



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, June 24, 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: 201 027 183#

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, June 22, 2026, to the Clerk of the Board at clerkoftheboard@thealliance.health.
 - i. Indicate in the subject line "Public Comment". Include your name, organization, agenda item number, and title of the item in the body of the e-mail along with your comments.
 - ii. Comments will be read during the meeting and are limited to three minutes.
 - b. In person, from an Alliance County office, during the meeting when that item

is announced.

- i. State your name and organization prior to providing comments.
- 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.– 9B.): 3:25 p.m.

5. Accept Chief Executive Officer (CEO) Report.

- Reference materials: Chief Executive Officer (CEO) Report

Pages 5-1 to 5-13

6. Accept Alliance Financial Highlights, Balance Sheet, Income Statement and Statement of Cash Flow for the fourth month ending April 30, 2026.

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

Pages 6-1 to 6-14

Minutes: (7A. – 7C.):

7A. Approve Commission regular Meeting Minutes of May 27, 2026.

- Reference materials: Minutes as above.

Pages 7A-1 to 7A-6

7B. Accept Compliance Committee Meeting Minutes of May 6, 2026.

- Reference materials: Minutes as above.

Pages 7B-1 to 7B-4

7C. Accept Member Services Advisory Group Meeting Minutes of November 6, 2025, and February 12, 2026.

- Reference materials: Minutes as above.

Pages 7C-1 to 7C-9

Appointments: (8A.):

8A. Approve the reappointment of Caroline Meraz to the Member Services Advisory Group.

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

Page 8A-1

Reports: (9A. – 9B.)

9A. Accept 2026 Legislation and Bill List.

- Reference materials:
 - Staff report on above topic
 - Central California Alliance for Health 2026 Bill List

Pages 9A-1 to 9A-45

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

- Reference materials:
 - Staff report and recommendation on above topic
 - Member Services Advisory Group (MSAG) Charter

Pages 9B-1 to 9B-6

Regular Agenda Items: (10. – 13.): 3:30 p.m. – 5:00 p.m.

10. Specialty Access Ad Hoc Committee Report Out. (3:30 – 4:00 p.m.)

- A. Ms. Van Wong, Chief Operating Officer, will review, and Board will discuss the outcomes and recommendations from the Specialty Access Ad Hoc Committee meetings conducted March through May 2026.
- B. Ms. Jessica Finney, Community Grants Director, will review, and Board will consider and approve reallocating \$20M from Provider Supplemental Payment to Specialty Recruitment Grants under the Medi-Cal Capacity Grant Program.
 - Reference materials: Staff report on above topic.

Pages 10-1 to 10-2

11. Community Reinvestment Plan. (4:00 – 4:15 p.m.)

- A. Ms. Jessica Finney, Community Grants Director, will review the Alliance's Community Reinvestment Plan required by Department of Health Care Services All Plan Letter 25-004, and Board will consider and approve the plan.
 - Reference materials:
 - Community Reinvestment Plan (draft)
 - Policy #xxxx – Community Reinvestment Plan (draft)

Pages 11-1 to 11-31

12. TotalCare D-SNP Operations Update. (4:15 p.m. – 4:45 p.m.)

- A. Mr. Scott Crawford, Medicare Program Executive Director and Ms. Lisa Ba, Chief Financial Officer, will review, and Board will discuss TotalCare Operations & Financials based on the first quarter's performance.
 - Reference materials: Staff report on above topic.

Pages 12-1 to 12-2

13. 2026-27 State Budget Update. (4:45 p.m. – 5:00 p.m.)

- A. Mr. Michael Schrader, Chief Executive Officer, will provide an update on the State Budget and Board will discuss.
 - Reference materials:
 - Coalition Letter – June 12, 2026
 - Guest Commentary, Santa Cruz Sentinel – June 10, 2026
 - Letter to the Editor, Lookout Santa Cruz – June 10, 2026

Pages 13-1 to 13-12

Information Items: (14A. – 14F.)

A. Alliance in the News	Pages 14A-1 to 14A-6
B. Membership Enrollment Report	Page 14B-1
C. Member Newsletter – June 2026 (English)	Page 14C-1 to 14C-12
D. Member Newsletter – June 2026 (Spanish)	Page 14D-1 to 14D-8
E. Provider Bulletin	Pages 14E-1 to 14E-12
F. Letters of Support	Pages 14F-1 to 14F-5

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, August 26, 2026; 1:30-2:45 p.m.
- Member Services Advisory Group
Thursday, August 13, 2026; 10:00 – 11:30 p.m.
- Physicians Advisory Group
Thursday, September 3, 2026; 12:00 – 1:30 p.m.
- Whole Child Model Clinical Advisory Committee [*Remote teleconference only*]
Wednesday, July 22, 2026; 12:00 – 1:00 p.m.
- Whole Child Model Family Advisory Committee [*Remote teleconference only*]
Monday, July 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 June 24 meeting, unless otherwise notified.

Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission
Wednesday, August 26, 2026, 3:00 – 5:00 p.m.

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

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

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

In Merced County:
Central California Alliance for Health
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In San Benito County:
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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 June 24, 2026
TO Governing Commission of the Central California Alliance for Health
FROM Michael Schrader, Chief Executive Officer
SUBJECT CEO Report

Alliance Medi-Cal Enrollment Trends. Alliance enrollment is projected to decline between August 2025 and December 2028 due to eligibility losses driven by the end of COVID-19 unwinding flexibilities, the implementation of federal H.R. 1 requirements, and the FY2025–26 state budget. Enrollment is also expected to decrease as DHCS carves out specific populations from managed care, should related provisions included in the May Revision of the FY2026–27 State Budget be approved in the final budget adopted in June 2026. (See additional information on the May Revision later in this report.)

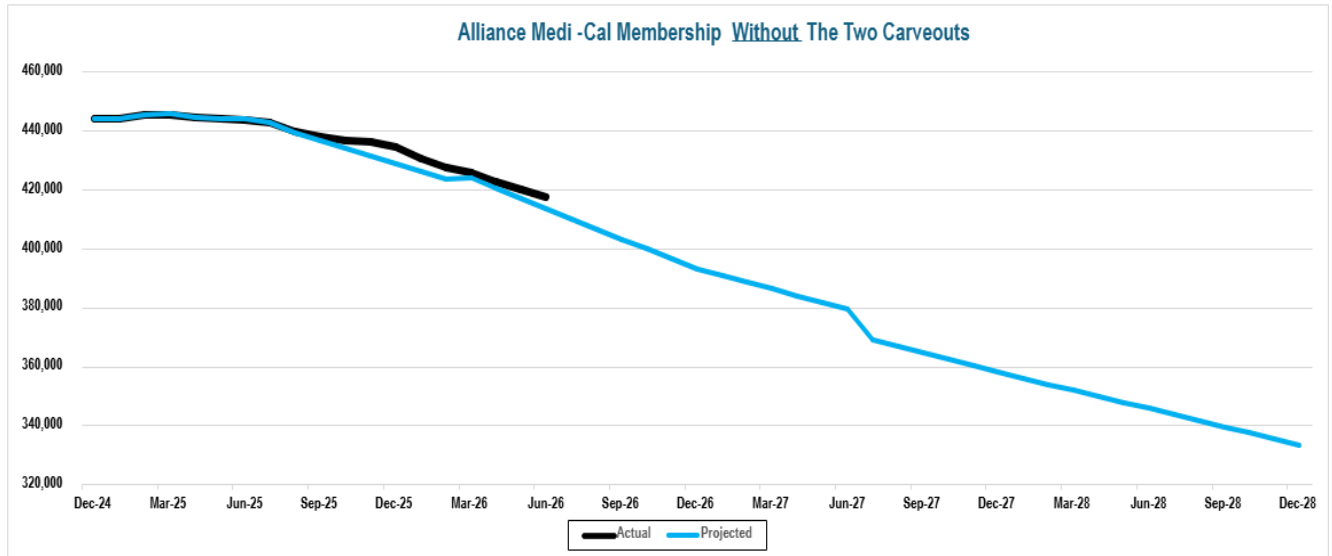
This section highlights two enrollment trends:

- Without The Two Carveouts. The decline in Alliance enrollment driven solely by members who lose Medi-Cal eligibility, for which the Alliance projects a **27%** reduction in Medi-Cal membership from January 2025 through December 2028. See Graph A and Table A.
- With the Two Carveouts. The overall decline in Alliance enrollment driven by both members who lose Medi-Cal eligibility and members who are carved out of managed care while remaining Medi-Cal eligible. The Alliance projects a **39%** reduction in Medi-Cal membership from January 2025 through December 2028 when considering both factors. See Graph B and Table B.

Without The Two Carveouts (Graph A and Table A). This graph and table show our actual versus projected membership decline attributed solely to members losing their eligibility. These figures do not include members who are expected to be carved out of managed care as proposed in the May Revision.

On the graph, the black line represents our actual membership loss to date, while the blue line reflects our projected **27%** decline in Alliance Medi-Cal membership from January 2025 through December 2028. To date, the black line has tracked closely along the blue line, indicating that the actual membership loss has closely mirrored the projection.

The table presents the actual month-to-month decline in our Alliance Medi-Cal membership to date, corresponding to the black line in the graph.



Graph A

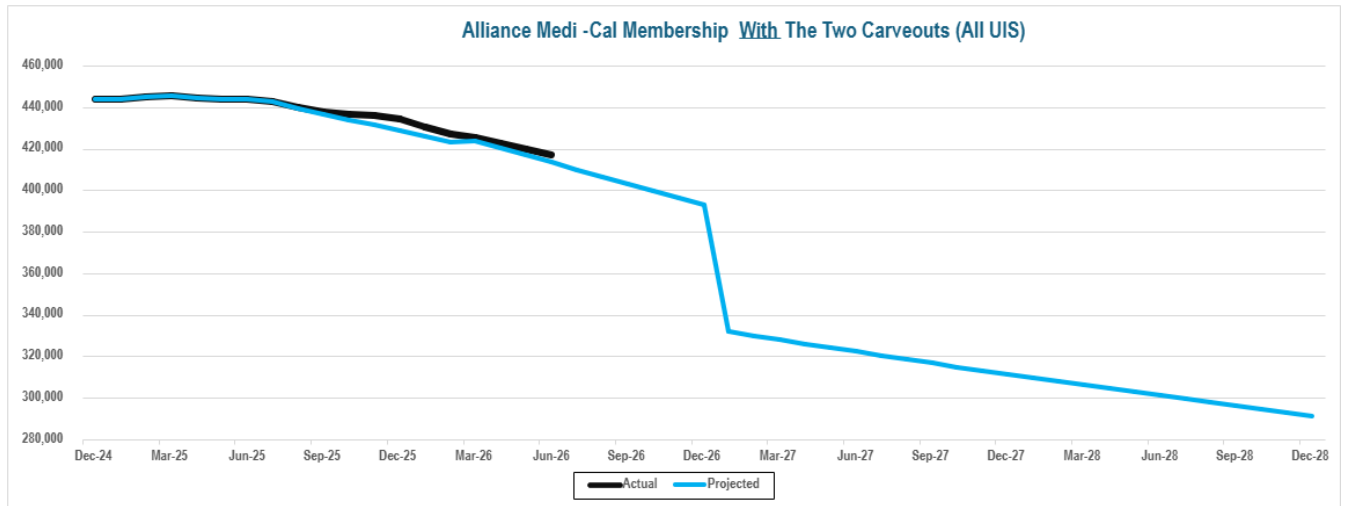
Month of Service	Santa Cruz	Monterey	Merced	Mariposa	San Benito	Total MCal Enroll	Actual % Chg	Projected % Chg
Aug-25	77,269	188,191	148,008	5,656	20,606	439,730	-0.66%	-0.66%
Sep-25	76,899	186,924	147,724	5,616	20,658	437,821	-0.43%	-0.43%
Oct-25	76,407	186,563	147,310	5,599	20,675	436,554	-0.29%	-0.29%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

Table A

Without The Two Carveouts (Graph B and Table B). This graph and table show our actual versus projected membership overall decline, attributed to both eligibility losses and the two carve outs. This includes the potential carve outs of Qualified Non-Citizens and members with Unsatisfactory Immigration Status (UIS) on January 1, 2027, should the May Revise proposals be enacted.

On the graph, the black line represents our actual membership loss to date, while the blue line reflects our projected **39%** decline in Alliance Medi-Cal membership from January 2025 through December 2028. *Because the carve-outs have not yet occurred, the black lines on Graphs A and B, representing actual enrollment decline, are identical at this point*

The table presents the month-to-month actual decline in Alliance Medi-Cal membership to date, corresponding to the black line in the graph. *For the same reason, the figures in Tables A and B are identical at this time.*



Graph B

Month of Service	Santa Cruz	Monterey	Merced	Mariposa	San Benito	Total MCal Enroll	Actual % Chg	Projected % Chg
Aug-25	77,269	188,191	148,008	5,656	20,606	439,730	-0.66%	-0.66%
Sep-25	76,899	186,924	147,724	5,616	20,658	437,821	-0.43%	-0.43%
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Apr-26	72,079	182,234	142,578	5,469	20,252	422,612	-0.70%	-0.81%
May-26	71,420	181,307	141,596	5,397	20,147	419,867	-0.65%	-0.82%
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Table B

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

General Member Outreach. Flight two of our bilingual media campaign launched June 1st, when we resumed radio and television ads. During the first phase of our campaign we delivered over 12 million ad impressions, including just over 2,100 television ads, contributing to significant growth in new and engaged website traffic to the landing page and a growth in organic search traffic. Changes to this flight include a modest investment in FIFA World Cup advertisements during June, as well as a small reallocation to Tik Tok and placements in local locations (laundromats, groceries, gas stations, convenience stores). To complement the refreshed visuals, we have also updated the flyers, social media ads, mobile ads, as well as new billboard placements in Moss Landing, Merced and Salinas. This is in addition to the current billboards in Los Banos.

Focused Member Outreach. In May, we sent out just over 7,400 text messages to members who were up for renewal. In addition to these efforts, we are also evaluating new messaging opportunities to address possible barriers members may be facing to return renewal paperwork, as well as preparing more focused messaging on the 2027 Medi-Cal changes. We also continue to leverage AI supported outreach calls to proactively engage members approaching their Medi-Cal renewal dates. These calls provide renewal reminders, answer common questions, and connect members with enrollment assistance resources, helping to reduce preventable disenrollments and maintain continuity of coverage.

Community Partner Trainings. The Alliance continues to provide community partner trainings across our service area to strengthen local capacity to support Medi-Cal members through the renewal process. These trainings equip community-based organizations, schools, providers, and other trusted partners with information on redetermination requirements, available enrollment resources, and strategies to help members maintain health coverage. To date, training sessions have been conducted in multiple counties, reaching more than 120 community partners and fostering stronger collaboration to reduce preventable disenrollments.

Grant Funding. The Alliance's Medi-Cal Member Outreach and Retention (MOR) grant program continues implementation following the April 2026 award cycle. The

program awarded approximately \$3.2 million to 23 organizations across the Alliance service area, with the majority of funding supporting direct renewal assistance activities. During May, separate orientations were conducted for Tier 1 (outreach) and Tier 2 (renewal assistance) grantees to review program expectations, reporting requirements, and member support strategies. An additional orientation was also completed with the Tier 2 grantees and the Alliance's outbound call campaign vendor to prepare for direct member call transfers to Tier 2 grantees to assist members. The MOR grant program also supports strengthening county-level coordination and training for community-based organizations (CBOs), including collaboration with county social services departments and partnering with UC Merced on a self-paced online training that will be available at no cost for organizations in the Alliance service area supporting renewal efforts. Staff continue to support funded CBOs and are planning a grantee convening later this year to share best practices and prepare for anticipated Medi-Cal renewal process changes in 2027.

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

Development of Our New Strategic Plan. As previously reported, staff continue to develop the Alliance's 2027–2029 Strategic Plan through an iterative process informed by external stakeholders, including board commissioners, and senior management feedback. The draft three-year plan is being refined for presentation to the Board in September, with final Board approval anticipated in December.

Key Alliance Initiatives.

Claims System Replacement. The Alliance has officially kicked off the RFP process to procure a replacement for its aging claims and eligibility processing system, HSP from Conduent. Recognizing the complexity and importance of this initiative, our team has partnered with industry experts from Wendigo Advisors, who will help guide us through each step of the RFP process. This partnership ensures that we are leveraging specialized knowledge to maximize the value and effectiveness of our future system.

The project is structured into several critical phases: discovery, RFP development, vendor response management, proposal evaluations, vendor demonstrations, final vendor recommendation, and contract terms negotiations. Each phase is designed to ensure that we thoroughly review all potential solutions and select the one that best meets our needs.

Replacing the Alliance's claims processing application is a significant undertaking and will require a substantial financial commitment as well as careful planning. To keep the Board informed, the team will present the results of the selection process, including specific pricing details, at the September board meeting. Implementation of the selected system is scheduled to kick off on January 1, 2027, upon board approval.

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

Marketing, Sales & Enrollment. Since TotalCare's launch, enrollment has steadily increased, reaching 865 enrolled lives for June 1st with another 20 enrollees pending. This represents a 91% growth in TotalCare since our launch. We continue to execute our monthly direct mail schedule, where monthly mailers are sent to approximately 24,000 dual eligibles with an in-network PCP. To maximize response rates, we are rotating the topic and visual creative. June's mailer is a "Benefits at a Glance" letter, aimed at providing a high-level overview of the plan benefits. This month, our paid advertising tactics will launch, which include radio, television, social media and paid Google search ads. To support lead generation efforts, we have posted a digital "Permission to Contact" form on the Alliance website, allowing us to direct lead traffic to this form for prospective members to request a call from the sales team.

Member Management & Engagement. TotalCare's integrated onboarding and care management model continues to deliver high performance. Health Risk Assessments completed at the point-of-sale trigger immediate care management engagement, with 98% of new members reached within 30 days. In addition, more than 95% of Individualized Care Plans are completed within 90 days. This level of execution exceeds Medicare D-SNP 4-Star benchmarks.

TotalCare Provider Network. This month the Alliance will undergo its Triennial Network Adequacy Audit to assess network adequacy. We have successfully closed the neurosurgery gap within Merced County. We are confident we have met all network adequacy criteria for our service area.

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.

May Revision of FY2026/27 State Budget. On June 11, 2026, the Legislature released its bipartisan budget agreement, which must be approved by June 15 to meet the constitutional deadline. The proposal reflects ongoing fiscal pressures while preserving key Medi-Cal investments and delaying several significant reductions.

Major health-related provisions include:

- **Maintains current Medi-Cal asset limits in 2026–27**, with a reduction to \$21,000 scheduled for 2027–28.
- **Delays dental supplemental payment reductions and UIS dental benefit cuts** by 12 months.
- **Defers a potential increase in UIS premiums**, providing the next Administration with discretion to determine future premium levels.
- **Postpones changes to restricted-scope Medi-Cal eligibility for asylees and other qualified immigrants** until 2027–28.
- **Provides additional funding to counties** to address increased eligibility workload associated with H.R. 1.
- **Defers most clinic payment reductions** for 12 months.
- **Authorizes up to \$190 million in loans for financially distressed hospitals.**
- **Reduces premiums in Covered California.**
- **Maintains investments in reproductive and gender-affirming care**, including \$40 million for reproductive health services and \$26 million for gender-affirming care.
- **Includes placeholder language regarding the proposed transition of the UIS population from managed care to fee-for-service**, allowing additional time for policy development and stakeholder engagement.

Importantly, as noted, the Legislature has not finalized the Administration's proposal to transition UIS populations to fee-for-service Medi-Cal, instead signaling intent to continue discussions and evaluate alternatives that preserve coordinated care and minimize disruption to members and providers.

The Local Health Plans of California (LHPC) is leading a broad coalition—including the California Medical Association, First 5 of California, the California Association of Public Hospitals and Health Systems, and the California Association of Health Plans—to advance an alternative approach that maintains coordinated care for Medi-Cal members with UIS.

Staff will provide an update on budget developments and anticipated implications at the Board's June 24 meeting.

County Indigent Care Programs In light of potential impacts of HR 1 on Medi-Cal eligibility, counties have begun to explore options for meeting their obligations to provide indigent care under Welfare and Institutions Code section 17000. At the request of Commissioners Morena-Peraza and Sullivan, staff recently met to discuss possible opportunities to partner with the Alliance to provide administrative services that may support the reestablishment of these programs. Discussions are preliminary and ongoing, and no decisions have been made. Counties will continue to evaluate their options, and the Alliance will assess the potential feasibility of an Administrative Services Organization (ASO) arrangement.

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 Certified Farmer's Market, Mariposa County
- Community Re-entry Resource Fair, Merced County
- 7th Annual Juneteenth Celebration, Monterey County
- Kids at the Park Health and Safety Fair, San Benito County
- Watsonville Senior Center Food Distribution, Santa Cruz County

In addition, Alliance staff participated in the Santa Cruz County Pride Parade on June 7th, engaging with community members, sharing health coverage resources, and demonstrating the Alliance's ongoing commitment to supporting and celebrating the diverse communities we serve.

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 Maternal Wellness Coalition, Merced County
- Building Brighter Futures Conference, Merced County
- Community Health Partnership, Monterey County
- Santa Cruz County Immigration Coalition, Santa Cruz County
- Health Careers Pathway Committee, Santa Cruz County

Communications and Marketing. The Alliance continues to prioritize timely, engaging and effective messaging to our members and providers on a variety of topics to ensure optimal awareness of issues impacting health and wellness. Recent activities include launching our yearlong "Care Can't Wait" campaign, ensuring members understand the importance of timely care. Our current messaging is aimed at urging men prioritize health screenings and other timely care, in alignment with Men's Health Month in June. Future angles include back-to-school checkup reminders, flu vaccine and Nurse Advice Line reminders. To support this campaign, we will continue to develop materials for members including flyers, newsletter articles, on-hold messaging, text messaging, social media posts and website content. We have also developed flyers for provider offices and newsletter content for the Member and Provider Bulletin. In June, we also partnered with Salud Para La Gente on an article celebrating Immigrant Heritage Month, highlighting how this provider partner supports immigrants and their families.

Quality and Health Equity including Health Education and Cultural & Linguistic Services (C&L).

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

Health Education. The Alliance is on track to launch eight member workshops in May, enrolling 54 participants across chronic condition management, diabetes, and healthy weight programs for adult members and families. Workshops are offered in English and Spanish through telephonic, virtual, and in-person formats, including sessions at Alliance offices in Merced and Salinas.

Cultural and Linguistic (C&L) Services. As part of NCQA requirements, the Alliance surveys members throughout the year to evaluate in-person interpreting services.

The 2025 results have been compiled and will be incorporated into the QIHETP evaluation. A total of 52 members completed the survey by phone with QHP staff. Of those surveyed, 94% reported being highly satisfied with their interpreter and 94% indicated they would use the services again, with 6% responding neutrally and no members reporting they would not. Members shared that interpreters were kind, thorough, and created an environment where they felt comfortable asking questions without feeling rushed or stressed. When asked for recommendations, members requested no changes, affirming that services should continue as currently delivered. These results reflect the Alliance's ongoing commitment to ensuring that every member, regardless of language or background, can access and navigate care with confidence and dignity.

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

Network Update. The Alliance participated in Collaborative Planning and Implementation (CPI) Meetings across our service area over the past few months. These meetings included ECM (Enhanced Care Management) and Community Supports (CS) providers and the CPI Facilitators. The group discussed HR1 impacts to ECM and changes outlined in the Governor's May revision budget. Discussions included how ECM providers can support members with Medi-Cal enrollment, and a preview of the Alliance's plan to implement significant changes to how it administers ECM. Some of these changes are:

- Stronger eligibility criteria, with a focus on members with the highest acuity
- Transition to strict fee-for-service provider reimbursement in 2027 along with expected reductions in reimbursement rates
- Increased emphasis on in-person encounters

The board will continue to be kept apprised of these changes, including providing approval for those that require board authority.

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.

Workforce. As of May 18, 2026, the Alliance has 764.90 budgeted positions (regular and contingent), with 631 regular positions currently filled. An additional 73 temporary employees support our workforce needs, bringing overall staffing to 93%.

All-Staff Meeting. On June 10, the Alliance held its in-person All-Staff Meeting at The Grove in Santa Cruz. This mid-year gathering recognized the Alliance's 30th anniversary and highlighted the organization's continued commitment to serving members across its five-county service area. CEO Michael Shrader moderated a panel discussion with prior CEOs Alan McKay and Stephanie Sonnenshine and discussed the values and efforts of the organization in the delivery of services to our members for the past three decades. The program also featured Mission in Motion stories and Member Outreach and Retention updates, Food Drive Raffles, with proceeds benefiting food drive partners throughout the Alliance's service area, and concluded with recognition of 5-, 10-, 15-, 20-, 25-, and 30-year service award recipients. Sixty-five Alliance employees were recognized.

Leadership Forum. On June 5, CEO Michael Schrader and the Executive Team facilitated a conversation with the leadership team on the topic of changes related to anticipated membership declines. The purpose of the meeting was to provide leaders with an opportunity to ask questions, share perspectives, and support overall change management.

Mid-Year Check-ins. The Alliance conducts two formal performance check-in cycles each year, one at mid-year and one at year-end. Supervisors are expected to actively participate by providing meaningful feedback on goal progress, strengths, and areas for development or improvement. The process also includes assessment of core, job-related, and leadership competencies, as applicable. The 2026 mid-year check-in cycle begins with employee self-evaluations on June 15, 2026, and concludes with supervisor check-ins to be delivered by July 31, 2026

Regulatory Audits and Compliance. The Alliance has structured processes to ensure that we operate in an ethical and compliant manner, so that we protect our members' rights. Like all Managed Care Plans, the Alliance is in a continuous state of preparing routine audits, experiencing them, or following up on regulators' requests.

Department of Managed Health Care (DMHC) Survey. The Alliance received notice of a DMHC Follow-Up Survey related to its 2024 DMHC Medical Survey. The review focuses on previously identified areas requiring corrective action, including quality

improvement, member grievances, utilization management, and pharmacy. The Alliance is preparing and submitting required materials in advance of the review.

CMS Medicare Network Review. CMS issued the Alliance notice of a routine, triennial Medicare network to evaluate whether the Alliance maintains sufficient provider access for members across required specialties and counties. The review requires submission of the Alliance's provider network data in June 2026, for which the Alliance is currently preparing deliverables and expects a timely submission.

Program Integrity. Program Integrity remains an area of focus for the Alliance. We continue to monitor state and federal developments and have proactively initiated an internal assessment to validate and confirm compliance in the operational focus areas where DHCS and CMS are most likely to concentrate oversight. The Alliance's self-assessment is nearing completion, and we are currently evaluating potential action items and opportunities for operational improvement.

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 healthy people and healthy communities. These investments focus on increasing the availability, quality and access of health care and supportive resources for Medi-Cal members. They also address that social drivers influence health and wellness.

Funding Opportunities. Round 2 is currently underway with the review of 43 eligible grant applications received by the May 5, 2026, deadline for Provider Recruitment, Community Health Worker Recruitment, and Healthcare Technology programs. Award decisions will be distributed on July 17, 2026. The application deadline for the third and final 2026 funding round for ongoing opportunities is August 18, 2026. Round 3 will include the launch of a one-time funding opportunity aimed at maintaining timely access to primary, specialty, and hospital services for Medi-Cal members by stabilizing essential safety net providers facing financial challenges. The funding opportunity will be published by July 6, 2026.

Trends in the Number of Awards and Total Spend. The MCGP has paid out \$16.8M year to date in 2026 for active grant awards, compared to \$28.5M for all of 2025. New MCGP awards year-to-date in the five-county service area total \$10.5M, which is 53% of the 2026 total award amount target of \$20M.

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

Housing Fund Project Openings. During the first half of 2026, two Alliance-funded projects reached significant milestones. Casa de Esperanza opened in March in King City (Monterey County) and provides 45 permanent supportive housing units. HOPE Village opened in May in Watsonville (Santa Cruz County) and provides a 34-bed low-barrier navigation center to help individuals transition from homelessness to permanent housing and will also serve as a recuperative care facility.



DATE: June 24, 2026
TO: Santa Cruz – Monterey - Merced - San Benito - Mariposa Managed Medical Care Commission
FROM: Lisa Ba, Chief Financial Officer
SUBJECT: Financial Highlights for the Fourth Month Ending April 30, 2026

Consolidated (All Lines of Business)

For the month ending April 30, 2026, the Alliance reported an Operating Loss of \$15.4M. The Year-to-Date (YTD) Operating Loss is \$14.7M, with a Medical Loss Ratio (MLR) of 97.0% and an Administrative Loss Ratio (ALR) of 4.9%. The Net Loss is \$19.7M after accounting for Non-Operating Income/Expenses.

The budget expected a \$0.9M Operating Loss for YTD April. The actual result is unfavorable to the budget by \$13.8M, driven by rate variances.

Apr-26 Income Statement Consolidated (\$ In 000s)								
Key Indicators	MTD Actual	MTD Budget	MTD Var \$	MTD Var %	YTD Actual	YTD Budget	YTD Var \$	YTD Var %
Membership	426,860	420,202	6,658	1.6%	1,723,052	1,695,213	27,839	1.6%
Revenue	\$189,744	\$190,612	(\$867)	-0.5%	768,057	765,566	2,491	0.3%
Medical Expenses	195,391	177,498	(17,893)	-10.1%	745,156	723,952	(21,205)	-2.9%
Admin Expenses	9,793	11,084	1,291	11.7%	37,625	42,551	4,925	11.6%
Operating Loss	(15,440)	2,029	(17,469)	-100.0%	(14,725)	(937)	(13,788)	-100.0%
Net Income/(Loss)	(\$15,675)	\$4,129	(\$19,804)	-100.0%	(\$19,682)	\$7,463	(\$27,145)	-100.0%
MLR %	103.0%	93.1%	-9.9%		97.0%	94.6%	-2.5%	
ALR %	5.2%	5.8%	0.7%		4.9%	5.6%	0.7%	
Operating Income %	-8.1%	1.1%	-9.2%		-1.9%	-0.1%	-1.8%	
Net Income %	-8.3%	2.2%	-10.4%		-2.6%	1.0%	-3.5%	

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Medi-Cal Line of Business (Including IHSS)

For the month ending April 30, 2026, the Alliance reported an Operating Loss of \$14.6M. The Year-to-Date (YTD) Operating Loss is \$10.6M, with a Medical Loss Ratio (MLR) of 96.9% and an Administrative Loss Ratio (ALR) of 4.5%. The Net Loss is \$15.6M after accounting for Non-Operating Income/Expenses.

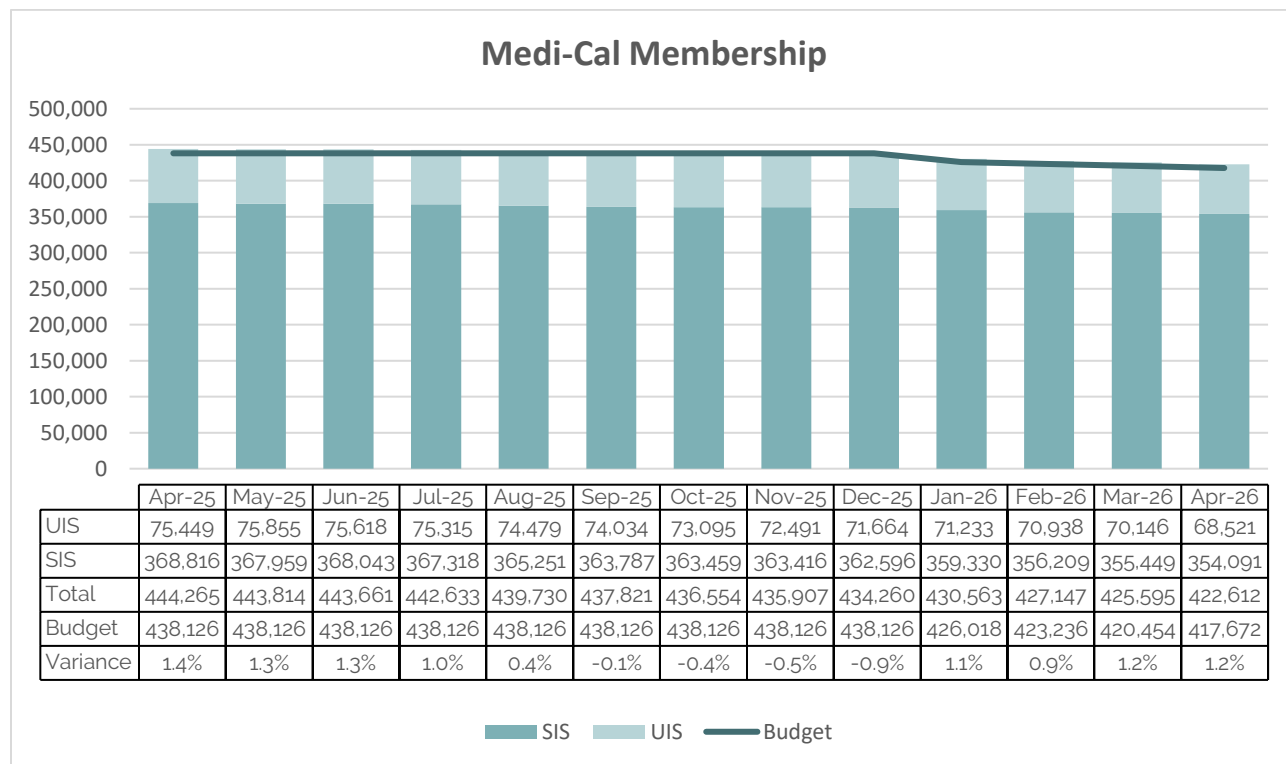
The budget expected an Operating Income of \$4.6M for YTD April. The actual result is unfavorable to the budget by \$15.3M or 100.0%, driven by rate variances.

Apr-26 Income Statement Medi-Cal (\$ In oos)								
<u>Key Indicators</u>	MTD Actual	MTD Budget	MTD Var \$	MTD Var %	YTD Actual	YTD Budget	YTD Var \$	YTD Var %
<i>Membership</i>	425,931	418,399	7,532	1.8%	1,720,803	1,690,293	30,510	1.8%
Revenue	\$188,344	\$187,485	\$859	0.5%	763,901	757,037	6,864	0.9%
Medical Expenses	194,382	173,860	(20,522)	-11.8%	739,983	713,773	(26,210)	-3.7%
Admin Expenses	8,540	10,047	1,507	15.0%	34,528	38,601	4,073	10.6%
Operating Loss	(14,577)	3,578	(18,155)	-100.0%	(10,610)	4,663	(15,272)	-100.0%
Net Income/(Loss)	(\$14,812)	\$5,678	(\$20,490)	-100.0%	(\$15,567)	\$13,062	(\$28,630)	-100.0%
PMPM								
Revenue	\$442.19	\$448.10	(\$5.91)	-1.3%	\$443.92	\$447.87	(\$3.95)	-0.9%
Medical Expenses	456.37	415.54	(40.83)	-9.8%	430.02	422.28	(7.74)	-1.8%
Admin Expenses	20.05	24.01	3.96	16.5%	20.07	22.84	2.77	12.1%
Operating Income/(Loss)	(0.55)	5.02	(5.57)	-100.0%	(6.17)	2.76	(8.92)	-100.0%
Net Income/(Loss)	(\$34.78)	\$13.57	(\$48.35)	-100.0%	(\$9.05)	\$7.73	(\$16.77)	-100.0%
<i>MLR %</i>	103.2%	92.7%	-10.5%		96.9%	94.3%	-2.6%	
<i>ALR %</i>	4.5%	5.4%	0.8%		4.5%	5.1%	0.6%	
<i>Operating Income %</i>	-7.7%	1.9%	-9.6%		-1.4%	0.6%	-2.0%	
<i>Net Income %</i>	-7.9%	3.0%	-10.9%		-2.0%	1.7%	-3.8%	

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

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

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



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

Apr-26 YTD Medi-Cal Capitation Revenue Summary (\$ In 000s)					
Region	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
CEC SIS	\$578,999	\$570,236	\$8,763	\$14,719	(\$5,956)
CEC UIS	141,813	145,378	(3,565)	(3,139)	(426)
SBN SIS	33,716	33,051	665	1,088	(423)
SBN UIS	6,469	6,369	100	(171)	272
Total*	\$760,998	\$755,035	\$5,963	\$12,496	(\$6,533)

*Excludes Apr-26 In-Home Supportive Services (IHSS) premiums revenue of \$2.1M and State Incentives of \$0.8M.

As of April YTD, capitation revenue exceeded the budget by \$5.9M, representing a positive 0.8% variance. This variance is primarily driven by higher-than-expected SPD-LTC

membership, which is 26.8% above budget. The budget did not adjust SPD aged 0-20 members from the Child category to SPD, which was introduced in 2026, further contributing to the revenue variance. Furthermore, offsetting the favorable enrollment is the rate variance from the risk corridors, including the UIS risk corridor and the ECM risk corridor. The ECM risk corridor for 2026, as noted last month, is recorded as payable because the encounter submission will be subject to dosage and intensity requirements, which will reduce the expenses eligible for recognition.

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

Apr-26 YTD Medi-Cal Medical Expense Summary (\$ In 000s)					
Category	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
Inpatient Hospital	\$205,454	\$187,777	(\$17,678)	(\$3,389)	(\$14,288)
Inpatient LTC	75,620	73,288	(2,332)	(1,323)	(1,010)
Physician Services	152,185	163,718	11,533	(2,955)	14,488
Outpatient Facility	87,768	78,669	(9,099)	(1,420)	(7,679)
ECM	49,501	57,519	8,018	(1,038)	9,057
Community Supports	23,848	20,541	(3,307)	(371)	(2,936)
Behavioral Health	39,125	31,534	(7,591)	(569)	(7,021)
Other Medical*	105,663	100,727	(4,936)	(1,818)	(3,118)
State Incentives	818	-	(818)	-	(818)
TOTAL COST	\$739,983	\$713,773	(\$26,210)	(\$12,884)	(\$13,326)

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

April 2026 Medical Expenses of \$194.4M are \$20.5M or 11.8% unfavorable to the budget. April 2026 YTD Medical Expenses of \$740.0M are above budget by \$26.2M or 3.7%. Of this amount, \$12.9M is due to higher enrollment and \$13.3M due to rate variances. The unfavorability is primarily driven by CS due to higher cost trends, followed by Inpatient Hospital and Outpatient, reflecting high prior-year adjustments made in January through March, and Behavioral Health (BH), driven by an increase in BH utilizers as well as higher utilization of Mental Health Outpatient (MHOP) and Behavioral Health Treatment (BHT) services.

At a PMPM level, YTD Medical Expenses are \$430.02, which is \$7.74 (1.8%) unfavorable compared to the budget.

Apr-26 YTD Medi-Cal Medical Expense by Category of Service (In PMPM)				
Category	Actual	Budget	Variance	Variance %
Inpatient Services - Hospital	\$119.39	\$111.09	(\$8.30)	-7.5%
Inpatient Services - LTC	43.94	43.36	(0.59)	-1.4%
Physician Services	88.44	96.86	8.42	8.7%
Outpatient Facility	51.00	46.54	(4.46)	-9.6%
ECM	28.77	34.03	5.26	15.5%
Community Supports	13.86	12.15	(1.71)	-14.0%
Behavioral Health	22.74	18.66	(4.08)	-21.9%
Other Medical	61.40	59.59	(1.81)	-3.0%
State Incentives	0.48	-	(0.48)	-100.0%
TOTAL MEDICAL COST	\$430.02	\$422.28	(\$7.74)	-1.8%

Inpatient Services: Inpatient Services are unfavorable to the budget due to high prior-period adjustments, including a \$2.7M claim for March of 2025 that was paid in April 2026, as well as an additional \$1.7M increase to early 2026. The YTD incurred PMPM is now \$107.71 compared to the budgeted YTD PMPM of \$109.24, suggesting that the actual PMPM is expected to decline as the year progresses.

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

Physician Services: Specialty utilization is trending slightly lower, while primary care and FQHC utilization continue to trend slightly higher, resulting in a favorable overall variance. The Specialty Physicians category includes \$4.3M in provider supplemental payments (PSP), funded by Board-approved strategic use of reserves.

Outpatient Facility: The Outpatient Facility category consists of both Outpatient and Emergency Room (ER) services. ER continues to show an upward trend in both utilization per 1k and unit cost. April included an additional \$1M increase over the prior period, which now pushes the YTD incurred PMPM to \$47.11, compared to the budgeted amount of \$46.54. This will be closely monitored as the budget assumed a 4% increase over projected 2025 YTD Outpatient costs, but Q4 2025 experienced 7% growth compared with the first half of 2025.

ECM: Overall, ECM performance is over budget and should be evaluated holistically, considering both revenue and expenses. The performance is over budget primarily due to unrecognized costs from lower encounter rates that must be absorbed by the plan, as well as revenue expected to be clawed back under the risk corridor. While the ECM risk corridor remains in effect through CY 2026, the State communicated to the Alliance on March 30, 2026, that DHCS will incorporate encounter-based adjustments into the ECM risk corridor calculation. Under this approach, costs will be credible only when supported by encounters. Low encounter rates will therefore reduce the amount of ECM expenses incurred eligible for recognition, increasing the risk of unreimbursed exposure. *As noted last month, the next step is to transition to an FFS reimbursement structure to align with the required service dosage and intensity.*

Community Supports: Community Supports is trending lower in April but remains above budget on a YTD basis. Declining CS enrollments and the implementation of program integrity initiatives, including Medically Tailored Meals (MTM), housing services, and the transition to case-rate reimbursement for housing effective March 2026, are contributing to improved performance. Personal care & Homemaker services (PCHS) are also beginning to moderate in April following targeted policy and provider education efforts.

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

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

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

Beginning January 2026, the Alliance launched the TotalCare (HMO D-SNP), a Medicare Advantage Dual Special Needs Plan (D-SNP) for people 65 years old and over and for some people with certain disabilities who are enrolled in both Medicare and Medi-Cal. For the month ending April 30, 2026, the Alliance reported an Operating Loss of \$0.9M. The Year-to-Date (YTD) Operating Loss is \$4.1M, with a Medical Loss Ratio (MLR) of 124.5% and an Administrative Loss Ratio (ALR) of 74.5%.

The budget expected an Operating Loss of \$6.0M for April YTD. The actual result is favorable to the budget by \$1.5M or 26.5%, due to the lower enrollment.

Apr-26 Income Statement								
D-SNP (\$ In 000s)								
<u>Key Indicators</u>	MTD Actual	MTD Budget	MTD Var \$	MTD Var %	YTD Actual	YTD Budget	YTD Var \$	YTD Var %
<i>Membership</i>	929	1,803	(874)	-48.5%	2,249	4,920	(2,671)	-54.3%
Revenue	\$1,400	\$3,126	(\$1,727)	-55.2%	\$4,156	\$8,529	(\$4,373)	-51.3%
Medical Expenses	1,010	3,638	2,628	72.2%	5,174	10,179	5,005	49.2%
Admin Expenses	1,253	1,037	(216)	-20.8%	3,097	3,949	852	21.6%
Operating Income/(Loss)	(\$863)	(\$1,549)	\$686	44.3%	(\$4,115)	(\$5,599)	1,484	26.5%
PMPM								
Revenue	\$1,506.91	\$1,733.97	(\$227.06)	-13.1%	\$1,847.98	\$1,733.46	\$114.51	6.6%
Medical Expenses	1,086.83	2,017.74	930.91	46.1%	2,300.49	2,068.84	(231.65)	-11.2%
Admin Expenses	1,348.66	575.06	(773.60)	-100.0%	1,377.18	802.64	(574.55)	-71.6%
Operating Income/(Loss)	(\$928.58)	(\$858.83)	(\$69.75)	-8.1%	(\$1,829.70)	(\$1,138.01)	(\$691.69)	-60.8%
<i>MLR %</i>	72.1%	116.4%	44.2%		124.5%	119.3%	-5.1%	
<i>ALR %</i>	89.5%	33.2%	-56.3%		74.5%	46.3%	-28.2%	
<i>Operating Income %</i>	-61.6%	-49.5%	-12.1%		-99.0%	-65.6%	-33.4%	

Membership: April 2026 D-SNP membership is unfavorable to the budget by 48.5%. D-SNP enrollment was projected to begin the year at approximately 635 members in January, with anticipated growth of about 350 members per month reaching an estimated 4,500 by year-end.

Actual April membership totaled 687, plus a retroactive adjustment of 242 for January through March to reconcile year-to-date member months. Beginning with this reporting period, membership reporting will reflect current membership levels, including retros.

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

Apr-26 YTD D-SNP Revenue Summary (\$ In 000s)					
CMS CAP	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
Part C	\$3,544	\$6,912	(\$3,369)	(\$3,753)	\$384
Part D	613	1,617	(1,004)	(878)	(126)
Total	\$4,156	\$8,529	(\$4,373)	(\$4,630)	\$258

As of April, actual revenue is \$1.7M below budget, or 55.2%. As of April YTD, actuals are \$4.4M below budget, representing a negative variance of 51.3%. This shortfall is primarily attributable to lower-than-anticipated enrollment, partially offset by a favorable variance in the risk-adjusted rate. The early months are expected to be highly volatile until enrollment stabilizes for this newly launched D-SNP line of business.

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

Apr-26 YTD D-SNP Medical Expense Summary (\$ In 000s)					
Category	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
Inpatient Hospital	\$1,166	\$2,382	\$1,215	\$1,293	(\$78)
Inpatient Services - LTC	325	551	226	299	(73)
Physician Services	789	2,549	1,760	1,384	376
Outpatient Facility	659	1,722	1,063	935	128
CMS Pharmacy Part D	758	1,640	883	891	(8)
Other Medical*	1,477	1,335	(141)	725	(866)
TOTAL COST	\$5,174	\$10,179	\$5,005	\$5,526	(\$521)

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

April 2026 Medical Expenses of \$1.0M are below budget by \$2.6M or 72.2%, primarily due to lower than anticipated enrollment.

April YTD 2026 Medical Expenses of \$5.2M are below budget by \$5.0M or 49.2%, primarily due to lower than anticipated enrollment.

Apr-26 YTD D-SNP Medical Expense by Category of Service (In PMPM)				
Category	Actual	Budget	Variance	Variance %
Inpatient Services - Hospital	\$518.66	\$484.09	(\$34.58)	-7.1%
Inpatient Services - LTC	144.35	111.96	(32.40)	-28.9%
Physician Services	350.84	517.99	167.15	32.3%
Outpatient Facility	293.23	350.05	56.82	16.2%
CMS Pharmacy Part D	336.86	333.40	(3.46)	-1.0%
Other Medical*	656.55	271.36	(385.19)	-100.0%
TOTAL MEDICAL COST	\$2,300.49	\$2,068.84	(\$231.65)	-11.2%

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

At the PMPM level, Medical Expenses are \$2,300.49, unfavorable by \$231.65 or 11.2% compared to the budget. The PMPM variance is unfavorable because costs are spread across a smaller membership base than projected, resulting in a favorable dollar variance. The actual results are heavily incurred but Not Reported (IBNR)- driven, using the bid submission as the basis.

As claims are fully processed and more complete data becomes available, a clearer picture of the underlying medical expense experience will emerge.

Administrative Expenses: April YTD Consolidated Administrative Expenses are favorable to the budget by \$4.9M or 11.6% with 4.9% ALR. Salaries are favorable by \$1.8M or 6.0%, driven by savings from vacant positions, employment taxes, and PTO. Non-salary administrative expenses are favorable at \$3.2M, or 24.0%, due to timing differences between actual and budget.

Non-Operating Revenue/Expenses: April YTD Net Non-Operating Loss totaled \$5.0M, unfavorable to budget by \$13.4M. Of the total variance, \$9.2M was attributable to unrealized investment losses due to lower bond prices. Since the investments are expected to be held to maturity, these losses are not anticipated to be realized. In addition, higher grant distributions contributed approximately \$4.6M to the unfavorable variance.

Summary of Results: Overall, the Alliance generated a Consolidated Net Loss of \$19.7M, with an MLR of 97.0% and an ALR of 4.9%.



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

Assets	
Cash	\$131,774
Restricted Cash	309
Short Term Investments	812,096
Receivables	393,871
Prepaid Expenses	(941)
Other Current Assets	2,824
Total Current Assets	\$1,339,933
Building, Land, Furniture & Equipment	
Capital Assets	\$82,874
Accumulated Depreciation	(47,097)
CIP	1,794
Lease Receivable	2,799
Subscription Asset net Accum Depr	10,673
Total Non-Current Assets	51,043
Total Assets	\$1,390,976
Liabilities	
Accounts Payable	\$92,666
IBNR/Claims Payable	319,861
Provider Incentives Payable	37,432
Other Current Liabilities	11,646
Due to State	83,506
Total Current Liabilities	\$545,112
Subscription Liabilities	7,963
Deferred Inflow of Resources	2,556
Total Long-Term Liabilities	\$10,520
Fund Balance	
Fund Balance - Prior	\$855,027
Retained Earnings - CY	(19,682)
Total Fund Balance	835,344
Total Liabilities & Fund Balance	\$1,390,976
Additional Information	
Total Fund Balance	\$835,344
Board Designated Reserves Target	563,082
Strategic Reserve (DSNP)	52,585
Medi-Cal Capacity Grant Program (MCGP)*	113,909
Value Based Payments	46,100
Provider Supplemental Payments	107,374
Total Reserves	883,049
Total Operating Reserve	(\$47,705)



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

	Medi-Cal				D-SNP				Consolidated			
	YTD Actual	YTD Budget	Var \$	Var %	YTD Actual	YTD Budget	Var \$	Var %	YTD Actual	YTD Budget	Var \$	Var %
<i>Member Months</i>	1,720,803	1,690,293	30,510	1.8%	2,249	4,920	(2,671)	-54.3%	1,723,052	1,695,213	27,839	1.6%
Dollars												
Revenue	\$763,901	\$757,037	\$6,864	0.9%	\$4,156	\$8,529	(\$4,373)	-51.3%	\$768,057	\$765,566	\$2,491	0.3%
Medical Expenses	739,983	713,773	(26,210)	-3.7%	5,174	10,179	5,005	49.2%	745,156	723,952	(21,205)	-2.9%
Administrative Expenses	34,528	38,601	4,073	10.6%	3,097	3,949	852	21.6%	37,625	42,551	4,925	11.6%
Operating Income/(Loss)	(10,610)	4,663	(15,272)	-100.0%	(4,115)	(5,599)	1,484	26.5%	(14,725)	(937)	(13,788)	-100.0%
Total Non-Op Income/(Expense)	(4,957)	8,400	(13,357)	-100.0%	-	-	0	0.0%	(4,957)	8,400	(13,357)	-100.0%
Net Income/(Loss)	(\$15,567)	\$13,062	(\$28,630)	-100.0%	(\$4,115)	(\$5,599)	\$1,484	26.5%	(\$19,682)	\$7,463	(\$27,145)	-100.0%
PMPM												
Revenue	\$443.92	\$447.87	(\$3.95)	-0.9%	\$1,847.98	\$1,733.46	\$114.51	6.6%	\$445.75	\$451.60	(\$5.85)	-1.3%
Medical Expenses	430.02	422.28	(7.74)	-1.8%	2,300.49	2,068.84	(231.65)	-11.2%	432.46	427.06	(5.41)	-1.3%
Administrative Expenses	20.07	22.84	2.77	12.1%	1,377.18	802.64	(574.55)	-71.6%	21.84	25.10	3.26	13.0%
Operating Income/(Loss)	(6.17)	2.76	(8.92)	-100.0%	(1,829.70)	(1,138.01)	(691.69)	-60.8%	(8.55)	(0.55)	(7.99)	-100.0%
Total Non-Op Income/(Expense)	(2.88)	4.97	(7.85)	-100.0%	-	-	-	0.0%	(2.88)	4.95	(7.83)	-100.0%
Net Income/(Loss)	(\$9.05)	\$7.73	(\$16.77)	-100.0%	(\$1,829.70)	(\$1,138.01)	(\$691.69)	-60.8%	(\$11.42)	\$4.40	(\$15.83)	100.0%
<i>MLR</i>	96.9%	94.3%			124.5%	119.3%			97.0%	94.6%		
<i>ALR</i>	4.5%	5.1%			74.5%	46.3%			4.9%	5.6%		
<i>Operating Income %</i>	-1.4%	0.6%			-99.0%	-65.6%			-1.9%	-0.1%		
<i>Net Income %</i>	-2.0%	1.7%			-99.0%	-65.6%			-2.6%	1.0%		



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

	<u>MTD Actual</u>	<u>MTD Budget</u>	<u>Variance</u>	<u>%</u>	<u>YTD Actual</u>	<u>YTD Budget</u>	<u>Variance</u>	<u>%</u>
<i>Member Months</i>	426,860	420,202	6,658	1.6%	1,723,052	1,695,213	27,839	1.6%
Capitation Revenue								
Capitation Revenue Medi-Cal	\$187,774	\$186,985	\$788	0.4%	\$760,998	\$755,035	\$5,963	0.8%
CMS D-SNP	1,400	3,126	(1,727)	-55.2%	4,156	8,529	(4,373)	-51.3%
State Incentive Programs	(0)	-	(0)	-100.0%	818	-	818	100.0%
Prior Year Revenue*	-	-	-	0.0%	-	-	-	0.0%
Premiums Commercial	571	500	71	14.2%	2,085	2,002	83	4.1%
Total Operating Revenue	\$189,744	\$190,612	(\$867)	-0.5%	\$768,057	\$765,566	\$2,491	0.3%
Medical Expenses								
Inpatient Services (Hospital)	\$58,882	\$46,499	(\$12,383)	-26.6%	\$206,621	\$190,158	(\$16,462)	-8.7%
Inpatient Services (LTC)	21,324	18,001	(3,323)	-18.5%	75,945	73,839	(2,106)	-2.9%
Physician Services	36,605	40,798	4,194	10.3%	152,974	166,267	13,293	8.0%
Outpatient Facility	22,200	19,739	(2,461)	-12.5%	88,428	80,392	(8,036)	-10.0%
ECM	16,239	14,224	(2,015)	-14.2%	49,501	57,519	8,018	13.9%
Community Supports	2,099	5,017	2,918	58.2%	23,848	20,541	(3,307)	-16.1%
Behavioral Health	9,564	7,664	(1,899)	-24.8%	39,129	31,534	(7,595)	-24.1%
CMS Pharmacy Part D	345	601	256	42.6%	758	1,640	883	53.8%
Other Medical**	28,135	24,955	(3,181)	-12.7%	107,135	102,062	(5,073)	-5.0%
State Incentive Programs	(0)	-	0	100.0%	818	-	(818)	-100.0%
Total Medical Expenses	\$195,391	\$177,498	(\$17,893)	-10.1%	\$745,156	\$723,952	(\$21,205)	-2.9%
Gross Margin	(\$5,647)	\$13,114	(\$18,761)	-100.0%	\$22,900	\$41,614	(\$18,714)	-45.0%
Administrative Expenses								
Salaries	\$6,772	\$7,683	\$911	11.9%	\$27,617	\$29,384	\$1,768	6.0%
Professional Fees	371	452	81	17.9%	1,255	1,878	623	33.2%
Purchased Services	506	650	144	22.2%	1,897	3,173	1,275	40.2%
Supplies & Other	973	1,310	337	25.7%	3,255	4,138	882	21.3%
Occupancy	109	140	31	22.4%	491	586	95	16.2%
Depreciation/Amortization	1,061	848	(213)	-25.1%	3,110	3,392	282	8.3%
Total Administrative Expenses	\$9,793	\$11,084	\$1,291	11.7%	\$37,625	\$42,551	\$4,925	11.6%
Operating Income/(Loss)	(\$15,440)	\$2,029	(\$17,469)	-100.0%	(\$14,725)	(\$937)	(\$13,788)	-100.0%
Non-Op Income/(Expense)								
Interest	\$3,898	\$3,330	\$568	17.1%	\$13,923	\$13,320	\$602	4.5%
Gain/(Loss) on Investments	(520)	833	(1,353)	-100.0%	(5,876)	3,333	(9,209)	-100.0%
Bank & Investment Fees	(97)	(38)	(58)	-100.0%	(276)	(153)	(123)	-80.1%
Other Revenues	309	308	1	0.3%	1,199	1,233	(34)	-2.8%
Grants	(3,826)	(2,333)	(1,493)	-64.0%	(13,927)	(9,333)	(4,593)	-49.2%
Total Non-Op Income/(Expense)	(235)	2,100	(2,335)	-100.0%	(4,957)	8,400	(\$13,357)	-100.0%
Net Income/(Loss)	(\$15,675)	\$4,129	(\$19,804)	-100.0%	(\$19,682)	\$7,463	(\$27,145)	-100.0%
<i>MLR</i>	103.0%	93.1%			97.0%	94.6%		
<i>ALR</i>	5.2%	5.8%			4.9%	5.6%		
<i>Operating Income %</i>	-8.1%	1.1%			-1.9%	-0.1%		
<i>Net Income %</i>	-8.3%	2.2%			-2.6%	1.0%		

**Other Medical includes Pharmacy and IHSS.



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

	<u>MTD Actual</u>	<u>MTD Budget</u>	<u>Variance</u>	<u>%</u>	<u>YTD Actual</u>	<u>YTD Budget</u>	<u>Variance</u>	<u>%</u>
Member Months	426,860	420,202	6,658	1.6%	1,723,052	1,695,213	27,839	1.6%
Capitation Revenue								
Capitation Revenue Medi-Cal	\$439.90	\$444.99	(\$5.09)	-1.1%	\$441.66	\$445.39	(\$3.74)	-0.8%
CMS D-SNP	3.28	7.44	(4.16)	-55.9%	2.41	5.03	(2.62)	-52.1%
State Incentive Programs	(0.00)	-	(0.00)	-100.0%	0.47	-	0.47	100.0%
Prior Year Revenue*	-	-	-	0.0%	-	-	-	0.0%
Premiums Commercial	1.34	1.19	0.15	12.4%	1.21	1.18	0.03	2.5%
Total Operating Revenue	\$444.51	\$453.62	(\$9.11)	-2.0%	\$445.75	\$451.60	(\$5.85)	-1.3%
Medical Expenses								
Inpatient Services (Hospital)	\$137.94	\$110.66	(\$27.28)	-24.7%	\$119.92	\$112.17	(\$7.74)	-6.9%
Inpatient Services (LTC)	49.96	42.84	(7.12)	-16.6%	44.08	43.56	(0.52)	-1.2%
Physician Services	85.75	97.09	11.34	11.7%	88.78	98.08	9.30	9.5%
Outpatient Facility	52.01	46.98	(5.03)	-10.7%	51.32	47.42	(3.90)	-8.2%
ECM	38.04	33.85	(4.19)	-12.4%	28.73	33.93	5.20	15.3%
Community Supports	4.92	11.94	7.02	58.8%	13.84	12.12	(1.72)	-14.2%
Behavioral Health	22.40	18.24	(4.16)	-22.8%	22.71	18.60	(4.11)	-22.1%
CMS Pharmacy Part D	0.81	1.43	0.62	43.5%	0.44	0.97	0.53	54.6%
Other Medical**	65.91	59.39	(6.52)	-11.0%	62.18	60.21	(1.97)	-3.3%
State Incentive Programs	(0.00)	-	0.00	100.0%	0.47	-	(0.47)	-100.0%
Total Medical Expenses	\$457.74	\$422.41	(\$35.33)	-8.4%	\$432.46	\$427.06	(\$5.41)	-1.3%
Gross Margin	(\$13.23)	\$31.21	(\$44.44)	-100.0%	\$13.29	\$24.55	(\$11.26)	-45.9%
Administrative Expenses								
Salaries	\$15.87	\$18.28	\$2.42	13.2%	\$16.03	\$17.33	\$1.31	7.5%
Professional Fees	0.87	1.08	0.21	19.2%	0.73	1.11	0.38	34.2%
Purchased Services	1.19	1.55	0.36	23.4%	1.10	1.87	0.77	41.2%
Supplies & Other	2.28	3.12	0.84	26.9%	1.89	2.44	0.55	22.6%
Occupancy	0.26	0.33	0.08	23.6%	0.28	0.35	0.06	17.6%
Depreciation/Amortization	2.49	2.02	(0.47)	-23.2%	1.80	2.00	0.20	9.8%
Total Administrative Expenses	\$22.94	\$26.38	\$3.44	13.0%	\$21.84	\$25.10	\$3.26	13.0%
Operating Income/(Loss)	(\$36.17)	\$4.83	(\$41.00)	-100.0%	(\$8.55)	(\$0.55)	(\$7.99)	-100.0%
Non-Op Income/(Expense)								
Interest	\$9.13	\$7.92	\$1.21	15.2%	\$8.08	\$7.86	\$0.22	2.8%
Gain/(Loss) on Investments	(1.22)	\$1.98	(3.20)	-100.0%	(3.41)	1.97	(5.38)	-100.0%
Bank & Investment Fees	(0.23)	(0.09)	(0.13)	-100.0%	(0.16)	(0.09)	(0.07)	-77.2%
Other Revenues	0.72	0.73	(0.01)	-1.3%	0.70	0.73	(0.03)	-4.3%
Grants	(8.96)	(5.55)	(3.41)	-61.4%	(8.08)	(5.51)	(2.58)	-46.8%
Total Non-Op Income/(Expense)	(\$0.55)	\$5.00	(\$5.55)	-100.0%	(\$2.88)	\$4.95	(\$7.83)	-100.0%
Net Income/(Loss)	(\$36.72)	\$9.83	(\$46.55)	-100.0%	(\$11.42)	\$4.40	(\$15.83)	-100.0%
MLR	103.0%	93.1%			97.0%	94.6%		
ALR	5.2%	5.8%			4.9%	5.6%		
Operating Income %	-8.1%	1.1%			-1.9%	-0.1%		
Net Income %	-8.3%	2.2%			-2.6%	1.0%		

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

**Other Medical includes Pharmacy and IHSS.



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

	MTD	YTD
Net Income	(\$15,675)	(\$19,682)
Items not requiring the use of cash: Depreciation	645	1,283
Adjustments to reconcile Net Income to Net Cash provided by operating activities:		
Changes to Assets:		
Restricted Cash	0	0
Receivables	2,506	3,523
Prepaid Expenses	(305)	(680)
Current Assets	(536)	2,206
Subscription Asset net Accum Depr	0	0
Net Changes to Assets	1,664	5,049
Changes to Payables:		
Accounts Payable	(124,861)	(114,895)
Other Current Liabilities	631	2,313
Incurred But Not Reported Claims/Claims Payable	(225,961)	(140,935)
Provider Incentives Payable	(9,200)	(3,677)
Due to State	0	(70,377)
Subscription Liabilities	0	0
Net Changes to Payables	(359,392)	(327,570)
Net Cash Provided by (Used in) Operating Activities	(372,757)	(340,921)
Change in Investments	(1,995)	(4,701)
Other Equipment Acquisitions	(178)	(832)
Net Cash Provided by (Used in) Investing Activities	(2,173)	(5,534)
Deferred Inflow of Resources	0	0
Net Cash Provided by (Used in) Financing Activities	0	0
Net Increase (Decrease) in Cash & Cash Equivalents	(374,930)	(346,455)
Cash & Cash Equivalents at Beginning of Period	504,123	394,722
Cash & Cash Equivalents at April 30, 2026	\$131,774	\$131,774



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

Meeting Minutes

Wednesday, May 27, 2026

3:00 p.m. – 5:00 p.m.

In Santa Cruz County:

Central California Alliance for Health
1600 Green Hills Road, Suite 101, Scotts Valley, California

In Monterey County:

Central California Alliance for Health
950 East Blanco Road, Suite 101, Salinas, California

In Merced County:

Central California Alliance for Health
530 West 16th Street, Suite B, Merced, California

In San Benito County:

San Benito County Health and Human Services Agency
1111 San Felipe Road, Building B, Hollister, CA

In Mariposa County:

Mariposa County Health and Human Services
5362 Lemee Lane, Mariposa, California

Commissioners Present:

Ms. Leslie Abasta-Cummings
Ms. Anita Aguirre
Ms. Tracey Belton
Dr. Maximiliano Cuevas
Dr. Donald Hernandez
Ms. Katrina Hodges
Supervisor Kim De Serpa
Dr. Kristina Keheley
Mr. Michael Molesky
Ms. Connie Moreno-Peraza

At Large Health Care Provider Representative
At Large Health Care Provider Representative
County Health and Human Services Agency
Health Care Provider Representative
Health Care Provider Representative
Public Representative
County Board of Supervisor
County Health Department Representative
Public Representative
County Health Department Representative

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Supervisor Josh Pedrozo
Dr. Allen Radner
Dr. Kristynn Sullivan
Mr. Ye Thao

County Board of Supervisor
At Large Health Care Provider Representative
County Health Department Representative
Public Representative

Commissioners Absent:

Dr. Ralph Armstrong
Supervisor Wendy Root Askew
Ms. Elsa Jimenez
Dr. James Rabago

At Large Health Care Provider Representative
County Board of Supervisor
County Director of Health Service
Health Care Provider Representative

Staff Present:

Mr. Michael Schrader
Ms. Jenifer Mandella
Mr. Cecil Newton
Ms. Van Wong
Dr. Mike Wang
Ms. Anne Brereton
Ms. Hayley Tut
Ms. Trisha Lizarraga
Mr. Jimmy Ho

Chief Executive Officer
Chief Compliance Officer
Chief Information Officer
Chief Operating Officer
Chief Medical Officers
Deputy County Counsel, Monterey County
Clerk of the Board
Admin Specialist
Accounting Director

1. Call to Order by Chair Pedrozo.

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

Roll call was taken and a quorum was present.

There were no supplements or deletions to the agenda.

2. Oral Communications.

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

There was no public comment.

3. Comments and announcements by Commission members.

Chair Pedrozo opened the floor for Commissioners to make comments.

There was no comment.

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

Mr. Michael Schrader, CEO, reported the following updates:

At the request of U.S. Senator Alex Padilla's office, he and Government Affairs Director Danita Carlson met with the Senator's District Director and Senior Advisor. They presented the local impacts of HR1 across our five counties. Key topics included declining Medi-Cal enrollment, the potential carveout of members with unsatisfactory immigration status, uncompensated care, distressed hospitals, impacts on FQHC clinics, and county indigent care programs. We also described the Alliance's efforts related to member outreach and renewals, advances for distressed hospitals, and grants supporting physician recruitment. As a result of that initial meeting, the Senator's office requested that we provide an HR1 overview for his entire California team. This follow-up briefing took place on May 20, 2026.

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

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

ACTION: The motion passed with the following vote:

:

Ayes: Commissioners Belton, Cuevas, Hodges, Keheley, Molesky, Moreno-Peraza, Pedrozo, Radner, Sullivan and Thao

Noes: None.

Absent: Commissioners Abasta Cummings, Aguirre, Armstrong, Askew, De Serpa, Hernandez, Jimenez, and Rabago

Abstain: None.

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

10. Alliance's Audited Financial Statements ending December 31, 2025. 3:08 p.m.

Ms. Rianne Suico, from Baker Tilly, presented the audited financial statements for the Alliance's fiscal year ending December 31, 2025, detailing audit procedures, findings, and confirming an unmodified opinion.

Ms. Suico introduced the Baker Tilly audit team, explained the merger with Moss Adams, and outlined the objectives and scope of the audit, including the review of financial statements, internal controls, and compliance with governmental accounting standards.

The audit confirmed the accuracy of cash balances, investments, capital assets, and receivables, with no issues found in reconciliations or compliance with accounting principles; a new risk corridor receivable was noted for 2025, and all other assets remained consistent with prior years.

The audit reviewed medical claims liability, provider incentives, and premium taxes payable, confirming management's estimates were reasonable and supported by data, with a look-back analysis showing actual payouts closely matched estimates.

The Alliance's revenues increased by 10% due to favorable state rate increases, a decline in T&E (tangible and equity) was observed due to higher medical expenses which is consistent with statewide trends. The Alliance continues to maintain compliance with required TNE levels.

No audit adjustments or disagreements with management were reported, and no material instances of fraud or non-compliance were found.

A discussion ensued among Commissioners.

MOTION: Commissioner Cuevas moved to approve the staff recommendation to accept the third-party financial audit seconded by Commissioner De Serpa.

ACTION: The motion passed with the following vote:

Ayes: Commissioners, Abasta Cummings, Aguirre, Armstrong, Cuevas, De Serpa, Hodges, Hernandez, Keheley, Molesky, Moreno-Peraza, Pedrozo, Radner, Sullivan and Thao

Noes: None.

Absent: Commissioners Armstrong, Askew, Jimenez, and Rabago

Abstain: None.

[Commissioner De Serpa arrived at 3:08pm]
[Commissioner Hernandez arrived at 3:08pm]
[Commissioner Aguirre arrived at 3:08pm]
[Commissioner Abasta-Cummings arrived at 3:09pm]

12. State Budget May Revise and Impact on Alliance Membership and Workforce. 3:25 p.m.

Mr. Michael Schrader, CEO, provided an in-depth update on the May revision of the state budget, focusing on the proposed carve-outs, projected membership declines, workforce planning, advocacy efforts, and ongoing negotiations with the state.

The May revision proposes carving out qualified non-citizens and members with unsatisfactory immigration status from managed care plans. These abrupt membership reductions, combined with the gradual decline associated with HR1 changes, are projected to result in a 25% drop in Alliance Medi-Cal membership by January 1, 2027 and a 39% decline by the end of 2028.

The Alliance has already begun reducing workforce by eliminating vacant and temporary positions, targeting a 5.4% reduction in CY2026, and is considering a voluntary separation program with severance in early 2027 to further align staffing with declining membership.

Staff have advocated opposition to the two carve-outs in meeting with the offices of state legislators, including Speaker Robert Rivas, Senator John Laird, and Assemblymember Dawn Addis. In parallel with our local Alliance advocacy, other local plans and the Local Health Plans of California have arranged testimony at public budget hearings, met with elected officials, and initiated a letter of coalition. The coalition includes the California Medical Association, California Association of Public Hospitals, California Primary Care Association, and the California Association of Health Plans.

Further, local plans, including the Alliance, have been developing an alternative to the carve-out proposal through the Local Health Plans of California. DHCS shared that any proposal must meet three criteria: 1) It must be implementable by January 1, 2027; 2) It must comply with CMS Guidance; and 3) It must not erode the May Revision savings attributed to the carveout.

A discussion ensued among Commissioners.

11. Second Opinion on Alliance Investment in Property. 4:08 p.m.

Attorneys John Puente and Jeremy Avila from Epstein Becker Green, at the request of the board, presented a second legal opinion confirming that California law prohibits the Alliance from purchasing real estate for investment purposes, except under strict criteria for immediate operational need, and outlined the legal and compliance considerations for any property acquisition.

Counsel affirmed that certain public agencies in California such as the Alliance may not purchase real estate as an investment vehicle but may do so under a high bar of immediate operational need, subject to public process and policy revision. Any property acquisition would require ongoing legal compliance efforts, including adherence to healthcare laws and fraud, waste, and abuse regulations, with the potential for state and federal review, especially in the current regulatory environment.

It was clarified that there is no current proposal to purchase property; the legal opinions were sought to answer a general question about the permissibility of investing reserves in real estate, and the discussion was informational only.

A discussion ensued among Commissioners.

13. Enhanced Care Management (ECM) Program Update and State Guidance. 4:25 p.m.

Dr. Mike Wang, Chief Medical and Health Equity Officer, provided an update on the Alliance's ECM program, detailing new state clarifications that require reduced enrollment and increased encounters, the Alliance's planned adjustments, financial impacts, and responses to commissioner questions about provider network and program quality.

The Department of Health Care Services (DHCS) clarified that ECM enrollment should be around 1-3% of total membership with 3 or more encounters per month, whereas the Alliance currently enrolls 6.6% of members with an average of 1.79 encounters, making the program both 'broad and shallow' by state standards. The Alliance has implemented new referral assessments, plans to disenroll low- and medium-risk members, continues network management and care plan audits, and will propose switching from a case rate to a fee-for-service payment structure for ECM providers in 2027.

The ECM program is significantly over budget, with a \$16 million loss projected for Q1 2026 and total program losses in the hundreds of millions, partially offset by a state risk corridor that is expected to end after the current year.

It was confirmed that members with unsatisfactory immigration status (UIS) will lose eligibility for ECM and community support under the May revise, and the Alliance will continue to manage care for D-SNP and other populations as appropriate.

A discussion ensued among Commissioners.

The Commission adjourned its meeting of May 27, 2026, at 4:48 p.m. to the regular meeting of June 24, 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.

COMPLIANCE COMMITTEE



Meeting Minutes
Wednesday, May 6, 2026
9:00 – 10:00 a.m.

Via Videoconference

Committee Members Present:

Cecil Newton	Chief Information Officer
Danita Carlson	Government Relations Director
Jenifer Mandella (chair)	Chief Compliance Officer
Lisa Ba	Chief Financial Officer
Michael Wang	Chief Medical Officer
Ryan Markley	Compliance Director
Scott Fortner	Chief Administrative Officer
Tammy Brass	Health Services Executive Director
Van Wong	Chief Operating Officer

Committee Members Excused:

Anita Guevin	Medicare Compliance Program Manager
Jill Drake	Compliance Manager
Michael Schrader	Chief Executive Officer
Scott Crawford	Medicare Program Executive Director

Staff Present:

Deanna Weatherly	Medicare Sales Director
Navneet Sachdeva	Pharmacy Director
Rebecca Seligman	Program Integrity Manager

1. Call to Order by Chair Mandella.

Chairperson Jenifer Mandella called the meeting to order at 9:02 a.m.
A quorum was present.

Consent Agenda

- 2. Approve Minutes of 04/01/2026 Committee Meeting**
- 3. Regulatory Affairs Snapshot**
- 4. Program Integrity Snapshot**
- 5. Approve Policy 105-0002 – Compliance Committee Operations**

Markley commented that the new policy details expectations for reporting, risk triggers and committee procedures and stating that the policy will be distributed to directors to ensure everyone is aligned on expectations.

ACTION: Committee reviewed and approved items 2-5 of the Consent Agenda with 9 Ayes and 0 Noes.

6. Follow-up on Action Items

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

- Crawford to schedule meeting with Guevin to review existing DSNP related reports for identification in compliance monitoring.
 - UPDATE: No update; Crawford and Guevin excused. Crawford and Guevin to provide written update to Committee prior to June meeting.
- Drake to investigate and clarify where Pharmacy Part D and Part B authorizations fall on high-medium-low grid.
 - RESOLUTION: Compliance staff were unable to provide immediate answer due to Drake's absence. Markley committed to following up with Sachdeva. Drake to present Pharmacy Part D and B to Leadership on 5/11/26.
 - Sachdeva confirmed that Drake is scheduled to present on Pharmacy Part D and Part B authorizations to leadership on 5/11/26.
- Inlow and workgroup to continue data gathering and solution formulation and report updates back to Committee.
 - UPDATE: Brass updated the group on the KP printing issue, explaining that staff are seeking guidance from CMS regarding whether verbal notification can extend the mail-out timeline for required 24-hour member notices. Brass noted that there is a current process in place for meeting the requirement and indicated that the workgroup is considering both immediate and long-term solutions for weekend mailings dependent on CMS guidance.
 - ACTION: Brass and workgroup to provide update to the Committee at key intervals when resolution plan is defined and when additional support and prioritization is needed
- Compliance to distribute Risk and Audit Work Plan presentation and report materials to Committee.
 - RESOLUTION: Presentation and report materials were distributed on 4/2/26.

Regular Agenda

7. Compliance Quarterly Report

Agenda item deferred to June 2026 meeting. Markley reported to the Committee that there are approximately 20 overdue Delegate Oversight Credentialing reviews spanning multiple quarters and indicated the need to impose a Corrective Action Plan (CAP) to ensure prioritization of the work and completion of the outstanding reviews within 30 days.

ACTION: Markley to issue CAP to Compliance and Provider Services to resolve overdue Delegate Oversight credentialing reviews within the next 30 days and report back at the June meeting.

10. Department Risk Reporting

DSNP Sales Grievance Volume

Weatherly, Medicare Sales Director, provided a comprehensive overview of the recent increase in sales grievances related to provider choice.

Weatherly reviewed root causes, including agent knowledge gaps and a lack of visibility of sales agents into provider participation and associated member assignment. As a result, sales staff were attempting to enroll beneficiaries whose PCPs declined to contract for TotalCare. Sales agents now have access to provider participation data, helping them to better serve members and target marketing campaigns.

Brass and Weatherly discussed working closely with Care Management team to coordinate continuity of care for members with out-of-network providers and the group discussed the need for improved access to member data - including medication lists - to streamline the process and reduce member impact and associated dissatisfaction.

Mandella and Seligman reviewed the current grievance volumes, noting that while there was an initial spike in sales-related grievances, recent trends show a decrease. The Committee discussed the importance of ongoing monitoring, internal feedback loops and proactive communication with Account Managers.

The Committee further discussed the need for updates and alignment of sales scripts and processes with commitments to collaborate on script revisions, clarify Compliance involvement and to ensure consistent member communication.

ACTION: Seligman to prepare policy edits to clarify Compliance and Program Integrity involvement in call monitoring and script review.

- ACTION: Weatherly to collaborate with Seligman, Wang and Chagolla to review and update sales scripts related to processes for clarity, compliance and member-friendliness.
- ACTION: Seligman to prepare Compliance policy edits to clarify Compliance and Program Integrity involvement in call monitoring and script review.

11. Wrap Up and Assignments

Mandella summarized action items as follows:

- Context – New policy 105-0002 – Compliance Committee Operations
 - Markley to submit policy for publication and distribute to Directors.
- Context – follow up from January 2026 Committee Action Item "Mandella to follow up with Crawford and relevant teams to identify opportunities to leverage existing operational reports to enable the review of high impact D-SNP functions prior to full dashboard automation."
 - Crawford and Guevin to provide written update to Committee prior to June meeting.
- Context – Risk Assessment
 - Action addressed; Drake to present Pharmacy Part D and B to Leadership on 5/11/26.
- Context – Vendor printing and mailing timeliness issues

- Brass and workgroup to provide update to the Committee at key intervals when resolution plan is defined and when additional support and prioritization is needed.
- Context – Delegate Oversight Corrective Action Plan
 - Markley to implement CAP to Compliance and Provider Services to resolve overdue Delegate Oversight credentialing reviews within the next 30 days and report back at the June meeting.
- Context – PHI Access for Sales team
 - Weatherly to connect with Markley to discuss and resolve the specifics of PHI access needed by sales team.
- Context – D-SNP Sales Grievance Volume
 - Seligman to prepare Compliance policy edits to clarify Compliance and Program Integrity involvement in call monitoring and script review.
- Context – Sales Scripts and Process Improvement
 - Weatherly to collaborate with Seligman, Wang and Chagolla to review and update sales scripts related to processes for clarity, compliance and member-friendliness.
- Context – Grievance Volume Analysis
 - Mandella and Compliance staff to conduct an analysis of sales-related grievance volume and notify the account manager of ongoing investigation.

The meeting adjourned at 9:43 a.m.

Respectfully submitted,
Robin Sihler
Compliance Administrative and Data Reporting Assistant



Meeting Minutes

Thursday, November 6, 2025

In San Benito County:

Community Services & Workforce Development – Conference Room
1161 San Felipe Road, Building B, Hollister, CA. 95023

In Santa Cruz County:

Central California Alliance for Health – Board Room
1600 Green Hills Road, Suite 101, Scotts Valley, CA, 95066

In Mariposa County:

Mariposa County Health and Human Services – Mariposa Room
5362 Lemee Lane, Mariposa, CA 95338

In Merced County:

Central California Alliance for Health – Board Room
530 West 16th Street, Suite B, Merced, CA 95340

In Monterey County:

Central California Alliance for Health – Board Room
950 East Blanco Road, Suite 101, Salinas, CA 93901

Members Present:

Aluriel Ceballos	Community Advocate
Candi Walker	Consumer
Doris Drost	Consumer
Frances Wong	Consumer
Guadalupe Barajas-Iniguez	Consumer Advocate
Janna Espinoza	Consumer
John Beleutz	Community Advocate
Mimi Park	Consumer
Moncerat Politron	Community Advocate
Stephanie Auld	Consumer

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Members Absent:

Adriana Zoghiami	Community Advocate
Carolina Meraz	Consumer
Humberto Carrillo	Consumer
Jamie Berry	Consumer
John Alexander	Community Advocate
Michael Molesky	Consumer, Commissioner
Rebekah Capron	Community Advocate

Staff Present:

Adourin Malco	Community Engagement Specialist
Alissa Gil	Provider Network Development Manager
Clarisa Gutierrez	Community Engagement Coordinator
Elvia Contreras	Call Center Quality Analyst
Gabriela Chavez	Community Engagement Manager
Jessica Finney	Community Grants Director
Jim Lyons	Provider Relations Manager
Kayla Zoliniak	Administrative Specialist
Kevin Lopez	Program Advisor – Quality and Health Programs
Maria Elena Villalobos	Administrative Specialist
Ronita Margain	Community Engagement Director
Sylvia Gutierrez	Provider Network Development Specialist
Ulises Cisneros-Abrego	Community Engagement Specialist

1. Call to Order by Chairperson Beleutz.

Chairperson Beleutz called the meeting to order at 10:01 a.m.

Roll call was taken and a quorum was present.

There were no supplements or deletions to the agenda.

2. Oral Communications.

Chairperson Beleutz opened the floor for any members of the public to address the Advisory Group on items not listed on the agenda. There was no public comment.

3. Comments and announcements by Member Services Advisory Group members.

Advisory Group member inquired about the Appeals and Grievance Report.

Advisory Group member inquired about medical necessity policy.

Advisory Group member commented about emergency preparedness.

Advisory Group member commented about the Medi-Cal change in eligibility.

4. Comments and Announcements by Plan Staff.

R. Margain, Community Engagement Director, announced Dr. Mike Wang as the Alliance's new Chief Medical Officer.

R. Margain, Community Engagement Director announced the launch of the Alliance's TotalCare (HMO D-SNP) Medicare Advantage Dual Special Needs Plan.

Consent Agenda Items:

5. – 6. Consent Agenda Items

Chairperson Beleutz opened the floor for approval of the consent agenda.

Action: Consent agenda items were approved.

Regular Agenda Items:

7. Community Health Assessment and Community Health Improvement Plan

J. Finney, Community Grants Director, provided an overview of Community Health Assessment and Community Health Improvement Plan and solicited feedback.

Advisory Group members recommended data sharing between healthcare providers and facilities, mental health access, and member navigation as priorities.

Advisory Group member stated there are individuals who don't know how or are afraid to call or seek help.

8. Community Reinvestments

J. Finney, Community Grants Director, provided an overview of Community Reinvestment and solicited feedback. J. Finney verbally updated the grantmaking priorities for 2026 slide to pull out Community Engagement through Community Health Workers (CHWs) as a top-level priority and CHWs will be utilized to help address behavioral health and parent education.

Advisory Group member inquired about support or funding for IHSS (in-home support services) recipient training. Community-based organizations, but not individuals, can apply for grant funding.

Advisory Group member inquired about cultural and linguistic competent care as a priority in 2026. J. Finney confirmed that culturally and linguistically appropriate care will continue as a priority.

Advisory Group member stated caregiver training classes are available online through Del Mar Resource Center and other resource centers throughout the state.

Advisory Group member recommended presenting about the Alliance to local college and nursing programs.

Advisory Group member recommended considering cultural barriers to accessing care and to promote accessing preventative care.

Advisory Group member recommended reviewing emerging issues such as youth mental health related to technology and bullying.

Advisory Group member inquired about the Alliance's participation in local politics. J. Finney stated that the Alliance is not involved in local politics.

9. Provider Services

J. Lyons, Provider Relations Manager, provided an overview of Provider Services and solicited feedback.

Advisory Group member recommended self-advocacy support. The Alliance's Member Services supports members.

Advisory Group member shared their provider did not receive notice of no longer being eligible for payment for services. Advisory Group member recommended sharing the need for provider outreach and training, especially for behavioral health providers, with the Alliance's Board.

Advisory Group member recommended alternative medicine for preventative care.

Advisory Group member inquired about grants or coverage, potentially as preventative care, for legal resources such as during disputes.

10. Medi-Cal Enrollment and Eligibility Changes

R. Margain, Community Engagement Director, provided an overview of upcoming Medi-Cal enrollment and eligibility changes and solicited feedback.

Advisory Group member expressed difficulty with the text messages that include links due to not having a smart phone.

Advisory Group member recommended banners and local news in Spanish and English and banners.

Advisory Group member recommended links to add redetermination dates as an appointment on calendar.

Advisory Group member expressed difficulty with renewal due to address being split between two counties and cautioned other members may be experiencing the same delay.

Advisory Group members expressed appreciation for the proactive approach and the outreach team.

Adjourn:

The meeting adjourned at 11:27 a.m.

The meeting minutes are respectfully submitted by Kayla Zoliniak, Community Engagement Administrative Specialist.

Next Meeting: Thursday, February 12, 2026.



Meeting Minutes

Thursday, February 12, 2026

10 – 11:30 a.m.

In San Benito County:

Community Services & Workforce Development
1161 San Felipe Road, Building B, Hollister, CA. 95023

In Santa Cruz County:

Central California Alliance for Health
1600 Green Hills Road, Suite 101, Scotts Valley, CA, 95066

In Mariposa County:

Mariposa County Health and Human Services
5362 Lemee Lane, Mariposa, CA 95338

In Merced County:

Central California Alliance for Health
530 West 16th Street, Suite B, Merced, CA 95340

In Monterey County:

Central California Alliance for Health
950 East Blanco Road, Suite 101, Salinas, CA 93901

Members Present:

Adriana Zoghiami	Community Advocate
Doris Drost	Consumer
Frances Wong	Consumer
Guadalupe Barajas-Iniguez	Consumer Advocate
Janna Espinoza	Consumer
John Beleutz	Community Advocate
Moncerat Politron	Community Advocate
Stephanie Auld	Consumer

Members Absent:

Aluriel Ceballos	Community Advocate
Candi Walker	Consumer

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Carolina Meraz	Consumer
Jamie Berry	Consumer
John Alexander	Community Advocate
Michael Molesky	Consumer, Commissioner
Mimi Park	Consumer
Rebekah Capron	Community Advocate

Staff Present:

Adourin Malco	Community Engagement Specialist
Clarisa Gutierrez	Community Engagement Coordinator
Desirre Herrera	Quality and Health Programs Manager
Elvia Contreras	Call Center Quality Analyst
Elvia Contreras	Call Center Quality Analyst
Gabriela Chavez	Community Engagement Manager
Kayla Zoliniak	Administrative Specialist
Ronita Margain	Community Engagement Director
Sarina King	Quality and Performance Improvement Manager
Sonia Menjivar	Call Center Quality Analyst
Ulises Cisneros-Abrego	Community Engagement Specialist

1. Call to Order by Chairperson Beleutz.

Chairperson Beleutz called the meeting to order at 10:00 a.m.

Roll call was taken and a quorum was not present.

There were no supplements or deletions to the agenda.

2. Oral Communications.

Chairperson Beleutz opened the floor for any members of the public to address the Advisory Group on items not listed on the agenda. There was no public comment.

3. Comments and announcements by Member Services Advisory Group members.

Advisory Group member shared on behalf of another family who expressed difficulty accessing ABA therapy for children over the age of ten years old.

Advisory Group member shared about limited eyewear vendors and options.

4. Comments and Announcements by Plan Staff.

R. Margain, Community Engagement Director, announced the Alliance is celebrating thirty years of serving our local communities and thanked Advisory Group members for their partnership and sharing in the vision of healthy people, healthy communities.

R. Margain, Community Engagement Director, announced the Alliance participated in over 150 outreach events in 2025.

R. Margain, Community Engagement Director, announced the Alliance recently launched a new Dual Eligible Special Needs Plan (D-SNP) program called TotalCare. The Alliance will be welcoming no more than four TotalCare enrollees to the Member Services Advisory Group.

Consent Agenda Items (5. – 6.)

Quorum was not met and no action was taken.

Regular Agenda Items:**7. Member Survey Results**

S. King, Quality and Performance Improvement Manager, provided an overview and solicited feedback on member survey results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS).

Advisory Group members recommended provider training on interacting with patients with a support person present at the appointment.

Advisory Group member recommended provider training on receiving patient feedback and grievances about provider support staff without bias.

Advisory Group member recommended provider training on communicating with patients in an appropriate manner.

Advisory Group member recommended providers review patient interactions and encounters, or lack thereof, for potential concerns.

Advisory Group member recommended provider training on interacting with Medi-Cal members in an appropriate manner.

Advisory Group member recommended provider training on patient communication and rapport, specifically including setting a clear and accurate expectation of how long the patient has to communicate with the doctor.

Advisory Group member commented on the provider shortage and shared in Santa Cruz County, the wait time for an appointment is at least one month but up to three months.

Advisory Group member commented on the importance of transportation for rural, disabled, and low-income populations and shared in Santa Cruz County, many doctors are in San Jose. For wheelchair transportation from Santa Cruz to San Jose is \$14 and two hours each way.

Advisory Group member recommended patients receiving substance use treatment are informed of mental and physical health support, especially as symptoms may arise through the treatment process.

Advisory Group member recommended provider training on services and benefits available to support sharing with patients.

Advisory Group member recommended member training, such as an article in the member newsletter, on preparing for a doctor's visit including writing a list to provide to the doctor or office support staff. Advisory Group member commented doctors only allowed topics provided at check-in to be discussed during the appointment.

Advisory Group member recommended provider training on holistic views of patients and treating patients with respect. Advisory Group member commented doctor made assumptions based on prescriptions without considering context.

8. Alliance Health Education Programs

D. Herrera, Quality and Health Programs Manager, provided an overview and solicited feedback on health education programs.

Advisory Group members asked clarifying questions about the program benefits and Alliance staff provided answers. Members should contact Member Services or the Health Education Line for more information.

Advisory Group member recommended Enhanced Care Management (ECM) provider training on the health education programs.

Advisory Group member recommended health education programs focus on the patient and patient empowerment.

Advisory Group member praised the expansion of the health education program.

Advisory Group member asked about outbound calls and support outside of the health education programs, especially for new parents with a child in the NICU as children in the NICU likely do not qualify for California Children's Services Whole Child Model program yet. Alliance staff shared about the new mom text campaign that includes links to the Healthy Moms, Healthy Babies program and the well check schedule.

Advisory Group member praised the use of QR codes.

Health Education staff can provide physical or digital copies of flyers if requested.

Advisory Group member recommended community workshops to provide information about TotalCare including requirements, enrollment, and benefits. The Advisory Group member shared their organization received many individuals who were confused about TotalCare.

Advisory Group member recommended accounting for literacy and technology proficiency when creating communication materials. Advisory Group member recommended alternative methods to engage members such as staff and providers talking about the programs.

Advisory Group member recommended asking previous participants to share about the program by word of mouth and flyers.

Advisory Group member recommended the consideration of using AI to create an audio format of the member newsletter to increase accessibility.

Advisory Group member recommended the doctor office announcement loop channel.

Adjourn:

Advisory Group members recommended TotalCare, addiction and housing, and Call the Car and transportation as future agenda items.

The meeting adjourned at 11:22 a.m.

The meeting minutes are respectfully submitted by Kayla Zoloniak, Community Engagement Administrative Specialist.

Next Meeting: Thursday, May 14, 2026.



DATE: June 24, 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

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 indicated interest in continuing participation on MSAG.

Name	Affiliation	County
Caroline Meraz	Consumer	Merced

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

Attachments. N/A

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DATE: June 24, 2026
TO: Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission
FROM: Danita Carlson, Government Relations Director
SUBJECT: 2026 Legislation and Bill List

Recommendation. This report is informational only.

Background. Each legislative session staff collaborate with health plan associations, including the Local Health Plans of California (LHPC) and California Association of Health Plans (CAHP) as well as the Alliance's legislative advocates in Sacramento, Edelstein, Gilbert, Robson and Smith (EGRS) to identify, review and monitor State legislation in the following areas of focus as adopted by the board:

- Access to Care
- Local Innovation
- Eligibility and Benefits
- Financing and Rates
- Health Equity
- Person Centered Delivery System Transformation

Bills in these categories are compiled into a bill list that staff monitor throughout the legislative session. Staff provide updates to the board at its regular board meetings and as needed.

Discussion The Legislature has entered the second year of its two-year session. With the house-of-origin deadline now passed, legislative activity is focused on consideration of bills in the second house. The final deadline for the Legislature to pass bills and send them to the Governor is August 31.

Staff has developed a bill list, which is attached, that includes approximately one-hundred-seven (107) bills in the above categories.

Staff will closely monitor bills for any amendments or changes that may be of significance to the Alliance and will work with our associations and representatives in Sacramento to discuss any areas of interest or concern.

Fiscal Impact The is no fiscal impact.

Attachments. Central California Alliance for Health 2026 Bill List

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Central California Alliance for Health 2026 Bill List

Assembly Bills	
<p>AB 54 Krell (D)</p> <p>Status: Ordered to inactive file at the request of Senator Umberg</p> <p>Position: Watch/Study</p>	<p>Access to Safe Abortion Care Act</p> <p>Summary: Existing law sets forth provisions under the California Constitution, regarding the fundamental right to choose to have an abortion. Existing law, the Reproductive Privacy Act, prohibits the state from denying or interfering with a pregnant person's right to choose or obtain an abortion prior to viability of the fetus, or when the abortion is necessary to protect the life or health of the pregnant person. This bill, the Access to Safe Abortion Care Act, would make legislative findings about medication abortion, with a focus on use of the drugs mifepristone and misoprostol. Under the bill, the Legislature would reaffirm that it has been, and would continue to be, lawful to cause the delivery of, or mail, ship, take, receive, or otherwise transport, any drug, medicine, or instrument that can be designed or adapted to produce an abortion that is lawful in the State of California. The bill would set forth provisions regarding the lack of civil or criminal liability, or professional disciplinary action, for accessing or administering brand name or generic mifepristone or any drug used for medication abortion that is lawful under the laws of the state, on or after January 1, 2020, with this provision applied retroactively, as specified. The bill would make its provisions severable.</p>
<p>AB 96 Jackson (D)</p> <p>Status: 05/06/2026 Referred to Com on Health</p> <p>Position: Watch/Study</p>	<p>Community Health Workers</p> <p>Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income persons receive health care benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law establishes a schedule of benefits under the Medi-Cal program and provides for various services, including behavioral and mental health services that are rendered by Medi-Cal enrolled providers. Existing law authorizes a county, or an agency representing the county, to develop a peer support specialist certification program, subject to department approval. Existing law imposes specified requirements on applicants for certification as a peer support specialist, including that the applicant be at least 18 years of age and possess a high school diploma or equivalent degree. This bill would remove the requirement of possessing a high school diploma or equivalent degree from the requirements necessary for an applicant to receive certification.</p>
<p>AB 220 Jackson (D)</p> <p>Status: 09/04/2025- In Senate. Held at desk.</p> <p>Position: Watch/Study</p>	<p>Medi-Cal Subacute Care Services</p> <p>Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law requires the department to establish a subacute care program in health facilities, as specified, to be available to patients in health facilities who meet subacute care criteria. Existing law requires that medical necessity for pediatric subacute care be substantiated by specified conditions. Existing regulations require a treatment authorization request for each admission to a subacute unit. This bill would require a provider seeking authorization for pediatric subacute or adult subacute care services pursuant to these provisions to submit with a treatment authorization request, including an electronic treatment authorization request, a specified</p>

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	<p>form when requesting authorization for subacute care services. The bill would prohibit a Medi-Cal managed care plan from developing or using its own criteria to substantiate medical necessity for pediatric subacute or adult subacute care services with a condition or standard not enumerated in those forms. The bill would prohibit a Medi-Cal managed care plan from requiring a subsequent treatment authorization request upon a patient's return from a bed hold for acute hospitalization. The bill would authorize the department to impose sanctions on Medi-Cal managed care plans for violations of these provisions, as specified</p>
<p>AB 280 Aguiar-Curry (D)</p> <p>Status: 09/08/2025: Ordered to inactive file at the request of Senator Durazo.</p> <p>Position: LHPC Oppose</p>	<p>Health care coverage: provider directories</p> <p>Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan and a health insurer that contracts with providers for alternative rates of payment to publish and maintain a provider directory or directories with information on contracting providers that deliver health care services enrollees or insureds, and requires a health care service plan and health insurer to regularly update its printed and online provider directory or directories, as specified. Existing law authorizes the departments to require a plan or insurer to provide coverage for all covered health care services provided to an enrollee or insured who reasonably relied on materially inaccurate, incomplete, or misleading information contained in a plan's or insurer's provider directory or directories. This bill would require a plan or insurer to annually verify and delete inaccurate listings from its provider directories, and would require a provider directory to be 60% accurate on July 1, 2026, with increasing required percentage accuracy benchmarks to be met each year until the directories are 95% accurate on or before July 1, 2029. The bill would subject a plan or insurer to administrative penalties for failure to meet the prescribed benchmarks. The bill would require a plan or insurer to provide coverage for all covered health care services provided to an enrollee or insured who reasonably relied on inaccurate, incomplete, or misleading information contained in a health plan or policy's provider directory or directories and to reimburse the provider the out-of-network amount for those services. The bill would prohibit a provider from collecting an additional amount from an enrollee or insured other than the applicable in-network cost sharing, which would count toward the in-network deductible and out of pocket maximum. The bill would require a plan or insurer to provide information about in-network providers to enrollees and insureds upon request, including whether the provider is accepting new patients at the time, and would limit the cost-sharing amounts an enrollee or insured is required to pay for services from those providers under specified circumstances. The bill would require the health care service plan or the insurer, as applicable, to ensure the accuracy of a request to add back a provider who was previously removed from a directory and approve the request within 10 business days of receipt, if accurate. The bill would authorize a health care service plan or insurer to include a specified statement in the provider listing before removing the provider from the directory if the provider does not respond within 5 calendar days of the plan or insurer's annual notification. Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.</p>
<p>AB 350 Bonta (D)</p> <p>Status: 05/14/2026. Read second time. Ordered to third reading.</p>	<p>Health care coverage: fluoride treatments</p> <p>Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law sets forth specified coverage requirements for health care service plan contracts and health insurance policies.</p>

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<p>Position: Watch/Study</p>	<p>Existing law requires an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2017, to include, at a minimum, coverage for essential health benefits pursuant to the federal Patient Protection and Affordable Care Act. Existing law requires an essential health benefit to be provided only to the extent that federal law does not require the state to defray the costs of the benefit. This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2027, that provides coverage for the application of fluoride varnish as a pediatric oral care benefit to provide coverage without cost sharing for the application of fluoride varnish as medically necessary regardless of whether the service is billed as a dental benefit or as a medical benefit, except as specified. If this coverage requirement creates an obligation for the state to defray costs for an individual, the bill would not require coverage unless there is an appropriation for this purpose, as specified. Because a willful violation of this provision by a health care service plan would be a crime, the bill would impose a state-mandated local program.</p>
<p>AB 408 Berman (D)</p> <p>Status: 09/22/2025 In Committee. Hearing cancelled at request of the author</p> <p>Position: Watch/Study</p>	<p>Physician Health and Wellness Program.</p> <p>Summary: Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons and licensed midwives by the Medical Board of California. A violation of the act is a crime. Existing law authorizes the board to establish a Physician and Surgeon Health and Wellness Program to support a physician and surgeon in their rehabilitation from substance abuse to ensure the physician and surgeon remains able to practice medicine in a manner that will not endanger the public health and safety and that will maintain the integrity of the medical profession. Existing law requires the board to contract with a third party for the program's administration in accordance with specified provisions of the Public Contract Code. Existing law provides that participation in the program shall not be a defense to any disciplinary action that may be taken by the board. Existing law requires the program to comply with the Uniform Standards Regarding Substance-Abusing Healing Arts Licensees adopted by the Substance Abuse Coordination Committee of the Department of Consumer Affairs. Existing law establishes the Physician and Surgeon Health and Wellness Program Account in the Contingent Fund of the Medical Board of California for the support of the program. This bill would revise and recast those provisions and would instead authorize the board to establish a Physician Health and Wellness Program to support, treat, monitor, and rehabilitate physicians and surgeons and other professionals licensed by the board with impairing physical and mental health conditions that may impact their ability to practice their profession in a reasonably safe, competent, and professional manner. The bill would require the administering entity to be a nonprofit entity and would require the contract with the administering entity to include procedures on specified topics. The bill would exempt the program from the Uniform Standards Regarding Substance-Abusing Healing Arts Licensees. The bill would exempt program records relating to current or former program participants from disclosure under the California Public Records Act, except as specified. The bill would authorize the board to establish advisory committees to assist in carrying out the duties of the administering entity and would establish duties and responsibilities authorized to be performed by a committee. The bill would rename the Physician and Surgeon Health and Wellness Program Account as the Physician Health and Wellness Program Account and would authorize the board to seek and use grant funds and gifts from public or private sources to pay any cost associated with the program. The bill would require the board to annually report to the Legislature and make available to the public the amount and source of funds. The bill would require a licensee to report a license to the administering entity or the board if they believe the licensee is impaired. By expanding the scope of a crime under the Medical Practice Act, the bill would impose a state-mandated local program. The bill would make a person who reports information or takes action in connection with the bill's provisions immune</p>

	<p>from civil liability for reporting information or taking the action, except as specified. The bill would make the program inapplicable to the Osteopathic Medical Board of California.</p>
<p>AB 539 Schiavo (D)</p> <p>Status: 09/22/2025 In Committee. Hearing cancelled at request of the author</p> <p>Position: LHPC- Oppose Unless Amended</p>	<p>Health care coverage: prior authorizations</p> <p>Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law provides that a health care service plan or a health insurer that authorizes a specific type of treatment by a health care provider shall not rescind or modify this authorization after the provider renders the health care service in good faith and pursuant to the authorization. This bill would require a prior authorization for a health care service by a health care service plan or a health insurer to remain valid for a period of at least one year from the date of approval, or throughout the course of prescribed treatment, if less than one year. Because a violation of the bill by a health care service plan would be a crime, the bill would impose a state-mandated local program.</p>
<p>AB 618 Krell (D)</p> <p>Status: 09/22/2025 In Committee. Held under submission.</p> <p>Position: LHPC Support/Cosponsor</p>	<p>Medi-Cal: behavioral health: data sharing</p> <p>Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, through fee-for-service or managed care delivery systems. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing Medi-Cal provisions, behavioral health services, including specialty mental health services and substance use disorder treatment, are provided under the Medi-Cal Specialty Mental Health Services Program, the Drug Medi Cal Treatment Program, and the Drug Medi-Cal organized delivery system (DMC-ODS) program, as specified. This bill would require each Medi-Cal managed care plan, county specialty mental health plan, Drug Medi-Cal certified program, and DMC-ODS program to electronically provide data for members of the respective entities to support member care. The bill would require the department to determine minimum data elements and the frequency and format of data sharing through a stakeholder process and guidance, with final guidance to be published by the department by January 1, 2027, in compliance with privacy laws.</p>
<p>AB 669 Haney (D)</p> <p>Status: 09/22/2025 In Committee. Held under submission.</p> <p>Position: LHPC Support</p>	<p>Substance use disorder coverage</p> <p>Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law generally authorizes a health care service plan or health insurer to use prior authorization and other utilization management functions, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. Existing law requires health care service plan contracts and health insurance policies that provide hospital, medical, or surgical coverage and are issued, amended, or renewed on or after January 1, 2021, to provide coverage for medically necessary treatment of mental health and substance use disorders under the same terms and conditions applied to other medical conditions, as specified. On and after January 1, 2027, this bill would prohibit concurrent or retrospective review of medical necessity of in-network health care services and benefits (1) for the first 28 days of a treatment plan for inpatient or residential substance use disorder stay at a specified licensed facility during each plan or policy year or (2) for outpatient services provided by specified certified</p>

	<p>programs for substance use disorder visits, except as specified. The bill would authorize, after the 29th day, in-network health care services and benefits for inpatient or residential substance use disorder care to be subject to concurrent review. On and after January 1, 2027, the bill would prohibit retrospective review of medical necessity for the first 28 days of intensive outpatient or partial hospitalization services for substance use disorder but would authorize concurrent or retrospective review for day 29 and days thereafter of that stay or service. With respect to health care service plans, the bill would specify that its provisions do not apply to Medi-Cal behavioral health delivery systems or Medi-Cal managed care plan contracts. Because a willful violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.</p>
<p>AB 787 Papan (D)</p> <p>Status: 09/22/2025 In Committee. Held under submission.</p> <p>Position: Watch/Study</p>	<p>Provider directory disclosures.</p> <p>Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires specified health care service plans and health insurers to publish and maintain a provider directory or directories with information on contracting providers that deliver health care services to enrollees or insureds and requires a health care service plan or health insurer to regularly update its printed and online provider directory or directories, as specified. Existing law requires provider directories to include specified information and disclosures. This bill would require a full service health care service plan, specialized mental health or dental plan, health insurer, or specialized mental health or dental insurer to include in its provider directory or directories a statement advising an enrollee or insured to contact the plan or insurer for assistance finding an in-network provider and for an explanation of their rights regarding out-of-network coverage, and would specify the format of the statement. The bill would require the plan or insurer to acknowledge the request within one business day if contacted for that assistance, and to provide a list of in-network providers confirmed to be accepting new patients within 2 business days for a request deemed urgent by the enrollee or insured and 5 business days for a request deemed nonurgent by an enrollee or insured. Because a violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.</p>
<p>AB 910 Bonta (D)</p> <p>Status: 05/06/2026 Referred to Com. On Health.</p> <p>Position: Watch/Study</p>	<p>Pharmacy benefit management.</p> <p>Summary: Existing law requires a pharmacy benefit manager engaging in business with a health care service plan or health insurer to secure a license from the Department of Managed Health Care on or after January 1, 2027, or the date on which the department has established the licensure process, whichever is later. Existing law requires a complaint about a pharmacy benefit manager to be considered as a complaint against the contracting health care service plan and authorizes it to be considered a complaint against the contracting health insurer. Existing law requires the Department of Health Care Access and Information to establish a Health Care Payments Data Program to collect information regarding health care costs, utilization, quality, and equity. Existing law requires a pharmacy benefit manager to provide specified information to the Department of Health Care Access and Information for inclusion in the program and requires the department to include specified information in an annual analysis. Existing law also requires the Department of Health Care Access and Information to notify the Department of Managed Health Care or the Department of Insurance, as appropriate, if a health care service plan or health insurer fails to comply with specified requirements and requires those departments to take appropriate action. This bill would require the Department of Health Care Access and Information to include data regarding pricing and payments related to prescription drugs in its annual analysis upon completion of specified</p>

	<p>regulations and to notify the Department of Managed Health Care if a pharmacy benefit manager fails to comply with specified requirements, and would require the Department of Managed Health Care to take appropriate action. The bill would require the Department of Managed Health Care to post on its internet website links to analyses and reporting published by the Department of Health Care Access and Information.</p>
<p>AB 1049 Rodriguez (D)</p> <p>Status: 05/28/2026 In committee, set first hearing. Hearing canceled at the request of author.</p> <p>Position: pending</p>	<p>CA Food Assistance Program Sponsor Deeming Rules</p> <p>Summary: Existing federal law establishes the Supplemental Nutrition Assistance Program (SNAP), known in California as CalFresh, under which supplemental nutrition assistance benefits allocated to the state by the federal government are distributed to eligible individuals by each county. Existing state law establishes, in addition to CalFresh, the California Food Assistance Program (CFAP) to provide nutrition benefits to households that are ineligible for CalFresh benefits solely due to their immigration status, as specified. Existing law sets forth provisions relating to state funding for CFAP. Under existing federal and state law, in determining the eligibility and amount of aid for a person who is not a citizen or national of the United States under certain public social services programs, the income and resources of the person are deemed to include the income and resources of any person who has executed an affidavit of support on behalf of the person and the spouse of that person, with certain exemptions. Existing state law requires that federal deeming rules and exemptions governing SNAP also govern CFAP, with certain exceptions. Under this bill, federal deeming rules and exemptions governing SNAP would instead not apply to CFAP. By creating new duties for counties relating to CFAP eligibility, the bill would impose a state-mandated local program.</p>
<p>AB 1126 Patterson (R)</p> <p>Status:05/06/2026: Referred to Com. On Health.</p> <p>Position: pending</p>	<p>Medi-Cal managed care plans: enrollees with other health care coverage.</p> <p>Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, under fee-for-service or managed care delivery systems. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing federal law, in accordance with third-party liability rules, Medicaid is generally the payer of last resort if a beneficiary has another source of health care coverage in addition to Medicaid coverage. This bill would require the department, in the case of a Medi-Cal managed care plan enrollee who also has other health care coverage and for whom the Medi-Cal program is a payer of last resort, to ensure that a provider that is not contracted with the plan and that is billing the plan for Medi-Cal allowable costs not paid by the other health care coverage does not face administrative requirements significantly in excess of the administrative requirements for billing those same costs to the Medi-Cal fee-for-service delivery system. Under the bill, in the case of an enrollee who meets those coverage criteria, except as specified, a Medi-Cal fee-for-service provider would not be required to contract as an in-network provider with the Medi-Cal managed care plan in order to bill the plan for Medi-Cal allowable costs for covered health care services. The bill would authorize a Medi-Cal managed care plan to require a letter of agreement, or a similar agreement, under specified circumstances, including if a covered service requires prior authorization, or if a service is not covered by the other health care coverage but is a covered service under the plan, as specified. The bill would require the department to take the actions that it deems necessary to provide clarification regarding the conditions for billing plans to providers that render services to enrollees who also have other health care coverage. The bill would specify the intent of the Legislature that the department offer educational resources to an enrollee who needs assistance with understanding continuity of care and coordinating Medi-Cal and their other health care coverage when requested by the enrollee.</p>

<p>AB 1328 Rodriguez, Michelle (D)</p> <p>Status: 08/29/2025 In Committee. Held under submission.</p> <p>Position: Watch/Study</p>	<p>Medi-Cal reimbursements: nonemergency ambulance transportation.</p> <p>Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, including emergency or nonemergency medical or nonmedical transportation services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under this bill, commencing on July 1, 2027, and subject to an appropriation, Medi-Cal fee-for-service reimbursement for nonemergency ambulance transportation services, as defined, would be in an amount equal to 80% of the amount set forth in the federal Medicare ambulance fee schedule for the corresponding level of service, adjusted by the Geographic Practice Cost Index, as specified. The bill would require the department to establish a Medi-Cal managed care directed payment program for nonemergency ambulance transportation services, with the reimbursement rates set in an amount equal to at least the amount set forth under fee-for-service reimbursement. The bill would require the department to maximize federal financial participation in implementing the above-described provisions to the extent allowable. To the extent that federal financial participation is unavailable, the bill would require the department to implement the provisions using state funds, as specified.</p>
<p>AB 1419 Addis (D)</p> <p>Status: 08/29/2025 In Committee. Held under submission.</p> <p>Position: Watch/Study</p>	<p>California Health Benefit Exchange: automatic health care coverage enrollment</p> <p>Summary: Existing law creates the California Health Benefit Exchange (Exchange), also known as Covered California, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under the federal Patient Protection and Affordable Care Act. Existing law requires the Exchange to enroll an individual in the lowest cost silver plan or another plan, as specified, upon receiving the individual's electronic account from an insurance affordability program. Existing law requires enrollment to occur before coverage through the insurance affordability program is terminated and prohibits the premium due date from being sooner than the last day of the first month of enrollment. This bill would, commencing July 1, 2026, additionally authorize the Exchange to enroll an individual in the plan in which other members of the individual's household are enrolled, as specified, or the lowest cost plan available to an Indian who is eligible for specified reduced cost sharing, as determined by the Exchange, and would require the Exchange to enroll an individual in any of the plans described above upon receipt of a complete application for an insurance affordability program submitted through the Statewide Automated Welfare System. The bill would require the Exchange to enroll the individual either before coverage through the insurance affordability program is terminated as described above or upon the receipt of a complete application for an insurance affordability program through the Statewide Automated Welfare System as described above.</p>
<p>AB 1561 Krell (D)</p> <p>Status: 02/03/2026 re-referred to Com on Health</p> <p>Position: Watch/Study</p>	<p>Medi-Cal: Complex Rehabilitation Technology</p> <p>Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law sets forth various Medi-Cal provisions relating to complex rehabilitation technology (CRT), which is a form of durable medical equipment, including, but not limited to, complex rehabilitation manual and power wheelchairs. Existing law requires a CRT provider to a Medi-Cal beneficiary to comply with certain standards, including with regard to CRT repairs. Existing law authorizes the department to adopt any utilization controls for CRT, as appropriate. This bill would prohibit the department from requiring prior authorization for the repair of a CRT-powered wheelchair if the cost of the repair does not exceed \$1,250. Under the bill, a treatment authorization request for repair</p>

	<p>or replacement of a CRT-powered wheelchair would not require an individual prescription or documentation of medical necessity from the treating practitioner if the CRT-powered wheelchair has already been approved for use by the patient. For repair of a CRT-powered wheelchair, the bill would require the supplier to document and maintain records of the items being repaired, the reason for the repair, and the labor details, as specified, with the information being subject to a post-payment audit by the department. The bill would set forth other recording requirements for the supplier.</p>
<p>AB 1570 Wilson (D)</p> <p>Status: 05/14/2026 In committee: Held under submission.</p> <p>Position: Watch/Study</p>	<p>Health Care Coverage: Diagnostic Imaging</p> <p>Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract issued, amended, delivered, or renewed on or after January 1, 2000, or an individual or group policy of disability insurance or self-insured employee welfare benefit plan to provide coverage for mammography for screening or diagnostic purposes upon referral by specified professionals. Under existing law, mammography performed pursuant to those requirements or that meets the current recommendations of the United States Preventive Services Task Force is provided to an enrollee or an insured without cost sharing. This bill would require a health care service plan contract, a health insurance policy, or a self-insured employee welfare benefit plan issued, amended, or renewed on or after January 1, 2028, to provide coverage without imposing cost sharing for, among other things, screening mammography and medically necessary diagnostic breast imaging, including diagnostic breast imaging following an abnormal mammography result and for an enrollee or insured indicated to have a risk factor associated with breast cancer, except as specified. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.</p>
<p>AB 1577 Bauer-Kahan (D)</p> <p>Status: 05/27/2026 In Senate. Read 1st time to Com on RLS for assignment.</p> <p>Position: Watch/Study</p>	<p>Data Centers: Monthly Reporting</p> <p>Summary: Existing law establishes the State Energy Resources Conservation and Development Commission (Energy Commission) and vests the commission with various responsibilities with respect to developing and implementing the state's energy policies. Existing law requires the commission to biennially adopt an integrated energy policy report, as specified, and to make the reports accessible to state, local, and federal entities and to the general public. This bill would require the commission to establish a process for the owner of a data center, as defined, to submit specified information to the commission on a monthly basis, including, among other information, the data center's power usage effectiveness, as defined, water usage effectiveness, as defined, and total water consumption and the quantity of fuel consumed by onsite generators or other fuel-based energy systems, as specified. The bill would require the owner of a data center to submit the required information in the manner and timeframe specified by the commission. The bill would require the commission, as part of the 2029 edition of the integrated energy policy report, to include an assessment of electrical load trends for data centers, as provided. The bill would require the commission to annually publish the information submitted in an anonymized and aggregated format on its internet website. The bill would require the owner or developer of a data center, upon applying for a discretionary permit, entitlement, or land use authorization required for the construction or operation of the data center, to submit to the applicable local agency, as defined, the information described above, as provided. By imposing a new duty on local agencies, the bill would impose a state-mandated local program.</p>

	<p>The bill would authorize the local agency to use this information for various purposes, including, but not limited to, land use planning, infrastructure planning, energy and water supply assessment, and environmental review. The bill would further authorize a lead local agency to use this information in the preparation of environmental documentation pursuant to the California Environmental Quality Act.</p>
<p>AB 1609 Zbur (D)</p> <p>Status: 05/28/2026 In Senate read 1st time to Com on RLS for assignment.</p> <p>Position: Watch/Study</p>	<p>Customer service chatbots</p> <p>Summary: Existing law prohibits a person from using a bot, as defined, to mislead another person about the bot's artificial identity to incentivize the customer service support and communications within 15 minutes of requesting human customer service. The bill would impose certain specific requirements on large private businesses and would require certain large private businesses to post prescribed contact information on their internet website. This bill contains other related provisions, purchase or sale of goods or services, among other things. Existing law requires an operator of a companion chatbot, as defined, to provide a disclosure regarding the companion chatbot's artificial identity if a reasonable person interacting with the companion chatbot would be misled to believe that the person is interacting with a human. This bill would prohibit a large private business, as defined, from representing that a customer service chatbot is a human. The bill would also require the large private business to provide certain disclosures if a reasonable person interacting with the chatbot would be misled to believe they are interacting with a human. The bill would require a large private business to provide customers with human customer service support and communications within 15 minutes of requesting human customer service. The bill would impose certain specific requirements on large private businesses and would require certain large private businesses to post prescribed contact information on their internet website.</p>
<p>AB 1637 Caloza (D)</p> <p>Status: 05/20/2026 Referred to Com on BP & ED</p> <p>Position: Watch/Study</p>	<p>Physicians & Surgeons: Medical Records.</p> <p>Summary: Existing law, the Medical Practice Act, establishes the Medical Board of California to license and regulate the practice of medicine. A violation of the act is a crime, unless otherwise specified. Existing law makes it unprofessional conduct for a failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients for at least 7 years after the last date of service to a patient. This bill would state that a physician and surgeon's patient notes, as defined, shall be the responsibility of that physician and surgeon. The bill would prohibit a physician and surgeon's patient notes from being altered, modified, or edited in any fashion by anyone other than the authoring physician and surgeon, except as specified. By expanding the scope of a crime under the act, the bill would impose a state-mandated local program.</p>
<p>AB 1649 Ahrens (D)</p> <p>Status: 02/09/2026 referred to Com on Health</p> <p>Position: Watch/Study</p>	<p>Medi-Cal: Monthly Maintenance Amount: Personal & Incidental Needs</p> <p>Summary: Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid provisions. Qualified individuals under the Medi-Cal program include medically needy persons and medically needy family persons who meet the required eligibility criteria, including applicable income requirements. Existing law requires the department to establish income levels for maintenance need at the lowest levels that reasonably permit a medically needy person to meet their basic needs for food, clothing, and shelter, and for which federal financial participation will still be provided under applicable federal law. In calculating the income of a medically needy person in a medical institution or nursing facility, or a person receiving institutional or noninstitutional services from a Program of All-Inclusive Care for the Elderly organization, the required monthly maintenance amount includes an amount providing for personal and incidental needs in the</p>

	<p>amount of not less than \$35 per month while a patient. Existing law authorizes the department to increase, by regulation, this amount as necessitated by increasing costs of personal and incidental needs. This bill would increase the monthly maintenance amount for personal and incidental needs from \$35 to \$50, and would require that the amount be increased annually, as specified. The bill would make these changes subject to receipt of necessary federal approvals.</p>
<p>AB 1670 Arambula (D)</p> <p>Status: 05/14/2026 In committee: held under submission.</p> <p>Position: Pending</p>	<p>Medi-Cal: additional compensation</p> <p>Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, including dental care, as specified. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law establishes reimbursement rates for services provided by Medi-Cal providers to beneficiaries. This bill would require that a provider be paid additional compensation when a patient's physical, behavioral, developmental, or emotional condition requires significant extra time, attention, or personnel to safely deliver dental care. The bill would limit this additional payment to 3 times in a 12-month period.</p>
<p>AB 1671 Tangipa (R)</p> <p>Status: 05/14/2026 In committee. Held under submission.</p> <p>Position: Pending</p>	<p>Rural Medical Services Grant Program</p> <p>Summary: Existing law establishes the Office of Rural Health within the California Health and Human Services Agency to promote a strong working relationship between state government and local and federal agencies, universities, private and public interest groups, rural consumers, health care providers, foundations, and other offices of rural health, as well as to develop health initiatives and maximize the use of existing resources without duplicating existing effort. Existing law requires the office to serve as a key information and referral source to promote coordinated planning for the delivery of health services in rural California. This bill would require the office to develop and administer, upon appropriation by the Legislature, a competitive grant program for the delivery of, or the support, sustenance, or expansion of the delivery of, medical services, as defined, to individuals who reside in rural areas, as defined. The bill would authorize the office upon that appropriation to expend up to \$3,000,000 annually and would authorize a qualified provider, as defined, to apply to the office once per year for a grant of up to \$10,000 for those purposes. The bill would require the office to establish specified standards and procedures, including criteria and standards for eligibility and the measurement of outcomes achieved, and, on or before January 1, 2028, and annually thereafter, to publish this information on its internet website</p>
<p>AB 1682 Hart (D)</p> <p>Status: 05/28/2026 In Senate. Read first time. To Com. on RLS. for assignment.</p> <p>Position: watch/study</p>	<p>Health Care Coverage: Scalp Cooling</p> <p>Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires coverage by health care service plans and health insurers for various screening and treatment services with respect to cancer. This bill would require a health care service plan contract or health insurance policy, except as specified, that is issued, amended, delivered, or renewed on or after January 1, 2027, to provide coverage for scalp cooling, as defined, as prescribed by a health care provider in connection with chemotherapy for persons with cancer. Because a violation of these provisions with respect to a health care service plan would be a crime, this bill would impose a state-mandated local program.</p>

<p>AB 1717 Castillo (R)</p> <p>Status: 05/14/2026 In committee. Held under submission.</p> <p>Position: watch/study</p>	<p>Medi-Cal Dental Reimbursement: House/Extended Care Facility Call</p> <p>Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, including certain dental services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under the Medi-Cal Dental Provider Handbook, the maximum allowance for a house/extended care facility call under a specified billing code is \$20. This bill would require the department to increase the Medi-Cal reimbursement base rate for a house/extended care facility call in order to reflect the reasonable travel costs for purposes of delivering dental services in the patient's private residence or applicable facility instead of the location of the dental provider. The bill would require that the rate be adjusted to a minimum of \$120 per patient per date of service, with subsequent readjustments every 2 years to account for inflation and provider cost data. The bill would require the department, every 2 years, to report to the Legislature about the impact of the rate adjustments on access, utilization, and reductions in emergency department visits for dental conditions. The bill would condition implementation of these provisions on an appropriation, receipt of any necessary federal approvals, and the availability of federal financial participation.</p>
<p>AB 1770 Garcia (D)</p> <p>Status: 05/28/2026 In Senate. Read first time. To Com. on RLS. for assignment.</p> <p>Position: Pending</p>	<p>Arbitration: health care service plans and health insurers.</p> <p>Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law provides that a willful violation of provisions regulating health care service plans is a crime. Existing law requires a health care service plan contract that includes terms requiring binding arbitration for dispute settlement to provide a specified disclosure to subscribers or enrollees. Existing law, the California Arbitration Act, provides a statutory framework for the enforcement of contractual arbitration under California law. Existing law establishes standards for arbitration and requires a court to vacate an arbitration award if it makes certain findings. This bill would require the Attorney General to oversee compliance by health care service plans with specified provisions regulating the use of binding arbitration to settle disputes. The bill would authorize the Attorney General to require reports from health care service plans for these purposes.</p>
<p>AB 1773 Rubion, Blanca (D)</p> <p>Status: 05/13/2026 Referred to Com. on HEALTH.</p> <p>Position: Pending</p>	<p>Pharmacy benefit managers.</p> <p>Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a pharmacy benefit manager contracting with a health care service plan or health insurer to secure a license from the Department of Managed Health Care on or after January 1, 2027, or the date on which the department has established the licensure process, whichever is later. This bill would require the department to maintain a public internet website displaying specified information for each licensed pharmacy benefit manager, including, among other things, the legal name, license number, and license expiration date</p>
<p>AB 1794 Ransom (D)</p> <p>Status: 05/20/2026 Referred to Com. on B. P. & E.D.</p>	<p>Pharmacy: enteral nutrition or replacements.</p> <p>Summary: Existing law, the Pharmacy Law, requires the California State Board of Pharmacy within the Department of Consumer Affairs to license and regulate the practice of pharmacy, including pharmacists, pharmacy technicians, and pharmacies. Under existing law, it is unlawful for any person to manufacture, compound, furnish, sell, or dispense a dangerous drug or dangerous device, or to dispense or compound a prescription unless they are licensed, as specified. Existing</p>

<p>Position: watch/study</p>	<p>law authorizes the distribution of drugs and devices directly to dialysis patients pursuant to regulations adopted by the board and other specified conditions. This bill would also authorize a pharmacist, manufacturer, or wholesaler to participate in an arrangement or agreement to deliver enteral nutrition supplements or replacements directly to a patient's residence pursuant to a valid order from a prescriber acting within their scope of practice. For these purposes, the bill would define "enteral nutrition supplements or replacements" to mean medical food used as a therapeutic regimen to prevent serious disability or death in patients with medically diagnosed conditions that preclude the full use of regular food. The bill would also make technical changes to existing provisions.</p>
<p>AB 1799 Ortega (D)</p> <p>Status: 02/11/2026 from printer may be heard in committee March 13</p> <p>Position: watch/study</p>	<p>Integrated health care service plan investment disclosures.</p> <p>Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law requires a health care service plan's assets to be invested in a prudent manner and requires the director of the department to determine the acceptability of a health care service plan's investments, as specified. This bill would state the intent of the Legislature to enact legislation to require the public disclosure of material investment holdings of nonprofit organizations providing integrated health care service plans.</p>
<p>AB 1811 Rogers (D)</p> <p>Status: 05/27/2026 referred to Com on Health</p> <p>Position: watch/study</p>	<p>Health Professional Shortage Areas</p> <p>Summary: Existing federal law requires the Secretary of Health and Human Services to designate health professional shortage areas, and requires the secretary, in establishing criteria for the designation of those areas, to consider, among other things, the ratio of available health manpower to the number of individuals in an area or population group and indicators of a need for health services, as specified. Existing state law makes references to federally recognized or designated health professional shortage areas in various contexts, including, among others, the California Physician Corps Program, the California Reproductive Health Services Corps, the Oral Health Program, the Virtual Health Hub for Rural Communities Pilot Program, and health professions planning grants. This bill, until January 1, 2035, would define the term "health professional shortage area" to mean (1) an area determined by the Department of Health Care Access and Information to have a shortage of health professionals, (2) a health professional shortage area designated or recognized by the United States Department of Health and Human Services, or (3) an area designated or recognized as a health professional shortage area by the United States Department of Health and Human Services on January 1, 2025, regardless of whether that area remains designated or recognized by the United States Department of Health and Human Services as a health professional shortage area</p>
<p>AB 1843 Elhawary (D)</p> <p>Status: 06/03/2026 Referred to Com. on HEALTH.</p> <p>Position: watch/study</p>	<p>Communicable diseases: hepatitis B and C.</p> <p>Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law generally prohibits a health care service plan or health insurer from subjecting antiretroviral drugs that are medically necessary for the prevention of HIV/AIDS to prior authorization or step therapy. This bill would prohibit a health care service plan and health insurer from subjecting direct-acting antiviral drugs that are medically necessary for the treatment of hepatitis C to prior authorization. The bill would specify that these provisions do not require a health care service plan or health insurer to cover all therapeutically equivalent versions without prior authorization. The bill would prohibit a health care service plan and health insurer</p>

	<p>from imposing prior authorization requirements, as specified, and would require a health care service plan and health insurer's clinical criteria for hepatitis C treatment to align with current guidelines and the standard of care consistent with the standards of the American Association for the Study of Liver Diseases and the Infectious Diseases Society of America. Because a violation of these provisions by a health care service plan would be a crime, this bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws</p>
<p>AB 1851 Gipson (D)</p> <p>Status: 05/28/2026 In Senate. Read first time. To Com. on RLS. for assignment.</p> <p>Position: watch/study</p>	<p>Pupil health: social-emotional, behavioral, and mental health supports.</p> <p>Summary: Existing law requires the governing board of a school district to give diligent care to the health and physical development of pupils and authorizes the governing board of a school district to employ properly certified persons for this purpose. Existing law requires a school district or county office of education and a charter school to notify pupils and parents or guardians of pupils no less than twice during the school year on how to initiate access to available pupil mental health services on campus or in the community, or both, as provided. This bill would require, on or before July 1, 2027, the State Department of Education to enter into a contract with one or more local educational agencies with capacity and established expertise, as provided, to serve as lead entities in providing support for the implementation of integrated, universal social-emotional learning, behavioral health, and restorative practices for pupils in kindergarten and grades 1 to 12, inclusive. The bill would require, on or before January 1, 2028, the lead entities, selected pursuant to a competitive process, to make available guidance, resources, and technical assistance to local educational agencies to expand the statewide implementation of integrated, universal social-emotional learning, behavioral health, and restorative practices, as provided. The bill would make the implementation of these provisions contingent upon an appropriation, as provided.</p>
<p>AB 1876 Addis (D)</p> <p>Status: 06/04/2026 From committee: Do pass and re-refer to Com. on JUD. (Ayes 7. Noes 1.) (June 3). Re-referred to Com. on JUD.</p> <p>Position: watch/study</p>	<p>Health care coverage: nondiscrimination.</p> <p>Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plans and health insurers, as specified, within 6 months after the relevant department issues specified guidance, or no later than March 1, 2025, to require all of their staff who are in direct contact with enrollees or insureds in the delivery of care or enrollee or insured services to complete evidence-based cultural competency training for the purpose of providing trans-inclusive health care for individuals who identify as transgender, gender diverse, or intersex. This bill would prohibit a subscriber, enrollee, policyholder, or insured from being excluded from enrollment or participation in, being denied the benefits of, or being subjected to discrimination by, any health care service plan or health insurer licensed in this state, on the basis of race, color, national origin, age, disability, or sex. The bill would define discrimination on the basis of sex for those purposes to include, among other things, sex characteristics, including intersex traits, pregnancy, and gender identity. The bill would prohibit a health care service plan or health insurer from taking specified actions relating to providing access to health programs and activities, including, but not limited to, denying or limiting health care services to an individual based upon the individual's sex assigned at birth, gender identity, or gender otherwise recorded. The bill would prohibit a health care service plan or health insurer, in specified circumstances, from taking various actions, including, but not limited to, denying, canceling, limiting, or refusing to issue or renew health care service plan enrollment, health insurance coverage, or other health-related coverage, or denying or limiting coverage of a claim, or imposing additional cost sharing or other limitations or restrictions on coverage, on the basis of race, color, national origin, sex, age,</p>

	<p>disability, as specified. Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.</p>
<p>AB 1887 Zbur (D)</p> <p>Status: 05/28/2026 In Senate. Read first time. To Com. on RLS. for assignment.</p> <p>Position: watch/study</p>	<p>Prescription drug coverage for rare diseases</p> <p>Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law sets forth specified prior authorization and step therapy limitations for health care service plans and health insurers. This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2027, to require a health care service plan or health insurer to complete prior authorization or other utilization review within 30 days upon initial request, as specified, for a drug approved for the treatment of a rare disease if the drug is prescribed by a specialist with expertise in the condition or disease being treated and the specialist has determined the drug is medically necessary, unless a biosimilar, interchangeable biologic, or generic version of the drug is available. The bill would prohibit a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2027, from imposing step therapy for these drugs. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.</p>
<p>AB 1900 Kalra (D)</p> <p>Status: 04/20/2026 Introduced measure version corrected.</p> <p>Position: watch/study</p>	<p>Guaranteed Health Care for All.</p> <p>Summary: Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA), requires each state to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. PPACA defines a "qualified health plan" as a plan that, among other requirements, provides an essential health benefits package. Existing state law creates the California Health Benefit Exchange, also known as Covered California, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA. This bill, the California Guaranteed Health Care for All Act, would create the California Guaranteed Health Care for All program, or CalCare, to provide comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of all residents of the state. Under the bill, CalCare would be a health care service plan subject to Knox-Keene. The bill, among other things, would provide that CalCare cover a wide range of medical benefits and other services and would incorporate the health care benefits and standards of other existing federal and state provisions, including the federal Children's Health Insurance Program, Medi-Cal, ancillary health care or social services covered by regional centers for persons with developmental disabilities, Knox-Keene, and the federal Medicare Program. The bill would make specified persons eligible to enroll as CalCare members during the implementation period and would provide for automatic enrollment. The bill would require the board to seek all necessary waivers, approvals, and agreements to allow various existing federal health care payments to be paid to CalCare, which would then assume responsibility for all benefits and services previously paid for with those funds.</p>
<p>AB 1906 Aguiar-Curry (D)</p> <p>Status: 06/03/2026 Referred to Com. on HEALTH.</p>	<p>Cervical cancer screening.</p> <p>Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or health</p>

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<p>Position: watch/study</p>	<p>insurance policy issued, amended, or renewed on or after January 1, 2002, to provide coverage for an annual cervical cancer screening test upon the referral of the patient's health care provider. This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2027, to provide coverage without cost sharing for an annual cervical cancer screening home test kit upon the referral of the patient's health care provider. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program. The bill would also include cervical cancer home test kits, upon the referral of a patient's health care provider, as a covered benefit under the Medi-Cal program on or after January 1, 2027, without cost sharing, to the extent required or permitted by federal law.</p>
<p>AB 1907 Addis (D)</p> <p>Status: 06/03/2026 Referred to Com. on HEALTH.</p> <p>Position: watch/study</p>	<p>California Health Benefit Exchange: automatic health care coverage enrollment.</p> <p>Summary: Existing law creates the California Health Benefit Exchange (Exchange), also known as Covered California, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under the federal Patient Protection and Affordable Care Act. Existing law requires the Exchange to enroll an individual in the lowest cost silver plan or another plan, as specified, upon receiving the individual's electronic account from an insurance affordability program. Existing law requires enrollment to occur before coverage through the insurance affordability program is terminated, and prohibits the premium due date from being sooner than the last day of the first month of enrollment. This bill would, commencing July 1, 2027, additionally authorize the Exchange to enroll an individual in the plan in which other members of the individual's household are enrolled, as specified, or the lowest cost plan available to an Indian who is eligible for specified reduced cost sharing, as determined by the Exchange, and would require the Exchange to enroll an individual in any of the plans described above upon receipt of a complete application for an insurance affordability program submitted through the Statewide Automated Welfare System. The bill would require the Exchange to enroll the individual either before coverage through the insurance affordability program is terminated as described above or upon the receipt of a complete application for an insurance affordability program through the Statewide Automated Welfare System as described above.</p>
<p>AB 1923 Soria (D)</p> <p>Status: 05/28/2026 In Senate. Read first time. To Com. on RLS. for assignment.</p> <p>Position: watch/study</p>	<p>Distressed Hospital Loan Program</p> <p>Summary: Existing law requires the Department of Health Care Access and Information to administer the Distressed Hospital Loan Program, until January 1, 2032, which provides loans to not-for-profit hospitals and public hospitals in significant financial distress or to governmental entities representing a closed hospital to prevent the closure of, or facilitate the reopening of, those hospitals. Existing law requires the department to develop a methodology to evaluate an at-risk hospital's potential eligibility for state assistance from the program, and authorizes the methodology for determining financial distress to consider the hospital's prior and projected performance on financial metrics, including, among other things, the amount of cash on hand. Existing law requires a hospital or a closed hospital applying for aid under this program to provide, among other things, the California Health Facilities Financing Authority and the department with financial information demonstrating the hospital's need for financial assistance due to financial hardship. Existing law requires the department to issue the loan award to a qualifying hospital as soon as reasonably practicable following its eligibility determination. Existing law prohibits not-for-profit hospitals and public hospitals that belong to integrated health care systems with more than 2 separately licensed hospital facilities from being eligible for state assistance under the program. This bill would, if an appropriation is made for this purpose, make any hospital, regardless of ownership type or system affiliation, eligible for state assistance under the program</p>

	<p>for awards provided on or after the effective date of this act, as specified, if the hospital, and its associated entities, if applicable, meets the applicable criteria for significant financial distress as established by the department and the authority. The bill would, if an appropriation is made for this purpose, authorize the methodology for determining financial distress to additionally consider the hospital's prior and projected performance on financial metrics that include, among other things, credit rating and debt capacity, and would also require the projections that determine financial distress to account for impacts of federal and state policy changes affecting hospital reimbursement or health care coverage, including, but not limited to, the federal One Big Beautiful Bill Act.</p>
<p>AB 1949 Lee (D)</p> <p>Status: 06/03/2026 Referred to Com. on HEALTH.</p> <p>Position: watch/study</p>	<p>Medi-Cal: acupuncture treatments.</p> <p>Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services, including pharmacy services and drugs. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law sets forth a schedule of benefits covered under the Medi-Cal program, including acupuncture, but only to the extent federal matching funds are provided for acupuncture. To the extent federal financial participation is available, this bill would require the Medi-Cal program to cover up to 24 acupuncture visits per beneficiary per calendar year and would state that additional visits per calendar year may be authorized based on medical necessity.</p>
<p>AB 1970 Harabedian (D)</p> <p>Status: 05/27/2026 Referred to Com. on HEALTH.</p> <p>Position: watch/study</p>	<p>Health care coverage: mental health or substance use disorders.</p> <p>Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law authorizes health care service plans and health insurers that cover prescription drugs to utilize reasonable medical management practices, including prior authorization and step therapy, consistent with applicable law. This bill would prohibit a health care service plan contract or a health insurance policy that is issued, amended, or renewed on or after January 1, 2027, from imposing step therapy as a prerequisite to authorizing coverage of any prescription drug used for the treatment of a serious mental illness or substance use disorder, as those terms are defined. The bill would specify that the prohibition on step therapy does not apply when the United States Food and Drug Administration-labeled indications and usage of a drug indicate that some prior medication must be taken. Because a willful violation of this provision by a health care service plan would be a crime, the bill would impose a state-mandated local program</p>
<p>AB 1979 Bonta (D)</p> <p>Status: 06/03/2026 Referred to Coms. on P., D.T., & C.P. and HEALTH.</p> <p>Position: watch/study</p>	<p>Health care services: artificial intelligence.</p> <p>Summary: The Confidentiality of Medical Information Act (CMIA) prohibits a provider of health care, a health care service plan, a contractor, or a corporation and its subsidiaries and affiliates from intentionally sharing, selling, using for marketing, or otherwise using any medical information, as defined, for any purpose not necessary to provide health care services to a patient, except as provided. Existing law deems a business that offers a mental health digital service or reproductive or sexual health digital service to a consumer for the purpose of allowing the individual to manage the individual's information, or for the diagnosis, treatment, or management of a medical condition of the individual, to be a provider of health care subject to the requirements of the CMIA. The bill would additionally deem a business that offers a healthcare chatbot, as defined, to a consumer for the above-described purposes to be a provider of health care subject to the requirements of the CMIA.</p>

<p>AB 2000 Aguiar-Curry (D)</p> <p>Status: 05/14/2026 In committee: Held under submission.</p> <p>Position: watch/study</p>	<p>Drug formularies.</p> <p>Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act's requirements a crime. Existing law requires specified services and drugs to be covered by the various plans. Existing law prohibits specified health care service plan contracts that cover prescription drug benefits from limiting or excluding coverage for a drug for an enrollee under specified conditions, including if the drug previously had been approved for coverage by the plan for a medical condition of the enrollee. Existing law specifies that these provisions do not preclude the prescribing provider from prescribing another drug covered by the plan that is medically appropriate for the enrollee. This bill would make technical, non-substantive changes to these provisions. The bill would state the intent of the Legislature to protect patients from mid-year health care service plan formulary changes that disrupt care and restrict access to medically necessary medications.</p>
<p>AB 2011 Hart (D)</p> <p>Status: 05/06/2026 Referred to Com. on HEALTH.</p> <p>Position: watch/study</p>	<p>Nonquantitative treatment limitations.</p> <p>Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing federal law, the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), requires group health plans and health insurance issuers that provide both medical and surgical benefits and mental health or substance use disorder benefits to ensure that financial requirements and treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical and surgical benefits. This bill would prohibit a health care service plan or insurer from relying upon discriminatory factors or evidentiary standards to design a nonquantitative treatment limitation (NQTL) to be imposed on mental health or substance use disorder benefits, as specified. To ensure that an NQTL applicable to mental health or substance use disorder benefits in a classification is no more restrictive than the predominant NQTL applied to substantially all medical/surgical benefits in the classification, the bill would require a health care service plan or insurer to collect and evaluate relevant data to assess the impact of the NQTL on outcomes related to access to mental health and substance use disorder benefits and medical/surgical benefits. The bill would require specified health care service plans or insurers to perform and document comparative analyses of the design and application of each NQTL applicable to mental health or substance use disorder benefits in accordance with prescribed requirements and submit the analyses to the respective departments by January 1, 2027, and annually thereafter. If the departments make a final determination of noncompliance, the bill would require the health care service plan or insurer to, among other things, notify all enrollees or insureds of its noncompliance with the requirements of parity. If a health care service plan or insurer receives a final determination of noncompliance with these provisions with respect to an NQTL or with the requirements of the MHPAEA, the bill would deem the NQTL to be a violation of parity and authorize the respective department to direct the plan or insurer not to impose the NQTL, as provided. The bill would define terms for purposes of these provisions and make related findings and declarations. Because a violation of these requirements by a health care service plan would be a crime, the bill would impose a state mandated local program.</p>

<p>AB 2036 Patel (D)</p> <p>Status: 04/13/2026 In committee: Set, first hearing. Hearing canceled at the request of author.</p> <p>Position: watch/study</p>	<p>Medi-Cal: federally qualified health centers and rural health clinics.</p> <p>Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, to the extent that federal financial participation is available, federally qualified health center (FQHC) services and rural health clinic (RHC) services are covered Medi-Cal benefits. Under existing law, FQHC and RHC services are reimbursed on a per-visit basis, as specified. FQHCs and RHCs receive a per-visit prospective payment system (PPS) rate for each visit. Existing law provides different methods by which an FQHC or RHC may establish a PPS. This bill would authorize an FQHC or RHC that has multiple PPS rates to elect to consolidate those rates into a single PPS rate to be applied uniformly for all FQHC and RHC services.</p>
<p>AB 2066 Rodriguez, Celeste (D)</p> <p>Status: 06/03/2026 Referred to Com. on HEALTH.</p> <p>Position: watch/study</p>	<p>Triggering event: pregnancy.</p> <p>Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of disability insurers by the Department of Insurance. Existing law requires a health care service plan or disability insurer to allow an individual to enroll in or change their health benefit plan as a result of a specified triggering event. This bill would make pregnancy a triggering event for purposes of enrollment or changing a health benefit plan. Because a willful violation of this provision by a health care service plan would be a crime, the bill would impose a state-mandated local program.</p>
<p>AB 2081 Stefani (D)</p> <p>Status: 06/03/2026 Referred to Com. on HEALTH.</p> <p>Position: watch/study</p>	<p>Medi-Cal: Home and Community-Based Alternatives Waiver</p> <p>Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is in part governed by, and funded pursuant to, federal Medicaid program provisions. Under existing law, home- and community-based services (HCBS) approved by the United States Department of Health and Human Services are covered for eligible individuals to the extent that federal financial participation is available for those services under the state plan or waivers granted in accordance with certain federal provisions. Existing law authorizes the Director of Health Care Services to seek waivers for any or all approvable HCBS. Existing law sets forth provisions for the implementation of the Nursing Facility/Acute Hospital Transition and Diversion Waiver, which is the predecessor of the Home and Community-Based Alternatives (HCBA) Waiver, for purposes of providing care management services to individuals who are at risk of nursing facility or institutional placement, subject to federal cost neutrality. Existing law sets forth provisions authorizing the director to expand the number of waiver slots up to 5,000 additional slots. This bill would recast the above-described waiver provisions to refer to the HCBA Waiver and would delete the provision relating to the 5,000 slots. The bill would require the department, beginning in 2027, and for the HCBA Waiver period, to increase the total number of waiver slots by 10,000, in addition to any planned expansion of waiver slots federally approved as of January 1, 2026, as specified. The bill would require the department, by March 1, 2027, to seek any necessary amendments to the HCBA Waiver to ensure that there is sufficient capacity to enroll all individuals who are eligible for, and express an interest in, participating in the HCBA Waiver who are currently on a waiting list. The bill would require the department to continue to monitor the capacity of the HCBA Waiver and to expand capacity, as specified.</p>

<p>AB 2082 Gonzalez, Jeff (R)</p> <p>Status: 05/14/2026 In committee: Held under submission.</p> <p>Position: watch/study</p>	<p>Rural Farmworker Women’s Health Act of 2026.</p> <p>Summary: Existing law requires the State Department of Public Health to develop a coordinated state strategy for addressing the health-related needs of women, as specified. This bill, the Rural Farmworker Women’s Health Act of 2026, would require the department to, beginning July 1, 2027, establish a program to work with local nonprofit organizations who have a history of serving farmworker communities to provide free menstrual products in rural or agricultural communities. The bill would require the department to prioritize those communities with the highest rates of poverty.</p>
<p>AB 2123 Aguiar-Curry (D)</p> <p>Status: 05/14/2026 In committee: Held under submission.</p> <p>Position: watch/study</p>	<p>Medical Debt Relief Act of 2026</p> <p>Summary: Existing law, the California Health Facilities Financing Authority Act, establishes the California Health Facilities Financing Authority, which has authority to, among other things, make secured or unsecured loans to, or purchase secured or unsecured loans of, any participating health institution in accordance with an agreement between the authority and the participating health institution to refinance indebtedness incurred by that participating health institution, as specified, in connection with projects undertaken, for health facilities acquired, or for working capital. Existing law also authorizes the authority to award grants to eligible clinics and health facilities, as specified. Existing law establishes the California Health Facilities Financing Authority Fund, a continuously appropriated fund, to carry out the purposes of the act. This bill, the Medical Debt Relief Act of 2026, would establish the medical debt relief program, which would be administered by the authority. The bill would authorize the authority to, among other things, contract with a medical debt relief coordinator, as defined, for purposes of acquiring medical debt of eligible recipients either directly from a providing health institution or from a debt buyer, as specified. The bill would require the authority to, among other things, maintain books and records of all the medical debt acquired and canceled. The bill would authorize the authority to adopt, amend, or repeal regulations to establish criteria for the operation and administration of the program, and would require the authority to take into account specified factors in developing its ranking and priority criteria. This bill would create the California Medical Debt Relief Program Account within the California Health Facilities Financing Authority Fund and would appropriate \$2,500,000 from the General Fund to the California Medical Debt Relief Program Account for the purposes of the Medical Debt Relief Act of 2026. The bill would require the authority to provide a report to the Legislature and Governor by January 1 of each year, starting January 1, 2028.</p>
<p>AB 2131 Rubio, Blanca (D)</p> <p>Status: 03/24/2026 In committee: Hearing postponed by committee.</p> <p>Position: watch/study</p>	<p>Hospitals: seismic standards.</p> <p>Summary: Existing law, the Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983, establishes, under the jurisdiction of the Department of Health Care Access and Information, a program of seismic safety building standards for certain hospital buildings. Under existing law, a hospital building includes any building that is used, or designed to be used, for a health facility of a type required to be licensed, as specified. Under existing law, a hospital building does not include, among others, a freestanding building used, or designed to be used, as a congregate living health facility or a hospice facility. This bill would exempt a general acute care hospital from the requirements of the act if, among other things, the hospital building is a freestanding building used, or designed to be used, exclusively to provide extended hospital care to patients with complex medical and rehabilitative needs and the hospital building has met all the seismic requirements that a hospital was required to meet prior to January 1, 2021.</p>

<p>AB 2135 Kalra (D)</p> <p>Status: 06/04/2026 From committee chair, with author's amendments: Amend, and re-refer to committee. Read second time, amended, and re-referred to Com. on HEALTH.</p> <p>Position: watch/study</p>	<p>Long-term health care facilities.</p> <p>Summary: Existing law provides for the licensing and regulation of health facilities, including, but not limited to, long-term health care facilities, as defined, by the State Department of Health Care Services. Existing law requires a contract for admission to a long-term care facility to state that a resident shall not be involuntarily transferred within, or discharged from, a long-term health care facility unless the resident is given reasonable notice in writing, and transfer or discharge planning, as specified. Willful or repeated violations of the provisions relating to long term health care facilities is a misdemeanor. This bill would require long-term health care facilities to provide residents with a notice of a facility-initiated transfer or discharge at least 30 days before a resident is transferred or discharged, unless an exception applies. The bill would require the notice of transfer or discharge to be signed by the resident or, if applicable, the resident's representative, and by a facility staff member who declares they delivered the notice to the resident and, if applicable, the resident's representative. The bill would make a violation of these provisions a class "B" violation and would make knowingly making a false verification regarding the delivery of a notice of transfer or discharge a willful violation for purposes of the criminal provision described above. The bill would require a notice of discharge or transfer to be provided to a resident and, if applicable, the resident's representative in a translated or accessible format at the same time as the written notice in English if the resident's primary language is not English or if the resident is vision impaired or blind, as specified. The bill would also require the translated or accessible-format notices to be made available to the local long-term care ombudsman upon request. The bill would require the translator to attest, under penalty of perjury, to the accuracy of the translation, thereby expanding the crime of perjury. The bill would require a resident's primary language or sensory impairments to be included in the minimum dataset maintained by the facility. The bill would make a violation of these provisions a class "B" violation subject to a \$1,000 civil penalty. Existing law requires that a copy of the notice of transfer or discharge be sent to the local long-term care ombudsman at the same time notice is provided to the resident or the resident's representative by facsimile machine, email, or first-class mail, as specified.</p>
<p>AB 2138 Krell (D)</p> <p>Status: 05/14/2026 In committee: Held under submission.</p> <p>Position: watch/study</p>	<p>Medi-Cal: enhanced care management: peer support specialists.</p> <p>Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is in part governed by, and funded pursuant to, federal Medicaid program provisions. Existing law requires the department to implement an enhanced care management (ECM) benefit designed to address the clinical and nonclinical needs on a whole-person-care basis for certain target populations of Medi-Cal beneficiaries enrolled in Medi-Cal managed care plans. Under existing law, target populations include, among others, high utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits, and individuals experiencing homelessness. Existing law authorizes a county, or an agency representing a county, to develop a peer support specialist certification program, subject to departmental approval. Under existing law, these specialists are individuals, at least 18 years of age, who self-identify as having lived experience with the process of recovery from mental illness, substance use disorder, or both, as specified. Existing law requires the department to seek any federal waivers that it deems necessary to establish a demonstration or pilot project for the provision of peer support services in counties that agree to participate. This bill would require the department to require, as a condition of providing ECM, that any ECM provider, whose caseload of members meets certain criteria, maintain an interdisciplinary care team that includes at least one peer support specialist or trainee, as defined, who is integrated into ECM service delivery and available to support ECM members. The bill would set forth the functions of a peer support specialist or trainee for ECM purposes.</p>

<p>AB 2160 Rodriguez, Celeste (D)</p> <p>Status: 06/03/2026 Referred to Com. on HEALTH.</p> <p>Position: watch/study</p>	<p>Medi-Cal: lactation services.</p> <p>Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law requires the department to streamline and simplify existing Medi-Cal program procedures to improve access to lactation supports and breast pumps among Medi-Cal beneficiaries. This bill would require the department to, by July 1, 2027, issue updated Medi-Cal guidance that clarifies Medi-Cal coverage for lactation services. The bill would also require the guidance to, among other things, clarify Medi-Cal coverage policies for a continuum of lactation services, including health education related to lactation, basic lactation support, and clinical lactation consultation. The bill would require the department to seek stakeholder input on draft guidance prior to issuing the guidance. The bill would make the implementation of these provisions contingent to the extent that federal financial participation is available and any necessary federal approvals are obtained.</p>
<p>AB 2161 Bonta (D)</p> <p>Status: 06/03/2026 Referred to Com. on HEALTH.</p> <p>Position: watch/study</p>	<p>Medi-Cal: redeterminations and work or community engagement</p> <p>Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is in part governed by, and funded pursuant to, federal Medicaid program provisions. Existing federal law, enacted on July 4, 2025, sets forth various changes to Medicaid eligibility with regard to community engagement reporting, redeterminations, cost sharing, and retroactive coverage, among other factors, for certain Medicaid populations, including beneficiaries between 19 and 64 years of age, inclusive, with income up to 138% of the federal poverty level, commonly known as Medicaid expansion adults. For purposes of Medicaid eligibility redeterminations, the above-described federal law requires that a Medicaid expansion adult undergo a redetermination once every 6 months, instead of an annual redetermination, except as specified. Existing state law generally requires a county to perform eligibility redeterminations for Medi-Cal beneficiaries every 12 months and to promptly redetermine eligibility whenever the county receives information about changes in a beneficiary's circumstances, as specified. This bill would make changes to those redetermination provisions to conform to the 6-month redetermination requirement under the above-described federal law for Medicaid expansion adults. The bill would make other conforming changes to related provisions.</p>
<p>AB 2165 Macedo (R)</p> <p>Status: 03/17/2026 re-referred to Com on Health</p> <p>Position: watch/study</p>	<p>Triggering event: loss of minimum essential coverage</p> <p>Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan or health insurer to allow an individual to enroll in or change their health benefit plan as a result of a specified triggering event, including when the individual or the individual's dependent loses minimum essential coverage, as provided. This bill, for purposes of the above, would specify that loss of minimum essential coverage includes loss of coverage due to circumstances in which a joint agreement between health care service plans or health insurers, or between a health care service plan and a health insurer, to provide coverage to an enrollee or insured located in a medically underserved area expires, dissolves, or is otherwise terminated. The bill would require a health care service plan or health insurer to provide a written or electronic notice to enrollees or insureds at least 60 days before the effective date of the expiration, dissolution, or other termination of that</p>

	<p>joint agreement and would require the notice to additionally indicate that the expiration, dissolution, or other termination of the joint agreement may constitute a loss of minimum essential coverage. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.</p>
<p>AB 2194 Valencia (D)</p> <p>Status: 06/03/2026 In committee: Set, first hearing. Hearing canceled at the request of author.</p> <p>Position: watch/study</p>	<p>Medi-Cal special commissions</p> <p>Summary: Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services, under which health care services are provided to qualified, low-income persons. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law authorizes a county board of supervisors to establish a commission to negotiate an exclusive contract with the department to provide, or arrange for the provision of, health care services under the Medi-Cal program. Pursuant to the authority described above, the County of Orange established a commission, known as the Orange County Health Authority or CalOptima, to provide health care services under the Medi-Cal program. Existing law vests governance of the commission in a 10-member governing body and requires that 2 of the governing body's members be members of the Board of Supervisors of the County of Orange, with one additional member from the Board of Supervisors of the County of Orange serving as an alternate. Existing law requires each member to serve a 4-year term, except as described. This bill would require those terms to be staggered and would require, for the term beginning after January 1, 2027, 3 members to serve 2 years, with a 4-year term beginning thereafter. The bill would also specify that the alternate member from the Board of Supervisors are required to have the same right of access as any other member of the governing body to the commission's books, communications, documents, and records, as specified. Because this bill would impose a unique requirement on how services are provided on a local government, the bill would impose a state-mandated local program. This bill would make legislative findings and declarations as to the necessity of a special statute for County of Orange</p>
<p>AB 2201 Boerner (D)</p> <p>Status: 06/03/2026 Referred to Com. on HEALTH.</p> <p>Position: watch/study</p>	<p>Medi-Cal: eligibility redetermination.</p> <p>Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is in part governed by, and funded pursuant to, federal Medicaid program provisions. Existing federal law, enacted on July 4, 2025, sets forth various changes to Medicaid eligibility with regard to community engagement reporting, redeterminations, retroactive coverage, and cost sharing, among other factors, for certain Medicaid populations. For purposes of eligibility redeterminations, existing federal law requires that certain beneficiaries between 19 and 64 years of age, inclusive, with income up to 138% of the federal poverty level, commonly known as Medicaid expansion adults, undergo a redetermination once every 6 months, instead of an annual redetermination, except as specified. Existing state law generally requires a county to perform eligibility redeterminations for Medi-Cal beneficiaries every 12 months and to promptly redetermine eligibility whenever the county receives information about changes in a beneficiary's circumstances, as specified. This bill would make changes to those redetermination provisions to conform to the 6-month redetermination requirement under the above-described federal law for Medicaid expansion adults. The bill would make other conforming changes to related provisions.</p>
<p>AB 2208 Stefani (D)</p>	<p>Medi-Cal: cost sharing, retroactivity, and accessibility.</p> <p>Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is in part governed</p>

<p>Status: 06/03/2026 Referred to Com. on HEALTH.</p> <p>Position: watch/study</p>	<p>by, and funded pursuant to, federal Medicaid program provisions. Existing federal law, enacted on July 4, 2025, sets forth various changes to Medicaid eligibility with regard to community engagement reporting, redeterminations, cost sharing, and retroactive coverage, among other factors, for certain Medicaid populations, including beneficiaries between 19 and 64 years of age, inclusive, with income up to 138% of the federal poverty level, commonly known as Medicaid expansion adults. The above-described federal law requires the state, beginning October 1, 2028, to impose deductions, cost sharing, or similar charges determined appropriate by the state, in an amount greater than \$0, with respect to certain care, items, or services furnished to Medicaid expansion adults, with income exceeding 100% and up to 138% of the federal poverty level, as determined by the state. The federal law excludes certain services from these provisions and prohibits the charge from exceeding \$35. This bill would, no sooner than October 1, 2028, set a copayment of \$0.01 for nonemergency services for the above-described population, as specified. The bill would authorize the provider to collect, retain, or waive the copayment amount. The bill would not apply the copayment requirements to emergency services, family planning services, or any services under certain categories. The bill would prohibit a service provider from denying care or services to an individual solely because of nonpayment of copayment. The bill would create an exemption from a copayment requirement for any visit, service, device, or item for which the Medi-Cal program's payment is \$10 or less. The bill would prohibit the total aggregate amount of deductions, cost sharing, or similar charges imposed for all individuals in a family from exceeding 5% of the family income.</p>
<p>AB 2327 Lowenthal (R)</p> <p>Status: 05/14/2026 In committee: Held under submission.</p> <p>Position: watch/study</p>	<p>Medi-Cal: subcontractors: rates.</p> <p>Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services under fee-for-service or managed care delivery systems. The Medi-Cal program is in part governed by, and funded pursuant to, federal Medicaid program provisions. Existing law sets forth various provisions relating to the department determining capitation rates for Medi-Cal managed care plans using actuarial methods and a certain methodology that considers, among other factors, utilization and cost data. Relative to these provisions of existing law, in 2023, the department entered into a multi-party settlement agreement for Medi-Cal managed care procurement for plan years beginning January 1, 2024, with specified Medi-Cal managed care plans and certain subcontracting plans. This bill would authorize a subcontracting plan subject to the above-described agreement to request a review of the Medi-Cal managed care rates paid by the primary plan for a particular rating period, as specified. The bill would require the department to direct an independent, qualified actuarial consultant to review those rates upon a showing by the subcontracting plan that certain conditions have occurred or are likely to occur, including, among others, a medical loss ratio in excess of 93% for the preceding 12-month period. If the department determines that the rates paid by the primary plan to the subcontracting plan for a particular rating period are not actuarially sound, the bill would require the department to order a revision of those rates, as specified. The bill would make any failure by the department to comply with these provisions reviewable and subject to appeal at the request of the subcontracting plan through a notice of dispute pursuant to the terms of the Medi-Cal managed care contract. The bill would require these disputes to be concluded and resolved within 120 calendar days of the initial request. The bill would authorize the department to implement, interpret, or make specific these provisions through the use of all-county letters, plan letters, plan bulletins, amendments to the state Medi-Cal managed care contract, or similar instructions without taking any further regulatory action.</p>

<p>AB 2348 Bonta (D)</p> <p>Status: 05/27/2026 In Senate. Read first time. To Com. on RLS. for assignment.</p> <p>Position: watch/study</p>	<p>Medi-Cal: community supports</p> <p>Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is in part governed by, and funded pursuant to, federal Medicaid program provisions. Existing law, the California Advancing and Innovating Medi-Cal (CalAIM) Act, subject to any necessary federal approvals, establishes the CalAIM initiative in order to, among other things, improve quality outcomes, reduce health disparities, and transition and transform the Medi-Cal program to a more consistent and seamless system by reducing complexity and increasing flexibility. Under existing law, the CalAIM initiative ends on December 31, 2026. Existing law authorizes the department to seek to extend the payment methodologies or programs set forth in CalAIM, as specified, consistent with applicable federal requirements. Existing law, subject to CalAIM implementation, authorizes a Medi-Cal managed care plan to elect to cover community supports. Under existing law, community supports that the department is authorized to approve include, among others, housing transition navigation services and medically supportive food and nutrition services. Existing law requires the department to annually publish a public report on reported community supports utilization data, populations served, and demographic data, as specified. This bill would authorize a Medi-Cal managed care plan to continue to cover those community supports approved by the department as cost effective and medically appropriate, as specified. Under the bill, this continued coverage would commence on January 1, 2027, would be conditioned on the availability of federal financial participation, and would be set forth as part of a CalAIM successor program. The bill would require the department to continue to publish the above-described public report, but on a quarterly basis. The bill would require the department to provide ongoing technical assistance to Medi-Cal managed care plans and providers of community supports to enhance their ability to effectively provide these services.</p>
<p>AB 2355 Gonzalez (R)</p> <p>Status: 03/09/2026 referred to Comm. on Health</p> <p>Position: watch/study</p>	<p>Medi-Cal.</p> <p>Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed by, and funded pursuant to, federal Medicaid program provisions. Existing law, the Budget Act of 2025, appropriates funds to the department to create a comprehensive hospital value strategy to advance access to high-quality inpatient and outpatient hospital services, financially incentivize appropriate care delivery, and improve health outcomes for Medi-Cal beneficiaries. In developing the comprehensive hospital value strategy described above, this bill would require the department to engage with relevant stakeholders with firsthand experience, including, but not limited to, hospitals, cities, counties, cities and counties, organizations representing these groups, and other affected stakeholders as the department deems necessary. The bill would require the department to ensure that the comprehensive hospital value strategy includes a focus on rural hospitals, critical access hospitals, and public hospitals.</p>
<p>AB 2368 Bonta (D)</p> <p>Status: 05/27/2026 In Senate. Read first time. To Com. on RLS. for assignment.</p>	<p>Indigent health care: information and planning.</p> <p>Summary: Existing law requires each county to provide aid, commonly known as a general assistance program, to the county's indigent residents who are not supported by other means and are ineligible for the Medi-Cal program, as specified. Existing law sets forth various provisions relating to county-based health care services for indigent individuals and to reporting systems for those services. This bill would require the State Department of Health Care Services, by July 1, 2027, to establish an internet website where the public can access information on safety-net health care services in the state. The bill would require that the website include</p>

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<p>Position: watch/study</p>	<p>certain information and resources, including, among other items, information about each county medically indigent health care program for uninsured individuals. The bill would require the department, in consultation with certain entities, to review the information and resources on the website, as specified. The bill would require each county, no later than January 1, 2028, to prepare and submit to the department a plan to operate programs to provide health care to medically indigent individuals. The bill would require that the plan include information on projected caseload and expenditure increases and projected investment, as specified. By creating new planning duties for counties, the bill would impose a state-mandated local program</p>
<p>AB 2386 Alvarez (D)</p> <p>Status: 05/27/2026 In Senate. Read first time. To Com. on RLS. for assignment.</p> <p>Position: watch/study</p>	<p>License to practice medicine: Licensed Physicians from Mexico Program and California Physician Expansion Act.</p> <p>Summary: Existing law, the Medical Practice Act, establishes the Medical Board of California to license and regulate the practice of medicine. Former law, repealed as of January 1, 2025, established the Licensed Physicians and Dentists from Mexico Pilot Program, which allowed up to 30 licensed physicians and up to 30 licensed dentists from Mexico to practice medicine or dentistry in California for a period not to exceed 3 years, in accordance with certain requirements. Existing law, operative January 1, 2025, instead, establishes within the act the Licensed Physicians from Mexico Program, which authorizes the board to issue a limited number of nonrenewable 3-year physician's and surgeon's licenses to licensed physicians from Mexico who meet specified criteria. This bill would require the board to issue a full and unrestricted physician's and surgeon's license to a person who has completed the 3-year term of the Licensed Physicians from Mexico Program or the former Licensed Physicians and Dentists from Mexico Pilot Program in good standing upon satisfaction of specified requirements, including having an offer of continued employment from a health care facility or practice in California. This bill would establish the California Physician Expansion Act, which would require the board to issue a provisional license to an applicant who holds a full and unrestricted license to practice medicine in another country who meets specified requirements, including that the applicant has not committed any acts or crimes constituting grounds for denial of a certificate, as specified. In this regard, the bill would require the board to submit to the Department of Justice fingerprint images and related information required by the department of all applicants for a provisional license to determine whether the applicant has a criminal conviction record, as specified, and would require the department to provide a state- and federal-level response pursuant to specified provisions for the board to determine whether the applicant is subject to denial of licensure, as specified</p>
<p>AB 2391 Ahrens (D)</p> <p>Status: 05/14/2026 In committee: Held under submission.</p> <p>Position: watch/study</p>	<p>Health care: workforce training programs</p> <p>Summary: Existing law, the Song-Brown Health Care Workforce Training Act, declares the intent of the Legislature to increase the number of students and residents receiving quality education and training in specified primary care specialties and as primary care physician's assistants, primary care nurse practitioners, and registered nurses. This bill would require the Department of Health Care Access and Information to maintain a New Nursing Graduate Support and Placement Program to award program grants to community college associate degree of nursing programs, through which support grants would be awarded to recent graduates for loan repayment assistance, relocation, transportation, housing assistance, childcare, and other financial support. The bill would specify grant eligibility criteria for community colleges and recent graduates. The bill would require the department to consider labor standards of hospital sites that employ support grant applicants when determining grant distribution. Under the bill, the program would be funded by a redirection of an unspecified amount provided annually upon appropriation by the Legislature. This bill would express the intent of the Legislature that funding for programs that train registered nurses be increased,</p>

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	<p>beginning in the 2027–28 fiscal year, by an unspecified amount upon appropriation by the Legislature. The bill would specify that unencumbered funds that were appropriated for the Song-Brown Health Care Workforce Training Act in the Budget Act of 2026 may be used for capacity building and equipment in the 2027–28 fiscal year, upon appropriation by the Legislature.</p>
<p>AB 2415 Tangipa (R)</p> <p>Status: 05/27/2026 In Senate. Read first time. To Com. on RLS. for assignment.</p> <p>Position: watch/study</p>	<p>Transient-oriented housing developments: alternative plans.</p> <p>Summary: Existing law requires a housing development project to be an allowed use as a transit-oriented housing development on any site zoned for residential, mixed, or commercial development within prescribed distances of a transit-oriented development stop if the development complies with specified requirements. Existing law applies these provisions to a local agency beginning July 1, 2026, unless the local agency adopts an ordinance or local transit-oriented development alternative plan, as specified. Existing law prescribes requirements for these plans, including requiring that the plan not reduce the capacity in any transit-oriented development zone in total units or residential floor area by more than 50%. Existing law defines various terms for these purposes. This bill would provide that a transit-oriented development alternative plan may reduce the capacity in up to one transit-oriented development zone in total units or residential floor area by more than 50% if certain requirements are met.</p>
<p>AB 2431 Patel (D)</p> <p>Status: 05/14/2026 In committee: Held under submission.</p> <p>Position: watch/study</p>	<p>Downcoding medical claims.</p> <p>Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law sets forth requirements by which a health care service plan or health insurer reimburses a provider for health care services. This bill would prohibit a health care service plan or an insurer issuing group or individual policies of health insurance from using an automated process, system, or tool to downcode a claim, which is the unilateral alteration by a payer of the service or procedure code submitted on a claim resulting in a lower payment. The bill would set forth requirements for and limitations of downcoding decisions, and, if a claim is downcoded, would require a plan or insurer to provide a billing provider with specified information and a clear and accessible process for disputing downcoded claims. The bill would prohibit a plan or insurer from using downcoding practices in a targeted or discriminatory manner against physicians or other health care providers who routinely treat patients with high acuity, complex, or chronic conditions, and would authorize the departments to take action against a plan or insurer that engages in a pattern or practice of discriminatory downcoding or that otherwise violates these provisions. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.</p>
<p>AB 2448 Berman (D)</p> <p>Status: 05/20/2026 Referred to Coms. on P., D.T., & C.P. and HEALTH</p> <p>Position: watch/study</p>	<p>Medical information: confidentiality.</p> <p>Summary: Existing law, the Confidentiality of Medical Information Act (CMIA), generally prohibits a provider of health care, a health care service plan, or a contractor from disclosing medical information regarding a patient, enrollee, or subscriber without first obtaining an authorization, unless a specified exception applies. Existing law makes a violation of the CMIA that results in economic loss or personal injury to a patient punishable as a misdemeanor. Existing law requires specified businesses that electronically store or maintain medical information on the provision of sensitive services on behalf of a provider of health care, health care service plan, pharmaceutical company, contractor, or employer to develop capabilities, policies, and procedures, on or before July 1, 2024, to enable certain</p>

	<p>security features, including limiting user access privileges and segregating medical information related to gender affirming care, abortion and abortion-related services, and contraception, as specified. This bill would also require those specified businesses to enable the above-specified capabilities, policies, and procedures for those security features, as specified. Because the bill would expand the scope of an existing crime, it would impose a state-mandated local program.</p>
<p>AB 2457 Connolly (D)</p> <p>Status: 05/14/2026 In committee: Held under submission.</p> <p>Position: watch/study</p>	<p>Health care provider credentialing.</p> <p>Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law requires a full service health care service plan, excluding a Medi-Cal managed care plan, or its delegate, to subscribe to and use the Council for Affordable Quality Healthcare credentialing form on and after January 1, 2028. On and after January 1, 2027, existing law requires a health care service plan, excluding a Medi-Cal managed care plan, or its delegate, that credentials health care providers for its networks to make a determination regarding the credentials of a provider within 90 days after receiving a completed provider credentialing application. This bill would extend the application of the above-described requirements to Medi-Cal managed care plans. Because a willful violation of these requirements by a Medi-Cal managed care plan would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.</p>
<p>AB 2486 Addis (D)</p> <p>Status: 05/27/2026 In Senate. Read first time. To Com. on RLS. for assignment.</p> <p>Position: watch/study</p>	<p>Medi-Cal: Whole Child Model program.</p> <p>Summary: Existing law establishes the California Children's Services (CCS) program, which is administered by the State Department of Health Care Services and counties, to provide medically necessary services, based on financial eligibility, for persons under 21 years of age who have certain medical conditions, including, among others, cystic fibrosis or hemophilia. Existing law provides for the Medi-Cal program, which is administered by the department, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law authorizes the department to establish a Whole Child Model program, under which managed care plans served by a county organized health system or Regional Health Authority in designated counties provide CCS treatment services to Medi-Cal eligible CCS children and youth. In implementing the program, existing law requires the department to, among other things, establish a statewide Whole Child Model program stakeholder advisory group and to consult with that advisory group on the implementation of the Whole Child Model program, as specified. Existing law terminates the advisory group on December 31, 2026. This bill would rename the statewide Whole Child Model program stakeholder advisory group to the California Children's Services (CCS) advisory group. The bill would require the advisory group to additionally be composed of representatives of CCS clients not enrolled in a managed care plan, former CCS clients, and caregivers of former CCS clients, among others. The bill would also require the department to consult with the advisory group on the implementation of the CCS Classic program and to consider the recommendations of the advisory group in developing monitoring processes and outcome measures for the CCS program. Beginning no later than December 31, 2027, the bill would require the department to biennially deliver a summary report to the Legislature that briefly describes the department's progress and actions on specified matters relating to the CCS program. The bill would delete the December 31, 2026, sunset date, thereby extending the operation of the advisory group indefinitely.</p>

<p>AB 2511 Ahrens (D)</p> <p>Status: 05/14/2026 In committee: Held under submission.</p> <p>Position: watch/study</p>	<p>Behavioral Health Provider Comparable Worth Study.</p> <p>Summary: Existing law establishes the Department of Industrial Relations in the Labor and Workforce Development Agency and provides that one of the functions of the department is to foster, promote, and develop the welfare of the wage earners of California, to improve their working conditions, and to advance their opportunities for profitable employment. This bill would require the department, in consultation with the Department of Managed Health Care, the Department of Insurance, the Department of Health Care Access and Information, and the Office of Health Care Affordability, to conduct a comparable worth study to examine and compare compensation and reimbursement for behavioral health providers with compensation and reimbursement for similarly situated medical-surgical providers. The bill would require the study to analyze compensation and reimbursement across specified payment flows, including payments made by health care service plans and health insurers directly to behavioral health providers and medical-surgical providers, and payments made to intermediaries and health systems for behavioral health services and medical-surgical services. The bill would require the department to take certain actions in conducting the study, including developing a methodology for determining which behavioral health provider roles are comparable to which medical-surgical provider roles. The bill would require a health care service plan or health insurer to report certain data to the department with respect to payments made directly to providers and payments made to intermediaries and health systems. The bill would also require specified intermediaries and health systems to report certain data to the department relating to payments received and payments made. The bill would make an entity that fails to comply with the reporting requirements subject to civil penalty, as prescribed.</p>
<p>AB 2551 Elhawary (D)</p> <p>Status: 05/27/2026 In Senate. Read first time. To Com. on RLS. for assignment.</p> <p>Position: watch/study</p>	<p>Health care coverage.</p> <p>Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2021, to provide coverage for medically necessary treatment of mental health and substance use disorders, as defined, under the same terms and conditions applied to other medical conditions. This bill would require health care service plans and health insurers to conduct an annual survey to assess the number and prevalence of enrollees or insureds seeking or accessing behavioral health care services from out-of-network providers, the total expenditures paid out-of-pocket by enrollees and insureds for out-of-network and in-network behavioral health care services, as specified, and the reasons for seeking out-of-network behavioral health services. The bill would require the annual survey to be optional for enrollees or insureds. The bill would require health care service plans and health insurers to report survey findings to the departments on or before May 1, 2028, and annually thereafter. The bill would require the departments to adopt regulations establishing standard requirements and a survey tool, as specified. The bill would require the departments to develop annual reports based on the annual survey and other data, as specified. Because a willful violation of these requirements by a health care service plan would be a crime, this bill would impose a state-mandated local program</p>
<p>AB 2565 Wallis (R)</p> <p>Status: 06/04/2026</p>	<p>Medi-Cal: pharmacist services: reporting</p> <p>Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services through fee-for-service (FFS) or managed</p>

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<p>From committee: Do pass and re-refer to Com. on APPR. with recommendation: To Consent Calendar. (Ayes 9. Noes 0.) (June 3). Re-referred to Com. on APPR.</p> <p>Position: watch/study</p>	<p>care delivery systems. The Medi-Cal program is in part governed by, and funded pursuant to, federal Medicaid program provisions. Under existing law, pharmacist services are a benefit under the Medi-Cal program, subject to federal approval, as specified. Existing law authorizes the department to provide and administer Medi-Cal pharmacy services under a single statewide FFS delivery system, commonly known as the Medi-Cal Rx program. The department has implemented a transition of Medi-Cal pharmacy services, through Medi-Cal Rx, from managed care to FFS as a result of a 2019 executive order by the Governor. This bill would require the department to issue guidance clarifying Medi-Cal managed care plan obligations to cover pharmacist services, as specified. The bill would require the department to update its model evidence of coverage to explicitly include coverage of pharmacist services. The bill would also require the department to take appropriate corrective action for failure to comply with existing provisions of law relating to Medi-Cal coverage of pharmacist services or the issued guidance. The bill would authorize the department to implement, interpret, or make specific these provisions by means of all-plan letters, plan letters, or other similar instructions, without taking any further regulatory action.</p>
<p>AB 2571 Flora (R)</p> <p>Status: 06/04/2026 From committee: Do pass and re-refer to Com. on APPR. with recommendation: To Consent Calendar. (Ayes 9. Noes 0.) (June 3).</p> <p>Position: watch/study</p>	<p>Reimbursement for pharmacist services.</p> <p>Summary: Existing law provides for the Medi-Cal program, administered by the State Department of Health Care Services and under which health care services are provided to low-income individuals pursuant to a schedule of benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, pharmacist services are a benefit under the Medi-Cal program, subject to federal approval, and the rate of reimbursement for pharmacist services is 85% of the fee schedule for physician services, except for medication therapy management (MTM) pharmacist services. Existing law requires the department to implement an MTM reimbursement methodology relating to the dispensing of qualified specialty drugs by an eligible contracting pharmacy, which would be intended to supplement Medi-Cal payments to eligible pharmacies for MTM pharmacist services provided in conjunction with certain specialty drug therapy categories. This bill would additionally require the rate of reimbursement for advanced practice pharmacist services to be the same as the fee schedule for physician services, including MTM pharmacist services. The bill would require the department to implement an MTM reimbursement methodology relating to the use of drugs to ensure that Medi-Cal payments are only made to eligible advanced practice pharmacists or pharmacies, including those operating at federally qualified health centers or rural health clinics, for MTM pharmacist services provided in conjunction with certain specialty drug therapy categories.</p>
<p>AB 2575 Ortega (D)</p> <p>Status: 05/28/2026 In Senate. Read first time. To Com. on RLS. for assignment.</p> <p>Position: watch/study</p>	<p>Health care services: artificial intelligence</p> <p>Summary: Existing law provides for the licensure and regulation of health facilities and clinics by the State Department of Public Health. Existing law generally makes a violation of these provisions a crime. Existing law, the Medical Practice Act, establishes the Medical Board of California for the licensing, regulation, and discipline of physicians and surgeons. Existing law requires a health facility, clinic, physician's office, or office of a group practice that uses generative artificial intelligence to generate written or verbal patient communications pertaining to patient clinical information, as defined, to ensure that those communications include both a disclaimer that indicates to the patient that a communication was generated by generative artificial intelligence, as specified, and clear instructions describing how a patient may contact a human health care provider, employee, or other appropriate person. This bill would require a health facility, clinic, physician's office, or office of a group practice that uses or deploys a clinical decision support system, as defined, for patient care to provide written notice of required information to any licensed health care professional or other person using a clinical decision support</p>

	<p>system or viewing outputs from a clinical decision support system. The bill would require, among other things, the disclosure to include a notice that a worker providing direct patient care is authorized to override the output of a clinical decision support system if, in the judgment of the worker acting within their scope of practice, an override is necessary to meet the applicable standard of care or comply with applicable law. The bill would specify the required time and manner the disclosure is to be provided pursuant to these provisions. By placing new requirements on health facilities and clinics, this bill would expand the scope of a crime and would impose a state mandated local program.</p>
<p>AB 2610 Addis (D)</p> <p>Status: 02/21/2026 from printer may be heard in committee March 23</p> <p>Position: watch/study</p>	<p>Patient access to health records</p> <p>Summary: Existing law generally governs a patient's access to the patient's own health records. Existing law establishes procedures for providing access to health care records or summaries of those records by patients and by those persons who have responsibility for decisions regarding the health care of others, as described. Existing law sets forth the Legislature's findings and declarations regarding the right of access to that information, as specified. This bill would make technical, non-substantive changes to those findings and declarations.</p>
<p>AB 2613 Sharp-Collins (D)</p> <p>Status: 06/03/2026 referred to Com on Health</p> <p>Position: watch/study</p>	<p>Health care service plans: provider contract termination: notice.</p> <p>Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act's requirements a crime. Existing law requires a health care service plan to notify an enrollee by United States mail at least 60 days before the termination date of a contract between a health care service plan and a provider group or a general acute care hospital to which the enrollee is assigned. If the plan reaches an agreement with a terminated provider after sending that notice, existing law requires the plan to offer each affected enrollee the option to return to that provider and to reassign the enrollee to another provider if the enrollee does not exercise that option. This bill would additionally require a health care service plan to notify an enrollee by email or text message, as specified, at least 60 days before the termination date of a contract between a health care service plan and a provider group or a general acute care hospital to which the enrollee is assigned. If the plan reaches an agreement with a terminated provider after sending the notice of termination, the bill would require the health care service plan to send written notice by United States mail and by email or text message, as specified, to affected enrollees within 60 days of reaching the agreement. Because a willful violation of these provisions would be a crime, this bill would impose a state-mandated local program.</p>
<p>AB 2624 Bonta (D)</p> <p>Status: 05/27/2026 In Senate. Read first time. To Com. on RLS. for assignment.</p> <p>Position: watch/study</p>	<p>Privacy for immigration support services providers</p> <p>Summary: Existing law authorizes designated health care services providers, employees, volunteers, and patients, and individuals who face threats of violence or violence or harassment from the public because of their affiliation with a designated health care services facility, to complete an application to be approved by the Secretary of State for the purposes of enabling state and local agencies to respond to requests for public records without disclosing a program participant's residence address contained in any public record and otherwise provide for confidentiality of identity for that person, subject to specified conditions. Existing law defines "designated health care services" to mean gender-affirming health care services or reproductive health care services. Under existing law, any person who makes a false statement in an application is guilty of a misdemeanor. Existing law prohibits a person, business, or association from knowingly publicly posting or publicly displaying, disclosing, or distributing on internet websites or on social media, the</p>

	<p>personal information or image of any designated health care services patient, provider, or assistant, or other individuals residing at the same home address, with the intent to incite a third person to cause imminent great bodily harm to the person identified in the posting or display, or to a coresident of that person, as specified, or to threaten the person identified in the posting or display, or a coresident of that person, as specified. This bill would similarly establish an address confidentiality program for a designated immigration support services provider, employee, or volunteer, as defined, who faces threats of violence or harassment from the public because of their affiliation with a designated immigration support services facility. This bill would additionally prohibit a person, business, or association from soliciting, selling, or trading on the internet the personal information or image of a designated immigration support services provider, employee, or volunteer with the intent described above. The bill would also, among other things, prohibit a person from posting on the internet the personal information or image of a designated immigration support services provider, employee, or volunteer, or other individuals residing at the same home address, with the specific intent that another person imminently use that information to commit a crime involving violence or a threat of violence that is imminently likely to occur against such an individual. The bill would define various terms for these purposes. By imposing new duties on local agencies and creating new crimes, this bill would create a state-mandated local program.</p>
<p>AB 2643 Caloza (D)</p> <p>Status: 02/21/2026 from printer may be heard in committee March 23</p> <p>Position: watch/study</p>	<p>Insurance: Health Coverage</p> <p>Summary: Existing law requires a person or other entity providing coverage in this state for medical, surgical, chiropractic, physical therapy, speech pathology, audiology, professional mental health, dental, hospital, or optometric services, whether this coverage is by direct payment, reimbursement, or otherwise, and that enters into an arrangement or contract with, or underwrites, a preferred provider organization or arrangement, as specified, be subject to the jurisdiction of the Department of Insurance. This bill would make technical, non substantive changes to these provisions.</p>
<p>AB 2670 Castillo (R)</p> <p>Status: 03/23/2026 Referred to Com. on HEALTH.</p> <p>Position: watch/study</p>	<p>Medi-Cal: fraud assessment task force.</p> <p>Summary: Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services and under which health care services are provided to qualified low-income persons pursuant to a state plan. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. This bill would, upon appropriation by the Legislature, require the department to convene a task force of specified members by no later than January 1, 2027, to conduct a comprehensive assessment of fraud risks in the Medi-Cal program. The bill would require the task force, within 6 months of formation, to review current fraud prevention tools, analyze data-sharing gaps, and evaluate how best practices from the federal government and other states could be applied in California. The bill would require the task force to submit specified recommendations based on this assessment to the appropriate policy and fiscal committees of the Legislature by no later than January 1, 2028.</p>
<p>AB 2729 Bonta (D)</p> <p>Status: 05/19/2026 Re-referred to Com. on APPR.</p>	<p>Medi-Cal: Employer Responsibility for Medi-Cal Trust Fund</p> <p>Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is in part governed by, and funded pursuant to, federal Medicaid program provisions. Existing federal law, Public Law 119-21, enacted on July 4, 2025, sets forth various changes to different health care programs, including certain requirements for Medicaid eligibility with regard to work or community engagement reporting, redeterminations, and cost sharing, among other factors, for certain Medicaid</p>

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<p>Position: watch/study</p>	<p>populations pursuant to a specified implementation timeline. Existing law, the federal Patient Protection and Affordable Care Act, imposes a certain assessment on an applicable large employer, as defined, that offers full-time employees and their dependents the opportunity to enroll in minimum essential coverage, and for whom one or more full-time employees have been certified as having enrolled in a qualified health plan for which a premium tax credit or cost-sharing reduction is allowed or paid. The bill would continuously appropriate moneys in the fund to the department to fund the costs of administering the Medi-Cal program in a manner necessary to prevent loss of or to restore health care coverage, benefits, or access to care following the passage of Public Law 119-21 and subsequent state budget actions. The bill would state that these provisions would become operative only if the Medicaid provisions of Public Law 119-21 are not repealed prior to January 1, 2027. By creating a continuously appropriated fund, the bill would make an appropriation.</p>
<p>AB 2756 Hadwick (R)</p> <p>Status: 06/03/2026 Referred to Com. on Health.</p> <p>Position: watch/study</p>	<p>Medi-Cal vision services: performance measures.</p> <p>Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is in part governed by, and funded pursuant to, federal Medicaid program provisions. Under existing law, certain vision care benefits are covered under the Medi-Cal program, relating to, among other things, optometric and optician services and eyeglasses, as specified. This bill would require the department to establish a list of performance measures to ensure that the vision services under the Medi-Cal program meet quality and access criteria. The bill would require that the performance measures be designed to evaluate utilization, access, and availability of Medi-Cal vision services. The bill would require certain information within the performance measures, relating to providers and examinations, among other factors. The bill would require the department, when evaluating performance measures, to consider certain criteria, including trended data and other state performance and quality measures. The bill would require the department to report on each performance measure only to the extent that the department has existing data sources from which to calculate the applicable measure, as specified. The bill would specify a timeline for the posting of performance measures and data on the department's internet website. The bill would also require the department to establish benchmarks for each performance measure and to annually prepare a summary report on complaints and grievances, as specified.</p>
<p>AJR 25 Bonta (D)</p> <p>Status: 02/18/2026 referred to Com on Health</p> <p>Position: LHPC Support</p>	<p>Health care coverage: enhanced Affordable Care Act premium tax credits.</p> <p>Summary: This measure would urge the United States Congress and the President of the United States to immediately restore and extend the enhanced Affordable Care Act premium tax credits.</p>
<p>Senate Bills</p>	
<p>SB 32 Weber Pierson (D)</p> <p>Status: 08/29/2025 In Committee. Held under submission.</p>	<p>Health care coverage: timely access to care</p> <p>Summary: Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law authorizes the provision of Medi-Cal benefits by a contracted managed care plan and requires that benefits provided by a managed care plan are subject to specified time and distance</p>

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<p>Position: LHPC Oppose</p>	<p>standards. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan or health insurer that provides or arranges for the provision of hospital or physician services to comply with specified timely access to care requirements, including ensuring that its network has adequate capacity and availability of licensed health care providers to offer enrollees and insureds appointments that meet specified timeframes. Existing law authorizes the department director to take enforcement action against health care plans that fail to comply with these provisions, including assessing administrative penalties. This bill would require, on or before July 1, 2027, the Department of Managed Health Care, the Department of Insurance, and the State Department of Health Care Services to consult together and with stakeholders develop and adopt standards for the geographic accessibility of perinatal units to ensure timely access for enrollees and insureds, as specified. The bill's provisions would become inoperative on July 1, 2033, and would be repealed on January 1, 2034. Because a violation by a health care service plan of a standard adopted by the Department of Managed Health Care would be a crime, the bill would impose a state-mandated local program.</p>
<p>SB 228 Cervantes (D)</p> <p>Status: 08/29/2025 In Committee. Held under submission.</p> <p>Position: Watch/Study</p>	<p>Comprehensive Perinatal Services Program.</p> <p>Summary: Existing law establishes the Comprehensive Perinatal Services Program, the goals of which are to decrease and maintain the decreased level of perinatal, maternal, and infant mortality and morbidity in the State of California and to support methods of providing comprehensive prenatal care that prevent prematurity and the incidence of low-birth-weight infants. Under the program, the State Department of Public Health is required to develop and maintain a statewide comprehensive community-based perinatal services program and enter into contracts, grants, or agreements with health care providers to deliver these services in a coordinated effort. Existing law also requires the department to monitor the delivery of services under those contracts, grants, and agreements through a uniform health data collection system that utilizes epidemiologic methodology. This bill would specify that the State Department of Health Care Services is responsible for implementing comprehensive community-based perinatal services for purposes of the Medi-Cal program. By July 1, 2027, the bill would require the State Department of Health Care Services, in consultation with the State Department of Public Health, to clarify each department's roles and responsibilities in the Comprehensive Perinatal Services Program by regulation. The bill would, among other things, require the State Department of Health Care Services to develop a training on administering the program, require all perinatal providers in the program to attend the training, and require all Medi-Cal managed care plans to ensure providers receive the training. The bill would require the State Department of Health Care Services, no later than July 15, 2026, to submit to the Assembly Health Committee and the Senate Health Committee, and post on its internet website, reports that identify the number of pregnant and postpartum individuals that received and were offered Comprehensive Perinatal Services Program services from January 1, 2022, to January 1, 2025, inclusive. The bill would also require the State Department of Health Care Services, commencing January 1, 2028, and every 3 years thereafter, to submit to those committees, and post on its internet website, reports that identify the number of pregnant and postpartum individuals that received and were offered Comprehensive Perinatal Services Program services during the previous 3 years. The bill would also state the intent of the Legislature to enact additional legislation relating to the program in order to implement several legislative recommendations made in a specified report issued by the California State Auditor's office including by, among other things, requiring</p>

	<p>the State Department of Health Care Services to create and use a perinatal services data form to engage in additional data collection duties, as specified.</p>
<p>SB 324 Menjivar (D)</p> <p>Status: 08/29/2025 In Committee. Held under submission.</p> <p>Position: Watch/Study</p>	<p>Medi-Cal: enhanced care management and community supports.</p> <p>Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law, subject to implementation of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, requires the department to implement an enhanced care management (ECM) benefit designed to address the clinical and nonclinical needs on a whole-person-care basis for certain target populations of Medi-Cal beneficiaries enrolled in Medi-Cal managed care plans. Under existing law, target populations include, among others, high utilizers with frequent hospital admissions, short term skilled nursing facility stays, or emergency room visits, and individuals experiencing homelessness. Existing law, subject to CalAIM implementation, authorizes a Medi-Cal managed care plan to elect to cover community supports, as specified. Under existing law, community supports that the department is authorized to approve include, among others, housing transition navigation services and medically supportive food and nutrition services. This bill would require a Medi-Cal managed care plan, for purposes of covering the ECM benefit, or if it elects to cover a community support, to contract with community providers, as defined, that can demonstrate that they are capable of providing access and meeting quality requirements in accordance with Medi-Cal guidelines. In determining which community providers to contract with, the bill would authorize Medi-Cal managed care plans to take into consideration whether those providers are available in the respective county and have experience in providing the applicable ECM or community support. The bill would require the department, for purposes of enforcing these provisions, to require Medi-Cal managed care plans to set goals every other year for the level of contracting and utilization of community providers and local entities, as defined. The bill would require these goals to be established in consultation with the department, as specified.</p>
<p>SB 363 Wiener (D)</p> <p>Status:08/29/2025- Hearing postponed by Committee.</p> <p>Position: Watch/Study</p>	<p>Health care coverage: independent medical review.</p> <p>Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law establishes the Independent Medical Review System within each department, under which an enrollee or insured may seek review if a health care service has been denied, modified, or delayed by a health care service plan or health insurer and the enrollee or insured has previously filed a grievance that remains unresolved after 30 days. This bill would require a health care service plan or health insurer to annually report to the appropriate department the total number of claims processed by the health care service plan or health insurer for the prior year and its number of treatment denials or modifications, separated and disaggregated as specified, commencing on or before June 1, 2026. The bill would require the departments to compare the number of a health care service plan's or health insurer's treatment denials and modifications to (1) the number of successful independent medical review overturns of the plan's or insurer's treatment denials or modifications and (2) the number of treatment denials or modifications reversed by a plan or insurer after an independent medical review for the denial or modification is requested, filed, or applied for. For a health care service plan or health insurer with 10 or more independent medical reviews in a given year, the bill would make the health care service plan or health insurer liable for an administrative penalty, as specified, if more than 50% of the independent medical reviews filed with a health</p>

	<p>care service plan or health insurer result in an overturning or reversal of a treatment denial or modification in any one individual category of specified general types of care. The bill would make a health care service plan or health insurer liable for additional administrative penalties for each independent medical review resulting in an additional overturned or reversed denial or modification in excess of that threshold. The bill would require the departments to annually include data, analysis, and conclusions relating to these provisions in specified reports.</p>
<p>SB 535 Richardson (D)</p> <p>Status: 08/29/2025- Hearing postponed by Committee.</p> <p>Position: Watch/Study</p>	<p>Obesity Care Access Act.</p> <p>Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act's requirements a crime. Existing law sets forth specified coverage requirements for plan contracts. This bill, the Obesity Care Access Act, would require an individual or group health care service plan contract or health insurance policy that provides coverage for outpatient prescription drug benefits and is issued, amended, or renewed on or after January 1, 2026, to include coverage for bariatric surgery and at least one anti-obesity medication approved by the United States Food and Drug Administration. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.</p>
<p>SB 762 Arreguin (D)</p> <p>Status: 06/01/2026 From committee with author's amendments. Read second time and amended. Re- referred to Com. on REV. & TAX</p> <p>CCAH's Position: Support</p>	<p>Transactions and use taxes: various jurisdictions.</p> <p>Summary: Existing law authorizes cities and counties, subject to certain limitations and approval requirements, to levy a transactions and use tax for general or specific purposes in accordance with the procedures and requirements set forth in the Transactions and Use Tax Law, including a requirement that the combined rate of all taxes that may be imposed in accordance with that law in the jurisdiction not exceed 2%. This bill would authorize, until December 31, 2031, various jurisdictions to levy taxes pursuant to the Transactions and Use Tax Law at specified rates, as prescribed. The bill would authorize those taxes to exceed the 2% limit described above. This bill would make legislative findings and declarations as to the necessity of a special statute for the jurisdictions authorized to impose a tax pursuant to the bill.</p>
<p>SB 812 Allen (D)</p> <p>Status: 08/29/2025 In Committee. Held under submission.</p> <p>Position: Watch/Study</p>	<p>Qualified youth drop-in center health care coverage.</p> <p>Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or health insurance policy issued, amended, renewed, or delivered on or after January 1, 2024, that provides coverage for medically necessary treatment of mental health and substance use disorders to cover the provision of those services to an individual 25 years of age or younger when delivered at a school site. This bill would expand the definition of school site to additionally require a contract or policy that provides coverage for medically necessary treatment of mental health and substance use disorders to cover the provision of those services to an individual 25 years of age or younger when delivered at a qualified youth drop-in center. Because a violation of this requirement relative to health care service plans would be a crime, the bill would create a state-mandated local program.</p>

<p>SB 874 Weber Pierson (D)</p> <p>Status: 06/03/2026 From committee with author's amendments. Read second time and amended. Re-referred to Com. on HEALTH.</p> <p>Position: Watch/Study</p>	<p>Medi-Cal: behavioral health treatment workgroup.</p> <p>Summary: Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Under existing law, to the extent required by the federal government and effective no sooner than required by the federal government, behavioral health treatment (BHT) is a covered service under the Medi-Cal program for individuals under 21 years of age. This bill would require the department, on or before July 1, 2027, to ensure that certain individuals providing BHT services under Medi-Cal undergo background checks. The bill would require the department to convene a stakeholder workgroup made up of BHT providers, managed care plans, and consumers with autism, among others, to review the implementation of BHT services in Medi-Cal and to advise the department on, among other topics, clinical guidelines for the provision of BHT services, treatment plan requirements, requirements for the provision of center-based services compared to services provided elsewhere, and supervision of unlicensed and uncertified professionals, as specified. The bill would require the department, on or before January 1, 2028, to release and maintain clear clinical guidance for the provision of the BHT benefit, as specified. The bill would require the department, on or before January 1, 2029, to report to the legislature on the utilization of the BHT benefit, a synopsis of changes made as a result of the stakeholder workgroup, and recommendations for actions necessary to ensure Medi-Cal reimbursement practices align with federal Medicaid program integrity requirements.</p>
<p>SB 912 Cervantes (D)</p> <p>Status 05/14/2026 Held in committee and under submission.</p> <p>Position: Watch/Study</p>	<p>Comprehensive perinatal services.</p> <p>Summary: Existing law provides for the Medi-Cal program, administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. Existing law establishes the Comprehensive Perinatal Services Program, the goals of which are to decrease and maintain the decreased level of perinatal, maternal, and infant mortality and morbidity in the State of California and to support methods of providing comprehensive prenatal care that prevent prematurity and the incidence of low-birth-weight infants. Under the program, the State Department of Public Health is required to develop and maintain a statewide comprehensive community-based perinatal services program and enter into contracts, grants, or agreements with health care providers to deliver these services in a coordinated effort. Existing law also requires the department to monitor the delivery of services under those contracts, grants, and agreements through a uniform health data collection system that utilizes epidemiologic methodology. This bill would instead require the State Department of Health Care Services to oversee a statewide comprehensive community-based perinatal services program and enroll health care providers to deliver these services to Medi-Cal members and make conforming changes, but would maintain the State Department of Public Health's role with related contracts, grants, and agreements. The bill would specify that any participation by the State Department of Public Health does not change the State Department of Health Care Services' authority to implement comprehensive community-based perinatal services for purposes of the Medi-Cal program. By January 1, 2028, the bill would require the State Department of Health Care Services, in consultation with the State Department of Public Health, to clarify each department's roles and responsibilities regarding comprehensive perinatal services by regulation. The bill would, among other things, require the State Department of Health Care Services to develop a training on administering the comprehensive perinatal services, require all perinatal providers providing perinatal care to Medi-Cal members to attend the training, and require all Medi-Cal managed care plans to ensure providers receive the training. The bill would require the State Department of Health Care Services, no later than July 15, 2027, to submit to the Assembly Committee on Health and the Senate Committee on Health, and post on its internet</p>

	<p>website, a report that identifies the number of pregnant and postpartum individuals that received comprehensive perinatal services from January 1, 2022, to January 1, 2025, inclusive.</p>
<p>SB 944 Wiener (D)</p> <p>Status: 5/26/2026 Referred to Com on Health</p> <p>Position: Watch/Study</p>	<p>Medi-Cal: acupuncture.</p> <p>Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is in part governed by, and funded pursuant to, federal Medicaid program provisions. Existing law sets forth a schedule of benefits covered under the Medi-Cal program, including acupuncture, but only to the extent federal matching funds are provided for acupuncture. This bill would remove the limitation requiring federal matching funds for acupuncture to be a covered benefit, thereby making acupuncture a covered benefit under Medi-Cal.</p>
<p>SB 950 Weber, Pierson (D)</p> <p>Status: 05/26/2026 Referred to Com. on HEALTH.</p> <p>Position: Watch/Study</p>	<p>Health care coverage: dementia.</p> <p>Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law prohibits specified health care service plan contracts and disability insurance policies from excluding persons covered by the plan from receiving benefits if they are diagnosed as having any significant destruction of brain tissue with resultant loss of brain function, including Alzheimer's disease. This bill would require a health care service plan contract or health insurance policy that is issued, amended, or renewed on or after January 1, 2027, to include coverage for all medically necessary treatments or medications, as determined by a health care provider, approved by the United States Food and Drug Administration (FDA) for the treatment of Alzheimer's disease or other related dementia. Under the bill, contracts and policies would not be required to cover drugs or treatments that are pharmaceutically equivalent drug products if the FDA approves more than one. On and after January 1, 2027, the bill would prohibit a health care service plan or health insurer from imposing step therapy protocols as a prerequisite to authorizing that coverage, except as provided. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state mandated local program.</p>
<p>SB 964 Smallwood-Cuevas (D)</p> <p>Status: 05/26/2026 Referred to Com. on HEALTH.</p> <p>Position: Watch/Study</p>	<p>Prescription drug coverage: dose adjustments</p> <p>Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law generally authorizes a health care service plan or health insurer to use utilization review, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. Existing law also prohibits a health care service plan that covers prescription drug benefits from limiting or excluding coverage for a drug that was previously approved for coverage if an enrollee continues to be prescribed that drug, as specified. This bill would authorize an enrollee's or insured's treating provider to request, and would require that they be granted, the authority to adjust the dose or frequency of a drug to meet the specific medical needs of the enrollee or insured without prior authorization if specified conditions are met. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.</p>

<p>SB 987 Weber Pierson (D)</p> <p>Status: 05/14/2026 May 14 hearing: Held in committee and under submission.</p> <p>Position: Watch/Study</p>	<p>California Health Access Fund.</p> <p>Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is in part governed by, and funded pursuant to, federal Medicaid program provisions. Existing federal law, enacted on July 4, 2025, sets forth various changes to different health care programs, including certain requirements for Medicaid eligibility with regard to work or community engagement reporting, redeterminations, and cost sharing, among other factors, for certain Medicaid populations pursuant to a specified implementation timeline. This bill would create the California Health Access Fund, to be administered by the department. Under the bill, moneys in the fund would include deposits, through any applicable transfers made by the Legislature, equal to the amount of any savings to the state resulting from decreased enrollment in the Medi-Cal program caused by enrollment barriers created by the above-described federal law. Under the bill, moneys in the fund would, upon appropriation, be used to ensure that California residents losing health care coverage due to the impacts of the federal law or due to any other divestments from the health care system can continue to receive health care services and that health care providers are reimbursed for these services.</p>
<p>SB 1002 Niello (R)</p> <p>Status: 5/11/2026 Referred to Com. on B. & P.</p> <p>Position: Watch/Study</p>	<p>Out-of-state physicians and surgeons: telehealth: license exemption.</p> <p>Summary: Existing law, the Medical Practice Act, establishes the Medical Board of California within the Department of Consumer Affairs and sets forth its powers and duties relating to the licensure and regulation of the practice of medicine by physicians and surgeons. Existing law generally prohibits the practice of medicine without a physician's and surgeon's certificate issued by the board. Existing law authorizes a health care provider to deliver health care via telehealth to a patient pursuant to specified protocols and conditions. Existing law defines "telehealth" as the delivery of health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care, and that telehealth includes synchronous interactions and asynchronous store and forward transfers. Existing law authorizes an eligible out-of-state physician and surgeon, as defined, to deliver health care via telehealth to an eligible patient. Existing law defines "eligible patient" as a person who, among other requirements, has a life-threatening disease or condition, as defined, and has not been accepted to participate in the clinical trial nearest to their home for the immediately life-threatening disease or condition, as specified, or in the medical judgment of a physician and surgeon, as defined, it is unreasonable for the patient to participate in that clinical trial due to the patient's current condition and state of disease. This bill would also include within the definition of "eligible patient" a patient whose immediately life-threatening disease or condition is in remission and the patient is continuing care with the previously established eligible out-of-state physician and surgeon, and would provide that those patients are not subject to the clinical trial requirement, as specified.</p>
<p>SB 1023 Laird (D)</p> <p>Status: 05/26/2026 Referred to Com. on HEALTH.</p>	<p>Health care coverage: antiretroviral drugs, drug devices, and drug products</p> <p>Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law generally prohibits a health care service plan, excluding a Medi-Cal managed care plan, or health insurer from subjecting antiretroviral drugs that are medically necessary for the prevention of HIV/AIDS, including preexposure</p>

<p>Position: TBD</p>	<p>prophylaxis or postexposure prophylaxis, to prior authorization or step therapy. Under existing law, a health care service plan or health insurer is not required to cover all of the therapeutically equivalent versions of those drugs without prior authorization or step therapy if at least one is covered without prior authorization or step therapy.</p> <p>This bill would instead prohibit a health care service plan, excluding a Medi-Cal managed care plan, or health insurer from subjecting antiretroviral drugs, drug devices, or drug products that are medically necessary for the prevention of HIV/AIDS to prior authorization or step therapy. The bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2027, that covers non-self-administered antiretroviral drugs, drug devices, or drug products that are approved by the United States Food and Drug Administration (FDA) for the prevention of HIV/AIDS as a medical benefit to also include those non-self-administered antiretroviral drugs, drug devices, or drug products as an outpatient prescription drug benefit. Because a willful violation of these provisions by a health care service plan would be a crime, this bill would impose a state-mandated local program.</p> <p>The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.</p>
<p>SB 1049 Pierson (D)</p> <p>Status: 05/26/2026 Referred to Com. on HEALTH.</p> <p>Position: TBD</p>	<p>Health Care Claims Reimbursement</p> <p>Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan or health insurer to reimburse a complete claim or a portion thereof within 30 calendar days after receipt of the claim, or, if a claim or portion thereof does not meet the criteria for completeness, to notify the claimant no later than 30 calendar days after receipt that the claim or portion thereof is contested or denied. This bill would grant a provider 90 days to submit a corrected claim after a health care service plan or health insurer denies a claim or sends a notice of overpayment for a claim based a defect that may be remedied by submitting a corrected claim. The bill would prohibit a plan or insurer from denying a corrected claim on the grounds that the provider did not submit the claim within the applicable claim filing deadline. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.</p>
<p>SB 1078 Laird (D)</p> <p>Status: 05/04/2026 Referred to Coms. on L. GOV. and REV. & TAX.</p> <p>Position: Support</p>	<p>Transactions and use taxes: County of Santa Cruz</p> <p>Summary: Existing law authorizes various local governmental entities, subject to certain limitations and approval requirements, to levy a transactions and use tax for general or specific purposes, in accordance with the procedures and requirements set forth in the Transactions and Use Tax Law, including a requirement that the combined rate of all taxes that may be imposed in accordance with that law in any county not exceed 2%. This bill would authorize, until December 31, 2030, the County of Santa Cruz, by an ordinance adopted by the Santa Cruz County Board of Supervisors, to levy a tax pursuant to the Transactions and Use Tax Law at a rate not to exceed 0.5% for general and special purposes, subject to voter approval, as</p>

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	<p>specified. The bill would authorize those taxes to exceed the 2% limit described above. This bill would make legislative findings and declarations as to the necessity of a special statute for the County of Santa Cruz. This bill would declare that it is to take effect immediately as an urgency statute.</p>
<p>SB 1089 Richardson (D)</p> <p>Status: 06/04/2026 Referred to Coms. on HEALTH and P. E. & R.</p> <p>Position: Watch/Study</p>	<p>Preventive Treatment Health Care Act.</p> <p>Summary: Existing law requires the California Health and Human Services Agency (CHHSA) to enter into partnerships resulting in the production of generic prescription drugs, including at least one form of insulin made available at production and dispensing costs, if one does not already exist in the market. Existing law additionally authorizes CHHSA to enter into partnerships to increase competition, lower prices, and address supply shortages for generic or brand name drugs to address emerging health concerns. This bill, the Preventive Treatment Health Care Act, would specify that the above-described authorized partnerships include those for at least one glucagonlike peptide-1 (GLP-1) approved by the United States Food and Drug Administration (FDA).</p>
<p>SB 1094 Weber Pierson (D)</p> <p>Status: 05/26/2026 Referred to Coms. on B. & P. and HEALTH.</p> <p>Position: Watch/Study</p>	<p>Prescription drugs.</p> <p>Summary: The Pharmacy Law governs the practice of pharmacy in this state, including the permissible duties of licensed pharmacists. A knowing violation of the Pharmacy Law is a misdemeanor. Existing law authorizes a pharmacist to select an alternative biological product when filling a prescription order for a prescribed biological product if the alternative biological product is interchangeable, as defined, and the prescriber does not personally indicate in a specified manner that a substitution is not to be made. This bill would additionally authorize a pharmacist to select an alternative biological product when filling a prescription order for a prescribed biological product if the alternative biological product is biosimilar to, as defined, or interchangeable with, the prescribed reference product, and the prescriber does not personally indicate in a specified manner that a substitution is not to be made. Because a knowing violation of this provision would be a misdemeanor, the bill would create a new crime, thereby imposing a state-mandated local program.</p>
<p>SB 1099 Reyes (D)</p> <p>Status: 05/18/2026 Referred to Coms. on HEALTH and HUM. S.</p> <p>Position: Watch/Study</p>	<p>State and local public benefits.</p> <p>Summary: Existing law establishes various public social services programs to provide eligible recipients with certain aid or health care benefits, among others. Existing law also requires each county to provide aid to its indigent residents who are not supported by other means under programs known as general assistance programs. Existing federal law, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), makes specified persons without lawful status in the United States ineligible for state and local public benefits unless a state law is enacted that affirmatively provides for that eligibility, and defines "state or local public benefit" to mean, among other things, any retirement, welfare, health, disability, public or assisted housing, postsecondary education, food assistance, unemployment benefit, or any other similar benefit for which payments or assistance are provided to an individual, household, or family eligibility unit by an agency of a state or local government or by appropriated funds of a state or local government. Existing state law authorizes a city, county, city and county, or hospital district, at its discretion, to provide aid, including health care, to persons who, but for the previously described provision of the federal PRWORA, would meet the eligibility requirements for any program of that entity. This bill would clarify that the above-described authorization for provision of aid is an authorization to provide a state or local public benefit, as defined by the federal PRWORA.</p>

<p>SB 1146 Gonzalez (D)</p> <p>Status: 05/26/2026</p> <p>Referred to Coms. on P. & C.P. and JUD.</p> <p>Position: Watch/Study</p>	<p>Advertisement claims: health-related consumer products and services: digital replicas and synthetic performers.</p> <p>Summary: Existing law makes it unlawful for any person doing business in California and advertising to consumers in California to make any false or misleading advertising claim. Existing law makes it unlawful for healing arts licensees, as specified, to disseminate or cause to be disseminated any form of public communication containing a false, fraudulent, misleading, or deceptive statement, claim, or image in order to induce the provision of services or products in connection with their licensed professional practice or business. Existing law makes a violation of these provisions punishable as a misdemeanor and, in the case of a licensed person, provides that a violation constitutes unprofessional conduct and grounds for suspension or revocation of a license by the relevant board. Existing law makes a person who produces, distributes, or makes available the digital replica, as defined, of a deceased personality's voice or likeness in an expressive audiovisual work or sound recording without specified prior consent liable to any injured party in an amount equal to the greater of \$10,000 or the actual damages suffered by a person controlling the rights to the deceased personality's likeness, except as prescribed. This bill would, subject to specified exceptions, require a person who creates or causes to be created an advertisement that includes the image, audio, or video of a digital replica or synthetic performer depicted as a health care provider that is generated or substantially altered using artificial intelligence or other computer technology to promote the sale of a health-related consumer product or service to include a clear and conspicuous disclosure that the image, audio, or video, as applicable, of the person in the advertisement was generated or substantially altered by artificial intelligence and that no human health care provider is depicted. The bill would also define terms for its purposes.</p>
<p>SB 1179 Menjivar (D)</p> <p>Status: 05/14/2026 May 14 hearing: Held in committee under submission.</p> <p>Position: Watch/Study</p>	<p>Doctors from El Salvador Program</p> <p>Summary: Existing law, the Medical Practice Act, establishes the Medical Board of California to license and regulate the practice of medicine. Existing law establishes within the act the Licensed Physicians from Mexico Program, which authorizes the board to issue a limited number of nonrenewable 3-year physician's and surgeon's licenses to physicians from Mexico who are licensed, certified, or recertified and in good standing in their medical specialty in Mexico and who meet specified other requirements. This bill would establish the Doctors from El Salvador Program for the purpose of permitting licensed physicians from El Salvador to practice medicine in California for up to 3 years. The bill would establish a program administration committee and would designate Clínica Monseñor Oscar A. Romero to serve as the primary administrator and lead representative of the committee. The bill would require the committee to, among other things, develop an interview examination for each specialty area, develop an orientation program, and recruit and vet candidates for the program. The bill would require the board to issue a nonrenewable 3-year physician and surgeon's license to a person who is licensed, certified, or recertified, and in good standing in the applicable medical specialty in El Salvador and who meets other requirements of the program. The bill would require a licensee in the program to only practice medicine in California at a federally qualified health center and any corresponding hospital. The bill would require a federally qualified health center employing a licensee in the program to take certain actions, including creating and maintaining medical quality assurance protocols for those licensees. The bill would also require the federally qualified health centers to work with a California medical school or residency program to conduct 10 secondary reviews of randomly selected patient encounters with each of those licensees every 6 months, as specified. The bill would also require the faculty from the medical school or residency program and federally qualified health center chief medical officers to jointly develop 2 quality assurance seminars to be attended by the licensees.</p>

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<p>SB 1202 Weber Pierson (D)</p> <p>Status: 05/26/2026 Referred to Com. on HEALTH.</p> <p>Position: Watch/Study</p>	<p>Medi-Cal: dashboard and outreach</p> <p>Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is in part governed by, and funded pursuant to, federal Medicaid program provisions. Existing federal law, enacted on July 4, 2025, sets forth various changes to Medicaid eligibility with regard to community engagement reporting, redeterminations, retroactive coverage, and cost sharing, among other factors, for certain Medicaid populations pursuant to a specified implementation timeline. This bill would require the department to establish a data dashboard that provides data on applications, enrollment, redeterminations, disenrollments, and terminations, with certain objectives in consideration, related to the impact of the above-described federal law on Medi-Cal eligibility and enrollment, as specified. The bill would require the dashboard to track and report on the specific data for work or community engagement requirements and exemptions. The bill would require the department, commencing no later than January 1, 2028, to operationalize the dashboard and to post the information on a monthly basis in a downloadable format. The bill would require the department to undertake efforts to conduct outreach about work or community engagement requirements, more frequent redeterminations, and changes to retroactive eligibility to impacted Medi-Cal beneficiaries, and to conduct listening sessions, as specified. Under the bill, beneficiary outreach and education would be coordinated across public social services programs to help minimize barriers to administrative disenrollments.</p>
<p>SB 1252 Durazo (D)</p> <p>Status: 04/22/2026 April 22 set for first hearing canceled at the request of author.</p> <p>Position: Watch/Study</p>	<p>California resident taxpayer health care coverage.</p> <p>Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. Existing law provides for the regulation of health care service plans by the Department of Managed Health Care and for the regulation of health insurers by the Department of Insurance. This bill would state the intent of the Legislature to enact legislation through which every California resident who pays taxes within the state would be entitled to health care coverage.</p>
<p>SB 1280 Valladares (R)</p> <p>Status: 04/22/2026 April 22 set for first hearing canceled at the request of author.</p> <p>Position: Watch/Study</p>	<p>Health care coverage for mental health and substance use disorders.</p> <p>Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law requires a health care service plan to meet specified requirements, and requires a health care service plan contract to provide to subscribers and enrollees specified basic health care services. This bill would make technical, non substantive changes to those provisions.</p>
<p>SB 1323 Rubio (D)</p> <p>Status: 05/26/2026 Referred to Coms. on HEALTH and JUD.</p> <p>Position: Watch/Study</p>	<p>Health care providers: patient access: immigration enforcement.</p> <p>Summary: Existing law requires a health care provider entity, as defined, to designate areas where a patient is receiving treatment or care, or where a patient is discussing protected health information, as nonpublic, in order to nonpublic areas of the facility. Existing law requires a health care provider entity to inform staff and relevant volunteers on how to respond to requests relating to immigration enforcement that grants access to health care provider entity sites or to patients. This bill would also require a health care provider entity to inform staff and relevant</p>

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	<p>volunteers on how to respond to requests by a person who is in lawful custody by immigration enforcement to notify a family member or designated support person about their current location. This bill contains other related provisions and other existing laws. enhance privacy available to facility users and promote a safe environment conducive to the facility's mission and patient care. Unless required by state or federal law, existing law prohibits a health care provider entity and its personnel from allowing any person access to the nonpublic areas of the facility for immigration enforcement purposes, unless that person has a valid judicial warrant or court order that specifically grants access to the nonpublic areas of the facility. Existing law requires a health care provider entity to inform staff and relevant volunteers on how to respond to requests relating to immigration enforcement that grants access to health care provider entity sites or to patients. This bill would also require a health care provider entity to inform staff and relevant volunteers on how to respond to requests by a person who is in lawful custody by immigration enforcement to notify a family member or designated support person about their current location.</p>
<p><u>SB 1422</u> Durazo (D)</p> <p>Status: 05/18/2026 Read second time. Ordered to third reading.</p> <p>Position: Watch/Study</p>	<p>Medi-Cal: eligibility: immigration status</p> <p>Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law sets a schedule of benefits that are covered by the Medi-Cal program. The federal Medicaid program prohibits payment to a state for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Existing state law extends Medi-Cal eligibility for the full scope of Medi-Cal benefits to individuals who do not have satisfactory immigration status if they are otherwise eligible for those benefits, with the exception of specified dental benefits for individuals who are 19 years of age or older. Existing law makes an individual who is 19 years of age or older, who does not have satisfactory immigration status, and who applies for Medi-Cal on or after January 1, 2026, or loses eligibility for pregnancy-related services and emergency medical treatment. Existing law, beginning no sooner than July 1, 2027, as specified, requires individuals who do not have satisfactory immigration status, who are not pregnant, and who are 19 to 59 years of of the Department of Finance to determine and report to the Legislature and the Governor the cost of implementing eligibility for the full scope of Medi-Cal benefits for individuals who do not have satisfactory immigration status if they are otherwise eligible, and whether including those costs the General Fund would be in a deficit, as defined. The bill would then, on January 1 of the year following such a determination, end the above described limitations on services for those who apply for Medi-Cal after January 1, 2026, or who lose eligibility for the full-scope of Medi-Cal benefits on or after January 1, 2026, thereby making an individual who is 19 years of age or older, who does not have satisfactory immigration status, eligible for the full scope of Medi-Cal benefits subject to certain limitations, such as the payment of premiums and certain dental benefits. The bill would require that the implementation of eligibility for the full-scope of Medi-Cal benefits be done by groups categorized by age, beginning with individuals over 49 years of age.</p>
<p><u>SB 1447</u> Senators Weber Pierson (Chair), Caballero, Durazo, Gonzalez, Grove, Menjivar, Padilla, Pérez, Rubio,</p>	<p>Health Omnibus</p> <p>Summary: Existing law, the California Retail Food Code, establishes uniform health and sanitation standards for retail food facilities, and defines multiple terms used in those provisions, including egg, food additive, beverage, and catering operation. Existing law requires that frozen potentially hazardous food be thawed in specified ways. A person who violates any provision of the California Retail Food Code is generally guilty of a misdemeanor. This bill would update the definition of catering</p>

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<p>Smallwood-Cuevas, and Valladares</p> <p>Status: 06/04/2026 June 9 hearing postponed by committee.</p> <p>Position: Watch/Study</p>	<p>operation to mean a permanent food facility approved for food preparation where food is served at a location other than its permitted location in specified circumstances. The bill would also add definitions for the terms egg product, intact meat, and mechanically tenderized. The bill would also require that reduced oxygen packaged fish bearing a label indicating it is to be kept frozen until time of use be completely removed from the packaging prior to thawing. By expanding the scope of an existing crime, the bill would impose a state-mandated local program. The bill would make additional technical changes to these provisions.</p>
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Total Bills:

- AB Bills 81
- SB Bills 28



DATE: June 24, 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

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

Summary. The Member Services Advisory Group (MSAG) Charter was revised to restore the purpose statement which was inadvertently omitted from the previous version.

Background. The MSAG ensures community and member participation in establishing the Alliance's public policy in quality, health equity, disparities, population health, children's services, and other ongoing plan functions. The Board reviewed and approved the initial MSAG charter for 2023 and for the integration of TotalCare (HMO D-SNP) Medicare Advantage Dual Special Needs Plan (D-SNP) in 2026.

Discussion. The purpose statement is being restored with no modifications from previous version of the charter.

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

Attachments.

1. Member Services Advisory Group (MSAG) Charter.

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Member Services Advisory Group (MSAG) Meeting Charter

Original Date: October 2023	Last Revision Date: 02/06/2026
Approved by: Alliance Board of Commissioners	

Overview	<p>The Member Services Advisory Group (MSAG) serves as the Alliance's Community Advisory Committee. 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).</p> <p style="color: red; text-decoration: underline;"><u>The MSAG ensures community and member participation in establishing the Alliance's public policy in quality, health equity, disparities, population health, children's services, and other ongoing plan functions.</u></p> <p>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.</p>
Duties	<p>Responsibilities of MSAG Members:</p> <ul style="list-style-type: none"> Review agenda and supporting documents in advance of the meeting. Attend meetings and arrive on time. Be prepared to discuss and vote on agenda items. Listen respectfully to all participants and actively engage in meeting topics. Follow the Alliance's Code of Conduct: Alliance Code of Conduct - Central California Alliance for Health. <p>Responsibilities of the Chair:</p> <ul style="list-style-type: none"> Provide meeting facilitation and direct the meeting process through the agenda. Guide and lead discussion to ensure all participants are provided equal opportunity for participation. <p>Responsibilities of the Vice Chair:</p>



Member Services Advisory Group (MSAG) Meeting Charter

	<ul style="list-style-type: none"> • Preside at the meetings in absence of the Chair. <p>Responsibilities of Alliance Staff:</p> <ul style="list-style-type: none"> • Alliance staff will serve as support to MSAG. • A coordinator will be assigned to support MSAG including but not limited to ensuring members are able effectively communicate and participate in meetings. • Staff supporting MSAG can be reached at MSAG@thealliance.health. • Alliance staff will ensure and monitor member and/or parent and caregiver input is considered for appropriate policies and decision-making.
Composition	<p>Membership</p> <ul style="list-style-type: none"> • 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). • One member of the MSAG will serve as Chair of the MSAG and one member will serve as Vice Chair of the MSAG. <p>Membership Terms</p> <ul style="list-style-type: none"> • Members will be appointed by the Alliance Board. • 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. • Members must attend at least 50% of meetings per calendar year. <p>Chair and Vice Chair Terms</p> <ul style="list-style-type: none"> • The Chair and Vice Chair shall be selected by MSAG members. • If both Chair and Vice Chair are absent, MSAG members present will select one member to act as Chair for the meeting.



Member Services Advisory Group (MSAG) Meeting Charter

	<p>The Chair and Vice Chair shall serve renewable one-year terms.</p>
Meeting Frequency and Locations	<ul style="list-style-type: none"> • Meetings will be held quarterly. • 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. • Meetings will take place in person in the Alliance offices listed below and joined together via videoconferencing. <ul style="list-style-type: none"> ○ <u>Mariposa County</u>: Mariposa County Health and Human Services 5362 Lemee Lane, Mariposa, CA 95338 ○ <u>Merced County</u>: 530 West 16th Street, Suite B, Merced, CA 95340 ○ <u>Monterey County</u>: 950 East Blanco Road, Suite 101, Salinas, CA 93901 ○ <u>San Benito County</u>: Community Services & Workforce Development (CSWD) 1161 San Felipe Road, Building B, Hollister, CA 95023 ○ <u>Santa Cruz County</u>: 1600 Green Hills Road, Suite 101, Scotts Valley, CA 95066
Agendas, Minutes, and Reporting	<ul style="list-style-type: none"> • Alliance staff are responsible for agenda and meeting material production and distribution. • Alliance staff will record minutes of meetings which will be approved by the MSAG members at each subsequent meeting.
Advisory Group Member Support	<ul style="list-style-type: none"> • 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. • MSAG members may receive a stipend to cover travel expenses and other costs associated with in-person meeting attendance.



Member Services Advisory Group (MSAG) Meeting Charter

	<ul style="list-style-type: none"> • 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. • MSAG complies with the Americans with Disabilities Act (ADA).
Open and Public Meetings	<ul style="list-style-type: none"> • Meetings are subject to the Brown Act, thus are open to the public. • Agendas and meeting materials will be published and posted publicly at least seventy-two (72) hours prior to each meeting. • Agenda packets are available by mail upon request.
Review of Charter	<p>MSAG shall review this charter at least annually.</p> <p>Any proposed changes shall be submitted to the Board for approval.</p>

Revision History:

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



Member Services Advisory Group (MSAG) Meeting Charter

February 25, 2026		Alliance Board of Commissioners
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DATE: June 24, 2026
TO: Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission
FROM: Van Wong, Chief Operating Officer
SUBJECT: Specialty Access Ad Hoc Committee Outcomes & Recommendations

Recommendation. Staff recommends the Board approve the reallocation of \$20 million from the Provider Supplemental Payment (PSP) program (2025–2027) to the Medi-Cal Capacity Grant Program (MCGP) to expand and redesign the Provider Recruitment Program and increase the number of specialist recruitment grants.

Summary. The Specialty Access Ad Hoc Committee met from March through May 2026 to evaluate specialty care access challenges and identify budget-neutral solutions for Board consideration. Across its meetings, the committee reviewed access conditions, discussed potential approaches to strengthen local specialty capacity, and aligned on specialist recruitment grants as the highest-impact near-term strategy. Committee members also supported a geographically responsive, data-driven approach to implementation that can reflect differences in provider market conditions across the service area.

Background. The Specialty Access Ad Hoc Committee was created to address persistent specialty care access challenges and identify budget-neutral strategies to improve local access across the service area. In February 2026, the Board approved developing and appointing members to an ad hoc committee, consistent with Brown Act requirements, to discuss and develop recommendations addressing specialty physician shortages in the Alliance service area. Over the course of its work, the committee reviewed current conditions, considered multiple strategic options, and narrowed its focus to the approaches most likely to improve access and inform a Board-level decision.

Discussion. The Committee concluded that expanding specialist recruitment grants is the most effective near-term strategy to improve local access and reduce reliance on out-of-area utilization. This conclusion reflected discussion of both the immediacy of current access challenges and the importance of pursuing an approach that can produce measurable capacity improvements within a reasonable implementation timeframe. Committee members also supported a geographically responsive strategy, recognizing that provider supply, recruitment barriers, and partnership opportunities differ across counties and regions.

The committee identified other promising strategies that require further exploration and discussion, including approaches focused on workforce deployment, shared or flexible specialist coverage models, partnerships and technology-enabled access solutions. Staff will use regional convenings to better understand local conditions, provider capacity, and

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partnership opportunities in each part of the service area. This input will help shape a more targeted approach that is appropriate to local geography, rather than advancing a single bundled solution before the specific needs and practical opportunities of each region are more fully defined. Staff will bring forward any recommended outcomes requiring Board approval.

Fiscal Impact. The recommended action reallocates \$20 million from the PSP program to the MCGP and does not require additional appropriation.

Attachments. N/A



DATE: June 24, 2026
TO: Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission
FROM: Jessica Finney, Community Grants Director
SUBJECT: Community Reinvestment Plan

Recommendation. Staff recommend the Board approve the Community Reinvestment Plan for Calendar Year 2024 net income obligations for submission to Department of Health Care Services (DHCS) per All Plan Letter (APL) 25-004.

Summary. DHCS requires Medi-Cal managed care plans (MCPs) to reinvest a portion of annual net income into community-based activities that improve health, advance health equity, and address community-identified needs. The proposed Community Reinvestment Plan establishes the Alliance's initial strategy for meeting its CY 2024 base and quality achievement obligations. Consistent with DHCS requirements, the final plan submitted to DHCS by September 1, 2026, will include required county-specific attestations from local Public Health and County Behavioral Health Directors acknowledging the proposed investment strategy.

Background. Consistent with the Alliance's Community Reinvestment policy pending DHCS approval (see attachment), Community Reinvestment planning is integrated with the Medi-Cal Capacity Grant Program (MCGP) annual investment planning process. The MCGP planning integrates with Community Health Assessment (CHA) priorities, Community Health Improvement Plans (CHIPs), Population Health Management requirements, member and physician advisory groups, and community stakeholder input. The Community Reinvestment plan does not represent a new allocation of funding but rather is a subsection of the board-directed reserve allocation to the MCGP. This alignment of the Community Reinvestment plan with the MCGP allows the Alliance to leverage and expand an established community-driven framework for investments, existing stakeholder engagement processes, and Board-approved investment priorities, while avoiding duplication of effort.

The Community Reinvestment Plan is the first year of a multi-year implementation approach. Future annual updates will incorporate obligations associated with CY 2025 and CY 2026 net income, additional stakeholder input, and any modifications necessary to maintain alignment with DHCS guidance, local community priorities, and the Alliance's annual investment planning process. There are two types of Community Reinvestment obligations: Base and Quality Achievement. Base applies to all counties, and Quality Achievement applies to those counties where the MCP operates in which the MCP does not meet minimum quality measure performance thresholds for the applicable CY. For CY 2024, the Quality Achievement obligation applies only to Merced County. This obligation must be met through investments in the Cultivating Improved Health category. For CY 2024, an MCP in its first year of operation in a

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given county is subject to community reinvestment beginning the following year in that county. Therefore, Mariposa and San Benito counties are not included in the proposed initial plan.

Discussion. The Medi-Cal Capacity Grant Program and Community Reinvestment program share common goals, including strengthening the health care workforce, addressing social drivers of health, expanding community capacity, and improving health equity. While aligned in planning and strategy, only activities that meet DHCS Community Reinvestment requirements and are not otherwise contractual Medi-Cal obligations may be counted toward Community Reinvestment funding obligations. Community Reinvestment funds are not used for activities required under the Medi-Cal contract, quality improvement activities (e.g., Care Gap grants), administrative costs, or CHA/CHIP participation requirements. Additionally, provider recruitment grants are not eligible for inclusion in the Community Reinvestment plan because the DHCS requirement states that “*expanding Provider Networks for the delivery of services covered under the MCP Contract*” is an impermissible use of funds.

For this initial Community Reinvestment submission for CY 2024, DHCS allows managed care plans to count certain voluntary investments already made by that meet Community Reinvestment categorical and timeframe specifications. Allowable investments must have been committed prior to March 7, 2025. Investments must be expended after the approval of the Community Reinvestment Plan submitted by September 1, 2026, and exhausted before the close of the initial three-year community reinvestment period at the end of 2029.

The Alliance's total CY 2024 obligation is \$5,015,758, Staff evaluated qualifying MCGP investments to determine where investments align with DHCS Community Reinvestment categories and requirements. The table below outlines the Alliance's Community Reinvestment obligations, the degree to which voluntary investments met the obligations, and where the gaps exist that would be addressed in year two (2025) through MCGP planning and grant investments to meet the remaining CY 2024 obligation.

Community Reinvestment Category	Merced	Monterey	Santa Cruz	Total Obligation
Cultivating Neighborhoods and Build Environment	\$1,675,000			\$1,675,000
Cultivating a Health Care Workforce		\$1,875,000	\$248,111	\$2,123,111
Cultivating Improved Health	\$932,027			\$932,027
Cultivating Local Communities				\$0
Cultivating Well-Being for Priority Populations				\$0
Total Voluntary Investments	\$2,607,027	\$1,875,000	\$248,111	\$4,730,138
Base Obligation	\$1,143,861	\$1,299,599	\$829,281	\$3,272,741
Met obligation	Yes	Yes	No	
Quality Achievement Obligation	\$1,743,018			\$1,743,018
Met obligation	No			
Total Obligation	\$2,886,878	\$1,299,599	\$829,281	\$5,015,758
Base Obligation Gap in Santa Cruz			\$581,170	
Quality Achievement Gap in Merced	\$810,991			

Voluntary investments identified through the Medi-Cal Capacity Grant Program (MCGP) satisfy the majority of the Alliance's CY 2024 Community Reinvestment obligation. The remaining obligation consists of a \$581,170 Base Community Reinvestment gap in Santa Cruz County and an \$810,991 Quality Achievement Community Reinvestment gap in Merced County. Consistent

with the Alliance's Community Reinvestment Policy, future Community Reinvestment allocations will be incorporated into the annual MCGP investment planning process. This approach allows the Alliance to evaluate community needs, stakeholder input, and funding opportunities through a single planning framework while ensuring all investments meet DHCS Community Reinvestment requirements.

Staff anticipate addressing the remaining obligation through future MCGP-funded activities already identified in the Community Reinvestment Plan, including community-based organization capacity-building efforts that support Medi-Cal member engagement, health and wellness initiatives, and member outreach and retention activities. These investments align with DHCS-approved Community Reinvestment categories and, if approved by DHCS in the Community Reinvestment Plan submission, can be incorporated into future MCGP funding recommendations brought to the Board for consideration.

Fiscal Impact. There is no fiscal impact associated with this agenda item. CY 2024 net income was allocated to the Medi-Cal Capacity Grant Program per policy #700-000 Board Designated Reserve.

Attachments.

1. Community Reinvestment Plan (draft)
2. Policy #xxxx – Community Reinvestment Plan (draft)

Central California Alliance For Health

Initial Community Reinvestment Plan CY 2024

Exhibit 1: Signed Attestation from the local Public Health Director for each local health jurisdiction in which the MCP operates indicating support for the proposed investment strategy or informed of Voluntary Investments (Voluntary Investments apply only to the Community Reinvestment Plan due by September 1, 2026).

Exhibit 2: Signed Attestation from the County Behavioral Health Director for each county in which the MCP operates indicating support for the proposed investment strategy or informed of Voluntary Investments (Voluntary Investments apply only to the Community Reinvestment Plan due by September 1, 2026).

Exhibit 4: Summary of Proposed Community Reinvestment Activities. MCPs with positive net income for the applicable CY must complete and submit this form for each proposed Community Reinvestment activity at minimum for the first year in each investment period. If an MCP and its Qualifying Subcontractors intend to modify its investment activities in years two and/or three of the investment period, it must complete and submit this form for the applicable CY.

Exhibit 5: Allocation of Community Reinvestment Obligations Across Counties. MCPs with positive net income for the applicable CY must indicate the proposed allocation of Community Reinvestment funds for each county in which it operates, including any investments by its Qualifying Subcontractors. MCPs must complete and submit this form on an annual basis for each year of the investment period based on net income for the applicable CY.

APPENDIX B, EXHIBIT 1: COMMUNITY REINVESTMENT ATTESTATION FORM FROM PUBLIC HEALTH DIRECTOR

Overview: On an annual basis, by September 1 or the first working day of September, MCPs with positive net income for the applicable calendar year are required to submit a Community Reinvestment Plan to DHCS. All new investment activities must align with community needs identified in the Community Health Assessment (CHA) and be generally agreeable to the Local Health Jurisdiction, and MCPs must obtain an attestation from Public Health Directors in support of this plan. In 2026 only, MCPs have the ability to claim voluntary investments toward their initial, 2026-2029 Community Reinvestment Obligation to honor existing investment commitments that may not be aligned with the CHA, but otherwise meet all requirements of [APL 25-004](#). If an MCP is claiming Voluntary Investments for all or part of their Community Reinvestment obligation, MCPs must inform LHJs of these activities but are not required to obtain an attestation of agreement with the planned activities.

Please complete the attestation statement(s) that applies to your MCP:

Community Reinvestment Plan Attestation of Support: *Applicable to all unless the MCP is fulfilling their entire obligation with voluntary investments in 2026.*

I, the undersigned, as an officer of [county / city name] _____, hereby attest that [MCP Name] _____ Community Reinvestment Plan for new investments anticipated in calendar year(s) [calendar year(s)] _____:

- » Aligns with community needs identified in the most current Community Health Assessment (CHA):

Yes

No (If no, explain):

Not applicable: This MCP is fulfilling their entire Community Reinvestment Obligation in this LHJ through voluntary investments.

- » Includes an investment strategy that is agreeable to the Local Health Jurisdiction (LHJ):

Yes

No (if no, explain):

Not applicable: This MCP is meeting their entire Community Reinvestment Obligation in this LHJ through voluntary investments.

And,

Voluntary Investment Attestation of Acknowledgement: *Applicable only in 2026.*

I, the undersigned, as an officer of [county/city name] _____, hereby attest that [MCP name] _____ has informed the Local Health Jurisdiction (LHJ) of its proposed voluntary investment activities included in its Community Reinvestment Plan, to be expended in calendar year(s) [calendar year(s)] _____:

Yes

No (if no, explain):

Not Applicable: This MCP is not claiming any voluntary investments in this LHJ.

By:

(Please type full name here)

(Please type title here)

(Signature)

(Date)

This attestation must be signed by the designated lead public health official of the associated jurisdiction, which may include the Public Health Director or another officially authorized equivalent and submitted to their MCP.

APPENDIX B, EXHIBIT 2: COMMUNITY REINVESTMENT ATTESTATION FORM FROM COUNTY BEHAVIORAL HEALTH DIRECTOR

Overview: On an annual basis, by September 1 or the first working day of September, MCPs with positive net income for the applicable calendar year are required to submit a Community Reinvestment Plan to DHCS. All new investment activities must align with community needs identified in the Community Health Assessment (CHA) and be generally agreeable to the Local Health Jurisdiction and County Behavioral Health Department, and MCPs must obtain an attestation from County Behavioral Health Directors in support of this plan. In 2026 only, MCPs have the ability to claim voluntary investments toward their initial, 2026-2029 Community Reinvestment Obligation to honor existing investment commitments that may not be aligned with the CHA, but otherwise meet all requirements of [APL 25-004](#). If an MCP is claiming Voluntary Investments for all or part of their Community Reinvestment obligation, MCPs must inform LHJs and County Behavioral Health Departments of these activities but are not required to obtain an attestation of agreement with the planned activities.

Please complete the attestation statement(s) that applies to your MCP:

Community Reinvestment Plan Attestation of Support: *Applicable to all unless the MCP is fulfilling their entire obligation with voluntary investments.*

I, the undersigned, as an officer of [county name] _____, hereby attest that [MCP Name] _____ Community Reinvestment Plan for new investments anticipated in calendar year(s) [calendar year(s)] _____:

- » Is informed by needs identified in the Behavioral Health Transformation planning process:
 - Yes
 - No (if no, explain):

 - Not applicable: This MCP is fulfilling their entire Community Reinvestment Obligation in this LHJ through voluntary investments.

- » To the extent CHA includes behavioral health needs as identified by the community, the County Behavioral Health Department agrees that the investment strategy is aligned with the CHA:
 - Yes
 - No (if no, explain):

 - Not applicable: This MCP is meeting their entire Community Reinvestment Obligation in this LHJ through voluntary investments.

» Includes an investment strategy that is agreeable to the County Behavioral Health Department:

Yes

No (if no, explain):

Not applicable: This MCP is meeting their entire Community Reinvestment Obligation in this LHJ through voluntary investments.

Voluntary Investment Attestation of Acknowledgement: *Applicable only in 2026.*

I, the undersigned, as an officer of [county name] _____, hereby attest that [MCP name] _____ has informed the County Behavioral Health Department of its proposed voluntary investment activities included in its Community Reinvestment Plan, to be expended in calendar year(s) [calendar year(s)] _____:

Yes

No (if no, explain):

Not Applicable: This MCP is not claiming any voluntary investments in this LHJ.

By:

(Please type full name here)

(Please type title here)

(Signature)

(Date)

This attestation must be signed by the designated lead behavioral health official of the associated jurisdiction, which may include the County Behavioral Health Director or another officially authorized equivalent and submitted to their MCP.

EXHIBIT 4: PROPOSED COMMUNITY REINVESTMENT ACTIVITIES

ACTIVITY #1: Capital: Health Care Facilities (Cultivating a Health Care Workforce)

Description of Proposed Community Reinvestment Activities	
Question	Response
<p>1) Provide a detailed description of the Community Reinvestment and the related use category or categories for the activity.</p>	<p>CCAH awarded four capital grants totaling \$4,081,111 to support the construction, renovation and acquisition of medical facilities, mobile medical clinic and hospital infrastructure that will increase access to health care services for Medi-Cal members. Of this total investment, \$2,123,111 will be expended under this plan. These investments directly support the Cultivating a Health Care Workforce Use category.</p>
<p>2) Please indicate all counties of operation where investments for this activity will occur.</p>	<p>Monterey, Santa Cruz</p>
<p>3) Please specify the intended timeline for funding this activity (e.g., the CY 2026 – CY 2029 investment period based on CY 2024 – CY 2026 net income).</p>	<p>CCAH is claiming voluntary investments towards its CY 2024 Community Reinvestment obligation. The voluntary investments included in this plan were awarded in CY 2024 and will be expended in CY 2027 – CY 2029.</p>
<p>4) Provide a description of how the activity is informed by the LHJ’s CHA. Please include a link or hard copy of the most recent CHA.</p>	<p>Access to health care was identified as a top health priority in the LHJ Community Health Assessments for Monterey and Santa Cruz counties. Capital grants to health care providers address access challenges by increasing the physical capacity of health care facilities, enabling providers to serve more Medi-Cal members serves, reduce wait time, and deliver more accessible services.</p> <p>Monterey CHA 2025: https://www.unitedwaymcca.org/sites/unitedwaymcca/files/HEalthy%20Monterey%20County/2025%20PRC%20CHNA%20Report%20-%20Monterey%20County%2C%20CA_.pdf</p> <p>Santa Cruz CHA 2024: https://www.datasharescc.org/stories/index/view?alias=2024CHA&pid=23369166541</p>
<p>5) If applicable, provide a description of how the activity is informed by the BHT community planning process.</p>	<p>This is not applicable because the Alliance is claiming voluntary investments made in 2024, prior to the BHT community planning process requirement.</p>

<p>6) If applicable, identify the LHJ CHIP activity that the Community Reinvestment activity matches. Please include a link or hard copy of the most recent CHIP.</p>	<p>Capital investments to expand health care facilities support an objective related access to health services outlined in the Monterey County CHIP. The Monterey County CHIP as published after the CY 2024 voluntary investments. The Santa Cruz County CHIP based on the 2024 CHA is not yet available.</p> <p>Monterey County 2025-2028 CHIP <u>Priority:</u> Increasing Access to Health Services <u>Objective:</u> Increase access to health services for people experiencing health disparities. https://www.countyofmonterey.gov/home/showpublisheddocument/144165/639075342181130000</p>
<p>7) Provide a description of the anticipated benefits of the Community Reinvestment activity, populations expected to benefit, and alignment with guiding principles identified in the APL. Note: If this activity is intended to meet the MCP’s Quality Achievement Community Reinvestment requirement, the MCP must indicate how the activity aligns with the “Cultivating Improved Health” category.</p>	<p>The anticipated benefits of these investments include increased access to primary, specialty, and hospital-based health care services for Medi-Cal members through expanded facility capacity, modernized infrastructure, and improved service delivery. The primary populations expected to benefit are Medi-Cal members, including Medi-Cal members living in communities with limited access to health care services in Monterey and Santa Cruz counties. These investments align with the APL guiding principles by strengthening community-based health care infrastructure and supporting long-term improvements in the availability and accessibility of services for Medi-Cal members.</p>
<p>8) Provide a description of the approach taken to engage the CAC in the Community Reinvestment planning process, including a summary of input and recommendations provided.</p>	<p>Community reinvestment planning is aligned with CCAH’s Medi-Cal Capacity Grant Program (MCGP) annual planning process, formally implemented in 2024, which integrates input from the Member Services Advisory Group (MSAG) about investment priorities. Among other identified needs to be addressed through the MCGP, the group confirmed the priority need of expanding the number of health care facilities and expanding infrastructure to improve access to care.</p>
<p>9) If applicable, provide a description of the approach taken to engage other community stakeholders in the Community Reinvestment planning process, including a</p>	<p>As part of the MCGP planning process, stakeholder engagement conducted in 2024 included interviews with community leaders representing health care providers, hospitals, community-based organizations, and local government across the Alliance’s five-county service area. Participants consistently identified access to care challenges,</p>

summary of stakeholders involved and any input or recommendations provided.	including provider shortages, limited specialty and behavioral health services, transportation barriers, and concerns about health care infrastructure in rural communities. The voluntary investments align with this input by expanding health care facility capacity and strengthening access to services for Medi-Cal members.
10) Provide a description of any investments recommended by the CAC not included in the Community Reinvestment Plan.	N/A
11) Provide a summary of input provided by the Chief Health Equity Officer on the Community Reinvestment Plan and/or planning efforts.	The Chief Health Equity Officer participates on the MCGP internal review committee with executive level oversight of grant investments and planning process.
12) If applicable, provide a summary of input provided by the QIHEC on the Community Reinvestment Plan and/or planning efforts.	N/A
13) Provide a description of how the Community Reinvestment activity will be measured and evaluated.	Evaluation of outcomes achieved relative to the project objectives and original need; measurement of effective capacity expansion resulting from the project and sustainability plan; report of unanticipated outcomes and opportunities.
14) If applicable, please provide the name of any Qualifying Subcontractors that intend to invest in this activity.	N/A

EXHIBIT 4: PROPOSED COMMUNITY REINVESTMENT ACTIVITIES

ACTIVITY #1: Capital – Housing (Cultivating Neighborhoods and Built Environment)

Description of Proposed Community Reinvestment Activities	
Question	Response
1) Provide a detailed description of the Community Reinvestment and the related use category or categories for the activity.	CCAH awarded a capital grant totaling \$2,500,000 to support the of short-term post hospitalization housing and permanent supportive housing. Of this total investment, \$1,675,000 will be expended under this plan. These investments directly support the Cultivating Neighborhoods and category.
2) Please indicate all counties of operation where investments for this activity will occur.	Merced
3) Please specify the intended timeline for funding this activity (e.g., the CY 2026 – CY 2029 investment period based on CY 2024 – CY 2026 net income).	CCAH is claiming voluntary investments towards its CY 2024 Community Reinvestment obligation. The voluntary investments included in this plan were awarded in CY 2024 and will be expended in CY 2027.
4) Provide a description of how the activity is informed by the LHJ’s CHA. Please include a link or hard copy of the most recent CHA.	Housing was identified as a top health priority in the LHJ Community Health Assessment for Merced County. Capital funding for solutions on the housing continuum addresses the short-term need of Medi-Cal members experiencing homelessness and long-term solutions for permanent housing that connect members to care. Merced County CHA 2023: https://www.countyofmerced.com/DocumentCenter/View/12213/Merced-County-Community-Health-Assessment
5) If applicable, provide a description of how the activity is informed by the BHT community planning process.	This is not applicable because the Alliance is claiming voluntary investments made in 2024, prior to the BHT community planning process requirement.

<p>6) If applicable, identify the LHJ CHIP activity that the Community Reinvestment activity matches. Please include a link or hard copy of the most recent CHIP.</p>	<p>Capital investments in housing facilities support an objective related access to health services outlined in the Monterey County CHIP. The Monterey County CHIP as published after the CY 2024 voluntary investments. The Santa Cruz County CHIP based on the 2024 CHA is not yet available.</p> <p>Merced County 2024-2029 CHIP <u>Priority:</u> Access to Health Care <u>Objective:</u> Increase integration across systems of care to increase continuity and quality of care.</p> <p>Merced County CHIP 2024-2029: https://www.countyofmerced.com/DocumentCenter/View/12852/MCDPH-Community-Health-Improvement-Plan-2024-2029</p>
<p>7) Provide a description of the anticipated benefits of the Community Reinvestment activity, populations expected to benefit, and alignment with guiding principles identified in the APL. Note: If this activity is intended to meet the MCP’s Quality Achievement Community Reinvestment requirement, the MCP must indicate how the activity aligns with the “Cultivating Improved Health” category.</p>	<p>The anticipated benefits of these investments include improved health outcomes and reduced barriers to care through access to short-term post-hospitalization housing and permanent supportive housing. The primary population expected to benefit is Medi-Cal members experiencing homelessness, including individuals with complex physical, behavioral health, and social needs in Merced County. These investments align with the APL guiding principles by addressing social drivers of health, advancing health equity, improving continuity of care, and supporting community-based solutions that promote housing stability and access to health services.</p>
<p>8) Provide a description of the approach taken to engage the CAC in the Community Reinvestment planning process, including a summary of input and recommendations provided.</p>	<p>Community reinvestment planning is aligned with CCAH’s Medi-Cal Capacity Grant Program (MCGP) annual planning process, formally implemented in 2024, which integrates input from the Member Services Advisory Group (MSAG) about investment priorities. Among other identified needs to be addressed through the MCGP, the group confirmed the priority need of increasing housing options and expanding awareness of new housing benefits.</p>
<p>9) If applicable, provide a description of the approach taken to engage other community stakeholders in the Community Reinvestment planning</p>	<p>As part of the MCGP planning process, stakeholder engagement conducted in 2024 included interviews with community leaders representing health care providers, hospitals, community-based organizations, and local government across the Alliance's five-county service area. Participants consistently identified</p>

<p>process, including a summary of stakeholders involved and any input or recommendations provided.</p>	<p>housing instability, homelessness, and the lack of affordable housing as significant barriers to health and well-being for Medi-Cal members. The voluntary investment aligns with this input by expanding short-term post-hospitalization housing and permanent supportive housing capacity, helping members achieve housing stability while improving access to health care and supportive services.</p>
<p>10) Provide a description of any investments recommended by the CAC not included in the Community Reinvestment Plan.</p>	<p>N/A</p>
<p>11) Provide a summary of input provided by the Chief Health Equity Officer on the Community Reinvestment Plan and/or planning efforts.</p>	<p>The Chief Health Equity Officer participates on the MCGP internal review committee with executive level oversight of grant investments and planning process.</p>
<p>12) If applicable, provide a summary of input provided by the QIHEC on the Community Reinvestment Plan and/or planning efforts.</p>	<p>N/A</p>
<p>13) Provide a description of how the Community Reinvestment activity will be measured and evaluated.</p>	<p>Evaluation of outcomes achieved relative to the project objectives and original need; measurement of effective capacity expansion resulting from the project and sustainability plan; report of unanticipated outcomes and opportunities.</p>
<p>14) If applicable, please provide the name of any Qualifying Subcontractors that intend to invest in this activity.</p>	<p>N/A</p>

EXHIBIT 4: PROPOSED COMMUNITY REINVESTMENT ACTIVITIES

ACTIVITY #3: Community-Based Health Programs (Cultivating Improved Health)

Description of Proposed Community Reinvestment Activities	
Question	Response
<p>1) Provide a detailed description of the Community Reinvestment and the related use category or categories for the activity.</p>	<p>CCAH awarded four grants totaling \$1,781,186 to support healthy behaviors, positive health outcomes and access to health services for Medi-Cal members in Merced County. Of this total investment, \$932,027 will be expended under this plan. These investments directly support the Cultivating Improved Health category and include culturally responsive home visiting services for families, community-based physical activity and wellness opportunities, capacity-building support for community organizations connecting members to health coverage, programs and services, and expanded nutrition education and healthy food access initiatives. To meet CCAH's full obligation for CY 2024, an additional \$810,991 will be invested in community-based organizations' capacity building to enhance Medi-Cal member access and engagement in health and wellness under the Cultivating Improved Health category in Merced County. Additionally, \$581,170 will be invested in connecting community-based organizations to support continued Medi-Cal coverage for Santa Cruz County members under the Cultivating Local Communities category.</p>
<p>2) Please indicate all counties of operation where investments for this activity will occur.</p>	<p>Merced, Santa Cruz</p>
<p>3) Please specify the intended timeline for funding this activity (e.g., the CY 2026 – CY 2029 investment period based on CY 2024 – CY 2026 net income).</p>	<p>CCAH is claiming voluntary investments towards its CY 2024 Community Reinvestment obligation. The voluntary investments included in this plan were awarded in CY 2024 and will be expended in CY 2027. The additional investments of \$1,392,161 to meet the remaining Base and Quality Achievement obligations will be expended 2027-2029.</p>
<p>4) Provide a description of how the activity is informed by the LHJ's CHA. Please include a link or hard copy of the most recent CHA.</p>	<p>The Merced County CHA identified a number of health priorities that are addressed through investments in community health programs, including: Preventable Chronic Diseases: Heart Disease, Stroke, Diabetes, Obesity, Pregnancy and Birth, and Child and Adolescent Health. Merced County CHA 2023:</p>

	<p>https://www.countyofmerced.com/DocumentCenter/View/12213/Merced-County-Community-Health-Assessment</p> <p>The Santa Cruz County CHA identified the priorities of availability, affordability, and accessibility to high-quality medical care and addressing the high cost of insurance.</p> <p>Santa Cruz CHA 2024: https://www.datasharescc.org/stories/index/view?alias=2024CHA&pid=23369166541</p>
<p>5) If applicable, provide a description of how the activity is informed by the BHT community planning process.</p>	<p>This is not applicable because the Alliance is claiming voluntary investments made in 2024, prior to the BHT community planning process requirement. The BHT plan is not yet complete in Merced County but would be consulted in planning of activities for expenditures 2027-2029 to invest in community-based organizations' capacity building to enhance Medi-Cal member access and engagement in health and wellness.</p>
<p>6) If applicable, identify the LHJ CHIP activity that the Community Reinvestment activity matches. Please include a link or hard copy of the most recent CHIP.</p>	<p>Investments in community-based health programs support an objective related access to health services outlined in the Merced County CHIP. The Merced County CHIP was published after the CY 2024 voluntary investments. The Santa Cruz County CHIP based on the 2024 CHA is not yet available.</p> <p>Merced County 2024-2029 CHIP Priority: Access to Health Care Objective: Create community-based health support services intended to enhance clinical care.</p> <p>Merced County CHIP 2024-2029: https://www.countyofmerced.com/DocumentCenter/View/12852/MCDPH-Community-Health-Improvement-Plan-2024-2029</p>
<p>7) Provide a description of the anticipated benefits of the Community Reinvestment activity, populations expected to benefit, and alignment with guiding principles identified in the APL. Note: If this activity is intended to meet the MCP's Quality Achievement Community Reinvestment requirement,</p>	<p>The anticipated benefits of these investments include improved health outcomes, increased engagement in preventive and wellness services, enhanced access to Medi-Cal coverage, health programs and resources, and stronger community-based support systems for Medi-Cal members. Populations expected to benefit include children and families, individuals at risk for chronic disease, residents of rural and underserved communities, and other Medi-Cal members facing barriers to accessing health services and healthy living opportunities in Merced and Santa Cruz counties. These investments align with the APL guiding principles by advancing health equity, addressing social drivers of health, strengthening community capacity, and improving access to culturally responsive, community-based services. The investments supporting home visiting, physical activity and wellness opportunities, nutrition education, healthy food access,</p>

the MCP must indicate how the activity aligns with the “Cultivating Improved Health” category.	and community-based organizational capacity building directly align with the Cultivating Improved Health category by promoting healthy behaviors, preventive care, and positive health outcomes for Medi-Cal members.
8) Provide a description of the approach taken to engage the CAC in the Community Reinvestment planning process, including a summary of input and recommendations provided.	Community reinvestment planning is aligned with CCAH’s Medi-Cal Capacity Grant Program (MCGP) annual planning process, formally implemented in 2024, which integrates input from the Member Services Advisory Group (MSAG) about investment priorities. Among other identified needs to be addressed through the MCGP, the group confirmed the priority need of expanded programs to address barriers to care, collaboration between health care providers and CBOs, and capacity building support for CBOs.
9) If applicable, provide a description of the approach taken to engage other community stakeholders in the Community Reinvestment planning process, including a summary of stakeholders involved and any input or recommendations provided.	As part of the MCGP planning process, stakeholder engagement conducted in 2024 included interviews with community leaders representing health care providers, hospitals, community-based organizations, and local government across the Alliance’s five-county service area. Participants identified the need for stronger community-based programs that connect residents to health services, improve health education and awareness, address language and cultural barriers, and expand trusted supports for populations facing challenges accessing care. These investments respond to that input by strengthening community-based organizations, expanding health and wellness programming, and increasing opportunities for Medi-Cal members to engage with preventive services and community resources.
10) Provide a description of any investments recommended by the CAC not included in the Community Reinvestment Plan.	N/A
11) Provide a summary of input provided by the Chief Health Equity Officer on the Community Reinvestment Plan and/or planning efforts.	The Chief Health Equity Officer participates on the MCGP internal review committee with executive level oversight of grant investments and planning process.
12) If applicable, provide a summary of	The QIHEC may be consulted in planning of activities for expenditures 2027-2029 to invest in community-based

input provided by the QIHEC on the Community Reinvestment Plan and/or planning efforts.	organizations' capacity building to enhance Medi-Cal member access and engagement in health and wellness.
13) Provide a description of how the Community Reinvestment activity will be measured and evaluated.	Evaluation of outcomes achieved relative to the project objectives and original need; measurement of effective capacity expansion, including increase member awareness and knowledge of Medi-Cal benefits, community resources, and how to access care; report of unanticipated outcomes and opportunities.
14) If applicable, please provide the name of any Qualifying Subcontractors that intend to invest in this activity.	N/A

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EXHIBIT 5: PROPOSED ALLOCATION OF FUNDS

MCP Name: Central California Alliance for Health

County Name: Merced County

Proposed Allocation of Funds by the MCP

Brief Description of Activity	Allocation of Base or Quality Achievement Funds?	Funding Allocation for Investment Period		
		Y1	Y2	Y3
Grant to support transitional housing and permanent supportive housing.	Base Community Reinvestment	\$1,675,000		
Grant to support promotora home visiting program for mothers with young children.	Quality Achievement Funds	\$121,750		
Grant to engage Medi-Cal members and local schools in physical activity programs.	Quality Achievement Funds	\$25,000		
Grant to support construction of community garden and nutrition education hub.	Quality Achievement Funds	\$302,750		
Grants for community-based organizations' capacity building to enhance Medi-Cal member access and engagement in health and wellness.	Quality Achievement Funds	\$482,527	\$810,991	
Total		\$2,607,027	\$810,991	

APPENDIX B, EXHIBIT 5: PROPOSED ALLOCATION OF FUNDS

MCP Name: Central California Alliance for Health

County Name: Monterey County

Proposed Allocation of Funds by the MCP

Brief Description of Activity	Allocation of Base or Quality Achievement Funds?	Funding Allocation for Investment Period		
		Y1	Y2	Y3
Grant to support the construction of a community health center facility.	Base Community Reinvestment	\$1,875,000		
Total		\$1,875,000		

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APPENDIX B, EXHIBIT 5: PROPOSED ALLOCATION OF FUNDS

MCP Name: Central California Alliance for Health

County Name: Santa Cruz County

Proposed Allocation of Funds by the MCP


Brief Description of Activity	Allocation of Base or Quality Achievement Funds?	Funding Allocation for Investment Period		
		Y1	Y2	Y3
Grants to support the infrastructure for a health care facility (ER/L&D) and purchase/build out of a mobile health clinic.	Base Community Reinvestment	\$248,111		
Grants for community-based organizations to support Medi-Cal member coverage and capacity to meet Medi-Cal renewal requirements.	Base Community Reinvestment		\$581,170	
Total		\$248,111	\$581,170	

	POLICIES AND PROCEDURES
Policy #: 107-XXXX	Lead Department: Community Grants
Title: Implementation of DHCS Community Reinvestment Requirements	
Original Date: 04/28/25	Date Published:
Approved by: Jessica Finney, Community Grants Director	

Purpose: This policy defines the Alliance's implementation of Community Reinvestments as defined by the Department of Health Services (DHCS) aligned with the Alliance's existing Medi-Cal Capacity Grant Program and describes the process by which the Alliance and Qualifying Subcontractors will meet the requirements of All Plan Letter (APL) 25-004: Community Reinvestment Requirements.

Policy:


- I. The Alliance will ensure Community Reinvestments are aligned with community-identified priorities with investments focused toward reducing existing health disparities and/or promoting health outcomes for members through investments primarily focused on upstream causes of poor health such as: housing instability, food insecurity, poverty, barriers in access to health and social services, and environments that negatively impact health.
- II. The Alliance shall align Community Reinvestment activities with the following principles in accordance with DHCS APL 25-004:
 1. Engage with the community
 2. Align community identified priorities with investments in health outcomes and equity
 3. Ensure funding targets non-contract activities
- III. The Alliance will ensure Community Reinvestment activities align with DHCS permitted categories in accordance with DHCS APL 25-004:
- IV. Community Reinvestment activities will be informed by Community Health Assessments (CHA) and Community Health Improvement Plans (CHIP) led by the by the Local Health Jurisdictions (LHJ) in the Alliance's service areas with meaningful participation by the Alliance, in accordance with the Alliance's Population Health Management Program Description and the DHCS Behavioral Health Transformation (BHT) process.
- V. The Alliance will engage Alliance members and community stakeholders in the Community Reinvestment planning process including, but not limited to, the Alliance's Member Services Advisory Group (MSAG) and Physician Advisory Group (PAG),
- VI. The Alliance will engage the Chief Health Equity Officer in the Community Reinvestment planning process and ensure all community reinvestment plans align with overall health equity needs and priorities.
- VII. Community Reinvestment funds will not be allocated towards activities included in the DHCS Contract (Contract) with the Alliance or services carved out of the Contract but covered under Medi-Cal.
- VIII. Community Reinvestment obligations will not be met through expenditures for:
 1. Provision of health care services to eligible Members within scope of Medi-Cal benefits or state-funded services as defined in the primary or secondary operations contracts, inclusive of all exhibits and attachments; or

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2. Provision of health care services to eligible members within the scope of Medi-Cal benefits or state-funded services that are carved out of the primary or secondary operations contracts; or
 3. Health care services inclusive of activities that improve health care quality as defined at 42 Code of Federal Regulations CFR section 438.8e3; or
 4. Alliance administrative activities; or
 5. Procedural or administrative activities related to Community Reinvestment planning or
 6. Implementation; or
 7. Member incentives or member grants.
- IX. The Alliance's planning and decision-making process for activities based on net income for Calendar Year (CY) 2025 and thereafter will include LHJs and County Behavioral Health Departments.
- X. The Alliance will initiate investments in community reinvestment activities no later than the close of the CY in which DHCS approves the initial Community Reinvestment Plan for the applicable investment period, and the Community Reinvestment funding obligations for each three-year investment period will be spent on specific activities included in the initial Community Reinvestment Plan by the end of the three-year period.
- XI. The Alliance will submit a Community Reinvestment Plan starting in Quarter 3 CY 2026 and annually thereafter, unless the Alliance does not have a positive net income for the applicable CY.
- XII. The Alliance will ensure that all Qualifying Subcontractors meet all requirements outlined within the scope of this policy, in alignment with DHCS APL 25-004 requirements.

Definitions:

- I. Medi-Cal Capacity Grant Program (MCGP): The Alliance's MCGP provides grants to health care providers and community organizations funded through an allocation of the Alliance's excess reserves to develop Medi-Cal capacity in Mariposa, Merced, Monterey, San Benito and Santa Cruz counties in priority focus areas, as directed by the Alliance's governing board and informed by community stakeholders.
- II. Community Health Assessment (CHA): – Comprehensive data assessment of health and social determinants of health in a County. Owned by the LHD, and a deliverable for Public Health Accreditation.
- III. Community Health Improvement Plan (CHIP): – Multi-agency strategic plan to address health issues in a County. Owned by the LHD, and a deliverable for Public Health Accreditation.
- IV. Local Health Jurisdiction: A county health department responsible for protecting and promoting public health within a defined geographic area, as defined by California Health and Safety Code Section 101185 responsible for delivering public health services, implementing


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programs, and coordinating initiatives such as community health assessments.


- V. Behavioral Health Transformation. Department of Health Care Services (DHCS) implementation of ballot initiative Proposition 1 to modernize the behavioral health delivery system to improve accountability, increase transparency, and expand the capacity of behavioral health care facilities.
- VI. Health Equity. Ensuring that every individual, regardless of race, background, gender, sexuality, or ability, has a fair and just opportunity to attain their highest level of health. This encompasses not only access to health care but also addresses broader social and economic factors that influence health outcomes.
- VII. Member Services Advisory Group (MSAG). A Community Advisory Committee of the Alliance composed of Alliance members that ensures that individuals enrolled in Medi-Cal, particularly those from historically marginalized communities, participate in establishing the Alliance's public policy in quality, health equity, disparities, population health, children services, and other ongoing plan functions.
- VIII. Physician Advisory Group (PAG). Contracted physicians who advise and provide perspective to the Chief Medical Officer and staff regarding Alliance policies, programs and initiatives including but not limited to 1) Advise the Chief Medical Officer and staff regarding Alliance policies on clinical matters; and 2) Advise the Chief Medical Officer and staff on Alliance programs, policies and communication that affect providers and/or members.
- IX. Qualifying Subcontractor. An entity in a Subcontractor Agreement with the Alliance that is required to submit a Medical Loss Ratio (MLR) report pursuant to DHCS APL 24-018 and assumes risk for at least 100,000 Members or at least 50% of the Alliance's Members within a given county or rating region.
- X. Quality Achievement Community Reinvestment. The additional net income that MCPs are required to invest into initiatives in counties where the MCP operates in which they do not meet minimum quality measure performance thresholds for the applicable CY, starting with CY 2024. The MCP Contract requires MCPs to allocate Quality Achievement Community Reinvestment funds equal to 7.5% of its annual net income.
- XI. Quality Improvement Health Equity Committee (QIHEC). The Alliance committee responsible for the Quality Improvement (QI) process.

Procedures:

- I. Community Reinvestment Planning and Implementation. The Alliance Community Reinvestment planning will begin in CY 2025.

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1. Community Reinvestment planning will be aligned with the Medi-Cal Capacity Grant Program annual investment planning process administered by the Community Grants Department as directed by the Alliance's governing board in CY 2025 and every year thereafter for which the Alliance is required to meet Community Reinvestment activity requirements.
 2. Community Reinvestment activities will start in CY 2026 and no later than the close of the CY in which DHCS approves the Alliance's Community Reinvestment plan.
 3. The Alliance will expend all funds for the initial investment period under the first Community Reinvestment plan approved by DHCS by the close of CY 2029.
- II. Community Reinvestment Categories. The Alliance shall make investments in activities that fall within one or more of the following five (5) permitted use categories in accordance with DHCS APL 25-004 Community Reinvestment Requirements. Activities may correspond to one or more categories:
1. Cultivating Neighborhoods and Built Environment – investments that create neighborhoods and environments that promote health, well-being and safety.
 2. Cultivating a Health Care Workforce – investments in health workforce development, recruitment, and training for diverse providers.
 3. Cultivating Well-Being for Priority Populations – investments that address community-specific needs through tailored supports and services not covered under the Alliance contract with DHCS for Medi-Cal services.
 4. Cultivating Local Communities – investments that bolster the lives of individuals and contribute to the advancement and wellbeing of community.
 5. Cultivating Improved Health – investments targeted toward upstream root causes of poor health that addresses immediate and long-term health related needs as defined by the community.
- III. Community Engagement. The Alliance shall engage and consult community stakeholders in the Community Reinvestments planning process.
1. The Alliance will solicit Community Reinvestment recommendations and validate the Community Reinvestment Plan ensuring investments are adequately focused on needs of the community by engaging with the following stakeholders: MSAG, PAG, LHJs and County Behavioral Health,
 2. The Alliance shall coordinate with other Medi-Cal Managed Care Plans (MCP) operating in the service areas to engage with LHJs during the Community Reinvestment planning

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process.

- IV. Community Reinvestment Allocation. On an annual basis beginning in CY 2026, DHCS will calculate the Alliance's minimum Community Reinvestment funding obligations according to DHCS APL 25-004 Community Reinvestment Requirements.

There are two types of Community Reinvestment obligations: Base Community Reinvestment and Quality Achievement Community Reinvestment (QACR). In contract years where the Alliance generates net positive income, the Alliance must allocate funds for Base Community Reinvestment and/or QACR as required by DHCS APL 25-004 Community Reinvestment Requirements.

The Alliance will notify its Qualifying Subcontractors of their minimum Community Reinvestment funding obligations, and any corrections to such obligations, within seven (7) calendar days of notice from DHCS.

1. Base Community Reinvestment.
 - a. Community Grants will collaborate with Accounting to establish Base Community Reinvestment allocations.
 - b. Base Community Reinvestment is the minimum level of net income the Alliance is required to invest in initiatives that serve the local communities, starting with net income based on CY 2024 contract revenues for Community Reinvestment activities initiated in CY 2026.
 - c. The Alliance shall allocate Base Community Reinvestment funds equal to:
 - i. 5% of the Alliance's annual net income that is less than or equal to 7.5% of Medi-Cal Contract Revenues for the year; and
 - ii. 7.5% of the Alliance's annual net income that is greater than 7.5% of Medi-Cal Contract Revenues for the year.
2. Quality Achievement Community Reinvestment (QACR).
 - a. The Alliance will collaborate with Quality Improvement and Population Health and Accounting to establish QACR allocations.
 - b. QACR is the net income the Alliance will invest in initiatives where the Alliance


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operates and does not meet the minimum quality measure performance thresholds for the applicable CY, beginning with CY 2024.


- c. For any contract year where the Alliance receives an Enforcement Tier 2 or Tier 3 assignment in accordance with All Plan Letter 23-012 Enforcement Actions: Administrative and Monetary Sanctions:
 - i. The Alliance will reinvest at a minimum an additional 7.5% of annual net income into Community Reinvestment initiatives.
 - ii. The Alliance will allocate 100% of the QACR funds toward investments in the Cultivating Improved Health category as described in Section III. B of this policy.
- d. QACR funds are separate and distinct from performance withholds or monetary sanctions imposed due to not meeting required quality performance levels.

V. Community Reinvestment Plan.

1. The Community Reinvestment Plan describes the permitted Community Reinvestment activities for each three-year investment period beginning with CY 2026 and recurring every three years after.
2. The Alliance will claim voluntary investments toward the CY 2024 Community Reinvestment obligation as allowable under (APL) 25-004: Community Reinvestment Requirements. one-year Community Reinvestment Plan in early Q3 CY 2026 for Community Reinvestment activities based on CY 2024 net income The Alliance will submit a separate, two-year Community Reinvestment Plan in early Q3 CY 2027 that meets all requirements under this APL for funding obligations based on CY 2025 and CY 2026 net income. The Alliance will obtain required attestation from Public Health and County Behavioral Health Directors.
3. The Community Reinvestment Plan will include:
 - a. A detailed description of the anticipated Community Reinvestment activities and their related use category or categories.
 - b. A description of how activities are directly informed by community stakeholder input and LHJ CHIP activity.
 - c. If applicable, identification of the LHJ CHIP activity that each Community Reinvestment activity matches.

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- d. If applicable, a description of community needs identified through the BHT community planning process that the Community Reinvestment activity addresses.
 - e. Anticipated benefits of Community Reinvestment activities in alignment with criteria described in DHCS APL 25-004.
 - f. A description of the approach taken to engage the MSAG and PAG in the Community Reinvestment planning process, including a summary of the recommendations.
 - g. A description of the approach taken to engage other interested stakeholders in the Community Reinvestment planning process, if any, and identification of those stakeholders
 - h. A description of any investments recommended by MSAG and PAG not included in the Community Reinvestment Plan.
 - i. A summary of input provided by the Chief Health Equity Officer, and the Quality Improvement Health Equity Committee (QIHEC) if applicable.
 - j. The expected dollar amount allocated for each Community Reinvestment activity, based on the overall funding obligation for the applicable CY.
 - k. The expected populations that will benefit from or participate in each Community Reinvestment activity.
 - l. A description of how the impact of Community Reinvestment activities will be measured and evaluated.
 - m. A signed attestation from local Public Health and County Behavioral Health Directors.
3. Each subsequent Community Reinvestment Plan within the investment period will either:
 - a. Indicate the allocation of additional investments for each activity documented in the initial Community Reinvestment Plan for funding obligations resulting from positive net income for the applicable CY; and/or
 - b. Propose funding allocations for any new/ revised activities for the applicable CY that meet all requirements in accordance with DHCS APL 24-005.
 4. Each subsequent Community Reinvestment Plan within the three-year investment period will include at a minimum:

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a. The expected dollar amount allocated for each Community Reinvestment activity in the initial Community Reinvestment Plan approved by DHCS based on funding obligations resulting from positive net income for the applicable CY.

b. A signed attestation from local Public Health and County Behavioral Health Directors.

5. Beginning in CY 2026 and on an annual basis, the Alliance will submit the initial or subsequent Community Reinvestment Plans, unless net income is negative for the applicable CY, using templates in accordance with DHCS APL 25-004 Appendix B.
6. The Alliance will submit the Community Reinvestment Plans to the Alliance governing board and DHCS for review and approval.
7. The Alliance will post the Community Reinvestment Plan within thirty (30) days of DHCS approval on the Alliance's public facing website, using the templates included in Appendix B.

VI. Community Reinvestment Report. The Alliance shall:

1. Publish a Community Reinvestment Report every three years, beginning in Quarter Two (Q2) CY 2030, that includes:
 - a. The actual dollar amount spent on each Community Reinvestment activity by county.
 - b. Description of each Community Reinvestment activity by category and county.
 - c. Description of how each Community Reinvestment activity aligns with DHCS' Guiding Principles described in DHCS APL 25-004.
 - d. Description of how each Community Reinvestment activity aligns with designated Reinvestment categories.
 - e. Outcomes from Community Reinvestment activities, including any preliminary data and qualitative description of benefits to Members and the communities in which they reside.
2. Post the Community Reinvestment Report on the Alliance's public facing website, using templates included in DHCS APL 25-004, Appendix D, in Q2 CY 2030 and every three years thereafter.
3. Submit a Community Reinvestment Report to DHCS.
 - a. Submission will include signed letters from the MSAG and PAC, and at minimum, the letters will describe the degree to which the MCP engaged these stakeholders in

	POLICIES AND PROCEDURES
Policy #: 107-XXXX	Lead Department: Community Grants
Title: Implementation of DHCS Community Reinvestment Requirements	
Original Date: 04/28/25	Date Published:
Approved by: Jessica Finney, Community Grants Director	

Community Reinvestment planning efforts and include their feedback regarding the completed Reinvestment activities.

References:

Alliance Policies:

- 450-0002 Population Needs Assessment and Population Health Strategy Deliverable
- 401-1201 Quality Improvement Health Equity Committee
- 401-1101_QI Health Equity Transformation_Program_20240924.pdf
- 401-1201 Quality Improvement Health Equity Committee
- 800-1002_Memoranda_of_Understanding_8-20-24 Clean.pdf
- 290-0001 Member Services Advisory Group
- 400-1109 Physicians Advisory Group Responsibilities and Functions
- 700-2000 Board Designated Reserves

Other References:

- Population Health Management Program Description (2024), Updated April 2024

Impacted Departments:

- Community Engagement
- Community Grants
- Finance
- Health Equity Division (Chief Health Equity Officer)
- Legal
- Program Development
- Quality Improvement and Population Health

Regulatory:

Legislative:

Contractual (Previous Contract):

Contractual (2024 Contract):

DHCS All Plan Letter:

- DHCS APL 25-004 Community Reinvestment Requirements


NCQA:

Supersedes:

Other References:

Attachments:

- A. Appendix B: Community Reinvestment Plan Template
- B. Appendix B, Exhibit 1: Attestation of Support from Public Health Director Template

	POLICIES AND PROCEDURES
Policy #: 107-XXXX	Lead Department: Community Grants
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- C. Appendix B, Exhibit 2: Attestation of Support from County Behavioral Health Director Template
- D. Appendix B, Exhibit 3: Attestation of Acknowledgement Template
- D. Appendix B, Exhibit 4: Proposed Community Reinvestment Activities Template
- D. Appendix B, Exhibit 5: Proposed Allocation of Funds Template
- D. Appendix D: Community Reinvestment Report Template

Lines of Business This Policy Applies To:

- DSNP
- Medi-Cal
- Alliance Care IHSS

Revision History:

Reviewed Date	Revised Date	Changes Made By	Approved By

DRAFT



DATE: June 24, 2026
TO: Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission
FROM: Scott Crawford, Executive Director, Medicare Programs
SUBJECT: TotalCare D-SNP Operations Update

Recommendation. This report is informational only.

Summary. As TotalCare completes its first six (6) months of operation, early performance indicators show steady progress in membership growth, member engagement, and operational execution. Although the program remains in its startup phase and financial results reflect expected launch investments, these indicators provide meaningful insight into the factors that will drive long-term success. Strong enrollment, timely outreach, comprehensive care planning, and high member engagement are critical to building a sustainable D-SNP program and supporting improved quality outcomes, member experience, and future financial performance.

Background. TotalCare launched on January 1, 2026, as the Alliance's Dual Special Needs Program (D-SNP) serving members eligible for both Medicare and Medi-Cal. As discussed with the Board in September 2022 and April 2025, the Alliance identified six key success factors for the program: membership growth, administrative cost, provider network, STAR Ratings, risk adjustment, and medical cost management. This report provides an initial Year 1 update on TotalCare's performance and emerging trends across those factors based on the first six months of operations. More detailed results and outcomes for each area will be presented separately during the Board presentation.

Discussion. TotalCare has transitioned from implementation to ongoing operations, with core functions – including enrollment administration, member services, care management, compliance oversight, and governance – operating as intended. Staff continue to refine processes to ensure Medicare compliance and support a positive member experience. Year-to-date performance shows encouraging results across the six key success factors previously shared with the Board.

- **Membership Growth:** Enrollment has reached 865 members, reflecting steady growth since launch and increasing awareness among eligible Alliance members.
- **Administrative Cost:** Financial performance remains consistent with expectations for a startup Medicare Advantage product, with initial investments supporting program infrastructure and operations.
- **Provider Network:** The provider network meets CMS network adequacy requirements and supports member access, with ongoing efforts to strengthen partnerships and advance value-based payment approaches.

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- **STAR Ratings:** Current operational metrics exceed key benchmarks, including strong Health Risk Assessment completion, timely member outreach, and high rates of individualized care planning – positioning the program well for future quality performance.
- **Risk Adjustment:** Preliminary results indicate a risk adjustment factor above projections, reflecting effective capture of member acuity and documentation during Year 1 operations.
- **Medical Cost Management:** Core care management and coordination processes are in place, supporting early identification of member needs and establishing a foundation for long-term cost management.

Overall, TotalCare demonstrates strong initial operational performance and is establishing the foundation needed to support long-term program sustainability.

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

Attachments. N/A



DATE: June 24, 2026
TO: Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission
FROM: Michael Schrader, Chief Executive Officer
SUBJECT: 2026-27 State Budget Update

Recommendation. This report is informational only.

Background. On June 11, 2026, the Legislature released its bipartisan budget agreement, which must be approved by June 15 to meet the constitutional deadline. The proposal reflects ongoing fiscal pressures while preserving key Medi-Cal investments and delaying several significant reductions.

Discussion. Attention now turns to negotiations between the Governor and the Legislature towards a June 30 deadline to pass a balanced budget.

Notably, the Legislature has not finalized the Administration's proposal to transition UIS populations to fee-for-service Medi-Cal, instead signaling intent to continue discussions and evaluate alternatives that preserve coordinated care and minimize disruption to members and providers.

The Local Health Plans of California (LHPC) is leading a broad coalition—including the California Medical Association, First 5 of California, the California Association of Public Hospitals and Health Systems, and the California Association of Health Plans—to advance an alternative approach that maintains coordinated care for Medi-Cal members with UIS.

Locally, staff have continued advocacy efforts with our elected representatives ensuring they are informed of the concerning impacts on members, providers and the community should the UIS transition to Medi-Cal fee-for-service be adopted.

Major health provisions included in the Legislature's budget include:

- **Maintains current Medi-Cal asset limits in 2026–27**, with a reduction to \$21,000 scheduled for 2027–28.

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

- **Delays dental supplemental payment reductions and UIS dental benefit cuts** by 12 months.
- **Defers a potential increase in UIS premiums**, providing the next Administration with discretion to determine future premium levels.
- **Postpones changes to restricted-scope Medi-Cal eligibility for asylees and other qualified immigrants** until 2027–28.
- **Provides additional funding to counties** to address increased eligibility workload associated with H.R. 1.
- **Defers most clinic payment reductions** for 12 months.
- **Authorizes up to \$190 million in loans for financially distressed hospitals.**
- **Reduces premiums in Covered California.**
- **Maintains investments in reproductive and gender-affirming care**, including \$40 million for reproductive health services and \$26 million for gender-affirming care.
- **Includes placeholder language regarding the proposed transition of the UIS population from managed care to fee-for-service**, allowing additional time for policy development and stakeholder engagement.

Staff will provide an update on budget developments and anticipated implications at the Board's June 24 meeting.

Fiscal Impact N/A.

Attachments.

1. Coalition Letter – June 12, 2026
2. Guest Commentary, Santa Cruz Sentinel – June 10, 2026
3. Letter to the Editor, Lookout Santa Cruz – June 10, 2026



June 12, 2026

Hon. Monique Limón
President Pro Tempore California Senate
1021 O Street, Suite 8518
Sacramento, CA 95814

Hon. Robert Rivas
Speaker of the California State Assembly
State Capitol Building, Room 219
Sacramento, CA 95814

Hon. John Laird
Chair, Senate Budget Committee
Capitol Office, 1021 O Street, Suite 8720
Sacramento, CA 95814

Hon. Jesse Gabriel
Chair, Assembly Budget Committee
Capitol Office, 1021 O Street, Suite 8230
Sacramento, CA 95814

Hon. Caroline Menjivar
Chair, Senate Budget Committee on Health
Capitol Office, 1021 O Street, Suite 6630
Sacramento, CA 95814

Hon. Dawn Addis
Chair, Assembly Budget Subcommittee on Health
Capitol Office, 1021 O Street, Suite 4120
Sacramento, CA 95814

Re: Adopt an Alternative Solution to Retain Coordinated Care for Medi-Cal Members with Unsatisfactory Immigration Status

Dear Senators Limón, Laird, Menjivar and Assemblymembers Rivas, Gabriel and Addis,

Our organizations strongly urge the Legislature to reject the proposal to move Medi-Cal beneficiaries with Unsatisfactory Immigration Status (UIS) out of managed care and into the Fee-For-Service (FFS) delivery system and instead adopt our proposal to retain coordinated and accessible Medi-Cal coverage for UIS Medi-Cal members. This proposal is compliant with federal guidance, maintains a large portion of the Administration's assumed savings, and is achievable by January 1, 2027.

The Administration's proposed shift would dismantle the coordinated care infrastructure that UIS beneficiaries rely on and **replace it with a fragmented system offering limited care management, reduced provider options, and significantly higher long-term costs.** The consequences would be immediate and severe. Reduced access to managed care providers will drive increased emergency room utilization, disrupt preventive and chronic care, and overwhelm the already strained safety net system. Far from reducing expenses, these proposals simply shift costs to more acute and expensive settings, thereby creating avoidable crises for families and greater financial pressure on counties, hospitals and community providers. These outcomes are not theoretical; they are baked into the savings and cost assumptions in the Administration's budget proposal.

Our proposal is straightforward: **maintain continuity, preserve provider rates for managed care services, and avoid the disruption of care for nearly 2 million vulnerable Medi-Cal members.** Under this model, UIS members would remain connected to their existing health plan, provider network, care coordination infrastructure, member services, and access supports, while the state would directly pay for the federally sensitive carve-out services through their proposed FFS system.

This approach **addresses the federal directive without eliminating meaningful access to care,** through a state-only contract with plans to manage outpatient, preventative and specialty care carved-in services and a targeted FFS carve-out for federally payable services. It also protects the safety net by avoiding the Administration's projected utilization consequences — including the proposed **16% increase in inpatient care and 12% increase in emergency room use** — because plans would continue managing outpatient access, primary and specialty care pathways, complex case management, community health worker services, and local care coordination.

Importantly, we are not asking to preserve the status quo. Plans are agreeing to give up approximately **\$224 million** through reduced administrative costs, underwriting gain concessions, and opportunities to right-size rates where UIS medical loss ratios are at or below 85%. The proposal **maintains nearly two-thirds** of the Administration's assumed savings, while avoiding larger downstream costs to hospitals, clinics, physicians, counties, and members. Importantly, it preserves physician rates for managed care services paid now by health plans.

We respectfully urge the Legislature to invest the approximately \$190 million necessary to preserve the safety net and direct DHCS to implement this compliant approach by January 1, 2027. California can address the federal directive and achieve meaningful savings without eliminating access to comprehensive, local, coordinated care for nearly 2 million Medi-Cal members.

While we are not naïve to the operational efforts of health plans, the Department of Health Care Services, and Medi-Cal providers necessary to implement this proposal, **we are confident it is achievable and the tradeoff is untenable.** The May Revision proposal is silent on the current readiness of the FFS system and the additional state resources that would be required to serve an additional 2 million Medi-Cal members in FFS. A dramatic increase in FFS member volume, combined with lower reimbursement rates that discourage provider participation, would place unsustainable strain on the FFS system and create significant access barriers.

Our plan does not fully address providers' need for sustainable payment levels, which will require further attention to support the stability of the broader delivery system. It also does not resolve the long-term financial viability of public hospitals, which remain essential to meeting the healthcare needs of our communities. While our model provides a compliant alternative that enables both hospitals and public health systems to optimize DSH funding, it does not by itself ensure their long-term sustainability. Similarly, there must be solution for sustainable support for community health centers/FQHCs as a core of the Medi-Cal delivery system. Supporting the safety net Medi-Cal providers will be essential to preserving comprehensive access for all populations.

We understand that the state is attempting to respond to federal guidance, but compliance does not require adopting this harmful policy. **We urge the Legislature to reject this proposal and instead adopt this solution that allow all populations, regardless of immigration status, to benefit from comprehensive and coordinated care.** We look forward to working with the Legislature to identify workable solutions that are both compliant with federal law and ensure true access to care.

Sincerely,



Linnea Koopmans
Chief Executive Officer
Local Health Plans of California



Dennis Cuevas-Romero, Esq.
Vice President of Government Affairs
California Primary Care Association



Angela Hill
Legislative Advocate
California Medical Association



Katie Rodriguez
Interim, President & Chief Executive Officer
California Association of Public Hospitals



Charles Bacchi
Chief Executive Officer
California Association of Health Plans



Cástulo de la Rocha, J.D.
President & CEO
AltaMed



Avo Makdessian
Executive Director
First 5 Association of California



Natalie Pita, MPH
Legislative and Policy Advocate
California Academy of Family Physicians



Michelle Cabrera
Executive Director
County Behavioral Health Directors Association



William "Bill" Barcellona
Executive Vice President of Government Affairs
America's Physician Groups



Anne McLeod
Chief Executive Officer
Private Essential Access Community Hospitals



Dawn Ortiz Legg
Supervisor, San Luis Obispo County
President, Latino Caucus of California Counties



Mike Odeh
Senior Director of Health
Children Now

Guest Commentary | State proposal to move Medi-Cal members will disrupt healthcare

By [SANTA CRUZ SENTINEL](#)

PUBLISHED: June 10, 2026 at 3:57 PM PDT By **Michael Schrader**

California spent years building a Medi-Cal program that goes beyond a card in your wallet. For millions of Californians, Medi-Cal managed care is not just coverage; it is a coordinated system of care that helps people access the right services at the right time.

Like other managed care plans, Central California Alliance for Health coordinates member care and is held to strict standards for timely access to appointments, services in a member's language, and access to local providers.

That is why California's budget proposal to move 1.8 million Medi-Cal members from managed care into the fee-for-service system raises serious concerns. This change would significantly disrupt care for vulnerable California residents who need coordinated support to stay healthy. This proposal targets individuals with unsatisfactory immigration status who are also our family, friends and neighbors, who are now at risk of losing access to critical health care services that help keep them healthy.

The consequences of this proposal could be immediate and far-reaching. Reduced access to managed care providers may lead to missed preventive visits, interruptions in chronic care, and increased reliance on emergency rooms. For people managing diabetes, asthma, pregnancy, behavioral health needs, disabilities or other ongoing conditions, even short gaps in care can result in worsening health, avoidable complications and greater long-term costs.

But this issue isn't limited to Medi-Cal members. When people cannot access timely primary or specialty care, they often turn to emergency departments that are already under strain. Increased emergency room use affects everyone in the community. It can mean longer waits for families seeking urgent care, greater pressure on hospitals, fewer available beds, and more stress on physicians, nurses, clinics and local safety net providers. A disruption of this size would ripple across the entire healthcare system.

This drastic change in the proposed budget is not necessary to ensure compliance with new federal guidance. There are better ways to preserve access, manage costs and protect the healthcare safety net without disrupting care for vulnerable members or destabilizing local healthcare systems.

We urge residents to immediately contact your state representative, encouraging them to maintain continuity for all Medi-Cal members, preserve provider rates for managed care services, and avoid unnecessary disruption to the healthcare system we all rely on.

Michael Schrader is chief executive officer of the Central California Alliance for Health.

OPINION FROM COMMUNITY VOICES

Letter to the editor: We must maintain Medi-cal benefits



BY LETTER TO THE EDITOR

June 10, 2026

Have something to say? Lookout welcomes letters to the editor, within our policies, from readers. Guidelines [here](#).

California spent years building a Medi-Cal program that goes beyond a card in your wallet. For millions of Californians, Medi-Cal managed care is not just coverage; it is a coordinated system of care that helps people access the right services at the right time. Like other managed care plans, Central California Alliance for Health coordinates member care and is held to strict standards for timely access to appointments, services in a member's language and access to local providers.

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This drastic change in the proposed budget is not necessary to ensure compliance with new federal guidance. We urge residents to immediately contact your state representative, encouraging them

to maintain continuity for all Medi-Cal members.

Michael Schrader, CEO, Central California Alliance for Health

Scotts Valley

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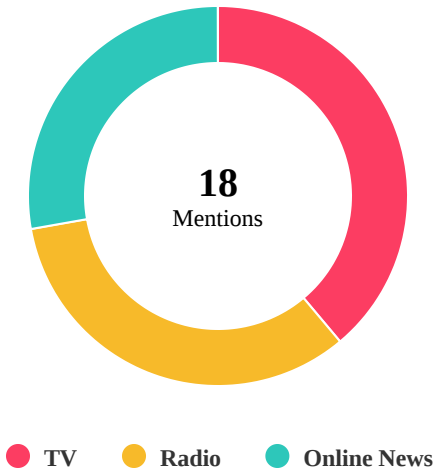
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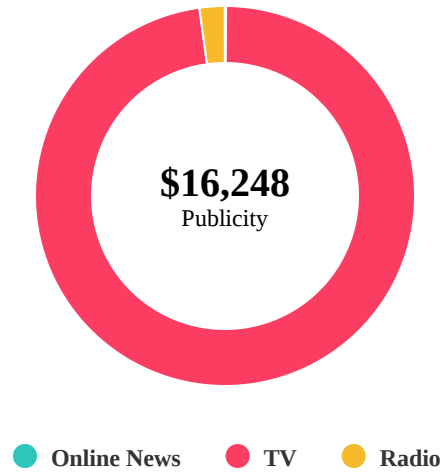
June 2026 Board Report

Mention Analytics

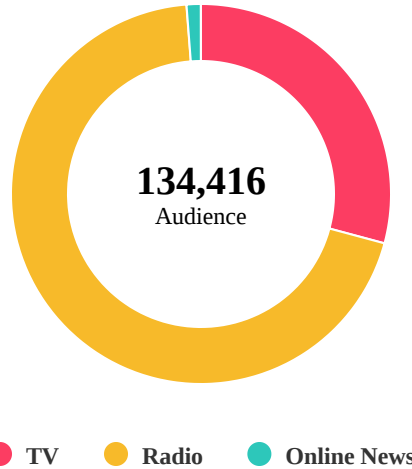
Mentions by Media Type



Publicity by Media Type



Audience by Media Type



18 Total Mentions

Mentions 18 Audience 134,416 Publicity USD \$16,248

Jun 3, 2026 7:22 PM

1

🌐 **Monterey County health officials warn of harm to public health from H.R. 1**

Type Online News



Franks, Harris and Jimenez stressed that Medi-Cal and CalFresh recipients should not assume they lost their health insurance and should contact their healthcare providers if they have questions. Jimenez said the **Central California Alliance for Health recently granted funding to community organizations to spread**

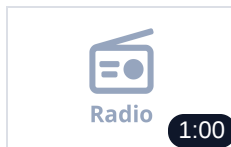
May 28, 2026 11:43 AM EDT

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📻 **KSJV-FM**

Station KSJV-FM Market Fresno, CA DMA: 56



A Grand **Central, California Alliance for Health** for Our Growing with Support Campaign in Fresno. El bienestar de sus hijos es su prioridad. Todos los días, miles de estudiantes reciben apoyo de salud mental. Alguien con quien hablar en momentos difíciles. Al completar la sección de seguro médico en su tarjeta de

🌐 Hope Village opens its doors

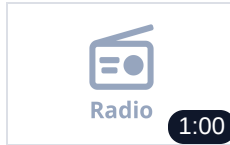
Source Register Pajaronian **Market** Watsonville, CA **Type** Digital News **Category** Local



... project. The project was developed through a collaboration involving Santa Cruz and Monterey counties, the Pajaro Regional Flood Management Agency, Westview Presbyterian Church and Community Action Board of Santa Cruz. Funding came primarily through California's Encampment Resolution Fund and the **Central**

📻 KSJV-FM

Station KSJV-FM **Market** Fresno, CA DMA: 56

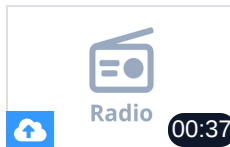


Taking care of your house. Can help prevent bigger issues in the future for one way to stay healthy is by keeping up with vaccines. Vaccines to be safe. And how. To cancer are a great time to make sure you up and they need to schedule a up and keep their vaccines. A Grand Central, California Alliance for Health for our growing



📻 KSJV-FM

Station KSJV-FM **Market** Fresno, CA DMA: 56



Y mi mensaje final sería que la salud es muy importante. La salud determina nuestra salud general y no debemos esperar hasta el final para sentir dolor. Para visitar algún dentista no hay que tenerles miedo. La prevención, los buenos hábitos y las visitas regulares pueden hacer una gran diferencia para toda nuestra familia. Y

🌐 Officials celebrate opening of HOPE Village low-barrier navigation center in Watsonville

Market Watsonville, CA

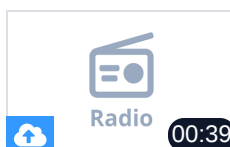


The project was primarily funded through Monterey County's Encampment Resolution Funding award and the Central California Alliance for Health with support from the Community Action Board of Santa Cruz County, Santa Cruz County Housing for Health Partnership and San Francisco-based housing nonprofit Dignity



📻 KSJV-FM

Station KSJV-FM **Market** Fresno, CA DMA: 56

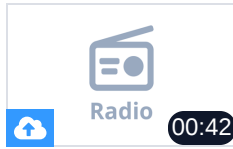


Org. Taking care of your health can help prevent bigger issues in the future for things to stay healthy is by keeping up with. Up with vaccines vaccines are prohíben to be safe and help protect a. To cancer regular a great time to make sure childs up and they need to schedule a and keep their vaccines. A Grand **Central, California**

KSJV-FM

Station KSJV-FM

Market Fresno, CA DMA: 56

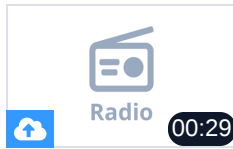


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Station KSJV-FM

Market Fresno, CA DMA: 56



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KSBW Action News 8 Weekend Sunrise

Channel KSBW (NBC)

Market Monterey, CA DMA: 128

Genre News

Program Type Local



lack of funding could have on medi-cal coverage.### <"one of the big changes starting next year is that a subset of our medical members are going to have to have their redetermination process, meaning they're going to have to apply to medical twice per year where as medical members right now apply once per year "> elsa

KSBW Action News 8 Weekend Sunrise

Channel KSBWDT2 (ABC)

Market Monterey, CA DMA: 128

Genre News

Program Type Local



starting next year is that a subset of our medical members are going to have to have their redetermination process, meaning they're going to have to apply to medical twice per year where as medical members right now apply once per year "> elsa jimenez with monterey county health ys that same population will have to prove they

KSBW Action News 8 Weekend Sunrise

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Monterey County, CA - Monterey County Community Health Needs Assessment Released

Source United States: Courts News and Docume... Market United Stat... Type Pr... Category Governm...



... -being of Monterey County residents. Founded in 2022, the Collaborative includes the County of Monterey Health Department, Mee Memorial Healthcare System, Montage Health, Natividad, Salinas Valley Health, and United Way Monterey County. In 2025, California State University Monterey Bay (CSUMB) and **Central**

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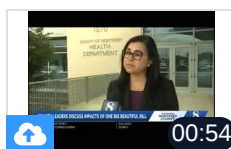


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KSBW Action News 8 Sunrise

Channel KSBW (NBC) Market Monterey, CA DMA: 128 Genre News Program Type Local

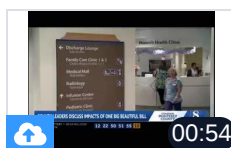


...on the central coast... funding is at the forefront for the county of monterey... county leaders say trump's 'big beautiful bill' is causing major reductions to funding for medi-cal and snap food assistance in california... this week...they addressed the impacts the lack of funding could have on medi-cal coverage.### <"one of the big



KSBW Action News 8 at 5:30

Channel KSBW (NBC) Market Monterey, CA DMA: 128 Genre News Program Type Local

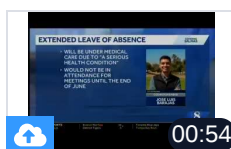


funding is also at the forefront for the county of monterey... county leaders say trump's 'big beautiful bill' is causing major reductions to funding for medi-cal and snap food assistance in california... this week...they addressed the impacts the lack of funding could have on medi-cal coverage.### <"one of the big changes starting



KSBW Action News 8 at 5:30

Channel KSBWDT2 (ABC) Market Monterey, CA DMA: 128 Genre News Program Type Local



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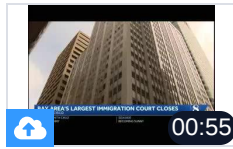
KSBW Action News 8 at 5:30

Channel KSBW (NBC)

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Genre News

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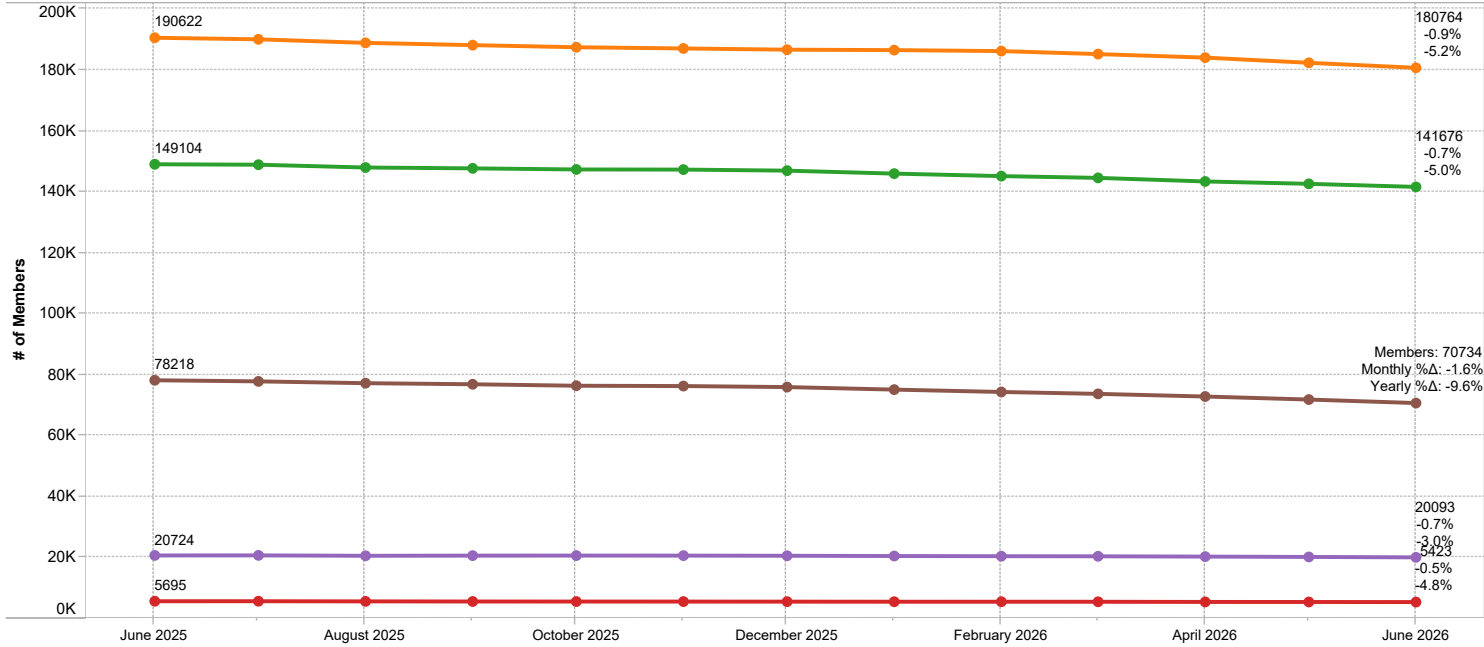


Enrollment Report

County: *None* Program: *None* Aid Cat Roll Up: *None* Data Refresh Date: 6/1/2026 6:34:28 AM

Enrollment Month
6/1/2025 to 6/30/2026

Membership Totals by County and Program, % Change Month-over-Month and % Change Year-over-Year



LOB	County	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	Jun 2026
Medi-Cal	SANTA CRUZ	78,218	77,851	77,257	76,903	76,419	76,315	75,980	74,958	74,174	73,496	72,603	71,593	70,415
	MONTEREY	189,972	189,461	188,262	187,473	186,779	186,373	185,976	185,675	185,337	184,333	183,034	181,252	179,585
	MERCED	149,104	148,956	148,038	147,762	147,397	147,358	147,008	145,960	145,133	144,534	143,340	142,557	141,534
	MARIPOSA	5,695	5,700	5,648	5,608	5,593	5,584	5,561	5,522	5,515	5,503	5,447	5,431	5,406
	SAN BENITO	20,724	20,745	20,610	20,664	20,681	20,668	20,620	20,514	20,460	20,428	20,326	20,212	20,068
	Total	443,713	442,713	439,815	438,410	436,869	436,298	435,145	432,629	430,619	428,294	424,750	421,045	417,008
IHSS	MONTEREY	650	648	680	727	731	738	731	735	725	721	819	832	823
	Total	650	648	680	727	731	738	731	735	725	721	819	832	823
DSNP Total Care	SANTA CRUZ								192	199	254	277	294	319
	MONTEREY								158	183	206	252	323	356
	MERCED								77	86	100	119	126	142
	MARIPOSA								15	17	18	19	18	17
	SAN BENITO								17	18	19	21	22	25
	Total								459	503	597	688	783	859
Total Members		444,363	443,361	440,495	439,137	437,600	437,036	435,876	433,823	431,847	429,612	426,257	422,660	418,690

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



Living Healthy

A newsletter for the members of
Central California Alliance for Health



June 2026 | VOLUME 32, ISSUE 2

Care can't wait

Life gets busy. Between work, family and daily stress, it is easy to put your health on hold. Taking care of your health now can help prevent bigger issues in the future.

Why this matters now

Putting your health on hold can make small health issues turn into bigger ones. Skipping checkups, vaccines or screenings can make it harder to stay healthy over time. You are not alone. We're here to help you stay healthy.

Getting care when you need it is one of the best ways to protect your health and your family's health.

Small steps can go a long way

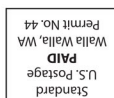
You do not need to do everything at once. Taking small steps can help make it easier. During a checkup, you can:

- Get vaccines that can help protect you from serious illness.
- Get tests to find problems early.
- Ask questions and talk about your medicines.
- Learn ways to stay healthy.

Appointments can fill up fast. Call your doctor to schedule your visit.



If you have any questions, please call Alliance Member Services at **800-700-3874** (TTY: Dial **711**), 8 a.m. to 5:30 p.m., Monday through Friday.



Central California Alliance for Health
1600 Green Hills Road, Suite 101
Scotts Valley, CA 95066

Ask the **doctor**

Why it's time to schedule back-to-school checkups

Dr. Mai Bui-Duy is a Medical Director at Central California Alliance for Health. She practiced internal medicine primary care in Santa Cruz County for seven years and has 15 years of experience in the medical field.



You may be thinking, "Summer just started. Isn't it too soon for a back-to-school checkup?" It can feel early, but this is the best time to schedule! Making appointments now helps you avoid the rush later in the summer.

Appointments can fill up fast, especially for vaccines and sports physicals.

Why are back-to-school checkups important?

Back-to-school checkups are a chance to:

- Ask questions and talk about your child's growth, sleep, learning and behavior.
- Find concerns early before the school year starts.
- Make sure vaccines are up-to-date so your child can start school on time.

Remember, checkups are offered at **no cost to Alliance members.**

What your child can get at a back-to-school checkup:

- A sports physical to be able to play in school sports. Contact your child's school to see if they need a physical before starting sports.
- The vaccines they need for the school year and updates for any missed doses.
- A referral if they need dental or vision care.

Tip: Bring your child's vaccine record and any school forms to the checkup.

Which vaccines does my child need for school?

The schools in California check vaccine records for new students in transitional kindergarten (TK) or kindergarten through 12th grade and for students starting seventh grade.

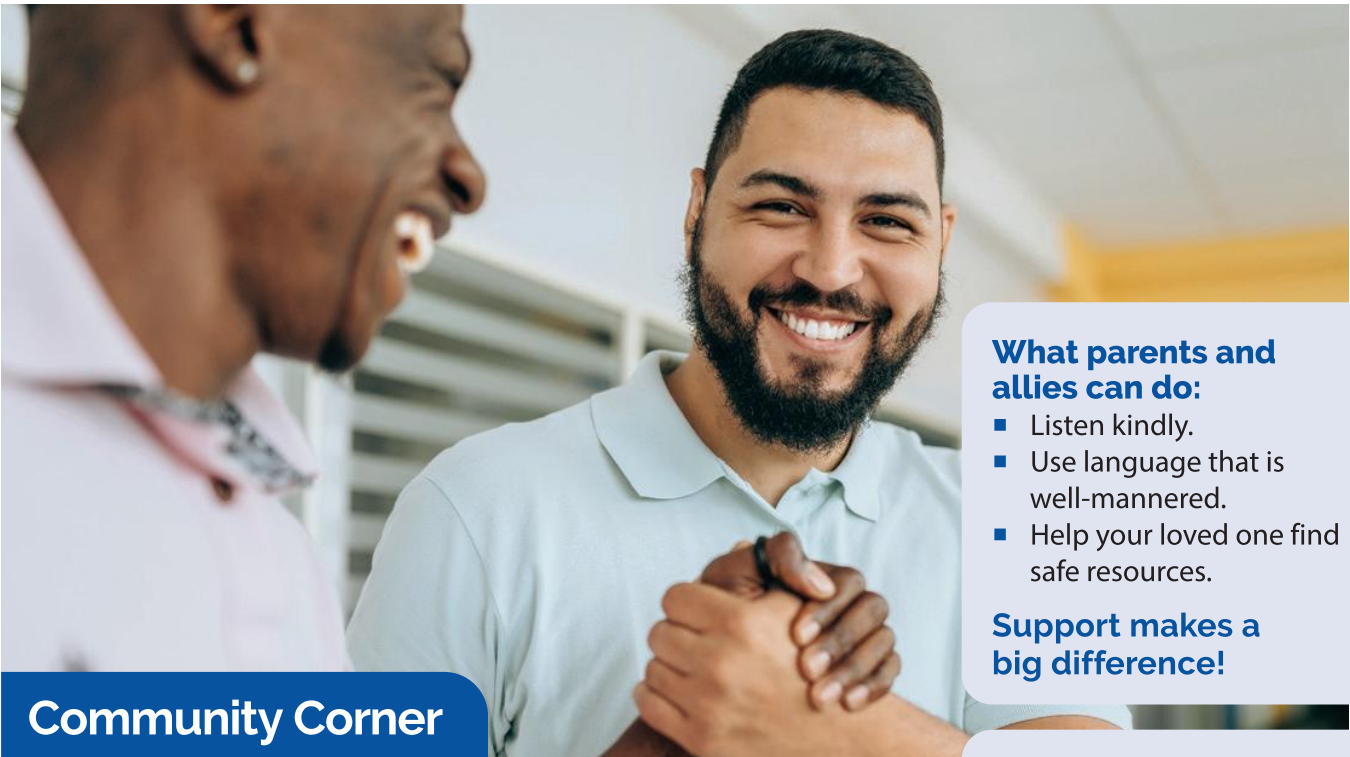
TK/kindergarten through 12th grade need:

- DTaP (diphtheria, tetanus, pertussis): 5 doses.
- Polio: 4 doses.
- Hepatitis B: 3 doses.
- MMR (measles, mumps, rubella): 2 doses.
- Chickenpox (varicella): 2 doses.

Seventh grade entry needs:

- Tdap booster: 1 dose (on or after the 7th birthday).

Next step: Call your child's doctor today to schedule a checkup and ask what vaccines your child needs to start school. Learn more at www.thealliance.health/vaccinesforschool.



What parents and allies can do:

- Listen kindly.
- Use language that is well-mannered.
- Help your loved one find safe resources.

Support makes a big difference!

Resources for members, parents and allies

- Call Member Services at **800-700-3874** or go to **www.thealliance.health/provider-directory** to find a behavioral health provider.
- Call or text **988** or visit **www.988lifeline.org** for the Suicide and Crisis Lifeline.
- Chat with a counselor at The Trevor Project. Visit **www.thetrevorproject.org** or **www.thetrevorproject.mx**.

Community Corner

Celebrate Pride Month

Find resources and support for lesbian, gay, bisexual, trans, queer + persons

June is Pride Month. It's a time to celebrate identity, community and kindness. This is also a good time to talk about mental health.

Many LGBTQ+ people face stress because of getting bullied, unfair treatment or not feeling accepted. LGBTQ+ adults are 2.5 times more likely to deal with depression, anxiety

and substance misuse compared to heterosexuals, says the American Psychiatric Association. According to the Centers for Disease Control and Prevention, 41% of LGBTQ+ youth say they have thought about suicide in the past year. These challenges can be hard, but resources are always available.

Reward yourself with healthier living

Living with a chronic condition can be hard, but the Alliance can help! You can join a Healthier Living Program (HLP) workshop and learn the skills to better manage your health. The Alliance HLP is a six-week workshop that focuses on health and wellness. Adult members can learn how to manage pain, fatigue, stress, anxiety and sleep loss. Members can also learn about healthy eating, staying active, building relationships and improving quality of life.

Alliance members who attend a six-week workshop can get up to a **\$50 Target gift card**.

If you would like to sign up for the program, you can call the Alliance Health Education Line at **800-700-3874, ext. 5580** or complete the sign-up form online at **www.thealliance.health/health-programs-sign-up**.



We are committed to your satisfaction!

We want you to be happy with your health care and our service. But sometimes, you might not be. When that is the case, we want to hear about it.

If you would like to talk to the Alliance about a problem, we are here to help.

You may file a **complaint** (also called a **grievance**) if:

- You are not happy with the care you received from your doctor or how you were treated in the office.
- You are not happy with your experience in a hospital or other facility.
- You received a bill for services covered by the Alliance.
- You are not able to get the care you need.
- You are not happy with the services you get from the Alliance.
- You feel a health care provider or the Alliance failed to give trans-inclusive health care.

There are other reasons you might file a complaint with us. These are listed in your Member Handbook, which you can find online at www.thealliance.health/memberhandbook.

If you are not happy with a decision we made, you can file an **appeal**. An appeal is a request for us to review and change a decision we made about your services.

How to file a complaint or appeal

You can file a complaint or an appeal by calling Member Services at **800-700-3874**, Monday through Friday, 8 a.m. to 5:30 p.m. You can also file a complaint or appeal in writing or through our website at www.thealliance.health/file-a-grievance.

Next steps

Once you let us know about your complaint or appeal, we will look into your concern. We will do all we can to help you. The information you share also helps us improve as an organization and helps our health partners. If you are still unhappy after we try to resolve your case, we will tell you what steps you can take next.



Wellness for all

Talking with your primary care provider

Practicing good communication with your primary care provider (PCP) is an important way to embrace your personal health care journey. Clear and honest communication between you and your PCP can help you both build a safe connection. Talking about your concerns can help you make informed choices about your health care.

Other tips for your visit to the doctor

- Bring a list of all the medications you are taking.
- If you have any medical needs, such as wheelchair access, let the doctor's office staff know so they can help you.
- If you need language assistance, let your doctor's office know which language you need when you call to make an appointment.

The Alliance can help with setting up language assistance services for your doctor visit. Please call the Alliance Health Education Line at **800-700-3874, ext. 5580**. For the Hearing or Speech Assistance Line, call **800-735-2929** (TTY: Dial **711**).

We know that talking with your PCP is not always easy. Here are some examples of what to talk about with your PCP during your visit if you have health concerns.

Question	Example
What am I feeling that I want the PCP to check?	My left ear aches each time I blow my nose.
When did it begin?	It started about a week ago when I first caught a cold.
What makes it better or worse?	It feels worse when I blow my nose and feels better in the morning after I shower.
What questions do I have, and what worries me?	When will I start to feel better? Does the medicine have side effects?

You have prescription benefits!

If you are a Medi-Cal member, your prescription drugs that are filled at a pharmacy are covered by Medi-Cal Rx and not the Alliance.



If you are an IHSS member or a TotalCare member, pharmacy services are managed by MedImpact.

If you have questions about prescription drugs or need to find out if a prescription is covered by your health plan:

- Medi-Cal members can call Medi-Cal Rx at **800-977-2273** (TTY: Dial **711**).
- IHSS members can call Member Services at **800-700-3874** (TTY: Dial **711**).
- TotalCare members can call MedImpact at **800-347-5841** (TTY: Dial **711**).

Drugs given in a doctor's office or clinic

These are considered physician-administered drugs (PAD). You can view coverage information in the Member Handbook and at www.thealliance.health/prescriptions. If you would like a mailed copy, please call Member Services at **800-700-3874** (TTY: Dial **711**).



Keep track of your blood pressure

Keeping your blood pressure at a healthy level helps protect your heart. It lowers your risk of stroke, heart failure and other serious conditions. High blood pressure sometimes has no signs. Checking it often can help find issues early and make sure you get the right care.

Correct readings matter. They help your doctor decide if you need medicine or other changes. When checking your blood pressure at home, sit quietly for a few minutes first. Keep both feet flat on the floor, and rest your arm at heart level. Use the right cuff size so your reading is correct.

Blood pressure monitors are covered for Alliance members. Eligible Medi-Cal members can get a monitor at no cost through AllCare Pharmacy, and it can be mailed to your home. Talk to your doctor to learn more.

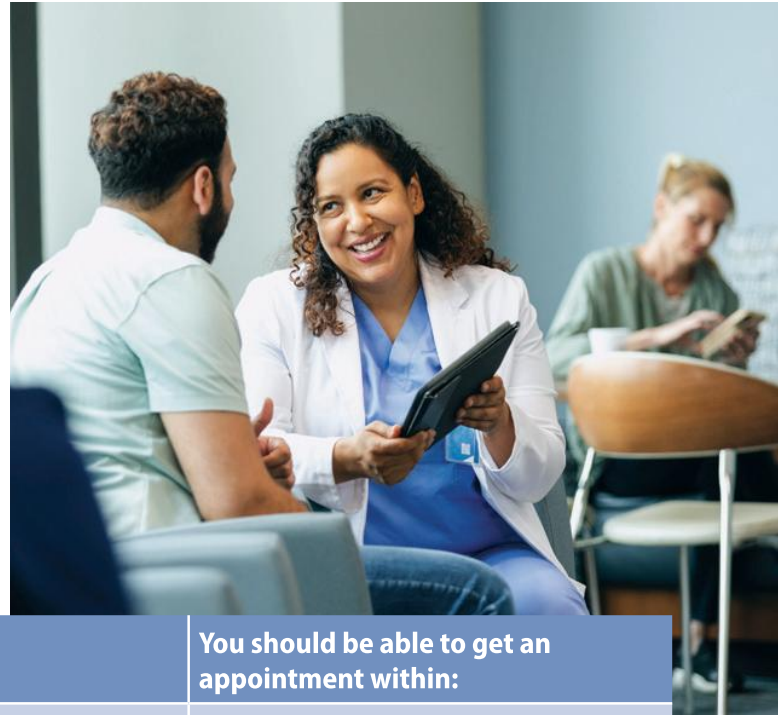
Getting an appointment: How long should you have to wait?

As an Alliance member, it is your right to have timely access to network providers, but sometimes a provider can't see you right away. Some appointments might take longer to schedule than others.

We work with the providers and clinics in our network to make sure you can get care when you need it.

Health plans in California must follow rules to make sure you can get care when you need it. These rules are called the Timely Access to Non-emergency Health Care Services standards.

The chart below shows the waiting times for different types of appointments. If the provider thinks that waiting longer will not harm your health, the wait time might be longer, and they must note it in your medical record.



Appointment type	You should be able to get an appointment within:
Urgent care appointments that do not require pre-approval (prior authorization)	48 hours
Urgent care appointments that do require pre-approval (prior authorization)	96 hours
Non-urgent (routine) primary care appointments	10 business days
Non-urgent (routine) specialist care appointments	15 business days
Non-urgent (routine) mental health provider (non-doctor) care appointments	10 business days
Non-urgent (routine) mental health provider (non-doctor) follow-up care appointments	10 business days of last appointment
Non-urgent (routine) appointments for ancillary (supporting) services for the diagnosis or treatment of injury, illness or other health condition	15 business days

Other wait time standards	You should be able to get connected within:
Member Services telephone wait times during normal business hours	10 minutes
Telephone wait times for Nurse Advice Line	30 minutes (connected to nurse)

If you feel you are not getting care when you need it, call Member Services at **800-700-3874** (TTY: Dial **800-735-2929** or **711**).



Feel your best with the Silver&Fit[®] program

One of the best ways to protect your health as you get older is to stay active. It can help with balance, energy and heart health. TotalCare members can use their no-cost Silver&Fit Healthy Aging and Exercise program benefit to get and stay active.

With the Silver&Fit program, you can:

- Join a fitness center.
- Stream workout videos from home.
- Get live, one-on-one coaching from a well-being coach.
- Get a home fitness kit sent to you.

Small steps can lead to big results! TotalCare and the Silver&Fit program are here to help you stay active and feel your best.

To learn more, visit www.thealliance.health/totalcare or call **833-530-9015** (TTY: Dial **800-735-2929** or **711**), 8 a.m. to 8 p.m., seven days a week.

The Silver&Fit program is provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated. Persons shown are not Silver&Fit members. Fitness center participation may vary by location and is subject to change. Kits are based on availability and subject to change. The Silver&Fit program is not a medical provider or pharmacist, and its coaches do not offer medical or pharmaceutical advice. They cannot and do not diagnose or treat medical, mental health or other health conditions. Coaches provide general information for educational purposes only. For any medical or health concerns, consult a qualified health care professional.



We are texting members!

The Alliance texts members to help them keep up-to-date on Alliance benefits and services. Alliance texts are from the short code **59849**. To learn more, visit our website at www.thealliance.health/member-texting.



At every life stage.
For any health condition.

Trusted, no cost Medi-Cal
health care from a local team
that understands you.

**The Alliance—your ally in
being your healthiest self.**

LIVING HEALTHY is published for the members and community partners of CENTRAL CALIFORNIA ALLIANCE FOR HEALTH, 1600 Green Hills Road, Suite 101, Scotts Valley, CA 95066, telephone 831-430-5500 or 800-700-3874, ext. 5505, website www.thealliance.health.

Information in LIVING HEALTHY comes from a wide range of medical experts. If you have any concerns or questions about specific content that may affect your health, please contact your health care provider.

Models may be used in photos and illustrations.

Editor

Quality and Health Programs Supervisor

Randi Motson

Ivonne Muñoz

www.thealliance.health

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Nondiscrimination Notice and Taglines

Discrimination is against the law. Central California Alliance for Health (the Alliance) follows state and federal civil rights laws. The Alliance does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

The Alliance provides:

- Free aids and services in a timely manner to people with disabilities to help them communicate better, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services in a timely manner to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Alliance between 8 a.m. and 5:30 p.m., Monday through Friday, by calling **800-700-3874**. If you cannot hear or speak well, please call **800-735-2929** (TTY: Dial **711**). Upon request, this document can be made available to you in braille, large print, audiocassette, or electronic form. TotalCare (HMO D-SNP) members—call **833-530-9015** (TTY: **800-735-2929** (Dial **711**)) 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from Oct. 1 through March 31, and Monday through Friday (except holidays) from April 1 through Sept. 30. To obtain a copy in one of these alternative formats, please call or write to:

Central California Alliance for Health
1600 Green Hills Road, Suite 101
Scotts Valley, CA 95066
800-700-3874

800-735-2929 (TTY: Dial **711**)

TotalCare: 833-530-9015 (TTY: **800-735-2929** (Dial **711**)).

HOW TO FILE A GRIEVANCE

If you believe that the Alliance has failed to provide these services or unlawfully discriminated in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital

status, gender, gender identity, or sexual orientation, you can file a grievance with the Alliance's Civil Rights Coordinator, also known as the Senior Grievance Specialist. You can file a grievance by phone, in writing, in person, or electronically:

- **By phone:** Contact the Alliance's Senior Grievance Specialist between 8 a.m. and 5:30 p.m., Monday through Friday, by calling **800-700-3874**. Or, if you cannot hear or speak well, please call **800-735-2929** (TTY: Dial **711**). TotalCare (HMO D-SNP) members—call **833-530-9015** (TTY: **800-735-2929** (Dial **711**)) 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from Oct. 1 through March 31, and Monday through Friday (except holidays) from April 1 through Sept. 30.
- **In writing:** Fill out a complaint form or write a letter and send it to:
Central California Alliance for Health
Attn: Senior Grievance Specialist
Green Hills Road, Suite 101
Scotts Valley, CA 95066
- **In person:** Visit your doctor's office or the Alliance and say you want to file a grievance.
- **Electronically:** Visit the Alliance's website at **www.thealliance.health** or the TotalCare (HMO D-SNP) site at **https://thealliance.health/totalcare/**.

OFFICE OF CIVIL RIGHTS – CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

You can also file a civil rights complaint with the California Department of Health Care Services, Office of Civil Rights by phone, in writing, or electronically:

- **By phone:** Call **916-440-7370**. If you cannot speak or hear well, please call **711 (Telecommunications Relay Service)**.
- **In writing:** Fill out a complaint form or send a letter to:
Deputy Director, Office of Civil Rights
Department of Health Care Services Office of Civil Rights
P.O. Box 997413, MS 0009
Sacramento, CA 95899-7413
Complaint forms are available at **http://www.dhcs.ca.gov/Pages/Language_Access.aspx**.
- **Electronically:** Send an email to **CivilRights@dhcs.ca.gov**.

OFFICE OF CIVIL RIGHTS – U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

If you believe you have been discriminated against on the basis of race, color, national origin, age, disability or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- **By phone:** Call **800-368-1019**. If you cannot speak or hear well, please call **TTY/TDD 800-537-7697**.
- **In writing:** Fill out a complaint form or send a letter to:
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

- **Electronically:** Visit the Office for Civil Rights Complaint Portal at <https://ocrportal.hhs.gov/ocrportal/lobby.jsf>.

If you have questions, call TotalCare (HMO D-SNP) at **833-530-9015** (TTY: **800-735-2929** (Dial **711**)), 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from Oct. 1 through March 31, and Monday through Friday (except holidays) from April 1 through Sept. 30.

TotalCare (HMO D-SNP) is a Medicare Advantage plan with a Medicare contract and a contract with the California Medicaid program. Enrollment in TotalCare depends on contract renewal. TotalCare is the trade name of the Central California Alliance for Health. TotalCare is a registered trademark of the Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission, a California public entity, operating as Central California Alliance for Health.



This newsletter is also available in large print and audio formats at www.thealliance.health/otherformats.

Daim ntawv tshaj xo no los kuj muaj ua ntawv luam loj thiab kaw ua suab nyob ntawm thealliance.health/hmn/tag/alternative-access.
Este boletín también está disponible en formato de letra grande y audio en thealliance.health/es/tag/alternative-access.

English

ATTENTION: If you need help in your language call 1-800-700-3874 (TTY: 1-800-735-2929). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call 1-800-700-3874 (TTY: 1-800-735-2929). These services are free of charge. TotalCare (HMO D-SNP) members call 1-833-530-9015 (TTY: 1-800-735-2929 (Dial 711)).

تعبیر علما (Arabic)

يُرجى الانتباه: إذا احتجت إلى المساعدة بلغتك، فاتصل بـ 1-833-530-9015 (TTY: 1-800-735-2929; 711). تتوفر أيضًا المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة

بريل والخط الكبير. اتصل بـ 1-833-530-9015

(TTY: 1-800-735-2929; 711). هذه الخدمات مجانية.

يُرجى من أعضاء TotalCare (HMO D-SNP) الاتصال برقم 1-833-530-9015 (TTY: 1-800-735-2929) للاتصال برقم (711).

Հայերեն (Armenian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Եթե Ձեզ օգնություն է հարկավոր Ձեր լեզվով, զանգահարեք 1-800-700-3874 (TTY: 1-800-735-2929; 711): Կան նաև օժանդակ միջոցներ ու ծառայություններ հաշմանդամություն ունեցող անձանց համար, օրինակ՝ Բրայլի գրատիպով ու խոշորատառ տպագրված նյութեր: Ձանգահարեք 1-800-700-3874 (TTY: 1-800-735-2929; 711): Այդ ծառայություններն անվճար են: TotalCare (HMO D-SNP) անդամները կարող են զանգահարել 1-833-530-9015 հեռախոսահամարով (TTY՝ 1-800-735-2929 (զանգահարեք 711)):

ឃ្លាសម្រាប់ភាសាខ្មែរ (Cambodian)

ចំណាំ: បើអ្នក ត្រូវ ការជំនួយ ជាភាសា របស់អ្នក សូម ទូរស័ព្ទទៅលេខ 1-800-700-3874 (TTY: 1-800-735-2929; 711)។ ជំនួយ និង សេវាកម្ម សម្រាប់ ជនពិការ ដូចជាឯកសារសរសេរជាអក្សរធំ សម្រាប់ជនពិការភ្នែក ឬឯកសារសរសេរជាអក្សរពង្រីក ក៏អាចរកបានផងដែរ។ ទូរស័ព្ទមកលេខ 1-800-700-3874 (TTY: 1-800-735-2929; 711)។ សេវាកម្មទាំងនេះមិនគិតថ្លៃឡើយ។ សមាជិក TotalCare (HMO D-SNP) សូមហៅទៅលេខ 1-833-530-9015 (TTY: 1-800-735-2929 (ចុចលេខ 711))។

中文 (Chinese)

请注意：如果您需要以您的母语提供帮助，请致电 1-800-700-3874 (TTY: 1-800-735-2929; 711)。另外还提供针对残疾人士的帮助和服务，例如盲文和需要较大字体阅读，也是方便取用的。请致电 1-800-700-3874 (TTY: 1-800-735-2929; 711)。这些服务都是免费的。TotalCare (HMO D-SNP) 會員請致電 1-833-530-9015 (TTY: 1-800-735-2929 (撥號711))。

فارسی (Farsi)

توجه: اگر می‌خواهید به زبان خود کمک دریافت کنید، با 1-800-700-3874 (TTY: 1-800-735-2929; 711) تماس بگیرید. کمک‌ها و خدمات مخصوص افراد دارای معلولیت، مانند نسخه‌های خط بریل و چاپ با حروف بزرگ، نیز موجود است. با 1-800-700-3874 (TTY: 1-800-735-2929; 711) تماس بگیرید. این خدمات رایگان ارائه می‌شوند. TotalCare (HMO D-SNP) اعضا با شماره 1-833-530-9015 تماس بگیرید (711 را شماره‌گیری کنید).

हिंदी (Hindi)

ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है तो 1-800-700-3874 (TTY: 1-800-735-2929; 711) पर कॉल करें। अशक्तता वाले लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में भी दस्तावेज़ उपलब्ध हैं। 1-800-700-3874 (TTY: 1-800-735-2929; 711) पर कॉल करें। ये सेवाएं नि: शुल्क हैं। TotalCare (HMO D-SNP) के सदस्य 1-833-530-9015 पर कॉल करें (TTY: 1-800-735-2929 (डायल करें 711))।

Hmoob (Hmong)

CEEB TOOM: Yog koj xav tau kev pab txhais koj hom lus hu rau 1-800-700-3874 (TTY: 1-800-735-2929; 711). Muaj cov kev pab txhawb thiab kev pab cuam rau cov neeg xiam oob qhab, xws li puav leej muaj ua cov ntawv su thiab luam tawm ua tus ntawv loj. Hu rau 1-800-700-3874 (TTY: 1-800-735-2929; 711). Cov kev pab cuam no yog pab dawb xwb. TotalCare (HMO D-SNP) tswvcuab hu tus xov tooj 833-530-9015 (TTY: 800-735-2929 (Ntaus 711)).

日本語 (Japanese)

注意日本語での対応が必要な場合は 1-800-700-3874 (TTY: 1-800-735-2929; 711)へお電話ください。点字の資料や文字の拡大表示など、障がいをお持ちの方のためのサービスも用意しています。 1-800-700-3874 (TTY: 1-800-735-2929; 711)へお電話ください。これらのサービスは無料で提供しています。TotalCare (HMO D-SNP) 会員専用電話番号：1-833-530-9015 (TTY: 1-800-735-2929 (直通711))

한국어 (Korean)

유의사항: 귀하의 언어로 도움을 받고 싶으시면 1-800-700-3874 (TTY: 1-800-735-2929; 711) 번으로 문의하십시오. 점자나 큰 활자로 된 문서와 같이 장애가 있는 분들을 위한 도움과 서비스도 이용 가능합니다. 1-800-700-3874 (TTY: 1-800-735-2929; 711) 번으로 문의하십시오. 이러한 서비스는 무료로 제공됩니다. TotalCare (HMO D-SNP) 가입자는 1-833-530-9015번으로 전화하십시오. (TTY: 1-800-735-2929 (711을 누르십시오)).

ພາສາລາວ (Laotian)

ປະກາດ: ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໃຫ້ໃຫ້ທາດປີ 1-800-700-3874 (TTY: 1-800-735-2929; 711). ຍັງມີຄວາມຊ່ວຍເຫຼືອແລະການບໍລິການສໍາລັບຄົນເພີການ ເຊັ່ນເອກະສານທີ່ບັນທຶກສອນນູນແລະມີໂຕເພີມໃຫຍ່ ໃຫ້ໃຫ້ທາດປີ 1-800-700-3874 (TTY: 1-800-735-2929; 711). ການບໍລິການເຫຼົ່ານີ້ບໍ່ຕ້ອງຈ່າຍຄ່າໃຊ້ຈ່າຍໃດໆ. ສະມາຊິກ TotalCare (HMO D-SNP) ໃຫ້ໃຫ້ທາດປີ 1-833-530-9015 (TTY: 1-800-735-2929 (ກົດ 711)).

Mien

LONGC HNYOUV JANGX LONGX OC: Beiv taux meih qiemx longc mienh tengx faan benx meih nyei waac nor douc waac daaih lorx taux 1-800-700-3874 (TTY: 1-800-735-2929; 711). Liouh lorx jauv-louc tengx aengx caux nzie gong bun taux ninh mbuo wuaaic fangx mienh, beiv taux longc benx nzangc-pokc bun hluc mbiutc aengx caux aamz mborqv benx domh sou se mbenc nzoih bun longc. Douc waac daaih lorx 1-800-700-3874 (TTY: 1-800-735-2929; 711). Naaiv deix nzie weih gong-bou jauv-louc se benx wang-henh tengx mv zuqc cuotv nyaanh oc. TotalCare (HMO D-SNP) nyei mienh mborqv finx heuc 1-833-530-9015 (TTY: 1-800-735-2929 (Guinh 711)).

ਪੰਜਾਬੀ (Punjabi)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਾਲ ਕਰੋ 1-800-700-3874 (TTY: 1-800-735-2929; 711). ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਮੋਟੀ ਛਪਾਈ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ। ਕਾਲ ਕਰੋ 1-800-700-3874 (TTY: 1-800-735-2929; 711). ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ। TotalCare (HMO D-SNP) ਦੇ ਮੈਂਬਰ 1-833-530-9015 (TTY: 1-800-735-2929 (711 ਡਾਇਲ ਕਰੋ)) 'ਤੇ ਕਾਲ ਕਰਦੇ ਹਨ

Русский (Russian)

ВНИМАНИЕ! Если вам нужна помощь на вашем родном языке, звоните по номеру 1-800-700-3874 (линия TTY: 1-800-735-2929). Также предоставляются средства и услуги для людей с ограниченными возможностями, например документы крупным шрифтом или шрифтом Брайля. Звоните по номеру 1-800-700-3874 (линия TTY: 1-800-735-2929; 711). Такие услуги предоставляются бесплатно. Участникам плана TotalCare (HMO D-SNP) звонить 1-833-530-9015 (TTY: 1-800-735-2929 (с номера 711)).

Español (Spanish)

ATENCIÓN: si necesita ayuda en su idioma, llame al 1-800-700-3874 (TTY: 1-800-855-3000 ; 711). También ofrecemos asistencia y servicios para personas con discapacidades, como documentos en braille y con letras grandes. Llame al 1-800-700-3874 (TTY: 1-800-855-3000; 711). Estos servicios son gratuitos. TotalCare (HMO D-SNP) miembro llame al 833-530-9015 (TTY: 800-855-3000 (Marque 711)).

Tagalog (Filipino)

ATENSIYON: Kung kailangan mo ng tulong sa iyong wika, tumawag sa 1-800-700-3874 (TTY: 1-800-735-2929; 711). Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan, tulad ng mga dokumento sa braille at malaking print. Tumawag sa 1-800-700-3874 (TTY: 1-800-735-2929; 711). Libre ang mga serbisyonang ito. Mga miyembro ng TotalCare (HMO D-SNP), tumawag sa 1-833-530-9015 (TTY: 1-800-735-2929 (I-dial ang 711)).

ภาษาไทย (Thai)

โปรดทราบ: หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ กรุณาโทรศัพท์ไปที่หมายเลข 1-800-700-3874 (TTY: 1-800-735-2929; 711) นอกจากนี้ ยังพร้อมให้ความช่วยเหลือและบริการต่าง ๆ สำหรับบุคคลที่มีความพิการ เช่น เอกสารต่าง ๆ ที่เป็นอักษรเบรลล์และเอกสารที่พิมพ์ด้วยตัวอักษรขนาดใหญ่ กรุณาโทรศัพท์ไปที่หมายเลข 1-800-700-3874 (TTY: 1-800-735-2929; 711) ไม่มีค่าใช้จ่ายสำหรับบริการเหล่านี้ สมาชิก TotalCare (HMO D-SNP) โปรดโทรไปที่ 1-833-530-9015 (TTY: 1-800-735-2929 (กด 711))

Українська (Ukrainian)

УВАГА! Якщо вам потрібна допомога вашою рідною мовою, телефонуйте на номер 1-800-700-3874 (TTY: 1-800-735-2929; 711). Люди з обмеженими можливостями також можуть скористатися допоміжними засобами та послугами, наприклад, отримати документи, надруковані шрифтом Брайля та великим шрифтом. Телефонуйте на номер 1-800-700-3874 (TTY: 1-800-735-2929; 711). Ці послуги безкоштовні. Номер для учасників програми TotalCare (HMO D-SNP) 1-833-530-9015 (TTY: 1-800-735-2929 (наберіть 711)).

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của mình, vui lòng gọi số 1-800-700-3874 (TTY: 1-800-735-2929; 711). Chúng tôi cũng hỗ trợ và cung cấp các dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và chữ khổ lớn (chữ hoa). Vui lòng gọi số 1-800-700-3874 (TTY: 1-800-735-2929; 711). Các dịch vụ này đều miễn phí. Hội viên của TotalCare (HMO-DSNP) vui lòng gọi số 1-833-530-9015 (TTY: 1-800-735-2929 (Quay số 711)).



La Vida **Saludable**

Un boletín informativo para los miembros de Central California Alliance for Health



JUNIO DEL 2026 | VOLUMEN 32, NÚMERO 2

El cuidado no puede esperar

La vida se vuelve ocupada. Entre el trabajo, la familia y el estrés diario, es fácil poner su salud en espera. Cuidar su salud ahora puede ayudar a prevenir problemas más grandes en el futuro.

Por qué importa esto ahora

Poner su salud en espera puede hacer que los problemas de salud pequeños se conviertan en problemas más grandes. Saltarse chequeos, vacunas o exámenes puede empeorar la salud con el tiempo. No está solo. Estamos aquí para ayudarle a mantenerse saludable.

Obtener cuidado cuando lo necesita es una de las mejores maneras de proteger su salud y la de su familia.

Los pasos pequeños pueden recorrer un largo camino

No es necesario hacerlo todo a la vez. Dar pasos pequeños puede ayudar a que sea más fácil. Durante un chequeo, puede:

- Recibir vacunas que puedan ayudar a brindarle protección contra enfermedades graves.
- Hacerse pruebas para detectar problemas con anticipación.
- Hacerse preguntas y hablar sobre sus medicamentos.



Si tiene alguna pregunta, llame a Servicios para Miembros de la Alianza al **800-700-3874** (TTY: Marque **711**), de 8 a.m. a 5:30 p.m., de lunes a viernes.

- Aprender formas de mantenerse saludable.

Las citas se pueden llenar rápidamente. Llame a su doctor para programar una visita.

Pregúntele al **doctor**

Por qué es hora de programar chequeos de regreso a la escuela

La Dra. Mai Bui-Duy es directora médica de Central California Alliance for Health. Practicó el cuidado primario de medicina interna en el condado de Santa Cruz durante siete años y tiene 15 años de experiencia en el campo de la medicina.



Es posible que esté pensando: “El verano acaba de empezar. ¿No es demasiado pronto para un chequeo de regreso a la escuela?” Puede parecer temprano, ¡pero este es el mejor momento para programarlo! Hacer citas ahora le ayuda a evitar las prisas más adelante en verano. **Las citas pueden llenarse rápidamente, especialmente para vacunas y exámenes físicos deportivos.**

¿Por qué son importantes los chequeos de regreso a la escuela?

Los chequeos de regreso a la escuela son una buena oportunidad para:

- Hacer preguntas y hablar sobre el crecimiento, el sueño, el aprendizaje y el comportamiento de su hijo.
- Encontrar las preocupaciones temprano antes de que comience el año escolar.
- Asegurarse de que las vacunas estén al día para que su hijo pueda comenzar la escuela a tiempo.

Recuerde, los chequeos se ofrecen **sin costo para los miembros de la Alianza.**

Lo que su hijo puede obtener en un chequeo de regreso a la escuela:

- Un examen físico deportivo para poder participar en los deportes escolares. Comuníquese con la escuela de su hijo para ver si necesita un examen físico antes de comenzar los deportes.

- Las vacunas que necesitan para el año escolar y actualizaciones para cualquier dosis omitida.
- Una referencia si necesita cuidado dental o cuidado de la vista.

Sugerencia: Lleve el registro de vacunas de su hijo y cualquier formulario escolar al chequeo.

¿Qué vacunas necesita mi hijo para la escuela?

Las escuelas en California revisan los registros de vacunación de los nuevos estudiantes en kínder de transición (TK) o desde kínder a 12º grado, y para los estudiantes que comienzan séptimo grado.

Desde TK/kínder hasta 12º grado necesitan:

- DTaP (difteria, tétanos, tosferina): 5 dosis.
- Polio: 4 dosis.
- Hepatitis B: 3 dosis.
- MMR (sarampión, paperas, rubéola): 2 dosis.
- Varicela: 2 dosis.

Para ingresar en séptimo grado necesitan:

- Refuerzo Tdap: 1 dosis (en o después del 7º cumpleaños).

Siguiente paso: Llame hoy mismo al doctor de su hijo para programar un chequeo y preguntarle qué vacunas necesita para comenzar la escuela. Obtenga más información en www.thealliance.health/vaccinesforschool.



Qué pueden hacer los padres y aliados:

- Escuchar amablemente.
- Usar un lenguaje bien atendido.
- Ayudar a su ser querido a encontrar recursos seguros.

¡El apoyo hace una gran diferencia!

Recursos para miembros, padres y aliados

- Llame a Servicios para Miembros al **800-700-3874** o visite **www.thealliance.health/es/provider-directory** para encontrar un proveedor de salud de la conducta.
- Llame o envíe un mensaje de texto al **988** o visite **www.988lifeline.org** para la Línea de Prevención del Suicidio y Crisis.
- Hable con un consejero en The Trevor Project (El Proyecto Trevor). Visite **www.thetrevorproject.org** o **www.thetrevorproject.mx**.

Rincón de la comunidad

Celebra el Mes del Orgullo

Busque recursos y apoyo para personas lesbianas, gays, bisexuales, trans, queer +

Junio es el Mes del Orgullo. Es hora de celebrar la identidad, la comunidad y la amabilidad. Este también es un buen momento para hablar sobre salud mental.

Muchas personas LGBTQ+ se enfrentan al estrés por ser acosadas, recibir un trato injusto o no sentirse aceptadas. Según la Asociación Americana de Psiquiatría, los adultos LGBTQ+ tienen 2.5 veces más probabilidades de lidiar con la depresión, la ansiedad

y el uso indebido de sustancias en comparación con los heterosexuales. Según los Centros para el Control y la Prevención de Enfermedades (Centers for Disease Control and Prevention; CDC, por sus siglas en inglés), el 41% de los jóvenes LGBTQ+ afirman haber pensado en suicidarse el año pasado. Estos desafíos pueden ser difíciles, pero los recursos siempre están disponibles.

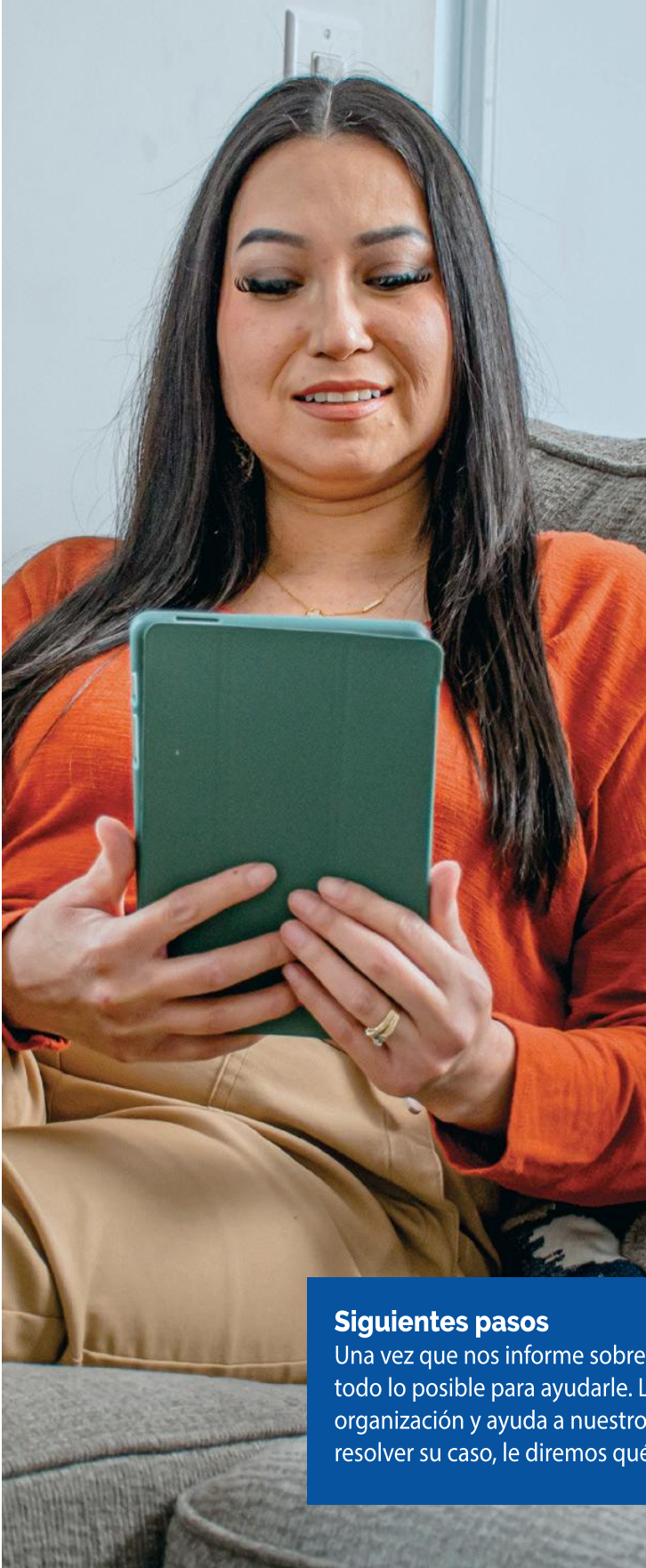
Recompéñese con una vida más saludable

Vivir con una condición crónica puede ser difícil, pero la Alianza puede ayudar. Puede unirse a un taller del Programa Tomando Control de Su Salud (Healthier Living Program; HLP, por sus siglas en inglés) y aprender las habilidades para manejar mejor su salud. El HLP de la Alianza es un taller de seis semanas que se centra en la salud y el bienestar. Los miembros adultos pueden aprender a controlar el dolor, la fatiga, el estrés, la ansiedad y la pérdida de sueño. Los miembros también pueden aprender sobre alimentación saludable,

mantenerse activos, construir relaciones y mejorar la calidad de vida.

Los miembros de la Alianza que asistan a un taller de seis semanas pueden obtener una **tarjeta de regalo de Target de hasta \$50**.

Si desea inscribirse en un programa o tiene preguntas, llame a la Línea de Educación de Salud de la Alianza al **800-700-3874, ext. 5580** o complete el formulario de inscripción en línea en **www.thealliance.health/health-programs-sign-up**.



¡Estamos comprometidos con su satisfacción!

Queremos que esté satisfecho con su cuidado de la salud y nuestro servicio. Pero, a veces, puede que no lo esté. Cuando ese es el caso, queremos saberlo.

Si desea hablar con la Alianza sobre un problema, estamos aquí para ayudarle.

Usted puede presentar una **queja** (también llamada **reclamación**) si:

- No le gustó el cuidado que recibió de su doctor ni con el trato que recibió en la oficina.
- No le gustó su experiencia en un hospital u otra institución.
- Ha recibido un cobro por servicios cubiertos por la Alianza.
- No puede recibir el cuidado que necesita.
- No le gustan los servicios que recibe de la Alianza.
- Siente que un proveedor de cuidado de salud o de la Alianza no proporcionaron cuidado de salud inclusiva para personas trans.

Hay otros motivos por los que puede presentar una queja con nosotros. Estos se enumeran en su Manual para Miembros, que puede encontrar en línea en www.thealliance.health/es/memberhandbook.

Si no le gusta la decisión que tomamos, puede presentar una apelación. Una **apelación** es una petición para que revisemos y cambiemos una decisión que tomamos sobre sus servicios.

Cómo presentar una queja o una apelación

Puede presentar una queja o apelación llamando a Servicios para Miembros al **800-700-3874**, de lunes a viernes de 8 a.m. a 5:30 p.m. También puede presentar una queja o apelación por escrito o a través de nuestro sitio web en www.thealliance.health/es/file-a-grievance.

Siguientes pasos

Una vez que nos informe sobre su queja o apelación, investigaremos su preocupación. Haremos todo lo posible para ayudarle. La información que comparta también nos ayuda a mejorar como organización y ayuda a nuestros socios de salud. Si sigue insatisfecho después de que tratemos de resolver su caso, le diremos qué pasos puede tomar a continuación.



Bienestar para todos

Hablar con su proveedor de cuidado primario

Practicar una buena comunicación con su proveedor de cuidado primario (Primary Care Provider; PCP, por sus siglas en inglés) es una forma importante de adoptar su viaje de cuidado de salud personal. La comunicación clara y honesta entre usted y su PCP puede ayudarles a ambos a crear una conexión segura. Hablar sobre sus preocupaciones puede ayudarle a tomar decisiones informadas sobre su cuidado de salud.

Otros consejos para su visita al doctor

- Lleve una lista de todos los medicamentos que está tomando.
- Si tiene alguna necesidad médica, como acceso para sillas de ruedas, informe al personal de la oficina del doctor para que puedan ayudarle.
- Si necesita ayuda con el idioma, informe a la oficina del doctor qué idioma necesita cuando llame para hacer una cita.

La Alianza puede ayudarle a establecer servicios de asistencia con el idioma para su visita al doctor. Llame a la Línea de Educación de Salud de la Alianza al **800-700-3874, ext. 5580**. Para la Línea de Asistencia para la Audición o el Habla, llame al **800-855-3000** (TTY: Marque **711**).

Sabemos que hablar con su PCP no siempre es fácil. Estos son algunos ejemplos sobre qué hablar con su PCP durante su visita si tiene problemas de salud.

Pregunta	Ejemplo
¿Qué es lo que siento y qué quiero que mi doctor revise?	Me duele el oído izquierdo cada vez que me sueno la nariz.
¿Cuándo comenzó?	Comenzó hace aproximadamente una semana cuando me resfrié por primera vez.
¿Qué lo mejora o empeora?	Se siente peor cuando me sueno la nariz y me siento mejor por la mañana después de bañarme.
¿Qué preguntas tengo y qué me preocupa?	¿Cuándo empezaré a sentirme mejor? ¿El medicamento tiene efectos secundarios?

¡Tiene beneficios de medicinas recetadas!

Si usted es miembro de Medi-Cal, sus medicinas recetadas que se surten en una farmacia están cubiertas por Medi-Cal Rx y no por la Alianza.



Si usted es miembro de IHSS o de TotalCare, los servicios de farmacia son administrados por MedImpact.

Si tiene preguntas sobre medicinas recetadas o necesita averiguar si un medicamento recetado está cubierto por su plan de salud:

- Los miembros de Medi-Cal pueden llamar a Medi-Cal Rx al **800-977-2273** (TTY: Marque **711**).
- Los miembros del IHSS pueden llamar a Servicios para Miembros al **800-700-3874** (TTY: Marque **711**).
- Los miembros de TotalCare pueden llamar a MedImpact al **800-347-5841** (TTY: Marque **711**).

Medicamentos que se administran en la oficina del doctor o en la clínica

Estos se consideran medicamentos administrados por el doctor (physician-administered drugs; PAD, por sus siglas en inglés). Puede ver la información de cobertura en el Manual para Miembros y en www.thealliance.health/es/prescriptions. Si desea que se le envíe una copia por correo, llame a Servicios para Miembros al **800-700-3874** (TTY: Marque **711**).



Lleve un registro de su presión arterial

Mantener la presión arterial a un nivel saludable ayuda a proteger el corazón. Reduce el riesgo de un derrame cerebral, insuficiencia cardíaca y otras condiciones graves. A veces, la presión arterial alta no tiene signos. Revisarla con frecuencia puede ayudar a encontrar problemas a tiempo y asegurarse de recibir el cuidado adecuado.

Los valores correctos son importantes. Ayudan a su doctor a decidir si necesita medicamentos u otros cambios. Cuando se revise la presión arterial en su casa, siéntese en silencio durante algunos minutos primero. Mantenga ambos pies apoyados en el suelo y apoye el brazo al nivel del corazón. Utilice el tamaño de manguito adecuado para que sus valores de presión arterial sean correctos.

Los monitores de presión arterial están cubiertos para los miembros de la Alianza. Los miembros elegibles de Medi-Cal pueden obtener un monitor sin costo a través de AllCare Pharmacy, y se puede enviar a su casa por correo. Hable con su doctor para obtener más información.

Conseguir una cita: ¿Cuánto tiempo debe esperar?

Como miembro de la Alianza, tiene derecho a tener acceso oportuno a los proveedores de la red, pero a veces un proveedor no puede verlo de inmediato. Algunas citas pueden tardar más en programarse que otras.

Trabajamos con los proveedores y clínicas de nuestra red para asegurarnos de que pueda recibir cuidado cuando lo necesite.

Los planes de salud en California deben seguir las reglas para asegurarse de que pueda recibir cuidado cuando lo necesite. Estas reglas se llaman los Estándares de Acceso Oportuno a los Servicios de Cuidado de Salud No Emergentes.

El gráfico de abajo muestra los tiempos de espera para diferentes tipos de citas. Si el proveedor cree que esperar más tiempo no dañará su salud, el tiempo de espera podría ser más largo y debe anotarlo en su expediente médico.



Tipo de cita	Debería poder obtener una cita en un plazo de:
Citas de atención de urgencia que no requieren aprobación previa (autorización previa)	48 horas
Citas de cuidado de urgencia que sí requieren aprobación previa (autorización previa)	96 horas
Citas de cuidado primario no urgentes (de rutina)	10 días laborables
Citas de cuidado especializado no urgentes (de rutina)	15 días laborables
Citas de cuidado no urgente (de rutina) con un proveedor de salud mental (no doctor)	10 días laborables
Citas de seguimiento para proveedores de salud mental (no doctores) que no sean urgentes (de rutina)	10 días hábiles desde la última cita
Citas no urgentes (de rutina) para servicios auxiliares (de apoyo) para el diagnóstico o tratamiento de lesiones, enfermedades u otras condiciones de salud	15 días laborables

Otros estándares de tiempo de espera	Debería ser capaz de conectarse en un plazo de:
Tiempos de espera telefónica de Servicios para Miembros durante el horario comercial normal	10 minutos
Tiempos de espera telefónica para la Línea de Consejos de Enfermeras	30 minutos (conectado a la enfermera)

Si siente que no está recibiendo cuidado cuando lo necesita, llame a Servicios para Miembros al **800-700-3874** (TTY: Marque el **800-855-3000** o **711**).



Siéntase mejor con el programa Silver&Fit®

Una de las mejores formas de proteger su salud a medida que envejece es mantenerse activo. Puede ayudarle con el equilibrio, la energía y la salud cardíaca. Los miembros de TotalCare pueden utilizar su beneficio del programa gratuito, Envejecimiento Saludable y Ejercicio de Silver&Fit, para mantenerse activos.

Con el programa Silver&Fit, puede:

- Unirse a un centro de actividad física.
- Reproducir videos de entrenamiento desde casa.
- Obtener entrenamiento en vivo, uno a uno, de un entrenador de bienestar.
- Recibir un kit de actividad física para el hogar.

¡Los pasos pequeños pueden llegar a grandes resultados! TotalCare y el programa Silver&Fit están aquí para ayudarle a mantenerse activo y sentirse lo mejor posible.

Para obtener más información, visite www.thealliance.health/es/totalcare o llame al **833-530-9015** (TTY: Marque **800-855-3000** o **711**), de 8 a.m. a 8 p.m., siete días a la semana.

El programa Silver&Fit es proporcionado por American Specialty Health Fitness, Inc., una filial de American Specialty Health Incorporated. Las personas que se muestran no son miembros de Silver&Fit. La participación en el gimnasio puede variar según la ubicación y está sujeta a cambios. Los kits se basan en la disponibilidad y están sujetos a cambios. El programa Silver&Fit no es un proveedor médico ni farmacéutico, y sus entrenadores no ofrecen asesoramiento médico ni farmacéutico. No pueden diagnosticar ni tratar afecciones médicas, de salud mental u otras afecciones. Los entrenadores proporcionan información general solo con fines educativos. Para cualquier problema médico o de salud, consulte a un profesional sanitario cualificado.



¡Enviamos mensajes de texto a los miembros!

La Alianza envía mensajes de texto a los miembros para ayudarles a mantenerse al día sobre los beneficios y servicios de la Alianza. Los textos de la Alianza son del código corto **59849**. Para obtener más información, visite nuestro sitio web en www.thealliance.health/es/member-texting.



En todas las etapas de la vida.
Para cualquier condición médica.

De confianza; cuidado de salud de Medi-Cal sin costo ofrecido por un equipo local que le entiende.

The Alliance: su aliado en ser su versión más saludable.

LA VIDA SALUDABLE se publica para los miembros y socios comunitarios de CENTRAL CALIFORNIA ALLIANCE FOR HEALTH, 1600 Green Hills Road, Suite 101, Scotts Valley, CA 95066, teléfono 831-430-5500 ó 800-700-3874, ext. 5508, sitio web www.thealliance.health/es.

La información de LA VIDA SALUDABLE proviene de una gran variedad de expertos médicos. Si tiene alguna inquietud o pregunta sobre el contenido específico que pueda afectar su salud, sírvase comunicarse con su proveedor de cuidado médico.

Se pueden usar modelos en fotos e ilustraciones.

Editor

Quality and Health Programs Supervisor

Randi Motson

Ivonne Muñoz

www.thealliance.health/es

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Provider Bulletin

A quarterly publication for providers. | June 2026



MEDICAID HMO



Three decades of partnering for healthier communities

Thirty years ago in Santa Cruz County, the Alliance began with a core belief: The most effective health care solutions come from a deep understanding of the people and communities we serve. Since then, we have grown to serve five counties, supporting more than 430,000 members through a network of over 14,000 contracted providers.

Our commitment to serving our provider partners and our members remains steadfast. We do this by listening to local needs; strengthening access to care; and promoting equitable, culturally responsive care for people of all ages and health conditions.

None of this would be possible without the expertise and collaboration of providers like you.

To support this partnership, we offer you:

- Competitive reimbursement rates that recognize the value of your care.
- Personalized support from teams who live in and understand our communities.
- Specialized training programs to support quality improvement.
- Incentive programs for primary care providers and specialists focused on reducing health disparities.
- Exclusive access to our Provider Portal for ease of doing business with us.
- In-house behavioral health care services for a more seamless, coordinated experience.
- Our TotalCare (HMO D-SNP) plan, enabling you to work with one insurance plan for dual-eligible members.

Alliance Board Meetings

Wednesday, June 24

3 p.m. to 5 p.m.

Wednesday, Aug. 26

3 p.m. to 5 p.m.

Whole Child Model Clinical Advisory Committee Meetings

Wednesday, July 22

Noon to 1 p.m.

Physicians Advisory Group Meetings

Thursday, Sept. 3

Noon to 1:30 p.m.

As we mark this 30-year milestone, we acknowledge the difficult road ahead with the reassurance that together, we will navigate the ever-evolving Medi-Cal landscape. Thank you for your partnership and for your shared commitment to helping people live healthier lives.



Michael Schrader

Michael Schrader, CEO

Care can't wait: Encouraging timely care for Alliance members

Timely care plays an important role in preventing serious health concerns and supporting long-term health outcomes. When routine visits and screenings are delayed, small health issues can become more complex over time.

To help reinforce the importance of preventive care, the Alliance is launching a member-focused campaign called “**Care Can’t Wait.**” Members may see this message across multiple communication channels, including newsletters, web content, text message and community engagement efforts.



The campaign encourages members to take an active role in their health and schedule recommended checkups, screenings and vaccines.

Why this matters

Many members face barriers that can make it difficult to prioritize preventive care. Consistent messaging from trusted providers can help reinforce the value of staying engaged in care and addressing health concerns early.

Providers play an essential role in helping members understand the importance of routine visits and recommended screenings.

How you can support this effort

You can help reinforce the “**Care Can’t Wait**” message by encouraging members to:

- Schedule routine checkups and preventive care visits.
- Stay up to date on recommended vaccines.
- Complete routine health screenings.
- Ask questions and discuss concerns during visits.

Encouraging preventive care and early screening helps support better health outcomes and strengthens continuity of care for Alliance members.

We appreciate your continued partnership in helping members stay connected to the care they need.

Provider reminder: Complete Model of Care training

The Centers for Medicare & Medicaid Services (CMS) requires all contracted Medicare Advantage Special Needs Plan and TotalCare providers to complete Model of Care training.

All employed, contracted and temporary staff, including in-network and out-of-network providers who routinely participate in a member’s

interdisciplinary care team, must complete this training upon onboarding and annually thereafter.

To complete the requirement:

1. Review the training at www.thealliance.health/moc-training.
2. Complete the attestation form at www.thealliance.health/moc-attestation.

The Alliance maintains training attestation records in compliance with CMS regulations.

Questions? Contact your Provider Relations Representative or call Provider Services at **831-430-5504**.

Welcome, new providers!

New ECM/CS providers

- **Central Coast Overdose Prevention.** ECM. Monterey County.
- **Exceptional Parents Unlimited.** ECM/CS. Housing Components, Respite Services, Personal Care and Homemaker Services. Mariposa and Merced counties.
- **Health Projects Center.** CS. Housing Transition Navigation and Housing Tenancy and Sustaining Services. Monterey, San Benito and Santa Cruz counties.
- **MindCure.** ECM/CS. Housing Components. Mariposa and Merced counties.
- **Sobriety Works.** ECM. Santa Cruz County.
- **United Way of Merced County.** CS. Transitional Rent. Merced County.
- **The Village Project Inc.** ECM/CS. Housing Components, Respite Services, Personal Care and Homemaker Services. Monterey County.

New physicians/specialists

Mariposa County

Referral physician/specialist

- **Prahalad Jajodia, MD,** Gastroenterology

Merced County

Primary care

- **Ian Carlo Cadiz, MD,** Family Medicine
- **Irma Castro, MD,** Family Medicine
- **Bernadette Chiu, MD,** Family Medicine
- **Shatha Hajja, MD,** Pediatrics



- **Harjot Hayer, DO,** Family Medicine
- **Agnes Nyeck, MD,** Family Medicine

Referral physician/specialist

- **Mildrede Bonglack, MD,** Obstetrics and Gynecology
- **Garima Handa, MD,** Cardiovascular Disease
- **Jenna Heath, MD,** Obstetrics and Gynecology
- **Jackie Leong, MD,** Radiologist
- **Eric Lu, MD,** Internal Medicine
- **Carmen Metildi, MD,** Diagnostic Radiology
- **Jennifer Rose-Nussbaumer, MD,** Ophthalmology
- **Anthony Waechter, MD,** Emergency Medicine

Monterey County

Primary care

- **Eleanor Battino, MD,** Family Medicine
- **Claudia Castelnovi, MD,** Pediatrics
- **Hsini Chu, DO,** Pediatrics
- **Arnold Cruz, DO,** Emergency Medicine
- **Steven Hand, MD,** Emergency Medicine

- **Larkin Holt, MD,** Family Medicine
- **Chun Ning Hu, DO,** Family Medicine
- **Cassandra Mahan-Richards, MD,** Pediatrics
- **Ginger Tissier, MD,** Family Medicine

Referral physician/specialist

- **Najib Allabadi, MD,** Surgery
- **Stephanie Chang, MD,** Obstetrics and Gynecology
- **Leo Fong, MD,** Vascular Surgery
- **Tatiana Hoyos Gomez, MD,** Surgery
- **Ollie Jackson, MD,** Surgery
- **Christopher Kim, MD,** Surgery
- **Divya Kishore, MD,** Diagnostic Radiology
- **Daniel Kosoy, MD,** Surgery
- **Vadim Leyenson, MD,** Pulmonary Disease
- **Henry Sanchez Ortigoza, MD,** Family Medicine
- **Frank Primus, MD,** Surgery
- **Kinza Sultan, DO,** Internal Medicine
- **Louis Zhang, MD,** Vascular Surgery

– Continued on back page



Expanding maternal support: Doula services available through the Alliance

The Alliance is proud to offer doula services as a covered benefit for eligible members. Doulas play an important role in supporting healthy pregnancies and positive birth experiences. The Alliance continues to expand access to these services across our region.

Today the Alliance has 90 doulas contracted within our provider network, serving members throughout Mariposa, Merced, Monterey, San Benito and Santa Cruz counties. This growing network helps ensure members have access to culturally responsive, community-based services across the perinatal period.

What is a doula?

A doula is a trained professional who provides non-medical support during pregnancy and after birth. Doulas offer emotional, physical and

educational support before, during and after childbirth. Their services can include helping members prepare for labor, providing comfort techniques during delivery, supporting communication with care teams, and assisting with recovery and infant care after birth.

Who qualifies for doula services?

Doula services are available to Alliance Medi-Cal members who are pregnant or recently gave birth. The benefit is designed to improve maternal health outcomes, provide additional guidance during pregnancy, and help families feel more confident and prepared throughout their birthing journey.

How members can access doula services

Members can access services by choosing a doula from the

Alliance's contracted provider network. A list of participating doulas is available through the Alliance Provider Directory, where members and providers can search by county.

Providers and care teams are encouraged to inform eligible members about this benefit and help connect them with doulas in the network, as appropriate. Expanding access to doula services reflects the Alliance's commitment to improving maternal health outcomes and ensuring members receive compassionate, community-centered care.

The Alliance offers a Specialty Care Incentive (SCI) Program measure to incentivize obstetrics and gynecology providers to refer patients to doulas. Learn more at www.thealliance.health/sci.

The Alliance offers language assistance training and resources

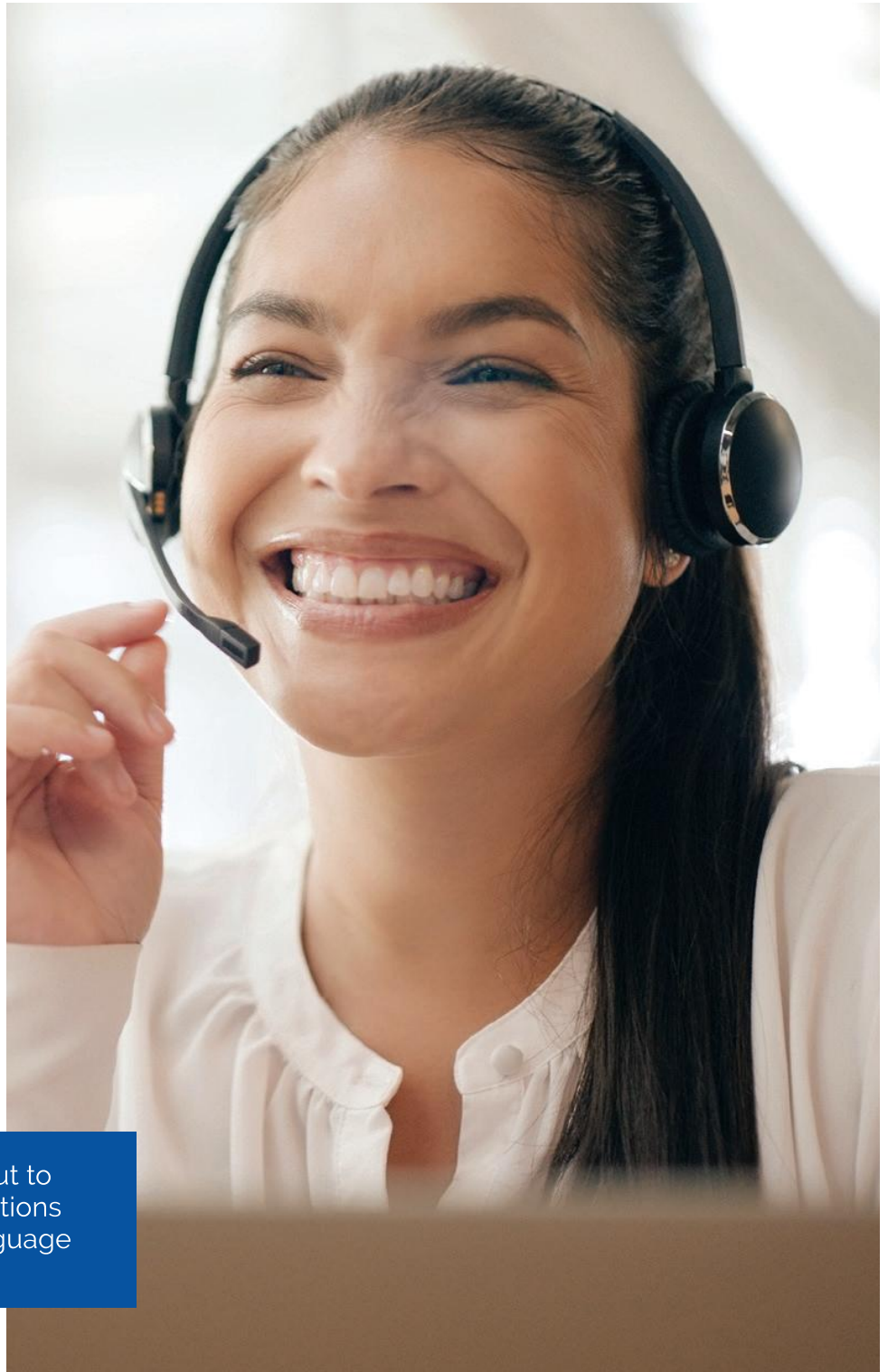
The Alliance offers a variety of language assistance services that our provider network can utilize to communicate with our members, including:

- Telephonic interpreting services.
- Face-to-face interpreting services.
- Virtual remote interpreting (VRI) services.

The Alliance's Cultural and Linguistics (C&L) team can provide training and support to make sure providers and staff know how to use the available interpreting services.

The Alliance can provide resources such as language assistance flyers and materials for office staff to use when working with members. Additionally, providers can use the Alliance Interpreter Services Provider Quick Reference Guide: www.thealliance.health/interpreter-services-quick-reference-guide.

For more information, visit www.thealliance.health/language-assistance or call the Alliance Health Education Line at **800-700-3874, ext. 5580**.



Providers can also reach out to their Alliance Provider Relations Representative for any language assistance training needs.

The Alliance offers health education workshops for members

The Alliance offers workshops to help members achieve healthier outcomes. The Alliance Health Programs team provides community resources and assists members with techniques for staying healthy.

Alliance members who participate in a workshop can receive up to a **\$50 Target gift card**.

Members who would like to sign up for a workshop can call the Alliance Health Education Line at **800-700-3874, ext. 5580**, or providers may fax a completed Health Program Referral form to **831-430-5852**. Forms are available at www.thealliance.health/health-programs-referral-form.

Members can also sign up for a workshop online at www.thealliance.health/health-programs-sign-up.

Workshops available:

- **Healthier Living Program (HLP)**. This program is available for adult members with chronic condition(s). The program teaches skills to help members manage issues including pain, fatigue, stress, anxiety and sleep loss. Members also learn about action planning, healthy eating and staying active. These workshops are offered in person, virtually and telephonically.
- **Healthy Weight for Life (HWL)**. This program is available for parents or guardians of Alliance members ages 2-18. The program teaches parents about healthy eating for children, increasing physical activity and making healthy lifestyle changes to support children to reach a healthy weight. These workshops are offered in person and virtually.
- **Live Better with Diabetes (LBD)**. This program is available for adult members with diabetes or prediabetes. The program teaches skills to help members manage diabetes or prediabetes. Members learn about the importance of healthy eating, physical activity and symptom management. Action planning and communication with their health care providers is included. These workshops are offered in person, virtually and telephonically.

Strengthening inclusive, affirming care for LGBTQ+ members

June is Pride Month: a time to celebrate the strength, diversity and resilience of our LGBTQ+ members and communities. This month reminds us to look at ways we can create a more inclusive, safe and affirming environment where LGBTQ+ individuals can feel seen, respected and supported.

In their 2025 State of LGBTQ Health Survey, the National Coalition for LGBTQ Health found the top two barriers to accessing care were distrust in the health system and the fear of stigma and discrimination (www.thealliance.health/lgbtqhealthsurvey).

Providers can make a difference! Based on current best practices and research, including the American Medical Association's recommendations for creating an LGBTQ+-friendly practice (www.thealliance.health/lgbtqfriendlypractice), health care providers can strengthen inclusivity by:

- **Using inclusive, affirming communication**, including asking about and using patients' pronouns and chosen names.
- **Creating visibly welcoming environments** with inclusive signage, updated forms and nondiscrimination statements.
- **Engaging in LGBTQ+ cultural competency training and continuing medical education (CME)/continuing education (CE) programs** to enhance knowledge about unique LGBTQ+ health needs. Help non-clinical staff access this training too.
- **Adopting evidence-based, gender-affirming care practices** to improve satisfaction and health outcomes.
- **Connecting patients to LGBTQ+ affirming resources**, including provider directories and specialty clinics with up-to-date resources.
- **Promoting institutional advocacy** to support policies and organizational changes that strengthen inclusion.
- **Remaining open, empathetic and curious.** Practice cultural humility, including active listening, acknowledging lived experience and recognizing the impact of stigma.



Learn more about behavioral health services for Alliance members at www.thealliance.health/bh. If you would like additional resources, contact Provider Services at **831-430-5504**.

Looking to learn more? Review the following resources.

Clinical guidelines for gender-affirming care

- UCSF Gender Affirming Health Program – Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People: <https://transcare.ucsf.edu/guidelines>.

Health care guidance

- American Psychological Association – Guidelines for Psychological Practice With Transgender and Gender Nonconforming People: www.apa.org/practice/guidelines/transgender.pdf.
- American Academy of Family Physicians LGBTQ+ Health Toolkit: www.thealliance.health/lgbtqtoolkit.

Training, CME/CE and implementation support

- National LGBTQIA+ Health Education Center – webinars, publications, tool kits and CME/CE opportunities: www.lgbtqihealtheducation.org.



Ensuring accuracy when measuring blood pressure

Best practices and resources for clinicians

Accurate blood pressure (BP) measurement is essential to effectively identify and manage hypertension. Reliable readings support appropriate clinical decision making, help prevent cardiovascular events such as stroke and heart failure, and reduce the risk of overtreatment or undertreatment.

Controlling High Blood Pressure, a Care-Based Incentive measure, recently moved from an exploratory measure to a paid programmatic measure in 2026. With this in mind, providers are encouraged to reinforce proper BP measurement techniques in both clinical and home settings, including:

- Appropriate patient positioning with back supported, legs uncrossed with feet flat on the floor and arm supported with BP cuff at heart level.

- Correct cuff sizing on a bare arm, not over clothing.
- Allowing patients to sit quietly before and during measurement.

Remember: If the first BP measurement is high, it is important to repeat the measurement after the patient rests quietly for five minutes to obtain a confirmatory measurement.

Provider training resources

Obtaining accurate BP values is a valuable clinical skill! The American Medical Association has published two training resources for office staff:

- BP Measurement Skills Assessment: www.thealliance.health/bp-skills-assessment.
- BP Measurement Competency Assessment: www.thealliance.health/bp-competency.

Blood pressure monitors for Alliance members

Did you know that blood pressure monitors are a covered benefit for Alliance members through Medi-Cal Rx? AllCare Pharmacy partners with clinics within Alliance service areas to ship blood pressure monitors directly to eligible members' homes at no cost.

How to send a prescription:

- Select the appropriate Microlife WatchBP Home Blood Pressure Monitor/Cuff from the Medi-Cal Rx Covered List (www.thealliance.health/bloodpressure).
- Remember to add a note on the prescription: "Please ship to patient's home. Please contact the patient to set up shipping."

Using Cozeva for TotalCare risk adjustment

The key to successful risk adjustment is to maintain accurate data and full documentation in order to capture the health plan’s full disease burden. That’s why the Alliance has contracted with Cozeva to seamlessly integrate with common industry electronic health record (EHR) systems and help close care gaps for patients.

If you are a TotalCare (HMO D-SNP) provider, we encourage you to participate in our Risk Adjustment Coding & Documentation Accuracy Incentive Program and use Cozeva to support risk adjustment efforts.

By integrating Cozeva with your EHR or electronic medical record (EMR) system, you can:

- Securely send data.
- Automate manual data entry.
- Improve data integrity and quality measure scores.
- Reduce administrative burden and save office staff time.

How to get started with Cozeva

1. Sign the agreement to participate in the CDA incentive program. Learn more about the program at www.thealliance.health/risk-adjustment-incentive.
2. To implement Cozeva at your practice, email emrintegration@cozeva.com.

Cozeva technical specifications

- Bi-directional and omni-directional.
- Options differ by EHR vendor.
- Set up at practice or group level.

Thank you for partnering with us to provide accessible, quality health care guided by local innovation!

Vendor	Connectivity	Benefits	Details
Veradigm	To Cozeva	Signed encounter notes are automatically sent to Cozeva and close care gaps weekly.	Connect through third-party vendor.
athenahealth	Bidirectional	Cozeva will automatically push care gaps for incoming patients into the appointment scheduler. Signed encounter notes are automatically sent to Cozeva and close care gaps weekly.	One solution fits all; no local installation needed.
eClinicalWorks	To Cozeva	Signed encounter notes are automatically sent to Cozeva and close care gaps weekly.	
Elation Health	To Cozeva	Signed encounter notes are automatically sent to Cozeva and close care gaps weekly.	One solution fits all; no local installation needed.
Epic	To Epic	Patient due report can be opened directly in Epic iframe.	Supports Epic Version 2017 or higher.
NextGen Healthcare	To Cozeva	Signed encounter notes are automatically sent to Cozeva and close care gaps weekly.	Uses NextGen’s Rosetta engine.
Office Ally	Bidirectional	Office Ally will pull patient due reports in Cozeva from the patient page within the EHR. Signed encounter notes are automatically sent to Cozeva and close care gaps weekly.	One solution fits all; no local installation needed.

If you are working with an EHR system not listed here, or if you have additional questions about Cozeva, please reach out to your Provider Services Representative.

PHARMACY



What you need to know about TotalCare drug coverage and prior authorizations

Drugs for TotalCare (HMO D-SNP) members are covered under either Part B or Part D.

Part B	Part D
Drugs that are not usually self-administered and injected or infused during doctor, hospital outpatient or ambulatory surgery center services.	Outpatient drugs, vaccines and some supplies not covered by Medicare Part A or B or Medicaid.
Immunizations: <ul style="list-style-type: none"> ■ Pneumonia. ■ Influenza (flu). ■ Hepatitis B – high or intermediate risk. ■ COVID-19. ■ Human papillomavirus (HPV). ■ Other vaccines if the member is at risk and meets Medicare Part B coverage rules. 	Immunizations: <ul style="list-style-type: none"> ■ Vaccines reasonable and necessary to prevent illness, except those covered by Part B.
Diabetes supplies: blood glucose monitors and test strips, lancets, continuous glucose monitors, etc.	Diabetes supplies: needles for insulin pens, insulin delivery devices, insulin pens and vials, etc.
Prior authorizations will be reviewed within 72 hours for routine requests by the Alliance. <ul style="list-style-type: none"> ■ Phone: 831-430-5507. ■ Fax: 831-430-5851. 	Prior authorizations will be reviewed within 72 hours for routine requests by MedImpact. <ul style="list-style-type: none"> ■ Phone: 800-347-5841. ■ Fax: 858-790-7100.

Part D formulary prior authorization and step therapy criteria

To search for Part D drugs, prior authorization and step therapy criteria using the online formulary search tool, visit www.thealliance.health/totalcare-formulary.

Medicare Part D excluded class drugs

By law, Medicare can't cover the following types of drugs:

- Drugs used to promote fertility.
- Drugs used for the relief of cough or cold symptoms.
- Drugs used for cosmetic purposes or to promote hair growth.
- Drugs used for the treatment of anorexia, weight loss or weight gain.
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.
- Outpatient drugs made by a company that states tests or services must be conducted by them.

Part B co-pay costs

Medicare Part B requires a deductible and/or co-insurance, which may be paid by Medi-Cal Rx.

Part D co-pay costs

Members may have a co-pay for Part D drugs, depending on their Extra Help level and the drug tier. For more information, visit www.thealliance.health/medicare/drug-costs.

For more information, visit the TotalCare Pharmacy page: www.thealliance.health/totalcare-pharmacy.



See the newest Medi-Cal Rx DUR article

Please review the following Medi-Cal Rx Drug Utilization Review (DUR) article published since February 2026: "Updated Guidance for the Treatment of High Blood Pressure."

This resource is available on the Alliance's Pharmacy Services webpage under the "Drug Utilization Review (DUR)" section: www.thealliance.health/more-pharmacy-info.

The Alliance's PAD List and procedures

The Alliance's Physician-Administered Drug List, restrictions, prior authorization criteria, policies and their updates are available in the Pharmacy area of our website: www.thealliance.health/pharmacy-services. If you would like to request physical copies, please contact the Pharmacy Department at **831-430-5507**.

Important phone numbers

Provider Services	831-430-5504
Claims	831-430-5503
Authorizations	831-430-5506
Status (non-pharmacy)	831-430-5511
Member Services	831-430-5505
Web and EDI	831-430-5510
Cultural & Linguistic Services	831-430-5580
Health Education Line	831-430-5580

Partnering with local doctors and specialists to ensure that Alliance members get access to the right care, at the right time.



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Welcome, new providers!

– Continued from page 3

San Benito County Referral physician/ specialist

- **Stefan Klein, MD,**
Orthopedic Surgery
- **Sarathy Mandayam, MD,**
Gastroenterology
- **John Wiemann, MD,**
Orthopedic Surgery

Santa Cruz County Primary care

- **Gustavo Diaz, MD,**
Emergency Medicine
- **Carolyn McAloon, DPM,**
Podiatric Medicine
- **Vijaya Mukthinuthalapati, MD,**
Internal Medicine

Referral physician/ specialist

- **Jennifer Etcheson, MD,**
Hand Surgery
- **Kimberly Gandy, MD,**
Thoracic Surgery
- **Teresa Walsh, MD,** Obstetrics
and Gynecology



The Alliance extends a warm welcome to all our newest providers. To see the complete list, please visit www.thealliance.health/welcome-new-providers-q2-2026.

Some of our new behavioral health providers

Mariposa County

- **Brian Raines, PsyD**

Merced County

- **Decinda Allen, LMFT**
- **Ashley Del Valle, LCSW**

Monterey County

- **Everett Allen, PA**
- **Jennifer Barreto, BCBA**

San Benito County

- **Merline Covington, PMHNP**
- **Nikkie Galaviz, LMFT**

Santa Cruz County

- **Erika Abrahamian, LMFT**
- **Rebecca Branch, BCBA**

Holiday office closures

- **Friday, June 19**
(Juneteenth)
- **Friday, July 3**
(Independence Day
observed)



June 2, 2026

The Honorable Jesse Gabriel
Chair, Assembly Budget Committee
1021 O Street, Site 8230
Sacramento, CA 95814

The Honorable Dawn Addis
Chair, Assembly Budget Subcommittee No. 1
1201 O Street, Room 4120
Sacramento, CA 95814

RE: Protecting Access to Healthcare

Dear Assemblymember Gabriel and Assemblymember Addis,

On behalf of Central California Alliance for Health, I write to express our support for efforts to protect access to care in light of anticipated Medi-Cal coverage losses associated with federal work requirements and related eligibility changes under H.R. 1. As a Medi-Cal managed care plan serving approximately 420,000 members across Santa Cruz, Monterey, Merced, San Benito and Mariposa counties, we are deeply concerned about the potential impacts these changes will have on our members, provider networks, and the broader county-based healthcare delivery systems.

California has made significant progress in expanding coverage and reducing the uninsured rate through Medi-Cal expansion and implementation of the Affordable Care Act. However, provisions in H.R. 1 risk reversing these gains, leading to coverage losses, procedural disenrollments, and increased administrative churn—particularly among vulnerable populations who rely on continuity of care.

Across the counties we serve, these changes are expected to increase demand for uncompensated care, place additional strain on hospitals, community clinics, behavioral health providers, and county health systems exacerbating existing workforce and financial challenges. Many individuals who lose coverage will continue to seek care through safety net providers, including those supported by counties that are already facing significant fiscal pressures.

As a local Medi-Cal managed care plan, we partner closely with counties, providers, and community-based organizations to ensure access to comprehensive, coordinated care. We share counties' concerns that the current system does not have the capacity to absorb a sudden increase in uninsured individuals without significant disruption to care delivery and health outcomes.

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We support consideration of a temporary, two-year “Protect Access to Healthcare” (PATH) pilot project as a reasonable and necessary stabilization strategy. This approach would provide a limited emergency-services-only Medi-Cal benefit for individuals who lose coverage due to new federal requirements while maintaining their connection to Medi-Cal eligibility systems.

We believe this approach would:

- Preserve access to lifesaving and stabilization services;
- Mitigate increases in the uninsured population relying solely on county indigent care systems;
- Support continued access to federal funding for allowable emergency services;
- Maintain continuity within eligibility systems to facilitate reenrollment; and
- Provide the State, counties, and key stakeholders with critical time and data to evaluate longer-term policy solutions.

Further, this strategy would help avoid destabilizing local healthcare systems and reduce the need to rapidly rebuild indigent care infrastructure that was scaled back following Medi-Cal expansion.

Our shared goal remains the preservation and expansion of full-scope coverage for individuals across our region. We remain committed to working in partnership with the State, counties, and providers to advance solutions that protect access to care, support delivery system stability, and ensure continuity of care for the communities we serve.

Thank you for your leadership and consideration of this important issue. We welcome the opportunity to continue working collaboratively to identify fiscally responsible, patient-centered solutions.

Sincerely

Michael Schrader

Michael Schrader

Chief Executive Officer

cc:

Senator Marie Alvarado-Gil

Senator Anna Caballero

Senator John Laird

Speaker Robert Rivas

Assemblymember Juan Alanis

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Assemblymember Gail Pellerin
Assemblymember Esmeralda Soria
Assemblymember David Tangipa

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June 5, 2026

The Honorable Mike Gipson, Chair
Assembly Revenue and Taxation Committee
1021 O Street, Suite 6210
Sacramento, CA 95814

Re: SB 762 (Arreguin): Transactions and use taxes: various jurisdictions, as amended 6/1/26 – SUPPORT

Dear Assemblymember Gipson

As the Chief Executive Officer of Central California Alliance for Health, the local Medi-Cal managed care plan serving Santa Cruz County, I write to express support for Senate Bill 762, which would authorize the Santa Cruz County Board of Supervisors—along with other eligible jurisdictions—to seek voter approval for a countywide transactions and use tax above the current 2% statutory cap. This authority is intended to help offset potential losses in federal funding that support critical local programs and services.

Consistent with prior legislation enacted for other jurisdictions, SB 762 would allow the County to place before voters a measure of up to 0.5% above the statutory cap. As an urgency measure, the bill would enable the County to consider this option as early as the November 2026 election, with the authority remaining in place through December 31, 2030.

Santa Cruz County, like many communities throughout California, continues to face increasing fiscal pressures related to the provision of safety net services. Uncertainty in federal and state funding presents challenges for maintaining access to care and other essential supports for vulnerable populations. Providing the County with limited, voter-approved revenue flexibility may help sustain critical services and promote continuity of care for Medi-Cal members and the broader community.

Importantly, SB 762 does not impose any new tax but instead provides local voters with the opportunity to consider this option. The Alliance supports the County's efforts to explore solutions that support the long-term stability of essential services and respectfully express our support for this measure.

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Sincerely,

Michael Schrader

Michael Schrader
Chief Executive Officer

cc:

Senator John Laird
Assemblymember Dawn Addis
Assemblymember Gail Pellerin
Senator Jesse Arreguin

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