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, October 28, 2026

3:00 p.m. – 5:00 p.m.

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

1. Members of the public wishing to observe the meeting remotely via online livestreaming may do so as follows.
    a. Computer, tablet or smartphone via Microsoft Teams:
        i. Click here to join the meeting
        ii. Meeting ID: 236 083 302 691 42
        iii. Enter your name if promoted (optional)
        iv. You may join as a guest without a Teams account
    b. Or by telephone at:
    United States: +1 872-242-9041
    Phone Conference ID: 807 857 275#

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, October 26, 2026, to the Clerk of the Board at clerkoftheboard@thealliance.health.
        i. Indicate in the subject line "Public Comment". Include your name, organization, agenda item number, and title of the item in the body of the e-mail along with your comments.

ii. Comments will be read during the meeting and are limited to three minutes.

b. In person, from an Alliance County office, during the Oral Communications section of the meeting for items not listed on the agenda or during the meeting when that item is announced.
   i. State your name and organization prior to providing comments.
   ii. Comments are limited to three minutes.

c. Via telephone by dialing:
   i. United States: +1 872-242-9041
   ii. Phone Conference ID: 807 857 275#
   iii. Press *5 to raise your hand.
   iv. The Clerk will call on you by using the last four digits of your phone number.
   v. Press *6 to unmute your line.
   vi. Comments are limited to three minutes.
   vii. Press *5 again to lower your hand when you are done speaking.

d. Via Microsoft Teams:
   i. Click here to join the meeting
   ii. Meeting ID: 236 083 302 691 42
   iii. Enter your name if prompted. Please identify yourself however you wish to be addressed as this appears online and is how we notify you when it is your turn to speak.
   iv. When the Board Chair calls for the item on which you wish to speak, select the "raise hand" icon in the meeting controls
   v. The Clerk will activate and unmute speakers in turn. Speakers will be notified shortly before they are called to speak.
   vi. Comments are limited to three minutes.
   vii. Select the "raise hand" icon again to lower your hand when you are done speaking.

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

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

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

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

3. Comments and announcements by Commission members.

A. Board members may provide comments and announcements.

4. Comments and announcements by Chief Executive Officer.

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

Consent Agenda Items: (5.– 9G.): 3:30 p.m.

5. Accept Chief Executive Officer (CEO) Report.

- Reference materials: Chief Executive Officer (CEO) Report

Pages 5-1 to 5-15

6. **Accept Alliance Financial Highlights, Balance Sheet, Income Statement and Statement of Cash Flow for the eighth month ending August 31, 2026.**

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

Pages 6-1 to 6-14

Minutes: (7A. – 7D.):

7A. **Approve Commission regular Meeting Minutes of September 23, 2026.**

- Reference materials: Minutes as above.

Pages 7A-1 to 7A-8

7B. **Accept Compliance Committee Meeting Minutes of September 2, 2026.**

- Reference materials: Minutes as above.

Pages 7B-1 to 7B-4

7C. **Accept Physician Advisory Group (PAG) Meeting Minutes of June 11, 2026.**

- Reference materials: Minutes as above.

Pages 7C-1 to 7C-6

7D. **Accept Quality Improvement Health Equity Committee (QIHEC) Meeting Minutes of June 18, 2026.**

- Reference materials: Minutes as above.

Pages 7D-1 to 7D-19

Appointments: (8A.)

8A. **Approve the appointment of Marni J. Friedman, MD, Alireza Mahmoudieh, MD, and Minoo Sarkarati, MD, to the Physicians Advisory Group (PAG).**

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

Page 8A-1

Reports: (9A-9G.)

9A. **Approve the updated 2026 Physicians Advisory Group (PAG) Meeting Calendar.**

- Reference materials:
  - Staff report and recommendation on above topic
  - Physicians Advisory Group 2026 Calendar v3

Pages 9A-1 to 9A-2

9B. **Approve the Quality Improvement Health Equity Transformation Program Workplan for Q2 2026.**

- Reference materials:
  - Staff report and recommendation on above topic
  - Q2 2026 Quality Improvement and Health Equity Transformation Program Workplan Master Updates

Pages 9B-1 to 9B-31

9C. **Approve the Quality Improvement Health Equity Transformation (QIHET) Program Evaluation.**

- Reference materials:
  - Staff report and recommendation on above topic
  - QIHET Program Evaluation 2026

Pages 9C-1 to 9C-229

9D. **Approve the Utilization Management Work Plan (UMWP) Report for Q2 2026.**

- Reference materials:
  - Staff report and recommendation on above topic
  - Utilization Management Work Plan Q2 2026

Pages 9D-1 to 9D-37

9E. **Accept the Medi-Cal Capacity Grant Program Mid-Year Report.**

- Reference materials:
  - Staff report and recommendation on above topic
  - MCGP Awards January-August 2026

Pages 9E-1 to 9E-14

9F. **Authorize the Alliance to negotiate and execute an agreement with Merced County to administer up to $2 million in Medi-Cal Administrative Activities funding in alignment with the Alliance's Medi-Cal Outreach and Retention initiative, subject to applicable requirements and agreed-upon terms.**

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

Pages 9F-1 to 9F-2

9G. **Authorize the Chairperson to sign contract amendment CY2026-A to the Alliance's Medi-Cal contract with the Department of Health Care Services (DHCS) (Contract # 23-30241 A13).**

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

Pages 9G-1 to 9G-2

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

10. **Consider and approve the Alliance Election of Officers for 2027. (3:30 – 3:40 p.m.)**

A. Michael Schrader, CEO, will review and board will consider and approve the Alliance Election of Officers for 2027

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

Page 10-1

11. **Update on Alliance Approach to Artificial Intelligence. (3:40 p.m. – 4:10 p.m.)**

A. Ms. Jenifer Mandella, Chief Compliance Officer, and Mr. Cecil Newton, Chief Information Officer, will provide an update on the Alliance's Approach to Artificial Intelligence.

- Reference materials: Staff report on above topic.

Pages 11-1 to 11-2

12. **Medi-Cal Capacity Grant Program 2027 Planning Inputs and Priorities. (4:10 – 4:40 p.m.)**

A. Ms. Jessica Finney, Community Grants Director, will review and board will discuss the inputs and emerging priorities for the 2027 MCGP Investment Plan

- Reference materials: Staff report on above topic.

Pages 12-1 to 12-4

13. **Member Outreach and Retention (MOR) Program Update. (4:40 p.m. – 5:00 p.m.)**

A. Ms. Ronita Margain, Community Engagement Director will provide an update on MOR program progress, renewal performance, key accomplishments, and ongoing efforts to support members through the Medi-Cal renewal process

- Reference materials: Staff report on above topic.

Pages 13-1 to 13-2

Information Items: (14A. – 14E.)

A. Alliance in the News Pages 14A-1 to 14A-4

B. Membership Enrollment Report Page 14B-1

Announcements:

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

- Finance Committee
  Wednesday, March 25, 2027; 1:30-2:45 p.m.
- Member Services Advisory Group
  Thursday, November 5, 2026; 10:00 – 11:30 p.m.
- Physicians Advisory Group
  Thursday, December 3, 2026; 12:00 – 1:30 p.m.
- Whole Child Model Clinical Advisory Committee [R*emote teleconference only*]
  Friday, April 16, 2027; 12:00 – 1:00 p.m.
- Whole Child Model Family Advisory Committee [R*emote teleconference only*]
  Monday, January 25, 2027; 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 October 28 meeting, unless otherwise notified.

Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission
Wednesday, December 2, 2026, 3:00 – 5:00 p.m.

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

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

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

In Merced County:
Central California Alliance for Health
530 West 16th Street, Suite B, Merced, CA

In San Benito County:
Community Services & Workforce Development (CSWD)
1161 San Felipe Road, Building B, Hollister, CA

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

Members of the public interested in attending should call the Alliance at (831) 430-2568 to verify meeting date and location prior to the meeting.

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

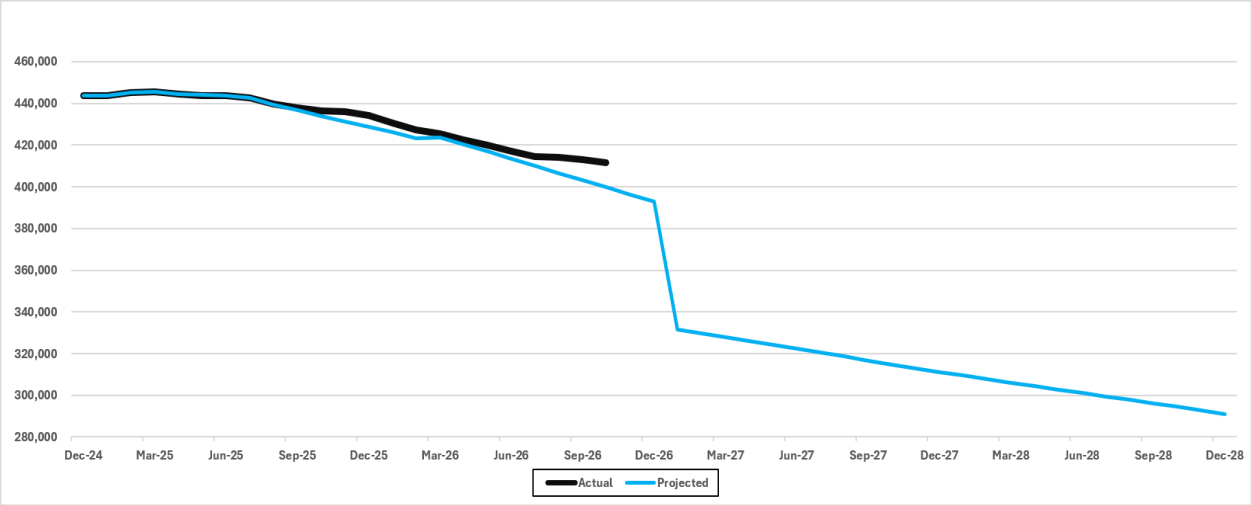
HEALTHY PEOPLE. **HEALTHY** COMMUNITIES.

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

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

Month of Service	Santa Cruz	Monterey	Merced	Mariposa	San Benito	Total MCal Enroll	Actual % Chg	Projected % Chg
Dec-24	78,574	188,781	150,138	5,769	20,612	**443,874**		
Jan-25	78,268	189,362	149,742	5,763	20,611	**443,746**	**-0.03%**	**-0.03%**
Feb-25	78,422	190,252	149,895	5,764	20,710	**445,043**	**0.29%**	**0.29%**
Mar-25	78,302	190,514	150,176	5,695	20,689	**445,376**	**0.07%**	**0.07%**
Apr-25	77,521	190,743	149,693	5,679	20,629	**444,265**	**-0.25%**	**-0.25%**
May-25	77,456	190,430	149,570	5,656	20,703	**443,814**	**-0.10%**	**-0.10%**
Jun-25	78,197	190,000	149,044	5,702	20,717	**443,661**	**-0.03%**	**-0.03%**
Jul-25	77,825	189,489	148,879	5,705	20,734	**442,633**	**-0.23%**	**-0.23%**
Aug-25	77,231	188,292	147,952	5,654	20,602	**439,730**	**-0.66%**	**-0.66%**
Sep-25	76,784	187,290	147,506	5,607	20,633	**437,821**	**-0.43%**	**-0.43%**
Oct-25	76,356	186,717	147,221	5,595	20,664	**436,554**	**-0.29%**	**-0.29%**
Nov-25	76,244	186,275	147,156	5,586	20,647	**435,907**	**-0.15%**	**-0.15%**
Dec-25	75,818	185,673	146,638	5,558	20,573	**434,260**	**-0.38%**	**-0.38%**
Jan-26	74,584	184,888	145,174	5,503	20,414	**430,563**	**-0.85%**	**-0.85%**
Feb-26	73,546	184,002	143,837	5,476	20,286	**427,147**	**-0.79%**	**-0.79%**
Mar-26	72,940	183,374	143,518	5,473	20,290	**425,595**	**-0.36%**	**-0.80%**
Apr-26	72,079	182,234	142,578	5,469	20,252	**422,612**	**-0.70%**	**-0.81%**
May-26	71,420	181,307	141,596	5,397	20,147	**419,867**	**-0.65%**	**-0.82%**
Jun-26	70,534	179,821	141,383	5,373	20,082	**417,193**	**-0.64%**	**-0.82%**
Jul-26	69,809	178,597	140,754	5,344	20,036	**414,540**	**-0.64%**	**-0.83%**
Aug-26	69,478	178,513	140,820	5,347	20,046	**414,204**	**-0.08%**	**-0.84%**
Sep-26	69,001	177,913	140,593	5,324	20,054	**412,884**	**-0.32%**	**-0.84%**
Oct-26	68,617	177,337	140,343	5,395	19,921	**411,613**	**-0.31%**	**-0.85%**

The table illustrates the monthly decline in Alliance Medi-Cal enrollment across each of our five counties and in total. Since December 2024, overall Alliance Medi-Cal enrollment has decreased from 443,874 to 411,613 members, a decline of 7.3%.



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

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

Between January 1, 2025, and December 31, 2028, Alliance enrollment is projected to decline by 39%, including a 25% reduction by January 1, 2027, of which 7.3% has already occurred.

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. Radio and television ads will resume in early October with a brand-new campaign. Changes to this upcoming flight include a modest increase in physical display (laundromats, convenience stores, gas stations, etc), YouTube and TikTok, and ad presence during the Latin Grammy awards on Univision in November. Our revised campaign features "Complete it, Check it, Return it.", which also includes a strong call to action for members to get help from our renewal partners if they need it, as well as stronger messaging encouraging them to return all

necessary forms and paperwork with their renewal packets. This campaign will run through the end of the year. We are also supporting the renewal provider events by providing signage and communications support.

Focused Member Outreach. In September, we sent out 5,368 text messages to members who were up for renewal. We are currently finalizing revised SMS messages to remind members that help is available and to be sure to return all requested materials for renewal.

Merced County Funding. Merced County Human Services Department has proposed that the Alliance administer up to $2 million in County Medi-Cal Administrative Activities funding to expand community-based outreach, member engagement, and communications efforts aligned with the Alliance's Medi-Cal Outreach and Retention (MOR) Initiative. The funding must be fully expended by June 30, 2027. At its October 28, 2026, meeting, the Alliance Board will consider a consent agenda item authorizing the Alliance to negotiate and execute an agreement with Merced County to administer these funds, subject to applicable requirements and agreed-upon terms.

Grant Funding. The Alliance's Medi-Cal Outreach and Retention (MOR) grant program continues implementation, with all 23 funded organizations supporting outreach, education and renewal assistance across the service area. The 13 active renewal assistance partners continue to accept warm transfers from the Alliance's outbound call campaign for members needing renewal assistance. Since June, 837 members have been successfully transferred to partners, representing 1 in 5 members engaged through campaign.

The Medi-Cal Renewal Events Pilot launched October 3, with five primary care providers participating across Santa Cruz, Monterey and Merced counties. Initial events have experienced limited appointments and walk-in participation. Outreach through the outbound call campaign, promotion at participating primary care sites and the event schedule available at https://thealliance.health/gethelp are helping build awareness of pilot events continuing through December.

Grant-funded training efforts continue, with Monterey County Department of Social Services completing two of five community partner training sessions. The introductory session focused on BenefitsCal drew 103 participants, followed by 59 attendees at the additional BenefitsCal support session. In partnership with UC Merced, the online Medi-Cal Renewal Support Training for CHWs and other community assisters is scheduled to launch in early November, following a delay to

ensure training content and resources are accurate and reflect evolving Medi-Cal policies and requirements. From October 19–22, the Alliance will convene MOR grantees across the service area to discuss Medi-Cal changes, share outreach and member support experiences, strengthen coordination and collaborative problem-solving, and inform 2027 community partner priorities.

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

Care Gaps and Safety Net Challenges. At the request of community partners and public agencies, CEO Michael Schrader has been presenting on Care Gaps and Safety Net Challenges to several audiences:

- Santa Cruz Health Improvement Partnership (HIP) Council (9/10)
- Salud Para La Gente Board of Directors (9/12)
- Monterey Health Symposium (9/16)
- Watsonville Community Hospital Board of Directors (9/30)
- Monterey County Board of Supervisors (10/13)
- Santa Cruz County Board of Supervisors (10/20)
- Santa Cruz County Office of Education (11/06)

The presentation focused on two populations: Alliance members expected to lose Medi-Cal coverage and become uninsured, and Alliance members with Unsatisfactory Immigration Status (UIS), who, under DHCS policy, will transition from managed care to the State Fee-For-Service program effective January 1, 2027. Tailored to each county audience, the presentation included estimates of the size of both populations within the county and examined the potential impact on affected individuals. It also reviewed anticipated reductions in state supplemental payments to providers and explored the combined effects of these changes on the local health care safety net, including federally qualified health centers, hospitals, and county-operated services.

Panel Discussion on Care Gaps and Safety Net Challenges. CEO Michael Schrader co-facilitated a panel discussion on care gaps and safety net challenges with the Executive Director of HIP at the Santa Cruz County Office of Education. Panelists included leaders from Dominican Hospital, Sutter Maternity & Surgery Center, the Pajaro Valley Health Care District, the Santa Cruz County Health Services Agency, and Salud Para La Gente, who discussed the challenges facing the local health care safety net and opportunities for community collaboration.

Labor & Delivery Convenings in Santa Cruz County. The Alliance has hosted two labor and delivery convenings, including one in-person meeting and one virtual meeting, with a third in-person convening planned. In anticipation of Salud Para La Gente's planned transition away from its labor and delivery role at Watsonville Community Hospital, the Alliance brought together representatives from Watsonville Community Hospital, Salud Para La Gente, Santa Cruz Community Health, Sutter Maternity & Surgery Center, Dominican Hospital, and the County of Santa Cruz. Through these collaborative discussions, participants have been working to identify solutions and coordinate arrangements to help ensure continued access to labor and delivery services for Santa Cruz County residents.

Watsonville Community Hospital CEO Recruitment. CEO Michael Schrader is serving on one of five interview panels participating in the recruitment of the next CEO for Watsonville Community Hospital. The Community Stakeholder Panel includes representatives from the County of Santa Cruz, County of Monterey, Pajaro Valley Unified School District, the City of Watsonville, Community Bridges, Salud Para La Gente, and the Alliance. Additional interview panels include a Physician Panel, two Hospital Leadership Panels, and an Executive Leadership Panel. Together, these panels are helping evaluate candidates and provide perspectives from key stakeholder groups involved in the hospital's future success.

Health Leadership Collaborative (HLC) in Merced. CEO Michael Schrader participated in the most recent quarterly meeting of the Health Leadership Collaborative (HLC), a convening of healthcare stakeholders from across Merced County.

The agenda included a presentation by Merced County Public Health Director and Alliance Commissioner Kristynn Sullivan, Ph.D., on the County Medical Services Program (CMSP), which Merced County is pursuing as its indigent care model rather than developing a separate county-run program.

CMSP currently serves 35 participating counties, primarily small and rural communities, including neighboring San Benito and Mariposa counties. Merced County has recently elected to join the program.

Merced County may experience a smaller increase in its uninsured population if it qualifies for an exemption from the HR1 work requirements based on local unemployment rates. If the exemption applies, fewer residents could lose coverage, which may reduce demand on the County's CMSP-administered indigent care program.

Santa Cruz County Indigent Care. Santa Cruz County continues to evaluate potential indigent care models and administrative partners. At the County's request, the Alliance is developing two proposals for consideration.

The first proposal would administer and expand the County's existing MediCruz program, which primarily provides specialty care services. The second proposal would establish a more comprehensive indigent care program that covers a broader range of healthcare services beyond specialty care.

To support the County's decision-making process, the Alliance is developing estimates for both the one-time implementation costs and the ongoing administrative costs associated with each model. In addition, the Alliance has engaged Health Management Associates (HMA) to develop a financial model that estimates the per member per month (PMPM) cost of medical services. The model will allow the County and the Alliance to evaluate different benefit designs by estimating the cost impact of adding or removing specific services and eligibility components.

Under either proposal, the Alliance would build and administer the program, including claims administration and provider payments, with medical expenses funded through a County-established fund.

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

- Mariposa Farmer's Market, Mariposa County
- Merced College Health and Wellness Fair, Merced County
- Ciclovia King City, Monterey County
- Galvilan College Health Fair, San Benito County
- San Andreas Regional Center Provider Resource Fair, Santa Cruz County

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

- Mariposa WCER Technical Assistance, Mariposa County
- Merced County Pediatric Health Workshop, Merced County

- Aging and Disabilities Resource Connection, Monterey County
- Aging and Long-Term Care Commission, San Benito County
- Uplift Central Coast, Santa Cruz County

"Care Can't Wait" Campaign. Our "Care Can't Wait" yearlong campaign aims to ensure members understand the importance of and prioritize timely care by rotating messaging in alignment with the theme. In October, we are messaging about flu vaccines and breast cancer screenings, and our winter effort will message about the Nurse Advice Line reminders. To support this campaign, we will continue to develop materials for members including flyers, newsletter articles, on-hold messaging, text messaging, social media posts, and website content.

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.

DHCS All-Plan CEO Meeting. CEO Michael Schrader participated in the quarterly DHCS All-Plan CEO meeting, which brought together managed care plan leaders from across the state. Agenda topics included the upcoming January 1, 2027 transition of Medi-Cal members with Unsatisfactory Immigration Status (UIS) from managed care plans to the State Fee-For-Service program; draft CY 2027 managed care capitation rates; updates on the Quality Withhold and Incentive Program; and developments related to the Managed Care Organization (MCO) tax. The meeting provided an opportunity for plan CEOs to discuss key policy, operational, and financing issues affecting California's Medi-Cal program.

Elected Officials Outreach. CEO Michael Schrader and Government Relations Director, Danita Carlson, met recently with our contracted representatives in Sacramento to discuss Alliance priorities and plan for outreach to elected officials after the election. With a new governor in office in January 2027 we can also expect significant turnover in key regulatory agencies and will plan for outreach and introductions. In the meantime, we have requested meetings with Speaker Robert Rivas and Senator John Laird to discuss the Alliance's role in supporting Watsonville Community Hospital.

Presentations to Monterey and Santa Cruz Counties' Boards of Supervisors. CEO Michael Schrader has been invited to present to the Monterey and Santa Cruz County Boards of Supervisors on October 13 and October 20, respectively. The

presentations will focus on emerging care gaps and safety-net challenges resulting from federal and state policy changes.

Key Alliance Initiatives. The Alliance's Project Governance Committee serves as the organization's project portfolio oversight and decision-making body. Its primary role is to ensure that projects are appropriately selected, prioritized, resourced, and monitored to align with organizational strategy and regulatory requirements. Several of the larger initiatives currently underway include:

Claims System Replacement. The Alliance is transitioning from HSP to a modern claims platform to address the current system's limitations and improve scalability, operational efficiency, regulatory adaptability, and the member and provider experience. The Alliance has completed the competitive evaluation and selected a preferred claims platform. Contract and pricing negotiations are underway, with an alternative vendor retained as a contingency, while staff advance governance, data conversion, resource, and implementation-readiness planning. The project remains targeted to begin implementation in early 2027 and go live in the second quarter of 2028.

UIS Transition. On January 1, 2027, DHCS will transition Medi-Cal members with Unsatisfactory Immigration Status (UIS) from managed care plans to the State Medi-Cal Fee-for-Service (FFS) program. To support a smooth transition, DHCS has issued a comprehensive policy guide outlining managed care plan responsibilities and operational requirements. The guidance addresses a broad range of transition activities, including member notification and outreach, provider communications, transition-of-care requirements, continuity of provider access, data-sharing requirements, authorization transfers, and additional support for special populations and high-risk members.

ECM Program Sustainability. DHCS is refocusing Enhanced Care Management (ECM) on its original design: a high-intensity care management model targeted to members with the most complex health and social needs. Expectations include frequent member engagement, primarily through in-person interactions, and the involvement of licensed professionals in the delivery of certain services. The Alliance is currently reviewing member reassessments submitted by ECM providers to ensure members continue to meet DHCS-defined populations of focus and to graduate members out of ECM when the program is no longer appropriate. Effective January 1, 2027, the Alliance's Board-approved ECM fee-for-service payment methodology and rates will take effect, aligning provider reimbursement with DHCS expectations and funding. The Alliance participated in two in-person Enhanced Care Management (ECM)

provider meetings in Merced and Salinas where the upcoming payment methodology changes were presented. The meetings provided opportunities for providers to collaborate, share strategies, and discuss operational adjustments needed to support the transition to the new payment structure.

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

Marketing, Sales & Enrollment. TotalCare enrollment reached 1,228 members effective October 1. The 2027 Annual Election Period is underway and continues through December 7, 2026. Medicare sales is supported by four permanent and three temporary sales agents. This year the Alliance has expanded Spanish-language capacity with four bi-lingual agents. Sales activity is supported by direct mail to approximately 42,000 dual-eligible members, and a paid media campaign highlighting 2027 benefits, which includes $0 covered prescription drugs. A cross-functional operations group is monitoring enrollment, call volume, appeals and grievances, and other emerging issues throughout AEP.

Member Management & Engagement. Member engagement measures continue to exceed targets: 100% of new members received care-management outreach within 30 days, compared with the 80% target, and 100% of members with complex needs received an individualized care plan within 90 days, compared with the 90% target. Health risk assessments remain timely, with approximately 80% completed at the point of sale. Our first TotalCare member has been incorporated into the Member Services Advisory Group, where members across the Alliance's five counties provide input on the program and broader member needs.

Operational Stabilization. TotalCare continues its transition from implementation to steady-state operations. Enrollment transactions are 99% accurate, 100% timely, and fully accepted by CMS. Current priorities include strengthening operational governance, improving provider assignment and enrollment workflows, monitoring grievances and voluntary disenrollment, completing 2027 benefit and vendor readiness, and further developing measures for avoidable emergency department use and other member outcomes as claims data mature.

Health Services Update. Health Services continues to monitor and respond to significant changes affecting Medi-Cal benefits, member access, and healthcare expenditures. Current areas of focus include changes to housing-related Community Supports, Personal Care and Homemaker Services, and Behavioral Health Treatment, where evolving state policy and utilization trends have implications for members, providers, and the Alliance.

Recuperative Care and Short-Term Post Hospitalization Housing (STPHH). DHCS released updated Recuperative Care policy in October, establishing a revised service model effective January 1, 2027, while confirming that STPHH will sunset as a separate Community Support on December 31, 2026. The revised model removes room and board from the covered Recuperative Care service while strengthening requirements for care coordination, case management, provider supervision, and discharge planning. DHCS also released a non-binding pricing benchmark to support plan-provider contracting under the new model. The Alliance is assessing the operational and financial implications of these changes, engaging affected providers to support network sustainability and access, and coordinating transition planning for members currently receiving STPHH services.

Personal Care and Homemaker Services (PCHS). Following discussions with the Alliance and other managed care plans, DHCS is refining PCHS policy to strengthen clinical oversight and better target the benefit to members with demonstrated functional and healthcare needs. Proposed changes include greater involvement of the member's healthcare team in determining need and requiring referrals to be supported by a licensed healthcare professional. The Alliance has advocated for additional safeguards, including clearer coordination with In-Home Supportive Services and stronger standards to prevent duplication of services. Based on this evolving policy direction, the Alliance plans to retain PCHS while continuing to strengthen oversight of the benefit.

Behavior Health Therapy (BHT). BHT expenditures continue to exceed budget expectations, driven by increased utilization of Applied Behavior Analysis and related services. In response, the Alliance is following DHCS guidance and strengthening management of the benefit through updated medical necessity and authorization standards, expanded clinical and treatment plan audits, enhanced monitoring of provider utilization patterns, and increased review of treatment intensity and continued service need. The Alliance is also monitoring emerging state and federal guidance related to standardized outcome measurement for Applied Behavior Analysis services. These efforts are intended to support appropriate access to

medically necessary services while improving program oversight and the long-term sustainability of the benefit.

Merced Community Health Fair. The Alliance hosted its fourth annual Merced Community Health Fair on October 4, providing community members with direct access to preventive health services and local resources. The event provided 383 flu vaccinations, including 320 to Alliance members, compared with 339 total vaccinations in 2025, and 29 mammography screenings. More than 30 local agencies and providers participated, and over 300 food bags and four pallets of food were distributed to families. The event supports the Alliance's broader efforts to reduce barriers to preventive care and connect members and the community with available health and social resources.

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.

Joint Operating Committee (JOC) Meetings. In October, the Alliance will participate in four Hospital Joint Operating Committee (JOC) meetings with Valley Children's Hospital, Stanford Health Care, John C. Fremont Healthcare District, and Watsonville Community Hospital. These meetings provide an opportunity to share relevant network and access data, discuss organizational and operational updates, and collaborate on opportunities to strengthen provider networks and improve access to care. The Alliance participates in more than 10 JOC meetings each quarter, supporting ongoing communication and collaboration with hospital partners across its service area. Similarly, the Alliance team also collaborates with high volume primary care clinics to have regular Clinic Joint Operating Committee (cJOC) Meetings across the five counties. These meetings include data review on HEDIS/MCAS measures, clinic operational updates, grievance trends, and care-based incentive metrics.

CommonSpirit Negotiation. The Alliance continues good-faith negotiations with CommonSpirit regarding hospital, primary care, specialty, home health, imaging, and ambulatory surgery center agreements. CommonSpirit has issued termination notices effective December 31, 2026; while the Alliance remains focused on reaching a sustainable agreement, contingency planning is underway to meet regulatory requirements, preserve continuity of care, and minimize potential member disruption.

Alliance Workforce. The Alliance's strong culture is grounded in its mission to serve members. Our guiding principles are simple: we put members first, we are here to serve, and we work as one team. Most employees live in the communities we serve across our five counties. To support and strengthen this culture, the Alliance offers All-Staff meetings, interactive town halls, coffee talks with executives, annual employee engagement surveys, and biannual performance check-ins.

Workforce Numbers. As of October 5, 2026, the Alliance has 755.9 budgeted positions (regular and contingent), with 621 regular positions currently filled. An additional 83 temporary employees support our workforce needs, bringing overall staffing to 93%.

Voluntary Separation Incentive Program (VSIP). To support the Alliance's workforce planning strategy in response to projected membership and revenue reductions associated with the UIS transition, the organization launched a Voluntary Separation Incentive Program (VSIP) on September 29, 2026. The program allows eligible employees to voluntarily request separation in exchange for incentive and transition benefits, subject to organizational review and approval. The VSIP is designed to align staffing with future operational needs while potentially reducing the extent of future involuntary workforce actions. Program requests are currently under review, with final decisions anticipated in November. Leadership will continue to monitor operational, service, and financial impacts and will keep the Board informed as implementation progresses.

Senior Leadership Team Meeting. On Thursday, September 24, 2026, the Executive and Director teams met to discuss workforce updates. Van Wong, COO, and Scott Fortner, CAO, led a presentation and discussion on workforce planning in response to membership reductions and changes in workforce practices. Lisa Artana, Human Resources Director, also reviewed the Voluntary Separation Incentive Plan, including its workflow and timeline. Directors then participated in small-group discussions on the upcoming workforce reductions and next steps.

Leadership Forum: On Tuesday, September 29, 2026, Scott Fortner, CAO, and Lisa Artana, Human Resources Director, discussed the Voluntary Separation Incentive Program and workforce strategy updates. A Q&A followed to ensure leaders had the detailed information needed to understand the VSIP and related workforce strategy changes.

2026 Employee Engagement Survey. The Alliance conducts an annual survey to measure employee engagement and satisfaction. This year's survey was open

August 1–15. Although the overall engagement score declined four points from last year, it remains strong at 80% favorable. Directors received their department results the week of October 12, and Human Resources shared organization-wide results at InfoSessions held between October 15 and October 20.

Open Enrollment. Open Enrollment is the annual opportunity for employees to review and update their health and wellness benefits for the upcoming plan year. Initial planning is underway, including reviewing market trends and assessing current benefits package. Employees will receive additional information during Open Enrollment meetings in November, with new selections taking effect January 1, 2027.

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

DMHC 2024 Medical Survey Follow-Up. In September, DMHC completed its follow-up review to confirm correction of the Alliance's 2024 Medical Survey findings. Staff timely submitted required documentation and participated in audit interviews with DMHC to describe process modifications and oversight mechanisms in place to confirm continuous compliance with requirements. The interview portion of the audit concluded earlier than anticipated. Final results are pending DMHC's release of the Final Report. Compliance teams continue to monitor regulatory requirements, oversee remediation activities, and support organizational audit readiness. No material regulatory issues requiring Board action have been identified at this time.

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

Funding Opportunities. Round 3 applications for Provider Recruitment, Community Health Worker Recruitment, and Healthcare Technology programs closed August 18,

with 43 eligible applications submitted by 29 organizations. Award decisions will be distributed October 30, 2026.

Invitations to apply for the Safety Net Critical Access program were issued October 15, with applications due November 10 and awards anticipated November 30. This one-time funding opportunity aims to stabilize essential safety net providers facing financial challenges to maintain Medi-Cal member access to primary, specialty, and hospital services. The program launch was delayed to accommodate competing grant program implementation priorities and ensure alignment with the 2026 MCGP Investment Plan, emerging priorities from Board discussions, and the Alliance's strategic planning process.

Trends in the Number of Awards and Total Spend. The MCGP has paid out $25M year to date in 2026 for active grant awards, compared to $28.5M for all of 2025. New MCGP awards year-to-date in the five-county service area total $13.1M, which is 66% of the 2026 total award amount target of $20M.

DHCS Community Reinvestment Requirement. The Alliance submitted its initial Community Reinvestment Plan to DHCS by the October 15, 2026 deadline, with approval anticipated in December. DHCS requires Medi-Cal managed care plans to reinvest a portion of annual net income in community activities that improve health and advance health equity. The Alliance's Community Reinvestment Plan satisfies the requirements through investments aligned with the MCGP. The initial plan addresses CY 2024 obligations in Merced, Monterey and Santa Cruz counties.

In July, DHCS reduced the Alliance's total obligation from $5 million to $4.6 million. Prior MCGP investments fully satisfy Monterey County's obligation, leaving approximately $1.4 million to invest in Merced ($892,517) and Santa Cruz ($520,175) counties. These remaining investments will be incorporated into the 2027 MCGP Investment Plan for Board consideration, informed by county public health and behavioral health directors consistent with Community Reinvestment requirements. Funds will be awarded and expended during the 2027–2029 Community Reinvestment period.

Alliance Housing Fund. In 2024, the Alliance launched a one-time Housing Fund to expand interim and permanent housing opportunities for Medi-Cal members experiencing homelessness or housing instability. The program invested $40M to support the development, acquisition, renovation, and furnishing of housing and recuperative care projects across the service area, blending funding from the MCGP with the DHCS Housing and Homelessness Incentive Program. These projects reflect

the Alliance's continued investment in housing as a key driver of health outcomes and the strong partnerships that make these community-based solutions possible. To date, the Housing Fund has reached 17% completion of the expected 494 units to be made available to Medi-Cal members

DATE: October 28, 2026

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

FROM: Lisa Ba, Chief Financial Officer

SUBJECT: Financial Highlights for the Eighth Month Ending August 31, 2026

Consolidated (All Lines of Business)

For the month ending August 31, 2026, the Alliance reported Operating Income of $4.6M. The Year-to-Date (YTD) Operating Income is $16k, with a Medical Loss Ratio (MLR) of 94.8% and an Administrative Loss Ratio (ALR) of 5.2%. The Net Loss is $6.5M after accounting for Non-Operating Income/Expenses.

The budget expected an $11.0M Operating Loss for YTD August. The actual result is favorable to the budget by $11.0M, driven by rate variances.

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

Key Indicators	MTD Actual	MTD Budget	MTD Var $	MTD Var %	YTD Actual	YTD Budget	YTD Var $	YTD Var %
Membership	*418,756*	*410,620*	*8,136*	*2.0%*	*3,405,037*	*3,352,068*	*52,969*	*1.6%*
Revenue	$201,649	$185,632	$16,017	8.6%	$1,549,788	$1,511,047	$38,742	2.6%
Medical Expenses	187,732	185,746	(1,986)	-1.1%	1,469,893	1,436,418	(33,475)	-2.3%
Admin Expenses	9,345	10,127	781	7.7%	79,879	85,582	5,704	6.7%
Operating Income/(Loss)	**4,572**	**(10,241)**	**14,813**	**100.0%**	**16**	**(10,953)**	**10,969**	**100.0%**
Net Income/(Loss)	$4,907	($8,141)	$13,049	100.0%	($6,460)	$5,846	($12,306)	-100.0%
MLR %	93.1%	100.1%	7.0%		94.8%	95.1%	0.2%	
ALR %	4.6%	5.5%	0.8%		5.2%	5.7%	0.5%	
Operating Income %	2.3%	-5.5%	7.8%		0.0%	-0.7%	0.7%	
Net Income %	2.4%	-4.4%	6.8%		-0.4%	0.4%	-0.8%	

Medi-Cal Line of Business (Including IHSS)

For the month ending August 31, 2026, the Alliance reported Operating Income of $5.1M. The Year-to-Date (YTD) Operating Income is $6.4M, with a Medical Loss Ratio (MLR) of 94.8% and an Administrative Loss Ratio (ALR) of 4.8%. The Net Loss is $110k after accounting for Non-Operating Income/Expenses.

The budget expected Operating Income of $1.9M for YTD August. The actual result is favorable to the budget by $4.5M or 100.0%, driven by rate variances.

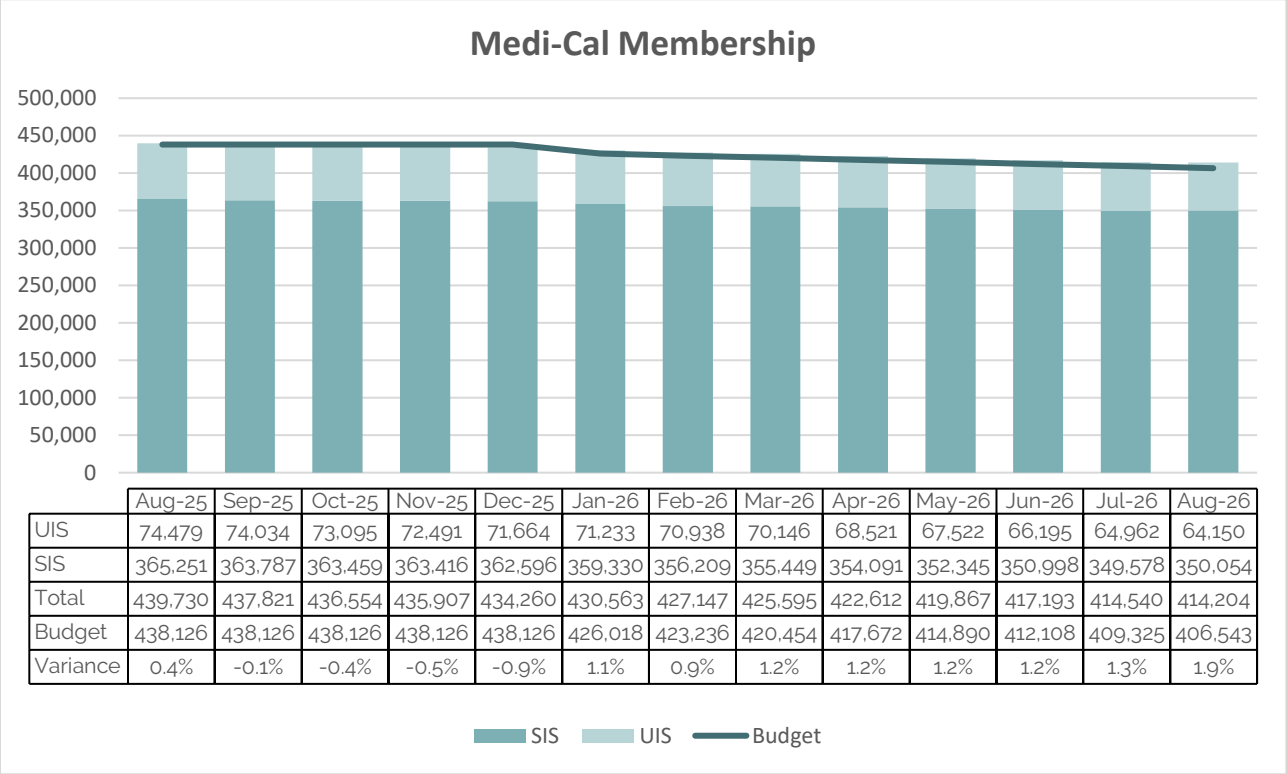
Aug-26 Income Statement
Medi-Cal ($ In 000s)

Key Indicators	MTD Actual	MTD Budget	MTD Var $	MTD Var %	YTD Actual	YTD Budget	YTD Var $	YTD Var %
Membership	*417,683*	*407,269*	*10,414*	*2.6%*	*3,399,106*	*3,336,064*	*63,042*	*1.9%*
Revenue	$199,643	$179,824	$19,819	11.0%	$1,538,473	$1,483,309	$55,165	3.7%
Medical Expenses	185,883	179,159	(6,724)	-3.8%	1,458,042	1,404,314	(53,728)	-3.8%
Admin Expenses	8,676	8,970	294	3.3%	74,065	77,117	3,051	4.0%
Operating Income/(Loss)	**5,084**	**(8,305)**	**13,389**	**100.0%**	**6,366**	**1,878**	**4,488**	**100.0%**
Net Income/(Loss)	$5,419	($6,205)	$11,625	100.0%	($110)	$18,677	($18,787)	-100.0%
PMPM								
Revenue	$477.98	$441.54	$36.44	8.3%	$452.61	$444.63	$7.98	1.8%
Medical Expenses	445.03	439.90	(5.13)	-1.2%	428.95	420.95	(8.00)	-1.9%
Admin Expenses	20.77	22.02	1.25	5.7%	21.79	23.12	1.33	5.7%
Operating Income/(Loss)	12.17	(20.39)	32.56	100.0%	1.87	0.56	1.31	100.0%
Net Income/(Loss)	$12.97	($15.24)	$28.21	100.0%	($0.03)	$5.60	($5.63)	-100.0%
MLR %	93.1%	99.6%	6.5%		94.8%	94.7%	-0.1%	
ALR %	4.3%	5.0%	0.6%		4.8%	5.2%	0.4%	
Operating Income %	2.5%	-4.6%	7.2%		0.4%	0.1%	0.3%	
Net Income %	2.7%	-3.5%	6.2%		0.0%	1.3%	-1.3%	

Membership: August 2026 Medi-Cal membership is favorable to the budget by 1.9%. The 2026 budgeted Medi-Cal enrollment assumed a 7.8% decline by year-end from projected December 2025 levels, driven by the expiration of federal flexibilities, changes to the state budget, and the implications of federal H.R. 1 legislation.

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

items, along with the ongoing redetermination process and the unwinding of COVID-19 flexibilities, are causing both Satisfactory Immigration Status (SIS) and UIS membership to trend downward and are projected to continue the remainder of the year.



	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
UIS	74,479	74,034	73,095	72,491	71,664	71,233	70,938	70,146	68,521	67,522	66,195	64,962	64,150
SIS	365,251	363,787	363,459	363,416	362,596	359,330	356,209	355,449	354,091	352,345	350,998	349,578	350,054
Total	439,730	437,821	436,554	435,907	434,260	430,563	427,147	425,595	422,612	419,867	417,193	414,540	414,204
Budget	438,126	438,126	438,126	438,126	438,126	426,018	423,236	420,454	417,672	414,890	412,108	409,325	406,543
Variance	0.4%	-0.1%	-0.4%	-0.5%	-0.9%	1.1%	0.9%	1.2%	1.2%	1.2%	1.2%	1.3%	1.9%

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

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

Region	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
CEC SIS	$1,166,491	$1,116,720	$49,771	$34,571	$15,200
CEC UIS	279,939	285,092	(5,153)	(12,358)	7,205
SBN SIS	67,229	64,957	2,273	2,992	(719)
SBN UIS	12,136	12,542	(406)	(850)	444
Total*	**$1,525,795**	**$1,479,310**	**$46,485**	**$24,356**	**$22,129**

*Excludes Aug-26 In-Home Supportive Services (IHSS) premiums revenue of $4.7M, State Incentives of $1.9M, and Prior Year revenue of $6.1M.

Back to Agenda

As of August YTD, capitation revenue exceeded the budget by $46.5M, representing a positive 3.1% variance. This variance is primarily driven by higher-than-expected SPD-LTC membership, which is 27.2% above budget. Additionally, the budget did not account for the reclassification of SPD members aged 0–20 from the Child category to SPD, implemented in 2026, which further contributes to the positive variance. Another key driver of the favorable variance was the recognition of prior-period revenue true-ups related to CY 2024 UIS Risk Corridor, TRI, and Directed Payments, which increased revenue above budget expectations. The ECM Risk Corridor was updated this month to neutralize the payable position following the DHCS' clarification of its methodology (pending the release of the official methodology), with the prior encounter-based adjustment to be recalculated in September.

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

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

Category	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
Inpatient Hospital	$395,343	$372,841	($22,502)	($7,046)	($15,456)
Inpatient LTC	150,423	145,536	(4,887)	(2,750)	(2,137)
Physician Services	300,652	324,861	24,208	(6,139)	30,347
Outpatient Facility	179,547	156,223	(23,324)	(2,952)	(20,371)
ECM	100,624	101,728	1,103	(1,922)	3,026
Community Supports	43,457	40,717	(2,740)	(769)	(1,971)
Behavioral Health	82,316	62,605	(19,711)	(1,183)	(18,528)
Other Medical*	203,768	199,804	(3,965)	(3,776)	(189)
State Incentives	1,911	-	(1,911)	-	(1,911)
TOTAL COST	**$1,458,042**	**$1,404,314**	**($53,728)**	**($26,537)**	**($27,190)**

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

August 2026 Medical Expenses of $185.9M are $6.7M or 3.8% unfavorable to the budget. August 2026 YTD Medical Expenses of $1,458.0M are above budget by $53.7M or 3.8%. Of this amount, $26.5M is due to higher enrollment and $27.2M due to rate variances. The unfavorability is primarily driven by Inpatient Hospital and Outpatient, reflecting high prior-year adjustments made in 2026, followed by Behavioral Health (BH), driven by an increase in BH utilizers as well as higher utilization of Mental Health Outpatient (MHOP) and Behavioral Health Treatment (BHT) services, and lastly by Community Supports (CS) due to higher cost trends,

At a PMPM level, YTD Medical Expenses are $428.95, which is $8.00 or 1.9% unfavorable compared to the budget.

Aug-26 YTD Medi-Cal Medical Expense by Category of Service (In PMPM)				
Category	Actual	Budget	Variance	Variance %
Inpatient Services - Hospital	$116.31	$111.76	($4.55)	-4.1%
Inpatient Services - LTC	44.25	43.62	(0.63)	-1.4%
Physician Services	88.45	97.38	8.93	9.2%
Outpatient Facility	52.82	46.83	(5.99)	-12.8%
ECM	29.60	30.49	0.89	2.9%
Community Supports	12.78	12.21	(0.58)	-4.7%
Behavioral Health	24.22	18.77	(5.45)	-29.0%
Other Medical	59.95	59.89	(0.06)	-0.1%
State Incentives	0.56	-	(0.56)	-100.0%
TOTAL MEDICAL COST	**$428.95**	**$420.95**	**($8.00)**	**-1.9%**

Inpatient Services: Inpatient Services are unfavorable to the budget, driven by higher-than expected prior-period adjustments in earlier months, which increased the expected cost included in IBNR.

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

Physician Services: Specialty utilization is trending slightly lower, consistent with normal seasonality and is expected to increase later in the year. This is partially offset by continued higher utilization in primary and FQHC, resulting in an overall favorable result for physician services. The Specialty Physicians category includes $4.3M per month in Provider Supplemental Payments (PSP), funded by Board-approved strategic use of reserves.

Outpatient Facility: The Outpatient Facility category consists of both Outpatient and Emergency Room (ER) services. This reflects a continued upward trend in both utilization per 1k and unit cost.

ECM: Overall, ECM performance is over budget and should be evaluated holistically, considering both revenue and expenses. The unfavorable variance is primarily driven by ECM enrollments experiencing an extended period of low-intensity services, which resulted in lower encounter service units and associated costs that were expected to remain unrecognized and be absorbed by the Plan.

However, DHCS clarified that because the encounter-based adjustment within the risk corridor methodology for CY 2026 was communicated late in the year, the lower encounter service units can be recognized under the risk corridor. As such, we will use August to reverse the payable estimate to date and recalculate the risk corridor receivable position in September.

To better align ECM provider reimbursement with the expected dosage and outcomes, the Board approved on August 26, 2026, a transition to a fee-for-service (FFS) reimbursement structure effective January 1, 2027. The Alliance will deploy targeted initiatives aligned with DHCS' ECM program guidance to strengthen sustainability, emphasizing high-touch,

community-based care, reducing low-value utilization, tighter eligibility and utilization management, and a focus on members with the greatest needs.

Community Supports: Community Supports costs remain elevated, primarily due to Personal Care and Homemaker Services (PCHS). The Alliance continues to work with DHCS on Plan-led eligibility guardrails subject to DHCS approval, which are expected to help mitigate PCHS cost volatility alongside continued provider education. The Alliance is also continuing to evaluate the clinical ROI of PCHS and exploring alternative supports to mitigate rising costs. Declining CS enrollments and the implementation of program integrity initiatives, including Medically Tailored Meals (MTM), housing services, and the transition to case-rate reimbursement for housing effective March 2026, continue to drive improved performance.

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

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

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

Beginning January 2026, the Alliance launched the TotalCare (HMO D-SNP), a Medicare Advantage Dual Special Needs Plan (D-SNP) for people 65 years old and over, and for some people with certain disabilities who are enrolled in both Medicare and Medi-Cal.
For the month ending August 31, 2026, the Alliance reported an Operating Loss of $0.5M. The Year-to-Date (YTD) Operating Loss is $6.4M, with a Medical Loss Ratio (MLR) of 104.7% and an Administrative Loss Ratio (ALR) of 51.4%.

The budget expected an Operating Loss of $12.8M for August YTD. The actual result is favorable to the budget by $6.5M or 50.5%, due to the lower enrollment.

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

Key Indicators	MTD Actual	MTD Budget	MTD Var $	MTD Var %	YTD Actual	YTD Budget	YTD Var $	YTD Var %
Membership	*1,073*	*3,351*	*(2,278)*	*-68.0%*	*5,931*	*16,003*	*(10,072)*	*-62.9%*
Revenue	$2,006	$5,808	($3,802)	-65.5%	$11,314	$27,738	($16,424)	-59.2%
Medical Expenses	1,848	6,587	4,739	71.9%	11,851	32,104	20,253	63.1%
Admin Expenses	669	1,157	488	42.2%	5,814	8,466	2,652	31.3%
Operating Income/(Loss)	($512)	($1,936)	$1,424	73.6%	($6,350)	($12,831)	$6,481	50.5%
PMPM								
Revenue	$1,869.36	$1,733.19	$136.16	7.9%	$1,907.67	$1,733.28	$174.40	10.1%
Medical Expenses	1,722.72	1,965.69	242.97	12.4%	1,998.06	2,006.05	7.99	0.4%
Admin Expenses	623.75	345.31	(278.44)	-80.6%	980.20	528.98	(451.21)	-85.3%
Operating Income/(Loss)	($477.11)	($577.81)	$100.69	17.4%	($1,070.59)	($801.76)	($268.83)	-33.5%
MLR %	92.2%	113.4%	21.3%		104.7%	115.7%	11.0%	
ALR %	33.4%	19.9%	-13.4%		51.4%	30.5%	-20.9%	
Operating Income %	-25.5%	-33.3%	7.8%		-56.1%	-46.3%	-9.9%	

Membership: August 2026 D-SNP membership is unfavorable to the budget by 68.0%. D-SNP enrollment was projected to begin the year at approximately 635 members in January, with anticipated growth of about 350 members per month reaching an estimated 4,500 by year-end. However, the most recent revised membership forecast assumes monthly membership growth of approximately 136 per month beginning in June, inclusive of an 8% attrition rate, resulting in a projected membership of 1,681 by year-end.

Actual August membership totaled 1,073, tracking closely to the revised membership forecast from January of 459. This represents more than doubling in membership over eight months as the newly launched DSNP product progresses through its first-year enrollment cycle.

Revenue: The 2026 D-SNP revenue budget was based on the bid submitted in June 2025, prepared by our actuarial 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.

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

CMS CAP	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
Part C	$9,659	$22,480	($12,821)	($14,149)	$1,328
Part D	1,655	5,258	(3,603)	(3,309)	(294)
Total	**$11,314**	**$27,738**	**($16,424)**	**($17,458)**	**$1,034**

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As of August, actual revenue is $3.8M below budget, or 65.5%. As of August YTD, actuals are $16.4M below budget, representing a negative variance of 59.2%. This shortfall is primarily attributable to lower-than-anticipated enrollment, partially offset by a favorable variance in the risk-adjusted rate. However, revenue is scaling in line with membership reaching $11.3M year-to-date, and revenue PMPM remains relatively stable and consistent with the assumptions reflected in the bid pricing.

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

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

Category	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
Inpatient Hospital	$2,613	$7,746	$5,133	$4,875	$257
Inpatient Services - LTC	585	1,791	1,206	1,128	79
Physician Services	1,723	8,289	6,565	5,217	1,348
Outpatient Facility	1,567	5,601	4,035	3,525	509
CMS Pharmacy Part D	1,964	5,336	3,371	3,358	13
Other Medical*	3,398	3,341	(57)	2,103	(2,160)
TOTAL COST	**$11,851**	**$32,104**	**$20,253**	**$20,206**	**$47**

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

August 2026 Medical Expenses of $1.8M are below budget by $4.7M or 71.9%, primarily due to lower than anticipated enrollment.

August YTD 2026 Medical Expenses of $11.9M are below budget by $20.3M or 63.1%, primarily due to lower than anticipated enrollment.

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

Category	Actual	Budget	Variance	Variance %
Inpatient Services - Hospital	$440.62	$484.02	$43.41	9.0%
Inpatient Services - LTC	98.64	111.94	13.30	11.9%
Physician Services	290.56	517.92	227.36	43.9%
Outpatient Facility	264.15	350.00	85.86	24.5%
CMS Pharmacy Part D	331.16	333.40	2.24	0.7%
Other Medical*	572.95	208.77	(364.18)	-100.0%
TOTAL MEDICAL COST	**$1,998.06**	**$2,006.05**	**$7.99**	**0.4%**

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

At the PMPM level, Medical Expenses are $1,998.06, favorable by $7.99 or 0.4% compared to the budget. Please note as membership continues to grow each month, the claims experience

is still developing and should be interpreted with some caution. With that said, Q1 claims experience is considered fairly complete as of August, with medical costs trending at approximately 113% MLR vs. 115% budgeted, indicating costs are tracking close to budget. However, results may continue to fluctuate as the membership base grows and additional claims develop, particularly for hospital and skilled nursing facility (SNF) services.

Administrative Expenses: August YTD Consolidated Administrative Expenses are favorable to the budget by $5.7M or 6.7% with 5.2% ALR. Salaries are favorable by $1.0M or 1.6%, driven by savings from vacant positions. Non-salary administrative expenses are favorable at $4.7M, or 18.2%, due to savings and unspent budgets.

Non-Operating Revenue/Expenses: August YTD Net Non-Operating Loss totaled $6.5M, unfavorable to budget by $23.3M. Of this amount, $19.2M was attributable to unrealized investment losses due to lower bond prices. Since the investments are expected to be held to maturity, these losses are not anticipated to be realized. In addition, higher grant distributions contributed approximately $4.0M to the unfavorable variance.

Summary of Results: Overall, the Alliance generated a Consolidated Net Loss of $6.5M, with an MLR of 94.8% and an ALR of 5.2%.

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

Assets	
Cash	$176,140
Restricted Cash	309
Short Term Investments	764,754
Receivables	378,203
Prepaid Expenses	131
Other Current Assets	4,969
Total Current Assets	**$1,324,507**
Building, Land, Furniture & Equipment	
Capital Assets	$83,672
Accumulated Depreciation	(48,513)
CIP	952
Lease Receivable	2,799
Subscription Asset net Accum Depr	10,673
Total Non-Current Assets	**49,583**
Total Assets	**$1,374,089**
Liabilities	
Accounts Payable	$161,242
IBNR/Claims Payable	326,490
Provider Incentives Payable	34,450
Other Current Liabilities	8,571
Due to State	(15,750)
Total Current Liabilities	**$515,003**
Subscription Liabilities	7,963
Deferred Inflow of Resources	2,556
Total Long-Term Liabilities	**$10,520**
Fund Balance	
Fund Balance - Prior	$855,027
Retained Earnings - CY	(6,460)
Total Fund Balance	**848,567**
Total Liabilities & Fund Balance	**$1,374,089**
Additional Information	
Total Fund Balance	**$848,567**
Board Designated Reserves Target	566,454
Strategic Reserve (DSNP)	50,350
Medi-Cal Capacity Grant Program (MCGP)*	125,191
Value Based Payments	9,949
Provider Supplemental Payments	73,394
Total Reserves	**825,339**
Total Operating Reserve	**$23,228**

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CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget-LOB Summary
For The Eighth Month Ending August 31, 2026
(In $000s)

	Medi-Cal				D-SNP				Consolidated			
	YTD Actual	YTD Budget	Var $	Var %	YTD Actual	YTD Budget	Var $	Var %	YTD Actual	YTD Budget	Var $	Var %
Member Months	*3,399,106*	*3,336,064*	*63,042*	*1.9%*	*5,931*	*16,003*	*(10,072)*	*-62.9%*	*3,405,037*	*3,352,068*	*52,969*	*1.6%*
Dollars												
Revenue	$1,538,473	$1,483,309	$55,165	3.7%	$11,314	$27,738	($16,424)	-59.2%	$1,549,788	$1,511,047	$38,741	2.6%
Medical Expenses	1,458,042	1,404,314	(53,728)	-3.8%	11,851	32,104	20,253	63.1%	1,469,893	1,436,418	(33,475)	-2.3%
Administrative Expenses	74,065	77,117	3,051	4.0%	5,814	8,466	2,652	31.3%	79,879	85,582	5,704	6.7%
Operating Income/(Loss)	6,366	1,878	4,488	100.0%	(6,350)	(12,831)	6,481	50.5%	16	(10,953)	10,969	100.0%
Total Non-Op Income/(Expense)	(6,476)	16,799	(23,275)	-100.0%	-	-	0	0.0%	(6,476)	16,799	(23,275)	-100.0%
Net Income/(Loss)	($110)	$18,677	($18,787)	-100.0%	($6,350)	($12,831)	$6,481	50.5%	($6,460)	$5,846	($12,306)	-100.0%
PMPM												
Revenue	$452.61	$444.63	$7.98	1.8%	$1,907.67	$1,733.28	$174.40	10.1%	$455.15	$450.78	$4.37	1.0%
Medical Expenses	428.95	420.95	(8.00)	-1.9%	1,998.06	2,006.05	7.99	0.4%	431.68	428.52	(3.16)	-0.7%
Administrative Expenses	21.79	23.12	1.33	5.7%	980.20	528.98	(451.21)	-85.3%	23.46	25.53	2.07	8.1%
Operating Income/(Loss)	1.87	0.56	1.31	100.0%	(1,070.59)	(801.76)	(268.83)	-33.5%	0.00	(3.27)	3.27	100.0%
Total Non-Op Income/(Expense)	(1.91)	5.04	(6.94)	-100.0%	-	-	-	0.0%	(1.90)	5.01	(6.91)	-100.0%
Net Income/(Loss)	($0.03)	$5.60	($5.63)	-100.0%	($1,070.59)	($801.76)	($268.83)	-33.5%	($1.90)	$1.74	($3.64)	-100.0%
MLR	*94.8%*	*94.7%*			*104.7%*	*115.7%*			*94.8%*	*95.1%*		
ALR	*4.8%*	*5.2%*			*51.4%*	*30.5%*			*5.2%*	*5.7%*		
Operating Income %	*0.4%*	*0.1%*			*-56.1%*	*-46.3%*			*0.0%*	*-0.7%*		
Net Income %	*0.0%*	*1.3%*			*-56.1%*	*-46.3%*			*-0.4%*	*0.4%*		

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

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*418,756*	*410,620*	*8,136*	*2.0%*	*3,405,037*	*3,352,068*	*52,969*	*1.6%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$192,568	$179,325	$13,242	7.4%	$1,525,795	$1,479,310	$46,485	3.1%
CMS D-SNP	2,006	5,808	(3,802)	-65.5%	11,314	27,738	(16,424)	-59.2%
State Incentive Programs	269	-	269	100.0%	1,911	-	1,911	100.0%
Prior Year Revenue*	6,092	-	6,092	100.0%	6,092	-	6,092	100.0%
Premiums Commercial	715	498	216	43.4%	4,675	3,999	677	16.9%
Total Operating Revenue	**$201,649**	**$185,632**	**$16,017**	**8.6%**	**$1,549,788**	**$1,511,047**	**$38,742**	**2.6%**
Medical Expenses								
Inpatient Services (Hospital)	$44,235	$49,923	$5,688	11.4%	$397,956	$380,587	($17,369)	-4.6%
Inpatient Services (LTC)	20,038	19,254	(784)	-4.1%	151,008	147,327	(3,681)	-2.5%
Physician Services	42,419	43,552	1,133	2.6%	302,376	333,149	30,774	9.2%
Outpatient Facility	22,740	21,435	(1,304)	-6.1%	181,113	161,824	(19,289)	-11.9%
ECM	14,444	10,984	(3,460)	-31.5%	100,624	101,728	1,103	1.1%
Community Supports	4,463	5,192	729	14.0%	43,457	40,717	(2,740)	-6.7%
Behavioral Health	10,688	8,102	(2,586)	-31.9%	82,321	62,605	(19,715)	-31.5%
CMS Pharmacy Part D	95	1,117	1,022	91.5%	1,964	5,336	3,371	63.2%
Other Medical**	28,340	26,187	(2,153)	-8.2%	207,162	203,144	(4,017)	-2.0%
State Incentive Programs	269	-	(269)	-100.0%	1,911	-	(1,911)	-100.0%
Total Medical Expenses	**$187,732**	**$185,746**	**($1,986)**	**-1.1%**	**$1,469,893**	**$1,436,418**	**($33,475)**	**-2.3%**
Gross Margin	**$13,917**	**($114)**	**$14,032**	**100.0%**	**$79,895**	**$74,629**	**$5,266**	**7.1%**
Administrative Expenses								
Salaries	$6,889	$7,253	$365	5.0%	$58,626	$59,604	$979	1.6%
Professional Fees	251	429	178	41.4%	2,905	3,660	754	20.6%
Purchased Services	632	611	(21)	-3.4%	4,758	6,181	1,422	23.0%
Supplies & Other	830	840	10	1.2%	6,532	8,221	1,689	20.5%
Occupancy	103	145	43	29.4%	918	1,133	215	19.0%
Depreciation/Amortization	641	848	207	24.4%	6,140	6,784	644	9.5%
Total Administrative Expenses	**$9,345**	**$10,127**	**$781**	**7.7%**	**$79,879**	**$85,582**	**$5,704**	**6.7%**
Operating Income/(Loss)	**$4,572**	**($10,241)**	**$14,813**	**100.0%**	**$16**	**($10,953)**	**$10,969**	**100.0%**
Non-Op Income/(Expense)								
Interest	$3,364	$3,330	$34	1.0%	$27,225	$26,640	$585	2.2%
Gain/(Loss) on Investments	(831)	833	(1,665)	-100.0%	(13,024)	6,667	(19,690)	-100.0%
Bank & Investment Fees	(10)	(38)	29	75.1%	(441)	(307)	(134)	-43.6%
Other Revenues	251	308	(57)	-18.5%	2,407	2,466	(59)	-2.4%
Grants	(2,438)	(2,333)	(105)	-4.5%	(22,644)	(18,667)	(3,978)	-21.3%
Total Non-Op Income/(Expense)	**336**	**2,100**	**(1,764)**	**-84.0%**	**(6,476)**	**16,799**	**($23,275)**	**-100.0%**
Net Income/(Loss)	**$4,907**	**($8,141)**	**$13,049**	**100.0%**	**($6,460)**	**$5,846**	**($12,306)**	**-100.0%**
MLR	*93.1%*	*100.1%*			*94.8%*	*95.1%*		
ALR	*4.6%*	*5.5%*			*5.2%*	*5.7%*		
Operating Income %	*2.3%*	*-5.5%*			*0.0%*	*-0.7%*		
Net Income %	*2.4%*	*-4.4%*			*-0.4%*	*0.4%*		

**Other Medical includes Pharmacy and IHSS.

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

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*418,756*	*410,620*	*8,136*	*2.0%*	*3,405,037*	*3,352,068*	*52,969*	*1.6%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$459.86	$436.72	$23.14	5.3%	$448.10	$441.31	$6.79	1.5%
CMS D-SNP	4.79	14.14	(9.35)	-66.1%	3.32	8.28	(4.95)	-59.8%
State Incentive Programs	0.64	-	0.64	100.0%	0.56	-	0.56	100.0%
Prior Year Revenue*	14.55	-	14.55	100.0%	1.79	-	1.79	100.0%
Premiums Commercial	1.71	1.21	0.49	40.6%	1.37	1.19	0.18	15.1%
Total Operating Revenue	**$481.54**	**$452.08**	**$29.47**	**6.5%**	**$455.15**	**$450.78**	**$4.37**	**1.0%**
Medical Expenses								
Inpatient Services (Hospital)	$105.63	$121.58	$15.94	13.1%	$116.87	$113.54	($3.33)	-2.9%
Inpatient Services (LTC)	47.85	46.89	(0.96)	-2.1%	44.35	43.95	(0.40)	-0.9%
Physician Services	101.30	106.06	4.77	4.5%	88.80	99.39	10.58	10.6%
Outpatient Facility	54.30	52.20	(2.10)	-4.0%	53.19	48.28	(4.91)	-10.2%
ECM	34.49	26.75	(7.74)	-28.9%	29.55	30.35	0.80	2.6%
Community Supports	10.66	12.64	1.99	15.7%	12.76	12.15	(0.62)	-5.1%
Behavioral Health	25.52	19.73	(5.79)	-29.4%	24.18	18.68	(5.50)	-29.4%
CMS Pharmacy Part D	0.23	2.72	2.49	91.7%	0.58	1.59	1.01	63.8%
Other Medical**	67.68	63.77	(3.90)	-6.1%	60.84	60.60	(0.24)	-0.4%
State Incentive Programs	0.64	-	(0.64)	-100.0%	0.56	-	(0.56)	-100.0%
Total Medical Expenses	**$448.31**	**$452.36**	**$4.05**	**0.9%**	**$431.68**	**$428.52**	**($3.16)**	**-0.7%**
Gross Margin	**$33.23**	**($0.28)**	**$33.51**	**100.0%**	**$23.46**	**$22.26**	**$1.20**	**5.4%**
Administrative Expenses								
Salaries	$16.45	$17.66	$1.21	6.9%	$17.22	$17.78	$0.56	3.2%
Professional Fees	0.60	1.04	0.44	42.6%	0.85	1.09	0.24	21.8%
Purchased Services	1.51	1.49	(0.02)	-1.4%	1.40	1.84	0.45	24.2%
Supplies & Other	1.98	2.05	0.06	3.2%	1.92	2.45	0.53	21.8%
Occupancy	0.24	0.35	0.11	30.8%	0.27	0.34	0.07	20.3%
Depreciation/Amortization	1.53	2.07	0.53	25.9%	1.80	2.02	0.22	10.9%
Total Administrative Expenses	**$22.32**	**$24.66**	**$2.35**	**9.5%**	**$23.46**	**$25.53**	**$2.07**	**8.1%**
Operating Income/(Loss)	**$10.92**	**($24.94)**	**$35.86**	**100.0%**	**$0.00**	**($3.27)**	**$3.27**	**100.0%**
Non-Op Income/(Expense)								
Interest	$8.03	$8.11	($0.08)	-1.0%	$8.00	$7.95	$0.05	0.6%
Gain/(Loss) on Investments	(1.99)	$2.03	(4.01)	-100.0%	(3.82)	1.99	(5.81)	-100.0%
Bank & Investment Fees	(0.02)	(0.09)	0.07	75.6%	(0.13)	(0.09)	(0.04)	-41.3%
Other Revenues	0.60	0.75	(0.15)	-20.1%	0.71	0.74	(0.03)	-3.9%
Grants	(5.82)	(5.68)	(0.14)	-2.5%	(6.65)	(5.57)	(1.08)	-19.4%
Total Non-Op Income/(Expense)	**$0.80**	**$5.11**	**($4.31)**	**-84.3%**	**($1.90)**	**$5.01**	**($6.91)**	**-100.0%**
Net Income/(Loss)	**$11.72**	**($19.83)**	**$31.55**	**100.0%**	**($1.90)**	**$1.74**	**($3.64)**	**-100.0%**
MLR	*93.1%*	*100.1%*			*94.8%*	95.1%		
ALR	*4.6%*	*5.5%*			*5.2%*	5.7%		
Operating Income %	*2.3%*	*-5.5%*			*0.0%*	-0.7%		
Net Income %	*2.4%*	*-4.4%*			*-0.4%*	0.4%		

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

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

	MTD	YTD
Net Income	$4,907	($6,460)
Items not requiring the use of cash: Depreciation	327	2,699
Adjustments to reconcile Net Income to Net Cash provided by operating activities:		
Changes to Assets:		
Restricted Cash	0	0
Receivables	1,925	19,192
Prepaid Expenses	(719)	(1,752)
Current Assets	120	60
Subscription Asset net Accum Depr	0	0
Net Changes to Assets	**1,326**	**17,499**
Changes to Payables:		
Accounts Payable	64,194	(46,319)
Other Current Liabilities	(1,945)	(763)
Incurred But Not Reported Claims/Claims Payable	6,695	(134,306)
Provider Incentives Payable	4,681	(6,658)
Due to State	0	(70,377)
Subscription Liabilities	0	0
Net Changes to Payables	**73,625**	**(258,423)**
Net Cash Provided by (Used in) Operating Activities	**80,185**	**(244,685)**
Change in Investments	48,497	42,641
Other Equipment Acquisitions	(161)	(788)
Net Cash Provided by (Used in) Investing Activities	**48,336**	**41,853**
Deferred Inflow of Resources	0	0
Net Cash Provided by (Used in) Financing Activities	**0**	**0**
Net Increase (Decrease) in Cash & Cash Equivalents	**128,521**	**(202,832)**
Cash & Cash Equivalents at Beginning of Period	**141,159**	**394,722**
Cash & Cash Equivalents at August 31, 2026	**$176,140**	**$176,140**

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

Meeting Minutes

Wednesday, September 23, 2026
3:00 p.m. – 5:00 p.m.

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

Commissioners Present:

Ms. Anita Aguirre	At Large Health Care Provider Representative
Dr. Ralph Armstrong	At Large Health Care Provider Representative
Supervisor Wendy Root Askew	County Board of Supervisor
Ms. Tracey Belton	County Health and Human Services Agency
Supervisor Kim De Serpa	County Board of Supervisor
Dr. Maximiliano Cuevas	Health Care Provider Representative
Dr. Donaldo Hernandez	Health Care Provider Representative
Ms. Katrina Hodges	Public Representative
Ms. Elsa Jimenez	County Director of Health Service
Mr. Michael Molesky	Public Representative

Ms. Connie Moreno-Peraza	County Health Department Representative
Dr. James Rabago	Health Care Provider Representative
Dr. Allen Radner	At Large Health Care Provider Representative
Dr. Kristynn Sullivan	County Health Department Representative
Mr. Ye Thao	Public Representative

Commissioners Absent:

Ms. Leslie Abasta-Cummings	At Large Health Care Provider Representative
Dr. Kristina Keheley	County Health Department Representative
Supervisor Josh Pedrozo	County Board of Supervisor

Staff Present:

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

1. Call to Order by Vice Chair Aguirre.

Vice Chair Aguirre called the meeting to order at 3:02 p.m.

Roll call was taken and a quorum was present.

There were no supplements or deletions to the agenda.

[Commissioner Cuevas arrived at 3:03pm]

2. Oral Communications.

We invited comments by e-mail and did not receive any.

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

Victoria Nora Gutierrez, Senior Director of Pay Relations with 24 Hour Home Care, addressed the Commission on Personal Care and Homemaker Services (PCHS).

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. 3:06 p.m.

Mr. Schrader highlighted five items from his written CEO report:

- Alliance strategic plan. CEO Michael Schrader reported that development of the Alliance's new three-year strategic plan is nearing completion. He noted that Item 13 on the agenda includes a presentation by Van Wong on the draft strategic plan for Board review. The purpose of the review is to provide Board members an opportunity to offer additional input before the plan is brought back for approval in December.
- Labor and delivery in Santa Cruz County. Mr. Schrader informed the Board that Salud Para La Gente is considering reducing its labor and delivery role at Watsonville Community Hospital. To proactively prepare for this potential change, the Alliance convened representatives from Watsonville Community Hospital, Salud Para La Gente, Santa Cruz Community Health, Sutter Maternity & Surgery Center, Dominican Hospital, and the County of Santa Cruz. The group has begun identifying alternatives to help ensure continued access to labor and delivery services for county residents.
- Indigent care in Santa Cruz County. Mr. Schrader provided an update regarding Santa Cruz County's ongoing exploration of models and potential partners for administration of its indigent care program. He reported that the Alliance has been engaged in discussions with the County and, at the County's request, is refining its proposal and associated cost estimate.
- Health symposium in Monterey County. Mr. Schrader reported that Dr. Radner hosted a health symposium in Monterey County attended by leaders from Natividad Medical Center, Community Hospital of the Monterey Peninsula (CHOMP), Mee Memorial Healthcare System, Montage Health, Commissioner Elsa Jimenez, and the Alliance. During the event, Mr. Schrader presented emerging care gaps and safety net challenges in Monterey County associated with federal and state policy changes.
- UC Merced renewal assistance training course. Mr. Schrader reported that the Alliance is partnering with UC Merced to develop a self-paced online Medi-Cal renewal assistance training program. He stated that the training will be made available to community partners across all five Alliance counties. The English-language version is targeted for launch in late September, with a Spanish-language version to follow.

[Commissioner Hernandez arrived at 3:06pm]
[Commissioner Rabago arrived at 3:08pm]

Consent Agenda Items: (5.- 9A.): 3:12 p.m.

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

ACTION: The motion passed with the following vote:

Ayes: Commissioners, Aguirre, Askew, Belton, Cuevas, De Serpa, Hernandez, Hodges, Jimenez, Molesky, Moreno-Peraza, Rabago, Radner, Sullivan and Thao

Noes:	None.
Absent:	Commissioners, Abasta Cummings, Armstrong, Keheley, and Pedrozo
Abstain:	None

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

10. Santa Cruz County Measure E. 3:13 p.m.

Mr. Schrader introduced Nicole Coburn, a volunteer for the Santa Cruz County Measure E Committee, and provided a brief overview of the legal restrictions governing public entities and ballot measures. He noted that public entities may communicate their position on a ballot measure and provide factual information but may not use public funds or resources to campaign for or against a measure.

Ms. Coburn presented an overview of Measure E, a half-cent countywide transaction and use tax placed on the November 3, 2026, general election ballot by the Santa Cruz County Board of Supervisors. Key points of the presentation included:

The HR 1 federal budget reconciliation bill has had dramatic impacts on county services, particularly Medi-Cal. Santa Cruz County estimated approximately $200 million in annual county-wide losses from HR 1 impacts and a specific county-level annual loss of over $25 million. The Alliance projected a 32% decline, or approximately 25,000 people in Santa Cruz County, losing Medi-Cal coverage. For fiscal year 2026–27, the county absorbed $25 million in HR 1 impacts primarily through one-time reserves of $21 million, resources that will not be available in future years.

Measure E is a general tax requiring 50% plus one approval, estimated to raise $27 million annually for five years. The measure includes exemptions for groceries, prescription medications, diapers, and feminine hygiene products. The companion board resolution adopted by the Santa Cruz County Board of Supervisors established budget priorities including hospitals, EMS, FQHCs, community health clinics, food assistance, and housing. Ms. Coburn noted that Watsonville Community Hospital is in serious financial distress and is estimated to be six to twelve months from shutting down if hard choices are not made. The measure requested that the Alliance Board take a position of support.

A discussion ensued among Commissioners. Concerns raised included the lack of a legal guarantee that funds would be directed to specific services since it is a general tax, potential regressive impacts on low-income residents, the five-year duration of the tax given the current federal administration's term, and whether the Alliance should take a formal position on a county-specific ballot measure.

We invited public comments. Mr. Josh Pedrozo (via teleconference) requested that the board not take a position of support and allow Santa Cruz County residents to decide through the ballot process.

MOTION:	Commissioner Askew moved to approve Alliance support for Measure E, seconded by Commissioner Hernandez.
ACTION:	The motion did not pass with the following vote:
Ayes:	Commissioners, Aguirre, Askew, Cuevas, Hernandez, and Radner
Noes:	Commissioners, Hodges, Molesky, and Rabago.
Absent:	Commissioners, Abasta Cummings, Armstrong, Keheley, and Pedrozo
Abstain:	Commissioners, Belton, De Serpa, Jimenez, Moreno-Peraza, Sullivan, Thao.

11. Q1-Q2 Compliance Program Report and Revisions to Alliance Compliance Plan and Code of Conduct. 3:47 p.m.

Ms. Jenifer Mandella, Chief Compliance Officer, presented the bi-annual compliance program report for Q1 and Q2 2026. She noted that the Alliance's compliance program incorporates all seven elements of an effective compliance program as promulgated by the U.S. Sentencing Guidelines, and that the program is effective in preventing wrongdoing, proactively identifying non-compliance, and addressing identified concerns through a continuous improvement cycle.

Ms. Mandella highlighted current areas of compliance focus:
(1) Total Care D-SNP remains an area of focus as a new line of business to establish and maintain a positive regulatory relationship with CMS;
(2) Artificial Intelligence, given rapid adoption and ongoing regulatory developments and the importance of ensuring AI is used in a manner that supports members and the Alliance's mission;
(3) Regulatory developments requiring ongoing monitoring and implementation; and
(4) Privacy and security, with a focus on protecting member data as the expectation to share data increases.

Ms. Mandell discussed program integrity, noting that state and federal regulators are placing intense focus on plan performance and integrity, with a specific emphasis on high-risk service areas including transportation, social determinants of health, behavioral health, and hospice. She reported on a comprehensive internal assessment within four domains: program integrity controls and documentation, auditing and oversight of high-risk services, provider screening and enrollment, and data extraction and governance. The overall assessment found the Alliance has controls in place, with opportunities to formalize existing control structures and standardize processes. A project has been launched to support the work and track progress.

Ms. Mandella provided an overview of Alliance investigative procedures, differentiating between in-scope matters which directly impact the Alliance's obligations, members or partners and out of scope matters which are typically referred to the appropriate agency for response. The Alliance monitors these issues and supports members as needed, but does not serve as the primary investigating authority

She also requested board approval of minor revisions to the Alliance's Compliance Plan and Code of Conduct, consisting of a format transition from a standalone document to a policy format for better integration with the Alliance's overall policy library.

A discussion ensued among Commissioners regarding the current federal regulatory environment and CMS's broad approach to fraud definitions, member education on data privacy, and provider breaches and the Alliance's scope of responsibility

MOTION:	Commissioner Molesky moved to approve the compliance program report and the revisions to the Compliance Plan and Code of Conduct, seconded by Commissioner Moreno-Peraza.
ACTION:	The motion passed with the following vote:
Ayes:	Commissioners, Aguirre, Askew, Belton, Cuevas, De Serpa, Hernandez, Hodges, Jimenez, Molesky, Moreno-Peraza. Rabago, Radner, Sullivan and Thao
Noes:	None.
Absent:	Commissioners, Armstrong, Abasta Cummings, Keheley, and Pedrozo.
Abstain:	None.

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12. Claims System Procurement and Implementation. 4:03 p.m.

Mr. Cecil Newton, Chief Information Officer, and Ms. Shelly Papadopoulos, Director of Operations Management, presented a request to authorize the CEO to execute a multi-year contract for the procurement and implementation of a next-generation core claims administration system for a total contract amount not to exceed $18 million.

The Alliance has used its current claims system (HSP, now operated by Conduent Inc.) since 2016. Issues with the current system include an auto-adjudication rate of approximately 80% (below the industry median of 88% or higher), limited innovation and new functionality, no committed or consistent product roadmap, and challenges configuring contracts and benefit plans. The request was presented as a 2027 capital funding item.

Staff described a comprehensive RFP process conducted earlier in 2026: requirements were gathered cross-functionally in Q2; the RFP was fielded in June to five vendors; written responses were evaluated and narrowed to three finalists in July; three-hour scripted live demonstrations were conducted with each finalist in August; and a preferred vendor was identified. Vendors were evaluated across five pillars: functional and technical requirements, architecture and integration, vendor experience and SLAs, five-year total cost of ownership and pricing, and live demonstration performance. Specific vendor names were not disclosed as contract negotiations remain ongoing.

The $18 million not-to-exceed contract amount comprises approximately $8 million for implementation (year one through year one-and-a-half) and approximately $10 million in licensing and maintenance costs over years two through five. Staff noted that licensing costs are comparable to current spending on the existing system. The implementation timeline calls for contract completion in late 2026, implementation build-out through 2027, and a go-live target of Q2 2028 (approximately April 1, 2028).

A discussion ensued among Commissioners. Topics included resourcing the implementation given current workforce reduction plans (staff noted a system integrator will be engaged and existing staff may be temporarily backfilled), comparison of the auto-adjudication rate to vendor claims, handling of non-traditional provider types such as ECM/CS providers, pricing structures that reflect membership levels over time, and the comparison to fully outsourcing claims administration (three vendors provided business process outsourcing quotes that were significantly higher).

MOTION:	Commissioner Hodges moved to authorize the CEO to execute a multi-year contract with the selected vendor for the procurement and implementation of a next-generation core claims administration system for a total contract amount not to exceed $18 million, seconded by Commissioner Molesky.
ACTION:	The motion passed with the following vote:
Ayes:	Commissioners, Aguirre, Armstrong, Askew, Belton, Cuevas, De Serpa, Hernandez, Hodges, Jimenez, Molesky, Moreno-Peraza. Rabago, Radner, Sullivan and Thao
Noes:	None.
Absent:	Commissioners, ,Abasta Cummings, Keheley, and Pedrozo.
Abstain:	None.

[Commissioner Armstong arrived at 4:25pm]

13. 2027–2029 Strategic Plan Update. 4:27 p.m.

Ms. Van Wong, Chief Operating Officer, presented the draft 2027–2029 three-year strategic plan for board review and input. She noted that the plan is intentionally limited to three years (compared to the previous five-year plan) to retain flexibility in a rapidly changing policy and financial environment. The plan development process spanned nearly a year and engaged El Cambia Consulting (Rafael Gomez) as facilitator.

Stakeholder engagement included interviews with all commissioners (beginning in November 2025), seven external stakeholder organizations representing a cross-section of the provider community including CBOs, and member voice through focus groups with member advisory committee members.

The draft plan is organized around three strategic priorities, each with two goals (six total goals):

1. **Member Access** – To ensure meaningful access to essential services and benefits for members, recognizing the difference between regulatory network adequacy and actual member experience when seeking care. Goals focus on (a) improving monitoring of access by benefit, region, and member population to identify barriers, and testing new models, technology, and value-based payment arrangements; and (b) safety net stability through targeted investment and advocacy to preserve provider infrastructure. The Alliance is launching the Safety Net Critical Access Fund in Q4 2026, a $6 million investment over two years to stabilize critical safety net providers.

2. **Community Partnership** – To collaborate with local partners to address shared community goals. Goals focus on (a) Medi-Cal retention by convening counties, providers, and community organizations around a common retention strategy and pursuing assertive but appropriate outreach and renewal assistance; and (b) community engagement through consistent forums, use of Alliance data and insights to inform local strategy, and helping partners understand Medi-Cal policy and funding changes. The Alliance's OB convening in Santa Cruz County was cited as an example of the Alliance's convener role.

3. **Plan Performance** – To optimize quality, operations, compliance, and program integrity as the internal foundation enabling the other two priorities. Goals focus on (a) program integrity and performance, including strong stewardship of public resources, effective internal controls, proactive monitoring, and embedding quality and health equity into operations; and (b) operational efficiency through simplifying and strengthening operations, modernizing systems and reporting, and using automation and AI selectively where it reduces manual work, improves accuracy, or increases capacity.

   A discussion ensued among Commissioners. Feedback included: a request for stronger community engagement with small community-based organizations and support groups that often lose leadership; a request to consider reinstituting board retreats to provide forums for commissioners to provide input outside formal agenda discussions; a comment on the increasing demands on dual eligible members; a question about improving front-end provider reimbursement rates versus back-end grant-making (CEO noted rates are largely governed by DHCS revenue and the state's focus on value-based purchasing); and a request to incorporate preventive care language in the plan's specific annual objectives.

The Commission adjourned its meeting of September 23, 2026, at 4:55 p.m. to the regular meeting of October 28, 2026, at 3:00 p.m. via videoconference from county offices in Scotts Valley, Salinas, Merced, Hollister and Mariposa unless otherwise noticed.

Respectfully submitted,

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

COMPLIANCE COMMITTEE

Meeting Minutes
Wednesday, September 2, 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
Douglas Press	Legal Services Director
Jenifer Mandella (chair)	Chief Compliance Officer
Lisa Ba	Chief Financial Officer
Michael Wang	Chief Medical Officer
Ryan Markley	Compliance Director
Scott Crawford	Medicare Program Executive Director
Scott Fortner	Chief Administrative Officer
Tammy Brass	Health Services Executive Director
Van Wong	Chief Operating Officer

Committee Members Excused:

Michael Schrader	Chief Executive Officer

Staff Present:

Aaron McMurray	Information Security Manager
Nicole Krupp	Regulatory Affairs Manager
Rebecca Seligman	Program Integrity Manager
Robin Sihler	Administrative and Data Reporting Assistant

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

Chairperson Jenifer Mandella called the meeting to order at 9:04 a.m. A quorum was present.

Consent Agenda

2. **Approve Minutes of 08/05/2026 Committee Meeting**
3. **Regulatory Affairs Snapshot**
4. **Compliance Snapshot**

ACTION: Committee reviewed and approved items 2-4 of the Consent Agenda with 11 Ayes, 0 Noes, and 1 Abstention. Carlson abstained from approval of the 08/05/2026 meeting minutes because she was not in attendance at that meeting.

5. Follow-up on Action Items

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

- Delegate Oversight and Provider Services CAP - Credentialing Reviews.
  - UPDATE: Markley reported the work was approximately 97% complete. The remaining MedImpact and VSP file reviews were with Credentialing for resolution of missing data fields. The Committee agreed the item did not need to return unless a material issue arose preventing completion as planned.
  - RESOLUTION: Closure is expected shortly; ongoing completion will be managed through the established process.
- D-SNP Call Center Monitoring
  - UPDATE: Guevin reported that the Committee-level item was closed. An internal CAP was issued and will be monitored through Internal Audit & Monitoring until all corrective actions are complete.
  - RESOLUTION: Closed with Compliance Committee as with previous item.

Regular Agenda

6. Program Integrity Report

Seligman presented the Q3 2026 Program Integrity Report covering June 16 through August 15, 2026 noting a shortened reporting period due to the revised reporting schedule.

Program Integrity received 78 fraud, waste, and abuse referrals, opened 38 investigations, and closed 30. Overall risk remained elevated but relatively stable, with concentrated risk in hospice and laboratory services, ECM (Enhanced Care Management), and CS (Community Supports). Staff continue to advance the Program Integrity Maturity Project and collaborate with Advanced Analytics to prioritize higher-risk, higher-impact matters.

Seligman reviewed a draft DHCS overpayment APL that would require reporting all managed care plan-identified overpayments within 30 days of identification and recovered amounts within 30 days of recovery. The draft also expands required reporting fields, internal process requirements, and annual reporting of recovered and unrecovered overpayments. The Committee discussed the administrative and operational impact across Compliance, Finance, Claims, Contracting, and Provider Relations. The changes are being considered within the Program Integrity Maturity Project.

Seligman reported that improper billing or non-compliance was identified in 40% of closed investigations; financial recovery was initiated in 17%, and corrective action without recovery occurred in 23%. Identified overpayments totaled approximately $895,788, with $96,756 recovered during the reporting period and additional recoupment pending. The Committee supported continued use of analytics and intake criteria to prioritize investigations with greater compliance and financial impact.
The Committee discussed emerging risk related to Personal Care and Homemaker Services and requested that available Program Integrity data be shared to support the ongoing return-on-investment analysis. The Committee also discussed unloaded

mileage for transportation services, including whether it is allowable for NEMT or NMT, whether the service is an Alliance-only benefit, and how related claims or encounter data should be treated for RDT reporting.
ACTION: Seligman will share relevant Personal Care and Homemaker Services data with Mandella and Wang. Compliance will research the transportation benefit, allowability, RDT treatment, and related data controls.

ACTION: Compliance to research service allowability, NEMT/NMT applicability, Alliance-only benefit status, RDT reporting treatment, and claims or encounter-data controls.

For the HIPAA program, 40 referrals were received and 14 investigations were closed. Ten matters were classified as incidents affecting 19 members; no breaches were identified. Incorrect selection and data entry remained the leading root cause. Corrective actions included routine training and education, disciplinary action for repeat disclosures, and increased controls related to a vendor incident.

Outside the FWA and HIPAA programs, four compliance concerns were received, two investigations were opened, and one founded determination was made. Three Tier 2 founded violations were undergoing operational corrective action, and seven concerns remained under investigation. Overall Program Integrity risk and readiness were assessed as elevated or strained due to high concern volume, aging cases, high-dollar schemes, enforcement attention, and limited data analytics capability.

COMMITTEE ACTION**:** Committee reviewed and approved the Program Integrity Quarterly Report.

7. Security Update

McMurray presented the Q2 2026 Security Update. Inbound email volume remained stable at approximately 3.48 million messages, while rejected traffic increased in May and June primarily because of sender reputation and poorly reputed sending infrastructure. Legitimate business email remained stable, indicating existing controls effectively managed the elevated unwanted traffic.

Phishing simulation failure rates remained within the established 2% risk threshold. McMurray emphasized the importance of employee reporting and vigilance, particularly for business email compromise messages that may appear to originate from known contacts. The Committee discussed opportunities for recurring staff education regarding current phishing, business email compromise, cyber events, and safe email-filtering practices.

McMurray reported continued progress on key remediation initiatives, including migration to Okta-native authentication, retirement of legacy ADFS infrastructure, expansion of CyberArk privileged-access coverage, network segmentation, and development of the Cybersecurity Incident Response Plan and ransomware runbook. Security activities continue to align with HIPAA and NIST requirements.

ACTION: Seligman and McMurray will explore a recurring newsletter or similar staff communication through the Privacy and Security Collaborative.

ACTION: Mandella will work with McMurray and Newton to define routine Security reporting to the Compliance Committee.

8. Wrap Up and Assignments

Action items are as follows:

- Personal Care and Homemaker Services
  - Seligman to share relevant Personal Care and Homemaker Services data with Mandella and Wang. Compliance will research the transportation benefit, allowability, RDT treatment, and related data controls.
- Security Awareness
  - Seligman and McMurray to explore recurring staff education regarding current phishing, business email compromise, and cyber-event trends.
- Compliance Committee Security Reporting:
  - Mandella to coordinate with McMurray and Newton to establish the content and cadence of routine Security reporting.

The meeting adjourned at 9:51 a.m.

Respectfully submitted,
Robin Sihler
Compliance Administrative and Data Reporting Assistant

Physicians Advisory Group

Date: June 11, 2026

Time: 12:00 – 1:30 p.m.

Location:

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

MINUTES

Chair: Mike Wang, MD, CMO			**Minutes by:** Jacqueline Van Voerkens
	Members Present:	Dr. Caroline Kennedy, Dr. Cheryl Scott, Dr. Cristina Mercado, Dr. Devon Francis, and Dr. Shirley Dickinson,	
	Members Absent:	Dr. Charles Harris, Dr. Donaldo Hernandez, Dr. James Rabago, Dr. Jason Novick, Dr. Mimi Carter, Dr. Misty Navarro, Dr. Ralph Armstrong, and Dr. Salvador Sandoval.	
	Public Attendees:	Becky Shaw	
	Central California Alliance for Health staff:	Dr. Mike Wang, Dr. Mai Bui-Duy, Ms. Cassie Russo, Ms. Jessie Dybdahl, Ms. Kelsey Riggs, Mr. Jim Lyons, Ms. Shamara Edwards, Ms. Tammy Brass, Mr. Travis Moody, and Mr. Michael Nashed	
Item No.	**Agenda Item**		
I.	**Call to Order**	Chairperson Dr. Mike Wang called the meeting to order at 12:05 p.m. Roll call was taken.	
II.	**Oral Communications**	Chairperson Wang opened the floor for any members of the public to address the Group on items not listed on the agenda. No members of the public addressed the Group.	

Items for Approval		Discussion	Action/Recommendation
III.	**Review & Approve Minutes**	**The Minutes from the March 5, 2026, Meeting were reviewed.** **Dr. Kennedy motioned to approve the minutes from the PAG March 5, 2026 meeting.* **Dr. Mercado 2nd the motion for approval.* **Group approved the March 5, 2026 meeting minutes as presented.*	*The **Physicians Advisory Group** approved the March 5, 2026, meeting minutes.*
Action Item Follow-Up			
		All action items from previous meetings are complete.	
Regular Agenda			
	Agenda item		
III.	**ECM and Community Supports Update**	Dr. Wang provided an update on Enhanced Care Management (ECM), including recent state guidance emphasizing that ECM should be high-touch, person-centered, and comprehensive. The state has indicated concern with broad but shallow utilization. The Alliance's ECM enrollment has increased significantly since 2024 and is currently above the state average, with current enrollment estimated at approximately 6–7% of members compared with a state average of approximately 1.8%. Dr. Wang explained that the Alliance's ECM engagement rate is approximately 1.8 encounters per member per month, compared with state expectations of approximately three or more encounters per month for higher effectiveness. Based on the updated guidance, the Alliance's ECM program may be viewed as both broad and shallow. The program is also currently over budget, with an estimated Q1 overage of approximately $15 million. The Alliance is implementing several ECM program changes for 2026–2027, including a new member referral and renewal assessment, risk-based disenrollment and graduation processes, enhanced network management, and anticipated payment structure changes. The new assessment went live on May 18, 2026, and is intended to improve data collection, confirm eligibility, and redirect members to other resources when ECM is not the appropriate level of support. The Alliance plans to begin gradual risk-based disenrollments for low- and medium-risk members who may not meet the high-touch, high-risk profile expected by the state. Members will receive notice 14 days before disenrollment. New applications may be submitted for reevaluation as needed. The Alliance will also continue care plan audits, clinical oversight expectations, encounter monitoring, utilization management review, grievance review, and quality concern monitoring. For 2027, the Alliance anticipates proposing a fee-for-service payment structure for ECM, with Board review expected in August 2026 and a target effective date of January 1, 2027. Dr. Wang noted that the Alliance currently receives approximately $408 per member per month from DHCS and reimburses providers approximately $625 per member per month, creating a financial gap.	**Action:** Ms. Dybdahl will ensure follow-up with MTM vendors to clarify documentation expectations and discourage inappropriate requests for medical records or wet signatures. Action Complete

		Dr. Wang asked the group for feedback on Overall Experiences for Clinical Providers with ECM-Enrolled Members. The group provided the following feedback: • Providers reported mixed experiences with ECM. Some found internal ECM providers immensely helpful, especially for high-touch, person-centered care across all ages, and appreciated seamless communication and coordination within their clinic. • Challenges were noted when patients were enrolled in external ECM programs (e.g., Walnut Creek), with limited communication, duplicative work, and unclear value, making it difficult to refer patients to their own internal ECM teams. Patients often did not know who their ECM provider was. • External ECM providers rarely communicated with clinical teams, and their engagement was often asynchronous and disruptive to clinic workflow. Providers felt ECM did not play a significant role unless they were integrated into their clinic. • Some clinics, like Salinas Pediatrics, were not aware of ECM or had never discussed it internally. They relied on their own coordinators and community health workers for care management and resource connection, expressing interest in learning more about ECM if it could benefit patients without disrupting clinic operations. • Providers emphasized the importance of ECM integration with their EMR (e.g., Epic) for visibility and coordination, and preferred local partnerships over external, less connected ECM providers. • Concerns were raised about burdensome intake forms and data collection for ECM enrollment, which could discourage quality providers and add barriers without improving patient care. Dr. Wang asked the group for feedback on ECM Providers That Stand Out. The group provided the following feedback: • Internal ECM providers within clinics, such as those at Salud, were highlighted as particularly effective and valuable due to seamless communication, direct engagement, and integrated care coordination. • External ECM providers, especially those outside the county (e.g., Walnut Creek), were noted as less effective, with unclear value, poor communication, and duplicative work. • Local community-based organizations were mentioned as potentially successful partners, but specific names or standout external providers were not identified in the meeting. • Providers preferred ECM groups that are local and integrated with their clinic systems (e.g., on Epic), rather than external or corporate entities. Dr. Wang asked the group for suggestions for Evaluating ECM Provider Quality. The group provided the following suggestions: • Ask patients directly about their ECM provider: Who is their ECM provider and what has the provider done for them recently? Patient feedback can indicate engagement and effectiveness. • Track hard data such as hospitalizations and re-hospitalizations for ECM-enrolled members to assess impact and quality, though statistical significance may be limited by sample size.	

		• Ensure ECM providers are integrated with clinic EMRs (e.g., Epic) so clinical teams can see what ECM providers are doing, improving transparency and coordination. • Avoid burdensome intake forms and excessive data collection that do not add value to patient care, as these may discourage quality providers and create unnecessary barriers. • Prefer care plan reviews or renewal submissions that demonstrate meaningful activity and alignment with clinical needs, rather than duplicative or irrelevant tasks. The group discussed **Medically Tailored Meals (MTM)** requests and provider burden. Providers reported receiving frequent requests and expressed concern that broad eligibility criteria may result in a high volume of patients qualifying based on conditions such as hyperlipidemia, diabetes, or elevated triglycerides. Dr. Wang clarified that the Alliance does not require a separate letter for MTM referrals. For initial approvals, documentation confirming the qualifying diagnosis may be sufficient when available. For renewals, the Alliance needs documentation in the treatment plan or clinical note indicating that MTM is part of treatment for the qualifying condition. The Alliance does not require a wet signature. Providers raised concerns regarding vendor practices, including requests for wet signatures, requests for medical records, and direct marketing to patients. Dr. Wang noted that some vendors may be applying requirements from multiple health plans rather than Alliance-specific requirements. **Action:** Ms. Dybdahl will ensure follow-up with MTM vendors to clarify documentation expectations and discourage inappropriate requests for medical records or wet signatures. The group also discussed the possibility that future state policy changes may narrow qualifying diagnostic categories for MTM, particularly broad categories such as gastrointestinal or neurological conditions, pending further guidance.	
IV.	**California Revised Budget**	Dr. Wang provided a summary of the May Revision to the State Budget for Fiscal Year 2026–2027 and its potential impact on the Alliance. The presentation reviewed the budget timeline, projected enrollment impacts, legislative advocacy, and alternative policy proposals under discussion. The May Revision proposes carving qualified non-citizens and individuals with unsatisfactory immigration status out of managed care plans. If finalized, affected members would lose Alliance managed care coverage effective January 1, 2027, but would remain eligible for Medi-Cal fee-for-service coverage. The group discussed concerns that fee-for-service coverage may significantly limit access to specialty care and reduce reimbursement to providers, particularly federally qualified health centers. Projected enrollment impacts are significant. Compared with December 2024 enrollment, Alliance enrollment is projected to decline by approximately 25% by January 1, 2027, and by approximately 39% by December 31, 2028, if the carve out is implemented as proposed.	

		Providers noted that the impact may be uneven across clinics and may disproportionately affect providers serving higher numbers of affected members. Dr. Francis inquired if Medi-Cal enrollment changes, especially due to UIS carve-outs, are tracked by providers, noting concerns about uneven impact across clinics. Jessie Dybdahl confirmed that when HR 1 was passed, notices with exact percentages and member counts were sent to CEOs of FQHCs and major clinics and suggested this could be done again. Ms. Dybdahl stated that FQHCs hold the majority of UIS population and emphasized the importance of tracking by provider due to potential significant budget impacts. The Alliance has engaged in legislative advocacy with elected officials and through Local Health Plans of California (LHPC). Advocacy efforts have emphasized the potential impact on reimbursement, access to care, provider stability, and member outcomes. A coalition letter was submitted on May 22, 2026, with multiple partner organizations. Dr. Kennedy asked if children will also be disenrolled from Medi-Cal or if the carve-out mainly affects adults, expressing concern about losing coverage for pediatric patients. Ms. Dybdahl answered that the UIS carve-out applies to both adults and children, but children under 19 have a 90-day re-enrollment window, while adults do not. She clarified that affected members will remain eligible for Medi-Cal fee-for-service, but specialty care access and reimbursement rates will be significantly reduced, especially for FQHCs. DHCS requested that health plans propose an alternative that could be operationalized by January 1, 2027, preserve state savings, maintain compliance, and allow the state to continue billing hospital care through fee-for-service. The plans developed and submitted a consensus alternative on May 27, 2026. The alternative is intended to preserve outpatient managed care coverage where possible while acknowledging that inpatient carve out provisions may proceed. Additional information is expected as the budget process advances.	
V.	**Manifest MedEx (MX)**	Michael Nashed provided an overview of the Alliance's Data Sharing Incentive (DSI) program and Manifest MedEx. The DSI was originally developed in 2022 with a health information exchange (HIE)-centered model and was influenced by federal and state data-sharing requirements, including the Data Exchange Framework. The goal is to support real-time, bidirectional data sharing among providers, hospitals, health plans, and the HIE. Mr. Nashed explained that the Alliance has separate incentive programs for hospitals and providers. The hospital connectivity incentive is based on sending data to Manifest and may pay up to $200,000 annually, distributed quarterly. The provider DSI is structured as a lump-sum incentive, currently described as up to $40,000 per provider organization per year based on milestones, including contracting with Manifest and actively sharing data. Manifest MedEx was described as a large statewide HIE with a significant California footprint. Its purpose is to reduce manual data exchange, such as faxes, emails, and spreadsheets, by serving as a centralized source for clinical data, claims data, laboratory data, ADT alerts, clinical summaries, CCDs, and other data services. Real-time ADT notifications were highlighted as	

		especially useful for care coordination and follow-up after emergency department or hospital encounters. The group discussed data gaps related to hospital participation, including Common Spirit/Dignity Health data. Mr. Nashed reported that the Alliance, Sac Valley MedShare, Dignity, and Manifest are working on a potential solution that would allow the Alliance to receive Dignity data from Sac Valley and transmit it to Manifest. The timing is still being worked out, with a goal of progress within one to two quarters. Providers asked whether they would be able to access clinical notes, such as specialty care plans, through Manifest. Mr. Nashed explained that CCDs and the Manifest portal should include clinical documentation and scanned documents when available, though the method of access depends on the provider's EHR capabilities and whether the system can ingest the data. Mr. Nashed clarified that Manifest has committed not to charge implementation fees for providers participating in the incentive program. EHR vendors may charge integration fees, often in the range of several thousand dollars, and the Alliance intends for the DSI to offset those costs. If a provider receives an unusually high quote, the Alliance asked providers to notify the team so that options can be explored. The program is expected to open more formally in Q3 2026 with the goal for full network participation by 2028.	

Action Items

Agenda Item	What is the action item	Due date	Responsible staff
ECM and Community Supports	Ms. Dybdahl will ensure follow-up with MTM vendors to clarify documentation expectations and discourage inappropriate requests for medical records or wet signatures. **Action Complete**: Upon research, the MTM vendor staff member requested additional verification with the intent to support compliance and documentation standards, and noted a wet signature has never been a requirement. Following this situation, the leadership representative discussed the matter with their team and reinforced that a wet signature is not required. The Vendor shared they do not want to create unnecessary barriers or delays for members receiving services.	9/3/2026	Ms. Dybdahl

Meeting adjourned at 1:26 pm

Next Meeting: 09/03/2026

Approved by Committee Date: September 3, 2026	***Signature:***	**Date**: September 3, 2026

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

Quality Improvement Health Equity Committee

Date: June 18, 2026

Time: 12pm – 1:30pm

Location: MS Team Meeting

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Chair: Mike Wang, MD, CMO			**Minutes by: Jacqueline Van Voerkens**
	Members Present:	Dr. Caroline Kennedy, Family Medicine, Dr. Eric Sanford, Family Medicine, Dr. Minoo Sarkarati, Internal Medicine/Pediatrics, Adriana Ceja, Julia Stevens, NP, and Vanessa Valedez-Pantoja.	
	Members Absent:	Dr. Oguchi Nkwocha, Family Medicine, Dr. Stephanie Chang, Family Medicine and Dr. Stephanie Graziani, Pediatrics.	
	Central California Alliance for Health staff:	Ms. Alex Sanchez — Quality Improvement Program Advisor III Ms. Alissa Gil — Provider Network Development Manager Ms. Amber Schnitzius — Medicare Stars Program Manager Ms. Andrea Swan — QI/ Population Health Director Ms. Carissa Grepo — UM Manager – Prior Authorizations Ms. Cassie Russo — Quality Improvement Health Equity Supervisor Ms. Desirre Herrera — Quality and Health Programs Manager Ms. Georgia Gordon — Quality Improvement Program Advisor II Ms. Kelsey Riggs — Care Management Director Ms. Kristen Rohlf — Quality and Population Health Manager Ms. Lilia Chagolla — Member Services Director Ms. Linda Gorman — Marketing and Communications Director Dr. Mai Bui-Duy, MD — Medical Director, Internal Medicine Ms. Rebecca McMullen — Behavioral Health Program Manager Ms. Sarah Sanders — Grievance and Quality Manager Ms. Shamara Edwards — Utilization Management Director Ms. Tisha Criswell — Clinical Safety Supervisor - Facility Site Review Ms. Vanessa Paz — Health Equity Program Manager Ms. Veronica Olivarria — Member Services Call Center Manager Ms. Yasuno Sato — Clinical Pharmacy Manager	
Item No.	**Agenda Item**		

Quality Improvement Health Equity Committee

Date: June 18, 2026

Time: 12pm – 1:30pm

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I.	**Call to Order**	Dr. Mike Wang called the meeting to order at 12:05 PM and welcomed the members. Dr. Wang opened the floor for any announcements. No announcements were received from the Committee. Dr. Wang welcomed Shamara Edwards, Alliance Utilization Management Director, and Julia Stevens, Site Medical Director at Live Oak Health Center and quality lead for Family Practice for Santa Cruz Community Health as new committee members.	
Items for Approval		**Discussion**	**Action/Recommendation**
II.	**Review & Approve Minutes**	**The Minutes from the March 19, 2026 QIHEC Meeting were reviewed.** **Dr. Carolyn Kennedy motioned to approve the minutes from the QIHEC meeting.* **Dr. Eric Sanford 2nd the motion for approval.* **Committee approved March 19, 2026 QIHEC as presented.*	*The QIHEC approved the March 19, 2026 QIHEC meeting minutes.*
Action Item Follow-Up			
III.	**2025 UM Program Evaluation**	Quarterly Data Analysis – Tammy Brass, RN, to provide a snapshot analysis of readmission rates and bed days by institution for the September QIHEC meeting, using available claims data.	
Items for Review/Approval		**Consent Agenda Items**	**Action/Recommendation**
IV.	**Review**	Subcommittee/Workgroup Meeting Minutes	
		• Pharmacy and Therapeutic (P&T) Committee Minutes	*Approved at P&T*
		• Quality Improvement Health Equity Workgroup (QIHEW) Minutes	*Approved at QIHEW*
		• Utilization Management Workgroup (UMWG) Minutes	*Approved at UMWG*
	Approve	Quality Improvement Health Equity Plan	*Approved*
	Approve	Medi-Cal Health Education and Cultural and Linguistic Population Needs Assessment (PNA) 2025	*Approved*
	Approve	Amended Quality Improvement and Health Equity Transformation Program Description	*Approved*

Quality Improvement Health Equity Committee

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	Approve	Provider Manual	*Approved*
	Approve	Delegate Oversight 2025 Annual Activity Report	*Approved*
	Approve	Delegate Oversight Report	*Approved*
Policies: Require QIHEC Approval			
Number/Title		**Significant Changes**	**Action/Recommendation**
401-1301 Potential Quality Issue		• Added impacted departments • Added language addressing the review of exempt grievances • Added PQI review timeframe language	*Approved*
401-1505 Childhood Preventive Care		Updated policy in response to AIR: Contractor must identify Members who have not utilized EPSDT screening services or AAP Bright Futures preventive services and ensure outreach to these Members in a culturally and linguistically appropriate manner.	*Approved*
401-1508 Facility Site Review Process		• Annual Review. • No major changes have been made to this policy other than administrative.	*Approved*
401-1511 Initial Health Appointment		• Added verbiage for dually eligible members must adhere to the IHA requirements in the OHM policy guide and MCP contract • Added definitions for HIF, HRA • Updated IHA requirements to include verbiage change of identification of risks, MH/BH and inclusion of the HIF form for compliance for IHA • Added under IHA administration the HIF form completion w/in 90 days for compliancy and HIF form completion for MC advantage plans and HRA completion for DSNP • Added reference FSR policy, PHM guide and APL 26-001	*Approved*
401-4101 Cultural and Linguistic Services Program		• Added the D-SNP nondiscrimination snippet per Kelly T recommendations and the D-SNP contract references at the bottom. • Added the required content for APL 25-016 • Updated the training section to align with current process. • Added reference to the required DEI training and policies.	*Approved*

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401-4103 Interpreter Services	• Added the DSNP nondiscrimination snippet per Kelly T recommendations. • Added the required content and references for APL 25-016 • Made minor revisions to align with current process.	*Approved*
Policies: Informational		
Number/Title	**Significant Changes**	**Action/Recommendation**
401-1305 Provider Preventable Conditions	• Annual review. No major changes except administrative have been made to this policy • Minor singular word change to Attachment B.	*Approved at QIHEW*
401-1401 QI Long Term Services and Supports	Annual review. No major changes except administrative have been made to this policy.	*Approved at QIHEW*
401-3101 Health Education and Disease Management Program	• Page 3 –Updated criteria for Healthy Weight Programs. • Minor updates on pages 1, 2, 4, 5, 6 to align with current process. Updated APL numbers in the references.	*Approved at QIHEW*
401-4102 Translation of Alliance Documents	• Added the D-SNP nondiscrimination snippet per Kelly T recommendations and the D-SNP contract references at the bottom. • Added the required content and references for APL 25-016 • Revised some paragraphs to better align with APL 25-005.	*Approved at QIHEW*
401-5002 Health Equity Training Program	Transfer policy from Health Equity Administration to Quality Improvement and Population Health Department.	*Approved at QIHEW*
404-1108 Monitoring of Over Under Utilization of Services	Removed Title 28 California Code of Regulations § 1300.70(b)(2)(H)(2) and (c) and added §1300.70(a)(1) and (a)(3) per 20242950 DMHC CT01 #11	*Approved at QIHEW*
404-1136 Enteral Nutrition Products	Definitions: • Added the different types of nutrition products, e.g., elemental, and semi-elemental enteral nutrition products to the definition. Added because the definition of formula seemed to be too narrow-see policy. Okay to remove. • Added definition of formula for treatment of PKU for B6 • Minor format changes Procedures: • Added coverage for PKU for B5	*Approved at QIHEW*

Quality Improvement Health Equity Committee

Date: June 18, 2026

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404-1149 Medical Nutrition Therapy + MNT Attachment	The changes made were to align with some of the criteria is outlined in "Alliance Policy 404-1745 "Community Supports Policy for Medically Tailored Meals/Medically Supportive Food." Pertinent changes to the Medical Nutrition Therapy Benefit and Quick Reference Guide were edited to now include: Adult members -Obesity for adults will now be covered with no restrictions if their BMI is greater than 30 -Lipid level thresholds for members have been lowered for those members with hyperlipidemia -Prediabetes and diabetes will now be covered for adults if their A1C is greater than 5.7% Pediatric Members -Added prediabetes and hypertension as qualifying diagnosis Codes for billing are now added to the benefit policy. Previously they were only included in the Quick Reference Guide	*Approved at UMWG*
404-1306 Extended and Standing Referral Authorizations	Policy Section: ✓ Updated the first through third paragraphs to align with Health and Safety Code section 1374.16(a) and (b) ✓ Minor sentence edits for clarity and readability Definitions: ✓ Revised the definitions of "standing referral" and "specialty care center" Procedure: ✓ Added reference to Policy 404-1758 References: Updated revision history	*Approved at UMWG*

Quality Improvement Health Equity Committee

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404-1307 Medical Second Opinions	Adding TotalCare verbiage	*Approved at UMWG*
404-1520 Administrative Day Criteria	No edits annual review	*Approved at UMWG*
404-1525 Skilled Nursing Facility Program for Medi-Cal	• Updated MCG Careweb references to clinical care guidelines and Alliance policy. • Clarified definitions included Medicare terminology. Added CFR 409.33 (examples of skilled nursing and rehabilitation services for Medicare). • Updated claims and finance policies regarding coordination of benefits (COB) and crossover claims, including information about retroactive Medicare claims. Added Medicare Part B to coverage considerations and • included payor of last resort information.	*Approved at UMWG*
404-1527 Palliative and Hospice Care	Revised due to AIR.	*Approved at UMWG*
404-1601 Durable Medical Equipment (DME) Authorization	• Split out & added review criteria for IHSS, MC and D-SNP. Also added definitions for DSNP • Added information regarding COB • Added coverage, prescription/SWO, and face-to-face criteria and prior auth required documentation. • Added quick reference link to NCD 280.1 & Noridian's • website. • Added documentation requirements for DMEPOS • supplied as refills • Added for D-SNP • Added regulatory links and references • Updated reference section to align with Compliance's new template set up.	*Approved at UMWG*
404-1611 Transcutaneous Electrical Nerve Stimulation (TENS) Unit Authorization Review Process	RETIRE	*Approved at UMWG*

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404-1702 Provision of Family Planning Services to Members	Purpose: • Minor grammar correction. Policy: • Updated "Treatment for Infertility and Fertility Services" to align with language in APL 25-021 (high level coverage overview) • *Added a standalone "Standard Fertility Preservation Services" section to highlight coverage for both infertility/fertility services and iatrogenic infertility. As well as call out neither coverage overrides the other. Definition • *Added Donor, Infertility, and surrogate definitions Policy • *Added section 5-"Infertility and Fertility Services – Coverage and Utilization Review | IHSS" section which pulls coverage details directly from APL 25-021, including, but not limited to cryopreservation and storage requirements and responsibilities if coverage ends/changes to other plans. • *Added section 6-"Member Notices | IHSS" which outlines noticing requirements (note call out of new plan noticing requirements in section 5) References • *Added AB116, 28 CCR 1300.74.551 & APL 25-021 • *Added revision history	*Approved at UMWG*
404-1702 Provision of Family Planning Services to Members	• Changes were made in accordance with APL 25-021 SB 729. Then DMHC released a revised APL 25-021 on 2.19.26. I updated it again to correspond to the updated language • APL 25-021 to reflect lifetime limits, min/max retrievals and out of state storage vendors.	*Approved at UMWG*
404-1732 Meals and Lodging Related Travel Expenses for Members	No edits annual review	*Approved at UMWG*
404-1754 Continuity of Care for D-SNP Members	• Updated policy language to align with current regulatory requirements. • Clarified roles and responsibilities for policy oversight and implementation. • Revised review and approval workflow.	*Approved at UMWG*

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		• Added documentation and reporting requirements. • Removed outdated references and terminology.	
404-1756 Inpatient Review for D-SNP Members		NEW	*Approved at UMWG*
404-1757 Discharge Planning for D-SNP Members		NEW	*Approved at UMWG*
404-1758 Authorization Request Process for D-SNP Members		• Updated Nondiscrimination notice • Updated coverage hierarchy and added reference to 404-1811 • Removed MCG definition • Added reference to 42 CFR 422.629(k)(3) applicable to AIPs • Removed duplicative language • Slightly reformatted due to hierarchy update • Updated reference to 404-1752 to 200-9108 • Removed reference to 404-1112	*Approved at UMWG*
		Regular Agenda	**Action/Recommendation**
IV.	Topic		
	Q1 2026 Quality Improvement Health Equity Transformation (QIHET) Program Work plan	Andrea Swan, RN, presented the Q1 2026 QIHET Program Work Plan update. **Population Health Management (PHM) and Health Equity** Ms. Swan informed the committee the Health Equity Plan was completed, incorporated into the PHM Program Description, published on the Alliance website, and included in the consent agenda. The plan defines goals, priority populations, and health equity interventions. An implementation tracker was developed within the ABT project management system to monitor interventions through completion. Efforts are underway to establish health equity goals across all Alliance units and develop a health equity dashboard to support organization-wide monitoring. **Gap identified**: health equity integration across all departments remains in progress. **Action taken**: implementation tracking and development of unit-specific health	*Approved*

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		equity goals. **Effectiveness**: foundational infrastructure has been established, and implementation activities are underway. **MCAS Intervention – Pediatric Care Gaps** Ms. Cassie Russo reported ongoing efforts to improve pediatric quality measures in Merced and Mariposa counties through provider data analysis, targeted outreach, assignment of practice coaches, technical support, care gap grants, and collaboration with community partners such as WIC and school immunization programs. Preliminary March 2026 results showed improvement across most pediatric measures compared to December 2025 performance, although childhood immunization Combo 10 rates declined. **Gaps identified**: provider and staffing shortages, limited access to locum providers, and rural access challenges. **Actions taken:** targeted outreach, practice coaching, grant support, and community partnerships. **Effectiveness**: most pediatric measures demonstrated positive trends, with some improvement in well-child visit rates, particularly in Mariposa County. Committee members discussed the significant impact of workforce shortages and geographic barriers on provider performance, noting long travel distances for specialty and preventive services in rural communities. Ms. Russo indicated interventions are individualized and adjusted based on provider capacity and readiness. **MCAS Intervention – Chronic Care Measures** Ms. Russo presented efforts focused on improving blood pressure control and diabetes outcomes in preparation for the Total Care and D-SNP populations. Collaboration among Quality Improvement, Care-Based Incentives (CBI), and Pharmacy teams supports provider outreach, education, and performance improvement activities. **Gap identified**: limited provider familiarity with D-SNP and incomplete clinical data reporting. **Actions taken**: collaborative provider outreach, technical assistance, and workflow support. **Effectiveness**: providers reported improved data submission processes are expected to significantly improve reported blood pressure performance rates.	

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		Care-Based Incentives (CBI) Ms. Russo reported a new focus on providers performing below the 24th percentile on three or more measures. Providers in Merced, San Benito, Monterey, Mariposa, and Santa Cruz counties were identified for targeted outreach. Planned activities include forensic data reviews, provider education, practice coaching referrals, and distribution of a CBI introductory training video. **Gap identified**: low provider engagement and limited understanding of program measures. **Actions taken**: identification of targeted providers and development of educational resources. **Effectiveness**: outreach activities were scheduled to begin in Q2; therefore, effectiveness data is not yet available. Dr. Caroline Kennedy mentioned blood pressure control data may be significantly affected by reporting challenges rather than actual clinical performance. She noted her clinic's true blood pressure control rates are substantially higher than reported because blood pressure data was not consistently transmitted until recently. Dr. Kennedy stated performance rates may improve simply through improved data submission processes. Ms. Russo agreed and explained the Quality Improvement team provides technical assistance to practices are struggling with workflow development and CPT II data submission. She noted practices often require individualized support to incorporate blood pressure reporting into their electronic health record workflows. Dr. Mai Bui-Duy asked whether the blood pressure and diabetes performance measures being presented reflected the Medi-Cal population or the D-SNP population. Ms. Russo clarified the data presented reflected the Medi-Cal population. She explained D-SNP enrollment was still relatively low, so the team elected to focus quality improvement efforts on Medi-Cal performance while preparing providers for future D-SNP quality requirements. Dr. Sanford asked whether focusing limited provider resources on blood pressure and diabetes quality measures in rural counties could potentially divert attention away from more urgent patient care needs and whether providers had been asked if those measures represented the best use of their available resources. Ms. Russo acknowledged the concern,	

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		and stated practice coaching is individualized to each provider's circumstances. She explained if a provider is experiencing operational challenges such as staffing shortages or leadership turnover, the team adjusts priorities and meets providers where they are, tailoring interventions to their specific needs and readiness. Dr. Kennedy mentioned low well-child visit rates likely reflect provider shortages and access limitations rather than patient unwillingness to obtain preventive care. She noted significant workforce challenges in underserved areas and expressed concern regarding provider recruitment and retention in rural communities. Ms. Russo agreed and stated the team has spent considerable time evaluating operational challenges and access barriers, particularly in Mariposa County. She cited long travel distances for mammography and colorectal cancer screening services, limited provider availability, and workforce shortages. She noted interventions are customized based on each practice's specific needs and circumstances. **Health Education** Ms. Desirre Herrera reported delivering 10 member workshops during Q1 2026, including telephonic, virtual, and in-person formats, representing an increase from the prior year. A member newsletter article, text messaging campaign, and online registration process were used to promote wellness programs and self-management resources. **Gap identified**: continued need for member engagement and awareness of available programs. **Actions taken**: expanded outreach through text campaigns and online registration. **Effectiveness**: 138 members registered through the online system during Q1, representing a 33% increase compared to Q1 2025, demonstrating strong member engagement through digital channels. **Facility Site Review (FSR) and Potential Quality Issues (PQI)** Ms. Tisha Criswell reported completing 87.5% of reviews on time, exceeding the 80% target. One review was delayed due to weather-related access issues. The team also achieved 100% compliance with corrective action plan submissions. **Gap identified**: weather-related access barriers affecting review scheduling. **Actions taken**: continued monitoring and development	

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		of contingency planning. **Effectiveness**: performance exceeded established targets and demonstrated strong provider responsiveness. Ms. Swan indicated the PQI program exceeded established timeliness goals despite increased case volumes. All **245 grievance-related PQIs (100%)** were completed within 30 days, and **29 of 32 non-grievance PQIs (91%)** were completed within 120 days, exceeding the 80% target. Increased grievance volume was identified as a challenge requiring enhanced coordination and monitoring. To address this, the team strengthened collaboration with Grievance, Member Services, and Provider Services; implemented workflow improvements; standardized case review processes; and conducted ongoing timeliness monitoring. These efforts were effective in maintaining regulatory compliance and ensuring timely, accurate resolution of quality concerns for members and providers. **Long-Term Support Services (LTSS)** Ms. Swan reviewed quality oversight activities for long-term care and subacute facilities, focusing on collection and evaluation of Quality Assurance and Performance Improvement (QAPI) plans. Compliance with QAPI submission requirements was 61% (21 of 34 facilities). Approximately 50% of submitted QAPIs met CMS requirements. **Gaps identified**: incomplete submissions and deficiencies within submitted QAPI plans. **Actions taken**: targeted outreach, Provider Services collaboration, risk stratification integration, and one-on-one technical assistance with facilities. **Effectiveness**: baseline performance measures have been established, and improvement efforts are ongoing. **Grievance** Ms. Sarah Sanders reported 98% compliance with grievance correspondence timeliness requirements, despite increased grievance volume. Quality of Service grievances increased to 1.20 per 1,000 member months, driven in part by Total Care and D-SNP implementation activities, while discrimination-related grievances remained stable at 12 cases. **Gaps:** Increased grievance volume related to D-SNP enrollment and member service concerns, and the need for improved service trend analysis. **Actions:** Implemented workflow revisions,	

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		reporting enhancements, a new service trending methodology, and an interdisciplinary process improvement initiative to strengthen oversight and data quality. The Q1 2026 Grievance Log was shared with the Committee. **Member Satisfaction Survey (CAHPS)** Ms. Alex Sanchez presented the Q1 2026 Member Satisfaction Survey intervention update. Review of the MY 2024 survey identified provider communication and getting needed care/access in Merced County as the lowest-performing measures and focus areas for improvement. **Gaps:** Lower performance in provider communication and access to needed care compared to benchmark goals. Additionally, the lag between interventions and survey results presents challenges in measuring impact. **Actions:** Staff analyzed survey results, collaborated with Quality, Health Programs, Community Health Integration, Provider Services, and Grants teams, developed intervention tracking processes, and implemented a new two-year intervention strategy to allow more time for interventions to influence future survey results. The intervention plan was reviewed and approved by the Member Experience Committee and Operations Committee. **Access and Availability** Ms. Alissa Gil presented the Q1 2026 Access and Availability update. Reported access measures included routine appointments at **13.5 days**, urgent appointments at **1.6 days**, and third next available appointments at and Credentialing to strengthen LOA oversight; implemented strategies to convert LOA providers to contracted providers; focused recruitment efforts in specialty gap areas; expanded telehealth options; and used provider satisfaction survey feedback to identify operational improvements.**22.3 days**. The program also utilized Letters of Agreement (LOAs) to address network gaps, engaged 110 telehealth providers, and received 111 responses to nurse advice line awareness efforts. **Gaps:** Specialty access shortages, reliance on LOAs, limited survey participation in some regions, and opportunities to improve provider experience and third next available appointment times. **Actions:** Partnered with Finance, Contracts,	

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		• **Discussion of Access Barriers and Specialty Care Gaps:** Dr. Bui-Duy, Dr. Kennedy, Julia Stevens, NP, and Dr. Sarkarati discussed ongoing challenges with specialty care access, particularly for autism evaluations, GI, and optometry in Santa Cruz and Watsonville, with regional disparities and the impact of provider turnover noted. • **Autism Evaluation Delays:** Dr. Kennedy and Dr. Sarkarati highlighted significant delays in obtaining autism assessments, with wait times of up to a year or more and noted the need for more in-person options in Santa Cruz County. • **Optometry and GI Access Issues:** Dr. Sarkarati described persistent difficulties in securing optometry appointments for Watsonville and Santa Cruz patients due to limited providers accepting VSP Medi-Cal, and ongoing GI specialty shortages. • **Impact of Provider Turnover:** Ms. Stevens, and Dr. Sarkarati discussed the anticipated effects of Dignity Health provider turnover, with some specialties already affected and others expected to experience access challenges in the coming months. **Telephone Access** Ms. Veronica Olivarria reported that Q1 telephone access goals were not met, with 53.33% of calls answered within 30 seconds against the 80% target and a 7.84% call abandonment rate exceeding the 5% goal. Increased call volume related to D-SNP implementation, member support needs, and high walk-in traffic contributed to performance challenges. **Gaps:** Increased call demand, higher call handle times, staffing pressures, and elevated call abandonment rates. **Actions:** Ongoing recruitment and staffing expansion, call audits to identify trends and training opportunities, workflow optimization, and implementation of technology enhancements to support self-service options, eligibility verification, authorization status inquiries, and improved call routing. **Cultural and Linguistics** Ms. Herrera reported increased utilization of language assistance services during Q1, including 9,887 phone interpretation requests (19% increase) and 2,403 in-person interpretation requests (38% increase) compared to Q1 2025. Video Remote Interpreting (VRI) services also continued to expand. **Gaps:** Challenges remain in measuring whether all members needing language	

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		assistance receive services, limited availability of some specialized languages (particularly indigenous languages), and occasional interpreter connection and technology issues reported by providers. **Actions:** Continued provider and member education through newsletters and outreach, monitoring interpreter utilization and connection times, expanding VRI services, collecting member feedback on interpretation services, and working with vendors to address service and connection concerns. Dr. Sanford raised concerns about data capture for clinical measures, questioned the ability to track the proportion of members needing interpreting services who receive them, and Ms. Herrera explained current tracking is based on provider requests, with ongoing efforts to inform providers and members and monitor service utilization. **M/S/D:** Dr. Kennedy moved to approve the QI work plan with Dr. Sanford seconding the motion; the committee approved the QI workplan without objection.	
	Q1 2026 Utilization Management Work Plan	Carissa Grepo, Prior Auth Manager presented on the Q1 2026 UMWP. **Care Management (CM) Program / D-SNP and Behavioral Health** Ms. Grepo reported successful implementation of the D-SNP Model of Care and continued growth of the Behavioral Health Case Management program, with timely outreach and care plan completion rates meeting expectations. **Gaps:** Increased member volume and care coordination demands associated with D-SNP implementation and behavioral health growth. **Actions:** Implemented D-SNP care management processes, individual care planning, and behavioral health outreach and engagement activities. **Effectiveness:** High performance in outreach, care planning, and member engagement demonstrated readiness to support coordinated care and CMS requirements. **Enhanced Care Management (ECM)** The ECM program expanded to more than 26,000 active members, including approximately 6,200 new members added during Q1. **Gaps:** Rapid program growth requires stronger operational controls and oversight. **Actions:** Enhanced enrollment, disenrollment, audit	*Approved*

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		processes, provider education, and interdisciplinary team support. **Effectiveness:** Membership growth exceeded state benchmarks and demonstrated successful program expansion. **Authorization Timeliness** Ms. Grepo reported near-perfect turnaround times for routine prior authorizations and 100% timeliness for urgent authorizations. **Gaps:** New D-SNP workflows and benefit requirements created operational challenges. **Actions:** Ongoing monitoring, staff education, and workflow support. **Effectiveness:** Timeliness goals were maintained despite implementation of new processes. **Utilization Management Trends and Oversight** Authorization volumes remained stable despite ECM and Community Supports expansion, while denial and appeal rates remained low and consistent with historical trends. **Gaps:** Continued monitoring needed for denials related to community supports, nutritional counseling, and genetic testing. **Actions:** Provider education, policy review, and implementation of the UM authorization transformation project. **Effectiveness:** Denial rates remained low and appeals were stable, demonstrating effective oversight and utilization management processes. **Concurrent Review and Care Transitions** Ms. Grepo reported improvements in avoidable emergency department utilization and reduced readmission rates across key populations. **Gaps:** Ongoing care coordination complexity associated with growing membership and programs. **Actions:** Strengthened discharge planning, transitions of care, and cross-functional care management activities. **Effectiveness:** Improved utilization outcomes and reduced readmissions suggest successful care coordination efforts. **Pharmacy and Delegate Oversight** Pharmacy authorization timeliness remained high at 95%, while authorization volume increased by approximately 13%. MedImpact achieved 100% compliance in delegated	

MINUTES

		oversight measures. **Gaps:** D-SNP Part B timeliness performance (72.3%) was impacted by system constraints and member notification delays. **Actions:** Evaluation of alternative notification processes and solutions to support urgent turnaround requirements. **Effectiveness:** Overall pharmacy and delegate oversight performance remained strong despite challenges with D-SNP Part B processes. **Behavioral Health Program** Behavioral health services continued to expand across all service areas, with authorization timeliness at 99%, a 99% medical necessity approval rate, and no appeals received during Q1. **Gaps:** Continued growth requires ongoing provider education and access monitoring. **Actions:** Provider education, oversight, and expansion of behavioral health access initiatives. **M/S/D:** Dr. Kennedy moved to approve the UM work plan, and with Dr. Sanford seconding the motion; the committee the UM Workplan without objection.	
	Utilization Management Criteria	Ms. Grepo presented Utilization Management Criteria and benefit updates, including the addition of new CPT codes and authorization criteria updates to align with regulatory and line-of-business requirements, particularly for D-SNP. Supporting documentation was included in the committee packet. **Gaps:** The potential for coding changes to affect measure reporting and data capture was identified, specifically regarding chlamydia testing codes. **Actions:** UM reviewed and updated coverage criteria, CPT codes, and authorization requirements to align with regulatory guidance and D-SNP benefits. Ms. Grepo also agreed to monitor reporting impacts associated with coding changes. **Effectiveness:** Criteria updates support regulatory compliance, accurate benefit administration, and alignment of authorization processes across lines of business. The committee subsequently approved the UM criteria and benefit updates. Dr. Sanford expressed concern regarding the addition of CPT code 87494 (Chlamydia testing), noting coding changes can sometimes result in lost reporting data and make provider performance appear lower than it is.	*Approved*

MINUTES

		Ms. Grepo clarified the code was being added for the D-SNP line of business and stated she would note the concern and ensure the code is captured appropriately in reporting activities. **M/S/D:** Dr. Kennedy moved to approve UM Criteria Dr. Sanford seconding the motion; the committee approved UM Criteria without objection.	
	Emerging Issues	**Budget Uncertainty and Strategic Planning:** Dr. Kennedy and Dr. Wang discussed the potential impact of Medi-Cal eligibility changes on Alliance membership and staffing, with ongoing internal discussions and an emphasis on maintaining quality initiatives despite budget uncertainties. **Anticipated Membership Loss and Cost Management:** Dr. Kennedy inquired about strategic plans to address a projected 30% loss in Medi-Cal patients, and Dr. Wang confirmed discussions are ongoing, with no final decisions pending the state budget outcome. **Advocacy for Quality Funding:** Dr. Kennedy requested continued advocacy for quality funding, and Dr. Wang affirmed the organization's commitment to prioritizing quality regardless of budget constraints. **Budget Uncertainty and Strategic Planning:** Dr. Kennedy and Dr. Wang discussed the potential impact of Medi-Cal eligibility changes on Alliance membership and staffing, with ongoing internal discussions and an emphasis on maintaining quality initiatives despite budget uncertainties. Emerging issues focused primarily on specialty access challenges, including autism evaluations, GI, optometry, rheumatology, urology, and potential impacts of provider turnover on network capacity. Members also discussed concerns regarding potential Medi-Cal membership reductions and the possible implications for Alliance operations and quality programs	

MINUTES

	Future Topics	The committee requested continued discussion regarding specialty access challenges, including autism evaluations, GI, optometry, rheumatology, adult urology, and the potential impact of Dignity Health provider turnover on network access. Members also expressed interest in monitoring state budget developments and potential Medi-Cal membership reductions and their impact on Alliance operations and quality initiatives.	

Action Items			
Agenda Item	**What is the action item**	**Due date**	**Responsible staff**
	No new action items were assigned at this meeting.		
Meeting adjourned at 1:20 p.m.			
Next Meeting September 17, 2026			
Approved by Committee Date: September 17, 2026	***Signature:*** 		**Date:** September 17, 2026

DATE: October 28, 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 1996 the Board established the Physicians Advisory Group (PAG) authorized in the Bylaws of the Santa Cruz-Monterey-Merced Managed Medical Care Commission.

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

Name	Affiliation	County
Marni J. Friedman, MD	Provider Representative	San Benito
Alireza Mahmoudieh, MD	Provider Representative	Merced
Minoo Sarkarati, MD	Provider Representative	Scotts Valley

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

Attachments. N/A

DATE: October 28, 2026

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

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

SUBJECT: Updated Physicians Advisory Group (PAG) 2026 Calendar

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Recommendation.
Staff recommend the Board approve the updated 2026 Physicians Advisory Group (PAG) Calendar.

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 Thursday, December 3, 2026, Physician Advisory Group (PAG) meeting was rescheduled to Wednesday, December 16, 2026, due to competing high-priority leadership commitments requiring executive and director attendance.

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

Attachments.

1. Physicians Advisory Group 2026 Calendar v3

Physicians Advisory Group
Meeting Calendar 2026

Thursday, March 5	12:00 - 1:30 PM
Thursday, June 11	12:00 – 1:30 PM
Thursday, September 3	12:00 - 1:30 PM
~~Thursday~~Wednesday, December ~~3~~16	12:00 - 1:30 PM

- Lunch Provided

DATE: October 28, 2026

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

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

SUBJECT: Q2 2026 Quality Improvement Health Equity Transformation Program Workplan

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Recommendation. Staff recommend the Board approve the Quality Improvement Health Equity Transformation Program Workplan for Q2 2026.

Summary. This informational report provides a summary of the activities planned for the Q2 2026 QIHET workplan. The workplan includes contractual required Performance Improvement Projects, operational performance metrics, health programs and cultural and linguistic services, health equity and population health management. Refer to the QIHET Workplan attachment for additional details.

Background. The Alliance is contractually required by the Department of Healthcare Services (DHCS) to maintain a quality improvement system to monitor, evaluate, and take effective action on any improvements needed in the quality of care for Alliance members. This is monitored through an annual QIHET workplan with a written description of goals, objectives, and planned activities, reviewed quarterly and evaluated at the end of the year. The QIHET workplan is approved by the Quality Improvement Health Equity Committee, and ultimately, the Alliance Board. The Board can direct and provide modifications to the quality improvement system on an on-going basis to ensure actions and improvements meet the overall Alliance mission.

Discussion. Approve the Q2 2026 Quality Improvement Health Equity Transformation Program Workplan.

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

Q2 2026 QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM WORKPLAN

QUALITY PROGRAM STRUCTURE

Population Health Management Program
Reporting purpose: Provide an update on Q2 PHMP activities.

Report Previously Identified Issues /Highlights:

- PHM Program compliance tracker (aka "regulatory crosswalk") was created and is in progress.
- LHD MOU compliance tracker also in progress.

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

Report Changes/Updates:

In quarter 2 2026, the Community Health Integration (CHI) Unit under the Quality Improvement & Health Equity (QIHE) Department prepared for the launch of the Population Health Management (PHM) Program Workgroup, which took place at the start of quarter 3 2026. Staff launched an internal PHM Program SharePoint site to support the PHM Program Workgroup in achieving the goals of

- Coordinate execution of strategies and planning.
- Review improvement opportunities and activities impacting compliance with PHM regulatory requirements in alignment with the Alliance strategic goals and organizational activities;
- Monitor execution of strategies, outcomes, and communication of activities both internally and externally;
- Serve as a hub among relevant stakeholders across Alliance departments and divisions to ensure coordination and collaborative planning of activities; and
- Serve as a forum for working sessions that include transparency, resolution, and guidance on implementation activities to meet program goals.

Additionally, CHI Unit staff hosted five Local Health Department (LHD) Memorandum of Understanding (MOU) meetings with one LHD in each of the five counties across the Alliance service area. In the LHD MOU meetings, Desirre Herrera, Quality and Health Programs Manager, presented on Alliance Health Education Programs and Alliance Member Incentives.

In quarter two, CHI Unit staff supporting the PHM Program also participated in a subgroup meeting to build a Transitional Care Services (TCS) workflow for high- and lower-risk members as segmented per the Alliance's Health Needs Index (HNI) tool, and later, by DHCS's Risk Segmentation, Stratification, and Tiering (RSST) tool. The quarter three focus is on building a TCS workflow specific to pregnancy and postpartum TCS.

As it relates to QIHETP Work Plan updates for the PHM Program, not all Staff at the Alliance have access to or working knowledge of APT. Therefore, CHI Unit staff will manage the PHM Program APT work plan directly and will report back to the PHM Program Workgroup on status updates (rather than tagging business owners on tasks directly in APT).

Health Equity

Reporting purpose: Provide an update on Q2 Health Equity activities.

Report Previously Identified Issues /Highlights:
In response to requirements to establish a Health Equity Plan, CCAH successfully developed and obtained approval of its Health Equity Workplan from QIHEC and DHCS. Following approval, implementation efforts are underway, with operational activities actively advancing the plan's goals and objectives.

Report Changes/Updates:
An APT workplan was established to systematically document, monitor, and support compliance with health equity-related regulatory requirements, providing a structured framework for tracking obligations, milestones, and implementation activities.

QUALITY OF CLINICAL CARE

Medi-Cal Managed Care Set (MCAS) Intervention:
Reporting purpose is to: Provide an update on MCAS intervention progress.

Report Previously Identified Issues/Highlights:

Practice Coaching, Provider Partnerships, and Care Gap Grant:
Key challenges have included provider and staff shortages, limited locum tenens availability, lengthy recruitment timelines, and the impact of H.R. 1 regulations. These factors continue to affect appointment access and provider capacity. Additionally, due to low D-SNP enrollment, initial outreach efforts focused on Medi-Cal enrollment data and CBI performance measures, specifically GSD and CBP. In some cases, by the time outreach was conducted using the available data, practices had already met the Minimum Performance Level (MPL), limiting opportunities for engagement.

Immunization Initiative:
Primary barriers have included transportation challenges, limited health education and vaccine awareness, members being unaware that their Medi-Cal coverage had lapsed or been canceled, and ongoing vaccine hesitancy. These factors continue to impact access to and uptake of recommended immunizations.

Report Changes/Updates:
Practice Coaching, Provider Partnerships, and Care Gap Grant:
Significant progress has been made across the Care Gap, Provider Partnership, Practice Coaching, and Immunization initiatives. To date, 75% of Care Gap funding has been distributed, supporting outreach to 8,691 members and resulting in 4,099 completed appointments. All participating Provider Partnership sites have improved their targeted quality measures, with five of seven improving in both focus areas. Practice Coaching efforts continue to expand through provider self-referrals, targeted outreach, and clinic engagement, with eight clinics participating and four enrolled in the PLAD program.

Immunization Initiative:
In immunizations, three community vaccine events were completed, resulting in 37 vaccinations administered and advancing efforts to improve vaccine access and uptake.

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

Report Previously Identified Issues/Highlights:

For Quarter 1, the CBI team has gathered preliminary data for the providers performance in Quarter 4. The validated Q4 data will not be available until April 2026. Roles, responsibilities, and assignments were outlined with the group along with expectations for targeted outreach. In Quarter 2, the team will begin outreaching and practice coaching with providers who are low performing in attempt to increase the measure rates to >25th percentile or MPL.

For Quarter 2, the CBI team has generated a list of low performing providers who need support. The team has a project lead, who is coordinating the targeted outreach attempts. The QIPAs have started outreaching to providers offering CBI Forensic meetings, practice coaching, resources, trainings (in-person or virtual) and education. The CBI 2026 Intro Video was also recorded and posted on the Alliance's website for training purposes. The video link was also directly emailed to providers and practices for ease of use.

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

Health Education

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

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

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

Q2 progress: A total of 16 member workshops were completed in Q2. Modalities provided included

- 7 telephonic workshops
- 7 virtual workshops
- 2 in-person workshops (1 in Merced, 1 in Salinas)

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

Q2 progress: The following activities were completed in Q2 to inform members of Health and Wellness programs:

- Member Newsletter: The project team included 1 article in the June 2026 Member Newsletter informing members of workshops available for chronic disease management.

- Text message campaign: 2 text message campaigns were completed in Q2 informing members of workshop programs available and how to sign up.

- Member online sign-ups: As a result of member informing activities in Q2, the team received 162 member sign-ups online.

- PCP referrals: A total of 69 PCP referrals were received in Q2. Health Educators are assigned the referrals and complete outreach calls to members referred to programs.

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

Q2 progress: A total of 72-member experience surveys were completed in Q2.
Summary of results to survey are included below.

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

Facility Site Review:
Report Previously Identified Issues /Highlights:
The weather-related scheduling delay identified in Q1 was successfully mitigated through continued proactive scheduling, centralized tracking, and routine monitoring. No similar delays occurred during Q2, and all required site reviews were completed within required timeframes.

Q2 Goal Results
1. 12 of 12 (100%) Facility Site Reviews due in Q2 2026 were completed within required timeframes, exceeding the 80% target.
2. 100% of corrective action plans (16 total: 7 FSR and 9 MRR) were submitted within required regulatory timeframes.

Report Changes / Updates
The FSR program achieved 100% timely completion of all required Facility Site Reviews during Q2, demonstrating that proactive scheduling and centralized monitoring successfully addressed the scheduling challenges experienced in Q1. The program also maintained 100% compliance for corrective action plan submissions through continued standardized tracking, provider communication, and routine follow-up. Existing oversight processes continue to support sustained regulatory compliance.

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

Report Previously Identified Issues /Highlights:
1. The increased grievance volume identified in Q1 continued during Q2 and remains an ongoing operational challenge requiring sustained coordination and nursing resources to maintain regulatory timeliness.
2. The complexity of non-grievance PQIs continues to require extensive investigation and interdisciplinary coordination, affecting overall case throughput. While the work plan target continued to be exceeded, continued workload optimization and process improvements are

needed to advance performance toward the long-term objective of timely completion of all non-grievance PQIs.

Q2 Goal Results

1. 297 of 300 (99%) grievance-related PQIs, including exempt grievance PQIs, were completed within the required regulatory timeframe.
2. 21 of 24 (87.5%) non-grievance PQIs were completed within 120 calendar days, exceeding the established work plan target of 80%.

Report Changes / Updates:

1. The increased grievance volume identified in Q1 continued during Q2 and remains an ongoing operational challenge requiring sustained coordination and nursing resources to maintain regulatory timeliness.
2. The complexity of non-grievance PQIs continues to require extensive investigation and interdisciplinary coordination, affecting overall case throughput. While the work plan target continued to be exceeded, continued workload optimization and process improvements are needed to advance performance toward the long-term objective of timely completion of all non-grievance PQIs.

Q2 Goal Results

1. 297 of 300 (99%) grievance-related PQIs, including exempt grievance PQIs, were completed within the required regulatory timeframe.
2. 21 of 24 (87.5%) non-grievance PQIs were completed within 120 calendar days, exceeding the established work plan target of 80%.

Long Term Support Services

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

Report Previously Identified Issues /Highlights:

1. Facility responsiveness improved during Q2, with QAPI submissions increasing from 21 of 34 (61%) in Q1 to 30 of 34 (88%). Four facilities remain pending submission and continue to require targeted outreach and escalation.
2. The standardized QAPI evaluation process established in Q1 successfully supported the first comprehensive assessment of facility compliance with CMS-required QAPI elements during Q2. Review findings confirmed continued variability in facility QAPI program maturity and completeness, reinforcing the need for ongoing technical assistance and follow-up.

Goal Results

1. 30 of 34 (88%) LTSS facilities submitted required QAPI programs.
2. 18 of 34 (53%) reviewed LTSS QAPI programs met all five CMS-required QAPI elements, exceeding the established 50% implementation benchmark.

Report Changes / Updates:

LTSS oversight activities during Q2 focused on increasing QAPI submission compliance and conducting standardized reviews of submitted QAPI programs using the SharePoint evaluation tool implemented in Q1. Continued outreach, individualized follow-up, and centralized tracking increased facility submissions from 61% to 88%. Standardized reviews established the first

quantitative baseline of facility compliance with CMS-required QAPI elements. Although the initial implementation benchmark of 50% was exceeded, the long-term objective remains for all applicable LTSS facilities to maintain QAPI programs that fully incorporate all five CMS-required elements. Ongoing technical assistance, follow-up reviews, and continued oversight will support progressive improvement toward full compliance.

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

Report Previously Identified Issues/Highlights
Identified Issues: Increased AG volume continues to strain staff capacity and limited resources across the organization.

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

- Q2 Results: The AG team met this requirement during this quarter. Missed deadlines continued to occur due to AG volume increases and staffing deficiencies.
- Actions: Extend AG temporary staff assignments to continue managing inbound work.

Goal 2:

- Maintain the AG rate below 2 for QOC and QOS with the Medi-Cal LOB.
- Q2 Results: MCAL LOB achieved this goal.

Goal 3:

- Improve AG data quality and reporting.
- Q2 Results: QA activities and implementation of QOS trending report supported this goal.

Goal 4:

- Improve monitoring and documented oversight.
- Q2 Results: Grievance Resolution and Oversight Workgroup (GROW) and documented process or system issues supported this goal.

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

MEMBER EXPERIENCE
Member Satisfaction Survey – CAHPS
Reporting purpose is to: Update the group on the progress of the CAHPS work and 2026 focus areas.

Report Previously Identified Issues/Highlights.

- Lunch and Learns: Continue to face time constraints due to speaker access and MarCom's priorities.
- Alt. Places of Medicine: There continues to be delays in receiving mobile mammography results/reports - impacted timely follow-up by clinics and providers. Immunizations are impacted by transportation, lack of education, and members not being aware that their Medi-Cal coverage was cancelled.

- BH Incentives: Ongoing outreach and education regarding behavioral health is a barrier. In addition, access remains an issue, with a continued need for behavioral health providers – especially services provided outside of traditional office hours.

Report Changes/Updates:

- Lunch & Learns: 4 quarterly topics confirmed with first two completed: Q1: Pediatrics - Q2: Access to Care in Rural Communities - Q3: Trauma-Informed Care - Q4: D-SNP. Next steps will be planning Q4 webinar.
- Provider touchpoints: 9 sites in pc work, 7/8 PP sites have shown improvement. 85% of EPT sites deliverables were met. The team will continue to review performance and run data to offer practice coaching to more providers in our servicing counties.
- C&L: 30% increase of in-person/VRI interpreting services utilized, 17% increase in utilization of telephonic interpreting services utilized. Next steps, leadership team is exploring options for a member online request form for interpreting services to potentially launch in Q1 2027.
- MCGP: Provider recruitment seeing 10 grants equating to over $2 million. Round 2 pending agreement, $3.5 million will be awarded. Next steps will be to launch of Safety Net Critical Access funding opportunity
- Alt. Places of Medicine: 19 total events with 528 mammograms, 388 incentives. 4 WIC events, 3 school vaccine events, 37 vaccinations occurred, 32 incentives given. Nearly 700 in-home Sprinter visits occurred. 1,468 gaps closures services (678 SDOH screenings, 302 COL w/ 40% return, 132 A1c, 98 BP, 14 EED, 149 lead, 90 TFL.
- BH Incentives: The behavioral health team has worked to increase collaboration with behavioral health provider groups to improve access. Targeted recruitment in the psychologist space and executed several outreach and education efforts including the BH lunch and learn webinar on depression.

QUALITY OF SERVICE

Access and Availability

Reporting purpose is to: Monitor non-contracted Letters of Agreement (LOAs) to identify trends and potential network gaps that may indicate opportunities for targeted provider recruitment. This allows Network Development to proactively identify frequently utilized non-contracted providers or services and pursue contracting opportunities to strengthen the network and improve member access.

Report Previously Identified Issues/Highlights:

During Q1, Network Development monitored non-contracted Letters of Agreement (LOAs) to identify potential network gaps and opportunities for provider recruitment. LOA activity was reviewed by specialty and geographic area to identify services with limited contracted provider availability and help prioritize targeted recruitment efforts.

A key issue identified was that some LOAs were being executed without first exploring whether the provider was interested in establishing a contract with the Alliance. This represented a missed opportunity to convert recurring or needed out-of-network services into long-term contracted relationships.

The findings highlighted the need for improved coordination between the LOA and provider recruitment processes, allowing Network Development to engage potential providers earlier and proactively strengthen the network.

Report Changes/Updates:

Network Development partnered closely with Finance, Contracts, and Credentialing to ensure earlier involvement in the LOA review process. This improved coordination provides greater visibility into non-contracted provider activity and creates an opportunity to explore contracting with providers before or during the LOA process.
The team will continue to monitor LOA activity and collaborate closely with Finance and Contracts to identify recruitment opportunities, establish appropriate parameters around LOA duration, and support the timely transition of appropriate providers from LOAs to fully contracted network participation.

Timely Access
Reporting Purpose:
During Q2, a key focus was supporting the Triennial Audit and ensuring the Alliance was well positioned to successfully meet network requirements. The team prioritized identifying and addressing network gaps, conducting targeted provider recruitment, and completing necessary follow-up to strengthen network adequacy.
As part of these efforts, the Q1 2026 GeoAccess analysis, utilizing the March 2026 274 data and DMHC Population Points, identified 237 network access gaps. Of these, 85 gaps (36%) were resolved through allowable telehealth providers, reducing the total to 151 remaining gaps. Telehealth-only practitioners may vary from month to month, as eligibility is based on claims activity for the applicable reporting month.
Together, these efforts were focused on achieving network compliance, reducing identified access gaps, and minimizing the need to submit exception reports as part of the Triennial Audit. This work demonstrates the important role Network Development plays in using GeoAccess reporting to identify and prioritize network needs, guide targeted recruitment efforts, proactively address access gaps, support regulatory compliance, and ensure members have appropriate access to care.

Report Previously Identified Issues/Highlights:

A previously identified concern was the potential lack of a Neurosurgery provider who could meet the required time and distance standards for the D-SNP network. This was identified as a priority network gap due to the potential impact on network adequacy, regulatory compliance, and member access to Neurosurgery services. Network Development prioritized recruitment efforts to identify a provider solution and address the gap.

Additionally, due to a technical issue with the ArcGIS Pro tool, completion of the Q1 GeoAccess Analysis was delayed. The analysis was subsequently completed and provided to PS on July 23.

Report Changes/Updates:
The Alliance successfully completed and passed the Triennial Audit. In addition, the required HSD tables were submitted with no exception requests needed, demonstrating that the network met applicable requirements without the need to request exceptions for identified network gaps.

To further support ongoing network development efforts, a Potential Recruitment Outreach tab was added to the GeoAccess analysis to identify next-nearest providers and health systems that may help address remaining access gaps. The analysis identified potential recruitment opportunities, particularly with Adventist Health and Dignity Health/CommonSpirit locations in San Luis Obispo and Fresno counties.
Recruitment outreach is currently underway based on these identified opportunities, with Network Development continuing to evaluate and pursue providers that may strengthen network adequacy and address remaining GeoAccess gaps.

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

Report Previously Identified Issues/Highlights:

- The Call Center will continue prioritizing recruitment efforts to maintain staffing levels and achieve key performance metrics.
- Walk-in visits experienced a slight decrease compared to the previous reporting period; however, the Member Services team continued to provide in-person assistance to **576** members, maintaining a strong commitment to member support.

Report Changes/Updates:
Recruitment, retention, and AI support will help the team meet member demand while maintaining service expectations and key performance metrics.

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

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

Report Changes/Updates:
Goal 1:
Increase provider utilization of language assistance services quarterly by a minimum of 5% in comparison to 2025 baseline utilization data.
.
Q2 progress:

- **Phone Interpreting Services:** There was a total of **10,698 calls** in Q2 by provider sites. This reflects a **14% increase** compared to Q2 2025.

- **In-Person interpreting services**: There was a total of **2,421 requests** for in-person interpreting services in Q1. This reflects a **21% increase** compared to Q2 2025.

- **Virtual Remote Interpreting (VRI) services:** There was a total of **56 requests** for VRI services in Q2. VRI services were not available until Q3 2025, baseline comparison will be shared in Q3.

- **Santa Cruz County providers** were the highest utilizers of in-person interpreting services in Q2.

- **Monterey County providers** were the highest utilizers of Virtual Remote Interpreting services in Q2.

Goal 2:
On a quarterly basis, inform members and/or providers of language assistance services utilizing at least 1 member and/or 1 provider informing modality.
Q2 progress:

- **Member Newsletter:** The project team included 1 article in the **June 2026** Member Newsletter members of the importance of being able to communicate with their doctor and language assistance services available to them.

- **Provider Bulletin:** The project team included 1 article in **June 2026** Provider Bulletin informing providers of language assistance services and training available to maximize utilization and avoid barriers to access.

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

Q2 progress:
A total of **52-member experience surveys** were completed in Q1-Q2.

Members were asked for feedback regarding experience with language assistance services and the interpreter in the clinical setting.

- 94% of members reported they were satisfied (4%) or highly satisfied (90%) with the interpreter at the doctor visit.

- 100% of members reported they would use the in-person interpreting services again. Responses included yes (6%) or strong yes, (94%).

Conclusion: The QIHET Workplan does not have any critical areas of concern that require further intervention or follow-up. There is continued progress toward goals for the initiatives and operational metrics, including addressing any barriers to achieve outcomes.

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

Attachments.
1. Q2 2026 Quality Improvement and Health Equity Transformation Program Workplan Master Updates

2026 QIPH Work Plan

SECTION 1: QUALITY PROGRAM STRUCTURE

ANNUAL EVALUATION (KRISTEN ROHLF)

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

PROGRAM DESCRIPTION (GEORGIA GORDON)

Goals/Objectives for Calendar Year 2026	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Annual Update	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Finalize 2026 Program Description for presentation to QI stakeholders.	1. Ensure all required sections of the workplan meet DHCS and NCQA requirements.	1/31/2026 - 2/13/2026	Georgia Gordon, Quality Improvement Program Advisor II	1st update:	1:	1	☐ Yes ☐ No	
2. Presentation of the Program Description to both the QIHEW, and QIHEC for approval by	1. Submission of Program Description to QIHEW staff after the creation of structure in APT for a Bi-annual update.	3/1/2026 - 3/31/2026	Georgia Gordon, Quality Improvement Program Advisor II				☐ Yes ☐ No	
3. Develop a comprehensive 2026 Quality improvement Program Description that outlines all required DHCS and NCQA requirements.	1. Review all DHCS and NCQA requirements to ensure all sections included are relevant and share the template with business owners to begin writing.	9/30/2026 - 12/31/2026	Georgia Gordon, Quality Improvement Program Advisor II		2:	2:	☐ Yes ☐ No	

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ANNUAL WORKPLAN (SARINA KING)

Goals/Objectives for Calendar Year 2026	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Execute a QI annual work plan that captures ongoing activities throughout the year and addresses all DHCS and NCQA requirements	1. Create a workplan that captures yearly activities, time frame for each activity's completion, staff members responsible for each activity, monitoring of previously identified issues, and evaluation of QI program in APT.	1/1/2026 - 2/24/2026	Sarina King, Quality and Performance Improvement Manager Georgia Gordon, Quality Improvement Program Advisor II	Qtr. 2: Q1 of the QIHETP – Work Plan was successfully completed and approved at the Q1 QIHEW and QIHEC. Qtr. 3: Qtr. 4:	2: No issues identified in Q2	2: Continue to capture activities in a timely manner and work with stakeholders according to NCQA and DHCS standards.	☑ Yes ☐ No	Cross-functional quality activities are captured and reviewed quarterly through the **QIHETP-WP** to monitor adherence to quality standards, evaluate performance, identify gaps and improvement opportunities, and track corrective actions. Findings and action items are documented, assigned, and followed through subsequent reviews to support accountability and continuous improvement.
2. Ensure all workplan elements are properly documented and reflect appropriate follow-up by each business owner.	1. Regularly quarterly check-ins to review workplan entries with regular feedback provided to business owners when applicable.	1/1/2026 - 3/30/2026 4/1/2026 - 6/30/2026 7/1/2026 - 9/30/2026 10/1/2026 - 12/31/2026	Sarina King, Quality and Performance Improvement Manager Georgia Gordon, Quality Improvement Program Advisor II					
3. Review and approval of workplan quarterly by QIHEC.	1. Review of all workplan entries prior to each committee to ensure appropriate documentation.	1/1/2026 - 3/30/2026 4/1/2026 - 6/30/2026 7/1/2026 - 9/30/2026 10/1/2026 - 12/31/2026	Sarina King, Quality and Performance Improvement Manager Georgia Gordon, Quality Improvement Program Advisor II					

POPULATIONS HEALTH MANAGEMENT PROGRAM (KATE NESTER)

Goals/Objectives for Calendar Year 2026	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. By the end of Q4 2026, ensure all teams responsible for PHM-related work are aware of DHCS and NCQA PHM requirements, have clearly defined and applicable goals aligned to those requirements, align all existing and new PHM initiatives to DHCS and NCQA PHM goals, and contribute to centralized PHM reporting.	2. Create a PHM Program compliance tracker, cross walking compliance requirements outlined in PHM associated DHCS APLs, the DHCS PHM Policy Guide, and NCQA PHM Standards, with processes and procedures in place to achieve each requirement. 3. Build, document, and activate processes and procedures to achieve requirements that remain out of compliance as of January 1, 2026.	1/1/2026-12/31/2026	Kate Nester, Community Health Integration Manager Christy Celis Puga, Senior Community Health Analyst Katie Morataya-Picazo, Community Health Specialist	Qtr.2: Staff prepared for the launch of the PHM Program Workgroup in early Q3 2026, with the intention of creating alignment across PHM workstreams. Staff hosted five Local Health Department (LHD) MOU meetings. Staff supported the development of a TCS high- and lower-risk workflow.	Qtr.2: The PHM work within the Alliance was solved and a comprehensive compliance tracking process did not exist. Where Alliance policies were aligned with regulatory requirements, the Alliance's system for mapping process documentation remained ad hoc by workstream owner.	Qtr.2: Launch PHM Program Workgroup. Support drafting of TCS pregnancy and postpartum workflow. Support SMEs in developing RSST Implementation Plan. Continue hosting five LHD MOU meetings per quarter. Continue participating in County-led Community Health Assessment (CHA) and Community Health Improvement Plans (CHIPs).	☑ Yes ☐ No	PHM Program compliance tracker created in alignment with regulatory requirements. Staff continue to identify where requirements remain out of compliance to bring the program fully into compliance by end of Q4 2026.

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1. By end of Q4 2026, execute an annual PHM work plan that captures ongoing activities throughout the year and addresses all DHCS and NCQA requirements.	2. Create a yearly work plan in APT. Ensure all required sections of the work plan meet DHCS and NCQA requirements. 3. Assign each task to a business owner and include start and end dates.	1/1/2026-3/31/2026	Kate Nester, Community Health Integration Manager Christy Celis Puga, Senior Community Health Analyst Katie Morataya-Picazo, Community Health Specialist	Qtr.2: PHM QIHETP tasks have transitioned to work plan tasks in APT to improve visibility and organization.	Qtr.2: Not all Staff at the Alliance have access to our working knowledge of APT. Therefore, CHI Unit staff will manage the PHM Program APT work plan directly and will report back to the PHM Program Workgroup on status updates (rather than tagging business owners directly on tasks in APT).	Qtr.2: Launch the PHM Program Workgroup in early Q3. Ensure all required sections of the APT work plan meet DHCS and NCQA requirements. Assign tasks to business owners and align work completion dates with regulatory requirements.	☑ Yes ☐ No	

HEALTH EQUITY (VANESSA PAZ)

Goals/Objectives for Calendar Year 2026	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. By end of Q1 2026, create a comprehensive Health Equity Plan that meets DHCS Regulatory requirements including posting on external Alliance website.	2. Review DHCS contract requirements for HEP plan to ensure all components are met. 3. Review current PNA, HEDIS rates, and Quality Evaluation to identify populations of focus for the HEP. 4. Submit Comms ticket to post HEP. All three you say by the end of QI 2026.	1/1/2026-3/31/2026	Andrea Swan, QIHETP Director Kate Nester, Community Health Integration Manager Vanessa Paz, Community Health Program Manager	Qtr.2: Health Equity Plan operational activities underway.	Qtr.2: CCAH needed to develop a health equity plan (HEP).	Qtr.2: HEP Workplan has since been developed and approved by QIHEC/DHCS. Health Equity planning operational activities are underway.	☑ Yes ☐ No	Operational activities and planning implementation of the Health Equity Plan. Health Equity Operations continue to be defined by the Community Integration Unit. Health equity regulatory requirements continue to be defined by state and local regulators. DHCS has not released new Health Equity alignment strategy.
1. By the end of Q2 2026, create a workplan within APT to track all DMHC, DHCS, CMS Health Equity requirements. 2. By end of Q4 2026, ensure equity principles are embedded into strategic plans, regulatory compliance activities, and quality improvement efforts.	1. Assign each task to a business owner and include start and end dates. 2. Ensure all work plan elements are properly documented and reflect appropriate follow-up by each business owner. 3. Hold quarterly check-ins to review work plan	1/1/2026-9/30/2026 9/30/2026-12/31/2026	Andrea Swan, QIHETP Director Kate Nester, Community Health Integration Manager Vanessa Paz, Community Health Program Manager	Qtr.2: APT workplan created to document and track regulatory requirements for health equity.	Qtr.2: No issues identified	Qtr.2: APT workplan created to document and track regulatory requirements for health equity.	☐ Yes ☑ No	Regulatory alignment is underway but not entirely complete at the end of Q2. This will remain a collaborative multidivisional alignment approach with Health services

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	entries with regular feedback provided to business owners when applicable. 4. Support each dept to develop their own Health Equity goals (PS, CM, UM, Grievance, etc.). by end of Q3 2026 5. Create a communication plan to ensure Health Equity work plan goals are distributed to Alliance wide staff by end of Q4 2026.							Operations as well as the compliance team.

SECTION 2: QUALITY OF CLINICAL CARE

MCAS INTERVENTION (KRISTEN ROHLF/SARINA KING)

Goals/Objectives for Calendar Year 2026	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Close pediatric care gaps in Merced and Mariposa County to have all pediatric measures at or above MPL or have a 5% increase in the measure rate. • Child and Adolescent Well-Care Visits (WCV) • Childhood Immunizations - Combo 10 (CIS-10) • Immunizations for Adolescents - Combo 2 (IMA–2) • Lead Screening in Children (LSC)	1. Analyze data for Q4 2025. 2. Identify providers that need support to increase their rates. 3. Provide workforce care gap closure grants to providers with large member populations in Merced and Mariposa 4. Continue Provider Partnership program in Merced and Mariposa Counties to support providers in their interventions that focus on	1/01/2026 – 3/31/2026 4/01/2026 – 6/30/2026 7/01/2026 – 9/30/2026 10/01/2026 – 12/31/2026	Sarina King, Quality and Performance Improvement Manager Alex Sanchez, Quality Improvement Program Advisor III Georgia Gordon, Quality Improvement Program Advisor II Jada Edwards, Quality Improvement Program Advisor II	Qtr.2: 75% of Care Gap funding has been issued out to all participating sites. Monthly pediatric measure Care Gap list are being sent out to Care Gap participants. Members Outreached:8,691 Appointments Completed:4,099 Monthly data reviews for our Provider Partnerships sites have begun with tailored interventions like Data Submission Tool training, analyzing data, and workflow creations	Qtr.2: Provider and staff shortages, coupled with limited locum availability and prolonged recruitment timelines, continue to constrain appointment access, provider efficiency, and H.R.1 regulations Transportation, limited health education, and members not being aware that their Medi-Cal coverage was cancelled	Qtr.2: Continue working with providers and community events.	☑ Yes ☐ No	Work continues in Mariposa and Merced counties. The interventions help but some of the same barriers remain an issue, especially vaccine hesitancy and provider availability as well as member fears around accessing care. We remain committed to

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• Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30-6) • Well-Child Visits for Age 15 Months to 30 Months—Two or More Well- Child Visits (W30-2) • Developmental Screening in the First 3 years	measures that are below MPL Q4. 5. Explore mobile unit use in rural areas		Juan Velarde, Quality Improvement & Health Equity Supervisor Annecy Majoros, Quality Improvement Program Advisor III Jo Pirie, Quality Improvement Program Advisor III Britta Vigurs, Quality Improvement Program Advisor III Cassie Russo, Quality Improvement & Health Equity Supervisor Daryl Ford, Quality Improvement Program Advisor III Villyginn Morris, Quality Improvement Program Advisor II Pa Moua, Quality Improvement Program Advisor II	All 7 providers have shown improvement of their focus measures 5/7 practices improved in both measures of focus An online referral for Practice Coaching has been created for providers to self-refer Total Events: • 4 WIC events completed • 3 SLVE completed • Other CBOs Total inoculations (by vaccine): • Dtap, Kinrix, MMR, Varicella, and Tdap • 37 Vaccinated • 22 were given 25% Target gift card				addressing the barriers and supporting members and providers.
2. Increase overall rates for Controlling Blood Pressure (CBP) and Comprehensive Diabetes Care: HgbA1c Poor Control >9% (GSD) by 5% or reach MPL from Q4 2025 to Q4 2026.	1. Develop a list of providers who are below MPL in either one or both measures (CBP & GSD) 2. Assign Practice Coaches and outreach to Providers 3. Begin practice coaching and implement best practices for these measures 4. Review rates and adjust interventions as needed	1/01/2026 – 3/31/2026 4/01/2026 – 6/30/2026 7/01/2026 – 9/30/2026 10/01/2026 – 12/31/2026	Juan Velarde, Quality Improvement & Health Equity Supervisor Hugh Jones, Quality Improvement Program Advisor II Luz Hernandez, Quality Improvement Program Advisor II	Qtr.2: COL and BCS data have been analyzed, practices have been identified. Second phase of outreach has been launched, practice coaches have been assigned, initial meetings are occurring. 4Clinics have signed up to participate in our PLAD program. 8 Clinics have agreed to participate in practice coaching.	Qtr.2: When initial data was used for identifying the practice by the time outreach was done some practices met MPL.	Qtr.2: Continue practice coaching and PLAD meetings, working directly with practices.	☑ Yes ☐ No	The work is just getting started but there has been a positive response from providers so far.

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

Goals/Objectives for Calendar Year 2026	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Identify low performing providers (with 3 or more CBI measures below the 24th percentile) and provide targeted outreach offering education, resources, support and practice coaching referrals by the end of CY2026 to increase rates by 2.5%.	1. The CBI team will generate a list of providers with 3 or more measures below the 24th percentile once 2025 Q4 rates have been finalized. 2. Analyze the list of providers' performance reports from Q4 2025 and develop a strategy to approach outreach assignments. 3. Outreach to targeted providers offering resources, CBI Forensic meetings, practice coaching referrals, and/or measure	1/01/2026 – 3/31/2026 4/01/2026 – 6/30/2026 7/01/2026 – 9/30/2026 10/01/2026 – 12/31/2026	Cassie Russo, Quality Improvement & Health Equity Supervisor. Pa Moua, Quality Improvement Program Advisor II Villyginn Morris, Quality Improvement Program Advisor II Britta Vigurs, Quality Improvement Program Advisor III Jo Pirie, Quality Improvement Program Advisor III	Qtr.2: The CBI team identified a list of low performing providers using finalized Q4 2025 rates. The team developed a targeted outreach plan and strategy to begin at the end of Q2. The team has begun the work of outreaching our targeted list of providers in Q2. Some of the providers were interested in CBIF meetings and others were non-responsive. The team offered sources, practice coaching, training and support. The CBI Intro Video was also recorded and posted in Q2 to the Alliance's website.	Qtr.2: Lack of engagement from certain providers.	Qtr.2: Email the CBI Intro Video directly to all providers for ease of use and accessibility. Continue meeting with providers in Q3 and Q4 to review their CBI Forensic data.	☑ Yes ☐ No	As of Q2, this goal has not been fully completed. We anticipate full completion by end of calendar year 2026.

	specific training (in-person or virtual). 4. Distribute the 2026 CBI Intro video directly to providers and incorporate a survey to evaluate effectiveness of materials presented in the video.		Daryl Ford, Quality Improvement Program Advisor III Annecy Majoros, Quality Improvement Program Advisor IV					

HEALTH EDUCATION (DESIRRE HERRERA)

Goals/Objectives for Calendar Year 2026	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Party	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Provide chronic disease management and wellness programs. A minimum of 4 member workshops will be provided per quarter.	1. The Health Educators will conduct a minimum of 4 member workshops per quarter. 2. Health Educators will lead recruitment and outreach efforts to members to enroll in the programs.	1/01/2026 – 3/31/2026 4/01/2026 – 6/30/2026 7/01/2026 – 9/30/2026 10/01/2026 – 12/31/2026	Veronica Lozano, Quality and Health Programs Supervisor Health Educator team Desirre Herrera, Quality and Health Programs Manager	Qtr. 2: A total of 16 member workshops were completed in Q2. The following workshop modalities were completed: • 7 telephonic workshops • 7 virtual workshops • 2 in-person workshops (1 Salinas, 1 Merced)	Qtr.2: No issues identified	Qtr.2: The project team will continue to schedule workshops in Q3.	☑ Yes ☐ No	There continues to be increases in member sign-ups for workshops. In Q2 2026 a total of 16 workshops were provided. This was an increase compared to last year Q2 2025, which had 11 workshops.
2. On a quarterly basis, inform members of Health and Wellness programs and self-management tools available to them.	1. The project team will conduct outreach and education activities to inform members of services available to them via: • Member outreach calls • Member newsletter articles • Sharing materials such as flyers • MSAG presentation • Social media and/or texting campaigns	1/01/2026 – 3/31/2026 4/01/2026 – 6/30/2026 7/01/2026 – 9/30/2026 10/01/2026 – 12/31/2026	Veronica Lozano, Quality and Health Programs Supervisor Health Educator team Kevin Lopez, Program Advisor – Quality and Health Programs Desirre Herrera, Quality and Health Programs Manager	Qtr. 2: The following activities were completed in Q2 to inform members of Health and Wellness programs: • Member Newsletter: The project team included 1 article in the June 2026 Member Newsletter informing members of workshops available for chronic disease management. • Member text campaign: 2 text message campaigns were sent out to members in Q2 to inform them of workshops available. The text linked members to the Alliance website page to sign-up. • Online member sign-ups received: A total of **162 sign-ups** were received in Q2 as a result of informing activities. • PCP referrals: A total of **69 PCP referrals** were received in Q2.	Qtr.2: No issues identified	Qtr.2: The project team will continue to conduct member informing activities quarterly in 2026.	☑ Yes ☐ No	Text message campaigns continue to successfully engage members and result in member online sign-ups.
3. On a bi-annual basis, collect member feedback from participants in chronic disease management and wellness	1. The project team will conduct member satisfaction surveys to evaluate:	1/01/2026 – 6/30/2026 7/01/2026 – 12/31/2026	Kevin Lopez, Program Advisor – Quality and Health Programs	Qtr. 2: A total of **72-member experience surveys** were completed in Q2. Summary of	Qtr.2: No issues identified	Qtr.2: The project team will schedule surveys and report out again in Q4.	☑ Yes ☐ No	A total of 72-member experience surveys were

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programs to evaluate impact. A minimum of 50 surveys will be collected annually.	• Information about the overall program • Usefulness of the information shared • Percentage of members indicated that the program helped them achieve health goals. 2. Request input from members regarding program and services. 3. Incorporate member feedback into planning health education activities.		Veronica Lozano, Quality and Health Programs Supervisor Desirre Herrera, Quality and Health Programs Manager	survey results to survey are included below. ***Chronic Disease Management Programs:*** <u>Healthier Living Program (HLP)</u> • 100% reported they were satisfied with the **Healthier Living Program (HLP)** workshops. • 96% reported HLP helped them reach their health goals. • 100% reported the information received in HLP was useful. <u>Live Better with Diabetes program (LBD)</u> • 100% reported they were satisfied with the **Live Better with Diabetes program (LBD)** workshops. • 92% reported LBD helped them reach their health goals. • 100% reported the information received in LBD was useful. ***Wellness programs:*** <u>Healthy Weight for Life (HWL)</u> • 100% reported they were satisfied with the **Healthy Weight for Life (HWL)** childhood obesity prevention program. • 100% reported the information received in HWL was useful. • 100% reported HWL helped them reach their health goals				collected to evaluate services provided in Q1-Q2 2026. Overall members are highly satisfied with the programs and services provided. Areas of improvement include offering workshops in later hours for people that work. Also offering more types of workshops due to the positive experience.

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SECTION 3: SAFETY OF CLINICAL CARE

FACILITY SITE REVIEW (DEANNA LEAMON)

Goals/Objectives for Calendar Year 2026	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Complete 80% of primary care provider site reviews due in the quarter within three years of the prior review date, as measured through Facility Site Review tracking.	1. Maintain centralized tracking of FSR due dates, scheduling activity, and completion status. 2. Prioritize scheduling of primary care provider site reviews approaching the three-year review cycle. 3. Conduct site reviews using Department of Health Care Services audit tools and standards, for facility, medical record, and physical accessibility reviews performed by the FSR team. 4. Monitor site review completion rates through routine oversight and internal reporting.	04/01/2026 – 06/03/2026	Tisha Criswell, FSR Supervisor Joana Castaneda, Quality Improvement Program Advisor II Yvette Sullivan, Quality Improvement Nurse Aaron Varela, Quality Improvement Nurse	Qtr.2: In Q2 2026, all 12 of 12 required primary care provider site reviews (100%) were completed within the required three-year review cycle, exceeding the annual performance target of 80%. All reviews were completed using DHCS Facility Site Review, Medical Record Review, and Physical Accessibility Review audit tools and standards. Centralized tracking of due dates, scheduling activities, and completion status continued to support proactive scheduling and timely completion of all required reviews throughout the quarter.	Qtr.2: No significant issues were identified during Q2. The weather-related scheduling delay identified in Q1 was successfully mitigated through continued proactive scheduling, centralized tracking, and routine monitoring of due dates.	Qtr.2: Continue proactive scheduling of site reviews well in advance of due dates while maintaining centralized tracking and routine monitoring to sustain timely completion. Continue evaluating scheduling flexibility where feasible to minimize the impact of unforeseen external events while maintaining compliance with DHCS requirements.	☑ Yes ☐ No	The goal was met, with 100% (12 of 12) of required Facility Site Reviews completed within the required three-year review cycle. The proactive scheduling and monitoring strategies implemented following the Q1 delay were effective in preventing recurrence and continue to support timely completion and ongoing regulatory compliance.
2. Ensure that 100% of primary care providers issued corrective action plans submit them within the required regulatory timeframes, as measured by corrective action plan tracking.	1. Issue corrective action plan requirements in accordance with DHCS standards and established timelines. 2. Track corrective action plan submission and due dates	04/01/2026 – 06/03/2026	Tisha Criswell, FSR Supervisor Joana Castaneda, Quality Improvement Program Advisor II Yvette Sullivan, Quality Improvement Nurse	Qtr.2: In Q2 2026, 100% compliance was achieved for the timely submission of corrective action plans. A total of 16 corrective action plans were issued, including 7 Facility Site Review (FSR) corrective action plans and 9 Medical Record Review (MRR) corrective action	Qtr.2: No significant issues were identified during Q1. Effective provider communication, standardized tracking, and routine follow-up continued to support timely corrective action plan submissions throughout Q2.	Qtr.1: Continue standardized tracking of corrective action plan submissions using established monitoring tools. Maintain proactive provider outreach, education, and communication to support timely and complete	☑ Yes ☐ No	The goal was fully met, with 100% of Facility Site Review and Medical Record Review corrective action plans submitted within

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	using standardized monitoring tools. 3. Provide education and technical assistance to primary care providers to support timely and complete corrective action plan submissions. 4. Escalate overdue corrective action plans in accordance with established internal escalation protocols.		Aaron Varela, Quality Improvement Nurse	plans. All primary care providers submitted their corrective action plans within the required regulatory timeframes. Standardized tracking of due dates, ongoing monitoring, proactive provider communication, and technical assistance continued to support timely and complete submissions.		submissions while sustaining established escalation processes for any future risk of non-compliance.		required regulatory timeframes. Existing tracking, communication, and provider support processes continue to effectively sustain regulatory compliance and support timely corrective action plan submissions.

POTENTIAL QUALITY ISSUES (DEANNA LEAMON)

Goals/Objectives for Calendar Year 2026	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
Resolve 100% of member grievances related to PQIs within regulatory timeframes, as measured through grievance and PQI coordination tracking.	1. Maintain structured coordination with Grievances and Appeals to ensure timely identification of grievances requiring clinical quality-of-care review. 2. Track quality-of-care–related grievances through established PQI workflows to support timely review and resolution. 3. Monitor grievance resolution timeliness through routine oversight and reporting mechanisms. 4. Use grievance trend analysis, collaboration, and process improvement efforts to inform workflow refinement.	04/01/2026 – 06/03/2026	Emily Kaufman, Clinical Safety Supervisor Eleni Pappazisis, Quality Improvement Program Advisor III Naomi Kawabata, Senior Quality Improvement Nurse Katie Lutz, Senior Quality Improvement Nurse Sandy Clay, Senior Quality Improvement Nurse Karen de Leon, Quality Improvement Nurse Bethany Fung, Quality Improvement Nurse	Qtr.2: In Q2 2026, 297 of 300 grievance-related Potential Quality Issues (99%) were completed within the required regulatory timeframe. Beginning in Q2, exempt grievance-related PQIs were incorporated into the grievance timeliness metric using the updated reporting methodology. Timely case processing continued to be supported through structured coordination with Grievances and Appeals, established PQI workflows, routine monitoring, and ongoing collaboration to promote timely case identification, routing, and resolution.	Qtr.2: The high and increasing grievance volume identified in Q1 continued during Q2 and remains an ongoing operational challenge. Established coordination with Grievances and Appeals, routine monitoring, and workflow refinement continued to support timely case processing despite increased workload. During this transition quarter, three exempt grievance PQIs included in the updated metric had been opened before the Alliance implemented its internal 30-day turnaround goal on April 1, 2026. They were processed under the standard grievance workflow. These cases were included using the updated methodology to establish consistent reporting as we advance.	Qtr.2: Continue close coordination with Grievances and Appeals to ensure timely case identification and routing. Maintain routine monitoring and reporting processes while continuing to refine workflows that support efficiency, consistency, and sustain compliance with regulatory timeframes. Monitor performance under the updated grievance timeliness methodology to ensure consistent reporting in future quarters.	☐ Yes ☑ No	The goal was not fully met, with 99% (297 of 300) of grievance-related PQIs completed within the required regulatory timeframe. Despite sustained high grievance volume, the implementation of the updated reporting methodology, established workflows, collaboration, and oversight processes continued to support timely case resolution. Continued monitoring and workflow refinement will support ongoing performance improvement.
Complete 80% of non-grievance PQIs within 120 calendar days, as measured through PQI timeliness monitoring.	1. Utilize standardized PQI case management workflows to support timely progression from intake through closure.	04/01/2026 – 06/03/2026	Emily Kaufman, Clinical Safety Supervisor Eleni Pappazisis, Quality Improvement Program Advisor III Naomi Kawabata, Senior Quality Improvement Nurse	Qtr.2: In Q2 2026, 21 of 24 non-grievance Potential Quality Issues (87.5%) were completed within 120 calendar days, exceeding the established work plan performance target of 80%. Timely completion was supported through	Qtr.2: The increased PQI volume and complexity identified in Q1 continued during Q2 and remain ongoing operational challenges. Regulatory grievance oversight requirements and the	Qtr.2: Continue routine review of open non-grievance PQIs to identify and address potential delays early. Maintain standardized case management workflows, prioritize aging and higher-	☑ Yes ☐ No	The work plan goal was exceeded, with 87.5% (21 of 24) of non-grievance PQIs completed within 120 calendar days.

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	2. Strengthen management of non-grievance PQIs through routine oversight. 3. Conduct periodic review of open PQIs to identify and address barriers to timely completion. 4. Monitor PQI timeliness trends to support continuous process improvement. 5. Support workload capacity and timeliness through onboarding and integration of additional Quality Improvement Registered Nurse.		Katie Lutz, Senior Quality Improvement Nurse Sandy Clay, Senior Quality Improvement Nurse Karen de Leon, Quality Improvement Nurse Bethany Fung, Quality Improvement Nurse	standardized case management workflows, routine oversight of open cases, prioritization of aging PQIs, and ongoing efforts to identify and address barriers to timely case progression. Team collaboration and continued monitoring of case timeliness supported sustained performance despite the complexity of non-grievance investigations.	significant increase in grievance-related PQIs have required substantial nursing resources, reducing capacity available for non-grievance investigations. Although the work plan target of 80% continues to be exceeded, the long-term objective remains timely completion of all non-grievance PQIs. Continued oversight of aging cases, workload prioritization, and integration of additional staffing resources helped sustain performance during the quarter.	acuity cases, monitor workload and case complexity trends, and continue optimizing workload distribution to improve performance toward the long-term objective of timely completion for all non-grievance PQIs while maintaining compliance with grievance regulatory requirements.		While performance exceeded the established target, opportunities remain to improve timeliness. Continued efforts to balance regulatory grievance oversight responsibilities with non-grievance investigations, optimize workload distribution, and strengthen operational capacity will be important to advance performance toward the program's long-term objective of timely completion of all non-grievance PQIs.

LONG TERM SUPPORT SERVICES (DEANNA LEAMON)

Goals/Objectives for Calendar Year 2026	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
Obtain 100% of required Quality Assurance and Performance Improvement (QAPI) program submissions from applicable LTSS facilities, as measured through LTSS oversight tracking.	1. Identify LTSS facilities subject to QAPI submission requirements. 2. Conduct outreach to request QAPI submissions and communicate submission expectations. 3. Track receipt of QAPI submissions and conduct follow-up as necessary. 4. Document submission status through routine LTSS oversight monitoring.	04/01/2026 – 06/03/2026	Tisha Criswell, FSR Supervisor Joana Castaneda, Quality Improvement Program Advisor II Yvette Sullivan, Quality Improvement Nurse Aaron Varela, Quality Improvement Nurse	Qtr.2: In Q2 2026, 30 of 34 applicable LTSS facilities (88%) submitted a Quality Assurance and Performance Improvement (QAPI) program. Continued outreach included individualized follow-up through calls and emails, ongoing submission tracking, and collaboration with LTSS liaisons to reinforce submission expectations. Centralized oversight tools continued to provide real-time visibility into submission status and supported prioritization of outstanding facilities.	Qtr.2: The variability in facility awareness and readiness identified in Q1 improved during Q2, with QAPI submissions increasing from 21 to 30 facilities. Four facilities remain pending submission and continue to require targeted outreach and follow-up to achieve full compliance.	Qtr.2: Continue targeted outreach and escalation efforts for the remaining non-submitting facilities. Partner with LTSS liaisons to reinforce submission expectations, monitor outstanding facilities through centralized tracking, and incorporate submission status into ongoing LTSS oversight activities to achieve full QAPI submission compliance.	☐ Yes ☑ No	Significant progress was achieved during Q2, with QAPI submissions increasing from 61% in Q1 to 88% (30 of 34 facilities). Continued outreach, individualized follow-up, and centralized tracking have proven effective in increasing facility participation. Focused

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								engagement with the remaining four facilities is expected to support achievement of the annual goal.
Ensure 50% of reviewed LTSS QAPI submissions include all five Quality Assurance and Performance Improvement elements required by the Centers for Medicare and Medicaid Services, as measured through documented QAPI review.	1. Review submitted QAPI programs for inclusion of all CMS-required elements. 2. Provide technical assistance to facilities requiring support to establish or strengthen QAPI programs. 3. Re-review revised submissions to confirm alignment with CMS requirements. Monitor completion and compliance through documented follow-up and oversight.		Tisha Criswell, FSR Supervisor Joana Castaneda, Quality Improvement Program Advisor II Yvette Sullivan, Quality Improvement Nurse Aaron Varela, Quality Improvement Nurse	Qtr.2: In Q2 2026, formal review of submitted LTSS QAPI programs was completed using the standardized SharePoint evaluation tool developed in Q1. Of the 34 QAPI submissions reviewed, 18 (53%) met all five Centers for Medicare & Medicaid Services (CMS) required QAPI elements, exceeding the established work plan goal of 50%. Facilities with identified deficiencies received individualized feedback to support improvement of their QAPI programs and ongoing compliance with CMS expectations.	Qtr.2: The standardized evaluation process established in Q1 successfully supported consistent and auditable review of LTSS QAPI submissions during Q2. As anticipated for a newly implemented oversight program, considerable variability in facility QAPI program structure, content, and maturity was identified, reinforcing the need for ongoing technical assistance and continued program development.	Qtr.2: Continue reviewing newly submitted and revised QAPI programs using the standardized evaluation tool. Provide targeted technical assistance to facilities that did not meet all CMS-required elements, conduct follow-up reviews of revised submissions, and monitor improvement over time with the objective of increasing the percentage of facilities demonstrating complete compliance with all five CMS QAPI elements.	☑ Yes ☐ No	The work plan benchmark was achieved, with 53% (18 of 34) of reviewed LTSS QAPI programs meeting all five CMS-required elements. The 50% benchmark was intentionally established as an initial milestone for the first year of LTSS QAPI oversight, recognizing that facility QAPI program maturity and consistency were expected to vary significantly. While the benchmark was exceeded, the long-term objective remains for all applicable LTSS facilities to maintain QAPI programs that fully incorporate all five CMS-required elements. The standardized review process now provides a reliable foundation for targeted

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								technical assistance, ongoing monitoring, and continuous improvement toward that objective.

GRIEVANCE & APPEALS REVIEW (SARAH SANDERS)

Goals/Objectives for Calendar Year 2026	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Meet regulatory requirements 98% of the time for timely acknowledgments and resolutions.	1. Monitor appeal and grievance (AG) inventory for daily, weekly and monthly oversight. 2. Ensure standard appeals and grievances are acknowledged within 5 days and resolutions occur within 30 calendar days.	1/01/2026 – 3/31/2026 4/01/2026 – 6/30/2026 7/01/2026 – 9/30/2026 10/01/2026 – 12/31/2026	Sarah Sanders, Grievance and Quality Manager Lee Xiong, Grievance Supervisor Ruth Zuniga, Grievance Supervisor	Qtr.2: Monitoring occurred to support timeframes and oversight. During Q2 achieved 99% with acknowledgment and 98% resolution due to AG leadership support and interventions.	Qtr. 2: High AG volume continues to compromise strong regulatory performance and meeting deadlines.	Qtr. 2: Continue monitoring and interventions as heavy volume is likely to impact regulatory performance.	☑ Yes ☐ No	Met Q2 goal due to AG leadership support due to the ongoing heavy volume.
2. Monitor and maintain Appeal and Grievance (AG) rates below 2 per 1,000 members per month for Quality of Care (QOC) concerns; below 2 per 1,000 members per month for Quality of Service (QOS) concerns (NCQA standards)	1. Track and trend appeal and grievance data by both NCQA categories for Quality of Care (QOC) and Quality of Service (QOS) and Access issues. 2. Track appeal and grievances for emerging trends including system issues and document corrections.	1/01/2026 – 3/31/2026 4/01/2026 – 6/30/2026 7/01/2026 – 9/30/2026 10/01/2026 – 12/31/2026	Sarah Sanders, Grievance and Quality Manager Lee Xiong, Grievance Supervisor Ruth Zuniga, Grievance Supervisor	Qtr.2: Appeal and Grievance trends satisfied for MCAL LOB. Emerging trends documented.	Qtr. 2: Monitor DSNP LOB for NCQA thresholds. *Watchlist as overall increases may breach the NCQA benchmarks.	Qtr. 2: Continue monitoring and tracking for preventable grievances and identify impactful remediations.	☑ Yes ☐ No	Met Q2 goal by tracking and continuing the oversight workgroups.
3. Improve Appeal and Grievance (AG) data quality and reporting.	1. Identify reporting recalibrations, gaps and common data entry errors for corrections 2. Develop report for trending QOS levels to inform systemic issues, actions and repeat patterns.	1/01/2026 – 3/31/2026 4/01/2026 – 6/30/2026 7/01/2026 – 9/30/2026 10/01/2026 – 12/31/2026	Sarah Sanders, Grievance and Quality Manager Lee Xiong, Grievance Supervisor Ruth Zuniga, Grievance Supervisor	Qtr.2: QA continued to identify recalibrations. QOS trending report in finalized for Quarter 2 use	Qtr. 2: No issues to report for Q2	Qtr. 2: Report implemented for service level indicators.	☑ Yes ☐ No	Met Q1 goal due to ongoing QA efforts and development of service trending report.
4. Improve monitoring and documented oversight	1. Document and monitor report of oversight activities to improve transparency with oversight. 2. Develop automated reports with data analytics team to identify concerns.	1/01/2026 – 3/31/2026 4/01/2026 – 6/30/2026 7/01/2026 – 9/30/2026 10/01/2026 – 12/31/2026	Sarah Sanders, Grievance and Quality Manager Lee Xiong, Grievance Supervisor Ruth Zuniga, Grievance Supervisor	Qtr. 2: Monitoring of oversight activities continued. Development continued and new report implemented to support accuracy.	Qtr.2: No issues to report for Q2	Qtr.2:	☑ Yes ☐ No	Met Q2 goal by tracking issues and documenting them in the oversight workgroups.

SECTION 4: MEMBER EXPERIENCE

MEMBER SATISFACTION SURVEY – CAHPS (SARINA KING)								
Goals/Objectives for Calendar Year 2026	Planned Activities to Accomplish Goals/Objectives	Target Completion (start& end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Improve the measure How Well Doctors Communicate in Merced to be at the NCQA Quality Compass Benchmark or by 2 percentage points.	1. Lunch and Learns. 2. Promotion of Cultural and Linguistic Services. 3. Attend Member Services Advisory Group to get additional member feedback.	1/01/2026 – 3/31/2026 4/01/2026 – 6/30/2026 7/01/2026 – 9/30/2026 10/01/2026 – 12/31/2026	Sarina King, Quality and Performance Improvement Manager Alex Sanchez, Quality Improvement Program Advisor III Georgia Gordon, Quality Improvement Program Advisor II Jada Edwards, Quality Improvement Program Advisor II	Qtr. 2: Lunch & Learns: 4 quarterly topics confirmed with first two completed: Q1: Pediatrics - Q2: Access to Care in Rural Communities - Q3: Trauma-Informed Care - Q4: D-SNP Provider touchpoints: 9 sites in pc work, 7/8 PP sites have shown improvement. 85% of EPT sites deliverables were met C&L: 30% increase of in-person/VRI interpreting services utilized, 17% increase in utilization of telephonic interpreting services utilized.	Qtr. 2: Lunch and Learns: Speaker time constraints, MarCom's timing. Provider touchpoints: Data, EPT - BH Screening Workflow | HRSN Screening Workflow | VBP Assessment C&L: No Issues.	Qtr. 2: Lunch & Learns: Plan Q4 – DSNP Provider touchpoints: Continue to run data & offer Practice Coaching to Merced, Mariposa, & San Benito C&L: The leadership team is exploring options for a member online request form for interpreting services to potentially launch in Q1 2027.	☑ Yes ☐ No	Goal is on track. Intervention tracking process kicked off with little issues as all intervention SMEs were engaged and completed the necessary updates within the time allowed. Updates provided to MEC on 8/10.
2. Improve the measure Getting Needed Care in Merced to be at the NCQA Quality Compass or by 2 percentage points.	1. Care Gap Grants 2. Provider Partnerships 3. Lunch and Learns 4. Immunization events 5. Attend Member Services Advisory Group to get additional member feedback.	1/01/2026 – 3/31/2026 4/01/2026 – 6/30/2026 7/01/2026 – 9/30/2026 10/01/2026 – 12/31/2026	Sarina King, Quality and Performance Improvement Manager Alex Sanchez, Quality Improvement Program Advisor III Georgia Gordon, Quality Improvement Program Advisor II Jada Edwards, Quality Improvement Program Advisor II	Qtr. 2: MCGP: Provider recruitment seeing 10 grants equating to over $2 million. Round 2 pending agreement, $3.5 million will be awarded. Alt. Places of Medicine: 19 total events with 528 mammograms, 388 incentives. 4 WIC events, 3 school vaccine events, 37 vaccinations occurred, 32 incentives given. Nearly 700 in-home Sprinter visits occurred. 1,468 gaps closures services (678 SDOH screenings, 302 COL w/ 40%	Qtr. 2: MCGP: No issues. Alt. Places of Medicine: Delays in receiving mobile mammography results/reports impacted on timely follow-up by clinics and providers. Transportation, lack of education, and members not being aware that their Medi-Cal coverage was cancelled. BH Incentives: Ongoing outreach and education regarding behavioral health is a barrier. In addition, access remains an issue, with a continued	Qtr.2: MCGP: Launch of Safety Net Critical Access funding opportunity Alt. Places of Medicine: Ensure each clinic/provider includes the appropriate email or fax on the event form to receive results/reports in a timely manner. partnership with schools – School Located Vaccine Events in Merced. Monitor effectiveness in	☑ Yes ☐ No	Goal is on track. Intervention tracking process kicked off with little issues as all intervention SMEs were engaged and completed the necessary updates within the time allowed. Updates provided to MEC on 8/10.

				return, 132 A1c, 98 BP, 14 EED, 149 lead, 90 TFL. BH Incentives: The behavioral health team has worked to increase collaboration with behavioral health provider groups to improve access. Targeted recruitment in the psychologist space and executed several outreach and education efforts including the BH lunch and learn webinar on depression.	need for behavioral health providers – especially services provided outside of traditional office hours.	Sprinter outreach and consider expanding to other counties with measures below MPL. BH Incentives: Continuing with the behavioral health lunch and learn series, ongoing provider recruitment, and tracking utilization.		

SECTION 4: QUALITY OF SERVICE

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

Goals/Objectives for Calendar Year 2026	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Monitor Timely Access to Care by ensuring timely access to needed high volume and high-risk specialties.	1. Conduct Quarterly Provider Appointment Monitoring Surveys	1/01/2026 – 3/31/2026 4/01/2026 – 6/30/2026 7/01/2026 – 9/30/2026 10/01/2026 – 12/31/2026	Jim Lyons, Provider Relations Manager	Qtr. 2: **Q2 2026** PAMS survey Focus area: **Obstetrics/Gynecology and Hematology Oncology** • Surveys Conducted from: **April 21 – May 29, 2026** • Hematology Oncology met the standards for Merced County (all surveyed standards) and Santa Cruz County, urgent appointments. - OBGYN met the following: • Routine and 3rd available for all counties combined • All surveyed standards for Merced and Santa Cruz County • Urgent appointments for Monterey and San Benito Counties • Routine and 3rd available for Outside Service Area Counties • For Q3 2026 PAMS will be completed for Cardiology & Allergy / Immunology.	Qtr. 2: It was found that Allergy & Immunology and OBGYN met the standard for average routine appointment and urgent appointment availability, while Neurological Services did not meet any of the standards. No surveyed provider types met the standard for 3rd available appointment timeframe.	Qtr. 2: For Q3 2026 PAMS will be completed for Cardiology & Allergy / Immunology.	☑ Yes ☐ No	Provider appointment availability and access standards were reviewed and monitored to ensure compliance with regulatory and contractual requirements. Findings were tracked and follow-up activities were initiated as needed to address identified access concerns and support ongoing network adequacy.

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2. Monitor Non-Contracted Letters of Agreements for areas of Provider Recruitment	1. On a quarterly basis monitor Letters of Agreement to ensure recruitment for new providers is done timely w/ access needs	1/01/2026 – 3/31/2026 4/01/2026 – 6/30/2026 7/01/2026 – 9/30/2026 10/01/2026 – 12/31/2026	Alissa Gil, Network Development Manager	Qtr. 2: Continued monitoring LOA's and have conducted outreach to many LOA providers. Working closely with finance and Contracts to monitor LOA's.	Qtr. 2: An issue identified in Q1 was that some LOAs were executed without first exploring an opportunity to contract with the provider. This limited our ability to strengthen the network long-term and highlighted the need for improved coordination between LOA processing and provider recruitment efforts.	Qtr. 2: Continue monitoring and working closely with finance and the contracts team	☑ Yes ☐ No	Communication across departments has been a key component to the success of the LOA process.

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

Goals/Objectives for Calendar Year 2026	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Semi-Annual Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Comply with DHCS Network Adequacy requirements.	1. Comply with DHCS Network Certification Annual Filing by Running ArcGIS geo access reports. 2. Monitor quarterly geo access reports	1/01/2026 – 3/31/2026 4/01/2026 – 6/30/2026 7/01/2026 – 9/30/2026 10/01/2026 – 12/31/2026	Alissa Gil, Network Development Manager	Qtr. 2: Q1 2026 GeoAccess analysis utilized March 2026 274 and DMHC Population Points. • A total of **237 network access gaps** were identified. • **85 gaps (36%)** were resolved through allowable telehealth providers, reducing the total to **151 remaining gaps**. • Please note that the number and types of telehealth-only practitioners may vary from month to month. • Telehealth eligibility is based on claims activity for the reporting month.	Qtr. 2: Due to a glitch with the ArcGIS Pro tool, the Quarter 1 GEO Access Analysis was completed and sent to PS on July 23rd.	Qtr. 2: A **Potential Recruitment Outreach** tab has been added to identify the next-nearest providers and health systems that may help address remaining GeoAccess gaps. The list identifies providers and health systems may support future network development efforts, particularly **Adventist Health** and **Dignity Health/CommonSpirit** locations in **San Luis Obispo** and **Fresno** counties. Recruitment efforts from this list are in motion.	☑ Yes ☐ No	Recruitment efforts are in motion.
2. Comply with CMS Network Adequacy Requirements	1. Participating in CMS Triennial Network Adequacy Survey 2. Submit HSD Tables and any exception requests when needed.	1/01/2026 – 3/31/2026 – practice survey 4/01/2026 – 6/30/2026 – Triennial Survey	Alissa Gil, Network Development Manager Jessie Dybdahl, Provider Service Director	Qtr. 2: Passed and completed the Triennial Audit. Submitted the HSD tables no exception requests.	Qtr. 2: Concern that we would not have a Neurosurgery provider that would adhere to the time and distance standards for DSNP.	Qtr. 2: Work on making the DSNP network Marketable	☑ Yes ☐ No	PS worked closely to communicate with the providers to make sure we were able to comply.

PROVIDER SATISFACTION SURVEY (JESSIE DYBDAHL/JIM LYONS)

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

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	2. Create a provider touch point map and share with internal staff to coordinate external provider communication							

TELEPHONE ACCESS (VERONICA OLIVARRIA)

Goals/Objectives for Calendar Year 2026	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. 80% of calls to Member Services answered within 30 seconds	1. The Call Center is continuously monitoring this metric as it is also included on the Operational Dashboard. Improvement efforts slated for 2024: • The adoption of a Workforce Management Tool to assist with call forecasting and representative scheduling, ensuring we have appropriate levels of staff supporting the queues at any given time/day. • Call Audit Optimization: We are developing formal call audit guidelines and defined audit methodology to ensure staff are adhering to Alliance updates and processes. • Developing additional call circles (queues) to: • Optimize resource availability. • Improve speed to answer. • Reduce representative training time. • Increase member satisfaction. • Computer Telephone Enhance HSP/FIVE 9 by adding a screen pop up of member's demographics when a member calls into the call center. This will reduce time spent on phone for the MSR and will make each call more efficient. Integration: • Assess staffing needs due to increased call volume and greater call complexity, resulting in longer average talk times.	1/01/2026 – 3/31/2026 4/01/2026 – 6/30/2026 7/01/2026 – 9/30/2026 10/01/2026 – 12/31/2026	Veronica Olivarria, Call Center Manager	Qtr. 2: Call volume remains high and continues to increase, including member walk-ins. Calls are increasingly complex and require highly skilled resolution, leading to longer talk times. Therefore, we did not meet the 80% SLA goal (68.16% achieved).	Qtr. 2: Staffing remains a key operational priority, with five temporary Member Services Representative (MSR) positions currently open and actively being recruited. Average talk time continues to increase due to the growing complexity of member inquiries, impacting overall call handling capacity.	Qtr. 2: The call center will continue to prioritize operational recruitment efforts to support achievement of key reportable performance metrics.	☐ Yes ☑ No	Recruitment and retention will help ensure the team is positioned to effectively manage member demand while maintaining service expectations.

2. Call abandonment rate will not exceed 5% of calls to Member Services answered before being abandoned.	1. The Call Center is continuously monitoring this metric as it is also included on the Operational Dashboard.	1/01/2026 – 3/31/2026 4/01/2026 – 6/30/2026 7/01/2026 – 9/30/2026 10/01/2026 – 12/31/2026	Veronica Olivarria, Call Center Manager	Qtr. 2: Call volume remains high and continues to increase, including member walk-ins. Calls are increasingly complex and require high-skilled resolution, leading to longer talk times. We were close to the target on abandonment (5% target; 5.68% achieved).	Qtr. 2: Staffing remains a key operational priority, with five temporary Member Services Representative (MSR) positions currently open and actively being recruited. Average talk time continues to increase due to the growing complexity of member inquiries, impacting overall call handling capacity.	Qtr. 2: The call center will continue to prioritize operational recruitment efforts to support achievement of key reportable performance metrics.	☐ Yes ☑ No	Recruitment and retention will help ensure the team is positioned to effectively manage member demand while maintaining service expectations.
3. New Member Welcome calls	1. The Call Center will contact and orient 30% of our new membership to: • Educate members on their benefits • Orient members to available services • Assign and connect members to a Primary Care Provider (PCP) • Offer a warm transfer to a provider when appropriate	1/01/2026 – 3/31/2026 4/01/2026 – 6/30/2026 7/01/2026 – 9/30/2026 10/01/2026 – 12/31/2026	Veronica Olivarria, Call Center Manager	Qtr. 2: Call volume remains high and continues to increase, including member walk-ins. Calls are increasingly complex and require high-skilled resolution, leading to longer talk times. Our current outbound call completion rate is 8.52%	Qtr. 2: We have assigned outbound calling responsibilities to our evening vendor, Harte Hanks, to provide additional support while our internal team remains focused on managing high inbound call volume and limited staffing.	Qtr. 2: The call center will continue to prioritize operational recruitment efforts to support achievement of key reportable performance metrics.	☐ Yes ☑ No	Recruitment and retention will help ensure the team is positioned to effectively manage member demand while maintaining service expectations.

CULTURE & LINGUISTICS (DESIRRE HERRERA)

Goals/Objectives for Calendar Year 2026	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Increase provider utilization of language assistance services quarterly by a minimum of 5% in comparison to 2025 baseline utilization data.	1. The project team will track utilization for the following services: • Phone interpreting services. • Face-to-Face (F2F) interpreting services • Virtual Remote Interpreting (VRI) 2. Use quarterly utilization data to identify potential need to training provider network on language assistance services.	1/01/2026 – 3/31/2026 4/01/2026 – 6/30/2026 7/01/2026 – 9/30/2026 10/01/2026 – 12/31/2026	Ivonne Muñoz, Quality and Health Programs Supervisor Desirre Herrera, Quality and Health Programs Manager	Qtr. 2: Provider Utilization for Q2 was as follows: Phone interpreting services: There was a total of 10,698 total calls in Q2 by provider sites. This reflects a 14% increase compared to Q2 2025. In-Person and Virtual Remote Interpreting (VRI): There was a total of 2,421 in-person interpreting services requests in all service counties for Q2. This reflects a 21% increase compared to Q2 2025. There was a total of 56 VRI requests in Q2. This service was not available in Q2 2025 so there is no baseline to compare. VRI services started in Q3 2025. Q2 Utilization trends: Santa Cruz County providers were the highest utilizers of in-person interpreter requests: • 946 Santa Cruz County	Qtr. 2: No issues to report in Q2.	Qtr. 2: The C&L team will continue informing providers of the services available and offer training and support services as requested.	☑ Yes ☐ No	There continues to be increases overall in utilization of language assistance services by providers. The data trends show there are differences in utilization of in-person interpreting versus Virtual Remote Interpreting (VRI). Monterey and Santa Cruz County providers continue to utilize in-person interpreting services more than the other service counties.

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				• 930 Monterey County • 522 Merced County • 22 San Benito County • 1 Mariposa County In Q2 Monterey County providers were the highest utilizers of VRI requests: • 31 Monterey County • 24 Merced County • 1 Santa Cruz County • 0 San Benito County • 0 Mariposa County				Merced and Monterey County providers continue to utilize Virtual Remote Interpreting services more than other counties.
2. On a quarterly basis, inform members and/or providers of language assistance services utilizing at least 1 member and/or 1 provider informing modality.	1. The C&L team will conduct outreach and educational activities to inform members and providers of services available using the following options: • Member newsletter articles • Provider bulletins or provider digest • Sharing education materials such as flyers • MSAG presentation 2. Request input from members regarding program and services. 3. Incorporate member feedback into planning of C&L interventions.	1/01/2026 – 3/31/2026 4/01/2026 – 6/30/2026 7/01/2026 – 9/30/2026 10/01/2026 – 12/31/2026	Kevin Lopez, Program Advisor – Quality and Health Programs Ivonne Muñoz, Quality and Health Programs Supervisor Desirre Herrera, Quality and Health Programs Manager	Qtr. 2: The following activities were completed in Q2 to inform members of C&L Services: • **Member Newsletter:** The project team included 1 article in the June 2026 Member Newsletter informing members of the importance of being able to communicate with their doctor and language assistance services available to them. • **Provider Bulletin:** The project team included 1 article in June 2026 Provider Bulletin informing providers of language assistance services and training available to maximize utilization and avoid barriers to access.	Qtr. 2: No issues to report in Q2.	Qtr. 2: The project team will continue to work on planning efforts to increase awareness of language assistance services to members and the provider network in 2026.	☑ Yes ☐ No	There continues to be increases in members calling the Health Education line to request interpreting services to be set up at their appointments. The project team has been working on options to make requesting services easier. In Q2 the team launched an online submission form for providers. In Q3-Q4 the project team hopes to develop and launch a member facing online request form.
3. On a bi-annual basis, collect member feedback on their experience with language assistance services in a clinical setting. A minimum of 50 surveys will be collected annually.	1. The project team will conduct satisfaction surveys with members to evaluate: • Individual ratings of access to language services. • Overall rating of interpretation services. • Access to language services at a health care encounter. • Gather individual experiences with the services. 2. Request input from members regarding programs and services. 3. Incorporate member feedback into planning and identifying areas of improvement for the services.	1/01/2026 – 6/30/2026 7/01/2026 – 12/31/2026	Kevin Lopez, Program Advisor – Quality and Health Programs Ivonne Muñoz, Quality and Health Programs Supervisor Desirre Herrera, Quality and Health Programs Manager	Qtr. 2: A total of 52-member experience surveys were completed in Q1-Q2. Members were asked for feedback regarding experience with language assistance services and the interpreter in the clinical setting. • 94% of members reported they were satisfied (4%) or highly satisfied (90%) with the interpreter at the doctor's visit. • 100% of members reported they would use the in-person interpreting services again. Responses included yes (6%) or strong yes, (94%).	Qtr. 2: No issues to report in Q2.	Qtr. 2: The project team will schedule surveys and report out again in Q4.	☑ Yes ☐ No	A total of 52-member experience surveys were collected to evaluate services provided in Q1-Q2 2026. Overall members are highly satisfied with the services provided. Member feedback included that some preferred in-person

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								interpreters rather than virtual.

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DATE: October 28, 2026

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

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

SUBJECT: Quality Improvement Health Equity Transformation (QIHET) Program Evaluation 2026

Recommendation. Staff recommend the Board approve the QIHET Program Evaluation.

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

Summary. The purpose of the Quality Improvement and Health Equity Transformation (QIHET) Program Evaluation is to provide a written summary of a comprehensive assessment of the QIHET activities undertaken, including an evaluation of the effectiveness of QI Interventions; a written analysis of required Quality Performance Measure results, and a plan of action to address performance deficiencies, including analyses of each Fully Delegated Subcontractor's and Downstream Fully Delegated Subcontractor's performance measure results and actions to address any deficiencies; an analysis of actions taken to address any Contractor-specific recommendations in the annual External Quality Review (EQR) technical report and Contractor's specific evaluation reports; an analysis of the delivery of services and Quality of Care of Contractor and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors, based on data from multiple sources, including quality performance results, Encounter Data, Grievances and Appeals, Utilization Review and the results of consumer satisfaction surveys; planned equity-focused interventions to address identified patterns of over- or under-utilization of physical and Behavioral Health care services; a description of Contractor's commitment to Member and/or family focused care through Member and community engagement such as review of CAC findings, Member listening sessions, focus groups or surveys, and collaboration with local community organizations; and how Contractor utilizes the information from this engagement to inform Contractor policies and decision-making; PHM activities and findings; and outcomes/findings from Performance Improvement Projects (PIPs), consumer satisfaction surveys and collaborative initiatives services including the integration of quality, population health, and health equity principles.

The QIHET Program Evaluation supports CCAH's mission and vision through the development and maintenance of a quality driven network of care for all lines of business. The QIHET Program Evaluation provides its clear definition of authority, its relationship to other components and departments within the organization, and its accountability to the governing body of the organization. The Program Evaluation outlines the major initiatives of the QIHET Program.

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

Attachments.

1. QIHET Program Evaluation 2026

Central California Alliance for Health

Year 2025

Quality Improvement (QI) Program Annual Evaluation

Written Date: September 2026

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1. Executive Summary

1.1. Overall Effectiveness of the QI Program

1.1.1. 2025 Accomplishments

The 2025 Quality Improvement (QI) Program at the Alliance has demonstrated a strong commitment to enhancing the quality of care and achieving health equity. Here is a breakdown of its components and effectiveness:

1.1.2. Achievements and Strategies

- **Effective Work Plan Utilization:** The 2025 QI Work Plan was instrumental in tracking and reporting on organization-wide goals. This comprehensive approach ensured that the quality initiatives were well-defined and impactful across all areas.
- **Leadership and Physician Engagement:** Leadership, along with network physicians, actively participated in relevant committee meetings, offering valuable recommendations and insights. This collaboration was crucial in identifying barriers and finding opportunities for improvement.
- **Provider Grant Program/Provider Partnership program:** The grant program played a major role in improving quality scores. It focused on innovative member engagement and interventions, aiming to deliver high-quality care. Providers were given funding to support member engagement activities.
- **Joint Operation Meetings (JOMs):** Regular JOMs with key provider groups helped to strengthen provider engagement in quality improvement initiatives. These meetings facilitated better collaboration and shared strategies for improvement. Clinic Joint Operation (cJOC) meetings and Joint Operation Committee (JOC) meetings with Hospitals are scheduled quarterly.
- **Advocacy for Increased Commitment:** Leadership advocated for a greater organization-wide focus on quality improvement. This included increasing collaboration with providers and driving member-centric engagement efforts by increasing outreach and incentives for both groups.
- **Continuous Quality Improvement Activities:** In 2025, there were several plans and activities aimed at improving:
    - **Member Access and Engagement:** Ensuring members can easily access and engage with care by maintaining a robust network of practitioners and providers.
    - **Member Experience:** Enhancing the overall experience of members through various initiatives (i.e., Outreach, incentive programs, member education, etc.).
    - **Systems and Reporting Enhancements:** Upgrading existing systems to support better care for members through case management and population health (i.e., use of gap in care reports).
    - **Data Analytics:** Leveraging advanced data analytics to drive improvements.

1.1.3. Key Functional Areas and Accomplishments

- ***Quality Improvement and Health Equity Transformation Program (QIHETP) and Culturally and Linguistically Appropriate Services (CLAS) Program*** – Both systems reporting requirements under DHCS and NCQA Accreditation are combined into a singular report for evaluation purposes.
- ***Consumer Assessment of Healthcare Providers and Systems (CAHPS)*** – In 2025, The Alliance improved ***in 6 Child Survey*** measures compared to 2024 but dropped in 5 Adult measures. Over 80% of respondents reported that they received care quickly, and over 85% of respondents gave favorable reviews of their personal doctor.

    - *90th percentile ranking* - One measure, "Rating of Health Plan" ranked above the 90th percentile with 92% of our child survey respondents ranking this measure favorably.
- ***Utilization of Language Services*** – The Alliance evaluated utilization of language services in 2025 among providers, members, and staff. Surveys were completed with members and Alliance staff to gather feedback and identify areas to improve services. Call logs were evaluated from the interpreting services vendors to evaluate utilization and identify areas for improvement.
- ***Member Experiences of Language Services*** - Surveys were collected from members that utilized in-person interpreting services during the reporting period.
- ***Staff Experiences of Language Services*** – Surveys were collected from Alliance staff that utilized telephonic interpreting services during the reporting period.
- ***Healthcare Effectiveness and Data Information Set (HEDIS)*** – The Alliance evaluated NCQA and DHCS HEDIS performance measures across Santa Cruz, Monterey, Merced, San Benito, Mariposa, and All Plan submissions. Overall plan performance remained strong, with 90% of NCQA reported measures exceeding the NCQA 50th percentile benchmark and 85% of DHCS MCAS measures exceeding their established performance benchmarks.
- ***Care-Based Incentive (CBI) Program*** – Improvement was made for 12 out of 17 measures across all five counties, as well as the total number of CBI groups with four or more measures below the 25th percentile decreased from the prior 2024 program year.
    - *Increased rates:* Adverse Childhood Experiences (ACEs) Screening in Children and Adolescents, Application of Dental Fluoride Varnish, Developmental Screening in the First 3 Years, Initial Health Appointment (IHA), Post-Discharge Care, Lead Screening in Children, and Depression Screening for Adolescents and Adults, Cervical Cancer Screening, Diabetic HgbA1c Poor Control >9%, Immunizations; Adolescents.
    - *Decreased rates:* Immunizations: Children (Combo 10) and Well-Child Visits in The First 15 months.

  Utilization of The Alliance's Provider Portal Data Submission Tool (DST) also showed positive benefit for providers in supplementing data not received through claims, with the highest submission for depression screening tools and results since the coding cannot be received through claims submissions.

- ***Reporting Stratified Measures***
    - *Member Experience Survey:* Most members of different races and ethnicities are satisfied with our services.
    - *HbA1c:* Glycemic status disparities vary by county, race, ethnicity, and gender, supporting a targeted approach rather than a single plan wide intervention. The hybrid data met the goal for HbA1c <8% in all but in Merced County and Mariposa County, and all for HbA1c >9%; Admin data was only met in Monterey and Santa Cruz Counties. There were wide shifts in year over year rate comparisons, as eligible population sizes grew in San Benito County in 2025 compared to 2024. Less dramatic changes noted in year over year changes in Mariposa County data. Largest changes seen in positive rate change of -10.19% in Merced County for White members, compared to large shifts in Monterey County for Black or African members for HbA1c <8% reducing by -10 percentage points. The health disparity analysis by gender also showed a consistent trend of females outperforming males across, similar to last year.
    - *W30-6+*: The data shows disparities in well-child visit rates across different racial and ethnic groups as well as spoken languages. The highest rate of Spanish-speaking children in Santa Cruz at 85%, differs from the lowest rate of English-speaking children in San Benito County at 27%. Highest rate of compliance amongst White and Hispanic/Latino children at 84% differed from the lowest rates among Asian children in San Benito at 21%, Mariposa at 33% and Merced County at 47%.

WCV: Spanish-speaking members had higher well-care visit compliance rates than English-speaking members across all five counties, with Spanish and English as the two primary languages spoken by the Alliance members. Compliance rates for Spanish-speaking members were 5 to 12 percentage points higher than those for English-speaking members. For race and ethnicity, variance noted from the highest performing group of Asian children (73%) in Monterey County compared to White children and Asian children (36%) in Mariposa County.

- ***Clinical Safety***
    - *Facility Site Review (FSR):* The FSR Program successfully met its 2025 goals by maintaining compliance with DHCS site review requirements, strengthening provider oversight, achieving timely Corrective Action Plan (CAP) oversight, successfully onboarding and training new FSR staff, advancing Medi-Cal Site Review Portal (MSRP) implementation, and expanding collaboration with neighboring MCPs through established MOUs.
    - *Potential Quality Issues (PQI):* The PQI Program successfully met its regulatory and operational goals by maintaining comprehensive oversight of member grievances, strengthening provider quality investigations through standardized review processes and implementation of the Track and Trend methodology, and enhancing cross-functional collaboration, reporting, and provider trend analysis to support provider quality improvement and organizational oversight.
    - *Long-Term Services and Supports (LTSS):* The LTSS Program successfully established a standardized framework for quality oversight of contracted LTSS providers through implementation of new DHCS requirements, development of governance and reporting processes, and integration of LTC quality metrics, facility QAPI activities, PIPs, PQIs, CIs, CDPH findings, Regional Center findings, member grievances, and other quality indicators into a comprehensive provider monitoring framework.
- ***Member Complaint and Appeal related to Access*** – The Alliance successfully met all five performance category benchmarks, including access and overall complaint and appeal threshold rates per 1,000 member months (MM). Overall complaint and appeal rates remained relatively low, demonstrating baseline stability in overall core plan administration. However, internal trend analysis revealed an emerging upward trend in non-Behavioral Health Grievances, specifically focused on Provider Attitude/Service (Interpersonal interactions, administrative friction at clinic touchpoints, and customer service delivery) and Access to Care/Provider Availability (challenges with securing timely appointments with physical health providers and specialists). While rates per 1,000 member months remain low and within benchmark limits, the upward trajectory poses a risk to overall member satisfaction and timely access to care. To protect member satisfaction and ensure timely access to care, ongoing root cause analysis, monitoring, and feasible interventions will occur during cross-departmental monthly reviews.
- ***Access to Care*** – The Alliance's assessment found that 70% of urgent care appointments for PCPs are available within 48 hours. This does not exceed the Alliance's performance target of 80%. Routine Care also missed the target of 80% at 73%.

  Geo-Access to Practitioners – Geo-access standards were mostly met, and the member to provider ratio standards were met except for Internists. The Alliance seeks to continuously improve its network to provide more options for members to obtain care. The Alliance will continue to recruit new providers, particularly focusing on rural areas, and offer medical capacity grants to fund specific required provider types. Attrition of existing providers has led to a shortage of providers in the service area. This has particularly impacted the geographically rural areas within Mariposa, Monterey, and San Benito counties. The Alliance's contracting department has done a good job of contracting with a very high percentage of providers in the service area, and this has helped the organization meet most of the goals.

- ***Telephone Access*** – The Member Services Call Center was able to support an additional 31,549 calls compared to the prior year, for a total of 217,566 received call in 2025. These calls also supported the transition of new services for members and training for staff for the in-service of non-specialty Behavioral Health Services on July 1, 2025, and D-SNP Open Enrollment beginning October 1, 2025.
- ***DHCS Population Health Management Strategy*** - The annual PHM Strategy submission, work with Local Health Jurisdiction, and NCQA Accreditation standards were met.
- ***Additional Activities: IHA & EPSDT Audits*** - 2025 IHA audits showed increases in overall IHA's completed within 120 days, as well as increases in SABIRT screenings and depression screenings, including pregnant women. Provider outreach remained in effect for the IHA audit in 2025 and will remain in place. Other initiatives that resulted from our 2025 IHA audit includes, attendance and support for a Managed Care Plan (MCP) collaborative aimed at standardizing coding throughout managed care plans, coordination with our Facility Site Review Nurses aligning audits, provider messaging and ensuring documentation elements are met, and continued provider education and support and increased EMR access.
- ***QIHETP and CLAS Program Initiatives*** – Highlights include expanding the Alliance's collaboration with Community Based Organizations, Increased member feedback, expanding the provider participation in the Provider Partnership Program, and increasing the focus on health equity and culturally and linguistically appropriate services

1.1.4. 2025 Opportunities

While the Alliance is happy with its 2025 QI Program accomplishments, the Alliance has a culture of continuous improvement. This requires the organization to self-evaluate and look critically at opportunities to improve (i) internal processes and (ii) quality of services provided to its members. Included below are selected highlights of focus areas for 2026.

- ***QIHETP and CLAS Program*** - The Alliance will continue to monitor staffing resources supporting the QI program and may adjust staff as needed.
- ***CAHPS*** – The CAHPS member results reflect some of the ongoing challenges already highlighted in other sections of this document. Although the network has grown, there are still challenges in accessing care, and doctor's communication. In 2025, Alliance staff worked to address access by expanding mobile unit providers and offering care gap grants for specific appointment types to aid in creating additional appointment availability for preventative care. In 2026, interdepartmental intervention planning continues as we tackle doctor's communication as an organization through a newly developed Member Experience Committee.
- ***Utilization of Language Services*** - High usage of interpreting services in Spanish shows the need to prioritize the quality Spanish language support, while also ensuring adequate resources for other frequently used languages like Vietnamese and Arabic. Opportunities for targeted interventions were indicated for addressing concerns about wait times and interpreter quality. A considerable proportion of calls were categorized under, "Unknown Department," highlighting the need for improved data collection practices to ensure accurate and complete departmental data.
- ***Member Experiences of Language Services*** - Although there was 1 member that reported dissatisfaction, they shared in their feedback this was due to not feeling comfortable having an interpreter from an outside agency. The member would prefer the medical staff at the clinic to interpret for her healthcare instead. The member shared they would use the service again, but this was something she wanted to share for consideration. Some provider offices do not have bilingual staff on-site, and although interpreters are available to schedule the member shared for her case, she preferred the interpreter would be part of the medical team. Feeback was also shared to recommend that providers proactively offer interpreting services instead of waiting for members to ask for it. Some members could feel stress or

embarrassment needing to ask for services so if the provider offers this can help members feel more comfortable with using the services. This feedback sheds light on opportunities to educate providers on the importance of normalizing language assistance as an important part of the visit to ensure the member receives all information accurately and can engage with the provider to ask questions about their healthcare.

- ***Staff Experiences of Language Services*** - Although there was 1 member that reported dissatisfaction, they shared in their feedback this was due to not feeling comfortable having an interpreter from an outside agency. The member would prefer the medical staff at the clinic to interpret for her healthcare instead. The member shared they would use the service again, but this was something she wanted to share for consideration. Some provider offices do not have bilingual staff on-site, and although interpreters are available to schedule, the member shared for her case, she preferred the interpreter would be part of the medical team. Feeback was also shared to recommend that providers proactively offer interpreting services instead of waiting for members to ask for it. Some members could feel stress or embarrassment needing to ask for services so if the provider offers this can help members feel more comfortable with using the services. This feedback sheds light on opportunities to educate providers on the importance of normalizing language assistance as an important part of the visit to ensure the member receives all information accurately and can engage with the provider to ask questions about their healthcare.
- ***HEDIS -*** In MY 2025, reporting year (RY) 2026, the identified priority measures for the Alliance that were at or below minimum performance levels (MPLs) designated by DHCS include:
    - *Santa Cruz County:* Topical Fluoride for Children (TFL-CH).
    - *Merced County:* Childhood Immunization Status-Combination 10 (CIS-10), Well-Child Visits in the First 30 Months of Life-0 to 15 Months-Six or More Well-Child Visits (W30-6).
    - *San Benito County:* Developmental Screening in the First Three Years of Life (DEV), Lead Screening in Children (LSC), Topical Fluoride for Children (TFL-CH), Well-Child Visits in the First 15 Months of Life – (W30-6+), Well-Child Visits for Children 15–30 Months of Age – (W30-2+).
    - *Mariposa County:* Childhood Immunization Status – Combination 10 (CIS-10), Developmental Screening in the First Three Years of Life (DEV), Immunizations for Adolescents – Combination 2 (IMA-2), Lead Screening in Children (LSC), Topical Fluoride for Children (TFL-CH), Well-Child Visits in the First 15 Months of Life – (W30-6+), Well-Child Visits for Children 15–30 Months of Age – (W30-2+), Child and Adolescent Well-Care Visits (WCV), Cervical Cancer Screening (CCS), Chlamydia Screening in Women (CHL), and Postpartum Care (PPC-Pst)
- ***CBI*** – The 2025 CBI program resulted in opportunities for improvement for 2026. For 2025, one challenge was working with providers who were not submitting supplemental data for compliance with the Depression Screening measure. The CBI team was able to provide education, support, and resources to providers who were not receiving points in this measure. Over the course of 2025, the team noted drastic increases in the supplemental data received as a result. For 2026, we will continue to outreach and build partnerships with providers who need support in achieving success in the CBI program.
- ***Reporting Stratified Measures***
    - *Member Experience Survey:* There is lower satisfaction rates specifically related to access to care among Merced County respondents. This may be due to language barriers and geographic limitations in accessing care as well as provider shortages.
    - *HbA1c:* Implement targeted interventions aimed at improving engagement in diabetes management in both males and females, inclusive of community outreach programs, cultural education initiatives to promote health literacy, and support mechanisms to encourage adherence to treatment plans to reduce gender disparities and enhance overall health outcomes for members.

    - *W30-6+*: There are opportunities to develop interventions focusing on the differences across counties for racial and ethnic groups as well as spoken languages, particularly for Asian children in San Benito, Mariposa, and Merced County.
    - *WCV:* Identified opportunities included educating members about OMB category definitions to ensure accurate responses during data collection as well as strategizing ways to collect member information directly. Also identified were opportunities internally to analysis disparities on a more frequent basis through visualization reports in Tableau.
- ***Clinical Safety***
  Clinical Safety remains committed to strengthening provider quality, regulatory compliance, and operational excellence across the FSR, PQI, and LTSS QA Programs. During 2026, the department will focus on the following strategic priorities.
    - *FSR Program:* The FSR Program will focus on maintaining compliance with DHCS FSR, Medical Record Review (MRR), and Physical Accessibility Review (PAR) requirements while supporting implementation of MSRP and strengthening provider oversight through data-driven reporting, targeted provider education, and effective CAP monitoring. The program will continue collaborating with neighboring MCPs through established MOUs to promote consistent application of DHCS site review standards, reduce duplicate review activities, and improve provider experience.
    - *PQI Program:* The PQI Program will focus on maintaining continued oversight of member grievances while advancing provider performance monitoring through refinement of the Track and Trend methodology. The program will integrate PQIs and other quality indicators to support comprehensive provider oversight. Priorities include improving reporting capabilities, streamlining operational workflows, utilizing provider trend analysis to guide provider education and progressive interventions, and supporting ongoing regulatory and accreditation readiness.
    - *LTSS Program:* The LTSS QA Program will focus on strengthening quality oversight of contracted LTSS providers by integrating LTC quality metrics, facility QAPI activities, PIPs, PQIs, CIs, CDPH findings, Regional Center findings, member grievances, and other quality indicators into a comprehensive provider monitoring framework. Priorities include advancing standardized reporting and governance processes, supporting facility quality improvement through provider education and technical assistance, strengthening collaboration with contracted providers, and implementing evolving LTSS quality oversight requirements.
    - *Clinical Safety:* Clinical Safety will focus on strengthening integrated provider oversight through cross-functional collaboration, technology-enabled process improvements, and data-informed decision-making. Department priorities include enhancing reporting capabilities, maintaining regulatory and accreditation readiness, evaluating program performance through established QI Work Plan goals and annual program evaluations, and supporting the Alliance's strategic priorities through coordinated quality oversight, operational excellence, and provider accountability.
- ***Complaint and Appeal related to Access*** – The Alliance will continue expanding its network by adding non-emergency medical transport vendors and telehealth services to improve access to care. We will enhance scheduling systems, gather patient feedback, and increase network capacity through partnerships with medical schools. The Alliance will also offer grants to recruit providers and improve staff training in customer service. Additionally, we will revise policies for flexible scheduling and better communication to reduce confusion and improve member satisfaction.
- ***Access to Care***

- *High-Volume Specialists (OB/GYN & Cardiology):* The Alliance has an opportunity to improve access for urgent and routine care appointments for the Alliance set a goal of 80% for urgent care appointments to be available within 96 hours of the initial request and for routine care of making appointments available within 15 business days. The OB/GYN specialty care appointment availability did not meet the urgent care and routine care goal with a 69%, and 70% success rate. The Cardiology specialty care appointment availability goal was met for urgent care. The performance rate was 83% for urgent care and 48% for routine care.
- *Specialty Care Practitioner (SCP) Performance – High-Impact Specialists (Oncology):* Performance standards were met for routine care appointments at 87%, however fell below the goal for urgent care at 78%.
- *Behavioral Healthcare Practitioner (BCP) Performance – Non-Prescriber: Non-Physician Mental Health (Licensed Clinical Social Worker and Psychologist):* The Alliance did not meet the goal of 80% for appointment availability for urgent care appointment visits but exceeded the set goal for both non-urgent appointments with 84.8% and non-urgent follow up appointments with 91.5%. The data regarding non-life-threatening emergency appointment availability within 6 hours is NA because members can go to ER without referral or making appointments.

- ***Geo-Access to Practitioners*** – Geo-access standards were mostly met, and the member to provider ratio standards were met except for Internists. The Alliance seeks to continuously improve its network to provide more options for members to obtain care. The Alliance will continue to recruit new providers, particularly focusing on rural areas, and offer medical capacity grants to fund specific required provider types.
- ***Telephone Access –*** The Call Center Service Level and Call Abandonment Rate goals were not met in 2025, providing opportunities optimize staffing levels and queue coverage to align with call volume and member demand, as well as work to identifying opportunities to improve service level and reduce abandonment. The goal for 2026 will be to maintain timely, accessible, and member-centered telephone service while continuously evaluating opportunities for quality improvement.
- ***DHCS Population Health Management Strategy*** – The shared goals and objectives identified with the five counties serves as opportunities for focused improvements for the next year, as well as identified improvements in the NCQA population health management standards reports.
- ***Additional Activities: IHA & EPSDT Audits*** – Identified improvements for future audits include improving Electronic Medical Record (EMR) Access for timely and thorough record procurement, continued provider engagement through the use of provider outreach materials and statewide collaboration with other Managed Care Plans for the standardization of IHA practices.

1.1.5. Conclusion

The 2025 QI Program was successful in aligning its components to support the Alliance's mission of improving member health through high-quality care. By focusing on key areas of clinical and non-clinical care, member safety, and experiences, and through active leadership and provider engagement, the program was able to drive meaningful improvements in care quality and health equity.

2. Quality Improvement Health Equity Transformation Program (QIHETP), Inclusive of Culturally and Linguistically Appropriate Services (CLAS) Program

2.1. Evaluation of Core Staff and Resources

The Quality Improvement and Population Health Director has many years of HEDIS and QI experience and oversaw all aspects of the QIHETP and CLAS Program in 2025. The Alliance has determined that the Quality Improvement and Population Health Director had the appropriate experience and skills necessary to effectively lead and manage the QIHETP and CLAS Program. Under the direction of the CMO, the QIPH Director is responsible for strategic direction and management of the QIHETP. The Quality Improvement and Population Health Director manages the Alliance's preparations and response to regulatory and internal medical audits and manages implementation of selected NCQA standards. The Quality Improvement and Population Health Director and the QI Managers are responsible for engagement with internal and external stakeholders in the QIHETP. This role acts at the Performance Improvement Lead or may delegate this role to staff across the organization for the quality and health improvement efforts across the organization, in addition to acting as part of the Regional Quality and Health Equity team.

In 2025, the Alliance had four managers comprised of the Quality and Performance Improvement Manager, Quality and Population Health Manager, Clinical Safety Quality Manager, and Quality and Health Programs Manager. Where the QIPH Director focuses on strategy and manages "up" and cross-functionally across the organization, the Quality Improvement and Population Managers focuses on operations and manages "down" to the QIPH team. The QIPH Director and QIPH Managers were able to successfully oversee and manage all aspects of the day-to-day operations of the QIHETP and CLAS Program along with being very hands-on for several strategic QI initiatives.

2.2. Evaluation of Reporting Relationships

Throughout 2025, the staff meet frequently, often more than 1x/week, with their direct supervisors. This includes all the following reporting relationships:

- Nurses reporting to 2 Supervisors who are reporting to the Clinical Safety Manager,
- Two Supervisors reporting to the Quality and Health Programs Manager
- One Supervisor reporting to the Quality and Performance Improvement Manager
- One Supervisor reporting to the Quality and Population Health Manager
- QI Managers (Clinical Safety Quality Manager, Quality and Health Programs Manager, Quality and Performance Improvement Manager, and Quality and Population Health Manager) reporting into the Quality Improvement and Population Health Director
- Quality Improvement and Population Health Director reporting to the Health Services Operations Executive Director, who reports to the Chief Medical Officer
- Chief Medical Officer reporting into the Chief Executive Officer

These direct-report meetings occurred in addition to ad hoc meetings, various team meetings, project meetings, interdepartmental meetings, etc. However, the direct-report meetings provided a crucial 1:1 touchpoint for all the various 2025 initiatives, which supported direct and clear accountability throughout the QI Program's chain of command. The quality of these reporting relationships supported and enhanced the execution of the 2025 QI Program activities.

2.3. Evaluation of Funding and Resources for QIHETP Initiatives

Current Activities

The Alliance is leveraging ongoing funding for both member and provider incentives to support various QI initiatives. The key activities included generating gap-in-care provider reports; executing member incentives coupled with outreach; and conducting member education through newsletters and in person, over the phone and virtual Health Education (HE) programs, text campaigns, and the website. Provider education was also part of the QI efforts, communicated via newsletters.

Future Plan Enhancements

The Alliance will expand in 2026, the number of providers and the counties participating in the Provider Partnership program. This program is a yearlong collaboration between QI staff and local providers to close care gaps in two priority quality measures.

Interventions that will be implemented in 2026 are additional texting programs for member outreach which will be help as a timely reminder. Furthermore, the Alliance is transitioning its provider incentive program structures to be more comprehensive than it currently is with a long-term goal of value-based incentives instead of claims based.

2.4. Evaluation of Member, Physician, Community, and Leadership Involvement

In 2025, the Alliance continued to strengthen the involvement of physicians within its QI Program. Initially, physician participation was limited to their presence at meetings. However, changes were implemented in 2024 and 2025 to encourage more active physicians' feedback and engagement. These adjustments aimed to enhance the quality and effectiveness of the program by ensuring that physician insights were fully integrated into decision-making processes.

Meetings were held as scheduled throughout the year, with a focus on achieving all established goals. These discussions placed a strong emphasis on improving behavioral health representation. The active participation of physicians played a crucial role in aligning the program's initiatives with the plan's objectives.

In 2025, the Alliance gathered member feedback on QI programs and interventions by presenting to the Alliance Member Services Advisory Group (MSAG). This group is composed of Alliance members and Community Based Organization representatives to discuss the needs of members in each service county. MSAG meetings are held on a quarterly basis, in-person at Alliance offices in the 5-county service area.

In terms of program efficiency, both the QI Director and Chief Medical Officer were directly involved in implementing the 2025 QI Program initiatives. They actively collaborated with other executives and provided continuous guidance and oversight. Their approach to overcoming challenges often involves coordination with multiple departments across the Alliance.

Based on the assessment, it can be concluded that the current staffing is sufficient to meet the program's needs.

2.5. Assessment of Systems

For 2025, the Alliance has continued to maintain systems to manage and administer its QI programs, including gap-in-care reports, mobile services, member incentives, and provider incentives, and cultural and linguistic services. The organization acknowledges both strengths and areas for improvement in these systems.

Current System Capabilities

Gap-in-Care Reports - The Alliance currently has systems in place to run gap-in-care reports and summarize relevant data. These systems support the generation of reports necessary for tracking and addressing care gaps.

Incentive Programs: Adequate resources and systems are set up to administer member and provider incentive programs. These systems facilitate the management and execution of incentives effectively, however the Healthy Start incentives and the Healthy Moms Healthy Babies incentives ended effective 9/30/25 due to challenges with vendor reporting. Due to contractual regulations, member incentive programs require strict reporting adherence which the vendor could not provide. Although these member incentive programs ended, the Alliance maintained other member incentive programs including incentives for member workshops and raffle incentives programs.

Cultural and Linguistics – The Alliance has systems in place to ensure that all Alliance members receive culturally and linguistically appropriate health care services. These systems improve communication between Alliance staff, Alliance health care providers, and Alliance members, and reduce health disparities related to language and cultural barriers.

Mobile Services - The Alliance has an ongoing partnership with Alinea Medical Imaging to improve access to breast cancer screenings and address gaps in preventive care. In 2025, 25 mobile mammography events were held across four of the five counties served by the Alliance. These events provided breast cancer screenings to 674 individuals, with 530 eligible the Alliance members receiving a member incentive for completing their screening.

Future Plan Enhancements

For 2026, the Alliance is undertaking a project aimed at enhancing its data systems to improve the timeliness and accuracy of gap-in-care reports through additional data collected through a local HIE. This initiative seeks to provide more precise insights for addressing care gaps. Additionally, there are plans to create a new gap in care reports for the TotalCare HMO D-SNP LOB. Upon providers' request, we are also in the process of updating the Members Not Seen by PCP (members not seen by their linked PCP in the past 12 months) report to include all ages. The Alliance has updated the Quality Reports to align with current HEDIS specifications, as well as adding a report for providers to identify members that are due for topical fluoride. We are in the process of updating the colorectal cancer screening report to include the last type of screening for providers to identify when their patients are due for their next screening. Lastly, we are updating our HEDIS (MCAS) reports to the measurement year (MY) 2026 MCAS measure list and incorporating NCQA accreditation measures.

It can be summarized that the Alliance has adequate systems in place to administer its QI programs, including gap-in-care reports, member incentives, provider incentives, and cultural and linguistic services. However, for better performance, the Alliance has identified a plan to improve the accuracy of gap-in-care reports. This enhancement will further optimize the effectiveness of these programs and ensure more precise outcomes.

2.6. Assessment of Delegated Vendors

In 2025, the Alliance maintained a delegation agreement with Carelon, to manage grievances and appeals related to Behavioral Health quality issues. The Alliance maintained commitment to ongoing oversight of its delegates to ensure they are performing their functions effectively, particularly in contributing to behavioral health initiatives until the benefit for non-specialty mental health services transitioned to the Alliance in July 2025.

The Alliance monitors the performance of its delegated vendors through a structured oversight process. This process includes reviews of the delegate's activities and outcomes. It focuses on areas where the delegate provides critical input, such as managing behavioral health issues. Joint operations meetings are held quarterly to assess performance. These meetings also address areas for improvement and implementing corrective actions when necessary.

For this Annual Evaluation, the Alliance has summarized the overall performance of Carelon for the first half of the year, emphasizing the vendor's role in managing behavioral health-related grievances and appeals and its contributions to the organization's quality improvement initiatives in sections 12.4.3 Complaints Behavioral Health, and 12.4.4 Appeals Behavioral Health.

3. Consumer Assessment of Healthcare Providers and Systems (CAHPS)

3.1. Introduction

The Alliance monitors member satisfaction with health plan functions on an annual basis through the CAHPS survey. The Alliance has established key CAHPS measures and quantifiable standards to evaluate member satisfaction. The two main focus areas of this survey were members getting the needed care and members receiving care promptly. This report provides an overview and analysis of CAHPS report for FY 2025.

3.2. Objectives

- Annually evaluate member satisfaction for member population.
- Identify opportunities to improve member satisfaction.
- Develop and implement solutions to improve member satisfaction.

3.3. Methodology

The methodology employed in this survey involves analyzing summary rates based on member responses. In particular, the rates were determined by analyzing the percentage of participants who revealed "Always" or "Usually" in their feedback regarding consistently receiving the care they needed and receiving it in a timely manner. This approach offers a clear measure of satisfaction and allows for year-over-year comparisons to identify trends and guide future improvements in service. By prioritizing these response categories, the Alliance can obtain valuable insights into the reliability and accessibility of the care provided to members.

- Total Completed Surveys: 245
- Surveys Sent: 2,005
- Response Rate: 12.2%

3.4. Results and Performance Evaluation

The Alliance evaluated satisfaction using the following measures and quantifiable standards that represent the percentage of favorable positive responses. The tables below show the Alliance's performance against the goals for the 2025 survey. The goals were previously based on the Press Ganey Book of Business (PG BoB) Data. In 2025, The Alliance changed its goal performance to meet the NCQA Quality Compass benchmark.

Access to Care

Measure	2022	2023	2024	2025	2025 QC	Goal met
Getting Needed Composite Score	82.90%	78.90%	80.7%	**79.0%**	82.1%	NO
Getting care, tests, or treatment	82.50%	82.60%	84.1%	**81.9%**	85.2%	NO
Getting specialist appointment	83.20%	75.30%	77.3%	**76.1%**	78.9%	NO
Getting Care Quickly Composite Score	73.40%	75.90%	82.4%	**80.3%**	81.6%	NO
Getting urgent care	74.50%	82.40%	88.8%	**82.4%**	83.7%	NO
Getting routine care	72.20%	69.40%	76.0%	**78.2%**	79.2%	NO

Key Findings

- The Alliance did not meet the goal for any key measures under "Access to Care."
- The Alliance saw a decrease across all "Access to Care" measures from 2024 to 2025.
- The lowest performing measure in 2025 was "Getting Specialist Appointment" at 76%, which was 2 percentage points below the benchmark, showing a small decrease over the previous year.
- When examining through the composite score of "Getting Needed Composite Care", we see the Alliance is 3.1 points from the Quality Compass.

Care Coordination

Measure	2022	2023	2024	2025	2025 QC	Goal met
Doctors were informed and up to date about care from other health providers	83.70%	79.60%	82.8	83.7%	85.9%	NO

Key Findings

- The Alliance did not meet the goal for the key measures under "Care Coordination."
- In 2025, the performance measure of "doctors was informed and up to date about care from other health providers" was 83.7%. It falls short of the goal by 2.2 percentage points.
- The 2025 rate is an improvement of 0.9 percentage points over the previous year.

Customer Service

Measure	2022	2023	2024	2025	2025 QC	Goal met
Customer Service Composite Score	91.10%	87.50%	87.8%	87.6%	89.3%	NO
Provided information or help	86.90%	80.30%	80.8%	80.9%	83.8%	NO
Treated with courtesy and respect	95.30%	94.70%	94.8%	94.4%	94.7%	NO

Key Findings

- When analyzing customer service composite score, the Alliance just missed the goal for "Treated with courtesy and respect" by 0.3 points and did not meet for the composite measure or "Provided information or help."
- The lowest performing measure (Customer service staff provided information or help) was 80.89%, which was 2.9 percentage points below the benchmark.
- The highest performing measure in 2023 was "Treated with Courtesy and Respect" at 94.40%, which was just below the goal.

Global Measures

Measure	2022	2023	2024	2025	2025 QC	Goal met
Rating of Health Plan	76.80%	77.10%	78.5%	76.8%	77.6%	NO

Rating of Health Care	75.60%	72.70%	78.2%	78.1%	76.5%	YES
Rating of Personal Doctor	83.10%	80.40%	86.4%	85.5%	84.6%	YES
Rating of Specialist	85.70%	81.50%	84.2%	83.8%	83.1%	YES

Key Findings

- The Alliance met 3 of the 4 goals for "Global Measures."
- All measures decreased slightly year over year.
- The lowest rate was "Rating of Health Plan" at 76.8%, which was 0.8 percentage points below the benchmark.
- The highest performing measure in 2023 was "Rating of Personal Doctor" at 85.5%, which was 0.6 percentage points above the benchmark.

How Well Doctors Communicate

Measure	2022	2023	2024	2025	2025 QC	Goal met
How Well Doctors Communicate Composite Score	91.50%	91.60%	91.8%	91.2%	93.4%	NO
Doctors explained things in an understandable way	90.50%	92.20%	92.6%	92.9%	93.2%	NO
Doctors listened carefully to you	92.70%	92.30%	93.3%	90.0%	93.7%	NO
Doctors showed respect for what you had to say	92.70%	94.30%	94.8%	94.9%	95.10%	NO
Doctors spent enough time with you	89.90%	87.80%	86.6%	87.0%	91.40%	NO

Key Findings

- The Alliance did not meet the goal for any of the key measures under "How Well Doctors Communicate."
- The lowest performing measure (Doctors spent enough time with you) was 4.40% below the goal.
- The highest performing measure (Doctors showed respect for what you had to say) was only 0.20% below the goal.

There was year over year improvement.

CAHPS Trend Analysis

The tables below show a trend analysis of CAHPS ratings from 2022 to 2025.

Measure*	2022	2023	2024	2025	2025 QC	Goal met	Difference from Goal
Rating of Health Plan	76.80%	77.10%	78.5%	76.8%	77.6%	NO	-0.8%
Rating of Health Care	75.60%	72.70%	78.2%	78.1%	76.5%	YES	+1.6%
Rating of Personal Doctor	83.10%	80.40%	86.4%	85.5%	84.60%	YES	+0.9%

Rating of Specialist +	85.70%	81.50%	84.2%	83.8%	83.10%	YES	+0.7%
Getting Needed Care Composite Score	82.90%	78.90%	80.7%	79.0%	82.1%	NO	-3.1%
Getting Care Quickly Composite Score	73.40%	75.90%	82.4%	80.3%	81.6%	NO	1.3%
Plan Administration Composite Score	91.10%	87.50%	87.8%	87.6%	89.30%	NO	1.7%
How Well Doctors Communicate Composite Score	91.50%	91.60%	91.8%	91.2%	93.4%%	NO	-2.2%
Coordination of Care Composite Score	83.70%	79.60%	82.8%	83.7%	85.9%	NO	-2.2%
Ease of Filling Out Forms Composite Score	93.10%	95.60%	93.6%	94.9%	95.0%	NO	-0.1%

**Full results of the CHILD and ADULT CAHPS surveys are in Appendix A.*

3.5. Quantitative Analysis

- The Alliance received a plan rating of 76.8% in 2025 which is down 1.7% points over the previous year but below the 2025QC benchmark by 0.8% points.
- In 2025,78.1% of respondents rated health care positively, which surpassed the 2025 QC benchmark of 76.5%. The goal was met.
- A rating of 85.5% was given to personal doctors in 2025, surpassing the 2025 QC benchmark of 84.6. The goal was met.
- The rating for specialists was 83.8% in 2025, which surpassed 2025 QC benchmark of 83.1%. The goal was met.
- When investigating CAHPS surveys focused on access to care, the Alliance did not meet the benchmark for getting needed care composite score or getting care quickly composite score.
- The rate for Getting Care Quickly is 2.10 percentage points below that in 2024 but 4.4 percentage points higher than 2023. It indicates an uncertain trend for members getting care quickly.
- Customer service was rated positively by 87.6% of respondents in 2025, below the 2025 QC benchmark of 89.3%. The goal was not met.
- The communication skills of doctors were rated positively by 91.2% of respondents in 2025, which did not meet the 2025 QC benchmark of 93.4%. The goal was not met.
- Care coordination received a 83.7% positive rating in 2025; underperforming compared to the 2025 QC benchmark of 85.9%. The goal was not met.
- The ease of filling out forms was rated positively by 94.9% of respondents in 2029, only 0.1% below the 2025 PG BoB benchmark of 95.0%

Qualitative Analysis - Opportunities for Improvement

Based on the CAHPS data review, the Alliance did not reach its goals for the "getting needed care." This outcome highlights members' struggles to access care. The Alliance has acknowledged that the

"getting needed care" measure is the most essential and is therefore the top priority for Plan improvements. The rate did increase year over year, showing improvement.

3.6. Qualitative Barrier Analysis

The SMEs, including Quality Improvement and Population Health Director, Quality and Health Programs Manager, Grievance and Quality Manager, Provider Services Director, Provider Quality and Network Development Manager, Quality and Performance Improvement Manager, Quality and Population Health Manager, and Grants Director, identified the challenges obstructing the transition and quality of health care service.

- *Access to Care*
    - The challenge to increase Access to Care, particularly in the rural communities the Alliance serves, can be attributed to many factors including member transportation and how to navigate the healthcare system, difficulty recruiting and retaining providers and provider staff. This has been especially challenging in a post-pandemic world where healthcare workers continue to struggle with burnout.
- *Member-Level*
    - Members often expect to receive appointments sooner, which contributes to the low CAHPS ratings. Although appointments are available, the delay in scheduling leads to member dissatisfaction. The gap between the expected and actual appointment times is the primary reason for the low ratings.
    - Members do not know how to navigate the healthcare system as well, and therefore they are not able to get appointments in a timely manner. Some members do not realize that the Alliance has appointment assistance for their member services unit that they can call to get the appointment services earlier.
    - Members do not always have transportation or the ability to go to appointment times offered.
- *Provider-Level*
    - Primary Care is getting negatively impacted:
        - Primary care availability was made more challenging due to the limited number of PCPs available for contracting. This is because many medical school graduates are opting for specialist careers, which are more financially rewarding.
    - Providers are not updating their panel status:
        - There are cases when patients contact the clinic to schedule an appointment but find that the office's panel is closed. Members may have the perception that there are fewer appointments available as there were in previous years.
            - Providers may close offices due to high patient volume.
            - Providers may fail to update the Alliance management team on their current panel status due to lack of awareness, time constraints, or staff turnover.
- *Health Plan-Level:*
    - There appears to be an imbalance between the number of patients seeking appointments and the availability of practitioners.
    - Some older recipients may have multiple chronic conditions and may require longer duration of appointments. Practitioner offices often struggle with the availability of longer appointment durations.

- There has been a reduction in the number of providers and medical staff as retention has become challenging in the past few years. Many providers and staff left the state due to high costs, a shortage of support staff, and burnout. Several providers faced unsustainable costs related to insurance, taxes, and malpractice, leading to further attrition. Additionally, a major shortage in both practitioners and support staff made it difficult for many providers to run their offices effectively. To address this issue, we instituted a medical assistant grant since 2023 to help support this critical staffing need. Additionally, a workforce care gap grant was implemented and targeted specifically to clinics with large care gaps and low appointment availability due to staffing shortages. The grants covered the staffing costs for additional clinic days so providers (locum-tenens or regular staff) as well as administrative and medical assistants could hold extra clinics to close substantial gaps in care.

Opportunities for Improvement

Based on the 2025 CAHPS Survey results, several opportunities have been identified to enhance the timeliness and accessibility of healthcare services for the Alliance members. These opportunities target specific areas where performance metrics did not meet the established goals.

- The Alliance investigated opportunities to enhance the telehealth solution. Telehealth services will be expanded by increasing the number of telehealth-only providers. Additionally, several clinics offer in-person appointments and provide telehealth options to their patients. This expansion aims to offer members more opportunities to receive care remotely and reduce the need for in-person visits.
- The Plan is using appropriate types of providers (i.e., CHWs, Doulas, and other types of ancillary providers), to cover shortage PCPs in the service area. These providers can see members and administer appropriate services instead of PCPs.
- The Plan is also offering grant funding to PCPs to incorporate CHWs into their practices to act as patient navigators.
- The Alliance increases network capacity by working with local medical schools, residency programs with University of California Merced and University of California San Francisco to expand the network in remote areas.
- The Alliance offers medical capacity grants to fund a portion of the salary for specific provider types to aid in recruiting additional practitioners and supporting medical assistants.
- Implement efficient scheduling systems and inform members about the appointment assistance available through the member services unit, which they can contact to secure earlier appointments.
- There are incentive programs currently in place for PCPs, SCPs, and hospitals to give more funding to the provider network. The Alliance is developing additional incentive programs to provide additional support to the provider network depending on availability of operational revenue. Additional operational revenue is distributed through grant funding or incentive payments to providers.
- The Alliance has developed a robust transportation benefit to help members get to appointments.
- The Alliance began a grant funding program to PCPs to provide after-hours clinics specifically for preventive care.

Since 2025, the Alliance has targeted access to care through alternative places of medicine. This work is collaborative with our primary care providers and meant to close gaps, not provide an alternative to the care home model.

By addressing these areas, the Alliance can work towards improving the overall healthcare service delivery efficiency and effectiveness, member satisfaction, and Plan goals for timely and accessible care.

Description of Intervention	Barrier Addressed	Timeframe
1. **Continuing to expand the Provider/Practitioner Network** Provider Relations continues to expand the practitioner panel to improve access for Alliance members. The Provider Relations department will focus on growing the specialty network. The Alliance is reviewing contract reimbursement amounts requested in specialty areas that have been identified for improvement.	Providers/Practitioners Not Participating with the Alliance	Ongoing
2. **Robust Grant Funding Program** In late 2023 and through 2025 the Plan offered Workforce Care Gap Grants to PCP offices which paid PCPs to hire locum providers or pay staff overtime to work additional weekend and evening clinics. The Grants team also continued its Workforce Recruitment Grants for all specialties and expanded it to include CHWs.	Provider Recruitment, After hours availability, Patient Navigators	Ongoing
3. **Continue to educate practitioners on appointment access** standards so they can make necessary arrangements to see patients in a timely manner. The Plan will send newsletters and update its websites to educate practitioners on the appointment access standards. Education distributed annually by Provider Relation Representatives between October – December during in-person office visits.	Practitioners are not aware of appointment availability standards	Ongoing
4. **Expand access through Alternative Places of Medicine** Through these efforts, we have: • Partnered with our vendor Alinea Health to offer mobile mammography services to provide breast cancer screening to our members. • Partnered with our vendor Sprinter Health to close gaps in care using in-home care services for a variety of HEDIS measures (GSD, CBP, COL, EDD). • Developed a collaborative relationship with county public health systems to hold immunization events to combat vaccination rates for children and adolescents.	Getting Needed Care & Getting Care Quickly	Ongoing

3.7. Conclusion and Next Steps

The Alliance has concluded that there are still some issues related to appointment access. Improving appointment access and making sure members receive the care they need is a key initiative for the Plan in its ongoing effort to improve quality. The Alliance is continuing to expand its specialty network to provide better coverage to its members. The Alliance will also continue to identify additional health groups and practitioners that can join the Plan in 2025.

4. Utilization of Language Services for Organization Functions

4.1. Provider Phone Utilization of Language Services

This analysis examines different languages used through phone interpreting services from providers to communicate with patients who speak various languages. By assessing the demand for different languages and identifying gaps, The Alliance aims to understand the patterns and challenges in provider utilization.

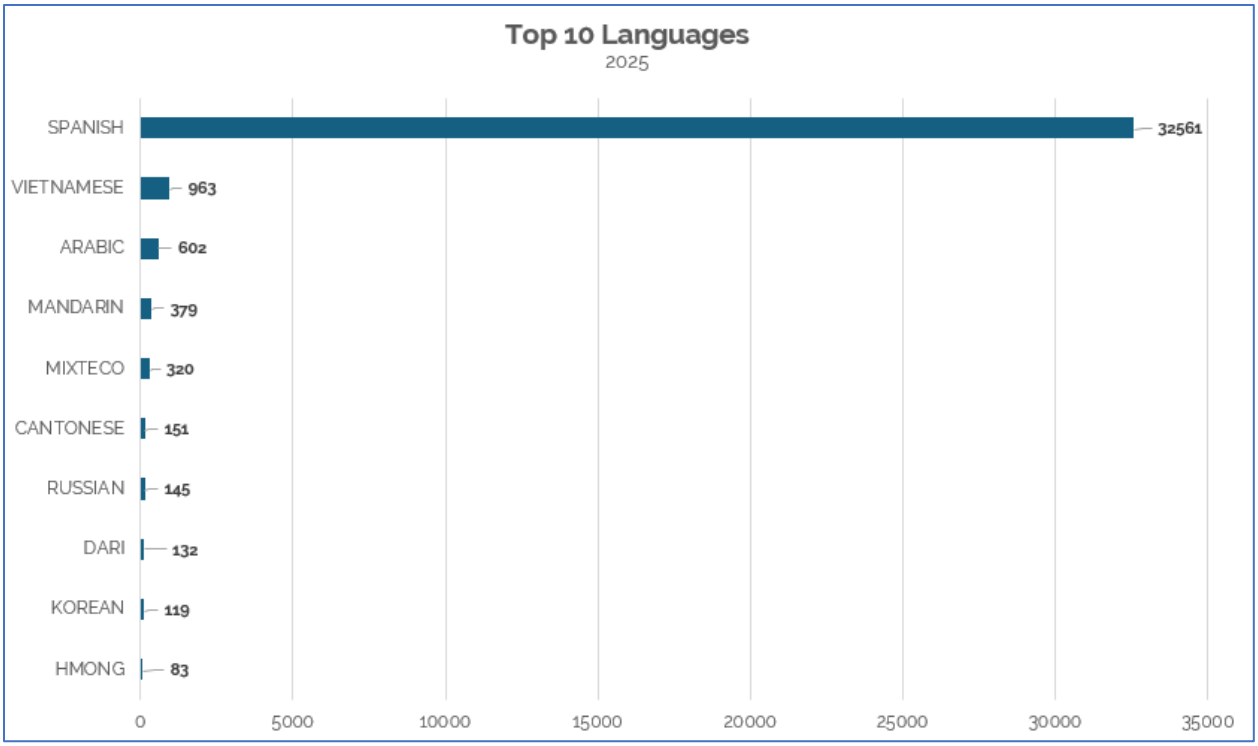
Methodology

- **Data Source:** Data on the utilization of language services was extracted from the phone call service records.

- **Total Calls:** There were **36,352** total calls made to members by **providers** using phone interpreting services from **January 1 to December 31, 2025.**

Language Usage Distribution

Language	Number of Calls	Percentage
SPANISH	**32,561**	**89.57%**
VIETNAMESE	**963**	**2.65%**
ARABIC	**602**	**1.66%**
MANDARIN	**379**	**1.04%**
MIXTECO	**320**	**0.88%**
CANTONESE	**151**	**0.42%**
RUSSIAN	**145**	**0.40%**
DARI	**132**	**0.36%**
KOREAN	**119**	**0.33%**
HMONG	**83**	**0.23%**
PUNJABI	**76**	**0.21%**
FARSI	**67**	**0.18%**
ALL OTHER LANGUAGES	**754**	**2.07%**
TOTALS	**36,352**	**100%**



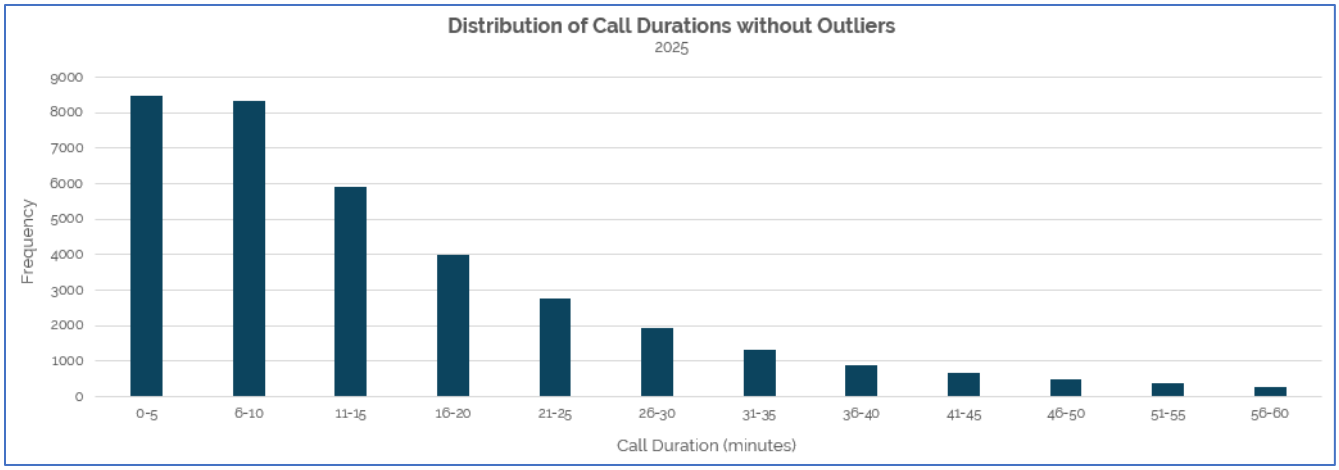
Quantitative Analysis

Language Usage Distribution

- **Total Number of Languages:** 60 unique languages.
- **Most Frequently Used Language:** Spanish (89.57%).
- **Top 3 Languages:** Spanish, Vietnamese (2.65%), Arabic (1.66%).

Spanish is the most frequently used language, with a significantly higher usage compared to other languages. This disparity emphasizes the critical need for high-quality Spanish interpreting services to meet the demands of most users. While Vietnamese and Arabic follow as the next most frequently used languages. This distribution of language usage pointed out the importance of prioritizing Spanish language services while also ensuring adequate resources are available for other languages.

Call Duration Distribution



Quantitative Analysis

Call Duration Distribution

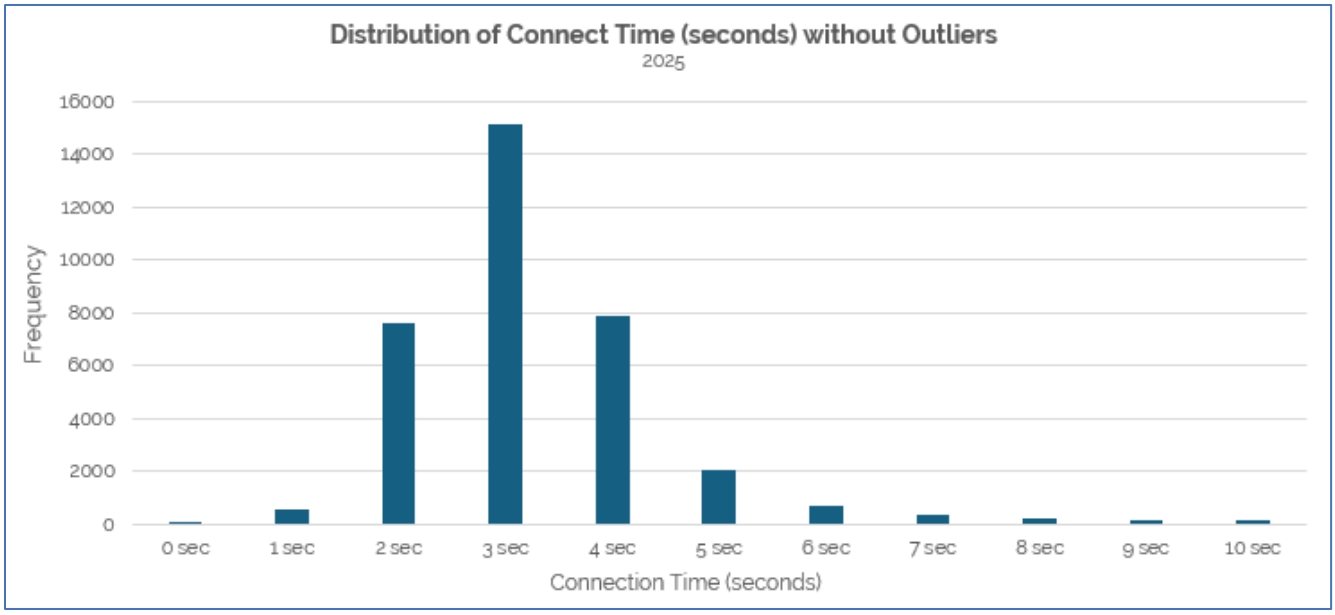
- **Mean Average Duration:** 0.433 minutes
- **Standard Deviation:** 0.431 minutes
- **Minimum Duration:** 0 minutes (421 calls), 1 minute (1,443 calls)
- **Maximum Duration:** 248 minutes. (outlier)

Quartiles

- **25th Percentile:** 3.5 minutes.
- **50th Percentile (Median):** 7.5 minutes.
- **75th Percentile:** 15.5 minutes.

75% of calls last between 1 and 21 minutes, with more than half of calls clustering around 1 to 11 minutes. This range suggests that while many calls are relatively short, it reflects diverse and varying communication needs among users.

Connect Time Distribution



Quantitative Analysis

Connect Time Distribution

- **Mean Connect Time:** 1.99 seconds
- **Standard Deviation:** 1.97 seconds
- **Minimum Connect Time:** 0 seconds (19 calls), 1 second (587 calls)
- **Maximum Connect Time:** 4474 seconds. (outlier)

Quartiles

- **25th Percentile:** 1 second
- **50th Percentile (Median):** 1.5 seconds
- **75th Percentile:** 2 seconds

Most calls have a connect time of less than 10 seconds, indicating that calls connect quickly.

Overall Conclusion Based on Quantitative Analysis

In conclusion, the high usage of interpreting services in Spanish underscores the need to prioritize the quality Spanish language support, while also ensuring adequate resources for other frequently used languages like Vietnamese and Arabic. Additionally, diverse call durations show varying communication needs among users. However, it should be met with efficient and responsive interpreting services that can connect quickly.

Qualitative Analysis

The analysis of provider phone utilization of language services reveals several potential barriers that may impact the effectiveness and efficiency of the services. The high demand for Spanish interpreting services may strain resources and lead to longer wait times for users of other languages. Limited availability of interpreters for less frequently used languages like Vietnamese and Arabic may cause delays and dissatisfaction. The wide range of call durations can create scheduling challenges and may lead to inconsistent service quality.

4.2. Staff Phone Interpreting Utilization of Language Services by Departments

The analysis evaluates how staff across different departments use phone interpreting services. By evaluating the disparities in service utilization among departments, the Alliance can pinpoint specific needs and areas for improvement.

Methodology

- **Data Source**: Data on the utilization of language services was extracted from the phone call service records.
- **Total Calls:** There were 9,918 total calls made from staff of every department using phone interpreting service January 1 to December 31, 2025.

Departmental Utilization Data

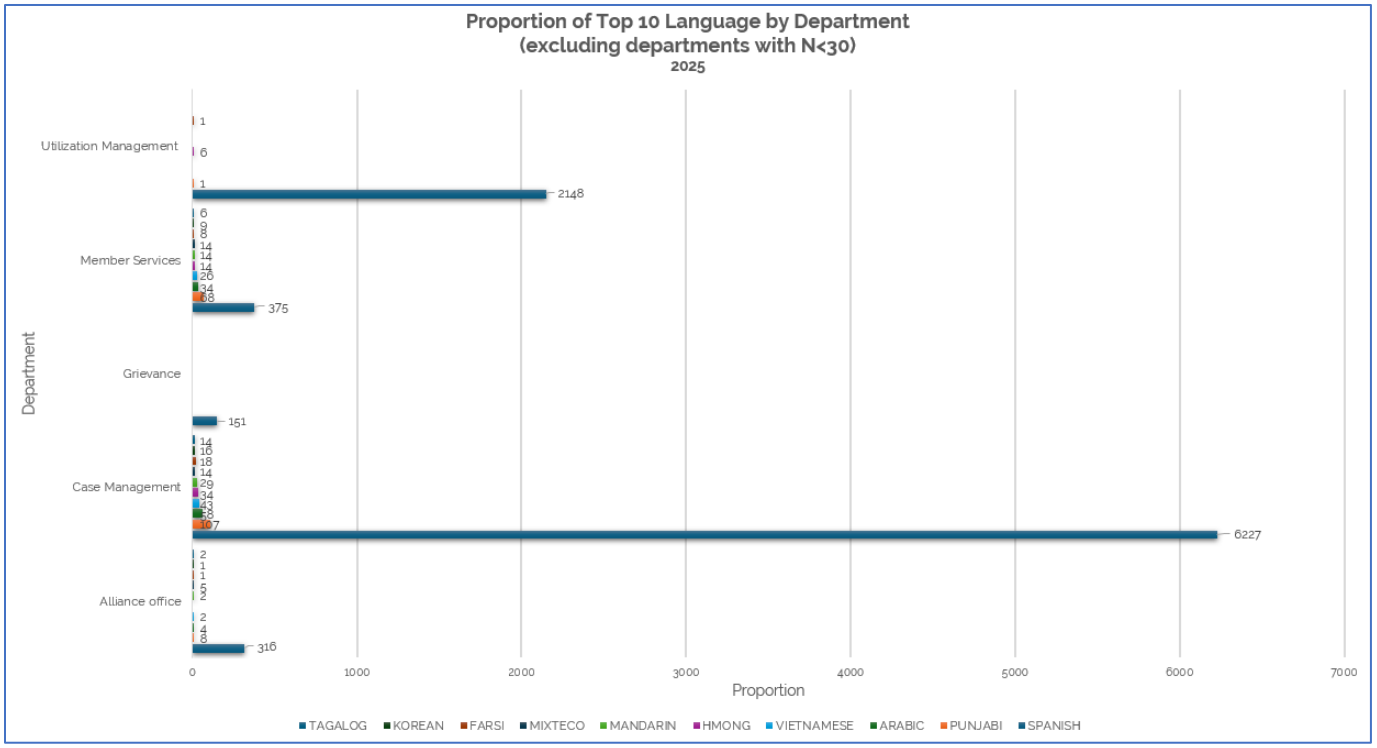
Department	Number of Language Service Request	Percentage of Language Service Request
Case Management	6,609	67%
Utilization Management	2,165	22%
Member Services	633	6%
Other / Alliance offices	358	4%
Complaints, Grievances, and Appeals	153	1%

Quantitative Analysis

Departmental Utilization Data

- **Case Management:** Highest utilization at 67%.
- **Utilization Management:** 22% of total calls.
- **Member Services:** 6% of calls, with the most diverse range of languages used.
- **Other /Alliance offices:** 4% of calls.
- **Complaints, Grievances, and Appeals:** Minimal usage at 1%.

Alliance staff utilized a total of 37 unique languages in 2025 with phone interpreting services. The top languages include Spanish at 93% of all calls, Punjabi at 2%, Arabic at 1% and all other languages total the remaining 4%. The chart below shows the top 10 languages by department.



Conclusion Based on Quantitative Analysis

Case Management is the primary user of phone interpreting services. It makes up over half of the total utilization. This indicates a high need for language support in these areas. The Member Services department, despite having a lower call volume, demonstrates the highest language diversity, highlighting a need for a wide range of linguistic support. Utilization Management shows moderate use, while departments such as Complaints, Grievances and Appeals, and general Alliance offices show minimal utilization, indicating potential underuse or lesser need for these services.

Qualitative Analysis

The analysis of operational unit phone utilization of language services reveals several potential barriers that may impact the effectiveness and efficiency of the services.

- The high demand for interpreting services in Spanish may strain resources and lead to longer wait times for users especially for Case Management department.
- The need for diverse linguistic support in Member Services could strain resources and affect service delivery.
- Variability in interpreter quality may lead to inconsistent communication outcomes.
- Staff may face difficulties managing call durations that range from short to exceptionally long, impacting their workflow and productivity.

5. Member Experience with Language Services During Health Care Encounters

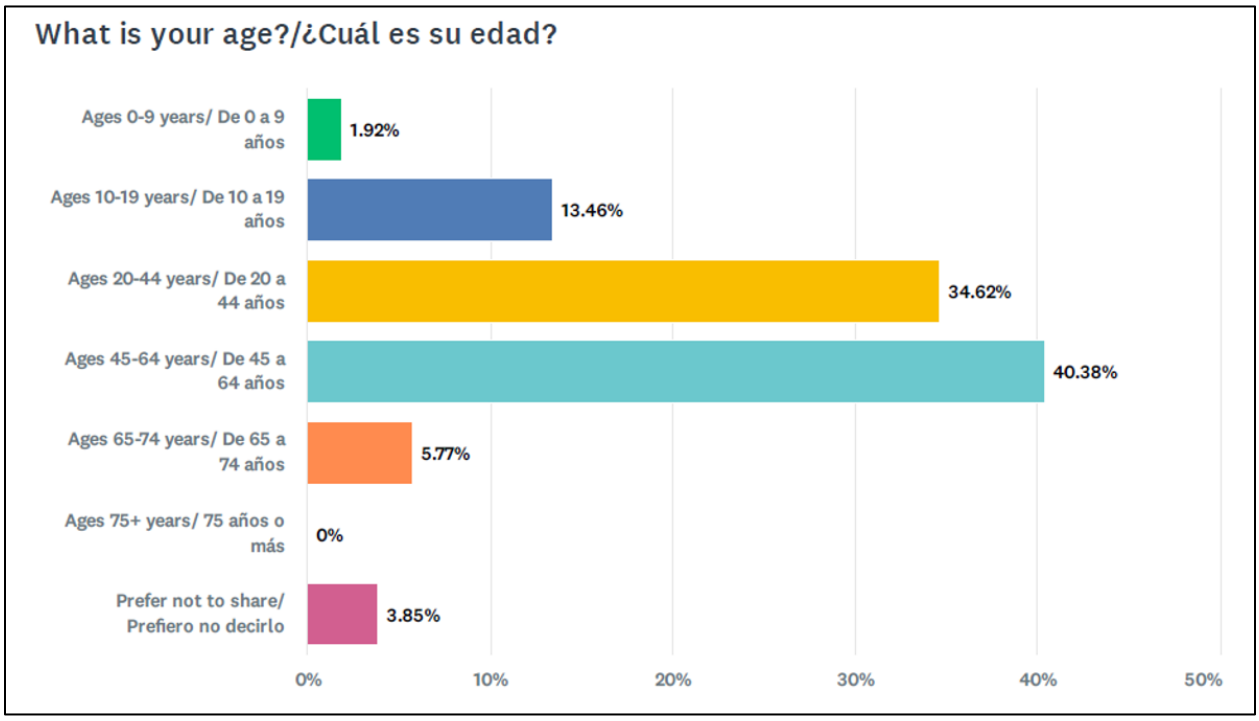
This report presents the findings from a member survey conducted to evaluate individual experiences with language services during organizational functions. The survey featured 10 questions aimed at assessing member satisfaction and overall experience with the language services provided. The results provide insights into the effectiveness of these services and highlight areas for

improvement. This analysis also identifies key patterns and challenges members face when accessing language support.

Methodology

- **Response Rate:** The total number of responses was 52.
- **Data Collection Period:** Members who used interpretation services from January 1, 2025 – December 31, 2025, were surveyed.
- **Survey Instrument:** The survey consisted of 10 questions aimed at assessing the satisfaction and experience of members with the language services provided. For this report, The Alliance focused on the relevant questions to provide meaningful insights.

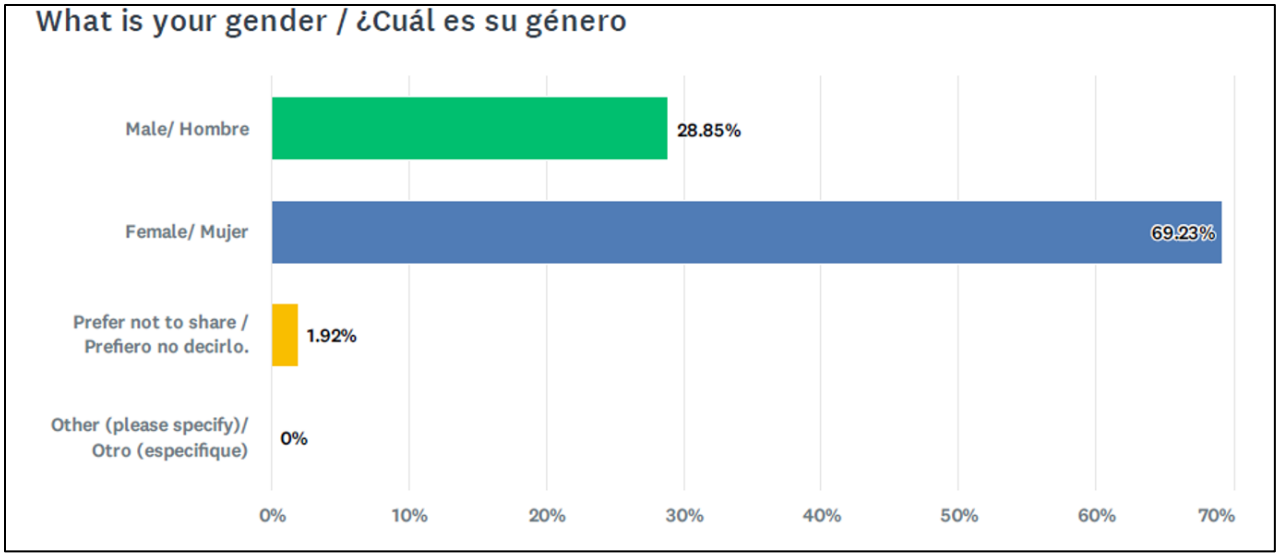
Age Distribution



Key Findings

The age distribution of respondents who have used language services shows a diverse range, with the highest representation in the 45-64 (40.38%) and 20-44 (34.62%) age groups. The lowest representation is in the 0-9 years age group at 1.92%.

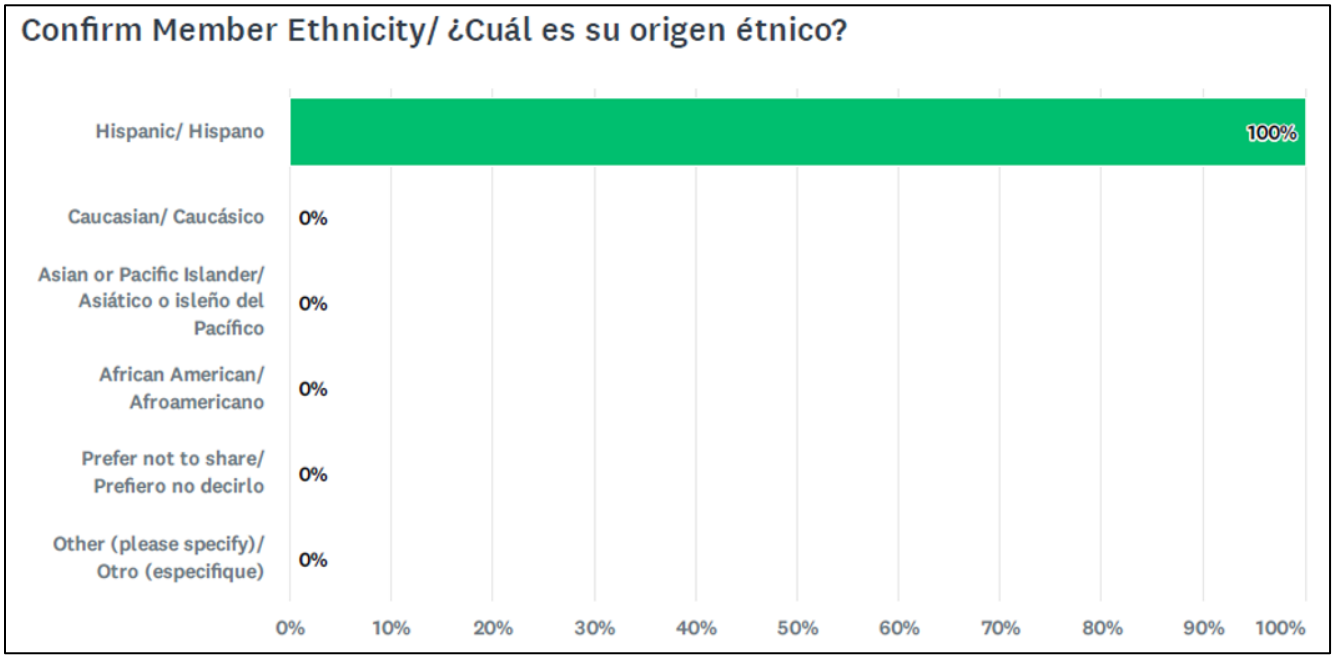
Gender Distribution



Key Findings

The majority of respondents who used language services are female (69.23%), while 28.85% are male. 1.92% of respondents chose not to share or specify another gender.

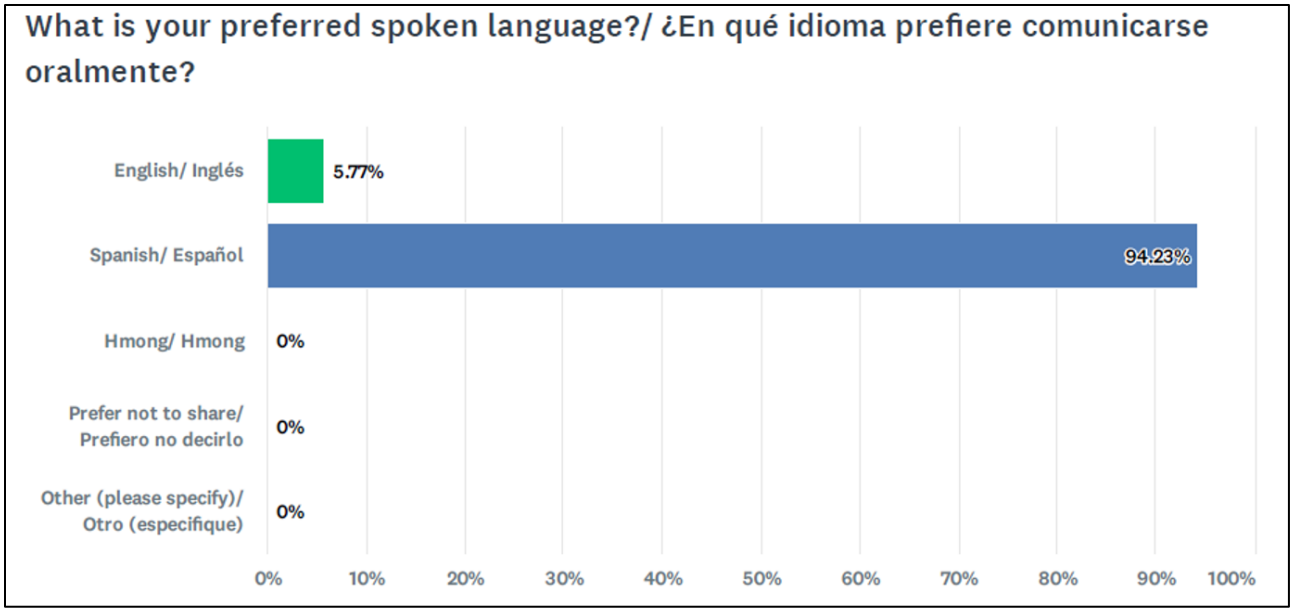
Ethnicity



Key Findings

All 52 respondents that were contacted for the survey identified as Hispanic (100%). Outreach was completed to attempt to survey members of other ethnicities, but there were no responses collected.

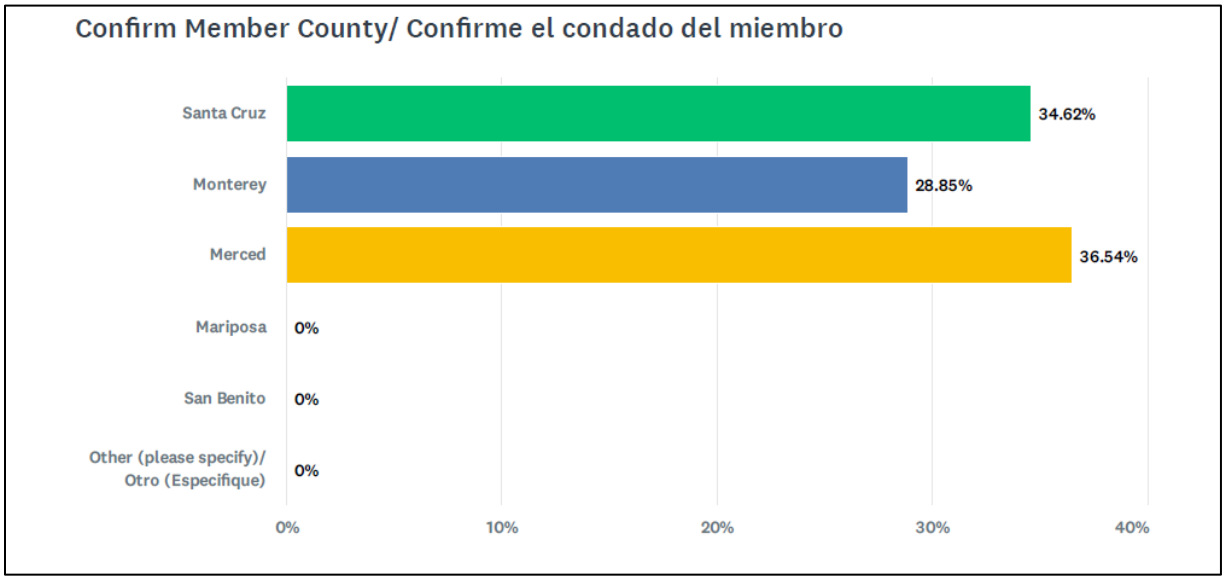
Preferred Spoken Language



Key Findings

The majority of respondents prefer to communicate in Spanish (94.23%). A small percentage prefers English (5.77%).

County Distribution

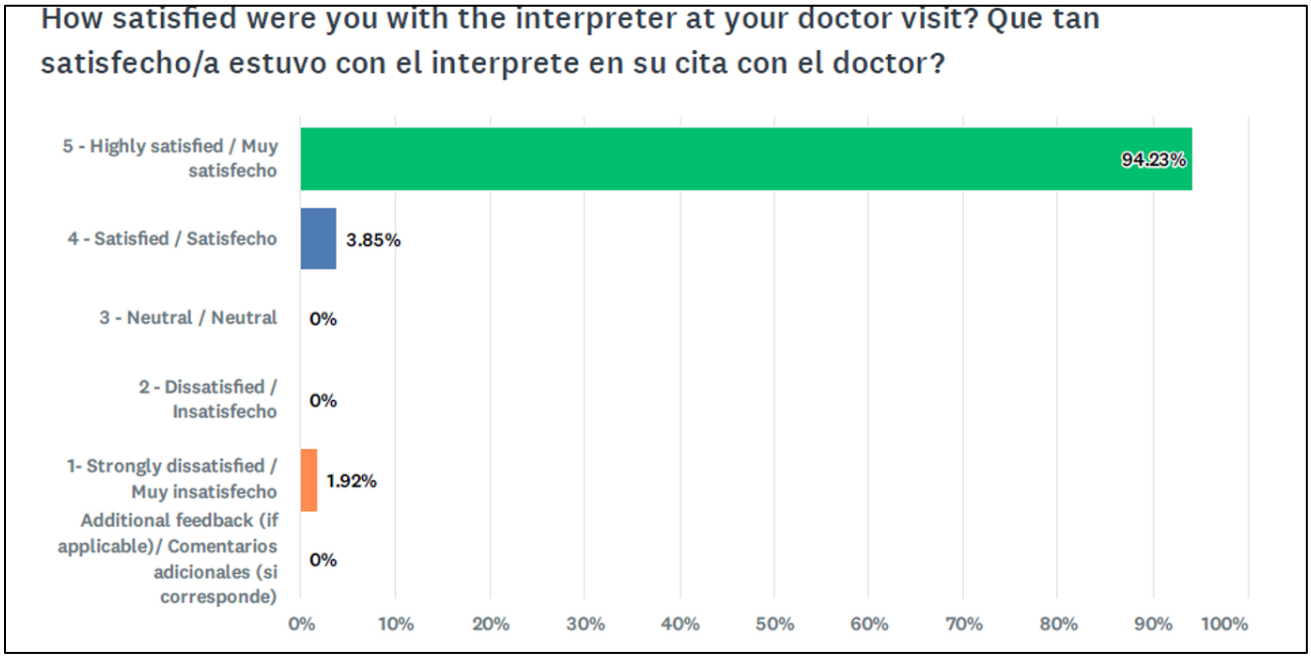


Key Findings

Most respondents are from Merced County (36.54%), followed by Santa Cruz (34.62%) and Monterey (28.85%). No respondents were from Mariposa or San Benito counties.

Quantitative Analysis

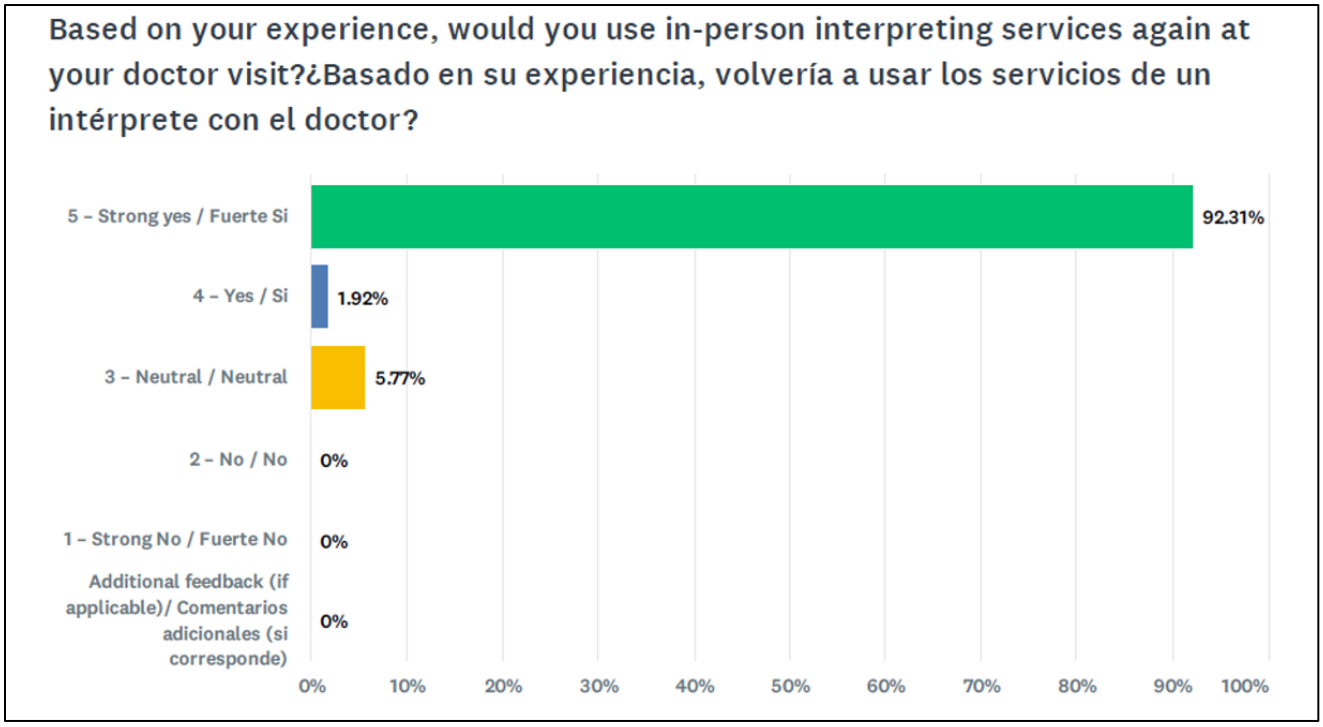
Member Experience Survey Question– How satisfied were you with the interpreter at your doctor visit?



- The chart illustrates the satisfaction levels of 52 respondents regarding interpreter services during their doctor's visits.
- 94.23% of respondents rated their experience as "Highly satisfied" and 3.85% as "Satisfied". This indicates a strong positive reception and effectiveness of the interpreter support provided.
- 1 respondent (1.92%) reported they were strongly dissatisfied.
- Overall, the data indicates a high level of satisfaction with the interpreter services during doctors' visits, with most respondents expressing a positive experience.

Quantitative Analysis

Member Experience Survey Question - Based on your experience, would you use in-person interpreting services again at your doctor visit?



- The chart presents the responses of 52 individuals to the question.
- A strong majority would use in-person interpreting services again, with 92.31% answering "Strong yes" and 1.92% answering "Yes". This reflects a positive reception and demonstrates that most of the members found the service satisfactory and would consider using it again.
- 3 respondents (5.77%) answered “Neutral”.
- There were no respondents that indicated they would not use the services again.

Conclusion Based on Overall Quantitative Analysis

- The survey shows members’ high satisfaction with in-person interpreting services.
- All respondents identified as Hispanic and preferred to communicate in Spanish.
- Although there was 1 member that reported dissatisfaction, they shared in their feedback this was due to not feeling comfortable with having an additional person that was not part of the medical team present while discussing her medical information. She stated she would use the service again but would prefer to have someone from the medical team interpreting rather than an outside agency.
- Feedback was highly positive with many sharing the interpreters were kind and helpful. Most shared the experience helped them feel more at ease and less stressed about the appointment.
- Overall, the interpreting services are well received, contributing positively to the healthcare experience of the members.

When comparing respondents feedback in 2024, there was more positive experience feedback and fewer areas identified for improvement. In 2025 respondents shared ways to improve services including having interpreters that are more aware of different Spanish words used in different regions of Mexico. Additionally, they recommended making sure to offer interpreting instead of asking if members need one to avoid the feelings of shame some members might feel to ask for one.

Qualitative Analysis

The results indicate that most members found the service beneficial and are willing to rely on it for future healthcare visits. There was little feedback shared from members for areas of improvement in 2025 but based on the findings, the SME at the Alliance identified the following key barriers to member satisfaction:

- Members shared to ensure interpreters are aware of the variations in Spanish spoken in different regions of Mexico. We plan to share this information with interpreting services vendors to ensure there is awareness and collaboration on ways to better communicate this with members.
- Members shared the importance of providers offering services instead of waiting until a member asks for it. For some member populations, especially elders, it can be a source of stress or shame to have to ask for help.

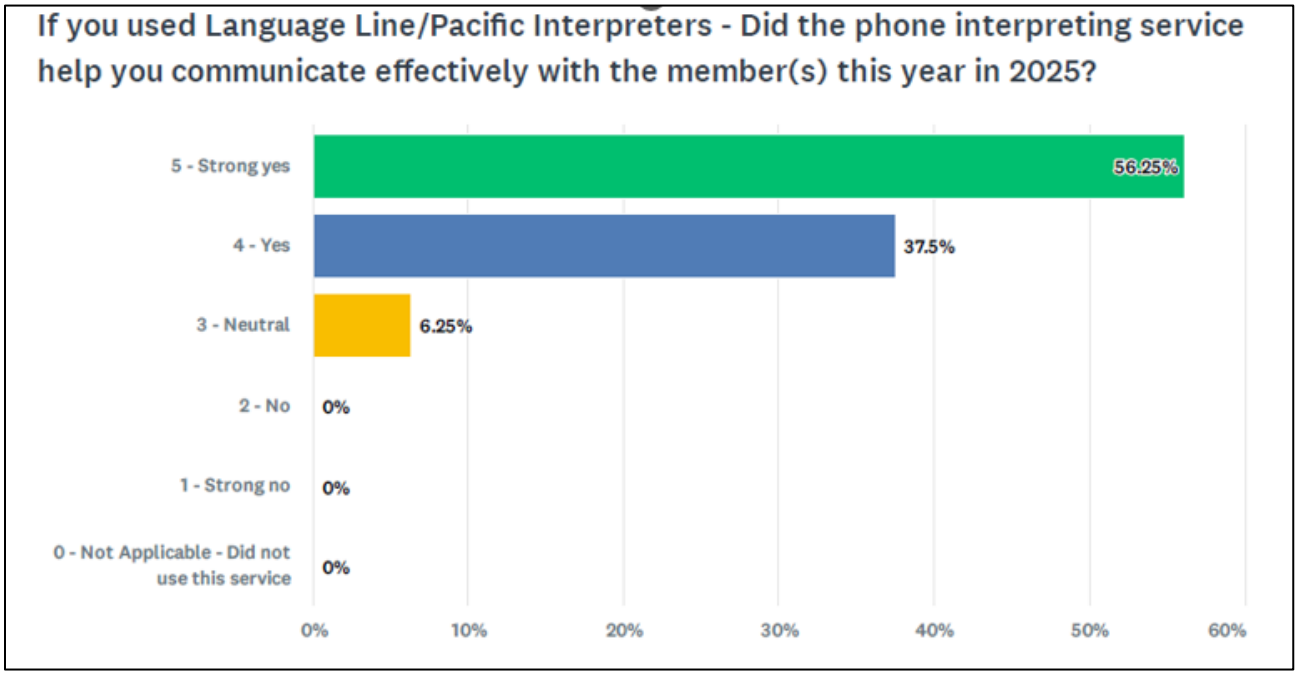
6. Staff Experience with Language Services for Organization Functions

The Alliance conducted a frontline staff survey to evaluate experience with language services used for organizational functions. The survey consisted of 5 questions specifically designed to assess the experiences of frontline staff when utilizing these language services. The firsthand insights gained from this survey aim to enhance our understanding of how language services are utilized effectively and identify potential areas for improvement in supporting staff interactions with diverse populations.

Methodology

- **Response Rate:** The total responses were 17.
- **Data Collection Period:** Alliance staff who used phone interpretating services from January 1, 2025 – December 31, 2025, were surveyed with a focus on high utilizers.
- **Survey Instrument:** The survey consisted of 5 questions focused on the staff's experience using language services for organizational functions. In this report, the Alliance focused on the relevant questions to provide meaningful insights. Please note that there are some questions that are asked for each vender in order to better understand satisfaction with each vendor's services.

Staff Survey Question - Based on your experience, did the phone interpreting service provided by Language Line help you communicate effectively with the member(s)?

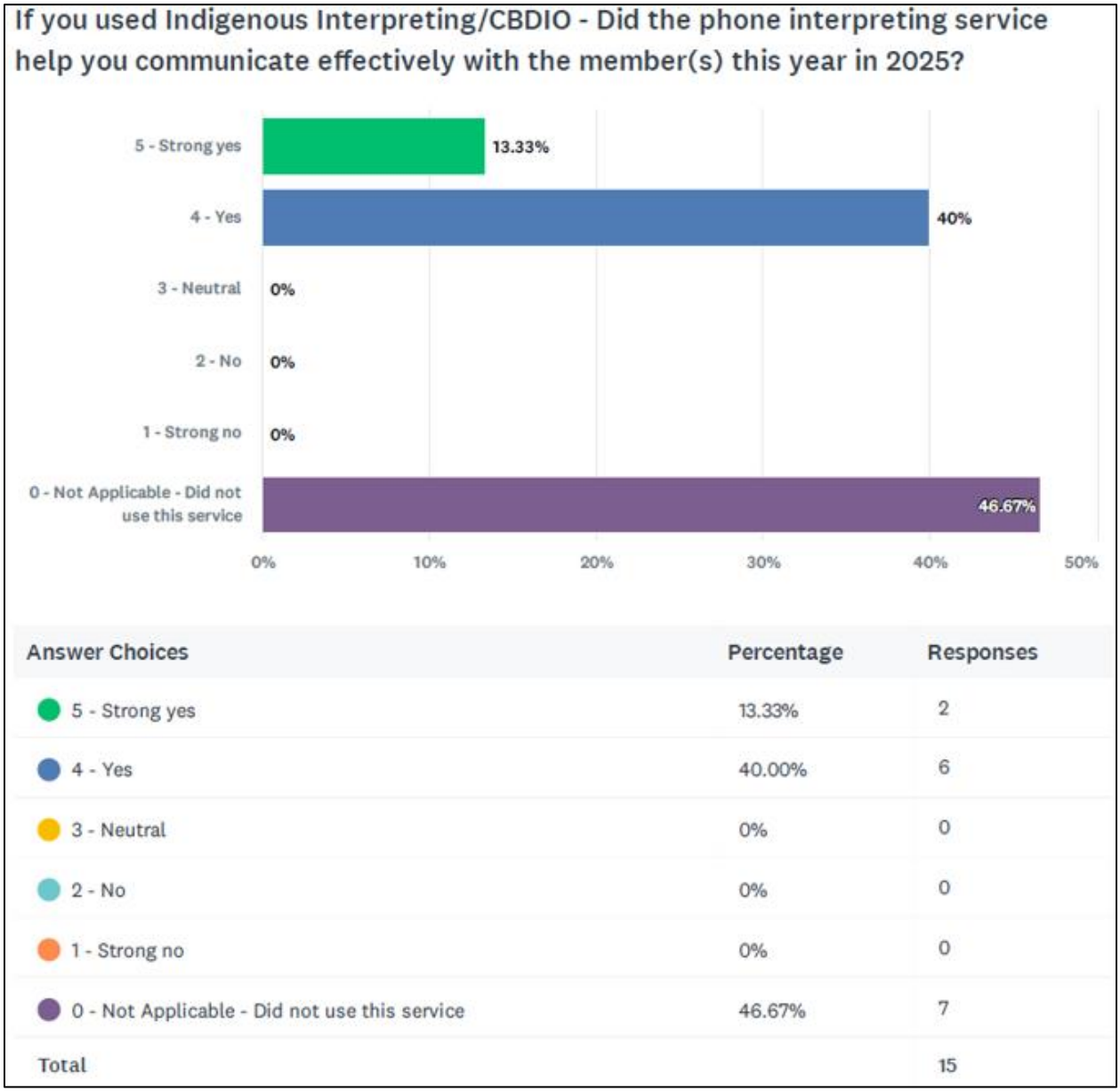


Goal: The interpretation service vendor must maintain a 95% accuracy rate.

Key Findings

- The accuracy rate for the vendor Language Line/Pacific Interpreters was not met. The performance totaled 93.75% against a goal of 95%. The rate was about 1.25 percentage points below the goal. This is an improvement of 11.75 percentage points compared to 2024 ratings.
- Approximately 56.25% of respondents indicated a “Strong yes.” It suggests that over half of the participants found the phone interpreting service to be highly effective in facilitating communication.
- Most of the remaining respondents, 37.25%, answered "Yes." This suggests most staff had positive experiences with the interpreting service.
- 6.25% of respondents were neutral.
- None of the respondents chose "No" or “Strong no.”
- Additional feedback provided for this question from staff includes:
    - Some interpreters are great, and some are not so great.
    - Some interpreters were not accurate, and the experience felt rushed.

Staff Survey Question – If you used Indigenous Interpreting/Centro Binacional para el Desarrollo Indígena Oaxaqueño (CBDIO) – Did the phone interpreting service help you communicate effectively with the members(s) this year in 2025?



Answer Choices	Percentage	Responses
5 - Strong yes	13.33%	2
4 - Yes	40.00%	6
3 - Neutral	0%	0
2 - No	0%	0
1 - Strong no	0%	0
0 - Not Applicable - Did not use this service	46.67%	7
Total		15

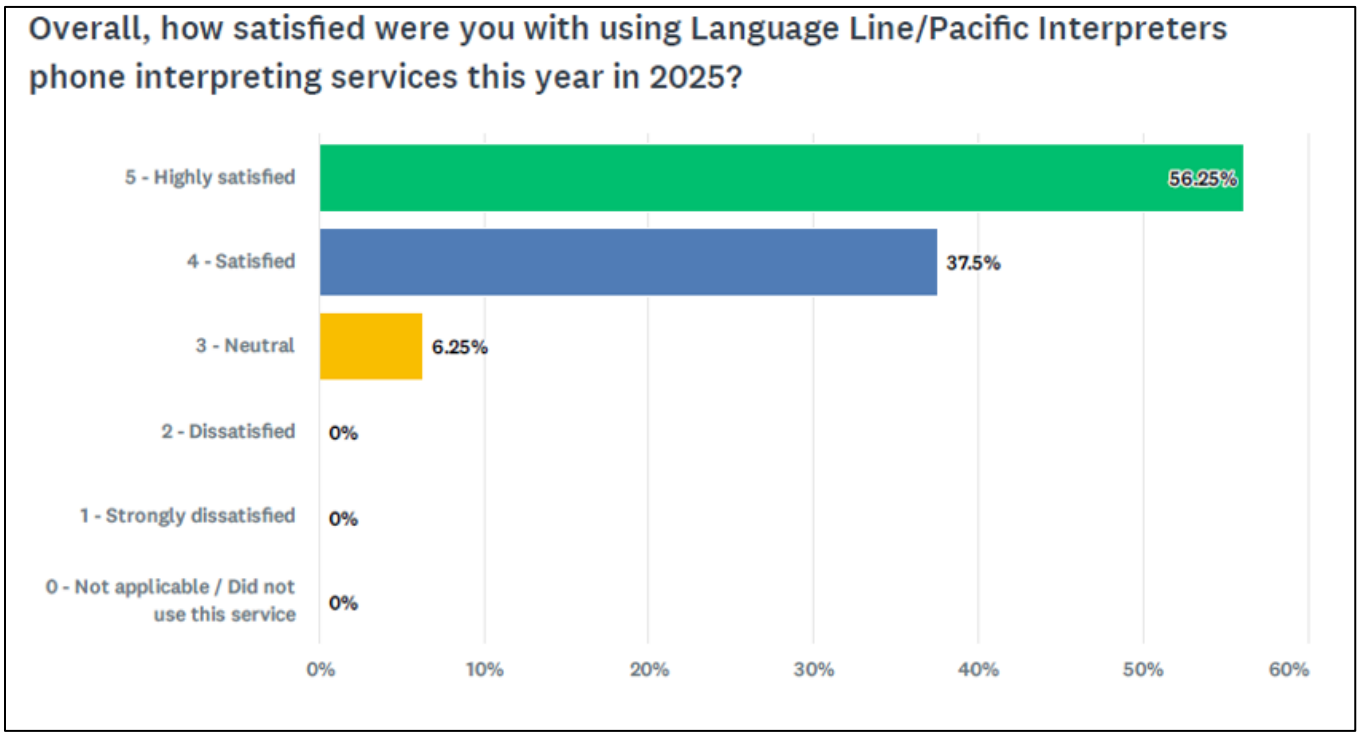
Goal: The interpretation service vendor must maintain a 95% accuracy rate.

Key Findings

- The accuracy rate for the vendor Indigenous Interpreting/CBDIO was met. There was a total of 8 respondents that used the services.
- 7 respondents did not use the service and were not counted in calculating the accuracy rate.
- Of the 8 respondents, 8 reported "Strong Yes" and "Yes" which resulted in 100% accuracy rate. This suggests that all participants found the indigenous interpreting service to be effective in facilitating communication.
- None of the respondents chose "Neutral," "No" or "Strong no."

- There was no additional feedback on this question.

Staff Survey Question – Overall, how satisfied were you with using Language Line/Pacific Interpreters phone interpreting services this year in 2025?

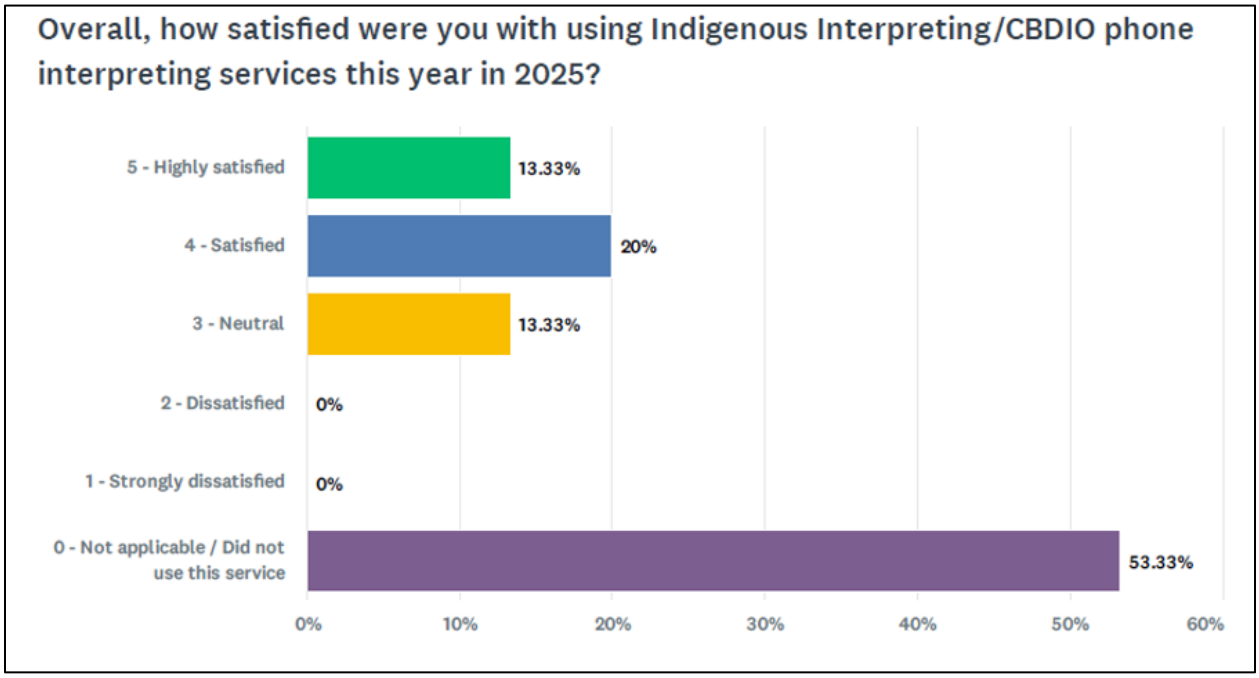


Goal: The interpretation service vendor must maintain a 95% satisfaction rate.

Key Findings

- The overall satisfaction rate for Language Line/Pacific Interpreters was not met. The performance totaled 93.75% against a goal of 95%. The rate was 1.25 percentage points below the goal. This is an improvement of 3.75 percentage points compared to 2024 ratings.
- There was a total of 16 respondents that used the service.
- A majority, 56.25%, indicated they were highly satisfied with the phone interpreting services.
- 37.5% indicated that they were satisfied with the service. This shows that the service was generally acceptable and met the needs of most users.
- There was 1 respondent (6.25%) reported "Neutral".
- There were no respondents that reported "Dissatisfied" or "Strongly Dissatisfied."
- Additional feedback on this question includes:
    - Calls are often dropped by the interpreter's phone.

Staff Survey Question – Overall, how satisfied were you with using Indigenous/ Centro Binacional para el Desarrollo Indígena Oaxaqueño (CBDIO) phone interpreting services this year in 2025?



Goal: The interpretation service vendor must maintain a 95% satisfaction rate.

Key Findings

- The overall satisfaction rate for Indigenous Interpreting/CBDIO was not met. The performance totaled 71% against a goal of 95%. The rate was 24 percentage points below the goal.
- There was a total of 7 respondents that answered this question.
- 8 respondents answered that they did not use this service, or the question was not applicable and were not included in calculating the rates.
- 2 of 7 (28.57%) indicated they were highly satisfied with the indigenous interpreting services.
- 3 of 7 (42.86%) indicated that they were satisfied with the service. This shows that the service was generally acceptable and met the needs of most users.
- 2 of 7 (28.57%) reported "Neutral".
- There were no respondents that reported "Dissatisfied" or "Strongly Dissatisfied."
- There was no additional feedback provided for this question.

6.1. Overall Quantitative Analysis

- Staff were satisfied overall with both vendors and found the services helpful.
- Although interpreter services received high marks from staff and members, there were comments about areas for improvement, including training and consistency with interpreters and the need for more access to Indigenous interpreters. These issues have led to some dissatisfaction among users.
- The negative feedback highlights issues with quality control, and the need for better availability for Indigenous languages, which impacts the overall service experience (see attachments 1-4).
- Addressing these concerns could be an opportunity for the Alliance to work with vendors to improve quality of services and access to indigenous interpreting to support member needs.

6.1.1. Conclusion Based on Quantitative Analysis

- While staff are satisfied with the Alliance's interpreting services, there were areas in need of improvement including availability of Indigenous interpreters and consistency in training and customer service with interpreters.
- For members, they were highly satisfied overall and shared feedback regarding areas where services can be improved including providers offering language assistance, so members do not feel added stress to request services. This indicates opportunities for improvement.

6.1.2. Qualitative Analysis

Barrier Analysis

The healthcare industry faces a significant shortage of in-person medical interpreters, impacting services across all levels of care. Additionally, the lack of support for all languages equally results in uneven access to accurate language assistance services and a lack of inclusivity for patients.

Even when health plans utilize large teams of professional interpreters from national vendors, their services may still fall short of meeting patients' needs. Effective communication not only requires language proficiency but also professionalism and cultural competence.

Overall, Alliance members report high satisfaction with the language assistance services being provided. Continued evaluations of services allow for the Alliance to identify areas in need of improvement as well as areas that are rated higher in comparison to previous years.

Conclusions based on Staff Feedback

- Additional feedback from staff mentions limited availability of Indigenous interpreters. This indicates that while the service is satisfactory, there can be challenges with access depending on the language required.
- Additional feedback from staff mentions the need for quality control of interpreters to ensure accuracy and not rushing through calls with members. This indicates that while the service is satisfactory, there can be challenges with individual interpreters' competencies and customer service skills.

The Alliance follows contractual requirements for language assistance services and has established language service policies, standards, and guidelines that meet regulatory requirements. These services are regularly promoted to members, and vendors are informed about the expectations. Despite all the current activities, gaps in care still exist and this presents an opportunity for the Alliance to implement interventions to improve the overall experience

6.2. Opportunities for Improvements

- Maintain and potentially expand Spanish language interpreting services to meet the high demand.
- Address a few concerns about interpreter customer service and expectations.
- Address a few concerns about increasing access to Indigenous interpreters.
- Address a few concerns about providers being proactive in offering language assistance services to members as opposed to waiting for members to ask for services.
- Continue engaging both internal and external stakeholders to monitor and identify areas for improvement and implement effective interventions to reduce health care inequities.

6.3. Attachment 1 – Member Survey Question

Member Survey Question: Do you have any recommendations to improve this service?

#	RESPONSES
1	Keep assigning interpreters when they need them.
2	Just for the interpreters to continue being kind and doing their job right (as they have been doing).
3	The interpreter must know in greater detail the colloquialisms/regionalisms used by Mexican Spanish speakers.
4	To always offer an interpreter to elder members. Sometimes they may be ashamed to ask for one.

6.4. Attachment 2– Member Survey Question

Member Survey Question: What part of the service contributed to the rating you gave?

All 52 respondents provided feedback to this question, but highlights were included below. Some responses were similar and not included below.

#	RESPONSES
1	It was easy and wasn't stressful.
2	The interpreter was attentive. They explained everything the doctor was saying patiently.
3	It was easy to get an interpreter.
4	The way the interpreter helped her and the well-intended manner they had.
5	It was easy to receive interpreting services. The interpreter was already there when she (the member) arrived at her appointment. The interpreter was very kind.
6	The interpreter was good; the lady was ready to help and kind. In other fields (not Alliance), the customer service that has helped her begrudgingly or has been rude, but not in this case.
7	The interpreter provided comfort and empathy and helped her calm down.
8	The person who was interpreting had good manners from the moment they presented themselves and was very kind.
9	Due to mother's limited English, an interpreter is always needed. With an interpreter present, mother feels more comfortable and at ease that there is better communication between her and the provider.

10	Mother has liked most of the interpreters she has worked with - she likes how they work and feels more comfortable because she can explain herself better and is also understood better.
11	English is understood a bit, but with an interpreter present, there is more accuracy in understanding the details within the appointment.
12	The service is needed; no English is spoken and as long as the same quality is delivered, member will continue to use the service.
13	All the interpreters the member has worked with are very kind and super helpful. Also, very professional.
14	She would use the service again if there were no other option, however, member expresses that it is super uncomfortable to have someone additional in the doctor's office that is not a part of the medical team. Feels vulnerable having to share private medical information with someone who is only there to interpret.
15	Member does not speak English, so it would be necessary. Interpreter explained service thoroughly and introduced herself - overall, very kind.
16	Interpreter provided a thorough explanation - she was precise and on time, father did not have to wait around when his child was called up for his appointment.
17	Mother can have better communication with the doctor, and there are no doubts/unanswered questions about the diagnosis or treatment options.

6.5. Attachment 3 – Member Survey Question

Member Survey Question: What did the interpreter do that contributed to the rating you gave?

All 52 respondents provided feedback to this question, but highlights were included below. Some responses were similar and not included below.

#	RESPONSES
1	She understood everything the doctor was saying and didn't struggle to say what she (the member) needed. The interpreter did a good job.
2	Was kind, interpreted clearly and exactly what she (the member) was saying to the doctor.
3	The interpreter was very kind and resolved the questions she had for the doctor. The interpreter was helpful.
4	The interpreter tried to give her confidence so she could ask her questions. It was good, the interpreter used simple words and was very kind. There are other people (non-Alliance) that are very serious and want to rush things.

5	The lady (interpreter) was very kind and would respond well her inquiries. Everything was well understood as she was very clear. There was good communication.
6	It helped because it was an appointment with a specialist and nobody in the office spoke Spanish. It helped here with nurses and front staff. The interpreter was there since the time she (the member) arrived to almost the time she (the member) left the appointment.
7	Was extremely helpful in interpreting questions that mother of teen was wanting to ask the doctor.
8	Everything that was said by the mother of the child was interpreted with accuracy and made mother feel as if she was the one speaking directly with the doctor. Member states she was a good interpreter.
9	Having an interpreter is very helpful. Although the therapist speaks some Spanish, she is not fluent, and having an interpreter allows for her to fill in the gaps for when the therapist cannot be understood. Interpreter was very kind and polite.
10	Interpreter helped fill out forms, explained/interpreted very well what doctor was explaining and what the parent was responding. She took her time and father of member did not feel rushed.

6.6. Attachment 4 – Staff Survey Question

Staff Survey: Do you recommend anything that could have improved your experience with Indigenous Interpreting/CBDIO phone interpreting services?

#	RESPONSES
1	They (CBDIO) often do not answer phone when you call. hard to count on service if you need to call out same day
2	They (CBDIO) don't know/have an interpreter ID. They should have that ready.
3	More availability. Or a designated time when you can reach someone.

Staff Survey: Do you recommend anything that could have improved your experience with Language Line/Pacific Interpreters phone interpreting services?

#	RESPONSES
1	I notice that apter 3:30pm there are longer wait times for Spanish interpreters
2	They are very good to exceptional.
3	More streamline training.
4	Yes, correcting issues noted above for future interpreting services.

Acting on Identified Opportunities

The Alliance will collaborate and generate a variety of potential interventions to enhance performance on the CLAS programs. The Quality and Health Programs leadership team will lead collaboration efforts and provide updates on the progress of the work plan. The Quality and Health Programs (QHP) leadership team will engage in a discussion with the Member Advisory Committee annually to explore the potential opportunities and gather input for implementation.

Prioritize Opportunities to Improve CLAS and Plan to Evaluate Effectiveness of Interventions

The analysis shows that the Alliance has a solid foundation for language assistance services through its partnership with contracted language assistance vendors. However, feedback from providers, members and staff identified areas for improvement, particularly in addressing having more access to interpreters.

In 2025, the QHP leadership team worked with internal departments including Communications, Provider Relations, and Member Services to identify ways to increase awareness of language assistance services for both members and providers. The QHP leadership team worked with contracted vendors to start offering Virtual Remote Interpreting (VRI) services to increase access to interpreters. For Alliance members, targeted communication was developed to include text message campaigns, a Member Newsletter article, social media, and website posts. Targeted communication has been developed for Providers to ensure they are aware of the language assistance services available, how to access them and best practices when working with Limited English Proficiency (LEP) members.

Conclusion

The Alliance has implemented a comprehensive approach for telephonic interpreter requests to ensure that language assistance services are available, robust, and used effectively for medical needs. Providers can request interpreters directly through language assistance vendors or coordinate with the Alliance staff, ensuring members get the needed support when they need it. In cases where members miss scheduled appointments, providers are encouraged to initiate new requests with language assistance vendors or the Alliance. When interpreters are unavailable, the Alliance recommends rescheduling the appointment for a time when services can be provided. To address availability challenges, the Alliance has worked collaboratively with language assistance vendors to expand interpreter access, including offering extended hours for appointments and adding Virtual Remote Interpreter options.

Additionally, the Alliance plans to conduct annual training for member-facing staff and collects feedback through surveys to continually assess and improve the quality of services. By fostering collaboration with contracted vendors and prioritizing member needs, the Alliance remains committed to delivering effective and accessible language assistance services.

Plan to Evaluate Effectiveness of Interventions

The Alliance is committed to enhancing equitable access to healthcare by addressing the linguistic needs of members. The following plan outlines the evaluation of the effectiveness of interventions aimed at improving interpreting services provided through the CLAS program.

The goals of the evaluation are to assess the accessibility of interpretation services, identify any remaining gaps in service availability, and ensure that interventions align with the Alliance's mission of equitable healthcare language services access.

The Alliance will engage both internal and external stakeholders in this evaluation process. Internally, the organization will collaborate with departments such as Member Services, Provider Relations, and Network Development to identify operational challenges, community impacts, and improvement opportunities.

Externally, the Alliance will work with contracted language assistance vendors to monitor and gather insights and ensure that interventions are informed by the experiences of both members and providers about language service assistance.

The Alliance will use a Plan-Do-Check-Act model to evaluate the effectiveness of changes. The model emphasizes the areas for improvement and the measurement of progress. This approach will be applied to CLAS program measures used to assess the effectiveness of the HE programs. In general, quality improvement initiatives adhere to the following process:

Measure the processes and/or outcomes to improve by identifying areas of deficiency in CLAS program. This involves conducting a thorough quantitative analysis that includes making comparisons of goals to national/regional/internal benchmarks and comparisons to prior performance. When possible, the Alliance will also perform tests of statistical significance using relevant tests (e.g., Chi-square, Z-test, T-test, etc.).

The qualitative analysis will cover the following aspects and will be subject to review by a diverse team of professions including the Chief Medical Officer, Case Management Manager, Health Education Manager, Quality Management Manager, Member Services Manager, Provider Relations Manager, Provider Network Development Manager, Medical Director, and the Director of Quality.

- Clarify knowledge about the process.
- Gain a comprehensive understanding and clearly define the crucial factors and characteristics of the process.
- Conduct a robust analysis that includes brainstorming, categorizing and prioritizing barriers, and/or completing a fish-bone analysis.
- Determine the high-priority areas that the Alliance will concentrate on as a group. Then, prioritize the 4-6 areas according to resource availability.
- Create a plan for enhancing and/or incorporate the necessary documentation into the current Health Equity workplan.
- Develop clear and measurable process indicators to evaluate the impact of improvements.
- Create an interim goal and schedule for continuous assessment.
- Initiate the process of improvement.
- Continuously analyze the situation to monitor progress at regular periods of time.
- Continue to enhance the process as needed.

7. Healthcare Effectiveness Data and Information Set (HEDIS) Program

7.1. Introduction

The Alliance monitors externally developed and internally established clinical quality measures to evaluate the accessibility, quality, effectiveness, timeliness, and outcomes of health care services delivered to members through its contracted provider network. Quality measures may assess health care processes, clinical outcomes, patient experiences, organizational systems, and other factors associated with the delivery of effective, safe, efficient, patient-centered, equitable, and timely care.

The Alliance calculates and reports measure results using data from multiple administrative, clinical, and supplemental sources, including, but not limited to:

- Annual National Committee for Quality Assurance (NCQA) HEDIS submissions
- Annual Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS) reporting
- Medical, behavioral health, pharmacy, and dental claims and encounter data
- Claims and encounter data submitted by contracted primary care and specialty providers
- Claims and encounter data from ancillary providers, including hospitals, laboratories, imaging facilities, pharmacies, and other service providers
- Electronic health record data
- Laboratory and pharmacy data
- State and regional immunization registry data
- Medical record review results
- Provider-submitted supplemental data
- Member eligibility, enrollment, and demographic information
- Care management and population health program data
- Health information exchanges and other approved electronic clinical data sources
- Member experience and satisfaction survey results, when applicable

The collection, measurement, and reporting of clinical quality information allow the Alliance to assess the care received by members, compare performance with established standards, and identify areas requiring further evaluation. These measures support the assessment of:

- Access to primary, specialty, behavioral health, dental, and preventive care
- Timeliness of recommended services and follow-up care
- Preventive screenings, immunizations, and well-care visits
- Maternal and reproductive health services
- Behavioral health and substance use services
- Oral health and dental preventive services
- Management of acute and chronic health conditions
- Medication use, adherence, and appropriate treatment
- Care coordination and transitions between care settings
- Clinical processes and adherence to evidence-based care recommendations
- Health outcomes and potentially avoidable complications
- Differences in performance among geographic and demographic populations
- Health disparities and opportunities to advance health equity

- Completeness and accuracy of clinical and administrative data
- Effectiveness of quality improvement, population health, and care management programs
- Progress toward internal, state, and national performance goals

For the Medi-Cal population, DHCS requires managed care plans to report the MCAS annually. MCAS is a set of performance measures selected by DHCS to evaluate Medi-Cal managed care plan performance and accountability. MCAS measures may address areas such as preventive care, access to services, chronic condition management, behavioral health, reproductive health, and oral health.

MCAS includes measures developed and maintained by nationally recognized measure stewards, including:

- The National Committee for Quality Assurance
- The Centers for Medicare & Medicaid Services
- The Dental Quality Alliance
- Other nationally recognized measure developers or stewards selected by DHCS

Measure stewards oversee the specifications, maintenance, and continued integrity of quality measures throughout their lifecycle. The Dental Quality Alliance develops and maintains performance measures specifically focused on oral health care quality, utilization, access, and outcomes.

The Alliance incorporates MCAS monitoring and related performance improvement priorities into its Quality Improvement and Health Equity Transformation Program. MCAS results are used to:

- Evaluate performance against DHCS-established standards and benchmarks
- Identify measures and populations requiring focused analysis
- Monitor county-level and plan-level performance
- Evaluate differences in care and outcomes among member populations
- Establish quality improvement priorities
- Support provider engagement and performance discussions
- Guide population health and care management activities
- Assess the effectiveness of implemented interventions
- Monitor progress over time
- Support regulatory reporting and oversight requirements

Effectiveness of HEDIS Measures

HEDIS is a nationally standardized set of health care performance measures used to evaluate health plan performance across critical areas of care and service. NCQA describes HEDIS as the most widely used set of health care quality measures, with measures focused on areas in which improvement can meaningfully affect members' health and care experiences.

The standardized structure of HEDIS supports consistent collection, auditing, reporting, and comparison of performance information across health plans and reporting periods. HEDIS results assist the Alliance in:

Through ongoing monitoring of HEDIS, MCAS, DQA, and internally developed measures, the Alliance evaluates whether members receive recommended services and whether improvement activities are producing measurable changes in care delivery and health outcomes.

7.2. Results and Performance

The table below compares the Alliance's performance on selected HEDIS measures with the national percentile benchmarks adopted by DHCS. In 2026, the Alliance will continue to prioritize quality improvement initiatives for measures that did not exceed established performance goals for Measurement Years (MY) 2024 and 2025.

The Line of Business (LOB) column reflects the reporting populations submitted to NCQA through the Interactive Data Submission System (IDSS). For MY2023, Santa Cruz and Monterey counties were reported as a combined population (SC/MON), while Merced County was reported separately. Beginning with MY2024 reporting (submitted in 2025), NCQA implemented a single all-plan submission methodology, while DHCS continued to require county-level reporting. As a result of these reporting changes, QIHETP and CLAS evaluations now include county-specific results for Mariposa, Merced, Monterey, San Benito, and Santa Cruz counties. Because the current reporting structure differs from prior years, both plan-level and county-level trend analyses will compare MY2024 and MY2025 data. Measures that fell below the required minimum denominator population for reporting are indicated as such.

Overall, the results show that the Alliance continues to maintain strong performance across a broad range of HEDIS measures, with most county-level reporting populations meeting or exceeding the NCQA 50th percentile benchmark. The All-Plan rates exceeded benchmark for nearly every measure presented, indicating that the organization's quality improvement strategies have been effective in improving clinical outcomes and preventive care delivery across its service area. Particularly strong performance was observed in behavioral health follow-up, chronic disease management, maternal health services, asthma medication management, breast cancer screening, and hypertension control, all of which consistently exceeded benchmark and, in many cases, improved over the previous measurement year.

Behavioral health measures represent a notable organizational strength. Both Follow-Up After Emergency Department Visit for Mental Illness (FUM) and Follow-Up After Emergency Department Visit for Substance Use (FUA) exceeded benchmark across virtually all reporting populations while demonstrating meaningful year-over-year improvement. These results suggest effective collaboration between primary care providers, behavioral health providers, and care management programs to ensure timely post-discharge follow-up and continuity of care. Similarly, Glycemic Status Assessment (GSD) results indicate continued success in diabetes management, with lower rates of poorly controlled diabetes than the benchmark across every county, reflecting sustained performance in chronic disease management.

Maternal health measures also continue to perform exceptionally well. Timeliness of Prenatal Care (PPC-Pre) and Postpartum Follow-Up (PPC-Pst) consistently exceeded benchmarks across most counties, demonstrating strong engagement with pregnant and postpartum members. These results reflect effective outreach, early prenatal enrollment, and coordinated care processes that support healthy maternal and infant outcomes throughout the perinatal period.

Although overall performance is strong, the report identifies several pediatric preventive care measures that continue to exhibit greater variability and represent the primary opportunities for improvement. Childhood Immunizations (CIS-10), Immunizations for Adolescents (IMA-2), Lead Screening in Children (LSC), Topical Fluoride for Children (TFL-CH), Developmental Screening (DEV), and the Well-Child Visit measures (W30-2+, W30-6+, and WCV) account for nearly all county-level performance gaps. These measures require multiple encounters over extended timeframes, rely on

coordination among pediatric providers, families, and public health resources, and are more susceptible to missed opportunities for preventive care than episodic clinical services. As a result, these measures remain important priorities for ongoing quality improvement.

Performance variation also demonstrates the impact of county-specific population characteristics. Santa Cruz and Monterey consistently performed at or well above benchmark across nearly every measure, reflecting stable performance and mature quality improvement infrastructure. Merced demonstrated favorable performance while identifying a limited number of pediatric measures requiring additional attention. In contrast, Mariposa exhibited the greatest variability, with several measures falling below benchmark despite meaningful year-over-year improvement. San Benito similarly experienced variability in selected pediatric measures despite maintaining strong performance in behavioral health and maternal care. Because these counties have smaller eligible populations, individual member outcomes can have a greater influence on reported rates, resulting in more pronounced year-to-year fluctuations. Nevertheless, the consistency of lower performance across several pediatric measures suggests that focused interventions remain warranted regardless of statistical variability.

The report also illustrates an encouraging trend that extends beyond simply meeting benchmarks. Many measures not only exceeded the NCQA 50th percentile but also demonstrated continued improvement compared to MY2024, indicating that quality improvement initiatives are producing measurable gains rather than simply maintaining historical performance. Where declines occurred, most counties remained above benchmark, suggesting that performance remains stable and that isolated decreases do not necessarily indicate deterioration of underlying care processes.

Taken together, these findings demonstrate that the Alliance has established a solid foundation of quality performance across behavioral health, chronic disease management, women's health, and many preventive care services. Future quality improvement efforts should increasingly focus on reducing county-level variation by strengthening pediatric preventive care delivery, particularly in rural and lower-volume counties. Enhancing childhood immunization outreach, increasing completion of developmental and lead screenings, improving well-child visit adherence, expanding dental preventive services, and continuing partnerships with pediatric providers will help close the remaining performance gaps. Sustaining high-performing measures while concentrating resources on these targeted opportunities will position the Alliance to improve both county-level consistency and overall organizational performance in future measurement years.

MCAS Measure Acronym	MCAS Held to MPL Measures	LOB	Rate MY2024	Rate MY2025	2025 Goal NCQA 50th	% Δ from previous year	Goal Achievement Percent of Benchmark	Goal Met
AMR	Asthma Medication Ratio	All Plan	69.69%	70.39%	63.66%	0.70%	6.73% ↗	Y
		Santa Cruz	66.16%	69.20%		3.04%	5.54% ↗	Y
		Monterey	65.05%	71.50%		6.45%	7.84% ↗	Y
		Merced	75.07%	70.02%		-5.05%	6.36% ↗	Y
		Mariposa	~~N/A~~	~~61.90%~~		~~N/A~~	~~-1.76%~~ ↙	EP<30
		San Benito	~~N/A~~	72.00%		~~N/A~~	8.34% ↗	Y
BCS-E	Breast Cancer Screening	All Plan	62.45%	61.61%	55.87%	-0.84%	5.74% ↗	Y
		Santa Cruz	62.21%	67.84%		5.63%	11.97% ↗	Y
		Monterey	66.25%	62.62%		-3.63%	6.75% ↗	Y
		Merced	58.29%	56.60%		-1.69%	0.73% ↗	Y
		Mariposa	~~N/A~~	~~0.00%~~		~~N/A~~	~~-55.87%~~ ↙	EP<30
		San Benito	88.89%	65.12%		-23.77%	9.25% ↗	Y
CBP	Controlling High Blood Pressure	All Plan	74.45%	72.75%	67.88%	-1.70%	4.87% ↗	Y
		Santa Cruz	69.00%	77.00%		8.00%	9.12% ↗	Y
		Monterey	75.57%	72.89%		-2.68%	5.01% ↗	Y
		Merced	75.69%	69.44%		-6.25%	1.56% ↗	Y
		Mariposa	68.00%	68.00%		0.00%	0.12% ↗	Y
		San Benito	71.00%	76.00%		5.00%	8.12% ↗	Y
CCS	Cervical Cancer Screening	All Plan	67.64%	64.66%	52.32%	-2.98%	12.34% ↗	Y
		Santa Cruz	78.00%	64.71%		-13.29%	12.39% ↗	Y
		Monterey	67.07%	68.84%		1.77%	16.52% ↗	Y
		Merced	69.39%	61.14%		-8.25%	8.82% ↗	Y
		Mariposa	44.00%	34.35%		-9.65%	-17.97% ↙	N
		San Benito	63.00%	57.33%		-5.67%	5.01% ↗	Y
CHL	Chlamydia Screening in Women Total	All Plan	61.38%	65.12%	56.30%	3.74%	8.82% ↗	Y
		Santa Cruz	68.77%	72.61%		3.84%	16.31% ↗	Y
		Monterey	61.25%	68.75%		7.50%	12.45% ↗	Y
		Merced	58.42%	57.54%		-0.88%	1.24% ↗	Y
		Mariposa	52.13%	41.35%		-10.78%	-14.95% ↙	N
		San Benito	59.42%	59.46%		0.04%	3.16% ↗	Y
CIS-10	Childhood Immunizations Combo 10	All Plan	35.84%	34.90%	23.89%	-0.94%	11.01% ↗	Y
		Santa Cruz	48.18%	44.51%		-3.67%	20.62% ↗	Y
		Monterey	44.43%	44.17%		-0.26%	20.28% ↗	Y
		Merced	18.88%	20.07%		1.19%	-3.82% ↙	N
		Mariposa	0.00%	5.80%		5.80%	-18.09% ↙	N
		San Benito	29.73%	26.39%		-3.34%	2.50% ↗	Y
DEV	Developmental Screening in the First Three Years of Life	All Plan	52.66%	53.41%	37.40%	0.75%	16.01% ↗	Y
		Santa Cruz	63.87%	49.16%		-14.71%	11.76% ↗	Y
		Monterey	58.27%	62.32%		4.05%	24.92% ↗	Y
		Merced	40.58%	43.09%		2.51%	5.69% ↗	Y
		Mariposa	12.50%	25.79%		13.29%	-11.61% ↙	N
		San Benito	21.74%	18.97%		-2.77%	-18.43% ↙	N
FUA - 30 Day	Follow-Up After Emergency Department Visit for Substance Use	All Plan	44.84%	49.55%	39.10%	4.71%	10.45% ↗	Y
		Santa Cruz	49.13%	53.61%		4.48%	14.51% ↗	Y
		Monterey	47.22%	51.60%		4.38%	12.50% ↗	Y
		Merced	38.35%	39.90%		1.55%	0.80% ↗	Y
		Mariposa	~~24.24%~~	~~31.82%~~		~~7.58%~~	~~-7.28%~~ ↙	EP<30
		San Benito	32.18%	64.00%		31.82%	24.90% ↗	Y

FUM - 30 Day	Follow-Up After Emergency Department Visit for Mental Illness	All Plan	63.95%	66.33%	57.13%	2.38%	9.20% ↗	Y
		Santa Cruz	68.02%	68.93%		0.91%	11.80% ↗	Y
		Monterey	67.17%	68.34%		1.17%	11.21% ↗	Y
		Merced	58.04%	62.45%		4.41%	5.32% ↗	Y
		Mariposa	48.48%	67.21%		18.73%	10.08% ↗	Y
		San Benito	57.02%	69.09%		12.07%	11.96% ↗	Y
GSD	Glycemic Status Assessment for Patients With Diabetes (>9%)	All Plan	29.20%	24.82%	30.41%	4.38%	5.59% ↗	Y
		Santa Cruz	23.00%	26.00%		-3.00%	4.41% ↗	Y
		Monterey	28.26%	21.89%		6.37%	8.52% ↗	Y
		Merced	33.33%	30.00%		3.33%	0.41% ↗	Y
		Mariposa	39.00%	30.00%		9.00%	0.41% ↗	Y
		San Benito	36.00%	23.00%		13.00%	7.41% ↗	Y
IMA-2	Immunizations for Adolescents Combo 2	All Plan	53.35%	56.40%	34.14%	3.05%	22.26% ↗	Y
		Santa Cruz	48.93%	55.08%		6.15%	20.94% ↗	Y
		Monterey	63.97%	68.87%		4.90%	34.73% ↗	Y
		Merced	42.13%	44.27%		2.14%	10.13% ↗	Y
		Mariposa	10.00%	16.22%		6.22%	-17.92% ↙	N
		San Benito	27.03%	37.85%		10.82%	3.71% ↗	Y
LSC	Lead Screening in Children	All Plan	77.13%	82.77%	69.96%	5.64%	12.81% ↗	Y
		Santa Cruz	81.00%	80.29%		-0.71%	10.33% ↗	Y
		Monterey	83.19%	90.76%		7.57%	20.80% ↗	Y
		Merced	64.75%	75.70%		10.95%	5.74% ↗	Y
		Mariposa	42.86%	39.13%		-3.73%	-30.83% ↙	N
		San Benito	81.58%	68.17%		-13.41%	-1.79% ↙	N
PPC-Pre	Timeliness of Prenatal	All Plan	92.46%	90.75%	86.37%	-1.71%	4.38% ↗	Y
		Santa Cruz	89.00%	91.00%		2.00%	4.63% ↗	Y
		Monterey	92.89%	90.29%		-2.60%	3.92% ↗	Y
		Merced	94.00%	89.63%		-4.37%	3.26% ↗	Y
		Mariposa	84.62%	91.67%		7.05%	5.30% ↗	Y
		San Benito	94.00%	89.00%		-5.00%	2.63% ↗	Y
PPC-Pst	Postpartum Follow Up	All Plan	88.56%	91.24%	82.48%	2.68%	4.87% ↗	Y
		Santa Cruz	95.00%	95.00%		0.00%	8.63% ↗	Y
		Monterey	92.39%	94.17%		1.78%	7.80% ↗	Y
		Merced	83.33%	84.44%		1.11%	-1.93% ↙	N
		Mariposa	73.08%	79.17%		6.09%	-7.20% ↙	N
		San Benito	89.00%	94.00%		5.00%	7.63% ↗	Y
TFL-CH	Topical Fluoride for Children - Dental or Oral Health Services	All Plan	24.13%	25.33%	21.60%	1.20%	3.73% ↗	Y
		Santa Cruz	14.02%	14.64%		0.62%	-6.96% ↙	N
		Monterey	27.91%	27.36%		-0.55%	5.76% ↗	Y
		Merced	25.15%	28.42%		3.27%	6.82% ↗	Y
		Mariposa	7.78%	9.94%		2.16%	-11.66% ↙	N
		San Benito	13.16%	16.28%		3.12%	-5.32% ↙	N
W30-2+	Well-Child Visits for Age 15 Months to 30 Month Two or More Well- Child Visits	All Plan	80.58%	83.09%	72.32%	2.51%	10.77% ↗	Y
		Santa Cruz	83.30%	86.74%		3.44%	14.42% ↗	Y
		Monterey	86.12%	88.83%		2.71%	16.51% ↗	Y
		Merced	71.71%	76.81%		5.10%	4.49% ↗	Y
		Mariposa	100.00%	36.51%		-63.49%	-35.81% ↙	N
		San Benito	100.00%	68.73%		-31.27%	-3.59% ↙	N
W30-6+	Well-Child Visits in the First 15 Months Six or More Well-Child Visits	All Plan	70.04%	67.95%	63.38%	-2.09%	4.57% ↗	Y
		Santa Cruz	79.78%	79.81%		0.03%	16.43% ↗	Y
		Monterey	76.22%	75.04%		-1.18%	11.66% ↗	Y
		Merced	55.19%	56.38%		1.19%	-7.00% ↙	N
		Mariposa	0.00%	45.95%		45.95%	-17.43% ↙	N
		San Benito	100.00%	31.09%		-68.91%	-32.29% ↙	N
WCV	Child and Adolescent Well-Care Visits	All Plan	63.32%	63.57%	55.41%	0.25%	8.16% ↗	Y
		Santa Cruz	61.21%	64.92%		3.71%	9.51% ↗	Y
		Monterey	70.84%	70.26%		-0.58%	14.85% ↗	Y
		Merced	56.59%	55.83%		-0.76%	0.42% ↗	Y
		Mariposa	39.29%	37.05%		-2.24%	-18.36% ↙	N
		San Benito	53.42%	58.40%		4.98%	2.99% ↗	Y

Note: EP<30 represents measures whose rate is not reported due to a population of less than 30.

Quantitative Analysis

- The Alliance evaluated 18 measures, totaling 108 individual goals across All Plan, Santa Cruz County, Monterey County, Merced County, Mariposa County, and San Benito County. Out of these measures, 88 met their goals and 20 did not, and three could not be evaluated due to limited eligible population size. MY24 rates for Mariposa County and San Benito County had limited population sizes compared to eligible population sizes reflected in the MY25 rates,
- All measures improved compared to the previous year for All Plan rate, but the lowest-performing measure in MY25 comparing the goal to performance rate for the All-Plan rate was Topical Fluoride for Children - Dental or Oral Health Services. It achieved only 3.73% higher than the goal of 21.6% at a rate of 25.33%.
- The highest performing measure in MY25 All Plan rate that exceeded the goal was Immunizations for Adolescents - Combo 2 in Santa Cruz/Monterey. The rate reached 56.40%. compared to a goal of 34.14%. The measure exceeded the target by 22.26 percentage points.

7.3. MCAS MY2025 Identified Priorities

Plan-Level Analysis

At the organizational level, the Alliance demonstrated strong overall quality performance during MY2025, with 18 All Plan HEDIS measures meeting or exceeding the NCQA 50th percentile benchmark. Performance strengths were observed across behavioral health, chronic disease management, women's health, maternal health, and adult preventive care, reflecting the continued effectiveness of system-wide quality improvement initiatives. The measures that did not meet benchmark were concentrated within pediatric preventive services, indicating that organizational opportunities are focused on improving care delivery for children rather than broad deficiencies across multiple clinical domains.

Behavioral health measures continued to perform exceptionally well. Follow-Up After Emergency Department Visit for Mental Illness (FUM-30) increased from 63.95% to 66.33%, exceeding benchmark by 9.20 percentage points, while Follow-Up After Emergency Department Visit for Substance Use (FUA-30) improved from 44.84% to 49.55%, exceeding benchmark by 10.45 percentage points. These results demonstrate sustained success in coordinating transitions of care following behavioral health crises and reflect effective collaboration among behavioral health providers, primary care, and care management teams.

Chronic disease management also remained an organizational strength. Controlling High Blood Pressure (CBP) achieved a rate of 72.75%, exceeding benchmark by 4.87 percentage points, while Asthma Medication Ratio (AMR) reached 70.39%, exceeding benchmark by 6.73 percentage points. Performance for Glycemic Status Assessment for Patients with Diabetes (GSD >9%) improved from 29.20% to 24.82%. As a lower rate reflects better diabetes control, the Plan outperformed the benchmark by 5.59 percentage points, demonstrating continued success in managing members with poorly controlled diabetes.

Women's health and maternal care measures continued to demonstrate consistently strong performance. Breast Cancer Screening (BCS-E) exceeded benchmark by 5.74 percentage points, while Cervical Cancer Screening (CCS) surpassed benchmark by 12.34 percentage points despite a modest decline from MY2024. Maternal health remained one of the organization's strongest clinical domains, with Timeliness of Prenatal Care (PPC-Pre) achieving 90.75%, exceeding benchmark by 4.38 percentage points, and Postpartum Follow-Up (PPC-Pst) reaching 91.24%, exceeding benchmark by

8.76 percentage points. These results reflect sustained engagement with pregnant and postpartum members and demonstrate the effectiveness of prenatal and maternity care coordination programs.

Childhood Immunization Status (CIS-10) achieved an All-Plan rate of 34.90%, approximately 11 percentage points above the NCQA benchmark of 23.89%. More importantly, county-level performance varied, with Merced and Mariposa falling below benchmark. This variation suggests opportunities to improve vaccine outreach, reminder and recall systems, and documentation practices across pediatric providers.

Topical Fluoride for Children (TFL-CH) also remained above benchmark, with an All-Plan rate of 25.33% compared to the benchmark of 21.60%. Although overall performance improved from MY2024, county-level variation persisted, particularly within rural counties, suggesting opportunities to strengthen integration between pediatric primary care and dental providers to increase delivery of preventive oral health services.

Other pediatric preventive measures, including Developmental Screening (DEV), Immunizations for Adolescents (IMA-2), Lead Screening in Children (LSC), and Child and Adolescent Well-Care Visits (WCV)all exceeded benchmark at the All-Plan level, demonstrating that organization-wide processes are generally effective. However, the county-level analyses reveal that performance remains inconsistent in smaller service areas, particularly Mariposa and San Benito. These findings indicate that future quality improvement efforts should focus less on developing new organization-wide interventions and more on expanding successful practices already implemented in higher-performing counties.

Overall, the Plan-level results show that the Alliance maintains a mature and effective quality improvement program capable of achieving strong performance across most HEDIS measures. The concentration of remaining opportunities within pediatric preventive services suggests that future gains will be achieved by improving access to and completion of recommended childhood preventive care, including well-child visits, immunizations, developmental and lead screenings, and preventive oral health services. By leveraging the successful strategies demonstrated in higher-performing counties and tailoring interventions to the unique needs of rural populations, the Alliance is well positioned to reduce county-level variation while sustaining high performance across its strongest clinical domains.

County-Level Analysis of Priority Quality Improvement Opportunities

Mariposa County

Mariposa County continues to represent the Alliance's highest priority for quality improvement. While several measures demonstrated meaningful year-over-year improvement, Mariposa accounted for the greatest number of measures that failed to achieve the NCQA 50th percentile benchmark. The county's small eligible populations (EP) contribute to greater year-to-year variability; however, the consistency of lower performance across multiple pediatric preventive care measures indicates opportunities for targeted interventions.

The largest opportunities remain within pediatric preventive services. Well-Child Visits in the First 15 Months of Life (W30-6+) improved substantially from 0.00% to 45.95%, representing the largest improvement observed among all county-level measures (+45.95 percentage points). Despite this improvement, performance remained 17.43 percentage points below the NCQA benchmark of 63.38%. Similarly, Well-Child Visits for Children 15 to 30 Months (W30-2+) declined sharply from

100.00% to 36.51%, creating the largest remaining performance gap in the report (35.81 percentage points below benchmark).

Preventive pediatric screenings also remain below benchmark. Developmental Screening (DEV) increased from 12.50% to 25.79%, a gain of 13.29 percentage points, but remained 11.61 percentage points below benchmark. Lead Screening in Children (LSC) declined from 42.86% to 39.13%, leaving the county 30.83 percentage points below benchmark, while Immunizations for Adolescents (IMA-2) improved from 10.00% to 16.22% but remained 17.92 percentage points below target. Childhood Immunization Status (CIS-10) also improved from 0.00% to 5.80% yet remained 18.09 percentage points below benchmark.

Additional opportunities include Topical Fluoride for Children (TFL-CH), which improved modestly from 7.78% to 9.94% but remained 11.66 percentage points below benchmark, and Child and Adolescent Well-Care Visits (WCV), which declined slightly from 39.29% to 37.05%, remaining 18.36 percentage points below benchmark.

Women's health measures also warrant attention. Cervical Cancer Screening (CCS) declined from 44.00% to 34.35%, resulting in a 17.97 percentage-point gap, while Chlamydia Screening in Women (CHL) declined from 52.13% to 41.35%, leaving the county 14.95 percentage points below benchmark.

Despite these challenges, Mariposa demonstrated strong performance in several areas. Behavioral health follow-up improved considerably, with Follow-Up After Emergency Department Visit for Mental Illness (FUM) increasing from 48.48% to 67.21% and Follow-Up After Emergency Department Visit for Substance Use (FUA) improving from 24.24% to 31.82%, although the latter remained unreportable due to having an eligible population less than 30 (EP<30). Maternal care also remained strong, with Prenatal Care (PPC-Pre) improving to 91.67%, exceeding benchmark, and Postpartum Follow-Up (PPC-Pst) improving from 73.08% to 79.17%, although still falling 7.20 percentage points below benchmark.

San Benito County

San Benito County demonstrated strong performance across behavioral health, maternal care, and chronic disease management but experienced significant declines in several pediatric preventive care measures, making this the county's highest priority for improvement.

The most notable declines occurred within the Well-Child Visit measures. W30-6+ decreased dramatically from 100.00% to 31.09%, representing the largest decline among all counties (68.91 percentage points) and leaving performance 32.29 percentage points below benchmark. W30-2+ also declined from 100.00% to 68.73%, falling 3.59 percentage points below benchmark.

Lead Screening in Children (LSC) declined from 81.58% to 68.17%, narrowly missing benchmark by 1.79 percentage points, while Developmental Screening (DEV) decreased from 21.74% to 18.97%, remaining 18.43 percentage points below benchmark. Topical Fluoride for Children (TFL-CH) also remained below benchmark at 16.28%.

Conversely, San Benito performed exceptionally well in behavioral health. FUA-30 improved from 32.18% to 64.00%, exceeding benchmark by 24.90 percentage points, while FUM-30 increased from 57.02% to 69.09%, nearly 12 percentage points above benchmark. Maternal care also remained strong, with Prenatal Care (91.00%) and Postpartum Follow-Up (94.00%) both exceeding the benchmark.

Merced County

Merced County demonstrated stable performance, with most measures meeting benchmark. Opportunities are concentrated within pediatric preventive services rather than broad system-wide performance.

Childhood Immunization Status (CIS-10) remains below benchmark despite improving from 18.88% to 20.07%, remaining 3.82 percentage points below target. Well-Child Visits in the First 15 Months (W30-6+) improved slightly from 55.19% to 56.38% but remained at 7.00 percentage points below benchmark.

Postpartum Follow-Up (84.44%), narrowly missed benchmark by 1.93 percentage points, suggesting opportunities for enhanced postpartum outreach.

Merced otherwise demonstrated strong performance across behavioral health measures, diabetes management, hypertension control, prenatal care, developmental screening, and lead screening, with all exceeding benchmarks.

Santa Cruz County

Santa Cruz County remains one of the Alliance's strongest-performing counties, with nearly every measure exceeding benchmark. Opportunities for improvement are limited and concentrated primarily within pediatric oral health.

Topical Fluoride for Children (TFL-CH) remained below benchmark at 14.64%, falling 6.96 percentage points below target despite modest improvement.

Otherwise, Santa Cruz exceeded benchmark across virtually every measure, including behavioral health follow-up, developmental screening, maternal care, hypertension control, asthma medication management, breast cancer screening, and both well-child visit measures.

Although several preventive measures experienced small year-over-year declines, including Cervical Cancer Screening and Developmental Screening, performance remained comfortably above benchmark.

Monterey County

Monterey County continues to demonstrate consistently high performance and represents one of the Alliance's strongest-performing counties.

Every measure either met or exceeded benchmark except Well-Child Visits in the First 15 Months (W30-6+), which reported 75.04%, well above benchmark, and therefore required no intervention. Measures such as Immunizations for Adolescents, Lead Screening, Behavioral Health Follow-Up, Hypertension Control, Breast Cancer Screening, and Well-Child Visits all exceeded benchmarks by comfortable margins.

While a few measures demonstrated modest year-over-year declines—including Prenatal Care, Hypertension Control, and Lead Screening—all remained significantly above benchmark and do not represent immediate quality concerns.

Overall County Summary

The county-level analysis demonstrates that quality improvement opportunities are concentrated within a small number of counties rather than reflecting organization-wide deficiencies. Mariposa represents the highest priority due to persistent performance gaps across multiple pediatric

preventive care measures despite several encouraging improvements. San Benito should prioritize restoring performance in well-child visits and pediatric screenings following significant year-over-year declines. Merced requires targeted improvement in a small number of pediatric and maternal health measures, while Santa Cruz and Monterey continue to demonstrate consistently high performance with only isolated opportunities for improvement. This pattern supports the use of county-specific quality improvement interventions rather than broad, organization-wide initiatives, allowing the Alliance to focus on resources where the greatest opportunity for measurable improvement exists.

7.4. Evaluation of MY2025 Quality Improvement Interventions

During Measurement Year (MY) 2025, the Alliance maintained a comprehensive portfolio of active quality improvement interventions designed to improve HEDIS and MCAS performance across preventive care, chronic disease management, behavioral health, maternal health, and care transitions. The interventions extended beyond passive education and reporting and included direct provider financial support, workforce development, member incentives, targeted outreach, point-of-care services, technology investments, community events, and structured partnerships with providers and local organizations. Activities were aligned with the 2025 Quality Improvement and Health Equity Workgroup Work Plan and Alliance Strategic Priorities, with particular emphasis on addressing access, workforce, and care-gap closure challenges in Merced County.

Provider and member interventions were selected in response to identified barriers, including difficulty recruiting and retaining clinical staff, limited appointment availability, transportation and access challenges, and gaps in completion of pediatric preventive services. Although the All-Plan rates met the NCQA 50th percentile benchmark for most measures, county-level results showed continued opportunities in Merced County for Childhood Immunization Status—Combination 10, Well-Child Visits in the First 15 Months of Life, and Postpartum Follow-Up. The interventions described below were intended to improve these county-level results while supporting sustained performance across the broader service area.

Provider Strategies

The Alliance continued and expanded the Workforce Support for Care-Gap Closure Grant, which was initially established in late 2023 for the largest Merced County providers. In 2025, the grant was expanded to support locum tenens providers at Merced County with over 1,000 linked members. Grant funding helped practices address staffing shortages and expand access to after-hours and weekend appointments, particularly for school-age children and working parents. Appointment capacity was directed toward visits and services associated with MCAS measures including Child and Adolescent Well-Care Visits (WCV), Well-Child Visits in the First 15 months (W15), Well-Child Visits for Ages 15 Month- 30 Months (w30)

As part of the grant program, the Alliance also reimbursed providers for equipment used to perform point-of-care blood lead screening. This intervention was designed to reduce barriers associated with referring children to a separate laboratory and to allow screening to be completed during the primary care visit. This active intervention was particularly relevant to Lead Screening in Children, for which Merced improved from 64.75% in MY2024 to 75.70% in MY2025, exceeding the NCQA benchmark of 69.96% by 5.74 percentage points.

Workforce recruitment grants continued in 2025 to support community health worker and doula networks. These roles support member navigation, culturally responsive outreach, maternity care, appointment coordination, and connection to community resources. This broader workforce strategy

was intended to strengthen both preventive care and maternal health services. Merced's Timeliness of Prenatal Care rate remained above benchmark at 89.63%, while Postpartum Follow-Up improved from 83.33% to 84.44%, although it remained 1.93 percentage points below the benchmark of 82.48% as displayed in the report's goal-achievement calculation and therefore continued to warrant targeted follow-up.

The Alliance also made technology grants available to providers to improve access, convenience, and care coordination for members. Practices can use the funding to implement technology that facilitates texting and reminder campaigns for members who are overdue for preventive care, approaching an appointment, or due for specific services such as influenza vaccination, well-child visits, breast cancer screening, or other recommended screenings. These interventions complemented the member lists and care-gap reports available through the Alliance's Provider Portal and enabled clinics to convert data into direct outreach.

The Provider Partnership Program continued into its second year, with five of the largest provider clinics in Merced County, with an initial focus on pediatric well-child visits. Participating clinics received focused performance support, care-gap information, and opportunities to test clinic-specific interventions. This strategy was directly aligned with Merced's MY2025 performance for Well-Child Visits in the First 15 Months of Life, which improved from 55.19% to 56.38% but remained 7.00 percentage points below the NCQA benchmark of 63.38%.

The Alliance also continued its forum for Merced County providers to discuss barriers to closing care gaps, local community culture, workforce limitations, and the types of support needed from the Alliance. Information gathered through this forum was used to identify topics for provider lunch-and-learn sessions and to refine future technical assistance. This created a structured feedback process through which providers could help shape interventions rather than receiving standardized strategies that might not address local conditions.

The Alliance partnered with the Merced County Department of Public Health (MCDPH), on the Pediatric Health Workshops which were conducted in March and October for healthcare providers and school nurses, supplemented by the Alliance wide Lunch-and-Learn on vaccine confidence and targeted clinical resources. Quality improvement efforts supported provider performance on the Childhood Immunization Status (CIS Combo 10) measure through ongoing collaboration, including education provided during Clinic Joint Operating Committee (cJOC) and Care-Based Incentive Forensic (CBIF) meetings.

Member Strategies

The Alliance continued the Healthy Start Program through 9/30/2025, originally launched in April 2023, which provides direct gift-card incentives to pediatric members for completing immunizations, well-child visits, and well-care visits. During 2024 and into 2025, the Alliance increased promotion of the program among members, providers, community partners, and internal departments whose staff regularly interact with members. The program was also highlighted in the quarterly Alliance Member Newsletter. These efforts supported the Plan's pediatric preventive care strategy, including Childhood Immunization Status, Immunizations for Adolescents, W30, and WCV.

Member incentive strategies were particularly important in Merced, where Childhood Immunization Status—Combination 10 improved from 18.88% to 20.07% but remained 3.82 percentage points below the NCQA benchmark of 23.89%. The Healthy Start Program and related outreach were intended to

increase completion of the full vaccine series rather than isolated vaccines and to encourage families to complete preventive visits within the required measurement periods.

The Alliance contracted with a vendor in late 2024 to develop new member texting campaigns. Campaigns continued in 2025 remained relevant to MY2025 outreach activities. Messages included new-member welcome texts; influenza and tdap shot reminders; reminders for pediatric well-child, adult preventive visits, cervical cancer screenings, colorectal cancer screenings, breast cancer screenings; nurse advice line, resources for new moms, Health Programs classes for Healthier Living Program (chronic disease self-management), Live Better with Diabetes program (diabetes/prediabetes self-management), and Healthy Weight for Life program (pediatric obesity prevention). Text messaging represented an active outreach strategy intended to prompt members to schedule or complete services rather than relying solely on mailed educational materials.

Additional strategies in Merced County included support for mobile mammography, which brought screening services closer to members and reduced transportation and scheduling barriers. This strategy aligned with the Alliance's broader breast cancer screening activities, including provider care-gap lists, mobile mammography events, member incentives, and health fair outreach.

The Alliance held its third annual community health fair in October to build trust with residents, connect members with health plan and community resources, and provide influenza vaccinations. The health fair supported preventive care engagement through an in-person community setting and included a $25 member gift-card incentive for participating members.

New point-of-service member incentives were also introduced for influenza vaccination among members under two years of age and for well-child visits among members ages 12 through 17. Unlike raffle-based incentives, point-of-service incentives provide an immediate reward at the time the qualifying service is completed. This strategy was intended to increase participation among age groups with persistent preventive care gaps.

During 2025, Merced County's immunization initiatives focused on provider education, community engagement, and member-informed strategies to improve vaccine confidence and childhood immunization rates.

The Alliance held community outreach including WIC Immunization collaborative events held throughout the year in partnership with MCDPH, WIC, First 5, Head Start, and Sutter Rural Health Clinics' mobile unit. Additional public awareness efforts included Back-to-School messaging, member newsletter articles, and social media campaigns promoting childhood immunizations.

To inform future program planning, focus group interviews were conducted with Merced County parents of children ages 2 through 3 to assess immunization knowledge, attitudes, and behaviors. Findings guided future outreach strategies and public health interventions.

7.5. Conclusion

The MY2025 results indicate that measures supported by multiple active interventions performed favorably at the Plan level. Provider reporting, direct member outreach, incentives, workforce and infrastructure grants, community events, and provider partnership activities created multiple opportunities to close care gaps. For example, Merced exceeded benchmarks for Lead Screening in Children, Developmental Screening, Prenatal Care, Breast Cancer Screening, Controlling High Blood Pressure, and behavioral health follow-up measures.

However, selected county-level gaps remained despite the breadth of interventions. In Merced, Childhood Immunization Status—Combination 10 remained below benchmark at 20.07%, and Well-Child Visits in the First 15 Months remained below benchmark at 56.38%. These results suggest that the interventions were appropriately directed toward documented areas of need, but that additional time, refinement, or intensity may be necessary before their full effect is reflected in annual HEDIS rates.

Overall, the Alliance's MY2025 quality improvement strategy reflected an active, multi-level approach to performance improvement. The organization invested directly in provider workforce and infrastructure, expanded clinic appointment capacity, supported point-of-care testing, offered provider and member financial incentives, deployed targeted text and reminder campaigns, and community organizations, and major provider groups. Continued evaluation should assess not only changes in annual rates, but also intervention reach, member participation, appointment completion, care-gap closure, and provider adoption so that the most effective strategies can be sustained and expanded in future measurement years.

8. Care-Based Incentive (CBI) Program

8.1. Introduction

The Care-Based Incentive program promotes the Patient-Centered Medical Home, through evidence-based best practice, access, value, and quality of care while rewarding performance and aligning with both the DHCS Quality Strategy and Alliance Strategic Plan. The CBI program is designed in collaboration with Alliance network providers, prioritizing areas that drive high quality of care and reduce healthcare costs in focusing on improvements in MCAS metrics and coordination of care metrics. The program offers rewards to primary care providers for:

- MCAS metrics above the NCQA Medicaid 50th percentile and for improvement on metrics from one program year to the next.
- Care coordination metrics above the CBI Provider's Comparison Group's 2019 Measurement Period median score for the applicable measure, or Alliance defined benchmarks, and improvement from one program year to the next.

The CBI Program incentivizes The Alliance's provider network with the following goals:

- Improve quality outcomes, as reflected in part by the Medi-Cal Accountability Set (MCAS), including National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) scores;
- Improve member experience;
- Encourage delivery of high value care;
- Improve patient access and utilization of primary care;
- Encouraging the use of disease registries to address population health;
- Encouraging adoption of best-practice care guidelines as recommended by the U.S. Preventive Services Task Force (USPSTF); and
- Reducing disparities in quality or service delivery between groups of members and/or geographic regions.

The Alliance collects data from the following sources:

- Claims and encounter data from contracted primary and specialty care providers

- Claims and encounters from ancillary care providers (e.g., Hospitals, Labs, Radiology centers, etc.)
- Data Submission Tool (DST) through the Alliance's Provider Portal which allows Alliance providers to upload data files via the Provider Portal. This data supplements what cannot be received through claims or labs.

Measuring and reporting these measures helps the Alliance assess the effectiveness of the care members have received. These clinical quality measures are used to evaluate multiple aspects of patient care including:

- Performance with healthcare outcomes and clinical processes.
- Effectiveness of programs used to manage chronic conditions.

8.2. Results and Performance

The table below compares the Alliance's performance between 2024 and 2025 CBI Measures.

CBI Quality of Care Measures

MEASURE	2024	2025	2024-2025 TREND	% CHANGE
Adverse Childhood Experiences (ACEs) Screening in Children and Adolescents	26.60%	29.52%	↑	2.92%
Application of Dental Fluoride Varnish	29.80%	29.97%	↑	0.17%
Developmental Screening in the First 3 Years	53.03%	53.04%	↑	0.01%
Initial Health Appointment (IHA)	34.72%	51.17%	↑	16.45%
Post-Discharge Care	37.63%	53.45%	↑	15.82%
***Ambulatory Care Sensitive Conditions**	6.08%	6.29%	↑	0.21%
***Plan All-Cause Readmissions**	8.52%	8.87%	↑	0.35%
***Preventable Emergency Visits**	13.67%	13.75%	↑	0.08%
Breast Cancer Screening	62.82%	66.11%	↑	3.29%
Cervical Cancer Screening	60.83%	65.68%	↑	4.85%

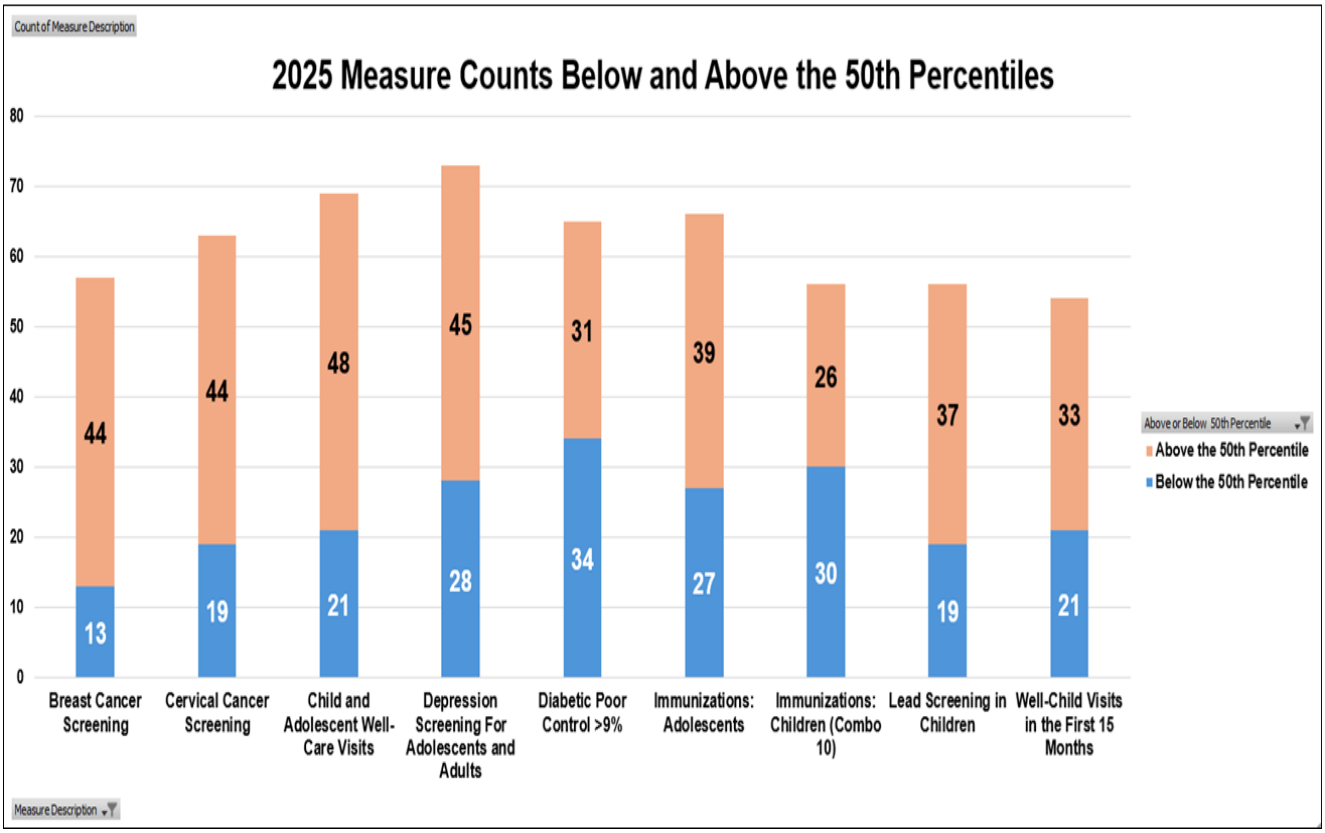
Child and Adolescent Well-Care Visits (3-21)	63.36%	63.51%	↑	0.15%
Depression Screening for Adolescents and Adults	29.97%	38.02%	↑	8.05%
***Diabetic HbA1c Poor Control >9.0%**	36.59%	32.71%	↓	-3.88%
Immunizations: Adolescents	53.20%	56.33%	↑	3.13%
Immunizations: Children (Combo 10)	35.88%	35.49%	↓	-0.39%
Lead Screening in Children	74.22%	82.84%	↑	8.62%
Well-Child Visit In The First 15 Months	72.58%	70.90%	↓	-1.68%

*Indicates a reverse measure, meaning a lower rate is desirable.

Improvement was made for 12 out of 17 measures, taking into account all five counties within the network. A few significant increases are noted in Initial Health Appointments, Post Discharge Care, Lead Screening in Children, and Depression Screening for Adolescents and Adults measures.

Measure Counts Below and Above the 50th Percentile

The graph below illustrates performance on all the Quality-of-Care Measures as they relate to above or below the 50th percentile. Most measures had more providers above the 50th percentile. Measures with the highest number of providers above the 50th percentile were Child and Adolescent Well-Care Visits and Depression Screening for Adolescents and Adults. The measures with the most providers below the 50th percentile are Diabetic Poor Control >9% and Immunizations: Children (Combo 10). A total of 73 provider groups are included in the graph below. However, not all providers qualify for all measures (e.g., internal medicine groups generally do not qualify for pediatric measures); all providers in the table below qualify at minimum for the Depression Screening for Adolescents and Adults measure.



CBI Tier Summary

In prior years, the Alliance implemented a payment adjustment, with a decrease in CBI payment using a tiered system for those providers that did not meet the 50th percentile on Quality of Care measures. Each provider group is categorized as meeting the requirements of one of the five tiers. The Alliance continues to monitor provider performance through the use of tiers, specifically examining the number of measures between the 25th and 49th percentiles, as well as below the 50th percentile for evaluation purposes. The Controlling High Blood Pressure measure is excluded from the Tier Analysis since the measure is new to the 2025 Quality of Care Measure set. This allows providers one year to improve their rates prior to inclusion in the analysis.

The table below takes into account 74 CBI provider groups. The percentage of providers within each tier has remained relatively consistent from Q1 2025 to Q4 2025, but with a slight decrease in Tier 3 indicating that less providers have one-three measures below the 50th percentile.

Tiers	Q1 2025 Tier	Q2 2025 Tier	Q3 2025 Tier	Q4 2025 Tier
All Measures > 50th Percentile	18.57%	28.99%	32.39%	32.86%
Tier 1: 1-3 Measures between 25th and 49th Percentile	15.71%	15.94%	5.63%	10.00%
Tier 2: 4+ Measures between 25th and 49th Percentiles	0.00%	0.00%	0.00%	0.00%
Tier 3: 1-3 Measures <50th Percentile	58.57%	44.93%	56.34%	50.00%
Tier 4: 4+ Measures <25th Percentile	7.14%	10.14%	5.63%	7.14%

Supplemental Data Submission Tool

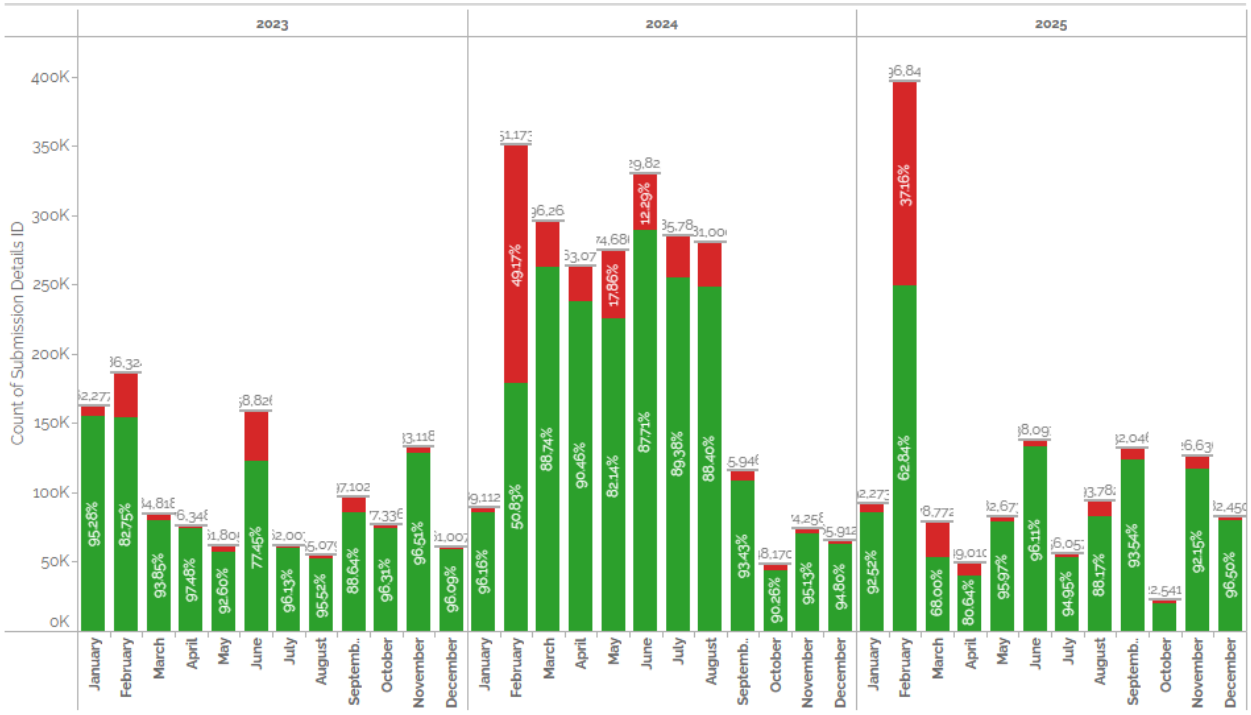
Providers can bridge data gaps as it relates to members receiving care. If there is a discrepancy between Alliance reports and provider records, providers can upload the required information with specified parameters to the Data Submission Tool (DST). Providers upload data to the DST. The table below lists all the measures for which providers can submit data to bridge data gaps.

Measures	
Breast Cancer Screening (Screening and Mastectomies)	Diabetic HbA1c Poor Control >9%
Cervical Cancer Screening	Depression Screening for Adolescents and Adults
Child and Adolescent Well-Visits	Application of Dental Fluoride Varnish
Chlamydia Screening	Immunizations for Adolescents, Children, and Adults
Controlling Blood Pressure	Initial Health Appointment (IHA)
Colorectal Cancer Screening	Lead Screening in Children
Developmental Screening in the First 3 Years	Post-Discharge Care

The graph below illustrates the total number and percentage of rows of data submitted through the DST from January 2023 to December 2025. Green bars indicate accepted rows, red bars indicate rejected rows. Rows of data can be rejected for several reasons including but not limited to:

- Invalid member id
- Invalid procedure code
- Invalid format for date of service or date of birth, and
- Duplicate row of data within the same file

2025 saw the highest number of submissions in February, which is the deadline to submit data for the prior program year. The high utilization within the DST indicates the usefulness of this tool to help bridge data gaps for members' care.



The table below details the number of submissions in 2025 for each of the CBI measures for which DST data is accepted. Depression Screening for Adolescents and Adults relies exclusively on DST submissions due to LOINC codes being the only allowable type of code accepted for the measure. As such, it has the highest number of submissions of all measures. Providers also had the most rejected rows for this measure as most of them found it particularly challenging to extract or crosswalk their existing codes to the required LOINC codes.

Submission Type	Rejected	Accepted	Grand Total
Breast Cancer Screening	4,537	13,140	17,677
Controlling Blood Pressure	3,641	148,480	152,121
Cervical Cancer Screening	11,968	63,591	75,559
Chlamydia Screening	978	3,416	4,394
Colorectal Cancer Screening	4,199	13,247	17,446

Developmental Screening	1,396	14,341	15,737
Depression Screening	39,209	300,695	339,904
Fluoride Varnish	1,727	26,298	28,025
HbA1c	11,508	104,182	115,690
Initial Health Appointment	4,609	31,907	36,516
Immunizations (Children, Adolescents, Adults)	143,562	235,333	378,895
Well-Visits (all)	7,050	100,633	107683
Grand Total	234,384	1,055,263	1,289,647

Overall, the DST is a valuable tool for providers to submit data and bridge existing data gaps that exist between Alliance reports and provider records. Correct and applicable submissions in turn improve provider rates on the respective measures, which is extremely important in quality improvement and representative of overall health plan quality performance audited by DHCS and NCQA.

Provider Engagement – CBI Meetings

The table below shows the CBI team's high level of provider engagement in 2025. There were a total of 276 documented encounters or requests that the team supported. There was a mixture of in-person and virtual meetings, at the providers request. The CBI team offers a variety of different support services such as CBI Forensic meetings, data investigations, Ad Hoc report requests, and training as needed. The Alliance prides itself on the level of support given to providers for providers to be more successful in serving Alliance members.

Meeting	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
CBI Forensics	3	1	1	5	3	3	10	1	7	4	4	6	**48**
Ad Hoc/Other	1	1	2	3	0	2	4	0	2	2	1	1	**19**
CBI Intro or Training):	1	0	0	0	0	0	0	1	5	2	1	1	**11**
cJOC	0	0	0	0	0	0	1	0	0	0	2	2	**5**
Provider Question	12	5	8	12	4	13	20	8	12	15	13	4	**126**
Provider Partnership or Practice Coaching	4	0	1	3	3	4	1	1	2	4	2	4	**29**

DST Investigation	5	0	0	1	0	2	4	0	5	10	2	1	**30**
Total completed	26	7	12	24	10	24	40	11	33	45	25	19	**276**

8.3. Conclusion

The CBI program is a very robust incentive program created to support primary care providers in their efforts to provide quality care for Alliance members. Providers are given many resources including quality reports, the DST to submit supplemental data, and training and communication with the CBI team as needed. From 2024 to 2025, providers mostly improved overall performance and primarily achieved above the 50th percentile on the Quality of Care measures.

9. Reporting Stratified Measures

The Alliance is committed to reducing health disparities and recognizes that racial and ethnic identity data is pivotal in reviewing population health. The purpose of this continued quality initiative is to improve member health outcomes by providing timely, equitable healthcare.

9.1. Member Experience Survey

Introduction

Central California Alliance for Health (The Alliance) conducts the annual Member Experience Survey to evaluate member-reported experiences with healthcare services and identify areas for improvement. For the Measurement Year 2024 survey, The Alliance partnered with Press Ganey, a National Committee for Quality Assurance (NCQA) certified HEDIS Survey Vendor, to administer the CAHPS 5.1 Medicaid Adult Survey. This survey is a critical tool for fulfilling NCQA accreditation requirements and aligns with HEDIS standards.

The survey's objective is to capture insights into member experiences and satisfaction, measure the extent to which plans meet members' expectations and needs, and identify opportunities to enhance care quality and member satisfaction. A core focus is identifying disparities in care and supporting efforts to deliver culturally and linguistically appropriate services to reduce healthcare inequities.

Methodology

The MY 2024 CAHPS® 5.1 Medicaid Adult Survey was conducted by Press Ganey, using a methods approach to ensure comprehensive data collection. The survey timeline included the first questionnaire mailed on March 21, 2025, followed by a second mailing on April 25, 2025. Members were also contacted through phone calls starting March 21, 2025, and the final day to accept completed surveys was June 13, 2025. The survey assessed key aspects of member experiences, such as access to care, communication, customer service, and experiences of unfair treatment due to race, ethnicity, language, or culture.

A total of 245 surveys were completed from an adjusted sample of 2,005 eligible members, resulting in a 12.2% response rate.

Goal

The goal of the Member Experience Survey is to assess healthcare disparities among diverse demographic groups, including race/ethnicity, language, gender identity, and sexual orientation. The Alliance set the member satisfaction standard at 80%.

Result

The Alliance selected survey questions related to race/ethnicity data to assess healthcare disparities. This analysis aims to identify areas of inequity and inform targeted quality improvement efforts to enhance culturally and linguistically appropriate services and reduce disparities.

- Equity in Treatment (Questions 1-3)
    - These questions assess members' experiences with fairness and cultural understanding in their healthcare interactions. The summary rates (% Never or Sometimes) indicate the frequency of minimal or no negative experiences.
- Access to Care (Questions 4-6)
    - The composite scores for access to care provide a comprehensive view of members' experiences with obtaining timely and necessary healthcare services. The summary rates (% Always or Usually) reflect the frequency of positive experiences.
- Communication (Question 7)
    - How Well Doctors Communicate Composite Score: This measure evaluates members' satisfaction with their doctors' communication skills, including listening, explaining, showing respect, and spending adequate time during appointments. The summary rates (% Always or Usually) reflect the frequency of positive experiences.

Equity in Treatment	**White**	**Black or African-American**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**American Indian or Alaska Native**	**Other**	**Hispanic**	**Not Hispanic**
1. In the last 6 months, how often were you treated unfairly at your personal doctor's office because you did not speak English very well?								
Numerator	98	9	17	3	5	76	162	70
Denominator	100	9	17	3	6	76	165	71
Rate	96.9%	100.0%	94.1%	100.0%	100.0%	98.7%	97.5%	97.1%
2. In the last 6 months, how often have you been treated unfairly at your personal doctor's office because of your race or ethnicity?								
Numerator	98	9	17	3	6	75	159	69
Denominator	100	9	17	3	6	76	165	71
Rate	99.0%	100.0%	94.1%	100.0%	100.0%	98.7%	98.7%	98.6%
3. In the last 6 months, how often did your personal doctor (or office staff) say or do something that made you feel that they did not understand your culture or language?								
Numerator	100	8	16	3	6	75	163	68
Denominator	100	9	17	3	6	76	165	71
Rate	99.0%	100.0%	100.0%	100.0%	100.0%	100.0 %	98.8%	100.0%

**Rate: show the summary rate of % Never or Sometimes*

Quantitative Analysis

Question 1

- When asked about unfair treatment due to language proficiency, all races and ethnicity met the goal of 80% member satisfaction.
- Black or African American, Asian, Native Hawaiian or Other Pacific Islander, American Indian or Alaska Native achieved 100% satisfaction, making them the top-performing groups. However, the numerator and denominator are quite small, making them statistically insignificant.
- For Ethnicity Not Hispanic/Latino (97.1) did worse than Hispanic/Latino (97.5%) by 0.4 percentage points.

Question 2

- For experiences of unfair treatment due to race or ethnicity, all groups achieved high marks, meeting the 80% goal.
- Black, or African American, Native Hawaiian or Other Pacific Islander, and American Indian or Alaska Native members reported 100.0 % satisfaction, and were the top-performing racial group, exceeding the goal by 20.0 percentage points.
- Asian members were the most dissatisfied group (94.1%). For ethnicity, Hispanic (98.7%) exceeded the goal by 18.7 percentage points, while Not Hispanic (98.6%) exceeded the goal by 18.6 percentage points. The difference between Not Hispanic and Hispanic was 0.1 percentage points.

Question 3

- In terms of whether personal doctors or office staff demonstrated an understanding of culture or language, all groups exceeded the 80% goal.
- The only group that did not rate this measure at 100.0% was the White population (99.0%).
- For ethnicity, Hispanic/Latino members achieved a satisfaction rate of 98.0 %, which was slightly lower than the 100.0 % satisfaction rate of Not Hispanic/Latino members.

Access to Care and Communication	**White**	**Black or African-American**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**American Indian or Alaska Native**	**Other**	**Hispanic**	**Not Hispanic**
4. Customer Service Composite Score								
Base	37	3	4	0	0	31	63	24
Rate	83.8%	100.0%	100.0	n/a	n/a	87.1	88.1%	85.4%
5. Getting Needed Care Composite Score								
Base	56	1	5	1	3	46	93	35
Rate	81.9%	100.0%	62.5 %	100.0%	100.0%	74.2%	77.6%	80.2%
6. Getting Care Quickly Composite Score								
Base	57	3	5	1	3	41	92	34
Rate	82.4%	75.0%	87.5%	75.0%	100.0%	78.3%	79.1%	781.3%

7. How Well Doctors Communicate Composite Score								
Base	65	4	3	1	3	46	96	37
Rate	95.0%	100.0%	72.9 %	100.0%	100.0%	90.3%	89..1%	95.3%

**Rate: show the summary rate of % Always or Usually*

Quantitative Analysis

Question 4: Customer Service Composite Score

- When the composite score for customer service was analyzed, all races and ethnicities did not meet the satisfaction goal of 80%.
- Black or African American and Asian populations achieved the highest satisfaction rate at 100%, exceeding the goal by 20 percentage points.
- Native Hawaiian or Other Pacific Islander and American Indian or Alaska Native groups had zero respondents.

The other group (87.1%) was the second highest followed by White (83.8%). These groups met the goal.

- For ethnicity, Hispanic members achieved a satisfaction rate of 88.1%, exceeding the goal by 8.1 percentage points, while Not Hispanic members had 85.4%, exceeding the goal by 5.4 percentage points. The difference between the two groups was 2.7 percentage points.

Question 5: Getting Needed Care Composite Score

- When analyzing the getting needed care composite score, White, Black or African American, Native Hawaiian or Other Pacific Islander, and American Indian or Alaska Native met the satisfaction goal of 80%. The Asian and Other group did not meet the goal.
- The Black or African American, Native Hawaiian or Other Pacific Islander, and American Indian or Alaska Native groups achieved the highest satisfaction rate at 100.0%, however combined respondents for all 3 groups only totaled 5 people.
- The Asian population has the lowest satisfaction at 62.5%, or 17.5 percentage points below the goal,
- White (81.9%) was the second highest performing group, 1.9 points above the goal.
- The "Other" group (74.2%) did not meet the goal. Their rate was 25.8 points below the goal.
- For ethnicity, Hispanic members achieved a satisfaction rate of 77.6%, below the goal by 2.4 percentage points. Not Hispanic members had 80.2%, surpassing the goal by 0.2 percentage points.

Question 6: Getting Care Quickly Composite Score

- For "getting care quickly" composite score, the racial groups White, Asian, and American Indian or Alaska Native met the satisfaction goal of 80%.
- Black or African American, Native Hawaiian or other Pacific Islander, and the Other population did not meet the goal of 80%.
- American Indian or Alaska Native achieved the highest satisfaction rate at 100.0%, but also only had one respondent.
- Asian (87.5% and White (82.4%) populations had the next-highest rates, exceeding the goal.
- The Other population (78.3%) was 1.7% below the goal.

- For ethnicity, Hispanic members achieved a satisfaction rate of 79.1%, just missing the goal by 0.9 percentage points, while Not Hispanic members had 81.3% satisfaction, achieving the goal by 1.3 percentage points. The difference between the two groups was 2.2 percentage points.

Question 7: How Well Doctors Communicate Composite Score

- All racial and ethnic groups met the goal of 80% when analyzing member satisfaction rate of how well doctors communicate, aside from 3 Asian members who scored the composite at 72.9%
- Black or African American, American Indian or Alaska Native, and Native Hawaiian or other Pacific Islanders achieved the highest satisfaction rates at 100%, exceeding the goal by 20 percentage points, however, overall response for these groups were significantly low.
- White (95%) had the second-highest rate, exceeding the goal by 15 percentage points.

The Other group (90.3%) was third with a significant response rate compared to other non-white respondents at 46 completed surveys. For ethnicity, Hispanic members achieved a satisfaction rate of 89.1%, exceeding the goal by over 9 percentage points, while Not Hispanic members had 95.3%, meeting the goal by 15.3 percentage points.

Qualitative Analysis

The analysis reveals disparities in member satisfaction across racial and ethnic groups, influenced by several factors related to access, communication, and cultural competence in healthcare services.

Language Barriers and Cultural Competence

- Higher satisfaction rates among groups like Black or African American and American Indian or Alaska Native in "How Well Doctors Communicate" scores (100%) suggest that culturally competent care significantly enhances patient experiences. In contrast, groups with lower satisfaction rates, such as Asian members (72.9%), face challenges in cultural understanding and language communication, particularly for those with limited English proficiency (LEP). Asian members who struggle to explain their symptoms because of language barriers visit doctors less often and get less preventive care, resulting in lower satisfaction compared to those who speak English well.

Accessibility to Care

- Low rates for Asian members in the "Getting Needed Care" and "Getting Care Quickly" composites (62.5% and 75%, respectively) shows potential barriers to timely access. These barriers could stem from geographic limitations, understaffed facilities, or a lack of culturally sensitive outreach efforts.

Conclusion

Hispanic members, when compared to non-Hispanic members showed lower rates overall for the majority of ratings and composite areas. Although there were differences, the differences were often not statistically significant, indicating that most members of different races and ethnicities are satisfied with our services. However, there are lower satisfaction rates specifically related to access to care amongst Asian members. Given the racial makeup of the counties, we serve, as well as the overall respondent make-up for the survey, it is important to say that many racial groups were not represented to make clear statistically significant inferences.

9.2. Glycemic Status Assessment for Patients With Diabetes (GSD)

Introduction

This health disparity analysis assesses glycemic status among Alliance members with diabetes using the Glycemic Status Assessment for Patients With Diabetes (GSD) measure for both MY2024 and MY2025. Administrative data support county-level disparity assessment across race, ethnicity, and gender, while hybrid data evaluate overall county and Medi-Cal aggregate performance. Each measurement year is compared with its applicable NCQA 50th percentile benchmark.

Goal

The goal of this analysis is to review HEDIS healthcare measures to identify opportunities for improvement among Alliance members who have not yet achieved their care objectives. MY2024 and MY2025 GSD performance is evaluated against the applicable 50th percentile benchmark for each measurement year, as supplied from NCQA's Quality Compass.

Product Type	Measurement Year / Measure	50th Percentile Goal	Goal Interpretation
Medicaid HMO	MY2024 GSD: Glycemic Status <8%	57.42%	Higher Rate is Better
Medicaid HMO	MY2024 GSD: Poor Glycemic Status >9%	33.33%	Lower Rate is Better
Medicaid HMO	MY2025 GSD: Glycemic Status <8%	60.58%	Higher Rate is Better
Medicaid HMO	MY2025 GSD: Glycemic Status >9%	30.41%	Lower Rate is Better

Objectives

- Monitor and trend annual HEDIS performance for health equity gaps.
- Identify disparities in care by race, ethnicity, and gender.
- Identify potential opportunities for improvement at the county level.
- Develop interventions to reduce disparities in care.

Methodology

Data Collection

The Alliance adheres to NCQA HEDIS reporting methodology. Administrative results are based on claims, encounters, and approved supplemental data. Hybrid results combine administrative data with medical record review and are presented as final county-level and Medi-Cal aggregate rates.

Methodology for Measurement

- Results are evaluated as MY2024 and MY2025 GSD, using the applicable measurement-year-specific 50th percentile benchmarks.
- Rates are calculated as the numerator divided by the denominator.
- Year-over-year trend is calculated as the MY2025 rate minus the MY2024 rate.
- Groups with fewer than 30 members are displayed but excluded from disparity comparisons and statistical testing.

- For higher-is-better measures, the highest eligible rate is the referent group. For lower-is-better measures, the lowest eligible rate is the referent group.
- Chi-square tests compare compliant/non-compliant counts across eligible demographic groups; $p<0.05$ is considered statistically significant.

Data Limitations

MY2024 reporting limitation for San Benito and Mariposa counties: San Benito and Mariposa were newly added to the plan's HEDIS reporting population for MY2024. During this initial reporting year, historical clinical information and supplemental data feeds for these counties were not yet as complete or mature as those available for the Alliance's established counties. As a result, qualifying glycemic-status results were not fully captured, which artificially lowered the MY2024 numerators and associated rates. The MY2024 results for San Benito and Mariposa should therefore be interpreted as transitional reporting baselines rather than definitive reflections of provider performance or the quality of diabetes care delivered in these counties. MY2025 results benefit from more complete data integration and provide a more reliable basis for assessing current performance and future trends.

Hybrid Reporting Consideration

Hybrid reporting is limited to county-level and Medi-Cal aggregate rates for MY2024 and MY2025. Across all county observations, denominators ranged from 100 to 201 members (MY2024: 100 to 184; MY2025: 100 to 201); the Medi-Cal aggregate denominator was 411 each year. Stratifying these samples by race, ethnicity, or gender would create small, unstable subgroups. Hybrid results therefore include only numerators, denominators, rates, benchmark status, and year-over-year change.

Results

MY2024 and MY2025 GSD Hybrid County and Medi-Cal Aggregate Rates

The table below presents MY2024 and MY2025 GSD hybrid rates at the county and Medi-Cal aggregate levels. County denominators ranged from 100 to 201 across the two measurement years (100 to 184 in MY2024 and 100 to 201 in MY2025), while the Medi-Cal aggregate denominator was 411 each year. Because further stratification would produce small counts and unstable estimates, hybrid results are not stratified by race, ethnicity, or gender. Each result is evaluated against the benchmark applicable to its measurement year, and year-over-year change is used to describe directional movement in overall hybrid performance.

Population / Year	<8% Num/Den	<8% Rate	<8% Benchmark / Status	>9% Num/Den	>9% Rate	>9% Benchmark / Status
Santa Cruz MY2024	62/100	62.00%	57.42% - Met	23/100	23.00%	33.33% - Met
Santa Cruz MY2025	64/100	64.00%	60.58% - Met	26/100	26.00%	30.41% - Met
Monterey MY2024	116/184	63.04%	57.42% - Met	52/184	28.26%	33.33% - Met
Monterey MY2025	138/201	68.66%	60.58% - Met	44/201	21.89%	30.41% - Met

Population / Year	<8% Num/Den	<8% Rate	<8% Benchmark / Status	>9% Num/Den	>9% Rate	>9% Benchmark / Status
Merced MY2024	87/147	59.18%	57.42% - Met	49/147	33.33%	33.33% - Met
Merced MY2025	71/120	59.17%	60.58% - Not Met	36/120	30.00%	30.41% - Met
San Benito MY2024	58/100	58.00%	57.42% - Met	36/100	36.00%	33.33% - Not Met
San Benito MY2025	65/100	65.00%	60.58% - Met	23/100	23.00%	30.41% - Met
Mariposa MY2024	50/100	50.00%	57.42% - Not Met	39/100	39.00%	33.33% - Not Met
Mariposa MY2025	58/100	58.00%	60.58% - Not Met	30/100	30.00%	30.41% - Met
Medi-Cal All MY2024	254/411	61.80%	57.42% - Met	120/411	29.20%	33.33% - Met
Medi-Cal All MY2025	268/411	65.21%	60.58% - Met	102/411	24.82%	30.41% - Met

Medi-Cal Mariposa Population

GSD <8%

The data below presents MY2024 and MY2025 GSD <8% results for the Mariposa population. The higher the rate, the better the performance. Each year is evaluated against its applicable 50th percentile benchmark.

Measurement Year	Administrative Data Num/Den	Administrative Data Rate	Benchmark	Benchmark Status
MY2024 GSD <8%	29/118	24.58%	57.42%	Not Met
MY2025 GSD <8%	54/148	36.49%	60.58%	Not Met

MY2024 and MY2025 GSD Hybrid Rates

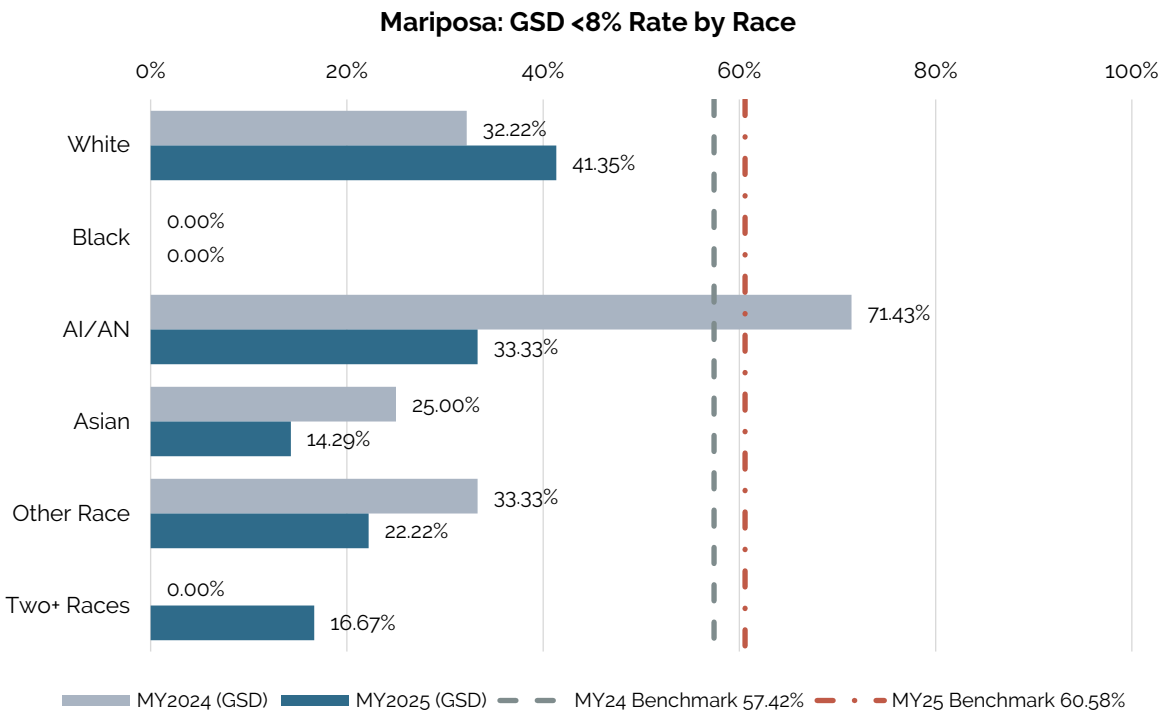
Measurement Year	Hybrid Num/Den	Hybrid Rate	Benchmark	Benchmark Status
MY2024 GSD <8%	50/100	50.00%	57.42%	Not Met

Measurement Year	Hybrid Num/Den	Hybrid Rate	Benchmark	Benchmark Status
MY2025 GSD <8%	58/100	58.00%	60.58%	Not Met

For Mariposa, the MY2024 GSD hybrid rate was 50.00% (50/100) and did not meet the MY2024 GSD 50th percentile benchmark of 57.42%, falling short by 7.42 percentage points. The MY2025 GSD hybrid rate was 58.00% (58/100) and did not meet the MY2025 GSD 50th percentile benchmark of 60.58%, falling short by 2.58 percentage points. The hybrid rate increased by 8.00 percentage points annually, representing improved performance. Further demographic stratification is not presented because dividing the county denominators (100 in MY2024 and 100 in MY2025) by race, ethnicity, or gender would create small subgroup counts and unstable estimates of limited statistical value.

GSD <8% Rate by Race for Mariposa Population

Race	MY24 GSD Administrative Data Den	Num	Rate	MY25 GSD Administrative Data Den	Num	Rate	Difference from Top	YoY Administrative Data Trend
White	90	29	32.22%	104	43	41.35%	0.00%	+9.12%
Black or African American	2	0	0.00%	2	0	0.00%	*N<30	N/A
American Indian and Alaska Native	7	5	71.43%	9	3	33.33%	*N<30	N/A
Asian	12	3	25.00%	14	2	14.29%	*N<30	N/A
Native Hawaiian and Other Pacific Islander	0	0		0	0		*N<30	N/A
Some Other Race	3	1	33.33%	9	2	22.22%	*N<30	N/A
Two or More Races	4	0	0.00%	6	1	16.67%	*N<30	N/A



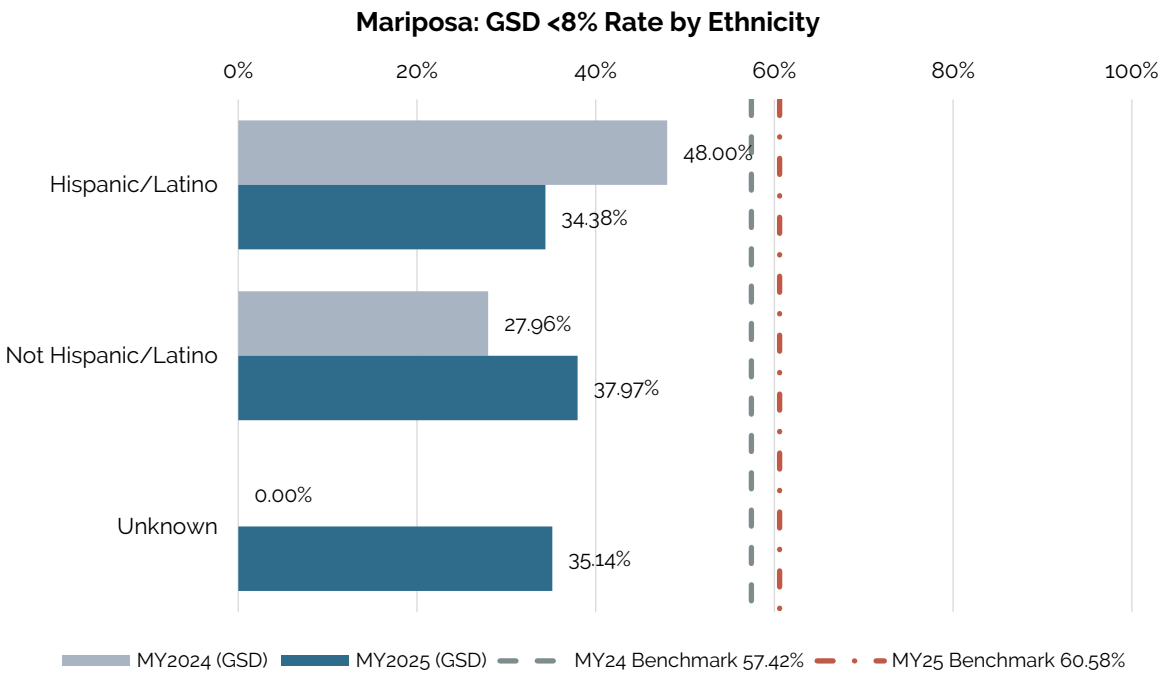
Quantitative Analysis

Administrative Data

- White was the top-performing group at 41.35% (n=104), not meeting the MY2025 GSD 50th percentile benchmark of 60.58%.
- White was the lowest-performing eligible group at 41.35%; the disparity from the top-performing group was 0.00 percentage points.
- White was the only group eligible for year-over-year comparison; its rate increased by 9.12 percentage points.

GSD <8% Rate by Ethnicity for Mariposa Population

Ethnicity	MY24 GSD Administrative Data Den	Num	Rate	MY25 GSD Administrative Data Den	Num	Rate	Difference from Top	YoY Administrative Data Trend
Hispanic/Latino	25	12	48.00%	32	11	34.38%	3.60%	N/A
Not Hispanic/Latino	93	26	27.96%	79	30	37.97%	0.00%	+10.02%
Unknown	0	0		37	13	35.14%	2.84%	N/A



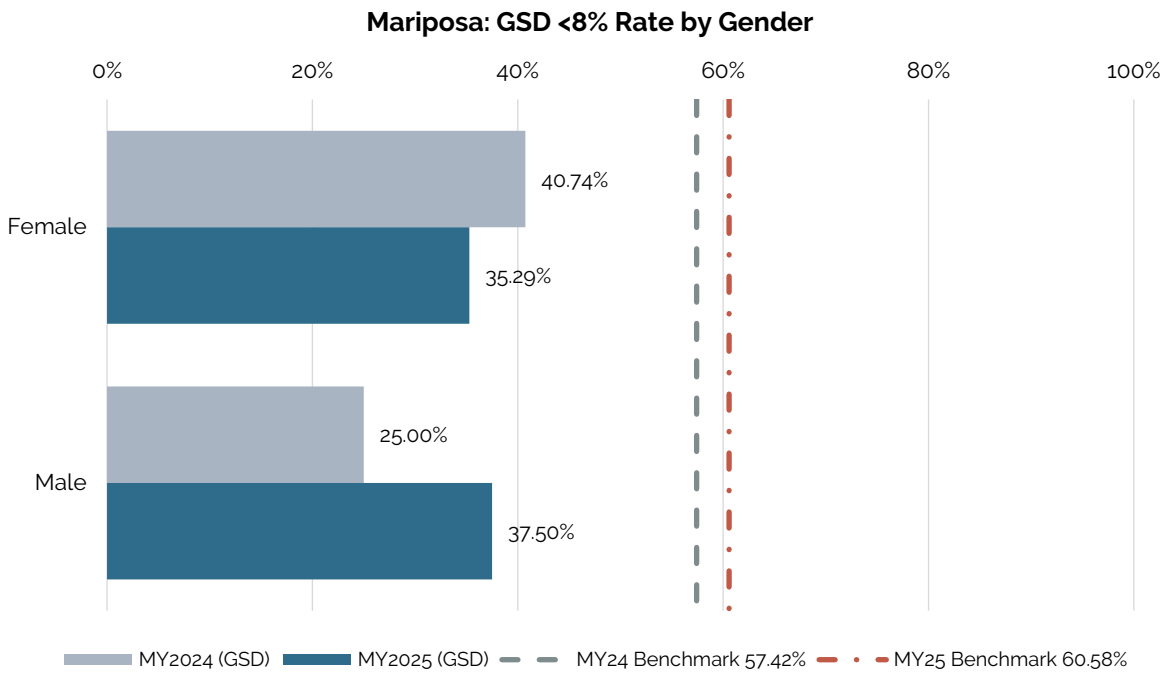
Quantitative Analysis

Administrative Data

- Not Hispanic/Latino was the top-performing group at 37.97% (n=79), not meeting the MY2025 GSD 50th percentile benchmark of 60.58%.
- Hispanic/Latino was the lowest-performing eligible group at 34.38%; the disparity from the top-performing group was 3.60 percentage points.
- Not Hispanic/Latino was the only group eligible for year-over-year comparison; its rate increased by 10.02 percentage points.
- Differences across eligible ethnicity groups were not statistically significant (χ^2=0.1662, p=0.9202).

GSD <8% Rate by Gender for Mariposa Population

Gender	MY24 GSD Administrative Data Den	Num	Rate	MY25 GSD Administrative Data Den	Num	Rate	Difference from Top	YoY Administrative Data Trend
Female	54	22	40.74%	68	24	35.29%	2.21%	-5.45%
Male	64	16	25.00%	80	30	37.50%	0.00%	+12.50%



Quantitative Analysis

Administrative Data

- Male was the top-performing group at 37.50% (n=80), not meeting the MY2025 GSD 50th percentile benchmark of 60.58%.
- Female was the lowest-performing eligible group at 35.29%; the disparity from the top-performing group was 2.21 percentage points.
- Among groups eligible for year-over-year comparison, Male had the largest increase (12.50 percentage points), while Female had the largest decline (5.45 percentage points).
- Differences across eligible gender groups were not statistically significant (χ^2=0.0113, p=0.9152).

Overall Conclusion

For Mariposa, MY2024 GSD administrative performance was 24.58% (29/118) and did not meet the MY2024 GSD 50th percentile benchmark of 57.42%, falling short by 32.84 percentage points. MY2025 GSD administrative performance was 36.49% (54/148) and did not meet the MY2025 GSD 50th percentile benchmark of 60.58%, falling short by 24.09 percentage points. Year-over-year administrative performance increased by 11.91 percentage points, representing improved performance. The MY2024 GSD hybrid rate was 50.00% (50/100) and did not meet the MY2024 GSD 50th percentile benchmark of 57.42%, falling short by 7.42 percentage points. The MY2025 GSD hybrid rate was 58.00% (58/100) and did not meet the MY2025 GSD 50th percentile benchmark of 60.58%, falling short by 2.58 percentage points. Year-over-year hybrid performance increased by 8.00 percentage points, representing improved performance. Hybrid demographic stratification was not performed because further division of the county samples would produce small subgroup counts and unstable estimates.

Health Equity Category	Top Performing	Rate	Lowest Performing	Rate	Disparity
Race	White	41.35%	White	41.35%	0.00%
Ethnicity	Not Hispanic/Latino	37.97%	Hispanic/Latino	34.38%	3.60%
Gender	Male	37.50%	Female	35.29%	2.21%

GSD >9%

The data below presents MY2024 and MY2025 GSD >9% results for the Mariposa population. The lower the rate, the better the performance. Each year is evaluated against its applicable 50th percentile benchmark.

Measurement Year	Administrative Data Num/Den	Administrative Data Rate	Benchmark	Benchmark Status
MY2024 GSD >9%	80/118	67.80%	33.33%	Not Met
MY2025 GSD >9%	88/148	59.46%	30.41%	Not Met

MY2024 and MY2025 GSD Hybrid Rates

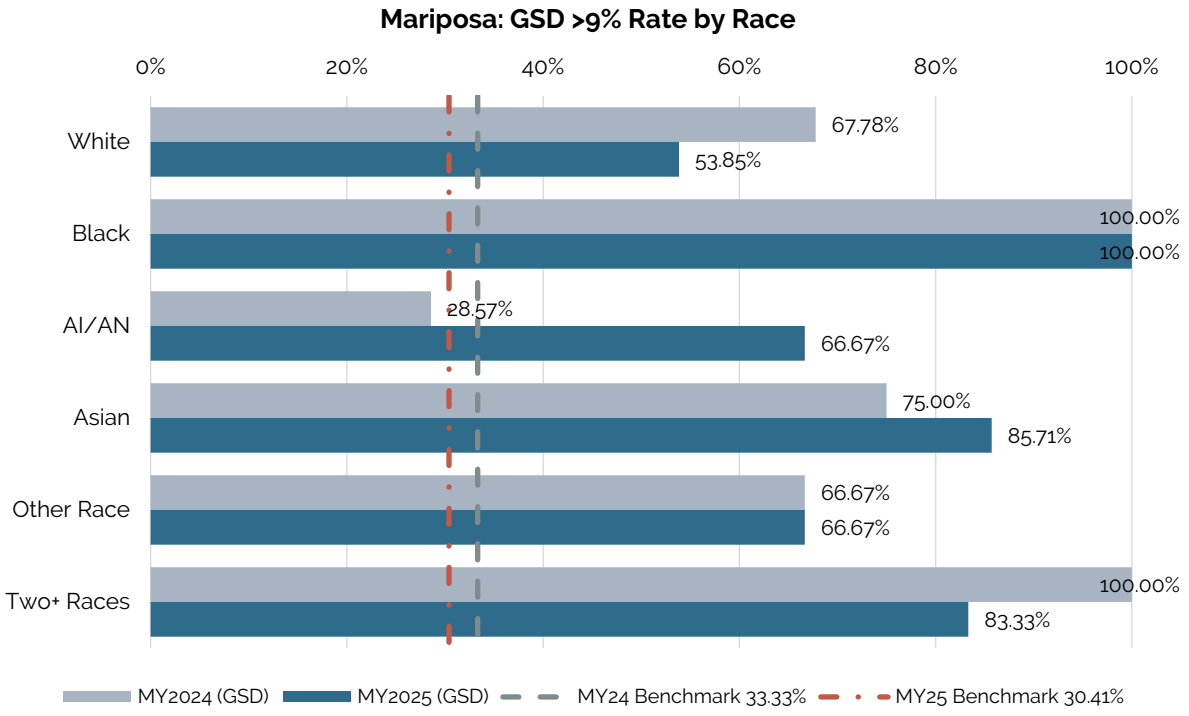
Measurement Year	Hybrid Num/Den	Hybrid Rate	Benchmark	Benchmark Status
MY2024 GSD >9%	39/100	39.00%	33.33%	Not Met
MY2025 GSD >9%	30/100	30.00%	30.41%	Met

For Mariposa, the MY2024 GSD hybrid rate was 39.00% (39/100) and did not meet the MY2024 GSD 50th percentile benchmark of 33.33%, exceeding it by 5.67 percentage points. The MY2025 GSD hybrid rate was 30.00% (30/100) and met the MY2025 GSD 50th percentile benchmark of 30.41% by 0.41 percentage points. The hybrid rate decreased by 9.00 percentage points, representing improved performance. Further demographic stratification is not presented because dividing the county denominators (100 in MY2024 and 100 in MY2025) by race, ethnicity, or gender would create small subgroup counts and unstable estimates of limited statistical value.

GSD >9% Rate by Race for Mariposa Population

Race	MY24 GSD Administrative Data Den	Num	Rate	MY25 GSD Administrative Data Den	Num	Rate	Difference from Top	YoY Administrative Data Trend
White	90	61	67.78%	104	56	53.85%	0.00%	-13.93%

Race	MY24 GSD Administrative Data Den	Num	Rate	MY25 GSD Administrative Data Den	Num	Rate	Difference from Top	YoY Administrative Data Trend
Black or African American	2	2	100.00%	2	2	100.00%	*N<30	N/A
American Indian and Alaska Native	7	2	28.57%	9	6	66.67%	*N<30	N/A
Asian	12	9	75.00%	14	12	85.71%	*N<30	N/A
Native Hawaiian and Other Pacific Islander	0	0	N/A	0	0	N/A	*N<30	N/A
Some Other Race	3	2	66.67%	9	6	66.67%	*N<30	N/A
Two or More Races	4	4	100.00%	6	5	83.33%	*N<30	N/A



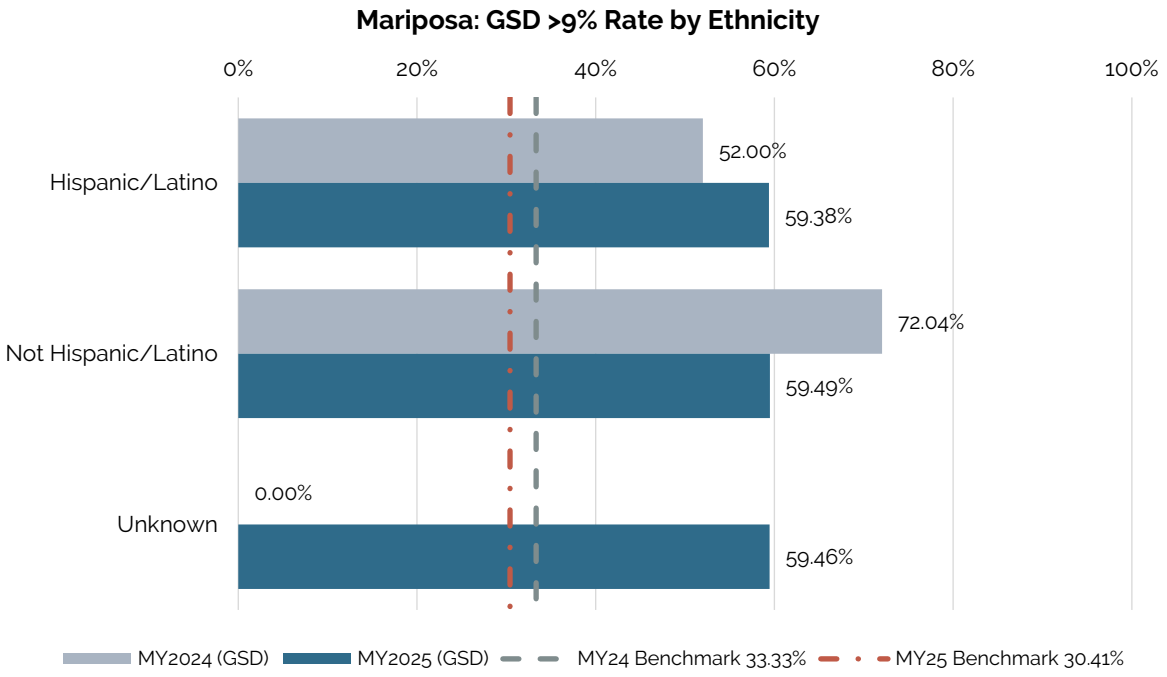
Quantitative Analysis

Administrative Data

- White was the top-performing group at 53.85% (n=104), not meeting the MY2025 GSD 50th percentile benchmark of 30.41%.
- White was the lowest-performing eligible group at 53.85%; the disparity from the top-performing group was 0.00 percentage points.
- White was the only group eligible for year-over-year comparison; its rate decreased by 13.93 percentage points.

GSD >9% Rate by Ethnicity for Mariposa Population

Ethnicity	MY24 GSD Administrative Data Den	Num	Rate	MY25 GSD Administrative Data Den	Num	Rate	Difference from Top	YoY Administrative Data Trend
Hispanic/Latino	25	13	52.00%	32	19	59.38%	0.00%	N/A
Not Hispanic/Latino	93	67	72.04%	79	47	59.49%	0.12%	-12.55%
Unknown	0	0		37	22	59.46%	0.08%	N/A



Quantitative Analysis

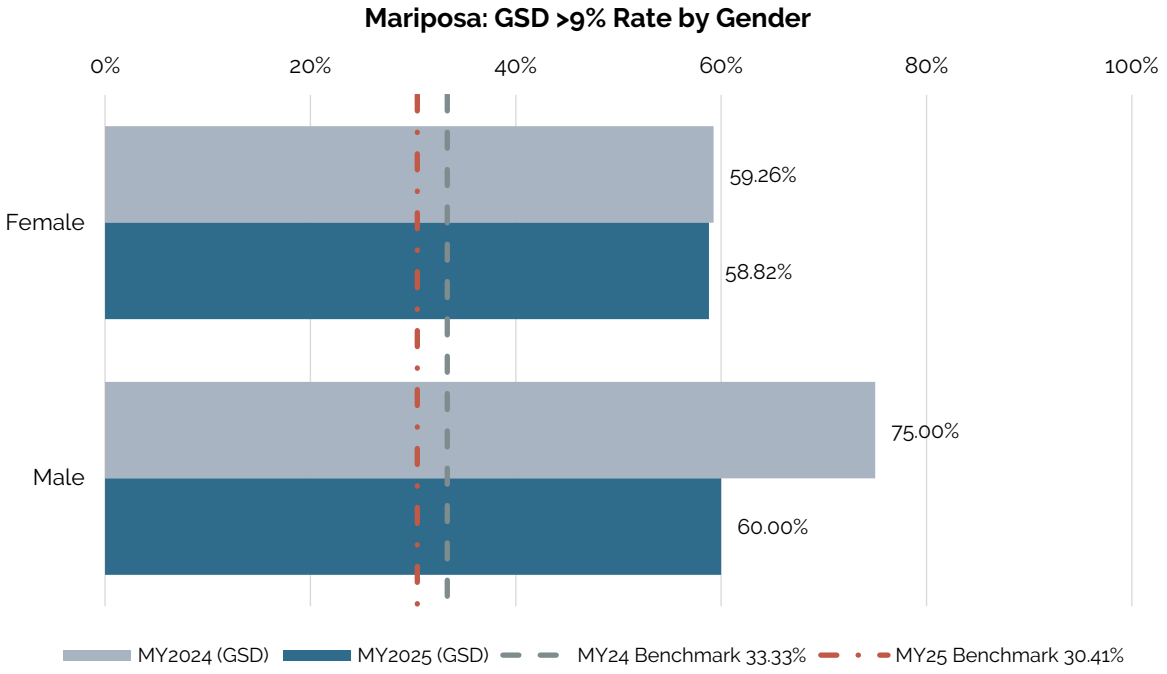
Administrative Data

- Hispanic/Latino was the top-performing group at 59.38% (n=32), not meeting the MY2025 GSD 50th percentile benchmark of 30.41%.
- Not Hispanic/Latino was the lowest-performing eligible group at 59.49%; the disparity from the top-performing group was 0.12 percentage points.

- Not Hispanic/Latino was the only group eligible for year-over-year comparison; its rate decreased by 12.55 percentage points.
- Differences across eligible ethnicity groups were not statistically significant (χ^2=0.0001, p=0.9999).

GSD >9% Rate by Gender for Mariposa Population

Gender	MY24 GSD Administrative Data Den	Num	Rate	MY25 GSD Administrative Data Den	Num	Rate	Difference from Top	YoY Administrative Data Trend
Female	54	32	59.26%	68	40	58.82%	0.00%	-0.44%
Male	64	48	75.00%	80	48	60.00%	1.18%	-15.00%



Quantitative Analysis

Administrative Data

- Female was the top-performing group at 58.82% (n=68), not meeting the MY2025 GSD 50th percentile benchmark of 30.41%.
- Male was the lowest-performing eligible group at 60.00%; the disparity from the top-performing group was 1.18 percentage points.
- Among groups eligible for year-over-year comparison, Male had the largest decrease (15.00 percentage points), while Female had the smallest decrease (0.44 percentage points).
- Differences across eligible gender groups were not statistically significant (χ^2=0.0000, p=1.0000).

Overall Conclusion

For Mariposa, MY2024 GSD administrative performance was 67.80% (80/118) and did not meet the MY2024 GSD 50th percentile benchmark of 33.33%, exceeding it by 34.47 percentage points. MY2025 GSD administrative performance was 59.46% (88/148) and did not meet the MY2025 GSD 50th percentile benchmark of 30.41%, exceeding it by 29.05 percentage points. Year-over-year administrative performance decreased by 8.34 percentage points, representing improved performance. The MY2024 GSD hybrid rate was 39.00% (39/100) and did not meet the MY2024 GSD 50th percentile benchmark of 33.33%, exceeding it by 5.67 percentage points. The MY2025 GSD hybrid rate was 30.00% (30/100) and met the MY2025 GSD 50th percentile benchmark of 30.41% by 0.41 percentage points. Year-over-year hybrid performance decreased by 9.00 percentage points, representing improved performance. Hybrid demographic stratification was not performed because further division of the county samples would produce small subgroup counts and unstable estimates.

Health Equity Category	Top Performing	Rate	Lowest Performing	Rate	Disparity
Race	White	53.85%	White	53.85%	0.00%
Ethnicity	Hispanic/Latino	59.38%	Not Hispanic/Latino	59.49%	0.12%
Gender	Female	58.82%	Male	60.00%	1.18%

Medi-Cal Merced Population

GSD <8%

The data below presents MY2024 and MY2025 GSD <8% results for the Merced population. The higher the rate, the better the performance. Each year is evaluated against its applicable 50th percentile benchmark.

Measurement Year	Administrative Data Num/Den	Administrative Data Rate	Benchmark	Benchmark Status
MY2024 GSD <8%	3,065/6,860	44.68%	57.42%	Not Met
MY2025 GSD <8%	3,562/6,814	52.27%	60.58%	Not Met

MY2024 and MY2025 GSD Hybrid Rates

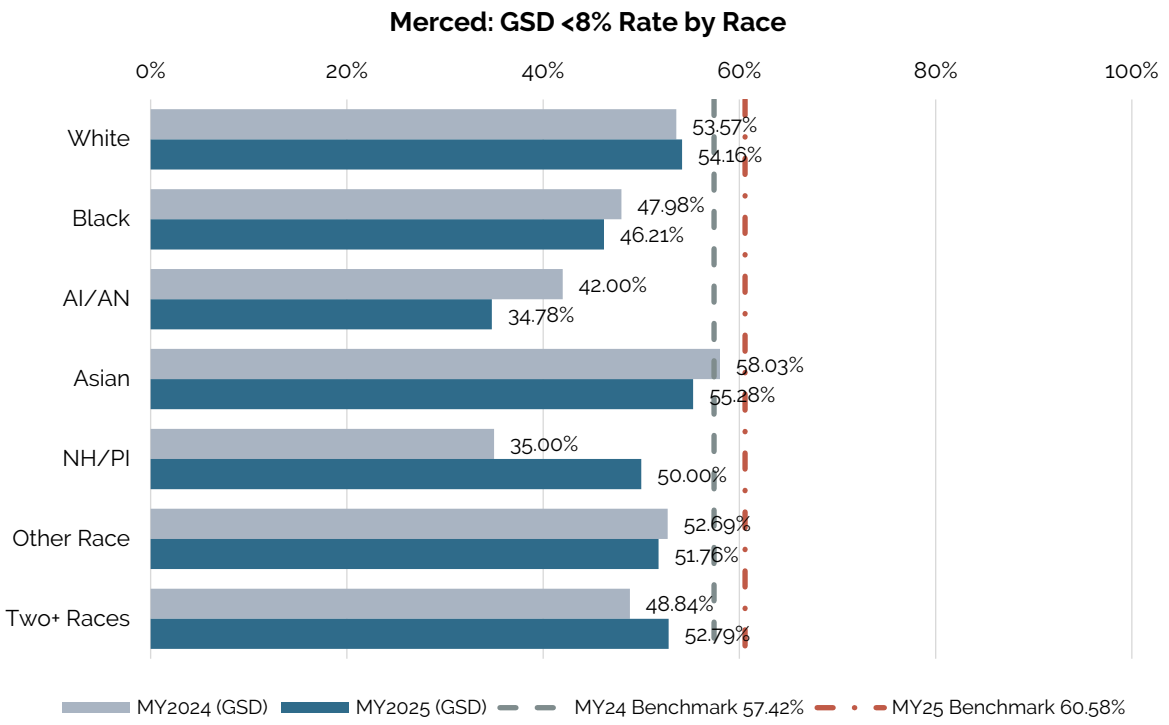
Measurement Year	Hybrid Num/Den	Hybrid Rate	Benchmark	Benchmark Status
MY2024 GSD <8%	87/147	59.18%	57.42%	Met
MY2025 GSD <8%	71/120	59.17%	60.58%	Not Met

For Merced, the MY2024 GSD hybrid rate was 59.18% (87/147) and met the MY2024 GSD 50th percentile benchmark of 57.42% by 1.76 percentage points. The MY2025 GSD hybrid rate was 59.17% (71/120) and did not meet the MY2025 GSD 50th percentile benchmark of 60.58%, falling short by 1.41

percentage points. Year over year, the hybrid rate decreased by 0.01 percentage points and was essentially unchanged. Further demographic stratification is not presented because dividing the county denominators (147 in MY2024 and 120 in MY2025) by race, ethnicity, or gender would create small subgroup counts and unstable estimates of limited statistical value.

GSD <8% Rate by Race for Merced Population

Race	MY24 GSD Administrative Data Den	Num	Rate	MY25 GSD Administrative Data Den	Num	Rate	Difference from Top	YoY Administrative Data Trend
White	3,259	1,746	53.57%	2,393	1,296	54.16%	1.13%	+0.58%
Black or African American	321	154	47.98%	264	122	46.21%	9.07%	-1.76%
American Indian and Alaska Native	50	21	42.00%	23	8	34.78%	*N<30	N/A
Asian	610	354	58.03%	530	293	55.28%	0.00%	-2.75%
Native Hawaiian and Other Pacific Islander	20	7	35.00%	20	10	50.00%	*N<30	N/A
Some Other Race	2,080	1,096	52.69%	1,702	881	51.76%	3.52%	-0.93%
Two or More Races	518	253	48.84%	877	463	52.79%	2.49%	+3.95%



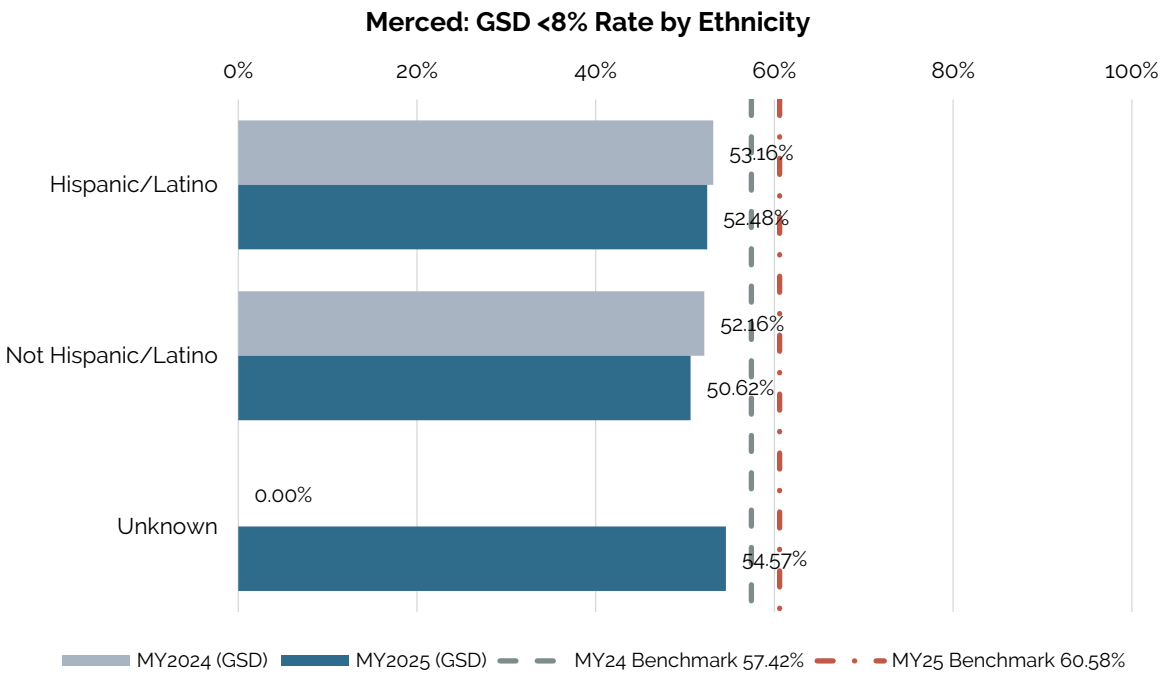
Quantitative Analysis

Administrative Data

- Asian was the top-performing group at 55.28% (n=530), not meeting the MY2025 GSD 50th percentile benchmark of 60.58%.
- Black or African American was the lowest-performing eligible group at 46.21%; the disparity from the top-performing group was 9.07 percentage points.
- Among groups eligible for year-over-year comparison, Two or More Races had the largest increase (3.95 percentage points), while Asian had the largest decline (2.75 percentage points).
- Differences across eligible race groups were not statistically significant (χ^2=8.3403, p=0.0799).

GSD <8% Rate by Ethnicity for Merced Population

Ethnicity	MY24 GSD Administrative Data Den	Num	Rate	MY25 GSD Administrative Data Den	Num	Rate	Difference from Top	YoY Administrative Data Trend
Hispanic/Latino	5,472	2,909	53.16%	5,192	2,725	52.48%	2.08%	-0.68%
Not Hispanic/Latino	1,386	723	52.16%	1,217	616	50.62%	3.95%	-1.55%
Unknown	2	0	0.00%	405	221	54.57%	0.00%	N/A



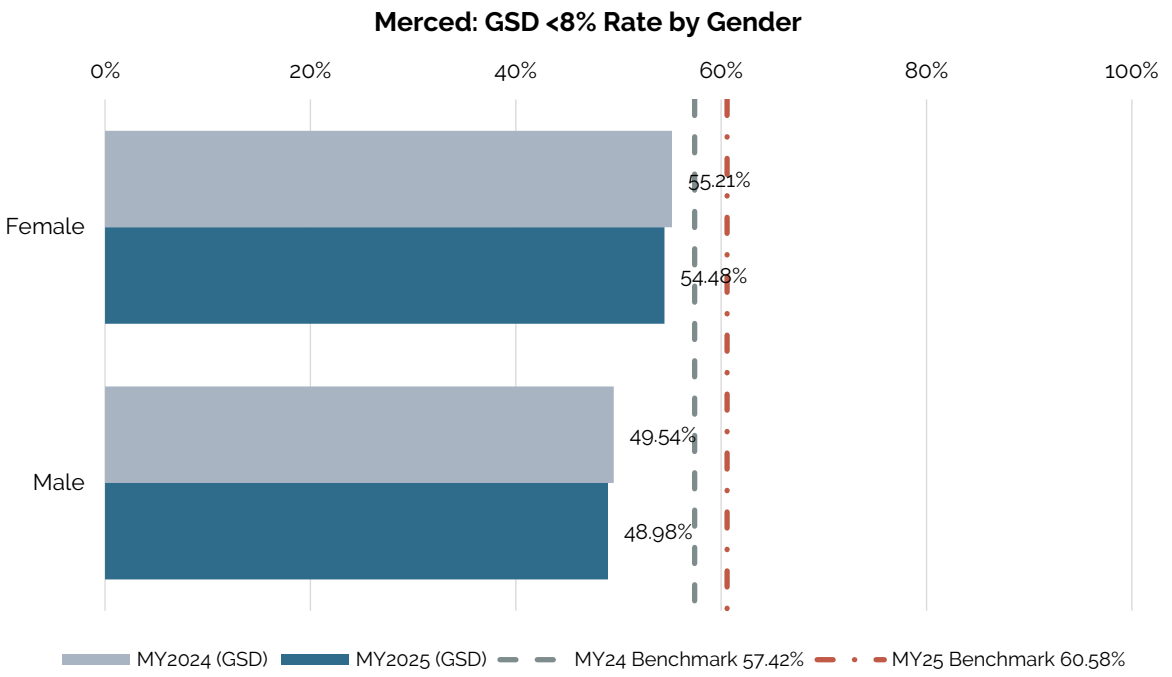
Quantitative Analysis

Administrative Data

- Unknown was the top-performing group at 54.57% (n=405), not meeting the MY2025 GSD 50th percentile benchmark of 60.58%.
- Not Hispanic/Latino was the lowest-performing eligible group at 50.62%; the disparity from the top-performing group was 3.95 percentage points.
- Among groups eligible for year-over-year comparison, Hispanic/Latino had the smallest decline (0.68 percentage points), while Not Hispanic/Latino had the largest decline (1.55 percentage points).
- Differences across eligible ethnicity groups were not statistically significant (χ^2=2.2870, p=0.3187).

GSD <8% Rate by Gender for Merced Population

Gender	MY24 GSD Administrative Data Den	Num	Rate	MY25 GSD Administrative Data Den	Num	Rate	Difference from Top	YoY Administrative Data Trend
Female	4,115	2,272	55.21%	4,082	2,224	54.48%	0.00%	-0.73%
Male	2,745	1,360	49.54%	2,732	1,338	48.98%	5.51%	-0.57%



Quantitative Analysis

Administrative Data

- Female was the top-performing group at 54.48% (n=4,082), not meeting the MY2025 GSD 50th percentile benchmark of 60.58%.
- Male was the lowest-performing eligible group at 48.98%; the disparity from the top-performing group was 5.51 percentage points.
- Among groups eligible for year-over-year comparison, Male had the smallest decline (0.57 percentage points), while Female had the largest decline (0.73 percentage points).
- Differences across eligible gender groups were statistically significant (χ^2=19.6819, p=0.0000).

Overall Conclusion

For Merced, MY2024 GSD administrative performance was 44.68% (3,065/6,860) and did not meet the MY2024 GSD 50th percentile benchmark of 57.42%, falling short by 12.74 percentage points. MY2025 GSD administrative performance was 52.27% (3,562/6,814) and did not meet the MY2025 GSD 50th percentile benchmark of 60.58%, falling short by 8.31 percentage points. Year-over-year administrative performance increased by 7.59 percentage points, representing improved performance. The MY2024 GSD hybrid rate was 59.18% (87/147) and met the MY2024 GSD 50th percentile benchmark of 57.42% by 1.76 percentage points. The MY2025 GSD hybrid rate was 59.17% (71/120) and did not meet the MY2025 GSD 50th percentile benchmark of 60.58%, falling short by 1.41 percentage points. Year-over-year hybrid performance decreased by 0.01 percentage points and was essentially unchanged. Hybrid demographic stratification was not performed because further division of the county samples would produce small subgroup counts and unstable estimates.

Health Equity Category	Top Performing	Rate	Lowest Performing	Rate	Disparity
Race	Asian	55.28%	Black or African American	46.21%	9.07%
Ethnicity	Unknown	54.57%	Not Hispanic/Latino	50.62%	3.95%
Gender	Female	54.48%	Male	48.98%	5.51%

GSD >9%

The data below presents MY2024 and MY2025 GSD >9% results for the Merced population. The lower the rate, the better the performance. Each year is evaluated against its applicable 50th percentile benchmark.

Measurement Year	Administrative Data Num/Den	Administrative Data Rate	Benchmark	Benchmark Status
MY2024 GSD >9%	3,228/6,860	47.06%	33.33%	Not Met
MY2025 GSD >9%	2,642/6,814	38.77%	30.41%	Not Met

MY2024 and MY2025 GSD Hybrid Rates

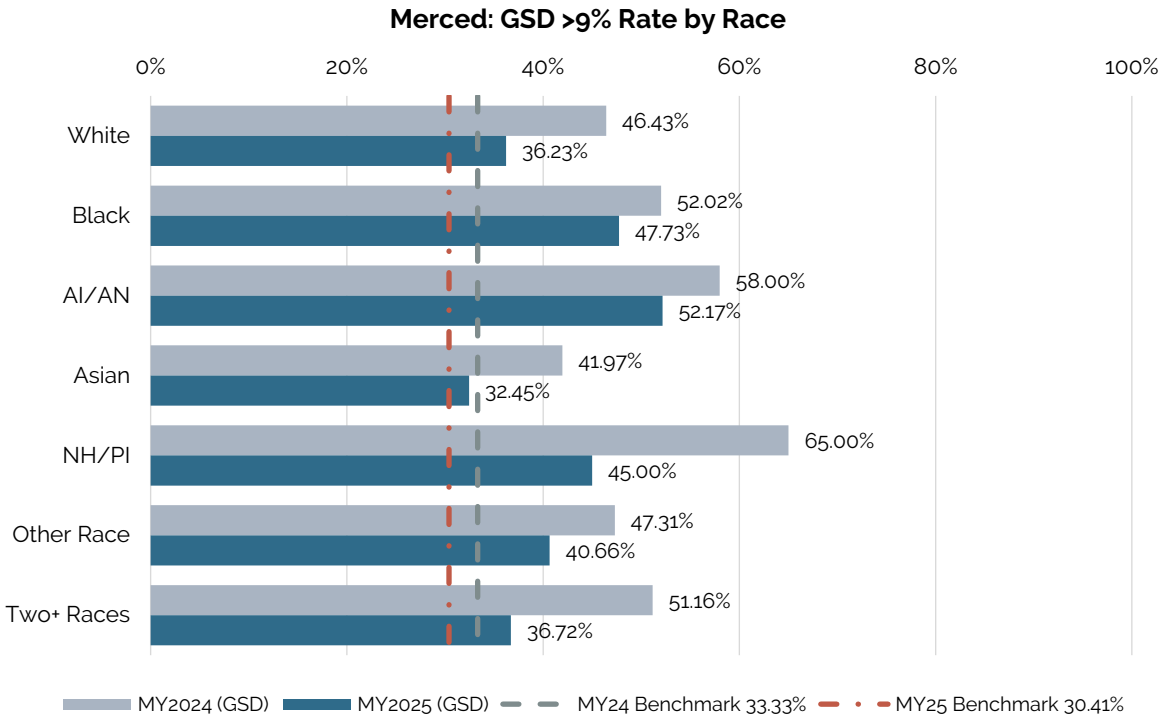
Measurement Year	Hybrid Num/Den	Hybrid Rate	Benchmark	Benchmark Status
MY2024 GSD >9%	49/147	33.33%	33.33%	Met
MY2025 GSD >9%	36/120	30.00%	30.41%	Met

For Merced, the MY2024 GSD hybrid rate was 33.33% (49/147) and met the MY2024 GSD 50th percentile benchmark of 33.33% by 0.00 percentage points. The MY2025 GSD hybrid rate was 30.00% (36/120) and met the MY2025 GSD 50th percentile benchmark of 30.41% by 0.41 percentage points. Year over year, the hybrid rate decreased by 3.33 percentage points, representing improved performance. Further demographic stratification is not presented because dividing the county denominators (147 in MY2024 and 120 in MY2025) by race, ethnicity, or gender would create small subgroup counts and unstable estimates of limited statistical value.

GSD >9% Rate by Race for Merced Population

Race	MY24 GSD Administrative Data Den	Num	Rate	MY25 GSD Administrative Data Den	Num	Rate	Difference from Top	YoY Administrative Data Trend
White	3,259	1,513	46.43%	2,393	867	36.23%	3.78%	-10.19%

Race	MY24 GSD Administrative Data Den	Num	Rate	MY25 GSD Administrative Data Den	Num	Rate	Difference from Top	YoY Administrative Data Trend
Black or African American	321	167	52.02%	264	126	47.73%	15.27%	-4.30%
American Indian and Alaska Native	50	29	58.00%	23	12	52.17%	*N<30	N/A
Asian	610	256	41.97%	530	172	32.45%	0.00%	-9.51%
Native Hawaiian and Other Pacific Islander	20	13	65.00%	20	9	45.00%	*N<30	N/A
Some Other Race	2,080	984	47.31%	1,702	692	40.66%	8.21%	-6.65%
Two or More Races	518	265	51.16%	877	322	36.72%	4.26%	-14.44%



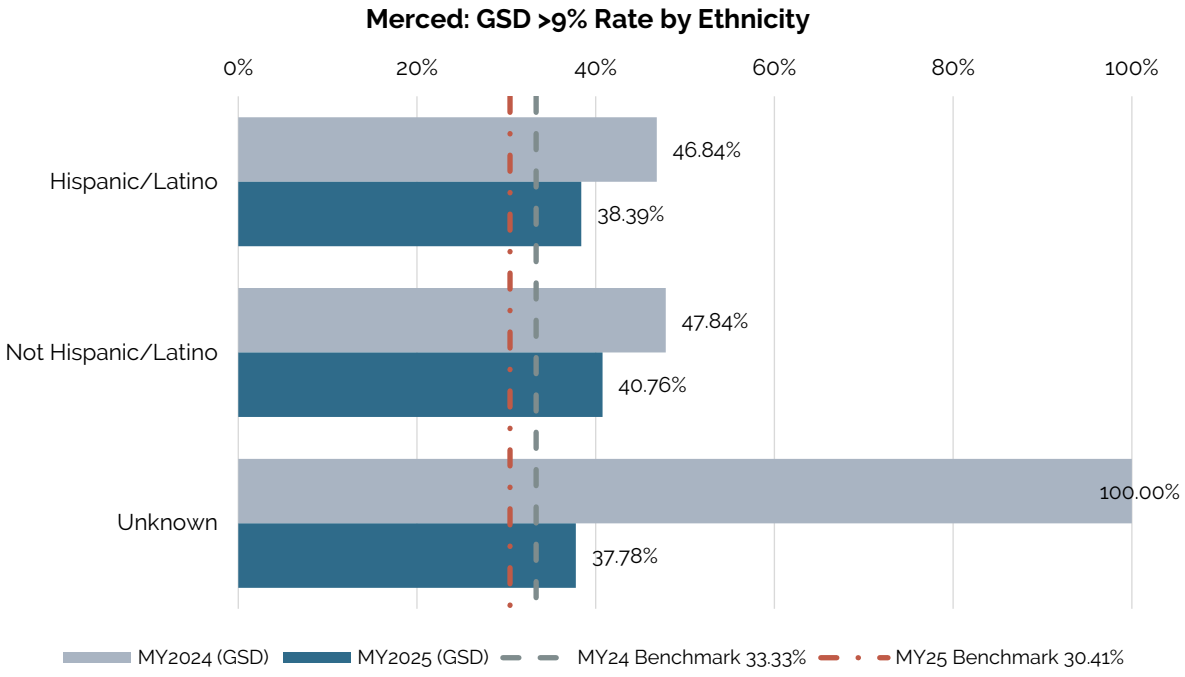
Quantitative Analysis

Administrative Data

- Asian was the top-performing group at 32.45% (n=530), not meeting the MY2025 GSD 50th percentile benchmark of 30.41%.
- Black or African American was the lowest-performing eligible group at 47.73%; the disparity from the top-performing group was 15.27 percentage points.
- Among groups eligible for year-over-year comparison, Two or More Races had the largest decrease (14.44 percentage points), while Black or African American had the smallest decrease (4.30 percentage points).
- Differences across eligible race groups were statistically significant (χ^2=26.3714, p=0.0000).

GSD >9% Rate by Ethnicity for Merced Population

Ethnicity	MY24 GSD Administrative Data Den	Num	Rate	MY25 GSD Administrative Data Den	Num	Rate	Difference from Top	YoY Administrative Data Trend
Hispanic/Latino	5,472	2,563	46.84%	5,192	1,993	38.39%	0.61%	-8.45%
Not Hispanic/Latino	1,386	663	47.84%	1,217	496	40.76%	2.98%	-7.08%
Unknown	2	2	100.00%	405	153	37.78%	0.00%	N/A



Quantitative Analysis

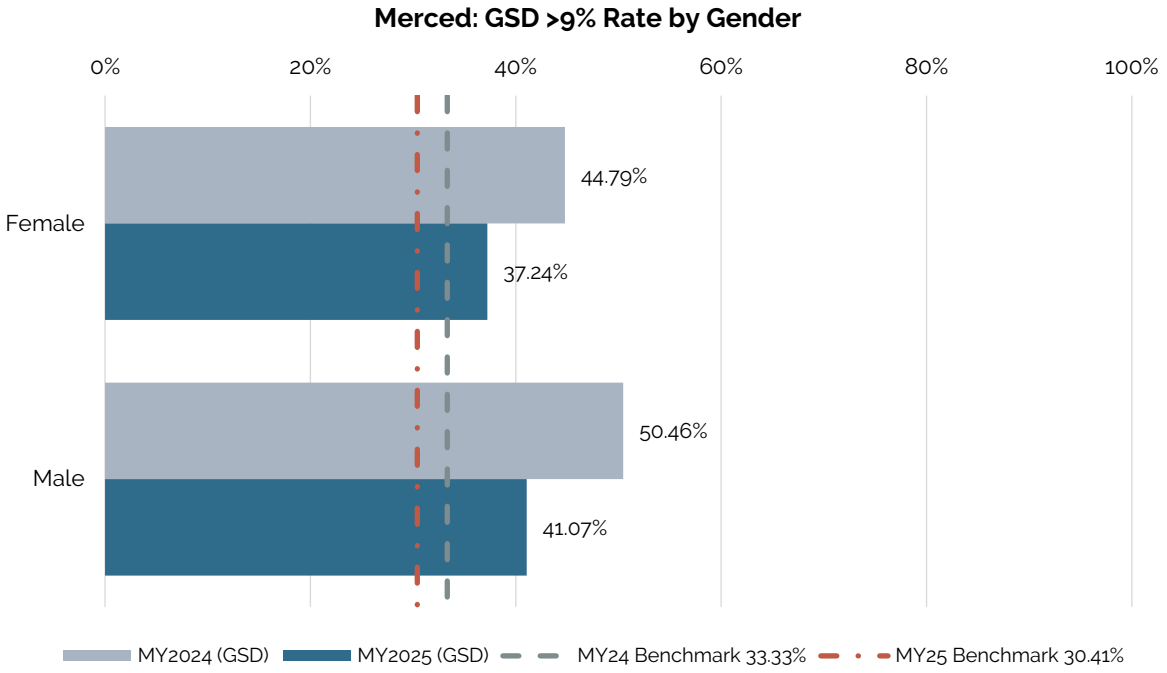
Administrative Data

- Unknown was the top-performing group at 37.78% (n=405), not meeting the MY2025 GSD 50th percentile benchmark of 30.41%.

- Not Hispanic/Latino was the lowest-performing eligible group at 40.76%; the disparity from the top-performing group was 2.98 percentage points.
- Among groups eligible for year-over-year comparison, Hispanic/Latino had the largest decrease (8.45 percentage points), while Not Hispanic/Latino had the smallest decrease (7.08 percentage points).
- Differences across eligible ethnicity groups were not statistically significant (χ^2=2.5124, p=0.2847).

GSD >9% Rate by Gender for Merced Population

Gender	MY24 GSD Administrative Data Den	Num	Rate	MY25 GSD Administrative Data Den	Num	Rate	Difference from Top	YoY Administrative Data Trend
Female	4,115	1,843	44.79%	4,082	1,520	37.24%	0.00%	-7.55%
Male	2,745	1,385	50.46%	2,732	1,122	41.07%	3.83%	-9.39%



Quantitative Analysis

Administrative Data

- Female was the top-performing group at 37.24% (n=4,082), not meeting the MY2025 GSD 50th percentile benchmark of 30.41%.
- Male was the lowest-performing eligible group at 41.07%; the disparity from the top-performing group was 3.83 percentage points.
- Among groups eligible for year-over-year comparison, Male had the largest decrease (9.39 percentage points), while Female had the smallest decrease (7.55 percentage points).
- Differences across eligible gender groups were statistically significant (χ^2=9.9636, p=0.0016).

Overall Conclusion

For Merced, MY2024 GSD administrative performance was 47.06% (3,228/6,860) and did not meet the MY2024 GSD 50th percentile benchmark of 33.33%, exceeding it by 13.73 percentage points. MY2025 GSD administrative performance was 38.77% (2,642/6,814) and did not meet the MY2025 GSD 50th percentile benchmark of 30.41%, exceeding it by 8.36 percentage points. Year-over-year administrative performance decreased by 8.29 percentage points, representing improved performance. The MY2024 GSD hybrid rate was 33.33% (49/147) and met the MY2024 GSD 50th percentile benchmark of 33.33% by 0.00 percentage points. The MY2025 GSD hybrid rate was 30.00% (36/120) and met the MY2025 GSD 50th percentile benchmark of 30.41% by 0.41 percentage points. Year-over-year hybrid performance decreased by 3.33 percentage points, representing improved performance. Hybrid demographic stratification was not performed because further division of the county samples would produce small subgroup counts and unstable estimates.

Health Equity Category	Top Performing	Rate	Lowest Performing	Rate	Disparity
Race	Asian	32.45%	Black or African American	47.73%	15.27%
Ethnicity	Unknown	37.78%	Not Hispanic/Latino	40.76%	2.98%
Gender	Female	37.24%	Male	41.07%	3.83%

Medi-Cal Monterey Population

GSD <8%

The data below presents MY2024 and MY2025 GSD <8% results for the Monterey population. The higher the rate, the better the performance. Each year is evaluated against its applicable 50th percentile benchmark.

Measurement Year	Administrative Data Num/Den	Administrative Data Rate	Benchmark	Benchmark Status
MY2024 GSD <8%	5,351/8,822	60.66%	57.42%	Met
MY2025 GSD <8%	6,107/9,583	63.73%	60.58%	Met

MY2024 and MY2025 GSD Hybrid Rates

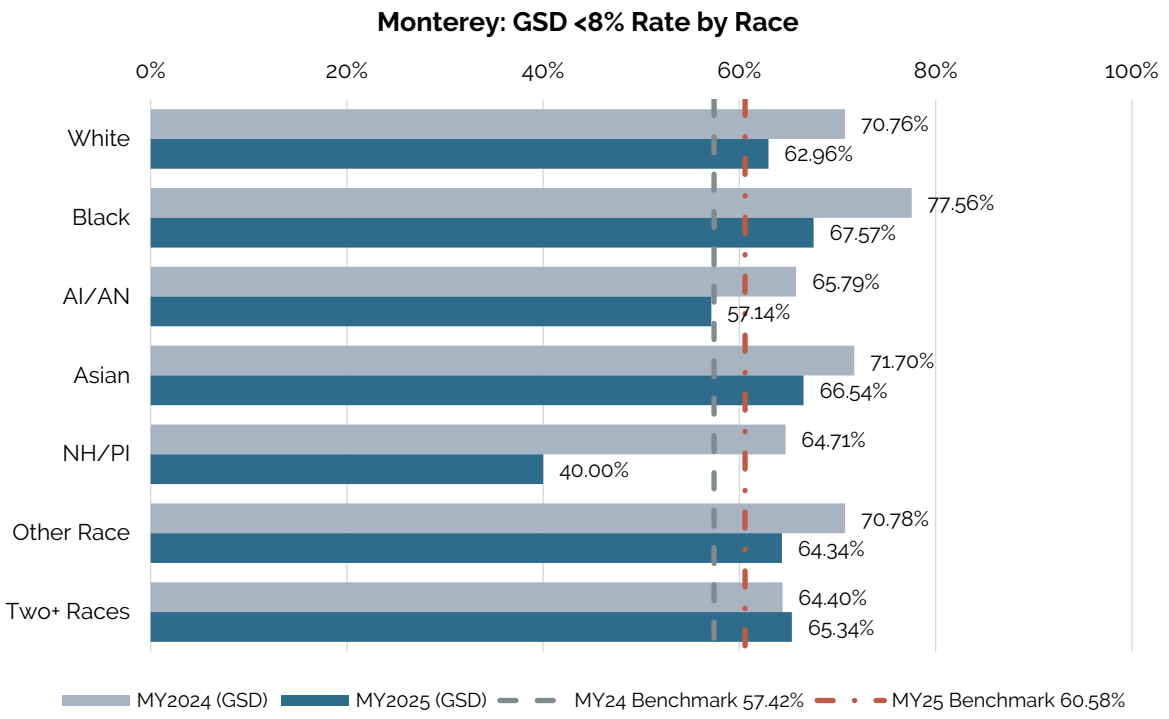
Measurement Year	Hybrid Num/Den	Hybrid Rate	Benchmark	Benchmark Status
MY2024 GSD <8%	116/184	63.04%	57.42%	Met
MY2025 GSD <8%	138/201	68.66%	60.58%	Met

For Monterey, the MY2024 GSD hybrid rate was 63.04% (116/184) and met the MY2024 GSD 50th percentile benchmark of 57.42% by 5.62 percentage points. The MY2025 GSD hybrid rate was 68.66%

(138/201) and met the MY2025 GSD 50th percentile benchmark of 60.58% by 8.08 percentage points. The hybrid rate increased by 5.62 percent, representing improved performance. Further demographic stratification is not presented because dividing the county denominators (184 in MY2024 and 201 in MY2025) by race, ethnicity, or gender would create small subgroup counts and unstable estimates of limited statistical value.

GSD <8% Rate by Race for Monterey Population

Race	MY24 GSD Administrative Data Den	Num	Rate	MY25 GSD Administrative Data Den	Num	Rate	Difference from Top	YoY Administrative Data Trend
White	4,781	3,383	70.76%	4,125	2,597	62.96%	4.61%	-7.80%
Black or African American	156	121	77.56%	111	75	67.57%	0.00%	-10.00%
American Indian and Alaska Native	38	25	65.79%	7	4	57.14%	*N<30	N/A
Asian	834	598	71.70%	771	513	66.54%	1.03%	-5.17%
Native Hawaiian and Other Pacific Islander	17	11	64.71%	15	6	40.00%	*N<30	N/A
Some Other Race	1,954	1,383	70.78%	1,360	875	64.34%	3.23%	-6.44%
Two or More Races	1,028	662	64.40%	1,962	1,282	65.34%	2.23%	+0.94%



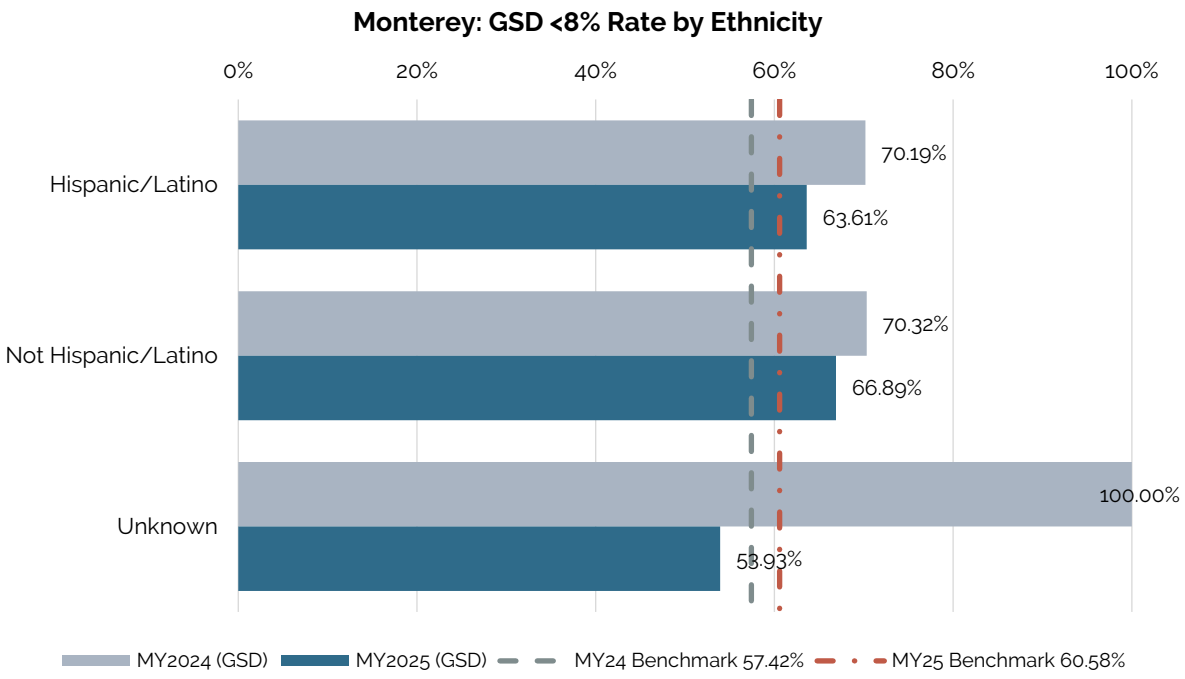
Quantitative Analysis

Administrative Data

- Black or African American was the top-performing group at 67.57% (n=111), meeting the MY2025 GSD 50th percentile benchmark of 60.58%.
- White was the lowest-performing eligible group at 62.96%; the disparity from the top-performing group was 4.61 percentage points.
- Among groups eligible for year-over-year comparison, Two or More Races had the largest increase (0.94 percentage points), while Black or African American had the largest decline (10.00 percentage points).
- Differences across eligible race groups were not statistically significant (χ^2=6.2547, p=0.1809).

GSD <8% Rate by Ethnicity for Monterey Population

Ethnicity	MY24 GSD Administrative Data Den	Num	Rate	MY25 GSD Administrative Data Den	Num	Rate	Difference from Top	YoY Administrative Data Trend
Hispanic/Latino	7,815	5,485	70.19%	8,483	5,396	63.61%	3.28%	-6.58%
Not Hispanic/Latino	1,004	706	70.32%	909	608	66.89%	0.00%	-3.43%
Unknown	3	3	100.00%	191	103	53.93%	12.96%	N/A



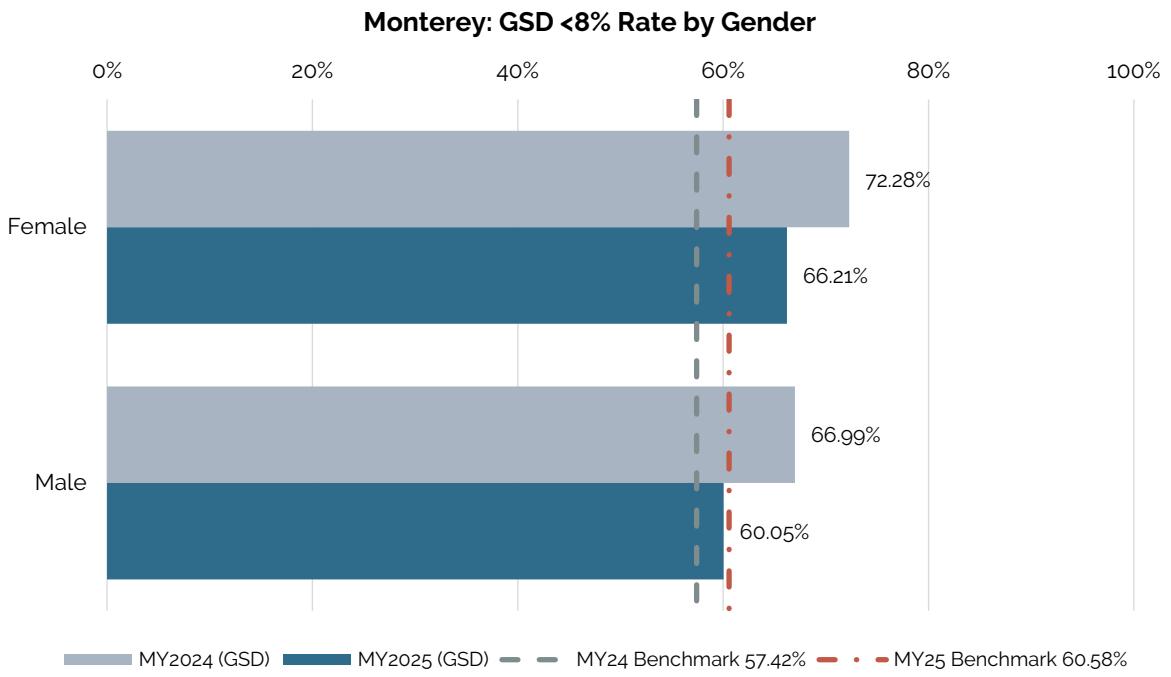
Quantitative Analysis

Administrative Data

- Not Hispanic/Latino was the top-performing group at 66.89% (n=909), meeting the MY2025 GSD 50th percentile benchmark of 60.58%.
- Unknown was the lowest-performing eligible group at 53.93%; the disparity from the top-performing group was 12.96 percentage points.
- Among groups eligible for year-over-year comparison, Not Hispanic/Latino had the smallest decline (3.43 percentage points), while Hispanic/Latino had the largest decline (6.58 percentage points).
- Differences across eligible ethnicity groups were statistically significant (χ^2=11.9127, p=0.0026).

GSD <8% Rate by Gender for Monterey Population

Gender	MY24 GSD Administrative Data Den	Num	Rate	MY25 GSD Administrative Data Den	Num	Rate	Difference from Top	YoY Administrative Data Trend
Female	5,372	3,883	72.28%	5,721	3,788	66.21%	0.00%	-6.07%
Male	3,450	2,311	66.99%	3,862	2,319	60.05%	6.17%	-6.94%



Quantitative Analysis

Administrative Data

- Female was the top-performing group at 66.21% (n=5,721), meeting the MY2025 GSD 50th percentile benchmark of 60.58%.
- Male was the lowest-performing eligible group at 60.05%; the disparity from the top-performing group was 6.17 percentage points.
- Among groups eligible for year-over-year comparison, Female had the smallest decline (6.07 percentage points), while Male had the largest decline (6.94 percentage points).
- Differences across eligible gender groups were statistically significant (χ^2=37.6502, p=0.0000).

Overall Conclusion

For Monterey, MY2024 GSD administrative performance was 60.66% (5,351/8,822) and met the MY2024 GSD 50th percentile benchmark of 57.42% by 3.24 percentage points. MY2025 GSD administrative performance was 63.73% (6,107/9,583) and met the MY2025 GSD 50th percentile benchmark of 60.58% by 3.15 percentage points. Year-over-year administrative performance increased by 3.07 percentage points, representing improved performance. The MY2024 GSD hybrid rate was 63.04% (116/184) and met the MY2024 GSD 50th percentile benchmark of 57.42% by 5.62 percentage points. The MY2025 GSD hybrid rate was 68.66% (138/201) and met the MY2025 GSD 50th percentile benchmark of 60.58% by 8.08 percentage points. Year-over-year hybrid performance increased by 5.62 percentage points, representing improved performance. Hybrid demographic stratification was not performed because further division of the county samples would produce small subgroup counts and unstable estimates.

Health Equity Category	Top Performing	Rate	Lowest Performing	Rate	Disparity
Race	Black or African American	67.57%	White	62.96%	4.61%
Ethnicity	Not Hispanic/Latino	66.89%	Unknown	53.93%	12.96%
Gender	Female	66.21%	Male	60.05%	6.17%

GSD >9%

The data below presents MY2024 and MY2025 GSD >9% results for the Monterey population. The lower the rate, the better the performance. Each year is evaluated against its applicable 50th percentile benchmark.

Measurement Year	Administrative Data Num/Den	Administrative Data Rate	Benchmark	Benchmark Status
MY2024 GSD >9%	2,628/8,822	29.79%	33.33%	Met
MY2025 GSD >9%	2,654/9,583	27.69%	30.41%	Met

MY2024 and MY2025 GSD Hybrid Rates

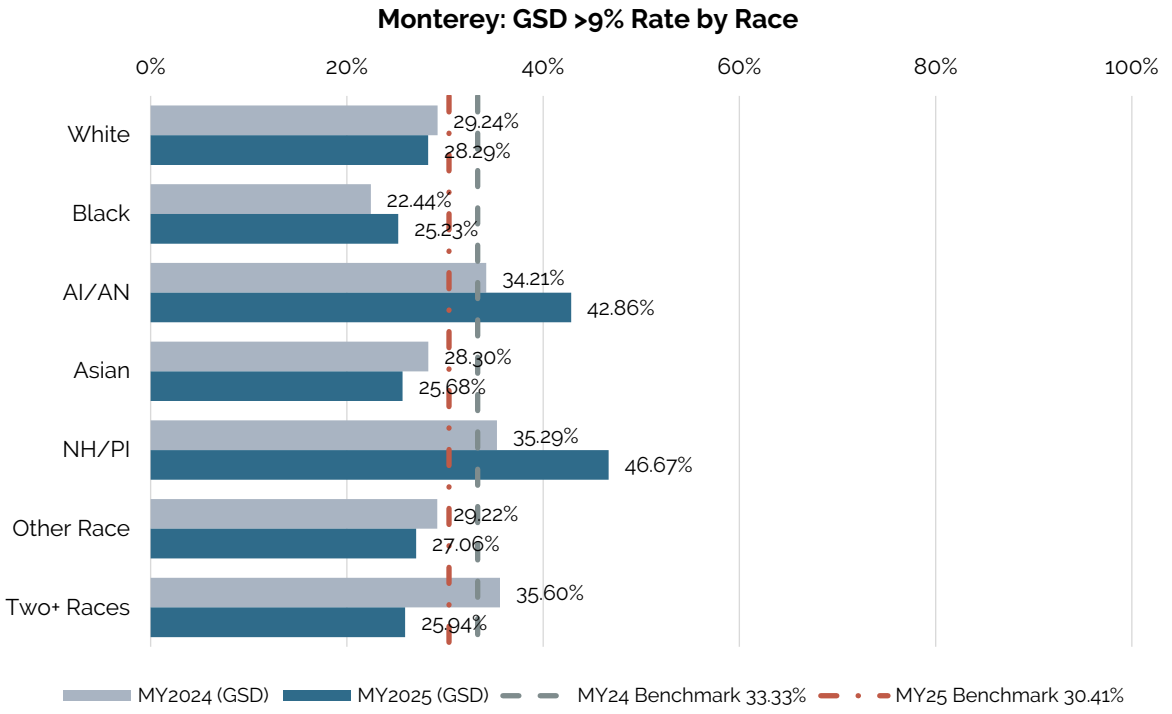
Measurement Year	Hybrid Num/Den	Hybrid Rate	Benchmark	Benchmark Status
MY2024 GSD >9%	52/184	28.26%	33.33%	Met
MY2025 GSD >9%	44/201	21.89%	30.41%	Met

For Monterey, the MY2024 GSD hybrid rate was 28.26% (52/184) and met the MY2024 GSD 50th percentile benchmark of 33.33% by 5.07 percentage points. The MY2025 GSD hybrid rate was 21.89% (44/201) and met the MY2025 GSD 50th percentile benchmark of 30.41% by 8.52 percentage points. Year over year, the hybrid rate decreased by 6.37 percentage points, representing improved performance. Further demographic stratification is not presented because dividing the county denominators (184 in MY2024 and 201 in MY2025) by race, ethnicity, or gender would create small subgroup counts and unstable estimates of limited statistical value.

GSD >9% Rate by Race for Monterey Population

Race	MY24 GSD Administrative Data Den	Num	Rate	MY25 GSD Administrative Data Den	Num	Rate	Difference from Top	YoY Administrative Data Trend
White	4,781	1,398	29.24%	4,125	1,167	28.29%	3.07%	-0.95%

Race	MY24 GSD Administrative Data Den	Num	Rate	MY25 GSD Administrative Data Den	Num	Rate	Difference from Top	YoY Administrative Data Trend
Black or African American	156	35	22.44%	111	28	25.23%	0.00%	+2.79%
American Indian and Alaska Native	38	13	34.21%	7	3	42.86%	*N<30	N/A
Asian	834	236	28.30%	771	198	25.68%	0.46%	-2.62%
Native Hawaiian and Other Pacific Islander	17	6	35.29%	15	7	46.67%	*N<30	N/A
Some Other Race	1,954	571	29.22%	1,360	368	27.06%	1.83%	-2.16%
Two or More Races	1,028	366	35.60%	1,962	509	25.94%	0.72%	-9.66%



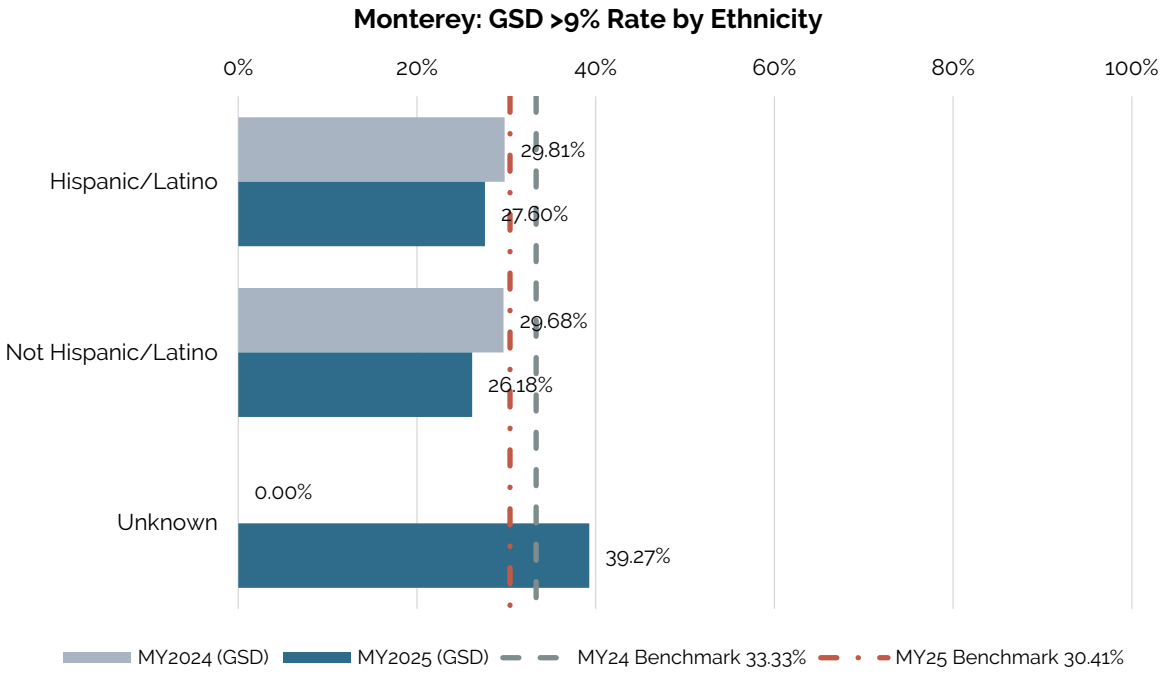
Quantitative Analysis

Administrative Data

- Black or African American was the top-performing group at 25.23% (n=111), meeting the MY2025 GSD 50th percentile benchmark of 30.41%.
- White was the lowest-performing eligible group at 28.29%; the disparity from the top-performing group was 3.07 percentage points.
- Among groups eligible for year-over-year comparison, Two or More Races had the largest decrease (9.66 percentage points), while Black or African American had the largest increase (2.79 percentage points).
- Differences across eligible race groups were not statistically significant (χ^2=5.1569, p=0.2716).

GSD >9% Rate by Ethnicity for Monterey Population

Ethnicity	MY24 GSD Administrative Data Den	Num	Rate	MY25 GSD Administrative Data Den	Num	Rate	Difference from Top	YoY Administrative Data Trend
Hispanic/Latino	7,815	2,330	29.81%	8,483	2,341	27.60%	1.41%	-2.22%
Not Hispanic/Latino	1,004	298	29.68%	909	238	26.18%	0.00%	-3.50%
Unknown	3	0	0.00%	191	75	39.27%	13.08%	N/A



Quantitative Analysis

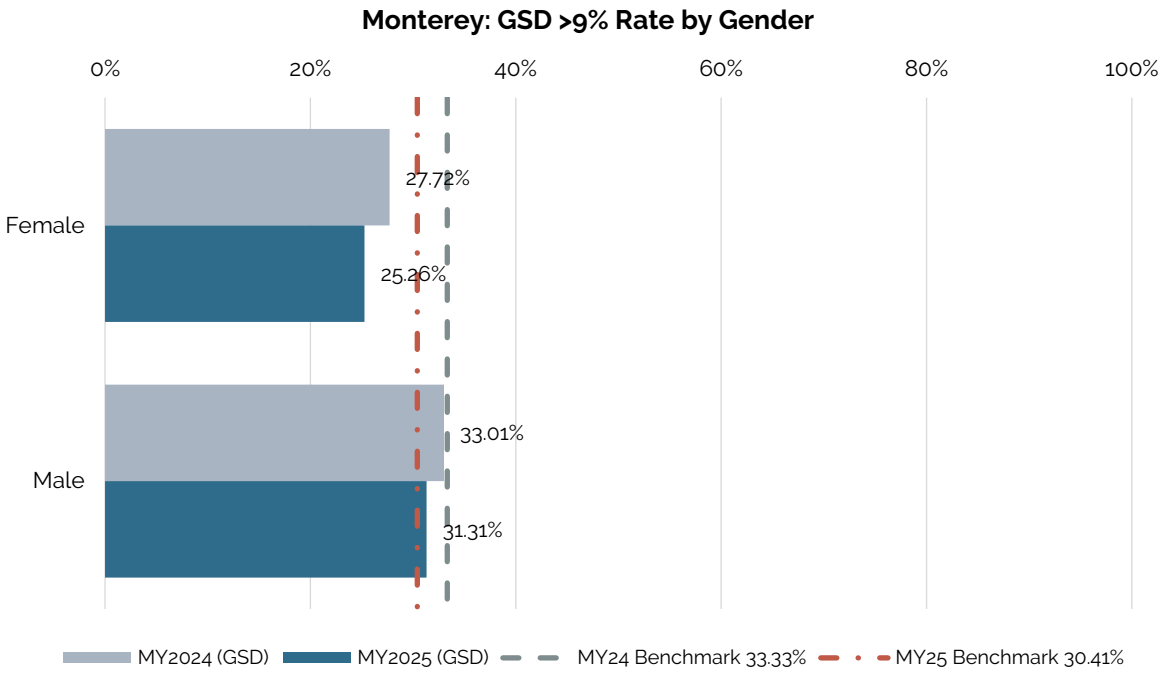
Administrative Data

- Not Hispanic/Latino was the top-performing group at 26.18% (n=909), meeting the MY2025 GSD 50th percentile benchmark of 30.41%.

- Unknown was the lowest-performing eligible group at 39.27%; the disparity from the top-performing group was 13.08 percentage points.
- Among groups eligible for year-over-year comparison, Not Hispanic/Latino had the largest decrease (3.50 percentage points), while Hispanic/Latino had the smallest decrease (2.22 percentage points).
- Differences across eligible ethnicity groups were statistically significant (χ^2=13.8522, p=0.0010).

GSD >9% Rate by Gender for Monterey Population

Gender	MY24 GSD Administrative Data Den	Num	Rate	MY25 GSD Administrative Data Den	Num	Rate	Difference from Top	YoY Administrative Data Trend
Female	5,372	1,489	27.72%	5,721	1,445	25.26%	0.00%	-2.46%
Male	3,450	1,139	33.01%	3,862	1,209	31.31%	6.05%	-1.71%



Quantitative Analysis

Administrative Data

- Female was the top-performing group at 25.26% (n=5,721), meeting the MY2025 GSD 50th percentile benchmark of 30.41%.
- Male was the lowest-performing eligible group at 31.31%; the disparity from the top-performing group was 6.05 percentage points.
- Among groups eligible for year-over-year comparison, Female had the largest decrease (2.46 percentage points), while Male had the smallest decrease (1.71 percentage points).
- Differences across eligible gender groups were statistically significant (χ^2=41.8025, p=0.0000).

Overall Conclusion

For Monterey, MY2024 GSD administrative performance was 29.79% (2,628/8,822) and met the MY2024 GSD 50th percentile benchmark of 33.33% by 3.54 percentage points. MY2025 GSD administrative performance was 27.69% (2,654/9,583) and met the MY2025 GSD 50th percentile benchmark of 30.41% by 2.72 percentage points. Year-over-year administrative performance decreased by 2.10 percentage points, representing improved performance. The MY2024 GSD hybrid rate was 28.26% (52/184) and met the MY2024 GSD 50th percentile benchmark of 33.33% by 5.07 percentage points. The MY2025 GSD hybrid rate was 21.89% (44/201) and met the MY2025 GSD 50th percentile benchmark of 30.41% by 8.52 percentage points. Year-over-year hybrid performance decreased by 6.37 percentage points, representing improved performance. Hybrid demographic stratification was not performed because further division of the county samples would produce small subgroup counts and unstable estimates.

Health Equity Category	Top Performing	Rate	Lowest Performing	Rate	Disparity
Race	Black or African American	25.23%	White	28.29%	3.07%
Ethnicity	Not Hispanic/Latino	26.18%	Unknown	39.27%	13.08%
Gender	Female	25.26%	Male	31.31%	6.05%

Medi-Cal San Benito Population

GSD <8%

The data below presents MY2024 and MY2025 GSD <8% results for the San Benito population. The higher the rate, the better the performance. Each year is evaluated against its applicable 50th percentile benchmark.

Measurement Year	Administrative Data Num/Den	Administrative Data Rate	Benchmark	Benchmark Status
MY2024 GSD <8%	76/799	9.51%	57.42%	Not Met
MY2025 GSD <8%	590/982	60.08%	60.58%	Not Met

MY2024 and MY2025 GSD Hybrid Rates

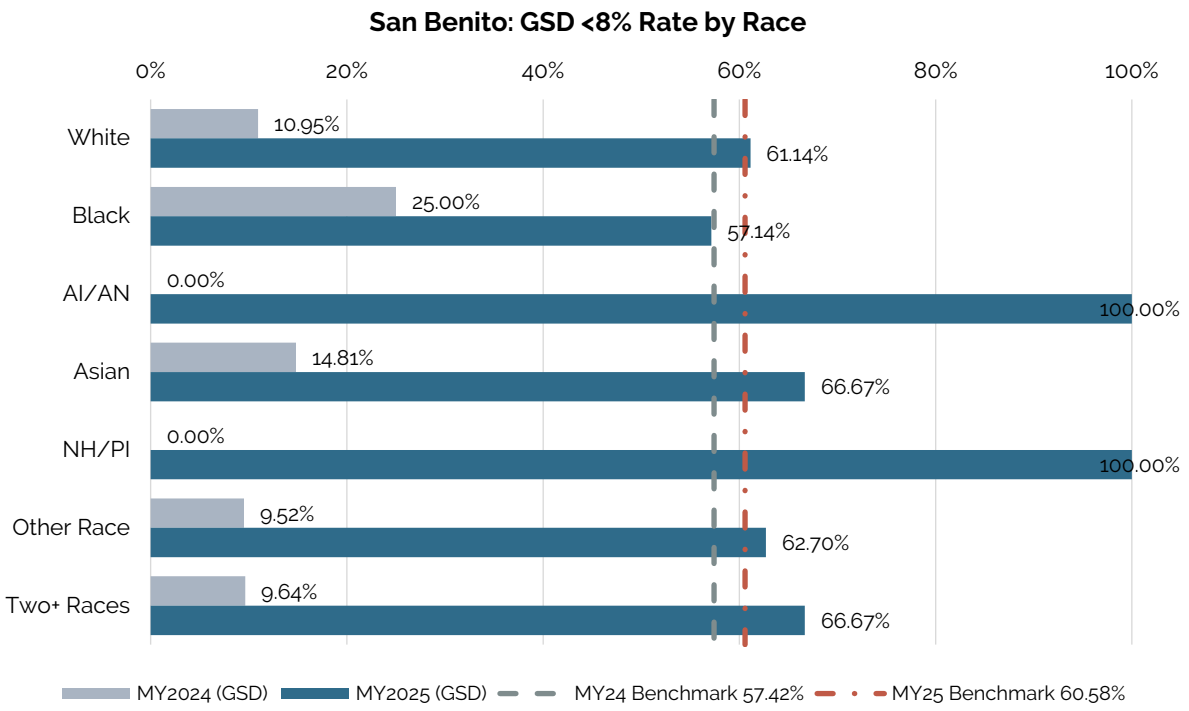
Measurement Year	Hybrid Num/Den	Hybrid Rate	Benchmark	Benchmark Status
MY2024 GSD <8%	58/100	58.00%	57.42%	Met
MY2025 GSD <8%	65/100	65.00%	60.58%	Met

For San Benito, the MY2024 GSD hybrid rate was 58.00% (58/100) and met the MY2024 GSD 50th percentile benchmark of 57.42% by 0.58 percentage points. The MY2025 GSD hybrid rate was 65.00%

(65/100) and met the MY2025 GSD 50th percentile benchmark of 60.58% by 4.42 percentage points. The hybrid rate increased by 7.00 percentage points annually, representing improved performance. Further demographic stratification is not presented because dividing the county denominators (100 in MY2024 and 100 in MY2025) by race, ethnicity, or gender would create small subgroup counts and unstable estimates of limited statistical value.

GSD <8% Rate by Race for San Benito Population

Race	MY24 GSD Administrative Data Den	Num	Rate	MY25 GSD Administrative Data Den	Num	Rate	Difference from Top	YoY Administrative Data Trend
White	347	38	10.95%	175	107	61.14%	5.52%	+50.19%
Black or African American	8	2	25.00%	7	4	57.14%	*N<30	N/A
American Indian and Alaska Native	9	0	0.00%	2	2	100.00%	*N<30	N/A
Asian	54	8	14.81%	57	38	66.67%	0.00%	+51.85%
Native Hawaiian and Other Pacific Islander	3	0	0.00%	1	1	100.00%	*N<30	N/A
Some Other Race	294	28	9.52%	252	158	62.70%	3.97%	+53.17%
Two or More Races	83	8	9.64%	120	80	66.67%	0.00%	+57.03%



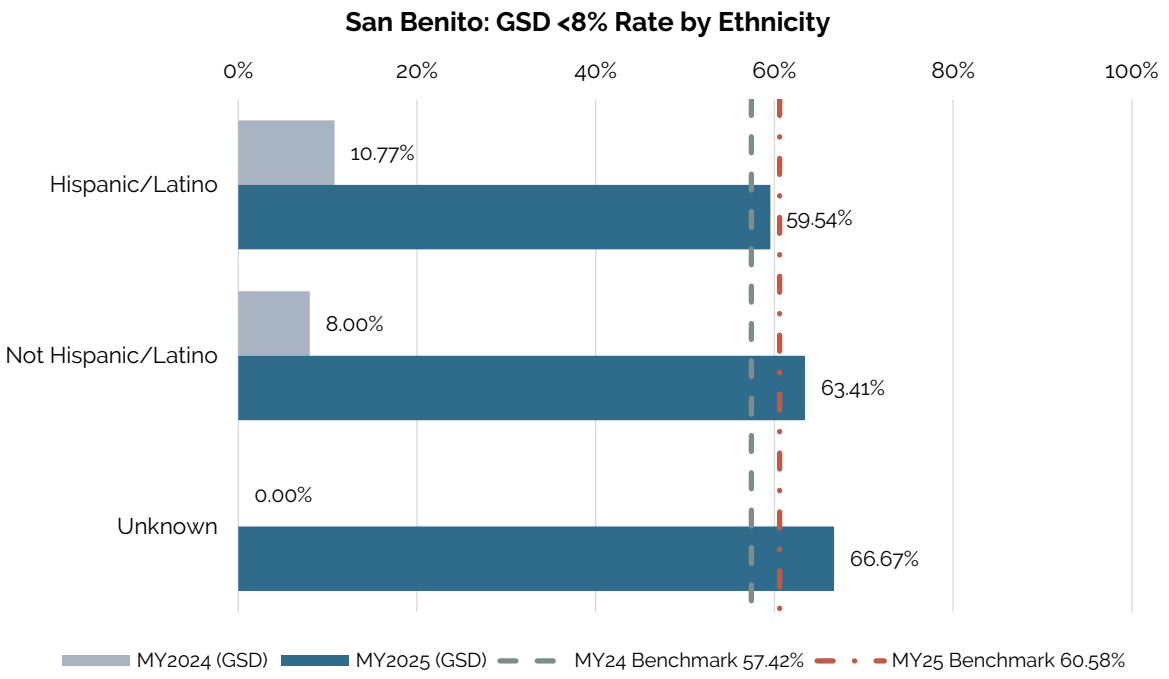
Quantitative Analysis

Administrative Data

- Asian was the top-performing group at 66.67% (n=57), meeting the MY2025 GSD 50th percentile benchmark of 60.58%.
- White was the lowest-performing eligible group at 61.14%; the disparity from the top-performing group was 5.52 percentage points.
- Among groups eligible for year-over-year comparison, Two or More Races had the largest increase (57.03 percentage points), while White had the smallest increase (50.19 percentage points).
- Differences across eligible race groups were not statistically significant (χ^2=1.2518, p=0.7406).

GSD <8% Rate by Ethnicity for San Benito Population

Ethnicity	MY24 GSD Administrative Data Den	Num	Rate	MY25 GSD Administrative Data Den	Num	Rate	Difference from Top	YoY Administrative Data Trend
Hispanic/Latino	724	78	10.77%	870	518	59.54%	7.13%	+48.77%
Not Hispanic/Latino	75	6	8.00%	82	52	63.41%	3.25%	+55.41%
Unknown	0	0		30	20	66.67%	0.00%	N/A



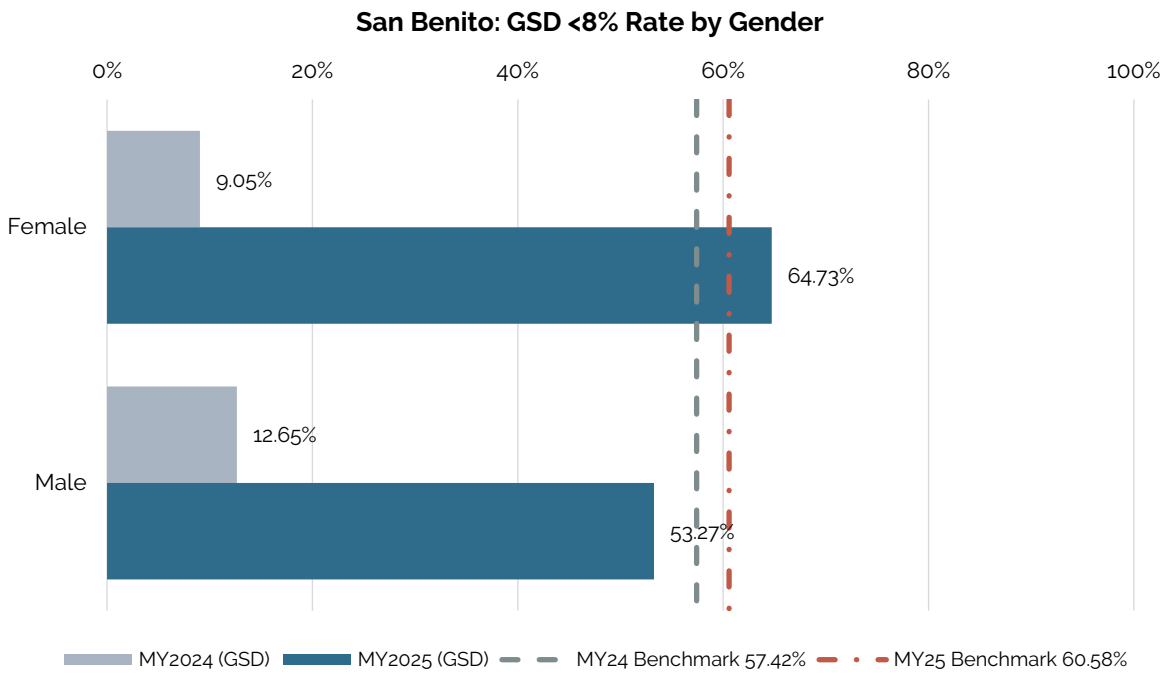
Quantitative Analysis

Administrative Data

- Unknown was the top-performing group at 66.67% (n=30), meeting the MY2025 GSD 50th percentile benchmark of 60.58%.
- Hispanic/Latino was the lowest-performing eligible group at 59.54%; the disparity from the top-performing group was 7.13 percentage points.
- Among groups eligible for year-over-year comparison, Not Hispanic/Latino had the largest increase (55.41 percentage points), while Hispanic/Latino had the smallest increase (48.77 percentage points).
- Differences across eligible ethnicity groups were not statistically significant (χ^2=1.0285, p=0.5979).

GSD <8% Rate by Gender for San Benito Population

Gender	MY24 GSD Administrative Data Den	Num	Rate	MY25 GSD Administrative Data Den	Num	Rate	Difference from Top	YoY Administrative Data Trend
Female	475	43	9.05%	584	378	64.73%	0.00%	+55.67%
Male	324	41	12.65%	398	212	53.27%	11.46%	+40.61%



Quantitative Analysis

Administrative Data

- Female was the top-performing group at 64.73% (n=584), meeting the MY2025 GSD 50th percentile benchmark of 60.58%.
- Male was the lowest-performing eligible group at 53.27%; the disparity from the top-performing group was 11.46 percentage points.
- Among groups eligible for year-over-year comparison, Female had the largest increase (55.67 percentage points), while Male had the smallest increase (40.61 percentage points).
- Differences across eligible gender groups were statistically significant (χ^2=12.4869, p=0.0004).

Overall Conclusion

For San Benito, MY2024 GSD administrative performance was 9.51% (76/799) and did not meet the MY2024 GSD 50th percentile benchmark of 57.42%, falling short by 47.91 percentage points. MY2025 GSD administrative performance was 60.08% (590/982) and did not meet the MY2025 GSD 50th percentile benchmark of 60.58%, falling short by 0.50 percentage points. Year-over-year administrative performance increased by 50.57 percentage points, representing improved performance. The MY2024 GSD hybrid rate was 58.00% (58/100) and met the MY2024 GSD 50th percentile benchmark of 57.42% by 0.58 percentage points. The MY2025 GSD hybrid rate was 65.00% (65/100) and met the MY2025 GSD 50th percentile benchmark of 60.58% by 4.42 percentage points. Year-over-year hybrid performance increased by 7.00 percentage points, representing improved performance. Hybrid demographic stratification was not performed because further division of the county samples would produce small subgroup counts and unstable estimates.

Health Equity Category	Top Performing	Rate	Lowest Performing	Rate	Disparity
Race	Asian	66.67%	White	61.14%	5.52%
Ethnicity	Unknown	66.67%	Hispanic/Latino	59.54%	7.13%
Gender	Female	64.73%	Male	53.27%	11.46%

GSD >9%

The data below presents MY2024 and MY2025 GSD >9% results for the San Benito population. The lower the rate, the better the performance. Each year is evaluated against its applicable 50th percentile benchmark.

Measurement Year	Administrative Data Num/Den	Administrative Data Rate	Benchmark	Benchmark Status
MY2024 GSD >9%	715/799	89.49%	33.33%	Not Met
MY2025 GSD >9%	314/982	31.98%	30.41%	Not Met

MY2024 and MY2025 GSD Hybrid Rates

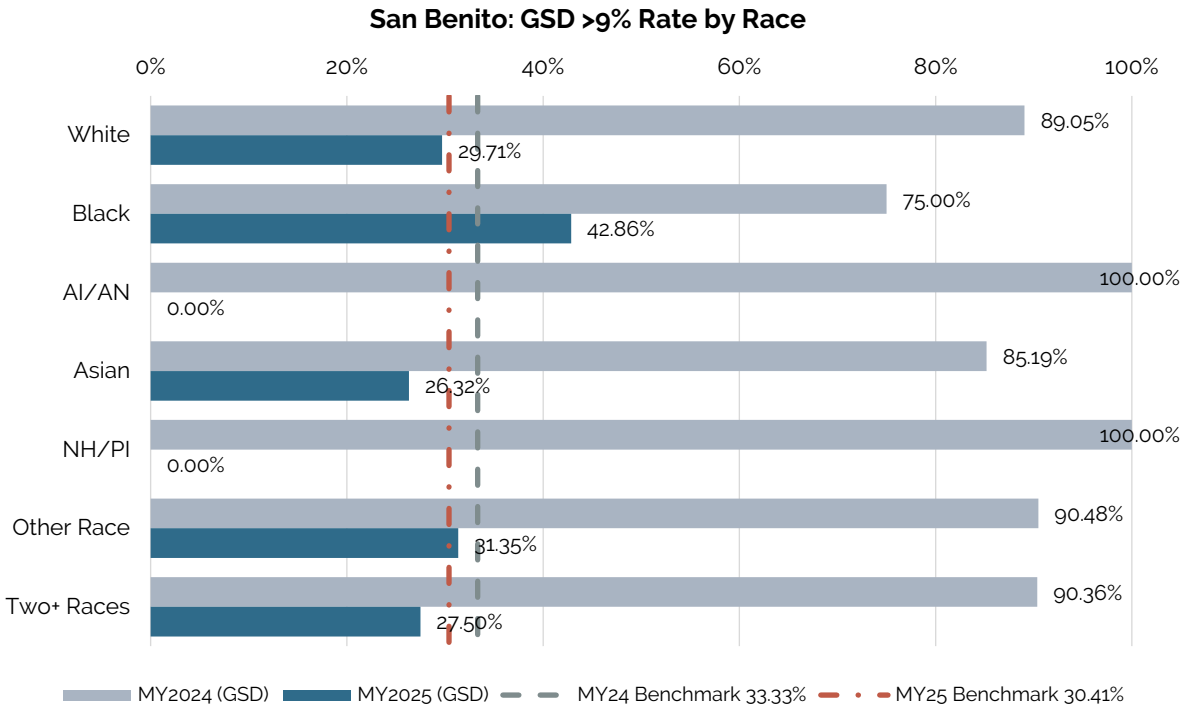
Measurement Year	Hybrid Num/Den	Hybrid Rate	Benchmark	Benchmark Status
MY2024 GSD >9%	36/100	36.00%	33.33%	Not Met
MY2025 GSD >9%	23/100	23.00%	30.41%	Met

For San Benito, the MY2024 GSD hybrid rate was 36.00% (36/100) and did not meet the MY2024 GSD 50th percentile benchmark of 33.33%, exceeding it by 2.67 percentage points. The MY2025 GSD hybrid rate was 23.00% (23/100) and met the MY2025 GSD 50th percentile benchmark of 30.41% by 7.41 percentage points. Year over year, the hybrid rate decreased by 13.00 percentage points, representing improved performance. Further demographic stratification is not presented because dividing the county denominators (100 in MY2024 and 100 in MY2025) by race, ethnicity, or gender would create small subgroup counts and unstable estimates of limited statistical value.

GSD >9% Rate by Race for San Benito Population

Race	MY24 GSD Administrative Data Den	Num	Rate	MY25 GSD Administrative Data Den	Num	Rate	Difference from Top	YoY Administrative Data Trend
White	347	309	89.05%	175	52	29.71%	3.40%	-59.33%

Race	MY24 GSD Administrative Data Den	Num	Rate	MY25 GSD Administrative Data Den	Num	Rate	Difference from Top	YoY Administrative Data Trend
Black or African American	8	6	75.00%	7	3	42.86%	*N<30	N/A
American Indian and Alaska Native	9	9	100.00%	2	0	0.00%	*N<30	N/A
Asian	54	46	85.19%	57	15	26.32%	0.00%	-58.87%
Native Hawaiian and Other Pacific Islander	3	3	100.00%	1	0	0.00%	*N<30	N/A
Some Other Race	294	266	90.48%	252	79	31.35%	5.03%	-59.13%
Two or More Races	83	75	90.36%	120	33	27.50%	1.18%	-62.86%



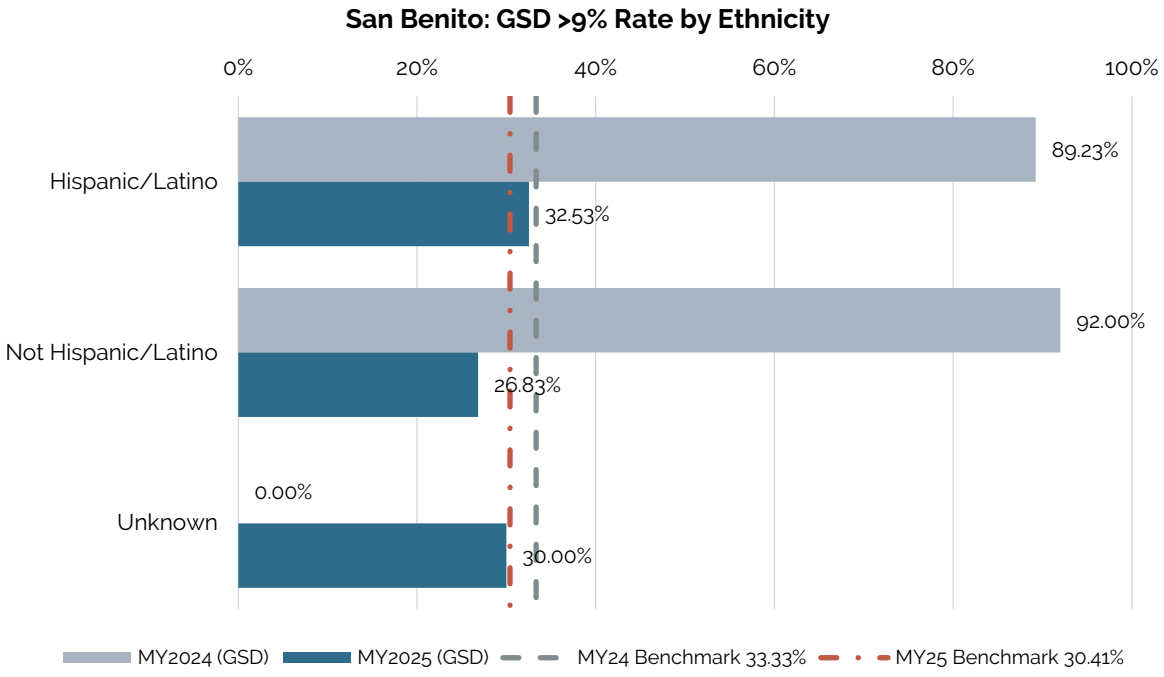
Quantitative Analysis

Administrative Data

- Asian was the top-performing group at 26.32% (n=57), meeting the MY2025 GSD 50th percentile benchmark of 30.41%.
- Some Other Race was the lowest-performing eligible group at 31.35%; the disparity from the top-performing group was 5.03 percentage points.
- Among groups eligible for year-over-year comparison, Two or More Races had the largest decrease (62.86 percentage points), while Asian had the smallest decrease (58.87 percentage points).
- Differences across eligible race groups were not statistically significant (χ^2=0.9191, p=0.8208).

GSD >9% Rate by Ethnicity for San Benito Population

Ethnicity	MY24 GSD Administrative Data Den	Num	Rate	MY25 GSD Administrative Data Den	Num	Rate	Difference from Top	YoY Administrative Data Trend
Hispanic/Latino	724	646	89.23%	870	283	32.53%	5.70%	-56.70%
Not Hispanic/Latino	75	69	92.00%	82	22	26.83%	0.00%	-65.17%
Unknown	0	0		30	9	30.00%	3.17%	N/A



Quantitative Analysis

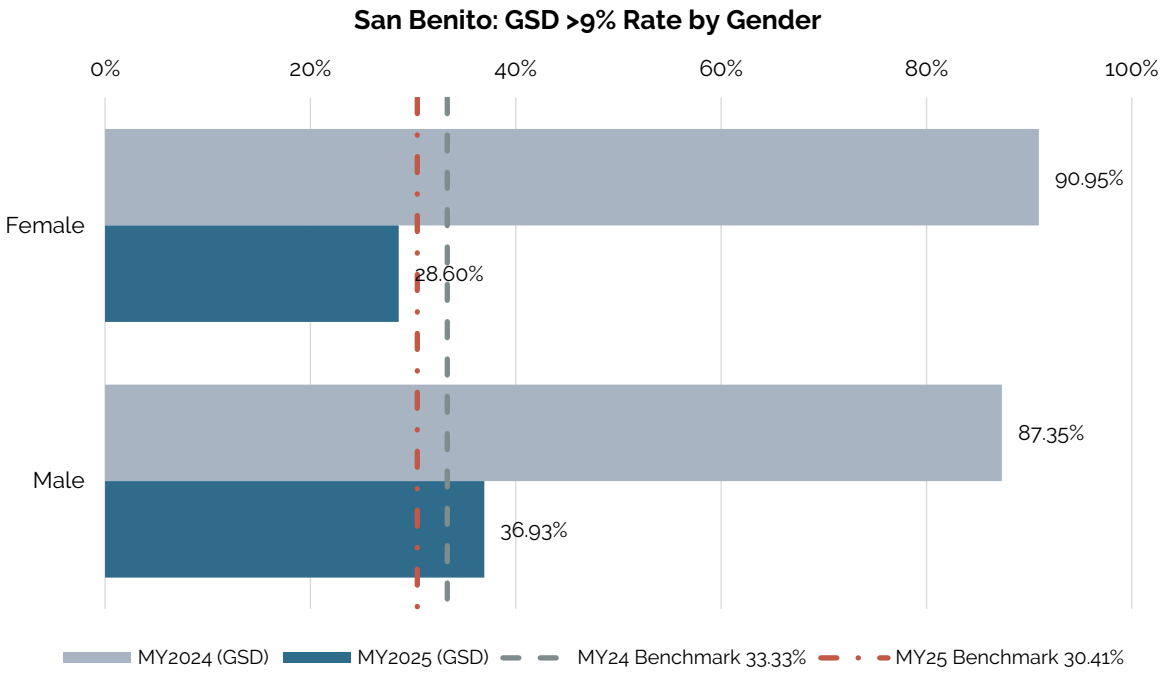
Administrative Data

- Not Hispanic/Latino was the top-performing group at 26.83% (n=82), meeting the MY2025 GSD 50th percentile benchmark of 30.41%.

- Hispanic/Latino was the lowest-performing eligible group at 32.53%; the disparity from the top-performing group was 5.70 percentage points.
- Among groups eligible for year-over-year comparison, Not Hispanic/Latino had the largest decrease (65.17 percentage points), while Hispanic/Latino had the smallest decrease (56.70 percentage points).
- Differences across eligible ethnicity groups were not statistically significant (χ^2=1.1747, p=0.5558).

GSD >9% Rate by Gender for San Benito Population

Gender	MY24 GSD Administrative Data Den	Num	Rate	MY25 GSD Administrative Data Den	Num	Rate	Difference from Top	YoY Administrative Data Trend
Female	475	432	90.95%	584	167	28.60%	0.00%	-62.35%
Male	324	283	87.35%	398	147	36.93%	8.34%	-50.41%



Quantitative Analysis

Administrative Data

- Female was the top-performing group at 28.60% (n=584), meeting the MY2025 GSD 50th percentile benchmark of 30.41%.
- Male was the lowest-performing eligible group at 36.93%; the disparity from the top-performing group was 8.34 percentage points.
- Among groups eligible for year-over-year comparison, Female had the largest decrease (62.35 percentage points), while Male had the smallest decrease (50.41 percentage points).
- Differences across eligible gender groups were statistically significant (χ^2=7.1882, p=0.0073).

Overall Conclusion

For San Benito, MY2024 GSD administrative performance was 89.49% (715/799) and did not meet the MY2024 GSD 50th percentile benchmark of 33.33%, exceeding it by 56.16 percentage points. MY2025 GSD administrative performance was 31.98% (314/982) and did not meet the MY2025 GSD 50th percentile benchmark of 30.41%, exceeding it by 1.57 percentage points. Year-over-year administrative performance decreased by 57.51 percentage points, representing improved performance. The MY2024 GSD hybrid rate was 36.00% (36/100) and did not meet the MY2024 GSD 50th percentile benchmark of 33.33%, exceeding it by 2.67 percentage points. The MY2025 GSD hybrid rate was 23.00% (23/100) and met the MY2025 GSD 50th percentile benchmark of 30.41% by 7.41 percentage points. Year-over-year hybrid performance decreased by 13.00 percentage points, representing improved performance. Hybrid demographic stratification was not performed because further division of the county samples would produce small subgroup counts and unstable estimates.

Health Equity Category	Top Performing	Rate	Lowest Performing	Rate	Disparity
Race	Asian	26.32%	Some Other Race	31.35%	5.03%
Ethnicity	Not Hispanic/Latino	26.83%	Hispanic/Latino	32.53%	5.70%
Gender	Female	28.60%	Male	36.93%	8.34%

Medi-Cal Santa Cruz Population

GSD <8%

The data below presents MY2024 and MY2025 GSD <8% results for the Santa Cruz population. The higher the rate, the better the performance. Each year is evaluated against its applicable 50th percentile benchmark.

Measurement Year	Administrative Data Num/Den	Administrative Data Rate	Benchmark	Benchmark Status
MY2024 GSD <8%	1,942/3,308	58.71%	57.42%	Met
MY2025 GSD <8%	2,119/3,451	61.40%	60.58%	Met

MY2024 and MY2025 GSD Hybrid Rates

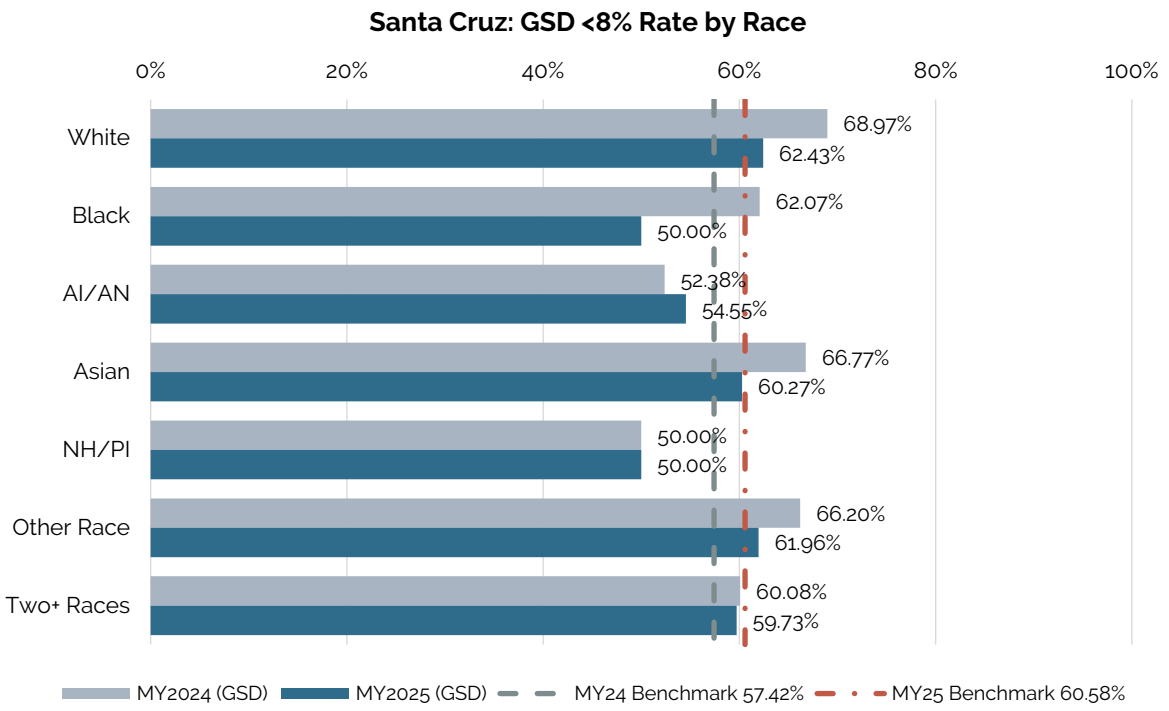
Measurement Year	Hybrid Num/Den	Hybrid Rate	Benchmark	Benchmark Status
MY2024 GSD <8%	62/100	62.00%	57.42%	Met
MY2025 GSD <8%	64/100	64.00%	60.58%	Met

For Santa Cruz, the MY2024 GSD hybrid rate was 62.00% (62/100) and met the MY2024 GSD 50th percentile benchmark of 57.42% by 4.58 percentage points. The MY2025 GSD hybrid rate was 64.00%

(64/100) and met the MY2025 GSD 50th percentile benchmark of 60.58% by 3.42 percentage points. Year over year, the hybrid rate increased by 2.00 percentage points, representing improved performance. Further demographic stratification is not presented because dividing the county denominators (100 in MY2024 and 100 in MY2025) by race, ethnicity, or gender would create small subgroup counts and unstable estimates of limited statistical value.

GSD <8% Rate by Race for Santa Cruz Population

Race	MY24 GSD Administrative Data Den	Num	Rate	MY25 GSD Administrative Data Den	Num	Rate	Difference from Top	YoY Administrative Data Trend
White	1,863	1,285	68.97%	1,549	967	62.43%	0.00%	-6.55%
Black or African American	29	18	62.07%	22	11	50.00%	*N<30	N/A
American Indian and Alaska Native	21	11	52.38%	11	6	54.55%	*N<30	N/A
Asian	635	424	66.77%	589	355	60.27%	2.16%	-6.50%
Native Hawaiian and Other Pacific Islander	2	1	50.00%	4	2	50.00%	*N<30	N/A
Some Other Race	497	329	66.20%	326	202	61.96%	0.46%	-4.23%
Two or More Races	258	155	60.08%	437	261	59.73%	2.70%	-0.35%



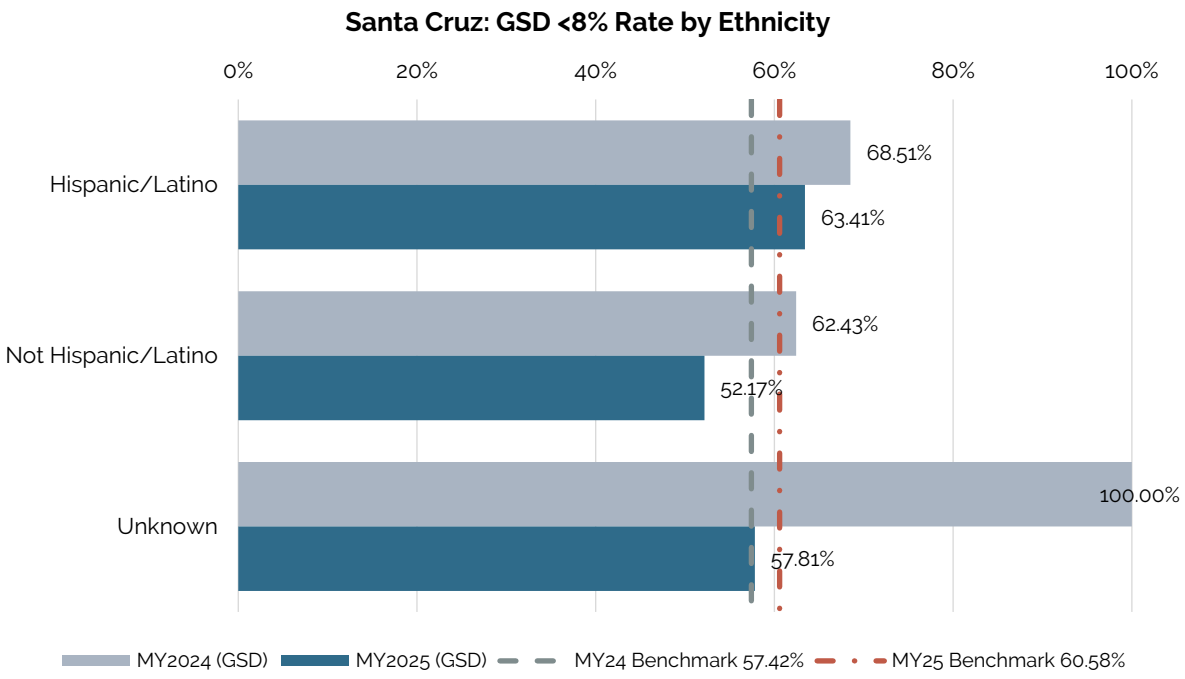
Quantitative Analysis

Administrative Data

- White was the top-performing group at 62.43% (n=1,549), meeting the MY2025 GSD 50th percentile benchmark of 60.58%.
- Two or More Races was the lowest-performing eligible group at 59.73%; the disparity from the top-performing group was 2.70 percentage points.
- Among groups eligible for year-over-year comparison, Two or More Races had the smallest decline (0.35 percentage points), while White had the largest decline (6.55 percentage points).
- Differences across eligible race groups were not statistically significant (χ^2=1.5481, p=0.6712).

GSD <8% Rate by Ethnicity for Santa Cruz Population

Ethnicity	MY24 GSD Administrative Data Den	Num	Rate	MY25 GSD Administrative Data Den	Num	Rate	Difference from Top	YoY Administrative Data Trend
Hispanic/Latino	2,639	1,808	68.51%	2,771	1,757	63.41%	0.00%	-5.10%
Not Hispanic/Latino	668	417	62.43%	552	288	52.17%	11.23%	-10.25%
Unknown	1	1	100.00%	128	74	57.81%	5.59%	N/A



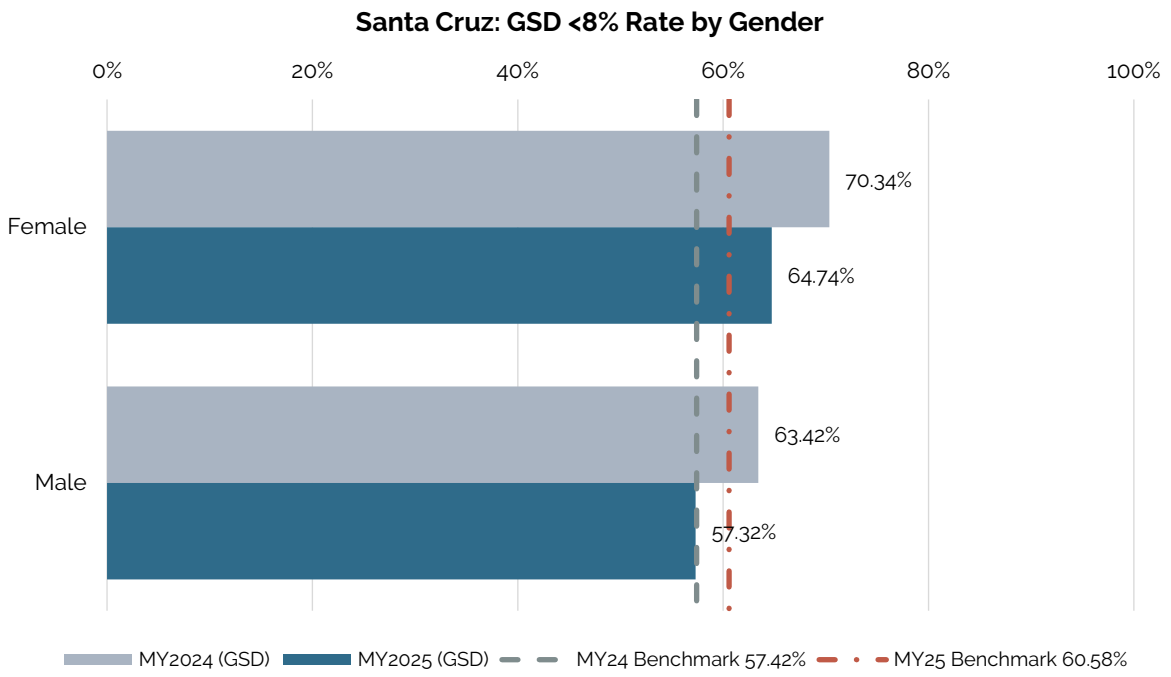
Quantitative Analysis

Administrative Data

- Hispanic/Latino was the top-performing group at 63.41% (n=2,771), meeting the MY2025 GSD 50th percentile benchmark of 60.58%.
- Not Hispanic/Latino was the lowest-performing eligible group at 52.17%; the disparity from the top-performing group was 11.23 percentage points.
- Among groups eligible for year-over-year comparison, Hispanic/Latino had the smallest decline (5.10 percentage points), while Not Hispanic/Latino had the largest decline (10.25 percentage points).
- Differences across eligible ethnicity groups were statistically significant (χ^2=25.2291, p=0.0000).

GSD <8% Rate by Gender for Santa Cruz Population

Gender	MY24 GSD Administrative Data Den	Num	Rate	MY25 GSD Administrative Data Den	Num	Rate	Difference from Top	YoY Administrative Data Trend
Female	1,851	1,302	70.34%	1,900	1,230	64.74%	0.00%	-5.60%
Male	1,457	924	63.42%	1,551	889	57.32%	7.42%	-6.10%



Quantitative Analysis

Administrative Data

- Female was the top-performing group at 64.74% (n=1,900), meeting the MY2025 GSD 50th percentile benchmark of 60.58%.
- Male was the lowest-performing eligible group at 57.32%; the disparity from the top-performing group was 7.42 percentage points.
- Among groups eligible for year-over-year comparison, Female had the smallest decline (5.60 percentage points), while Male had the largest decline (6.10 percentage points).
- Differences across eligible gender groups were statistically significant (χ^2=19.5201, p=0.0000).

Overall Conclusion

For Santa Cruz, MY2024 GSD administrative performance was 58.71% (1,942/3,308) and met the MY2024 GSD 50th percentile benchmark of 57.42% by 1.29 percentage points. MY2025 GSD administrative performance was 61.40% (2,119/3,451) and met the MY2025 GSD 50th percentile benchmark of 60.58% by 0.82 percentage points. Year-over-year administrative performance increased by 2.69 percentage points, representing improved performance. The MY2024 GSD hybrid rate was 62.00% (62/100) and met the MY2024 GSD 50th percentile benchmark of 57.42% by 4.58 percentage points. The MY2025 GSD hybrid rate was 64.00% (64/100) and met the MY2025 GSD 50th percentile benchmark of 60.58% by 3.42 percentage points. Year-over-year hybrid performance increased by 2.00 percentage points, representing improved performance. Hybrid demographic stratification was not performed because further division of the county samples would produce small subgroup counts and unstable estimates.

Health Equity Category	Top Performing	Rate	Lowest Performing	Rate	Disparity
Race	White	62.43%	Two or More Races	59.73%	2.70%
Ethnicity	Hispanic/Latino	63.41%	Not Hispanic/Latino	52.17%	11.23%
Gender	Female	64.74%	Male	57.32%	7.42%

GSD >9%

The data below presents MY2024 and MY2025 GSD >9% results for the Santa Cruz population. The lower the rate, the better the performance. Each year is evaluated against its applicable 50th percentile benchmark.

Measurement Year	Administrative Data Num/Den	Administrative Data Rate	Benchmark	Benchmark Status
MY2024 GSD >9%	2,226/3,308	67.29%	33.33%	Not Met
MY2025 GSD >9%	1,016/3,451	29.44%	30.41%	Met

MY2024 and MY2025 GSD Hybrid Rates

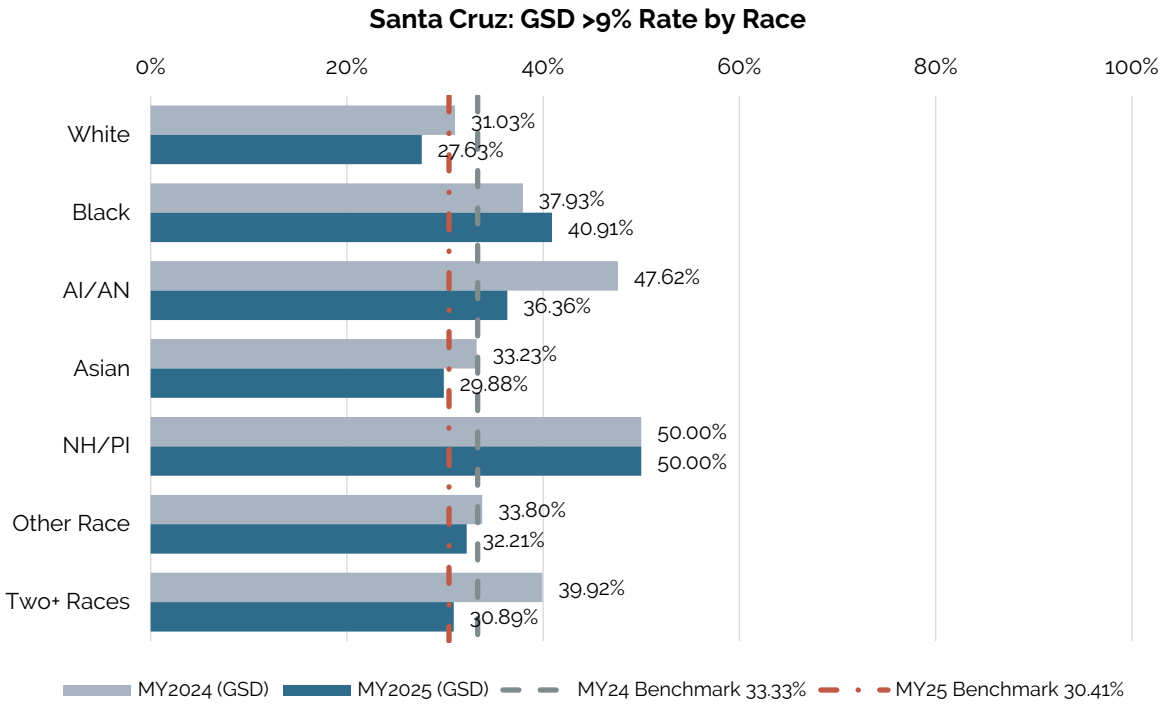
Measurement Year	Hybrid Num/Den	Hybrid Rate	Benchmark	Benchmark Status
MY2024 GSD >9%	23/100	23.00%	33.33%	Met
MY2025 GSD >9%	26/100	26.00%	30.41%	Met

For Santa Cruz, the MY2024 GSD hybrid rate was 23.00% (23/100) and met the MY2024 GSD 50th percentile benchmark of 33.33% by 10.33 percentage points. The MY2025 GSD hybrid rate was 26.00% (26/100) and met the MY2025 GSD 50th percentile benchmark of 30.41% by 4.41 percentage points. Year over year, the hybrid rate increased by 3.00 percentage points, representing worsened performance. Further demographic stratification is not presented because dividing the county denominators (100 in MY2024 and 100 in MY2025) by race, ethnicity, or gender would create small subgroup counts and unstable estimates of limited statistical value.

GSD >9% Rate by Race for Santa Cruz Population

Race	MY24 GSD Administrative Data Den	Num	Rate	MY25 GSD Administrative Data Den	Num	Rate	Difference from Top	YoY Administrative Data Trend
White	1,863	578	31.03%	1,549	428	27.63%	0.00%	-3.39%

Race	MY24 GSD Administrative Data Den	Num	Rate	MY25 GSD Administrative Data Den	Num	Rate	Difference from Top	YoY Administrative Data Trend
Black or African American	29	11	37.93%	22	9	40.91%	*N<30	N/A
American Indian and Alaska Native	21	10	47.62%	11	4	36.36%	*N<30	N/A
Asian	635	211	33.23%	589	176	29.88%	2.25%	-3.35%
Native Hawaiian and Other Pacific Islander	2	1	50.00%	4	2	50.00%	*N<30	N/A
Some Other Race	497	168	33.80%	326	105	32.21%	4.58%	-1.59%
Two or More Races	258	103	39.92%	437	135	30.89%	3.26%	-9.03%



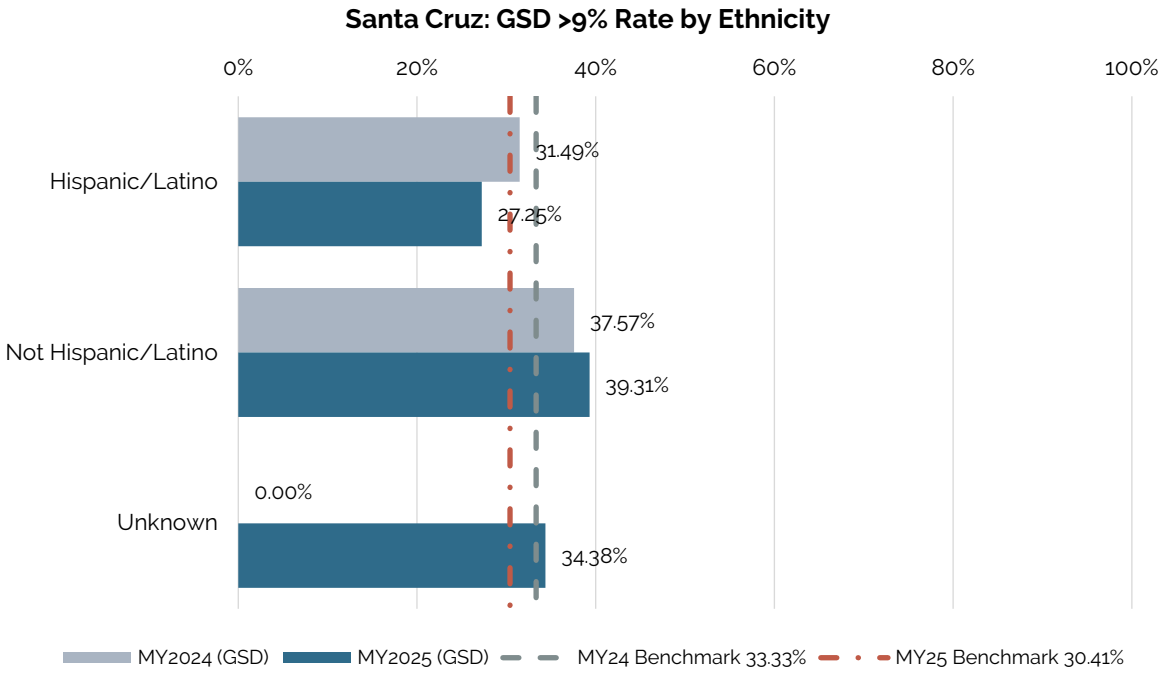
Quantitative Analysis

Administrative Data

- White was the top-performing group at 27.63% (n=1,549), meeting the MY2025 GSD 50th percentile benchmark of 30.41%.
- Some Other Race was the lowest-performing eligible group at 32.21%; the disparity from the top-performing group was 4.58 percentage points.
- Among groups eligible for year-over-year comparison, Two or More Races had the largest decrease (9.03 percentage points), while Some Other Race had the smallest decrease (1.59 percentage points).
- Differences across eligible race groups were not statistically significant (χ^2=4.0028, p=0.2612).

GSD >9% Rate by Ethnicity for Santa Cruz Population

Ethnicity	MY24 GSD Administrative Data Den	Num	Rate	MY25 GSD Administrative Data Den	Num	Rate	Difference from Top	YoY Administrative Data Trend
Hispanic/Latino	2,639	831	31.49%	2,771	755	27.25%	0.00%	-4.24%
Not Hispanic/Latino	668	251	37.57%	552	217	39.31%	12.07%	+1.74%
Unknown	1	0	0.00%	128	44	34.38%	7.13%	N/A



Quantitative Analysis

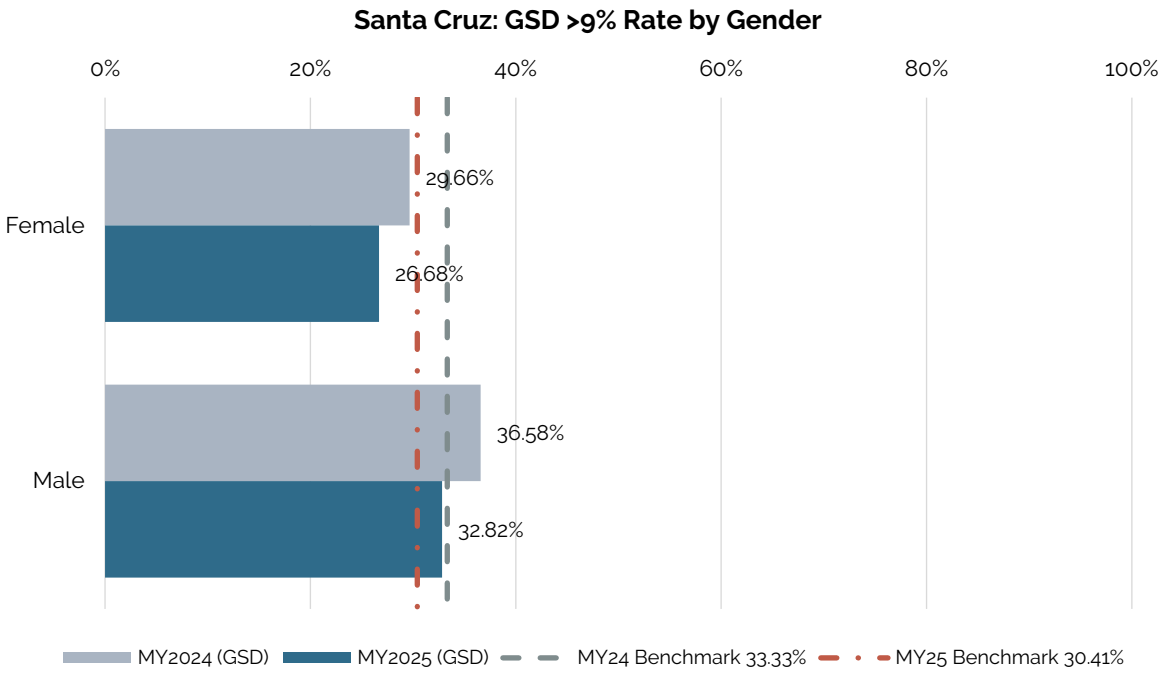
Administrative Data

- Hispanic/Latino was the top-performing group at 27.25% (n=2,771), meeting the MY2025 GSD 50th percentile benchmark of 30.41%.

- Not Hispanic/Latino was the lowest-performing eligible group at 39.31%; the disparity from the top-performing group was 12.07 percentage points.
- Among groups eligible for year-over-year comparison, Hispanic/Latino had the largest decrease (4.24 percentage points), while Not Hispanic/Latino had the largest increase (1.74 percentage points).
- Differences across eligible ethnicity groups were statistically significant (χ^2=33.8136, p=0.0000).

GSD >9% Rate by Gender for Santa Cruz Population

Gender	MY24 GSD Administrative Data Den	Num	Rate	MY25 GSD Administrative Data Den	Num	Rate	Difference from Top	YoY Administrative Data Trend
Female	1,851	549	29.66%	1,900	507	26.68%	0.00%	-2.98%
Male	1,457	533	36.58%	1,551	509	32.82%	6.13%	-3.76%



Quantitative Analysis

Administrative Data

- Female was the top-performing group at 26.68% (n=1,900), meeting the MY2025 GSD 50th percentile benchmark of 30.41%.
- Male was the lowest-performing eligible group at 32.82%; the disparity from the top-performing group was 6.13 percentage points.
- Among groups eligible for year-over-year comparison, Male had the largest decrease (3.76 percentage points), while Female had the smallest decrease (2.98 percentage points).
- Differences across eligible gender groups were statistically significant (χ^2=15.1697, p=0.0001).

Overall Conclusion

For Santa Cruz, MY2024 GSD administrative performance was 67.29% (2,226/3,308) and did not meet the MY2024 GSD 50th percentile benchmark of 33.33%, exceeding it by 33.96 percentage points. MY2025 GSD administrative performance was 29.44% (1,016/3,451) and met the MY2025 GSD 50th percentile benchmark of 30.41% by 0.97 percentage points. Year-over-year administrative performance decreased by 37.85 percentage points, representing improved performance. The MY2024 GSD hybrid rate was 23.00% (23/100) and met the MY2024 GSD 50th percentile benchmark of 33.33% by 10.33 percentage points. The MY2025 GSD hybrid rate was 26.00% (26/100) and met the MY2025 GSD 50th percentile benchmark of 30.41% by 4.41 percentage points. Year-over-year hybrid performance increased by 3.00 percentage points, representing worsened performance. Hybrid demographic stratification was not performed because further division of the county samples would produce small subgroup counts and unstable estimates.

Health Equity Category	Top Performing	Rate	Lowest Performing	Rate	Disparity
Race	White	27.63%	Some Other Race	32.21%	4.58%
Ethnicity	Hispanic/Latino	27.25%	Not Hispanic/Latino	39.31%	12.07%
Gender	Female	26.68%	Male	32.82%	6.13%

Qualitative Analysis Based on GSD by Race, Ethnicity, and Gender

The Alliance is committed to improving glycemic status outcomes and reducing avoidable differences in diabetes care across its service area. The MY2024 and MY2025 GSD administrative results identify variation by county and demographic group. These findings should be interpreted as signals for further review rather than proof that a demographic characteristic caused the observed difference. The Alliance subject matter experts, provider partners, and community representatives should use the findings to validate barriers and select interventions that are responsive to local needs.

Disparities Analysis:

The table below summarizes the principal qualitative themes suggested by the quantitative findings. The themes are intended to guide root-cause assessment and should be confirmed through member, provider, and operational data.

Health Equity Category	Observed Pattern	Potential Contributing Factors	Recommended Validation
Race	Performance varied across racial groups and counties. The direction and size of the gap were not uniform, and several race comparisons were not statistically significant.	Differences in continuity of care, access to laboratory testing, medication affordability, transportation, food access, health literacy, trust, and completeness of race data may influence results.	Review gaps in care, medication adherence, laboratory completion, primary-care attribution, geographic access, and data completeness by county and race. Conduct member and provider interviews where gaps persist.
Ethnicity	Ethnicity differences were more pronounced in some counties, including statistically significant MY2025 differences in selected county analyses. The results were not consistent across every county.	Language access, culturally responsive education, immigration-related concerns, work schedules, transportation, food insecurity, and variation in access to regular diabetes care may contribute.	Stratify by preferred language, interpreter need, provider assignment, visit frequency, medication fills, and laboratory completion. Engage Hispanic/Latino and non-Hispanic/Latino members to validate barriers.
Gender	Females generally performed better than males in several county analyses for both good control and poor control, although the magnitude varied by county.	Differences in preventive-care use, care-seeking behavior, social support, competing work responsibilities, willingness to discuss health concerns, and engagement with diabetes education may affect outcomes.	Compare primary-care utilization, missed appointments, medication adherence, laboratory completion, and participation in diabetes education by gender. Test male-focused outreach approaches.
County/ Geography	County-level performance and demographic gaps varied, indicating that a single plan wide explanation is unlikely to account for all findings.	Provider supply, travel distance, rural access, appointment availability, local referral pathways, socioeconomic conditions, and county-specific data capture may contribute.	Pair demographic findings with provider-level, ZIP-code, rurality, transportation, appointment-access, and network-capacity analyses before selecting interventions.

Qualitative Analysis by Gender

The gender analysis shows a recurring pattern in which females often achieved more favorable glycemic status rates than males. This pattern may reflect differences in healthcare engagement rather than an inherent effect of gender. Females may have more frequent contact with healthcare services and may be more likely to participate in preventive care, laboratory monitoring, and socially supported disease-management activities. Males may be more likely to delay routine care, rely on

self-directed management, or seek care after symptoms or complications develop. These hypotheses require confirmation using utilization, adherence, and member-experience data.

A gender-responsive approach should avoid treating males or females as uniform groups. Outreach should be tailored to the barriers identified in each county. For males, useful strategies may include flexible appointment hours, concise action-oriented education, outreach through trusted community settings, and simplified laboratory scheduling. For females, interventions should continue to support medication access, caregiving-related scheduling needs, and sustained engagement with primary and specialty care.

Qualitative Analysis by Race and Ethnicity

The race and ethnicity findings demonstrate that disparities are not identical across counties. A group that performs well in one county may perform less favorably in another, suggesting that local access, provider, socioeconomic, and data-quality conditions influence performance. Statistical significance in selected comparisons indicates that some observed differences are unlikely to be explained by random variation alone; however, significance does not identify the cause of the difference.

Potential barriers include inconsistent access to primary care and laboratory services, medication cost or refill interruptions, limited availability of culturally and linguistically appropriate diabetes education, transportation, food insecurity, competing work, or caregiving demands, and mistrust or prior negative experiences with the healthcare system. Incomplete or changing demographic data may also affect comparisons. These factors should be evaluated before attributing results to member behavior or provider performance.

Opportunities for Improvement

- Use county- and provider-level gap lists to identify members who are overdue for glycemic testing, medication follow-up, or diabetes visits, with outreach prioritized to demographic groups showing persistent gaps.
- Expand culturally and linguistically appropriate diabetes education, including plain-language materials, interpreter-supported counseling, and community-based education developed with member input.
- Reduce practical barriers by supporting flexible laboratory scheduling, transportation resources, mobile or point-of-care testing where feasible and coordinated appointment reminders.
- Assess medication access and adherence through pharmacy-fill data, refill outreach, synchronization, and referral to financial or social-service supports when barriers are identified.
- Develop gender-responsive outreach, including male-focused engagement strategies and scheduling options that account for employment and caregiving responsibilities.
- Improve demographic data completeness and consistency so that changes in race, ethnicity, language, and gender coding do not obscure true performance trends.
- Reassess interventions annually using quantitative rates, statistical testing, member feedback, provider feedback, and operational measures to determine whether disparities are narrowing.

Qualitative Analysis of Hybrid Rates

At the Medi-Cal aggregate level, the MY2024 GSD hybrid rate for <8% was 61.80% (254/411) and met the MY2024 GSD 50th percentile benchmark of 57.42% by 4.38 percentage points; the MY2025 GSD hybrid rate was 65.21% (268/411) and met the MY2025 GSD 50th percentile benchmark of 60.58% by 4.63 percentage points. The aggregate <8% rate increased by 3.41 percentage points.

For >9%, the MY2024 GSD aggregate hybrid rate was 29.20% (120/411) and met the MY2024 GSD 50th percentile benchmark of 33.33% by 4.13 percentage points; the MY2025 GSD rate was 24.82% (102/411) and met the MY2025 GSD 50th percentile benchmark of 30.41% by 5.59 percentage points. The aggregate >9% rate decreased by 4.38 percentage points, representing improvement.

At the county level, MY2024 GSD <8% rates met the 57.42% benchmark in Merced, Monterey, San Benito, and Santa Cruz; MY2025 GSD <8% rates met the 60.58% benchmark in Monterey, San Benito, and Santa Cruz. MY2024 GSD >9% rates met the 33.33% benchmark in Merced, Monterey, and Santa Cruz, and all five counties met the MY2025 GSD >9% benchmark of 30.41%. Across the two measurement years, county denominators ranged from 100 to 201 members (MY2024: 100 to 184; MY2025: 100 to 201). Because demographic stratification would divide these county samples into much smaller cells, hybrid findings are used to describe overall county and Medi-Cal performance rather than to infer disparities by race, ethnicity, or gender. Administrative data remain the primary source for demographic disparity analysis because they provide larger denominators and more stable subgroup comparisons.

Overall Qualitative Analysis

The combined findings indicate that glycemic status disparities are multifactorial and vary by county, race, ethnicity, and gender. The results support a targeted approach rather than a single plan wide intervention. The Alliance should prioritize groups with persistent and statistically significant gaps while also considering population size, year-over-year direction, and whether the group met the applicable measurement-year-specific benchmark.

The analysis also shows the importance of pairing outcome data with information about access, utilization, medication adherence, laboratory completion, social needs, provider capacity, and member experience. Quantitative differences identify where closer review is warranted; qualitative assessment determines why the difference may be occurring and which intervention is most likely to improve outcomes. Continued collaboration with members, providers, community partners, and internal subject matter experts will be essential to validate root causes and reduce disparities in glycemic control.

9.3. Well-Child Visits

The Well-Child Visits health disparity analysis focuses on the Well-Child Visits in the First 15 Months. (W30-6) measure, which tracks the percentage of children who turned 15 months old in the measurement year and received six or more well-child visits with a provider, as well as the Child and Adolescent Well-Care Visits (WCV-Total), which tracks the percentage of members 3-21 years of age who had at least one comprehensive well-care visits with a PCP or an OB/GYN practitioner during the measurement year. These visits are crucial during early childhood, offering an opportunity to monitor growth, assess developmental milestones, and identify potential health concerns at an early stage.

Despite the clear benefits, well-child visit rates for infants have historically been low in certain counties. However, recent data shows improvement since 2021. County-specific rates reveal disparities, with San Benito County at 31.09%, Mariposa County at 45.95%, and Merced County at 56.38%, while Monterey and Santa Cruz counties both achieved a high performance rate of at 75.04% and 79.81%, respectively for Well Child Visits in the First 15 months. This analysis seeks to explore these variations, identify contributing factors, and guide interventions to enhance access to well-childcare and promote equitable health outcomes for all children in the Alliance service area.

Goal

This analysis aims to review well child rates to uncover health disparities among Alliance members and determine areas for improvement. This assessment supports the Alliance's mission to enhance health equity by providing all members with access to preventive healthcare services across all races, ethnicities, and languages. The goals are benchmarked against the 50th percentile of MCAS MY2025 administrative data to provide measurable targets for improvement.

Product Type	Measure	Goal 50th percentile
Medicaid HMO	Well Child Visits in the First 15 Months (W30-6+)	63.38%
Medicaid HMO	Child and Adolescent Well-Care Visits - Total	55.41%

Methodology

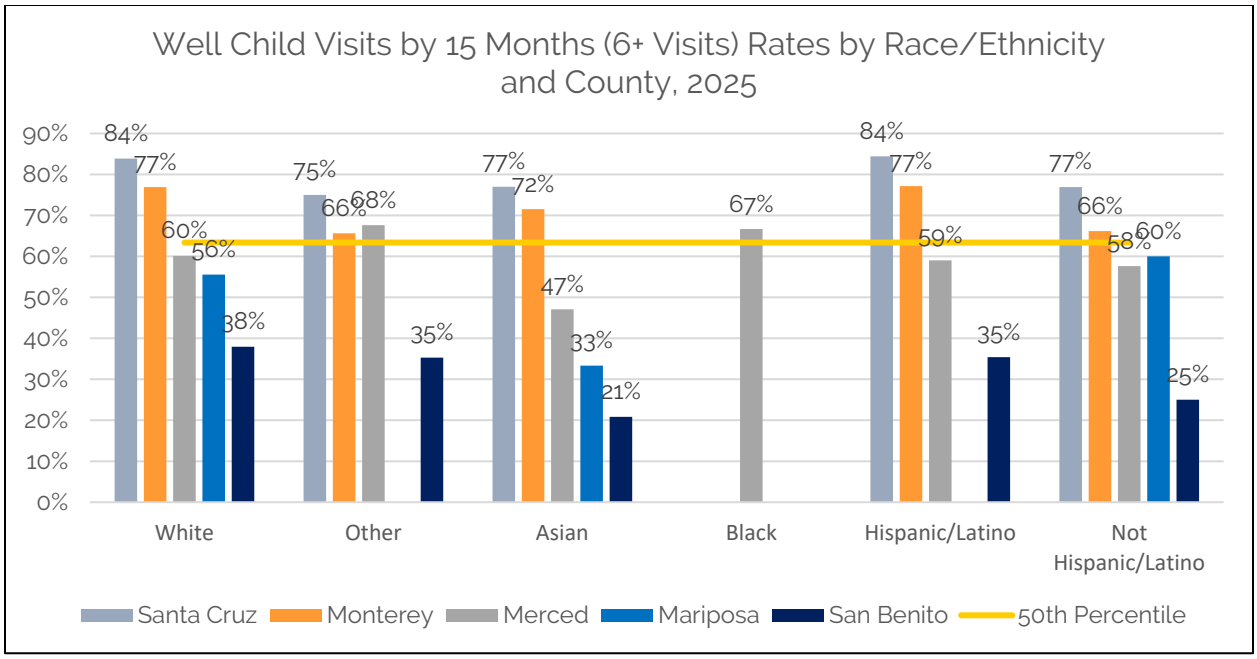
The Alliance conducted the well child analysis following NCQA HEDIS standards. The analysis breaks down W30-6+ and WCV-Total data by race/ethnicity and language spoken to identify disparities in care access and emerging trends.

Result

9.3.1. Analysis by Race and Ethnicity: Well Child Visits in the First 15 Months

Analysis by Race/Ethnicity below displays the percentage of visits stratified by race/ethnicity and county. White (N=93) and Hispanic/Latino (N=552) infants had the highest rate in Santa Cruz County, with all above the 50th percentile. Monterey County's highest rate reports was in members identified as White (N=1074) and Hispanic/Latino (N=2506), with all above the 50th percentile. Merced County Other (N=71) was the highest rate followed by Black (N=33), with all other groups below the 50th percentile. All of Mariposa County's stratified rates were below the goal, with the lowest rate for Asian (N=18). San Benito County's rates were well below the goal, with the with the lowest at 21% for Asian (N=72) for this measure.

Well Child Visits (6+) by 15 Months by Race/Ethnicity and County/Region, 2025.



Source: MCAS MY2025 administrative data, direct reference only, denominator >10.

Quantitative Analysis

Santa Cruz County

- The chart illustrates the rates of Well Child Visits by 15 months across different ethnic groups and counties for 2025, with the benchmark set at the 50th percentile (63.38%).
- White and Hispanic/Latino children in Santa Cruz County achieved the highest rate at 84%, exceeding the 50th percentile benchmark by 20.62 percentage points. This makes them perform as the reference population group.
- Other racial groups in Santa Cruz County had the lowest rate at 75%, which is 11.6 percentage points above the goal but 9 percentage points lower than the White and Hispanic/Latino group.
- Asian and Not Hispanic/Latino children in Santa Cruz County had a rate of 77%, which is 13.6 percentage points above the goal but 7 percentage points lower than the top-performing White and Hispanic/Latino group.

Monterey County

- In Monterey County, White and Hispanic/Latino children had the highest rate of well-child visits by 15 months at 77%, making them the reference population for this county. This rate is 13.6 percentage points above the goal but 7 percentage points lower than the top-performing White and Hispanic/Latino children in Santa Cruz County.

- Asian children in Monterey followed closely with a rate of 72%, which is 8.6 percentage points above the goal and 5 percentage point lower than the top-performing White and Hispanic/Latino group in Monterey.
- Other ethnic groups and Not Hispanic/Latino children had the lowest rate at 66%, which is 2.6 percentage points above the goal and 11 percentage point lower than the top-performing White and Hispanic/Latino group in Monterey.

Merced County

- Merced County has improved with Black and Other racial/ethnic group children above benchmark set at the 50th percentile (63.38%) compared to last year.
- The highest rate was 68% among Other racial/ethnic group children. This makes them the reference population for this county. This rate is 4.6 percentage points below the goal and 16 percentage points lower than the top-performing White and Hispanic/Latino in Santa Cruz County.
- White children in Merced had a rate of 60%, which is 3.4 percentage points below the goal and 8 percentage points lower than the top-performing Other racial/ethnic groups in Merced.
- Asian children in Merced had the lowest rate at 47%, which is 16.4 percentage points below the goal and 21 percentage points lower than the highest rate among Other racial/ethnic group children in Merced.
- Black children in Merced had a rate of 67%, which is 17.9 percentage points below the goal and 5 percentage points lower than the top-performing Other racial/ethnic groups in Merced.
- Hispanic/Latino children in Merced had a rate of 59%, which is 3.6 percentage points below the goal and 1 percentage points lower than the top-performing Other racial/ethnic groups in Merced.
- Non-Hispanic/Latino children in Merced had a rate of 58%, which is 5.4 percentage points below the goal and 10 percentage points lower than the Other racial/ethnic groups in Merced.

Mariposa County

- Mariposa County showed lower rates across all racial/ethnic groups. None of the racial/ethnic groups met the benchmark set at the 50th percentile (63.38%).
- The highest rate was 60% among Not Hispanic/Latino children. This makes them the reference population for this county. This rate is 3.4 percentage points below the goal and 24 percentage points lower than the top-performing White and Hispanic/Latino children in Santa Cruz County.
- White children in Mariposa had a rate of 56%, which is 36.9 percentage points below the goal and 24 percentage points lower than the highest rate among Not Hispanic/Latino children in Mariposa.

- Asian children in Mariposa had the lowest rate at 33%, which is 7.4 percentage points below the goal and 27 percentage points lower than the top performing Not Hispanic/Latino group in Mariposa.

San Benito County

- San Benito County showed lower rates across all racial/ethnic groups. None of the racial/ethnic groups met the benchmark set at the 50th percentile (63.38%).
- The highest rate was 38% among White children. This makes them the reference population for this county. This rate is 25.4 percentage points below the goal and 46 percentage points lower than the top-performing White and Hispanic/Latino children in Santa Cruz County.
- Other racial/ethnic groups and Hispanic/Latino children in San Benito had a visit rate of 35%, which is 24.9 percentage points below the goal and 3 percentage points lower than the top-performing White group in San Benito.
- Asian children in San Benito had the lowest rate of 21%, which is 42.4 percentage points below the goal and 17 percentage points lower than the top-performing White group in San Benito.
- Non-Hispanic/Latino children in San Benito had a rate of 25%, which is 38.4 percentage points below the goal and 13 percentage points lower than the White group in Merced.

Conclusion

In summary, White and Hispanic/Latino children in Santa Cruz County significantly outperformed other groups, while the other counties, especially Merced, Mariposa, and San Benito, did not meet the 50th percentile benchmark across all race/ethnic groups.

Qualitative Analysis

The qualitative analysis examined well-child visit compliance rates across five counties and pointed out disparities in performance among racial and ethnic groups. The analysis identifies the top-performing and low-performing groups in each county, evaluates overall compliance with benchmarks, and emphasizes gaps that require targeted interventions to improve equitable access to healthcare services.

Santa Cruz County

- **Top-Performing Group:** White and Hispanic/Latino children at 84% compliance, serving as the reference group.
- **Lowest-Performing Group:** Other racial groups children at 75% were 9 percentage points lower than White and Hispanic/Latino children but still exceeded the goal by 1.1.6 percentage points.
- **Overall Compliance:** All groups met or exceeded the benchmark of 63.38%, demonstrating strong engagement with well-child services across racial/ethnic groups.

- **Disparities:** There is 9% a disparity in compliance rates between different racial groups in the Santa Cruz County data, with White and Hispanic/Latino performing the best (84%) and Other racial groups performing the worst (75%).

Monterey County

- **Top-Performing Group:** White and Hispanic/Latino children at 77%, serving as the reference group for Monterey County.
- **Lowest-Performing Group:** Not Hispanic/Latino and Other racial groups at 66%, which were 11 percentage points lower than the top-performing White and Hispanic/Latino group but exceeded the goal by 2.6 percentage points.
- **Overall Compliance:** All groups met or exceeded the benchmark of 63.38%, with White and Hispanic/Latino groups performing the best.
- **Disparities:** There was a 11% disparity in compliance rates between the highest-performing White and Hispanic/Latino group (77%) and the lowest-performing Not Hispanic/Latino and Other racial groups (66%) in Monterey County.

Merced County

- **Top-Performing Group:** Other racial/ethnic groups children at 68%, serving as the reference group despite not meeting the goal.
- **Lowest-Performing Group:** Asian children at 47%, which were 21 percentage points lower than the top-performing Other racial/ethnic groups and 16.4 percentage points below the goal.
- **Overall Compliance:** Most groups in Merced County did not meet the benchmark of 63.38%, indicating widespread underperformance across all racial/ethnic groups.
- **Disparities:** There was a 21% disparity in compliance rates between the top-performing Other racial/ethnic groups group (68%) and the lowest-performing Asian group (47%) in Merced County.

Mariposa County

- **Top-Performing Group:** Not Hispanic/Latino children at 60% compliance, serving as the reference group.
- **Lowest-Performing Group:** Asian children at 33% were 4 percentage points lower than the top-performing Not Hispanic/Latino children and 27 percentage points below the goal.
- **Overall Compliance:** No groups in Mariposa met the benchmark of 63.38%, indicating widespread underperformance across all racial/ethnic groups.
- **Disparities:** There is 27% a disparity in compliance rates between top performing Not Hispanic/Latino (60%) groups and the lowest-performing Asian group (33%) in Mariposa County.

San Benito County

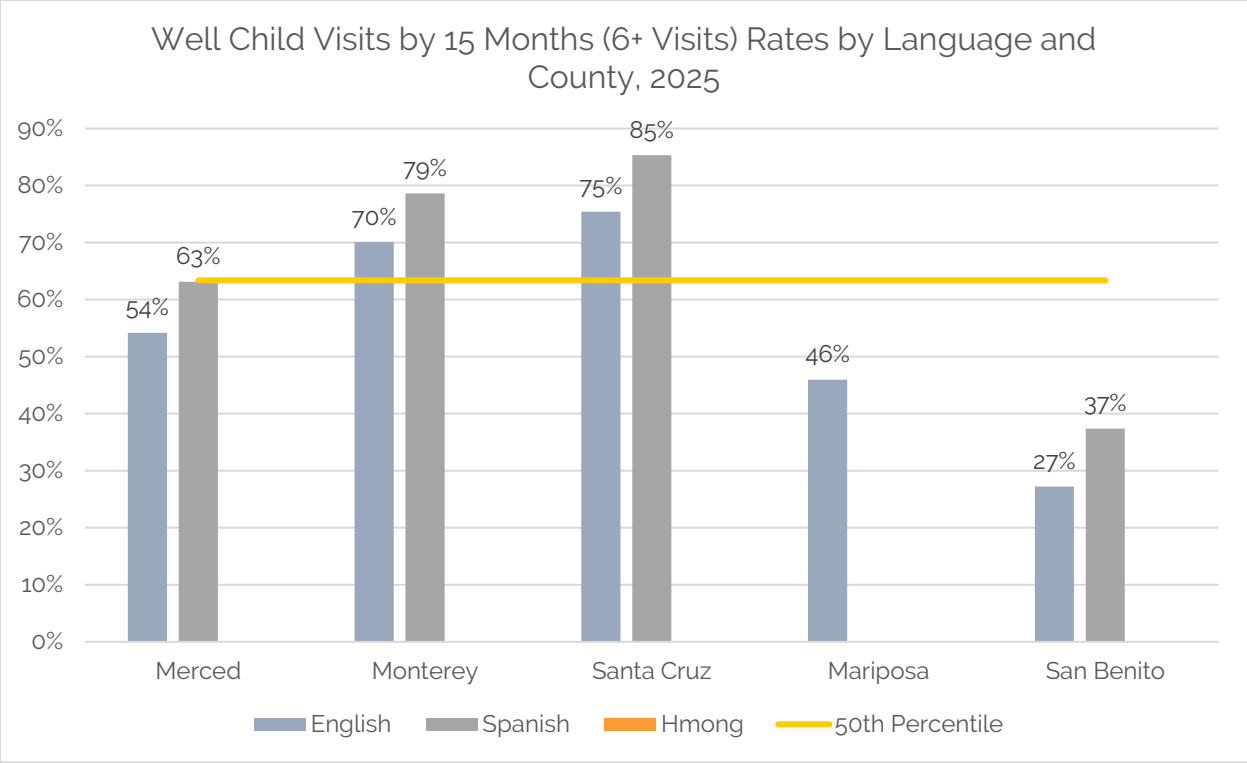
- **Top-Performing Group:** White children at 38% compliance, serving as the reference group.

- **Lowest-Performing Group:** Asian children at 21% were 17 percentage points lower than the top-performing Not Hispanic/Latino children and 42.4 percentage points below the goal.
- **Overall Compliance:** No groups in San Benito met the benchmark of 63.38%, indicating widespread underperformance across all racial/ethnic groups.
- **Disparities:** There is 17% a disparity in compliance rates between top performing White (38%) groups and the lowest-performing Asian group (21%) in San Benito County.

The analysis reveals disparities in well-child visit compliance across counties. In **Santa Cruz County**, White and Hispanic/Latino children showed the highest compliance, possibly due to effective outreach and culturally tailored programs. However, Asian children in San Benito County had the lowest compliance rates overall. It reflects differences in access to well-child services between these two counties, and disparities for Asian children were also indicated in Merced and Mariposa County. Other racial groups children had the lowest compliance in Santa Cruz. In **Monterey County**, White and Hispanic/Latino children performed the best, likely benefiting from strong community engagement and language-specific resources, while Not Hispanic/Latino and Other racial groups lagged, potentially due to systemic inequities or limited outreach. **Merced County** faced underperformance, with Other racial/ethnic groups children showing the highest compliance and Asian children the lowest. The underperformance in Merced County may result from socioeconomic challenges, healthcare access barriers, and insufficient provider capacity, particularly for Asian children and other underserved populations. In **Mariposa County,** Not Hispanic/Latino children showed the highest compliance with well visits, and Asian children had the lowest compliance. In **San Benito County,** White children showed the highest level of compliance, and Asian children had the lowest level of compliance. Further analysis is suggested for Asian children in Merced, Mariposa, and San Benito to understand driving factors for their differences.

9.3.2. Analysis by Spoken Languages: Well Child Visits in the First 15 Months

Well Child Visits by 15 Months (6 Visits) by Spoken Language and County*, 2025



Source: MCAS MY2025 administrative data. Spoken language groups included if the denominator was >10 members. No county had a population large enough to report Hmong.

Quantitative Analysis

Santa Cruz County

- Spanish-speaking children had the highest rate in the county at 85%, exceeding the goal by 21.6 percentage points and making them the reference population (top-performing group).
- English-speaking children had the lowest rate of well-child visits at 75%, which was 11.6 percentage points above the goal but 10 percentage points lower than the Spanish-speaking top-performing group.

Monterey County

- Spanish-speaking children showed a rate of 79%, with 15.6 percentage points above the goal, and were the reference population for this county.
- English-speaking children had the lowest rate of well-child visits of 60%, which was 6.6 percentage points above the goal but 9 percentage point lower than the Spanish-speaking top-performing group.

Merced County

- None of the language groups met the 50th percentile goal (63.38%) in Merced County.
- Spanish-speaking children had a well-child visit rate of 63%, which was 0.4 percentage points below the goal but made them the reference population (top-performing group) in Merced County.
- English-speaking children had a rate of 54%, which was 9.4 percentage points below the goal and 9 percentage points lower than the top-performing Spanish-speaking group.

Mariposa County

- None of the language groups met the 50th percentile goal (63.38%) in Mariposa County.
- English-speaking children had a well-child visit rate of 46%, which was 17.4 percentage points below the goal but made them the reference population (top-performing group) as the only reportable language in Mariposa County, and 29 percentage points below the top performing English-speaking children in Santa Cruz County.

San Benito County

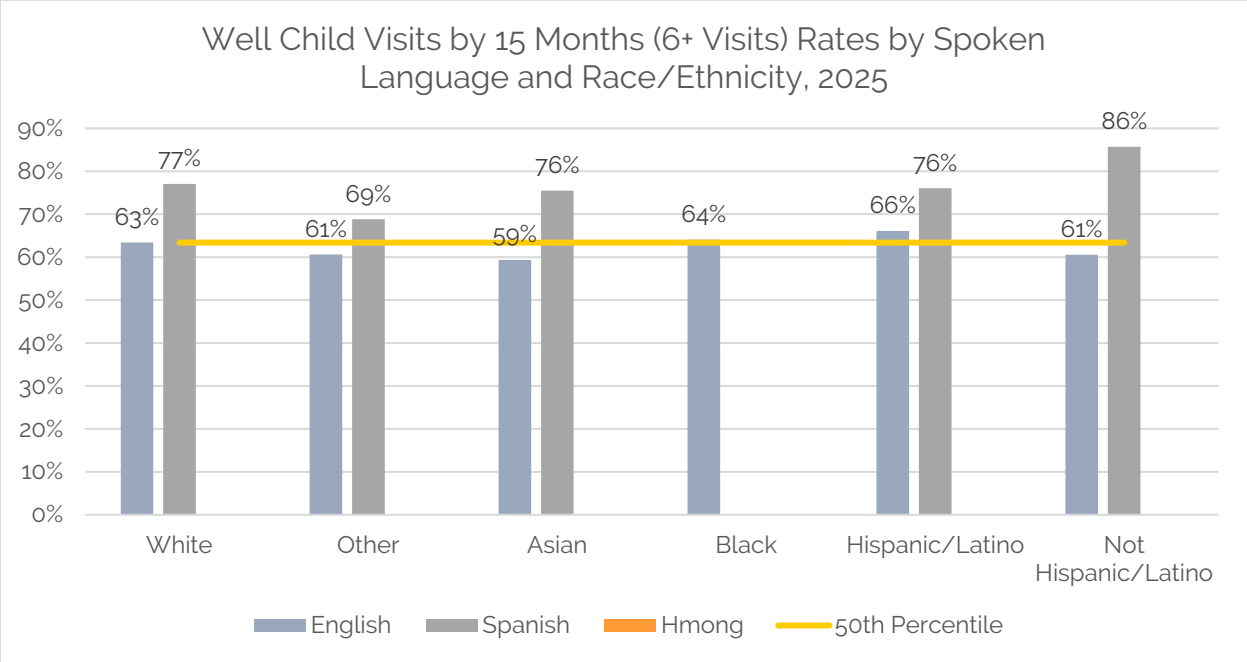
- None of the language groups met the 50th percentile goal (63.38%) in San Benito County.
- Spanish-speaking children had a well-child visit rate of 37%, which was 26.4 percentage points below the goal but made them the reference population (top-performing group) in San Benito County.
- English-speaking children had a rate of 27%, which was 36.4 percentage points below the goal and 10 percentage points lower than the top-performing Spanish-speaking group.

Conclusion

Santa Cruz County showed the highest performance for Spanish-speaking children at 85%, while San Benito County showed the lowest overall performance, with none of the language groups meeting the 50th percentile benchmark. The English-speaking group showed the most significant gap in all five counties, especially in San Benito, Mariposa, and Merced, where they are below the 50th percentile goal (63.38%). This year there were no counties with eligible members with spoken language of Hmong that met criteria for inclusion (>10 in denominator).

9.3.3. Analysis by Spoken Language and Race and Ethnicity: Well Child Visits in the First 15 Months

Well Child Visits by 15 Months (6 Visits) by Spoken Language and Race and Ethnicity, 2025



Source: MCAS MY2025 administrative data, direct reference only. Spoken language groups included if the denominator was >10 members. No race/ethnicity had a population large enough to report Hmong.

Spanish speaking families were the highest rates in Not Hispanic/Latino at 86%.

Quantitative Analysis

- For the White population, the most spoken language was Spanish. The rate for English-speaking White children was 63%. This did not meet the goal of the 50th percentile benchmark of 63.38% and was 0.4 percentage points below the goal. When compared to the top-performing group, which was Spanish-speaking children from Not Hispanic/Latino with a rate of 86%, the rate for English-speaking White children was 9 percentage points lower. Spanish-speaking White children had a rate of 77%. This was 13.6 percentage points above the goal and 9 percentage points lower than the top performing group.
- For Other racial groups, the most spoken language was English. Spanish-speaking children from this group achieved a rate of 69%. This rate exceeded the goal by 5.6 percentage points and made them the top-performing group. English-speaking children from Other racial groups had a rate of 61%. This rate was 2.4 percentage points below the goal but 8 percentage points lower than the Spanish-speaking children in the same racial group.
- Among Asian children, Spanish-speaking children achieved a rate of 76%. This met the goal and exceeded it by 12.6 percentage points. However, this rate was still 10 percentage points lower than the top-performing Spanish-speaking group from Not Hispanic/Latino groups. English-speaking Asian children had a rate of 59%. This rate was 4.4 percentage points below the goal and 27 percentage points lower than the top-performing group.
- Black children spoke only English. The rate for Black children was 64%. This was 0.6 percentage points above the goal and 22 percentage points lower than the top-performing Spanish-speaking group from Not Hispanic/Latino groups.
- Spanish-speaking Hispanic or Latino children achieved a rate of 76%. This rate exceeded the goal by 12.6 percentage points but was 10 percentage points lower than the top-performing Spanish-speaking group from Not Hispanic/Latino groups. English-speaking Hispanic or Latino children had a rate of 66%. This rate was 2.6 percentage points above the goal and 20 percentage points lower than the top-performing group.
- Spanish-speaking children from the Not Hispanic or Latino population achieved a rate of 86%. This rate exceeded the goal by 22.6 percentage points and made them the top-performing group. English-speaking children from this group had a rate of 61%. This rate was 2.4 percentage points below the goal but 25 percentage points lower than the top-performing Spanish-speaking group.

Conclusion

In summary, the data shows significant disparities in well-child visit rates across different racial and ethnic groups as well as spoken languages. Spanish-speaking children, especially those identified as Not Hispanic/Latino, achieve the highest compliance rates. In contrast, English-speaking Asian children show the lowest rates across all racial and ethnic categories.

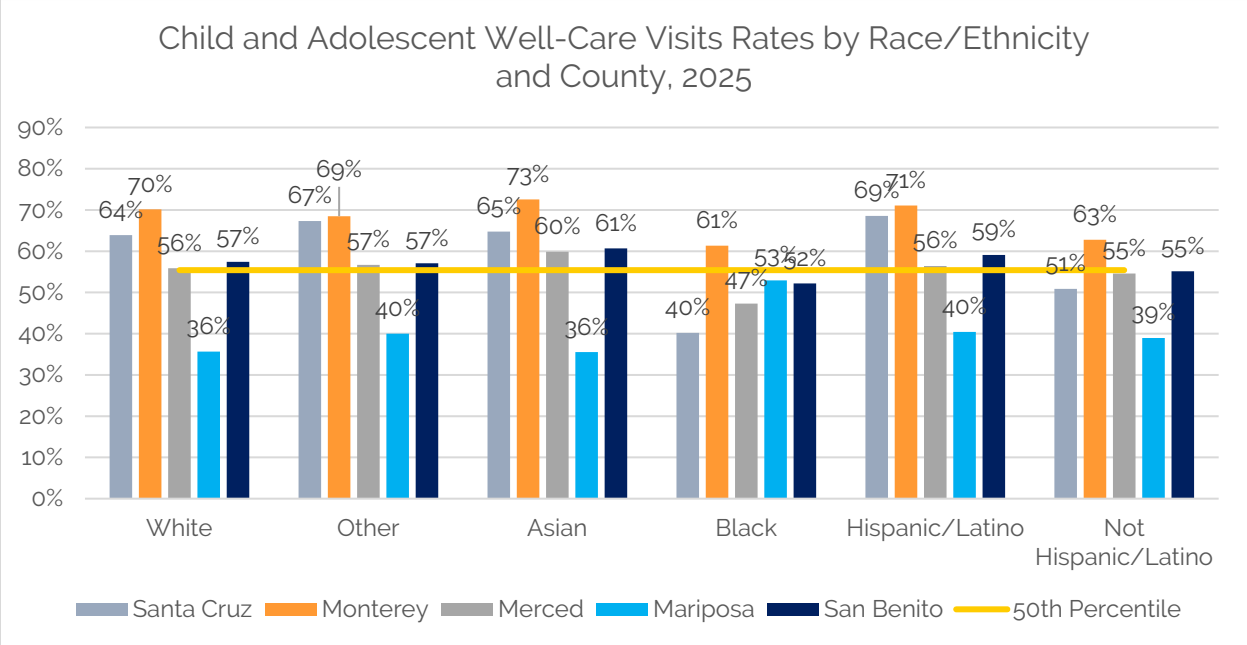
9.4. Child and Adolescent Well-Care Visits – Total

The Child and Adolescent Well-Care Visits – Total (WCV) measure represents the percentage of children aged 3 to 21 years who had at least one comprehensive well-care visit with a PCP or OBGYN practitioner during the measurement year. Overall, 63.57% of eligible child and adolescent Alliance members ages 3-21 had at least one well child visit in 2025, with Merced County at 55.83%, Monterey at 70.26%, 64.92% in Santa Cruz County, 37.05% in Mariposa County, and 58.4% in San Benito County.

The analysis below displays the percentage of WCV visits stratified by race/ethnicity and county. As shown, Asian children and adolescents in Monterey had the highest rates of visits overall (73%), followed by Hispanic/Latino (71%), and White (70%) in Monterey County. In Santa Cruz County, Hispanic/Latino children (69%) had the highest rate. In Merced and San Benito County, Asian children and adolescents had the highest compliance rates at 60% and 61%, respectively. White (N=841) and Asian children (N=166) and adolescents in Mariposa County had the lowest rates of compliance overall, at 36%, compared to Black children and adolescents at 53%. Although White children and adolescents in Mariposa County represent a considerable proportion of members in the denominator and a priority population for preventive care in Mariposa County, understanding the root cause of these disparities will take time to uncover.

9.4.1.Analysis by Race and Ethnicity: Well-Care Visits – Total

Child and Adolescent Well-Care Visit Rates by Race/Ethnicity and County, 2025



Source: MCAS MY2025 administrative data, direct reference only, denominator >10.

Quantitative Analysis

Santa Cruz County

- Hispanic/Latino children show the highest rate in Santa Cruz County, at 69%. This rate is above the 50th percentile benchmark (55.41%) by 13.4 percentage points, making them the top-performing group within the county.

- Not Hispanic/Latino children other group achieve a rate of 51%, which was 4.4 percentage points below the goal but 18 percentage points lower than the top-performing Hispanic/Latino group.
- White children had a rate of 64%, which was 8.6 percentage points above the goal and 5 percentage points lower than the highest-performing group in the county.
- Other race group had a rate of 67%, which was 11.6 percentage points above the goal and 2 percentage points lower than the highest-performing group in the county.
- Asian children in Santa Cruz County had a rate of 65%, which was 9.6 percentage points above the goal but 4 percentage points lower than the top-performing Hispanic/Latino group.
- Black children had the lowest rate in Santa Cruz County at 40%. This rate was 15.4 percentage points below the goal and 29 percentage points lower than the top-performing Hispanic/Latino group.

Monterey County

- Asian children in Monterey County had the highest rate of well-care visits at 73%. This rate exceeded the goal by 17.6 percentage points, making them the top-performing groups within the county.
- White children in Monterey County had a rate of 70%, which was 14.6 percentage points above the goal and 2 percentage points lower than the top-performing Asian groups.
- Other race group had a rate of 69%, which was 13.6 percentage points above the goal and 4 percentage points lower than the highest-performing Asian group in the county.
- Black children in Monterey County had the lowest rate at 61%, which was 5.6 percentage points above the goal and 12 percentage points lower than the top-performing Asian groups.
- Hispanic/Latino children in Monterey County had a rate of 71%, which was 15.6 percentage points above the goal but 2 percentage points lower than the top-performing Asian group.
- Not Hispanic/Latino children achieved a rate of 63%, which was 7.69 percentage points above the goal but 10 percentage points lower than the top-performing Asian groups.

Merced County

- Asian children achieved a rate of 60%, which was 4.5 percentage points above the goal and made them the top-performing group in Merced County.
- White children and Hispanic/Latino had a rate of 56%, which was 0.6 percentage points above the goal and 4 percentage points lower than the top-performing group in the county.
- Other race group had a rate of 57%, which was 1.6 percentage points above the goal and 3 percentage points lower than the highest-performing Asian group in the county.
- Black children showed the lowest rate at 47%, which was 8.4 percentage points below the goal and 13 percentage points lower than the highest-performing group in Merced County.
- Not Hispanic/Latino children achieved a rate of 55%, which was 0.4 percentage points below the goal but 5 percentage points lower than the top-performing Asian groups.

Mariposa County

- Black children achieved a rate of 53%, which made them the top-performing group in Mariposa County, however they were 2.4 percentage points below the goal.
- White children and Asian children showed the lowest rate at 36%, which was 8.31 percentage points below the goal and 11 percentage points lower than the top-performing group in the county.

- Other race group and Hispanic/Latino children had a rate of 40%, which was 1.6 percentage points above the goal and 3 percentage points lower than the highest-performing Asian group in the county.
- Not Hispanic/Latino children had a rate of 39%, which was 1.69 percentage points above the goal and only 1 percentage point below the top-performing group in Mariposa County.

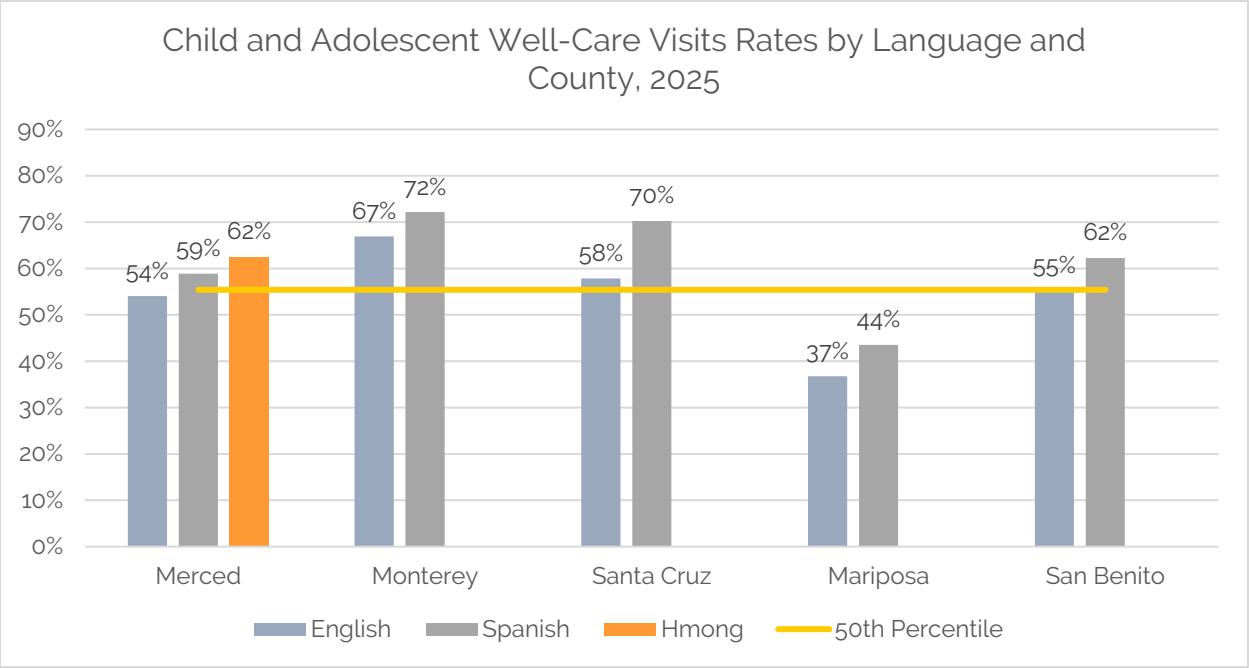
San Benito County

- Asian children achieved a rate of 61%, which was 2.69 percentage points above the goal and made them the top-performing group in San Benito County.
- White children and Other race group children had a rate of 57%, which was 1.6 percentage points above the goal and 4 percentage points lower than the top-performing group in the county.
- Black children showed the lowest rate at 52%, which was 3.4 percentage points below the goal and 9 percentage points lower than the highest-performing Asian group in San Benito County.
- Hispanic/Latino children had a rate of 59%, which was 3.6 percentage points above the goal and 2 percentage points lower than the highest-performing Asian group in the county.
- Not Hispanic/Latino children had a rate of 55%, which was 0.4 percentage points below the goal and 6 percentage point below the top-performing Asian group in San Benito County.

9.4.2. Analysis by Spoken Languages: Child and Adolescent Well-Care Visit – Total

As shown in Child and Adolescent Well-Care Visit Rates by Spoken Language* and County, members in Monterey County whose spoken language was listed as Spanish had the highest overall rate of WCV compliance (72%), followed by Spanish speaking members in Santa Cruz County at 70%. All but English was above the 50th percentile in Merced County and San Benito County, however all languages were below the goal in Mariposa County. In the Child and Adolescent Well-Care Visit Rates by Spoken Language and Race/Ethnicity graph below, the highest compliance is from Other race group Hmong speakers (76%, N= 46), contrasted with the lowest for White Hmong speakers (20%, N=13).

Child and Adolescent Well-Care Visit Rates by Spoken Language* and County, 2025



Source: MCAS MY2025 administrative data, direct reference only. Spoken language groups included if the denominator was >10 members.

Child and Adolescent Well-Care Visit Rates by Spoken Language and Race/Ethnicity, 2025

Source: MCAS MY2025 administrative data, direct reference only. Spoken language groups included if the denominator was >10 members.

Quantitative Analysis

Santa Cruz County

- Spanish-speaking members achieved a compliance rate of 70%, which exceeded the goal of 55.41% by 14.6 percentage points. This group was the top-performing population in the county.
- English-speaking members had a compliance rate of 58%, which was 2.6 percentage points above the goal but 12 percentage points lower than the top-performing Spanish-speaking group.

Monterey County

- Spanish-speaking members achieved a compliance rate of 72%, which exceeded the goal by 16.6 percentage points, making them the top-performing population in the county.
- English-speaking members had a compliance rate of 67%, which was 11.6 percentage points above the goal but 5 percentage points lower than the top-performing Spanish-speaking group.

Merced County

- Hmong-speaking members had a compliance rate of 62%, which met the goal by 6.6 percentage points and was the top-performing group in Merced.

- Spanish-speaking members showed a compliance rate of 59%, which met the goal by 3.6 percentage points, and 3 percentage points lower than the top-performing Hmong-speaking group.
- English-speaking members had a compliance rate of 54%, which was 1.4 percentage points below the goal and 8 percentage points lower than the top-performing Hmong-speaking group.

Mariposa County

- Spanish-speaking members achieved a compliance rate of 44%, which exceeded the goal by 19.69 percentage points, making them the top-performing population in the county.
- English-speaking members had a compliance rate of 37%, which was 11.69 percentage points above the goal but 8 percentage points lower than the top-performing Spanish-speaking group.

San Benito County

- Spanish-speaking members achieved a compliance rate of 62%, which exceeded the goal by 19.69 percentage points, making them the top-performing population in San Benito County.
- English-speaking members had a compliance rate of 55%, which was 11.69 percentage points above the goal but 8 percentage points lower than the top-performing Spanish-speaking group.

Conclusion

Spanish-speaking members had higher well-care visit compliance rates than English-speaking members across all five counties. Spanish and English remain the two primary languages spoken by the Alliance members. Compliance rates for Spanish-speaking members were 5 to 12 percentage points higher than those for English-speaking members, however in Merced County, Hmong-speaking members was 3 to 8 percentage points higher than Spanish and English-speaking members. The higher rates among Spanish-speaking and Hmong-speaking members suggest that language-specific outreach and access support for other languages were effectively improved engagement.

Qualitative Analysis by Language and Race/Ethnicity

Member's likelihood of adhering to clinical recommendations is dependent upon their health status, demographic and socioeconomic characteristics, health insurance, and state of residence.
It is likely that in California, there has been a lot of promotion about healthy behaviors in Spanish and among the Hispanic population.

The Alliance scheduled a meeting with the PHM team focused on understanding these reverse disparities in well-child visit rates, particularly the lower performance of the White Medicaid population compared to the Hispanic Medicaid population. Internal discussions for the reasons for these disparities included:

- According to data from the USDA in 2020, 3.9 million White-only non-Hispanic infants and children were eligible for WIC which is the highest eligible numbers of all race and ethnic. This was followed by 3.2 million Hispanic/Latino children, 2.1 million Black-only non-Hispanic children, and 0.8 million from other races. But Hispanic/Latino children had the highest WIC coverage rate at 62 percent while White-only non-Hispanic children had the lowest at 35

percent. Additionally, most eligible children lived in households with four or more members, and 37 percent were enrolled in Medicaid without receiving SNAP or TANF benefits[1].
    - This data aligns with our findings that Hispanic members and Spanish-speaking members perform better than White or English-speaking members.
- Over time, the Alliance has focused numerous health initiatives on the Hispanic population to improve their engagement with healthcare services. This may have contributed to their increased well-child visit rates compared to White populations.
- A key point raised was that Hispanic populations in counties like Merced often participate in programs like WIC and Head Start. These programs provide education on the importance of well-child visits and immunizations. Such participation may contribute to the higher well-child visit rates among Hispanic families.
    - The Alliance initiated the Healthy Start Program in April 2023, offering incentives for well-child visits and immunizations. These promotions are available in English, Spanish, and Hmong. We have collaborated with several community-based organizations like WIC and Head Start. Many of these programs serve Latino populations and require vaccines along with discussions about well-child visits.
    - Participation in these programs typically begins early, sometimes during pregnancy, which leads to improved health literacy and healthcare engagement for children in Hispanic families. The Alliance team noted that participation in these programs is widespread in Merced County, which may influence well-child visit rates among Hispanic children in that area.

Opportunities for Improvement

1. Educate members about OMB category definitions to ensure accurate data collection responses. This will improve the specificity of data for the White population.
    - Clinics will be tasked with educating members using phrases such as, "Please review this definition before answering the question." This effort will address the issue of the Alliance relying on second-hand data from the state by promoting direct and accurate data collection at the clinic level.
    - To achieve the most accurate data, the Alliance plans to collect member information directly through a member portal, which will have gradual phases of functionality launched to expand accessibility to all members.
2. Educational Materials for Providers
    - Develop and distribute educational materials targeting providers to address care delivery disparities. Focus on highlighting existing disparities and emphasizing the need to provide equal opportunities for all members to complete well-child visits. Providers will be encouraged to consider disparities during patient interactions to ensure all members receive equitable care.
3. Utilize tableau reporting to support internal analysis of health disparities in prioritizing well-child visits for underperforming populations.
    - The QIPH team submitted requests for MCAS tableau report visuals to the internal Analytics team. Report request included options for geomapping by county and zip code, comparisons

[1] https://www.fns.usda.gov/research/wic/eligibility-program-reach-estimates-2020#:~:text=The%20coverage%20rate%20was%20estimated,other%20races%20and%20multiple%20races

for race, ethnicity, age grouping, county, gender, language, and assigned primary care provider.

As discussed by the Alliance, we aim to implement the opportunities outlined in items 2 and 3.

Action Taken for Interventions

Intervention	Purpose	Details	Timeline
Educational Materials for Providers	Raise provider awareness about gaps in well-child visits and promote equitable care.	Develop materials to highlight disparities and emphasize equitable care during patient interactions.	Q1-Q2 2025 Planning activities Q3-Q4 2025 Implementation activities
Tableau Reporting Analysis for Health Disparities	Focus on ongoing identification of gaps for underperforming populations.	Create a tableau report for ongoing management and prioritizing of health disparities for interventions for well-child visits.	Initial report request was created in Q1 and completed by Q4 2025.

Plan to Evaluate Effectiveness of Interventions for Hemoglobin A1c and Well-Child Visits

The Alliance is committed to improving the quality and accessibility of healthcare services for members of all ages. This includes enhancing diabetes management outcomes for patients with Hemoglobin A1c needs and increasing the completion rates of Well-Child Visits. To evaluate the effectiveness of interventions, we will focus on assessing healthcare disparities based on race/ethnicity, language, and other social determinants of health for both measures.

Evaluation Methodology

1. Identify and Prioritize Opportunities

- Utilize data to identify and prioritize opportunities to reduce health care inequities in diabetes management.
- Focus on disparities in Hemoglobin A1c control and Well-Child Visits among different racial, ethnic, and language groups.

2. Implement Interventions

- Implement targeted interventions to address identified inequities in Hemoglobin A1c control rates and well-child visit rates.
- Examples of interventions may include culturally tailored education programs, enhanced language services, and community outreach initiatives.

3. Evaluate Effectiveness

- Utilize the Plan-Do-Check-Act (PDCA) model to evaluate the effectiveness of interventions.
- Measure processes and outcomes to identify areas of deficiency and track improvements over time.

Internal and External Stakeholder Engagement

Internal Collaboration

- Engage with relevant Alliance departments, including Network Development, Member Services, and Provider Relations, to observe operational challenges, community impacts, and opportunities for improvement.

External Collaboration

- Involve external stakeholders to gain insights into the perceived effectiveness of interventions.
- Collaborate with local health organizations, community health partners, and advisory committees to ensure a comprehensive approach.

Evaluation Process

Quantitative Analysis

- Conduct thorough quantitative analysis to compare performance to goals, benchmarks, and prior performance.
- Perform statistical significance tests (e.g., Chi-square, Z-test, T-test) where applicable.

Qualitative Analysis

- Review reports by a diverse team of professionals, including the Chief Medical Officer, Quality and Health Programs Manager, Quality and Performance Improvement Manager, Quality and Population Health Manager, Quality Improvement and Health Equity Director, and others.
- Conduct brainstorming sessions, categorize and prioritize barriers, and perform root cause analyses.

Continuous Improvement

- Develop clear and measurable process indicators to evaluate the impact of improvements.
- Set interim goals and schedule for continuous assessment.
- Monitor progress regularly and enhance the process as needed.

Acting on Identified Opportunities

- Generate potential interventions to enhance performance on Hemoglobin A1c control and well-child visits.
- Select a team to carry out activities and provide updates on progress.
- Engage in discussions with the Member Advisory Committee to explore potential opportunities before implementation.

By following this structured approach, the Alliance aims to address healthcare inequities, improve clinical management outcomes, and provide high-quality, equitable care for all patients.

10. Clinical Safety

10.1. Introduction

The Clinical Safety unit within the Quality Improvement Department administers two complementary quality oversight programs that support the Central California Alliance for Health (Alliance) Quality Assurance Program: The Facility Site Review (FSR) Program and the Potential Quality Issue (PQI) Program. Together, these programs provide prospective oversight of provider compliance and retrospective evaluation of Quality of Care (QoC) concerns, promoting provider accountability and quality improvement across the provider network.

During calendar year 2025, the Clinical Safety unit successfully fulfilled its primary regulatory responsibilities while responding to significant operational changes and increasing program demands. Through the combined efforts of the FSR and PQI Programs, the unit maintained strong regulatory performance, enhanced provider oversight, strengthened organizational quality oversight, and implemented operational improvements that strengthened provider monitoring, regulatory reporting, and cross-functional collaboration.

The Clinical Safety unit also operates within a structured governance framework that includes routine MD oversight and recurring cross-functional governance meetings to support coordinated provider oversight, organizational transparency, and evidence-based decision-making across the Alliance.

The FSR Program monitored provider compliance through FSRs, Medical Record Reviews (MRRs), Physical Accessibility Reviews (PARs), Interim Monitoring Reviews, and oversight of Corrective Action Plans (CAPs). Concurrently, the PQI Program maintained 100% compliance with grievance-related regulatory timeframes while adapting to a substantial increase in workload resulting from standardized grievance-review processes that improved the identification of potential QoC concerns.

Beyond regulatory responsibilities, both programs contributed to organizational quality improvement through provider monitoring, progressive interventions, regulatory reporting, cross-functional collaboration, and operational improvements. Site review findings, PQI investigations, and provider trend analyses informed organizational decision-making, enhanced provider performance, and guided operational improvements across multiple departments.

Although each program has distinct regulatory responsibilities, they function together to provide comprehensive oversight across the provider's quality continuum. The FSR Program provides prospective oversight by evaluating provider compliance with regulatory and contractual requirements before deficiencies affect member care. In contrast, the PQI Program provides retrospective clinical oversight by evaluating the quality and appropriateness of care delivered to

Alliance members, identifying trends in provider performance, and informing evidence-based quality improvement. Together, these complementary programs promote regulatory compliance, strengthen provider accountability, and advance the delivery of safe, effective, accessible, and high-quality care for Alliance members.

Clinical Safety Governance and Oversight

The Clinical Safety unit operates within a structured governance framework that supports oversight of the FSR and PQI Programs while promoting clinical oversight, cross-functional collaboration, transparency, and coordinated provider oversight across the Alliance.

Weekly Medical Director Oversight

Clinical Safety meets weekly with MDs to provide ongoing clinical oversight of the FSR and PQI Programs. These meetings provide a structured forum to review complex PQIs, discuss clinical findings, assign severity determinations, evaluate provider quality trends, review FSR activities, and discuss emerging quality concerns. Weekly MD oversight promotes consistent application of clinical standards, supports evidence-based provider interventions, and provides continuous oversight of Clinical Safety program activities.

Clinical Safety Quality Management (CSQM)

CSQM is held monthly to provide cross-functional oversight of the Clinical Safety unit. Participants include Clinical Safety, MDs, Provider Services (PS), and Provider Partnerships. The meeting provides a forum to review FSR and PQI program performance, provider quality trends, operational findings, CAP activities, and emerging quality concerns. CSQM promotes transparency, facilitates communication across departments, supports coordinated provider oversight, and identifies opportunities for operational and quality improvement.

Provider Concerns Collaborative

Clinical Safety also participates in the monthly Provider Concerns Collaborative, a multidisciplinary meeting led by Program Integrity. Participants include Program Integrity, QI, UM, CM, MG, MDs, and other operational departments, as appropriate. The collaborative reviews emerging provider concerns, CAPs, ongoing monitoring activities, and other quality findings to coordinate provider oversight, identify opportunities for process improvement, reduce duplication of effort, and support consistent organizational responses to provider quality concerns.

Organizational Governance

Collectively, these governance activities provide a coordinated framework for provider quality oversight across the Alliance. Through routine MD engagement, cross-functional governance, and enterprise collaboration, the Clinical Safety unit promotes consistent application of regulatory requirements, strengthens provider accountability, enhances organizational transparency, and advances quality improvement.

10.2. Facility Site Review (FSR)

Introduction

The FSR Program is a key component of the Alliance's Quality Assurance Program. It supports the

organization's responsibility to monitor primary care provider (PCP) compliance with Department of Health Care Services (DHCS) site review requirements, the credentialing of providers entering the Alliance's network, and the recredentialing of participating PCP sites. Through FSRs, MRRs, PARs, and CAP oversight, the program evaluates compliance with standards governing patient safety, accessibility, clinical documentation, office operations, and regulatory requirements.

Beyond regulatory compliance, the program provides provider education, technical assistance, CAP oversight, and ongoing monitoring to promote sustained compliance and provider accountability. Review findings identify recurring compliance trends, guide provider education, prioritize monitoring activities, and support organizational oversight of provider performance.

This evaluation assesses the FSR Program's performance during calendar year 2025 by measuring achievement of the Quality Improvement Work Plan goals and fulfillment of its regulatory responsibilities. In addition to quantitative performance measures, it examines provider compliance trends, operational improvements, workforce development, cross-functional collaboration, and additional initiatives implemented during the year.

The purpose of this evaluation is to determine whether the FSR Program effectively fulfilled its regulatory responsibilities, achieved established performance objectives, and supported the Alliance's Quality Assurance Program through proactive provider oversight, regulatory readiness, and quality improvement.

Program Goals and Evaluation Methodology

The FSR Program was evaluated using multiple performance measures to assess achievement of established objectives, regulatory performance, operational effectiveness, and overall program performance during calendar year 2025. Evaluation criteria included performance against the Alliance's 2025 Quality Improvement Work Plan goals, completion of required review activities, provider compliance trends, operational improvements, workforce development, cross-functional collaboration, and overall program effectiveness.

Performance data were collected throughout the year using Healthy Data Systems (HDS), program tracking tools, DHCS reporting requirements, and internal monitoring processes. Review completion was assessed by comparing provider sites due for review with those completed within the required three-year review cycle. CAP performance was assessed by evaluating providers' timely submission of CAPs in accordance with regulatory requirements.

Findings were derived from FSR, MRR, PAR, and CAP activities, internal program reports, and regulatory data. Quantitative measures assessed review completion, provider compliance, timeliness, and workload, while qualitative analysis evaluated provider education, workforce development, cross-functional collaboration, operational improvements, and the program's contribution to the Alliance's Quality Assurance Program.

Program Activity and Performance

Throughout calendar year 2025, the FSR Program conducted FSRs, MRRs, PARs, Interim Monitoring Reviews, and CAP oversight to evaluate provider compliance with DHCS site review requirements. These activities supported regulatory compliance, corrective action implementation, and continuous quality improvement.

Overall Program Activity

During 2025, the FSR Program completed all scheduled FSRs, MRRs, PARs, and CAP oversight activities while exceeding its Quality Improvement Work Plan goals.

Quantitative Analysis

Activity	Scheduled/Due	Completed	Performance
FSRs	55	55	53 provider sites (96%) completed within the required 3-year review cycle
MRRs	51	51	100%
PARs	55	55	100%
CAPs	78	78	100%

The FSR Program completed all scheduled review activities during 2025. While two provider sites were reviewed outside the required three-year review cycle, all required reviews were finalized during the evaluation period, maintaining compliance with DHCS requirements. These results demonstrate effective operational planning, provider engagement, and ongoing monitoring.

2025 FSR Performance Highlights

Performance Measure	2025 Result
FSR Completion	100%
MRR Completion	100%
PAR Completion	100%
Review Cycle Compliance	96%
CAP Timeliness	100%

Facility Site Review Performance

FSRs remained the primary mechanism for evaluating provider compliance with DHCS site review standards.

Quarter	Reviews Due	Reviews Completed	Completion Rate
Q1	14	13	92%
Q2	13	12	92%
Q3	15	15	100%
Q4	13	13	100%

Total	**55**	**55**	**53 provider sites (96%) completed within the required 3-year review cycle**

Quarterly performance remained strong throughout 2025, culminating in 100% completion of all provider sites due in the third and fourth quarters.

Review Activity by County

County	FSRs	MRRs	PARs
Merced	15	18	15
Monterey	16	13	16
Santa Cruz	19	13	19
San Benito	2	4	2
Mariposa	3	3	3
Total	**55**	**51**	**55**

Medical Record Review Performance

All scheduled MRRs were completed during 2025 to evaluate provider compliance with DHCS medical record standards.

Review Type	Completed
Initial Reviews	7
Periodic Reviews	44
Total	**51**

Physical Accessibility Review Performance

All scheduled PARs were completed during 2025 to evaluate provider compliance with DHCS accessibility standards.

Review Type	Completed
Initial Reviews	3
Periodic Reviews	52
Total	**55**

Corrective Action Plan Performance

CAPs provide a structured process for addressing deficiencies identified during provider site reviews.

Quarter	CAPs Issued	Received on Time	Timeliness

Q1	14	14	100%
Q2	12	12	100%
Q3	31	31	100%
Q4	21	21	100%
Total	**78**	**78**	**100%**

The program maintained 100% CAP timeliness throughout 2025, reflecting effective provider engagement, consistent follow-up, and oversight of corrective actions.

Year-over-Year Performance Comparison

Measure	2024	2025	Change
Review Completion Rate	92%	96%	+4 percentage points
CAP Timeliness	89%	100%	+11 percentage points
Reviews Completed Within Cycle	44	53	+9 (+20.5%)
Total FSRs Completed	44	63	+19 (+43.2%)
CAPs Issued	38	78	+40 (+105.3%)

Compared with 2024, the FSR Program demonstrated measurable improvement across all major performance indicators, including review completion, CAP timeliness, overall review activity, and review completion within the required cycle. These gains reflect streamlined workflows, expanded reviewer capacity, and enhanced provider monitoring.

Although these results demonstrate robust performance against established goals, review findings also identified recurring compliance trends and opportunities for improvement. The following section examines the most common findings identified during 2025 and their role in guiding provider education, monitoring, and quality improvement efforts.

Provider Compliance Trends

Analysis of FSR and MRR results identified recurring compliance trends, characterized the most common deficiencies, and informed provider education, monitoring, and quality improvement throughout 2025. Most deficiencies involved documentation, administrative processes, or required staff training rather than direct patient safety concerns. These trends guided provider education, monitoring reviews, CAP oversight, and targeted interventions to promote sustained compliance.

Facility Site Review Trends

Analysis of FSR results identified the most common compliance trends observed during 2025.

DHCS Site Review Standard	Compliance
Vision screening process (literate and illiterate) and occluder for vision testing	41%

Practice Agreement defining the scope of services provided by Physician Assistants and Supervisory Guidelines defining physician oversight	47%
Disability Rights and Provider Obligations training	53%
Infection Control/Universal Precautions training	57%
Autoclave/Steam Sterilization	59%

Recurring FSR results highlighted opportunities to strengthen preventive care resources, clinical oversight documentation, annual staff training, and infection prevention practices. Vision screening deficiencies were the most frequently identified finding, reinforcing the importance of maintaining required preventive care resources. Additional opportunities involving Physician Assistant Practice Agreements, Supervisory Guidelines, annual staff training, and sterilization practices highlighted documentation and workflow improvements needed to support regulatory compliance and effective infection prevention.

Medical Record Review Trends

MRRs identified recurring documentation deficiencies related to preventive care services, clinical assessments, and required medical record documentation. Like FSR results, most deficiencies reflect incomplete or inconsistent documentation rather than a failure to provide required services. These trends highlighted opportunities to strengthen documentation practices, support continuity of care, and demonstrate compliance with DHCS requirements.

The findings also informed provider education, technical assistance, monitoring, and follow-up reviews to promote more complete and consistent clinical documentation.

Program Response to Identified Trends

Analysis of FSR results informed provider education, CAP oversight, monitoring reviews, technical assistance, and targeted follow-up throughout 2025.

Interim Monitoring Reviews expanded to focus on recurring compliance concerns, including annual staff training, Physician Assistant documentation, and pediatric vision screening requirements. This targeted approach concentrated oversight on areas with the greatest opportunity for improvement while supporting sustained provider compliance.

Review results were routinely shared with Provider Partnerships, Provider Services, Credentialing, Compliance, Medical Affairs, and the PQI Program to promote coordinated oversight. This collaboration informed provider education, corrective action planning, and consistent oversight across the Alliance.

Overall Compliance Assessment

Overall, providers showed compliance with most DHCS site review standards evaluated in 2025. The recurring deficiencies identified through FSRs and MRRs represented targeted opportunities for improvement rather than widespread noncompliance and were consistent with routine program oversight.

Review findings informed provider education, monitoring, CAP oversight, and technical assistance throughout the year. Collectively, these efforts promoted sustained compliance, enhanced provider performance, and reinforced organizational oversight of provider quality.

Operational Improvements

Operational improvements implemented during 2025 enhanced workflow efficiency, data management, regulatory readiness, and provider monitoring. Collectively, these initiatives strengthened program operations, improved regulatory reporting, and increased the program's ability to respond to evolving DHCS requirements.

Healthy Data Systems (HDS)

Implementation and expansion of HDS enhanced provider inventory management, review scheduling, documentation, CAP tracking, and regulatory reporting. Expanded system functionality improved data integrity, reduced reliance on manual tracking processes, and strengthened reporting and provider monitoring capabilities.

MCQMD Site Review Portal (MSRP)

Preparation for MCQMD (Managed Care Quality and Monitoring Division) MSRP implementation included participation in DHCS testing, system validation, and refinement of internal workflows to support future electronic submission of site review results. These efforts strengthened regulatory readiness and positioned the program for an efficient transition to evolving DHCS reporting requirements.

Interim Monitoring Review Enhancements

Interim Monitoring Reviews expanded to focus on recurring compliance concerns, including annual staff training, Physician Assistant documentation, and pediatric vision screening requirements. This targeted approach enhances oversight between review cycles, reinforced sustained compliance, and focused technical assistance on recurring deficiencies.

Provider Education and Technical Assistance

Provider education remains a core component of the site review process. Reviewers provided real-time education during site visits, discussed identified deficiencies with provider offices, and offered technical assistance to support corrective actions and sustained compliance. Educational efforts focused on recurring compliance trends while promoting a collaborative approach to achieving and maintaining regulatory compliance.

Cross-Functional Collaboration

Cross-functional partnerships were integral to the FSR Program's ability to coordinate provider oversight, support regulatory compliance, and advance quality improvement. Collaboration with internal departments, external partners, and contracted providers strengthened communication, reduced duplication of effort, and promoted consistent application of DHCS site review standards.

Internal Collaboration

Partnerships with Provider Partnerships, Provider Services, Credentialing, Compliance, Medical Affairs, and the PQI Program supported coordinated provider oversight, provider education, corrective action planning, and ongoing performance monitoring. Site review results were routinely shared to identify opportunities for technical assistance, operational improvements, and coordinated follow-up, ensuring provider concerns were addressed through a consistent, organization-wide approach.

External Collaboration

Participation in statewide MCP workgroups promoted consistent interpretation and application of DHCS site review standards while keeping the program informed of evolving regulatory expectations and best practices.

Coordination with neighboring MCPs that share PCP sites strengthened provider oversight in accordance with executed MOUs and APL 22-017. Participating health plans shared FSR results, discussed CAP status, and coordinated review activities to promote consistent application of DHCS site review standards while reducing duplicate review efforts.

Provider Collaboration

Site reviews also provided opportunities to engage directly with provider offices through education and technical assistance. Reviewers discussed site review findings, clarified regulatory requirements, identified opportunities for improvement, and supported implementation of corrective actions. This collaborative approach encouraged open communication, strengthened provider engagement, and promoted sustained compliance.

Organizational Impact

These partnerships extended the value of the FSR Program beyond regulatory review activities. Integrating site review findings with provider education, credentialing, corrective action planning, and quality monitoring strengthened communication across departments, enhanced provider performance, and reinforced organizational oversight of quality throughout the Alliance's PCP network.

II.H Program Effectiveness

The FSR Program effectively fulfilled its regulatory responsibilities during 2025 while enhancing provider oversight, improving operational performance, and supporting the Alliance's Quality Assurance Program.

Workforce Development

Certification of three additional FSR Nurse Reviewers under the supervision of the Alliance's DHCS-certified Master Trainer expanded reviewer capacity and strengthened succession planning. This investment increased the program's ability to complete required review activities while ensuring consistent application of DHCS site review standards.

Operational Excellence

Operational improvements implemented during 2025 increased workflow efficiency, regulatory readiness, provider monitoring, and reporting capabilities. Continued expansion of HDS, preparation for MSRP implementation, and enhanced Interim Monitoring Reviews strengthened program operations and positioned the FSR Program to respond effectively to evolving DHCS requirements.

Quality Improvement

Analysis of site review results informed provider education, monitoring, CAP oversight, and workflow improvements throughout the year. These efforts promoted sustained provider compliance while reinforcing a proactive quality-improvement approach across the PCP network.

Overall Program Effectiveness

Overall, the FSR Program successfully achieved its intended purpose by exceeding both Quality Improvement Work Plan goals, completing all scheduled FSR, MRR, and PAR activities, maintaining 100% CAP timeliness, expanding reviewer capacity, and implementing operational improvements that increased efficiency and regulatory readiness.

Beyond regulatory compliance, site review results informed provider education, corrective action planning, monitoring, and cross-functional collaboration. Collectively, these efforts enhanced provider performance, reinforced organizational oversight of quality, and advanced quality improvement across the Alliance.

Future Program Direction

The FSR Program is well-positioned to build on operational improvements and strong performance achieved in 2025. As DHCS requirements continue to evolve, the program will continue enhancing data-informed oversight, operational efficiency, and regulatory readiness.

Recurring trends identified through site reviews will continue to guide provider education, monitoring reviews, and technical assistance related to preventive care requirements, documentation standards, infection prevention practices, and annual staff training. These activities will help providers sustain compliance between full review cycles.

Continued expansion of HDS and preparation for full implementation of MSRP will strengthen workflow management, reporting efficiency, data integrity, and compliance with evolving DHCS reporting requirements.

Collaboration with Provider Partnerships, Provider Services, Credentialing, Compliance, Medical Affairs, the PQI Program, neighboring MCPs, and DHCS will continue to strengthen coordinated provider oversight and promote consistent application of regulatory standards across PCP sites.

Continued investment in workforce development, operational improvements, provider education, and data-informed oversight will position the FSR Program to sustain strong performance, strengthen provider accountability, and advance quality improvement across the PCP network.

Conclusion

The FSR Program successfully fulfilled its regulatory responsibilities during 2025 while strengthening provider performance and supporting the Alliance's Quality Assurance Program. Through comprehensive site reviews, provider monitoring, operational improvements, and cross-functional collaboration, the program maintained strong regulatory performance and advanced quality improvement across the provider network.

The program exceeded both Quality Improvement Work Plan goals, maintained 100% CAP timeliness, expanded reviewer capacity, enhanced operational efficiency, and strengthened regulatory readiness through continued advancement of HDS and preparation for MSRP implementation.

Beyond regulatory compliance, site review results informed provider education, technical assistance, CAP oversight, and ongoing monitoring. Collectively, these efforts enhanced provider performance, reinforced organizational oversight of quality, and promoted consistent application of DHCS site review standards across the Alliance.

Looking ahead, the FSR Program will continue building on its 2025 accomplishments through ongoing investment in technology, workforce development, provider education, and data-informed

oversight. Together, these efforts will sustain strong regulatory performance, strengthen provider accountability, and support the delivery of safe, accessible, and high-quality care for Alliance members.

10.3. Potential Quality Issue (PQI) Program

Introduction

The PQI Program is a key part of Alliance's Quality Assurance Program. It supports the organization's responsibility to identify, investigate, and monitor potential QoC concerns involving participating providers while promoting provider accountability, regulatory compliance, and quality improvement. Through clinical review, Medical Director oversight, provider monitoring, and corrective action activities, the program evaluates concerns related to the quality, appropriateness, and safety of care delivered to Alliance members.

PQIs may be identified through member grievances, internal referrals, Provider Preventable Condition (PPC) claims reporting, and other organizational quality oversight activities. Each PQI undergoes clinical review to determine whether the care provided met the applicable standard of care and to identify opportunities for provider education, performance improvement, or additional oversight. Severity determinations assigned by a Medical Director provide a standardized, evidence-based framework for assessing provider performance and determining appropriate follow-up actions, including CAPs and referral to the Peer Review and Credentialing Committee (PRCC), when warranted.

Beyond investigating individual quality concerns, the program uses investigation results to identify recurring quality trends, guide provider education, strengthen provider monitoring, inform regulatory reporting, and advance quality improvement across the Alliance.

This evaluation assesses the PQI Program's performance during calendar year 2025 by measuring achievement of the Quality Improvement Work Plan goals and fulfillment of its regulatory responsibilities. In addition to quantitative performance measures, it examines provider quality trends, operational improvements, cross-functional collaboration, organizational contributions, and other initiatives implemented during the year.

The purpose of this evaluation is to determine whether the PQI Program effectively fulfilled its regulatory responsibilities while supporting provider accountability, organizational oversight of quality, and the Alliance's Quality Assurance Program through timely investigation of potential quality concerns, meaningful provider interventions, and data-informed quality improvement.

Program Goals and Evaluation Methodology

The PQI Program was evaluated using multiple performance measures to assess achievement of established objectives, regulatory performance, operational effectiveness, and overall program performance during calendar year 2025. Evaluation criteria included performance against the Alliance's 2025 Quality Improvement Work Plan goals; workload trends; program activity; provider quality trends; provider monitoring; regulatory reporting; operational improvements; quality improvement initiatives; cross-functional collaboration; and organizational contributions.

Performance data were collected throughout the year using internal PQI case management and tracking systems, regulatory reporting, Track and Trend analyses, Medical Director severity determinations, and internal monitoring processes. Comparative analyses of 2024 baseline and 2025

performance data assessed workload trends, program growth, regulatory performance, provider oversight, and operational impacts.

Quantitative analysis assessed workload, program activity, timeliness, referral sources, severity trends, provider monitoring, Track and Trend outcomes, provider interventions, regulatory reporting, and other operational performance measures.

Qualitative analysis evaluated operational effectiveness, provider oversight methodologies, quality improvement initiatives, cross-functional collaboration, regulatory oversight activities, provider performance improvement efforts, organizational process improvements, and the program's contribution to provider accountability, quality improvement, and patient safety.

Evaluation findings were derived from PQI case data, Medical Director severity determinations, Track and Trend analyses, provider monitoring activities, provider intervention records, grievance reviews, regulatory reporting, and internal operational reports. Program performance was evaluated against the Quality Improvement Work Plan goals, regulatory requirements, internal performance expectations, and organizational quality improvement objectives.

In addition to measuring established performance goals, this evaluation assesses the PQI Program's effectiveness in supporting regulatory compliance, provider accountability, organizational oversight of quality, quality improvement, and responsiveness to evolving regulatory requirements.

Evaluation Against the 2025 Quality Improvement Work Plan

The PQI Program was evaluated against the Alliance's 2025 Quality Improvement Work Plan goals.

Goal 1

Resolve 100% of member grievances received by Quality Improvement involving potential QoC concerns within the applicable regulatory timeframe.

Goal 2

Complete 80% of non-grievance-related PQIs within 120 calendar days.

The following table summarizes the PQI Program's performance against the Alliance's 2025 Quality Improvement Work Plan goals.

Quality Improvement Work Plan Goal	Target	2025 Performance	Status
Member grievances involving potential QoC concerns were resolved within the applicable regulatory timeframe	100%	100%	Met
Non-grievance-related PQIs completed within 120 calendar days	80%	74%	Not Met

The PQI Program maintained 100% compliance with all applicable regulatory investigation timeframes for grievance-related PQIs despite a substantial increase in grievance-related workload. In comparison, non-grievance-related PQIs achieved a 74% completion rate, falling short of the internal performance target of 80%.

The difference in performance reflects operational improvements implemented in 2025 that standardized grievance review processes and expanded regulatory oversight by enabling more consistent identification of PQIs requiring clinical investigation. As a result, more cases required

Quality Improvement oversight and investigation. To maintain compliance with applicable regulatory investigation timeframes, program resources were appropriately prioritized toward grievance-related PQIs, reducing capacity for non-grievance investigations and affecting performance against the internal Quality Improvement Work Plan target.

Although the Quality Improvement Work Plan establishes two formal goals, they represent only one measure of the PQI Program's overall effectiveness. To provide a comprehensive assessment, this evaluation also examines workload trends, program activity, provider quality trends, provider monitoring, regulatory reporting, operational improvements, cross-functional collaboration, and quality improvement initiatives.

The following sections present the findings supporting this evaluation and assess the program's overall performance, operational impacts, accomplishments, effectiveness, and future direction.

Program Activity and Performance

During 2025, the PQI Program experienced substantial growth in workload while continuing to fulfill its primary responsibility for the timely investigation and resolution of grievance-related QoC concerns. Standardized grievance review processes resulted in more consistent identification of PQIs requiring clinical investigation, driving significant growth in program activity and Quality Improvement oversight.

Grievance-related PQI volume increased steadily throughout 2025, rising from 124 cases in the first quarter to 237 cases in the fourth quarter. Compared with the fourth quarter of 2024, when 120 grievance-related PQIs were closed, the workload increased by approximately 98%, illustrating the impact of the enhanced grievance review process. Despite this sustained growth, the program maintained 100% compliance with all applicable regulatory investigation timeframes for grievance-related PQIs.

Grievance-Related PQIs Closed by Quarter

Quarter	Closed PQIs	Change
Q4 2024	120	—
Q1 2025	124	+3%
Q2 2025	211	+70%
Q3 2025	220	+4%
Q4 2025	237	+8%
Q4 2024 to Q4 2025	**120 → 237**	**+98%**

The increase in grievance-related PQIs reflected improved identification and investigation of potential QoC concerns rather than a decline in provider performance. The enhanced grievance review process strengthened the program's ability to consistently evaluate member grievances, including those initially categorized as Quality of Service (QoS) concerns and exempt grievances, for potential QoC concerns requiring clinical investigation. As a result, more cases appropriately entered the PQI process, substantially increasing investigation volume while strengthening organizational quality oversight.

As regulatory responsibilities expanded, resources were appropriately prioritized to maintain timely investigation of grievance-related PQIs. This shift reduced capacity for non-grievance investigations, quality studies, consultative support for organizational quality and provider oversight initiatives, and other proactive quality improvement activities.

Member Grievance Screening and Clinical Review Activity

Measure	2024	2025	Difference	% Change
Total grievances screened for potential QoC concerns	1,986	4,376	+2,390	+120.3%
Opened as QoC grievance PQIs	449	837	+388	+86.4%
Not opened as PQI (Quality of Service only)	1,537	3,539	+2,002	+130.3%

Process improvements implemented during 2025 significantly increased the volume of member grievances requiring Quality Improvement review. Total grievances screened for potential QoC concerns increased by 120.3%, while grievances requiring formal PQI investigation increased by 86.4%. Although many grievances were ultimately determined to involve only Quality of Service (QoS) concerns, each required clinical screening to determine whether a potential QoC concern existed. These findings demonstrate that the enhanced grievance review process substantially increased both upstream screening and downstream clinical investigations, while improving the organization's ability to consistently identify and evaluate potential QoC concerns.

PQIs Closed by Referral Source

Referral Source	2024	2025	% Change	% of 2025 Total
Grievance	449	792	+76.4%	82.1%
Concurrent Review	35	52	+48.6%	5.4%
Quality Improvement	26	52	+100.0%	5.4%
HAC/PPC Report	86	43	-50.0%	4.5%
Case Management	4	15	+275.0%	1.6%
Exempt Grievance	1	10	+900.0%	1.0%
Other	0	1	N/A	0.1%
Total	**601**	**965**	**+60.6%**	**100%**

Grievance referrals remained the primary source of PQI activity during 2025, accounting for 82.1% of all closed PQIs. These findings demonstrate the significant impact of the enhanced grievance review process on the overall program workload, while confirming that member grievances remain the program's primary referral source.

PQIs Closed by Provider Type

Provider Type	2025 Total	% of Total

PCP	535	55.4%
Specialist	154	16.0%
Inpatient	136	14.1%
Outpatient	57	5.9%
SNF / LTC / SA	39	4.0%
Durable Medical Equipment (DME)	18	1.9%
Other	11	1.1%
Home Health	5	0.5%
BH	4	0.4%
ECM	4	0.4%
Pharmacy	2	0.2%
Total	**965**	**100%**

PCPs accounted for more than half of all PQIs closed during 2025. Together, PCPs, Specialists, and Inpatient providers accounted for 85.5% of total PQI activity, demonstrating that clinical investigation efforts remained concentrated among the provider types serving the majority of Alliance members.

Annual Severity Level Comparison

Severity Level	2024	2025	% Change	% of 2025 Total
N/A	11	24	+118.2%	2.5%
P0	349	644	+84.5%	66.7%
P1	116	212	+82.8%	22.0%
P2	119	81	-31.9%	8.4%
P3	6	4	-33.3%	0.4%
Total	**601**	**965**	**+60.6%**	**100%**

Severity-level analysis demonstrated that workload growth was driven primarily by lower-severity PQIs identified through the enhanced grievance review process. P0 and P1 cases accounted for 88.7% of all PQIs closed during 2025 and experienced the largest year-over-year increases, while higher-severity P2 and P3 cases declined. Collectively, these findings indicate that workload growth consisted primarily of lower-severity PQIs requiring clinical review, while higher-severity quality concerns accounted for a declining share of overall program activity.

Provider Quality Trends

Analysis of PQI investigations identified recurring provider quality trends that informed provider education, monitoring, corrective action planning, and quality improvement throughout 2025. PQIs evaluated a broad range of clinical, medication, documentation, access, and service-related concerns. Review of P1-P3 indicator assignments identified recurring opportunities for improvement and informed targeted provider oversight, cross-functional collaboration, and organizational quality improvement initiatives.

P1-P3 PQI Indicator Themes

Indicator Theme	*Indicator Count	Percent of P1-P3 Indicator Selections
QoC	312	71.7%
Medication Administration	39	9.0%
Medical Documentation	39	9.0%
*Attitude / Service	37	8.5%
*Access	4	0.9%
Other	4	0.9%
Total Indicator Selections	**435**	**100%**

**Access, attitude, and service concerns were assigned only when associated with a QoC concern.*
**Indicator counts and percentages represent total P1-P3 indicator selections. Because multiple indicators may be assigned to a single PQI, totals do not represent unique cases.*

QoC concerns accounted for the majority of P1-P3 indicator assignments, representing 312 of 435 selections (71.7%). When Medication Administration and Medical Documentation are considered together with QoC, clinically related concerns accounted for 390 indicator assignments, or 89.7% of all P1-P3 selections. This distribution demonstrates that the PQI Program remained primarily focused on evaluating clinical quality, patient safety, and the appropriateness of care delivered to Alliance members while also identifying opportunities to improve medication management, documentation practices, member experience, and timely access to care. Collectively, these findings informed provider education, monitoring, corrective action planning, and collaboration with operational departments to address recurring quality concerns across the provider network.

Most Frequently Identified P1-P3 Indicators

Indicator	*Indicator Count	Percent of P1-P3 Indicator Selections
Delay in referral to a specialist or the emergency department/hospital	82	18.9%
PPC	50	11.5%
Inadequate workup/evaluation	32	7.4%

Inadequate documentation	23	5.3%
DME services	23	5.3%

**Indicator counts and percentages represent total P1-P3 indicator selections. Because multiple indicators may be assigned to a single PQI, totals do not represent unique cases.*

The most frequently assigned P1-P3 indicators highlighted recurring opportunities to improve timely access to specialty care, care coordination, clinical assessment, documentation practices, and delivery of medically necessary services. Delays in referral to a specialist, emergency department, or hospital accounted for nearly one-fifth of all P1-P3 indicator assignments during 2025, followed by PPCs, inadequate workup or evaluation, inadequate documentation, and delays in DME services. Collectively, these indicators demonstrate the breadth of clinical concerns evaluated through the PQI Program and illustrate its role in identifying systemic opportunities to improve provider performance.

Although recurring quality themes were identified during 2025, each PQI underwent individualized clinical review by a Medical Director to determine whether the applicable standard of care was met and whether provider education, monitoring, corrective action, or additional oversight was warranted. Investigation findings were aggregated across a rolling four-quarter review period to evaluate provider performance trends and determine whether progressive interventions were appropriate. This standardized methodology ensured interventions remained evidence-based, consistently applied, and proportional to the quality concerns identified.

Track and Trend Outcomes

Provider performance analysis extended beyond individual PQI investigations through the program's structured Track and Trend process. Providers and facilities exceeding established thresholds underwent additional review using a rolling four-quarter analysis that considered PQI severity, recurring indicator themes, QoC and QoS concerns, member grievances, provider type, peer comparisons, and previous intervention history. This methodology enabled the program to distinguish isolated events from recurring performance concerns and focus interventions on providers demonstrating meaningful quality trends.

Comprehensive trend analysis identified providers and facilities requiring continued monitoring or intervention based on objective performance patterns rather than isolated quality concerns. Investigation findings informed progressive provider oversight, including ongoing monitoring, provider communications, Trend Letters, CAPs, and, when appropriate, referral to the Peer Review and Credentialing Committee (PRCC). Monitoring continued until performance improved; corrective actions were successfully implemented; or additional interventions were deemed necessary.

Additional Regulatory Oversight Activities

Beyond provider monitoring and progressive interventions, the PQI Program supports multiple regulatory oversight activities that reinforce provider accountability, patient safety, and organizational quality oversight. PQI investigations, regulatory reporting, external oversight findings, and cross-functional quality reviews provide a comprehensive view of provider performance to support ongoing monitoring, regulatory compliance, and evidence-based interventions.

Regulatory Oversight Activity	Purpose	Program Impact

PPC reporting to DHCS	Evaluate and report validated PPC events	Supports regulatory compliance and provider accountability
Critical Incident reporting to DHCS	Evaluate and report qualifying Critical Incidents	Supports patient safety oversight and regulatory compliance
California Department of Public Health (CDPH) survey findings for Long-Term Care (LTC), Subacute, and Intermediate Care Facilities (ICF) providers	Incorporate state survey findings into provider monitoring	Strengthens provider trend analysis and progressive interventions
Monthly Regional Center collaboration for ICF members	Review quality findings, discuss care provided, and coordinate follow-up activities.	Strengthens shared oversight and quality improvement for ICF members

The PQI Program evaluates reportable PPCs and Critical Incidents and coordinates cross-functional clinical reviews to ensure required reports are submitted to DHCS in accordance with regulatory requirements. Quarterly review of CDPH survey findings for LTC, Subacute, and ICF providers is incorporated into provider trend analysis and considered alongside PQIs, Critical Incidents, member grievances, and other quality oversight activities when determining whether continued monitoring, provider education, or progressive interventions are warranted. Monthly collaboration with Regional Centers further enhances quality oversight for ICF providers through shared review of quality findings, discussion of care provided to Alliance members, and coordination of follow-up activities when quality concerns are identified.

Collectively, these activities demonstrate that the PQI Program extends beyond the investigation of individual quality concerns. By integrating clinical review, provider monitoring, regulatory reporting, external oversight, trend analysis, progressive interventions, and cross-functional collaboration, the program strengthens provider accountability, informs organizational decision-making, and advances quality improvement across the Alliance.

The provider quality trends identified through PQI investigations also informed several operational improvements that strengthened provider oversight, standardized quality review activities, and enhanced organizational oversight of quality. These initiatives are described in the following section.

Operational Improvements

Throughout 2025, the PQI Program implemented significant operational improvements that strengthened quality oversight, standardized core workflows, enhanced provider performance monitoring, and advanced quality improvement across the Alliance. Collectively, these initiatives increased the program's ability to identify, investigate, monitor, and respond to quality concerns while supporting increased regulatory workload and strengthening collaboration across the organization.

Member Grievance Process Improvements

In collaboration with the Operational Excellence Department (OpEx), the PQI Program implemented significant enhancements to member grievance workflows for QoS reviews and exempt grievance

oversight. These initiatives standardized grievance review activities, improved workflow consistency, strengthened regulatory compliance, and resulted in more consistent identification of PQIs requiring clinical investigation throughout 2025.

Track and Trend Enhancements

Enhancements to the Track and Trend process strengthened longitudinal provider performance monitoring and standardized progressive provider interventions. Investigation findings continued to inform provider education, Trend Letters, CAPs, and referral to the PRCC, when appropriate. These enhancements reinforced an objective, evidence-based approach to provider oversight while promoting provider accountability and quality improvement.

Technology and Reporting Enhancements

Enhancements to SharePoint and Tableau strengthened workflow management, provider trend analysis, Track and Trend activities, case management, and program reporting. These improvements increased visibility into program performance, supported data-informed decision-making, reduced reliance on manual processes, and enhanced the program's ability to monitor provider performance over time.

Cross-Functional Operational Improvements

The PQI Program partnered with OpEx, Health Services Operations, Member Services, Provider Services, Behavioral Health, Pharmacy, Medical Affairs, and other operational departments to strengthen quality oversight, standardize workflows, and improve collaboration across The Alliance.

These efforts promoted consistent application of quality review processes, improved communication between departments, and reinforced organizational quality oversight.

Major Operational Improvements Completed During 2025

Operational Improvement	Primary Benefit	Organizational Impact
Member grievance workflow improvements in collaboration with OpEx, including QoS review and exempt grievance oversight	Standardized grievance review activities	Enhanced regulatory compliance, quality oversight, and member protections
Track and Trend enhancements	Strengthened longitudinal provider performance monitoring and standardized progressive provider interventions	Supported objective, evidence-based provider oversight, and strengthened provider accountability.
SharePoint and Tableau enhancements	Strengthened workflow management, provider trend analysis, Track and Trend activities, case management, and program reporting	Increased visibility into program performance and supported data-informed decision-making.

Cross-functional workflow improvements	Improved coordination across Alliance departments and standardized quality review processes	Advanced organization-wide quality improvement and strengthened collaboration

Collectively, these operational improvements established a stronger operational foundation by standardizing core workflows, improving operational efficiency, strengthening provider monitoring, and expanding the organization's ability to use investigation findings to support provider education, organizational learning, regulatory compliance, and quality improvement.

Cross-Functional Collaboration

The PQI Program collaborated extensively with departments across the Alliance and external partners throughout 2025 to support consistent identification, investigation, and resolution of potential QoC concerns. Cross-functional partnerships were essential to evaluating clinical concerns, coordinating provider oversight, implementing operational improvements, and strengthening organizational quality oversight.

Member Grievance Collaboration

A significant area of collaboration during 2025 centered on member grievance processes. The PQI Program partnered closely with OpEx, Member Services, Grievance and Appeals, and Provider Services to enhance member grievance workflows and strengthen coordination throughout the grievance process. Member Services Representatives conducting telephonic grievance intake, Grievance Coordinators establishing grievance cases, and Quality Improvement staff worked together to improve identification and routing of grievance types, facilitate timely Quality Improvement oversight, and support consistent clinical review.

These collaborative efforts also led to the development of a structured Track and Trend methodology for QoS concerns, strengthening the organization's ability to identify recurring service-related issues, analyze patterns across multiple departments, and support coordinated interventions. In addition, the Staff Grievance Review Committee (SGRC) meeting structure was redesigned from monthly case reviews to a quarterly forum focused on integrated analysis of Member Services, Provider Services, and PQI findings. This enhanced approach improved identification of relationships between quality and service concerns, strengthened cross-functional communication, and informed organizational process improvements. Additional multidisciplinary case review meetings and routine operational touchpoints were also established to coordinate complex case reviews, improve member outcomes, and identify opportunities to strengthen internal processes.

Clinical and Operational Collaboration

Successful PQI investigations depended on collaboration among multiple operational departments involved in a member's care. The PQI Program routinely partnered with Utilization Management, Case Management, Enhanced Care Management, Behavioral Health, Pharmacy, Provider Services, Medical Affairs, Compliance, and other operational departments to obtain clinical information, evaluate quality concerns, coordinate investigations, and resolve complex cases. These partnerships ensured investigations incorporated relevant clinical, operational, and member-specific information, supporting consistent, evidence-based decision-making across the organization.

External Collaboration

The PQI Program collaborated monthly with Regional Centers to review quality findings, discuss care provided to Alliance members residing in Intermediate Care Facilities (ICFs), and coordinate follow-up activities when quality concerns were identified. Regional Center findings were incorporated into provider monitoring activities and considered alongside PQI investigations, Critical Incidents, and other quality oversight activities. This collaboration strengthened shared oversight responsibilities, enhanced communication between organizations, and supported evidence-based provider monitoring and progressive interventions.

Quality Improvement Collaboration

Within the Quality Improvement Department, the PQI Program collaborated closely with the FSR Program and the Provider Partnerships team to identify providers demonstrating opportunities for improvement through multiple quality oversight activities. Investigation findings, provider performance trends, and FSR findings informed provider education, technical assistance, and monitoring activities, supporting targeted provider improvement efforts and sustained provider performance.

The PQI Program also partnered with the HEDIS team and the Care-Based Incentive team to identify providers whose quality performance metrics indicated opportunities for improvement. PQI findings and provider trend analysis supported provider education, presentations, technical assistance, and performance improvement initiatives designed to improve quality outcomes and promote sustained provider engagement.

Credentialing Collaboration

Collaboration with the Credentialing Department and the PRCC strengthened provider accountability by incorporating PQI investigation findings into credentialing and recredentialing oversight. PQI findings provided objective information regarding provider quality performance, recurring quality trends, and ongoing monitoring activities to support informed credentialing decisions.

Organizational Impact

Collectively, these partnerships demonstrate that the PQI Program serves as an organizational clinical quality resource extending well beyond the investigation of individual quality concerns. Through consultation, provider education, technical assistance, shared quality oversight, application of investigation findings, and collaborative operational improvements, the program strengthened provider accountability, informed organizational decision-making, enhanced organizational learning, and advanced quality improvement across the Alliance.

Program Effectiveness

The PQI Program successfully fulfilled its primary responsibility of identifying, investigating, monitoring, and resolving potential QoC concerns while supporting the Alliance's Quality Assurance Program throughout 2025. Despite a substantial increase in regulatory workload resulting from operational improvements, the program maintained full compliance with grievance-related regulatory investigation timeframes, strengthened provider monitoring, expanded cross-functional collaboration, and promoted provider accountability through progressive interventions and ongoing quality oversight.

Operational improvements implemented during 2025 achieved their intended objectives by standardizing member grievance review processes, improving identification of potential QoC concerns, strengthening provider monitoring, and promoting more consistent quality oversight

across the organization. Although these enhancements significantly increased regulatory case volume and reduced capacity for certain proactive quality improvement activities, they also improved the organization's ability to consistently identify and respond to potential quality concerns affecting Alliance members.

Investigation findings extended beyond resolution of individual cases by supporting longitudinal provider performance monitoring, targeted provider education, Trend Letters, CAPs, and other progressive interventions. The Track and Trend methodology ensured provider interventions were based on objective performance patterns rather than isolated events, promoting fair, consistent, and evidence-based provider oversight.

The PQI Program also served as an organizational resource for clinical quality. Collaboration with operational departments, clinical programs, provider-facing teams, and external partners enabled investigation findings to support broader quality improvement initiatives, provider education, technical assistance, operational improvements, and organizational learning. These partnerships extended the value of PQI investigations beyond regulatory compliance by informing system improvements, strengthening collaboration across the Alliance, and advancing quality improvement.

Resource Allocation and Higher-Severity Clinical Oversight

In 2025, approximately 82% of all PQIs were grievance-related, reflecting the program's significant regulatory responsibilities and the impact of standardized grievance review processes. Analysis of higher-severity PQIs, however, demonstrated a markedly different distribution of clinical risk. Although grievance investigations accounted for most of the program's workload, nearly 4 out of 5 P2/P3 PQIs originated from non-grievance referral sources, including PPC reporting, internal referrals, and other proactive quality oversight activities.

Overall PQI Workload

Referral Category	Total PQIs	% of Total PQIs
Grievance-related*	792	82.1%
Non-grievance	173	17.9%
Total	**965**	**100%**

**Includes Grievance and Exempt Grievance referral sources.*

Higher-Severity (P2/P3) PQIs

Referral Category	P2/P3 Cases	% of All P2/P3 Cases
Grievance-related	16	18.8%
Non-grievance	69	81.1%
Total	**85**	**100%**

Likelihood of Identifying Higher-Severity PQIs

Referral Category	Total PQIs	P2/P3 Cases	% High Severity
Grievance-related	792	16	2%
Non-grievance	173	69	39.8%

Key Evaluation Finding

Although non-grievance referrals accounted for only 17.9% of all PQIs during 2025, they accounted for 81.1% of higher-severity (P2/P3) cases. Non-grievance referrals were nearly 19 times more likely than grievance-related referrals to identify significant quality concerns requiring intensive clinical review, provider engagement, and progressive interventions (39.8% versus 2%).

These findings demonstrate that the program's most clinically complex investigations and highest-risk patient safety concerns continue to be identified primarily through proactive quality oversight activities rather than solely through the member grievance process. PPC reporting, Concurrent Review, and internal Quality Improvement referrals represented the largest sources of higher-severity PQIs, underscoring the importance of maintaining robust non-grievance quality oversight activities.

The substantial increase in grievance-related workload appropriately required the PQI Program to prioritize resources to maintain compliance with regulatory investigation timeframes. While this approach successfully achieved full regulatory compliance, it reduced capacity for proactive quality studies, consultative support for organizational quality, and non-grievance investigations that frequently identify significant patient safety concerns and opportunities for system-wide improvement.

Maintaining sufficient capacity for proactive quality oversight remains essential to identifying serious quality concerns, supporting evidence-based provider accountability, informing organizational quality improvement initiatives, and strengthening the Alliance's Quality Assurance Program. As regulatory processes continue to mature and operational efficiencies are realized, the PQI Program is well-positioned to further leverage its clinical expertise through expanded proactive quality improvement initiatives, broader consultative partnerships, and data-informed decision-making that address systemic quality concerns before they result in member harm or regulatory risk.

Overall Program Effectiveness

Overall, the PQI Program effectively achieved its core mission during 2025 by balancing regulatory responsibilities with provider performance improvement, organizational collaboration, and quality improvement. Through clinical investigations, provider monitoring, regulatory oversight, operational improvements, and cross-functional partnerships, the program strengthened provider accountability, enhanced organizational oversight of quality, and supported the delivery of safe, timely, effective, and high-quality care for Alliance members.

Future Program Direction

The PQI Program is well-positioned to build on the significant accomplishments achieved in 2025. As operational improvements continue to mature, opportunities exist to strengthen further provider performance monitoring, quality oversight, organizational collaboration, and proactive quality improvement while maintaining strong regulatory performance.

Continued refinement of provider trend analysis, Track and Trend methodologies, and reporting capabilities will strengthen the program's ability to identify emerging quality concerns, prioritize provider interventions, evaluate the effectiveness of quality improvement efforts, and support data-informed decision-making. Ongoing enhancements to SharePoint, Tableau reporting, and workflow standardization will further improve PQI case management, provider monitoring, organizational reporting, and program oversight.

The PQI Program will continue collaborating with internal departments to strengthen quality oversight and support organization-wide quality improvement. Continued cross-functional collaboration will promote consistent application of quality review processes, strengthen communication across departments, and improve the organization's ability to identify opportunities for provider performance improvement, operational improvements, and enhanced member outcomes.

As regulatory processes continue to mature and operational efficiencies are realized, the PQI Program is well-positioned to expand proactive quality improvement activities, including quality studies, broader analysis of provider performance trends, consultative support for operational improvements, and data-informed quality improvement initiatives. Continued use of PQI investigation findings to identify emerging quality trends, inform program-specific improvements, and support organizational decision-making will further strengthen the Alliance's Quality Assurance Program and support the delivery of safe, timely, effective, and high-quality care for Alliance members.

Conclusion

The 2025 evaluation demonstrates that the PQI Program successfully fulfilled its primary responsibilities by providing comprehensive oversight of potential QoC concerns, maintaining full compliance with grievance-related regulatory investigation timeframes, and promoting provider accountability through structured provider monitoring, progressive interventions, and quality improvement.

The program effectively balanced expanding regulatory responsibilities with broader organizational quality improvement by strengthening provider oversight, implementing operational improvements, enhancing provider monitoring methodologies, and expanding collaboration across the Alliance.

Beyond regulatory compliance, investigation findings informed provider performance monitoring, provider education, corrective action planning, regulatory oversight, and broader organizational quality improvement. Through provider monitoring, Track and Trend analysis, cross-functional collaboration, and standardized provider intervention processes, the PQI Program promoted consistent, evidence-based provider oversight while strengthening the Alliance's Quality Assurance Program.

The evaluation also demonstrates that the PQI Program extends beyond an investigative or regulatory compliance function. Through clinical investigations, provider trend analysis, regulatory reporting, organizational collaboration, and proactive quality improvement, the program informed organizational decision-making, strengthened provider accountability, enhanced organizational quality oversight, and supported the delivery of safe, timely, effective, and high-quality care for Alliance members.

Looking ahead, the PQI Program is well-positioned to build on its 2025 accomplishments through continued investment in operational improvements, provider performance monitoring, consultative partnerships, and data-informed quality improvement. Together, these efforts will sustain strong

regulatory performance, strengthen provider accountability, and further advance the Alliance's Quality Assurance Program.

10.4. Clinical Safety Program Conclusion

The 2025 evaluation demonstrates that the Clinical Safety unit successfully fulfilled its mission by providing comprehensive oversight of provider quality through the complementary FSR and PQI Programs. Together, these programs strengthened regulatory compliance, provider accountability, organizational oversight of quality, and quality improvement across the Alliance.

Throughout 2025, the Clinical Safety unit successfully adapted to evolving regulatory requirements while maintaining strong operational performance. The FSR Program exceeded its Quality Improvement Work Plan goals, strengthened provider compliance through proactive site review activities, and enhanced regulatory readiness through operational improvements and workforce development. Concurrently, the PQI Program maintained full compliance with grievance-related regulatory investigation timeframes despite a significant increase in workload, strengthened provider monitoring, implemented meaningful operational improvements, and expanded its role as an organizational clinical quality resource.

Together, the programs demonstrated the value of integrating prospective provider oversight with retrospective clinical quality review. FSRs, MRRs, PARs, PQI investigations, provider trend analysis, regulatory reporting, and cross-functional collaboration created a comprehensive framework for evaluating provider performance, identifying opportunities for improvement, and supporting evidence-based provider interventions.

The evaluation also demonstrates that the Clinical Safety unit extends beyond regulatory compliance by serving as a strategic partner in organizational quality improvement. Through provider education, operational improvements, data-informed decision-making, consultative support, and collaboration across operational departments, Clinical Safety strengthened provider accountability, enhanced organizational learning, and advanced the Alliance's Quality Assurance Program.

Looking ahead, the Clinical Safety unit is well-positioned to build on its accomplishments through continued investment in operational improvements, data-informed oversight, provider performance monitoring, and cross-functional collaboration. Together, the FSR and PQI Programs provide an integrated approach to provider quality that strengthens regulatory oversight, promotes provider accountability, and supports the delivery of safe, accessible, timely, effective, and high-quality care for Alliance members.

11. Member Complaints and Appeals Related to Access

11.1. Introduction

The Alliance consistently collects data on factors that impact the member experience. The sources concerning complaints (grievances) and appeals challenges in the non-behavioral healthcare and behavioral healthcare (BH) sectors are divided into five NCQA categories. Complaints and appeals are an important source of information about the impact of Alliance services and potential opportunities for improvement. The data is carefully analyzed to assess the effectiveness of the network and to review member concerns. The report summarizes the results of the annual evaluation of member complaints and appeals, which identify challenges to member satisfaction and propose solutions to address these gaps.

11.2. Methodology

- Complaint and appeal data is analyzed from the universe of complaints, and appeals received by the Alliance during the measurement time period.
- The Alliance Grievance team retrieved complaints and appeals from the database.
- This report includes 2025 data.
- All complaints and appeals are categorized into one of the five NCQA categories:
    - Access
    - Attitude/Service
    - Billing/Financial
    - Quality of Care
    - Quality of Practitioner Office Site
- The rate of complaints per 1,000 member months per month allows the Plan to compare complaint rates with the formula:
    - Annual Rate per 1,000 Member Months = (Total Number of complaints or appeals for the Year / Total Member Months for the Year) x 1,000
    - Total Member Months for the Year = Sum of monthly membership over the course of the Year

11.3. Goal Standards for Member Complaints and Appeals

- Goal for the annual total complaints and appeals per 1,000 member months: **≤5/1,000.**
- Goal for the annual per category of complaints and appeals per 1,000 member months: **≤2/1,000.**

11.4. Key Findings

11.4.1. Complaints Non-Behavioral Health

Category	Previous Year (2024)		Current Measurement Year (2025)			
	Total Member Months 5,394,067		Total Member Months 5,295,476			
	2024 Total Complaints	2024 Complaints per 1,000 Member Months	2025 Total Complaints	2025 Complaints per 1,000 Member Months	Goal (Per 1,000 Members Months)	Goal Met?
Quality of Care	611	0.11	910	0.17	2	YES
Access	1,027	0.19	878	0.17	2	YES
Attitude/Service	2,146	0.40	3,524	0.67	2	YES
Billing/Financial	370	0.07	436	0.08	2	YES

Quality of Practitioner Office Site	1	0.0001	5	0.0001	2	YES
Total/Number per 1,000	4,155	0.77	5,752	1.09	5	YES

Quantitative Analysis

- The Alliance set the goal for evaluating complaints per category to be below 2 per thousand member months and the overall goal to be below 5 per thousand member months.
- The Alliance met all goals for access, attitude/service, quality of care, billing/financial, and quality of practitioner office site.
- Attitude and service continue to be the most common complaints received, with 0.67 complaints per 1,000 member months.
- Access and Quality of Care complaints were the next most common category of complaints received in 2025, at 0.17 complaints per thousand member months.
- There were 0.08 billing and finance-related complaints for every 1,000 member months.
- The quality of the practitioner office site was the lowest complaint category received. It was presented only at 0.0001 complaints per 1,000 member months.
- The total rates of all complaint categories met the goal of less than 5 per 1,000 members. The total was 1.09 per 1,000 member months.
- The overall trend in complaint rates per 1,000 member months showed increases across most categories in 2025, with the total increasing by 0.32.

Conclusion Based on Quantitative Analysis

The Alliance met all five categories and the total complaints rate per 1,000 member months when evaluating complaints received through the measurement year 2025. When investigating trend data, the Alliance noticed an overall increase in complaints regarding non-BH services. The grievance data reflects member dissatisfaction with the provider and staff's attitude and service, followed by quality of care and delays with access to care.

Qualitative Analysis

The analysis of access complaints revealed that the goal of maintaining less than 2 complaints per 1,000 member months was achieved. As most complaints are concentrated in the categories of Attitude/Service, Quality of Care and Access, this indicates that members are dissatisfied with the attitude of providers and Alliance staff, quality of care concerns and service access. The Grievance data shows an opportunity for improved interaction with all member facing teams including the Call Center and Provider Office Staff. Routine reminders and training opportunities will reinforce the importance of the member experience during interactions. An interdisciplinary team comprised of Subject Matter Experts (SMEs) included Quality Improvement and Population Health Director, Quality and Health Programs Manager, Grievance and Quality Manager, Provider Services Director, Provider Quality and Network Development Manager, Health Services Operations Manager, and explored a detailed examination of the grievances related to access complaints to identify provider availability and timely access issues in specific areas.

Barrier at Member Level:

- Both Monterey and Merced counties have significant rural populations, which face additional barriers to accessing healthcare. Limited transportation options and fewer healthcare facilities contribute to the high number of complaints.
- Members might not be fully aware of the services covered or how to receive care, treatment, tests, and case management, which causes frustrations that inevitably develop into complaints.
- Members do not know how to navigate the healthcare system as well, and therefore they are not able to get appointments in a timely manner. Some members do not realize that providers have same day waitlist appointments, and they can receive appointment assistance with care management.
- Members' geographic location, economic status, or educational background might influence their access to healthcare services and their experiences. These factors could hinder their ability to receive timely and quality care. It then contributed to higher complaints in access and attitude/service categories.

Barrier at Provider Level:

- Limited staffing or an imbalance between the number of healthcare providers and the high demand for services can lead to longer wait times and reduced quality of service. As reflected in the increased complaints in the Attitude/Service category, providers and front office staff may lack sufficient training in service or empathy for positive member interactions.
- Limited resources of specialist availability affect quality of care and access to it. As exploring a detailed examination of the categories related to access complaints, provider availability and timely access are the primary issues in specific areas.

County	Provider Availability	Timely Access	Grand Total
Monterey	350	17	367
Merced	229	14	243
Santa Cruz	132	7	139
Mariposa	17	0	17
San Benito	53	5	58

In conclusion, provider availability and timely access appeared to be the top challenges in access-related complaints. These challenges not only lead to lower levels of member satisfaction but also interfere with the desired outcomes. The table above shows that most complaints are likely to occur in Monterey and Merced counties. The specific types of providers that mostly cause complaints are family practitioners and clinics with mixed specialty types. The potential causes for these complaints in the particular areas are identified as follows:

- There are a limited number of NEMT vendors that are contracted with the Alliance. This limits the ability of members to get transportation to provider offices.

- Monterey and Merced County are designated as health professional shortage areas. These designations are typically made by the Health Resources and Services Administration (HRSA), which assesses regions based on specific criteria to determine shortages of healthcare professionals. It means that there are a limited number of providers in those areas. Because of the shortage, patients have limited access to providers, and the plan has limited opportunity to contact additional providers in that area.
- Many complaints mention that patients had long wait times to secure an appointment with their PCPs or SCPs. For example, members reported wait times of several weeks for new patient appointments and delays in scheduling follow-up visits.
- Several providers, clinics, and health centers refused to schedule appointments for new patients or those who had not been seen in a long time. This issue is particularly acute with providers like Alisal Health Center and Federally Qualified Health Centers (FQHCs).
- The Provider network shows that practitioners are in-network and/or accepting new patients. However, when members contact the practitioner, they are told that the provider is not accepting new patients.

Barriers at Plan-Level Barriers

- Ineffective communication from providers that may not update their availability or specialty information with the Alliance regularly.
- Inefficiencies in the appointment scheduling systems and inadequate capacity to handle patient preferred times were recurrent themes.
- Policy and procedures regarding appointment scheduling, billing, and eligibility for services can create barriers to accessing care.

Conclusion Based on Qualitative Analysis

In conclusion, the Alliance reported the total complaints per 1,000 members and complaints regarding access met their goals. The data reveal successful performance in keeping the complaints rate low for non-behavioral health services. While ongoing network adequacy steering committee activities will continue to use grievance data as a data insight, no additional barrier analysis is needed to address network adequacy gaps.

Opportunities for Improvement

- The Alliance has been working to expand the network by adding several vendors. These vendors can provide non-emergency medical transport to members so that the member can go to providers that are located far from their residence.
- Implement and expand telehealth clinics to reach remote and underserved areas. The Alliance is in the process of implementing telehealth for both non-behavioral health and behavioral health to expand the number of telehealth only providers. In addition, several clinics offer in-person services, and Telehealth appointments to their patients. This reduces the need for patients to travel long distances and allows providers to see patients virtually, which can reduce the pressure on physical clinic spaces.
- The Alliance continues to work with internal front-line staff, developed resources and updated scripting to ensure consistent messaging to prevent member abrasion.
- The Alliance continues to work with health partners, to ensure efficient scheduling systems and member communications about available appointment assistance.

- The Alliance continues to increase member feedback monitoring mechanisms to regularly gather and use this data to inform service adjustments. These efforts aim to enhance service quality and member satisfaction while addressing gaps in care.
- The Alliance continues to work towards increasing network capacity by working with local medical schools, residency programs with University of California Merced and University of California San Francisco to expand the network in remote areas.
- The Alliance offers workforce recruitment grants to fund a portion of the salary for specific provider types to aid in recruiting additional practitioners and supporting medical assistants.
- The Alliance enhanced comprehensive training and staff development programs focused on empathy, customer service, and cultural competence. This approach aims to improve staff interactions with members and reduce complaints related to attitude and service.
- The Alliance continues to develop effective communication methods to help members understand their coverage, how to access services, and how to voice concerns. These ongoing improvements are expected to reduce confusion and dissatisfaction.

11.4.2. Appeals Non-Behavioral Health

Category	Previous Year (2024)		Current Measurement Year (2025)			
	Total Member Months 5,394,067		Total Member Months 5,295,476			
	2024 Total Appeals	2024 Appeals per 1,000 Member Months	2025Total Appeals	2025 Appeals per 1,000 Member Months	Goal (Per 1,000 Member Months)	Goal Met?
Quality of Care	7	0.0001	3	0.0001	2	YES
Access	208	0.04	549	0.10	2	YES
Attitude/Service	36	0.01	5	0.0001	2	YES
Billing/Financial	3	0.0001	2	0.0001	2	YES
Quality of Practitioner Office Site	0	0.00	0	0.00	2	YES
Total/Number per 1,000	254	0.05	559	0.11	5	YES

Quantitative Analysis

- The target for appeal rates per category was set below 2 appeals per 1,000 member months, with an overall organizational goal of less than 5 appeals per 1,000 member months.

- The Alliance successfully met the goals for all categories, including quality of care, access, attitude/service, billing/financial, and quality of practitioner office site.
- The total appeals increased 100% from between 2024 and 2025; however, they remained consistently low at 0.10 per 1,000 member months. This rate met the organization's overall goal of less than 5 appeals per 1,000 member months. The increased appeals primarily focused within the community supports benefits, (medically tailored meals & housing supports) and applying policy criteria.
- Appeals related to access represented the highest appeal category received in 2025.This rate was stabilized below .10 per 1,000 member months. This also achieved the goal of having fewer than two appeals per thousand members.
- Appeals within the other NCQA categories (Attitude/Service; QOC, billing/financial, etc.) were statistically low and well under the set goals.
- Overall, appeal rates achieved the goal with a successful performance of under .11 appeals per 1,000 member months.

Conclusion Based on Quantitative Analysis

The Alliance met all goals for evaluating non-behavioral health appeals for 2025. The report highlights the positive aspect of member satisfaction with the Alliance health services.

Qualitative Analysis

In summary, the Alliance met all goals with appeal categories, at below 2 per 1,000 member months, and there is a zero-complaint rate in the quality of practitioner office site category. Other categories such as billing/financial, quality of care, and attitude/service remain below a .01 rate. This indicates an excellent level of service and care with appeals. The increase of appeal volume during 2025 is attributed to an increase in Community Supports services, such as medically tailored meals and housing services. The recorded appeal rates for access, attitude/service and quality of care were relatively low. This low volume could be attributed to efforts to improve the accessibility of services. It further suggests that the Alliance has successfully implemented optimized processes to address and resolve benefit issues promptly, preventing them from escalating into appeals.

The Alliance maintained appeal rates below the set goals in every category. This shows the organizational dedication to proactive measures and ongoing development.

Conclusion Based on Qualitative Analysis

Overall, analysis of the 2025 results for complaints and appeals indicates goals were achieved. The low volume of the Alliance's members are highly satisfied with non-behavioral health services. This conclusion is supported by the relatively low numbers of complaints and appeals across all service categories. There is no need to identify opportunities or address network adequacy issues at the moment.

11.4.3. Complaints Behavioral Health

Category	Previous Year (2024)	Current Measurement Year (2025)

	Total Member Months 5,394,067		Total Member Months 5,295,476			
	2024 Total Complaints	2024 Complaints per 1,000 Member Months	2025Total Complaints	2025 Complaints per 1,000 Member Months	Goal (Per 1,000 Member Months)	Goal Met?
Quality of Care	21	<0.01	24	<0.01	2	YES
Access	44	0.01	44	0.01	2	YES
Attitude/Service	65	0.01	82	0.01	2	YES
Billing/Financial	23	<0.01	16	<0.01	2	YES
Quality of Practitioner Office Site	1	<0.01	0	<.01	2	YES
Total/Number per 1,000	154	0.03	166	0.03	5	YES

Quantitative Analysis

- The goals were to maintain complaints per category below 2 per 1,000 member months, with an organizational target of fewer than 5 complaints per 1,000 member months overall.
- The Alliance met all the goals. It demonstrates effective overall management and resolution of member complaints.
- In 2025, the rate of total complaints remained consistent at 0.03 per 1,000 member months. This demonstrates a strong performance,
- Complaints related to attitude or service were reported as having the highest number at a rate of 0.01 per 1,000 member months. From 2024 to 2025, the volume increased from 65 to 82 complaints.
- The rates across the remaining categories remained consistent and reflect stable performance in access complaints, demonstrating effective measures taken to enhance access services.
- The complaint Quality of Care in Behavioral Health Care 2025 registered 24 complaints with a rate of less than < 0.001 complaints per 1,000 member months. There was a slight increase from 21 complaints in 2024, indicating a slight increase to monitor, but remains well below the complaint threshold.
- There were no complaints about the quality of practitioner office site. This indicates the ongoing satisfaction of members with the practitioner office environment.

Conclusion Based on Quantitative Analysis

In conclusion, the Alliance has demonstrated effective complaint management across access and various service categories in 2025. All categories have met the goals set. The overall low rate of complaints, especially in the category of access, underscores the Alliances' dedication and effort to enhance member satisfaction to address concerns promptly and efficiently.

Qualitative Analysis

The rates of complaints regarding access and other categories of behavioral health services remained consistently low from 2024 to 2025. This consistent performance suggests the Alliance effective network adequacy, which contributes to heightened member satisfaction. One plausible reason for this success is the Alliance's proactive approach to engaging with members, which helps to address issues before they become serious. Implementing strategies such as conducting regular satisfaction surveys, maintaining open and empathetic communication, and deploying a responsive member services team are crucial for success. The Alliance is in a strong position to improve member satisfaction and lower complaint rates in the coming years through proactive issue resolution and continuous monitoring.

Conclusion Based on Qualitative Analysis

In summary, the qualitative analysis reveals a positive trend in member satisfaction regarding behavioral health services. The results showed low complaint frequencies across various categories. In 2025, The objectives concerning service quality, accessibility, and practitioner office site criteria were successfully achieved.

11.4.4. Appeals Behavioral Health

Category	Previous Year (2024)		Current Measurement Year (2025)			
	Total Member Months 5,394,067		Total Member Months 5,295,476			
	2024 Total Appeals	2024 Appeals per 1,000 Member Months	2025 Total Appeals	2025 Appeals per 1,000 Member Months	Goal (Per 1,000 Members)	Goal Met?
Quality of Care	0	0.00	0	0.00	2	YES
Access	0	0.00	0	0.00	2	YES
Attitude/Service	0	0.00	0	0.00	2	YES
Billing/Financial	0	0.00	0	0.00	2	YES

Quality of Practitioner Office Site	0	0.00	0	0.00	2	YES
Total/Number per 1,000	0	0.00	0	0.00	5	YES

Quantitative Analysis

- The set goals were to keep complaints per category below 2 per 1,000 member months, with an overall organizational goal of fewer than 5 complaints per 1,000 member months.
- The Alliance met all the goals for the appeals rate as no appeals were reported for behavioral health care service in all five categories. This demonstrates effective overall management and resolution of member appeals.
- There were zero access appeals per 1,000 member months between 2024 and 2025. This reflects the effective ongoing access services of the Alliance, leading to the ongoing satisfaction of members.

Conclusion Based on Quantitative Analysis

The Alliance has demonstrated outstanding performance in managing and resolving member complaints and appeals across all service categories. The organization successfully met all goals of maintaining complaints below 2 per 1,000 member months and sustaining the overall complaint rate under 5 per 1,000 member months. No appeals were reported for behavioral health care services in all five categories. These results underscored the effectiveness of the Alliance management practices and highlighted a consistent and positive trend in member satisfaction.

Qualitative Analysis

There has been a consistent and positive trend in the zero number of appeals across all categories in behavioral health appeals for 2024 and 2025. This demonstrates a high level of satisfaction with care and service access. The reason could be that the Alliance has implemented strong systems to ensure that members can easily access services, encounter no billing or financial discrepancies, experience high-quality practitioner office environments, and receive service with a positive attitude. This thorough focus on member experience helps minimize the occurrence of issues in these areas. Furthermore, it suggests that the Alliance has promptly put in place effective procedures to address problems before they become appeals. Continued monitoring and proactive measures will be essential to sustain this positive trend and further improve the quality of care and access provided to Alliance members.

Conclusion Based on Qualitative Analysis

The outcomes reflect a robust framework within the Alliance that ensures ongoing member satisfaction and operational excellence by proactively addressing any potential concerns. There were no barriers and opportunities identified based on the analysis of the 2025 outcomes; however, the Alliance will continue to identify potential barriers and opportunities for improvement to sustain this performance.

Opportunity to Improvement

- Provide healthcare providers with regular training sessions to improve their skills and understanding of delivering quality care.
- Provide members with educational materials to better understand their treatment options and expected outcomes.
- Establish standardized treatment plans and policies to ensure reliable, exceptional healthcare.

12. Access To Care

12.1. Introduction

Central California Alliance for Health (The Alliance) review the provider appointment availability survey (PAAS) of services standards to measure appointment availability, network service adequacy, and capacity for Primary Care Providers (PCPs), high volume specialists, high impact specialists, and behavioral health specialists to ensure adequate access is provided for members. The Alliance conducts a thorough assessment of network adequacy in relation to the state Department of Health Care Services (DHCS) standards, performing this evaluation quarterly and annually. The group in charge of reviewing and analyzing this process consists of Quality Improvement and Population Health Director, Quality and Health Programs Manager, Grievance and Quality Manager, Provider Services Director, Provider Quality and Network Development Manager, Health Services Operations Manager, and Compliance Director.

12.2. Program Goal

The program goal is to ensure that the Alliance meets the appointment access standards established to meet the needs of members.

12.3. Program Objectives

The program objectives include the following:

- Determine appropriate access and availability thresholds for the specified areas of care.
- Re-evaluate the appropriateness of network availability standards at least annually.
- Measure the availability of practitioner networks in our geographic area.
- Identify any areas for improving the network to meet the needs of members.
- Develop, prioritize, and implement interventions to improve access for members.

12.4. Methodology

The Alliance works with a vendor to complete data collection to monitor appointment availability via PAAS for primary care, high-volume specialty, and high-impact practitioner providers. The survey was conducted via telephone, mail, and web with a contracted survey vendor. The survey included a census of all primary care and specialty care providers to measure appointment availability against access standards. The Timely Access Survey was filed on May 1, 2025. The final data files were received from the vendor on April 3, 2026.

Performance Standards for Primary Care Practitioners (PCP)

The performance standard for PCPs is that >80% of the appointment types below meet their respective timeframe requirements:

- Urgent care – within 48 hours
- Routine care – within 10 days

Performance Standards for Specialty Care Practitioners (SPC)

The performance standard for SCPs is that >80% of the below appointment types meet their respective timeframe requirements:

- Urgent care – within 96 hours
- Routine care – within 15 days

Performance Standards for Behavioral HealthCare Practitioners (BPC)

The performance standard for SCPs is that >80% of the below appointment types meet their respective timeframe requirements:

- Non-life-threatening emergency– within 6 hours
- Urgent care – within 96 hours
- First Appointment Routine care – within 15 days

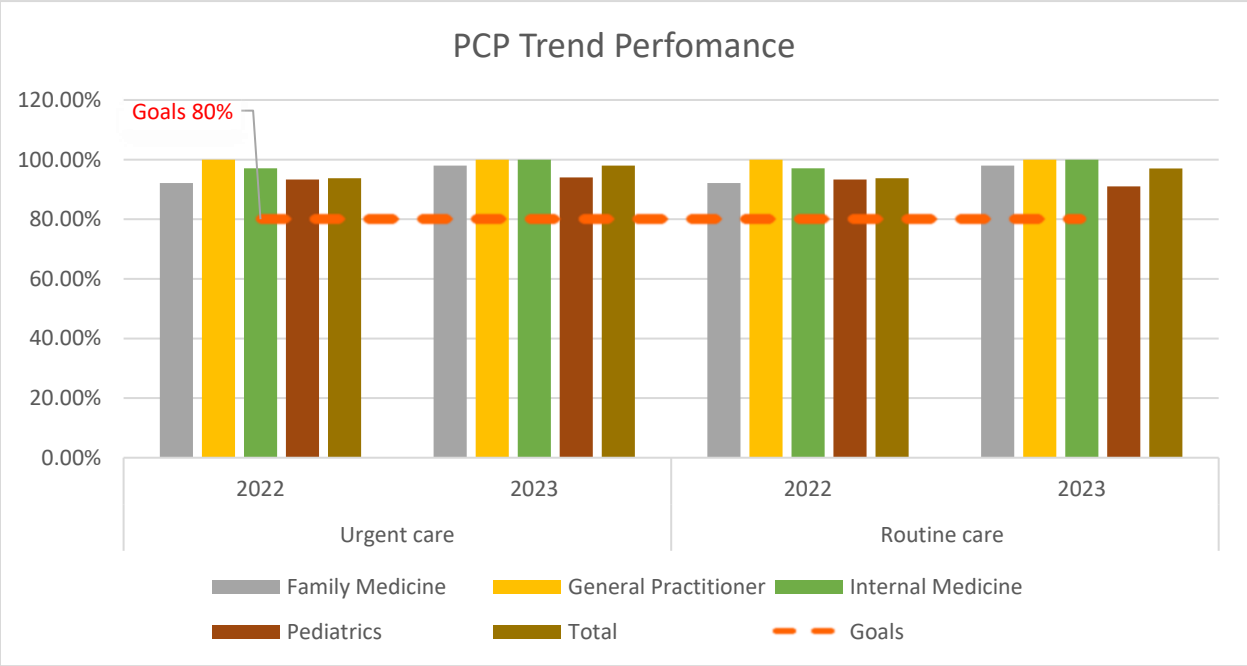
12.5. Program Performance

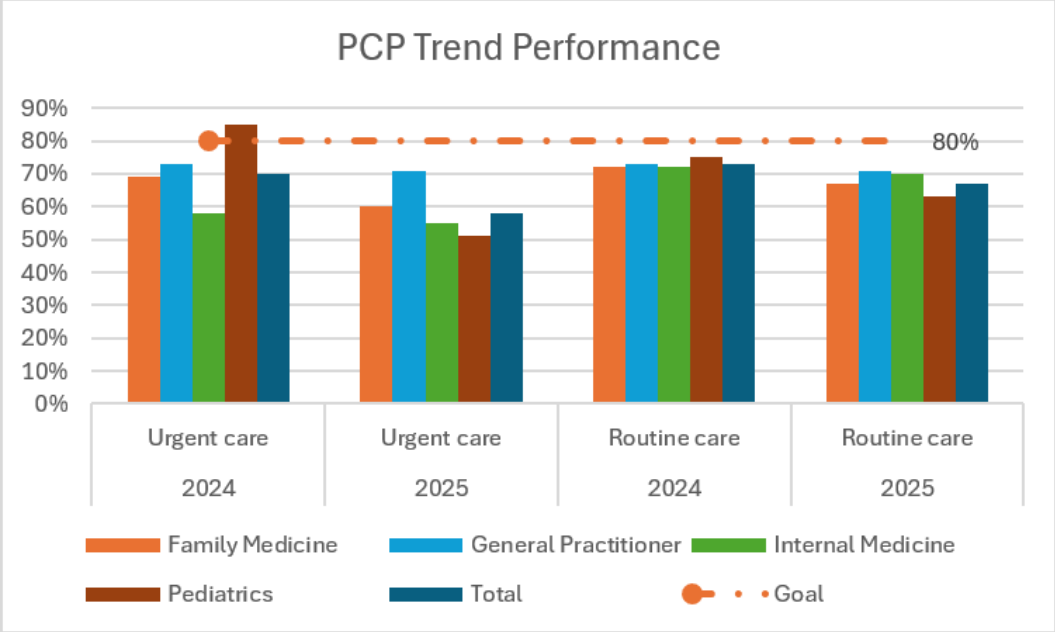
The tables below show the Plan's performance for different types of practitioners over time.

12.5.1. Primary Care Practitioner (PCP) Performance

PCPs include Family Medicine; General Practitioners; Internal Medicine; Pediatrics.

Appointment Type	Performance Standard	PCP Type	2024 Results (Pass/Count)	2025 Results (Pass/Count)	Goal Met (YES/NO)
Urgent care GOAL: 80%	Appointment available within 48 hours of patient will be seen today as a walk in or work in	Family Medicine	69% (149/215)	60% (91/152)	NO
		General Practitioner	73% (8/11)	71% (5/7)	NO
		Internal Medicine	58% (21/36)	55% (11/20)	NO
		Pediatrics	85% (34/40)	51% (18/35)	NO
		Total	70% (212/302)	58% 125/214)	NO
Routine care GOAL: 80%	Appointment available within 10 business days of patient will be seen today as a walk in or work in	Family Medicine	72% (155/215)	67% (102/152)	NO
		General Practitioner	73% (8/11)	71% (5/7)	NO
		Internal Medicine	72% (26/36)	70% (14/20	NO
		Pediatrics	75% (30/40)	63% (22/35)	NO
		Total	73% (219/302)	67% (143/214)	NO





Quantitative Analysis

- The Alliance did not exceed the 80% benchmark for accessibility to both urgent and routine care across all types of primary care practitioners.
- When assessing urgent care for appointment availability within 48 hours, the overall Alliance result fell short by 22 percentage points.
- In urgent care, General Practitioners had the highest service accessibility percentage at 71%.

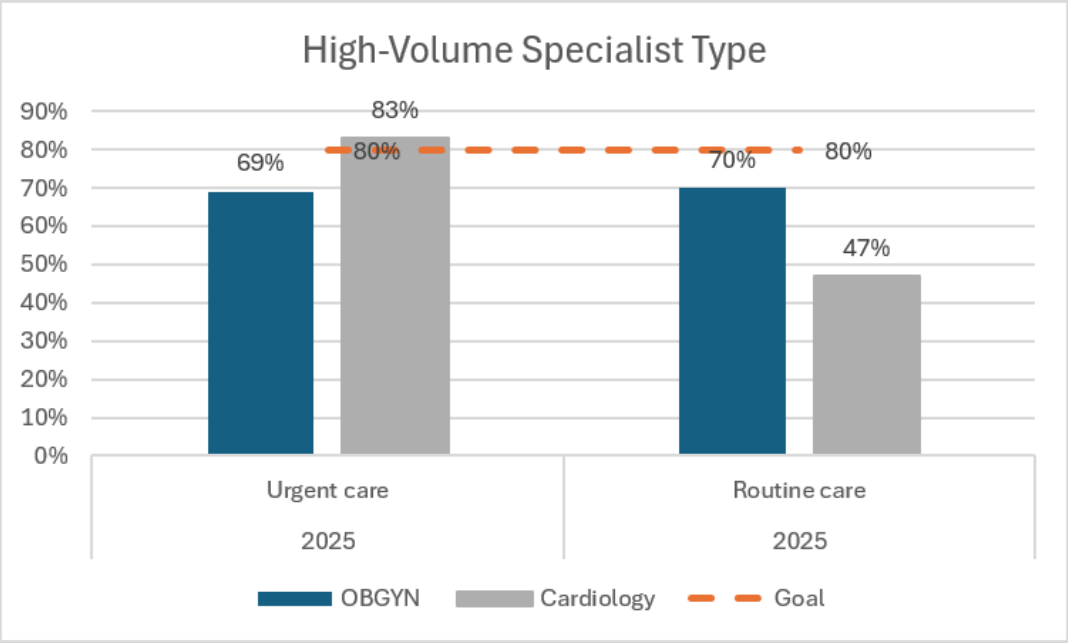
- Overall, the performance in urgent care and routine care was not met for evaluating appointment availability.

12.5.2. Specialty Care Practitioner (SCP) Performance – High-Volume Specialists

High-Volume SCPs include OB/GYN and Cardiology

Appointment Type	Performance Standard	High-Volume Specialist Type	2025 Result (Pass/Total Count)	Goal Met (YES/NO)
Urgent care GOAL: 80%	Appointment available within 96 hours of initial request	OB/GYN	69% (72/105)	NO
		Cardiology	83% (24/29)	YES
Routine care GOAL: 80%	Appointment available within 15 business days of initial request	OB/GYN	70% (73/105)	NO
		Cardiology	47% (14/29)	NO

High-Volume SCPs: Urgent Care (w/in 96 hours) and Routine Care (w/in 15 days) Visit Availability



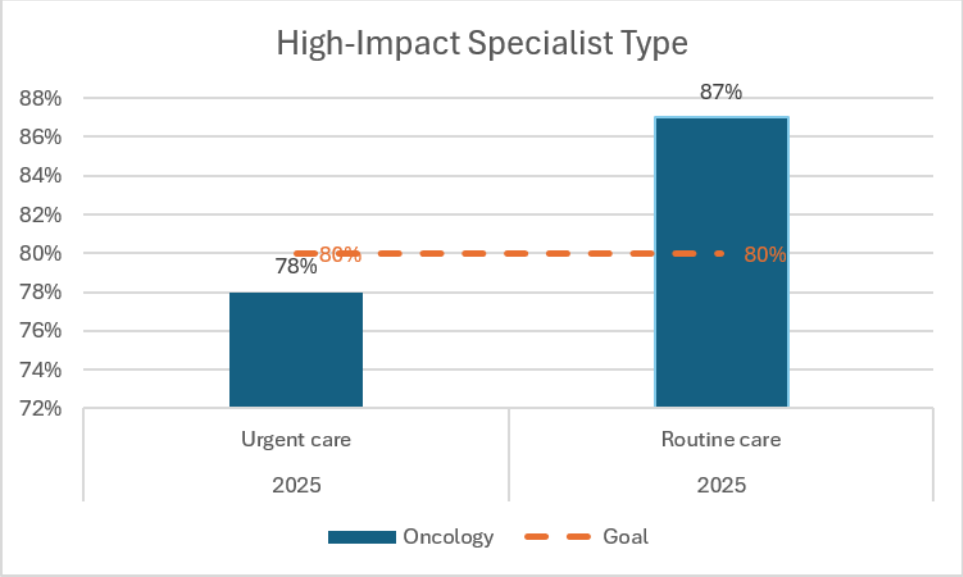
Quantitative Analysis

- The Alliance set a goal of 80% for urgent care appointments to be available within 96 hours of the initial request and for routine care of making appointments available within 15 business days.
- The OBGYN specialty care appointment availability goal was not met for either urgent care or routine care. The performance rate fell short at 69% for urgent care and 70% for routine care
- The Alliance met the Cardiology specialty care appointment availability for urgent care goals with an 83% success rate, surpassing the goal of 80% by 3 percentage points. The Cardiology specialty care appointment availability goal was not met for routine care. The performance rate was relatively low at 48% for routine care.

12.5.3. Specialty Care Practitioner (SCP) Performance – High-Impact Specialists

High-Impact SPCs include Oncology

Appointment Type	Performance Standard	High-Impact Specialist Type	2023 Result (Pass/Total Count)	Goal Met (YES/NO)
Urgent care GOAL: 80%	Appointment available within 96 hours of initial request	Oncology	78% (18/23)	NO
Routine care GOAL: 80%	Appointment available within 15 business days of initial request	Oncology	87% (20/23)	YES



Quantitative Analysis

- The Alliance set a performance goal for evaluating urgent care appointment availability within 96 hours and routine care appointment availability within 15 business days at an 80% goal.
- The Alliance did not meet performance standards for urgent care appointments. The urgent care performance rate for Oncology was 78% and fell approximately 2 percentage points short of the 80% target.
- The routine care performance rate for Oncology was 87% and exceeded the 80% target by 7 percentage points.
- This minimal shortfall in the goal indicates a gap in appointment availability for Oncology within the timeframe.

12.5.4. Behavioral Healthcare Practitioner (BCP) Performance – Non-Prescriber: Non-Physician Mental Health

Non-Prescriber BPCs include: Licensed Clinical Social Worker and Psychologist

Appointment Type	Performance Standard	BHCP type	2024 Result (Pass/Total Count)	2025 Result (Pass/Total Count)	Goal Met (YES/NO)
Non-Life Threatening Emergency GOAL:80%	Members are scheduled to be seen within 6 hours of contacting the provider	LCSW	NA	NA	NA
		Psychologists	NA	NA	NA
Urgent Care GOAL: 80%	Appointment available within 96 hours	LCSW	83% (33/40))	67% (29/43)	NO
		Psychologists	65% (28/43)	54% (20/37)	NO
First Appointment Visit For Routine Care GOAL: 80%	Members are scheduled to be seen within 10 business days of contacting the provider	LCSW	90% (43/48)	79% (59/75)	NO
		Psychologists	77% (51/66)	73% (33/45)	NO

Quantitative Analysis

- The data show that the Alliance did not meet the goal of 80% for appointment availability for urgent care and for the first appointment visit for routine care.
- The data regarding non-life-threatening emergency appointment availability within 6 hours is NA because members can go to ER without referral or making appointments.
- For routine care appointments where members should receive appointment availability within 10 days of contacting the provider, the Alliance's Licensed Clinical Social Workers achieved a performance result of 79%, only 1 percentage point short of the target goal. However, for urgent care appointments within 96 hours, LCSWs missed the goal by 13percentage points.
- Psychologists failed to achieve the goal by 26 percentage points for urgent care and 7 percentage points for routine care. The rates were 54% and 73%, respectively, compared to the goal of 80%.

12.5.5. Behavioral Healthcare Practitioner (BHCP) Performance – Prescriber

Non-Prescriber BHPCs include Psychiatrists.

Appointment Type	Performance Standard	2024 Results (Pass/Total Count)	2025 Results (Pass/Total Count)	Goal Met (YES/NO)
Non-Life Threatening Emergency GOAL:80%	Members are scheduled to be seen within 6 hours of contacting the provider	NA	NA	NA
Urgent Care GOAL: 80%	Appointment available within 96 hours	53% (24/45)	100% (7/7)	YES
First Appointment Visit For Routine Care GOAL: 80%	Members are scheduled to be seen within 15 business days of contacting the provider	98% (49/50)	50% (5/10)	NO

Quantitative Analysis

- The Alliance had a limited number of psychiatrists available. The Alliance did meet the goal for 2025 urgent appointment availability.
- The data regarding non-life-threatening emergency appointment availability within 6 hours is NA because members can go to ER without referral or making appointments.
- The performance rate for evaluating appointment accessibility for urgent care did meet the goal, with a performance result of only 100%.
- For first-appointment visits, the rate dropped significantly by 48 percentage points from 2024. The 2025 compliance rate of 50% did not reach the goal of 80%.

13. Network Adequacy including Surveys

13.1. Introduction

The Alliance has established provider availability standards for the number and geographic distribution of Primary Care Providers (PCPs), high volume Specialists, high impact Specialists, and Behavioral Health providers to ensure adequate access is provided for the Health Plan membership. At least annually the Alliance measures performance against its standards.

In 2025, the provider network geo-access was analyzed against the established standards as outlined below. The rows highlighted in red show the geo-access to practitioner standards that were not met and align with the information provided below. This analysis is conducted at least annually.

Santa Cruz County

GEO-ACCESS TO PRACTITIONERS				
Practitioner Type	**Measure**	**Performance Goal**	**Performance**	**Met/Not Met**
Primary Care Physicians	1 within 30 minutes or ten miles of member's residence or workplace	100%	92%	Not Met
Hospitals	1 within 30 minutes or 15 miles of member's residence or workplace	100%	92%	Not Met
High-Volume Specialists				
Cardiology	1 within 60 minutes or 30 miles of member's residence or workplace	100%	100%	Met
Obstetrics/Gynecology (OB/GYN)	1 within 60 minutes or 30 miles of member's residence or workplace	100%	100%	Met
High-Volume Behavioral Health Providers				
Licensed Clinical Social Workers (LCSW)	LCSW Providers to Members	100%	100%	Met
Psychiatrists	1 within 60 minutes or 30 miles of member's residence or workplace	100%	100%	Met
Psychologists	1 within 60 minutes or 30 miles of member's residence or workplace	100%	100%	Met
High-Impact Providers				
Oncologists	1 within 60 minutes or 30 miles of member's residence or workplace	100%	100%	Met

Core Specialists				
Dermatology	1 within 60 minutes or 30 miles of member's residence or workplace	100%	100%	Met
Ear, Nose, and Throat/Otolaryngology	1 within 60 minutes or 30 miles of member's residence or workplace	100%	100%	Met
Endocrinology	1 within 60 minutes or 30 miles of member's residence or workplace	100%	100%	Met
Gastroenterology	1 within 60 minutes or 30 miles of member's residence or workplace	100%	100%	Met
General Surgery	1 within 60 minutes or 30 miles of member's residence or workplace	100%	100%	Met
Hematology	1 within 60 minutes or 30 miles of member's residence or workplace	100%	100%	Met
HIV/AIDS Specialists/Infectious Diseases	1 within 60 minutes or 30 miles of member's residence or workplace	100%	100%	Met
Nephrology	1 within 60 minutes or 30 miles of member's residence or workplace	100%	100%	Met
Neurology	1 within 60 minutes or 30 miles of member's residence or workplace	100%	100%	Met
Oncology	1 within 60 minutes or 30 miles of member's	100%	100%	Met

	residence or workplace			
Ophthalmology	1 within 60 minutes or 30 miles of member's residence or workplace	100%	100%	Met
Orthopedic Surgery	1 within 60 minutes or 30 miles of member's residence or workplace	100%	100%	Met
Physical Medicine and Rehabilitation	1 within 60 minutes or 30 miles of member's residence or workplace	100%	100%	Met
Pulmonology	1 within 60 minutes or 30 miles of member's residence or workplace	100%	100%	Met
Allergy/Immunology	1 within 60 minutes or 30 miles of member's residence or workplace	100%	100%	Met
Neurosurgeons	1 within 60 minutes or 30 miles of member's residence or workplace	100%	100%	Met

Monterey County

GEO-ACCESS TO PRACTITIONERS				
Practitioner Type	**Measure**	**Performance Goal**	**Performance**	**Met/Not Met**
Primary Care Physicians	1 within 30 minutes or ten miles of member's residence or workplace	100%	96%	Not Met
Hospitals	1 within 30 minutes or 15 miles of member's residence or workplace	100%	90 %	Not Met

High-Volume Specialists				
Cardiology	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Obstetrics/Gynecology (OB/GYN)	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
High-Volume Behavioral Health Providers				
Licensed Clinical Social Workers (LCSW)	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Psychiatrists	1 within 75 minutes or 45 miles of their residence or workplace	100%	99%	Not Met
Psychologists	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
High-Impact Providers				
Oncologists	1 within 75 minutes or 45 miles of their residence or workplace	100%	95%	Not Met
Core Specialists				
Dermatology	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Ear, Nose, and Throat/Otolaryngology	1 within 75 minutes or 45 miles of their residence or workplace	100%	99 %	Not Met
Endocrinology	1 within 75 minutes or 45 miles of their	100%	99%	Not Met

	residence or workplace			
Gastroenterology	1 within 75 minutes or 45 miles of their residence or workplace	100%	99%	Not Met
General Surgery	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Hematology	1 within 75 minutes or 45 miles of their residence or workplace	100%	99%	Not Met
HIV/AIDS Specialists/Infectious Diseases	1 within 75 minutes or 45 miles of their residence or workplace	100%	99%	Not Met
Nephrology	1 within 75 minutes or 45 miles of their residence or workplace	100%	99%	Not Met
Neurology	1 within 75 minutes or 45 miles of their residence or workplace	100%	99%	Not Met
Oncology	1 within 75 minutes or 45 miles of their residence or workplace	100%	95%	Not Met
Ophthalmology	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Orthopedic Surgery	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Physical Medicine and Rehabilitation	1 within 75 minutes or 45 miles of their	100%	100%	Met

	residence or workplace			
Pulmonology	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Allergy/Immunology	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Neurosurgeons	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met

Merced County

GEO-ACCESS TO PRACTITIONERS				
Practitioner Type	**Measure**	**Performance Goal**	**Performance**	**Met/Not Met**
Primary Care Physicians	1 within 30 minutes or ten miles of member's residence or workplace	100%	100%	Met
Hospitals	1 within 30 minutes or 15 miles of member's residence or workplace	100%	96%	Not Met
High-Volume Specialists				
Cardiology	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Obstetrics/Gynecology (OB/GYN)	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
High-Volume Behavioral Health Providers				

Licensed Clinical Social Workers (LCSW)	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Psychiatrists	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Psychologists	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
High-Impact Providers				
Oncologists	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Core Specialists				
Dermatology	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Ear, Nose, and Throat/Otolaryngology	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Endocrinology	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Gastroenterology	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
General Surgery	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met

Hematology	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
HIV/AIDS Specialists/Infectious Diseases	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Nephrology	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Neurology	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Oncology	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Ophthalmology	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Orthopedic Surgery	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Physical Medicine and Rehabilitation	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Pulmonology	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met
Allergy/Immunology	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met

Neurosurgeons	1 within 75 minutes or 45 miles of their residence or workplace	100%	100%	Met

Mariposa County

GEOACCESS TO PRACTITIONERS				
Practitioner Type	**Measure**	**Performance Goal**	**Performance**	**Met/Not Met**
Primary Care Physicians	1 within 30 minutes or ten miles of member's residence or workplace	100%	93%	Not Met
Hospitals	1 within 30 minutes or 15 miles of member's residence or workplace	100%	75%	Not Met
High-Volume Specialists				
Cardiology	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Obstetrics/Gynecology (OB/GYN)	1 within 90 minutes or 60 miles of their residence or workplace	100%	98%	Not Met
High-Volume Behavioral Health Providers				
Licensed Clinical Social Workers (LCSW)	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Psychiatrists	1 within 90 minutes or 60 miles of their residence or workplace	100%	98%	Not Met
Psychologists	1 within 90 minutes or 60 miles of their	100%	100%	Met

	residence or workplace			
High-Impact Providers				
Oncologists	1 within 90 minutes or 60 miles of their residence or workplace	100%	95%	Not Met
Core Specialists				
Dermatology	1 within 90 minutes or 60 miles of their residence or workplace	100%	95%	Not Met
Ear, Nose, and Throat/Otolaryngology	1 within 90 minutes or 60 miles of their residence or workplace	100%	95%	Not Met
Endocrinology	1 within 90 minutes or 60 miles of their residence or workplace	100%	95%	Not Met
Gastroenterology	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
General Surgery	1 within 90 minutes or 60 miles of their residence or workplace	100%	95%	Not Met
Hematology	1 within 90 minutes or 60 miles of their residence or workplace	100%	95%	Not Met
HIV/AIDS Specialists/Infectious Diseases	1 within 90 minutes or 60 miles of their residence or workplace	100%	95%	Not Met
Nephrology	1 within 90 minutes or 60 miles of their	100%	95%	Not Met

	residence or workplace			
Neurology	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Oncology	1 within 90 minutes or 60 miles of their residence or workplace	100%	95%	Not Met
Ophthalmology	1 within 90 minutes or 60 miles of their residence or workplace	100%	95%	Not Met
Orthopedic Surgery	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Physical Medicine and Rehabilitation	1 within 90 minutes or 60 miles of their residence or workplace	100%	95%	Not Met
Pulmonology	1 within 90 minutes or 60 miles of their residence or workplace	100%	95%	Not Met
Allergy/Immunology	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Neurosurgeons	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met

San Benito County

GEO-ACCESS TO PRACTITIONERS

Practitioner Type	Measure	Performance Goal	Performance	Met/Not Met
Primary Care Physicians	1 within 30 minutes or ten miles of member's residence or workplace	100%	99%	Not Met
Hospitals	1 within 30 minutes or 15 miles of member's residence or workplace	100%	95%	Not Met
High-Volume Specialists				
Cardiology	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Obstetrics/Gynecology (OB/GYN)	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
High-Volume Behavioral Health Providers				
Licensed Clinical Social Workers (LCSW)	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Psychiatrists	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Psychologists	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
High-Impact Providers				
Oncologists	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Core Specialists				

Dermatology	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Ear, Nose, and Throat/Otolaryngology	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Endocrinology	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Gastroenterology	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
General Surgery	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Hematology	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
HIV/AIDS Specialists/Infectious Diseases	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Nephrology	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Neurology	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Oncology	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met

Ophthalmology	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Orthopedic Surgery	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Physical Medicine and Rehabilitation	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Pulmonology	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Allergy/Immunology	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met
Neurosurgeons	1 within 90 minutes or 60 miles of their residence or workplace	100%	100%	Met

Quantitative Analysis

The Geo-Access tables show that goals were met except for the 29 county and provider type combinations listed below. The goals were not met due to a number of reasons discussed in the qualitative analysis.

County Name	Provider Type	% Below Goal
Mariposa	Obstetrics/Gynecology (OB/GYN)	5%
Mariposa	Oncologists	5%
Mariposa	Psychiatrists	2%
Mariposa	Dermatology	5%
Mariposa	Ear, Nose, and Throat/Otolaryngology	5%
Mariposa	Endocrinology	5%
Mariposa	General Surgery	5%
Mariposa	Hematology	5%

Mariposa	HIV/AIDS Specialists/Infectious Diseases	5%
Mariposa	Hospitals	25%
Mariposa	Nephrology	5%
Mariposa	Oncology	5%
Mariposa	Ophthalmology	5%
Mariposa	Physical Medicine and Rehabilitation	5%
Mariposa	Primary Care Physicians	7%
Mariposa	Pulmonology	5%
Merced	Hospitals	4%
Monterey	Oncologists	5%
Monterey	Hospitals	10%
Monterey	Primary Care Physicians	4%
Monterey	Psychiatrists	1%
Monterey	Ear, Nose, and Throat/Otolaryngology	5%
Monterey	Endocrinology	5
Monterey	Gastroenterology	1%
Monterey	Hematology	1%
Monterey	HIV/AIDS Specialists/Infectious Diseases	1%
Monterey	Nephrology	1%
Monterey	Oncology	5%
Monterey	Gastroenterology	1%
San Benito	Primary Care Physicians	1%
San Benito	Hospitals	5%
Santa Cruz	Hospitals	8%
Santa Cruz	Primary Care Physicians	8%

Quantitative Analysis

Operations Business Analysis worked with Health Analytics to align the geo-access monitoring report from ArcGIS Analytics to the standards established in Policy 300-5050 – Geographic Accessibility Standards.

Identify reasons why goals are not met for a type of practitioner:

1. Attrition of existing providers has led to a shortage of providers in the service area. This has particularly impacted the geographically rural areas within Mariposa, Monterey, and San Benito counties.
2. Generally, the GeoAccess analysis shows a trend in that Hospital and Primary Care networks do not meet GeoAccess standards for specific zip codes in all counties except Merced

County. The other gaps are for specialty care (Allergy/Immunology, Dermatology, Ear, Nose, and Throat/Otolaryngology, Endocrinology, Gastroenterology, General Surgery, Hematology, HIV/AIDS Specialists/Infectious Diseases, Nephrology, Neurosurgeons, Obstetrics/Gynecology (OB/GYN), Oncology, Ophthalmology, Physical Medicine and Rehabilitation, Psychiatrists, and Pulmonology) in Mariposa and southern Monterey County.

13.2. Provider Ratio Analysis

In June 2024, provider network ratios were analyzed against the established standards as outlined below. This analysis is conducted at least annually.

Practitioner Type	Standard (Requirement) Provider to Member Ratio	Medi-Cal Ratio (RY Actuals) Provider to Member Ratio	Met/Not Met
Total Physicians	1:2,000	1:25	Met
Primary Care Physicians	1:2,000	1:531	Met
General Medicine/Family Practice	1:2,000	1:986	Met
Internal Medicine	1:2,000	1:2,801	Not Met
Pediatrics	1:2,000	1:917	Met
High Volume Specialists			
Cardiology	1:5,000	1:660	Met
Obstetrics/Gynecology (OB/GYN)	1:3,000	1:316	Met
High Volume Mental Health Providers			
Licensed Clinical Social Workers (LCSW)	1:2,000	1:543	Met
Psychiatrists	1:5,000	1:1,632	Met
Psychologists	1:5,000	1:1,157	Met
High Impact Specialists			
Oncologists	1:10,000	1:840	Met
Other Specialists			
Allergy/Immunology	1:5,000	1: 4,678	Met
Neurosurgeons	1:10,000	1:2,648	Met

Quantitative Analysis

The ratios table shows that goals were met for all provider types except Internists. y. The ratio was above the goals for these practitioner types by 5801 members for Internist. This goal was not met due to the reasons discussed below.

Qualitative Analysis

Operational Business Analysis worked with Health Analytics to align the Provider to Patient Ratio report in Tableau to the NCQA standards.

Identify reasons why goals are not met for a type of practitioner:

1. Attrition of existing providers has led to a shortage of primary care providers in the service area. This has greatly impacted the rural areas of the Alliance's service area.
2. The Alliance service area can be challenging to recruit providers due to the rural nature of the network. The network is in a health care shortage area, referenced by having three CMS designated Critical Access Hospitals within the counties where members are served.

13.3. Overall Geographic Analysis

- Numerical standards are met and exceeded for all PCP types except Internal Medicine. Drive distance standards are met and exceeded for all PCP types in Santa Cruz and Merced. but for Monterey, Mariposa, and San Benito the drive distance standards for PCP are not met.
- Numerical standards are met and exceeded for all high-volume specialists and high-impact specialists. Drive distance standards are met and exceeded for all high-volume specialists and high-impact specialists except oncologists in Monterey.
- Numerical standards are met and exceeded for all Behavioral Health provider types. Drive distance standards are met and exceeded for all Behavioral Health provider types.

13.4. Conclusion and Next Steps:

The Alliance meets the member-to-provider ratio standards for most of the provider types. There is only one provider type that does not meet the ratio standards, and this is because several of the areas that the Alliance operates in locations that are considered rural and areas designated to have low providers. The Alliance's contracting department has done an excellent job of contracting with a very high percentage of providers in the service area, and this has helped the organization meet most of the goals.

14. Telephone Access

14.1. Introduction

The Call Center provides assistance to members regarding benefits, eligibility verification, Primary Care Provider (PCP) updates or changes, and community resources. In addition to telephone access, the Alliance provides face-to-face assistance to members through Call Center staff.

The Call Center aligns staffing and operational practices with member demand and service needs, optimizing coverage during peak periods while scheduling staff meetings and training during non-peak hours to minimize impacts on telephone access. Member Services staff are available Monday–Friday, 8:00 a.m.–5:30 p.m. The D-SNP Call Center is available from 8:00 a.m.–8:00 p.m., seven days a week from October 1 through March 31, except Thanksgiving and Christmas, and Monday–Friday from April 1 through September 30, except holidays.

The Alliance promotes self-service options through its website and online member portal. Call Center staff assist members with establishing online accounts, allowing members to access information and complete certain transactions without waiting for assistance from an agent.

14.2. Results and Performance

The Call Center monitors telephone access and operational performance through established service standards designed to promote timely and appropriate access to Member Services. The Call Center's performance standards are:

- **80% of Member Services calls answered within 30 seconds**
- **Call abandonment rate of 5% or less**

Measure	Performance 2024	Performance2025	Performance Goal	Goal Met
Call Center Service Level	81.9%	58.4%	80%	NO
Call Abandonment Rate	3.6%	6.0%	5% or Less	NO

Quantitative Analysis

During the evaluation period of 2025, the Call Center received 217,566 inbound calls, with an average service level of 58.4% and a 6.0% abandonment rate. Call Center staff also assisted 3,892 members through face-to-face interactions.

- **Call Center Volume** - Increased 31,549 from 184,017 calls in 2024 to 217,566 in 2025.
- **Call Center Service Level** - Decreased from 81.9% in 2024, to 58.4% in 2025. The goal of 80% of Member Services calls answered within 30 seconds was not met in 2025.
- **Call Abandonment Rate** - Increased from 3.6% in 2024 to 6.0% in 2025. The 5% or less goal was not met for 2025.
- **Face-To-Face Interactions** - Decreased from 5,014 members in 2024 to 3,892 members in 2025.

Qualitative Analysis

The increase in call volume reflects expanded services and operational changes during the evaluation period, including the implementation of the Five9 phone system on June 16, 2026, Behavioral Health Services on July 1, 2025, and D-SNP Open Enrollment beginning October 1, 2025. As additional benefits and services to members were introduced, staff were required to review new information, complete training, and participate in testing to ensure readiness to support members.

The Member Services department also experienced staffing challenges during the evaluation period, including call center staffing attendance and coverage reliability issues with multiple staffing leave of absences and unexpected absences. These challenges contributed to reduced staffing capacity and impacted the department's ability to consistently meet key performance metrics like the Call Center Service Level and maintain expected service levels.

Face-to-face interactions decreased for 2025 because in-person services were temporarily paused the last quarter of the year due to increased call volume, staffing constraints, and the department's inability to consistently meet required reportable performance metrics.

14.4. Conclusion and Next Steps

The Alliance will continue to monitor telephone access, call volume, service level, abandonment rates, and staffing capacity. Operational needs will be evaluated against member demand to identify opportunities to improve access and service performance.

Continued focus will include:

- Optimizing staffing levels and queue coverage to align with call volume and member demand
- Monitoring staffing capacity, attendance, and reliability to support consistent coverage and operational performance
- Monitoring trends in call volume and member needs
- Identifying opportunities to improve service level and reduce abandonment
- Promoting self-service and online member resources
- Incorporating AI-enabled tools and resources, such as chat-based support, to improve access to routine information and services
- Expanding digital self-service options, including ID card requests and address updates
- Evaluating processes and staffing needs as services and membership needs evolve

Overall Goal for 2026 will be to maintain timely, accessible, and member-centered telephone service while continuously evaluating opportunities for quality improvement.

15.DHCS Population Health Management Strategy

15.1. Introduction

The Population Health Management Program (PHMP) was launched by DHCS in January 2023, to establish a cohesive statewide framework for Managed Care Plans. Priority was placed on whole-person care, prevention, and responding to Member's medical and social needs and preferences. Documentation and participation transitioned from the prior Population Needs Assessment (PNA) reporting, to annual submissions of a Population Health Management Strategy, and meaningful collaboration with the local health department (LHD) partners on their Community Health Assessments (CHAs) and Community Health Improvement Plans (CHIPs) - know, as of July 2026, as "Local Planning" requirements.

15.2. PHM Program Values and Process

Alliance PHM Program values include:

- Focusing on keeping members healthy through health and wellness/prevention.
- Understanding needs and solutions through community outreach.
- Incorporating equity - that members have the same opportunity to live a healthy and thriving life, regardless of race/ethnicity, gender and gender identity, sexual orientation, age, or other demographic drivers – in all programs.
- When possible, building programs upstream to address the social drivers of health.
- Embracing inter-sectoral action and partnerships.
- Patient Centered Medical Home (PCMH) model.

Which are accomplished through:

- Meaningful collaboration with Local Health Jurisdictions (LHJs) and Stakeholders to complete local planning efforts, including participation in Community Health Improvement Plans (CHIPs)/Community Health Assessments (CHAs).
- Population Identification & Data integration.
- Regular Risk Stratification, Segmentation, and Tiering of entire member population, including management of members with emerging risk and with multiple chronic illnesses.

- Increasing access to services and support to members, including basic population health management services (BPHM), care management including Complex Case Management (CCM) and Enhanced Care Management (ECM), and Transitions of Care Services (TCS).
- Providing support to the healthcare delivery system and ensuring patient safety and outcomes across settings.
- Addressing health inequities and elimination of health disparities to achieve optimal health outcomes.
- Evaluation and continuous improvement.

15.3. Strategic Alignment

The design of the Alliance PHM Program aligns with the following local and State strategic priorities:

- Alliance strategic priorities to advance health equity and person-centered delivery system transformation.
- DHCS Comprehensive Quality Strategy (CQS) Bold Goals: 50x2025 Initiative focused on children's preventative care, behavioral health integration and maternity outcomes and birth equity.
- DHCS comprehensive Cal AIM program.
- The Quintuple Aim goals from the Institute for Healthcare Improvement: improve the health of our population, enhance our member's experience of care, reduce per capita cost of healthcare, support wellbeing and joy in the workforce, and advance health equity.
- Compliance with DHCS and NCQA standards for Population Health Management.

15.4. Partnership with Local Health Jurisdiction

As part of the PHM Program, the Alliance will continue to participate in each County's respective local planning efforts, Community Health Assessments (CHAs) and Community Health Improvement Plans (CHIPs). The completed plans for the most recent assessments below can be found on the Alliance's website: https://thealliance.health/for-communities/community-publications/community-health-assessments-and-community-health-improvement-plans/

- Mariposa County Health & Human Services Agency's 2024 Community Health Assessment (CHA) and 2025 Community Health Improvement Plan (CHIP)
- Merced County Department of Public Health's 2023 CHA and 2024-2029 CHIP
- Monterey County Health Department's 2025 Community Health Needs Assessment (CHNA) and 2025-2028 CHIP
- San Benito County Health & Human Services Agency, Public Health Services Department's 2023/2024 CHA and 2023/2024 CHIP and
- Santa Cruz County Health Services Agency, Public Health Division's 2024 CHA (CHIP publication to be announced)

Shared Goals and Objectives

For the annual 2025 PHM Strategy Deliverable submission, goals and objectives were developed in partnership Mariposa County, Merced County, Monterey County, San Benito County, and Santa Cruz County, to help direct resources and planning for the coming year.

Mariposa County

Shared Goal

- Increase access to mental health and substance use disorder prevention and treatment programs and individuals and their families residing in Mariposa County.

SMART Objective

- By December 31, 2025, Mariposa County and the Alliance will develop and complete a catalogue of mental health and substance use disorder providers and programs existing within the county. Both the MCP and LHJ will use this catalogue to inform targeted community and MCP-specific intervention alignment and indicated collaborations to increase access to mental health and substance use disorder programs within the respective CHIP and PHM strategies.

Progress on Shared Goal and SMART Objective

In collaboration with our partners at Mariposa County, the Alliance developed a comprehensive provider directory through a process informed by feedback, education, and information sharing. This effort aimed to increase access to mental health and substance use disorder services by improving connectivity between members, providers, and county resources.

With behavioral health insourcing as of July 1, 2025, the Alliance's online directory now enables members to directly connect with mental health and addiction counseling providers through their MCP. The directory includes robust search criteria such as provider contact information (phone, hours, location, language), specialty types (Psychiatrist, Psychologist, LCSW, LMFT, LPCC), and over 40 specialty focus areas (e.g., trauma, grief, addiction, women's issues).

Members can also filter by treatment modalities and populations served (e.g., CBT, DBT, LGBTQIA, youth, adults), telehealth or in-person options, provider gender, and geographic location (county, city, zip code).

Additionally, the Alliance website hosts information on MHP/DMC-ODS services and links to behavioral health resources such as NAMI, 211, 988, and the National Eating Disorders Association. The BH department also compiled a comprehensive list of eating disorder treatment programs across California, including virtual and local

Implementation Challenges or Barriers

Implementation of the shared goal faced several challenges. First, leadership transitions within both the MCP and County created delays in decision-making and continuity of planning. Second, there was no clear path forward for establishing a shared, centralized space to house all county behavioral health resources, which limited the ability to streamline access for members. Next, Mariposa County is one of our smallest county service areas, with a lack of providers in the area, which makes providing a larger repository difficult. While the Alliance developed a provider directory, we also added several telehealth provider options, increasing resources for areas where there are less providers. A final challenge is that our provider search does not currently include all substance use disorder (SUD) treatment options. This is due to the County Behavioral Health Department maintaining separate referral pathways and linking members directly to SUD services. Through "No Wrong Door" Members can start their request in any system and get connected; however not all SUD resources are held in one shared space. These issues are being actively monitored, and collaborative efforts continue to improve integration and resource visibility.

Unintended Outcomes

Insourcing and this shared goal created the opportunity to develop and strengthen new relationships with our county partners, particularly in a county that we recently expanded into in 2024. These relationships have expanded the capacity for new planning in support of Behavioral Health Transformation efforts.

Merced County

Shared Goal

- Increase access to mental health and substance use disorder prevention and treatment programs and individuals and their families residing in Merced County.

SMART Objective

- By December 31, 2025, Merced County and the Alliance will develop and complete a catalogue of mental health and substance use disorder providers and programs existing within the county. Both the MCP and LHJ will use this catalogue to inform targeted community and MCP-specific intervention alignment and indicated collaborations to increase access to mental health and substance use disorder programs within the respective CHIP and PHM strategies.

Progress on Shared Goal and SMART Objective

In collaboration with our partners at Merced County, the Alliance developed a comprehensive provider directory through a process informed by feedback, education, and information sharing. This effort aimed to increase access to mental health and substance use disorder services by improving connectivity between members, providers, and county resources.

With behavioral health insourcing as of July 1, 2025, the Alliance's online directory now enables members to directly connect with mental health and addiction counseling providers through their MCP. The directory includes robust search criteria such as provider contact information (phone, hours, location, language), specialty types (Psychiatrist, Psychologist, LCSW, LMFT, LPCC), and over 40 specialty focus areas (e.g., trauma, grief, addiction, women's issues).

Members can also filter by treatment modalities and populations served (e.g., CBT, DBT, LGBTQIA, youth, adults), telehealth or in-person options, provider gender, and geographic location (county, city, zip code).

Additionally, the Alliance website hosts information on MHP/DMC-ODS services and links to behavioral health resources such as NAMI, 211, 988, and the National Eating Disorders Association. The BH department also compiled a comprehensive list of eating disorder treatment programs across California, including virtual and local options. This list was shared with County Behavioral Health and is available to LHJs and providers. This collaborative approach has strengthened cross-agency partnerships and enhanced access to behavioral health services for Merced County residents.

Implementation Challenges or Barriers

Implementation of the shared goal faced several challenges. Leadership transitions within the MCP created delays in decision-making and continuity of planning. Additionally, there was no clear path forward for establishing a shared, centralized space to house all county behavioral health resources, which limited the ability to streamline access for members. While the Alliance developed a robust provider directory, it does not currently include all substance use disorder (SUD) treatment options. This is due to the County Behavioral Health Department maintaining separate referral pathways and linking members directly to SUD services. Through "No Wrong Door" members can start their request in any system and get connected; however not all SUD resources are held in one shared space. These issues are being actively monitored, and collaborative efforts continue to improve integration and resource visibility.

Unintended Outcomes

The Alliance also participated alongside Merced County BHRS in the DHCS IHI collaborative from June 2024-June 2025, to partner together to work toward common goals to increase access to members that visit our hospitals for Mental health or SUD reasons. Within this collaborative, data sharing, clinical interventions, and member level review and coordination were completed.

Monterey County

Shared Goal

- Monterey County will increase maternal depression screening in the County.

SMART Objective

- By December 2025, Monterey County Health Department and Central California Alliance for Health will develop and complete a plan to increase maternal and adolescent depression screenings in the County. and indicated collaborations to increase access to mental health and substance use disorder programs within the respective CHIP and PHM strategies.

Progress on Shared Goal and SMART Objective

In collaboration with Monterey County partners, the Alliance has advanced efforts to improve maternal mental health screening through a shared educational and resource-driven approach. As part of the Monterey Maternal Mental Health Task Force (MMMHTF), the Alliance Behavioral Health Department works alongside LHJ, Doulas, Public Health, County BH, and community partners to promote awareness and capacity-building around perinatal mental health. This collaborative effort is focused not only on system-level improvements but also on educating providers and the broader community about the importance of maternal mental health support.

To support this goal, the Alliance updated its Behavioral Health webpage to include a curated list of validated screeners for perinatal mental health conditions. These tools go beyond depression to capture a broader spectrum of maternal mental health disorders, including anxiety, bipolar disorder, PTSD, suicidality, OCD, and psychosis-conditions that may arise during pregnancy or the postpartum period. Screeners featured include the Edinburgh Postnatal Depression Scale, PHQ-9, GAD-7, PC-PTSD, MDQ, and the Columbia-Suicide Severity Rating Scale (C-SSRS). These resources are intended to guide OB-GYNs, primary care providers, mental health providers, and obstetric care teams in identifying and addressing Perinatal Mood and Anxiety Disorders (PMADs), which are among the most common complications during pregnancy.

The Alliance will present its new Perinatal Health & Wellness Collaborative and provide a review of these screeners at the November 2025 MMMHTF meeting, further reinforcing its commitment to integrated, community-informed strategies that improve maternal mental health outcomes across Monterey County.

Implementation Challenges or Barriers

One of the primary challenges in implementing the shared goal has been the absence of a unified, countywide approach to increasing maternal mental health screenings, outside of what is already standard. While the Alliance has made progress through participation in the Monterey Maternal Mental Health Task Force (MMMHTF), there is no shared strategy on increasing screenings. At recent MMMHTF meeting, CCAH initiated discussions around potential strategies to address this gap, including incentivizing providers to conduct screenings, offering education, and training on validated screening tools, and exploring opportunities to align future shared goals with broader system-level maternal mental health initiatives. Continued collaboration will be essential to overcome these barriers and ensure sustainable improvements in screening practices.

Unintended Outcomes

An unintended outcome was the encouragement of new/broader support for establishing unified, countywide approach to increasing maternal mental health screenings, outside of what is already standard.

San Benito County

Shared Goal

- San Benito County Public Health Services Department will increase access to mental health and substance use disorder prevention and treatment programs for individuals and their families residing within the county.

SMART Objective

- By December 2025, San Benito County Public Health Department and Central California Alliance for Health will develop and complete a catalogue of mental health and substance use disorder providers and programs existing within the county. Both the MCP and LHD will use this catalogue to inform targeted community and MCP-specific intervention alignment and indicated collaborations to increase access to mental health and substance use disorder programs within the respective CHIP and PHM Strategies.

Progress on Shared Goal and SMART Objective

In collaboration with our partners in San Benito County, the Alliance developed a comprehensive provider directory through a process informed by feedback, education, and information sharing. This effort aimed to increase access to mental health and substance use disorder services by improving connectivity between members, providers, and county resources.

With behavioral health insourcing as of July 1, 2025, the Alliance's online directory now enables members to directly connect with mental health and addiction counseling providers through their MCP. The directory includes robust search criteria such as provider contact information (phone,

hours, location, language), specialty types (Psychiatrist, Psychologist, LCSW, LMFT, LPCC), and over 40 specialty focus areas (e.g., trauma, grief, addiction, women's issues).

Members can also filter by treatment modalities and populations served (e.g., CBT, DBT, LGBTQIA, youth, adults), telehealth or in-person options, provider gender, and geographic location (county, city, zip code).

Additionally, the Alliance website hosts information on MHP/DMC-ODS services and links to behavioral health resources such as NAMI, 211, 988, and the National Eating Disorders Association. The BH department also compiled a comprehensive list of eating disorder treatment programs across California, including virtual and local options, which was shared with County Behavioral Health and is available to LHJs and providers.
Implementation Challenges or Barriers

Implementation Challenges or Barriers

Implementation of the shared goal faced several challenges. Leadership transitions within the MCP created delays in decision-making and continuity of planning. Additionally, there was no clear path forward for establishing a shared, centralized space to house all county behavioral health resources, which limited the ability to streamline access for members. San Benito County is one of our smallest county service areas, with a lack of providers in the area, which makes providing a larger repository difficult. While the Alliance developed a provider directory, we also added several telehealth provider options, which increase resources for areas where there are less providers. Another challenge is that our provider search does not currently include all substance use disorder (SUD) treatment options. This is due to the County Behavioral Health Department maintaining separate referral pathways and linking members directly to SUD services. Through "No Wrong Door" Members can start their request in any system and get connected; however not all SUD resources are held in one shared space. These issues are being actively monitored, and collaborative efforts continue to improve integration and resource visibility.

Unintended Outcomes

Insourcing and this shared goal created the opportunity to develop and strengthen new relationships with our county partners, particularly in a county that we recently expanded into in 2024. These relationships have expanded the capacity for new planning in support of Behavioral Health Transformation efforts.

Santa Cruz County

Shared Goal

- Santa Cruz County Health Services Agency, Public Health Division will increase fluoride varnish applications in the medical setting from 1,989 fluoride varnish applications in 2021, to 2,386 fluoride varnish applications in 2027 (20% increase).

SMART Objective

- By December 2025, Santa Cruz County LHJ, the Central California Alliance, and Kaiser Permanente Health Plan will work collaboratively to develop targeted community and MCP-

specific interventions that improve the percentage of children who receive topical fluoride application to meet or exceed the DHCS Minimum Performance Level of 19.3%.

Progress on Shared Goal and SMART Objective

The Alliance has been attending the Santa Cruz County Oral Health Collaborative meetings and working with community partners to improve topical fluoride varnish application for the pediatric population. The Alliance has provided provider and member education in the form of newsletter articles and hosted a provider webinar on topical fluoride varnish in collaboration with community partners.

Implementation Challenges or Barriers
There have been some challenges with respect to data collection and submission by providers when applying the varnish.

Unintended Outcomes
The Alliance has no additional observations to report.

15.5. 2025 Statewide Behavioral Health Goals

Mariposa County

Priority Goals

1. Access to Care
2. Homelessness
3. Untreated Behavioral Health Conditions

Improvement Plans

- Goal 1: Access to Care

  Mariposa County 2023 Access to care rates reference when the county was under a different plan. Since extending The Alliance to Mariposa, we have heard from members and the county that access to care is a continued barrier. Despite 2023 rates identifying penetration being above the median in NSMHS adults, SMHS adults and SMHS youth, the rates for NSMHS youth were below, and data in a small county is easily skewed by a low population.

  The plan will support improvement in the efforts to improve access to care, in both the SMHS and NSMHS space for adults and youth through various efforts including but not limited to: insourced BH from an MBHO on 7/1/25, where we are able to continue building direct connections and relationships to BH providers to expand services and service areas, regular meetings with county partners on strengths, opportunities and challenges, transparency in member needs via data as supported through shared FUA FUM files, ED notifications when available and closed loop referral systems, clear workflows for BH members needing referrals/resources and Case management support, improved systems for care coordination and increased visibility to members and providers in Mariposa county about BH services and benefits available to them.

- Goal 2: Homelessness

  Mariposa County 2023 Homelessness rates reference when the county was under a different plan. Since extending the Alliance health plan coverage to Mariposa County, there have been

many new developments from DHCS to MCPs and BHPs regarding homelessness, housing, and transitional rent to support data improvement. The data from 2023 did identify that Mariposa was above the median in PIT count (per 10,000 people), above the median in the K-12 population, and below in the SMI population.

The plan will support improvement in the efforts to improve homelessness rates across the spectrum in a variety of ways. The plan insourced BH from an MBHO on 7/1/25, where we can continue building direct connections and relationships to BH providers, ECM providers, and BHP county partners to identify strengths, opportunities, and challenges when it comes to housing needs for our shared members. There will be continued work on transparency in member needs via data and closed loop referral systems. With Transitional Rent going live on January 1, 2026, in Mariposa County, the Alliance is working closely with County BH and our Transitional Rent provider (add name once contracted) to delineate roles and responsibilities and create shared workflows. We will execute data sharing agreements with our partners and will ensure that Transitional Rent utilization is tracked in HMIS, as required by DHCS by January 1, 2027.

- Goal 3: Untreated Behavioral Health Conditions

  Mariposa County 2023 Untreated Behavioral Health Conditions rates reference when the county was under a different plan. Since extending The Alliance to Mariposa, we have heard from members and the county that access to care is a continued barrier, which is addressed in Goal 1 and extends to those with untreated BH needs. The 2023 rates identify that Mariposa FUA rate was under the statewide rate and median goal, and that adults that needed help for emotional/mental health problems or alcohol/drugs that had no visits in the last year was higher that median or goal (goal for this rate is to be lower). There were no reportable rates at that time for FUM, but given trends in FUA and in other counties, we anticipate this as a need, and data in a small county is easily skewed by a low population.

  The plan will support improvement in the efforts to improve rates and outcomes for Untreated behavioral health conditions through various efforts including but not limited to: The Alliance insourced BH from an MBHO on 7/1/25, where we are able to continue building direct connections and relationships to BH providers to expand services and service areas, regular meetings with county partners on strengths, opportunities and challenges, transparency in member needs via data as supported through shared FUA FUM files, ED notifications when available and closed loop referral systems, clear workflows for BH members needing referrals/resources and Case management support, improved systems for care coordination and increased visibility to members and providers in Mariposa county about BH services and benefits available to them.

Disparity Analysis

In determining populations and goals of focus for Mariposa County, the following measures from the DHCS Population Level Behavioral Measure Workbook were considered:

Access to Care: The reported NSMHS Penetration Rate for Children & Youth at 9.1% is 41% lower than the statewide rate of 15.5%, indicating more limited mental health service access for youth. This finding suggests that youth should be a key population of focus within access-to-care efforts.

Homelessness: K-12 students experiencing homelessness comprise 7.1% of enrollment, 34% higher than the statewide rate of 5.3%. Additionally, the PIT Count rate (rate per 10K) for people experiencing homelessness with SUD is 11.2, 22% higher than the statewide median of 9.2.

Untreated BH Conditions: Among adults needing help for mental health or substance issues, 62.6% received no treatment in the past year, 29% higher than the statewide rate of 48.4%, ranking Mariposa as the 4th highest county in the state related to this metric.

Summary: Mariposa County faces significant behavioral health challenges, including limited access to care, particularly for youth, high rates of student homelessness, and substantial untreated behavioral health needs among adults. Targeted interventions should focus on improving access to treatment for children, youth, and adults, and addressing homelessness as an SDOH.

County Behavioral Health Plans Partnership

The Alliance will be partnering with Mariposa County to work together on improvements to these priority goals. We will do this through a variety of methods, in part highlighted in Goal 1 above.

To clarify further, The Alliance BH department and other applicable department staff, meets with the county BHP at minimum quarterly, however monthly is the goal, in order to discuss topics such as but not limited to: Care coordination, referral concerns, collaboration effectiveness (strengths, barriers and opportunities for improvement), strategies to address duplication of services, member engagement, challenges and successes. Key MCP and BHP staff are present for decision making and next steps, to collaborate on shared goals and improvements.

Additional meetings take place with other key staff regularly to partner on other priority goals such as FUA FUM improvements, transitional rent, Emergency Department meetings and specific case consultations.

County BHPs invite The Alliance staff to BH outreach events and share opportunities to partner in the community.

Merced County

Priority Goals

1. Access to Care
2. Homelessness
3. Untreated Behavioral Health Conditions

Improvement Plans

- Goal 1: Access to Care

  Merced County 2023 Access to care rates identify patterns of penetration being below the median in NSMHS adults/ youth and for SMHS adults/youth. However, penetration for adult populations in both systems of care is slightly over the statewide rate but not by a large margin.

  The plan will support improvement in the efforts to improve access to care, in both the SMHS and NSMHS space for adults and youth through various efforts including but not limited to: insourced BH from an MBHO on 7/1/25, where we are able to continue building direct connections and relationships to BH providers to expand services and service areas, regular meetings with county partners on strengths, opportunities and challenges, transparency in member needs via data as supported through shared FUA FUM files, ED notifications when available and closed loop referral systems, clear workflows for BH members needing referrals/resources and Case management support, improved systems for care coordination and increased visibility to members and providers in Merced county about BH services and benefits available to them.

- Goal 2: Homelessness

  Merced County 2023 Homelessness rates identified that Merced County was below the median in PIT count (per 10,000 people), below the median in the K-12 population, and below in the SMI population.

  The plan will support ongoing improvement in the efforts to continue to improve homelessness rates across the spectrum in a variety of ways, despite current rates being within goal range.

  The plan insourced BH from an MBHO on 7/1/25, where we can continue building direct connections and relationships to BH providers, ECM providers, and BHP county partners to identify strengths, opportunities, and challenges when it comes to housing needs for our shared members.

  There will be continued work on transparency in member needs via data and closed loop referral systems.

  With Transitional Rent going live on January 1, 2026, in Merced County, the Alliance is working closely with County BH and our Transitional Rent provider to delineate roles and responsibilities and create shared workflows. We will execute data sharing agreements with our partners and will ensure that Transitional Rent utilization is tracked in HMIS, as required by DHCS by January 1, 2027.

- Goal 3: Untreated Behavioral Health Conditions

  Merced County 2023 Untreated Behavioral Health rates identified that Merced County was under the statewide Rate and Median for FUA, slightly over for FUM and for adults that needed help for emotional/mental health problems or alcohol/drugs that had no visits in the last year was over statewide rate/median (where a lower % is the goal).
  The plan will support improvement in the efforts to improve rates and outcomes for Untreated behavioral health conditions through various efforts including but not limited to: The Alliance insourced BH from an MBHO on 7/1/25, where we are able to continue building direct connections and relationships to BH providers to expand services and service areas, regular meetings with county partners on strengths, opportunities and challenges, transparency in member needs via data as supported through shared FUA FUM files, ED notifications when available and closed loop referral systems, clear workflows for BH members needing referrals/resources and Case management support, improved systems for care coordination and increased visibility to members and providers in Mariposa county about BH services and benefits available to them.

  Additionally, in Merced County, there are specific meetings with the EDs, MCP, and the BHP on FUA FUM processes, interventions, and workflows, to address the needs of these members.

Disparity Analysis

In determining populations and goals of focus for Merced County, the following measures from the DHCS Population Level Behavioral Measure Workbook were considered:

Access to Care: The reported NSMHS Penetration Rate for Children & Youth is 14.3%, 7.7% lower than the statewide rate of 15.5%. The Initiation of SUD Treatment (IET-INI) rate is 41.2%, 12.6% higher than the statewide rate of 36.6%. These findings suggest that youth should be a key population of focus within access-to-care efforts with focus on access to earlier NSMHS interventions.

Homelessness: Although Merced County homelessness metrics are near or slightly better than the statewide median, the impact on our members is disproportionately high. Limited infrastructure and capacity to address homelessness create greater challenges for individuals experiencing housing instability. Efforts should focus on improving access to behavioral health services and coordinated care for this specific population, even when overall rates appear moderate.

Untreated BH Conditions: Among adults needing help with mental health or substance issues, 52.6% received no treatment in the past year, 8.7% higher than the statewide rate of 48.4%.

Summary: Merced County faces significant behavioral health challenges, including limited access to care, particularly for youth, capacity to address homelessness as a SDOH, and untreated behavioral health needs among adults. Targeted interventions should focus on improving access to treatment for children, youth, and adults, and addressing homelessness as a social determinant of health.

County Behavioral Health Plans Partnership

The Alliance will be partnering with Merced County to work together on improvements to these priority goals. We will do this through a variety of methods, in part highlighted in Goal 1 above.

To clarify further, The Alliance BH department and other applicable department staff, meets with the county BHP at minimum quarterly, however monthly is the goal, in order to discuss topics such as but not limited to: Care coordination, referral concerns, collaboration effectiveness (strengths, barriers and opportunities for improvement), strategies to address duplication of services, member engagement, challenges and successes. Key MCP and BHP staff are present for decision making and next steps, to collaborate on shared goals and improvements.

Additional meetings take place with other key staff regularly to partner on other priority goals such as FUA FUM improvements, transitional rent, Emergency Department meetings and specific case consultations.

County BHPs invite The Alliance staff to BH outreach events and share opportunities to partner in the community.

Monterey County

Priority Goals

1. Access to Care
2. Homelessness
3. Untreated Behavioral Health Conditions

Improvement Plans

- Goal 1: Access to Care

  Monterey County 2023 Access to care rates identify patterns of penetration being below the median in NSMHS adults and for SMHS youth. While penetration for NSMHS youth and SMHS adult populations in both systems of care is slightly over the statewide rate but not by a large margin and further improvements across all populations is a key area of focus.

  The plan will support improvement in the efforts to improve access to care, in both the SMHS and NSMHS space for adults and youth through various efforts including but not limited to: insourced BH from an MBHO on 7/1/25, where we are able to continue building direct connections and relationships to BH providers to expand services and service areas, regular meetings with county partners on strengths, opportunities and challenges, transparency in member needs via data as supported through shared FUA FUM files, ED notifications when available and closed loop referral systems, clear workflows for BH members needing referrals/resources and Case management support, improved systems for care coordination and increased visibility to members and providers in Monterey county about BH services and benefits available to them.

- Goal 2: Homelessness

  Monterey County 2023 Homelessness rates identified that Monterey County was above the median in PIT count (per 10,000 people), above the median in the K-12 population, and above in the SMI population, signaling areas of improvements needed across all areas. The plan will support improvement in the efforts to improve homelessness rates across the spectrum in a variety of ways.

  The plan insourced BH from an MBHO on 7/1/25, where we can continue building direct connections and relationships to BH providers, ECM providers, and BHP county partners to identify strengths, opportunities, and challenges when it comes to housing needs for our shared members. There will be continued work on transparency in member needs via data and closed loop referral systems.

  With Transitional Rent going live on January 1, 2026, in Monterey County, the Alliance is working closely with County BH and our Transitional Rent provider to delineate roles and responsibilities and create shared workflows. We will execute data sharing agreements with our partners and will ensure that Transitional Rent utilization is tracked in HMIS, as required by DHCS by January 1, 2027.

- Goal 3: Untreated Behavioral Health Conditions

  Monterey County 2023 Untreated Behavioral Health rates identified that Monterey County was above the statewide Rate and Median for FUA, approaching goal for FUM and for adults that needed help for emotional/mental health problems or alcohol/drugs that had no visits in the last year was highly over statewide rate/median (where a lower % is the goal).

The plan will support improvement in the efforts to improve rates and outcomes for Untreated behavioral health conditions through various efforts including but not limited to: The Alliance insourced BH from an MBHO on 7/1/25, where we are able to continue building direct connections and relationships to BH providers to expand services and service areas, regular meetings with county partners on strengths, opportunities and challenges, transparency in member needs via data as supported through shared FUA FUM files, ED notifications when available and closed loop referral systems, clear workflows for BH members needing referrals/resources and Case management support, improved systems for care coordination and increased visibility to members and providers in Mariposa county about BH services and benefits available to them.

Additionally, in Monterey County, there are ongoing specific efforts to increase meetings and communication with the local EDs, MCP, and the BHP on FUA FUM processes, interventions, and workflows, to address the needs of these members.

Disparity Analysis

In determining populations and goals of focus for Monterey County, the following measures from the DHCS Population Level Behavioral Measure Workbook were considered:

Access to Care: The reported NSMHS Penetration Rate for Adults, at 8.5%, is 19.8% lower than the statewide rate of 10.6%. And the Initiation of SUD Treatment (IET-INI) rate is 40.9%, 11.8% higher than the statewide rate of 36.6%. These findings suggest that access-to-care efforts should focus on earlier NSMHS interventions, particularly for adults.

Homelessness: Monterey County is in the highest tier on every metric associated with Homelessness. The PIT Count is 61.3 (rate per 10k), 27.7% higher than the statewide rate of 48. K-12 students experiencing homelessness comprise 16.8% of enrollment, 217% higher than the statewide rate of 5.3%. The PIT Count rate for people experiencing homelessness with SMI is 15.5, 34.8% higher than the statewide median of 11.5. The PIT Count rate for people experiencing homelessness with SUD is 12.7, 15.5% higher than the statewide rate of 11.

Untreated BH Conditions: Among adults needing help for mental health or substance issues, 65.4% received no treatment in the past year, 35.1% higher than the statewide rate of 48.4%, ranking Monterey as 2nd highest in the state related to this metric.

Summary: Monterey County faces significant behavioral health challenges, including limited access to care, high rates of homelessness, and substantial untreated behavioral health needs among adults. Targeted interventions should focus on improving access to NSMHS treatment for adults and addressing homelessness as SDOH.

County Behavioral Health Plans Partnership

The Alliance will be partnering with Monterey County to work together on improvements to these priority goals. We will do this through a variety of methods, in part highlighted in Goal 1 above.

To clarify further, The Alliance BH department and other applicable department staff, meets with the county BHP at minimum quarterly, however monthly is the goal, in order to discuss topics such as but not limited to: Care coordination, referral concerns, collaboration effectiveness (strengths, barriers and opportunities for improvement), strategies to address duplication of services, member engagement, challenges and successes. Key MCP and BHP staff are present for decision making and next steps, to collaborate on shared goals and improvements.

Additional meetings take place with other key staff regularly to partner on other priority goals such as FUA FUM improvements, transitional rent, Emergency Department meetings and specific case consultations.

County BHPs invite The Alliance staff to BH outreach events and share opportunities to partner in the community.

San Benito County

Priority Goals

1. Access to Care
2. Homelessness
3. Untreated Behavioral Health Conditions

Improvement Plans

- Goal 1: Access to Care

  San Benito County 2023 Access to care rates reference when the county was under a different plan. Since extending The Alliance to San Benito, we have heard from members and the county that access to care is a continued barrier. Data from 2023 identified that penetration is well below median for NSMHS adults, NSMHS youth, and SMHS youth, while the rates for SMHS adults were slightly above. However, it is worth noting that data in a small county is easily skewed and/or changed by a low population.

  The plan will support improvement in the efforts to improve access to care, in both the SMHS and NSMHS space for adults and youth through various efforts including but not limited to: insourced BH from an MBHO on 7/1/25, where we are able to continue building direct connections and relationships to BH providers to expand services and service areas, regular meetings with county partners on strengths, opportunities and challenges, transparency in member needs via data as supported through shared FUA FUM files, ED notifications when available and closed loop referral systems, clear workflows for BH members needing referrals/resources and Case management support, improved systems for care coordination and increased visibility to members and providers in San Benito county about BH services and benefits available to them.

- Goal 2: Homelessness

  San Benito County 2023 Homelessness rates reference when the county was under a different plan. Since extending the Alliance health plan coverage to San Benito

County in 2024, there have been many new developments from DHCS to MCPs and BHPs regarding homelessness, housing, and transitional rent to support data improvement. The data from 2023 did identify that San Benito was above the median in PIT count (per 10,000 people), below the median in the K-12 population, and above in the SMI population.

The plan will support improvement in the efforts to improve homelessness rates across the spectrum in a variety of ways.

The plan insourced BH from an MBHO on 7/1/25, where we can continue building direct connections and relationships to BH providers, ECM providers, and BHP county partners to identify strengths, opportunities, and challenges when it comes to housing needs for our shared members.

There will be continued work on transparency in member needs via data and closed loop referral systems.

With Transitional Rent going live on January 1, 2026, in San Benito County, the Alliance is working closely with County BH and our Transitional Rent provider to delineate roles and responsibilities and create shared workflows. We will execute data sharing agreements with our partners and will ensure that Transitional Rent utilization is tracked in HMIS, as required by DHCS by January 1, 2027.

- Goal 3: Untreated Behavioral Health Conditions

  San Benito County 2023 Untreated Behavioral Health Conditions rates reference when the county was under a different plan. Since extending The Alliance to San Benito, we have heard from members and the county that access to care is a continued barrier, which is addressed in Goal 1 and extends to those with untreated BH needs. The 2023 rates identify that San Benito FUA rate was above the statewide rate and median goal, the FUM rates were under goal and that adults that needed help for emotional/mental health problems or alcohol/drugs that had no visits in the last year was higher that median or goal (goal for this rate is to be lower). We want to note that data in a small county is easily skewed by a low population.

  The plan will support improvement in the efforts to improve rates and outcomes for Untreated behavioral health conditions through various efforts including but not limited to: The Alliance insourced BH from an MBHO on 7/1/25, where we are able to continue building direct connections and relationships to BH providers to expand services and service areas, regular meetings with county partners on strengths, opportunities and challenges, transparency in member needs via data as supported through shared FUA FUM files, ED notifications when available and closed loop referral systems, clear workflows for BH members needing referrals/resources and Case management support, improved systems for care coordination and increased visibility to members and providers in San Benito county about BH services and benefits available to them.

Disparity Analysis

In determining populations and goals of focus for San Benito County, the following measures from the DHCS Population Level Behavioral Measure Workbook were considered:

Access to Care: The reported NSMHS Penetration Rate for Adults, at 5.9%, is 44.3% lower than the statewide rate of 10.6%. The reported NSMHS Penetration Rate for Children & Youth is 8.7%, 43.9% lower than the statewide rate of 15.5%. These findings suggest that access-to-care efforts should focus on earlier NSMHS interventions for all ages.

Homelessness: The PIT Count is 61.3 (rate per 10k), 27.7% higher than the statewide rate of 48. The PIT Count rate for people experiencing homelessness with SMI is 15.5, 34.8% higher than the statewide median of 11.5. The PIT Count rate for people experiencing homelessness with SUD is 12.7, 15.5% higher than the statewide rate of 11.

Untreated BH Conditions: Among adults needing help for mental health or substance issues, 61.2% received no treatment in the past year, 26.5% higher than the statewide rate of 48.4%, ranking San Benito as one of the highest counties related to this metric.

Summary: San Benito County faces significant behavioral health challenges, including limited access to care, high rates of homelessness, and untreated behavioral health needs among adults. Targeted interventions should focus on improving access to NSMHS treatment for both adults and youth and addressing homelessness as a SDOH.

County Behavioral Health Plans Partnership

The Alliance will be partnering with San Benito County to work together on improvement on these priority goals. We will do this through a variety of methods, in part highlighted in Goal 1 above.

To clarify further, The Alliance BH department and other applicable department staff, meets with the county BHP at minimum quarterly, however monthly is the goal, in order to discuss topics such as but not limited to: Care coordination, referral concerns, collaboration effectiveness (strengths, barriers and opportunities for improvement), strategies to address duplication of services, member engagement, challenges and successes. Key MCP and BHP staff are present for decision making and next steps, to collaborate on shared goals and improvements.

Additional meetings take place with other key staff regularly to partner on other priority goals such as FUA FUM improvements, transitional rent, Emergency Department meetings and specific case consultations.

County BHPs invite The Alliance staff to BH outreach events and share opportunities to partner in the community.

Santa Cruz County

Priority Goals

1. Access to Care
2. Homelessness
3. Untreated Behavioral Health Conditions

Improvement Plans

- Goal 1: Access to Care

Santa Cruz County 2023 Access to care rates identify patterns of penetration being below the median in SMHS adults and for SMHS youth. While penetration for NSMHS youth and adult populations exceeds the statewide rate. Despite the varying penetration results, we have heard from Santa Cruz County a desire to increase penetration and access to care across all systems for BH services.

The plan will support improvement in the efforts to improve access to care, in both the SMHS and NSMHS space for adults and youth through various efforts including but not limited to: insourced BH from an MBHO on 7/1/25, where we are able to continue building direct connections and relationships to BH providers to expand services and service areas, regular meetings with county partners on strengths, opportunities and challenges, transparency in member needs via data as supported through shared FUA FUM files, ED notifications when available and closed loop referral systems, clear workflows for BH members needing referrals/resources and Case management support, improved systems for care coordination and increased visibility to members and providers in Santa Cruz county about BH services and benefits available to them.

- Goal 2: Homelessness

  Santa Cruz County 2023 Homelessness rates identified that Santa Cruz County was above the median in PIT count (per 10,000 people), above the median in the K-12 population, and above in the SMI population, signaling ongoing opportunities for improvements.

  The plan will support ongoing improvement in the efforts to continue to improve homelessness rates across the spectrum in a variety of ways, despite current rates being within goal range.

  The plan insourced BH from an MBHO on 7/1/25, where we can continue building direct connections and relationships to BH providers, ECM providers, and BHP county partners to identify strengths, opportunities, and challenges when it comes to housing needs for our shared members.

  There will be continued work on transparency in member needs via data and closed loop referral systems.

  With Transitional Rent going live on January 1, 2026, in Santa Cruz County, the Alliance is working closely with County BH and our Transitional Rent provider to delineate roles and responsibilities and create shared workflows. We will execute data sharing agreements with our partners and will ensure that Transitional Rent utilization is tracked in HMIS, as required by DHCS by January 1, 2027.

- Goal 3: Untreated Behavioral Health Conditions

  Santa Cruz County 2023 Untreated Behavioral Health rates identified that the County was above the statewide Rate and Median for FUA and FUM and below the median for adults that needed help for emotional/mental health problems or alcohol/drugs that had no visits in the last year was highly over statewide rate/median (where a lower % is the goal), identifying progress here.

The plan will support continued improvement in the efforts to maintain and improve rates and outcomes for Untreated behavioral health conditions through various efforts including but not limited to: The Alliance insourced BH from an MBHO on 7/1/25, where we are able to continue building direct connections and relationships to BH providers to expand services and service areas, regular meetings with county partners on strengths, opportunities and challenges, transparency in member needs via data as supported through shared FUA FUM files, ED notifications when available and closed loop referral systems, clear workflows for BH members needing referrals/resources and Case management support, improved systems for care coordination and increased visibility to members and providers in Mariposa county about BH services and benefits available to them.

Additionally, in Santa Cruz County, there are ongoing specific efforts to increase meetings and communication with the local EDs, MCP, and the BHP on FUA FUM processes, interventions, and workflows, to address the needs of these members.

16. Additional Activities: IHA & EPSDT Audits

16.1. Introduction

The Initial Health Appointment (IHA) and the Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) medical record audits occur twice a year, in quarter 2 and quarter 4 to monitor and ensure provider compliance and member access to necessary services. The information collected from these audits is used to capture opportunities to provide educational outreach to providers, improve members' access to services, and to evaluate overall performance. Audit results are shared with organizational stakeholders, where they are given the opportunity to collaborate on results. Additionally, providers are outreached to after the IHA audit and given an opportunity to provide missing elements. This outreach provides transparency and encourages provider engagement.

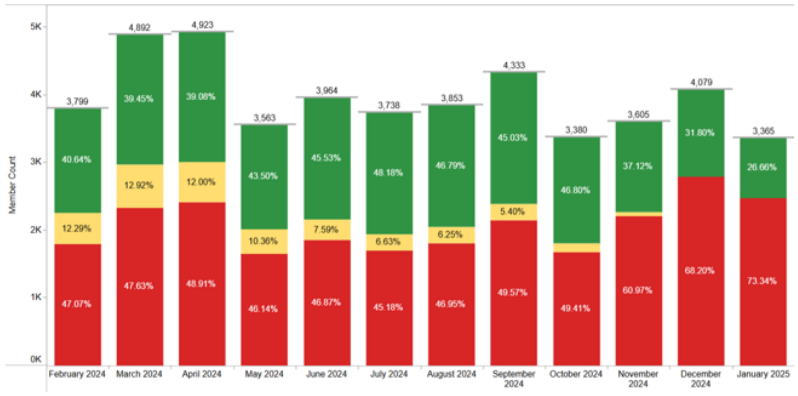
16.2. Methodology

IHA and EPSDT audits begin by pulling in member data through a Tableau report. A 20-member sample will be pulled from each county for each audit. These samples are pulled in using specific encounter types, member demographics, and clinics, as indicated in the audit work instructions. All member information and elements audited will be recorded on a tracking sheet, and results presented on a power point at an internal cross-departmental meeting and distributed in the consent agenda to the Quality Improvement Health Equity Committee.

16.3. Results

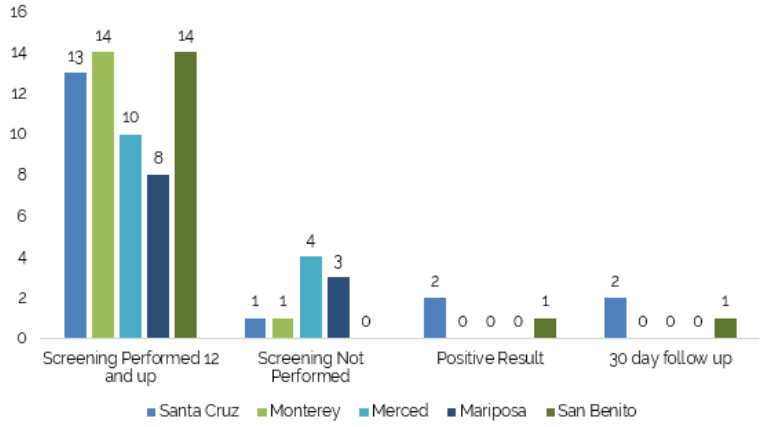
The results of the IHA Q2 2025 audit showed an 8% increase in completed IHA's within 120-days over a 12-month period, compared to the previous audit, remaining above plan goals. The Q2 audit saw an increase in members over the age of 12 receiving a depression screening, including pregnant members and postpartum depression screenings. Alcohol screenings continued to see an increase audit over audit, along with ACE screenings.

IHA COMPLETION AND COMPLIANCE



- Overall 12-month compliance rate of 41%
- Increase of 8% from Q2 2024 IHA audit.

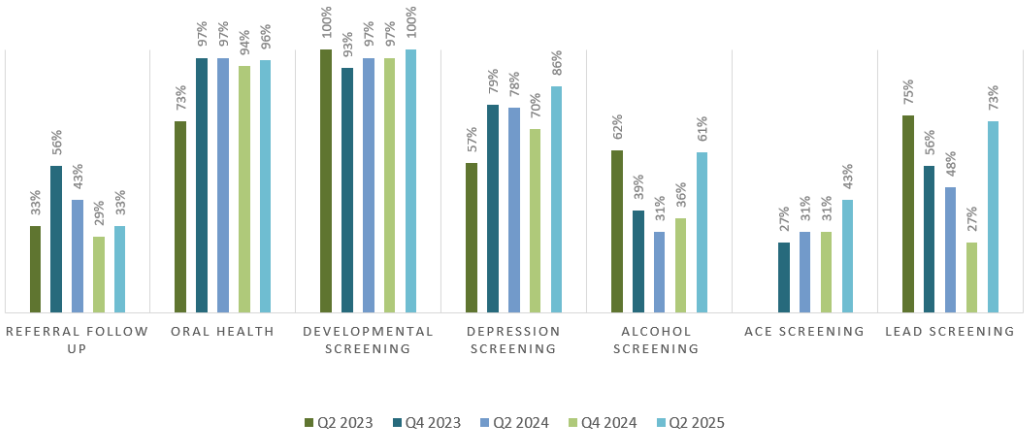
12+ DEPRESSION SCREENING



- 87% of members received depression screening
  - Increase from 52% last audit
- All positive screenings received follow up within 30 days

The results of the Q2 2025 EPSDT audit showed improvement in all areas. Other key takeaways include low claim volume in our smaller counties, making it difficult to pull a full claim sample.

OVERALL SUMMARY

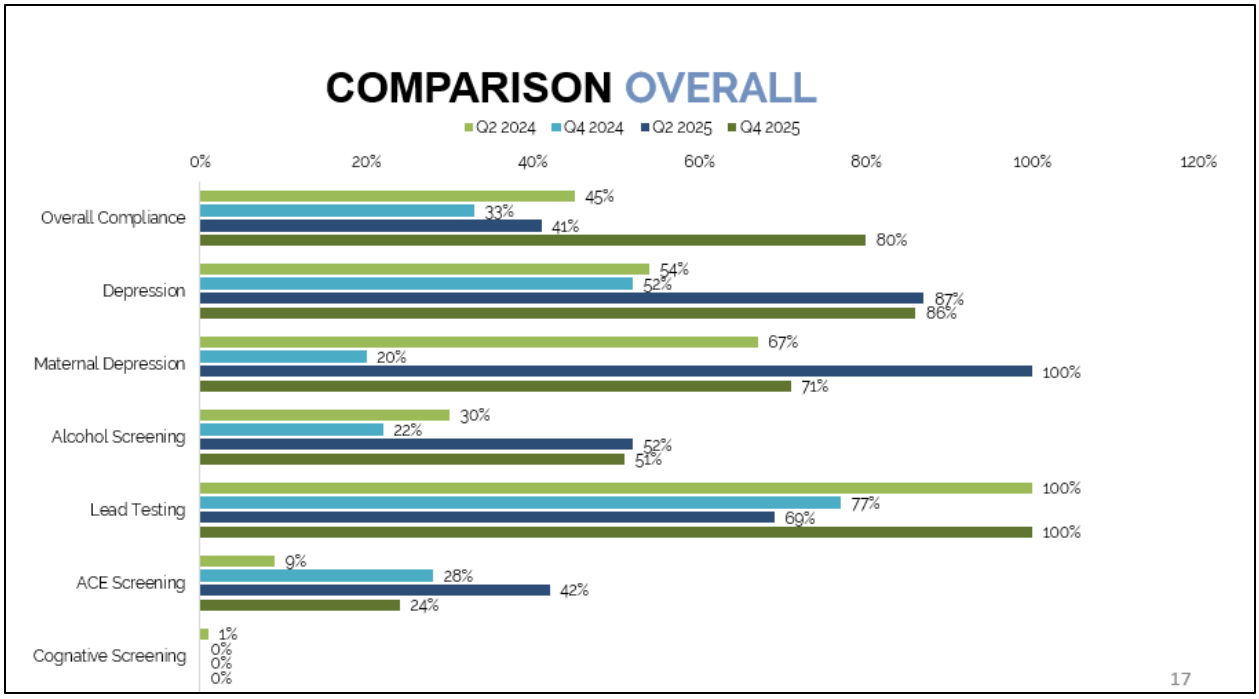


The Q4 2025 IHA audit continued to show a significant increase in overall IHA's completed within 120 days. Key take aways from this audit include both Mariposa and San Benito counties lacking enough claims to pull in a complete sample. Minor decreases in depression screening and alcohol screenings. ACE screenings saw a significant increase of 18%.

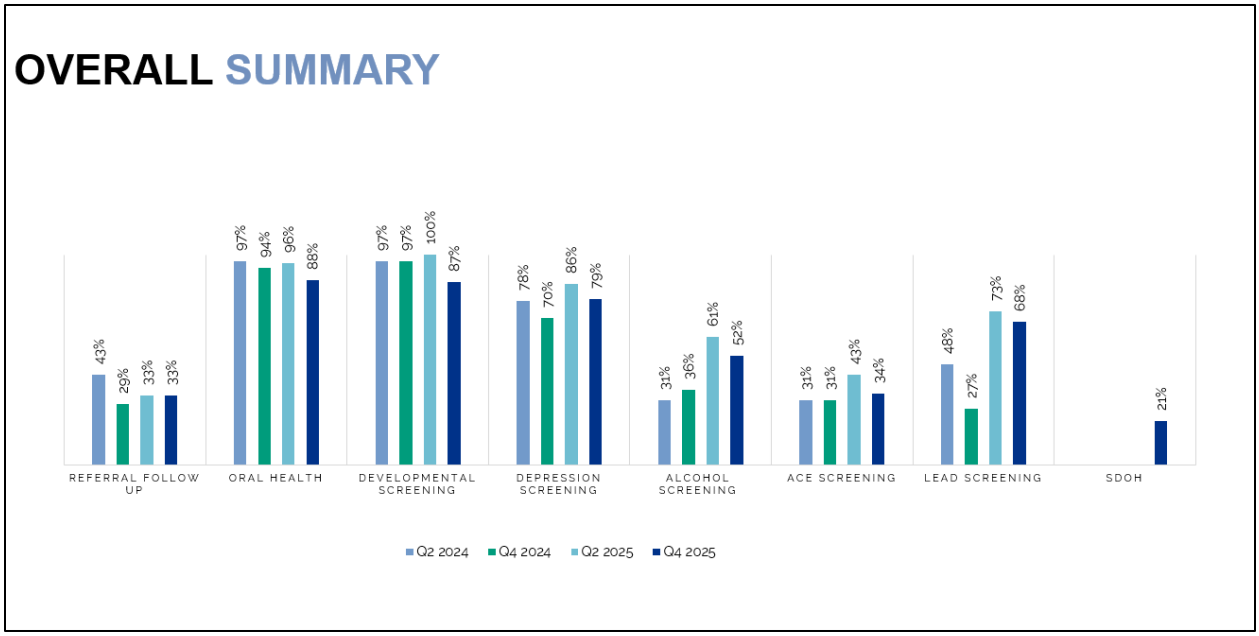
IHA COMPLETION AND COMPLIANCE



- Overall 12-month compliance rate of 48%
- Increase of 7% from Q2 2025 IHA audit.



The Q4 2025 EPSDT audit saw a decrease in almost all areas except referral follow up. This was in part to a couple of clinics with documentation lacking information, and EMR capabilities limiting implementation of certain screenings for providers' offices. SDOH screenings were added to the EPSDT audit



16.4. Conclusion and Next Steps

Provider outreach remains in effect for the IHA audit through 2025, maintaining the goal of at least 75% provider engagement. During the outreach periods, provider engagement and collaboration went well, resulting in missing elements being submitted, providers implementing new workflows for risk assessment implementation, individualized meetings, and working together to fix gaps. Other

next steps that resulted from our 2025 IHA audit includes, attendance and support for a Managed Care Plan (MCP) collaborative aimed at standardizing coding throughout managed care plans, coordination with our Facility Site Review Nurses aligning audits, provider messaging and ensuring documentation elements are met, and continued provider education and support. Other Interventions that occurred during the 2025 audits include an effort to increased access to providers EMR systems for medical record procurement.

Next steps for future audits include continued provider engagement through provider report cards,

17. 2025 QIHETP and CLAS Program Initiatives

For 2025, the Quality Improvement Program at the Alliance will build upon its previous successes with a renewed focus on innovation and strategic goals. Here is an overview of the key initiatives planned for the year:

1. **Expand the Alliance's Collaboration with Community Based Organizations**
    - **Incorporate collaboration with Community Based Organizations:** The program will integrate the Alliance's Model into its mission, vision, and values. This model emphasizes addressing the unique needs of members and aims to broaden internal programs and partnerships with Community-Based Organizations (CBOs) to better support members.
2. **Increased member feedback**
    - **Member Feedback** will continue to be strengthened to gather direct feedback from members regarding the quality of care and overall satisfaction. This initiative will provide valuable insights to refine and improve services.
3. **Expand Provider Participation in the Provider Partnership Program**
    - **Inclusion of Smaller Providers:** The program will work on increasing participation from smaller network providers in the program and sustained engagement from providers. This expansion aims to ensure that quality improvement efforts reach a broader range of providers and benefit a more diverse set of members.
4. **Increase Focus on Health Equity and Culturally and Linguistically Appropriate Services (CLAS)**
    - **Engagement and Feedback:** There will be a heightened emphasis on health equity and CLAS. This includes:
        - **Consumer Advisory Committee (CAC):** Engaging community and member feedback through the CAC.

The 2025 QIHET Program aims to advance the Alliance's mission by integrating its Model of Care, enhancing member feedback mechanisms, expanding provider participation and engagement, and focusing on health equity and culturally appropriate services. These initiatives are designed to support continuous improvement in care quality and member outcomes while fostering stronger community and provider engagement.

18. Overall Assessment of QIHETP & CLAS

After reviewing the results of measurement of health care inequities and CLAS Program. The Alliance determined that the current and ongoing activities were sufficient to support the Health Equity initiatives. The CLAS Program will continue collaborating with stakeholders and community representatives to enhance cultural and linguistic services for our members.

18.1. Accomplishments

In 2025, the CLAS Program was able to:

- Address challenges related to several educational materials for providers and members, specifically for Hispanic diabetic members and Hispanic members needing well-child visits.
- Begin expanding the availability of member materials in languages other than English and Spanish.
- Perform outreach to the Hispanic community to further educate members about managing their care.

18.2. Opportunities for Improvement

The Alliance was successful in several initiatives in 2025. However, in areas that were not met as the Latino Diabetes goal for 2025, the Alliance identified the following opportunities for improvement:

- The Alliance collaborates with a language services vendor to identify issues such as limited interpreters for indigenous languages, long waiting times for calls, and extended call durations. Steps were taken to resolve these issues by offering training to the language service.
- The Alliance is dedicated to addressing disparities in healthcare language services and recognizes that the best way to support members with limited English proficiency (LEP) and all members is by advocating for the Member Services Department to provide direct assistance in finding a culturally responsive provider who speaks the member's preferred language.
- The Alliance is aware that some website updates, like the availability of forms, directory information, and new providers in the online directory, may not effectively serve members with limited English proficiency who need to access the site in English.
- Focus on San Benito and Mariposa County for diabetic members and well-child visits, ensuring members are properly accounted for and receive the appropriate materials and care.

18.3. Next Steps

The Alliance prioritized the following interventions for 2026:

- **Child Preventive Services:** Efforts to bring all providers in Merced to the MPL on child preventive service measures include:
  - Continue Merced Provider Group Meetings
  - Continue Provider Partnerships and Care-Based Incentive Program and expand support in Mariposa and San Benito County.
  - Continue to Promote MCP Grant Opportunities
  - Leverage Member Texting Project for Care Gap Closure, starting with preventive health measures and expanding to broader care gap closures in the future.
  - Continue working to address Vaccine Hesitancy and other Social Drivers of Disparities through a coordinated strategy
- **Community Engagement:** To elevate the voices of members and engage the community more effectively, the Alliance will:
  - Continue leveraging relationships built by the Community Engagement Team.
  - Continue expanding partnerships with Community-Based Organizations (CBOs).
  - Continue the Population Health Management Strategy submissions,
  - Continue Local Planning with meaningful collaboration with the local health department (LHD) partners on their Community Health Assessments (CHAs) and Community Health Improvement Plans (CHIPs).
  - Continue fostering feedback from member-facing advisory groups.
  - Utilize Community Health Workers (CHWs) to perform focus groups.

    - Continue hosting an Annual Health Fair.
- **Reducing Disparities:** The Alliance will identify and address health inequities in the communities served through targeted interventions and policy support:
    - Analyze stratified MCAS data to develop and complete Performance Improvement Projects (PIPs).
    - Review stratified grievance data to create a Plan of Action to address key issues.
    - Measure access to culturally and linguistically competent care.
    - Review internal policies and procedures to ensure alignment with a Health Equity Lens.
    - Conduct root cause analyses of identified health inequities and link findings to determinants of health to develop actionable solutions.

18.4. Interventions to be completed in 2026.

Level	Intervention	Timeline and Frequency	Barriers Addressed
Patients	The Live Better with Diabetes (LBD) program utilizes an evidence-based curriculum on diabetes self-management. The LBD program will be provided to Alliance members by Health Educators.	1/01/2026 – 12/31/2026 Implementation activities Staff responsible: QHP	In 2025, member feedback surveys have shown that they have interest in participating in workshops in later afternoon. Workshops will be added in 2026 to offer more options in the later afternoons.
Patients	Offer at-home lab testing for diabetic patients through Sprinter Health.	Go live 01/01/2025 with monthly data files sent to Sprinter. Continue services to members in Merced County and review expansion to other counties June-September 2026. Staff responsible: Quality and Performance Improvement and Quality and Population Health	Vendor provides at home services for non-compliant members to improve access to care and appointment compliance amongst members and increases access to more rural areas of service.
Provider	Provider education consistently adhering to nationally recognized guidelines for all ethnic groups.	04/01/2025 – 6/30/2025 Planning activities including material development. 7/01/2025 – 11/30/2025 Implementation activities Evaluation of activities in 2026. Staff responsible: C&L team	Providers might unintentionally provide inconsistent care to different ethnic groups. This training will encourage the providers to consistently follow nationally recognized guidelines and therefore ensure members of all groups get equitable care.
Provider	Grants funding to offer point-of-care A1c testing in office	01/01/2025 – 3/31/2025 Planning activities including material development. Kick off to for Care Gap Grant is April 1 – December 31st	The Care Gap Closure Grant has proven exceptionally beneficial for improving access for our members. This funding has allowed for point-of-care testing, after hours

		12/1/25-3/31/26 review of 2025 activities for 2026 project planning. Staff responsible: Quality and Performance Improvement and Community Grants	clinics, and targeted care gap clinics.
Provider	Educational Materials for Providers to raise provider awareness about disparities in well-child visits and promote equitable care.	01/01/2026 – 5/30/2026 Planning activities including material development. 6/01/2025 – 12/30/2025 Implementation activities Staff responsible: QHP, Quality and Performance Improvement, and Quality and Population Health	Providers may not be fully aware of existing disparities in well-child visits.
Plan	Conduct PCPs Gap reports targeting White and Black/African American populations prioritizing well-child visits report to close care gaps for underperforming populations for DHCS target populations.	Evaluate current rates and distribute reports to providers July 2026-September 2026. Staff responsible: Quality and Performance Improvement and Quality and Population Health	Care gaps may persist due to limited provider awareness or lack of targeted performance data. Gap reports address this by identifying areas of need and tracking progress.
Plan	Continue leveraging Texting for Care Gap Closure, starting with preventive health measures, and expanding to broader care gap closures.	Launched in September 2024, to continue into 2026. Staff responsible: QHP, Marketing & Communications, and Quality and Population Health	Members miss preventive health screenings due to communication challenges or lack of reminders.

Appendices

Appendix A: CAHPS Results

MY 2024 CHILD

Measure	2025 Valid n	2023	2024	2025	2025 PG BoB	2024 QC	Goal Met
Rating Questions (% 9 or 10)							
Q31. Rating of Health Plan	187	72.5%	77.5%	79.1%	72.7%	71.3%	YES
Q8. Rating of Health Care	120	58.5%	65.8%	58.3%	72.1%	69.6%	NO
Q21. Rating of Personal Doctor	145	72.1%	72.9%	74.5%	78.4%	76.5%	NO
Q25. Rating of Specialist +	41	77.1%	79.6%	68.3%	74.9%	72.8%	NO
Rating Questions (% 8, 9 or 10)							
Q31. Rating of Health Plan	187	89.0%	91.0%	92.0%	86.8%	86.3%	YES
Q8. Rating of Health Care	120	79.3%	84.2%	88.3%	88.0%	86.9%	YES
Q21. Rating of Personal Doctor	145	87.9%	88.8%	89.7%	90.8%	89.7%	YES
Q25. Rating of Specialist +	41	90.4%	85.2%	87.8%	88.0%	87.2%	YES
Getting Needed Care Composite Score	83	79.4%	81.1%	80.4%	84.6%	83.3%	NO
Q9. Getting care, tests, or treatment	120	82.7%	79.7%	84.2%	90.4%	89.6%	NO
Q23. Getting specialist appointment	47	76.1%	82.5%	76.6%	78.8%	77.7%	NO
Getting Care Quickly Composite Score	82	82.3%	83..8%	79.4%	86.7%	86.3%	NO
Q4. Getting urgent care	42	83.3%	88.9%	81.0%	90.5%	90.5%	NO
Q6. Getting routine care	122	81.3%	78.7%	77.9%	83.0%	82.5%	NO
Q20. Coordination of Care	49	87.8%	81.9%	81.6%	86.4%	83.5%	NO
Customer Service Composite Score	63	88.0%	91.0%	89.6%	88.9%	88.3%	YES

Q27. Provided information or help	62	80.0%	88.0%	87.1%	83.3%	82.7%	YES
Q28. Treated with courtesy and respect	64	96.0%	94.0%	92.2%	94.5%	93.8%	NO
How Well Doctors Communicate Composite Score	103	91.7%	91.5%	93.0%	94.4%	93.8%	NO
Q12. Dr. explained things	104	93.0%	92.5%	95.2%	94.7%	94.3%	YES
Q13. Dr. listened carefully	104	94.0%	93.2%	97.1%	95.9%	95.2%	YES
Q14. Dr. showed respect	104	96.0%	96.6%	97.1%	97.2%	96.7%	NO
Q17. Dr. spent enough time	103	83.8%	83.8%	82.5%	89.7%	89.1%	NO
Q30. Ease of Filling Out Forms Composite Score	181	94.1%	96.7%	95.6%	95.1%	94.9%	YES

MY 2024 ADULT

Measure	2024 Valid n	2023	2024	2025	2025 PG BoB	2025 QC	Goal Met
Rating Questions (% 9 or 10)							
Q28. Rating of Health Plan	241	59.3%	63.8%	63.9%	63..8%	61.7%	YES
Q8. Rating of Health Care	155	48.7%	60.5%	56.1%	58.0%	57.7%	NO
Q18. Rating of Personal Doctor	166	68.1%	72.2%	71.1%	71.4%	70.7%	YES
Q22. Rating of Specialist +	99	64.0%	73.3%	72.7%	68.9%	68.2%	YES
Rating Questions (% 8, 9 or 10)							
Q28. Rating of Health Plan	241	77.1%	78.5%	76.8%	79.1%	77.6%	NO
Q8. Rating of Health Care	155	72.7%	78.2%	78.1%	76.7%	76.5%	YES

Q18. Rating of Personal Doctor	166	80.4%	86.4%	85.5%	84.9%	84.6%	YES
Q22. Rating of Specialist +	99	81.5%	84.2%	83.8%	83.5%	83.1%	YES
Getting Needed Care Composite Score	132	78.9%	80.7%	79.0%	82.4%	82.1%	NO
Q9. Getting care, tests, or treatment	155	82.6%	84.1%	81.9%	85.5%	85.2%	NO
Q20. Getting specialist appointment	109	75.3%	77.3%	76.1%	79.4%	78.9%	NO
Getting Care Quickly Composite Score	130	75.9%	82.4%	80.3%	82.0%	81.6%	NO
Q4. Getting urgent care	91	82.4%	88.8%	82.4%	83.9%	83.7%	NO
Q6. Getting routine care	170	69.4%	76.0%	78.2%	80.1%	79.2%	NO
Effectiveness of Care							
Q33. Advised to Quit Smoking: 2YR	48	69.1%	69.8%	70.8%	74.4%	73.4%	NO
Q34. Discussing Cessation Meds: 2YR +	47	53.5%	51.7%	55.3%	55.1%	53.2%	YES
Q35. Discussing Cessation Strategies: 2YR +	47	42.1%	43.0%	40.4%	48.5%	47.2%	NO
Customer Service Composite Score	89	87.50%	87.8%	87.6%	89.9%	89.3%	NO
Q24. Provided information or help	89	80.30%	80.8%	80.9%	84.7%	83.8%	NO
Q25. Treated with courtesy and respect	89	94.70%	94.8%	94.4%	95.0%	94.7%	NO
How Well Doctors Communicate	139	91.60%	91.8%	91.2%	93.6%	93.4%	NO

Composite Score							
Q12. Dr. explained things	140	92.2%	92.6%	92.9%	93.5%	93.2%	NO
Q13. Dr. listened carefully	140	92.3%	93.3%	90.0%	93.8%	93.7%	NO
Q14. Dr. showed respect	138	94.3%	94.8%	94.9%	95.3%	95.1%	NO
Q15. Dr. spent enough time	138	87.8%	86.6%	87.0%	91.8%	91.4%	NO
Q17. Coordination of Care Composite Score	92	79.6%	82.8%	83.7%	86.3%	85.9%	NO
Q27. Ease of Filling Out Forms Composite Score	234	95.6%	93.6%	94.9%	95.0%	95.0%	NO

DATE: October 28, 2026

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

FROM: Shamara Edwards, RN, UM Director

SUBJECT: Utilization Management Work Plan Report for Q2 2026

Recommendation. Staff recommend the Board accept the Utilization Management Work Plan (UMWP) Report for Q2 2026.

Summary. This attached report provides details and summaries of the UMWP activities for Q2 2026.

Background. The Utilization Management Workgroup (UMWG) provides guidance and oversight to the Utilization Management (UM) Program and operates under the authority of the Quality Improvement Health Equity Committee (QIHEC). This quarterly summary highlights outcomes from the updates to the UMWP implemented in Q2 2026. Ongoing projects and initiatives carried forward from 2024, as well as newly established goals for 2026 continue to be monitored, with progress tracked against established goals.

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

Discussion. The Q2 2026 Utilization Management (UM) Workplan reflects ongoing improvements in care coordination, access, and service utilization across programs.

Case Management (CM)

Pediatrics Team: In Quarter 2 the proportion of pediatric members identified as NCQA High Risk increased notably in this period, accompanied by a corresponding decline in members categorized as High Risk (non-NCQA). This shift reflects a change in how members are being classified rather than an increase in overall member acuity. The Care Management team continues to review auto-authorizations for CCS-eligible conditions as part of ongoing CCS identification. The number of completed Individualized Care Plans (ICPs) remained stable, consistent with active care management engagement. Care plans remain open while members are actively engaged with the care team and are closed only when the member transitions to care coordination support or no longer requires services. As a result, steady completion numbers indicate sustained engagement rather than reduced activity. The team will continue to monitor these trends and report on any material changes.

Adult Team: The Adult Case Management Program is focused on improving the health of our Complex Case Management members, with a primary goal of increasing the number of compliant NCQA qualifying members. During the second quarter of 2026, there were 759 total NCQA eligible members, of whom 694 were enrolled in the program, reflecting a 91.4% enrollment rate. Of those enrolled, 107 members had a completed assessment, plan of care, and remained open for 60 days. Supervisors continue to audit nurses' quality of NCQA assessments to ensure ongoing compliance with assessment completion and plan of care requirements. This quarter the team achieved a 99% success rate in outreaching to possible NCQA cases, and efforts are ongoing to develop and implement techniques to support member engagement through the 60-day threshold.

Behavioral Health: The Behavioral Health Case Management (BHCM) Team works to ensure timely outreach and engagement for members referred for behavioral health support. During the second quarter of 2026, the program received 1,631 referrals and successfully conducted outreach for 1,629 of those members, reflecting an overall compliance rate of 99.9%. Of the two fallouts, at least one attempt was made to reach the member, but staff failed to follow the required 3-attempt UTC process; remediation was provided.

Adult Team**:**

TotalCare / DSNP

DSNP/TotalCare has 310 newly enrolled members for Q2 2026 (April, May, and June enrollees). Of those members, 97.41% (301 members) completed their initial Health Risk Assessment, and 306 members had a completed Individualized Care Plan, a completion rate of 99.03%. All 255 ICPs completed were shared with the member or caregiver within 2 weeks, a 100% timeliness rate. For 30-day outreach, 97.69% of members (296 of 303) were successfully contacted.

Enhanced Care Management (ECM) & Community Supports (CS):

Work to optimize ECM and Community Supports continued through Q2. ECM membership decreased by approximately 3,000 through ongoing member reassessments, provider education, and detailed manual reviews to confirm eligibility and assess readiness for graduation. Community Supports enrollment remained steady, reflecting the impact of our earlier right-sizing efforts. We continue to monitor utilization and refine our review processes and tools to improve consistency and provide a more complete picture of member needs. Since January 1, Care Integration Unit has completed comprehensive oversight reviews for 70.7% of the 92 ECM providers requiring audits, representing strong progress toward completing provider oversight.

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Utilization & Access Trends:

Q2 2026 PA data indicate that member access to authorized services remains strong, with near-perfect turnaround times and stable authorization activity. Utilization trends continue to be driven by Community Supports and ECM-related services, while increases in denials and appeals appear primarily related to documentation and eligibility requirements rather than

inappropriate access restrictions. Key focus areas for Q3 include Community Supports education, DSNP workflow maturation, NOA compliance improvements and continued authorization transformation efforts to support both access and appropriate utilization.

Prior Authorization (PA):
The UM PA program remains high-performing and compliant, with timeliness metrics consistently exceeding regulatory expectations and maintaining operational stability despite significant workload demands. Key opportunities for improvement include reducing preventable denials, improving NOA timeliness, supporting DSNP program maturation and continuing authorization workflow transformation initiatives. Overall, the department demonstrated strong operational effectiveness, successful management of increasing complexity and sustained commitment to quality and regulatory compliance during Q2 2026.

Concurrent Review:
Q2 2026 demonstrated overall improvement in inpatient utilization, including reductions in bed days and generally stable or improved ALOS across several Medi-Cal populations, while DSNP utilization continues to mature and requires ongoing monitoring. Readmission performance was mixed, with increases in select populations and counties, reinforcing the need for continued TCS, CM/ECM, multidisciplinary IDTs, and targeted post-discharge interventions. ED utilization also showed mixed trends, with improvement in some populations but continued opportunities related to avoidable ED use and regional variation; internal reporting is being developed to strengthen tracking, trending, and targeted interventions. LTC utilization increased, prompting enhanced Concurrent Review oversight and more frequent reassessment of continued level-of-care and placement appropriateness. Operationally, expedited authorization TAT remained high at 98.07% for Medi-Cal/IHSS and 98.6% for DSNP, while provider NOA timeliness improved from 84.0% in Q1 to 93.5% in Q2. Overall, continued focus will remain on utilization oversight, care transitions, readmission prevention, timely access to outpatient care, and data-driven identification of opportunities for improvement.

Behavioral Health Therapy
Q2 demonstrated continued improvement across key BHT access, quality, and operational measures compared with Q1. Member/provider case-management outreach needs declined 33% from 1,303 in Q1 to 874 in Q2, while voids related to insufficient information decreased 60.9%, suggesting improved provider submission quality and reduced need for intervention. BHT authorization turnaround-time performance remained consistently strong at approximately 99.5%, with all adverse determinations completed within required timeframes. A significant access achievement was the reduction of the historical CDE backlog: 360 of 910 members had been addressed by Q1, increasing to 902 of 910 (99.1%) by Q2, leaving only eight members from the original backlog. Quality and compliance also remained strong, with 100% NOA audit compliance in both quarters and NOA timeliness improving from 99.5% in Q1 to 100% in Q2. Overall, Q2 reflects notable strengths in access improvement, provider engagement, reduced administrative barriers, and sustained regulatory compliance.

Pharmacy

The Alliance Pharmacy Department reviews prior authorization (PA) requests for Physician Administered Drugs (PADs) for Medi-Cal and Alliance Care IHSS LOBs, and for Part B drugs for D-SNP LOB. Operational performance remained stable for Medi-Cal and IHSS LOBs with prior authorization (PA) review timeliness at 96%, a decrease in PA volume by 1.4%, and a low denial rate at 2.1%. For D-SNP Part B drugs, PA timeliness was low at 75%, caused by delay with member letter mailings for urgent PAs. The Alliance has implemented an internal mailing solution as of 7/3/2026 and verbal notification process in August to meet the 24-hour turnaround time for urgent D-SNP PA requests.

MedImpact Delegate Oversight: Drugs billed as a pharmacy claim for IHSS LOB and Part D drugs for D-SNP LOB are delegated to MedImpact. For both LOBs, audits of MedImpact PAs showed 100% compliance with PA review timeliness, clinical PA review, member/provider notifications, and member letter readability.

Other Highlights

Behavioral Health –

In Quarter 2 2026, Penetration rates for utilization for behavioral health services have continued to show increases across most age groups and counties. Our overall penetration rate for Q2 2026 was 11.14%, up from 10.62% last quarter. Santa Cruz remains our highest penetration county in the 0-12, 13-18 and 19+ groups, followed by Monterey, Mariposa, San Benito and finally, Merced; however, Mariposa, San Benito and Merced rates are all similar and still higher than thresholds and targets for each county, with continued increased penetration. Note that the Alliance includes Behavioral health services that occur in both the Behavioral Health and Physical Health space for penetration rates. This continues to reflect the Alliances strategic goals of increasing access to Behavioral Health services for our members, across all counties and in all age groups. As we surpassed a year of insourcing the Behavioral health benefit (July 1, 2026), we continue to see increased access and positive feedback.

The Behavioral Health team will continue outreach and education to providers, members and community partners regarding services, referral pathways and coordination of care efforts to maintain penetration rates. This includes but is not limited to county and other stakeholder outreach, and collaboration, MOU meetings, presentations with CBOs, provider digests, member newsletters and provider lunch and learns. In addition, we will continue to monitor UM requests, grievances, and member needs identified through care management. Rates will continue to be tracked as overall membership declines.

Attachments.

1. Utilization Management Work Plan Q2 2026

Central California Alliance for Health
2026 Utilization Management Work Plan and Evaluation

I. Projects and Initiatives

- A. Pediatric Case Management
- B Adult Case Management
- C. BH Case Management
- D. TotalCare DSNP Case Management
- E ECM and CS
- F. Reducing Readmissions Initiative
- G. Strategic Goals (NEW)

II. Operational Performance

- A. Routine Prior Authorization Turn Around Time
- A2. Expedited Concurrent Review Authorization Turn Around Time
- B. Prior Authorization Request Determination Metrics/ DSNP
- C. Top 10 Prior Authorization Medical Necessity Denials /DSNP
- D. Inter-Rater Reliability -Clinicians
- E. Inter-Rater Reliability - Physicians
- F. Inter-Rater Reliability -–Pharmacy
- G. Written Notification of PA NOAs to Providers /DSNP
- H. Written Notification of CR NOAs to Providers / DSNP

III. Utilization Performance

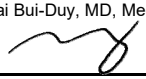
- A. Inpatient Utilization /DSNP
- B Ambulatory Care Sensitive Admissions (ACSA) /DSNP
- C Readmissions/ DSNP
- D Alternatives to Acute Inpatient Days/ DSNP
- E Long-term Care/ DSNP
- F Emergency Department Utilization /DSNP
- G. Out-of-Network Specialist Utilization Metric added DSNP
- H. Under / Over Utilization Tracking and Reporting for HEDIS Measures /DSNP
- H2. Under / Over Utilization Tracking and Reporting for High-Risk Services
- I Under / Over Utilization Analysis/ DSNP

INITIAL WORK PLAN AND EVALUATION APPROVAL:

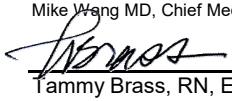
Submitted and approved by UMWG	Date:	3/17/2026
Submitted and approved by QIHEC	Date:	3/19/2026
Submitted and approved by Board	Date:	4/22/2026



Mai Bui-Duy, MD, Medical Director — Date: 3/17/2026



Mike Wang MD, Chief Medical Officer — Date: 3/17/2026



Tammy Brass, RN, Executive Director — Date: 3/17/2026

FINAL EVALUATION APPROVAL:

Submitted and approved by UMWG	Date:	
Submitted and approved by QIHEC	Date:	
Submitted and approved by Board	Date:	

Mai Bui-Duy, MD, Medical Director — Date:

Mike Wang MD, Chief Medical Officer — Date:

Tammy Brass, RN, Executive Director — Date:

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IV. Pharmacy 2026

Projects and Initiatives

Pharmacist-Led Academic Detailing (PLAD) Program

Naloxone Distribution Program

Operational Performance

Pharmacy Prior Authorization Timeliness Report

Pharmacy Prior Authorization Request Determination Metrics

Top 5 Denied Physician-Administered Drugs

Written Notification of Pharmacy NOAs to Members & Providers /DNSP

IRR Pharmacists

Utilization Performance

Drug Utilization Review (DUR) Program

V. BH 2026

Projects and Initiatives

A BHT Caregiver Engagement

B BHT Provider Engagement

Operational Performance

A Routine Behavioral Health Treatment (BHT) Turn Around Time

B Routine Behavioral Health Turn Around Time

C Behavioral Health (BHT) Request Determination Metrics

D Inter-rater Reliability Review – BCBA's

E Inter-rater Reliability Review on Approved ABA/BHT auths

Utilization Performance

A Out of Area / Out of Network BHT providers Utilization Metric

B Reduction of Comprehensive Diagnostic Evaluation (CDE) waitlist

C Behavioral Health Treatment (BHT) NOA Audit

D Behavioral Health (BHT) Written Notification of NOA to Providers

E Behavioral Health Written Notification of NOA to Providers

F Behavioral Health penetration Rates.

VI MedImpact Delegate Oversight

A MedImpact Pharmacy File Audit

B MedImpact Per Member Per Month (PMPM) Cost

C MedImpact Medical Necessity Pharmacy Denials Per Quarter Prior Authorization

Back to Agenda

I. Projects and Initiatives

A. Pediatric Case Management

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

2026 Evaluation									
Time Period	**Total # of Eligible members by County**	**# Newly Eligible by County**	**# Aged Out by County**	**# Approved NICU/PICU by County**	**# High Risk NCQA Members**	**# High Risk Members (non-NCQA)**	**# Low Risk Members**	**# ICPs**	**Comments/ Recommendations**
1st Quarter	Santa Cruz: 916 Monterey: 3175 Merced: 2357 Mariposa: 62 San Benito: 261	Santa Cruz: 20 Monterey: 38 Merced: 41 Mariposa: 1 San Benito: 3	Santa Cruz: 4 Monterey: 14 Merced: 7 Mariposa: 0 San Benito: 0	Santa Cruz: 5 Monterey: 18 Merced: 4 Mariposa: 1 San Benito: 1	**65**	**86**	**297**	**30**	Continued focus on identifying NCQA-eligible members remains a priority while successfully balancing new workflows designed to increase identification of CCS-eligible members through auto authorizations. Since the rollout of this new workflow on April 5, CCS referral volumes increased 8.9% in the first four weeks compared to the previous month. Additionally, the UTC texting campaign launched in late Q1 is expected to strengthen member engagement and support higher ICP completion rates moving forward.
2nd Quarter	Santa Cruz: 923 Monterey: 3189 Merced: 2434 Mariposa: 63 San Benito: 291	Santa Cruz: 14 Monterey: 34 Merced: 43 Mariposa: 0 San Benito: 6	Santa Cruz: 2 Monterey: 13 Merced: 9 Mariposa: 0 San Benito: 3	Santa Cruz: 1 Monterey: 14 Merced: 13 Mariposa: 0 San Benito: 0	**105**	**30**	**217**	**30**	The increase in members identified as NCQA High Risk is notable. There is a corresponding decline in members identified as High Risk non-NCQA, reflecting a shift in how members are being categorized rather than a change in overall acuity. The team continues to review auto-authorizations for CCS-eligible conditions. The number of completed ICPs held steady, which is consistent with ongoing care management activity: care plans remain open while the member is actively engaged with the care team and are not marked complete until the member transitions to care coordination support or no longer needs support. We will continue to monitor.
3rd Quarter	Santa Cruz: Monterey: Merced: Mariposa: San Benito:	Santa Cruz: Monterey: Merced: Mariposa: San Benito:	Santa Cruz: Monterey: Merced: Mariposa: San Benito:	Santa Cruz: Monterey: Merced: Mariposa: San Benito:					
4th Quarter	Santa Cruz: Monterey: Merced: Mariposa: San Benito:	Santa Cruz: Monterey: Merced: Mariposa: San Benito:	Santa Cruz: Monterey: Merced: Mariposa: San Benito:	Santa Cruz: Monterey: Merced: Mariposa: San Benito:					
Year End	Santa Cruz: Monterey: Merced: Mariposa: San Benito:	Santa Cruz: Monterey: Merced: Mariposa: San Benito:	Santa Cruz: Monterey: Merced: Mariposa: San Benito:	Santa Cruz: Monterey: Merced: Mariposa: San Benito:					

B. Adult Case Management

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

2026 Evaluation				
Time Period	**Total # of NCQA Eligible members**	**# Enrolled NCQA members**	**# NCQA members with a completed Assessment, POC and open for 60 days**	**Comments/ Recommendations**
1st Quarter	**785**	**725**	**118**	In addition to our NCQA performance metrics, we continue to conduct routine audits of individual assessments and collaborate directly with staff to ensure ongoing compliance with assessment completion and plan of care requirements. We will continue to work on techniques to members engaged for 60 days.
2nd Quarter	**759**	**694**	**107**	In addition to our NCQA performance metrics, supervisors continue to audit nurses' quality of NCQA assessments to ensure ongoing compliance with assessment completion and plan of care requirements. This quarter we had a 99% success rate in outreaching to possible NCQA cases. We will continue to work on techniques to keep members engaged for 60 days.
3rd Quarter				
4th Quarter				
Year End				

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C. BH Case Management

2026 Evaluation			
Time Period	**# members assigned to BHCM**	**# Number of those members who received outreach**	**Comments/ Recommendations**
1st Quarter	1683	1680	During the first quarter, we received 1,683 referrals and successfully conducted outreach for 1,680 of them. Of these, 328 cases were classified as unable to contact after completing the required UTC protocol of at least three outreach attempts. This reflects an overall compliance rate of 99.8%.
2nd Quarter	**1631**	**1629**	During the second quarter, we received 1,631 referrals and successfully conducted outreach for 1,629 of them. This reflects an overall compliance rate of 99.9%. Of the two fallouts, at least one attempt was made to reach the member, but staff failed to follow our required 3-attempt UTC process. Remediation was provided.
3rd Quarter			
4th Quarter			
Year End			

D. TotalCare DSNP Case Management

The D-SNP Case Management Program focuses on improving outcomes for TotalCare members through coordinated care management and Model of Care–compliant individualized care planning.

2026 Evaluation				
Time Period	**Initial HRA completion rate within 90 calendar days of enrollment**	**ICPs completed within 90 calendar days of enrollment**	**Initial outreach of newly enrolled DSNP Members within 30 calendar days**	**Comments/ Recommendations**
1st Quarter	**95.30%**	**99.83%**	**99.82%**	Individualized Care Plan (ICP) completion is calculated using engaged and unable to contact (UTC) members (minimum 3 outreach attempts) with a completed ICP as the numerator and the total member population (engaged + UTC) as the denominator. Current ICP completion, Initial Health Risk Assessment (HRA) completion, and 30 day outreach metrics include January–March enrollees.
2nd Quarter	97.41%	99.03	97.69%	Of 310 newly enrolled DSNP members in Q2 (April through June 2026), 301 received a timely Initial HRA, 296 completed the 30 day outreach, and 306 had a timely ICP completed within 90 days of enrollment. All 255 ICPs completed were shared with the member or caregiver within 2 weeks.
3rd Quarter				
4th Quarter				
Year End				

E.ECM and CS

Monitor utilization and quality of ECM and Community Supports services to ensure appropriate ECM/CS program enrollment, including timely graduation or disenrollment when member needs have been met.
Progressive increases are expected in both disenrollments and audit completion rates while decreases are anticipated in overall enrollment totals.

Time Period	ECM Member Enrollment Totals	ECM Member Disenrolled Totals	Standardized ECM Audit Completion Rate (%)	CS Member Enrollment Totals	CS Member Disenrolled Totals	Comments/Recommendations
1st Quarter	Santa Cruz: 4,473 Monterey: 10,228 Merced: 14,063 Mariposa: 271 San Benito: 1,072	Santa Cruz: 774 Monterey: 1,846 Merced: 1,648 Mariposa: 44 San Benito: 176	Santa Cruz: Monterey: Merced: Mariposa: San Benito:	Santa Cruz: 1,631 Monterey: 4,516 Merced: 16,193 Mariposa: 22,248 San Benito: 1,166	Santa Cruz: 1,427 Monterey: 3,548 Merced: 3,753 Mariposa: 138 San Benito: 266	Extensive work in Q1 for ECM/CS optimization. Membership volumes continued high in Q1 at over 26k enrolled. Assessment tool added post outreach for enrollment into ongoing services and to further assess POF, goals of ECM enrollment and graduation readiness. Audit processes updated and reviewed in ongoing external provider trainings. Completion rates will be tallied Q2 forward.
2nd Quarter	Santa Cruz: 3,577 Monterey: 6,478 Merced: 16,661 Mariposa: San Benito: 1,073	Santa Cruz: 768 Monterey: 1,806 Merced: 2,334 Mariposa: 38 San Benito: 126	Santa Cruz: Monterey: Merced: Mariposa: San Benito:	Santa Cruz: 1,874 Monterey: 5,816 Merced: 16,620 Mariposa: 20,995 San Benito: 1,050	Santa Cruz: 623 Monterey: 1,265 Merced: 1,168 Mariposa: 29 San Benito: 88	Extensive work for ECM/CS optimization continuing into Q2. Membership volumes remained high but significantly declined by ~3k through right-sizing measures including member reassessment, provider education, and rigorous manual reviews to ensure ECM eligibility and consider graduation readiness. Community Supports enrollment has remained steady, a testament to prior work right-sizing those services and eligibility requirements. Ongoing monitoring and adjustments continue to optimize reviews and ensure appropriate utilization as well as the creation of review tools for consistency and better full member picture. Since January 1st, CIU has completed comprehensive oversight reviews for 70.7% of the 92 ECM providers requiring audits, strong progress.
3rd Quarter						
4th Quarter						
Year End						

F. Reducing Readmissions Initiative

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

2026 Evaluation									
Time Period	OOA RCFE /CLF Placements	Total RCFE/CLF Placements	Merced County 30 day Readmissions	Monterey County 30 day Readmissions	Santa Cruz County 30 day Readmissions	Mariposa County 30 day Readmissions	San Benito County 30 day Readmissions	Total 30 day Readmissions	Comments/ Recommendations
1st Quarter	0 CLHF/ 0 RCFE	0 CLHF/ 6 RCFE	13%	11%	12%	9%	13%	12%	Readmission percentages are for ALL 30 day readmits from ANY level of care. Manual breakdown and review of CLHF and RCFE, there were no reported ER visits or IP stays for new members residing in CLHF/RCFE for Q1 2026.
2nd Quarter	0 CLHF/ 0 RCFE	8 CLHF/8 RCFE	19%	17%	17%	31%	18%	18%	Readmission percentages are for ALL 30 day readmits from ANY level of care. Manual breakdown of RCFE/CLHF, there is one noted admission to acute from RCFE and one admission to acute from CLHF during Q2 2026. Compared to Q1 2026, total 30-day readmissions increased from 12% to 18% in Q2 2026, with increases across all counties. Mariposa demonstrated the largest increase, from 9% to 31%. During the same period, CLHF/RCFE placements increased, reflecting expanded use of alternative care settings for members with complex care needs. Continued monitoring is needed to evaluate readmission trends and the impact of placement and transition-of-care interventions. Strengthen collaboration between UM, CM, TCS, and Population Health to identify members at high risk for readmission and support transitions across care settings. Continue multidisciplinary review of readmissions, with targeted evaluation of contributing factors and regional trends. Monitor outcomes following CLHF/RCFE placement and strengthen post-discharge follow-up, care coordination, and connection to appropriate community-based services.
3rd Quarter									
4th Quarter									
Year End									

G. Strategic Goals (NEW)

Monitor organizational performance in the key areas of the organization's strategic goals

2026 Evaluation					
Time Period	**Convert at least 85% of BH Care Management Referrals to engagement as measured by open CM episode**	**80% of new TotalCare members receiving case management outreach within 30 days of enrollment**	**90% of TotalCare members with complex needs having an individualized care plan within 90 days**	Reduce # of members with avoidable ED visits for TotalCare members compared to non-TotalCare Duals by 5%	**Comments/ Recommendations**
1st Quarter	**100%**	**98%**	**95%**	**?**	DL: Strategic Goal Efforts 2026 Q1 2026 presented is where this data (column e-f) came from. BHCM; See comments in C: BH Care Management
2nd Quarter	**99.9%**	**97.7%**	**100.0%**	11 visits in the first 2 quarters*	DL: *Metrics have one and three-month lags respectively. Preliminary results as of 7/14/26. ED use is based on raw number of visits. (column G)
3rd Quarter					
4th Quarter					
Year End					

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II. Operational Performance

A. Routine Prior Authorization Turn Around Time

Percent of routine prior authorizations completed within 7 calendar days

Medi-Cal & IHSS 2026 Evaluation

Time Period	Goal	Results	Assessment & Interventions	Recommendation for Future
1st Quarter	**100%**	**99.85%**	(35,699/35,754) Q1 2026 prior authorization turnaround time performance remained consistent with historical trends observed in prior quarters and previous years. Despite increased authorization volumes associated with expanded ECM/CS activity, particularly for housing-related services and medically tailored meals, as well as staffing fluctuations related to leaves of absence and vacancies, the team continued to maintain timeliness rates as close to 100% as possible. Ongoing staff collaboration, prioritization efforts, and workflow management contributed to sustained performance during periods of operational strain	Future recommendations include continued assessment of authorization requirements and workflows through the UM Authorization Transformation Project to identify opportunities for process optimization, administrative burden reduction, and improved operational efficiency.
2nd Quarter	**100%**	**99.64%**	(36,324 / 36,454) Q2 2026 Prior authorization turnaround time remained strong at 99.64% (36,324/36,454) despite sustained high authorization volumes, ECM/CS service demand, staffing fluctuations, and competing operational priorities. Timely processing was supported through proactive workload management, daily queue monitoring, prioritization of aging cases, cross-team collaboration, and leadership oversight, helping maintain compliance with routine authorization turnaround time requirements.	Continue advancing UM Authorization Transformation Project initiatives, with a focus on workflow optimization, workload balancing, and identification of process improvements to support timeliness, reduce administrative burden, and sustain compliance as authorization volumes. service demands and staffing proportions continue to evolve.
3rd Quarter	**100%**			
4th Quarter	**100%**			

DSNP 2026 Evaluation

Time Period	Goal	Results	Assessment & Interventions	Recommendation for Future
1st Quarter	**100%**	**96.09%**	(246 / 256) Q1 2026 represents the 1st quarter of DSNP auth review following implementation of the DSNP LOB. TAT results were lower than Medi-Cal and IHSS LOBs due, in part, to the lower overall authorization volume, which creates a narrower margin for error. Additionally, all operational teams involved in the authorization process, from authorization creation through PA review, are continuing to learn DSNP-specific requirements and workflows, resulting in slower processing times compared to established Medi-Cal processes. Ongoing monitoring, auditing and staff education were implemented throughout the quarter to support improved timeliness and processing accuracy.	Continue to track, trend, and audit DSNP authorization turnaround times to identify patterns and opportunities for improvement, with focused education and feedback provided both at the team and individual staff level as operational experience with DSNP authorizations continues to develop.

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DSNP 2026 Evaluation (cont.)				
2nd Quarter	**100%**	**95.83%**	(482 / 503) Q2 2026 DSNP prior authorization turnaround time performance was 95.83% (482/503), a slight decrease from Q1 despite increased DSNP authorization volume during the quarter. As a newer line of business, ongoing refinement of DSNP-specific authorization requirements and workflows continued to impact processing efficiency. Competing PA workload demands across all lines of business, combined with staffing vacancies and coverage challenges, created additional pressure on queue management. To support operational readiness, cross-training efforts continued to expand the number of staff proficient in DSNP authorization processes, improving coverage flexibility and process consistency. The department also began exploring MCG enhancements to embed NCD and LCD criteria within the CareWeb Q platform integrated with Jiva, with the goal of streamlining reviews and supporting more efficient authorization processing. Ongoing monitoring, auditing, staff education, and workloa prioritization were implemented throughout the quarter to support timeliness and accuracy.	Continue expanding DSNP cross-training, monitor authorization volume trends and staffing needs, and advance MCG/CareWeb QI integration efforts to improve workflow efficiency, support consistent application of NCD/LCD criteria, and enhance authorization turnaround time performance.
3rd Quarter	**100%**			
4th Quarter	**100%**			

A2. Expedited Concurrent Review Authorization Turn Around Time

Percent of expedited authorizations completed within 72 hours of received date.

Medi-Ca l & IHSS 2026 Evaluation				
Time Period	**Goal**	**Results**	**Assessment & Interventions**	**Recommendation for Future**
1st Quarter	**100%**	**100%**	100%: Q1 expedited concurrent review authorization turnaround time compliance for the Medi-Cal & IHSS population achieved 100%, meeting the established goal of completing expedited authorizations within 72 hours of receipt. Performance reflects continued adherence to regulatory turnaround time requirements, timely case review processes, and effective coordination between utilization management and clinical review teams.	Continue ongoing monitoring of expedited authorization turnaround times to maintain compliance with regulatory requirements and organizational goals. Reinforce timely documentation, accurate receipt date entry, and prompt escalation of urgent cases to support sustained performance. Conduct routine audits and staff education to ensure consistency in expedited review workflows and identify opportunities for process improvement as authorization volumes and regulatory requirements evolve.
2nd Quarter	**100%**	**98.07%**	Q2 expedited concurrent review authorization turnaround time compliance was 98.07%, compared to 100% in Q1 2026. While slightly below the 100% goal, overall performance remained high. Continue monitoring turnaround times and reviewing cases that exceed regulatory timeframes to identify trends and opportunities for process improvement.	Continue routine monitoring and targeted review of non-compliant cases. Reinforce timely receipt date documentation, case prioritization, and escalation processes to support sustained compliance and return performance to the established goal.
3rd Quarter	**100%**			
4th Quarter	**100%**			

DSNP 2026 Evaluation				
Time Period	**Goal**	**Results**	**Assessment & Interventions**	**Recommendation for Future**
1st Quarter	**100%**	**100%**	Q1 2026 DSNP expedited turnaround time compliance achieved 100% compliance, meeting the established goal of 100%. All reviewed cases were completed within required regulatory timeframes, demonstrating effective management of timeliness requirements. Continue ongoing monitoring, quality oversight, and staff awareness of turnaround time requirements to sustain compliance performance as DSNP membership and volume increase.	Maintain routine monitoring and auditing of expedited turnaround time performance to ensure continued compliance with regulatory requirements. As DSNP volume grows, continue evaluating timeliness trends and workflow capacity to support sustained performance and early identification of potential barriers to compliance.
2nd Quarter	**100%**	**98.6%**	Q2 2026 DSNP expedited turnaround time compliance was 98.6%, compared to 100% in Q1 2026. While slightly below the 100% goal, overall performance remained high. Continue monitoring turnaround times and reviewing cases that exceed required timeframes to identify trends, workflow barriers, and opportunities for improvement as DSNP volume continues to develop.	Continue routine monitoring and targeted auditing of non-compliant cases. Reinforce timely case identification, prioritization, and escalation processes to support sustained regulatory compliance and achievement of the established goal.
3rd Quarter	**100%**			
4th Quarter	**100%**			

B. Prior Authorization Request Determination Metrics

Monitoring of prior authorization volume, and appeals (including information regarding appeals upheld and appeals overturned). Auth reduction impact to be monitored through PA volume review.

Medi-Cal & IHSS 2026 Evaluation						
Time Period	**#PA Volume**	**# Medical Necessity Denials**	**# Appeals**	**#Appeals Upheld**	**# Overturned**	**Assessment & Interventions**
1st Quarter	64,714	1,445	111	73	23	PA volume remained stable in Q1 2026 (64,714) following increased utilization trends observed throughout 2025 related to ECM and Community Supports expansion. Medical necessity denials decreased to 1,445 (2.2%) from 2025 year-end trends, suggesting stabilization of ECM/CS policy application and authorization review processes. Appeal volume (n=111) and upheld vs. overturned outcomes remained generally consistent with historical patterns. Continued interventions include ongoing monitoring of PA determination trends, review of denial rationales for provider education opportunities, continued refinement of ECM/CS criteria and policies and collaboration with clinical and operational teams to support regulatory compliance and consistent decision-making.
2nd Quarter	62,739	2,173	226	164	38	(62,739 Q2 2026) PA volume decreased slightly to 62,739 from Q1 (64,714), while medical necessity denials increased to 2,173 (3.5%), reflecting increased authorization complexity, higher utilization across multiple service categories, and continued refinement of review criteria application. Appeal volume increased to 226, with 164 upheld and 38 overturned, largely driven by the higher volume of denials and ongoing provider adjustment to authorization requirements and documentation standards. Increased DSNP and Medi-Cal authorization activity, staffing challenges, and competing workload priorities continued to place pressure on utilization management operations. Interventions included ongoing monitoring and trending of denial and appeal data, targeted review of overturn reasons to identify improvement opportunities, provider and staff education regarding documentation and medical necessity requirements, continued auditing to support consistency in determinations, and evaluation of workflow enhancements to improve operational efficiency and decision-making accuracy. Recommendation for Q3 2026: Continue monitoring authorization, denial, and appeal trends with focused analysis of overturn drivers and high-volume service categories. Expand provider outreach and education to address common documentation deficiencies, advance workflow optimization initiatives through the UM Authorization Transformation Project, and assess staffing and cross-training opportunities to support increasing authorization volumes while maintaining consistent, evidence-based determinations. Continued reporting enhancements and automated tools to prepare for upcoming reduction in membership and scaled reduction in force.
3rd Quarter						
4th Quarter						
YTD/Year End						

DSNP 2026 Evaluation						
Time Period	**#PA Volume**	**# Medical Necessity Denials**	**# Appeals**	**#Appeals Upheld**	**# Overturned**	**Assessment & Interventions**
1st Quarter	466	35	5	2	3	As the first quarter of DSNP PA reporting following implementation of the DSNP LOB on 1/1/2026, Q1 data establishes the baseline for future trend analysis. PA volume was low (n=466), consistent with the early stages of program implementation. Medical necessity denials totaled 35 (7.5%), which is higher than th Medi-Cal denial rate (2.2%), likely reflecting initial application of DSNP-specific coverage criteria, provider education opportunities and the small volume of requests reviewed during the reporting period. Appeal volume remained low (n=5), with three overturned and two upheld determinations. Continued interventions include ongoing monitoring of authorization and denial trends, review of denial and appeal outcomes to identify educational opportunities, collaboration with clinical and operational teams to promote consistent application of coverage criteria and comparison of future DSNP performance against established Medi-Cal benchmarks as volume and utilization patterns mature. In addition, implementation of LCD/NCD criteria in our current CareWebQI imbedded application in Jiva is under review. This implementation would streamline and increase consistency in DSNP PA reviews.
2nd Quarter	635	52	12	7	5	DSNP PA volume increased to 635 from 466 in Q1, reflecting continued growth and utilization of the DSNP line of business. Medical necessity denials increased to 52 (8.2%), while appeal volume increased to 12, with 7 upheld and 5 overturned determinations. The increase in denials and appeals is consistent with maturation of the DSNP program, continued application of DSNP-specific coverage requirements, and provider adaptation to documentation and medical necessity expectations. Additionally, CMS does not permit reconsiderations for denied requests, requiring providers and members to submit formal appeals when additional supporting information becomes available. As a result, some overturned appeal decisions were associated with initially incomplete submissions that were subsequently supported with additional clinical documentation during the appeal process. Interventions included ongoing monitoring and trending of authorization, denial, and appeal activity; review of denial and overturn patterns to identify provider and staff education opportunities; continued DSNP cross-training to strengthen operational expertise and coverage flexibility; and evaluation of LCD/NCD integration within the CareWebQI application embedded in Jiva to improve review consistency and streamline authorization decision-making. Recommendation for Q3 2026: Continue monitoring DSNP authorization, denial, and appeal trends as volume grows, with focused review of appeal overturn drivers and documentation-related denials. Expand provider education regarding DSNP documentation requirements to reduce avoidable denials and appeals, continue DSNP cross-training efforts, and advance LCD/NCD integration within CareWebQI to support consistent, efficient, and evidence-based utilization review decisions.
3rd Quarter						
4th Quarter						
YTD/Year End						

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

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

Medi-Cal & IHSS 2026 Evaluation

Time Period	List Denials	Assessment & Interventions
1st Quarter	1. S9470 (407) Nutritional Counseling, Dietitian Visit 2. S9977 (277) Meals, Per Diem 3. S5170 (138) Home Delivered Meals 4. CS03A (110) Housing Deposit Eligibility 5. 0449U (51) Carrier Screening For Severe Inherited Condition 6. 81420 (50) Fetal Chromosomal Aneuploidy 7. 15830 (35) Excision, Excessive Skin & Subcutaneous 8. 81443 (28) Genetic Testing For Severe Inherited Conditions 9. 81456 (22) Solid Organ Or Hematolymphoid Neoplasm 10. 15847 (21) Excision, Excessive Skin And Subcutaneous	Community Supports services, including Medically Tailored Meals (MTM), continue to comprise a large portion of medical necessity denials, though volumes decreased from Q4 2025. Genetic testing services remain highly represented, consistent with prior quarters, prompting continued review of authorization criteria, policies and provider education to ensure alignment with clinical and regulatory guidance. Excision procedures (15830, 15847) continue to trend within the Top 10 denials and require ongoing monitoring of documentation and medical necessity criteria. Newly identified Housing Deposit Eligibility requests (CS03A) will continue to be monitored for trends and provider education opportunities.
2nd Quarter	1. S9470 (608) Nutritional Counseling, Dietitian Visit 2. S9977 (361) Meals, Per Diem 3. CS03A (257) Housing Deposit Eligibility 4. S5170 (253) Home Delivered Meals 5. 15830 (42) Excision, Excessive Skin & Subcutaneous 6. 81443 (31) Genetic Testing For Severe Inherited Conditions 7. 0449U (29) Carrier Screening For Severe Inherited Condition 8. 81420 (27) Fetal Chromosomal Aneuploidy 9. E1399 (25) Durable Medical Equipment 10. 81404 - 81456 (19) Molecular Pathology	Community Supports services continued to account for the highest volume of medical necessity denials in Q2 2026, with Nutritional Counseling (S9470), Meals Per Diem (S9977), Housing Deposit Eligibility (CS03A), and Home Delivered Meals (S5170) representing the top four denial categories. Increases across these services are consistent with ongoing growth in ECM and Community Supports utilization and continued application of eligibility and medical necessity requirements. Housing Deposit Eligibility denials increased substantially from Q1, indicating the need for continued provider education regarding qualifying criteria and documentation requirements. Genetic testing services remained represented within the Top 10 denials, supporting ongoing review of authorization criteria, provider documentation, and alignment with clinical and regulatory guidance. Excision procedures (15830) continued to trend within the Top 10 denials, warranting continued monitoring of medical necessity documentation. Durable Medical Equipment (E1399) and Molecular Pathology services emerged as notable denial categories during the quarter and will be monitored for trends, policy adherence, and provider education opportunities. Interventions included continued review of denial patterns, continued office hours to support provider questions, auditing of authorization determinations, and collaboration with clinical and operational teams to promote consistent application of medical necessity criteria. Recommendation for Q3 2026: Continue monitoring Community Supports, genetic testing, surgical, DME, and molecular pathology denial trends, with targeted provider education focused on documentation deficiencies and eligibility requirements. Evaluate denial drivers within high-volume categories and by provider to identify opportunities f policy clarification, workflow improvements, and reduction of avoidable denials while ensuring continued compliance with regulatory and clinical guidelines. Work is underway to develop internal reports for improved monitoring and increased ability to drill down on various utilization drivers to come to better conclusions about the trends identified.
3rd Quarter		
4th Quarter		
YTD/Year End		

DSNP 2026 Evaluation		
Time Period	**List Denials**	**Assessment & Interventions**
1st Quarter	1. S9470 (7) Nutritional Counseling, Dietitian Visit 2. S9977 (4) Meals, Per Diem 3. S5170 (3) Home Delivered Meals 4. 57599 84400 (2) Free Style Libre 3 Plus 5. 10021 (1) Fine needle aspiration biopsy	Consistent with the Medi-Cal and IHSS LOB, Community Supports services, including Medically Tailored Meals (MTM), comprised the majority of DSNP medical necessity denials in Q1 2026. However, overall DSNP denial volumes remain significantly lower than the Medi-Cal and IHSS population, likely reflecting lower utilization and membership volume within the DSNP LOB. Unlike the Medi-Cal and IHSS Top 10 denials, DSNP denials did not demonstrate significant trends related to genetic testing or excision procedures. Continued monitoring of Community Supports authorization requests and ongoing provider education regarding benefit criteria and documentation requirements will continue across all lines of business.
2nd Quarter	1. CS03A (2) Housing Deposit Eligibility 2. E1390 (2) Oxygen Concentrator 3. E1399 (2) Durable Medical Equipment 4. S9470 (2) Nutritional Counseling, Dietitian Visit 5. S9977 (2) Meals, Per Diem	DSNP medical necessity denial volume remained low in Q2 2026, with no single service category demonstrating a significant concentration of denials. Unlike the Medi-Cal and IHSS populations, denial activity was distributed across multiple service categories, including Housing Deposit Eligibility (CS03A), Oxygen Concentrator (E1390), Durable Medical Equipment (E1399), Nutritional Counseling (S9470), and Meals Per Diem (S9977). The low volume of denials is consistent with the relatively small and developing DSNP membership and authorization population. Community Supports services continued to appear among the most frequent denial categories, similar to trends observed in Medi-Cal and IHSS, indicating ongoing opportunities for provider education regarding eligibility and documentation requirements. Durable Medical Equipment and oxygen-related denials emerged as notable categories during the quarter and will continue to be monitored to ensure consistent application of coverage criteria and identify potential educational needs. Interventions included ongoing review of denial trends, monitoring of authorization outcomes, provider outreach regarding medical necessity and documentation requirements, and continued evaluation of LCD/NCD integration within CareWebQI to support consistent and evidence-based authorization determinations. Future Planning: Continue monitoring DSNP denial trends as authorization volume and membership growth mature, with focused review of Community Supports and DME-related denials. Provide targeted provider education on benefit eligibility, coverage requirements, and documentation standards, while advancing LCD/NCD integration efforts within CareWebQI to promote consistency, efficiency, and regulatory compliance in DSNP authorization reviews.
3rd Quarter		
4th Quarter		
YTD/Year End		

D. Inter-rater Reliability Review – Clinicians

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

2026 Evaluation				
Time Period	**Goal**	**Result**	**Comments**	**Recommendation for Future**
Q4 Yearly	**100%**		Pending	

E. Inter-rater Reliability Review – Physicians

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

2026 Evaluation				
Time Period	**Goal**	**Result**	**Comments**	**Recommendation for Future**
Q4 Yearly	**100%**		Pending	

F. Inter-rater Reliability Review – Pharmacists

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

2026 Evaluation				
Time Period	**Goal**	**Result**	**Comments**	**Recommendation for Future**
Q4 Yearly	**100%**		Pending	

G. PA Written Notification of NOA to Providers

Audit of timeliness of written notification of NOA to Providers

Medi-Cal & IHSS 2026 Evaluation

Time Period	Goal	Results (%)	Assessment	Interventions
1st Quarter	**100%**	**88.0%**	Q1 2026 provider NOA timeliness compliance was 88.0%, below the 100% goal. Root cause analysis identified that the majority of untimely NOAs were not due to delayed processing, but rather process failures that prevented correspondence from being generated and mailed. Of 125 untimely cases, 79 (61%) were related to translation workflow issues where authorizations were not returned from translation, preventing NOA generation and distribution. Additional contributing factors included inconsistent monitoring, variation in staff performance and gaps in queue management processes.	Implemented monthly NOA compliance audits with leadership review and trend tracking at the team and individual level. Established recurring biweekly and monthly PA/AC supervisor meetings to review NOA timeliness, identify barriers and implement process improvements. Conducting one-on-one remediation and targeted training for staff with compliance findings, including focused training on translation workflows for identified team members. Reinforced queue management and NOA timeliness expectations through team huddles and ongoing education. Supervisors will continue weekly monitoring of Tableau NOA timeliness reports and translation-related workflows to ensure timely issuance of provider and member notifications and improve compliance toward the 100% goal.
2nd Quarter	**100%**	**94.3%**	Q2 2026 provider NOA timeliness compliance improved to 94.3%, a 6.3 percentage-point increase from Q1 (88.0%), but remained below the 100% goal. The improvement reflects the impact of enhanced monitoring, education, and workflow interventions; however, continued exceptions indicate opportunities to further improve process consistency. Additional review of Q2 findings will be completed to identify remaining root causes and targeted opportunities for improvement.	Continue monthly audits and weekly supervisor monitoring of NOA timeliness and related workflows. Review Q2 exceptions for trends and root causes and provide targeted education/remediation as needed. Continue leadership oversight through recurring PA/AC supervisor meetings, reinforce queue management and timeliness expectations, and monitor performance toward the 100% compliance goal.
3rd Quarter	**100%**			
4th Quarter	**100%**			
Year End	**100%**			

DSNP 2026 Evaluation

Time Period	Goal	Results (%)	Assessment	Interventions
1st Quarter	**100%**	**86.0%**	Q1 2026 represents the first reporting period following DSNP go-live on 1/1/26. Provider NOA timeliness was 86.0%, slightly below Medi-Cal performance (88.0%) and the 100% goal. Contributing factors included implementation-related challenges such as vendor mailing schedule limitations requiring manual workarounds, tighter DSNP notification turnaround requirements, staff adaptation to new DSNP workflows and process gaps associated with a newly implemented line of business.	Continued monitoring of NOA timeliness through routine audits and leadership review, ongoing staff education and coaching on DSNP-specific requirements, refinement of notification workflows, collaboration with vendors to address mailing process limitations and enhanced oversight of correspondence queues and reporting to improve compliance and support achievement of the 100% goal.
2nd Quarter	**100%**	**84.4%**	Q2 2026 represents the second reporting period following DSNP go-live on 1/1/26. Provider NOA timeliness was 84.4%, slightly below Medi-Cal performance (88.0%) and the 100% goal. Additionally we are slightly lower than reporting in Q1. (86.0%) Contributing factors included implementation-related challenges such as vendor mailing schedule limitations requiring manual workarounds, tighter DSNP notification turnaround requirements, staff adaptation to new DSNP workflows and process gaps associated with a newly implemented line of business.	Continued monitoring of NOA timeliness through routine audits and leadership review, ongoing staff education and coaching on DSNP-specific requirements, refinement of notification workflows, collaboration with vendors to address mailing process limitations and enhanced oversight of correspondence queues and reporting to improve compliance and support achievement of the 100% goal.
3rd Quarter	**100%**			
4th Quarter	**100%**			
Year End	**100%**			

H. CR Written Notification of NOA to Providers

Audit of timeliness of written

Medi-Cal & IHSS 2026 Evaluation

Time Period	Goal	Results (%)	Assessment	Interventions
1st Quarter	100%	84.0%	Q1 CR written notification of NOA to providers for the Medi-Cal & IHSS population achieved 83.8% compliance against a goal of 100%, indicating opportunities to improve timeliness of provider notification processes and strengthen adherence to regulatory notification requirements. Results suggest the need for continued monitoring of workflow efficiency, documentation practices, and correspondence processing to reduce delays in NOA issuance.	Strengthen monitoring and oversight of CR NOA notification workflows to improve timely provider communication and regulatory compliance. Reinforce staff education on required TAT standards, accurate documentation practices, and timely letter generation processes. Collaborate with UM, HS, operations, and correspondence vendors to identify workflow gaps, system delays, or processing barriers contributing to untimely notifications, and implement corrective actions to improve overall NOA compliance performance.
2nd Quarter	100%	93.5%	Q2 2026 CR written NOA notification compliance improved to 93.5%, compared to 84.0% in Q1 2026. While performance remains below the 100% goal, the quarter-over-quarter improvement reflects progress in notification timeliness and workflow compliance. Continued monitoring is needed to identify remaining causes of untimely notifications.	Continue increased monitoring and oversight of CR NOA notification workflows. Reinforce staff education on TAT requirements, accurate documentation, and timely letter processing. Continue collaboration with UM operations and correspondence teams to identify workflow or system barriers and implement targeted interventions to further improve compliance toward the 100% goal.
3rd Quarter	100%			
4th Quarter	100%			
Year End	100%			

DSNP 2026 Evaluation

Time Period	Goal	Results (%)	Assessment	Interventions
1st Quarter	100%	94.0%	Q1 2026 DSNP compliance results were initially reported at 33.9%; however, a subsequent manual audit determined the accurate compliance rate was 87.0%, which, while below the established goal of 100%, demonstrates substantially stronger performance than originally reflected. During the audit process, potential reporting and system logic discrepancies were identified and escalated for review, indicating that the originally reported results may not have accurately captured compliance activity. 84 authorizations and 5 out of compliance	Continue collaboration with reporting, analytics, and operational teams to review and validate compliance reporting methodologies and ensure accurate performance measurement. Perform routine audits and reconciliation of system-generated reports against case-level findings to identify discrepancies and monitor data integrity. Increase oversight of CR NOA's timeliness through ongoing quality monitoring and focused audits to ensure compliance with regulatory requirements.
2nd Quarter	100%	96.0%	Q2 2026 DSNP compliance improved to 96.0%, compared to 94.0% in Q1 2026. While performance remains below the 100% goal, the quarter-over-quarter improvement reflects continued progress in CR NOA timeliness and strengthened oversight of compliance processes.	Continue enhanced oversight of CR NOA timeliness through routine monitoring, targeted audits, and reconciliation of system-generated reporting with case-level findings. Maintain collaboration with reporting, analytics, and operational teams to address identified discrepancies, strengthen data integrity, and support continued improvement toward the 100% compliance goal.
3rd Quarter	100%			
4th Quarter	100%			
Year End	100%			

III. Utilization Performance

A. Inpatient Utilization

Goals by line of business and Medi-Cal aid category were developed using Alliance historical performance and DHCS state benchmarks. The bed-days per thousand per year (BD/K/Y) goal was established using historical data and state averages. Ambulatory Care Sensitive Admissions (ACSA) and 30-day readmissions are tracked by line of business and region. The benchmark for dual-eligible Medicare populations reflects expected hospitalization rates and will be reassessed as plan-specific utilization trends become available.

IHSS

Time Period	Admit/K/Y Reported	Admit/K/Y Updated	ALOS	BD/K/Y Reported	BD/K/Y Updated	BD/K/Y Goal	Variance	ACSA %	Readmits %	Assessment	Interventions
1st Quarter	67	68	6.5	439	246	200	**23%**	16.7%	0%	Compared to Q1 2025, Q1 2026 IHSS IP utilization remained relatively unchanged, increasing slightly from 66 to 68 Admit/KY. However, IP utilization increased, as reflected by an increase in ALOS from 2.9 to 6.5 days and BD/KY reported from 201 to 439. BD/KY updated improved from 192 to 246, exceeding the established goal of 200. ACSA rates improved significantly, decreasing from 27.0% to 16.7%, suggesting fewer potentially preventable IP admissions. Readmissions remained the same at 0% in both periods, reflecting stable post-discharge outcomes.	Continue efforts that have contributed to the reduction in ACSA rates by strengthening care coordination, TCS, member engagement, and access to primary and preventive care services. Conduct focused reviews of cases with extended LOS to identify opportunities for earlier DC planning, timely care transitions, and resolution of barriers to discharge. Maintain current utilization management processes that support BD/KY performance above goal, while continuing to monitor IP utilization trends and high-utilizing members for targeted CM/ECM interventions. Sustain post DC follow-up and TCS activities to maintain the 0% readmission rate and support positive member outcomes.
2nd Quarter	55	62	3.2	174	393	200	**49%**	9.1%	17%	Compared to Q2 2025, Q2 2026 IHSS inpatient utilization improved, with Admit/KY decreasing from 69 to 62 and ALOS decreasing from 6.6 to 3.2. ACSA remained stable at 9.1%, while readmissions increased from 9% to 17%. Compared to Q1 2026, Admit/KY decreased from 68 to 62, ALOS improved from 6.5 to 3.2, and ACSA improved from 16.7% to 9.1%; however, BD/KY increased from 246 to 393. Readmissions also increased from 0% to 17%. Overall, admission utilization, ALOS, and ACSA improved, while bed day utilization and readmissions remain areas of focus.	Continue increased IP CR involvement, multidisciplinary IDTs, and early identification of high-risk members, with focused review of drivers contributing to increased bed days and readmissions. Strengthen discharge planning, CM/ECM/TCS referrals, and post-discharge follow-up to reduce avoidable utilization and improve transitions of care.
3rd Quarter						200					
4th Quarter						200					
YTD/Year End						200					

Medi-Cal Child and Family Aid Codes (OTLIC + other)

Time Period	Admit/K/Y Reported	Admit/K/Y Updated	ALOS	BD/K/Y Reported	BD/K/Y Updated	BD/K/Y Goal	Variance	% CCS	ACSA %	Readmits %	Assessment	Interventions
1st Quarter	53	51	3.8	200	199	170	**17.1%**	29.2%	3.2%	5%	Compared to Q1 2025, Q1 2026 IP utilization remained relatively unchanged, with Admit/KY increasing slightly from 51 to 53. ALOS decreased from 4.1 to 3.8 days, suggesting shorter inpatient stays. BD/KY reported remained essentially unchanged (198 vs. 200), while BD/KY updated decreased from 211 to 199 but continued to exceed the established goal of 170. CCS membership decreased from 35.0% to 29.2%, while ACSA rates increased slightly from 2.9% to 3.2%. Readmissions remained unchanged at 5%, indicating stable post-discharge outcomes and overall utilization performance.	Continue utilization management and care coordination activities that support BD/KY performance above goal and maintain stable readmission rates. Monitor the slight increase in ACSA rates to identify opportunities for enhanced outpatient management, preventive care, and timely access to primary care services. Continue targeted CM for high-risk members and maintain DC planning and TCS processes to support appropriate LOS and reduce avoidable IP utilization.
2nd Quarter	56	50	3.7	207	200	170	15%	29.2%	2.9%	5%	Compared to Q2 2025, Q2 2026 showed improvement in overall inpatient utilization, with Admit/KY decreasing from 53 to 50 and BD/KY decreasing from 205 to 200, although BD/KY remains above the goal of 170. ALOS and ACSA remained relatively stable, while readmissions increased slightly from 4% to 5%. CCS utilization increased from 24.5% to 29.2%. Compared to Q1 2026, Q2 performance was generally stable, with slight improvement in Admit/KY, ALOS, and ACSA; BD/KY, CCS utilization, and readmissions remained relatively unchanged.	Continue IP CR oversight with focus on appropriate bed day utilization, LOS management, and early discharge planning. Monitor CCS utilization and complex care needs to identify opportunities for enhanced care coordination. Continue multidisciplinary collaboration and timely CM/ECM/TCS referrals, with post-discharge follow-up to reduce avoidable utilization and readmissions.
3rd Quarter						170						
4th Quarter						170						
YTD/Year End						170						

Medi-Cal Seniors and Persons with Disabilities Aid Codes (SPD+Dual)

Time Period	Admit/K/Y Reported	Admit/K/Y Updated	ALOS	BD/K/Y Reported	BD/K/Y Updated	BD/K/Y Goal	Variance	% CCS	ACSA %	Readmits %	Assessment	Interventions
1st Quarter	240	228	5.4	1298	1300	1300	**0%**	12.4%	11.80%	19%	Compared to Q1 2025, Q1 2026 IP utilization remained relatively unchanged, with Admit/KY decreasing slightly from 232 to 228. ALOS improved from 6.0 to 5.4 days, indicating shorter IP stays. BD/KY reported decreased from 1,513 to 1,298, while BD/KY updated decreased from 1,396 to 1,300, meeting the established goal of 1,300 in 2026 compared to performance above goal in 2025. CCS percentage increased slightly from 10.2% to 12.4%, while ACSA improved from 13.4% to 11.8%, suggesting a reduction in potentially preventable IP admissions. Readmissions improved from 21% to 19%, reflecting modest improvement in post-discharge outcomes and care transitions.	Continue targeted CM and TCS program for high-risk SPD members to support further reductions in readmissions and avoidable IP utilization. Maintain focus on chronic disease management, timely outpatient follow-up, and coordination with PCP, specialists, and community-based services to sustain improvements in ACSA rates. Continue monitoring members with frequent admissions and complex medical needs, while reinforcing discharge planning processes and post-discharge outreach to support positive outcomes and appropriate utilization.
2nd Quarter	240	230	5.5	1317	1239	1300	4.7%	13%	12.5	17%	Compared to Q2 2025, Q2 2026 SPD inpatient utilization improved, with Admit/KY decreasing from 247 to 230 and BD/KY decreasing from 1,481 to 1,239, bringing BD/KY below the goal of 1,300. ALOS remained relatively stable at 5.4 vs. 5.5, while readmissions remained stable at 17%. ACSA increased from 10.6% to 12.5%, and CCS utilization increased from 11.2% to 13%. Compared to Q1 2026, overall utilization remained relatively stable, with BD/KY improving from 1,300 to 1,239 and readmissions improving from 19% to 17%, while ALOS, ACSA, and CCS utilization increased slightly.	Continue IP CR oversight and multidisciplinary IDTs for complex SPD members, with focus on appropriate LOS, discharge planning, and maintaining favorable bed day utilization. Monitor ACSA and CCS trends and strengthen CM/ECM/TCS involvement, chronic disease management, and post-discharge follow-up to address potentially avoidable admissions and readmissions.
3rd Quarter						1300						
4th Quarter						1300						
YTD/Year End						1300						

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New Medicaid Expansion Members (i.e. former LIHP, as well as new M aid code and 7U/7W aid code members) (ACA+Other)

Time Period	Admit/K/Y Reported	Admit/K/Y Updated	ALOS	BD/K/Y Reported	BD/K/Y Updated	BD/K/Y Goal	Variance	% CCS	ACSA %	Readmits %	Assessment	Interventions
1st Quarter	77	72	5.4	410	361	375	**3.7%**	1.3%	8.1%	13%	Compared to Q1 2025, Q1 2026 IP utilization remained relatively unchanged, with Admit/KY decreasing slightly from 74 to 72. ALOS remained unchanged at 5.4 days, while BD/KY reported remained essentially the same (409 vs. 410). BD/KY updated decreased from 398 to 361 but remained close to the established goal of 375 compared to 6% above goal in 2025. CCS percentage remained relatively unchanged (1.2% vs. 1.3%). ACSA improved from 9.2% to 8.1%, suggesting a reduction in potentially preventable IP admissions, while readmissions improved from 15% to 13%, indicating modest improvement in post DC outcomes and care transitions.	Continue targeted care coordination and TCS activities that support reductions in ACSA and readmission rates. Focus on timely post-discharge follow-up, member engagement, and linkage to primary and specialty care to further reduce avoidable inpatient utilization. Monitor members with frequent admissions and complex care needs for enhanced case management interventions, while reinforcing utilization management processes to improve BD/KY performance and achieve established goals.
2nd Quarter	78	73	4.6	363	386	375	**2.9%**	2.4%	7.1%	14%	Compared to Q2 2025, Q2 2026 Medicaid Expansion inpatient utilization improved, with Admit/KY decreasing from 74 to 73, ALOS decreasing from 4.9 to 4.6, and BD/KY decreasing from 411 to 386. ACSA remained relatively stable at 6.9% vs. 7.1%, while CCS utilization increased slightly from 2.0% to 2.4% and readmissions improved from 15% to 14%. Compared to Q1 2026, Q2 showed improvement in ALOS and ACSA, while Admit/KY, BD/KY, CCS utilization, and readmissions increased slightly. BD/KY remains slightly above the goal of 375.	Continue IP CR oversight with focus on bed day utilization, appropriate LOS, and early discharge planning. Monitor CCS and ACSA trends and continue multidisciplinary IDTs, CM/ECM/TCS involvement, and post-discharge follow-up for high-risk members to reduce avoidable utilization and readmissions.
3rd Quarter						375						
4th Quarter						375						
YTD/Year End						375						

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

Time Period	Admit/K/Y Reported	Admit/K/Y Updated	ALOS	BD/K/Y Reported	BD/K/Y Updated	BD/K/Y Goal	Variance	ACSA %	Readmits %	Assessment	Interventions
1st Quarter	50	65	4.2	208	297	290	**2.4%**	6.4%	6%	Compared to Q1 2025, Q1 2026 IP utilization showed a slight decrease in utilization, with Admit/KY decreasing from 66 to 65 and ALOS improving from 4.9 to 4.2 days. BD/KY reported decreased from 316 to 208, while BD/KY updated decreased from 321 to 297 but continued to exceed the established goal of 290, resulting in a favorable variance of 2.4% above goal compared to 11% above goal in Q1 2025. ACSA remained relatively unchanged, improving slightly from 6.7% to 6.4%, while readmissions improved significantly from 11% to 6%, indicating stronger post DC outcomes and TCS performance	Continue current utilization management and care coordination strategies that have supported reductions in readmissions and maintenance of low ACSA rates. Reinforce discharge planning and timely post-discharge follow-up for high-risk members to sustain improvements in readmission performance. Continue monitoring IP utilization trends, including LOS and bed day utilization, and utilize targeted CM/ECM interventions for members with complex medical needs or frequent hospitalizations. Maintain collaboration with providers and community resources through IDTs to support appropriate care transitions and prevent avoidable IP utilization.
2nd Quarter	72	66	4.3	313	306	290	**5.5%**	5.9%	10%	Compared to Q2 2025, Q2 2026 total Medi-Cal inpatient utilization showed relatively stable Admit/KY, increasing slightly from 65 to 66, while BD/KY improved from 322 to 306. ALOS remained relatively stable at 4.1 vs. 4.3, ACSA increased slightly from 5.3% to 5.9%, and readmissions increased from 7% to 10%. Compared to Q1 2026, Admit/KY increased slightly from 65 to 66, ALOS remained stable, and BD/KY increased from 297 to 306. ACSA improved from 6.4% to 5.9%, while readmissions increased from 6% to 10%. Overall, BD/KY improved year over year but remains approximately 5.5% above the goal of 290, with readmissions remaining an area of focus.	Continue IP CR involvement in IDTs with focus on high-risk members, early discharge planning, and readmission prevention. Continue multidisciplinary collaboration with providers/facilities and timely CM/ECM/MSW/TCS referrals.
3rd Quarter						290						
4th Quarter						290						
YTD/Year End						290						

DSNP

Time Period	2026 Admit/K/Y Reported	2026 Admit/K/Y Updated	ALOS	BD/K/Y Reported	BD/K/Y Updated	BD/K/Y Goal	Variance	ACSA %	Readmits %	Assessment	Interventions
1st Quarter	131	131	6.1	792	792	350		0%	0%	Q1 2026 establishes the baseline for DSNP IP utilization. During the quarter, Admit/KY was 131, ALOS was 6.1 days, and BD/KY reported was 792, which exceeded the established goal of 350 BD/KY, indicating higher IP utilization than anticipated for the population. ACSA and readmission rates were both 0%, suggesting no ambulatory care sensitive admissions or readmissions were identified during the reporting period. As this is the first year of DSNP reporting, additional quarters of data will be needed to establish utilization trends, evaluate performance against benchmarks, and determine whether the elevated BD/KY utilization represents a persistent pattern or an early population stabilization trend.	Continue monitoring IP utilization, LOS, bed day utilization, ACSA, and readmission metrics to establish meaningful performance trends. Implement ongoing care coordination and case management activities for high-risk DSNP members, with emphasis on chronic disease management, transitions of care, and timely access to primary and specialty care services. Conduct routine reviews of inpatient admissions and high-utilizing members to identify opportunities to optimize care delivery, reduce avoidable utilization, and support positive health outcomes as the DSNP population matures.
2nd Quarter	164	146	4.9	801	817	350		1	5	Compared to Q1 2026, Q2 2026 showed increased DSNP utilization, with Admit/KY increasing from 131 to 146 and BD/KY increasing from 792 to 817. ALOS improved from 6.1 to 4.9. ACSA increased from 0% to 1%, and readmissions increased from 0% to 5%. As the DSNP population continues to mature, utilization trends will continue to be monitored.	Continue close IP CR monitoring with focus on high-risk DSNP members, LOS management, early discharge planning, and readmission prevention. Continue multidisciplinary IDTs and timely CM/ECM/TCS referrals to support care coordination and post-discharge needs.
3rd Quarter						350					
4th Quarter						350					
YTD/Year End						350					

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Total Alliance Inpatient Utilization: BD/K/Y goal based on historical data and state averages and adjusted slightly up for DSNP population.

Time Period	Admit/K/Y Reported	Admit/K/Y Updated	ALOS	BD/K/Y Reported	BD/K/Y Updated	BD/K/Y Goal	Variance	ACSA %	Readmits %	Assessment	Interventions
1st Quarter	65	67	4.3	278	291	300	3%	0%	0%	Q1 2026 IP utilization established a baseline for the combined population. Admit/KY was 67, ALOS was 4.3 days, and BD/KY updated was 291, which was 3% below the established goal of 300. Despite BD/KY utilization remaining slightly below target, ACSA and readmission rates were both 0%, indicating no ambulatory care sensitive admissions or readmissions were identified during the reporting period. Overall, IP utilization remained relatively stable, and additional quarters of data will be needed to establish meaningful trends and evaluate performance across the combined population.	Continue monitoring IP utilization, bed day utilization, ALOS, ACSA, and readmission trends to establish baseline performance and identify emerging utilization patterns. Maintain concurrent review, discharge planning, and care coordination activities to support appropriate IP utilization and timely transitions of care. Conduct targeted reviews of members with extended or frequent admissions and extended LOS to identify opportunities for CM/ECM and utilization management interventions. Continue to monitor future quarters to evaluate whether BD/KY utilization aligns more closely with established goals while maintaining favorable quality outcomes.
2nd Quarter	66	67	4.0	264	301	300	0.33	0%	0%	Compared to Q2 2025, Q2 2026 showed Admit/KY increasing slightly from 65 to 67. ALOS improved from 4.1 to 4.0, and BD/KY improved from 322 to 301, bringing utilization essentially to the goal of 300. ACSA decreased from 5.3% to 0%, and readmissions improved from 7% to 0%.	Continue IP CR monitoring with focus on LOS, bed day utilization, and early discharge planning. Continue multidisciplinary IDTs and timely CM/ECM/MSW/TCS referrals to sustain improvements in readmissions and overall inpatient utilization.
3rd Quarter						300					
4th Quarter						300					
YTD/Year End						300					

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

Ambulatory Care Sensitive Admissions (ACSA) per region.

IHSS/Medi-Cal

Time Period	Santa Cruz ACSA %	Monterey ACSA %	Merced ACSA %	Mariposa ACSA %	San Benito ACSA %	Assessment	Interventions
1st Quarter	6.15%	5.71%	7.02%	7.25%	6.30%	Compared to Q1 2025, Q1 2026 IHSS/Medi-Cal ACSA rates were relatively stable overall, with some regional variation. Santa Cruz increased slightly from 5.86% to 6.15%, Merced increased from 6.84% to 7.02%, Mariposa increased from 5.33% to 7.25%, and San Benito increased from 5.86% to 6.30%. Monterey improved from 6.38% to 5.71%, reflecting a reduction in potentially preventable IP admissions. Mariposa reported the highest ACSA rate in Q1 2026 at 7.25%, while Monterey reported the lowest at 5.71%. Overall, ACSA performance remained within a relatively narrow range across all counties, suggesting generally stable access to and utilization of OP services.	Continue efforts to improve access to primary and preventive care services, with focused outreach and care coordination in counties demonstrating increased ACSA rates, particularly Mariposa and Merced. Review common ACSA admission diagnoses to identify opportunities for earlier intervention and chronic disease management. Strengthen member engagement, PCP follow-up, and coordination with community resources to address barriers to outpatient care and reduce avoidable inpatient admissions. Maintain monitoring of regional ACSA trends to identify emerging utilization patterns and target interventions accordingly
2nd Quarter	4.36%	5.58%	6.87%	5.95%	3.90%	Compared to Q2 2025, Q2 2026 ACSA increased in Santa Cruz (3.99% to 4.36%), Monterey (5.22% to 5.58%), Merced (5.78% to 6.87%), and Mariposa (2.35% to 5.95%), while San Benito improved from 5.99% to 3.90%. Compared to Q1 2026, Q2 2026 ACSA improved across all five counties, with the greatest improvement in Mariposa (7.25% to 5.95%) and San Benito (6.30% to 3.90%). Overall, quarter-over-quarter improvement was seen across all regions despite year-over-year increases in four counties.	Continue collaboration with CM/ECM, TCS, and providers to identify members at risk for potentially avoidable admissions. Strengthen chronic disease management, timely PCP/specialty follow-up, and access to outpatient care, with continued monitoring of county-level ACSA trends to identify opportunities for targeted interventions.
3rd Quarter							
4th Quarter							
YTD/Year End							

DSNP

Time Period	Santa Cruz ACSA %	Monterey ACSA %	Merced ACSA %	Mariposa ACSA %	San Benito ACSA %	Assessment	Interventions
1st Quarter	0%	0%	0%	0%	0%	Q1 DSNP ACSA data shows 0% across all counties, indicating no reported potentially avoidable inpatient admissions during the reporting period. Results reflect favorable inpatient utilization performance and suggest effective care coordination, outpatient management, and early intervention strategies within the DSNP population.	Continue ongoing monitoring of IP utilization and ACSA trends across all counties to sustain low rates of avoidable admissions within the DSNP population. Maintain collaboration between utilization management, case management, providers, and community-based services to support early intervention, chronic condition management, and timely access to outpatient care. Reinforce TCS and post-discharge follow-up processes to promote continuity of care and prevent avoidable inpatient utilization as membership and service needs evolve.
2nd Quarter	14.29%	4.35%	0%	0%	0%	Compared to Q1 2026, Q2 2026 DSNP ACSA increased from 0% to 14.29% in Santa Cruz and 4.35% in Monterey. Merced, Mariposa, and San Benito remained at 0%. Continued monitoring is needed as the DSNP population and utilization mature.	Continue monitoring DSNP ACSA trends with increased focus on Santa Cruz and Monterey. Identify members with potentially avoidable admissions and strengthen CM/ECM/TCS involvement, PCP follow-up, chronic disease management, and post-discharge support.
3rd Quarter							
4th Quarter							
YTD/Year End							

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C. Readmissions (%)

*30-day Readmissions per region

IHSS/Medi-Cal

Time Period	Santa Cruz %					Monterey %					Merced %					Mariposa %					San Benito %						Assessment	Interventions
	0-18 YO	19-55 YO	Over 55 YO	Total Readmission %	% CCS	0-18 YO	19-55 YO	Over 55 YO	Total Readmission %	% CCS	0-18YO	19-55 YO	Over 55 YO	Total Readmission %	% CCS	0-18YO	19-55 YO	Over 55 YO	Total Readmission %	% CCS	0-18YO	19-55 YO	Over 55	19-55 YO	Over 55 YO	Total Readmission %	% CCS		
1st Quarter	4.61	9.42	13.23	9.83	0.4	4.61	8.40	14.83	9.09	0.6	6.90	8.59	15.16	9.67	0.7	6.06	11.44	21.00	13.48	0.7	2.91			9.76	13.65	9.83	0.6	Compared to Q1 2025, Q1 2026 30-day readmission rates improved across all counties. Santa Cruz decreased from 10.89% to 9.83%, Monterey from 9.35% to 9.09%, Merced from 9.68% to 9.67% (relatively unchanged), Mariposa from 6.43% to 13.48% (increase), and San Benito from 9.89% to 9.83% (relatively unchanged). Across most counties, the over 55 population continued to have the highest readmission rates, with Mariposa reporting the highest rate at 21.0%, followed by Merced (15.16%), Monterey (14.83%), San Benito (13.65%), and Santa Cruz (13.23%). Readmission rates among members aged 19–55 remained moderate, while rates for the 0–18 population remained the lowest overall. CCS percentages remained low across all counties and were generally lower than the prior year. Overall, readmission performance remained relatively stable to improved in most regions, with the exception of Mariposa, which experienced a notable increase.	Continue TCS and post DC outreach efforts, with a particular focus on members over age 55 who continue to demonstrate the highest risk for readmission. Conduct targeted reviews of readmission drivers in Mariposa County to identify opportunities for improvement in care transitions, chronic disease management, and access to outpatient services. Maintain timely PCP and specialist follow-up after discharge, strengthen case management support for high-risk members, and collaborate with providers and community resources to address barriers such as medication management, transportation, caregiver support, and social determinants of health. Monitor county-level readmission trends quarterly to identify emerging patterns and target interventions where needed.
2nd Quarter	4.13	10.31	12.9	10.24	0.4	4.29	8.78	15.27	9.39	0.5	9.21	9.47	15.82	10.71	1	0	11.81	11.29	10.48	0.7	0.56			9.57	15.28	9.88	0.2	Compared to Q2 2025, Q2 2026 readmission rates improved in Santa Cruz (10.72% to 10.24%) and San Benito (10.10% to 9.88%), while increasing in Monterey (9.07% to 9.39%), Merced (9.25% to 10.71%), and Mariposa (7.47% to 10.48%). Compared to Q1 2026, rates increased slightly in all regions except Mariposa, which improved from 13.48% to 10.48%. Overall, performance was mixed, with Merced and Mariposa having the highest Q2 2026 readmission rates.	Continue targeted readmission reduction efforts, with increased focus on Merced and Mariposa. Strengthen transition-of-care follow-up, timely post-discharge outreach, and coordination with providers and care management for members at highest risk for readmission.
3rd Quarter																													
4th Quarter																													
YTD/Year End																													

DSNP

Time Period	Santa Cruz %				Monterey %				Merced %				Mariposa %				San Benito %				Assessment	Interventions
	0-18 YO	19-55 YO	Over 55 YO	Total Readmission %	0-18 YO	19-55 YO	Over 55 YO	Total Readmission %	0-18YO	19-55 YO	Over 55 YO	Total Readmission %	0-18YO	19-55 YO	Over 55 YO	Total Readmission %	0-18YO	19-55 YO	Over 55 YO	Total Readmission %		
1st Quarter	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Q1 2026 establishes the baseline for DSNP 30-day readmission performance. No readmissions were identified across any county or age group, resulting in an overall readmission rate of 0%. While this reflects a favorable outcome, additional quarters of data will be needed to establish meaningful trends and determine whether performance remains consistent as DSNP membership and utilization mature.	Continue TCS and post-discharge follow-up activities to maintain favorable readmission performance. Monitor IP admissions and care transitions for high-risk DSNP members, with a focus on timely PCP and specialist follow-up, medication reconciliation, and care coordination. As additional data becomes available, evaluate county- and age-specific trends to identify opportunities for targeted interventions and sustained reductions in avoidable readmissions.
2nd Quarter	0	0	17.39	17.39	0	0	10.34	9.38	0	0	0	0	0	0	0	0	0	0	0	0	Compared to Q1 2026, Q2 2026 DSNP readmissions increased from 0% to 17.39% in Santa Cruz and 9.38% in Monterey, with readmissions concentrated in members over age 55. Merced, Mariposa, and San Benito remained at 0%. Continued monitoring is needed as the DSNP population matures.	Increase focus on high-risk DSNP members, particularly those over age 55 in Santa Cruz and Monterey. Continue TCS post-discharge support, multidisciplinary IDTs, and timely CM/ECM referrals with emphasis on PCP/specialty follow-up, medication reconciliation, and readmission prevention.
3rd Quarter																						
4th Quarter																						
YTD/Year End																						

D. Alternatives to Acute Inpatient Days - Skilled Nursing Facility

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

Medi-Cal

Time Period	#SNF Bed days (Updated #)	PKPY SNF SPD (Updated #)	PKPY IPT Bed days SPD (Updated #)	Total # STR	STR Readmits After Discharge	Assessment	Interventions
1st Quarter	1,026	1,447	1,298	277	63	Compared to Q1 2025, Q1 2026 SNF utilization showed a shift toward greater SNF use as an alternative to acute IP days. PKPY SNF bed days increased from 352 to 1,447, while PKPY inpatient bed days decreased slightly from 1,406 to 1,298, suggesting increased utilization of SNF services to support care at a lower LOC. Total STR placements increased from 250 to 277, while STR readmissions after discharge increased from 47 to 63, indicating an opportunity to further strengthen care transitions and post-SNF discharge planning.	Continue to promote appropriate use of SNF as an alternative to acute IP care while closely monitoring STR outcomes and readmissions. Conduct targeted reviews of members readmitted following STR placement to identify common clinical and social barriers contributing to hospital returns. Strengthen TCS and DC planning and post DC follow-up processes for members transitioning from SNF to the community. Collaborate with SNFs, and case management teams through IDT's to improve care coordination, ensure timely follow-up appointments, and support successful transitions across care settings.
2nd Quarter	1194	282	1317	299	55	Compared to Q2 2025, Q2 2026 SNF bed days decreased from 1,869 to 1,194 and PKPY inpatient bed days decreased from 1,485 to 1,317, while STR placements increased from 246 to 299. STR readmissions after discharge improved from 71 to 55. Compared to Q1 2026, SNF bed days increased from 1,026 to 1,194 and inpatient bed days remained relatively stable (1,298 to 1,317), while STR placements increased from 277 to 299 and STR readmissions improved from 63 to 55. Overall, Q2 reflects lower year-over-year bed day utilization with increased use of STR and improved post-STR readmissions.	Continue promoting appropriate SNF utilization as an alternative to acute IP care. Maintain multidisciplinary IDTs and collaboration with SNFs, CM/ECM, and discharge planners to support timely placement, reduce avoidable inpatient days, and ensure safe transitions across care settings.
3rd Quarter							
4th Quarter							
YTD/Year End							

DSNP

Time Period	#SNF Bed days (Updated #)	PKPY SNF SPD (Updated #)	PKPY IPT Bed days SPD (Updated #)	Total # STR	STR Readmits After Discharge	Assessment	Interventions
1st Quarter	327			10	3	(Dawn advised no data yet from Mariposa & San Benito) Q1 2026 establishes the baseline for DSNP SNF utilization. During the quarter, 327 SNF bed days were reported, with 10 STR and 3 readmissions following STR discharge. Data from Mariposa and San Benito counties were not yet available, limiting a comprehensive assessment of utilization across the full DSNP population. Additional quarters of data will be needed to establish trends, evaluate STR outcomes, and assess the effectiveness of SNF utilization as an alternative to acute IP care.	Continue monitoring SNF utilization, STR placements, and post-discharge readmissions as additional county data becomes available. Conduct targeted reviews of members readmitted following STR placement to identify opportunities for improved discharge planning, care transitions, and post-discharge support. Strengthen coordination among SNFs, case management, primary care providers, and community resources through IDT's and TCS to support successful transitions of care and reduce avoidable readmissions. Monitor future utilization trends to establish benchmarks and identify opportunities for performance improvement within the DSNP population.
2nd Quarter	221			12	1	Automated data not available. During Q2 12 members were in STR equaling 221 days. Out of those 12 members, 1 member readmitted within 30 days.	Continue to monitor SNF utilization and readmissions. Conduct targeted audits for increasing trends and implement Process improvements including external providers to decease utilization and readmissions.
3rd Quarter							
4th Quarter							
YTD/Year End							

E. Long-term Care

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

Medi-Cal

Time Period	# of New Admissions	# of LTC	Total # of Members in LTC	Total # of Medi/Medi	Assessment	Interventions
1st Quarter	243	354	2039	1,685	Compared to Q1 2025, Q1 2026 LTC utilization increased across all measured categories. New admissions increased from 215 to 243, number of LTC members increased from 335 to 354, total members in LTC increased from 1,925 to 2,039, and Medi/Medi members increased from 1,590 to 1,685. The growth in LTC membership and admissions indicates continued demand for LTC services and underscores the importance of ongoing monitoring to ensure members remain appropriately placed and continue to meet LTC level-of-care criteria.	Continue routine LOC and placement reviews to ensure members remain in the most appropriate setting based on clinical needs. Prioritize timely assessment of new LTC admissions and conduct periodic reassessments to identify members who may be appropriate for transition to lower LOC's or community-based services. Strengthen collaboration with facilities, CM teams, and community partners to support care planning, optimize resource utilization, and promote safe transitions when clinically appropriate. Monitor LTC population growth trends and utilization patterns to ensure adequate care management oversight and access to necessary services.
2nd Quarter	298	376	2101	1725	Compared to Q2 2025, Q2 2026 LTC utilization increased, with new admissions increasing from 229 to 298 and total LTC members increasing from 1,868 to 2,101. Compared to Q1 2026, new admissions increased from 243 to 298, LTC members increased from 354 to 376, and total members in LTC increased from 2,039 to 2,101. Medi/Medi membership also increased from 1,685 to 1,725. Overall, LTC utilization continues to trend upward.	Increase oversight of the LTC population through more frequent Concurrent Review assessments of continued LOC and placement appropriateness. Continue collaboration with facilities, CM/ECM, and community partners to identify opportunities for lower levels of care or community-based services and support safe transitions when appropriate.
3rd Quarter						
4th Quarter						
YTD/Year End						

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E. Long-term Care (cont.)

DSNP

Time Period	# of New Admissions	# of LTC	Total # of Members in LTC	Total # of Medi/Medi	Assessment	Interventions
1st Quarter	14	8	6	2	Q1 DSNP LTC data shows 14 new admissions, with 8 members identified as requiring LTC services. Of the total LTC population reviewed, 6 members met long-term care criteria and 2 members were identified as Medi/Medi. Continued monitoring supports appropriate level of care placement and compliance with Title 22 criteria.	Continue ongoing review and monitoring of LTC placements to ensure members continue to meet Title 22 criteria and remain in the appropriate level of care. Collaborate with CM teams, providers, and facility staff to support timely reassessments, discharge planning, and identification of members who may safely transition to lower levels of care when clinically appropriate. Strengthen coordination for Medi/Medi members to ensure alignment of Medicare and Medi-Cal services, improve continuity of care, and support appropriate utilization of LTC resources.
2nd Quarter	8	12	10	2	Compared to Q1 2026, Q2 2026 DSNP new LTC admissions decreased from 14 to 8, while the number of members requiring LTC services increased from 8 to 12. Total members in LTC increased from 6 to 10, while Medi/Medi membership remained stable at 2. Continued monitoring is warranted as the DSNP LTC population develops.	Continue ongoing review and monitoring of LTC placements to ensure members meet Title 22 criteria and remain at the appropriate level of care, with increased Concurrent Review oversight and more frequent reassessments. Continue collaboration with CM teams, providers, and facility staff to support discharge planning and identify members who may safely transition to lower levels of care. Maintain coordination for Medi/Medi members to align Medicare and Medi-Cal services and support appropriate LTC utilization.
3rd Quarter						
4th Quarter						
YTD/Year End						

F. Emergency Department

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

IHSS

Time Period	Avoidable Visits %	Total Visits/K/Y Reported	Total Visits/K/Y Updated	Total Visits K/Y Goal	Total visits: Variance	Assessment	Interventions
1st Quarter	12.16%	413	510	N/A	19%	Compared to Q1 2025, Q1 2026 IHSS ED utilization remained relatively stable, with total ED visits/KY reported decreasing slightly from 415 to 413. Avoidable ED visits improved from 14.49% to 12.16%, indicating a reduction in potentially preventable ED utilization and suggesting improved access to appropriate OP care. Total ED visits remained well below the goal of 510 visits/KY, reflecting a favorable variance of 19% compared to 12% in Q1 2025. Overall, ED utilization performance demonstrates continued effective management of non-emergent care needs	Continue strategies that support appropriate ED utilization, including member education on accessing PCP, urgent care, and nurse advice services for non-emergent conditions. Maintain TCS/care coordination and CM outreach for members with chronic conditions and frequent ED utilization to address barriers to routine care. Strengthen post-ED follow-up processes to ensure timely PCP appointments, and linkage to community resources. Monitor avoidable ED visit trends and high-utilizing members to identify opportunities for targeted interventions and sustain performance below the established ED utilization goal.
2nd Quarter	14.06%	317	425	N/A	25%	Compared to Q2 2025, Q2 2026 IHSS ED utilization improved, with total ED visits/KY decreasing from 427 to 317. Compared to Q1 2026, total ED visits/KY also decreased from 413 to 317. Avoidable ED visits increased from 13.85% in Q2 2025 and 12.16% in Q1 2026 to 14.06% in Q2 2026. Overall ED utilization improved, while avoidable ED visits remain an area of focus.	Continue strategies to support appropriate ED utilization, including member education on PCP, urgent care, and nurse advice services. Maintain CM/TCS outreach for members with chronic conditions and frequent ED utilization, with targeted review of avoidable ED visits and barriers to timely outpatient care. Develop internal reporting to enhance tracking and trending of ED utilization and identify opportunities for targeted interventions.
3rd Quarter				N/A			
4th Quarter				N/A			
YTD/Year End				N/A			

Medi-Cal Child and Family

Time Period	Avoidable Visits %	Total Visits/K/Y Reported	Total Visits/K/Y Updated	Total Visits K/Y Goal	Total visits: Variance	% CCS Visits	Assessment	Interventions
1st Quarter	17.54%	537	**485**	400	21.25%	17.54%	Compared to Q1 2025, Q1 2026 ED utilization showed modest improvement, with total ED visits/KY updated decreasing from 519 to 485, although utilization remained above the goal of 400 visits/KY. Avoidable ED visits remained relatively unchanged, decreasing slightly from 17.76% to 17.54%, indicating ongoing opportunities to improve access to appropriate non-emergent care settings. Total reported visits increased slightly from 520 to 537, while the variance above goal improved from approximately 30% to 21.25%. CCS-related ED utilization also decreased from 19.26% to 17.54%, suggesting modest improvement among members with complex healthcare needs.	Strengthen TCS by increasing MSW, CM, and ECM engagement for members with high ED utilization and gaps in preventive care. Enhance post-ED follow-up and care coordination to improve linkage to primary care, pediatric specialists, and community resources. Collaborate with providers to improve timely appointment availability and reduce barriers to non-emergent care access. Monitor avoidable ED utilization trends and target interventions for high-risk members and frequent ED utilizers.
2nd Quarter	16.92%	511	**542**	400	35.50%	16.87%	Compared to Q2 2025, Q2 2026 Child and Family ED utilization increased, with total ED visits/KY increasing from 459 to 542, while avoidable ED visits improved from 17.36% to 16.92%. Compared to Q1 2026, total ED visits/KY increased from 485 to 542, while avoidable ED visits improved from 17.54% to 16.92%. ED utilization remains above the goal of 400, despite improvement in avoidable ED visits.	Continue TCS, CM, MSW, and ECM engagement for members with high ED utilization and gaps in preventive care. Strengthen PCP follow-up and access to appropriate non-emergent care. Develop internal reporting to enhance tracking and trending of ED utilization, identify high-risk members and utilization patterns, and support targeted interventions.
3rd Quarter				400				
4th Quarter				400				
YTD/Year End				400				

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F. Emergency Department (cont.)

Medi-Cal Seniors and Persons with Disabilities

Time Period	Avoidable Visits %	Total Visits/K/Y Reported	Total Visits/K/Y Updated	Total Visits K/Y Goal	Total visits: Variance	% CCS Visits	Assessment	Interventions
1st Quarter	10.78%	833	961	830	15.8%	10.78	Compared to Q1 2025, Q1 2026 ED utilization showed modest improvement, with total ED visits/KY updated decreasing from 995 to 961 and reported visits decreasing from 1,045 to 833. Avoidable ED visits improved slightly from 11.09% to 10.78%, indicating a reduction in potentially preventable ED utilization. Despite these improvements, total ED visits remained above the goal of 830 visits/KY, with a variance of 15.8% above goal, though improved from approximately 20% above goal in Q1 2025. CCS-related ED utilization also improved, decreasing from 12.21% to 10.78%. Overall, the data reflects positive movement in ED utilization and avoidable visit rates, while continued opportunities remain to further reduce ED use among this high-risk population.	Continue targeted CM/ECM and care coordination through TCS and IDT's for high-risk SPD members, with a focus on chronic disease management, medication adherence, and timely access to primary and specialty care. Strengthen member outreach and education regarding appropriate ED utilization and available alternatives, including urgent care and after-hours resources. Enhance post-ED follow-up and transitional care activities to address barriers to outpatient care and reduce repeat ED utilization. Monitor utilization patterns among frequent ED users and CCS members to identify opportunities for targeted interventions and improved care coordination.
2nd Quarter	10.41%	767	845	830	1.81%	17.87	Compared to Q2 2025, Q2 2026 SPD ED utilization remained relatively stable, with total ED visits/KY decreasing slightly from 847 to 845, while avoidable ED visits increased from 9.16% to 10.41%. Compared to Q1 2026, total ED visits/KY improved from 961 to 845 and avoidable ED visits improved from 10.78% to 10.41%. ED utilization is approaching the goal of 830, showing improvement from Q1 2026.	Continue targeted CM/ECM and TCS involvement for high-risk SPD members, with focus on chronic disease management, timely PCP/specialty follow-up, and access to appropriate non-emergent care. Develop internal reporting to enhance tracking and trending of ED utilization, identify frequent ED users and utilization patterns, and support targeted interventions.
3rd Quarter				830				
4th Quarter				830				
YTD/Year End				830				

DSNP

Time Period	Avoidable Visits %	Total Visits/K/Y Reported	Total Visits/K/Y Updated	Total Visits K/Y Goal	Total visits: Variance	Assessment	Interventions
1st Quarter	6.67%	347	N/A	600	N/A	Q1 DSNP ED utilization data shows 347 total visits/KY reported against a goal of 600 visits/KY, indicating utilization below the established benchmark. Avoidable ED visits were 6.67%, suggesting opportunities to continue strengthening access to appropriate outpatient services, care coordination, and early intervention strategies to prevent non-emergent ED utilization.	Continue strengthening care coordination, TCS, and member outreach to support appropriate ED utilization and improve linkage to PCP, specialty care, and urgent care services. Increase engagement with high-risk and high-utilizing members to address barriers to routine care access, medication management, and chronic condition management. Collaborate with providers and case management teams to promote early intervention, improve follow-up after ED visits, and reduce avoidable ED within the DSNP population.
2nd Quarter	7.69%	803		600		Compared to Q1 2026, Q2 2026 DSNP ED utilization increased , with total ED visits/KY increasing from 347 to 803 and exceeding the goal of 600. Avoidable ED visits also increased from 6.67% to 7.69%. Continued monitoring is needed to better understand utilization patterns as the DSNP population matures.	Continue strengthening TCS, CM/ECM, and care coordination for high-risk DSNP members, with focus on PCP/specialty access, chronic disease management, and post-ED follow-up. Develop internal reporting to enhance tracking and trending of ED utilization, identify frequent ED users and utilization patterns, and support targeted interventions to reduce avoidable ED use.
3rd Quarter				600			
4th Quarter				600			
YTD/Year End							

Medicaid Expansion (i.e. former LIHP, as well as new M aid code and 7U/W aid code members)

Time Period	Avoidable Visits %	Total Visits/K/Y Reported	Total Visits/K/Y Updated	Total Visits K/Y Goal	Total visits: Variance	% CCS Visits	Assessment	Interventions
1st Quarter	10.41%	477	482	420	14.8%	16.92%	Compared to Q1 2025, Q1 2026 ED utilization demonstrated improvement, with total ED visits/KY updated decreasing from 567 to 482 and reported visits decreasing from 576 to 477. Avoidable ED visits improved slightly from 10.60% to 10.41%, indicating a modest reduction in potentially preventable ED utilization. Although total ED visits remained above the goal of 420 visits/KY, the variance improved from approximately 35% above goal in Q1 2025 to 14.8% above goal in Q1 2026. CCS-related ED utilization increased from 12.64% to 16.92%, suggesting a greater proportion of ED utilization among members with complex healthcare needs. Overall, the data reflects improved ED utilization performance while highlighting opportunities to further reduce utilization among high-risk populations.	Continue targeted outreach and care coordination for Medicaid Expansion members with frequent ED utilization, focusing on improving access to PCP and preventive services. Strengthen post-ED follow-up and member engagement efforts to address barriers to care and reduce avoidable ED visits. Increase case management support for members with chronic conditions and complex healthcare needs, particularly those contributing to higher CCS-related utilization. Monitor ED utilization trends and high-utilizer patterns to identify opportunities for targeted interventions and continued reduction in ED visits.
2nd Quarter	7.69%	803	503	420	19.8%	0.00%	Compared to Q2 2025, Q2 2026 Medicaid Expansion ED utilization remained relatively stable, with updated ED visits/KY decreasing slightly from 508 to 503 and avoidable ED visits improving from 10.19% to 7.69%. Compared to Q1 2026, updated ED visits/KY increased from 482 to 503; however, avoidable ED visits improved significantly from 10.41% to 7.69%. While ED utilization remains above the goal of 420, the continued reduction in avoidable ED visits reflects improvement in potentially preventable utilization.	Continue targeted outreach and care coordination for members with frequent ED utilization, focusing on access to PCP, urgent care, and other appropriate alternatives to the ED. Strengthen CM/ECM/TCS involvement and post-ED follow-up for high-risk members. Continue development of internal reporting to track and trend ED utilization, identify frequent ED users and emerging patterns, and support targeted interventions.
3rd Quarter				420				
4th Quarter				420				
YTD/Year End				420				

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F. Emergency Department (cont.)

Medi-Cal Seniors and Persons with Disabilities

Time Period	Avoidable Visits %	Total Visits/K/Y Reported	Total Visits/K/Y Updated	Total Visits K/Y Goal	Total visits: Variance	% CCS Visits	Assessment	Interventions
1st Quarter	10.78%	833	961	830	15.8%	10.78	Compared to Q1 2025, Q1 2026 ED utilization showed modest improvement, with total ED visits/KY updated decreasing from 995 to 961 and reported visits decreasing from 1,045 to 833. Avoidable ED visits improved slightly from 11.09% to 10.78%, indicating a reduction in potentially preventable ED utilization. Despite these improvements, total ED visits remained above the goal of 830 visits/KY, with a variance of 15.8% above goal, though improved from approximately 20% above goal in Q1 2025. CCS-related ED utilization also improved, decreasing from 12.21% to 10.78%. Overall, the data reflects positive movement in ED utilization and avoidable visit rates, while continued opportunities remain to further reduce ED use among this high-risk population.	Continue targeted CM/ECM and care coordination through TCS and IDT's for high-risk SPD members, with a focus on chronic disease management, medication adherence, and timely access to primary and specialty care. Strengthen member outreach and education regarding appropriate ED utilization and available alternatives, including urgent care and after-hours resources. Enhance post-ED follow-up and transitional care activities to address barriers to outpatient care and reduce repeat ED utilization. Monitor utilization patterns among frequent ED users and CCS members to identify opportunities for targeted interventions and improved care coordination.
2nd Quarter	10.41%	767	845	830	1.81%	17.87	Compared to Q2 2025, Q2 2026 SPD ED utilization remained relatively stable, with total ED visits/KY decreasing slightly from 847 to 845, while avoidable ED visits increased from 9.16% to 10.41%. Compared to Q1 2026, total ED visits/KY improved from 961 to 845 and avoidable ED visits improved from 10.78% to 10.41%. ED utilization is approaching the goal of 830, showing improvement from Q1 2026.	Continue targeted CM/ECM and TCS involvement for high-risk SPD members, with focus on chronic disease management, timely PCP/specialty follow-up, and access to appropriate non-emergent care. Develop internal reporting to enhance tracking and trending of ED utilization, identify frequent ED users and utilization patterns, and support targeted interventions.
3rd Quarter				830				
4th Quarter				830				
YTD/Year End				830				

DSNP

Time Period	Avoidable Visits %	Total Visits/K/Y Reported	Total Visits/K/Y Updated	Total Visits K/Y Goal	Total visits: Variance	Assessment	Interventions
1st Quarter	6.67%	347	N/A	600	N/A	Q1 DSNP ED utilization data shows 347 total visits/KY reported against a goal of 600 visits/KY, indicating utilization below the established benchmark. Avoidable ED visits were 6.67%, suggesting opportunities to continue strengthening access to appropriate outpatient services, care coordination, and early intervention strategies to prevent non-emergent ED utilization.	Continue strengthening care coordination, TCS, and member outreach to support appropriate ED utilization and improve linkage to PCP, specialty care, and urgent care services. Increase engagement with high-risk and high-utilizing members to address barriers to routine care access, medication management, and chronic condition management. Collaborate with providers and case management teams to promote early intervention, improve follow-up after ED visits, and reduce avoidable ED within the DSNP population.
2nd Quarter	7.69%	803		600		Compared to Q1 2026, Q2 2026 DSNP ED utilization increased , with total ED visits/KY increasing from 347 to 803 and exceeding the goal of 600. Avoidable ED visits also increased from 6.67% to 7.69%. Continued monitoring is needed to better understand utilization patterns as the DSNP population matures.	Continue strengthening TCS, CM/ECM, and care coordination for high-risk DSNP members, with focus on PCP/specialty access, chronic disease management, and post-ED follow-up. Develop internal reporting to enhance tracking and trending of ED utilization, identify frequent ED users and utilization patterns, and support targeted interventions to reduce avoidable ED use.
3rd Quarter				600			
4th Quarter				600			
YTD/Year End							

Medicaid Expansion (i.e. former LIHP, as well as new M aid code and 7U/W aid code members)

Time Period	Avoidable Visits %	Total Visits/K/Y Reported	Total Visits/K/Y Updated	Total Visits K/Y Goal	Total visits: Variance	% CCS Visits	Assessment	Interventions
1st Quarter	10.41%	477	482	420	14.8%	16.92%	Compared to Q1 2025, Q1 2026 ED utilization demonstrated improvement, with total ED visits/KY updated decreasing from 567 to 482 and reported visits decreasing from 576 to 477. Avoidable ED visits improved slightly from 10.60% to 10.41%, indicating a modest reduction in potentially preventable ED utilization. Although total ED visits remained above the goal of 420 visits/KY, the variance improved from approximately 35% above goal in Q1 2025 to 14.8% above goal in Q1 2026. CCS-related ED utilization increased from 12.64% to 16.92%, suggesting a greater proportion of ED utilization among members with complex healthcare needs. Overall, the data reflects improved ED utilization performance while highlighting opportunities to further reduce utilization among high-risk populations.	Continue targeted outreach and care coordination for Medicaid Expansion members with frequent ED utilization, focusing on improving access to PCP and preventive services. Strengthen post-ED follow-up and member engagement efforts to address barriers to care and reduce avoidable ED visits. Increase case management support for members with chronic conditions and complex healthcare needs, particularly those contributing to higher CCS-related utilization. Monitor ED utilization trends and high-utilizer patterns to identify opportunities for targeted interventions and continued reduction in ED visits.
2nd Quarter	7.69%	803	503	420	19.8%	0.00%	Compared to Q2 2025, Q2 2026 Medicaid Expansion ED utilization remained relatively stable, with updated ED visits/KY decreasing slightly from 508 to 503 and avoidable ED visits improving from 10.19% to 7.69%. Compared to Q1 2026, updated ED visits/KY increased from 482 to 503; however, avoidable ED visits improved significantly from 10.41% to 7.69%. While ED utilization remains above the goal of 420, the continued reduction in avoidable ED visits reflects improvement in potentially preventable utilization.	Continue targeted outreach and care coordination for members with frequent ED utilization, focusing on access to PCP, urgent care, and other appropriate alternatives to the ED. Strengthen CM/ECM/TCS involvement and post-ED follow-up for high-risk members. Continue development of internal reporting to track and trend ED utilization, identify frequent ED users and emerging patterns, and support targeted interventions.
3rd Quarter				420				
4th Quarter				420				
YTD/Year End				420				

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F. Emergency Department (cont.)

ED Visits per County

IHSS & Medi-Cal

Time Period	Santa Cruz Avoidable Visits %	Santa Cruz Total Visits/K/Y	Monterey Avoidable Visits %	Monterey Total Visits K/Y	Merced Avoidable Visits %	Merced Total Visits K/Y	Mariposa Avoidable Visits %	Mariposa Total Visits K/Y	San Benito Avoidable Visits %	San Benito Total Visits K/Y	Assessment	Interventions
1st Quarter	12.17%	71	14.52%	271	15.94%	97	14.16%	7	16.91%	35	Note: weighted average goal for total Medi-Cal ED visits for (in Alliance Dashboard) is 590: Compared to Q1 2025, ED utilization remained relatively stable across counties, with mixed performance by region. Santa Cruz improved, with avoidable ED visits increasing only slightly (11.98% to 12.17%) while total visits/KY decreased from 83 to 71. Monterey demonstrated improvement, with avoidable ED visits decreasing from 16.00% to 14.52%, although total visits/KY increased from 252 to 271. Merced experienced a slight increase in avoidable ED visits (14.61% to 15.94%) while total visits/KY decreased substantially from 184 to 97. Mariposa remained relatively unchanged, with avoidable ED visits decreasing slightly (14.31% to 14.16%) and total visits/KY remaining at 7. San Benito showed increased avoidable ED utilization (15.10% to 16.91%) while total visits/KY decreased from 39 to 35. Overall, total ED utilization decreased in most counties, while avoidable ED visit rates remained relatively stable, with opportunities for improvement in Merced and San Benito.	Continue targeted outreach and member education regarding appropriate ED utilization and available alternatives, including PCP, urgent care, and nurse advice services. Focus care coordination and case management efforts in Merced and San Benito to address the increase in avoidable ED visits. Strengthen post-ED follow-up and provider engagement to improve access to timely outpatient care and reduce non-emergent ED utilization. Monitor county-level utilization trends and common drivers of avoidable ED visits to support targeted interventions and sustain reductions in overall ED utilization.
2nd Quarter	13.24%	77	15.73	243	12.85	170	8.31%	7	17.79%	34	Compared to Q2 2025, Q2 2026 ED utilization showed mixed trends by county. Total visits/KY decreased in Monterey (245 to 243) and San Benito (37 to 34), remained slightly lower in Mariposa (6 to 7), and increased in Santa Cruz (83 to 77) and notably in Merced (101 to 170). Compared to Q1 2026, total visits/KY increased in Santa Cruz and Merced, decreased in Monterey and San Benito, and remained stable in Mariposa. Avoidable ED visit rates increased in Santa Cruz, Monterey, and San Benito, while improving in Merced and Mariposa.	Continue targeted outreach and member education regarding appropriate ED alternatives, including PCP, urgent care, and nurse advice services. Strengthen CM/ECM/TCS involvement for high-risk and frequent ED users, with increased focus on counties demonstrating higher utilization. Continue development of internal reporting to track and trend county-level ED utilization, identify emerging patterns, and support targeted interventions.
3rd Quarter												
4th Quarter												
YTD/Year End												

DSNP

Time Period	Santa Cruz Avoidable Visits %	Santa Cruz Total Visits/K/Y	Monterey Avoidable Visits %	Monterey Total Visits K/Y	Merced Avoidable Visits %	Merced Total Visits K/Y	Mariposa Avoidable Visits %	Mariposa Total Visits K/Y	San Benito Avoidable Visits %	San Benito Total Visits K/Y	Assessment	Interventions
1st Quarter	5.00%	154	10.00%	154	0	0	0	0	0%	39	Note: weighted average goal for total Medi-Cal ED visits for (in Alliance Dashboard) is 590:Q1 data shows variation in avoidable ED visit rates across counties, with Santa Cruz reporting 5.0%, Monterey County reporting 10.0%, and San Benito County reporting 0% avoidable ED visits. Total ED utilization was highest in Santa Cruz and Monterey Counties at 154 visits/KY each, while San Benito County reported 39 visits/KY. No utilization was reported for Merced or Mariposa Counties during the reporting period. The data indicates opportunities to continue strengthening care coordination, access to outpatient services, and member engagement strategies to reduce avoidable Emergency Department utilization within the DSNP population.	Continue strengthening care coordination, TCS, and post-ED follow-up processes to improve linkage to primary care, specialty care, behavioral health, and community-based services for DSNP members. Increase outreach and case management support for high-risk and high-utilizing members to address barriers to routine care access, medication management, and chronic condition management. Collaborate with providers and community partners across counties to promote appropriate use of urgent care and outpatient services, support early intervention strategies, and reduce preventable ED utilization.
2nd Quarter	7.94%	175	8.89%	463	0	144	0%	13.9	0%	25	Compared to Q1 2026, Q2 2026 DSNP ED utilization increased in Santa Cruz (154 to 175 visits/KY), Monterey (154 to 463), and Merced (0 to 144), while San Benito decreased from 39 to 25. Mariposa reported utilization in Q2 after no utilization in Q1. Avoidable ED visits increased in Santa Cruz from 5.00% to 7.94%, improved in Monterey from 10.00% to 8.89%, and remained at 0% in Merced, Mariposa, and San Benito. Continued monitoring is needed as DSNP utilization patterns develop.	Continue strengthening care coordination, TCS, and post-ED follow-up for DSNP members, with targeted focus on counties demonstrating increased ED utilization. Increase CM/ECM engagement for high-risk and frequent ED users and reinforce access to PCP, specialty, urgent care, and nurse advice services. Develop internal reporting to track and trend county-level DSNP ED utilization, identify emerging patterns, and support targeted interventions.
3rd Quarter												
4th Quarter												
YTD/Year End												

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G. Out of Area / Out of Network Specialist Utilization Metric

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

IHSS & Medi-Cal

Time Period	Total Auths	Approvals	Denials	Voided / Canceled	Top 5 Specialty Types by County	Assessment & Interventions
1st Quarter	900	894	6	0	Merced: Other (162), Cardiovascular Disease(1), Ophthalmology (39), Neurology (11), Oncology (12) Monterey: Other (38), Dermatology (1), Neurology (3), Oncology (2), Ophthalmology (9) Santa Cruz: Other (43), Dermatology (2), Ophthalmology (3), Surgery General (3), Surgery Orthopedic (4) Mariposa: Other (22), Surgery General (2), Neurology (1), Oncology (1), Ophthalmology (1) San Benito: Other (13), Oncology (2), Ophthalmology (2), Surgery General (1)	Out of Area/Out of Network (OON) specialist utilization remained stable in Q1 2026, with 900 total authorizations, 894 approvals and a low denial rate consistent with prior years. Following increased utilization in 2024 related to County Expansion and stabilization throughout 2025, current trends continue to reflect appropriate oversight and referral practices. "Other" remains the most frequently reported specialty category across counties, supporting continued review of specialty classification refinement opportunities. Ophthalmology, Oncology, Neurology, and Surgery specialties continue to appear across multiple counties, indicating ongoing network access challenges in certain regions. Continued interventions include monitoring OON utilization trends, targeted network development, review of referral patterns by county and specialty and ongoing efforts to redirect medically necessary services to in-network providers when appropriate. This is also an area of review for our impending UM Auth Transformation Project.
2nd Quarter	768	764	4	0	Merced: Other (146), Podiatry(5), Ophthalmology (48), Neurology (3), Oncology (9) Monterey: Other (43), Dermatology (4), Neurology (2), Podiatry (2), Ophthalmology (9) Santa Cruz: Other (41), Dermatology (4), Ophthalmology (6), Surgery General (7), Surgery Orthopedic (5) Mariposa: Other (15), Surgery Orthopedic(3), Neurology (4), Oncology (2), Ophthalmology (3) San Benito: Other (20), Oncology (4), Ophthalmology (3), Surgery General (2), Surgery Orthopedic (3)	Out of Area/Out of Network (OON) specialist utilization remained stable in Q2 2026, with 928 total authorizations, 924 approvals, and only 4 denials, demonstrating continued appropriate application of referral and authorization criteria. "Other" remained the highest utilized specialty category across all counties, suggesting ongoing opportunities to refine specialty classification and reporting. Ophthalmology continued to be a consistently utilized OON specialty across multiple counties, while Oncology, Neurology, Orthopedic Surgery, General Surgery, and Podiatry were also frequently represented. The persistence of these specialties across counties may indicate ongoing provider network access limitations and workforce shortages in certain geographic areas. Compared to Q1, overall utilization patterns remained relatively consistent, supporting the effectiveness of current referral management and network oversight activities. Interventions: Continue monitoring OON utilization trends by county and specialty to identify emerging access issues and network gaps. Collaborate with Provider Network Management to evaluate opportunities for targeted provider recruitment in high-utilization specialties, particularly Ophthalmology, Oncology, Neurology, and Surgical services. Continue reviewing referral patterns and opportunities to redirect medically necessary services to qualified in-network providers when available. Additionally, incorporate OON referral and specialty utilization analysis into the UM Authorization Transformation Project to identify workflow improvements, enhance reporting capabilities, and support long-term network adequacy and access-to-care initiatives.
3rd Quarter					Merced: Monterey: Santa Cruz: Mariposa: San Benito:	
4th Quarter					Merced: Monterey: Santa Cruz: Mariposa: San Benito:	
YTD/Year End						

G. Out of Area / Out of Network Specialist Utilization Metric (cont.)

DSNP

Time Period	Total Auths	Approvals	Denials	Voided / Canceled	Top 5 Specialty Types by County	Assessment & Interventions
1st Quarter	24	24	0	0	Merced: Oncology (1), Neurology (1), Other (5) Monterey: Neurology (1), Ophthalmology (1), Other (6) Santa Cruz: Ophthalmology (1), Surgery - General (1), Surgery - Orthopedic (1), Other (1) Mariposa: Ophthalmology (1), Neurology (1), Podiatry (1) San Benito: Podiatry (1), Other (1)	Q1 2026 represents the baseline reporting period following DSNP implementation on 1/1/26. Out-of-area/out-of-network specialist utilization was low (24 total authorizations) with all requests approved, suggesting appropriate referral practices and adequate access management during early program implementation. Similar to Medi-Cal, the most common specialty category was "Other," with Ophthalmology and Neurology appearing across multiple counties, potentially indicating emerging specialty access needs. Given the small volume, no definitive utilization trends can be established at this time. Continued interventions include monitoring OON utilization and referral patterns by county and specialty, evaluating opportunities for network development where recurring access gaps are identified, reviewing specialty classification reporting to better define "Other" referrals and comparing future DSNP trends against established Medi-Cal benchmarks as membership and utilization mature.
2nd Quarter	12	12	0	0	Merced: Other (2), Neurology (1) Monterey: Other (2) Santa Cruz: Other (2), Ophthalmology (1) Mariposa: Neurology (1), Podiatry (1) San Benito: Other (1), Ophthalmology (1)	Q2 2026 out-of-area/out-of-network specialist utilization decreased to 12 authorizations, compared with 24 in Q1. All requests were approved, with no denials or voids/cancellations, indicating that submitted requests continued to meet applicable criteria. Utilization remained low across counties and specialty types, with "Other," Neurology, and Ophthalmology representing the most frequently reported categories. Due to the small volume and early stage of DSNP implementation, there is insufficient data to establish a meaningful utilization trend or identify definitive network access gaps at this time. Interventions Continue monitoring out-of-area/out-of-network specialist utilization by county and specialty to identify recurring patterns or potential access concerns as DSNP membership and utilization mature. Continue reviewing requests for appropriate use of out-of-network services and evaluate recurring specialty needs for potential network development opportunities. Continue monitoring the "Other" specialty category to better identify the types of services being requested and improve the specificity of utilization reporting. Future quarterly results will be compared with prior DSNP periods and established Medi-Cal benchmarks to identify meaningful changes in utilization patterns.
3rd Quarter					Merced: Monterey: Santa Cruz: Mariposa: San Benito:	
4th Quarter					Merced: Monterey: Santa Cruz: Mariposa: San Benito:	
YTD/Year End					Merced: Monterey: Santa Cruz: Mariposa: San Benito:	

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H. Under / Over Utilization Tracking and Reporting for HEDIS Measures

UM monitors under/over utilization of the QI HEDIS categories below. Over/under utilization is determined by a 5% variance from the previous quarter's values.

2026 Evaluation (Medi-Cal & IHSS)

Time Period	Monitored Category		Assessment	Interventions
1st Quarter	1. IHA 2. Breast Cancer Screening 3. Colon Cancer Screening 4. Lead Screening 5. ACE Screening 6. Mental Health Visits 7. Depression Screening	1. Under 2. Under 3. Under 4. Under 5. Over 6. 7. Under	Q1 2026 HEDIS utilization monitoring identified underutilization trends in IHA, Breast Cancer Screening, Colon Cancer Screening, Lead Screening and Depression Screening measures, while ACE Screening demonstrated overutilization compared to the prior quarter benchmark. Consistent with prior utilization monitoring efforts, current findings do not indicate systemic concerns but highlight opportunities for continued oversight and trend analysis across preventive care measures. QI Dept closely monitors and completes trend analysis.	Continue quarterly monitoring of HEDIS utilization trends and collaborate with QI, Provider Services and operational teams to identify root causes of underutilization and overutilization patterns. Implement targeted provider and member outreach, review preventive screening workflows and refine monitoring methodologies as needed to support appropriate utilization and improve performance on preventive care measures.
2nd Quarter	1. IHA 2. Breast Cancer Screening 3. Colon Cancer Screening 4. Lead Screening 5. ACE Screening 6. Mental Health Visits 7. Depression Screening	1. Under 2. Over 3. Under 4. Under 5. Under 6. 7. Over	Q2 2026 HEDIS utilization monitoring identified underutilization trends in IHA, Colon Cancer Screening, Lead Screening, and ACE Screening measures, while Breast Cancer Screening and Depression Screening demonstrated overutilization compared to the prior quarter benchmark. Variances observed during the quarter may reflect seasonal fluctuations, ongoing outreach activities, improvements in screening capture and documentation, member engagement efforts, and changes in provider performance across specific measures. Consistent with prior utilization monitoring efforts, the findings do not indicate systemic utilization concerns but highlight the importance of continued oversight, validation of reporting accuracy, and trend analysis to better understand drivers of measure performance. The QI Department continues to closely monitor utilization patterns and evaluate measure specific trends to support appropriate service utilization and quality outcomes.	Continue quarterly monitoring and analysis of HEDIS utilization trends in collaboration with QI, Provider Services, and operational teams to identify root causes of observed variances. Conduct targeted review of underutilized measures to evaluate barriers to preventive care access, member outreach effectiveness, and provider engagement opportunities. Review overutilization trends to ensure accurate documentation, coding, and reporting practices. Continue provider and member education efforts, evaluate screening and outreach workflows, and incorporate findings into ongoing quality improvement initiatives to support appropriate utilization and optimize HEDIS performance.
3rd Quarter	1. IHA 2. Breast Cancer Screening 3. Colon Cancer Screening 4. Lead Screening 5. ACE Screening 6. Mental Health Visits 7. Depression Screening			
4th Quarter	1. IHA 2. Breast Cancer Screening 3. Colon Cancer Screening 4. Lead Screening 5. ACE Screening 6. Mental Health Visits 7. Depression Screening			

2026 Evaluation (D-SNP)

Time Period	Monitored Category		Assessment	Interventions
1st Quarter	1. IHA 2. Breast Cancer Screening 3. Colon Cancer Screening 4. Lead Screening 5. ACE Screening 6. Mental Health Visits 7. Depression Screening	1. 259 2. 65 3. 29 4. 1 5. 20 6. 7. 1	Q1 2026 represents the first quarter of DSNP HEDIS utilization monitoring and serves as the baseline for future underutilization and overutilization trend analysis. Current values have been established for IHA, Breast Cancer Screening, Colon Cancer Screening, Lead Screening, ACE Screening, and Depression Screening measures. As no prior DSNP quarter data is available for comparison, no utilization concerns or trends have been identified at this time. QI Department will continue to monitor and analyze utilization patterns as additional quarterly data becomes available.	Continue quarterly monitoring of DSNP HEDIS utilization measures to establish trend data and identify future opportunities for intervention. Collaborate with QI, Provider Services, and operational teams to review emerging utilization patterns and develop targeted provider and member outreach strategies as needed. Future quarters will be compared against the Q1 2026 baseline to assess underutilization and overutilization trends and support appropriate preventive care utilization.
2nd Quarter	1. IHA 2. Breast Cancer Screening 3. Colon Cancer Screening 4. Lead Screening 5. ACE Screening 6. Mental Health Visits 7. Depression Screening	1. Over 2. Over 3. Over 4. Under 5. Under 6. 7. Under	Q2 2026 marks the first quarter of comparative DSNP HEDIS utilization analysis against the Q1 2026 baseline established at program implementation. Utilization increases were identified in IHA, Breast Cancer Screening, and Colon Cancer Screening, resulting in overutilization when compared to Q1 baseline values and suggesting increased member engagement, provider participation, and preventive care activity as the DSNP population continues to mature. Lead Screening, ACE Screening, and Depression Screening demonstrated lower utilization compared to the Q1 baseline and were identified as underutilized for the quarter. Given the relatively small and growing DSNP membership, quarter-to-quarter fluctuations are expected and may appear more pronounced than in larger Medi-Cal populations. At this time, the observed variances do not indicate systemic concerns but provide an opportunity to establish emerging utilization trends and prioritize ongoing monitoring as the DSNP program continues to expand. The QI Department will continue evaluating utilization patterns to determine whether these variances represent sustained trends or normal fluctuations associated with a newly implemented line of business.	Continue quarterly monitoring and trend analysis of DSNP HEDIS utilization measures against the established Q1 2026 baseline. Collaborate with QI, Provider Services, Care Management, and operational teams to evaluate drivers of increased preventive screening utilization and identify potential barriers contributing to lower utilization of Lead Screening, ACE Screening, and Depression Screening measures. Continue provider and member outreach efforts promoting preventive care services, validate measure reporting and data capture processes, and monitor membership growth impacts on utilization performance. As additional quarters of data become available, utilize trend analyses to develop targeted interventions that support appropriate utilization and improved quality outcomes across the DSNP population.
3rd Quarter	1. IHA 2. Breast Cancer Screening 3. Colon Cancer Screening 4. Lead Screening 5. ACE Screening 6. Mental Health Visits 7. Depression Screening			
4th Quarter	1. IHA 2. Breast Cancer Screening 3. Colon Cancer Screening 4. Lead Screening 5. ACE Screening 6. Mental Health Visits 7. Depression Screening			

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H2. Under / Over Utilization Tracking and Reporting for High-Risk Services

As part of the Auth Reduction Project, UM will monitor the over/under utilization of codes, specifically those that are on DHCS' FWA list of high-risk services as well as auto-approved codes with >5% variance from previous quarter's utilization. Over/under utilization is determined by a 5% variance from the previous quarter's values.

2026 Evaluation (Medi-Cal & IHSS)

Time Period	Monitored Category	Over or Under	Assessment	Interventions
1st Quarter	1. Hospice 2. Medically Tailored Meals 3. Housing Transition/Navigation Services 4. Housing Tenancy & Sustaining Services 5. Housing Deposits 6. Personal Care & Homemaker Services 7. Environmental Accessibility Adaptations 8. Respite Services 9. Recuperative Care 10. Short-Term Post-Hospitalization Housing 11. Sobering Centers 12. NEMT	No data available	See Interventions notes	Development of enhanced reporting and monitoring tools for high-risk services is currently underway in collaboration with Data Analytics and the Advanced Analytics teams. Reporting will support routine review of utilization trends for DHCS-designated high-risk services and auto-approved codes, including identification of overutilization and underutilization based on established variance thresholds. Once implemented, reports will be used to conduct ongoing monitoring, trend analysis and targeted investigations of identified utilization concerns, with findings shared across UM, QI, Program Integrity and operational teams as appropriate.
2nd Quarter	1. Hospice 2. Medically Tailored Meals 3. Housing Transition/Navigation Services 4. Housing Tenancy & Sustaining Services 5. Housing Deposits 6. Personal Care & Homemaker Services 7. Environmental Accessibility Adaptations 8. Respite Services 9. Recuperative Care 10. Short-Term Post-Hospitalization Housing 11. Sobering Centers 12. NEMT		Hospice: Q2 2026 hospice utilization decreased compared to Q1, with claims declining from 2,757 to 2,181 and claims per 1,000 member months decreasing from 2.13 to 1.72. Highest utilizers included Bristol Hospice, Central Coast VNA, Home Connect Hospice, Compassionate Care, and Coastal Kids Home Care. Lowest utilizers included Los Robles Healthcare, Covenant Care Hospice, Healthy Living at Home, Prime Care Hospice, and ProHealth Hospice. Overall, Q2 reflects decreased hospice utilization. Medically Tailored Meals: Q2 2026 utilization increased compared to Q1, with claims increasing from 51,112 to 53,574 and claims per 1,000 member months increasing from 39 to 42. Utilization was heavily concentrated with Project Food Box, followed by Second Harvest Food Bank, Teen Kitchen Project, and Moms Meals. Overall, Q2 reflects a modest increase in utilization with significant provider concentration. Housing Transition/Navigation: Q2 2026 utilization decreased compared to Q1, with claims declining from 11,486 to 7,795 and claims per 1,000 member months decreasing from 8 to 6. There were 4,933 requests, with a 51.8% approval rate and 14.2% denial rate. Utilization was spread across multiple providers, with Health Advocacy Team, Star Nursing, Mission Merced, and Merced County Community Services among the highest utilizers. Housing Tenancy & Sustaining Services: Q2 2026 utilization decreased compared to Q1, with claims declining from 4,402 to 2,987 and claims per 1,000 member months decreasing from 3.40 to 2.35. There were 1,267 requests, with a 46.1% approval rate and 20.7% denial rate. Utilization was concentrated among Institute on Aging, Merced County Community Services, MidPen Resident Services, and Sierra Saving Grace. Housing Deposits: Q2 2026 utilization decreased compared to Q1, with claims declining from 252 to 175 and claims per 1,000 member months decreasing from 0.19 to 0.14. There were 823 requests, with a 63.8% approval rate and 3.0% denial rate. Utilization was highest among Star Nursing, Health Advocacy Team, Mission Merced, Healthy House Within, and Merced County Community Services. Personal Care & Homemaker Services: Q2 2026 utilization increased compared to Q1, with claims increasing from 4,939 to 6,884 and claims per 1,000 members increasing from 3.82 to 5.42. Utilization remained concentrated among 24 Hour Home Care and OMATOCHI Corp, with additional volume from Accent Care of California and Mystis Adult and Family Services. Overall, Q2 reflects a notable increase in service utilization, supported by a strong authorization approval rate (83.7%) and a low denial rate (5.5%).. Environmental Accessibility: Q2 2026 utilization increased compared to Q1, with claims increasing from 1,345 to 1,568 and claims per 1,000 members increasing from 1 to 1.23. Utilization was largely concentrated with Lifeline Systems Company. Overall, Q2 reflects modest utilization growth, with an approval rate (36.0%) and denial rate (17.4%). Respite Services: Q2 2026 utilization increased compared to Q1, with claims increasing from 968 to 1,290 and claims per 1,000 members increasing from 0.75 to 1.02. Utilization was concentrated with 24 Hour Home Care, followed by Accent Care of California. Overall, Q2 reflects continued growth in service utilization, supported by a strong authorization approval rate (91.1%) and a low denial rate (1.1%). Recuperative Care: Q2 2026 utilization decreased compared to Q1, with claims declining from 473 to 394 and claims per 1,000 members decreasing from 0.37 to 0.31. Utilization was concentrated among Housing Matters, Mission Merced Incorporated, and Merced County Community providers. Overall, Q2 reflects a modest decline in service utilization, while authorization performance remained favorable, with a 90.0% approval rate and a 4.6% denial rate. Short-Term Post-Hospitalization Housing: Q2 2026 utilization declined compared to Q1, with claims decreasing from 8,838 to 5,900 and claims per 1,000 members decreasing from 6.83 to 4.65. Utilization was concentrated among Health Advocacy Team, Star Nursing, and Mission Merced Incorporated. Authorization performance remained strong, with a 90.0% approval rate and 4.6% denial rate. Sobering Centers: Q2 2026 utilization remained stable compared to Q1, with claims increasing slightly from 318 to 324 and claims per 1,000 members increasing from 0.25 to 0.26. Utilization was concentrated among Janus of Santa Cruz and Sun Street Centers. No authorization activity was recorded during the reporting period. NEMT: Q2 2026 utilization was concentrated among TLC Non-Emergency Medical Transportation (6,696 requests), Hearts & Hands of California (2,484), Freedom Medical Transport (2,105), Active Transport Medical (905), and Vida Non-Emergency Transportation (742). The lowest-utilizing servicing providers included Stanford Life Flight, Satellite Dialysis Center, Regional Emergency Medical Services, Project Food box, and My Loving Hands Non-Med Transportation, each with one request. Approval rates remained favorable among the highest-volume providers, with TLC Non-Emergency Medical Transportation (96.8%), Hearts & Hands of California (91.8%), Freedom Medical Transport (89.5%), Active Transport Medical (92.8%), and Vida Non-Emergency Transportation (93.7%), supporting continued access to transportation services through a concentrated servicing provider network.	Continue monitoring utilization, provider concentration, and authorization trends across services. Target provider education and oversight where denial rates or utilization changes warrant further review, while supporting appropriate access and referrals for underutilized services. Maintain focused monitoring of high-volume providers and NEMT utilization to support appropriate and equitable service delivery.
3rd Quarter	1. Hospice 2. Medically Tailored Meals 3. Housing Transition/Navigation Services 4. Housing Tenancy & Sustaining			
4th Quarter	1. Hospice 2. Medically Tailored Meals 3. Housing Transition/Navigation Services 4. Housing Tenancy & Sustaining			

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H2. Under / Over Utilization Tracking and Reporting for High-Risk Services (Cont.)

2026 Evaluation (D-SNP)

Time Period	Monitored Category	Over or Under	Assessment	Interventions
1st Quarter	1. Hospice 2. Medically Tailored Meals 3. Housing Transition/Navigation Services 4. Housing Tenancy & Sustaining Services 5. Housing Deposits 6. Personal Care & Homemaker Services 7. Environmental Accessibility Adaptations 8. Respite Services 9. Recuperative Care 10. Short-Term Post-Hospitalization Housing 11. Sobering Centers	No data available	See Interventions notes	Development of enhanced reporting and monitoring tools for high-risk services is currently underway in collaboration with Data Analytics and the Advanced Analytics teams. Reporting will support routine review of utilization trends for DHCS-designated high-risk services and auto-approved codes, including identification of overutilization and underutilization based on established variance thresholds. Once implemented, reports will be used to conduct ongoing monitoring, trend analysis and targeted investigations of identified utilization concerns, with findings shared across UM, QI, Program Integrity and operational teams as appropriate.
2nd Quarter	1. Hospice 2. Medically Tailored Meals 3. Housing Transition/Navigation Services 4. Housing Tenancy & Sustaining Services 5. Housing Deposits 6. Personal Care & Homemaker Services 7. Environmental Accessibility Adaptations 8. Respite Services 9. Recuperative Care 10. Short-Term Post-Hospitalization Housing 11. Sobering Centers 12. NEMT		Hospice utilization increased in Q2 2026 compared to Q1 2026, with claims increasing from 25 to 72 and claims per 1,000 member months increasing from 242 to 30.81. Provider utilization was concentrated with Choice Home Health Care, which was identified as both the highest and lowest utilizer among providers meeting the reporting threshold, possibly reflecting the limited provider population. -Medically Tailored Meals: Compared to Q1 2026, Q2 2026 claims increased from 359 to 411, while utilization per 1,000 member months decreased from 230 to 175. Provider utilization was primarily concentrated among Project Food Box, Teen Kitchen Project, Moms Meals, and Second Harvest Food Bank. Overall, Q2 reflects increased claim volume but lower utilization when adjusted for membership. Housing Transition/Navigation Services: Compared to Q1 2026, Q2 2026 utilization decreased, with claims declining from 29 to 25 and claims per 1,000 member months decreasing from 18 to 10.70. The 81.8% denial rate indicates an opportunity to evaluate referral appropriateness and denial trends. Housing Tenancy & Sustaining Services: Compared to Q1 2026, Q2 2026 Housing Tenancy and Sustaining Services utilization decreased, with claims declining from 21 to 7 and claims per 1,000 member months decreasing from 13.to 3. Q2 had a 20% approval rate and 80% denial rate. Provider-level utilization was concentrated primarily with Front Street, followed by Institute on Aging, Interim, and Encompass Community Services. Housing Deposits: Q2 2026 Housing Deposit utilization remained low but increased from Q1, with claims increasing from 0 to 3 and claims per 1,000 member months increasing from 0 to 1.28. Four authorization requests were received, with a 25% approval rate and 50% denial rate. Claims were limited to two providers, with Central Coast Center accounting for 2 claims/2 members and Sierra Saving Grace accounting for 1 claim/1 member. Personal Care & Homemaker Services: Q2 2026 utilization increased from 24 to 29 claims, while claims per 1,000 decreased from 15 to 12. Twelve requests were received with a 66.7% approval rate and no denials. Utilization was concentrated among Omatochi Corp, AccentCare, and 24 Hour Home Care. Environmental Accessibility: Q2 2026 Environmental Accessibility Adaptation utilization increased from Q1, with claims increasing from 20 to 61 and claims per 1,000 member months increasing from 12.85 to 26.10. Seven authorization requests were received, all denied. Utilization was primarily with Lifeline Systems, followed by Home Safety Services. Respite Services: Q2 2026 Respite Services utilization remained very low, with 1 claim compared to none in Q1 and a rate of 0.43 claims per 1,000 member months. Four requests were received, with a 50% approval and 25% denial rate. The single claim was associated with AccentCare of California. Recuperative Care: Q2 2026 Recuperative Care utilization decreased from Q1, with claims declining from 10 to 2 and claims per 1,000 member months decreasing from 6 to 0.86. No authorization requests were received. Utilization was associated with Housing Matters and Omatochi Corp. Short-Term Post-Hospitalization Housing: Q2 2026 Short-Term Post-Hospitalization Housing utilization increased from 23 to 28 claims, while claims per 1,000 member months decreased from 14 to 11. No authorization requests were reported. Utilization was spread across multiple providers, with United Way of Merced, Central Coast Center, Front Street, and Pacific Health Group having the highest claim volumes. Sobering Centers: Q2 2026, unchanged from Q1 2026. There were no authorization requests, claims, or paid utilization in either quarter, indicating continued non-utilization of this service. NEMT: NEMT Assessment: Overall utilization remained low. Among servicing providers, Dobbins Transportation and Hearts & Hands were the highest utilizers with 3 requests each and 100% approval; Freedom Medical Transportation was the lowest at 2 requests with a 50% approval rate. Among referring sources, member self-request was the highest utilizer with 7 requests, all approved, while facility referrals remained low at 1 request each. No significant utilization concerns identified.	Continue monitoring utilization, provider concentration, approval/denial trends, and access across services. Provide targeted provider education for benefits with higher denial rates, strengthen awareness and appropriate referrals for underutilized services, and continue oversight of emerging utilization trends to support appropriate use of services.
3rd Quarter	1. Hospice 2. Medically Tailored Meals 3. Housing Transition/Navigation Services 4. Housing Tenancy & Sustaining Services 5. Housing Deposits 6. Personal Care & Homemaker Services 7. Environmental Accessibility Adaptations			
4th Quarter	1. Hospice 2. Medically Tailored Meals 3. Housing Transition/Navigation Services 4. Housing Tenancy & Sustaining Services 5. Housing Deposits 6. Personal Care & Homemaker Services			

I. OVER/UNDER Utilization Review: This report monitors the most frequently overutilized and underutilized and auto approved procedure codes, along with their associated service and benefit types. The purpose is to identify patterns that may indicate services being provided more or less frequently than appropriate and to support ongoing assessment and targeted interventions where needed.

Time Period	Top 5 Over	Top 5 Under	Service / Benefit Type	Medi-Cal & IHSS Top 5 Auto Approved/NTR Codes	Assessment
1st Quarter	1. 72,424 - G9012 OTHERSPECIFIEDCASE 2. 72,023 - 99213 OFFICEOROTHER OUTPATIENT 3. 58,096 - 99214 OFFICEOROTHER OUTPATIENTVISIT 4. 27,528 - Z7610 MISCELLANEOUS DRUGSANDMEDICAL SUPPLIES 5. 25,969 - 85025 BLOODCOUNT; COMPLETE	1. 2 - Electromyography(95885-95887 2. 2 - NerveConductionTests(95905-95913) 3. 1 - Respiratory Supplies(A7000-A7049) 4. No Data 5. No Data	1. Misc. Non Benefit codes (supplies, pdn) 2.Nerve Conduction tests 3. Constant Attendance 4. Dressings 5. Supervised	1. 410 - (T1000-T5999) 2. 316 - NerveConductionTests(95905-95913) 3. 235 - Constant Attendance(97032-97039) 4. 216 - Dressings(A6000-A6412) 5. 171 - Supervised(97010-97028)	Q1 2026 utilization patterns remain generally consistent with trends identified in 2024 and 2025. High-volume utilization continues to be driven by case management, outpatient evaluation and management visits, laboratory services, and miscellaneous supplies, reflecting ongoing member engagement with care management and routine healthcare services. Underutilized and auto-approved/NTR code categories continue to be dominated by non-benefit supply codes, dressings, nerve conduction studies, constant attendance and supervised modalities, consistent with historical trends. No new overutilization concerns were identified during the quarter, however, ongoing monitoring is warranted as ECM/CS services and other high-volume benefit categories continue to mature and utilization patterns evolve.
2nd Quarter	1. 43,522 - G9012 OTHERSPECIFIEDCASE 2. 20,840 - 80053 COMPREHENSIVE 3. 20,208 - 3074F MOST RECENT SYSTOLIC 4. 19,598 - 3078F MOST RECENT SYSTOLIC 5. 15,395 - 90837 PSYCHOTHERAPY	1. 2. 3. 4. 5.	1. Misc. Non Benefit codes (supplies, pdn) 2. Dressings 3. Nerve Conduction tests 4. Constant Attendance 5. Supervised	1. 732 - (T1000-T5999) 2. 481 - Dressings(A6000-A6412) 3. 322 - NerveConductionTests(95905-95913) 4. 209 - Constant Attendance(97032-97039) 5. 199 - Supervised(97010-97028)	Q2 2026 utilization patterns remained generally consistent with historical trends and Q1 findings. High-volume utilization continued to be driven by case management services (G9012), laboratory testing (80053), quality reporting measures related to blood pressure control (3074F, 3078F), and behavioral health services (90837 Psychotherapy), reflecting ongoing member engagement in care management, preventive care, chronic disease management, and mental health treatment. Compared to Q1, the emergence of quality measure reporting codes and psychotherapy services among the top utilized codes may indicate increased focus on preventive care monitoring and behavioral health service utilization. Auto-approved/NTR categories continued to be dominated by miscellaneous non-benefit codes, dressings, nerve conduction studies, constant attendance, and supervised modalities, consistent with prior reporting periods. No significant overutilization concerns were identified; however, ongoing monitoring remains warranted to evaluate evolving utilization patterns, particularly as ECM, Community Supports, behavioral health services, and quality improvement initiatives continue to mature. Plan: Continue quarterly monitoring and trend analysis of overutilized, underutilized, and auto-approved/NTR procedure codes to identify emerging utilization patterns and potential opportunities for intervention. Collaborate with QI, CM, AG and other teams to review utilization drivers associated with high-volume service categories, including case management, behavioral health, and preventive care services. Continue evaluating auto-approved/NTR categories to ensure appropriate utilization and alignment with benefit coverage and authorization requirements. Incorporate findings into the UM Authorization Transformation Project to support data-driven workflow improvements, enhance reporting capabilities, and promote appropriate utilization across all lines of business.
3rd Quarter	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.	
4th Quarter	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.	

DSNP

Time Period	Top 5 Over	Top 5 Under	Service / Benefit Type	D-SNP Top 5 Auto	Assessment
1st Quarter	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.	1. Electromyography 2. NerveConductionTest 3. Respiratory Supplies 4. 5.	1. 2 - (95885-95887) 2. 2 - (95905-95913) 3. 1 - (A7000-A7049) 4. 5.	Q1 2026 represents the baseline reporting period following DSNP implementation on 1/1/26; therefore, sufficient historical data is not yet available to identify overutilization or underutilization trends. Initial utilization patterns show limited auto-approved/NTR activity, primarily involving Electromyography, Nerve Conduction Tests, and Respiratory Supplies, which is generally consistent with low-volume underutilized categories observed within the Medi-Cal population. No utilization concerns were identified during this initial reporting period. Continued interventions include ongoing monitoring of authorization and utilization patterns, establishment of DSNP-specific utilization benchmarks, comparison of emerging trends against Medi-Cal experience where appropriate and review of service categories to identify potential opportunities for provider education, benefit optimization or utilization management as membership and service volume mature.
2nd Quarter	1. (379) - 99214 OFFICE OR OTHER OUTPATIENT VISIT 2. (284) - 99213 OFFICE OR OTHER OUTPATIENT VISIT 3. (217) - T1019 PERSONAL CARE SERVICES 4. (171) - A4657 SYRINGE 5. (167) - 85025 BLOOD COUNT	1. 2. 3. 4. 5.	1. Cardiac Catheterization 2. Not Valid for Medicare 3. Electromyography 4. Nerve Conduction Tests 5. Supervise	1. 3 - (93451 - 93598) 2. 2 - (T1000 - T5999) 3. 1 - (95885 - 95887) 4. 1 - (95905 - 95913) 5. 1 - (97010 - 97028)	Q2 2026 represents the first quarter in which meaningful DSNP utilization trends can be evaluated following implementation of the DSNP line of business on January 1, 2026. Utilization was primarily driven by routine outpatient evaluation and management visits (99214, 99213), personal care services (T1019), laboratory services (85025), and medical supplies (A4657), reflecting expected utilization patterns for a growing DSNP population with complex medical and care coordination needs. No significant overutilization or underutilization concerns were identified during the quarter. Auto-approved/NTR activity remained low, with limited utilization involving Cardiac Catheterization, Electromyography, Nerve Conduction Tests, and other specialty services. Overall utilization patterns appear appropriate and consistent with early program maturation, increasing member engagement, and standard healthcare service utilization. Continued monitoring will be necessary as membership and authorization volumes increase to determine whether emerging trends warrant targeted interventions or utilization management activities. Plan: Continue quarterly monitoring and trending of DSNP utilization patterns to establish reliable benchmarks and identify emerging overutilization or underutilization concerns as the line of business matures. Compare DSNP utilization trends with Medi-Cal experience where appropriate to identify potential differences in service utilization, access, or member needs. Collaborate with QI, Care Management, Provider Services, and UM teams to evaluate high-volume service categories and ensure appropriate utilization of outpatient, personal care, laboratory, and specialty services. Continue monitoring auto-approved/NTR categories for trend development and incorporate findings into ongoing DSNP operational reviews, provider education initiatives, and UM Authorization Transformation Project efforts to support appropriate utilization and efficient service delivery.
3rd Quarter	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.	
4th Quarter	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.	

Back to Agenda

I. Projects and Initiatives

Pharmacist-Led Academic Detailing (PLAD) Program

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

Time Period	# Providers	# Sessions	Comments
1st Quarter	0	0	Presented 2025 results in QIHEW and shared challenges from the year. Discussed ideas for improving provider outreaches by collaborating with QI teams.
2nd Quarter	0	0	Started a new provider outreach process in collaboration with QI team for improved efficiency. Scheduling sessions for interested clinics in Q3.
3rd Quarter			
4th Quarter			
Year End			

Naloxone Distribution Program

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

Time Period	Total # Distributed	# Distributed (Merced, Mariposa)	# Reversals Reported (Lives Saved)	Comments
1st Quarter	17	16	0	Highest number of kits distributed from Merced office.
2nd Quarter	15	11	0	A large number of kits expired in April. DHCS advised following local protocols for safe medication disposal. Pharmacy team made outreach to local law enforcement and were directed to a local pharmacy. The pharmacy confirmed they can accommodate large number of kits for disposal. Given small # distributed each quarter, will reduce the amount of kits to keep at each office.
3rd Quarter				
4th Quarter				
Year End				

Operational Performance

Pharmacy Prior Authorization Timeliness Report

Percent of Pharmacy prior authorizations completed timely.

Medi-Cal and IHSS			
Time Period	**Results (%)**	**Assessment**	**Interventions**
1st Quarter	95.7%	Compliance rate continues to be above 95% threshold despite 13% increase in PA volume from previous quarter. Pharmacy no longer allowing Medi-Cal PA requests to be deferred as of 1/1/2026.	Daily timeliness reporting on open authorizations continue to be sent to Pharmacy team 3 times a day. Pharmacy technicians continue to work late Friday shifts. Saturday technician shifts started 1/1/2026 as well as technicians and Pharmacists covering holidays. Reminders in weekly meeting of workflow and workflow changes continue.
2nd Quarter	96.1%	Compliance rate remains above threshold. Authorization volume remains similar to previous quarter (1.4% decrease).	Frequent reporting continues to monitor timeliness. Recruitment for temporary technician in Q3 to cover leave of absence.
3rd Quarter			
4th Quarter			
Year End			

Operational Performance (Cont.)

D-SNP

Time Period	Results (%)	Assessment	Interventions
1st Quarter	72.3%	47 DSNP Part B authorizations received in Q1. Most non-timely authorizations were due to delay in member notifications with the mailing vendor, as well as the Alliance not receiving Part B auth request forwarded from PBM in time for review.	Weekend and holiday coverage began on 1/1/2026. Workflows established with HS Admin for DSNP letter printing and mailing during weekends and holidays when mailing vendor is unavailable. PBM alerted to non-compliance of sending Part B requests to the Alliance in timely fashion and issue appears to be resolved. Will continue to monitor.
2nd Quarter	75.6%	Slightly improved PA timeliness for pre-service Part B requests. Majority of PAs that were not timely were urgent PAs (7/10). Timely mailing continued to be an area of concern in Q2, as the process with mailing vendor cannot meet the 24-hour turnaround time for urgent Part B drug requests.	Discussions on implementing a verbal notification process and internal mailing by Facilities to meet timeliness for urgent prior authorization requests. The Alliance continues to monitor and coach PBM on timely Part B PA notification to the Alliance.
3rd Quarter			New internal Facilities mailing process established to cover gaps in printing vendor availability (as of 7/3/26 holiday) and to meet urgent PA timeliness. Verbal notification process started as of 8/5/26. CGM and enteral nutrition are now categorized under DME benefit and not as Part B drugs.
4th Quarter			
Year End			

Pharmacy Prior Authorization Request Determination Metrics

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

Medi-Cal and IHSS

Time Period	# Auth Volume	# Denials or Modified	# Appeals	# Upheld	# Overturned	#SFH	Assessment	Interventions
1st Quarter	2181	68	0	0	0	0	13% increase in auth volume from previous quarter. Denial rate remains low at 3%. Pharmacists no longer defer Medi-Cal requests as of 1/1/2026.	Pharmacists and technicians reaching out to providers to obtain missing information within 24 hours as we no longer defer for Medi-Cal LOB. Will continue to monitor.
2nd Quarter	2150	45	2	1	1	1	Denial rate remains low at 2.1%. Decrease in denial rate as well as overall volume by 1%. 1 SFH filed regarding Medi-Cal Rx denial of Physician-Administered Drug but likely will not be scheduled until Q3.	Will continue to monitor for any changes in PA volume and denial rate.
3rd Quarter								
4th Quarter								
Year End							(2025 avg: 1942 PAs, total 7768 PAs, 3.2% denial rate)	

D-SNP

Time Period	# Auth Volume	# Denials or Modified	# Appeals	# Upheld	# Overturned	Assessment	Interventions
1st Quarter	47	3	3	1	2	6% denial rate. All Part B denials and appeals for CGM devices.	CGM PAs are reviewed based on criteria defined in Local Coverage Determination (LCD).
2nd Quarter	43	2	1	0	1	Decrease in denial rate at 4.7%. Denials for CGM device and nutritional supplement.	Workflow update in Q3 (7/20/26) for CGM and nutritional supplement review to follow UM procedure as DME benefit. Will continue to monitor.
3rd Quarter							
4th Quarter							
Year End							

Top 5 Denied Physician-Administered Drugs

List of top 5 Pharmacy prior authorization denials, by volume. Includes Medi-Cal, IHSS, D-SNP LOB.

Time Period	List of Drugs	Assessment	Interventions
1st Quarter	1. Aflibercept-Ayyh (Pavblu) 2. Onabotulinumtoxina 3. Faricimab-Sova 4. Aflibercept, Hyaluronan (Hyalgan, Supartz, or Visco-3)	Top denied PADs remain similar to previous quarter.	PA criteria for aflibercept, aflibercept--ayyh, faricimab, and onabotulinumtoxina will be reviewed in Q2 Pharmacy & Therapeutics (P&T) Committee.
2nd Quarter	1. Aflibercept-Ayyh (Pavblu) 2. Inclisiran 3. Hyaluronan (Supartz or Visco-3) 4. Hyaluronan (Monovisc) 5. Aflibercept HD, Onabotulinumtoxina, Capsaicin patch	Top denied PADs remain similar to previous quarter.	Aflibercept--ayyh, aflibercept HD, and onabotulinumtoxina PA criteria reviewed in Q2 P&T Committee. Hyaluronic acid and capsaicin patch criteria to be reviewed in Q3. Will monitor inclisiran PA requests.
3rd Quarter			
4th Quarter			
Year End			

Written Notification of Pharmacy NOAs to Members & Providers

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

Medi-Cal and IHSS			
Time Period	**Results (%)**	**Assessment**	**Interventions**
1st Quarter	100%	Sample of Pharmacy Medi-Cal and IHSS NOAs reviewed. 100% passed for readability, all letters were free of technical terms or technical terms were defined. All letters included NDN, Member Rights, and taglines. All letters clearly stated what guideline or criteria was used in decision.	Will continue to monitor
2nd Quarter	100%	Sample of Pharmacy Medi-Cal and IHSS NOAs reviewed. 100% passed for readability, all letters were free of technical terms or technical terms were defined. All letters included NDN, Member Rights, and taglines. All letters clearly stated what guideline or criteria was used in decision.	Will continue to monitor
3rd Quarter			
4th Quarter			
Year End			

D-SNP			
Time Period	**Results (%)**	**Assessment**	**Interventions**
1st Quarter	100%	Sample of Pharmacy DSNP NOAs reviewed. 100% passed for readability. All letters were free of technical terms or technical terms were defined. Letters included taglines, member rights, and appeal forms. Letters all included guidelines used in determination.	Will continue to monitor
2nd Quarter	100%	Sample of Pharmacy DSNP NOAs reviewed. 100% passed for readability. All letters were free of technical terms or technical terms were defined. Letters included taglines, member rights, and appeal forms. Letters all included guidelines used in determination.	Will continue to monitor
3rd Quarter			
4th Quarter			
Year End			

Inter-rater Reliability Review – Pharmacists

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

2026 Evaluation	Goal	Results	Comments	Recommendation for Future
Q4 Yearly	**100%**			

Utilization Performance

Drug Utilization Review (DUR) Program

Summary of interventions performed based on DUR analyses.

Time Period	List of DURs	Comments	Interventions
1st Quarter	1. High-dose opioids (>90MME daily)	Evaluated prescribing trends, dose changes, and naloxone utilization.	1. Outreach to 5 pediatric otolaryngology providers to encourage naloxone co-prescribing 2. Outreach to 4 PCPs whose members received high-dose opioids from≥5 prescribers, encouraging CURES review, care coordination, and naloxone co-prescribing.
2nd Quarter	1. Naloxone & buprenorphine in members at high risk	Analyzed buprenorphine and naloxone utilization following opioid poisoning-related ED and hospitalization in Q1–Q2 2026. Evaluated utilization by demographic factors to identify treatment disparities. Assessed prescribing patterns to identify access gaps and guide targeted interventions.	1. Planning fax-based outreach to PCPs encouraging care coordination after discharge. Pharmacy education only: 1. San Benito County Health Pharmacist Best Practices Guide distributed to 41 independent pharmacies. One-page best practices guide on discussing opioids, overdose prevention, and naloxone with patients.
3rd Quarter			
4th Quarter			
Year End			

MedImpact Delegate Oversight

MedImpact Pharmacy File Audit

Review occurring every quarter that looks at previous quarter MedImpact work. For review, 5 files are randomly selected. Non-compliance with any of the elements require follow up analysis and correction by the vendor. Categories for review include: timeliness of decisions and notifications, appropriate practitioner review of denials, relevant information used for decisions, appeal rights communications to member, content of notifications to member and provider, in easily understandable language.

IHSS			
Time Period	**% Compliance**	**Assessment**	**Follow-up Actions**
1st Quarter	100%	100% MedImpact auths reviewed passed for timeliness, clinical review, provider/member notifications, and readability. Letters contained correct addenda and reason for determination (guideline name).	Will continue to monitor
2nd Quarter	100%	100% MedImpact auths reviewed passed for timeliness, clinical review, provider/member notifications, and readability. Letters contained correct addenda and reason for determination (guideline name).	Will continue to monitor
3rd Quarter			
4th Quarter			

D-SNP			
Time Period	**% Compliance**	**Assessment**	**Follow-up Actions**
1st Quarter	100%	100% MedImpact auths reviewed passed for timeliness, clinical review, provider/member notifications, and readability. Letters contained correct addenda and reason for determination (guideline name).	Following up with MedImpact on their PA process when providers request a withdrawal.
2nd Quarter	100%	100% MedImpact auths reviewed passed for timeliness, clinical review, provider/member notifications, and readability. Letters contained correct addenda and reason for determination (guideline name).	MedImpact provided coaching to staff for a Q1 PA that should have been dismissed, as the request was withdrawn by provider. Will continue to monitor.
3rd Quarter			
4th Quarter			

MedImpact Per Member Per Month (PMPM) Cost

Line of Business	2025	2026 Q1	2026 Q2	2026 Q3	2026 Q4	2026 YTD	Change from 2025
IHSS	$359.95	$308.34	$277.74			$293.04	-18.6%
D-SNP	N/A	$530.60	$576.41			$553.51	N/A

MedImpact -Prior Authorization Request Determination Metrics

Monitoring of Pharmacy prior authorization volume and appeals (denial upheld/overturned).

IHSS						
Time Period	**# Auth Volume**	**# Denial or Partial Approval**	**# Appeals**	**# Upheld**	**# Overturned**	**Assessment**
1st Quarter	47	5	2	0	2	5 denials for clinical necessity. Denial rate slightly lower than previous quarter (10.6 vs 13.2%). 5 PA not required, 3 closed (2 re-routed to appeal, 1 duplicate).
2nd Quarter	58	17	3	3	0	Increase in PA volume by 23%. Denial rate at 27.6%, an increase over 10% from previous quarter (10.6%). 16 denials and 1 partial approval: 16 reviewed for clinical necessity, 1 administrative. Half of denials were for GLP-1. 3 PA not required, 1 dismissed (OTC exclusion), 1 closed (merged with duplicate PA). Reminded MedImpact to deny for exclusions instead of dismissing PA. Appeal rate at 17.6%.
3rd Quarter						
4th Quarter						
Year End						(2025 avg: 46 PAs, total 184 PAs,19.6% denial rate)

MedImpact Delegate Oversight (cont.)

D-SNP						
Time Period	**# Auth Volume**	**# Denial or Partial Approval**	**# Appeals**	**# Upheld**	**# Overturned**	**Assessment**
1st Quarter	132	42	19	5	14	Denial includes 41 denial and 1 partial approval. 29 denials for clinical necessity, 13 administrative denials (4 exclusions). 1 dismissed to use brand, 6 PA not required, 12 closed (10 Part B PA routed to Alliance, 1 re-routed to appeal, 1 duplicate). Will continue to monitor.
2nd Quarter	149	54	18	7	11	Increase in PA volume by 12%, denial rate at 33.6%, a slight increase by 1%. 50 denials and 4 partial approvals: 32 reviewed for clinical necessity, 22 administrative. 5 PA not required, 3 dismissed, 2 withdrawn requests, 11 closed (re-routed to appeal or to Alliance for Part B review). Appeal rate at 12.1% and overturn rate at 61.1%.
3rd Quarter						
4th Quarter						
Year End						

DATE: October 28, 2026

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

FROM: Jessica Finney, Community Grants Director

SUBJECT: Medi-Cal Capacity Grant Program Mid-Year Report

Summary. This report is informational only. To ensure transparency and keep the Board informed, staff provide biannual Medi-Cal Capacity Grant Program (MCGP) reporting in the Board packet of all grantmaking activities per the Board-approved annual investment plan. This mid-year report summarizes MCGP activities and includes a summary list of 2026 MCGP awards to date.

Background. The Alliance established the MCGP in July 2015 in response to the rapid expansion of the Medi-Cal population as a result of the Affordable Care Act. Through investment of a portion of the Alliance's reserves, the MCGP provides grants to local health care and community organizations in the Alliance's service area to increase the availability, quality and access of health care and supportive services for Medi-Cal members and to address social drivers that influence health and wellness in our communities. Since 2015, the Alliance has awarded over 1,200 grants totaling over $248M to 285 organizations in the Alliance's service area.

MCGP Governance and Funding Allocations. Through an annual planning process, the Board provides input on community needs and grantmaking priorities in the Alliance's service area and makes funding allocations for Board-directed strategies. The Board directs staff to manage program-level implementation and budgets based on allocated funding. In January 2026, the Board approved the 2026 MCGP Investment Plan with a $20M total award target allocated across three strategies: Healthcare Workforce (50%, $10M), Health Care System Infrastructure, including support for safety net capacity (30%, $6M), and Community Resources, Engagement & Empowerment (20%, $4M). 2026 is the first year under the single service-area budget the Board approved in June 2025 which replaced county-specific budgets. This change supports investing more significantly where need is highest while ensuring a minimum investment in each county. In June 2026, following the Specialty Access Ad Hoc Committee's recommendations, the Board directed a dedicated $20M specialist recruitment allocation over two years (2027 and 2028).

Grant Awards Year to Date. Between January and September 2026, 111 grants totaling $13,128,918 were awarded to 72 organizations, or 66% of the $20M 2026 award target. Awards were made through two of three regular 2026 funding rounds (April and July), a rapid Medi-Cal Member Outreach and Retention (MOR) funding round (April) and targeted off-cycle awards. As of October, the MCGP has paid out $25M in 2026 for active grants, compared to $28.5M in all of 2025.

By county, awards to date total $5,090,963 in Merced (44 grants), $4,673,450 in Monterey (37), $2,012,480 in Santa Cruz (18), $712,025 in Mariposa (7) and $640,000 in San Benito (5). In the first year of the single service-area budget, all five counties have received awards, and Merced County accounts for the largest share (39%), including seven of nine care gap closure grants.

Equity Methodology. In June 2025, the Board adopted an equity grantmaking methodology to guide award decisions under the new single service-area budget. The methodology weights Medi-Cal membership, MCAS measures below the minimum performance level and Healthy Places Index scores, and it sets a minimum investment for each county. It provides general guidance rather than fixed county amounts, because awards depend on the applications received in each round. Through September (before Round 3 and Safety Net Critical Access awards are made), Merced, Monterey and Santa Cruz counties have received 76% to 86% of their methodology targets to date. Mariposa and San Benito counties have received 20% and 28% respectively. The total number of applications from these two counties is significantly lower. This reflects the risk identified when adopting the methodology that smaller counties with limited organizational capacity may submit fewer applications and would require more outreach and application support. An update with end of year figures will be included in the MCGP Annual Impact Report in January 2027.

2026 Highlights. Three themes stand out in 2026 grantmaking to date: a rapid response to Medi-Cal coverage changes, continued investment in recruiting providers, and a shift toward fewer, more targeted programs. Round 1 was the final round for four programs that are now retired: Doula Recruitment, Medical Assistant Recruitment, Parent Education and Support, and Community Health Champions.

Medi-Cal Member Outreach and Retention (MOR): Launched in March as a rapid, off-cycle funding round, MOR received 92 applications requesting approximately $15.5M. In April, the Alliance awarded $3.2M to 23 community partners across all five counties (nine Tier 1 outreach and education grants and 14 Tier 2 renewal assistance grants) and funded UC Merced to develop an online renewal assistance training. More than 90% of MOR funding supports hands-on renewal assistance. A Medi-Cal Renewal Events Pilot ($105,000 to five primary care providers) launched October 3 with renewal events outside regular business hours; early turnout has been limited, and outreach is building awareness. Staff convened MOR grantees October 19–22 to reinforce outreach and renewal assistance interventions and inform 2027 priorities. Merced County has also proposed that the Alliance administer up to $2M in County Medi-Cal Administrative Activities funding to expand MOR outreach (consent item at the October 28, 2026 meeting).

Healthcare workforce: 32 Provider Recruitment grants ($5.6M) support recruitment of 14 primary care providers, 16 specialty, dental and therapy providers (including cardiology, pulmonology, sleep medicine, radiology, podiatry, optometry and pediatric dentistry) and two behavioral health providers. Nine Workforce Support for Care Gap Closure grants ($1.1M), seven in Merced County, help clinics add existing staff hours or locum tenens providers to close quality measure care gaps through the end of 2026.

Community health workers (CHWs): Six CHW Recruitment grants ($384,227) and the first CHW Capacity Building grant ($250,000) to the County of Monterey Health Department's

Office of Equity, which will establish a CHW Hub that serves as the Medi-Cal supervising provider for local community-based organizations.

Healthcare technology: 18 Healthcare Technology grants ($776,041, up to $50,000 each) fund equipment and technology upgrades that expand access to care, improve quality through enhanced diagnostic and treatment capabilities, strengthen care coordination, and increase provider efficiency.

Safety Net Critical Access: The one-time Safety Net Critical Access program will help stabilize essential safety net providers facing financial challenges to maintain member access to primary, specialty and hospital services. Its launch was delayed to accommodate competing grant program implementation priorities and to allow time to assess new information and respond to new information. Invitations to apply were issued October 15, and awards are anticipated by November 30, 2026.

Housing Fund: The one-time $40M Alliance Housing Fund, launched in 2024 and blending MCGP and DHCS Housing and Homelessness Incentive Program funding, has reached 17% completion of the 494 housing and recuperative care units expected for Medi-Cal members.

Current Funding Cycle. Applications for the third and final 2026 round of ongoing programs (Provider Recruitment, CHW Recruitment and Healthcare Technology) closed August 18, with 43 eligible applications from 29 organizations. Award decisions will be distributed October 30, 2026. The Safety Net Critical Access program, the largest planned investment under this strategy, was delayed and will be awarded in November 2026 (see Current Funding Cycle). Safety Net Critical Access applications are due November 10, with awards anticipated November 30, 2026. These awards will be shared with the Board in January 2027 as part of the end-of-year 2026 MCGP Impact Report, which will also include a report of remaining funds available in the MCGP budget.

Annual Planning Activities. The Alliance submitted its initial Community Reinvestment Plan to the Department of Health Care Services (DHCS) by the October 15, 2026 deadline, with approval anticipated in December. In July, DHCS reduced the Alliance's calendar year 2024 obligation from $5M to $4.6M. Prior MCGP investments fully satisfy Monterey County's obligation, leaving approximately $1.4M to invest in Merced ($892,517) and Santa Cruz ($520,175) counties. These investments will be incorporated into 2027 MCGP grantmaking and expended during the 2027–2029 Community Reinvestment period.

At the October 28, 2026 meeting, the Board will discuss inputs and emerging priorities for the 2027 MCGP Investment Plan. Staff will return with a recommended 2027 MCGP Investment Plan for Board action on January 27, 2027.

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

Attachments.

1. MCGP Awards January – September 2026
   - Summaries by County and Program; Grant Awards List

Medi-Cal Capacity Grant Program Summary of Grant Awards | Year To Date | January–September 2026		
County	**Program**	**Total**
Mariposa	Doula Recruitment	$65,000
	Healthcare Technology	$100,000
	MOR Tier 1: Medi-Cal Outreach and Education	$25,000
	MOR Tier 2: Medi-Cal Renewal Assistance	$122,100
	Provider Recruitment	$250,000
	Workforce Support for Caregap Closures	$149,925
	Mariposa Total	**$712,025**
Merced	Community Health Champions	$499,205
	Community Health Worker Recruitment	$124,227
	Doula Recruitment	$130,000
	Healthcare Technology	$259,136
	MOR Medi-Cal Renewal Events Pilot	$21,000
	MOR Tier 1: Medi-Cal Outreach and Education	$150,000
	MOR Tier 2: Medi-Cal Renewal Assistance	$725,382
	Medical Assistant Recruitment	$213,060
	Parent Education and Support	$250,000
	Provider Recruitment	$1,834,570
	Workforce Support for Caregap Closures	$884,383
	Merced Total	**$5,090,963**
Monterey	Community Health Worker Capacity Building	$250,000
	Community Health Worker Recruitment	$195,000
	Healthcare Technology	$269,216
	MOR Medi-Cal Renewal Events Pilot	$42,000
	MOR Tier 1: Medi-Cal Outreach and Education	$50,000
	MOR Tier 2: Medi-Cal Renewal Assistance	$1,146,502
	Medical Assistant Recruitment	$119,914
	Provider Recruitment	$2,560,690
	Workforce Support for Caregap Closures	$40,128
	Monterey Total	**$4,673,450**
San Benito	Community Health Worker Recruitment	$65,000
	Healthcare Technology	$50,000
	MOR Tier 1: Medi-Cal Outreach and Education	$25,000
	MOR Tier 2: Medi-Cal Renewal Assistance	$250,000
	Provider Recruitment	$250,000
	San Benito Total	**$640,000**
Santa Cruz	CHA/CHIP Support	$50,000
	Doula Recruitment	$65,000
	Healthcare Technology	$97,689
	MOR Medi-Cal Renewal Events Pilot	$42,000
	MOR Tier 1: Medi-Cal Outreach and Education	$50,000
	MOR Tier 2: Medi-Cal Renewal Assistance	$700,497
	Medical Assistant Recruitment	$65,000
	Parent Education and Support	$250,000
	Provider Recruitment	$692,294
	Santa Cruz Total	**$2,012,480**
Award Total To Date		**$13,128,918**

Medi-Cal Capacity Grant Program Summary of Grant Awards | Year To Date January–September 2026	
Program	**Total**
CHA/CHIP Support	$50,000
Community Health Champions	$499,205
Community Health Worker Capacity Building	$250,000
Community Health Worker Recruitment	$384,227
Doula Recruitment	$260,000
Healthcare Technology	$776,041
MOR Medi-Cal Renewal Events Pilot	$105,000
MOR Tier 1: Medi-Cal Outreach and Education	$300,000
MOR Tier 2: Medi-Cal Renewal Assistance	$2,944,481
Medical Assistant Recruitment	$397,974
Parent Education and Support	$500,000
Provider Recruitment	$5,587,554
Workforce Support for Caregap Closures	$1,074,436
Award Total To Date	**$13,128,918**

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County	Organization Name	Funding Opportunity	Grant Description	Award Amount	Date Awarded
Mariposa	John C. Fremont Healthcare District	Healthcare Technology	John C. Fremont Healthcare District will implement TruBridge Application Managed Services to optimize electronic health record (EHR) performance and improve data exchange for Medi-Cal members in Mariposa and Merced counties. The project will enhance clinical workflows, strengthen interoperability with external providers, and improve accuracy of patient care reporting, supporting more coordinated and efficient care delivery in a rural setting.	$50,000	4/3/2026
Mariposa	John C. Fremont Healthcare District	Workforce Support for Caregap Closures	To support the hiring of locum tenens providers and/or to allocate additional hours for existing staff to augment clinic hours and/or days to assist with closing the remaining Managed Care Accountability Sets (MCAS) care gaps through the end of 2026.	$149,925	2/20/2026
Mariposa	Mariposa County Health and Human Services Agency	MOR Tier 1: Medi-Cal Outreach and Education	To support community-based efforts to keep Alliance Medi-Cal members enrolled in Medi-Cal by funding linguisitcally and culturally responsive outreach and education activities.	$25,000	4/17/2026
Mariposa	Mariposa Safe Families, Inc.	MOR Tier 2: Medi-Cal Renewal Assistance	To support community-based efforts to keep Alliance Medi-Cal members enrolled in Medi-Cal by funding linguisitcally and culturally responsive education and direct, hands-on assistance to Alliance members to complete the Medi-Cal renewal (redetermination) process.	$122,100	4/17/2026
Mariposa	Radiologica	Healthcare Technology	The HT project implements Merge software and Merge PACS, a clinical data management tool and imaging archiving system, to streamline access to patient medical histories, lab results, and imaging. This upgrade reduces errors, improves communication, and decreases patient wait times. The project aims to improve access to care and operational efficiency for approximately 8,944 individuals, including 2,951 Medi-Cal members, by improving patient outcomes through quicker decision-making and reduced turnaround times.	$50,000	7/17/2026
Mariposa	Radiologica	Provider Recruitment	Recruitment of one Radiologist	$250,000	7/17/2026
Mariposa	Sierra Natural Birth Center	Doula Recruitment	Recruitment of one Doula.	$65,000	4/3/2026
Merced	ACE Overcomers of Merced County	Community Health Champions	ACE Overcomers will implement the Merced County Health Champions Program, a two-year initiative to recruit and train 30 Health Champions—including youth, adult Medi-Cal members, and community gatekeepers—to deliver bilingual (English/Spanish) health education and navigation support in Merced County. Champions will lead workshops and outreach on Medi-Cal benefits, CalAIM navigation, preventive health, social drivers of health, and behavioral health/SUD destigmatization, while providing warm referrals to services. The program includes stipends, transportation support, and participant-led outreach projects, with a goal of reaching at least 400 Medi-Cal members and increasing confidence in navigating health and social services.	$249,205	4/3/2026
Merced	ACE Overcomers of Merced County	MOR Tier 2: Medi-Cal Renewal Assistance	To support community-based efforts to keep Alliance Medi-Cal members enrolled in Medi-Cal by funding linguisitcally and culturally responsive education and direct, hands-on assistance to Alliance members to complete the Medi-Cal renewal (redetermination) process.	$225,382	4/17/2026
Merced	Apex Annex Health Center, Inc.	Healthcare Technology	Apex Annex Health Center will acquire vaccine refrigerators to improve vaccine storage, handling, and compliance with VFC guidelines for Medi-Cal members in Los Banos, Dos Palos, and Gustine. The project will support proper temperature monitoring, enhance immunization quality, and ensure safe and effective vaccine delivery for over 4,870 Medi-Cal members.	$4,616	4/3/2026
Merced	Apex Annex Health Center, Inc.	Medical Assistant Recruitment	Recruitment of one Medical Assistant.	$41,810	4/3/2026
Merced	Apex Annex Health Center, Inc.	Provider Recruitment	Recruitment of one Podiatrist	$138,819	4/3/2026

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County	Organization Name	Funding Opportunity	Grant Description	Award Amount	Date Awarded
Merced	Apex Medical Group	Medical Assistant Recruitment	Recruitment of one Medical Assistant.	$50,000	4/3/2026
Merced	Apex Medical Group	Provider Recruitment	Recruitment of one Non-Physician Medical Practitioner (NPMP)	$136,214	4/3/2026
Merced	Apex Medical Group	Provider Recruitment	Recruitment of one Internal Medicine Physician	$217,555	7/17/2026
Merced	Apex Medical Group	Workforce Support for Caregap Closures	To support the hiring of locum tenens providers and/or to allocate additional hours for existing staff to augment clinic hours and/or days to assist with closing the remaining Managed Care Accountability Sets (MCAS) care gaps through the end of 2026.	$45,504	2/20/2026
Merced	Bloss Memorial Healthcare District	MOR Tier 1: Medi-Cal Outreach and Education	To support community-based efforts to keep Alliance Medi-Cal members enrolled in Medi-Cal by funding linguisitcally and culturally responsive outreach and education activities.	$25,000	4/17/2026
Merced	Castle Family Health Centers	Community Health Worker Recruitment	Recruitment of one Community Health Worker (CHW).	$59,227	7/17/2026
Merced	Castle Family Health Centers	Healthcare Technology	Castle Family Health Centers will implement digital intake and communication tools through its Artera platform to improve patient flow, reduce administrative burden, and enhance access to care for Medi-Cal members in Merced County. The project will streamline check-in, automate patient outreach, and improve care coordination, supporting more efficient clinic operations and a better patient experience for approximately 32,000 Medi-Cal members.	$50,000	4/3/2026
Merced	Castle Family Health Centers	Provider Recruitment	Recruitment of one Optometrist	$153,419	7/17/2026
Merced	Castle Family Health Centers	Workforce Support for Caregap Closures	To support the hiring of locum tenens providers and/or to allocate additional hours for existing staff to augment clinic hours and/or days to assist with closing the remaining Managed Care Accountability Sets (MCAS) care gaps through the end of 2026.	$250,000	2/20/2026
Merced	Community Health Centers of America	Workforce Support for Caregap Closures	To support the hiring of locum tenens providers and/or to allocate additional hours for existing staff to augment clinic hours and/or days to assist with closing the remaining Managed Care Accountability Sets (MCAS) care gaps through the end of 2026.	$150,000	2/20/2026
Merced	Dos Palos Apex Health Center, Inc.	Healthcare Technology	Dos Palos Apex Health Center will acquire vaccine refrigerators to improve vaccine storage, handling, and compliance with VFC guidelines for Medi-Cal members in Los Banos, Dos Palos, and Gustine. The project will support proper temperature monitoring, enhance immunization quality, and ensure safe and effective vaccine delivery for over 2,500 Medi-Cal members.	$4,574	4/3/2026
Merced	Dr. Jennifer M. Jones Foundation	Healthcare Technology	The HT project upgrades the Dr. Jennifer M. Jones Foundation's electronic health record system to a more streamlined and user-friendly platform from Sprite Health. Key upgrades include procuring the system, onboarding fees, and monthly subscription fees. This project aims to improve the delivery of ECM/CHW/CS services through better system navigation, centralizing care coordination, referrals, documentation, and client history, and enhancing reporting, billing readiness, and outcome tracking	$50,000	7/17/2026
Merced	Family Health Medical Center	Workforce Support for Caregap Closures	To support the hiring of locum tenens providers and/or to allocate additional hours for existing staff to augment clinic hours and/or days to assist with closing the remaining Managed Care Accountability Sets (MCAS) care gaps through the end of 2026.	$48,720	2/20/2026
Merced	Gettysburg Medical Clinic	Workforce Support for Caregap Closures	To support the hiring of locum tenens providers and/or to allocate additional hours for existing staff to augment clinic hours and/or days to assist with closing the remaining Managed Care Accountability Sets (MCAS) care gaps through the end of 2026.	$149,986	2/20/2026

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County	Organization Name	Funding Opportunity	Grant Description	Award Amount	Date Awarded
Merced	Golden Valley Health Centers	Healthcare Technology	The HT project enhances care delivery and documentation for Medi-Cal members in Merced County by implementing Microsoft Dragon Ambient eXperience Copilot (DAX) licenses for primary care providers. Key upgrades include procuring additional DAX licenses, training providers and staff, and implementing the platform in clinical care. This project aims to reduce administrative time, decrease entry errors, and improve patient understanding and care through automated note-taking and charting. The organization expects that 70-80% of patients served by DAX-assisted care teams will be Medi-Cal members, leading to more efficient and accurately documented care, and improved satisfaction among patients, providers, and staff.	$50,000	7/17/2026
Merced	Golden Valley Health Centers	Medical Assistant Recruitment	Recruitment of one Medical Assistant.	$56,250	4/3/2026
Merced	Golden Valley Health Centers	Provider Recruitment	Recruitment of one Licensed Clinical Social Worker (LCSW)	$52,500	7/17/2026
Merced	Golden Valley Health Centers	Workforce Support for Caregap Closures	To support the allocation of additional hours for existing staff to augment clinic hours and/or days to assist with closing the Child and Adolescent Well Care Visits Managed Care Accountability Set (MCAS) care gap amongst the African American/Black Medi-Cal member population through the end of 2026 through targeted outreach, engagement and care coordination efforts at two clinic locations.	$91,200	9/8/2026
Merced	Merced County Community Action Board (Agency)	MOR Tier 1: Medi-Cal Outreach and Education	To support community-based efforts to keep Alliance Medi-Cal members enrolled in Medi-Cal by funding linguisitcally and culturally responsive outreach and education activities.	$25,000	4/17/2026
Merced	Merced County Office of Education	MOR Tier 1: Medi-Cal Outreach and Education	To support community-based efforts to keep Alliance Medi-Cal members enrolled in Medi-Cal by funding linguisitcally and culturally responsive outreach and education activities.	$25,000	4/17/2026
Merced	Merced County Office of Education	Parent Education and Support	Merced County Office of Education will implement the Triple P for Baby program through the Family Resource Center, delivering eight evidence-based parenting education series for Medi-Cal families with children ages 0–12 months in Merced County. The program will provide bilingual (English/Spanish) group sessions focused on child development, parenting skills, and caregiver well-being, while connecting families to preventive health and behavioral health services through coordinated referrals. The project includes training facilitators across community partners and aims to strengthen parent-child attachment, reduce caregiver stress, and increase access to supportive resources.	$250,000	4/3/2026
Merced	Merced Faculty Associates Medical Group	Provider Recruitment	Recruitment of one Primary Care Provider	$250,000	7/17/2026
Merced	Merced Faculty Associates Medical Group	Provider Recruitment	Recruitment of one Family Nurse Practitioner	$79,463	7/17/2026
Merced	Merced Heart Associates	Provider Recruitment	Recruitment of one Nurse Practitioner	$250,000	7/17/2026
Merced	Merced Lung & Sleep Specialists	Provider Recruitment	Recruitment of one Pulmonary Disease/Sleep Medicine Physician	$250,000	4/3/2026
Merced	Mercy Medical Center Merced	MOR Medi-Cal Renewal Events Pilot	To support participation in a pilot program to implement a series of weekend and/or evening events at primary care provider sites to provide in-person assistance for Medi-Cal renewals for Alliance members.	$21,000	9/1/2026
Merced	Mercy Medical Center Merced (Dignity Health)	Community Health Worker Recruitment	Recruitment of one Community Health Worker (CHW).	$65,000	7/17/2026

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County	Organization Name	Funding Opportunity	Grant Description	Award Amount	Date Awarded
Merced	Mercy Medical Center Merced (Dignity Health)	Healthcare Technology	Mercy Medical Center Merced will implement an Ankle-Brachial Index (ABI) machine to improve early detection and management of Peripheral Artery Disease (PAD) and related conditions for Medi-Cal members in Merced and Mariposa Counties. The project will support on-site vascular screening for high-risk patients, enabling timely diagnosis and intervention to prevent disease progression, reduce unnecessary referrals, and improve clinical workflow efficiency.	$49,946	4/3/2026
Merced	Mercy Medical Center Merced (Dignity Health)	Workforce Support for Caregap Closures	To support the hiring of locum tenens providers and/or to allocate additional hours for existing staff to augment clinic hours and/or days to assist with closing the remaining Managed Care Accountability Sets (MCAS) care gaps through the end of 2026.	$148,973	2/20/2026
Merced	NAMI Merced County	Community Health Champions	NAMI Merced County will implement the Líder-con-Líder Cultivating Corazones Academy to train and support 12 Spanish-speaking Medi-Cal members as certified peer leaders in Merced County. Participants will complete the Nurtured Heart Approach® (NHA) Trainer Certification and lead culturally responsive behavioral health education and support groups focused on emotional resilience and stigma reduction. Champions will participate in ongoing coaching, mentorship, and leadership development, and will deliver trainings within their communities through partnerships with local schools and organizations. The program builds a pipeline into Peer Support Specialist and Community Health Worker roles, expanding culturally and linguistically appropriate behavioral health capacity.	$250,000	4/3/2026
Merced	Provident Primary Care Inc.	Healthcare Technology	Provident Primary Care Inc. will expand telehealth, e-Consult, and care coordination services for Medi-Cal members in Merced and Mariposa Counties through targeted technology upgrades. The project will improve access to care, reduce specialty referral delays, and enhance patient follow-up and communication, supporting more timely and coordinated care for approximately 1,800 Medi-Cal members.	$50,000	4/3/2026
Merced	Sierra Vista Child & Family Services	MOR Tier 2: Medi-Cal Renewal Assistance	To support community-based efforts to keep Alliance Medi-Cal members enrolled in Medi-Cal by funding linguisitcally and culturally responsive education and direct, hands-on assistance to Alliance members to complete the Medi-Cal renewal (redetermination) process.	$250,000	4/17/2026
Merced	Timothy S. Johnston, MD	Medical Assistant Recruitment	Recruitment of one Medical Assistant.	$65,000	4/3/2026
Merced	Timothy S. Johnston, MD	Provider Recruitment	Recruitment of one Family Medicine Physician.	$156,600	4/3/2026
Merced	Total Care Podiatry Services	Provider Recruitment	Recruitment of one Podiatrist	$150,000	7/17/2026
Merced	Turlock Doula Services	Doula Recruitment	Recruitment of one Doula.	$65,000	4/3/2026
Merced	UC Merced Professional and Continuing Education	MOR Tier 1: Medi-Cal Outreach and Education	To support community-based efforts to keep Alliance Medi-Cal members enrolled in Medi-Cal by funding linguisitcally and culturally responsive outreach and education activities.	$75,000	4/17/2026
Merced	United Way of Merced County (Merced County HSA, Lifeline CDC, Cultiva Central Valley, Valley Onward, Lao Family, and NAMI)	MOR Tier 2: Medi-Cal Renewal Assistance	To support community-based efforts to keep Alliance Medi-Cal members enrolled in Medi-Cal by funding linguisitcally and culturally responsive education and direct, hands-on assistance to Alliance members to complete the Medi-Cal renewal (redetermination) process.	$250,000	4/17/2026
Merced	Wave's Embrace Doula Services	Doula Recruitment	Recruitment of one Doula.	$65,000	4/3/2026
Monterey	Action Council of Monterey County, Inc.	MOR Tier 2: Medi-Cal Renewal Assistance	To support community-based efforts to keep Alliance Medi-Cal members enrolled in Medi-Cal by funding linguisitcally and culturally responsive education and direct, hands-on assistance to Alliance members to complete the Medi-Cal renewal (redetermination) process.	$186,502	4/17/2026

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County	Organization Name	Funding Opportunity	Grant Description	Award Amount	Date Awarded
Monterey	Apex Medical Group	Healthcare Technology	The HT project aims to increase access to regular diabetic eye exams for rural Medi-Cal members in Merced County by bringing an optometrist and necessary equipment to the clinic. Key upgrades include procuring specialized equipment such as the Lobart CS-6 Chair & Stand Combo, Lobart B3 Slit Lamp, and icare IC200 Tonometer. This will enhance eye health evaluation and detection capabilities for children and adults, improving access to care and operational efficiency for approximately 2500 individuals, including 1250 Medi-Cal members.	$50,000	7/17/2026
Monterey	Apex Medical Group	Provider Recruitment	Recruitment of one Optometrist	$185,485	7/17/2026
Monterey	Catholic Charities Diocese of Monterey	MOR Tier 2: Medi-Cal Renewal Assistance	To support community-based efforts to keep Alliance Medi-Cal members enrolled in Medi-Cal by funding linguisitcally and culturally responsive education and direct, hands-on assistance to Alliance members to complete the Medi-Cal renewal (redetermination) process.	$250,000	4/17/2026
Monterey	Center for Community Advocacy	MOR Tier 2: Medi-Cal Renewal Assistance	To support community-based efforts to keep Alliance Medi-Cal members enrolled in Medi-Cal by funding linguisitcally and culturally responsive education and direct, hands-on assistance to Alliance members to complete the Medi-Cal renewal (redetermination) process.	$250,000	4/17/2026
Monterey	Centro Binacional para el Desarrollo Indígena Oaxaqueño	MOR Tier 2: Medi-Cal Renewal Assistance	To support community-based efforts to keep Alliance Medi-Cal members enrolled in Medi-Cal by funding linguisitcally and culturally responsive education and direct, hands-on assistance to Alliance members to complete the Medi-Cal renewal (redetermination) process.	$125,000	4/17/2026
Monterey	Clinica de Salud del Valle de Salinas	MOR Medi-Cal Renewal Events Pilot	To support participation in a pilot program to implement a series of weekend and/or evening events at primary care provider sites to provide in-person assistance for Medi-Cal renewals for Alliance members.	$21,000	9/1/2026
Monterey	Community Health Partnership	MOR Tier 1: Medi-Cal Outreach and Education	To support community-based efforts to keep Alliance Medi-Cal members enrolled in Medi-Cal by funding linguisitcally and culturally responsive outreach and education activities.	$25,000	4/17/2026
Monterey	County of Monterey Department of Social Services	MOR Tier 2: Medi-Cal Renewal Assistance	To support community-based efforts to keep Alliance Medi-Cal members enrolled in Medi-Cal by funding linguisitcally and culturally responsive education and direct, hands-on assistance to Alliance members to complete the Medi-Cal renewal (redetermination) process.	$85,000	4/17/2026
Monterey	County of Monterey Health Department - Clinic Services Bureau	Provider Recruitment	Recruitment of one Primary Care Provider	$250,000	7/17/2026
Monterey	County of Monterey Health Department - Clinic Services Bureau	Provider Recruitment	Recruitment of one Primary Care Provider	$250,000	7/17/2026
Monterey	County of Monterey Health Department - Clinic Services Bureau	Workforce Support for Caregap Closures	To support the allocation of additional hours for existing staff to augment clinic hours and/or days to assist with closing the Child and Adolescent Well Care Visits Managed Care Accountability Set (MCAS) care gap amongst the African American/Black Medi-Cal member population through the end of 2026 through targeted outreach, engagement and care coordination efforts at four clinic locations.	$40,128	9/8/2026
Monterey	County of Monterey Health Department - Public Health Bureau	Healthcare Technology	The OCHIN EPIC Implementation CCS project aims to modernize its Electronic Health Record (EHR) system by transitioning to OCHIN EPIC, a supported system used by Health Department outpatient clinics. This upgrade will enable CPT-based billing for Medi-Cal members in Monterey County, improve documentation of rehabilitative care, and enhance care coordination with primary care providers. The project will also expedite referrals to pediatric specialists and align with CalAIM service providers, ultimately improving access to equitable, person-centered care for Medi-Cal members.	$49,246	7/17/2026

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County	Organization Name	Funding Opportunity	Grant Description	Award Amount	Date Awarded
Monterey	County of Monterey Health Department Office of Equity	MOR Tier 1: Medi-Cal Outreach and Education	To support community-based efforts to keep Alliance Medi-Cal members enrolled in Medi-Cal by funding linguisitcally and culturally responsive outreach and education activities.	$25,000	4/17/2026
Monterey	County of Monterey Health Department, Office of Equity	Community Health Worker Capacity Building	The County of Monterey Health Department's Office of Equity, will create a Community Health Worker (CHW) Hub, a centralized administrative model to expand access to culturally responsive Medi-Cal CHW Benefit services while strengthening the capacity of local community-based organizations (CBOs). The Office of Equity will serve as the Medi-Cal supervising provider, managing billing, compliance, and program oversight, while providing participating CBOs with shared infrastructure, training, care coordination tools, and administrative support. Initially partnering with four (4) CBOs, the initiative aims to improve care coordination, establish sustainable Medi-Cal reimbursement pathways, and develop a scalable, long-term model for CHW services.	$250,000	8/25/2026
Monterey	George L. Mee Memorial Hospital	Community Health Worker Recruitment	Recruitment of one Community Health Worker (CHW).	$65,000	7/17/2026
Monterey	George L. Mee Memorial Hospital	MOR Medi-Cal Renewal Events Pilot	To support participation in a pilot program to implement a series of weekend and/or evening events at primary care provider sites to provide in-person assistance for Medi-Cal renewals for Alliance members.	$21,000	9/1/2026
Monterey	George L. Mee Memorial Hospital	Provider Recruitment	Recruitment of one Nurse Practitioner	$150,000	7/17/2026
Monterey	Gonzales Primary Care	Healthcare Technology	Gonzales Primary Care will implement mobile workstations and wireless network upgrades to expand telehealth capacity and improve point-of-care efficiency for Medi-Cal members residing in Monterey, San Benito, and Santa Cruz counties. The project will support bedside documentation, real-time care coordination, and increased access to virtual visits, improving efficiency and access to care for approximately 6,750 Medi-Cal members served by the clinic.	$50,000	4/3/2026
Monterey	Gonzales Primary Care	Medical Assistant Recruitment	Recruitment of one Medical Assistant.	$64,914	4/3/2026
Monterey	Leland H. Rosenblum, MD	Healthcare Technology	The HT project expands specialty ophthalmology capacity by acquiring the Valeda Light Delivery System, an FDA-approved treatment for dry age-related macular degeneration (AMD). This project improves access to care and operational efficiency for approximately 1000 individuals, including 200 Medi-Cal members in Monterey and San Benito counties. The Valeda system will enhance visual acuity, slow disease progression, and improve patient quality of life, while reducing treatment burden and healthcare utilization. The project will be implemented over 12 months, with key milestones including system deployment, patient treatment initiation, interim outcomes evaluation, and final reporting.	$50,000	7/17/2026
Monterey	Monterey Bay Speech Therapy	Provider Recruitment	Recruitment of one Occupational Therapist	$24,810	7/17/2026
Monterey	Monterey Bay Speech Therapy	Provider Recruitment	Recruitment of one Occupational Therapist	$74,433	7/17/2026
Monterey	Monterey Bay Speech Therapy	Provider Recruitment	Recruitment of one Speech Therapist	$29,429	7/17/2026
Monterey	Monterey County Eye Associates	Healthcare Technology	The 0526-MCEA-HT project implements direct selective laser trabeculoplasty (DSLT), a non-contact, in-office laser therapy for glaucoma and narrow angles. This technology upgrade enables scalable treatment delivery, reduces patient medication use, and improves comfort. The project aims to improve access to care and operational efficiency for approximately 300 individuals, including 180 Medi-Cal members, by reducing intraocular pressure by 20-30%, medication use by over 50%, and surgical interventions, while tracking outcomes through the applicant's electronic health record system.	$50,000	7/17/2026

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County	Organization Name	Funding Opportunity	Grant Description	Award Amount	Date Awarded
Monterey	Mujeres en Acción	MOR Tier 2: Medi-Cal Renewal Assistance	To support community-based efforts to keep Alliance Medi-Cal members enrolled in Medi-Cal by funding linguisitcally and culturally responsive education and direct, hands-on assistance to Alliance members to complete the Medi-Cal renewal (redetermination) process.	$250,000	4/17/2026
Monterey	Natividad Medical Center	Provider Recruitment	Recruitment of one Cardiologist	$250,000	4/3/2026
Monterey	Natividad Medical Center	Provider Recruitment	Recruitment of one Pulmonologist	$250,000	4/3/2026
Monterey	Salinas Valley Medical Clinic	Provider Recruitment	Recruitment of one Cardiologist	$250,000	4/3/2026
Monterey	Salinas Valley Medical Clinic	Provider Recruitment	Recruitment of one Pulmonary & Critical Care Physician	$250,000	7/17/2026
Monterey	Salinas Valley Medical Clinic	Provider Recruitment	Recruitment of one Sleep Medicince Physician	$250,000	7/17/2026
Monterey	Santa Lucia Medical Group, Inc.	Medical Assistant Recruitment	Recruitment of one Medical Assistant.	$55,000	4/3/2026
Monterey	Sun Street Centers	Healthcare Technology	The HT project upgrades the existing myEvolv electronic health record (EHR) system to improve clinical workflows, security, and navigation. Key upgrades include purchasing tablets for counselors to conduct intake, complete documentation, and access client records in real-time, reducing delays and improving accuracy. Additional costs include a HIPAA-compliant server, data migration, and tablet onboarding. The project aims to improve access to care for Medi-Cal members through reduced wait times, consistent documentation, and improved coordination across programs and partner agencies. Real-time data access and standardized information sharing will support timely clinical decision-making, referrals, and continuity of care, increasing Sun Street Centers' capacity to serve Medi-Cal members.	$19,970	7/17/2026
Monterey	Taylor Farms Family Health & Wellness Center	Provider Recruitment	Recruitment of one Family Medicine Physician	$222,713	7/17/2026
Monterey	Taylor Farms Family Health & Wellness Center	Provider Recruitment	Recruitment of one Nurse Practitioner	$123,820	7/17/2026
Monterey	The Parenting Connection of Monterey County	Community Health Worker Recruitment	Recruitment of one Community Health Worker (CHW).	$65,000	7/17/2026
Monterey	Victory Mission	Community Health Worker Recruitment	Recruitment of one Community Health Worker (CHW).	$65,000	4/3/2026
San Benito	First 5 San Benito	MOR Tier 1: Medi-Cal Outreach and Education	To support community-based efforts to keep Alliance Medi-Cal members enrolled in Medi-Cal by funding linguisitcally and culturally responsive outreach and education activities.	$25,000	4/17/2026
San Benito	Hazel Hawkins Hospital	Provider Recruitment	Recruitment of one Family Medicine Physician.	$250,000	4/3/2026
San Benito	Jmm Dance Co	Community Health Worker Recruitment	Recruitment of one Community Health Worker (CHW).	$65,000	4/3/2026
San Benito	Jmm Dance Co	Healthcare Technology	JMM Dance Co. will implement telehealth and digital infrastructure to expand asthma prevention education and Community Health Worker (CHW)-aligned services for Medi-Cal families in San Benito, Monterey, and Santa Cruz counties. The project will support virtual and hybrid delivery of asthma education, caregiver coaching, and health navigation, improving access, care coordination, and chronic condition self-management for underserved families in rural communities.	$50,000	4/3/2026
San Benito	Youth Recovery Connections	MOR Tier 2: Medi-Cal Renewal Assistance	To support community-based efforts to keep Alliance Medi-Cal members enrolled in Medi-Cal by funding linguisitcally and culturally responsive education and direct, hands-on assistance to Alliance members to complete the Medi-Cal renewal (redetermination) process.	$250,000	4/17/2026

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County	Organization Name	Funding Opportunity	Grant Description	Award Amount	Date Awarded
Santa Cruz	Central Coast Gastroenterology Associates Inc.	Healthcare Technology	The HT project addresses the lack of endoscopy equipment at the surgery center, enabling the performance of colonoscopies and advanced endoscopic procedures for Medi-Cal patients. Key upgrades include procuring an Olympus-based refurbished endoscopy system, patient safety equipment, and procedure room infrastructure. This project aims to increase Medi-Cal colonoscopies to a minimum of 20/month, reduce referral-to-procedure wait time to ≤21 days, and complete 100% of complex colorectal polyp referrals within 30 days. By improving access to care and operational efficiency, the project will benefit approximately 800 individuals, including 400 Medi-Cal members, and will be evaluated through regular metrics tracking and HEDIS CCS rate comparisons.	$50,000	7/17/2026
Santa Cruz	Community Action Board of Santa Cruz County, Inc.	MOR Tier 2: Medi-Cal Renewal Assistance	To support community-based efforts to keep Alliance Medi-Cal members enrolled in Medi-Cal by funding linguisitcally and culturally responsive education and direct, hands-on assistance to Alliance members to complete the Medi-Cal renewal (redetermination) process.	$250,000	4/17/2026
Santa Cruz	Community Bridges	MOR Tier 2: Medi-Cal Renewal Assistance	To support community-based efforts to keep Alliance Medi-Cal members enrolled in Medi-Cal by funding linguisitcally and culturally responsive education and direct, hands-on assistance to Alliance members to complete the Medi-Cal renewal (redetermination) process.	$250,000	4/17/2026
Santa Cruz	County of Santa Cruz, Health Services Agency, Public Health Division	CHA/CHIP Support	To support Grantee in the development and/or implementation of their CHA and/or Community Health Improvement Plan (CHIP)	$50,000	7/31/2026
Santa Cruz	Cradle to Career	MOR Tier 1: Medi-Cal Outreach and Education	To support community-based efforts to keep Alliance Medi-Cal members enrolled in Medi-Cal by funding linguisitcally and culturally responsive outreach and education activities.	$25,000	4/17/2026
Santa Cruz	Dientes	Provider Recruitment	Recruitment of one Pediatric Dentist	$153,900	7/17/2026
Santa Cruz	Dientes	Provider Recruitment	Recruitment of one Pediatric Dentist	$159,500	7/17/2026
Santa Cruz	First 5 Santa Cruz County	MOR Tier 2: Medi-Cal Renewal Assistance	To support community-based efforts to keep Alliance Medi-Cal members enrolled in Medi-Cal by funding linguisitcally and culturally responsive education and direct, hands-on assistance to Alliance members to complete the Medi-Cal renewal (redetermination) process.	$200,497	4/17/2026
Santa Cruz	First 5 Santa Cruz County	Parent Education and Support	First 5 Santa Cruz County will implement Triple P Parenting Support for Medi-Cal families across Santa Cruz County, providing group sessions, workshops, and one-on-one consultations for pregnant individuals and parents of children ages 0–5. The program will deliver Level 3 Primary Care Triple P and Level 4 Triple P Baby services to up to 200 Medi-Cal families through partnerships with local health and community providers. Services will be delivered by trained promotoras and clinical staff, supported by multilingual outreach, culturally responsive materials, and childcare to reduce participation barriers. The program aims to improve parenting confidence, reduce caregiver stress and postpartum depressive symptoms, and strengthen access to behavioral health and supportive services.	$250,000	4/3/2026
Santa Cruz	Holistic Acupuncture Santa Cruz Corp	Doula Recruitment	Recruitment of one Doula.	$65,000	4/3/2026
Santa Cruz	Plazita Medical Clinic	Medical Assistant Recruitment	Recruitment of one Medical Assistant.	$65,000	4/3/2026
Santa Cruz	Plazita Medical Clinic	Provider Recruitment	Recruitment of one Non-Physician Medical Practitioner (NPMP)	$134,000	4/3/2026
Santa Cruz	Salud Para La Gente	MOR Medi-Cal Renewal Events Pilot	To support participation in a pilot program to implement a series of weekend and/or evening events at primary care provider sites to provide in-person assistance for Medi-Cal renewals for Alliance members.	$21,000	9/1/2026

Back to Agenda

Medi-Cal Capacity Grant Program

2026 Grant Awards To Date | January 2026 - September 2026

County	Organization Name	Funding Opportunity	Grant Description	Award Amount	Date Awarded
Santa Cruz	Salud Para La Gente	Provider Recruitment	Recruitment of one Primary Care Provider	$209,034	4/3/2026
Santa Cruz	Santa Cruz Community Health Centers	MOR Medi-Cal Renewal Events Pilot	To support participation in a pilot program to implement a series of weekend and/or evening events at primary care provider sites to provide in-person assistance for Medi-Cal renewals for Alliance members.	$21,000	9/1/2026
Santa Cruz	Sobriety Works	Provider Recruitment	Recruitment of one Substance Use Disorder Counselor	$35,860	7/17/2026
Santa Cruz	United Way of Santa Cruz County	MOR Tier 1: Medi-Cal Outreach and Education	To support community-based efforts to keep Alliance Medi-Cal members enrolled in Medi-Cal by funding linguisitcally and culturally responsive outreach and education activities.	$25,000	4/17/2026
Santa Cruz	Watsonville Community Hospital	Healthcare Technology	The HT project upgrades the technology and equipment for Watsonville Community Hospital's Special Procedures service line, enabling it to expand its capacity and improve operational efficiency. Key upgrades include upgrading the EndoSoft program, purchasing laptops, and replacing and expanding portable patient monitors. These upgrades will enhance system uptime, reduce administrative time, and decrease patient check-in times, improving access to care and operational efficiency for approximately 2,010 individuals, including 1,005 Medi-Cal members, served at two clinic sites in Santa Cruz County. The project aims to increase volume to 2,500 individuals and increase revenue for the hospital, leading to greater stability and improved services for all patients.	$47,689	7/17/2026

Back to Agenda

DATE: October 28, 2026

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

FROM: Jessica Finney, Community Grants Director

SUBJECT: Merced County Medi-Cal Administrative Activities Funding Agreement

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Recommendation. Staff recommend the Board authorize the Alliance to negotiate and execute an agreement with Merced County to administer up to $2 million in Medi-Cal Administrative Activities funding in alignment with the Alliance's Medi-Cal Outreach and Retention (MOR) initiative, subject to applicable requirements and agreed-upon terms.

Summary. Merced County, through its Human Services Agency (HSA) has approached the Alliance to administer up to $2 million in Medi-Cal Administrative Activities, that may include, for example, funding for outreach, education, and renewal assistance activities in Merced County. This opportunity would expand community-based support for Medi-Cal members and complement the Alliance's existing MOR initiative.

Background. The Alliance's Medi-Cal Outreach and Retention (MOR) initiative uses multiple strategies to help members maintain Medi-Cal coverage, including a comprehensive communications campaign, community-based renewal education and connections to trusted community-based organizations (CBOs) for assistance. Merced County has been an integral partner in these efforts, contributing to strategy development, CBO training, and data sharing. Merced County has proposed contracting with the Alliance to administer its unspent Medi-Cal Administrative Activities funding to expand MOR activities, leveraging the Alliance's existing infrastructure and community partnerships. This funding would supplement, rather than draw from, existing Alliance MOR grant resources.

Discussion. Alliance staff met with County HSA staff to review the funding opportunity, allowable activities, contracting and reporting requirements, and spending timeline. Funding must be expended by June 30, 2027. Staff also consulted with Alliance Legal and Accounting departments and, based on the information currently available, no issues were identified that would prohibit moving forward with negotiations. Staff are now working with internal and community partners to develop a proposed spending plan and scope of activities, as well as continuing to obtain clarifying information from the County about the funding requirements.

The Alliance would enter into an administrative agreement with the County. County staff have indicated that a proposed scope is needed promptly to pursue County Board of Supervisors approval in November 2026, with subcontractor activities occurring January 2027 through May 2027 and expense reporting in June 2027. The agreement would be finalized only after confirming eligible activities, subcontracting requirements, reporting expectations,

reimbursement provisions, and a feasible expenditure schedule. Eligible use of funding determination would be the responsibility of County staff and would be explicitly stated in the subcontractor agreement. Costs would be reimbursed by the County rather than advanced, requiring the Alliance to carry expenditures pending reimbursement. Payment of subcontracted funds would not be paid to the Alliance until all expenditure reporting and accounting is completed. The County has indicated that administrative overhead of up to 15% of actual eligible expenditures may be reimbursable, subject to final agreement terms.

Fiscal Impact. The Alliance would incur a liability for the funding expenditure until reimbursed by Merced County based on expenditure reporting. The Alliance would receive a 15% administrative fee as revenue.

Attachments. N/A

DATE: October 28, 2026

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

FROM: Michael Schrader, Chief Executive Officer

SUBJECT: Department of Health Care Services Contract Amendment: CY 2026-A

Recommendation. Staff recommend the Board authorize the Chairperson to sign contract amendment CY 2026-A to the Alliance's Medi-Cal contract with the Department of Health Services (DHCS) (Contract # 23-30241, A13)

Background. The Alliance contracts with DHCS to provide Covered Services to eligible and enrolled Medi-Cal beneficiaries in Santa Cruz, Monterey, Merced, San Benito and Mariposa counties. The Alliance entered into the primary Agreement 23-03421 with DHCS on January 1, 2024. The agreement has subsequently been amended via written amendments A 01 through A 12.

Discussion. DHCS has prepared a contract amendment to the Alliance's State Medi-Cal contract to incorporate changes and new requirements in the following areas:

- Definitions
- Mental Health Plan to Behavioral Health Plan,
- Dyadic Services
- Non-Specialty Mental Health Services Provider
- Dual Eligible Special Needs
- Operational Readiness Deliverable and Requirements
- Medical Loss Ratio
- Data Management
- Application Programming Interface Requirements
- NCQA Audit Activities
- School-Based Services
- Prior Authorizations and Review Procedures
- Timeframes for Medical Authorization
- Claims Processing
- Asthma Remediation
- Transitional Rent
- Community Supports Providers
- Notice of Action
- Member's Right to Access Individual Health Records

- Access to Emergency Service Providers and Emergency Services
- Linguistic Services
- Organ and Bone Marrow Transplants
- Transportation
- FQHC Alternative Payment Methodology
- Contractor's Dispute Resolution Process
- Delegation Reporting and Delegation Model

Staff have reviewed the language and are assessing operational impacts and any necessary implementation steps to ensure compliance.

Fiscal Impact. There is no anticipated fiscal impact associated with the language included in these contract amendments.

Attachments. N/A

DATE: October 28, 2026

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

FROM: Michael Schrader, Chief Executive Officer

SUBJECT: Annual Election of Officers of the Commission

Recommendation. Staff recommend the Board nominate one member of the Santa Cruz-Monterey-Merced-San Benito-Merced Managed Medical Care Commission (SCMMSBMMMCC) to serve as Chairperson and one member to serve as Vice Chairperson.

Background. The SCMMSBMMMCC is due for its annual election of Chairperson and Vice Chairperson, pursuant to section 3.1 of the bylaws.

Discussion. The SCMMMMCC shall elect officers (Chairperson and Vice Chairperson) for one-year terms, at the first meeting in October of each year. Officers shall serve a term which begins on the day of the election and ends at the first meeting in October of the following calendar year.

Commissioners may be nominated by other Commissioners or may nominate themselves for offices.

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

Attachments. N/A

DATE: October 28, 2026

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

FROM: Cecil Newton, Chief Information Officer; Jenifer Mandella, Chief Compliance Officer

SUBJECT: Artificial Intelligence at the Alliance

Recommendation. This report is informational only.

Summary. Artificial intelligence (AI) has moved from isolated pilots to a managed enterprise portfolio at the Alliance. Current uses support member service, clinical intelligence, compliance, workflow processing, advanced analytics, financial forecasting, and staff productivity. These tools are governed through Policy 500-2002 (Alliance AI Policy), formal intake and risk-tier processes, prerequisite reviews, production approval, lifecycle monitoring, and required human oversight.

Background. The Alliance is using both internally developed and vendor-supported AI capabilities. The portfolio includes the AllyAI platform; advanced analytics such as the High-Needs Individual model, Opioid Treatment Analytics, Alliance Insights Compass, and financial forecasting; CareForce.ai for member outreach; Readily for governance, risk, and compliance; the Grant Analysis AI Application; the D2R Provider Dispute Resolution application; and Microsoft Copilot for staff productivity.

The Alliance AI Governance Committee provides lifecycle oversight and production approval. The governance model begins with a defined business purpose, data, users, and accountable owner; incorporates architecture, security, privacy, data governance, procurement, and legal reviews; assigns controls based on risk tier; and continues with monitoring for performance, drift, fairness, incidents, and vendor changes.

Discussion. The Alliance approach is to enable responsible innovation within clear guardrails. AI can accelerate work and improve service, insight, speed, or consistency, but accountability remains with named business owners and qualified human reviewers.

- **Governance and policy controls.** Policy 500-2002 establishes requirements for data protection, human review, member choice, sensitive sessions, clinical boundaries, transparency, and fairness. PHI or PII may not be entered into unapproved external AI tools, and AI outputs must be reviewed before they are finalized, saved as records, or distributed.
- **Human accountability.** AI assists; people decide. AI does not independently make medical decisions. Members retain the ability to opt out of AI-assisted engagement

and reach a staff person. Staff remain responsible for reviewing AI-generated work products before use or distribution.

- **Operational value.** The D2R application (Provider Dispute Resolution application) demonstrates how AI can support case intake, triage, assignment, tracking, and management visibility while Provider Dispute Specialists retain final determination authority. The application produces confidence bands and an auditable recommendation trail.
- **Risk posture.** Portfolio monitoring addresses data protection, member trust, vendor reliance, operational controls, model behavior, and risk-tier coverage. The control objective is approved AI used for defined purposes with traceable human accountability.
- **Next-phase priorities.** The Alliance plans to strengthen quarterly portfolio reporting, scale proven applications, standardize member protections, and build staff fluency through role-based training on safe use, prompting, human review, and governance intake.

AI is already helping the Alliance better serve members, support its workforce, and make more informed decisions.

Fiscal Impact. There is no fiscal impact associated with this informational agenda item. No additional appropriation or funding action is requested from the Board.

Attachments.

- N/A

DATE: October 28, 2026

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

FROM: Jessica Finney, Community Grants Director

SUBJECT: Medi-Cal Capacity Grant Program 2027 Planning Inputs and Priorities

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Summary. This report outlines emerging priorities for Medi-Cal Capacity Grant Program (MCGP) investments in 2027 for the Board's consideration and discussion. This item is for information only; no Board action is requested. On January 27, 2027, staff will return with a Board action recommendation on the 2027 MCGP Investment Plan.

This report provides background on the MCGP annual investment plan process and summarizes the key inputs gathered to date on the most critical needs and opportunities for the Alliance's MCGP investments in the upcoming year. It introduces three emerging priorities for the 2027 MCGP Investment Plan and proposes a $25M total award target allocated across three strategies.

Background. Each year, the Board approves an MCGP Investment Plan that serves as a roadmap for grantmaking. The plan sets priorities that respond to Medi-Cal capacity needs in the Alliance's service area, and it allocates funding across Board-directed strategies. To develop the plan, staff review data, gather stakeholder input and draw on what was learned from previous years' investments. Selected priorities: 1) address community needs; 2) align with the Board-directed MCGP framework, focus areas, and goals, including Medi-Cal purpose and sustainability requirements; 3) support Alliance strategic objectives; and 4) fund work outside core health plan responsibilities where other funding isn't available.

Discussion. To identify 2027 priorities, staff reviewed the Medi-Cal landscape, including community needs and DHCS priorities, and reviewed each county's Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP). Staff also gathered input from the Member Services Advisory Group (MSAG), grantees and other external stakeholders on an ad hoc basis, and the Alliance MCGP Internal Review Committee. Board input from 2026 also informed the priorities, including the Specialty Access Ad Hoc Committee's recommendations and stakeholder interviews for the proposed 2027–2029 Alliance Strategic Plan.

Staff are soliciting input from the Board on the emerging priorities at this meeting and will solicit feedback from the Member and Physician Advisory Groups before finalizing the 2027 MCGP Investment Plan recommendations. Key themes from the strategic inputs gathered to date are summarized below.

DHCS Priorities. DHCS has published priorities that will shape the Medi-Cal program and the Alliance's work in 2027 and beyond, including:

- Coverage and retention: eligibility, work/community engagement and renewal changes;
- Safety net access: addressing access and continuity needs arising from coverage and delivery-system transitions;
- CalAIM sustainability: policy changes and continuity of Enhanced Care Management (ECM) and Community Supports;
- Workforce and integrated care: behavioral health delivery-system changes, integrated care access, provider capacity, workforce and community-based care; and
- Community reinvestments: coordinating funding streams, aligning with community needs, addressing county-specific gaps and defining measurable capacity-building outcomes.

DHCS Community Reinvestment Requirement. DHCS now requires Medi-Cal managed care plans to reinvest a minimum share of annual net income in their local communities. Based on DHCS's final determination, the Alliance's calendar year (CY) 2024 obligation is approximately $4.6M ($3M base and $1.6M quality achievement). Qualifying community reinvestments are a subset of MCGP grants, and eligible prior grants count as voluntary investments toward the CY 2024 obligation. Mariposa and San Benito counties are not included in the CY 2024 obligation.

In the Alliance's initial plan submitted to DHCS, prior voluntary investments fully satisfy Monterey County's obligation. A remaining gap of approximately $1.4M would be awarded in 2027 and must be spent down by 2029: $892,517 in Merced County and $520,175 in Santa Cruz County. Staff propose to include these investments, aligned with county-specific priorities and DHCS policy, in 2027 grantmaking. They would be funded separately from the 2027 award target, using grant funds returned to the 2026 budget.

Community Health Needs. Each county's local health department develops a CHA and a CHIP using data and community participation. Across the five-county service area, the top health issues are:

- access to health care
- mental health and substance use disorder (SUD)
- housing security
- employment, education and income
- nutrition, physical activity and weight
- chronic disease
- infectious disease and immunizations
- safety, injury and violence

The CHIP priorities that line up most across counties are access to health care, mental health and SUD, child and adolescent health/family support, and chronic disease prevention. MSAG reviewed these findings and identified the greatest needs for Medi-Cal members as access to care access to care (especially transportation, specialty care, dental care and services for older adults), chronic disease prevention, SUD and behavioral health support, child and adolescent health, trauma-informed care, and housing.

Board Input and Alliance Strategic Priorities. The Board has provided direction at several points in 2026. In June 2026, following the Specialty Access Ad Hoc Committee's recommendations, the Board directed a dedicated specialist recruitment grant allocation. In September 2026, the Board reviewed the proposed 2027–2029 Alliance Strategic Plan, which is planned for approval in December 2026. The proposed plan includes three strategic priorities (*member access, community partnership and plan performance*) and six strategic goals: *realized access, safety-net stability, Medi-Cal retention, community engagement, program integrity and performance*, and

operational efficiency. Stakeholder interviews conducted from January to March 2026 to inform the plan included 17 Board Commissioners, seven external stakeholders from local organizations, and four leaders from the Whole Child Model Family Advisory Committee and MSAG. Current work under the two goals *safety-net stability* and *community engagement*. includes community stakeholder convenings on obstetric access in Santa Cruz County and regional specialty access convenings.

Emerging Priorities for MCGP Investments in 2027. Staff identified the proposed investment priorities for 2027 by evaluating the Medi-Cal landscape and stakeholder-identified needs, reviewing alignment with MCGP and Alliance priorities, and assessing the remaining MCGP budget needed to sustain the MCGP through 2030 based on current financial projections. Based on this analysis, three key priorities have emerged:

- Healthcare Workforce: recruit and retain providers in documented local gaps, including primary care, behavioral health, specialty care and other hard-to-fill roles, and continue to strengthen local community-based organization (CBO) capacity and partnerships to expand community health worker (CHW) services.
- Safety Net Capacity & Access: stabilize essential services and make targeted investments in provider infrastructure, technology and care delivery where access is at risk.
- Medi-Cal Coverage & Member Support: build on Medi-Cal Member Outreach and Retention (MOR) implementation by supporting trusted local partners to provide outreach, renewal assistance and connections to care.

To advance these priorities and build on MCGP investments under current focus areas, staff propose the following 2027 grantmaking activities under each strategy:

1. Healthcare Workforce (Focus Area: Access to Care)
    - Workforce recruitment: primary care, pediatrics, behavioral health and specialty care (dedicated specialty allocation).
    - CHW pathway: move from CHW Recruitment grants to hubs, training and technical assistance that help CBOs become contracted CHW and doula providers with sustained revenue (pending Q4 2026 assessment findings).
    - Workforce development: continued smaller commitments for CHW training and "grow your own" Merced County internships.

2. Safety Net Capacity & Access (Focus Area: Access to Care)
    - Collaborative convenings: local and regional convenings, supported by a community consultant, to address safety net challenges (e.g., CHW/doula–hospital partnerships and ECM community-based care).
    - Closed loop referral: community convenings, governance and capacity building.
    - Healthcare technology: improve access, quality, care coordination and data sharing in underserved areas to reduce out-of-area referrals, member transportation and wait times.
    - Emerging opportunities: targeted, one-time investments in specific gaps (e.g., recuperative care).

3. Medi-Cal Coverage & Member Support (Focus Area: Healthy Communities)
    - Member enrollment and retention through MOR initiative strategies.

MCGP Remaining Budget and Proposed Allocation. Current financial projections show limited to no expected surpluses over the next three fiscal years, requiring the MCGP to rely on existing funding. Approximately $45M remains in the MCGP budget, plus the Board-directed $20M specialist recruitment allocation over two years (2027 and 2028). Staff recommend a 2027 total award target of $25M: $15M in general MCGP funding and $10M for specialist recruitment. The approximately $1.4M community reinvestment requirement is not included in this target and would be funded with remaining grant funds returned to the 2026 budget.

Next Step. Based on available funding and identified priorities, staff will synthesize Board and stakeholder input to develop recommendations for the 2027 MCGP Investment Plan, including funding allocations for each strategy. Staff will return to the Board with a final 2027 MCGP Investment Plan for Board action on January 27, 2027. After the 2027 MCGP Investment Plan is approved, staff will develop new responsive funding opportunities and refine existing programs to address the Board-directed priorities.

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

Attachments. N/A

DATE: October 28, 2026

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

FROM: Ronita Margain, Community Engagement Director

SUBJECT: Member Outreach and Retention (MOR) Program Update

Recommendation. This report is informational only.

Summary. Staff will provide an update on the Alliance's Member Outreach and Retention (MOR) Program, including progress toward the organization's 2026-member retention goal, key accomplishments, lessons learned and ongoing efforts to support Medi-Cal members through the annual renewal process.

The MOR Program brings together member communications, community and county partnerships, provider engagement, outreach and technology to increase awareness of the Medi-Cal renewal process and connect members with resources to help them maintain coverage when eligible.

Background. The Alliance launched its coordinated MOR strategy in late 2025 in response to the anticipated impacts of federal Medicaid policy changes and funding reductions associated with HR1. The program focuses on helping eligible members maintain coverage, particularly those who are not renewed automatically through the ex parte process and must take action to complete their renewal.

The Alliance established a 2026 organizational goal focused on member retention, using a baseline renewal rate of 74% from the second half of 2025. Performance targets were established at 73% minimum, 75% meets expectations and 80% stretch.

Since implementation, MOR has evolved into a cross-functional effort involving Community Engagement, Member Services, Marketing and Communications, Community Grants, Operations Management, and other Alliance departments supporting, as well as county eligibility agencies, health care providers and community-based organizations throughout the Alliance's five-county service area.

Discussion. Throughout 2026, the Alliance has implemented a multi-channel strategy designed to reach members at different points in the renewal process and provide multiple opportunities for support. Key areas of work include targeted member notifications and outreach, a broad-based media and awareness campaign, AI-supported calling and text messaging, community outreach and renewal assistance, provider engagement, and coordination with county eligibility agencies and community partners.

Renewal performance continues to be monitored against the Alliance's established organizational targets. Results through the second quarter exceeded the minimum performance target, demonstrating progress from earlier in the year. Staff will present the most current available results at the October Board meeting and discuss progress toward the year-end goal.

The program has also expanded the network of organizations equipped to assist members. The Alliance has provided renewal education and training to community partners across its service area, including a series of six training sessions in Merced County that reached approximately 200 participants. Community outreach, targeted renewal events and ongoing coordination with county partners have complemented direct member communications.

The Alliance has also engaged peer Medi-Cal managed care plans to better understand their renewal strategies, methodologies and promising practices. These discussions have identified opportunities to strengthen the Alliance's approach, including continued refinement of AI-supported outreach, increased provider engagement and stronger coordination with county eligibility agencies.

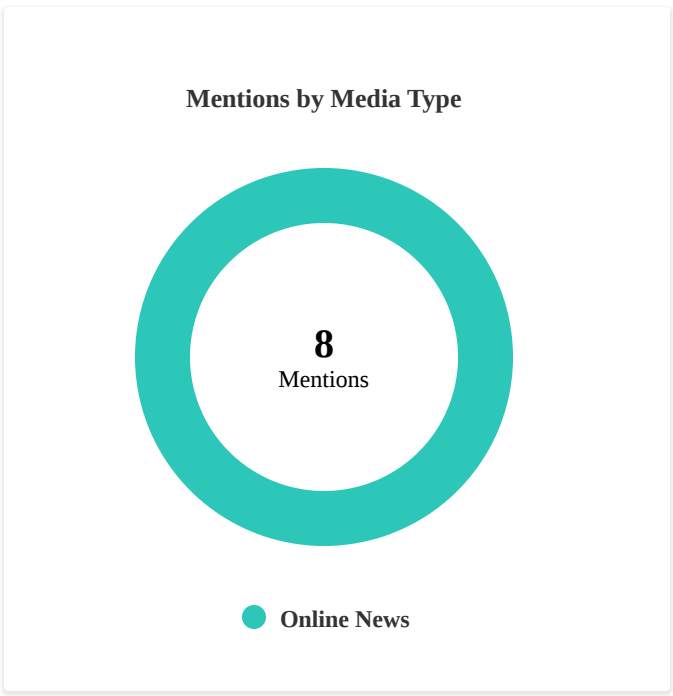
Through the remainder of 2026, staff will continue to monitor renewal performance, assess the effectiveness of key interventions and focus resources on approaches that demonstrate the greatest potential to help members successfully complete the renewal process. Lessons from the MOR Program will also inform longer-term approaches to member engagement and retention.

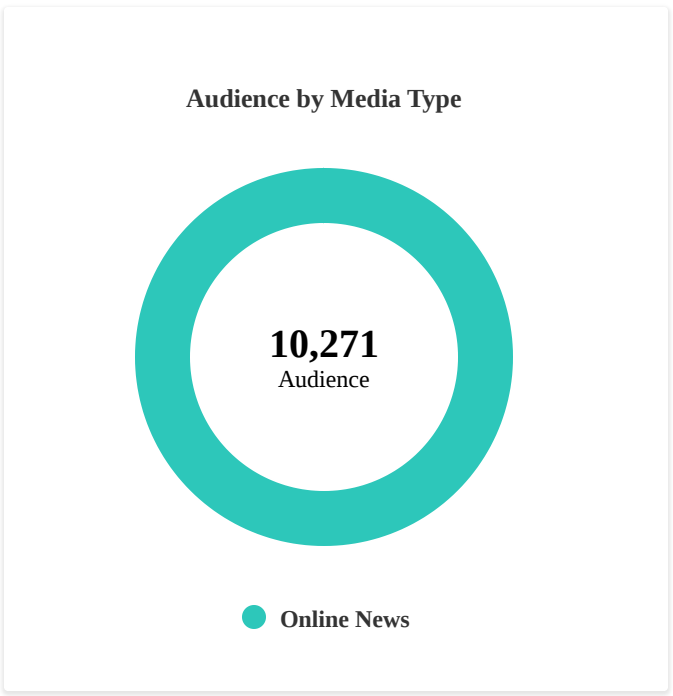
Fiscal Impact. There is no fiscal impact associated with this agenda item.

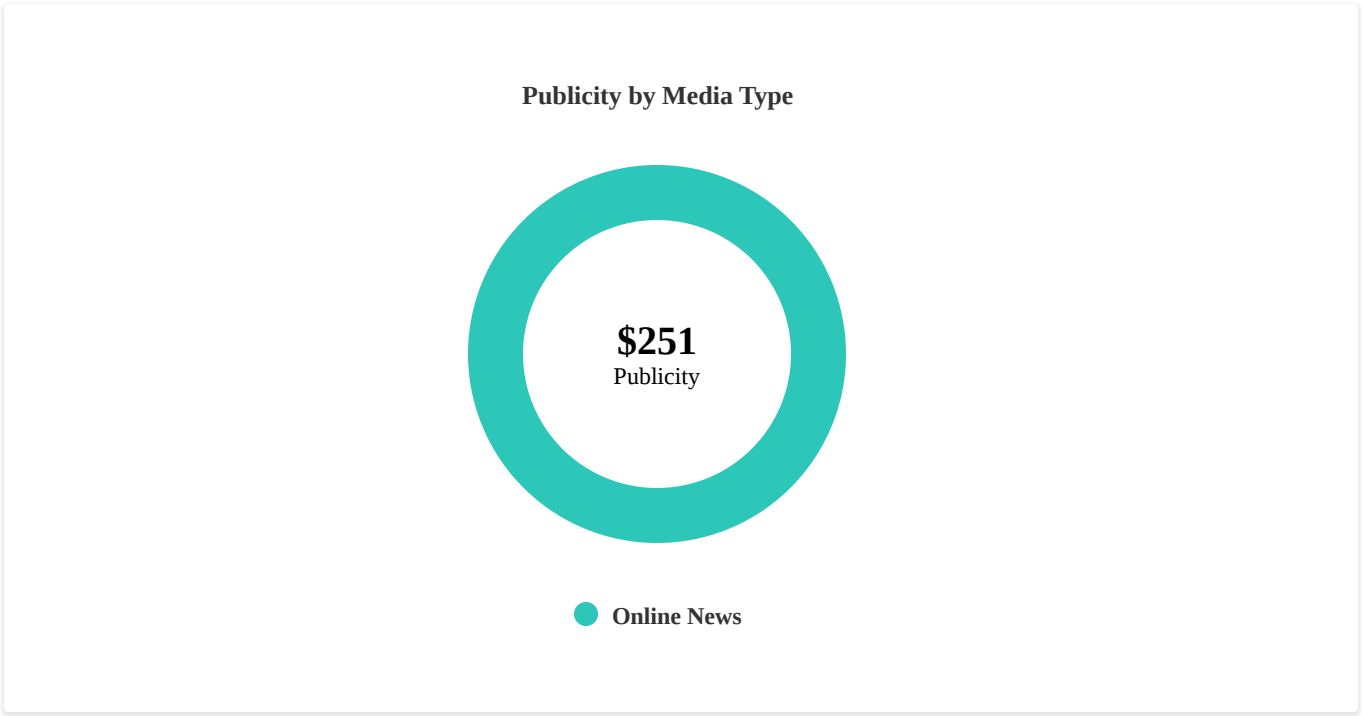
Attachments. N/A

October 2026 Board Report

Mention Analytics







Impact Metrics

10.3k
Total Online Audience

$251
Total Online Publicity

8 Total Mentions

Mentions 8 **Audience** 10,271 **Publicity** USD $251

Sep 18, 2026 1:46 AM EDT

Pos. **1**

2026 general election Q&A: San Benito Health Care District Zone 4

Source BenitoLink (CA) **Market** Hollister, CA **Type** Digital News **Category** Local

... the community. Marni J. Friedman Friedman, 55, is a family physician who has lived in the district for 27 years. She has not held an elected position, but has served on various boards including First 5 San Benito, San Benito Medical Associates, Temple Beth El and Physician Advisory Group for **Central California Alliance for**

Sep 17, 2026 3:53 PM EDT

Pos. 2

2026 general election Q&A: San Benito Health Care District Zone 4

Source Benito Link **Market** Hollister, CA **Type** Digital News **Category** Local

... to the community. Marni J. Friedman Friedman, 55, is a family physician who has lived in the district for 27 years. She has not held an elected position, but has served on various boards including First 5 San Benito, San Benito Medical Associates, Temple Beth El and Physician Advisory Group for **Central California**

Sep 17, 2026 3:01 PM EDT

Pos. 3

2026 general election Q&A: San Benito Health Care District Zone 4

Source Benito Link **Market** United States **Type** Digital News



... to the community. Marni J. Friedman Friedman, 55, is a family physician who has lived in the district for 27 years. She has not held an elected position, but has served on various boards including First 5 San Benito, San Benito Medical Associates, Temple Beth El and Physician Advisory Group for **Central California Alliance for**

Sep 9, 2026 10:56 AM EDT

Pos. 4

Santa Cruz Celebrates Grand Opening of 50 Affordable Apartments

Source RealEstateRama **Market** United States **Type** Blog **Category** Other

Online News

... funding through the No Place Like Home Program, Veterans Housing and Homeless Prevention Program (a first for MidPen), Loan Portfolio Restructuring Program and California Housing Accelerator Program. Additional funding comes from the Housing Authority of the County of Santa Cruz, JP Morgan Chase, **Central**

Sep 3, 2026 2:08 PM EDT

Pos. 5

Mobile mammography services coming to Soledad this fall, winter

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



4 dates scheduled for women to receive local access to breast cancer screenings 1 Alinea Medical Imaging coaches bring mobile mammography services to communities across the region. (Courtesy of Alinea Medical Imaging) SOLEDAD — Soledad Community Health Care District is bringing mobile mammography services

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Sep 3, 2026 3:18 AM EDT

Neu. 6

Public Citizen 09.03.26

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

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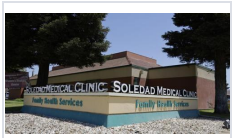
MOBILE MAMMOGRAMS The Soledad Community Health Care District is expanding access to breast cancer screening by offering mammograms to women ages 40-74 through a mobile clinic in partnership with the **Central California Alliance for Health** and Alinea Medical Imaging. 8am-5pm Friday, Sept. 4. SCHCD

Sep 1, 2026 10:38 PM EDT

Pos. **7**

Soledad health care district to offer mobile mammography services as it searches for a per…

Source Monterey County Now **Market** Seaside, CA **Type** Digital News **Category** Local



It's been a challenge to find a permanent mammography technologist for the Soledad Community Health Care District, so district officials have entered into a partnership to expand the service in Soledad this fall through a mobile service. The partnership includes the **Central California Alliance for Health** and Alinea Medical

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Sep 1, 2026 9:11 AM EDT

Pos. **8**

Soledad health care district to offer mobile mammography services as it searches for a per…

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



It's been a challenge to find a permanent mammography technologist for the Soledad Community Health Care District, so district officials have entered into a partnership to expand the service in Soledad this fall through a mobile service. The partnership includes the **Central California Alliance for Health** and Alinea Medical

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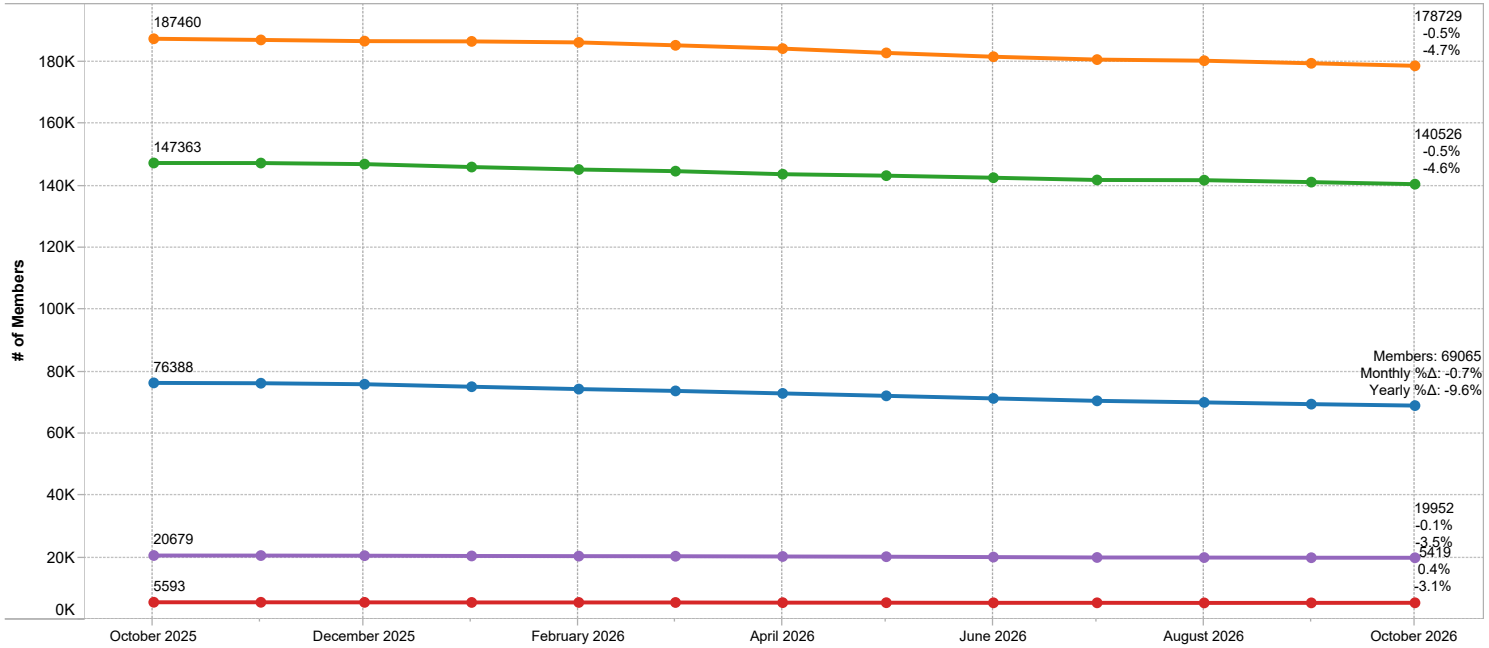
www.CriticalMention.com

Enrollment Report

County: *None* **Program:** *None* **Aid Cat Roll Up:** *None* **Data Refresh Date:** *10/2/2026 6:31:47 AM*

Enrollment Month
10/1/2025 12:00:00 AM to 10/31/2026 11:59:59 PM

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



LOB	County	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	Jun 2026	Jul 2026	Aug 2026	Sep 2026	Oct 2026
Medi-Cal	SANTA CRUZ	76,388	76,281	75,961	74,961	74,196	73,548	72,719	71,920	71,065	70,254	69,734	69,147	68,659
	MONTEREY	186,729	186,343	185,962	185,713	185,370	184,418	183,211	181,737	180,467	179,488	179,068	178,202	177,345
	MERCED	147,363	147,343	147,000	145,981	145,171	144,627	143,626	143,146	142,463	141,727	141,647	141,010	140,335
	MARIPOSA	5,593	5,584	5,560	5,521	5,514	5,504	5,450	5,432	5,394	5,393	5,357	5,371	5,393
	SAN BENITO	20,679	20,666	20,625	20,518	20,462	20,428	20,348	20,273	20,147	20,023	19,994	19,943	19,923
	Total	**436,752**	**436,217**	**435,108**	**432,694**	**430,713**	**428,525**	**425,354**	**422,508**	**419,536**	**416,885**	**415,800**	**413,673**	**411,655**
IHSS	MONTEREY	731	738	731	735	725	721	819	833	824	824	816	813	816
	Total	**731**	**738**	**731**	**735**	**725**	**721**	**819**	**833**	**824**	**824**	**816**	**813**	**816**
DSNP Total Care	SANTA CRUZ				192	199	254	277	294	316	343	364	387	406
	MONTEREY				158	182	205	251	323	365	423	489	527	568
	MERCED				77	86	100	119	126	144	151	168	181	191
	MARIPOSA				15	17	18	19	18	17	21	24	27	26
	SAN BENITO				17	18	19	21	22	25	25	27	28	29
	Total				**459**	**502**	**596**	**687**	**783**	**867**	**963**	**1,072**	**1,150**	**1,220**
Total Members		**437,483**	**436,955**	**435,839**	**433,888**	**431,940**	**429,842**	**426,860**	**424,124**	**421,227**	**418,672**	**417,688**	**415,636**	**413,691**

MONTEREY
MERCED
SANTA CRUZ
SAN BENITO
MARIPOSA

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