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, March 25, 2026

3:00 p.m. – 5:00 p.m.

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

1. Members of the public wishing to observe the meeting remotely via online livestreaming may do so as follows. Note: Livestreaming for the public listening/viewing only.
    a. Computer, tablet or smartphone via Microsoft Teams:
    Click here to join the meeting
    b. Or by telephone at:
    United States: +1 872-242-9041
    Phone Conference ID: 224 974 496#

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, March 23, 2025, to the Clerk of the Board at clerkoftheboard@thealliance.health.
        i. Indicate in the subject line "Public Comment". Include your name, organization, agenda item number, and title of the item in the body of the e-mail along with your comments.
        ii. Comments will be read during the meeting and are limited to three minutes.
    b. In person, from an Alliance County office, during the meeting when that item is announced.

i. State your name and organization prior to providing comment.
ii. Comments are limited to three minutes.

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

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

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

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

3. Comments and announcements by Commission members.

A. Board members may provide comments and announcements.

4. Comments and announcements by Chief Executive Officer.

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

Consent Agenda Items: (5.– 10E.): 3:30 p.m.

5. Accept Chief Executive Officer (CEO) Report.

- Reference materials: Chief Executive Officer (CEO) Report

Pages 5-1 to 5-10

6. Accept Alliance Dashboard for Q4 2025.

- Reference materials:
  - Staff report on above topic
  - Alliance Dashboard – Q4 2025

Pages 6-1 to 6-3

7. Accept Alliance Financial Highlights, Balance Sheet, Income Statement and Statement of Cash Flow for the twelfth month ending January 31, 2026.

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

Pages 7-1 to 7-16

Minutes: (8A. – 8D.):

8A. Approve Commission regular Meeting Minutes of February 25, 2026.

- Reference materials: Minutes as above.

Pages 8A-1 to 8A-6

8B. Accept Compliance Committee Meeting Minutes of January 28, 2026.

- Reference materials: Minutes as above.

Pages 8B-1 to 8B-5

8C. Accept Whole Child Model Clinical Advisory Committee Meeting Minutes of December 16, 2025.

- Reference materials: Minutes as above.

Pages 8C-1 to 8C-4

8D. **Accept Physicians Advisory Group Meeting Minutes of December 4, 2025.**
- Reference materials: Minutes as above.

Pages 8D-1 to 8D-6

Appointments: (9A. – 9D.)

9A. **Approve the appointment of Sandra Settrini to the Member Services Advisory Group.**
- Reference materials: Staff report and recommendation on above topic.

Page 9A-1

9B. **Approve the reappointments of Adriana Zoghlami and Janna Espinoza to the Member Services Advisory Group.**
- Reference materials: Staff report and recommendation on above topic.

Page 9B-1

9C. **Approve the appointments of John Mark, MD to the Whole Child Model Clinical Advisory Committee.**
- Reference materials: Staff report and recommendation on above topic.

Page 9C-1

9D. **Approve the appointments of Caroline Kennedy, MD, Devon Francis, MD, Misty Navarro, MD, and Shirley Dickinson, MD to the Physicians Advisory Group.**
- Reference materials: Staff report and recommendation on above topic.

Page 9D-1

Reports: (10A. – 10E.)

10A. **Accept 2026 Legislation and Bill List.**
- Reference materials:
  - Staff report on above topic
  - Central California Alliance for Health 2026 Bill List

Page 10A-1 to 10A-41

10B. **Accept Business Continuity and Disaster Recovery Program 2025 Annual Report.**
- Reference materials: Staff report on above topic.

Page 10B-1 to 10B-2

10C. **Accept Inclusion and Belonging 2025 Annual Report.**
- Reference materials: Staff report on above topic.

Page 10C-1 to 10C-2

10D. **Approve revisions to the Whole Child Model Clinical Advisory Committee (WCMCAC) Charter.**
- Reference materials:
  - Staff report and recommendation on above topic
  - Whole Child Model Clinical Advisory Committee 2025 Charter

Pages 10D-1 to 10D-7

10E. **Approve revisions to the Physicians Advisory Group (PAG) Charter.**
- Reference materials:
  - Staff report and recommendation on above topic
  - Physicians Advisory Group 2025 Charter

Pages 10E-1 to 10E-3

Regular Agenda Items: (11. – 13.): 3:35 p.m. – 5:00 p.m.

11. Consider and approve the Alliance's legal and regulatory Compliance Program Report Q3-4 2025 and receive required Board training in Compliance and Fraud, Waste and Abuse prevention. (3:35 – 4:20 p.m.)

A. Ms. Jenifer Mandella, Chief Compliance Officer, will review and Board will consider and approve the Alliance's Compliance Program Report for Q3-4 2025 and board will receive mandated Compliance and FWA Prevention training.

- Reference materials:
  - Staff report and recommendation on above topic
  - Alliance Compliance Plan
  - Q3 & Q4 2025 Internal A&M Dashboard
  - Q3 & Q4 2025 HIPAA Dashboards
  - Q3 & Q4 2025 Program Integrity Dashboards

Pages 11-1 to 11-34

12. Alliance Owned Properties Annual Report. (4:20 p.m. – 4:40 p.m.)

A. Mr. Ryan Inlow, Facilities and Administrative Services Director, will provide an update on the Alliance Commercial Properties.

- Reference materials: Staff report on above topic.

Page 12-1

13. Brown Act Updates: Senate Bill 707. (4:40 p.m. – 5:00 p.m.)

A. Ms. Anne Brereton, Monterey County Counsel, will provide an update and training for the board on recent changes to the Brown Act.
- Reference materials: Staff report on above topic.

Pages 13-1 to 13-2

Information Items: (14A. – 14F.)

A.	**Alliance in the News**	Pages 14A-1 to 14A-6
B.	**Membership Enrollment Report**	Page 14B-1
C.	**Letters of Support**	Pages 14C-1 to 14C-3
D.	Provider Bulletin – March 2026	Page 14D-1 to 14D-12
E.	Member Newsletter – March 2026 (English)	Page 14E-1 to 14D-12
F.	Member Newsletter – March 2026 (Spanish)	Page 14F-1 to 14F-8

Announcements:

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

- Finance Committee
  Wednesday, June 24, 2026; 1:30-2:45 p.m.

- Member Services Advisory Group
  Thursday, May 14, 2026; 10:00 – 11:30 p.m.

- Physicians Advisory Group
  Thursday, June 4, 2026; 12:00 – 1:30 p.m.

- Whole Child Model Clinical Advisory Committee [R*emote teleconference only*]
  Tuesday, April 16, 2026; 12:00 – 1:00 p.m.

- Whole Child Model Family Advisory Committee [R*emote teleconference only*]
  Monday, April 27, 2026; 1:30 – 3:00 p.m.

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

The next regular meeting of the Commission, after this March 25 meeting, unless otherwise notified.

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

Date:	Wednesday, April 22, 2022
Time:	10:00 a.m. - 3:00 p.m.
Location:	El Capitan Hotel Sentinel Conference Room 609 W Main Street Merced, CA 95340

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.

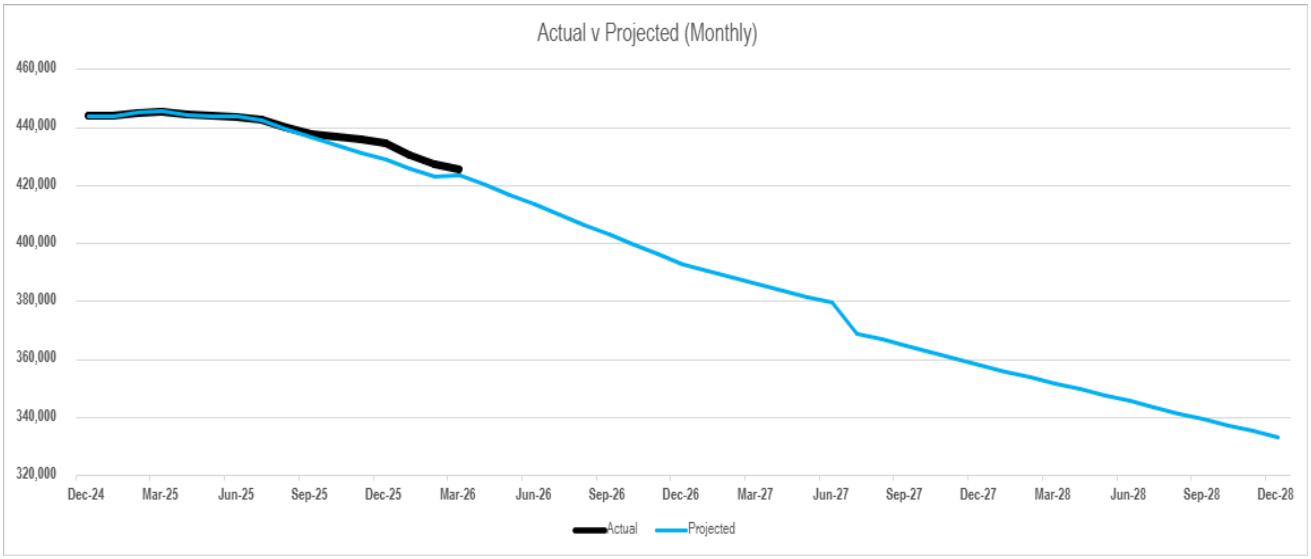
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

DATE	March 25, 2026
TO	Governing Commission of the Central California Alliance for Health
FROM	Michael Schrader, Chief Executive Officer
SUBJECT	CEO Report

Projected Declines in Alliance Medi-Cal Enrollment. Alliance enrollment is projected to decline between August 2025 and December 2028 due to the end of COVID-19 unwinding flexibilities, the implementation of federal H.R. 1 requirements, and the FY2025–26 state budget.

Alliance Medi-Cal Membership Decline: Actual vs. Projected

In the graph below, 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. So far, the black line has tracked almost directly along the blue line, indicating that our actual membership decline is closely mirroring our projection.



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

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%**

The Alliance projection (shown as the blue line in the graph above, reflecting a 27% decline in Alliance Medi-Cal membership from January 2025 through December 2028), does not account for two potential carve-outs described below that could further reduce Alliance enrollment.

Possible Carve Out of Medi-Cal Enrollees with UIS from Managed Care Plans. Our projection does not incorporate the possibility that DHCS may carve out Medi-Cal enrollees with Unsatisfactory Immigration Status (UIS) from managed care and assume direct responsibility for their coverage. Whether a carve-out occurs will depend on how DHCS chooses to implement recent CMS guidance. On September 30, 2025, CMS clarified that monthly capitation payments for individuals with UIS will no longer qualify for federal financial participation for emergency Medi-Cal coverage, effective January 1, 2027. Currently, approximately 17% of Alliance members have UIS, though some portion of this group will likely have already lost coverage by the effective date as part of the projected 27% enrollment decline.

Non Qualified Citizens. Another factor with potential impact on enrollment projections, not reflected in the current forecast, is the provision in H.R. 1 that narrows the definition of "qualified non-citizen" for purposes of federally funded Medicaid. As a result, many lawfully present immigrants who currently receive full-scope Medi-Cal benefits, including refugees, asylees, humanitarian parolees, and other protected groups, would no longer qualify for federally funded comprehensive coverage beginning October 1, 2026. Whether these individuals continue to receive full-scope benefits in California will depend on a state policy and budget decision; the state could elect to use 100 percent General Fund dollars to maintain coverage, consistent with prior state-only expansions. Absent such action, impacted individuals would be limited to restricted-scope benefits, affecting approximately 6,000 Alliance Medi-Cal enrollees.

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

General Member Outreach. The Alliance's bilingual paid media campaign is in flight, featuring advertisements across television, mobile platforms, radio, YouTube, social media, and billboards. The first phase of the campaign emphasizes helping members renew their Medi-Cal coverage on time through a simple three-step process. We have also created posters and handouts for provider offices and community partners and published related articles on our website as well as in our community, provider, and member newsletters. The radio and broadcast television ads will pause from April 20-May 31, allowing us to maximize our budget and refresh messaging imagery. The digital elements will continue to run during this time, ensuring we maintain minimum media presence throughout the year.

Focused Member Outreach. In February, we sent text messages to nearly 13,000 members who needed to complete their annual Medi-Cal renewals within the next 45 days.

Community Partner Trainings. In February, the Alliance continued its partnership with local county departments and hosted three community partner training sessions in Merced, Monterey, and Santa Cruz Counties as part of the MOR Initiative. A total of 121 community partners representing approximately 20 community organizations participated across the sessions. These trainings expanded the network of community-based partners equipped to assist members with Medi-Cal redetermination and renewal processes, while also helping the Alliance and counties identify knowledge gaps and strengthen communication about upcoming Medi-Cal changes.

Grant Funding. The Medi-Cal Member Outreach and Retention grant program was announced on March 6, 2026. The application deadline is March 27, 2026. An informational webinar will be held March 18, 2026 to provide an overview of program requirements and the application process. This funding opportunity will fund trusted community partners to conduct outreach, education, and hands-on assistance that helps eligible Medi-Cal members stay enrolled. Two types of grants are available: Tier 1 - Outreach and Education to raise awareness about Medi-Cal eligibility and renewal requirements; and Tier 2 - Medi-Cal Renewal Assistance to provide direct

assistance helping Medi-Cal members complete the renewal (redetermination) process. Information is available on the Alliance website at www.thealliance.health/MORgrant.

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. Our current five-year strategic plan concludes at the end of this year, and work on our next plan is well underway. El Cambio Consulting is facilitating the process and has already completed individual interviews with all 17 commissioners, 7 key stakeholders, and 4 representatives from our member advisory committees. At the April Board meeting in Merced, El Cambio will present the major themes that emerged from these interviews with commissioners, stakeholders, and staff.

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 & Enrollment. Since TotalCare's launch, **enrollment has steadily increased, reaching 592 active members at the end of February**, **with an additional 40 enrollees set for future effective dates**. The Alliance remains committed to expanding participation and continues to invest in targeted sales and marketing efforts to support that growth. Focused marketing targeting existing Medi-Cal members who are connected to an in-network PCP will begin in April with monthly mailers and continue for the remainder of the year. In addition, we will execute a paid media campaign in June through the rest of the year.

New Member Onboarding. The TotalCare team has implemented structured onboarding processes, including welcome materials, care coordination outreach, and assistance navigating integrated Medicare and Medi-Cal benefits. Early success includes capturing Health Risk Assessments (HRAs) at the point of sale, which supports early care management engagement. Based on current quality indicators, TotalCare is performing at a greater than four-Star level.

TotalCare Provider Network. The Alliance continues to strengthen its specialty network to meet all adequacy requirements. In Merced County, staff are finalizing the credentialing of a neurosurgery provider, which will successfully close an identified gap. Concurrently, the Alliance is preparing for the triennial DHCS provider network audit in June and will submit its first network alignment report this month as part of DHCS's oversight of Medi-Cal and Medicare integration. Meeting the DHCS-recommended 90% alignment for primary and specialty care is a key priority, ensuring seamless continuity for members as they age into TotalCare.

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.

2026 Legislative Session. The Legislature reconvened for the start of the 2026 Legislative Session on January 5, 2026, with the deadline of February 20, 2026, to introduce new legislation. Staff review newly introduced bills in the Board's approved areas of legislative focus and have developed a bill list, which is included as Agenda Item 10A, which includes approximately one-hundred-six bills (106) Staff will collaborate with the Local Health Plans of California and the California Association of Health Plans to review, monitor and advocate, as appropriate on bills of interest.

Legislative Analyst Office (LAO) Medi-Cal Budget Analysis. A recently issued LAO 2026-27 Budget: Medi-Cal Analysis report from the LAO suggests that the Legislature may face difficult decisions and trade-offs as it considers option to manage long-term cost growth in the Medi-Cal program. The report finds that spending in Medi-Cal continues to grow rapidly, with General Fund costs projected to reach $49 billion ($222 billion total funds) by 2026–27, largely driven by rising per-enrollee costs rather than caseload growth. The report also highlights fiscal pressures from declining provider tax revenues under new federal rules and policy choices related to eligibility changes and program savings.

Alliance Care IHSS program. The Alliance contracts with the County of Monterey Public Authority to administer the Alliance Care IHSS program, which provides health care coverage for individuals enrolled by the County who deliver IHSS services to Alliance members in Monterey County. Each year, the Alliance works with its contracted actuaries to establish a per-member per-month premium, and the County sets its budget and determines how many IHSS workers can be enrolled in

the program. After holding premiums steady last year, the Alliance noticed the County that, effective July 1, 2026, a 12.2% annualized premium increase was determined to be necessary due to rising costs that have exceeded premium revenue. Contributing factors include the plan's relatively small membership base and increasing prescription drug expenses, particularly costs associated with GLP-1 medications.

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:

- New Faith Tabernacle's Community Baby Shower, Merced County
- Divers-ability Resource Fair, Merced County
- Salinas Pink Shirt Day, Monterey County
- Salinas Senior Social, Monterey County
- Alinea Mobile Mammography Clinic, Merced, Monterey and Santa Cruz Counties

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

- Mariposa Health and Wellness Coalition, Mariposa County
- Head Start Health and Mental Health Advisory Committee, Merced County
- Health Leadership County, Merced County
- Safe Kids Coalition of San Benito County, San Benito County
- Youth Access Coalition, Santa Cruz County

Communications and Marketing. The Alliance is developing a public awareness campaign called "Care Can't Wait" which will focus on ensuring members access the care they need. The campaign will begin in April and run throughout the year on Alliance communication channels, focusing on encouraging members to seek care for chronic conditions, acute illnesses and remain up to date on their well-check visits and preventive screenings.

Quality & Health Equity and Health Education. The Alliance continues to build on its commitment to delivering high-quality care while actively addressing health disparities.

Health Education Workshops. In Q1 2026, the Alliance implemented 15 member workshops with 133 participants enrolled, including Alliance members, TotalCare members, and members with the Alliance as secondary coverage. Workshops included seven Healthier Living Program sessions for adult members with chronic conditions, six Live Better with Diabetes sessions for members with diabetes or prediabetes, and two Healthy Weight for Life sessions for parents or guardians of Alliance members ages 2 to 18. These programs focus on action planning, healthy eating, physical activity, symptom monitoring, and communication skills. Workshops were delivered through telephonic, virtual, and in-person formats, including an in-person session at the Alliance office in Merced. Workshops are offered quarterly in English and Spanish, with members able to enroll through the Alliance Health Education line or online registration, and referrals also available through primary care providers. Additional outreach efforts are underway to strengthen coordination with Enhanced Care Management providers and further expand member awareness and enrollment in available workshops.

Equity and Practice Transformation (EPT). In collaboration with the California Department of Health Care Services, the Alliance launched its Equity and Practice Transformation (EPT) Program in 2025 to improve primary care for Medi-Cal members by supporting clinics in transforming care delivery and addressing health disparities. The program focuses on key populations, including pregnant people, adults with chronic conditions, children and youth, and adults with preventive care needs. Currently, fifteen clinical sites across four of the Alliance's five counties are participating. Now in its second year, three practices are demonstrating strong progress toward key performance goals. Performance is measured through several Key Performance Indicators (KPIs). Eleven of the sites meet the Access to Care target of securing a primary care appointment within 10 days. Nine sites meet the Continuity of Care threshold, ensuring members see their assigned primary care provider (PCP) at least 70% of the time rather than another provider within the practice supporting stronger patient-provider relationships. In addition, nine sites exceed the Empanelment benchmark of greater than 90% patient-to-PCP accuracy, which measures whether a member's health record correctly reflects their assigned PCP.

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 Expansion. Effective March 1, 2026, the Alliance expanded its provider network with several key additions. These include a pediatric long-term acute care facility in Mountain View, an OB/GYN in South Santa Cruz County, and two physical therapists, four primary care providers, and a vascular surgeon in Monterey County. The expansion also adds an ophthalmologist in Merced County, a skilled nursing facility in Mariposa, and a foot and ankle surgeon in Oakhurst, located in adjacent Madera County.

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 February 23, 2026, the Alliance has 762 budgeted positions (regular and contingent) with 707 positions filled, bringing overall staffing to 92%. Staffing strategies continue to emphasize the use of contingent labor where appropriate, aligning workforce levels with decreasing membership and service volumes associated with HR1 and the annual state budget.

Employee Appreciation Day: In recognition of employee contributions, the Alliance marked Employee Appreciation Day with a message from Michael Schrader, CEO, reflecting on the organization's 30-year history and reaffirming its commitment to local, compassionate, and culturally responsive care. As a tangible expression of appreciation, all employees will receive an additional $25 in their March 13 paycheck.

Alliance Q1 All-Staff: The Q1 2026 All-Staff meeting was held virtually on March 12, 2026. This forum recognized employee achievements through the Star Awards program and highlighted current initiatives and member-focused impact through the Mission in Motion segment. This quarter, Dr. Bruce Metcalf, CEO of Merced County Rescue Mission, spoke to staff about his organization's partnership with the Alliance. Our Chief Compliance Officer Jenifer Mandela presented to staff on the topic of Program Integrity. Chief Information Officer Cecil Newton presented on recent IT satisfaction ratings, and Janet Williams from our consulting firm Progressive Discoveries presented to staff on the topic of psychological safety. CEO Michael Schrader presented his quarterly State of the Alliance address, sharing details on our

current environment, our D-SNP launch, and the forthcoming three-year strategic plan. Our next all-staff meeting will be held on Wednesday, June 10.

Senior Leadership Quarterly Meeting: The first Senior Leadership meeting of 2026 will be held on March 26, 2026, in Scotts Valley. These quarterly meetings bring together the Executive and Director teams to discuss strategic priorities, address organizational challenges, and strengthen cross-functional collaboration.

Regulatory Audits and Compliance: Program Integrity.
In early 2026, federal oversight of California's Medi-Cal program intensified through parallel executive and congressional actions focused on program integrity. Federal leaders directed the state to produce a comprehensive action plan, addressing fraud controls, member eligibility verification, provider screening and enrollment. Within the fraud-control domain, federal officials highlighted several high-risk service areas, including hospice, transportation, behavioral health therapy, and housing-related community supports. DHCS has underscored that health plans share direct responsibility for implementing effective fraud-prevention measures. The Alliance takes this responsibility seriously and maintains a robust program to support strong fraud, waste, and abuse controls. For additional detail, please see Agenda Item 11, Compliance Program Report for Q3–4 2025, under Legal and Regulatory Updates.

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

Security Gap Assessment. In Q4 of 2025, the Alliance engaged an external security firm, Tevora to conduct a HIPAA/NIST Security Gap Assessment. The results of that assessment, which were positive, were shared with Alliance staff on February 25, 2026.

Overall Security Posture

Category	Status	What This Means
Threat Activity	Moderate	We regularly see attempts to attack our systems, but nothing serious or impactful has gotten through our defenses.
Security Controls	Effective	Our defenses—like email filters and computer protections—are working as expected.

User Security Awareness	Strong	Our staff are well trained to spot suspicious emails. Very few (<1%) staff fall for phishing scams as demonstrated by our ongoing phishing simulations.
Vulnerability Management	Moderate	On an ongoing basis, we are actively fixing important security weaknesses.
Strategic Security Initiatives	On Track	Large security improvement projects—like better access controls and faster response to threats—are moving forward as planned.
Overall Security Posture Assessment is based on internal and external measurements compiled for and by the CIO/Information Security Officer		

The Alliance is working with Conduent on their nationwide security breach response, as noted in prior CEO Reports.

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

Trends in the Number of Awards and Total Spend. The MCGP has paid out $8M year to date in 2026 for active grant awards, compared to $28.5M for all of 2025. The 2026 award target is $20 million. The application deadline for the first funding round in 2026 was January 20, 2026. There are 69 eligible grant applications currently under review for Workforce Recruitment, Healthcare Technology, Community Health Champions and Parent Education and Support programs. Award decisions will be distributed on April 3, 2026. Round 1 2026 was the final application round for the Doula Recruitment, Medical Assistant Recruitment, Parent Education and Support, and Community Health Champions programs, which are now retired. The next two regular funding rounds in 2026 have application deadlines on May 5 and August 18.

DATE: March 25, 2026

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

FROM: Van Wong, Chief Operating Officer

SUBJECT: Q425 Alliance Dashboard

Recommendation. Staff recommend the Board accept the Q4-25 Alliance Dashboard performance outcome report.

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

Discussion. The Q4 2025 Alliance Dashboard provides a structured overview of the organization's performance for the fourth quarter of the year, highlighting areas of strength along with operational and financial challenges. Overall, the organization demonstrated progress in several domains while continuing to implement strategic initiatives aimed at improving efficiency, member experience, and long-term financial stability. Results for eight of 13 Level 1 processes met or exceeded 95% of target. Three operational processes that did not meet the 95% standard are outlined below:

Engage and Support Members: 90.8% (-0.8% from previous quarter)
Performance was primarily impacted by two metrics: calls answered within 30 seconds and completion of new member welcome calls. Average talk time has increased by 1.1 minutes per call, largely due to the added complexity of D-SNP and Behavioral Health inquiries. Despite these longer durations, the phone abandonment rate remains low at 10%, and members continue to report high satisfaction with the plan. To mitigate these pressures, the Alliance is hiring six temporary staff members and transitioning new member welcome calls to a third-party vendor, Harte Hanks, to increase internal capacity.

Pay Providers: 88.1% (+1.7 percentage points from previous quarter)
Current performance remains below target due to delays in mailing resolution letters for both contracted (30-day) and non-contracted (45-day) provider disputes. While dispute volumes have increased steadily over several years without corresponding adjustments to staffing, the Alliance has successfully reversed the downward trend this quarter. Staff closed more cases in this period than in previous quarters by leveraging new tools and dashboards. Specifically, the implementation of a predictive prioritization and assignment tool identifies cases likely to be upheld and automatically assigns them based on established work patterns. This performance

increase is a strong indicator that these technological investments are successfully offsetting historical staffing gaps and positioning the Alliance for improved future performance.

Manage Finances: 89.0% (+1.8 percentage points from previous quarter)
While overall financial performance improved this quarter, three specific measures remain below target, primarily driven by Operating Income and the Medical Loss Ratio. Both metrics are heavily impacted by high service costs and inadequate revenue associated with Enhanced Care Management (ECM), Community Supports (CS), and medical transportation. To address these rising costs and stabilize margins, the Alliance transitioned provider contracts from a global capitation model to a fee-for-service rate structure effective January 1st for ECM and March 1st for CS. This provider reimbursement methodology shift is designed to ensure more precise alignment between service delivery and reimbursement as the Alliance works toward meeting its long-term financial targets.

As these initiatives are implemented, performance in the noted areas is expected to improve over the coming quarters, supporting the Alliance's continued focus on operational excellence, member experience, and long-term financial stability.

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

Attachments.

1. Q4 2025 Alliance Dashboard

Alliance Dashboard

Quarter 4, 2025

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

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

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

Core Processes

Deliver value to our members, providers and community

Engage & Support Members

90.8% Of Target

SUBPROCESSES
- 100 Help Members Engage
- 73.7 Help Members Navigate
- 98.8 Member Experience

Manage & Improve Care

98.6% Of Target

SUBPROCESSES
- 97.1 Manage Care Use
- 100 Improve Care

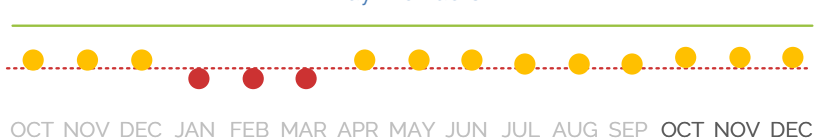
Develop & Maintain the Provider Network

97.5% Of Target

SUBPROCESSES
- 98.7 Develop the Network
- 96.4 Maintain the Network

Pay Providers

88.1% Of Target



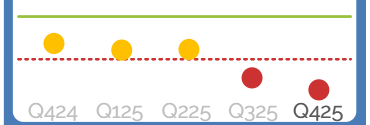
SUBPROCESSES
- 100 Payment Strategy
- 80.8 Make Payments
- 99.8 Payment Integrity
- 72.0 Resolve & Settle Payments

Managerial Processes

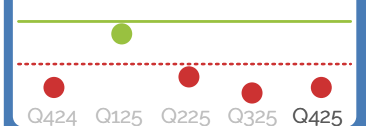
Guide core and support processes

96.5 Enhance Operational Effectiveness

76.8 Manage Compliance Commitments



89.0 Manage Finances

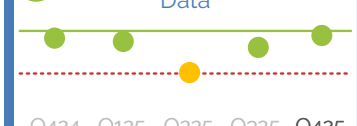


99.7 Manage Governmental & Community Relations

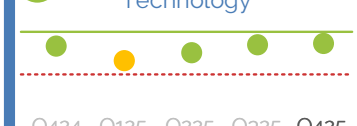
Support Processes *Enable core processes to work*

93.7 Optimize Alliance Workforce

99.5 Manage Data

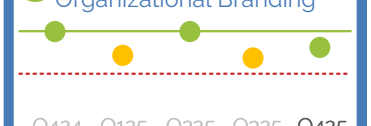


98.9 Manage Technology



100 Provide Administrative Services

96.9 Communications & Organizational Branding



Back to Agenda

DATE: March 25, 2026

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

FROM: Lisa Ba, Chief Financial Officer

SUBJECT: Financial Highlights for the First Month Ending January 31, 2026

Consolidated (All Lines of Business)

For the month ending January 31, 2026, the Alliance reported an Operating Income of $6.9M with a Medical Loss Ratio (MLR) of 91.9% and an Administrative Loss Ratio (ALR) of 4.6%. The Net Income is $6.2M after accounting for Non-Operating Income/Expenses.

The budget expected $1.4M in Operating Income for January. The actual result is favorable to the budget by $5.6M or 100%, driven by rate variances.

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

Key Indicators	YTD Actual	YTD Budget	YTD Variance	% Variance to Budget
Member Months	*431,178*	*427,404*	*3,774*	*0.9%*
Revenue	$197,715	$192,172	$5,543	2.9%
Medical Expenses	181,747	180,329	(1,419)	-0.8%
Administrative Expenses	9,029	10,472	1,444	13.8%
Operating Income/(Loss)	6,939	1,371	5,568	100.0%
Net Income	$6,167	$3,471	$2,697	77.7%
MLR %	91.9%	93.8%	1.9%	
ALR %	4.6%	5.4%	0.9%	
Operating Income %	3.5%	0.7%	2.8%	
Net Income %	3.1%	1.8%	1.3%	

Medi-Cal Line of Business (Including IHSS)

For the month ending January 31, 2026, the Alliance reported an Operating Income of $8.0M or 4.0% with a Medical Loss Ratio (MLR) of 91.6% and an Administrative Loss Ratio (ALR) of 4.4%.

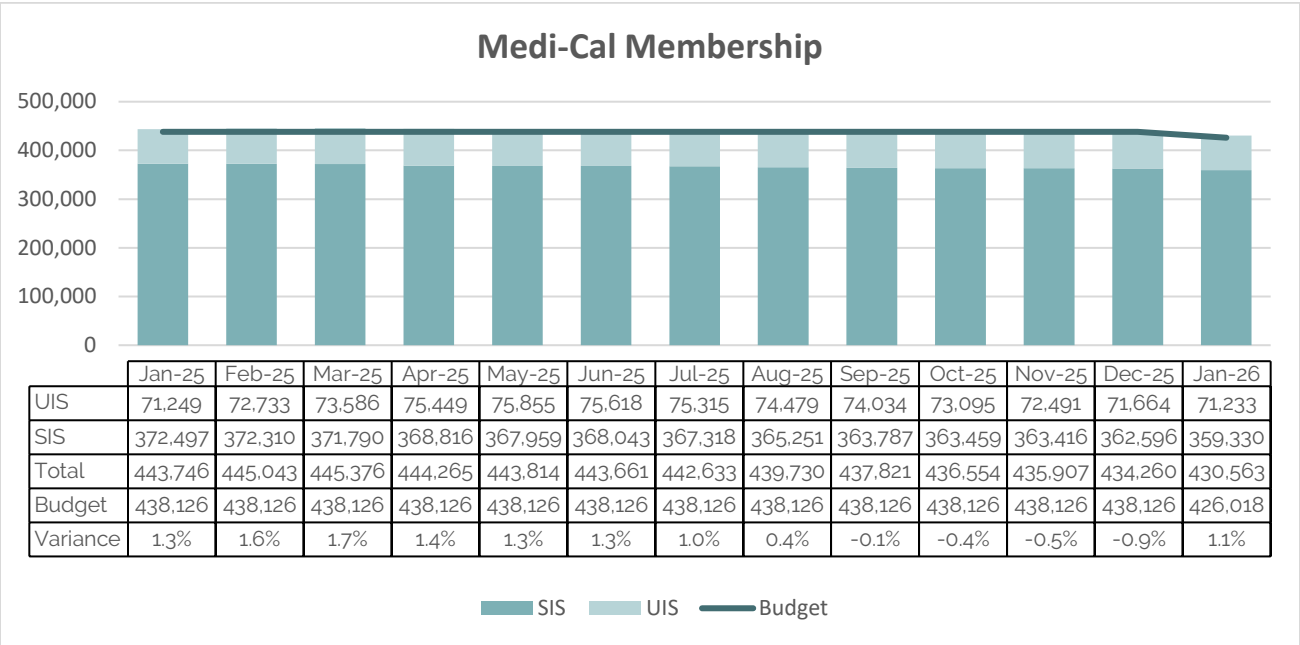
Net Income is $7.2M or 3.6% after accounting for Non-Operating Income/Expenses. The budget expected an Operating Income of $2.6M for January. The actual result is favorable to the budget by $5.3M or 100%, driven by rate variances and enrollment.

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

Key Indicators	YTD Actual	YTD Budget	YTD Variance	% Variance to Budget
Member Months	*430,848*	*426,747*	*4,101*	*1.0%*
Revenue	$197,063	$191,033	$6,030	3.2%
Medical Expenses	180,526	178,876	(1,649)	-0.9%
Administrative Expenses	8,574	9,532	959	10.1%
Operating Income/(Loss)	7,964	2,624	5,340	100.0%
Net Income/(Loss)	$7,192	$4,724	$2,468	52.2%
PMPM				
Revenue	$457.38	$447.65	$9.73	2.2%
Medical Expenses	419.00	419.16	0.16	0.0%
Administrative Expenses	19.90	22.34	2.44	10.9%
Operating Income/(Loss)	$18.48	$6.15	$12.33	100.0%
MLR %	91.6%	93.6%	2.0%	
ALR %	4.4%	5.0%	0.6%	
Operating Income %	4.0%	1.4%	2.7%	
Net Income %	3.6%	2.5%	1.2%	

Membership: January 2026 Medi-Cal membership is favorable to the budget by 1.1%. 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 the federal H.R.1 legislation.

For January 2026, two new provisions were implemented: a UIS enrollment freeze, with no newly enrolled members between the ages of 19 and 64, and a 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 Unsatisfactory Immigrant Status (UIS) membership to trend downward and are projected to continue the remainder of the year.



	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
UIS	71,249	72,733	73,586	75,449	75,855	75,618	75,315	74,479	74,034	73,095	72,491	71,664	71,233
SIS	372,497	372,310	371,790	368,816	367,959	368,043	367,318	365,251	363,787	363,459	363,416	362,596	359,330
Total	443,746	445,043	445,376	444,265	443,814	443,661	442,633	439,730	437,821	436,554	435,907	434,260	430,563
Budget	438,126	438,126	438,126	438,126	438,126	438,126	438,126	438,126	438,126	438,126	438,126	438,126	426,018
Variance	1.3%	1.6%	1.7%	1.4%	1.3%	1.3%	1.0%	0.4%	-0.1%	-0.4%	-0.5%	-0.9%	1.1%

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 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.

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

Region	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
CEC SIS	$149,826	$143,909	$5,917	$2,041	$3,876
CEC UIS	36,641	36,695	(54)	(487)	433
SBN SIS	8,490	8,326	164	119	45
SBN UIS	1,597	1,602	(5)	(6)	0
Total*	**$196,554**	**$190,532**	**$6,022**	**$1,668**	**$4,355**

*Excludes Jan-26 In-Home Supportive Services (IHSS) premiums revenue of $0.5M,

As of January, actuals exceeded the budget by $6.0M, representing a 3.2% positive variance. This variance is primarily driven by underbudgeted maternity revenue and changes in member mix. Maternity revenue was budgeted at $0.5M per month, but actual revenue averages $5.5M per month, creating a significant favorable variance. Additionally, SPD-LTC membership is 24% higher than budget, while overall membership is only 0.5% above budget, indicating that the shift in member mix is also contributing to the revenue favorability. Part of the rate variance is related to the ECM Risk Corridor. The budget assumed $5.1M, but January included only a $2.7M accrual, resulting in a $2.4M shortfall.

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 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).

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

Category	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
Inpatient Hospital	$49,627	$47,006	($2,621)	($452)	($2,169)
Inpatient Services - LTC	17,585	18,343	758	(176)	934
Physician Services	38,852	41,022	2,171	(394)	2,565
Outpatient Facility	21,557	19,690	(1,867)	(189)	(1,678)
ECM / CS	21,558	19,668	(1,889)	(189)	(1,700)
Behavioral Health	7,797	7,895	98	(76)	174
Other Medical*	23,551	25,252	1,701	(243)	1,944
State Incentives	-	-	-	-	-
TOTAL COST	**$180,526**	**$178,876**	**($1,649)**	**($1,719)**	**$70**

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

January 2026 Medical Expenses of $180.5M are $1.6M or 0.9% unfavorable to the budget. Of this amount, $1.7M is due to higher enrollment offsetting lower rate variances of $70k. The unfavorability is primarily driven by ECM and Community Supports (CS) due to the higher-than-budget enrollment, followed by Inpatient and Outpatient, which are impacted by high prior-year adjustments made in January. Please note that January medical expenses are typically regarded as preliminary, with a clearer picture emerging as the year progresses and claims are fully processed.

At a PMPM level, YTD Medical Expenses are $419.00, favorable by $0.16 or 0.0% compared to the budget.

Jan-26 YTD Medi-Cal Medical Expense by Category of Service (In PMPM)

Category	Actual	Budget	Variance	Variance %
Inpatient Services - Hospital	$115.18	$110.15	($5.03)	-4.6%
Inpatient Services - LTC	40.81	42.98	2.17	5.0%
Physician Services	90.18	96.13	5.95	6.2%
Outpatient Facility	50.03	46.14	(3.89)	-8.4%
ECM /CS	50.04	46.09	(3.95)	-8.6%
Behavioral Health	18.10	18.50	0.40	2.2%
Other Medical	54.66	59.17	4.51	7.6%
State Incentives	-	-	-	0.0%
TOTAL MEDICAL COST	**$419.00**	**$419.16**	**$0.16**	**0.0%**

Inpatient Services: Inpatient Services are unfavorable to the budget due to high prior period adjustments. The January incurred PMPM is $102.42, and approximately $13 PMPM is recorded in the current month that relates to a prior period.

Inpatient Services—Long Term Care (LTC): LTC is in line with the budget and slightly favorable, primarily due to a methodology change in IBNR reserve, reflecting a downward adjustment of $3M for SPD/LTC duals.

Physician Services: Physician services are trending consistently month over month, with slight favorability to budget. The Specialty Physicians category includes $4.3M in supplemental payment through the reserve for January, with an estimated annual total of $50M funded by Board-approved strategic use of reserve.

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. The January incurred PMPM is $45.23, which is within budget; however, it does not fully capture the additional $5 PMPM recorded in the current period that relates to prior periods, causing an unfavorable variance. This will continue to be monitored as the budget assumed a 4% increase and expects trends to align going forward.

ECM: Effective January, ECM reflects the Board-approved transition from capitation to a fee-for-service (FFS) case rate methodology, including the elimination of the one-time incentive. While the ECM risk corridor remains in effect through CY 2026, with net loss limited to 5% of ECM revenue, DHCS has advised that ECM costs will be considered credible only if supported by corresponding encounters. As a result, the current low encounter rate can materially reduce expense amounts recognized under the risk corridor and future rate-setting, creating potential for significant unreimbursed exposure. In addition, a change in the current case rate to an FFS reimbursement rate would be required to ensure the ECM services meet dosage and intensity expectations.

Community Supports: Community Supports is trending above budget, as policy changes intended to enhance program integrity were assumed in the 2026 budget but have not yet materialized. These changes are expected to begin in February for Medically Tailored Meals (MTM) and in April for Housing deposits and Housing Transitional services. A portion of the policy change savings is expected to be offset by ongoing increases in Personal care & Homemaker services since October 2025, which are currently under review by Health Services.

Behavioral Health: Behavioral Health expenses are tracking closely to budget, as the budget accounts for the anticipated increase in utilization resulting from the in-sourcing initiative implemented in July 2025. Additionally, the budget reflects the expected increase in unit costs associated with incorporating TRI services, which further aligns current performance with projected spending.

Other Medical: Other Medical expenses are favorable to the budget, largely due to accurate budget development that appropriately accounted for historical utilization growth in Transportation, Hospice, and Allied Health services. To help manage elevated non-medical transportation, several operational controls are expected to be implemented to promote appropriate utilization.

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 January 31, 2026, the Alliance reported an Operating Loss of $1.0M with a Medical Loss Ratio (MLR) of 187.7% and an Administrative Loss Ratio (ALR) of 69.8%. The budget expected an Operating Loss of $1.3M for January. The actual result is favorable to the budget by $0.2M or 18.1%.

Jan-26 Income Statement
D-SNP (In $000s)

Key Indicators	YTD Actual	YTD Budget	YTD Variance	% Variance to Budget
Member Months	*330*	*657*	*(327)*	*-49.8%*
Revenue	$652	$1,139	($487)	-42.8%
Medical Expenses	1,223	1,452	229	15.8%
Administrative Expenses	455	940	485	51.6%
Operating Income/(Loss)	(1,026)	(1,253)	227	18.1%
PMPM				
Revenue	$1,974.86	$1,733.15	$241.70	13.9%
Medical Expenses	3,706.29	2,210.23	(1,496.06)	-67.7%
Administrative Expenses	1,378.93	1,430.57	51.64	3.6%
Operating Income/(Loss)	($3,110.37)	($1,907.65)	($1,202.72)	-63.0%
MLR %	187.7%	127.5%	-60.1%	
ALR %	69.8%	82.5%	12.7%	
Operating Income %	-157.5%	-110.1%	-47.4%	

Membership: January 2026 D-SNP membership is unfavorable to the budget by 49.8%. 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 January membership totaled 330, reflecting the figures reported in CMS's January Monthly Membership Report (MMR), with enrollment adds largely attributable to telephonic sales conversions and Medicare.gov activity. We expect February to include substantial retroactive adjustments of approximately 147 enrollments to capture eligible members who were not submitted in time for January's MMR cutoff.

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.

As of January, actuals are below the budget by $0.5M, representing a negative variance of 42.8%. This shortfall is primarily attributable to lower-than-anticipated enrollment, partially offset by a favorable variance in the risk-adjusted rate. It is important to note that early months are expected to exhibit significant volatility until enrollment levels stabilize for this newly launched D-SNP line of business.

Jan-26 YTD D-SNP Revenue Summary (In $000s)

CMS CAP	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
Part C	$557	$923	($366)	($459)	$93
Part D	95	216	(121)	(107)	(13)
Total	**$652**	**$1,139**	**($487)**	**($567)**	**$80**

Medical Expenses: The 2026 budget is based on the bid submitted in June 2025, prepared by our actuary partners, which covers Medicare Part A and B services, including Part D pharmacy benefits, as well as supplemental benefits that are 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.

January 2026 Medical Expenses of $1.2M are below budget by $0.2M or 15.8%, primarily due to lower than anticipated enrollment.

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

Category	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
Inpatient Hospital	$245	$318	$73	$158	($86)
Inpatient Services - LTC	57	74	17	37	(20)
Physician Services	274	340	67	169	(103)
Outpatient Facility	180	230	50	114	(64)
CMS Pharmacy Part D	114	219	105	109	(4)
Other Medical*	354	271	(82)	135	(217)
TOTAL COST	**$1,223**	**$1,452**	**$229**	**$723**	**($494)**

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

At a PMPM level, Medical Expenses are $3,706.29, unfavorable by $1,496.06 or 67.7% compared to the budget. The PMPM variance is unfavorable because costs are spread across a smaller membership base than projected, leading to an unfavorable PMPM variance despite the favorable dollar variance. It is important to note that the actual results are heavily Incurred but Not Reported (IBNR) driven, utilizing 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. As such, these early-month results are considered preliminary.

Jan-26 YTD D-SNP Medical Expense by Category of Service (In PMPM)				
Category	Actual	Budget	Variance	Variance %
Inpatient Services - Hospital	$743.76	$483.98	($259.78)	-53.7%
Inpatient Services - LTC	172.01	111.93	(60.08)	-53.7%
Physician Services	829.14	517.88	(311.27)	-60.1%
Outpatient Facility	545.14	349.97	(195.17)	-55.8%
CMS Pharmacy Part D	344.45	333.40	(11.06)	-3.3%
Other Medical*	1,071.77	413.07	(658.70)	-159.5%
TOTAL MEDICAL COST	**$3,706.29**	**$2,210.23**	**($1,496.06)**	**-67.7%**

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

Administrative Expenses: January Consolidated Administrative Expenses are favorable to the budget by $1.4M or 13.8% with 4.6% ALR. Salaries are favorable by $0.9M or 12.1%, driven by savings from vacant positions, benefits, employment taxes, and PTO. Non-salary administrative expenses are favorable by $0.6M, or 17.5%, due to the timing of actual vs. budget.

Non-Operating Revenue/Expenses: January Net Non-Operating Loss is $0.8M, which is $2.9M unfavorable to the budget. The unfavorability as compared to the budget is derived from the Net Investment Loss of $0.9M. The Other Revenue is $0.3M and is slightly below budget. The Non-Operating Expense is $4.3M from the grant distribution. This is unfavorable to the budget by $1.9M.

Summary of Results: Overall, the Alliance generated a Consolidated Net Income of $6.2M, with an MLR of 91.9% and an ALR of 4.6%.

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Balance Sheet
For The First Month Ending January 31, 2026
(In $000s)

Assets	
Cash	$144,010
Restricted Cash	309
Short Term Investments	809,919
Receivables	406,683
Prepaid Expenses	1,845
Other Current Assets	5,145
Total Current Assets	**$1,367,910**
Building, Land, Furniture & Equipment	
Capital Assets	$79,537
Accumulated Depreciation	(46,031)
CIP	4,735
Lease Receivable	4,133
Subscription Asset net Accum Depr	13,214
Total Non-Current Assets	**55,587**
Total Assets	**$1,423,497**
Liabilities	
Accounts Payable	$84,700
IBNR/Claims Payable	334,091
Provider Incentives Payable	45,791
Other Current Liabilities	11,463
Due to State	73,549
Total Current Liabilities	**$549,594**
Subscription Liabilities	10,590
Deferred Inflow of Resources	3,899
Total Long-Term Liabilities	**$14,489**
Fund Balance	
Fund Balance - Prior	$853,246
Retained Earnings - CY	6,167
Total Fund Balance	**859,413**
Total Liabilities & Fund Balance	**$1,423,497**
Additional Information	
Total Fund Balance	**$859,413**
Board Designated Reserves Target	562,418
Strategic Reserve (DSNP)	55,674
Medi-Cal Capacity Grant Program (MCGP)*	123,573
Value Based Payments	46,100
Provider Supplemental Payments	119,009
Total Reserves	**906,773**
Total Operating Reserve	**($47,360)**

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget-Consolidated
For The First Month Ending January 31, 2026
(In $000s)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*431,178*	*427,404*	*3,774*	*0.9%*	*431,178*	*427,404*	*3,774*	*0.9%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$196,554	$190,532	$6,022	3.2%	$196,554	$190,532	$6,022	3.2%
CMS D-SNP	$652	$1,139	(487)	-42.8%	$652	$1,139	(487)	-42.8%
State Incentive Programs	-	-	-	0.0%	-	-	-	0.0%
Prior Year Revenue*	-	-	-	0.0%	-	-	-	0.0%
Premiums Commercial	509	501	8	1.5%	509	501	8	1.5%
Total Operating Revenue	**$197,715**	**$192,172**	**$5,543**	**2.9%**	**$197,715**	**$192,172**	**$5,543**	**2.9%**
Medical Expenses								
Inpatient Services (Hospital)	$49,873	$47,324	($2,548)	-5.4%	$49,873	$47,324	($2,548)	-5.4%
Inpatient Services (LTC)	17,641	18,416	775	4.2%	17,641	18,416	775	4.2%
Physician Services	39,125	41,363	2,237	5.4%	39,125	41,363	2,237	5.4%
Outpatient Facility	21,737	19,920	(1,817)	-9.1%	21,737	19,920	(1,817)	-9.1%
ECM/Community Supports	21,558	19,668	(1,889)	-9.6%	21,558	19,668	(1,889)	-9.6%
Behavioral Health	7,797	7,895	98	1.2%	7,797	7,895	98	1.2%
CMS Pharmacy Part D	114	219	105	48.1%	114	219	105	48.1%
Other Medical**	23,903	25,523	1,620	6.3%	23,903	25,523	1,620	6.3%
State Incentive Programs	-	-	-	0.0%	-	-	-	0.0%
Total Medical Expenses	**$181,747**	**$180,329**	**($1,419)**	**-0.8%**	**$181,747**	**$180,329**	**($1,419)**	**-0.8%**
Gross Margin	**$15,968**	**$11,843**	**$4,124**	**34.8%**	**$15,968**	**$11,843**	**$4,124**	**34.8%**
Administrative Expenses								
Salaries	$6,358	$7,234	$877	12.1%	$6,358	$7,234	$877	12.1%
Professional Fees	277	487	210	43.2%	277	487	210	43.2%
Purchased Services	640	630	(10)	-1.6%	640	630	(10)	-1.6%
Supplies & Other	936	1,119	183	16.4%	936	1,119	183	16.4%
Occupancy	131	154	23	15.2%	131	154	23	15.2%
Depreciation/Amortization	687	848	161	18.9%	687	848	161	18.9%
Total Administrative Expenses	**$9,029**	**$10,472**	**$1,444**	**13.8%**	**$9,029**	**$10,472**	**$1,444**	**13.8%**
Operating Income	**$6,939**	**$1,371**	**$5,568**	**100.0%**	**$6,939**	**$1,371**	**$5,568**	**100.0%**
Non-Op Income/(Expense)								
Interest	$3,597	$3,292	$306	9.3%	$3,597	$3,292	$306	9.3%
Gain/(Loss) on Investments	(322)	833	(1,155)	-100.0%	(322)	833	(1,155)	-100.0%
Bank & Investment Fees	(74)	-	(74)	-100.0%	(74)	-	(74)	-100.0%
Other Revenues	289	308	(19)	-6.1%	289	308	(19)	-6.1%
Grants	(4,263)	(2,333)	(1,929)	82.7%	(4,263)	(2,333)	(1,929)	82.7%
Total Non-Op Income/(Expense)	**(772)**	**2,100**	**(2,871)**	**-100.0%**	**(772)**	**2,100**	**($2,871)**	**-100.0%**
Net Income/(Loss)	**$6,167**	**$3,471**	**$2,697**	**77.7%**	**$6,167**	**$3,471**	**$2,697**	**77.7%**
MLR	*91.9%*	*93.8%*			*91.9%*	*93.8%*		
ALR	*4.6%*	*5.4%*			*4.6%*	*5.4%*		
Operating Income	*3.5%*	*0.7%*			*3.5%*	*0.7%*		
Net Income %	*3.1%*	*1.8%*			*3.1%*	*1.8%*		

**Other Medical includes Pharmacy and IHSS.

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CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget-Consolidated
For The First Month Ending January 31, 2026
(In PMPM)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*431,178*	*427,404*	*3,774*	*0.9%*	*431,178*	*427,404*	*3,774*	*0.9%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$455.85	$445.79	$10.07	2.3%	$455.85	$445.79	$10.07	2.3%
CMS D-SNP	1.51	2.66	(1.15)	-43.3%	1.51	2.66	(1.15)	-43.3%
State Incentive Programs	-	-	-	0.0%	-	-	-	0.0%
Prior Year Revenue*	-	-	-	0.0%	-	-	-	0.0%
Premiums Commercial	1.18	1.17	0.01	0.7%	1.18	1.17	0.01	0.7%
Total Operating Revenue	**$458.55**	**$449.63**	**$8.92**	**2.0%**	**$458.55**	**$449.63**	**$8.92**	**2.0%**
Medical Expenses								
Inpatient Services (Hospital)	$115.67	$110.73	($4.94)	-4.5%	$115.67	$110.73	($4.94)	-4.5%
Inpatient Services (LTC)	40.91	43.09	2.17	5.0%	40.91	43.09	2.17	5.0%
Physician Services	90.74	96.78	6.04	6.2%	90.74	96.78	6.04	6.2%
Outpatient Facility	50.41	46.61	(3.81)	-8.2%	50.41	46.61	(3.81)	-8.2%
ECM/Community Supports	50.00	46.02	(3.98)	-8.6%	50.00	46.02	(3.98)	-8.6%
Behavioral Health	18.08	18.47	0.39	2.1%	18.08	18.47	0.39	2.1%
CMS Pharmacy Part D	0.26	0.51	0.25	48.6%	0.26	0.51	0.25	48.6%
Other Medical**	55.44	59.72	4.28	7.2%	55.44	59.72	4.28	7.2%
State Incentive Programs	-	-	-	0.0%	-	-	-	0.0%
Total Medical Expenses	**$421.51**	**$421.92**	**$0.40**	**0.1%**	**$421.51**	**$421.92**	**$0.40**	**0.1%**
Gross Margin	**$37.03**	**$27.71**	**$9.32**	**33.6%**	**$37.03**	**$27.71**	**$9.32**	**33.6%**
Administrative Expenses								
Salaries	$14.75	$16.93	$2.18	12.9%	$14.75	$16.93	$2.18	12.9%
Professional Fees	0.64	1.14	0.50	43.7%	0.64	1.14	0.50	43.7%
Purchased Services	1.48	1.47	(0.01)	-0.7%	1.48	1.47	(0.01)	-0.7%
Supplies & Other	2.17	2.62	0.45	17.1%	2.17	2.62	0.45	17.1%
Occupancy	0.30	0.36	0.06	15.9%	0.30	0.36	0.06	15.9%
Depreciation/Amortization	1.59	1.98	0.39	19.6%	1.59	1.98	0.39	19.6%
Total Administrative Expenses	**$20.94**	**$24.50**	**$3.56**	**14.5%**	**$20.94**	**$24.50**	**$3.56**	**14.5%**
Operating Income	**$16.09**	**$3.21**	**$12.89**	**100.0%**	**$16.09**	**$3.21**	**$12.89**	**100.0%**
Non-Op Income/(Expense)								
Interest	$8.34	$7.70	$0.64	8.3%	$8.34	$7.70	$0.64	8.3%
Gain/(Loss) on Investments	(0.75)	$1.95	(2.70)	-100.0%	(0.75)	1.95	(2.70)	-100.0%
Bank & Investment Fees	(0.17)	-	(0.17)	-100.0%	(0.17)	-	(0.17)	-100.0%
Other Revenues	0.67	0.72	(0.05)	-6.9%	0.67	0.72	(0.05)	-6.9%
Grants	(9.89)	(5.46)	(4.43)	-81.1%	(9.89)	(5.46)	(4.43)	-81.1%
Total Non-Op Income/(Expense)	**($1.79)**	**$4.91**	**($6.70)**	**-100.0%**	**($1.79)**	**$4.91**	**($6.70)**	**-100.0%**
Net Income/(Loss)	**$14.30**	**$8.12**	**$6.18**	**76.1%**	**$14.30**	**$8.12**	**$6.18**	**76.1%**
MLR	*91.9%*	*93.8%*			*91.9%*	93.8%		
ALR	*4.6%*	*5.4%*			*4.6%*	5.4%		
Operating Income	*3.5%*	*0.7%*			*3.5%*	0.7%		
Net Income %	*3.1%*	*1.8%*			*3.1%*	1.8%		

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

**Other Medical includes Pharmacy and IHSS.

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CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget-Medi-Cal
For The First Month Ending January 31, 2026
(In $000s)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*430,848*	*426,747*	*4,101*	*1.0%*	*430,848*	*426,747*	*4,101*	*1.0%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$196,554	$190,532	$6,022	3.2%	$196,554	$190,532	$6,022	3.2%
State Incentive Programs	0	0	-	0.0%	0	0	-	0.0%
Prior Year Revenue*	0	0	-	0.0%	0	0	-	0.0%
Premiums Commercial	509	501	8	1.5%	509	501	8	1.5%
Total Operating Revenue	**$197,063**	**$191,033**	**$6,030**	**3.2%**	**$197,063**	**$191,033**	**$6,030**	**3.2%**
Medical Expenses								
Inpatient Services (Hospital)	$49,627	$47,006	($2,621)	-5.6%	$49,627	$47,006	($2,621)	-5.6%
Inpatient Services (LTC)	17,585	18,343	758	4.1%	17,585	18,343	758	4.1%
Physician Services	38,852	41,022	2,171	5.3%	38,852	41,022	2,171	5.3%
Outpatient Facility	21,557	19,690	(1,867)	-9.5%	21,557	19,690	(1,867)	-9.5%
ECM/Community Supports	21,558	19,668	(1,889)	-9.6%	21,558	19,668	(1,889)	-9.6%
Behavioral Health	7,797	7,895	98	1.2%	7,797	7,895	98	1.2%
Other Medical**	23,551	25,252	1,701	6.7%	23,551	25,252	1,701	6.7%
State Incentive Programs	0	0	-	0.0%	0	0	-	0.0%
Total Medical Expenses	**$180,526**	**$178,876**	**($1,649)**	**-0.9%**	**$180,526**	**$178,876**	**($1,649)**	**-0.9%**
Gross Margin	**$16,538**	**$12,157**	**$4,381**	**36.0%**	**$16,538**	**$12,157**	**$4,381**	**36.0%**
Administrative Expenses								
Salaries	$6,125	$6,799	$674	9.9%	$6,125	$6,799	$674	9.9%
Professional Fees	198	336	138	41.0%	198	336	138	41.0%
Purchased Services	512	451	(61)	-13.5%	512	451	(61)	-13.5%
Supplies & Other	921	1,025	104	10.1%	921	1,025	104	10.1%
Occupancy	131	154	23	15.2%	131	154	23	15.2%
Depreciation/Amortization	687	768	81	10.5%	687	768	81	10.5%
Total Administrative Expenses	**$8,574**	**$9,532**	**$959**	**10.1%**	**$8,574**	**$9,532**	**$959**	**10.1%**
Operating Income	**$7,964**	**$2,624**	**$5,340**	**100.0%**	**$7,964**	**$2,624**	**$5,340**	**100.0%**
Non-Op Income/(Expense)								
Interest	$3,597	$3,292	$306	9.3%	$3,597	$3,292	$306	9.3%
Gain/(Loss) on Investments	(322)	833	(1,155)	-100.0%	(322)	833	(1,155)	-100.0%
Bank & Investment Fees	(74)	0	(74)	-100.0%	(74)	0	(74)	-100.0%
Other Revenues	289	308	(19)	-6.1%	289	308	(19)	-6.1%
Grants	(4,263)	(2,333)	(1,929)	82.7%	(4,263)	(2,333)	(1,929)	82.7%
Total Non-Op Income/(Expense)	**(772)**	**2,100**	**(2,871)**	**-100.0%**	**(772)**	**2,100**	**($2,871)**	**-100.0%**
Net Income/(Loss)	**$7,192**	**$4,724**	**$2,468**	**52.2%**	**$7,192**	**$4,724**	**$2,468**	**52.2%**
MLR	*91.6%*	*93.6%*			*91.6%*	*93.6%*		
ALR	*4.4%*	*5.0%*			*4.4%*	*5.0%*		
Operating Income	*4.0%*	*1.4%*			*4.0%*	*1.4%*		
Net Income %	*3.6%*	*2.5%*			*3.6%*	*2.5%*		

**Other Medical includes Pharmacy and IHSS.

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CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget-Medi-Cal
For The First Month Ending January 31, 2026
(In PMPM)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*430,848*	*426,747*	*4,101*	*1.0%*	*430,848*	*426,747*	*4,101*	*1.0%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$456.20	$446.48	$9.73	2.2%	$456.20	$446.48	$9.73	2.2%
State Incentive Programs	-	-	-	0.0%	-	-	-	0.0%
Prior Year Revenue*	-	-	-	0.0%	-	-	-	0.0%
Premiums Commercial	1.18	1.17	0.01	0.6%	1.18	1.17	0.01	0.6%
Total Operating Revenue	**$457.38**	**$447.65**	**$9.73**	**2.2%**	**$457.38**	**$447.65**	**$9.73**	**2.2%**
Medical Expenses								
Inpatient Services (Hospital)	$115.18	$110.15	($5.03)	-4.6%	$115.18	$110.15	($5.03)	-4.6%
Inpatient Services (LTC)	40.81	42.98	2.17	5.0%	40.81	42.98	2.17	5.0%
Physician Services	90.18	96.13	5.95	6.2%	90.18	96.13	5.95	6.2%
Outpatient Facility	50.03	46.14	(3.89)	-8.4%	50.03	46.14	(3.89)	-8.4%
ECM/Community Supports	50.04	46.09	(3.95)	-8.6%	50.04	46.09	(3.95)	-8.6%
Behavioral Health	18.10	18.50	0.40	2.2%	18.10	18.50	0.40	2.2%
Other Medical**	54.66	59.17	4.51	7.6%	54.66	59.17	4.51	7.6%
State Incentive Programs	-	-	-	0.0%	-	-	-	0.0%
Total Medical Expenses	**$419.00**	**$419.16**	**$0.16**	**0.0%**	**$419.00**	**$419.16**	**$0.16**	**0.0%**
Gross Margin	**$38.38**	**$28.49**	**$9.90**	**34.7%**	**$38.38**	**$28.49**	**$9.90**	**34.7%**
Administrative Expenses								
Salaries	$14.22	$15.93	$1.72	10.8%	$14.22	$15.93	$1.72	10.8%
Professional Fees	0.46	0.79	0.33	41.6%	0.46	0.79	0.33	41.6%
Purchased Services	1.19	1.06	(0.13)	-12.4%	1.19	1.06	(0.13)	-12.4%
Supplies & Other	2.14	2.40	0.26	11.0%	2.14	2.40	0.26	11.0%
Occupancy	0.30	0.36	0.06	16.0%	0.30	0.36	0.06	16.0%
Depreciation/Amortization	1.60	1.80	0.20	11.3%	1.60	1.80	0.20	11.3%
Total Administrative Expenses	**$19.90**	**$22.34**	**$2.44**	**10.9%**	**$19.90**	**$22.34**	**$2.44**	**10.9%**
Operating Income	**$18.48**	**$6.15**	**$12.33**	**100.0%**	**$18.48**	**$6.15**	**$12.33**	**100.0%**
Non-Op Income/(Expense)								
Interest	$8.35	$7.71	$0.64	8.2%	$8.35	$7.71	$0.64	8.2%
Gain/(Loss) on Investments	(0.75)	$1.95	(2.70)	-100.0%	(0.75)	1.95	(2.70)	-100.0%
Bank & Investment Fees	(0.17)	-	(0.17)	-100.0%	(0.17)	-	(0.17)	-100.0%
Other Revenues	0.67	0.72	(0.05)	-7.0%	0.67	0.72	(0.05)	-7.0%
Grants	(9.89)	(5.47)	(4.43)	-80.9%	(9.89)	(5.47)	(4.43)	-80.9%
Total Non-Op Income/(Expense)	**($1.79)**	**$4.92**	**($6.71)**	**-100.0%**	**($1.79)**	**$4.92**	**($6.71)**	**-100.0%**
Net Income/(Loss)	**$16.69**	**$11.07**	**$5.62**	**50.8%**	**$16.69**	**$11.07**	**$5.62**	**50.8%**
MLR	*91.6%*	*93.6%*			*91.6%*	93.6%		
ALR	*4.4%*	*5.0%*			*4.4%*	5.0%		
Operating Income	*4.0%*	*1.4%*			*4.0%*	1.4%		
Net Income %	*3.6%*	*2.5%*			*3.6%*	2.5%		

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

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CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget-D-SNP
For The First Month Ending January 31, 2026
(In $000s)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*330*	*657*	*(327)*	*-49.8%*	*330*	*657*	*(327)*	*-49.8%*
Capitation Revenue								
CMS Capitation Revenue Part C	$557	$923	($366)	-39.7%	$557	$923	($366)	-39.7%
CMS Capitation Revenue Part D	95	216	(121)	-55.9%	95	216	(121)	-55.9%
Total Operating Revenue	**$652**	**$1,139**	**($487)**	**-42.8%**	**$652**	**$1,139**	**($487)**	**-42.8%**
Medical Expenses								
Inpatient Services (Hospital)	$245	$318	$73	22.8%	$245	$318	$73	22.8%
Inpatient Services (LTC)	57	74	17	22.8%	57	74	17	22.8%
Physician Services	274	340	67	19.6%	274	340	67	19.6%
Outpatient Facility	180	230	50	21.8%	180	230	50	21.8%
Behavioral Health	0	0	(0)	0.0%	0	0	(0)	0.0%
CMS Pharmacy Part D	114	219	105	48.1%	114	219	105	48.1%
Other Medical**	354	271	(82)	-30.3%	354	271	(82)	-30.3%
Total Medical Expenses	**$1,223**	**$1,452**	**$229**	**15.8%**	**$1,223**	**$1,452**	**$229**	**15.8%**
Gross Margin	**($571)**	**($313)**	**($258)**	**-82.3%**	**($571)**	**($313)**	**($258)**	**-82.3%**
Administrative Expenses								
Salaries	$233	$436	$202	46.5%	$233	$436	$202	46.5%
Professional Fees	79	151	73	48.1%	79	151	73	48.1%
Purchased Services	129	179	51	28.2%	129	179	51	28.2%
Supplies & Other	15	94	79	84.3%	15	94	79	84.3%
Occupancy	0	-	-	0.0%	0	-	-	0.0%
Depreciation/Amortization	0	80	80	100.0%	0	80	80	100.0%
Total Administrative Expenses	**$455**	**$940**	**$485**	**51.6%**	**$455**	**$940**	**$485**	**51.6%**
Operating Income	**($1,026)**	**($1,253)**	**$227**	**18.1%**	**($1,026)**	**($1,253)**	**$227**	**18.1%**
Net Income/(Loss)	**($1,026)**	**($1,253)**	**$227**	**18.1%**	**($1,026)**	**($1,253)**	**$227**	**18.1%**
MLR	*187.7%*	*127.5%*			*187.7%*	*127.5%*		
ALR	*69.8%*	*82.5%*			*69.8%*	*82.5%*		
Operating Income	*-157.5%*	*-110.1%*			*-157.5%*	*-110.1%*		
Net Income %	*-157.5%*	*-110.1%*			*-157.5%*	*-110.1%*		

**Other Medical includes Pharmacy and IHSS.

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CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget-D-SNP
For The First Month Ending January 31, 2026
(In PMPM)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*330*	*657*	*(327)*	*-49.8%*	*330*	*657*	*(327)*	*-49.8%*
Capitation Revenue								
CMS Capitation Revenue Part C	$1,686.37	$1,404.60	$281.77	20.1%	$1,686.37	$1,404.60	$281.77	20.1%
CMS Capitation Revenue Part D	288.49	328.55	(40.07)	-12.2%	288.49	328.55	(40.07)	-12.2%
Total Operating Revenue	**$1,974.86**	**$1,733.15**	**$241.70**	**13.9%**	**$1,974.86**	**$1,733.15**	**$241.70**	**13.9%**
Medical Expenses								
Inpatient Services (Hospital)	$743.76	$483.98	($259.78)	-53.7%	$743.76	$483.98	($259.78)	-53.7%
Inpatient Services (LTC)	172.01	111.93	(60.08)	-53.7%	172.01	111.93	(60.08)	-53.7%
Physician Services	829.14	517.88	(311.27)	-60.1%	829.14	517.88	(311.27)	-60.1%
Outpatient Facility	545.14	349.97	(195.17)	-55.8%	545.14	349.97	(195.17)	-55.8%
Behavioral Health	0.02	-	(0.02)	-100.0%	0.02	-	(0.02)	-100.0%
CMS Pharmacy Part D	344.45	333.40	(11.06)	-3.3%	344.45	333.40	(11.06)	-3.3%
Other Medical**	1,071.75	413.07	(658.68)	-100.0%	1,071.75	413.07	(658.68)	-100.0%
Total Medical Expenses	**$3,706.29**	**$2,210.23**	**($1,496.06)**	**-67.7%**	**$3,706.29**	**$2,210.23**	**($1,496.06)**	**-67.7%**
Gross Margin	**($1,731.43)**	**($477.08)**	**($1,254.36)**	**-100.0%**	**($1,731.43)**	**($477.08)**	**($1,254.36)**	**-100.0%**
Administrative Expenses								
Salaries	$706.64	$663.00	($43.64)	-6.6%	$706.64	$663.00	($43.64)	-6.6%
Professional Fees	237.88	230.17	(7.70)	-3.3%	237.88	230.17	(7.70)	-3.3%
Purchased Services	389.69	272.61	(117.08)	-42.9%	389.69	272.61	(117.08)	-42.9%
Supplies & Other	44.72	143.05	98.33	68.7%	44.72	143.05	98.33	68.7%
Occupancy	-	-	-	0.0%	-	-	-	0.0%
Depreciation/Amortization	-	121.74	121.74	100.0%	-	121.74	121.74	100.0%
Total Administrative Expenses	**$1,378.93**	**$1,430.57**	**$51.64**	**3.6%**	**$1,378.93**	**$1,430.57**	**$51.64**	**3.6%**
Operating Income	**($3,110.37)**	**($1,907.65)**	**($1,202.72)**	**-63.0%**	**($3,110.37)**	**($1,907.65)**	**($1,202.72)**	**-63.0%**
Net Income/(Loss)	**($3,110.37)**	**($1,907.65)**	**($1,202.72)**	**-63.0%**	**($3,110.37)**	**($1,907.65)**	**($1,202.72)**	**-63.0%**
MLR	*187.7%*	*127.5%*			*187.7%*	127.5%		
ALR	*69.8%*	*82.5%*			*69.8%*	82.5%		
Operating Income	*-157.5%*	*-110.1%*			*-157.5%*	-110.1%		
Net Income %	*-157.5%*	*-110.1%*			*-157.5%*	-110.1%		

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CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Statement of Cash Flow
For The First Month Ending Janaury 31, 2026
(In $000s)

	MTD	YTD
Net Income	$6,167	$6,167
Items not requiring the use of cash: Depreciation	217	217
Adjustments to reconcile Net Income to Net Cash provided by operating activities:		
Changes to Assets:		
Restricted Cash	0	0
Receivables	(6,497)	(6,497)
Prepaid Expenses	(263)	(263)
Current Assets	(116)	(116)
Subscription Asset net Accum Depr	0	0
Net Changes to Assets	**(6,876)**	**(6,876)**
Changes to Payables:		
Accounts Payable	(122,861)	(122,861)
Other Current Liabilities	2,129	2,129
Incurred But Not Reported Claims/Claims Payable	(131,594)	(131,594)
Provider Incentives Payable	4,683	4,683
Due to State	0	(73,167)
Subscription Liabilities	0	0
Net Changes to Payables	**(247,643)**	**(320,810)**
Net Cash Provided by (Used in) Operating Activities	**(248,135)**	**(321,302)**
Change in Investments	(2,524)	(2,524)
Other Equipment Acquisitions	(435)	(435)
Net Cash Provided by (Used in) Investing Activities	**(2,959)**	**(2,959)**
Deferred Inflow of Resources	0	0
Net Cash Provided by (Used in) Financing Activities	**0**	**0**
Net Increase (Decrease) in Cash & Cash Equivalents	**(251,094)**	**(324,261)**
Cash & Cash Equivalents at Beginning of Period	**394,722**	**394,722**
Cash & Cash Equivalents at January 31, 2026	**$144,010**	**$144,010**

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

Meeting Minutes

Wednesday, February 25, 2026
3:00 p.m. – 5:00 p.m.

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

Commissioners Present:

Ms. Leslie Abasta-Cummings	At Large Health Care Provider Representative
Ms. Anita Aguirre	At Large Health Care Provider Representative
Dr. Ralph Armstrong	At Large Health Care Provider Representative
Ms. Tracey Belton	County Health and Human Services Agency
Dr. Maximiliano Cuevas	Health Care Provider Representative
Ms. Elsa Jimenez	County Director of Health Services
Dr. Kristina Keheley	County Health Department Representative
Mr. Michael Molesky	Public Representative
Ms. Connie Moreno-Peraza	County Health Department Representative

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Dr. James Rabago	Health Care Provider Representative
Dr. Allen Radner	At Large Health Care Provider Representative
Mr. Ye Thao	Public Representative

Commissioners Absent:

Supervisor Wendy Root Askew	County Board of Supervisor
Supervisor Kim De Serpa	County Board of Supervisor
Dr. Donaldo Hernandez	Health Care Provider Representative
Supervisor Josh Pedrozo	County Board of Supervisor
Dr. Kristynn Sullivan	County Health Department Representative

Staff Present:

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

1. Call to Order by Vice Chair Aguirre.

Vice Chairperson Aguirre called the meeting to order at 3:00 p.m.

Roll call was taken and a quorum was present.

There were no supplements or deletions to the agenda.

2. Oral Communications.

Vice Chair Aguirre 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.

Vice Chair Aguirre opened the floor for Commissioners to make comments.

There was no comment.

4. Comments and announcements by Chief Executive Officer.

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

- Mr. Schrader highlighted three items on the Consent Calendar. Item 9A covered the Voluntary Rate Range Program. The board was being asked to authorize the Chair and CEO to execute the necessary amendments and agreements to implement the program for the CY 2025 rating period. This annual process allows qualified local entities to transfer funds to the state, which are then used to draw down federal matching funds. Item 9B was the revised charter for the Member Services Advisory Committee. As a Medicare D-SNP, the Alliance is required to maintain an Enrollee Advisory Committee (EAC). After reviewing the EAC requirements, staff determined that the existing Member Services Advisory Group already provides the structure needed to gather meaningful input from TotalCare enrollees. As such, the MSAG charter had been updated to formally incorporate the EAC. Item 9D outlines the Alliance's policy priorities for calendar year 2026. The updated priorities provide guidance for staff on legislative, budgetary, and policy advocacy efforts, ensuring our work aligns with the current environment.
- Mr. Schrader notified the Board on changing Form 700 submission requirements. On February 19, the Fair Political Practices Commission informed the Alliance that there is a new requirement. Alliance board members must file Form 700 statements through the FPPC electronic filing system, instead of through the NetFile system. Board members will each be receiving a communication from the FPPC providing this information and the filing instructions. The FPPC confirmed that even if Board members have already completed the filing through NetFile, they must complete it again through the FPPC system.
- Mr. Schrader reminded the Board that the April meeting will be held in Merced and will be a half-day fully in-person session. The agenda will include an update on the six initiatives that were part of our two-year marathon. This will be followed by guest speaker Jennifer Kent, former Director of the Department of Health Care Services, who will share her perspective on the future of the Medi-Cal program. Afterward, Rafael Gomez will lead a discussion with the Board to kick off the development of our next strategic plan. The day will conclude with a Closed Session to conduct the CEO annual performance evaluation.

[Commissioner Abasta-Cummings arrived at 3:03pm]

Consent Agenda Items: (5.- 8B. and 9B. – 9D.): 3:08 p.m.

MOTION:	Commissioner Molesky moved to approve Consent Agenda items 5-8B and 9B through 9D seconded by Commissioner Moreno-Peraza.
ACTION:	The motion passed with the following vote:
Ayes:	Commissioners, Abasta Cummings, Aguirre, Belton, Cuevas, Jimenez, Keheley, Molesky, Moreno-Peraza, Rabago, Radner, and Thao
Noes:	None.

Absent: Commissioners Armstrong, Askew, De Serpa, Hernandez Pedrozo and Sullivan

Abstain: None.

Consent Agenda Item: (9A):

MOTION: Commissioner Molesky moved to approve Consent Agenda item 9A seconded by Commissioner Jimenez.

ACTION: The motion passed with the following vote:

Ayes: Commissioners, Abasta Cummings, Aguirre, Belton, Cuevas, Jimenez, Keheley, Molesky and Thao

Noes: None.

Absent: Commissioners Armstrong, Askew, De Serpa, Hernandez, Pedrozo and Sullivan

Abstain: Commissioners Moreno-Peraza, Rabago, and Radner

Regular Agenda Items: (10. – 12.): 3:23 p.m.

10.Ad Hoc Committee of the Board to address Specialty Physician Shortages. 3:12 p.m.

Mr. Michael Schrader, Chief Executive Officer, presented a proposal to establish a Board ad hoc committee to consider options for addressing specialty physician shortages across the Alliance's service area. He summarized national, state, and local data demonstrating ongoing and worsening specialty care shortages, particularly in rural and inland regions, and described the Alliance's current investments and financial constraints related to specialty access.

Mr. Schrader explained that the proposed ad hoc committee would be advisory in nature, limited in duration and formed consistent with Brown Act requirements. The committee's charge would be to review existing Alliance strategies and explore alternative approaches to improve specialty care access, and provide input for staff, with the expectation that any recommendations would be budget neutral and returned to the full Board for consideration.

As presented on the Board slide, staff recommended appointing the following members to the Ad Hoc Committee on Specialty Provider Shortages:

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

The committee will conclude its work no later than June 30, 2026.

A discussion ensued among Commissioners.

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

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11. Security Office Report Q1 2026. 3:35 p.m.

Mr. Cecil Newton, Chief Information Officer, presented the Security Officer Report, providing an update on the Alliance's overall cybersecurity posture. He reported that the Alliance's security posture remained stable during the reporting period, with core preventative controls operating effectively and key security initiatives remaining on track. No Board action was requested.

Mr. Newton highlighted that the Alliance experienced a 33% reduction in cybersecurity insurance premiums, which he cited as external validation of the strength of the organization's security controls and security culture. He noted that employee awareness and reporting of potential threats remained strong, with phishing susceptibility rates below the organization's established risk threshold.

Mr**.** Newton discussed a national security breach involving Conduent, the Alliance's claims system vendor. He explained that while the Alliance does not host its claims system with Conduent, a limited subset of Alliance member data was affected due to historical work performed by the vendor. He reported that the Alliance filed all required regulatory notifications and coordinated closely with Compliance, and that Conduent is responsible for member notifications and related remediation associated with the breach.

Mr**.** Newton reviewed ongoing and completed security initiatives, including:

- Identity and access management controls
- Privileged access management and network segmentation
- Independent security assessments, including penetration testing and HIPAA/NIST gap assessments
- Ransomware prevention and response measures, including 24/7 monitoring and incident response capabilities

He emphasized that these efforts are intended to reduce enterprise risk, limit the impact of potential incidents, and ensure continued protection of member data. He concluded that the Alliance continues to monitor evolving cybersecurity threats, including increased AI driven risks, and remains committed to maintaining a strong security posture through continuous improvement and third party risk management. He confirmed that there were no indicators of elevated cyber risk at the time of the report

A discussion ensued among Commissioners.

[Commissioner Armstrong arrived at 3:50pm]

12.H.R. 1 and Enrollment Update. 3:35 p.m.

Mr. Michael Schrader, Chief Executive Officer explained that Alliance Medi-Cal membership began declining in August 2025, primarily due to the expiration of COVID19 unwinding flexibilities, which increased the volume of required eligibility redeterminations.

Mr. Schrader reported that the Alliance's actual membership decline to date is closely tracking the projected trend. The Alliance continues to anticipate an overall Medi-Cal membership reduction of approximately 27% over the four-year period from 2025 to 2028, driven by the combined impacts of HR1 and prior state budget actions. This projection does not include two possible carveouts.

- A potential carveout of members with unsatisfactory immigration status (UIS) from managed care plans.
- A potential carveout of certain qualified noncitizens

Mr. Schrader noted that the Governor's January budget proposal for FY2026/2027 did not include any new reductions to the Medi-Cal program. However, he cautioned that future budget revisions could introduce cuts depending on actual state revenue collections relative to the estimates used in the January proposal.

A discussion ensued among Commissioners.

The Commission adjourned its meeting of February 25, 2026, at 4:30 p.m. to the regular meeting of March 25, 2026, at 3:00 p.m. via videoconference from county offices in Scotts Valley, Salinas, Merced, Hollister and Mariposa unless otherwise noticed.

Respectfully submitted,

Ms. Hayley Tut
Clerk of the Board

Minutes were supported by AI-generated content.

COMPLIANCE COMMITTEE

Meeting Minutes
Wednesday, January 28, 2026
9:00 – 10:00 a.m.

Via Videoconference

Committee Members Present:

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

Staff Present:

Jill Drake	Compliance 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.

2. Approval of December Compliance Committee Meeting Minutes

Mandella reviewed outstanding action items from the December Compliance Committee meeting:

- Delegate Oversight Quarterly and Annual Reviews: Staff continue to coordinate with delegates on open quarterly reviews for Q125 and Q225. The MedImpact 2025 Annual Review has been completed, and staff continue to coordinate to complete annual reviews with select delegates. Formal reporting will be presented to the Committee at the April meeting.
- Corrective Action Plan (CAP) Follow Up: There is an outstanding action item regarding oversight of the Nurse Advice Line. Wang clarified that Jessie Newton, Adult Care Management Manager, will be the point of follow-up with his participation to prevent duplication of efforts and explore automation of oversight metrics.
- HIPAA: Pending action items related to network segmentation information and incident follow-up will be addressed with formal reporting from the HIPAA unit at the March meeting.

COMMITTEE ACTION: Committee reviewed and approved December Compliance Committee Meeting Minutes with 13 Ayes and 0 Noes.

3. Consent Agenda.

1. Revisions to Compliance Committee Charter

COMMITTEE ACTION: Committee reviewed and approved Consent Agenda with 13 Ayes and 0 Noes.

4. Regular Agenda

1. Welcome and Chair Comments

Mandella introduced the new Compliance Committee structure outlining the rationale for restructuring to a smaller core group and a shift towards action-oriented, data-driven oversight in furtherance of CMS compliance, including regular monthly snapshot reviews and rotating in-depth quarterly reviews of Compliance department functions, and ad-hoc department risk reporting based on defined metrics and event triggers.

2. Shapshot Reviews

Program Integrity

Markley presented the Program Integrity monthly snapshot, highlighting 1) minor HIPAA events related to the App Services department, and 2) emerging trends in Fraud Waste and Abuse (FWA) related to suspected fraudulent claims in hospice and palliative care:

1) HIPAA. The Committee discussed the HIPAA events, acknowledging that although there is no evidence of inappropriate disclosure of member data, the App Services department will ensure quality checks over its data outputs to mitigate further risk. Markley stated that Program Integrity will continue its monitoring of remediation efforts.

2) Program Integrity. Markley stated the Program Integrity team is collaborating with the Provider Services and Claims departments to address the hospice and palliative care issues. The Committee discussed monitoring trends, provider engagement and the need for tighter controls. Ba raised the need for proactive measures such as provider notifications or pre-payment checks. Brass and Mandella discussed the role of Utilization Management's authorization reviews and ideated outlier letters be sent to select providers to mitigate risk of improper payments.

   The Committee further discussed increased scrutiny from DHCS And CMS on hospice billing. and Markley informed the Committee that Program Integrity's Provider Concerns Collaborative is an effective forum in which Program Integrity shares provider-level case details across departments.

ACTION: Program Integrity to send letters to Hospice providers identified as outliers to potentially curb inappropriate billing behavior

Regulatory Affairs

Markley presented the Regulatory Affairs monthly snapshot, noting that CMS obligations are being met but there is a growing backlog of mandate implementation and policy review due to prioritization of D-SNP and Behavioral Health.

Markley explained that Compliance staff have shifted towards a risk-based approach focusing on ensuring implementation of high-risk and high-impact regulatory deliverables, resulting in lower overall completion percentages but no material regulatory risk to the Alliance or its members. Wong inquired about tracking of APL completion with Markley clarifying a disparity between performance metrics for APLs being tracked at the APL level and operational metrics for APLs being tracked at the action item level.

ACTION:

1) Mandella and Markley to bring a proposal regarding risk tolerance surrounding APL implementation and backlog management to February Committee meeting.
2) Markley to propose a revised New Requirements completion metric to Operational Excellence in light of the shift New Requirements' execution.

3. Compliance Quarterly Report

Drake presented the Q4 2025 Compliance Quarterly Report, highlighting audit outcomes, identified risks and delegate oversight.

Internal Audit & Monitoring

Drake reported that of 34 metrics reviewed, two failed threshold requirements, both of which have been addressed through CAPs.

Regulatory Audits

There were no updates to report related to regulatory audits in Q4 2025, as none occurred during the reporting period and all prior corrective action had been sufficiently completed.

Delegate and FDR Oversight

Drake reported that delegate and FDR oversight reviews were on schedule with eight open assessments pending delegate action noting that VSP has indicated their intent to end delegation for grievances and appeals after 2026.

Identified Risks

Drake reviewed four key risks identified during the time period as follows:

- Failed employee permissions audits
- Failed Non-Emergency Transportation (NEMT) PCS form audit
- Risk adjustment oversight framework gaps

- VSP's intent to de-delegate grievances and appeals after 2026

A discussion ensued among the members regarding the implications of VSP de-delegation including contract renegotiation strategies and D-SNP reporting process planning. Mandella raised an additional risk related to the need for early D-SNP KPI monitoring before Tableau dashboards are available.

ACTION: Brass and Crawford to collaborate with Mandella on sharing reports and dashboards related to D-SNP operational compliance metrics..

Delegate and FDR Oversight

Drake reported that all other delegate and FDR oversight reviews were on schedule with eight open assessments pending delegate action.

COMMITTEE ACTION: Committee reviewed and approved Q4 2025 Compliance Quarterly Report with 13 Ayes and 0 Noes.

4. Department Risk Reporting

Markley presented department triggered risk reporting, refreshing the Committee to the purpose and reiterating rationale agreed upon by the Compliance Committee

Regulatory Affairs

Markley reported that 75% of Alliance policies were reviewed in 2025, which is below the 90% threshold. Markley attributed the shortfall to D-SNP implementation and behavioral health priorities and outlined targeted actions by Regulatory Affairs staff such as enhanced monitoring, ongoing reminders and improved dashboard access within Readily.

Risk Adjustment

Mandella expressed concern about the absence of a formal risk adjustment plan. Ba clarified that operational risk adjustment activity is not yet underway, which limits risk. Ba noted that staff are targeting March or April for oversight development. A discussion occurred regarding the submission of 2024 data to CMS to bolster reporting of member acuity, with Brass and Wong questioning the value and feasibility of the proposed work. Ba emphasized the need for further education and clarification from Risk Adjustment staff, which can be accomplished with more visibility of the staff.

ACTION: Lucerio to present an oversight plan at February meeting.

5. Wrap Up and Assignments

Mandella summarized action items as follows:

- Drake and Wang to follow up with Newton regarding current oversight of the Nurse Advice Line to ensure appropriate oversight and explore automation of oversight metrics.
- Program Integrity staff to consider send letters to hospice providers identified as outliers to potentially curb inappropriate billing behavior.
- Brass to review UM coding configuration to ensure out-of-network hospice claims are appropriately routed and not bypassing controls.
- Mandella and Markley to bring a proposal regarding risk tolerance for implementation of new requirements to February meeting.
- Mandella to follow up with Crawford and relevant teams to identify opportunities to leverage existing operational reports to enable the review high-impact D-SNP functions prior to full dashboard automation.
- Lucerio to clarify requirements and limitations on submission of 2024 data to CMS for risk adjustment, determine if coding for 2024 and 2025 chronic diagnoses is worthwhile and present an oversight plan at February meeting.

The meeting adjourned at 10:03 a.m.

Respectfully submitted,
Robin Sihler
Compliance Administrative and Data Reporting Assistant

Whole Child Model Clinical Advisory Committee

Meeting Minutes

Thursday, December 16, 2025
12:00 p.m. - 1:00 p.m.

Teleconference Meeting

Committee Members Present:

Hue Nguyen, MD	Provider Representative
John Mark, MD	Provider Representative
Lena Malik, MD	Provider Representative
Michelle Perez, MD	Provider Representative
Nicole Shelton, PA	Provider Representative

Committee Members Absent:

Aditi Mhaskar, MD	Provider Representative
Cal Gordon, MD	Provider Representative
Camille Guzel. MD	Provider Representative
James Rabago, MD	Board Representative
Jennifer Yu, MD	Provider Representative

Staff Present:

Mike Wang, MD	Chair, CMO
Andrea Swan	Quality Improvement and Population Health Director
Ashley McEowen, RN	Complex Case Management Supervisor
Cynthia Bali	Provider Relations Supervisor
Desirre Herrera	Quality and Health Programs Manager
Ivonne Munoz	Quality and Health Programs Supervisor
Jacqueline Morales	Provider Relations Representative
Jenna Stromsoe, RN	Complex Case Management Supervisor
Jessica Villar	Care Management Supervisor (LCSW/LMFT/LPCC)
Lisa Moody, RN	Senior Complex Case Manager
Rebecca McMullen	Behavioral Health Manager
Sarah Sanders	Grievance & Quality Manager
Tammy Brass	UM Director and Interim Health Services Operations Executive Director
Jacqueline Van Voerkens	Clerk of the Committee

Other Representatives Present:

Cara Chesney	Public
Dale Urbelis	Call the Care
Janna Espinoza	FAC Representative
Linda Smith	Director of Nursing, Merced Public Health
Ignacio Santana, MD	Provider Representative

1. **Call to Order by Chairperson Dr. Mike Wang.**
   Chairperson Wang called the meeting to order at 12:05 p.m.

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Roll call was taken.

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

No members of the public addressed the Committee.

3. Consent Agenda Items.
A. Approval of WCMCAC Minutes
Minutes from the September 30, 2025, meeting were reviewed.
B. Grievance Update
Grievance data and update were provided to the Committee.
C. WCMCAC Charter

M/S/A Consent agenda items approved.

4. Regular Business Items.
A. Interpreting Services:
Desiree Herrera presented an overview of the Alliance's interpreting services for providers, which include telephonic interpreting (available 24/7 in over 200 languages), in-person/face-to-face interpreting (by request, with a 5–10 business day lead time depending on language), and a new virtual remote interpreting option launched in July, coordinated via Zoom or Teams.

Providers can request in-person or virtual interpreters using a specific form, typically submitted by fax or email. The team processes requests daily and can sometimes accommodate urgent or same-day needs, especially for certain languages. 18:00
The telephone interpreting line is always available for immediate needs. Providers are encouraged to report any interpreter issues or positive feedback promptly so the team can address them with vendors.

Resources include flyers in English, Spanish, and Hmong, as well as language line business cards and desk displays for provider offices. These materials can be requested through provider relations or the team's email.

Contact information for the interpreting services team and health education line was shared, with the note that requests are processed during business hours and not on weekends.

1-800-700-3874 ext 5580 (Health Education Line
listc&l@thealliance.health (cultural and linguistics team email)

5. Old Business Items.
A. Behavioral Health Insourcing Update:
Rebecca McMullen reported that the Alliance fully insourced behavioral health services in July, transitioning from a third-party manager (Carelon) to internal teams, including a dedicated ABA team for service management.

Since insourcing, there has been an increase in behavioral health service penetration rates across nearly all counties and age groups, including smaller counties, indicating improved access and collaboration.

The transition required significant effort and involved resolving some challenges, but it has streamlined processes for members and providers by removing the third-party intermediary.

The Alliance is actively building relationships with larger provider groups to further expand access and support for members.

Behavioral health access and collaboration remain a high priority for Alliance leadership, with ongoing efforts to address related issues.

B. Transportation Update:
Dale Urblis provided an update on transportation services, specifically addressing previous negative feedback from Stanford staff about long-distance trip booking for CCS members due to a required appointment verification process for trips over 50 miles.

In response, a new process was implemented in August allowing Stanford staff to bypass the 50+ mile verification, resulting in improved call times and smoother scheduling, as confirmed by feedback from both Stanford and the internal case management team.
Dr. John Mark noted overall improvement but mentioned a recent individual case with booking difficulties, which Dale agreed to follow up on directly.

Dr. Mark also shared that Stanford's core team has experienced staffing reductions, impacting care coordination and social work coverage, but current staff are adapting to the changes.

Linda Smith requested Mr. Urbelis' contact information to discuss future transportation needs for long-term cases. Mr. Urbelis provided his contact number during the meeting and agreed to be a direct contact for transportation issues.

daurbelis@callthecar.com

Lisa Moody asked if the improved process for Stanford could be extended to other specialty centers (UCSF, Valley Children's). Mr. Urbelis said he would discuss this with his management and follow up.

Action Items:
1. Mr. Urbelis will follow up on booking difficulty issue presented by Dr. Mark
Action Complete: Callthecar was able to connect with the member's parent, and transportation has been scheduled.
2. Mr. Urbelis will follow up with Ms. Moody regarding extending the improved transportation process to other specialty centers.
Action Pending: Callthecar is currently working internally with our executive leadership team to evaluate the viability of the request.

C. WCM Family Advisory Committee Update
Janna Espinoza shared that more parents from underserved counties have joined the committee, including a parent recently moved from Mexico, bringing valuable perspective on differences in care and the need for community support.

The committee discussed emergency preparedness challenges, especially the difficulty for parents to obtain a 30-day supply of controlled substances for their children due to prescription laws.

Ms. Espinoza and Dr. Malik discussed workaround strategies, such as early refills, but acknowledged legal and practical limitations, especially for compounded medications.

Ms. Moody provided information that during natural disasters, Medi-Cal RX can approve a 30-day emergency supply, and case management can assist families in these situations.

The committee also expressed concerns about upcoming changes to education laws and the impact on services for children with complex needs, noting uncertainty for both families and schools.

D. WCM CCS Referral Volumes

Ashley McEowen presented an update on CCS referral volumes, comparing recent quarters and noting that numbers are consistent, with a notable increase in October referrals. Referral counts by county were shared: quarter three saw 409 referrals across five counties, and 326 referrals were recorded for October and November, with the expectation that final quarter numbers will rise as pending determinations are completed.

Approval rates for referrals in quarter three averaged 57.7%, while the current quarter shows a lower rate (33.7%) due to many referrals still pending determination.

Denial rates by county were also presented: quarter three averaged 18.1%, and the current quarter is at 3.1%, expected to change as more determinations are finalized.

The current WCM member count is 9,729, with 64 members having aged out, and county-level breakdowns were provided.

6. Open Discussion.

Dr. Wang opened the floor for the Committee to have an open discussion. The Committee did not discuss any topics at this time.

Adjourn.

The meeting adjourned at 12:45 p.m.

Respectfully submitted,

Ms. Jacqueline Van Voerkens
Clerk of the Advisory Committee

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

Physicians Advisory Group

Date: December 4, 2025

Time: 12:00 – 1:30 p.m.

Location:

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

MINUTES

Chair: Mike Wang, MD, CMO			**Minutes by:** Christy Pool
	Members Present:	Dr. Mimi Carter, Dr. Cheryl Scott, Dr. Caroline Kennedy, Dr. Ralph Armstrong, Kathryn Kane, CEO Doctors on Duty	
	Members Absent:	Dr. Devon Francis, Dr. Cristina Mercado, Dr. James Rabago, Dr. Jason Novick, Dr. Donaldo Hernandez, Dr. Shirley Dickinson, Dr. Amy McEntee, Dr. Jennifer Hastings, Dr. Misty Navarro, Dr. Charles Harris, Dr. Salvador Sandoval	
	Central California Alliance for Health staff:	Dr. Mike Wang, Dr. Mai Bui-Duy, Dr. Dianna Myers, Dr. Gray Clarke, Ms. Jessica Finney, Ms. Jessie Dybdahl, Ms. Kelsey Riggs, Ms. Kate Nester, Ms. Nicolette Shalita-Vega, Ms. Tammy Brass, Ms. Cassie Russo, Mr. Travis Moody, Ms. Jacqueline Van Voerkens	
Item No.	**Agenda Item**		
I.	**Call to Order**	Chairperson Dr. Mike Wang called the meeting to order at 12:05 p.m. Roll call was taken.	

II.	**Oral Communications**	Chairperson Wang opened the floor for any members of the public to address the Group on items not listed on the agenda. Dr. Caroline Kennedy supported the idea of a future meeting topic focused on updates regarding access to autism care and related priorities, especially within pediatrics. No members of the public addressed the Group.	
Items for Approval		**Discussion**	**Action/Recommendation**
III.	**Review & Approve Minutes**	**The Minutes from the September 4, 2025 meeting were reviewed.** **Dr. Kennedy motioned to approve the minutes from the PAG 9/04/25 meeting.* **Ms. Katie Kane 2nd the motion for approval.* **Group approved 9/4/2025 meeting minutes as presented.* **The charter was brought up for review and approval. No concerns were raised, and Dr. Kennedy moved to approve it, Ms. Nicolette Shalita-Vega 2nd the approval.*	*The **Physicians Advisory Group** approved the 9/4/2025 meeting minutes.*
Action Item Follow-Up			
		N/A	
Regular Agenda			
	Agenda item		
III.	**Medi-Cal Capacity Grant Program Investment Planning Process**	Ms. Jessica Finney presented an overview of the Medi-Cal Capacity Grant Program (MCGP), which funds healthcare providers and community organizations in five counties, focusing on access, quality, and upstream prevention/social drivers of health. The program's three focus areas are: Access to Care, Healthy Beginnings, and Healthy Communities. The board sets annual investment targets; for 2025, $33 million was awarded (with a third for provider recruitment), but for 2026, the target is reduced to $20 million due to projected lack of net income and the need to stretch reserves over four years. The program supports provider recruitment (notably 85 new providers over two years), infrastructure, technology, capital projects, and community engagement/education, with a new emphasis on supporting safety net providers facing financial constraints.	

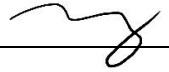
		The grant program aligns with a new DHCS community reinvestment requirement, ensuring investments match state-mandated categories. Planning for 2026 incorporates data from community health needs assessments, county priorities, state landscape, and stakeholder input. Top priorities include access to healthcare, mental health, workforce (especially pediatrics and specialty care), and culturally/linguistically appropriate care. There will be a focus on supporting Medi-Cal member enrollment and retention, especially as policy changes will require more frequent redetermination and introduce work requirements in 2027. Funding will help community-based organizations and providers with outreach, education, and administrative support. Training for Community Health Workers (CHWs) and support for indigenous language access are also included in the planning.	
IV.	**Behavioral Health Insourcing Update**	Dr. Gray Clarke presented the update, noting the Alliance insourced behavioral health services starting July 2025, aiming for NCQA and regulatory compliance, integrated services, and improved provider support. New behavioral health care management and utilization management teams were created and integrated with medical teams; 23 workflows were developed for clinical and quality operations. A provider network was built, meeting DHCS/DMHC requirements, with 243 behavioral health and 132 behavioral health therapy providers, including sign-on bonuses and ongoing expansion. Prior authorization requirements were waived for IHSS indefinitely and for Medi-Cal until January 2026 to reduce provider burden. 53 positions were hired across 11 departments, with 45 tailored training sessions delivered. Claims payment processes were reconfigured for behavioral health, which differs from medical claims. Financially, insourcing is considered sustainable due to savings from ending vendor administrative fees. Claims payment rates have improved, with 99.69% paid within 30 days; call center volume has doubled since July 2025, and staffing is being increased. Utilization of non-specialty mental health services has increased, with penetration rates rising from 8.27% to 9.25%. Top claim denial reasons include missing modifiers and missing supervising clinician information.	

		Care management teams are busy, with high caseloads and frequent referrals to county and internal services; warm handoffs from the call center are common. Feedback from providers indicates improved access and satisfaction with local support, though onboarding new providers requires education on billing and authorizations. Lessons learned include the need for early leadership alignment, subject matter expertise, clear business requirements, enhanced training, and strong communication for future projects.	
V.	**Dual Eligible Special Needs Plan (D-SNP)**	Ms. Sherri Katz presented the launch of the Alliance's new D-SNP, branded as Total Care HMO, exclusively aligned with the Alliance Medi-Cal plan. The plan targets dual-eligible (Medicare and Medi-Cal) members in the service area, where Medicare Advantage penetration is much lower than the national average, especially in rural counties. D-SNP members receive all Medicare Parts A & B benefits, plus vision (annual exam, $350 eyewear every two years), a $100 quarterly over-the-counter flex card, and a Silver & Fit gym membership (including local and national gyms, fitness coaching, and home fitness kits). The plan includes worldwide urgent/emergent care coverage up to $50,000. Prescription drug coverage uses a six-tier formulary, with low or zero copays for low-income subsidy members. Behavioral health and inpatient psych are covered under the plan, with the Alliance administering the benefit as the primary payer. Enrollment began with a soft launch, using postcards and birthday cards for outreach, and is expected to grow from about 400 members at launch to 3,500 by the end of 2026. The plan emphasizes care coordination, member education, and support for maintaining coverage, with ongoing community engagement planned.	
VI.	**Open Discussion**	A participant in the Salinas board room raised concerns about a recent notification that CMS plans to share Medicaid data with ICE, which could increase fears among immigrant families about accessing healthcare coverage.	

		Alliance staff stated they are not sharing any data directly and are not aware of any requirements for them to do so; they acknowledged the issue is significant and expressed concern about its impact. The group recognized the seriousness of the situation and noted it is beyond their control, with potential legal challenges anticipated.	

Action Items

Agenda Item	What is the action item	Due date	Responsible staff
Autism and Developmental Delay Access Update	Coordinate and prepare a presentation or update on access to autism evaluations and care, including recent improvements and ongoing challenges, for a future meeting. **Action Complete:** Presentation created and will be presented at the March 2026 meeting.		Jessie Dybdahl / Dr. Clark
Indigenous Language Interpretation Services	Collect and communicate specific feedback regarding interpreter wait times and language gaps (e.g., Chatino, Mixteco, Zapoteco) to Desirre and explore solutions, including outreach to other plans with similar challenges. **Action Complete:** The Alliance implemented a new gap analysis report in 2025, as required by NCQA, and final data analysis is in progress. This gap analysis will include call time/wait time and will inform improvement strategies. Part of the improvement activities may include asking other Medi-Cal managed care plans if they are using other vendors besides the ones the Alliance is currently using. Language needs and barriers are also included in the Alliance's Population Needs Assessment. The 2025 PNA will be posted on the Alliance website in March. The Alliance currently has two vendors that provide interpretation in Indigenous languages available by appointment and based on interpreter availability. There are no vendors that can provide Indigenous language interpretation available 24 hours per day, 7 days per week. There are currently not enough trained interpreters for Indigenous languages that can meet demand for this service. There is 24/7 interpretation availability for over 200 languages for any appointment including telehealth. The Alliance's Medi-Cal Capacity Grant Program provides financial incentive for recruiting bilingual and multilingual providers into the network. Between 2024 -2025, there were 90 new bilingual providers recruited into the Alliance network with grant support, 80 of whom are Spanish-speaking and two who speak Mixteco.		Jessica Finney

Provider Communication on Behavioral Health Care Management	Disseminate updated information to primary care and mental health providers about behavioral health care management referral processes, including the use of the screening tool and available services. **Action Complete:** A comprehensive provider training was provided serially, to multiple provider groups before go-live, the last update being June, 2025.		Dr. Clarke
DSNP Gym Membership Network Expansion	Identify and contract with local, non-national gyms within the service area to expand the Silver and Fit network for DSNP members, ensuring accessibility in rural and metro areas. **In Progress:** The ASH team is in the process of identifying and making outreach to more fitness centers in our service area. A list of the fitness centers is in creation.		Sherri Katz
Meeting adjourned at 1:20 p.m.			
Next Meeting: 3/5/2026			
Approved by Committee Date: March 5, 2026	***Signature:*** 		**Date**: March 5, 2026

Chair: Mike Wang, MD	Minutes by: Christy Pool

DATE: Wednesday, March 25, 2026

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

FROM: Ronita Margain, Community Engagement Director

SUBJECT: Member Services Advisory Group: Member Appointment

Recommendation. Staff recommend the Board approve the appointment 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 has indicated interest in participating on MSAG.

Name	Affiliation	County
Sandra Settrini	Consumer	San Benito

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

Attachments. N/A

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

DATE: March 25, 2026

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

FROM: Ronita Margain, Community Engagement Director

SUBJECT: Member Services Advisory Group: Member Reappointments

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Recommendation. Staff recommend the Board approve the reappointment of the individuals 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 individuals have indicated interest in continuing participation on MSAG.

Name	Affiliation	County
Adriana Zoghlami	Community Partner	San Benito
Janna Espinoza	Consumer	Monterey

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

Attachments. N/A

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

DATE: March 25, 2026

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

FROM: Dr. Mike Wang, Chief Medical Officer

SUBJECT: Whole Child Model Clinical Advisory Committee: Member Appointment

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

Background. The Board established the WCMCAC pursuant to Welfare and Institutions Code §14094.17(a) (SB 586 – Statutes 2015).

Discussion. The following individual has indicated interest in participating on the WCMCAC and is recommended.

Name	Affiliation	County
John Mark, MD	Provider Representative	Santa Cruz

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

Attachments. N/A

DATE: March 25, 2026

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

FROM: Dr. Mike Wang, Chief Medical Officer

SUBJECT: Physicians Advisory Group: Member Appointment

Recommendation. Staff recommend the Board approve the appointments of the individuals listed below to the Physicians Advisory Group (PAG).

Background. In 2023 the Board established the Physicians Advisory Group (PAG) authorized in the Bylaws of the Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission.

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

Name	Affiliation	County
Caroline Kennedy, MD	Provider Representative	Monterey
Devon Francis, MD	Provider Representative	Monterey
Misty Navarro, MD	Provider Representative	Scotts Valley
Shirley Dickinson, MD	Provider Representative	Monterey

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

Attachments. N/A

DATE: March 25, 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 newly introduced 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

Newly introduced 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 reconvened for the start of the 2026 Legislative Session on January 5, 2026, with the deadline of February 20, 2026 to introduce new legislation. This is the second year of the current two-year legislative session. Staff has developed a bill list, which is attached, that includes approximately one-hundred-seven bills (107), eighty-seven (87) of which were introduced this year with the remaining twenty (20) being two-year bills.

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

Central California Alliance for Health
2026 Bill List

Assembly Bills	
AB 40 **Bonta (D)** **Status: 9/13/2025-Ordered to inactive file at the request of Senator Grayson.** **Position: Watch/Study**	**Redistricting: congressional districts.** **Summary:** The California Constitution requires the Citizens Redistricting Commission to adjust the boundary lines of the congressional, State Senate, Assembly, and State Board of Equalization districts in each year ending in 1. If approved by the electors, ACA 8 of the 2025–26 Regular Session would temporarily adopt new congressional district boundaries until 2031. The new congressional district boundaries are set forth in AB 604 of the 2025–26 Regular Session, which specifies that those district boundaries would become operative only if ACA 8 is approved by the electors. This bill would instead make the congressional district boundaries in AB 604 operative only if ACA 8 is approved by the electors and another state adopts a new congressional district map that takes effect after August 1, 2025, and before January 1, 2031, and that was not required by a federal court order. This bill would declare that it is to take effect immediately as an urgency statute.
AB 54 **Krell (D)** **Status: Ordered to inactive file at the request of Senator Umberg, 2-Year** **Position: Watch/Study**	**Access to Safe Abortion Care Act** **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.
AB 96 **Jackson (D)** **Status:01/27/26: In Senate, read 1st time on RLS for assignment** **Position: Watch/Study**	**Community Health Workers** **Summary:** Existing law required the Department of Health Care Access and Information, on or before July 1, 2023, to develop and approve statewide requirements for community health worker certificate programs. Existing law requires the department, as part of developing those requirements, to, among other things, determine the necessary curriculum to meet certificate program objectives. Existing law defines "community health worker" for these purposes to mean a liaison, link, or intermediary between health and social services and the community to facilitate access to services and to improve the access and cultural competence of service delivery. Existing law specifies that "community health worker" include Promotores de Salud, Community Health Representatives, navigators, and other

	non-licensed health workers with the qualifications developed by the department. This bill would also specify for these purposes that a "community health worker" includes a peer support specialist and would deem a certified peer support specialist to have satisfied all education and training requirements developed by the department for certification as a community health worker.
AB 220 **Jackson (D)** **Status: 9/22/2025-2-Year** **Position: Watch/Study**	**Medi-Cal Subacute Care Services** **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 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
AB 280 **Aguiar-Curry (D)** **Status: 9/11/2025: Ordered to inactive file at the request of Senator Durazo. 2-Year** **Position: LHPC Oppose**	Health care coverage: provider directories 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. This bill contains other related provisions and other existing laws
AB 350 **Bonta (D)** **Status**: **9/10/2025. Ordered to inactive file at the request of Senator Rubio. 2-Year** **Position: Watch/Study**	**Health care coverage: fluoride treatments** **Summary:** 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. 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, 2026, 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. 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. This bill contains other related provisions and other existing laws.
AB 408 **Berman (D)** **Status**: **9/22/2025 2-Year** **Position: Watch/Study**	**Physician Health and Wellness Program.** **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 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. This bill contains other related provisions and other existing laws.
AB 539 **Schiavo (D)** **Status: 9/22/2025 2-Year** **Position: LHPC-Oppose Unless Amended**	**Health care coverage: prior authorizations** **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. This bill contains other related provisions and other existing laws.
AB 618 **Krell (D)** **Status: 9/22/2025 2-Year** **Position: LHPC Support/Cosponsor**	**Medi-Cal: behavioral health: data sharing** **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.

AB 669 **Haney (D)** **Status: 9/22/2025 2-Year** **Position: LHPC Support**	**Substance use disorder coverage** **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 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. This bill contains other existing laws.
AB 787 **Papan (D)** **Status: 9/22/2025 2-Year** **Position: Watch/Study**	**Provider directory disclosures.** **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. This bill contains other related provisions and other existing laws.

AB 910 **Bonta (D)** **Status: 01/29/2026 In Senate, read 1st time, on RLS for assignment** **Position: Watch/Study**	**Pharmacy benefit management.** **Summary:** Existing law provides for the regulation of health care service plans by the Department of Managed Health Care. A willful violation of those provisions is a crime. Existing law requires health care service plans that cover prescription drug benefits and contract with pharmacy providers and pharmacy benefit managers to meet specified requirements, including requiring pharmacy benefit managers with whom they contract to register with the department and exercise good faith and fair dealing, among other requirements. This bill would modify the above-described requirement that the pharmacy benefit manager exercise good faith and fair dealing to instead require the pharmacy benefit manager to hold a fiduciary duty in the performance of its contractual duties and carry out that duty in accordance with state and federal law. The bill would require the pharmacy benefit manager to remit 100% of specified rebates, fees, alternative discounts, and other remuneration received to the health care service plan and would prohibit the pharmacy benefit manager from entering into any contract for pharmacy benefit management services that is contrary to that requirement. This bill contains other related provisions and other existing laws.
AB 1049 **Rodriguez (D)** **Status: 01/29/2026 Read 3rd time ordered to the Senate** **Position: pending**	**CA Food Assistance Program Sponsor Deeming Rules** **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. This bill contains other related provisions and other existing laws. (Based on 02/20/2025 text)
AB 1126 **Patterson (R)** **Status:01/29/26: In Senate, read 1st time on RLS for assignment** **Position: pending**	**Medi-Cal managed care plans: enrollees with other health care coverage.** **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.
AB 1328 **Rodriguez, Michelle (D)** **Status: 8/29/2025 2-Year** **Position: Watch/Study**	**Medi-Cal reimbursements: nonemergency ambulance transportation.** **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. This bill contains other related provisions and other existing laws.
AB 1419 **Addis (D)** **Status: 8/29/2025 2-Year** **Position: Watch/Study**	**California Health Benefit Exchange: automatic health care coverage enrollment** **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. This bill contains other related provisions and other existing laws.

AB 1547 **Bains (D)** **Status: 02/02/2026 referred to comm on higher ED** **Position: Watch/Study**	**UC: Branch Campus of a School of Medicine in the County of Kern: Feasibility Study** **Summary:** Existing law establishes the University of California Kern County Medical Education Endowment Fund. Upon appropriation by the Legislature, existing law requires moneys in the endowment fund to be allocated to the University of California to support the annual operating costs for the development, operation, and maintenance of a branch campus of an existing University of California School of Medicine in the County of Kern, and to conduct a feasibility study related to that campus. This bill would require the University of California, on or before January 1, 2028, to complete a feasibility study, and reasonably attempt to consult with local stakeholders, to determine the steps necessary to establish a branch campus of an existing University of California medical school in the County of Kern, and to submit the feasibility study, including detailed findings, recommendations, and an implementation timeline, to the Governor and Legislature, as provided. The bill would require the feasibility study to include a comprehensive analysis of the requirements, challenges, and opportunities related to establishing a branch campus of an existing University of California medical school in the County of Kern, as provided. This bill contains other related provisions. (Based on 01/06/2026 text)
AB 1561 **Krell (D)** **Status: 03/03/2026 re-referred to Com on Health** **Position: Watch/Study**	**Medi-Cal: Complex Rehabilitation Technology** **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 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. (Based on 02/02/2026 text)
AB 1570 **Wilson (D)** **Status: 02/02/2026 referred to Com on Health** **Position: Watch/Study**	**Health Care Coverage: Diagnostic Imaging** **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 policy of health insurance that provides hospital, medical, or surgical coverage, 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. This bill contains other related provisions and other existing laws. (Based on 01/12/2026 text)
AB 1577 **Bauer-Kahan (D)** **Status: 01/13/2026 may be heard in committee Feb 12** **Position: Watch/Study**	**Data Centers: Monthly Reporting** **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. 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. This bill contains other related provisions and other existing laws.
AB 1609 **Zbur (D)** **Status: 01/20/2026 may be heard in committee Feb 20** **Position: Watch/Study**	**Customer Service Support** **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 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 declare the Legislature's intent to enact legislation that would regulate telephonic and internet customer service support in specified ways. (Based on 01/20/2026 text)
AB 1637 **Caloza (D)** **Status: 02/09/2026 referred to Com on B&P**	**Physicians & Surgeons: Medical Records.** **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

Position: Watch/Study	date of service to a patient. This bill would state that a physician and surgeon's patient medical documentation shall be the responsibility of that physician and surgeon. The bill would prohibit a physician and surgeon's patient notes, after-visit summaries, and diagnoses and treatment plans from being altered, modified, or edited in any fashion by anyone other than the authoring physician and surgeon. By expanding the scope of a crime under the act, the bill would impose a state mandated local program. This bill contains other related provisions and other existing laws. (Based on 01/26/2026 text)
AB 1649 **Ahrens (D)** **Status: 02/09/2026 referred to Com on Health** **Position: Watch/Study**	**Medi-Cal: Monthly Maintenance Amount: Personal & Incidental Needs** **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 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. (Based on 01/28/2026 text)
AB 1670 **Arambula (D)** **Status: 02/03/2026 may be heard in committee March 5** **Position: Pending**	**Medi-Cal: Excluded Services** **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, as specified. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law excludes certain optional Medi-Cal benefits from coverage under the Medi-Cal program, except for beneficiaries under certain circumstances. This bill would make a technical non-substantive change to this provision. (Based on 02/02/2026 text)
AB 1671 **Tangipa (R)** **Status: 02/17/2026 referred to Com on Health** **Position: Pending**	**Rural Medical Services Grant Program** **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 to publish this information on its internet website.
AB 1672 **Solache (D)** **Status: 02/17/2026 referred to Com on Health** **Position: watch/study**	**Medi-Cal: Program of All-Inclusive Care for the Elderly: Rates** **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 various delivery systems, including fee-for-service and managed care. The Medi-Cal program is, in part, governed by, and funded pursuant to, federal Medicaid program provisions. Existing law establishes the California Program of All-Inclusive Care for the Elderly (PACE program) to provide community-based, risk-based, and capitated long-term care services as optional services for older individuals under the state's Medi-Cal State Plan and under contracts entered into between the federal Centers for Medicare and Medicaid Services, the department, and PACE organizations. Existing law requires the department to pay capitation rates to health plans participating in the Medi-Cal managed care program using actuarial methods. Existing law requires the department to develop and pay capitation rates to entities contracted pursuant to the PACE program, using actuarial methods consistent with those provisions, with specified exceptions. Existing law requires the department to consult with those contracted entities in developing a rate methodology. This bill would delete the consultation-related requirement. Under the bill, and consistent with the requirements under federal law, capitation rates would be negotiated between the department and each contracting PACE organization. The bill would require the department, as part of this negotiation before submission for federal approval, to respond in writing to any comments made by a contracting PACE organization concerning prospective rates, provide the rationale for any assumptions or calculations concerning rates upon request, and make a good faith effort to reach agreement with the contracting PACE organization on capitation rates. (Based on 02/02/2026 text)
AB 1682 **Hart (D)** **Status: 02/17/2026 referred to Com on Health** **Position: watch/study**	**Health Care Coverage: Scalp Cooling** **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. This bill contains other related provisions and other existing laws. (Based on 02/02/2026 text)
AB 1717 **Castillo (R)** **Status: 02/05/2026 from printer may be heard in committee March 7**	**Medi-Cal Dental Reimbursement: House/Extended Care Facility Call** **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

Position: watch/study	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. (Based on 02/04/2026 text))
AB 1770 **Garcia (D)** **Status: 02/10/2026 from printer may be heard in committee March 12** **Position: Pending**	**Arbitration: health care service plans and health insurers.** **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 provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract and any disability insurance policy that includes terms requiring binding arbitration for dispute settlement to provide a specified disclosure to subscribers, enrollees, or insureds. 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. The bill would require the disclosure provided to subscribers, enrollees, or insureds to include a statement that the parties are able to appeal the result of an arbitration on the basis of legal or factual error made by the arbitrator and would require the disclosure to be provided to a subscriber, enrollee, or insured annually. This bill would also require, by no later than February 1, 2027, the Department of Managed Health Care to create a panel of qualified arbitrators, as defined, and would require any arbitration between a health care service plan and an enrollee or subscriber, or between a health care insurer and an insured, to be conducted by an arbitrator selected by the department. The bill would specify the process for selection of an arbitrator and would require a health care service plan or health insurer to be responsible for the costs of the arbitrator appointed pursuant to these provisions. The bill would require that a court reporter be present for an arbitration proceeding and would make the health care service plan or health insurer responsible for the cost of the court reporter. The bill would require the arbitrator to complete a report within 30 days of the completion of arbitration, to include, among other things, the amount of an award, if any, and the reasons for any award rendered or denied. The bill would also require all documents relating to the arbitration to be preserved by the health care service plan or health insurer and would require a copy of the documents to be provided the Director of the Department of Managed Health Care and to be maintained by the department for 5 years. The bill would require that all records of arbitration pursuant to these provisions be available to the public, except as specified. 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. (Based on 02/09/2026 text)
AB 1773 **Rubion, Blanca (D)** **Status: 02/10/2026 from printer may be heard in committee March 12**	**Medi-Cal: prerelease services for inmates.** **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 establishes the California Advancing and Innovating Medi-Cal (CalAIM) Act, and requires that implementation of CalAIM, set forth as provided by law and in the CalAIM Terms and

Position: Pending	Conditions, supports specified goals. Existing law makes a qualifying inmate of a public institution eligible, commencing no sooner than January 1, 2023, to receive targeted Medi-Cal services, limited to those services approved in the CalAIM Terms and Conditions for 90 days, as specified. This bill would make a technical, non substantive change to that provision. (Based on 02/09/2026 text)
AB 1776 **Aguiar-Curry (D)** **Status: 02/10/2026 from printer may be heard in committee March 12** **Position: watch/study**	**Cartwright Act: trust.** **Summary:** Existing law, known as the Cartwright Act, makes every trust unlawful, against public policy, and void, subject to specified exemptions. A "trust" is defined for these purposes as a combination of capital, skill, or acts by 2 or more persons for certain prohibited purposes. A violation of the act is punishable as a crime. This bill would, instead, define a trust as a combination of capital, skill, or acts by one or more persons. Because the bill would expand the scope of activities prohibited by the Cartwright Act, the violation of which is punishable as a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws. (Based on 02/09/2026 text)
AB 1794 **Ransom (D)** **Status: 02/11/2026 from printer may be heard in committee March 13** **Position: watch/study**	**Pharmacy: enteral products.** **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 law exempts a manufacturer or wholesaler that provides dialysis drugs and devices directly to patients from these provisions and 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 exempt a manufacturer, wholesaler, or distributor that furnishes enteral nutrition products directly to a patient's residence, as specified, from these provisions. The bill would also authorize a pharmacist or an exempted manufacturer, wholesaler, or distributor to distribute enteral nutrition products directly to patients with medically diagnosed conditions that preclude the full use of regular food pursuant to regulations adopted by the board. The bill would also make technical changes to existing provisions. (Based on 02/10/2026 text
AB 1799 **Ortega (D)** **Status: 02/11/2026 from printer may be heard in committee March 13** **Position: watch/study**	**Integrated health care service plan investment disclosures.** **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. (Based on 02/10/2026 text)
AB 1811 **Rogers (D)** **Status: 02/11/2026 may be heard in committee March 13**	**California Physician Corps Program** **Summary**: Existing law establishes the California Physician Corps Program within the Department of Health Care Access and Information. Existing law defines various terms for purposes of the program. This bill would make technical, no substantive changes to these provisions. (Based on 02/10/2026 text)

Position: watch/study	
AB 1843 **Elhawary (D)** **Status: 02/12/2026 from printer may be heard in committee March 14** **Position: watch/study**	**Communicable diseases: hepatitis B and C.** **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. 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 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 Liver Foundation and 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. (Based on 02/11/2026 text)
AB 1851 **Gipson (D)** **Status: 02/12/2026 from printer may be heard in committee March 14** **Position: watch/study**	**Pupil health: social-emotional, behavioral, and mental health supports.** **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 of 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 the State Department of Education to establish a statewide Tier 1 Social and Emotional Learning, behavioral health, and restorative justice education program for pupils in kindergarten and any of grades 1 to 12, inclusive, as provided. The bill would require a school district, county office of education, or charter school to implement the program with guidance issued by the department and supported using funds appropriated for the Children and Youth Behavioral Health Initiative, as specified. By changing the purposes for which previously appropriated funds may be used, this bill would make an appropriation. This bill contains other related provisions and other existing laws. (Based on 02/11/2026 text)
AB 1852 **Bains (D)** **Status: 02/12/2026 from printer may be heard in committee March 14** **Position: watch/study**	**Kern Medical Education Authority.** **Summary**: Existing law establishes the California Community Colleges, under the administration of the Board of Governors of the California Community Colleges, the California State University, under the administration of the Trustees of the California State University, and the University of California, under the administration of the Regents of the University of California, as the 3 segments of public postsecondary education in the state. Existing law grants the University of California exclusive jurisdiction in public higher education over, among other things, graduate instruction in the profession of medicine. Existing law establishes the University of California Kern County Medical Education Endowment Fund in the State Treasury. Upon appropriation by the Legislature, existing law requires moneys in the endowment fund to be allocated to the University of California to support the annual operating costs for the development, operation, and maintenance of a branch campus of an existing University of California School of Medicine in the County of Kern, to conduct a feasibility study related to that campus, and to generate funding through investment earnings for the support of medical education in the San Joaquin Valley. Existing law also requires moneys in the endowment fund to be used, upon

	appropriation by the Legislature and a determination by the Controller of sufficient funds in the endowment fund, to cover the University of California's estimated costs of applying for and obtaining approval and accreditation from the Liaison Committee on Medical Education, as provided. This bill would, if the office of the President of the University of California has not taken formal, verifiable steps to establish a school of medicine in the County of Kern by July 1, 2027, additionally authorize the Trustees of the California State University, acting through California State University, Bakersfield, and the Board of Trustees of the Kern Community College District to establish a school of medicine in the County of Kern, as provided. The bill would authorize the establishment of a unit of local government, known as the Kern Medical Education Authority, to facilitate the establishment of this medical school in the County of Kern. The bill would require the authority to governed by a Board of Governors of unspecified size, and require the California State University, Bakersfield, and the Kern Community College District to each appoint an unspecified number of members to the board. The bill would, among other things, grant the authority specified powers and duties of a local unit of government within the state, as provided. This bill contains other related provisions and other existing laws. (Based on 02/11/2026 text)
AB 1876 **Addis (D)** **Status: 02/13/2026 from printer may be heard in committee March 15** **Position: watch/study**	**Health care coverage: nondiscrimination.** 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, 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. This bill contains other related provisions and other existing laws. (Based on 02/12/2026 text)
AB 1887 **Zbur (D)** **Status: 02/13/2026 from printer may be**	**Prescription drug coverage for rare diseases** **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.

heard in committee March 15 **Position: watch/study**	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 prohibit a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2027, from imposing prior authorization, step therapy, or other utilization review for a drug prescribed for the treatment of a rare disease, as specified, unless a biosimilar, interchangeable biologic, or generic version of the drug is available. 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. This bill contains other related provisions and other existing laws. (Based on 02/12/2026 text)
AB 1900 **Kalra (D)** **Status: 02/12/2026 from printer may be heard in committee March 15** **Position: watch/study**	**Guaranteed Health Care for All.** **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. This bill contains other related provisions and other existing laws. (Based on 02/12/2026 text)
AB 1906 **Aguiar-Curry (D)** **Status: 02/12/2026 from printer may be heard in committee March 15** **Position: watch/study**	**Cervical cancer screening.** **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, 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. This bill contains other related provisions and other existing laws. (Based on 02/12/2026 text)
AB 1907 **Addis (D)** **Status: 02/12/2026 from printer may be heard in committee March 15** **Position: watch/study**	**California Health Benefit Exchange: automatic health care coverage enrollment.** **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. This bill contains other related provisions and other existing laws. (Based on 02/12/2026 text)
AB 1923 **Soria (D)** **Status: 02/12/2026 from printer may be heard in committee March 15** **Position: watch/study**	**Distressed Hospital Loan Program** 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, as specified. 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 make any hospital, regardless of ownership type or system affiliation, eligible for state assistance under the program for awards provided on or after the effective date of this act, as specified, if it meets the applicable criteria for significant financial distress as established by the department and the authority. The bill would require 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.

AB 1926 **Pacheco (D)** **Status: 02/12/2026 from printer may be heard in committee March 15** **Position: watch/study**	**Health Care Payments Data Program.** **Summary:** Existing law establishes the Health Care Payments Data Program administered by the Department of Health Care Access and Information. Existing law requires the department to develop guidance requiring data submission from specified entities to include a methodology for the collection, validation, refinement, analysis, comparison, review, and improvement of health care data, including, but not limited to, data from fee-for-service, capitated, integrated delivery system, and other alternative, value-based, payment sources, and other forms of payment to health care providers and suppliers by health plans, health insurers, or other specified entities. This bill would make technical, non-substantive changes to these provisions. (Based on 02/12/2026 text)
AB 1949 **Lee (D)** **Status: 02/14/2026 from printer may be heard in committee March 16** **Position: watch/study**	**Medi-Cal: acupuncture treatments.** **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. This bill would state the intent of the Legislature to enact legislation that allows more flexibility in Medi-Cal coverage for acupuncture treatments. (Based on 02/13/2026 text)
AB 1970 **Harabedian (D)** **Status: 02/14/2026 from printer may be heard in committee March 16** **Position: watch/study**	**Health care coverage: mental health or substance use disorders.** **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 mental health or substance use disorders, as 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. This bill contains other related provisions and other existing laws.
AB 1979 **Bonta (D)** **Status: 02/14/2026 from printer may be heard in committee March 16** **Position: watch/study**	**Confidentiality of Medical Information Act: definitions.** **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. The act defines various terms for its purposes. This bill would make a non-substantive change to that provision. (Based on 02/13/2026 text)

AB 2000 **Aguiar-Curry (D)** **Status: 02/18/2026 from printer may be heard in committee March 20** **Position: watch/study**	**Prescription drugs.** **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. (Based on 02/17/2026 text)
AB 2011 **Hart (D)** **Status: 02/18/2026 from printer may be heard in committee March 20** **Position: watch/study**	**Nonquantitative treatment limitations.** **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. This bill contains other related provisions and other existing laws. (Based on 02/17/2026 text)

AB 2036 **Patel (D)** **Status: 02/18/2026 from printer may be heard in committee March 20** **Position: watch/study**	**Medi-Cal: federally qualified health centers and rural health clinics.** **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. This bill would make technical, non-substantive changes to those provisions. (Based on 02/17/2026 text)
AB 2066 **Rodriguez, Celeste (D)** **Status: 02/18/2026 from printer may be heard in committee March 21** **Position: watch/study**	**Triggering event: pregnancy.** **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. This bill contains other related provisions and other existing laws. (Based on 02/18/2026 text)
AB 2081 **Stefani (D)** **Status: 02/18/2026 from printer may be heard in committee March 20** **Position: watch/study**	**Medi-Cal: Home and Community-Based Alternatives Waiver** **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. 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, to ensure that the HCBA Waiver provides for an annual increase of not fewer than 10,000 waiver slots for each waiver year, as specified. The bill would require the department to prepare and submit an annual report to the Legislature that provides certain information about waiver slot numbers, waiting list numbers, demographics, and departmental efforts, as specified. This bill contains other related provisions and other existing laws. (Based on 02/18/2026 text)
AB 2082 **Gonzalez, Jeff (R)** **Status: 02/18/2026 from printer may be**	**Rural Farmworker Women's Health Act of 2026.** **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

heard in committee March 21 **Position: watch/study**	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. (Based on 02/18/2026 text
AB 2123 **Aguiar-Curry (D)** **Status: 02/19/2026 from printer may be heard in committee March 21** **Position: watch/study**	**Health care service plan requirements.** **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. (Based on 02/18/2026 text)
AB 2131 **Rubio, Blanca (D)** **Status: 02/19/2026 from printer may be heard in committee March 21** **Position: watch/study**	**Hospitals: seismic standards.** **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. (Based on 02/18/2026 text)
AB 2135 **Kalra (D)** **Status: 02/19/2026 from printer may be heard in committee March 21** **Position: watch/study**	**Long-term health care facilities.** **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, consistent with federal law, require long-term health care facilities to provide residents with a notice of 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 the resident's representative and by a facility staff member who declares they delivered the notice to the resident or 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 or 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 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. This bill contains other related provisions and other existing laws. (Based on 02/18/2026 text)
AB 2138 **Krell (D)** **Status: 02/19/2026 from printer may be heard in committee March 21** **Position: watch/study**	**Medi-Cal: enhanced care management: peer support specialists.** **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 each ECM provider maintain an interdisciplinary care team that includes at least one peer support specialist 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 for ECM purposes. The bill would authorize the department to allow an ECM provider to satisfy the requirement through any combination of staffing models, as specified. The bill would require the department to ensure that Medi-Cal managed care plan contracts, policies, and guidance reflect the requirement and to establish monitoring and compliance mechanisms to ensure that ECM providers implement the requirement. This bill contains other related provisions and other existing laws. (Based on 02/18/2026 text)
AB 2160 **Rodriguez, Celeste (D)** **Status: 02/19/2026 from printer may be heard in committee March 21** **Position: watch/study**	**Medi-Cal: lactation services.** **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 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. (Based on 02/18/2026 text)
AB 2161 **Bonta (D)**	**Medi-Cal: work or community engagement.** **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

Status: 02/19/2026 from printer may be heard in committee March 21 **Position: watch/study**	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. The above-described federal law generally requires a Medicaid expansion adult, commencing January 1, 2027, or earlier at state option, to demonstrate community engagement as a condition of Medicaid eligibility. Existing law sets forth the mechanisms for complying with that requirement on a monthly basis, including, among others, a minimum of 80 hours of work or community service or a minimum of half-time enrollment in an educational program. Existing law exempts certain categories of individuals from the requirement, including, among others, a parent or family caregiver of a dependent child 13 years of age or younger or a disabled individual, and a medically frail person. This bill would state the intent of the Legislature that the department implement work or community engagement requirements under the above-described federal law to ensure that all eligible Medi-Cal applicants and beneficiaries obtain and maintain coverage in ways that are least administratively burdensome to those individuals. The bill would set forth provisions to conform to the above-described federal provisions, including work or community engagement requirements, exemptions, and notices of noncompliance if applicable. This bill contains other related provisions and other existing laws. (Based on 02/18/2026 text)
AB 2165 **Macedo (R)** **Status: 02/19/2026 from printer may be heard in committee March 21** **Position: watch/study**	**Behavioral health and wellness screenings.** **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 annually provide to enrollees a written or electronic notice regarding the benefits of a behavioral health and wellness screening for children and adolescents 8 to 18 years of age. This bill would make a technical, non-substantive change to that provision. (Based on 02/18/2026 text)
AB 2201 **Boerner (D)** **Status: 03/02/2026 Referred to Comm on Health** **Position: watch/study**	**Medi-Cal: eligibility redetermination.** **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. This bill contains other related provisions and other existing laws. (Based on text date 2/19/2026)

AB 2208 **Stefani (D)** **Status: 02/20/2026 From printer may be heard in committee March 22** **Position: watch/study**	**Medi-Cal: cost sharing, retroactivity, and accessibility.** **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. 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. This bill contains other related provisions and other existing laws. (Based on text date 2/19/2026)
AB 2327 **Lowenthal (D)** **Status: 02/20/2026 from printer may be heard in committee March 22** **Position: watch/study**	**Medi-Cal: subcontractors: rates.** **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. This bill would require the department, for rates effective on or after January 1, 2027, to require that a Medi-Cal managed care plan operating as a downstream fully or partially delegated subcontractor, as defined, be paid actuarially sound rates developed in accordance with generally accepted actuarial rate development principles and practices. Under the bill, failure to pay the subcontractor in a manner consistent with these provisions would be deemed a violation, constituting an unlawful and unfair business practice, as specified. The bill would afford the contractor the opportunity to enforce these requirements by filing a notice of dispute with the department. (Based on text date 2/19/2026)
AB 2368 **Bonta (D)** **Status: 02/19/2026 from printer may be heard in committee March 21**	**Indigent health care: information and planning.** **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

Position: watch/study	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 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, as necessary to meet additional need due to reduced access to health care coverage. The bill would require that the plan include information on projected caseload and expenditure increases, projected investment, and assessment of funding sources, as specified. By creating new planning duties for counties, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws. (Based on 02/19/2026 text)
AB 2386 **Alvarez (D)** **Status: 02/21/2026 from printer may be heard in committee March 23** **Position: watch/study**	**License to practice medicine: Licensed Physicians from Mexico Program and Provisional License for Qualified International Physicians Act.** **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 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 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 Provisional License for Qualified International Physicians 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. The bill would make the license valid for 5 years and renewable for one additional 5-year period. The bill would require the board to issue a full and unrestricted physician's and surgeon's license to a provisional licensee applicant who meets specified requirements, including having completed at least 5 years of practice under the provisional license without any disciplinary actions. The bill would require the board to establish application, initial licensure, renewal, and conversion fees for the provisional license, as specified. (Based on 02/20/2026 text)
AB 2391 **Ahrens (D)** **Status: 02/21/2026 from printer may be heard in committee March 23** **Position: watch/study**	**Health care: workforce training programs** **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 make technical, non-substantive changes to those provisions. (Based on 02/20/2026 text)
AB 2415 **Tangipa (R)** **Status: 02/21/2026 from printer may be heard in committee March 23**	**Air ambulance services** **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 also provides for the regulation of health insurers by the Department of Insurance. Existing law requires that health care service plan contracts and health insurance policies provide coverage for certain services and treatments, including emergency medical transportation services.

Position: watch/study	Existing law requires a health care service plan contract or a health insurance policy issued, amended, or renewed on or after January 1, 2020, to provide, among other things, that if an enrollee, insured, or subscriber receives covered services from a noncontracting air ambulance provider, the individual will pay no more than the same cost sharing that the individual would pay for the same covered services received from a contracting air ambulance provider, referred to as the in-network cost-sharing amount. This bill would make a technical, non-substantive change to those provisions. (Based on 02/20/2026 text)
AB 2448 **Berman (D)** **Status: 02/21/2026 from printer may be heard in committee March 23** **Position: watch/study**	**Medical information: confidentiality.** **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 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. This bill contains other related provisions and other existing laws. (Based on 02/20/2026 text)
AB 2457 **Connolly (D)** **Status: 02/21/2026 from printer may be heard in committee March 23** **Position: watch/study**	**Health care provider credentialing.** **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. (Based on 02/20/2026 text)
AB 2511 **Ahrens (D)** **Status: 02/21/2026 from printer may be heard in committee March 23**	**Behavioral Health Provider Comparable Worth Study.** **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

Position: watch/study	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. This bill contains other related provisions and other existing laws. (Based on 02/20/2026 text)
AB 2551 **Elhawary (D)** **Status: 02/21/2026 from printer may be heard in committee March 23** **Position: watch/study**	**Behavioral health care coverage.** **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 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 express the intent of the Legislature to enact legislation to require health care service plans and health insurers to survey and publicly report the percentage of enrollees or insureds going in network or out of network for behavioral health care, among other things. The bill would also make related findings and declarations. (Based on 02/20/2026 text)
AB 2565 **Wallis (R)** **Status: 02/21/2026 from printer may be heard in committee March 23** **Position: watch/study**	**Medi-Cal** **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, the provisions relating to the Medi-Cal program are known as the Medi-Cal Act. This bill would make technical, non substantive changes to the provision naming the Medi-Cal Act. (Based on 02/20/2026 text)
AB 2571 **Flora (R)** **Status: 02/21/2026 from printer may be heard in committee March 23** **Position: watch/study**	**Reimbursement for pharmacist services.** **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 for MTM pharmacist services provided in conjunction with certain specialty drug therapy categories. This bill contains other related provisions and other existing laws. (Based on 02/20/2026 text)
AB 2575 **Ortega (D)** **Status: 02/21/2026 from printer may be heard in committee March 23** **Position: watch/study**	**Health care services: artificial intelligence** **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 covered tool, as defined, for patient care to disclose required information to any licensed health care professional or other person using a covered tool or viewing outputs from a covered tool. The bill would require, among other things, the disclosure to include a notice that a worker providing direct patient care is permitted to override the output of a covered tool if, in the judgment of the worker acting in their scope of practice, an override is appropriate for the patient, or as necessary to comply with applicable law, including civil rights 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. This bill contains other related provisions and other existing laws. (Based on 02/20/2026 text)
AB 2610 **Addis (D)** **Status: 02/21/2026 from printer may be heard in committee March 23** **Position: watch/study**	**Patient access to health records** **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. (Based on 02/20/2026 text)
AB 2613 **Sharp-Collins (D)** **Status: 02/21/2026 from printer may be heard in committee March 23**	**Health care service plans: notice.** **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, including notice requirements, and requires a health care service plan contract to provide to subscribers and enrollees specified basic health care services. This bill would state the intent of the Legislature to enact

Position: watch/study	legislation to require health care service plans to provide clear notice to consumers about their health care coverage. (Based on 02/20/2026 text)
AB 2624 **Bonta (D)** **Status: 02/21/2026 from printer may be heard in committee March 23** **Position: watch/study**	**Privacy for immigration support services providers** **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. 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 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. Existing law prohibits a person from posting on the internet or social media, with the intent that another person imminently use that information to commit a crime involving violence or a threat of violence against a designated health care services patient, provider, or assistant, or other individuals residing at the same home address, the personal information or image of a reproductive health care services patient, provider, or assistant, or other individuals residing at the same home address. 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 or social media the personal information or image of a designated immigration support services provider, employee, volunteer, or patient with the intent described above. The bill would also prohibit a person from posting on the internet or social media, as described above, the personal information or image of a designated immigration support services provider, employee, volunteer, or patient, or other individuals residing at the same home address. The bill would define various terms for these purposes. (Based on 02/20/2026 text)
AB 2643 **Caloza (D)** **Status: 02/21/2026 from printer may be heard in committee March 23** **Position: watch/study**	**Insurance: Health Coverage** **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. (Based on 02/20/2026 text)
AB 2665 **Tangipa (R)** **Status: 02/21/2026 from printer may be**	**Health and human services: approved plans or waivers: notifications.** **Summary**: Existing law requires a department within the California Health and Human Services Agency that has received approval of an operational state plan by a federal agency, or that has applied and has been approved for a waiver from a federal law or regulation, to make any and all approved plans and waivers available to the public by publishing a hyperlink to that information on the homepage of the

heard in committee March 23 **Position: watch/study**	department's internet website. This bill would require the above-described department to expeditiously make an approved plan or waiver available to the public. The bill would require the agency to promptly notify the legislative health committees about an approved plan or waiver. (Based on 02/20/2026 text)
AB 2670 **Castillo (R)** **Status: 02/21/2026 from printer may be heard in committee March 23** **Position: watch/study**	**Medi-Cal: fraud assessment task force.** **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. (Based on 02/20/2026 text)
AB 2706 **Soria (D)** **Status: 02/21/2026 from printer may be heard in committee March 23** **Position: watch/study**	**Health and care facilities** **Summary**: Existing law provides for the licensure and regulation of health and care facilities by the State Department of Public Health, the State Department of Social Services, and the State Department of Health Care Services, depending on the type of facility. This bill would state the intent of the Legislature to enact legislation relating to health and care facility operations. (Based on 02/20/2026 text)
AB 2729 **Bonta (D)** **Status: 02/21/2026 from printer may be heard in committee March 23** **Position: watch/study**	**Medi-Cal: employer penalty: contribution.** **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. This bill would state the intent of the Legislature to enact legislation that would require employers that employ individuals who are enrolled in the Medi-Cal program to pay a penalty as a contribution to a Medi-Cal fund. (Based on 02/20/2026 text)
AB 2756 **Hadwick (R)** **Status: 02/21/2026 from printer may be heard in committee March 23** **Position: watch/study**	**Health care: unified health care financing.** **Summary**: Existing law requires the Secretary of the California Health and Human Services Agency to research, develop, and pursue discussions of a waiver framework in consultation with the federal government with the objective of a health care system that incorporates specified features and objectives, including, among others, unified financing and a comprehensive package of medical, behavioral health, pharmaceutical, dental, and vision benefits, and the absence of cost sharing for essential services and treatments. Existing law makes related findings and declarations. This bill would make a technical, non substantive change to those findings and declarations. (Based on 02/20/2026 text)

AJR 25 **Bonta (D)** **Status: 02/18/2026 referred to Com on Health** **Position: LHPC Support**	**Health care coverage: enhanced Affordable Care Act premium tax credits.** **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. (Based on 01/29/2026 text)
Senate Bills	
SB 32 **Weber Pierson (D)** **Status: 8/29/2025 2-Year** **Position: LHPC Oppose**	**Health care coverage: timely access to care** **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 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. This bill contains other related provisions and other existing laws.
SB 106 **Laird (D)** **Status: 02/11/2026: Chaptered by Secretary of State. Chapter 4, Statutes of 2026.** **Position: Watch/Study**	**Budget Act of 2025.** **Summary:** The Assembly has amended SB 106 and is now in print. It proposes to provide $90 million to reproductive health care providers (aka, Planned Parenthood) in response to the Prohibited Entities provision in H.R. 1.
SB 228 **Cervantes (D)**	**Comprehensive Perinatal Services Program.** **Summary:** Existing law establishes the Comprehensive Perinatal Services Program, the goals of which are to decrease and maintain the decreased level of perinatal,

Status: 8/29/2025 2-Year **Position: Watch/Study**	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 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.
SB 324 **Menjivar (D)** **Status: 8/29/2025 2-Year** **Position: Watch/Study**	**Medi-Cal: enhanced care management and community supports.** **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. This bill contains other related provisions and other existing laws.
SB 363 **Wiener (D)** **Status: 8/29/2025-2-Year** **Position: Watch/Study**	**Health care coverage: independent medical review.** **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 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. This bill contains other related provisions and other existing laws.
SB 535 **Richardson (D)** **Status: 8/29/2025-2-Year** **Position: Watch/Study**	**Obesity Care Access Act.** **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.

SB 812 **Allen (D)** **Status: 8/29/2025 2-Year** **Position: Watch/Study**	**Qualified youth drop-in center health care coverage.** **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. This bill contains other related provisions and other existing laws.
SB 912 **Cervantes (D)** **Status: 2/11/2026 Referred to Com on Health** **Position: Watch/Study**	**Comprehensive perinatal services.** **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 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. This bill contains other related provisions and other existing laws. (Based on 01/26/2026 text)

SB 944 **Wiener (D)** **Status: 2/11/2026 Referred to Com on Health** **Position: Watch/Study**	**Medi-Cal: acupuncture.** **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. (Based on 02/02/2026 text)
SB 950 **Weber, Pierson (D)** **Status: 2/11/2026 Referred to Com on Health** **Position: Watch/Study**	**Health care coverage: dementia.** **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. 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. The bill would require a health care service plan or health insurer that, as a medical benefit, covers non-self-administered treatments approved by the FDA for the treatment of Alzheimer's disease or other medical conditions affecting memory to also include those non-self-administered treatments as an outpatient prescription drug benefit. 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. This bill contains other related provisions and other existing laws. (Based on 02/02/2026 text)
SB 964 **Smallwood-Cuevas (D)** **Status: 2/11/2026 Referred to Com on Health** **Position: Watch/Study**	**Prescription drug coverage: dose adjustments** **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 a licensed health care professional 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. Under the bill, if the enrollee or insured has been continuously using a prescription drug selected by their prescribing provider for the medical condition under consideration while covered by their current or previous health coverage, the health care service plan or health

	insurance policy would be prohibited from limiting or excluding coverage of that prescription. 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. This bill contains other related provisions and other existing laws. (Based on 02/03/2026 text)
SB 987 **Weber Pierson (D)** **Status: 2/18/2026 Referred to Com on Health** **Position: Watch/Study**	**California Health Access Fund.** **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. (Based on 02/05/2026 text)
SB 1002 **Niello (R)** **Status: 2/18/2026 Referred to Com on BP & ED** **Position: Watch/Study**	**Out-of-state physicians and surgeons: telehealth: license exemption.** **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. (Based on 02/09/2026 text)
SB 1078 **Laird (D)**	**Transactions and use taxes: County of Santa Cruz** **Summary:** Existing law authorizes various local governmental entities, subject to certain limitations and approval requirements, to levy a transactions and use tax for

Status: 03/05/2026 Set for hearing March 18 **Position: Support**	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 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.
SB 1089 **Richardson (D)** **Status: 2/26/2026 Referred to Com on Health** **Position: Watch/Study**	**Preventive Care Act.** **Summary**: Existing law requires the California Health and Human Services Agency 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 requires the insulin production partnership to consider guaranteeing priority access to insulin supply for the state. This bill, the Preventive Care Act, would require the above-described partnerships to also include the production of at least one glucagon-like peptide-1 (GLP-1) or GLP-1 receptor agonist (GLP-1RA) made available at production and dispensing costs and to consider guaranteeing priority access to GLP-1 or GLP-1RA supply for the state. This bill contains other related provisions and other existing laws. (Based on 02/13/2026 text)
SB 1094 **Weber Pierson (D)** **Status: 2/26/2026 Referred to Com on Health** **Position: Watch/Study**	**Prescription drugs.** **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 a biosimilar, as defined, 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. This bill contains other related provisions and other existing laws. (Based on 02/13/2026 text)
SB 1146 **Gonzalez (D)** **Status: 03/04/2026 Referred to Com on Health** **Position: Watch/Study**	**Health-related consumer products and services: artificial intelligence.** **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. This bill would require an advertisement that uses the image, audio, or video of a natural person 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. The bill would also define terms for its purposes. This bill would require actions for relief brought pursuant to this bill to be prosecuted exclusively by the Attorney General or a district attorney in the name of the people of the State of California, and would provide that a violation of the bill does not constitute a misdemeanor. (Based on 02/18/2026 text)
SB 1179 **Menjivar (D)** **Status: 2/26/2026 Referred to Com on BP & ED** **Position: Watch/Study**	**Doctors from El Salvador Program** **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. This bill contains other related provisions. (Based on 02/18/2026 text)
SB 1240 **McNerney (D)** **Status: 03/04/2026 Referred to Com on GO** **Position: Watch/Study**	**Office of Nonprofit Empowerment.** **Summary**: Existing law contains numerous provisions authorizing state agencies to award grants or contracts to nonprofit organizations to carry out various services and programs. Existing law authorizes a state agency that administers a grant program or contract to advance funds to a private nonprofit organization to which it has awarded a grant or contract, subject to certain limitations and requirements, as specified. This bill would create the Office of Nonprofit Empowerment with the primary responsibility of overseeing and coordinating state policy in support of California's nonprofit organizations. The bill would specify various duties and functions of the office, including providing guidance, resources, and technical assistance to nonprofit organizations on procurement and grantmaking laws, regulations, and best practices. The bill would also require the office to develop and administer training and materials to state entities on advance payment and other strategies to reduce hurdles for nonprofit organizations to access state funding and implement state projects, as specified. The bill would authorize the office to update the State Administrative Manual and State Contracting Manual, as specified. The bill would establish the office within an unspecified agency, would place the office under the control of a director who would be appointed by the Governor, and would require the director to hire staff to assist in the fulfillment of its duties and responsibilities. The bill would also require the office to submit a report to the

	Governor and the Legislature, on or before March 1, 2027, on ways to improve how nonprofits and the state partner, as specified. The bill would include related legislative findings and declarations. This bill contains other related provisions. (Based on 02/19/2026 text)
SB 1280 **Valladares (R)** **Status: 03/04/2026 Referred to Com on RLS** **Position: Watch/Study**	**Health care service plan requirements.** **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. (Based on 02/20/2026 text)
SB 1323 **Rubio (D)** **Status: 03/04/2026 Referred to Com on RLS** **Position: Watch/Study**	**Hospitals.** **Summary**: Existing law establishes the State Department of Public Health in the California Health and Human Services Agency. Existing law provides for the licensing and regulation of health facilities, including hospitals, by the department. This bill would state the intent of the Legislature to enact legislation relating to hospitals. (Based on 02/20/2026 text)
SB 1366 **Rubio (D)** **Status: 03/04/2026 Referred to Com on RLS** **Position: Watch/Study**	**California Prompt Payment Act.** **Summary**: The California Prompt Payment Act requires a state agency that acquires property or services pursuant to a contract with a business to make payment to the person or business on the date required by the contract or be subject to a late payment penalty, as specified. The act requires a state agency that awards a grant to make payment to the person or business that is the recipient of the grant on the date required by the grant or be subject to a late payment penalty, as specified. The act provides that, to avoid late payment penalties, the maximum time from state agency receipt of an undisputed invoice to the date of payment is 45 calendar days. This bill would state the intent of the Legislature to enact legislation relating to the act. (Based on 02/20/2026 text)
SB 1400 **Arreguin (D)** **Status: 03/04/2026 Referred to Com on L.GOV & Health** **Position: Watch/Study**	**Alameda Health System: hospital authority** **Summary**: Existing law authorizes the Board of Supervisors of the County of Alameda to establish a hospital authority for the purpose of effecting a transfer of the management, administration, and control of the Alameda Health System. Existing law requires the hospital authority to be governed by a board that is appointed, both initially and continually, by the board of supervisors. Existing law requires the enabling ordinance to specify the membership of the hospital authority governing board, the qualifications for individual members, the manner of appointment, selection, or removal of governing board members, their terms of office, and all other matters that the board of supervisors deems necessary or convenient for the conduct of the hospital authority's activities. Existing law specifies that a hospital authority established pursuant to these provisions, but that does not obtain the administration, management, and control of the medical center or has those duties and responsibilities revoked by the board of supervisors, is not empowered with the powers provided to an independent hospital authority, as specified. This bill would require the enabling ordinance to authorize the membership of the governing board to include, with the approval of the board of supervisors, a representative of any local public entity that contributes financial or

	other support to the hospital authority, as specified. The bill would authorize, at the board of supervisors' discretion and as specified in the enabling ordinance, the governing board to consist entirely of members of the board of supervisors or to include any number of the members of the board of supervisors or county officers or employees appointed to represent the interests of the county. The bill would prohibit the inclusion of members of the board of supervisors or county employees on the governing board from being a basis to determine that the hospital authority is not an independent entity or that the hospital authority has

Total Bills:

- AB Bills 84
- SB Bills 23

DATE: March 25, 2026

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

FROM: Scott Fortner, Chief Administrative Officer

SUBJECT: Business Continuity and Disaster Recovery Program 2025 Annual Report

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Recommendation. This report is information only.

Background. The purpose of the program is to prevent or mitigate the impacts of a business interruption on Alliance, members, providers, employees, partners, and communities. Should an incident occur, the Emergency Management Team (EMT) is responsible for managing response to the event and the subsequent recovery. The Business Continuity and Disaster Recovery Plan (BCDRP) is designed to be used to respond to the business impacting event to ensure the delivery of critical operational functions, minimize potential loss exposure, maintain compliance with regulatory and contractual requirements, and promote employee safety.

Summary of 2025 Activities

Post COVID-19 Pandemic
Throughout 2025, we continued to monitor COVID-19 following public health guidelines for our service areas. Alliance offices are open.

Power Outages
• Monitored all Public Safety Power Shutdown (PSPS)

Weather
• Monitored Winter Storm events

Technology Interruptions
• Monitored cyber security events for impact to the Alliance

The EMT Advisory Group met monthly in 2025 to manage the oversight of the BCDRP. Using the ISO 22301 Gap Analysis and Maturity Assessment of 2023, program objectives were identified and approved by the EMT Advisory Group. And a Maturity Assessment was conducted, measuring the extent to which the Alliance is making use of the standard practices. Based upon the findings the plan for 2025 was made and approved by the EMT Advisory Team. The following initiatives were executed:

- Remediate gaps from 2024-5 ISO 22301 Gap Analysis
- Successfully conducted annual Disaster Recovery exercise August 1-3, 2025, failing over from the production data center in Scotts Valley to the backup data center in Merced within the 4-hour Recovery Point and Time Objective.

- Implemented business continuity software and executed Business Impact Analysis for all departments using the new tool.
- Conducted EMT Tabletop Exercise using measles scenario on November 18, 2025
- Migrated to new emergency notification system
- Supported new D-SNP requirements
- Conducted Home Preparedness Training for all Alliance employees
- Executed Annual BIA update for all departments
- Executed Annual ISO Gap Assessment and Maturity Assessment Update

The EMT Advisory Group met on December 16th and approved the plan for 2026 below:

- Remediate gaps from 2024 ISO 22301 Gap Analysis
- Conduct annual Disaster Recovery exercise in Q3 2026
- Complete implementation of business continuity software (business unit contingency plans, EMT training and use of tools)
- Conduct EMT Tabletop Exercise in May and November 2026
- Execute Annual BIA update for all departments
- Execute Annual ISO Gap Assessment and Maturity Assessment Update
- Execute OCR Risk Assessment

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

Attachments. N/A

DATE: March 25, 2026

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

FROM: Scott Fortner, Chief Administrative Officer

SUBJECT: Inclusion and Belonging Annual Report

Recommendation. This report is informational only.

Summary. "Alliance UNITY," our Inclusion and Belonging Committee, supports the organization's commitment to fostering an inclusive workplace culture where staff feel respected, supported, and connected. Through Alliance Unity, the Committee promotes learning, reflection, and engagement around inclusion and belonging. Key efforts during the reporting period included organization-wide learning opportunities such as the Feed Your Mind sessions and monthly psychological safety workshops facilitated by Progressive Discoveries.

Background. Alliance UNITY serves as the internal platform for sharing learning opportunities and resources related to inclusion and belonging. The Committee's work is guided by a purpose to nurture a culture that embraces the diversity of humanity in an inclusive way to energize and empower the Alliance in our community.

Discussion. During the reporting period, the Alliance UNITY supported organizational learning through multiple, complementary efforts focused on awareness, reflection, and workplace culture.

One key component was the *Feed Your Mind* learning session series, which is archived and available through the Alliance Unity company website. These sessions elevate lived experiences and provide practical perspectives on allyship and inclusive workplace behaviors. Session topics included:

- Black Birthing Health: A lunch-and-learn series focused on the barriers, stigmas, and challenges Black pregnant persons face in health care, along with information about available benefits and supportive resources. Recorded sessions and curated materials were provided to support continued learning.

- LGBTQIA+ Lived Experiences and Allyship: A session centered on the lived experiences of LGBTQIA+ staff, with an emphasis on sharing allyship practices and fostering inclusive day-to-day interactions in the workplace. Supporting materials were developed to complement the session content.

- Hispanic and Latino Immigration Experiences: A session focused on the voices and lived immigration experiences of Hispanic and Latino American colleagues, highlighting

meaningful ways to practice inclusive allyship in everyday interactions. Recorded content and educational resources accompanied the session.

In addition to these learning sessions, the Alliance partnered with Progressive Discoveries, an external consulting firm, to support organization-wide learning related to psychological safety. Throughout 2025, Progressive Discoveries facilitated monthly psychological safety workshops, creating structured opportunities for staff to engage in open dialogue, reflection, and skill-building. Over 500 Alliance employees participated in these sessions during the year. These workshops reinforced shared expectations around respectful communication, speaking up, listening, and contributing to a workplace culture where employees feel safe to engage and collaborate.

Collectively, these efforts reflect a sustained organizational commitment to inclusion and belonging by investing in learning opportunities that are accessible, reflective, and grounded in real experiences. By making resources available through the Alliance Unity website and offering recurring workshops throughout the year, the Committee helps ensure that learning remains available beyond individual sessions and supports ongoing engagement across the workforce.

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

Attachments. N/A

DATE: March 25, 2026

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

FROM: Mike Wang, M.D., Chief Medical Officer

SUBJECT: Whole Child Model Clinical Advisory Committee (WCMCAC) Charter

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Recommendation. Staff recommend the Board approve the 2025 Whole Child Model Clinical Advisory Committee WCMCAC Charter.

Background. The Whole Child Model Clinical Advisory Committee (WCMCAC) is an advisory committee providing input and recommendations to the health plan on important strategic issues that impact California Children Services (CCS) members, families, and providers.

The primary responsibility of the WCMCAC is to advise on clinical issues and provide perspective on issues relating to diagnosis and treatment of California Children's Services (CCS) conditions as well as to review and offer advice about policies, programs and initiatives relating to care of members in the CCS program.

Discussion. The WCMCAC met on Thursday, December 16, 2025 and approved the updated charter. Major content changes included indicating that the WCMCAC reports to the Board of Commissioners, through Committee minutes as well as recommendations for policy revisions, updated the Meetings section noting the contractual reference to Exhibit L 3.1.3 which stipulates the regulatory purpose of the meeting, updated the Chair information, membership information, the meeting location information noting the meet takes place virtually, as well as minor abbreviation changes, and update the commission title.

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

Attachments.

1. Whole Child Model Clinical Advisory Committee (WCMCAC) 2025 Charter

	COMMITTEE CHARTER
Committee: Whole Child Model Clinical Advisory Committee (WCMCAC)	
Original Date: February 2018	**Last Revision Date:** DecemberNovember 202518
Approved by: Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care CommissionAlliance Board	

Purpose:	The Whole Child Model Clinical Advisory Committee (WCMCAC) is an advisory committee providing input and recommendations to the health plan on important strategic issues that impact California Children Services (CCS) members, families, and providers. The WCCACWCMCAC will provide feedback to assist in meeting the six goals of the WCM: • Implement Patient and Family-Family Centered Approaches to Care • Improve Care Coordination through an Organized Delivery System • Maintain Quality of Services • Streamline Care Delivery • Build on Lessons Learned • Provide Quality, Cost Effective Services
Authority and Responsibility .	The primary responsibility of the WCCACWCMCAC is to to advise on clinical issues relating to CCS conditions, including treatment authorization guidelines, and serve as clinical advisers on other clinical issues relating to CCS conditions . The WCCACWCMCAC will provide perspective on issues relating to diagnosis

	COMMITTEE CHARTER
Committee: Whole Child Model Clinical Advisory Committee (WCMCAC)	
Original Date: February 2018	**Last Revision Date:** DecemberNovember 202518
Approved by: Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care CommissionAlliance Board	

	and treatment of Alliance members with conditions that have been traditionally covered through the California Children's Services (CCS) program. In addition, the WCCACWCMCAC will review and offer advice about policies, programs and initiatives relating to care of members as the CCS program is integrated into the Whole Child Program.
Membership	WCMCAC members are appointed by the Alliance board. Membership includes: The Alliance Chief Medical Officer, or Board Certified Pediatric Medical Director. Each County's CCS Medical Director At least four (4) CCS paneled providers, ideally to include with representation from each of the Alliance counties served. Membership will reflect demographic representation within practical limits, including geographic distribution, primary cCare and specialists. Selection of Members: Members are recruited several ways including, but not limited to: 1. Recommendation of CCS staff representing each County 2. Volunteer by individual physician 3. Physicians with specific expertise may be invited to assist with the group's work.

	COMMITTEE CHARTER
Committee: Whole Child Model Clinical Advisory Committee (WCMCAC)	
Original Date: February 2018	**Last Revision Date:** DecemberNovember 202518
Approved by: Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care CommissionAlliance Board	

	WCCACWCMCAC members will be appointed by the Alliance Board . Alliance staff, including, but not limited to the Chief Health Services OfficerExecutive Director, Utilization Management Director, Quality Improvement Director, Provider Services Director, and Member Services Director may attend depending upon agenda items.
Terms	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 or terms. Physicians unable to attend at least half of meetings will be encouraged to yield their seats to others with more compliant schedules.
WCMCAC Chair	The Chief Medical Officer or Board Certified Pediatric Medical Director will serve as Chair.
Meetings	As per contractual requirement Exhibit L 3.1.3 WCM Advisory Committees: In Accordance with W&I section 14094.17(a) and APL 23-034 "Contractor must create and maintain a WCM clinical advisory committee, separate and distinct from its Quality Improvement and Health Equity Committee described in Exhibit A, Attachment III, Section 2.3 (Quality Improvement and Health Equity Committee). The WCM clinical advisory committee must be composed of Contractor's Medical Officer or the

	COMMITTEE CHARTER
Committee: Whole Child Model Clinical Advisory Committee (WCMCAC)	
Original Date: February 2018	**Last Revision Date:** DecemberNovember 202518
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	equivalent, the county CCS medical director, and at least four CCS paneled Providers. 1. The WCM clinical advisory committee must advise on clinical issues relating to CCS conditions, including treatment authorization guidelines, and to serve as clinical advisers on other clinical issues relating to CCS conditions. 2. The WCM clinical advisory committee must meet at least quarterly, or more frequently if determined necessaryThe WCCAC will meet quarterly, with a minimum of three (3) meetings per year. Meetings fall within the Ralph M. Brown Act (Brown Act). An opportunity for public comment will be offered and agendas and meeting materials will be published and distributed to PAG members and posted publicly at least 72 hours prior to each meeting. WCMCAC is a non-voting advisory group and does not require a quorum.
Meeting Compensation	WCCACWCMCAC may receive a stipend for in-person participation in the WCCACWCMCAC.
Agenda, Minutes, Reports	WCMCAC reports to the Board of

	COMMITTEE CHARTER
Committee: Whole Child Model Clinical Advisory Committee (WCMCAC)	
Original Date: February 2018	**Last Revision Date:** DecemberNovember 202518
Approved by: Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care CommissionAlliance Board	

	Commissioners, through Committee Minutes as well as recommendations for policy revisions and innovations. Alliance staff will work in collaboration with the Chair to develop the agenda for each meeting. Alliance staff are responsible for agenda and meeting material production and distribution. Agendas and meeting materials will be published and distributed to WCMCAC members and posted publicly at least seventy-two (72) hours prior to each meeting. Alliance staff will record minutes of meetings which will be approved by the WCMCAC members at each subsequent meeting.
Open and Public meetings	WCCACWCMCAC meetings are open to the public. To facilitate participation WCMCAC members may attend meetings telephonically.
Meeting Location	Meetings will take place virtually. in the Alliance offices listed below and joined together via videoconferencing.telephonically. • In Merced County: Board Room 530 West 16th Street, Suite B, Merced, CA • In Monterey County: Board Room

	COMMITTEE CHARTER
Committee: Whole Child Model Clinical Advisory Committee (WCMCAC)	
Original Date: February 2018	**Last Revision Date:** December~~November~~ 2025~~18~~
Approved by: Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission~~Alliance Board~~	

	~~950 East Blanco Road, Suite 101, Salinas, CA~~ • ~~In Santa Cruz County: Board Room 1600 Green Hills Road, Suite 101, Scotts Valley, CA~~
Translation and Interpreter Services/ Assistive Devices	Requests for translation and interpreter services, including sign-language interpretation or other assistive devices such as real-time c, aptioning, 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.
Review of Charter	The WCMCAC shall review this charter at least annually. Any proposed changes shall be submitted to the Board for approval.

Revision History:

Review Date	Revised Date	Changes Made By	Approved By
11/8/2018	12/6/2018	Danita Carlson, Government Relations Director	Alliance Board
11/01/2025	11/01/2025	Dianna Myers, MD, Interim CHEO	

DATE: March 25, 2026

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

FROM: Mike Wang, M.D., Chief Medical Officer

SUBJECT: Physicians Advisory Group (PAG) 2025 Charter

Recommendation.
Staff recommend the Board approve the 2025 Physicians Advisory Group (PAG) Charter.

Background.
The primary responsibilities of PAG are to 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.
2. Advise the Chief Medical Officer and staff on Alliance programs, policies and communication that affect providers and/or members.

Discussion.
The Physicans Advisory Group (PAG) met on Thursday, December 4, 2025, and approved the updated charter. The revisions included the addition of language noting that physician members attending PAG meetings may receive a stipend for their participation.

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

Attachments.

1. Physicians Advisory Group (PAG) 2025 Charter

	Physicians Advisory Group (PAG) Meeting Charter
Original Date: October 2023	**Last Revision Date:** October 1, 2025
Approved by: Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission	

Purpose	The primary responsibilities of the Physicians Advisory Group (PAG) are to advise and provide perspective to the Chief Medical Officer and staff regarding Alliance policies, programs, and initiatives.
Meetings	Meetings are held quarterly with a minimum of three (3) meetings per year. Meetings fall within the Ralph M. Brown Act (Brown Act). An opportunity for public comment will be offered and agendas and meeting materials will be published and distributed to PAG members and posted publicly at least 72 hours prior to each meeting.
Meeting Compensation	PAG may receive a stipend for participation in the PAG.
Structure and Process	The Chief Medical Officer will serve as Chair and **PAG is a non-voting advisory group and does not require a quorum.**
Committee Membership	PAG consists of between ten and twenty contracted Alliance Primary Care Providers, Chief Medical Officer, Medical Directors, Utilization Management Director, Quality Improvement and Population Health Director, Provider Services Director, Member Services Director, and other staff may attend depending upon agenda items. The specific number of participating physicians shall be determined by the group annually as needed. Membership will reflect demographic representation within practical limits, including geographic distribution, Primary Care and Specialists, as well as structurally distinct practice types (clinics, independent office practice, etc.).

	Members serve a one-year term, renewable by the Commission. Physicians unable to attend at least half of meetings will be encouraged to yield their seats to others with more compliant schedules.
Minutes and Reporting	PAG reports to the Board of Commissioners, through Committee Minutes as well as recommendations for policy revisions and innovations.
Review of Charter	The PAG Charter will be reviewed annually. Any proposed changes shall be submitted to the Board for approval.

Revision History

Review Date	Revised Date	Changes Made By	Approved By
10/13/2023	10/13/2023	Tracy Neves Administrative Specialist	Board of Commissioners
10/01/2025	10/01/2025	Jacqueline Van Voerkens, Administrative Specialist	

DATE: March 25, 2026

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

FROM: Jenifer Mandella, Chief Compliance Officer

SUBJECT: Q3 – 4 2025 Compliance Program Reporting

Recommendation. Staff recommend the Board approve the Compliance Program Report for Q3 – 4 2025, and revisions to the Alliance Compliance Plan.

Summary. This report summarizes the Alliance's Compliance Program activities for Q3 - 4 2025, highlights key compliance risk for the Board's awareness, and includes a recommendation to approve the Compliance Program Report as well as Compliance guiding documents, which have been revised to reflect additional Medicare standards and supporting operational arrangements.

Background. The Alliance is required to implement an effective Compliance Program that meets the requirements set forth in 42 C.F.R. § 438.608, as well as and 42 CFR § 422.503(b)(4)(vi) effective January 2026. In alignment with the United States Federal Sentencing Guidelines' (FSG's) seven elements of an effective compliance program, and articulated in the Compliance Plan and Code of Conduct, the Alliance's Compliance Program takes a systematic and strategic approach to decreasing risk posed by non-compliance, including fraud, waste, and abuse (FWA).

The Alliance Board has delegated authority for overseeing the Compliance Program to the Compliance Committee. The FSGs state "the organization's governing authority shall be knowledgeable about the content and operation of the compliance and ethics program and shall exercise reasonable oversight with respect to the implementation and effectiveness of the compliance and ethics program." Accordingly, the Alliance Board receives updates on Compliance Program activity, including efficacy metrics, through the routine submission of Compliance Committee minutes, the inclusion of key Compliance Program metrics in the Alliance Dashboard, and the receipt of bi-annual reporting from the Chief Compliance Officer.

Discussion. This report serves to inform the Board of the Alliance's Compliance Program activities for Q3 - 4 2025.

Program Updates

As with the remainder of the organization, Compliance staff dedicated much of 2025 to adjusting existing processes and building new processes, when needed, to align with CMS expectations and incorporate Medicare-specific operations and risk areas. The Q1-2 Compliance Report outlined a number of those changes, including

- Revisions to Compliance Plan guiding documents, including the Compliance Plan and Code of Conduct;

- Instituted more frequent Board reporting;
- Modified processes to intake and implement federal program updates, and processes related to reviewing and filing marketing materials, as needed;
- Modified organizational compliance training to incorporate CMS-required content; and
- Centralized administration of HIPAA, FWA and other compliance concerns; and
- Development of processes to identify first tier, downstream, and related entities (FDRs) and modifications to existing delegate oversight processes to incorporate Medicare standards.

In the latter half of 2025, Compliance staff implemented the afore-mentioned changes while simultaneously continuing the build-out of CMS-compliant processes, as follows:

- Enhanced compliance governance and oversight by reconfiguring the Compliance Committee membership and reporting structure. Core committee membership has been limited to executives and key director and management staff, with ad-hoc attendees as needed to address specific issues. This change provides the opportunity for open discussion and solutioning on risks and frames the Committee as an action-oriented decision-making board. Compliance oversight of risk has been improved through formal reporting across Program Integrity, HIPAA, Delegate Oversight, Internal Audits & Monitoring, Regulatory Affairs, NCQA oversight, and Medicare compliance, with formal Committee review of risk assessments, monitoring outcomes, and corrective actions to ensure timely identification and mitigation of compliance risks.
- Overhauled the organizational risk assessment process to be more focused on data and objective escalation criteria, and to incorporate Medicare risk areas; this is in the final stages and once approved by Compliance Committee, will drive the annual audit plan;
- Advanced ability to proactively identify and address FWA through identifying and planning implementation for a FWA detection software;
- Partnered with business units to ensure the Alliance Dashboard addresses CMS standards; this work will continue into 2026;

Legal and Regulatory Updates

Compliance staff track and analyze federal and state regulatory developments and new requirements, and manage internal processes to ensure implementation of legislation, contract changes, and sub-regulatory guidance. A brief summary of significant regulatory developments is provided below for Board awareness.

Federal Medicaid Policy Changes (H.R.1). H.R. 1, signed into law July 4th, 2025, is being monitored by staff to assess potential impacts to the Plan and the broader Medi-Cal delivery system. The impacts of H.R. 1 include changes to provider funding mechanisms like state directed payments, outright prohibitions on the use of federal funding to reimburse certain provider types, and changes to member eligibility criteria; all of which put fiscal pressure on state Medicaid programs, which in turn is expected to flow down to managed care program funding and Plan revenue.

H.R. 1 was enacted within a broader environment in which plans and providers operating in California increasingly grapple with conflicting federal directives and state policy priorities.

Examples include areas such as gender-affirming care, where California has legally required coverage that federal policy now challenges, and in the delivery of programs aimed at addressing social determinants of health (SDOH), including housing stabilization and nutrition supports.

Interaction with State Environment. Medi-Cal spending has grown substantially in recent years, and the state faces a significant budget deficit. Recent state budget analyses and DHCS policy discussions signal increased focus on managed care plan oversight, program integrity, and cost containment; meaning, health plans should expect less revenue, and heightened scrutiny from both federal and state regulators simultaneously.

Enhanced Focus on Medi-Cal Program Integrity. Recently communications from the federal government to Governor Newsom's office send a strong signal that program integrity and fraud prevention is a key priority of the administration.

- On January 27, 2026, CMS Administrator Dr. Mehmet Oz sent a formal letter to Governor Newsom citing serious concerns about program integrity, eligibility verification, and provider eligibility and oversight within the Medi-Cal delivery system. CMS noted over $1.6 billion in federal financial participation funding had been recouped from California, representing more than 88% of total national recoupments across all states operating similar programs. The letter specifically flagged a number of areas of concern, including hospice, home health, behavioral health therapy (BHT), and housing and SDOH-related services, as well as a number of carved out Medi-Cal services including In-Home Supportive Services (IHSS) and substance use disorder (SUD) treatment, CMS required a comprehensive action plan from the state within 21 days, covering fraud and improper payment controls, eligibility and immigration status verification, provider screening and enrollment practices, and delivery system oversight mechanisms. The letter signals that CMS views California's program integrity infrastructure as inadequate relative to the scale of its Medi-Cal program.
- DHCS responded on February 17, 2026, contesting several of CMS' characterizations while affirming the efficacy of its program controls. They cited an average annual return on investment of $8.6 for every $1 spent on its audits and investigations function; over 1,700 fraud referrals received monthly; and longstanding collaborative relationships with CMS, the DOJ, FBI, and OIG. DHCS did object to certain elements of CMS's data requests, specifically the demand for immigration identifiers for all Medi-Cal beneficiaries, citing active litigation and a federal court injunction limiting data sharing about lawfully present recipients. The response illustrates the broader tension between federal oversight ambitions and California's legal and policy posture, and signals that this dynamic is likely to be ongoing and contested.
- On March 3, 2026, the U.S. House Committee on Energy and Commerce sent a parallel letter to Governor Newsom and CHHS Secretary Johnson demanding detailed information about California's fraud controls. The letter was an outcome of a Committee hearing in February 2026 at which expert witnesses testified that Medicaid fraud schemes increasingly cross state lines and that the highest risk areas were home and community-based services (HCBS), non-emergency medical transportation (NEMT), BHT, and SUD treatment. The Committee explicitly identified California's Medi-Cal program as potentially vulnerable to such schemes. As did CMS,

the Committee demanded a comprehensive written response within 14 days covering fraud detection and investigation activities, provider screening and disenrollment practices, program integrity measures across high-risk service categories, and improper payment data going back to 2021.

Taken together, these actions place DHCS, and by extension, contracted plans, under federal scrutiny. Plans should expect that DHCS will respond to this pressure through increased oversight and compliance demands.

Medicare Advantage Compliance Program Guidance. The Office of Inspector General recently issued industry segment-specific compliance program guidance for Medicare Advantage Organizations, highlighting risks associated with operating a Medicare Advantage (MA) plan. Key risk areas include marketing practices and beneficiary inducements, risk adjustment and diagnosis coding accuracy, prior authorization and utilization management, and oversight of first-tier, downstream, and related entities (FDRs).

This guidance provides helpful direction to support risk assessment and prioritization; especially important as a new entrant into the MA space. In addition, the guidance signals potential areas of focus for the Medicaid program, an area for which the OIG has yet to release industry-specific guidance.

Implications for the Alliance. Taken together, these developments reflect a new era of heightened scrutiny from our regulatory agencies. This emerging environment is defined by three converging pressures: financial constraints that will reduce revenue available to states plans, and providers; heightened scrutiny from a program integrity lens; and increasing friction between federal and state policy. Beyond regulatory and financial risk, the end result of this instability are our members who depend on this coverage and the providers who make that coverage meaningful.

Compliance staff are actively monitoring federal and state implementation guidance and coordinating across departments to assess operational, financial, and regulatory implications for the Alliance, our members, and provider network.

Regulatory Audits

The Alliance undergoes routine audits and examinations of its finances and operations by its regulatory oversight agencies, as well as by independent auditing firms. Following is a list of audits and examinations that the Alliance was involved in during Q3-4 2025, including the auditing entity and a description of the audit status.

- 2025 DHCS Medical Audit – This is a routine audit that assesses plan performance in service delivery, access and availability, member rights, and administrative capacity. DHCS issued its final report in June 2025, identifying two findings related to Grievance and Appeals. The Alliance implemented corrective actions including enhanced supporting processes and improved documentation practices. DHCS confirmed closure of both findings in Q4 2025.

- 2026 DHCS Medical Audit – DHCS approved the Alliance's request to defer its 2026 routine Medical Audit due to launch of the Alliance's TotalCare D-SNP program. The next Medical Audit will occur in January 2027 and will cover a two-year review period.

Regulatory Notices of Non-Compliance

Regulators routinely monitor the Alliance's activities to confirm compliance with requirements. Where regulators have found the Alliance to be non-compliant, they may issue warning letters or notices of non-compliance, may implement corrective action plans (CAPs), and may impose sanctions. Following is a list of active concerns addressed during Q3-4 2025.

- DHCS Pre-CAP for Transitional Rent (TR) Model of Care – The Alliance continues efforts to establish TR provider agreements across all service counties. DHCS issued pre-CAP notices in December 2025 to plans that had not yet secured a provider in each county; this approach was taken statewide due to implementation challenges across plans. The Alliance currently has an active TR provider in Merced County, with additional agreements in progress across its remaining counties. The Alliance continues providing DHCS with monthly implementation updates while finalizing provider participation across all Alliance service area counties.
- DMHC timely access sanctions – Following engagement with the DMHC regarding a $15,000 administrative penalty tied to the Alliance's MY 2019 Timely Access Report (submitted in 2020), the Department rescinded its financial penalty in October 2025 and instead reclassified the matter as an admonishment with no monetary penalty.

Privacy and Security

The Alliance maintains a comprehensive process to ensure appropriate controls are in place to prevent inappropriate access to Alliance systems and data, as well as to prevent unnecessary disclosure of protected health information (PHI). Where such access or disclosure does occur, the Alliance maintains a process to investigate, respond, and report disclosures to relevant oversight bodies. The table below summarizes HIPAA Program activity for Q3 - Q4 2025.

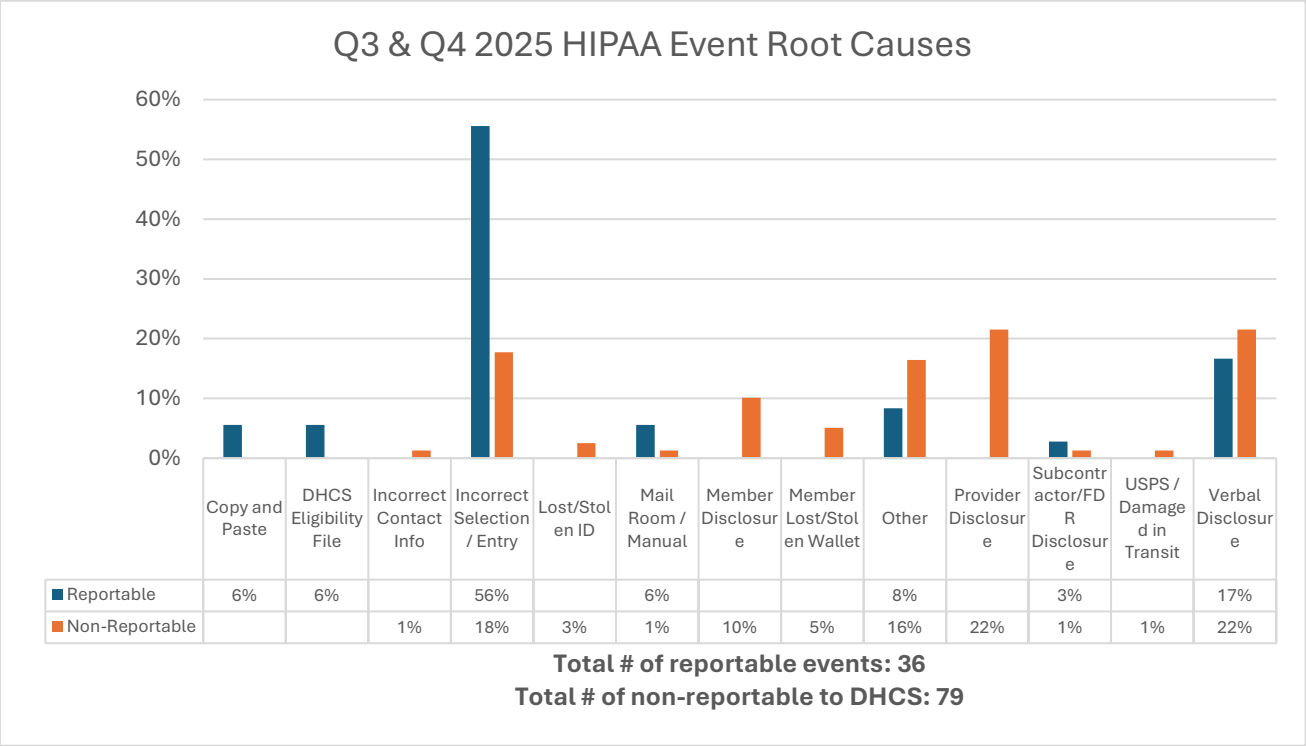
		Q3 2025	Q4 2025
Referrals Received		59	56
Investigation Outcome	Breach	0	1
	Incident	20	15
	Non-reportable	39	40
	Pending	0	0
Members Impacted		5,627	3,280

Referral volume remained high in the second half of 2025, with 59 referrals in Q3 and 56 referrals in Q4. Both quarters saw volume well over the three-year average of 37 referrals per quarter. Consistent with the first half of the year, 37% of referrals required DHCS notification pursuant to the DHCS Medi-Cal contract, with one referral determined to be a breach.

During the reporting period, 7,342 Alliance members were impacted by incidents and/or breaches. The majority of the impacted members are associated with two events: (1) the

disclosure of information beyond minimum necessary to a contracted partner (5,500 members); and (2) a breach resulting from a cybersecurity event impacting a prior vendor (1,300 members). As a routine practice, corrective action is put in place to prevent recurrence.

Compliance staff conduct root cause analysis on all referrals, whether a reportable disclosure occurred or not, as shown below. Incorrect selection/entry, lost/stolen wallets, and verbal disclosures are typically the main drivers of HIPAA referrals, with all those root causes reflected in Q3-4 data. However, for this reporting period, provider disclosures surpassed lost/stolen wallets as a top root cause.



	Copy and Paste	DHCS Eligibility File	Incorrect Contact Info	Incorrect Selection / Entry	Lost/Stolen ID	Mail Room / Manual	Member Disclosure	Member Lost/Stolen Wallet	Other	Provider Disclosure	Subcontractor/FDR Disclosure	USPS / Damaged in Transit	Verbal Disclosure
Reportable	6%	6%		56%		6%			8%		3%		17%
Non-Reportable			1%	18%	3%	1%	10%	5%	16%	22%	1%	1%	22%

Total # of reportable events: 36
Total # of non-reportable to DHCS: 79

Finally, during the reporting period, Compliance staff and Information Technology Services (ITS) staff continued close collaboration through an informal privacy and security meeting. A key area of focus was the biennial HIPAA/NIST assessment conducted by an external vendor. The 2025 assessment evaluated the Alliance's alignment with HIPAA requirements and the NIST framework. Overall, results were positive, with a small number of expected gaps identified; remediation efforts are being prioritized and incorporated into our existing technology road map.

FWA Prevention, Detection, Investigation and Reporting

The Alliance Program Integrity function is responsible for ensuring the Plan has controls in place to prevent and detect FWA, and to investigate, report, and resolve suspected and/or actual FWA. In limited instances, Alliance delegates may conduct some FWA-related activities at the Plan's direction. The table below summarizes Program Integrity investigative activity for Q3 – 4 2025.

	Q3 2025	Q4 2025
Referred	162	135
Opened	86	78
Reported	86	77

As with the beginning of the year, referral volume in Q3-4 2025 remained well above the 5-year average of 20 referrals per quarter. Referral volume and activity is largely driven by member and provider-related referrals linked to Enhanced Care Management (ECM) and Community Supports, non-medical transportation (NMT), laboratory, and hospice/palliative care. Almost all cases opened after initial assessment met the threshold for DHCS reporting. In addition to the required DHCS reporting, 10 reports of suspected provider FWA were made to the CA Department of Justice (DOJ), and 7 reports were made to Monterey County for IHSS-specific concerns. The Alliance also receives referrals, including credible allegations of fraud, and data requests from state law enforcement agencies such as DHCS and DOJ. Staff note an increase in these requests, with 11 investigations opened in the reporting period and no apparent trend in provider or service type that would suggest areas of interest.

In addition to making required reports, Plan staff ensure action is taken to resolve the concern at hand and prevent recurrence. This may include providing education, issuing CAPs, and/or implementing or enhancing internal controls. As examples, Compliance and Care Management staff are partnering to enhance internal ECM controls and provider oversight. In addition, Compliance is supporting Member Services in implementing more controls to prevent FWA in the NMT benefit. Compliance reporting indicates these corrective actions are effective as there were minimal repeat concerns during the reporting period.

Where the Alliance identifies overpayments, those recoupments are pursued in accordance with DHCS and CMS requirements. The table below includes the Program Integrity-initiated claim recoveries for Q3 – Q4 2025. We suspect this under-represents recoveries attributable to Compliance investigations, and staff are working to align reporting methodologies with what we expect regulators to be benchmarking plans against in coming months.

Recoupment	Alliance-initiated	Delegate-initiated
Requested Recoupment	$11,880.37	N/A
Completed Recoupment	$21,823.64	N/A

Finally, Program Integrity staff collaborate with regulators and other plans through activities such as attendance at the DOJ quarterly and statewide Managed Care Anti-Fraud Trainings. Discussion at the 2025 meetings so far have largely focused on laboratory, hospice, and ECM

providers, with information shared in these forums informing contributing to multiple internal investigations.

Delegate Oversight

Where regulated plan functions are carried out by a contracted entity, the Alliance is obligated to ensure those operations are compliant. Prior to delegating any functions, the Alliance conducts a pre-delegation audit to ensure adequate procedures are in place, and oversees the performance of those core functions through annual desk audits and review of quarterly reporting. Where delegate documentation does not demonstrate full compliance, staff request clarification and/or implement CAPs, as indicated,

The Alliance contracts with 13 entities (12 active during the report period) considered delegates for administrative and clinical Plan functions for its multiple lines of business, with details as follows.

Name	Description and Delegated Functions	Lines of Business	Activity and Notes
AristaMD	Provides specialty eConsult for contracted PCPs. Delegated functions: Credentialing/Recredentialing	Medi-Cal	Existing delegate; routine oversight in place
Call The Car	Manages and administers non-medical transportation benefit. Delegated functions: Quality Improvement, Member Experience	Medi-Cal	Existing delegate; routine oversight in place
Carelon	Managed non-specialty mental health (NSMH) benefit for Medi-Cal and complete BH and substance use disorder benefits for IHSS. Delegated functions: Claims Processing, Provider Disputes, Member Connections, Member Grievances, Credentialing / Recredentialing, Network Management, Quality Improvement, Utilization Management	Medi-Cal IHSS	Delegation agreement terminated 7/1/2025. Oversight of claims payment continues through runout period, ending 6/30/2026.
CareNet	Provides nurse advice line and health information form information collection Delegated functions: Call Center	Medi-Cal	Existing delegate; routine oversight in place
ChildNet	Medical group and hospital provider. Delegated function: Credentialing/Recredentialing	Medi-Cal	Existing delegate; routine oversight in place
Dignity Health	Medical group and hospital provider.	Medi-Cal D-SNP	Existing Medi-Cal delegate; contract expanded to include D-SNP effective

Medical Foundation	Delegated function: Credentialing/Recredentialing		01/01/2026; predelegation assessment approved without conditions.
Grow Therapy	Technology-enabled mental health platform connecting patients with licensed behavioral health therapists and prescribers. Delegated function: Credentialing/Recredentialing	Medi-Cal D-SNP	New delegate, effective 3/14/2026. Delegation approved with conditions, related to updating policies to document existing practices regarding plan notification of suspended providers.
Lucile Packard Children's Hospital	Medical group and hospital provider. Delegated function: Credentialing/Recredentialing	Medi-Cal	Existing delegate; routine oversight in place
MedImpact	Pharmacy benefit manager that manages and administers prescription drug benefits. Delegated functions: Call Center, Provider Disputes, Utilization Management, Grievance & Appeals, Credentialing/Recredentialing, Member Experience, Claims, Pharmacy Benefits	D-SNP IHSS	Existing IHSS delegate. Relationship expanded to include CMS Part D Pharmacy benefit effective 1/1/2026. New MA plans are required to engage a PBM to administer Part D in first 2 years of operation. Predelegation conducted in 2024 to enable Part D bid submission; CAP closed in Q4 25, as noted below.
Palo Alto Medical Foundation	Medical group providing PCP, ancillary, and specialty services. Delegated function: Credentialing/Recredentialing	Medi-Cal D-SNP	Existing Medi-Cal delegate; contract expanded to include D-SNP effective 01/01/2026; predelegation assessment approved without conditions.
Santa Clara Valley Medical Center	Medical group and hospital provider. Delegated function: Credentialing/Recredentialing	Medi-Cal D-SNP	Existing Medi-Cal delegate; contract expanded to include D-SNP effective 01/01/2026; predelegation assessment approved without conditions.
Stanford	Medical group and hospital provider. Delegated function: Credentialing/Recredentialing	Medi-Cal	Existing delegate; routine oversight in place
UCSF	Tertiary care hospital provider. Delegated function: Credentialing/Recredentialing	Medi-Cal	Existing delegate; routine oversight in place
Vision Service Plan	Administers limited vision benefit for Medi-Cal and D-SNP supplemental vision benefit. Delegated functions: Quality Improvement, Provider Disputes, Network Management, Provider Services, Claims, Quality Management, Member Experience, Grievance & Appeals, Credentialing/Recredentialing	D-SNP Medi-Cal	Existing Medi-Cal delegate; contract expanded to include DSNP effective 1/1/2026; predelegaton assessment approved without conditions.

As a standard, Plan staff conduct quarterly assessments of delegate performance using retrospective data (e.g., assessments conducted in Q3 would review Q2 delegate performance). During the reporting period, 51 quarterly reviews were initiated, with an average of 75% reviews closed. Detailed statistics are as follows.

Function		Claims	Provider Disputes	Member Connections	Grievance & Appeals	Cred / Recred	QI	UM	Network Adequacy	Case Management
Q3 2025										
Scheduled:	28	3	3	3	3	10	2	1	2	1
Closed:	23	3	3	3	3	5	2	1	2	1
	82% Closed		*Open assessments are currently pending additional delegate or SME documentation*							
Q4 2025										
Scheduled:	23	3	3	3	2	10	1	1		
Closed	15	3	3	1	1	5	1	1		
	65% Closed		*Open assessments are currently pending additional delegate or SME documentation*							

Additionally, in support of our TotalCare launch, Compliance staff assessed existing vendors to identify First Tier Entities (FTEs). 30 entities were categorized as FTEs, including vendors connected to language access, network adequacy and availability, and provider directory, to name a few. The Alliance requires all FTEs to complete an attestation upon contracting an annually thereafter affirming the entity's ability to meet key compliance and FWA program requirements. Of the 30 assessments issued, 18 met plan expectations, 9 are pending initial response or additional information, and 3 have identified risks, which will be explored further via internal audit in the coming months. Beginning in 2026, this report will include information on oversight of FTEs as a standard.

Where concerns are identified with delegate and FTE performance. Compliance staff issue CAPs and work with delegates and business units to support CAP completion and closure. The table below summarizes delegate CAP activity in the reporting period.

Status	Entity	Concern
Closed	MedImpact	Concern identified with readability of Notices of Action (NOAs). MedImpact developed plan-approved letter templates for the top 5 denied drugs, created staff work instructions, provided additional staff training, and implemented a letter-readability quality control process. Staff determined the corrections were sufficient and closed the CAP.
Closed	MedImpact	CAP imposed as an outcome of pre-delegation assessment of PBM for Part D benefits administration. A total of 11 functions will be delegated, including call center, drug utilization review, claims, and appeals. The delegate met the terms of our CAP and this was closed on 12/22/25.

Internal A&M Program

The Alliance's Internal Audit & Monitoring (IA&M) Program proactively assesses compliance with regulatory and contractual obligations, ensures internal controls are in place to prevent and

detect non-compliance, and implements corrective action when non-compliance is identified. The IA&M program includes conducting targeted audits of risk areas and routine monitoring of compliance-related metrics on the Alliance Dashboard.

During the reporting period, staff closed 7 audits of medium-risk areas, focused on utilization management, pharmacy, IT security, and member services. There is a need to develop audit process and management to ensure staff are able to conduct more audits per quarter, given the introduction of new operational areas via TotalCare, and the increasing scrutiny expected from the federal government, related to both Medicare oversight and the changing environment.

2 of 5 audits received a failing result during, with details as follows.

- Employee Permissions – which assessed whether staff were timely removing system access for staff and contractors upon termination or separation. While this particular audit showed a gap related to contracted workforce members, a system was implemented in early 2026 that automates and tracks onboarding and separation for all workforce members. Staff do not expect this audit finding to recur.
- Non-Emergency Medical Transportation (NEMT) - which reviewed whether provider certification forms were on file for all members receiving NEMT. This specific form is a focus of DHCS; and staff identified deficiencies in listed date ranges and form content. As transportation services are a growing concern with state and federal agencies, staff intend to expand the review of NEMT services beyond form compliance in 2026.

For all aforementioned areas, Compliance staff ensured the implementation of corrective action – either through documented action plans or formal CAPs - and will assess the need to re-audit to confirm full remediation.

Routine monitoring of compliance-related metrics on the Alliance Dashboard revealed that two regulatory metrics related to provider dispute resolution timeliness, continued to not meet thresholds. Compliance had initiated CAPs in Q2 of 2025, and intends to keep them open until acceptable performance is achieved. To date, plan staff have implemented a technology-supported triage and case assignment mechanism, which has shown a reduction in time to case closure in the initial months of operation. The plan also plans to launch an enterprise project in Q2 26 to support dispute processing via technology and process interventions.

		Q3 2025 monitoring	Q4 2025 monitoring
Total Metrics Monitored		34	34
Result	Pass	32	32
	Fail	2	2

Confidential Reporting

In support of the requirement to ensure effective lines of communication from staff to the Compliance Officer, the Alliance maintains a confidential hotline, which Alliance staff may use to report compliance issues anonymously. During Q3-4 2025 three reports were received trough the hotline; one was an employee-related concerns managed by Human Resources, one was a compliance concern managed by Compliance, and one was a combined employee relations-compliance concern jointly managed.

The Alliance also maintains a reporting mechanism on its public website that enables members, providers, contractors, or any other person or entity to submit reports of non-compliance, including anonymously if desired. During the reporting period, Compliance received a total of 5 submissions through this channel. Each report was reviewed by Compliance staff to determine appropriate follow-up actions.

- 2 reports were submitted by Alliance members aggrieving interactions with an Alliance vendor or provider, one related to a Community Supports provider, and the other to the Alliance's non-medical transportation benefit. Both submissions were re-routed to our Member Services department for intake as a Grievance to be investigated and resolved therein.
- 14 reports were submitted alleging concerns of potential FWA. Reports were reviewed and processed by our Program Integrity Special Investigations Unit and were either voided as not in scope for the Alliance SIU, or were opened for investigation and reported to the appropriate regulatory agency. Reports included:
    - 2 reports alleging medical identity theft;
    - 11 reports of potential provider FWA relating to ECM and/or CS providers (5 reports), general medicine or primary care (3 reports), behavioral health (2 reports), and long-term care (1 report);
    - 1 report of potential FWA related to an Alliance subcontractor.
- 2 reports of HIPAA breaches. One report was related to the afore-mentioned cybersecurity incident involving an Alliance vendor; the other to a security incident experienced by an Alliance provider's vendor, which is not a reportable event.
- 1 report included allegations of potential FWA and privacy concern, both related to an Alliance ECM provider. Program Integrity reviewed through the anti-FWA program as well as the HIPAA privacy program to ensure all allegations were addressed.

Training and Education

All Alliance staff receive web-based compliance training, which reviews FWA prevention, HIPAA policies and procedures, the Alliance's Compliance Plan and Code of Conduct, the Alliance's DHCS Medi-Cal contract, CMS requirements for MA plans, and mechanisms for reporting non-compliance. New hires must complete training within two weeks for staff-level positions, or four weeks for supervisory-level positions. Existing staff are enrolled in the web-based module annually as a refresher.

During the reporting period, 1,392 of 1,471 (95%) of required compliance training modules were completed as assigned. The dramatic increase in volume from Q1-2 (165) is a result of the roll out of a revised compliance module and a new FWA module, both containing CMS-required content. All staff were required to complete the new training modules prior to the January 1 2026 launch of TotalCare, which resulted in several staff receiving compliance training twice during the year.

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

Attachments.

1. Alliance Compliance Plan
2. Q3 & Q4 2025 Internal A&M Dashboard

3. Q3 & Q4 2025 HIPAA Dashboards
4. Q3 & Q4 2025 Program Integrity Dashboards

Alliance Compliance Plan

PURPOSE

The Central California Alliance for Health's (the Alliance's) Compliance Program ensures that the organization and its staff operate in compliance with contractual, regulatory and statutory requirements. Through its Compliance Program, the Alliance maintains its business operations to ensure alignment with these requirements. The Alliance exercises due diligence to prevent and detect criminal conduct, and when necessary, takes corrective action to ensure that its business operations are compliant with governing requirements. The Alliance promotes an organizational culture that encourages ethical conduct and a commitment to compliance with the law. The Alliance takes appropriate steps to ensure that its staff members are knowledgeable of requirements and that they consistently work towards meeting them. To maintain its independence, the Alliance's Compliance Program acts independently of operational and program areas without fear of repercussions for identifying non-compliance.

Following is a description of how the Alliance aligns with the Effective Compliance and Ethics Program guidance published by the United States Sentencing Commission.

WRITTEN POLICIES, PROCEDURES, AND STANDARDS OF CONDUCT

Policies and procedures ensure that Board members, employees, and contractors, including Network Providers, Subcontractors and Downstream Subcontractors, understand and perform their responsibilities in compliance with regulatory and contractual obligations and applicable law. The Alliance maintains policies and procedures that demonstrate compliance with relevant requirements and updates are made as needed to reflect alignment with changing operations and requirements. Compliance Department staff regularly reviews proposed changes to policies and procedures and responds to needs identified through program monitoring. Policies and procedures are developed within the applicable departments, are reviewed and approved through the Policy intake process. Compliance staff leverage compliance's management software to ensure that all Alliance policies are reviewed and/or revised at least annually. Policies and Procedures are available to all staff through the Alliance's Policy Library located on its Intranet. .

The Compliance Department maintains a suite of policies that implement this Compliance Plan, including, but not limited to the following:

- Policies describing the obligations of plan Board members, employees, and contractors to maintain the confidentiality of protected health information (PHI) in accordance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and HIPAA Program operations;
- Policies describing the Alliance's Program Integrity Program, including procedures in place to prevent, detect, investigate, and resolve fraud, waste, and abuse (FWA);
- Policies related to reporting, investigation, and resolution of non-compliance;
- Policies related to the oversight of delegated entities, including Subcontractors and Downstream Subcontractors, and the operations of the Delegate Oversight Program; and
- Policies regarding regulatory audits and the operations of the Internal Audit and Monitoring Program

A full listing of Compliance Department policies can be found in Appendix A.

In addition, the Compliance Plan includes a Code of Conduct, included in a separate document, which guides Alliance Board members, employees, and contractors in conducting their business activities in a professional, ethical, and legal manner. The Human Resources Department also reflects these expectations in its Employee Handbook. In addition to being made available to Alliance staff, this Compliance Plan and Code of Conduct are publicly posted on the Alliance's Intranet.

STRUCTURE AND OVERSIGHT

Alliance Governing Board – The Alliance Governing Board (Board) is responsible for oversight of the Compliance Program. The Board receives and approves reports from the Compliance Program, including: (1) a verbal update no less frequently than annually; (2) quarterly written reports on compliance trends, risks, activities, and outcomes escalated through the Compliance Committee; and (3) ad hoc escalations of significant non-compliance, as warranted. These reports include a review of activities of the Compliance Program, results of internal and external audits, and reporting of other compliance-related issues. To ensure that the Board is aware of the content and operation of the Alliance's Compliance Program, the Board receives compliance training, including FWA prevention training, on appointment and annually thereafter. The Board is also responsible for review and approval of revisions to the Alliance's Compliance Plan and Code of Conduct, which are made at minimum annually.

Chief Executive Officer – The Chief Executive Officer (CEO) provides executive oversight of the Compliance Program and participates in the Compliance Committee to support cross-functional accountability, prioritization, and risk resolution. The Chief Compliance Officer (CCO) reports directly to the CEO, while also maintaining direct access to the Alliance Governing Board, including the ability to escalate significant compliance matters independent of management when necessary.

Compliance Committee – The Compliance Committee serves as the Alliance's primary governance forum for assessing, prioritizing, and directing resolution of organizational compliance risks, trends, and compliance issues. Committee members possess sufficient oversight and decision-making authority to ensure identified compliance issues are acted upon timely, completely and effectively.

The Committee reports to the Board, is comprised of permanent Director and Chief level representatives from across the organization, and is chaired by the CCO. In addition to permanent members, ad hoc Director-level members are required to participate when compliance risks, audits, investigations, or regulatory issues implicate their functional areas.

The Compliance Committee oversees and governs the Alliance's Compliance Program and directs and supports the CCO in the development, implementation, and ongoing effectiveness of the Compliance Program. The Compliance Committee typically meets monthly, but no less frequently than quarterly and may convene additional meetings as necessary to address emerging or urgent compliance issues. Additional responsibilities of the Compliance Committee include, but are not limited to:

- Reviewing information regarding new requirements or changes to existing requirements that are brought before it by the CCO, Compliance Department staff, or Government Relations Department staff, and determining necessary steps for implementation;
- Reviewing and acting upon escalated compliance risks and issues, including determining appropriate disposition, required participants, corrective actions, and internal and external reporting pathways;
- Reviewing and approving an annual Compliance and FDR Risk Assessment developed by Compliance staff; overseeing the outcomes of auditing and monitoring activities identified in the Internal Audit and Monitoring Workplan, and, re-evaluating risk ratings and workplans as necessary based on monitoring outcomes, audit results, and emerging risk indicators;
- Annually reviewing and, as necessary, updating the Code of Conduct and Compliance Plan;

- Ensuring that Compliance and FWA training and education are effective and appropriately completed;
- Reviewing areas of non-compliance and overseeing the development, implementation, timeliness, and effectiveness of CAPs, whether corrective or preventive to mitigate compliance concerns, or those imposed by regulators;
- Overseeing the performance of delegated entities, including the Alliance's Subcontractors, Downstream Subcontractors, First-Tier, Downstream, and Related Entities (FDRs), to ensure their performance on delegated functions meets contractual, legal, and regulatory obligations, and Alliance standards;
- Overseeing the Alliance's Program Integrity activities to ensure that the organization deters, identifies, investigates and resolves potential and actual FWA, both internally and through delegated entities and providers; and,
- Ensuring the Alliance implements appropriate safeguards, including administrative policies and procedures, to protect the confidentiality of PHI and ensure compliance with HIPAA requirements.

The Compliance Committee provides oversight of the Alliance's Compliance Program as set forth in this Compliance Plan across all lines of Alliance business, including Medi-Cal, Medicare Advantage (TotalCare (HMO D-SNP)), and In-Home Supportive Services (IHSS), ensuring that compliance risks, audits, monitoring activities, and corrective actions are appropriately identified, escalated, and addressed within each line of business.

In addition to the Compliance Committee, the Alliance has other committees that oversee its contractual, legal, and regulatory obligations, including the following:

Quality Improvement and Health Equity Committee

The Quality Improvement and Health Equity Committee (QIHEC) monitors progress on the Quality Improvement work plan, oversees Utilization Management activities, and receives reports from the Pharmacy and Therapeutics Committee. In addition, the Committee oversees various plan activities including: care-based incentives, HEDIS results, analysis and suggested interventions, disease management and educational programs, cultural and linguistic initiatives, grievances and potential quality issues, emergency department utilization projects, and the annual review of Alliance's preventive health guidelines. The QIHEC reports its activities to the Board on a regular basis.

Staff Grievance Review Committee

The Staff Grievance Review Committee (SGRC) monitors and reports on trends in member complaints and provider disputes to assess timeliness, appropriateness of resolution, and opportunities for upstream process improvement. The SGRC focuses on identifying recurring issues and systemic drivers of dissatisfaction and recommending operational improvements to prevent repeated concerns. SGRC reports its activities to the Interdisciplinary Clinical Quality Improvement Workgroup and the Board on a regular basis.

Chief Compliance Officer – The CCO, under the guidance of the CEO, directs the Compliance Program in support of Alliance goals, provides executive leadership in developing, implementing, and monitoring the Alliance's Compliance Program, serves as the HIPAA Privacy Officer and Fraud Prevention Officer, and chairs the Compliance Committee in accordance with its Charter. The CCO executes the Compliance Program under the governance, oversight, and direction of the Compliance Committee. The CCO maintains a direct reporting relationship to the Board, providing routine reports and updates to the Board on Compliance Program activities, including matters escalated through the Compliance Committee. The CCO is responsible for overseeing the implementation of the Compliance Program, including defining the program structure, educational requirements, reporting and complaint mechanisms, response and correction procedures, and compliance expectations of all staff and contractors. In the event the CCO is unavailable, the Compliance Director serves as the backup Compliance Officer, Privacy Officer, and Fraud Prevention Officer. The CCO, in coordination with the Compliance Committee and staff, ensures the following activities are performed:

- Ensuring that updates from the Compliance Program are presented to the CEO and the Board on a periodic basis;
- Escalating significant compliance risks, investigations, audit findings, and systemic issues to the Compliance Committee and/or Board, as needed;
- Ensuring that the Alliance's Compliance Programs, including the Delegate Oversight Program, HIPAA Program, Internal Audit and Monitoring Program, and Program Integrity Program adhere to relevant state and federal requirements, are responsive to the Alliance's needs, and are effective in identifying and mitigating, and ultimately preventing compliance risk;
- Ensuring processes and reporting mechanisms are in place that encourage staff to report suspected noncompliance, FWA, PHI disclosures, or other misconduct without fear of retaliation;
- Ensuring that effective compliance training is in place and that staff are aware of the Alliance's Compliance Program, Code of Conduct, and all applicable statutory and regulatory requirements as applicable to their roles;

- Ensuring effective processes are in place to allow two-way communication between the Compliance Division and Alliance staff such that staff are aware of new and changing requirements and are knowledgeable about how to report noncompliance, suspected FWA, or other misconduct without fear of retaliation; and
- Ensuring corrective action plans (CAPs) are implemented when non-compliance is identified, consistent with direction and oversight provided by the Compliance Committee, and that the CAPs address the identified root cause for durable remediation.

Compliance Director – The Compliance Director, under the guidance of the CCO, executes and oversees the Compliance Program in support of Alliance goals, directs the Alliance's Compliance function. The Compliance Director is responsible for implementing Compliance Program, including ensuring that the Compliance Plan is implemented, maintaining reporting and complaint mechanisms, directing response and correction procedures, and recommending revisions to the Compliance Program to meet organizational need. The Compliance Director, in coordination with the Compliance Committee and staff, ensures the following activities are performed:

- Escalating compliance risks, investigations, and systemic issues to the Compliance Committee in accordance with the established risk-based triage and escalation framework;
- Directing and overseeing the Alliance's Compliance Programs, including the Delegate Oversight Program, HIPAA Program, Internal Audit and Monitoring Program, and Program Integrity Program to ensure alignment with the CCO's stated objectives;
- Interacting with the operational units of the company and being involved in and aware of the daily business activities;
- Maintaining processes that encourage staff to report potential compliance concerns without fear of retaliation;
- Ensuring reports of potential instances of FWA, disclosures of PHI, and noncompliance are resolved, including overseeing internal investigations and developing corrective or disciplinary actions, if necessary;
- Maintaining documentation for each report of potential noncompliance or FWA received;
- In partnership with the Alliance's Human Resources Department, developing training programs to ensure that staff are aware of the Alliance's Compliance Program, Code of Conduct, and all applicable statutory and regulatory requirements;
- Maintaining the compliance reporting mechanism and initiating audits through the Internal Audit and Monitoring Program, operational departments, and the Program Integrity function, where applicable;

- Ensuring that the Alliance does not employ or contract with individuals excluded from participation in federal programs. This function has been delegated to the Alliance's Human Resources Department, Provider Services Department, and Administrative Contracts Unit; and,
- Overseeing development and implementation of CAPs.

Compliance Manager – The Compliance Manager reports to the Compliance Director and is responsible for managing the day-to-day activities of the core Compliance Program functions, including the Internal Audit and Monitoring Program,, Delegate Oversight Program, and regulatory audit coordination.

Compliance Specialists – Compliance Specialists are responsible for conducting day-to-day operational work related to implementation of the Alliance's Delegate Oversight Program and Internal Audit and Monitoring Program. Compliance Specialists are also responsible for managing regulatory audits, including pre-onsite and onsite document requests and logistics, and coordinating any required CAPs. Other duties may be assigned as appropriate.

Program Integrity Manager – The Program Integrity Manager reports to the Compliance Director and is responsible for managing the day-to-day activities of the Alliance's Program Integrity and HIPAA Privacy Programs, including oversight of FWA prevention; investigations and related resolution activities; regulatory reporting; HIPAA privacy incident intake and breach risk assessment; and coordination of corrective actions and mitigation efforts. In coordination with Compliance leadership, this Manager also oversees investigations of Compliance Concerns, as reported and received through the Alliance's reporting channels defined in this Compliance Plan.

Program Integrity Specialists - Program Integrity Specialists are responsible for conducting day-to-day operational work in support of the Alliance's Program Integrity and HIPAA Privacy Programs, including investigation of potential FWA; HIPAA privacy incident investigations and breach risk assessments; review of claims, medical records, and protected health information; documentation of investigative findings; and coordination with internal and external parties. Specialists escalate investigative and privacy-related matters in accordance with the Compliance Department's risk-based triage and escalation framework.

Regulatory Affairs Manager– The Regulatory Affairs Manager reports to the Compliance Director and is responsible for managing the day-to-day activities of the Alliance's

regulatory affairs function, which includes analyzing and monitoring state and federal policy, legislation and regulations affecting the Alliance; maintaining systems and procedures to intake, assessing and implementing regulatory policies and legislative information; and ensuring the submission of timely and accurate program reporting to regulators.

Regulatory Affairs Specialists – Regulatory Affairs Specialists are responsible for conducting day-to-day operational work related to implementation of new requirements, policy development and maintenance, regulatory reporting, and regulatory filings. Other duties may be assigned as appropriate.

Medicare Compliance Program Manager - The Medicare Compliance Program Manager reports to the CCO and is responsible for supporting the day-to-day operations of the Alliance's Medicare-integrated compliance program, including Medicare Advantage and D-SNP requirements. Responsibilities include oversight and support of Medicare-specific compliance monitoring, auditing, issue tracking, regulatory reporting, and corrective actions, and ensuring overall alignment with CMS requirements and guidance. The Medicare Compliance Program Manager coordinates with Compliance department staff and operational departments, and escalates Medicare-related compliance risks and issues in accordance with the Compliance Department's risk-based triage and escalation framework.

NCQA Compliance Program Manager - The NCQA Compliance Program Manager reports to the Compliance Director and is responsible for managing the day-to-day operations of the Alliance's NCQA compliance and accreditation programs. Responsibilities include oversight of NCQA Survey readiness, NCQA Standards implementation, evidence management, compliance monitoring, corrective actions, and regulatory submissions related to NCQA requirements. The NCQA Compliance Program Manager coordinates with Compliance department staff and operational departments, and escalates NCQA-related compliance risks and issues in accordance with the Compliance Department's risk-based triage and escalation framework.

Government Relations Director – The Government Relations Director is the primary health plan contact with external regulatory and government agencies. The Government Relations Director monitors legislative, regulatory, and contractual requirements to identify new or changing, policies, standards, laws and regulations that may impact plan operations and ensures that these are brought to the relevant departments for review and implementation.

EDUCATION AND TRAINING

As part of their orientation and training, Alliance staff are informed of the Alliance's commitment to compliance with contractual, regulatory and legal standards. New employees receive general compliance training and receive a copy of the Compliance Plan, Code of Conduct, and policies and procedures pertinent to that individual's job responsibilities, where applicable.

General compliance trainings are conducted via the Alliance Learning Center (ALC), a web-based training module, for all employees upon initial hiring. The Learning & Development Unit ensures that all employees are trained on the Alliance's Code of Conduct and Compliance Plan within 90 days of the date of hire and annually thereafter.

Staff are trained on the Alliance's Code of Conduct and Compliance Plan, including but not limited to:

- Policies and procedures relevant to their job functions to ensure compliance with requirements;
- The Alliance's Program Integrity function, including information regarding the False Claims Act and the Anti-kickback Statute;
- HIPAA compliance training, with emphasis on confidentiality of PHI;
- An overview of compliance issues and how to report potential non-compliance or FWA; and
- How to report suspected non-compliance with law or policy to Compliance Department staff.

To gauge the effectiveness of this training, staff are required to take a pre-test prior to the specific training module and a post-test after the completion of the training. The results of these tests indicate enhanced understanding of the Alliance's Compliance Program through effective training. Staff must attain a passing score of 80% in the post-test to complete the training module.

Board members receive a copy of the Compliance Plan, Code of Conduct, and policies and procedures pertinent to their appointment as part of their orientation. In addition, Board members receive general compliance training, including FWA prevention training, as part of their orientation and on an annual basis thereafter.

Compliance staff also monitor reports on an ongoing basis to ensure the following required training is occurring:

- For Member Services staff, training must cover Alliance policies and procedures; contractually required services for all members; how to utilize services in the Medi-Cal program; how to access carved out services; how to obtain referrals to community resources; how to assist members with disabilities and chronic conditions; and diversity, equity and inclusion (DEI) training.
- For staff carrying out obligations under MOUs, training must cover how complaints can be raised and how to resolve disputes between the parties in the MOU.
- For Network Providers, training includes an overview of the Medi-Cal Managed Care program; covered services, policies and procedures for clinical protocols governing prior authorization and utilization management; how to refer to and coordinate care for carved out services; preventive healthcare services including Early Periodic Screening, Diagnosis and Testing (EPSDT); medical record and coding requirements; Population Health Management program requirements; member access, including appointment wait time standards, telephone access, translation and language access services; secure data sharing methods; member rights; DEI training; and advanced health care directives.

EFFECTIVE LINES OF COMMUNICATION

The Alliance has formal and routine mechanisms of communication available to staff, contractors, and members. The Alliance promotes communication through a variety of meetings and processes, including Board meetings, Compliance Committee meetings, Operations Committee, the Administrative Contract Review Process, the Policy intake process, all-staff assemblies, regular departmental meetings, internal committee meetings, and ad-hoc provider and member communications. Additionally, information is communicated to Board members, employees, contractors, and members by email distributions, internal and external websites, reports, newsletters, and handbooks.

Policies and procedures ensure that staff members understand and perform their responsibilities in compliance with their positions and applicable law. Staff members are responsible for complying with the policies and procedures relevant to job descriptions and contractors are responsible for complying with their contractual obligations.

The Alliance expects that all Board members, employees, and contractors report compliance issues including noncompliant, unethical and/or illegal behavior. All compliance issues regarding potential FWA or HIPAA concerns are required to be reported immediately to the Compliance Department for investigation by Compliance Department staff. Reports of non-compliance with standards are investigated by supervisors and/or Compliance Department staff and leadership, as appropriate. Additionally, reports of non-

compliance or other significant compliance concerns are escalated through the Compliance Department's risk-based triage and escalation framework and referred to the Compliance Committee when escalation thresholds are met. The Compliance Committee reviews these reports and ensures corrective actions are implemented and monitored for effectiveness.

The Alliance encourages staff to discuss issues directly with their supervisor or manager, Compliance Department staff, the Human Resources Director, or the Chief Administrative Officer. Should staff not feel comfortable reporting concerns directly, they may do so anonymously through the Confidential Disclosure Hotline. Staff can be assured that they may report compliance issues or concerns without risk of retaliation. The Alliance has a zero-tolerance policy for retaliation or retribution against any employee who in good faith reports suspected misconduct.

The Alliance's Confidential Disclosure Hotline is accessible 24 hours a day to report violations, or suspected violations of the law and/or the Compliance Program as well as concerns with Alliance personnel practices, such as allegations of discrimination, harassment or poor treatment. Additionally, staff may use the Alliance's Confidential Disclosure website.

TOLL FREE CONFIDENTIAL DISCLOSURE HOTLINE

844-910-4228

CONFIDENTIAL DISCLOSURE WEBSITE

https://ccah.ethicspoint.com

Additional reporting information is located on the Compliance Intranet page. The Alliance takes all reports of violations, or suspected violations, seriously and is committed to investigating all reported concerns promptly and confidentially to the extent possible.

The Alliance also maintains a reporting mechanism on its public website that allows members, Network Providers, Subcontractors, or any other person or entity to submit reports of non-compliance, including anonymous reports if desired.

MONITORING AND AUDITING TO IDENTIFY COMPLIANCE RISK

The Alliance conducts monitoring and auditing activities to test and confirm the effectiveness of the Compliance Program, to ensure that plan operations align with

contractual, legal, and regulatory requirements, and to identify the Alliance's organizational risk areas. This includes the evaluation of delegated entities – Subcontractors and Downstream Subcontractors – for compliance with standards, in alignment with the Delegation Reporting and Compliance Plan.

To comply with regulatory and contractual requirements, the Alliance conducts routine internal auditing in identified risk areas and routinely monitors plan performance through the Alliance Dashboard. The Alliance is also subject to external audits by federal and state agencies in connection with the Medi-Cal Program and its IHSS line of business.

Compliance Department staff conduct the Compliance Risk Assessment and develop the Internal Audit and Monitoring Work Plan identifying areas selected for audit and monitoring. The annual Compliance Risk Assessment and Internal Audit and Monitoring Work Plan, as well as material modifications prompted by escalated compliance issues, emerging risks, audit results, or other triage outcomes identified through the Compliance Department's risk-based escalation framework, are reviewed and approved by the Compliance Committee. The Compliance Manager oversees the Internal Audit and Monitoring Work Plan, ensuring that internal audits are conducted, deficiencies are identified, reports are developed, and corrective action is taken, as needed.

DISCIPLINARY STANDARDS

The Alliance does not condone any conduct that negatively affects the operation, mission, or image of the Alliance. The Alliance ensures that standards and policies and procedures are consistently enforced through disciplinary mechanisms. Any employee or contractor engaging in a violation of laws or regulations (depending on the magnitude of the violation) will be disciplined up to, and including, termination from employment or their contract.

In the event of discovery of such activity, the Alliance will implement prompt action to correct the problem and may institute appropriate disciplinary action given the facts and circumstances.

RESPONSE TO COMPLIANCE ISSUES

Upon verification of non-compliance of a particular standard or requirement, the Alliance will take appropriate action steps to correct and prevent repeat non-compliance. These

steps may include disclosing the incident to applicable regulatory agencies, retraining staff, and amending Alliance policies and procedures in an effort to avoid future recurrence. Compliance staff will initiate and document oversight of corrective action to ensure the instance of noncompliance has been effectively mitigated. Matters meeting defined escalation criteria are brought to the Compliance Committee for review, direction, and oversight of corrective action.

Revision History:

Reviewed Date	Revised Date	Changes Made By	Approved By
	8/24/2021	Jenifer Mandella, Compliance Officer	Alliance Board
	8/19/2022	Jenifer Mandella, Compliance Officer	Alliance Board
	8/10/2023, with changes effective 1/1/2024	Jenifer Mandella, Chief Compliance Officer	Alliance Board
	8/14/2024	Jenifer Mandella, Chief Compliance Officer	Alliance Board
	4/24/2025	Jenifer Mandella, Chief Compliance Officer	Alliance Board
	02/04/2026	Jenifer Mandella, Chief Compliance Officer	Compliance Committee, pending Alliance Board approval

Additional Addenda incorporated by reference:

- Appendix B – Non-retaliation Policy
- Appendix C – Code of Conduct

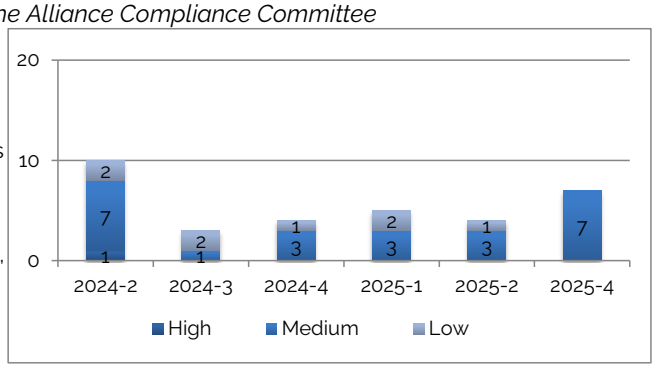
APPENDIX A – COMPLIANCE POLICIES AND PROCEDURES

Policy Number	Policy Title
105-0001	Policy Development, Maintenance, Review and Submission
105-0004	Delegate Oversight
105-0005	Federal Funding Suspension and Debarment
105-0009	Mandated Reporting of Suspected Abuse and Neglect
105-0011	Internal Audit & Monitoring
105-0014	Subcontractor Sanctions
105-0500	External Audits
105-1000	Certification of Data, Information and Documentation
105-1001	Medicare Part C and Part D Plan Reporting
105-1002	Review of Marketing and Communications Materials
105-1003	Medicare Advantage Regulatory Review, Tracking and Distribution
105-2001	Self-Reporting to CMS
105-2002	Prohibition of False Claims
105-2003	Investigation of Sales Allegations
105-3001	Program Integrity: Fraud Waste and Abuse Prevention Program
105-3002	Program Integrity: Special Investigations Unit Operations
105-3003	Suspended, Excluded, and Ineligible Providers
105-3004	Verification of Billed Services by Network Providers
105-4000	HIPAA-HITECH Privacy and Security Glossary
105-4001	Notice of Privacy Practices
105-4002	Accounting of Disclosures
105-4003	No Retaliation or Waiver
105-4004	Privacy Officer Designation and Responsibilities
105-4007	Safeguarding Protected Health Information
105-4008	Uses and Disclosures of Limited Data Sets
105-4009	Minimum Necessary Use and Disclosure
105-4010	Verification of Requester Authority Prior to Release of PHI
105-4011	De-identification and Re-identification of Health Information
105-4012	Use and Disclosure of PHI, including Member Authorizations to Disclose

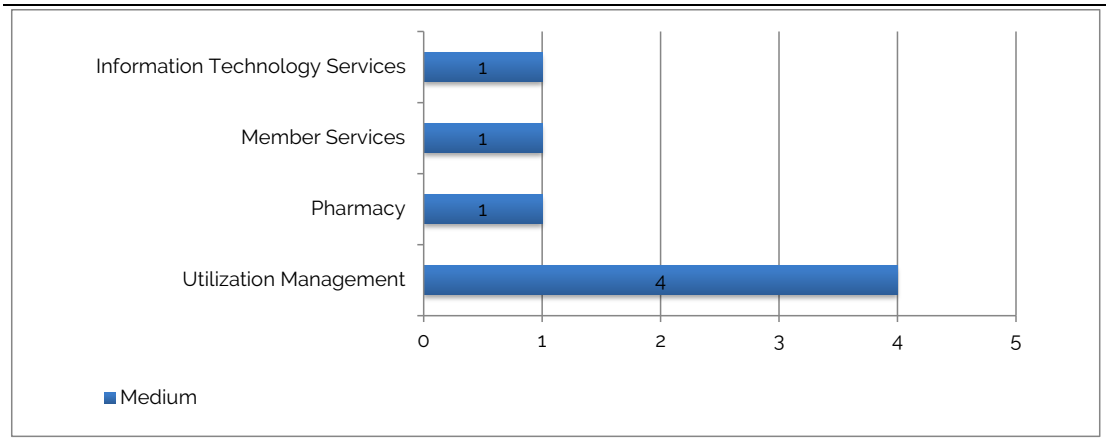
105-4013	Request to Access Records
105-4014	Requests for Amendment of Protected Health Information
105-4017	Permission to Leave Messages with PHI
105-4018	Personal, Authorized and Member Representatives
105-4019	Disclosures to Family, Caregivers and Friends
105-4020	Official Statement: Need for Information About Possible Victim of Crime
105-4020	Disclosures to Law Enforcement and Government Officials
105-4021	Uses and Disclosures about Decedents
105-4022	Uses and Disclosures for Disaster Relief Purposes
105-4023	Uses and Disclosures for Public Health Activities
105-4024	Uses and Disclosures for Treatment, Payment and Health Care Operations
105-4025	Uses and Disclosures for Health Oversight Activities
105-4026	Communication with Minors
105-4027	Disclosures of Protected Health Information of Members with Mental Incapacities
105-4028	Uses and Disclosures for Marketing
105-4029	Breach Risk Assessment and Response
105-4030	Internal Reporting
105-4031	Data Sharing with County Mental Health Plans
105-4039	Access to and Confidentiality of ePHI
105-4043	Compliance Training and Education
105-4044	Disclosing Sensitive Personal Health Information
105-4045	Requests for Confidential Communications and Restrictions on Uses and Disclosures
105-4046	Enforcement Sanctions: Administrative & Monetary Sanctions

Compliance
Internal Audit Dashboard - Q4-2025
Prepared for the Alliance Compliance Committee

Reviews Closed by Risk Level
Compliance closed a total of 7 risk-based internal reviews during Q4-2025. The internal audit program assesses and mitigates risk to ensure Plan readiness for regulatory audits and forthcoming accreditations. Items were selected for the work plan based on recent audit findings, new requirements, and regulatory sanctions.

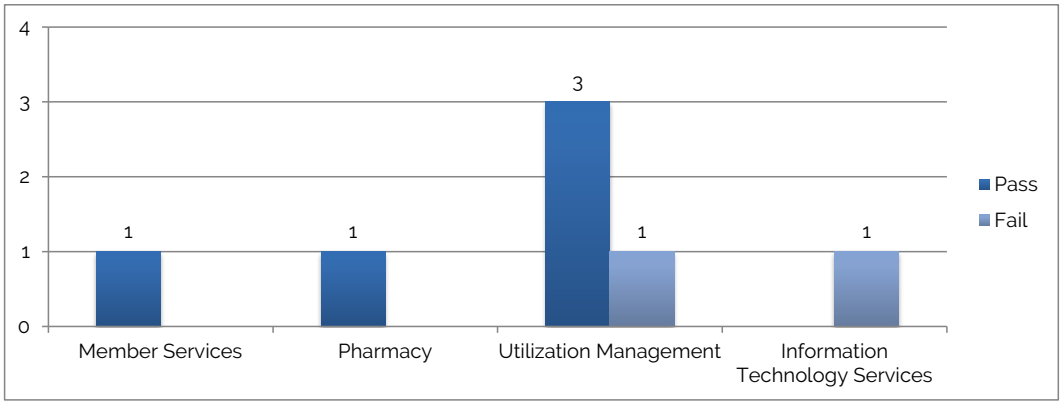


7 Total Reviews Closed in Q4-2025

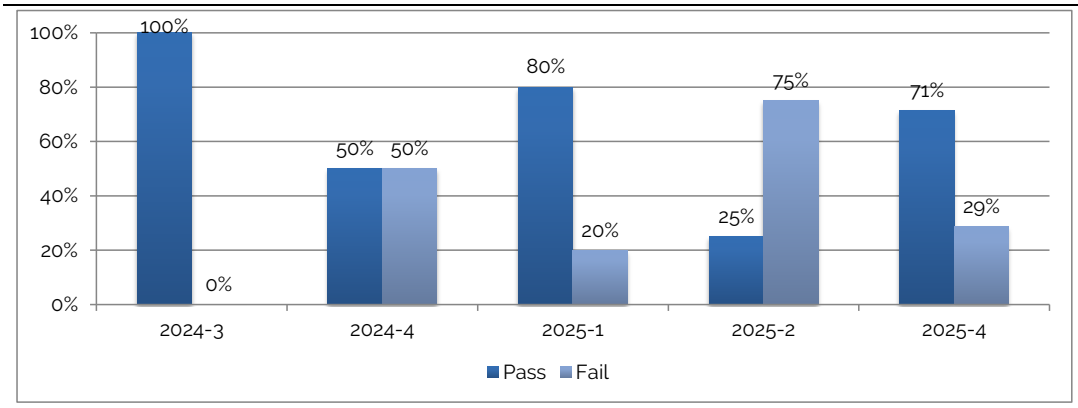


Q4 Reviews by Operational Area & Risk Level
Each review is assigned to a SME department with oversight responsibility of the requirement. The reviews are assigned a risk level based on objective risk criteria such as impact and complexity. The chart shows the number of reviews conducted, separated by department within each risk level.

Q4-2025 Review Results by Operational Area
5 of 7 closed reviews received a passing score
2 of 7 closed reviews received a failing score



Mitigation for Failed Reviews
In response to failed reviews, Compliance partners with SME departments to ensure deficiencies are corrected through the following:
- Recommending process improvements
- Requesting action plans from departments to cure deficiencies
- Re-auditing to ensure correction



Trending and Quarterly Review Results by Risk Level
Information presented here depicts Compliance-issued findings for audits conducted over the past 4 quarters.

Q4-2025 Outcomes
High Risk Areas: N/A
Medium Risk Areas: 71% passed
Low Risk Areas: N/A
Overall Result: 71% Passed

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Compliance

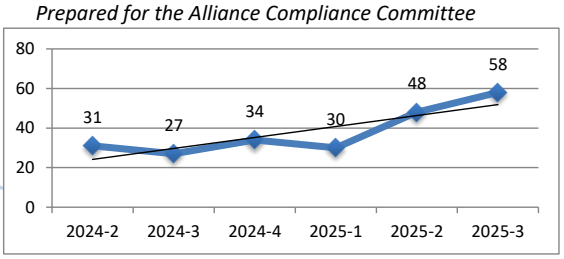
HIPAA Dashboard - Q3-2025

Prepared for the Alliance Compliance Committee

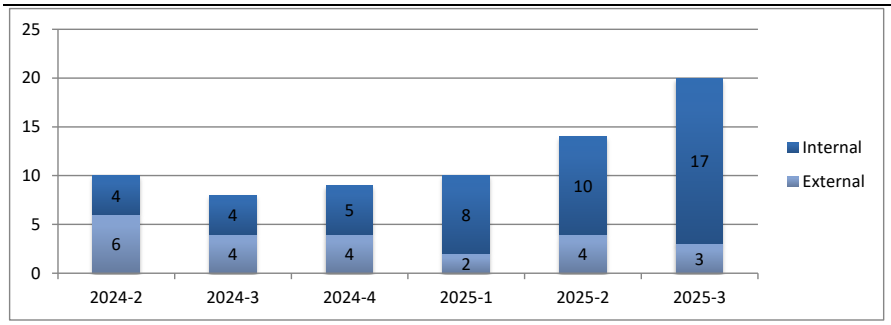
Reports of Suspected Disclosures by Quarter

Compliance received a total of 58 reports of suspected unauthorized disclosures of Protected Health Information (PHI) during Q3-2025.

(This is all suspected events, whether or not they were deemed reportable upon investigation)



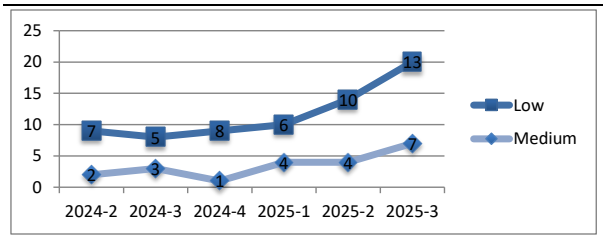
58 Total HIPAA Reports in Q3-2025



Sources of Disclosures:
Internal (Alliance) & External (Non-Alliance)

Compliance tracks whether the disclosure was caused by internal Alliance departments or by external entities, including providers and delegates.

**Excludes Non-Events, Duplicates and Non-Reportable Incidents*



Impact of Events

(excludes Non-Events and Events Pending Investigation)

13 of 20 events had an impact of low;
7 of 20 had an impact of of medium;
0 of 20 had an impact of high.

Impact levels are determined by analyzing whether PHI was disclosed to a HIPAA covered entity, whether the PHI has been destroyed or recovered, and the amount of time passed between discovery and notification to Compliance.

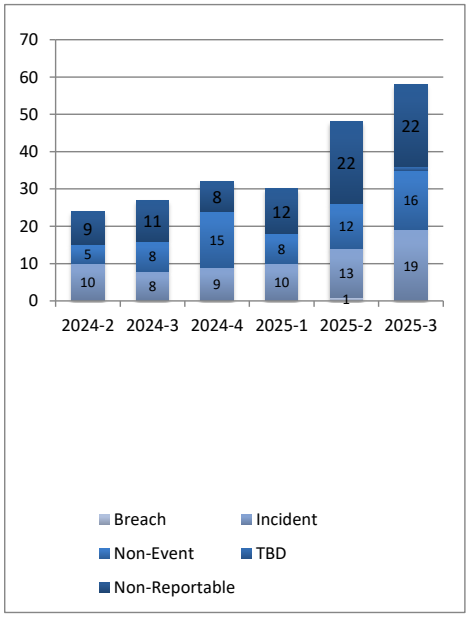
Final Classification

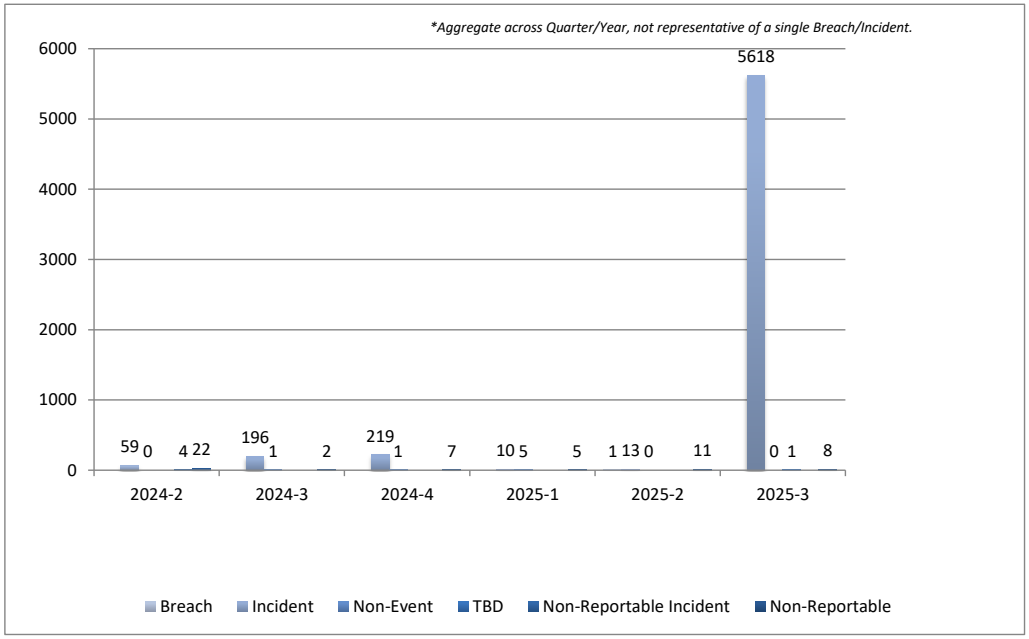
Breaches are unauthorized disclosures of PHI to a non-covered entity; Incidents are unauthorized disclosures to covered entities; Non-events are when the investigation reveals that no unauthorized disclosure of PHI occured; Mitigated incidents are when the Plan is able to mitigate the disclosure within the 24-hour reporting window.

Member Impact

5627 members were impacted by HIPAA events in Q3-2025;
0 were due to breaches and 5618 were due to incidents, 1 is still pending a final classification, and 8 were classified as non-reportable events.

An incident occurs when PHI has been compromised or has a high probabiliy of being compromised. A breach is when PHI has bee n compromised and can only be determined as such by the Alliance Privacy Officer.





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Compliance

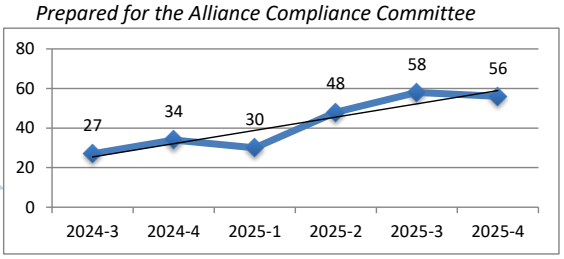
HIPAA Dashboard - Q4-2025

Prepared for the Alliance Compliance Committee

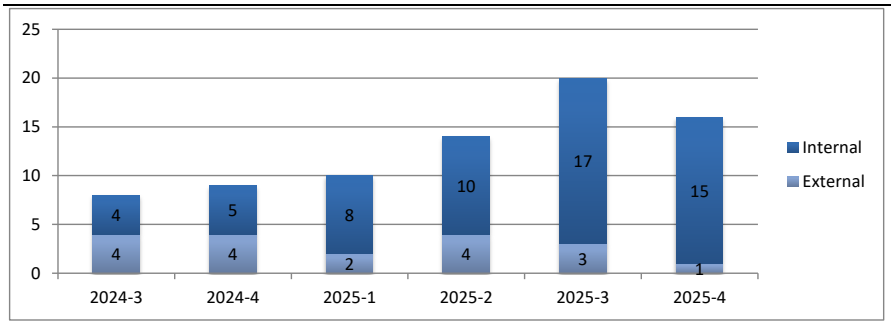
Reports of Suspected Disclosures by Quarter

Compliance received a total of 56 reports of suspected unauthorized disclosures of Protected Health Information (PHI) during Q4-2025.

(This is all suspected events, whether or not they were deemed reportable upon investigation)



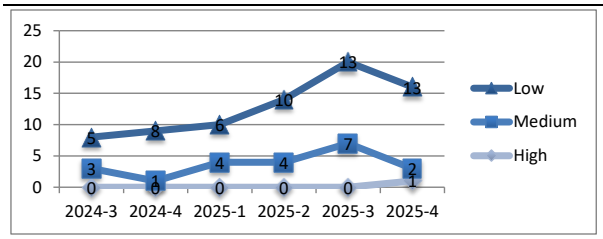
56 Total HIPAA Reports in Q4-2025



Sources of Disclosures:
Internal (Alliance) & External (Non-Alliance)

Compliance tracks whether the disclosure was caused by internal Alliance departments or by external entities, including providers and delegates.

**Excludes Non-Events, Duplicates and Non-Reportable Incidents*



Impact of Events

(excludes Non-Events and Events Pending Investigation)

13 of 16 events had an impact of low;
2 of 16 had an impact of of medium;
1 of 16 had an impact of high.

Impact levels are determined by analyzing whether PHI was disclosed to a HIPAA covered entity, whether the PHI has been destroyed or recovered, and the amount of time passed between discovery and notification to Compliance.

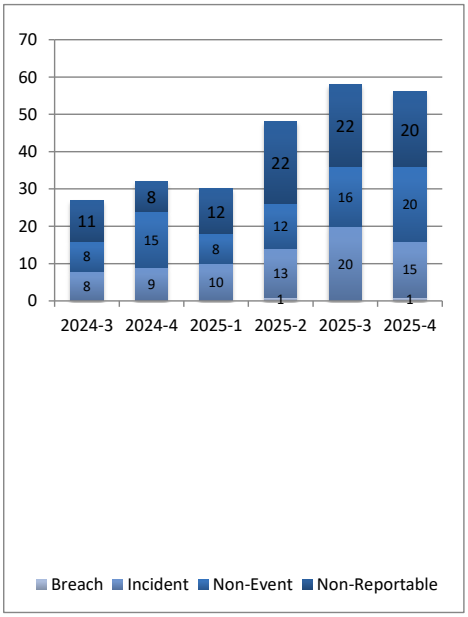
Final Classification

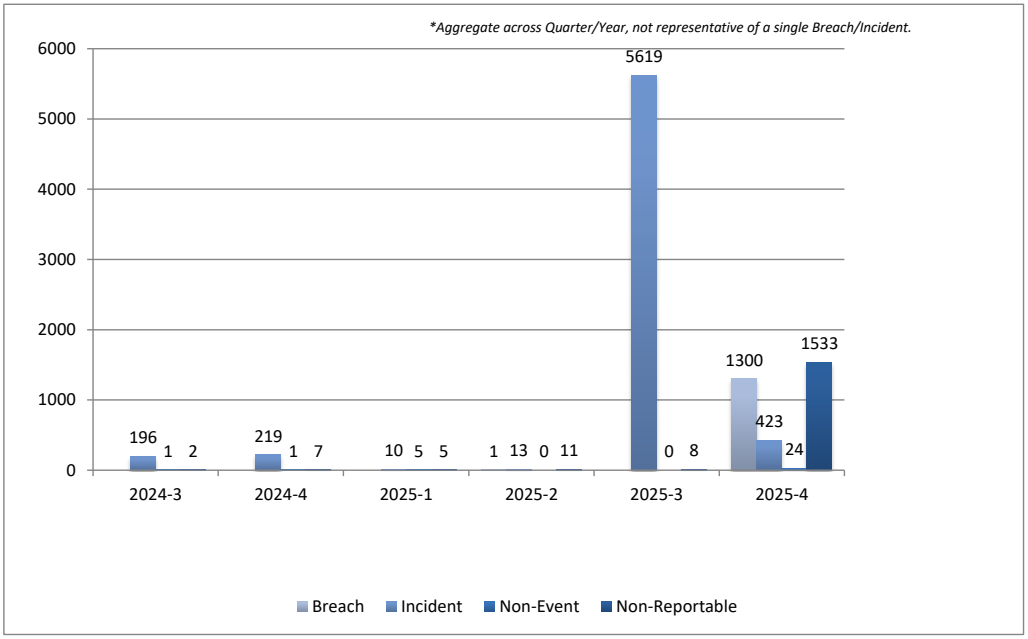
Breaches are unauthorized disclosures of PHI to a non-covered entity; Incidents are unauthorized disclosures to covered entities; Non-events are when the investigation reveals that no unauthorized disclosure of PHI occured; Mitigated incidents are when the Plan is able to mitigate the disclosure within the 24-hour reporting window.

Member Impact

3,280 members were impacted by HIPAA events in Q4-2025;
1,300 were due to a breach, 15 were due to incidents, and 1,533 were classified as non-reportable and non- events.

An incident occurs when PHI has been compromised or has a high probabiliy of being compromised. A breach is when PHI has been compromised and can only be determined as such by the Alliance Privacy Officer.





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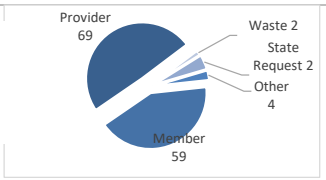
Program Integrity
Special Investigations Unit Dashboard - Q3-2025

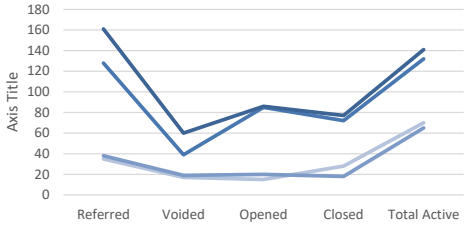
Prepared for the Compliance Committee

Note: Unless otherwise indicated, statistics represent data for the quarter only.

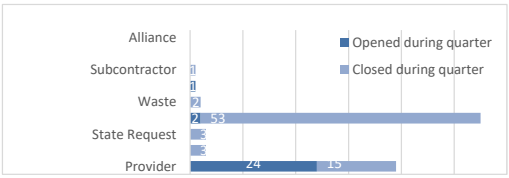
Matters Under Investigation (MUIs)
MUIs are classified by the target of the allegation/concern. ("Other" example: If a member alleges a non-Alliance member may be using his/her Alliance ID card to fraudulently obtain services.)



141 Total

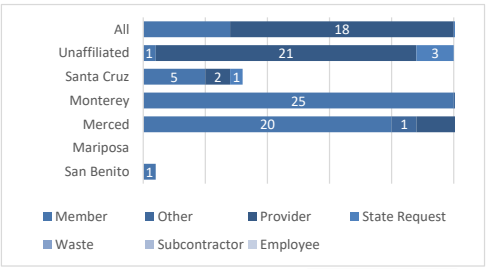


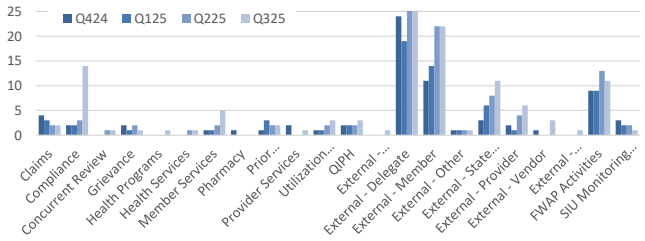
Referral Trends
Referrals come from various sources (internal, delegate, etc.) These referrals are either opened or voided depending on the scope of the referral. MUIs are closed when an investigaton is complete.



MUIs by Status
If MUIs undergo a status change in a single quarter, they are reported once under current status at end of quarter. MUIs by status does not account for MUIs not in an Opened or Closed status

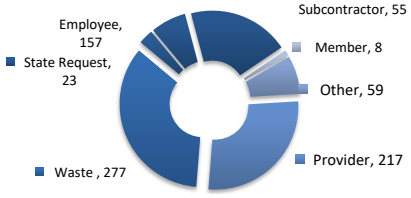
MUIs by County
Most MUIs are assigned a county affiliation. Where a provider serves multiple Alliance counties, or a member receives services in multiple Alliance counties, the county affiliation is identified by the billing address or mailing address, respectively.



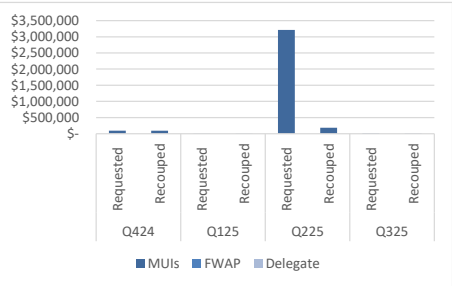


MUI Reporting Department
The referral source represents the origin of the referral, not the nature of the allegation/ concern.

Investigation Duration Average
- Statistics are in business days, excluding Alliance holidays.
- Statistics represent the average of all MUIs closed in previous 12 months.



77 Days



Financial Reporting

MUIs and FWAP: represent claims requested for recovery by the SIU during the review period, subsequent to the resolution of an MUI or a FWAP Program audit.

Recoupment: represent claims on which reoupment was completed during the review period.

Q325 Requested Recoupment:
- MUI: $11,880.37
- FWAP: $0
- Delegate: $7,434.24

Completed Recoupment:
- MUI/FWAP: $7,297.44
- Delegate: $0

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Program Integrity
Special Investigations Unit Dashboard - Q4-2025

Prepared for the Compliance Committee

Note: Unless otherwise indicated, statistics represent data for the quarter only.

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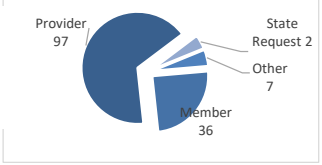
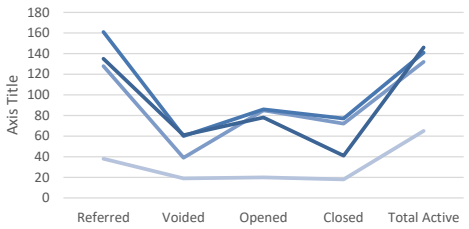
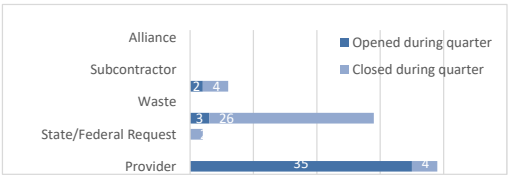


146
Total



Referral Trends
Referrals come from various sources (internal, delegate, etc.) These referrals are either opened or voided depending on the scope of the referral. MUIs are closed when an investigaton is complete.



MUIs by Status
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MUIs by County
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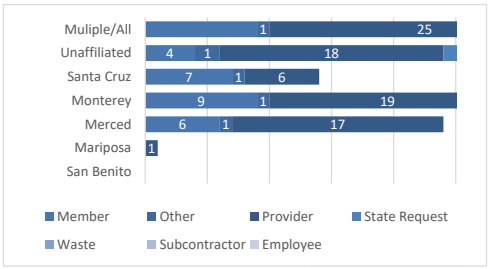
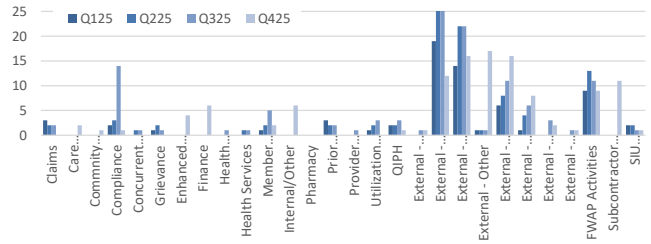
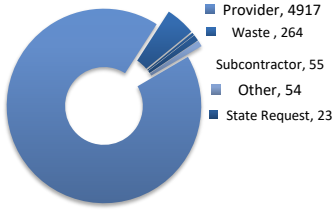


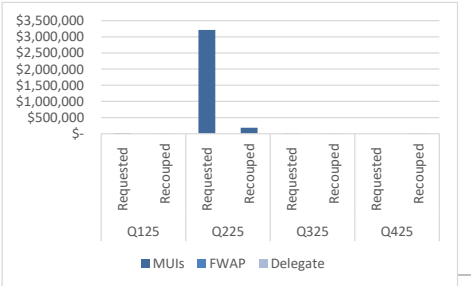


MUI Reporting Department
The referral source represents the origin of the referral, not the nature of the allegation/ concern.

Investigation Duration Average
- Statistics are in business days, excluding Alliance holidays.
- Statistics represent the average of all MUIs closed in previous 12 months.

1263
Days





Financial Reporting

MUIs and FWAP: represent claims requested for recovery by the SIU during the review period, subsequent to the resolution of an MUI or a FWAP Program audit.

Recoupment: represent claims on which reoupment was completed during the review period.

Q425 Requested Recoupment:
- MUI: $0
- FWAP: $0
- Delegate: $0

Completed Recoupment:
- MUI/FWAP: $14,256.20
- Delegate: $0

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DATE: March 25, 2026

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

FROM: Ryan Inlow, Facilities & Administrative Services Director

SUBJECT: Alliance Owned Properties Annual Report

Recommendation. This report is informational only.

Summary. This report provides an informational overview of Alliance-owned commercial properties, including facility leasing performance, current tenant occupancy, tenant services and support activities, and marketing strategies for available space. The information reflects current property holdings, space utilization, and operational support provided by Facilities and Administrative Services. This serves as the Alliance Owned Properties Report that is provided to your board annually.

Background. Since 2004, the Alliance has owned commercial real estate for operational use, with available space leased to tenants to generate revenue. Properties are in Scotts Valley, Merced, and Salinas. In total, the Alliance owns and operates approximately 284,924 square feet of commercial office space. Of this total, approximately 50.2 percent is occupied by Alliance operations, 22.3 percent is leased to external tenants, and 27.4 percent is currently available and actively marketed. As of 2025, the Alliance leases space to 18 external tenants. For calendar year 2025, rental operations generated $1,557,096.41 in rental income, incurred $666,297.49 in rental related expenses, and produced $890,798.02 in gross income. Rental expenses include utilities, janitorial services, repairs and maintenance, property taxes, tenant improvements, and brokerage commissions.

Facilities and Administrative Services staff support Alliance operations and external tenants through daily facility management, tenant relations, maintenance and repairs, safety and security, sustainability initiatives, and coordination with Contracts/Legal Services and Finance for lease administration, compliance, and rent tracking. A Facility Asset Management Committee provides strategic oversight related to lease performance, risk management, budgeting, and decision-making associated with Alliance-owned real estate.

Available commercial space is actively marketed through multiple channels, including on-site signage, online listings, paid advertisements, and distribution of marketing materials during property tours. The Alliance is also exploring future space-use options, such as leasing shared workspaces and hot-desk configurations, to optimize utilization of available space.

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

Attachments. N/A

DATE: March 25, 2026

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

FROM: Michael Schrader, Chief Executive Officer

SUBJECT: Brown Act Updates: Senate Bill 707

Recommendation. This report is informational only.

Summary. Senate Bill (SB) 707 updates provisions of the Ralph M. Brown Act to expand public access and participation in meetings of local legislative bodies. The legislation requires agencies subject to the Brown Act to implement updated procedures related to meeting accessibility and remote participation.

Background. The Ralph M. Brown Act governs meetings of local legislative bodies and establishes requirements intended to ensure transparency and public access to meetings and governmental decision-making. The Act requires meetings of legislative bodies to be open and public, with limited exceptions, and sets rules for meeting notices, agendas, and opportunities for public comment.

Discussion. SB 707 modifies certain provisions of the Brown Act to enhance public participation and access to meetings. These updates include requirements related to remote participation, procedures for addressing technological disruptions during meetings, and other measures intended to improve transparency and accessibility for members of the public.

At the Board's meeting on March 25, 2026, Counsel will provide an overview of relevant provisions of SB 707 and discuss the potential impacts on Board meetings, member attendance, and public participation. Topics to be discussed include the following:

- Remote participation requirements
    - "Just cause" exceptions
        - SB 707 provides limited flexibility for remote participation under certain "just cause" circumstances. However, these provisions require that a majority of the legislative body participate from a single physical meeting location. Because this requirement would not be met, these "just cause" provisions would generally not apply to Alliance Board members.
    - Reasonable accommodation
        - SB 707 allows members of a legislative body to request reasonable accommodation to participate remotely when needed due to a qualifying disability.
- Public participation via remote real time two-way communication

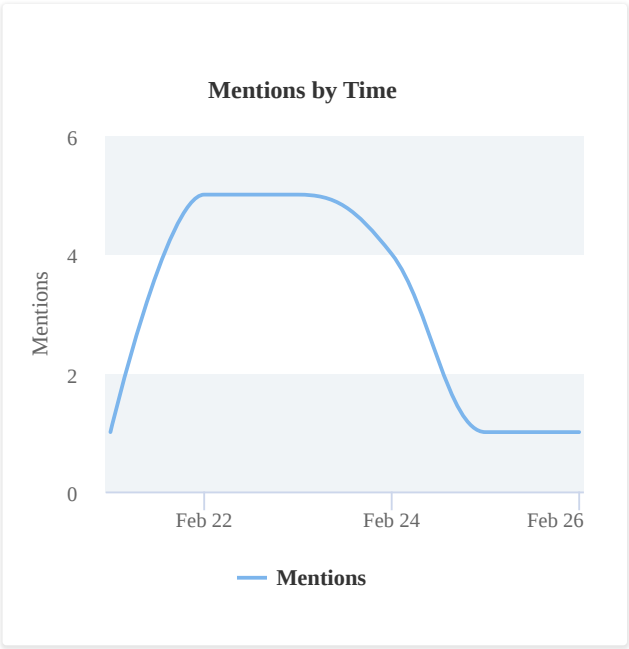
- Effective July 1, 2026, agencies must provide members of the public with the opportunity to attend meetings and provide public comment through real-time, two-way remote communication.

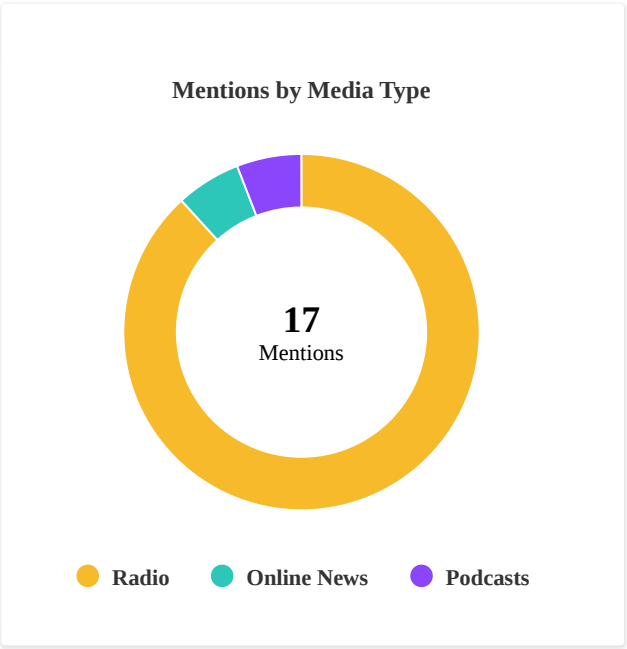
Fiscal Impact. There is no fiscal impact associated with this agenda item.

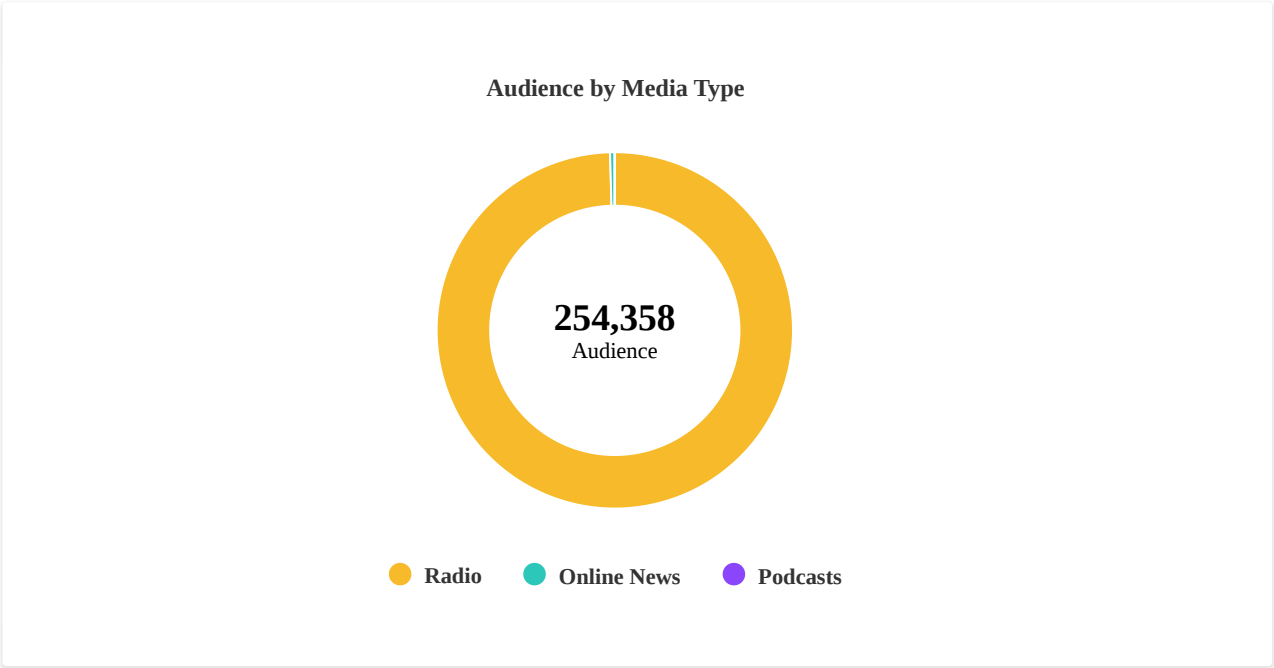
Attachments. N/A

March 2026 Board Report

Mention Analytics







17 Total Mentions

Mentions 17 **Audience** 254,358 **Publicity** USD $1,390

Feb 26, 2026 6:31 PM EST Pos. **1**

New clinic expected to increase health access in western Merced County

Source KVPR **Market** United States **Type** Digital News **Category** Organization

... has four exam rooms, one treatment room and 10 new clinicians. Officials said the clinic will also provide wraparound services in behavioral health, primary care and specialty care. It is expected to support 1,000 visits per month. The clinic was built in part by a $2.5 million grant from the **Central California Alliance for Health**.

Feb 25, 2026 12:15 PM EST Neg. **2**

KSJV-FM

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

Influenza o gripe es una enfermedad grave causada por virus y es muy contagiosa y peligrosa. Aunque la mayoría de las personas y los niños se curan en menos de una semana, algunos pueden enfermarse gravemente y ser hospitalizados. Por eso, así como proteges a tus niños del frío abrigando los. Protégelos de la gripe,

Feb 24, 2026 11:33 AM EST Pos. **3**

KVPR-FM

Station KVPR-FM (NPR) **Market** Fresno, CA DMA: 56

Were than doubled last year from ten thousand to twenty two thousand officers D. H. Has said in a statement that the weapons investments one news worthy that's would be raining with our partner holiest the city of los van as has a new medical clinic it's operated by sutter health christy marion is the C. E. O. Of sutter's new

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Feb 24, 2026 11:17 AM EST **4**

KSJV-FM

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

Deje a los que los rodean. Mensaje producido con el apoyo de The **Central California Alliance for Health** Support Cristiano con apoyo. De. México Grande Líder en México Mágico Mundo Nuestro México Azteca más grande y con todo el universo. Grande de México, así como con nuestro.

Feb 24, 2026 10:33 AM EST Neu. **5**

KVPR-FM

Station KVPR-FM (NPR) **Market** Fresno, CA DMA: 56

Area in is the C. E. O. Of sutter's new memorial hospital in will spend this she said the clinic will expand health care access to local residents here she is speaking at a press conference late last week yeah her name and the name and he at the the clinic was paid for in large part by grant from the **central california alliance for**

Feb 24, 2026 7:34 AM EST Pos. **6**

Feb. 24: A Small Fresno County Town Is Now In The Same Congressional District As San Jose

Podcast Central Valley Daily **Market** United States **Category** News

that the party listens to young people but ultimately i think the right candidate will get the nomination and i'll be happy to throw my support behind a democratic candidate especially if it's a serve up but yeah with no official endorsement yet in republicans pulling competitively many here say they're still waiting to see who earns their

---

Feb 23, 2026 10:50 PM EST **7**

KSJV-FM

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

Deje a los que los rodean. Mensaje producido con el apoyo de The **Central California Alliance for Health** Support. Creciendo con apoyo. Acaríciame. Siente mi cuerpo, mujer. Quiero que me des tu amor otra vez. Acaríciame. Lleva tus brazos a mí. Y cuando cae la luna aquí, hazme perder el control.

Feb 23, 2026 7:05 PM EST Neu. **8**

KVPR-FM

Station KVPR-FM (NPR) **Market** Fresno, CA DMA: 56

I took place in parts of california and hawaii workers were demanding better wages and staffing the union of health care worker said quote significant movement at the bargaining table prompted the end to the walkout though they did provide any details about what progress was made or what potential deal might look like the

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Feb 23, 2026 5:44 PM EST Neg. **9**

KSJV-FM

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

Si estás planeando embarazarte, es necesario que empieces a tomar vitaminas prenatales tres meses antes del embarazo. Porque aunque tú comas muchos alimentos ricos en folato como las naranjas, las lentejas, los frijoles, espinacas y otros vegetales, es difícil que obtengas lo suficiente para ayudar a tu bebé. Por eso

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Feb 23, 2026 10:28 AM EST **10**

KSJV-FM

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

Se pongan lápices prestados en la boca o se expongan a estornudos de otros. Cuando llega el invierno no sólo llegan los días fríos, pero también los virus respiratorios, incluyendo el de la influenza o gripe. La influenza o gripe es una enfermedad grave causada por virus y es muy contagiosa y peligrosa. Aunque la

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Feb 23, 2026 9:46 AM EST Pos. **11**

KSJV-FM

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

No solo protege a las personas que reciben la vacuna, sino que también protege a los que los rodean. Mensaje producido con el apoyo de The **Central, California Alliance for Health** Support con apoyo. Ya sea radio bilingüe en redes sociales. Nuestras noticias y contenido están en Facebook, Instagram y en radio bilingüe

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Feb 22, 2026 12:46 PM EST Pos. **12**

KSJV-FM

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

Sólo fíjate que la etiqueta diga que el suplemento tiene 400 microgramos de ácido fólico. Mensaje producido con el apoyo de The **Central California Alliance for Health** Support. Creciendo con apoyo. De. Los ojos de los que tienes. Esa linda joven que estoy mirando. Que miradita. Es la que me está matando. Yo la voy a

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Feb 22, 2026 8:30 AM EST Neu. 13

KSJV-FM

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

Solo protege a las personas que reciben la vacuna, sino que también protege a los que los rodean. Mensaje producido con el apoyo de The **Central California Alliance for Health** Support. Creciendo con apoyo. Esta semana en la edición semanal de noticias. Cierre parcial de gobierno continúa por desacuerdos sobre

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Feb 22, 2026 6:30 AM EST Neg. 14

KSJV-FM

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

A tomar vitaminas prenatales tres meses antes del embarazo. Porque aunque tú comas muchos alimentos ricos en folato como las naranjas, las lentejas, los frijoles, espinacas y otros vegetales, es difícil que obtengas lo suficiente para ayudar a tu bebé. Por eso es más fácil tomar una vitamina suplementaria cada día que

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Feb 22, 2026 5:45 AM EST Pos. 15

KSJV-FM

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

Mensaje producido con el apoyo de The **Central California Alliance for Health** Support. Creciendo con apoyo. Una manera fácil de apoyar tus programas favoritos es donar un vehículo que ya no uses o que ya no funcione. Visita nuestra página Radio bilingüe punto org y haz click en el recuadro. Dona tu carro a Radio bilingüe.

Feb 22, 2026 3:30 AM EST Neg. 16

KSJV-FM

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

No siempre podemos evitar que se ensucien jugando, se pongan lápices prestados en la boca o se expongan a estornudos de otros. Cuando llega el invierno no sólo llegan los días fríos, pero también los virus respiratorios, incluyendo el de la influenza o gripe. La influenza o gripe es una enfermedad grave causada por virus y

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Feb 21, 2026 8:28 PM EST Pos. 17

KSJV-FM

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

Puedes comprar en cualquier tienda o farmacia. Sólo fíjate que la etiqueta diga que el suplemento tiene 400 microgramos de ácido fólico. Mensaje producido con el apoyo de The **Central California Alliance for Health** Support. Creciendo con apoyo. Estás escuchando un programa musical pregrabado. Te conocí. Revolución

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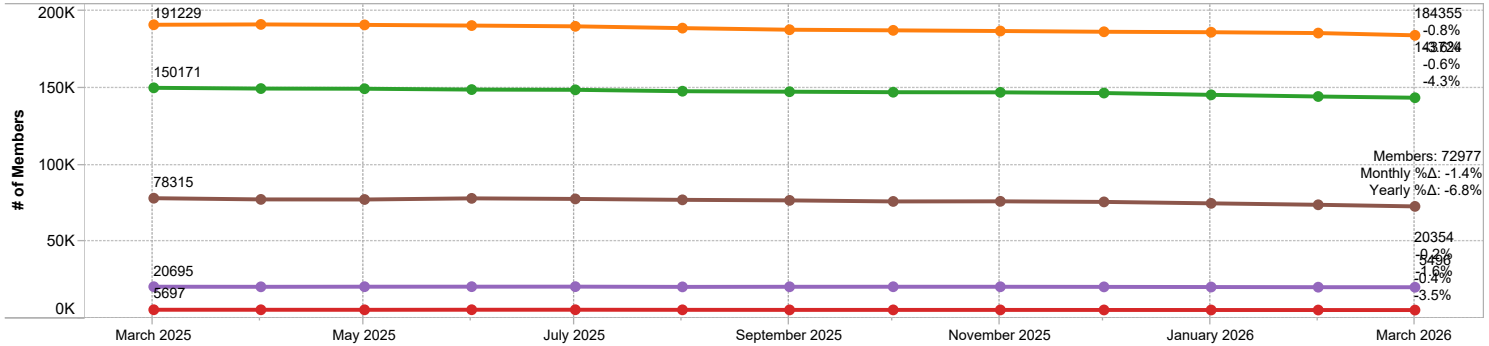
Enrollment Report

County: *None* **Program:** *None* **Aid Cat Roll Up:** *None* **Data Refresh Date:** *3/3/2026 6:34:16 AM*

Enrollment Month
3/1/2025 to 3/31/2026

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



LOB	County	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026
Medi-Cal	SANTA CRUZ	78,315	77,530	77,469	78,212	77,842	77,249	76,889	76,211	76,277	75,905	74,771	73,830	72,728
	MONTEREY	190,554	190,786	190,485	190,055	189,554	188,360	187,265	186,860	186,413	185,931	185,474	184,913	183,432
	MERCED	150,171	149,688	149,572	149,027	148,866	147,965	147,647	147,322	147,225	146,774	145,524	144,437	143,624
	MARIPOSA	5,697	5,681	5,657	5,704	5,704	5,642	5,602	5,599	5,590	5,565	5,523	5,499	5,478
	SAN BENITO	20,695	20,635	20,705	20,721	20,739	20,584	20,652	20,679	20,662	20,588	20,470	20,372	20,333
IHSS	MONTEREY	675	663	654	650	648	680	727	731	738	731	735	725	720
DSNP Total Care	SANTA CRUZ											193	201	249
	MONTEREY											157	181	203
	MERCED											77	86	100
	MARIPOSA											15	17	18
	SAN BENITO											17	18	21
Total Members		**446,107**	**444,983**	**444,542**	**444,369**	**443,353**	**440,480**	**438,782**	**437,402**	**436,905**	**435,494**	**432,956**	**430,279**	**426,906**

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

Back to Agenda

March 11, 2026

The Honorable John Laird
California State Senate
1021 O Street, Suite 8720
Sacramento, CA 95814
RE: SB 1078 (Laird): Transactions and use taxes: County of Santa Cruz – SUPPORT

Dear Senator Laird:

On behalf of Central California Alliance for Health (the Alliance"), which provides health care coverage for approximately 73,000 Santa Cruz County Medi-Cal beneficiaries, I write to express our support for Senate Bill 1078. This measure would allow the Santa Cruz County Board of Supervisors to seek voter approval for a countywide transactions and use tax above the 2% statutory cap to help offset the loss of federal funding for local programs and services.

SB 1078 would authorize the County to seek voter approval for a countywide transactions and use tax of up to 0.5% above the 2% statutory cap. The additional authority would provide a potential local funding option to help offset reductions in federal support for essential programs and services. As an urgency measure, SB 1078 would allow the County to consider placing a measure before voters as early as the November 2026 election. This authority would sunset on December 31, 2030.

Santa Cruz County and its community partners rely on a combination of federal, state, and local funding to support essential services such as hospital and emergency room access, ambulance response, healthcare, housing programs, and food assistance. Potential reductions in federal support, combined with rising demand and increasing costs to provide services locally, create significant fiscal uncertainty for the County and its partners. Without additional fiscal tools available to local communities, maintaining these critical services may become increasingly challenging in the years ahead.

Importantly, passage of SB 1078 does not automatically adjust the local sales tax rate. Rather, it would simply allow the County the opportunity to present the option to the community.

I am pleased to offer the Alliance's support for this important measure and thank you for your leadership and your continued commitment to supporting the health and well-being of Santa Cruz County residents.

Sincerely,

Michael Schrader

Michael Schrader
Chief Executive Officer

cc: The Honorable Maria Elena Durazo, Chair, Senate Local Government Committee
Members and Consultants, Senate Local Government Committee
The Honorable Jerry McNerny, Chair Senate Revenue and Taxation Committee
Members and Consultants, Senate Revenue and Taxation Committee

March 11, 2026

California Community Colleges Chancellor's Office
Workforce and Economic Development Division
1102 Q Street, 6th Floor Sacramento, CA 95811

RE: English Language Learner (ELL) Healthcare Vocational Pathways Grant (Round 3)

To Whom It May Concern:

Central California Alliance for Health (The Alliance) is writing this letter of support for the English Language Learner (ELL) Healthcare Pathway Plan (26-29) project submitted by the Greater Opportunities through Adult Learning (GOAL) consortium, which include Cabrillo College, Santa Cruz County Office of Education, and Watsonville / Aptos / Santa Cruz for Adult Education. GOAL's plan will invest in local healthcare training programs to address the shortage of healthcare workers in our region. Their project addresses the biliteracy and cultural competency needs of our English Language Learning (ELL) students seeking to build skills and competencies in their pursuit of a healthcare certificate that will enable them to work in healthcare. This project will address significant regional demand for healthcare workers by increasing the pipeline of skilled entry-level workers, many of whom have educational goals to further pursue a career in healthcare.

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

The Alliance has developed a successful working relationship with GOAL members through multiple workforce development initiatives under the collaborative leadership of the Healthcare Improvement Partnership of Santa Cruz County. The Alliance is proud to support Cabrillo College's efforts to grow the healthcare workforce, specifically Cabrillo College's Community Health Worker (CHW) Certificate Program. Community Health Workers provide trusted, culturally informed support, and lived experience that helps Medi-Cal members understand and access care. Community Health Workers provide trusted, culturally informed support, and lived experience that helps Medi-Cal members understand and access care.

With grant funds, Cabrillo College will embed language learning and fluency in the context of teaching healthcare skills and competency for Community Health Workers. They will learn how to navigate school support resources and will connect with a bilingual job developer who can offer career services support. In addition, our educators will receive additional professional development in cutting-edge teaching practices to best prepare ELL students for their health fields. Project outcomes include enabling our ELL students to persist in their studies and complete their training program, so they graduate with in-demand skills and knowledge relevant to the pressing challenges of the healthcare industry.

We are excited to partner with the GOAL consortium on this project to support the acceleration of language fluency in the context of healthcare training and supporting the success of this ELL Healthcare Pathway project in Santa Cruz County.

Sincerely,

Michael Schrader

Michael Schrader
Chief Executive Officer

March 9, 2026

Dragonfly Forward
3611 Dupont Circle
Virgina Beach VA 23455
RE: Letter of Intent to participate as Health Care Partner – BHSSA-Evaluation 002: School Behavioral Health Performance Management Systems

Dear Ms. Barrett and Dr. Yanek,

This letter serves as a Letter of Intent confirming that Central California Alliance for Health intends to participate as a learning partner, contingent upon the successful award of the BHSSA-Evaluation 002 grant. If the grant is awarded, Central California Alliance for Health will partner with Dragonfly Forward to support goals and deliverables outlined in the grant RFP. Anticipated services may include, but are not limited to:

- Participating in the project kickoff meeting and initial planning sessions to align cross-sector partners on project goals, evaluation priorities, and implementation timelines.
- Contributing as subject-matter expertise related to health care and behavioral health performance management systems that support school behavioral health services.
- Participating in quarterly collaborative learning groups with cross-sector partners (education, health care, behavioral health, and community organizations) to share lessons learned and inform continuous improvement.
- Providing consultation on performance metrics, data use, and system alignment to strengthen school behavioral health performance management and population-level monitoring.
- Offering strategic input on integrating school, health care, and behavioral health data practices to support equity-focused evaluation and sustainable cross-system collaboration.

All services will be delivered in close collaboration with Dragonfly Forward and designed to support culturally responsive, equity-centered evaluation practices that are designed in partnership with LEAs. Final scope of work, timelines, and deliverables will be mutually determined following grant award and execution of a formal agreement.

This letter is provided solely to demonstrate intent to collaborate and does not constitute a binding agreement or contractual obligation.

Please feel free to contact me should additional information be required.

Sincerely,

Michael Schrader

Michael Schrader
Chief Executive Officer

Provider Bulletin

A **quarterly** publication for providers. | **March** 2026

MEDICAID HMO

Helping members navigate changes to Medi-Cal

January marked the start of several Medi-Cal changes that will continue rolling out over the next few years. While most members will not see immediate impacts, updates in January included:

- An enrollment freeze for new members with unsatisfactory immigration status (UIS).
- Asset limits for some individuals – up to $130,000 for one person and $65,000 for each additional family member.
- The elimination of dental coverage for members with UIS ages 19 and older who are not pregnant. Emergency dental care will still be covered for everyone, no matter their immigration status. Pregnant people with UIS will continue to receive full dental benefits up to one year after the pregnancy ends.

We recognize these shifts may cause confusion and uncertainty for members. The Alliance is committed to preparing them for these changes and ensuring that they maintain access to care. A cross-collaborative team is implementing a range of outreach strategies, including:

- Texting members who are up for redetermination to remind them to return paperwork on time and ensure that their mailing address on file is current.
- Equipping trusted organizations to help members understand these changes.
- Sponsoring media campaigns on how to maintain coverage.
- Creating multichannel resources that reinforce the importance of timely renewal.

Alliance Board Meetings

Wednesday, March 25
3 p.m. to 5 p.m.

Wednesday, April 22
3 p.m. to 5 p.m.

Wednesday, May 27
3 p.m. to 5 p.m.

Whole Child Model Clinical Advisory Committee Meetings

Thursday, April 16
Noon to 1 p.m.

Physicians Advisory Group Meetings

Thursday, June 4
Noon to 1:30 p.m.

We've created a Provider Tool Kit with resources to help you assist members. Access it at **www.thealliance.health/redetermination-tool-kit**.

Thank you for your ongoing partnership and your commitment to our communities.

Michael Schrader

Michael Schrader, CEO

Back to Agenda

The Alliance celebrates 30 years

This year, the Alliance celebrates 30 years serving our local communities. Thank you for making our work possible through a shared commitment to healthy people, healthy communities.

We started serving Santa Cruz County in 1996. Over the years, we've expanded to include Mariposa, Merced, Monterey and San Benito counties. We now serve over **434,000 members** with a network of over **14,000 contracted providers**. In 2025, we earned full Health Plan and Health Equity Accreditation from the National Committee for Quality Assurance.

We've been proud to be a trusted ally for our members across three decades, striving to understand our communities' unique needs and offer compassionate and culturally appropriate care for all stages of life and health conditions. **This work would not be possible without strong partnerships with our providers!**

We know that our members' needs go beyond health care. Thanks to the power of community-based collaboration, we've been able to address social determinants of health and meet members where they're at through efforts like:

- Investing $235 million into our service areas since 2015 through the Medi-Cal Capacity Grant Program. These grants have helped build permanent supportive housing and health care facilities, develop the health care workforce, and strengthen the capacity of community-based organizations to influence health and wellness for Medi-Cal members.
- Conducting multilingual outreach at local events with our Your Health Matters team (last year, we participated in over 150 events!).

We have risen to meet the needs presented by an ever-changing health care landscape, from adapting to the challenges of the COVID-19 pandemic to maximizing member retention amid upcoming changes to Medicaid.

Innovation-driven initiatives in recent years have included:

- Enhanced Care Management and Community Supports.
- Community health worker and doula benefits.
- Bringing our behavioral health care services in-house for a more seamless member experience.
- Launching our TotalCare (HMO D-SNP) plan.

There is still so much work left to do in our communities. We remain committed to our mission to provide accessible, quality health care and look forward to continuing this important work together for years to come!

Welcome, new providers!

Merced County

Primary care

- **Jivitesh Gaurav, MD,** Internal Medicine

Monterey County

Primary care

- **Victor Carrasco, MD,** Family Medicine
- **Charles Gaccione, DO,** Family Medicine
- **Vivian Garcia, MD,** Family Medicine
- **Harry Jang, MD,** Internal Medicine
- **Stephanie Morales, MD,** Family Medicine
- **Rachel Quinn, MD,** Family Medicine
- **Kayla Rasmussen, MD,** Family Medicine
- **Stephanie Seasly, MD,** Family Medicine
- **Ariel Wagner, MD,** Family Medicine

Referral physician/ specialist

- **Faisal Amin, MD,** Internal Medicine
- **Lee Au, MD,** Surgery
- **Taylor Burch Barnikel, MD,** Family Medicine
- **Richard Berkowitz, MD,** Diagnostic Radiology
- **Alexander Besser, DO,** Neurology
- **Gregory Caputy, MD,** Plastic and Reconstructive Surgery
- **Vincent Covelli, DO,** Infectious Disease
- **Ilja Dejanovic, MD,** Cardiovascular Disease
- **Winnie Feng, DO,** Surgery
- **Natalie Fredricks, MD,** Obstetrics and Gynecology
- **Artineh Hayrapetian, MD,** Diagnostic Radiology
- **Luana Hossain, MD,** Obstetrics and Gynecology
- **Mohamed Kadry-Hassanein, MD,** Internal Medicine
- **Andrew Kelada, MD,** Pulmonary Disease
- **Meghan Kubala, MD,** Surgery
- **Iosif Lelesidis, MD,** Clinical Cardiac Electrophysiology
- **Sharon McBeth, MD,** Emergency Medicine
- **Ujjala Moolani, MD,** Nephrology
- **Manas Rane, MD,** Internal Medicine
- **Hayden Schultz, MD,** Surgery
- **Sienna Titen, MD,** Obstetrics and Gynecology

Santa Cruz County

Primary care

- **Karissa Leclair-Cortez, MD,** Family Medicine
- **Mi Hwa Yoo, MD,** Pediatrics

Referral physician/ specialist

- **Paul Kim, MD,** Orthopedic Surgery
- **Chim Yang, DO,** Otolaryngology

– Continued on back page

Tell us about your upcoming events!

Did you know that the Alliance attends outreach events to provide our members with information about Medi-Cal updates and member benefits?

Community events are a great way to connect with our members and provide them with information on their health plan. If you plan to host an event and would like to have the Alliance there, let us know!

- **Mariposa and Merced County events:** Email Maria Colomer, Community Engagement Program Coordinator, at **mcolomer@thealliance.health**.
- **Monterey and San Benito County events:** Email Clarisa Gutierrez, Community Engagement Program Coordinator, at **cgutierrez@thealliance.health**.
- **Santa Cruz County events:** Email Ulises Cisneros-Abrego, Community Engagement Specialist, at **ucisneros@thealliance.health**.

We also participate in pop-up tabling opportunities so we can connect with members in the areas they frequent. To see if a pop-up tabling opportunity may be the right fit for your office, email Gabriela Chavez, Community Engagement Manager, at **gchavez@thealliance.health**.

MAY IS MATERNAL MENTAL HEALTH AWARENESS MONTH

Perinatal mental health screening: A lifesaving standard of care for providers

Perinatal mental health conditions are among the leading causes of maternal morbidity, contributing to 22% of maternal deaths in the U.S. According to the American Medical Association, 1 out of 5 mothers experiences a mental health condition, yet 75% receive no care.

Communities including American Indian and Alaska Native, Asian American and Pacific Islander, Black and African American, and Hispanic and Latino populations face structural racism and barriers to culturally appropriate services, making disparities in care and treatment access even more pronounced.

Why screening matters

Early identification through standardized screening and timely referral can save lives. Providers are uniquely positioned to normalize mental health and substance use conversations through an open and non-stigmatizing approach.

Providers can screen for anxiety and depression, which are more common, but birthing individuals may also experience other conditions, such as obsessive-compulsive disorder, post-traumatic stress disorder, bipolar disorder, postpartum psychosis, substance use or suicidal symptoms. Of those that have or develop mental health conditions, 27% enter pregnancy with anxiety or depression, 33% develop symptoms during pregnancy and 40% develop symptoms following childbirth.

Best practices for providers

- Adopt a nonjudgmental, compassionate approach to minimize stigma, build trust and ensure prompt identification.
  - Screen at least once during pregnancy and within six weeks postpartum. Complete additional screenings as clinically indicated, per AB 1936. Visit **www.thealliance.health/AB1936** to learn more.
- Use validated screening tools for the perinatal population.
  - Visit **www.thealliance.health/perinatal-mental-health-screening**.

- Act promptly on positive screens by giving immediate referrals.
  - Visit **www.thealliance.health/behavioral-health-referral-form** or call the Alliance Care Management line at **800-700-3874, ext. 5512**.
- Establish referral pathways and collaborate with mental health professionals.
- Document screenings and follow-ups.
- Learn more from the Maternal Mental Health Leadership Alliance at **www.thealliance.health/maternal-mental-health-factsheet**.

Connect members to support

Providers can refer members to the following resources for additional support:

- Member Services. Call **800-700-3874** or visit the Provider Directory at **www.thealliance.health/provider-directory** to locate a behavioral health provider.
- 988 Suicide and Crisis Lifeline. Visit **www.988lifeline.org** or dial **988**.
- National Maternal Mental Health Hotline. Visit **www.thealliance.health/maternal-mental-health-hotline** or call **833-TLC-MAMA** (**833-852-6262**).
- Postpartum Support International. Visit **www.postpartum.net** or text **HELP** to **800-944-4773**.

Population Health Needs Assessment

The Alliance conducts an annual comprehensive Health Education and Cultural and Linguistic Population Health Needs Assessment (PNA) that focuses on:

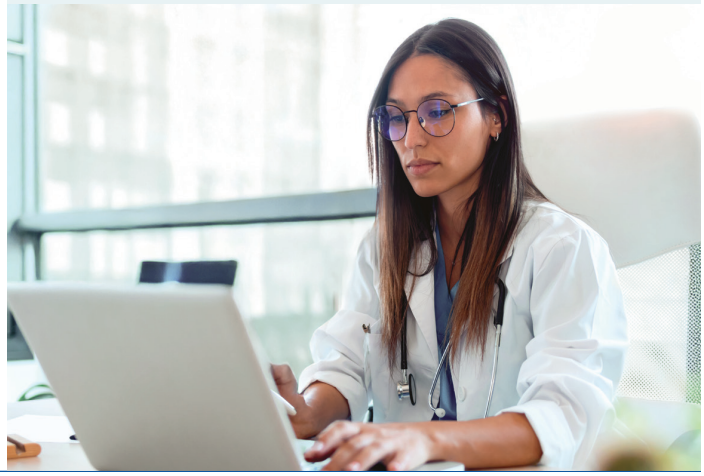
- Health disparities.
- Member health status and behaviors.
- Member health education and cultural and linguistic needs.

The PNA helps us identify gaps in services. The data collected from the assessment is used to update the Alliance's population health management activities and resources to address member needs. The Alliance also uses the PNA to guide activities that address health care disparities. The primary goals of the assessment are to improve health outcomes and meet the needs of Medi-Cal members.

The PNA also focuses on the unique needs of:

- Seniors and persons with disabilities.
- Members who have children with special health care needs.
- Members with limited English proficiency.
- Members from diverse cultural and ethnic backgrounds.

Providers can access a copy of the most recent PNA on our Cultural and Linguistic Services webpage at **www.thealliance.health/cultural-and-linguistic-services**. If you have questions about the PNA, please call the Alliance Health Education Line at **800-700-3874, ext. 5580**.



The importance of screening for ACEs

Adverse childhood experiences (ACEs) are traumatic events that occur during childhood that can affect individuals for years and impact lifelong health. Providers should administer ACEs screenings and refer members for treatment as needed. Providers can earn $29 per ACEs screening of patients.

Health consequences of ACEs

ACEs are linked to increased risk of chronic health conditions like mental illness, asthma, diabetes and heart disease.

Screening tools and required trainings

Age-appropriate screening tools are available at **www.thealliance.health/screening-tools**.

Screening frequencies:

- Children from birth through age 20 should be screened annually.
- Adults ages 21 and older should be screened once in a lifetime.

Early childhood screenings can be completed by the parent or caregiver.

Providers must take the Becoming ACEs Aware in California training and complete the attestation form to get reimbursed. Complete the training at **www.thealliance.health/aces-training**.

Required billing codes

HCPCS code	Description	Reimbursement
G9919	Score four or greater (high risk), results are positive.	$29
G9920	Score from zero to three (low risk), results are negative.	$29

Federally qualified health centers are eligible for payment but will need to bill using the appropriate code on a separate claim.

Health education and disease management programs

Providers can refer members who would like additional support in managing their health to the Alliance's health education and disease management programs.

The following Alliance programs support members in their journey to health and wellness:

- **Healthy Moms and Healthy Babies:** for members who are pregnant or recently had a baby.
- **Healthier Living Program:** for adult members living with a chronic condition(s).
- **Live Better with Diabetes:** for adult members diagnosed with diabetes or prediabetes.
- **Adult Weight Management:** for adult members who are interested in reaching a healthy weight.
- **Healthy Weight for Life:** for parents of pediatric members between the ages of 2 and 18 who are interested in learning how to help their child eat healthy and be more active.
- **Tobacco Cessation Support Program:** for adult members who want to stop smoking and/or using tobacco products.

To refer a member to any of the Alliance programs, please use the Health Programs Referral Form located on the Alliance website at **www.thealliance.health/health-programs-referral-form**.

Best practices: Prevent and screen for colorectal cancer

March is Colorectal Cancer Awareness Month. According to the American Cancer Society, colorectal cancer is the third most common cancer found in men and women in the U.S. The good news is that it is highly preventable with screening.

Alliance members can get screened for colorectal cancer at no cost to them. Here are ways to help support patients to prevent and screen for colorectal cancer.

Emphasize modifiable lifestyle risk factors

The American Cancer Society shares a few ways that patients can lower their risk of colorectal cancer:

- Maintain a healthy body weight.
- Participate in regular, moderate to vigorous physical activity.
- Eat well. Overall, diets high in vegetables, fruits and whole grains and low in red and processed meats probably lower colorectal cancer risk. Many studies have found a link between red or processed meats and increased colorectal cancer risk.
- Limit alcohol intake. It's recommended to have no more than one drink per day for women or two drinks per day for men. Several studies found a higher risk of colorectal cancer with increased alcohol intake.
- Quit smoking. Long-term smoking is linked to an increased risk of colorectal cancer.

Tip: There is a report in the Alliance Provider Portal (**www.thealliance.health/provider-portal**) that helps practices identify and reach patients due for colorectal cancer screening.

Talk to patients about their preferences

A 2025 literature review in the Journal of the American Board of Family Medicine surfaced four themes about shared decision-making in colorectal cancer screenings:

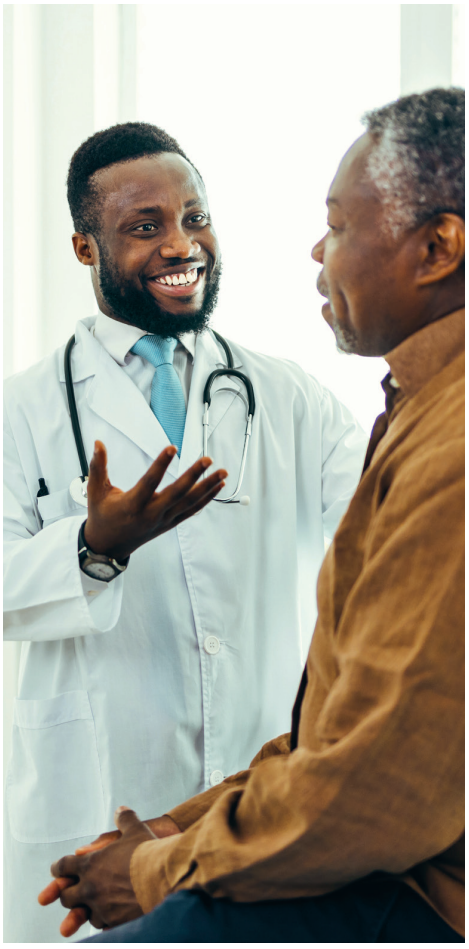
- Patients appreciate knowing details about each test.
- Patients value screening recommendations from a trusted clinician.
- It is important to acknowledge patients' emotions around screening.
- External factors such as culture, family and socioeconomic status can influence screening decisions.

Remove structural barriers for screenings

This can look like:

- Extending clinic hours.
- Providing stool tests outside of traditional medical visits.
- Connecting patients with transportation for their appointment. Alliance members may be able to get transportation services at no cost to them.

As part of our Care-Based Incentive Program, providers can earn financial incentives for the percentage of members 45-75 years of age who had appropriate screening for colorectal cancer. Learn more at **www.thealliance.health/crcscreening**.



Know the difference between ECM and CICM

Enhanced Care Management (ECM) and California Integrated Care Management (CICM) are two care management approaches under CalAIM. Understanding which program applies to a given patient ensures proper referral and coordination and avoids duplicating services.

ECM program

ECM is a Medi-Cal benefit designed for individuals with the most complex medical, behavioral and social needs.

Under ECM, eligible members are assigned a single care manager who coordinates a comprehensive, whole-person care plan, which includes:

- Physical and behavioral health.
- Long-term services and supports.
- Oral care.
- Social needs.

This care is primarily delivered through in-person, community-based services. Learn more at **www.thealliance.health/ecm-cs-provider-information**.

CICM program

CICM is for members of dual-eligible plans (D-SNPs) within Medi-Cal managed care. It's the program under which D-SNP beneficiaries receive integrated care coordination, especially when ECM would otherwise apply.

In practice, CICM effectively replaces ECM-like care management for D-SNP members, helping avoid parallel care management efforts. Learn more at **www.thealliance.health/cicm-providers**.

The Alliance offers no-cost language assistance services

The Alliance is committed to ensuring that our members have access to culturally and linguistically appropriate care. We offer a variety of language assistance services that our provider network can utilize, including the following.

Telephonic interpreting services

Alliance providers may directly access a qualified telephonic interpreter 24 hours a day, 7 days a week. Please see our quick reference guide for instructions on how to utilize this service at **www.thealliance.health/interpreter-services-provider-quick-reference-guide**.

Face-to-face and virtual remote interpreting services

Providers may request an interpreter for a member's appointment by submitting a request form by fax to **831-430-5850**. The form is available on our website at **www.thealliance.health/interpreter-request-form**. Prior approval is required.

Interpreter services for hearing-impaired members

Providers may also use the Hearing or Speech Assistance Line at **800-735-2922** (English) or **800-855-3000** (Spanish) to communicate with a hearing-impaired member via phone.

Training and support available

Providers may request training support with language assistance services. Call the Health Education Line at **800-700-3874, ext. 5580,** or email **listcl@thealliance.health** for additional information.

Using an untrained interpreter may result in miscommunication of medical information, compromising quality of care. For this reason, the Alliance discourages providers from using family members or any unqualified personnel as interpreters.

Risk adjustment improves quality of care for members

What is risk adjustment?

Risk adjustment is a reimbursement model that funds health plans based on patient health risks.

The Centers for Medicare & Medicaid Services (CMS) created this payment model to ensure that patients with complex health conditions have equitable access to necessary resources and care. The model:

- Identifies patient needs based on their risk profiles, helping providers to develop care plans.
- Assigns each enrollee a risk score based on their health status and other factors. A higher risk score indicates a higher likelihood of needing more health care services.
- Uses certain ICD-10 diagnosis codes reported by clinicians to calculate risk-adjusted reimbursements.

How do providers support risk adjustment?

Providers can support risk adjustment by identifying and addressing risk-related care gaps and documenting them accurately in each patient's medical record. This way, an Alliance member's health status is correctly documented.

Incentives for providers

The Alliance Risk Adjustment Coding & Documentation Accuracy Incentive Program is designed to support providers with addressing chronic conditions and improving health care outcomes for Alliance members. The program helps ensure patients are scheduled annually for a comprehensive visit and supports providers with managing chronic health conditions.

Visit **www.thealliance.health/risk-adjustment-incentive** to learn more about the program. We also have trainings and webinars about the program available for your review at **www.thealliance.health/risk-adjustment-101**.

Introducing Cozeva: Point-of-care solutions for better patient outcomes

The Alliance has selected Cozeva as its point-of-care solution system to help share information with CMS and support risk adjustment. The Alliance is in the process of working with a subset of providers to implement Cozeva.

For all other providers, if you have questions about Cozeva implementation or want to know more about this program, please reach out to your designated Provider Relations Representative.

What does Cozeva do?

With Cozeva, providers can involve patients in their care through better communication about health risks and personalized care strategies. This system helps providers deliver high-quality care by displaying potential conditions a patient may have. To learn more about Cozeva, visit **www.thealliance.health/risk-adjustment**.

Concurrent use of opioids with other CNS depressants: Safe prescribing considerations

Prescribing opioids concurrently with other central nervous system (CNS) depressants significantly increases risk of overdose and respiratory depression. The U.S. Food and Drug Administration (FDA) and the Centers for Disease Control and Prevention (CDC) caution against combining opioids with benzodiazepines, sedative hypnotics or antipsychotics because their addictive, depressant effects can be dangerous, particularly in patients with comorbid psychiatric or chronic pain conditions.

Antipsychotics

FDA issued a boxed warning for co-prescription of antipsychotics with opioids. Patients with severe mental illness are approximately 2.5 times more likely to receive opioids for chronic pain, making targeted risk mitigation for this population especially important.

A study using data from 2004 to 2017 found that concurrent use of any antipsychotic with opioids nearly doubled the risk of overdose versus using opioids alone. Sedating antipsychotics increased overdose risk almost threefold. Nonsedating antipsychotics increased it by 71%. Although this was an observational study only, it highlights clinically meaningful risk differentials that should inform prescribing decisions.[1]

Benzodiazepines

Benzodiazepines are frequently prescribed alongside opioids. One study found this combination in about 80% of patients on opioid therapy. A 2016 cohort study showed patients taking both opioids and benzodiazepines had nearly 10 times the risk of death from overdose compared to those using opioids alone. This underscores how strongly these medications can compound respiratory depressant effects.[2]

Z-drugs

Z-drugs are often used for insomnia. A cohort analysis found that co-use of opioids with Z-drugs resulted in nearly a fourfold increased overdose risk

before adjustment and more than double the risk after adjustment, demonstrating that even non-benzodiazepine sedatives raise safety concerns when combined with opioids.[3]

Clinical recommendations

- Co-prescribe naloxone. Educate patients and caregivers on overdose response.
- Reserve concurrent prescribing of opioids with antipsychotics, benzodiazepines or sedatives for cases where alternatives are inadequate.
- Implement tapering strategies where feasible to reduce polypharmacy.
- Use nonpharmacologic therapies such as CBT-I and behavioral pain management.

[1]Szmulewicz AG, Bateman BT, Levin R, Huybrechts KF. "Risk of Overdose Associated With Co-prescription of Antipsychotics and Opioids: A Population-Based Cohort Study." *Schizophr Bull.* 2022;48(2):405-413.

[2]Dasgupta N, Funk MJ, Proescholdbell S, Hirsch A, Ribisl KM, Marshall S. "Cohort Study of the Impact of High-Dose Opioid Analgesics on Overdose Mortality." *Pain Med.* 2016;17(1):85-98.

[3]Szmulewicz AG, et al. "The Risk of Overdose With Concomitant Use of Z-Drugs and Prescription Opioids: A Population-Based Cohort Study." *Am J Psychiatry.* 2021;178(7):643–650.

Medi-Cal Rx drug utilization review (DUR) articles

Please review the following Medi-Cal Rx DUR articles published since January 2025:

1. Mail-Back Envelopes for Opioids Now Available.
2. Xylazine in Illicit Drugs Increases Dangers Associated With Overdose.
3. Menopausal Hormone Therapy for Bothersome Vasomotor Symptoms.
4. Pharmacists Furnishing of Nicotine Replacement Therapy Products.
5. Measles Vaccination Prevents Outbreaks, Protects Californians.
6. 2024 Immunization Update: COVID-19, Influenza, RSV, Pneumococcal, Polio, Meningococcal, Hib, HepB and Mpox.

These resources are linked on the Alliance's Additional Pharmacy Information webpage. Visit **www.thealliance.health/pharmacydur**.

Alliance's physician-administered drugs 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 at **www.thealliance.health/pad**. If you would like to request physical copies, please call 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.

Welcome, new providers!

– Continued from page 3

Merced County

Behavioral health

- **Mary Bartels, MD,** Psychiatry
- **Gillian Gong, BCBA**
- **Dominic Gonzalez-Ramos, BCBA**
- **Jordan Ingersoll, BCBA**
- **Sharon Jones, LMFT**
- **Eva Lomeli, LCSW**
- **Alexis Lopez, BCBA**
- **Joseph Vallejos, BCBA**
- **Susan Vang, LCSW**
- **Veronica Watson, LMFT**
- **Kerstyn Wilson, BCBA**
- **Jillian Yelinek, BCBA**

Monterey County

Behavioral health

- **Rachel Angeley, BCBA**
- **Alexis Arias, BCBA**
- **Vagik Babakhanian, BCBA**
- **Stephanie Bouc, PhD**
- **Anjanette Brannon, LMFT**
- **Helen Bryant, LCSW**
- **Courtney Ford, BCBA**
- **Genesiss Gomez, BCBA**
- **Ofelia Gonzalez-Gomez, LCSW**
- **Lauren Grawert, MD,** Psychiatry
- **Segen Isaac, BCBA**
- **Jennifer Lewis, LCSW**
- **Karina Madrigal, BCBA**
- **Rosa Sanchez Martinez, BCBA**
- **Chinh Nguyen, LCSW**
- **Lorraine Romano, BCBA**
- **Cristal Santana, LMFT**
- **Jessica Spells, BCBA**
- **Selia Torres, BCBA**
- **Lizeth Toscano, LCSW**
- **Martha Tovar, LMFT**
- **Stephen Watson, BCBA**

Santa Cruz County

Behavioral health

- **Robert Bartee, PhD,** Psychology
- **Mary Cahill, LMFT**
- **Craig Clark, LMFT**
- **Daniel Dailey, LMFT**
- **Kelley Herrin, LMFT**
- **Barbara Oberg, LMFT**
- **Erica Prindle, LCSW**

New ECM/CS providers

- **CommuniT.** ECM/CS housing services, respite services, personal care and homemaker services. All counties.
- **Court-Appointed Special Advocates of San Benito (CASA).** ECM. San Benito County.
- **Esteem Health.** ECM. Monterey County.
- **Fresh Start Recovery Homes.** CS recuperative care, short-term post-hospitalization services. Mariposa and Merced counties.
- **Loving Solutions.** ECM. Merced, Monterey and San Benito counties.

Holiday office closures

- **Monday, May 25** (Memorial Day)
- **Friday, June 19** (Juneteenth)

Living **Healthy**

A newsletter for the members of
Central California Alliance for Health

March 2026 | VOLUME 32, ISSUE 1

The Alliance earns national recognition for quality and equity in health care

Central California Alliance for Health earned accreditation from the National Committee for Quality Assurance (NCQA) for meeting high national standards for quality, fairness and safety in health care.

NCQA Health Plan Accreditation

This shows that we meet national standards for:

- Managing care.
- Helping members get the right care at the right time.

NCQA Health Equity Accreditation

This shows how we make health care fair and respectful for all. NCQA looks at how health plans:

- Offer culturally competent care and services.
- Provide language assistance services.
- Work to reduce health gaps in their communities.

"Our team, providers and community partners all share one goal: to make sure every member receives the best care possible," says Michael Schrader, the Alliance CEO.

Learn more at **www.thealliance.health/ncqa**.

As we celebrate our 30th anniversary this year, this national recognition reflects our long-standing commitment to providing high-quality, equitable care.

We continue to work toward a vision of healthy people, healthy communities in Mariposa, Merced, Monterey, San Benito and Santa Cruz counties.

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Medi-Cal has changed: Here's what you need to know

Medi-Cal changes took effect on Jan. 1, 2026. For most Alliance members, coverage and benefits stayed the same. You can keep going to your doctor and using your health care benefits. If you need care from home, ask about telehealth options.

Some members saw updates to their Medi-Cal. You can learn about these updates at **www.thealliance.health/mcc2026**. If you are not sure if your Medi-Cal is active, call your county's Medi-Cal office or check your status on **www.benefitscal.com**.

Make sure to renew your Medi-Cal on time. Watch for a yellow renewal envelope in the mail from your county Medi-Cal office. Complete and return it before the deadline, or renew through the BenefitsCal website. If your contact information changes, update it right away so you don't miss important updates.

If your coverage ended because of missing paperwork or a late renewal, you have 90 days to submit your forms. This will restart your Medi-Cal without having to apply again.

For the most up-to-date information, visit the California Department of Health Care Services website at **www.thealliance.health/DHCS-changes**.

Alliance language assistance services

Do you have trouble talking to your doctor? We can help! You do not have to use family or friends to interpret for you at doctor visits. The Alliance offers interpreting services in person and by phone.

If you would like to get an interpreter or written information in your language, please call the Alliance Health Education Line at **800-700-3874, ext. 5580**. We have a special telephone line to get an interpreter who speaks your language. This is available at no cost to you. For the Hearing or Speech Assistance Line, call **800-735-2929** (TTY: Dial **711**).

About your Provider Directory and Member Handbook

The Provider Directory and Member Handbook have important information about your health plan.

- **Provider Directory:** lists all the primary care doctors in the Alliance network.
- **Member Handbook:** tells you about the coverage that the Alliance provides for you.

You can view the Provider Directory and the Member Handbook on our website at **www.thealliance.health/member-handbook**. Call Member Services if you want a copy mailed to you, need help finding a provider or have benefit questions.

To talk to our Member Services team, please call **800-700-3874**. For the Hearing or Speech Assistance Line, call **800-735-2929** (TTY: Dial **711**). We are here from 8 a.m. to 5:30 p.m., Monday through Friday. The call is toll-free. If you speak a language other than English, language assistance services are available to you at no cost.

Important phone numbers to know

- Alliance Member Services: **800-700-3874** (TTY: Dial **711**).
- 24/7 Alliance Nurse Advice Line: **844-971-8907**.
- Alliance Language Assistance Services: **800-700-3874, ext. 5580**.
- Mental Health Services: Alliance Member Services: **800-700-3874** (TTY: Dial **711**).
- Vision Services Plan (for routine vision services): **800-877-7195**.
- Medi-Cal Dental Program (for dental services): **800-322-6384**.
- 24/7 Medi-Cal Rx (for pharmacy services): **800-977-2273** (TTY: Dial **711**).
- Alliance Care Management Line: **800-700-3874, ext. 5512**.
- Alliance Health Education Line: **800-700-3874, ext. 5580**.
- Alliance Transportation Services: **800-700-3874, ext. 5577**.

The Member Handbook has information about Continuity of Care, Member Rights and Responsibilities, how to get help with appointments, filing a grievance or an appeal, and how to request materials in other languages and formats to meet members' needs at no cost to the member. It is updated every year.

Ask the **doctor**

Do I need a colorectal cancer screening?

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.

In the United States, colorectal cancer is the fourth most common cancer found in men and women. Colorectal cancer happens when cells in the colon or rectum grow out of control. Here are a few things you need to know about a colorectal cancer screening.

What is a colorectal cancer screening? Why is it important?

A colorectal cancer screening is when your doctor checks to see if you have any precancerous polyps (small clumps of cells) or signs of colorectal cancer. The screening is used to check for disease even if you don't have any symptoms. It is important to check for cancer through regular screenings. Early treatment works best to help prevent serious health issues!

Screening tests consist of something as simple as a stool test. The stool test is usually done every year in people 45 to 75 years of age. Some people need a colonoscopy. This lets a doctor see inside the intestine using a flexible scope. Your doctor can answer questions about screenings and decide the best test for you.

If you are an Alliance member, you can be screened for colorectal cancer at no cost to you. Talk to your doctor to set up your screening!

Am I at risk for colorectal cancer?

Colorectal cancer is commonly found in adults over age 50. However, there has been an increase in colorectal cancer in adults 40 to 49 years old.

You might be more likely to have colorectal cancer if:

- You have inflammatory bowel disease.
- Someone in your family had colorectal cancer or polyps.

There are other parts of your lifestyle that can affect your risk level for colorectal cancer. These include:

- Diet.
- Exercise.
- Alcohol and tobacco use.

When should I get screened for colorectal cancer?

If you are 45 to 75 years old, you should be screened for colorectal cancer. How often you get screened depends on the type of screening test you get. For example, you might need a stool test every year, or you might need to get a colonoscopy once every 10 years.

You have prescription benefits!

If you are a Medi-Cal member, your prescription drugs that are filled at a pharmacy are covered by Medi-Cal Rx and not the Alliance. To find out if a drug is covered, call **800-977-2273** (TTY: Dial **711**) or go to **www.medi-calrx.dhcs.ca.gov**.

If you are an IHSS member, pharmacy services are managed by MedImpact. You can view the list of covered drugs at **www.thealliance.health/prescriptions**. You can also request a mailed copy by calling Member Services at **800-700-3874** (TTY: Dial **711**).

Drugs given in a doctor's office or clinic

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

Wellness for all

The Alliance offers health education programs

At the Alliance, we care about your health! Our health education programs give Alliance members the tools they need to get healthy and stay healthy. There is no cost for Alliance members to join. Programs are offered in person, online or over the phone.

The Alliance also has a Health Rewards Program that rewards you and your family for taking actions that support your health! Check out our rewards at **www.thealliance.health/health-rewards-program**.

For more information on our health education programs, visit **www.thealliance.health/health-and-wellness**. If you would like to sign up for a program or have questions, please call the Alliance Health Education Line at **800-700-3874, ext. 5580**. If you need language assistance, we have a special telephone line to get an interpreter who speaks your language at no cost to you. For the Hearing or Speech Assistance Line, call **800-735-2929** (TTY: Dial **711**).

Program	Who is it for ?
Live Better with Diabetes Program	Adult members who have diabetes or prediabetes.
Healthier Living Program	Adult members who have chronic conditions like asthma, heart disease, high blood pressure, obesity or depression.
Adult Weight Management Program	Adult members who are interested in reaching a healthy weight.
Healthy Weight for Life	Parents of members ages 2 to 18 who want to help their child reach a healthy weight.
Healthy Moms and Healthy Babies	Members who are pregnant or who had a baby in the last 12 months.
Tobacco Cessation Support	Members who want to stop smoking and/or using tobacco products.

Community Corner

Neurodiversity Celebration Week is in March

Everyone's brain is unique!

Neurodiversity means that everyone's brain works in its own way. That's a good thing. These differences help us see new points of view and solve problems in creative ways.

Neurodivergent means that a person may think, learn or act in different ways than other people they know.

About 1 in 5 people are neurodivergent. This can be people with:

- Autism.
- Attention-deficit/hyperactivity disorder (ADHD).
- Dyslexia.
- Other brain differences.

These differences are not problems to fix. They are just different ways of thinking and learning. Many people with neurodivergent minds have special strengths, like creativity, new ideas and problem-solving skills.

At the Alliance, we believe caring for your brain is as important as caring for your body. We work with families and doctors so people with neurodivergent minds get support.

Learn more at **www.thealliance.health/behavioral-health-care**.

Need support?

- Call **Alliance Member Services** at **800-700-3874**.
- Talk to your doctor about your concerns. Your doctor can also refer you to other providers so you can get the care you need.

If you're looking for mental health or substance use support, you can:

- Call **Alliance Member Services** at **800-700-3874**.
- Find a provider near you or an online provider. See our **Provider Directory** at **www.thealliance.health/provider-directory**. We can also mail you a printed Provider Directory.
- Call your **local county behavioral health office**.

It's important to support and include everyone, no matter how their brain works. Let's work together to help everyone feel welcome and respected. Everyone should have a chance to succeed.

TotalCare is here: One plan, more support, better health

As of Jan. 1, 2026, Alliance members who are eligible for both Medicare and Medi-Cal may be able to sign up for the Alliance's Medicare Advantage plan, TotalCare (HMO D-SNP). TotalCare combines Medi-Cal and Medicare benefits into one plan.

Who can sign up for TotalCare?

You may be able to sign up for TotalCare if:

- You are age 65 years or older during enrollment.
- You are age 21 years or older with certain disabilities.
- You live in one of these counties: Mariposa, Merced, Monterey, San Benito or Santa Cruz.
- You are eligible right now for full Medi-Cal.
- You have both Medicare Part A and Part B.

What are the benefits of TotalCare?

TotalCare members get no-cost health care and no- or low-cost prescription drugs. They also get extra benefits like:

- More vision care.
- A flexible spending card to buy over-the-counter (OTC) products.
- A fitness benefit.
- Worldwide emergency/urgent care coverage.

TotalCare members also get a care manager. A care manager can help you with things like:

- Understanding your plan benefits.
- Finding providers in the TotalCare network.
- Getting authorizations for health care or supplies.

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

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 — Randi Motson
Quality and Health Programs Supervisor — Ivonne Muñoz

www.thealliance.health

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/ocr/portal/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)).

العربية (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) (الاتصال 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: Զանգահարեք 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)):

ភ្ជាសម្គាល់ជាភាសាខ្មែរ (Cambodian)
ចំណាំៈ បើអ្នក ត្រូវ ការជំនួយ ជាភាសា របស់អ្នក សូម ទូរស័ព្ទទៅលេខ 1-800-700-3874 (TTY: 1-800-735-2929; 711)។ ជំនួយ និង សេវាកម្ម សម្រាប់ ជនពិការ ដូចជាឯកសារសរសេរជាអក្សរធ្ងន់ សម្រាប់ជនពិការភ្នែក ឬឯកសារសរសេរជាអក្សរពុម្ពធំ 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.
اعضا با شماره TotalCare (HMO D-SNP) 1-833-530-9015تماس بگیرند(TTY: 1-800-735-2929 (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: ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໃຫ້ໂທຫາເບີ 1-800-700-3874 (TTY: 1-800-735-2929; 711). ຍັງມີຄວາມຊ່ວຍເຫຼືອແລະການບໍລິການສໍາລັບຄົນພິການ ເຊັ່ນເອກະສານທີ່ເປັນອັກສອນນູນແລະມີໂຕພິມໃຫຍ່ ໃຫ້ໂທຫາເບີ 1-800-700-3874 (TTY: 1-800-735-2929; 711). ການບໍລິການເຫຼົ່ານີ້ບໍ່ຕ້ອງເສຍຄ່າໃຊ້ຈ່າຍໃດໆ. ສະມາຊິກ TotalCare (HMO D-SNP) ໃຫ້ໂທຫາ 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 hluo mbiutc aengx caux aamz mborqv benx domh sou se mbenc nzoih bun longc. Douc waac daaih lorx 1-800-700-3874 (TTY: 1-800-735-2929; 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 serbisyong 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

Marzo 2026 | VOLUMEN 32, NÚMERO 1

La Alianza consigue reconocimiento nacional por su calidad y equidad en el cuidado de la salud

Central California Alliance for Health obtuvo la acreditación del Comité Nacional de Garantía de Calidad (National Committee for Quality Assurance; NCQA, por sus siglas en inglés) por cumplir con altos estándares nacionales de calidad, equidad y seguridad en el cuidado de la salud.

Acreditación de los planes de salud del NCQA

Esto demuestra que cumplimos los estándares nacionales de:

- Manejo del cuidado.
- Ayuda a los miembros a recibir el cuidado correcto en el momento adecuado.

Acreditación de equidad de salud del NCQA

Esto demuestra cómo hacemos que el cuidado de la salud sea justo y respetuoso para todos. NCQA analiza cómo los planes de salud:

- Ofrecen cuidado y servicios culturalmente competentes.
- Proporcionan servicios de asistencia lingüística.
- Trabajan para reducir las brechas de salud en sus comunidades.

Obtenga más información en **www.thealliance.health/es/ncqa**.

"Nuestro equipo, proveedores y socios comunitarios comparten un objetivo: asegurar que cada miembro reciba el mejor cuidado posible", dice Michael Schrader, CEO de la Alianza.

Al celebrar este año nuestro 30.º aniversario, este reconocimiento nacional refleja nuestro compromiso de larga data con la oferta de un cuidado de alta calidad y equitativo. Seguimos trabajando hacia una visión de personas sanas y comunidades sanas en los condados de Mariposa, Merced, Monterey, San Benito y Santa Cruz.

Medi-Cal ha cambiado: Esto es lo que usted debe saber

Los cambios en Medi-Cal entraron en vigor el 1.º de enero de 2026. Para la mayoría de los miembros de la Alianza, la cobertura y los beneficios quedaron iguales. Usted puede seguir yendo a su doctor y usando sus beneficios de salud. Si necesita cuidado desde su casa, pregunte por las opciones de telesalud.

Algunos miembros vieron actualizaciones en su Medi-Cal. Puede informarse sobre estas actualizaciones en **www.thealliance.health/es/mcc2026.** Si no está seguro de que su Medi-Cal está activo, llame a la oficina de Medi-Cal de su condado o verifique su estado en **www.benefitscal.com**.

Asegúrese de renovar su Medi-Cal a tiempo. Esté atento a recibir por correo un sobre amarillo de renovación enviado por la oficina de Medi-Cal de su condado. Rellénelo y devuélvalo antes de la fecha límite, o renuévalo mediante el sitio web de BenefitsCal. Si cambia su información de contacto, actualícela cuanto antes para no perderse actualizaciones importantes.

Si su cobertura terminó por falta de documentación o por una renovación tardía, tiene 90 días para enviar sus formularios. Esto reiniciará su Medi-Cal sin que tenga que volver a solicitarlo.

Para tener la información más actualizada, visite el sitio web del Departamento de Servicios de Cuidado de Salud de California en **www.thealliance.health/DHCS-changes**.

Servicios de asistencia lingüística de la Alianza

¿Tiene problemas para hablar con su doctor? ¡Podemos ayudar! No tiene que recurrir a familiares o amistades para que le interpreten en las visitas al doctor. La Alianza ofrece servicios de interpretación en persona y por teléfono.

Si desea la ayuda de un intérprete o información escrita en su propio idioma, llame a la Línea de Educación de Salud de la Alianza al **800-700-3874, ext. 5580**. Tenemos una línea telefónica especial para conseguir un intérprete que hable su idioma. Usted tiene esto disponible sin costo alguno. Para la Línea de Asistencia de Audición o del Habla, llame al **800-855-3000** (TTY: Marque **711**).

Acerca de su Directorio de Proveedores y Manual para Miembros

El Directorio de Proveedores y el Manual para Miembros contienen información importante sobre su plan de salud.

- **Directorio de Proveedores:** enumera todos los doctores de cuidado primario en la red de la Alianza.
- **Manual para Miembros:** le informa sobre la cobertura que le brinda la Alianza.

Puede ver el Directorio de Proveedores y el Manual para Miembros en nuestro sitio web en **www.thealliance.health/es/member-handbook**. Llame a Servicios para Miembros si desea que se le envíe una copia por correo, necesita ayuda encontrando un proveedor o tiene preguntas sobre los beneficios.

Para hablar con nuestro equipo de Servicios para Miembros, llame al **800-700-3874**. Para la Línea de Asistencia de Audición o del Habla, llame al **800-855-3000** (TTY: Marque **711**). Estamos aquí de 8 a.m. a 5:30 p.m., de lunes a viernes. La llamada es gratuita. Si habla un idioma que no sea el inglés, tenemos servicios de asistencia con el idioma disponibles para usted sin costo.

Números de teléfono importantes que debe conocer

- Servicios para Miembros de la Alianza: **800-700-3874** (TTY: Marque **711**).
- Línea de Consejos de Enfermeras de la Alianza (Nurse Advice Line; NAL, por sus siglas en inglés) las 24 horas, los 7 días de la semana: **844-971-8907**.
- Servicios de Asistencia del Idioma de la Alianza: **800-700-3874, ext. 5580**.
- Servicios de Salud Mental: Servicios para Miembros de la Alianza: **800-700-3874** (TTY: Marque **711**).
- Plan de Servicios de la Vista (para servicios de la vista de rutina): **800-877-7195**.
- Programa Dental de Medi-Cal (para servicios dentales): **800-322-6384**.
- Medi-Cal Rx 24/7 (para servicios de farmacia): **800-977-2273** (TTY: Marque **711**).
- Línea de Manejo de Cuidado de la Alianza: **800-700-3874, ext. 5512**.
- Línea de Educación de Salud de la Alianza: **800-700-3874, ext. 5580**.
- Servicios de Transporte de la Alianza: **800-700-3874, ext. 5577**.

El Manual para Miembros contiene información sobre el Cuidado Continuo, Derechos y Responsabilidades del Miembro, cómo obtener ayuda con las citas, presentar una queja o apelación, y cómo solicitar materiales en otros idiomas y formatos para satisfacer las necesidades de los miembros sin costo alguno para ellos. Se actualiza cada año.

Pregúntele al **doctor**

¿Necesito una prueba de cáncer colorrectal?

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.

En los Estados Unidos, el cáncer colorrectal es el cuarto cáncer más común en hombres y mujeres. El cáncer colorrectal ocurre cuando las células del colon o recto crecen de forma incontrolada. Éstas son algunas cosas que usted debe saber sobre la prueba de cáncer colorrectal.

¿Qué es una prueba de cáncer colorrectal? ¿Por qué es importante?

En una prueba colorrectal, el doctor verifica si usted tiene pólipos precancerosos (pequeñas agrupaciones de células) o signos de cáncer colorrectal. La prueba se usa para detectar la enfermedad incluso si usted no tiene ningún síntoma. Es importante detectar el cáncer a través de hacerse pruebas regularmente. ¡El tratamiento temprano funciona mejor para ayudar a prevenir problemas de salud graves!

Las pruebas son tan simples como una prueba de heces. La prueba de heces suele realizarse cada año en personas de entre 45 y 75 años. Algunas personas necesitan una colonoscopia. Esto permite al doctor ver el interior del intestino mediante un endoscopio flexible. Su doctor puede responder preguntas sobre las pruebas y decidir cuál es la mejor prueba para usted.

Si usted es miembro de la Alianza, puede hacerse la prueba de cáncer colorrectal sin costo alguno. ¡Hable con su doctor para programar su prueba!

¿Tengo algún riesgo de padecer cáncer colorrectal?

El cáncer colorrectal se encuentra con mayor frecuencia en adultos mayores de 50 años. Sin embargo, ha habido un aumento en el cáncer colorrectal en adultos de 40 a 49 años.

Usted podría tener más probabilidades de desarrollar cáncer colorrectal si:

- Tiene enfermedad inflamatoria intestinal.
- Alguien de su familia ha tenido cáncer colorrectal o pólipos.

Hay otras partes de su estilo de vida que pueden afectar su nivel de riesgo del cáncer colorrectal. Entre ellas están:

- La dieta.
- El ejercicio.
- El consumo de alcohol y tabaco.

¿Cuándo debo hacerme la prueba de cáncer colorrectal?

Si tiene entre 45 y 75 años, debe hacerse una prueba de cáncer colorrectal. La frecuencia con la que se haga la prueba depende del tipo de prueba que le hagan. Por ejemplo, puede que necesite una prueba de heces cada año, o que necesite una colonoscopia cada 10 años.

¡Tiene beneficios de medicinas recetadas!

Si usted es miembro de Medi-Cal, sus medicinas recetadas que se surten en una farmacia están cubiertas por Medi-Cal Rx y no por la Alianza. Para averiguar si una medicina está cubierta, llame al **800-977-2273** (TTY: Marque **711**) o vaya a **www.medi-calrx.dhcs.ca.gov**.

Si usted es miembro de IHSS, los servicios de farmacia son administrados por MedImpact. Puede ver la lista de medicinas cubiertas en **www.thealliance.health/es/prescriptions**. También puede solicitar una copia enviada por correo llamando a Servicios para Miembros al **800-700-3874** (TTY: Marque **711**).

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

Estos se consideran medicinas administradas 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, comuníquese con Servicios para Miembros al **800-700-3874** (TTY: Marque **711**).

Bienestar para todos

La Alianza ofrece programas de educación para la salud

¡En la Alianza, nos preocupamos por su salud! Nuestros programas de educación para la salud brindan a los miembros de la Alianza las herramientas que necesitan para estar y mantenerse saludables. No hay ningún costo para que participen los miembros de la Alianza. Los programas se ofrecen en persona, en línea o por teléfono.

La Alianza también tiene un Programa de Recompensas de Salud que los recompensa a usted y a su familia por tomar medidas que apoyan su salud. Eche un vistazo a nuestras recompensas en **www.thealliance.health/es/health-rewards-program**.

Para obtener más información sobre nuestros programas de educación para la salud, visite **www.thealliance.health/es/health-and-wellness**. 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**. Si necesita asistencia lingüística, tenemos una línea telefónica especial para conseguir un intérprete que hable su idioma sin costo alguno para usted. Para la Línea de Asistencia de Audición o del Habla, llame al **800-855-3000** (TTY: Marque **711**).

Programa	¿Para quién es?
Programa *Viva Mejor con Diabetes (Live Better with Diabetes)*	Miembros adultos que tienen diabetes o prediabetes.
Programa *Tomando Control de Su Salud (Healthier Living)*	Miembros adultos que tienen condiciones crónicas como asma, enfermedades cardíacas, presión arterial alta, obesidad o depresión.
Programa *Control de Peso para Adultos (Adult Weight Management)*	Miembros adultos interesados en alcanzar un peso saludable.
Peso Sano de por Vida (Healthy Weight for Life)	Padres de miembros de 2 a 18 años que desean ayudar a su niño/a a alcanzar un peso saludable.
Mamás Saludables y Bebés Sanos (Healthy Moms and Healthy Babies)	Miembros que estén embarazadas o que hayan tenido un bebé en los últimos 12 meses.
Apoyo para Dejar de Fumar (Tobacco Cessation Support)	Miembros que quieran dejar de fumar o consumir productos de tabaco.

Rincón de la comunidad

La Semana de Celebración de la Neurodiversidad es en marzo

¡Cada cerebro es único!

La neurodiversidad significa que el cerebro de cada persona funciona a su manera. Eso es bueno. Estas diferencias nos ayudan a ver nuevos puntos de vista y a resolver problemas de formas creativas.

Neurodivergente significa que una persona puede pensar, aprender o actuar de manera diferente a otras personas a las que conoce.

Aproximadamente 1 de cada 5 personas es neurodivergente. Estas pueden ser personas con:

- Autismo.
- Trastorno de hiperactividad con déficit de atención (TDAH).
- Dislexia.
- Otras diferencias cerebrales.

Estas diferencias no son problemas que se puedan arreglar. Son simplemente formas diferentes de pensar y aprender. Muchas personas con mentes neurodivergentes tienen fortalezas especiales, como la creatividad, las ideas nuevas y la capacidad de resolver problemas.

En la Alianza creemos que cuidar de su cerebro es tan importante como cuidar de su cuerpo. Trabajamos con familias y doctores para que las personas con mentes neurodivergentes reciban apoyo.

Obtenga más información en **www.thealliance.health/es/behavioral-health-care**.

¿Necesita apoyo?

- Llame a **Servicios para Miembros de la Alianza** al **800-700-3874**.
- Hable con su doctor sobre sus preocupaciones. Su doctor también puede referirlo a otros proveedores para que reciba el cuidado que usted necesita.

Si está buscando apoyo para la salud mental o el consumo de sustancias, puede:

- Llamar a **Servicios para Miembros de la Alianza** al **800-700-3874**.
- Encontrar a un proveedor cerca de usted o que atienda en línea. Vea nuestro **Directorio de Proveedores** en **www.thealliance.health/es/provider-directory**. También podemos enviarle por correo un Directorio de Proveedores impreso.
- Llame a la **oficina local de salud de la conducta de su condado**.

Es importante apoyar e incluir a todos, sin importar cómo funcione su cerebro. Trabajemos unidos para que todos se sientan bienvenidos y respetados. Todos deberían tener una oportunidad de triunfar.

TotalCare está aquí: Un plan, más apoyo, mejor salud

A partir de 1.º del enero de 2026, los miembros de la Alianza que sean elegibles tanto para Medicare como para Medi-Cal pueden inscribirse en el plan Medicare Advantage de la Alianza, TotalCare (HMO D-SNP). TotalCare combina los beneficios de Medi-Cal y Medicare en un solo plan.

¿Quién puede inscribirse en TotalCare?

Usted puede inscribirse en TotalCare si:

- Tiene 65 años o más en el momento de la inscripción.
- Tiene 21 años o más con ciertas discapacidades.
- Vive en uno de estos condados: Mariposa, Merced, Monterey, San Benito o Santa Cruz.
- Ahora mismo es elegible para Medi-Cal completo.
- Tiene tanto la Parte A como la Parte B de Medicare.

¿Cuáles son los beneficios de TotalCare?

Los miembros de TotalCare reciben cuidado de salud gratuito y medicamentos con receta sin costo o a bajo costo. También obtienen beneficios adicionales como:

- Más cuidado de la vista.
- Una tarjeta de gasto flexible para comprar productos de venta libre.
- Un beneficio para la actividad física.
- Cobertura mundial de emergencias/cuidado urgente.

Los miembros de TotalCare también obtienen un manejador de cuidado. Un manejador de cuidado puede ayudarle con cosas como:

- Comprender los beneficios de su plan.
- Encontrar a proveedores en la red TotalCare.
- Obtener autorizaciones para el cuidado de salud o suministros.

Para saber más sobre TotalCare y cómo inscribirse, visite **www.thealliance.health/es/totalcare** o llame al **833-530-9015** (TTY: **800-735-2922** o marque **711**), de 8 a.m. a 8 p.m., siete días a la semana.

¡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.

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www.thealliance.health/es