Whole Child Model Clinical Advisory Committee

Meeting Agenda

Wednesday, July 22, 2026

12:00 p.m. - 1:00 p.m.

Held Via Teleconference

1. Members of the public wishing to join the meeting may do so as follows:
   Join on your computer, mobile app, or room device.

   Join Teams Meeting
   Meeting ID: 212 614 468 187 06
   Passcode: dx3B4oZ3

   Dial in by phone
   +1 872-242-9041,,495794215#
   Find a local number
   Phone conference ID: 495 794 215#

2. Members of the public wishing to provide public comment on items not listed on the agenda that are within jurisdiction of the Committee 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 July 20, 2026 to the Clerk of the Advisory Committee 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. Public comment 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.

3. Mute your phone during presentations to eliminate background noise.
   a. State your name prior to speaking during comment periods.
   b. Limit background noise when unmuted (i.e., paper shuffling, cell phone calls, etc.)

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

A. Roll call.
B. Introduction: Adriana Ceja, Chief Clinical Officer, MFAMG
C. Introduction: Dr. Allyson Garcia, Medical Director, The Alliance
D. Supplements and deletions to the agenda.

2. Oral Communications. 12:05 p.m.

A. Members of the public may address the Committee on items not listed on today's agenda that are within the jurisdiction of the Committee. 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 Committee 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.

<u>Consent Agenda Items</u>: 12:10 p.m.

3. Approve Whole Child Model Clinical Advisory Committee (WCMCAC) Meeting Minutes of April 22, 2026.

A. Reference materials: Minutes as above.
B. Grievance Update — S. Sanders
C. WCM CCS Referral Volumes — A. McEowen, RN

<u>Regular Agenda Items</u>: 12:15 p.m.

4. New Business

A. ECM / CM Updates — M. Wang, MD, CMO
B. Member Outreach & Retention (MOR) Campaign — R. Margain

Old Business

A. WCMFAC Update — J. Espinoza

5. Open Discussion: 12:40 p.m.

A. Committee to have roundtable discussion, share updates, concerns, and experiences.
   i. Unsatisfactory Immigration Status (UIS) / WCM Population

6. Future Topics

7. Adjourn: 12:50 p.m.

The next meeting of the Whole Child Model Clinical Advisory Committee, after this July 22, 2026, meeting:

- Wednesday, October 28, 2026, 12:00-1:00 p.m.
  Locations: Teleconference via MS Teams

The meeting is held in accordance with the requirements of the Ralph M. Brown Act. Members of the public interested in attending should call the Alliance at (831) 430-2621 to verify meeting dates prior to the meetings.

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The complete agenda packet is available for review on the Alliance website at: www.ccah-alliance.org bottom of page under Community – Meetings and Events.

Whole Child Model Clinical Advisory Committee

Meeting Minutes

Wednesday, April 22, 2026
12:00 p.m. - 1:00 p.m.

Teleconference Meeting

Committee Members Present:

Cal Gordon, MD	Provider Representative
Camille Guzel. MD	Provider Representative
John Mark, MD	Provider Representative

Committee Members Absent:

Aditi Mhaskar, MD	Provider Representative
Hue Nguyen, MD	Provider Representative
James Rabago, MD	Board Representative
Jennifer Yu, MD	Provider Representative
Michelle Perez, MD	Provider Representative
Nicole Shelton, PA	Provider Representative

Guest Speakers:

Staff Present:

Clyde Wesp, MD	Chair
Ashley McEowen, RN	Complex Case Management Supervisor – Pediatric
Christy Pool	Temporary HS Administrative Assistant
Jana Brodock	Lead Clinical Analyst - BCBA
Jacqueline Morales	Provider Relations Representative
Jenna Stromsoe, RN	Complex Case Management Supervisor - Pediatric
Lisa Moody, RN	Senior Complex Case Manager
Sarah Sanders	Grievance & Quality Manager
Jacqueline Van Voerkens	Clerk of the Committee

Other Representatives Present:

Dale Urbelis	Call the Care
Janna Espinoza	WCMFAC Chair
Kevin Smith	Director, MCSD

1. **Call to Order by Chairperson Dr. Clyde Wesp.**
   Chairperson Wesp called the meeting to order at 12:05 p.m.
   Roll call was taken.

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

No members of the public addressed the Committee.

3. Consent Agenda Items.

A. Approval of WCMCAC Minutes
Minutes from the February 19, 2026, meeting were reviewed.

B. Grievance Update
Sarah Sanders provided the grievance update, noting that quarter one data for PCS was included in the PowerPoint and that volume remains stable with no specific trends identified. Common themes for grievances continue to be transportation, quality of care, quality of service, provider billing issues, and provider communications. Ms. Sanders invited committee members to reach out directly if they have questions or want to discuss specific grievances.

M/S/A Consent agenda items approved as written.

4. New Business

A. Age Out Process:
The age out process from CCS to adult care was discussed as a critical challenge, with over 200 youth transitioning annually. Jenna Stromsoe explained that the Alliance starts targeted transition outreach at age 17, or earlier if conservatorship is needed, using assessments, mailed letters, and risk stratification to prepare members. The process involves interdisciplinary teams and collaboration with county CCS partners, with monthly and ad hoc meetings to address case reviews and process improvements.

Key gaps identified include difficulty connecting members to adult specialists familiar with complex pediatric conditions, limited local provider availability (often requiring families to travel), and a lack of continuity in nursing care and in-home support after age 21. Families and providers expressed concern about reduced services post-transition, especially for nursing hours, and the challenge of navigating adult systems. The need for better coordination, more robust relationships with adult teams, and improved resource sharing was emphasized, with ongoing efforts to collect data, share best practices, and advocate for system-level improvements.

Dr. Cal Gordon raised concerns about connecting youth to adult specialists, noting that internal medicine doctors often feel uncomfortable with chronic pediatric conditions and that family medicine doctors are better suited for transitions. Ms. Stromsoe agreed, acknowledging provider network limitations and the need for families to travel for care, and stated that while gaps exist, the Alliance does its best to recruit providers.

Janna Espinoza, speaking as a parent and chair of the Whole Child Model Family Advisory Committee, shared fears about loss of services after age 21 and praised improvements in pediatric case management. She asked about the biggest complaints from members, especially regarding reduced nursing hours post-transition. Lisa Moody responded that the main complaint is access to providers familiar with complex needs, and promised to bring feedback from the adult team about nursing care to future meetings.

Dr. John Mark from Stanford described ongoing challenges in finding adult specialists for complex cases, sometimes continuing to follow patients into adulthood due to lack of suitable providers, and highlighted variability in specialist willingness to accept aged-out patients. Dr. Wesp and Dr. Mark discussed the need to identify specialists with relevant expertise and improve coordination for complex cases.

The group agreed on the importance of robust relationships with adult teams, better resource sharing, and ongoing advocacy for system improvements.

B. Medical Therapy Unit in Specialty Centers:
The Medical Therapy Unit (MTU) coordination in specialty centers was discussed by Dr. Wesp, Janna Espinoza, Kevin Smith, Dr. Camille Gonzalez, and Dr. Cal Gordon. Dr. Wesp described operational challenges, including duplication of services, delays, conflicting equipment requests, and lack of coordination between MTU, schools, and outside providers.

Ms. Espinoza highlighted confusion among parents about service rules and the need for better resources, noting variability in school district coordination and rural gaps. Mr. Smith, as a special education director, explained differences between medical and educational PT/OT and offered collaboration.

Ms. Gonzalez, a physiatrist, raised issues with accessing MTU records for adult transitions and families seeking more therapy than maintenance plans allow. Dr. Gordon pointed out the lack of a common EMR across counties, making records access inconsistent.

The main gaps identified were fragmented communication, inconsistent documentation, and unclear ownership of therapy goals, especially for families navigating multiple systems.

C. Transgender Care for Pediatrics:
Transgender pediatric care in Northern California was discussed by Dr. Wesp, who noted that while gender-affirming care remains legal and recognized by Medi-Cal and state policy, access has significantly narrowed due to federal funding threats and hospital policy changes. Major programs at UCSF, Stanford, Sutter, and Kaiser have limited services, with no hospitals performing surgery for those under 19. UCSF remains the most comprehensive, offering medical and psychological therapy but not surgery.

Dr. Wesp highlighted a gap between what state law permits and what hospitals feel safe providing, resulting in limited options for minors. Data shared included 285,300 trans youth in Shield Law States, with care increasingly concentrated at UCSF. The practical advice was to refer pediatric patients to UCSF, as other systems have reduced or closed their programs.

Old Business

A. Auto Authorizations:
Lisa Moody explained that auto authorizations for specialty providers have increased, with over 4,500 auto authorizations in Q1 identified as potentially linked to CCS diagnoses. The CCS referral volumes have remained stable (about 1,600–1,650 per year across five counties), but the Alliance is now proactively using auto auth data to identify more CCS-eligible members. The Peds team launched a new workflow in April, prioritizing high-risk or urgent diagnoses from auto authorizations, with social work and nursing staff sorting cases. The process is phased to avoid overwhelming county partners and ensure quality referrals.

Dr. Cal Gordon noted that CCS client numbers are declining statewide, and staffing resources have dropped by 80% since the Whole Child Model transition. There is concern about balancing quality referrals with limited county capacity, avoiding high denial rates from irrelevant cases.

The team plans to review referral conversion rates and county absorption in future meetings.

B. WCM Family Advisory Committee Update:
Janna Espinoza provided an update on the Whole Child Model Family Advisory Committee, focusing on the development of a resource guide for families, available in multiple languages and formats. The guide aims to address gaps in accessible information for families, especially in rural counties like Mariposa and San Benito, where resources are limited.

Ms. Espinoza emphasized the need for contributions from committee members to expand the guide and offered to distribute it directly to clinics and offices. Lisa Moody confirmed the guide's availability in Hmong for Merced. The discussion highlighted the importance of practical, tangible support for families navigating complex care, and invited ongoing suggestions for resource distribution.

Action: Whole Child Model Family Resource Guide is available in English, Spanish, and Hmong. Guide will be shared digitally and distributed in print upon request.
Action complete: California Children's Services (CCS) Whole Child Model Program - Central California Alliance for Health

5. Open Discussion

Janna Espinoza discussed challenges with duplicative therapy services across regional centers, medical therapy units, and schools, noting confusion about eligibility and rules, especially for new parents.

Dr. Clyde Wesp asked about coordination with school districts, and Ms. Espinoza explained variability in special education support across districts, with rural areas facing more gaps.

Kevin Smith, as Director of Special Education for Merced City School District, clarified differences between medical and educational PT/OT, offering collaboration and insight into school district capabilities.

Dr. Camille Guzel raised issues with accessing CCS MTU records for adult transitions and families seeking more therapy than maintenance levels, noting both accidental and intentional duplication.

Dr. Cal Gordon responded to Dr. Guzel, highlighting the lack of a common EMR across MTUs as a barrier to record sharing and coordination, with Santa Cruz recently moving to Epic.

6. Future Topics

The Committee did not request any topics at this time.

7. Adjourn

The meeting adjourned at 12:50 p.m.

Respectfully submitted,

Ms. Jacqueline Van Voerkens
Clerk of the Advisory Committee

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

Action Item	Owner	Due Date	Status	Notes
Whole Child Model Family Resource Guide is available in English, Spanish, and Hmong. Guide will be shared digitally and distributed in print upon request.	Janna Espinoza	July 22, 2026	Completed	

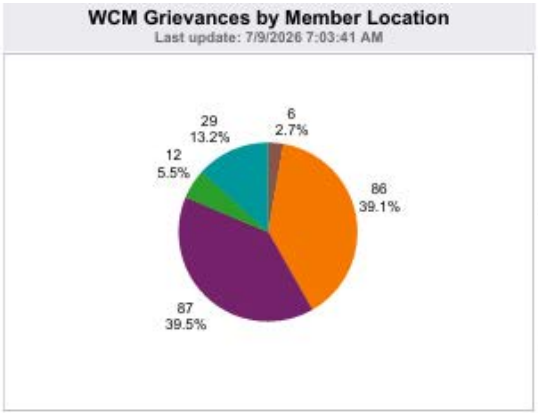
Whole Child Model Grievances

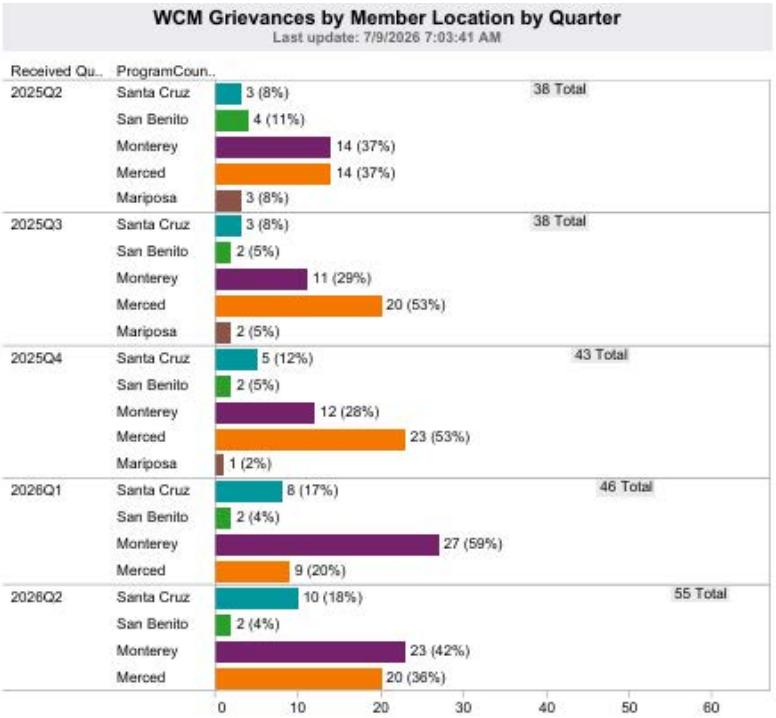
Q2 2026 Appeal & Grievance (AG) Review
Whole Child Model, Clinical Advisory Committee: WCM CAC
Prepared by: Sarah Sanders, Grievance and Quality Manager
7/22/2026

Key Highlights and Q2 2026 **Trend Summary**

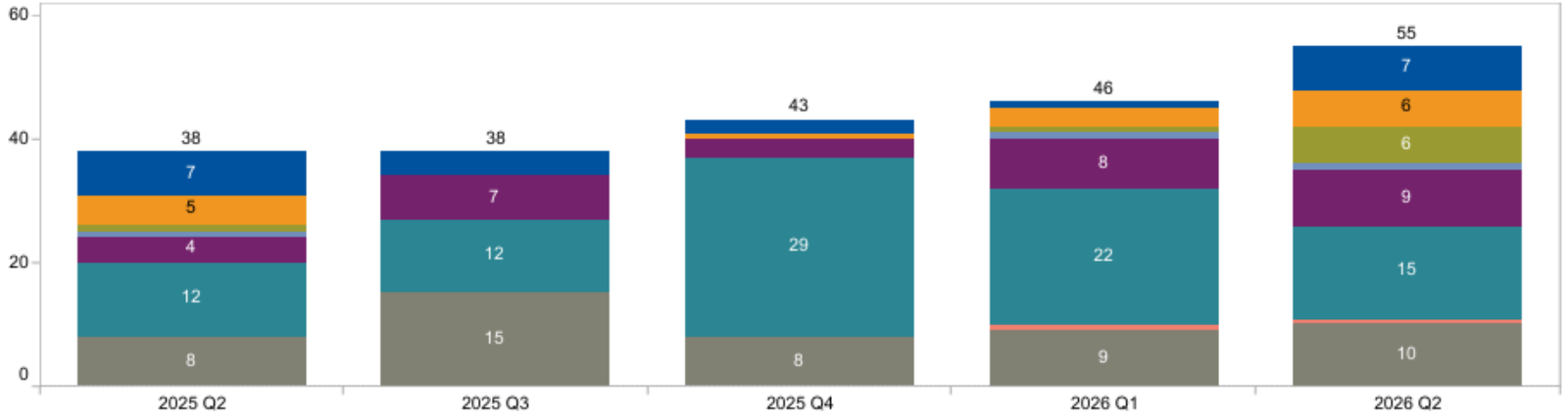
- Overall, WCM Grievance volume ⬆ increased compared to Q1.
- Grievance distribution remains consistent across all counties with no significant geographic outlier.
- Current review does not identify a single systemic driver for the increase.
- WCM grievances continue to represent isolated member specific concerns requiring individualized resolutions.
- The Appeals and Grievance (AG) team continues routine monitoring through internal oversight committees, Staff Grievance Review Committee (SGRC) and quality review process to identify emerging trends and opportunities for improvement.

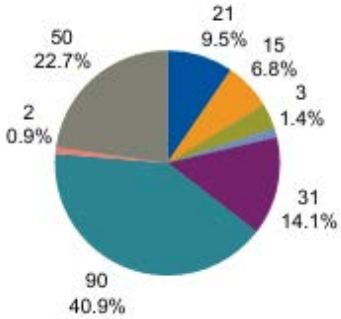
WCM Q2 2025– Q2 2026 GRIEVANCES by **LOCATION**





WCM Q2 2025 through Q2 2026 GRIEVANCES by **TYPE**





Most Frequently Reported Concerns

- **Transportation**
  - Missed or delayed transportation
  - Scheduling Issues
  - Vendor coordination challenges
  - Member Reimbursement status
- **Quality of Service**
  - Member experience concerns
  - Communications
  - Provider office experiences
- **Provider Billing**
  - Member Billing inquiries
  - Coordination of Benefit
- **DME**
  - Billing questions
  - Quantity concerns
  - Equipment pick up delays
  - Delivery timing challenges

Key Observation

While these types represent the highest volume of WCM grievances, individual cases vary considerably and do not demonstrate a recurring provider of systemic pattern.

WCM **GRIEVANCE** Actions

- Continue engaged monitoring and interventions.
- **Solicit feedback:** Clinical Partners, please send to ssanders@thealliance.health

WCM CCS Referral Volumes

WCM Clinical Advisory Committee

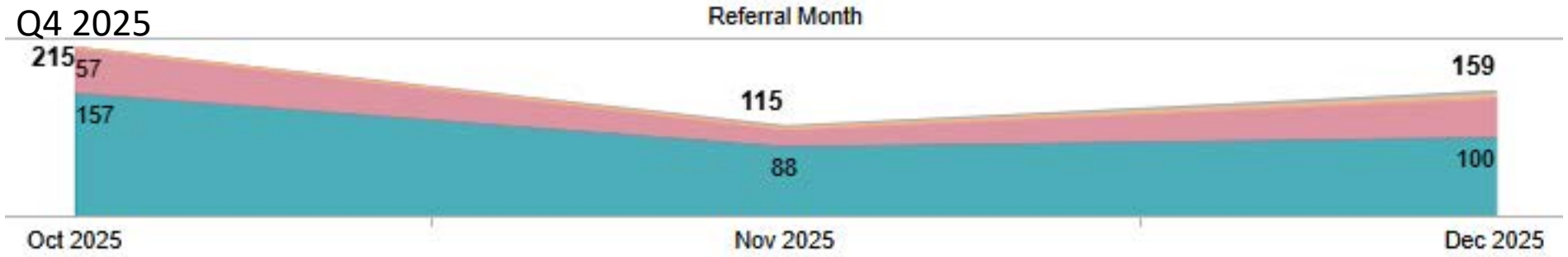
Pediatric Complex Case Management

Ashley McEowen, RN

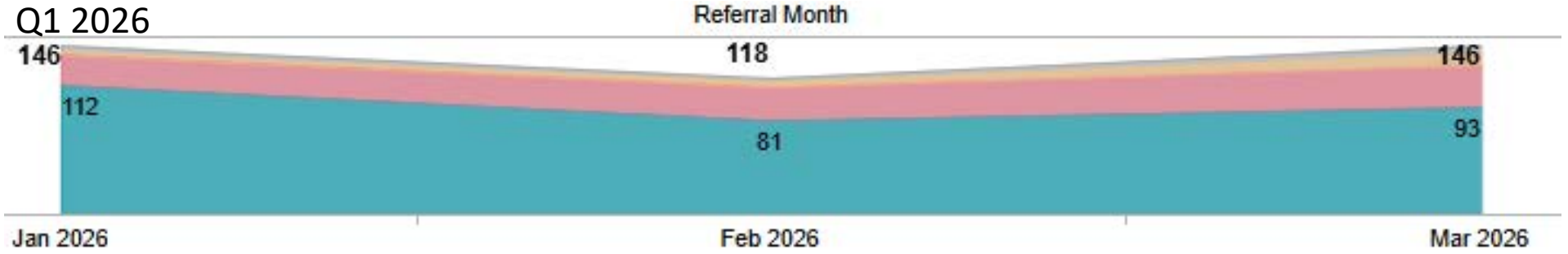
7.22.2026

CCAH CCS Referral Volumes

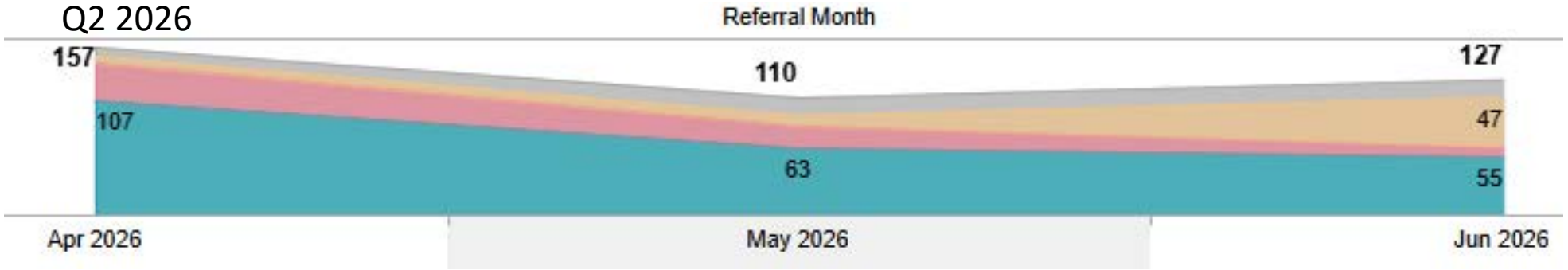
Q4 2025

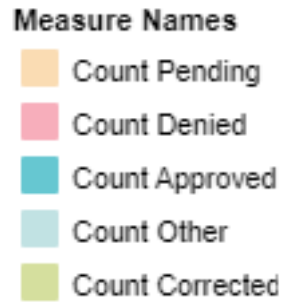


Q1 2026



Q2 2026





Referral Counts by County

Q1 2026	Q2 2026
• Merced: 132	• Merced: 155
• Monterey: 196	• Monterey: 146
• Santa Cruz: 61	• Santa Cruz: 64
• Mariposa: 6	• Mariposa: 4
• San Benito: 15	• San Benito: 25
• Total Referrals: 410	• Total Referrals: 394

Referral Approval Rates **by County**

Q1 2026	Q2 2026
• Merced: 78.0%	• Merced: 67.1%
• Monterey: 70.4%	• Monterey: 48.6%
• Santa Cruz: 57.4%	• Santa Cruz: 65.6%
• Mariposa: 33.3%	• Mariposa: 25.0%
• San Benito: 53.3%	• San Benito: 28%
• Average Approval Rate: 69.8%	• Average Approval Rate: 57.1%

Referral Denial Rates **by County**

Q1 2026	Q2 2026
• Merced: 19.7%	• Merced: 14.8%
• Monterey: 18.4%	• Monterey: 21.2%
• Santa Cruz: 37.7%	• Santa Cruz: 14.1%
• Mariposa: 33.3%	• Mariposa: 0.0%
• San Benito: 26.7%	• San Benito: 28.0%
• Average Denial Rate: 22.2%	• Average Denial Rate: 16.2%

WCM Member Volumes

May 2026: WCM Members	Age Out Volumes
• Merced: 2443	• Merced: 5
• Monterey: 3184	• Monterey: 9
• Santa Cruz: 925	• Santa Cruz: 6
• San Benito: 281	• San Benito: 0
• Mariposa: 64	• Mariposa: 0
• Total: 6897	• Total: 20

ECM Update

Mike Wang, MD
Chief Medical Officer
Whole Child Model Clinical Advisory Committee
July 22, 2026

Roadmap

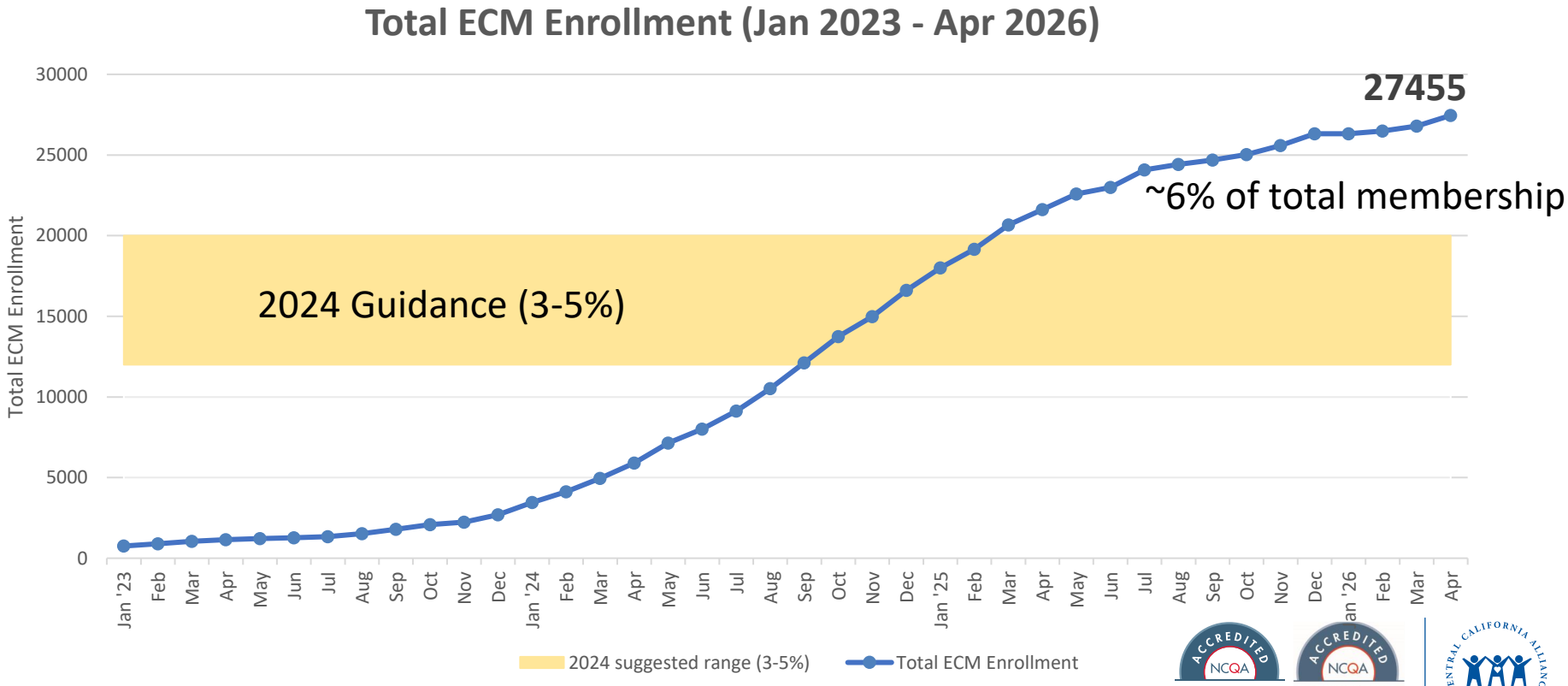
- ❑ DHCS ECM Clarifications
- ❑ ECM Upcoming Program Changes
- ❑ CS Quick Hits

Q1 2026 DHCS ECM Clarifications

Updated DHCS Clarification on ECM

"The goal of ECM service delivery is **high-touch**, person-centered, comprehensive care management. **Broad but shallow** utilization is contrary to the intent of the program."

Broad


Total ECM Enrollment (Jan 2023 - Apr 2026)
27455
~6% of total membership
2024 Guidance (3-5%)
Total ECM Enrollment
30000
25000
20000
15000
10000
5000
0
Jan '23
Feb
Mar
Apr
May
Jun
Jul
Aug
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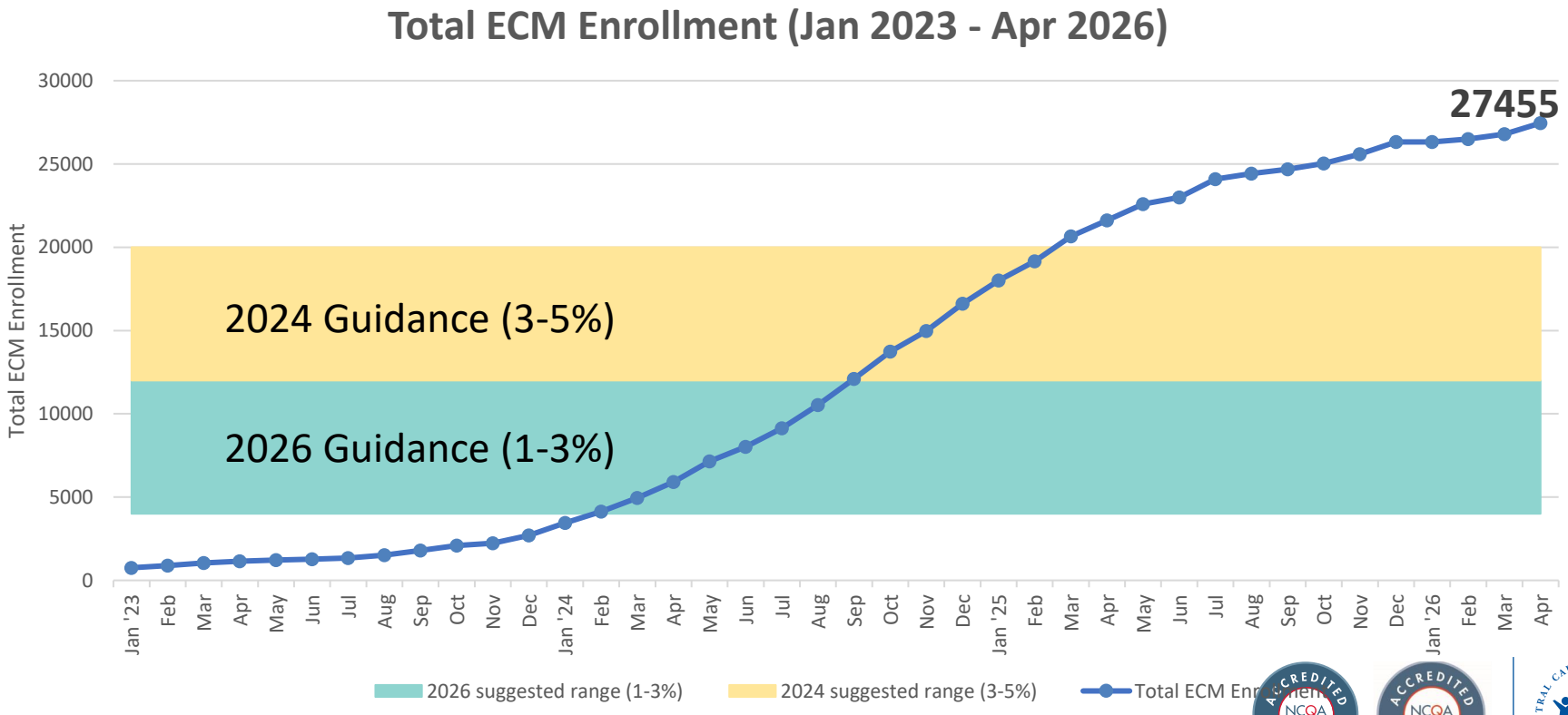
2024 suggested range (3-5%)
Total ECM Enrollment

Broad


Total ECM Enrollment (Jan 2023 - Apr 2026)
Total ECM Enrollment
30000
25000
20000
15000
10000
5000
0
27455
2024 Guidance (3-5%)
2026 Guidance (1-3%)
Jan '23
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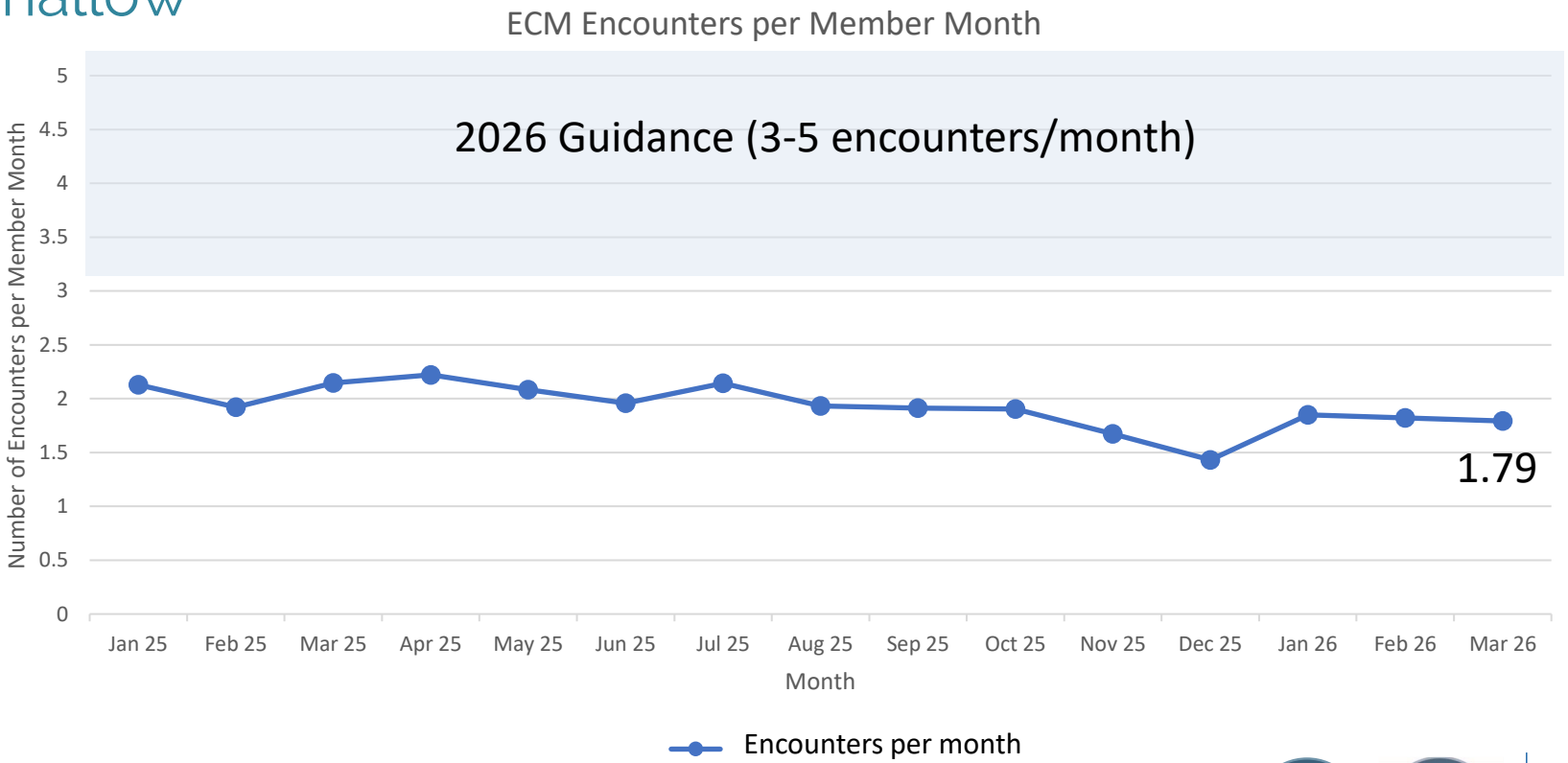
2026 suggested range (1-3%)
2024 suggested range (3-5%)

Shallow


ECM Encounters per Member Month
2026 Guidance (3-5 encounters/month)
Number of Encounters per Member Month
5
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
1.79
Jan 25
Feb 25
Mar 25
Apr 25
May 25
Jun 25
Jul 25
Aug 25
Sep 25
Oct 25
Nov 25
Dec 25
Jan 26
Feb 26
Mar 26
Month
Encounters per month

Impact

- The Alliance's ECM program is both broad and shallow based on DHCS clarifications
  - The Alliance is an outlier for ECM enrollment compared to other plans (6% vs ~1.8% state average)
  - Significantly over budget in Q1 (~$15.8M)

Roadmap

- ❑ DHCS ECM Clarifications
- ❑ ECM Upcoming Program Changes
- ❑ CS Quick Hits

ECM Upcoming Program Changes

2026-2027 Change Overview

Four Categories for ECM Program Changes

Based on Federal and State changes, we need to make changes to align with our regulatory expectations.

Member Referral Assessment

Member Reassessments

Network Management

Payment Changes

Enrollment & Renewal Assessments

Member Enrollment & Renewal Assessment – **Live 5/18**

- New Utilization Management Assessment implemented 5/18/2026
  - Improved data collection on member eligibility, CM need
  - Assist in assessing appropriate level of care management tailored to their specific needs: PCP, CHWs, Alliance CM or ECM
  - Improve appropriateness of ECM utilization

Member Reassessments

Member Reassessments

- Members who do not meet criteria for high risk based on a health needs index in line with DHCS guidance
  - Low risk members
  - Medium risk members
- Risk-based disenrollments will:
  - Started in June
  - Be ongoing
- Members will be notified of need for reassessment
- Members are assessed for eligibility upon submission of a new referral

Network Management

Network Management

Ensure Clinical Oversight

Care Plan Audits

Ongoing Monitor

- Appropriate Encounters
- Grievance Volumes
- Quality Concerns

Payment Changes

Payment Changes

- Currently the Alliance is operating at a loss per member per month for ECM enrolled members
- Need to align rate received from DHCS and rate we provide to providers
- Propose switch to Fee-for-Service (FFS) payment structure
  - Payment based on each encounter received by the Alliance
  - Finance will present this new payment model in August
  - Intended effective date 1/1/27

Roadmap

- ❑ DHCS ECM Clarifications
- ❑ ECM Upcoming Program Changes
- ❑ CS Quick Hits

ECM Discussion Questions

- What has been the overall experience for clinical providers for ECM enrolled members?
- What ECM providers particularly stand out?
- What suggestions does this workgroup have for the Alliance in evaluating ECM provider quality?

Roadmap

- ❑ DHCS ECM Clarifications
- ❑ ECM Upcoming Program Changes
- ❑ CS Quick Hits

CS Quick Hits

Are you an Alliance-contracted CS-Meals provider?

- ◯ Yes
- ◯ No

Has the patient/member been informed that a CS referral is being requested? *

- ◯ Yes
- ◯ No

Does the patient/member have a preferred meals provider?

Is this request for *

- ◯ Meals (2 meals a day for 12 weeks)
- ◯ Grocery Box (1 box a week for 12 weeks)
- ◯ Produce Box (1 box a week for 12 weeks)

Does the member have one of the following conditions (see Alliance Policy 404-1745 Medically Tailored Meals/Medically Supportive Foods for more details on qualifying conditions): *

- [ ] Prediabetes or Diabetes (Hgb A1c > or = 5.7)
- [ ] Hypertension (On medication or blood pressure > 140/90 on two office visits in the past 12 months)
- [ ] Hyperlipidemia (On medication or high LDL/Non-HDL/TG/HLD labs)
- [ ] Congestive Heart Failure
- [ ] HIV/AIDS
- [ ] Cancer (undergoing active treatment)
- [ ] Malnutrition/Failure to Thrive (Adult: BMI <18.5, albumin <3.5, or unintentional weight loss over 10 % in 6 months; Children: BMI < 10th percentile or unintentional weight loss over 10% in 6 months)
- [ ] Obesity (Adult: BMI >30; Children: BMI > 95th percentile)
- [ ] Celiac Disease (genetically or biopsy driven)
- [ ] Gestational Diabetes
- [ ] High-Risk Pregnancy (excluding maternal age)
- [ ] Disabling Mental Health Disorder (Referred to or receiving care from County BH)
- [ ] Chronic Kidney Disease
- [ ] Non-Alcoholic Fatty Liver Disease
- [ ] Polycystic Ovary Syndrome
- [ ] Metabolic Syndrome
- [ ] Atherosclerosis (coronary/peripheral/carotid artery disease, stroke, cerebrovascular disease)
- [ ] Mild Cognitive Impairment/Early Dementia
- [ ] Non-Healing Wounds
- [ ] Other (Add details on medical necessity below)

What is the ICD-10 diagnostic code for this member's condition? *

What is the ICD-10 diagnostic code for this member's condition? *

Is the member currently in the hospital or a skilled nursing facility and will be discharged soon?

- Yes
- No

Is the member enrolled in an ECM program?

- Yes
- No

Can the member eat solid foods *

- Yes
- No

Does the member have a food allergy (soy, egg, nuts, etc.) *

- Yes
- No

Is the member receiving meals from another meal delivery program that provides more than 7 meals a week to the patient *

- Yes
- No

Does the member have enough refrigeration to safely store the Medically Tailored Meals *

- Yes
- No

Is the member vegetarian *

- Yes
- No

Does the member have a gluten allergy *

- Yes
- No

Please attach medical documents supporting the member's condition. Examples include a note from their primary or specialist provider or a recent discharge summary from a hospital stay. Documents must include the diagnostic code for the condition. If we cannot confirm their condition, your request might be voided or denied. *

Browse Files

Drag and drop files here

Note: These documents can also be faxed to the Authorizations Department at 831-430-5850

Member Outreach and Retention (MOR) Program

Ronita Margain, Community Engagement Director

WCMCAC| July 22, 2026

Member Outreach and Retention (MOR) Program

AGENDA

AGENDA:

1. Key Drivers of Change
2. MOR Goal
3. MOR Structure
4. MOR Tactics
5. How YOU can help!

Drivers of Change

Expiration of Federal COVID-19 Unwinding Flexibilities

Federal HR1 Law

Annual State Budgets

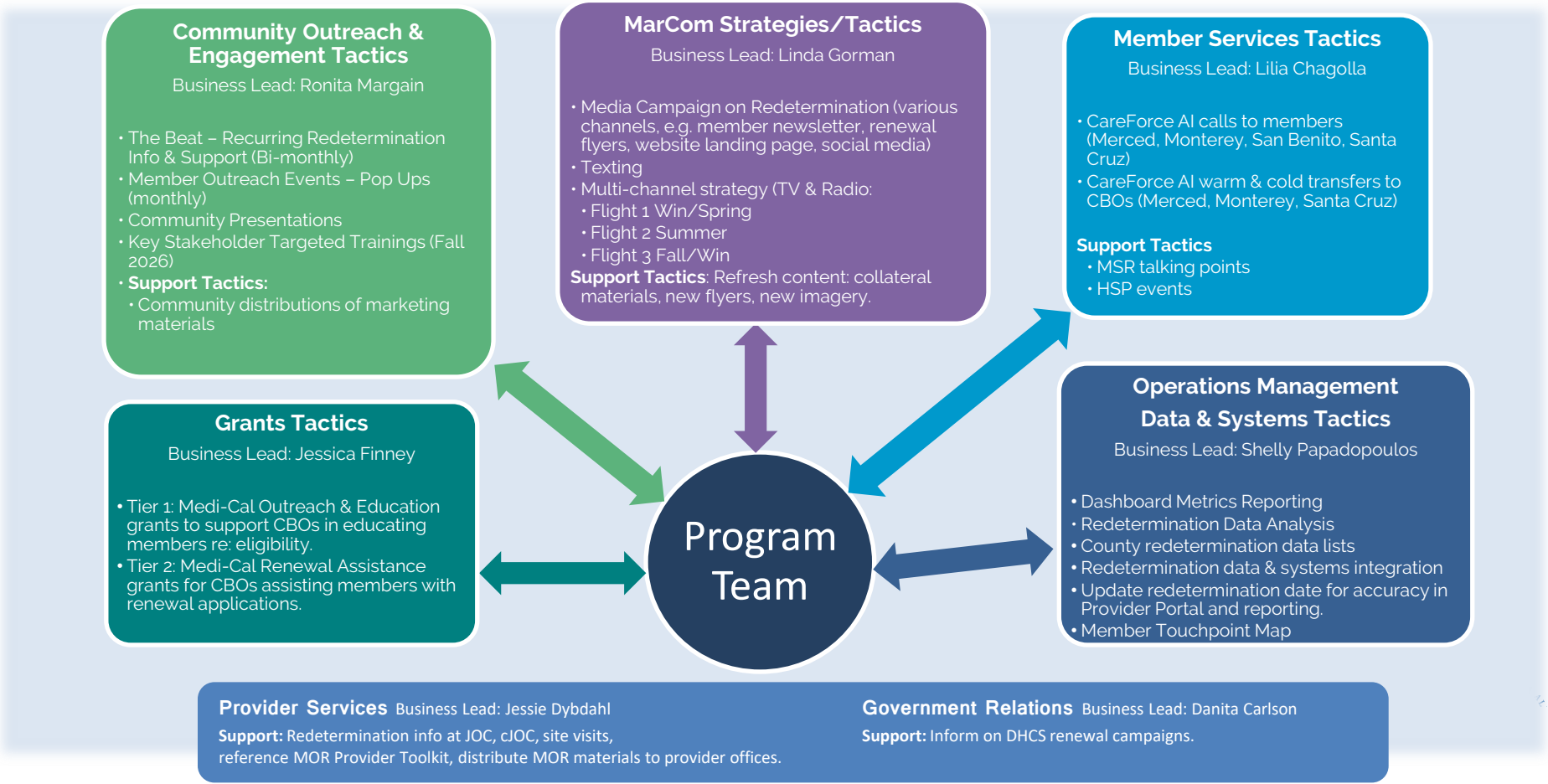
Key Eligibility & Enrollment Provisions

Source	Eligibility Change	Effective Date
Federal	Expiration of COVID-19 Unwinding Flexibilities	Jun 30, 2025
State Budget	**Enrollment freeze** for full-scope MCal for UIS for ages 19+	Jan 1, 2026
State Budget	**Reinstatement of MCal asset limit** to $130K for an individual	Jan 1, 2026
Federal HR1	Elimination of 90-day elig while verifying immigration status	Oct 1, 2026
Federal HR1	**Redeterminations every 6 months** for ME adults	Jan 1, 2027
Federal HR1	**Work requirements** for ME adults 19-64 w/o dependents	Jan 1, 2027
Federal HR1	Retroactive coverage restricted to 1 month before application	Jan 1, 2027
Federal HR1	Asset limit of $1M ceiling for permissible home equity values	Jan 1, 2027
State Budget	**$30 monthly premium** for members with UIS, ages 19-59	Jul 1, 2027
Federal HR1	Copayments for ME adults	Jan 1, 2028

Member Outreach and Retention Program (MOR) **Goal**

Help eligible members maintain their Medi-Cal coverage and stay connected to care.

Member Outreach and Retention Program Team Structure



MOR Program **Building Awareness**

Media Spots: Repeat video segment

- TV & DMV ads
- Bi-lingual Radio
- Social Media/Geo Ads
- Billboards
- Provider Office Materials
- Newsletters

Pop-Up Outreach: Alliance representatives in the communities where our members live

MOR Program **Direct Member Outreach**

Text Messages: Reminders to members who must complete annual renewals within 45 days.

Angelica: Careforce AI agent reminds members of their renewal date and provides telephone support.

MOR Program **Renewal Support**

- In-Person and/or Telephonic support available to our members via local community agencies.
- Grants awarded to 14 organizations across 5 counties to provide application/renewal support to members.
- Weekend Renewal Support (coming soon!)

MOR Program **How everyone can help!**

- Know the 3-step process to keep Medi-Cal coverage!

- Reinforce three simple steps for members to stay covered:
  1. **Update contact information** with the county.
  2. **Know renewal date and check mail** for renewal notices.
  3. **Complete and return forms on time**, if required.

Questions?

WHOLE CHILD MODEL
CLINICAL ADVISORY COMMITTEE
MEETING CALENDAR FOR 2026

Thursday, February 19th	12:00 PM to 1:00 PM
Wednesday, April 22nd	12:00 PM to 1:00 PM
Wednesday, July 22nd	12:00 PM to 1:00 PM
Wednesday, October 28th	12:00 PM to 1:00 PM

All Meetings will be held via virtually