ALAMEDA Alliance FOR HEALTH

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Board of Governors

Regular Meeting

Friday, June 13th, 2025
12:00 p.m. – 2:00 p.m.

Video Conference Call and

1240 South Loop Road, Alameda, CA 94502

AGENDA

BOARD OF GOVERNORS
Regular Meeting
Friday, June 13th, 2025
12:00 p.m. – 2:00 p.m.

In-Person and Video Conference Call

1240 S. Loop Road
Alameda, CA 94502

PUBLIC COMMENTS: Public Comments can be submitted for any agendized item or for any item not listed on the agenda, by mailing your comment to: "Attn: Clerk of the Board," 1240 S. Loop Road, Alameda, CA 94502 or by emailing the Clerk of the Board at brmartinez@alamedaalliance.org. You may attend meetings in person or by computer by logging in to the following link: Click here to join the meeting. You may also listen to the meeting by calling in to the following telephone number: 1-510-210-0967 conference id 407926431#. If you use the link and participate via computer, you may use the chat function, and request an opportunity to speak on any agendized item, including general public comment. Your request to speak must be received before the item is called on the agenda. If you participate by telephone, please submit your comments to the Clerk of the Board at the email address listed above or by providing your comments during the meeting at the end of each agenda item. Oral comments to address the Board of Governors are limited to three (3) minutes per person. Whenever possible, the board would appreciate it if public comment communication was provided prior to the commencement of the meeting.

PLEASE NOTE: The Alameda Alliance for Health is making every effort to follow the spirit and intent of the Brown Act and other applicable laws regulating the conduct of public meetings.

1. CALL TO ORDER

(A regular meeting of the Alameda Alliance for Health Board of Governors will be called to order on June 13th, 2025, at 12:00 p.m. in Alameda County, California, by Rebecca Gebhart, Presiding Officer. This meeting is to take place in person and by video conference call)

2. ROLL CALL

3. AGENDA APPROVAL

4. INTRODUCTIONS

5. CONSENT CALENDAR

(All matters listed on the Consent Calendar are to be approved with one motion unless a member of the Board of Governors removes an item for separate action. Any consent calendar item for which separate action is requested shall be heard as the next agenda item.)

a) MAY 6th, 2025, FINANCE COMMITTEE MEETING MINUTES

b) MAY 9th, 2025, BOARD OF GOVERNORS MEETING MINUTES

6. **BOARD MEMBER REPORTS**

   a) **DHCS AND DMHC JUNE 2 MEETING UPDATE**

   b) **CAC SELECTION COMMITTEE UPDATE**

   c) **COMPLIANCE ADVISORY COMMITTEE**

   d) **FINANCE COMMITTEE**

7. **CEO UPDATE**

8. **BOARD BUSINESS**

   a) **COMMUNITY SUPPORTS DISCUSSION (*May 9 public comment*)**

      (i) REVIEW AND APPROVE – COMMUNITY SUPPORTS

   b) **REVIEW AND APPROVE APRIL 2025 MONTHLY FINANCIAL STATEMENTS**

   c) **REVIEW AND APPROVE FISCAL YEAR 2026 BUDGET**

9. **UNFINISHED BUSINESS**

10. **STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS**

11. **PUBLIC COMMENT (NON-AGENDA ITEMS)**

12. **ADJOURNMENT**

NOTICE TO THE PUBLIC

The foregoing does not constitute the final agenda. The final agenda will be posted no later than 24 hours prior to the meeting date.

The agenda may also be accessed through the Alameda Alliance for Health's Web page at: www.alamedaalliance.org

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Board of Governors meetings are regularly held on the second Friday of each month at 12:00 p.m., unless otherwise noted. This meeting is held both in person and as a video conference call. Meeting agendas and approved minutes are kept current on the Alameda Alliance for Health's website at www.alamedaalliance.org.

Additions and Deletions to the Agenda: Additions to the agenda are limited by California Government Code Section 54954.2 and confined to items that arise after the posting of the agenda and must be acted upon prior to the next Board meeting. For special meeting agendas, only those items listed on the published agenda may be discussed. The items on the agenda are arranged in three categories. **Consent Calendar:** These items are relatively minor in nature, do not have any outstanding issues or concerns, and do not require a public hearing. All consent calendar items are considered by the Board as one item and a single vote is taken for their approval, unless an item is pulled from the consent calendar for individual discussion. There is no public discussion of consent calendar items unless requested by the Board of Governors. **Public Hearings:** This category is for matters that require, by law, a hearing open to public comment because of the particular nature of the request. Public hearings are formally conducted, and public input/testimony is requested at a specific time. This is your opportunity to speak on the item(s) that concern you. If in the future, you wish to challenge in court any of the matters on this agenda for which a public hearing is to be conducted, you may be limited to raising only those issues which you (or someone else) raised orally at the public hearing or in written correspondence received by the Board at or before the hearing. **Board Business:** Items in this category are general in nature and may require Board action. Public input will be received on each item of Board Business.

Supplemental Material Received After the Posting of the Agenda: Any supplemental materials or documents distributed to a majority of the Board regarding any item on this agenda after the posting of the agenda will be available for public review. To obtain a document, please call the Clerk of the Board at (510) 995-1207.

Submittal of Information by Members of the Public for Dissemination or Presentation at Public Meetings (Written Materials/handouts): Any member of the public who desires to submit documentation in hard copy form may do so prior to the meeting by sending it to "Attn: Clerk of the Board", 1240 S. Loop Road, Alameda, CA 94502. This information will be disseminated to the Committee at the time testimony is given.

Americans With Disabilities Act (ADA): It is the intention of the Alameda Alliance for Health to comply with the Americans with Disabilities Act (ADA) in all respects. If, as an attendee or a participant at this meeting, you will need special assistance beyond what is normally provided, the Alameda Alliance for Health will attempt to accommodate you in every reasonable manner. Please contact the Clerk of the Board, Brenda Martinez, at (510) 995-1207 at least 48 hours prior to the meeting to inform us of your needs and to determine if accommodation is feasible. Please advise us at that time if you will need accommodations to attend or participate in meetings on a regular basis.

I hereby certify that the agenda for the Board of Governors was posted on the Alameda Alliance for Health's web page at www.alamedaalliance.org by June 10th, 2025, by 12:00 p.m.

Brenda Martinez, Clerk of the Board

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EXECUTIVE SUMMARY APPENDIX

Please click on the hyperlink(s) below to direct you to corresponding material for each item.

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PRESENTATIONS APPENDIX

Please click on the hyperlink(s) below to direct you to corresponding material for each item.

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SUPPORTING MATERIALS APPENDIX

Please click on the hyperlink(s) below to direct you to corresponding material for each item.

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Consent Calendar

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Finance Committee Meeting Minutes

ALAMEDA ALLIANCE FOR HEALTH
FINANCE COMMITTEE
REGULAR MEETING

May 6th, 2025
8:00 am – 9:00 am

SUMMARY OF PROCEEDINGS

Meeting Conducted in-person and by Teleconference.

Committee Members in-person: Dr. Rollington Ferguson, Rebecca Gebhart, James Jackson, Yeon Park, Gil Riojas
Committee Members by Teleconference: None
Committee Members Excused: None
Board of Governor members in-person and on Conference Call: Andie Martinez-Patterson, Wendy Peterson

Alliance Staff in-person and on Conference Call: Matt Woodruff, Tiffany Cheang, Richard Golfin III, Sasi Karaiyan, Anastasia Swift, Lao Paul Vang, Ruth Watson, Yen Ang, Christine Corpus, Linda Ly, Brenda Martinez, Tome Meyers, Felix Rodriguez, Allison Lam, Danube Serri

CALL TO ORDER

Dr. Ferguson convened the Finance Committee meeting at 8:05 a.m.

ROLL CALL

Roll call was conducted and confirmed.

INTRODUCTIONS

There were no introductions.

CONSENT CALENDAR

Dr. Ferguson presented the Consent Calendar.

There were no modifications to the Consent Calendar, and no items to approve.

a) CEO UPDATE

- Fiscal Year 2026 Budget Preparation: Matt provided an update on the fiscal year 2026 budget preparation, highlighting the uncertainties and cuts occurring at the federal government level. The team is considering various scenarios and planning for a best case and worst case scenario.
- Undocumented Members' Care: Matt shared information about the planning for undocumented members to be disenrolled from Alameda Alliance early next calendar year. He has been providing Alameda County with details on where undocumented members will receive care and the associated costs. Meetings with assembly members are ongoing to address this issue.
- Automation and AI Initiatives: Matt and Sasi discussed the ongoing efforts to automate operational services and move into the AI world. They provided examples of automation

projects, such as authorizations, speech-to-text for call centers, and Copilot for staff. The goal is to increase efficiency and reduce the need for new hires.

- Community Supports Update: Matt provided an update on community supports, mentioning the pause on changes due to new policy guides and the need for further evaluation. He discussed the possibility of changing payment structures to a tiered approach similar to ECM. The team is finalizing the details and will report back to the board with the information.

Question: Dr. Ferguson posed a question about AI and authorizations, specifically related to the process.

Response: Mr. Woodruff assured that no medical decisions will be made by AI, and the focus is on automating administrative tasks to minimize manual data entry.

Question: Dr. Ferguson inquired about the average monthly community support expense.

Response: Mr. Riojas estimated community support expenses, targeting approximately $14 million for the year, with monthly costs slightly exceeding $1 million.

b) REVIEW AND APPROVE MARCH 2025 MONTHLY FINANCIAL STATEMENTS

MARCH 2025 Financial Statement Summary

Enrollment:

Enrollment decreased by 648 members since February and an overall increase of 8,640 members since June 2024.

Net Income:

For the month ending March 31st, 2025, the Alliance reported a Net Income of $458,000 (versus budgeted Net Income of $7.6 million). For the year-to-date, the Alliance recorded a Net Loss of $98.3 million versus a budgeted Net Loss of $76.3 million.

Premium Revenue:

For the month ending March 31st, 2025, actual Revenue was $191.7 million vs. our budgeted amount of $190.9 million.

Medical Expense:

Actual Medical Expenses for the month were $183.8 million, vs. budgeted amount of $172.4 million. For the year-to-date, actual Medical Expenses were $1.6 billion vs. budgeted Medical Expense of $1.6 billion.

Medical Loss Ratio:

Our MLR ratio for this month was reported as 95.9%. The year-to-date MLR was 102.0%.

Administrative Expense:

Actual YTD Administrative Expenses for the month ending March 31st, 2025, were $86.8 million vs. our budgeted amount of $91.1 million. Our Administrative Loss Ratio (ALR) is 5.5% of our Revenue for the month, and 5.5% of Net Revenue for year-to-date.

Other Income / (Expense):

As of March 31st, 2025, our YTD interest income from investments show a gain of $25.3 million.

Managed Care Organization (MCO) Provider Tax:

For the month ending March 31st, 2025, we reported $68.5 million MCO Tax Revenue vs. budgeted MCO Tax Revenue of $63.8 million. Our MCO Tax Expense was $68.5 million vs. budgeted MCO Tax Expense of $66.8 million.

Tangible Net Equity (TNE):

For March, the DMHC requires that we have $79.8 million in TNE, and we reported $157.1 million, leaving an excess of $77.3 million. As a percentage we are at 197%, which remains above the minimum required.

Cash and Cash Equivalents:

We reported $811.1 million in cash; $555.0 million is uncommitted. Our current ratio is above the minimum required at 1.08 compared to regulatory minimum of 1.0.

Capital Investments:

We have acquired $859,000 in Capital Assets year-to-date. Our annual capital budget is $2.0 million.

Question: Ms. Gebhart inquired whether the MCO tax fluctuates month to month and, if it is risk-based, whether a particular population is affected more than others, as is the case with TNE.

Response: Mr. Riojas stated that the MCO tax varies monthly and yearly. Last year, there was a net loss of $14 million, but this year, a net gain of $10 million is projected. The MCO tax is determined by total enrollment.

Question: Dr. Ferguson inquired about SPDs and long-term care, noting that both have been losing propositions for us. Now, they have been combined into one. Will the state address this issue?

Response: Mr. Riojas stated that the state combined the categories for simplicity and that it is too soon to determine the impact.

Question: Dr. Ferguson asked about our leasing agreement ending this month, inquiring about our current status, potential savings this year and next, and whether we still need the same amount of space.

Response: Mr. Riojas mentioned that the lease ends in May 2025, which will save about $900,000 annually. While the current space is sufficient, future options might include moving closer to public transportation. The main focus remains on maintaining the existing space.

Motion: A motion was made by Yeon Park, and seconded by Rebecca Gebhart, to accept and approve the March 2025 Financial Statements.

Motion Passed

No opposition or abstentions.

c) INVESTMENT PORTFOLIO UPDATE

Current Investment Portfolio

- Total funds of $846M invested at the end of March.
- 73% of investments maturing within 0-90 days.
- 27% of investments maturing after 90 days.
- Average Yield to Maturity is 4.30%.
- Estimated annual return approximately $34M for FY25.
- FY24 return was approximately $32M.
- Continued focus on quality and liquidity of investments.
- All investments are compliant with California Government Code 53600.

Market Update and Portfolio Changes

- Market confidence is waning. Tariffs, the US economic outlook, consumer sentiment and the softening labor market are weighing down the market.
- The Federal Reserve is now expected to make 1-2 interest rate cuts this year versus a previously expected 3-4 cuts.
- Less rate cuts means we can take advantage of short-term interest rates for longer.
- Our primary investment focus will be maintaining short-term investments (shorter than 90 days) to continue to take advantage of high interest rates.
- We anticipate keeping short-term and long-term investment mixes stable to continue maximizing short-term gains while the market steadies.

Question: Mr. Jackson asked if the return is consistent with our projections. Last year, the return was approximately $32 million, and we are estimating $34 million for this year. Is this in line with what was budgeted?

Response: Mr. Riojas stated that this year's return is slightly higher than budgeted, approximately $34 million compared to the projected $25 million.

Question: Ms. Gebhart asked whether the overnight investments fall into one category more than another.

Response: Mr. Riojas confirms that they do typically fall into the categories of repurchase orders and commercial paper.

Comment: Mr. Jackson praised the Alliance for proactively addressing investment issues that other organizations have faced, which in turn has helped us avoid controversy and benefit financially.

Informational Only. No action taken.

d) VERBAL UPDATE ON DRAFT OF GRANT POLICY AND PROCEDURE

Gil and Matt discussed the draft grant policy and procedure, aligning approval levels with the purchasing policy and outlining the criteria for grantees.

- Approval Levels: Gil mentioned that the grant policy aligns approval levels with the purchasing policy, allowing the CEO to approve grants up to $1.5 million, with higher amounts requiring board approval.
- Grantee Criteria: Gil outlined the criteria for grantees, including reporting objectives, timelines, key milestones, and outcomes to ensure effective use of funds.

The grant policy will be reviewed and approved by the Finance Committee in June. If approved, it will also go to the board in June.

Informational only. No action taken.

UNFINISHED BUSINESS

There was no unfinished business.

PUBLIC COMMENTS

There were no public comments.

ADJOURNMENT

Dr. Ferguson adjourned the meeting at 9:02 a.m.

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Board of Governors Meeting Minutes

BOARD OF GOVERNORS
Regular Meeting Minutes
Friday, May 9th, 2025
12:00 p.m. – 2:00 p.m.

Video Conference Call and

1240 S. Loop Road
Alameda, CA 94502

1. CALL TO ORDER

Board of Governors Present: Rebecca Gebhart (Chair), Dr. Noha Aboelata (Vice-Chair), Aarondeep Basrai, Dr. Kathleen Clanon, Dr. Rollington Ferguson, James Jackson, Jody Moore, Yeon Park, Wendy Peterson, Andrea Schwab-Galindo, Dr. Evan Seevak, Supervisor Lena Tam, Natalie Williams

Board of Governors Remote: Andrea Ford (Traditional Brown Act), Andie Martinez-Patterson (AB 2449 "Just Cause"), Dr. Kelley Meade (AB 2449 "Just Cause")

Board of Governors Excused: Tosan Boyo, Byron Lopez, Dr. Marty Lynch

Alliance Staff Present: Matthew Woodruff, Gil Riojas, Anastacia Swift, Sasi Karaiyan, Tiffany Cheang, Michelle Lewis, Lao Paul Vang

Chair Gebhart called the regular Board of Governors meeting to order at 12:02 p.m.

2. ROLL CALL

Roll call was taken, and a quorum was established.

3. AGENDA APPROVAL

There were no modifications to the agenda.

4. INTRODUCTIONS

There were no introductions.

5. CONSENT CALENDAR

a) **MARCH 14th, 2025, BOARD OF GOVERNORS MEETING MINUTES**

b) **MARCH 11th, 2025, FINANCE COMMITTEE MEETING MINUTES**

c) **APRIL 22nd, 2025, FINANCE COMMITTEE MEETING MINUTES**

d) **MARCH 14th, 2025, COMPLIANCE ADVISORY COMMITTEE MEETING MINUTES**

e) APPROVE RESOLUTION FOR QIHEC NOMINEE

Motion: A motion was made by Natalie Williams and seconded by Yeon Park to approve the Consent Calendar.

Vote: The motion was passed unanimously.

Ayes: Aarondeep Basrai, Dr. Kathleen Clanon, Dr. Rollington Ferguson, Andrea Ford, James Jackson, Andie Martinez-Patterson, Dr. Kelley Meade, Jody Moore, Yeon Park, Wendy Peterson, Andrea Schwab-Galindo, Dr. Evan Seevak, Supervisor Lena Tam, Natalie Williams, Vice Chair Dr. Noha Aboelata, Chair Rebecca Gebhart

No opposition or abstentions.

6. BOARD MEMBER REPORTS

a) COMPLIANCE ADVISORY COMMITTEE

There were no updates due to the cancellation of the meeting. The Compliance Advisory Committee is scheduled to reconvene on June 13th.

b) FINANCE COMMITTEE

February Financial Results: Mr. Jackson reported that the Finance Committee met on April 22nd to discuss the financial results. Enrollment increased by 450 members, totaling 413,000 members. A net income of $5.1 million was reported, marking the first positive net income in twelve months. The medical loss ratio (MLR) was at 90%, within the ideal range of 90-95%. Tangible net equity increased from 186% to 202%, driven by a reduction in outstanding claims and a shorter month, resulting in fewer claims due.

March Financial Results: Mr. Jackson discussed the March financial results, noting a decrease in enrollment by 648 members, totaling 412,000 members. A net income of $450,000 was reported, marking the second consecutive month of positive net income. The MLR was 96%, and tangible net equity remained stable at around 200%. Positive revenue from the MCO tax and better-than-expected investment income were highlighted as key drivers of the positive results.

7. CEO UPDATE

Mr. Woodruff highlighted that the Alliance achieved positive net income for two consecutive months for the first time in a year. He thanked the teams working on finances and medical management for their efforts in achieving this milestone. There have also been ongoing efforts to manage the budget amidst changing federal and state regulations. He emphasized the importance of contingency planning and being prepared for various scenarios that may impact the budget.

Question: Ms. Schwab-Galindo inquired about the internal timeline for the information needed for contingency planning. What aspects is the plan evaluating and reviewing?

Answer: Mr. Woodruff mentioned that when the revised budget is released next week, we will review it promptly to incorporate any relevant information into our budget. The federal government is expected to finalize its budget in September, and the state may call a special session depending on the outcome of the federal budget. We are developing contingency plans based on various scenarios.

Question: Chair Gebhart asked if we approve a budget, and then there is a material change at the federal level, can we then ~~do~~ create an adjusted budget?

Answer: Mr. Woodruff stated that in June, we will approve a draft budget based on the information available at that time. Then, in December, we will finalize the budget, incorporating any changes that may arise. The draft budget will serve as our operating budget until the final version is approved.

Question: Chair Gebhart asked how the Alliance's professional organizations and lobbyists are advocating for managed care in California, particularly against the elimination of the MCO tax and UIS. How are our associations representing members on these issues?

Answer: Mr. Woodruff noted that the Alliance cannot hire a lobbyist directly. Instead, we partner with the Local Health Plan Coalition, allocating part of our dues for their lobbying efforts. Over the past year, we have actively supported various bills and sent letters of support.

Informational Item only.

8. BOARD BUSINESS

a) REVIEW AND APPROVE FEBRUARY AND MARCH 2025 MONTHLY FINANCIAL STATEMENTS

Chief Financial Officer Mr. Gil Riojas provided updates on the financials for February and March 2025.

FEBRUARY 2025 MONTHLY FINANCIAL STATEMENT

Executive Summary

For the month of February, the Alliance continues to see incremental increases in enrollment, reaching 413,278 members. A Net Income of $5.1 million was reported, and the Plan's Medical Expenses represented 89.9% of revenue. Alliance reserves increased slightly to 202% of the required and continue to remain above minimum requirements.

Enrollment – In February, Enrollment increased by 450 members.

Net Income – For the month ended February 28th, 2025, actual Net Income was $5.1 million vs. budgeted Net Income of $10.6 million. For the fiscal YTD, actual Net Loss was $98.8 million vs. budgeted Net Loss of $83.9 million. For the month, Premium Revenue was unfavorable to budget, actual Revenue was $176.8 million vs. budgeted Revenue of $191.5 million, Premium Revenue

variance of $14.7 million is primarily due to reconciliation of CY2022 Prop56 MEP, which led to a $13.8 million reduction in revenue.

Medical Loss Ratio (MLR) – The Medical Loss Ratio was 89.9% for the month, and 102.9% for fiscal YTD. The major variances include unfavorable Outpatient FFS, Long-Term Care, Inpatient Hospital FFS, and Ancillary FFS.

Tangible Net Equity (TNE) – The Department of Managed Health Care (DMHC) required $77.7M in reserves, we reported $156.6M. Our overall TNE remains just above DMHC requirements at 202%.

The Alliance continues to benefit from increased non-operating income. For the Fiscal year-to-date, investment shows a gain of $22.2M. Capital assets acquired so far are $592k.

MARCH 2025 MONTHLY FINANCIAL STATEMENT

Executive Summary

For the month of March, the Alliance dipped slightly in enrollment, reaching 412,630 members. A Net Income of $458,000 was reported, and the Plan's Medical Expenses represented 95.9% of revenue. Alliance reserves decreased slightly to 197% of the required and continue to remain above minimum requirements.

Enrollment – In March, Enrollment decreased by 648 members.

Net Income – For the month ended March, actual Net Income was $458,000 vs. budgeted Net Income of $7.6 million. For the fiscal YTD, actual Net Loss was $98.3 million vs. budgeted Net Loss of $76.3 million. For the month, Premium Revenue was favorable to budget, actual Revenue was $191.7 million vs. budgeted Revenue of $190.9 million. Premium Revenue variance of $811,000 is primarily due to CY2024 rate adjustments.

Medical Loss Ratio (MLR) - The Medical Loss Ratio was 95.9% for the month and 102% for fiscal YTD. The major variances include unfavorable Inpatient Hospital FFS, Long Term Care FFS, Pharmacy FFS, and Ancillary FFS.

Tangible Net Equity (TNE) – The Department of Managed Health Care (DMHC) required $79.8 million in reserves, we reported $157.1 million. Our overall TNE remains above DMHC requirements at 197%.

The Alliance continues to benefit from increased non-operating income. For the Fiscal year-to-date, investments show a gain of $3.1 million. Capital assets acquired so far are $859,000.

Question: Dr. Seevak asked about our expectations for this year's MCO tax net amount.

Response: Mr. Riojas mentioned that our quarterly payments amount to approximately $188 million, which total around $750 million annually. We expect to receive that total, although there is some risk based on the state's calculations.

Motion: A motion was made by Yeon Park and seconded by Natalie Williams to approve the February and March 2025 monthly financial statements.

Vote: The motion was passed unanimously.

Ayes: Aarondeep Basrai, Dr. Kathleen Clanon, Dr. Rollington Ferguson, Andrea Ford, James Jackson, Andie Martinez-Patterson, Dr. Kelley Meade, Jody Moore, Yeon Park, Wendy Peterson, Andrea Schwab-Galindo, Dr. Evan Seevak, Supervisor Lena Tam, Natalie Williams, Vice Chair Dr. Noha Aboelata, Chair Rebecca Gebhart

No opposition or abstentions.

b) COMMUNITY SUPPORTS INFORMATIONAL UPDATE

Mr. Woodruff explained the impact of recent policy guides on the Alliance's ability to manage Community Supports and the need to address a $12 million deficit. He mentioned an upcoming meeting with DHCS and DMHC to discuss additional funding. Mr. Woodruff also acknowledged the feedback received from providers and emphasized the importance of working together to address the funding challenges. He thanked Alameda County Health for their constructive feedback and ongoing collaboration.

Multiple speakers expressed concerns about potential cuts to Community Supports funding and emphasized the importance of these services for vulnerable populations.

Public comment speakers:

1. Beatriz Saki, East Bay Innovations
2. Alexis Chettiar, Cardea Health
3. Catherine Hayes, Cardea Health
4. Andrew Somera, Alameda County Health, Housing & Homeless Services
5. Katie Jackson, Project Open Hand
6. Karen Cooper, Cardea Health
7. Meg O'Neill, Cardea Health
8. John Miller, Cardea Health
9. Dr. Steven Chen, Recipe4Health, Alameda County
10. Dr. June Tester, UCSF
11. Jenny Wang, Alameda County Public Health
12. Kimi Watkins Tart, Alameda County Public Health
13. Jovan Yglecias, Bay Area Community Services
14. Gemma Jamena, Bay Area Community Health
15. Brenda Goldstein, LifeLong Medical Care
16. Rebecca Murillo, Alameda County Community Food Bank

Discussions will continue, and there will be an update on this item at the next board meeting.

Informational Item only.

c) MEDICAL MANAGEMENT UPDATE

AAH Top 5%

- Top 5% of AAH members account for ~80% of total costs*
  - ~26K members
  - Top Cost categories:
    - Inpatient = 32%
    - SNF/ICF/DD = 5.5%

- ER = 3.6%
- Pharmacy** = 20%

Inpatient Interventions

On-going

- Over/Under Utilization Workgroup- started in Dec 2024 – meets monthly
- Receive real-time information/Hospital partner rounds - weekly
- Transitional Care Services (TCS); close follow-up of members discharged from a facility/hospital
- Expanded Pharmacy outreach to members with discharge diagnosis of heart failure or sepsis (AHS/Sutter– started Oct 2024; Washington Hosp - Feb 2025)
- Continue to work with hospital partners to refine the identification of high-utilizing members
- Fund CHCN's CTRN program (11 RN FTEs, 3.5 coordinator FTEs)
- Delegate P4P incentive for reduced unplanned readmissions

Future

- Targeted enrollment in ECM–MIF prioritization to ECM providers (June 2025)
- TCS vendor for high-risk members to assist with PCP follow-up (~Summer 2025)
- Further expand Pharmacy outreach to include additional hospitals (~Summer 2025)
- Inpatient-focused interventions with the largest delegate (~Summer 2025)
- Work with Finance and Contracting to ensure appropriate payment for inpatient services, such as contracted versus noncontracted and diagnosis per diem vs APR-DRG.

Long-Term Support Services Interventions

On-going

- Sitter program restructured with contracting
- On-site visitation in LTC facilities
- LTC rounds (LTC/IP/ECM) – weekly
- Monitor payment of non-covered MediCal benefits, such as Congregate Living Health Facilities
- Updated Community Supports Criteria – Dec 2024

Future

- Ensure members have the appropriate DHCS LTC aid code
- Refine Community Supports criteria (new policy guides 4/30/25)

Emergency Department Interventions

On-going

- Member education campaign- increase Telehealth and Urgent Care utilization; New brochures to members
- Community Health Workers (CHW) care coordination in EDs (Highland, Sutter) – Aug/Sept 2024
- QI navigators (2) f/u ED visits (AHS) for Mental Health (MH) or Substance Use Disorder (SUD)→warm transfer to Behavioral Health (BH) – Jan 2025
- Monthly rounds with Kaiser ED/IP Teams for Alliance utilizers of ED/IP – Feb 2025
- Incentives to expand PCP hours of operation
- QI Team meets monthly with direct and delegated providers to share access data, encourage incentive participation

Future

- Expand network access to PCPs, Urgent care, and MH providers
- Train SUD ED navigators to include/link to MH; Expand ED SUD Navigators to other EDs
- Expand Admission/Discharge/Transfer to receive from Tertiary Hospitals (UCSF/Stanford)
- Partner with Delegates for CHW ED Navigation for PCP/BH follow-up after ED visits

Pharmacy Interventions

Ongoing

- Formulary/Prior Authorization (PA) review (ex – Anticoagulants)
- Monitor new claims for carve out drugs/Physician Administered Drugs process – Oct 2024
- Process change: logic for payment of new J codes/PA– Feb 2025 (pend not pay); UM impact
- Monitor drug rebate opportunities
- Expanded pharmacy network with better pricing (partnership between Perform Rx and Optum)
- Gap in care report for HTN, DM, and Asthma for med non-adherence shared with providers via the QI Team.
- New policy regarding self-injectables administered in office (June 2025)

Special Health Care Strategies

- Identify members with special health care needs.
- Work closely with members and PCP to assist with education and care coordination.
- Enroll members in ECM to coordinate care.
- Create and monitor a report.

Strategies for All Other Members

- Evaluate and understand the members within this category
- Enroll members in ECM to assist with care coordination

Question: Ms. Peterson inquired about what portion of the inpatient high utilizers come through the ED?

Response: Dr. Carey mentioned that they do not have that information yet, but it is part of the deep dive they are looking at to understand where the inpatient members are coming from.

Informational Item only.

9. STANDING COMMITTEE UPDATES

a) PEER REVIEW AND CREDENTIALING COMMITTEE

b) QUALITY IMPROVEMENT HEALTH EQUITY COMMITTEE

Due to time constraints, updates from the standing committees will be shared at the next board meeting.

10. STAFF UPDATES

There were no staff updates.

11. UNFINISHED BUSINESS

None.

12. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS

None.

13. PUBLIC COMMENT (NON-AGENDA ITEMS)

There were no public comments for non-agenda items.

14. ADJOURNMENT

Vice-Chair Aboelata adjourned the meeting at 2:02 p.m.

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CEO Update

Matthew Woodruff

To: **Alameda Alliance for Health Board of Governors**

From: **Matthew Woodruff, Chief Executive Officer**

Date: **June 13th, 2025**

Subject: **CEO Report**

- **Financials:**
  - **April 2025:** Net Operating Performance by Line of Business for the month of April 2025 and Year-To-Date (YTD):

	April	**YTD**
Medi-Cal	$5.7M	($85.4M)
Group Care	$585K	$389K
Medicare	($375K)	($7.3M)
Total	$5.9M	($92.4M)

  - **Revenue was $193.0 million in April 2025 and $1.8 billion Year-to-Date (YTD)**.
    - Medical expenses were $181.2 million in April and $1.8 billion for the fiscal year-to-date; the medical loss ratio is 93.9% for the month and 101.1% for the fiscal year-to-date.
    - Administrative expenses were $8.7 million in April and $95.5 million for the fiscal year-to-date; the administrative loss ratio is 4.5% of net revenue for the month and 5.4% of net revenue year-to-date.
  - **Tangible Net Equity (TNE)**: Financial reserves are 202% of the required DMHC minimum, representing $82.2 million in excess TNE.
  - **Total enrollment in April 2025 was 410,784**, decreased by 1,846 Medi-Cal members compared to March 2025.

- **BUDGET UPDATES**
  - **State and Federal – See Presentation**

- **Key Performance Indicators:**
  - **Regulatory Metrics:**
    - The G&A team currently faces challenges in managing a high volume of cases along with staffing shortages. During the month of April, the team missed the expedited case criteria for both grievances, 83% (5 out of 6 were compliant), and appeals, 75% (3 out of 4 were compliant). The criteria are that these cases be resolved in 3 calendar days. The staffing shortages resulted in the team's being noncompliant on these two metrics.

- **Non-Regulatory Metrics:**
  - All non-regulatory metrics were met for May.

- **Alliance Updates:**
  - **Demographics**
    - Please see the attached PowerPoint describing the demographics of the Alliance employees.
- **COMMUNITY SUPPORTS**
  - There will be a Board discussion
- **STRATEGIC PLANNING**
  - July Board meeting
- **AUTOMATION AND AI**
  - There will be an update at a future Board meeting
- **ALLIANCE IN THE COMMUNITY**
  - This will be a new section focused on partnership work the community
- **MEDICARE OVERVIEW**
  - **<u>D-SNP Readiness</u>**

- Alameda Alliance for Health (AAH) Medicare Advantage (MA) Duals Eligible Special Needs Plan (D-SNP) will begin serving members on January 1st, 2026. Currently, there are 17 different departmental workstreams and a total of 111 projects, 69 of which are active, 37 requested, and five (5) on hold.
  - Final QA of 2026 CMS Formulary and Bid Submission (Benefit Determination) was completed on Friday, May 30th, 2025, and on track for submission on Monday, June 2nd, 2025.
  - CMS Account Manager assigned on Friday, May 30th.
- Onsite with CHCN was conducted on Tuesday, May 27th, 2025, to review operational readiness and discuss continued collaboration/partnership.
- Sales scripts, enrollment letters, & enrollment form are all complete. Nations SOW fully executed for Sales System, Hearing, and FlexCard OTC benefit. D-SNP elements added to Utilization Management Committee (UMC) and Community Advisory Committee (CAC).
- Stars strategy continues to gain momentum with full staff and focusing on EMR care gap closure opportunities, enhancing data feed capabilities, and implementing pay for performance. Future opportunities include concierge care cap program, annual wellness visit program, and health awareness campaign.
- PBM implementation is on track. Core systems implementations are underway with EMR upgrades at 60% complete. Sprint sessions are in full swing.

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Summary of Medicaid Related Provisions in the Federal Reconciliation Package and California's May Revise (Budget)

Summary of Medicaid Related Provisions in the Federal Reconciliation Package and California's May Revise (Budget)

Alliance Public Affairs Department

June 13th, 2025

ALAMEDA Alliance FOR HEALTH

House Reconciliation Package

- On May 22nd, the House of Representatives passed its reconciliation package (H.R. 1) by a 215-214 vote.
- The Congressional Budget Office (CBO)estimates that under provisions within Energy and Commerce, the national uninsurance rate would increase by 10.9 million by 2034 with 7.8 million related to the Medicaid provisions (1.4 million of those individuals are estimated to lose coverage due to citizenship or immigration status).
- Medicaid provisions are organized under the following sections:
  - Fraud Reduction and Enrollment Gaming
  - Wasteful Spending Reduction
  - Reducing abuse practices
  - Personal Accountability

Major Provisons in the House Reconciliation Bill

- Citizenship/Immigration Status
  - → No federal match if immigration status is not verified. Removes the 90-day period in which states can enroll individuals and receive FFP while verifying immigration status. Effective: December 31, 2026.
- FMAP Penalty
  - → Reduction in federal match by 10% for expansion states that provide Medicaid coverage for undocumented individuals – from 90% to 80%. Effective: October 1, 2027.
- Work Requirements/Community Engagement
  - → 80 hours for 19-64 age group (without dependents), with exemption for medically frail as defined by state. Eliminates the discretion of future administrations to waive work requirements for various populations. Effective: December 31, 2026, with guidance for states to adopt as soon as December 31, 2025.

Major Provisons in the House Reconciliation Bill

- Supplemental Payments
  - → Freeze on state provider tax rates; prohibits states from increasing the amount or rate of an existing provider tax and/or establishing new provider taxes. Effective: Upon enactment.
  - → Provider Tax Requirements: tightens requirements for uniform taxes, requires states to modify models to comply with requirements. Effective: Upon enactment. Subject to transition period as determined by HHS Secretary, not to exceed 3 years.
  - → State Directed Payments: limits new state-directed payments (SDPs) for services provided to 100% of Medicare rates (for expansion states).

    *According to CHA, could result in cuts of $10 billion (2% of total hospital Medicaid revenue)
- Redeterminations
  - → Requires Redeterminations for adults in expansion population (19-64) every 6 months. Effective: December 31, 2026.

Major Provisons in the House Reconciliation Bill

- Gender Services
  - → No federal match for gender transition procedures for children and adults. Effective: Upon enactment.
- Assets
  - → $1M ceiling for permissible home equity values for LTSS eligibility. Effective: January 1, 2028.
- Retroactive Coverage
  - → Restricted to 1 month (currently 3 months) before application. Effective: December 31, 2026.
- Provider Screening
  - → Requires states to conduct monthly checks to determine whether HHS or another state has already terminated a provider/supplier in Medicaid and to disenroll them from the program. Effective: January 1, 2028.

Major Provisons in the House Reconciliation Bill

- Cost Sharing for Expansion Adults (19-64 age group)
  - → Cost sharing for adults over 100% FPL. Effective: October 1, 2028.
  - → Max $35 copay/service
  - → No cost share for primary care, prenatal care, pediatric care, or emergency room care (except for non-emergency care provided in an emergency room).
- Beneficiary Addresses
  - → Requires states to obtain correct member addresses. Effective: October 1, 2029.
  - → Requires states to submit Social Security Numbers and other information to HHS to prevent duplicate enrollment. Effective: October 1, 2029.

Next Steps in Reconcilation Process

- Senate Amends the House Package (H.R. 1, the One Big Beautiful Bill Act)
- Senate Reconciliation Package goes through “Byrd Bath” to determine whether any provisions need to be excluded.
- Senate votes on Reconciliation Package
- House and Senate resolve differences and vote on a final reconciliation bill that goes to the president.
- President signs bill into law. Current goal is to have it to the president by July 4th.

Reconciliation Bill and Impacts to California

- Medicaid (Medi-Cal) coverage could be stripped from up to 3.4 million Californians and cost the state over $30 million in lost federal funding.
  - → Redetermination provision (every 6 months) could cause up to 400,00 Californians in expansion population to lose their coverage.
  - → Work requirement provision could lead to a loss of up to $22.3 billion in federal funding and cause up to 3 million to lose coverage.
  - → FMAP penalty for covering undocumented population could lead to loss of $4.4 billion.
  - → State funding tools:
    - Freezing provider taxes
    - Provider tax requirements
    - State directed payments

State Budget: Governor's May Revise and Legislature's Proposals

ALAMEDA Alliance FOR HEALTH

Revised Budget and Shortfall

- On May 14th, Governor Newsom released his 2024-25 $321.9 billion *($226.4 billion GF)* budget proposal, a decrease of $400 million from his January Budget.
- The revised budget projects a deficit of $12 billion, compared to his January budget which forecasted a $16.5 billion surplus.
- The balanced budget proposed the following:
  - $15.7 billion, a decrease of $2.7 billion from the January Budget.
  - $11.2 billion in Budget Stabilization Account, an increase of $300 million from the January Budget.
  - $4.5 billion in Special Fund for Economic Uncertainties, no change from the January Budget.
  - $1.5 billion earmarked in the January Budget for the Public School System Stabilization Account is not reflected in the May Revision.

Revised Budget and Shortfall

- Medi-Cal is mentioned as a key source of expenditure growth and reason for increased budget shortfall as well federal government policies and proposals that have destabilized the state's economic conditions.
- Medi-Cal expenditures continue to grow and outpace revenues. References the $3.4 billion cash flow loan that DHCS obtained and the additional $2.8 billion approved by the legislature for the Medi-Cal program in March and April 2025.
- Increased costs for the Medi-Cal program are attributed to higher overall enrollment, pharmacy costs, and higher managed care costs. Major cost drivers include:
  - Increase for undocumented members
  - Higher enrollment/utilization resulting from continuation of unwinding flexibilities
  - Repayment of Medical Providers Interim Payment Fund loan
  - Offset reduction related to MCO tax.

Medi-Cal Budget Proposals

- Medi-Cal cuts that would impact the undocumented population:
  - Enrollment freeze for full-scope Medi-Cal for adults, starting 1/1/2026.
  - $100 monthly premiums, beginning 1/1/2027.
  - Elimination of long-term care coverage, starting 1/1/2026.
  - Elimination of dental benefits for adults, starting 7/1/2026.
    - →Does not include restricted-scope emergency dental coverage
  - Reduction in funding for FQHCs and Rural Health Clinics for undocumented population (via elimination of PPS rates) in 2026-2027.
  - Implement a pharmacy rebate aggregator for the undocumented population.

Medi-Cal Budget Proposals

- Medical Loss Ratio (MLR) – increase the minimum MLR for Managed Care Organizations to 90% (from current 85%), beginning 1/1/2026.
- Provider Supplemental Payments
  - Elimination of Prop 56 payments for dental, family planning and women's health providers
  - Elimination of the Workforce and Quality Incentive Program (Skilled Nursing Facility)
- Governor moving MCO tax dollars to offset Medi-Cal budget (lawsuit?)

Medi-Cal Budget Proposals

- Other Medi-Cal Cuts
  - Reinstating Medi-Cal asset limits.
  - Elimination of acupuncture as an optional benefit.
  - Implementation of prior authorization requirements for hospice services.
  - Limiting payments to PACE providers.
- CalAIM
  - Continues to fund ECM and Community Supports (including transitional rent) with estimated $2.4 billion in expenses.
  - $200 million from Prop 35 to support Flexible Housing Pool rental assistance and housing supports over two years.

Pharmacy Budget Proposals

- Includes policies aimed at addressing pharmacy costs within the Medi-Cal program, including:
  - Minimum rebate for HIV/AIDS and cancer drug rebates
  - Elimination of pharmacy coverage for COVID-19 tests (out of network), OTC vitamins, and certain antihistamines.
  - Ongoing implementation of UM and PA policies.
  - Implementation of a step therapy strategy.
  - Elimination of weight loss drugs (GL-Ps).

IHSS Budget Proposals

- Includes reductions to In-Home Supportive Services, including:
  - Reduction to conform IHSS with Medi-Cal asset limit reinstatement
  - Elimination of IHSS benefits for undocumented population.
  - Reduction to conform the IHSS Residual Program coverage, a program available to individuals who are not eligible for full-scope Medi-Cal, with the timing of Medi-Cal coverage.
  - Reduction and ongoing cap on IHSS provider overtime and travel at 50 hours, a decrease from the current 60–70-hour cap beginning 2025-26.

Legislature's Budget Version

- On June 9th, Assembly and Senate Leaders announced a Budget Plan which includes the following budget solutions of note:
  - Modifies Medi-Cal enrollment freeze proposal, applying to UIS 19 years and older, beginning 1/1/2026 and establishes a 6-month re-enrollment grace period for those that fall off the rolls. Clarifies that an individual cannot 'age out' of the program.
  - Modifies $100 Medi-Cal premiums for UIS population by lowering to $30 per month, limits to those aged 19-59, and postpones to 1/1/2027.
  - Delays elimination of dental benefits for UIS population until 7/1/2027.
  - Restores the Medi-Cal Asset Limit to $130k for an individual and $195K for a couple.
  - Approves Governor's proposal on weight loss drugs.
  - Delays implementation of PA for hospice services in Medi-Cal to 7/1/2026.

Legislature's Budget Version

- Assembly and Senate Budget Plan continued:
  - Delays Prop 56 supplemental payments for dental until 7/1/2027 and rejects Prop 56 supplemental payments for family panning and women's health.
  - Delays the proposed $1.1B cuts to Health Centers and Rural clinics until 7/1/2027.
  - Adjusts rebate aggregator for prescription drugs for UIS population.
  - Approves Governor's MCO tax proposal.
  - Rejects proposal to eliminate LTC and IHSS for UIS adults.
  - Rejects proposal to eliminate acupuncture benefit.
  - Approves Governor's proposal to eliminates the Workforce and Quality Incentive Program for SNFs.
  - Proposes the development of a large employer contribution requirement for employers with employees enrolled in Medi-Cal.

What happens next?

- Assembly and Senate leaders vote on and pass a Budget Act by June 15th
- The Governor and the legislature negotiate to reach a three-party deal on the Budget Package.
- The Governor signs the Budget Package and any accompanying budget bill jrs. and trailer bills.
- If the federal reconciliation bill passes, legislators will have to come back for a special budget session in the fall.

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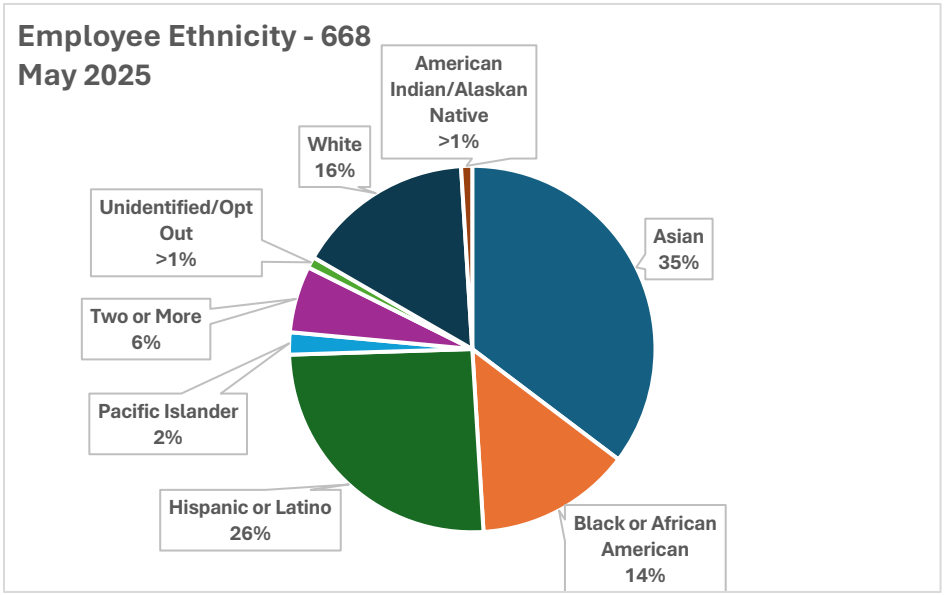
Demographics

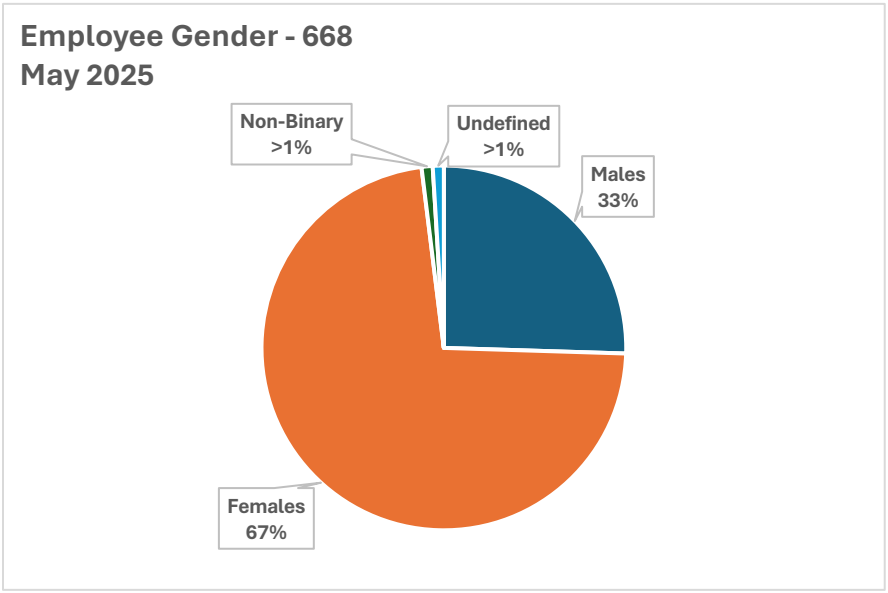
The purpose of this report is to conduct a comparative analysis of the demographic composition of Alameda Alliance for Health's workforce and the population distribution of Alameda County. The primary focus of this comparison will be on key metrics, including race/ethnicity, gender, and age distribution. Through the analysis of these data points, our objective is to evaluate the extent to which our workforce reflects the county's population and to pinpoint areas for enhancing diversity, equity, and inclusion.

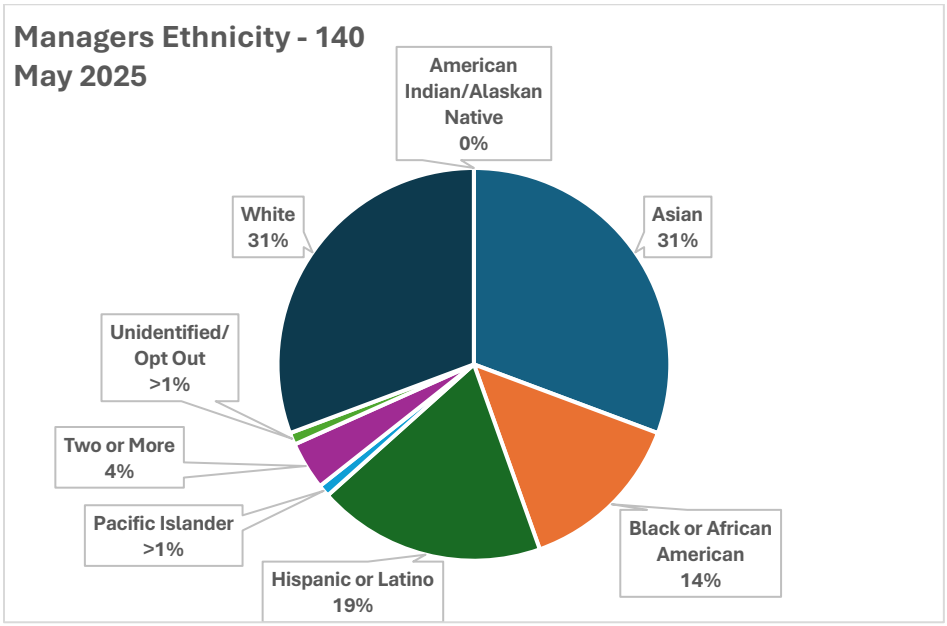
The demographic data for the county, including the total population and demographic breakdown, is sourced from Healthy Alameda County, which is sponsored by the Alameda County Public Health Department. This site serves as a central repository of information related to Alameda County, providing the most current data and over 250 community wellbeing indicators (Healthy Alameda County :: Demographics :: County :: Alameda). The information presented in this report was last updated in May 2025. Additionally, the data used for Alameda Alliance for Health was last updated in May 2025 and is collected and maintained monthly by the Human Resources Department internally.

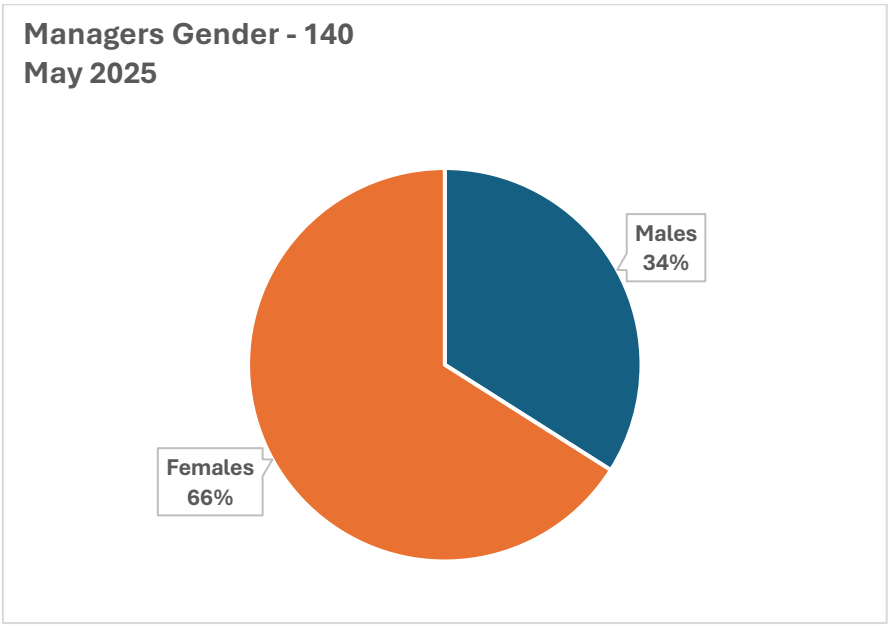
Category	**Alameda Alliance for Health** (Workforce information last updated May 2025)	**Alameda County** (Population Information last updated in May 2025)
Population/Total Employees	668	1,626,575
Race & Ethnicity		
Asian	36%	35.39%
Hispanic	26%	23.94%
White	16%	28.26%
Black/African American	14%	9.15%
Native Hawaiian/Pacific Islander	2%	0.82%
American Indian/Alaskan Native	>1%	1.18%
Two or More Races	6%	11.62%
Unidentified/Opt Out	>1%	-
Gender		
Male	26%	49.67%
Female	74%	50.33%
Non-Binary	>1%	-
Undefined	>1%	-
Age Distribution		
Under 25	>1%	8.33%
25-34	21%	14.34%
35-44	36%	15.89%
45-54	25%	13.44%
55-Older	17%	27.65%

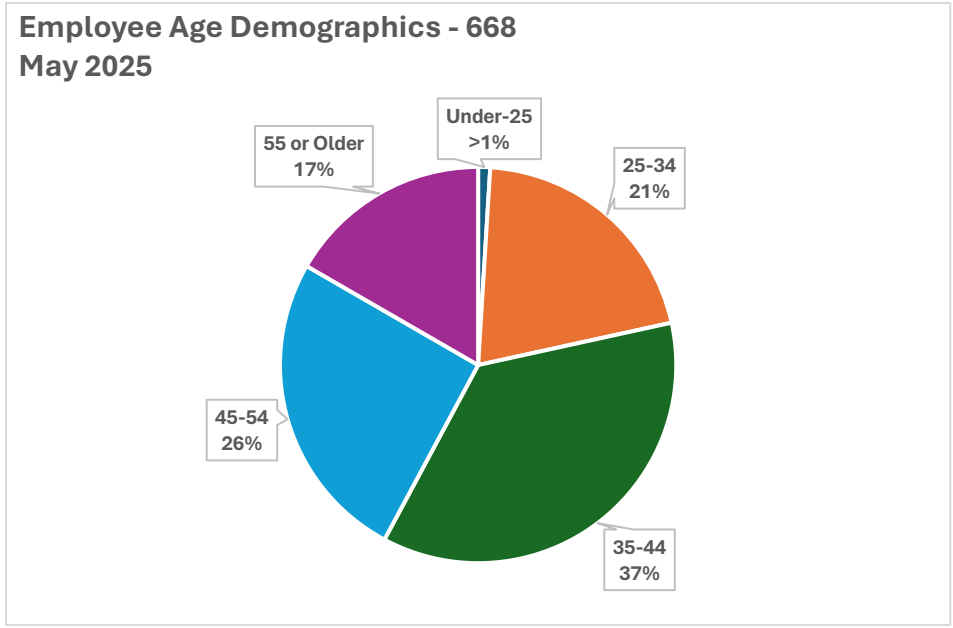
AAH Employee Demographics Data Report May 2025










Employee Age Demographics - 668
May 2025
Under-25
>1%
25-34
21%
35-44
37%
45-54
26%
55 or Older
17%

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Legislative Tracking

2025 –2026 Legislative Tracking List

Last month, Governor Newsom released the May Revision of his proposed State Budget which includes proposals that would make major cuts to the Medi-Cal program and cause many low-income families to lose health coverage. The Governor noted that the proposed budget does not consider possible cuts to the Medicaid (Medi-Cal) program. Meanwhile, state legislators have been working to move bills through the legislature and will continue to hold convenings to review the budget proposal with the goal of reaching a unified version of the budget package to vote on and pass by June 15th.

The following is a list of state bills tracked by the Public Affairs and Compliance Departments. These bills are of interest to and could have a direct impact on the Alameda Alliance for Health and its membership.

AB 4 **(Arambula D) Covered California expansion.**
Current Text: Introduced: 12/2/2024 html pdf
Introduced: 12/2/2024
Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 4/23/2025)(May be acted upon Jan 2026)

Desk	Policy	2 year	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing federal law, the Patient Protection and Affordable Care Act (PPACA), requires each state to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. Existing state law creates the California Health Benefit Exchange, also known as Covered California, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA. Existing law requires the Exchange to apply for a federal waiver to allow persons otherwise not able to obtain coverage through the Exchange because of their immigration status to obtain coverage from the Exchange. This bill would delete that requirement and would instead require the Exchange, no sooner than January 1, 2027, and upon appropriation by the Legislature for this purpose, to administer a program to allow persons otherwise not able to obtain coverage by reason of immigration status to enroll in health insurance coverage in a manner as substantially similar to other Californians as feasible, consistent with federal guidance and given existing federal law and rules. The bill would require the Exchange to undertake outreach, marketing, and other efforts to ensure enrollment, which would begin on October 1, 2028. The bill would also require the Exchange to adopt an annual program design for each coverage year to implement the program, provide appropriate opportunities for stakeholders, including the Legislature, and the public to consult on the design of the program, and report to the Department of Finance and the Legislature on progress toward implementation, as specified. The bill would establish the Covered California for All Fund in the General Fund, to be administered by the Exchange, into which user fees, appropriations, and other funds would be deposited to be used upon appropriation to pay for the administration of the program.

AB 29 **(Arambula D) Medi-Cal: Adverse Childhood Experiences trauma screenings: providers.**
Current Text: Amended: 3/19/2025 html pdf
Introduced: 12/2/2024
Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 4/23/2025)(May be acted upon Jan 2026)

Desk	Policy	2 year	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law requires that Medi-Cal provider

payments and payments for specified non-Medi-Cal programs be reduced by 10% for dates of service on and after June 1, 2011, and conditions implementation of those payment reductions on receipt of any necessary federal approvals. Existing law, for dates of service on and after July 1, 2022, authorizes the maintenance of the reimbursement rates or payments for specified services, including, among others, Adverse Childhood Experiences (ACEs) trauma screenings and specified providers, using General Fund or other state funds appropriated to the State Department of Health Care Services as the state share, at the payment levels in effect on December 31, 2021, as specified, under the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 that were implemented with funds from the Healthcare Treatment Fund, as specified. Existing law requires the department to develop the eligibility criteria, methodologies, and parameters for the payments and rate increases maintained, and would authorize revisions, as specified. This bill would require the department, as part of its above-described duties, to include (1)community-based organizations and local health jurisdictions that provide health services through community health workers and (2)doulas, that are enrolled Medi-Cal providers, as providers qualified to provide, and eligible to receive payments for, ACEs trauma screenings pursuant to the provisions described above. The bill would require the department to require these providers to make clinical or other appropriate referrals, as specified, as a condition of payment for conducting ACEs trauma screenings. The bill would require the department to file a state plan amendment and seek any federal approvals it deems necessary to implement these provisions and condition implementation on receipt of any necessary federal approvals and the availability of federal financial participation. The bill would also require the department to update its internet website and the ACEs Aware internet website to reflect the addition of the Medi-Cal providers described above as authorized to provide ACEs screenings. The bill would authorize the department to implement, interpret, or make specific these provisions by means of a provider manual, provider bulletins or notices, policy letters, or other similar instructions, without taking regulatory action.

AB 37 **(Elhawary D) Workforce development: mental health service providers: homelessness.**
Current Text: Amended: 3/13/2025 html pdf
Introduced: 12/2/2024
Status: 5/1/2025-Failed Deadline pursuant to Rule 61(a)(2). (Last location was L. & E. on 3/13/2025)(May be acted upon Jan 2026)

Desk	2 year	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law establishes the California Workforce Development Board as the body responsible for assisting the Governor in the development, oversight, and continuous improvement of California's workforce investment system and the alignment of the education and workforce investment systems to the needs of the 21st century economy and workforce. Existing law requires the board to assist the Governor in certain activities, including the review and technical assistance of statewide policies, programs, and recommendations to support workforce development systems in the state, as specified. This bill would require the board to study how to expand the workforce of mental health service providers who provide services to homeless persons.

AB 40 **(Bonta D) Emergency services and care.**
Current Text: Amended: 3/5/2025 html pdf
Introduced: 12/2/2024
Status: 5/7/2025-Referred to Com. on HEALTH.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law provides for the licensing and regulation of health facilities by the State Department of Public Health and makes a violation of those provisions a crime. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law requires a health facility to provide emergency services and care upon request or when a person is in danger of loss of life or serious injury or illness and requires a health care service plan to reimburse providers for emergency services and care. Existing law defines "emergency services and care" for these purposes to mean medical screening, examination, and evaluation by a physician and surgeon, or other appropriate licensed persons under the supervision of a physician and surgeon, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person's

license, necessary to relieve or eliminate the emergency medical condition, within the capability of the facility, among other things. This bill would additionally define "emergency services and care" for the above-described purposes to mean reproductive health services, including abortion. By expanding the applicability of a crime with respect to health facilities and health care service plans, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 45 **(Bauer-Kahan D) Privacy: health data: location and research.**
Current Text: Amended: 4/9/2025 html pdf
Introduced: 12/2/2024
Status: 6/4/2025-In Senate. Read first time. To Com. on RLS. for assignment.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law prohibits a person or business, as defined, from collecting, using, disclosing, or retaining the personal information of a person who is physically located at, or within a precise geolocation of, a family planning center, as defined, except as necessary to perform the services or provide the goods requested and not sold or shared. Existing law authorizes an aggrieved person or entity to institute and prosecute a civil action against a person or business for a violation of these provisions and specify damages and costs authorized to be recovered. This bill would recast the above-described provisions, and instead prohibit the collection, use, disclosure, sale, sharing, or retention of the personal information of a natural person who is physically located at, or within a precise geolocation of, a family planning center, except collection or use as necessary to perform the services or provide the goods requested. The bill would authorize an aggrieved person to institute and prosecute a civil action against a natural person, association, proprietorship, corporation, trust, foundation, partnership, or any other organization or group of people acting in concert for a violation of these provisions. The bill would also make other nonsubstantive changes. This bill would, subject to specified exceptions, prohibit geofencing, or selling or sharing personal information with a third party to geofence, as defined, an entity that provides in-person health care services in California for specified purposes, and would prohibit the use of personal information obtained in violation of this provision. The bill would provide that violators are subject to an injunction and liable for a civil penalty assessed and recovered in a civil action brought by the Attorney General and deposited in the California Reproductive Justice and Freedom Fund. The bill would also provide that a statement signed under penalty of perjury, as specified, that the personal information will not be used for selling or sharing personal information in violation of these geofencing provisions is prima facie evidence that the personal information was not sold or shared in violation of these geofencing provisions. By expanding the crime of perjury, this bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 49 **(Muratsuchi D) Schoolsites: immigration enforcement.**
Current Text: Amended: 4/21/2025 html pdf
Introduced: 12/2/2024
Status: 6/4/2025-Referred to Coms. on ED. and JUD.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law prohibits, except as required by state or federal law or as required to administer a state or federally supported educational program, school officials and employees of a school district, county office of education, or charter school from collecting information or documents regarding citizenship or immigration status of pupils or their family members. Existing law requires the superintendent of a school district, the superintendent of a county office of education, and the principal of a charter school, as applicable, to report to the respective governing board or body of the local educational agency in a timely manner any requests for information or access to a school site by an officer or employee of a law enforcement agency for the purpose of enforcing the immigration laws in a manner that ensures the confidentiality and privacy of any potentially identifying information. This bill would prohibit school officials and employees of a local educational agency from allowing an officer or employee of an agency conducting immigration enforcement to enter a school site for any purpose without providing valid identification and a valid judicial warrant, a court order, or exigent circumstances necessitating immediate action. The bill would require the local educational agency, if the officer or employee meets those requirements, to limit access to facilities where pupils are not present. By imposing additional duties on local educational agencies, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

ALAMEDA Alliance FOR HEALTH

AB 50 **(Bonta D) Pharmacists: furnishing contraceptives.**
Current Text: Amended: 4/2/2025 html pdf
Introduced: 12/2/2024
Status: 5/7/2025-Referred to Com. on B. P. & E.D.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law, the Pharmacy Law, establishes in the Department of Consumer Affairs the California State Board of Pharmacy to license and regulate the practice of pharmacy. Exiting law requires a pharmacist, when furnishing self-administered hormonal contraceptives, to follow specified standardized procedures or protocols developed and approved by both the board and the Medical Board of California in consultation with the American Congress of Obstetricians and Gynecologists, the California Pharmacists Association, and other appropriate entities. Existing law requires those standardized procedures or protocols to require that the patient use a self-screening tool that will identify related patient risk factors and that require the pharmacist to refer the patient for appropriate follow-up care, as specified. Existing law requires the pharmacist to provide the recipient of the drug with a standardized factsheet that includes the indications and contraindications for use of the drug, the appropriate method for using the drug, the need for medical followup, and other appropriate information. Existing law authorizes a pharmacist furnishing an FDA-approved, self-administered hormonal contraceptive pursuant to the above-described protocols to furnish, at the patient's request, up to a 12-month supply at one time. This bill would limit the application of those requirements to self-administered hormonal contraceptives that are prescription-only, and would authorize a pharmacist to furnish over-the-counter contraceptives without following those standardized procedures or protocols. The bill would additionally authorize a pharmacist to furnish up to a 12-month supply at one time of over-the-counter contraceptives at the patient's request. The bill would make related conforming changes. This bill contains other related provisions.

AB 54 **(Krell D) Access to Safe Abortion Care Act.**
Current Text: Amended: 3/17/2025 html pdf
Introduced: 12/2/2024
Status: 5/21/2025-Referred to Coms. on HEALTH and JUD.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law sets forth provisions, under the California Constitution, regarding the fundamental right to choose to have an abortion. Existing law, the Reproductive Privacy Act, prohibits the state from denying or interfering with a pregnant person's right to choose or obtain an abortion prior to viability of the fetus, or when the abortion is necessary to protect the life or health of the pregnant person. This bill, the Access to Safe Abortion Care Act, would make legislative findings about medication abortion, with a focus on use of the drugs mifepristone and misoprostol. Under the bill, the Legislature would reaffirm that it has been, and would continue to be, lawful to cause the delivery of, or mail, ship, take, receive, or otherwise transport, any drug, medicine, or instrument that can be designed or adapted to produce an abortion that is lawful in the State of California. The bill would set forth provisions regarding the lack of civil or criminal liability, or professional disciplinary action, for accessing or administering mifepristone or misoprostol, among other certain conduct, on or after January 1, 2020, with this provision applied retroactively, as specified. The bill would make its provisions severable.

AB 55 **(Bonta D) Alternative birth centers: licensing and Medi-Cal reimbursement.**
Current Text: Amended: 5/29/2025 html pdf
Introduced: 12/2/2024
Status: 5/29/2025-From committee chair, with author's amendments: Amend, and re-refer to committee. Read second time, amended, and re-referred to Com. on HEALTH.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law provides for the licensure and regulation of various types of clinics, including alternative birth centers, by the State Department of Public Health, and makes a violation of those provisions a crime. Existing law defines an alternative birth center as a clinic that is not part of a hospital and that provides comprehensive perinatal services and delivery care to pregnant women who remain less than 24 hours at the facility. Existing law requires a licensed alternative birth center specialty clinic, and a licensed primary care clinic that provides services as an alternative birth center, to meet certain criteria, including, among others, being located in proximity to a facility with the capacity for management of obstetrical and neonatal emergencies, as specified. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law sets forth certain criteria for Medi-Cal reimbursement to alternative birth centers for facility-related delivery costs. Under existing law, as a criterion under both the licensing provisions and the Medi-Cal reimbursement provisions described above, the facility is required to be a provider of comprehensive perinatal services as defined in the Medi-Cal provisions. This bill would remove, under both sets of criteria, the certification condition of being a provider of comprehensive perinatal services as defined in the Medi-Cal provisions. The bill would require the facility to provide pregnancy and postpartum services, consistent with certain standards. The bill would remove the above-described proximity requirement and would instead require a written policy for hospital transfer. The bill would require the policy to include certain requirements with regard to providing the hospital with specified medical records, speaking with the receiving provider, and providing patients and clients with the estimated transfer time, including a clear explanation of the facility's overall emergency transfer plan, as specified. This bill contains other related provisions and other existing laws.

AB 67 **(Bauer-Kahan D) Attorney General: Reproductive Privacy Act: enforcement.**
Current Text: Amended: 4/23/2025 html pdf
Introduced: 12/4/2024
Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/14/2025)(May be acted upon Jan 2026)

Desk	Policy	2 year	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law, the Reproductive Privacy Act, prohibits a person from being subject to civil or criminal liability, or otherwise deprived of their rights, based on their actions or omissions with respect to their pregnancy or actual, potential, or alleged pregnancy outcome or based solely on their actions to aid or assist a woman or pregnant person who is exercising their reproductive rights as specified in the act. Existing law authorizes a party whose rights are protected by the Reproductive Privacy Act to bring a civil action against an offending state actor when those rights are interfered with by conduct or by statute, ordinance, or other state or local rule, regulation, or enactment in violation of the act, as specified, and require a court, upon a motion, to award reasonable attorneys' fees and costs to a prevailing plaintiff. This bill would authorize the Attorney General, if it appears to them that a person has engaged, or is about to engage, in any act or practice constituting a violation of the Reproductive Privacy Act, to bring an action in the name of the people of the State of California in the superior court to enjoin the acts or practices or to enforce compliance with the act, as specified. In this context, the bill would authorize the Attorney General to make public or private investigations, publish information concerning violation of the Reproductive Privacy Act, and subpoena witnesses, compel their attendance, take evidence, and require the production of documents or records that they deem relevant or material to the inquiry. This bill would impose a civil penalty not exceeding $25,000 upon any person or governmental entity that violates any provision of the act and a civil penalty for violation of the bill's provisions, to be determined as specified. The bill would require any costs, fees, and civil penalties collected pursuant to these provisions to be available to the office of the Attorney General upon appropriation of the Legislature for exclusive use by the Attorney General for enforcement of act. This bill contains other related provisions and other existing laws.

AB 73 **(Jackson D) Mental Health: Black Mental Health Navigator Certification.**
Current Text: Introduced: 12/12/2024 html pdf
Introduced: 12/12/2024
Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 4/9/2025)(May be acted upon Jan 2026)

Desk	Policy	2 year	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law establishes, within the Health and Welfare Agency, the Department of Health Care Access and Information, which is responsible for, among other things, administering various health professions training and development programs. Existing law requires the department to develop and approve statewide requirements for community health worker certificate programs. Existing law defines "community health worker" to mean a liaison, link, or intermediary between health and social services and the community to facilitate access to services and to improve the access and cultural competence of service delivery. This bill would require the department to develop criteria for a specialty certificate program and specialized training requirements for a Black Mental Health Navigator Certification, as specified. The bill would require the department to collect and regularly publish data, not less than annually, including, but not limited to, the number of individuals certified, including those who complete a specialty certificate program, as specified, and the number of individuals who are actively employed in a community health worker role. The bill would make these provisions subject to an appropriation by the Legislature.

AB 92 **(Gallagher R) Patient visitation.**
Current Text: Introduced: 1/6/2025 html pdf
Introduced: 1/6/2025
Status: 5/1/2025-Failed Deadline pursuant to Rule 61(a)(2). (Last location was HEALTH on 2/3/2025)(May be acted upon Jan 2026)

Desk	2 year	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law provides for the licensure and regulation by the State Department of Public Health of health facilities, as defined. Existing law requires a health facility to allow a patient's domestic partner, the children of the patient's domestic partner, and the domestic partner of the patient's parent or child to visit unless no visitors are allowed, the facility reasonably determines that the presence of a particular visitor would endanger the health or safety of a patient, member of the health facility staff, or other visitor to the health facility, or would significantly disrupt the operations of a facility, or the patient has indicated to the health facility staff that the patient does not want this person to visit. A violation of this provision is a misdemeanor. This bill, Dianne's Law, would require a health facility to allow specified persons to visit, including the patient's children and grandparents. The bill would require the health facility to develop alternate visitation protocols, if circumstances require the health facility to restrict visitor access to the facility due to health or safety concerns, that allow visitation to the greatest extent possible while maintaining patient, visitor, and staff health and safety. Notwithstanding the requirement mentioned above, the bill would prohibit a health facility from prohibiting in-person visitation in end-of-life situations unless the patient has indicated to the health facility staff that the patient does not want this person to visit, as specified, and would authorize a health facility to require visitors to adhere to personal protective equipment and testing protocols not greater than those required of facility staff for the duration of their visit. The bill would also require the facility to provide personal protective equipment and testing resources to each visitor for a patient in an end-of-life situation, to the extent that those resources have been made readily available to the facility by state or local entities for that purpose. By expanding an existing crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 96 **(Jackson D) Community health workers.**
Current Text: Amended: 2/11/2025 html pdf
Introduced: 1/7/2025
Status: 5/1/2025-Failed Deadline pursuant to Rule 61(a)(2). (Last location was HEALTH on 2/3/2025)(May be acted upon Jan 2026)

Desk	2 year	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law required the Department of Health Care Access and Information, on or before July 1, 2023, to develop and approve statewide requirements for community health worker certificate programs. Existing law requires the

department, as part of developing those requirements, to, among other things, determine the necessary curriculum to meet certificate program objectives. Existing law defines "community health worker" for these purposes to mean a liaison, link, or intermediary between health and social services and the community to facilitate access to services and to improve the access and cultural competence of service delivery. Existing law specifies that "community health worker" include Promotores, Promotores de Salud, Community Health Representatives, navigators, and other nonlicensed health workers with the qualifications developed by the department. This bill would also specify for these purposes that a "community health worker" includes a peer support specialist and would deem a certified peer support specialist to have satisfied all education and training requirements developed by the department for certification as a community health worker.

AB 220 **(Jackson D) Medi-Cal: subacute care services.**
Current Text: Introduced: 1/8/2025 html pdf
Introduced: 1/8/2025
Status: 5/29/2025-Read third time. Passed. Ordered to the Senate. (Ayes 70. Noes 0.) In Senate. Read first time. To Com. on RLS. for assignment.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law requires the department to establish a subacute care program in health facilities, as specified, to be available to patients in health facilities who meet subacute care criteria. Existing law requires that medical necessity for pediatric subacute care be substantiated by specified conditions. Existing regulations require a treatment authorization request for each admission to a subacute unit. This bill would require a health facility that provides pediatric subacute or adult subacute care services pursuant to these provisions to submit with a treatment authorization request, including an electronic treatment authorization request, a specified form when requesting authorization for subacute care services. The bill would prohibit a Medi-Cal managed care plan from developing or using its own criteria to substantiate medical necessity for pediatric subacute or adult subacute care services with a condition or standard not enumerated in those forms. The bill would require the department to develop and implement procedures, and authorize the department to impose sanctions, to ensure that a Medi-Cal managed care plan complies with these provisions.

AB 224 **(Bonta D) Health care coverage: essential health benefits.**
Current Text: Amended: 4/23/2025 html pdf
Introduced: 1/9/2025
Status: 5/29/2025-Read third time. Passed. Ordered to the Senate. (Ayes 60. Noes 1.) In Senate. Read first time. To Com. on RLS. for assignment.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, requires the Department of Managed Health Care to license and regulate health care service plans and makes a willful violation of the act a crime. Existing law requires the Department of Insurance to regulate health insurers. Existing law requires an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2017, to include, at a minimum, coverage for essential health benefits pursuant to the federal Patient Protection and Affordable Care Act. Existing law requires a health care service plan contract or health insurance policy to cover the same health benefits that the benchmark plan, the Kaiser Foundation Health Plan Small Group HMO 30 plan, offered during the first quarter of 2014, as specified. This bill would express the intent of the Legislature to review California's essential health benefits benchmark plan and establish a new benchmark plan for the 2027 plan year. The bill would require, commencing January 1, 2027, if the United States Department of Health and Human Services approves a new essential health benefits benchmark plan for the state, as specified, the benchmark plan identified above to include certain additional benefits, including coverage for specified fertility services and specified durable medical equipment. Because a violation of the bill by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other existing laws.

AB 225 **(Bonta D) State hospitals for persons with mental health disorders: patient funds.**
Current Text: Introduced: 1/9/2025 html pdf
Introduced: 1/9/2025
Status: 5/7/2025-Referred to Com. on HEALTH.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law sets forth various functions and duties for the State Department of State Hospitals with respect to the administration of state institutions for the care and treatment of persons with mental health disorders. Existing law authorizes the Director of State Hospitals to deposit funds of patients in trust, as specified. Existing law also authorizes the hospital administrator, with the consent of the patient, to deposit the interest or increment on the funds of the patient in the state hospital in a special fund for each state hospital, designated the "Benefit Fund," and requires the hospital administrator to be the trustee of the fund. Existing law authorizes the hospital administrator, with the approval of the Director of State Hospitals, to expend moneys in the fund for the education or entertainment of the patients of the institution. Existing law requires that the hospital administrator take into consideration the recommendations of representatives of patient government and recommendations submitted by patient groups before expending any moneys in the fund. This bill would additionally authorize the funds to be expended for the welfare of the patients of the institution. The bill would require the hospital administrator of a state hospital to notify patients, patient governments, and patient groups, in writing, about any newly authorized expenditure options for the benefit fund, when applicable.

AB 228 **(Sanchez R) Pupil health: epinephrine delivery systems.**
Current Text: Introduced: 1/13/2025 html pdf
Introduced: 1/13/2025
Status: 5/23/2025-In committee: Hearing postponed by committee.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law requires school districts, county offices of education, and charter schools to provide emergency epinephrine auto-injectors to school nurses or trained volunteer personnel, and authorizes school nurses and trained personnel to use epinephrine auto-injectors to provide emergency medical aid to persons suffering, or reasonably believed to be suffering, from an anaphylactic reaction, as provided. Existing law requires school districts, county offices of education, and charter schools to, among other things, store those emergency epinephrine auto-injectors in an accessible location upon need for emergency use and include that location in specified annual notices. Existing law authorizes a pupil to carry and self-administer prescription auto-injectable epinephrine if the school district receives specified written statements from a physician and surgeon or a physician assistant, and from the parent, foster parent, or guardian of the pupil, as specified. This bill would replace all references to epinephrine auto-injectors or auto-injectable epinephrine in the above-described provisions with references instead to epinephrine delivery systems, as defined, and would require school districts, county offices of education, and charter schools to instead provide at least one type of United States Food and Drug Administration-approved epinephrine delivery system, as specified. To the extent the bill would impose additional duties on local educational agencies, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 242 **(Boerner D) Genetic disease screening.**
Current Text: Introduced: 1/14/2025 html pdf
Introduced: 1/14/2025
Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 4/23/2025)(May be acted upon Jan 2026)

Desk	Policy	2 year	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law requires the State Department of Public Health to establish a program for the development, provision, and evaluation of genetic disease testing. This bill would require the department to expand statewide screening of newborns to include screening for Duchenne muscular dystrophy as soon as possible, but no later than

January 1, 2027. By expanding the purposes for which moneys from the Genetic Disease Testing Fund (GDTF) may be expended, this bill would make an appropriation. This bill contains other existing laws.

AB 260 **(Aguiar-Curry D) Sexual and reproductive health care.**
Current Text: Amended: 6/2/2025 html pdf
Introduced: 1/16/2025
Status: 6/2/2025-From committee chair, with author's amendments: Amend, and re-refer to committee. Read second time, amended, and re-referred to Com. on HEALTH.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: The California Constitution provides for the fundamental rights of privacy and to choose to have an abortion. Existing law, the Reproductive Privacy Act, prohibits the state from denying or interfering with a pregnant person's right to choose or obtain an abortion before the viability of the fetus, or when the abortion is necessary to protect the life or health of the pregnant person. Existing law prohibits conditions or restrictions from being imposed on abortion access for incarcerated persons and committed juveniles. Existing laws requiring parental consent for abortion and making assisting in or advertising abortion a crime have been held to be unconstitutional. This bill would repeal those unconstitutional provisions and delete obsolete references to criminal abortion penalties. The bill would make technical changes to provisions authorizing abortion for incarcerated and committed persons. This bill contains other related provisions and other existing laws.

AB 277 **(Alanis R) Behavioral health centers, facilities, and programs: background checks.**
Current Text: Amended: 4/22/2025 html pdf
Introduced: 1/21/2025
Status: 5/1/2025-Failed Deadline pursuant to Rule 61(a)(2). (Last location was HUM. S. on 2/10/2025)(May be acted upon Jan 2026)

Desk	2 year	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law generally provides requirements for the licensing of business establishments. Existing law requires a business that provides services to minors, as defined, to provide written notice to the parent or guardian of a minor participating in the service offered by the business regarding the business' policies relating to criminal background checks for employees, as specified. Existing law requires the Department of Justice to maintain state summary criminal history information, as defined, and to furnish this information as required by statute to specified entities, including a human resource agency or an employer. Under existing law, the disclosure of state summary criminal history information to an unauthorized person is a crime. This bill would require a person who provides behavioral health treatment for a behavioral health center, facility, or program to undergo a background check, as specified. By expanding the scope of the crime of unlawful disclosure of state summary criminal history information, this bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 278 **(Ransom D) Health care affordability.**
Current Text: Introduced: 1/21/2025 html pdf
Introduced: 1/21/2025
Status: 5/1/2025-Failed Deadline pursuant to Rule 61(a)(2). (Last location was HEALTH on 2/10/2025)(May be acted upon Jan 2026)

Desk	2 year	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law establishes the Office of Health Care Affordability within the Department of Health Care Access and Information to analyze the health care market for cost trends and drivers of spending, develop data-informed policies for lowering health care costs for consumers and purchasers, and create a state strategy for controlling the cost of health care. Existing law establishes the Health Care Affordability Board to establish, among other things, a statewide

health care cost target and the standards necessary to meet exemptions from health care cost targets or submitting data to the office. Existing law authorizes the office to establish advisory or technical committees, as necessary, in order to support the board's decisionmaking. This bill would require the board, on or before June 1, 2026, to establish a Patient Advocate Advisory Standing Committee, as specified, that is required to publicly meet, and receive public comments, at least 4 times annually. The bill would require the committee to include specified data from the meetings to the board as part of its annual report.

AB 280 **(Aguiar-Curry D) Health care coverage: provider directories.**
Current Text: Amended: 5/23/2025 html pdf
Introduced: 1/21/2025
Status: 6/3/2025-In Senate. Read first time. To Com. on RLS. for assignment.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan and a health insurer that contracts with providers for alternative rates of payment to publish and maintain a provider directory or directories with information on contracting providers that deliver health care services enrollees or insureds, and requires a health care service plan and health insurer to regularly update its printed and online provider directory or directories, as specified. Existing law authorizes the departments to require a plan or insurer to provide coverage for all covered health care services provided to an enrollee or insured who reasonably relied on materially inaccurate, incomplete, or misleading information contained in a plan's or insurer's provider directory or directories. This bill would require a plan or insurer to annually verify and delete inaccurate listings from its provider directories, and would require a provider directory to be 60% accurate on July 1, 2026, with increasing required percentage accuracy benchmarks to be met each year until the directories are 95% accurate on or before July 1, 2029. The bill would subject a plan or insurer to administrative penalties for failure to meet the prescribed benchmarks. The bill would require a plan or insurer to provide coverage for all covered health care services provided to an enrollee or insured who reasonably relied on inaccurate, incomplete, or misleading information contained in a health plan or policy's provider directory or directories and to reimburse the provider the out-of-network amount for those services. The bill would prohibit a provider from collecting an additional amount from an enrollee or insured other than the applicable in-network cost sharing. The bill would require a plan or insurer to provide information about in-network providers to enrollees and insureds upon request, and would limit the cost-sharing amounts an enrollee or insured is required to pay for services from those providers under specified circumstances. The bill would require the health care service plan or the insurer, as applicable, to ensure the accuracy of a request to add back a provider who was previously removed from a directory and approve the request within 10 business days of receipt, if accurate. Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 281 **(Gallagher R) Comprehensive sexual health education and human immunodeficiency virus (HIV) prevention education: outside consultants.**
Current Text: Amended: 3/17/2025 html pdf
Introduced: 1/22/2025
Status: 4/21/2025-Read second time. Ordered to third reading.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: The California Healthy Youth Act requires school districts, defined to include county boards of education, county superintendents of schools, the California School for the Deaf, the California School for the Blind, and charter schools, to ensure that all pupils in grades 7 to 12, inclusive, receive comprehensive sexual health education and human immunodeficiency virus (HIV) prevention education, as specified. The act authorizes a school district to provide that education earlier than grade 7 with age-appropriate and medically accurate information. The act authorizes a school district to provide sexual health education and HIV prevention to be taught by an outside consultant, and to hold an assembly to deliver that education by guest speakers. Under the act, if a school district exercises that authorization, the school district is required to provide notice of the date of instruction, name of the organization or affiliation of each guest

speaker, and information stating the right of the parent or guardian to request a copy of various laws, as specified. This bill would require a school district, if it elects to provide sexual health education or HIV prevention education to be taught by outside consultants, to also provide notice of the name of the organization or affiliation of the outside consultants.

AB 290 **(Bauer-Kahan D) California FAIR Plan Association: automatic payments.**
Current Text: Amended: 5/1/2025 html pdf
Introduced: 1/22/2025
Status: 5/28/2025-Referred to Com. on INS.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law establishes the California FAIR Plan Association, a joint reinsurance association in which all insurers licensed to write basic property insurance participate to administer a program for the equitable apportionment of basic property insurance for persons who are unable to obtain that coverage through normal channels. Existing law authorizes cancellation of an insurance policy for nonpayment of premium, and requires an insurer to notify a policyholder at least 10 business days before the policy will be canceled for nonpayment. This bill, on or before April 1, 2026, would require the California FAIR Plan Association to create an automatic payment system and accept automatic payments for premiums from policyholders. The bill would prohibit an automatic payment amount from being different than if the policyholder made a payment through another method. The bill would prohibit cancellation or nonrenewal of a FAIR Plan policy solely because the policyholder is not enrolled in automatic payments, except as specified. The bill would provide a 10-day grace period for the policyholder to pay any outstanding installment premium.

AB 298 **(Bonta D) Health care coverage cost sharing.**
Current Text: Amended: 3/4/2025 html pdf
Introduced: 1/23/2025
Status: 5/1/2025-Failed Deadline pursuant to Rule 61(a)(2). (Last location was HEALTH on 2/10/2025)(May be acted upon Jan 2026)

Desk	2 year	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law limits the copayment, coinsurance, deductible, and other cost sharing that may be imposed for specified health care services. This bill would prohibit a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2026, from imposing a deductible, coinsurance, copayment, or other cost-sharing requirement for in-network health care services, as defined, provided to an enrollee or insured under 21 years of age, except as otherwise specified. The bill would prohibit an individual or entity from billing or seeking reimbursement for in-network health care services provided to an enrollee or insured under 21 years of age, except as otherwise specified. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 302 **(Bauer-Kahan D) Confidentiality of Medical Information Act.**
Current Text: Amended: 5/1/2025 html pdf
Introduced: 1/23/2025
Status: 6/4/2025-Referred to Coms. on HEALTH and JUD.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law, the Confidentiality of Medical Information Act, prohibits a provider of health care, a health care service plan, or a contractor from disclosing medical information, as defined, regarding a patient of the provider of health care or an enrollee or subscriber of the health care service plan without first obtaining an authorization, except as

prescribed. The act punishes a violation of its provisions that results in economic loss or personal injury to a patient as a misdemeanor. This bill would revise the disclosure requirement relating to a court order to instead require disclosure if compelled by a court order issued by a California state court, including California state court orders relating to foreign subpoenas, as defined. The bill would revise the disclosure requirement relating to a search warrant to require disclosure if compelled by a warrant from another state based on another state's law so long as that law does not interfere with California law, and execution of the search warrant would not violate specified prohibitions against enforcement actions regarding lawful abortions. By narrowing the exceptions for disclosing medical information, and thereby expanding the crime of violating the act, this bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 309 **(Zbur D) Hypodermic needles and syringes.**
Current Text: Introduced: 1/23/2025 html pdf
Introduced: 1/23/2025
Status: 5/28/2025-Referred to Coms. on HEALTH and B. P. & E.D.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law, the Pharmacy Law, provides for the licensure and regulation of pharmacists and pharmacies by the California State Board of Pharmacy. Existing law, until January 1, 2026, authorizes a physician or pharmacist to, without a prescription or permit, furnish hypodermic needles and syringes for human use to a person 18 years of age or older, and authorizes a person 18 years of age or older to, without a prescription or license, obtain hypodermic needles and syringes solely for personal use from a physician or pharmacist, as a public health measure, as specified. Existing law, until January 1, 2026, requires a pharmacy that furnishes nonprescription syringes to provide written information or verbal counseling to consumers, as specified, at the time of furnishing or sale of nonprescription hypodermic needles or syringes. Existing law, when no other penalty is provided, makes a knowing violation of the Pharmacy Law a misdemeanor and, in all other instances, makes a violation punishable as an infraction. This bill would delete the January 1, 2026, repeal date, thereby extending those provisions indefinitely, and would make other conforming changes. By indefinitely extending an existing requirement under the Pharmacy Law, the violation of which is a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 315 **(Bonta D) Medi-Cal: Home and Community-Based Alternatives Waiver.**
Current Text: Introduced: 1/23/2025 html pdf
Introduced: 1/23/2025
Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 4/9/2025)(May be acted upon Jan 2026)

Desk	Policy	2 year	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, home- and community-based services (HCBS) approved by the United States Department of Health and Human Services are covered for eligible individuals to the extent that federal financial participation is available for those services under the state plan or waivers granted in accordance with certain federal provisions. Existing law authorizes the Director of Health Care Services to seek waivers for any or all approvable HCBS. Existing law sets forth provisions for the implementation of the Nursing Facility/Acute Hospital Transition and Diversion Waiver, which is the predecessor of the Home and Community-Based Alternatives (HCBA) Waiver, for purposes of providing care management services to individuals who are at risk of nursing facility or institutional placement. This bill would recast those provisions to refer to the HCBA Waiver. The bill would delete a provision authorizing the expansion of the number of waiver slots up to 5,000 additional slots, and would instead require the enrollment of all eligible individuals who apply for the HCBA Waiver. The bill would require the department, by March 1, 2026, to seek any necessary amendments to the waiver to ensure that there is sufficient capacity to enroll all eligible individuals who are currently on a waiting list for the waiver, as specified. This bill contains other related provisions and other existing laws.

AB 316 **(Krell D) Artificial intelligence: defenses.**
Current Text: Amended: 4/28/2025 html pdf
Introduced: 1/24/2025
Status: 5/28/2025-Referred to Coms. on JUD. and APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law provides that everyone is responsible not only for the result of their willful acts, but also for an injury occasioned to another by their want of ordinary care or skill in the management of their property or person. Existing law requires the developer of a generative artificial intelligence system or service that is released on or after January 1, 2022, and made publicly available to Californians for use, to post on the developer's internet website documentation regarding the data used by the developer to train the generative artificial intelligence system or service. Existing law defines "artificial intelligence" for these purposes. This bill would prohibit a defendant who developed, modified, or used artificial intelligence, as defined, from asserting a defense that the artificial intelligence autonomously caused the harm to the plaintiff. This bill contains other existing laws.

AB 322 **(Ward D) Pupil health: school-based health services and school-based mental health services.**
Current Text: Introduced: 1/24/2025 html pdf
Introduced: 1/24/2025
Status: 5/7/2025-Referred to Com. on ED.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law establishes the State Department of Education in state government, and vests the department with specified powers and duties relating to the state's public school system, including encouraging and assisting school districts to improve and monitor the health of their pupils. Existing law requires the department, as part of that assistance, to provide information and guidance to schools that request the information and guidance to establish "Health Days" to provide screenings for common health problems among pupils. This bill would require the department to include county offices of education and charter schools in the above-described provisions. The bill would require the department to encourage school districts, county offices of education, and charter schools to participate in programs that offer reimbursement for school-based health services and school-based mental health services, as provided.

AB 350 **(Bonta D) Health care coverage: fluoride treatments.**
Current Text: Amended: 5/23/2025 html pdf
Introduced: 1/29/2025
Status: 6/3/2025-In Senate. Read first time. To Com. on RLS. for assignment.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law sets forth specified coverage requirements for health care service plan contracts and health insurance policies. Existing law provides for the Medi-Cal program, administered by the State Department of Health Care Services and under which health care services are provided to low-income individuals. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law establishes a schedule of benefits under the Medi-Cal program and provides for various services, including certain dental services, that are rendered by Medi-Cal enrolled providers. Under existing law, silver diamine fluoride treatments are a covered benefit for eligible children 0 to 6 years of age, inclusive, as specified, and application of fluoride or other appropriate fluoride treatment is covered for children 17 years of age and under. This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2026, to provide coverage without cost sharing for the application of fluoride varnish in the primary care setting for children under 21 years of age. Because a willful violation of this provision by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill would make the application of fluoride or other appropriate fluoride treatment, including fluoride varnish, a covered

benefit under the Medi-Cal program for children under 21 years of age. The bill would require the State Department of Health Care Services to establish and promulgate a policy governing billing and reimbursement for the application of fluoride varnish, as specified. This bill contains other related provisions and other existing laws.

AB 360 **(Papan D) Menopause.**
Current Text: Amended: 4/9/2025 html pdf
Introduced: 1/30/2025
Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 4/23/2025)(May be acted upon Jan 2026)

Desk	Policy	2 year	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law establishes the Department of Health Care Access and Information to oversee and administer various health programs and to collect health data. Existing law establishes the Medical Board of California and the Osteopathic Medical Board of California for the licensure and regulation of physicians and surgeons and osteopathic physicians and surgeons. Existing law requires the boards to adopt and administer standards, including for the continuing education of those licensees. This bill would require the department to work with the Medical Board of California, the Osteopathic Medical Board of California, and state higher education entities to assess, among other things, physicians and surgeons' education and training, as specified, relating to menopause diagnosis and treatment. The bill would require the department to prepare a report to the Legislature on or before January 1, 2027, that, among other things, identifies gaps in medical education and training related to menopause and in menopause diagnosis and management practices among physicians and surgeons.

AB 371 **(Haney D) Dental coverage.**
Current Text: Amended: 4/24/2025 html pdf
Introduced: 2/3/2025
Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/14/2025)(May be acted upon Jan 2026)

Desk	Policy	2 year	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Department of Managed Health Care and makes a willful violation of the act's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law prohibits a contract between a plan or insurer and a dentist from requiring a dentist to accept an amount set by the plan or insurer as payment for dental care services provided to an enrollee or insured that are not covered services under the enrollee's contract or the insured's policy. Existing law requires a plan or insurer to make specified disclosures to an enrollee or insured regarding noncovered dental services. Existing law requires a health care service plan or health insurer to comply with specified timely access requirements. For a specified plan or insurer offering coverage for dental services, existing law requires urgent dental appointments to be offered within 72 hours of a request, nonurgent dental appointments to be offered within 36 business days of a request, and preventive dental care appointments to be offered within 40 business days of a request, as specified. Existing law requires a contract between a health care service plan and health care provider to ensure compliance with network adequacy standards and to require reporting by providers to plans to ensure compliance. Under existing law, a health care service plan is required to annually report to the Department of Managed Health Care on this compliance. Existing law authorizes the Department of Insurance to issue guidance to insurers regarding annual timely access and network reporting methodologies. If a health care service plan or health insurer pays a contracting dental provider directly for covered services, this bill would require the plan or insurer to pay a noncontracting dental provider directly for covered services if the noncontracting provider submits to the plan or insurer a written assignment of benefits form signed by the enrollee or insured. The bill would require the plan or insurer to provide a predetermination or prior authorization to the dental provider and to reimburse the provider for not less than that amount, except as specified. The bill would require the plan or insurer to notify the enrollee or insured that the provider was paid and that the out-of-network cost may count towards their annual or lifetime maximum. The bill would require a noncontracting dental provider to make specified disclosures to an enrollee or insured before accepting an assignment of benefits. This bill contains other related provisions and other existing laws.

AB 375 **(Nguyen D) Medical Practice Act: health care providers: qualified autism service paraprofessionals.**
Current Text: Introduced: 2/3/2025 html pdf
Introduced: 2/3/2025
Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. on 4/8/2025)(May be acted upon Jan 2026)

Desk	Policy	2 year	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law, the Medical Practice Act, establishes the Medical Board of California and charges it with administrative and enforcement duties related to the provision of medical services under the act. Existing law establishes requirements for the delivery of medical services, including via telehealth by specified health care providers. A violation of the act is a crime. Under existing law, a "health care provider," for purpose of the act, includes a qualified autism service provider or a qualified autism service professional that is certified by a national entity, as specified. This bill would expand that definition of "health care provider" to also include a qualified autism service paraprofessional. By expanding the scope of a crime under the act, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 384 **(Connolly D) Health care coverage: mental health and substance use disorders: inpatient admissions.**
Current Text: Amended: 3/17/2025 html pdf
Introduced: 2/3/2025
Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/14/2025)(May be acted upon Jan 2026)

Desk	Policy	2 year	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan or health insurer to ensure that processes necessary to obtain covered health care services, including, but not limited to, prior authorization processes, are completed in a manner that assures the provision of covered health care services to an enrollee or insured in a timely manner appropriate for the enrollee's or insured's condition, as specified. This bill, the California Mental Health Protection Act, would prohibit a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2027, that provides coverage for mental health and substance use disorders from requiring prior authorization (1) for an enrollee or insured to be admitted for medically necessary 24-hour care in inpatient settings for mental health and substance use disorders, as specified, and (2) for any medically necessary health care services provided to an enrollee or insured while admitted for that care. The bill would authorize the Director of the Department of Managed Health Care or the Insurance Commissioner, as applicable, to assess administrative or civil penalties, as specified, for violations of these provisions. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 403 **(Ortega D) Medi-Cal: community health worker services.**
Current Text: Amended: 3/17/2025 html pdf
Introduced: 2/4/2025
Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 4/9/2025)(May be acted upon Jan 2026)

Desk	Policy	2 year	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health

Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, community health worker (CHW) services are a covered Medi-Cal benefit subject to any necessary federal approvals. CHW is defined as a liaison, link, or intermediary between health and social services and the community to facilitate access to services and to improve the access and cultural competence of service delivery. Existing law requires a Medi-Cal managed care plan to engage in outreach and education efforts to enrollees with regard to the CHW services benefit, as specified. Existing law requires the department to inform stakeholders about implementation of the benefit. This bill would require the department to annually conduct an analysis of the CHW services benefit, submit the analysis to the Legislature, and publish the analysis on the department's internet website, with the first analysis due July 1, 2027. This bill contains other related provisions and other existing laws.

AB 408 **(Berman D) Physician Health and Wellness Program.**
Current Text: Amended: 4/21/2025 html pdf
Introduced: 2/4/2025
Status: 6/4/2025-Referred to Coms. on B. P. & E.D. and JUD.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

Summary: Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons and licensed midwives by the Medical Board of California. A violation of the act is a crime. Existing law authorizes the board to establish a Physician and Surgeon Health and Wellness Program to support a physician and surgeon in their rehabilitation from substance abuse to ensure the physician and surgeon remains able to practice medicine in a manner that will not endanger the public health and safety and that will maintain the integrity of the medical profession. Existing law requires the board to contract with a third party for the program's administration in accordance with specified provisions of the Public Contract Code. Existing law provides that participation in the program shall not be a defense to any disciplinary action that may be taken by the board. Existing law requires the program to comply with the Uniform Standards Regarding Substance-Abusing Healing Arts Licensees adopted by the Substance Abuse Coordination Committee of the Department of Consumer Affairs. Existing law establishes the Physician and Surgeon Health and Wellness Program Account in the Contingent Fund of the Medical Board of California for the support of the program. This bill would revise and recast those provisions and would instead authorize the board to establish a Physician Health and Wellness Program to support, treat, monitor, and rehabilitate physicians and surgeons and other professionals licensed by the board with impairing physical and mental health conditions that may impact their ability to practice their profession in a reasonably safe, competent, and professional manner. The bill would require the administering entity to be a nonprofit entity and would require the contract with the administering entity to include procedures on specified topics. The bill would exempt the program from the Uniform Standards Regarding Substance-Abusing Healing Arts Licensees. The bill would exempt program records relating to program participants from disclosure under the California Public Records Act, except as specified. The bill would authorize the board to establish advisory committees to assist in carrying out the duties of the administering entity, and would establish duties and responsibilities authorized to be performed by a committee. The bill would rename the Physician and Surgeon Health and Wellness Program Account as the Physician Health and Wellness Program Account, and would authorize the board to seek and use grant funds and gifts from public or private sources to pay any cost associated with the program. The bill would require the board to annually report to the Legislature and make available to the public the amount and source of funds. The bill would require a licensee to report a license to the administering entity or the board if they believe the licensee is impaired. By expanding the scope of a crime under the Medical Practice Act, the bill would impose a state-mandated local program. The bill would make a person who reports information or takes action in connection with the bill's provisions immune from civil liability for reporting information or taking the action, except as specified. The bill would make the program inapplicable to the Osteopathic Medical Board of California. This bill contains other related provisions and other existing laws.

AB 412 **(Bauer-Kahan D) Generative artificial intelligence: training data: copyrighted materials.**
Current Text: Amended: 5/7/2025 html pdf
Introduced: 2/4/2025
Status: 5/21/2025-Referred to Coms. on JUD. and APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered

1st House	2nd House	Conc.			

Summary: Existing federal law, through copyright, provides authors of original works of authorship, as defined, with certain rights and protections. Existing federal law generally gives the owner of the copyright the right to reproduce the work in copies or phonorecords and the right to distribute copies or phonorecords of the work to the public. Existing federal law provides that sound recordings fixed before February 15, 1972, are not subject to copyright, but are subject to similar rights and protections under the Classics Protection and Access Act. Existing law requires, on or before January 1, 2026, and before each time thereafter that a generative artificial intelligence system or service, as defined, or a substantial modification to a generative artificial intelligence system or service, released on or after January 1, 2022, is made available to Californians for use, regardless of whether the terms of that use include compensation, a developer of the system or service to post on the developer's internet website documentation, as specified, regarding the data used to train the generative artificial intelligence system or service. This bill would require a developer of a generative artificial intelligence model to, among other things, document any covered materials that the developer knows were used by the developer to train the model. The bill would require the developer to make available a mechanism on the developer's internet website allowing a rights owner to submit a request for information about the developer's use of covered materials that would allow the rights owner to provide the developer with, among other things, registration, preregistration, or index numbers and fingerprints for one or more covered materials. The bill would, subject to specified exceptions, require a developer to, within 30 days of receiving that request from the rights owner, assess whether the covered material represented by a fingerprint provided by the rights owner is likely to be present in the developer's dataset and provide the rights owner with a list of their covered materials that were used to train the model and are likely to be present in the developer's dataset, as specified. The bill would provide that each day following the 30-day period that a developer fails to provide a rights owner with that information constitutes a discrete violation. The bill would authorize a rights owner who complies with specified requirements for submitting a request that is not provided with information according to these provisions to bring a civil action against the developer for specified relief. The bill would provide that the bill's requirements do not apply to a model that meets certain criteria, including, among other things, being trained exclusively using data the developer makes publicly available at no cost, as specified. The bill would define various terms for these purposes. This bill contains other existing laws.

AB 416 **(Krell D) Involuntary commitment.**
Current Text: Amended: 5/7/2025 html pdf
Introduced: 2/5/2025
Status: 5/28/2025-Referred to Coms. on HEALTH, JUD. and APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law, the Lanterman-Petris-Short Act, authorizes the involuntary commitment and treatment of persons with specified mental disorders. Under the act, when a person, as a result of a mental health disorder, is a danger to self or others, or gravely disabled, the person may, upon probable cause, be taken into custody by specified individuals, including, among others, by a peace officer, a designated member of a mobile crisis team, or a professional person designated by the county, and placed in a facility designated by the county and approved by the State Department of Health Care Services for up to 72 hours for evaluation and treatment. Existing law authorizes county behavioral health director to develop procedures for the county's designation and training of professionals who will be designated to perform the above-described provisions. Existing law authorizes the procedures to include, among others, the license types, practice disciplines, and clinical experience of the professionals eligible to be designated by the county. Existing law exempts specified individuals, including a peace officer responsible for the detainment of a person under these provisions from criminal and civil liability for an action by a person who is released at or before the end of the period for which they were detained. This bill would require a county behavioral health director to include an emergency physician, as defined, as a professional who is eligible to be designated by the county when developing and implementing procedures for the designation and training of those professionals. The bill would also exempt an emergency physician who is responsible for the detainment of a person under those provisions from criminal and civil liability, as specified.

AB 423 **(Davies R) Alcoholism or drug abuse recovery or treatment programs and facilities: disclosures.**
Current Text: Amended: 4/2/2025 html pdf
Introduced: 2/5/2025
Status: 5/1/2025-Failed Deadline pursuant to Rule 61(a)(2). (Last location was HEALTH on 2/18/2025)(May be acted

upon Jan 2026)

Desk	2 year	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law grants the sole authority in state government to the State Department of Health Care Services to certify alcohol or other drug programs and to license adult alcoholism or drug abuse recovery or treatment facilities. Existing law requires certified programs and licensed facilities to disclose to the department if any of its agents, partners, directors, officers, or owners own or have a financial interest in a recovery residence and whether it has contractual relationships with entities that provide recovery services to clients of certified programs or licensed facilities if the entity is not a part of a certified program or a licensed facility. Existing law defines "recovery residence" as a residential dwelling that provides primary housing for individuals who seek a cooperative living arrangement that supports personal recovery from a substance use disorder and that does not require licensure by the department or does not provide licensable services. This bill would require a business-operated recovery residence to register its location with the department. The bill would define a business-operated recovery residence as a recovery residence in which a business, in exchange for compensation, provides more than one service beyond those of a typical tenancy arrangement to more than one occupant, including, but not limited to, drug testing, supervision, scheduling, rule setting, rule enforcement, room assignment, entertainment, gym memberships, transportation, laundry, or meal preparation and coordination.

AB 432 **(Bauer-Kahan D) Menopause.**
Current Text: Amended: 5/27/2025 html pdf
Introduced: 2/5/2025
Status: 6/4/2025-In Senate. Read first time. To Com. on RLS. for assignment.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California and requires the board to adopt and administer standards for the continuing education of those licensees. Existing law requires the board, in determining its continuing education requirements, to consider including a course in menopausal mental or physical health. This bill would delete that requirement of the board and, instead, require specified physicians whose patient population is composed of 25% or more adult women under 65 years of age, for their first license renewal after July 1, 2026, and every 4 years thereafter, to complete at least 5 hours of mandatory continuing medical education in a course in perimenopause, menopause, and postmenopausal care. This bill contains other related provisions and other existing laws.

AB 489 **(Bonta D) Health care professions: deceptive terms or letters: artificial intelligence.**
Current Text: Amended: 4/10/2025 html pdf
Introduced: 2/10/2025
Status: 6/3/2025-In Senate. Read first time. To Com. on RLS. for assignment.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law establishes various healing arts boards within the Department of Consumer Affairs that license and regulate various healing arts licensees. Existing laws, including, among others, the Medical Practice Act and the Dental Practice Act, make it a crime for a person who is not licensed as a specified health care professional to use certain words, letters, and phrases or any other terms that imply that they are authorized to practice that profession. Existing law requires, with certain exemptions, a health facility, clinic, physician's office, or office of a group practice that uses generative artificial intelligence, as defined, to generate written or verbal patient communications pertaining to patient clinical information, as defined, to ensure that those communications include both (1) a disclaimer that indicates to the patient that a communication was generated by generative artificial intelligence, as specified, and (2) clear instructions describing how a patient may contact a human health care provider, employee, or other appropriate person. Existing law provides that a violation of these provisions by a physician shall be subject to the jurisdiction of the Medical Board of California or the Osteopathic Medical Board of California, as appropriate. This bill would make provisions of law that prohibit the use of specified terms, letters, or phrases to falsely indicate or imply possession of a license or certificate to practice a health care profession, as defined, enforceable against an entity who develops or deploys artificial intelligence

(AI) or generative artificial intelligence (GenAI) technology that uses one or more of those terms, letters, or phrases in its advertising or functionality. The bill would prohibit the use by AI or GenAI technology of certain terms, letters, or phrases that indicate or imply that the advice or care advice, care, reports, or assessments being provided through AI or GenAI is being provided by a natural person with the appropriated health care license or certificate. This bill would make a violation of these provisions subject to the jurisdiction of the appropriate health care profession board, and would make each use of a prohibited term, letter, or phrase punishable as a separate violation. This bill contains other related provisions and other existing laws.

AB 510 **(Addis D) Health care coverage: utilization review: peer-to-peer review.**
Current Text: Amended: 4/28/2025 html pdf
Introduced: 2/10/2025
Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/7/2025)(May be acted upon Jan 2026)

Desk	Policy	2 year	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of disability insurers by the Department of Insurance. Existing law generally authorizes a health care service plan or disability insurer to use prior authorization and other utilization review or utilization management functions, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. This bill, upon communication of a decision by a health care service plan or health insurer delaying, denying, or modifying a health care service based in whole or in part on medical necessity, would authorize a provider to request review of the decision by a licensed physician, or a licensed health care professional under specified circumstances, who is competent to evaluate the specific clinical issues involved in the health care service being requested, and is of the same or similar specialty as the requesting provider. The bill would authorize a licensed health care professional to be the reviewer if the provider requesting peer-to-peer review is not a physician. The bill, notwithstanding any other law, would require these reviews to occur within 2 business days, or if an enrollee or insured faces an imminent and serious threat to their health, within a timely fashion appropriate for the nature of the enrollee's or insured's condition, as specified. If a health care service plan or health insurer fails to meet those timelines, the bill would deem the request for the health care service as approved and supersede any prior delay, denial, or modification. This bill contains other related provisions and other existing laws.

AB 512 **(Harabedian D) Health care coverage: prior authorization.**
Current Text: Amended: 4/28/2025 html pdf
Introduced: 2/10/2025
Status: 6/3/2025-In Senate. Read first time. To Com. on RLS. for assignment.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of disability insurers by the Department of Insurance. Existing law generally authorizes a health care service plan or disability insurer to use utilization review, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. For a request prior to or concurrent with the provision of health care services, existing law requires utilization review decisions to be made within 5 business days from the plan's or insurer's receipt of the information reasonably necessary and requested by the plan or insurer to make the determination, or within 72 hours if the enrollee or insured faces an imminent and serious threat to their health or the normal timeframe would be detrimental to their life or health, as specified. This bill would shorten the timeline for prior or concurrent authorization requests to no more than 48 hours for standard requests or 24 hours for urgent requests from the plan's or insurer's receipt of the information reasonably necessary and requested by the plan or insurer to make the determination. Because a willful violation of this provision by a health care service plan would be a crime, the bill

would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 517 **(Krell D) Medi-Cal: complex rehabilitation technology: wheelchairs.**
Current Text: Introduced: 2/10/2025 html pdf
Introduced: 2/10/2025
Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 4/30/2025)(May be acted upon Jan 2026)

Desk	Policy	2 year	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. This bill would prohibit the department from requiring prior authorization for the repair of a CRT-powered wheelchair if the cost of the repair does not exceed $1,250. Under the bill, a treatment authorization request for repair or replacement of a CRT-powered wheelchair would not require an individual prescription or documentation of medical necessity from the treating practitioner if the CRT-powered wheelchair has already been approved for use by the patient. This bill contains other existing laws.

AB 534 **(Schiavo D) Transitional housing placement providers.**
Current Text: Amended: 5/23/2025 html pdf
Introduced: 2/11/2025
Status: 6/3/2025-In Senate. Read first time. To Com. on RLS. for assignment.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law, the California Community Care Facilities Act, requires the State Department of Social Services to license and regulate transitional housing placement providers as community care facilities. Existing law defines a "transitional housing placement provider" to mean an organization licensed by the department to provide transitional housing to foster children who are at least 16 years of age. A violation of the act is a misdemeanor. Existing law defines "Transitional Housing Program-Plus" to mean a provider certified by the applicable county to provide transitional housing services to former foster youth who have exited the foster care system on or after their 18th birthday. Existing law exempts Transitional Housing Program-Plus providers from licensure under the California Community Care Facilities Act if they are certified and have obtained a local fire clearance. This bill would require a contract for a transitional housing placement provider or a Transitional Housing Program-Plus provider to have an initial term of 3 years. The bill would authorize a contract to be renewed for 2 additional 1-year terms. If a contract has been renewed for 2 additional 1-year terms, the bill would authorize a contract to be renewed for additional 10-year terms. The bill would authorize the county to terminate a contract or a portion of the contracted services prior to the end of the contract term by providing at least 90 days' notice to the contractor. By imposing new duties on counties, this bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 536 **(Patterson R) Health care coverage: colorectal cancer screening.**
Current Text: Amended: 3/24/2025 html pdf
Introduced: 2/11/2025
Status: 5/14/2025-Referred to Com. on HEALTH.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law generally requires a health care service plan contract or a health insurance policy issued, amended, or renewed on or after January 1, 2022, to provide coverage without cost sharing for a colorectal cancer screening test assigned either a grade of A or a grade of B by the United States Preventive Services Task Force and for a required colonoscopy for a positive result on a test with those grades.

This bill would additionally require that coverage if the screening test is approved by the United States Food and Drug Administration and either meets requirements for coverage established by the federal Centers for Medicare and Medicaid Services, as specified, or is included in the most recently published guidelines from the American Cancer Society.

AB 539 **(Schiavo D) Health care coverage: prior authorizations.**
Current Text: Amended: 4/28/2025 html pdf
Introduced: 2/11/2025
Status: 5/21/2025-Referred to Com. on HEALTH.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law provides that a health care service plan or a health insurer that authorizes a specific type of treatment by a health care provider shall not rescind or modify this authorization after the provider renders the health care service in good faith and pursuant to the authorization. This bill would require a prior authorization for a health care service by a health care service plan or a health insurer to remain valid for a period of at least one year from the date of approval, or throughout the course of prescribed treatment, if less than one year. Because a violation of the bill by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 543 **(González, Mark D) Medi-Cal: street medicine.**
Current Text: Amended: 4/8/2025 html pdf
Introduced: 2/11/2025
Status: 6/3/2025-In Senate. Read first time. To Com. on RLS. for assignment.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law sets forth various provisions for Medi-Cal coverage of community health worker services, enhanced care management, and community supports, subject to any necessary federal approvals. Under existing law, these benefits are designed to, respectively, provide a link between health and social services and the community; address the clinical and nonclinical needs on a whole-person-care basis for certain target populations of Medi-Cal beneficiaries, including individuals experiencing homelessness; and provide housing transition navigation services, among other supports. Existing law establishes mechanisms for Medi-Cal presumptive eligibility for certain target populations, including, among others, pregnant persons, children, and patients of qualified hospitals, for purposes of Medi-Cal coverage while other Medi-Cal eligibility determination procedures are pending, as specified. This bill would set forth provisions regarding street medicine, as defined, under the Medi-Cal program for persons experiencing homelessness, as defined. The bill would state the intent of the Legislature that the street medicine-related provisions coexist with, and not duplicate, other Medi-Cal provisions, including, but not limited to, those regarding community health worker services, enhanced care management, and community supports. The bill would require the department to implement a program of presumptive eligibility for persons experiencing homelessness for purposes of full-scope Medi-Cal benefits without a share of cost. The bill would authorize an enrolled Medi-Cal provider to make a presumptive eligibility determination for those persons. This bill contains other related provisions and other existing laws.

AB 546 **(Caloza D) Health care coverage: portable HEPA purifiers.**
Current Text: Amended: 5/1/2025 html pdf
Introduced: 2/11/2025
Status: 6/4/2025-Referred to Com. on HEALTH.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered

1st House	2nd House	Conc.			

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law sets forth specified coverage requirements for plan contracts and insurance policies, and limits the copayment, coinsurance, deductible, and other cost sharing that may be imposed for specified health care services. This bill would require a large group health care service plan contract or group health insurance policy, except a specialized health care service plan contract or health insurance policy, that is issued, amended, or renewed on or after January 1, 2026, to include coverage for portable high-efficiency particulate air (HEPA) purifiers for enrollees or insureds who are pregnant or diagnosed with asthma or chronic obstructive pulmonary disease if the enrollee or insured is in a county where a local or state emergency has been declared due to wildfires. The bill would prohibit the cost of the HEPA purifier from exceeding $500, adjusted for inflation. This bill contains other related provisions and other existing laws.

AB 554 **(González, Mark D) Health care coverage: antiretroviral drugs, drug devices, and drug products.**
Current Text: Amended: 5/23/2025 html pdf
Introduced: 2/11/2025
Status: 6/4/2025-In Senate. Read first time. To Com. on RLS. for assignment.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law generally prohibits a health care service plan, excluding a Medi-Cal managed care plan, or health insurer from subjecting antiretroviral drugs that are medically necessary for the prevention of HIV/AIDS, including preexposure prophylaxis or postexposure prophylaxis, to prior authorization or step therapy. Under existing law, a health care service plan or health insurer is not required to cover all the therapeutically equivalent versions of those drugs without prior authorization or step therapy if at least one is covered without prior authorization or step therapy. This bill, the Protecting Rights, Expanding Prevention, and Advancing Reimbursement for Equity (PrEPARE) Act of 2025, would instead prohibit a health care service plan, excluding a Medi-Cal managed care plan, or health insurer from subjecting antiretroviral drugs, drug devices, or drug products that are either approved by the United States Food and Drug Administration (FDA) or recommended by the federal Centers for Disease Control and Prevention (CDC) for the prevention of HIV/AIDS, to prior authorization, step therapy, or any other protocol designed to delay treatment, but would authorize prior authorization or step therapy if at least one therapeutically equivalent version is covered without prior authorization or step therapy and the plan or insurer provides coverage for a noncovered therapeutic equivalent antiretroviral drug, drug device, or drug product without cost sharing pursuant to an exception request. The bill would specify that, for therapeutically equivalent coverage purposes, a long-acting injectable drug is not therapeutically equivalent to a long-acting injectable drug with a different duration. The bill would require a plan or insurer to provide coverage under the outpatient prescription drug benefit for those drugs, drug devices, or drug products, including by supplying participating providers directly with a drug, drug device, or drug product, as specified. This bill contains other related provisions and other existing laws.

AB 575 **(Arambula D) Obesity Prevention Treatment Parity Act.**
Current Text: Amended: 3/12/2025 html pdf
Introduced: 2/12/2025
Status: 5/1/2025-Failed Deadline pursuant to Rule 61(a)(2). (Last location was HEALTH on 2/24/2025)(May be acted upon Jan 2026)

Desk	2 year	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act's requirements a crime. Existing law provides for the regulation of disability and health insurers by the Department

of Insurance. Existing law sets forth specified coverage requirements for plan contracts and insurance policies. This bill, the Obesity Prevention Treatment Parity Act, would require an individual or group health care service plan contract or health insurance policy that provides coverage for outpatient prescription drug benefits, as specified, and is issued, amended, or renewed on or after January 1, 2026, to include coverage for at least one specified anti-obesity medication and intensive behavioral therapy for the treatment of obesity without prior authorization. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 577 **(Wilson D) Health care coverage: antisteering.**
Current Text: Amended: 5/1/2025 html pdf
Introduced: 2/12/2025
Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/14/2025)(May be acted upon Jan 2026)

Desk	Policy	2 year	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes the willful violation of its provisions a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or health insurance policy that provides coverage for outpatient prescription drugs to cover medically necessary prescription drugs. For a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2026, this bill would prohibit a health care service plan, health insurer, or pharmacy benefit manager from engaging in specified steering practices, including, among others, requiring an enrollee or insured to use a retail pharmacy for dispensing prescription oral medications, as specified, and imposing any requirements, conditions, or exclusions that discriminate against an in-network physician in connection with dispensing prescription oral medications. The bill would require a health care provider, physician's office, clinic, or infusion center to obtain consent from an enrollee or insured and disclose a good faith estimate of the enrollee's or insured's applicable cost-sharing amount before supplying or administering an injected or infused medication to an enrollee or insured, or sending an enrollee or insured to receive an injected or infused medication, if the setting or manner of administration is different than the setting or manner of administration for which the health care service plan, health insurer, or pharmacy benefit manager directed the enrollee or insured, as specified. Because a willful violation of these provisions relative to health care service plans would be a crime, the bill would impose a state-mandated local program. This bill contains other existing laws.

AB 582 **(Pacheco D) Administrative Procedure Act.**
Current Text: Introduced: 2/12/2025 html pdf
Introduced: 2/12/2025
Status: 5/8/2025-Failed Deadline pursuant to Rule 61(a)(3). (Last location was PRINT on 2/12/2025)(May be acted upon Jan 2026)

2 year	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law, the Administrative Procedure Act, governs, among other things, the procedures for the adoption, amendment, or repeal of regulations by state agencies and for the review of those regulatory actions by the Office of Administrative Law. Existing law specifies which code sections constitute the Administrative Procedure Act. This bill would make a nonsubstantive change to those provisions.

AB 602 **(Haney D) Public postsecondary education: student behavior: drug and alcohol use: rehabilitation programs.**
Current Text: Amended: 5/23/2025 html pdf
Introduced: 2/13/2025
Status: 6/3/2025-In Senate. Read first time. To Com. on RLS. for assignment.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered

1st House	2nd House	Conc.			

Summary: Existing law, known as the Donahoe Higher Education Act, establishes the California Community Colleges, the California State University, and the University of California as the public segments of postsecondary education in the state. Existing law requires the Regents of the University of California, the Trustees of the California State University, and the governing board of every community college district to adopt or provide for the adoption of specific rules and regulations governing student behavior and to adopt procedures by which all students are informed of the rules and regulations, with applicable penalties, as provided. Provisions of the act apply to the University of California only to the extent that the Regents of the University of California, by appropriate resolution, act to make a provision applicable. Existing federal law requires, as a condition of receiving federal funds or other forms of financial assistance, institutions of higher education to annually distribute to each student and employee standards of conduct that clearly prohibit unlawful possession, use, or distribution of illicit drugs or alcohol, as provided, and a clear statement that the institution will impose sanctions for violations of the standards of conduct. Existing federal law characterizes the completion of an appropriate rehabilitation program as a permissible form of the required sanctions. This bill would require the Regents of the University of California and the Trustees of the California State University, in adopting the above-described rules and regulations, to place in the highest priority the health, safety, and well-being of the campus community. The bill would also require those entities to adopt, or provide for the adoption of, rules and regulations that (1) prohibit students seeking medical treatment for themselves or another person, or receiving medical treatment, related to the use of drugs or alcohol in violation of the rules and regulations governing student behavior, from being subject to disciplinary action for that use of drugs or alcohol if they complete an appropriate rehabilitation program, and (2) require students who seek or receive medical treatment for the use of drugs or alcohol in a manner that violates the rules or regulations of the university to be offered the chance to complete an appropriate rehabilitation program, as provided. The bill would establish that this prohibition on disciplinary action, and the requirement that the university offer an appropriate rehabilitation program, only apply to a student once in an academic term, as provided. This bill contains other existing laws.

AB 618 **(Krell D) Medi-Cal: behavioral health: data sharing.**
Current Text: Amended: 5/23/2025 html pdf
Introduced: 2/13/2025
Status: 6/3/2025-In Senate. Read first time. To Com. on RLS. for assignment.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, through fee-for-service or managed care delivery systems. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing Medi-Cal provisions, behavioral health services, including specialty mental health services and substance use disorder treatment, are provided under the Medi-Cal Specialty Mental Health Services Program, the Drug Medi-Cal Treatment Program, and the Drug Medi-Cal organized delivery system (DMC-ODS) program, as specified. This bill would require each Medi-Cal managed care plan, county specialty mental health plan, Drug Medi-Cal certified program, and DMC-ODS program to electronically provide data for members of the respective entities to support member care. The bill would require the department California Health and Human Services Agency to determine minimum data elements and the frequency and format of data sharing through a stakeholder process and guidance, with final guidance to be published by the State Department of Health Care Services by January 1, 2027, in compliance with privacy laws.

AB 636 **(Ortega D) Medi-Cal: diapers.**
Current Text: Amended: 3/13/2025 html pdf
Introduced: 2/13/2025
Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 4/23/2025)(May be acted upon Jan 2026)

Desk	Policy	2 year	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed by, and funded pursuant to, federal Medicaid program provisions. Under existing law, incontinence medical supplies are covered by the Medi-Cal program. This bill would establish diapers as a covered Medi-Cal benefit for a child greater than 3 years of age who has been diagnosed with a condition, as specified, that contributes to incontinence, and for an individual under 21 years of age if necessary to correct or ameliorate a condition pursuant to certain federal standards. The bill would limit the provided diapers to an appropriate supply based on the diagnosed condition and the age of the Medi-Cal beneficiary. The bill would require the department to seek any necessary federal approvals to implement these provisions. The bill would condition implementation of these provisions on receipt of any necessary federal approvals, the availability of federal financial participation, and an appropriation by the Legislature. The bill would require the department to update the Medi-Cal provider manual, as applicable, in the course of implementing these provisions.

AB 669 **(Haney D) Substance use disorder coverage.**
Current Text: Amended: 4/28/2025 html pdf
Introduced: 2/14/2025
Status: 6/4/2025-In Senate. Read first time. To Com. on RLS. for assignment.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law generally authorizes a health care service plan or health insurer to use prior authorization and other utilization management functions, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. Existing law requires health care service plan contracts and health insurance policies that provide hospital, medical, or surgical coverage and are issued, amended, or renewed on or after January 1, 2021, to provide coverage for medically necessary treatment of mental health and substance use disorders under the same terms and conditions applied to other medical conditions, as specified. On and after January 1, 2027, this bill would prohibit concurrent or retrospective review of medical necessity of in-network health care services and benefits (1) for the first 28 days of an inpatient substance use disorder stay during each plan or policy year or (2) for outpatient substance use disorder visits, except as specified. The bill would authorize, after the 29th day, in-network health care services and benefits for inpatient substance use disorder care to be subject to concurrent review. On and after January 1, 2027, the bill would prohibit retrospective review of medical necessity for the first 28 days of intensive outpatient or partial hospitalization services for substance use disorder, but would require specified review for day 29 and days thereafter of that stay or service. On and after January 1, 2027, the bill would prohibit the imposition of prior authorization or other prospective utilization management requirements for in-network coverage of outpatient prescription drugs to treat substance use disorder that are determined medically necessary by the enrollee's or insured's physician or psychiatrist. Because a willful violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other existing laws.

AB 676 **(Gonzalez, Jeff R) Medi-Cal: unrecovered payments: interest rate.**
Current Text: Amended: 4/9/2025 html pdf
Introduced: 2/14/2025
Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 4/30/2025)(May be acted upon Jan 2026)

Desk	Policy	2 year	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law requires the Director of Health Care Services to establish administrative appeal processes to review grievances or complaints arising from the findings of an

audit or examination. Under existing law, if recovery of a disallowed payment has been made by the department, a provider who prevails in an appeal of that payment is entitled to interest at the rate equal to the monthly average received on investments in the Surplus Money Investment Fund, or simple interest at the rate of 7% per annum, whichever is higher. Under existing law, with exceptions, interest at that same rate is assessed against any unrecovered overpayment due to the department. In the case of an assessment against any unrecovered overpayment due to the department, this bill would require the department to waive the interest, as part of a repayment agreement entered into with the provider, if the latest date of service for a retroactive payment adjustment or audit period end date for the unrecovered overpayment occurred 4 or more years before the issuance of the first statement of account status or demand for repayment, and the department determines that certain factors apply. Under the bill, those factors would include, among others, the impact of the repayment amounts on the fiscal solvency of the provider, and whether the overpayment was caused by a policy change or departmental error that was not caused by the billing provider. The bill would preserve the rights of the department to seek all remedies available at law if a provider defaults on a repayment plan. This bill would authorize the department to implement, interpret, or make specific these provisions, in whole or in part, by means of information notices, all-county letters, or other similar instructions without taking regulatory action.

AB 682 **(Ortega D) Health care coverage reporting.**
Current Text: Introduced: 2/14/2025 html pdf
Introduced: 2/14/2025
Status: 6/4/2025-Referred to Com. on HEALTH.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law requires a plan to submit financial statements to the Director of Managed Health Care at specified times. Existing law provides for the regulation of health insurers by the Department of Insurance and requires a health insurer or multiple employer welfare arrangement to annually report specified information to the department. This bill would require the above-described reports to include specified information for each month, including the total number of claims processed, adjudicated, denied, or partially denied. Because a violation of this requirement by a health care service plan would be a crime, the bill would create a state-mandated local program. The bill would require each department to publish on its internet website monthly claims denial information for each plan or insurer. This bill contains other related provisions and other existing laws.

AB 787 **(Papan D) Provider directory disclosures.**
Current Text: Amended: 4/7/2025 html pdf
Introduced: 2/18/2025
Status: 5/14/2025-Referred to Com. on HEALTH.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires specified health care service plans and health insurers to publish and maintain a provider directory or directories with information on contracting providers that deliver health care services to enrollees or insureds, and requires a health care service plan or health insurer to regularly update its printed and online provider directory or directories, as specified. Existing law requires provider directories to include specified information and disclosures. This bill would require a full service health care service plan, specialized mental health plan, health insurer, or specialized mental health insurer to include in its provider directory or directories a statement at the top of the directory advising an enrollee or insured to contact the plan or insurer for assistance in finding an in-network provider. The bill would require the plan or insurer to respond within one business day if contacted for that assistance, and to provide a list of in-network providers confirmed to be accepting new patients within 2 business days. Because a violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 789 **(Bonta D) Health care coverage: unreasonable rate increases.**
Current Text: Amended: 3/17/2025 html pdf
Introduced: 2/18/2025
Status: 5/7/2025-Referred to Com. on HEALTH.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and the regulation of health insurers by the Department of Insurance. For these purposes, existing law defines "unreasonable rate increase" to have the same meaning as in the federal Patient Protection and Affordable Care Act, which is that an unreasonable rate increase exists when the federal Centers for Medicare and Medicaid Services makes a determination that a rate increase is excessive, unjustified, or unfairly discriminatory, among other things. This bill would instead provide that an "unreasonable rate increase" exists if the Director of the Department of Managed Health Care or the Insurance Commissioner, as applicable, makes a determination that a rate increase is excessive, unjustified, unfairly discriminatory, or otherwise unreasonable.

AB 798 **(Calderon D) State Emergency Food Bank Reserve Program: diapers and wipes.**
Current Text: Amended: 4/22/2025 html pdf
Introduced: 2/18/2025
Status: 6/4/2025-In Senate. Read first time. To Com. on RLS. for assignment.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law requires the State Department of Social Services, subject to appropriation, to administer the State Emergency Food Bank Reserve Program in order to provide food and funding for the provision of emergency food and related costs to food banks serving low-income Californians to prevent hunger during natural or human-made disasters, as specified. Existing law authorizes the department to distribute funds under the program upon a proclamation or declaration of a disaster or state of emergency. Under existing law, a recipient of the California Work Opportunity and Responsibility to Kids (CalWORKs) program who is participating in a welfare-to-work plan is eligible for $30 per month to assist with diaper costs for each child who is under 36 months of age. Under the Budget Act of 2024, certain funding is appropriated to the department to allocate to specified food banks and other regional entities for the purpose of distributing diapers and wipes to low-income families with infants or toddlers. This bill would include children's diapers and wipes in the list of supplies under the State Emergency Food Bank Reserve Program. The bill would authorize the use of funds distributed under the program for purchasing and distributing children's diapers and wipes in eligible communities and for reimbursing food banks, as specified.

AB 804 **(Wicks D) Medi-Cal: housing support services.**
Current Text: Introduced: 2/18/2025 html pdf
Introduced: 2/18/2025
Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 4/30/2025)(May be acted upon Jan 2026)

Desk	Policy	2 year	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law, subject to implementation of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, authorizes a Medi-Cal managed care plan to elect to cover community supports approved by the department as cost effective and medically appropriate in a comprehensive risk contract that are in lieu of applicable Medi-Cal state plan services. Under existing law, community supports that the department is authorized to approve include, among other things, housing transition navigation services, housing deposits, and housing tenancy sustaining services. Existing law, subject to an appropriation, requires the department to complete an independent analysis to determine whether network adequacy exists to obtain federal approval for a covered

Medi-Cal benefit that provides housing support services. Existing law requires that the analysis take into consideration specified information, including the number of providers in relation to each region's or county's number of people experiencing homelessness. Existing law requires the department to report the outcomes of the analysis to the Legislature by January 1, 2024. This bill would delete the requirement for the department to complete that analysis, and instead would make housing support services for specified populations a covered Medi-Cal benefit when the Legislature has made an appropriation for purposes of the housing support services. The bill would require the department to seek federal approval for the housing support services benefit, as specified. Under the bill, subject to an appropriation by the Legislature, a Medi-Cal beneficiary would be eligible for those services if they either experience homelessness or are at risk of homelessness. Under the bill, the services would include housing transition navigation services, housing deposits, and housing tenancy sustaining services, as defined. This bill contains other related provisions and other existing laws.

AB 836 **(Stefani D) Midwifery Workforce Training Act.**
Current Text: Amended: 3/24/2025 html pdf
Introduced: 2/19/2025
Status: 6/3/2025-In Senate. Read first time. To Com. on RLS. for assignment.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law requires the Office of Statewide Health Planning and Development to establish a program to contract with programs that train certified nurse-midwives and programs that train licensed midwives in accordance with the global standards for midwifery education and the international definition of "midwife" as established by the International Confederation of Midwives in order to increase the number of students receiving quality education and training as a certified nurse-midwife or as a licensed midwife. Existing law requires these provisions to be implemented only upon an appropriation by the Legislature for these purposes in the annual Budget Act or another act. This bill would require the Department of Health Care Access and Information, upon appropriation from the Legislature for this purpose, to administer funding for a statewide study on midwifery education. The bill would require the study to be conducted by an outside consultant familiar with the health care and midwifery landscapes and workforce in California that would, among other things, identify viable education programs that can serve both rural and urban geographic areas. The bill would require the department to submit a report from the study's findings to the Legislature, to post the report on the department's internet website, and to notify all persons in the department's reproductive health and maternity care electronic mailing list, as specified. The bill would define "reproductive health care professionals" as, among others, medical doctors and licensed midwives.

AB 843 **(Garcia D) Health care coverage: language access.**
Current Text: Introduced: 2/19/2025 html pdf
Introduced: 2/19/2025
Status: 6/3/2025-In Senate. Read first time. To Com. on RLS. for assignment.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance, which is under the control of the Insurance Commissioner. Existing law requires the Department of Managed Health Care and the commissioner to develop and adopt regulations establishing standards and requirements to provide enrollees and insureds with appropriate access to language assistance in obtaining health care services and covered benefits. Existing law requires the Department of Managed Health Care and commissioner, in developing the regulations, to require health care service plans and health insurers to assess the linguistic needs of the enrollee and insured population, and to provide for translation and interpretation for medical services, as indicated. This bill would require a health care service plan or health insurer to take reasonable steps to provide meaningful access to each individual with limited English proficiency, including companions with limited English proficiency, eligible to receive services or likely to be directly affected by its programs and activities. The bill would require a health care service plan or health insurer to offer a qualified interpreter or to utilize a qualified translator when interpretation or translation services are required, as specified. The bill would prohibit a health care service plan or health insurer from requiring an individual with limited English proficiency to provide or pay for the costs of their own interpreter. The bill would require a health care service plan or health insurer to

comply with specified requirements when providing remote interpreting services. The bill would make a health care service plan or health insurer that violates these provisions liable for civil penalties, as specified. This bill contains other related provisions and other existing laws.

AB 877 **(Dixon R) Health care coverage: substance use disorder: residential facilities.**
Current Text: Amended: 4/21/2025 html pdf
Introduced: 2/19/2025
Status: 5/1/2025-Failed Deadline pursuant to Rule 61(a)(2). (Last location was HEALTH on 3/3/2025)(May be acted upon Jan 2026)

Desk	2 year	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law provides for the regulation of health care service plans by the Department of Managed Health Care and health insurers by the Department of Insurance. Existing law requires a health care service plan contract or disability insurance policy to provide coverage for medically necessary treatment of mental health and substance use disorders, as defined, under the same terms and conditions applied to other medical conditions. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive medically necessary health care services, including specified mental health and substance use disorder services, pursuant to a schedule of benefits. Existing law provides for the regulation of community care facilities that provide nonmedical care, including residential facilities, short-term residential therapeutic programs, and group homes by the State Department of Social Services. Existing law requires the care and supervision provided by a short-term residential therapeutic program or group home to be nonmedical, except as otherwise permitted by law. This bill would require the Department of Managed Health Care, the Department of Insurance, and the State Department of Health Care Services to prepare and send one letter to each chief financial officer of a health care service plan, health insurer, or Medi-Cal managed care plan that provides coverage, including out-of-network benefits, in California for substance use disorder in residential facilities, as defined. The bill would require the letter to include, among other things, a statement informing the plan or insurer that substance use disorder treatment in licensed or unlicensed residential facilities is almost exclusively nonmedical, with rare exceptions. The bill would authorize the Department of Managed Health Care, the Department of Insurance, and the State Department of Health Care Services to consult with each other, and would require those departments to consult with the State Department of Social Services, when preparing the contents of the letter. The bill would require the letters to be sent on or before October 1, 2026. The bill would repeal these provisions on January 1, 2027.

AB 910 **(Bonta D) Pharmacy benefit management.**
Current Text: Amended: 4/10/2025 html pdf
Introduced: 2/19/2025
Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/7/2025)(May be acted upon Jan 2026)

Desk	Policy	2 year	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law provides for the regulation of health care service plans by the Department of Managed Health Care. A willful violation of those provisions is a crime. Existing law requires health care service plans that cover prescription drug benefits and contract with pharmacy providers and pharmacy benefit managers to meet specified requirements, including requiring pharmacy benefit managers with whom they contract to register with the department and exercise good faith and fair dealing, among other requirements. This bill would modify the above-described requirement that the pharmacy benefit manager exercise good faith and fair dealing to instead require the pharmacy benefit manager to hold a fiduciary duty in the performance of its contractual duties and carry out that duty in accordance with state and federal law. The bill would require the pharmacy benefit manager to remit 100% of specified rebates, fees, alternative discounts, and other remuneration received to the health care service plan and would prohibit the pharmacy benefit manager from entering into any contract for pharmacy benefit management services that is contrary to that requirement. This bill contains other related provisions and other existing laws.

ALAMEDA Alliance FOR HEALTH

AB 951 **(Ta R) Health care coverage: behavioral diagnoses.**
Current Text: Introduced: 2/20/2025 html pdf
Introduced: 2/20/2025
Status: 5/7/2025-Referred to Com. on HEALTH.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or health insurance policy to provide coverage for behavioral health treatment for pervasive developmental disorder or autism. This bill would prohibit a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2026, from requiring an enrollee or insured previously diagnosed with pervasive developmental disorder or autism to receive a rediagnosis to maintain coverage for behavioral health treatment for their condition. The bill would require a treatment plan to be made available to the plan or insurer upon request. Because a willful violation of this provision by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 960 **(Garcia D) Patient visitation.**
Current Text: Amended: 5/29/2025 html pdf
Introduced: 2/20/2025
Status: 6/3/2025-In Senate. Read first time. To Com. on RLS. for assignment.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law provides for the licensure and regulation by the State Department of Public Health of health facilities, including general acute care hospitals, as defined. Existing law requires a health facility to allow a patient's domestic partner, the children of the patient's domestic partner, and the domestic partner of the patient's parent or child to visit unless no visitors are allowed, the facility reasonably determines that the presence of a particular visitor would endanger the health or safety of a patient, a member of the health facility staff, or other visitor to the health facility, or would significantly disrupt the operations of a facility, or the patient has indicated to the health facility staff that the patient does not want this person to visit. A violation of this provision is a misdemeanor. This bill would require a general acute care hospital to allow a patient with physical, intellectual, or developmental disabilities, a patient with cognitive impairment, including dementia, and a patient with another disability, as specified, to have a family or friend caregiver with them as needed, including outside standard visiting hours, unless specified conditions are met, including, but not limited to, that the hospital reasonably determines that the presence of a particular visitor would endanger the health or safety of the visitor, a patient, a member of the staff, or other visitor to the hospital, or would significantly disrupt the operations of the hospital. The bill would not prohibit a hospital from otherwise establishing reasonable restrictions upon visitation. The bill would authorize the hospital to impose legitimate health and safety requirements on visitors, as specified. The bill would specify that its provisions do not create any new civil or criminal liability, including, but not limited to, liability for any illness, infection, or injury experienced by a patient or visitor on the part of a hospital that complies with its requirements. By expanding the scope of a crime, this bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 974 **(Patterson R) Medi-Cal managed care plans: enrollees with other health care coverage.**
Current Text: Amended: 3/24/2025 html pdf
Introduced: 2/20/2025
Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 4/30/2025)(May be acted upon Jan 2026)

Desk	Policy	2 year	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health

Care Services and under which qualified low-income individuals receive health care services, under fee-for-service or managed care delivery systems. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing federal law, in accordance with third-party liability rules, Medicaid is generally the payer of last resort if a beneficiary has another source of health care coverage in addition to Medicaid coverage. Under this bill, in the case of a Medi-Cal managed care plan enrollee who also has other health care coverage and for whom the Medi-Cal program is a payer of last resort, the department would be required to ensure that a provider that is not contracted with the plan and that is billing the plan for Medi-Cal allowable costs not paid by the other health care coverage does not face administrative requirements significantly in excess of the administrative requirements for billing those same costs to the Medi-Cal fee-for-service delivery system. Under the bill, in the case of an enrollee who meets those coverage criteria, except as specified, a Medi-Cal fee-for-service provider would not be required to contract as an in-network provider with the Medi-Cal managed care plan in order to bill the plan for Medi-Cal allowable costs for covered health care services. The bill would authorize a Medi-Cal managed care plan to require a letter of agreement, or a similar agreement, under either of the following circumstances: (1) if a covered service requires prior authorization, or if a service is not covered by the other health care coverage but is a covered service under the plan, as specified, or (2) if an enrollee requires a covered service and meets the requirements for continuity of care or the completion of covered services through a Medi-Cal managed care plan pursuant to specified provisions under existing law regarding services by a terminated or nonparticipating provider.

AB 979 **(Irwin D) California Cybersecurity Integration Center: artificial intelligence.**
Current Text: Amended: 4/23/2025 html pdf
Introduced: 2/20/2025
Status: 6/3/2025-In Senate. Read first time. To Com. on RLS. for assignment.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law requires the Office of Emergency Services to establish and lead the California Cybersecurity Integration Center. Existing law states that the center's mission is to reduce the likelihood and severity of cyber incidents that could damage California's economy, its critical infrastructure, or public and private sector computer networks in the state. Existing law requires the center to serve as the central organizing hub of state government's cybersecurity activities and coordinate information sharing with specified entities, including local, state, and federal agencies. This bill would require the California Cybersecurity Integration Center to develop, on or before July 1, 2026, in consultation with the Office of Information Security and the Government Operations Agency, a California AI Cybersecurity Collaboration Playbook, as specified, to facilitate information sharing across the artificial intelligence community and to strengthen collective cyber defenses against emerging threats. The bill would require the center to review federal requirements, standards, and industry best practices, as specified, and to use those resources to inform the development of the California AI Cybersecurity Collaboration Playbook. Except as specified, the bill would provide that any information related to cyber threat indicators or defensive measures for a cybersecurity purpose shared in accordance with the California AI Cybersecurity Collaboration Playbook is confidential and would prohibit that information from being disclosed, except as specified. The bill would also make findings and declarations related to its provisions. This bill contains other related provisions and other existing laws.

AB 980 **(Arambula D) Health care: medically necessary treatment.**
Current Text: Amended: 4/21/2025 html pdf
Introduced: 2/20/2025
Status: 5/1/2025-Failed Deadline pursuant to Rule 61(a)(2). (Last location was HEALTH on 3/10/2025)(May be acted upon Jan 2026)

Desk	2 year	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or health insurance policy to provide coverage for medically necessary treatment of mental health and substance use disorders under the same terms and conditions applied to other medical

conditions, as specified. Existing law generally authorizes a health care service plan or health insurer to use utilization review to approve, modify, delay, or deny requests for health care services based on medical necessity. This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2026, to provide coverage for medically necessary treatment of physical conditions and diseases under the same terms and conditions applied to other medical conditions, as specified. The bill would require the delivery of medically necessary services out of network if those services are not available within geographic and timely access standards. The bill would require a plan or insurer to apply specified clinical criteria and guidelines in conducting utilization review of the covered health care services and benefits for physical conditions and diseases. The bill would authorize the Director of the Department of Managed Health Care or the Insurance Commissioner, as applicable, to assess administrative or civil penalties, as specified, for violation of the requirements relating to utilization review. Because a willful violation of these requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program. This bill contains other existing laws.

AB 1012 **(Essayli R) Medi-Cal: immigration status.**
Current Text: Introduced: 2/20/2025 html pdf
Introduced: 2/20/2025
Status: 2/21/2025-From printer. May be heard in committee March 23.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing federal law provides for the Medicare Program, which is a public health insurance program for persons 65 years of age and older and specified persons with disabilities who are under 65 years of age. Existing law provides for the Medi-Cal program, administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. The federal Medicaid program prohibits payment to a state for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Existing state law extends Medi-Cal eligibility for the full scope of Medi-Cal benefits to an individual who does not have satisfactory immigrant status if they are otherwise eligible for those benefits, as specified. This bill would create the Serving Our Seniors Fund, would make an individual who does not have satisfactory immigrant status ineligible for Medi-Cal benefits, and would transfer funds previously appropriated for the provision of Medi-Cal benefits to those individuals to that fund. The bill would appropriate the moneys in that fund to the State Department of Health Care Services to restore and maintain payments for Medicare Part B premiums for eligible individuals. By making the moneys available without regard to fiscal years, the bill would create a continuous appropriation.

AB 1018 **(Bauer-Kahan D) Automated decision systems.**
Current Text: Amended: 5/1/2025 html pdf
Introduced: 2/20/2025
Status: 6/3/2025-In Senate. Read first time. To Com. on RLS. for assignment.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: The California Fair Employment and Housing Act establishes the Civil Rights Department within the Business, Consumer Services, and Housing Agency and requires the department to, among other things, bring civil actions to enforce the act. Existing law requires, on or before September 1, 2024, the Department of Technology to conduct, in coordination with other interagency bodies as it deems appropriate, a comprehensive inventory of all high-risk automated decision systems that have been proposed for use, development, or procurement by, or are being used, developed, or procured by, any state agency. This bill would generally regulate the development and deployment of an automated decision system (ADS) used to make consequential decisions, as defined. The bill would define "automated decision system" to mean a computational process derived from machine learning, statistical modeling, data analytics, or artificial intelligence that issues simplified output, including a score, classification, or recommendation, that is designed or used to assist or replace human discretionary decisionmaking and materially impacts natural persons. This bill would require a developer of a covered ADS, as defined, to take certain actions, including conduct performance evaluations of the covered ADS and provide deployers to whom the developer transfers the covered ADS with certain information, including the results of those performance evaluations. This bill would, beginning January 1, 2027, require a deployer of

a covered ADS to take certain actions, including provide certain disclosures to a subject of a consequential decision made or facilitated by the covered ADS, provide the subject an opportunity to opt out of the use of the covered ADS, provide the subject with an opportunity to appeal the outcome of the consequential decision, and submit the covered ADS to third-party audits, as prescribed. The bill would also prescribe requirements for a third party to audit a covered ADS. This bill contains other related provisions and other existing laws.

AB 1032 **(Harabedian D) Coverage for behavioral health visits.**
Current Text: Amended: 5/5/2025 html pdf
Introduced: 2/20/2025
Status: 6/3/2025-In Senate. Read first time. To Com. on RLS. for assignment.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2021, to provide coverage for medically necessary treatment of mental health and substance use disorders, as defined, under the same terms and conditions applied to other medical conditions. This bill would generally require a large group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2026, to reimburse an eligible enrollee or insured for up to 12 visits per year with a licensed behavioral health provider if the enrollee or insured is in a county where a local or state emergency has been declared due to wildfires. The bill would prohibit these benefits from being subject to utilization review. Under the bill, an enrollee or insured would be entitled to those benefits until one year from the date the local or state emergency is lifted, whichever is later. The bill would require a health care service plan contract or health insurer to provide notice to all affected enrollees of these provisions, as specified. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 1037 **(Elhawary D) Public health: substance use disorder.**
Current Text: Amended: 4/24/2025 html pdf
Introduced: 2/20/2025
Status: 6/5/2025-Read third time. Passed. Ordered to the Senate. (Ayes 55. Noes 19.)

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Under existing law, a licensed health care provider who is authorized by law to prescribe an opioid antagonist may issue standing orders for the distribution of an opioid antagonist to a person at risk of an opioid-related overdose or to a family member, friend, or other person in a position to assist a person at risk of an opioid-related overdose. Existing law exempts a health care provider who acts with reasonable care in issuing a prescription or order for an opioid antagonist from professional review, civil action, or criminal prosecution, under certain circumstances. Existing law requires that a person who receives an opioid antagonist pursuant to a standing order or otherwise possesses an opioid antagonist receive training, as specified. Existing law provides that a person who is trained in the use of an opioid antagonist and acts with reasonable care and in good faith is not subject to professional review, liable in a civil action, or subject to criminal prosecution. This bill would expand the above-described authorizations to those who are at risk of or any person who may be in a position to assist a person experiencing any overdose and would strike the requirement that those who receive and possess opioid antagonists receive training. The bill would authorize a person in a position to assist a person at risk of an overdose to possess an opioid antagonist and subsequently dispense or distribute an opioid antagonist to a person at risk of an overdose or another person in a position to assist a person at risk of an overdose. The bill would instead exempt a person who administers an opioid antagonist in good faith, whether or not they were trained, from liability for civil damages, as specified, and would instead exempt a health care provider who acts with reasonable care from liability in a civil action for any injuries or damages relating to or resulting from the acts or omissions of any person who administers the opioid antagonist in good faith, as specified. This bill contains other related provisions and other existing laws.

ALAMEDA Alliance FOR HEALTH

AB 1041 **(Bennett D) Health care coverage: health care provider credentials.**
Current Text: Amended: 5/23/2025 html pdf
Introduced: 2/20/2025
Status: 6/4/2025-In Senate. Read first time. To Com. on RLS. for assignment.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. This bill would require those departments to adopt specified credentialing requirements and adopt regulations to establish minimum standards or policies and processes that can streamline and reduce redundancy and delay in provider credentialing. The bill would also require those departments to adopt regulations to adopt, on or before January 1, 2028, the National Committee for Quality Assurance standardized credentialing form to be used by full service health care service plans and health insurers and their designees for credentialing and recredentialing purposes. The bill would require every full service health care service plan or health insurer or their designees to use the standardized credentialing form on and after January 1, 2028, or six months after the form is adopted, whichever is later. The bill would require those departments to update the form every three years, or as necessary to comply with changes in laws, regulations, and guidelines, as specified. This bill contains other related provisions and other existing laws.

AB 1090 **(Davies R) Alcoholism or drug abuse treatment facilities: County of Orange pilot program.**
Current Text: Amended: 3/24/2025 html pdf
Introduced: 2/20/2025
Status: 5/1/2025-Failed Deadline pursuant to Rule 61(a)(2). (Last location was HEALTH on 3/24/2025)(May be acted upon Jan 2026)

Desk	2 year	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law provides that the State Department of Health Care Services has the sole authority in state government to license adult alcoholism or drug abuse recovery or treatment facilities, as defined. Existing law authorizes the department to conduct announced or unannounced site visits to licensed facilities to review compliance with all applicable statutes and regulations. This bill would require the State Department of Health Care Services to establish a pilot program to locate an investigator within a participating county to investigate complaints against licensed adult alcoholism or drug abuse recovery or treatment facilities within the county. The participating county would be the County of Orange if the Orange County Board of Supervisors elects to participate in the pilot program. The bill would require the department to implement the pilot program by executing a contract with the County of Orange providing that the department will assign an investigator and the county will reimburse the department for the costs associated with the pilot program, including, but not limited to, the administrative costs and the investigator's compensation and benefits. The bill would require the pilot program to be completed no later than December 31, 2029, and would require the county to submit a report of the results of the pilot program, as specified, to the Legislature no later than December 31, 2030. The provisions of this bill would be repealed on December 31, 2034.

AB 1113 **(González, Mark D) Federally qualified health centers: mission spend ratio.**
Current Text: Amended: 5/5/2025 html pdf
Introduced: 2/20/2025
Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/21/2025)(May be acted upon Jan 2026)

Desk	Policy	2 year	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, including federally qualified health center (FQHC) services as described by federal law. The Medi-Cal program is, in part, governed and

funded by federal Medicaid program provisions. This bill would require each FQHC to have an annual mission spend ratio, as defined, of no less than 90% and would provide a methodology for calculation of that ratio, as specified, until the State Department of Public Health (department) has adopted a methodology for this purpose, with a goal of implementation of the latter methodology by January 1, 2027. By June 30, 2026, and annually thereafter by June 30, the bill would require each FQHC or its parent corporation to report to the department total revenues collected in a form to be determined by the department. The bill would require each report to include, among other things, one of certain Internal Revenue Service (IRS) forms. The bill would require each FQHC to submit an annual registration fee in an amount to be determined by the department and adjusted as necessary to fund these provisions. The bill would require the department to calculate and prepare a report of each FQHC's mission spend ratio no later than 90 days after the deadline for receipt of each FQHC's submission, and to transmit the report to the State Department of Health Care Services. The bill would require the department to conduct an audit of the financial information reported by FQHCs every 3 years, as specified. This bill contains other related provisions and other existing laws.

AB 1129 **(Rodriguez, Celeste D) Birth defects monitoring.**
Current Text: Amended: 6/2/2025 html pdf
Introduced: 2/20/2025
Status: 6/5/2025-Read third time. Passed. Ordered to the Senate. (Ayes 77. Noes 0.)

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law states that it is the intent of the Legislature to maintain an ongoing program of birth defects monitoring statewide, and requires the State Public Health Officer to maintain a system for the collection of information related to birth defects, as specified. Existing law requires the officer to require general acute care hospitals and physician-owned or physician-operated clinics that regularly provide services for the diagnosis or treatment of birth defects, genetic counseling, or prenatal diagnostic services to make available to the department the medical records of children suspected or diagnosed as having birth defects, as specified. Existing law authorizes the department to enter into a contract for the establishment and implementation of the birth defects monitoring program. This bill would state that it is additionally the intent of the Legislature to enable and maintain an ongoing program to monitor conditions, as defined, that occur during the 12-month period after an individual's birth statewide. The bill would authorize a local health officer to maintain a system for the collection of specified information related to birth defects and conditions. The bill would authorize a local health officer to require providers and laboratories, as specified, in addition to the facilities listed above, to either make available or to transmit to the local health department information related to birth defects and conditions, as specified. The bill would authorize a local health officer to enter into contracts for implementation of programs to collect information regarding, and to monitor, birth defects and conditions in their jurisdiction. This bill contains other related provisions and other existing laws.

AB 1137 **(Krell D) Reporting mechanism: child sexual abuse material.**
Current Text: Amended: 4/21/2025 html pdf
Introduced: 2/20/2025
Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/7/2025)(May be acted upon Jan 2026)

Desk	Policy	2 year	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law requires a social media platform to take certain actions with respect to child sexual abuse material on the social media platform, including by requiring the social media platform to provide, in a mechanism that is reasonably accessible to users, a means for a user who is a California resident to report material to the social media platform that the user reasonably believes meets certain criteria, including that the reported material is child sexual abuse material and that the reporting user is depicted in the material. Existing law also requires the social media platform to collect information reasonably sufficient to enable the social media platform to contact, as specified, a reporting user. This bill would delete the requirement for reporting material that the reporting user be depicted in the material, would require that the depicted individual be depicted as a minor, and would additionally require the mechanism to be clear and conspicuous. The bill would require a social media platform to ensure that any report submitted using the reporting mechanism is reviewed through a hash matching process and would require a social media company to ensure review by

a natural person if there is not an established or known hash match to child sexual abuse material with respect to the reported material and the reported material is not otherwise blocked. This bill contains other related provisions and other existing laws.

AB 1328 **(Rodriguez, Michelle D) Medi-Cal reimbursements: nonemergency ambulance transportation.**
Current Text: Amended: 5/23/2025 html pdf
Introduced: 2/21/2025
Status: 6/3/2025-In Senate. Read first time. To Com. on RLS. for assignment.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, including emergency or nonemergency medical or nonmedical transportation services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under this bill, commencing on January 1, 2026, and subject to an appropriation, Medi-Cal fee-for-service reimbursement for nonemergency ambulance transportation services, as defined, would be in an amount equal to 80% of the amount set forth in the federal Medicare ambulance fee schedule for the corresponding level of service, adjusted by the Geographic Practice Cost Index, as specified. The bill would require the department to establish a directed payment program for Medi-Cal managed care in order to follow a similar treatment to reimbursement rates for nonemergency ambulance transportation services. This bill contains other related provisions.

AB 1405 **(Bauer-Kahan D) Artificial intelligence: auditors: enrollment.**
Current Text: Amended: 4/3/2025 html pdf
Introduced: 2/21/2025
Status: 6/3/2025-In Senate. Read first time. To Com. on RLS. for assignment.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law establishes the Department of Technology within the Government Operations Agency. Existing law requires the department to conduct, in coordination with other interagency bodies as it deems appropriate, a comprehensive inventory of all high-risk automated decision systems that have been proposed for use, development, or procurement by, or are being used, developed, or procured by, any state agency. Existing law defines “automated decision system” as a computational process derived from machine learning, statistical modeling, data analytics, or artificial intelligence that issues simplified output, including a score, classification, or recommendation, that is used to assist or replace human discretionary decisionmaking and materially impacts natural persons. Existing law defines “artificial intelligence” as an engineered or machine-based system that varies in its level of autonomy and that can, for explicit or implicit objectives, infer from the input it receives how to generate outputs that can influence physical or virtual environments. This bill would require the Government Operations Agency, by January 1, 2027, to establish a mechanism on the agency’s internet website allowing AI auditors to enroll with the agency and allowing natural persons to report misconduct by an enrolled AI auditor. The bill would require the agency, commencing January 1, 2027, to publish information provided by an enrolled AI auditor on the agency’s internet website, retain specified reports for as long as the auditor remains enrolled, plus 10 years, and share reports submitted by persons reporting misconduct with other state agencies as necessary for enforcement purposes. This bill contains other related provisions and other existing laws.

AB 1415 **(Bonta D) California Health Care Quality and Affordability Act.**
Current Text: Amended: 4/24/2025 html pdf
Introduced: 2/21/2025
Status: 5/28/2025-Referred to Com. on HEALTH.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law, the California Health Care Quality and Affordability Act, establishes within the Department of Health Care Access and Information the Office of Health Care Affordability to analyze the health care market for cost

trends and drivers of spending, develop data-informed policies for lowering health care costs for consumers and purchasers, set and enforce cost targets, and create a state strategy for controlling the cost of health care and ensuring affordability for consumers and purchasers. Existing law requires the office to conduct ongoing research and evaluation on payers, fully integrated delivery systems, and providers to determine whether the definitions or other provisions of the act include those entities that significantly affect health care cost, quality, equity, and workforce stability. Existing law defines multiple terms relating to these provisions, including a health care entity to mean a payer, provider, or a fully integrated delivery system and a provider to mean specified entities delivering or furnishing health care services. This bill would update the definitions applying to these provisions, including defining a provider to mean specified private or public health care providers and would include a health system, as defined, in the existing definition. The bill would include additional definitions, including, but not limited to, a health system to mean specified entities under common ownership or control and a hedge fund to mean a pool of funds managed by investors for the purpose of earning a return on those funds, regardless of strategies used to manage the funds, subject to certain exceptions. The bill would require the office to conduct ongoing research and evaluation on management services organizations, as specified, and to establish requirements for management services organizations to submit data as necessary to carry out the functions of the office. This bill contains other related provisions and other existing laws.

AB 1418 **(Schiavo D) Department of Health Care Access and Information.**
Current Text: Amended: 5/23/2025 html pdf
Introduced: 2/21/2025
Status: 6/4/2025-In Senate. Read first time. To Com. on RLS. for assignment.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law requires the Department of Health Care Access and Information to establish a health care workforce research and data center to serve as the central source of health care workforce and educational data in the state. Existing law requires the department to prepare an annual report to the Legislature that, among other things, identifies education and employment trends in the health care profession and describes the health care workforce program outcomes and effectiveness. This bill would additionally require the department's report to include health care coverage trends for health care workers subject to waiting periods before receiving employer-sponsored health care coverage, and provide recommendations for state policy necessary to address gaps in health care coverage for those same health care workers. The bill would also specify the format for the above-described report.

SB 7 **(McNerney D) Employment: automated decision systems.**
Current Text: Amended: 5/1/2025 html pdf
Introduced: 12/2/2024
Status: 6/3/2025-In Assembly. Read first time. Held at Desk.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law requires the Department of Technology to conduct, in coordination with other interagency bodies as it deems appropriate, a comprehensive inventory of all high-risk automated decision systems (ADS) that have been proposed for use, development, or procurement by, or are being used, developed, or procured by, any state agency. Existing law establishes the Labor and Workforce Development Agency, which is composed of various departments responsible for protecting and promoting the rights and interests of workers in California, including the Division of Labor Standards Enforcement, led by the Labor Commissioner, within the Department of Industrial Relations. This bill would require an employer, or a vendor engaged by the employer, to provide a written notice that an ADS, for the purpose of making employment-related decisions, not including hiring, is in use at the workplace to all workers that will be directly or indirectly affected by the ADS, as specified. The bill would require the employer or vendor to maintain a list of all ADS currently in use and would require the notice to include the updated list. The bill would require an employer or vendor to notify, as provided, a job applicant that the employer utilizes an ADS in hiring decisions. The bill would prohibit an employer or vendor from using an ADS that does certain functions and would limit the purposes and manner in which an ADS may be used to make decisions. The bill would require an employer to allow a worker to access data collected or used by an ADS and to correct errors in data, as specified. This bill would require an employer or vendor to provide a written notice to a worker that has been affected by an a nonhiring employment-related decision made by an ADS, and provide that worker with a form or a link to an electronic form to appeal the decision within 30

days of the notification. The bill would require an employer or vendor to respond to an appeal within 14 business days, designate a human reviewer who meets specified criteria to objectively evaluate all evidence, and rectify the decision within 21 business days if the human reviewer determines that the employment-related decision should be overturned.This bill contains other related provisions and other existing laws.

SB 12

(Gonzalez D) State government: Immigrant and Refugee Affairs Agency: Office of Immigrant and Refugee Affairs.
Current Text: Amended: 4/10/2025 html pdf
Introduced: 12/2/2024
Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/5/2025)(May be acted upon Jan 2026)

Desk	Policy	2 year	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law designates 8 agencies in state government and requires the secretary of an agency to be generally responsible for the sound fiscal management of each department, office, or other unit within the agency. Existing law further requires the secretary of an agency to, among other duties, continually seek to improve the organization structure, the operating policies, and the management information systems of each department, office, or other unit. This bill would establish the Immigrant and Refugee Affairs Agency as an agency within state government, to be headed by a secretary who is appointed by the Governor and subject to Senate confirmation. The bill would specify that the purpose of the agency is to enhance, and reduce obstacles to, immigrant and refugee inclusion into the social, cultural, economic, and civic life of the state. The bill would authorize the secretary to, among other things, assist other state agencies in evaluating their programs for accessibility and effectiveness in providing services to immigrants and refugees and recommending policy and budget mechanisms for meeting immigrant and refugee inclusion. This bill would establish the Office of Immigrant and Refugee Affairs within the agency, under the direction of the Statewide Director of Immigrant and Refugee Inclusion. The bill would declare the intent to incorporate existing and future programs created to assist immigrants and refugees into the office. The bill would transfer to the office the property of any other office, agency, or department that relates to functions concerning immigrant and refugee affairs. The bill would require every officer and employee who is performing a function at another office, agency, or department that is transferred to the Office of Immigrant and Refugee Affairs to also be transferred to the office, and would provide that every officer and employee who is serving in the state civil service who is transferred to the office shall retain their status, position, and rights, except as specified. The bill would create the Immigrant and Refugee Inclusion Fund within the State Treasury, and would make the moneys in the fund available to the office upon appropriation by the Legislature. The bill would transfer to the office any unencumbered balance of any appropriation or other funds that were available for use in connection with any function transferred to the office. This bill contains other related provisions and other existing laws.

SB 27

(Umberg D) Community Assistance, Recovery, and Empowerment (CARE) Court Program.
Current Text: Introduced: 12/2/2024 html pdf
Introduced: 12/2/2024
Status: 6/5/2025-Referred to Com. on JUD.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law, the Community Assistance, Recovery, and Empowerment (CARE) Act, authorizes specified adult persons to petition a civil court to create a voluntary CARE agreement or a court-ordered CARE plan and implement services, to be provided by county behavioral health agencies, to provide behavioral health care, including stabilization medication, housing, and other enumerated services, to adults who are currently experiencing a severe mental illness and have a diagnosis identified in the disorder class schizophrenia and other psychotic disorders, and who meet other specified criteria. Existing law authorizes a specified individual to commence the CARE process, known as the original petitioner. Existing law authorizes the court to dismiss a case without prejudice when the court finds that a petitioner has not made a prima facie showing that they qualify for the CARE process. Existing law requires the court to take prescribed actions if it finds that a prima facie showing has been made, including, but not limited to, setting the matter for an initial appearance on the petition. This bill would allow the court to conduct the initial appearance on the

petition at the same time as the prima facie determination if specified requirements are met. This bill would declare that it is to take effect immediately as an urgency statute.

SB 32 **(Weber Pierson D) Health care coverage: timely access to care.**
Current Text: Amended: 3/25/2025 html pdf
Introduced: 12/2/2024
Status: 6/3/2025-In Assembly. Read first time. Held at Desk.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law authorizes the provision of Medi-Cal benefits by a contracted managed care plan and requires that benefits provided by a managed care plan are subject to specified time and distance standards. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan or health insurer that provides or arranges for the provision of hospital or physician services to comply with specified timely access to care requirements, including ensuring that its network has adequate capacity and availability of licensed health care providers to offer enrollees and insureds appointments that meet specified timeframes. Existing law authorizes the department director to take enforcement action against health care plans that fail to comply with these provisions, including assessing administrative penalties. This bill would require, on or before July 1, 2027, the Department of Managed Health Care, the Department of Insurance, and the State Department of Health Care Services to consult together and with stakeholders develop and adopt standards for the geographic accessibility of perinatal units to ensure timely access for enrollees and insureds, as specified. The bill's provisions would become inoperative on July 1, 2033, and would be repealed on January 1, 2034. This bill contains other existing laws.

SB 40 **(Wiener D) Health care coverage: insulin.**
Current Text: Amended: 5/23/2025 html pdf
Introduced: 12/3/2024
Status: 6/5/2025-Referred to Com. on HEALTH.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or disability insurance policy issued, amended, delivered, or renewed on or after January 1, 2000, that covers prescription benefits to include coverage for insulin if it is determined to be medically necessary. This bill would generally prohibit a health care service plan contract or health insurance policy issued, amended, delivered, or renewed on or after January 1, 2026, or a contract or policy offered in the individual or small group market on or after January 1, 2027, from imposing a copayment, coinsurance, deductible, or other cost sharing of more than $35 for a 30-day supply of an insulin prescription drug, except as specified. On and after January 1, 2026, the bill would prohibit a health care service plan or health insurer from imposing step therapy as a prerequisite to authorizing coverage of insulin, except as provided. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

SB 41 **(Wiener D) Pharmacy benefits.**
Current Text: Amended: 5/1/2025 html pdf
Introduced: 12/3/2024
Status: 6/5/2025-Referred to Coms. on HEALTH and JUD.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered

1st House	2nd House	Conc.			

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law requires a pharmacy benefit manager under contract with a health care service plan to, among other things, register with the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance. This bill would additionally require a pharmacy benefit manager to apply for and obtain a license from the Department of Insurance to operate as a pharmacy benefit manager no later than January 1, 2027. The bill would establish application qualifications and requirements, and would require initial license and renewal fees to be collected into the newly created Pharmacy Benefit Manager Account in the Insurance Fund to be available to the department for use, upon appropriation by the Legislature, as specified, for costs related to licensing and regulating pharmacy benefit managers. The bill would impose specified duties on pharmacy benefit managers and requirements for pharmacy benefit manager services and pharmacy benefit manager contracts, including requiring a pharmacy benefit manager to file specified reports with the department, the contents of which are not to be disclosed to the public. The bill would require the department, at specified intervals, to submit reports to the Legislature based on the reports submitted by pharmacy benefit managers, and would require the department to post the reports on the department's internet website. This bill would make a violation of these provisions subject to specified civil penalties. The bill would create the Pharmacy Benefit Manager Fines and Penalties Account in the General Fund, into which fines and administrative penalties would be deposited. This bill contains other related provisions and other existing laws.

SB 53 **(Wiener D) CalCompute: foundation models: whistleblowers.**
Current Text: Amended: 5/23/2025 html pdf
Introduced: 1/7/2025
Status: 6/5/2025-Referred to Coms. on P. & C.P. and JUD.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law establishes the Department of Technology within the Government Operations Agency. Existing law requires the department to conduct, in coordination with other interagency bodies as it deems appropriate, a comprehensive inventory of all high-risk automated decision systems that have been proposed for use, development, or procurement by, or are being used, developed, or procured by, any state agency. This bill would establish within the Government Operations Agency a consortium required to develop a framework for the creation of a public cloud computing cluster to be known as "CalCompute" that advances the development and deployment of artificial intelligence that is safe, ethical, equitable, and sustainable by, among other things, fostering research and innovation that benefits the public, as prescribed. The bill would require the Government Operations Agency to, on or before January 1, 2027, submit a report from the consortium to the Legislature with that framework, and would dissolve the consortium upon submission of that report. The bill would make those provisions operative only upon an appropriation in a budget act, or other measure, for its purposes. This bill contains other related provisions and other existing laws.

SB 62 **(Menjivar D) Health care coverage: essential health benefits.**
Current Text: Amended: 4/23/2025 html pdf
Introduced: 1/9/2025
Status: 6/5/2025-Referred to Com. on HEALTH.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, requires the Department of Managed Health Care to license and regulate health care service plans and makes a willful violation of the act a crime. Existing law requires the Department of Insurance to regulate health insurers. Existing law requires an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2017, to include, at a minimum, coverage for essential health benefits pursuant to the federal Patient Protection and Affordable Care Act. Existing law requires a health care service plan contract or health insurance policy to cover the same health benefits that the benchmark plan, the Kaiser Foundation Health Plan Small Group HMO 30 plan, offered during the first quarter of 2014, as specified. This bill would express the intent of the Legislature to review California's essential health benefits benchmark plan and establish a new benchmark plan for the 2027 plan year. The bill would require,

commencing January 1, 2027, if the United States Department of Health and Human Services approves a new essential health benefits benchmark plan for the state, as specified, the benchmark plan to include certain additional benefits, including coverage for specified fertility services and specified durable medical equipment. Because a violation of the bill by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other existing laws.

SB 81 **(Arreguín D) Health and care facilities: information sharing.**
Current Text: Amended: 5/6/2025 html pdf
Introduced: 1/17/2025
Status: 6/3/2025-In Assembly. Read first time. Held at Desk.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: The Confidentiality of Medical Information Act (CMIA) prohibits a provider of health care, a health care service plan, a contractor, or a corporation and its subsidiaries and affiliates from intentionally sharing, selling, using for marketing, or otherwise using any medical information, as defined, for any purpose not necessary to provide health care services to a patient, except as provided. The CMIA authorizes a provider of health care, health care service plan, or contractor to disclose medical information regarding a patient of the provider of health care or an enrollee or subscriber of a health care service plan with authorization from the patient or pursuant to a search warrant lawfully issued to a governmental law enforcement agency. Existing law makes a violation of these provisions that results in economic loss or personal injury to a patient punishable as a misdemeanor. This bill would revise the definition of "medical information" to include immigration status, including current and prior immigration status, and place of birth, and would define "immigration enforcement" to mean any and all efforts to investigate, enforce, or assist in the investigation or enforcement of any federal civil immigration law, and also includes any and all efforts to investigate, enforce, or assist in the investigation or enforcement of any federal criminal immigration that penalizes a person's presence in, entry or reentry to, or employment in, the United States. The bill would specify that a provider of health care, health care service plan, or contractor may disclose medical information regarding a patient of the provider of health care or an enrollee or subscriber or a health care service plan pursuant to a valid search warrant issued by a judicial officer, including a magistrate, to a governmental law enforcement agency. The bill would also prohibit, except to the extent expressly authorized by a patient, enrollee, or subscriber, or as otherwise required, a provider of health care, health care service plan, contractor, or corporation and its subsidiaries and affiliates from disclosing medical information for immigration enforcement. Because the bill would expand the scope of a crime, it would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

SB 85 **(Umberg D) Civil actions: service of summons.**
Current Text: Amended: 4/8/2025 html pdf
Introduced: 1/21/2025
Status: 5/29/2025-Referred to Com. on JUD.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law prescribes specified methods for the service of a summons in a civil action. Under existing law, if no provision is made in statute for the service of summons, a court may direct a summons to be served in a manner that is reasonably calculated to give actual notice to the party to be served. This bill would also authorize a court to direct a summons to be served in a manner that is reasonably calculated to give actual notice to the party to be served if a plaintiff, using due diligence, has been unable to serve the summons using methods prescribed by statute. The bill would authorize a court to direct service of the summons by electronic means, if such service is reasonably calculated to give actual notice. The bill would also except actions against public entities or agents or employees of public entities from these provisions and those in existing law described above.

SB 228 **(Cervantes D) Comprehensive Perinatal Services Program.**
Current Text: Amended: 5/23/2025 html pdf
Introduced: 1/28/2025
Status: 6/5/2025-In Assembly. Read first time. Held at Desk.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law establishes the Comprehensive Perinatal Services Program, the goals of which are to decrease and maintain the decreased level of perinatal, maternal, and infant mortality and morbidity in the State of California and to support methods of providing comprehensive prenatal care that prevent prematurity and the incidence of low birth weight infants. Under the program, the State Department of Public Health is required to develop and maintain a statewide comprehensive community-based perinatal services program and enter into contracts, grants, or agreements with health care providers to deliver these services in a coordinated effort. Existing law also requires the department to monitor the delivery of services under those contracts, grants, and agreements through a uniform health data collection system that utilizes epidemiologic methodology. This bill would specify that the State Department of Health Care Services is responsible for implementing comprehensive community-based perinatal services for purposes of the Medi-Cal program. By July 1, 2027, the bill would require the State Department of Health Care Services, in consultation with the State Department of Public Health, to clarify each department's roles and responsibilities in the Comprehensive Perinatal Services Program by regulation. The bill would, among other things, require the State Department of Health Care Services to develop a training on administering the program, require all perinatal providers in the program to attend the training, and require all Medi-Cal managed care plans to ensure providers receive the training. The bill would require the State Department of Health Care Services, no later than July 15, 2026, to submit to the Assembly Health Committee and the Senate Health Committee, and post on its internet website, reports that identify the number of pregnant and postpartum individuals that received and were offered Comprehensive Perinatal Services Program services from January 1, 2022, to January 1, 2025, inclusive. The bill would also require the State Department of Health Care Services, commencing January 1, 2028, and every 3 years thereafter, to submit to those committees, and post on its internet website, reports that identify the number of pregnant and postpartum individuals that received and were offered Comprehensive Perinatal Services Program services during the previous 3 years. The bill would also state the intent of the Legislature to enact additional legislation relating to the program in order to implement several legislative recommendations made in a specified report issued by the California State Auditor's office including by, among other things, requiring the State Department of Health Care Services to create and use a perinatal services data form to engage in additional data collection duties, as specified.

SB 238 **(Smallwood-Cuevas D) Workplace surveillance tools.**
Current Text: Amended: 5/1/2025 html pdf
Introduced: 1/29/2025
Status: 6/4/2025-In Assembly. Read first time. Held at Desk.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law establishes the Department of Industrial Relations in the Labor and Workforce Development Agency to administer and enforce various laws relating to employment and working conditions. This bill would require an employer to annually provide a notice to the department of all the workplace surveillance tools the employer is using in the workplace. The bill would require the notice to include, among other information, the personal information that will be collected from workers and consumers and whether they will have the option of opting out of the collection of personal information. The bill would require the department to make the notice publicly available on the department's internet website within 30 days of receiving the notice. The bill would define "employer" to include, among other entities, public employers, as specified.

SB 242 **(Blakespear D) Medicare supplement coverage: open enrollment periods.**
Current Text: Amended: 5/5/2025 html pdf
Introduced: 1/30/2025
Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/19/2025)(May be acted upon Jan 2026)

Desk	Policy	2 year	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing federal law provides for the Medicare Program, which is a public health insurance program for

persons 65 years of age and older and specified persons with disabilities who are under 65 years of age. Existing federal law specifies different parts of Medicare that cover specific services, such as Medicare Part B, which generally covers medically necessary services and supplies and preventive services. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing federal law additionally provides for the issuance of Medicare supplement policies or certificates, also known as Medigap coverage, which are advertised, marketed, or designed primarily as a supplement to reimbursements under the Medicare Program for the hospital, medical, or surgical expenses of persons eligible for the Medicare Program, including coverage of Medicare deductible, copayment, or coinsurance amounts, as specified. Existing law, among other provisions, requires supplement benefit plans to be uniform in structure, language, designation, and format with the standard benefit plans, as prescribed. Existing law prohibits an issuer from denying or conditioning the offering or effectiveness of any Medicare supplement contract, policy, or certificate available for sale in this state, or discriminating in the pricing of a contract, policy, or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application that is submitted prior to or during the 6-month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Existing law requires an issuer to make available specified Medicare supplement benefit plans to a qualifying applicant under those circumstances who is 64 years of age or younger who does not have end stage renal disease. This bill would delete the exclusion of otherwise qualified applicants who have end stage renal disease, thereby making the specified Medicare supplement benefit plans available to those individuals. The bill, on and after January 1, 2026, 2027, would prohibit an issuer of Medicare supplement coverage in this state from denying or conditioning the issuance or effectiveness of any Medicare supplement coverage available for sale in the state, or discriminate in the pricing of that coverage because of the health status, claims experience, receipt of health care, medical condition, or age of an applicant, except as specified, if an application for coverage is submitted during an open enrollment period, as specified in the bill. The bill would entitle an individual enrolled in Medicare Part B to a 90-day annual open enrollment period beginning on January 1 of each year, as specified, during which period the bill would require applications to be accepted for any Medicare supplement coverage available from an issuer, as specified. The bill would require the open enrollment period to be a guaranteed issue period. The bill would authorize premium rates offered to applicants during the open enrollment period to vary based on the applicants' age at the time of issue, as specified, but would prohibit the premiums from varying based on age after the contract is issued. This bill contains other related provisions and other existing laws.

SB 246 **(Grove R) Medi-Cal: graduate medical education payments.**
Current Text: Introduced: 1/30/2025 html pdf
Introduced: 1/30/2025
Status: 6/5/2025-Referred to Com. on HEALTH.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law requires the department, subject to any necessary federal approvals and the availability of federal financial participation, to make Medi-Cal payments to designated public hospitals (DPHs) and their affiliated government entities, as defined, in recognition of the Medi-Cal managed care share of graduate medical education (GME) costs. Existing law requires that the payments consist of direct and indirect GME payments made in recognition and support of the direct costs incurred in the operation of GME programs and the increased operating and patient care costs associated with teaching programs, respectively. Under existing law, the nonfederal share of these payments consist of voluntary intergovernmental transfers (IGTs) of funds provided by DPHs or their affiliated government entities, or other eligible public entities, as specified. Under existing law, the continuously appropriated DPH GME Special Fund is established for these purposes. This bill would require the department, subject to any necessary federal approvals and the availability of federal financial participation, to make additional Medi-Cal payments to district and municipal public hospitals (DMPHs), defined as nondesignated public hospitals, and to their affiliated government entities, in recognition of the Medi-Cal managed care share of GME costs. Under the bill, these payments would be made in a manner consistent with the methodology for GME payments to DPHs and their affiliated government entities and would consist of the above-described direct and indirect GME payment components. The bill would authorize the department to seek federal approval for other forms of GME payments to

DMPHs and their affiliated government entities, as specified. This bill contains other related provisions and other existing laws.

SB 250 **(Ochoa Bogh R) Medi-Cal: provider directory: skilled nursing facilities.**
Current Text: Introduced: 1/30/2025 html pdf
Introduced: 1/30/2025
Status: 6/5/2025-Referred to Com. on HEALTH.

1st House				2nd House				Conf. Conc.	Enrolled	Vetoed	Chaptered
Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor				

Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, under fee-for-service or managed care delivery systems. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing federal Medicaid law requires the state to publish an online directory of physicians and, at state option, other providers, as specified. Existing state law sets forth Medi-Cal managed care provisions relating to a Medi-Cal applicant or beneficiary being informed of the health care options available regarding methods of receiving Medi-Cal benefits, including through certain provider directories. The department has administratively created an online provider directory through an internet website known as Medi-Cal Managed Care Health Care Options. This bill would require, as part of the health care options information posted by the department, in the provider directory that lists accepted Medi-Cal managed care plans, through the Medi-Cal Managed Care Health Care Options internet website and any other applicable mechanisms, that the directory include skilled nursing facilities as one of the available searchable provider types. The bill would require that this provision be implemented in conjunction with implementation of the above-described provisions.

SB 257 **(Wahab D) Pregnancy As a Recognized Event for Nondiscriminatory Treatment (PARENT) Act.**
Current Text: Introduced: 2/3/2025 html pdf
Introduced: 2/3/2025
Status: 6/4/2025-In Assembly. Read first time. Held at Desk.

1st House				2nd House				Conf. Conc.	Enrolled	Vetoed	Chaptered
Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor				

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of disability insurers by the Department of Insurance. Existing law requires a health care service plan or disability insurer to allow an individual to enroll in or change their health benefit plan as a result of a specified triggering event. Existing law prohibits a health care service plan contract or disability insurance policy issued, amended, renewed, or delivered on or after July 1, 2003, from imposing a copayment or deductible for specified maternity services that exceeds the most common amount of the copayment or deductible imposed for services provided for other covered medical conditions. This bill, the Pregnancy As a Recognized Event for Nondiscriminatory Treatment (PARENT) Act, would make pregnancy a triggering event for purposes of enrollment or changing a health benefit plan. The bill would prohibit a health care service plan contract or disability insurance policy issued, amended, or renewed on or after January 1, 2026, that provides coverage for maternity services or newborn and pediatric care services from taking specified actions based on the circumstances of conception, including denying, limiting, or seeking reimbursement for maternity services or newborn and pediatric care services because the enrollee or insured is acting as a gestational carrier. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

SB 278 **(Cabaldon D) Health data: HIV test results.**
Current Text: Amended: 3/28/2025 html pdf
Introduced: 2/4/2025
Status: 6/5/2025-Referred to Coms. on HEALTH and P. & C.P.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered

1st House	2nd House	Conc.			

Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, public health records relating to human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS), containing personally identifying information, that were developed or acquired by a state or local public health agency, or an agent of that agency, are generally confidential and are prohibited from being disclosed. Under existing law, in the form of exceptions, certain disclosures of the information are authorized for the purpose of facilitating appropriate HIV/AIDS medical care and treatment, including disclosures by state or local public health agency staff to agency staff, the designated health care provider, or the HIV-positive person who is the subject of the record, as specified. This bill would additionally authorize state public health agency HIV surveillance staff to disclose the information to State Department of Health Care Services staff, followed by authorized disclosures to the Medi-Cal managed care plan if applicable, the HIV-positive person who is the subject of the record, and the designated health care provider, for the purpose of proactively offering and coordinating care and treatment services to the person or for the purpose of administering quality improvement programs, as specified, designed to improve HIV care for Medi-Cal beneficiaries. The bill would require the State Department of Health Care Services, in consultation with the State Department of Public Health, to develop a mechanism by which a Medi-Cal beneficiary would be authorized to opt out of the disclosure of personally identifying information in public health records relating to HIV or AIDS to State Department of Health Care Services staff or the Medi-Cal managed care plan for the above-described purposes. This bill contains other related provisions and other existing laws.

SB 306 **(Becker D) Health care coverage: prior authorizations.**
Current Text: Amended: 4/28/2025 html pdf
Introduced: 2/10/2025
Status: 6/5/2025-Referred to Com. on HEALTH.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law generally authorizes a health care service plan or health insurer to use prior authorization and other utilization review or utilization management functions, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. Existing law requires a health care service plan or health insurer, including those plans or insurers that delegate utilization review or utilization management functions to medical groups, independent practice associations, or to other contracting providers, to comply with specified requirements and limitations on their utilization review or utilization management functions. Existing law requires the criteria or guidelines used to determine whether or not to authorize, modify, or deny health care services to be developed with involvement from actively practicing health care providers. This bill would prohibit a health care service plan or health insurer, or an entity with which the plan or insurer contracts for prior authorization, from imposing prior authorization, as defined, or prior notification on a covered health care service for a period of one year beginning on April first of the current calendar year, if specified conditions exist, including that the health care service plan approved 90% or more of the requests for a covered service in the prior calendar year. The bill would also require a health care service plan or health insurer to post specified information, including a list of covered health care services exempted from prior authorization, on its internet website by March 15 of each calendar year. The bill would also clarify how to calculate a plan's or insurer's approval rate for purposes of determining whether a service may be exempted from prior authorization. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

SB 324 **(Menjivar D) Medi-Cal: enhanced care management and community supports.**
Current Text: Amended: 4/7/2025 html pdf
Introduced: 2/11/2025
Status: 6/5/2025-Referred to Com. on HEALTH.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law, subject to implementation of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, requires the department to implement an enhanced care management (ECM) benefit designed to address the clinical and nonclinical needs on a whole-person-care basis for certain target populations of Medi-Cal beneficiaries enrolled in Medi-Cal managed care plans. Under existing law, target populations include, among others, high utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits, and individuals experiencing homelessness. Existing law, subject to CalAIM implementation, authorizes a Medi-Cal managed care plan to elect to cover community supports, as specified. Under existing law, community supports that the department is authorized to approve include, among others, housing transition navigation services and medically supportive food and nutrition services. This bill would require a Medi-Cal managed care plan, for purposes of covering the ECM benefit, or if it elects to cover a community support, to contract with community providers, as defined, whenever those providers are available in the respective county and have experience in providing the applicable ECM or community support, and can demonstrate that they are capable of providing access and meeting quality requirements in accordance with Medi-Cal guidelines. The bill would require a managed care plan to honor member preference with regard to the applicable ECM or community support by authorizing service delivery to the contracted provider who is submitting a request for approval of services to the managed care plan. This bill contains other related provisions and other existing laws.

SB 339 **(Cabaldon D) Medi-Cal: laboratory rates.**
Current Text: Amended: 4/9/2025 html pdf
Introduced: 2/12/2025
Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/12/2025)(May be acted upon Jan 2026)

Desk	Policy	2 year	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law prohibits Medi-Cal reimbursement to providers for clinical laboratory or laboratory services from exceeding the lowest of the following: (1) the amount billed; (2) the charge to the general public; (3) 100% of the lowest maximum allowance established by the federal Medicare Program; or (4) a reimbursement rate based on an average of the lowest amount that other payers and other state Medicaid programs are paying. This bill would instead require the above-described Medi-Cal reimbursement to equal the lowest of those metrics. The bill would carve out, from the above-described provision, for dates of service on or after July 1, 2027, or when funding is appropriated to implement this provision, whichever is sooner, Medi-Cal reimbursement to providers for clinical laboratory or laboratory services related to the diagnosis and treatment of sexually transmitted infections, and would apply that threshold but excluding the reimbursement rate described in clause (4) above. This bill contains other related provisions and other existing laws.

SB 363 **(Wiener D) Health care coverage: independent medical review.**
Current Text: Amended: 5/23/2025 html pdf
Introduced: 2/13/2025
Status: 6/5/2025-Referred to Com. on HEALTH.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law establishes the Independent Medical Review System within each department, under which an enrollee or insured may

seek review if a health care service has been denied, modified, or delayed by a health care service plan or health insurer and the enrollee or insured has previously filed a grievance that remains unresolved after 30 days. This bill would require a health care service plan or health insurer to annually report to the appropriate department the total number of claims processed by the health care service plan or health insurer for the prior year and its number of treatment denials or modifications, separated and disaggregated as specified, commencing on or before June 1, 2026. The bill would require the departments to compare the number of a health care service plan's or health insurer's treatment denials and modifications to (1) the number of successful independent medical review overturns of the plan's or insurer's treatment denials or modifications and (2) the number of treatment denials or modifications reversed by a plan or insurer after an independent medical review for the denial or modification is requested, filed, or applied for. The bill would make a health care service plan or health insurer liable for an administrative penalty, as specified, if more than 50% of the independent medical reviews filed with a health care service plan or health insurer result in an overturning or reversal of a treatment denial or modification in any one individual category of specified general types of care. The bill would make a health care service plan or health insurer liable for additional administrative penalties for each independent medical review resulting in an additional overturned or reversed denial or modification in excess of that threshold. The bill would require the departments to annually include data, analysis, and conclusions relating to these provisions in specified reports.

SB 402 **(Valladares R) Health care coverage: autism.**
Current Text: Introduced: 2/14/2025 html pdf
Introduced: 2/14/2025
Status: 6/4/2025-In Assembly. Read first time. Held at Desk.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or a health insurance policy to provide coverage for behavioral health treatment for pervasive developmental disorder or autism and defines "behavioral health treatment" to mean specified services and treatment programs, including treatment provided pursuant to a treatment plan that is prescribed by a qualified autism service provider and administered either by a qualified autism service provider or by a qualified autism service professional or qualified autism service paraprofessional. Existing law defines "qualified autism service provider," "qualified autism service professional," and "qualified autism service paraprofessional" for those purposes. Those definitions are contained in the Health and Safety Code and the Insurance Code. This bill would move those definitions to the Business and Professions Code. The bill would also make technical and conforming changes.

SB 418 **(Menjivar D) Health care coverage: nondiscrimination.**
Current Text: Amended: 4/24/2025 html pdf
Introduced: 2/18/2025
Status: 6/5/2025-Referred to Coms. on HEALTH and JUD.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plans and health insurers, as specified, within 6 months after the relevant department issues specified guidance, or no later than March 1, 2025, to require all of their staff who are in direct contact with enrollees or insureds in the delivery of care or enrollee or insured services to complete evidence-based cultural competency training for the purpose of providing trans-inclusive health care for individuals who identify as transgender, gender diverse, or intersex. This bill would prohibit a subscriber, enrollee, policyholder, or insured from being excluded from enrollment or participation in, being denied the benefits of, or being subjected to discrimination by, any health care service plan or health insurer licensed in this state, on the basis of race, color, national origin, age, disability, or sex. The bill would define discrimination on the basis of sex for those purposes to include, among other things, sex characteristics, including intersex traits, pregnancy, and gender identity. The bill would prohibit a health care service plan or health

insurer from taking specified actions relating to providing access to health programs and activities, including, but not limited to, denying or limiting health care services to an individual based upon the individual's sex assigned at birth, gender identity, or gender otherwise recorded. The bill would prohibit a health care service plan or health insurer, in specified circumstances, from taking various actions, including, but not limited to, denying, canceling, limiting, or refusing to issue or renew health care service plan enrollment, health insurance coverage, or other health-related coverage, or denying or limiting coverage of a claim, or imposing additional cost sharing or other limitations or restrictions on coverage, on the basis of race, color, national origin, sex, age, disability, as specified. Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

SB 439 **(Weber Pierson D) California Health Benefit Review Program: extension.**
Current Text: Amended: 4/10/2025 html pdf
Introduced: 2/18/2025
Status: 6/3/2025-In Assembly. Read first time. Held at Desk.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law establishes the Health Care Benefits Fund to support the University of California's implementation of the California Health Benefit Review Program. Under the program, the University of California assesses legislation proposing to repeal or mandate a benefit or service requirement on health care insurance plans or health insurers. Under the program, the University of California provides a written analysis that includes, among other data, financial impacts of legislation on publicly funded state health insurance programs, including the Medi-Cal program and the Healthy Families Program. Existing law imposes an annual charge on health care service plans and health insurers for the 2022–23 to 2026–27 fiscal years, inclusive, as specified, to be deposited into the fund. Existing law prohibits the total annual assessment on health care service plans and health insurers from exceeding $2,200,000. Under existing law, the fund and the program become inoperative on July 1, 2027, and are repealed as of January 1, 2028. This bill would extend the operation of the California Health Benefit Review Program and the Health Care Benefits Fund through July 1, 2033, and would authorize the continued assessment of the annual charge on health care service plans and health insurers for that purpose for the 2026–27 to 2032–33 fiscal years, inclusive. The bill would increase the allowable total annual assessment on health care service plans and health insurers to $3,200,000. The bill would remove the Healthy Families Program as an example of the publicly funded state health insurance programs within an analysis of financial impacts of legislation. This bill contains other related provisions.

SB 449 **(Valladares R) Health care service plan requirements.**
Current Text: Introduced: 2/18/2025 html pdf
Introduced: 2/18/2025
Status: 2/26/2025-Referred to Com. on RLS.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law requires a health care service plan to meet specified requirements, and requires a health care service plan contract to provide to subscribers and enrollees specified basic health care services. This bill would make technical, nonsubstantive changes to those provisions.

SB 466 **(Caballero D) Drinking water: hexavalent chromium: civil liability: exemption.**
Current Text: Amended: 5/21/2025 html pdf
Introduced: 2/19/2025
Status: 6/5/2025-Referred to Coms. on E.S & T.M. and JUD.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: The California Safe Drinking Water Act provides for the operation of public water systems and imposes on

the State Water Resources Control Board various duties and responsibilities for the regulation and control of drinking water in the State of California. The act requires the state board to adopt primary drinking water standards for contaminants in drinking water based upon specified criteria, and requires a primary drinking water standard to be established for hexavalent chromium. Existing law authorizes the state board to grant a variance from primary drinking water standards to a public water system. This bill would prohibit a public water system that meets the total chromium maximum containment level (MCL) enforceable standard for drinking water in California from being held liable in any civil action brought by an individual or entity that is not a governmental agency related to hexavalent chromium in drinking water while implementing and in compliance with a state board-approved hexavalent chromium MCL compliance plan, or during the period between when it has submitted a hexavalent chromium MCL compliance plan for approval to the state board and action on the proposed compliance plan by the state board is pending, except as specified.

SB 468 **(Becker D) High-risk artificial intelligence systems: duty to protect personal information.**
Current Text: Introduced: 2/19/2025 html pdf
Introduced: 2/19/2025
Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/5/2025)(May be acted upon Jan 2026)

Desk	Policy	2 year	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law, the California Consumer Privacy Act of 2018 (CCPA), grants a consumer various rights with respect to personal information that is collected or sold by a business. The CCPA defines various terms for these purposes. The California Privacy Rights Act of 2020 (CPRA), approved by the voters as Proposition 24 at the November 3, 2020, statewide general election, amended, added to, and reenacted the CCPA and establishes the California Privacy Protection Agency (agency) and vests the agency with full administrative power, authority, and jurisdiction to enforce the CCPA. Existing law requires, on or before January 1, 2026, and before each time thereafter that a generative artificial intelligence system or service, as defined, or a substantial modification to a generative artificial intelligence system or service, released on or after January 1, 2022, is made available to Californians for use, regardless of whether the terms of that use include compensation, a developer of the system or service to post on the developer's internet website documentation, as specified, regarding the data used to train the generative artificial intelligence system or service. This bill would impose a duty on a covered deployer, defined as a business that deploys a high-risk artificial intelligence system that processes personal information, to protect personal information held by the covered deployer, subject to certain requirements. In this regard, the bill would require a covered deployer whose high-risk artificial intelligence systems process personal information to develop, implement, and maintain a comprehensive information security program, as specified, that contains administrative, technical, and physical safeguards that are appropriate for, among other things, the covered deployer's size, scope, and type of business. The bill would require the program described above to meet specified requirements, including, among other things, that the program incorporates safeguards that are consistent with the safeguards for the protection of personal information and information of a similar character under applicable state or federal laws and regulations. This bill contains other related provisions and other existing laws.

SB 481 **(Alvarado-Gil R) In-home supportive services.**
Current Text: Introduced: 2/19/2025 html pdf
Introduced: 2/19/2025
Status: 2/26/2025-Referred to Com. on RLS.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law provides for the In-Home Supportive Services (IHSS) program, administered by the State Department of Social Services and counties, under which qualified aged, blind, and disabled persons are provided with supportive services in order to permit them to remain in their own homes. This bill would make technical, nonsubstantive changes to those provisions.

SB 528 **(Weber Pierson D) Health care: maintenance and expansion.**
Current Text: Amended: 5/5/2025 html pdf

Introduced: 2/20/2025
Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/19/2025)(May be acted upon Jan 2026)

Desk	Policy	2 year	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law establishes, under the Medi-Cal program, the Family Planning, Access, Care, and Treatment (Family PACT) Program. If Family PACT becomes inoperative, existing law requires all persons who have received, or are eligible to receive, comprehensive clinical family planning services pursuant to Family PACT to receive family planning services under other specified provisions of the Medi-Cal program or under the State-Only Family Planning Program, which is also established within the department for purposes of family planning services. This bill would require the department, subject to an appropriation, to develop a new program or to expand any existing state-only-funded health programs, in order to provide to Medi-Cal beneficiaries certain services or benefits that are otherwise covered under the Medi-Cal program but for any lack of, elimination of, reduction in, or limitation on, federal financial participation. This bill contains other related provisions and other existing laws.

SB 530 **(Richardson D) Medi-Cal: time and distance standards.**
Current Text: Amended: 5/23/2025 html pdf
Introduced: 2/20/2025
Status: 6/5/2025-Referred to Com. on HEALTH.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, under fee-for-service or managed care delivery systems. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. This bill would extend the operation of those standards indefinitely. The bill would also require a managed care plan to ensure that each subcontractor network complies with certain appointment time standards unless already required to do so. The bill would set forth related reporting requirements with regard to subcontractor networks.

SB 535 **(Richardson D) Obesity Treatment Parity Act.**
Current Text: Introduced: 2/20/2025 html pdf
Introduced: 2/20/2025
Status: 6/5/2025-Referred to Com. on HEALTH.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act's requirements a crime. Existing law provides for the regulation of disability and health insurers by the Department of Insurance. Existing law sets forth specified coverage requirements for plan contracts and insurance policies. This bill, the Obesity Treatment Parity Act, would require an individual or group health care service plan contract or health insurance policy that provides coverage for outpatient prescription drug benefits and is issued, amended, or renewed on or after January 1, 2026, to include coverage for intensive behavioral therapy for the treatment of obesity, bariatric surgery, and at least one antiobesity medication approved by the United States Food and Drug Administration. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

SB 579 **(Padilla D) Mental health and artificial intelligence working group.**
Current Text: Amended: 3/26/2025 html pdf

Introduced: 2/20/2025
Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 4/21/2025)(May be acted upon Jan 2026)

Desk	Policy	2 year	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law establishes the Government Operations Agency, which consists of several state entities, including, among others, the State Personnel Board, the Department of General Services, and the Office of Administrative Law. Under existing law, the Government Operations Agency is under the direction of an executive officer known as the Secretary of Government Operations, who is appointed by, and holds office at the pleasure of, the Governor, subject to confirmation by the Senate. This bill would require the secretary, by July 1, 2026, to appoint a mental health and artificial intelligence working group, as specified, that would evaluate certain issues to determine the role of artificial intelligence in mental health settings. The bill would require the working group to take input from various stakeholder groups, including health organizations and academic institutions, and conduct at least 3 public meetings. The bill would require the working group to produce a report of its findings to the Legislature by July 1, 2028, and issue a followup report by January 1, 2030, as specified. The bill would repeal its provisions on July 1, 2031.

SB 626 **(Smallwood-Cuevas D) Perinatal health screenings and treatment.**
Current Text: Amended: 5/5/2025 html pdf
Introduced: 2/20/2025
Status: 6/3/2025-In Assembly. Read first time. Held at Desk.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law requires a licensed health care practitioner who provides prenatal, postpartum, or interpregnancy care for a patient to offer to screen or appropriately screen a mother for maternal mental health conditions. For purposes of that requirement, existing law defines “maternal mental health condition” to mean a mental health condition that occurs during pregnancy, the postpartum period, or interpregnancy, as specified. This bill would modify the term “maternal mental health condition” to “perinatal mental health condition” and additionally include in its definition a mental health condition that occurs during the perinatal period. The bill would require a licensed health care practitioner who provides perinatal care for a patient to screen, diagnose, and treat the patient for a perinatal mental health condition in accordance with applicable clinical guidelines or standards appropriate to the provider’s license, training, and scope of practice, as specified. This bill contains other related provisions and other existing laws.

SB 660 **(Menjivar D) California Health and Human Services Data Exchange Framework.**
Current Text: Amended: 4/22/2025 html pdf
Introduced: 2/20/2025
Status: 6/3/2025-In Assembly. Read first time. Held at Desk.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law establishes the Center for Data Insights and Innovation, within the California Health and Human Services Agency, to ensure the enforcement of state law mandating the confidentiality of medical information. The center is administered by a director who also serves as the California Health and Human Services Chief Data Officer. Existing law further establishes the California Health and Human Services Data Exchange Framework to require the exchange of health information among health care entities and government agencies in the state, among other things. Existing law requires the agency to convene a stakeholder advisory group to advise on the development of implementation of the California Health and Human Services Data Exchange Framework. This bill would require the center, on or before January 1, 2026, and subject to an appropriation in the annual Budget Act, to take over the establishment, implementation, and all of the functions related to the California Health and Human Services Data Exchange Framework, including the data sharing agreement and policies and procedures, from the agency. The bill would expand the entities that are specifically required to execute a data sharing agreement with the California Health and Human Services Data Exchange Framework and authorize the center to determine other categories of entities required to execute a data sharing agreement. agreement, as specified. The bill would require the center, no later than

July 1, 2025, 2026, to establish a process to designate qualified health information organizations as data sharing intermediaries that have demonstrated their ability to meet requirements of the California Health and Human Services Data Exchange Framework. The bill would require the center to annually report to the Legislature on the California Health and Human Services Data Exchange Framework, including compliance with data sharing agreements. This bill contains other related provisions.

SB 812 **(Allen D) Qualified youth drop-in center health care coverage.**
Current Text: Amended: 5/5/2025 html pdf
Introduced: 2/21/2025
Status: 5/28/2025-Read third time. Passed. (Ayes 35. Noes 0.) Ordered to the Assembly. In Assembly. Read first time. Held at Desk.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or health insurance policy issued, amended, renewed, or delivered on or after January 1, 2024, that provides coverage for medically necessary treatment of mental health and substance use disorders to cover the provision of those services to an individual 25 years of age or younger when delivered at a schoolsite. This bill would additionally require a contract or policy that provides coverage for medically necessary treatment of mental health and substance use disorders to cover the provision of those services to an individual 25 years of age or younger when delivered at a qualified youth drop-in center. Because a violation of this requirement relative to health care service plans would be a crime, the bill would create a state-mandated local program. This bill contains other related provisions and other existing laws.

SB 833 **(McNerney D) Critical infrastructure: automated decision systems: human oversight.**
Current Text: Amended: 3/26/2025 html pdf
Introduced: 2/21/2025
Status: 6/4/2025-In Assembly. Read first time. Held at Desk.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law, the California Emergency Services Act, establishes the California Cybersecurity Integration Center within the Office of Emergency Services to serve as the central organizing hub of state government's cybersecurity activities and to coordinate information sharing with various entities. Existing law also requires the Technology Recovery Plan element of the State Administrative Manual to ensure the inclusion of cybersecurity strategy incident response standards for each state agency to secure its critical infrastructure controls and information, as prescribed. This bill would require an operator, defined as a state agency in charge of critical infrastructure, that deploys artificial intelligence to establish a human oversight mechanism to monitor the system's operations in real time and review and approve any plan or action proposed by the artificial intelligence system before execution, except as provided. The bill would require the Department of Technology to administer specialized training in artificial intelligence safety protocols and risk management techniques to oversight personnel. The bill would require an operator to conduct an annual assessment of its artificial intelligence systems and automated decision systems, as specified, and to submit a summary of the findings to the department.

SB 862 **(Committee on Health) Health.**
Current Text: Amended: 4/22/2025 html pdf
Introduced: 3/17/2025
Status: 6/5/2025-Referred to Com. on HEALTH.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law, the Mental Health Services Act (MHSA), an initiative measure enacted by the voters as

Proposition 63 at the November 2, 2004, statewide general election, established the Mental Health Services Oversight and Accountability Commission to oversee the implementation of the MHSA. Existing law specifies the composition of the 16-member commission, including the Attorney General or their designee, the Superintendent of Public Instruction or their designee, specified members of the Legislature, and 12 members appointed by the Governor, as prescribed. Existing law, the Behavioral Health Services Act (BHSA), an initiative measure enacted by the voters as Proposition 1 at the March 5, 2024, statewide primary election, recast the MHSA by, among other things, renaming the commission to the Behavioral Health Services Oversight and Accountability Commission and changing its composition and duties. This bill would make technical changes to reflect the correct name of the commission. This bill contains other related provisions and other existing laws.

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Executive Dashboard

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Financials

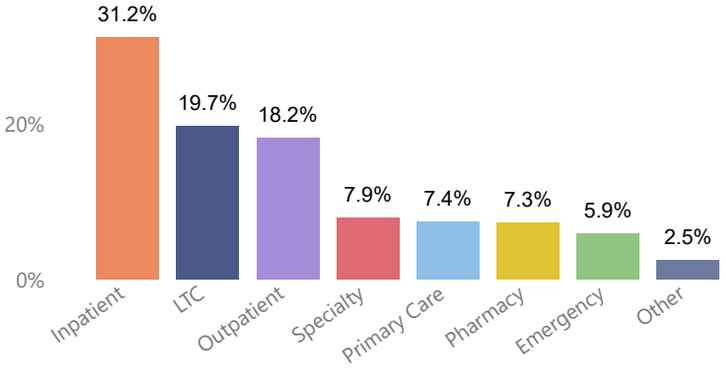
Income & Expenses

	APRIL 2025	FISCAL YTD
REVENUE	$ 258.4 M	$ 2.5 B
MEDICAL EXPENSE	$ (181.2) M	$ (1.8) B
ADMIN EXPENSE	$ (8.7) M	$ (95.5) M
OTHER/TAX	$ (62.6) M	$ (722.4) M
NET INCOME	$ 5.9 M	$ (92.4) M

Medical Loss % (Fiscal YTD)

101.1%

Medical Expenses



Liquid Reserves

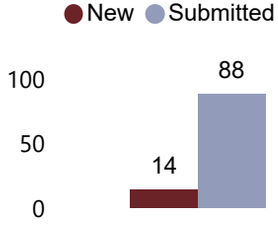
TNE %

201.6%

TNE $

$163.0M

Reinsurance Cases



Balance Sheet

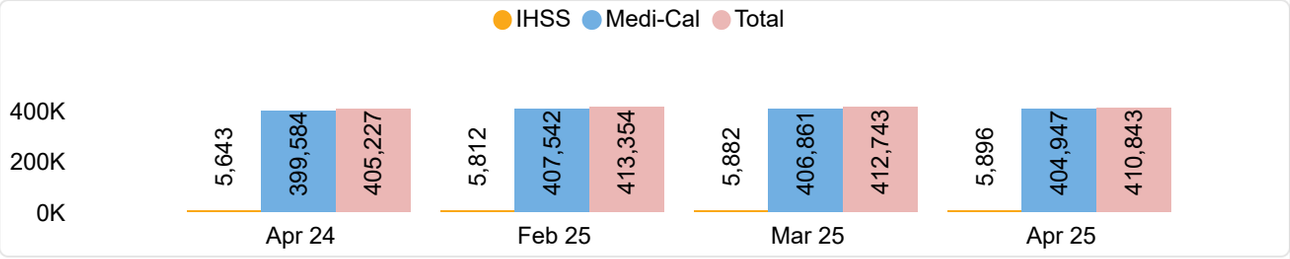
Cash Equivalents	$568.4M
Pass-Through Liabilities	$190.5M
Uncommitted Cash	$378.0M
Working Capital	$105.3M

Current Ratio

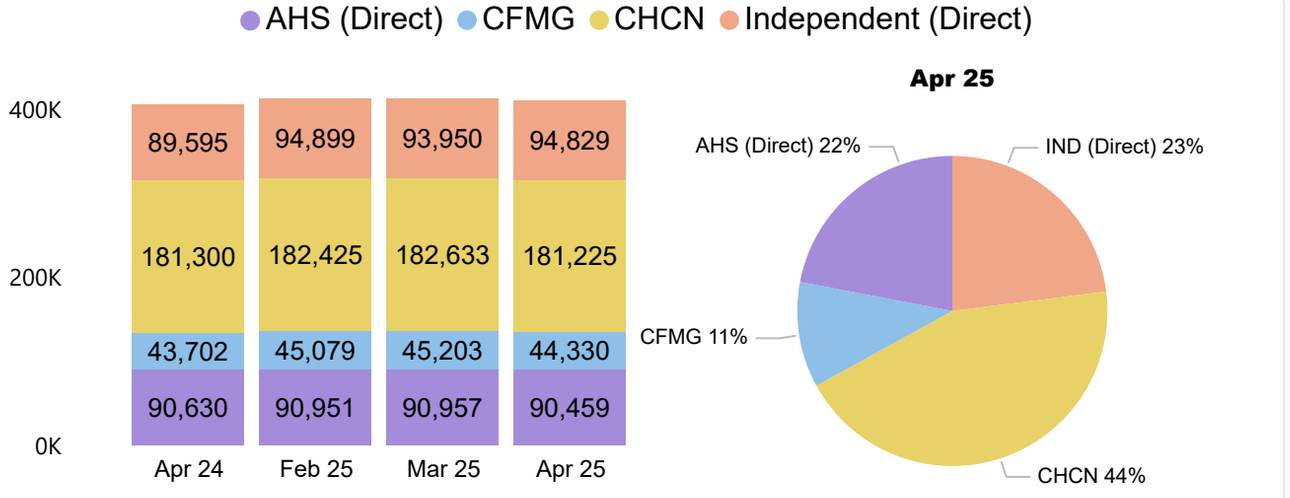
1.13

Membership

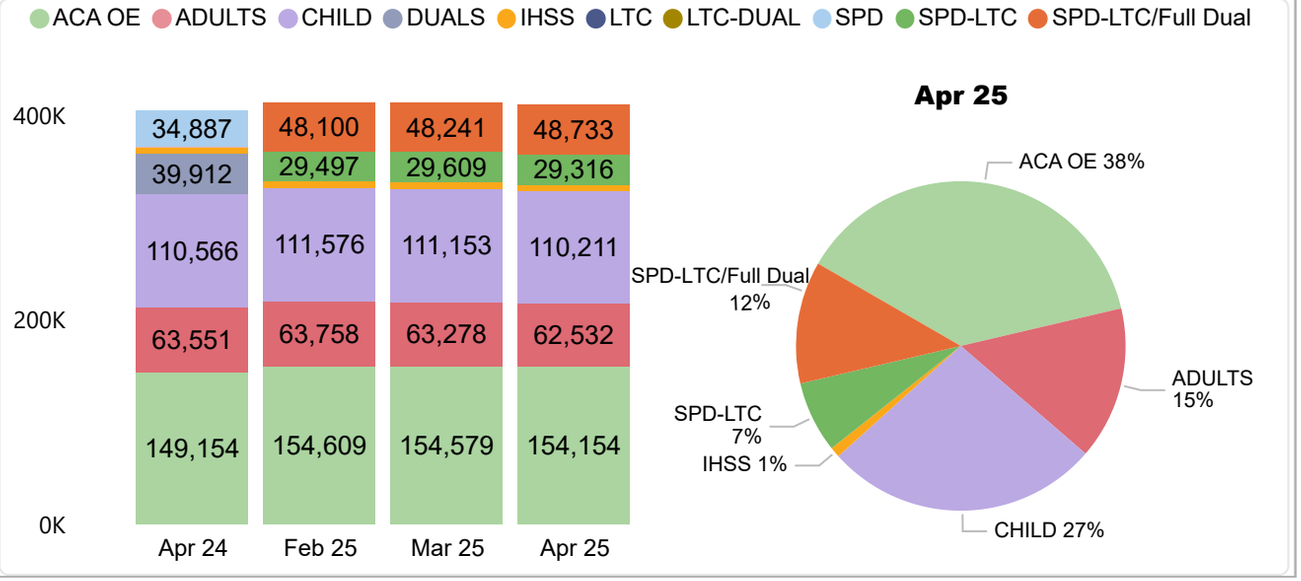
By Plan



By Network



By Category



OPERATIONS DASHBOARD

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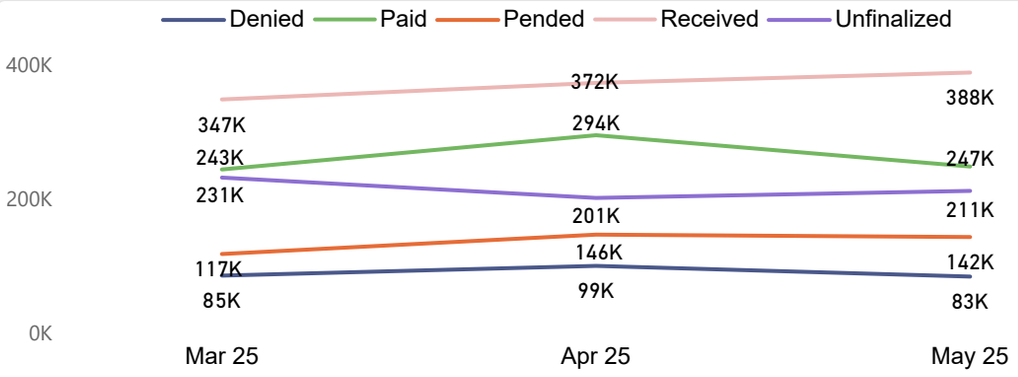
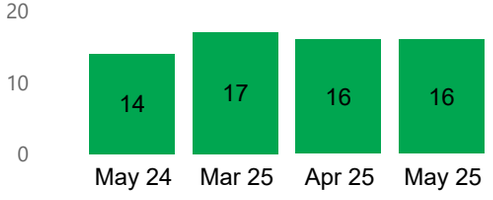
Claims

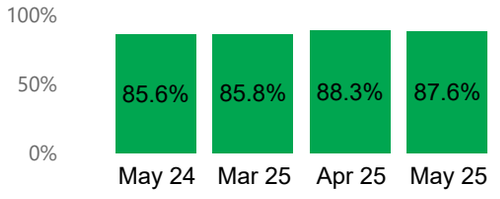
Claims Processing



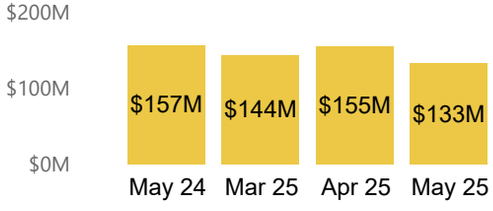
Average Payment TAT (Days)



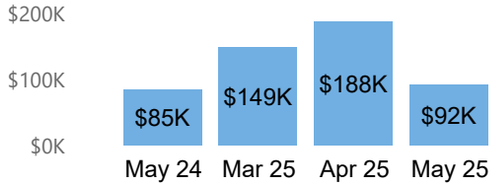
Auto Adjudication Rate (%)



Claims Paid ($)

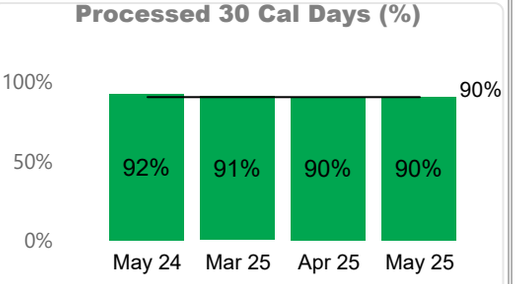


Interest Paid ($)

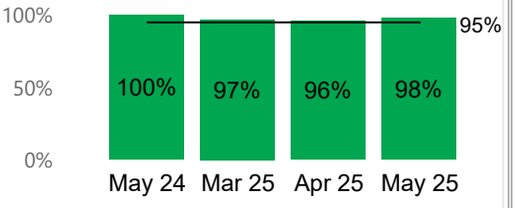


Claims Compliance

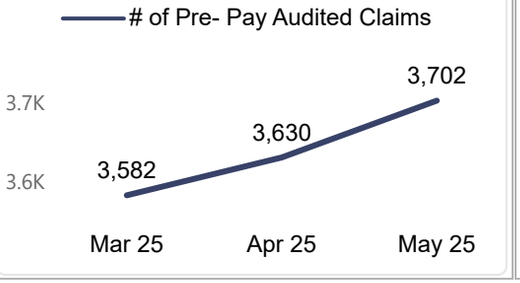
Processed 30 Cal Days (%)



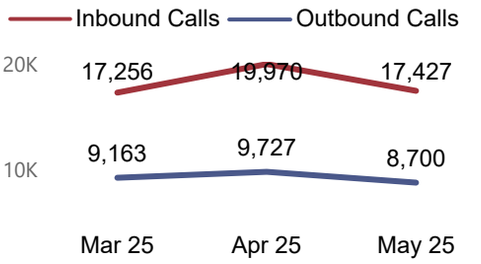
Processed 45 Work Days (%)



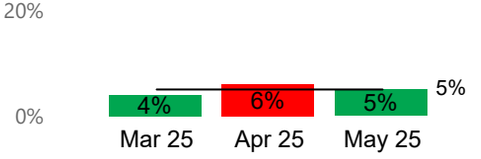
Claims Auditing



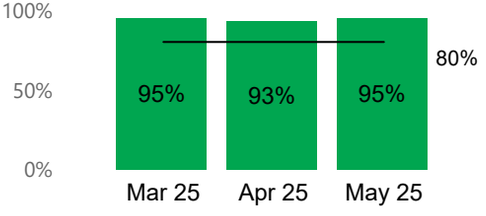
Member Services



Abandoned Call Rate (%)

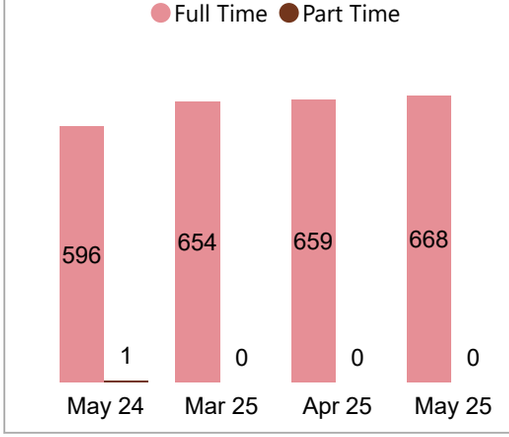


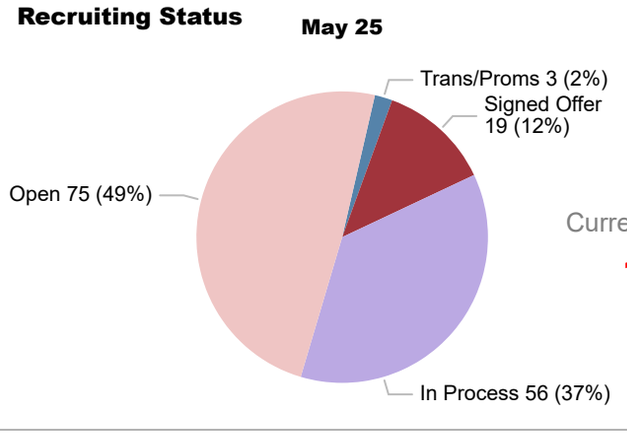
Calls Answered in 30 Seconds (%)



Average Call Times	Mar 25	Apr 25	May 25
Wait Time	00:11	00:15	00:11
Call Duration	07:29	07:25	07:33

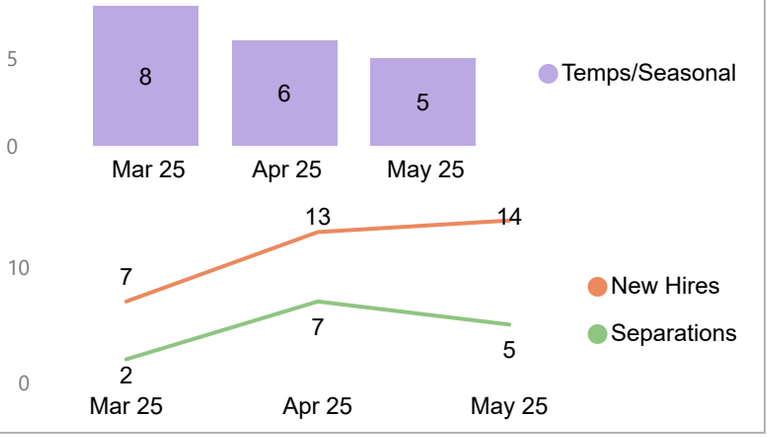
Human Resources





Current Vacancy

11%



OPERATIONS DASHBOARD

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Provider Services

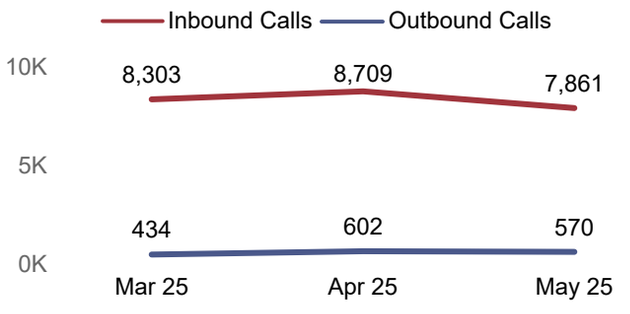
Provider Network

Hospital	17
Specialist	11,230
Primary Care Physician	782
Skilled Nursing Facility	107
Urgent Care	16
Health Centers (FQHCs and Non-FQHCs)	86
TOTAL	**12,238**

Provider Credentialing

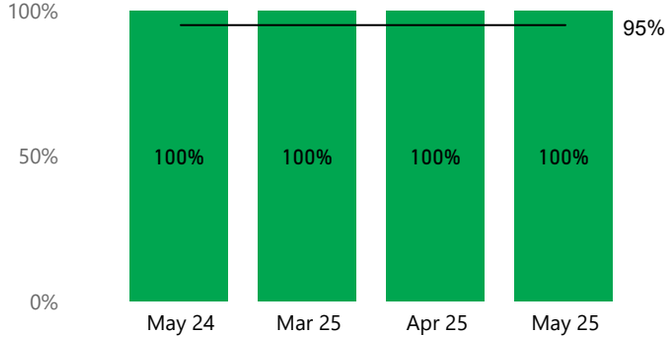
4,809

Provider Call Center



Provider Disputes & Resolutions

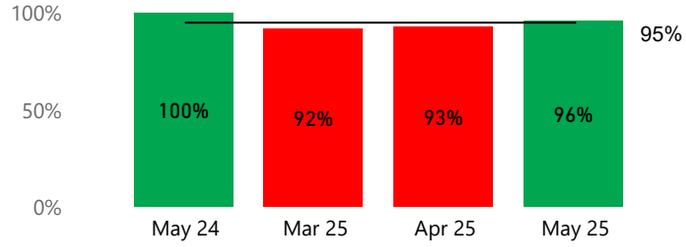
Turnaround Compliance (45 business days)



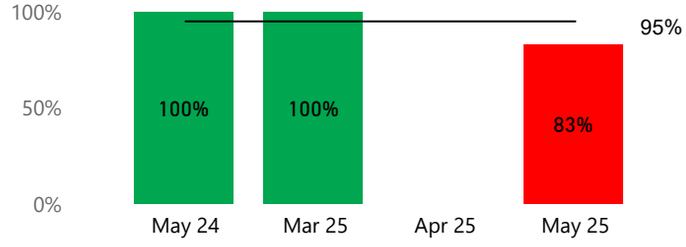
Compliance

Member Grievances

Standard (30 calendar days)

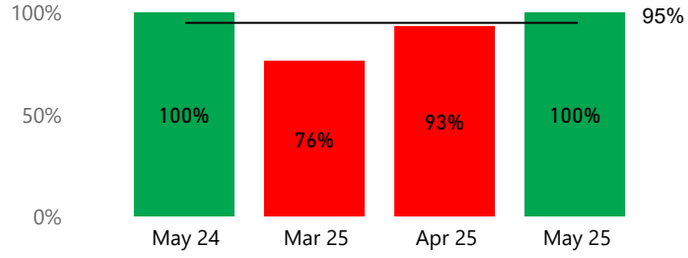


Expedited (3 calendar days)

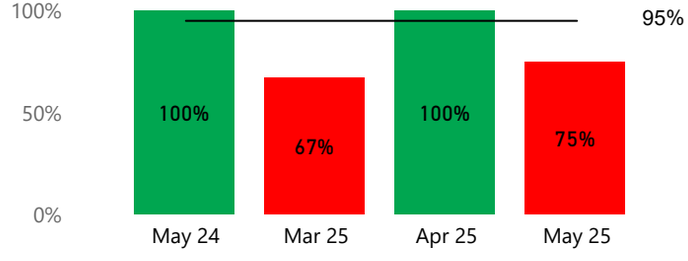


Member Appeals

Standard (30 calendar days)

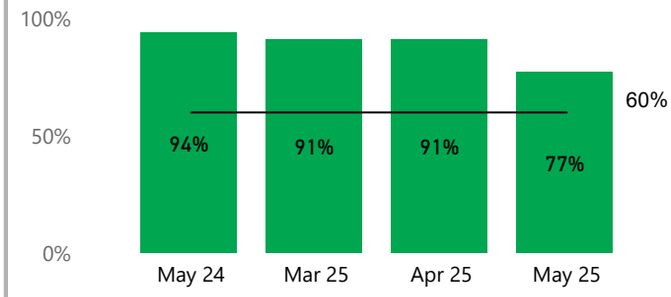


Expedited (3 calendar days)

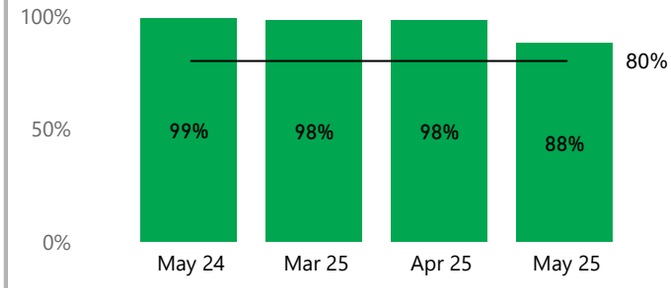


Encounter Data

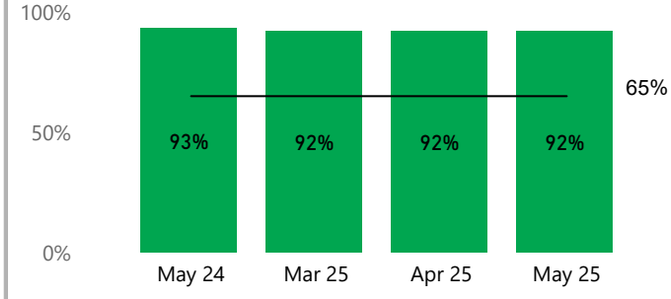
Institutional 0-90 days



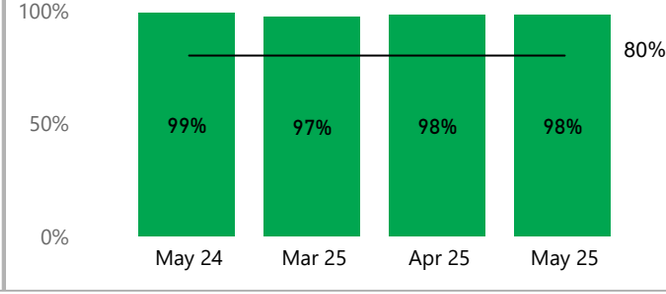
Institutional 0-180 days



Professional 0-90 days



Professional 0-180 days



OPERATIONS DASHBOARD

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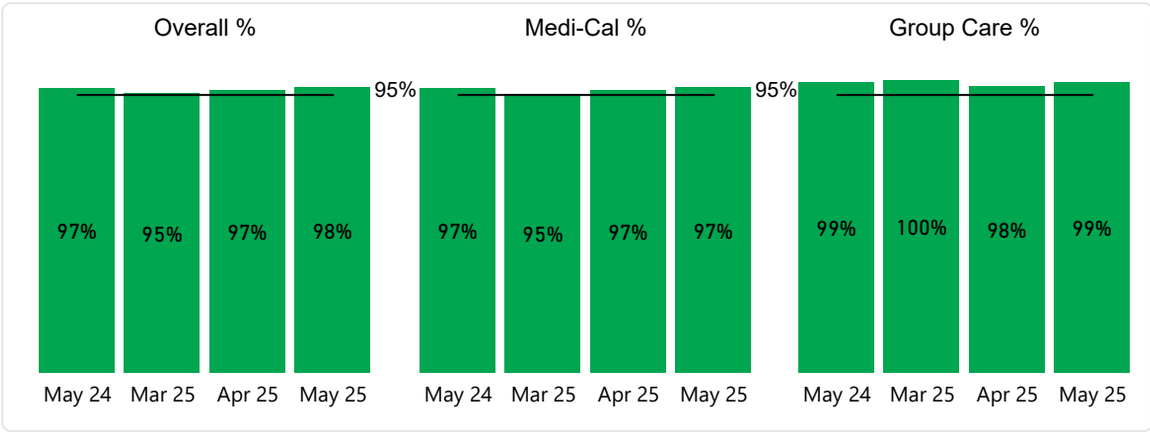
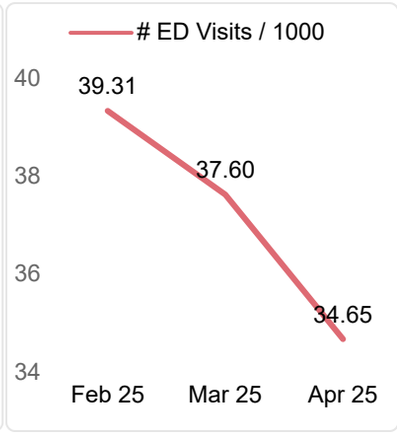
Health Care Services

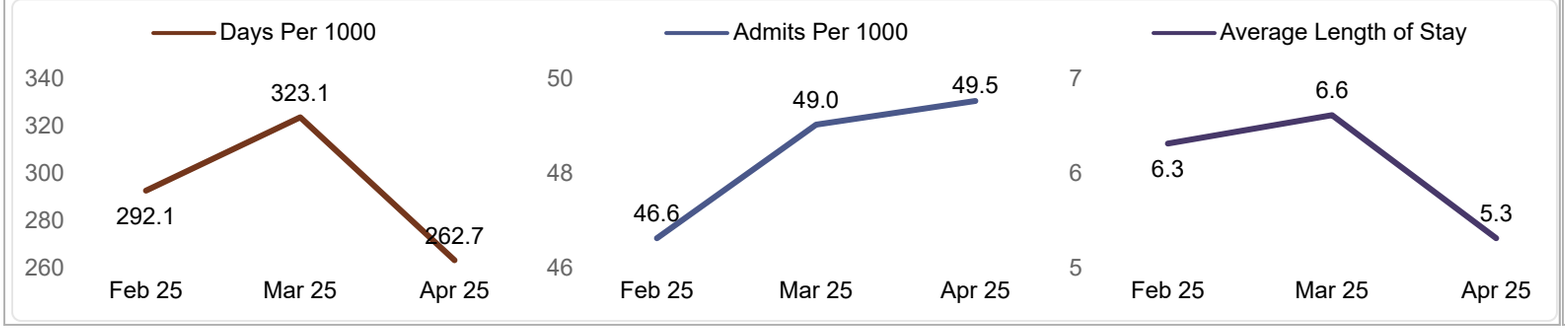
Authorization Turnaround



ED Utilization

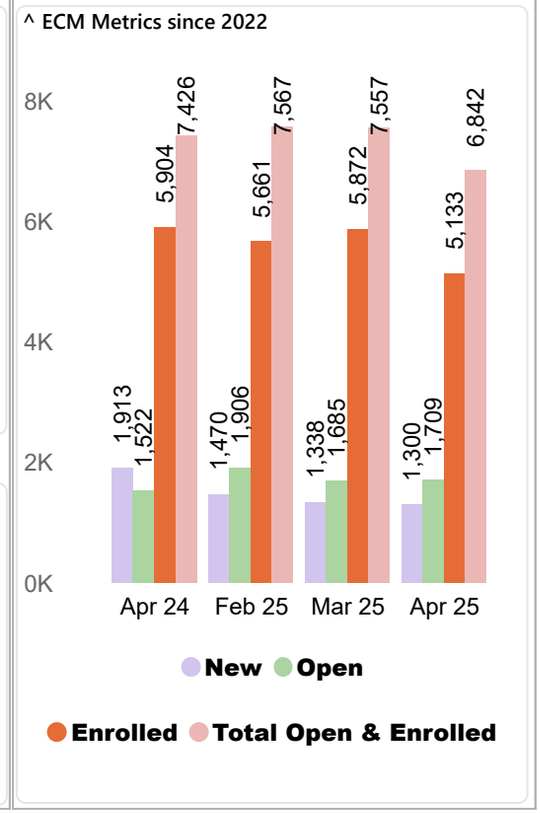


Inpatient Utilization

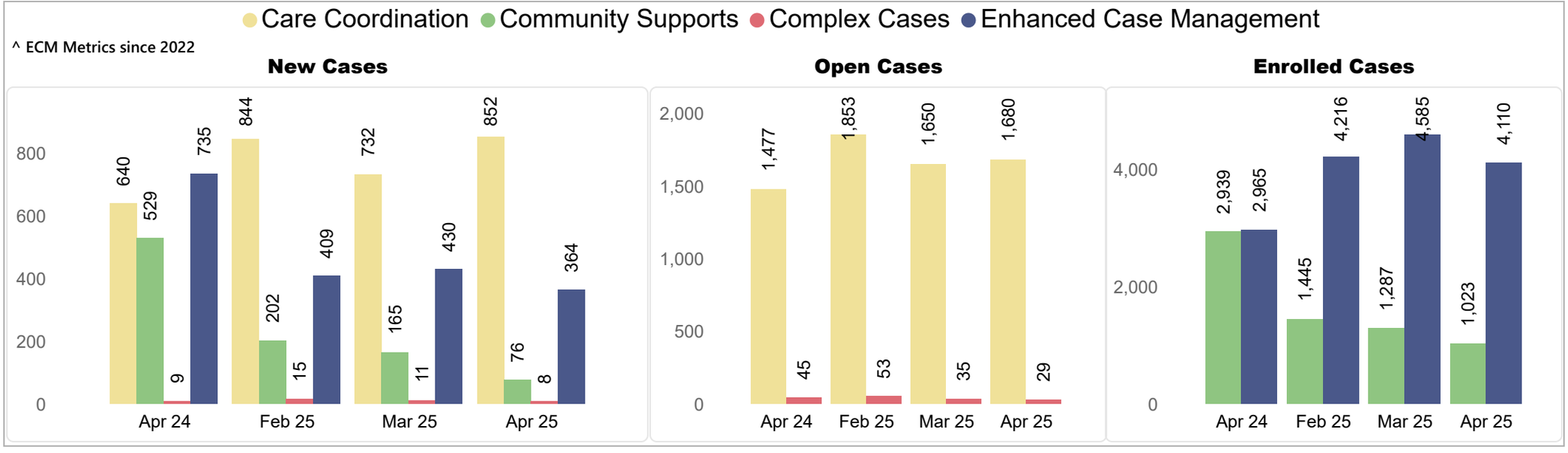


Case Management

Total Cases^



Case Management^



OPERATIONS DASHBOARD

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Technology (Business Availability)

Applications	May 24	Mar 25	Apr 25	May 25
HEALTHsuite System	100.0%	100.0%	99.5%	100.0%
Other Applications	100.0%	100.0%	99.5%	100.0%
TruCare System	100.0%	100.0%	100.0%	100.0%

Outpatient Authorization Denial Rates *

OP Authorization Denial Rates	May 24	Mar 25	Apr 25	May 25
Denial Rate Excluding Partial Denials (%)	3.7%	4.4%	4.9%	4.4%
Overall Denial Rate (%)	3.9%	4.5%	5.2%	4.8%
Partial Denial Rate (%)	0.2%	0.2%	0.4%	0.3%

*** IHSS and Medi-Cal Line Of Business**

Pharmacy Authorizations

Authorizations	May 24	Mar 25	Apr 25	May 25
Approved Prior Authorizations	39	43	37	41
Closed Prior Authorizations	92	27	26	23
Denied Prior Authorizations	48	83	92	97
Total Prior Authorizations	179	153	155	161

ALAMEDA Alliance FOR HEALTH

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Board Business

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Fiscal Year 2026 Budget

FY 2026 Preliminary Budget

Presented to the Alameda Alliance Board of Governors

June 13, 2025

ALAMEDA Alliance FOR HEALTH

Budget Process

- Preliminary budget presented to Finance Committee on June 10th and to the Board of Governors on June 13th.
- Final Budget to be presented in December 2025.

FY 2026 Preliminary Budget

Highlights

- 2026 Projected Net Loss of $22 million.
- Projected excess Tangible Net Equity at 6/30/26 of $71 million is 186% of required TNE.
- Year-end enrollment is 30,000 lower than June 2025. Fiscal Year member months are 146,000 lower than prior year. Year-end projected enrollment is 378,000 in June 2026.
- Revenue is $3.0 billion in FY 2026, a decrease of $136 million (-4.5%) from FY 2025.
- Fee-for-Service and Capitated Medical Expense is $2.1 billion in FY 2026, decrease of $50 million (-2.4%) from FY 2025.
- Expenses for Long-Term Care are projected to be approximately $33 million higher than FY2025 3Q Forecast.
- Administrative Department Expenses is $5 million higher than FY 2025 3Q Forecast and represents 5.6% of revenue.
- Clinical Department Expenses is $31 million lower than FY 2025 3Q Forecast and comprises 1.0% of revenue.
- DSNP Program is projected to start on January 2026.

FY 2026 Preliminary Budget

Budget Assumptions

Revenue:

- 98.1% of Revenue for Medi-Cal, 1.7% for Group Care, 0.2% for Medicare.
- Medi-Cal base rates are expected to rise by 4.3% per member, per month. However, uncertainty surrounding members with Unsatisfactory Immigration Status is anticipated to result in a $92 million reduction in premium revenue.
- Per-member-per-month Group Care premium remains the same as FY2025.
- Medicare Revenue projected to be $4.4 million.

Medical Expense:

- 97.8% of Expense for Medi-Cal, 1.9% for Group Care, 0.4% for Medicare.
- Medical loss ratio is 96.5%, a decrease of 2% over FY25.
- Lower Medi-Cal enrollment volume contributes to $82 million reduction in Medical Expense.
- Community Supports expenditures are projected at $17 million but may go up as DHCS criteria changes.

Hospital and Provider Rates:

- FY26 Hospital contracted rates increase by $48.9 million over FY 2025.
- The most current information was used to capture changes in Hospital and Provider Rates. However, not all rate changes have been finalized.

Budget Assumptions (cont.)

Staffing:

- Staffing includes 655 full-time equivalent employees by June 30, 2026.
- The Alliance is in the process of implementing another soft hiring freeze to appropriately manage staffing as enrollment declines.

Enrollment:

- Medi-Cal enrollment is projected to decrease over FY2026.
- Group Care Enrollment is project to remain unchanged at 5,900 members.
- Projected Membership also reflects a reduction of members with Unsatisfactory Immigration Status (UIS) as Governor Newson proposes freezing UIS enrollment effective January 2026.

FY 2026 Preliminary Budget

Comparison to FY2025 Forecast

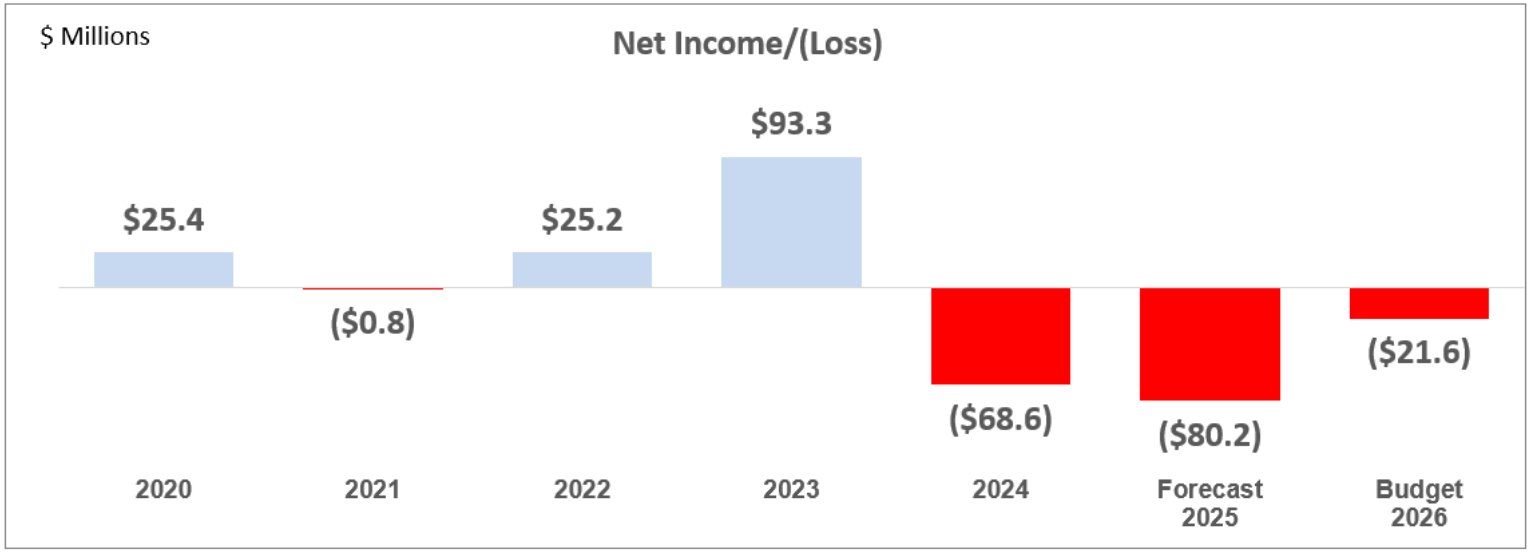
$ in Thousands	FY 2025 3Q Forecast				FY 2026 Preliminary Budget				Variance F/(U)			
	Medi-Cal	Group Care	Medicare	Total	Medi-Cal	Group Care	Medicare	Total	Medi-Cal	Group Care	Medicare	Total
Enrollment at Year-End	402,405	5,887	0	408,292	371,349	5,887	826	378,062	31,056	0	(826)	30,230
Member Months	4,838,281	69,545	0	4,907,826	4,688,129	70,644	3,278	4,762,051	150,152	(1,099)	(3,278)	145,775
Premium Revenue	$2,098,231	$38,022	$0	$2,136,252	$2,190,393	$38,621	$4,429	$2,233,442	($92,162)	($599)	($4,429)	($97,190)
MCO Tax Revenue	$875,559	$0	$0	$875,559	$757,414	$0	$0	$757,414	$118,145	$0	$0	$118,145
Total Revenue	2,973,790	38,022	0	3,011,811	2,947,807	38,621	4,429	2,990,856	25,983	(599)	(4,429)	20,955
Medical Expense	2,084,580	37,444	404	2,122,428	2,106,728	40,342	7,662	2,154,731	22,148	2,898	7,258	32,303
Gross Margin	889,210	578	(404)	889,383	841,079	(1,721)	(3,233)	836,125	48,130	2,299	2,829	53,258
Administrative Expense	106,887	1,871	10,337	119,095	105,392	2,218	16,655	124,265	(1,495)	347	6,318	5,169
Operating Margin	782,323	(1,293)	(10,741)	770,288	735,687	(3,939)	(19,888)	711,860	46,635	2,645	9,147	58,427
MCO Tax Expense	882,559	0	0	882,559	757,414	0	0	757,414	(125,145)	0	0	(125,145)
Other Income / (Expense)	31,607	354	72	32,033	23,364	420	216	24,000	8,243	(66)	(144)	8,033
Net Income / (Loss)	($68,629)	($940)	($10,669)	($80,238)	$1,637	($3,519)	($19,672)	($21,554)	($70,266)	$2,579	$9,003	($58,684)
Admin. Expense % of Revenue	5.1%	4.9%		5.6%	4.8%	5.7%		5.6%	-0.3%	0.8%		0.0%
Medical Loss Ratio	99.3%	98.5%		99.4%	96.2%	104.5%		96.5%	-3.2%	6.0%		-2.9%
TNE at Year-End				$175,137				$153,583				$21,554
TNE Percent of Required at YE				219%				186%				32%

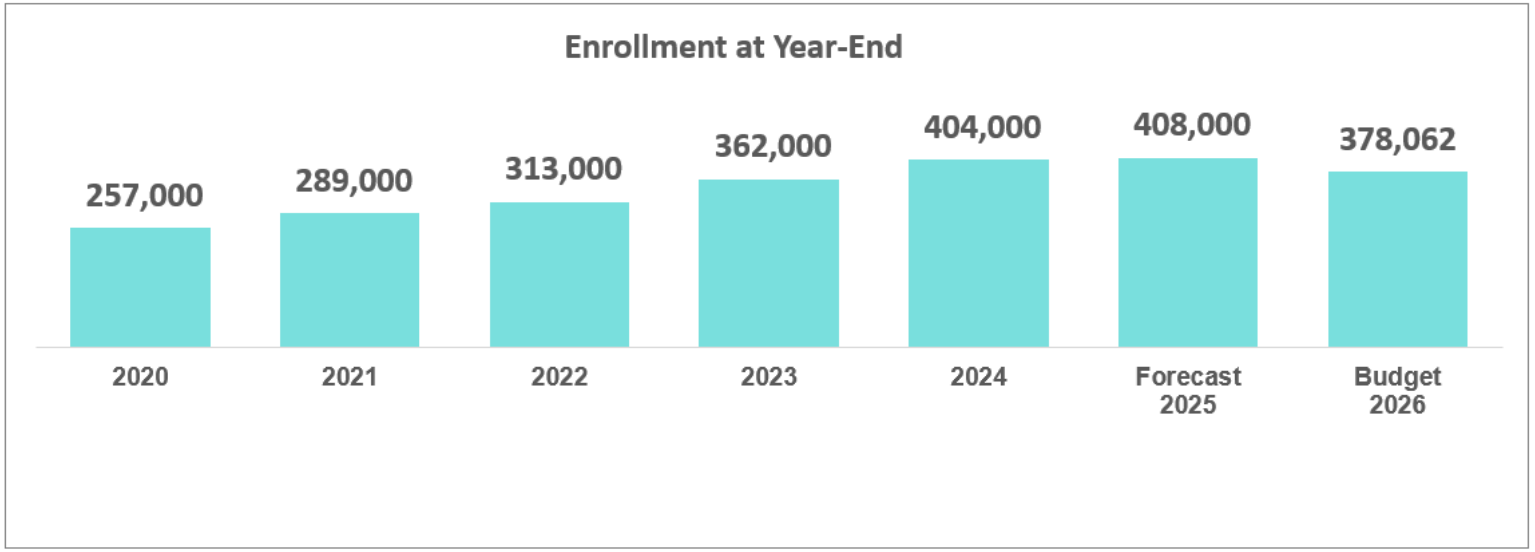
Department Expenses by Line of Business

FY 2026 Preliminary	Administrative Departments				Clinical Departments				Total
	Medi-Cal	Group Care	Medicare	Total	Medi-Cal	Group Care	Medicare	Total	
Employee Expense	$62,608	$1,125	$8,647	$72,380	$33,393	$600	$2,246	$36,239	108,619
Member Benefits Admin.	$609	$358	$286	$1,253	($21,804)	$0	$0	($21,804)	(20,550)
Purchased & Prof. Svcs.	$23,205	$380	$7,012	$30,597	$8,313	$1,127	$426	$9,867	40,464
Other	$18,970	$355	$710	$20,034	$4,198	$77	$52	$4,327	24,361
Total	**$105,392**	**$2,218**	**$16,655**	**$124,265**	**$24,100**	**$1,805**	**$2,724**	**$28,629**	**$152,894**

- Administrative Department Expenses are $5.2 million higher than FY 2025. Increases are led by Labor ($2.5 million) and Purchased & Professional Services ($3.4 million), Member Benefits Administration ($0.3 million), and offset by Other Services ($1.1 million).
- Clinical Department Expenses are $31.3 million lower than FY25. Increases led by Labor ($1.2 million), offset by Other ($2.6 million), Member Benefits Administration ($27.5 million), and Purchased & Professional Services ($57 thousand).

Operating Performance: 2020 to 2026





Capital Expenditures

Preliminary budget is $1.4 million for capitalized purchases.

- This is a decrease of $0.6 million from FY25.
- Totals include $1.2 million for IT hardware and $0.1 million for building improvements.

FY 2026 Preliminary Budget

Material Areas of Uncertainty

- The Department of Health Care Services intends to adjustment to Calendar Year 2025 rates in the Fall. We are anticipating a slight rate decrease.
- CY2026 Rates from DHCS are expected at the end of October.
- The State May Revision budget proposes to freeze new enrollment for full-scope state-only Medi-Cal coverage for undocumented individuals aged 19 and older who lack satisfactory immigration status.
- It is unknown how significant the impact from the Federal Budget will have on the Medi-Cal enrollment, but AAH is preparing for material impacts to membership in CY2026 and CY2027.
- Contract changes for hospitals and delegated providers in projections have not been finalized.
- Proposition 35 (TRI) impact for CY2025 rate is unknown and not budgeted.
- Uncertain if the State will implement an increase to the MLR effectively January 2026.

FY 2026 Preliminary Budget

Staffing: Full-time Employees at Year-end

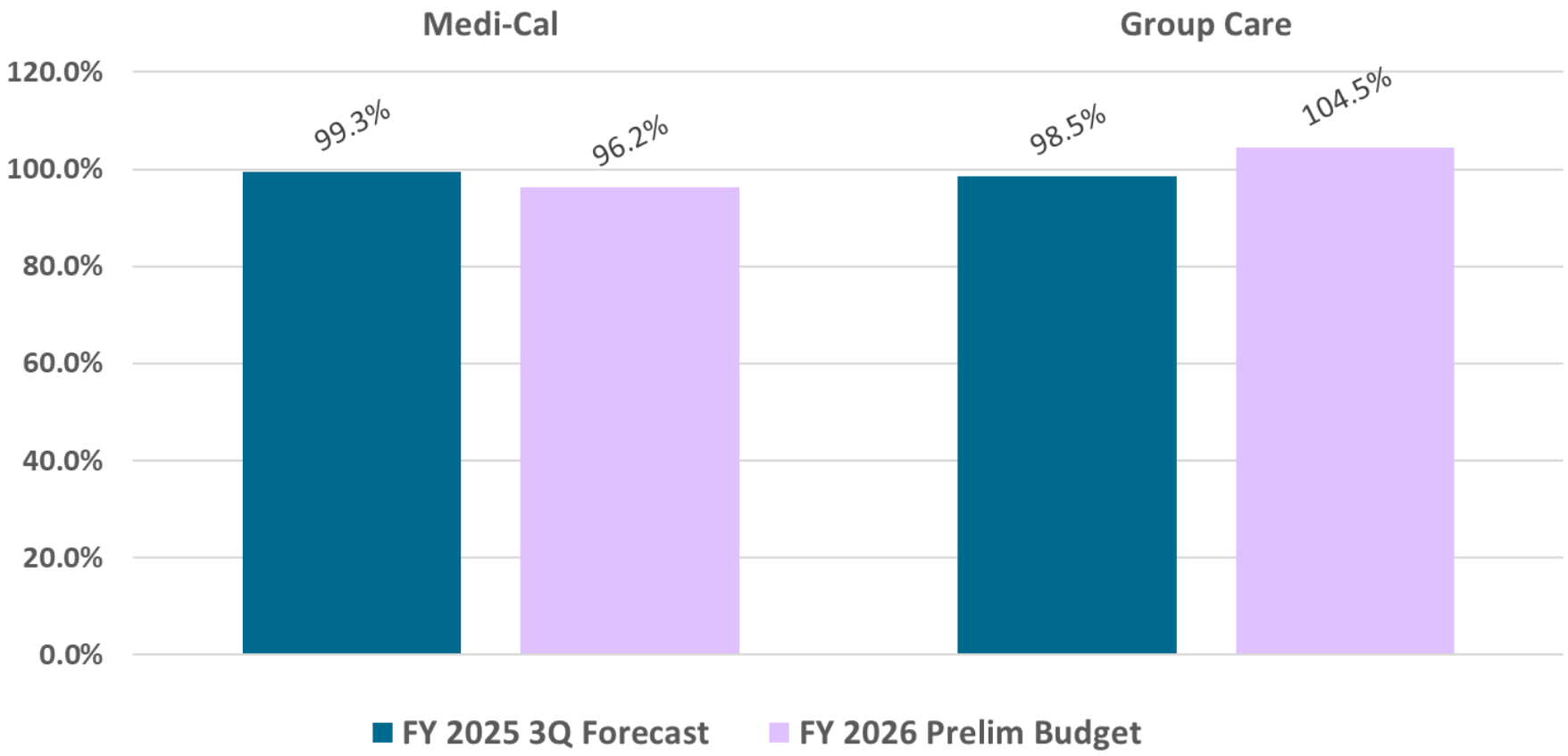
Administrative FTEs/Temps at Year-End	FY26 Prelim	FY25 Forecast	Increase/ Decrease
Administrative Vacancy	(87)	(40)	(47)
Operations	5	6	(1)
Medicare Operations	11	9	2
Executive	3	2	1
Accounting	16	0	16
Finance	19	35	(16)
Healthcare Analytics	20	19	1
Claims	54	54	0
Information Technology	15	15	0
IT Infrastructure	7	8	(1)
Apps Mgmt., IT Quality & Process Imp.	21	21	0
IT Development	16	17	(1)
IT Data Exchange	10	9	1
IT-Ops and Quality Apps Mgt.	16	17	(1)
Member Services	98	88	10
Provider Services	44	42	2
Credentialing	9	9	0
Health Plan Operations	1	1	0
Human Resources	12	12	0
Vendor Management	10	10	0
Legal Services	4	3	1
Facilities & Support Services	8	8	0
Marketing & Communication	14	13	1
Privacy and SIU	18	15	3
Regulatory Affairs & Compliance	14	12	2
Risk Mgmt. & Operations Oversite	2	1	1
Grievance and Appeals	32	29	3
Integrated Planning	24	21	3
State Directed & Special Programs	5	5	0
Portfolio Mgmt. & Svc Excellence	0	0	0
Workforce Development	9	9	0
Health Equity	3	3	0
Total Administrative	**433**	**453**	**(20)**

Clinical FTEs/Temps at Year-End	FY26 Prelim	FY25 Forecast	Increase/ Decrease
Clinical Vacancy	(47)	(13)	(34)
Quality Analytics	6	5	1
Long-Term services and Supports	31	30	1
Utilization Management	72	66	6
Case/Disease Management	65	58	7
Medical Services	8	6	2
Quality Management	49	45	4
HCS Behavioral Health	28	28	-
Pharmacy Services	10	9	1
Regulatory Readiness	-	-	-
Total Clinical FTEs	**222**	**234**	**(12)**

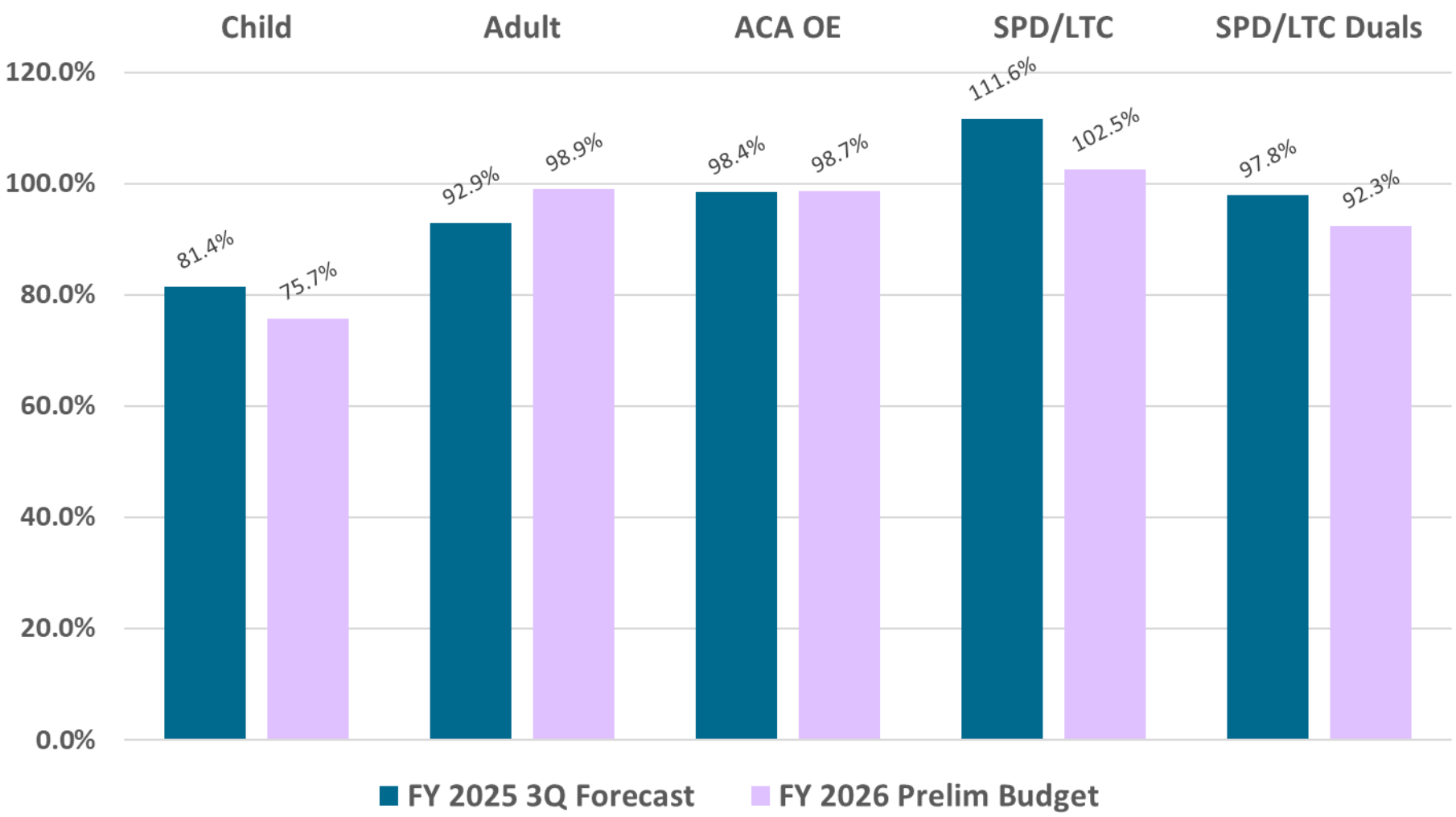
Total FTEs	**655**	**687**	**(32)**

**FTE = Full-Time Equivalent Personnel working approximately 2,080 hours per year. Includes Temporary Employees.*

Medical Loss Ratio by Line of Business



Medi-Cal Loss Ratio by Category of Aid



Finance

Gil Riojas

To: **Alameda Alliance for Health, Board of Governors**

From: **Gil Riojas, Chief Financial Officer**

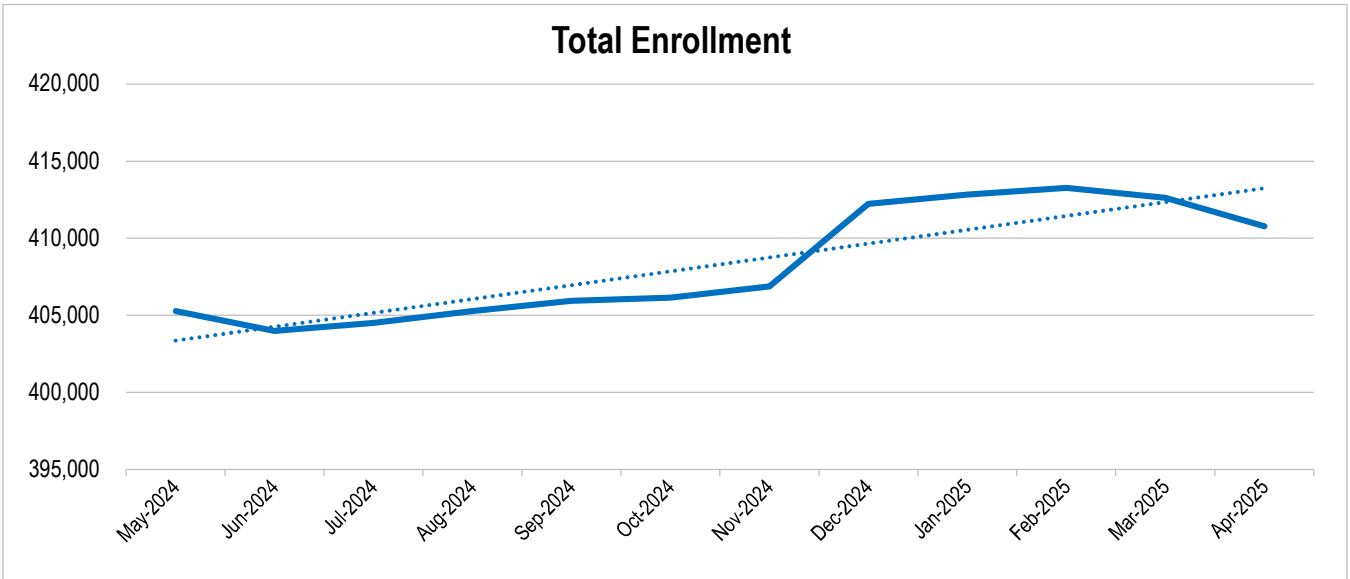
Date: **June 13th, 2025**

Subject: **Finance Report – April 2025 Financials**

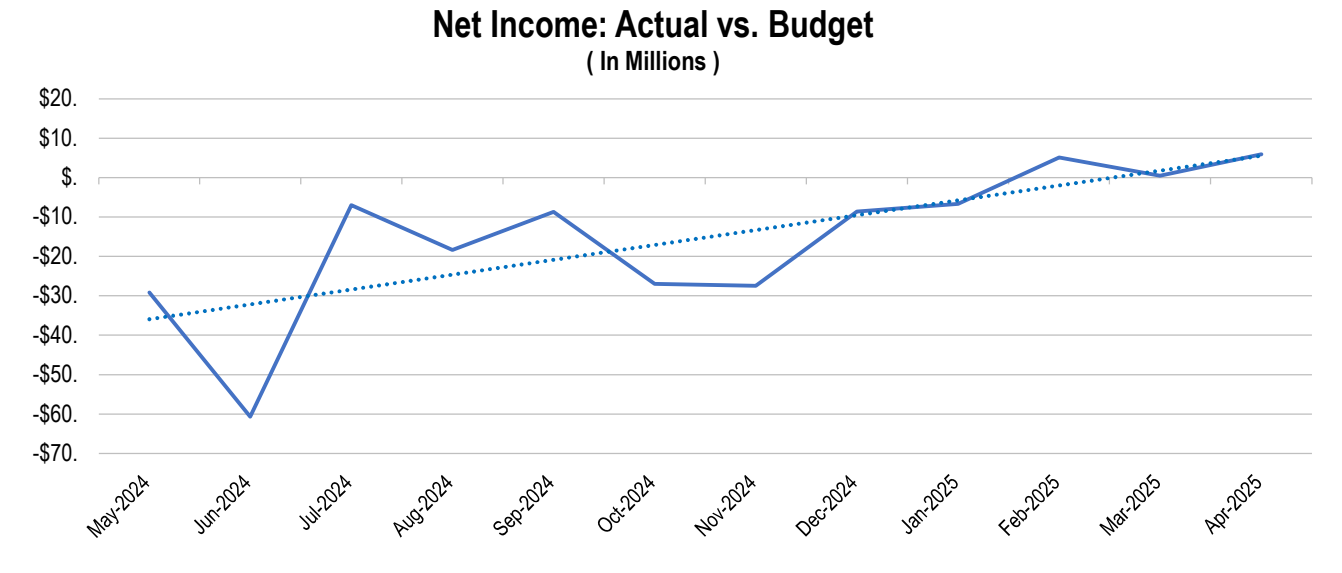
Executive Summary

For the month of April, the Alliance dipped slightly in enrollment, reaching 410,784 members. Net Income of $5.9 million was reported, and the Plan's Medical Expenses represented 93.9% of Premium Revenue. Alliance reserves increased slightly to 202% of required and continue to remain above minimum requirements.

Enrollment – In April, Enrollment decreased by 1,846 members.

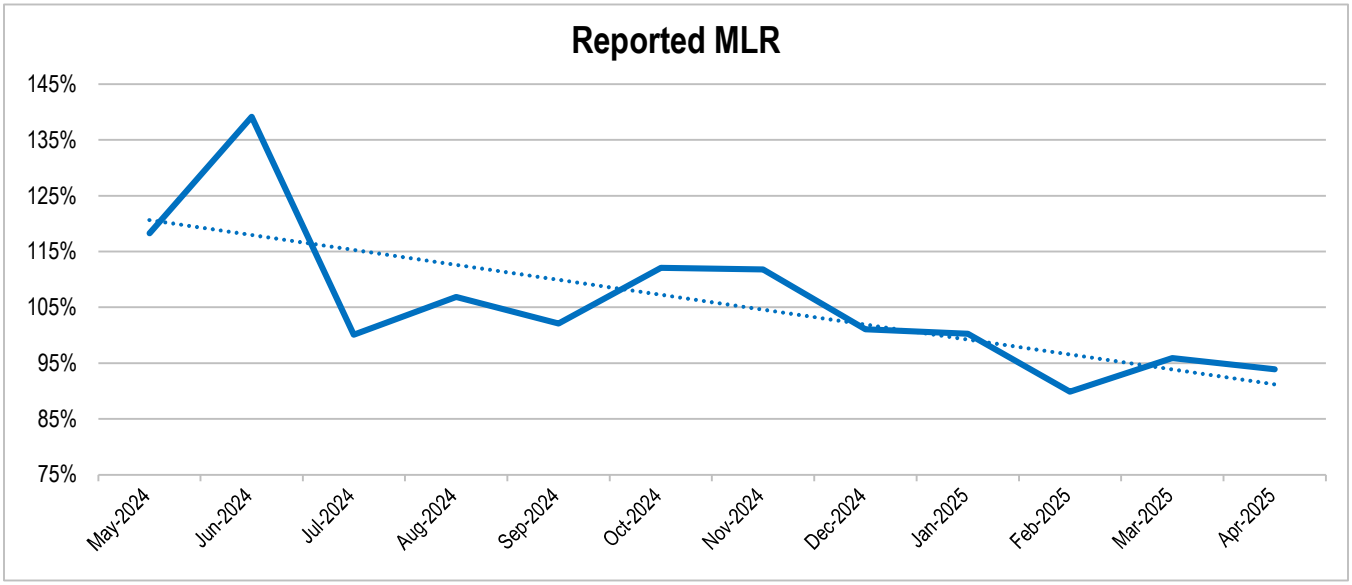


Net Income – For the month ended April, actual Net Income was $5.9 million vs. budgeted Net Income of $3.9 million. For the fiscal YTD, actual Net Loss was $92.4 million vs. budgeted Net Loss of $72.4 million. For the month, Premium Revenue was favorable to budget, actual

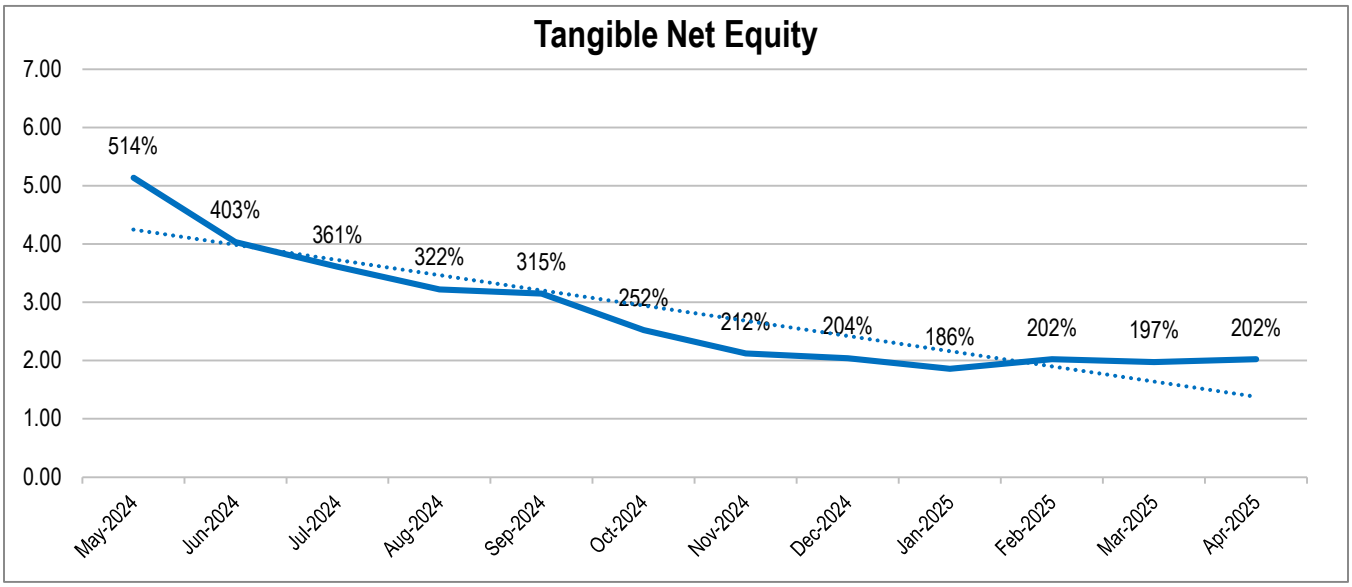


Revenue was $193.0 million vs. budgeted Revenue of $190.3 million. Premium Revenue variance of $2.8 million is primarily due to MOT Risk Corridor adjustments.

Medical Loss Ratio (MLR) – The Medical Loss Ratio was 93.9% for the month, and 101.1% for fiscal YTD. The major unfavorable variances include Inpatient Hospital FFS, Long Term Care FFS, Pharmacy FFS, and Ancillary FFS. The major favorable variances include Pharmacy FFS and Ancillary FFS.



Tangible Net Equity (TNE) - The Department of Managed Health Care (DMHC) required $80.8 million in reserves, we reported $163.0 million. Our overall TNE remains above DMHC requirements at 202%.



The Alliance continues to benefit from increased non-operating income. For Fiscal year-to-date investments show a gain of $28.1 million. Capital assets acquired so far are $859,000.

To: **Alameda Alliance for Health, Finance Committee**

From: **Gil Riojas, Chief Financial Officer**

Date: **June 10th, 2025**

Subject: **Finance Report – April 2025**

Executive Summary

- For the month ended April 30th, 2025, the Alliance had enrollment of 410,784 members, a Net Income of $5.9 million and 202% of required Tangible Net Equity (TNE).

Overall Results: (in Thousands)

	Month	YTD
Revenue	$258,449	$2,504,026
Medical Expense	181,220	1,778,558
Admin. Expense	8,656	95,454
MCO Tax Expense	65,414	750,412
Other Inc. / (Exp.)	2,779	28,033
Net Income	**$5,939**	**($92,364)**

Net Income by Program: (in Thousands)

	Month	YTD
Medi-Cal	$5,729	($85,426)
Group Care	585	389
Medicare	(375)	(7,326)
	$5,939	**($92,364)**

Enrollment

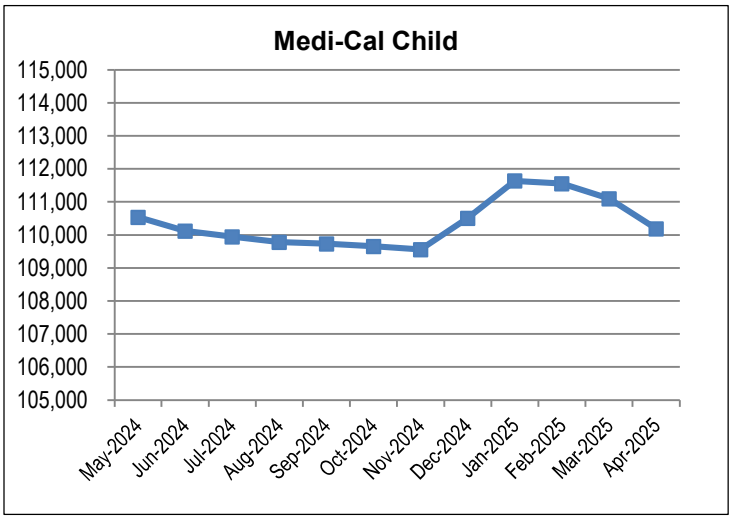
- Total enrollment decreased by 1,846 members since March 2025.
- Total enrollment increased by 6,794 members since June 2024.

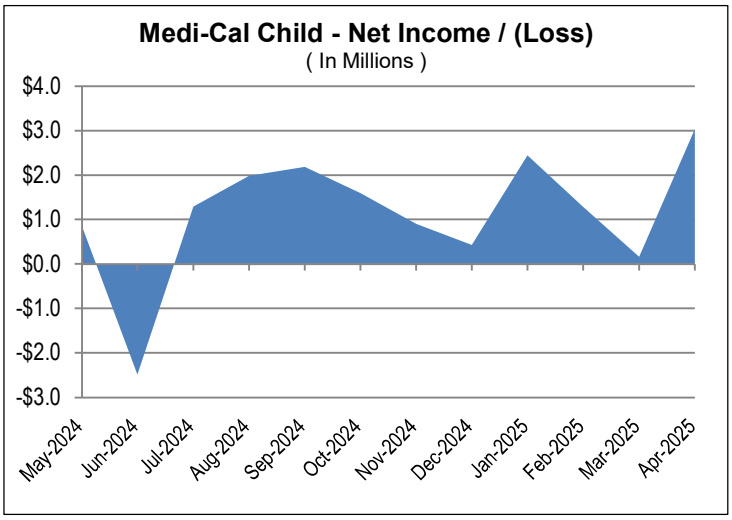
Monthly Membership and YTD Member Months
Actual vs. Budget

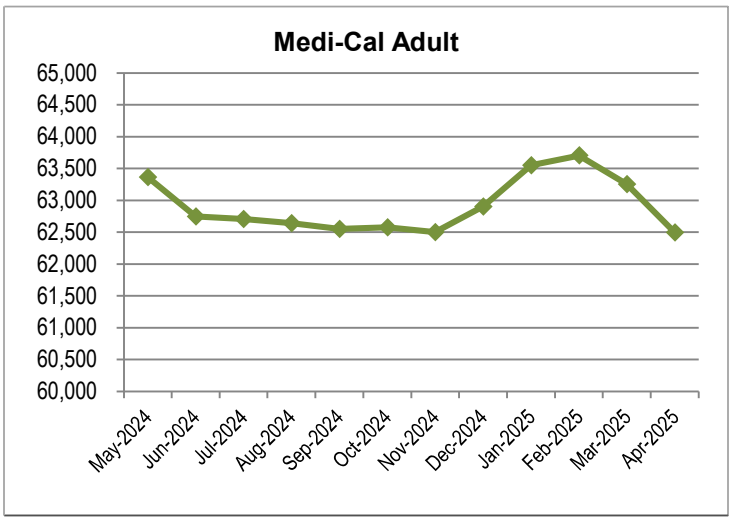
Enrollment					Member Months			
Current Month					Year-to-Date			
Actual	Budget	Variance	Variance %		Actual	Budget	Variance	Variance %
				Medi-Cal:				
110,186	110,432	(246)	(0.2%)	Child	1,103,681	1,099,850	3,831	0.3%
62,499	62,956	(457)	(0.7%)	Adult	628,897	627,268	1,629	0.3%
0	0	0	100.0%	SPD*	212,632	211,783	849	0.4%
0	0	0	100.0%	Duals*	241,339	240,472	867	0.4%
154,154	152,007	2,147	1.4%	ACA OE	1,525,963	1,512,151	13,812	0.9%
0	0	0	100.0%	MCAL LTC*	1,446	1,442	4	0.3%
0	0	0	100.0%	MCAL LTC Duals*	7,562	7,540	22	0.3%
29,316	31,861	(2,545)	(8.0%)	SPD with LTC	117,982	133,224	(15,242)	(11.4%)
48,733	45,415	3,318	7.3%	Duals with LTC	193,212	175,654	17,558	10.0%
404,888	**402,671**	**2,217**	**0.6%**	**Medi-Cal Total**	**4,032,714**	**4,009,384**	**23,330**	**0.6%**
5,896	5,769	127	2.2%	Group Care	57,771	57,454	317	0.6%
410,784	**408,440**	**2,344**	**0.6%**	**Total**	**4,090,485**	**4,066,838**	**23,647**	**0.6%**

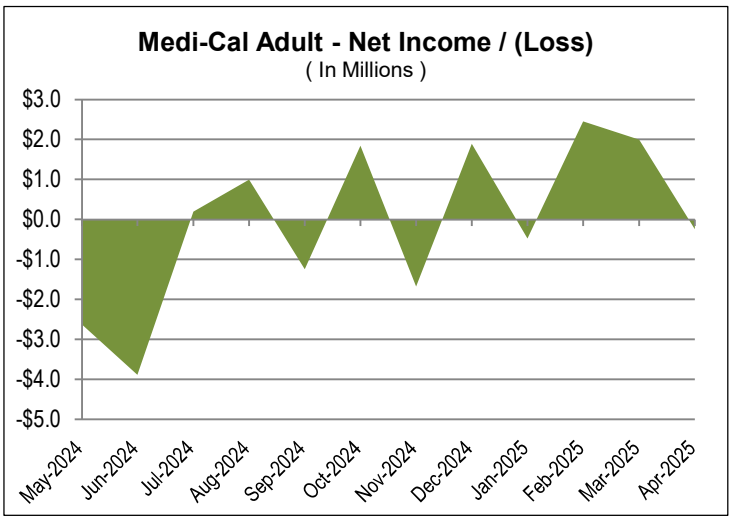
*As of January 2025, service month, "SPD", "Duals", "LTC", and "LTC Duals" will be discontinued. Effective January 2025 service month new consolidated groupings will be "SPD with LTC" and "Duals with LTC".

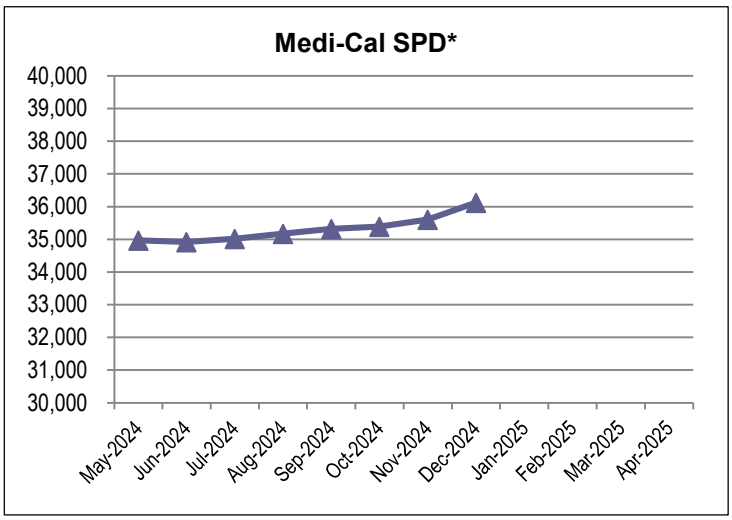
Enrollment and Profitability by Program and Category of Aid

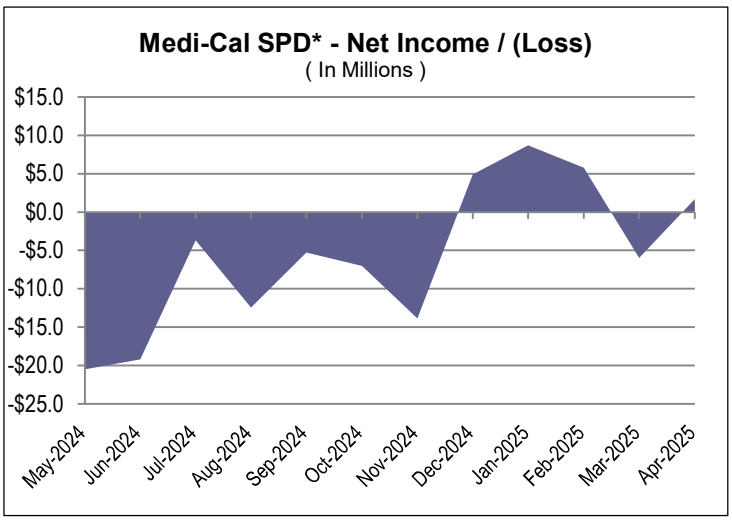




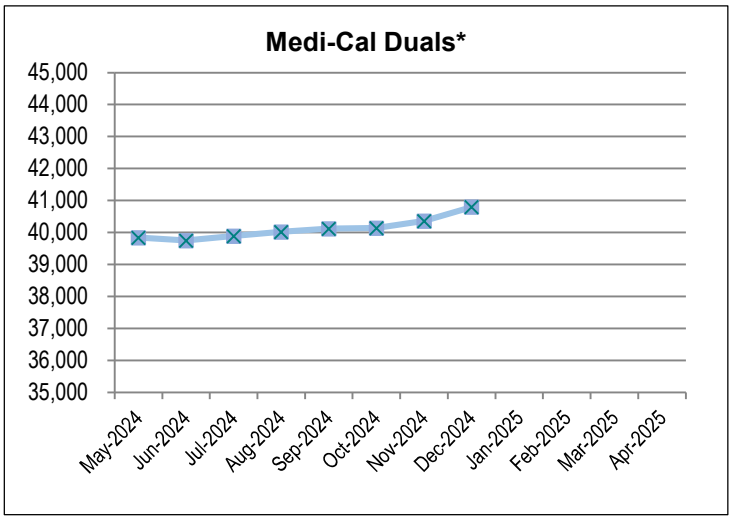


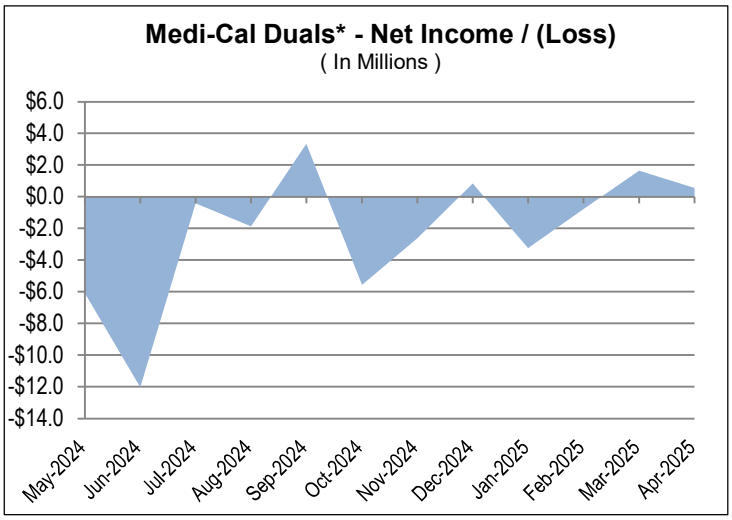


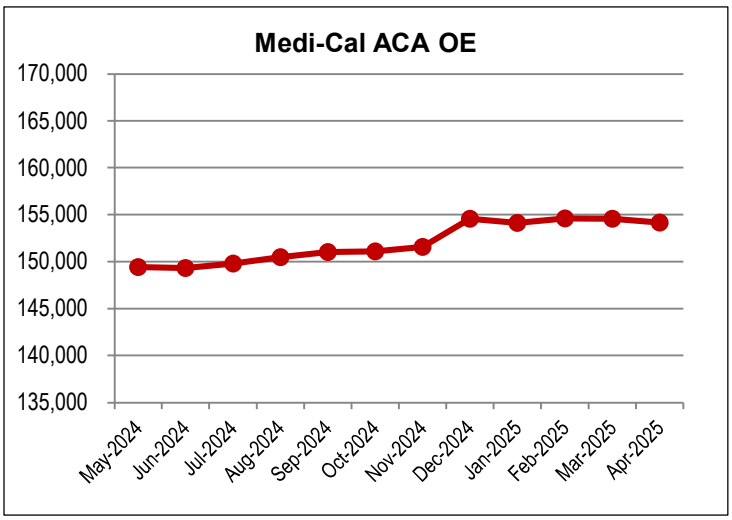


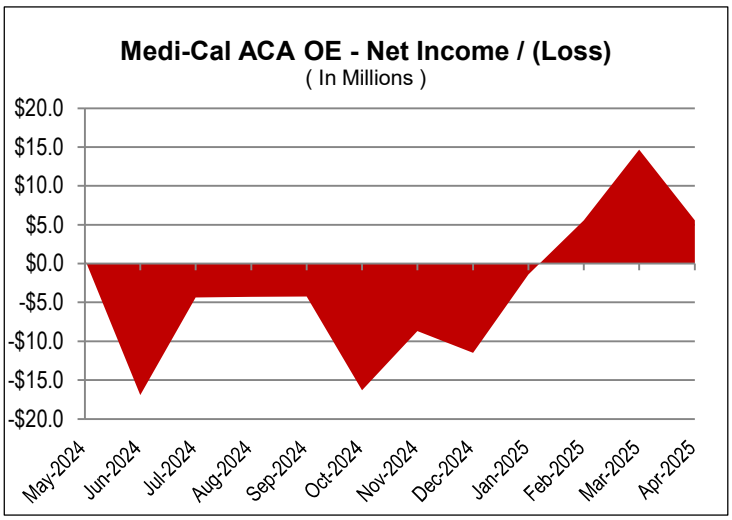


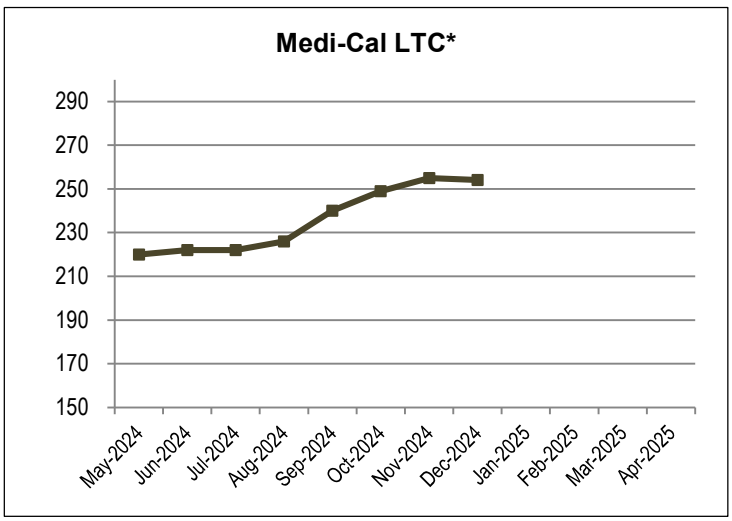
Enrollment and Profitability by Program and Category of Aid

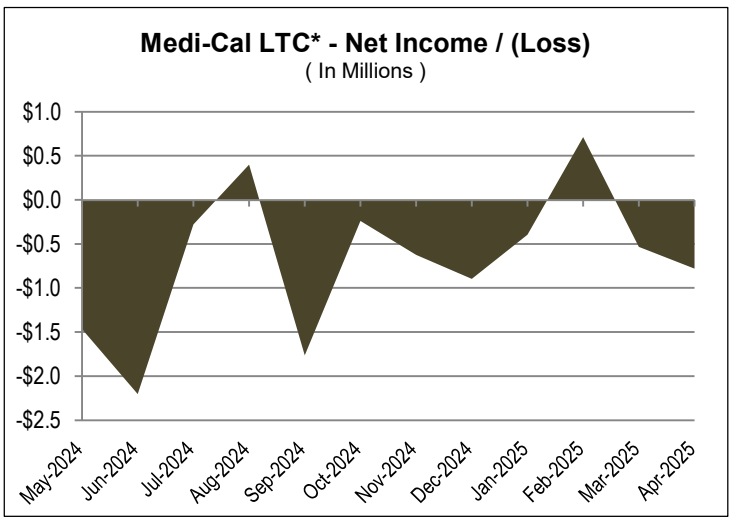




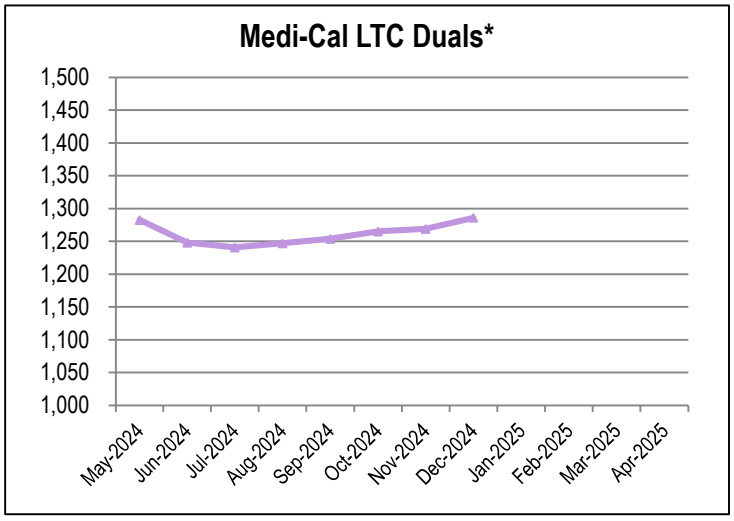


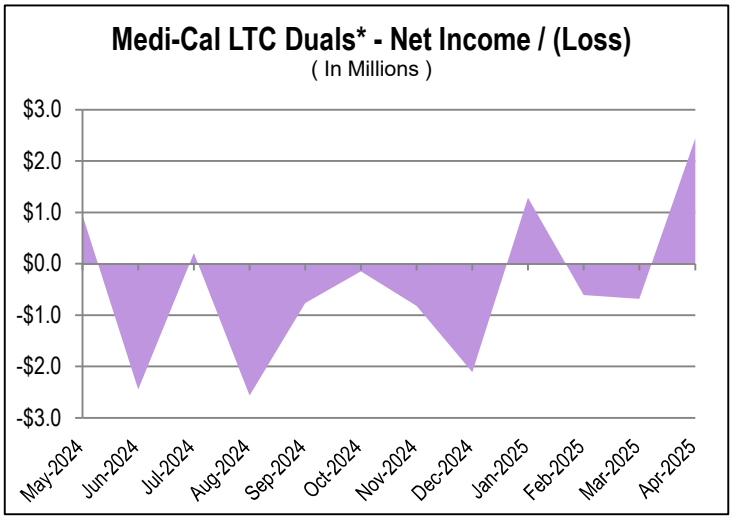


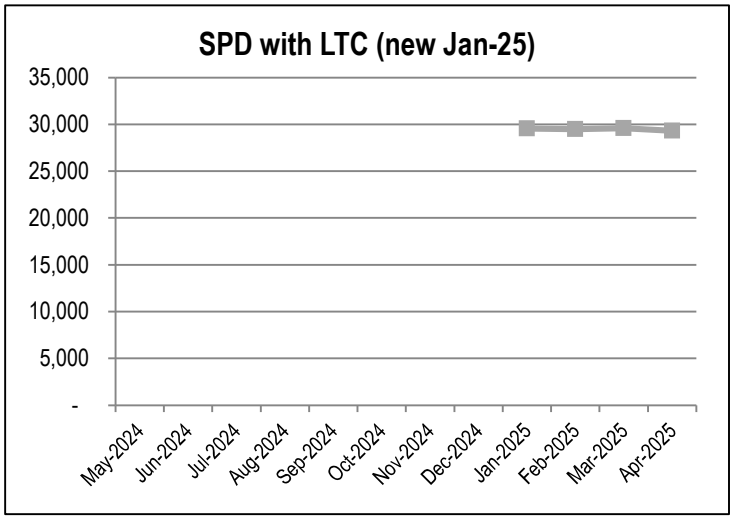


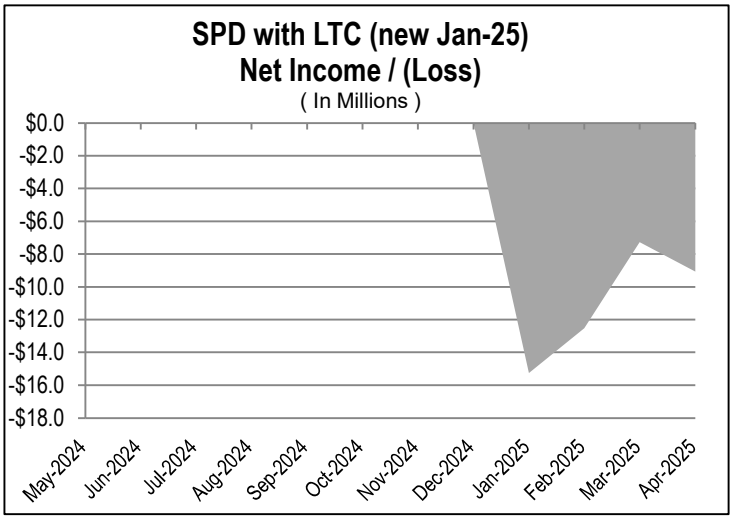


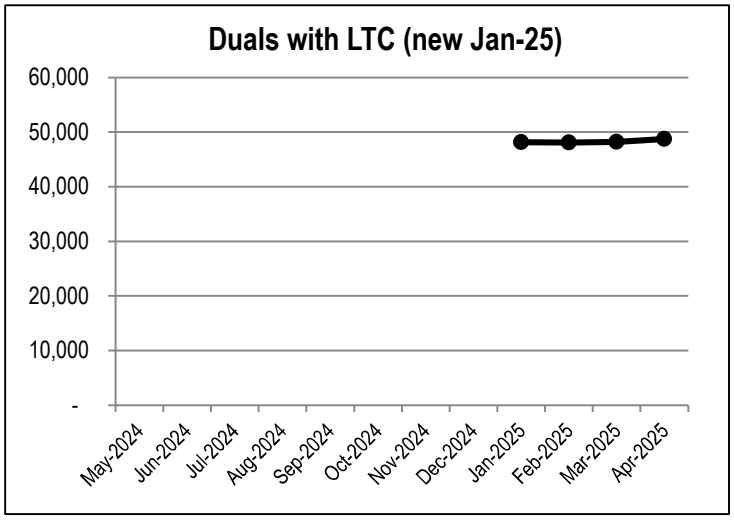
Enrollment and Profitability by Program and Category of Aid

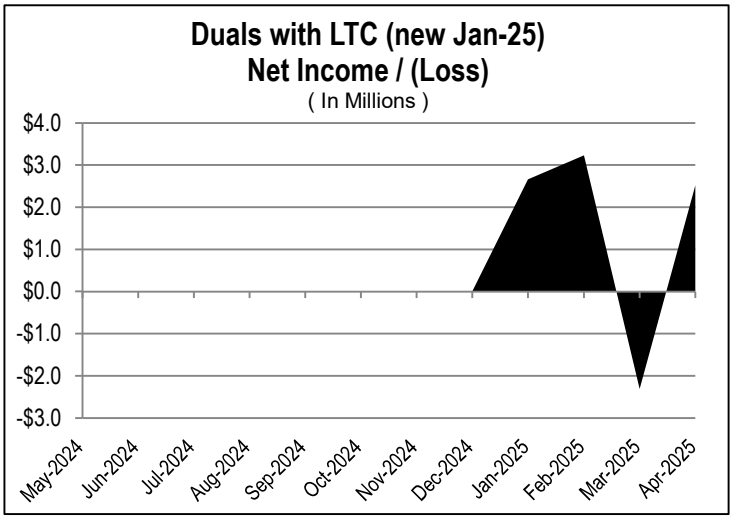




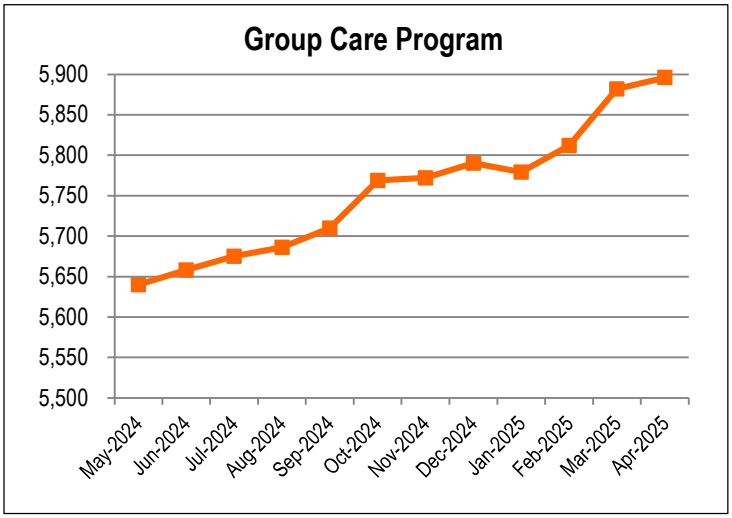


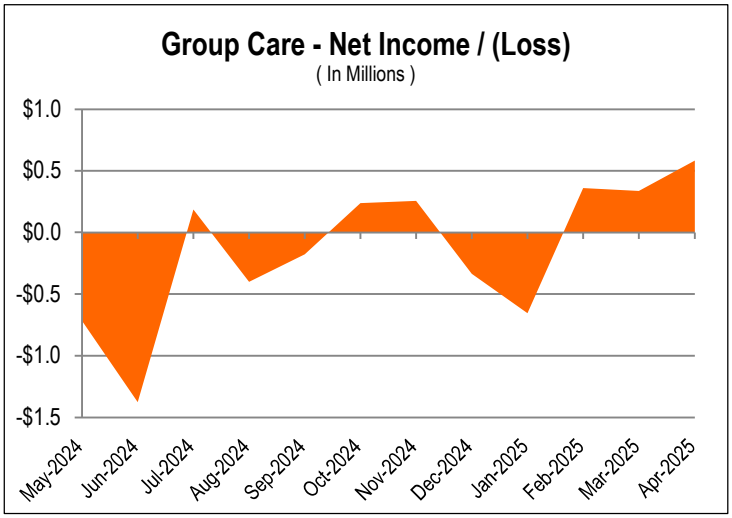


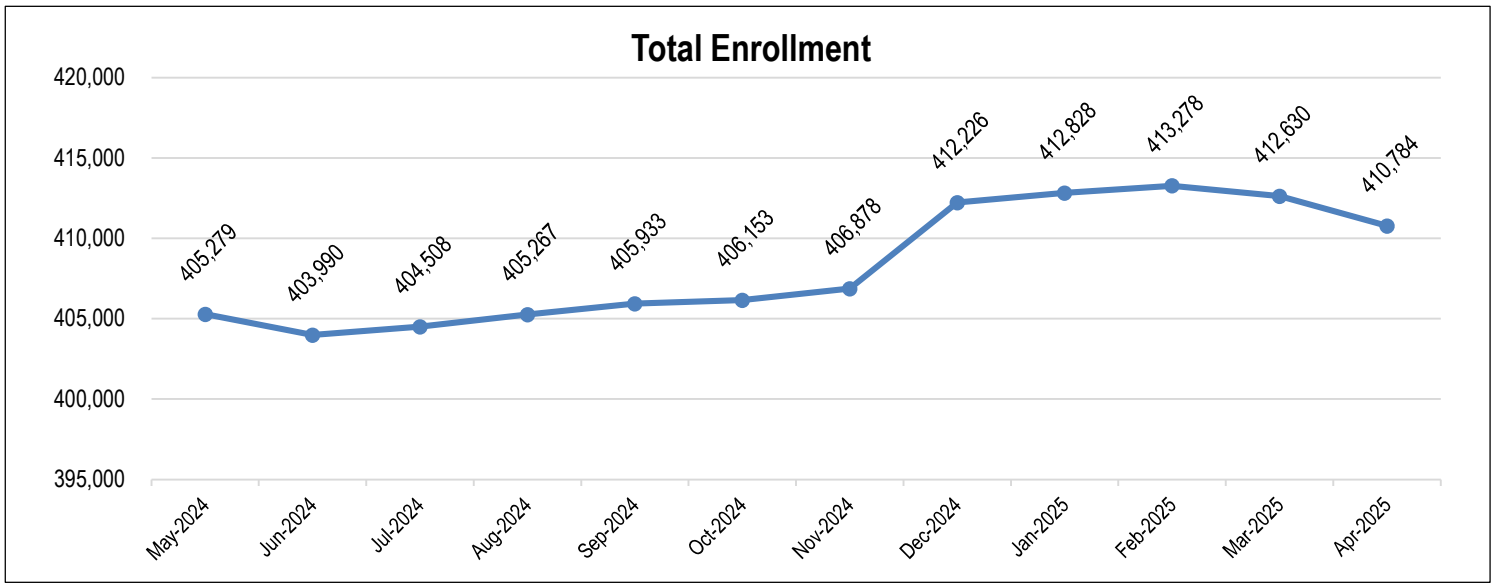


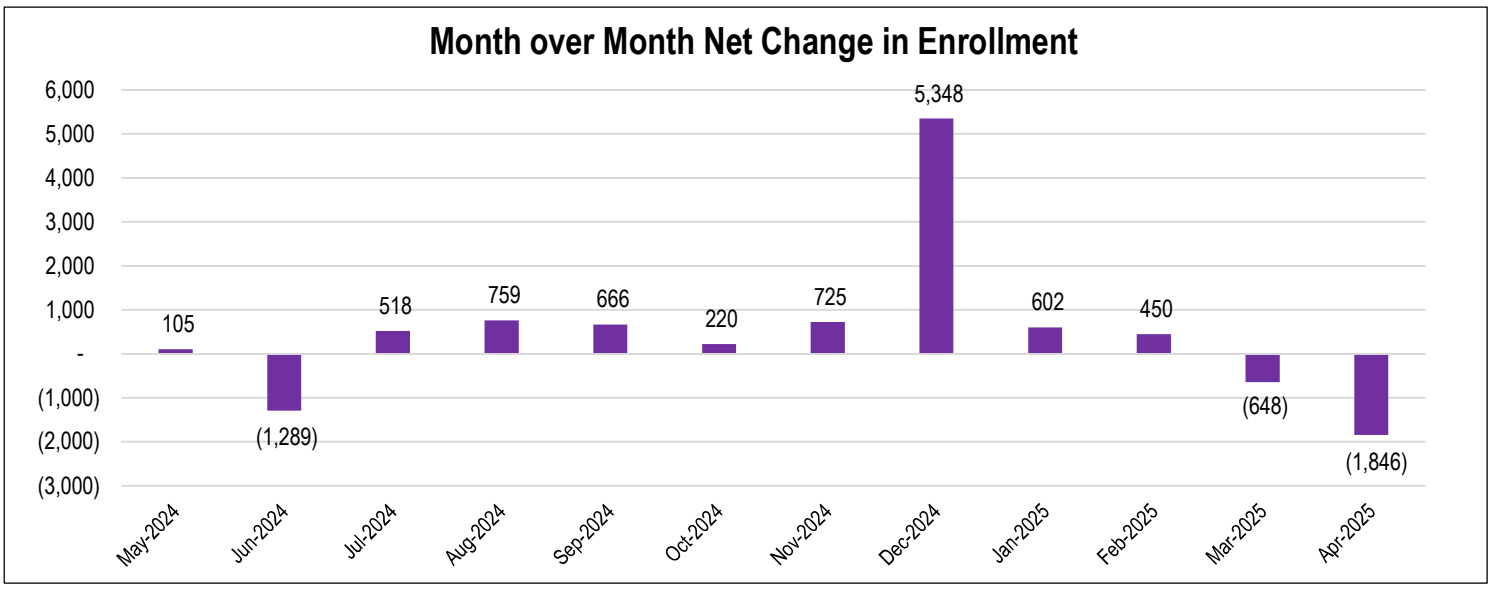


Enrollment and Profitability by Program and Category of Aid



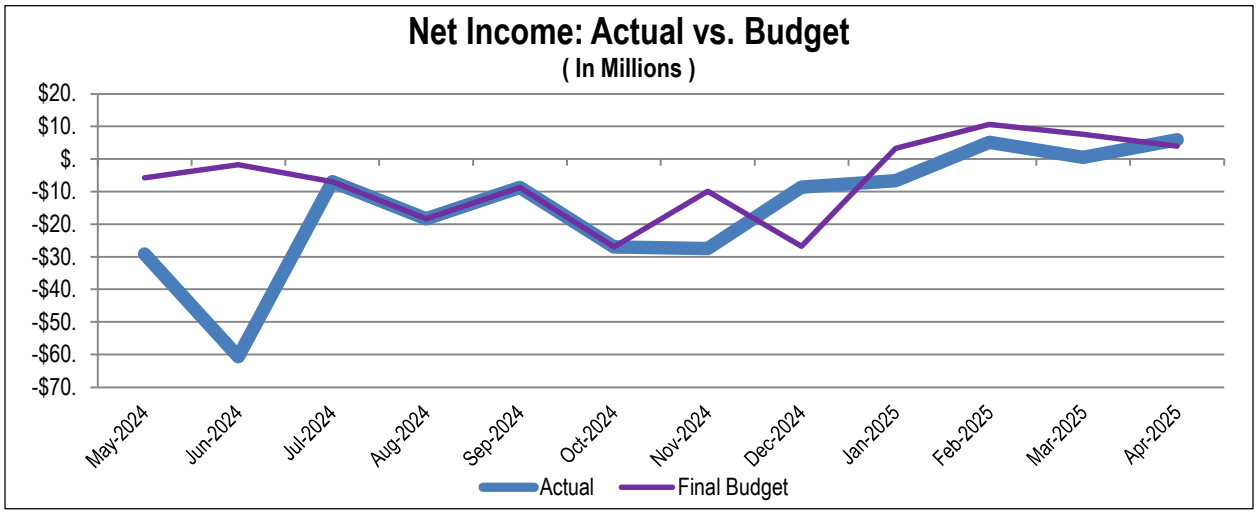






Net Income

- For the month ended April 30th, 2025:
  - Actual Net Income $5.9 million.
  - Budgeted Net Income $3.9 million.
- For the fiscal YTD ended April 30th, 2025:
  - Actual Net Loss $92.4 million.
  - Budgeted Net Loss $72.4 million.

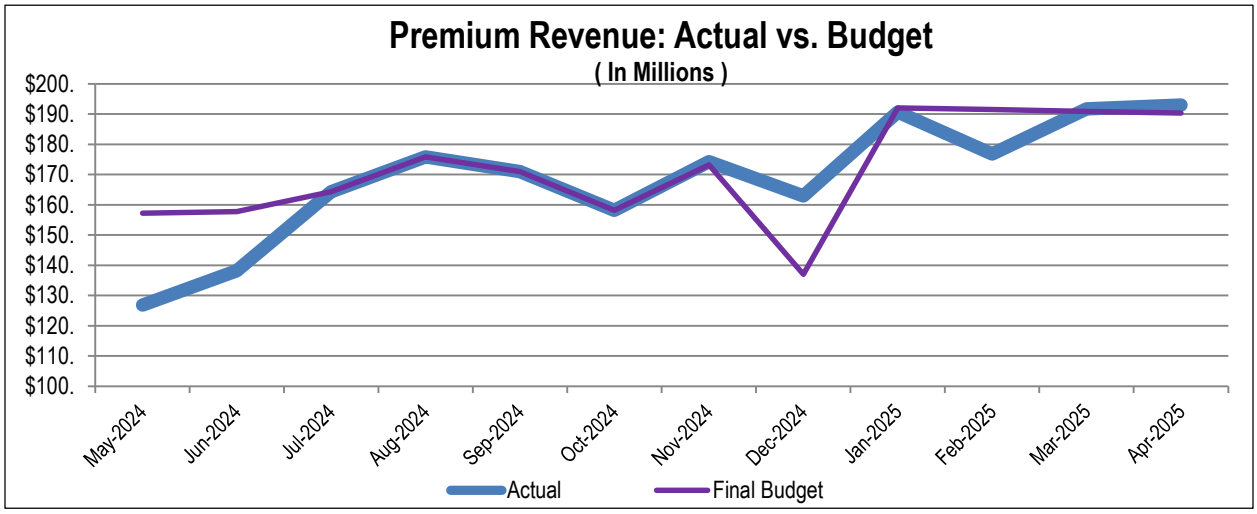


- The favorable variance of $2.0 million in the current month is primarily due to:
  - Favorable $2.8 million higher than anticipated Premium Revenue.
  - Favorable $1.5 million higher than anticipated MCO Tax Revenue.
  - Favorable $1.5 million lower than anticipated MCO Tax Expense.
  - Favorable $1.3 million lower than anticipated Administrative Expense.
  - Favorable $1.3 million higher than anticipated Other Income.
  - Unfavorable $6.3 million higher than anticipated Medical Expense.

Premium Revenue

- For the month ended April 30th, 2025:
  - Actual Revenue: $193.0 million.
  - Budgeted Revenue: $190.3 million.

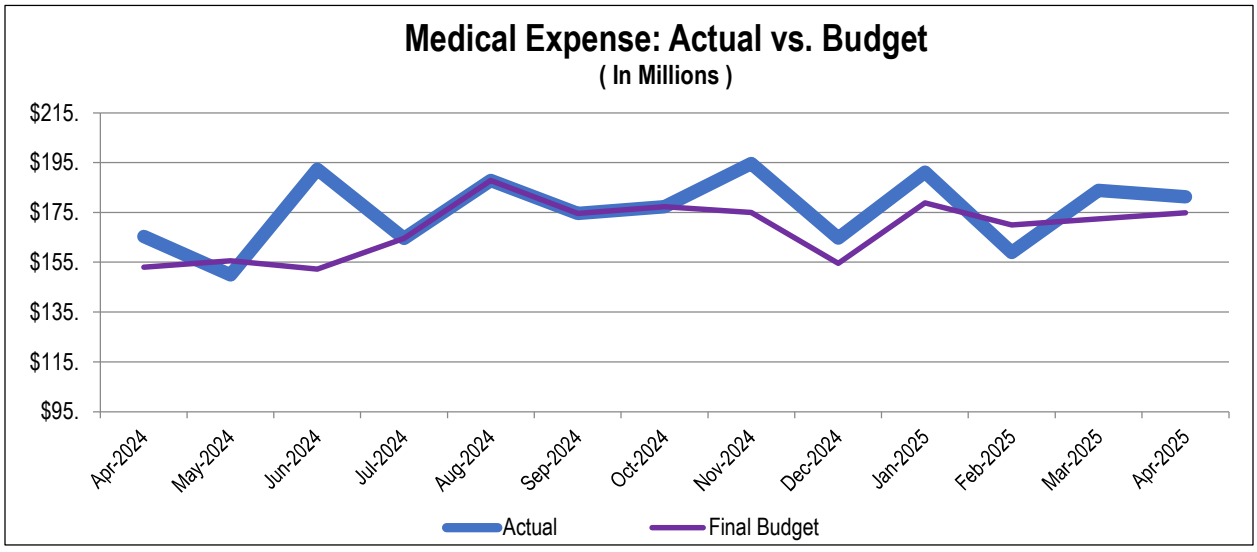
- For the fiscal YTD ended April 30th, 2025:
  - Actual Revenue: $1.8 billion.
  - Budgeted Revenue: $1.7 billion.



- For the month ended April 30th, 2025, the favorable Premium Revenue variance of $2.8 million is primarily due to the following:
  - Favorable MOT Risk Corridor Adjustment.
  - Favorable Blended Medi-Cal Capitation Rate Variance.
  - Favorable Liability Release CY2022 - CY2023.
  - Unfavorable CY2025 Rate Acuity Reserve.

Medical Expense

- For the month ended April 30th, 2025:
  - Actual Medical Expense: $181.2 million.
  - Budgeted Medical Expense: $174.9 million.
- For the fiscal YTD ended April 30th, 2025:
  - Actual Medical Expense: $1.8 billion.
  - Budgeted Medical Expense: $1.7 billion.



- Reported financial results include medical expense, which contains estimates for Incurred-But-Not-Paid (IBNP) claims. Calculation of monthly IBNP is based on historical trends and claims payment. The Alliance's IBNP reserves are reviewed by our actuarial consultants.

- For April, updates to Fee-For-Service (FFS) increased the estimate for prior period unpaid Medical Expenses by $4.5 million. Year to date, the estimate for prior years increased by $11.4 million (per table below).

Medical Expense - Actual vs. Budget (In Dollars)
Adjusted to Eliminate the Impact of Prior Period IBNP Estimates

	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$179,387,709	$0	$179,387,709	$166,512,220	($12,875,489)	(7.7%)
Primary Care FFS	$27,548,881	$159,755	$27,708,635	$36,400,094	$8,851,214	24.3%
Specialty Care FFS	$81,463,482	$474,802	$81,938,284	$82,583,234	$1,119,752	1.4%
Outpatient FFS	$125,310,170	$957,244	$126,267,415	$118,787,063	($6,523,107)	(5.5%)
Ancillary FFS	$179,715,767	($392,640)	$179,323,128	$178,266,277	($1,449,491)	(0.8%)
Pharmacy FFS	$129,193,388	$327,244	$129,520,632	$129,199,362	$5,974	0.0%
ER Services FFS	$104,067,245	$662,328	$104,729,573	$104,456,689	$389,444	0.4%
Inpatient Hospital FFS	$548,743,589	$5,790,837	$554,534,427	$526,330,147	($22,413,443)	(4.3%)
Long Term Care & SNF FFS	$346,878,568	$3,420,096	$350,298,664	$333,452,213	($13,426,356)	(4.0%)
Other Benefits & Services	$46,929,169	$0	$46,929,169	$50,715,182	$3,786,014	7.5%
Net Reinsurance	($2,079,914)	$0	($2,079,914)	$2,890,550	$4,970,463	172.0%
	$1,767,158,055	**$11,399,666**	**$1,778,557,721**	**$1,729,593,030**	**($37,565,024)**	**(2.2%)**

Medical Expense - Actual vs. Budget (Per Member Per Month)
Adjusted to Eliminate the Impact of Prior Year IBNP Estimates

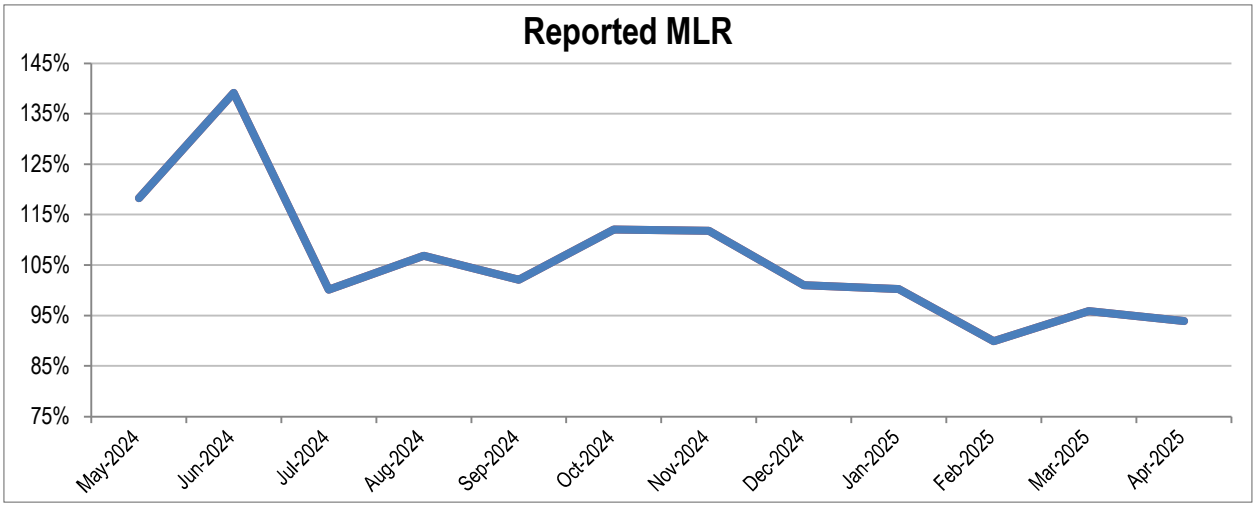
	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$43.85	$0.00	$43.85	$40.94	($2.91)	(7.1%)
Primary Care FFS	$6.73	$0.04	$6.77	$8.95	$2.22	24.8%
Specialty Care FFS	$19.92	$0.12	$20.03	$20.31	$0.39	1.9%
Outpatient FFS	$30.63	$0.23	$30.87	$29.21	($1.43)	(4.9%)
Ancillary FFS	$43.94	($0.10)	$43.84	$43.83	($0.10)	(0.2%)
Pharmacy FFS	$31.58	$0.08	$31.66	$31.77	$0.19	0.6%
ER Services FFS	$25.44	$0.16	$25.60	$25.68	$0.24	0.9%
Inpatient Hospital & SNF FFS	$134.15	$1.42	$135.57	$129.42	($4.73)	(3.7%)
Long Term Care & SNF FFS	$84.80	$0.84	$85.64	$81.99	($2.81)	(3.4%)
Other Benefits & Services	$11.47	$0.00	$11.47	$12.47	$1.00	8.0%
Net Reinsurance	($0.51)	$0.00	($0.51)	$0.71	$1.22	171.5%
	$432.02	**$2.79**	**$434.80**	**$425.29**	**($6.72)**	**(1.6%)**

- Excluding the impact of prior year estimates for IBNP, year-to-date medical expense variance is $37.6 million unfavorable to budget. On a PMPM basis, medical expense is 1.6% unfavorable to budget. For per-member-per-month expense:

- Capitated Expense is over budget due to inclusion of Targeted Rate Increases (TRI) in capitation payments.
- Primary Care Expense is under budget due to lower utilization in the ACA OE, Child, Adult and SPD aid code categories.
- Specialty Care Expense is slightly below budget, driven by lower SPD, Child and ACA OE unit cost and Adult utilization.
- Outpatient Expense is over budget mostly driven by lab and radiology unit cost, along with higher dialysis and facility (other) utilization in the SPD with LTC, ACA OE and Adult aid code categories.
- Ancillary Expense is over budget due to higher Behavioral Health utilization in the Child aid code category.
- Pharmacy Expense is under budget lower Non-PBM utilization in the SPD with LTC and ACA OE categories of aid.
- Emergency Room Expense is slightly under budget driven by lower-than-expected units cost across most populations.
- Inpatient Expense is over budget driven by higher utilization in the SPD with LTC and ACA OE aid code categories.
- Long Term Care Expense is over budget due to higher unit cost in the ACA OE, SPD with LTC, Duals, and Dual with LTC aid code categories.
- Other Benefits & Services is under budget, due to lower-than-expected employee, professional services and community relations expense.
- Net Reinsurance is under budget because more recoveries were received than expected.

Medical Loss Ratio (MLR)

The Medical Loss Ratio (total reported Medical Expense divided by Premium Revenue) was 93.9% for the month and 101.1% for the fiscal year-to-date.



Administrative Expense

- For the month ended April 30th, 2025:
  - Actual Administrative Expense: $8.7 million.
  - Budgeted Administrative Expense: $10.0 million.

- For the fiscal YTD ended April 30th, 2025:
  - Actual Administrative Expense: $95.5 million.
  - Budgeted Administrative Expense: $101.1 million.

Summary of Administrative Expense (In Dollars)
For the Month and Fiscal Year-to-Date
Favorable/(Unfavorable)

Current Month					Year-to-Date			
Actual	Budget	Variance $	Variance %		Actual	Budget	Variance $	Variance %
$5,834,237	$6,201,806	$367,569	5.9%	Personnel Expense	$57,482,397	$58,590,084	$1,107,687	1.9%
82,259	75,115	(7,143)	(9.5%)	Medical Benefits Admin Expense	786,218	754,810	(31,408)	(4.2%)
1,203,981	2,028,103	824,122	40.6%	Purchased & Professional Services	20,532,833	24,737,752	4,204,920	17.0%
1,535,178	1,697,790	162,612	9.6%	Other Admin Expense	16,652,363	16,971,641	319,278	1.9%
$8,655,654	$10,002,814	$1,347,160	13.5%	Total Administrative Expense	$95,453,810	$101,054,287	$5,600,477	5.5%

The year-to-date variances include:

- Favorable Employee and Temporary Services and delayed training, travel, and other employee-related expenses.
- Favorable Purchased & Professional Services, primarily due to timing of Consulting Services and Other Purchased Services.
- Favorable Printing/Postage/Promotion.
- Favorable Licenses, Insurance & Fees.
- Favorable Building Occupancy costs.
- Partially offset by the unfavorable Medical Benefit Admin Fees, primarily due to increases Pharmacy Administrative Fees.
- Partially offset by Supplies & Other Expenses.

The Administrative Loss Ratio (ALR) is 4.5% of net revenue for the month and 5.4% of net revenue year-to-date. Fiscal year-to-date claims interest expense, due to delayed payment of certain claims, or recalculated interest on previously paid claims is $1.4 million.

Other Income / (Expense)

Other Income & Expense is comprised primarily of investment income. Fiscal year-to-date net investments show a gain of $28.1 million.

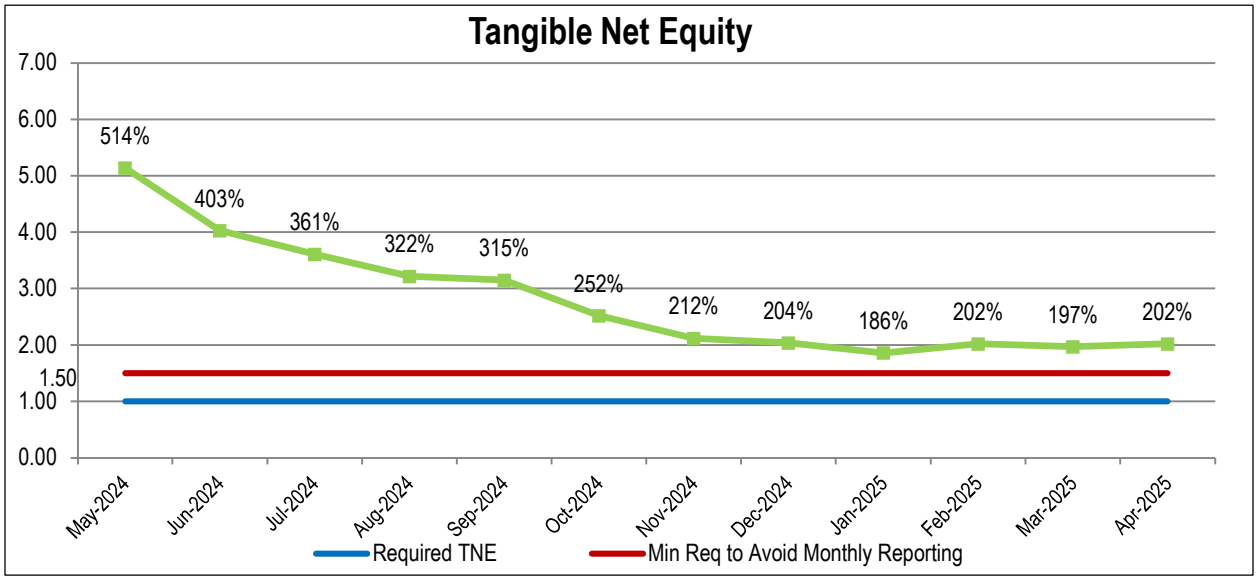
Managed Care Organization (MCO) Provider Tax

- Revenue:
  - For the month ended April 30th, 2025:
    - Actual: $65.4 million.
    - Budgeted: $63.9 million.

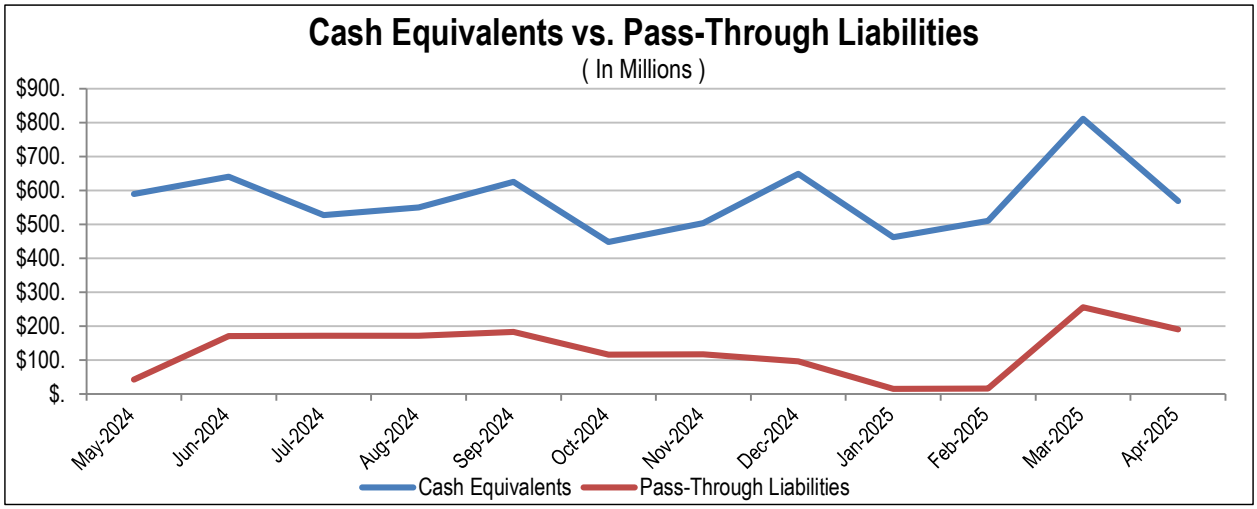
    - For the fiscal YTD ended April 30th, 2025:
        - Actual: $745.4 million.
        - Budgeted: $734.3 million.
- Expense:
    - For the month ended April 30th, 2025:
        - Actual: $65.4 million.
        - Budgeted: $66.9 million.
    - For the fiscal YTD ended April 30th, 2025:
        - Actual: $750.4 million.
        - Budgeted: $743.3 million.

Tangible Net Equity (TNE)

- The Department of Managed Health Care (DMHC) monitors the financial stability of health plans to ensure that they can meet their financial obligations to providers. TNE is a calculation of a company's total tangible assets minus a percentage of fee-for-service medical expenses. The Alliance exceeds DMHC's required TNE.
    - Required TNE $80.8 million
    - Actual TNE $163.0 million
    - Excess TNE $82.2 million
    - TNE % of Required TNE 202%



- To ensure appropriate liquidity and limit risk, the majority of Alliance financial assets are kept in short-term investments.
- Key Metrics
    - Cash & Cash Equivalents $568.4 million
    - Pass-Through Liabilities $190.5 million
    - Uncommitted Cash $378.0 million
    - Working Capital $105.3 million
    - Current Ratio 1.13 (regulatory minimum is 1.00)



Capital Investment

- Fiscal year-to-date capital assets acquired: $859,000.
- Annual capital budget: $2.0 million.
- A summary of year-to-date capital asset acquisitions is included in this monthly financial statement package.

Caveats to Financial Statements

- We continue to caveat these financial statements that, due to challenges of projecting medical expense and liabilities based on incomplete claims experience, financial results are subject to revision.
- The full set of financial statements and reports are included in the Board of Governors Report. This is a high-level summary of key components of those statements, which are unaudited.

Finance

Supporting Documents

ALAMEDA ALLIANCE FOR HEALTH
STATEMENT OF REVENUE & EXPENSES
ACTUAL VS. BUDGET
COMBINED BASIS (RESTRICTED & UNRESTRICTED FUNDS)
FOR THE MONTH AND FISCAL YTD ENDED 30 APRIL, 2025

CURRENT MONTH					FISCAL YEAR TO DATE			
		$ Variance	% Variance				$ Variance	% Variance
Actual	Budget	(Unfavorable)	(Unfavorable)	Account Description	Actual	Budget	(Unfavorable)	(Unfavorable)
				MEMBERSHIP				
404,888	402,671	2,217	0.6%	1. Medi-Cal	4,032,714	4,009,384	23,330	0.6%
5,896	5,769	127	2.2%	2. GroupCare	57,771	57,454	317	0.6%
410,784	**408,440**	**2,344**	**0.6%**	**3. TOTAL MEMBER MONTHS**	**4,090,485**	**4,066,838**	**23,647**	**0.6%**
				REVENUE				
$193,035,440	$190,285,172	$2,750,268	1.4%	4. Premium Revenue	$1,758,614,767	$1,744,243,874	$14,370,893	0.8%
$65,413,705	$63,899,861	$1,513,844	2.4%	5. MCO Tax Revenue AB119	$745,411,699	$734,252,913	$11,158,786	1.5%
$258,449,145	**$254,185,033**	**$4,264,112**	**1.7%**	**6. TOTAL REVENUE**	**$2,504,026,466**	**$2,478,496,786**	**$25,529,680**	**1.0%**
				MEDICAL EXPENSES				
				Capitated Medical Expenses				
$16,598,534	$17,115,184	$516,649	3.0%	7. Capitated Medical Expense	$179,387,709	$166,512,220	($12,875,489)	(7.7%)
				Fee for Service Medical Expenses				
$56,720,983	$51,596,435	($5,124,548)	(9.9%)	8. Inpatient Hospital Expense	$554,534,427	$526,330,147	($28,204,280)	(5.4%)
$3,269,778	$4,681,004	$1,411,226	30.1%	9. Primary Care Physician Expense	$27,708,635	$36,400,095	$8,691,459	23.9%
$8,189,030	$8,317,838	$128,808	1.5%	10. Specialty Care Physician Expense	$81,938,284	$82,583,234	$644,950	0.8%
$18,303,678	$19,827,392	$1,523,714	7.7%	11. Ancillary Medical Expense	$179,323,128	$178,266,277	($1,056,851)	(0.6%)
$13,311,797	$11,639,748	($1,672,048)	(14.4%)	12. Outpatient Medical Expense	$126,267,415	$118,787,063	($7,480,351)	(6.3%)
$11,865,713	$10,611,910	($1,253,803)	(11.8%)	13. Emergency Expense	$104,729,573	$104,456,689	($272,884)	(0.3%)
$10,577,249	$12,036,120	$1,458,872	12.1%	14. Pharmacy Expense	$129,520,632	$129,199,362	($321,270)	(0.2%)
$36,111,313	$33,879,825	($2,231,488)	(6.6%)	15. Long Term Care Expense	$350,298,664	$333,452,213	($16,846,451)	(5.1%)
$158,349,540	$152,590,273	($5,759,266)	(3.8%)	16. Total Fee for Service Expense	$1,554,320,757	$1,509,475,078	($44,845,678)	(3.0%)
$5,193,412	$4,741,816	($451,596)	(9.5%)	17. Other Benefits & Services	$46,929,169	$50,715,182	$3,786,014	7.5%
$1,078,699	$426,492	($652,207)	(152.9%)	18. Reinsurance Expense	($2,079,914)	$2,890,550	$4,970,463	172.0%
$181,220,185	**$174,873,765**	**($6,346,420)**	**(3.6%)**	**20. TOTAL MEDICAL EXPENSES**	**$1,778,557,721**	**$1,729,593,030**	**($48,964,691)**	**(2.8%)**
$77,228,960	**$79,311,268**	**($2,082,308)**	**(2.6%)**	**21. GROSS MARGIN**	**$725,468,745**	**$748,903,756**	**($23,435,011)**	**(3.1%)**
				ADMINISTRATIVE EXPENSES				
$5,834,237	$6,201,806	$367,569	5.9%	22. Personnel Expense	$57,482,397	$58,590,084	$1,107,687	1.9%
$82,259	$75,115	($7,143)	(9.5%)	23. Benefits Administration Expense	$786,218	$754,810	($31,408)	(4.2%)
$1,203,981	$2,028,103	$824,122	40.6%	24. Purchased & Professional Services	$20,532,833	$24,737,752	$4,204,920	17.0%
$1,535,178	$1,697,790	$162,612	9.6%	25. Other Administrative Expense	$16,652,363	$16,971,640	$319,278	1.9%
$8,655,654	**$10,002,814**	**$1,347,160**	**13.5%**	**26. TOTAL ADMINISTRATIVE EXPENSES**	**$95,453,810**	**$101,054,287**	**$5,600,477**	**5.5%**
$65,413,705	**$66,899,861**	**$1,486,156**	**2.2%**	**27. MCO TAX EXPENSES**	**$750,411,699**	**$743,252,913**	**($7,158,786)**	**(1.0%)**
$3,159,600	**$2,408,593**	**$751,008**	**31.2%**	**28. NET OPERATING INCOME / (LOSS)**	**($120,396,765)**	**($95,403,444)**	**($24,993,321)**	**(26.2%)**
				OTHER INCOME / EXPENSES				
$2,779,270	**$1,500,000**	**$1,279,270**	**85.3%**	**29. TOTAL OTHER INCOME / (EXPENSES)**	**$28,033,025**	**$22,981,002**	**$5,052,023**	**22.0%**
$5,938,870	**$3,908,593**	**$2,030,277**	**51.9%**	**30. NET SURPLUS (DEFICIT)**	**($92,363,740)**	**($72,422,442)**	**($19,941,298)**	**(27.5%)**
93.9%	91.9%	(2.0%)	(2.2%)	31. Medical Loss Ratio	101.1%	99.2%	(1.9%)	(1.9%)
4.5%	5.3%	0.8%	15.1%	32. Administrative Expense Ratio	5.4%	5.8%	0.4%	6.9%
2.3%	1.5%	0.8%	53.3%	33. Net Surplus (Deficit) Ratio	(3.7%)	(2.9%)	(0.8%)	(27.6%)

ALAMEDA ALLIANCE FOR HEALTH
BALANCE SHEETS
CURRENT MONTH VS. PRIOR MONTH
FOR THE MONTH AND FISCAL YTD ENDED 30 APRIL, 2025

	4/30/2025	3/31/2025	Difference	% Difference
CURRENT ASSETS				
Cash and Cash Equivalent				
Cash	$92,485,445	$31,325,120	$61,160,326	195.2%
CNB Short-Term Investment	475,954,357	779,790,546	(303,836,189)	(39.0%)
Interest Receivable	3,129,121	4,004,280	(875,159)	(21.9%)
Premium Receivables	365,046,255	258,180,311	106,865,944	41.4%
Reinsurance Recovery Receivable	8,135,264	10,087,857	(1,952,593)	(19.4%)
Other Receivables	1,249,398	1,598,669	(349,271)	(21.8%)
Prepaid Expenses	788,128	823,287	(35,159)	(4.3%)
TOTAL CURRENT ASSETS	**946,787,969**	**1,085,810,070**	**(139,022,100)**	**(12.8%)**
OTHER ASSETS				
CNB Long-Term Investment	44,018,618	66,730,524	(22,711,906)	(34.0%)
CalPERS Net Pension Asset	(6,144,132)	(6,144,132)	0	0.0%
Deferred Outflow	14,319,532	14,319,532	0	0.0%
Restricted Asset-Bank Note	351,895	350,898	997	0.3%
GASB 87-Lease Assets (Net)	147,788	213,702	(65,913)	(30.8%)
GASB 96-SBITA Assets (Net)	2,850,345	3,093,815	(243,470)	(7.9%)
TOTAL OTHER ASSETS	**55,544,047**	**78,564,339**	**(23,020,293)**	**(29.3%)**
PROPERTY AND EQUIPMENT				
Land, Building & Improvements	9,842,648	9,842,648	0	0.0%
Furniture And Equipment	13,400,309	13,400,309	0	0.0%
Leasehold Improvement	902,447	902,447	0	0.0%
Internally Developed Software	14,824,002	14,824,002	0	0.0%
Fixed Assets at Cost	38,969,405	38,969,405	0	0.0%
Less: Accumulated Depreciation	(33,268,891)	(33,204,029)	(64,862)	0.2%
PROPERTY AND EQUIPMENT (NET)	**5,700,514**	**5,765,376**	**(64,862)**	**(1.1%)**
TOTAL ASSETS	**1,008,032,530**	**1,170,139,784**	**(162,107,255)**	**(13.9%)**
CURRENT LIABILITIES				
Trade Accounts Payable	9,516,161	9,068,994	447,168	4.9%
Incurred But Not Reported Claims	386,593,973	387,146,912	(552,938)	(0.1%)
Other Medical Liabilities	150,958,997	130,204,088	20,754,909	15.9%
Pass-Through Liabilities	190,458,089	256,119,187	(65,661,098)	(25.6%)
MCO Tax Liabilities	93,788,781	216,750,076	(122,961,295)	(56.7%)
GASB 87 and 96 ST Liabilities	1,358,053	1,391,062	(33,010)	(2.4%)
Payroll Liabilities	8,772,625	8,809,211	(36,586)	(0.4%)
TOTAL CURRENT LIABILITIES	**841,446,679**	**1,009,489,529**	**(168,042,850)**	**(16.6%)**
LONG TERM LIABILITIES				
GASB 87 and 96 LT Liabilities	246,917	250,192	(3,275)	(1.3%)
Deferred Inflow	3,327,530	3,327,530	0	0.0%
TOTAL LONG TERM LIABILITIES	**3,574,446**	**3,577,721**	**(3,275)**	**(0.1%)**
TOTAL LIABILITIES	**845,021,126**	**1,013,067,251**	**(168,046,125)**	**(16.6%)**
NET WORTH				
Contributed Capital	840,233	840,233	0	0.0%
Restricted & Unrestricted Funds	254,534,911	254,534,911	0	0.0%
Year-To-Date Net Surplus (Deficit)	(92,363,740)	(98,302,610)	5,938,870	(6.0%)
TOTAL NET WORTH	**163,011,404**	**157,072,534**	**5,938,870**	**3.8%**
TOTAL LIABILITIES AND NET WORTH	**1,008,032,530**	**1,170,139,785**	**(162,107,255)**	**(13.9%)**
Cash Equivalents	568,439,803	811,115,666	(242,675,864)	(29.9%)
Pass-Through	190,458,089	256,119,187	(65,661,098)	(25.6%)
Uncommitted Cash	377,981,714	554,996,479	(177,014,765)	(31.9%)
Working Capital	105,341,290	76,320,540	29,020,750	38.0%
Current Ratio	112.5%	107.6%	4.9%	4.6%

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED **April 30, 2025**

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM OPERATING ACTIVITIES				
Commercial Premium Cash Flows				
Commercial Premium Revenue	$3,224,437	$9,609,893	$19,092,404	$31,584,787
GroupCare Receivable	(16,401)	(3,207,489)	(154,269)	(3,214,805)
Total	3,208,036	6,402,404	18,938,135	28,369,982
Medi-Cal Premium Cash Flows				
Medi-Cal Revenue	255,224,709	751,647,946	1,463,923,258	2,472,441,680
Premium Receivable	(106,849,544)	119,207,356	111,611,759	5,112,070
Total	148,375,165	870,855,302	1,575,535,017	2,477,553,750
Investment & Other Income Cash Flows				
Other Revenues	(527,375)	(1,307,036)	381,459	1,862,865
Interest Income	3,311,199	9,211,272	14,728,319	26,276,338
Interest Receivable	875,159	687,164	2,061,759	(1,213,058)
Total	3,658,983	8,591,400	17,171,537	26,926,145
Medical & Hospital Cash Flows				
Total Medical Expenses	(181,220,185)	(523,972,263)	(1,074,445,378)	(1,778,557,721)
Other Health Care Receivables	2,302,119	1,074,195	2,075,883	1,540,134
Capitation Payable	-	-	-	-
IBNP Payable	(552,938)	21,446,922	85,781,873	90,289,715
Other Medical Payable	(44,906,190)	188,312,877	116,018,227	5,576,329
Risk Share Payable	-	-	-	(2,680,192)
New Health Program Payable	-	-	-	-
Total	(224,377,194)	(313,138,269)	(870,569,395)	(1,683,831,735)
Administrative Cash Flows				
Total Administrative Expenses	(8,660,206)	(28,955,873)	(56,336,758)	(95,559,988)
Prepaid Expenses	35,159	(93,009)	836	(549,511)
Other Receivables	(255)	37,326	37,652	69,746
CalPERS Pension	-	-	-	-
Trade Accounts Payable	447,167	(1,251,630)	2,459,089	3,025,866
Payroll Liabilities	(36,585)	146,488	(1,585,833)	673,400
GASB Assets and Liabilities	273,098	1,111,380	(89,534)	(891,679)
Depreciation Expense	64,862	190,140	368,260	606,219
Total	(7,876,760)	(28,815,178)	(55,146,288)	(92,625,947)
MCO Tax AB119 Cash Flows				
MCO Tax Expense AB119	(65,413,705)	(204,747,614)	(398,659,291)	(750,411,699)
MCO Tax Liabilities	(122,961,295)	(235,252,386)	(166,809,459)	(65,994,733)
Total	(188,375,000)	(440,000,000)	(565,468,750)	(816,406,432)
Net Cash Flows from Operating Activities	**(265,386,770)**	**103,895,659**	**120,460,256**	**(60,014,237)**

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED **April 30, 2025**

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM INVESTING ACTIVITIES				
Investment Cash Flows				
Long Term Investments	22,711,904	2,751,188	88,292	(11,026,375)
Total	22,711,904	2,751,188	88,292	(11,026,375)
Restricted Cash & Other Asset Cash Flows				
Restricted Assets-Treasury Account	(997.00)	(1,895.00)	(1,895.00)	(1,895.00)
Total	(997.00)	(1,895.00)	(1,895.00)	(1,895.00)
Fixed Asset Cash Flows				
Fixed Asset Acquisitions	-	(329,306)	(329,306)	(858,916)
Purchases of Property and Equipment	-	(329,306)	(329,306)	(858,916)
Net Cash Flows from Investing Activities	**22,710,907**	**2,419,987**	**(242,909)**	**(11,887,186)**
Net Change in Cash	**(242,675,863)**	**106,315,646**	**120,217,347**	**(71,901,423)**
Rounding	-	-	-	-
Cash @ Beginning of Period	811,115,665	462,124,156	448,222,455	640,341,225
Cash @ End of Period	**$568,439,802**	**$568,439,802**	**$568,439,802**	**$568,439,802**
Variance	-	-	-	-

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED **April 30, 2025**

	MONTH	3 MONTHS	6 MONTHS	YTD
NET INCOME RECONCILIATION				
Net Income / (Loss)	$5,938,874	$11,486,325	($31,315,987)	($92,363,738)
Add back: Depreciation & Amortization	64,862	190,140	368,260	606,219
Receivables				
Premiums Receivable	(106,849,544)	119,207,356	111,611,759	5,112,070
Interest Receivable	875,159	687,164	2,061,759	(1,213,058)
Other Health Care Receivables	2,302,119	1,074,195	2,075,883	1,540,134
Other Receivables	(255)	37,326	37,652	69,746
GroupCare Receivable	(16,401)	(3,207,489)	(154,269)	(3,214,805)
Total	(103,688,922)	117,798,552	115,632,784	2,294,087
Prepaid Expenses	35,159	(93,009)	836	(549,511)
Trade Payables	447,167	(1,251,630)	2,459,089	3,025,866
Claims Payable and Shared Risk Pool				
IBNP Payable	(552,938)	21,446,922	85,781,873	90,289,715
Capitation Payable & Other Medical Payable	(44,906,190)	188,312,877	116,018,227	5,576,329
Risk Share Payable	-	-	0	(2,680,192)
Claims Payable				
Total	(45,459,128)	209,759,799	201,800,100	93,185,852
Other Liabilities				
CalPERS Pension	-	-	-	-
Payroll Liabilities	(36,585)	146,488	(1,585,832)	673,400
GASB Assets and Liabilities	273,098	1,111,380	(89,534)	(891,679)
New Health Program	-	-	-	-
MCO Tax Liabilities	(122,961,295)	(235,252,386)	(166,809,459)	(65,994,733)
Total	(122,724,782)	(233,994,518)	(168,484,825)	(66,213,012)
Rounding	-	-	(1.00)	-
Cash Flows from Operating Activities	**(265,386,770)**	**103,895,659**	**120,460,256**	**(60,014,237)**
Variance	-	-	-	-

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED **April 30, 2025**

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOW STATEMENT:				
Cash Flows from Operating Activities:				
Cash Received				
Capitation Received from State of CA	$148,375,165	$870,855,302	$1,575,535,017	$2,477,553,750
Medicare Revenue	$0	$0	$0	$0
GroupCare Premium Revenue	3,208,036	6,402,404	18,938,135	28,369,982
Other Income	(527,375)	(1,307,036)	381,459	1,862,865
Interest Income	4,186,358	9,898,436	16,790,078	25,063,280
Less Cash Paid				
Medical Expenses	(224,377,194)	(313,138,269)	(870,569,395)	(1,683,831,735)
Vendor & Employee Expenses	(7,876,760)	(28,815,178)	(55,146,288)	(92,625,947)
MCO Tax Expense AB119	(188,375,000)	(440,000,000)	(565,468,750)	(816,406,432)
Net Cash Flows from Operating Activities	**(265,386,770)**	**103,895,659**	**120,460,256**	**(60,014,237)**
Cash Flows from Investing Activities:				
Long Term Investments	22,711,904	2,751,188	88,292	(11,026,375)
Restricted Assets-Treasury Account	(997)	(1,895)	(1,895)	(1,895)
Purchases of Property and Equipment	0	(329,306)	(329,306)	(858,916)
Net Cash Flows from Investing Activities	**22,710,907**	**2,419,987**	**(242,909)**	**(11,887,186)**
Net Change in Cash	**(242,675,863)**	**106,315,646**	**120,217,347**	**(71,901,423)**
Rounding	-	-	-	-
Cash @ Beginning of Period	811,115,665	462,124,156	448,222,455	640,341,225
Cash @ End of Period	**$568,439,802**	**$568,439,802**	**$568,439,802**	**$568,439,802**
Variance	$0	-	-	-
RECONCILIATION OF NET INCOME TO NET CASH FLOW FROM OPERATING ACTIVITIES:				
Net Income / (Loss)	$5,938,874	$11,486,326	($31,315,988)	($92,363,738)
Add Back: Depreciation	64,862	190,140	368,260	606,219
Net Change in Operating Assets & Liabilities				
Premium & Other Receivables	(103,688,922)	117,798,552	115,632,784	2,294,087
Prepaid Expenses	35,159	(93,010)	837	(549,511)
Trade Payables	447,167	(1,251,630)	2,459,089	3,025,866
Claims Payable, IBNP and Risk Sharing	(45,459,128)	209,759,799	201,800,100	93,185,852
Deferred Revenue	0	0	0	0
Other Liabilities	(122,724,782)	(233,994,518)	(168,484,825)	(66,213,012)
Total	(265,386,770)	103,895,659	120,460,257	(60,014,237)
Rounding	-	-	(1)	-
Cash Flows from Operating Activities	**($265,386,770)**	**$103,895,659**	**$120,460,256**	**($60,014,237)**
Variance	$0	-	-	-

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE MONTH OF APRIL 2025

	Medi-Cal Child	Medi-Cal Adult	Medi-Cal SPD*	Medi-Cal Duals*	Medi-Cal ACA OE	Medi-Cal LTC*	Medi-Cal LTC Duals*	Medi-Cal SPD with LTC	Medi-Cal Duals with LTC	Medi-Cal Total	Group Care	Medicare	Grand Total
Enrollments/Member Months	110,186	62,499	-	-	154,154	-	-	29,316	48,733	404,888	5,896	-	410,784
Revenue	$36,191,749	$33,511,538	$2,980,524	$708,863	$92,215,533	($374,177)	$1,774,842	$45,935,372	$42,280,465	$255,224,708	$3,224,437	$0	$258,449,145
Medical Expense	$14,873,705	$22,389,117	$1,225,183	$131,108	$59,945,877	$405,984	($671,262)	$48,958,498	$31,375,431	$178,633,642	$2,586,543	$0	$181,220,185
Gross Margin	$21,318,044	$11,122,421	$1,755,340	$577,756	$32,269,655	($780,161)	$2,446,104	($3,023,126)	$10,905,034	$76,591,066	$637,894	$0	$77,228,960
Administrative Expense	$417,391	$957,759	$53,564	$21,859	$2,727,249	$770	$2,231	$2,450,183	$1,513,914	$8,144,919	$135,503	$375,231	$8,655,654
MCO Tax Expense	$17,801,650	$10,097,338	$0	$0	$24,905,120	$0	$0	$4,736,293	$7,873,303	$65,413,705	$0	$0	$65,413,705
Operating Income / (Expense)	$3,099,003	$67,324	$1,701,776	$555,897	$4,637,286	($780,932)	$2,443,873	($10,209,602)	$1,517,816	$3,032,442	$502,390	($375,231)	$3,159,600
Other Income / (Expense)	($65,494)	($315,209)	$0	$0	$939,599	$0	$0	$1,142,650	$995,205	$2,696,751	$82,519	$0	$2,779,270
Net Income / (Loss)	$3,033,509	($247,885)	$1,701,776	$555,897	$5,576,885	($780,932)	$2,443,873	($9,066,952)	$2,513,022	$5,729,192	$584,909	($375,231)	$5,938,870
PMPM Metrics:													
Revenue PMPM	$328.46	$536.19	$0.00	$0.00	$598.20	$0.00	$0.00	$1,566.90	$867.59	$630.36	$546.89	$0.00	$629.16
Medical Expense PMPM	$134.99	$358.23	$0.00	$0.00	$388.87	$0.00	$0.00	$1,670.03	$643.82	$441.19	$438.69	$0.00	$441.16
Gross Margin PMPM	$193.47	$177.96	$0.00	$0.00	$209.33	$0.00	$0.00	($103.12)	$223.77	$189.17	$108.19	$0.00	$188.00
Administrative Expense PMPM	$3.79	$15.32	$0.00	$0.00	$17.69	$0.00	$0.00	$83.58	$31.07	$20.12	$22.98	$0.00	$21.07
MCO Tax Expense PMPM	$161.56	$161.56	$0.00	$0.00	$161.56	$0.00	$0.00	$161.56	$161.56	$161.56	$0.00	$0.00	$159.24
Operating Income / (Expense) PMPM	$28.13	$1.08	$0.00	$0.00	$30.08	$0.00	$0.00	($348.26)	$31.15	$7.49	$85.21	$0.00	$7.69
Other Income / (Expense) PMPM	($0.59)	($5.04)	$0.00	$0.00	$6.10	$0.00	$0.00	$38.98	$20.42	$6.66	$14.00	$0.00	$6.77
Net Income / (Loss) PMPM	$27.53	($3.97)	$0.00	$0.00	$36.18	$0.00	$0.00	($309.28)	$51.57	$14.15	$99.20	$0.00	$14.46
Ratio:													
Medical Loss Ratio	80.9%	95.6%	41.1%	18.5%	89.1%	-108.5%	-37.8%	118.8%	91.2%	94.1%	80.2%	0.0%	93.9%
Administrative Expense Ratio	2.3%	4.1%	1.8%	3.1%	4.1%	-0.2%	0.1%	5.9%	4.4%	4.3%	4.2%	0.0%	4.5%
Net Income Ratio	8.4%	-0.7%	57.1%	78.4%	6.0%	208.7%	137.7%	-19.7%	5.9%	2.2%	18.1%	0.0%	2.3%

*As of January 2025 service month, "SPD", "Duals", "LTC", and "LTC Duals" will be discontinued. Effective January 2025, service month new consolidated groupings will be "SPD with LTC" and "Duals with LTC".

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE FISCAL YEAR TO DATE APRIL 2025

	Medi-Cal Child	Medi-Cal Adult	Medi-Cal SPD*	Medi-Cal Duals*	Medi-Cal ACA OE	Medi-Cal LTC*	Medi-Cal LTC Duals*	Medi-Cal SPD with LTC	Medi-Cal Duals with LTC	Medi-Cal Total	Group Care	Medicare	Grand Total
Enrollments/Member Months	1,103,681	628,897	212,632	241,339	1,525,963	1,446	7,562	117,982	193,212	4,032,714	57,771	-	4,090,485
Revenue	$360,207,610	$340,724,064	$302,336,374	$139,043,984	$894,028,601	$14,776,062	$66,329,080	$188,109,034	$166,886,869	$2,472,441,679	$31,584,787	$0	$2,504,026,466
Medical Expense	$135,790,616	$210,548,344	$276,590,852	$94,573,250	$616,072,668	$18,217,731	$65,402,720	$205,991,155	$125,129,841	$1,748,317,178	$29,954,701	$285,843	$1,778,557,721
Gross Margin	$224,416,994	$130,175,720	$25,745,522	$44,470,734	$277,955,934	($3,441,669)	$926,359	($17,882,120)	$41,757,028	$724,124,501	$1,630,087	($285,843)	$725,468,745
Administrative Expense	$4,556,165	$10,694,353	$14,506,074	$4,978,616	$29,584,522	$1,013,876	$4,703,905	$10,417,458	$6,431,010	$86,885,978	$1,527,187	$7,040,645	$95,453,810
MCO Tax Expense	$205,956,682	$117,183,410	$43,043,470	$49,233,964	$282,892,130	$285,308	$1,540,232	$19,061,172	$31,215,331	$750,411,699	$0	$0	$750,411,699
Operating Income / (Expense)	$13,904,148	$2,297,957	($31,804,023)	($9,741,846)	($34,520,719)	($4,740,853)	($5,317,778)	($47,360,751)	$4,110,687	($113,173,176)	$102,900	($7,326,488)	($120,396,765)
Other Income / (Expense)	$1,402,006	$3,421,641	$4,709,375	$1,609,737	$9,484,544	$338,837	$1,557,352	$3,233,088	$1,990,817	$27,747,397	$285,628	$0	$28,033,025
Net Income / (Loss)	$15,306,154	$5,719,597	($27,094,648)	($8,132,109)	($25,036,174)	($4,402,016)	($3,760,425)	($44,127,663)	$6,101,505	($85,425,779)	$388,527	($7,326,488)	($92,363,740)
PMPM Metrics:													
Revenue PMPM	$326.37	$541.78	$1,421.88	$576.14	$585.88	$10,218.58	$8,771.37	$1,594.39	$863.75	$613.10	$546.72	$0.00	$612.16
Medical Expense PMPM	$123.03	$334.79	$1,300.80	$391.87	$403.73	$12,598.71	$8,648.87	$1,745.95	$647.63	$433.53	$518.51	$0.00	$434.80
Gross Margin PMPM	$203.34	$206.99	$121.08	$184.27	$182.15	($2,380.13)	$122.50	($151.57)	$216.12	$179.56	$28.22	$0.00	$177.36
Administrative Expense PMPM	$4.13	$17.00	$68.22	$20.63	$19.39	$701.16	$622.05	$88.30	$33.28	$21.55	$26.44	$0.00	$23.34
MCO Tax Expense PMPM	$186.61	$186.33	$202.43	$204.00	$185.39	$197.31	$203.68	$161.56	$161.56	$186.08	$0.00	$0.00	$183.45
Operating Income / (Expense) PMPM	$12.60	$3.65	($149.57)	($40.37)	($22.62)	($3,278.60)	($703.22)	($401.42)	$21.28	($28.06)	$1.78	$0.00	($29.43)
Other Income / (Expense) PMPM	$1.27	$5.44	$22.15	$6.67	$6.22	$234.33	$205.94	$27.40	$10.30	$6.88	$4.94	$0.00	$6.85
Net Income / (Loss) PMPM	$13.87	$9.09	($127.43)	($33.70)	($16.41)	($3,044.27)	($497.28)	($374.02)	$31.58	($21.18)	$6.73	$0.00	($22.58)
Ratio:													
Medical Loss Ratio	87.1%	93.9%	106.5%	104.4%	100.6%	125.7%	100.9%	121.9%	92.2%	101.2%	94.8%	0.0%	101.1%
Administrative Expense Ratio	2.9%	4.8%	5.6%	5.5%	4.8%	7.0%	7.3%	6.2%	4.7%	5.0%	4.8%	0.0%	5.4%
Net Income Ratio	4.2%	1.7%	-9.0%	-5.8%	-2.8%	-29.8%	-5.7%	-23.5%	3.7%	-3.5%	1.2%	0.0%	-3.7%

*As of January 2025 service month, "SPD", "Duals", "LTC", and "LTC Duals" will be discontinued. Effective January 2025, service month new consolidated groupings will be "SPD with LTC" and "Duals with LTC".

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 30 April, 2025

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				ADMINISTRATIVE EXPENSES SUMMARY (ADMIN. DEPT. ONLY)				
$5,834,237	$6,201,806	$367,569	5.9%	Personnel Expenses	$57,482,397	$58,590,084	$1,107,687	1.9%
$82,259	$75,115	($7,143)	(9.5%)	Benefits Administration Expense	$786,218	$754,810	($31,408)	(4.2%)
$1,203,981	$2,028,103	$824,122	40.6%	Purchased & Professional Services	$20,532,833	$24,737,752	$4,204,920	17.0%
$550,451	$589,319	$38,869	6.6%	Occupancy	$5,219,409	$5,520,094	$300,685	5.4%
$417,096	$543,012	$125,916	23.2%	Printing Postage & Promotion	$4,390,870	$4,744,786	$353,916	7.5%
$338,171	$393,068	$54,897	14.0%	Licenses Insurance & Fees	$4,325,075	$4,838,301	$513,226	10.6%
$229,461	$172,391	($57,070)	(33.1%)	Other Administrative Expense	$2,717,008	$1,868,459	($848,549)	(45.4%)
$2,821,417	$3,801,008	$979,591	25.8%	Total Other Administrative Expenses (excludes Personnel Expenses)	$37,971,413	$42,464,203	$4,492,790	10.6%
$8,655,654	$10,002,814	$1,347,160	13.5%	Total Administrative Expenses	$95,453,810	$101,054,287	$5,600,477	5.5%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 30 April, 2025

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
3,721,124	4,375,181	654,058	14.9%	Salaries & Wages	37,639,635	38,828,225	1,188,590	3.1%
421,712	393,744	(27,968)	(7.1%)	Paid Time Off	3,516,384	3,755,319	238,935	6.4%
200	3,805	3,605	94.7%	Compensated Incentives	22,560	41,369	18,809	45.5%
0	0	0	0.0%	Severence	0	400,000	400,000	100.0%
62,060	62,981	921	1.5%	Payroll Taxes	715,122	902,530	187,408	20.8%
13,577	26,210	12,633	48.2%	Overtime	631,694	469,379	(162,316)	(34.6%)
356,262	320,644	(35,618)	(11.1%)	CalPERS ER Match	3,263,688	3,243,873	(19,816)	(0.6%)
1,053,184	712,159	(341,025)	(47.9%)	Employee Benefits	9,983,204	7,870,915	(2,112,289)	(26.8%)
5,866	0	(5,866)	0.0%	Personal Floating Holiday	193,833	202,966	9,132	4.5%
12,694	38,500	25,806	67.0%	Language Pay	210,112	309,759	99,647	32.2%
4,180	0	(4,180)	0.0%	Med Ins Opted Out Stipend	36,370	16,010	(20,360)	(127.2%)
0	0	0	0.0%	Holiday Bonus	(400,000)	0	400,000	1,333,333,4…
90,586	0	(90,586)	0.0%	Sick Leave	826,882	270,728	(556,154)	(205.4%)
300	26,417	26,117	98.9%	Compensated Employee Relations	8,813	223,355	214,543	96.1%
20,320	26,750	6,430	24.0%	Work from Home Stipend	200,860	235,420	34,560	14.7%
878	5,693	4,815	84.6%	Mileage, Parking & LocalTravel	13,937	49,280	35,342	71.7%
10,023	24,687	14,664	59.4%	Travel & Lodging	37,420	187,945	150,525	80.1%
17,541	109,045	91,504	83.9%	Temporary Help Services	303,013	840,514	537,500	63.9%
20,499	32,976	12,477	37.8%	Staff Development/Training	170,733	443,143	272,409	61.5%
23,231	43,015	19,783	46.0%	Staff Recruitment/Advertisement	108,135	299,355	191,220	63.9%
5,834,237	**6,201,806**	**367,569**	**5.9%**	**Personnel Expense**	**57,482,397**	**58,590,084**	**1,107,687**	**1.9%**
29,124	22,018	(7,106)	(32.3%)	Pharmacy Administrative Fees	257,264	227,240	(30,024)	(13.2%)
53,135	53,097	(37)	(0.1%)	Telemedicine Admin. Fees	528,954	527,570	(1,384)	(0.3%)
82,259	**75,115**	**(7,143)**	**(9.5%)**	**Benefits Administration Expense**	**786,218**	**754,810**	**(31,408)**	**(4.2%)**
238,817	434,030	195,214	45.0%	Consultant Fees - Non Medical	5,106,304	6,761,708	1,655,404	24.5%
290,198	347,340	57,142	16.5%	Computer Support Services	4,711,737	5,529,254	817,517	14.8%
12,500	15,000	2,500	16.7%	Audit Fees	196,158	158,158	(38,000)	(24.0%)
15,190	8	(15,182)	(182,034.3%)	Consultant Fees - Medical	7,685	(15,288)	(22,973)	150.3%
198,232	260,631	62,399	23.9%	Other Purchased Services	2,396,158	2,506,724	110,566	4.4%
2,543	844	(1,699)	(201.4%)	Maint.&Repair-Office Equipment	8,705	8,440	(265)	(3.1%)
0	0	0	0.0%	Maint.&Repair-Computer Hardwar	2,018	0	(2,018)	0.0%
0	70,067	70,067	100.0%	Legal Fees	839,153	751,686	(87,467)	(11.6%)
0	0	0	0.0%	Member Health Education	320	320	0	0.0%
24,906	26,000	1,094	4.2%	Translation Services	260,312	243,064	(17,249)	(7.1%)
93,634	157,650	64,016	40.6%	Medical Refund Recovery Fees	2,157,275	2,100,571	(56,704)	(2.7%)
239,443	617,149	377,706	61.2%	Software - IT Licenses & Subsc	4,154,572	5,547,610	1,393,038	25.1%
28,192	43,584	15,392	35.3%	Hardware (Non-Capital)	204,447	636,792	432,345	67.9%
60,326	55,800	(4,526)	(8.1%)	Provider Credentialing	487,988	508,713	20,725	4.1%
1,203,981	**2,028,103**	**824,122**	**40.6%**	**Purchased & Professional Services**	**20,532,833**	**24,737,752**	**4,204,920**	**17.0%**
64,862	113,554	48,692	42.9%	Depreciation	606,219	825,548	219,329	26.6%
62,638	76,371	13,733	18.0%	Lease Building	699,378	707,627	8,249	1.2%
8,526	5,960	(2,566)	(43.1%)	Lease Rented Office Equipment	60,851	72,165	11,314	15.7%
17,930	18,343	413	2.2%	Utilities	133,658	213,196	79,538	37.3%
93,202	91,065	(2,137)	(2.3%)	Telephone	872,074	894,055	21,981	2.5%
59,822	34,891	(24,931)	(71.5%)	Building Maintenance	346,703	388,910	42,207	10.9%
243,470	249,136	5,666	2.3%	GASB96 SBITA Amort. Expense	2,500,527	2,418,594	(81,933)	(3.4%)

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 30 April, 2025

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
550,451	**589,319**	**38,869**	**6.6%**	**Occupancy**	**5,219,409**	**5,520,094**	**300,685**	**5.4%**
77,479	36,743	(40,736)	(110.9%)	Postage	687,614	817,445	129,831	15.9%
935	30,300	29,365	96.9%	Design & Layout	48,995	82,980	33,985	41.0%
126,336	123,140	(3,196)	(2.6%)	Printing Services	1,317,550	1,115,940	(201,609)	(18.1%)
7,792	19,410	11,618	59.9%	Mailing Services	111,718	125,843	14,125	11.2%
7,524	15,373	7,850	51.1%	Courier/Delivery Service	56,166	99,964	43,798	43.8%
0	229	229	100.0%	Pre-Printed Materials & Public	589	3,332	2,743	82.3%
0	0	0	0.0%	Promotional Products	111,069	54,020	(57,049)	(105.6%)
0	150	150	100.0%	Promotional Services	0	1,200	1,200	100.0%
197,030	317,667	120,637	38.0%	Community Relations	2,057,169	2,444,062	386,893	15.8%
417,096	**543,012**	**125,916**	**23.2%**	**Printing Postage & Promotion**	**4,390,870**	**4,744,786**	**353,916**	**7.5%**
0	100,000	100,000	100.0%	Regulatory Penalties	295,000	485,000	190,000	39.2%
13,563	31,600	18,037	57.1%	Bank Fees	375,370	322,581	(52,789)	(16.4%)
99,960	120,000	20,040	16.7%	Insurance Premium	1,076,688	1,102,916	26,228	2.4%
196,692	104,451	(92,241)	(88.3%)	License,Permits, & Fee - NonIT	1,976,832	2,227,017	250,186	11.2%
27,955	37,017	9,062	24.5%	Subscriptions and Dues - NonIT	601,186	700,787	99,601	14.2%
338,171	**393,068**	**54,897**	**14.0%**	**License Insurance & Fees**	**4,325,075**	**4,838,301**	**513,226**	**10.6%**
5,218	11,008	5,790	52.6%	Office and Other Supplies	68,268	110,082	41,814	38.0%
0	1,000	1,000	100.0%	Furniture & Equipment	0	10,000	10,000	100.0%
18,549	26,483	7,934	30.0%	Ergonomic Supplies	244,020	296,948	52,928	17.8%
18,517	13,899	(4,618)	(33.2%)	Meals and Entertainment	118,540	158,371	39,831	25.2%
(192)	0	192	0.0%	Miscellaneous	898,625	5,300	(893,325)	(16,855.2%)
0	0	0	0.0%	Member Incentive	0	14,550	14,550	100.0%
187,368	120,000	(67,368)	(56.1%)	Provider Interest (All Depts)	1,387,556	1,273,208	(114,348)	(9.0%)
229,461	**172,391**	**(57,070)**	**(33.1%)**	**Other Administrative Expense**	**2,717,008**	**1,868,459**	**(848,549)**	**(45.4%)**
2,821,417	**3,801,008**	**979,591**	**25.8%**	**Total Other Administrative ExpenseS (excludes Personnel Expenses)**	**37,971,413**	**42,464,203**	**4,492,790**	**10.6%**
8,655,654	**10,002,814**	**1,347,160**	**13.5%**	**TOTAL ADMINISTRATIVE EXPENSES**	**95,453,810**	**101,054,287**	**5,600,477**	**5.5%**

ALAMEDA ALLIANCE FOR HEALTH
CAPITAL SPENDING INCLUDING CONSTRUCTION-IN-PROCESS
ACTUAL VS. BUDGET
FOR THE FISCAL YEAR-TO-DATE ENDED JUNE 30, 2025

		Project ID	Prior YTD Acquisitions	Current Month Acquisitions	Fiscal YTD Acquisitions	Capital Budget Total	$ Variance Fav/(Unf.)
1. Hardware:							
	Cisco UCS-X M6 or M7 Blades x 6	IT-FY24-04	$ 265,100	$ -	**$ 265,100**	$ 265,100	$ 0
	Cisco Routers	IT-FY25-01	$ -	$ -	**$ -**	$ 120,000	$ 120,000
	Cisco UCS Blades	IT-FY25-04	$ 264,510	$ -	**$ 264,510**	$ 873,000	$ 608,490
	PURE Storage	IT-FY25-06	$ 266,709	$ -	**$ 266,709**	$ 150,000	$ (116,709)
	Exagrid Immutable Storage	IT-FY25-07	$ -	$ -	**$ -**	$ 500,000	$ 500,000
	Network Cabling	IT-FY25-09	$ 62,598	$ -	**$ 62,598**	$ 40,000	$ (22,598)
Hardware Subtotal			**$ 858,916**	**$ -**	**$ 858,916**	**$ 1,948,100**	**$ 1,089,184**
2. Software:							
	Zerto renewal and Tier 2 add		$ -	$ -	**$ -**	$ -	$ -
Software Subtotal			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
3. Building Improvement:							
	1240 Exterior lighting update	FA-FY25-03	**$ -**	$ -	**$ -**	$ 30,000	$ 30,000
Building Improvement Subtotal			**$ -**	**$ -**	**$ -**	**$ 30,000**	**$ 30,000**
4. Furniture & Equipment:							
	Office desks, cabinets, shelvings (all building/suites: new or replacement)		$ -	$ -	**$ -**	$ -	$ -
	Replace, reconfigure, re-design workstations		$ -	$ -	**$ -**	$ -	$ -
Furniture & Equipment Subtotal			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
5. Leasehold Improvement:							
	ExacqVision NVR Upgrade, Cameras/Video System upgrade		$ -		**$ -**	$ -	$ -
Leasehold Improvement Subtotal			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
6. Contingency:							
			$ -		**$ -**	$ -	$ -
Contingency Subtotal			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
GRAND TOTAL			**$ 858,916**	**$ -**	**$ 858,916**	**$ 1,978,100**	**$ 1,119,184**

6. Reconciliation to Balance Sheet:

Fixed Assets @ Cost - 4/30/25	**$ 38,969,405**
Fixed Assets @ Cost - 6/30/24	**$ 38,110,489**
Fixed Assets Acquired YTD	**$ 858,916**

ALAMEDA ALLIANCE FOR HEALTH
TANGIBLE NET EQUITY (TNE) AND LIQUID TNE ANALYSIS
FOR THE MONTH AND FISCAL YTD ENDED FEBRUARY 28, 2025

TANGIBLE NET EQUITY (TNE)	**QRT. END Jun-24**	**Jul-24**	**Aug-24**	**QRT. END Sep-24**	**Oct-24**	**Nov-24**	**QRT. END Dec-24**	**Jan-25**	**Feb-25**	**QRT. END Mar-25**	**Apr-25**
Current Month Net Income / (Loss)	$ (60,612,285)	$ (6,989,301)	$ (18,354,880)	$ (8,719,238)	$ (26,984,341)	$ (27,470,264)	$ (8,643,229)	$ (6,688,826)	$ 5,089,524	$ 457,935	$ 5,938,872
YTD Net Income / (Loss)	$ (68,581,898)	$ (6,989,303)	$ (25,344,182)	$ (34,063,414)	$ (61,047,753)	$ (88,518,015)	$ (97,161,241)	$ (103,850,064)	$ (98,760,546)	$ (98,302,610)	$ (92,363,740)
Net Assets	$ 255,375,143	$ 248,385,840	$ 230,030,961	$ 221,311,729	$ 194,327,390	$ 166,857,128	$ 158,213,902	$ 151,525,079	$ 156,614,597	$ 157,072,533	$ 163,011,403
Subordinated Debt & Interest	-	-	-	-	-	-	-	-	-	-	-
Total Actual TNE	**$ 255,375,143**	**$ 248,385,840**	**$ 230,030,961**	**$ 221,311,729**	**$ 194,327,390**	**$ 166,857,128**	**$ 158,213,902**	**$ 151,525,079**	**$ 156,614,597**	**$ 157,072,533**	**$ 163,011,403**
Increase/(Decrease) in Actual TNE	$ (60,612,285)	$ (6,989,301)	$ (18,354,880)	$ (8,719,238)	$ (26,984,341)	$ (27,470,264)	$ (8,643,229)	$ (6,688,826)	$ 5,089,524	$ 457,935	$ 5,938,872
Required TNE (1)	**$ 63,328,179**	**$ 68,750,939**	**$ 71,470,183**	**$ 70,224,330**	**$ 77,225,116**	**$ 78,852,430**	**$ 77,630,344**	**$ 81,350,675**	**$ 77,665,855**	**$ 79,764,820**	**$ 80,840,793**
Min. Req'd to Avoid Monthly Reporting at 150% of Required TNE	$ 94,992,268	$ 103,126,409	$ 107,205,275	$ 105,336,495	$ 115,837,673	$ 118,278,645	$ 116,445,516	$ 122,026,012	$ 116,498,783	$ 119,647,230	$ 121,261,190
TNE Excess / (Deficiency)	$ 192,046,964	$ 179,634,901	$ 158,560,778	$ 151,087,399	$ 117,102,274	$ 88,004,698	$ 80,583,558	$ 70,174,404	$ 78,948,742	$ 77,307,713	$ 82,170,610
Actual TNE as a Multiple of Required	**4.03**	**3.61**	**3.22**	**3.15**	**2.52**	**2.12**	**2.04**	**1.86**	**2.02**	**1.97**	**2.02**
LIQUID TANGIBLE NET EQUITY											
Net Assets	$ 255,375,143	$ 248,385,840	$ 230,030,961	$ 221,311,729	$ 194,327,390	$ 166,857,128	$ 158,213,902	$ 151,525,079	$ 156,614,597	$ 157,072,533	$ 163,011,403
Less: Fixed Assets at Net Book Value	(5,447,816)	(5,662,370)	(5,863,098)	(5,803,725)	(5,739,467)	(5,680,094)	(5,620,721)	(5,561,346)	(5,563,528)	(5,765,375)	(5,700,514)
Net Lease Assets	(501,485)	(319,957)	(496,877)	(1,004,186)	(1,303,630)	(1,065,182)	(2,704,898)	(2,504,545)	(1,864,566)	(1,666,263)	(1,393,164)
CD Pledged to DMHC	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,898)	(351,895)
Liquid TNE (Liquid Reserves)	**$ 249,075,842**	**$ 242,053,513**	**$ 223,320,986**	**$ 214,153,818**	**$ 186,934,293**	**$ 159,761,852**	**$ 149,538,283**	**$ 143,109,188**	**$ 148,836,503**	**$ 149,289,997**	**$ 155,565,830**
Liquid TNE as Multiple of Required	**3.93**	**3.52**	**3.12**	**3.05**	**2.42**	**2.03**	**1.93**	**1.76**	**1.92**	**1.87**	**1.92**

Note (1): Required TNE reflects monthly and quarterly DMHC TNE calculations. Quarterly and Monthly Required TNE calculations differ slightly in calculation methodology.

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2025

	Actual Jul-24	Actual Aug-24	Actual Sep-24	Actual Oct-24	Actual Nov-24	Actual Dec-24	Actual Jan-25	Actual Feb-25	Actual Mar-25	Actual Apr-25	Actual May-25	Actual Jun-25	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program:													
Child	109,951	109,784	109,731	109,662	109,561	110,506	111,643	111,554	111,103	110,186			1,103,681
Adult	62,708	62,641	62,550	62,578	62,502	62,905	63,553	63,706	63,255	62,499			628,897
SPD (retired Dec-24)*	35,018	35,177	35,319	35,388	35,603	36,127	0	0	0	0			212,632
Duals (retired Dec-24)*	39,892	40,024	40,124	40,144	40,357	40,798	0	0	0	0			241,339
ACA OE	149,801	150,482	151,005	151,098	151,559	154,560	154,136	154,609	154,559	154,154			1,525,963
LTC (retired Dec-24)*	222	226	240	249	255	254	0	0	0	0			1,446
LTC Duals (retired Dec-24)*	1,241	1,247	1,254	1,265	1,269	1,286	0	0	0	0			7,562
SPD with LTC (new Jan-25)	0	0	0	0	0	0	29,564	29,497	29,605	29,316			117,982
Duals with LTC (new Jan-25)	0	0	0	0	0	0	48,153	48,100	48,226	48,733			193,212
Medi-Cal Program	398,833	399,581	400,223	400,384	401,106	406,436	407,049	407,466	406,748	404,888			4,032,714
Group Care Program	5,675	5,686	5,710	5,769	5,772	5,790	5,779	5,812	5,882	5,896			57,771
Total	**404,508**	**405,267**	**405,933**	**406,153**	**406,878**	**412,226**	**412,828**	**413,278**	**412,630**	**410,784**			**4,090,485**

*As of January 2025, service month, "SPD", "Duals", "LTC", and "LTC Duals" will be discontinued. Effective January 2025 service month new consolidated groupings will be "SPD with LTC" and "Duals with LTC".

Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	(173)	(167)	(53)	(69)	(101)	945	1,137	(89)	(451)	(917)			62
Adult	(38)	(67)	(91)	28	(76)	403	648	153	(451)	(756)			(247)
SPD (retired Dec-24)	98	159	142	69	215	524	(36,127)	0	0	0			(34,920)
Duals (retired Dec-24)	144	132	100	20	213	441	(40,798)	0	0	0			(39,748)
ACA OE	477	681	523	93	461	3,001	(424)	473	(50)	(405)			4,830
LTC (retired Dec-24)	0	4	14	9	6	(1)	(254)	0	0	0			(222)
LTC Duals (retired Dec-24)	(7)	6	7	11	4	17	(1,286)	0	0	0			(1,248)
SPD with LTC (new Jan-25)	0	0	0	0	0	0	29,564	(67)	108	(289)			29,316
Duals with LTC (new Jan-25)	0	0	0	0	0	0	48,153	(53)	126	507			48,733
Medi-Cal Program	501	748	642	161	722	5,330	613	417	(718)	(1,860)			6,556
Group Care Program	17	11	24	59	3	18	(11)	33	70	14			238
Total	**518**	**759**	**666**	**220**	**725**	**5,348**	**602**	**450**	**(648)**	**(1,846)**			**6,794**

Enrollment Percentages:													
Medi-Cal Program:													
Child % of Medi-Cal	27.6%	27.5%	27.4%	27.4%	27.3%	27.2%	27.4%	27.4%	27.3%	27.2%			27.4%
Adult % of Medi-Cal	15.7%	15.7%	15.6%	15.6%	15.6%	15.5%	15.6%	15.6%	15.6%	15.4%			15.6%
SPD % of Medi-Cal	8.8%	8.8%	8.8%	8.8%	8.9%	8.9%	0.0%	0.0%	0.0%	0.0%			5.3%
Duals % of Medi-Cal	10.0%	10.0%	10.0%	10.0%	10.1%	10.0%	0.0%	0.0%	0.0%	0.0%			6.0%
ACA OE % of Medi-Cal	37.6%	37.7%	37.7%	37.7%	37.8%	38.0%	37.9%	37.9%	38.0%	38.1%			37.8%
LTC % of Medi-Cal	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%			0.0%
LTC Duals % of Medi-Cal	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.0%	0.0%	0.0%	0.0%			0.2%
SPD with LTC % of Medi-Cal	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.3%	7.2%	7.3%	7.2%			2.9%
Duals with LTC % of Medi-Cal	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	11.8%	11.8%	11.9%	12.0%			4.8%
Medi-Cal Program % of Total	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%			98.6%
Group Care Program % of Total	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%			1.4%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**			**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2025

	Actual Jul-24	Actual Aug-24	Actual Sep-24	Actual Oct-24	Actual Nov-24	Actual Dec-24	Actual Jan-25	Actual Feb-25	Actual Mar-25	Actual Apr-25	Actual May-25	Actual Jun-25	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted													
Directly Contracted (DCP)	87,980	88,518	89,634	89,724	90,655	96,247	94,389	94,869	93,866	94,804			920,686
Alameda Health System	91,091	91,170	91,024	90,756	90,451	90,222	91,158	90,932	90,950	90,450			908,204
Directly-Contracted Subtotal	179,071	179,688	180,658	180,480	181,106	186,469	185,547	185,801	184,816	185,254			1,828,890
Delegated:													
CFMG	44,087	43,956	43,837	43,910	44,029	44,099	44,982	45,072	45,190	44,318			443,480
CHCN	181,350	181,623	181,438	181,763	181,743	181,658	182,299	182,405	182,624	181,212			1,818,115
Delegated Subtotal	225,437	225,579	225,275	225,673	225,772	225,757	227,281	227,477	227,814	225,530			2,261,595
Total	**404,508**	**405,267**	**405,933**	**406,153**	**406,878**	**412,226**	**412,828**	**413,278**	**412,630**	**410,784**			**4,090,485**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	167	617	970	(178)	626	5,363	(922)	254	(985)	438			6,350
Delegated:													
CFMG	96	(131)	(119)	73	119	70	883	90	118	(872)			327
CHCN	255	273	(185)	325	(20)	(85)	641	106	219	(1,412)			117
Delegated Subtotal	351	142	(304)	398	99	(15)	1,524	196	337	(2,284)			444
Total	**518**	**759**	**666**	**220**	**725**	**5,348**	**602**	**450**	**(648)**	**(1,846)**			**6,794**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	44.3%	44.3%	44.5%	44.4%	44.5%	45.2%	44.9%	45.0%	44.8%	45.1%			44.7%
Delegated:													
CFMG	10.9%	10.8%	10.8%	10.8%	10.8%	10.7%	10.9%	10.9%	11.0%	10.8%			10.8%
CHCN	44.8%	44.8%	44.7%	44.8%	44.7%	44.1%	44.2%	44.1%	44.3%	44.1%			44.4%
Delegated Subtotal	55.7%	55.7%	55.5%	55.6%	55.5%	54.8%	55.1%	55.0%	55.2%	54.9%			55.3%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**			**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING

FOR THE FISCAL YEAR 2025	FINAL BUDGET												
	Budget Jul-24	Budget Aug-24	Budget Sep-24	Budget Oct-24	Budget Nov-24	Budget Dec-24	Budget Jan-25	Budget Feb-25	Budget Mar-25	Budget Apr-25	Budget May-25	Budget Jun-25	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program:													
Child	109,951	109,784	109,731	109,662	109,772	109,882	110,102	110,212	110,322	110,432	110,542	110,653	1,321,045
Adult	62,708	62,641	62,550	62,578	62,641	62,704	62,767	62,830	62,893	62,956	63,019	63,082	753,369
SPD (retired Dec-24)	35,018	35,177	35,319	35,388	35,423	35,458	0	0	0	0	0	0	211,783
Duals (retired Dec-24)	39,892	40,024	40,124	40,144	40,144	40,144	0	0	0	0	0	0	240,472
ACA OE	149,801	150,482	151,005	151,098	151,249	151,400	151,551	151,703	151,855	152,007	152,159	152,311	1,816,621
LTC (retired Dec-24)	222	226	240	249	251	254	0	0	0	0	0	0	1,442
LTC Duals (retired Dec-24)	1,241	1,247	1,254	1,265	1,266	1,267	0	0	0	0	0	0	7,540
SPD with LTC (new Jan-25)	0	0	0	0	0	0	34,750	33,788	32,825	31,861	30,896	29,930	194,050
Duals with LTC (new Jan-25)	0	0	0	0	0	0	42,412	43,413	44,414	45,415	46,416	47,417	269,487
Medi-Cal Program	398,833	399,581	400,223	400,384	400,746	401,109	401,582	401,946	402,309	402,671	403,032	403,393	4,815,809
Group Care Program	5,675	5,686	5,710	5,769	5,769	5,769	5,769	5,769	5,769	5,769	5,769	5,769	68,992
Total	**404,508**	**405,267**	**405,933**	**406,153**	**406,515**	**406,878**	**407,351**	**407,715**	**408,078**	**408,440**	**408,801**	**409,162**	**4,884,801**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	13,386	(167)	(53)	(69)	110	110	220	110	110	110	110	111	14,088
Adult	8,596	(67)	(91)	28	63	63	63	63	63	63	63	63	8,970
SPD (retired Dec-24)	(5,783)	159	142	69	35	35	(35,458)	0	0	0	0	0	(40,801)
Duals (retired Dec-24)	(5,426)	132	100	20	0	0	(40,144)	0	0	0	0	0	(45,318)
ACA OE	8,631	681	523	93	151	151	151	152	152	152	152	152	11,141
LTC (retired Dec-24)	45	4	14	9	2	3	(254)	0	0	0	0	0	(177)
LTC Duals (retired Dec-24)	133	6	7	11	1	1	(1,267)	0	0	0	0	0	(1,108)
SPD with LTC (new Jan-25)	0	0	0	0	0	0	34,750	(962)	(963)	(964)	(965)	(966)	29,930
Duals with LTC (new Jan-25)	0	0	0	0	0	0	42,412	1,001	1,001	1,001	1,001	1,001	47,417
Medi-Cal Program	19,582	748	642	161	362	363	473	364	363	362	361	361	24,142
Group Care Program	182	11	24	59	0	0	0	0	0	0	0	0	276
Total	**19,764**	**759**	**666**	**220**	**362**	**363**	**473**	**364**	**363**	**362**	**361**	**361**	**24,418**
													0
Enrollment Percentages:													
Medi-Cal Program:													
Child % of Medi-Cal	27.6%	27.5%	27.4%	27.4%	27.4%	27.4%	27.4%	27.4%	27.4%	27.4%	27.4%	27.4%	27.4%
Adult % of Medi-Cal	15.7%	15.7%	15.6%	15.6%	15.6%	15.6%	15.6%	15.6%	15.6%	15.6%	15.6%	15.6%	15.6%
SPD % of Medi-Cal	8.8%	8.8%	8.8%	8.8%	8.8%	8.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	4.4%
Duals % of Medi-Cal	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	5.0%
ACA OE % of Medi-Cal	37.6%	37.7%	37.7%	37.7%	37.7%	37.7%	37.7%	37.7%	37.7%	37.7%	37.8%	37.8%	37.7%
LTC % of Medi-Cal	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
LTC Duals % of Medi-Cal	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%
SPD with LTC % of Medi-Cal	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	8.7%	8.4%	8.2%	7.9%	7.7%	7.4%	4.0%
Duals with LTC % of Medi-Cal	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	10.6%	10.8%	11.0%	11.3%	11.5%	11.8%	5.6%
Medi-Cal Program % of Total	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	100.0%
Group Care Program % of Total	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**101.4%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING

FOR THE FISCAL YEAR 2025	FINAL BUDGET												
	Budget Jul-24	Budget Aug-24	Budget Sep-24	Budget Oct-24	Budget Nov-24	Budget Dec-24	Budget Jan-25	Budget Feb-25	Budget Mar-25	Budget Apr-25	Budget May-25	Budget Jun-25	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted													
Directly Contracted (DCP)	87,980	88,518	89,634	89,724	89,786	89,849	90,244	90,630	91,016	91,401	91,786	92,171	1,082,739
Alameda Health System	91,091	91,170	91,024	90,756	90,843	90,930	90,951	90,960	90,968	90,976	90,984	90,992	1,091,645
Directly-Contracted Subtotal	179,071	179,688	180,658	180,480	180,629	180,779	181,195	181,590	181,984	182,377	182,770	183,163	2,174,384
Delegated:													
CFMG	44,087	43,956	43,837	43,910	43,953	43,996	44,035	44,033	44,030	44,027	44,024	44,021	527,909
CHCN	181,350	181,623	181,438	181,763	181,933	182,103	182,121	182,092	182,064	182,036	182,007	181,978	2,182,508
Delegated Subtotal	225,437	225,579	225,275	225,673	225,886	226,099	226,156	226,125	226,094	226,063	226,031	225,999	2,710,417
Total	**404,508**	**405,267**	**405,933**	**406,153**	**406,515**	**406,878**	**407,351**	**407,715**	**408,078**	**408,440**	**408,801**	**409,162**	**4,884,801**
													0
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted													
Directly Contracted (DCP)	(11,969)	538	1,116	90	62	63	395	386	386	385	385	385	(7,778)
Alameda Health System	8,720	79	(146)	(268)	87	87	21	9	8	8	8	8	8,621
Directly-Contracted Subtotal	(3,249)	617	970	(178)	149	150	416	395	394	393	393	393	843
Delegated:													
CFMG	3,320	(131)	(119)	73	43	43	39	(2)	(3)	(3)	(3)	(3)	3,254
CHCN	19,693	273	(185)	325	170	170	18	(29)	(28)	(28)	(29)	(29)	20,321
Delegated Subtotal	23,013	142	(304)	398	213	213	57	(31)	(31)	(31)	(32)	(32)	23,575
Total	**19,764**	**759**	**666**	**220**	**362**	**363**	**473**	**364**	**363**	**362**	**361**	**361**	**24,418**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted													
Directly Contracted (DCP)	21.7%	21.8%	22.1%	22.1%	22.1%	22.1%	22.2%	22.2%	22.3%	22.4%	22.5%	22.5%	22.2%
Alameda Health System	22.5%	22.5%	22.4%	22.3%	22.3%	22.3%	22.3%	22.3%	22.3%	22.3%	22.3%	22.2%	22.3%
Directly-Contracted Subtotal	44.3%	44.3%	44.5%	44.4%	44.4%	44.4%	44.5%	44.5%	44.6%	44.7%	44.7%	44.8%	44.5%
Delegated:													
CFMG	10.9%	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%
CHCN	44.8%	44.8%	44.7%	44.8%	44.8%	44.8%	44.7%	44.7%	44.6%	44.6%	44.5%	44.5%	44.7%
Delegated Subtotal	55.7%	55.7%	55.5%	55.6%	55.6%	55.6%	55.5%	55.5%	55.4%	55.3%	55.3%	55.2%	55.5%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2025

	Variance Jul-24	Variance Aug-24	Variance Sep-24	Variance Oct-24	Variance Nov-24	Variance Dec-24	Variance Jan-25	Variance Feb-25	Variance Mar-25	Variance Apr-25	Variance May-25	Variance Jun-25	YTD Member Month Variance
Enrollment Variance by Plan & Aid Category - Favorable/(Unfavorable)													
Medi-Cal Program:													
Child	0	0	0	0	(211)	624	1,541	1,342	781	(246)			3,831
Adult	0	0	0	0	(139)	201	786	876	362	(457)			1,629
SPD (retired Dec-24)	0	0	0	0	180	669	0	0	0	0			849
Duals (retired Dec-24)	0	0	0	0	213	654	0	0	0	0			867
ACA OE	0	0	0	0	310	3,160	2,585	2,906	2,704	2,147			13,812
LTC (retired Dec-24)	0	0	0	0	4	0	0	0	0	0			4
LTC Duals (retired Dec-24)	0	0	0	0	3	19	0	0	0	0			22
SPD with LTC (new Jan-25)	0	0	0	0	0	0	(5,186)	(4,291)	(3,220)	(2,545)			(15,242)
Duals with LTC (new Jan-25)	0	0	0	0	0	0	5,741	4,687	3,812	3,318			17,558
Medi-Cal Program	0	0	0	0	360	5,327	5,467	5,520	4,439	2,217			23,330
Group Care Program	0	0	0	0	3	21	10	43	113	127			317
Total	**0**	**0**	**0**	**0**	**363**	**5,348**	**5,477**	**5,563**	**4,552**	**2,344**			**23,647**
Current Direct/Delegate Enrollment Variance - Favorable/(Unfavorable)													
Directly-Contracted													
Directly Contracted (DCP)	0	0	0	0	869	6,398	4,145	4,239	2,850	3,403			21,904
Alameda Health System	0	0	0	0	(392)	(708)	207	(28)	(18)	(526)			(1,465)
Directly-Contracted Subtotal	0	0	0	0	477	5,690	4,352	4,211	2,832	2,877			20,439
Delegated:													
CFMG	0	0	0	0	76	103	947	1,039	1,160	291			3,616
CHCN	0	0	0	0	(190)	(445)	178	313	560	(824)			(408)
Delegated Subtotal	0	0	0	0	(114)	(342)	1,125	1,352	1,720	(533)			3,208
Total	**0**	**0**	**0**	**0**	**363**	**5,348**	**5,477**	**5,563**	**4,552**	**2,344**			**23,647**

ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 30 APRIL, 2025

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				CAPITATED MEDICAL EXPENSES				
$1,240,861	$1,745,528	$504,667	28.9%	PCP Capitation	$41,819,410	$25,093,710	($16,725,701)	(66.7%)
6,251,984	6,590,675	338,690	5.1%	PCP Capitation FQHC	61,631,078	64,163,635	2,532,557	3.9%
491,582	455,568	(36,014)	(7.9%)	Specialty Capitation	4,271,558	4,225,340	(46,218)	(1.1%)
5,519,291	5,977,995	458,703	7.7%	Specialty Capitation FQHC	54,161,034	57,596,636	3,435,602	6.0%
763,983	716,448	(47,534)	(6.6%)	Laboratory Capitation	7,587,451	7,284,651	(302,799)	(4.2%)
343,437	341,487	(1,951)	(0.6%)	Vision Capitation	3,421,088	3,401,409	(19,679)	(0.6%)
111,811	132,538	20,727	15.6%	CFMG Capitation	1,116,123	1,229,433	113,310	9.2%
844,613	291,224	(553,389)	(190.0%)	ANC IPA Admin Capitation FQHC	3,819,034	2,816,619	(1,002,415)	(35.6%)
0	0	0	0.0%	Kaiser Capitation	(8,639,235)	(8,639,177)	57	0.0%
0	0	0	0.0%	BHT Supplemental Expense	(65,356)	0	65,356	0.0%
0	0	0	0.0%	Maternity Supplemental Expense	37,270	27,953	(9,318)	(33.3%)
1,030,972	863,722	(167,249)	(19.4%)	DME Capitation	10,228,254	9,312,012	(916,242)	(9.8%)
16,598,534	**17,115,184**	**516,649**	**3.0%**	**7. TOTAL CAPITATED EXPENSES**	**179,387,709**	**166,512,220**	**(12,875,489)**	**(7.7%)**
				FEE FOR SERVICE MEDICAL EXPENSES				
4,614,227	0	(4,614,227)	0.0%	IBNR Inpatient Services	35,249,394	(3,303,163)	(38,552,557)	1,167.1%
138,426	0	(138,426)	0.0%	IBNR Settlement (IP)	1,057,480	(99,094)	(1,156,574)	1,167.2%
369,137	0	(369,137)	0.0%	IBNR Claims Fluctuation (IP)	2,819,949	(264,254)	(3,084,203)	1,167.1%
46,178,283	51,596,435	5,418,152	10.5%	Inpatient Hospitalization FFS	464,884,969	510,615,451	45,730,482	9.0%
3,506,260	0	(3,506,260)	0.0%	IP OB - Mom & NB	31,929,499	12,540,164	(19,389,335)	(154.6%)
405,218	0	(405,218)	0.0%	IP Behavioral Health	5,625,401	1,070,307	(4,555,094)	(425.6%)
1,509,432	0	(1,509,432)	0.0%	Inpatient Facility Rehab FFS	12,967,735	5,770,736	(7,196,999)	(124.7%)
56,720,983	**51,596,435**	**(5,124,548)**	**(9.9%)**	**8. Inpatient Hospital Expense**	**554,534,427**	**526,330,147**	**(28,204,280)**	**(5.4%)**
(518,823)	0	518,823	0.0%	IBNR PCP	208,614	(293,439)	(502,053)	171.1%
(15,565)	0	15,565	0.0%	IBNR Settlement (PCP)	6,261	(8,801)	(15,062)	171.1%
(41,506)	0	41,506	0.0%	IBNR Claims Fluctuation (PCP)	84,951	44,791	(40,160)	(89.7%)
2,549,162	2,909,560	360,399	12.4%	PCP FFS	38,506,258	32,420,901	(6,085,357)	(18.8%)
443,534	855,304	411,770	48.1%	PCP FQHC FFS	3,911,990	6,661,321	2,749,331	41.3%
0	0	0	0.0%	Physician Extended Hrs. Incent	19,000	12,000	(7,000)	(58.3%)
0	916,140	916,140	100.0%	Prop 56 Physician Pmt	(12,256,206)	778,634	13,034,840	1,674.1%
16,370	0	(16,370)	0.0%	Prop 56 Hyde	214,151	64,923	(149,228)	(229.9%)
77,199	0	(77,199)	0.0%	Prop 56 Trauma Screening	259,850	110,133	(149,717)	(135.9%)
92,133	0	(92,133)	0.0%	Prop 56 Developmentl Screening	241,659	96,040	(145,619)	(151.6%)
667,274	0	(667,274)	0.0%	Prop 56 Family Planning	(1,081,798)	(767,666)	314,131	(40.9%)
0	0	0	0.0%	Prop 56 VBP	(2,406,095)	(2,718,741)	(312,647)	11.5%
3,269,778	**4,681,004**	**1,411,226**	**30.1%**	**9. Primary Care Physician Expense**	**27,708,635**	**36,400,095**	**8,691,459**	**23.9%**
(966,593)	0	966,593	0.0%	IBNR Specialist	1,005,401	(747,176)	(1,752,577)	234.6%
(28,998)	0	28,998	0.0%	IBNR Settlement (SCP)	30,166	(22,414)	(52,580)	234.6%
(77,327)	0	77,327	0.0%	IBNR Claims Fluctuation (SCP)	80,431	(59,775)	(140,206)	234.6%
619,324	0	(619,324)	0.0%	Psychiatrist FFS	4,240,061	1,559,071	(2,680,990)	(172.0%)
3,974,546	8,190,811	4,216,265	51.5%	Specialty Care FFS	35,444,317	63,902,918	28,458,601	44.5%
196,353	0	(196,353)	0.0%	Specialty Anesthesiology	2,324,796	1,061,004	(1,263,792)	(119.1%)
1,886,253	0	(1,886,253)	0.0%	Specialty Imaging FFS	16,625,045	6,843,037	(9,782,008)	(142.9%)
30,277	0	(30,277)	0.0%	Obstetrics FFS	366,817	181,208	(185,610)	(102.4%)
469,418	0	(469,418)	0.0%	Specialty IP Surgery FFS	4,083,666	1,679,499	(2,404,167)	(143.1%)
926,456	0	(926,456)	0.0%	Specialty OP Surgery FFS	9,742,721	4,353,452	(5,389,269)	(123.8%)
1,010,234	0	(1,010,234)	0.0%	Speciality IP Physician	6,727,773	2,543,833	(4,183,940)	(164.5%)
149,086	127,028	(22,058)	(17.4%)	Specialist FQHC FFS	1,267,090	1,288,577	21,486	1.7%
8,189,030	**8,317,838**	**128,808**	**1.5%**	**10. Specialty Care Physician Expense**	**81,938,284**	**82,583,234**	**644,950**	**0.8%**
(517,872)	0	517,872	0.0%	IBNR Ancillary (ANC)	3,185,857	904,191	(2,281,666)	(252.3%)

ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 30 APRIL, 2025

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
(15,538)	0	15,538	0.0%	IBNR Settlement (ANC)	182,637	114,188	(68,449)	(59.9%)
(41,430)	0	41,430	0.0%	IBNR Claims Fluctuation (ANC)	418,780	236,248	(182,532)	(77.3%)
(312,979)	0	312,979	0.0%	IBNR Transportation FFS	311,070	207,856	(103,214)	(49.7%)
3,075,370	0	(3,075,370)	0.0%	Behavioral Health Therapy FFS	22,255,708	8,190,565	(14,065,143)	(171.7%)
2,880,742	0	(2,880,742)	0.0%	Psychologist & Other MH Prof	19,883,766	7,234,250	(12,649,516)	(174.9%)
606,629	0	(606,629)	0.0%	Other Medical Professional	4,764,823	1,865,835	(2,898,988)	(155.4%)
148,455	0	(148,455)	0.0%	Hearing Devices	1,461,313	674,558	(786,756)	(116.6%)
19,413	0	(19,413)	0.0%	ANC Imaging	359,622	228,147	(131,475)	(57.6%)
82,519	0	(82,519)	0.0%	Vision FFS	741,471	280,298	(461,173)	(164.5%)
0	0	0	0.0%	Family Planning	56	10	(46)	(464.6%)
740,495	0	(740,495)	0.0%	Laboratory FFS	10,613,096	6,593,456	(4,019,640)	(61.0%)
178,263	0	(178,263)	0.0%	ANC Therapist	1,507,619	644,262	(863,356)	(134.0%)
2,454,785	0	(2,454,785)	0.0%	Transp/Ambulance FFS	16,447,206	5,962,027	(10,485,179)	(175.9%)
1,491,022	0	(1,491,022)	0.0%	Non-ER Transportation FFS	23,354,864	8,526,483	(14,828,381)	(173.9%)
2,161,428	0	(2,161,428)	0.0%	Hospice FFS	22,776,925	9,250,960	(13,525,965)	(146.2%)
2,233,007	0	(2,233,007)	0.0%	Home Health Services	18,138,300	7,088,754	(11,049,547)	(155.9%)
0	14,610,799	14,610,799	100.0%	Other Medical FFS	128	85,790,976	85,790,848	100.0%
(2,212,663)	0	2,212,663	0.0%	Medical Refunds through HMS	(1,516,814)	290,192	1,807,006	622.7%
0	0	0	0.0%	Medical Refunds	10,037	0	(10,037)	0.0%
28,085	0	(28,085)	0.0%	DME & Medical Supplies FFS	370,713	187,833	(182,879)	(97.4%)
2,619,073	2,300,216	(318,857)	(13.9%)	ECM Base/Outreach FFS ANC	5,242,033	4,073,024	(1,169,009)	(28.7%)
101,228	105,386	4,158	3.9%	CS Housing Deposits FFS ANC	1,104,450	1,088,760	(15,690)	(1.4%)
783,286	825,597	42,311	5.1%	CS Housing Tenancy FFS ANC	7,580,652	7,992,859	412,206	5.2%
425,579	456,699	31,119	6.8%	CS Housing Navi Servic FFS ANC	4,436,439	4,572,494	136,054	3.0%
471,833	731,040	259,207	35.5%	CS Medical Respite FFS ANC	5,716,941	6,784,108	1,067,168	15.7%
330,889	166,221	(164,668)	(99.1%)	CS Med. Tailored Meals FFS ANC	2,524,188	1,855,789	(668,399)	(36.0%)
24,040	25,378	1,338	5.3%	CS Asthma Remediation FFS ANC	112,774	169,252	56,479	33.4%
0	10,064	10,064	100.0%	MOT Wrap Around (Non Med MOT)	0	59,881	59,881	100.0%
0	10,014	10,014	100.0%	CS Home Modifications FFS ANC	24,053	84,035	59,983	71.4%
88,968	533,437	444,469	83.3%	CS P.Care & Hmker Svcs FFS ANC	2,375,951	4,686,520	2,310,569	49.3%
1,188	20,025	18,837	94.1%	CS Cgiver Respite Svcs FFS ANC	54,963	162,334	107,372	66.1%
200	0	(200)	0.0%	CS Housing Outreach	200	0	(200)	0.0%
440,267	0	(440,267)	0.0%	CommunityBased Adult Svc(CBAS)	4,696,987	2,203,374	(2,493,614)	(113.2%)
17,394	25,000	7,606	30.4%	CS LTC Diversion FFS ANC	181,315	217,778	36,463	16.7%
0	7,517	7,517	100.0%	CS LTC Transition FFS ANC	5,003	44,978	39,975	88.9%
18,303,678	**19,827,392**	**1,523,714**	**7.7%**	**11. Ancillary Medical Expense**	**179,323,128**	**178,266,277**	**(1,056,851)**	**(0.6%)**
(711,621)	0	711,621	0.0%	IBNR Outpatient	4,132,183	231,629	(3,900,554)	(1,684.0%)
(21,349)	0	21,349	0.0%	IBNR Settlement (OP)	123,970	6,949	(117,021)	(1,684.0%)
(56,930)	0	56,930	0.0%	IBNR Claims Fluctuation (OP)	330,569	18,527	(312,041)	(1,684.2%)
2,746,650	11,639,748	8,893,099	76.4%	Outpatient FFS	24,575,061	79,952,414	55,377,353	69.3%
2,872,799	0	(2,872,799)	0.0%	OP Ambul Surgery FFS	27,462,271	11,593,959	(15,868,312)	(136.9%)
3,292,146	0	(3,292,146)	0.0%	Imaging Services FFS	26,263,556	10,130,403	(16,133,153)	(159.3%)
127,833	0	(127,833)	0.0%	Behavioral Health FFS	537,326	97,460	(439,865)	(451.3%)
921,218	0	(921,218)	0.0%	Outpatient Facility Lab FFS	7,610,794	2,863,424	(4,747,370)	(165.8%)
298,097	0	(298,097)	0.0%	Outpatient Facility Cardio FFS	2,174,482	844,453	(1,330,029)	(157.5%)
99,829	0	(99,829)	0.0%	OP Facility PT/OT/ST FFS	991,050	400,408	(590,642)	(147.5%)
3,743,125	0	(3,743,125)	0.0%	OP Facility Dialysis Ctr FFS	32,066,154	12,647,437	(19,418,717)	(153.5%)
13,311,797	**11,639,748**	**(1,672,048)**	**(14.4%)**	**12. Outpatient Medical Expense**	**126,267,415**	**118,787,063**	**(7,480,351)**	**(6.3%)**
103,133	0	(103,133)	0.0%	IBNR Emergency	2,664,997	(165,803)	(2,830,800)	1,707.3%
3,094	0	(3,094)	0.0%	IBNR Settlement (ER)	79,951	(4,974)	(84,925)	1,707.3%
8,251	0	(8,251)	0.0%	IBNR Claims Fluctuation (ER)	213,196	(13,266)	(226,462)	1,707.1%
10,177,566	10,611,910	434,344	4.1%	ER Facility	89,228,801	99,760,340	10,531,539	10.6%
1,573,669	0	(1,573,669)	0.0%	Specialty ER Physician FFS	12,542,629	4,880,392	(7,662,237)	(157.0%)
11,865,713	**10,611,910**	**(1,253,803)**	**(11.8%)**	**13. Emergency Expense**	**104,729,573**	**104,456,689**	**(272,884)**	**(0.3%)**

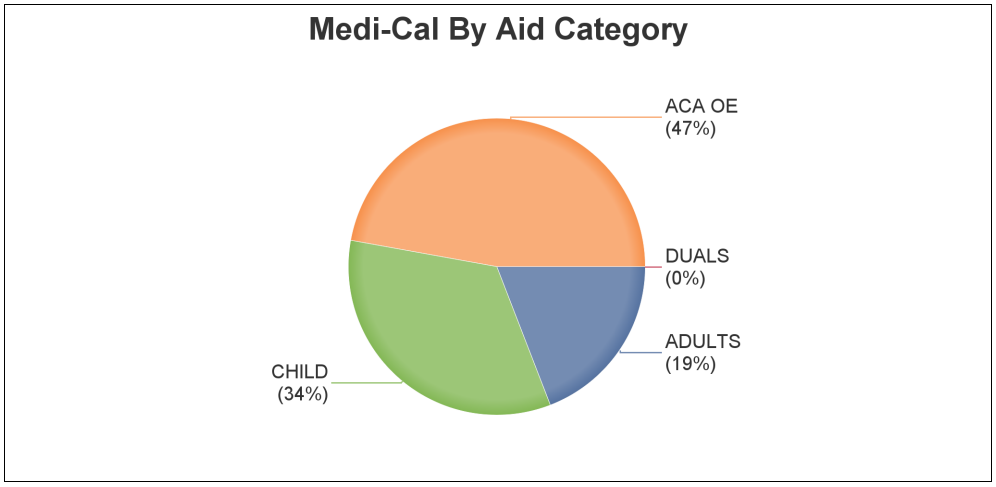
ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 30 APRIL, 2025

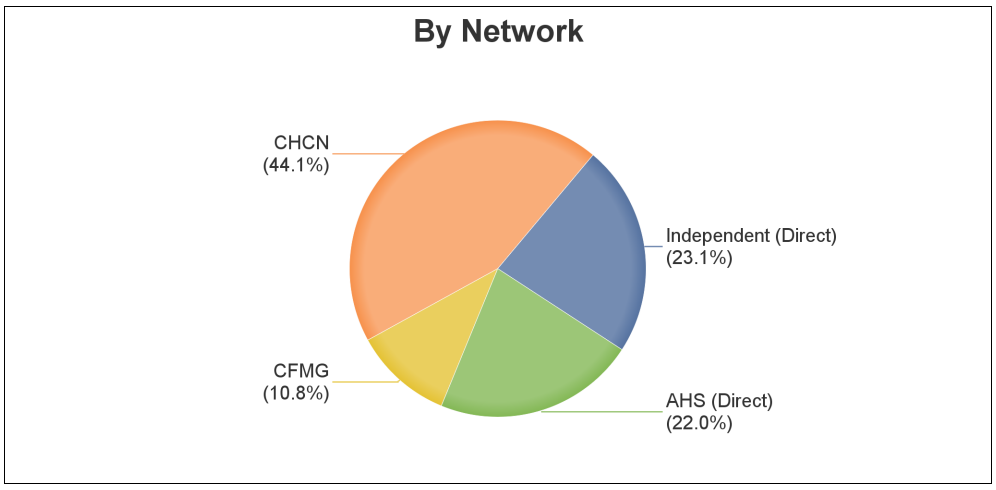
CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
(1,002,490)	0	1,002,490	0.0%	IBNR Pharmacy (OP)	3,085,956	1,991,773	(1,094,183)	(54.9%)
(30,075)	0	30,075	0.0%	IBNR Settlement Rx (OP)	92,579	59,755	(32,824)	(54.9%)
(80,200)	0	80,200	0.0%	IBNR Claims Fluctuation Rx(OP)	246,879	159,342	(87,537)	(54.9%)
634,704	462,419	(172,285)	(37.3%)	Pharmacy FFS (OP)	6,993,205	5,793,684	(1,199,521)	(20.7%)
125,464	11,521,840	11,396,376	98.9%	Pharmacy Non PBM FFS Other-ANC	1,293,912	69,998,208	68,704,296	98.2%
8,117,291	0	(8,117,291)	0.0%	Pharmacy Non PBM FFS OP-FAC	91,154,815	39,326,556	(51,828,259)	(131.8%)
342,978	0	(342,978)	0.0%	Pharmacy Non PBM FFS PCP	2,456,272	985,563	(1,470,709)	(149.2%)
2,899,147	0	(2,899,147)	0.0%	Pharmacy Non PBM FFS SCP	24,578,801	10,617,727	(13,961,074)	(131.5%)
25,956	0	(25,956)	0.0%	Pharmacy Non PBM FFS FQHC	218,050	82,575	(135,475)	(164.1%)
(17,860)	0	17,860	0.0%	Pharmacy Non PBM FFS HH	152,745	91,629	(61,116)	(66.7%)
0	0	0	0.0%	RX Refunds HMS	(345)	(306)	39	(12.6%)
(437,666)	51,861	489,527	943.9%	Medical Expenses Pharm Rebate	(752,237)	92,858	845,095	910.1%
10,577,249	**12,036,120**	**1,458,872**	**12.1%**	**14. Pharmacy Expense**	**129,520,632**	**129,199,362**	**(321,270)**	**(0.2%)**
618,893	0	(618,893)	0.0%	IBNR LTC	19,382,600	(3,756,936)	(23,139,536)	615.9%
18,565	0	(18,565)	0.0%	IBNR Settlement (LTC)	581,476	(112,709)	(694,185)	615.9%
49,511	0	(49,511)	0.0%	IBNR Claims Fluctuation (LTC)	1,550,606	(300,555)	(1,851,161)	615.9%
1,666,564	0	(1,666,564)	0.0%	LTC - ICF/DD	16,019,373	6,755,726	(9,263,647)	(137.1%)
25,056,018	0	(25,056,018)	0.0%	LTC Custodial Care	236,214,635	99,683,289	(136,531,346)	(137.0%)
8,701,762	33,879,825	25,178,063	74.3%	LTC SNF	76,549,974	231,183,398	154,633,424	66.9%
36,111,313	**33,879,825**	**(2,231,488)**	**(6.6%)**	**15. Long Term Care Expense**	**350,298,664**	**333,452,213**	**(16,846,451)**	**(5.1%)**
158,349,540	**152,590,273**	**(5,759,266)**	**(3.8%)**	**16. TOTAL FFS MEDICAL EXPENSES**	**1,554,320,757**	**1,509,475,078**	**(44,845,678)**	**(3.0%)**
0	182,579	182,579	100.0%	Clinical Vacancy #102	0	(775,885)	(775,885)	100.0%
141,553	216,536	74,983	34.6%	Quality Analytics #123	1,995,979	2,248,348	252,369	11.2%
376,327	327,552	(48,774)	(14.9%)	LongTerm Services and Support #139	2,769,140	2,859,848	90,708	3.2%
1,130,614	862,373	(268,241)	(31.1%)	Utilization Management #140	9,776,533	9,506,741	(269,793)	(2.8%)
730,908	648,910	(81,998)	(12.6%)	Case & Disease Management #185	7,090,751	6,917,576	(173,175)	(2.5%)
227,698	780,153	552,455	70.8%	Medical Management #230	8,914,736	11,091,823	2,177,087	19.6%
2,012,793	1,069,717	(943,076)	(88.2%)	Quality Improvement #235	11,139,977	12,327,946	1,187,969	9.6%
376,966	362,953	(14,013)	(3.9%)	HCS Behavioral Health #238	3,321,058	3,560,330	239,272	6.7%
155,524	229,935	74,411	32.4%	Pharmacy Services #245	1,307,871	2,296,394	988,523	43.0%
41,030	61,107	20,077	32.9%	Regulatory Readiness #268	613,123	682,062	68,939	10.1%
5,193,412	**4,741,816**	**(451,596)**	**(9.5%)**	**17. Other Benefits & Services**	**46,929,169**	**50,715,182**	**3,786,014**	**7.5%**
(602,576)	(1,279,477)	(676,901)	52.9%	Reinsurance Recoveries	(19,376,004)	(14,526,720)	4,849,284	(33.4%)
1,681,276	1,705,969	24,694	1.4%	Reinsurance Premium	17,296,090	17,417,270	121,180	0.7%
1,078,699	**426,492**	**(652,207)**	**(152.9%)**	**18. Reinsurance Expense**	**(2,079,914)**	**2,890,550**	**4,970,463**	**172.0%**
181,220,185	**174,873,765**	**(6,346,420)**	**(3.6%)**	**20. TOTAL MEDICAL EXPENSES**	**1,778,557,721**	**1,729,593,030**	**(48,964,691)**	**(2.8%)**

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend

Category of Aid	Apr 2025	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN
ADULTS	62,532	15%	13,585	14,080	0	34,867
CHILD	110,211	27%	10,486	13,429	41,303	44,993
SPD	0	0%	0	0	0	0
ACA OE	154,154	38%	28,361	53,370	1,545	70,878
DUALS	1	0%	1	0	0	0
LTC	0	0%	0	0	0	0
LTC-DUAL	0	0%	0	0	0	0
SPD-LTC	29,316	7%	8,653	5,074	1,479	14,110
SPD-LTC/Full Dual	48,733	12%	31,539	3,518	3	13,673
Medi-Cal	404,947		92,625	89,471	44,330	178,521
Group Care	5,896		2,204	988	0	2,704
Total	**410,843**	**100%**	**94,829**	**90,459**	**44,330**	**181,225**
Medi-Cal %	98.6%		97.7%	98.9%	100.0%	98.5%
Group Care %	1.4%		2.3%	1.1%	0.0%	1.5%
	Network Distribution		**23.1%**	**22.0%**	**10.8%**	**44.1%**
			% Direct:	**45%**	**% Delegated:**	**55%**

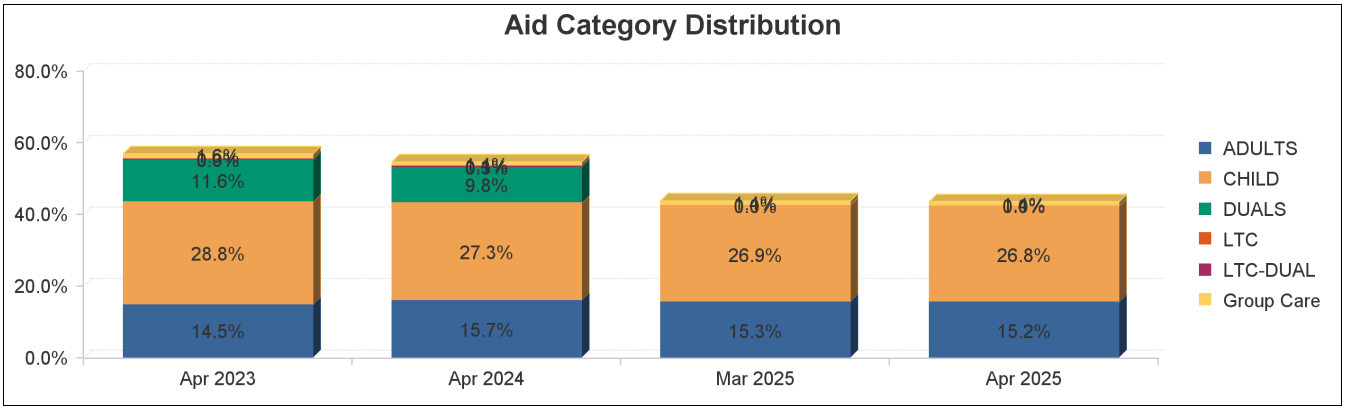




Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

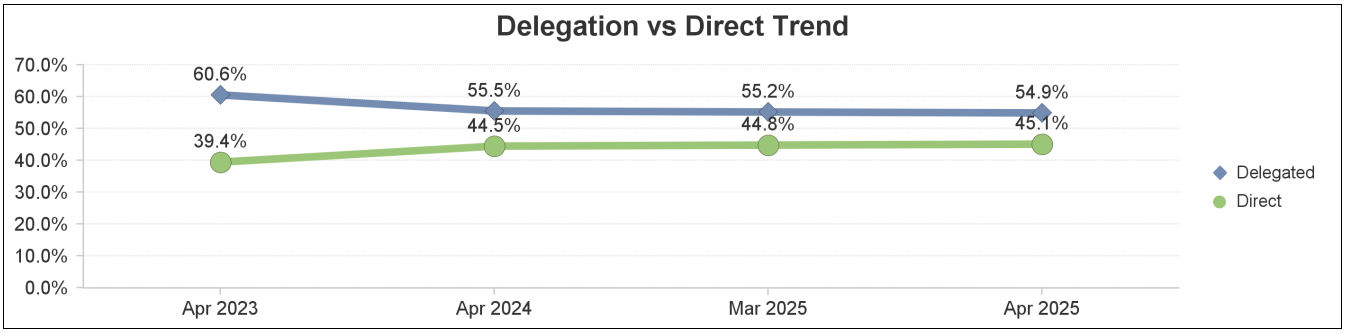
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Apr 2023	Apr 2024	Mar 2025	Apr 2025	Apr 2023	Apr 2024	Mar 2025	Apr 2025	Apr 2023 to Apr 2024	Apr 2024 to Apr 2025	Mar 2025 to Apr 2025
ADULTS	52,047	63,551	63,278	**62,532**	14.5%	15.7%	15.3%	15.2%	18.1%	-1.6%	-1.2%
CHILD	103,173	110,566	111,153	**110,211**	28.8%	27.3%	26.9%	26.8%	6.7%	-0.3%	-0.9%
SPD	31,130	34,887	0	**0**	8.7%	8.6%	0.0%	0.0%	10.8%	0.0%	0.0%
ACA OE	123,606	149,154	154,579	**154,154**	34.5%	36.8%	37.5%	37.5%	17.1%	3.2%	-0.3%
DUALS	41,473	39,912	1	**1**	11.6%	9.8%	0.0%	0.0%	-3.9%	##########	0.0%
LTC	145	223	0	**0**	0.0%	0.1%	0.0%	0.0%	35.0%	0.0%	0.0%
LTC-DUAL	983	1,291	0	**0**	0.3%	0.3%	0.0%	0.0%	23.9%	0.0%	0.0%
SPD-LTC	0	0	29,609	**29,316**	0.0%	0.0%	7.2%	7.1%	0.0%	100.0%	-1.0%
SPD-LTC/ Full Dual	0	0	48,241	**48,733**	0.0%	0.0%	11.7%	11.9%	0.0%	100.0%	1.0%
Medi-Cal	352,557	399,584	406,861	**404,947**	98.4%	98.6%	98.6%	98.6%	11.8%	1.3%	-0.5%
Group Care	5,669	5,643	5,882	**5,896**	1.6%	1.4%	1.4%	1.4%	-0.5%	4.3%	0.2%
Total	**358,226**	**405,227**	**412,743**	**410,843**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**11.6%**	**1.4%**	**-0.5%**



Delegation vs Direct Trend

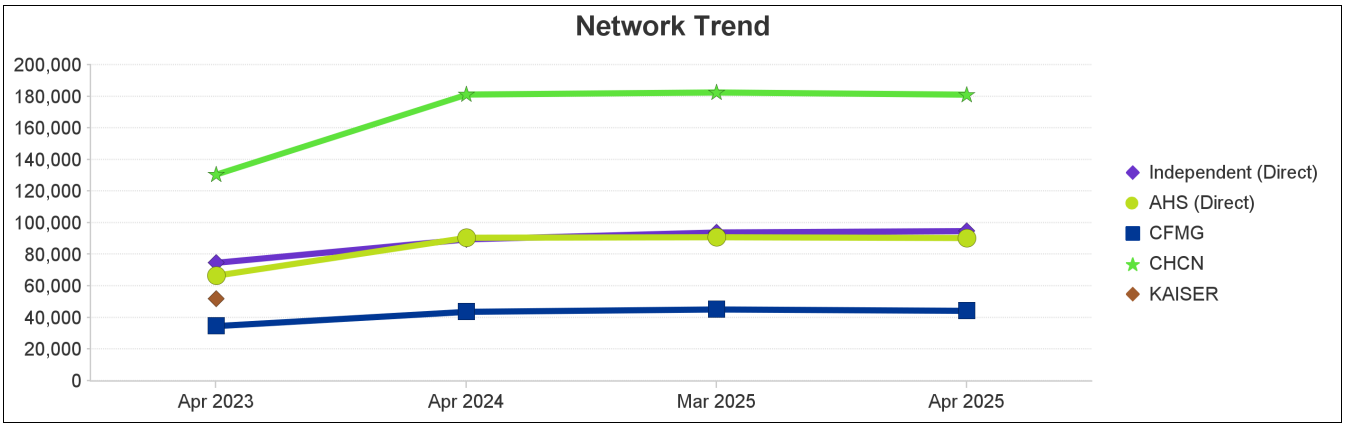
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	Apr 2023	Apr 2024	Mar 2025	Apr 2025	Apr 2023	Apr 2024	Mar 2025	Apr 2025	Apr 2023 to Apr 2024	Apr 2024 to Apr 2025	Mar 2025 to Apr 2025
Delegated	216,961	225,002	227,836	**225,555**	60.6%	55.5%	55.2%	54.9%	3.6%	0.2%	-1.0%
Direct	141,265	180,225	184,907	**185,288**	39.4%	44.5%	44.8%	45.1%	21.6%	2.7%	0.2%
Total	**358,226**	**405,227**	**412,743**	**410,843**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**11.6%**	**1.4%**	**-0.5%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Network Trend

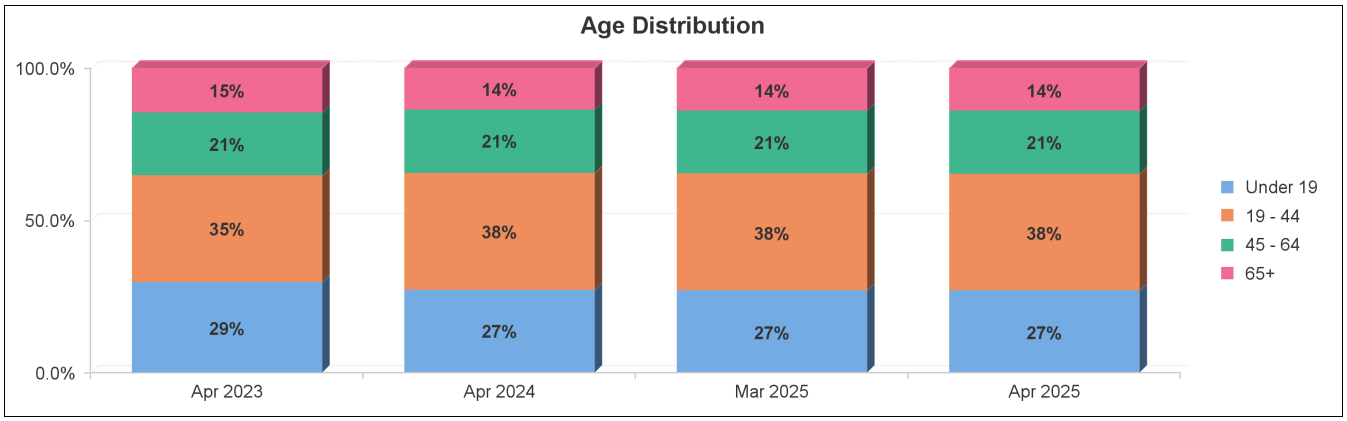
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Apr 2023	Apr 2024	Mar 2025	Apr 2025	Apr 2023	Apr 2024	Mar 2025	Apr 2025	Apr 2023 to Apr 2024	Apr 2024 to Apr 2025	Mar 2025 to Apr 2025
Independent (Direct)	74,713	89,595	93,950	**94,829**	20.9%	22.1%	22.8%	23.1%	16.6%	5.5%	0.9%
AHS (Direct)	66,552	90,630	90,957	**90,459**	18.6%	22.4%	22.0%	22.0%	26.6%	-0.2%	-0.6%
CFMG	34,644	43,702	45,203	**44,330**	9.7%	10.8%	11.0%	10.8%	20.7%	1.4%	-2.0%
CHCN	130,508	181,300	182,633	**181,225**	36.4%	44.7%	44.2%	44.1%	28.0%	0.0%	-0.8%
KAISER	51,809	0	0	**0**	14.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	**358,226**	**405,227**	**412,743**	**410,843**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**11.6%**	**1.4%**	**-0.5%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

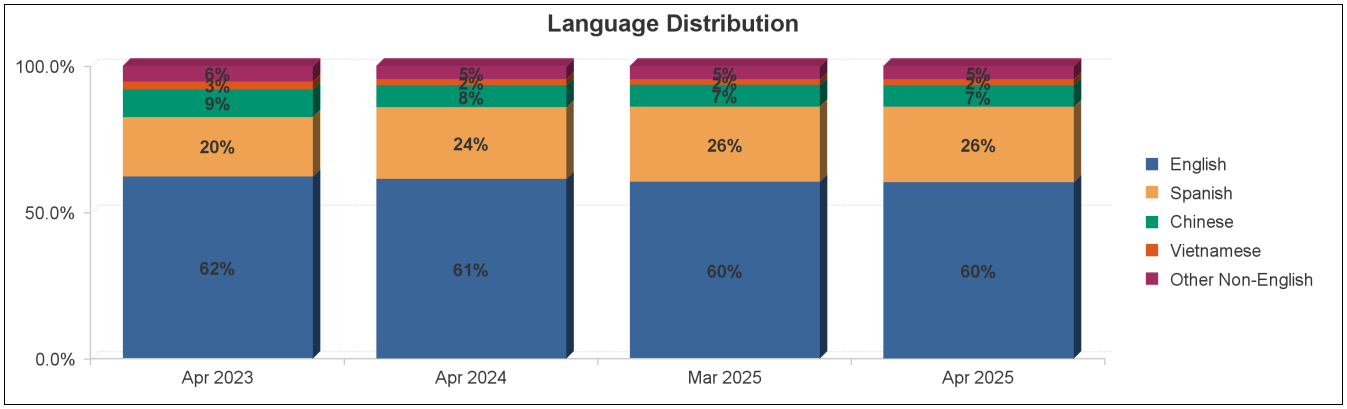
Age Category Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Apr 2023	Apr 2024	Mar 2025	Apr 2025	Apr 2023	Apr 2024	Mar 2025	Apr 2025	Apr 2023 to Apr 2024	Apr 2024 to Apr 2025	Mar 2025 to Apr 2025
Under 19	105,525	108,917	110,282	**109,618**	29%	27%	27%	27%	3%	1%	-1%
19 - 44	125,496	156,001	158,678	**157,592**	35%	38%	38%	38%	20%	1%	-1%
45 - 64	73,669	84,128	85,158	**84,775**	21%	21%	21%	21%	12%	1%	0%
65+	53,536	56,181	58,625	**58,858**	15%	14%	14%	14%	5%	5%	0%
Total	**358,226**	**405,227**	**412,743**	**410,843**	**100%**	**100%**	**100%**	**100%**	**12%**	**1%**	**0%**



Language Trend

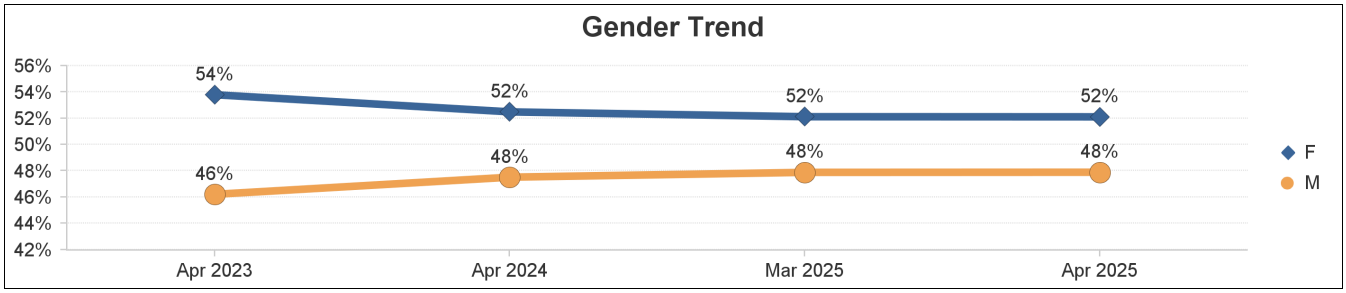
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	Apr 2023	Apr 2024	Mar 2025	Apr 2025	pr 2023	pr 2024	Mar 2025	pr 2025	Apr 2023 to Apr 2024	Apr 2024 to Apr 2025	Mar 2025 to Apr 2025
English	221,974	247,927	248,349	**246,716**	62%	61%	60%	60%	10%	0%	-1%
Spanish	72,728	98,970	105,898	**105,652**	20%	24%	26%	26%	27%	6%	0%
Chinese	33,747	30,725	30,544	**30,517**	9%	8%	7%	7%	-10%	-1%	0%
Vietnamese	9,787	8,548	8,209	**8,174**	3%	2%	2%	2%	-14%	-5%	0%
Other Non-English	19,990	19,057	19,743	**19,784**	6%	5%	5%	5%	-5%	4%	0%
Total	**358,226**	**405,227**	**412,743**	**410,843**	**100%**	**100%**	**100%**	**100%**	**12%**	**1%**	**0%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

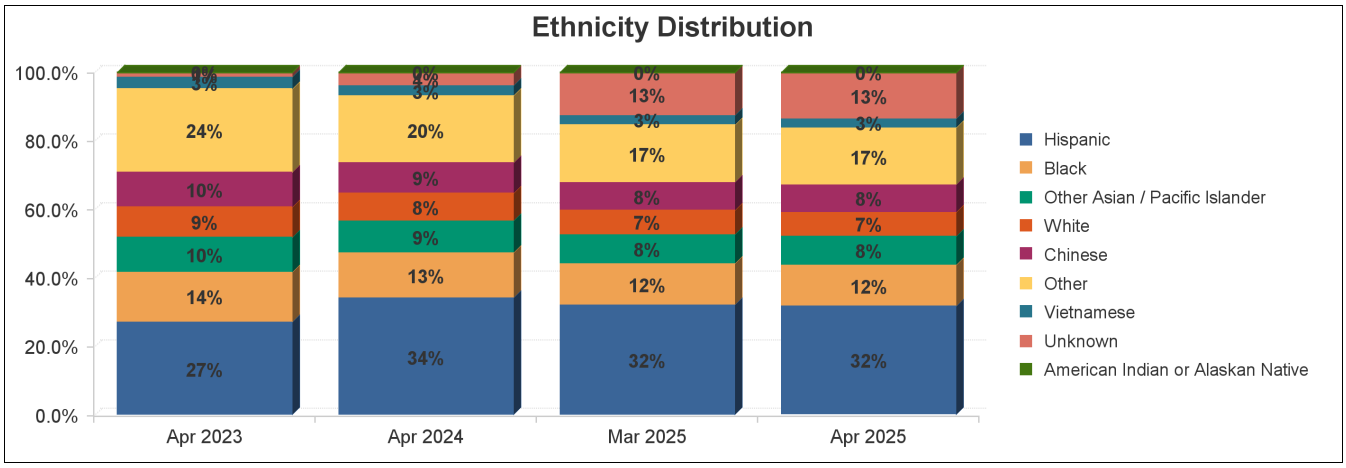
Gender Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Apr 2023	Apr 2024	Mar 2025	Apr 2025	Apr 2023	Apr 2024	Mar 2025	Apr 2025	Apr 2023 to Apr 2024	Apr 2024 to Apr 2025	Mar 2025 to Apr 2025
F	192,712	212,693	215,119	**214,090**	54%	52%	52%	52%	9%	1%	0%
M	165,514	192,534	197,624	**196,753**	46%	48%	48%	48%	14%	2%	0%
Total	**358,226**	**405,227**	**412,743**	**410,843**	**100%**	**100%**	**100%**	**100%**	**12%**	**1%**	**0%**



Ethnicity Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Apr 2023	Apr 2024	Mar 2025	Apr 2025	Apr 2023	Apr 2024	Mar 2025	Apr 2025	Apr 2023 to Apr 2024	Apr 2024 to Apr 2025	Mar 2025 to Apr 2025
Hispanic	96,968	138,080	132,032	**130,033**	27%	34%	32%	32%	30%	-6%	-2%
Black	51,913	53,580	49,884	**49,313**	14%	13%	12%	12%	3%	-9%	-1%
Other Asian / Pacific Islander	36,482	37,409	34,933	**34,386**	10%	9%	8%	8%	2%	-9%	-2%
White	31,763	32,949	29,347	**28,815**	9%	8%	7%	7%	4%	-14%	-2%
Chinese	36,306	35,847	33,490	**33,056**	10%	9%	8%	8%	-1%	-8%	-1%
Other	87,251	79,277	69,451	**68,358**	24%	20%	17%	17%	-10%	-16%	-2%
Vietnamese	12,333	12,050	10,972	**10,834**	3%	3%	3%	3%	-2%	-11%	-1%
Unknown	4,471	15,231	51,888	**55,315**	1%	4%	13%	13%	71%	72%	6%
American Indian or Alaskan Native	739	804	746	**733**	0%	0%	0%	0%	8%	-10%	-2%
Total	**358,226**	**405,227**	**412,743**	**410,843**	**100%**	**100%**	**100%**	**100%**	**12%**	**1%**	**0%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile By City

Medi-Cal By City

City	Apr 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	161,908	40%	25,161	42,075	17,344	77,328
HAYWARD	53,634	13%	12,227	15,133	5,878	20,396
FREMONT	38,585	10%	16,191	6,787	2,405	13,202
SAN LEANDRO	26,205	6%	7,124	4,360	3,239	11,482
UNION CITY	14,555	4%	5,809	2,617	847	5,282
ALAMEDA	13,812	3%	3,378	2,490	2,057	5,887
BERKELEY	15,792	4%	4,092	2,332	1,797	7,571
LIVERMORE	13,291	3%	2,027	525	2,244	8,495
NEWARK	9,386	2%	2,783	4,043	574	1,986
CASTRO VALLEY	11,119	3%	3,215	1,784	1,756	4,364
SAN LORENZO	6,276	2%	1,337	1,426	723	2,790
PLEASANTON	8,051	2%	2,063	384	843	4,761
DUBLIN	7,762	2%	2,257	390	911	4,204
EMERYVILLE	2,990	1%	653	629	493	1,215
ALBANY	2,565	1%	620	297	573	1,075
PIEDMONT	504	0%	114	180	85	125
SUNOL	82	0%	21	15	7	39
ANTIOCH	22	0%	7	10	4	1
Other	18,408	5%	3,546	3,994	2,550	8,318
Total	404,947	100%	**92,625**	**89,471**	**44,330**	**178,521**

Group Care By City

City	Apr 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	1,834	31%	350	371	0	1,113
HAYWARD	667	11%	313	171	0	183
FREMONT	664	11%	441	79	0	144
SAN LEANDRO	623	11%	254	92	0	277
UNION CITY	294	5%	184	45	0	65
ALAMEDA	303	5%	86	25	0	192
BERKELEY	149	3%	48	13	0	88
LIVERMORE	101	2%	31	3	0	67
NEWARK	145	2%	83	36	0	26
CASTRO VALLEY	206	3%	87	33	0	86
SAN LORENZO	145	2%	44	30	0	71
PLEASANTON	71	1%	22	4	0	45
DUBLIN	123	2%	43	7	0	73
EMERYVILLE	42	1%	13	6	0	23
ALBANY	23	0%	12	1	0	10
PIEDMONT	7	0%	1	1	0	5
SUNOL	1	0%	1	0	0	0
ANTIOCH	24	0%	8	4	0	12
Other	474	8%	183	67	0	224
Total	**5,896**	**100%**	**2,204**	**988**	**0**	**2,704**

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile By City

Total By City

City	Apr 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	163,742	40%	25,511	42,446	17,344	78,441
HAYWARD	54,301	13%	12,540	15,304	5,878	20,579
FREMONT	39,249	10%	16,632	6,866	2,405	13,346
SAN LEANDRO	26,828	7%	7,378	4,452	3,239	11,759
UNION CITY	14,849	4%	5,993	2,662	847	5,347
ALAMEDA	14,115	3%	3,464	2,515	2,057	6,079
BERKELEY	15,941	4%	4,140	2,345	1,797	7,659
LIVERMORE	13,392	3%	2,058	528	2,244	8,562
NEWARK	9,531	2%	2,866	4,079	574	2,012
CASTRO VALLEY	11,325	3%	3,302	1,817	1,756	4,450
SAN LORENZO	6,421	2%	1,381	1,456	723	2,861
PLEASANTON	8,122	2%	2,085	388	843	4,806
DUBLIN	7,885	2%	2,300	397	911	4,277
EMERYVILLE	3,032	1%	666	635	493	1,238
ALBANY	2,588	1%	632	298	573	1,085
PIEDMONT	511	0%	115	181	85	130
SUNOL	83	0%	22	15	7	39
ANTIOCH	46	0%	15	14	4	13
Other	18,882	5%	3,729	4,061	2,550	8,542
Total	410,843	100%	**94,829**	**90,459**	**44,330**	**181,225**

ALAMEDA Alliance FOR HEALTH

Health care you can count on.
Service you can trust.

Operations

Ruth Watson

To: **Alameda Alliance for Health Board of Governors**

From: **Ruth Watson, Chief Operating Officer**

Date: **June 13th, 2025**

Subject: **Operations Report**

Member Services

- 12-Month Trend Blended Summary:

    - The Member Services Department received 17,427 calls in May 2025 compared to 18,406 in May 2024 and represents a 5% decrease in calls.
    - The abandonment rate for May 2025 was 5% compared to 4% in May 2024.
    - The Department's service level was 95% in May 2025, compared to 93% in May 2024. The average speed to answer (ASA) was eleven seconds (00:11) compared to nineteen seconds (00:19) in May 2024. The Department continues to recruit to fill open positions. Customer Service support service vendor continues to provide overflow call center support.
    - The average talk time (ATT) was seven minutes and thirty-three seconds (07:33) for May 2025 compared to six minutes and forty-eight seconds (06:48) for May 2024.
    - 100% of calls were answered within 10 minutes for May 2025 and 100% of calls were answered within 10 minutes for May 2024.
    - Outbound calls totaled 8,700 in May 2025 compared to 7,985 in May 2024.
    - The top five call reasons for May 2025 were 1) Change of PCP, 2) Eligibility/Enrollment 3) Grievances/Appeals, 4) Benefits, 5) Provider Network. The top five call reasons for May 2024 were: 1) Change of PCP, 2) Eligibility/Enrollment, 3) Benefits, 4) Provider Network, 5) ID Card Requests.
    - May utilization for the member automated eligibility IVR system totaled 1,448 in May 2025 compared to 1,731 in May 2024.
    - The Department continues to service members via multiple communication channels (telephonic, email, online, web-based requests and in-person) while honoring the organization's policies. The Department responded to 1,049 web-based requests in May 2025 compared to 1,182 in May 2024. The top three web reason requests for May 2025 were: 1) Change of PCP, 2) ID Card Requests, 3) Update Contact Information. 43 members were assisted in-person in May 2025 compared to 79 in 2024.

- Member Services Behavioral Health:

    - The Member Services Behavioral Health (BH) Unit received a total of 1,157 calls in May 2025 compared to 1,460 in May 2024.
    - The abandonment rate was 3% in May 2025 compared to 13% in 2024.
    - The service level was 92% in May 2025 and 78% in May 2024.
    - The average speed to answer (ASA) was twenty-three seconds (00:23) compared to one minute and twelve seconds (01:12) in May 2024.
    - Calls answered in 10 minutes were 100% in May 2025 compared to 98% in May 2024.
    - The Average Talk Time (ATT) was eight minutes and twenty-four seconds (08:24) compared to eight minutes and thirty-nine seconds (08:39) in May 2024. MS BH Team utilizes the DHCS age-appropriate screening tools for Medi-Cal Mental Health Services to determine the appropriate delivery system for members who are not currently receiving mental health services when they contact the plan.
    - 1,012 outbound calls were completed in May 2025 compared to 1,018 in May 2024.
    - 118 screenings were completed in May 2025 compared to 137 in May 2024.
    - 42 outreach campaigns were completed in May 2025 compared to 76 in May 2024; the decrease was due to process change. The BH Team is managing provider referrals.
    - 44 referrals were made to the County (ACCESS) in May 2025 compared to 29 in May 2024.
    - 17 members were referred to Center Point for SUD services in May 2025 compared to nineteen 20 in May 2024.

Claims

- 12-Month Trend Summary:
    - The Claims Department received 387,564 claims in May 2025 compared to 375,454 in May 2024.
    - The Auto Adjudication rate was 87.6% in May 2025 compared to 85.6% in May 2024.
    - Claims compliance for the 30-day turn-around time was 90.4% in May 2025 compared to 92.3% in May 2024.
    - The 45-day turn-around time was 97.6% in May 2025 compared to 100% in May 2024.

- Monthly Analysis: May 2025

    - The Alliance received a total of 387,564 claims which represents a 4% increase from April 2025. It is also higher than the number of claims received in May 2024 by 12,110.
    - Drivers of the higher volume includes:

        - Increased membership and higher utilization of services
        - Certain provider types that bill more frequently, e.g., LTC facilities that bill weekly or bi-weekly
        - Providers with dual eligible members who are submitting paper claims even though we receive the same claim in our COBA file.
    - 91% of the claims were submitted via EDI while the remaining 9% were submitted via paper.
    - 97.6% of claims were processed within 45 working days during the month.
    - The Auto Adjudication rate was 87.6%.

Provider Services

- 12-Month Trend Summary:

    - The Provider Services department's call volume in May 2025 was 7,861 calls compared to 7,469 calls in May 2024.
    - Provider Services continuously works to achieve first call resolution and reduction of the abandonment rates. Efforts to promote provider satisfaction is our first priority.
    - The Provider Services department completed 506 calls/visits during May 2025.
    - The Provider Services department answered 6,607 calls for May 2025 and made 570 outbound calls.

Credentialing

- 12-Month Trend Summary:

    - At the Peer Review and Credentialing (PRCC) meeting held on May 20th, 2025, there were 187 initial network providers approved; 6 primary care providers, 13 specialists, 9 ancillary providers, 9 midlevel providers, and 150 behavioral health providers. Additionally, 63 providers were re-credentialed at this meeting; 14 primary care providers, 28 specialists, 1 ancillary provider, and 20 midlevel providers.

    - Please refer to the Credentialing charts and graphs located in the Operations supporting documentation for more information.

Provider Dispute Resolution

- 12-Month Trend Summary:
    - The Provider Dispute Resolution (PDR) team received 2,462 PDRs in May 2025 compared to 2,386 in May 2024; this reflects a decrease of 27.82% from April 2025.
    - The PDR team resolved 2,517 cases in May 2025 compared to 2,039 cases in May 2024.
    - In May 2025, the PDR team upheld 79% of cases versus 68% in May 2024.
    - The PDR team resolved 99.6% of cases within the compliance standard of 95% within 45 working days in May 2025, compared to 99.5% in May 2024.

- Monthly Analysis:
    - The Alliance received 2,462 PDRs in May 2025 which represents a decrease of 28% from April 2025.
    - In the month of May, 2,517 PDRs were resolved, with 1,988 being upheld and 529 being overturned.
    - 2,508 out of 2,517 cases were resolved within 45 working days, resulting in a 99.6% compliance rate.
    - The average turnaround time for resolving PDRs in May was 40 days.
    - There were 5,019 PDRs pending resolution as of 5/31/2025, with no cases older than 45 working days.
    - The overturn rate for PDRs was 21%, which met the Alliance goal of 25% or less.

Community Relations and Outreach

- 12-Month Trend Summary:
    - In May 2025, the Alliance completed 1,083 member orientation outreach calls and 92 member orientations by phone.
    - The C&O Department reached 358 people (61% identified as Alliance members) during outreach activities, compared to 1,158 individuals (46% self-identified as Alliance members) in May 2024.
    - The C&O Department spent a total of $0.00 on donations, fees, and/or sponsorships, compared to $430.00 in May 2024.
    - The C&O Department reached members in 12 cities/unincorporated areas throughout Alameda County compared to 16 cities in May 2024.

- Monthly Analysis:
    - In May 2025, the C&O Department completed 1,083 member orientation outreach calls, 92 member orientations by phone, and 44 Alliance website inquiries.

- Among the 358 people reached, 61% identified as Alliance members.
- In May 2025, the C&O Department reached members in 12 locations throughout Alameda County, the Bay Area, and the U.S.
- Please see attached **Addendum A**.

Housing and Community Services Program Report

Overview

The Housing and Community Services Program (HCSP) has been transitioned over to Healthcare Services.

Incentives & Reporting Board Report – May 2025 Activities

Current Incentive and Grant Programs

Student Behavioral Health Incentive Program (SBHIP) – DHCS program commenced January 1st, 2022, and ended on December 31st, 2024

- The Alliance worked with Local Education Agencies (LEAs) and program partners on the Project Outcome Report (POR), which was submitted to DHCS on December 19th
    - The POR was the final SBHIP report for the entire program measurement period of January 1st, 2022, to December 31st, 2024
        - On April 18th, DHCS notified the Alliance that the POR was approved and that we earned the full amount of eligible dollars (12.5% or $1.1M) for this final report; payment was received April 24th
- The Alliance earned a total of $9.7M (100% of eligible funds) based on submission of DHCS deliverables and achievement of milestones
    - A total of $8.9M has been paid to LEA and SBHIP partners; in May 2025, the Alliance completed all payments to partners for the POR submission

Housing and Homelessness Incentive Program (HHIP) – DHCS program commenced January 1st, 2022, and ended on December 31st, 2023

- The Alliance earned $38M out of $44M available under this program based on submission of deliverables and achievement of DHCS-defined metrics
    - $23.5M has been awarded to our HHIP partners to date
- A HHIP funding opportunity was released in June 2024 to SBHIP LEAs to address the challenges of students experiencing homelessness and associated behavioral health needs (i.e., anxiety, depression, etc.)
    - The Alliance received applications from 10 LEAs totaling $1.3M in requests; all submitted applications were approved and work on the funded programs continued

- In a separate HHIP-funded initiative, the Alliance awarded $11.2M in funding to 10 community partners through a program that supports the HHIP goals of reducing and preventing homelessness
    - Projects are underway with activities taking place through 2028 related to capacity building, innovation, diversity and health equity, and housing stability
- The Alliance continues to review partner project deliverables prior to payment and meet with partners to discuss program activities and barriers
    - One partner has withdrawn from the program as they could not reach an agreement with an external partner to complete the work; the unused funding will now be reviewed by the Alliance to determine potential areas of investment

Provider Recruitment Initiative (PRI) – internal Alliance program with funding up to $2M in fiscal year 2024-25

- Program highlights:
    - Launched on June 1st, 2024
    - 15 applications received totaling $6M in funding requests
    - $2M in funding awarded to 13 provider partners for the following:
        - Nineteen providers in total, six (6) of which are bi-lingual, including:
            - ❖ Six (6) Mid-Level Providers
            - ❖ Five (5) Behavioral Health Clinicians
            - ❖ Five (5) MD/DOs
            - ❖ Three (3) OB/GYNs
    - $218,000 has been awarded to our PRI partners to date
    - Grants were provided to five (5) practices to support Community Health Worker (CHW) training certificate costs for 33 CHWs
    - PRI deliverable trackers, to assist with program requirements, have been created and distributed to all awardees with signed MOUs

Equity and Practice Transformation (EPT) Payments Program – DHCS launched a one-time primary care provider practice transformation program in 2024 called the Equity and Practice Transformation (EPT) Payments Program. The program is designed to advance health equity, reduce COVID-19-driven care disparities, and prepare practices to participate in alternative payment models.

- The original funding was $700 million over five (5) years; however, due to state budget constraints, the funding was reduced to $140 million over three (3) years
- Alameda Health System (AHS) was the only Alliance-associated applicant selected by DHCS to participate
    - The Alliance last met with AHS on April 15th to discuss the EPT program
    - AHS submitted their latest program deliverables that were due May 1st
- The Alliance submitted EPT MCP Practice numerators, denominators, and rates for Alameda Health System, the contracted EPT practices, for the Healthcare Effectiveness Data and Information Set (HEDIS) like key performance indicators (28 measures total) for MY 2023

Doula Scholarship Program – the Alliance Health Care Services team launched this program in December 2024 with a goal to grow the Doula provider network aimed at increasing access to these services for members; I&R is providing administrative support.

- Scholarships are intended to offset costs related to the following:
    - Medi-Cal Provider Application and Validation for Enrollment (PAVE)
    - Contracting and credentialing with the Alliance
    - Continued education, training, and administrative and operational support required to be a Doula
- Scholarships of up to $1,000 per person are available for Doulas both intending to contract with the Alliance and Doulas already contracted with the Alliance
- MOUs for the 20 scholarship awardees have been signed, including seven (7) awards to support currently contracted Doulas and 13 awards for Doulas that intend to contract with the Alliance
    - To date, $12,500 of the available $20,000 in scholarships has been paid to program participants for completion of scholarship deliverables
    - The Alliance continues to receive interest in the scholarship program, although all scholarship funds have been expended
- Training materials were created and distributed to all Doulas that completed their MOUs to provide assistance with deliverable submission via the new grant software system, Submittable
    - Additional coordination is being done among internal teams to help the Doulas who intend to contract understand internal processes

Grant Program Updates

- The Incentives and Reporting team has implemented a grant management software system, Submittable, to support the various grant and incentive programs the Alliance participates in
    - Submittable creates an online application process for community partners, an electronic evaluation process, reporting for fund management, and awardee deliverable tracking
    - The Doula Scholarship Program application was piloted within Submittable in December and continues to be used for partner communications and deliverable tracking
    - The Alliance is currently working with Submittable on a Statement of Work to potentially create a dashboard to manage and track program related deliverables, including fund distribution
- California Improvement Network – the Alliance was selected, along with 24 other partners, to participate in an opportunity through the California Improvement Network (CIN), which is a learning and action community that advances equitable health care experiences and outcomes for Californians through cross-sector connections, spreading good ideas, and implementing improvements
    - CIN participation provides the Alliance with an opportunity to partner and connect with other organizations that are also working to improve health equity
        - The Alliance is receiving a small grant to cover the costs related to travel for participating in program activities

    - Participants are eligible to apply for a $40k action project award to support implementation efforts for partners; the Alliance will be submitting its application in June
    - The Director, Health Equity will be participating in the equity focused learning network and leading project initiatives; Incentives & Reporting will provide program management support
    - The first in-person CIN Partner Meeting was held on May 8th; the Alliance was represented by Health Equity and Incentives & Reporting
- The California Wellness Foundation – a meeting with The California Wellness Foundation was held on January 23rd to discuss funding opportunities and eligibility criteria; however, the Foundation confirmed in February that MCPs are not eligible for funding
    - Future funding may be attainable by partnering with a Community Based Organization (CBO) as the lead applicant
- California Endowment - a Letter of Inquiry (LOI) was submitted to the California Endowment on January 31st to be considered for their grant opportunities; a response is still pending
- California Health Care Foundation – a LOI was submitted to the California Health Care Foundation on March 21st, in collaboration with support from Behavioral Health (BH) leads from Operations and Health Care Services, for two proposals focusing on the need for funding to support BH workforce needs, as well as infrastructure support for CBOs to bill for Medi-Cal covered services
- Robert Wood Johnson Foundation – planning and application development is underway, in collaboration with True Vine Ministries, Health and Human Resource Center, and the Alliance Health Equity department, for an application to a Robert Wood Johnson research grant
    - Funding is for a new cohort of community-led pilot studies to produce new, actionable evidence about how to help medical, social, and public health systems work together to address forms of systemic racism
    - The Alliance will be submitting the application in June
- Meetings continue with internal teams such as Health Equity, Health Care Services, and Behavioral Health (clinical and operational) leads to further develop and pursue grant seeking strategies
    - On April 4th, Incentives & Reporting shared a Grants Administration overview presentation with the Senior Leadership Team to bring awareness to the work
    - In May 2025, the Incentives & Reporting team met twice with the Quality Management team to introduce grant seeking, and discuss funding priorities for the Quality team

Recruiting and Staffing

- Incentives & Reporting Open position(s): There are no open positions at this time

Incentive and Grant Program Descriptions

Student Behavioral Health Incentive Program (SBHIP) – program launched in January 2022 to support new investments in behavioral health services, infrastructure, information technology and data exchange, and workforce capacity for school-based and school-affiliated behavioral health providers. Incentive payments will be paid to Medi-Cal managed care plans (MCPs) to build infrastructure, partnerships, and capacity, statewide, for school behavioral health services. The program ended December 31st, 2024.

Housing and Homelessness Incentive Program (HHIP) – program launched in January 2022 and is part of the Home and Community-Based (HCBS) Spending Plan.

- Enables MCPs to earn incentive funds for making progress in addressing homelessness and housing insecurity as social determinants of health
- MCPs must collaborate with local homeless Continuums of Care (CoCs) and submit a Local Homelessness Plan (LHP) to be eligible for HHIP funding
- The program ended December 31st, 2023

Equity and Practice Transformation (EPT) Payments Program – program released by DHCS in August 2023 as a one-time primary care provider practice transformation program designed to advance health equity, reduce COVID-19-driven care disparities, and prepare practices to participate in alternative payment models. EPT is for primary care practices, including Family Medicine, Internal Medicine, Pediatrics, Primary Care OB/GYN, and/or Behavioral Health in an integrated primary care setting. The original program was a $700 million, five (5) year program; however, due to state budget constraints, the program was revised to a $140 million, three (3) year program.

The Provider Recruitment Initiative (PRI) – program launched on June 1st, 2024, and is designed to provide grants to support the Alameda County Safety Net and community-based organizations to hire and retain healthcare professionals who serve the Alameda County Medi-Cal population. The PRI aims to grow the Alliance provider network and support our community partners' ability to supply culturally and linguistically competent care to increase accessibility and to reflect the diversity of Alliance members. Program goals include:

- Expanding the Alameda Alliance Provider network
- Improving member access to Primary Care Providers, Specialists, and Behavioral Health professionals
- Promoting diverse and culturally inclusive care reflective of Alliance members

Doula Scholarship Program – program launched in December 2024 to grow the Doula provider network to increase access to these services for members.

ALAMEDA Alliance FOR HEALTH

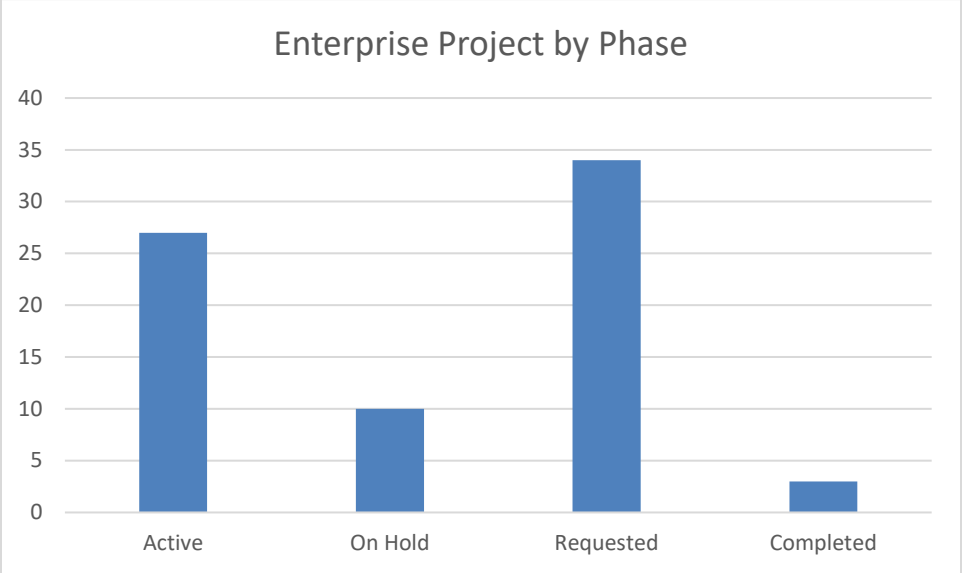
Health care you can count on.
Service you can trust.

Integrated Planning

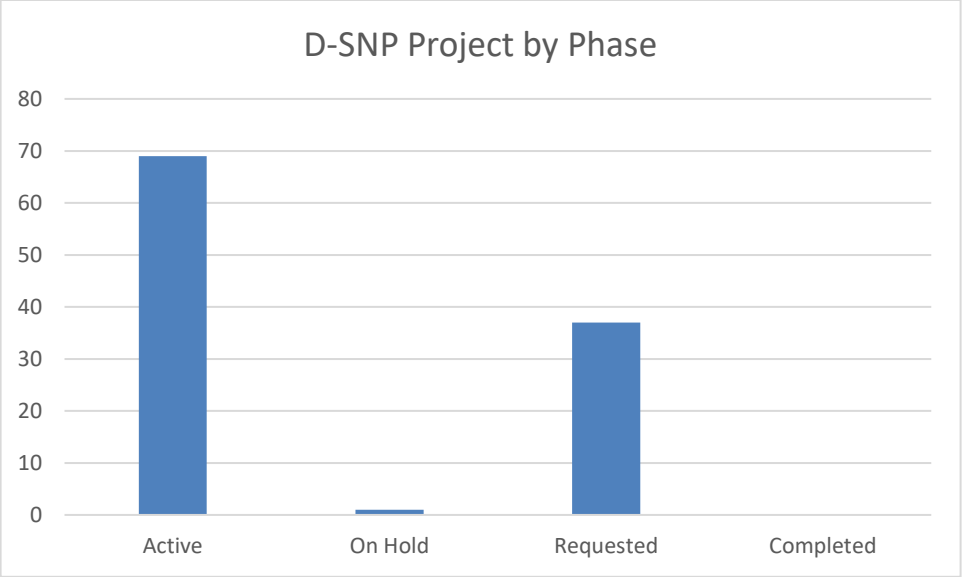
Ruth Watson

INTEGRATED PLANNING DIVISION BOARD REPORT – MAY 2025 ACTIVITIES

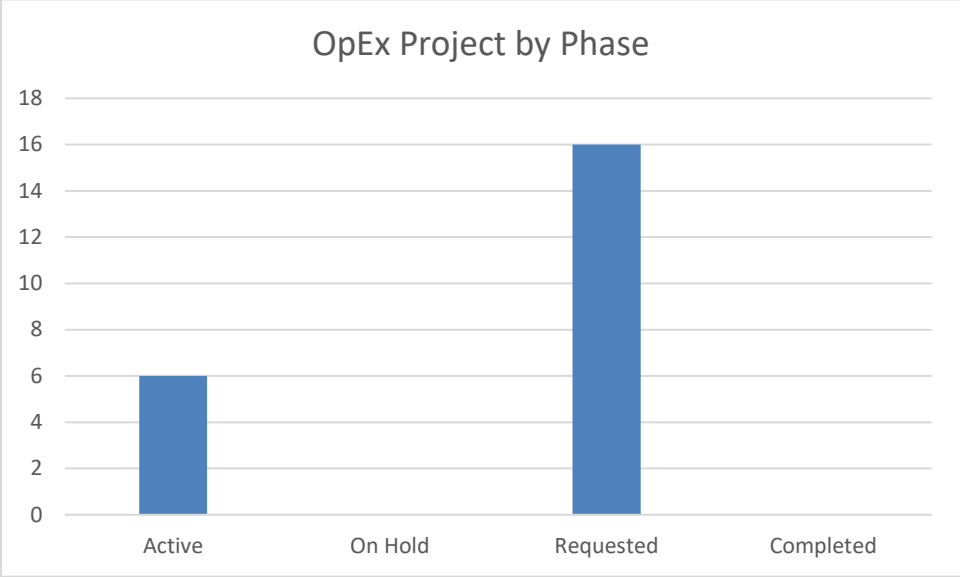
- Enterprise Portfolio
  - 71 projects currently on the Alameda Alliance for Health (AAH) enterprise-wide portfolio
    - 27 Active projects (discovery, initiation, planning, execution, warranty)
    - 10 On Hold projects
    - 34 Requested and Approved projects
    - 3 Completed projects (Last month)



- D-SNP Portfolio
  - 107 projects currently on the Alameda Alliance for Health (AAH) enterprise-wide portfolio
    - 69 Active projects (discovery, initiation, planning, execution, warranty)
    - 37 Requested projects
    - 1 On Hold



- Operational Excellence (OpEx) Portfolio
  - 22 projects currently on the Alameda Alliance for Health (AAH) enterprise-wide portfolio
    - 6 Active projects (discovery, initiation, planning, execution, warranty)
    - 16 Requested projects
    - 0 On Hold



  - D-SNP Key Initiatives and Dates
    - DMHC Material Modification Submission – MA Service Area Expansion – March 2024 - COMPLETE
    - DMHC Material Modification Submission – D-SNP Product – August 2024
    - CMS Notice of Intent to Apply – November 2024 - COMPLETE
    - CMS Application Submission including MOC, Provider Network Adequacy & DMHC Approval – February 2025 - COMPLETE

- CMS Formulary & Bid Submission (Benefit Determination) – June 2025
- CMS SMAC Submission – July 7, 2025
- Rebate Allocation with CMS and Health Plan – July / August 2025
- Annual Enrollment Period (AEP) – October thru December 2025
- IT System Readiness – December 15, 2025
- Open Enrollment Period (OEP) Begins – January 1, 2026

- D-SNP Activities
  - Provider Services & Contracting
    - Complete onsite meeting with CHCN on Tuesday, May 27th
    - Provider Contracting
      - Continued outreach to AAH provide network to complete the execution of the D-SNP Provider Amendment. As of May 28th, 100 contracts are fully executed, which supports 14% completion
      - Continued contract negotiations with Brown & Towland, Sutter, UCF, and Teladoc
    - Provider Services
      - Started review and edits of the Provider Manual to support inclusion of D-SNP requirements
      - Continued updates to the Provider Repository for the executed D-SNP Provider Amendments
    - Provider Rates and Reimbursement
      - Continued development of the Pay4Performance (P4P) plan
  - Product
    - Onboarded 2 FTEs within Medicare Operations department – (1) Manager, Medicare Marketing, Communications and Branding and (2) Manager, Member Experience & Program Management
    - Attended D-SNP Virtual Sessions with El Cambio Consulting.
    - Final QA of 2026 CMS Formulary and Bid Submission (Benefit Determination) was completed on Friday, May 30th and on track for submission on June 2nd, 2025
    - CMS Account Manager Assigned on Friday, May 30th, and his name is Mr. Eric Hansen
    - Preparing for SMAC submission due July 7th
    - Developing Standard Operating Procedures (SOPs) and Policies and Procedures (P&Ps) to standardize departmental operations and ensure adherence to best practices annually.
  - Sales
    - Continued implementation of the Sales System with Nations and on track
    - Sales Script initial draft completed and submitted to Compliance and for approval to route to CMS
      - Implementation of sales script into Cirrus
    - Developed required Policy and Standard Operating Procedures outline

- Developed initial draft of Incentive Plan for Medicare Sales agents and working with leadership on approval
- Job Description for licensed full-time agent created and submitted for approval
- D-SNP plan name approach on CMS model documents confirmed
- Identifying staffing agency to provide temporary licensed agents to meet business needs
- Creating phone tree for call flow between member services, providers, and sales

- Marketing
  - Marketing and Compliance reviews of Enrollment Letters have been completed. Currently awaiting final CMS Material ID tracking numbers from Compliance in order to finalize the letters
  - Enrollment Form has been successfully drafted and reviewed by all relevant stakeholders. It is scheduled for submission to C&O/Compliance on June 4
  - Identified D-SNP website requirements and currently collaborating with the IPD team to conduct a gap analysis. This will help ensure alignment between current capabilities and required functionality for upcoming D-SNP website launch
  - Drafting EOC document using the CY2025 model as a foundation. When the CY2026 model is released, we will pivot and update the draft accordingly to ensure alignment with the latest CMS requirements.
    - This process will also apply to other integrated marketing materials. We will begin drafting based on CY2025 models and revise the materials as needed once the CY2026 models are available.
  - Developing Standard Operating Procedures (SOPs) and Policies and Procedures (P&Ps) to standardize departmental operations and ensure adherence to best practices annually.
- Vendor Management
  - Continued engagement with the following vendors to support Supplemental Benefit Offering(s)
    - Dental – completed contracting
    - Vision – contracting in process
    - Hearing – completed contracting
    - Flex Card – completed contracting
    - Sales System – contracting complete
    - Medicare Prescription Payment Plan (M3P) – contracting in process
- Quality
  - Model of Care
    - MOC has been approved by both DHCS and CMS
      - 96.25% earning three (3) year approval
  - Quality Program

        - Quality Improvement Health Equity P&Ps continue to be updated/developed to align with D-SNP
        - Quality Workplan
            - Aligning QI Workplan and Stars Playbook
            - Developing BRD's for reporting requirements related to QI Workplan
        - Gathering Quality Website and Provider Manual Requirements Quality Committees
            - Charter redlines (Seven Quality Committees)
            - Establishing new committees for Utilization Management and Community Advisory Committee
- Health Care Services (HCS) and Behavioral Health (BH)
    - Continuing policy development and revisions (130 policies)
    - Redlining UM and CM Program Descriptions for D-SNP elements
    - Finalizing D-SNP Prior authorization code list. Prior Authorization Code List has been finalized
    - HRA draft was submitted to DHCS and was approved
    - Final stages of future State D-SNP CM Global Workflow draft – Outlining process flows for new D-SNP components to include Face-to-Face visit, Palliative Care Program, and Dementia Care Program
    - Continuing to define structure and net new processes for California Integrated Care Management (CICM) to include new requirements outlined in the CY2026 Program Guide
    - D-SNP CM Assessment/HRA mapping to care plan for rules generation
        - Other assessments SRD to TruCare Team for configuration
    - Continuing to build out system rules documents for D-SNP TruCare to submit to IT for configuration – Finalizing Tru-Care Core Feeds SRD
    - D-SNP authorization workstream in building out requirements and work efforts for stand-up
        - Finalizing UM customer set up requirements for configuration
    - BH CM – D-SNP CM program structure finalizing structure
    - Establishing framework to coordinate Medicare non-covered services with Alameda County Behavioral Health
    - BH programs policy and procedure development and revisions underway
    - Completing BH call flow and intersections with Member Services
    - Completed edits for D-SNP Member and Provider letters; additional letters created to support CMS and DHCS requirements
    - Risk Stratification model alignment with Medi-Cal model
    - Working to establish a framework for identification of populations of focus for CICM, Palliative Care and Most Vulnerable Populations

- BH UM – establishing additional levels of care for DSNP population and documenting design requirements for TruCare
- Initial stages of collaboration outline with ACBH for carve out BH services; first meeting with ACBH occurred on 03/26/2025 with additional follow-up meetings being scheduled

- Finance
  - Finance policies approved at the May AOC meeting
- Compliance
  - DMHC Material Modification – D-SNP Product (Filing #20244060)
    - Initial AAH responses submitted to DMHC on 9/9/24
    - DMHC Comment Table received 1/7/25; responses submitted 2/6/25; no further comments received from DMHC
  - DHCS Local Plan 2026 D-SNP Readiness Checklist
    - Received April 16th
    - Responses due May 16th
    - Responses submitted to DHCS on May 16th
  - D-SNP Compliance Policies
    - Twenty-one (21) in review with projected review at the Administrative Oversight Committee (AOC) on August 5th
  - HPMS User Access Form (aka CARE Form)
    - Completed User Testing
    - Moved form to Production
- Enrollment and Eligibility
  - D-SNP Enrollment Form is pending approval
  - Initial letter testing with RAM (HEALTHsuite) and KP (AAH Print Vendor)
- Pharmacy
  - PBM Technical and Operations meetings are in progress
  - MTM Operational meetings are in progress. MTM submission into HPMS is on track for June 4th and MTM attestation on track for June 18th.
    - AAH MTM program design in progress
  - 1 Tier Formulary from PBM will be implemented for AAH
  - M3P program in AAH will be managed by the PBM
  - Part D benefit design package in progress and is being led by the Operations workgroup
  - Call Center functionalities for member calls and technical calls are in progress
  - AAH will delegate Part D appeals to PerformRx (PBM) and AAH will own Part D grievances
- Integrated Grievance and Appeals
  - Policies and Procedures are under review by SMEs
  - G&A Letter inventory completed
  - Grooming sessions are active with the business and IT partners to implement business requirements

- Waiver of Liability (WOL) process for out of network provider will be owned and managed by the Grievance and Appeals team
- Payment Reconsideration workgroup is active
- CMS five (5) levels of appeal are currently being configured in Quality Suite

- Operations (Claims / Member Services / Mailroom / IVR)
  - Continue development of Claims, Member Services, Mailroom, and IVR business process and requirements
- IT
  - TruCare: Project is 60% complete. Preparing to start configuration of CM and UM letters and assessments this month. Continuing to work closely with Zyter and the business to complete the remaining system requirement documents. Workstream meetings in progress to continue documenting system requirements for the various TruCare UM, CM and Core functions. Finalizing mapping specifications to loading DM Care Opportunities data. Care Opportunities QA completed, BRD for TruCare Actions will be shared for approvals this week. Core feeds mapping and development is in progress for the provider, product/network and member feeds.
  - HEALTHsuite: Plan Structure decision finalized. Enrollment Letters High and Medium priority configuration is completed. Enrollment Testing strategy reviewed with RAM team. Membership and Eligibility workflow configuration in progress
  - QualitySuite: QualitySuite D-SNP stage environment tracking to be enabled by 5/30. Grievance module development is underway. Complaint Tracking Module (CTM) user stories are ready for sprint planning and Appeals user stories are actively in the grooming process in partnership with the G&A business team and QS technical team. Provider Dispute Resolution (PDR) requirements have been finalized; initiation of user story grooming for PDR is pending.
- Stars
  - Phase 1 of Star strategy
    - Identified initiatives for the HEDIS measures supported in the Medi-Cal line of business and Operational measures that will impact Star ratings on Day 1
    - Building out Stars playbook to align interventions to D-SNP for Day 1
    - Aligning interventions to Quality Workplan
    - Process flow documentation for the measures is underway with Quality, Health Care Services, and Analytics. We will plan to implement foundational initiatives to support Star gap closure.
      - TruCare Star gap integration in process
      - Pay-for-Performance and Pay-for-Reporting program – This is ongoing. Confirmed with CHCN that they will not have their own P4P Program

        - EMR Data feeds – This is already in production and will be slightly modified to ensure support for D-SNP measures
        - Prospective Chart Review – This is already in production and will be slightly modified to ensure support for D-SNP measures Phase 1 of Star strategy
    - We will plan to implement operational initiatives to support Star gap closure.
        - New:
            - Concierge Care Gap Closure Program – Beginning development of a member/provider outreach program for members with 2+ care gaps
            - Awareness Campaign – Beginning development of ad hoc awareness campaigns to deploy in 2026 (medication adherence and preventative services)
            - Annual Wellness Visits – Beginning development of AWV program to engage providers and members for gap closure and accurate diagnosis capture

- **<u>CalAIM Initiatives:</u>**
    - Community Supports (CS):
        - Due to Budget Constraints, all CS enhancement and expansion are on hold
    - Justice-Involved (JI) Initiative:
        - CalAIM Re-entry
            - Correctional facilities go-live date for pre-release services is determined based on DHCS readiness assessment and will go-live with pre-release services within a 24-month phase in period (10/1/2024 – 9/30/2026)
                - Santa Rita Jail is targeting to go-live on 7/1/2026 with pre-release services; Juvenile Justice Center's go-live is TBD
                - Managed Care Plans (MCPs) must be prepared to coordinate with correctional facilities as of October 1st, 2024, even if facilities in their county will go-live later
                - JI project team is developing a contact list for the counties going live with pre-release to support coordination of referrals for any AAH members being released from these counties
            - DHCS has indicated they intend to release a revised JI Policy Guide; impacts to project scope and schedule will be assessed once this is released
            - DHCS JI Learning Collaboratives initiated in August 2024 and continues through January 2025. These collaborative sessions include correctional facilities, county behavioral health agencies, probation, managed care plans, and ECM providers
            - On 10/28/24, AAH SLT approved to place CalAIM JI Re-Entry project on hold until July 2025 to await final policy guide from DHCS and give

Alameda County partners time to develop their internal processes and readiness

- CYBHI Fee Schedule – Effective January 1st, 2024, the Alliance is partnering with Carelon (formerly known as Beacon) to implement the CYBHI Fee Schedule
    - Cohort 1 is intended to be a "learning" cohort
    - The Alliance was not selected to participate in the permanent ASO Model and will participate in an interim solution until further notice from Carelon and DHCS
- MOU
    - Interim Model MOU has been executed by AAH CEO 4/29/25 and returned to Carelon
    - AAH Finance Team shall receive Invoice File from Carelon for billing purposes via secured file transfer process and process payments manually
        - This includes checking member eligibility internally to deliver payments when services have been rendered
        - SFTP File Exchange template executed and resubmitted to Carelon 6/2/25
    - Banking information with Carelon has been established and ready for invoice payments
    - Final stages of testing data with Carelon and DHCS
    - Project Close Activities
        - Upon completion of file transfer validation, the AAH business stakeholders propose closing this project
        - Anticipate project close in June 2025
        - Warranty period through end of July to monitor stabilization of potential incoming invoices

Recruiting and Staffing

- Integrated Planning Open position(s):
    - Supervisor, Business Analyst - Candidate Target Start: June 16, 2025
    - Backfill Business Analyst, Integrated Planning – Posting reactivated
    - Backfill Business Process Analyst, Integrated Planning – Candidate Target Start: July 7, 2025

Supporting Documents Project Descriptions

Key projects currently in-flight:

- California Advancing and Innovating Medi-Cal (CalAIM) – program to provide targeted and coordinated care for vulnerable populations with complex health needs.
  - Enhanced Care Management (ECM) – ECM will target eight (8) specific populations of vulnerable and high-risk children and adults
    - Three (3) Populations of Focus (PoF) transitioned from HHP and/or WPC on January 1st, 2022
    - Two (2) additional PoF became effective on January 1st, 2023
    - One (1) PoF became effective on July 1st, 2023
    - Two (2) PoF became effective on January 1st, 2024
  - *Restarting in July 2025* - Justice Involved Initiative – adults and children/youth transitioning from incarceration or juvenile facilities will be enrolled into Medi-Cal upon release
    - DHCS is finalizing policy and operational requirements for MCPs to implement the CalAIM Justice-Involved Initiative
      - MCPs must be prepared to go live with ECM for the Individuals Transitioning from Incarceration as of January 1st, 2024
      - MCPs must be prepared to coordinate with correctional facilities to support reentry of members as the return to the community by October 1st, 2024
      - Correctional facilities will have two years from 10/1/2024-9/30/2026 to go live based on readiness
  - Dual Eligible Special Needs Plan (D-SNP) Implementation – All Medi-Cal MCPs will be required to operate Medicare Medi-Cal Plans (MMPs), the California-specific program name for Exclusively Aligned Enrollment Dual Eligible Special Needs Plans (EAE D-SNPs) by January 2026 to provide better coordination of care and improve care integration and person-centered care. Additionally, this transition will create both program and financial alignment, simplify administration and billing for providers and plans, and provide a more seamless experience for dual eligible beneficiaries by having one plan manage both sets of benefits for the beneficiary.
- CYBHI Statewide Fee Schedule – The Department of Health Care Services (DHCS), in collaboration with the Department of Managed Health Care (DMHC), has developed a multi-payer, school-linked statewide fee schedule for outpatient mental health or substance use disorder services provided to a student 25 years of age or younger at or near a school site. CYBHI requires commercial health plans and the Medi-Cal delivery system, as applicable, to reimburse, at or above the published rates, these school-linked providers, regardless of network provider status, for services furnished to students pursuant to the fee schedule. Effective January 1st, 2024, the Alliance is partnering with the Alameda County Office of Education (ACOE) and several Local Education Agencies (LEAs) who were selected to participate in the CYBHI Fee Schedule Cohort 1.

Operations

Supporting Documents

Member Services

Blended Call Results

Blended Results	May 2025
Incoming Calls (R/V)	17,427
Abandoned Rate (R/V)	5%
Answered Calls (R/V)	16,624
Average Speed to Answer (ASA)	00:11
Calls Answered in 30 Seconds (R/V)	95%
Average Talk Time (ATT)	07:33
Calls Answered in 10 minutes	100%
Outbound Calls	8,700

Top 5 Call Reasons (Medi-Cal and Group Care) May 2025
Change of PCP
Eligibility/Enrollment
Grievances/Appeals
Benefits
Provider Network Info
Top 3 Web-Based Request Reasons (Medi-Cal and Group Care) May 2025
Change PCP
ID Card Requests
Update Contact Info

MSBH	May 2025
Incoming Calls (R/V)	1157
Abandoned Rate (R/V)	3%
Answered Calls (R/V)	1124
Average Speed to Answer (ASA)	00:23
Calls Answered in 30 Seconds (R/V)	92%
Average Talk Time (ATT)	08:24
Calls Answered in 10 minutes	100%
Outbound Calls	1012
Screenings Completed	118
ACBH Referrals	44
SUD referrals to Center Point	17

Claims Department
April 2025 Final and May 2025 Final

METRICS

Claims Compliance	Apr-25	May-25
90% of clean claims processed within 30 calendar days	90.4%	90.4%
95% of all claims processed within 45 working days	95.5%	97.6%
Claims Volume (Received)	**Apr-25**	**May-25**
Paper claims	43,656	35,937
EDI claims	328,470	351,627
Claim Volume Total	**372,126**	**387,564**
Percentage of Claims Volume by Submission Method	**Apr-25**	**May-25**
% Paper	11.73%	9.27%
% EDI	88.27%	90.73%
Claims Processed	**Apr-25**	**May-25**
HEALTHsuite Paid (original claims)	293,807	247,441
HEALTHsuite Denied (original claims)	99,135	83,314
HEALTHsuite Original Claims Sub-Total	**392,942**	**330,755**
HEALTHsuite Adjustments	20,719	3,333
HEALTHsuite Total	**413,661**	**334,088**
Claims Expense	**Apr-25**	**May-25**
Medical Claims Paid	$154,887,607	$133,062,018
Interest Paid	$187,359	$92,371
Auto Adjudication	**Apr-25**	**May-25**
Claims Auto Adjudicated	347,343	289,805
% Auto Adjudicated	88.3%	87.6%
Average Days from Receipt to Payment	**Apr-25**	**May-25**
HEALTHsuite	16	16
Pended Claim Age	**Apr-25**	**May-25**
0-30 calendar days	63,587	52,859
HEALTHsuite		
31-61 calendar days	34,105	31,491
HEALTHsuite		
Over 62 calendar days	48,172	57,931
HEALTHsuite		
*Pended claims over 31 days are high due to investigation of 3 providers for FWA		
Overall Denial Rate	**Apr-25**	**May-25**
Claims denied in HEALTHsuite	99,135	83,314
% Denied	24.0%	24.9%

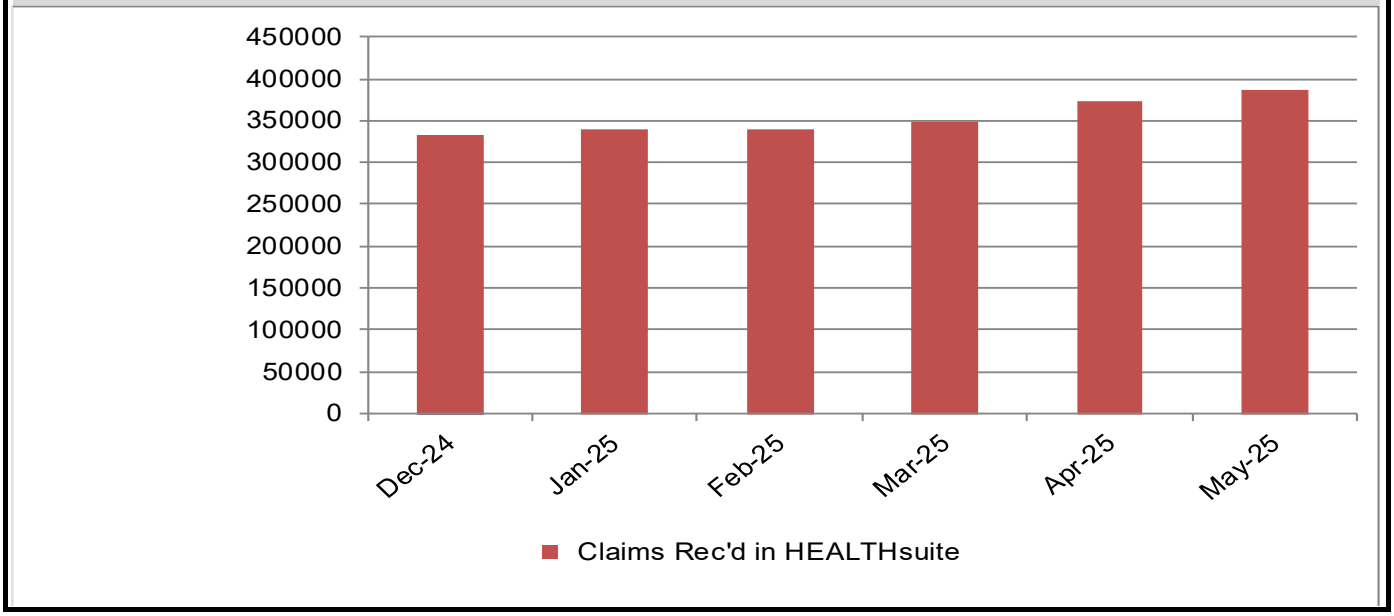
Claims Department
April 2025 Final and May 2025 Final

May-25

Top 5 HEALTHsuite Denial Reasons	% of all denials
Responsibility of Provider	25%
No Benefits Found For Dates of Service	14%
Must Submit Paper Claim With Copy of Primary Payor EOB	12%
Non-Covered Benefit For This Plan	10%
Duplicate Claims	7%
% Total of all denials	**68%**

Claims Received By Month

	1/1/2025	2/1/2025	3/1/2025	4/1/2025	5/1/2025	6/1/2025
Claims Received Through	**Dec-24**	**Jan-25**	**Feb-25**	**Mar-25**	**Apr-25**	**May-25**
Claims Rec'd in HEALTHsuite	332,108	339,760	339,840	347,469	372,126	387,564



Claims Year Over Year Summary

Monthly Results	Regulatory Requirement	AAH Goal
Claims Compliance - comparing May 2025 to May 2024 as follows: 30 Days - 90.4% (2025) vs 92.3% (2024) 45 Days - 97.6% (2025) vs 100% (2024) 90 Days - 99.9% (2025) vs 99.9% (2024)	90% of clean claims in 30 calendar days 95% of all claims in 45 working days 99% of all claims in 90 calendar days	90% of clean claims in 30 calendar days 95% of all claims in 45 working days 99% of all claims in 90 calendar days
Claims Received - AAH received 387,564 claims in May 2025 vs 375,454 in May 2024	N/A	N/A
EDI - the volume of EDI submissions was 87.6% which falls within the desired range of ~77% - 87%	N/A	N/A
Original Claims Processed - AAH processed 330,755 in May 2025 (22 working days) vs 374,133 in May 2024 (23 working days)	N/A	N/A
Medical Claims Expense - the amount of paid claims in May 2025 was $133,062,018 (4 check runs) vs $156,841,938 in May 2024 (5 check runs)	N/A	N/A
Interest Expense - the amount of interest paid in May 2025 was $92,371 vs $84,769 in May 2024	N/A	.05% - .075% of the monthly medical expense
Auto Adjudication - the AAH rate in May 2025 was 87.6% vs 85.6% in May 2024	N/A	85% or higher
Average Days from Receipt to Payment - the average # of days from receipt to payment in May 2025 was 16 days vs 14 days in May 2024	N/A	<= 25 days
Pended Claim Age - comparing May 2025 to May 2024 as follows: 0-30 calendar days - 52,859 (2025) vs 39,193 (2024) 31-61 calendar days - 31,491 (2025) vs 7,841 (2024) Over 62 calendar days - 57,931 (2025) vs 7 (2024) *Pended claims over 31 days are high due to the investigation of 3 providers for FWA	N/A	N/A
Top 5 Denial Reasons - the claim denial reasons remain consistent from month to month so there is no significant changes to report from May 2025 to May 2024	N/A	N/A

Provider Relations Dashboard May 2025

Alliance Provider Relations Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Incoming Calls (PR)	10977	8885	8303	8709	7861							
Abandoned Calls	3600	1133	1434	1685	1254							
Answered Calls (PR)	7377	7752	6869	7024	6607							
Recordings/Voicemails	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Incoming Calls (R/V)	2910	2140	13	15	12							
Abandoned Calls (R/V)												
Answered Calls (R/V)	2910	2140	13	15	12							
Outbound Calls	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Outbound Calls	868	1162	434	602	570							
N/A												
Outbound Calls	868	1162	434	602	570							
Totals	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Total Incoming, R/V, Outbound Calls	14755	12187	8750	9326	8443							
Abandoned Calls	3600	1133	1434	1685	1254							
Total Answered Incoming, R/V, Outbound Calls	11155	11054	7316	7641	7189							

Provider Relations Dashboard May 2025

Call Reasons (Medi-Cal and Group Care)

Category	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Authorizations	5.1%	5.8%	5.4%	5.0%	5.2%							
Benefits	5.1%	3.7%	3.4%	3.9%	6.4%							
Claims Inquiry	39.4%	43.9%	43.7%	46.3%	47.7%							
Change of PCP	2.5%	2.7%	2.4%	2.9%	2.8%							
Check Tracer	0.7%	0.6%	1.0%	0.9%	0.7%							
Complaint/Grievance (includes PDR's)	5.8%	6.7%	6.8%	6.5%	7.6%							
Contracts/Credentialing	0.8%	0.8%	0.7%	0.8%	0.8%							
Demographic Change	0.0%	0.0%	0.0%	0.0%	0.0%							
Eligibility - Call from Provider	21.0%	17.4%	17.0%	17.9%	16.5%							
Exempt Grievance/ G&A	0.0%	0.1%	6.8%	0.0%	0.1%							
General Inquiry/Non member	0.0%	0.0%	0.0%	0.0%	0.0%							
Health Education	0.0%	0.0%	0.0%	0.0%	0.0%							
Intrepreter Services Request	0.5%	0.5%	0.6%	0.4%	0.4%							
Provider Portal Assistance	3.4%	3.2%	3.9%	3.4%	3.4%							
Pharmacy	0.1%	0.2%	0.1%	0.0%	0.1%							
Prop 56	0.1%	0.0%	0.0%	0.1%	0.1%							
Provider Network Info	0.0%	0.0%	0.0%	0.0%	0.0%							
Transportation Services	0.0%	0.2%	0.2%	0.2%	0.3%							
Transferred Call	0.0%	0.0%	0.0%	0.0%	0.0%							
All Other Calls	15.5%	14.4%	7.9%	11.4%	7.9%							
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%							

Field Visit Activity Details

Alliance Provider Relations Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Claims Issues	28	72	89	54	60							
Contracting/Credentialing	29	41	50	59	150							
Drop-ins	127	83	141	146	149							
JOM's	2	2	3	2	3							
New Provider Orientation	100	134	118	173	143							
Quarterly Visits	0	0	0	82	0							
UM Issues	0	0	3	1	1							
Total Field Visits	286	332	404	517	506	0	0	0	0	0	0	0

ALLIANCE NETWORK SUMMARY, CURRENTLY CREDENTIALED PRACTITIONERS - May 2025						
Practitioners		PCP 388	SPEC 757	AHP 655	BH/ABA 2,997	PCP/SPEC 12
Direct Network vs Delegated Network Breakdown			AAH 3,589	AHS 297	CHCN 594	COMBINATION OF GROUPS 329
Facilities	443					

VENDOR SUMMARY **Credentialing Verification Organization, Symplyr CVO**					
	Number	**Average Calendar Days in Process**	**Goal - 25 Business Days***	**Goal - 98% Accuracy**	**Compliant**
Initial Files in Process	121	13	Y	Y	Y
Recred Files in Process	5	0	Y	Y	Y
Expirables updated **Insurance, License, DEA, Board Certifications**					Y
Files currently in process	**126**				
		*** 25 business days = 35 calendar days**			

May 2025 Peer Review and Credentialing Committee Approvals	
Initial Credentialing	**Number**
PCP	6
SPEC	13
ANCILLARY	9
MIDLEVEL/AHP	9
BH/ABA	150
Sub-total	**187**
Recredentialing	
PCP	14
SPEC	28
ANCILLARY	1
MIDLEVEL/AHP	20
Sub-total	**63**
TOTAL	**250**

May 2025 Facility Approvals	
Initial Credentialing	2
Recredentialing	10
Sub-total	**12**
Facility Files in Process	**58**

May 2025 Employee Metrics (6 FTEs)	**Goal**		**Met (Y/N)**
File Processing	Timely processing within 3 days of receipt		Y
Credentialing Accuracy	<3% error rate		Y
DHCS, DMHC, CMS, NCQA Compliant	98%		Y
MBC Monitoring	Timely processing within 3 days of receipt		Y

LAST NAME	FIRST NAME	CATEGORY	INITIAL / RE-CRED	CRED DATE
Adeniji	Adebowale	BH/ABA	INITIAL	5/20/2025
Aguilar Cota	Enrique	BH/ABA-Telehealth	INITIAL	5/20/2025
Ahmed	Jibran	BH/ABA-Telehealth	INITIAL	5/20/2025
Almanza	Rebecca	BH/ABA-Telehealth	INITIAL	5/20/2025
Ambery	Teresa	BH/ABA-Telehealth	INITIAL	5/20/2025
Amparano	Shawn	BH/ABA-Telehealth	INITIAL	5/20/2025
Anderson	Nayeli	BH/ABA-Telehealth	INITIAL	5/20/2025
Atreya	Prerana	BH/ABA-Telehealth	INITIAL	5/20/2025
Attalla	Monica	BH/ABA-Telehealth	INITIAL	5/20/2025
Bauman	Chloe	BH/ABA	INITIAL	5/20/2025
Bazan	Yesenia	BH/ABA-Telehealth	INITIAL	5/20/2025
Beard	Jordyn	BH/ABA-Telehealth	INITIAL	5/20/2025
Bechelli	Matthew	BH/ABA-Telehealth	INITIAL	5/20/2025
Bendele	Candace	BH/ABA-Telehealth	INITIAL	5/20/2025
Berger	Aaron	BH/ABA-Telehealth	INITIAL	5/20/2025
Bernaldo	Marianne	BH/ABA-Telehealth	INITIAL	5/20/2025
Bernstein	Gail	BH/ABA-Telehealth	INITIAL	5/20/2025
Boykin	Keyona	Allied Health	INITIAL	5/20/2025
Brown	Karina	BH/ABA-Telehealth	INITIAL	5/20/2025
Brown	Zariyah	BH/ABA	INITIAL	5/20/2025
Bump	Bryan	BH/ABA-Telehealth	INITIAL	5/20/2025
Cahalin	Daniel	BH/ABA-Telehealth	INITIAL	5/20/2025
Caro	Andrea	Allied Health	INITIAL	5/20/2025
Casas	Andre Nicholas	BH/ABA	INITIAL	5/20/2025
Castillo	Mayra	BH/ABA-Telehealth	INITIAL	5/20/2025
Chin	Daphne	BH/ABA	INITIAL	5/20/2025
Clark	Anitra	BH/ABA-Telehealth	INITIAL	5/20/2025
Cohen	Michael	Specialist	INITIAL	5/20/2025
Coldwell	Alaura	BH/ABA-Telehealth	INITIAL	5/20/2025
Collins	Jennifer	BH/ABA-Telehealth	INITIAL	5/20/2025
Connors	Alyssa	Allied Health	INITIAL	5/20/2025
Covelli	Vincent	Specialist	INITIAL	5/20/2025
Cubelio	Pauline	BH/ABA-Telehealth	INITIAL	5/20/2025
Cuenin	Taylor	Allied Health	INITIAL	5/20/2025
Currie	Rebecca	BH/ABA-Telehealth	INITIAL	5/20/2025
Daoulatian	Karina	BH/ABA-Telehealth	INITIAL	5/20/2025
Dom	Nancy	BH/ABA	INITIAL	5/20/2025
Esquivel	Evelyn	BH/ABA-Telehealth	INITIAL	5/20/2025
Farey	Krista	Primary Care Physician	INITIAL	5/20/2025
Fecske	Paige	BH/ABA	INITIAL	5/20/2025
Flores	Yesenia	BH/ABA-Telehealth	INITIAL	5/20/2025
Fredricks-Hearen	Rebecca	BH/ABA-Telehealth	INITIAL	5/20/2025
Galvan	Esmeralda	BH/ABA-Telehealth	INITIAL	5/20/2025
Galvez	Adriana	BH/ABA-Telehealth	INITIAL	5/20/2025
Gamble	Bruce	BH/ABA-Telehealth	INITIAL	5/20/2025
Green	Crystal	BH/ABA	INITIAL	5/20/2025
Grier	Dian	BH/ABA	INITIAL	5/20/2025
Hajja	Shatha	Primary Care Physician	INITIAL	5/20/2025
Hall	Jameela	BH/ABA-Telehealth	INITIAL	5/20/2025
Harper	Christine	BH/ABA-Telehealth	INITIAL	5/20/2025
Hauch	Heather	Ancillary	INITIAL	5/20/2025
Heaney	Catherine	BH/ABA-Telehealth	INITIAL	5/20/2025
Hecker	Charlene	BH/ABA	INITIAL	5/20/2025
Hermosillo	Monica	BH/ABA-Telehealth	INITIAL	5/20/2025
Hernandez	Isabel	BH/ABA-Telehealth	INITIAL	5/20/2025
Hernandez-Espinoza	Amanda	BH/ABA-Telehealth	INITIAL	5/20/2025
Herrera	Laura	BH/ABA-Telehealth	INITIAL	5/20/2025
Hidrogo	Priscilla	BH/ABA-Telehealth	INITIAL	5/20/2025
Holbrook	Ashley	BH/ABA-Telehealth	INITIAL	5/20/2025
Ibrahim	Claire	Ancillary	INITIAL	5/20/2025

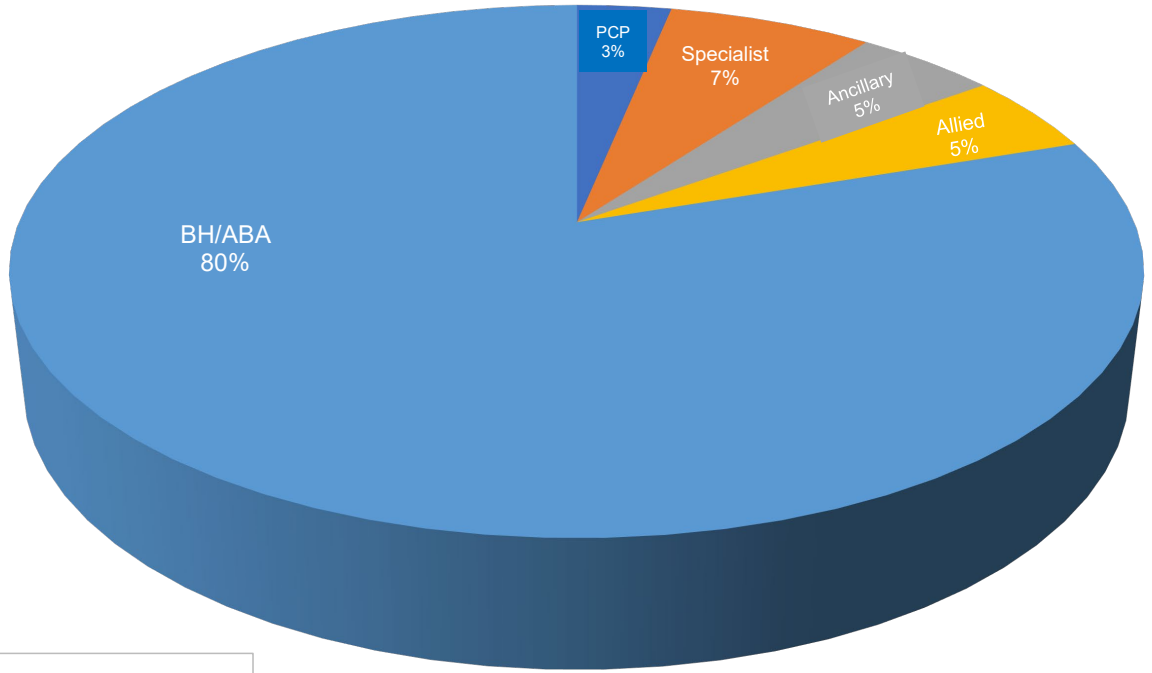
LAST NAME	FIRST NAME	CATEGORY	INITIAL / RE-CRED	CRED DATE
Isaac	Segen	BH/ABA	INITIAL	5/20/2025
Jayaramaswamy Sulochana	Shilpa	Primary Care Physician	INITIAL	5/20/2025
Jenkins	William	BH/ABA-Telehealth	INITIAL	5/20/2025
Johnson	Willishia	BH/ABA	INITIAL	5/20/2025
Kamath	Nandan	Specialist	INITIAL	5/20/2025
Kamdar	Toral	Specialist	INITIAL	5/20/2025
Kawai	Mari	BH/ABA-Telehealth	INITIAL	5/20/2025
Keim	James	BH/ABA	INITIAL	5/20/2025
Kelesidis	Iosif	Specialist	INITIAL	5/20/2025
Kelton	David	BH/ABA-Telehealth	INITIAL	5/20/2025
King	Deidra	BH/ABA-Telehealth	INITIAL	5/20/2025
Koelle	Jonathan	BH/ABA-Telehealth	INITIAL	5/20/2025
Kreymer	Jacqueline	BH/ABA-Telehealth	INITIAL	5/20/2025
Lajara	Kassandra	BH/ABA-Telehealth	INITIAL	5/20/2025
Lassettre	Victoria	BH/ABA	INITIAL	5/20/2025
Leasure	Bailey	BH/ABA-Telehealth	INITIAL	5/20/2025
Leasure	Jordyn	BH/ABA-Telehealth	INITIAL	5/20/2025
Lee	Nina	BH/ABA-Telehealth	INITIAL	5/20/2025
Lilley	Jacob	BH/ABA-Telehealth	INITIAL	5/20/2025
Love	Lester	BH/ABA	INITIAL	5/20/2025
Macis	Angela	BH/ABA-Telehealth	INITIAL	5/20/2025
Mai	Jessie	Primary Care Physician	INITIAL	5/20/2025
Mathew	Lincy	Primary Care Physician	INITIAL	5/20/2025
McAdams	Holly	BH/ABA	INITIAL	5/20/2025
McFerren	J'eannine	BH/ABA	INITIAL	5/20/2025
McMillan	Rosalind	BH/ABA	INITIAL	5/20/2025
McQueen	Bridget	BH/ABA	INITIAL	5/20/2025
Mercado	Valerie	BH/ABA-Telehealth	INITIAL	5/20/2025
Mokler	Rachel	BH/ABA-Telehealth	INITIAL	5/20/2025
Moolani	Ujjala	Specialist	INITIAL	5/20/2025
Mundo	Lakoyea	BH/ABA-Telehealth	INITIAL	5/20/2025
Mundo	Melissa	BH/ABA-Telehealth	INITIAL	5/20/2025
Munoz Rivera	Kenia	BH/ABA-Telehealth	INITIAL	5/20/2025
Najera	Emmanuel	BH/ABA-Telehealth	INITIAL	5/20/2025
Narog	Emily	BH/ABA-Telehealth	INITIAL	5/20/2025
Navarro	Nicolette	BH/ABA-Telehealth	INITIAL	5/20/2025
Nguyen	Maria	BH/ABA	INITIAL	5/20/2025
Olsen	Rebecca	BH/ABA	INITIAL	5/20/2025
Onofrei	Rares	Ancillary	INITIAL	5/20/2025
Orozco-Barajas	Jessica	BH/ABA-Telehealth	INITIAL	5/20/2025
Otto	Sara	BH/ABA-Telehealth	INITIAL	5/20/2025
Overstreet	Rachel	BH/ABA	INITIAL	5/20/2025
Pal	Jayanta	BH/ABA-Telehealth	INITIAL	5/20/2025
Patterson	Jennifer	Allied Health	INITIAL	5/20/2025
Petersen	Kate	BH/ABA	INITIAL	5/20/2025
Pierce	Rashida	Doula	INITIAL	5/20/2025
Pinkerton	Katrina	AHP SP_CHW	INITIAL	5/20/2025
Pipitone	Jessica	BH/ABA-Telehealth	INITIAL	5/20/2025
Powell	Kurita	Doula	INITIAL	5/20/2025
Primus	Frank	Specialist	INITIAL	5/20/2025
Pujara	Nikita	BH/ABA-Telehealth	INITIAL	5/20/2025
Raya	Lindsay	BH/ABA-Telehealth	INITIAL	5/20/2025
Rehart	Alyssa	BH/ABA-Telehealth	INITIAL	5/20/2025
Rhodes	Susan	BH/ABA	INITIAL	5/20/2025
Rockwood	Anne	BH/ABA	INITIAL	5/20/2025
Rodriguez	Jessica	BH/ABA-Telehealth	INITIAL	5/20/2025
Rothlind	Kalia	BH/ABA	INITIAL	5/20/2025
Rountree	Jessica	BH/ABA-Telehealth	INITIAL	5/20/2025
Roye-Madison	Marcia	Allied Health	INITIAL	5/20/2025
Sabharwal	Umesh	Specialist	INITIAL	5/20/2025

LAST NAME	FIRST NAME	CATEGORY	INITIAL / RE-CRED	CRED DATE
Saggboy	Michelle	BH/ABA-Telehealth	INITIAL	5/20/2025
Salgado	Stephanie	BH/ABA-Telehealth	INITIAL	5/20/2025
Sanchez	Felix	BH/ABA-Telehealth	INITIAL	5/20/2025
Sannaz	Keyhani	Doula	INITIAL	5/20/2025
Sarkaria	Sandeep	Specialist	INITIAL	5/20/2025
Schoneman	Katie	Specialist	INITIAL	5/20/2025
Seifoddini	Mahnoosh	Primary Care Physician	INITIAL	5/20/2025
Serrano	Andrea	BH/ABA-Telehealth	INITIAL	5/20/2025
Shahbazi	Anahita	BH/ABA-Telehealth	INITIAL	5/20/2025
Shaw	Melauree	BH/ABA-Telehealth	INITIAL	5/20/2025
Shirley	Bryanna	BH/ABA-Telehealth	INITIAL	5/20/2025
Simko	Marissa	Allied Health	INITIAL	5/20/2025
Simms	Shala	BH/ABA-Telehealth	INITIAL	5/20/2025
Slown	Samuel	Allied Health	INITIAL	5/20/2025
Smith	Ryan	BH/ABA	INITIAL	5/20/2025
Stark	Rohn	BH/ABA	INITIAL	5/20/2025
Starkey	Cherrilyn	BH/ABA-Telehealth	INITIAL	5/20/2025
Stewart	Shelby	Doula	INITIAL	5/20/2025
Stockton	Natalie	BH/ABA	INITIAL	5/20/2025
Swayzer	Cassandra	BH/ABA	INITIAL	5/20/2025
Tabares	Blanca	BH/ABA-Telehealth	INITIAL	5/20/2025
Tan	Alison	BH/ABA	INITIAL	5/20/2025
Tarrant	Christine	BH/ABA	INITIAL	5/20/2025
Teacher	Teresa	BH/ABA-Telehealth	INITIAL	5/20/2025
Thao	Lee	BH/ABA-Telehealth	INITIAL	5/20/2025
Thind	Sukhbir	Allied Health	INITIAL	5/20/2025
Thomas	Jacob	BH/ABA-Telehealth	INITIAL	5/20/2025
Threadgill-Powderll	Johnetta	BH/ABA	INITIAL	5/20/2025
Tindall	Connor	BH/ABA	INITIAL	5/20/2025
Tran	Adrienne	BH/ABA-Telehealth	INITIAL	5/20/2025
Trevor	Everrett	Specialist	INITIAL	5/20/2025
Trottier	Audrey	BH/ABA-Telehealth	INITIAL	5/20/2025
Truex	Laura	BH/ABA-Telehealth	INITIAL	5/20/2025
Tyler	Carol	BH/ABA-Telehealth	INITIAL	5/20/2025
Tymon	Halee	BH/ABA-Telehealth	INITIAL	5/20/2025
Uche	Simon	BH/ABA-Telehealth	INITIAL	5/20/2025
Ushijima-Mwesigwa	Keiko	BH/ABA	INITIAL	5/20/2025
Valdez	Esau	BH/ABA	INITIAL	5/20/2025
Valentine	Daniel	BH/ABA	INITIAL	5/20/2025
Vasquez	Thania	BH/ABA-Telehealth	INITIAL	5/20/2025
Venegas	Stephanie	BH/ABA-Telehealth	INITIAL	5/20/2025
Verduzco	Judith	BH/ABA	INITIAL	5/20/2025
Vermeulen	Jessica	BH/ABA-Telehealth	INITIAL	5/20/2025
Vien	Eliza	Specialist	INITIAL	5/20/2025
Vieni	Jeannine	BH/ABA	INITIAL	5/20/2025
Villegas	Monserrat	BH/ABA-Telehealth	INITIAL	5/20/2025
Viviani	Alicia	BH/ABA-Telehealth	INITIAL	5/20/2025
Walker	Ebony	BH/ABA	INITIAL	5/20/2025
Wang	Hsinyi	BH/ABA	INITIAL	5/20/2025
Ward	Kelly	BH/ABA-Telehealth	INITIAL	5/20/2025
Watkins	Heather	BH/ABA	INITIAL	5/20/2025
Watson	Courtney	BH/ABA	INITIAL	5/20/2025
Watson	Kimesha	BH/ABA	INITIAL	5/20/2025
Wehner	JesSeLa	Doula	INITIAL	5/20/2025
Wei	Man-Tso	BH/ABA	INITIAL	5/20/2025
Weidman	Mikaela	BH/ABA	INITIAL	5/20/2025
Wiestling	Sarah	BH/ABA-Telehealth	INITIAL	5/20/2025
Williams	Karina	BH/ABA-Telehealth	INITIAL	5/20/2025
Williams	Melody	BH/ABA-Telehealth	INITIAL	5/20/2025

LAST NAME	FIRST NAME	CATEGORY	INITIAL / RE-CRED	CRED DATE
Williams	Traci	BH/ABA	INITIAL	5/20/2025
Woltmann	Tai	BH/ABA-Telehealth	INITIAL	5/20/2025
Young	Oliesha	BH/ABA-Telehealth	INITIAL	5/20/2025
Zachary	Alexandra	BH/ABA-Telehealth	INITIAL	5/20/2025
Zaragoza	Diana	BH/ABA-Telehealth	INITIAL	5/20/2025
Zarghamravanbakhsh	Paria	Specialist	INITIAL	5/20/2025
Zhang	Shiyu	BH/ABA-Telehealth	INITIAL	5/20/2025
Zhou	Ying	BH/ABA	INITIAL	5/20/2025
Akkinapalli	Neelima	Allied Health	RE-CRED	5/20/2025
Alwattar	Basil	Specialist	RE-CRED	5/20/2025
Angle	Niren	Specialist	RE-CRED	5/20/2025
Armani	Kathy	Ancillary	RE-CRED	5/20/2025
Athos	Laurence	Specialist	RE-CRED	5/20/2025
Balakrishnan	Sangeetha	Specialist	RE-CRED	5/20/2025
Baron	John	Specialist	RE-CRED	5/20/2025
Beg	Sumbul	Specialist	RE-CRED	5/20/2025
Bushman	Leah	Allied Health	RE-CRED	5/20/2025
Carter	Kristine	Allied Health	RE-CRED	5/20/2025
Deutsch	Robert	Specialist	RE-CRED	5/20/2025
Duir	Kimberly	Primary Care Physician	RE-CRED	5/20/2025
Economou	Vasiliki	Specialist	RE-CRED	5/20/2025
Ellis	Selena	Specialist	RE-CRED	5/20/2025
Fagan	James	Specialist	RE-CRED	5/20/2025
Fong	Stewart	Primary Care Physician	RE-CRED	5/20/2025
Gersten	Dana	Primary Care Physician	RE-CRED	5/20/2025
Ghosh	Dipankar	Primary Care Physician	RE-CRED	5/20/2025
Gordon	Stracey	Allied Health	RE-CRED	5/20/2025
Huet	Luisa	Allied Health	RE-CRED	5/20/2025
Ing	Dennis	Primary Care Physician	RE-CRED	5/20/2025
Jiang	Lei	Allied Health	RE-CRED	5/20/2025
Kang	Steven	Specialist	RE-CRED	5/20/2025
Kaur	Harpreet	Allied Health	RE-CRED	5/20/2025
Kelley	Kanwar	Specialist	RE-CRED	5/20/2025
Kragie	Alexandria	Specialist	RE-CRED	5/20/2025
Kramer	Arin	Allied Health	RE-CRED	5/20/2025
Kudaravalli	Padmavathi	Primary Care Physician	RE-CRED	5/20/2025
Lahsaei	Saba	Specialist	RE-CRED	5/20/2025
Lande	Arthur	Primary Care Physician	RE-CRED	5/20/2025
Lee	Peter	Specialist	RE-CRED	5/20/2025
Lerner	Dimitry	Specialist	RE-CRED	5/20/2025
Lien	Kenneth	Specialist	RE-CRED	5/20/2025
Lopez	Monica	Specialist	RE-CRED	5/20/2025
Lowery	William	Specialist	RE-CRED	5/20/2025
McBride	Thomas	Primary Care Physician	RE-CRED	5/20/2025
McDonald	Shivaun	Allied Health	RE-CRED	5/20/2025
Mehandru	Leena	Specialist	RE-CRED	5/20/2025
Nachtwey	Frederick	Specialist	RE-CRED	5/20/2025
Nguyen	Danielle	Primary Care Physician	RE-CRED	5/20/2025
Nguyen	Tam	Primary Care Physician	RE-CRED	5/20/2025
Nguyen	Thanh Trung	Allied Health	RE-CRED	5/20/2025
Nguyen-Magdael	Gina	Allied Health	RE-CRED	5/20/2025
Poggio	Anthony	Specialist	RE-CRED	5/20/2025
Poon	James	Allied Health	RE-CRED	5/20/2025
Proddatoori	Kruthika	Primary Care Physician	RE-CRED	5/20/2025
Rhodes	Katherine	Allied Health	RE-CRED	5/20/2025
Rishi	Rahul	Specialist	RE-CRED	5/20/2025
Rogers	Kallyn	Allied Health	RE-CRED	5/20/2025
Ruiz-Iniguez	Norma	Allied Health	RE-CRED	5/20/2025

LAST NAME	FIRST NAME	CATEGORY	INITIAL / RE-CRED	CRED DATE
Sabharwal	Maskeen	Specialist	RE-CRED	5/20/2025
Schott	Katherine	Allied Health	RE-CRED	5/20/2025
Silkiss	Rona	Specialist	RE-CRED	5/20/2025
Singh	Harpreet	Primary Care Physician	RE-CRED	5/20/2025
Smith	Amy	Allied Health	RE-CRED	5/20/2025
Sundar	Shalini	Specialist	RE-CRED	5/20/2025
Takeda	Alisa	Primary Care Physician	RE-CRED	5/20/2025
Tran	Yen	Allied Health	RE-CRED	5/20/2025
Trilesskaya	Marina	Specialist	RE-CRED	5/20/2025
Trinclisti	Bonita	Allied Health	RE-CRED	5/20/2025
Tsao	Lilian	Primary Care Physician	RE-CRED	5/20/2025
Veeragandham	Ramesh	Specialist	RE-CRED	5/20/2025
Wren	Jyesha	Allied Health	RE-CRED	5/20/2025

MAY PEER REVIEW AND CREDENTIALING
INITIAL APPROVALS BY SPECIALTY



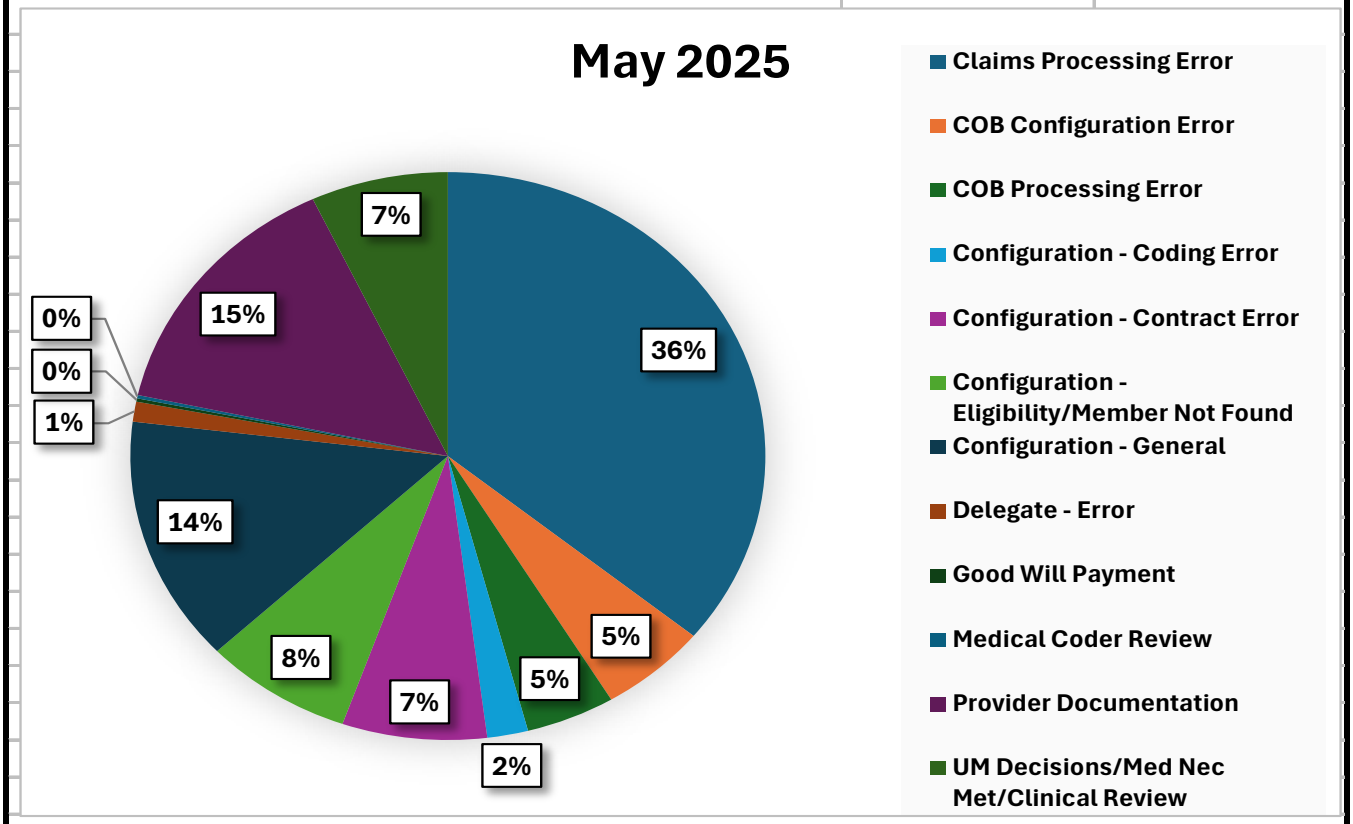
PCP	6
SPECIALIST	13
ANCILLARY	9
ALLIED	9
BH/ABA	150
TOTAL	187

Provider Dispute Resolution		
April 2025 and May 2025		
METRICS		
PDR Compliance	**Apr-25**	**May-25**
# of PDRs Resolved	1,889	2,517
# Resolved Within 45 Working Days	1,883	2,508
% of PDRs Resolved Within 45 Working Days	99.7%	99.6%
PDRs Received	**Apr-25**	**May-25**
# of PDRs Received	3,411	2,462
PDR Volume Total	**3,411**	**2,462**
PDRs Resolved	**Apr-25**	**May-25**
# of PDRs Upheld	1,354	1,988
% of PDRs Upheld	72%	79%
# of PDRs Overturned	535	529
% of PDRs Overturned	28%	21%
Total # of PDRs Resolved	**1,889**	**2,517**
Average Turnaround Time	**Apr-25**	**May-25**
Average # of Days to Resolve PDRs	37	40
Oldest Resolved PDR in Days	199	286
Unresolved PDR Age	**Apr-25**	**May-25**
0-45 Working Days	4,923	5,019
Over 45 Working Days	0	0
Total # of Unresolved PDRs	**4,923**	**5,019**

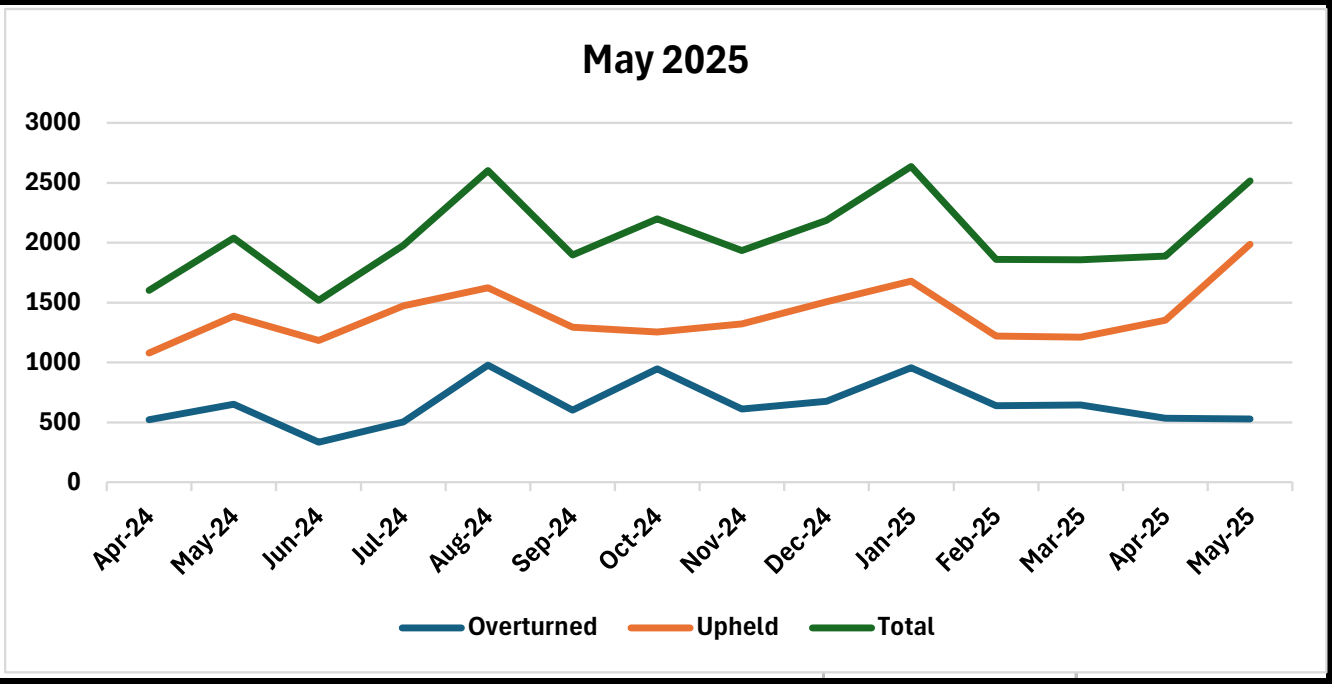
Provider Dispute Resolution
April 2025 and May 2025

May-25

PDR Resolved Case Overturn Reasons



Rolling 12-Month PDR Trend Line



Provider Dispute Resolution Year Over Year Summary

Monthly Results	Regulatory Requirements	AAH Goal
# of PDRs Resolved - 2,517 in May 2025 vs 2,039 in May 2024	N/A	N/A
# of PDRs Received - 2,462 in May 2025 vs 2,386 in May 2024	N/A	N/A
# of PDRs Resolved within 45 working days - 2,508 in May 2025 vs 2,029 in May 2024	N/A	N/A
% of PDRs Resolved within 45 working days - 99.6% in May 2025 vs 99.5% in May 2024	95%	95%
Average # of Days to Resolve PDRs - 40 days in May 2025 vs 43 days in May 2024	N/A	30
Oldest Resolved PDR in Days - 286 days in May 2025 vs 52 days in May 2024	N/A	N/A
# of PDRs Upheld -1,988 in May 2025 vs 1,388 in May 2024	N/A	N/A
% of PDRs Upheld - 79% in May 2025 vs 68% in May 2024	N/A	> 75%
# of PDRs Overturned - 529 in May 2025 vs 651 in May 2024	N/A	N/A
% of PDRs Overturned - 21% in May 2025 vs 32% in May 2024	N/A	< 25%
PDR Overturn Reasons: Claims processing errors - 36% (2025) vs 16% (2024) Configuration errors - 31% (2025) vs 35% (2024) COB -10% (2025) vs 16% (2024) Clinical Review/UM Decisions/Medical Necessity Met - 23% (2025) vs 16% (2024)	N/A	N/A

COMMUNICATIONS & OUTREACH DEPARTMENT

ALLIANCE IN THE COMMUNITY

FY 2024-2025 | **MAY 2025 OUTREACH REPORT**

ALLIANCE IN THE COMMUNITY
FY 2024-2025 | MAY 2025 OUTREACH REPORT

In May 2025, the Alliance completed **1083** member orientation outreach calls among net new and non-utilizer members and conducted **80** net new member orientations and **12** non-utilizer member orientations (**8%** member participation rate). In addition, in May 2025, the Outreach team completed **44** Alliance website inquiries, **4** service requests, and **4** member education events. The Alliance reached a total of **266** people and spent a total of $0 on donations, fees, and/or sponsorships at the Key Academy Night Market, Senior Wellness Fair in Oakland, Community Support Summit and Reach for A Better Community 2025 events.*

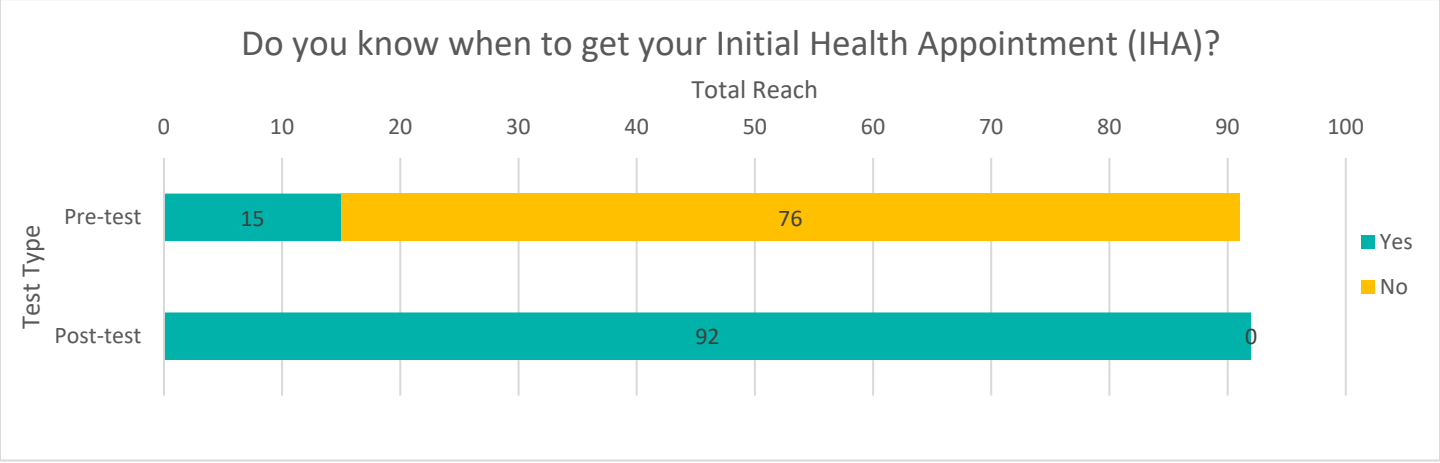
The Communications & Outreach Department began reporting the number of members reached during outreach activities in late February 2018. Since July 2018, **38,473** self-identified Alliance members have been reached during outreach activities.

On Monday, March 16, 2020, the Alliance began helping members by telephone only, following the statewide Shelter-in-Place (SIP) guidance to protect the public from Coronavirus Disease (COVID-19). Subsequently, the Alliance proactively postponed all face-to-face member orientations until further notice.

On **Wednesday, March 18, 2020,** the Alliance began conducting member orientations by phone. As of May 31, 2025, the Outreach Team has completed **49,513** member orientation outreach calls and conducted **9,797** member orientations (**19.8%** member participation rate).

The Alliance Member Orientation (MO) program has existed since August 2016. In 2019, the program was recognized as a promising practice to increase member knowledge and awareness about the Initial Health Appointment (IHA) by the Department of Health Care Services (DHCS), Managed Care Quality and Monitoring Division (MCQMD). We have steadily increased program participation. Our 2019 6-month average participation rate was **111** members per month. Between May 1, through May 31, 2025 (21 working days) – **92** members completed an MO by phone.

After completing the MO **100%** of members who completed the post-test survey in May 2025 reported knowing when to get their IHA, compared to only **16.5%** of members knowing when to get their IHA in the pre-test survey.



All report details can be reviewed at: **W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Outreach Reports\FY 24-25\Q4\May 2025**

ALLIANCE IN THE COMMUNITY

FY 2024-2025 | MAY 2025 OUTREACH REPORT

FY 2023-2024 MAY 2024 TOTALS

- 3 COMMUNITY EVENTS
- 2 MEMBER EDUCATION EVENTS
- 150 MEMBER ORIENTATIONS
- 1 MEETINGS/ PRESENTATIONS/
- 0 COMMUNITY TRAINING
- 9 TOTAL INITIATED/ INVITED EVENTS
- 156 TOTAL COMPLETED **EVENTS**

16 CITIES**

Alameda
Albany
Berkeley
Castro Valley
Dublin
Fremont
Hayward
Livermore
Newark
Oakland
Pleasanton
Sacramento
San Leandro
San Lorenzo
San Ramon
Union City

- 635 TOTAL REACHED AT COMMUNITY EVENTS
- 360 TOTAL REACHED AT MEMBER EDUCATION EVENTS
- 150 TOTAL REACHED AT MEMBER ORIENTATIONS
- 13 TOTAL REACHED AT MEETINGS/PRESENTATIONS
- 0 TOTAL REACHED AT COMMUNITY TRAINING
- 537 MEMBERS REACHED AT ALL EVENTS
- 1158 **TOTAL REACHED AT ALL EVENTS**

$430.00
TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

FY 2024-2025 MAY 2025 TOTALS

- 0 COMMUNITY EVENTS
- 4 MEMBER EDUCATION EVENTS
- 92 MEMBER ORIENTATIONS
- 0 MEETINGS/ PRESENTATIONS
- 0 COMMUNITY TRAINING
- 12 TOTAL INITIATED/ INVITED EVENTS
- 96 TOTAL COMPLETED **EVENTS**

12 CITIES**

Alameda
Ashland
Berkeley
Dublin
Fremont
Hayward
Livermore
Oakland
Pleasanton
San Leandro
San Lorenzo
Union City

- 0 TOTAL REACHED AT COMMUNITY EVENTS
- 266 TOTAL REACHED AT MEMBER EDUCATION EVENTS
- 92 TOTAL REACHED AT MEMBER ORIENTATIONS
- 0 TOTAL REACHED AT MEETINGS/PRESENTATIONS
- 0 COMMUNITY TRAINING
- 217 MEMBERS REACHED AT ALL EVENTS
- 358 **TOTAL REACHED AT ALL EVENTS**

$0.00
TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

***Cities represent the mailing address designations for members who completed a member orientation by phone and community event. The italicized cities are outside of Alameda County. The C&O Department started including these cities in the Q3 FY21 Outreach Report.*

Compliance

Richard Golfin III

To: **Alameda Alliance for Health Board of Governors**

From: **Richard Golfin III, Chief Compliance & Privacy Officer**

Date: **June 13th, 2025**

Subject: **Compliance Division Report**

Enterprise Audit Updates

- 2025 Department of Managed Health Care (DMHC) and Department of Health Care Services (DHCS) Routine Full Medical Survey
    - The DMHC lookback period spans October 1st, 2022, through September 30th, 2024, while the DHCS lookback period covered June 1st, 2024, through February 28th, 2025. Both agencies conducted onsite interview sessions from March 3rd to March 7th, 2025.
    - During its preliminary exit session on March 20th, 2025, the DHCS shared three concerns regarding Post-Stabilization Authorization (PSA): The Plan did not consistently authorize PSA in a timely manner, ensure 24/7 physician availability, or transfer out-of-network hospitalized members as required.
    - The department stated that these observations are preliminary and subject to further review. The DHCS has scheduled a formal exit conference for June 11th, 2025, and the Plan anticipates receiving the preliminary report beforehand. The DMHC preliminary report is due to the Plan ninety (90) days from completion of the survey (June 2025).
- 2024 Department of Health Care Services (DHCS) Routine Full Medical Survey
    - The DHCS conducted its 2024 Routine Full Medical Survey from June 17th, 2024, through June 28th, 2024. The Plan received its Final Audit Report on November 18th, 2024, citing twenty (20) final audit findings. Monthly CAP updates were submitted to the DHCS by the 15th of each month. To date eight (8) CAPs have been accepted, nine (9) CAPs have been partially accepted, one (1) CAP has a question, and two (2) CAPs are pending deliverables. The final CAP update was submitted timely on May 21st, 2025. The Plan is awaiting DHCS' review.
- 2023 Department of Health Care Services (DHCS) Focused Medical Survey
    - On September 4th, 2024, the DHCS issued the Final Medical Survey Audit Report and CAP Request for the 2023 DHCS Focused Medical Survey. The DHCS identified findings related to Behavioral Health Services and Transportation Services. Nine (9) CAPs were identified. To date six (6) CAPs have been accepted and three (3) CAPs have been partially accepted. The

Plan submitted the last update on May 18th, 2025. The Plan is awaiting DHCS' review and response.

- 2025 Department of Managed Health Care (DMHC) Financial Examination
    - On April 14th, 2025, the DMHC notified the Plan of its intent to conduct a routine examination of the Plan's fiscal and administrative affairs, including an examination of the financial report for the quarter ended March 31st, 2025. The pre-audit materials are due to the department on June 16th, 2025. The Plan is on track for timely submission.
    - The examination will begin on August 4th, 2025, and will be conducted remotely.
- 2025 Health Services Advisory Group, Inc. (HSAG) Network Adequacy Validation Audit (NAV)
    - On May 29th, 2025, the Plan received the document request packet, including the audit memo, from HSAG. The technical assistance webinar on June 5th, 2025, will cover the audit activities and the document request packet. Pre-audit materials are due to HSAG by July 17th, 2025. Virtual interviews will be scheduled from August 11th to September 5th, 2025, with an expected duration of 2–3 days.
- 2025 AAH Compliance Audit Tool Enhancement
    - As part of strengthening the Alliance's privacy posture, additional privacy checks were strategically embedded into the 2025 AAH Compliance Audit Tool. This enhancement ensures that all delegates, subcontractors, and vendors handling PHI are monitored for compliance with HIPAA and contractual requirements. Key focus areas include timely incident escalation, verification of PHI return or secure destruction at the end of engagement, and documentation of safeguards for delegates, subcontractors, and vendors. These measures not only reduce the risk of improper disclosures but also promote accountability and transparency across third-party relationships.

Compliance Program Activity – All LOBs

- Bid and Formulary Submission
    - The Plan successfully submitted its CY2026 Medicare Bid and Formulary to the Centers for Medicare & Medicaid Services (CMS) on the required deadline of June 2nd, 2025. The submission process was completed smoothly and without any technical or compliance issues. All required documentation and data elements were validated and accepted by CMS.

- Centers for Medicare & Medicaid Services (CMS) D-SNP Application and Model of Care (MOC)

    - On April 14th, 2025, the Alliance received a CMS cure notice indicating that CMS determined that the Plan's contracted network of facilities did not meet the network standards. CMS evaluated the Alliance's response and granted conditional approval on May 14th, 2025.

- Department of Health Care Services (DHCS)

    - The Alliance is awaiting the issuance of the State Medicaid Agency Contract (SMAC).

- Department of Managed Health Care (DMHC) Medicare Filings

    - CY26 Medicare, 2024 EAE D-SNP Material Modification Filing (E-Filing No. 20244060). On May 9th, 2025, the Plan responded to and is awaiting DMHC's further comments or an approval and closeout by June 8th, 2025.

- New Legislation

    - On March 21st, 2025, Compliance submitted DMHC's 2024 Annual Newly Enacted Statutes All Plan Letter (APL 24-023) filing. This APL includes seventeen newly enacted laws that impact the Plan's Medi-Cal and/or Group Care lines of business. On April 17th, 2025, DMHC sent 24 comments. Compliance submitted a response to the Comment Table on May 23rd, 2025, and continues to collaborate with subject matter experts to successfully implement all legislations and demonstrate compliance. Notably, Senate Bill 729 (Health Care Coverage: Treatment for Infertility and Fertility Services) was intended to become effective on July 1st, 2025. However, a Trailer Bill Language has been proposed to delay the implementation to January 1st, 2026. Despite the proposed delay, Compliance continues to partner with its internal workgroup to identify the necessary operational activities.

    - On April 1st, 2025, DMHC published APL 25-007 which provides guidance and outlines compliance requirements related to Assembly Bill 3275. The bill, effective January 1st, 2025, adjusts the claims reimbursement timeframe from 45 working days to 30 calendar days. Compliance has created several workstreams to submit an e-Filing to DMHC by August 1st, 2025.

- 2024 Board of Governors Training
    - As outlined in the Compliance Plan, the Plan has assigned HIPAA and FWA training to all new and standing members of the Board. Of the eighteen Board members, fifteen (83%) have either completed their training or submitted sufficient proof of equivalent outside training, and three (17%) have not started. The Plan continues efforts to encourage the Board of Governors to complete the required 2024 BOG Training. The Plan continues coordination with the Board Clerk and the Board Chair to improve Board training rates of compliance and will be scheduling an in person or virtual training opportunity for the three Board of Governors still needing to complete the training.

Compliance

Supporting Documents

2025 APL IMPLEMENTATION TRACKING LIST						
#	Date Released	Regulatory Agency	APL #	APL Title	LOB	APL Purpose Summary
1	1/9/2025	DMHC	25-001	Southern California Fires and Enrollees' Continued Access to Health Care Services	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) 25-001, which provides information regarding Health and Safety Code section 1368.7.
2	1/17/2025	DHCS	25-001	2024-2025 Medi-Cal Managed Care Health Plan Meds/834 Cutoff and Processing Scheduling	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with the 2024-2025 Medi-Cal Eligibility Data System (MEDS)/834 cutoff and processing schedule.
3	1/13/2025	DHCS	25-002	Skilled Nursing Facility Workforce Quality Incentive Program	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with instructions on the payment and data sharing process required for the Skilled Nursing Facility (SNF) Workforce and Quality Incentive Program (WQIP) for Rating Periods between January 1, 2023, and December 31, 2026. The Calendar Year (CY) 2023 Rating Period is referred to as Program Year (PY) 1, CY 2024 Rating Period as PY 2, and so forth.
4	1/15/2025	DHCS	25-003	Establishing D-SNPs by 2026	DSNP	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with information regarding the Department of Health Care Services' (DHCS) enforcement of California Welfare and Institutions Code (W&I) section 14184.208, related to the requirement for MCPs to operate or be affiliated with a Dual Eligible Special Needs Plan (D-SNP) by 2026, to provide integrated care through affiliated MCPs and D-SNPs for dually eligible Medicare and Medi-Cal Members.
5	1/28/2025	DMHC	25-002	Plan Year 2026 QHP, QDP, and Off-Exchange Filing Requirements	N/A	The Department of Managed Health Care (Department) issues this All Plan Letter (APL) 25-002 to assist in the preparation of Plan Year 2026 regulatory submissions, in compliance with the Knox- Keene Act at California Health and Safety Code sections 1340 et seq. (Act) and regulations promulgated by the Department at California Code of Regulations, title 28 (Rules).
6	2/5/2025	DMHC	25-003	Large Group Renewal Notice Requirements	GROUP CARE	The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 25-003 to provide guidance to plans on the timing and content requirements for renewal notices to large group contractholders under HSC section 1374.21 and HSC section 1385.046.
7	2/7/2025	DHCS	25-004	Community Reinvestments Requirements	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with guidance regarding the MCP Contract's requirement that MCPs reinvest a minimum level of their net income into their local communities.
8	2/12/2025	DHCS	25-005	Standards For Determining Threshold Languages, Nondiscrimination Requirements, Language Assistance Services, And Alternative Formats	MEDI-CAL	This All Plan Letter (APL) serves to inform all Medi-Cal managed care plans (MCPs) of the dataset for threshold and concentration languages and clarifies the threshold and concentration standards specified in state and federal law and the MCP Contract. This dataset identifies the threshold and concentration languages in which, at a minimum, MCPs must provide written translated Member information. This APL also provides guidance on federal and state requirements regarding nondiscrimination, discrimination grievance procedures, language assistance, and communications with individuals with disabilities as set forth in the federal regulations implementing Section 1557 of the Patient Protection and Affordable Care Act (ACA), Title 42 of the Code of Federal Regulations (CFR) Part 438, Senate Bill (SB) 223 (Atkins, Chapter 771, Statutes of 2017), and SB 1423 (Hernandez, Chapter 568, Statutes of 2018)
9	3/12/2025	DMHC	25-004	AB 118: Part 1 - Compliance with Large Group Standardized Evidence of Coverage/Disclosure Form	GROUP CARE	Assembly Bill (AB) 118 (Ting, Chapter 42, Statutes of 2023) added Health and Safety Code section 1363.3 and revised Sections 1352.1, 1363, 1367.041, and 1367.24, effective January 1, 2025. These statutory changes apply to all commercial full-service health care service plans (plans), and require the Department of Managed Health Care (DMHC) to develop standardized templates for various documents describing health plan member benefits, such as the Evidence of Coverage (EOC), Disclosure Form (DF), Schedule of Benefits (SOB), Explanation of Benefits (EOB), and Cost-Share Summary (CSS). The DMHC's work to implement AB 118's requirement to develop standardized templates will be an iterative process. The first part of the standardized EOC/DF will be the following template components: (1) Exclusions and Limitations, (2) Members' Rights and Responsibilities, and (3) Definitions, for use in large group health care service plan contracts issued, amended, or renewed on or after January 1, 2026. This All Plan Letter (APL) and its accompanying attachments set out the filing requirements needed to demonstrate compliance with each template component.
10	3/19/2025	DMHC	25-005	Southern California Fires and Flexibilities to Impacted Providers	GROUP CARE & MEDI-CAL	On January 7, 2025, California Governor Gavin Newsom declared a State of Emergency in Los Angeles and Ventura Counties due to wildfires. The fires destroyed homes and businesses and displaced enrollees and health care providers. After the Governor declares a state of emergency, Health and Safety Code section 1368.7 allows the DMHC to take actions to help mitigate the impact to enrollees and providers.
11	3/21/2025	DMHC	25-006	Health Plan Coverage of Mobile Crisis Services	GROUP CARE	This APL provides guidance regarding the obligations of health plans related to behavioral health crisis services provided to an enrollee by a 988 center or mobile crisis team.
12	4/1/2025	DMHC	25-007	Assembly Bill 3275 Guidance (Claim Reimbursement)	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) under the Knox-Keene Health Care Service Plan Act of 1975, as amended, to provide guidance to health care service plans (plans) on requirements for the processing and reimbursement of claims for health care services with a date of receipt on or after January 1, 2026. Assembly Bill 3275 (Soria, 2024) amended Health and Safety Code sections 1371 and 1371.35 relating to reimbursement of claims for health care services, and enacted Health and Safety Code section 1371.34 enhancing consumer protections relating to grievances about claims for health care services.

#	Date Released	Regulatory Agency	APL #	APL Title	LOB	APL Purpose Summary
13	4/9/2025	DMHC	25-008	Provider Directory Annual Filing Requirements	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (the Department) issues this All Plan Letter (APL) to remind health care service plans (plans) of California Health and Safety Code section 1367.27, subdivision (m)'s requirement to annually submit provider directory policies and procedures to the Department. In addition, the Department reminds plans to submit the changes to their provider directory policies and procedures as instructed in APL 24-018 – Compliance with Senate Bill 923.
14	4/15/2025	DMHC	25-009	2025 Health Plan Annual Assessments	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) to provide information to health care service plans (health plans) pertaining to the DMHC's fiscal year (FY) 2025-26 annual assessment.
15	4/25/2025	DHCS	25-006	Timely Access Requirements	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with guidance regarding the ongoing requirement to meet timely access standards as outlined in Health and Safety Code (H&S) section 1367.03, as set forth by Senate Bill (SB) 221 (Chapter 724, Statutes of 2021) and SB 225 (Chapter 601, Statutes of 2022). MCPs are required to comply with these requirements pursuant to Welfare and Institutions Code (W&I) section 14197(d)(1)(a).1 Additionally, this APL outlines the required minimum performance levels (MPLs) as set by the Department of Health Care Services (DHCS) which go into effect Measurement Year (MY) 2025 for the Timely Access Survey.
16	4/25/2025	DHCS	25-007	Enforcement Actions: Corrective Action Plans, Administrative and Monetary Sanctions	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide clarification to Medi-Cal managed care plans (MCPs) of the Department of Health Care Services' (DHCS) policy regarding the imposition of enforcement actions, including corrective action plans, and administrative and monetary sanctions, which are among the enforcement actions DHCS may take to enforce compliance with MCP contractual provisions and applicable state and federal laws.
17	5/5/2025	DHCS	25-008	Hospice Services and Medi-Cal Managed Care	MEDI-CAL	The purpose of this All Plan Letter (APL) is to highlight contractual, regulatory, and statutory requirements applicable to Medi-Cal managed care plans (MCPs) with respect to their responsibilities to provide Medically Necessary hospice services to their MCP Members.
18	5/12/2025	DHCS	25-009	Commyunity Advisory Committee	MEDI-CAL	The purpose of this All Plan Letter (APL) is to summarize the Community Advisory Committee (CAC) requirements and provide Medi-Cal managed care plans (MCP) with information and guidance regarding their responsibility to implement, maintain, and maximize Member, family, and community engagement through the CAC.
19	5/20/2025	DMHC	25-010	Sections 1357.503 and 1357.505 MEWA Registration and Annual Compliance Requirements	N/A	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) to inform health care service plans (Plans) and association of employers defined as multiple employer welfare arrangements (MEWAs) of the requirements of AB 2072 (Weber, Ch. 374, Stats. 2024) and AB 2434 (Grayson, Ch. 398, Stats. 2024). This APL discusses the requirements on Plans and MEWAs for the initial MEWA registration pursuant to Section 1357.505. This APL also discusses the ongoing compliance requirements for Plans and registered MEWAs pursuant to Section 1357.503. Plans are asked to disseminate this information to their contracted MEWAs.
20	5/23/2025	DMHC	25-011	Health Plan Coverage of HIV Preexposure Prophylaxis (PrEP)	GROUP CARE & MEDI-CAL	On July 8, 2020 and July 6, 2021, the Department of Managed Health Care (DMHC) issued All Plan Letter (APL) 20-026 and 21-018 regarding health plans' obligations to cover Human Immunodeficiency Virus (HIV) antiretroviral drugs and preexposure prophylaxis (PrEP). This APL supplements the two prior APLs and gives further guidance to ensure health plans meet their obligations to cover PrEP with no prior authorization or cost-sharing.

ALAMEDA Alliance FOR HEALTH

Health care you can count on.
Service you can trust.

Health Care Services

Donna Carey, MD

To: **Alameda Alliance for Health Board of Governors**

From: **Dr. Donna Carey, Chief Medical Officer**

Date: **June 13th, 2025**

Subject: **Health Care Services (HCS) Report**

Operational Updates:

- Criteria changes to Community Supports paused due to two new policy guides released by DHCS on April 30, 2025.

Utilization Management (UM)

- Denial Rates
    - Overall, 2.5% (0.7% decrease from 2022)

- Authorization Turn-Around Times (goal = 95%)
    - Inpatient/outpatient: overall 98%, above goal
    - LTC: overall 98%, above goal
    - BH: overall 100%, MH 96%, both above goal

- Pharmacy:
    - Outpatient RX: overall 100%, above goal
    - Physician Administered Medications/Injections: overall 99%, above goal

- Over/Under Utilization Measures
    - ER visits: average 525 visits/K
    - Acute Inpatient Hospitalization Readmission Rate: 20.1%

- Opportunities incorporated into 2024 Program/Workplan:
    - Stabilizing team infrastructure
    - Enhanced coordination across internal departments to support Population Health Management and Quality Improvement activities
    - Increased collaboration with external partners to improve over/under utilization

Overall Authorization Volumes *(inpatient, outpatient, and long-term care):*

- Total authorization volume decreased month-over-month from April to May 2025.

Total Authorization Volume (Medical Services)			
Authorization Type	**March 2025**	**April 2025**	**May 2025**
Inpatient	2,963	3,688	3,390
Outpatient	4,008	5,597	4,926
Long-Term Care	1,124	909	844
Total	**8,095**	**10,194**	**9,160**

***Source**: #02569_AuthTAT_Summary*

- The following sections provide additional detail on utilization management trends in each department.

Utilization Management: Outpatient

- Foster care CoC cases continue to average 3-5/day. We are reviewing pended claims each week to identify CoC services and ensure there are no delays in the care for this population. With each case, we are reviewing for any potential care coordination or case management needs and referring to CM as needed.

- We continue to partner with our Medical Directors to review current prior authorization rules and evaluate which services should continue to require prior authorization, and which services should have prior authorization requirements removed (to decrease provider administrative burden).

- OP processed a total of 4,926 authorizations in the month of May. The decrease is related to changes in PA rules.

- OP Turnaround times continue to exceed the benchmark of 95% with the average being 99.3% in the month of May.

- The top 5 categories remain unchanged Radiology, OP Rehab, TQ, Home Health and Outpatient facility.

Total Outpatient Authorization Volume			
Authorization Status	**March 2025**	**April 2025**	**May2025**
Approvals	3,728	5,253	4,689
Partial Approvals	79	36	20
Denials	201	308	217
Total	**4,008**	**5,597**	4,926

***Source**: #02569_AuthTAT_Summary*

Outpatient Authorization Denial Rates			
Denial Rate Type	**March 2025**	**April 2025**	**May2025**
Overall Denial Rate	**3.5%**	**2.7%**	**4.8%**
Denial Rate Excluding Partial Denials	**3.3%**	**2.3%**	**4.4%**
Partial Denial Rate	**0.1%**	**0.4%**	**0.4%**

***Source**: #03690_Executive_Dashboard*

Outpatient Turn Around Time Compliance			
Line of Business	**March2025**	**April 2025**	**May 2025**
Overall	97.8%	99.2%	99.3%
Medi-Cal	98%	99.5%	99.2%
IHSS	100%	98.9%	98.8%
Benchmark	95%	*95%*	*95%*

***Source**: #02569_AuthTAT_Summary*

Utilization Management: Inpatient

- Total inpatient auth volume decreased slightly from 3,688 authorizations processed in April 2025 to 3,390 in the month of May.

- Inpatient overall average LOS increased from 6.3 in February to 6.6 in March, followed by a dramatic decrease to 5.3 in April. Admits per thousand increased from 46.6 in February to 49.0 in March, followed by a slight increase to 49.5 in April. Days per thousand 292.1 in February increased to 323.1 in March, falling to 262.7 in April. . The trend is consistent among Child, Adult, ACA and SPD categories.

- IP overall denial rate was 2.8% in March, and 1.3% in April, and 0.8% in May.

- IP Auth TAT compliance continues to meet or surpass 95% benchmark, with overall TAT of 97% in March, 95% in April and 97% in May.

- IP Concurrent clinical review standard process of validating appropriate acute level of care being provided to members in: including ICU, Telemetry/Intermediate/ICU step-down, Med/Surg and Administrative stay levels in Acute care and Long Term Acute Care hospitals. Recent implementation of process change involved matching appropriate authorized level of care in Auth system TruCare with Claims system HealthSuite. This change led to accurate matching of authorizations to claim/billing that resulted in significant savings.

- External hospital rounds are ongoing with UCSF, Stanford, Alameda Health System, Kindred LTACH, Kentfield LTACH, Washington, Eden, Alta Bates, and Summit, to review members' current active admissions discuss UM issues, address discharge barriers, offer other opportunities for supporting throughput and appropriate discharge.

- Kaiser interdisciplinary rounds began in January, with the goal of supporting AAH members at Kaiser facilities who have complex discharge needs and high ER utilization.

Total Inpatient Authorization Volume			
Authorization Status	**March 2025**	**April 2025**	**May 2025**
Approvals	3,023	3,613	3,308
Partial Approvals	0	0	0
Denials	62	75	82
Total	**2963**	**3688**	**3,390**

Source: #02569_AuthTAT_Summary

Inpatient Med-Surg Utilization			
Total All Aid Categories			
Actuals (excludes Maternity)			
Metric	**February 2025**	**March 2025**	**April 2025**
Authorized LOS	6.3	6.6	5.3
Admits/1,000	46.6	49.0	49.5
Days/1,000	292.1	323.1	262.7

Source: #01034_AuthUtilizationStatistics – *data only available through April 2025

Inpatient Authorization Denial Rates			
Denial Rate Type	**March 2025**	**April 2025**	**May 2025**
Full Denials Rate	2.1%	1.3%	0.8 %
Partial Denials	0.7%	.0%	0%
All Types of Denials Rate	2.8%	1.3%	0.8%

Source: #01292_AllAuthDenialsRates

Inpatient Turn Around Time Compliance			
Line of Business	**March 2025**	**April 2025**	**May 2025**
Overall	97%	95%	97%
Medi-Cal	97%	95%	97%
IHSS	100%	93%	96%
Benchmark	*95%*	*95%*	*95%*

Source: #02569_AuthTAT_Summary

Utilization Management: Long-Term Care

- LTC census during May 2025 was 2,312 members. This is an increase of 0.04% (1 member) from April 2025.

- Month to Month, the admissions, days and readmissions are decreasing. From March to April the admissions decreased by -60.14%, the days decreased by -63.47% and the readmissions also decreased by 60.61%. Some of this could be due to a lag in claims data being available, but we are seeing a decrease overall.

Totals	March 2025	April 2025	May 2025*
Admissions	138	55	Not Avail
Days	772	282	Not Avail
Readmissions	33	13	Not Avail

Source: #14236_LTC_Dashboard – data only available through April

- LTC Staff continue to participate in SNF collaboratives around the county to ensure that our facility partners are updated with the processes and program enhancements.

- Having virtual rounds with AHS, San Leandro, Kyakameena, Elmwood, Jones Convalescent and Eden LTC facilities to coordinate on complex cases

- Quarterly rounds with Regional Center of Easy Bay to discuss any ICF/DD members.

- Continued internal Long Term Care rounds to discuss members coming into and leaving a long-term care setting.

- Social Workers continue visiting LTC facilities in person, on a monthly and quarterly basis depending on census, to assist with discharge planning and access to other resources. The team continues referrals to TCS and other internal/external programs to provide wraparound support to members preparing to discharge from an LTC custodial facility.

- LTSS Liaison is visiting and meeting with facilities to discuss any claims issues and educating on processes.

- Health Navigator and dedicated RN continue to assist with TCS for members coming back from an acute stay or transitioning from acute into long-term care.

- The team is working closely with the facilities to assist in getting all long-term member AID Codes updated to reflect their long-term care status.

- Authorization volume decreased in May, compared to March and April.

- Authorization processing turn-around time (TAT) has remained between 98%- 99%, which is exceeding the threshold of 95%.

Total LTC Authorization Volume			
Authorization Status	**March 2025**	**April 2025**	**May2025**
Approvals	1079	877	811
Partial Approvals	0	0	0
Denials	45	32	33
Total	**935**	**909**	**844**

Source: #02569_AuthTAT_Summary

****Numbers change month over month based on the void and copy process to adjust authorizations for bed holds***

LTC Turn Around Time Compliance			
Line of Business	**March2025**	**April 2025**	**May 2025**
Medi-Cal	**~~99~~ ~~99.6%~~**	**~~9999%~~**	**~~99~~ 98%**
Benchmark	*95%*	*95%*	*95%*

Source: #02569_AuthTAT_Summary

Behavioral Health

- In May, the Behavioral Health Department processed 664 authorizations, 512 Care Coordination referrals, and 226 mental health screenings and transition of care tools.

Total BH Authorization Volume			
	25-Mar	**25-Apr**	**25-May**
Approvals	680	741	650
Partial Approval	0	0	0
Denials	9	8	14
Total	689	749	664

Source: 14939_BH_AuthTAT

Mental Health Turnaround Times

MH TAT			
	25-Mar	**25-Apr**	**25-May**
Determination TAT%	99%	97%	100%
Notification TAT%	96%	99%	96%

Behavioral Health Therapies (BHT/ABA) Turnaround Times

BHT TAT			
*Goal ≥95%	25-Mar	25-Apr	25-May
Determination TAT%	100%	100%	97%
Notification TAT%	100%	100%	100%

Behavioral Health Denial Rates

*Goal ≤ 5%	BH Denial Rates	
25-Mar	25-Apr	25-May
1%	1%	1%

Source: 14939_BH_AuthTAT

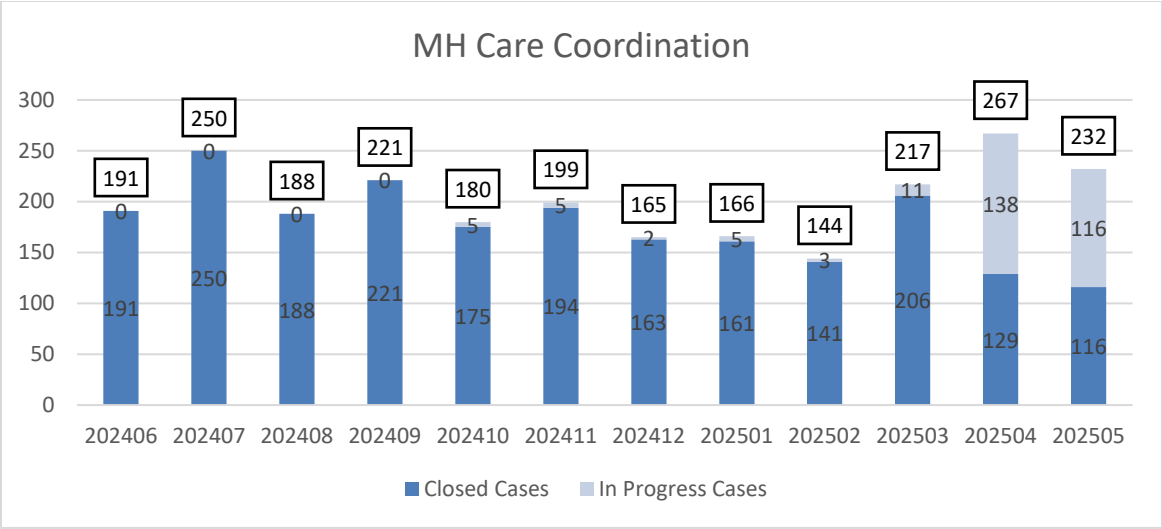
Mental Health Care Coordination

- In compliance with the No Wrong Door policy, the Alliance completes the DHCS-required screening tools when members are seeking to start new mental health services. The screening tools determine if members meet the criteria to be referred to ACBH for Specialty Mental Health Services.

Total # Medi-Cal Screenings & TOC			
	25-Mar	25-Apr	25-May
Youth Screenings	81	90	91
Adults Screenings	130	164	135
Transition of Care Tools	2	1	1

Source: 16015_MH_Assessments

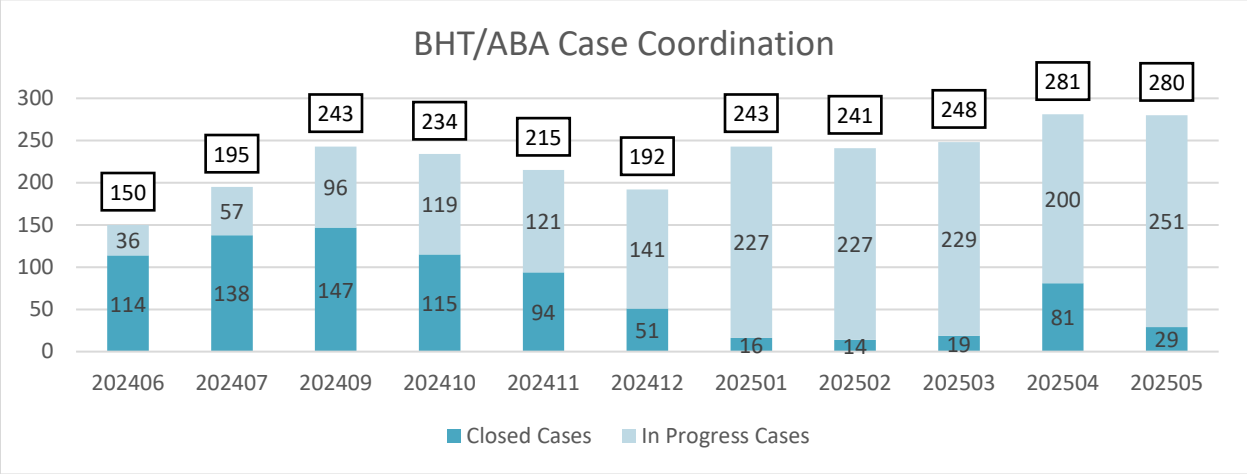
- Alliance licensed mental health clinicians, psychiatric nurses, and behavioral health navigators provide care coordination for members who need assistance accessing the mental health treatment services they need.



Source: 14665_BH_Cases

Behavioral Health Therapies (BHT/ABA)

- Children and youth referred for BHT/ABA services, including Applied Behavioral Analysis (ABA) and Comprehensive Diagnostic Evaluations (CDE), require Care Coordination to access the services needed. The Alliance manages each child's unique needs and follows up with parents and caregivers to resolve barriers to care.

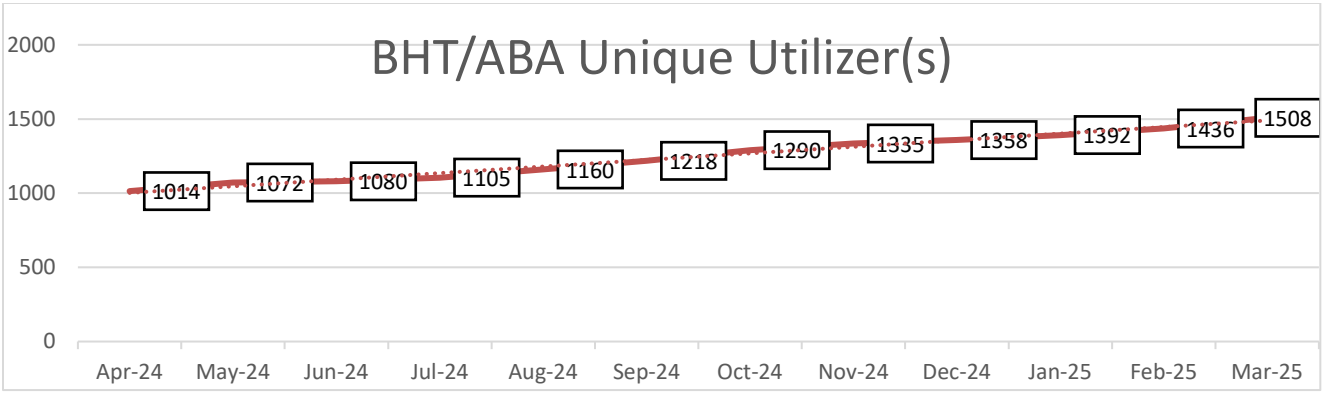


Source: 14665_BH_Cases

Behavioral Health Unique Utilizers

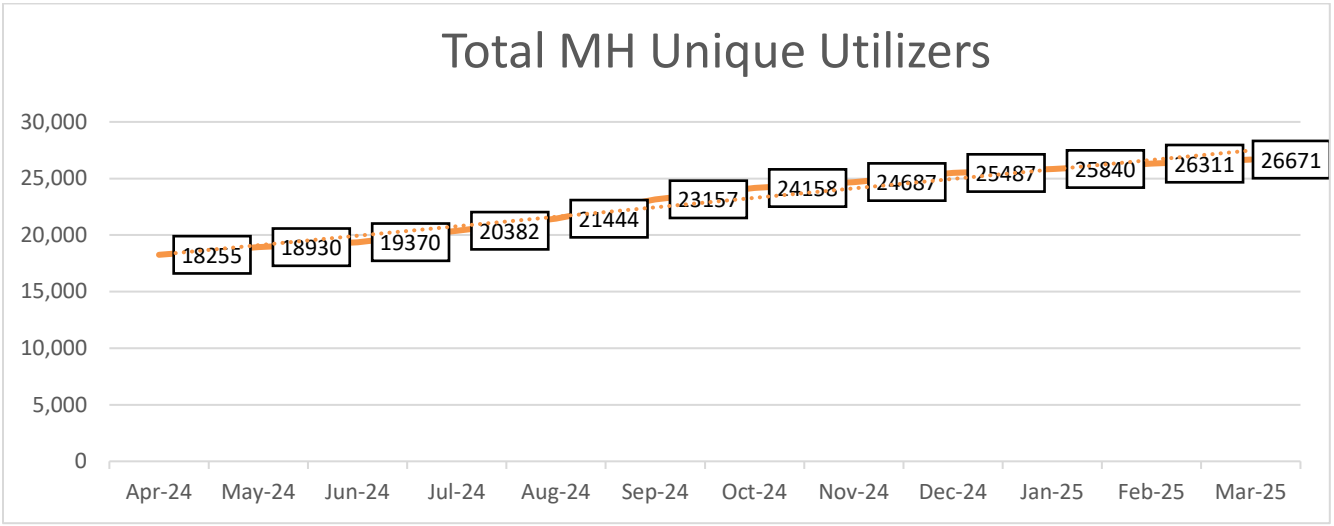
Removing barriers to accessing BHT/ABA services remains a primary goal for the Alliance Behavioral Health team. One way to measure that is to monitor unique utilizers who are accessing care when interventions are implemented.

- We observed a continuing rise in unique utilizers of BHT/ABA services, reflecting a 5% increase compared to the previous month.



Source: PBI 14621 BHT Utilization Report

- The number of unique utilizers of mental health services has increased by 1% compared to the previous month.



Source: PBI 14637 BH12M Report

Pharmacy

- Pharmacy Services process outpatient pharmacy claims, and pharmacy prior authorization (PA) has met turn-around time compliance for GroupCare line of business (LOB) for May, 2025:

LOB	Number of Outpatient PAs Processed	Turn Around Rate Compliance (%)
GroupCare	161	100%

Decisions	Number of PAs Processed in May, 2025
Approved	41
Denied	97
Closed	23
Total	**161**

- Medications for diabetes, weight management, nerve pain, osteoporosis, dry eye disease, eye inflammation and alopecia are in the top ten categories for denials.

May Ranking	Drug Name	Common Use	Common Denial Reason
1	JARDIANCE Tablet 10MG	Type 2 Diabetes	Criteria for approval not met
2	WEGOVY Soln Auto-inj 0.25MG/0.5ML	Weight Management	Criteria for approval not met
3	WEGOVY Soln Auto-inj 2.4MG/0.75ML	Weight Management	Criteria for approval not met
4	JARDIANCE Tablet 25MG	Diabetes	Criteria for approval not met
5	LIDOCAINE Patch 5%	Nerve Pain	Greater than 30-day supply
6	ZEPBOUND Soln Auto-inj 2.5MG/0.5ML	Weight Management	Criteria for approval not met
7	TERIPARATIDE Soln Pen-inj 620MCG/2.48ML	Osteoporosis	Criteria for approval not met
8	XIIDRA Solution 5%	Dry Eye Disease	Criteria for approval not met
9	DIFLUPREDNATE Emulsion 0.05%	Eye inflammation	Criteria for approval not met
10	FINASTERIDE Tablet 1MG	Alopecia	Criteria for approval not met

- Pharmacy is leading initiatives on PAD (physician administered drugs) focused internal and external partnership and reviewed PAD related UM authorizations as follows:

Top 10 Requested Drugs Submitted for Authorizations

HCPCS Code	Drug Name	Authorizations
J2919	INJ METHYLPRED SOD SUCC 5MG	219
J9035	INJECTION BEVACIZUMAB 10 MG	133
J7030	INFUS NORMAL SALINE SOL 1000 CC	94
J0585	BOTULINUM TOXIN TYPE A PER UNIT	89
J1100	INJ DEXMETHOSON SODIM PHOSHATE 1 MG	69
J0897	INJECTION DENOSUMAB 1 MG	68
J0178	INJECTION AFLIBERCEPT 1 MG	61
J9190	INJECTION FLUOROURACIL 500 MG	53
J2405	INJECTION ONDANSETRON HCL PER 1 MG	51
J2469	INJECTION PALONOSETRON HCL 25 MCG	50

Authorization Overview[1]

Line of Business	January 2025	February 2025	March 2025
IHSS	19	6	7
Medi-Cal	548	439	515

Turnaround Time and Determinations By Line of Business[2]

LOB	Determination	January 2025	February 2025	March 2025
Medi-Cal	Approved	369	326	345
	Denied/Partials	6	6	15
	TAT	99.47%	99.70%	99.72%
IHSS	Approved	15	6	6
	Denied/Partials	0	0	0
	TAT	100.0%	100.0%	100.0%

Case and Disease Management

- The CM team continues to assist the high volume of members needing Transitional Care Services (TCS) as they transition from one level of care to another. This includes member transitions where the Alliance is not the primary payor (such as members with Medicare primary insurance).

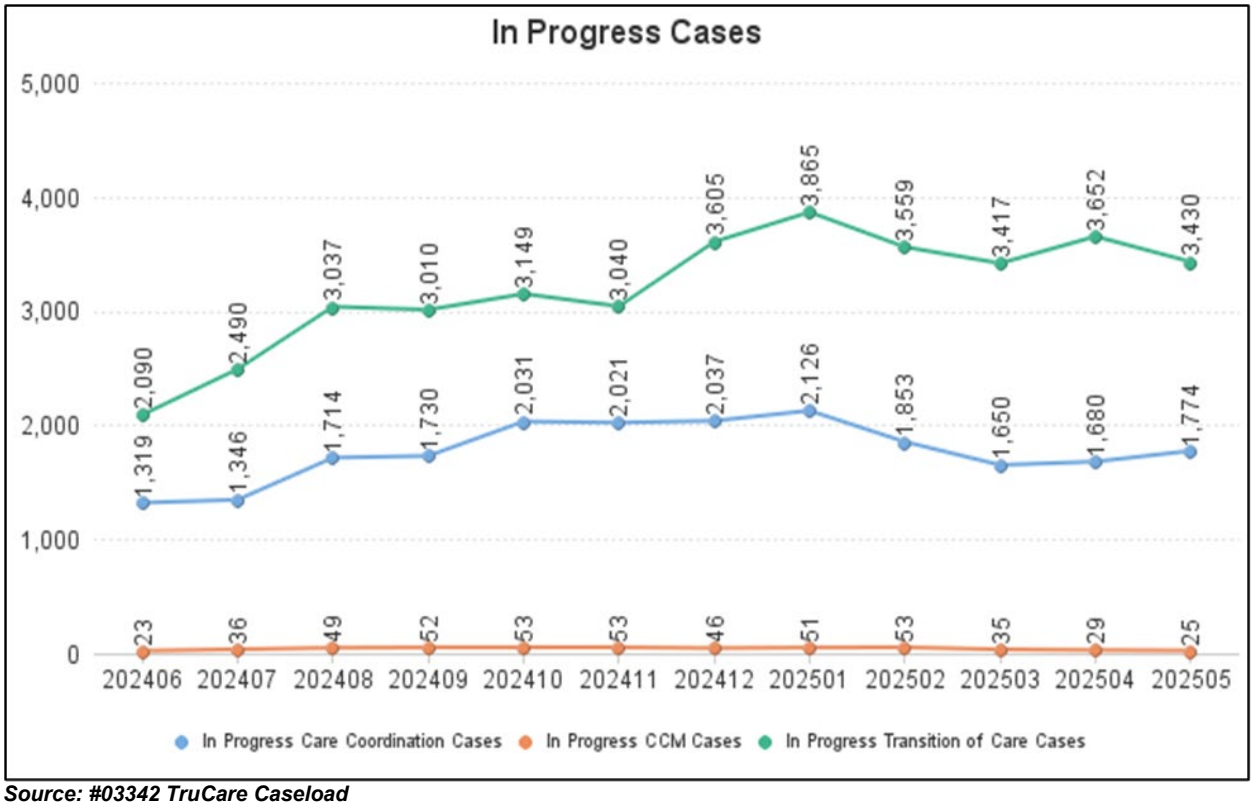
- The CM team continues to collaborate with clinic partners to ensure the TCS requirements are met, including but not limited to scheduling and ensuring follow-up appointments for members, informing members of CM services, notifying appropriate individuals of TCS services (hospital discharge planners, members, caregivers, support teams, etc.).

- CM is collaborating with UM and LTC to support members at hospitals with long-length stays and complex discharge barriers, including facilitating referrals to Community Supports, ECM and other community resources, as needed.

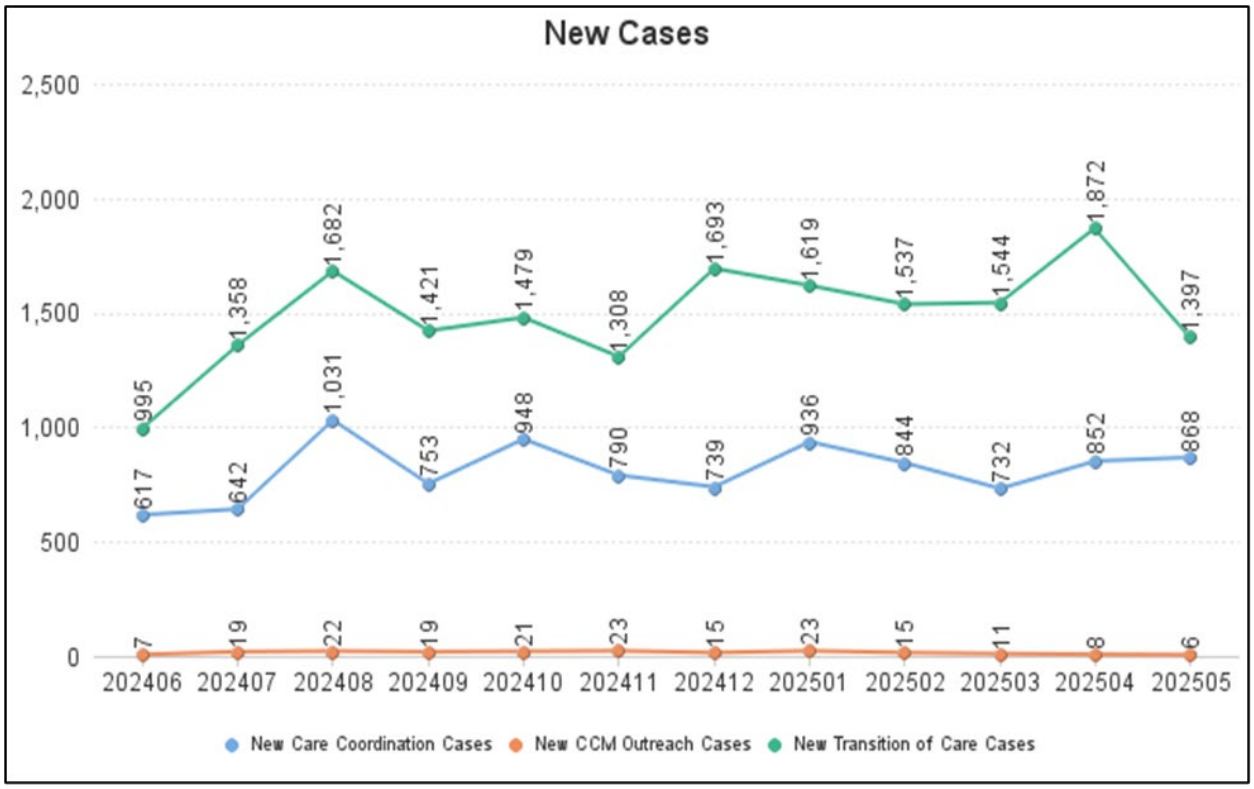
- CM is responsible for acquiring Physician Certification Statement (PCS) forms before Non-Emergency Medical Transportation (NEMT) trips to better align with DHCS requirements for members who need that higher level of transportation (former completed by Transportation broker, Modivcare). CM continues to educate the provider network, including hospital discharge planners, and dialysis centers about PCS form requirements. Transportation liaison has also increased oversight of

[2] Only includes authorizations that have been determined excluding closed authorizations.

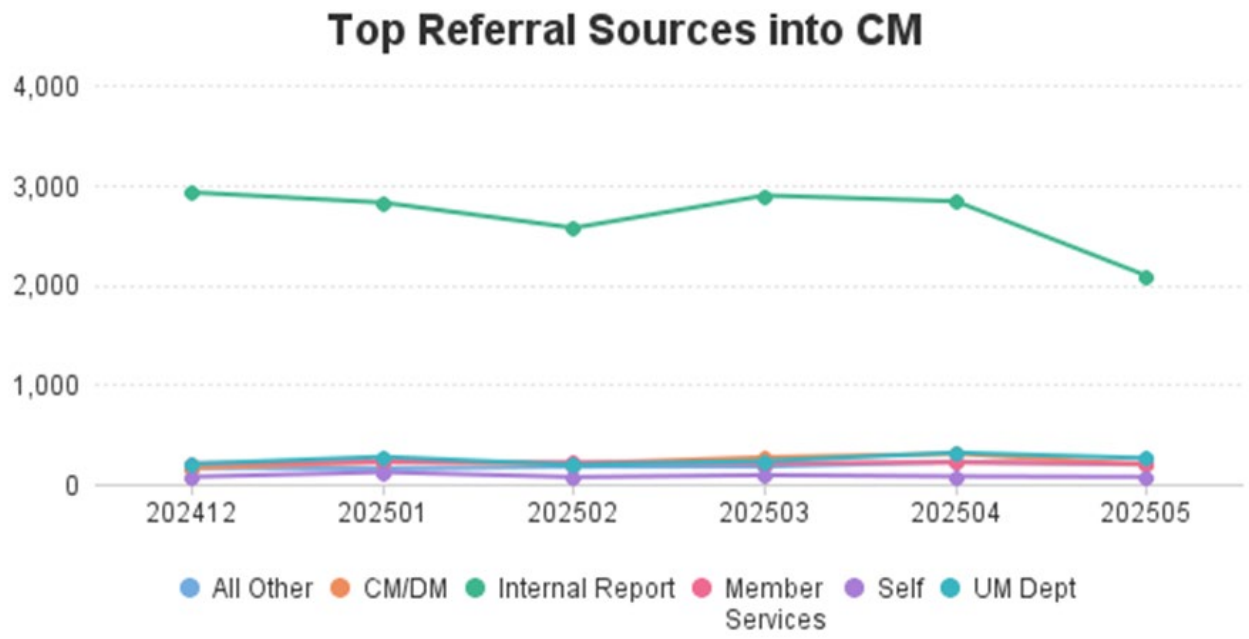
ModivCare's facility transportation services, including making onsite visits with hospitals to address transportation concerns.



Source: #03342 TruCare Caseload



Source: #03342 TruCare Caseload



*Internal Report represents Transitional Care Services (TCS) data for recently admitted patients via Admissions Discharges Transfers (ADT) feed from hospital / skilled nursing facility partners

Source: #03881 Case and Disease Management Dashboard - *data only available through March 2025

CalAIM

Enhanced Case Management

- All Populations of Focus have been live since January 1, 2024.

- The ECM team is working closely with IT and IPD to automate creation of authorizations and potential other areas of ECM. This will improve processing time of authorizations and free up the team to work on other areas of ECM like graduating or stepping members down into a lower level of care.

- The Standardized ECM referral form and ECM eligibility information will be visible to providers on the provider portal by next month. Provider training and communications are forthcoming.

- The ECM team continues to build rapport with the ECM providers, meeting at a minimum twice a month: once to discuss specific cases and once to discuss operational issues. This is leading to more collaboration and community referrals to additional resources. Additional meetings are scheduled with ECM providers for case conferencing as needed.

- ECM and CS are beginning a collaboration to confirm communication is occurring between Community Supports providers and ECM lead care managers. Further ensuring non-duplicative services and members are receiving appropriate services to meet their needs.

- As a result of this fall's audit of ECM providers, the ECM team has developed training for the ECM providers to re-educate the ECM provider network on the core services DHCS is requiring for ECM. The ECM team has scheduled monthly training sessions for all ECM providers' frontline staff to reinforce ECM requirements and expectations. Trainings have been scheduled to occur from February through July 2025.

- AAH continues to collaborate with Alameda County (AC) Health to discuss Street Medicine alignment. The ECM team works closely with the Street Team providers to make sure encounters are submitted and billed appropriately.

- ECM staff, including the Foster Care/Child Welfare Liaison continue to participate in DHCS Foster Care Youth Transition Stakeholder meetings and work with county foster youth programs. This has led to the initial training of the Foster Care Youth Liaisons, which occurred in early February.

- MCPs are required to implement Closed-Loop Referral (CLR) requirements starting on July 1, 2025. The closed-loop referral framework is designed to ensure that referrals between healthcare providers are completed efficiently and effectively. The ECM team is partnering with IPD to make sure Alameda Alliance can meet the regulatory requirements.

	February 2025		March 2025		April 2025	
ECM Providers	**Outreach**	**Enrolled**	**Outreach**	**Enrolled**	**Outreach**	**Enrolled**
ACBH	-	14	-	14	-	14
Alameda Health System (AHS)	24	208	27	212	-	204
Bay Area Community Services (BACS)	-	124	-	128	-	128
California Cardiovascular Consultants	-	156	-	159	-	158
California Children's Services (CCS)	6	25	5	25	-	26
CHCN	114	1,038	86	1,020	-	974
East Bay Innovations (EBI)	2	119	8	118	-	121
Full Circle	-	179	1	173	-	165
Institute on Aging	16	256	-	253	-	248
La Familia	44	42	57	35	-	32
MedZed	262	529	1	565	-	523
Roots Community Health Center	9	309	11	301	-	295
Seneca Family Services	61	64	38	65	-	63
Pair Team	207	805	800	851	-	801
Titanium Health Care	643	792	932	860	-	815
Tiburcio Vasquez Health Center (Street Medicine)	-	117	-	112		113
BACH (Street Medicine)	-	76	-	77	-	77
Lifelong (Street Medicine)	0	233	-	229	-	234
Roots Community Health Center (Street Medicine)	Combined with Roots 'traditional' ECM program					

Community Supports (CS)

- DHCS released new policy guides for all Community Supports on 04/30/25. They are currently under review to identify impact on current processes and potential criteria changes.
- CS services are focused on offering services or settings that are medically appropriate and cost-effective alternatives. The Alliance offers the following community supports:
    - Housing Navigation
    - Housing Deposits
    - Tenancy Sustaining Services
    - Medical Respite
    - Medically Tailored/Supportive Meals
    - Asthma Remediation
    - (Caregiver) Respite Services
    - Personal Care & Homemaker Services
    - Environmental Accessibility Adaptations (Home Modifications)
    - Assisted Living Facility Transition
    - Community or Home Transition Services

- Further CS service & network expansion is paused; potential providers have been notified.
- AAH CS staff continue to meet with CS providers to work through logistical issues as they arise, including referral management, claims payment and member throughput.
- DHCS closed loop referral requirements go into affect on 07/01/25. AAH is working on finishing processes to comply with the new DHCS requirements.

Community Supports	Services Authorized in February 2025	Services Authorized in March 2025	Services Authorized in April 2025
Housing Navigation	913	943	945
Housing Deposits	242	245	278
Housing Tenancy	796	797	708
Asthma Remediation	130	139	144
Meals	1,340	1,162	903
Medical Respite	82	73	72
Transition to Home	24	25	27
Nursing Facility	20	16	14
Home Modifications	0	0	3
Homemaker Services	53	50	41
Caregiver Respite	2	0	0
Total	**3,602**	**3,450**	**3,135**

Quality

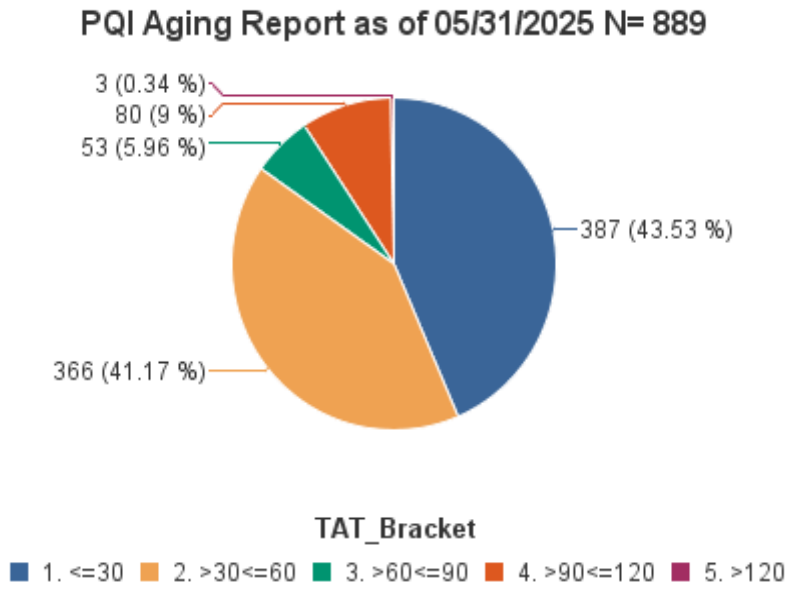
- Quality Improvement continues to track and trend PQI Turn-Around-Time (TAT) compliance. Our goal is closure of PQI cases within 120 days from receipt to resolution via nurse investigation and procurement of medical records and/or provider responses followed by final MD review when applicable.

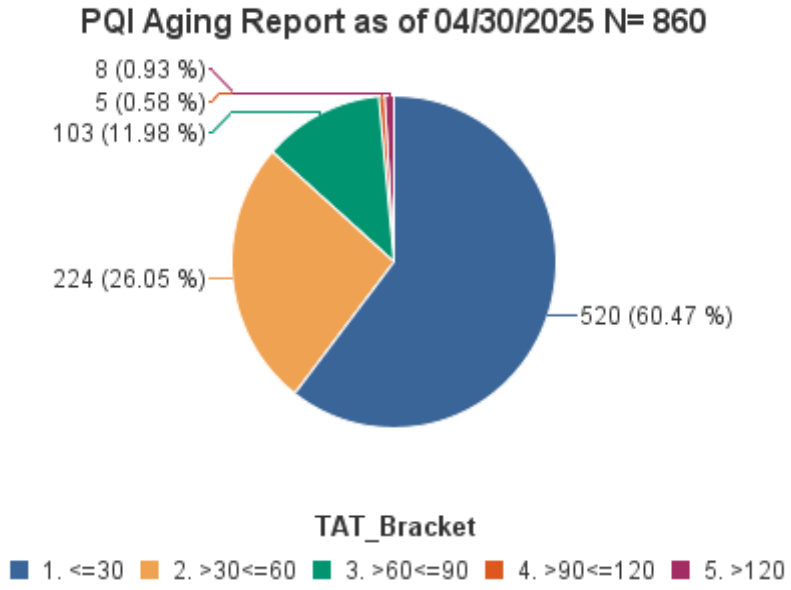
- Quality of Access issues are reviewed by the Access & Availability team and Quality of Language issues by the Cultural & Linguistics Services team after they are triaged by the QI Clinical team. Quality of Care and Service issues are reviewed by the QI RN Reviewers. Final leveling for Quality-of-Care cases is determined by the Sr Medical Director of Quality after RN review is completed. Weekly meetings are scheduled for the purpose of Quality-of-Care case review with the Sr Medical Director.

- 99% of cases in April and May 2025 were closed within the 120-day TAT. Therefore, turnaround times for case review and closure remain well within the benchmark of 95% per PQI P&P QI-104 for this lookback period.

- When cases are open for >120 days, the reason continues to be primarily due to delay in receipt of medical records and/or provider responses. As part of the escalation process of obtaining medical records and/or responses, efforts are made to identify barriers with specific providers to find ways to better collaborate to achieve resolution.

- The total number of PQIs including all categories increased by 29 referrals from April to May 2025. TATs are closely monitored on a weekly basis to ensure timely closure of cases within the standard 95%.





Quality Improvement Health Equity Committee (QIHEC) activities

- Background: The Alliance is contractually required to maintain a Quality and Health Equity (QIHE) Program to monitor, evaluate, and improve upon the Health Equity and health care delivered to all members. The Board is accountable for the QIHE Program

and delegated the Quality Improvement Health Equity Committee (QIHEC) the authority to oversee the performance activities of the program.

- Summary: The following are QIHEC activities of findings, actions, and recommendations from the April 11, 2025 and May 9, 2025 meeting:

- Key Updates and Discussions (QIHEC April 11, 2025):

- Committee Member Presentations:
    - Dr. Aaron Chapman, Medical Director, Alameda County Behavioral Health Care Services discussed the challenges of managing mental health and substance use disorders in emergency departments, highlighting the shortage of psychiatric acute inpatient beds and referral systems. Recommendation was the need for better outreach and engagement teams to address the system issues. There was a call for collaboration among healthcare systems to improve access and care for patients with mental health and substance use disorders.

- Utilization Management Program (2024 Evaluation, 2025 Program Description and Workplan):
    - The 2024 evaluation highlighted key metrics such as turnaround times, authorization volume, denial rates, emergency room visits, readmission rates, out-of-network utilization, and provider satisfaction. Initiatives for 2025 include using community health workers and enhancing training and oversight.

- Case Management Program (2024 Evaluation, 2025 Program Description and Workplan):
    - The annual review emphasized assessment, care planning, and interventions, with a focus on improving the Health Risk Assessment completion rate. Case authorization volumes showed significant monthly increases, and member satisfaction was 88.2% in 2024. For 2025, the focus is on tailored approaches and collaborations to address readmission rates and ER utilization.

- Behavioral Health:
    - There were highlights reported on care coordination between medical and behavioral health services, demographic data on children using ABA services, network expansion, and efforts to address the gap between authorized and delivered ABA services. Recommendations included enhancing care coordination, promoting health equity, and improving access to non-specialty mental health services.

- NCQA Update:

    - Preparation is underway for the Health Plan accreditation survey is scheduled for submission on July 15th, survey call on August 12th, with file review and closing conference on September 8th and 9th.
    - The Health Equity survey is scheduled for submission on June 10th, survey call on July 10th, and closing conference on July 28th . There are changes to the scoring methodology due to the executive orders relating to DEI and will be continually monitored for any updates.

- Key Updates and Discussions (QIHEC May 9, 2025):

- Health Equity Initiatives: Rollout of DEI pilot training and TGI training completion for staff, with expansion to member-facing vendors. Finalization of a three-year roadmap with six milestones
    - Quality Improvement Health Equity Program: Review of the QI Trilogy Program Description, Evaluation from 2024, and Work Plan for 2025.

- Quality Performance/HEDIS: Presentation of final HEDIS rates for 2024, with benchmarks met above the minimum performance level (MPL) except for topical fluoride in children, asthma medication ratio, and controlling blood pressure. for 17 out of 18 measures. Quality performance activities in 2024 focused on outreach, education, and data collection, with plans for an immunization campaign and Emergency Department utilization focus in 2025.
    - Potential Quality Issues & Facility Site Reviews: Discussed the clinical safety program and corrective action plans (CAPs). The potential quality issue (PQI) dashboard for 2024, showing a decline in referrals over the year. Most PQIs resolved within 30 days, with a maximum turnaround time of 120 days. CAPs were primarily from C2 or C3 cases. Facility Site Review/Medical Record Review (FSR/MRR) reported 178 reviews in 2024, with all corrective action plans closed within 120 days. The state's new FSR/MRR tool, updated in 2022, led to a 7-8% decrease in provider scores. Focus areas for 2025 include clinical safety oversight and addressing provider trends

- Member Experience & Access: CAHPS survey results and strategies to improve access and member education. Key measures included "getting needed care" and "getting care quickly," with improvements in the latter but declines in the former. Focus areas for 2025 include provider engagement strategies and development of member-facing documents to improve timely access.

- Population Health & Equity: Review of the Health Education and Population Health Programs, including the Population Health Management (PHM0 strategy, needs assessment, and collaboration with counties. Future plans to improve doula utilization and enhance disease management programs.

- Cultural & Linguistic Services: Significant growth in interpreter services encounters with over 97,000 interpreter services encounters across 135 languages, 70% increase from 2023. and focus on improving accessibility and quality assurance. Key initiatives included adding a community advisory committee member, establishing a selection committee, and completing the first annual demographic report. Focus for 2025 is on improving accessibility, streamlining services, and enhancing quality assurance.
- Population Health: Assessment, Impact & Strategy: Highlights in 2024 included strong outreach in high-risk programs, partnerships with providers and community organizations, and maintaining high breast cancer screening rates for Black/African American members. The 2025 population health management strategy focuses on data-driven approaches to address member needs and social determinants of health. The strategy includes health analytics, risk stratification, and a continuum of care services from low to high risk. Key metrics include a 20% increase in blood pressure monitor outreach and a 5% rise in well-child visit rates for Black African American members. The strategy also emphasizes disease management, health education, and transitional care services, aiming for 80% member satisfaction and a 5% weight loss in the diabetes prevention program. Recommendations included strengthening outreach and education, expanding care coordination efforts, enhancing preventive care and screening, improving staff training and internal coordination, leveraging community partnerships, and optimizing incentive programs

- Network Cultural Linguistic Capacity: The 2024 network capacity report evaluated the health plan's ability to meet cultural, racial, and linguistic needs, focusing on English, Spanish, Chinese, Vietnamese, and Tagalog speakers. There was a 6% increase in Spanish speakers, 5% decrease in English speakers. Spanish-speaking member-to-provider ratios exceeded the third quartile benchmark, indicating potential access gaps. Interpreting services usage increased by 70% in 2024. Grievances related to language assistance rose by 75%, while discrimination cases declined by 41%. Action steps include partnering with community organizations, expanding provider education, and ongoing data collection

- 2024 DHCS Audit Findings: Update on ongoing corrective action plans (CAPs), including blood lead screening compliance (now above MPL) and appointment wait list management (on-going meetings with Alameda Health System to decrease the wait list, member auto-assignment held, and monitoring of provider recruitment/vacancies), and Cultural & Linguistic Services (CLS) monitoring of vendors (awaiting vendor interpreter qualification verification for submission to DHCS); 2 out 3 CAP responses were accepted by DHCS.

- Access & Availability Update: Discussion on the 2024 after-hours survey results; rates dropped slightly to 80% for all provider types except Behavioral Health which was included for the first time. Focused efforts are to improve provider contact accuracy and compliance monitoring.

Subject: 2024 Annual Network Capacity Assessment to Meet Members' Cultural and Linguistic Needs Report (NCQA HP Net 1A)

Purpose of the Report

- The annual Network Capacity Assessment to Meet Members' Cultural and Linguistic Needs Report also referred to as Net 1A, meets the NCQA Health Plan Accreditation requirements.
- The report assesses the Alliance's provider network capacity to meet the cultural, ethnic, racial, and linguistic needs of Alliance members.
- The analysis helps to provide opportunities for quality improvement provider network adjustment, and ongoing activities to ensure the Alliance's provider network meets the cultural and linguistic needs of our members.

Key Findings

Member Demographics-Language 2023- 2024 change:

- In 2024, the Alliance had a total of 407,721 Medi-Cal members.
    - Spanish (25.8%) and Chinese (7.2%) are the most common non-English threshold languages.
    - Spanish-speaking members increased by 6.5%.
    - English-speaking members decreased by 5.2%.

- For Group Care, there were a total of 5,788 members.
    - English (58.1%) is the most common spoken language, followed by Chinese (25.3%)
    - Chinese-speaking members slightly increased by .34%.

Member and Provider Race/Ethnicity Comparison:

- 55% of providers reported their race/ethnicity.
- There is underrepresentation in the following areas:
    - Latinx PCPs, Specialists, and Behavioral Health (BH) providers compared to the Alliance membership.
    - Black (African American) Specialists.
    - Pacific Islander PCPs, Specialists, and BH providers.
- Overall, most providers self-identify as White (PCPs: 34%, BH: 48%), while the majority of members are Hispanic (33%) and Asian (13%).

Provider Language Capacity: Member-to-Provider Category by Threshold Language

- Medi-Cal:
    - There were more Spanish-speaking members per PCP than the target threshold (75% percentile) in all quarters in 2024.
    - The number of members per Vietnamese and Spanish-speaking Specialists was higher than the target threshold in Q1 and Q2 but improved in Q3 and Q4 and were within the target threshold.
    - For Vietnamese and Chinese-speaking BH providers, the number of members per provider were also higher in Q1 and Q2 but improved in Q3 and Q4 and were within the target threshold.
- Group Care:
    - No language access concerns were identified. Member-to-provider ratios for all threshold languages stayed within the target threshold in 2024.

Language Use-Interpreter Services Utilization:

- Interpreter service utilization increased by 70% since 2023.
- Highest increases in:
    - Telephonic: Spanish, Mandarin, and Mam languages
    - In-person: Spanish, Mandarin, and Cantonese languages
    - Video: Spanish
- Overall, use of family and friends as interpreters remain prevalent among Chinese-speaking adults. This may be due to cultural preferences.

Grievances and Discrimination Cases:

- Language-Related Grievances:
    - 503 Medi-Cal and 16 Group Case Cases in 2024.
    - A 75% increase from 2023, however still below the 1 complaint/1,000 members.
    - Most common grievances:
        - PCP change request (In most cases Member Services Representative assisted with PCP change to align with member's preferred spoken language.)
        - Providers not scheduling interpreting services (In most cases, Alliance Member Services Representatives connected the member to services.)
        - Quality of interpreter services (Cases where the interpreter was identified were addressed and resolved with the vendor.)
- Discrimination Cases:
    - A total of 109 discrimination cases were reported and only 1 found to be substantiated.
    - Decreased by 41% from 2023.
- Overall, there were no patterns of provider issues in 2024.

Assessment and Actions

- There were no significant provider network gaps or patterns of concern found, however, the Alliance will continue the following activities to ensure the provider network meets the cultural and linguistic needs of members:

    - For Members:
        - Partner with community-based organizations to meet cultural needs (i.e., wellness, preventive, and care management services)
        - Provide culturally and linguistically appropriate materials
        - Respond to member grievances
        - Use non-clinical cultural liaisons where appropriate
    - For Providers:
        - Monitor member-to-provider ratios by language and race/ethnicity
        - Ongoing DEI training
        - Data sharing regarding language needs of members
        - Provider education on access to language services
        - Provider race/ethnicity data collection.

ALAMEDA Alliance FOR HEALTH

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Health Equity

Lao Paul Vang

To: **Alameda Alliance for Health Board of Governors**

From: **Lao Paul Vang, Chief Health Equity Officer**

Date: **June 13th, 2025**

Subject: **Health Equity Report**

Internal Collaboration

- **Meetings and check-ins with Division Chiefs Update**
  - The CHEO meets with the Alliance division chiefs on a 1x1 basis monthly to update on Health Equity (HE) and Diversity, Equity, and Inclusion (DEI) activities.

- **Faith-Based Community Engagement Update**
  - At the March meeting, the team explored new opportunities such as health educational sessions and resource fair planning.

- **NCQA Health Equity Related Issues**
  - Continued collaboration with the NCQA Health Equity Accreditation Working Group, including the new DSNP Consultant who was hired to manage DSNP related health equity issues as they pertain to NCQA health equity standards.

  - The NCQA Health Equity Accreditation application is tentatively scheduled to be submitted next month (July 2025).

- **PHM Workgroup**
  - The Health Equity team continues to collaborate with PHM team and participates in the weekly PHM work group, including reviewing the new PHM strategies for the coming year.

- **Over/Under Utilization Workgroup**
  - The Health Equity team continues to engage in ongoing meetings with the Healthcare Service workgroup to discuss and share best practices relating to ways to overcome over- and underutilization.

- **Alliance Publication Workgroup**
  - As part of the Health Equity Roadmap milestone # 4 Communication, the Health Equity joined the Alliance Publication workgroup organized by Communication & Outreach to help create content for social media postings and articles.
  - The aim is to position the Alliance as the champion of health equity for our members.

External Collaboration

- **Bi-weekly meetings with Local Health Plans' Chief Health Equity Officers (CHEOs) Update**
  - Ongoing discussions regarding health equity-related issues and DEI training curriculum.

- **Monthly Meetings with DHCS' Chief Health Equity Officer (DHCS CHEO) Update**
  - The DHCS CHEO and MCPs CHEOs meet to collaborate on Health Equity and DEI initiatives.
  - The meeting consisted of DHCS and CHEO Updates.

- **Local Initiatives DEI Training Monthly Collaborative Meeting**
  - Local MCPs continue to meet to update, share, and collaborate on the DEI Training Program. The monthly collaborative allows MCPs to ask questions, update each other on curriculum information, and assist with moving the DEI Training forward**.**

Alliance Health Equity Strategic Roadmap Update

- The Health Equity Department is pleased to resubmit the Alliance Health Equity Roadmap, which was presented to the BOG in December 2024:

Milestone	Goals
1. Organization Transformation	a) CHEO works collaboratively with SLT to facilitate system-wide organization transformation that supports the long-term vision of health equity for the Alliance.
2. Data-Driven	a) Collaboration with UM, PHM, QI, and Analytics. b) Utilize grant-funded health equity projects to gather data that will augment the Alliance's claim data depository to formulate a comprehensive understanding of the SDOHs that perpetuate the health disparities faced by our Medicaid members.
3. Education	a) Lead in the development of DEI Training APL 23-025 and APL 24-018 TGI-SB 923 training. b) Collaboration with Culture and Linguistic, PHM, QI, and other stakeholders to ensure all our policies, services, and programs are rooted in the core foundation of health equity.

	c) Participation in various Functional Area Delegate (FAD) workgroups to ensure the Alliance work supports the health equity vision and mission
4. Communication	a) Collaboration with Alliance Publication Workgroup to develop effective communications on all aspects of health equity activities to ensure that staff and members are fully informed.
5. Community Engagement	a) Faith-Based Community Engagement (FBCE) workgroup b) CIN membership c) Other CBO, and national or local organizations such as AHA, First-5.
6. SDOH Mitigation Measures	a) Collaborate with CMO and HCS team to assess and analyze non-utilization data aimed at identifying health disparities.

Recommendations:

The Health Equity Team would like to recommend the following BOG actions:

1. BOG review and provide feedback regarding the above milestones and goals.
2. BOG can add additional milestones and goals or revise the current milestones and goals.
3. Upon receiving BOG's feedback, the final milestones and goals will be established, and the HE Team will begin the implementation process of the Alliance Health Equity Roadmap.
4. Implementation of the Roadmap milestones will begin on July 1, 2025, and will be completed by June 30, 2028 (3 years).

DHCS-DMCS APL Update

- **DEI Training APL 23-025 Update**
  - We received approval from DHCS regarding the DEI training curriculum.
  - Updated Timeline:
    - May 2025: DEI Provider's Pilot will launch. California Cardiovascular Consultants (CCC) has been selected to receive pilot training.
    - May – June 2025: pilot training completed.
    - July to Dec 2025: training given to downstream network providers and vendors.

- **APL 24-018: TGI-SB 923 Update**
    - The Transgender, Gender Diverse, and Intersex (TGI) Cultural Competency Training was provided to AAH staff who are directly working and communicating with our members.
    - The next step is to train our vendors, and then the last step is to train our providers.

    - Timeline and completion rate:
        - Dec 2024: confirmation of vendor
        - Jan-Feb 2025: Implementation of training for all Alliance staff
        - Feb 14: 97% of AAH staff completed the mandatory training. The 3% of non-completion represents staff who were on vacation or medical leave. Upon returning to the office, they will have up to 30 days to complete the training.
        - Feb 14, 2025: submission of documents per APL to the State, including evidence-based TGI training curriculum, updated online Providers Directory for gender-confirming services, G&A, and Policy and Procedures.
        - Feb 28, 2025: Attestation was submitted to DHCS.
        - HE Team is working with the TGI working group to develop plans to train member-facing vendors as part of the next step in this APL.
        - Our overall goal is to achieve 90+% on both DEI and TGI training programs.

Diversity, Equity, Inclusion, and Belonging Committee (DEIBC) and Values in Action Committee (VIAC):

- **DEIB Committee Update**
    - The DEIB Committee met on May 2nd and discussed Health Equity DEI Activities and the Alliance dental staff insurance options.

- **VIA Committee Update**
    - At the May 19th VIA Committee meeting, the committee discussed the success of the Alliance Spring Social and a request for agenda items for the June meeting.
    - The Committee was updated on the DEI Pilot Training and the TGI Training.
    - The Alliance dental insurance was discussed, and Megan Clinton agreed to discuss with the leadership team the possibility of adding a second dental option for the staff.

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Information Technology

Sasikumar Karaiyan

To: **Alameda Alliance for Health Board of Governors**

From: **Sasi Karaiyan, Chief Information & Security Officer**

Date: **June 13th, 2025**

Subject: **Information Technology Report**

Call Center System Availability

- In April 2024, AAH phone systems and call center applications maintained 100% availability even as they supported 97% of employees working remotely.

- Alliance continues to introduce new features to enhance efficiency. Alliance is working on extending this system to include Spanish language support. The project to enable the Spanish language pack for Calabrio is currently in progress, including the preparation of installation scripts. Selected Member Services staff will conduct translation reviews and phrase tuning, with this phase expected to commence by the end of September 2025.

Encounter Data

- In the month of May 2025, the Alliance submitted 141 encounter files to the Department of Health Care Services (DHCS) with a total of 435,150 encounters. Institutional lag-time was lower than average due to the processing of over 22,000 claims for replacement with dates of service over 90 days.

Enrollment

- The Medi-Cal Enrollment file for the month of May 2025 was received and loaded to HEALTHsuite.

HEALTHsuite

- The Alliance received 349,255 claims in the month of May 2025.

- A total of 330,755 claims were finalized during the month out of which 289,805 claims auto adjudicated. This sets the auto-adjudication rate for this period to 87.6%.

TruCare

- A total of 20,482 authorizations were loaded and processed in the TruCare application.

- TruCare Application Uptime – 99.9%.

SQL Server Upgrade to version 2022

Objective:

- To upgrade SQL server from 2016 to 2022 for SQLPROD/DBR1PROD by end of Q1 2026

Execution Plan:

- The upgrade is divided into two phases as Phase 1 and Phase 2

Phase 1:

- Windows upgrade to 2019 has been completed in SQLTEST and ISR01-TEST.
- SQLPROD database compatibility upgrade has been planned for 06/20.

Phase 2:

- SQL server migration from 2016 to 2022 version needs to be completed.
- This is being targeted for Q3 of 2025 and to be planned after phase 1 is completed.
- Post compatibility monitoring stabilization will take place until end of June.

Challenges:

- None

IT Security Program

- The IT Security 3.0 initiative ranks among the Alliance's foremost objectives for fiscal year 2025. Our aim is to consistently enhance and advance our security measures, secure our network perimeter against threats and vulnerabilities, and bolster our security policies and procedures.

- Trued up SecureLink and associated onboarding for IntelliSwift.

- In partnership with Infrastructure team, hardened server provisioning process by (1) eliminating EoI/EoS software and (2) vulnerability scanning remediation prior to release.

- Vulnerability Management (Tenable Nessus) - Technical debt reduction and EoL/EoS software removal exercise has begun.

Information Technology

Supporting Documents

Enrollment

- See Table 1-1 “Summary of Medi-Cal and Group Care member enrolment in the month of May 2025”.
- See Table 1-2 “Summary of Primary Care Physician (PCP) Auto-assignment in the month of May 2025”.
- The following tables 1-1 and 1-2 are supporting documents from the enrollment summary section.

Table 1-1 Summary of Medi-Cal and Group Care Member enrollment in the month of May 2025

Month	Total MC[1]	MC[1] - Add/ Reinstatements	MC[1] - Terminated	Total GC[2]	GC[2] - Add/ Reinstatements	GC[2]- Terminated
May	409,354	7,603	9,838	5,888	142	150

1. MC – Medi-Cal Member 2. GC – Group Care Member

Table 1-2 Summary of Primary Care Physician (PCP) Auto-Assignment for the Month of May 2025

Auto-Assignments	Member Count
Auto-assignments MC	2,781
Auto-assignments Expansion	2,543
Auto-assignments GC	71
PCP Changes (PCP Change Tool) Total	5,395

TruCare Application

- See Table 2-1 “Summary of TruCare Authorizations for the month of May 2025”.
- There were 20,482 authorizations processed within the TruCare application.
- TruCare Application Uptime – 99.9%.
- The following table 2-1 is a supporting document from the TruCare summary section.

Table 2-1 Summary of TruCare Authorizations for the Month of May 2025*

Transaction Type	Total Auths Received
Paper Fax to Scan (DocuStream)	2,313
Provider Portal Requests (Zipari)	6,029
EDI (CHCN)	6,619
Provider Portal to AAH Online (Long Term Care)	3
ADT	1248
Behavioral Health COC Update - Online	53
Behavioral initial evaluation - Online	24
Manual Entry	2,536
OCR Face sheets	1,657
Total	20,482

Key: EDI – Electronic Data Interchange

Web Portal Consumer Platform

- The following table 3-1 is a supporting document from the Web Portal summary section. (Portal reports are always one month behind current month)

Table 3-1 Web Portal Usage for the Month of May 2025

Group	Individual User Accounts	Individual User Accounts Accessed	Total Logins	New Users
Provider	8,431	6,147	627,479	806
MCAL	126,398	4,027	9,543	1,276
IHSS	4,032	83	675	25
Total	138,861	10,257	637,697	2,107

Table 3-2 Top Pages Viewed for the Month of May 2025

Category	Page Name	Page Views
Provider - eligibility/claim	Member Eligibility	1948464
Provider - Claims	Claim Status	350830
Provider - authorizations	Auth Submit	11130
Directory Config	Provider Directory	10441
Provider - authorizations	Auth Search	8946
Member Home	MC ID Card	6813
Provider - Claims	Submit professional claims	5452
Member My Care	Member Eligibility	5097
Member Config	Provider Directory	4408
Member Help Resources	Find a Doctor or Hospital	3268
Member Help Resources	ID Card	2844
Member Help Resources	Select or Change Your PCP	1964
Provider - eligibility/claim	Member Roster	1919
Member My Care	My Claims Services	1658
Provider - Provider Directory	Provider Directory 2019	1066
Member My Care	Authorization	975
Provider - Home	Behavior Health Forms SSO	956
Provider - reports	Reports	785
Provider - Home	Forms	640
Member My Care	My Pharmacy Medication Benefits	484
Member Help Resources	Forms Resources	447
Provider - eligibility/claim	Claim Status	408
Member My Care	Member Benefits Materials	382
Member Help Resources	FAQs	335
Provider - Provider Directory	Manual	304
Member Help Resources	Authorizations Referrals	275
Provider - Provider Directory	Instruction Guide	259
Provider - Home	Long Term Care Forms SSO	255
Member Help Resources	Contact Us	249

Call Center – Call Volume Overview:

Members - Call Center Statistics			
Month	Calls Presented	Calls Handled	Calls Abandoned
December	8438	6912	414
January	14078	10705	1483
February	11335	9026	869
March	11867	11151	709
April	15436	10925	1420
May	13306	10204	999

Providers - Call Center Statistics			
Month	Calls Presented	Calls Handled	Calls Abandoned
December	9598	7285	2152
January	13400	8682	3822
February	10986	7586	1931
March	8303	6869	1434
April	11128	8864	1768
May	10018	8263	1328

- Calls Presented: Total number of calls received.
- Calls Handled: Total number of calls answered.
- Calls Abandoned: Calls abandoned before being completely answered.

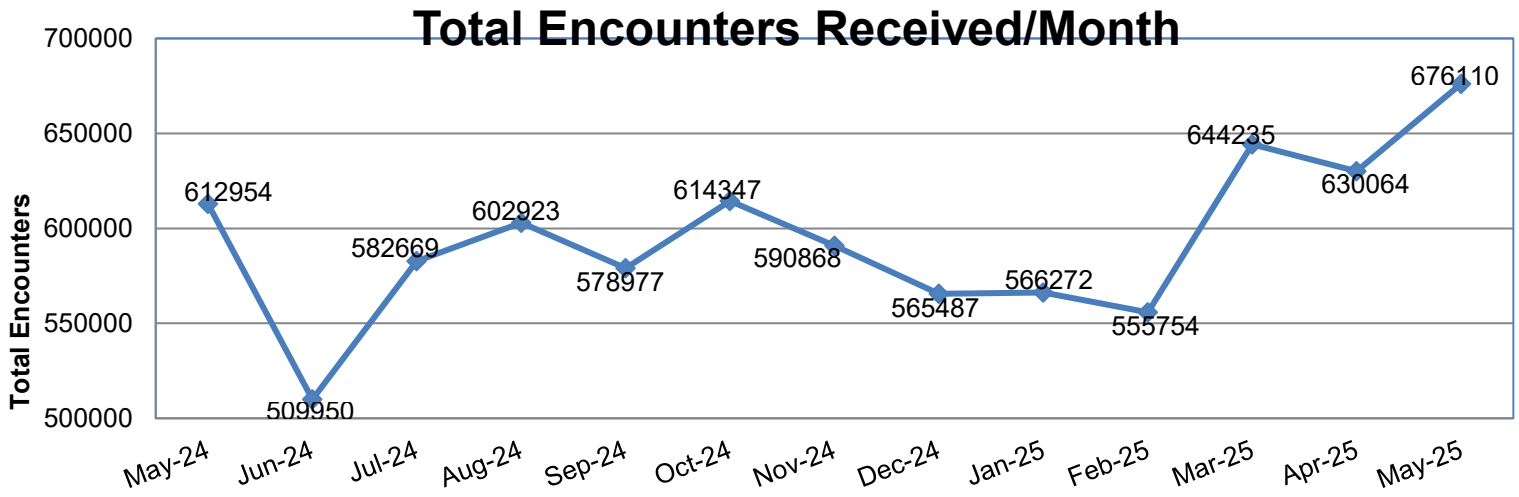
Note: It is important to note that there is a slight discrepancy between the number of calls presented, handled, and abandoned. This discrepancy is due to calls being rerouted to the XAQT vendor, which are not included in the calls handled or abandoned statistics. This rerouting can account for some of the differences observed in the totals.

Encounter Data from Trading Partners 2025

- **AHS**: May weekly files (15,875 records) were received on time.
- **BACH**: May monthly files (0 records) were received on time.
- **BACS**: May monthly files (88 records) were received on time.
- **CHCN**: May weekly files (151,416 records) were received on time.
- **CHME**: May monthly files (9,045 records) were received on time.
- **CFMG**: May weekly files (21,443 records) were received on time.
- **Docustream**: May monthly files (1,068 records) were received on time.
- **EBI**: May monthly files (1,457 records) were received on time.
- **FULLCIR**: May monthly files (1,479 records) were received on time.
- **HCSA**: May monthly files (2,628 records) were received on time.
- **IOA**: May monthly files (2,068 records) were received on time.
- **Kaiser**: May bi-weekly files (0 records) were received on time.
- **LAFAM**: May monthly files (101 records) were received on time.
- **LIFE**: May monthly files (1,274 records) were received on time
- **LogistiCare**: May weekly files (35,875 records) were received on time.
- **March Vision**: May monthly files (7,929 records) were received on time.
- **MED**: May monthly files (1,581 records) were received on time.
- **OMATOCHI**: May monthly files (0 records) were received on time.
- **PAIRTEAM**: May monthly files (9,244 records) were received on time.
- **Quest Diagnostics**: May weekly files (22,501 records) were received on time.
- **SENECA**: May monthly files (109 records) were received on time.
- **SERENE**: May monthly files (0 records) were received on time.
- **TITANIUM**: May monthly files (2,970 records) were received on time.
- **TVHC**: May monthly files (395 records) were received on time.
- **Magellan**: May monthly files (509,162 records) were received on time.

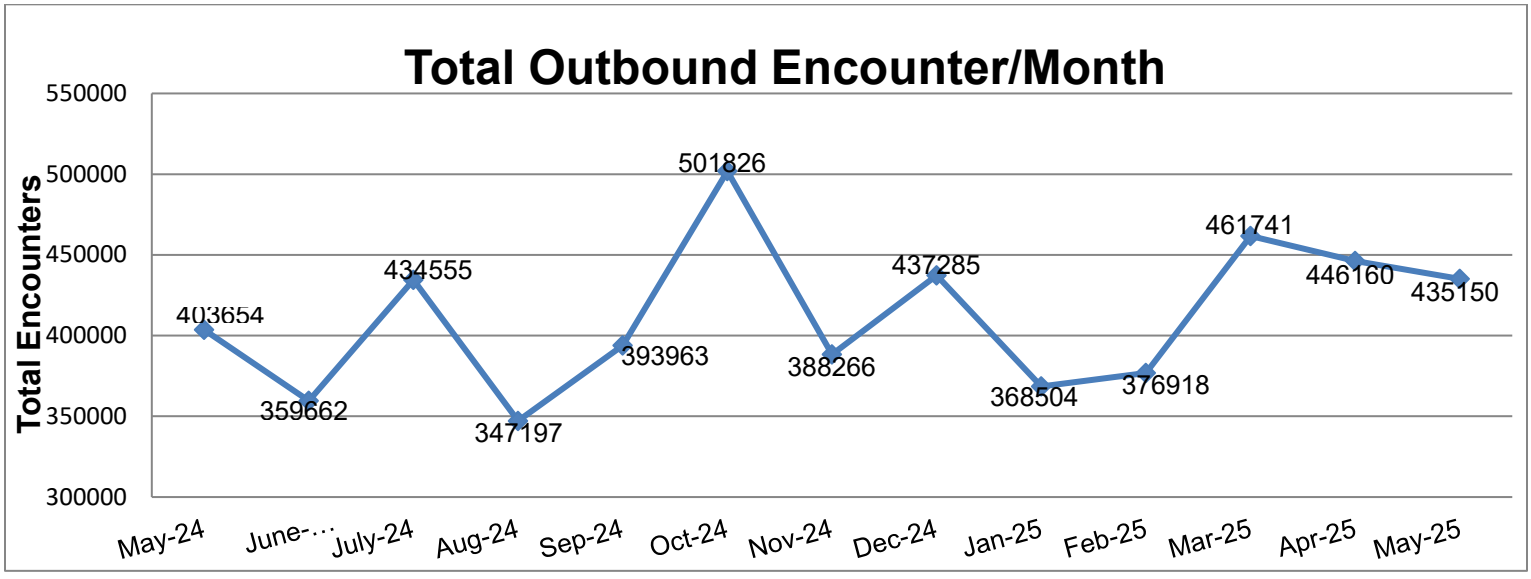
Trading Partner Encounter Inbound Submission History

Trading Partners	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Health Suite	375454	297267	332150	368235	322196	367989	364130	332108	339760	339840	347469	372126	387564
AHS	8412	13316	7296	8859	7498	8309	10535	7261	9709	8654	9273	8211	15875
BACH							795		426		291	131	
BACS	70	77	88	86	85	76	98	104	93	113	81	72	88
CHCN	122445	110650	135444	122293	155825	125042	127223	127327	117483	118972	181049	117350	151416
CHME	7107	7449	7242	6902	7680	7102	7589	7458	7781	7553	6794	8293	9045
CFMG	15934	21143	10776	22335	16421	16045	21352	16696	13536	17329	21767	15856	21443
Docustream	1589	749	934	1102	1067	704	678	828	694	808	770	891	1068
EBI	184	2043	1623	1825	3394	1640	1725	1476	1440	1597	1390	2926	1457
FULLCIR	8478	2842	1362	1798	3809	2523	2038	1085	806	1534	2099	2025	1479
HCSA	5535	3663	6841	3256	3386	2389	3423	2335	2432	2725	2118	2384	2628
IOA	1163	1280	847	752	4227	588	1064		3008	933	736		2068
Kaiser	886	1079	2052	172	236	159							
LAFAM	116	86	70	88	63	89	76	83	112	96	85	93	101
LIFE		1694		614	168	119	335	997	228	267	431	317	1274
LogistiCare	27531	16205	43038	29732	16139	49941	16183	34122	28671	32550	33754	55059	35875
March Vision	8546	7092	6404	7719	5769	5143	6016	6285	15146		6985	6704	7929
MED	722	744	615	608	610	645	656	619	758	1182	775		1581
OMATOCHI				2									
PAIRTEAM	7582		5763		9359	1108	2204	5816	3436		2055	16360	9244
Quest	18001	22500	18000	22502	18004	18002	22501	18003	18002	18001	22502	18003	22501
SENECA	113	71	109	129	101	105	117	131	1	69	129	108	109
SERENE								654	107		209		
TITANIUM	3086		2015	3914	2815	6192	1537	2099	2487	3531	2855	3039	2970
TVHC					125	437	593		156		618	116	395
Total	612954	509950	582669	602923	578977	614347	590868	565487	566272	555754	644235	630064	676110



Outbound Encounter Submission

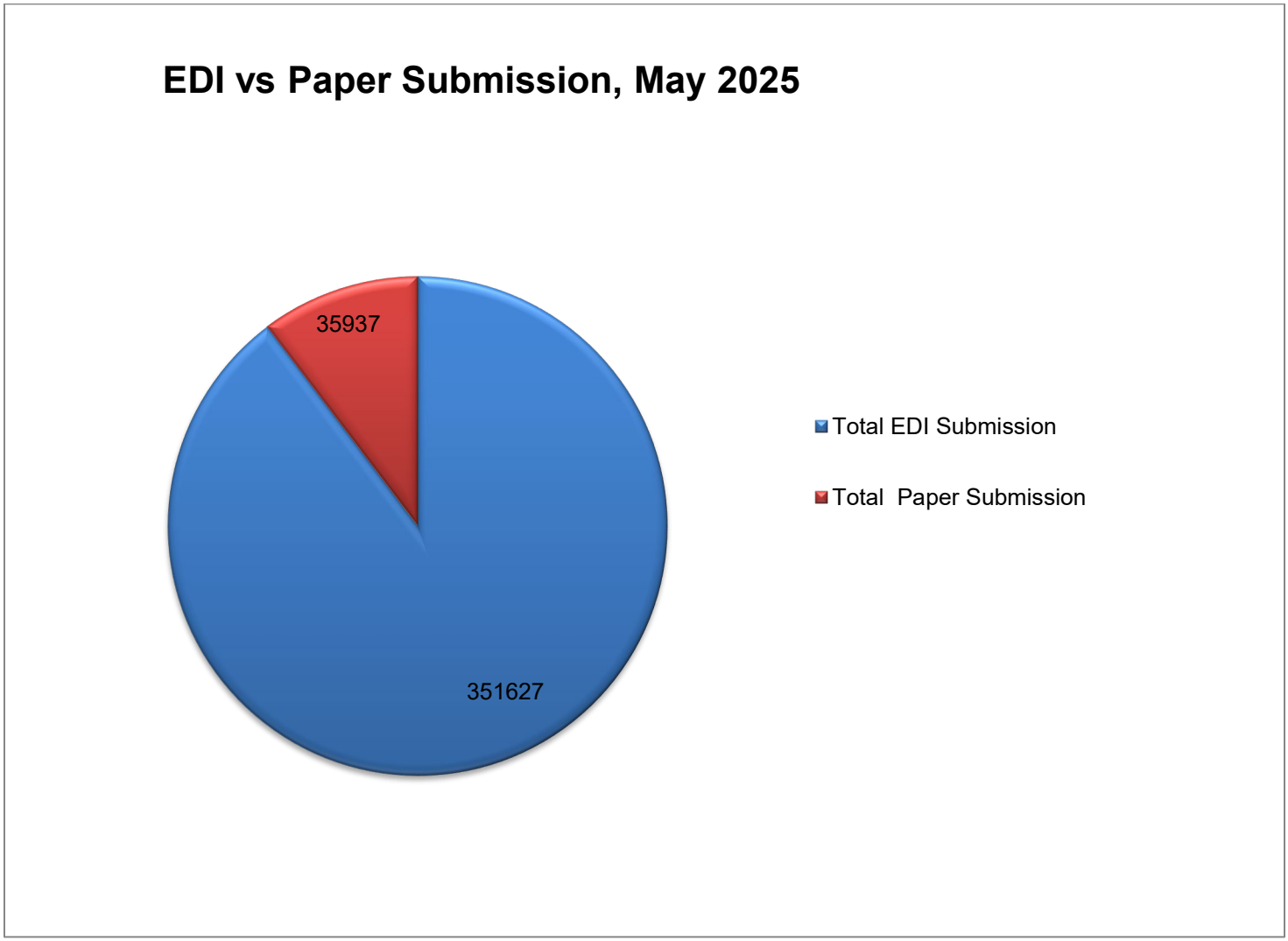
Trading Partners	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Health Suite	198595	204068	230706	183371	210971	276473	218194	263242	182192	205804	264948	210745	226401
AHS	7002	10684	6703	7101	8727	8201	10403	6850	7710	8135	7952	4510	9326
BACH							739	6	407		272	110	
BACS	66	72	80	80	78	74	79	41	128	87	59	23	51
CHCN	107577	77200	94476	87485	87806	108806	88573	84649	85439	82973	95918	115571	106733
CHME	6749	7310	7095	6762	6994	6974	7474	7342	7426	7167	6682	8156	8914
CFMG	11561	11506	9994	4	24076	13152	13882	11342	9362	11960	15008	11394	12430
Docustream	839	570	725	806	715	545	482	239	634	559	478	551	540
EBI	60	1835	1443	1727	3242	1559	1641	494	2208	1475	1308	1493	1346
FULLCIR	5401	2410	1084	674	1515	1767	1470	79	1298	1251	1823	1658	1155
HCSA	5363	3493	6757	3171	3310	2376	3394	2255	2497	2693	2103	2332	2603
IOA	1029	1221	749	680	1374	549	949		2783	781	626		48
Kaiser	1292	812	1404	113	216	62		23					
LAFAM	103	58	66	81	58	86	62	3	178	89	80	84	90
LIFE		28		598	159	91	76	202	508	63	65	116	93
LogistiCare	27487	16221	43019	30006	16046	49705	15235	34035	28502	32441	33656	54971	35829
March Vision	5719	4553	3766	3482	4066	3543	3980	4156	9586	371	4354	3870	4591
MED	579	654	552	540	514	579	568	55	546	1083	731		595
PAIRTEAM	4422		3246		4617	782	1960	994	6334		1489	10873	4670
Quest	16912	16898	20898	16854	16937	21144	16909	21044	16828	16855	21048	16795	16853
SENECA	109	69	108	127	94	91	100	6	112	60	116	101	98
SERENE									82		20		
TITANIUM	2789		1684	3535	2332	5267	1278	228	3600	3071	2551	2764	2714
TVHC					116		818		144		454	43	70
Total	403654	359662	434555	347197	393963	501826	388266	437285	368504	376918	461741	446160	435150



HealthSuite Paper vs EDI Claims Submission Breakdown

Period	Total EDI Submission	Total Paper Submission	Total claims
25-May	351627	35937	387564

Key: EDI – Electronic Data Interchange



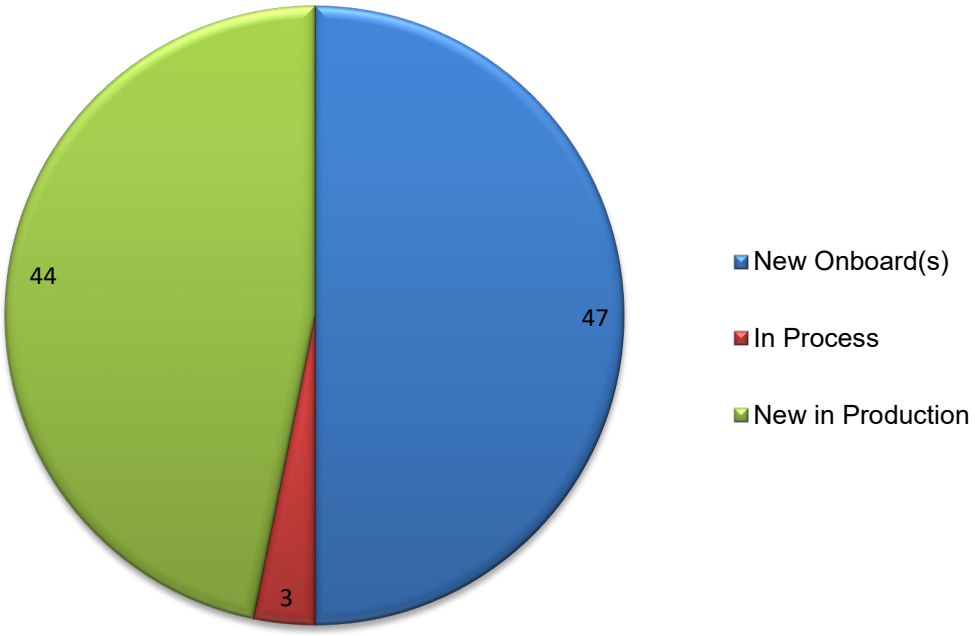
Onboarding EDI Providers – Updates

- May 2025 EDI Claims:
  - A total of 3025 new EDI submitters have been added since October 2015, with 44 added in May 2025.
  - The total number of EDI submitters is 3765 providers.

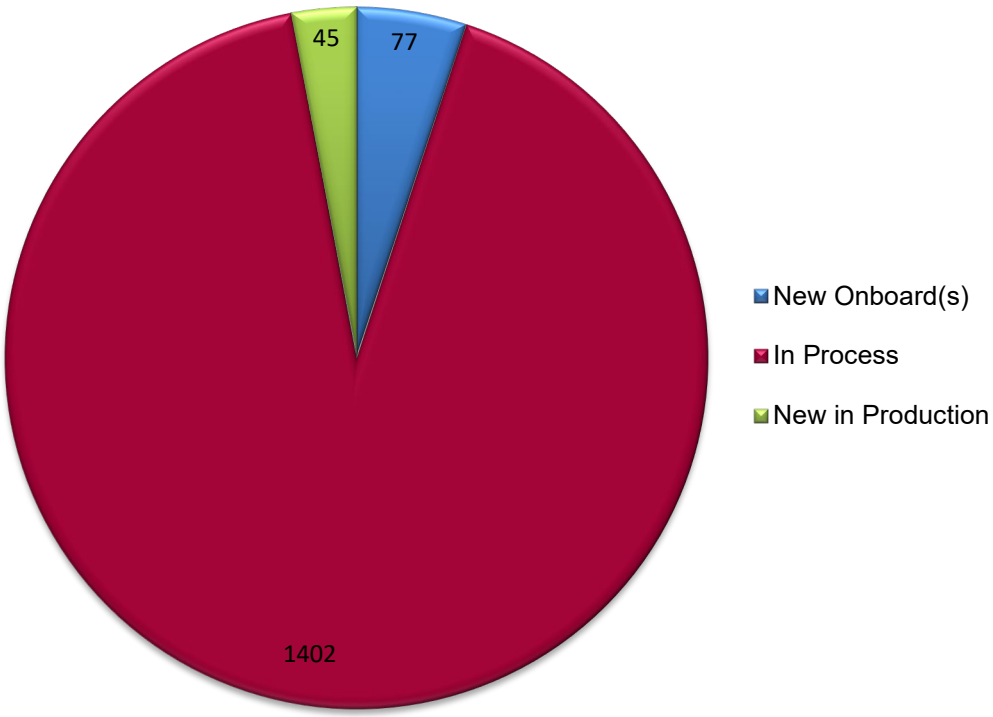
- May 2025 EDI Remittances (ERA):
  - A total of 1423 new ERA receivers have been added since October 2015, with 45 added in May 2025.
  - The total number of ERA receivers is 1410 providers.

	837				835			
	New on Boards	In Process	New In Production	Total in Production	New on Boards	In Process	New In Production	Total in Production
Jun-24	39	4	35	3120	50	908	16	1068
Jul-24	86	3	83	3203	54	937	25	1093
Aug-24	181	2	179	3382	62	982	17	1110
Sep-24	46	5	41	3423	73	1027	28	1138
Oct-24	60	4	56	3479	80	1071	36	1174
Nov-24	61	20	41	3520	89	1131	29	1203
Dec-24	61	22	39	3559	97	1177	51	1254
Jan-25	61	8	53	3612	79	1234	22	1276
Feb-25	58	16	42	3654	83	1286	31	1307
Mar-25	46	3	43	3697	74	1328	32	1339
Apr-25	38	14	24	3721	63	1370	26	1365
May-25	47	3	44	3765	77	1402	45	1410

837 EDI Submitters - May 2025



835 EDI Receivers - May 2025



Encounter Data Submission Reconciliation Form (EDSRF) and File Reconciliations

- EDSRF Submission: Below is the total number of encounter files that AAH submitted in the month of **May** 2025.

File Type	May-25
837 I Files	30
837 P Files	111
Total Files	141

Lag-time Metrics/Key Performance Indicators (KPI)

AAH Encounters: Outbound 837	May-25	Target
Timeliness-% Within Lag Time - Institutional 0-90 days	77%	60%
Timeliness-% Within Lag Time - Institutional 0-180 days	88%	80%
Timeliness-% Within Lag Time - Professional 0-90 days	92%	65%
Timeliness-% Within Lag Time – Professional 0-180 days	98%	80%

*Note, the Number of Encounters comes from: Total at bottom of this chart: **Outbound Encounter Submission**

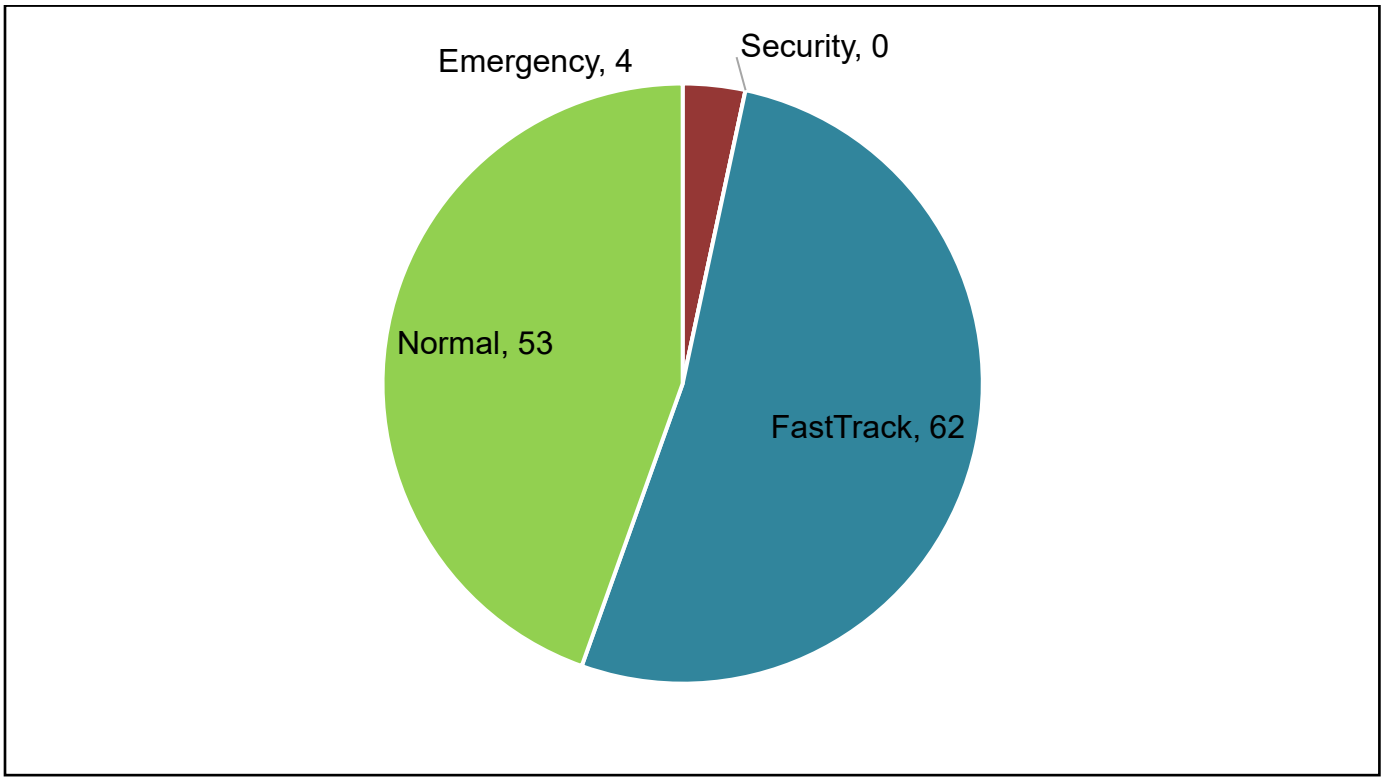
Encounter Data

- In the month of **May** 2025, the Alliance submitted **141** encounter files to the Department of Health Care Services (DHCS) with a total of **435,150** encounters.

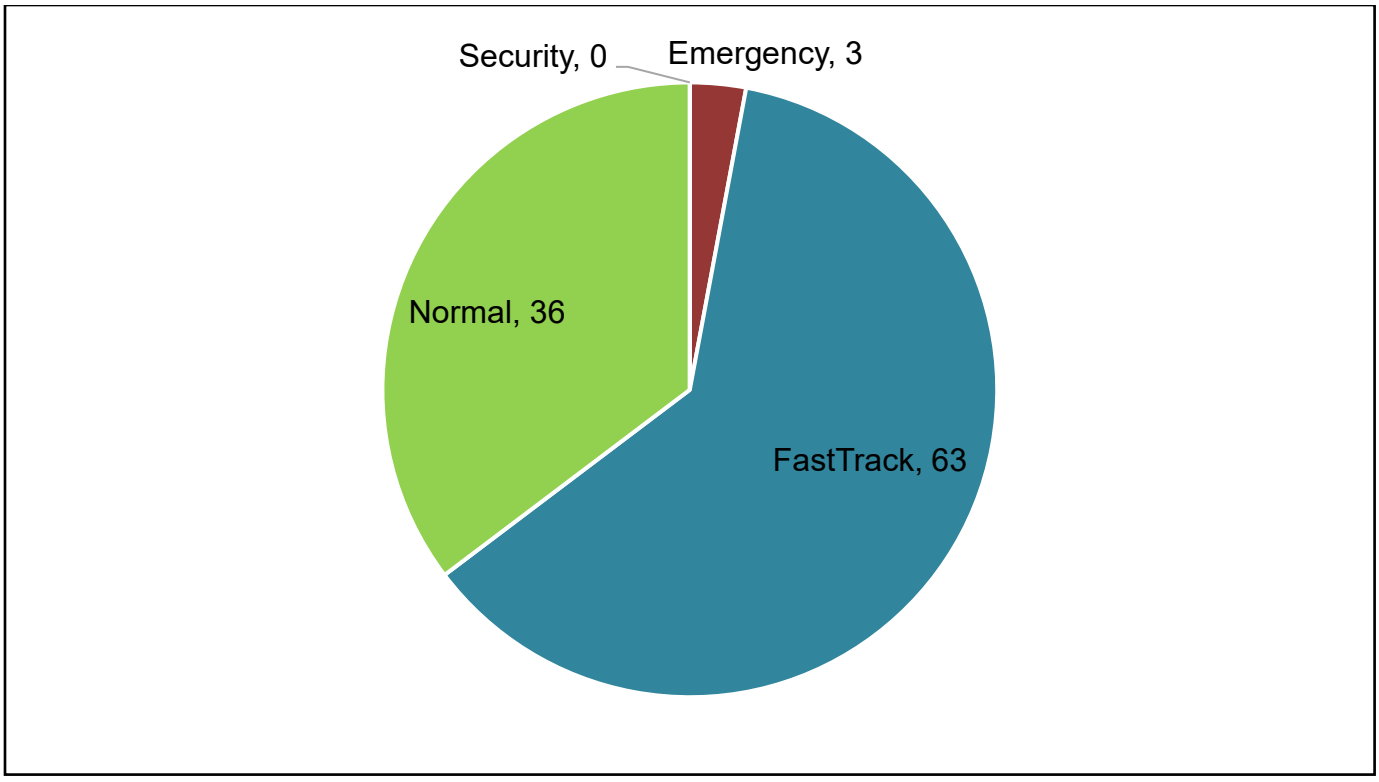
Change Management Key Performance Indicator (KPI)

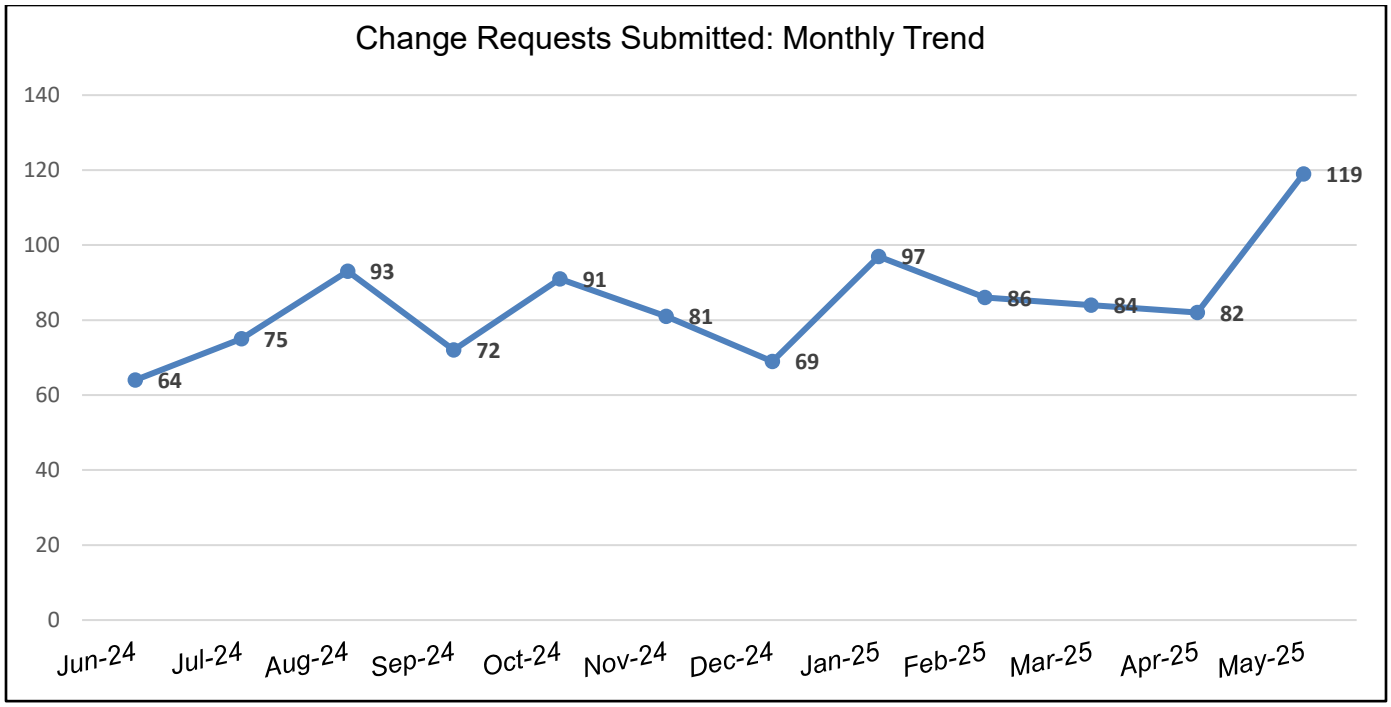
- Change Request Overall Summary in the month of May 2025 KPI:
  - 119 Changes Submitted.
  - 102 Changes Completed and Closed.
  - 132 Active Change Requests in pipeline.
  - 6 Change Requests Cancelled or Rejected.

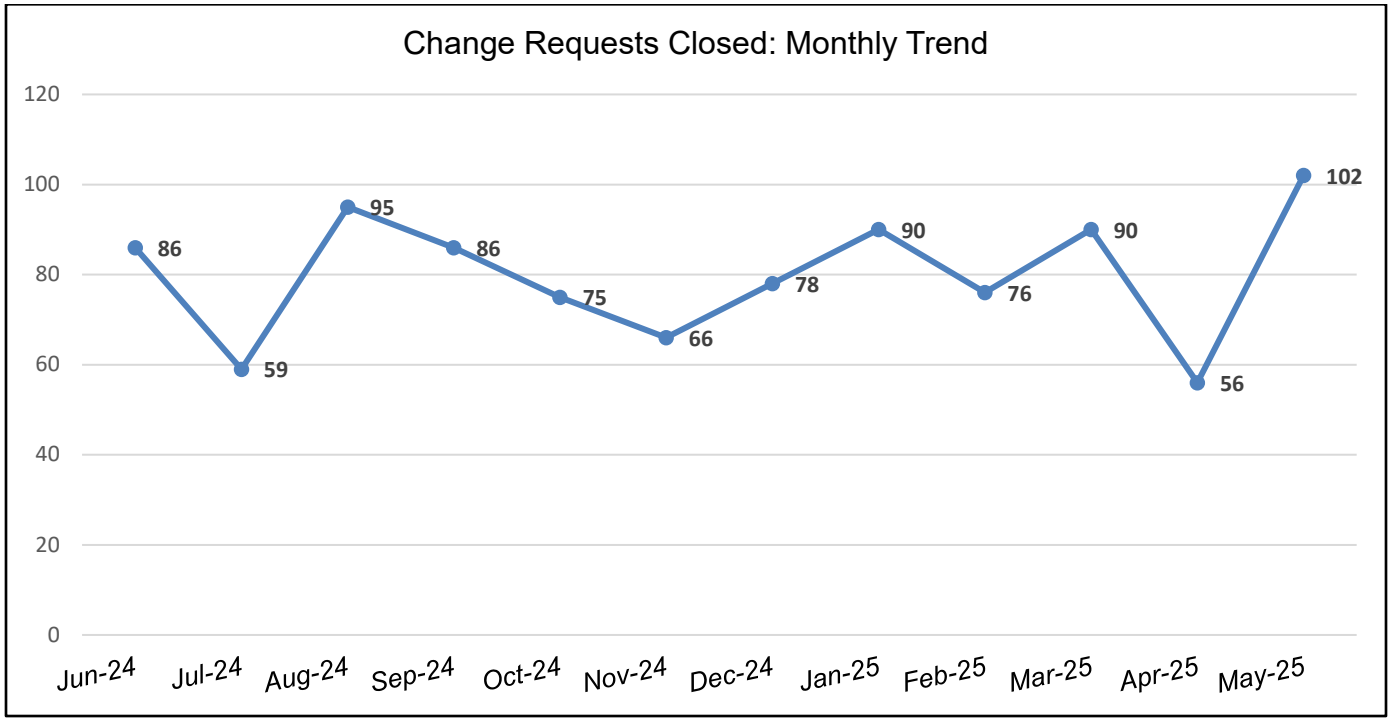
- 119 Change Requests Submitted/Logged in the month of May 2025



- 102 Change Requests Closed in the month of May 2025

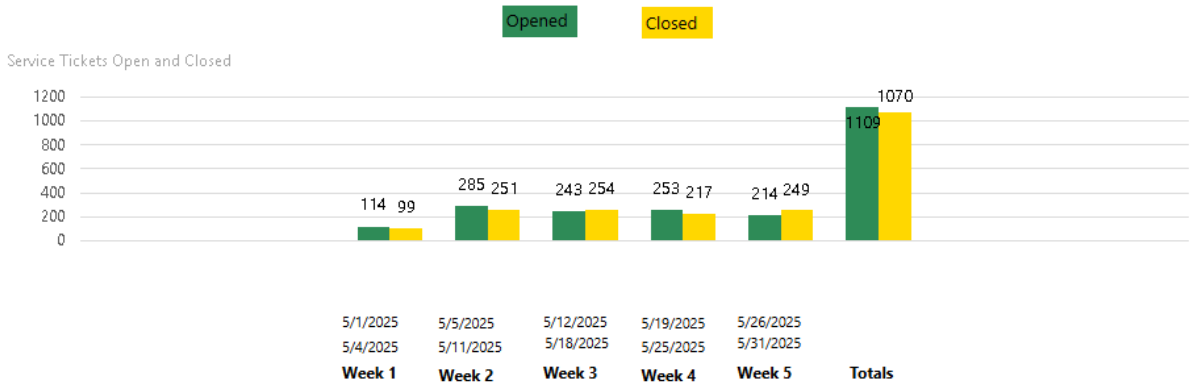



Change Requests Submitted: Monthly Trend
140
120
100
80
60
40
20
0
64
75
93
72
91
81
69
97
86
84
82
119
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25
Apr-25
May-25


Change Requests Closed: Monthly Trend
120
100
80
60
40
20
0
86
59
95
86
75
66
78
90
76
90
56
102
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25
Apr-25
May-25

IT Stats: Service Desk

IT Service Tickets Open and Closed



- 1109 Service Desk tickets were opened in the month of May 2025, which is 9.46% lower than the previous month (1225) and 5.31% higher than the previous 3-month average of 1053.

- 1070 Service Desk tickets were closed in the month of May 2025, which is 10.90% lower than the previous month (1201) and 5.84% higher than the previous 3-month average of 1010.

IT Stats: Security

Security + Network Updates

Areas	Item Status
Ops.	• Completed ○ Trued up SecureLink and associated onboarding for IntelliSwift. ○ In partnership with Infra., developed a clean base image for server provisioning. ○ No suspicious (email) activity surrounding DaVita's ransomware compromise. ○ Enforced email TLS protocol with DHCS. ○ Removal of Silverlight (EoL/EoS) sw. • Underway ○ Certificate import from Smartsheet -> IT Glue in process. ○ POC'ing PodSec for vulnerability management and patch management. ○ Arctic Wolf agent re-up. ○ Successful testing of SmartSearch function (Cisco Umbrella).
Projects	• Network Segmentation – initiating scoping and requirements
GRC	• In partnership with Infrastructure team, hardened server provisioning process by (1) eliminating Eol/EoS software and (2) vulnerability scanning remediation prior to release. • Informed CIO/CISO directs of a pending IT Security Architectural review process for new IT implementations.

Analytics

Tiffany Cheang

To: **Alameda Alliance for Health Board of Governors**

From: **Tiffany Cheang, Chief Analytics Officer**

Date: **June 13th, 2025**

Subject: **Performance & Analytics Report**

Member Cost Analysis

The Member Cost Analysis below is based on the following 12 month rolling periods:

Current reporting period: Mar 2024 – Feb 2025 dates of service
Prior reporting period: Mar 2023 – Feb 2024 dates of service
(Note: Data excludes Kaiser membership data.)

- For the Current reporting period, the top 11.5% of members account for 89.5% of total costs.

- In comparison, the Prior reporting period was lower at 7.7% of members accounting for 83.6% of total costs.

- Characteristics of the top utilizing population remained fairly consistent between the reporting periods:

    - The SPD/LTC (non duals) and ACA OE categories of aid slightly increased to account for 53.7% of the members, with SPD/LTCs accounting for 18.5% and ACA OE's at 35.2%.
    - The percent of members with costs >= $30K increased from 2.1% to 3.0%.
    - Of those members with costs >= $100K, the percentage of total members has increased to 1.0%.
        - For these members, non-trauma/pregnancy inpatient costs continue to comprise the majority of costs, decreasing to 31.1%.
    - Demographics for member city and gender for members with costs >= $30K follow the same distribution as the overall Alliance population.
    - However, the age distribution of the top 11.5% is more concentrated in the 45-66 year old category (35.8%) compared to the overall population (20.6%).

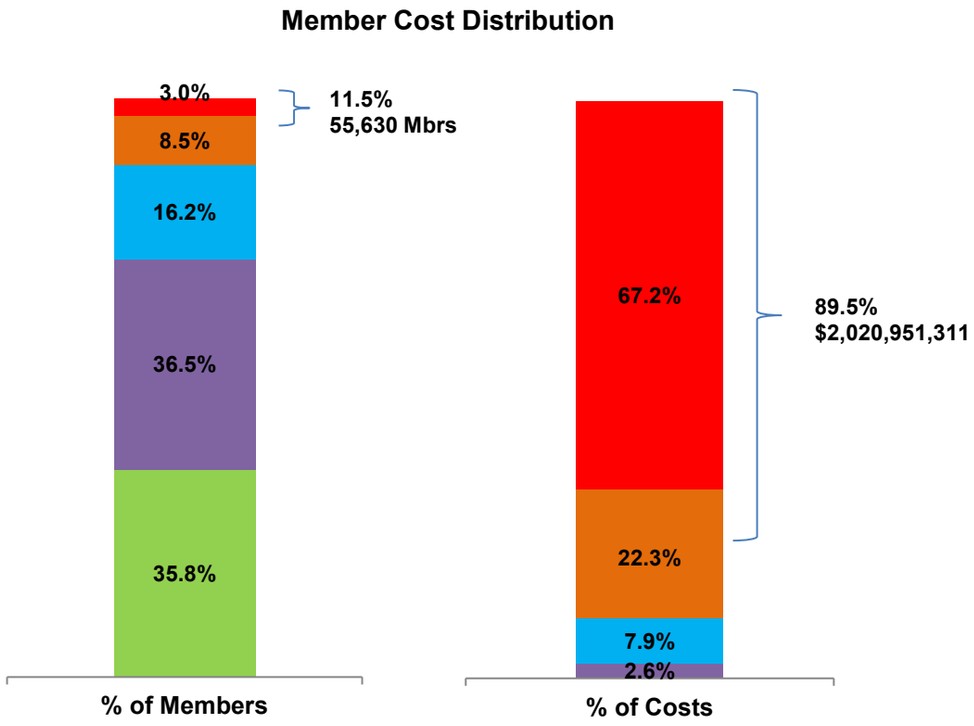
Analytics

Supporting Documents

Alameda Alliance for Health - Analytics Supporting Documentation: Member - Cost Analysis
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Mar 2024 - Feb 2025

Note: Data incomplete due to claims lag

Run Date: 05/28/2025



Cost Range	Members	% of Members	Costs	% of Costs
$30K+	14,516	3.0%	$ 1,517,559,701	67.2%
$5K - $30K	41,114	8.5%	$ 503,391,609	22.3%
$1K - $5K	78,703	16.2%	$ 177,302,650	7.9%
< $1K	177,079	36.5%	$ 59,089,134	2.6%
$0	173,932	35.8%	$ -	0.0%
Totals	**485,344**	**100.0%**	**$ 2,257,343,094**	**100.0%**

Top 11.5% of Members = 89.5% of Costs

Cost Range	Members	% of Total Members	Costs	% of Total Costs
$100K+	4,742	1.0%	$ 986,596,936	43.7%
$75K to $100K	1,872	0.4%	$ 163,680,459	7.3%
$50K to $75K	2,755	0.6%	$ 167,732,350	7.4%
$40K to $50K	2,097	0.4%	$ 94,043,068	4.2%
$30K to $40K	3,050	0.6%	$ 105,506,888	4.7%
SubTotal	***14,516***	***3.0%***	***$ 1,517,559,701***	***67.2%***
$20K to $30K	5,792	1.2%	$ 140,936,893	6.2%
$10K to $20K	15,807	3.3%	$ 223,145,365	9.9%
$5K to $10K	19,515	4.0%	$ 139,309,352	6.2%
SubTotal	***41,114***	***8.5%***	***$ 503,391,609***	***22.3%***
Total	**55,630**	***11.5%***	**$ 2,020,951,311**	***89.5%***

Enrollment Status	Members	Total Costs
Still Enrolled as of Feb 2025	413,909	$ 2,037,500,813
Dis-Enrolled During Year	71,435	$ 219,842,281
Totals	**485,344**	**$ 2,257,343,094**

Notes:
- Report includes medical costs (HS & Diamond Claims, Beacon, Logisticare FFS, CHCN FFS Preventive Services, CHME) and pharmacy costs. IBNP factors are not applied.
- CFMG and CHCN encounter data has been priced out.

Alameda Alliance for Health - Analytics Supporting Documentation: Member - Cost Analysis
11.5% of Members = 89.5% of Costs
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Mar 2024 - Feb 2025
Note: Data incomplete due to claims lag
Run Date: 05/28/2025

11.5% of Members = 89.5% of Costs
18.5% of members are SPD/LTCs and account for 24.6% of costs.
35.2% of members are ACA OE and account for 32.4% of costs.
7.8% of members disenrolled as of Feb 2025 and account for 10.0% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Members	% of Members
IHSS	IHSS	194	943	1,137	2.0%
MCAL	MCAL - ADULT	1,260	7,834	9,094	16.3%
	MCAL - BCCTP	-	-	-	0.0%
	MCAL - CHILD	656	3,876	4,532	8.1%
	MCAL - ACA OE	4,713	14,884	19,597	35.2%
	MCAL - DUALS	-	-	-	0.0%
	MCAL - SPD-LTC	3,593	6,674	10,267	18.5%
	MCAL - SPD-LTC/Full Dual	2,644	4,040	6,684	12.0%
Not Eligible	Not Eligible	1,456	2,863	4,319	7.8%
Total		**14,516**	**41,114**	**55,630**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Costs	% of Costs
IHSS	IHSS	$ 17,758,453	$ 10,825,214	$ 28,583,667	1.4%
MCAL	MCAL - ADULT	$ 127,302,829	$ 94,597,556	$ 221,900,385	11.0%
	MCAL - BCCTP	$ -	$ -	$ -	0.0%
	MCAL - CHILD	$ 50,980,266	$ 43,706,729	$ 94,686,995	4.7%
	MCAL - ACA OE	$ 471,645,882	$ 182,543,355	$ 654,189,237	32.4%
	MCAL - DUALS	$ -	$ -	$ -	0.0%
	MCAL - SPD-LTC	$ 411,068,413	$ 86,398,483	$ 497,466,896	24.6%
	MCAL - SPD-LTC/Full Dual	$ 272,365,097	$ 49,501,911	$ 321,867,008	15.9%
Not Eligible	Not Eligible	$ 166,438,761	$ 35,818,361	$ 202,257,123	10.0%
Total		**$ 1,517,559,701**	**$ 503,391,609**	**$ 2,020,951,311**	**100.0%**

Highest Cost Members; Cost Per Member >= $100K
27.2% of members are SPD/LTCs and account for 29.1% of costs.
26.7% of members are ACA OE and account for 29.7% of costs.
9.0% of members disenrolled as of Feb 2025 and account for 10.9% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Total Members	% of Members
IHSS	IHSS	45	0.9%
MCAL	MCAL - ADULT	283	6.0%
	MCAL - BCCTP	-	0.0%
	MCAL - CHILD	92	1.9%
	MCAL - ACA OE	1,267	26.7%
	MCAL - DUALS	-	0.0%
	MCAL - SPD-LTC	1,289	27.2%
	MCAL - SPD-LTC/Full Dual	1,337	28.2%
Not Eligible	Not Eligible	429	9.0%
Total		**4,742**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Total Costs	% of Costs
IHSS	IHSS	$ 9,750,024	1.0%
MCAL	MCAL - ADULT	$ 77,325,560	7.8%
	MCAL - BCCTP	$ -	0.0%
	MCAL - CHILD	$ 23,179,767	2.3%
	MCAL - ACA OE	$ 292,997,942	29.7%
	MCAL - DUALS	$ -	0.0%
	MCAL - SPD-LTC	$ 286,693,544	29.1%
	MCAL - SPD-LTC/Full Dual	$ 188,673,997	19.1%
Not Eligible	Not Eligible	$ 107,976,102	10.9%
Total		**$ 986,596,936**	**100.0%**

% of Total Costs By Service Type

Breakout by Service Type/Location

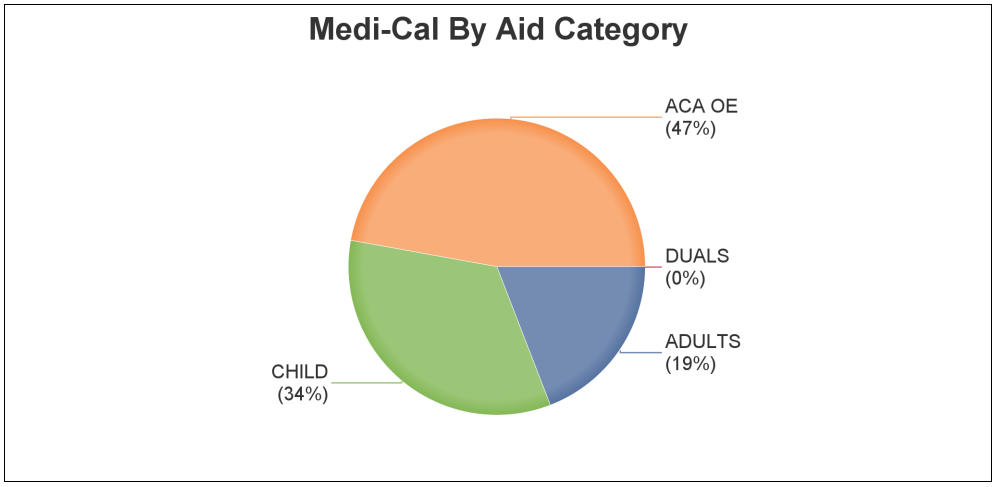
Cost Range	Trauma Costs	Hep C Rx Costs	Pregnancy, Childbirth & Newborn Related Costs	Pharmacy Costs	Inpatient Costs (POS 21)	ER Costs (POS 23)	Outpatient Costs (POS 22)	Office Costs (POS 11)	Dialysis Costs (POS 65)	Other Costs (All Other POS)
$100K+	5%	0%	1%	14%	36%	1%	11%	2%	2%	32%
$75K to $100K	4%	0%	1%	18%	25%	3%	5%	4%	5%	40%
$50K to $75K	5%	0%	2%	26%	29%	5%	6%	6%	4%	25%
$40K to $50K	7%	0%	2%	33%	28%	8%	5%	7%	1%	19%
$30K to $40K	10%	0%	3%	33%	23%	13%	6%	7%	1%	18%
$20K to $30K	2%	1%	6%	36%	23%	7%	8%	7%	1%	17%
$10K to $20K	0%	0%	11%	35%	24%	7%	9%	9%	1%	15%
$5K to $10K	0%	0%	5%	31%	12%	11%	13%	13%	0%	19%
Total	**4%**	**0%**	**3%**	**22%**	**30%**	**4%**	**9%**	**5%**	**2%**	**27%**

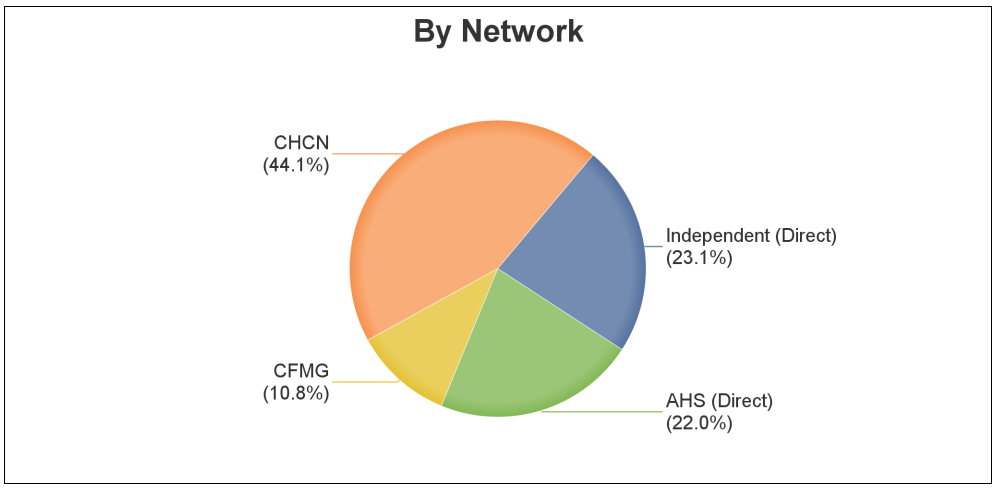
Notes:
- Report includes medical costs (HS & Diamond Claims, Beacon, Logisticare FFS, CHCN FFS Preventive Services, CHME) and pharmacy costs. IBNP factors are not applied.
- CFMG and CHCN encounter data has been priced out.
- Report excludes Capitation Expense

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend

Category of Aid	Apr 2025	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN
ADULTS	62,532	15%	13,585	14,080	0	34,867
CHILD	110,211	27%	10,486	13,429	41,303	44,993
SPD	0	0%	0	0	0	0
ACA OE	154,154	38%	28,361	53,370	1,545	70,878
DUALS	1	0%	1	0	0	0
LTC	0	0%	0	0	0	0
LTC-DUAL	0	0%	0	0	0	0
SPD-LTC	29,316	7%	8,653	5,074	1,479	14,110
SPD-LTC/Full Dual	48,733	12%	31,539	3,518	3	13,673
Medi-Cal	404,947		92,625	89,471	44,330	178,521
Group Care	5,896		2,204	988	0	2,704
Total	**410,843**	**100%**	**94,829**	**90,459**	**44,330**	**181,225**
Medi-Cal %	98.6%		97.7%	98.9%	100.0%	98.5%
Group Care %	1.4%		2.3%	1.1%	0.0%	1.5%
	Network Distribution		**23.1%**	**22.0%**	**10.8%**	**44.1%**
			% Direct:	**45%**	**% Delegated:**	**55%**

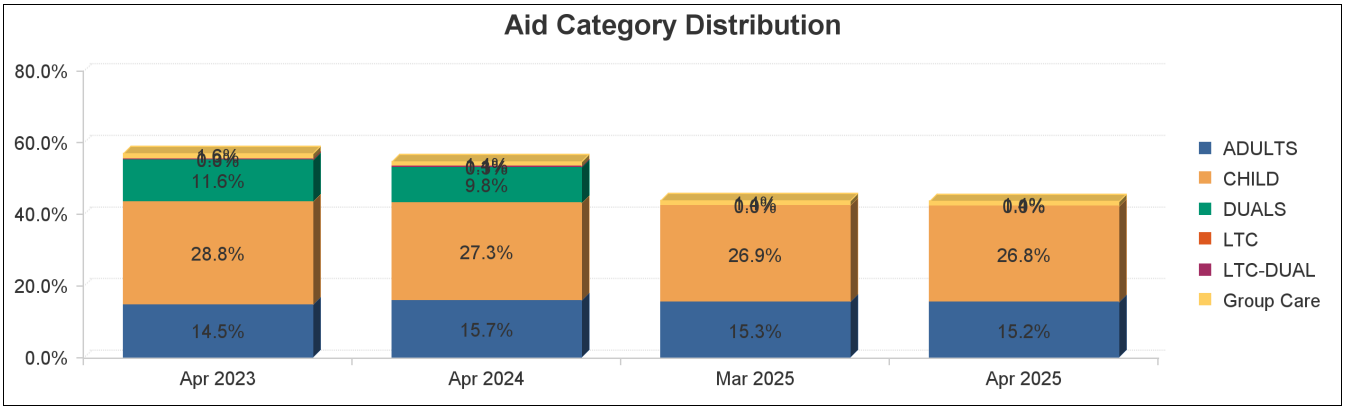




Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

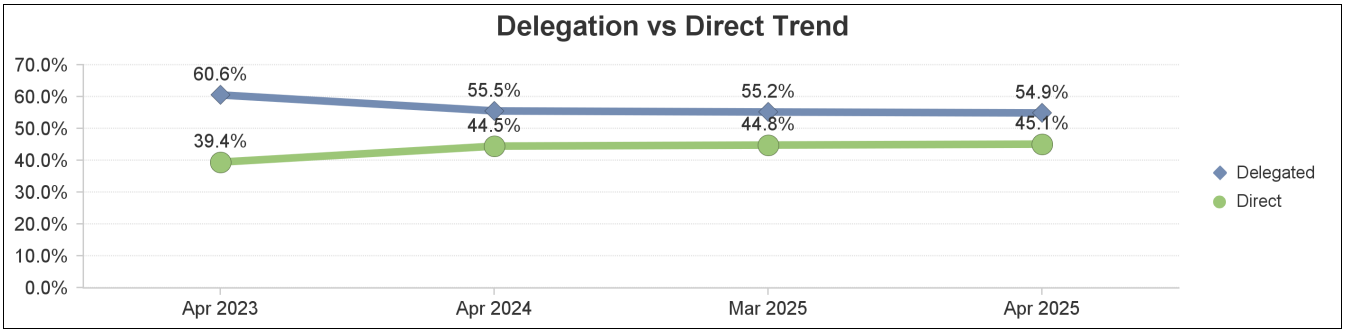
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Apr 2023	Apr 2024	Mar 2025	Apr 2025	Apr 2023	Apr 2024	Mar 2025	Apr 2025	Apr 2023 to Apr 2024	Apr 2024 to Apr 2025	Mar 2025 to Apr 2025
ADULTS	52,047	63,551	63,278	**62,532**	14.5%	15.7%	15.3%	15.2%	18.1%	-1.6%	-1.2%
CHILD	103,173	110,566	111,153	**110,211**	28.8%	27.3%	26.9%	26.8%	6.7%	-0.3%	-0.9%
SPD	31,130	34,887	0	**0**	8.7%	8.6%	0.0%	0.0%	10.8%	0.0%	0.0%
ACA OE	123,606	149,154	154,579	**154,154**	34.5%	36.8%	37.5%	37.5%	17.1%	3.2%	-0.3%
DUALS	41,473	39,912	1	**1**	11.6%	9.8%	0.0%	0.0%	-3.9%	##########	0.0%
LTC	145	223	0	**0**	0.0%	0.1%	0.0%	0.0%	35.0%	0.0%	0.0%
LTC-DUAL	983	1,291	0	**0**	0.3%	0.3%	0.0%	0.0%	23.9%	0.0%	0.0%
SPD-LTC	0	0	29,609	**29,316**	0.0%	0.0%	7.2%	7.1%	0.0%	100.0%	-1.0%
SPD-LTC/ Full Dual	0	0	48,241	**48,733**	0.0%	0.0%	11.7%	11.9%	0.0%	100.0%	1.0%
Medi-Cal	352,557	399,584	406,861	**404,947**	98.4%	98.6%	98.6%	98.6%	11.8%	1.3%	-0.5%
Group Care	5,669	5,643	5,882	**5,896**	1.6%	1.4%	1.4%	1.4%	-0.5%	4.3%	0.2%
Total	**358,226**	**405,227**	**412,743**	**410,843**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**11.6%**	**1.4%**	**-0.5%**



Delegation vs Direct Trend

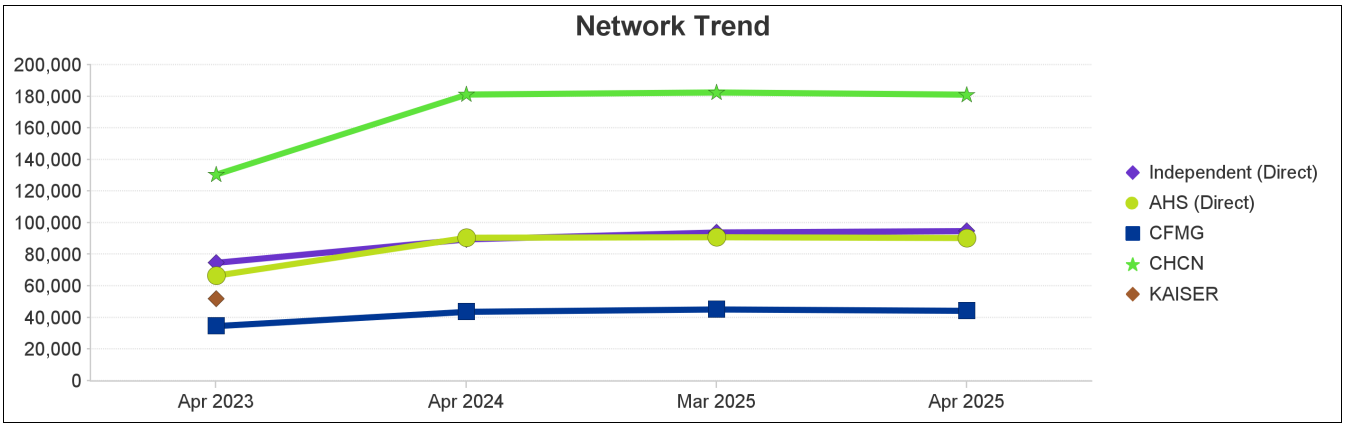
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	Apr 2023	Apr 2024	Mar 2025	Apr 2025	Apr 2023	Apr 2024	Mar 2025	Apr 2025	Apr 2023 to Apr 2024	Apr 2024 to Apr 2025	Mar 2025 to Apr 2025
Delegated	216,961	225,002	227,836	**225,555**	60.6%	55.5%	55.2%	54.9%	3.6%	0.2%	-1.0%
Direct	141,265	180,225	184,907	**185,288**	39.4%	44.5%	44.8%	45.1%	21.6%	2.7%	0.2%
Total	**358,226**	**405,227**	**412,743**	**410,843**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**11.6%**	**1.4%**	**-0.5%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Network Trend

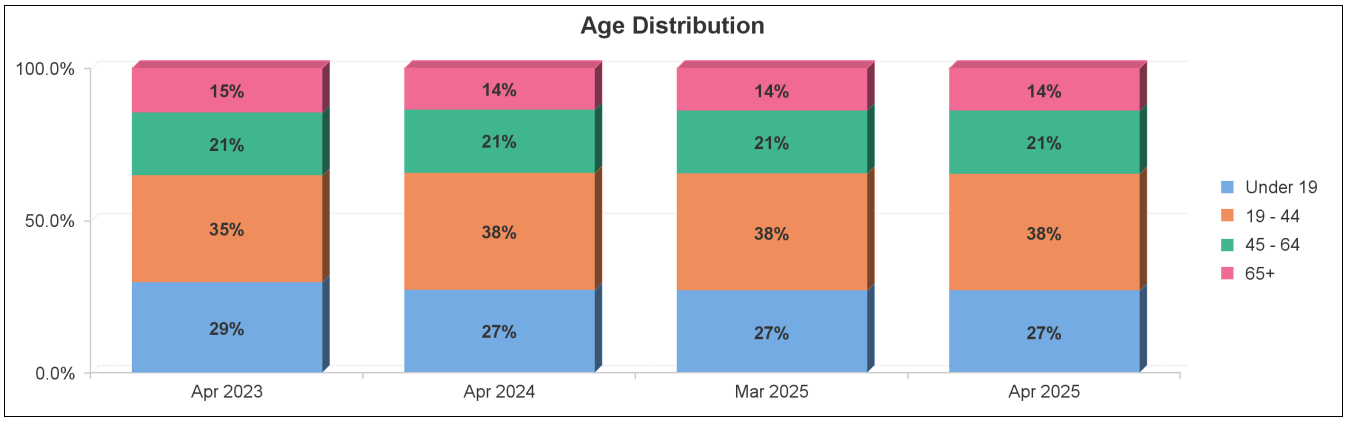
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Apr 2023	Apr 2024	Mar 2025	Apr 2025	Apr 2023	Apr 2024	Mar 2025	Apr 2025	Apr 2023 to Apr 2024	Apr 2024 to Apr 2025	Mar 2025 to Apr 2025
Independent (Direct)	74,713	89,595	93,950	**94,829**	20.9%	22.1%	22.8%	23.1%	16.6%	5.5%	0.9%
AHS (Direct)	66,552	90,630	90,957	**90,459**	18.6%	22.4%	22.0%	22.0%	26.6%	-0.2%	-0.6%
CFMG	34,644	43,702	45,203	**44,330**	9.7%	10.8%	11.0%	10.8%	20.7%	1.4%	-2.0%
CHCN	130,508	181,300	182,633	**181,225**	36.4%	44.7%	44.2%	44.1%	28.0%	0.0%	-0.8%
KAISER	51,809	0	0	**0**	14.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	**358,226**	**405,227**	**412,743**	**410,843**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**11.6%**	**1.4%**	**-0.5%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

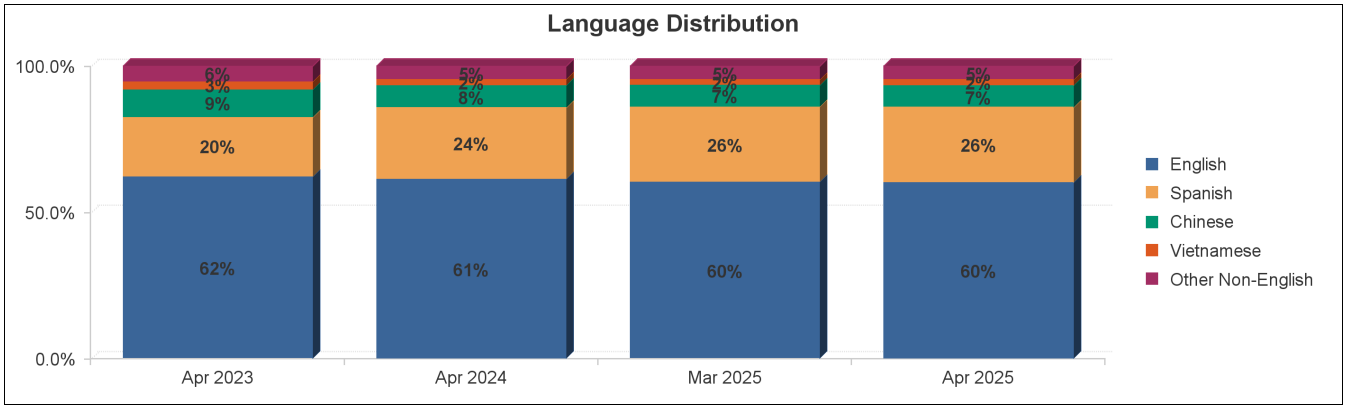
Age Category Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Apr 2023	Apr 2024	Mar 2025	Apr 2025	Apr 2023	Apr 2024	Mar 2025	Apr 2025	Apr 2023 to Apr 2024	Apr 2024 to Apr 2025	Mar 2025 to Apr 2025
Under 19	105,525	108,917	110,282	**109,618**	29%	27%	27%	27%	3%	1%	-1%
19 - 44	125,496	156,001	158,678	**157,592**	35%	38%	38%	38%	20%	1%	-1%
45 - 64	73,669	84,128	85,158	**84,775**	21%	21%	21%	21%	12%	1%	0%
65+	53,536	56,181	58,625	**58,858**	15%	14%	14%	14%	5%	5%	0%
Total	**358,226**	**405,227**	**412,743**	**410,843**	**100%**	**100%**	**100%**	**100%**	**12%**	**1%**	**0%**



Language Trend

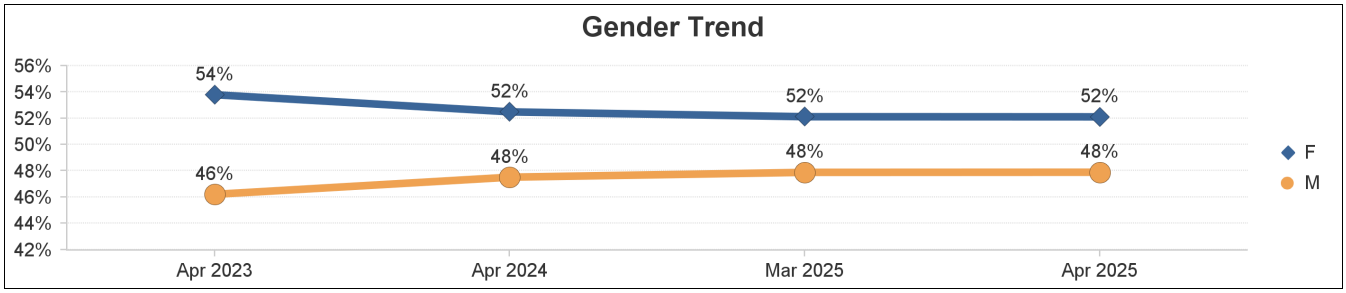
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	Apr 2023	Apr 2024	Mar 2025	Apr 2025	pr 2023	pr 2024	Mar 2025	pr 2025	Apr 2023 to Apr 2024	Apr 2024 to Apr 2025	Mar 2025 to Apr 2025
English	221,974	247,927	248,349	**246,716**	62%	61%	60%	60%	10%	0%	-1%
Spanish	72,728	98,970	105,898	**105,652**	20%	24%	26%	26%	27%	6%	0%
Chinese	33,747	30,725	30,544	**30,517**	9%	8%	7%	7%	-10%	-1%	0%
Vietnamese	9,787	8,548	8,209	**8,174**	3%	2%	2%	2%	-14%	-5%	0%
Other Non-English	19,990	19,057	19,743	**19,784**	6%	5%	5%	5%	-5%	4%	0%
Total	**358,226**	**405,227**	**412,743**	**410,843**	**100%**	**100%**	**100%**	**100%**	**12%**	**1%**	**0%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

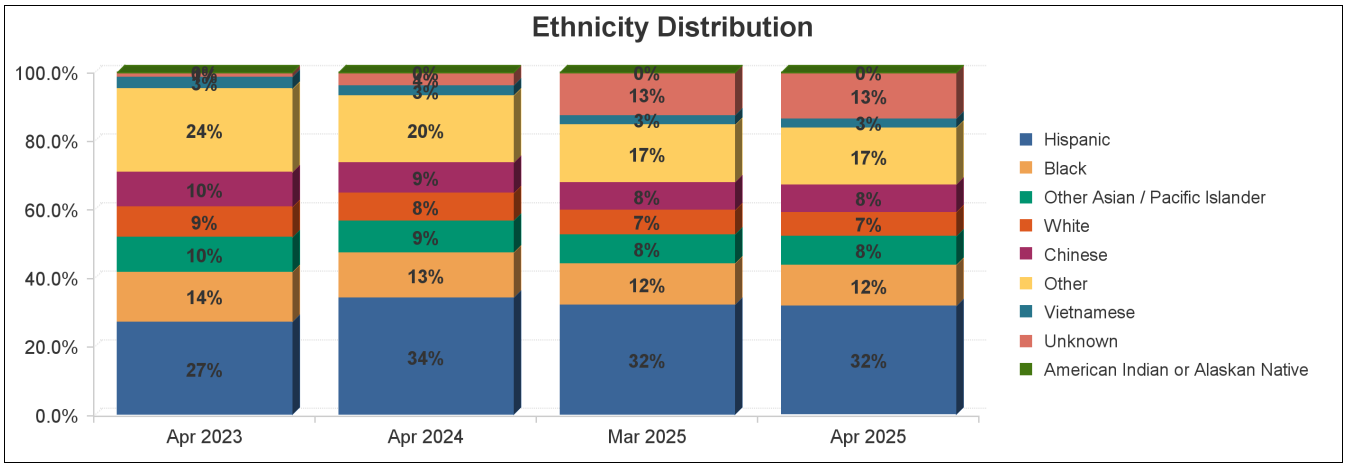
Gender Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Apr 2023	Apr 2024	Mar 2025	Apr 2025	Apr 2023	Apr 2024	Mar 2025	Apr 2025	Apr 2023 to Apr 2024	Apr 2024 to Apr 2025	Mar 2025 to Apr 2025
F	192,712	212,693	215,119	**214,090**	54%	52%	52%	52%	9%	1%	0%
M	165,514	192,534	197,624	**196,753**	46%	48%	48%	48%	14%	2%	0%
Total	**358,226**	**405,227**	**412,743**	**410,843**	**100%**	**100%**	**100%**	**100%**	**12%**	**1%**	**0%**



Ethnicity Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Apr 2023	Apr 2024	Mar 2025	Apr 2025	Apr 2023	Apr 2024	Mar 2025	Apr 2025	Apr 2023 to Apr 2024	Apr 2024 to Apr 2025	Mar 2025 to Apr 2025
Hispanic	96,968	138,080	132,032	**130,033**	27%	34%	32%	32%	30%	-6%	-2%
Black	51,913	53,580	49,884	**49,313**	14%	13%	12%	12%	3%	-9%	-1%
Other Asian / Pacific Islander	36,482	37,409	34,933	**34,386**	10%	9%	8%	8%	2%	-9%	-2%
White	31,763	32,949	29,347	**28,815**	9%	8%	7%	7%	4%	-14%	-2%
Chinese	36,306	35,847	33,490	**33,056**	10%	9%	8%	8%	-1%	-8%	-1%
Other	87,251	79,277	69,451	**68,358**	24%	20%	17%	17%	-10%	-16%	-2%
Vietnamese	12,333	12,050	10,972	**10,834**	3%	3%	3%	3%	-2%	-11%	-1%
Unknown	4,471	15,231	51,888	**55,315**	1%	4%	13%	13%	71%	72%	6%
American Indian or Alaskan Native	739	804	746	**733**	0%	0%	0%	0%	8%	-10%	-2%
Total	**358,226**	**405,227**	**412,743**	**410,843**	**100%**	**100%**	**100%**	**100%**	**12%**	**1%**	**0%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile By City

Medi-Cal By City

City	Apr 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	161,908	40%	25,161	42,075	17,344	77,328
HAYWARD	53,634	13%	12,227	15,133	5,878	20,396
FREMONT	38,585	10%	16,191	6,787	2,405	13,202
SAN LEANDRO	26,205	6%	7,124	4,360	3,239	11,482
UNION CITY	14,555	4%	5,809	2,617	847	5,282
ALAMEDA	13,812	3%	3,378	2,490	2,057	5,887
BERKELEY	15,792	4%	4,092	2,332	1,797	7,571
LIVERMORE	13,291	3%	2,027	525	2,244	8,495
NEWARK	9,386	2%	2,783	4,043	574	1,986
CASTRO VALLEY	11,119	3%	3,215	1,784	1,756	4,364
SAN LORENZO	6,276	2%	1,337	1,426	723	2,790
PLEASANTON	8,051	2%	2,063	384	843	4,761
DUBLIN	7,762	2%	2,257	390	911	4,204
EMERYVILLE	2,990	1%	653	629	493	1,215
ALBANY	2,565	1%	620	297	573	1,075
PIEDMONT	504	0%	114	180	85	125
SUNOL	82	0%	21	15	7	39
ANTIOCH	22	0%	7	10	4	1
Other	18,408	5%	3,546	3,994	2,550	8,318
Total	404,947	100%	**92,625**	**89,471**	**44,330**	**178,521**

Group Care By City

City	Apr 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	1,834	31%	350	371	0	1,113
HAYWARD	667	11%	313	171	0	183
FREMONT	664	11%	441	79	0	144
SAN LEANDRO	623	11%	254	92	0	277
UNION CITY	294	5%	184	45	0	65
ALAMEDA	303	5%	86	25	0	192
BERKELEY	149	3%	48	13	0	88
LIVERMORE	101	2%	31	3	0	67
NEWARK	145	2%	83	36	0	26
CASTRO VALLEY	206	3%	87	33	0	86
SAN LORENZO	145	2%	44	30	0	71
PLEASANTON	71	1%	22	4	0	45
DUBLIN	123	2%	43	7	0	73
EMERYVILLE	42	1%	13	6	0	23
ALBANY	23	0%	12	1	0	10
PIEDMONT	7	0%	1	1	0	5
SUNOL	1	0%	1	0	0	0
ANTIOCH	24	0%	8	4	0	12
Other	474	8%	183	67	0	224
Total	**5,896**	**100%**	**2,204**	**988**	**0**	**2,704**

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile By City

Total By City

City	Apr 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	163,742	40%	25,511	42,446	17,344	78,441
HAYWARD	54,301	13%	12,540	15,304	5,878	20,579
FREMONT	39,249	10%	16,632	6,866	2,405	13,346
SAN LEANDRO	26,828	7%	7,378	4,452	3,239	11,759
UNION CITY	14,849	4%	5,993	2,662	847	5,347
ALAMEDA	14,115	3%	3,464	2,515	2,057	6,079
BERKELEY	15,941	4%	4,140	2,345	1,797	7,659
LIVERMORE	13,392	3%	2,058	528	2,244	8,562
NEWARK	9,531	2%	2,866	4,079	574	2,012
CASTRO VALLEY	11,325	3%	3,302	1,817	1,756	4,450
SAN LORENZO	6,421	2%	1,381	1,456	723	2,861
PLEASANTON	8,122	2%	2,085	388	843	4,806
DUBLIN	7,885	2%	2,300	397	911	4,277
EMERYVILLE	3,032	1%	666	635	493	1,238
ALBANY	2,588	1%	632	298	573	1,085
PIEDMONT	511	0%	115	181	85	130
SUNOL	83	0%	22	15	7	39
ANTIOCH	46	0%	15	14	4	13
Other	18,882	5%	3,729	4,061	2,550	8,542
Total	410,843	100%	**94,829**	**90,459**	**44,330**	**181,225**

ALAMEDA Alliance FOR HEALTH

Health care you can count on.
Service you can trust.

Human Resources

Anastacia Swift

To: **Alameda Alliance for Health Board of Governors**

From: **Anastacia Swift, Chief Human Resources Officer**

Date: **June 13th, 2025**

Subject: **Human Resources Report**

Staffing

- As of June 1st, 2025, the Alliance had 668 full time employees and 0 part time employee.

- On June 1st, 2025, the Alliance had 75 open positions in which 19 signed offer acceptance letters have been received with start dates in the near future resulting in a total of 56 positions open to date. The Alliance is actively recruiting for the remaining 56 positions and several of these positions are in the interviewing or job offer stage.

- Summary of open positions by division:

Division	Open Position June 1st	Signed Offers Accepted by Department	Remaining Recruitment Positions
Healthcare Services	13	6	7
Operations	37	6	31
Healthcare Analytics	3	1	2
Information Technology	12	3	9
Finance	2	0	2
Compliance	5	3	2
Human Resources	3	0	3
Health Equity	0	0	0
Executive	0	0	0
Total	75	19	56

- Our current recruitment rate is 11%.

Employee Recognition

- Employees reaching major milestones in their length of service at the Alliance in May 2025 included:

  5 years:
  - Cassie V (Utilization Management)
  - Fiona Q (Quality Management)

  6 years:
  - Reya J (Case/Disease Management)
  - Carla H (Utilization Management)
  - Pedro L (Information Technology)

  7 years:
  - Randy S (Quality Analytics)
  - Jessica J (Quality Management)
  - Hope D (Utilization Management)
  - Leticia A (Provider Services)
  - Aman A (IT Infrastructure)

  8 years:
  - Rahel N (Pharmacy Services)
  - Kwan P (IT Data Exchange)

  9 years:
  - Ria H (Claims)
  - Aracely M (Claims)

  10 years:
  - Jeremy A (IT Ops And Quality Apps Mgt)

  12 years:
  - Michelle L (Marketing & Communications)
  - Alicia G (Utilization Management)

  13 years:
  - Linda A (Quality Management)

  17 years:
  - Cecilia G (Provider Services)

  22 years:
  - Nancy K (Case/Disease Management)

ALAMEDA Alliance FOR HEALTH

Health care you can count on.
Service you can trust.

Standing Committee Updates

To: **Alameda Alliance for Health Board of Governors**

From: **Dr. Donna Carey, Chief Medical Officer**

Date: **June 13th, 2025**

Subject: **Standing Committee Updates**

Peer Review Credentialing Committee – April and May

April 15, 2025

- Cat 1 med– 22 + Cat 2 med-3 =25
- Cat 1 BH-110 + Cat 2 BH – 5 = 115

May 20, 2025

- Cat 1 Med, initial – 34, Cat 1 Med Re-credential -44, Cat 1 BH, initial – 135
- Cat 2, Med – 5, Cat 2 Med Re-credential- 20, Cat 2 BH -5

Pharmacy & Therapeutics Committee - March

March 18, 2025

- Reviewed P&Ps
    - 5 DSNP

Monographs and Class Reviews

- Alcohol Use Disorder Agents Class Review
- Direct Oral Anticoagulants Class Review
- Fluoride Dental Preparations Class Review
- Inhaled Corticosteroids Class Review
- Leukotriene Inhibitors Class Review
- Methergine Monograph

Medication Request Guidelines Interim Formulary Updates
Physician Administered Drug (PAD) Guidelines

Quality Improvement and Health Equity Committee (QIHEC) – April and May

April 11, 2025

- Community presentation – Dr. Aaron Chapman: MH/SUD Challenges in the ED, UM/ CM Trilogy Docs, BH updates

May 9, 2025

- QI Trilogy Doc, PHM Strategy, Cultural Linguistic and Access Updates