The County of Santa Cruz
Integrated Community Health Center Commission
MEETING AGENDA

January 7, 2026 @ 1:00pm - 2:00pm

MEETING LOCATION: In-Person – 150 Westridge, Suite 101, Watsonville, Ca 95076 and 1080 Emeline Ave., Bldg. D, Admin Conference Room, Santa Cruz, CA 95060, 40 Eileen Street, Watsonville CA 95076, will connect through Microsoft Teams Meeting or call in (audio only) +1 831-454-2222,191727602# United States, Salinas Phone Conference ID: **191 727 602#**

ORAL COMMUNICATIONS - Any person may address the Commission during its Oral Communications period. Presentations must not exceed three (3) minutes in length, and individuals may speak only once during Oral Communications. All Oral Communications must be directed to an item not listed on today's Agenda and must be within the jurisdiction of the Commission. Commission members will not take actions or respond immediately to any Oral Communications presented but may choose to follow up at a later time, either individually, or on a subsequent Commission Agenda.

1. Welcome/Introductions
2. Oral Communications
3. December 10, 2025, Meeting Minutes – Action Required
4. 2026 Health Center Goals - Action Item
5. Policy 420.06 - 340B Policy and Procedure – Action Item
6. Quality Management Update
7. MyChart Security Levels
8. CA Initiative #25-0008
9. Financial Update
10. CEO Update

Action Items from Previous Meetings: Action Item	Person(s) Responsible	Date Completed	Comments

Next meeting: Wednesday, February 4, 2026, 1:00pm - 2:00pm **Meeting Location: In-Person** - 150 Westridge, Suite 101, Watsonville, Ca 95076 and 1080 Emeline Ave., Bldg. D, Admin Conference Room, Santa Cruz, CA 95060. Commission will connect through Microsoft Teams Meeting or call in (audio only) +1 831-454- 2222,191727602# United States, Salinas Phone Conference ID: **191 727 602#**

The County of Santa Cruz Integrated Community Health Center Commission

Minute Taker: Mary Olivares

Minutes of the meeting held January 7, 2026

TELECOMMUNICATION MEETING: Microsoft Teams Meeting - or call-in number +1 916-318-9542 – PIN# 500021499#

Attendance	
Christina Berberich	Executive Board – Chair
Len Finocchio	Executive Board – Co-Chair
Rahn Garcia	Member
Dinah Phillips	Member
Marco Martinez-Galarce	Member
Michelle Morton	Member
Nicole Pfeil	Member
Amy Peeler	County of Santa Cruz, Chief of Clinics
Raquel Ruiz	County of Santa Cruz, Senior Health Services Manager
Julian Wren	County of Santa Cruz, Admin Services Manager
Mary Olivares	County of Santa Cruz, Admin Aide
Meeting Commenced at 1:00 pm and concluded at 1:45 pm	

Excused/Absent:

Absent: Maximus Grisso

1. Welcome/Introductions

2. Oral Communications:

Christina asked commissioners whether they were aware of any changes to the Brown Act regarding remote meetings. It was noted that County Counsel would likely notify commissions if any changes occur.

3. December 10, 2025, Meeting Minutes – Action Required

Review of December 10, 2025 Meeting Minutes: The minutes were reviewed and recommended for approval. Len motioned to accept the minutes as presented. Marco seconded the motion, and all members present voted in favor.

4. 2026 Health Center Goals - Action Item

2026 Clinical Quality Goals: Raquel presented the 2026 Clinical Quality Goals that will be addressed in the coming year. The primary goals include:

- **Cervical Cancer Screening:** Increase screening rates at Santa Cruz County HSA Health Centers from 58.46% (Q2 2025) to 65% by December 31, 2026 (Alliance 2026 Goal: 64.21%).
- **Breast Cancer Screening:** Increase screening rates from 57.31% (Q2 2025) to 67% by December 31, 2026 (Alliance 2026 Goal: 66.31%).
- **Colorectal Cancer Screening:** Increase screening rates at Santa Cruz County HSA Health Centers from 52.46% (Q2 2025) to 60% by December 31, 2026 (Alliance 2026 Goal: 53.31%).

Raquel also reported the secondary clinical quality goals for 2026, which include Initial Health Appointments, Controlling High Blood Pressure, Well-Child Visits in the First 15 Months of Life, Depression Screening for Adolescents and Adults (≥75th percentile), and Lead Screening (between the 75th and 89th percentiles). Dedicated staff have been assigned to work on these initiatives.

Rahn motioned to accept the 2026 Health Center Goals as presented. Dinah seconded the motion, and all other members present voted in favor.

5. Policy 420.06 - 340B Policy and Procedure – Action Item

Policy 420.06 – 340B Policy and Procedure: Julian presented Policy 420.06 – 340B Policy and Procedure and reviewed the policy with the commissioners for any recommended edits. Lehn motioned to accept the policy with the recommended edits. Nicole seconded the motion, and all other members present voted in favor.

6. Quality Management Update

Raquel provided a quality management update. She reported that the Watsonville clinic is discussing a pilot for DEXA scans (bone density scans). Due to low X-ray volume, this pilot is expected to increase overall imaging volume at the clinic. Raquel also provided an update on the Outreach Campaign – Population Health, noting that this team will support quality measures by assisting with patient outreach and scheduling. Lastly, Raquel presented the Central California Alliance for Health Quarter 3 data, reviewing percentile group rankings and practice points. She reported that the Health Centers are close to meeting all measured benchmarks.

7. MyChart Security Levels

Raquel reported on an action item from a previous meeting. She stated that the Electronic Health Record Manager provided the privacy and security guidelines for MyChart. Raquel reviewed the FAQs, noting that patient information is kept private and that MyChart is more secure than email, with multi-factor authentication in place.

8. CA Initiative #25-0008

Julian brought this item for informational purposes only. Julian reported This proposed California ballot initiative, sponsored by SEIU-UHW, would require nonprofit Federally Qualified Health Centers (FQHCs) to spend at least 90% of annual revenue on mission-related program services. The initiative is framed as a transparency and accountability measure but presents material fiscal, operational, and compliance risk for safety-net providers. **What This Means for Our Health Centers**
Under our current cost structure, compliance with this initiative depends entirely on how the state defines administrative spending:

- If administrative spending is limited to what we traditionally classify as executive and leadership functions, our administrative spend is approximately **4% of total revenue**, and we would remain compliant.
- If administrative spending is defined to include all non-patient-care administrative and enabling functions, our administrative spend is approximately **14.7% of total revenue**, which would place our Health Centers in violation of this requirement.

This distinction is significant. Many non-patient-facing functions are required to operate safely, comply with federal and state rules, maintain access, and meet HRSA Section 330 requirements. The absence of statutory clarity creates a direct fiscal and operational risk.

9. Financial Update

Julian presented fiscal data as of October 31, 2025. He reported that net charges and net payments continue to increase; however, multiple payment delays during the current fiscal year have resulted in a lag. Julian reviewed the Fiscal Year July–December comparison of billable completed appointments and noted sustained increases in completed billable visits. He also presented the Payor Mix (July–December) charges. Lastly, Julian emphasized the importance of continuing to track Payor Mix charges and payments to assess the potential impacts of the HR.1 "Big Beautiful Bill." To date, no significant changes have been observed, with the exception of Commercial payors.

10. CEO Update

Amy reported that several HUD grants were pulled back and noted that staff are monitoring the situation closely.

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☐ Minutes approved _____ ___/___/___
(Signature of Board Chair or Co-Chair) (Date)

SUBJECT: 340B	POLICY NO.: **420.06** PAGE: 1 OF 1	COUNTY OF SANTA CRUZ HEALTH SERVICES AGENCY
SERIES: 400 Ancillary Services	EFFECTIVE DATE: July 2001	**Clinics and Ancillary Services**
APPROVED BY: Amy Peeler, Chief of Clinic Services	REVISED: January 2018	

I. PURPOSE

This document contains descriptions of the policies and procedures used at Santa Cruz HSA [Entity] to maintain compliance with the 340B Program. The purpose of this tool is to provide a 340B Policy and Procedure Manual (P&P Manual) that exhibits high program integrity, to assist participating Santa Cruz County Clinic leaders a unique, site-specific, P&P Manual that supports placing compliant guidance/policy into practice.

II. DEFINITIONS

Definitions of terms may be found in [Appendix: 340B Glossary of Terms].

III. REFERENCES

Include other references to P&Ps, 340B Glossary of Terms, OPA website, etc.

IV. POLICY REVIEW, UPDATES, AND APPROVAL

This policy will be reviewed, updated, and approved on annual basis.

V. BACKGROUND

Section 340B of the Public Health Services Act (1992) requires drug manufacturers participating in the Medicaid Drug Rebate Program to sign an agreement with the Secretary of Health and Human Services. This agreement limits the price manufacturers may charge certain covered entities for covered outpatient drugs. The resulting program is called the 340B Program. The program is administered by the Office of Pharmacy Affairs (OPA), a part of the federal Health Resources and Services Administration/Department of Health and Human Services.

Upon registration on the OPA database as a participant in the 340B Program, entities agree to abide by specific statutory requirements and prohibitions.

VI. 340B POLICY STATEMENTS

As a participant in the 340B Drug Pricing Program, SSC's HSA policies are:

- SCC HSA uses any savings generated from 340B in accordance with 340B Program intent.

- SCC HSA meets all 340B Program eligibility requirements:
  - Entity's OPA Database covered entity listing is complete, accurate, and correct.
  - Entity receives a grant or designation consistent with that conferring 340B eligibility

- Entity complies with all requirements and restrictions of Section 340B of the Public Health Service Act and any accompanying regulations or guidelines including, but not limited to, the prohibition against duplicate discounts/rebates under Medicaid, and the prohibition against transferring drugs purchased under 340B to anyone other than a patient of the entity. [REFERENCE: Public Law 102-585, Section 602, 340B Guidelines, 340B Policy Releases]

- Entity maintains auditable records demonstrating compliance with the 340B requirement described in the preceding bullet.

    - Prescribers are employed by the Entity, or under contractual or other arrangements with the Entity. The individual patient receives health care service (within the scope of grant/designation for which 340B status was conferred) from this professional such that the responsibility for care remains with the entity.
    - Entity maintains records of the individual's health care.
    - Entity does not bill Medicaid for 340B medications and has reflected this information on the OPA website.
        - Entity informs OPA immediately of any changes to its information on the OPA website.

- Entity has systems/mechanisms and internal controls in place to reasonably ensure ongoing compliance with all 340B requirements.

- Entity has an internal audit plan adapted by the internal compliance officer and conducted annually.

- Entity uses contract pharmacy services, and the contract pharmacy arrangement is performed in accordance with OPA requirements and guidelines including, but not limited to:

    - The Entity obtains sufficient information from the contractor to ensure compliance with applicable policy and legal requirements, and has utilized an appropriate methodology to ensure compliance via its pharmacy consultant.
    - Signed Contract Pharmacy Services Agreement(s) complies with essential compliance elements (http://www.hrsa.gov/opa/programrequirements/federalregisternotices/contractpharmacyservices030510.pdf).

- Entity acknowledges its responsibility to contact OPA as soon as reasonably possible if there is any change in 340B eligibility or a material breach by the Entity of any of the foregoing policies.

- Entity acknowledges that if there is a breach of the 340B requirements, Entity may be liable to the manufacturer of the covered outpatient drug that is the subject of the violation; and depending upon the circumstances, may be subject to the payment of interest and/or removal from the list of eligible 340B entities.

- Entity elects to receive information about the 340B Program from trusted sources, including, but not limited to:
  - The Office of Pharmacy Affairs
  - The 340B Prime Vendor Program, managed by Apexus
  - Any OPA contractors

VII. RESPONSIBLE STAFF, COMPETENCY

The following Entity Staff are engaged with 340B program compliance. Pharmacy staff member(s) participating in the 340B Program will make efforts to complete initial basic training via webinar on the 340B and Prime Vendor Programs (https://docs.340bvp.com/apps/public/gps/gps.html) and possibly attend 340B University every 1-2 years. Comprehensive training is conducted on the 340B Program initially upon hire and competency is also verified annually by staff through verbal assessment and as part of the staff development plan.

A. Chief Executive Office (Connie Moreno-Peraza) — Formatted: Highlight
   - Responsible as the principal office in charge for the compliance and administration of the program
   - Responsible for attesting to the compliance of the program in form of recertification

B. Chief Financial Officer (Christine Williams) — Formatted: Highlight
   - Responsible for above in many cases
   - Must account for savings and use of funds to provide care the indigent under the indigent care agreement

C. Director of Internal Audit (Janet Aiso, Rph) — Formatted: Highlight
   - Designs and maintains an internal audit plan of the compliance of the 340B program
   - Designs the annual plan to cover all changes in the program from the past year
   - Responsible for communication of all changes to Medicaid reimbursement for pharmacy services/products that impact 340B status
   - Responsible for modeling all managed care contracts (with/without 340B)
   - Engage pharmacy in those conversations that impact reimbursement

D. Enrollment, Recertification, Change Requests (Kristina Riera)

VIII. 340B ENROLLMENT, RECERTIFICATION, CHANGE REQUESTS

Recertification Procedure

OPA requires entities to recertify their information as listed in the OPA database annually. Connie Moreno-Peraza annually recertifies Entity's information by following the directions in the recertification email sent from the OPA to Connie Moreno-Peraza by the requested deadline. Specific recertification questions should be sent to: 340b.recertification@hrsa.gov

Enrollment Procedure: New Clinic Sites

The Entity staff evaluates a new service area or facility to determine if the location is eligible for participation in the 340B Program. The criteria used include: service area must be within the scope of the grant/designation received by the Entity that confers 340B status; have outpatient drug use; and have patients that meet the 340B patient definition.

If a new clinic meets these criteria, the Entity Authorizing Official, Connie Moreno-Peraza, completes the online registration process during the registration window (January 1-January 15 for an effective start date of April 1; April –April 15 for an effective start date of July 1; July 1 – July 15 for an effective start date of October 1; and October 1 – October 15 for an effective start date of January 1). http://opanet.hrsa.gov/opa/CERegister.aspx?mode=opf&isnew=true

Entity Staff follows the online registration process here:
http://opanet.hrsa.gov/opa/CERegister.aspx?isnew=true

Enrollment Procedure: New Contract Pharmacy(ies)

1. The Entity staff ensures a signed contract pharmacy services agreement is in place between the entity and contract pharmacy prior to submission to OPA. This staff ensures the Entity's legal counsel has reviewed the contract as to form. ~~and~~HSA and representative have verified that all Federal, State, and local requirements have been met. Also ensures that agreement between Entity and Pharmacy Benefit Manager & between Contract Pharmacies and Pharmacy Benefit Manager are in place.

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2. The Entity Authorizing Official completes the online process here: http://opanet.hrsa.gov/opa/CPRegister.aspx during the registration window (January 1-January 15 for an effective start date of April 1; April –April 15 for an effective start date of July 1; July 1 – July 15 for an effective start date of October 1; and October 1 – October 15 for an effective start date of January 1).

3. The Entity Staff ensures that the Contact Pharmacy Registration Form is signed by a responsible representative of each organization and the original is submitted to OPA by mail or fax, within fifteen (15) calendar days from the date the online registration was completed. (Entity: responsible representative may be the President, CEO, COO, or CFO.

4. The Entity Staff begins the contract pharmacy arrangement only on or after the effective date shown on the OPA website.

Changes to Entity's Information in OPA Database Procedure

It is Entity's ongoing responsibility to immediately inform OPA of any changes to its information or eligibility. As soon as Entity is aware that it loses eligibility, it will notify OPA immediately and stop purchasing (or may be required to repay manufacturers).

An online change request will be submitted to OPA by Entity's Authorizing Official for changes to Entity's information outside of the annual recertification timeframe. Change form will be submitted to OPA as soon as the entity is aware of the need to make a change to its database entry. The entity will expect changes to be reflected within about 2 weeks of submission of the changes/requests. Types of handled through a change from include:

- Changes to entity contact information
- Adding a shipping address [Reference 340B Glossary of Terms]

2. Contract Pharmacy Staff places 340B orders on behalf of Entity, based upon 340B eligible use from Wholesaler.
3. Entity pays invoice to Wholesaler for all 340B drugs.
4. Contract Pharmacy Staff receives 340B inventory by examining the wholesaler invoice against the order, and reports inaccuracies to Wholesaler and Entity Staff within thirty (30) calendar days.
5. Contract Pharmacy notifies pharmacy consultant if Contract Pharmacy doesn't receive 11 digit NDC replenishment order within 30 days of original order fulfillment request. Entity will reimburse Contract Pharmacy at a pre-negotiated rate for such drugs.
6. Any non-replacement 340B inventory is stored at Contract Pharmacy, and clearly marked as belonging to the 340B entity. The inventory is protected by a security system. Only pharmacy employees have access to the pharmacy.
7. Contract Pharmacy will provide an interval report to the Entity.

XI. MONITORING AND REPORTING

The following reports are internal controls and audit reports. The purpose of these reports is to provide internal control and monitoring of trends in order to comprehensively monitor 340B compliance. The reports specifically monitor trends that could indicate diversion, software inaccuracies, problem areas that need to be addressed, and should be designed to ensure systems are functioning properly.

Contract Pharmacy Summary Report

This report serves as a high-level summary report, intended to allow Entity to monitor 340B inventory compliance of random samples. Multiple contract pharmacies will have data broken down by pharmacy and in aggregate (where applicable). Rx Strategies (PBM) is responsible for preparing the Contract Pharmacy Summary Report monthly. Data and reports will be maintained for 3 years with Rx Strategies.

Data	Data Source	Sample(s) (time/date/description)	Acceptable Range	Action Steps
Total Quantity 340B Eligible Units Dispensed by NDC				
Total Quantity 340B Units Replenished/Ordered by NDC	Wholesaler invoices or system report			
Total Pharmacy Collections (by payer type)				
Total # Rxs Dispensed				

340B COMPLIANCE REVIEW

The 340B Compliance Review summarizes all activities necessary to ensure comprehensive review of 340B compliance at Entity. Entity Staff is responsible and accountable for overseeing this review process, as well as taking corrective actions based upon findings.

Activity	Frequency (suggested)	Area of Focus		
		Entity Eligibility	No Diversion	No Duplicate Discount
Review of all OPA database information for [ENTITY], indigent care agreement with state/local government, and Medicare Cost Report (Worksheet E, Part A and Worksheet A), prior to recertification [Entity] Staff responsible: Kristina Riera	Annual			
Review of 340B Summary Reports and Self-Audit Reports [Entity] Staff responsible: Janet Aiso				
Review of quarterly contract price load [Entity] Staff responsible: Janet Aiso				
Update (minimum) of prescriber and patient eligibility files with PBM/contract pharmacy [Entity] Staff responsible: Amy Peeler				

XII. 340B PROCUREMENT, INVENTORY MANAGEMENT, DISPENSING

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In accordance with **White House Executive Order 14273** and the terms of federal health center awards, the Entity adopts the following policies and procedures to ensure affordable access to insulin and injectable epinephrine:

Policy Statements

- The Entity will make insulin and injectable epinephrine available at or below the **340B discounted purchase price paid by the Entity (plus a minimal administration fee)** to qualifying individuals.
- For the purposes of this policy, a **qualifying individual** is defined as a low-income patient who meets one or more of the following criteria:
    - (a) Has a high cost-sharing requirement for either insulin or injectable epinephrine;
    - (b) Has a high unmet deductible; or
    - (c) Has no health insurance coverage.
- For this purpose, a **low-income individual** means an individual living in a household with an income level at or below **200 percent of the Federal Poverty Guidelines (FPG)**.
- The Entity will implement a **sliding fee scale or equivalent verification process** to determine income eligibility, consistent with HRSA requirements.
- The Entity will maintain **auditable records** documenting eligibility determinations, pricing, and dispensing to demonstrate compliance with this provision.
- Any administration fee applied must be **reasonable, minimal, and directly tied to the cost of dispensing**.

- The Entity will ensure that staff are trained annually on these requirements as part of overall 340B compliance training.

Procedures

1. **Eligibility Determination**
    - Patients requesting access under this provision will be screened using the Entity's existing income verification process aligned with the Sliding Fee Discount Program.
2. **Pricing Application**
    - Once eligibility is confirmed, the patient will be charged no more than the Entity's 340B acquisition cost for insulin or injectable epinephrine, plus the approved minimal administration fee.
3. **Documentation and Reporting**
    - All transactions will be logged in the Entity's 340B compliance records.
    - Records will be reviewed quarterly as part of the Entity's internal audit plan to verify adherence to this policy.
4. **Communication to Patients**
    - Information regarding the availability of this program will be made accessible to patients through clinic notices, patient education materials, and staff communication.

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Appendix [I]: Contract Pharmacy Compliance Elements

HRSA has provided essential covered entity compliance elements as guidelines for the contractual provisions expected in al contract pharmacy arrangements. Excerpt from: http://www.hrsa.gov/opa/programrequirements/federalregisternotices/contractpharmacyservices030510.pdf

a) The covered entity will purchase the drug, maintain title to the drug and assume responsibility for establishing its price, pursuant to the terms of an HHS grant and any applicable Federal, State and local laws. A "ship to, bill to" procedure is used in which the covered entity purchases the drug; the manufacturer/wholesaler must bill the covered entity for the drug that it purchased, but ships the drug directly to the contract pharmacy. In cases where a covered entity has more than one site, it may choose between having each site billed individually or designating a single covered entity billing address for all 340B drug purchases.
b) The agreement will specify the responsibility of the parties to provide comprehensive pharmacy services (e.g., dispensing, recordkeeping, drug utilization review, formulary maintenance, patient profile, patient counseling, and medication therapy management services and other clinical pharmacy services). Each covered entity has the option of individually contracting for pharmacy services with a pharmacy(ies) of its choice. Covered entities are not limited to providing comprehensive pharmacy services to any particular location and may choose to provide them at multiple locations and/or "in-house".
c) The covered entity will inform the patient of his or her freedom to choose a pharmacy provider. If the patient does not elect to use the contracted service, the patient may obtain the

prescription from the covered entity and then obtain the drug(s) from the pharmacy provider of his or her choice. When a patient obtains a drug from a pharmacy other than a covered entity's contract pharmacy or the covered entity's in-house pharmacy, the manufacturer is not required to offer this drug at the 340B price.

d) The contract pharmacy may provide other services to the covered entity or its patients at the option of the covered entity (e.g., home care, delivery, reimbursement services). Regardless of the services provided by the contract pharmacy, access to 340B pricing will always be restricted to patients of the covered entity.

e) The contract pharmacy and the covered entity will adhere to all Federal, State, and local laws and requirements. Both the covered entity and the contract pharmacy are aware of the potential for civil or criminal penalties if either violated Federal or State law.

f) The contract pharmacy will provide the covered entity with reports consistent with customary business practices (e.g., quarterly billing statements, status reports or collections and receiving and dispensing records).

g) The contract pharmacy, with the assistance of the covered Entity, will establish and maintain a tracking system suitable to prevent diversion of section 340B drugs to individual who are not patients of the covered entity. Customary business records may be used for this purpose. The covered Entity will establish a process for periodic comparison of its prescribing records with the contract pharmacy's dispensing records to detect potential irregularities.

h) The covered Entity and the contract pharmacy will develop a system to verify patient eligibility, as defined by HRSA guidelines. The system should be subject to modification in the event of change in such guidelines. Both parties agree that they will not resell or transfer a drug purchased at section 340B prices to an individual who is not a patient of the covered entity. See 42 U.S.C. 256b(a)(5)(B). The covered Entity understands that it may be removed from the list of covered entities because of its participation in drug diversion and no longer be eligible for 340B pricing.

i) Neither party will use drugs purchased under section 340B to dispense Medicaid prescriptions, unless the covered Entity, the contract pharmacy and the State Medicaid agency have established an arrangement to prevent duplicate discounts. Any such arrangement shall be reported to the OPA, HRSA, by the covered entity.

j) The covered Entity and contact pharmacy will identify the necessary information for the covered Entity to meet its ongoing responsibility of ensuring that the elements listed herein are being complied with and establish mechanisms to ensure availability of that information for periodic independent audits performed by the covered entity.

k) Both parties understand that they are subject to audits by outside parties (by the Department and participating manufacturers) of records that directly pertain to the Entity's compliance with the drug resale or transfer prohibition and the prohibition against duplicate discounts. See 42 U.S.C. 256b(a)(5)(c). The contract pharmacy will assure that all pertinent reimbursement accounts and dispensing records, maintained by the pharmacy, will be accessible separately from the pharmacy's own operations and will be made available to the covered Entity, HRSA, and the manufacturer in the case of an audit. Such auditable records will be maintained for a period of time that complies with all applicable Federal, State and local requirements.

l) Upon written request to the covered Entity, a copy of the contract pharmacy service agreement will be provided to the Office of Pharmacy Affairs

Executive Summary: California FQHC 90% Mission Spending Initiative

This proposed California ballot initiative, sponsored by SEIU-UHW, would require nonprofit Federally Qualified Health Centers (FQHCs) to spend at least 90% of annual revenue on mission-related program services. The initiative is framed as a transparency and accountability measure but presents material fiscal, operational, and compliance risk for safety-net providers.

Core Requirement

- FQHCs must maintain a minimum 90% spending ratio on "program services advancing their charitable purpose."
- Administrative and overhead costs would be implicitly capped at approximately 10% of total revenue.
- The requirement applies annually and is subject to state enforcement.

Definition Risk

The initiative does not define mission-related or program service spending in statute. Instead, it authorizes the California Attorney General to issue guidance defining qualifying expenditures after passage. This creates uncertainty around the treatment of core FQHC functions, including compliance, IT systems, finance, quality improvement, care coordination, workforce training, and enabling services.

Enforcement and Penalties

- Mandatory annual financial reporting to the Attorney General.
- Monetary penalties for non-compliance.
- Potential criminal liability for false reporting or artificial manipulation of spending ratios.
- Limited waiver authority through the Department of Public Health for exceptional circumstances.

What This Means for Our Health Centers

Under our current cost structure, compliance with this initiative depends entirely on how the state defines administrative spending:

- If administrative spending is limited to what we traditionally classify as executive and leadership functions, our administrative spend is approximately **4% of total revenue**, and we would remain compliant.
- If administrative spending is defined to include all non-patient-care administrative and enabling functions, our administrative spend is approximately **14.7% of total revenue**, which would place our Health Centers in violation of this requirement.

This distinction is significant. Many non-patient-facing functions are required to operate safely, comply with federal and state rules, maintain access, and meet HRSA Section 330 requirements. The absence of statutory clarity creates a direct fiscal and operational risk.

Oversight Considerations

- Risk of service disruption if infrastructure or compliance capacity is reduced to meet spending ratios.
- Tension with HRSA governance, financial management, and quality oversight expectations.
- Increased audit, enforcement, and legal exposure.
- Long-term sustainability risk for safety-net care delivery.

Health Centers Division

Integrated Community Health Center Commission Fiscal Report

1-7-26

Fiscal Data as of 10/31/25:

1st Estimated Actuals

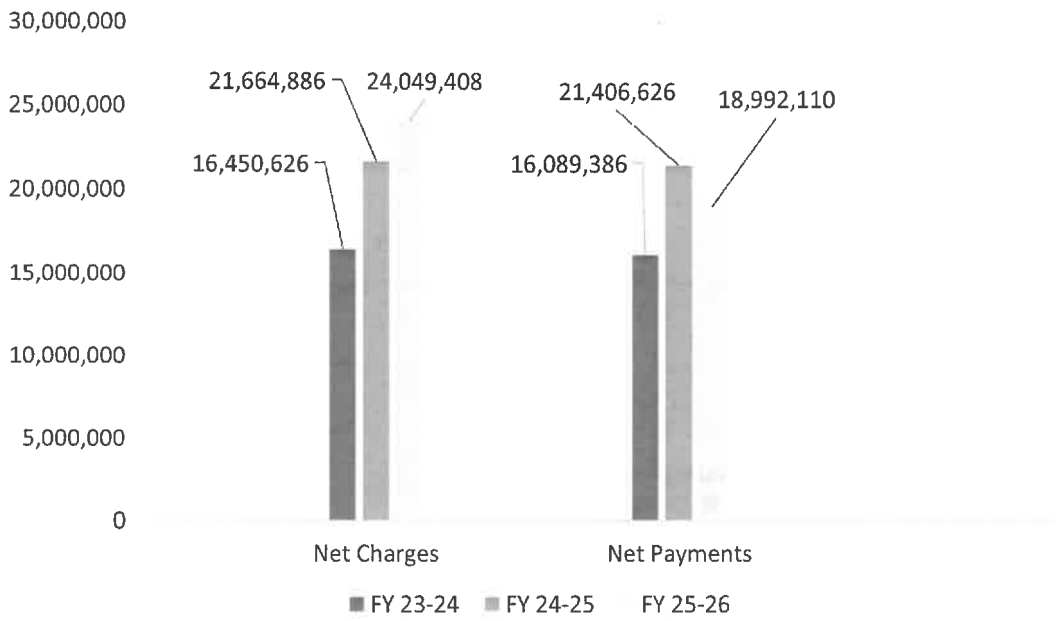
Health Centers 1st Estimated Actuals

County of Santa Cruz (HSA)
FY 25/26 HEALTH CENTERS(All)
As of10/31/2025

Division	HEALTH CENTERS
GLKey	(All)

Row Labels	Adopted Budget	Adjusted Budget	Division EA's 1	Division EA Difference Budget to EA's
⊟REVENUE	(55,178,889)	(63,831,171)	(58,243,970)	(5,587,201)
⊞15-INTERGOVERNMENTAL REVENUES	(6,700,158)	(6,700,158)	(6,293,895)	(406,263)
⊞19-CHARGES FOR SERVICES	(48,018,733)	(56,451,015)	(51,270,077)	(5,180,938)
⊞23-MISC. REVENUES	(459,998)	(679,998)	(679,998)	0
⊟EXPENDITURE	55,117,602	63,819,884	58,232,683	5,587,200
⊞50-SALARIES AND EMPLOYEE BENEF	35,791,862	36,266,243	36,265,409	834
⊞60-SERVICES AND SUPPLIES	7,211,706	15,521,840	10,600,542	4,921,298
⊞61-SERVICES AND SUPPLIES-ISF	1,234,710	1,217,004	1,217,004	0
⊞70-OTHER CHARGES	48,404	48,404	48,404	0
⊞80-FIXED ASSETS	0	0	0	0
⊞95-INTRAFUND TRANSFERS	10,830,920	10,766,393	10,101,325	665,068
Grand Total	(61,288)	(11,287)	(11,287)	(1)

Net Charges and Payments by Service Date July – Dec comparison

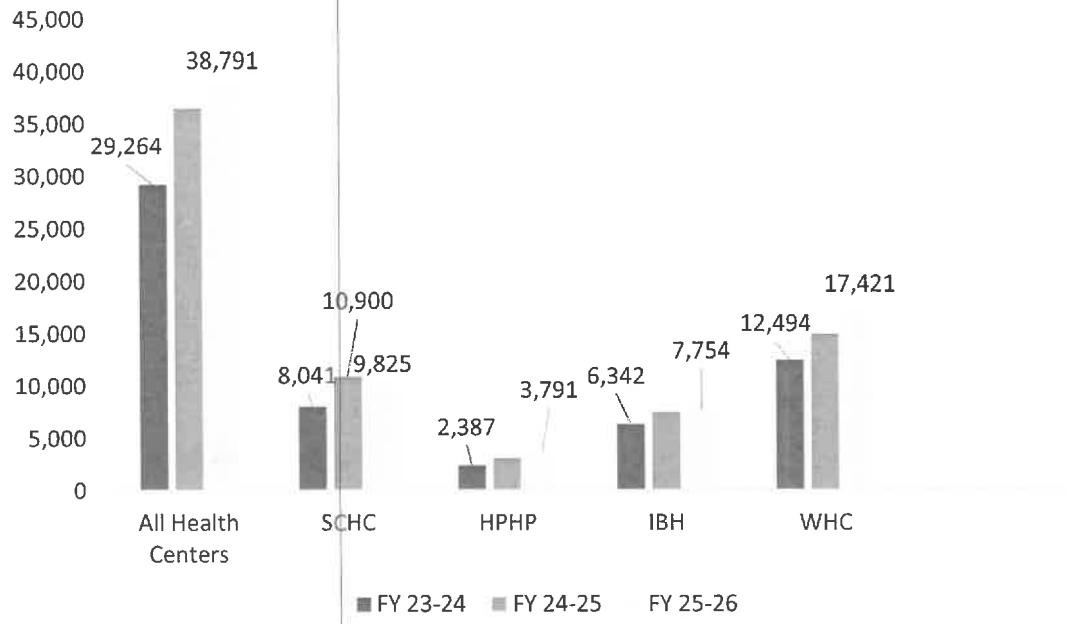


Net charges and Net Payments are continuing to increase.

This FY, there have been multiple delays on payments that have resulted in a lag.

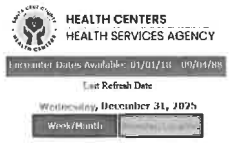
REVENUE ANALYSIS SUMMARY BY PAYER - EPIC
Data by Service Date

Fiscal Year July-Dec completed billable appointment comparison



Continue to see sustained increases in billable completed appointments.

Reminder that SCHC is down a full-time doctor due to a protected leave.

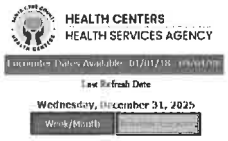


Payor Mix July-Dec: Charges

Payor mix — Charges

Payor	Charges ($)	% of Total Charges
Medicaid	10,210,080.81	71.52%
Medicare	3,432,813.72	24.05%
Commercial	438,010.41	3.07%
Uninsured	195,311.01	1.37%
Total	**14,276,215.95**	**100.0%**

Charges are overwhelmingly Medicaid.



Payor Mix July-Dec: Payments

Payor mix — Payments

Payor	Payments ($)	% of Total Payments
Medicaid	-13,361,643.58	78.56%
Medicare	-3,456,852.74	20.33%
Commercial	-182,861.40	1.08%
Uninsured	-5,952.00	0.04%
Total	**-17,007,309.72**	**100.0%**

Payments are overwhelmingly Medicaid.

Payor Mix July-Dec: Comparison

Payor mix — Charges (%)

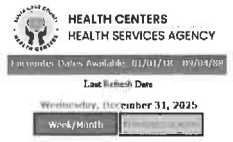
Payor	FY24	FY25	YoY Δ (pp)
Medicaid	64.18%	71.52%	+7.34
Medicare	23.20%	24.05%	+0.84
Commercial	11.04%	3.07%	–7.97
Uninsured	1.58%	1.37%	–0.21
Total	100%	100%	—

Payor mix — Payments (%)

Payor	FY24	FY25	YoY Δ (pp)
Medicaid	73.92%	78.56%	+4.65
Medicare	22.11%	20.33%	–1.79
Commercial	3.94%	1.08%	–2.86
Uninsured	0.04%	0.04%	~0.00
Total	100%	100%	—

(Payments are net, including adjustments and wraps.)

It will be important to track Payor Mix charges and Payments to assess the effects of HR.1 Big Beautiful Bill. So, far no significant changes, except for Commercial.



Is there anything I can answer for you?

Thank You

SANTA CRUZ COUNTY HEALTH SERVICES AGENCY

SANTA CRUZ COUNTY HEALTH CENTERS

Health Centers Division

Quality Management Report

January 7, 2026

Quality Management Committee

- Dexa Scan (bone density scan) Pilot
- Outreach Campaign- Population Health Team
  - Initial Health Appointment
- Central California Alliance for Health Quarter 3 Data

Quality of Care Measures	Your Practice	Plan Benchmark	Plan Goal	Improvement Rate (%) *	Percentile Group	Eligible for Measure	Possible Points	Practice Points
Breast Cancer Screening	Your Practice							
Members eligible	965							
Members screened	593							
Rate (%)	61.45%	52.68%	63.48%	4.73%	Between 75th and 89th	Yes	4.42	4.42
Cervical Cancer Screening	Your Practice							
Members eligible	3,088							
Members screened	1,820							
Rate (%)	58.94%	57.18%	67.46%	1.55%	Between 50th and 74th	Yes	4.42	3.09
Child and Adolescent Well-Care Visits	Your Practice							
Members eligible	2,269							
Members with a visit	1,404							
Rate (%)	61.88%	51.81%	64.74%	-1.14%	Between 75th and 89th	Yes	4.42	4.42
Chlamydia Screening in Women	Your Practice							
Members eligible	379							
Members screened	286							
Rate (%)	75.46%	55.95%	69.07%	N/A	≥90th percentile	Yes	4.42	4.42
Colorectal Cancer Screening	Your Practice							
Members eligible	2,952							
Members screened	1,526							
Rate (%)	51.69%	38.07%	49.35%	N/A	≥90th percentile	Yes	4.42	4.42
Depression Screening for Adolescents and Adults	Your Practice							
Members eligible	7,981							
Members screened	3,173							
Rate (%)	39.76%	7%	17%	-3.52%	≥75th percentile	Yes	4.42	4.42
Diabetic Poor Control >9% ↓	Your Practice							
Members eligible	1,183							
Members in poor control	326							
Rate (%)	27.56%	33.33%	27.01%	-1.88%	Between 75th and 89th	Yes	4.42	4.42
Immunizations: Adolescents	Your Practice							
Members eligible	123							
Members immunized	77							
Rate (%)	62.60%	34.3%	48.66%	5.46%	≥90th percentile	Yes	4.42	4.42
Immunizations: Children (Combo 10)	Your Practice							
Members eligible	36							
Members immunized	12							
Rate (%)	33.33%	27.49%	42.34%	-11.95%	Between 50th and 74th	Yes	4.42	3.09
Lead Screening in Children	Your Practice							
Members eligible	37							
Members screened	34							
Rate (%)	91.89%	63.84%	79.51%	25.22%	≥90th percentile	Yes	4.42	4.42

Questions?

Thank You