Physicians Advisory Group

Meeting Agenda

Date: **Thursday, September 3, 2026**

Time: **12:00 p.m. - 1:30 p.m.**

Place: **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 – Mariposa Room
5362 Lemee Lane, Mariposa, CA
San Benito County
Community Foundation Epicenter- San Benito Board Room
440 San Benito Street, Hollister, CA

Teams: 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. **Join the meeting now**
   ii. Meeting ID: 225 206 408 423 1
   iii. Passcode: jX3fU6gH
   iv. Enter your name if prompted (optional)
b. Or by telephone:
   i. United States:1-872-242-9041
   ii. Conference ID: 442596224#
   iii. Or click: +1 872-242-9041,,442596224#

---

1. Members of the public wishing to provide public comment on items not listed on the agenda that are within jurisdiction of the Advisory Group 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 Tuesday, September 1st to the Clerk of the Advisory Group at jvanvoerkens@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 five 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: 442 596 224#
      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: 225 206 408 423 1
   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 Wang. 12:00 p.m.**
   A. Roll call.
   B. Welcome new members:
      i. Adriana Ceja, CCO, Merced Faculty Associates
      ii. Marnie Friedman, MD, Hazel Hawkins Memorial Hospital
      iii. Minoo Sarkarati, MD, Clinic Physician, Clinical Dir. of Quality, SC Co. HS Agency
      iv. Ally Garcia, MD, new Medical Director at the Alliance
      v. David Nessim, MD, new Medical Director at the Alliance
   C. Supplements and deletions to the agenda.
   D. Group suggestions for future topics

2. **Oral Communications. 12:10 p.m.**
   A. Members of the public may address the Advisory Group on items not listed on today's agenda that are within the jurisdiction of the Advisory Group. Presentations must not exceed five minutes in length, and any individual may speak only once during Oral Communications.
   B. If any member of the public wishes to address the Advisory Group on any item that is listed on today's agenda, they may do so when that item is called. Speakers are limited to five minutes per item.

Consent Agenda Items: 12:15 p.m.

3. **Approve PAG Meeting minutes of June 11, 2026**
   A. Reference materials: Minutes as above.

Regular Agenda Items: 12:20 p.m.

4. **New Business**
   A. Transitional Care Services (TCS) Update — M. Bui-Duy, MD
   B. Behavioral Health — R. McMullen / Dr. Clarke
   C. Cal Aim Updates — M. Wang, MD

5. **Open Discussion: 1:00 p.m.**
   A. Group may discuss any urgent items.

6. **Adjourn: 1:30 p.m.**

The next meeting of the Physicians Advisory Group, after this September 3, 2026, meeting:
Date/Time: Wednesday, December 16, 2026 12:00-1:30 p.m.
Location: All Alliance counties

The complete agenda packet is available on the Alliance website at Central California Alliance for Health. This meeting is held in accordance with the Ralph M. Brown Act. The Alliance complies with the Americans with Disabilities Act (ADA). Anyone who needs special assistance or a disability-

related accommodation to participate should contact the Clerk of the Advisory Group at least 72 hours before the meeting at (831) 430-2621.

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:	***Signature:***	**Date**:

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

Transitional Care Services Update

Physician Advisory Group

Mai Bui-Duy, MD | Medical Director

9/3/2026

TCS OVERVIEW

- Per CalAIM Population Health Management Policy Guide, MCPs are accountable for providing Transitional Care Services (TCS), ensuring members are supported from discharge planning until successful connection to all needed services and supports.

TCS OVERVIEW – DHCS Framework

High-Risk TCS (Not Pregnant or Postpartum)

- Applies to all members listed under PHM Policy Guide definition; and who are **not** pregnant or postpartum (including but not limited to Members with LTSS needs, in or entering ECM or CCM, children with special health care needs)

Lower-Risk TCS (Not Pregnant or Postpartum)

- Lower-risk members in transitions are defined as those not included in **any of the three categories (in orange, blue, and green)**

High-Intensity Pregnancy and Postpartum TCS

- Any pregnant or postpartum member who meets any one of the criteria outlined on slide 15

Moderate-Intensity Pregnancy and Postpartum TCS

- Any pregnant or postpartum member who does not meet the criteria for the high-intensity TCS outlined on slide 15

Pregnancy and Postpartum TCS Categories

**Requirements align with CPSP requirements and ACOG and USPSTF guidelines*

WHO QUALIFIES FOR **HIGH RISK TCS** (NOT PREGNANT/POSTPARTUM)

- Members with **LTSS needs**, including receiving IHSS, CBAS and/or MSSP services
- Members transitioning to/from **SNF** or residing in **acute hospital setting**
- Members with **high utilization**: 3 or more ED/IP visits in past year or hospitalized within last 90 days
- Members with **ESRD, AIDS, cancer** undergoing treatment, recent organ **transplant**
- Members with **15 or more rx** in past 90 days
- **BH dx or developmental disability** WITH chronic medical diagnosis
- Any member served by **county SMHS/DMC within last 12 months**
- Members in or entering **ECM or CCM**
- **Children with special health care needs**
- Other members assessed as high-risk by **RSST**

HIGH RISK TCS REQUIREMENTS

- **Single Point of Contact** for TCS responsibilities
  - This may be ECM provider if enrolled in ECM; otherwise CCAH CM point of contact
  - Letters identifying CCAH CM and phone # faxed to hospital as well as assigned PCP
- TCS CM to connect with member within 7 calendar days post-discharge to ensure:
  - **PCP F/U** within 7 days, ensuring transportation
  - **Medication reconciliation** post-discharge
  - Completion of any **discharge summary instructions**
  - Completion of referrals for **at-home services** (DME, home health, etc)
  - Connection to **Community Supports** as needed
- High risk TCS support wraps at 30 days post-discharge and when all needs met

LOWER RISK TCS REQUIREMENTS

- Member will be notified by SMS & letter regarding CCAH TCS phone line as a resource post-discharge
- **Dedicated CCAH TCS phone line** to assist with
  - **PCP F/U within 30 days** of discharge, including **transportation** needs
  - **Medication reconciliation**
  - Completion of any **discharge summary instructions**
  - Connection to **ECM** or **Community Supports** as needed

- Lower risk TCS support wraps at 30 days post-discharge and when all needs met

Questions?

Behavioral Health Insourcing Update

Dr. Gray Clarke, BH Medical Director
Rebecca McMullen, LPCC, BH Manager
September 3, 2026

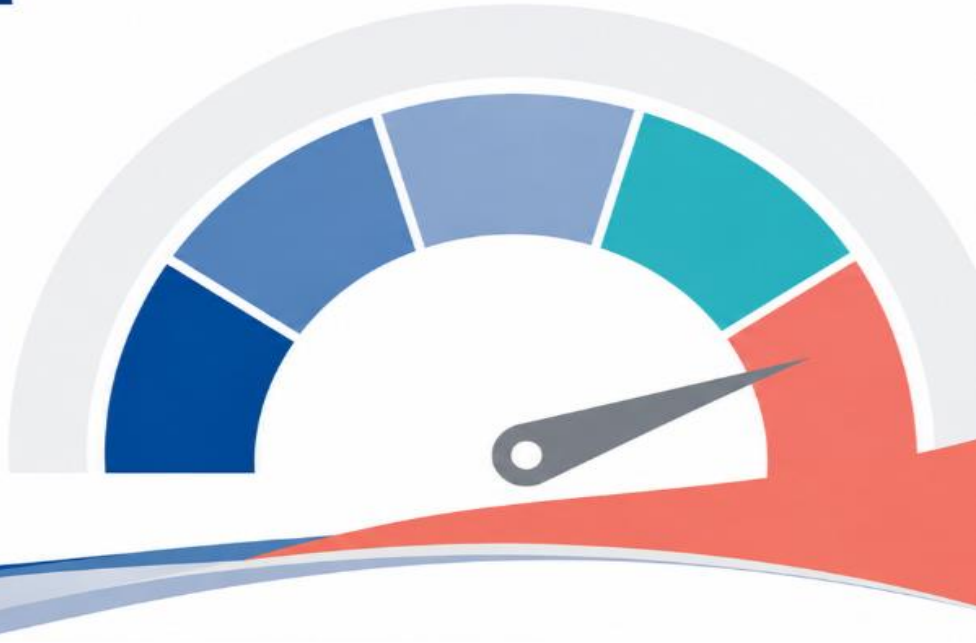
Goals of Behavioral Health Insourcing and Integration

Develop and execute an insourced NCQA compliant Behavioral Health Model, integrating BH services into core organizational functions to include:

- Execution of provider network that offers analogous access to the Managed Behavioral Health Organization.
- Timely claims processing for BH services to ensure compensation within same timeliness threshold as medical providers.
- Analogous utilization to vendor.
- Workforce training adequately prepares staff to meet BH member and provider needs.
- Improved service quality, responsiveness, and integration over vendor.

**Insourced from Carelon effective 7/1/25*

How did we do?



Execution of provider network that offers analogous access to the Managed Behavioral Health Organization.

- Over 5000 credentialed providers .
  - Added high-priority contracts and sign-on bonuses
  - Multiple BH Provider incentives
  - Increase in ABA provider groups from delegate
  - Successful recruitment and onboarding since insourcing
  - Expanded the CDE provider network from 5 (delegate network) to now 11 providers
    - 5 bilingual CDE providers.
    - This expansion contributed to near complete resolution in the CDE waitlist, demonstrating meaningful improvement in member access and timely care

Behavioral Health Network Updates

July 2024–June 2025 (Delegate) vs. July 2025–June 2026 (Alliance Insourced BH Program)

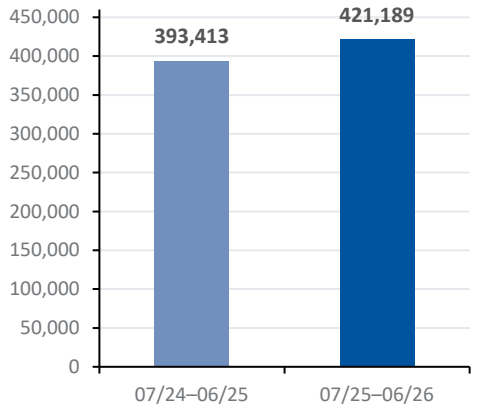
Paid BH Claims
421,189 +7.1%

Distinct Rendering NPIs
2,422 +17.3%

Distinct Contracted NPIs
5,201 +16.3%

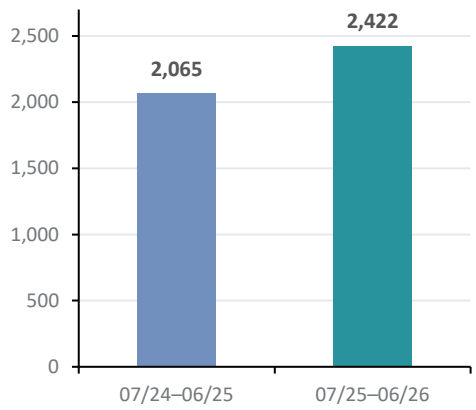
Paid BH Claims by BH Network

+7.1%



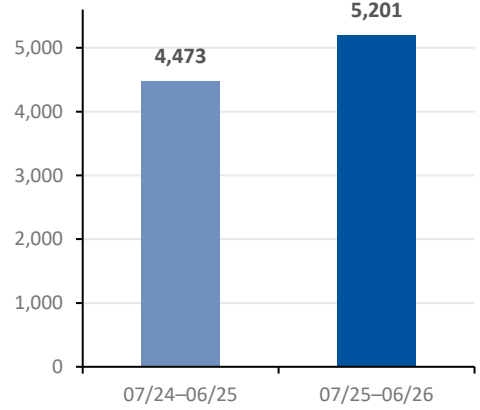
Distinct Rendering NPIs

+17.3%



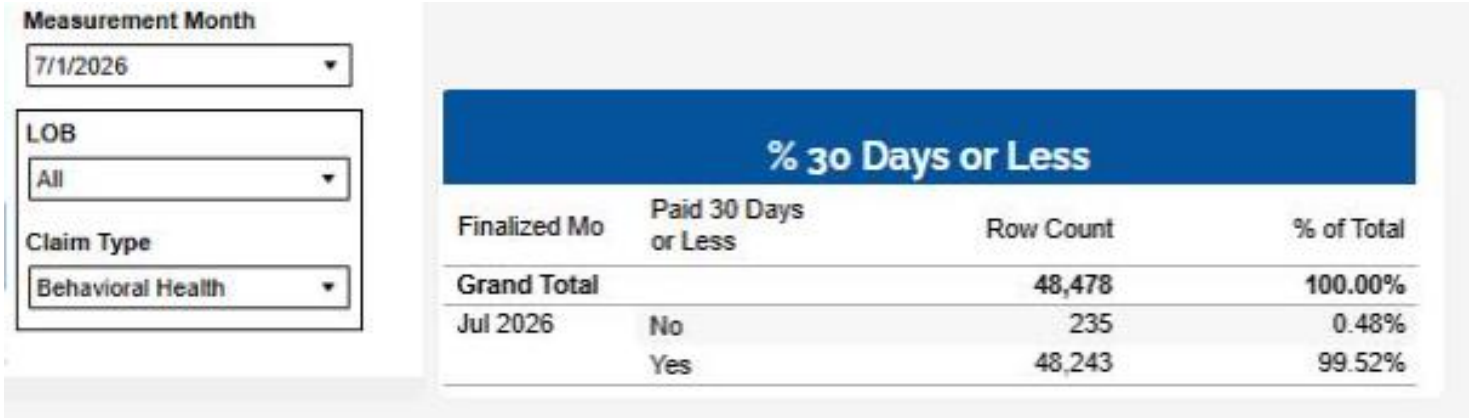
Distinct Contracted NPIs

+16.3%



Key takeaway: Provider participation and BH utilization both increased, supporting broader network capacity and access to services.

Timely claims processing for BH services to ensure compensation within same timeliness threshold as medical providers.



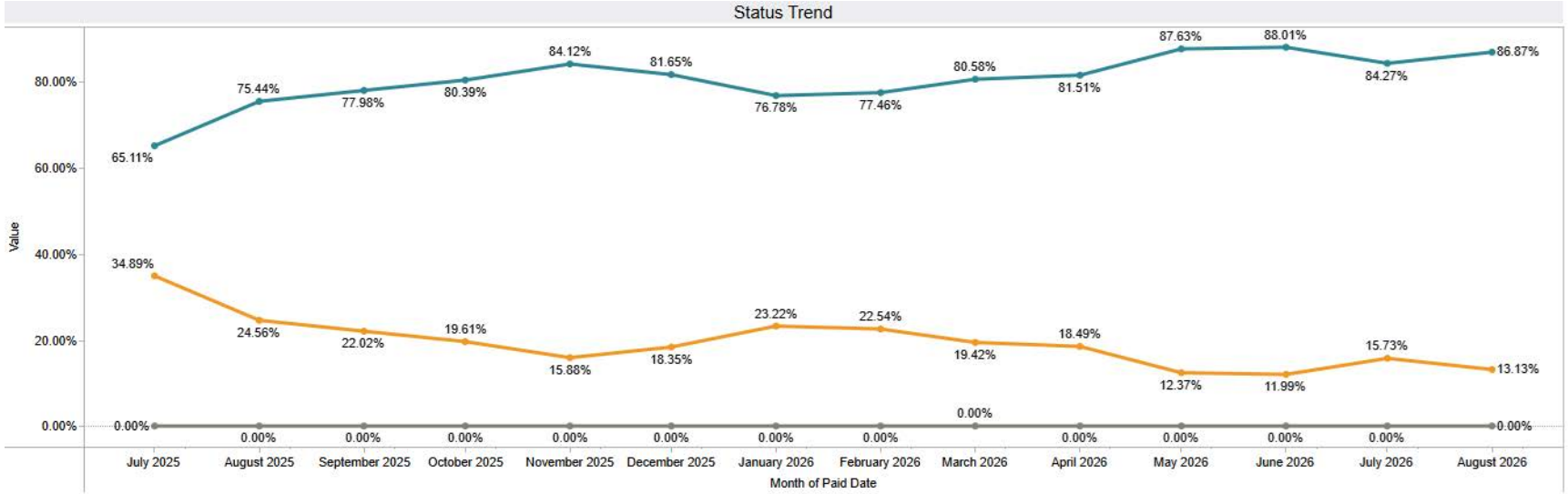
% 30 Days or Less

Finalized Mo	Paid 30 Days or Less	Row Count	% of Total
Grand Total		**48,478**	**100.00%**
Jul 2026	No	235	0.48%
	Yes	48,243	99.52%

- 99.52% of BH Clean claims are paid within 30 days or less, meeting DHCS requirements

Claims Payment rate now stabilized, denials decreasing

Paid	Denied	Pending
81.21%	18.48%	0.32%
754,738	171,715	2,934



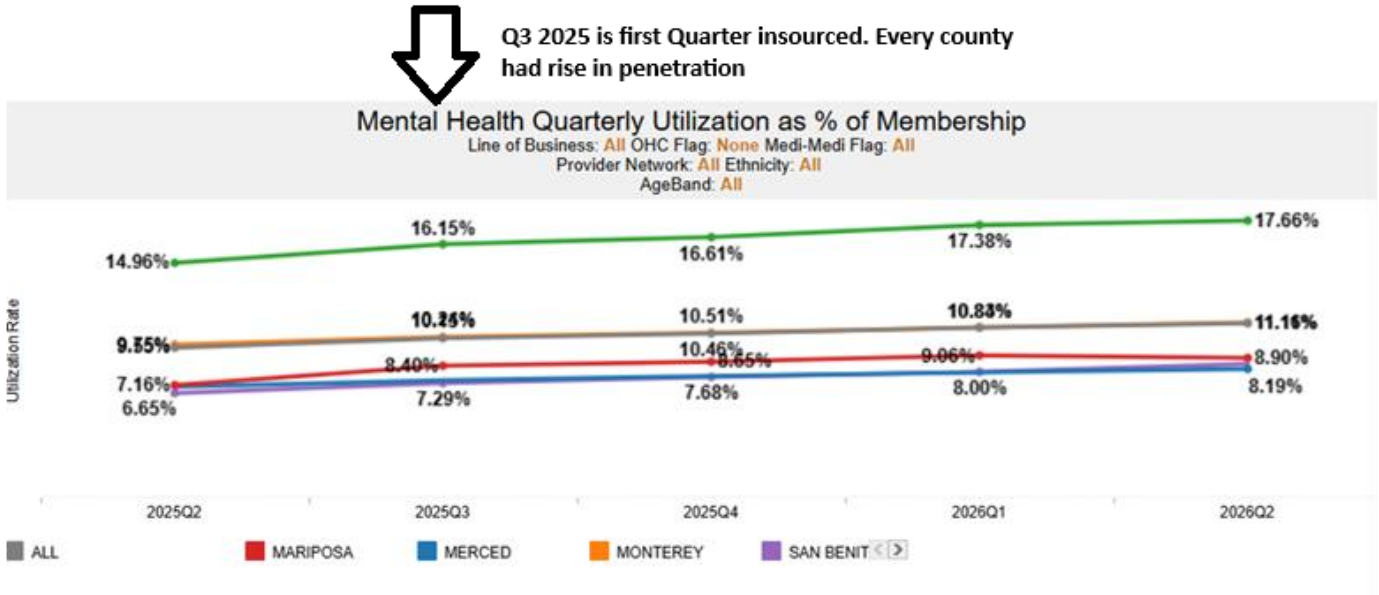
Analogous utilization to vendor.

- **<u>Increased member access to BH care:</u>**
  - Penetration reached 11.11% in Q2 2026 (rolling year) up from 9.55% pre-insourcing (Q2 2025)
  - This data represents 6K+ additional unique members accessing BH care this year.

- **<u>Strong utilization of BH care management:</u>** BH CM received approximately 10.5K referrals since July 2025. These include:
  - FUM follow ups
  - screening and transition of care tools (over 9000)
  - continuity of care cases.

  All engageable BH referrals to CCAH touch a BH CM or CC, whereas Delegate had less successful engagement. Delegate BH CM served ~3900 members during previous fiscal year, reflecting an increase of ~169% annual service volume

BH Penetration Rates since Insourcing



***Q2 2025**: overall 9.55% penetration rate, at 42,517 unique members*
***Q2 2026:** overall 11.14% penetration rate, at 48,265 unique members*

Workforce training adequately prepares staff to meet BH member and provider needs.

- New BH care management and UM teams established and maintained
- Created new distinct workflows for clinical and quality teams, including DHCS-compliant screening and transition to county . County BHP providers were also trained on workflow and system access.
- Delivered foundational training to all departments
- Delivered 45 tailored training sessions
- Built cross-functional educational library
- Executed outreach and education efforts, including training, provider digest articles, outreach events, and targeted education to provider needs, including BH specific Lunch and learns

Improved service quality, responsiveness, and integration over vendor.

- Waived prior authorizations requirements through January 2026 for Medi-Cal and for IHSS BH indefinitely
- Created a more automated and streamlined Screening and Transition process using Closed Loop Referrals with counties; prior process was manual and incomplete
- Increased collaboration with a subset of large behavioral health provider groups, including regular monthly meetings and improved referral processes
- Improved oversight for BH grievances, including county coordination
- 6.8% of over 17K calls to our Call Center are BH in nature
- Member Services/CM Teams are collaborating effectively to ensure members are routed to appropriate resources, including providing warm hand offs when needed
- Improved workflows for outreach for members in ED for FUA FUM

FUA FUM Rate Improvements

- Improved workflows for outreach to members in ED
- Improved coordination with county partners for FUA outreach
- Real time referral Processes in place with 2 county EDs

MEASURE	CARELON DELEGATE 2024 RATES	OUR PLAN 2025 RATES (Q2 DATA)	IMPROVEMENT
FUM 7 DAY	48.17%	51.04%	+2.87
FUM 30 DAY	63.95%	66.44%	+2.49
FUA 7 DAY	30.30%	37.52%	+7.22
FUA 30 DAY	44.84%	51.82%	+6.98

Focused on What Matters.
Driving timely follow–up and stronger outcomes through proactive engagement and continuous improvement.

Current 2026 CCAH strategic goals

- Focus in 2026 shifts from behavioral health implementation & operationalization to population management & care coordination
- Behavioral Health Care Management Referrals are converted to engagement
- Increase Depression Screening rates – all counties

Objective	Measure	Baseline	Target	Update Q226
Strategic Goals – Strategic Plan				
Assess Behavioral Health System	Behavioral Health Care Management Referrals are converted to engagement	85.0%	85.0%	99.9%
	Increase Depression Screening rates- all counties	36.8%	38.5%	31.66%

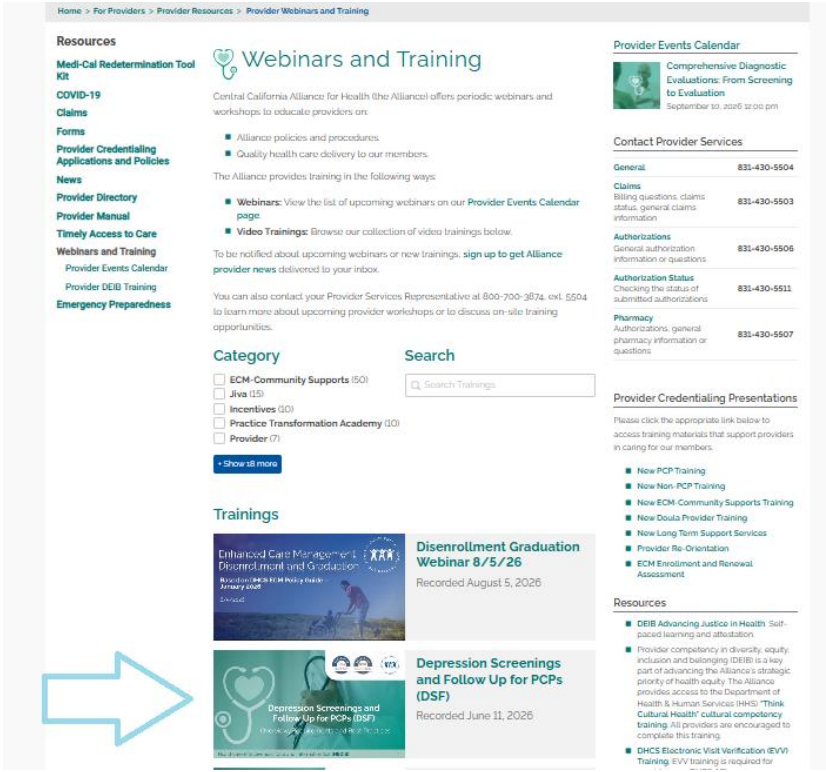
NCQA percentile	Depression Screening for Adolescents and Adults*
75th-90th (plan goal)	≥ 17.00-18.24%
50th-74th	7.00- 16.99%
25th-49th	3.50-6.99 %
24th or below	≤ 3.49 %

While below internal target, we are above NCQA plan goal and MPL

*Baseline shows Carelon's reported rate

Increase Depression Screening rates-
History and Interventions

- 2025 saw a dramatic increase in rates (from 13.87% to 36.8%)
  - Providers began using the Data Submission Tool (DST) more in 2025 due to CBI
  - CBI incentive and performance on the measure is tied to use of DST and LOINC code submission
- Lunch and Learn for providers was conducted June 11th, 2026, with 85 providers attending. Lower performing providers were targeted for the activity. [Depression Screenings and Follow Up for PCPs (DSF) - Central California Alliance for Health]
- More intensive engagement occurring and planned for August and September through cJOCs



UPCOMING: Webinar - BH Lunch & Learn:

Comprehensive Diagnostic Evaluations (CDEs) : *From Screening to Evaluation*

Event Details
Date: Thursday, September 10th
Time: 12:00 PM – 1:00 PM Virtual Only
Registration: Both internal and external attendees are welcome to register **Here**

Presenters:
Nicole Gend, CCAH BHT Clinical Administrator, PsyD/Licensed Psychologist
Special guest speaker, Shannon Stovall, PsyD/Licensed Psychologist from Wellity Behavioral Health

Key Topics Include:
- Understanding CDEs
- Screening
- Signs That May Warrant a Referral
- How to Refer and What Information to Include
- The Testing Process

Who Should Attend:
This session is intended for providers and staff involved in CDE referrals and follow-up care, including but not limited to: Primary Care Providers, Pediatricians, Clinic Managers and Administrative Staff, Physician Assistants and Nurse Practitioners, Nurses Other Clinical Staff

Questions/Comments?

CCAH CalAim Update

Mike Wang, MD
CCAH CMO/CHEO
Physicians Advisory Group
September 3, 2026

Community Supports

CS: Benefit Overview

Community Support	Description
Housing Transition Navigation Services	Helps members locate, apply for, and secure housing.
Housing Deposits	Covers eligible move-in expenses such as security deposits, utility setup, and certain medically necessary household items.
Housing Tenancy and Sustaining Services	Helps members maintain housing and prevent eviction.
Transitional Rent	Provides up to six months of rental assistance for eligible members experiencing or at risk of homelessness.
Short-Term Post-Hospitalization Housing	*Provides temporary housing after discharge from specified institutional settings. Available through December 31, 2026; ending as a separately defined Community Support effective January 1, 2027 and will be folded into Recuperative Care.*
Recuperative Care (Medical Respite)	Provides short-term residential recovery services for members with unstable housing who no longer require hospitalization.
Nursing Facility Transition or Diversion to Assisted Living	Helps eligible members move from, or avoid placement in, a nursing facility by residing in an assisted-living setting.
Personal Care and Homemaker Services	Provides assistance with bathing, dressing, meals, shopping, housework, and medical appointments.
Environmental Accessibility Adaptations	Provides medically necessary home modifications such as ramps, grab bars, widened doorways, stair lifts, or accessible bathrooms.
Caregiver Respite Services	Provides temporary relief for an unpaid caregiver.
Medically Supportive Food, Meals, and Medically Tailored Meals	Provides prepared meals, groceries, food vouchers, or other nutrition interventions for qualifying medical conditions.
Sobering Centers	Provides a safe, short-term alternative to an emergency department or jail for individuals who are publicly intoxicated.

Proposed Updates to Select Housing-Related Community Supports

Recuperative Care

Short-Term Post-Hospitalization Housing (STPHH)

Housing Transition Navigation Services (HTNS)

Housing Tenancy and Sustaining Services (HTSS)

Recuperative Care: Eligibility Criteria

Significant Updates

- Eliminate coverage of room and board.
- Establish greater precision, standardization, and quality in service delivery.
- Establish an achievable standard that mitigates attrition of today's Recuperative Care Providers.

Eligibility (Population Subset)

Members are eligible for Recuperative Care if they meet **both** of the following criteria:

(1) Requiring recovery in order to heal from an injury or illness, including recovery from an acute exacerbation of a chronic condition.[5]

AND

(2) Experiencing or at risk of homelessness.[6]

Short-Term Post-Hospitalization Housing

Benefit is sunsetting 1/1/2027

Effective July 1, 2026, MCPs must limit new STPHH authorizations; specifically, for Members requesting the maximum six-month service duration, authorizations must be adjusted to ensure they do not extend beyond December 31, 2026, the end of the State's coverage authority for the service.

Housing Transition Navigation Service

Standardized Initial Authorization and Reauthorizations Timeframes for HTNS:

DHCS expects MCPs to monitor the quality of HTNS delivery and Member progress towards obtaining housing on a consistent and ongoing basis. To safeguard program integrity and ensure that Members who need HTNS are receiving appropriate support, it is critical MCPs take an active approach in monitoring Network Provider activity, and ensure they are actively engaging with Members as needed.

To promote oversight of service delivery and assessment of ongoing need, for all Members authorized to receive HTNS by their MCP, the initial authorization period will be six (6) months, with reauthorization every six (6) months after that.

At the conclusion of each authorization period, MCPs must determine whether Members require a reauthorization for HTNS or meet one or more of the graduation/discontinuation criteria outlined below and are therefore ready to discontinue services.

Housing Tenancy and Sustaining Services

Evidence indicates that a minimum of 12 months of housing tenancy services is often needed to help Members achieve housing stability and shift health care utilization patterns. Accordingly, DHCS expects that most Members receiving HTSS will likely require additional months of services beyond the initial authorization period and may require one or more reauthorizations. In some instances, Members may achieve housing stability in fewer than six months. DHCS also recognizes that Members' tenancy support needs can fluctuate over time due to changes in life circumstances, behavioral health acuity, or aging.

To promote oversight of service delivery and assessment of ongoing need, for all Members authorized to receive HTSS by their MCP, the initial authorization period will be six (6) months, with reauthorization every six (6) months after that.

At the conclusion of each authorization period, MCPs must determine whether Members require a reauthorization for HTSS or meet one or more of the graduation/discontinuation criteria outlined below and are therefore ready to discontinue services.

Medically Tailored Meals

Referral Pathways(s):

Referrals for MTM/MSF must originate from the Member's established healthcare team and include clinical documentation of the nutrition-sensitive condition.

Member self-referrals, family-initiated requests, and direct referrals from MTM/MSF providers must go through the Member's healthcare team to ensure appropriate clinical oversight. This requirement reinforces that the service is a clinical intervention rather than a general food assistance benefit.

Enhanced Care Management

DHCS VISION: RETURN TO THE ORIGINAL SERVICE MODEL

- **Fidelity to the original service model**
  - Deliver ECM as originally designed: high touch
  - Prevent drift into a low-intensity model: low touch

- **Low-touch member engagement**
  - Infrequent member engagement (2 services per month, <5 hours)*
  - Primarily telephonic
  - Less than 37% licensed (e.g., social worker, nurse)

- **High touch member engagement**
  - Frequent member engagement (3+ services per month, >5 hours)*
  - Primarily in-person
  - At least 37% licensed

CURRENT STATE: ALLIANCE ECM PROGRAM IS BROAD, SHALLOW, AND FINANCIALLY UNSUSTAINABLE

Broad (across many members)

- More than 6% of Alliance Medi-Cal members are enrolled in ECM
- Compared to the statewide average of 1.8% and
- Most Medi-Cal plans falling between 0.5-3%
- DHCS actuary, Mercer said based on clinical acuity, target ECM enrollment between 1-2%
- Enrolled members have largely remained in the program indefinitely without graduation

Shallow (low intensity)

- Average of 2.3 encounters per month
- Approximately 75% of services are delivered via telehealth
- Approximately 94% rendered by non-licensed providers

Financially Unsustainable

- The Alliance is paying ECM providers more than we get in revenue from DHCS
- In 2025, the Alliance lost $41M with risk corridor protection ($138M w/o)
- In 2026, we're projecting a $58M loss with ***new*** risk corridor protection

ALLIANCE ACTIONS: PROPOSED ECM PAYMENT CHANGES

Provider payment methodology and rates, effective 1/1/2027

- Transition from a case-rate to a fee-for-service (FFS) payment methodology
- Align provider reimbursement rates with provided services
- Establish higher reimbursement for in-person ECM services than for telehealth services
- Establish higher reimbursement for clinical services than non-clinical
- Reimburse providers for indirect services
- Require authorization for service units beyond a defined range

ECM PROVIDER RATE PROPOSAL – FEE-FOR-SERVICE

	Alliance Provider Rate Build Up Hourly Rate			
ECM Service	2026 DHCS Base Rate	5% Trend + 3% Wage Adj.	30% Indirect Service Adj	DHCS Service Expectation
Clinical ECM In-Person	$128.00	$157.00	$204.00	40%
Clinical ECM Telehealth	$103.00	$126.00	$163.00	
Non-Clinical ECM In-Person	$64.00	$79.00	$102.00	60%
Non-Clinical ECM Telehealth	$52.00	$63.00	$82.00	
*ECM Outreach	$150.00	N/A	Final Provider Rates	

*ECM Outreach - $25 per target, not to exceed $150

Discussion Questions

- As the Alliance identifies members who are referred to ECM, but don’t meet ECM criteria, how do PCPs want to be engaged in the redirection of those members’ care management needs?
- How are providers identifying preferred ECM providers if at all?
- What are measures of ECM provider quality the Alliance should be looking at from clinical providers’ perspective?

Questions?

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, December 16	12:00 - 1:30 PM

- Lunch Provided