Physicians Advisory Group

Meeting Agenda

Date: **Thursday, December 4, 2025**

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 (new location):
Community Foundation Epicenter- San Benito Board Room
440 San Benito Street, Hollister, CA

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 Wednesday, December 3rd 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 meeting when that item is announced.
      i. State your name and organization prior to providing comment.
      ii. Comments are limited to five minutes.

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1. Call to Order by Chairperson Wang. 12:00 p.m.

A. Roll call.
B. Supplements and deletions to the agenda.
C. 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 September 4, 2025 and Charter

A. Reference materials: Minutes as above.
B. Charter

Regular Agenda Items: 12:20 p.m.

4. New Business

A.	Medi-Cal Capacity Grant Program Investment Planning Process	J. Finney
B.	Dual Eligible Special Needs Plan (D-SNP)	S. Katz
C.	Behavioral Health Insourcing Update	G. Clarke, MD
D.	ECM / Community Supports Update	K. Nester, Dr. Wang

5. Open Discussion: 1:20 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 December 4, 2025, meeting:

Date/Time: Thursday, March 5, 2026 12:00-1:30 p.m.
Location: All Alliance counties

The complete agenda packet is available for review on the Alliance website at Central California Alliance for Health The Alliance 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 Advisory Group at least 72 hours prior to the meeting at (831) 430-2621.

Physicians Advisory Group

Date: September 4, 2025

Time: 12:00 – 1:30 p.m.

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MINUTES

Chair: Mike Wang, MD, CMO			**Minutes by:** Jacqueline Van Voerkens
	Members Present:	Dr. Casey KirkHart, Dr. Mimi Carter, Dr. Cristina Mercado, Dr. James Rabago, Dr. Caroline Kennedy, Dr. Misty Navarro, Becky Shaw, and Dr. Ralph Armstrong,	
	Members Absent:	Dr. Cheryl Scott, Dr. Devon Francis, Dr. Jason Novick, Dr. Donaldo Hernandez, Dr. Shirley Dickinson, Dr. Amy McEntee, Dr. Jennifer Hastings, Dr. Charles Harris, and Dr. Salvador Sandoval.	
	Central California Alliance for Health staff:	Dr. Mike Wang, Dr. Mai Bui-Duy, Dr. Dianna Myers, Arti Sinha, Ms. Lilia Chagolla, Ms. Tammy Brass, Ms. Jessie Dybdahl, Ms. Kelsey Riggs, Travis Moody, and Jacqueline Van Voerkens.	
Item No.	**Agenda Item**		

I.	**Call to Order**	Chairperson Dr. Mike Wang called the meeting to order at 12:05 p.m. Roll call was taken.	
II.	**Oral Communications**	Chairperson Wang opened the floor for any members of the public to address the Group on items not listed on the agenda. No supplements or deletions to the agenda were requested. No members of the public addressed the Group.	
Items for Approval		**Discussion**	**Action/Recommendation**
III.	**Review & Approve Minutes**	**The Minutes from the March 6, 2025, meeting were reviewed.** **Dr. KirkHart motioned to approve the minutes from the PAG 03/06/2025 meeting.* **Dr. Kennedy 2nd the motion for approval.* **Group approved March 6, 2025 meeting minutes as presented.*	*The **Physicians Advisory Group** approved the March 6, 2025 meeting minutes.*
Action Item Follow-Up			
	March 6, 2025 Meeting	Care Based Incentives: Investigate CPT2 coding support for practices. **Action pending**	Dr. Wang
	March 6, 2025 Meeting	Continuity & Coordination of Care, Behavioral Health & Primary Care: Investigate the data regarding lab ordering whether from the PCP or psychiatrist. **Action Pending**	Sarina King
Consent Agenda			
	Approval 2026 PAG Meeting Schedule	2026 PAG Meeting Schedule approved by Group.	
Regular Agenda			
	Agenda item		
III.	**Member Portal**	Lilia Chagolla and Arti Sinha presented on the Member Portal to the Group. Highlights included the member portal's phased rollout, noting partnership with Z Omega and the goal to empower members with self-service options. The portal launched in early 2025, initially offering features such as primary care provider (PCP) changes, demographic updates, ID card ordering, and health risk assessments. Planned enhancements for 2025–2026 include viewing care plans, authorizations, claims, filing grievances/appeals, interactive care plans, two-	

		way communication, role-based accounts, Spanish language support, and account access for minors and their guardians. The team is addressing technical and regulatory challenges, such as minor consent and privacy. The portal is currently mobile browser-friendly but does not yet have a standalone app. Multiple participants stressed the importance of developing an app, as most members use smartphones. The team acknowledged this need and is considering it for future development. There is no AI chat feature yet, but feedback suggested adding search and AI support similar to commercial insurance portals. The team is collecting suggestions for future improvements. Member Engagement & Marketing soft launch is underway, with a few hundred members using the portal. Broader marketing will follow after refining features based on feedback. The portal is promoted to tech-savvy callers, and support is available via the call center. It was noted during the meeting that currently, only adults can access the portal due to consent and privacy concerns for minors. The team is working on solutions to allow appropriate access for minors and their guardians in the future. Spanish language support is planned for 2026. The team is working with vendors to ensure accurate translation and accessibility. The Group emphasized using plain language (e.g., "primary doctor" instead of "PCP") and making terms like "care plan" and "grievance" more member-friendly (e.g., "my health goals," "complaint"). Suggestions included adding hyperlinks to provider clinics and ensuring the portal is accessible to those with varying technical skills.	

		Discussion highlighted that while many members prefer in-person or phone support, there is a growing need for digital solutions, especially app-based access. The team is balancing these needs and collecting ongoing feedback. Next Steps: • **Language Simplification** –revise terminology (e.g., replace "PCP" with "primary doctor" and "care plan" with "health goals") for better member understanding. • **Complaint/Grievance Terminology** –update "file a grievance or appeal" to more accessible language like "file a complaint." • **Hyperlinks to Clinics** – to consider adding hyperlinks to provider clinic websites in the portal. • **App Development** – Team to explore development of a standalone mobile app for the member portal. • **AI Chat/Search Feature** – Team to consider adding AI chat or enhanced search functionality for member support. • **Spanish Language Support** – Team to work with vendors to implement Spanish language access by 2026. • **Minor Consent & Access** – Team to develop solutions for minor consent and privacy to enable portal access for minors and guardians. **Marketing & Member Feedback** –share portal updates with the member advisory group and incorporate ongoing feedback before broader marketing.	
IV.	**Criteria Development, Adoption and Review: Community Supports - Medically Tailored Meals and Housing**	Dr. Mike Wang explained that the Medially Tailored Meals (MTM) policy updates are driven by the need for reliable diagnosis verification and to address inconsistent validation by vendors. The new process requires documentation of a qualifying diet-sensitive diagnosis (e.g., diabetes, hypertension) for MTM approval, regardless of referral source (member, vendor, ECM provider). Non-clinical referrals must provide some form of clinical evidence (e.g., discharge summary, medication bottle photo). If	

		documentation is missing, the authorization team will reach out to the member's primary care provider to obtain it. The benefit is available to both adults and children. Pediatric-specific conditions (e.g., prediabetes, high cholesterol, fatty liver) are included, with flexibility for provider documentation. The list of qualifying conditions is not exhaustive and is based on literature review and alignment with available diets from vendors. Initial MTM approval lasts up to 12 weeks with diagnosis documentation. Renewals require evidence that MTM is part of the care plan and that a provider is monitoring outcomes (e.g., improved A1C for diabetes). Vendors and dietitians are expected to coordinate with PCPs, and the Alliance is working on improving closed-loop communication and documentation sharing. The MTM benefit is intended for diet-sensitive conditions, not general food insecurity. The Alliance is not reimbursed by the state for these services, so appropriate targeting is emphasized. Providers are encouraged to refer patients who would benefit most. Providers in the Group requested clear notification when their patients start MTM and access to dietitian notes. The team acknowledged the need for better integration with provider workflows (e.g., fax, portal, HIE) and is considering bulk reporting for quality improvement. There was a request for practical referral guides and clarity on how to select appropriate meal types (e.g., vegetable-only boxes) in the referral process. Jessie Dybdahl shared a Meal Referral Form link in the chat for provider use. There was no substantive discussion or review of housing supports criteria or related topics in the meeting content.	

		Medically Tailored Meals – Next Steps: • **Provider Notification & Documentation:** Alliance team to improve notification processes for PCPs when patients start MTM and explore ways to share dietitian notes and intervention start dates (e.g., via fax, portal, or HIE). • **Closed-Loop Referral System:** Alliance to continue developing a closed-loop referral system for community supports and ECM, targeting mid-next year for implementation. • **Criteria Review:** Alliance to consider future agenda topics for reviewing and simplifying qualifying conditions, especially for behavioral health and pediatric populations. **Vendor Coordination:** Alliance to encourage vendors to coordinate with PCPs and send relevant documentation for renewals and ongoing monitoring.	
V.	**Alliance Data Management Strategy Update/ Data Sharing Incentive**	M. Wang, MD informed the Group that the Alliance is advancing a multi-year data management strategy focused on sharing, managing, and distributing data across its network, with a strong emphasis on Health Information Exchange (HIE) integration. The strategy includes internal and external socialization, ongoing modernization of the enterprise data warehouse, and compliance with CMS interoperability requirements via a QHIO platform. Agreements are in progress with Merced and Monterey for HIE participation, and provider onboarding guidelines are being developed to streamline the process. The data sharing incentive program targets provider types in phases, starting with hospitals and SNFs, then expanding to pediatricians, PCPs, ECM providers, and behavioral health. The approach is data-driven, prioritizing providers serving the largest member populations. Hospitals and SNFs are incentivized to send ADT messages (admissions, discharges, transfers), results (labs, notes, EKGs), and medication/treatment orders to	

		the HIE, with performance measured by the percentage of encounters reported and completeness of data. The program has increased real-time inpatient data sharing from about 20% to 80% over the past year and a half. Payment schedules for incentives are structured around milestones, such as agreement signing, data submission initiation, and increasing data completeness over time. The provider portal includes a redetermination date within the linked member list, supporting eligibility management. **The Group inquired on how clinics access member redetermination data?** Clinics can access redetermination dates for their members via the Alliance Provider Portal, which allows organizations to download and sort by who needs redetermination. **The Group asked if there is funding for clinics to support redetermination work?** Community health workers can bill the Alliance for health navigation services, which includes eligibility and documentation support for redetermination. **The Group asked what types of data are providers expected to share?** Providers are expected to send ADT messages (admissions, discharges, transfers), labs, notes, EKGs, medications, and treatment orders to the HIE. **The Group inquired on what is the incentive structure for data sharing?** Incentives are milestone-based, with payments tied to agreement signing, initial data submission, and increasing data completeness. **The Group asked if technical assistance or grant support available?**	

		Technical assistance is available and ongoing, and the Alliance is evaluating cost-sharing for HIE connectivity and bandwidth. Grant support is available for infrastructure upgrades, including potential EHR enhancements, with a maximum award of $250,000 **The Group inquired on which provider types are targeted and in what order?** The program started with hospitals and SNFs, then expanded to pediatricians, PCPs, ECM, and behavioral health providers, prioritizing those serving the most Alliance members. Next steps: **Provider Onboarding** – Alliance to continue onboarding new provider types in phases, prioritizing those with the largest member populations.	
VI.	**Open Discussion**	The group discussed Medi-Cal Redetermination. The Group indicated that some clinics and hospitals have dedicated staff or community health workers (CHWs) to assist with Medi-Cal redetermination, while others direct members back to county eligibility offices. Some hospitals (e.g., Salinas Valley) have registration staff handling redetermination, while others rely on referrals to county offices. The Alliance Provider Portal contains a linked member list with redetermination dates, allowing clinics to identify and support members needing redetermination. Questions were raised about funding and sustainability for dedicating staff to redetermination. The Group was informed that Clinics can bill the Alliance for CHW services related to health navigation, including eligibility and documentation for redetermination.	

		Overall, it was noted that there is no standardized process across all clinics; practices vary based on resources and internal workflows.	
Action Items			
Agenda Item	**What is the action item**	**Due date**	**Responsible staff**
	n/a		
Meeting adjourned at 1:30 p.m.			
Next Meeting:			
Approved by Committee Date:	***Signature:***		**Date**:

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

	Physicians Advisory Group (PAG) **Meeting Charter**
Original Date: October 2023	**Last Revision Date:** ~~October 13, 2023~~October 1, 2025
Approved by: Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission	

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

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

Revision History

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

Medi-Cal Capacity Grant Program: Planning for 2026

Jessica Finney
Community Grants Director
Physicians Advisory Group
December 4, 2025

PURPOSE OF TODAY'S DISCUSSION

Review and discuss inputs and emerging priorities for the 2026 MCGP Investment Plan.

QUESTIONS FOR PAG

Do the identified needs and priorities align with what you observe?

What needs to be emphasized in grant program planning?

BACKGROUND: MCGP PURPOSE

The Alliance makes investments to health care and community organizations in Mariposa, Merced, Monterey, San Benito and Santa Cruz counties through the Medi-Cal Capacity Grant Program to realize the Alliance's vision of heathy people, healthy communities.

These investments focus on:

- Increasing the availability, quality and access of health care and supportive resources for Medi-Cal members.
- Addressing social drivers that influence health and wellness in our communities.

The MCGP includes funding opportunities in three focus areas:

1. Access to Care
2. Healthy Beginnings
3. Healthy Communities

BACKGROUND: MCGP GOVERNANCE

- Board established grantmaking focus areas and goals in August 2022 and governance policy for annual plan in February 2024.
- MCGP Investment Plan guides annual investments and award amount target.
- Grantmaking priorities identified through a comprehensive planning process.
- The Board provides strategic direction:
  - Provides input on community needs and grantmaking priorities.
  - Allocates funding to specific Board-approved focus areas and strategies.
- Operations managed by staff, ensuring alignment with the Board-approved plan.

MCGP ANNUAL INVESTMENT PLAN OVERVIEW

- Annual Investment Plan serves as a roadmap for MCGP funding priorities and decisions.
  - Establishes grantmaking priorities for the year that are responsive to identified community needs.
  - Allocates funding across Board-directed strategies.
  - Incorporates learnings from previous years' investments to optimize impact.
- New Community Reinvestment requirements will be incorporated into the existing MCGP Annual Investment Plan process to ensure alignment and streamlined administration.
- 2026 Investment Plan will be presented for Board approval in January 2026.

2026 INVESTMENT PLAN **INPUTS**

- Environment Scan
  - County Community Needs Assessments and Community Health Improvement Plans
  - State Landscape
  - Alliance Strategic Priorities
- Stakeholder Input
  - Stakeholder Interviews with Community Leaders (2024)
  - Internal Grants Review Committee
  - Member Advisory Group (Nov. 2025) and Survey (May 2025)
  - Physician Advisory Group (Dec. 2025)
  - Board (Oct. 2025 & Jan. 2026)

CHA & CHIP **PRIORITIES ACROSS SERVICE AREA**

Top Health Issues (CHA)
1. Access to Health Care
2. Mental Health and SUD
3. Housing Security/Burden
4. Nutrition, Physical Activity & Weight

Top Priorities (CHIP)
1. Access to Health Care
2. Mental Health and SUD
3. Child and Adolescent Health/Family Support
4. Chronic Disease Prevention
5. Housing

CRITICAL NEEDS IDENTIFIED DURING STAKEHOLDER INTERVIEWS

- Access to Health Care Services
- Health Care Workforce
- Culturally and Linguistically Competent Care
- Community Education and Engagement
- Mental Health and SUD Treatment
- Affordable Housing/ Homelessness
- Access to Healthy Food and Physical Activity Opportunities
- Early Childhood Support

MSAG SURVEY TAKEAWAYS

- Recent MSAG survey included a question about MCGP funding priorities requiring increased investment.
- Key investment opportunities identified:
  - Behavioral health
  - Community health education and engagement
  - Housing capacity and homeless service provider capacity

DHCS PRIORITIES

- Declining Medi-Cal enrollment over the next 3+ years due to changes in enrollment and eligibility requirements
- Disruption in Medi-Cal financing for safety net providers
- Continuing core commitments of CalAIM
- Investing in SUD and mental health delivery systems through Behavioral Health Transformation

ALLIANCE PRIORITIES

- Member enrollment and redetermination
- Need for flexibility to respond to community needs caused by HR1/state budget
- Person-centered behavioral health services and systems
- Sustaining pediatrics, specialty care, and quality measures
  - Health equity outcomes in Merced and Mariposa counties, esp. children
- Increasing member access to culturally and linguistically appropriate health care

ALIGNMENT OF IDENTIFIED NEEDS & PRIORITIES

CRITICAL NEEDS	CHIP Priority	Community Stakeholder Priority	MCGP Investment Areas	Alliance Strategic Plan Priority
Access to Care - Health Care Workforce (Care Gaps/Quality) - Culturally and Linguistically Competent Care	X	X	X	X
Mental Health and SUD	X	X	X	X
Child and Adolescent Health/Family Support	X	X	X	X
Community Engagement and Education		X	X	X
Housing Security/Affordable Housing	X	X	X	
Chronic Disease Prevention	X	X	X	

IDENTIFYING GRANTMAKING PRIORITIES FOR 2026

Access to Care

- Workforce Recruitment/Support
  - Pediatrics, Behavioral Health, Specialty, Community Health Worker
  - Workforce support to close care gaps
- Health Care System Infrastructure
  - Technology, capital
- Safety Net Critical Access

Community Engagement & Education

- Medi-Cal Member Enrollment and Retention
- Training and support for delivery of CHW Benefit (health care navigation and health education services)

DISCUSSION: MCGP 2026 INVESTMENT PRIORITIES

Do the identified needs and priorities align with what you observe?

What needs to be emphasized in grant program planning?

TotalCare℠ HMO D-SNP

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH®

Physician's Advisory Group 12.04.2025

Presented by Sherri Katz, Director of Medicare Operations

Alliance Service Area - Market Characteristics

2025 Market Characteristics					
County	**Mariposa (CA)**	**Merced (CA)**	**Monterey (CA)**	**San Benito (CA)**	**Santa Cruz (CA)**
County Type	Rural	Metro	Metro	Micro	Metro
County Population	17,048	296,774	436,251	69,159	262,406
Eligibility and Enrollment Data					
Eligibles by County[1]	5,072	41,352	73,456	10,799	58,812
Enrolled by County[2]	723	11,181	11,227	1,721	15,193
Medicare Market Characteristics					
Medicare Penetration Rate*	14%	27%	15%	16%	26%

[1]Indicates overall Medicare eligibility, not only those with dual eligibility
[2]Indicates Medicare eligibles enrolled in a Medicare Advantage plan
*The national average is 51% MA penetration

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Alliance Service Area – Dual Eligibility by County

2025 Market Characteristics					
County	**Mariposa (CA)**	**Merced (CA)**	**Monterey (CA)**	**San Benito (CA)**	**Santa Cruz (CA)**
Medicare Eligibles by County*	5,072	41,352	73,456	10,799	58,812
Dual Eligibles by Type					
Dual Eligibles[1]	880	13,645	15,357	1,942	9,799
Age-Ins[2]	116	1,553	1,845	237	1,104
TOTAL	996	15,198	17,202	2,179	10,903
Dual Eligibility as a Percent of Medicare Eligibles					
Duals as a % of Medicare Pop.	19.6%	36.8%	23.4%	20.2%	18.5%

*All Medicare eligibles (includes Duals and Non-Duals)
[1]Data as of 11/2025
[2]Represents Medi-Cal members aging into Medicare between January and December 2026

Marketing & Sales Strategy

TotalCare℠ HMO D-SNP

What will TotalCare (HMO D-SNP) offer in 2026?

Medicare Supplemental Benefits (PART C*)

Vision	OTC	Fitness	Worldwide emergency care
1 routine eye exam/year & $350 eyewear allowance/2 years	$100 quarterly benefit (unused dollars roll over to following quarter)	Gym membership or home fitness kit; digital exercise programs; fitness coaching	Emergent and Urgent care coverage anywhere in the world (up to $50,000)

*In addition to all covered Medicare Parts A and B services

TotalCare℠ HMO D-SNP

Part D: TotalCare (HMO D-SNP) Tiers

There are 6 tiers of drugs for TotalCare (HMO D-SNP) members.

Tier 1	Tier 2	Tier 3	Tier 4	Tier 5	Tier 6
Lowest cost sharing tier; preferred generic drugs	Generic drugs; more expensive than Tier 1	Preferred brand drugs	Non-preferred drugs	Highest cost sharing tier; specialty drugs	Lowest cost sharing tier; select care drugs
Member copay is $0.	Member copay is either $1.60 or $4.90.	Member copay is either $1.60 or $4.90.	Member copay is either $1.60 or $4.90.	Member copay is either $1.60 or $4.90.	Member copay is $0.

TotalCare (HMO D-SNP) Summary

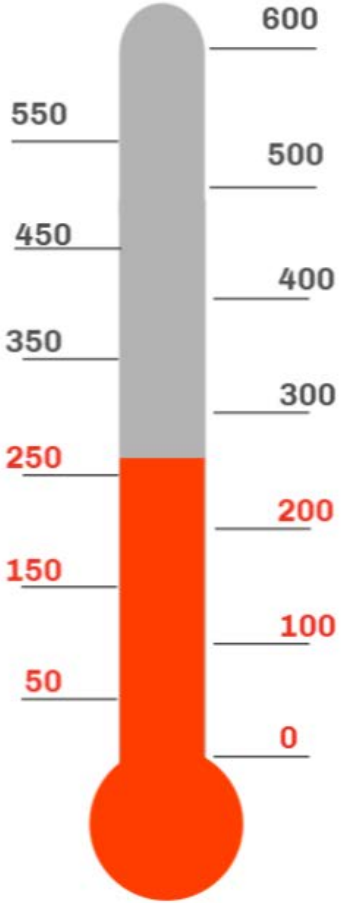
1. Governed by CMS & DHCS
2. Members enjoy the benefits of both programs under one roof
3. Members receive dedicated care management
4. Integrated materials, improved care coordination, and integrated member services (G&A)
5. Medicare cost sharing protections

TotalCare (HMO D-SNP) Enrollment*

	Mariposa	Merced	Monterey	San Benito	Santa Cruz	Grand Total	Enrollment by Channel and Type
Agent Total	**8**	**30**	**92**	**9**	**76**	**215**	**85.32%**
• Age-in			1	1	2	4	*1.86%*
• Existing Dual - Age	7	21	72	7	66	173	*80.47%*
• Existing Dual - Disability	1	9	19	1	8	38	*17.67%*
OEC Total		**6**	**8**	**3**	**18**	**35**	**13.89%**
• Existing Dual - Age		4	8	3	14	29	*82.86%*
• Existing Dual - Disability		2			4	6	*17.14%*
Paper App Total					**2**	**2**	**0.79%**
• Existing Dual - Age					2	2	*100.00%*
Grand Total	**8**	**36**	**100**	**12**	**96**	**252**	**100.00%**
Enrollment by County	**3.17%**	**14.29%**	**39.68%**	**4.76%**	**38.10%**	**100.00%**	

*Enrollment as of 11/21/25

Progress to Goal



- Outbound Call Campaigns to existing Alliance Dual Eligible members (those with Parts A&B and those with Parts A,B&D)
- Birthday Cards for Medi-Cal members aging into Medicare in November and December
- Text Campaigns to raise awareness to TotalCare (HMO D-SNP)
- Wave 2 of TotalCare Postcards to existing Dual Eligible Population

TotalCare℠ HMO D-SNP
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Behavioral Health Insourcing Update

Gray Clarke, MD
Behavioral Health Medical Director
Provider Advisory Group
December 4, 2025

AGENDA:

1. Background and Goals of Insourcing
2. Summary of Efforts
3. Current Performance
4. Lessons Learned

Behavioral Health Integration Program Goals

Executive Summary: Facilitate the planning and execution of enterprise-wide operational readiness to administer the non-specialty behavioral health suite of benefits in accordance with regulatory compliance.

Main Objective:
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 current vendor.
- Workforce training adequately prepares staff to meet BH member and provider needs.
- Improved service quality, responsiveness, and integration over vendor.

Cross-functional Program Efforts and Achievements

Clinical/Operational

- New BH care management and UM teams established
- Created new distinct workflows for clinical and quality teams, including DHCS-compliant screening and transition to county
- Maintained continuity during transition

Provider Network Development

- Built a strong BH network meeting DHCS and DMHC requirements
- 2243 BH and 1324 BHT providers
- Added high priority contracts and sign on bonuses
- 799 providers credentialed
- Ongoing network expansion

Member and Provider Engagement

- Created member touchpoint map and call center protocols
- Delivered timely communications and provider notifications
- Waived prior authorizations requirements (for IHSS indefinitely) until January 2026

Cross Functional

- Hired 53 positions across 11 departments
- Delivered foundational training to all departments
- Delivered 45 tailored training sessions
- Built cross-functional educational library
- Claims configuration and rules

Current Operations Performance

Claims and Call Center

- 242,613 claims paid
- Successful claims payment rates rapidly increasing (denial rates declining)
- Timeliness: 99.69% of claims paid in 30 days
- Call center experiencing increased call volume (doubling since July 2025). Staffing hires underway to address.

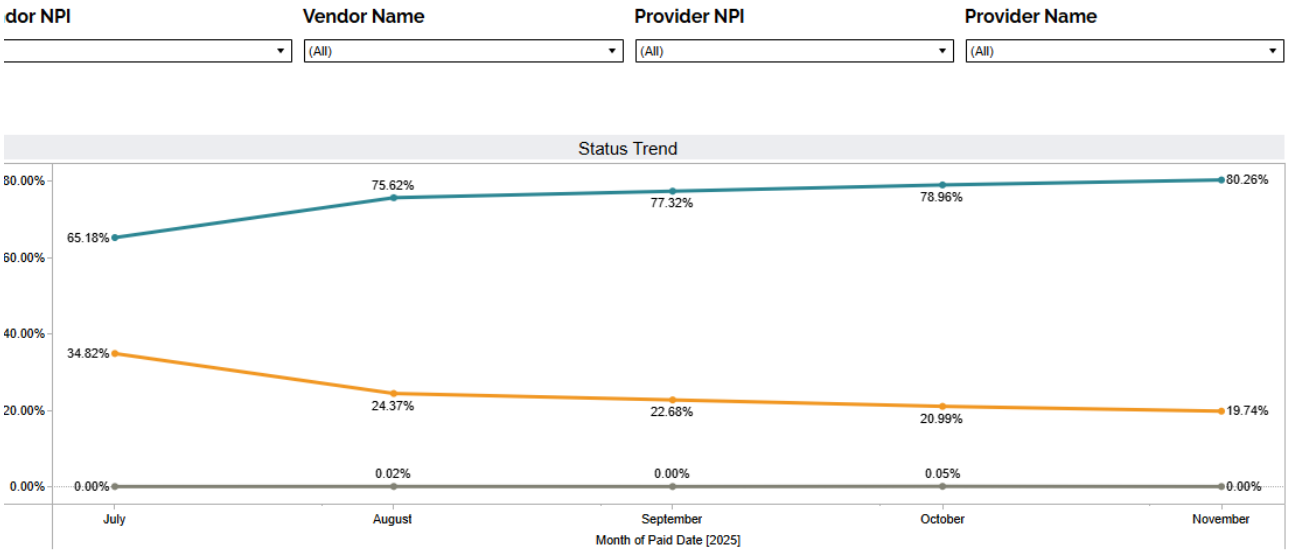
CM, UM and Grievances

- CM team receiving > 3000 referrals per month
- Prior authorization requirements have been waived until January 1, 2026
- Grievances: low volume to date, drill downs occurring to address early complaints

Utilization of Behavioral Health Services

- Being monitored and already showing improvement – 9.25% versus baseline of 8.27%

Claims Payment rate steadily increasing - (%) out of total 242,613 claims to date



Top denial reasons: 1. Missing modifier required for payment rate 2. Associate provider missing supervising clinician

BH Care Management by the Number

DHCS Screening Tool: 2000+ completed since 7/1

County BH Referrals: 320 per month

Alliance BH CM Referrals: 255 per month

Mental Health ED Visit Follow up (FUA FUM): 45 per week

Outbound Member Calls: 20 per day per staff person

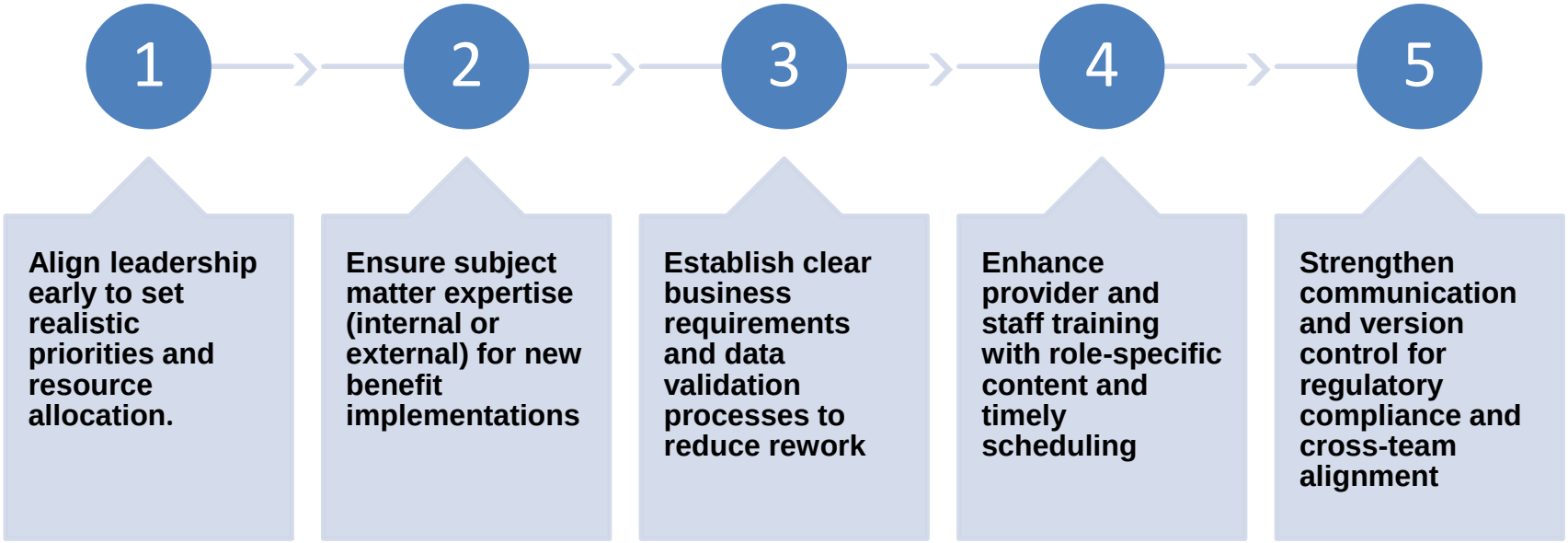
Current Caseload avg: 1:85

Member Services Warm Transfers: 751 last 60 days

Ongoing Monitoring

- 2025 Strategic Goals (execution of insourcing)
- 2026 Strategic Goals include BH
- BH Utilization – Alliance Dashboard
- Compliance Audit Metrics
- Department Specific Metrics (multiple)
- Quality Measures (MCAS, HEDIS)
- Readiness for DSNP Go-Live

Lessons Learned: Top Five Recommendations for Future Projects



TRANSITIONAL RENT

Dr. Mike Wang, CMO &
Kate Nester, Program Development Manager

Physicians Advisory Group (PAG)

December 4, 2025

Physicians Advisory Group (PAG)

December 4, 2025

AGENDA:

1. Background - Transitional Rent
2. Behavioral Health Population of Focus
3. DHCS Rate Payment Methodology

TRANSITIONAL RENT BACKGROUND

BACKGROUND

- Effective 1/1/2026 – Mandate Service
- First mandatory Community Support Benefit
- Purpose:
  - Provide temporary housing to members experiencing or at risk of homelessness
- Coverage for Behavioral Health - Population of Focus (POF)

Six Community Supports (CS) to Support Members Experiencing or At Risk of Homelessness

Housing Trio Services

- Housing Transition Navigation Services (HTNS)
- Housing Deposits
- Housing Tenancy and Sustaining Services (HTSS)

Room and Board Services

- Recuperative Care (Medical Respite)
- Short-Term Post-Hospitalization Housing (STPHH)
- *NEW* Transitional Rent (Starting 1/1/26)

Mandatory Service

WHAT TRANSITIONAL RENT COVERS

Transitional Rent may be used to cover the following expenses:

Rental assistance in allowable settings for up to six months.

Storage fees, amenity fees, and landlord-paid utilities that are charged as part of the rent payment.

ALLOWABLE SETTINGS *(DHCS Policy Guide Vol.#2)*

Interim Setting	Permanent Housing
o Single room occupancy (SRO) units o Tiny homes o Hotels/motels when serving as the Member's primary residence o Interim settings with a small number of individuals per room (not large dormitory sleeping halls) o Transitional and recovery housing with no lease agreement, including: ▪ Bridge, site-based, population-specific, and community living programs that may or may not offer supportive services and programming ▪ License-exempt room and board ▪ Peer respite	o Single-family and multi-family homes (e.g., duplexes) o Apartments o Housing in mobile home communities o Accessory dwelling units (ADUs) o Shared housing—where two or more people live in one rental unit o Project-based or scattered site permanent supportive housing o Single room occupancy (SRO) units o Tiny homes o Recovery housing o License-exempt room and board

BEHAVIORAL HEALTH

POPULATION OF FOCUS (POF)

Physicians Advisory Group (PAG)

December 4, 2025

Transitional Rent Eligibility Criteria

Eligible high-need Members enrolled in a MCP may be eligible for up to six months of Transitional Rent if they meet the following criteria:

1 MEET CLINICAL RISK FACTORS

- Meet the access criteria for Medi-Cal SMHS[1], *or*
- Meet the access criteria for DMC[2] or DMC-ODS[3] services, *or*
- One or more serious chronic physical health conditions, *or*
- One or more physical, intellectual, or developmental disabilities; *or*
- Individuals who are pregnant up through 12-months postpartum

+ 2 EXPERIENCING OR AT RISK OF HOMELESSNESS

- As defined by US Department of Housing and Urban Development (HUD) with certain modifications

+ 3 PART OF SPECIFIED "TRANSITIONING POPULATIONS" *or* UNSHELTERED HOMELESS *or* FSP ELIGIBLE

- Transitioning out of an institutional or congregate residential setting, *or*
- Transitioning out of a carceral setting, *or*
- Transitioning out of interim housing, *or*
- Transitioning out of recuperative care or short-term post-hospitalization housing, *or*
- Transitioning out of foster care, *or*
- Experiencing unsheltered homelessness, *or*
- Eligible for FSP[4]

First Year – Start with BH POF

Upcoming Housing Related Services

- DHCS will soon broaden its housing-related services and supports, both within Medi-Cal, through Transitional Rent, and beyond Medi-Cal, with the implementation of BH Transformation.

Transitional Rent
(Medi-Cal Community Support)

- Delivered via Medi-Cal Managed Care (MCMC) Delivery System
- Optional MCP coverage in 7/1/25
- Mandatory MCP coverage in 1/1/26, starting with Behavioral Health Population of Focus, followed by additional Populations of Focus in future phases
- Includes coverage of up to six months of rent for members who are experiencing or at risk of homelessness and meet additional eligibility criteria.

Behavioral Health Service Act (BHSA) Housing Interventions
(Non-Medical Program)

- Delivered via County Behavioral Health Delivery System
- Effective 7/1/26
- Counties will place and sustain individuals with significant behavioral health needs in permanent and interim housing settings

How Transitional Rent and BHSA Housing Interventions Fit Together

MCPs and county behavioral health agencies must establish stronger partnerships, coordination, and communication to serve Members with significant behavioral health needs.

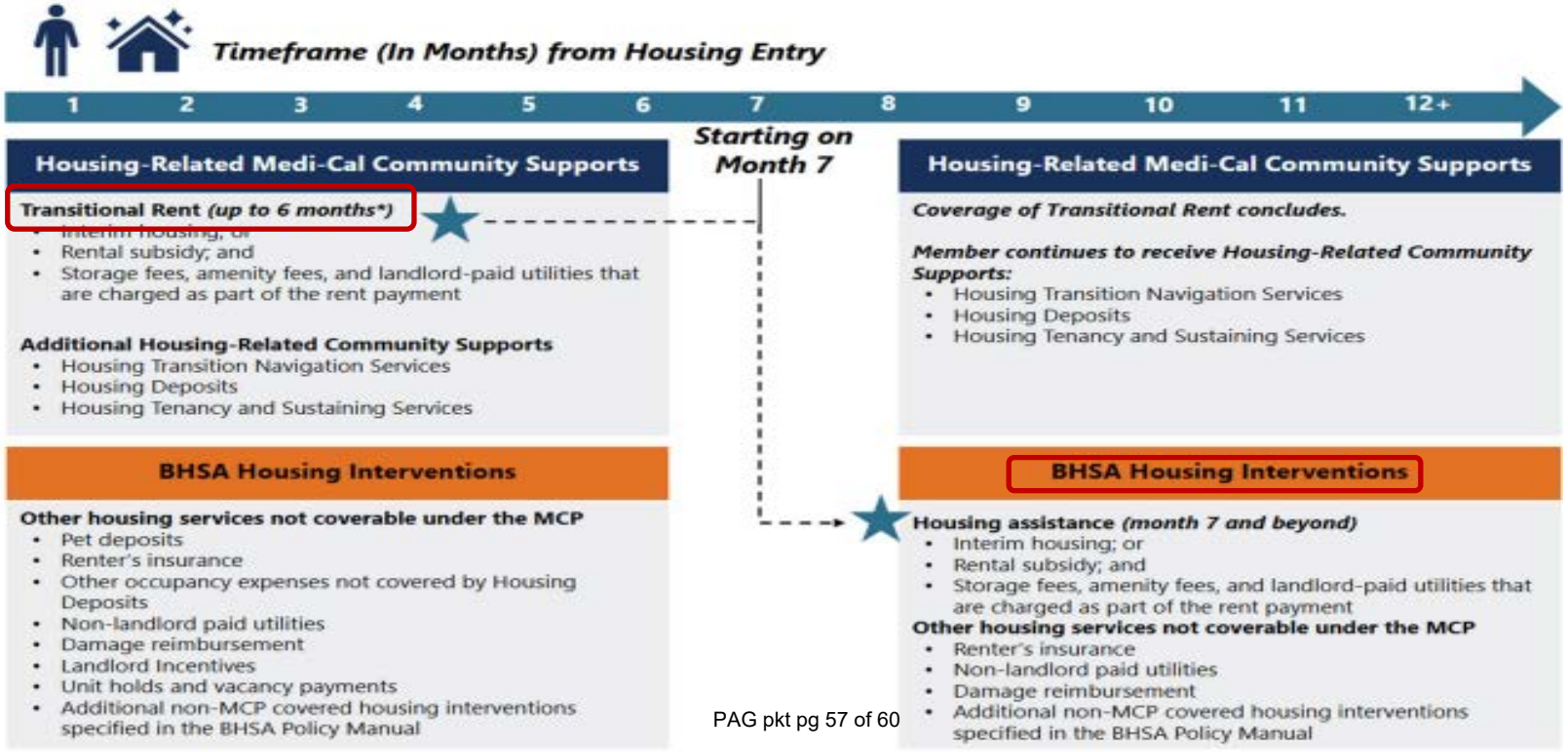
- A central reform of the BHSA is the **requirement that county behavioral health agencies spend 30% of their BHSA funds on Housing Interventions** for individuals with significant behavioral health needs who are experiencing or at risk of homelessness.

- Importantly, BHSA "funds shall not be used for housing interventions covered by a Medi-Cal managed care plan". This means that **Members will not be permitted to receive rental assistance under the BHSA so long as Transitional Rent is available to the Member.**

- Ultimately, DHCS expects Members who receive Transitional Rent from their MCP will **seamlessly continue to receive coverage** of rental assistance and other housing interventions (as applicable) **through BHSA, following the conclusion of Transitional Rent.**

TRANSITIONING SERVICES (continuity of care)

Figure 1. Sequencing Housing Supports for Medi-Cal Members Receiving Transitional Rent and BHSA Housing Interventions



DEPARTMENT OF HEALTHCARE SERVICES (DHCS) RENT PAYMENT METHODOLOGY

Physicians Advisory Group (PAG)

December 4, 2025

DHCS RENT PAYMENT METHODOLOGY

DHCS Payments to MCPs Consist of Two Components

(1) Cost of Rent *(subject to a cap)*	(2) Administrative Fee *(providing the service)*
Actual rental cost paid to landlords *Rental payment is not to exceed the ceilings tied to a percentage of Housing and Urban Development (HUD) Smal Area Fair Market Rents (SAFMR)*	Administrative cost to deliver service for both Managed Care Plans (MCPs) and network providers *DHCS does not specify split between MCPs and Providers. Alliance Board approved a 70%/30% fee split between network providers and the Alliance.*

Physicians Advisory Group
Meeting Calendar 2026

Thursday, March 5	12:00 - 1:30 PM
Thursday, June 4	12:00 – 1:30 PM
Thursday, September 3	12:00 - 1:30 PM
Thursday, December 3	12:00 - 1:30 PM

- Lunch Provided