Physicians Advisory Group

Meeting Agenda

Date: **Thursday, March 5, 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

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, March 4th 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 December 4, 2025

A. Reference materials: Minutes as above.

Regular Agenda Items: 12:20 p.m.

4. New Business

A. Access to Psychological Testing: Current Challenges and Mitigation Strategies	N. Gend, PhD.
B. Enhanced Care Management and Community Supports Updates	S. Sherman, M. Wang, MD
C. CBI 2027	C. Russo
D. Manifest MedEx (MX)	M. Wang, MD

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 March 5, 2026, meeting:

Date/Time: Thursday, June 4, 2026 12:00-1:30 p.m.

Location: All Alliance counties

The complete agenda packet is available for review at the Alliances offices, and on the Alliance website at Central California Alliance for Health. The meeting and the Physician Advisory Group is held in accordance with the requirements of the Ralph M. Brown Act. The Alliance complies with the Americans with Disabilities Act (ADA). Individuals who need special assistance or require 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. As a courtesy to people affected, please attend the meeting smoke and scent free.

Physicians Advisory Group

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MINUTES

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

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

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

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

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

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

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

Chair: Mike Wang, MD	Minutes by: Christy Pool

Access to Psychological Testing: Current Challenges and Mitigation Strategies

Nicole Gend PsyD, BCBA
Behavioral Health Therapy Clinical Administrator

OBJECTIVES:

- Current Trends
- Comprehensive Diagnostic Evaluations (CDEs)
- Impact on Members
- Transition and Historical Context
- Expected Outcomes

Current Trends

California is experiencing a shortage of licensed psychologists, a challenge also seen nationwide.

Wait times for diagnostic evaluations have extended from weeks to months creating significant access barriers.

Limited availability of psychologists providing psychological testing has resulted in extended wait times and delayed access to diagnostic evaluations.

What is a Comprehensive Diagnostic Evaluation (CDE)?

A CDE is an evaluation to determine diagnostic criteria that provides a detailed understanding of an individual's cognitive, adaptive, social, and behavioral functioning, forming the foundation for treatment planning and access to services.

More thorough than other psychiatric/psychological diagnostic evaluations.

Gold standard for diagnosis of Autism Spectrum and Related Disorders.

Core Components

- Clinical intake and parent interview
- Detailed developmental and medical history
- Standardized assessment tools (ADOS, ADI-R)
- Cognitive and IQ testing
- Adaptive functioning measures
- Language and communication assessment
- Evidenced-based treatment recommendations

What is the purpose of a CDE?

A comprehensive psychological evaluation is indicated when standardized testing is needed to confirm a diagnosis, evaluate co-occurring conditions, or establish diagnostic clarity beyond what can be determined through history and clinical observation alone.

Impact on Members

Delays in psychological testing can create cascading effects for members and their families.

Access Delays

Average wait times extended to 6+ months.

Caregiver Strain

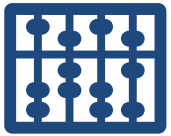
Caregivers experience strain waiting for diagnostic clarity.

System Pressure

MCPs face mounting pressure from members, providers, and regulators to address access gaps.

Carelon Transition and Historical Context

Under Carelon administration, utilization controls and clear guidelines were limited.



Providers often exceeded testing frequencies without oversight.

This created inconsistent expectations across providers and members.

Alliance Transition and Provider Concerns

When CCAH assumed responsibility, MUEs and guidelines were applied and adhered to.

Some providers expressed frustration due to reduced frequencies compared to prior practice.

CCAH focused on aligning care with medical necessity and evidence-based standards.

Why Standardization Matters

Ensures equitable access to services for all members.

Supports medical necessity and regulatory compliance.

Reduces overutilization while preserving access for those who truly need testing.

Referral Triage

Effective referral triage ensures that members are directed to the most appropriate provider type based on their clinical needs.

Mitigation Efforts

Developmental Testing (CDE) frequency limits were expanded up to 20 hours to support the full scope of evaluation needs.

Capacity-building efforts expand access to psychological testing through bilingual psychologist recruitment, interpreter support, locum tenens coverage, extended hours, and telehealth.

Educating members on differences between therapy-based diagnosis and formal testing.

Redirecting members to LMFTs, LCSWs, or psychiatrists, when clinically indicated.

Preserving psychologist capacity for complex cases.

Expected Outcomes

Shortened wait times for members on existing waitlists.

Improved alignment of members to appropriate provider type.

Improved provider satisfaction through clearer expectations.

Efficient use of limited psychologist resources.

Questions?

Enhanced Care Management and Community Supports Updates

Sabryna Sherman, UM Manager – Authorizations, Utilization Management

March 2026

ECM AND CS

Updates

AGENDA:

1. ECM Overview and Updates
2. CS Housing and MTM Overview and Updates
3. Provider Expectations
4. Upcoming Focus

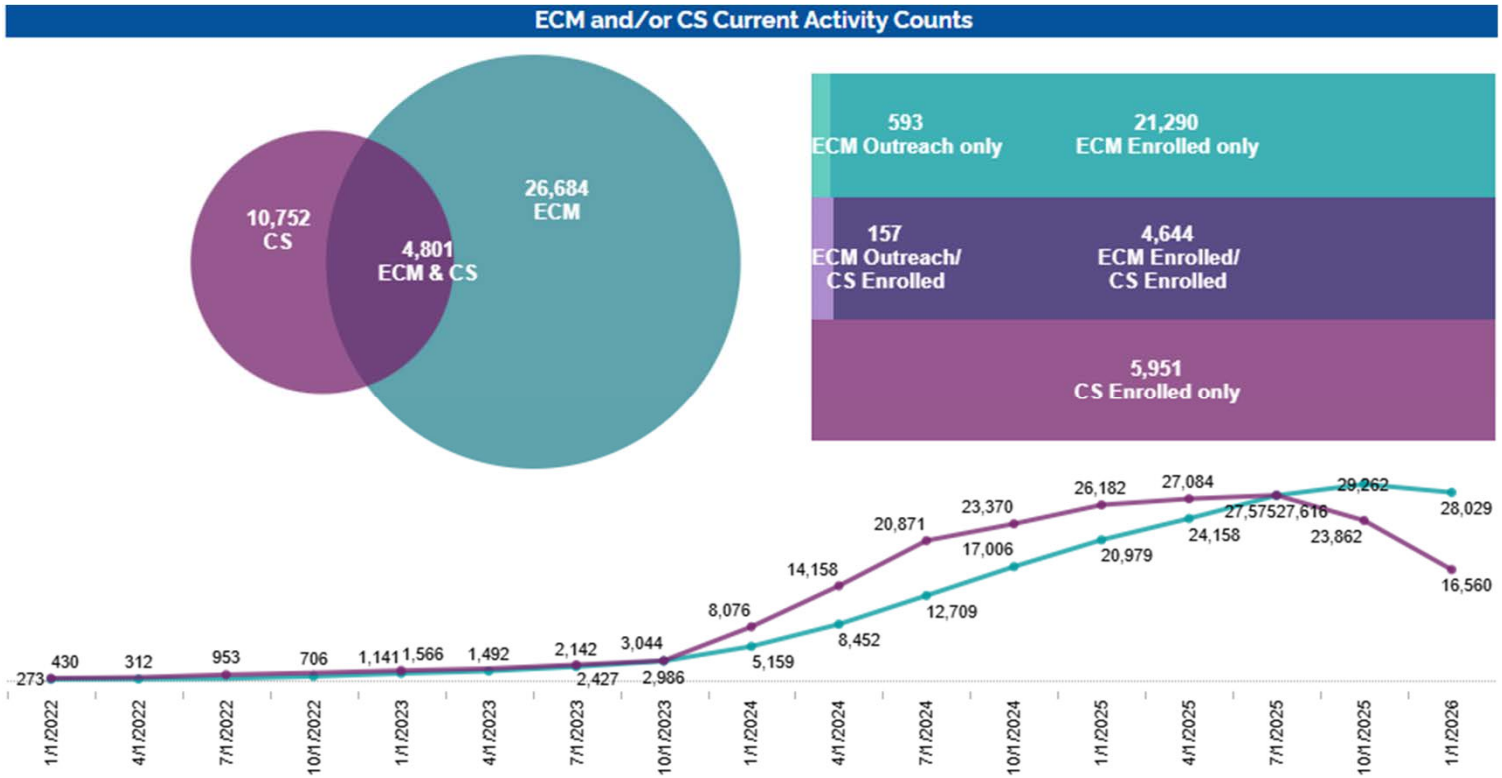
Enhanced Care Management (ECM) Overview

INTENDED TO MEET MEMBERS IN THE COMMUNITY

INTENDED FOR HIGHEST NEED MEMBERS

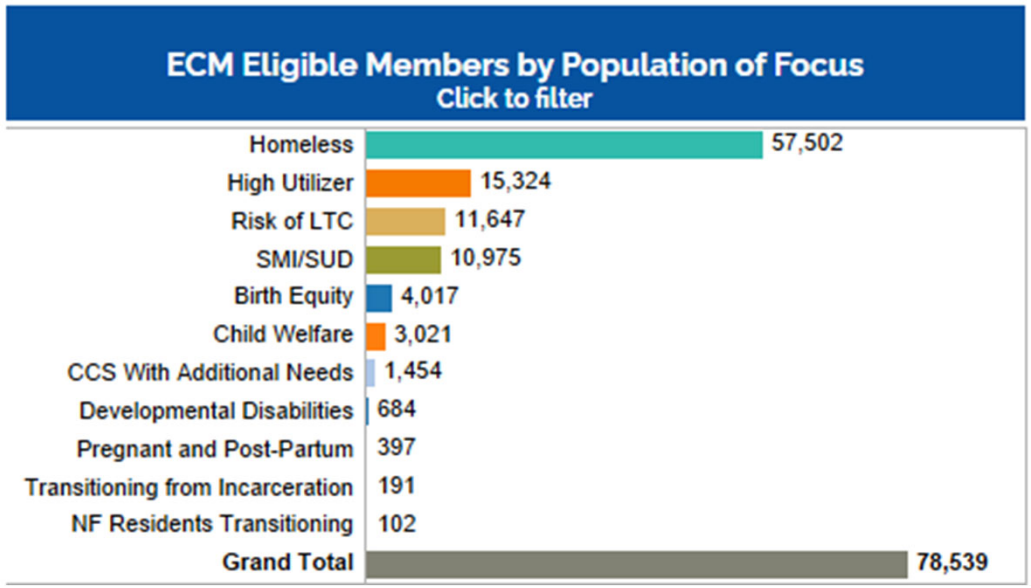
SPECIFIC POPULATIONS OF FOCUS (POFS)

Enhanced Care Management and Community Supports Utilization



Enhanced Care Management Utilization

- DHCS expected enrollment is 3%
- Alliance enrollment is 6%
- Highest POF is Homeless
- Focus on appropriate enrollment and quality care
  - POF verification
  - Graduation criteria
  - Expected touch points



Enhanced Care Management **Graduation Criteria**

- Individual Care Plan should indicate:
  - At least one ongoing medical or behavioral health need
  - At least one ongoing social determinant of health need
  - Specific, individualized goals with plans to meet
  - Graduation or transition plan

Community Supports (CS) Overview

Housing Trio (HTNS, HD, HTSS)	Intended to improve chronic disease outcomes and reduce ED/IP admissions by reducing homelessness and increasing self-sustainability among high-risk members
Medically Tailored Meals (MTM)	“Food as Medicine” intended to treat diet-sensitive conditions through targeted nutritional interventions

Housing Trio Policy Changes effective November 2025

- Reintroduced clinical risk factor requirement
- Clarified documentation requirements
- Clarified definition of homeless/at risk of homelessness
- Changes to covered items for Deposits

Clinical risk factor requirement

Requires supporting clinical documentation for the member's condition.

- Meets access criteria for SMHS or DMC/DMC-ODS
- Has a serious chronic physical condition resulting in at least one inpatient stay in the last year
- Has a physical, intellectual, or developmental disability that meets for State SSI or SSDI
- Is pregnant up to 12 months postpartum
- Meets criteria for the ECM High Utilizer population of focus
  - Adult: 5+ avoidable ED visits or 3+ avoidable IP/SNF stays in the past 6 months
  - Youth: 3+ avoidable ED visits or 2+ avoidable IP/SNF stays in the past 12 months

AT RISK OF HOMELESSNESS DEFINITIONS

Has insufficient resources immediately available to attain housing stability; **and meets one of the following**

has moved frequently because of economic reasons (2 or more times in 60 days)

is living in the home of another person or family because of economic hardship (couch-surfing, not room rental)

has been notified that their right to occupy their current housing or living situation will be terminated

lives in a hotel or motel

lives in severely overcrowded housing (more than 1.5 persons per room)

MTM POLICY CHANGES

Expanded list of qualifying conditions and definitions

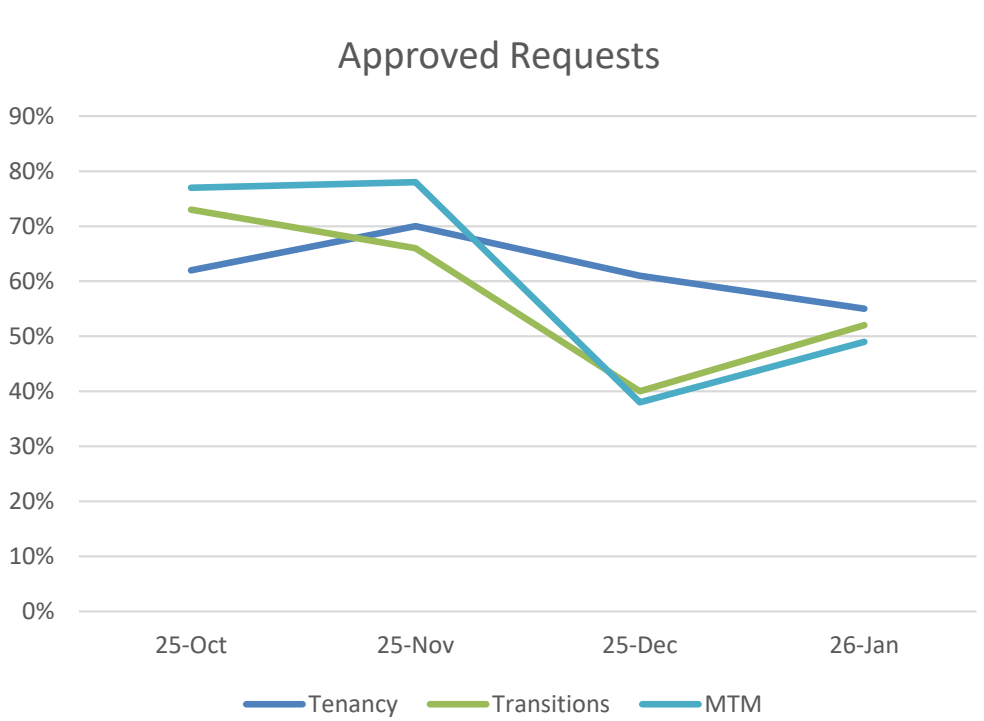
Clarified documentation requirements

Clarified initial and renewal request criteria

MTM CLINICAL REQUIREMENTS

- Initial request (1st auth) – clinical documentation of member's qualifying condition, with ICD-10 diagnosis code
- Renewal requests (2nd auth+) – clinical documentation with continued diagnosis, medical rationale for ongoing support, MTM as part of the treatment plan, evidence of member adherence to overall treatment plan, review of member outcomes, and dietitian notes.
- Clinical documentation must come from MD, DO, NP, or PA
- General tip:
  - Initial – docs should show *can* this diagnosis be treated by diet
  - Renewal – docs should show *is* this diagnosis being treated by diet

COMMUNITY SUPPORTS **APPROVALS**



Approvals have declined with the implementation of clinical documentation.

PROVIDER EXPECTATIONS

- Ensure member meets criteria before referring
- Provide supporting clinical documentation
- Requests for documentation may come from the Alliance, the member, or the CBO
- Consider goals and intents of benefits

Upcoming Focus

ECM oversight and graduation criteria

CS - eligibility and requirement refinement

Personal Care Homemaker Services

Environmental Accessibility and Adaptability (Home Modifications)

Questions?

Care-Based Incentives 2027

Physician Advisory Group

PROPOSAL FOR CBI 2027 Care Coordination

Access Measures

- Adverse Childhood Experiences (ACEs) screening in Children and Adolescents
  - Changing screening age to start at age “0” instead of age “1”.

- Application of Dental Fluoride Varnish
  - Include co-located FQHC Dental Office claims as acceptable data via DST
  - Increase dental fluoride to two (2) applications
  - Include Denti-Cal claims
  - Include dental data from non-FQHC via the DST

IDEAS FOR CBI 2027 Care Coordination

Hospital & Outpatient Measures

- Ambulatory Care Sensitive Conditions (ACSC) - Proposed to remove
- Preventable Emergency Visits
- Plan All-Cause Readmission

IDEAS FOR CBI 2027 **Quality of Care Measures**

- Breast Cancer Screening
- Cervical Cancer Screening
- Child and Adolescent Well-Care
- Colorectal Cancer Screening
- Controlling Blood Pressure
- Diabetic Poor Control >9%
- Depression Screening for Adolescents and Adults
- Immunizations: Adolescents
- Immunizations: Children (Combo 10)
- Lead Screening in Children
- Well-Child Visits in the First 15 Months
- Well-Child Visits for Age 15 Months–30 Months
- Chlamydia Screening – Proposed to remove as this measure is removed from MCAS measure set for MY2026

SUMMARY OF PROPOSED CBI 2027 **Programmatic Measures**

Pediatric Measures (9)	Adult Measures (5)	Measures for Both (5)
ACEs Screening	Breast Cancer Screening	Initial Health Assessment
Application of Dental Fluoride Varnish	Cervical Cancer Screening	Post Discharge Care
Developmental Screening in First 3 Yrs	Colorectal Cancer Screening	Plan All-Cause Readmission
Child and Adolescent WCV (3-21 yrs)	Controlling High Blood Pressure	Preventable ED Visits
WCV 0-15	Diabetic Poor Control >9%	Depression Screening for Adolescents & Adults
WCV 15-30		
Lead Screening in Children		
IZ Children		
IZ Adolescents		

Measures in **black** – Access Measures; Measures in **dark blue** – Hospital & Outpatient Measures; Measures in **teal** – Quality of Care Measures

IDEAS FOR CBI 2027 **Fee-For-Service**

- Adverse Childhood Experiences (ACEs) Training and Attestation
- Behavioral Health Integration
- Cognitive Assessment Training and Attestation
- Diagnostic Accuracy and Completeness Training
- Patient Centered Medical Home (PCMH)
- Quality Performance Improvement Project
- Social Determinants of Health (SDOH) ICD-10 Z-Codes

IDEAS FOR CBI 2027 **Exploratory Measures**

Exploratory Measures

- Consider adding two NCQA Measures
  - BPD: Blood Pressure Control for Patients with Diabetes
  - KED: Kidney Health Evaluation for Patients with Diabetes

Member Reassignment

- Updating Alliance Policy #300-6050 “Provider Request to Reassign Member”
- No changes to the basic categories:
    - **Alleged Member Fraud or Theft**
    - **Alleged Abusive/Disruptive Behavior by Member**
    - **Violation of Medication Management Agreement**
    - **Request for Non-Medically Necessary Orders**
    - **Non-Compliance with Treatment Plan**
    - **Ineffective Relationship**
    - **Failure to Keep Appointment**
- However, for reasons in green, if PCP documents CM referral (internal/CCAH) and behavior continues despite CM involvement, then no impact to CBI
    - If no CM referral documented, then reassignment request may impact CBI
    - Reasons in black continue to not impact CBI

Calculation of Quality-of-Care measures

For measures already at or above the 50th percentile (Minimum Performance Level):

- Practices earn 70% of measure points by meeting the 50th percentile.
- Practices earn the rest of the available points (30%) by meeting the 75th percentile **or** showing a 2.5 percentage point improvement from the prior year's performance.

For measures below the 50th percentile (Minimum Performance Level):

- Practices earn 50% of measure points If they attain a 2.5 percentage point improvement from the prior year.
- Practices earn the rest of the available points (50%) if they attain a 5-percentage point improvement from the prior year.

- Points earned through improvement are based on measures where the Provider met the Eligible Member requirement in both 2024 and 2025 and made the requisite improvement over the Provider's prior year performance.

NEXT STEPS

- The finalized CBI 2027 proposal will be shared with PAG in March 2026.
- CBI 2027 Board presentation in April – May 2026 for approval.

Suggestions?

Conversion from SCHIO to Manifest MedEx

Mike Wang, MD, Chief Medical Officer
Physicians Advisory Group
March 5, 2026

SCHIO -> Manifest MedEx Feb 13, 2026

Manifest MedEx and SCHIO Announce Strategic Affiliation To Connect California and Advance Statewide Health and Social Services Data Infrastructure

Collaboration will accelerate seamless, secure whole person data sharing to empower healthier communities in Bay Area and across state

[Riverside, Calif., and Santa Cruz, Calif. – BUSINESS WIRE – October 22, 2025] Manifest MedEx (MX) and Serving Communities Health Information Organization (SCHIO), two of California's most respected nonprofit health data networks and Data Exchange Framework (DxF) Qualified Health Information Organizations (QHIOs) announced today that they have entered a strategic affiliation, with SCHIO becoming an affiliate of MX.

This significant collaboration between MX, the state's largest nonprofit health data network, and SCHIO, one of the oldest and most advanced multi-stakeholder health information exchanges (HIEs) in the country, will help communities in Santa Cruz, the Bay area, and across the state get critical health, behavioral, and social data from both networks to better coordinate whole person care and optimize health and wellness.

"MX and SCHIO have aligned missions and are both committed to serving California communities, recognizing the need to bring together disparate data, such as social and behavioral health data," said Jarrod McNaughton, Board Chair, MX, and CEO, Inland Empire Health Plan (IEHP). "This collaboration marks a major step toward advancing comprehensive data sharing across California to ensure our communities receive the care they need when they need it."

Under the affiliation arrangement, Manifest MedEx will provide data sharing technology and services to SCHIO participants. MX has been combining clinical and claims data for more than 50 million people to support value-based care and improved health outcomes since 2017. The HITRUST® certified statewide network spans more than 140 hospitals, 2,600 providers, and 19 health plans, including Blue Shield of California, Anthem Blue Cross, and Health Net.

Impact To Frontline Staff

- SCHIO portal no longer available as of 12/31/25
- Providers previously using SCHIO portal will need to sign with Manifest for continued access

CCAH Providers Converting to Manifest

- County Behavioral Health
  - Santa Cruz
- Hospitals
  - SVMH
  - WCH/Pajaro Valley

END

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