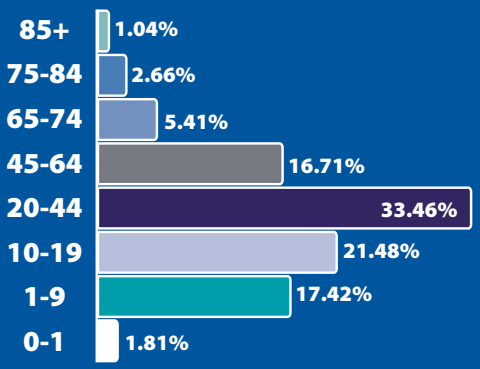
**1 out of every 2**
Merced County residents.

**1 out of every 2**
Monterey County residents.

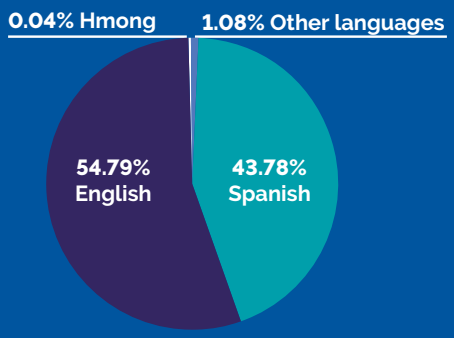
**1 out of every 3**
San Benito County residents.

**1 out of every 3**
Santa Cruz County residents.

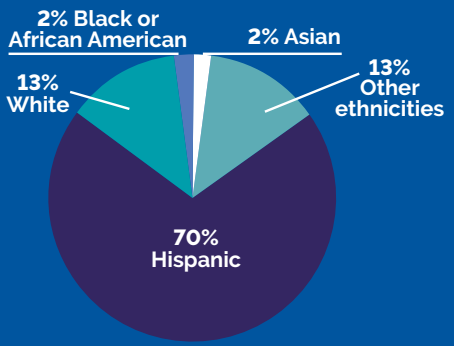
### Membership by Age Group




### Preferred Language




### Race/Ethnicity




## Executive Leadership

**Michael Schrader**
Chief Executive Officer

**Lisa Ba**
Chief Financial Officer

**Cecil Newton**
Chief Information Officer

**Scott Fortner**
Chief Administrative Officer

**Dr. Mike Wang**
Chief Medical Officer

**Jenifer Mandella**
Chief Compliance Officer

**Van Wong**
Chief Operating Officer

## Governing Board

The Alliance's governing board, the Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission (Alliance Board), sets policy and strategic priorities for the organization and oversees health plan service effectiveness. The Alliance Board has fiscal and operational responsibility for the health plan.

In alphabetical order, current Board members are:

- **Leslie Abasta-Cummings,** Chief Executive Officer, Livingston Community Health, At Large Health Care Provider Representative
- **Anita Aguirre,** Chief Executive Officer, Santa Cruz Community Health, At Large Public Representative, Alliance Board Vice Chairperson
- **Ralph Armstrong,** DO FACOG, Hollister Women's Health, At Large Health Care Provider Representative
- **Wendy Root Askew,** Supervisor, County of Monterey, County Board of Supervisors Representative
- **Tracey Belton,** Health and Human Services Agency Director, San Benito County, County Health Department Representative
- **Maximiliano Cuevas, MD,** Executive Director, Clinica de Salud del Valle de Salinas, Health Care Provider Representative
- **Kimberly De Serpa,** Supervisor, County of Santa Cruz, County Board of Supervisors Representative
- **Donaldo Hernandez, MD,** Health Care Provider Representative
- **Elsa Jimenez,** Director of Health Services, Monterey County Health Department, County Health Department Representative
- **Kristina Keheley, PhD,** Health and Human Services Agency Director, Mariposa County Health and Human Services Agency, County Health Department Representative
- **Michael Molesky,** Public Representative
- **Connie Moreno-Peraza,** County Health Services Agency Director, Santa Cruz County, County Health Department Representative
- **Supervisor Josh Pedrozo,** County of Merced, County Board of Supervisors Representative, Alliance Board Chairperson
- **James Rabago, MD,** Merced Faculty Associates Medical Group, Health Care Provider Representative
- **Allen Radner, MD,** President/CEO, Salinas Valley Health, At Large Health Care Provider Representative
- **Kristynn Sullivan,** Public Health Director, Merced County, County Health Department Representative
- **Ye Thao,** Public Representative
- **Vacant,** Public Representative

*Unless otherwise stated, Fact Sheet data as of January 1, 2026.*

*[1]Amounts based on 2026 annual budget.*

*[2]Represents 2025 investments through the Alliance's Medi-Cal Capacity Grant Program.*

*[3]County population data source: U.S. Census Bureau 2024 population estimate (as of Jul. 1, 2024).*

*[4]Represents an approximate visual representation. Membership percentage by county: Mariposa (33 percent) Merced (49 percent); Monterey (43 percent); San Benito (30 percent); Santa Cruz (29 percent).*

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH®

30TH ANNIVERSARY

2026

# Community Impact Report

**Built on trust. Rooted in care.**
**Grounded in 30 years of service.**

ACCREDITED NCQA HEALTH PLAN ACCREDITED

ACCREDITED NCQA HEALTH EQUITY ACCREDITED

MEDICAID HMO



Back to Agenda

# A Message From Our CEO

For three decades, the Alliance's work has been guided by a deep commitment to those we serve. This year's Community Impact Report reflects that obligation—one built on trust, rooted in care, and grounded in thirty years of service to our communities.

In 2025, we deepened our engagement with members and partner organizations across our service area, providing trusted support when and where it was needed most. Through community outreach events, culturally responsive education and partnerships with community-based organizations, we strengthened the connections that improved access to equitable care for our members. At every turn, we sought to provide vital information about Medi-Cal resources to our members and those who serve them.

Last year, we also invested nearly $45 million through the Alliance's Medi-Cal Capacity Grant Program and State incentive programs, which continued to uplift programs focused on housing stability, behavioral health, health care infrastructure and access to care. These investments are not only helping individuals today; they're also shaping healthier futures for everyone in our communities. By working together to address social drivers of health, we sought to remove barriers that keep people from living their healthiest lives.

As we enter our fourth decade of service, our roots in compassionate, equitable care will continue to guide us as we fulfill our responsibility to serve our members and our communities. Thank you for the continued trust you place in the Alliance and thank you for sharing our vision of healthy people, healthy communities.

*Michael Schrader*

Michael Schrader, CEO

# Community Investments by the Numbers

The Alliance makes investments to health care and community organizations through the Alliance's Medi-Cal Capacity Grant Program (MCGP) and by administering Department of Health Care Services (DHCS) incentive programs to realize the Alliance's vision of "healthy people, healthy communities."

## 2025 Community Investments

**$44.9M**
Total

**$32.6M**
MCGP

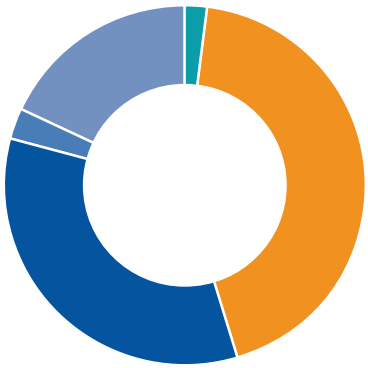
**$12.3M**
DHCS Incentives

**186**
Investments

**158**
Grants

**28**
Awards

## 2025 Investments by County



- **Mariposa** | $810K | 2%
- **Merced** | $19.6M | 44%
- **Monterey** | $15.3M | 34%
- **San Benito** | $1.2M | 3%
- **Santa Cruz** | $7.9M | 18%

## 2025 Community Investments by Funding Priority


*Ulises Cisneros-Abrego, Community Engagement Specialist, connects members to Alliance resources.*

# Community Outreach

As a local health plan, the Alliance values the opportunity to engage with members at health fairs, cultural celebrations and other local gatherings. At these events, we share information about:

- **Benefits and services available to members.**
- **Nurse Advice Line.**
- **Transportation and language assistance.**
- **Health education programs.**
- **Health rewards.**
- **Key Medi-Cal updates.**

In 2025, we expanded our presence by participating in more events than ever before — over **150 events** across Mariposa, Merced, Monterey, San Benito and Santa Cruz counties.

Last year, we also prioritized more than **100 pop-up outreach opportunities**, which allowed us to meet our members where they are — at locations that they already frequent. Past pop-ups have been held at support groups, schools, farmers markets, summer food distribution sites, senior centers and other trusted spaces.

> ***"Collaborating with the Alliance at our Winton LifeLine Community Center during our food distribution has been very beneficial to our community members. Their presence helps to provide resources and education for our neighbors and helps them understand enrollments, etc. Thank you for this partnership."***
>
> **Rosmarie Rosales, Community Connector, LifeLine CDC**

**150+**
**Events**

**100+**
**Pop-ups**

**150+**
**Meetings**


*Adourin Malco, Community Engagement Specialist with the Alliance (standing center), gave a presentation to Valley Onward's Community Health Workers about the Alliance's member benefits and services.*

# Community Education

The Alliance recognizes that raising awareness and increasing understanding of Medi-Cal services is only possible through collaboration with local community-based organizations, non-profits and health agencies who are trusted messengers in our communities. That is why we work to foster strong relationships with those stakeholders.

Through more than **150 relational meetings** held across our five-county region, we:

- **Strengthened** partnerships.
- **Provided** education on Medi-Cal resources.
- **Increased** cross-organizational referrals.

Additionally, through the facilitation of over **50 partner and staff presentations**, we helped increase awareness of member benefits and offered updates on changes to the Medi-Cal program.

Community partners shared positive experiences from relational meetings and staff presentations, expressing that the information received through these opportunities was very important for the community members they support.

**50+**
**Partner and staff presentations**

# Community Collaboratives

The Alliance participated in more than **40 regional collaboratives** led by various community organizations and agencies across Mariposa, Merced, Monterey, San Benito and Santa Cruz counties. These collaboratives:

- **Gave** Alliance members a voice in county-level decisions.
- **Ensured** that their needs were represented.
- **Supported** collaboration with county agencies, CBOs, nonprofits and other partners.
- **Focused** on community health initiatives that meet our strategic priorities.
- **Created** opportunities to coordinate efforts that strengthen support for Medi-Cal members.

Across these collaborative meetings — including maternal health, wellness, safety and community benefit groups — we shared valuable updates with partners regarding Medi-Cal program changes, member benefits and funding opportunities offered by the Alliance.

In addition to participating in county-level collaboratives, we also hosted several convenings, including the Merced Public Information Officer (PIO) Roundtable. 2025 marked the roundtable's third year, and the partnerships formed through this convening have been highly impactful. They have led to co-branding opportunities with Merced County Office of Education (MCOE), such as the Vax Facts Challenge to promote vaccinations, improved connection with United Way's 211 platform and increased engagement with our food bank partners.

**40+**
**Regional Collaboratives**

*From left to right: Adourin Malco, Alliance Community Engagement Specialist, Megan Cope, Principal of El Capitan High School, Areesha Tariq, Vax Facts challenge winner and Ronita Margain, Alliance Community Engagement Director.*

# Rooted in Community Partnership

The Alliance's partnerships grow from deep local roots and a shared commitment to caring for the people we serve. Across our region, we collaborated with health care providers, county agencies, community-based organizations (CBOs) and social service partners to strengthen regional capacity and advance solutions that improve health for Medi-Cal members.

We worked closely with public health and behavioral health departments to improve access to preventive care and coordinated services through:

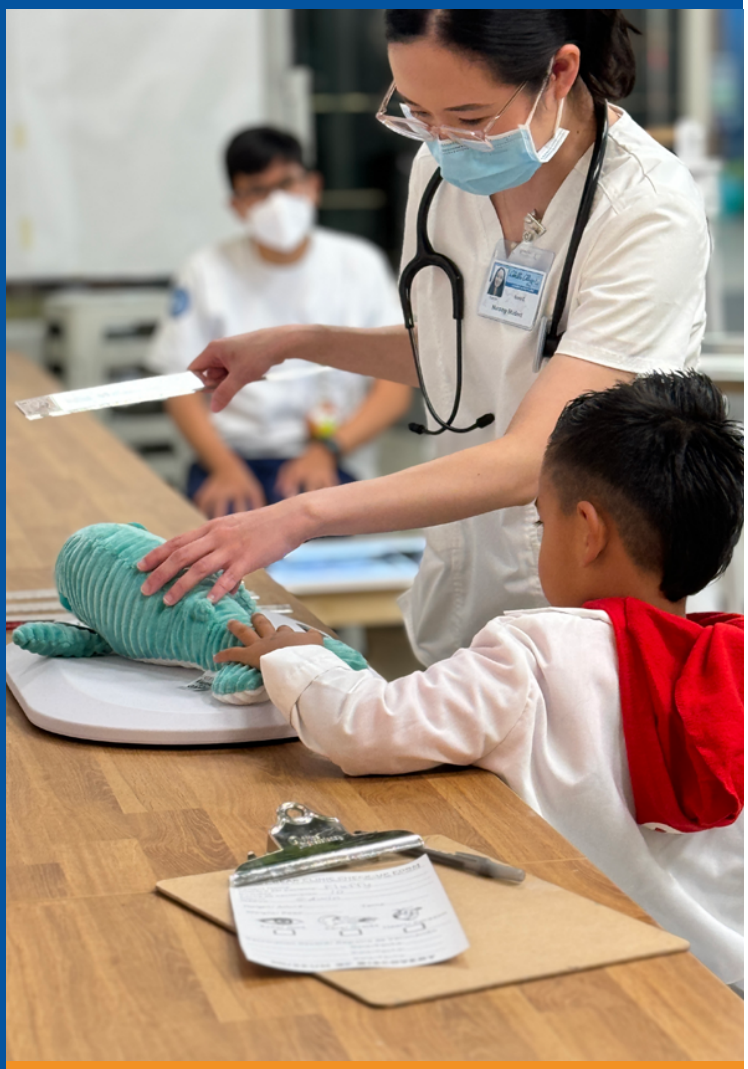
- **Immunization** clinic partnerships.
- **Behavioral health** linkages.
- **Local** health improvement planning.

Together, we ensured our resources responded to community-identified needs and promoted whole-person care.

Grant investments in local organizations across the service area continue to grow a trusted, connected workforce of Community Health Workers and doulas, focused on outreach, health education and member navigation. The expansion of a trusted frontline workforce helps families navigate coverage and care, pregnancy and postpartum services and prevention and management of chronic disease.

We broadened our focus on organizational capacity by partnering with United Way Merced County through the RISE Program (Reinforce, Innovate, Strengthen, Empower). This investment helped CBOs in Merced and Mariposa counties:

- **Strengthen** operations.
- **Build** long-term sustainability.
- **Enhance** their ability to participate in the Medi-Cal delivery system.



*Cabrillo College Nursing Program student teaches a young Medi-Cal member about vaccines at a Teddy Bear Clinic hosted by Santa Cruz Children's Museum of Discovery.*

In Santa Cruz County, a new partnership with the Housing Accelerator Fund served as a revolving loan fund designed to increase both temporary and permanent housing opportunities for Medi-Cal members to advance stability, recovery and long-term health outcomes.

Together, these partnerships and targeted investments strengthened local infrastructure and supported the people who care for our members every day.

# Sustaining Early Childhood Support

The Parent Education and Support grant program invests in initiatives that expand access to early childhood development education and parenting support for families with children ages 0–5, while reducing barriers to preventive health care and community resources. In 2023, First Five Monterey County (F5MC) proposed an enhanced home visiting collaborative — an approach that strengthened parent education and support activities and intentionally laid the groundwork for a sustainable model built on Medi-Cal-reimbursable services.

With their partners Door to Hope, Go Kids, and North Monterey County Unified School District, the collaborative reached approximately **100 families** over two years. Home visits created consistent opportunities for families to connect with care:

- **100%** of families received referrals to community resources.
- **87%** of children received developmental screenings within 90 days.
- **93%** received timely health reviews.
- **82%** of families completed parenting skills assessments.
- **67%** of parents received depression screenings.

These outcomes demonstrate strong coordination and an integrated model of early support.

To ensure these services extend beyond the grant period, in October 2025 F5MC and its partners became an Alliance-contracted provider, enabling them to sustain services by leveraging Medi-Cal Community Health Worker (CHW) and Enhanced Care Management (ECM) benefits for reimbursable in-home support activities.

**100%**
**of families received referrals to community resources**

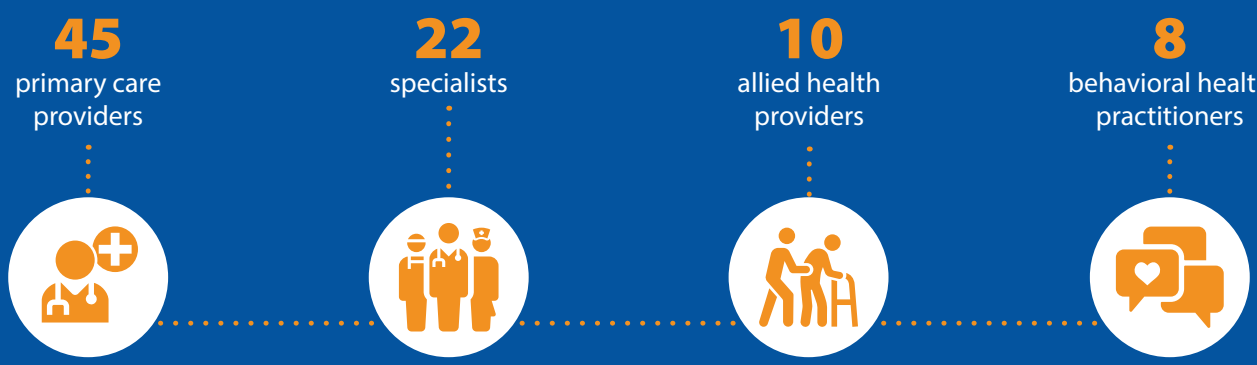
By shifting from a grant-dependent model to a sustainable billing pathway, F5MC created a strong springboard for partner organizations to become contracted CHW and ECM providers — preserving and strengthening essential supports for parents and young children well into the future.

*First 5 Monterey County case manager visiting family.*

# Building the Network for Timely Care

The Alliance's Provider Recruitment grant program provides grant funding to support the recruitment of new health care professionals who serve the Medi-Cal population in the Alliance service areas. Grants support recruiting primary care clinicians and much-needed specialists, effectively expanding the network of care available to Medi-Cal members while providing culturally and linguistically competent care. Between 2024 and 2025, these Provider Recruitment grants expanded into Mariposa and San Benito counties.

Over the past two years, these grants supported the addition of **85 professionals in total**:




As a result, participating organizations saw average **wait times decrease by 34%**, improving Medi-Cal members' ability to receive timely care when needed most.

# Closing the Gap in Merced County

Designed to strengthen preventive care and reduce disparities, the Care Gap Closure grant program helped Merced County clinics enhance quality and equity in care for Medi-Cal members. The initiative supported **15 primary care sites** serving nearly **125,000 members** by funding added clinical staff and essential equipment to improve low-performing quality measures.

Clinics implemented innovative scheduling and workflow strategies, including evening and weekend hours, to maximize appointment availability and reach more members. As a result:

- **88%** of members reached through clinics.
- **39%** were scheduled for appointments.
- **73%** of scheduled visits were completed.

By the end of 2024, **14 of 15 sites improved across every quality measure**—collectively boosting **Minimum Performance Levels from 36 to 56** and **High Performance Levels from 8 to 25**. Care Gap grants enhanced both quality and equity in care for Merced County members and demonstrated the value of targeted, data-driven investment in local providers.

*Castle Family Health Centers pediatric care team.*

# Advancing Health Equity for Indigenous Language Communities

The Central Coast is a linguistically diverse region, home to Indigenous communities who speak Mixteco, Triqui, and Zapoteco. Recognizing that language builds trust, access and belonging, the Alliance invests in programs that bridge communication gaps and connect members to culturally and linguistically responsive care.

*Mujeres en Acción translates available health resources to support Spanish and Indigenous language speakers in Monterey County.*

In 2025, we supported a range of initiatives focused on Indigenous-language-speaking families:

- **Equipped** Mixteco-and Triqui-speaking parents through Parent Education and Support projects with tools to:
  - **Support** early childhood development.
  - **Strengthen** preventive health.
  - **Access** community resources.
- **Educated** Indigenous-language-speaking youth and adults as trusted health messengers through Community Health Champion projects.
- **Hired** trilingual Community Health Workers through CHW Recruitment grants to help families navigate care in Mixteco.
- **Trained** six doulas through a 20-hour Indigenous-language course funded by a Doula Network Technical Assistance grant.

With momentum into 2026, we are building a more inclusive, responsive system for Indigenous-language-speaking communities.

# Trusted Voices, Healthier Communities

The Alliance invests in workforce development to build sustainable networks of trusted health advocates. In 2025:

- **Funded** graduation of **106** Certified Community Health Workers (CHWs) from UC Merced and Monterey County Works training programs through tuition scholarships.
- **Expanded** the local doula workforce through Doula Recruitment grants.

**106**

**CHWs graduated from training programs supported by Alliance-funded tuition scholarships**

Investments in local doula training programs increased access to culturally responsive, compassionate support.

CHWs and doulas play a critical role in connecting members to care by bridging cultural, linguistic and trust gaps that often limit access. As community members with lived experience, they help patients:

- **Navigate** complex systems.
- **Understand** care plans.
- **Address** barriers such as transportation, housing and food insecurity.
- **Receive** advocacy, education and emotional support.

Through this work, CHWs and doulas expand access to equitable, whole-person care.

# Investing in Infrastructure and Innovation

As part of the Alliance's commitment to health equity and improved member well-being, we continue to invest in projects that reinforce the foundation of local health care systems. These investments create a more connected, resilient ecosystem — one that expands access, strengthens provider capacity and supports healthier communities.

### Expanding Access Through Facilities

New and expanded health care sites are bringing care closer to where members live and work, reducing travel and wait times. Alliance-supported facilities that became operational in 2025 include:

- Sun Street Centers | Huntington Recovery Center, Salinas (*expanded*)
- Mercy Medical Center Merced | Family Practice Clinic, Merced (*expanded*)
- Dientes Community Dental Care | Penny Lane Clinic, Watsonville (*new*)

### Strengthening Care Through Technology

Healthcare Technology grants support tools such as AI-assisted transcription, digital intake platforms, enhanced clinical equipment, and updated electronic medical records. These innovations improve care coordination, documentation accuracy and the time clinicians can spend with patients.

### Improving Diagnostics and Reducing Referrals

Up-to-date diagnostic equipment enables clinics to manage more care in-house.

- Harold L. Schick MD, Inc. reduced **192 external retinal referrals** in the first 10 months of using its optical coherence tomography system, now used roughly **40 times per day**.
- Merced Urology Medical Group now performs all cystoscopy procedures onsite with new video cystoscopy equipment, eliminating approximately **550 monthly external referrals** and reducing hospital treatment needs to **2%**.

### Addressing Social Drivers of Health

We also invest in transportation and housing — key factors that influence members' ability to stay healthy.

- **Transportation:** Across four contracted providers in Merced and Mariposa counties, monthly capacity increased by **58%** for members served and **60%** for rides delivered.
- **Housing:** Progress continues across multiple permanent supportive housing projects, including Midpen's Sparrow Terrace, King City's Casa de Esperanza and City of Los Banos' One Tree Village (under construction) and HOPE Village in Pajaro Valley (anticipated December 2025).

*Groundbreaking at One Tree Village, a 58-unit housing development, with Stacy Souza Elms and Christy McCammond of City of Los Banos, Janet Kasper of United Way Merced County, and Jessica Finney, Alliance Community Grants Director.*

**The Alliance is a regional Medi-Cal managed care health plan established in 1996, dedicated to improving access to health care for over 430,000 members in Mariposa, Merced, Monterey, Santa Cruz and San Benito counties.** The organization has received full accreditation from the National Committee for Quality Assurance (NCQA) for both Health Plan Accreditation and Health Equity Accreditation. Operating under the state's County Organized Health System (COHS) model, the Alliance connects members with providers to deliver timely services and care, emphasizing prevention, early detection and effective treatment. With a vision of "healthy people, healthy communities," the Alliance remains committed to enhancing access to quality health care for its members.

**The Alliance's 18-member governing Board of Commissioners:**

- **Leslie Abasta-Cummings,** Chief Executive Officer, Livingston Community Health, At Large Health Care Provider Representative
- **Anita Aguirre,** Chief Executive Officer, Santa Cruz Community Health, At Large Public Representative, Alliance Board Vice Chairperson
- **Ralph Armstrong,** DO FACOG, Hollister Women's Health, At Large Health Care Provider Representative
- **Wendy Root Askew,** Supervisor, County of Monterey, County Board of Supervisors Representative
- **Tracey Belton,** Health and Human Services Agency Director, San Benito County, County Health Department Representative
- **Maximiliano Cuevas, MD,** Executive Director, Clinica de Salud del Valle de Salinas, Health Care Provider Representative
- **Kimberly De Serpa,** Supervisor, County of Santa Cruz, County Board of Supervisors Representative
- **Donaldo Hernandez, MD,** Health Care Provider Representative
- **Elsa Jimenez,** Director of Health Services, Monterey County Health Department, County Health Department Representative
- **Kristina Keheley, PhD,** Health and Human Services Agency Director, Mariposa County Health and Human Services Agency, County Health Department Representative
- **Michael Molesky,** Public Representative
- **Connie Moreno-Peraza,** County Health Services Agency Director, Santa Cruz County, County Health Department Representative
- **Supervisor Josh Pedrozo,** County of Merced, County Board of Supervisors Representative, Alliance Board Chairperson
- **James Rabago, MD,** Merced Faculty Associates Medical Group, Health Care Provider Representative
- **Allen Radner, MD,** President/CEO, Salinas Valley Health, At Large Health Care Provider Representative
- **Kristynn Sullivan,** Public Health Director, Merced County, County Health Department Representative
- **Ye Thao,** Public Representative

**www.thealliance.health · 800-700-3874**

January 21, 2026

ACM Awards Committee
Association of Children's Museums
2500 South Clark St., Ste. 600
Arlington, VA 22202
RE: Letter of Support – Central California Alliance for Health (the Alliance)

Dear ACM Awards Committee:

I am pleased to offer this letter of support for the Santa Cruz Children's Museum of Discovery's Teddy Bear Clinic program as an outstanding practice in the children's museum field.

The Alliance is a regional Medi-Cal (Medicaid in California) managed care health plan established in 1996, dedicated to improving access to health care for over 430,000 members in Mariposa, Merced, Monterey, Santa Cruz and San Benito counties. The Alliance connects members with providers to deliver timely services and care, emphasizing prevention, early detection and effective treatment. With a vision of "healthy people, healthy communities," the Alliance remains committed to enhancing access to quality health care for its members.

Through a Parent Education & Support grant from the Alliance's Medi-Cal Capacity Grant Program, we have partnered with the museum to support families enrolled in Medi-Cal by reducing barriers to preventative health education and access to trusted community spaces. The Teddy Bear Clinic exemplifies the goals of our program by meeting families where they are—emotionally, culturally, and economically—and using play to address fear and uncertainty around healthcare.

The clinic is particularly effective in engaging families who may otherwise avoid preventative care due to prior negative experiences or discomfort with medical settings. By pairing the clinic with free museum memberships and tangible incentives, the program creates sustained engagement rather than one-time participation. Approximately 200 Medi-Cal–qualified families have become museum members through this initiative, expanding their access to learning, play, and community connection.

What sets this work apart is its intentional design, strong partnerships, and measurable outcomes. The museum has demonstrated that small, community-rooted institutions can play a powerful role in advancing health equity through culturally responsive, play-based approaches.

We strongly believe the Teddy Bear Clinic represents an exemplary model for the field and are proud to support its nomination.

Sincerely,

Michael Schrader

Michael Schrader
Chief Executive Officer

February 6, 2026

RE: Letter of Support for Merced County Rescue Mission Funding Request

To Whom It May Concern:

I am pleased to offer this letter of support for the Phase II development of Merced County Rescue Mission's Village of Hope Campus expansion project. This development will increase access to recuperative care, post-hospitalization beds, and much-needed transitional and permanent housing for some of the most vulnerable individuals living in Merced County. These facilities will not only help homeless individuals who are high utilizers of public services find housing stability but will also provide an economic benefit through cost savings for the entire community.

The Alliance is a regional Medi-Cal (Medicaid in California) managed care health plan established in 1996, dedicated to improving access to health care for over 430,000 members in Mariposa, Merced, Monterey, Santa Cruz and San Benito counties. The Alliance connects members with providers to deliver timely services and care, emphasizing prevention, early detection and effective treatment. With a vision of "healthy people, healthy communities," the Alliance remains committed to enhancing access to quality health care for its members.

Through a grant to Merced County Rescue Mission from our Medi-Cal Capacity Grant Program, the Alliance supported the development of the Hope Respite Care to provide recuperative care services to Medi-Cal members experience homelessness after being discharged from the hospital. We are proud to continue our partnership through additional funding to support the phase II construction of a second building on the Village of Hope Campus for short-term post hospitalization housing and permanent supportive housing. These beds and apartments will be made available to Medi-Cal members and other unhoused individuals in Merced County.

The Village of Hope Campus expansion aligns closely with federal and state benchmarks aimed at making homelessness rare, brief, and non-recurring. Together with Merced County Rescue Mission and the County of Merced, we hope to meet the goal of "functional zero" within the next few years. This second phase at Village of Hope will go a long way to meet this mutually shared goal.

Thank you for your consideration and for your commitment to improving outcomes for Merced County's most vulnerable residents.

Sincerely,

Michael Schrader

Michael Schrader
Chief Executive Officer

**2025**
**ANNUAL REPORT**
**TO THE SANTA CRUZ, MONTEREY, MERCED, SAN BENITO, AND MARIPOSA COUNTY BOARDS OF SUPERVISORS**
**FROM**
**THE SANTA CRUZ-MONTEREY-MERCED-SAN BENITO-MARIPOSA MANAGED MEDICAL CARE COMMISSION**

Central California Alliance for Health (the Alliance) is a locally governed and operated public agency established by Ordinances adopted by the counties of Santa Cruz, Monterey, Merced, San Benito, and Mariposa. The Alliance is governed by the Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission (the Commission), whose members are appointed by the Boards of Supervisors in each county.

- The Alliance's Vision: Healthy people. Healthy communities.
- The Alliance's Mission: Accessible, quality health care guided by local innovation.
- The Alliance's Values: Improvement, Integrity, Collaboration, Equity

The Commission seeks to achieve the Alliance's mission through operation of a County Organized Health System (COHS) health plan, currently serving over 434,000 members in Santa Cruz, Monterey, Merced, San Benito, and Mariposa counties.

## Commission Structure

The Alliance is governed by the Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission, whose members are appointed by each counties' Boards of Supervisors including individuals representing interests of the public, providers, and government. Additionally, the Commission has established advisory groups consisting of member and physician representatives, which advise the Commission on policy matters.

The Commission meets regularly in public meetings pursuant to the Ralph M. Brown Act open meeting laws. In 2025, the Commission held nine regular board meetings, including a half-day retreat to discuss key strategic issues. All meetings are accessible to members of the public in compliance with the Brown Act. During these meetings, the Commission discusses and decides upon policy issues and receives reports regarding ongoing operations from Alliance staff.

At the October 22, 2025, meeting, Merced County Supervisor Josh Pedrozo was elected to serve as Chairperson of the Commission, replacing Elsa Jimenez, Director of Health Services for the County of Monterey, who had served as Chair since October 2023.

Anita Aguirre, Chief Executive Officer of Santa Cruz Community Health, was selected as Vice Chair.

See Attachment A for a list of Commissioners who served during 2025, including each Commissioner's category of representation, and Attachment B for a report of Commissioner meeting attendance during 2025.

## Commission Activities and Accomplishments in 2025

Throughout calendar year 2025, the Alliance continued its focus on remaining key initiatives in its "2024-25 Two-Year Marathon", while also closely monitoring activities at the State and federal levels with significant impacts on the Medi-Cal program and its members, providers, and the community.

Activities and accomplishments of the Commission and the Alliance throughout 2025 included:

1. **Health Plan Accreditation.** In 2025, the Alliance achieved two National Committee for Quality Assurance (NCQA) accreditations, including Health Plan Accreditation and Health Equity Accreditation. Achieving NCQA accreditation demonstrates the Alliance meets nationally recognized standards for quality, patient-centered care, and strong clinical and administrative processes, as well as evidence-based standards for quality, access and patient experience.

2. **Insourcing of Behavioral Health.** Effective July 1, 2025, the Alliance terminated its contract with Carelon Healthcare Services and transitioned the behavioral health benefit in-house, enabling direct oversight of care delivery. This change strengthens access for members, improves support for providers, and enhances collaboration with counties and schools through more coordinated and responsive administration.

3. **Medicare Advantage D-SNP.** Throughout 2025, the Alliance continued development of a Medicare Advantage D-SNP program to be launched on January 1, 2026. A D-SNP is for individuals who are dually eligible for Medicare and Medi-Cal and combines Medicare and Medi-Cal benefits into a single coordinated plan. Through a D-SNP, the Alliance offers improved care integration and reduced fragmentation of services to improve health outcomes, member experience, and cost efficiencies while better managing the needs of enrolled members.

4. **Member Outreach and Retention.** In response to threats to member eligibility present in the federal H.R. 1, "One Big Beautiful Bill Act", and provisions in the State budget, the Alliance developed an aggressive outreach campaign, in conjunction with counties, providers and community partners to support member eligibility, enrollment, and retention. Between September and December 2025, the Alliance worked in collaboration with county benefits offices to conduct outreach to members and the community regarding upcoming changes to Medi-Cal. The efforts were multifaceted, and included media spots, training, outreach, and resource sharing. Additionally, Alliance staff met regularly with benefits staff to evaluate bandwidth and identify partner agencies supporting outreach and application assistance. The Alliance has shared Medi-Cal change collateral with local partners, with members during outreach, providers, and through promotion at local businesses.

5. **Voluntary Rate Range Program.** With approval from the federal Centers for Medicare and Medicaid Services and DHCS, and using the Alliance's Medi-Cal managed care contract as a funding mechanism, the Alliance facilitated the receipt and distribution of over $55M in increased federal funds to county public health departments and public hospitals by leveraging local funds contributed by interested, qualified governmental agencies through intergovernmental transfers to draw down federal matching funds, which, in turn, were distributed to identified providers to support the provision of services to Alliance members.

## Community Investment Activities and Accomplishments in 2025

The Alliance makes investments in health care and community organizations through the Alliance's Medi-Cal Capacity Grant Program (MCGP) and by administering Department of Health Care Services incentive programs to support the Alliance's vision of Healthy People, Healthy Communities.

**Medi-Cal Capacity Grant Program (MCGP).** In 2025, the Alliance's Medi-Cal Capacity Grant Program (MCGP) continued to expand its impact across the Alliance's five-county service area by awarding grant investments that strengthen provider and community capacity for Medi-Cal members. The purpose of the MCGP is to increase the availability, quality, and access of health care and supportive resources for Medi-Cal members in the Alliance service area, as well as to address social drivers that influence health and wellness.

In January 2025, the Board approved an annual investment plan policy for the MCGP to serve as a roadmap for the year, defining grantmaking priorities to address Medi-Cal capacity needs in the Alliance's service area and allocating funding through the investment of a portion of the Alliance's fund balance to advance the goals under

each focus area and strategy. The stakeholder priorities informing the 2025 Investment Plan were identified by: 1) evaluating critical stakeholder-identified needs obtained through interviews and surveys, 2) analyzing each county's Community Health Assessment and Community Health Improvement Plan; and 3) reviewing alignment with MCGP and Alliance priorities.

In parallel, the MCGP advanced a key governance policy to support equitable, data-driven investments. The Board engaged in strategic discussions on emerging community needs and approved refinements to the program's funding allocation methodology, including a shift toward a unified, equity-based budget model across the service area. These efforts strengthened MCGP's operational effectiveness and positioned the program for sustained impact and responsiveness to Medi-Cal capacity needs in future years.

Through three competitive funding rounds and strategic direct grants in 2025, the Alliance awarded 160 grants totaling $33M to community partners. Strong demand persisted across program areas, with a high volume 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 aligned with the Board's approved funding strategies 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.
- $1M to support healthcare technology to improve care quality and coordination.

**Alliance Housing Fund.** To support housing partners in the Alliance service in increasing the number of housing units available to Medi-Cal members, the Alliance established a Housing Fund in 2024. The Housing Fund awarded $33.2M for 20 projects in the service area and, in 2025, continued to execute and manage funding agreements. This funding is combined from the Alliance's MCGP and the health

plan's earned funds through the Department of Health Care Services (DHCS) Housing and Homelessness Incentive Program. All available funds have been fully committed to these 20 projects. The projects will result in over 342 units dedicated to Medi-Cal members, including permanent housing, recuperative care facilities, and short-term post-hospitalization housing.

Also, through the Housing Fund, the Alliance is piloting a partnership with the San Francisco Housing Accelerator Fund (HAF) to launch a first-of-its-kind revolving loan fund addressing the intersection of health and housing for Medi-Cal members. Through a $6.8 million investment, the Alliance is supporting the expansion of temporary and permanent housing options in Santa Cruz County, including deeply affordable permanent housing, recuperative care, and short-term post-hospitalization housing. The fund will provide capital for the acquisition, construction, renovation, and equipping of at least 170 housing units dedicated for Medi-Cal members. By leveraging the Alliance's investment with HAF's existing and future capital, the initiative is expected to mobilize more than $40 million in total financing and support the development of over 600 affordable homes countywide.

**CalAIM Incentive Payment Program (IPP).** The Alliance participated in DHCS's CalAIM Incentive Payment Program (IPP) from 2022 through 2024 earning a total of $47.8M to support capacity building within the Alliance's provider network for Enhanced Care Management (ECM) and Community Supports (CS) service delivery. Although DHCS sunset the program in December 2024, the Alliance continued in 2025 to deploy remaining earned funds to support new ECM and CS providers in launching programs and to enable existing ECM providers to expand into new counties or serve new populations. Through IPP, the Alliance has supported a total of 69 ECM and/or CS providers in building the infrastructure and workforce needed to enroll members and deliver high-quality services. When combined with supplemental funding from the Alliance's MCGP, a total of $48.4M has been awarded through CalAIM IPP. Remaining funds are earmarked for contracted Transitional Rent providers to support implementation of the new mandatory Community Support taking effect on January 1, 2026.

**Equity and Practice Transformation (EPT).** The EPT Program advances health equity and reduces disparities by incentivizing primary care practices to implement practice transformation and improve the quality-of-service delivery. Fifteen primary care providers are participating in this DHCS program, which is supplemented with Alliance funding due to programmatic changes made by DHCS after EPT launched. In 2025, all 15 practices successfully completed the first year of the three-year program and met required milestones. Across participating practices, $24M in total funding is available ($17.3M DHCS and $6.7M Alliance), with $4.9M paid to date. All

practices remain fully engaged and have committed to continuing their equity and transformation work with the Alliance. A primary focus in Year 1 was enhancing patient access by improving key performance indicators, including empanelment, third next available appointment, and continuity of care.

**Student Behavioral Health Incentive Program (SBHIP).** In 2025, the Student Behavioral Health Incentive Program (SBHIP) successfully concluded with the Alliance earning and distributing 100% of its DHCS allocation, totaling $12.6 million. Final payments were issued by June 2025. Alliance staff advanced sustainability planning to ensure continuity of school-based behavioral health services beyond SBHIP. All but one participating Local Education Agency (LEA) across the five-county service area has been accepted into the Children and Youth Behavioral Health Incentive (CYBHI) Fee Schedule cohort, establishing a path to ongoing Medi-Cal reimbursement. Going forward, the Alliance's Behavioral Health team will manage LEA relationships.

## Alliance Members

As of December 31, 2025, the Alliance served approximately 433,506 Medi-Cal beneficiaries and 731 Alliance Care IHSS members with membership by county as follows.

- In Santa Cruz County, 75,707 Medi-Cal members.
- In Monterey County, there were 185,371 Medi-Cal members and 731 Alliance Care IHSS members.
- In Merced County, 146,324 Medi-Cal members.
- In Mariposa County, 5,551 Medi-Cal members.
- In San Benito, 20,560 Medi-Cal members.

## Alliance Medi-Cal Members

Alliance Medi-Cal members are lower income persons in eligible aid categories (e.g., aged, disabled, single-parent, childless adult), and include nearly all Medi-Cal beneficiaries in the region. The Alliance's member demographic composition is as follows:

- 69.94% are Latino, 12.67% Caucasian, 11.35% Filipino, 1.82% African American, 0.75% Asian or Pacific Islander, 0.67% Asian Indian, 0.25% Vietnamese, 0.21% Chinese, 0.17% Alaskan Native or American Indian, 0.13% Laotian, 0.09% Korean, 0.05% Samoan, 0.05% Japanese, 0.05% Cambodian, 0.03% Hawaiian, 0.02% Guamanian, and 1.23% Other, and 0.00% not provided.

- 54.8% report primary language as English, 43.08% as Spanish, 0.04% as Hmong and .01% as other or not reported.
- 53.27% are female and 46.73% are male.
- 40% are 19 years old and younger, while 10% are 65 years or older.

## Alliance Care IHSS Members

Alliance Care IHSS members are in-home caregivers who provide home care services to recipients of the IHSS program in Monterey County.

## Alliance Services for Members

The Alliance Member Services Department engages and supports members through the operation of a call center to respond to member requests, a Grievance System to resolve member issues, and an Operations Unit to train staff, monitor call center Quality, and execute member-informing materials. Member Services staff reside in the counties served by the Alliance, and many staff are bilingual in English/Spanish or English/Hmong. Staff provide high-quality service and support to Alliance members, providers, and community-based partners. They educate members on how to access Alliance health care benefits within the managed care environment. This includes providing new member orientations, helping members understand their benefits, answering questions, and resolving member concerns. Member Services also develops and distributes member identification cards and member handbooks.

The Community Engagement Department assists in the facilitation of two public committees that seek feedback from members to inform programs and procedures, including the quarterly Member Services Advisory Group (MSAG) and the Whole Child Model Family Advisory Committee (WCMFAC).

Alliance Operations Management staff are responsible for reviewing and resolving plan enrollment data issues through collaboration with the local county Medi-Cal offices, the Social Security Administration, and the Department of Health Care Services (DHCS).

## Alliance Health Services Division

The Alliance's Health Services (HS) Division is responsible for ensuring that members receive the right care, in the right place, at the right time, and that care is evidence-based and high quality. The Alliance works closely with its network of providers, including physicians, hospitals, pharmacies, and ancillary providers, to ensure members have appropriate and timely access to care.

Dr. Michael Wang assumed the role of Chief Medical Officer in 2025, leading the Health Services Division with the support of Interim Health Services Executive Director Tammy Brass, RN, and Alliance Medical Directors Dr. Dianna Meyers, Dr. Mai Bui-Duy, and Dr. Gray Clarke. Alliance medical consultants Dr. Clyde Wesp and Dr. Heloisa Junqueira continued to provide additional clinical support.

Physician clinical oversight responsibilities include Quality Improvement & Population Health (QI/PH), Utilization Management, Care Management, Pharmacy, and Behavioral Health, ensuring clinical standards are maintained across the organization while supporting member access and outcomes.

Quality

The Alliance maintains a Quality Improvement (QI) System to monitor, evaluate, and take effective action to address any necessary improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. The QI/PH Department monitors the quality of health care services provided and reviews quality of care at both the individual member level and across the Alliance's member population.

The QI/PH department leads the Alliance's population health strategy and effectiveness efforts, as well as initiatives to increase the provision of preventive care services for members. Performance in these areas is measured through the National Committee for Quality Assurance (NCQA) HEDIS/MCAS measures, and the Alliance rewards provider performance through its Care Based Incentives (CBI) program and value-based payments. Health equity is a top priority, integrated into all QI/PH's work, as the Alliance service area communities continue to face challenges in accessing basic, preventive healthcare.

In addition, the QI/PH Department manages the Alliance's clinical safety program, including the review of Potential Quality Issues, Facility Site Review audits, and ongoing quality monitoring activities. To support providers in their clinical improvement efforts, QI/PH provides technical assistance through practice coaching, learning collaboratives, and continuously accessible webinars. Furthermore, QI/PH offers health education and cultural and linguistic programs to support members with preventive care and chronic care management interventions.

Key achievements include:

- Achieved NCQA accreditation for both Health Plan and Health Equity.
- Expanded Care Based Initiative (CBI) relationships to San Benito and Mariposa Counties.
- Expanded Provider Partnership Program and Care Gap Grant Programs for continued improvement of MCAS measures, with six out of eight measures being

at or above the minimum performance level of the 50th percentile.
- Launched Mobile Mammography clinics, screening over 500 members.
- Successfully coached 14 of the 15 EPT sites to complete all deliverables and earn full funding.
- Expanded Health Education classes including the delivery of over 40 member workshops.

Enhanced Case Management and Community Supports

The Care Integration Team, which includes Enhanced Case Management (ECM) and Community Supports (CS), is responsible for overseeing and coordinating the delivery of ECM and CS benefits for members with complex medical, behavioral, and social needs. The team focuses on stabilization, care transitions, and ensuring appropriate connections to community-based providers and health plan resources.

In 2025, the team was integrated into the Care Management Department to further strengthen alignment and collaboration between ECM/CS providers and the Alliance Care Management team, supporting a more cohesive, whole-person approach to member care.

To promote high-quality care and ensure compliance with ECM Program standards, the Care Integration Team is prioritizing Oversight Reviews through provider audits. These audits assess the completeness and accuracy of provider documentation, care planning, and member engagement to confirm alignment with program requirements and best practices.

In the coming year, the team will emphasize active management of care transitions to ensure members receive services at the appropriate level and duration, including timely graduations, disenrollments, and transitions to other levels of care as clinically indicated. This approach supports responsible stewardship of resources while ensuring members receive the right level of support based on their evolving needs.

Care Management

Care Management is a fully integrated department with four distinct teams: Adult Care Management, Pediatric Care Management including the Whole Child Model Program (WCM), Behavioral Health Care Management, and, in 2026, the Dual Eligible Special Needs Plan (D-SNP) Care Management program. Together, these teams deliver coordinated, whole-person care that addresses members' medical, behavioral health, social, and functional needs across the continuum.

The department provides both complex case management and care coordination services. Care Coordination supports members with lower-acuity needs, while Care

Management delivers clinically oriented, longitudinal support for adults and children with chronic, complex, or high-risk conditions. This integrated model enables seamless collaboration across disciplines and reduces fragmentation of care for members with overlapping needs.

Within Pediatric Care Management, the Whole Child Model California Children's Services team continues to serve children with particularly acute and high-risk conditions. In 2025, the team completed expansion of WCM services into San Benito and Mariposa counties, further strengthening access to specialized pediatric care across the service area.

Behavioral Health Care Management is now fully insourced and embedded within the Care Management department, allowing for closer integration with medical and behavioral health services. This model supports timely identification of behavioral health needs, improved coordination between physical and behavioral health care, and more consistent, member-centered care planning.

In preparation for the launch of the Alliance's Dual Eligible Special Needs Plan (D-SNP), Care Management developed a dedicated D-SNP Care Management team and supporting infrastructure. The program is designed to align with federal and state Model of Care requirements, and will go live on January 1, 2026, providing integrated care coordination for members eligible for both Medicare and Medi-Cal, with a focus on transitions of care and addressing social drivers of health.

Utilization Management

In 2025, the Utilization Management (UM) Department successfully advanced several major initiatives while maintaining strong operational performance and continued improvement in utilization outcomes. Key milestones included achieving NCQA accreditation, the successful insourcing of Behavioral Health services in July 2025, and completion of the Dual Eligible Special Needs Plan (D-SNP) build, with a successful launch effective January 1, 2026.

Throughout the year, the UM team met and exceeded performance threshold goals while navigating the complex operational builds required for NCQA accreditation, Behavioral Health insourcing, and D-SNP readiness. Internal metrics continued to improve, including reductions in avoidable emergency department utilization, inpatient readmissions, and average inpatient length of stay.

The department further strengthened Transitions of Care processes through expanded interdisciplinary team meetings that engaged Enhanced Case Management (ECM) providers, inpatient facilities, and skilled nursing facilities, supporting improved care coordination and timely member access.

In response to updated DHCS guidance, UM revised Community Supports policies and processes to refine delivery of medically tailored meals and housing supports. ECM office hours, provider trainings, audits, and disenrollment processes were refined to further support benefit delivery. Operational efficiency was also enhanced through the launch of a new phone system, which reduced provider and member waiting times and increased team productivity.

Overall, the UM Department demonstrated resilience and strong cross-functional collaboration, sustaining high performance while supporting significant organizational growth and integration initiatives.

Pharmacy

In 2025, Pharmacy Services delivered strong operational performance while playing a central role in the planning, implementation, and successful go-live of the Alliance's Dual Eligible Special Needs Plan (D-SNP). Pharmacy leadership ensured readiness across benefit design, operations, compliance, and clinical programs to support continuity of care and regulatory requirements for dual-eligible members.

D-SNP Implementation and Readiness

Pharmacy Services led comprehensive D-SNP implementation activities. Policies and procedures were created and operationalized to support D-SNP requirements. In addition, clinical pharmacy programs were established to meet Medicare requirements, including Medication Therapy Management (MTM), Drug Management Programs (DMP), and retroactive and concurrent Drug Utilization Review (DUR).

Pharmacy Services also led multiple quality and safety initiatives through the DUR program. Interventions focused on high-risk medication use, including opioid safety, naloxone access, psychotropic medication use in children, and appropriate use of buprenorphine. These efforts were supported through provider education, member outreach, and collaboration with Care Management and Behavioral Health teams.

Community-focused pharmacy programs expanded in 2025. The Naloxone Distribution Program continued targeted outreach, particularly in Merced County, resulting in increased distribution and documented overdose reversals. Pharmacist-Led Academic Detailing supported providers with evidence-based education in hypertension, diabetes, and asthma management, aligned with quality improvement priorities and updated national guidelines.

## Alliance Providers

The Alliance recognizes the critical importance of its providers in furthering its mission to ensure access to quality health care for members. The Alliance continues its efforts to strengthen provider capacity to provide services, and enhance the network across all five counties in its service area.

In 2025, the Alliance insourced Behavioral Health and credentialed 1,399 behavioral health providers into the network. A breakdown by behavioral provider type is listed below:

| Behavioral Health Provider Types | Distinct Individual Providers |
|---|---|
| Board Certified Associate Behavioral Analysts | 3 |
| Board Certified Behavioral Analysts | 502 |
| Licensed Clinical Social Workers | 252 |
| Licensed Marriage and Family Therapists | 444 |
| Licensed Professional Clinical Counselors | 26 |
| Licensed Psychologists | 70 |
| Psychiatrists | 102 |
| **Total Count** | **1,399** |

Additionally, the Alliance added 759 new non-behavioral health providers to its provider network, with the following breakdown by provider type:

| Provider Type | Distinct Individual Providers |
|---|---|
| Physicians (MD, DO, or DPM) | 324 |
| Non-Physician Medical Practitioners | 202 |
| Allied Providers | 92 |
| Organizational Providers | 46 |
| Doulas | 68 |
| Community Health Workers | 5 |
| Enhanced Case Management and Community Supports Providers | 22 |
| **Total Count** | **759** |

In 2025 the Alliance added a total of 2,158 new providers to the network representing the largest volume of provider additions to the network, since the go-live in Merced County.

The Alliance also conducted its annual provider satisfaction survey to better understand its providers' experience with the Plan.

The satisfaction survey is stratified by Primary Care Physician & Specialty Providers and Behavioral Health Providers. The 2025 survey marks the first year the survey included Behavioral Health Providers.

As this is the inaugural year of the survey, overall satisfaction scores should be interpreted in the context of the recent transition from a subcontracted model to an in-house Behavioral Health structure. Ratings are likely to reflect this period of operational transition rather than ongoing performance and will serve as a baseline for future measurement and improvement.

| Survey Question | Provider Type | 2025 Response |
|---|---|---|
| Overall Satisfaction with the plan (Completely or somewhat above average)? | PCP & Specialist | 91.5% |
| | Behavioral Health Providers | 69.1% |
| Would Recommend the plan to other providers (yes)? | PCP & Specialist | 94.6% |
| | Behavioral Health Providers | 91.3% |

## Alliance Financial Performance

The Alliance's operating revenue for 2025 reached $2.08 billion through November 30, 2025. The organization operated with a Medical Loss Ratio (MLR) of 98.0% and an Administrative Loss Ratio (ALR) of 5.0% , indicating that 98 cents of every dollar was spent directly on healthcare services.

Enrollment decreased from 444,442 in January to 437,400 by November. The expiration of COVID-related eligibility flexibilities in June contributed to the decline in enrollment during the latter half of the year.

Although revenue increased, it was not sufficient to offset rising medical costs. Medical expenses continued to rise across several service categories, putting pressure on overall margins. Factors such as higher costs in ECM and CS, increased transportation utilization, and greater use of outpatient and hospice services contributed to this impact. Consequently, the Alliance reported a net loss of $27.5 million for the eleven months ending November 30, 2025.

The Alliance must maintain adequate financial reserves to ensure sufficient funds are available to cover incurred claims liabilities. The Commission has established a target reserve fund balance for this purpose. As of November 30, 2025, the Alliance was operating at 90% of its targeted reserve fund balance.

## Alliance Staff

As of December 31, 2025, the Alliance employed 688 staff across the following divisions: Administration, Compliance, Employee Services and Communications, Finance, Health Services, Information Technology Services, and Operations. In 2025, the Alliance continued to successfully provide services and support to members through a hybrid workforce strategy. This approach enabled Talent Acquisition to fill 249 temporary and new positions in 2025 across five-county service areas.

## Alliance in the Community

In 2025, the Alliance outreach team participated in 150 community events and over 100 pop-up outreach opportunities, reaching more than 30,000 members across our five-county region. Significant efforts were made to engage communities in our two newest counties, Mariposa and San Benito.

Community engagement efforts included over 150 relational meetings, where Alliance staff connected with local organizations and county leaders to strengthen relationships and foster collaboration. The Alliance also delivered over 50 presentations in 2025 that educated and informed community organization staff about the services and benefits available to Alliance members, and to provide updates on upcoming Medi-Cal changes. The Alliance remains committed to keeping community-based organizations and partners informed through the bi-monthly community newsletter, *The Beat*.

Additionally, throughout 2025, the Alliance staff participated in 40 regional and community coalitions and collaboratives addressing public health issues, health care access, community networking and eligibility outreach in the Alliance service area, Including Alliance involvement and participation in the following groups:

In Mariposa County

- Mariposa Health and Wellness Coalition
- Mariposa Community Health Improvement Plan (CHIP)
- MAP-C Meeting
- Gold Country CPI
- Food Insecurities in Mariposa

County Highlight: Mariposa Back to School Health and Resource Fair

Mariposa Safe Families at Home hosted the Mariposa Back-to-School Health and Resource Fair. The event focused on providing families with back-to-school essentials, including backpacks and school supplies. Children received health checkups, vaccinations, and vision and dental screenings. Alliance staff shared critical information with over 80 members and their families.

In Merced County

- ACEsINC Committee
- Maternal Wellness Coalition
- Outreach Committee Meetings
- Connected Care Network
- CPI Merced Collaborative
- Health and Mental Health Services Advisory Committee
- Merced County LADAP Advisory Committee Meeting
- HFA/PAT Community Advisory Board (CAB)
- Merced ACCT (Tobacco Prevention Coalition)
- Merced Breastfeeding Network
- Merced Public Information Officer (PIO) Roundtable
- Help Me Grow Merced County Coalition
  BHRS Ongoing Planning Council

County Highlight: Dream Big Parent Institute

In collaboration with the Merced Union High School District, the Dream Big Parent Institute is designed to empower parents and guardians with tools and resources to help support their child's education, health, safety, and overall development. The day-long conference provided attendees with the opportunity to participate in a variety of workshops and explore resources from nearly 100 local community organizations. The Alliance shared valuable information with approximately 250 members and their families.

In Monterey County

- Community Alliance for Safety and Peace (CASP)
- Monterey County Collaborates
- Monterey County Aging and Disability Resource Connections
- County of Monterey Ad-Hoc Immigration Committee
- South County Outreach Efforts (SCORE)
- United Way Hope and Help Coalition
- Maternal Mental Health Task Force

County Highlight: Meals on Wheels of the Salinas Valley Senior Socials

During 2025, the Alliance participated in the county-wide monthly Senior Socials hosted by Meals on Wheels of the Salinas Valley. These congregate meal programs for seniors who are not homebound, providing an opportunity to meet others for a monthly luncheon/social. Events included fresh lunches, live music,

other activities, a produce box from the Food Bank for Monterey County, and senior resources presented by local agencies The Alliance attended 17 socials throughout the year in Salinas, North County, South County, and Marina. connecting with nearly 1,000 senior members to share critical updates and resources.

In San Benito County

- Adult Long Term Care Committee (ALTCC)
- Health Reimagined Workgroup
- Safe Kids Coalition of San Benito County
- Oral Health Advisory Committee
- Wellness Coalition of San Benito County
- Equity Diversity Inclusion Committee

County Highlight: San Benito Stands Together

San Benito Stands Together: A Suicide Prevention Resource Fair was hosted by the Family Service Agency's Suicide Prevention Service in collaboration with Gavilan College and the San Benito County Behavioral Health. The event took place at Gavilan College's new Hollister campus, and featured resource tables, wellness activities and educational talks with the aim of sharing stories, making connections, and raising awareness about suicide prevention in San Benito County.

In Santa Cruz County

- Cradle to Career CHW Leaders Collective
- Health Workforce Council
- Health Improvement Partnerships of Santa Cruz County (HIPSCC)
- Monterey Bay CHW Collaborative
- ParkRx Santa Cruz County
- Santa Cruz County PATH Collaborative
- Semillitas Advisory Committee
- County of Santa Cruz Benefits Collaborative
- Go for Health! Collaborative

County Highlight: Reiter Farms Community Education Resource Fairs

The Community Education Resource Fairs are coordinated in collaboration with the Community Action Board of Santa Cruz County and Reiter Farms, a local agricultural company. The fairs are held monthly during the berry harvest season and bring resources directly to Reiter Farms employees directly to the fields (cuadrillas) where they work. Several agencies join to provide critical information. In 2025, the Alliance

joined for the first time and attended five of the six resource fairs, reaching over 300 members.

**Multi-County Convenings:**

- CCS Advisory Group
- ITUP Regional Equity Collaborative
- LHPC Community Engagement Workgroup
- CPI Coastal Collaborative (Multi-County: Monterey & San Benito)
- Uplift Central Coast Advisory Committee (Multi-County: Monterey, San Benito & Santa Cruz)
- WCM FAC Network Meeting (Multi-County)
- Mariposa and Merced Healthcare Partnership for Emergency Preparedness (Multi-County: Merced & Mariposa)

**Local Campaigns for Community Benefit**

Alliance staff continued their involvement with community food banks and United Way campaigns across Santa Cruz, Monterey, Merced, San Benito and Mariposa counties in 2025. As part of the Season of Giving holiday food drive efforts, Alliance staff raised $86,392.00 (equivalent to 259,176 meals) for the food banks in the five-county service area and raised about $24,938.50 in contributions to United Way.

**Looking Ahead**

Throughout 2026, the Alliance will continue to focus on fulfilling the core health plan obligations outlined in this report, while further developing and strengthening its D-SNP program.

At the same time, the health care delivery system faces external challenges stemming from federal actions and policy decisions. Funding levels and eligibility requirements for the Medi-Cal program remain at risk, and the Alliance will continue its advocacy efforts to protect and strengthen Medi-Cal.

Federal funding availability and changes in federal policy and guidance will directly influence the State's Fiscal Year 2026–27 budget. The Alliance remains prepared to respond and adapt as needed to ensure its long-term viability and sustainability.

In parallel, the Alliance will maintain a strong emphasis on member outreach, enrollment, and retention strategies to help mitigate the potential impacts of these funding and eligibility uncertainties.

The Alliance appreciates the opportunity to provide this report to the county Boards of Supervisors and is appreciative of the Supervisors' continued support.

Attachment A

# Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission
## Roster for January 1, 2025 – December 31, 2025

The Alliance has eighteen board seats (five from Santa Cruz County, five from Monterey County, five from Merced County, one from Mariposa County and two from San Benito County), in categories of representation including County government and health services, public representatives and health care provider representatives.
Board members during January 1, 2025, through December 31, 2025, included:

| | |
|---|---|
| From Santa Cruz County: | |
| Anita Aquirre, Vice Chair (*Vice Chair effective 10/22/25)* | At Large Health Care Provider Representative |
| Connie Moreno-Peraza *(effective 10/7/25)* | Health Services Agency Director |
| Kimberly De Serpa *(effective 1/28/25)* | Board of Supervisors |
| Donaldo Hernandez, MD | Health Care Provider Representative |
| Monica Morales *(through 6/3/25)* | Health Services Agency Director |
| Michael Molesky | Public Representative |
| From Monterey County: | |
| Wendy Root Askew | Board of Supervisors |
| Maximiliano Cuevas, MD | Health Care Provider Representative |
| Janna Espinoza *(through 10/31/25)* | Public Representative |
| Elsa Jimenez, Chair (*Chair through 10/22/25*) | Director of Health Services |
| Allen Radner, MD | At Large Health Care Provider Representative |
| From Merced County: | |
| Leslie Abasta-Cummings, Vice Chair *(Vice Chair through 10/22/25)* | At Large Health Care Provider Representative |
| Dorothy Bizzini *(through 9/1/25)* | Public Representative |
| Mark Hendrickson *(effective 2/17/25 through 7/1/25)* | Interim Public Health Director |
| Josh Pedrozo, Chair *(Chair effective 10/22/25)* | Board of Supervisors |
| James Rabago, MD | Health Care Provider Representative |
| Kristynn Sullivan (*effective 7/1/25)* | Public Health Director |
| Ye Thao (*effective 12/9/25)* | Public Representative |
| From Mariposa County: | |
| Kristina Keheley, PhD | County Health Department Representative |
| From San Benito County: | |
| Tracey Belton | Health and Human Services Agency Director |
| Ralph Armstrong, DO | At Large Health Care Provider Representative |

## Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission
## 2025 Meeting Attendance Log (January 1, 2025, through December 31, 2025)

| Commissioner | Attendance Rate | 1.22.25 (Regular) | 3.26.25 (Regular) | 4.23.25 (Merced) | 5.28.25 (Regular) | 6.25.25 (Regular) | 8.27.25 (Regular) | 9.24.25 (Regular | 10.22.25 (Regular) | 12.10.25 (Special) |
|---|---|---|---|---|---|---|---|---|---|---|
| Abasta-Cummings, Leslie | 67% | Present | Present | Present | Present | EX | EX | Present | EX | Present |
| Aquirre, Anita | 67% | Present | Present | Present | EX | Present | Present | EX | EX | Present |
| Armstrong, Ralph | 67% | EX | Present | Present | Present | EX | Present | EX | Present | Present |
| Askew, Wendy Root | 67% | Present | Present | Present | EX | Present | Present | Present | EX | EX |
| Belton, Tracey | 55% | EX | Present | EX | Present | EX | Present | EX | Present | Present |
| Bizzini, Dorothy | 50% | Present | Present | X | X | X | Present | N/A | N/A | N/A |
| Cuevas, Maximiliano | 89% | Present | Present | Present | Present | Present | Present | Present | EX | Present |
| De Serpa, Kimberly | 89% | Present | Present | Present | Present | Present | Present | EX | Present | Present |
| Espinoza, Janna | 100% | Present | Present | Present | Present | Present | Present | Present | Present | N/A |
| Hendrickson, Mark | 60% | EX | Present | EX | Present | Present | N/A | N/A | N/A | N/A |
| Hernandez, Donaldo | 89% | Present | Present | Present | Present | Present | Present | X | Present | Present |
| Jimenez, Elsa | 89% | Present | Present | Present | Present | Present | Present | Present | Present | EX |
| Keheley, Kristina | 78% | Present | Present | EX | Present | Present | Present | Present | Present | EX |
| Molesky, Michael | 100% | Present | Present | Present | Present | Present | Present | Present | Present | Present |
| Morales, Monica | 50% | Present | EX | Present | EX | N/A | N/A | N/A | N/A | N/A |
| Moreno-Peraza, Connie | 100% | N/A | N/A | N/A | N/A | N/A | N/A | N/A | Present | Present |
| Pedrozo, Josh | 56% | Present | EX | EX | Present | Present | Present | EX | EX | Present |
| Rabago, James | 67% | Present | Present | EX | Present | Present | EX | EX | Present | Present |
| Radner, Allen | 78% | Present | Present | EX | Present | Present | Present | Present | Present | EX |
| Sullivan, Kristynn | 100% | N/A | N/A | N/A | N/A | N/A | Present | Present | Present | Present |
| Thao, Ye | 0% | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | EX |

X = Unexcused
EX = Excused
"N/A" indicates person was not a Commissioner at this time.