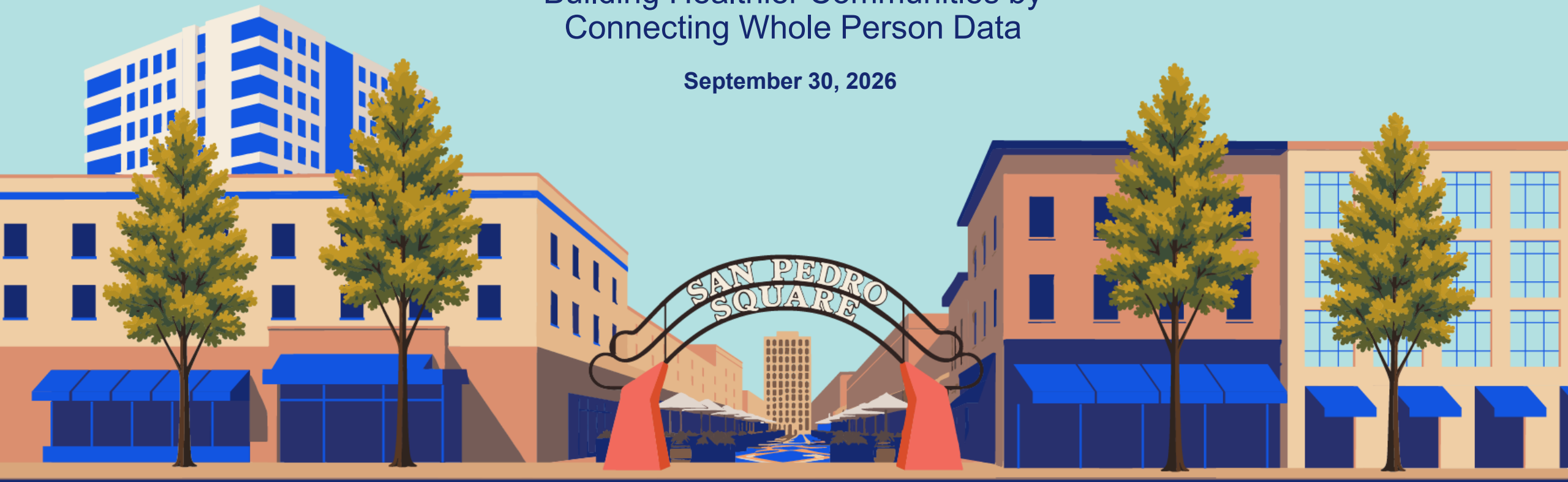
Manifest MEDEX

Evolution CA 2026: Bay Area

Building Healthier Communities by Connecting Whole Person Data

September 30, 2026



Welcome Remarks

Erica Galvez
Chief Executive Officer,
Manifest MedEx

The Sustainable Safety Net:
Charting Medi-Cal's Path Through Budget Pressures

Michelle Baass
Director,
California Department of Health Care Services

Manifest MEDEX

The Sustainable Safety Net: Charting Medi-Cal's Path Through Budget Pressures

Michelle Baass, Director,
Department of Health Care Services

September 30, 2026

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Our Purpose:

We provide equitable access to quality health care, leading to a healthy California for all.

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

Medi-Cal

DHCS finances and administers the state's Medicaid program, Medi-Cal.

About one-third of California's population, or about 14 million people, is covered by Medi-Cal.

From Medi-Cal to behavioral health, DHCS offers many programs that support Californians' well-being.

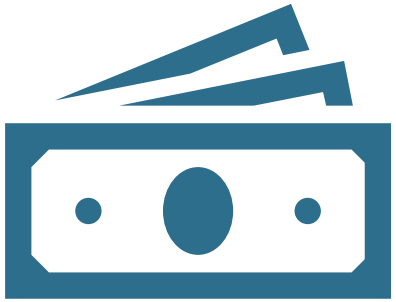
Topics for Today

- 2026-27 State Budget Act
- Major Medi-Cal Impacts of H.R. 1
- CalAIM
- Behavioral Health Transformation
- Behavioral Health Facility Throughput: Data Exchange

2026-27 State Budget Act

DHCS

2026-27 Budget Act



- The Budget Act includes $337.7 billion in total funds for all health and human services programs.
  - The Budget includes **$226.3 billion in total funds** and **4,765.5 positions for DHCS.**
- Of this amount, $1.5 billion is State Operations (DHCS operations), while $224.7 billion is Local Assistance (program costs, partners and administration).
- The proposed budget continues to support the Department's purpose to provide equitable access to quality health care.

DHCS Major Budget Issues: Managed Care Organization (MCO) Tax

- The budget includes tax revenue of $2.5 billion in 2026-27 to support payment increases relative to calendar year 2024.
- The MCO tax renewal is effective January 1, 2027, and conforms to the new H.R. 1 federal requirements.
  - The budget includes net revenue of:
    - $575 million in 2026-27.
    - $2.3 billion in each of 2027-28 and 2028-29.
    - $1.7 billion in 2029-30.
  - This renewed MCO tax supports the Medi-Cal program and maintains targeted rate increases for primary, maternal and non-specialty mental health care.

DHCS Major Budget Issues: Unsatisfactory Immigration Status (UIS) to Fee-For-Service (FFS)

- Beginning January 1, 2027, members with UIS will transition to the FFS delivery system.
- The budget includes cost reductions for current year and ongoing:
  - 2026-27 $637.1 million ($524.9 million General Fund).
  - Ongoing $1.6 billion ($1.3 billion General Fund).
- The budget includes $39 million to provide care coordination and navigation services to this population.

DHCS Major Budget Issues: H.R. 1

» The Budget includes the following H.R. 1 (2025) highlights:

- **Affordable Care Act (ACA) Adult Expansion with UIS Federal Medical Assistance Percentage (FMAP) adjustment for Emergency Services.**
  - Results in an additional General Fund (GF) cost of $669 million in 2026-27.
- **Work and Community Engagement Requirement.**
  - Results in a cost reduction of $357.6 million in total funds ($90.3 million GF) in 2026-27 and $9.6 billion ($2.4 billion GF) by 2029-30. Projected disenrollments are 43,000 in 2026-27 and 1.1 million by 2029-30.
- **ACA Adult Expansion Population Six-Month Redetermination.**
  - Results in a cost reduction of $747.3 million in total funds ($186.4 million GF) in 2027-28 and $2.5 billion ($633 million GF) by 2029-30. Projected disenrollments are estimated to be zero in 2026-27 and approximately 278,600 in 2029-30.
- **Restrictions on Immigrant Eligibility.**
  - Full-scope Medi-Cal cost is projected to be $365 million GF in the budget year for a delayed July 1, 2027, transition to restricted-scope Medi-Cal.

DHCS Major Budget Issues

- **County Medi-Cal Administration Augmentation** – $709 million ($196.8 million GF) one-time augmentation in 2026-27 to support H.R. 1 implementation. The budget includes a total of $3.3 billion ($828.2 million GF) for Medi-Cal county administration in 2026-27.
- **Community Mobile Crisis Services** – $42.2 million in GF to extend the community-based mobile crisis response services benefit until June 30, 2027.
- The Budget includes additional funding for the following programs:
  - **988 and Behavioral Health Crisis Continuum** - $25.9 million in total funds.
  - **Behavioral Health Transformation** - $41.8 million in total funds for Behavioral Health Services Act (BHSA) ongoing implementation, oversight, and monitoring.

DHCS Major Budget Issues

- Refines criteria for **Enhanced Care Management** (ECM) and **Community Supports** including eligibility criteria, service definitions and utilization management criteria. The Budget includes General Fund savings of $41.4 million in 2026-27 and $99.2 million ongoing related to the ECM changes and General Fund savings of $26.9 million in 2026-27, $58.8 million in 2027-28, and $51.0 million ongoing related to the Community Supports changes.
- Includes a General Fund reduction of $68 million in 2026-27 increasing to $552 million in 2029-30 to strengthen utilization management controls for **applied behavioral health analysis** and **transportation** in the Medi-Cal program and eliminates the incentive component of the quality with hold and incentive program in Medi-Cal.
- Redirects the **Medical Loss Ratio** remittances to the General Fund to achieve a $25 million savings.

DHCS Major Budget Issues: Delay of 2025 Budget Act Actions

- The Budget includes increased costs due to the delay of the following 2025 Budget Act General Fund Solutions:
  - Delays elimination of **state-only prospective payment system (PPS) payments** to Federally Qualified Health Centers and Rural Health Clinics from July 1, 2026, to July 1, 2027.
  - Delays elimination of **dental benefits** for UIS and of **Dental Supplemental Payments** from July 1, 2026, to July 1, 2027.

DHCS Major Budget Issues

- Maintains the current **Medi-Cal asset limit** that went into effect January 1, 2026, and also reinstates the asset limit for seniors and adults with disabilities to $21,000 for an individual or $31,000 for a couple, effective no sooner than July 1, 2027.
- Includes General Fund savings of approximately $427.3 million in 2027-28, decreasing to approximately $314.3 million annually in 2029-30 from increasing **monthly premiums for adults with unsatisfactory immigration status** to $50, effective July 1, 2027, subject to a determination in the 2027-28 May Revision.

DHCS Major Budget Issues: One-Time Funding

» The Budget includes one-time funding for the following policies:

- Support for **Designated Public Hospitals** in the amount of $250 million General Fund for grants to support health care expenditures.
- **Proposition 36** funding for grants to county behavioral health departments in the amount of $20 million General Fund over three-years.
- One-time increases for **Private Duty Nursing**, $30 million General Fund, and **Congregate Living Health Facility**, $7.7 million General Fund.
- **Anosognosia Pilot Program** funding in the amount of $5 million General Fund for a one-time direct payment to CenCal Health to establish a pilot program for the treatment of severe schizophrenia or anosognosia.

Additional Information and Resources

- DHCS Website - **Governor's Budget Documents 2026-27**.
  - **DHCS FY 2026-27 Budget Act Highlights**.
  - **What Medi-Cal Members Need to Know**.
- Statewide Budget Website – **ebudget.ca.gov**.
- Department of Finance Website - **https://dof.ca.gov/**.
  - Budget Change Proposals - **Governor's Budget BCPs**.
  - Trailer Bill Language - **DOF Trailer Bill Language**.

Major Medi-Cal Impacts of H.R.1

DHCS

Major Medicaid Provisions of H.R. 1

On July 4, 2025, President Trump signed H.R. 1 into law, which made significant changes to Medicaid including impacts on enrollment and federal matching funds.

Eligibility/Access Requirements

- Work requirements
- 6-month eligibility checks
- Retroactive coverage restrictions
- Cost sharing

State Financing Restrictions

- MCO and Provider Tax limitations
- State Directed Payment restrictions
- Federal funding repayment penalties for eligibility-related improper payments

Immigrant Coverage Limitations

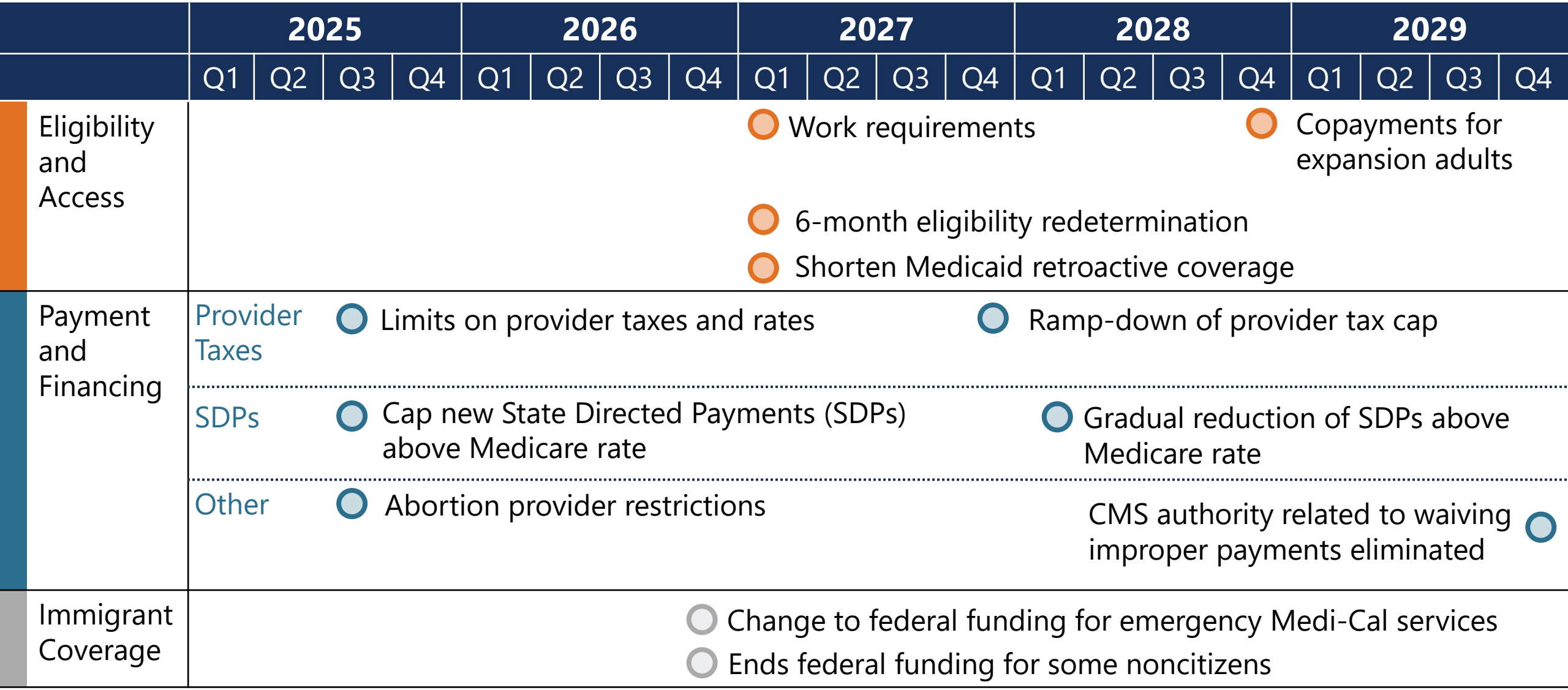
- Reduction in FMAP* for emergency UIS**
- Restrictions on lawful immigrant eligibility (increases UIS)

**Federal matching assistance percentage*
***Unsatisfactory immigration status*

Abortion Providers Ban

- One-year ban on federal Medicaid funding for "prohibited entities" that provide abortion services

Effective Dates for Key Provisions



Q1: Jan–Mar **Q2:** Apr–Jun **Q3:** Jul–Sept **Q4:** Oct–Dec

Effective Dates for Key Provisions: Eligibility and Access

2025				2026				2027				2028				2029			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

- **JANUARY 1, 2027:** Implement **mandatory work requirements** for Medicaid expansion adults ages 19 to 64.

  ⏱ *State option to delay implementation until December 31, 2028; California unlikely to obtain approval from HHS Secretary.*

- **JANUARY 1, 2027:** **Redetermine eligibility** for expansion adults once every 6 months.
- **JANUARY 1, 2027:** Shorten Medicaid **retroactive coverage**; provide Children's Health Insurance Program (CHIP) retroactive coverage at state option.
- **OCTOBER 1, 2028:** Impose **copayments** on most services for expansion adults with incomes above 100% of the federal poverty level (FPL).

Q1: Jan–Mar **Q2:** Apr–Jun **Q3:** Jul–Sept **Q4:** Oct–Dec

New Work and Community Engagement Requirements in Medi-Cal

- **H.R. 1** establishes Medicaid **work and community engagement requirements** as a new condition of eligibility for members in the "New Adult Group."
- California must implement work and community engagement requirements by **January 1, 2027**, meaning individuals in this group must demonstrate compliance with or meet an exclusion or exception from the requirements to be determined eligible for Medi-Cal.
- **CMS issued an interim final rule** on June 1 that establishes the operational framework for work and community engagement requirements. The rule became final on July 31.

Individuals in the New Adult Group:

(1) Ages 19-64

(2) Not pregnant

(3) Not enrolled in or entitled to Medicare Part A or B

(4) Not otherwise eligible for another mandatory Medi-Cal eligibility group

(5) Have income less than 138% of the federal poverty level, which is $22,025 for an individual and $45,540 for a family of four.

Good Faith Waivers

The Interim Final Rule outlines how states may seek approval for a good faith waiver to temporarily delay implementation for up to six months at a time through December 31, 2028.

Note: CMS has not provided guidance or submission instructions for the good faith waiver.

CMS will consider the following when reviewing waiver requests:

- **Progress the state has made** toward implementing work reporting requirements.
- **Key barriers or challenges**, including funding, design, development, procurement, or system readiness.
- The state's **implementation plan**, including timeline and milestones.
- Any **exigent circumstances** (e.g., administrative or external emergencies) affecting implementation.

The rule anticipates that ten states will submit waiver requests and that CMS will only approve two.

CalAIM

DHCS

CalAIM Overview

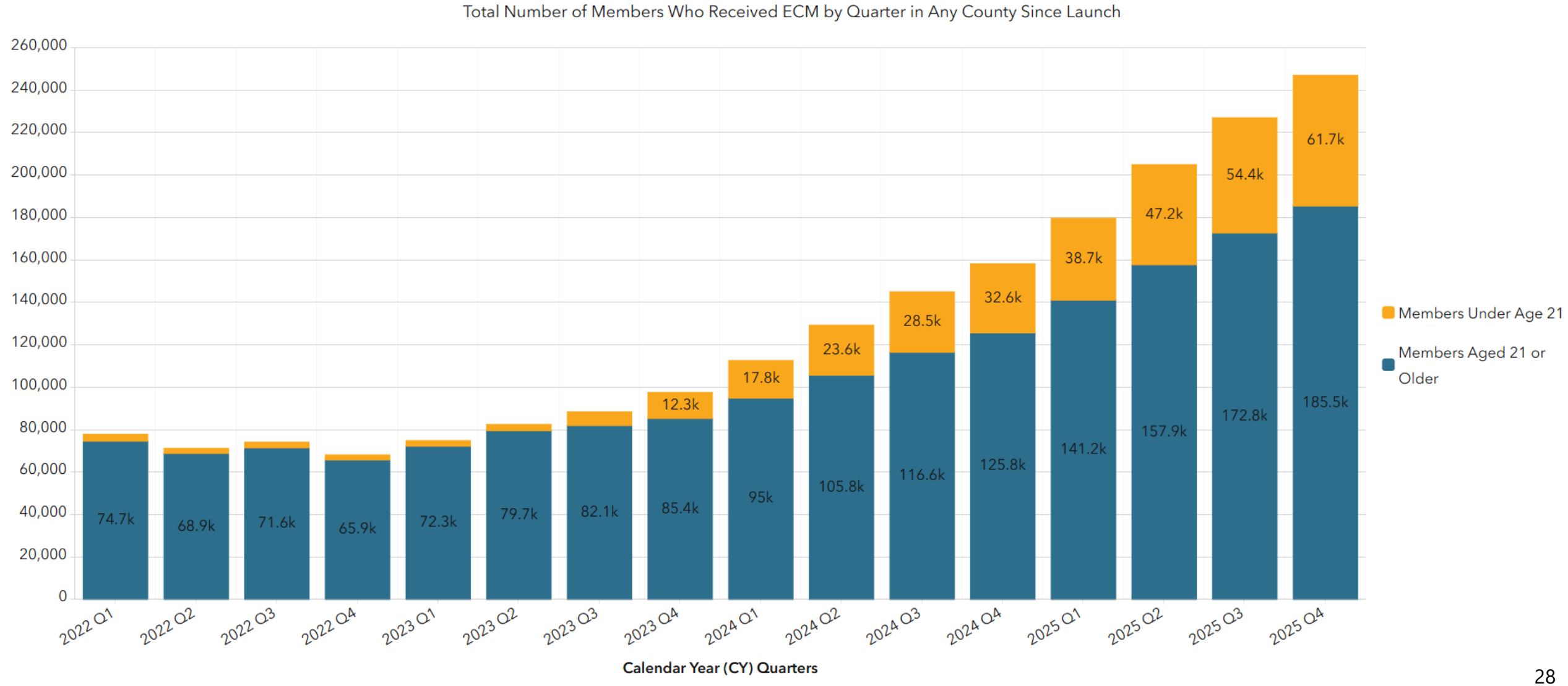
- DHCS is transforming Medi-Cal to ensure Californians can get the care they need to live healthier lives.
- This includes new initiatives and services that go beyond the traditional doctor's office or hospital setting to address social, physical, and mental health needs.
- CalAIM is a multi-year initiative to build a more coordinated, person-centered, and equitable health system that works for everyone.
- CalAIM is authorized through a variety of federal Medicaid authorities, including the **CalAIM Section 1115 demonstration, the CalAIM 1915(b) waiver, Medicaid State Plan, and managed care contracts.**
- In 2021, DHCS received authority for the CalAIM Section 1115 demonstration. DHCS is now seeking to renew the CalAIM Section 1115 demonstration for another five years to **build upon and consolidate the successes of the CalAIM initiative**.

Enhanced Care Management (ECM)

- ECM is a statewide Medi-Cal Managed Care Plan benefit to support elevated **comprehensive care management** for members who have the most complex cases
- Assigns members with complex needs a single **Lead Care Manager** to help them navigate their care and services across the physical, behavioral, and dental health delivery systems.

ECM Implementation Highlights

Data from January 2022 to December 2025

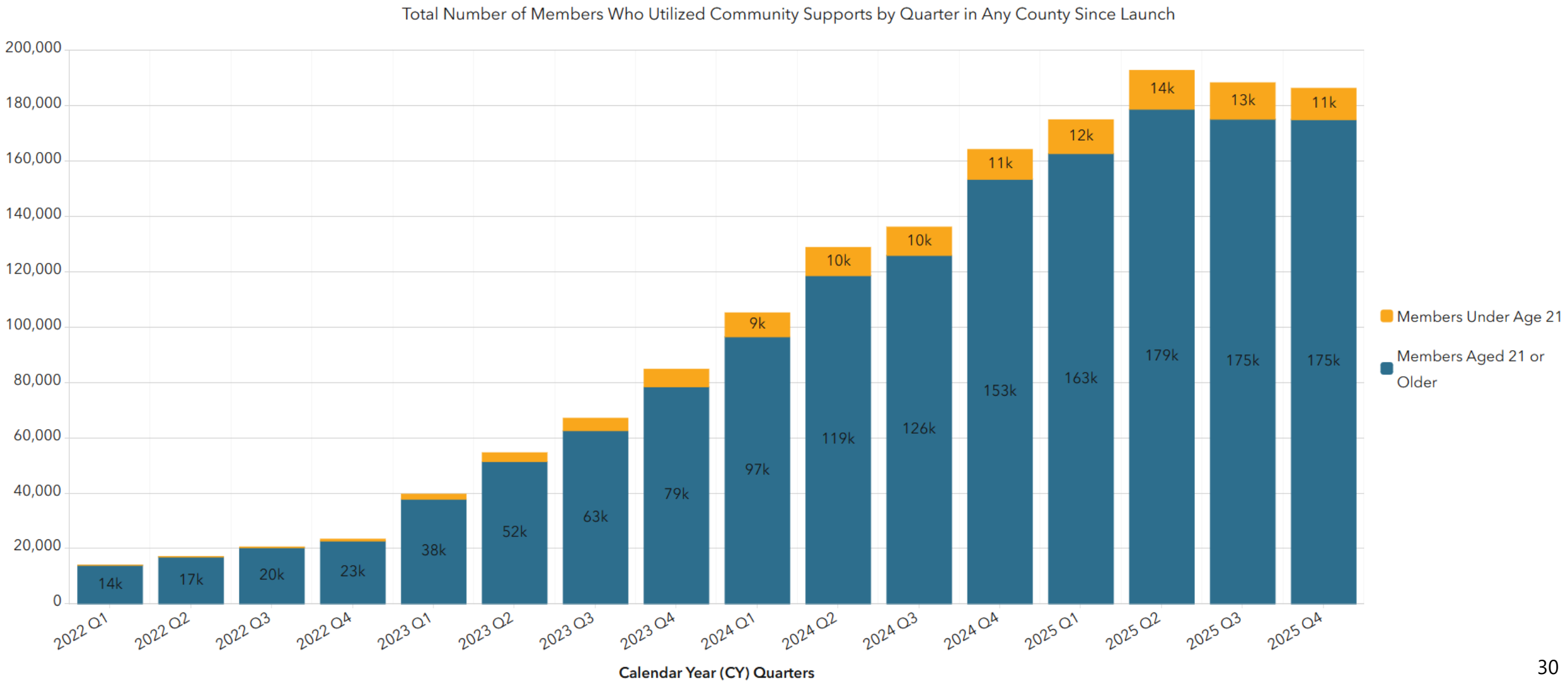


Community Supports

Community Supports services are provided by Medi-Cal health plans to **address social drivers of health**, such as access to healthy food, helping people to live more independently and safely at home.

Community Supports Implementation Highlights

Data from January 2022 to December 2025



Community Supports are Cost-Effective

DHCS compared the cost of providing each service to the savings generated from reduced use of hospital, emergency, and long-term care.

Personal Care and Homemaker Services were associated with a 79.9% net cost reduction, when compared to the cost of a member receiving long-term care instead.

Environmental Accessibility Adaptations — 51.4% net cost reduction

Respite Services — 19.9% net cost reduction

Housing Deposits —15.2% net cost reduction

Medically Tailored Meals/Medically Supportive Food — 10.5% net cost reduction

Assisted Living Facility Transitions — 9.7% net cost reduction

Updated CalAIM 1115 Demonstration Goals

Building on stakeholder feedback, DHCS proposed three primary goals to expand the reach and impact of CalAIM, aligned with California's broader vision for Medi-Cal.

- Strengthen the ability of DHCS, plans, and providers to identify and intervene early to manage member risk and need through whole person care approaches that optimize member experience.

- Continue to move Medi-Cal to a more consistent and seamless system by further reducing complexity, strengthening accountability, and improving program efficiency.

- Continue to improve quality outcomes and drive delivery system transformation and innovation through value-based initiatives that allow members to receive the right care, at the right time, in the right place, at the right cost.

1115 Demonstration Renewal

The Section 1115 demonstration renewal advances California's efforts to deliver more coordinated, person-centered, and value-based care by continuing existing initiatives, introducing targeted new supports, and transitioning certain services to more permanent Medicaid authorities.

Renew Authority

- Reentry Services for Justice-Involved Populations 90-Days Pre-Release
- Drug Medi-Cal Organized Delivery System (DMC-ODS) – Waiver of Institutions for Mental Diseases (IMD) Exclusion for SUD Services
- County Option to Cover Select Outpatient Substance Use Disorder Services
- Recovery Incentives (Contingency Management)
- Traditional Healers and Natural Helpers
- Coverage for Out-of-State Former Foster Care Youth
- Chiropractic Services from Indian Health Service (IHS) and Tribal Facilities
- Align Dually Eligible Enrollees' Medi-Cal Managed Care Plan (MCP) and Medicare Advantage (MA) Plan
- Managed Care Authority to Limit Plan Choice in Certain Counties
- Modification of Asset Test for Deemed Supplemental Security Income (SSI) Populations
- Global Payment Program

Request New Authority

- BridgeCare Pilots
- Employment Supports

Sunset Authority

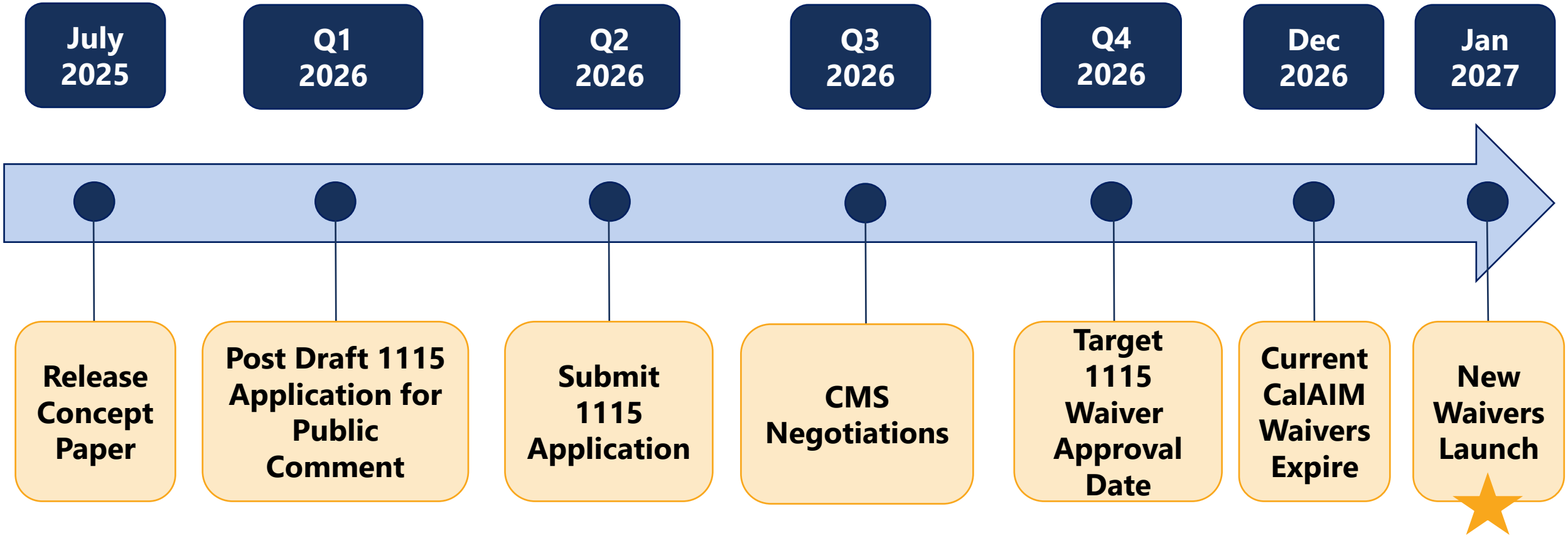
- Low-Income Pregnant Women
- Providing Access and Transforming Health (PATH) Initiative
- Designated State Health Programs
- Short-Term Post-Hospitalization Housing

Transition Authority

- Recuperative Care
- Community-Based Adult Services

Waiver Renewal Timeline

California submitted its comprehensive application to renew its 1115 waiver in Q2 2026. California is committed to engaging with stakeholders on an ongoing basis throughout the design and implementation of the proposed demonstration.



Behavioral Health Transformation

DHCS

Putting all the Pieces Together – California is Transforming Behavioral Health

Transforming Behavioral Health: Proposition 1

Proposition 1 is a **two-bill package** to modernize the state's behavioral health care system:

Behavioral Health Services Act (BHSA):

- **Reforms behavioral health care funding** to provide services to Californians with the **most significant behavioral health needs**
- Expands the behavioral health **workforce**
- Focuses on **outcomes**, **accountability**, and **equity**

Behavioral Health Bond:

- Funds behavioral health treatment **beds**, **supportive housing**, and **community sites**

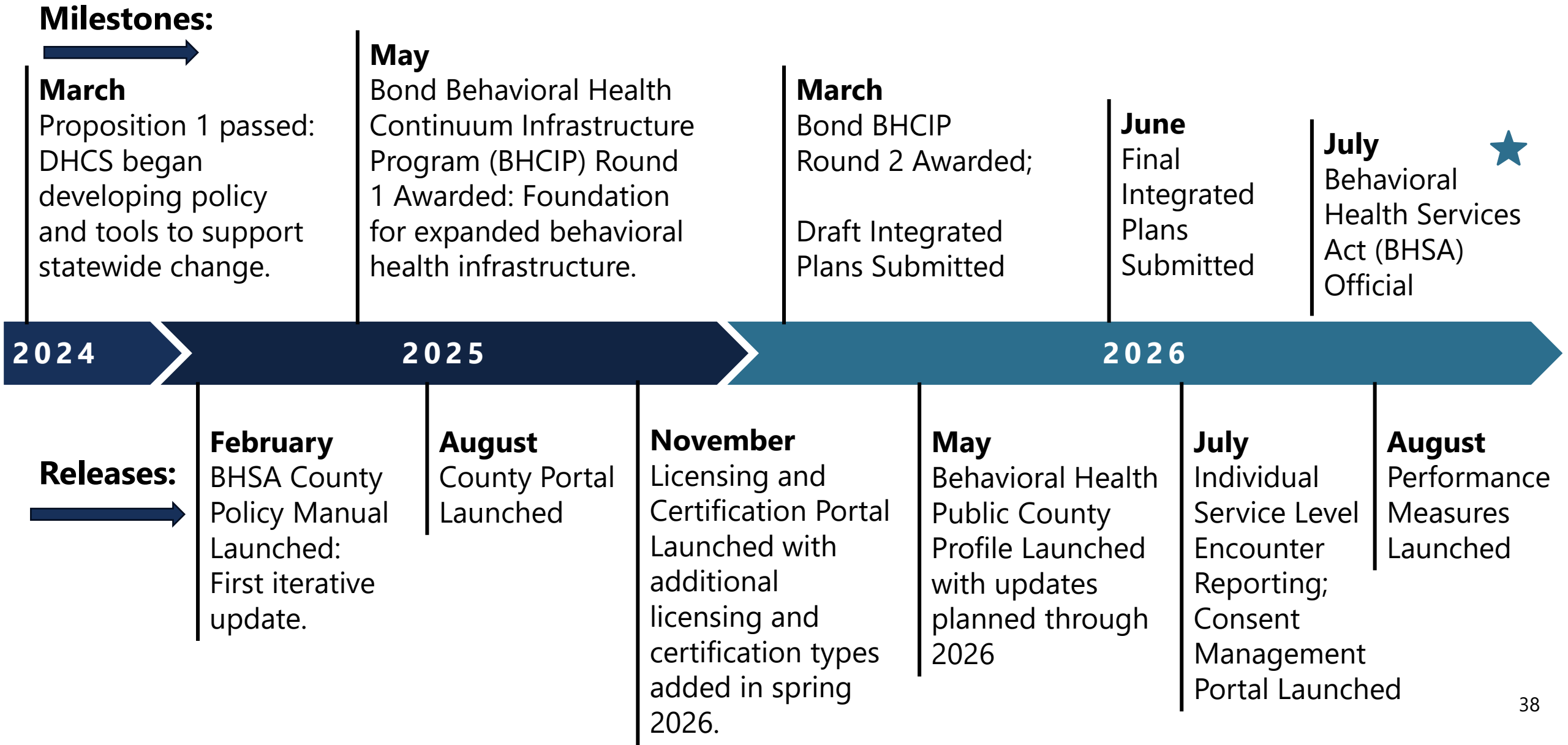
Bond Behavioral Health Continuum Infrastructure Program (BHCIP)

$4.4 billion for behavioral health treatment settings

Homekey+

$1.972 billion for supportive housing

Behavioral Health Transformation Progress



Building Care Facilities and Housing

Bond BHCIP
Goal Beds: 6,800 new
Goal Slots: 26,700 new

Round 1: Launch Ready ($3.3 billion):
- 4,236 beds
- 23,288 slots

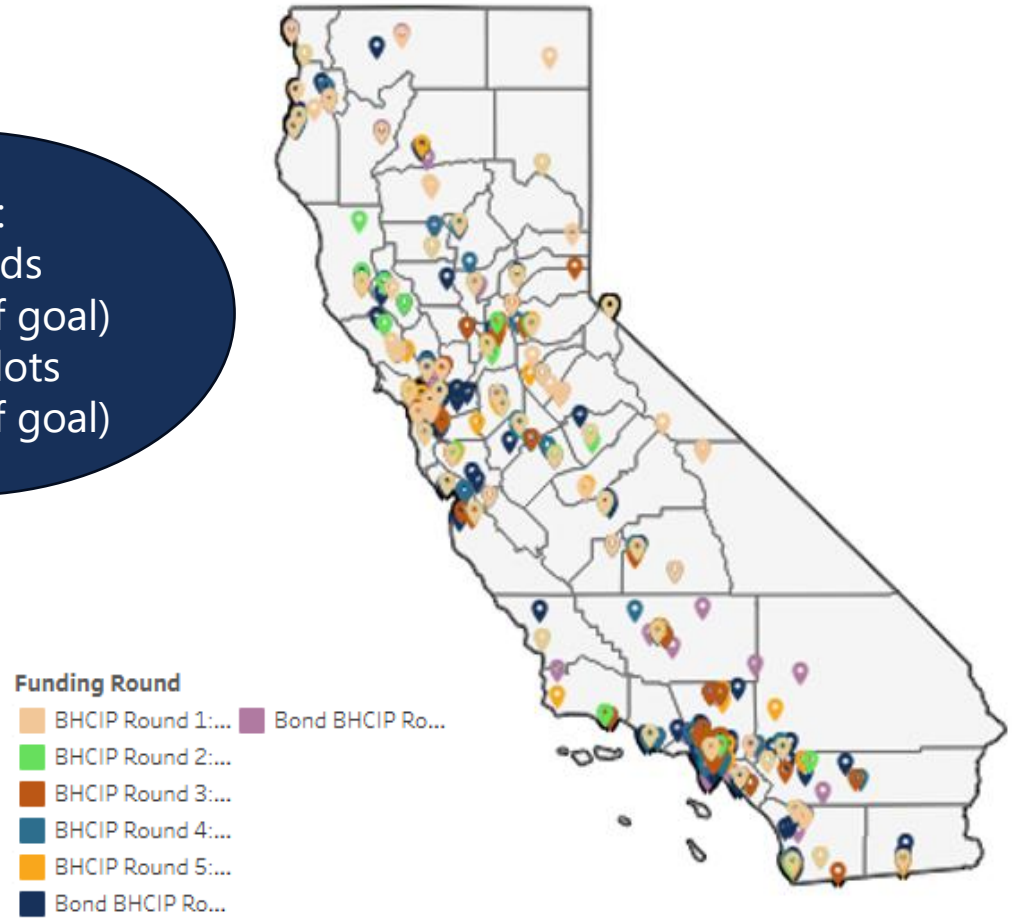
Round 2: Unmet Needs ($1.1 billion):
- 2,554 beds
- 4,273 slots

Total:
- 6,919 beds (102% of goal)
- 27,561 slots (103% of goal)

Homekey+
Goal PSH units: 4,000 new

Homekey+ ($2.1 billion) and **Tribal Homekey+** ($121 million)
- 2,749 Units Funded (as of 7/2/26)

BHCIP/ Bond BHCIP All Rounds



BHCIP + Bond BHCIP: Total Capacity

	BHCIP Round 3	BHCIP Round 4	BHCIP Round 5	Bond BHCIP Round 1	Bond BHCIP Round 2	Grand Total
Beds	1,291	534	809	4,365	2,554	**9,553**
Slots	6,919	8,306	4,377	23,288	4,273	**47,163**
Award Funding	$492M	$460M	$482M	$2.99B	$1.18B	**$5.6B**

Integrated Plan for Behavioral Health Services and Outcomes

	Three-Year County Integrated Plan
Purpose	Prospective plan and budget for all county behavioral health services.
Goal	Standardize data collection and reporting to increase transparency, promote stakeholder engagement, and improve local outcomes.
Frequency	Developed every three years.
Timing	Draft due on March 31, 2026. Final due on June 30, 2026.
Documents	A narrative and budget will be required.

See Welfare and Institutions Code 5963.02 (SB 326 Sec. 109)

Community Planning Process

Counties already engage in extensive community program planning and engagement with their communities under the **Mental Health Services Act** (MHSA).

The **Behavioral Health Services Act** (BHSA) builds upon the MHSA requirements to meaningfully engage with stakeholders with a few key changes.

Key changes to community planning process:

- Stakeholder list expanded to include SUD.
- Key stakeholder groups updated to include but are not limited to:
  - Historically marginalized communities.
  - Representatives from organizations specializing in working with underserved racially and ethnically diverse communities.
  - Representatives from LGBTQ+ communities.
  - Victims of domestic violence and sexual abuse.
  - People with lived experience of homelessness.
  - Health Plans, Education, Housing and Social Services.

Statewide Behavioral Health Goals

DHCS is advancing a population behavioral health approach that is grounded in the following 14 goals. It will take cross-service delivery system collaboration to advance these goals.

Goals for Improvement

- Care experience
- Access to care
- Prevention and treatment of co-occurring physical health conditions
- Quality of life
- Social connection
- Engagement in school
- Engagement in work

Goals for Reduction

- Suicides
- Overdoses
- Untreated behavioral health conditions
- Institutionalization
- Homelessness
- Justice-involvement
- Removal of children from home

Health equity will be incorporated across each of these goals.

*Additional information on the statewide behavioral health goals is available in the **BHSA Policy Manual**.*

Performance Measures Development

DHCS developed the first-of-their kind measures in two phases, with cohorts aligned to behavioral health goals developed and refined over time, with input from Subject Matter Experts and the Quality and Equity Advisory Committee to create a comprehensive statewide performance framework.

Phase 1: Population-Level Behavioral Health Measures

- 39 publicly available measures (19 primary, 20 supplemental).
- County-level reporting only.
- Supports BHSA Integration Plans and MCP Population Health Management planning activities.
- Not attributable to individual BHPs or MCPs.

Phase 2: Performance Measures

- 28 currently released measures based on individual-level data.
- Reported at goal, sub-goal, and intervention levels.
- Attributable to specific BHPs and MCPs.
- Support planning, population health management, and accountability.
- Replace Phase 1 measures.

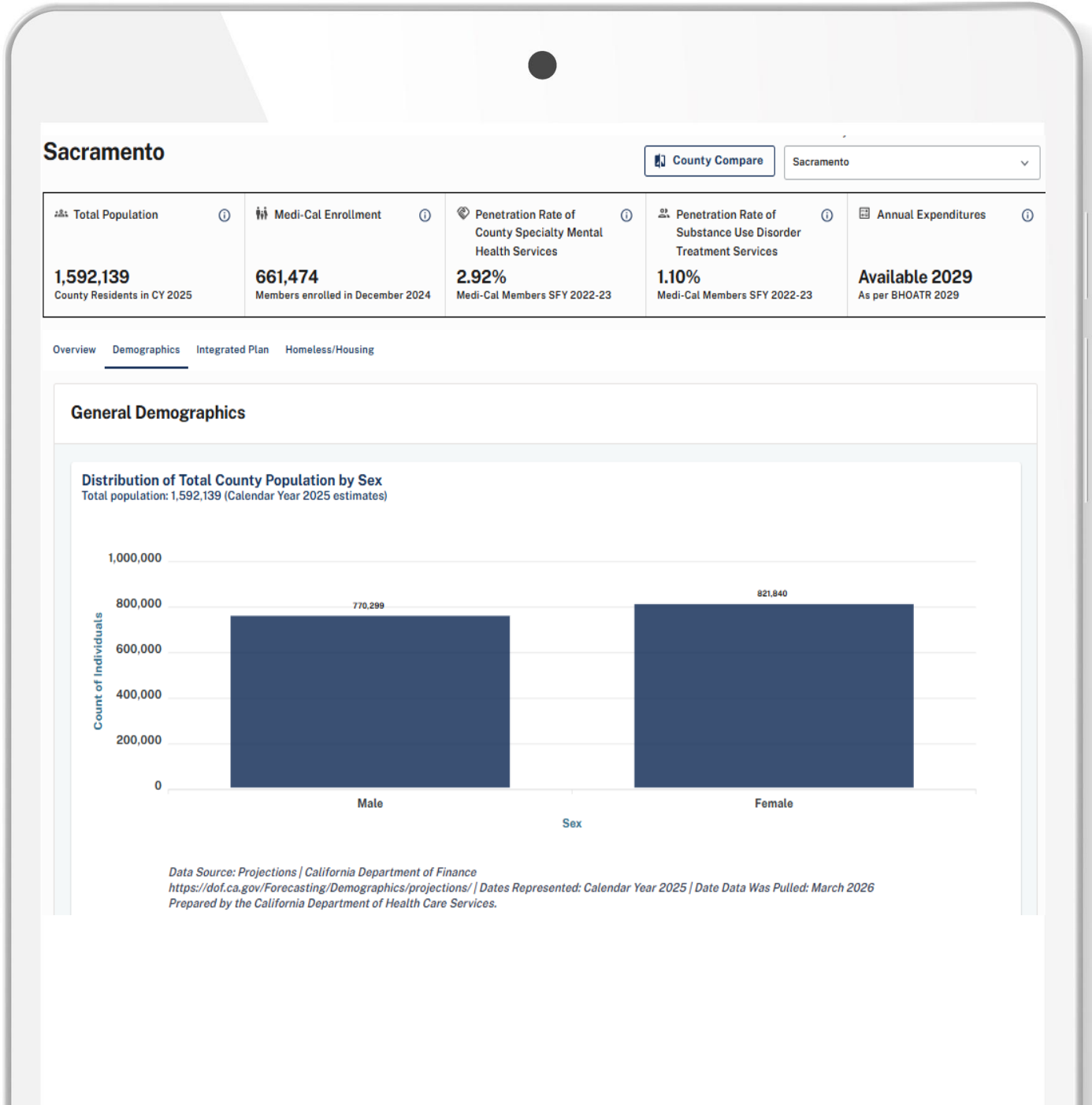
Cohorts 1-3

- Cohorts 1 and 2 focused on high-priority outcomes such as homelessness, justice involvement, access to care, care experience, overdoses, and suicides.
- Cohort 3 addresses broader well-being outcomes including school engagement, employment, quality of life, and social connection.

Behavioral Health Public County Profile

Launched in May 2026

- Brings together a **variety of data sources into a single platform**.
- The profile goes beyond the county behavioral health system.
- **Increases transparency** and understanding of behavioral health data for the public through **clear visualizations and standardized context**.
- Accessible through the **DHCS Behavioral Health Transformation** webpage. Login not required.



Public County Profile Version 1 Release

DHCS released the first version of the County Profile in May 2026, including the views and information outlined below.

Overview

County size, general population data, Medi-Cal enrollment by age group, and MCP information.

Demographics

Demographic breakdowns for each county's overall and Medi-Cal populations.

Integrated Plan

Downloadable draft Integrated Plan submissions outlining county strategies for the use of behavioral health funds.

Homelessness/ Housing

Information on services provided through the Homelessness Response System, BHSA-funded housing interventions, and Medi-Cal housing-related Community Supports and Enhanced Care Management (ECM).

Public County Profile Version 2 Release

DHCS will release an updated version of the Behavioral Health Public County Profile soon with expanded content and two new tabs.

Integrated Plan (Updated)

Final Integrated Plan submission content can be exported and displayed, including revenue projections, services projected by continuum of care, transfers and exemptions, base versus adjusted allocations, prudent reserve, and county priority goals.

Performance (New)

A subset of Behavioral Health Transformation performance measure results across the six priority statewide goals will be displayed.

Behavioral Health Reporting (New)

Data will also be available from:

- Community Assistance, Recovery, and Empowerment (CARE) Act
- Lanterman-Petris-Short (LPS) Act
- BH-CONNECT
- California's overdose surveillance dashboard

Behavioral Health Facility Throughput: Data Exchange

DHCS

Data Exchange and BH Throughput

DHCS has prioritized advancing real time data exchange through statewide initiatives, such as the **Authorization to Share Confidential Member Information (ASCMI) Initiative**, detailed guidance, and requirements for managed care plans and counties to exchange data in real time data to coordinate care across physical health, behavioral health, and social services.

- For individuals with behavioral health needs, effective care often requires coordination across multiple organizations and care settings, as well as the exchange of protected health data.
- DHCS is requiring the **statewide adoption of the ASCMI Form** and is launching a **Consent Management Portal** (CMP) to enable DHCS Care Partners to verify if their Clients have a documented Part 2 data sharing consent record.
- Real time data exchange remains a challenge due to **inconsistent technical capabilities**, **limited interoperability, and lack of standardized consent management processes** across sectors.

Seamless Real Time Data Exchange = ⬆ Throughput

When providers across sectors can access **behavioral health, physical health, and social service information** for individuals with behavioral health needs in real time, it enables true coordinated care that reduces treatment gaps and helps patients move toward achieving clinical and social stability in lower-acuity levels of care.

Proposed BH Data Exchange Eligibility

DHCS proposes the following grantee categories and eligibility parameters for BH Throughputs funding to support real time behavioral health and housing data exchange across California.

Milestone-Based Grants

DHCS is proposing to provide milestone-based grants in which **grantees will receive funds in installments based on demonstration of meeting specific milestones.** Grantee allocations could be proportional to entity size, need, and activity.

Counties (74%)

- County Behavioral Health Plans (BHPs), Drug Medi-Cal (DMC) counties, and county-contracted behavioral health providers.

CoCs (12%)

- Local CoCs.

Data Exchange Intermediaries (10%)

- Qualified Health Information Organizations, Health Information Exchanges, Community Information Exchanges, and other data intermediaries

Training & Technical Assistance (4%)

- One or more organizations with expertise in BH data exchange, consent management, and implementation support may be selected to provide statewide and targeted assistance.

Proposed BH Data Exchange Investments

DHCS proposes **$59.9M for targeted investments** across counties, Continuums of Care (CoCs), data exchange intermediaries, and training and technical assistance providers to **advance real time behavioral health and housing data exchange** and timely care coordination.

County BH Agencies and Providers

- Onboard with a data exchange intermediary to facilitate real time data exchange, including ADT notifications.
- ASCMI Form implementation and Consent Management Portal (CMP) connection and use.
- Provider grants through counties for intermediary onboarding and adoption of ASCMI Form and CMP.

Data Exchange Intermediaries

- Facilitate real time data exchange, including support for ASCMI and CMP adoption and ADT notifications for counties, CoCs, and providers.
- Data segmentation of substance use treatment information protected by 42 C.F.R. Part 2.

CoCs

- Onboard with a data exchange intermediary to facilitate real time, bidirectional data exchange of housing and health information.

Training & Technical Assistance

- Learning collaboratives and office hours.
- Targeted implementation support.
- Webinars, FAQs, and tip sheets.

Previously funded data exchange activities are not eligible for BH Throughputs funding.

Proposed Workplan for Data Exchange Activities

The proposed timeline includes two competitive funding rounds, with initial awards issued in early 2027, a second round in late 2027, and implementation activities continuing through 2028.

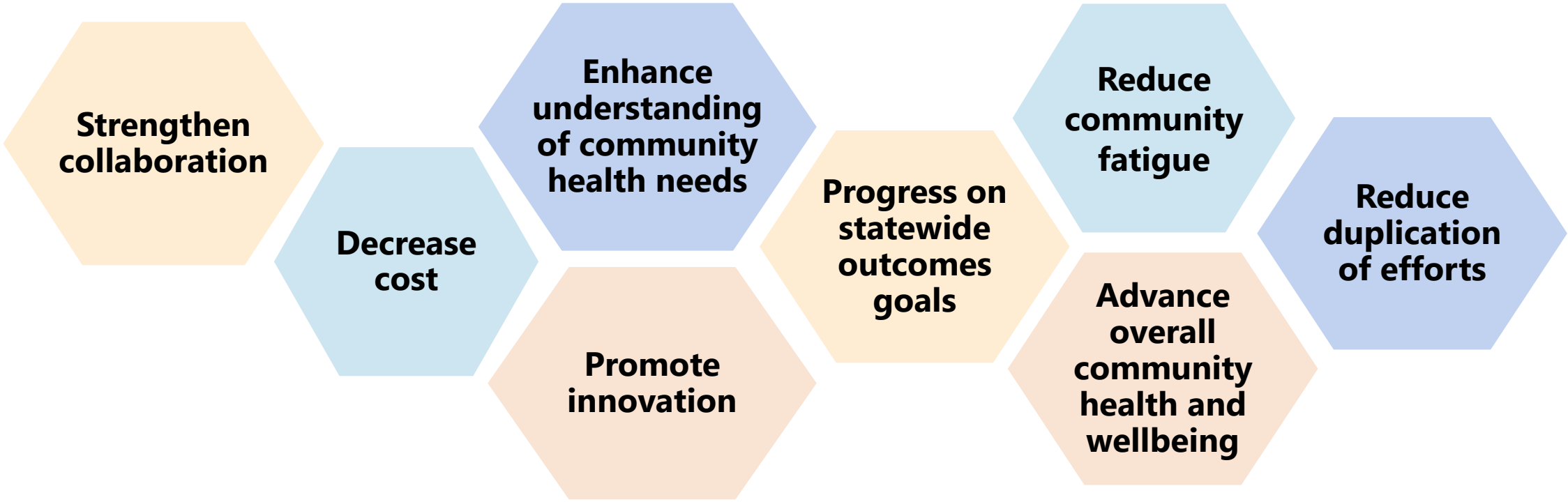
Activity	Timeline
Present proposal at PAHCA-SAC meeting	Mid to Late September 2026
Finalize and release Round 1 RFA	Fall 2026
Round 1 Grant Awards	January 2027
Finalize and release Round 2 RFA	Fall 2027
Round 2 Grant Awards	December 2027

Closing

The Need for Aligned Community Planning

Aligned planning foundational to achieving statewide goals and improving the overall health and wellbeing of California communities.

Aligned community planning provides an opportunity to:



DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Become a Coverage Ambassador

Help your community stay covered.

Many Californians are navigating changes to Medi-Cal. Coverage Ambassadors are trusted messengers who help members stay informed and understand what to do to keep vital health benefits.

Ambassadors:

- Stay up-to-date on Medi-Cal information through regular webinars and newsletters.
- Educate members about key deadlines and upcoming changes.
- Help members understand steps to keep their coverage.
- Share multilingual flyers, FAQs, and social media content.
- Provide feedback on outreach materials.
- Stay connected to CalHHS outreach on coming federal changes to CalFresh, Covered California, data sharing, and public charge.

Join the network: Scan the code or visit www.dhcs.ca.gov/coverage-ambassadors to sign up.

Thank you!

DHCS

Questions?

DHCS

Whole Person Care Without Silos: How Santa Cruz County is Rising to the Moment

Jessica Randolph
Director,
Administrator Services
Santa Cruz County HSA

Darlene Torres Voss
Director,
Community Health Services
Salud Para La Gente

David Nessim, MD, MBA
Medical Director
Central California
Alliance for Health

Erica Galvez
Chief Executive Officer
Manifest MedEx

Manifest MEDEX

BREAK: 10:45 a.m. – 11:00 a.m.

Thank you to our sponsors!

InterSystems
Creative data technology

ClinNEXUS

Google Cloud

Cures

J2 INTERACTIVE

NinePatch

HICKMAN STRATEGIES
Technology enables, *relationships transform.*™

Microsoft

BEYOND LUCID

Connected Communities:
Uniting Schools and HIOs for Youth Mental Health

Joe Prado
Director,
Fresno County Department of Public Health

HEALTHY FRESNO COUNTY
Better Together

Connected Communities: Uniting Schools and HIOs for Youth Mental Health

Joe Prado, Director, Fresno County Department of Public Health

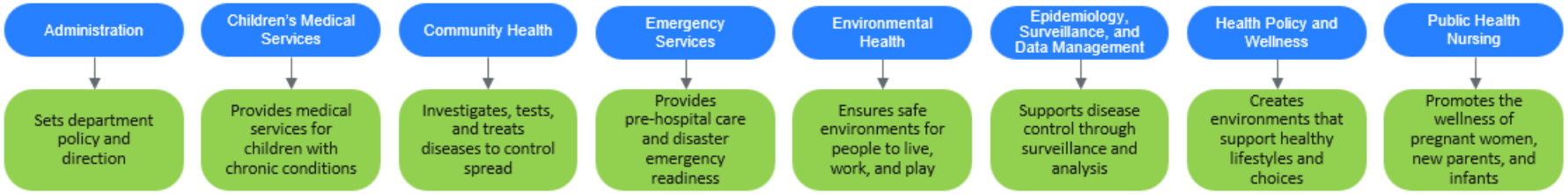
September 30

Department of Public Health
www.fcdph.org

About Fresno County Department of Public Health

Mission: ***The promotion, preservation, and protection of the community's health***

- County profile:
  - 5,959 square miles (6th largest)
  - 1,022,707 residents (10th most populous)
  - 53% Hispanic, 29% White, 10% Asian, 4% Black, 2% Multiracial
  - 21% of families with children live in poverty
  - 21% of the population are K-12 students
- Organization Profile:
  - 392 employees across Administration and 7 Division



Department of Public Health
www.fcdph.org

Fresno County Information Exchange: Mission, Vision, and Objectives

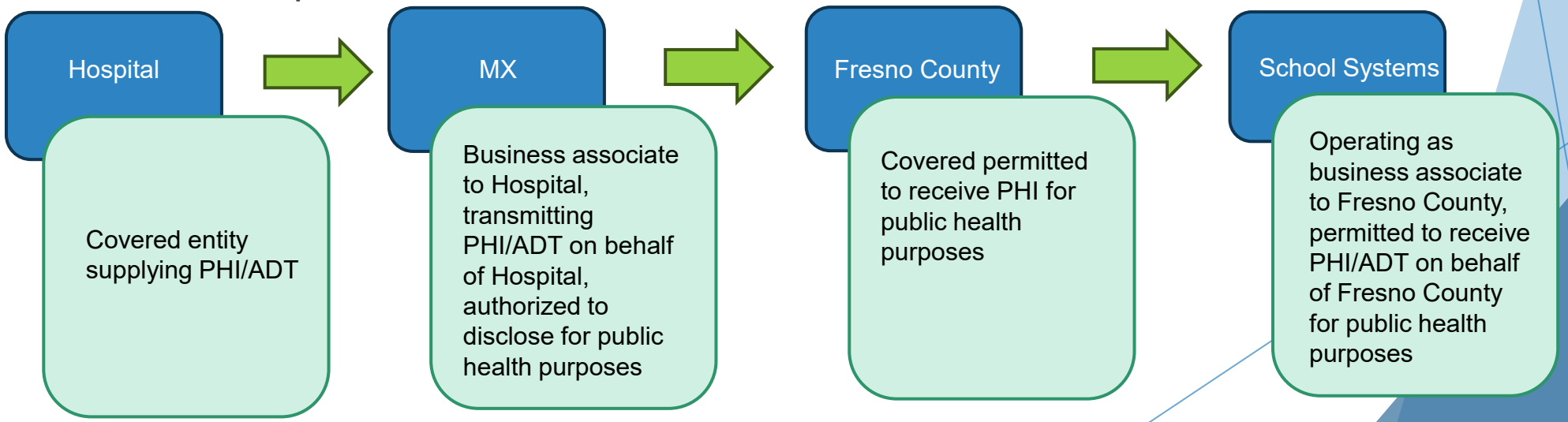
- Vision
  - To create a data-driven, interconnected community in Fresno County where timely and effective support is provided to those in need.
- Mission
  - Expedite data sharing across sectors to allow for improved communication and coordinated services for families in Fresno County.
- Objectives
  - Develop initial FCIE partnerships, governance, legal framework, and technical infrastructure to set the stage for ongoing development.
  - Enhance care coordination and expand accessibility to services for Fresno residents.
  - Streamline service delivery and improve outcomes in key areas.
  - Foster trust among stakeholders through clear and effective data governance.

Pilot Overview

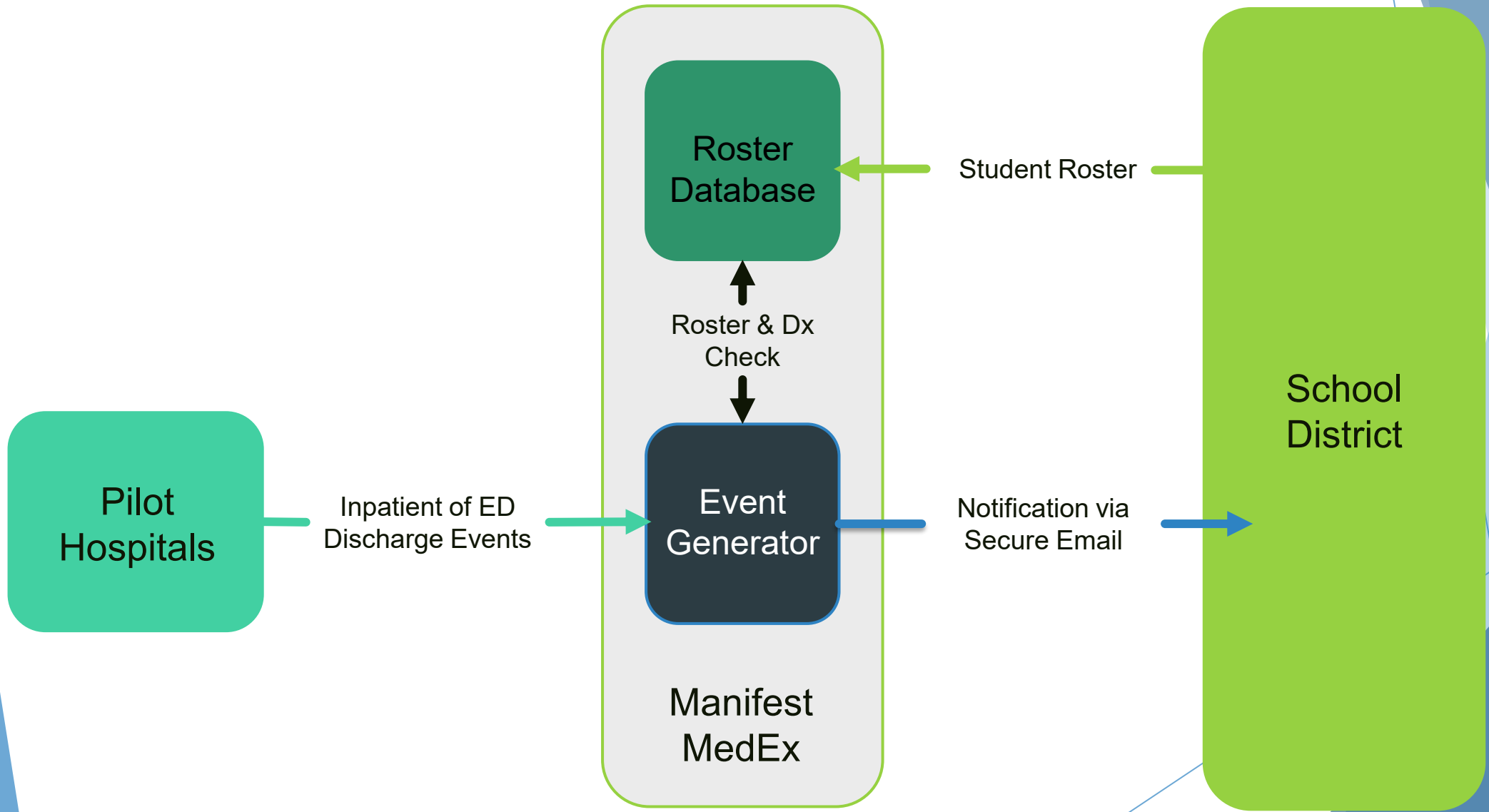
- The Youth Suicide Prevention (YSP) pilot tested the feasibility of leveraging real-time hospital admit, discharge, transfer (ADT) data to alert school district support staff when a student is in crisis.
- Real-time alerts will enable appropriate school district staff to support the student as quickly as possible.
- Partners in the pilot include:
  - Five Local School Districts
  - Schools Districts participating represent 70% of all school aged children in Fresno County
  - Manifest MedEx Health Information Exchange (MX)
  - Fresno County Department of Public Health (FCDPH)
  - Fresno County Hospital Partners
- Pre-cursors to pilot launch included:
  - Development of a legal framework to allow for the secure exchange of data
  - Collaboration efforts to design the technical solution.

Legal Framework

- Through business associate agreements (BAAs) between participating school districts and FCDPH, the use and disclosure of PHI for public health purposes is permissible under HIPAA.
  - **School district staff who receive ADT alerts will be required to complete HIPAA training.**
- FERPA: For patient matching purposes, the schools will provide only demographic data not protected by FERPA (directory data). Schools are required to inform parents (or eligible students) what will be disclosed and give them an opportunity to submit an opt-out form.



Technical Workflow



Department of Public Health
www.fcdph.org

Technical Collaboration: Identifying ICD-10 Codes

- The following ICD-10 codes are leveraged to identify qualifying ADTs, over 1,000 potential ICD-10 codes are included in the filtering logic.

ICD-10	Description	Modifiers
Z91.5	Personal history of a suicide attempt(s)	N/A
R45.851	Suicidal ideation	N/A
T14. 91	Suicide attempts and interrupted attempts	N/A
X71-X83	Intentional Self-Harm Codes	N/A
T36-T50	Poisoning	Intentional Self-Harm
T51-T65	Toxic Affects of Substances	Intentional Self-Harm
T71	Asphyxiation, suffocation, hanging	Intentional Self-Harm

Gabella, B. A., Hume, B., Li, L., Mabida, M., & Costich, J. (2022). High Positive Predictive Value of ICD-10 Code Filters for Intentional Self-Harm. *Public Health Reports*, *137*(3), 485–492. https://doi.org/10.1177/00333549221081518

Technical Collaboration: 2024–2025 Encounters

- Applying the same ICD-10 filtering logic to the confirmed FY24–25 export, Fresno County youth (ages 0–18) with a self-harm or suicidality diagnosis totaled:
- **2024: 295** unique ED encounters
- **2025: 347** unique ED encounters — a **17.6%** year-over-year increase
- **642** combined unique encounters across both years

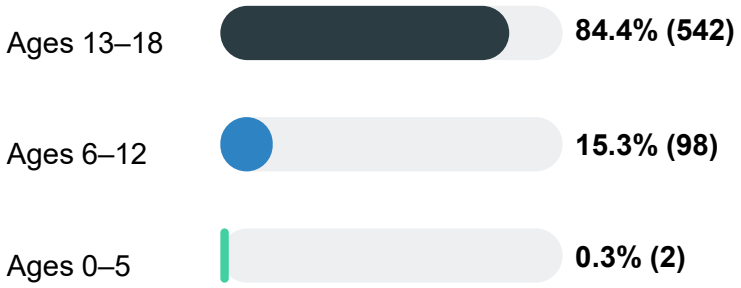
- **Methodology note:** These are deduplicated, encounter-level counts, refined this year to include a more precise measure than the broader criteria used last year, giving us greater confidence that every encounter counted is genuinely self-harm related.

Who is affected, and where, matters as much as how many — the next two slides break down the demographic and geographic patterns that can help target prevention resources.

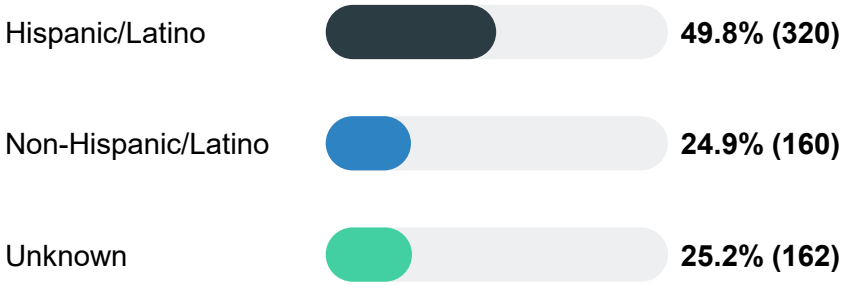
Who Is Affected: Age & Ethnicity Trends

Teenagers remain the overwhelming majority of encounters — and demographic gaps limit how precisely we can target support.

Age Group (2024–2025)



Ethnicity (2024–2025)



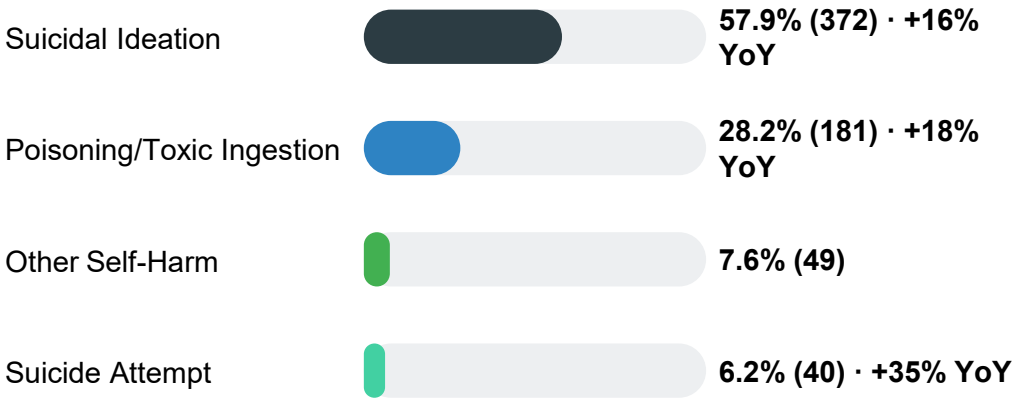
Hispanic/Latino encounters rose from 132 (2024) to 188 (2025), while non-Hispanic/Latino encounters declined slightly (83 → 77). Nearly 1 in 4 encounters has unknown ethnicity — improving intake capture at the point of care would sharpen how prevention resources are targeted

Note: 2 encounters for ages 0-5 is likely erroneous, which highlights coding accuracy concerns.

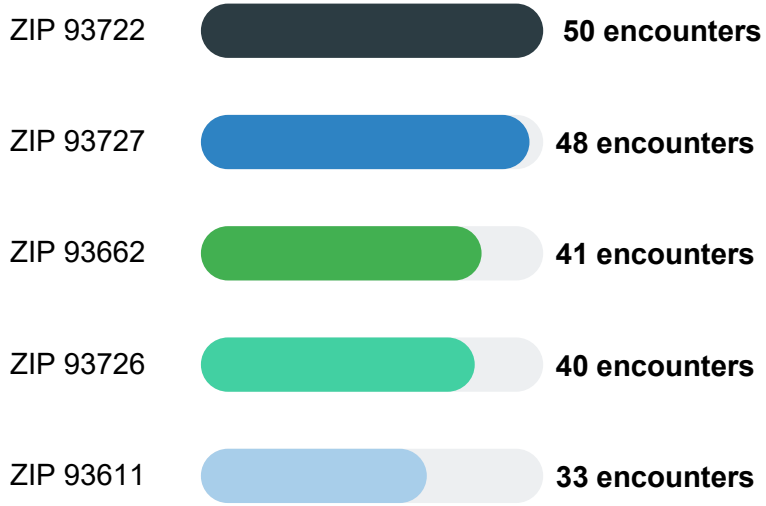
Where & How: Diagnosis & Geographic Hotspots

Suicide attempts are growing fastest of any category, and encounters cluster in specific Fresno neighborhoods.

Diagnosis Type (2024-2025)

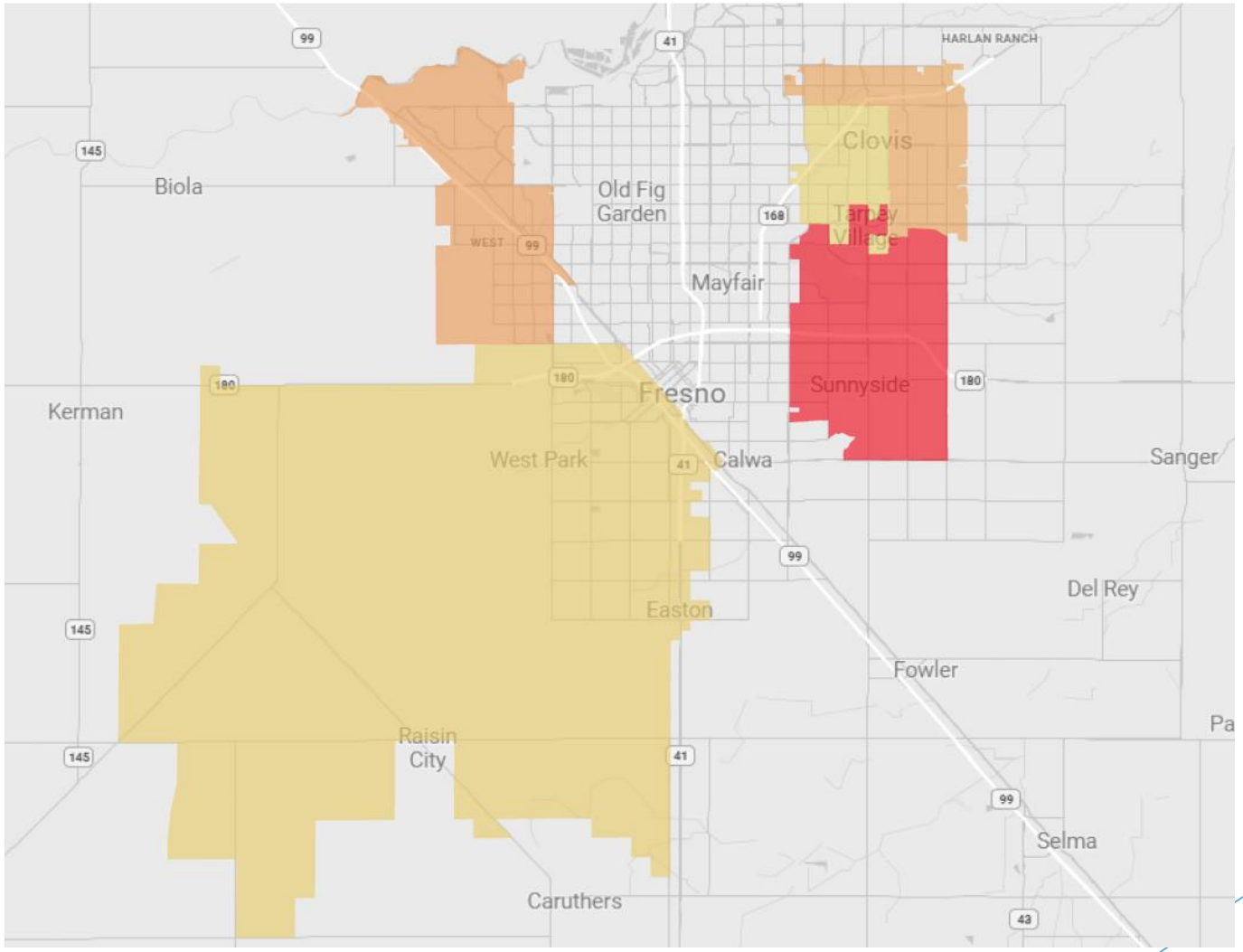


Top ZIP Codes by Volume



Suicide attempts rose 35% year-over-year despite the smallest share of total volume — an early signal worth monitoring closely. The highest encounter volumes cluster in western and southeastern Fresno (ZIPs 93722, 93727, 93662, 93726), consistent with prior years and useful for targeting school- and community-based outreach.

Encounters Analysis: Geography



Department of Public Health
www.fcdph.org

Lessons Learned

- FERPA considerations
  - FERPA protects student IDs. Schools needed to generate another unique ID for purpose of sharing data with MX.
  - The student's association with the school district will be blinded to the MX network and in outgoing data feeds.
  - School districts must inform parents of directory data disclosures and provide an opportunity to opt-out; pilot school districts have decided to include the YSP disclosures in their annual student handbook distribution.
- Schools want to minimize exposure to PHI. Minimal details about their hospital encounter are shared.
- School districts have existing workflows to receive crisis alerts and perform "wellness" check-ins with students. Our solution needed to feed into those processes.

Technical Collaboration: Continuous Improvement

Phase 1

- ADT filtering based upon ICD-10 codes

Phase 2

- Investigate free-text search in ADT data.

Phase 3

- Evaluate **AI** to identify qualifying visits using other clinical data not found in ADT.

Next Steps

- Post-launch
  - MX will monitor ADT alerts and provide monthly reports to school districts.
  - Stakeholder workgroup will convene to review data, processes, and workflow.
  - Process refinements to take place as they are identified.
- Identify and recruit additional school districts for SY '27-28

It Takes a Village!

- This wouldn't be possible without:
  - Fresno County Superintendent of Schools
  - Fresno County Cradle 2 Career
  - All the school districts
  - Fresno Department of Public Health
  - Future State Consulting
  - Manifest MedEx

Department of Public Health
www.fcdph.org

Thank you!

Department of Public Health

Questions?

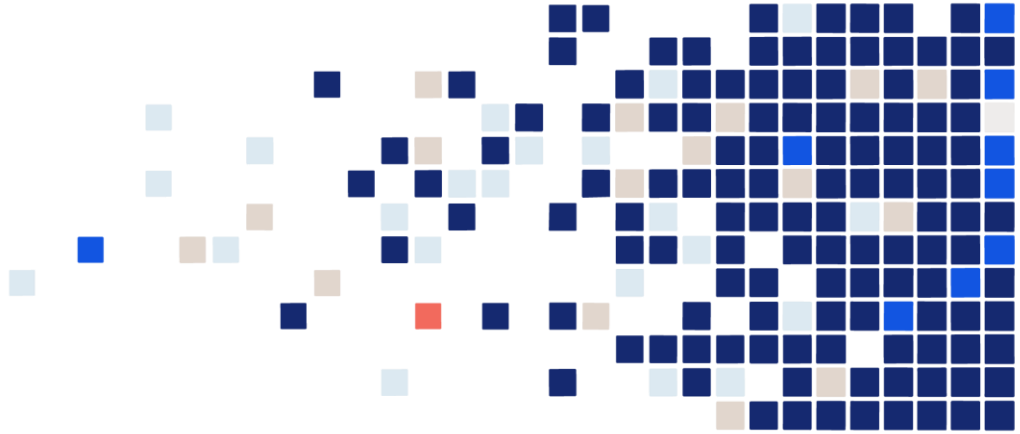
Department of Public Health

The Next Generation of HIOs: Innovation, AI, and Value That Matters

Jason Buckner
Chief Information Officer,
Manifest MedEx

The Next Generation of HIOs: Innovation, AI, and Value That Matters

Jason Buckner, Chief Information Officer, Manifest MedEx



September 30, 2026

Agenda

1. About Manifest MedEx (MX)
2. Social Health Information Exchange
3. Support for Sensitive Data
4. AI-Assisted Summarization of Audit Logs
5. High Resolution Data

About Manifest MedEx

- As California's largest nonprofit health data network, we securely bring together data to provide actionable clarity for coordinating health and powering an equitable future.
- We focus on the hard-to-reach data—including behavioral health and social drivers of health (SDOH)—because we believe every individual and their care team should be able to rely on health data as a foundational resource: always accurate, highly secure, and seamlessly available.

4000+
NETWORK PARTICIPANTS

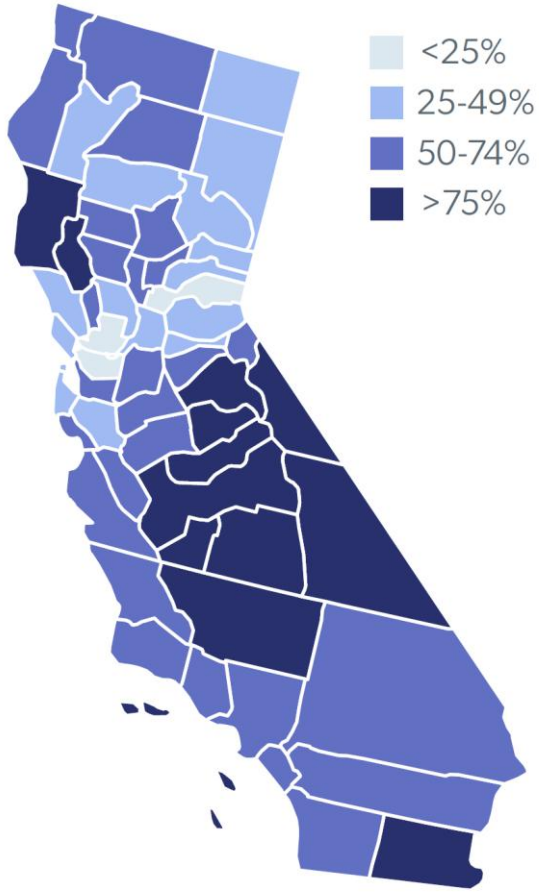
3200+
AMBULATORY PROVIDERS

190+
HOSPITALS

21
HEALTH PLANS

53M
LONGITUDINAL HEALTH RECORDS

3M
REAL-TIME ADTS PER MONTH



Social Health Information Exchange: *One Record for the Whole Person*

MX Engage, a platform for collaborative care coordination that brings together social, behavioral, and clinical data into one longitudinal social care record.

- **Core Infrastructure.** One source of truth, visible across every department and agency.
- **The Social Care Record.** A longitudinal view of social needs, behavioral history, and program enrollments — pulled from county systems, CBOs, and social services users across the network.
- **Care Coordination Tools.** Built-in intake forms and behavioral health screeners to document needs, assessments, and care activity collaboratively.
- **MX HIE Access.** Permitted users see relevant MX HIE data easily from within MX Engage.
- **Closed-Loop Referrals.** Make and track referrals in your own resource directory, so clients actually get the services they need.

Manifest MEDEX

User Support | Rashel Kostolansky | Logout

Home | Client Search & Services | Case Mgmt Tools | Reporting & Analytics | Admin Tools

Home
Access
Notify
Engage
Audit Report
Admin

CW

35 Years - Gender: Male DOB: (07/28/1991)

Craig Wolfman

MX Engage ID: 16998661 | Consent thru 05/25/2028 | Household Members D MW

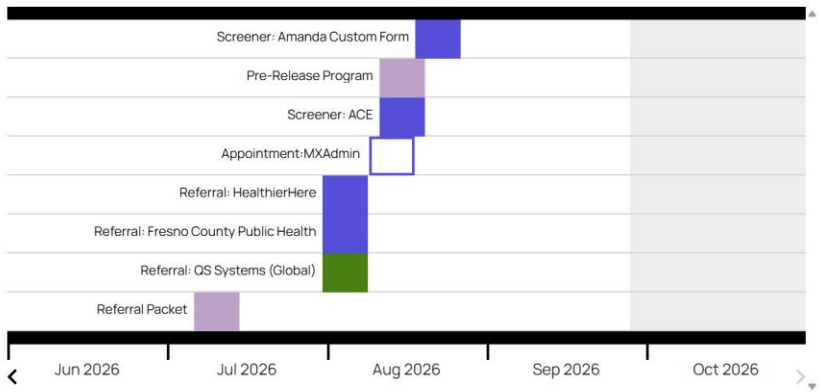
Client Launchpad

Shared Client Profile | My Case Work Case Activity | Find Resources | HIE Medical Record

Craig's OneView

Has a dog named Lilo

Craig's Services Timeline



+ Add a New Care Task

Craig's Care Team | Team Messages

CW **Client Communications**

AAMSAC **Amanda Anson - Mx Super Admin - Qs**
Super Admin 1
QS Systems (Global)
care team since May 2026
See Bio and Contact Info...

SP **Stephanie Peters**
Sr. Project Manger
MXAdmin
care team since May 2026
See Bio and Contact Info...

AAMASA **Amanda Anson - Mx Admin - Super Admin**
Senior Systems Analyst (SHIE)
MXAdmin
care team since May 2026
See Bio and Contact Info...

RN **Rashel Nashed**
Senior Product Manager
MXAdmin

Sensitive Data: *The Problem Every HIE Has, and Almost No One Talks About*

- For years, the default has been simple: leave it out. Part 2, behavioral health, and reproductive health data are excluded from the exchange.
- **That default has a cost.** Participants serving these patients get partial participation in networks meant to serve them.
- Why it persists:
  - **Consent architecture mismatch** — sensitive data needs disclosure-specific consent; most infrastructure runs on org-level opt-out
  - **No interoperable standard** — no common model for capturing this consent at scale
  - **Regulatory fragmentation** — Part 2, LPS Act, HSC § 11845.5 don't align

Exclusion isn't a compliance strategy. It's a workaround for a problem no one has solved.

Sensitive Data: *Why We Refused Easy Answers*

- We scanned the industry and this is what we found: org-level exclusion, manual attestation, opt-out defaults dressed up as consent. None cleared our bar.

- **We will not ship a compliant product that's painful to use.** A consent flow patients and participants can't actually navigate is a failure no matter what the policy says.

- **Simultaneous compliance, not sequential:** one approach that satisfies Part 2, LPS, and § 11845.5 at once, not three patches bolted together

Legal and usable aren't a trade-off. If it's not both, we start over.

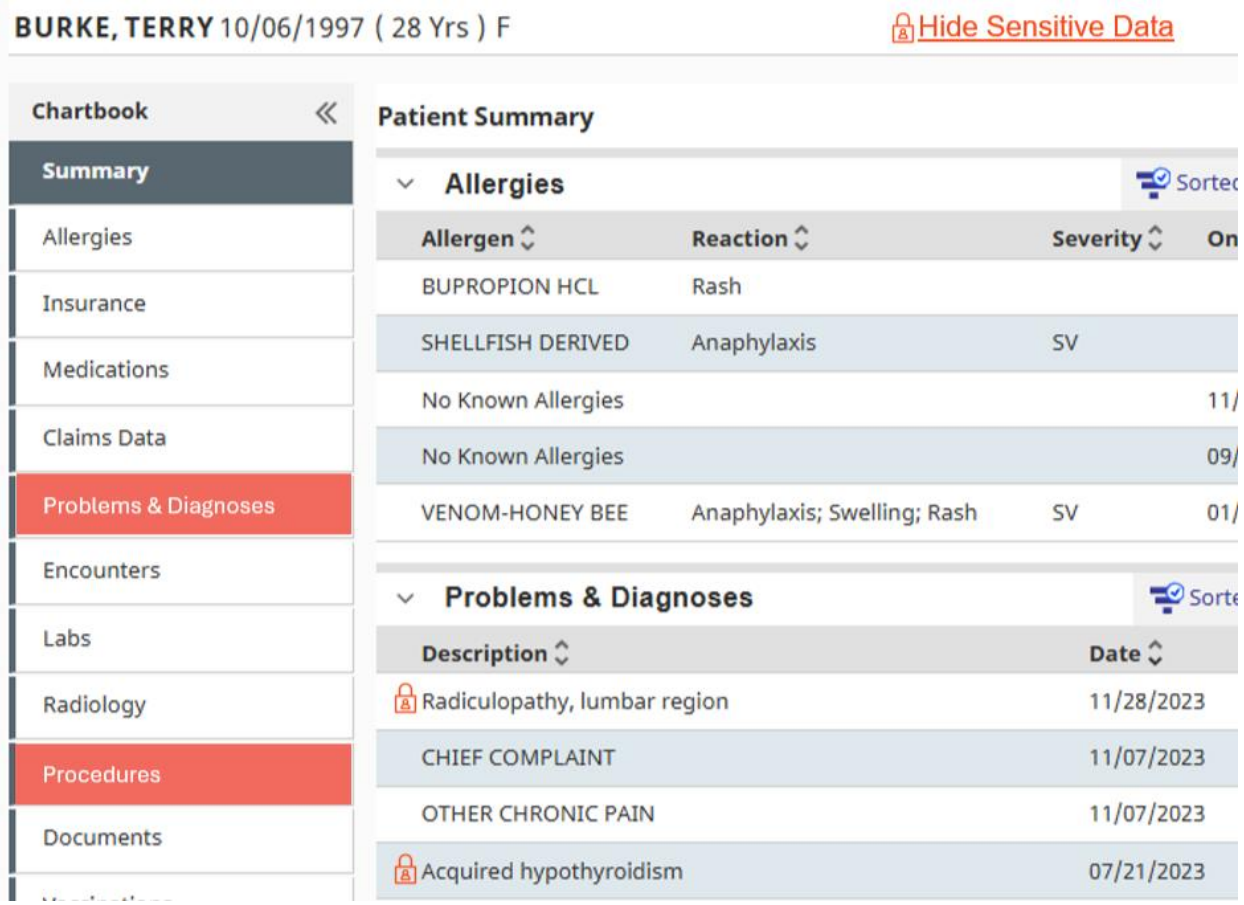
Sensitive Data: *The Solution*

Role-based access — only users with the MX Access SSD role can request sensitive source data

Consent-gated — data appears only where active patient consent exists

Attested and audited — every view is attested to and logged

Visually clear, fully reversible — sensitive records sit inline, flagged by a lock icon, and can be hidden again in one click



Audit Logs: *Oversight Shouldn't Require a Data Science Team*

- For years, the default has been simple: publish the raw audit log and call it oversight. Every login, every record access, delivered as a CSV — thousands of rows, zero structure.

- That default has a cost.
  - Small participants especially don't have the analytics resources to parse it
  - Commercial log-analysis tooling is expensive and complex to stand up
  - Even where tooling exists, it buries real signal under false positives.

Publishing the log met the letter of oversight. It never gave anyone the ability to actually exercise it.

Audit Logs: *Why We Built This With AI, Not Around It*

- We didn't build better view of raw data. We built a monthly summary of the same data, organized around the question participants actually have: what happened, and does it matter?

Where AI did the work

Faster Value to Participants

Development started in September; participants are planned to get this in December. A vendor RFP and implementation cycle typically takes 6-12 months.

Catches risks a checklist can't

Because the AI looks at patterns of behavior rather than just fixed rules, you get visibility into risks, like unusual combinations of activity, that a simple rules engine would never flag.

Audit Logs: *One Report, Two Types of Signal*

Confirmed Findings (deterministic, rule-based)

Factor	User	Observation
Bulk access	user09 (Records Analyst)	Session starting 2026-04-07 13:11 accessed 34 unique patients, at or above the global ceiling (10).
Login volume	user04 (Front Desk)	Login count (18) on 2026-04-14 met or exceeded the global ceiling (15/day).
Off-hours access	user17 (After-Hours Nurse)	41 of 52 events (79%) recorded outside the defined operating window (Mon-Fri 07:00-19:00) this period.

Patterns Worth Reviewing (the AI piece)

- ***Three users each recorded their highest single-day activity within the same 48-hour window*** (2026-04-14 to 2026-04-15) — a concentration that may warrant review alongside any known operational events.
- ***User09 appears in multiple threshold observations this period*** (Bulk access, Rapid navigation) — co-occurring signals that, together, may warrant a combined review even though neither alone crosses a hard rule.

The rules catch what we can define. *The AI catches what we can't.*

High Resolution Data – *From Static to Signal*

- Exchanged clinical data has long looked like an old analog broadcast, technically a picture, but full of snow, static, dropped detail. What participants expect today is the 4K/8K standard: sharp, structured, trustworthy down to the pixel.
- Pain points in the industry: non-standard codes, structured data missing entirely, data that can't be attributed to an encounter, no consistency even for the same EHR.
- **On "changing data":** enhancing a record understandably raises a question — are you changing what we sent? We're not rewriting anyone's data. Our methods will keep improving as we learn, and we always preserve and make available both the original and the enhanced version, side by side.

Higher resolution doesn't mean a different picture. It means finally being able to see the one that was always there.

High Resolution Data – *A Disciplined Approach*

- **Step 1 — Analyze**: score every document on structure, coding, and plausibility, then publish our findings.
- **Step 2 — Show Improvement**: Enhanced Data Services is live — over 1 million clinical documents evaluated, roughly 83% successfully enhanced. Already running in NCQA DAV and Longitudinal Patient Summaries.
- **Step 3 — Apply AI**: today's rules catch what we can define. Our next step (not yet fully built) is applying AI to catch what rules can’t, generally focused on clinical plausibility.

Rules today. AI next. Transparency throughout.

High Resolution Data – *What Low Resolution Data Looks Like*

- **Content Plausibility**: a 63-year-old female seen for hand pain had a lab result with a specimen source of amniotic fluid, but she wasn't pregnant.
  - ***Why it matters****: implausible values like this can silently mislead a clinician reading the chart or get treated as valid by downstream systems that don't know to question it.*
- **Systemic missing structured data**: one ambulatory EHR vendor had zero medications carrying a structured dose or route across an entire 10-CCD sample.
  - ***Why it matters:*** *without dose or route, drug-interaction checks and care coordination tools have nothing to work with.*
- **Duplicate entries**: one vendor returned every lab component in a panel duplicated 4 times, identically.
  - ***Why it matters:*** *duplicated results clutter chart review and can make a clinician think a test was repeated or a value confirmed, when it's really the same single result counted several times.*

Thank You!

Questions?

LUNCH: 12:00 p.m. – 1:15 p.m.

Thank you to our sponsors!

InterSystems
Creative data technology

ClinNEXUS

Google Cloud

Cures

J2 INTERACTIVE

NinePatch

HICKMAN STRATEGIES Technology enables, *relationships transform.*™

Microsoft

BEYOND LUCID

Partnership Spotlights: Data Sharing in Action

Amie Miller, PsyD
Executive Director
California Mental Health Services Authority

Daniel Welch
Director, IT Business Integration
Santa Clara Family Health Plan

Kristen Azar, PhD
Vice President,
Quality & Performance Excellence
Institute on Aging

Manifest MEDEX

Partnership Spotlights: Data Sharing in Action

Amie Miller, PsyD
Executive Director,
California Mental Health Services Authority

Data Exchange & Behavioral Health

PRESENTED BY:

Dr. Amie Miller, Executive Director, CalMHSA

CalMHSA
California Mental Health Services Authority

Challenges with Behavioral Health Data Sharing

- County Behavioral Health Plans are the public agencies that manage and pay for specialty mental health and substance use treatment for Medicaid members in their county, contracting with a local network of clinics and providers.
- Substance use treatment records carry a second set of rules under 42 CFR Part 2. Patient consent is required before the data can be shared, the consent has to name who receives it and for what purpose, and it follows the record downstream, so every exchange partner has to honor it.
- Without a valid consent on file, staff in one part of a plan cannot share a client's information with staff in another, even when everyone is treating the same person.

Solution: ASCMI Consent

ASCMI stands for Authorization to Share Confidential Member Information.

It's a statewide DHCS initiative to promote and standardize the exchange of clients' sensitive information - including certain physical health, behavioral health, and social services information (HSSI) - among Care Partners such as providers, health plans, county agencies, and social services organizations.

CalMHSA in Practice

- We have integrated the ASCMI form in the EHR.
- The EHR Communicates directly with the Connex.
- The embedded consent functionality drives what people can see each time they log in.

One client. One chart. Two very different views.

What a Mental Health program user sees in this client's record

ASCMI NOT ON FILE

Authorization to Share Confidential Member Information

No ASCMI on file — lights OFF

CDAG restrictions apply. Records from programs outside your group aren't locked — they're invisible.

CalMHSA has partnered with DHCS to support early adopter counties implementing the ASCMI form

Key Findings: Clients are accepting of the ASCMI, and providers are excited about improved care coordination.

CLIENT ACCEPTANCE

Most (82%) describe clients as generally receptive

Some (36%) report no outright refusals

Some (36%) note clients don't ask many questions — yet all are actively explaining the form

PROVIDER ACCEPTANCE

Most (82%) say form is easy for clients to read

Most (64%) feel the form has enough information

Some (36%) say it fits their workflow

Some (27%) value multi-agency design reducing paperwork

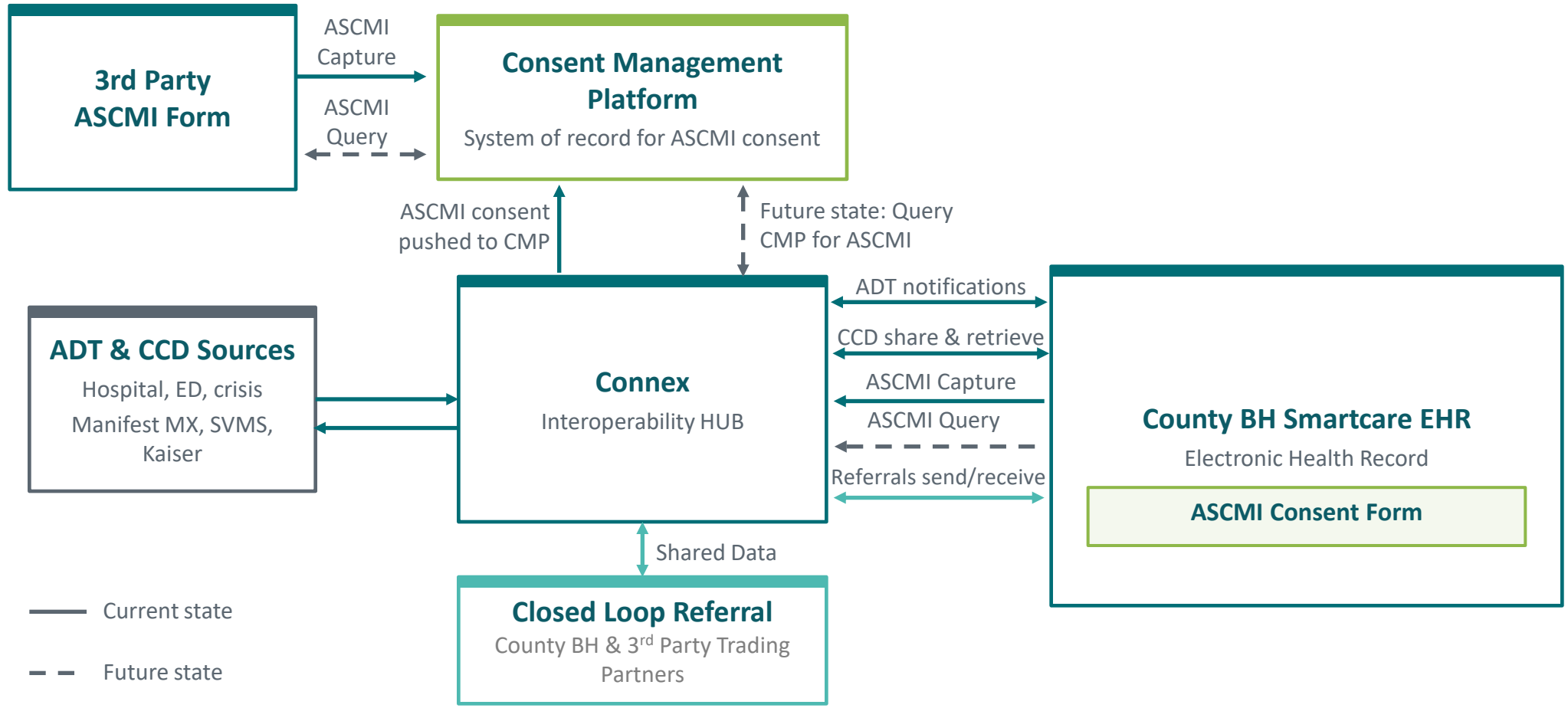
Some (27%) appreciate the form's consent descriptions

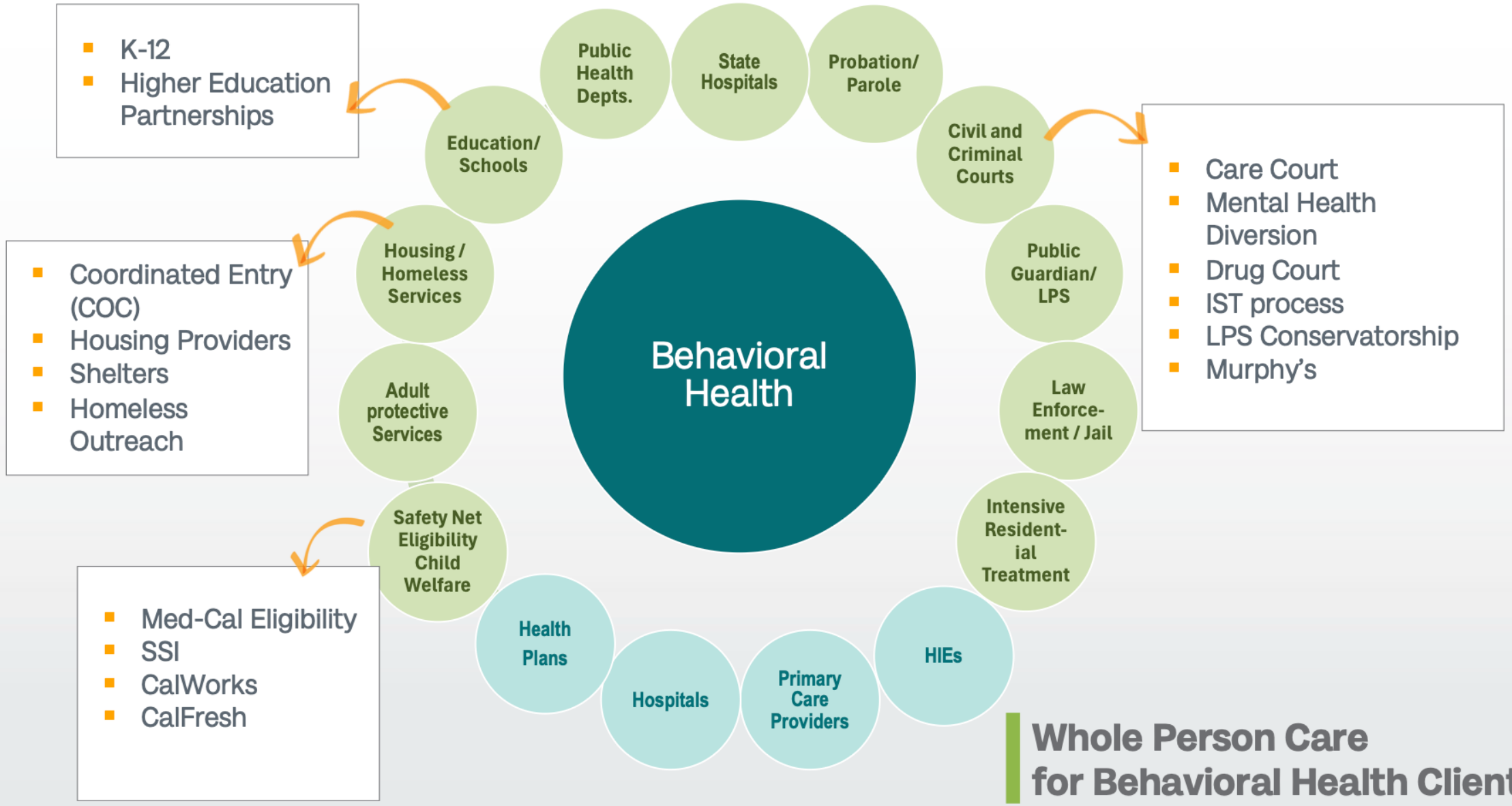
Some (27%) praise accelerated care coordination from expanded data sharing

Real-Time Data Exchange & Behavioral Health

- Real-time information exchange can support more coordinated care.
- Timely access to relevant information can enable faster intervention.
- Behavioral health brings unique considerations around privacy, consent, and information sharing.
- The challenge is enabling appropriate access while maintaining appropriate protections.

Our Ecosystem





Whole Person Care for Behavioral Health Clients

From Technology to Impact

The goal isn't data exchange for its own sake

- The value comes from what happens when information reaches the right person at the right time.
- Effective exchange has the potential to support better coordination and more timely care.
- Responsible information sharing requires attention to consent, privacy, workflow, and implementation.
- The opportunity is to make information exchange both useful and trustworthy.

Thank you!

CalMHSA
California Mental Health Services Authority

Questions?

CalMHSA
California Mental Health Services Authority

Operationalizing Health Information Organization Data

Daniel Welch
Director, IT Business Integration
Santa Clara Family Health Plan

Manifest MEDEX

Santa Clara Family Health Plan™

Operationalizing Health Information Organization Data

Daniel Welch | Director, IT Business Integration
Manifest MedEx Evolution CA 2026 | Bay Area

What SCFHP needed from an HIO

A reusable data foundation for operational needs beyond compliance

Timely

More real-time clinical events, especially ADTs, so operational teams can act while the information is still useful.

Comprehensive

A longitudinal view across claims, pharmacy, and clinical data to reduce gaps from fragmented systems.

Flexible

Data feeds to support operational workflows and portal access for targeted investigation.

THE DESIGN PRINCIPLE

Limit the number of data connections while supporting many operational use cases

Workflow-based implementation

IT enabled each business workflow with the right MX data service

01

Understand

Define the business outcome the team wants to improve.

02

Assess

Assess the current workflow and identify information gaps.

03

Match

Choose the MX service and delivery method that fit the workflow.

04

Operationalize

Embed ADT outreach, PCP notifications, and DualConnect chart retrieval in daily workflows.

CROSS-FUNCTIONAL PARTNERS

IT, Care Management, Utilization Management, Quality Improvement, Risk Adjustment, Compliance and Operations

Santa Clara Family Health Plan

Three workflows in operation

Each uses the same HIO foundation in a different operational process

FUA/FUM quality outreach

NEED

Identify eligible emergency department events quickly.

APPROACH

Add MX ADTs into Quality Health Partners outreach list.

RESULT

The event signal can start outreach before the claim arrives.

PCP and network notifications

NEED

Keep assigned PCPs and network partners aware of hospital events.

APPROACH

Use MX ADTs to drive outbound notifications.

RESULT

Partners receive timely information for follow-up and care transitions.

DSNP (DualConnect) chart retrieval

NEED

Obtain clinical documentation for risk-adjustment review.

APPROACH

Use MX chart capture in the DualConnect chart chase.

RESULT

A repeatable retrieval process that can reduce provider outreach.

What is working today

Core data exchange supports three operational workflows

Data contribution	Membership, medical claims, and pharmacy claims feeds. Clinical data exchange from a subset of network providers.
ADT in production	Stanford is live, with additional local connections in the implementation process.
Operational use	FUA/FUM outreach, PCP notifications, and DualConnect chart retrieval.
Next layer	Expand network participation and implement validated data for HEDIS and other operational processes.

MEMBER COVERAGE

45.5%

of members served by a participating MX provider

3 workflows

implemented

What made the partnership valuable

Four practices helped SCFHP teams put HIO data to work

01	**Design around outcomes**	Start with the business goal and assess the current workflow.
02	**Use the right delivery model**	Feeds for recurring work and portal access for targeted review.
03	**Build reusable data services**	Reuse the same data foundation across operational needs.
04	**Keep growing the network**	Prioritize participants that close important local data gaps.

Santa Clara Family Health Plan™

Thank you

Connect the data to the workflow. Keep expanding the network.

Santa Clara Family Health Plan™

Questions?

Connect the data to the workflow. Keep expanding the network.

Partnership Spotlights: Data Sharing in Action

Kristen Azar, PhD
Vice President, Quality & Performance Excellence
Institute on Aging

EVOLUTION CA 2026 · SAN JOSE

Data, community-based care, and the quest to answer a simple question: “Did it work?”

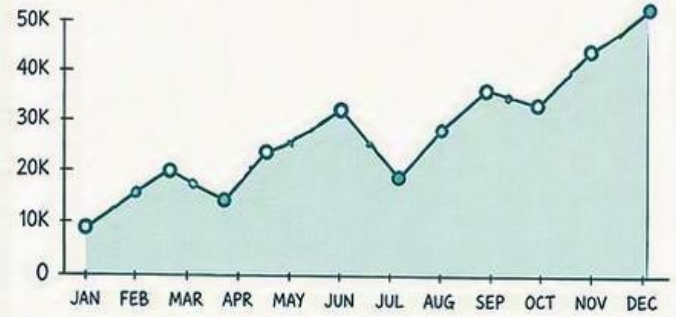
Kristen M.J. Azar, RN, PhD, MSN/MPH
VP Quality and Performance Excellence
Institute on Aging

Institute
on Aging

OVERVIEW

REVENUE	SALES	NEW USERS	PROFIT
$ 1,287,000	24,631	7,326	$ 247,000
↑ 12.4%	↑ 8.6%	↑ 9.3%	↑ 11.7%

SALES OVER TIME



TOTAL USERS

USERS BY REGION

NORTH AMERICA	37%
EUROPE	27%
ASIA	21%
SOUTH AMERICA	8%
AFRICA	5%
OTHER	2%

TOP PRODUCTS

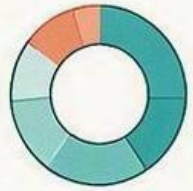
Product A	23.4%
Product B	17.8%
Product C	14.2%
Product D	12.6%
Product E	8.7%
Product F	6.3%
Product G	3.0%

REVENUE OVER TIME

CONVERSION RATE

THIS MONTH	3.25%
LAST MONTH	2.65%
CHANGE	0.60%

TRAFFIC SOURCES



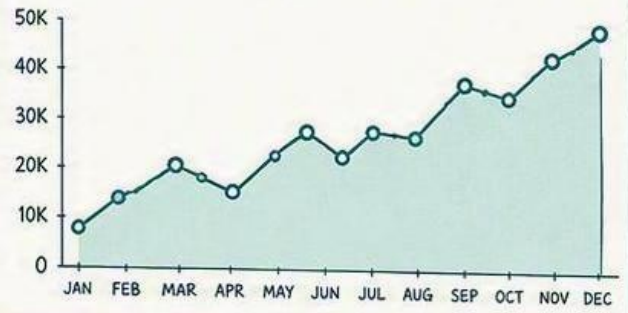
Organic Search	45%
Direct	25%
Referral	15%
Social Media	10%
Email	5%

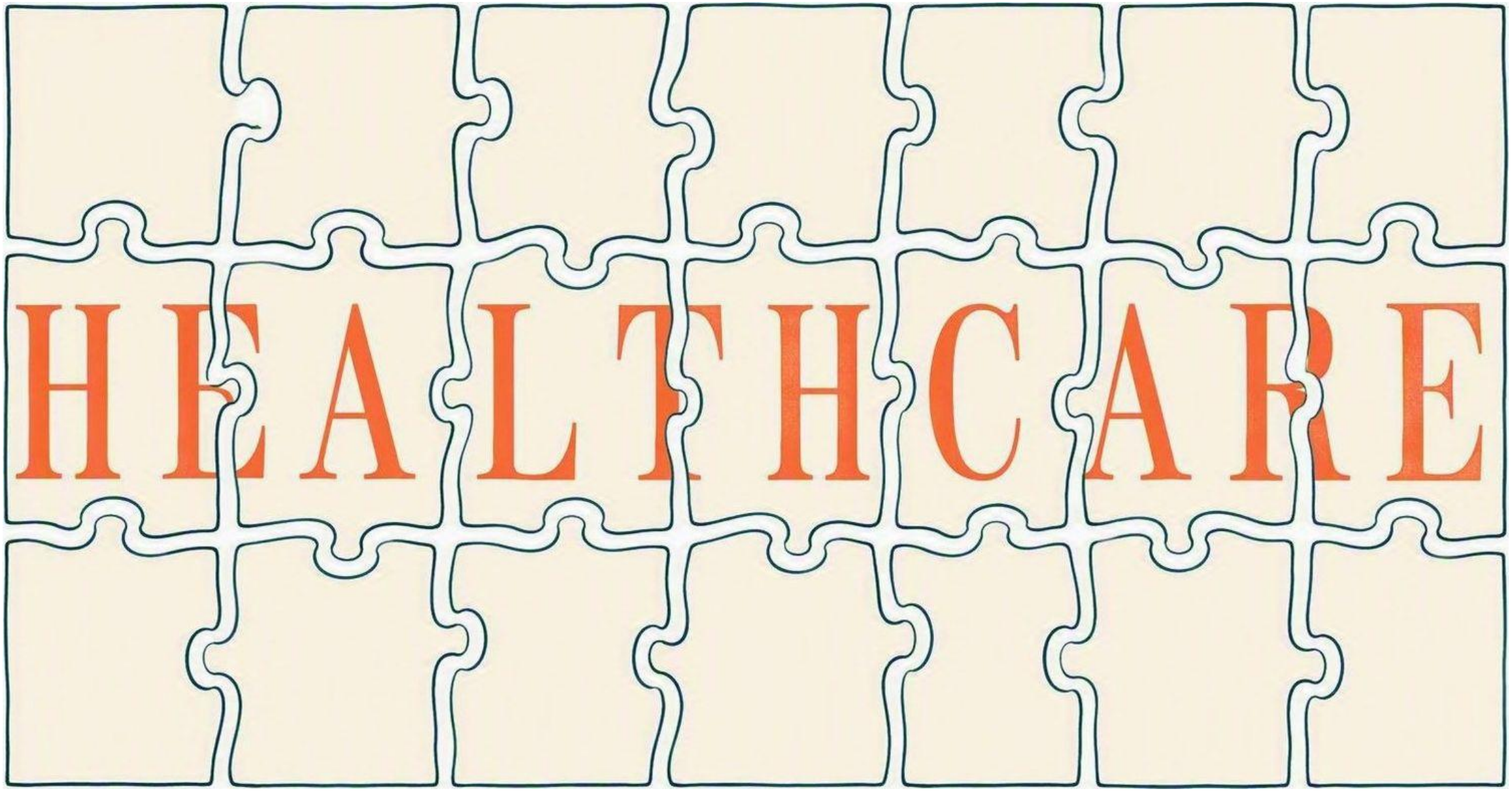
SESSIONS BY DEVICE

REAL-TIME ACTIVITY

New order #1234	2m ago
New user signed up	5m ago
Email opened	7m ago
Ad click (Google)	9m ago
New order #1235	12m ago
New user signed up	15m ago

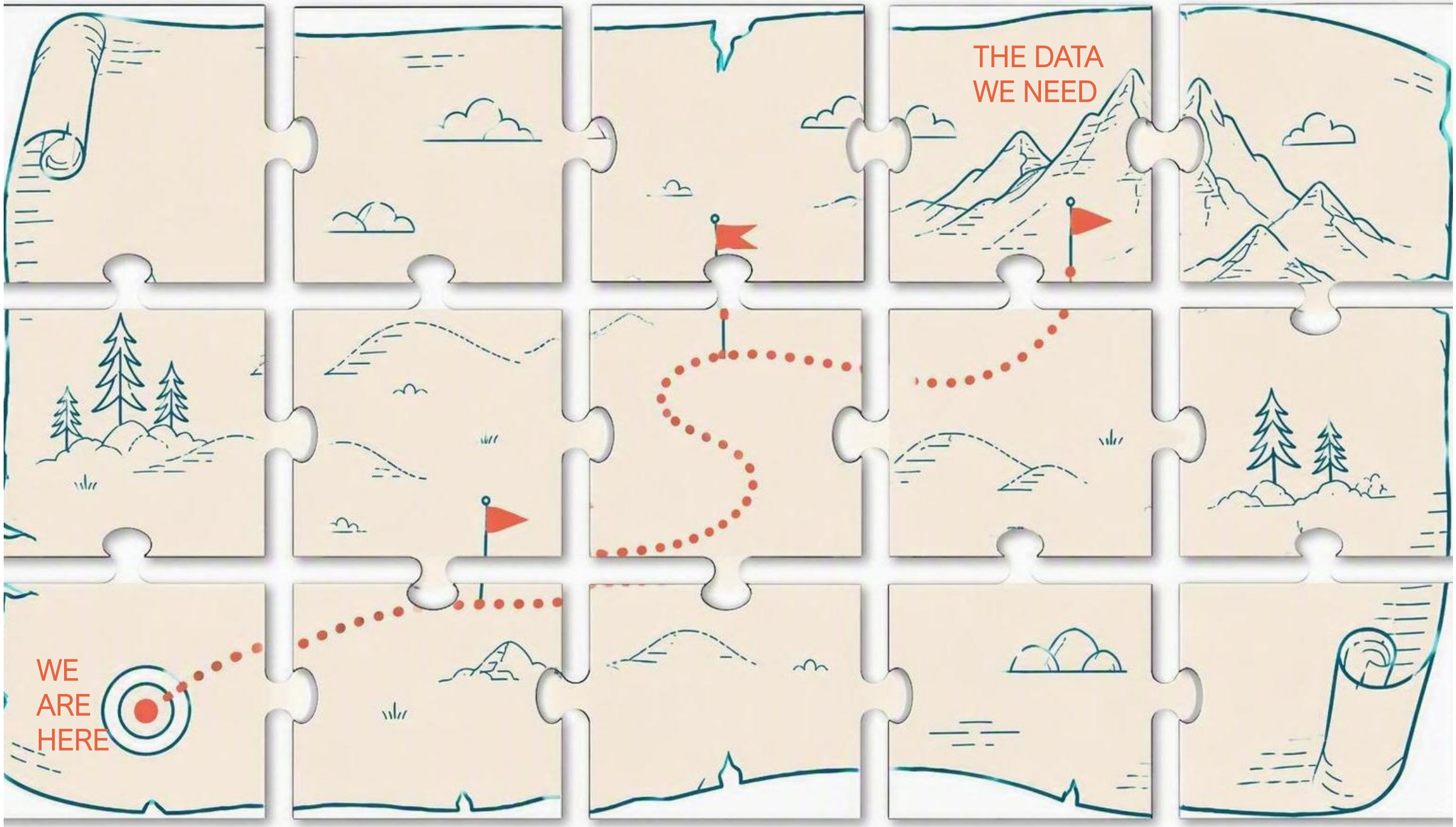
ACTIVE USERS OVER TIME



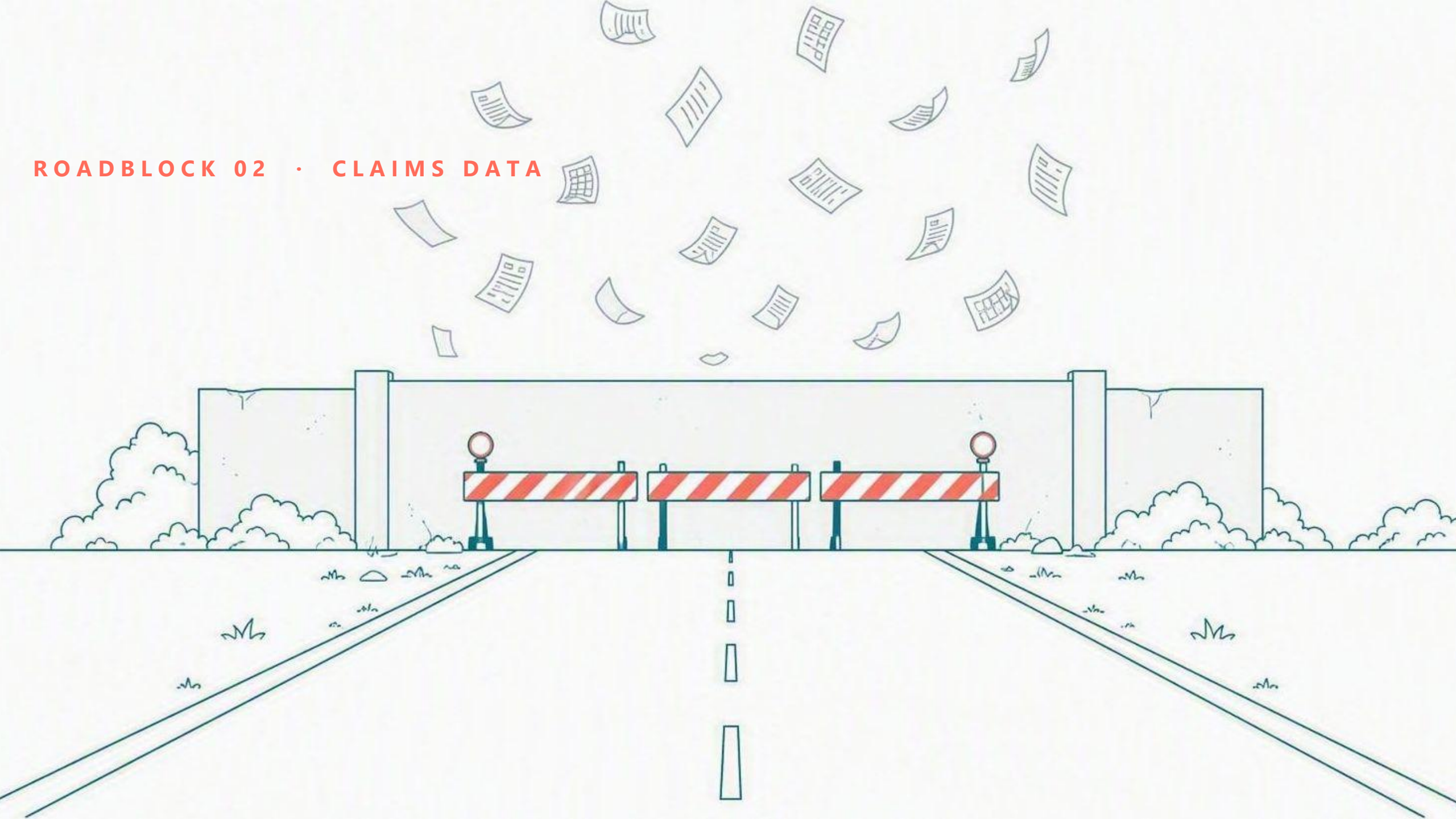

HEALTHCARE

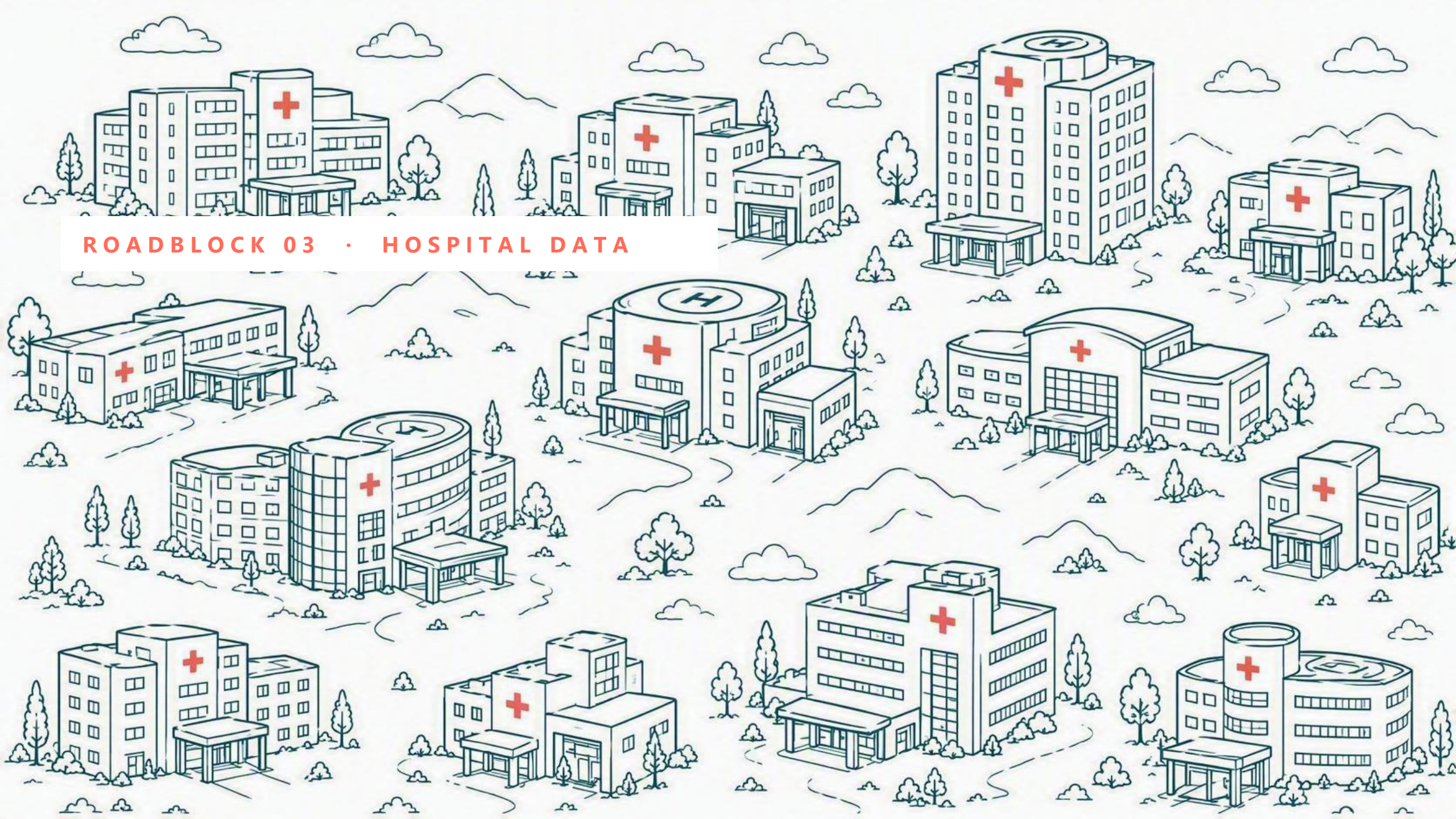
IOA

Did they go back to the hospital?


THE DATA
WE NEED
WE
ARE
HERE

ROADBLOCK 02 · CLAIMS DATA



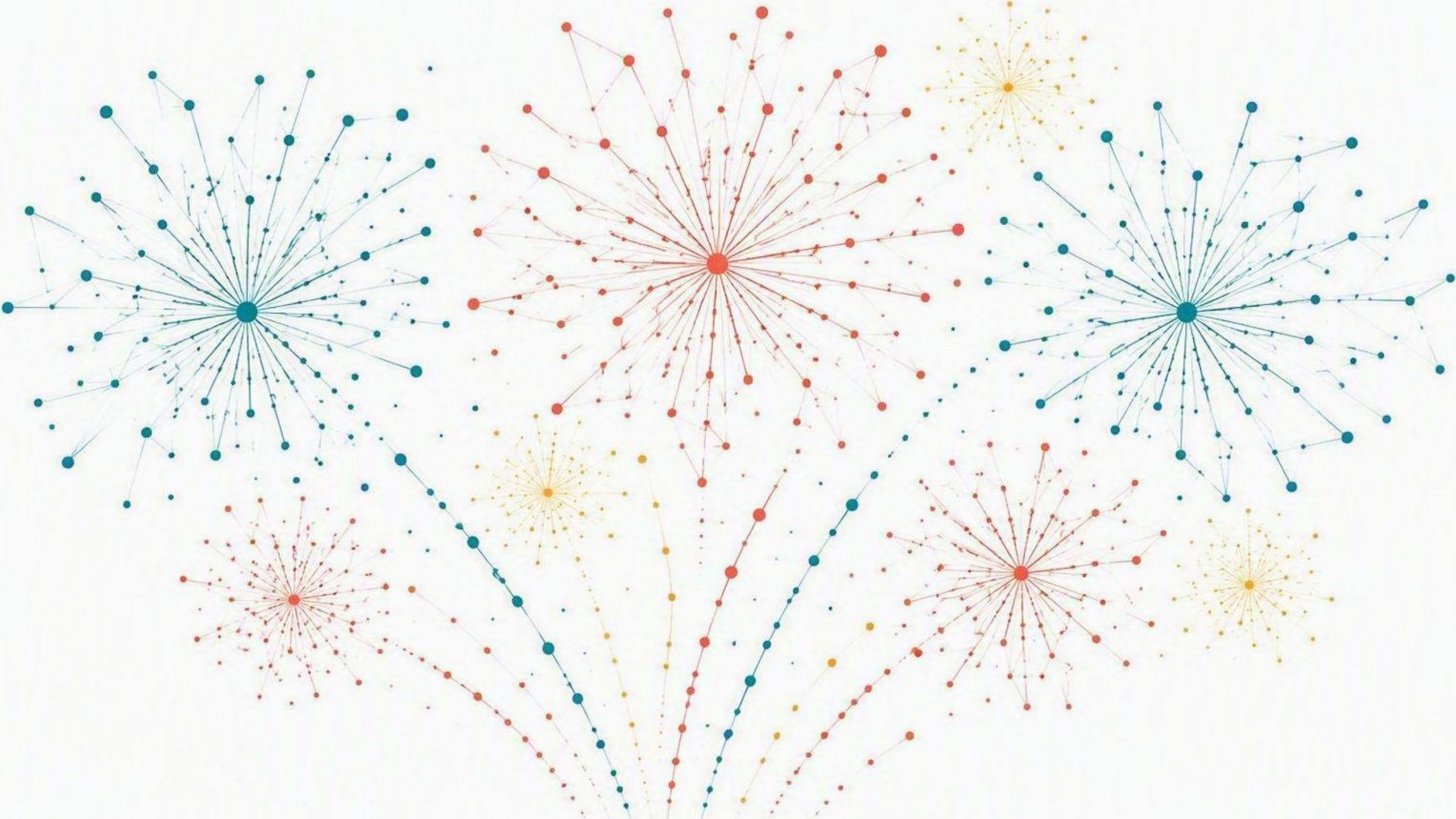


ROADBLOCK 03 · HOSPITAL DATA

Manifest
MEDEX

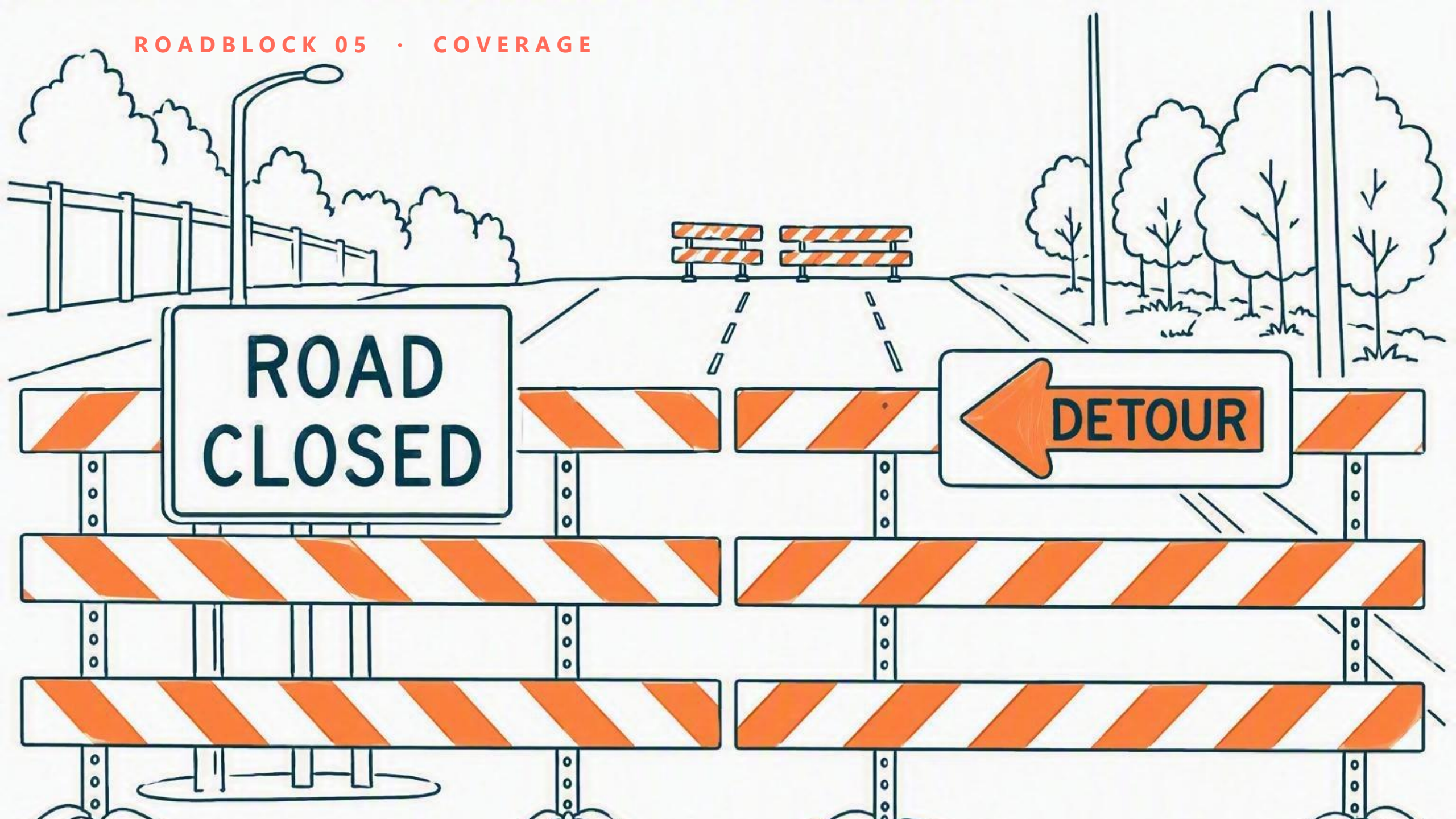
TIPPING
POINT
COMMUNITY

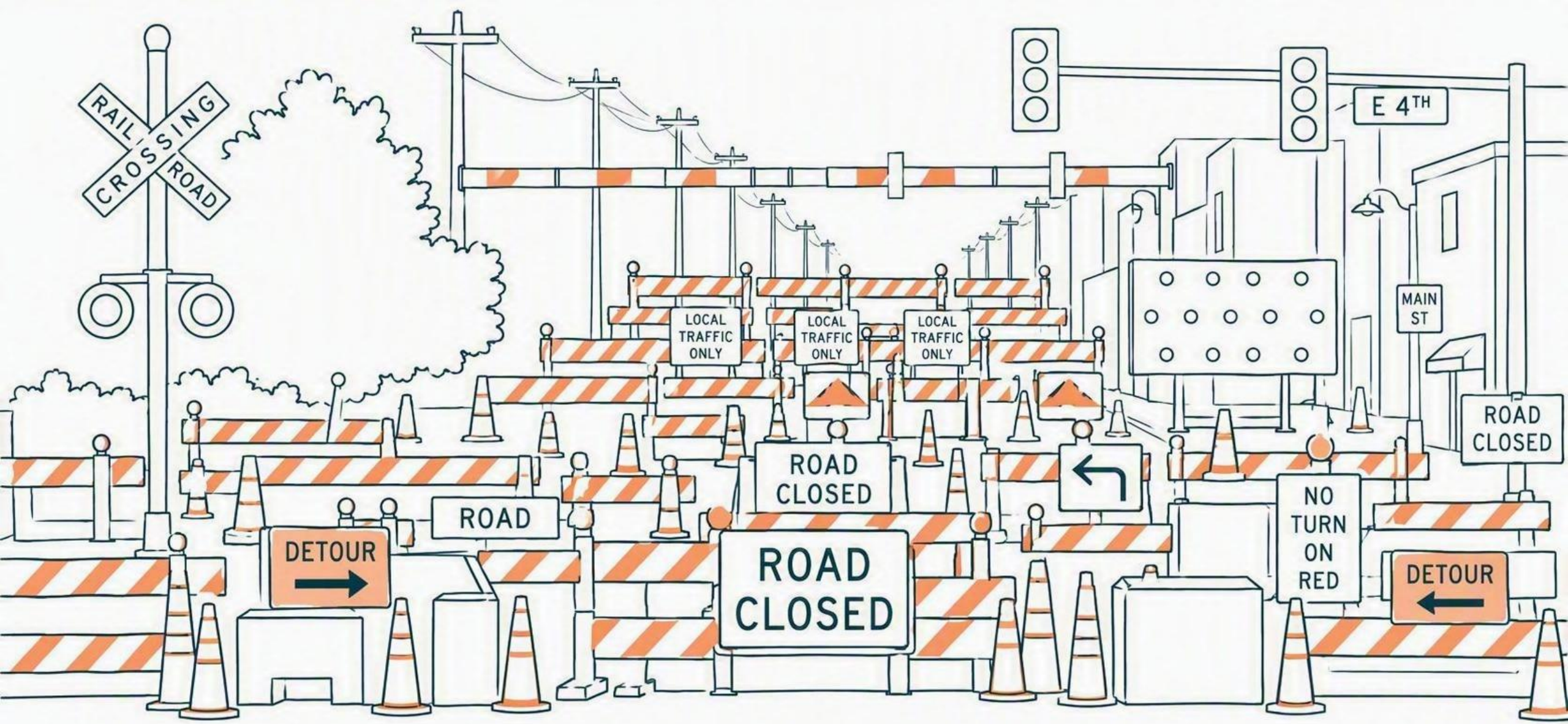
IOA



ROADBLOCK 04 · FIRST FEED

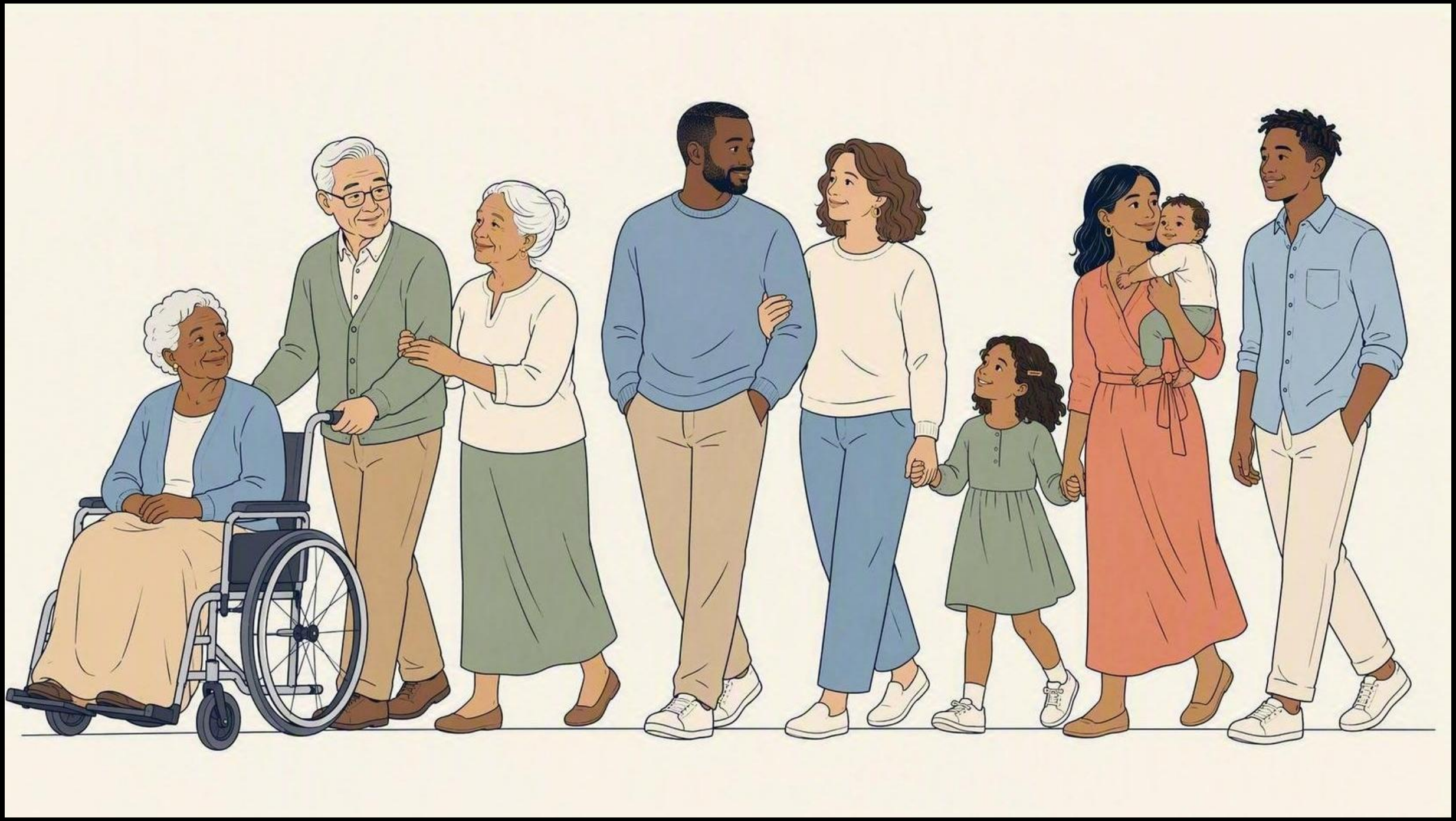
ROADBLOCK 05 · COVERAGE



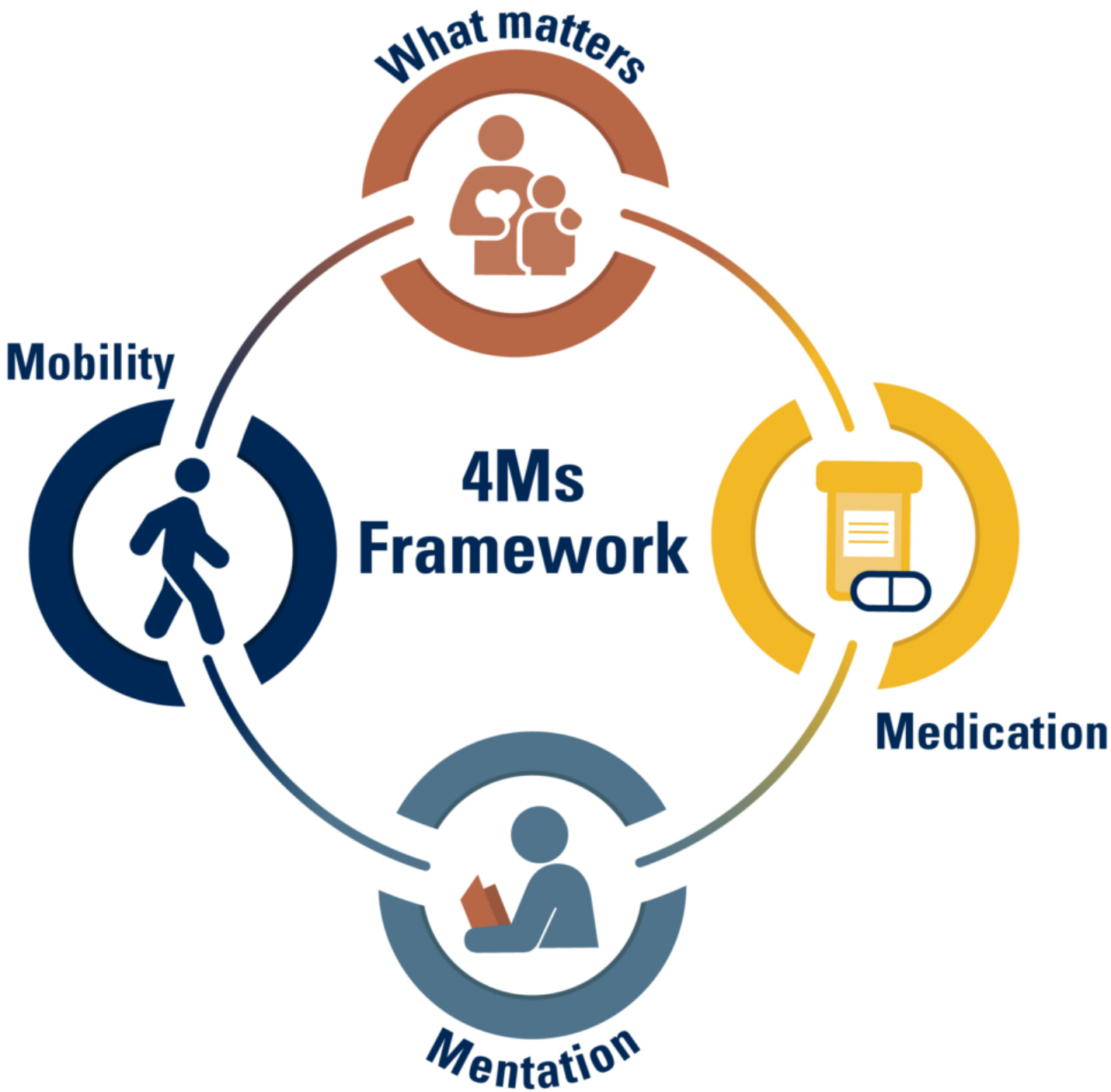


ROADBLOCK 06 · SECOND PARTNER

DATA EXCHANGE FRAMEWORK

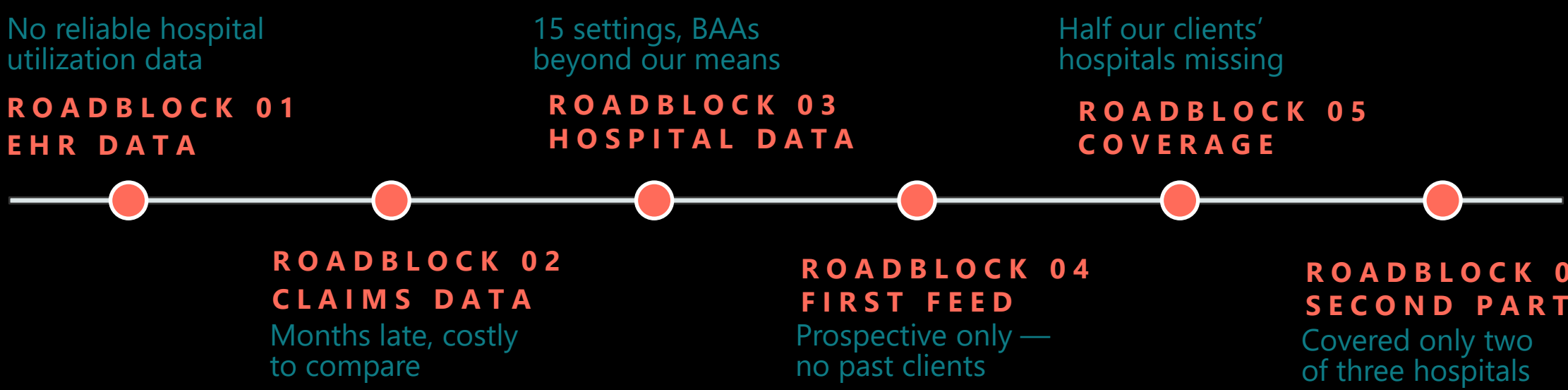


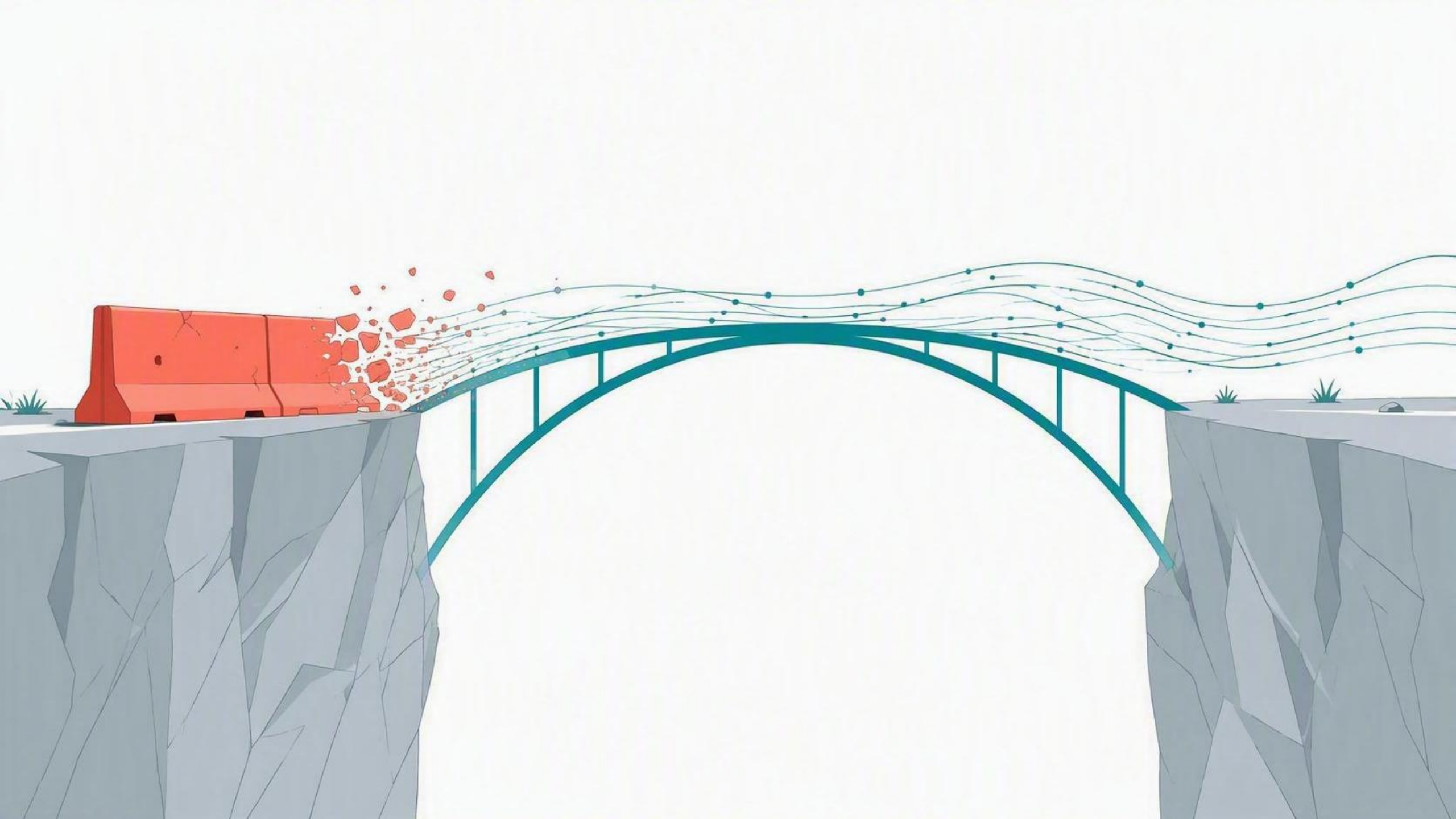
Education Access and Quality
Health Care Access and Quality
Economic Stability
Neighborhood and Built Environment
Social and Community Context


What matters
Mobility
4Ms
Framework
Medication
Mentation

THE FULL JOURNEY

Almost a year of roadblocks.





Thank you!

Kristen M.J. Azar, RN, PhD, MSN/MPH
VP Quality and Performance Excellence
Institute on Aging

Questions?

Kristen M.J. Azar, RN, PhD, MSN/MPH
VP Quality and Performance Excellence
Institute on Aging

WHOLE PERSON CARE

HEALTH DATA & THE YEARS AHEAD

Assemblymember Mia Bonta

Chair, Assembly Health Committee

District 18 – Oakland, Alameda, & Emeryville

"The right information, in the right place, at the right time."

If someone from Los Angeles shows up in an emergency room in Truckee, Tahoe Forest Hospital should be able to find out she is allergic to penicillin. **Not after a fax. Right then.**

SB 660 IS NOW LAW

JAN 1, 2026

HCAI takes over the Data Exchange Framework

JULY 1, 2026

Data sharing required to contract with DHCS, CalPERS, and Covered California. EMS and medical foundations join.

JAN 1, 2027

HCAI publicly lists required signers that have not complied

JULY 1, 2027

Report to the Legislature on participation, gaps, and enforcement

Your paragraph text

4,400+ ORGANIZATIONS PARTICIPATING TODAY

TRUST IN INFRASTRUCTURE

SB 660 keeps this information out of required data exchange:

- Abortion and abortion-related care
- Gender-affirming care
- Immigration or citizenship status
- Place of birth

H.R. 1: THREE WAYS FAMILIES LOSE COVERAGE

	Mechanism	Who's at Risk
1	Disproven Work Requirements	Estimated 1.9M Californians
2	Six-Month Re-Verification Burden	Estimated 270,000 Californians
3	Immigration Status Restrictions	Estimated 200,000 Californians

Source: UC Berkeley Labor Center

THE STATE SHOULDN'T ASK PEOPLE FOR WHAT IT ALREADY KNOWS.

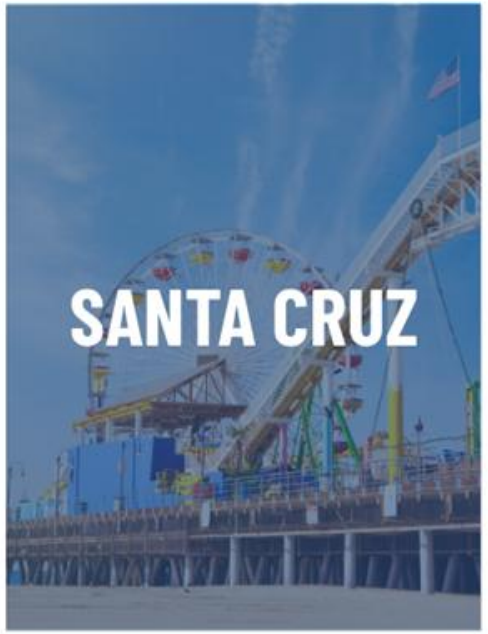
AB 2161

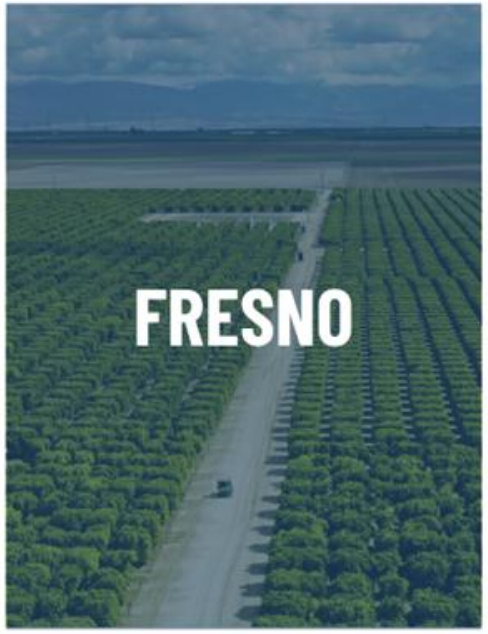
Coverage stays in place while compliance is verified. Counties check every other path to eligibility before anyone is cut off.

2 in 3

who lost Medi-Cal during the COVID-era unwinding lost it for procedural reasons

Whole Person Care is Already Working





COMMUNITY SUPPORTS

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-Term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Day Habilitation Programs
- Nursing Facility Transition/ Diversion to Assisted Living Facilities
- Community Transition Services/ Nursing Facility Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Medically-Supportive Food/ Medically Tailored Meals
- Sobering Centers
- Asthma Remediation

TECHNOLOGY SHOULD NOT REPLACE HUMAN DECISION-MAKING IN HEALTH CARE

A NEW GOVERNOR, A NEW ERA

HOW WE'LL KNOW IT'S WORKING

Are care teams getting information when they need it?

Are we cutting duplication and paperwork?

Are we coordinating care better?

Are Californians staying covered?

WE DESERVE NO LESS

Thank you!

Mia Bonta
Assemblymember, District 18

MX Mosaic Award Recipient

Joe Prado
Director,
Fresno County Department of Public Health

Closing Reflections

Erica Galvez
Chief Executive Officer,
Manifest MedEx

Thank you for attending!

Please complete our post-event survey:

Join us for our Networking Reception!

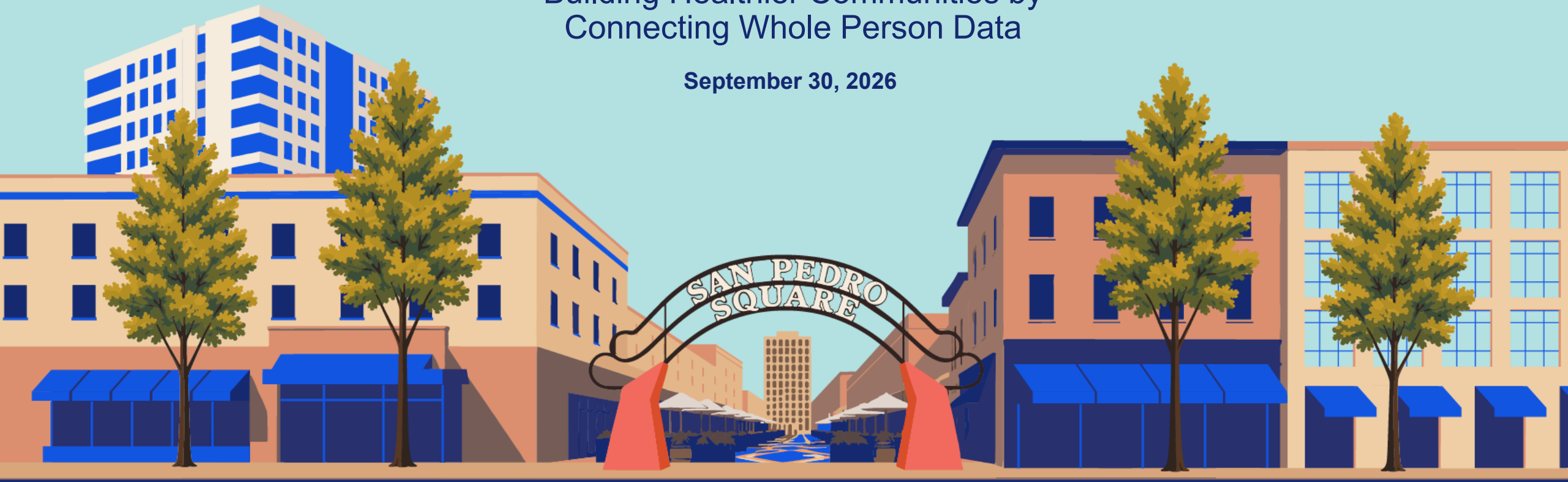
3:00 p.m. – 4:00 p.m.

Farmers Union Restaurant

(right across the street!)

Manifest MEDEX

Evolution CA 2026: Bay Area

Building Healthier Communities by Connecting Whole Person Data

September 30, 2026