ALAMEDA Alliance FOR HEALTH

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Board of Governors

Regular Meeting

Friday, March 14th, 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, March 14th, 2025
12:00 p.m. – 2:00 p.m.

In-Person and Video Conference Call

1240 S. Loop Road
Alameda, CA 94502

828 I Street
Sacramento, CA 95814

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 463888504#. 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 March 14th, 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. CLOSED SESSION
PERSONNEL MATTER: PUBLIC EMPLOYEE EVALUATION – CHIEF EXECUTIVE OFFICER
(GOV.CODE SECTION 54957(b)(1)).

6. REPORT OUT: CLOSED SESSION

7. 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) DECEMBER 10th, 2024, FINANCE COMMITTEE MEETING MINUTES

b) JANUARY 22nd, 2025, FINANCE COMMITTEE MEETING MINUTES

c) FEBRUARY 11th, 2025, FINANCE COMMITTEE MEETING MINUTES

d) DECEMBER 13th, 2024, COMPLIANCE ADVISORY COMMITTEE MEETING MINUTES

e) DECEMBER 13th, 2024, BOARD OF GOVERNORS MEETING MINUTES

f) JANUARY 31st, 2025, BOARD OF GOVERNORS RETREAT MINUTES

g) REVIEW AND APPROVE RESOLUTION RE-APPOINTING NATALIE WILLIAMS TO ALLIANCE CONSUMER MEMBER SEAT

h) REVIEW AND APPROVE RESOLUTION RE-APPOINTING JODY MOORE TO ALLIANCE CONSUMER MEMBER SEAT

i) STANDING COMMITTEE UPDATES
   i. PEER REVIEW AND CREDENTIALING COMMITTEE
   ii. PHARMACY & THERAPEUTICS
   iii. QUALITY IMPROVEMENT HEALTH EQUITY COMMITTEE
   iv. COMMUNITY ADVISORY COMMITTEE

8. BOARD MEMBER REPORTS

a) BOARD CHAIR REPORT
   i. FORM 700 SUBMISSION

b) COMPLIANCE ADVISORY COMMITTEE

c) FINANCE COMMITTEE

9. **CEO UPDATE**

10. **BOARD BUSINESS**

    a) **REVIEW AND APPROVE NOVEMBER 2024, DECEMBER 2024 AND JANUARY 2025 MONTHLY FINANCIAL STATEMENTS**

    b) **FISCAL YEAR 2025 SECOND QUARTER FORECAST**

    c) **REVIEW AND APPROVE FINANCE COMMITTEE'S RECOMMENDATION TO REDUCE COMMUNITY SUPPORTS DOLLARS**

    d) **MEDICAL MANAGEMENT UPDATE**

11. **STAFF UPDATES**

12. **UNFINISHED BUSINESS**

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

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

15. **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

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) 747-6160.

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) 747-6160 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 March 11th, 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

December 10th, 2024
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, Tosan Boyo

Alliance Staff in-person and on Conference Call: Matt Woodruff, Dr. Donna Carey, Tiffany Cheang, Sasi Karaiyan, Richard Golfin III, Anastacia Swift, Lao Paul Vang, Ruth Watson, Yen Ang, Shulin Lin, Carol van Oosterwijk, Linda Ly, Brenda Martinez, Felix Rodriguez, Danube Serri, Christine Corpus

CALL TO ORDER

Dr. Ferguson convened the Finance Committee meeting at 8:00 a.m.

ROLL CALL

Roll call was conducted and confirmed.

INTRODUCTIONS

Gil Riojas acknowledged Carol VanOosterwijk, Senior Director of FP&A, who is retiring at the end of the calendar year after 20+ years of service. She has been instrumental in budget and finance-related matters and a great leader for their team. The team hopes to have Carol back on a part-time basis next year. Carol expressed her gratitude for the opportunity to work with the team and serve the members.

CONSENT CALENDAR

Dr. Ferguson presented the Consent Calendar.

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

a) CEO UPDATE

Matt Woodruff discussed the current state of the budget. The DHCS Finance team will reopen the calendar year 2024 rates. This is the result of the persistent efforts by Matt and Gil, who have met with the team multiple times since July.

A special meeting of the Finance Committee is scheduled to take place in January to provide a comprehensive overview of the budget which will include the newly established rates for 2024 as well as supporting documentation for 2025. The meeting will address the important go/no-go decision concerning Medicare, which has the potential to postpone the implementation of the DSNP by one year if that course of action is chosen. This decision will need to be made by February 3rd.

b) REVIEW AND APPROVE THE OCTOBER 2024 MONTHLY FINANCIAL STATEMENTS

OCTOBER 2024 Financial Statement Summary

Enrollment:

Enrollment increased by 220 members since September and an overall increase of 2,163 members since June 2024.

Net Income:

For the month ending October 31st, 2024, the Alliance reported a Net Loss of $27.0 million (versus budgeted Net Loss of $4.9 million). For the year-to-date, the Alliance recorded a Net Loss of $61.0 million versus a budgeted Net Loss of $10.3 million.

Premium Revenue:

For the month ending October 31st, 2024, actual Revenue was $158.2 million vs. our budgeted amount of $166.3 million.

Medical Expense:

Actual Medical Expenses for the month were $177.2 million, vs. budgeted amount of $164.3 million. For the year-to-date, actual Medical Expenses were $704.1 million vs. budgeted Medical Expense of $648.1 million.

Medical Loss Ratio:

Our MLR ratio for this month was reported as 112.0%. The year-to-date MLR was 105.2%.

Administrative Expense:

Actual Administrative Expenses for the month ending October 31st, 2024, were $10.0 million vs. our budgeted amount of $9.5 million. Our Administrative Loss Ratio (ALR) is 6.3% of our Revenue for the month, and 5.9% of Net Revenue for year-to-date.

Other Income / (Expense):

As of October 31st, 2024, our YTD interest income from investments show a gain of $13.0 million.

Managed Care Organization (MCO) Provider Tax:

For the month ending October 31st, 2024, we reported $63.5 million MCO Tax Revenue vs. budgeted MCO Tax Revenue of $47.2 million. Our MCO Tax Expense was $63.5 million vs. budgeted MCO Tax Expense of $47.2 million.

Tangible Net Equity (TNE):

For October, the DMHC requires that we have $77.2 million in TNE, and we reported $194.3 million, leaving an excess of $117.1 million. As a percentage we are at 252%, which remains above the minimum required.

Cash and Cash Equivalents:

We reported $448.2 million in cash; $332.6 million is uncommitted. Our current ratio is above the minimum required at 1.17 compared to regulatory minimum of 1.0.

Capital Investments:

We have acquired $530,000 in Capital Assets year-to-date. Our annual capital budget is $1.7 million.

Question: Dr. Ferguson inquired about the steps we are taking to address the ongoing rise in expenses.

Answer: Dr. Carey explained that various medical management interventions are being implemented, including targeting high readmission rates, improving medication reconciliation, emergency room diversions, and ensuring timely follow-up appointments for discharged patients.

Question: Rebecca inquired about the extent of the intervention in long-term care facilities.

Answer: Dr. Carey mentioned that three staff members visit facilities weekly, biweekly, or monthly, depending on the number of members in those facilities.

Question: Rebecca sought clarification on the roles of the three staff members in the authorization process.

Answer: Dr. Carey explained that they do not manage primary authorizations. Their primary role is to assist members and support the facilities.

Question: Yeon asked if there is a plan for outreach that includes individual conversations with the members.

Answer: Dr. Carey explained that although we do not have a one-on-one outreach plan currently in place, our strategy includes sending mailings, implementing a digital campaign, and running radio and TV ads. Additionally, we will make outreach calls to some members who are visiting the emergency room more frequently than expected.

Question: Dr. Ferguson asked what the top readmission diagnoses are.

Answer: Dr. Carey stated that the leading causes of readmission are behavioral and mental health issues, followed by congestive heart failure and hypertension.

Question: Dr. Ferguson asked how we are ensuring that physicians see patients promptly after discharge.

Answer: Dr. Carey stated that the care management team and vendors ensure follow-up visits within seven days of discharge, with some vendors going into members' homes for the initial follow-up visit.

Question: Tosan requested additional insight as to what information and resources are needed from hospitals that are not being received in a timely manner?

Response: Dr. Carey emphasized the importance of improving access to specialists and facilitating timely appointments for high-risk individuals as crucial areas requiring support.

Motion: A motion was made by Yeon Park, and seconded by James Jackson, to accept and approve the October 2024 Financial Statements.

Motion Passed

No opposed or abstained.

c) REVIEW AND APPROVE FISCAL YEAR 2025 FINAL BUDGET

Budget Process

- Preliminary Budget presented to Finance Committee on June 11th and to the Board of Governors on June 14th.
- Draft 2025 Medi-Cal rates were received on October 21st. They were in line with the estimates in the Preliminary Budget but did not support the Alliance's most recent expense experience.
- The Plan shared data with the State, and had multiple conversations with DHCS leadership, sharing findings regarding medical expense trends and the Alliance's financial challenges.
- High-level final Medi-Cal base rates were received on December 2nd. The rates were favorable to those received on October 21st.
- Final Budget was presented to Finance Committee on December 10th and to the Board of Governors on December 13th.

Risks and Opportunities

- Details for the high-level CY 2025 Final Medi-Cal rates received on December 2nd are not yet available and may differ from assumptions that were made based on Preliminary rates.
- DHCS informed the Plans on November 27th that revised Medi-Cal rates will be sent for CY 2024. The revised rates will include changes to the population acuity and TRI adjustments.
- It is unclear whether the significant increase in utilization trends.
- will continue.
- The ratio of members with Satisfactory versus Unsatisfactory Immigration Status may vary from DHCS projections.
- Contract changes for hospitals and delegated providers in projections have not been finalized.

Highlights

- 2025 Projected Net Loss of $65.3 million.
- Projected TNE excess at 6/30/25 of $26.6 million is 134% of required TNE.
- Year-end enrollment is slightly lower than the Preliminary Budget.
- Revenue is $2.1 billion in FY 2024, $86 million higher than Preliminary, due favorable new rates.
- PMPM Fee-for-Service and Capitated Medical Expense increases by 6.2%.
- Administrative expenses represent 5.6% of revenue, $7.8 million higher than Preliminary. Increases include Purchased & Professional Services ($ 9.2 million), Licenses, Insurance & Fees ($600K), and Other Expense ($400K). These were offset by reductions in Employee Expense ($2.4 million).
- Clinical expenses comprise 2.8% of revenue, $8.7 million higher than Preliminary. CalAIM Incentives ($5.2 million), Community Relations ($2.1 million), Purchased & Professional Services ($2.3 million), Licenses, Insurance & Fees ($500K), other ($900K).
- A CY 2024 Major Organ Transplant Risk Corridor Payment to DHCS of $21.0 million is planned for December 2024.

Staffing

- Staffing includes 718 full-time equivalent employees by June 30, 2025.
- There are 87 new positions requested for FY 2025, a reduction of 13 from the Preliminary

Budget Enrollment

- Enrollment at year-end is 409,000, 1,100 lower than in the Preliminary Budget.
- Member Months of 4,885,000 are 8,800 lower than in the Preliminary Budget.
- As a Single Plan County, Alameda will have responsibility for Foster Children and Youth as of January 2025.
- LTC and LTC Duals will be combined by DHCS with the SPD and SPD Duals COAs beginning January 2025.
- Total Medi-Cal enrollment is projected to grow very slightly throughout the year.
- Group Care enrollment is projected to be virtually unchanged.

Revenue

- 98% of Revenue for Medi-Cal, 2% for Group Care.

Medical Expense

- 98% of Expense for Medi-Cal, 2% for Group Care.
- Medical loss ratio is 97.9%, an increase of 2.0% over the Preliminary Budget.

Hospital and Provider Rates

- FY 2025 Hospital and SNF contract rates increase by $3.3 million compared to the Preliminary Budget.

Community Supports

- The Alliance anticipates spending $33.6 million for Community Supports in FY25.
- CS Revenue is included in FY 2025 Medi-Cal Base Rates is $11.5 million.

Capital Expenditures

- Full Year budget is $2.0 million for capitalized purchases, compared to the Preliminary Budget of $1.7 million.

Question: Dr. Ferguson requested further clarification on the adjustment for the calendar year 2024 and asked about the management plan. Is there an intention to restate the statement?

Answer: Gil mentioned that revisiting and restating the previous months' data is unlikely, as it would require significant effort. Instead, we will consolidate everything into one or two future months.

Question: Dr. Ferguson inquired about the status of the final budget, given that our rates have not yet been established. He also requested clarification on whether we will have a definitive final budget available.

Answer: Gil stated that any rate changes will be included in our forecast.

Motion: A motion was made by Rebecca Gebhart and seconded by Yeon Park to approve the Fiscal Year 2025 Final Budget.

Motion Passed

No opposed or abstained.

UNFINISHED BUSINESS

There was no unfinished business.

PUBLIC COMMENTS

There were no public comments.

ADJOURNMENT

Dr. Ferguson adjourned the meeting at 9:06 a.m.

ALAMEDA ALLIANCE FOR HEALTH
FINANCE COMMITTEE
REGULAR MEETING

January 22nd, 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, Andrea Schwab-Galindo, Dr. Evan Seevak, Dr. Marty Lynch, Dr. Kelley Meade, Wendy Peterson

Alliance Staff in-person and on Conference Call: Matt Woodruff, Dr. Donna Carey, Tiffany Cheang, Sasi Karaiyan, Richard Golfin III, Lao Paul Vang, Ruth Watson, Yen Ang, Shulin Lin, Linda Ly, Brenda Martinez, Felix Rodriguez, Danube Serri, Christine Corpus, Charles Walmann, Corry Keenan, Tome Meyers

CALL TO ORDER

Dr. Ferguson convened the Finance Committee meeting at 8:00 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

Matt Woodruff provided an update on the CEO's plans regarding Medicare, discussing the finalized APL on D-SNP and the lack of a delay option. He emphasized the importance of financials and recommended starting small with Medicare and gradually expanding to keep out commercial plans and ensure financial stability and readiness.

The plan needs to report six months of income to come off the DMHC watch list, projecting this to happen from January to June, with the goal of being off the watch list by July.

We need to achieve six months of financial readings to come off the DMHC punch list, projected from January to June, with a possibility of being ready by July. Our financials will dictate our decisions, as emphasized by DMHC.

Question: Dr. Seevak requested additional information regarding being on the watchlist.

Answer: Matt explained it was a precautionary measure due to the financial trends, despite not falling below any required thresholds. Starting in November, the Plan began reporting monthly financials to DMHC. It is projected that we will be off the watch list by July if financials improve.

b) REVIEW AND APPROVE THE NOVEMBER 2024 MONTHLY FINANCIAL STATEMENTS

NOVEMBER 2024 Financial Statement Summary

Enrollment:

Enrollment increased by 725 members since October and an overall increase of 2,888 members since June 2024.

Net Income:

For the month ending November 30th, 2024, the Alliance reported a Net Loss of $27.5 million (versus budgeted Net Loss of $10.0 million). For the year-to-date, the Alliance recorded a Net Loss of $88.5 million versus a budgeted Net Loss of $71.0 million.

Premium Revenue:

For the month ending November 30th, 2024, actual Revenue was $174.2 million vs. our budgeted amount of $173.2 million.

Medical Expense:

Actual Medical Expenses for the month were $194.7 million, vs. budgeted amount of $174.9 million. For the year-to-date, actual Medical Expenses were $898.8 million vs. budgeted Medical Expense of $879.0 million.

Medical Loss Ratio:

Our MLR ratio for this month was reported as 111.8%. The year-to-date MLR was 106.6%.

Administrative Expense:

Actual Administrative Expenses for the month ending November 30th, 2024, were $9.0 million vs. our budgeted amount of $10.2 million. Our Administrative Loss Ratio (ALR) is 5.2% of our Revenue for the month, and 5.7% of Net Revenue for year-to-date.

Other Income / (Expense):

As of November 30th, 2024, our YTD interest income from investments show a gain of $15.0 million.

Managed Care Organization (MCO) Provider Tax:

For the month ending November 30th, 2024, we reported $63.7 million MCO Tax Revenue vs. budgeted MCO Tax Revenue of $63.6 million. Our MCO Tax Expense was $63.7 million vs. budgeted MCO Tax Expense of $63.6 million.

Tangible Net Equity (TNE):

For November, the DMHC requires that we have $78.9 million in TNE, and we reported $166.9 million, leaving an excess of $88.0 million. As a percentage we are at 212%, which remains above the minimum required.

Cash and Cash Equivalents:

We reported $503.4 million in cash; $386.4 million is uncommitted. Our current ratio is above the minimum required at 1.12 compared to regulatory minimum of 1.0.

Capital Investments:

We have acquired $530,000 in Capital Assets year-to-date. Our annual capital budget is $1.7 million.

Question: Mr. Jackson inquired about inpatient expenses, wondering if there will be an adjusted assessment based on the level of sickness. He asked whether this adjustment would be considered in our next budget or if we anticipate that the level of need will be reduced due to the measures we have implemented this year.

Answer: Gil stated that we will update our forecast in response to the increased trends reflected in our quarterly forecast. However, some of these expenses will be partially offset by increased revenue expected in calendar year 2025, as the state has raised our rates to reflect our higher costs. We will also incorporate these changes into our preliminary budget for 2026.

Question: Ms. Gebhart asked if the state's adjusted 2024 rates are reflected in the November financials.

Answer: Gil says it’s not reflected in the November financials, but it is going to be reflected in December.

Question: Dr. Ferguson asked Gil for his assessment of specifically on where we are going and what is the overall sense in terms of our financials.

Answer: Gil mentioned that 2024 was a challenging year due to unexpected paybacks to the state and rising medical expenses. Teams are actively working to identify cost-saving measures. He expressed hope for 2025, citing anticipated rate increases that could improve the situation, although medical expense trends remain a concern. Gil reassured that they will continue to focus on managing costs effectively while looking forward to enhancing the bottom line.

Motion: A motion was made by James Jackson, and seconded by Yeon Park, to accept and approve the November 2024 Financial Statements.

Motion Passed

No opposed or abstained.

c) BUDGET UPDATES – RATES AND DECEMBER FINANCIAL RESULTS

Calendar Year 2024 Rate Update

- On December 30, the Department of Health Care Services (DHCS) provided amended CY24 rates removing negative adjustments related to the Targeted Rate Increase program and population acuity.
- AAH CY24 rates increase by approximately 1.38% or $26M.
- Additional revenue was fully reflected in December preliminary financial results, offsetting losses that occurred in the month.

Calendar Year 2025 Rate Update

- October draft rates reflected a 4.3% increase in base rates from original CY24 rates.
- Updated rates were received December 18. Some details are still needed but sufficient data was shared to determine potential base rate increase.
- An additional 5% increase was added to the 4.3% increase from October.
- Estimated additional revenue approximately $100M for the second half of FY25 (Jan-June).

Calendar Year 2024 Financial Results
FY25 Updated Results

- Estimated December Net Loss of $8.6M.
- Calendar year 2024 results recorded a $201M Net Loss for the year.
- This includes additional revenue from recent CY24 rate increase.
- Final budget estimated $65.2M Net Loss for FY25 (July 2024- June 2025).
- Updated forecast estimates based on November and December actual results plus updated CY24 rate increase slightly reduce FY25 Net Loss to $64.7M.

Question: Dr. Ferguson has a question about major organ transplants. For heart patients, before the actual transplant at UCSF, there's complicated management involved. Is this considered part of the transplant process or only after the surgery?

Answer: Gil explained that while some expenses are captured in pre- and post-transplant care, the main cost comes from the transplants themselves, which were lower than expected. The state anticipated a higher number of major organ transplants, allocating funds accordingly. Since the actual utilization did not meet those expectations, they now need to repay a significant amount to the state, as the reported costs couldn’t fully offset the transplant expenses.

Question: Ms. Gebhart asked if the major organ surgical events we perform align with state expectations and if they are influenced by the external provider network, or if there are internal efforts to increase these events.

Answer: Matt stated that there haven't been many transplant cases due to extensive pre-work and follow-up. They need to assess whether patients are ready before authorizing the procedure, especially with a significant payback to the state. They prefer that members get the transplant.

Question: Ms. Park inquired whether we have data on the amount of money paid through fraud and abuse cases.

Answer: Gil noted they are refining criteria to identify potential fraud, estimating up to half a million dollars based on current analysis. While initial community support criteria were broad, they anticipate future data insights.

Question: Dr. Ferguson noted that our potential savings of 8 million annually are quickly outpaced by monthly medical expenses, indicating a need for deeper analysis. Rebecca highlighted that inpatient and long-term care costs drive many overruns and questioned whether adjusting rates alone can resolve these issues. She also referenced Dr. Carey's suggestion for increased outreach in long-term care facilities due to possible over-authorization of services.

Answer: Matt reported that the claims authorization limit project focuses on inpatient care, complying with legal guidelines. Gil mentioned that the expected rate increase will positively impact the budget. Dr. Carey noted rising medical expenses due to a sicker membership but confirmed the average length of hospital stays is appropriate. The team is targeting readmissions

for improvement, enhancing transitions of care and refining community support criteria to ensure resources are effectively used.

Question: Ms. Park asked what the criteria updates are for community supports.

Answer: Dr. Carey mentioned that we currently have eleven community supports and are revisiting guidance from DHCS to align our criteria with their policy guides. We're also collaborating with our compliance team to ensure proper coordination.

d) MEDICARE DISCUSSION

Gil and Matt presented two scenarios for the D-SNP implementation in 2026.

Business as Usual – Scenario 1

- Assumes enrollment of approximately 4,000 members in 2026.
- Approved FTEs for FY25 move forward, assume FTE count grows for DSNP in CY26 and CY27.
- FTE assumptions were compiled as part of an exercise determining what departments needed to stand up the DSNP program.
- Total FTEs dedicated to DSNP are 75 costing $34.7 million for Calendar Years 2025 through 2027.
- Consulting and vendor costs estimated to be $15.5 million for the same period. Total estimated cost to stand up the DSNP is $216.4 million.
- Total costs include FTEs, Operating and Vendor cost plus Medical Expenses.
- Revenue begins in 2026 to offset some expenses.

Delay until 2027 – Scenario 2

Scenario 2 has been removed from the discussion because last week, the state issued an APL indicating that we must start D-SNP in 2026.

Reduced Scale – Scenario 3

- Assumed enrollment builds up to 1,500 members by the end of 2026.
- Limited savings related to volume related departments (Call Center, Claims, etc.).
- Fixed cost to stand up a DSNP remain.
- This allows the Alliance to enter the market on a small scale while learning from 2026 experience.
- Total FTEs dedicated to DSNP are 60 costing $27.3 million for Calendar Years 2025 through 2027.
- Consulting and vendor costs estimated to be $16.0 million for the same period.
- Total estimated cost to stand up DSNP is $131.7 million.
- Total estimate includes scaled back revenue stream but begins in 2026.

Question: James sought clarification regarding the estimated losses. In the first scenario, the total estimated loss over three years is 52 million. In the subsequent scenarios, the total estimated losses are 39.7 million and 40.1 million. Are these also calculated over a three-year period?

Answer: Gil explained that for the same period, we had more savings in the second scenario because it started in 2027, resulting in lower medical expenses over three years. However, this option is no longer available. The remaining options are Scenario 1 and Scenario 3.

Question: Dr. Seevak asked why we chose 1,500 members instead of 2,000 or 1,000. He noted that fewer members likely mean lower medical expenses but is concerned about those not being served as the number decreases.

Answer: Matt mentioned that the projections for the 4,000 members and 1,500 members are based on a full year, with both targets set for the end of the calendar year. Starting in January and considering scenario #3, we plan to focus on one to three small community sites throughout the year rather than a large launch to effectively work with these select locations across the county.

Matt recommended Scenario 3, not only due to its financial advantages and the required work, but also because it keeps other providers out of the county. This approach strengthens our position in the marketplace.

UNFINISHED BUSINESS

There was no unfinished business.

PUBLIC COMMENTS

There were no public comments.

ADJOURNMENT

Dr. Ferguson adjourned the meeting at 9:09 a.m.

ALAMEDA ALLIANCE FOR HEALTH
FINANCE COMMITTEE
REGULAR MEETING

February 11th, 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: Tosan Boyo, Andie Martinez Patterson, Andrea Schwab-Galindo

Alliance Staff in-person and on Conference Call: Matt Woodruff, Dr. Donna Carey, Tiffany Cheang, Sasi Karaiyan, Richard Golfin III, Lao Paul Vang, Ruth Watson, Yen Ang, Brett Kish, Shulin Lin, Linda Ly, Brenda Martinez, Renan Ramirez

CALL TO ORDER

Dr. Ferguson convened the Finance Committee meeting at 8:00 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

Matt Woodruff provided an update on the upcoming Fiscal Year 2026 budget, emphasizing preparations for a major enrollment loss and limited staffing growth. Specifically, there was a discussion about the financial impact of losing 80,000 individuals from the undocumented population, estimating a potential revenue loss of $500 to $600 million. Matt is collaborating with Alameda County Health to gather data and plan for this change. This significant reduction would impact both revenue and expenses, and the team is working on detailed calculations to present at the March meeting.

Matt will meet with the state to discuss three key topics: the undocumented population, DEI, and transgender issues. This meeting is expected to offer more information on the state's plans and potential impacts on health plans.

Question: Dr. Ferguson asked what the 80,000 lives translate to in dollars.

Answer: Matt mentioned they are assembling details for the March board meeting, where he will explain the specifics. The estimated range is $500 to $600 million.

Question: Dr. Ferguson inquired about the potential impact on our budget.

Answer: Gil noted that an evaluation of expenses and revenue indicates $500-600 million in expenditures could reduce both. This impacts the medical loss ratio and overall income. A key consideration is the financial outcome of providing coverage, requiring assessment of whether expenses exceed revenue. Preliminary evaluations suggest a potential positive margin, affecting our financial performance.

Comment: Ms. Gebhart indicated that Alameda County has historically been required to assist its indigent population according to the welfare and institutions code, unlike other counties. The budget designated for the indigent program amounts to $60 million, and if current trends continue, funding from the health plan is anticipated to decrease, leading to significant losses for providers as payments will mainly revert to the county at lower rates. Furthermore, Gil noted that the scope of funding includes the MCO tax, which contributes approximately $100 to $130 million.

b) REVIEW AND APPROVE THE DECEMBER 2024 MONTHLY FINANCIAL STATEMENTS

DECEMBER 2024 Financial Statement Summary

Enrollment:

Enrollment increased by 5,348 members since November and an overall increase of 8,236 members since June 2024.

Net Income:

For the month ending December 31st, 2024, the Alliance reported a Net Loss of $8.6 million (versus budgeted Net Loss of $26.8 million). For the year-to-date, the Alliance recorded a Net Loss of $97.2 million versus a budgeted Net Loss of $97.8 million.

Premium Revenue:

For the month ending December 31st, 2024, actual Revenue was $163.0 million vs. our budgeted amount of $137.1 million.

Medical Expense:

Actual Medical Expenses for the month were $164.6 million, vs. budgeted amount of $154.5 million. For the year-to-date, actual Medical Expenses were $1.1 billion vs. budgeted Medical Expense of $1.0 billion.

Medical Loss Ratio:

Our MLR ratio for this month was reported as 101.0%. The year-to-date MLR was 105.7%.

Administrative Expense:

Actual Administrative Expenses for the month ending December 31st, 2024, were $9.4 million vs. our budgeted amount of $11.3 million. Our Administrative Loss Ratio (ALR) is 5.8% of our Revenue for the month, and 5.7% of Net Revenue for year-to-date.

Other Income / (Expense):

As of December 31st, 2024, our YTD interest income from investments show a gain of $17.5 million.

Managed Care Organization (MCO) Provider Tax:

For the month ending December 31st, 2024, we reported $64.5 million MCO Tax Revenue vs. budgeted MCO Tax Revenue of $63.7 million. Our MCO Tax Expense was $64.5 million vs. budgeted MCO Tax Expense of $63.7 million.

Tangible Net Equity (TNE):

For December, the DMHC requires that we have $77.6 million in TNE, and we reported $158.2 million, leaving an excess of $80.6 million. As a percentage we are at 204%, which remains above the minimum required.

Cash and Cash Equivalents:

We reported $648.6 million in cash; $552.4 million is uncommitted. Our current ratio is above the minimum required at 1.10 compared to regulatory minimum of 1.0.

Capital Investments:

We have acquired $530,000 in Capital Assets year-to-date. Our annual capital budget is $2.0 million.

Comment: Rebecca expressed her appreciation to Gil and the Finance team for maximizing investment returns, as this has greatly benefited us.

Question: Dr. Ferguson warned that serious issues could arise if we do not control the situation. If we fail to manage our medical expenses, the state will take over the plan. What steps are we currently taking? We have not observed an effective decline. What drastic measures are we implementing, and if we can have a plan for that?

Answer: Matt confirmed support for Dr. Carey as a first-time CMO, with collaboration from Dr. Carter on various initiatives. We expect progress on our metrics and will review strategies and savings in March, particularly in finances and medical management.

Matt also mentioned a $22 million shortfall in community supports and discussed potential service cuts due to state underfunding, particularly impacting housing and food services.

Question: Yeon inquired about the status of our investments.

Answer: Gil mentioned that this will be presented in March, as our investments are reviewed annually, with some categorized as short-term and others as long-term.

Motion: A motion was made by James Jackson, and seconded by Yeon Park, to accept and approve the December 2024 Financial Statements.

Motion Passed

No opposed or abstained.

UNFINISHED BUSINESS

There was no unfinished business.

PUBLIC COMMENTS

There were no public comments.

ADJOURNMENT

Dr. Ferguson adjourned the meeting at 8:33 a.m.

ALAMEDA Alliance FOR HEALTH

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Compliance Advisory Committee Meeting Minutes

COMPLIANCE ADVISORY COMMITTEE
Regular Meeting Minutes
Friday, December 13th, 2024
10:30 a.m. – 11:30 a.m.

Video Conference Call and

1240 S. Loop Road
Alameda, CA 94502

CALL TO ORDER

Committee Members Attendance: Byron Lopez, Richard Golfin III, Dr. Kelley Meade, Rebecca Gebhart

Remote: None

Committee Members Excused: None

1. **CALL TO ORDER**

The regular Compliance Advisory Committee meeting was called to order by Dr. Kelley Meade at 10:30 am.

2. **ROLL CALL**

A roll call was taken of the Committee Members, quorum was confirmed.

3. **AGENDA APPROVAL OR MODIFICATIONS**

Approved

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

None

5. **CONSENT CALENDAR**

   a) **September 13th, 2024, COMPLIANCE ADVISORY COMMITTEE MEETING MINUTES**

Motion: A motion was made by Richard Golfin III and seconded by Byron Lopez to approve Consent Calendar Agenda Items.

Vote: Motion passed

6. COMPLIANCE MEMBER REPORTS

a) Compliance Activity Report

The committee discussed the importance of completing compliance training, which have been sent to members' inboxes. It was emphasized that completing these trainings is crucial for minimizing compliance issues, especially in relation to the Medicare application.

i Plan Audits and State Regulatory Oversight

1. Joint 2025 DMHC and DHCS Routine Full Medical Survey

    a. The 2025 DHCS and DMHC Joint Routine Full Medical Survey has been confirmed.

    b. The audit will take place from March 3rd – March 14th, 2025.

        - This will take place on site the first week
        - If a second week is needed, it will take place virtually

    c. The DHCS lookback period will be June1st,2024-February 28th, 2025.

    d. The pre-audit document requests are expected to be received by December 20th.

2. 2024 DHCS PCP Facility Site Review and Medical Record Review
    a. The review was conducted by DHCS on September 17th, 2024.
    b. It was a random full-scope facility site review and medical record review, consistent with APL 22-017.
    c. We received the final report, which included a corrective action plan (CAP) from all ten providers that were reviewed.
    d. The CAP response was submitted to DHCS on November 21st, 2024.
    e. The Alliance Facilities Site Review team is working with the PCPs to assist with CAP implementation and validation.

3. Compliance Dashboard:
    a. The final audit report for the 2024 DHCS routine medical survey was issued on November 18th, 2024. The team is currently working on the CAP, which is due to the State on December 21, 2024.
        - There are a total of 20 findings from the State and 6 self-identified findings.

- 18 of the 20 findings are on the preliminary audit report and the remaining two were received in the final audit report.
- The CAP is due to the state on December 21st, 2024.
- Utilization Management:
    - Referral to Transplant Program Within 72 Hours
      The Plan did not directly refer an adult member to a transplant program for evaluation within 72 hours of the member's specialist identifying the member as a potential candidate for MOT.

Question: Clarification, does that mean that we did not have any members sent for observation period for the finding? Do we refer any patients during the audit period?

Answer: Yes, we did. It's at the turnaround time that we follow was five business days and not the required 72 hours.

    - Centers of Excellence (COE) for Major Organ Transplants (MOT)
      The Plan did not ensure that all MOT procedures were performed in a Medi-Cal approved COE transplant program. The Plan did not confirm that its COEs were unable to perform a MOT surgery before arranging the MOT at a transplant program that is not a Medi-Cal approved COE.
    - Written Member Consent
      The Plan did not obtain members' written consent when providers requested appeals on behalf of members.
    - Appeals Letters: Nondiscrimination Notice (NDN) and Language Assistance Taglines (LAT)
      The Plan did not send NDN and LAT information that met the minimum requirements in APL 21-004 with member notifications for appeals.
    - Overutilization of Subacute Level of Facility Care
      The Plan did not ensure that its delegate, Community Health Center Network (CHCN), had mechanisms to detect overutilization of subacute level of facility care; the delegate inappropriately approved higher levels of subacute care for members who required lower levels of regular skilled nursing facility care.

Question: Do you have a sense of the scale of nursing facility care? It is one of the areas of concern for budget.

Answer: It is nuanced in terms of the finding due to a system configuration issue which made it appear as though the delegate was approving at a higher level when they were approving at the lower level. It was being rectified at the time of the audit. This data tracking issue will be reflected in corrective action.

- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services. The Plan did not ensure that its delegate, CHCN, provided medically necessary EPSDT services, care coordination, and appointment scheduling assistance to members under the age of 21.

Question: Was there a specific issue that arose or was it just general on all EPSDT services?
Answer: They do not have a specific formalized process for supporting members that are under the age of 21 years old. They were in the process of developing policies and procedures at the time of the audit. There was no formalized process – they were following their normal care and coordination process.

- Case Management:
  - Provision of Blood Lead Screening
    The Plan did not ensure that blood lead screening tests were conducted for members up to six years of age.

Question: How much of the requirement is satisfied by a Point-of-Care test? There is often a referral to off-site labs or other provider to do the venous test?

Answer: It could be either Point-of-Care or venous. Both count. It was determined that it was easier for families to get them to the office.

  - Provision of Behavioral Health Therapy (BHT) Services
    The Plan did not ensure the provision of BHT services in accordance with approved BHT treatment plans for members under the age of 21.
  - Timely Access to Behavioral Health Therapy (BHT) Services
    The Plan did not arrange and coordinate BHT services for members under the age of 21 within 60 calendar days.
  - Notice of Action (NOA) Letters for Continuity of Care (COC) Requests

The Plan did not ensure that NOAs for COC requests that were sent to members contained a clear explanation of the reason for the denial decision.

- Appointment Waitlist Timeliness
  The Plan did not ensure members were able to obtain medically necessary appointments within established timely access standards. One of the Plan's medical groups placed members on an appointment waitlist and had members waiting up to six months to make an appointment.
- Monitoring In-Office Wait Times for Specialty and Behavioral Health Services
  The Plan did not monitor in-office wait time for specialists and behavioral health providers.

- Member Rights
  - Grievances Involving Clinical Issues
    The Plan did not ensure that a person with clinical expertise in treating a member's condition made the resolution decision for grievances involving clinical issues.
  - Resolution of Grievances
    The Plan did not completely resolve the members' grievances.
  - Clear and Concise Resolution Letters
    The Plan's written resolution did not contain a clear and concise explanation of the Plan's decision.
  - Grievance Letters: Non-Discrimination Notice (NDN) and Language Assistance Tagline (LAT)
    The Plan did not include updated NDN and LAT information with grievance acknowledgement and resolution letters.

Question: The corrective action in general around grievance and appeals and these processes, is this an extensive fix? Medium fix or easy fix?

Answer: Medium fix. The processes are changing and re-evaluated who performs which functions, retraining staff. Multiple levels going into the correction process.

- Monitoring of Linguistic Performance
  The Plan did not assess the performance of its vendors' staff that provided linguistic services such as interpreter services.

- Notification to DHCS
  The Plan did not notify DHCS within 24 hours upon discovery of any suspected breach or security incident, unauthorized access, use or disclosure of PHI or PI.

Question: Is there any harm in training managers to over report potentials?

Answer: It would be an administrative burden as there are hundreds to thousands of calls per week. We are looking into technological solutions that could flag the calls. A work in progress.

Question: Are there any Audits on non-benefits of community support or any audits from the state?
Answer: No, not yet. We report monthly. However, DHCS has started Auditing other plans.

b. 2023 DHCS Focused Medical Survey. The Audit took place April 17th – April 28th, 2023 – looked back at activities that occurred April 1, 2022 to March 31, 2023. The Audit report was received September 4, 2024.
   - There was a total of nine findings, one has since been completed.
   - The team is sending monthly updates to DHCS on their progress.

c. The 2023 DMHC follow-up review was conducted in October 2023 The look back was November 1, 2022 through May 31, 2023. The Audit was to follow up on the 2021 DMHC Follow-Up Survey which included 6 findings. The Final Audit report was received in October, with a total of three findings.

   - Grievance and Appeals
     - When the Plan has notice of a case requiring expedited review, the Plan does not immediately inform complainants of their right to contact the Department.
     - The Plan does not correctly display the statement required by Section 1368.02(b) in all required enrollee communications.
   - Prescription (Rx) Drug Coverage
     - The Plan does not display its formularies in a manner consistent with the Department's standard formulary template.

b) MEDI-CAL PROGRAM UPDATES

i Sanctions Dispositions

1. EA-24-442 $85,000 Sanction
    a. This was due to three findings from the 2021 DMHC audit. They are in reference to cases requiring expedited review and informing complainants immediately of their right to contact the department, correctly displaying required by Section 1368.02(b) in all required enrollee communications and the plan did not display the formulary correctly. This review was done by DMHC in 2021. The plan did not make audit corrections in a certain time frame.

Question: This impacted us in 2024?

Answer: Yes, the 2021 findings impacted us in 2024, and we can anticipate we will get 2022 and 2023 sanctions in the following years. The state is still working through old audit findings and CAP documents.

    b. This is where the CAP validation process comes into play – we started the process in 2021, now internally auditing findings when they close to ensure they are creating the changes that are expected.

2. MCAS MY 2023 $37,000 (Appeal Reduced from $72,000)
    a. This was originally for $72,000 for managed care and accountability set (MCAS) for model year (MY) 2023 it had to do with topical fluoride (TFL) application. The state found it to be insufficient, sanctioned our plan and all other plans.
    b. AAH had a meet and confer with agency and based on the data the state reduced the sanction to $37,000. AAH was the only plan that received a reduction. All other plans had theirs upheld.
    c. Two measures were not met: TFL and Blood Screening (both in child measure category)
    d. AAH held a meet and confer for TFL and due to the documentation, communications with state, data, that we didn't know minimum proficiency level (MPL) until after the fact, and the state decided to reduce TFL measure, but still penalized for lead screening.
    e. Quality sanctions are by domain. Both were in the child domain that triggered sanctions. If they were in two different domains there would not have been a trigger, but since two were in the same domain (child) it triggered. (close on lead, 7 members missed)
    f. Topical fluoride coverage is challenging because it extends to a high age but still

does not fully cover up to that range—it only goes up to age 20. This also ties into the argument that, although coverage up to age 20 is required, it is not provided. However, addressing this issue with the state played a role in reducing our sanction.

3. EA 22-414 $10,000
    a. Independent Medical Review (IMR) timeliness response from G&A from June 18th, 2022.
    b. This is a Training issue. We were given the opportunity to remediate and give reason. In reviewing the notes there were no attempts and follow up with the provider office. No further steps were taken. We have a better process in place now.
4. Goals for Future Sanctions
    a. Approval for budget of $200,000 sanctions this year. We have come in below budget. The goal is trying to avoid million dollar sanctions.
    b. Higher sanctions are typically linked to IT services, making it crucial for us to maintain strict vigilance in IT operations, security office, and the privacy office to mitigate the risk of ransomware attacks.

1. COMPLIANCE ADVISORY COMMITTEE BUSINESS

a) None

2. STAFF UPDATES

a) Introduction of General Counsel Troy Szabo

3. UNFINISHED BUSINESS

a) None

4. STAFF ADVISORIES ON COMPLIANCE BUSINESS FOR FUTURE MEETINGS

a) None

5. ADJOURNMENT

a) Dr. Kelley Meade adjourned the meeting at 11:25 am.

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Board of Governors Meeting Minutes

BOARD OF GOVERNORS
Regular Meeting Minutes
Friday, December 13th, 2024
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), Aarondeep Basrai, Colleen Chawla, Dr. Rollington Ferguson, Andrea Ford, James Jackson, Byron Lopez, Dr. Marty Lynch, Andie Martinez Patterson, Dr. Kelley Meade, Yeon Park, Wendy Peterson, Andrea Schwab-Galindo, Dr. Evan Seevak, Supervisor Lena Tam

Board of Governors Remote: Dr. Noha Aboelata (Vice-Chair), Tosan Boyo, Natalie Williams

Board of Governors Excused: Jody Moore

Alliance Staff Present: Matthew Woodruff, Dr. Donna Carey, Gil Riojas, Anastacia Swift, Ruth Watson, Sasi Karaiyan, Tiffany Cheang, Michelle Lewis, Lao Paul Vang

Chair Gebhart called the regular Board of Governors meeting to order at noon.

2. ROLL CALL

Roll call was taken, and a quorum was established.

3. AGENDA APPROVAL OR MODIFICATIONS

There were no modifications to the agenda.

4. INTRODUCTIONS

Matt Woodruff introduced Troy Szabo, the new general counsel, who attended the meeting in person for the first time.

Colleen Chawla was acknowledged for her contributions as she prepares to leave Alameda County to become the San Mateo County Health Chief. Colleen expressed her appreciation for her time on the board and the connections she made.

5. CONSENT CALENDAR

a) OCTOBER 8th, 2024, FINANCE COMMITTEE MEETING MINUTES

b) NOVEMBER 12th, 2024, FINANCE COMMITTEE MEETING MINUTES

c) OCTOBER 11th, 2024, COMPLIANCE ADVISORY COMMITTEE MEETING MINUTES

d) OCTOBER 11th, 2024, BOARD OF GOVERNORS MEETING MINUTES

e) APPROVE RESOLUTION FOR QIHEC NOMINEES

f) APPROVE RESOLUTION FOR PHARMACY & THERAPEUTICS (P&T) COMMITTEE NOMINEE

g) APPROVE RESOLUTION AMENDING THE ALAMEDA ALLIANCE FOR HEALTH CONFLICT OF INTEREST CODE AND LIST OF DESIGNATED FILERS

h) APPROVE THE 2024-2025 HOURLY AND SALARY SCHEDULE

Motion: A motion was made by Supervisor Lena Tam and seconded by James Jackson to approve the Consent Calendar.

Vote: The motion was passed unanimously.

Ayes: Aarondeep Basrai, Tosan Boyo, Colleen Chawla, Dr. Rollington Ferguson, Andrea Ford, James Jackson, Byron Lopez, Dr. Marty Lynch, Andie Martinez Patterson, Dr. Kelley Meade, 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

Dr. Kelley Meade reported on the Compliance Advisory Committee meeting that took place on December 13th. The 2025 joint DMHC and DHCS routine full medical survey was discussed, with a reduction in findings from 21 to 20 and six self-identified issues. She also discussed the importance of completing mandatory compliance training, including HIPAA and Fraud, Waste, and Abuse training, was emphasized. An email reminder was sent to those who had not yet completed the training. Documentation of transplant referrals and other compliance topics were also reviewed during the meeting.

b) FINANCE COMMITTEE

Dr. Rollington Ferguson provided an update on the Finance Committee meeting held on December 10th. The committee reported on the financial challenges, including a significant net loss, increasing medical expenses, and the need for measures to address financial challenges. A special Finance Committee meeting was scheduled for January 22nd to discuss financials, re-forecasting, and measures implemented to address costs.

7. CEO UPDATE

Matt Woodruff provided an update on the financial situation, the impact of increased utilization, and the measures being taken to address costs.

Financials

- Revenue was $158.2 million in October 2024 and $669.3 million Year-to-Date.
- Tangible Net Equity (TNE): Financial reserves are 252% of the required DMHC minimum, representing $117.1 million in excess TNE.
- Total enrollment in October 2024 was 406,153, an increase of 220 Medi-Cal members compared to September 2024.

Utilization

The increase in utilization was attributed to the single plan model and the addition of new members with higher utilization rates.

Board Retreat

The Board retreat will be held on January 31st from 9:00 am – 4:00 p.m. at Alameda Alliance with plans to discuss Medicare and other financial topics.

Special Finance Committee Meeting

A special Finance committee meeting will be held on January 22nd at 8:00 a.m. to discuss the updated budget and forecast.

Question: Colleen Chawla requested clarification on the factors contributing to the financial difficulties.

Answer: Matt mentioned that utilization is up, especially with new members having higher utilization. Long-term care costs were the first area of concern, and measures are being implemented to address this.

Question: James Jackson inquired about how other plans are managing this situation.

Answer: Matt mentioned that other plans have sued the state for rates in the calendar year 2024. However, the approach taken by Gil and Matt has been to collaborate with the state, resulting in better information and possible rate adjustments.

Question: Andie inquired whether the state wants us to participate in D-SNP.

Answer: Matt stated that the state intends for the plan to be incorporated into Medicare and has issued a draft All Plan Letter (APL) indicating potential consequences for plans that do not comply. The state believes that this integration will enhance the coordination of services.

Question: Rebecca requested clarification on the go/no-go date for the D-SNP.

Answer: Matt indicated that the application for the D-SNP must be submitted by February 12th. Therefore, the final decision will be made during the board retreat on January 31st.

8. BOARD BUSINESS

a) BEHAVIORAL HEALTH AUDIT

Richard Golfin III provided an update on the Behavioral Health Comparison Audit (BHCA), an audit review comparing the Behavioral Health Clinical Operations at the Alameda Alliance to the findings in the DMHC settlement agreement with Kaiser Foundation Health Plan & its associated companies.

Specific Goals of the Review

- Identify potential areas for improvement.
- Mitigate risk.
- Reduce potential and future findings and/or sanctions as a result of State Oversight.

BHCA Details and Procedure

- The BHCA review criteria excludes analysis of both Behavioral Health Treatment and Kaiser delegation.
- The BHCA included a review of current policies, procedures, workflows, and program documents.
- The BHCA Analyzed data from October 1, 2023, through December 31, 2023.
- The Internal Audit Department conducted in-depth meetings with subject matter experts.

Summary

- 66 Review Criteria
- 11 Criteria: Findings and/or observations identified.
- 47 Criteria: Fully compliant with review parameters.
- 8 Criteria: Not applicable due to de-delegation of behavioral health services.

Next Steps

- Meet with stakeholders for a Plan of action on findings and observations and generate the final report.
- Issue the final report and action plans by December 27, 2024.

Question: Yeon inquired whether service providers and members are engaged for feedback during the audit process.

Answer: Richard stated that this exercise reviewed policies, procedures, and workflows with internal stakeholders. Direct feedback from members and providers was not included but may be considered for future reviews.

Informational Item only.

b) REVIEW AND APPROVE SEPTEMBER AND OCTOBER 2024 MONTHLY FINANCIAL STATEMENTS

Chief Financial Officer Gil Riojas provided the following updates on the September and October 2024 Financials:

SEPTEMBER 2024 FINANCIAL STATEMENTS

Enrollment

Enrollment increased by 666 members since August and an overall increase of 1,943 members since June 2024.

Net Income

For the month ending September 30th, 2024, the Alliance reported a Net Loss of $8.7 million (versus budgeted Net Loss of $215,000). For the year-to-date, the Alliance recorded a Net Loss of $34.1 million versus a budgeted Net Income of $5.4 million.

Premium Revenue

For the month ending September 30th, 2024, actual Revenue was $170.9 million vs. our budgeted amount of $166.2 million.

Medical Expense

Actual Medical Expenses for the month were $174.5 million, vs. the budgeted amount of $159.0 million. For the year-to-date, actual Medical Expenses were $526.9 million vs. budgeted Medical Expenses of $483.8 million.

Medical Loss Ratio

Our MLR ratio for this month was reported as 102.1%. The year-to-date MLR was 103.1%. Normally, we aim to be between 90-95%. Thus, we are significantly higher than our target range.

Administrative Expense

Actual Administrative Expenses for the month ending September 30th, 2024, were $8.9 million vs. our budgeted amount of $10.0 million. Our Administrative Loss Ratio (ALR) is 5.2% of our Revenue for the month and 5.7% of Net Revenue year-to-date.

Other Income / (Expense)

As of September 30th, 2024, our YTD interest income from investments shows a gain of $10.9 million.

Managed Care Organization (MCO) Provider Tax

For the month ending September 30th, 2024, we reported $194.3 million unbudgeted MCO Tax Revenue and $47.1 million unbudgeted MCO Tax Expense.

Tangible Net Equity (TNE)

For September, the DMHC requires that we have $70.2 million in TNE, and we reported $221.3 million, leaving an excess of $151.1 million. As a percentage we are at 315%, which remains above the minimum required.

Cash and Cash Equivalents

We reported $625.4 million in cash; $442.3 million is uncommitted. Our current ratio is above the minimum required at 1.17 compared to the regulatory minimum of 1.0.

Capital Investments

We have acquired $530,000 in Capital Assets year-to-date. Our annual capital budget is $1.7 million.

OCTOBER 2024 FINANCIAL STATEMENTS

Enrollment

Enrollment increased by 220 members since September, and an overall increase of 2,163 members since June 2024.

Net Income

For the month ending October 31st, 2024, the Alliance reported a Net Loss of $27.0 million (versus budgeted Net Loss of $4.9 million). For the year-to-date, the Alliance recorded a Net Loss of $61.0 million versus a budgeted Net Loss of $10.3 million.

Premium Revenue

For the month ending October 31st, 2024, actual Revenue was $158.2 million vs. our budgeted amount of $166.3 million.

Medical Expense

Actual Medical Expenses for the month were $177.2 million, vs. the budgeted amount of $164.3 million. For the year-to-date, actual Medical Expenses were $704.1 million vs. budgeted Medical Expenses of $648.1 million.

Medical Loss Ratio

Our MLR ratio for this month was reported as 112.0%. The year-to-date MLR was 105.2%.

Administrative Expense

Actual Administrative Expenses for the month ending October 31st, 2024, were $10.0 million vs. our budgeted amount of $9.5 million. Our Administrative Loss Ratio (ALR) is 6.3% of our Revenue for the month and 5.9% of Net Revenue year-to-date.

Other Income / (Expense)

As of October 31st, 2024, our YTD interest income from investments shows a gain of $13.0 million.

Managed Care Organization (MCO) Provider Tax

For the month ending October 31st, 2024, we reported $63.5 million in MCO Tax Revenue vs. budgeted MCO Tax Revenue of $47.2 million. Our MCO Tax Expense was $63.5 million vs. the budgeted MCO Tax Expense of $47.2 million.

Tangible Net Equity (TNE)

For October, the DMHC requires that we have $77.2 million in TNE, and we reported $194.3 million, leaving an excess of $117.1 million. As a percentage, we are at 252%, which remains above the minimum required.

Cash and Cash Equivalents

We reported $448.2 million in cash; $332.6 million is uncommitted. Our current ratio is above the minimum required at 1.17 compared to regulatory minimum of 1.0.

Capital Investments

We have acquired $530,000 in Capital Assets year-to-date. Our annual capital budget is $1.7 million.

Motion: A motion was made by Yeon Park and seconded by Dr. Kelley Meade to approve the September and October 2024 Financial Statements.

Vote: The motion was passed unanimously.

Ayes: Aarondeep Basrai, Tosan Boyo, Colleen Chawla, Dr. Rollington Ferguson, Andrea Ford, James Jackson, Byron Lopez, Dr. Marty Lynch, Andie Martinez Patterson, Dr. Kelley Meade, 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.

c) REVIEW AND APPROVE FISCAL YEAR 2025 FINAL BUDGET

Highlights

- 2025 Projected Net Loss of $65.3 million.
- Projected TNE excess at 6/30/25 of $26.6 million is 134% of required TNE.
- Year-end enrollment is slightly lower than the Preliminary Budget.
- Revenue is $2.1 billion in FY 2024, $86 million higher than Preliminary, due to favorable new rates.
- PMPM Fee-for-Service and Capitated Medical Expense increases by 6.2%.
- Administrative expenses represent 5.6% of revenue, $7.8 million higher than Preliminary expenses. Increases include Purchased & Professional Services ($ 9.2 million), Licenses, Insurance & Fees ($600K), and Other Expense ($400K). These were offset by reductions in Employee Expense ($2.4 million). Clinical expenses comprise 2.8% of revenue, $8.7 million higher than Preliminary. CalAIM Incentives ($5.2 million), Community Relations ($2.1 million), Purchased & Professional Services ($2.3 million), Licenses, Insurance & Fees ($500K), other ($900K).

- A CY 2024 Major Organ Transplant Risk Corridor Payment to DHCS of $21.0 million is planned for December 2024.

Staffing

- Staffing includes 718 full-time equivalent employees by June 30, 2025. This includes 480 Administrative employees and 238 Clinical employees.
- There are 87 new positions requested for FY 2025, a reduction of 13 from the Preliminary Budget. The new positions are in Operations (40), Healthcare Services (21), Compliance (7), Analytics (6), Finance/Vendor Management (6), Information Technology (5), Integrated Planning (3), and a decrease in Executive/Legal (-1).

Enrollment

- Enrollment at year-end is 409,000, 1,100 lower than in the Preliminary Budget.
- Member Months of 4,885,000 are 8,800 lower than in the Preliminary Budget.
- As a Single Plan County, Alameda will have responsibility for Foster Children and Youth as of January 2025.
- LTC and LTC Duals will be combined by DHCS with the SPD and SPD Duals COAs beginning January 2025.
- Total Medi-Cal enrollment is projected to grow very slightly throughout the year.
- Group Care enrollment is projected to be virtually unchanged.

Revenue

- 98% of Revenue for Medi-Cal, and 2% for Group Care.
- High-level final Medi-Cal base rates were received on 12/2/24. The rates were favorable compared to the previous draft rates.
- Details for ECM, MOT, GEMT, Community Supports, etc., are not yet available.
- Final PMPM Medi-Cal base rates are 5.8% higher than the Preliminary Budget. This is driven by higher rates for SIS members in the SPD and ACA OE Categories of Aid.
- The Supplemental Maternity Kick payment per delivery was reduced by 4.4%.
- Per-member-per-month Group Care rates are unchanged.

Medical Expense

- 98% of Expense for Medi-Cal, 2% for Group Care.
- Medical loss ratio is 97.9%, an increase of 2.0% over the Preliminary Budget.
- Material increases in the Inpatient and Long-term Care Categories of Service were partially offset by decreases in Capitated Expense.
- $3.0 million has been added to the Provider Incentive Pool.

Hospital and Provider Rates

- FY 2025 Hospital and SNF contract rates increased by $3.3 million compared to the Preliminary Budget.
- Professional capitation decreased by $26.8 million, as current rates will be largely sufficient to cover the new TRI fee schedule.

Question: Dr. Seevak inquired about the budgetary impact of postponing the Medicare component for one year.

Answer: Gil indicated that delaying the Medicare piece for a year would save money in terms of FTEs and consulting costs, potentially saving upwards of eight or nine million dollars in the short term.

Question: Wendy inquired whether the 2025 rates are sufficient if the medical loss ratio and other drivers are controlled.

Answer: Gil stated the 2025 rates are expected to be better than the current rates and should result in positive financial results for the entirety of the calendar year 2025, assuming medical management is appropriately handled.

Question: Yeon asked if the FTE number will change based on the final budget.

Answer: Matt replied that the number of FTEs has already been reduced from the original count, and while the current request is included in the final budget, it will still be reviewed on a case-by-case basis. The overall FTE count by the end of the fiscal year may be less than what is currently projected.

Motion: A motion was made by Dr. Rollington Ferguson and seconded by Natalie Williams to approve the Fiscal Year 2025 Final Budget.

Vote: The motion was passed unanimously.

Ayes: Aarondeep Basrai, Colleen Chawla, Dr. Rollington Ferguson, Andrea Ford, James Jackson, Byron Lopez, Dr. Marty Lynch, Andie Martinez Patterson, Dr. Kelley Meade, 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.

d) HEALTH EQUITY UPDATE

Lao Paul Vang presented the Health Equity update, outlining the vision, mission, priorities, and action plans for addressing health disparities and promoting Health Equity among Alliance members.

4 Quadrants of Priority

- Internal Stakeholders, Members, Providers, CBOs, and downstream networks
- Intersectoral, Collaboration, and Partnerships

Short-term Action Plans

1. DHCS 23-025 implemented this All-Plan Letter on 09/14/2023 that represents DHCS' multi-pronged vision:
    - Data collection and stratification
    - Workforce diversity and cultural responsiveness
    - Eliminating health disparities
2. Comprehensive DEI training includes three modules:
    - Health Equity
    - Cultural Sensitivity
    - Diversity, Equity, Inclusion & Belonging (DEIB)

3. Timeline:
    - Submission for DHCS approval: December 2024
    - Rollout of Pilot Training: January 2025
    - General Rollout Training: Summer 2025

Mid-term Action Plans

Non-Utilization Equity Project: Alliance Data

- The macro and micro data will guide us in developing priorities and targeted interventions for specific vulnerable populations who need help the most.
- Alliance Utilization vs Non-utilization data stratified by race, ethnicity, neighborhood, etc., will help explain variance.
- The equity-based information might provide indication into potential SDOHs, thereby allowing for more effective and targeted intervention.

Long-term Action Plans

Health Equity & DEIB Roadmap
(3 Yr. Milestones)

- Stakeholders Committee's Meetings & Discussions
- Identify and create milestones.
- Rollout 2025-2028

Question: Yeon Park asked whether the data on Pacific Islanders includes broader Asian communities.

Answer: Paul explained that the data presented refers explicitly to the Pacific Islander community. There is separate data available for the broader Asian population, and efforts are being made to work with community organizations for deeper data desegregation.

Comment: Yeon Park emphasized the importance of including family members in the co-design strategy, as they can provide valuable insights and perspectives, particularly for individuals who may lack their own opinions or voices.

Informational Item only.

e) REVIEW AND APPROVE STANDING COMMITTEE STIPENDS POLICY

Motion: A motion was made by Aaron Basrai and seconded by Andrea Schwab-Galindo to approve the Standing Committee Stipends Policy.

Vote: The motion was passed unanimously.

Ayes: Aarondeep Basrai, Colleen Chawla, Dr. Rollington Ferguson, Andrea Ford, James Jackson, Byron Lopez, Dr. Marty Lynch, Andie Martinez Patterson, Dr. Kelley Meade, Yeon Park,

Wendy Peterson, Andrea Schwab-Galindo, Dr. Evan Seevak, Natalie Williams, Chair Rebecca Gebhart.

No opposition or abstentions.

9. UNFINISHED BUSINESS

None.

10. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS

None.

11. PUBLIC COMMENT (NON-AGENDA ITEMS)

There were no public comments for non-agenda items.

12. ADJOURNMENT

Chair Gebhart adjourned the meeting at 2:08 p.m.

BOARD OF GOVERNORS
Annual Retreat Meeting Minutes
Friday, January 31st, 2025
9:30 a.m. – 4:00 p.m.

Video Conference Call and

1240 S. Loop Road
Alameda, CA 94502

1. MEET AND GREET – LIGHT BREAKFAST

2. CALL TO ORDER

Board of Governors Present: Rebecca Gebhart (Chair), Dr. Noha Aboelata (Vice Chair), Aarondeep Basrai, Tosan Boyo, Dr. Rollington Ferguson, Andrea Ford, Byron Lopez, Dr. Marty Lynch, Andie Martinez-Patterson, Dr. Kelley Meade, Jody Moore, Yeon Park, Wendy Peterson, Andrea Schwab-Galindo, Dr. Evan Seevak, Supervisor Lena Tam

Board of Governors Remote: None

Board of Governors Excused: James Jackson, Natalie Williams

Alliance Staff Present: Matthew Woodruff, Dr. Donna Carey, Gil Riojas, Anastacia Swift, Ruth Watson, Sasi Karaiyan, Tiffany Cheang, Richard Golfin, Michelle Lewis, Lao Paul Vang

Chair Gebhart called the regular Board of Governors meeting to order at 9:30 a.m.

3. ROLL CALL

Roll call was taken and a quorum was established.

4. MEDICARE FINAL DECISION DISCUSSION – VOTE

Gil Riojas provided a presentation on the Budget Update.

Calendar Year 2024 Rate Update

- On December 30, the Department of Health Care Services (DHCS) provided amended CY24 rates removing negative adjustments related to the Targeted Rate Increase program and population acuity.
- AAH CY24 rates increase by approximately 1.38% or $26M.
- Additional revenue was fully reflected in December's preliminary financial results, offsetting losses that occurred in the month.

Calendar Year 2025 Rate Update

- October draft rates reflected a 4.3% increase in base rates from original CY24 rates. Updated rates were received December 18. Some details are still needed but sufficient data was shared to determine potential base rate increase.
- An additional 5% increase was added to the 4.3% increase from October.
- Estimated additional revenue of $100M for the second half of FY25 (Jan-June).

Calendar Year 2024 Financial Results

FY25 Updated Results

- Estimated December Net Loss of $8.6M.
- Calendar year 2024 results recorded a $201M Net Loss for the year.
- This includes additional revenue from the recent CY24 rate increase.
- Final budget estimated a $65.2M Net Loss for FY25 (July 2024- June 2025).
- Updated forecast estimates based on November and December actual results plus updated CY24 rate increase slightly reduce FY25 Net Loss to $64.7M.

The Board discussed the DSNP scenarios that were presented by Matt Woodruff and Gil Riojas

Business as Usual – Scenario 1

- Assumes enrollment of approximately 4,000 members in 2026.
- Approved FTEs for FY25 move forward, assuming the FTE count grows for DSNP in CY26 and CY27.
- FTE assumptions were compiled as part of an exercise to determine what departments needed to stand up to the DSNP program.
- Total FTEs dedicated to DSNP are 75 costing $34.7 million for Calendar Years 2025 through 2027.
- Consulting and vendor costs are estimated to be $15.5 million for the same period.
- Total estimated cost to set up the DSNP is $216.4 million.
- Total costs include FTEs, Operating and Vendor costs plus Medical Expenses.
- Revenue begins in 2026 to offset some expenses.

Reduced Scale – Scenario 2

- Assumed enrollment builds up to 1,500 members by the end of 2026.
- Limited savings related to volume related departments (Call Center, Claims, etc.).
- Fixed cost to set up a DSNP remains.
- This allows the Alliance to enter the market on a small scale while learning from its 2026 experience.
- Total FTEs dedicated to DSNP are 60 costing $27.3 million for Calendar Years 2025 through 2027.
- Consulting and vendor costs are estimated to be $16.0 million for the same period.
- Total estimated cost to stand up DSNP is $131.7 million.
- Total estimate includes scaled back revenue stream but begins in 2026.

Question: Dr. Seevak inquired about our performance for the first half of the calendar year 2025 compared to the budget.

Response: Gil indicated that we have revised our final budget. Initially, significant losses were expected; however, due to a substantial increase in revenue, it is now anticipated that we will achieve a break-even point or slightly exceed it in the second half of our fiscal year.

Question: Chair Gebhart raised a question regarding the medical management aspect of the six-month projection. She inquired about the basis of our projections: Are we adopting a conservative approach, assuming we will make less progress over the next six months compared to what we might achieve later? How are we preparing this forecast?

Response: Gil mentioned that we are actively analyzing our existing medical trends and moving forward with them. We are leveraging our historical data on these trends to guide our efforts. Some initiatives began in December of last year, and more are expected to launch in the early part of this calendar year. However, we did not give much consideration to medical management in the initiatives reflected in our current forecast. An update will be provided in the March forecast, but for this budget update, there were not any significant changes included to the medical expenses as a result of these initiatives.

Question: Dr. Lynch asked about the risk adjustment and whether we made projections on the average risk score.

Do we have any data on the existing duals' scores?

Response: Tome explained the collaboration with Milliman on feasibility studies assessing the population's risk. They analyze CMS data from a county perspective, giving us scenarios with risk scores both below and above 1, which influences our reimbursement process. For the first year, we decided to set a standard risk score of 1 due to county coding, which will help us understand the population better. Moving forward, we will work with provider groups and community organizations to refine our coding and assess risk more accurately with Milliman's assistance. We are in the process of selecting a vendor, and once chosen, we will provide them with data to further evaluate the population's riskiness.

Question: Dr. Meade inquired about any regulatory or compliance issues regarding initially limiting access to care.

Response: Matt explained that, although we are not planning to engage in mass marketing or be as active in the community as before, members can still enroll if they call us. We cannot turn people away. Access to our services will remain unchanged, and we are required to maintain the same network with all the existing rules still in effect.

Question: Dr. Seevak asked, "What is the goal for 2027?"

Response: Matt stated that the objective is to target the remaining population.

Question: Andie asked for further clarification on the requirement to have the same network. For example, if someone calls and is part of a group that is being considered for enrollment but is not one of the first providers being onboarded, will they be enrolled at Baywell, or will they be enrolled with another provider that you have a contract with? What does it mean to have the same network if we are not starting with all the same providers?

Response: Matt explained that our approach to marketing differs from our network strategy. All access and quality requirements apply in Medicare, even with only one member. We must establish a full network and will be contracting with all providers in Alameda County.

However, we will not engage in active marketing or hire many sales reps or brokers. Instead, we will focus on a few key partnerships, ensuring smooth data flow and operations.

As we enter the Medicare space, more providers are interested in contracting with us. The board must consider this, as the Alliance requires providers to accept both commercial and Medi-Cal plans. While some are willing to take on all options, others only want dual-eligible patients, and we are currently insisting that providers accept both.

Question: Wendy inquired about individuals in a plan that is being terminated out of the county. How many are affected, and do they have an effortless way to join The Alliance?

Response: Matt explained that health plans cannot enroll new members, so no plan is eliminated; their enrollment is just paused. Currently, there are four plans in the county, and by submitting our application in two weeks, we will stop new enrollments for all but Kaiser. This limits new enrollments in the county to us and Kaiser.

Question: Andrea Schwab-Galindo highlighted the importance of considering current political implications, particularly regarding the administration's examination of Medicare. This could impact us financially and operationally in the future, and there are many uncertainties. As a board member, Andrea thinks having a clear timeline or roadmap for our initiatives would be helpful. If we choose to proceed gradually, we need to know when to accelerate or step back, as these decisions could significantly affect the plan and require substantial operational effort.

Response: Matt mentioned that we are finalizing the milestones and will share them with the board in a few months. The plan is to provide monthly updates on the D-SNP progress during board meetings, covering what is working and what is not. The board can expect this information shortly.

Question: Dr. Aboelata asked about starting small and selecting a couple of providers. What do we hope to learn from this, and how will it guide our choices? What are our goals and learnings with this gradual strategy?

Response: Matt noted that we are focusing on practices with 400 to 500 members that represent diverse races and ethnicities. Our goal is to ensure effective reporting, tracking appeals, grievances, member data, and quality data. For risk adjustment, we need to accurately capture and report this data. Our strategies will vary for different demographic groups, and we will work with smaller practices for initial testing. It is important to remember that marketing materials require approval from CMS, DHCS, and DMHC, making the process slower as all content needs regulatory review.

Question: Supervisor Tam values the discussion on minimizing competition. Lessons learned from absorbing Anthem patients and their cost impacts on the Alliance noted at 131.7 million under Scenario 2, are crucial. Given uncertainties with federal reimbursements and other plans, how can we contain costs if projections are inaccurate? We must avoid a scenario where Medi-Cal funds subsidize Medicare, leading to a deficit and the risk of conservatorship.

Supervisor Tam asked for more information on improving collaboration between the compliance, fraud, and claims departments, as there are potential savings, but past issues need to be addressed.

Response: Matt highlighted three key areas that impact Medicare members: medical management, risk adjustment, and star ratings. Starting small allows us to establish the systems and reporting needed to effectively influence future payments. One of the main focuses is getting things right before scaling up.

Gil mentioned that we are coordinating with our compliance department to investigate potential fraud and billing errors among providers. While some cases are under investigation, this does not confirm fraud. We are identifying suspicious patterns and taking action to avoid unnecessary costs, estimating around half a million dollars in open cases. Richard emphasized that any recovered funds from potential fraud should not be labeled as savings, as they simply represent money returned to the plan.

Question: Chair Gebhart raised a question regarding the selection of participants in the pilot phase. Is there a team responsible for this choice that evaluates individuals? How is this decision made?

Response: Matt mentioned we will evaluate those with a good track record in grievances and appeals, as well as reporting capabilities. We will reach out next month or the following one to see if they are interested in participating.

Motion: A motion was made by Yeon Park and seconded by Dr. Marty Lynch to approve the Executive Committee's recommendation to select Scenario 2.

Vote: The motion was passed unanimously.

Ayes: Aarondeep Basrai, Tosan Boyo, Dr. Rollington Ferguson, Andrea Ford, Byron Lopez, Dr. Marty Lynch, Andie Martinez-Patterson, Dr. Kelley Meade, Jody Moore, Yeon Park, Wendy Peterson, Andrea Schwab-Galindo, Dr. Evan Seevak, Supervisor Lena Tam, Chair Rebecca Gebhart and Vice-Chair Dr. Noha Aboelata.

No opposition or abstentions.

Medical Management Presentation presented by Dr. Carey

Medical Management Strategies

1. Inpatient strategies

   • Enhanced Care Management (expansion, TCS, prioritize MIF) – future
   • Over/Under Utilization Workgroup – current
   • Hospital partner rounds - current
   • On-site staffing (vendor partner) – future

2. Long-term care strategies

   • Implement Sitter criteria-future
   • Community Supports criteria update – current
   • Alliance staff on-site visitation in LTC facilities – current

3. Pharmacy strategies

   • Heart Failure/Sepsis pilot – current
   • Process improvements - ex-carve-out drugs - Sept 2024/Dec 2024
   • Pharmacy network update – current
   • Formulary/PA review and updates – current

4. Improving Access to clinical care (Avoidable ED visits)

   • ED navigators (partner with AHS) – future

- Member education campaign – current
  - Telehealth
  - Urgent Care
- Expand networks (PCP, Urgent care) – future

4. Reduce Avoidable Re-admissions
   - Designated analyst – current
   - Transition of Care Services
     - High/low-risk outreach – current
     - Vendor contract – future

5. WELCOME, INTRODUCTIONS, AND REVIEW OF MEETING GOALS/AGENDA

Dr. Kathleen Clanon was introduced as the new Board member who will soon fill the seat vacated by Colleen Chawla.

6. LEADERSHIP UPDATE AND BOARD DISCUSSION: QUALITY, ACCESS AND HEALTH EQUITY

a) What have we achieved, and where have we made progress?
b) Where have we struggled and what have we learned?
c) What directions and strategies are we exploring for the future?

Quality and Access to Care Presentation presented by Dr. Carey.

<u>California's "Bold Goals"</u>

- Close racial/ethnic disparities in childhood well-child visits and immunization
- Close disparity gap in maternity care for Black and Native American persons
- Improve maternal and adolescent depression screening
- Improve follow-up for mental health and substance abuse
- Improve children's preventative care measures

<u>Alliance 2024 Quality Programs</u>

State Mandated PIPs
- Improve FUM/FUA
- WCV 0-15 months AA Children

MCAS

Health Equity

Community Programs
- CFMG
- Washington Hospital
- Roots

DHCS 2024 Focus
- Health Equity
- Quality
- Access

- Accountability
- Transparency

2025 QIHE Key Priorities

- HEDIS
  - Achieve rates above MPLs and incremental improvement above HPLs

- Access to Care/Member Experience
  - Improve timely access to care survey scores (i.e., CAHPS, CG- CAHPS) and the number of corrective action plans

- Population Health & Equity
  - Implement data-driven and coordinated efforts to address health disparities in prioritized sub-populations

- Utilization
  - Identify and act on trends of over and under-utilization of services

PCP Network Access

- DHCS PCP Time Standard – 30 minutes, Distance Standard – 10 miles
  - Met for 98% of Alliance members with a PCP assignment

- DHCS Annual Network Certification requires the FTE ratio of 1 FTE PCP to every 2,000 members (1:2,000)
  - No need to request alternative access standards for primary care

- While DHCS requirements are met, the data does not account for potential delays or access issues members may experience when trying to obtain an appointment with their assigned PCP.

What are we doing to improve access?

- Local network expansion
- Transitions of Care
- Telehealth Providers
- Provider incentives/retention

Question: Yeon asked how our organization can improve our partnerships with community organizations. She inquired about what we learned from our past experiences, the challenges we faced, and how we can better coordinate our efforts to enhance services for community members.

Response: Dr. Carey highlighted challenges faced by CFMG in encouraging well-child visits. Their phone calls and emails were ineffective, so they sought funding for a texting campaign. We helped them develop a texting platform, which successfully increased visit rates and improved quality scores. Dr. Carey also emphasized that incentives are effective.

Comment: Dr. Meade shared her perspective as a pediatrician, highlighting community messaging and vaccination challenges. She noted many undecided families and emphasized that texting incentives for groups are effective. However, she mentioned difficulties with the California registry interface, which needs improvement. Any assistance in enhancing this process would be beneficial.

Question: Andrea Schwab-Galindo raised a question about improving workforce metrics, especially regarding utilization and data analysis for specific groups. She asked how we can use technology to prioritize and educate individuals, as we noted last year that the right groups are not always prioritized.

Additionally, she inquired about addressing the connection between workforce, utilization, and quality metrics. How can we leverage technology, like AI, to enhance efficiency and improve our quality metrics moving forward?

Response: Dr. Carey highlighted that for 2025, the focus is on addressing workforce challenges, particularly in health and in the MA workforce of our clinics. High turnover complicates maintaining quality programs due to constant hiring and training needs. One potential initiative is to support the MA workforce to stabilize medical assistance in primary care offices and clinics, enabling staff to make calls and assist with screenings. This is a key strategy for moving forward in workforce support.

Question: Dr. Lynch inquired about bold goals for the SPD and elderly populations.

Response: Dr. Carey emphasizes that we need to understand the reasons behind the high readmission rates among our SPD and elderly population. Our initial focus is to identify these causes so we can address them and reduce readmissions. Currently, we are exploring ways to intervene and break this cycle.

Question: Andie emphasized the importance of adding an Alliance bold goal in addition to California's goals. She inquired about the quality programs highlighted in the slide, specifically if there's data showing that the interventions achieved the desired outcomes, noting that some interventions take years to show results. She also asked if, now that CFMG has found texting effective, there are plans to implement this across all providers. Additionally, she mentioned a table in the appendix showing membership proportions: HCN 43%, Alliance 22%, and Alameda Health System 20%. She wondered if there is a forum for these entities to share successful collaborations and best practices.

Response: Dr. Carey mentioned that the QIHEC Meeting brings together representatives from various areas to share best practices on quality. Last year, we focused on improving lead screening, as we did not meet the minimum performance level. We provided funding for point of care testing and equipment in different clinics, which significantly increased our performance in that area. This support allowed providers to conduct lead screenings in-office, making it easier for members compared to going to a laboratory.

Question: Doctor Meade noted that our targeted interventions in the ED for children with asthma were effective. To build on this, it is crucial to analyze data to identify the most beneficial interventions.

Response: Dr. Carey emphasized the importance of long-term cancer screenings rather than just one-year interventions. Low screening rates can lead to higher costs later due to advanced cancer cases. It is essential to invest more in preventive care rather than readmissions, while balancing member needs and state expectations to ensure optimal health for members.

Comment: Judy Moore recommends contacting UC Santa Barbara's exceptional autism clinic, which utilizes state-of-the-art research. Their behavioral experts implement standard goals using PRT (Pivotal Response Training), offering a vast library of research beneficial for families, children, and institutions.

Question: Yeon mentioned that with the new federal administration, immigration agents are appearing at schools and clinics, causing fear in the community, and affecting attendance at check-ups. How will it affect our organization, and do we have a plan for this?

Response: Matt mentioned that during the previous Trump administration, we did not get undocumented status information from California. We are updating our materials to emphasize the importance of care and rights protection for everyone. Our legal team is creating talking points to guide community interactions and inform individuals of their rights. More updates will come as we progress.

Question: Doctor Seevak asked about the over-utilization point, wanting to confirm it aligns with the medical management work aimed at identifying frequent emergency room visitors and redirecting them for better care management.

Response: Dr. Carey noted that we need to analyze the reasons behind the overutilization of inpatient stays and emergency department visits. Understanding these factors will take time, but it will allow us to implement targeted interventions to address the issue.

Question: Dr. Ferguson discussed HEDIS in relation to the single plan model and concerns over a potential drop in scores due to removing the Kaiser subset. What was the outcome of the HEDIS score? What trends are we observing, and if there was a decline, how are we addressing it?

Response: Matt and Tiffany said our scores improved in 2023. We are missing 4 measures for 2024, but the Quality team has worked hard on outreach and data cleanup to counteract the lower rates from Kaiser and Anthem members. So far, these efforts are paying off.

Question: Tosan mentioned that in 2024, there has been an increase in the number of medical patients visiting emergency departments, especially following Anthem's departure. He asked what steps can be taken to proactively guide these patients back to their primary care physicians (PCPs). It is important to have the right care at the right time and in the right place, and building a relationship with PCPs is essential. What strategies are being considered for 2025 to address this issue?

Response: Dr. Carey mentioned that a member campaign started in December to educate members about alternatives to emergency departments, such as 24/7 telehealth services for acute issues and expanding urgent care networks. Members are encouraged to use urgent care for minor issues instead of the emergency room. They are also open to suggestions.

Question: Dr. Ferguson raised concerns about access to psychiatry for members and asked what steps are being taken to improve this. He emphasized the need for better integration of psychiatrists in member care and believes it should be a priority for the organization.

Response: Dr. Carey mentions collaborating with Alameda County Behavioral Health to link psychiatrists for mild to moderate cases, though most of their members require more severe psychiatric care. The operations team actively seeks local psychiatrists who are not already credentialed to expand their network. However, there is a shortage of psychiatrists available to take on new members, which is why they are exploring virtual psychiatry options.

Question: Dr. Aboelata believes recruitment incentives would be beneficial and suggests discussing workforce pipelines, such as CHW to LCSW or medical assisting to nursing. She emphasizes the need to connect various providers and strategically leverage available resources for effective matchmaking.

Response: Matt noted that last year, the alliance leadership worked with the board to create a two-year plan, allocating $2 million for provider recruitment this year and another $2 million next year. However, there were over $6.5 million in requests for providers. An additional $2 million will be available in June or July. The gap between requests and budget underlines the urgent need, and they may seek more funding from the board based on the financial situation.

Comment: Andrea Schwab Galindo stresses the need to prioritize retention alongside recruitment in workforce issues. She cites research highlighting the importance of keeping current providers due to their limited availability. While she values the existing recruitment plan, she recommends revisiting it for flexibility in the upcoming budget. Additionally, she emphasizes that improving processes along with technology is crucial for enhancing telehealth access and helping providers adopt new systems. Her main focus is on retaining the valuable providers already in the system.

Comment: Wendy noted that telehealth benefits older adults and individuals with disabilities, particularly those facing mobility and transportation challenges. However, low-income individuals often struggle with device accessibility and bandwidth issues for both phone and internet. Providers should find solutions, such as providing higher volume phones or addressing bandwidth limitations, to support these individuals effectively at the Alliance.

Health Equity Presentation presented by Lao Paul Vang, Chief Health Equity Officer

Achievements

1. Established 3-year HE & DEIB Roadmap (6 milestones & Goals)
2. Regulatory Compliant Issues: DHCS APL 23–025/APL 24–016 DEI Training Curriculum and DMHC APL-24-018 (SB 923) TGI Training.
3. Established intersectoral collaboration with key stakeholders (Providers, CBOs & Faith-Based Communities).

Challenges & Lessons Learned

1. Unfunded Health Equity Mandate & Structure.
2. System Approach to effectively mitigate SDOH, institutional racism & systemic inequities in healthcare practices.
3. Organizational Transformation – can be challenging, expensive, and time–consuming.
4. Overlapping and gaps in Health Equity Activities; and parallel operations.
5. Community Engagement and Intersectoral Collaboration.

2025 Strategies/Directions

1. Implement 3-Year Roadmap Strategies (2025 – 2028) - Solicit BOG feedback on milestones.
2. Advocate and integrate HE & DEIB into healthcare policies and services.
3. Establish a health equity data governance system to comprehensively assess and identify health disparities.
4. Collaborate and support HCS, PHM, QI & UM to ensure quality and access.

Question: Yeon inquired if this strategy is only based on state requirements and if we are gathering input from stakeholders, providers, or members and wants the diagram to reflect that stakeholders are involved in the process.

Response: Lao states that our initiative goes beyond state requirements, driven by a committee of staff, members, and providers providing feedback on milestone design.

Question: Dr. Meade suggested that part of the strategic plan should focus on forming search committees and vetting vendors from that diverse perspective.

Response: Lao emphasized that we currently have two diverse committees representing all divisions, contributing perspectives on how HealthEquity and DEI are implemented within the agency. Engaging staff members is crucial for creating a holistic and inclusive approach. Additionally, our vendor management department ensures we evaluate potential vendors and providers through a different lens.

Comment: Dr. Clanon noted that the County of Alameda's Public Health Department has a Community Health Improvement Planning (CHIP) process, which includes various elements. She is interested in the potential for collaboration between the two processes.

Question: Dr. Lynch asked how our equity engagement strategy relates to eliminating health disparities, such as heart failure and hypertension, and addressing mortality rates among our members. How do these elements connect?

Response: Lao mentions that he collaborates closely with Dr. Carey, who provides a technical perspective. Their work aligns well in addressing health inequities related to ethnicity and gender in the county. This effort is part of milestone number six, focusing on both tackling these specific inequities and enhancing MCAS and HEDIS measures simultaneously.

Question: Dr. Ferguson noted that DEI has gained a negative connotation. How do we plan to redefine it and ensure our work continues regardless of national developments? What steps will we take to navigate this space?

Response: Lao emphasizes that HealthEquity initiatives have always focused on marginalized communities. DEI aims to create equal opportunities across various areas, ensuring equality and engagement. Unfortunately, DEI is often seen as token gestures rather than addressing systemic inequities.

HealthEquity strategies must factor in historical data on social determinants affecting health disparities in America, aiming to serve these communities better by tackling historical marginalization.

Tosan, with experience on national committees, highlighted the importance of targeting health outcomes to address disparities. He cited Joint Commission regulations and stressed urgent issues like higher maternal mortality rates among Black women.

The strategy should close outcome gaps without getting sidetracked by political debates, which risk funding and effectiveness. Tosan believes aligning HealthEquity initiatives with broader healthcare goals will drive progress.

Comment: Wendy highlighted that ageism and ableism are significant issues often overlooked in society. For marginalized individuals who age into these categories, additional challenges arise. She stressed the importance of considering age and disabilities when engaging with CBOs and community members to ensure these factors are not overlooked.

7. WORKING LUNCH – PRESENTATION AND DISCUSSION OF POLITICAL ENVIRONMENT

Linnea Koopmans, Local Health Plans of California provided a presentation on the political environment.

State Landscape

Governor's Budget

Big picture:
- $322.3 billion proposed budget
- LAO Estimates a $2B budget deficit but a double-digit budget deficit in future years
- "No capacity for new commitments"
- Overall revenue running higher, likely near $7B from expectations
- Risks include activity at the federal level that would impact state revenue

Medi-Cal:
- $188.1 billion total funds ($42.1 billion General Fund)
- Preserves major commitments in recent years, and funding to implement new CalAIM components
    - Approximately $20 million for transitional rent ($10 million General Fund)
- Funding for counties to implement Prop 1, BHSA, and BH-CONNECT waiver
- Allocates funding for Prop 35 but no details regarding implementation
- Proposed elimination of PHE unwinding Medi-Cal eligibility flexibilities that will decrease the Medi-Cal caseload
- Largely a placeholder budget until the May Revision when more will be known about what occurs (or will likely occur) at the federal level.

Health & Medi-Cal Legislative Issues
Issues that may be the subject of policy bills:
- Maternity access, including addressing the trend of Labor & Delivery unit closures.
- Rural health care and access.
- Medi-Cal network adequacy, including alternative access standards.
    - Current Medi-Cal time and distance standards sunset and need to be renewed (or modified).
- CalAIM
    - Addressing provider pain points
    - Transitioning community support to benefits
- Other issues:
    - Health plan provider directories

    - Utilization management/prior authorization
    - Timely payment
- Other emerging issues or priorities of new members in the Legislature

Federal Landscape

Potential Congressional Agenda

- House GOP menu of spending cuts
- Extension of Trump's tax cuts relies on substantial reductions to federal spending.
- Included many proposed Medicaid cuts, totaling $2.3T.
- Provides options for proposals to include in the budget reconciliation process.
- Possible Medicaid financing proposals include:
    - Work requirements
    - Decreasing the enhanced federal match for ACA expansion populations
    - Per capita caps
    - Limiting Medicaid provider taxes
    - Lowering floor for federal Medicaid match
- Budget reconciliation may begin as early as late Spring, but it is still unknown whether there will be one or two packages.

What's at Stake for California

- Any major changes to Medicaid financing will have significant impacts on California's Budget:
    - The ACA Medi-Cal Expansion population represents approximately one-third of overall Medi-Cal enrollment (nearly 5 million beneficiaries).
    - Federal funding to California for this population is in the tens of billions of dollars annually.
    - Timeline and impact may not be immediate given reconciliation process scores savings over a decade, so effective dates may be multiple years out.
    - Some spending cuts are simpler or easier politically, whereas others are more complex. However, it is more of a question around what cuts will be made rather than whether cuts will be made.
- Waivers:
    - CalAIM waiver is up for renewal effective 2027.
    - In addition to political influence on waiver negotiations, Medicaid financing changes could pose challenges for program sustainability.
    - However, much of CalAIM is in California's 1915(b) waiver which is more procedural in nature, which could provide a degree of protection.
- Nexus of health and immigration:
    - California's investment in the state-only expansion to undocumented populations represents billions of dollars of state spending.
    - Day 1 Executive Orders targeting immigrant communities, some of which were quickly challenged by many states including California.
    - Public charge.

Protecting Medicaid

- Protecting Medicaid will require significant coalition work at the local, state, and national levels.
- Partnerships with local business leaders, hospitals, doctors, and others will be important to support messaging about the impact of potential cuts.

- Connection through state and national trade associations will be key, including working together or supporting red states that have expanded Medicaid or provider taxes similar to California and have a lot of Medicaid funding on the line.
- Messaging will need to be tailored to the interests of the Republican Congressional delegation.

Question: Rebecca asked if the new housing benefits are similarly funded, considering that community supports require significant subsidies from all implementing plans.

Response: Linnea mentioned that DHCS will finance the state differently than community supports, which are often not fully funded. While details on the reimbursement structure are pending, it will not be risk-based. Instead, it will involve an add-on payment based on the number of members placed, with a ceiling to be established. Utilization will be submitted for reimbursement. This approach will reduce risk for plans compared to community support. Implementation is set for 2026, and eligibility may be determined through local provider referrals or by the plan itself.

Question: Andrea Schwab-Galindo asked about the impact of current political implications on the alliance's financial and operational stability.

Response: Matt assured the board that they are monitoring the situation and will provide updates as needed.

Question: Andie asked Linnea about consultants' views on block grants and per capita caps. Are they expecting the current waiver and SPA structures to stay, or do they foresee tougher negotiations with reduced funding? Will states likely accept less money in exchange for more flexibility? Andie is curious about what Linnea is hearing.

Response: Linnea mentioned that she initially overlooked block grants in the Medicaid financing discussion but believes they could be easier to implement than per capita caps, which involve complex formulas based on diagnosis groups and can vary per enrollee. She noted skepticism around the feasibility of per capita caps due to their complexity. A simpler mechanism like block grants could streamline the process.

She also pointed out that the enhanced federal match introduced by the Affordable Care Act offers a straightforward change that could significantly impact funding. Lastly, while waivers might seem less financially advantageous, they could allow for more flexibility and creativity in program implementation, though negotiations would remain challenging.

Question: Andie mentioned that California's FMAP is already low, and she heard it might drop to 20%. Can California have a 20% FMAP while other states have 50%, or is there a law against setting different rates by state?

Response: Linnea mentioned that FMAP rates vary by state based on revenue and wealth. States with lower income may have a higher FMAP, while California has significant wealth disparity, with 1/3 of residents on Medicaid. She suggested that differential FMAP rates should have a logical basis rather than arbitrary percentages for states like California and Texas. Richard stated that it is currently protected by law at 50%. Any changes would require a change in law.

Question: Dr. Lynch asked if the association has begun scenario planning and discussed potential program designs for various scenarios.

Response: Linnea mentioned they have discussed needing to address it depending on what proposals are made and what unfolds in the coming months.

Comment: Dr. Meade believes we should collaborate with national organizations like the American Academy for Pediatrics to promote the importance of vaccinations. Recently, her patients avoided in-person visits due to fear and opted for telehealth instead. She urges collective action with these organizations to emphasize the necessity of in-person care, as we will not meet vaccine quality standards if children do not come in.

8. LEADERSHIP UPDATE AND BOARD DISCUSSION: FINANCIAL POSITION, PROJECTIONS AND STRATEGIC APPROACH

Gil Riojas discussed our current financial position, the 2025 forecast and the Alliance's strategic approach and framing.

Alameda Alliance Financial Strategy, Short-Term and Long-Term

Short-Term

- Medical management initiatives begin in 2025
- Provider and hospital contract management (billed charges, DRG) ongoing
- Authorization and claims alignment project goes live March 2025
- Fraud waste and abuse avoidance
- Continued advocacy with the state (DHCS, DMHC) executive leadership

Long-Term

- Provider and hospital contract process revamp
- Complete program evaluation of CalAIM and in lieu of services savings
- High-cost member engagement and management
- Preparation for policy changes related to federal administration changes

Question: Dr. Seevak inquired about which lines of business might be at risk due to federal changes, especially related to care for undocumented individuals and optional expansions, and how these might impact the bottom line. He also asked if launching new programs, like dental care, would mean initially assuming losses and how that might influence the decision to pursue them.

Response: Gil emphasized that the priority is ensuring members receive care, noting the risk of members losing coverage. He mentioned that optional expansion members have negatively impacted margins recently, but losing that membership might have a short-term positive financial effect, though it overlooks the care needs of members and staff.

Regarding program changes, Gil stressed the importance of focusing on core business. He acknowledged that new programs might pose risks to margins amid uncertainty and that these factors would influence future decisions about expanding services like dental care.

Comment: Dr. Meade hopes as we move forward in the next couple of years she hopes that if we do have to make hard financial decisions that we focus on the people and the direct service so that the values of quality, mandatory, regulatory and people stay balanced.

9. CHARTING THE FUTURE - STRATEGIC PLANNING PROCESS OVERVIEW AND EXTERNAL ENVIRONMENT/STRATEGIC ISSUES DISCUSSION

The Board and executive team reviewed strategic planning goals and discussed items to address in the strategic planning process.

Discussion Goals

- Introduce strategic planning, outline Board role and input opportunities
- Share staff leadership preliminary reflections on strategic issues, questions, and directions to address in planning
- Solicit Board perspectives on key environmental factors and strategic issues to address in planning

Strategic Planning Goals

- 5-year strategic plan that serves as a roadmap for the future
- Craft a strategic plan that is…
    - Clear, simple, focused, and flexible
    - Has a broad vision but offers achievable steps
    - Looks forward and outward, not just internally or immediate
    - Prioritizes wide buy-in and participation by the Board, executives, staff leaders, and stakeholders
    - Has clear outcomes that let us know if we have been successful

Board Discussion

- Small Group exercises to address the following questions
    - Planning Assumptions
        - What are some key assumptions about the future that the Alliance should use to inform its next strategic plan?
    - Strategic Issues and Questions
        - What strategic directions, issues or questions do you think are the most critical to address during strategic planning?
    - Preliminary Priorities
        - Preliminarily, what are one or two top strategic priorities that you would articulate right now for the Alliance in the next 5 years?

Question: Andie asked what we are currently trying to solve with the strategic plan.

Response: Matt mentioned that the old strategic plan is complete. As he discusses the next five years, we must quickly adapt to changes at the federal level and consider new state programs and benefits. He would like to begin the conversations with the board to think about taking on some of these initiatives for the community, focusing on opportunities that could be beneficial.

Comment: Dr. Meade believes that Covered California will not benefit current members, but that behavioral health and dental services would help the Alliance's population.

Comment: Andrea has observed that Medicare Advantage is frequently mentioned in memos and communications from the White House. Considering potential political implications and forthcoming changes, we might need to consider looking into this further.

Comment: Dr. Aboelata asked that we explore the fiscal impacts of dental and behavioral.

Comment: Andie highlighted that if we lose half of our Medi-Cal patient population, that impacts our mission significantly. Regarding Medicare Advantage, while it may be beneficial as it allows for growth and creativity, there is a risk in optional benefits like dental to set them up and potential costs. Additionally, integrating behavioral health is crucial since mental illness significantly drives hospital utilization. Addressing these complexities aligns with our core challenges, and having accurate data would be valuable.

Comment: Andrea Schwab-Galindo suggested revisiting our values and principles. She emphasized the need to balance our mission-driven business and identify priorities and areas for subsidization in line with our values. Revisiting this could help address some of our current questions.

Comment: Supervisor Tam supports the integration of behavioral health from the perspective of medical coverage and reimbursement. While she acknowledges that the complexities surrounding this issue can be scary, she believes it is important for us to explore it to provide the necessary care for our clients.

Group Exercise Questions and Suggestions from the Board:

- What are the values and principles that we should use to guide our decision-making around the line of business?
- What should the organizational focus be, ensuring alignment with the organization's mission and goals?

Comment: Supervisor Tam wants to avoid duplication, operating in silos is not helpful in different managed plans.

Comment: Dr. Aboelata wants to make sure we fill in gaps in the landscape, and how we invest in the resources of partners that we have so we are not duplicating the wheel, but we are actually investing in who is out there doing this work but may not be connected as well to us.

Comment: Wendy emphasized the organization's responsibility to the community, highlighting the importance of compassion and ensuring that decisions impacting people's lives involve their meaningful participation.

Comment: Dr. Clanon emphasized the importance of safeguarding the plan, as doing so involves risks both to the plan itself and to the people we care about. There will be times when protecting the plan may create tension with other priorities we wish to pursue.

Comment: Rebecca highlighted that we have struggled to manage our high-utilizing population effectively. As we plan our next steps, it is crucial to integrate strategies for this group since it consumes a significant portion of our budget. What adjustments can we make to better manage this population and improve outcomes?

Comment: Dr. Lynch stated that to improve quality work, if the state lacks a bold goal for our population, we should help establish a bold goal for the aging population that frequently utilizes the hospital.

Comment: Dr. Aboelata emphasized that when we seek grants, it is essential to clearly communicate our strengths. We need either an academic or a research partner to help distinguish us. By doing this, we can gain a competitive edge and significantly advance our efforts if we get this aspect right.

Comment: Dr. Seevak emphasizes the importance of retaining our current providers and clinicians, especially given the challenges in recruiting new ones. It is not just about physicians; this applies to nurses, nurse practitioners, administrators, and others as well. We have an opportunity to simplify their lives as a health plan by making it easier for them to navigate the system. Additionally, we can provide training and support to help combat burnout and better support our providers.

Comment: Dr. Meade wants to revisit the discussion on coalition building and identifying roles. There has been an overlap in the care management space over the last five years, so we need to clarify responsibilities and advocate for our respective positions in an organized manner.

Comment: Andrea Schwab-Galindo emphasized the importance of involving patients in discussions about how to improve their care. She pointed out the need to understand patients' wants and needs better, questioning if they have truly done their due diligence in gathering this information. For instance, the rise of telehealth highlights opportunities that could have been identified earlier. She urged the board and leadership to avoid making assumptions about patient needs and to consider what outsiders might do differently to improve their approach. This perspective can help reframe discussions and encourage innovative thinking.

Comment: Rebecca emphasized the need to shift from traditional approaches to a more engaging relationship with members, encouraging innovative strategies to enhance care.

10. ANNOUNCEMENTS

There were no announcements.

11. PUBLIC COMMENT (NON-AGENDA ITEMS)

There were no public comments.

12. BOARD REFLECTIONS AND ADJOURNMENT

Chair Gebhart adjourned the meeting at 3:32 p.m.

RESOLUTION NO. 2025-

A RESOLUTION OF THE ALAMEDA ALLIANCE FOR HEALTH RECOMMENDING THAT THE ALAMEDA COUNTY BOARD OF SUPERVISORS REAPPOINT MS. NATALIE WILLIAMS TO THE REGULAR #7 AT CONSUMER MEMBER OR PARENT/GUARDIAN SEAT TO THE ALAMEDA ALLIANCE FOR HEALTH BOARD OF GOVERNORS

WHEREAS, Ms. Natalie Williams' current term as an Alameda Alliance for Health (Alliance) Board of Governors member, in the Consumer Member or Parent/Guardian seat (Regular #7), expires June 22, 2025 and

WHEREAS, the Alliance Chief Executive Officer recommends that the Alliance Board of Governors nominate Ms. Natalie Williams for reappointment to Consumer Member or Parent/Guardian seat (Regular #7), pursuant to Section 3.D.5 of the Alliance *Bylaws*; and

WHEREAS, pursuant to Sections 3.C and 3.J of the Alliance *Bylaws*, the Alliance Board of Governors has reviewed the recommendation; and

WHEREAS, the Alliance Board of Governors desires to nominate Ms. Natalie Williams for reappointment to the Alliance Board of Governors (Regular #7); and

WHEREAS, pursuant to Sections 3.C and 3.J of the Alliance *Bylaws*, the Alliance Board of Governors is required to adopt a resolution, which in turn will be provided to the Alameda County Board of Supervisors; and

WHEREAS, upon receipt of the Alliance Board of Governors' resolution, the Alameda County Board of Supervisors may choose to reappoint by majority vote this member to the Alliance Board of Governors.

NOW, THEREFORE, THE ALLIANCE BOARD OF GOVERNORS DOES HEREBY RESOLVE, DECLARE, DETERMINE, ORDER, AND RECOMMEND AS FOLLOWS:

SECTION 1. That the Alliance Board of Governors approves the Chief Executive Officer's recommendation to nominate Ms. Natalie Williams for reappointment to Consumer Member or Parent/Guardian seat (Regular #7), pursuant to Section 3.D.5 of the Alliance *Bylaws*.

SECTION 2. The Alliance Board of Governors hereby recommends that the Alameda County Board of Supervisors, by majority vote, reappoint Ms. Natalie Williams to the Consumer Member or Parent/Guardian seat (Regular #7), on the Alliance Board of Governors.

SECTION 3. The Alliance Secretary shall certify the adoption of this resolution and immediately forward it to the Clerk of the Board of the Alameda County Board of Supervisors.

PASSED AND ADOPTED by the Board at a meeting held on the 14th day of March 2025.

_____
CHAIR, BOARD OF GOVERNORS

ATTEST:

_____
Secretary

RESOLUTION NO. 2025-

A RESOLUTION OF THE ALAMEDA ALLIANCE FOR HEALTH RECOMMENDING THAT THE ALAMEDA COUNTY BOARD OF SUPERVISORS REAPPOINT MS. JODY MOORE TO THE REGULAR #13 AT CONSUMER MEMBER OR PARENT/GUARDIAN SEAT TO THE ALAMEDA ALLIANCE FOR HEALTH BOARD OF GOVERNORS

WHEREAS, Ms. Jody Moore's current term as an Alameda Alliance for Health (Alliance) Board of Governors member, in the Consumer Member or Parent/Guardian seat (Regular #13), expires May 24, 2025 and

WHEREAS, the Alliance Chief Executive Officer recommends that the Alliance Board of Governors nominate Ms. Jody Moore for reappointment to Consumer Member or Parent/Guardian seat (Regular #13), pursuant to Section 3.D.5 of the Alliance *Bylaws*; and

WHEREAS, pursuant to Sections 3.C and 3.J of the Alliance *Bylaws*, the Alliance Board of Governors has reviewed the recommendation; and

WHEREAS, the Alliance Board of Governors desires to nominate Ms. Jody Moore for reappointment to the Alliance Board of Governors (Regular #13); and

WHEREAS, pursuant to Sections 3.C and 3.J of the Alliance *Bylaws*, the Alliance Board of Governors is required to adopt a resolution, which in turn will be provided to the Alameda County Board of Supervisors; and

WHEREAS, upon receipt of the Alliance Board of Governors' resolution, the Alameda County Board of Supervisors may choose to reappoint by majority vote this member to the Alliance Board of Governors.

NOW, THEREFORE, THE ALLIANCE BOARD OF GOVERNORS DOES HEREBY RESOLVE, DECLARE, DETERMINE, ORDER, AND RECOMMEND AS FOLLOWS:

SECTION 1. That the Alliance Board of Governors approves the Chief Executive Officer's recommendation to nominate Ms. Jody Moore for reappointment to Consumer Member or Parent/Guardian seat (Regular #13), pursuant to Section 3.D.5 of the Alliance *Bylaws*.

SECTION 2. The Alliance Board of Governors hereby recommends that the Alameda County Board of Supervisors, by majority vote, reappoint Ms. Jody Moore to the Consumer Member or Parent/Guardian seat (Regular #13), on the Alliance Board of Governors.

SECTION 3. The Alliance Secretary shall certify the adoption of this resolution and immediately forward it to the Clerk of the Board of the Alameda County Board of Supervisors.

PASSED AND ADOPTED by the Board at a meeting held on the 14th day of March 2025.

_____
CHAIR, BOARD OF GOVERNORS

ATTEST:

_____
Secretary

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Standing Committee Updates

CMO Standing Committee Updates - PRCC, P&T, & QIHEC

September 2024 – February 2025

Peer Review and Credentialing Committee (PRCC)

Meeting date: November 19, 2024

Initial – 190

Re-cred – 235

Meeting date: January 2025

At the Peer Review and Credentialing (PRCC) meetings held on January 21, 2025, there were one hundred forty-one (141) initial network providers approved; four (4) primary care providers, eight (8) specialists, thirteen (13) ancillary providers, ten (10) midlevel providers, and one hundred six (106) behavioral health providers.

Additionally, thirty (30) providers were re-credentialed at this meeting; eleven (11) primary care providers, ten (10) specialists, two (2) ancillary providers, and seven (7) midlevel providers.

Meeting date: February 2025

The PRCC Meeting was held February 18, 2025.

Initial providers (105)

Re-credentialed providers (12)

Behavior Health (90)

Reviewed PRCC Charter

Approved updates to policy CRE-002 – updated.

1) Updated to Physicians will be reviewed by PRCC after probation period ends on a cases by case basis (previously Providers had to wait until 7 years following probation period ended).
2) Update that Board certification is preferred (not required) for primary care Providers.

Pharmacy and Therapeutics Committee (P&T)

Meeting date: September 24, 2024

Reviewed:

-top 50 high-cost drugs (top 5: #1 &2 &4 HIV, #3 & 5 GLP-1)

-drug classes: Hep B and Glaucoma

- 8 medication guidelines

- 5 Physician Administered Drugs

QUALITY IMPROVEMENT HEALTH EQUITY COMMITTEE (QIHEC)

Meeting date: November 15, 2024

Presentation: CFMG – Dr. Jim Florey-Best practices in Pediatric Care

- **Approval of Committee Meeting Minutes**
  - QIHEC: 8/16/2024
  - CLSS: 8/28/2024
  - A&A: 9/04/2024
  - CAC: 6/13/2024

UMC: 8/30/2024 & 9/27/2024

Workplan updates:

LTSS

Quality

Meeting date: February 14, 2025

Introduction of 5 new committee members

Presentations:

Cultural and Linguistic Committee

DHCS 2024 Audit Findings

Utilization Management Workplan

Case Management Workplan

Alameda County Public Health Community Health Needs Assessment and Plan

PQI Dashboard

Community Advisory Committee Update

Non-Specialty Mental Health Services Outreach and Education Plan

Summary of Community Advisory Committee (CAC) Meetings:
December 5, 2024 and December 16, 2024

CAC Meeting Date: December 5, 2024

Key Discussions:

- **Alliance Updates (Matt Woodruff, CEO):**
  - Reviewed Alliance Financial Outlook including projected loses and challenges.
  - Shared Alliance Preliminary Quality Scores, Met 16 out of 18 measures.

- **City of Berkeley, Janice Chin, Manager of Public Health Division**
  - Shared landscape scan of Berkeley residents (See details below)
  - Finalizing their Community Health Assessment (CHA)
  - Will develop a Community Health Improvement Plan (CHIP) focusing on key health areas identified in the CHA – complete by May 2024.
  - Will establish a Community Steering Committee as well
  - Created a shared Goal with AAH and Kaiser:
    - Improve access to care for priority populations (LGBTQ+, adolescents, older adults, perinatal residents).

ADDITIONAL Details on Berkeley Landscape Scan:

- Berkeley residents have good health and wellness.
- Inequities and disparities were highlighted during the pandemic:
  - Life expectancy: 16-year difference between Berkeley Hills-Cragmont (93 years) and South Berkeley-Lorin (77 years).
  - Economic environment: Significant variation in poverty rates by race, affecting children and seniors; marginalized groups experience high rates of poverty.
  - Physical environment: Some neighborhoods (Berkeley Marina, Downtown Berkeley, South Berkeley) are considered at-risk by FEMA.
- City of Berkeley's Demographic Overview:
  - Race/Ethnicity:
    - White: 51.9%
    - Asian: 20.7%
    - Hispanic or Latino: 12.1%
    - Black/Two or More Races: 6.6%
  - Educational Attainment: High level of education among the population.
  - Key Priority Areas:
    - Housing
    - Community Safety
    - Environmental Health Hazards
    - Health Disparities
    - Mental Health

CAC Meeting Date: December 16, 2024

Key Discussions:

1. **Review of Alliance Logo and DSNP Name Feedback**
   (Presented by Michelle Lewis and Karina Rivera)
   - CAC members provided the following feedback:
     - Liked diverse colors.
     - Needed clarification and understanding of symbols in the logo and name.
2. **Review of the Alliance Provider Manual**
   (Presented by Cecilia Gomez and Michelle Lewis)
   - CAC members provided the following feedback:
     - The layout was clear and straightforward.
3. **Non-Specialty Mental Health Services Outreach and Education Plan**
   (Presented by Andrea DeRochi)
   - Alliance staff asked CAC members how the Alliance could encourage more members to use mental health services. CAC members provided the following feedback:
     - Use of community organization's social media
     - Provider referrals are helpful.
     - Partner with sports teams to help reduce mental health stigma.
   - Additionally, CAC members shared that they were:
     - Interested in the ease of access to talking to someone about mental health problems and getting connected to services.
     - Concerned that someone with a mental health condition may not be as consistent with a follow-up appointment.
     - Needing clarification on the pre-authorization process.
4. **CAC Selection Committee**
   (Presented by Linda Ayala)
   - CAC Selection Committee: new committee that ensures Alliance CAC is reflective of our membership representation.
   - Held first meeting on 09/30/2024.
   - CAC Selection Committee approved a new CAC member, Kerri Lowe, from Alameda County Public Health Department.
   - CAC Selection Committee will focus recruitment on members with Limited English Proficient (LEP), Men, Ages 19-44.
5. **CAC Membership Recruitment**
   (Presented by Linda Ayala)
   - Updated CAC on current recruitment efforts with community-based organizations
6. **Alliance Care Bags**
   (Presented by Michelle Lewis)
   - Updated CAC members on care bag distribution plans (5,000 bags)
   - Alliance shares care bags with /individuals and organizations who distribute to unhoused in our community:
     - Alliance CAC members
     - Local Alameda County shelters
     - Local churches
     - Street medicine teams
     - Warming centers

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CEO Update

Matthew Woodruff

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

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

Date: **March 14th, 2025**

Subject: **CEO Report**

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

	January	YTD
Medi-Cal	($5.7M)	($97.9M)
Group Care	($656K)	($893K)
Medicare	($371K)	($5.0M)
Total	($6.7M)	($103.9M)

  - **Revenue was $190.7 million in January 2025 and $1.2 billion Year-to-Date (YTD)**.
    - Medical expenses were $191.1 million in January and $1.3 billion for the fiscal year-to-date; the medical loss ratio is 100.2% for the month and 104.8% for the fiscal year-to-date.
    - Administrative expenses were $8.9 million in January and $66.5 million for the fiscal year-to-date; the administrative loss ratio is 4.6% of net revenue for the month and 5.6% of net revenue year-to-date.
  - **Tangible Net Equity (TNE)**: Financial reserves are 186% of the required DMHC minimum, representing $70.2 million in excess TNE.
  - **Total enrollment in January 2025 was 412,828**, an increase of 602 Medi-Cal members compared to December 2024.
- **Key Performance Indicators:**
  - **Regulatory Metrics:**
    - Nothing to report
  - **Non-Regulatory Metrics:**
    - Nothing to report
- **Alliance Updates:**
  - **Demographics**
    - Please see the attached PowerPoint describing the demographics of the Alliance employees.

- **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 112 projects, of which 58 are active, 50 requested, and 4 are on hold.
        - Submitted CMS Application via HPMS on February 12th, 2025, which included Part C (MA), Part D, SNP Attestations, supporting documentation, Model of Care (MOC), Model of Care (MOC) Matrix, and Provider Network Adequacy report.
            - Submitted to DHCS the Model of Care (MOC), CA Specific Model of Care (MOC) Matrix, and Health Risk Adjustment Tool (HRAT).
            - PBM, MTM, Call Center Overflow, and Marketing Contracts are all complete.
        - AAH participated in CHCF Joint D-SNP Planning with CHCN on February 28th, 2025, which was facilitated by El Cambio Consulting.
        - Continued Sales System, Hearing, and FlexCard implementation with Nations vendor. Choose a vendor for the Health Risk Assessment Tool (HRAT) and demoing 4 different vendors for Risk Adjustment.
        - The Medicare Operations Department is interviewing for 8 positions. 69 policies have been submitted to PolicyTech for review and approval by leadership.
        - Continuing to collaborate with IT in updating Core Claims / Medical Management Systems and identified 321 requirements collected within Microsoft List.

- **Department of Health Care Services**

    - The Alliance audit has finished. A report will be given in the Compliance Committee and at the Board meeting in my update.

- **Meeting Recap**

    - An Executive committee of the Board was called on March 3, 2025, to discuss the January financial results and potential cuts the Alliance will need to make. The Alliance will update the Finance committee with two options with the goal of carrying forward one to the full Board at the March 14, 2025 meeting.

ALAMEDA Alliance FOR HEALTH

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Demographics

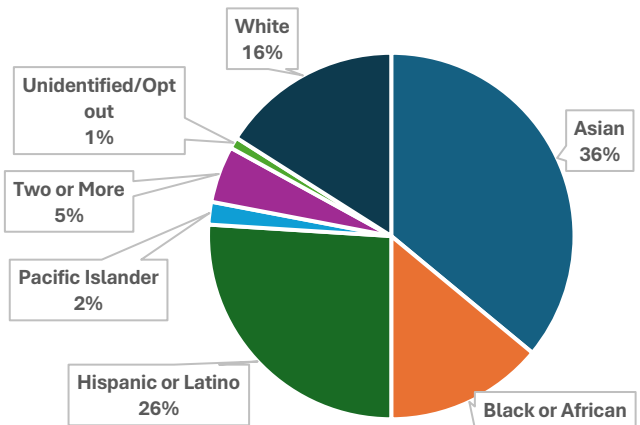
The purpose of this report is to conduct a comparative analysis of the demographic composition of Alameda Alliance for Health's workforce and the population distribution of Alameda Count. The primary focus of this comparison will be on key metrics, including race/ethnicity, gender, and age distribution. 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 April 2024. Additionally, the data used for Alameda Alliance for Health was last updated in February 2025 and is collected and maintained monthly by the Human Resources Department internally.

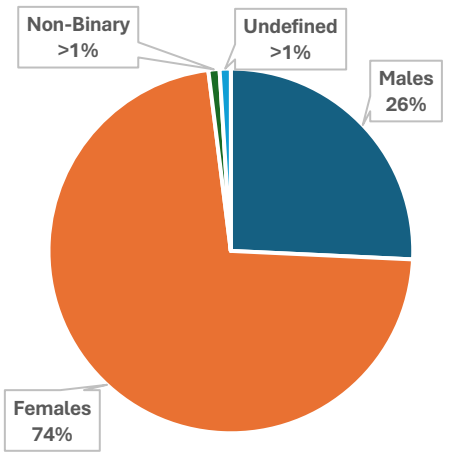
Category	**Alameda Alliance for Health** (Workforce information last updated February 2025)	**Alameda County** (Population Information last updated in April 2024)
Population/Total Employees	649	1,634,785
Race & Ethnicity		
Asian	36%	34.68%
Hispanic	26%	23.95%
White	16%	28.75%
Black/African American	14%	9.27%
Native Hawaiian/Pacific Islander	2%	0.85%
Two or More Races	5%	11.68%
Unidentified/Opt Out	1%	
Gender		
Male	26%	48.98%
Female	74%	51.02%
Non-Binary	>1%	0%
Undefined	>1%	0%
Age Distribution		
Under 25	>1%	12.47%
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 February 2025

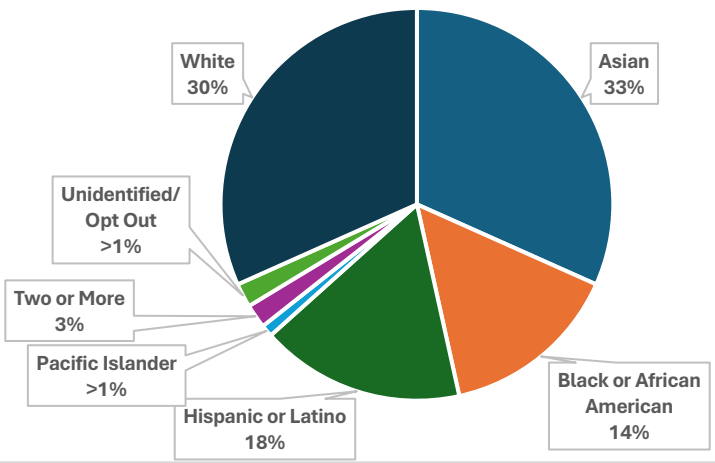
Employee Ethnicity - 649
February 2025



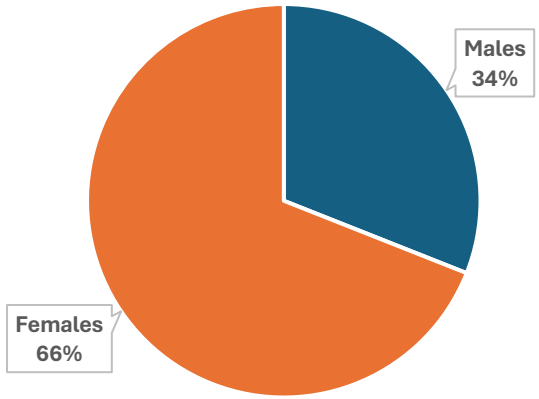
Employee Gender - 649
February 2025

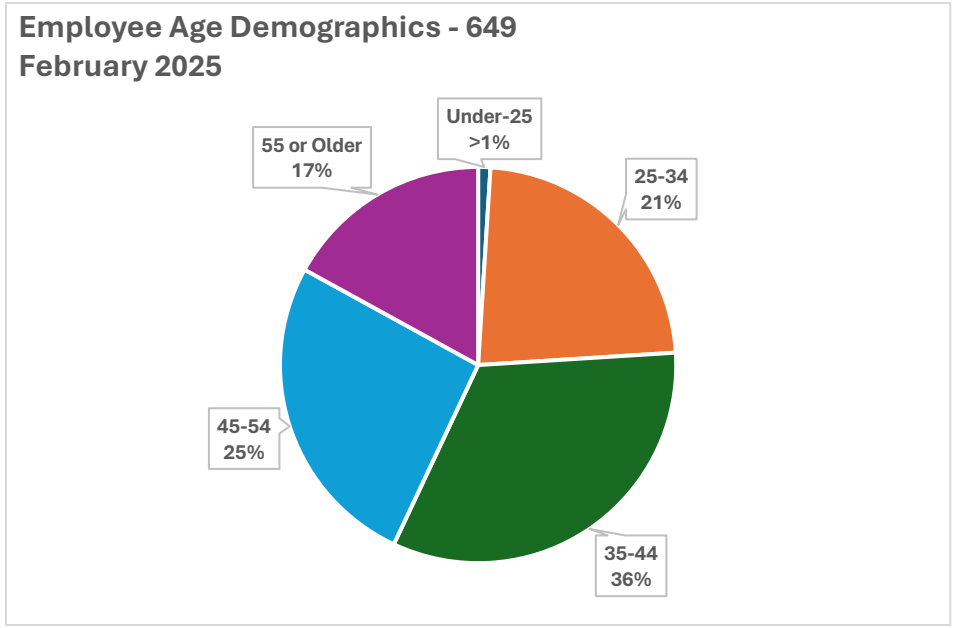


Managers Ethnicity - 130
February 2025



Managers Gender - 130
February 2025




Employee Age Demographics - 649
February 2025
Under-25
>1%
25-34
21%
35-44
36%
45-54
25%
55 or Older
17%

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Legislative Tracking

2025 –2026 Legislative Tracking List

The February 21st deadline for new bills to be introduced by California Legislators has now passed and over 2,300 bills were introduced. On the Assembly side, around 1,500 bills were introduced, while the Senate introduced 850 bills. Several bills have been labeled as "spot bills", which means they are likely to change as they move through their respective committees.

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: 2/3/2025-Referred to Com. on Health.

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

Summary: Existing 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: Introduced: 12/2/2024 html pdf
Introduced: 12/2/2024
Status: 2/3/2025-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. 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 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.

AB 37 **(Elhawary D) Workforce development: mental health service providers: homelessness.**
Current Text: Introduced: 12/2/2024 html pdf
Introduced: 12/2/2024
Status: 12/3/2024-From printer. May be heard in committee January 2.

Desk	Policy	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. This bill would state the intent of the Legislature to enact legislation relating to expanding the workforce of those who provide mental health services to "homeless persons" or "homeless people," as specified.

AB 40 **(Bonta D) Emergency services and care.**
Current Text: Amended: 3/5/2025 html pdf
Introduced: 12/2/2024
Status: 3/5/2025-From committee chair, with author's amendments: Amend, and re-refer to Com. on Health. Read second time and amended.

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 care data.**
Current Text: Introduced: 12/2/2024 html pdf
Introduced: 12/2/2024
Status: 12/3/2024-From printer. May be heard in committee January 2.

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

1st House	2nd House	Conc.			

Summary: Under the California Constitution, the state is prohibited from denying or interfering with an individual's reproductive freedom in their most intimate decisions, including their 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. 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. This bill would state the intent of the Legislature to enact legislation to make it unlawful to geofence an entity that provides in-person health care services and to prohibit health care providers from releasing medical research information related to an individual seeking or obtaining an abortion in response to a subpoena or request if that subpoena or request is based on another state's laws that interfere with a person's rights under the Reproductive Privacy Act. This bill contains other existing laws.

AB 49 **(Muratsuchi D) Schoolsites and day care centers: entry requirements: immigration enforcement.**
Current Text: Introduced: 12/2/2024 html pdf
Introduced: 12/2/2024
Status: 3/3/2025-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 schoolsite 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 the United States Immigration and Customs Enforcement (ICE) to enter a schoolsite for any purpose without providing valid identification, a written statement of purpose, and a valid judicial warrant, and receiving approval from the superintendent of the school district, the superintendent of the county office of education, or the principal of the charter school, or their designee, as applicable. The bill would require the local educational agency, if the officer or employee of ICE 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.

AB 50 **(Bonta D) Pharmacists: furnishing contraceptives.**
Current Text: Introduced: 12/2/2024 html pdf
Introduced: 12/2/2024
Status: 2/18/2025-Referred to Coms. on B. & P. and Health.

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

follow-up, and other appropriate information. 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 make related conforming changes. This bill would declare that it is to take effect immediately as an urgency statute.

AB 54 **(Krell D) Access to Safe Abortion Care Act.**
Current Text: Introduced: 12/2/2024 html pdf
Introduced: 12/2/2024
Status: 12/3/2024-From printer. May be heard in committee January 2.

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. The bill would state the intent of the Legislature to enact legislation that would ensure access to medication abortion.

AB 55 **(Bonta D) Alternative birth centers: licensing and Medi-Cal reimbursement.**
Current Text: Amended: 2/25/2025 html pdf
Introduced: 12/2/2024
Status: 2/26/2025-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. 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 delete the above-described proximity requirement and instead require a written policy for hospital transfer, as provided. The bill would also make a technical change to an obsolete reference within a related provision. By creating a new requirement for an alternative birth center or a primary care clinic that provides services as an alternative birth center, the violation of which is a crime, the bill would impose a state-mandated local program. This bill contains other existing laws.

AB 67 **(Bauer-Kahan D) Attorney General: Reproductive Privacy Act: enforcement.**
Current Text: Introduced: 12/4/2024 html pdf
Introduced: 12/4/2024
Status: 1/6/2025-Read first time.

Desk	Policy	Fiscal	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 contains other related provisions.

AB 73 **(Jackson D) Mental Health: Black Mental Health Navigator Certification.**
Current Text: Introduced: 12/12/2024 html pdf
Introduced: 12/12/2024
Status: 2/3/2025-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, 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: 2/3/2025-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 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: 2/12/2025-Re-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 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: 2/3/2025-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 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: Introduced: 1/9/2025 html pdf
Introduced: 1/9/2025
Status: 2/3/2025-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, requires the Department of Managed Health Care to license and regulate health care service plans. 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 limit the applicability of the current benchmark plan benefits to plan years on or before the 2027 plan year.

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: 2/3/2025-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: 2/3/2025-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 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: 2/10/2025-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 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: Introduced: 1/16/2025 html pdf
Introduced: 1/16/2025
Status: 1/17/2025-From printer. May be heard in committee February 16.

Desk	Policy	Fiscal	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. Existing law establishes the California Reproductive Health Equity Program within the department to ensure abortion and contraception services are affordable for and accessible to all patients and to provide financial support for safety net providers of these services. Existing law establishes the California Reproductive Health Service Corps within the department for the purposes of recruiting, training, and retaining a diverse workforce of reproductive health care professionals who will be part of reproductive health care teams to work in underserved areas. Existing law defines reproductive health, for purposes of the corps, to mean health services relating to abortion care, sexual health counseling, contraception, sexually transmitted infections, reproductive tract infections, HIV, gynecology, perinatal care, midwifery care, gender-affirming care, and gender-based violence prevention. This bill would state the intent of the Legislature to enact legislation to ensure that patients can continue to access care, including abortion, gender-affirming care, and other sexual and reproductive health care in California, and to allow patients to access care through asynchronous modes.

AB 277 **(Alanis R) Behavioral health centers, facilities, and programs: background checks.**
Current Text: Amended: 2/20/2025 html pdf
Introduced: 1/21/2025
Status: 2/21/2025-Re-referred to Com. on HUM. S.

Desk	Policy	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 existing laws.

AB 278 **(Ransom D) Health care affordability.**
Current Text: Introduced: 1/21/2025 html pdf
Introduced: 1/21/2025
Status: 2/10/2025-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 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 decision making. 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: Introduced: 1/21/2025 html pdf
Introduced: 1/21/2025
Status: 2/10/2025-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 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.**
Current Text: Introduced: 1/22/2025 html pdf
Introduced: 1/22/2025
Status: 2/10/2025-Referred to Com. on ED.

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 requires each school district to notify parents and guardians of pupils about its plan to provide sexual health education and HIV prevention

instruction for the upcoming school year and to inform them, among other things, that written and audiovisual educational materials used in this instruction are available for inspection. This bill would require a school district, as defined, to allow a pupil's parent or guardian to inspect any written or audiovisual educational material used in comprehensive sexual health education and HIV prevention education and would authorize a parent or guardian to make copies of any written educational material that will be distributed to pupils, if it is not copyrighted and has been or will be presented by an outside consultant or guest speaker. The bill would authorize a school to charge up to $0.10 per page if a parent or guardian elects to make copies of this written educational material. The bill would also require a school district to inform parents and guardians of their right to make these copies and of the training in comprehensive sexual health education and HIV prevention education of each outside consultant or guest speaker providing this instruction. 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.

AB 290 **(Bauer-Kahan D) Emergency services and care.**
Current Text: Amended: 2/18/2025 html pdf
Introduced: 1/22/2025
Status: 2/19/2025-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 requires the State Department of Public Health (department) to license and regulate each health facility, defined to mean a facility, place, or building that is organized, maintained, and operated for the diagnosis, care, prevention, and treatment of human illness, and includes, among others, a general acute care hospital and an acute psychiatric hospital. Existing law, the Unruh Civil Rights Act (Unruh Act), specifies that all persons within the jurisdiction of the state are free and equal, and no matter their sex, race, color, religion, ancestry, national origin, disability, medical condition, genetic information, marital status, sexual orientation, citizenship, primary language, or immigration status are entitled to the full and equal accommodations, advantages, facilities, privileges, or services in all business establishments of every kind. Existing law requires a health facility that maintains and operates an emergency department to provide emergency services and care, as defined, to any person requesting the services or care for any condition in which the person is in danger of loss of life, or serious injury or illness, as specified. Existing law prohibits the provision of emergency services and care from being based on or affected by, among other characteristics, a person's ethnicity, citizenship, age, preexisting medical condition, insurance status, economic status, or a characteristic identified in the Unruh Act, as specified. Existing law requires a hospital to adopt a policy prohibiting discrimination in the provision of emergency services and care, and to prohibit physicians and surgeons who serve on an "on-call" basis to the hospital's emergency room from refusing to respond to a call, based on the characteristics described above. If a hospital fails to timely adopt the required policies and protocols, in addition to denial or revocation of any of its licenses, existing law subjects the hospital to a fine not to exceed $1,000 for each day after 60 days' written notice from the department that the hospital's policies or protocols are inadequate, as specified. This bill would increase the fine for a hospital's failure to adopt the policies and protocols required for the provision of emergency services and care to $1,000,000 per day. This bill contains other related provisions and other existing laws.

AB 298 **(Bonta D) Health care coverage cost sharing.**
Current Text: Amended: 3/4/2025 html pdf
Introduced: 1/23/2025
Status: 3/5/2025-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, 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: Introduced: 1/23/2025 html pdf
Introduced: 1/23/2025
Status: 1/24/2025-From printer. May be heard in committee February 23.

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. Existing law requires a provider of health care, a health care service plan, or a contractor to disclose medical information when specifically required by law or if the disclosure is compelled by, among other things, a court order or a search warrant lawfully issued to a governmental law enforcement agency. This bill would instead require a provider of health care, a health care service plan, or a contractor to disclose medical information when specifically required by California law. The bill would revise the disclosure requirement relating to a court order to require disclosure if compelled by a California state court pursuant to an order of that court or a court order from another state based on another state's law so long as that law does not interfere with California law, as specified. 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. 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: 2/10/2025-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 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: 2/10/2025-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. 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: Introduced: 1/24/2025 html pdf
Introduced: 1/24/2025
Status: 2/10/2025-Referred to Coms. on JUD. and P. & C.P.

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 that developed or used artificial intelligence, as defined, from asserting a defense that the artificial intelligence autonomously caused the harm to the plaintiff.

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: 2/10/2025-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: Introduced: 1/29/2025 html pdf
Introduced: 1/29/2025
Status: 2/18/2025-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 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 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) Physicians and surgeons: menopause surveys.**
Current Text: Amended: 3/4/2025 html pdf
Introduced: 1/30/2025
Status: 3/5/2025-Re-referred to Com. on B. & P.

Desk	Policy	Fiscal	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 for the licensure and regulation of physicians and surgeons. Existing law, the Osteopathic Act, establishes the Osteopathic Medical Board of California for the licensure and regulation of osteopathic physicians and surgeons. Those boards are required to adopt and administer standards, including for the continuing education of those licensees, and each licensee is required to demonstrate satisfaction of the continuing education requirements at specified intervals and as a condition for renewal of a license. This bill would require the Medical Board of California and the Osteopathic Medical Board of California to develop and administer to a licensed physician and surgeon as part of the license renewal process certain menopause training surveys. The bill would require the boards to determine the format of the surveys, which would be conducted anonymously, as prescribed. The bill would prohibit the boards from denying an application for license renewal solely on the basis that the applicant failed to complete a survey.

AB 371 **(Haney D) Dental coverage.**
Current Text: Introduced: 2/3/2025 html pdf
Introduced: 2/3/2025
Status: 2/18/2025-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 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: 2/18/2025-Referred to Com. on B. & P.

Desk	Policy	Fiscal	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: Introduced: 2/3/2025 html pdf
Introduced: 2/3/2025
Status: 2/18/2025-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 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: Introduced: 2/4/2025 html pdf
Introduced: 2/4/2025
Status: 2/18/2025-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. 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 review the above-described outreach and education efforts conducted by Medi-Cal managed care plans. The bill would require the department to annually conduct an analysis of the CHW services benefit, submit each analysis to the Legislature, and publish each 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) Healing arts.**
Current Text: Introduced: 2/4/2025 html pdf
Introduced: 2/4/2025
Status: 2/5/2025-From printer. May be heard in committee March 7.

Desk	Policy	Fiscal	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 for the licensing, regulation, and discipline of physicians and surgeons. This bill would state the intent of the Legislature to enact legislation to revise the authority of the Medical Board of California to establish a physician health and wellness program.

AB 412 **(Bauer-Kahan D) Generative artificial intelligence: training data: copyrighted materials.**
Current Text: Amended: 2/25/2025 html pdf
Introduced: 2/4/2025
Status: 2/26/2025-Re-referred to Com. on P. & C.P.

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

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 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 that makes a generative artificial intelligence system or model available to Californians for use, to, among other things, document any copyrighted materials used to train the system or model and document the copyright owner of that material. The bill would require a developer to provide a copyright owner with a comprehensive list of materials used to train the system or model for which the copyright owner holds the copyright within 7 days of receiving a written request from the copyright owner of the material, and would provide that each day following the 7-day period that a developer fails to provide a copyright owner with that list of materials constitutes a discrete violation. The bill would, if the written request is from a copyright owner whose materials were not used to train a generative artificial intelligence (GenAI) system or model, require a developer to notify the copyright owner within 30 days that no materials for which

the copyright owner holds the copyright were used to train the GenAI system or model. The bill would authorize a copyright owner that is not provided with a list of materials or notified by a developer according to these provisions to bring a civil action against the developer for specified relief.

AB 416 **(Krell D) Involuntary commitment.**
Current Text: Introduced: 2/5/2025 html pdf
Introduced: 2/5/2025
Status: 2/18/2025-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 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 and a designated member of a mobile crisis team, 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 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 additionally authorize a person to be taken into custody, pursuant to those provisions, by an emergency physician, as defined. 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) Alcohol and drug recovery or treatment facilities: discharge and continuing care planning.**
Current Text: Introduced: 2/5/2025 html pdf
Introduced: 2/5/2025
Status: 2/18/2025-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 adult alcoholism or drug abuse recovery and treatment facilities by the State Department of Health Care Services. Existing law requires a licensee to provide recovery, treatment, or detoxification services. Existing law authorizes the department to adopt regulations requiring records and procedures that are appropriate for each of those services, including, among others, discharge and continuing care planning. This bill would instead require the department to adopt regulations requiring discharge and continuing care planning that are appropriate for each of the aforementioned services. The bill would require the department to adopt regulations requiring a licensee to, among other things, develop a plan to help the patient return to their home community at the conclusion of treatment, as specified, and schedule for the patient a follow-up meeting with a mental health or substance use disorder professional to occur no more than 7 days after discharge.

AB 432 **(Bauer-Kahan D) Menopause.**
Current Text: Introduced: 2/5/2025 html pdf
Introduced: 2/5/2025
Status: 2/18/2025-Referred to Coms. on Health and B. & P.

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 instead require the board, in determining its continuing education requirements, to include a course in menopausal mental or physical health. The bill would require physicians who have a patient population composed of 25% or more of women to complete a mandatory continuing medical education 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: Introduced: 2/10/2025 html pdf
Introduced: 2/10/2025
Status: 2/11/2025-From printer. May be heard in committee March 13.

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 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 technology of certain terms, letters, or phrases that indicate or imply that the advice or care being provided through AI 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: appeals and grievances.**
Current Text: Introduced: 2/10/2025 html pdf
Introduced: 2/10/2025
Status: 2/24/2025-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 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. Existing law requires a health care service plan or disability insurer to include in a response regarding decisions to deny, delay, or modify health care services, among other things, information on how the provider, enrollee, or insured may file a grievance or appeal with the plan or insurer. Existing law requires a health care service plan's grievance system to resolve grievances within 30 days, except as specified. Existing law requires a contract between a health insurer and a provider to contain provisions requiring a dispute resolution mechanism, and requires an insurer to resolve each provider dispute within 45 working days, as specified. This bill would, upon request, require that an appeal or grievance regarding a decision by a health care service plan or disability insurer delaying, denying, or modifying a health care service based in whole or in part on medical necessity, be reviewed by a licensed physician who is competent to evaluate the specific clinical issues involved in the health care service being requested, and of the same or similar specialty as the requesting provider. The bill, notwithstanding the above-described timelines, 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 disability insurer fails to meet those timelines, the bill would deem the prior authorization request as

approved and supersede any prior delay, denial, or modification. The bill would make conforming changes to related provisions. Because a violation of these provisions by a health care service plan would be a crime, this bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 512 **(Harabedian D) Health care coverage: prior authorization.**
Current Text: Introduced: 2/10/2025 html pdf
Introduced: 2/10/2025
Status: 2/24/2025-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 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 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: 2/24/2025-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. 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: Introduced: 2/11/2025 html pdf
Introduced: 2/11/2025
Status: 2/24/2025-Referred to Com. on HUM. S.

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 contracts for a transitional housing placement provider or a Transitional Housing Program-Plus provider to have an initial term of 10 years. 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. The bill would authorize the county and contractor to agree to enter into an extension of the contract, either at the time of the initial contract or at any time thereafter. 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: Introduced: 2/11/2025 html pdf
Introduced: 2/11/2025
Status: 2/12/2025-From printer. May be heard in committee March 14.

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 make technical, nonsubstantive changes to those provisions.

AB 539 **(Schiavo D) Health care coverage: prior authorizations.**
Current Text: Introduced: 2/11/2025 html pdf
Introduced: 2/11/2025
Status: 2/24/2025-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. 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: Introduced: 2/11/2025 html pdf
Introduced: 2/11/2025
Status: 2/24/2025-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 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 and filters.**
Current Text: Introduced: 2/11/2025 html pdf
Introduced: 2/11/2025
Status: 2/24/2025-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 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 health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2026, to include coverage for portable high-efficiency particulate air (HEPA) purifiers and filters for enrollees or insureds who are pregnant or diagnosed with asthma or chronic obstructive pulmonary disease. The bill would prohibit a portable HEPA purifier and filter covered pursuant to these provisions from being subject to a deductible, coinsurance, or copayment requirement. Because a willful violation of these provisions by a health care service plan would be a crime, this bill would impose a state-mandated local program. 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: 3/3/2025 html pdf
Introduced: 2/11/2025
Status: 3/4/2025-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, 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: Introduced: 2/12/2025 html pdf
Introduced: 2/12/2025
Status: 2/24/2025-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 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 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: Introduced: 2/12/2025 html pdf
Introduced: 2/12/2025
Status: 2/24/2025-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 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 a physician in connection with dispensing prescription oral medications. 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 existing laws.

AB 582 **(Pacheco D) Administrative Procedure Act.**
Current Text: Introduced: 2/12/2025 html pdf
Introduced: 2/12/2025
Status: 2/13/2025-From printer. May be heard in committee March 15.

Desk	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) Health care coverage: antiretroviral drugs.**
Current Text: Introduced: 2/13/2025 html pdf
Introduced: 2/13/2025
Status: 2/24/2025-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 or health insurer to cover preexposure prophylaxis (PrEP) and postexposure prophylaxis (PEP) furnished by a pharmacist, and prohibits a plan or insurer from subjecting antiretroviral drugs medically necessary for the prevention of AIDS/HIV to prior authorization or step therapy, except as specified. Existing law does not require a plan or insurer to cover all therapeutically equivalent versions of a drug, device, or product for the prevention of AIDS/HIV without prior authorization or step therapy. 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 cover specified antiretroviral drugs for the prevention of AIDS/HIV, including PrEP and PEP, and would prohibit the imposition of any cost-sharing or utilization review requirements for those drugs. 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. Because a willful violation of these provisions by a health care service plan would be a crime, this bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 618 **(Krell D) Medi-Cal: behavioral health: data sharing.**
Current Text: Introduced: 2/13/2025 html pdf
Introduced: 2/13/2025
Status: 3/3/2025-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, 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 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 January 1, 2027, in compliance with privacy laws.

AB 636 **(Ortega D) Medi-Cal: diapers.**
Current Text: Introduced: 2/13/2025 html pdf
Introduced: 2/13/2025
Status: 2/24/2025-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 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.

AB 669 **(Haney D) Substance use disorder coverage.**
Current Text: Introduced: 2/14/2025 html pdf
Introduced: 2/14/2025
Status: 3/3/2025-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 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 for the first 28 days of an inpatient substance use disorder stay during each plan or policy year, and 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 outpatient prescription drugs to treat substance use disorder that are determined medically necessary by the enrollee's or insured's physician, psychologist, 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: Introduced: 2/14/2025 html pdf
Introduced: 2/14/2025
Status: 3/3/2025-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 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 authorize the department to waive the interest, as part of a repayment agreement entered into with the provider, if the unrecovered overpayment occurred 4 or more years before the issuance of the first statement of account status or demand for repayment, after taking into account specified factors. 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 the fault of the billing provider.

AB 682 **(Ortega D) Health care coverage reporting.**
Current Text: Introduced: 2/14/2025 html pdf
Introduced: 2/14/2025
Status: 3/3/2025-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) Hospitals: community benefits.**
Current Text: Introduced: 2/18/2025 html pdf
Introduced: 2/18/2025
Status: 2/19/2025-From printer. May be heard in committee March 21.

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

Summary: Existing law requires a private not-for-profit acute hospital to annually adopt and update a community benefits plan that describes the activities that the hospital has undertaken to address identified community needs within its mission and financial capacity. Under existing law, “community benefit” includes, among other things, health care services rendered to vulnerable populations, including, but not limited to, charity care and the unreimbursed cost of providing services to the uninsured, underinsured, and persons eligible for specified public health care programs. Existing law requires the hospital to annually submit its community benefits plan to the Department of Health Care Access and Information. This bill would make technical, nonsubstantive changes to certain definitions for purposes of the above-described provisions.

AB 789 **(Bonta D) Health care coverage: rate review.**
Current Text: Introduced: 2/18/2025 html pdf
Introduced: 2/18/2025
Status: 2/19/2025-From printer. May be heard in committee March 21.

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 offering a contract in the individual or small group market to file specified information, including total earned premiums and total incurred claims for each contract or policy form, with the department at least 120 days before implementing a rate change. This bill would make technical, nonsubstantive changes to that provision.

AB 804 **(Wicks D) Medi-Cal: housing support services.**
Current Text: Introduced: 2/18/2025 html pdf
Introduced: 2/18/2025
Status: 3/3/2025-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, 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 843 **(Garcia D) Health care coverage: language access.**
Current Text: Introduced: 2/19/2025 html pdf
Introduced: 2/19/2025
Status: 3/3/2025-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, 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: Introduced: 2/19/2025 html pdf
Introduced: 2/19/2025
Status: 3/3/2025-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 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 and certified 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 an unspecified date. This bill contains other related provisions and other existing laws.

AB 910 **(Bonta D) Pharmacy benefit management.**
Current Text: Introduced: 2/19/2025 html pdf
Introduced: 2/19/2025
Status: 2/20/2025-From printer. May be heard in committee March 22.

Desk	Policy	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. 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 make a technical, nonsubstantive change to that provision.

AB 951 **(Ta R) Health care coverage: behavioral diagnoses.**
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 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: 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 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, 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 health facility to allow a patient with demonstrated dementia needs to have a family or friend caregiver with them as needed unless specified conditions are met, including, but not limited to, that the facility reasonably determines that the presence of a particular visitor would endanger the health or safety of the visitor, a patient, a member of the health facility staff, or other visitor to the health facility, or would significantly disrupt the operations of the facility. The bill would authorize a health facility to require visitors to adhere to personal protective equipment and testing protocols, as specified, and does not prohibit a health facility from otherwise establishing reasonable restrictions upon visitation. 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 facility 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: exemption from mandatory enrollment.**
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 law, the Lanterman Developmental Disabilities Services Act, requires the State Department of Developmental Services to contract with regional centers to provide community services and supports for persons with developmental disabilities and their families. 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. Existing law authorizes the department to standardize those populations that are subject to mandatory enrollment in a Medi-Cal managed care plan across all aid code groups and Medi-Cal managed care models statewide, as specified. If the department standardizes those populations, existing law exempts certain dual eligible and non-dual-eligible beneficiary groups from that mandatory enrollment. Under existing law, a dual eligible beneficiary is an individual 21 years of age or older who is enrolled for benefits under the federal Medicare Program and is eligible for medical assistance under the Medi-Cal program. This bill would state the intent of the Legislature to enact legislation that would exempt, from mandatory enrollment in a Medi-Cal managed care plan, dual eligible and non-dual-eligible beneficiaries who receive services from a regional center and who use a Medi-Cal fee-for-service delivery system as a secondary form of health care coverage.

AB 979 **(Irwin D) Artificial intelligence.**
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 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 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 decision making and materially impacts natural persons. This bill would state the intent of the Legislature to enact legislation relating to artificial intelligence.

AB 980 **(Arambula D) Health care service plan: managed care entity: duty of care.**
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: Under existing law, a health care service plan or managed care entity has a duty of ordinary care to arrange for the provision of medically necessary health care services to its subscribers or enrollees and is liable for all harm legally caused by its failure to exercise that ordinary care when the failure resulted in the denial, delay, or modification of the health care service recommended for, or furnished to, a subscriber or enrollee and the subscriber or enrollee suffers substantial harm, as defined. This bill would define “medically necessary health care service” for purposes of the above-described provision to mean legally prescribed medical care that is reasonable and comports with the medical community standard.

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: 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: 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 used to assist or replace human discretionary decision making 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 contains other related provisions and other existing laws.

AB 1032 **(Harabedian D) Coverage for behavioral health visits.**
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 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 an individual or 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. 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. 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 1041 **(Bennett D) Health care coverage: physician and provider credentials.**
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 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 review specified credentialing requirements and adopt regulations to establish minimum standards or policies and processes that can streamline and reduce redundancy and delay in physician credentialing. The bill would also require those departments to adopt regulations to develop, on or before July 1, 2027, a standardized credentialing form to be used by health care service plans and health insurers for credentialing and recredentialing purposes. The bill would require every health care service plan or health insurer to use the standardized credentialing form on and after July 1, 2027, or six months after the form is completed, 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) Behavioral health and wellness screenings.**
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.	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. Existing law requires a health care service plan to annually provide to enrollees a written or electronic notice regarding the benefits of a behavioral health and wellness screening for children and adolescents 8 to 18 years of age. This bill would make a technical, nonsubstantive change to that provision.

AB 1129 **(Rodriguez, Celeste D) Birth defects monitoring.**
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 law 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 authorize a local health officer to maintain a system for the collection of information related to birth defects and other birth anomalies. The bill would authorize a local health officer to require laboratories, as specified, in addition to the facilities listed above, to either make available or to transmit to the local health department birth defects and other birth anomalies information, as specified. The bill would authorize a local health officer to enter into contracts for implementation of programs to collect and monitor birth anomalies in their jurisdiction. This bill contains other related provisions and other existing laws.

AB 1137 **(Krell D) Artificial intelligence: data transparency.**
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 law requires a developer of a generative artificial intelligence system or service to post certain documentation on its internet website regarding the data it uses before making that system or service publicly available to Californians for use, as prescribed, and defines various terms for these purposes. This bill would make a nonsubstantive change to those definition provisions.

AB 1328 **(Rodriguez, Michelle D) Medi-Cal reimbursements: nonemergency interfacility transfers.**
Current Text: Introduced: 2/21/2025 html pdf
Introduced: 2/21/2025
Status: 2/24/2025-Read first time.

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. Existing law sets forth various provisions relating to nonemergency medical or nonmedical transportation with regard to scope, prior authorization, reimbursement rates, and payments, and other provisions relating to transfers between facilities. This bill would state the intent of the Legislature to enact legislation that would, upon appropriation, provide an unspecified amount of additional funding for Medi-Cal reimbursements for nonemergency interfacility transfers.

AB 1405 **(Bauer-Kahan D) Artificial intelligence: auditors: enrollment.**
Current Text: Introduced: 2/21/2025 html pdf
Introduced: 2/21/2025
Status: 2/24/2025-Read first time.

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 decision making 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 and retain specified reports for as long as the auditor remains enrolled, plus 10 years. This bill would, commencing January 1, 2027, require an AI auditor, prior to initially conducting a covered audit, as defined, to enroll with the agency. The bill would require an AI auditor that enrolls with the agency to pay an enrollment fee, to be fixed by the agency by January 1, 2027, and provide specified information. The bill would impose various requirements on an AI auditor that conducts a covered audit, including, among other things, providing the auditee with an audit report after the covered audit. This bill contains other related provisions and other existing laws.

AB 1415 **(Bonta D) California Health Care Quality and Affordability Act.**
Current Text: Introduced: 2/21/2025 html pdf
Introduced: 2/21/2025
Status: 2/24/2025-Read first time.

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 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 to include a management services organization, as defined, as a health care entity. The bill would also update a provider to mean specified private or public health care providers and would include a health system, as defined, and an entity that owns, operates, or controls an entity specified in the existing definition, regardless of whether it is currently operating, providing services, or has a pending or suspended license. 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. This bill contains other related provisions and other existing laws.

AB 1418 **(Schiavo D) Department of Health Care Access and Information.**
Current Text: Introduced: 2/21/2025 html pdf
Introduced: 2/21/2025
Status: 2/24/2025-Read first time.

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 employees 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 employees. The bill would also specify the format for the above-described report.

SB 7 **(McNerney D) Artificial intelligence.**
Current Text: Introduced: 12/2/2024 html pdf
Introduced: 12/2/2024
Status: 1/29/2025-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 establishes within the Government Operations Agency the Department of Technology, which is supervised by the Director of Technology. Existing law authorizes the director and the department to exercise various powers in creating and managing the information technology policy of the state. This bill would declare the intent of the Legislature to enact legislation relating to artificial intelligence.

SB 12 **(Gonzalez D) State government: Immigrant and Refugee Affairs Agency: Office of Immigrant and Refugee Affairs.**
Current Text: Amended: 2/27/2025 html pdf
Introduced: 12/2/2024
Status: 2/27/2025-From committee with author's amendments. Read second time and amended. Re-referred to Com. on G.O.

Desk	Policy	Fiscal	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 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 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: 1/29/2025-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, 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) Public health: maternity ward closures.**
Current Text: Introduced: 12/2/2024 html pdf
Introduced: 12/2/2024
Status: 1/29/2025-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 establishes the licensure and regulation of health facilities by the State Department of Public Health, including, among others, general acute care hospitals. This bill would express the intent of the Legislature to enact legislation to address maternity ward closures.

SB 40 **(Wiener D) Health care coverage: insulin.**
Current Text: Introduced: 12/3/2024 html pdf
Introduced: 12/3/2024
Status: 1/29/2025-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 disability insurance policy issued, amended, delivered, or renewed on or after January 1, 2026, from imposing a copayment of more than $35 for a 30-day supply of an insulin prescription drug or imposing a deductible, coinsurance, or any other cost sharing on an insulin prescription drug, except as specified. On and after January 1, 2026, the bill would prohibit a health care service plan or disability insurer from imposing step therapy protocols as a prerequisite to authorizing coverage of insulin. 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: Introduced: 12/3/2024 html pdf
Introduced: 12/3/2024
Status: 1/29/2025-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 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: 2/27/2025 html pdf
Introduced: 1/7/2025
Status: 2/27/2025-From committee with author's amendments. Read second time and amended. Re-referred to Com. on RLS.

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

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. 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: Introduced: 1/9/2025 html pdf
Introduced: 1/9/2025
Status: 1/29/2025-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, requires the Department of Managed Health Care to license and regulate health care service plans. 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 limit the applicability of the current benchmark plan benefits to plan years on or before the 2027 plan year.

SB 81 **(Arreguín D) Health facilities: information sharing.**
Current Text: Introduced: 1/17/2025 html pdf
Introduced: 1/17/2025

Status: 1/29/2025-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 requires the State Department of Public Health to license and regulate each health facility, defined to mean a facility, place, or building that is organized, maintained, and operated for the diagnosis, care, prevention, and treatment of human illness, and to which persons are admitted for a 24-hour stay or longer, and includes, among others, a general acute care hospital, an acute psychiatric hospital, and a skilled nursing facility. Existing law, the Confidentiality of Medical Information Act, prohibits a health care provider, a contractor, or a health care service plan from disclosing medical information, as defined, regarding a patient of the provider or an enrollee or subscriber of the health care service plan without first obtaining an authorization, except as specified. This bill would state the intent of the Legislature to enact legislation to prohibit health facilities from collaborating with, providing access to, or providing information, including patient data or records, about patients to, immigration authorities.

SB 85 **(Umberg D) Patient access to health records.**
Current Text: Introduced: 1/21/2025 html pdf
Introduced: 1/21/2025
Status: 1/29/2025-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 generally governs a patient's access to the patient's own health records. Existing law establishes procedures for providing access to health care records or summaries of those records by patients and by those persons who have responsibility for decisions regarding the health care of others, as described. Existing law sets forth the Legislature's findings and declarations regarding the right of access to that information, as specified. This bill would make technical, nonsubstantive changes to those findings and declarations.

SB 238 **(Smallwood-Cuevas D) Employment: artificial intelligence.**
Current Text: Introduced: 1/29/2025 html pdf
Introduced: 1/29/2025
Status: 2/5/2025-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 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 state the intent of the Legislature to enact legislation relating to the use of artificial intelligence in the workplace.

SB 242 **(Blakespear D) Medicare supplement coverage: open enrollment periods.**
Current Text: Introduced: 1/30/2025 html pdf
Introduced: 1/30/2025
Status: 2/14/2025-Referred to Com. on HEALTH.

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

Summary: Existing 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, 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, 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.

SB 246 **(Grove R) Medi-Cal: graduate medical education payments.**
Current Text: Introduced: 1/30/2025 html pdf
Introduced: 1/30/2025
Status: 2/14/2025-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 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 non designated 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: 2/14/2025-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 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: 2/14/2025-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 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: Introduced: 2/4/2025 html pdf
Introduced: 2/4/2025
Status: 2/14/2025-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 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, 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 specified 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 designed to improve HIV care for Medi-Cal beneficiaries. The bill would make a conforming change to a related provision regarding authorized disclosure of HIV test results for the purpose of administering quality improvement programs under Medi-Cal as described above.

SB 306 **(Becker D) Health care coverage: prior authorizations.**
Current Text: Introduced: 2/10/2025 html pdf
Introduced: 2/10/2025
Status: 2/19/2025-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 from imposing prior authorizations, as defined, 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 list any covered services exempted from prior authorization on their internet website by March 15 of each calendar year. The bill would also clarify how to calculate a plan 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: Introduced: 2/11/2025 html pdf
Introduced: 2/11/2025
Status: 2/19/2025-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 give preference to contracting 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. This bill contains other related provisions and

other existing laws.

SB 339 **(Cabaldon D) Medi-Cal: laboratory rates.**
Current Text: Introduced: 2/12/2025 html pdf
Introduced: 2/12/2025
Status: 2/19/2025-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 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 carve out, from the above-described provision, Medi-Cal reimbursement to providers for clinical laboratory or laboratory services related to the diagnosis and treatment of sexually transmitted infections, and would apply the above-described threshold but excluding the reimbursement rate described in paragraph (4). The bill would exempt data on those services from certain data-reporting requirements that are applicable to the reimbursement rate described in paragraph (4). This bill contains other related provisions and other existing laws.

SB 363 **(Wiener D) Health care coverage: independent medical review.**
Current Text: Introduced: 2/13/2025 html pdf
Introduced: 2/13/2025
Status: 2/26/2025-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 its number of treatment denials or modifications, separated by type of care and disaggregated by age, to the appropriate department, 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 half 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 the specified 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 specify that these provisions do not apply to Medi-Cal managed care plan contracts. Because a willful violation of these provisions by a health care service plan would be a crime, this bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

SB 402 **(Valladares R) Health care coverage: autism.**
Current Text: Introduced: 2/14/2025 html pdf
Introduced: 2/14/2025
Status: 2/26/2025-Referred to Com. on B. P. & E.D.

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 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: Introduced: 2/18/2025 html pdf
Introduced: 2/18/2025
Status: 2/26/2025-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 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 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 providing or administering health insurance coverage or other health-related coverage, from taking various actions, including, but not limited to, denying, canceling, limiting, or refusing to issue or renew 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 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) Public health: women's health.**
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 requires the State Department of Public Health to develop a coordinated state strategy for addressing the health-related needs of women and makes the approved programmatic costs associated with this strategy be the responsibility of the department. This bill would make a technical, nonsubstantive change to that provision.

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: 2/26/2025-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 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: family planning.**
Current Text: Introduced: 2/20/2025 html pdf
Introduced: 2/20/2025

Status: 3/5/2025-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 requires local health departments to make copies of circulars and pamphlets relating to family planning available in a certain language if 10% or more of the population in a county, as specified, speaks a language other than English as its native language. Existing law requires the State Department of Health Care Services to make a translation of the family planning information materials available upon request. This bill would make technical, nonsubstantive changes to those provisions.

SB 530 **(Richardson D) Medi-Cal: time and distance standards.**
Current Text: Introduced: 2/20/2025 html pdf
Introduced: 2/20/2025
Status: 3/5/2025-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. This bill contains other related provisions and other existing laws.

SB 535 **(Richardson D) Obesity Treatment Parity Act.**
Current Text: Introduced: 2/20/2025 html pdf
Introduced: 2/20/2025
Status: 3/5/2025-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 anti obesity 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: Introduced: 2/20/2025 html pdf
Introduced: 2/20/2025
Status: 3/5/2025-Referred to Com. on G.O.

Desk	Policy	Fiscal	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, but not limited to, 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. The bill would require the working group to produce a report of its findings to the Legislature by July 1, 2028.

SB 626 **(Smallwood-Cuevas D) Maternal health screenings and treatment.**
Current Text: Introduced: 2/20/2025 html pdf
Introduced: 2/20/2025
Status: 3/5/2025-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 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. This bill would require a licensed health care practitioner who provides perinatal care for a patient to screen, diagnose, and treat the patient for a maternal mental health condition according to the clinical guidelines from the American College of Obstetricians and Gynecologists. This bill contains other related provisions and other existing laws.

SB 812 **(Allen D) Qualified youth drop-in center health care coverage.**
Current Text: Introduced: 2/21/2025 html pdf
Introduced: 2/21/2025
Status: 2/24/2025-From printer. May be acted upon on or after March 24. Read first time.

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) Artificial intelligence: critical infrastructure.**
Current Text: Introduced: 2/21/2025 html pdf
Introduced: 2/21/2025
Status: 2/24/2025-From printer. May be acted upon on or after March 24. Read first time.

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

Summary: Existing law, the Generative Artificial Intelligence Accountability Act, among other things, requires the Department of Technology, under the guidance of the Government Operations Agency, the Office of Data and Innovation, and the Department of Human Resources, to update the report to the Governor, as required by Executive Order No. N-12-23, as prescribed, and requires the Office of Emergency Services to perform, as appropriate, a risk analysis of potential threats posed by the use of generative AI to California's critical infrastructure, including those that could lead to mass casualty events. This bill would declare the intent of the Legislature to enact subsequent legislation that would prohibit artificial intelligence from making a plan or executing a plan on critical infrastructure.

2025 Alliance Legislative Agenda

Introduction

Alameda Alliance for Health (Alliance) is a local, public, not-for-profit managed care health plan committed to improving the health and well-being of our members by collaborating with our provider and community partners to deliver high quality and accessible services. Our vision is that all residents of Alameda County will achieve optimal health and well-being at every stage of life. The purpose of this legislative agenda is to promote the Alliance's mission and priorities as well as serve as a guide for monitoring and advocating for policies that impact the Alliance and its members.

Alameda Alliance for Health Overview

The Alliance is a public health plan formed in 1996 by the Alameda County Board of Supervisors, currently serving nearly 415,000 members through our Medi-Cal and Group Care lines of business. Beginning January 1st, 2026, the Alliance will begin serving members through a Medicare Advantage Duals Special Needs Plan (D-SNP). The Alliance provides health coverage to 2 out of every 10 Alameda County residents and partners with a network of more than 10,000 physicians, specialists, hospitals, and pharmacies.

Major policies and administration of the organization are overseen by the Alliance Board of Governors, which is made up of major stakeholders, such as Alliance members, local physicians, hospital and clinic representatives, county agency leaders, and labor representatives.

Major Issues Impacting Alliance Members

Defending Medicaid

Medicaid (known in California as Medi-Cal) provides coverage to over 79 million Americans. In Alameda County, over 480,000 individuals rely on this crucial program – 28% which are children, and about 27% of births in the county are covered by Medi-Cal. Additionally, over 64,000 of the county's residents aged 65 or older are covered by Medi-Cal. With the current GOP trifecta, federal policymakers are considering introducing major reductions to the Medicaid budget. Any large-scale cuts to the Medicaid program would threaten the health and security of the millions of Americans who rely on this important program, including many of our current Alliance Medi-Cal members.

Housing/Homelessness

Housing costs in Alameda County continue to be a major challenge to the adults, children, and families that the Alliance serves. While more people than ever continue to gain housing each year, there are many more housing opportunities needed to significantly reduce homelessness in Alameda County. In the last 12 months, the Alliance served over 15,000 members who were experiencing homelessness – showing an urgent need for continued investment.

Medically Supportive Food

Medically supportive food is an effective intervention used to treat, reverse, and prevent chronic health conditions like diabetes, hypertension, and depression. Prior to the integration of Medically supportive food into the CalAIM Community Supports program, the Alliance invested in efforts to expand local 'food as medicine' programs that prescribed patients' produce and connected them to group medical visits. Through this investment, thousands of the Alliance's Medi-Cal members have been connected to this critical intervention that has assisted them with improved

health and emotional well-being.

Immigration

Alameda County is home to over half a million immigrants who live, work, and attend school in our community, many who are Alliance members. According to the U.S. Census' 2017 American Community Survey, 1 in 3 Alameda County residents is an immigrant. As of January 1st, 2024, all income-eligible Californians qualify for full-scope Medi-Cal, regardless of immigration status. As of February 2025, nearly 80,000 undocumented residents are enrolled with the Alliance. As the current federal administration seeks to change U.S. immigration laws and policies that would harm immigrant communities, the Alliance is committed to ensuring that our members can continue to safely access preventive services and medical treatment they need without fear.

Health Equity

At the Alliance, we believe that all members of our community should have the opportunity to achieve their highest level of health. We recognize that addressing health inequities throughout our communities will require a broad effort – one that looks at organizational policies and practices, as well as individual education and responsibility. We are committed to improving health equity within our organization and throughout the communities that we serve.

Aging in Place and D-SNP

Approximately 15 percent of the County's population is age 65 or older. According to the California Department of Finance, this population is projected to increase to 21.1 percent by 2032. The Alliance is committed to helping address the challenges that our older members face so that they may age in place, maintain their health and mobility and thrive in our community. As part of CalAIM, the state is implementing policies to promote integrated care for beneficiaries that are dually eligible for both Medicare and Medi-Cal. Starting January 2026, the Alliance will implement a Dual Eligible Special Needs Plan (D-SNP) that will serve members that are dually eligible for Medi-Cal and Medicare.

Justice Involvement

Justice-involved individuals – people who have spent time in jails or prisons – experience disproportionately higher rates of physical and behavioral health diagnoses and are at higher risk for injury and death as a result of trauma, violence, overdose, and suicide than people who have never been incarcerated. Through CalAIM, California is taking steps to address this population by establishing pre- and post-release Medi-Cal enrollment strategies that will assist individuals with continuity of coverage upon release and provide access to services to help them successfully return to their communities. Santa Rita Jail in Alameda County will go live with pre-release services in 2026. In the meantime, the Alliance is working with the County's Sheriff's Office, Probation, Behavioral Health, Social Security Administration, Kaiser to support collaboration for this initiative

California Advancing & Innovating Medi-Cal (CalAIM)

In January 2022, the Alliance launched series of new services as part of the Department of Health Care Services (DHCS) multi-year initiative, CalAIM. CalAIM seeks to address many of the complex challenges facing California's most vulnerable residents, such as homelessness, improving behavioral health care access, better supporting children with complex medical conditions, coordinating re-entry services for incarcerated persons, and delivering a broader range of services to aging adults.

2025 Policy Priorities

The following areas set out the Alliance's policy principles and priority issues for 2025:

Health and Well-being

I. Support policies that simplify Medi-Cal enrollment and redetermination processes.

II. Support policies that eliminate barriers that low-income populations face in accessing health and social services.

III. Support policies that increase no or low-cost health insurance coverage to uninsured and low-income individuals.

IV. Support policies that help improve quality outcomes for Medi-Cal beneficiaries.

V. Support policies that address social determinants of health and improve health outcomes among Medi-Cal beneficiaries.

VI. Support policies that improve coordination of health care and social services for Medi-Cal beneficiaries.

VII. Support policies that promote community-based and at home care for individuals who would otherwise be at risk for institutionalization.

VIII. Support policies that enhance coordination of services for older adults, including those with disabilities and that promote independent living, and safeguard against neglect and exploitation, isolation, and discrimination.

IX. Oppose legislative proposals that could overhaul Medicaid, including block grants, per capita caps, work requirements, reducing the Federal Medical Assistance Percentage (FMAP), restricting provider taxes, and other proposals that would lead to drastically cut funding and services of the program.

Organizational Strength

I. Support proposals that attract and retain a high-quality and culturally competent health care workforce.

II. Support policies that focus on recruitment and retainment of high-quality primary and specialty care physicians.

III. Support policies that increase access to mental health supports.

IV. Support proposals that incentivize our provider network to offer high quality care to our members.

V. Support policies that ensure that the Alliance receives sufficient state and federal resources to adequately serve our members.

VI. Support policies that protect coverage expansions, and rates.

VII. Support policies that eliminate unnecessary requirements and regulations to ensure increased operational efficiency.

Health Equity & Social Determinants of Health

I. Housing – Support policies that increase funding for programs and services for homeless individuals including emergency shelters, rental assistance, transitional housing, and permanent supportive housing. Support funding that works to preserve and rehabilitate existing housing and preserve housing for vulnerable populations that are at risk of becoming homeless.

II. Immigration – Support legislation that expands health care coverage to individuals regardless of immigration status. Support comprehensive Immigration Reform that provides a clear pathway to citizenship that encourages family reunification and opportunities for workers and employers. Oppose efforts to restrict immigrant access to all necessary services and benefits, specifically health care benefits.

III. Health Equity – Support policies that help reduce disparities, among the most vulnerable residents.

IV. Maternal Health – Support policies that support clinical improvements, enhance services, and community investments needed to reduce racial disparities in maternal health outcomes.

V. CalAIM Community Supports – Support the adoption of supportive services such as the Medically Supportive Food/nutrition services and Housing Bundle Community Supports as a permanent Medi-Cal benefit.

ALAMEDA Alliance FOR HEALTH

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

Executive Dashboard

OPERATIONS DASHBOARD

MARCH 2025

3/5/2025 1:34:08 PM

Financials

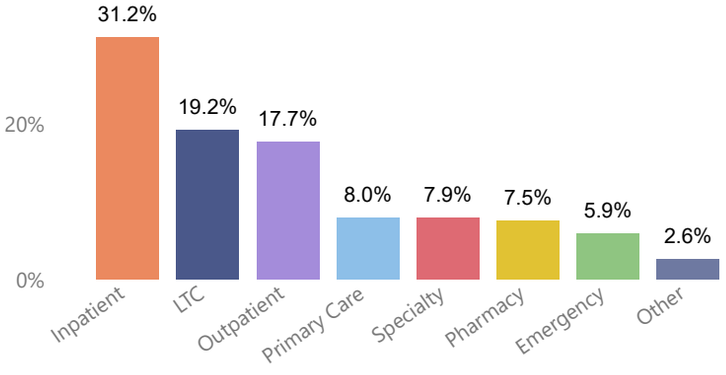
Income & Expenses

	JANUARY 2025	FISCAL YTD
REVENUE	$ 256.4 M	$ 1.7 B
MEDICAL EXPENSE	$ (191.1) M	$ (1.3) B
ADMIN EXPENSE	$ (8.9) M	$ (66.5) M
OTHER/TAX	$ (63.1) M	$ (525.5) M
NET INCOME	$ (6.7) M	$ (103.9) M

Medical Loss % (Fiscal YTD)

104.8%

Medical Expenses



Liquid Reserves

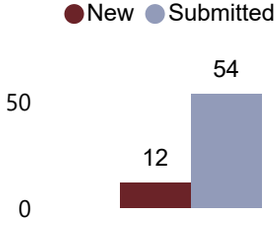
TNE %

186.3%

TNE $

$151.5M

Reinsurance Cases



Balance Sheet

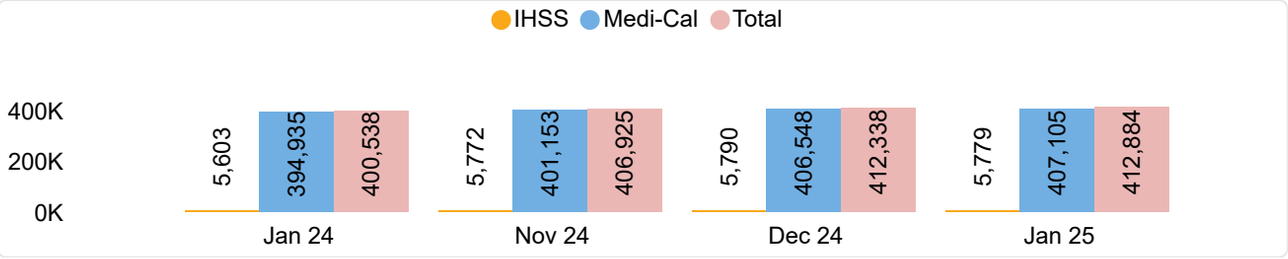
Cash Equivalents	$462.1M
Pass-Through Liabilities	$15.7M
Uncommitted Cash	$446.5M
Working Capital	$90.4M

Current Ratio

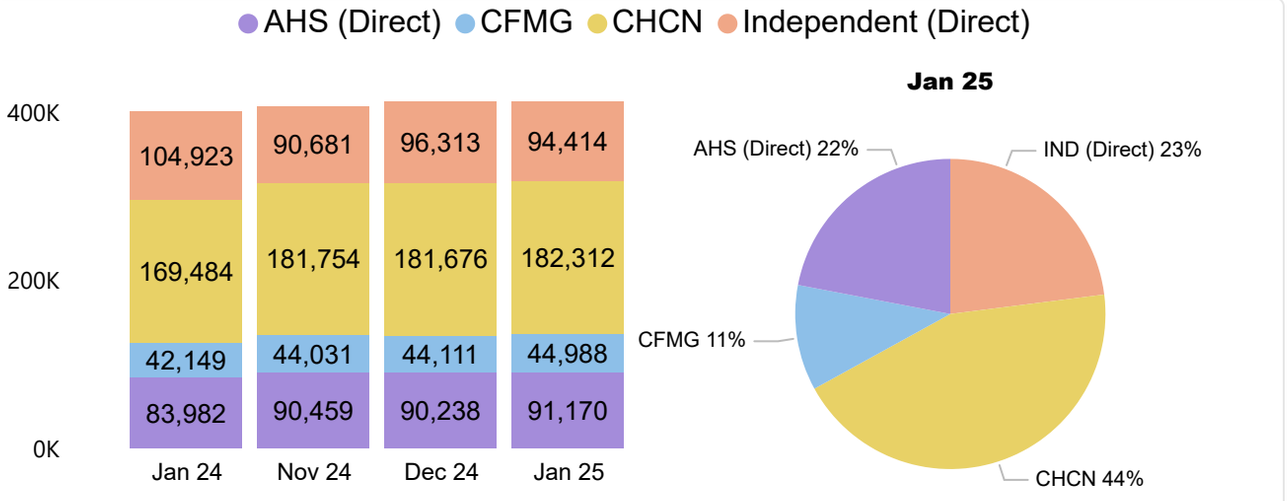
1.10

Membership

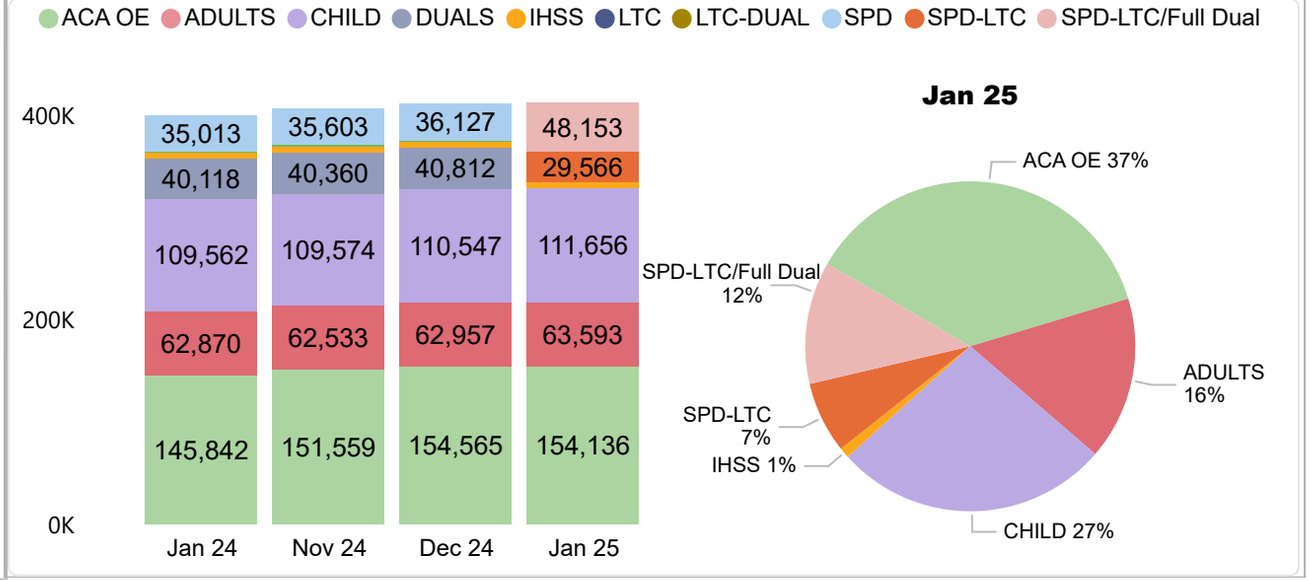
By Plan



By Network



By Category



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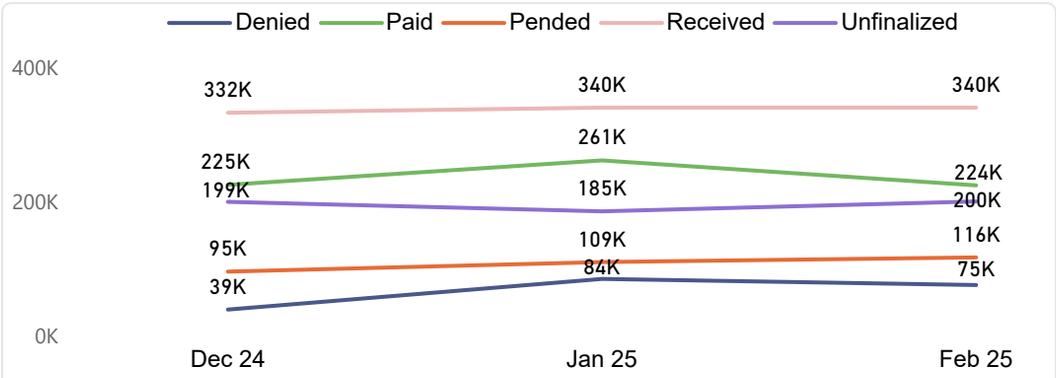
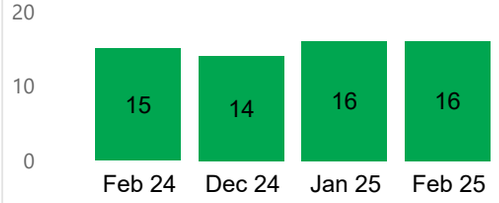
Claims

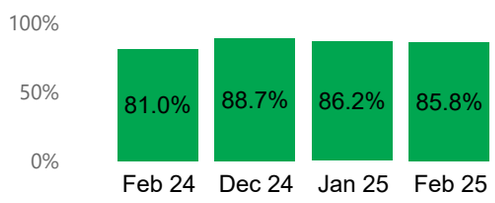
Claims Processing



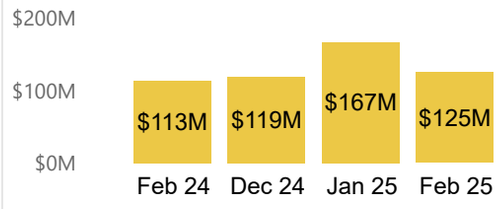
Average Payment TAT (Days)



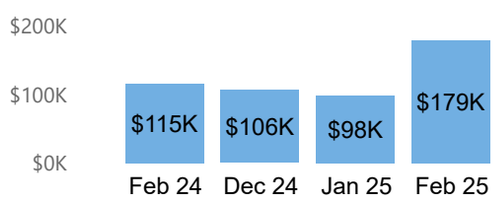
Auto Adjudication Rate (%)



Claims Paid ($)

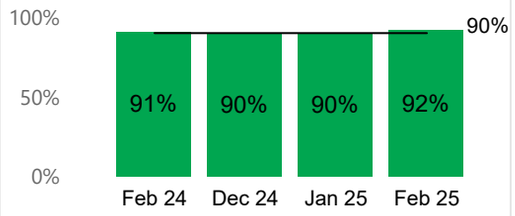


Interest Paid ($)

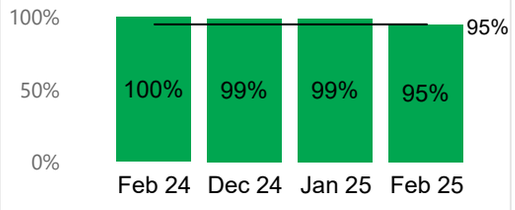


Claims Compliance

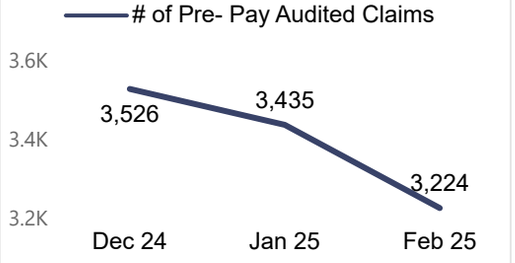
Processed 30 Cal Days (%)



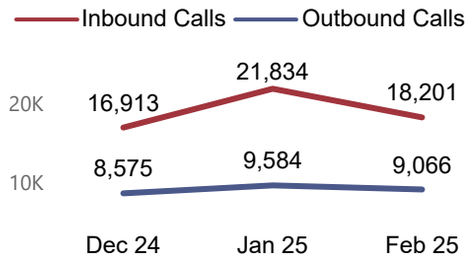
Processed 45 Work Days (%)



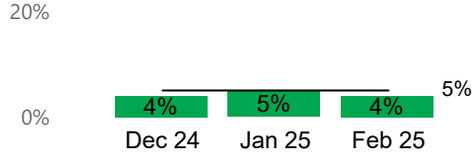
Claims Auditing



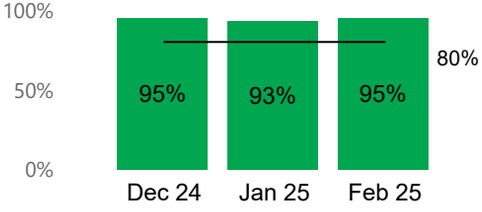
Member Services



Abandoned Call Rate (%)

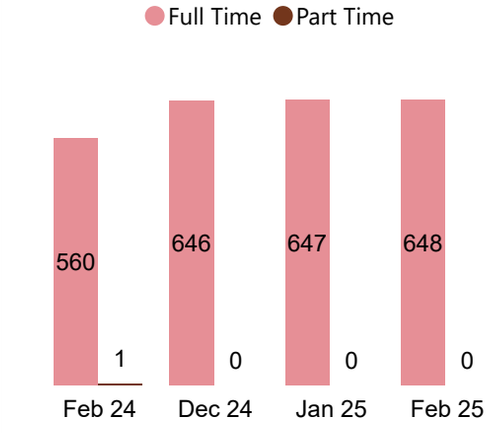


Calls Answered in 30 Seconds (%)



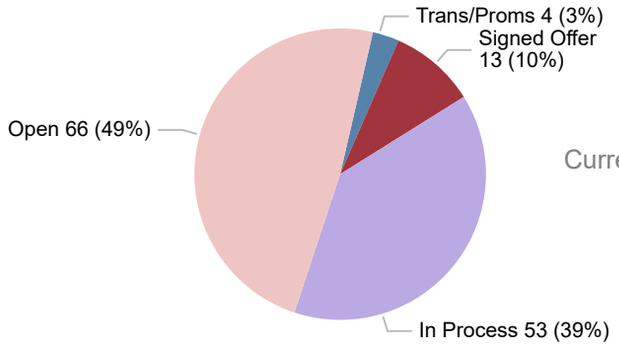
Average Call Times	Dec 24	Jan 25	Feb 25
Wait Time	00:14	00:16	00:12
Call Duration	07:33	07:34	07:30

Human Resources



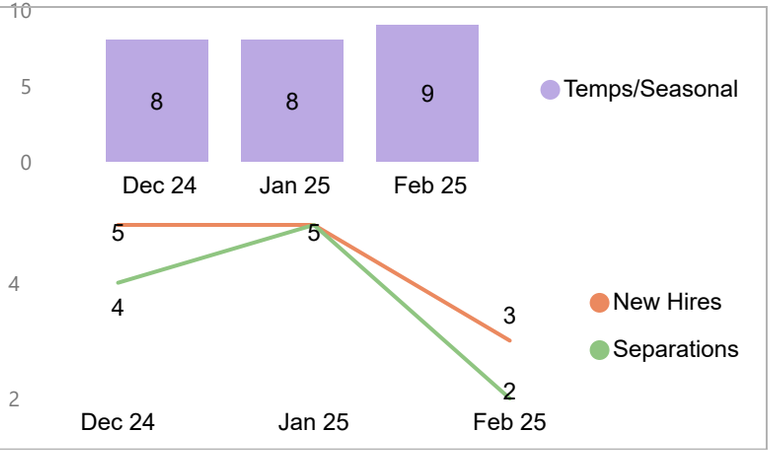
Recruiting Status

Feb 25



Current Vacancy

9%



OPERATIONS DASHBOARD

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Provider Services

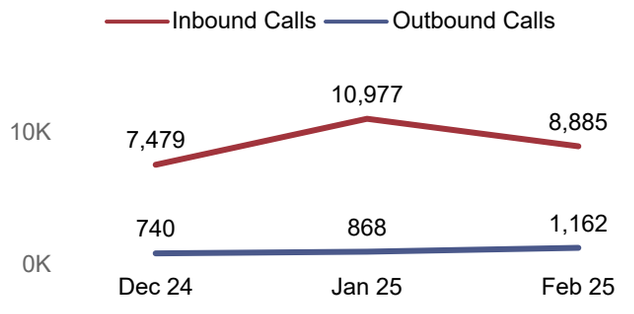
Provider Network

Hospital	17
Specialist	11,205
Primary Care Physician	789
Skilled Nursing Facility	106
Urgent Care	15
Health Centers (FQHCs and Non-FQHCs)	82
TOTAL	**12,214**

Provider Credentialing

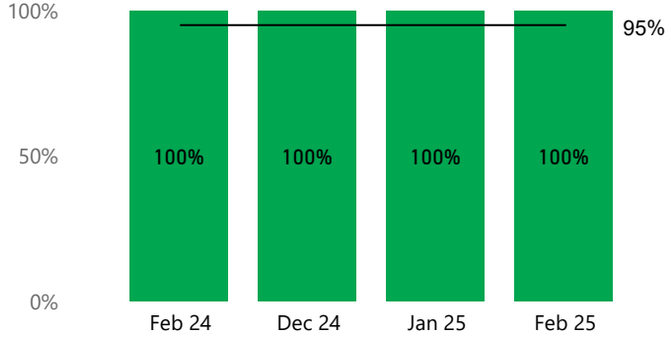
4,489

Provider Call Center



Provider Disputes & Resolutions

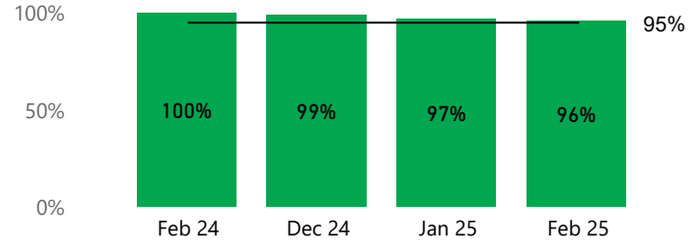
Turnaround Compliance (45 business days)



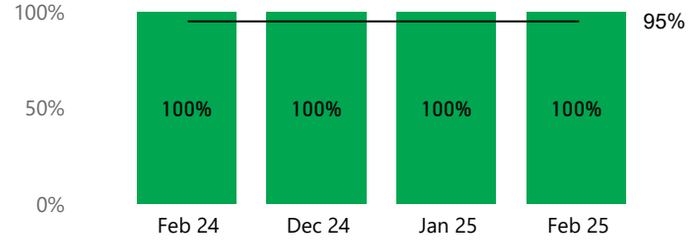
Compliance

Member Grievances

Standard (30 calendar days)

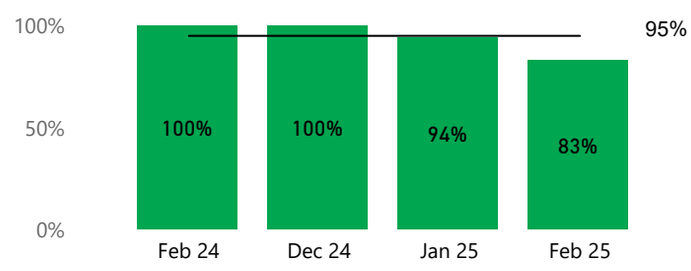


Expedited (3 calendar days)

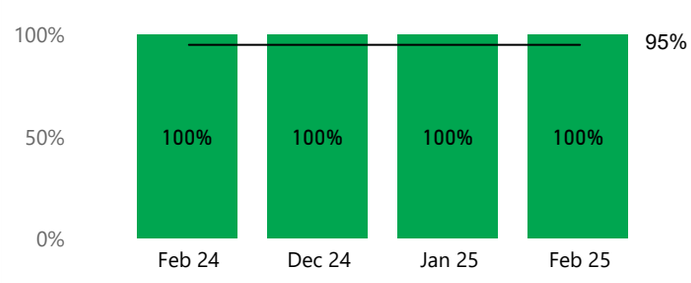


Member Appeals

Standard (30 calendar days)

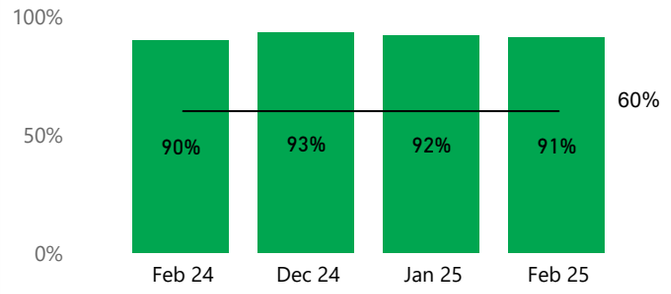


Expedited (3 calendar days)

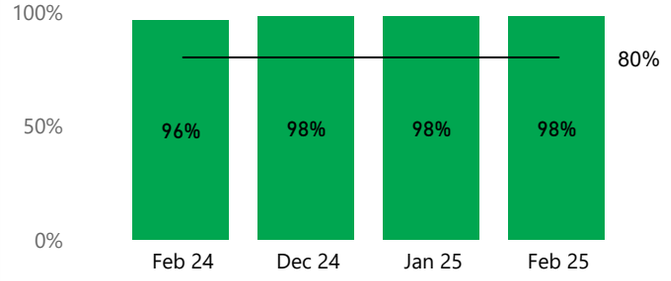


Encounter Data

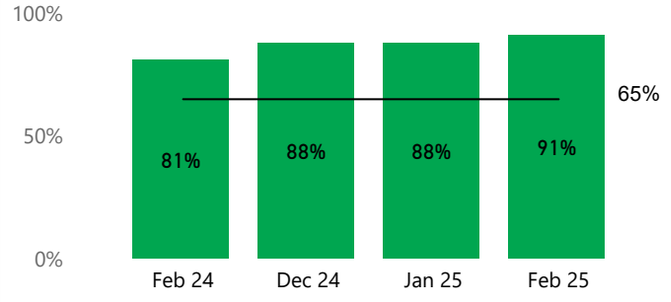
Institutional 0-90 days



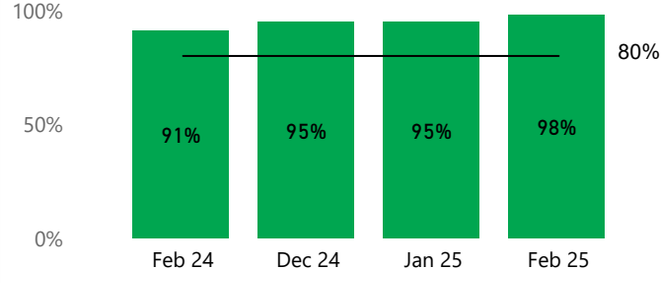
Institutional 0-180 days



Professional 0-90 days



Professional 0-180 days



OPERATIONS DASHBOARD

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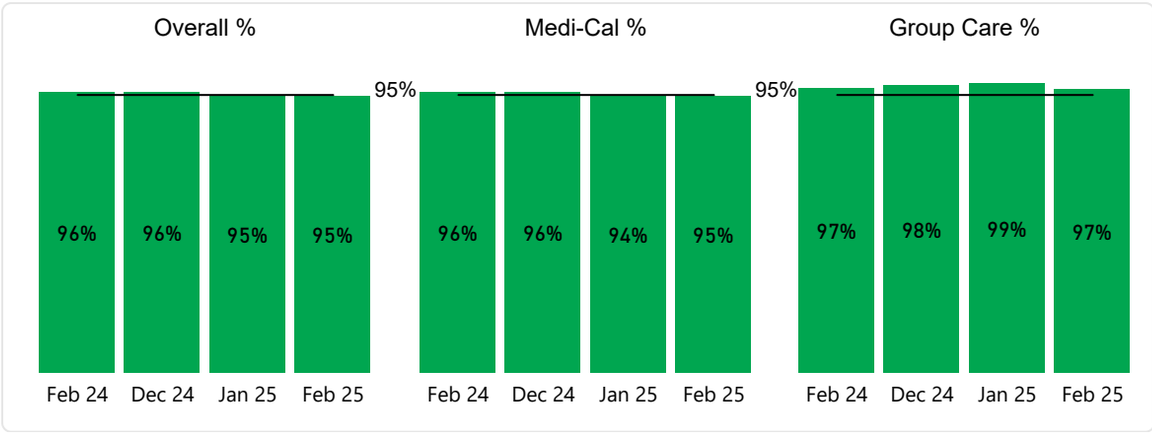
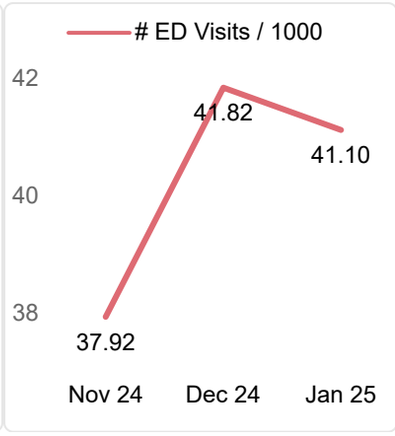
Health Care Services

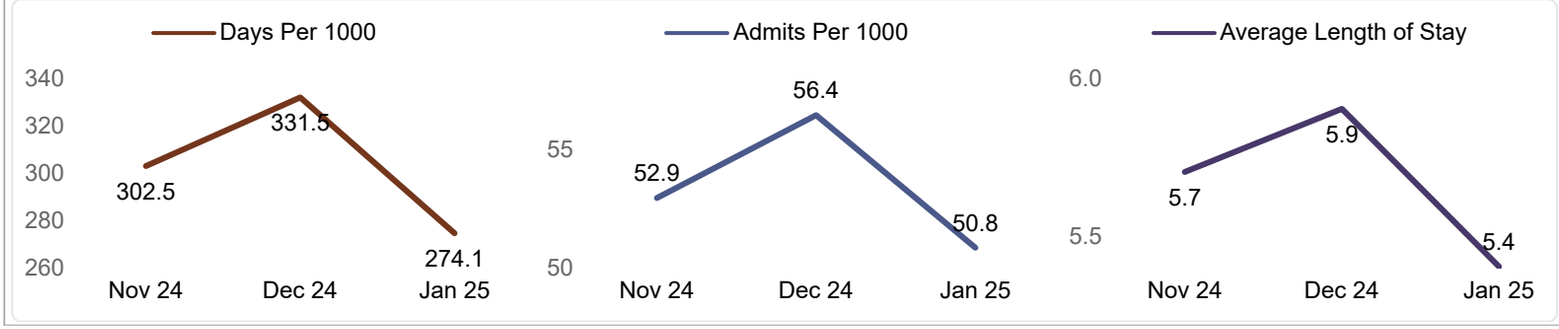
Authorization Turnaround



ED Utilization

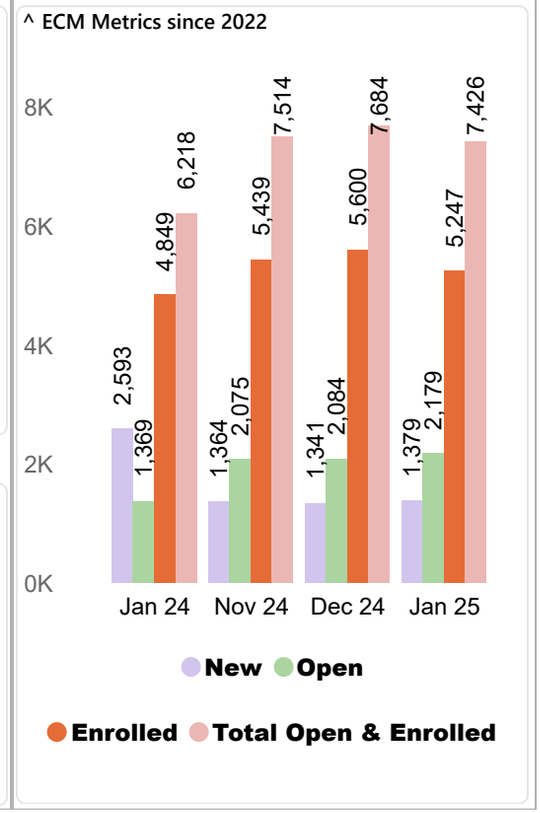


Inpatient Utilization

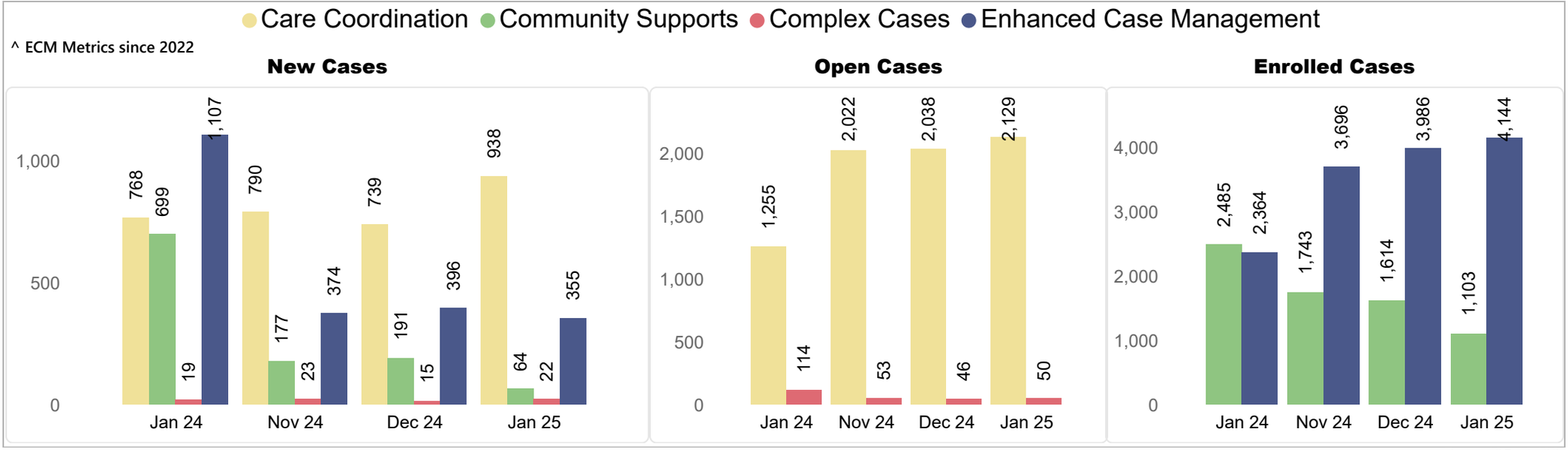


Case Management

Total Cases^



Case Management^



Technology (Business Availability)

Applications	Feb 24	Dec 24	Jan 25	Feb 25
HEALTHsuite System	100.0%	100.0%	100.0%	99.9%
Other Applications	100.0%	100.0%	100.0%	100.0%
TruCare System	100.0%	100.0%	100.0%	100.0%

Outpatient Authorization Denial Rates *

OP Authorization Denial Rates	Feb 24	Dec 24	Jan 25	Feb 25
Denial Rate Excluding Partial Denials (%)	4.7%	3.7%	3.5%	2.7%
Overall Denial Rate (%)	5.0%	4.0%	3.9%	3.0%
Partial Denial Rate (%)	0.3%	0.3%	0.4%	0.2%

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

Pharmacy Authorizations

Authorizations	Feb 24	Dec 24	Jan 25	Feb 25
Approved Prior Authorizations	35	43	49	35
Closed Prior Authorizations	91	26	23	17
Denied Prior Authorizations	36	73	77	91
Total Prior Authorizations	162	142	149	143

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Board Business

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FY 2025 SECOND QUARTER FORECAST

FY 2025 Second Quarter Forecast

Presented to the Alameda Alliance Board of Governors

March 14th, 2025

ALAMEDA Alliance FOR HEALTH

FY 2025 Q2 Forecast

Highlights

- 2024 Projected Net Loss of $97.8 million.
- Projected excess Tangible Net Equity at 6/30/25 of $75.8 million is 193% of required TNE.
- Year-end enrollment is 415,000.
- The Forecast now includes MCO Tax Revenue and Expense as the Plan is at-risk for differences in MCO Revenue received vs. MCO Tax owed. The Forecast reflects retroactive CY23-CY24 MCO Tax expense of $5.0 million accrued in February 2025 to June 2025.
- There is a 10.5% increase when comparing CY2025 to CY2024 PMPM rates.
- Expenses for Inpatient and Long-Term Care are projected to be approximately $39.6 million and $15 million (respectively) higher than originally anticipated.
- There are 477 Administrative FTEs and 239 Clinical FTEs at year-end; 2 lower than budget.
- Operating Expenses are lower by $5.3 million, largely due to decreased employee expenses and consultant expense.

FY 2025 Q2 Forecast

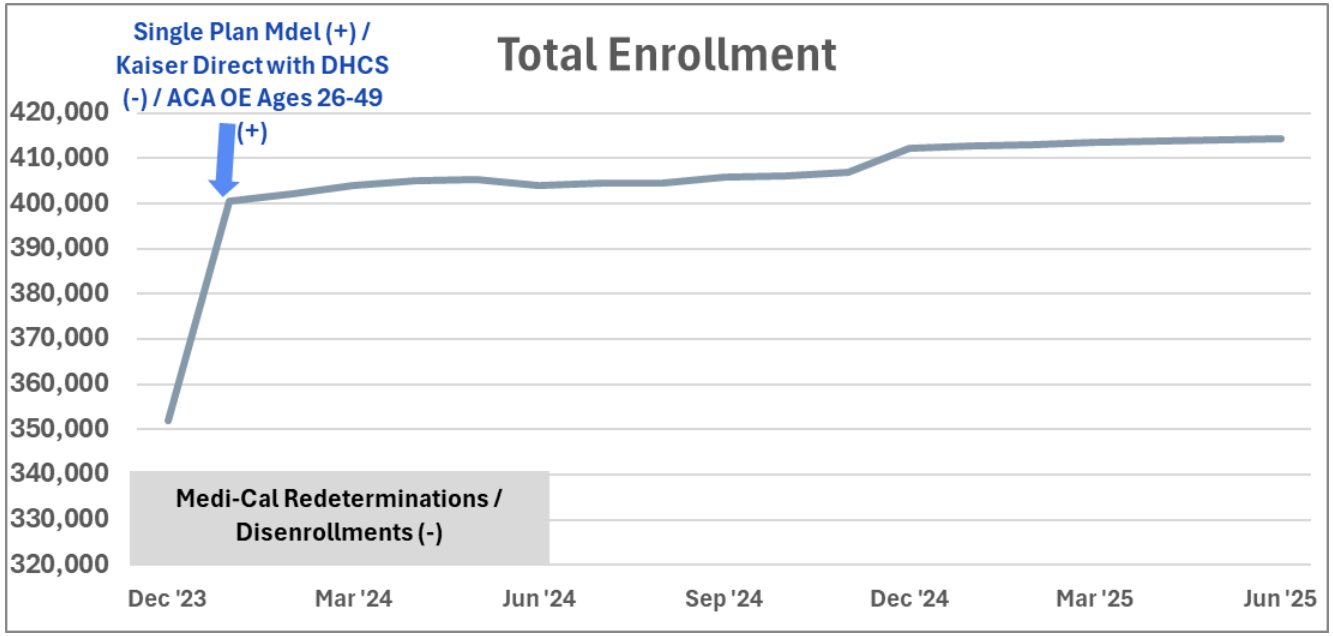
Material Areas of Uncertainty

- Federal administration changes may materially impact enrollment in FY25. The timing and impacts are currently unknown.
- The second quarter forecast updated final budget assumptions by using more current experience from CY2024, versus a mixture of CY2023 and CY2024 trend data.
- The revenue forecast is calculated on the current mix of UIS/SIS members. Material changes in the SIS/UIS member mix will impact results.
- Contract changes for hospitals and delegated providers in projections have not been finalized.
- New Part A Buy-In program monetary impact to medical expenses is unknown.
- Capitation Rates are subject to future amendments with UIS and Targeted Rate Increases adjustments still to be finalized.

FY 2025 Q2 Forecast
Comparison to Budget

$ in Thousands	FY 2025 Q2 Forecast				FY 2025 Final 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	408,701	5,779	0	414,480	403,393	5,769	0	409,162	5,308	10	0	5,318
Member Months	4,853,810	69,076	0	4,922,886	4,815,809	68,992	0	4,884,801	38,001	84	0	38,085
Premium Revenue	$2,118,132	$37,772	$0	$2,155,904	$2,085,255	$37,724	$0	$2,122,979	$32,877	$48	$0	$32,925
MCO Tax Revenue	$875,278	$0	$0	$875,278	$862,224	$0	$0	$862,224	$13,054	$0	$0	$13,054
Total Revenue	**2,993,410**	**37,772**	**0**	**3,031,182**	**2,947,480**	**37,724**	**0**	**2,985,203**	**45,931**	**48**	**0**	**45,979**
Medical Expense	2,125,058	36,795	411	2,162,263	2,043,579	35,347	366	2,079,292	(81,479)	(1,447)	(45)	(82,971)
Gross Margin	**868,352**	**977**	**(411)**	**868,919**	**903,901**	**2,376**	**(366)**	**905,911**	**(35,548)**	**(1,399)**	**(45)**	**(36,992)**
Administrative Expense	104,249	1,833	10,484	116,566	109,431	1,835	8,676	119,942	5,182	3	(1,808)	3,377
Operating Margin	**764,104**	**(856)**	**(10,895)**	**752,353**	**794,470**	**541**	**(9,042)**	**785,969**	**(30,366)**	**(1,397)**	**(1,853)**	**(33,616)**
MCO Tax Expense	880,278	0	0	880,278	877,224	0	0	877,224	(3,054)	0	0	(3,054)
Other Income / (Expense)	29,722	422	0	30,144	25,620	361	0	25,981	4,102	61	0	4,163
Net Income / (Loss)	**($86,453)**	**($434)**	**($10,895)**	**($97,781)**	**($57,135)**	**$902**	**($9,042)**	**($65,275)**	**($29,318)**	**($1,336)**	**($1,853)**	**($32,506)**
Admin. Expense % of Revenue	4.9%	4.9%		5.4%	5.2%	4.9%		5.6%	0.3%	0.0%		0.2%
Medical Loss Ratio	100.3%	97.4%		100.3%	98.0%	93.7%		97.9%	-2.3%	-3.7%		-2.4%
TNE at Year-End				$157,594				$105,123				$52,471
TNE Percent of Required at YE				193%				134%				59%

Enrollment by Month



Staffing: Full-time Employees at Year-end

Administrative FTEs/Temps at Year-End	FY25 Q2 FCST	FY25 Final	Increase/ Decrease
Administrative Vacancy	(58)	(59)	1
Operations	8	8	0
Medicare Operations	10	18	(8)
Executive	2	2	0
Finance	37	37	0
Healthcare Analytics	20	20	0
Claims	53	53	0
Information Technology	15	15	0
IT Infrastructure	9	9	0
Apps Mgmt., IT Quality & Process Imp.	24	23	1
IT Development	16	17	(1)
IT Data Exchange	10	10	0
IT-Ops and Quality Apps Mgt.	15	14	1
Member Services	107	108	(1)
Provider Services	42	42	0
Credentialing	11	11	0
Health Plan Operations	1	1	0
Human Resources	13	13	0
Vendor Management	10	10	0
Legal Services	4	4	0
Facilities & Support Services	8	8	0
Marketing & Communication	12	12	0
Privacy and SIU	17	17	0
Regulatory Affairs & Compliance	11	11	0
Risk Mgmt. & Operations Oversite	4	4	0
Grievance and Appeals	29	27	2
Integrated Planning	23	23	0
State Directed & Special Programs	11	9	2
Portfolio Mgmt. & Svc Excellence	0	0	0
Workforce Development	9	9	0
Health Equity	4	4	0
Total Administrative	**477**	**480**	**(3)**

Clinical FTEs	FY25 Q2 FCST	FY25 Final	Increase/ Decrease
Clinical Vacancy	(6)	(6)	(0)
Quality Analytics	7	7	0
Long-Term services and Supports (LTSS)	29	28	1
Utilization Management	67	67	0
Case/Disease Management	56	56	0
Medical Services	8	8	0
Quality Management	39	39	0
HCS Behavioral Health	27	27	0
Pharmacy Services	8	8	0
Regulatory Readiness	4	4	0
Total Clinical FTEs	**239**	**238**	**1**

Total FTEs	**716**	**718**	**(2)**

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

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Community Support Discontinuation Considerations

Community Support Discontinuation Considerations & Scenario Forecast

3/14/2025

ALAMEDA Alliance FOR HEALTH

CS Forecast Scenarios

Discontinuation of:	Potential Annual Savings (in millions)
1) Discontinue All Community Supports	$26M
2) Spend to revenue assumptions	$12M

Note: Housing Bundle cost is expected to be $13.5 million for FY25

CS Revenue Analysis

1) Three-year margin (FY23-FY25)	$17M Net Loss
2) Estimated FY25 Revenue	$14M
3) FY26 estimated savings	$12M

Note: Material changes in FY26 revenue are at risk with potential downward shifts in enrollment (ex parte, UIS, ACA OE). Original FY25 budget estimate was $35M.

CS Discontinuation Considerations

- DHCS requires 90-day notification before termination
- Contract changes required 60-day notification
- Criteria changes related to Medically Tailored Meals and Personal Care and Homemaker Services began in December of last year and have yielded results
- Housing criteria changes are expected to begin in July of this year
- There will be a financial impact to community benefit organizations currently offering the services

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MEDICAL MANAGEMENT UPDATE

Medical Management

Donna White Carey, MD,MS
Chief Medical Officer
3/14/25

ALAMEDA Alliance FOR HEALTH

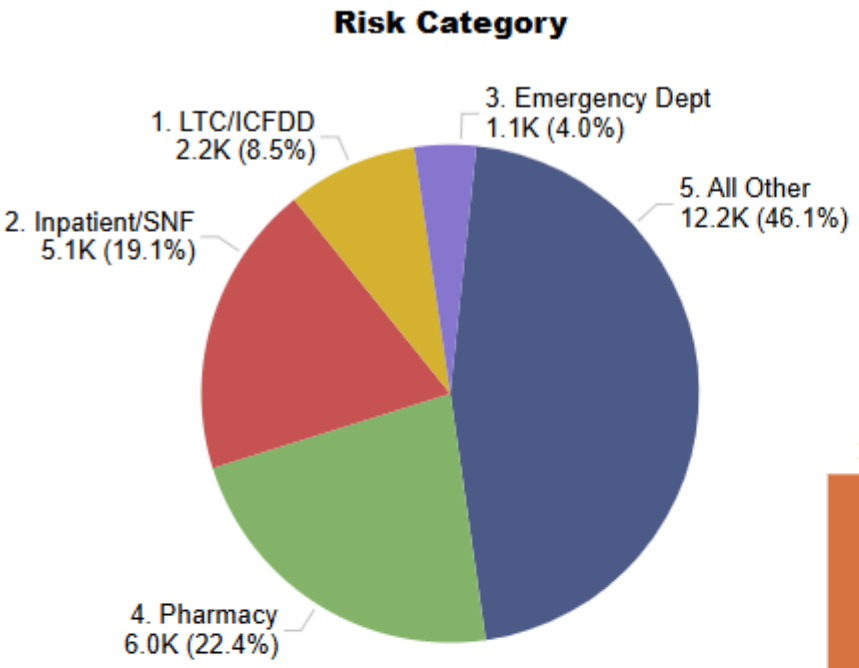
AAH Top 5%

- 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%

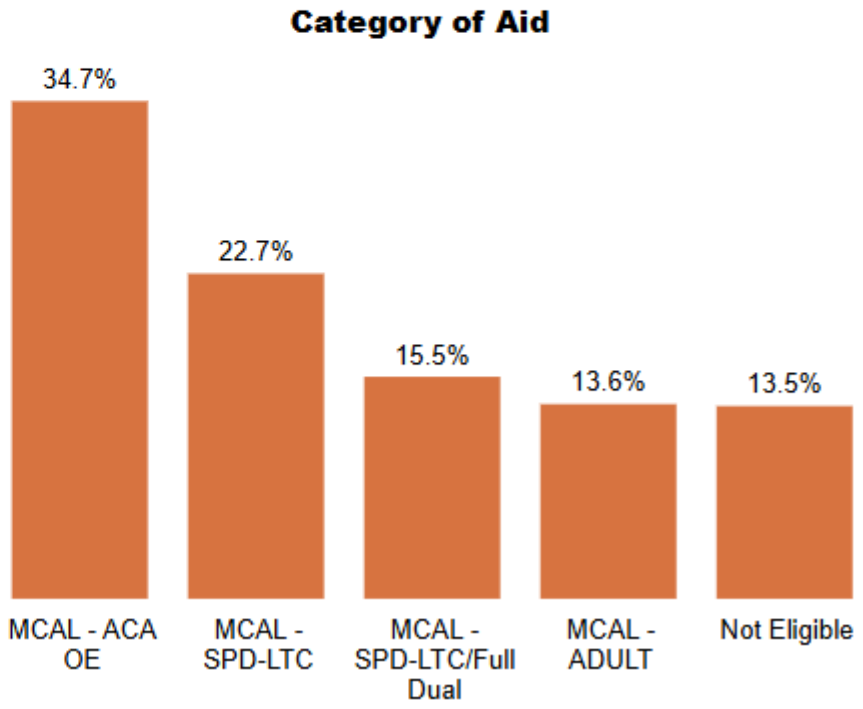
*Total Costs include claims paid, priced encounters and DHCS pharmacy costs.

**Pharmacy accounts for services covered by DHCS.

AAH Top 5%



- Members were assigned a risk category based on utilization and/or cost to help focus the initiatives for Top 5%.
- ~35% of the members are in the ACA OE aid category.



AAH Top 5%

% ECM Eligible

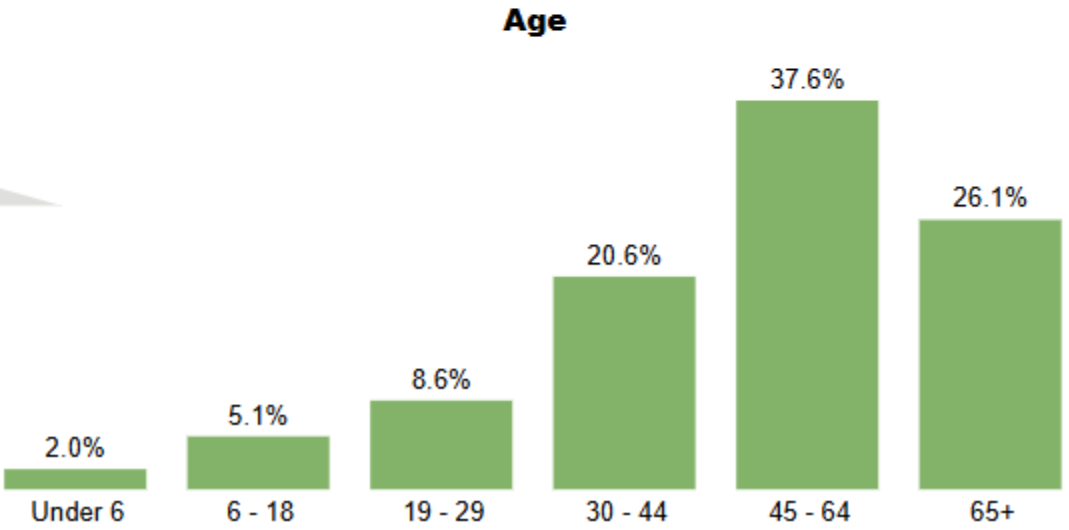
31.68%

% ECM Enrolled

4.82%

% CS Enrolled

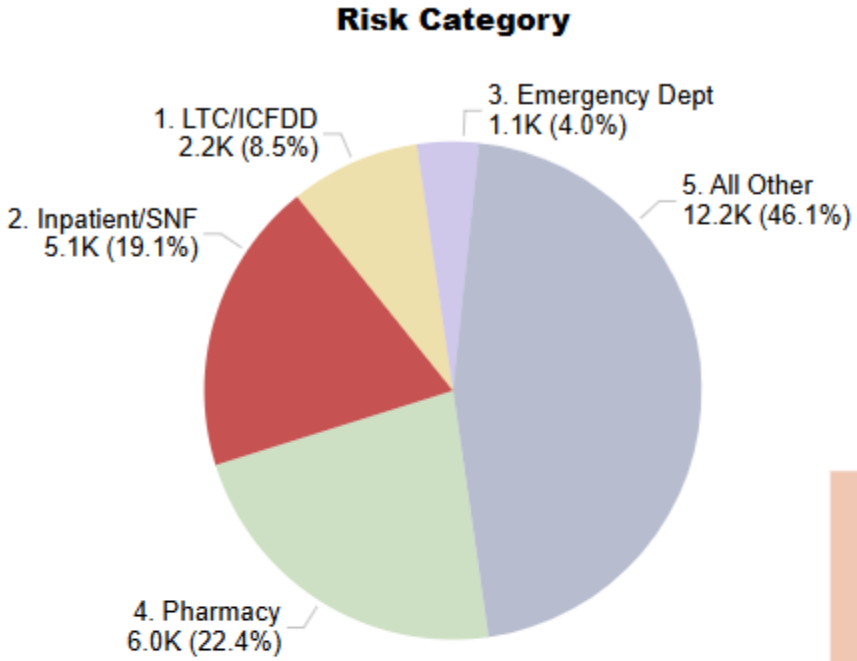
3.20%



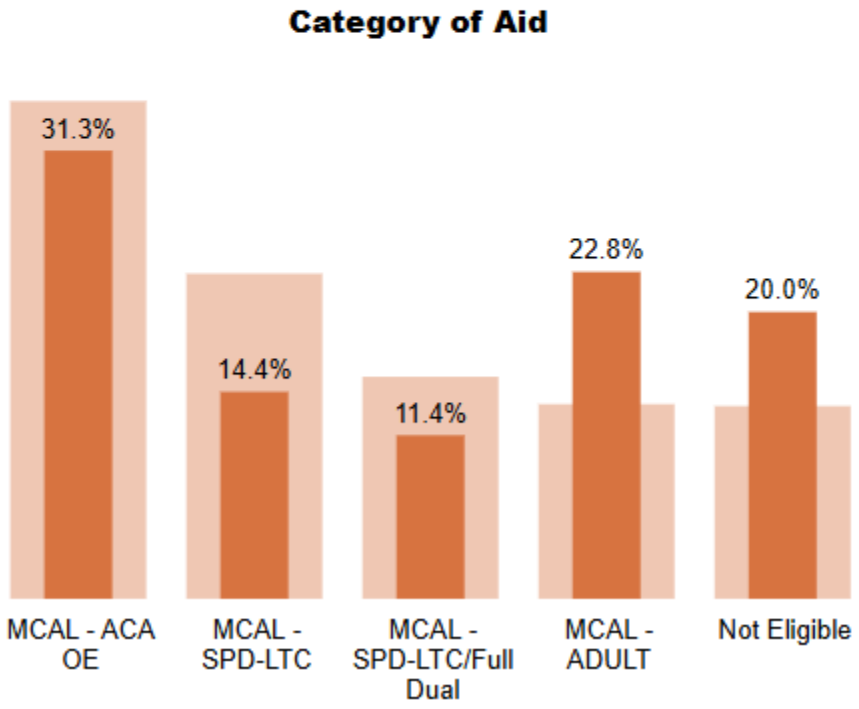
Inpatient Data & Strategy

ALAMEDA Alliance FOR HEALTH

Inpatient/SNF



- This risk category has a higher % in the Adult category of aid than the overall Top 5%.



Inpatient/SNF

% ECM Eligible

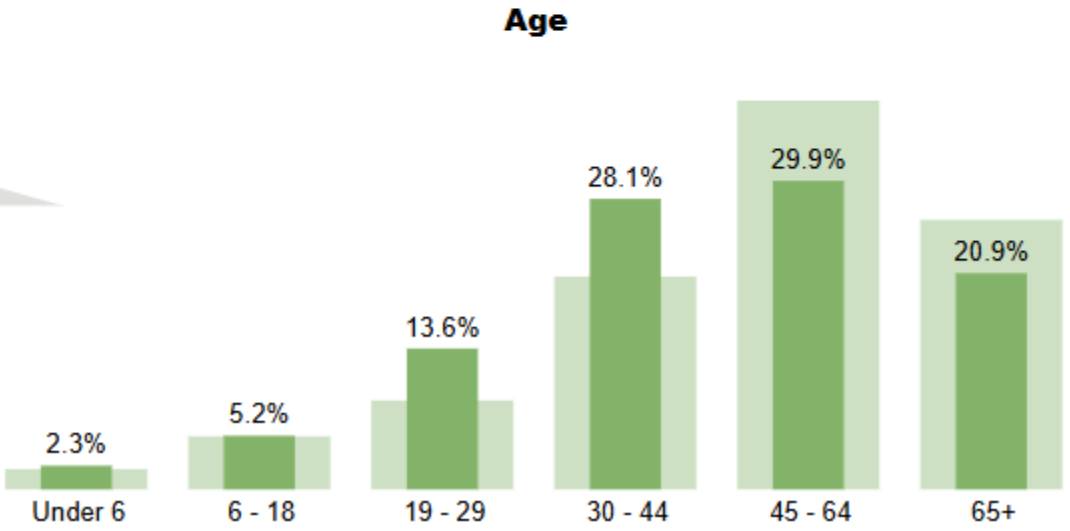
39.61%

% ECM Enrolled

6.00%

% CS Enrolled

3.58%



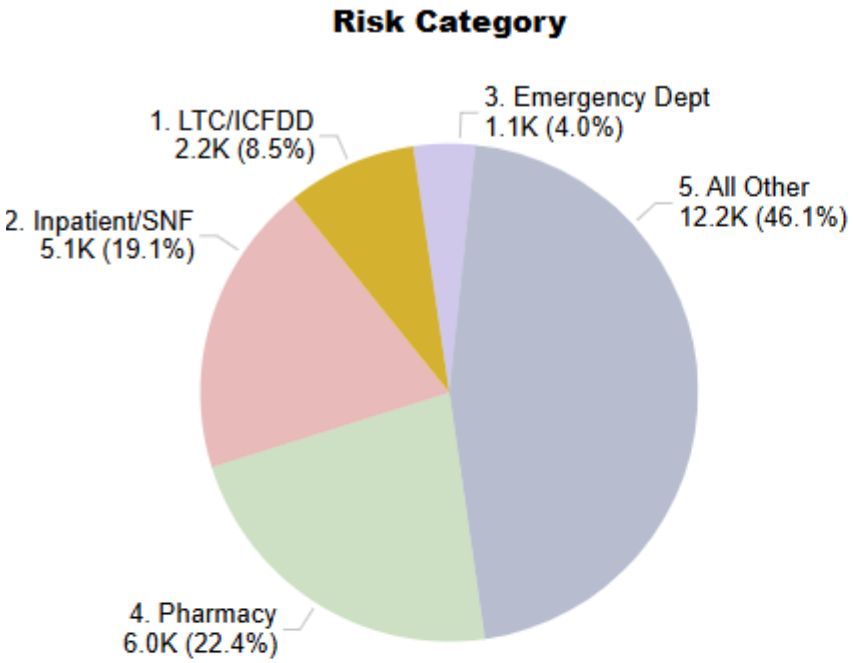
Inpatient Interventions

- On-going
  - **Over/Under Utilization Workgroup-** started in Dec 2024 – meets monthly
  - Receive real time information/Hospital 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)
  - Work with Finance and Contracting to ensure appropriate payment for inpatient services, such as contracted versus non-contracted and diagnosis per diem vs APR-DRG.
  - Continue to work with hospital partners to refine identification of high utilizing members
  - Fund CHCN's **CTRN program** (11 RN FTEs, 3.5 coordinator FTEs)
- Future
  - Enhanced Care Management – MIF prioritization to ECM providers (April 2025)
  - TCS vendor for high risk members to assist with PCP follow up (~June 2025)
  - Further expand Pharmacy outreach to include additional hospitals (~April 2025)
  - Inpatient-focused interventions with largest delegate (~July 2025)

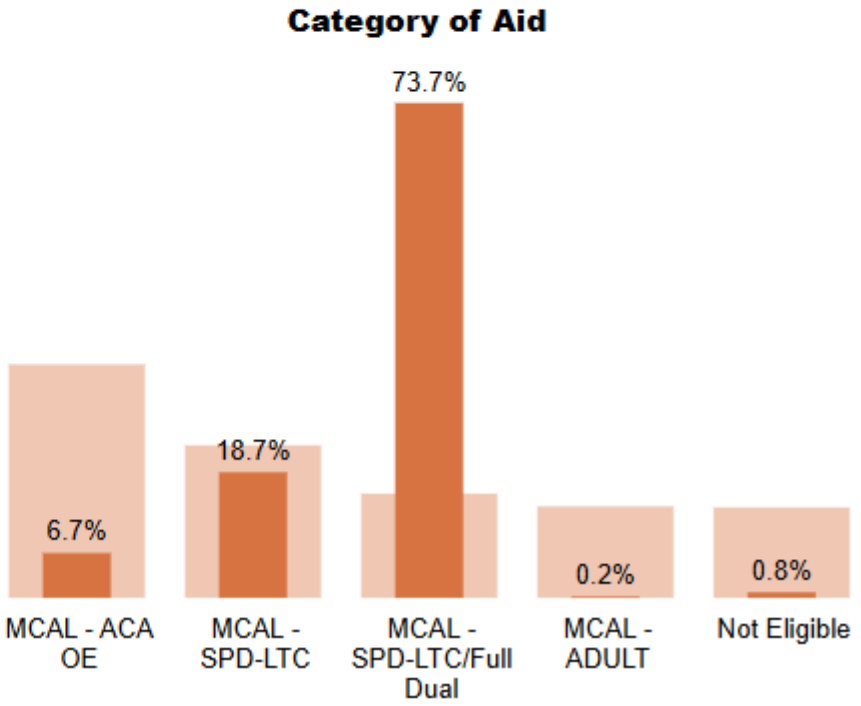
Long Term Support Services Data and Strategy

ALAMEDA Alliance FOR HEALTH

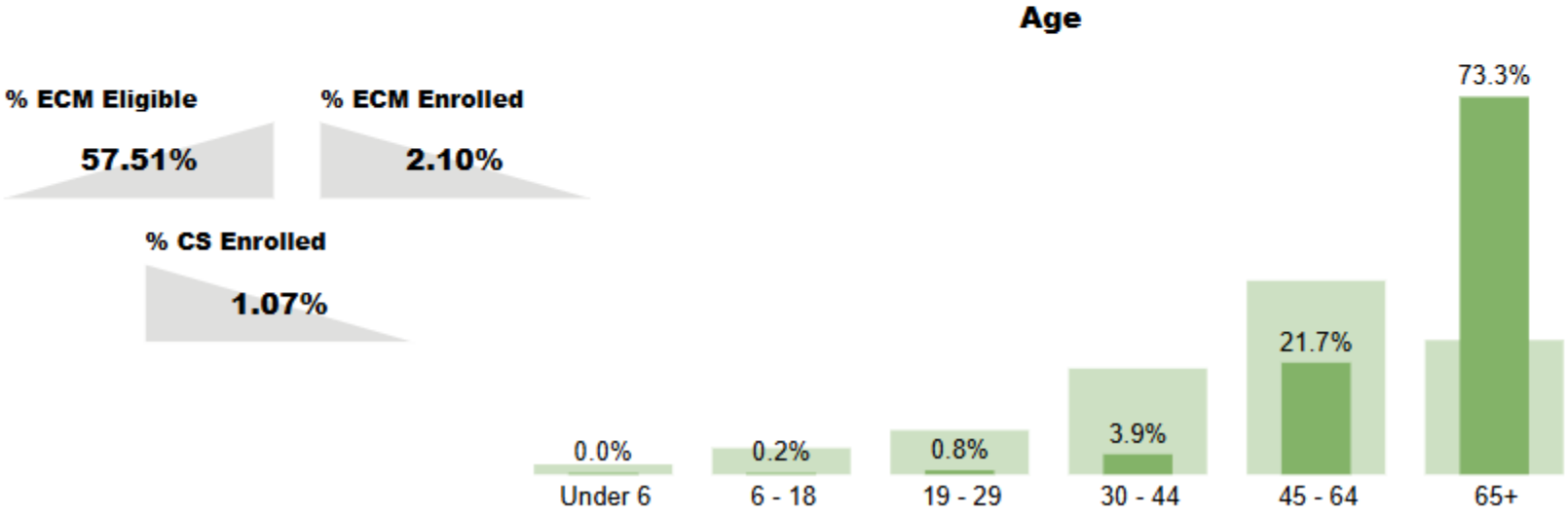
LTC and ICF/DD



- The majority of the members (~74%) are assigned to the SPD-LTC/Full Dual aid category.



LTC and ICF/DD



Long Term Support Services Interventions

- On-going
  - → **Sitter program** restructure
  - → **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 appropriate DHCS LTC aid code
  - → Further refine Community Supports criteria – March 2025 (effective ~July 2025)

ED Data and Strategy

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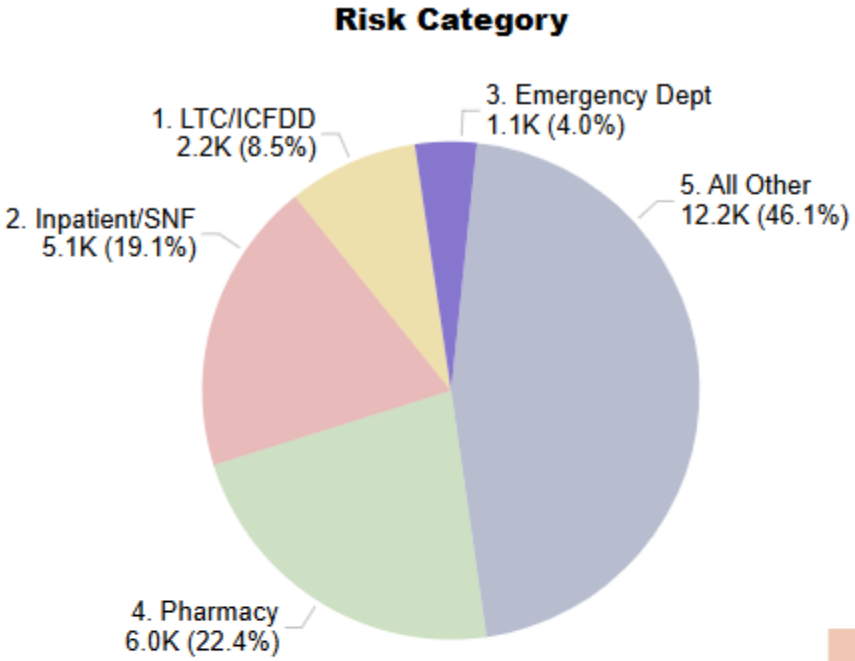
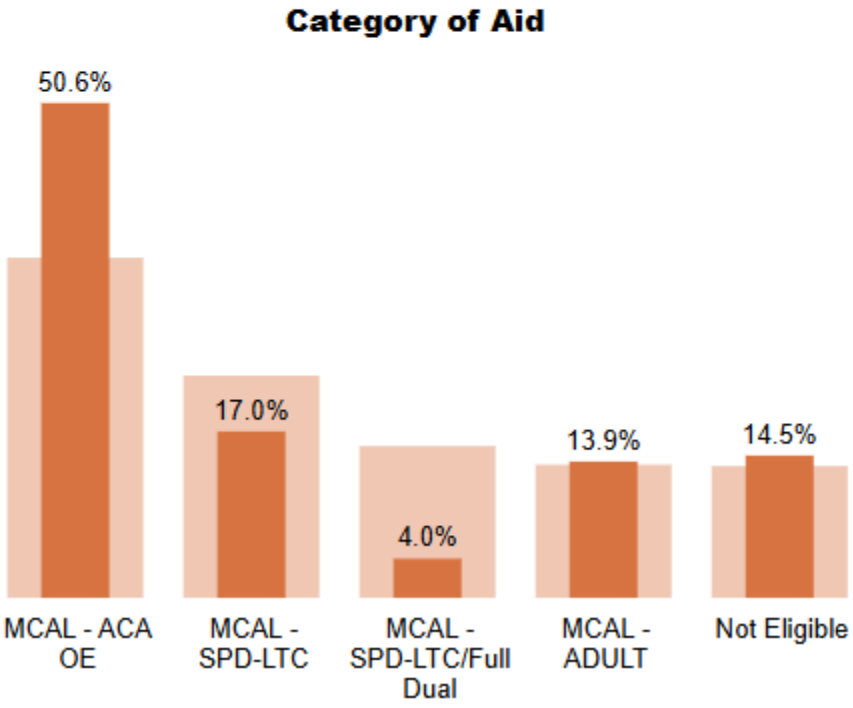
Emergency Department



- This risk category has a higher % in the ACA OE category of aid than the overall Top 5%.



Emergency Department

% ECM Eligible

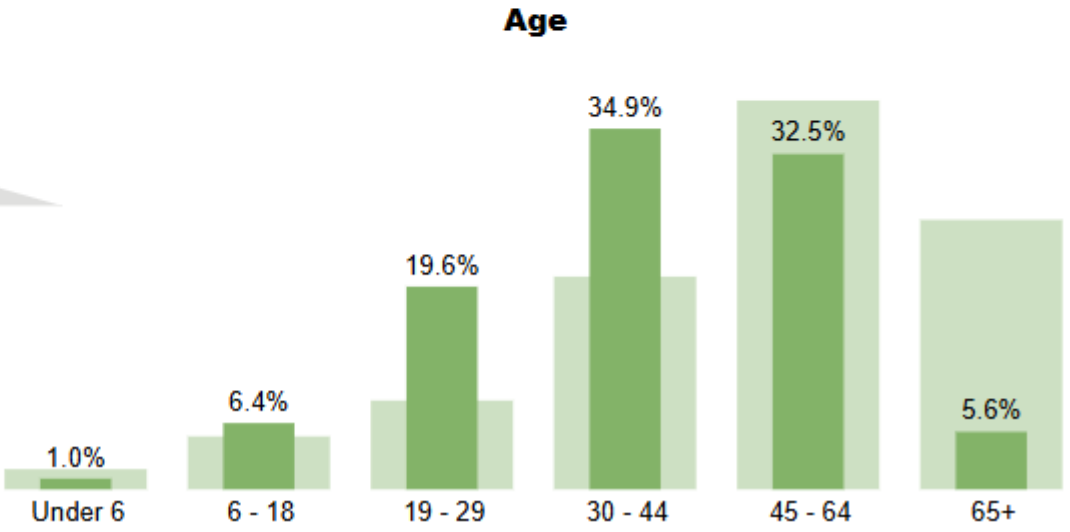
52.26%

% ECM Enrolled

5.66%

% CS Enrolled

4.72%



Emergency Department Interventions

- On-going
  - → Member education campaign-increase Telehealth and Urgent Care utilization
  - → **Community Health Workers (CHW)** care coordination in ED (Highland) – Aug 2024
  - → **CHWs in ED (Sutter)** – Sept 2024
  - → **QI navigators f/u ED visits** 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
- Future
  - → Expand network access to PCPs, Urgent care, MH providers
  - → Expand PCP available hours of operation (incentives to PCPs)
  - → Train SUD ED navigators to include/link 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
  - → Targeted enrollment in ECM/CM

Pharmacy Data and Strategy

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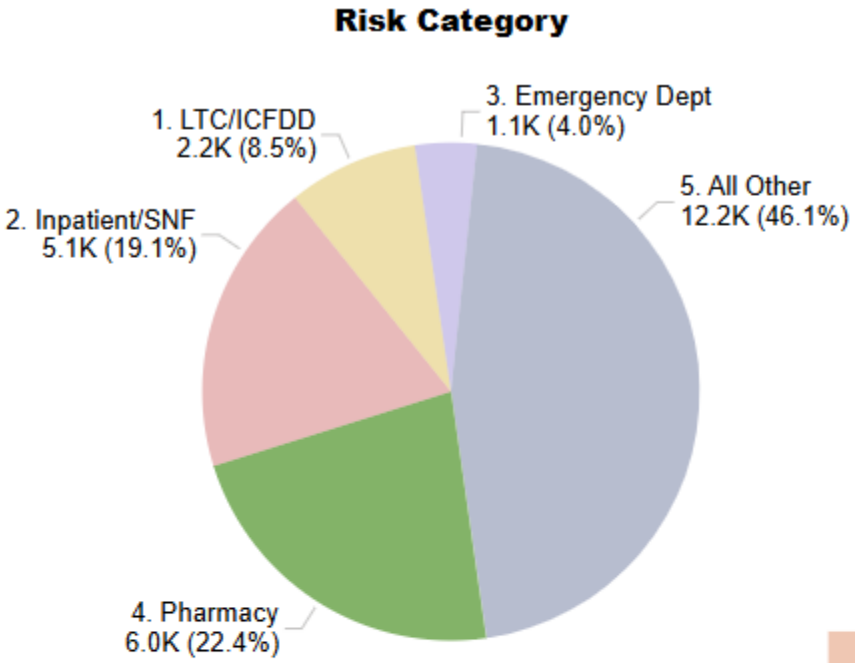
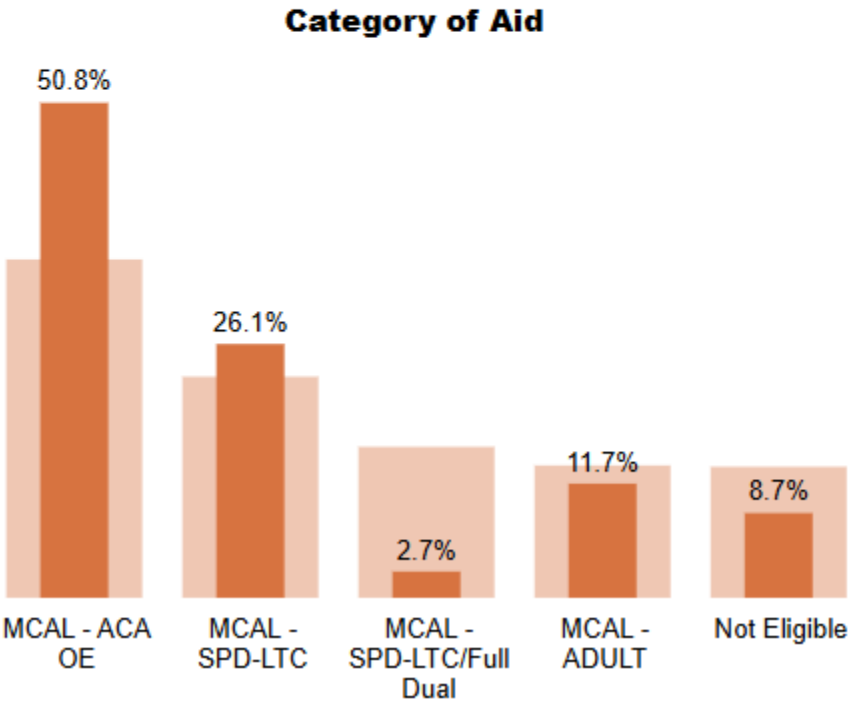
Pharmacy



- This risk category has a higher % in the ACA OE category of aid than the overall Top 5%.



Pharmacy

% ECM Eligible

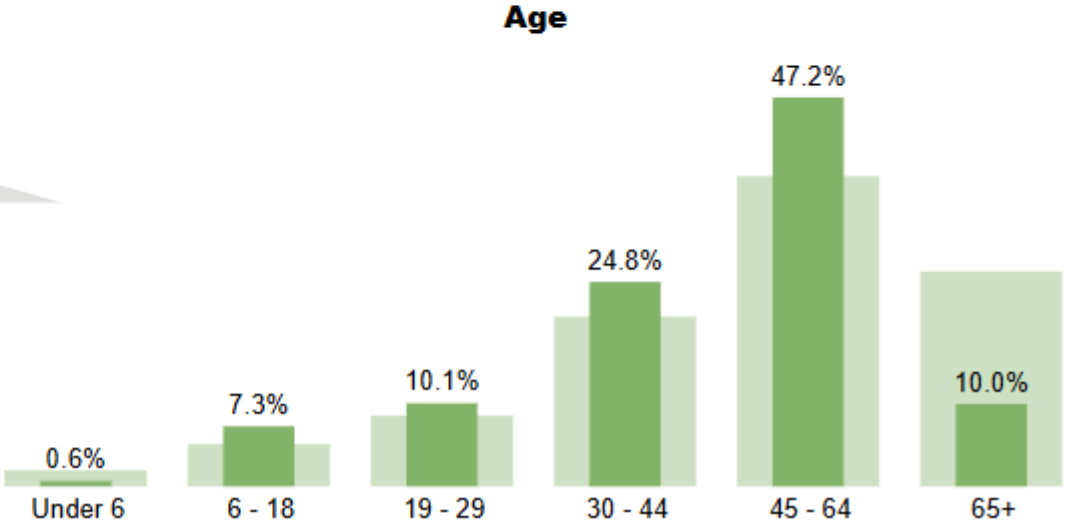
10.44%

% ECM Enrolled

2.00%

% CS Enrolled

2.03%



Pharmacy Interventions

- Ongoing
  - → **Formulary/Prior Authorization** (PA) review (ex – Anticoagulants)
  - → **Monitor new claims for carve out drugs/Physician Administrered 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)
- Future
  - → Creating policy and process for self-injectables administered in office (~May 2025)

Special Health Care Needs

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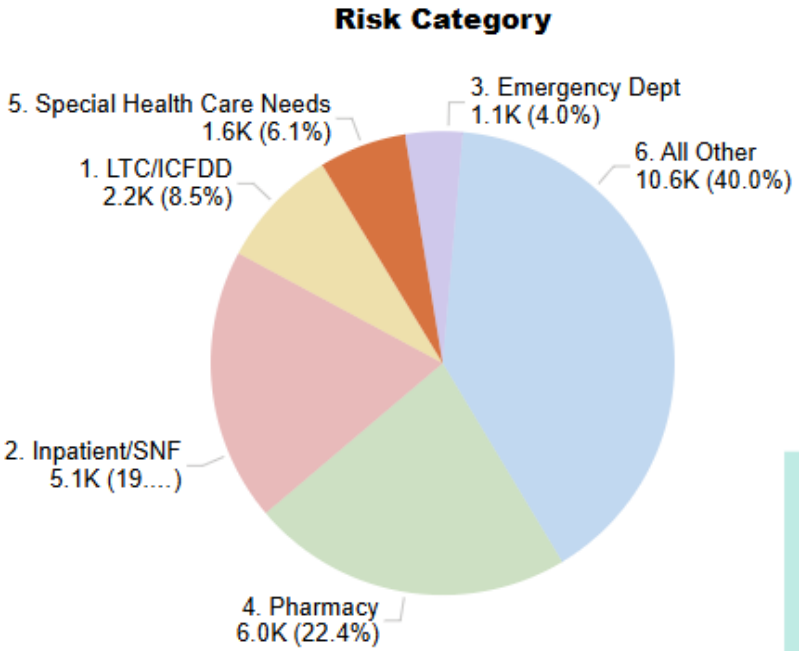
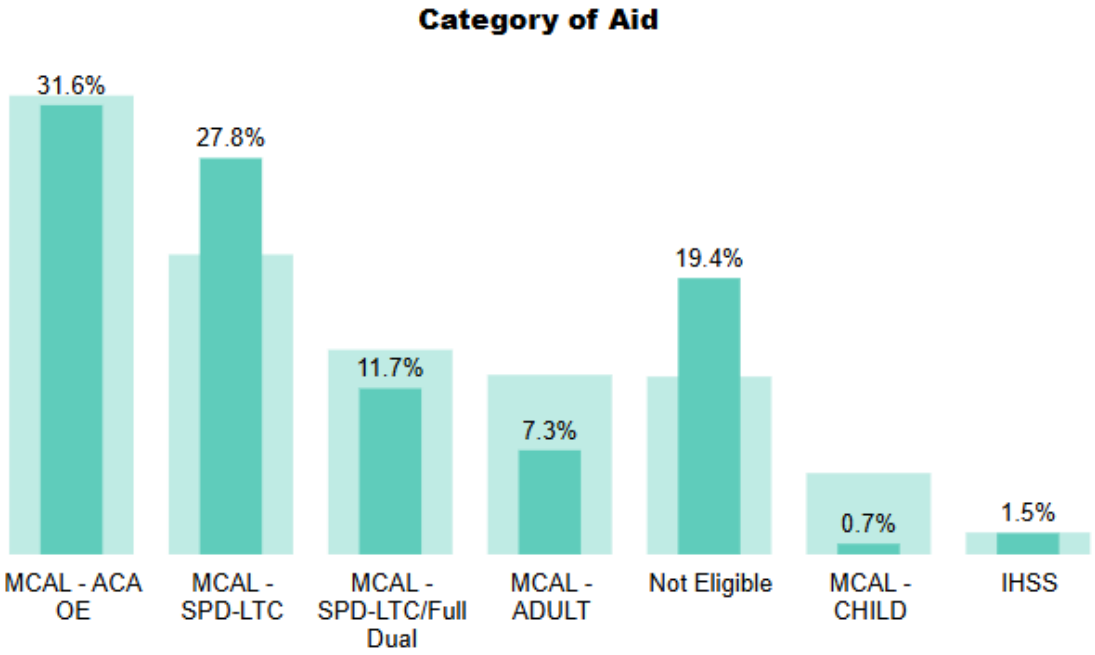
5. Special Health Care Needs



- This risk category has a higher % in the SPD-LTC category of aid than the overall Top 5%.



5. Special Health Care Needs

% ECM Eligible

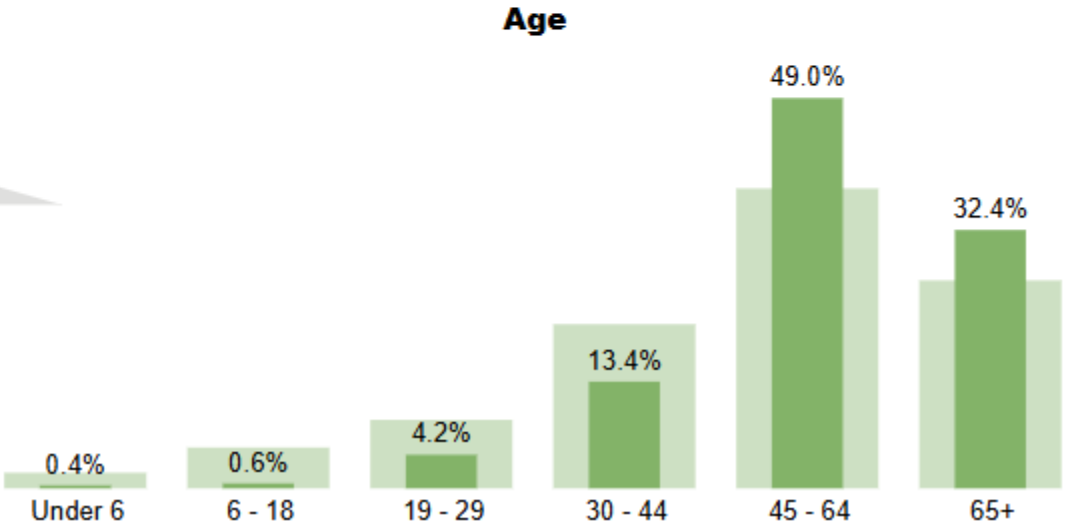
43.34%

% ECM Enrolled

7.81%

% CS Enrolled

6.26%



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.

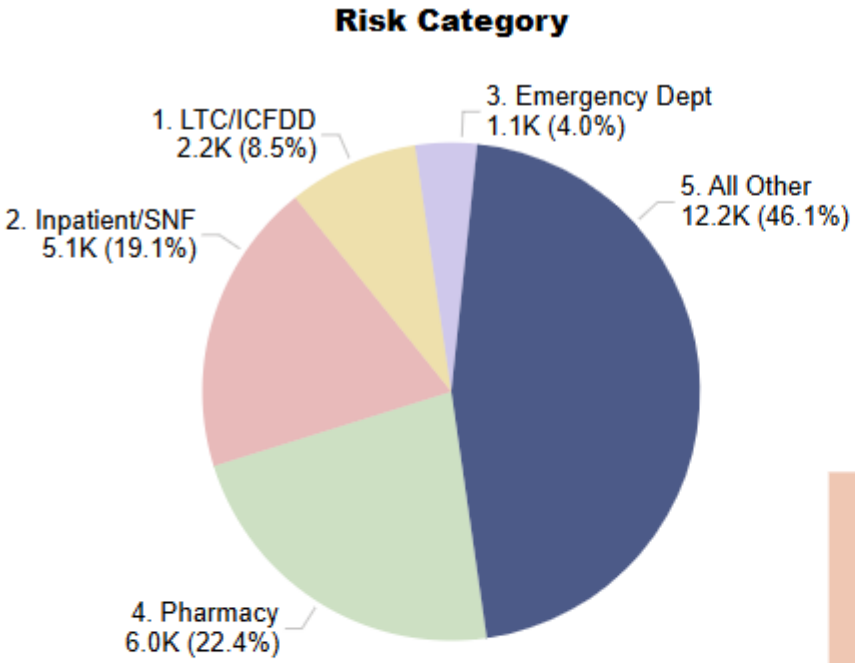
Thank You!

Questions?

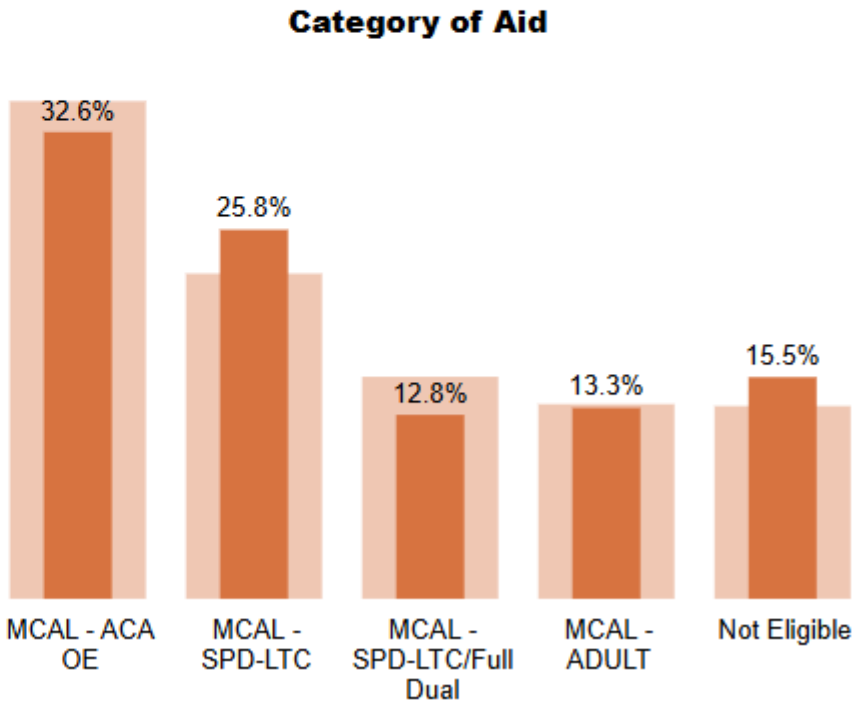
ALAMEDA Alliance FOR HEALTH

Other Members

All Other Members



- The aid categories in this risk category align with the overall Top 5%.



All Other Members

% ECM Eligible

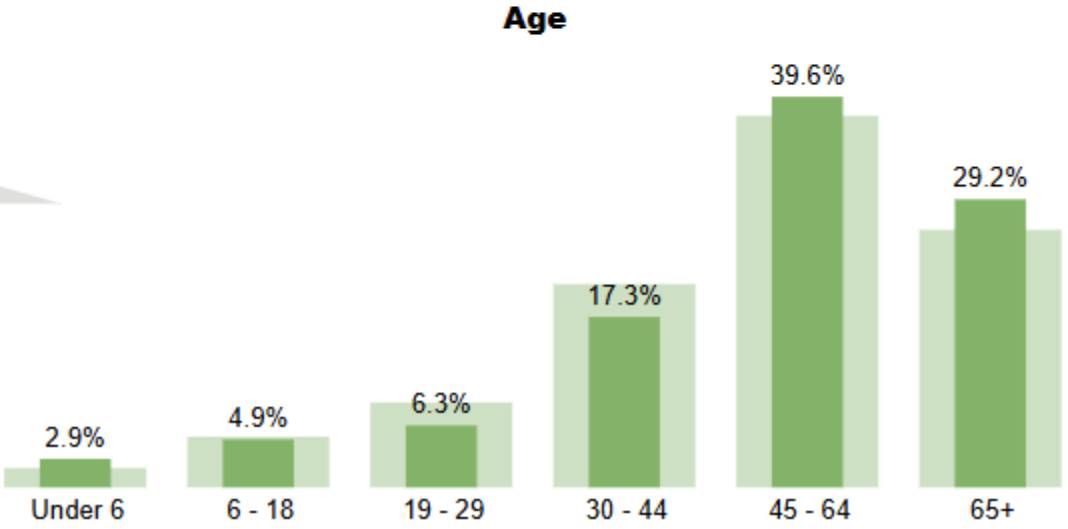
32.22%

% ECM Enrolled

6.14%

% CS Enrolled

3.87%



Strategies

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

ALAMEDA Alliance FOR HEALTH

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

Finance

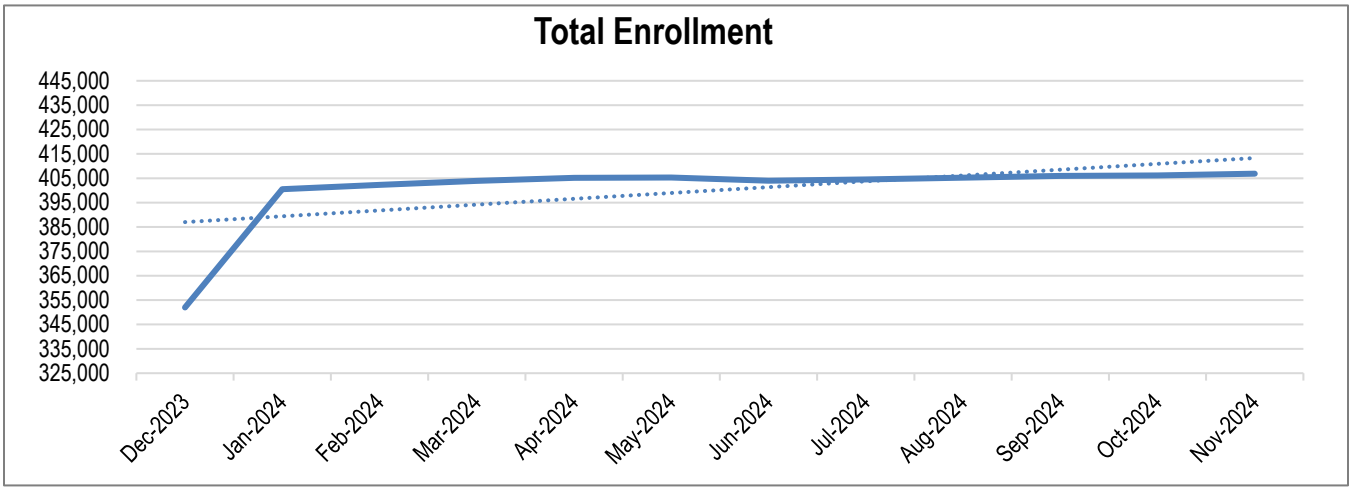
Gil Riojas

To: **Alameda Alliance for Health, Board of Governors**
From: **Gil Riojas, Chief Financial Officer**
Date: **March 14th, 2025**
Subject: **Finance Report – November 2024 Financials**

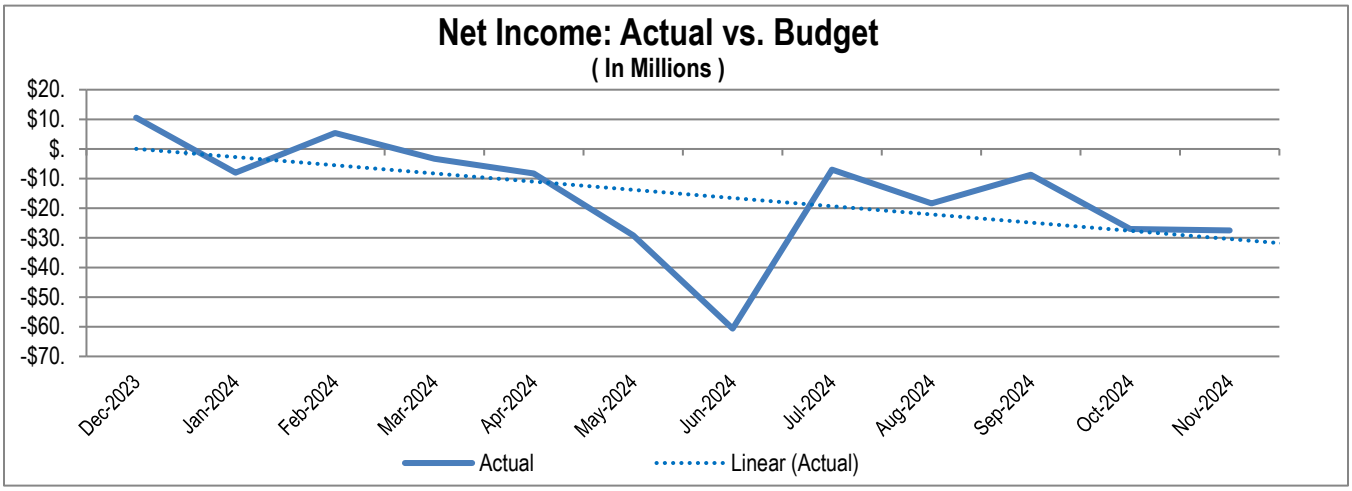
Executive Summary

For the month of November, the Alliance continued to see slight increases in enrollment, reaching 406,878 members. A Net Loss of $27.5 million was reported, and the Plan's Medical Expenses represented 111.8% of revenue. Alliance reserves decreased to 212% of required but continue to remain above minimum requirements.

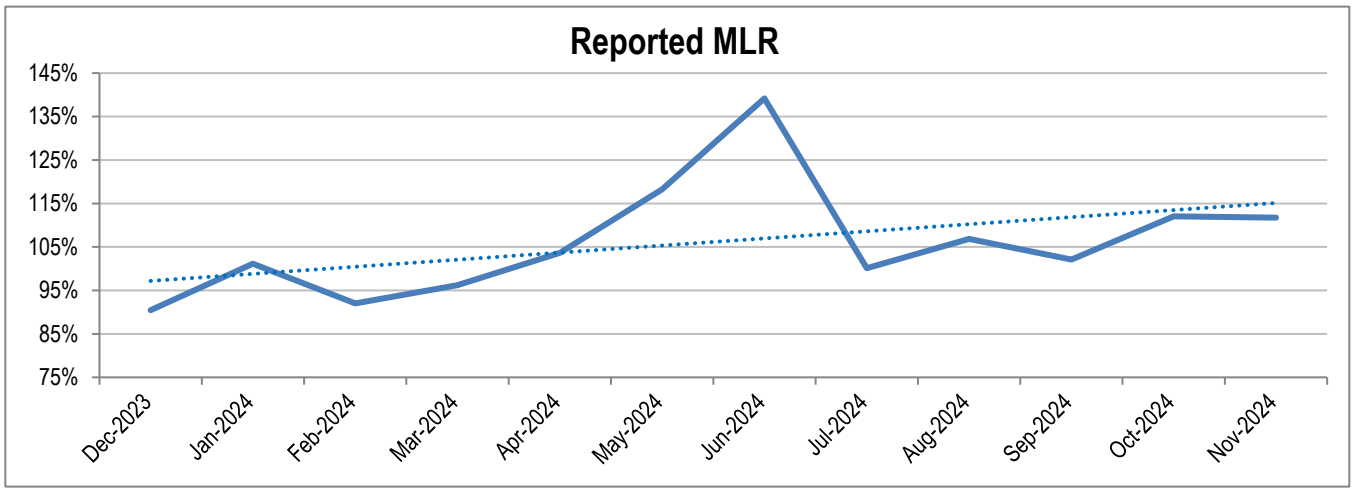
Enrollment – In November, Enrollment increased by 725 members.



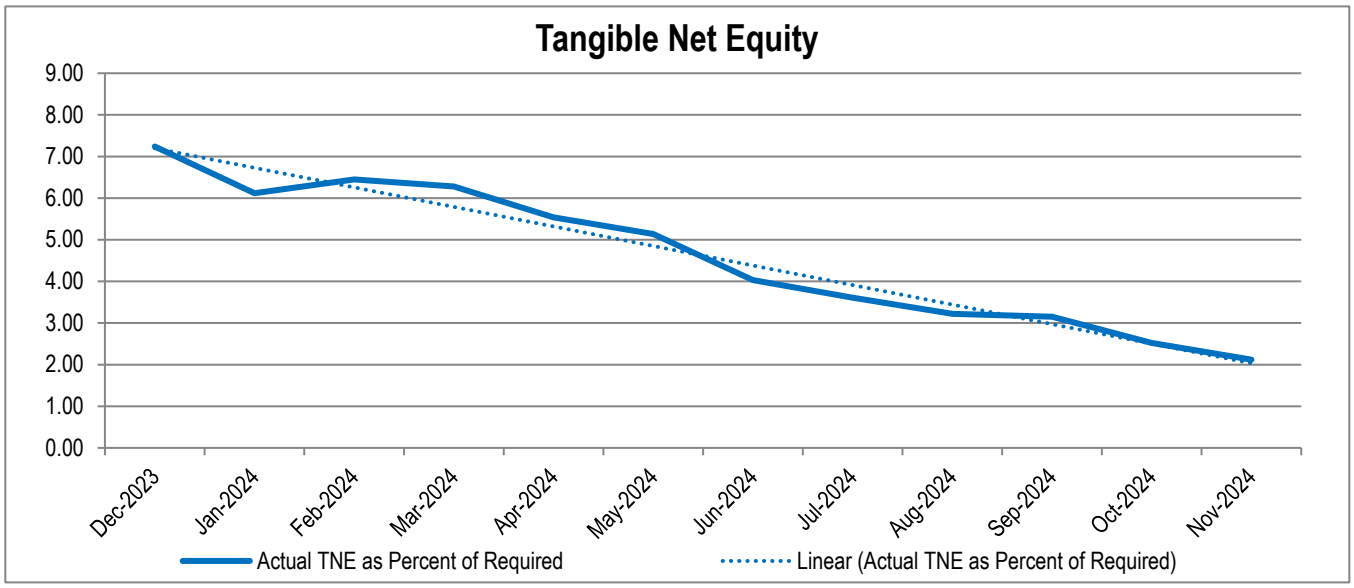
Net Income – For the month ended November 30th, 2024, actual Net Loss was $27.5 million vs. budgeted Net Loss of $10.0 million. For the fiscal YTD, actual Net Loss was $88.5 million vs. budgeted Net Loss of $71.0 million. For the month, Premium Revenue was favorable to budget, actual Revenue was $174.2 million vs. budgeted Revenue of $173.2 million.



Medical Loss Ratio (MLR) – The Medical Loss Ratio was 111.8% for the month, and 106.6% for fiscal YTD. The major variances include unfavorable Inpatient/SNF, Ancillary FFS, Outpatient FFS, Long-Term Care, and Pharmacy expenses.



Tangible Net Equity (TNE) - The Department of Managed Health Care (DMHC) required $78.9M in reserves, we reported $166.9M. Our overall TNE remains above DMHC requirements at 212%.



The Alliance continues to benefit from increased non-operating income. For Fiscal year-to-date investments show a gain of $15.0M. Capital assets acquired so far are $530k.

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

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

Date: **January 9th, 2025**

Subject: **Finance Report – November 2024**

Executive Summary

- For the month ended November 30th, 2024, the Alliance had enrollment of 406,878 members, a Net Loss of $27.5 million and 212% of required Tangible Net Equity (TNE).

Overall Results: (in Thousands)

	Month	YTD
Revenue	$237,868	$1,258,879
Medical Expense	194,705	898,817
Admin. Expense	9,042	48,217
MCO Tax Expense	63,652	415,404
Other Inc. / (Exp.)	2,059	15,040
Net Income	**($27,470)**	**($88,518)**

Net Income by Program: (in Thousands)

	Month	YTD
Medi-Cal*	($27,376)	($85,867)
Group Care	255	99
Medicare	(349)	(2,750)
	($27,470)	**($88,518)**

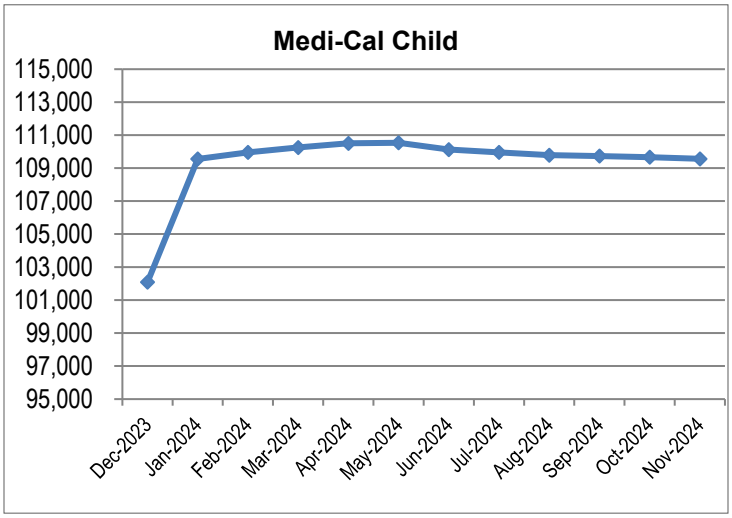
Enrollment

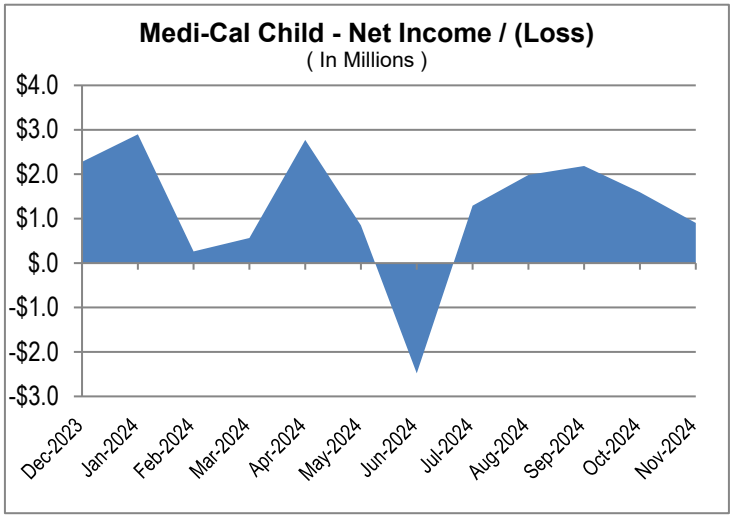
- Total enrollment increased by 725 members since October 2024.
- Total enrollment increased by 2,888 members since June 2024.

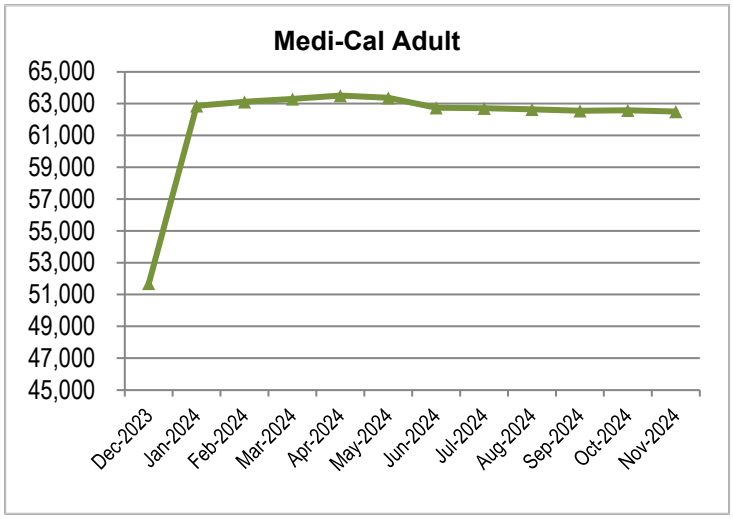
Monthly Membership and YTD Member Months
Actual vs. Budget
For the Month and Fiscal Year-to-Date

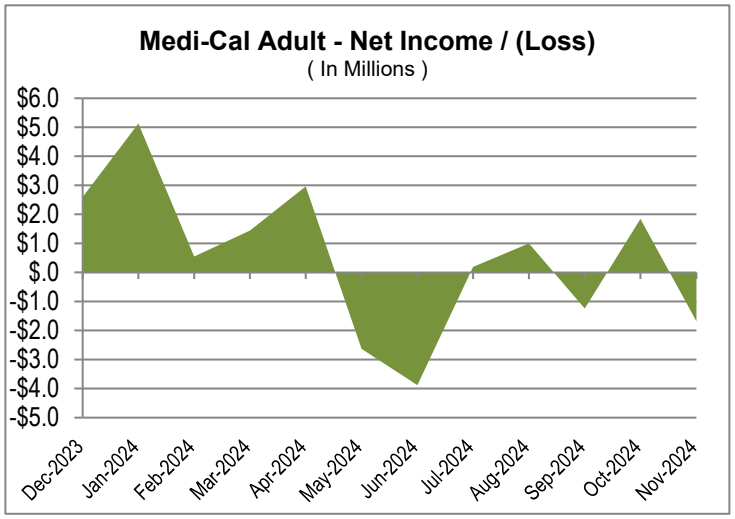
Enrollment					Member Months			
Current Month					Year-to-Date			
Actual	Budget	Variance	Variance %		Actual	Budget	Variance	Variance %
				Medi-Cal:				
62,502	62,641	(139)	-0.2%	Adult	312,979	313,118	(139)	0.0%
109,561	109,772	(211)	-0.2%	Child	548,689	548,900	(211)	0.0%
35,603	35,423	180	0.5%	SPD	176,505	176,325	180	0.1%
40,357	40,144	213	0.5%	Duals	200,541	200,328	213	0.1%
151,559	151,249	310	0.2%	ACA OE	753,945	753,635	310	0.0%
255	251	4	1.6%	LTC	1,192	1,188	4	0.3%
1,269	1,266	3	0.2%	LTC Duals	6,276	6,273	3	0.0%
401,106	**400,746**	**360**	**0.1%**	**Medi-Cal Total**	**2,000,127**	**1,999,767**	**360**	**0.0%**
5,772	5,769	3	0.1%	Group Care	28,612	28,609	3	0.0%
406,878	**406,515**	**363**	**0.1%**	**Total**	**2,028,739**	**2,028,376**	**363**	**0.0%**

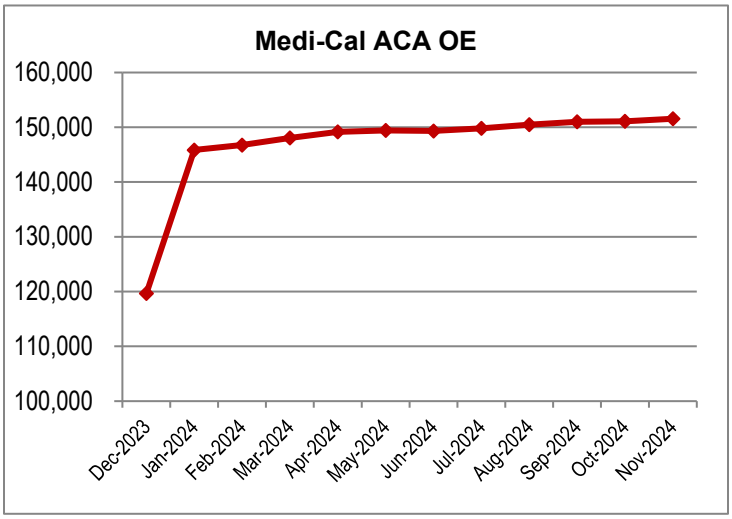
Enrollment and Profitability by Program and Category of Aid

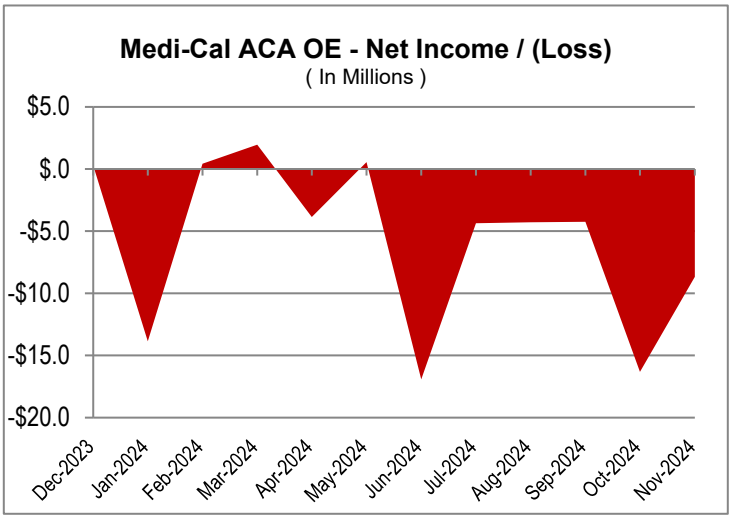




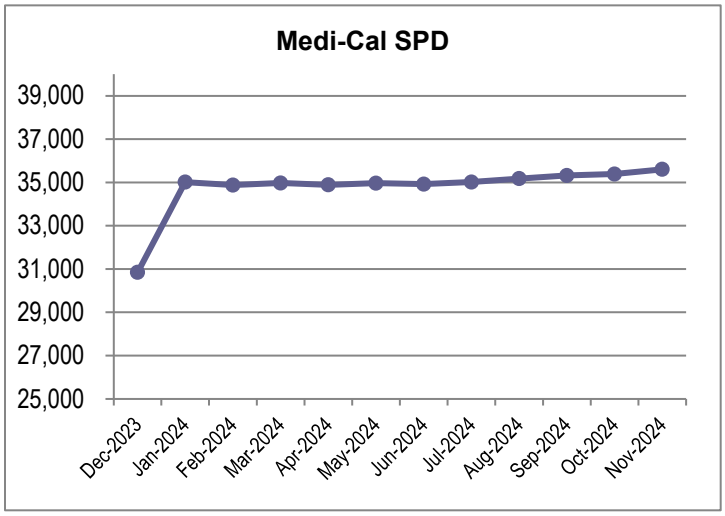


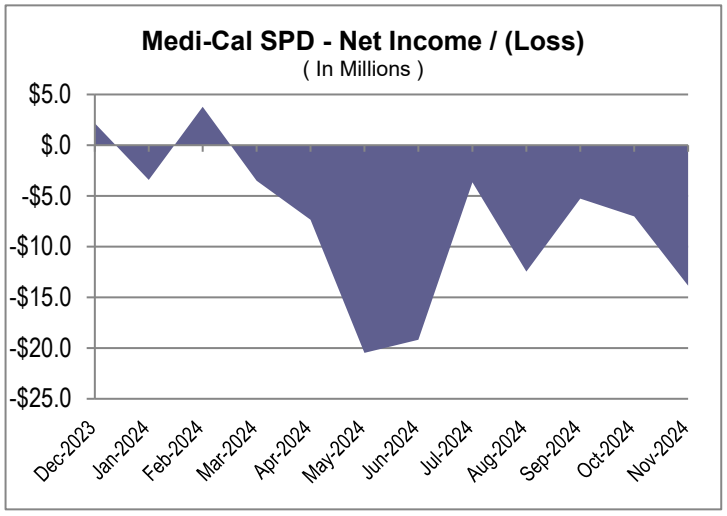


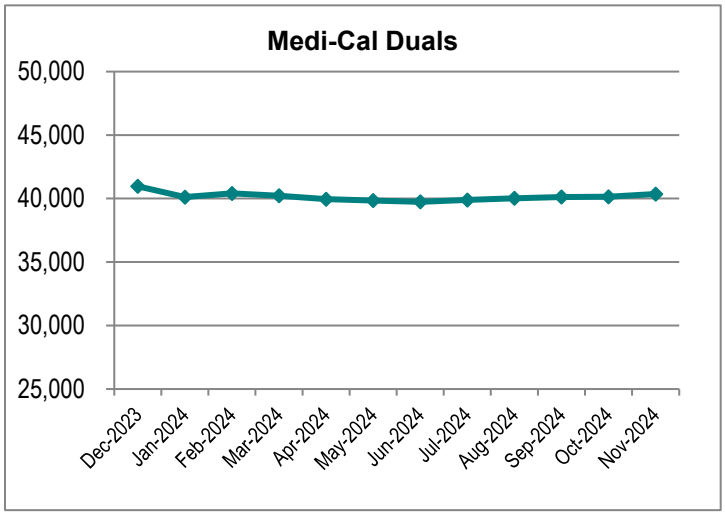


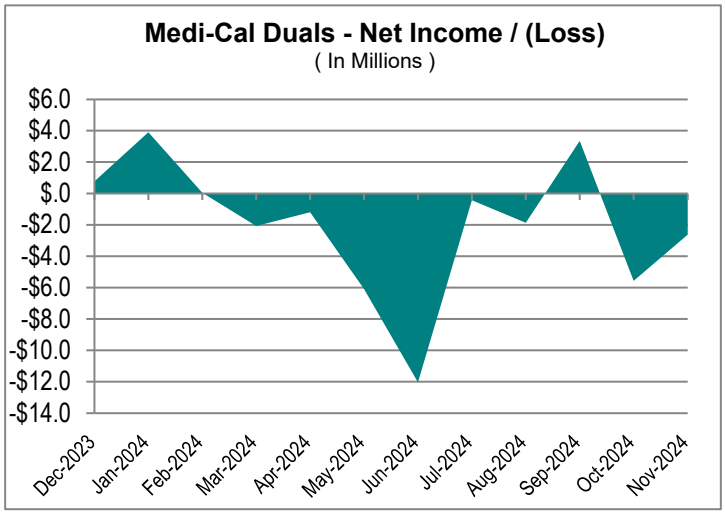


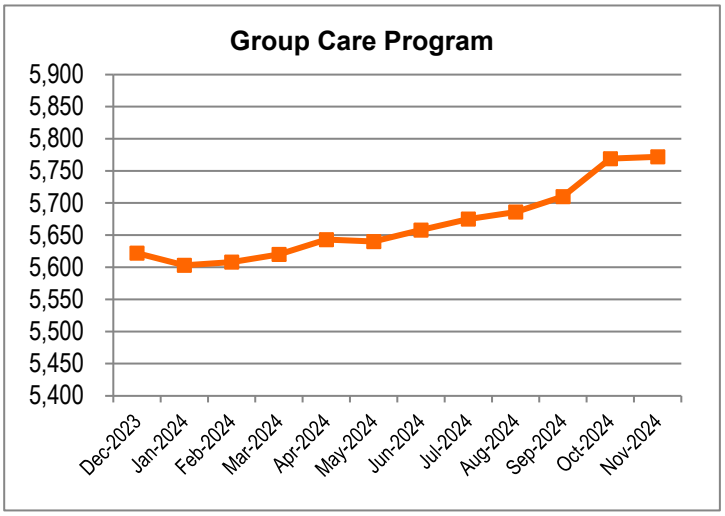
Enrollment and Profitability by Program and Category of Aid

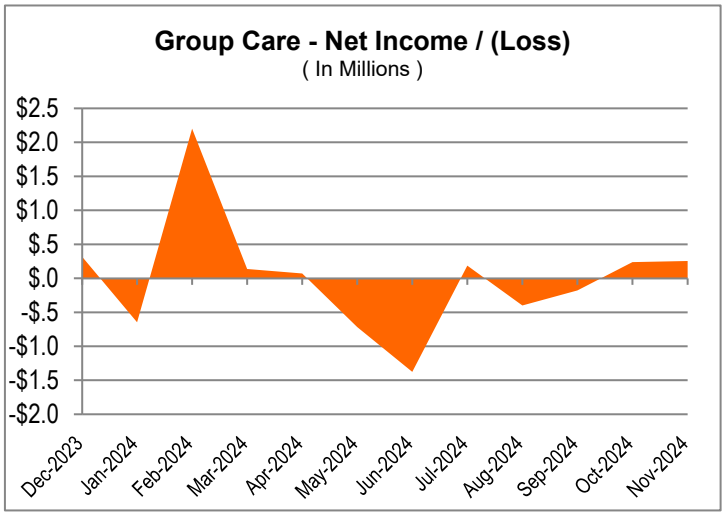




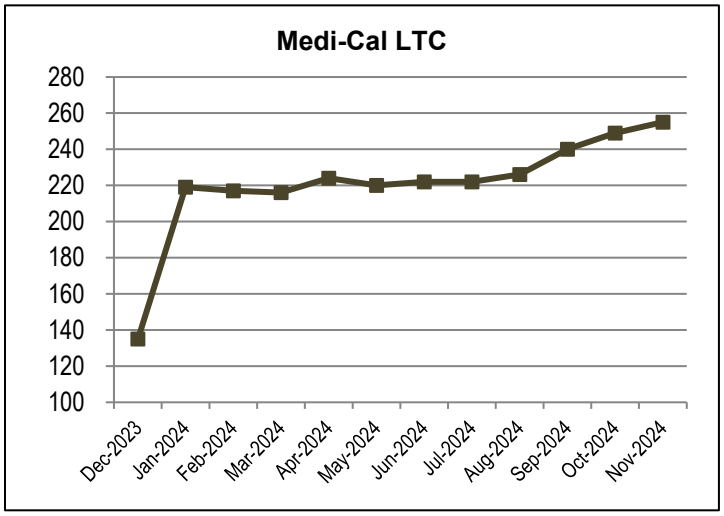


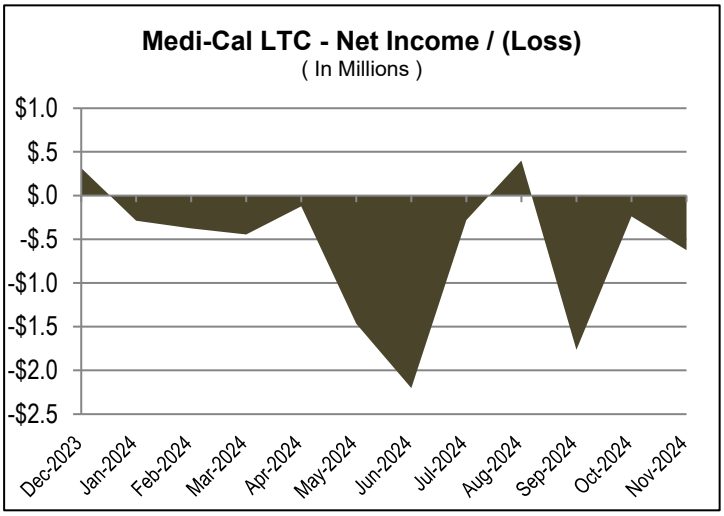


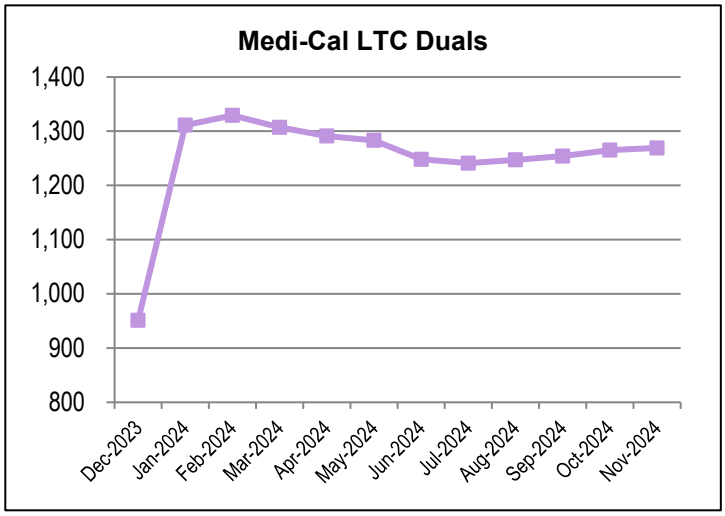


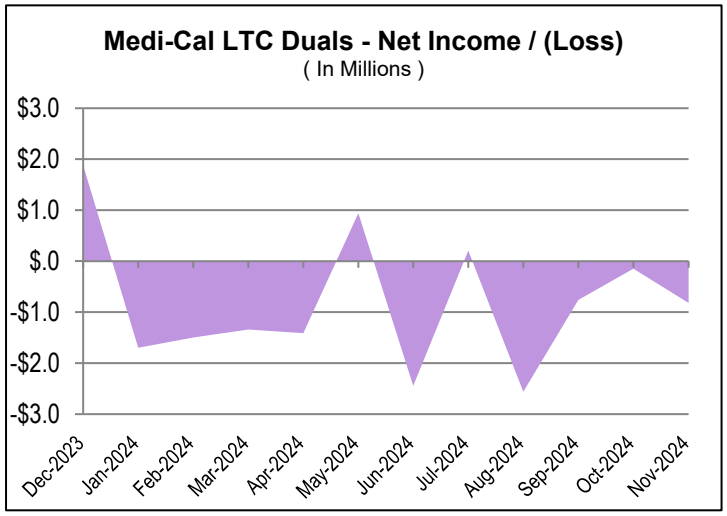


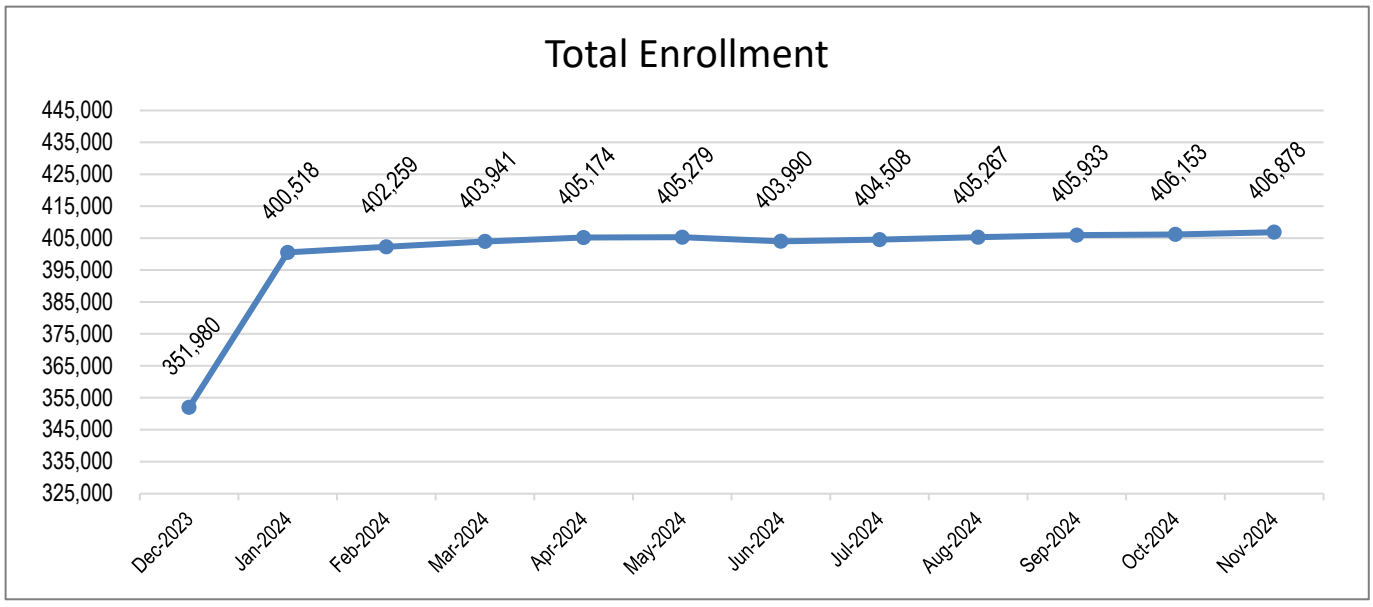
Enrollment and Profitability by Program and Category of Aid

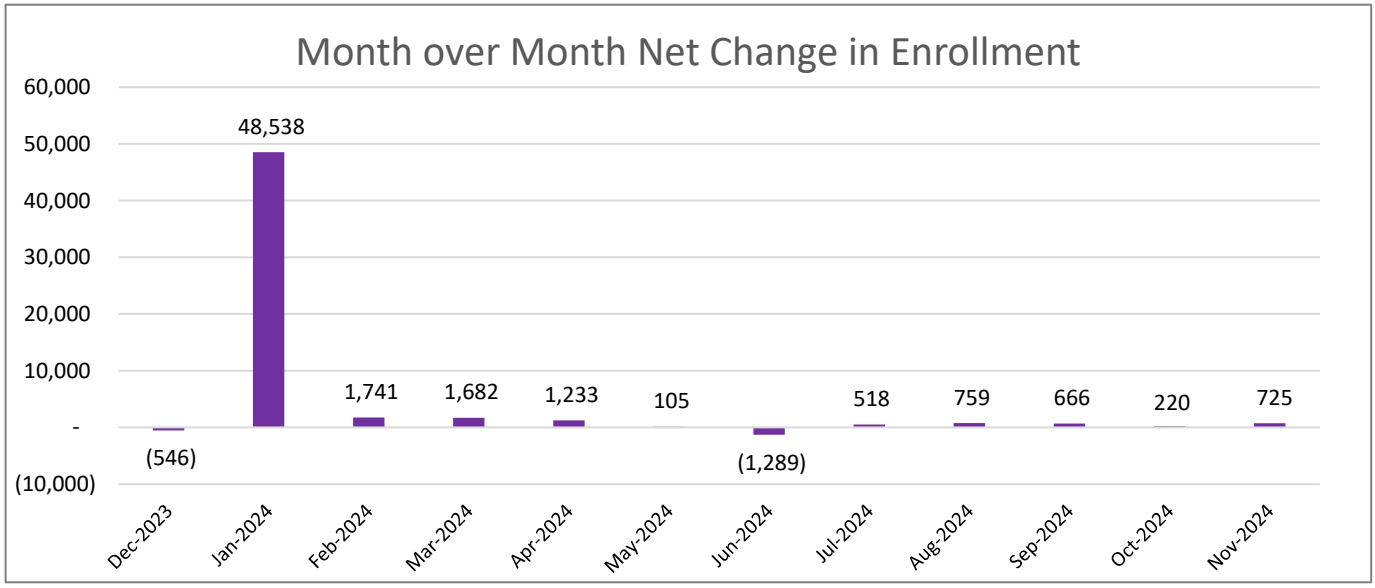








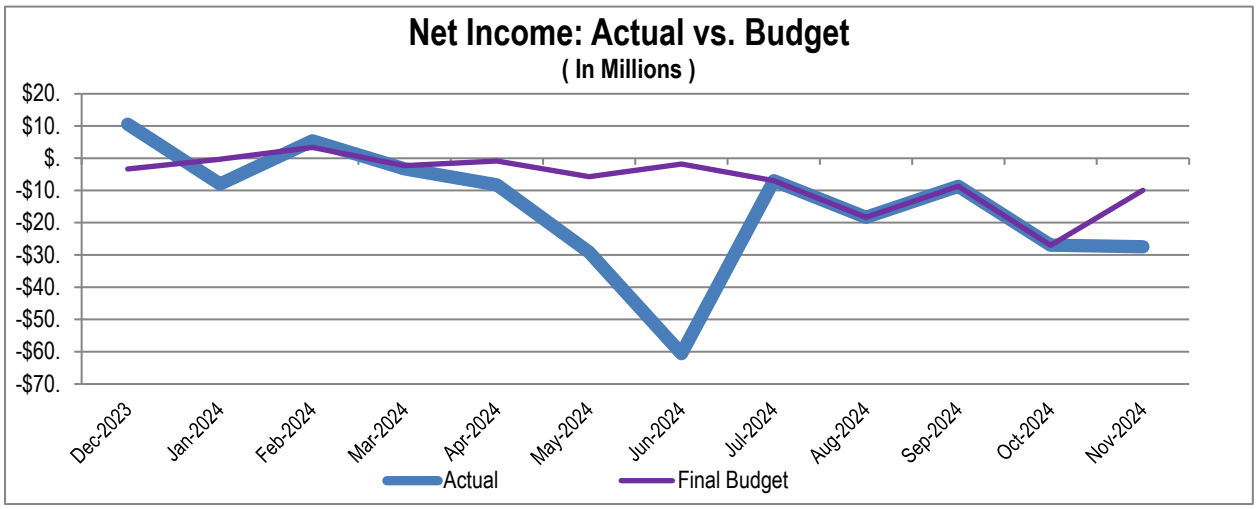




- The Public Health Emergency (PHE) ended May 2023. Disenrollments related to redetermination started July 2023 and ended May 2024. In preparation for the Single Plan Model, effective October 2023 DHCS no longer assigned members to Anthem, and instead new members were assigned to the Alliance.
- In January 2024, enrollment significantly increased due to transition to Single Plan Model and expansion of full scope Medi-Cal to California residents 26-49 regardless of immigration status. Kaiser's transition to a direct contract with the State resulted in a partially offsetting membership reduction.

Net Income

- For the month ended November 30th, 2024:
  - Actual Net Loss $27.5 million.
  - Budgeted Net Loss $10.0 million.
- For the fiscal YTD ended November 30th, 2024:
  - Actual Net Loss $88.5 million.
  - Budgeted Net Loss $71.0 million.

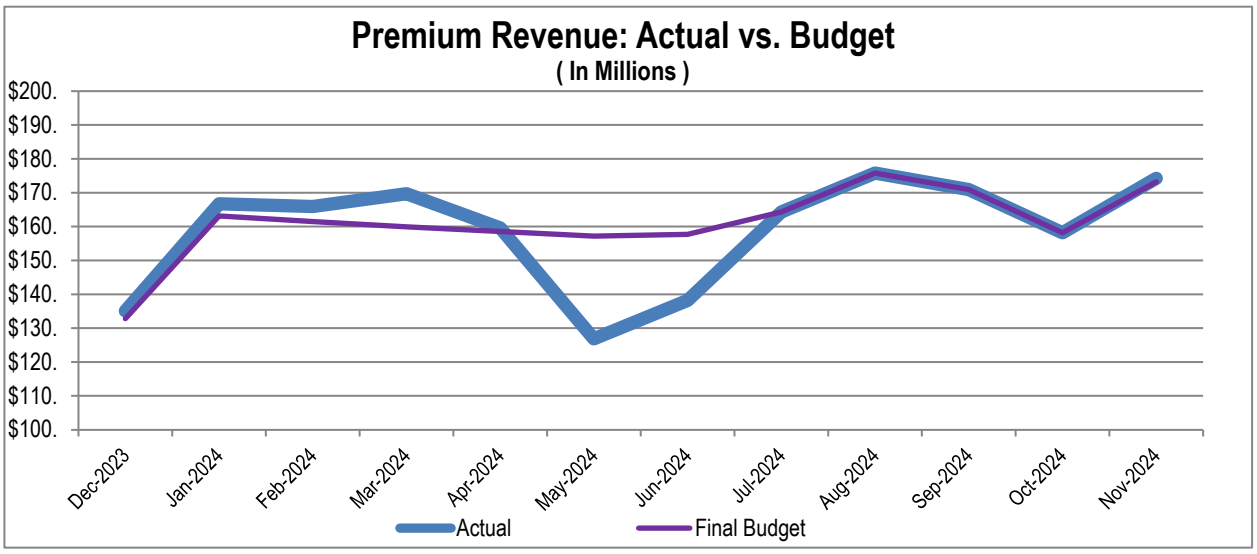


- The unfavorable variance of $17.5 million in the current month is primarily due to:
    - Favorable $1.0 million higher than anticipated Premium Revenue.
    - Favorable $1.2 million lower than anticipated Administrative Expense.
    - Unfavorable $19.8 million higher than anticipated Medical Expense.

Premium Revenue

- For the month ended November 30th, 2024:
    - Actual Revenue: $174.2 million.
    - Budgeted Revenue: $173.2 million.

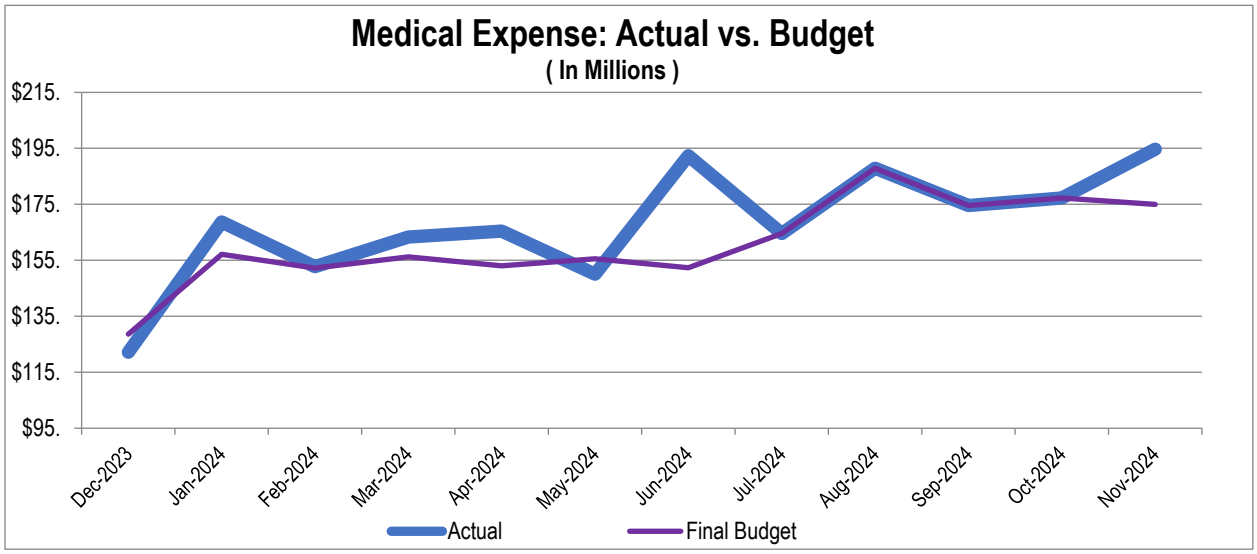
- For the fiscal YTD ended November 30th, 2024:
    - Actual Revenue: $843.5 million
    - Budgeted Revenue: $842.5 million.



- For the month ended November 30th, 2024, the favorable Premium Revenue variance of $1.1 million is primarily due to the following:
    - Favorable retroactive Medi-Cal member months for October 2023 through August 2024.
    - Favorable volume variance for the current month.
    - Partially offset by a reduction in CY2022 Prop 56 revenue via MEP (Medical Expenditure Percentage) reconciliation.

Medical Expense

- For the month ended November 30th, 2024:
    - Actual Medical Expense: $194.7 million.
    - Budgeted Medical Expense: $174.9 million.
- For the fiscal YTD ended November 30th, 2024:
    - Actual Medical Expense: $898.8 million.
    - Budgeted Medical Expense: $879.0 million.



- 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 November, updates to Fee-For-Service (FFS) increased the estimate for prior period unpaid Medical Expenses by $8.5 million. Year to date, the estimate for prior years increased by $4.0 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	$91,414,645	$0	$91,414,645	$89,346,770	($2,067,875)	-2.3%
Primary Care FFS	$13,636,584	$67,913	$13,704,496	$13,156,438	($480,145)	-3.6%
Specialty Care FFS	$41,162,628	$122,741	$41,285,369	$41,241,843	$79,215	0.2%
Outpatient FFS	$62,182,826	$277,046	$62,459,872	$60,764,895	($1,417,931)	-2.3%
Ancillary FFS	$95,729,894	$77,245	$95,807,138	$92,900,588	($2,829,306)	-3.0%
Pharmacy FFS	$69,574,367	$75,079	$69,649,446	$68,740,897	($833,470)	-1.2%
ER Services FFS	$51,782,597	$117,296	$51,899,893	$52,112,987	$330,389	0.6%
Inpatient Hospital & SNF FFS	$275,999,223	$2,695,345	$278,694,568	$267,777,065	($8,222,157)	-3.1%
Long Term Care FFS	$168,110,709	$563,057	$168,673,767	$166,730,694	($1,380,015)	-0.8%
Other Benefits & Services	$24,589,265	$0	$24,589,265	$25,545,610	$956,345	3.7%
Net Reinsurance	$638,482	$0	$638,482	$724,938	$86,456	11.9%
	$894,821,219	**$3,995,722**	**$898,816,941**	**$879,042,725**	**($15,778,495)**	**-1.8%**

Medical Expense - Actual vs. Budget (Per Member Per Month)

Adjusted to Eliminate the Impact of Prior Year IBNP Estimates

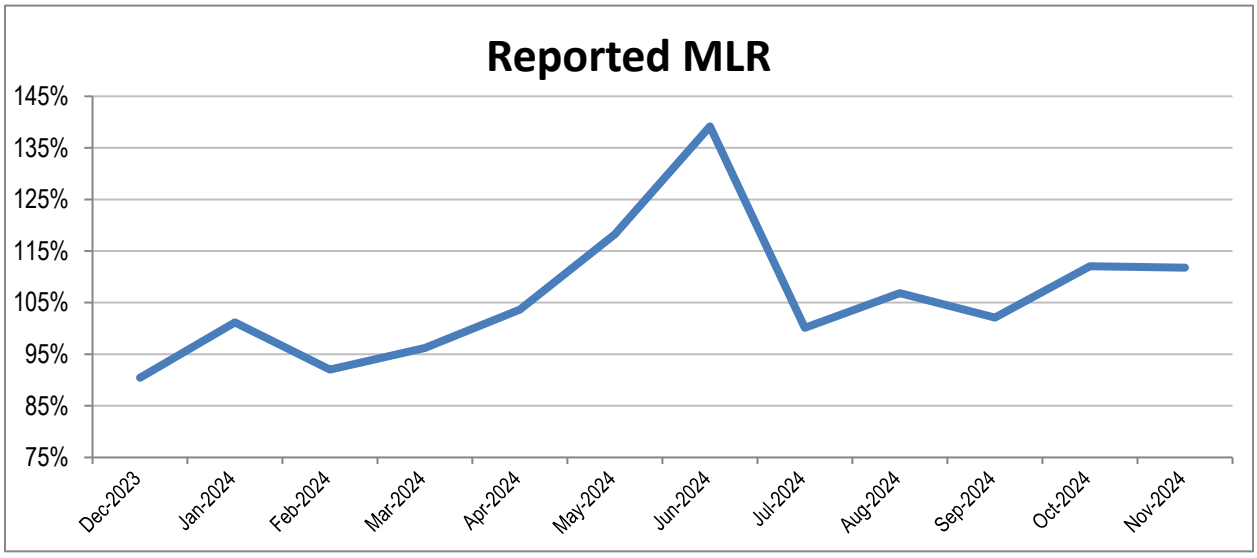
	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$45.06	$0.00	$45.06	$44.05	($1.01)	-2.3%
Primary Care FFS	$6.72	$0.03	$6.76	$6.49	($0.24)	-3.6%
Specialty Care FFS	$20.29	$0.06	$20.35	$20.33	$0.04	0.2%
Outpatient FFS	$30.65	$0.14	$30.79	$29.96	($0.69)	-2.3%
Ancillary FFS	$47.19	$0.04	$47.22	$45.80	($1.39)	-3.0%
Pharmacy FFS	$34.29	$0.04	$34.33	$33.89	($0.40)	-1.2%
ER Services FFS	$25.52	$0.06	$25.58	$25.69	$0.17	0.7%
Inpatient Hospital & SNF FFS	$136.04	$1.33	$137.37	$132.02	($4.03)	-3.1%
Long Term Care FFS	$82.86	$0.28	$83.14	$82.20	($0.67)	-0.8%
Other Benefits & Services	$12.12	$0.00	$12.12	$12.59	$0.47	3.8%
Net Reinsurance	$0.31	$0.00	$0.31	$0.36	$0.04	11.9%
	$441.07	**$1.97**	**$443.04**	**$433.37**	**($7.70)**	**-1.8%**

- Excluding the impact of prior year estimates for IBNP, year-to-date medical expense variance is $15.8 million unfavorable to budget. On a PMPM basis, medical expense is 1.8% unfavorable to budget. For per-member-per-month expense:
    - Capitated Expense is over budget due to inclusion of Targeted Rate Increase (TRI) in capitation payments.
    - Primary Care Expense is over budget due to higher utilization and unit cost in the ACA OE and Child aid code categories.

- Specialty Care Expense is slightly below budget, driven by lower than expected Child and Adult utilization.
- Outpatient Expense is over budget mostly driven by utilization in the SPD, ACA OE, Adult and Group Care populations.
- Ancillary Expense is over budget due to higher Non-Emergency Transportation, lab and radiology, Behavioral Health, Home Health, DME, Medical Supplies and CBAS expense in the Child, SPD and ACA OE aid code categories.
- Pharmacy Expense is above budget due to Non-PBM expense driven by higher utilization in the SPD, Adult and Group Care populations.
- Emergency Room Expense is under budget driven by lower utilization mostly in the Child aid code category.
- Inpatient Expense is over budget driven by higher utilization in the SPD and ACA OE aid code categories.
- Long Term Care Expense is over budget due to higher unit cost in the SPD aid code category.
- Other Benefits & Services is under budget, due to lower than purchased and professional services, community relations, licenses and insurance 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 111.8% for the month and 106.6% for the fiscal year-to-date.



Administrative Expense

- For the month ended November 30th, 2024:
  - Actual Administrative Expense: $9.0 million.
  - Budgeted Administrative Expense: $10.2 million.

- For the fiscal YTD ended November 30th, 2024:
  - Actual Administrative Expense: $48.2 million.
  - Budgeted Administrative Expense: $49.4 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 %**
$5,070,267	$5,423,966	$353,699	6.5%	Employee Expense	$28,101,202	$28,454,900	$353,699	1.2%
77,450	74,865	(2,585)	-3.5%	Medical Benefits Admin Expense	382,305	379,720	(2,585)	-0.7%
2,476,546	2,941,795	465,249	15.8%	Purchased & Professional Services	11,320,663	11,785,912	465,249	3.9%
1,417,485	1,787,123	369,637	20.7%	Other Admin Expense	8,412,386	8,782,024	369,637	4.2%
$9,041,748	$10,227,748	$1,186,000	11.6%	Total Administrative Expense	$48,216,556	$49,402,556	$1,186,000	2.4%

The year-to-date variances include:

- $1.0 million reversal of previously accrued holiday bonus occurred in November 2024.
- Unfavorable Favorable Employee and Temporary Services and delayed training, travel, and other employee-related expenses.
- Favorable in Purchased & Professional Services, primarily for the timing for Consulting Services and Other Purchased Services.
- Favorable Printing/Postage/Promotion and Supplies & Other Expenses.
- Favorable in Licenses, Insurance & Fees - for IT-related Licenses and Subscriptions as well as reduction in Bank Fees and the timing of Insurance Premiums.
- Favorable in Provider Interest, Supplies & Other Expenses.
- Unfavorable Medical Benefit Admin Fees as well as Building Occupancy costs.

The Administrative Loss Ratio (ALR) is 5.2% of net revenue for the month and 5.7% 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 $669,000.

Other Income / (Expense)

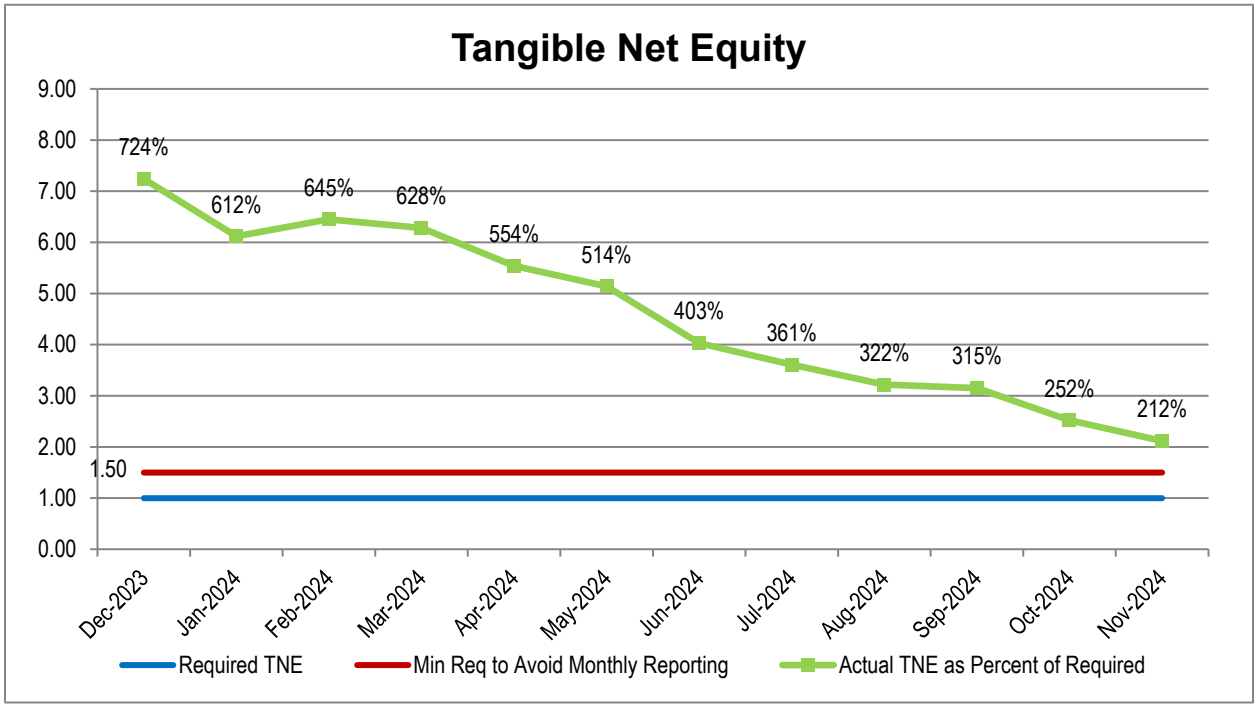
Other Income & Expense is comprised of investment income and claims interest. Fiscal year-to-date net investments show a gain of $15.0 million.

Managed Care Organization (MCO) Provider Tax

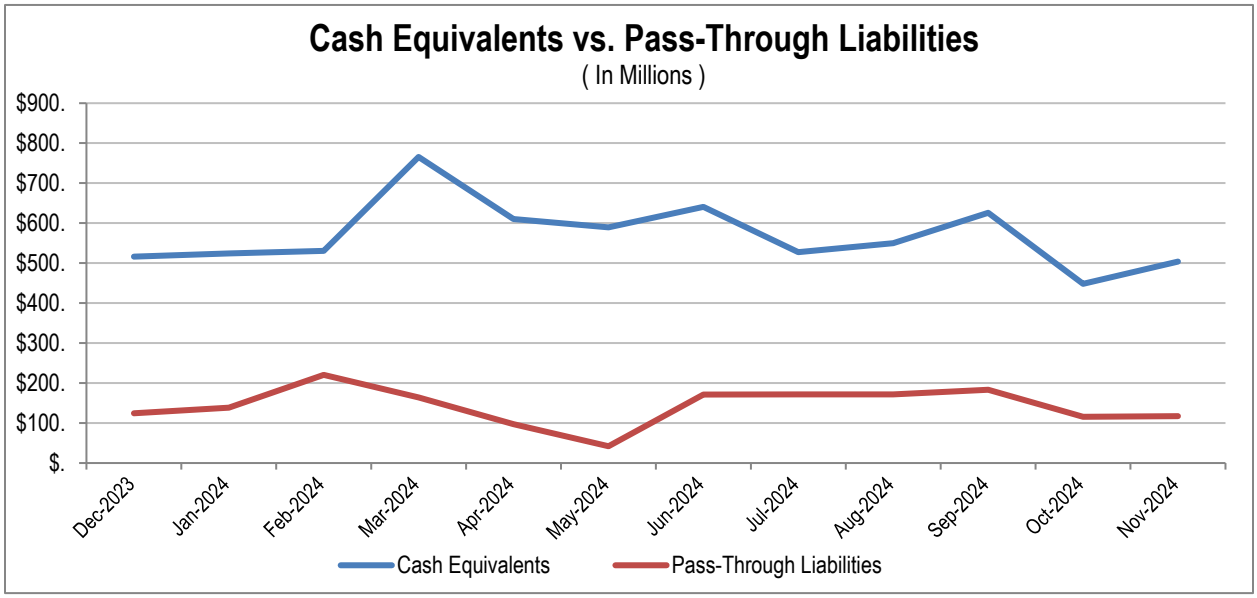
- Revenue:
  - For the month ended November 30th, 2024:
    - Actual: $63.7 million.
    - Budgeted: $63.6 million.
  - For the fiscal YTD ended November 30th, 2024:
    - Actual: $415.4 million.
    - Budgeted: $415.3 million.
- Expense:
  - For the month ended November 30th, 2024:
    - Actual: $63.7 million.
    - Budgeted: $63.6 million.
  - For the fiscal YTD ended November 30th, 2024:
    - Actual: $415.4 million.
    - Budgeted: $415.3 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 $78.9 million
  - Actual TNE $166.9 million
  - Excess TNE $88.0 million
  - TNE % of Required TNE 212%



- To ensure appropriate liquidity and limit risk, the majority of Alliance financial assets are kept in short-term investments.
- Key Metrics
    - Cash & Cash Equivalents $503.4 million
    - Pass-Through Liabilities $117.0 million
    - Uncommitted Cash $386.4 million
    - Working Capital $107.8 million
    - Current Ratio 1.12 (regulatory minimum is 1.00)



Capital Investment

- Fiscal year-to-date capital assets acquired: $530,000.
- Annual capital budget: $1.7 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 NOVEMBER 30, 2024

CURRENT MONTH					FISCAL YEAR TO DATE			
		$ Variance	% Variance				$ Variance	% Variance
Actual	Budget	(Unfavorable)	(Unfavorable)	Account Description	Actual	Budget	(Unfavorable)	(Unfavorable)
				MEMBERSHIP				
401,106	400,746	360	0.1%	1. Medi-Cal	2,000,127	1,999,767	360	0.0%
5,772	5,769	3	0.1%	2. GroupCare	28,612	28,609	3	0.0%
406,878	**406,515**	**363**	**0.1%**	**3. TOTAL MEMBER MONTHS**	**2,028,739**	**2,028,376**	**363**	**0.0%**
				REVENUE				
$174,216,763	$173,204,149	$1,012,614	0.6%	4. Premium Revenue	$843,475,159	$842,462,545	$1,012,614	0.1%
$63,651,511	$63,594,383	$57,128	0.1%	5. MCO Tax Revenue AB119	$415,403,919	$415,346,791	$57,128	0.0%
$237,868,274	**$236,798,532**	**$1,069,742**	**0.5%**	**6. TOTAL REVENUE**	**$1,258,879,078**	**$1,257,809,336**	**$1,069,742**	**0.1%**
				MEDICAL EXPENSES				
				Capitated Medical Expenses				
$19,073,869	$17,005,995	($2,067,875)	(12.2%)	7. Capitated Medical Expense	$91,414,645	$89,346,770	($2,067,875)	(2.3%)
				Fee for Service Medical Expenses				
$62,101,789	$51,184,287	($10,917,502)	(21.3%)	8. Inpatient Hospital Expense	$278,694,568	$267,777,065	($10,917,502)	(4.1%)
$5,079,679	$4,531,621	($548,058)	(12.1%)	9. Primary Care Physician Expense	$13,704,496	$13,156,438	($548,058)	(4.2%)
$8,108,321	$8,064,795	($43,526)	(0.5%)	10. Specialty Care Physician Expense	$41,285,369	$41,241,843	($43,526)	(0.1%)
$21,248,937	$18,342,387	($2,906,550)	(15.8%)	11. Ancillary Medical Expense	$95,807,138	$92,900,588	($2,906,550)	(3.1%)
$13,137,113	$11,442,136	($1,694,977)	(14.8%)	12. Outpatient Medical Expense	$62,459,872	$60,764,895	($1,694,977)	(2.8%)
$9,967,647	$10,180,741	$213,093	2.1%	13. Emergency Expense	$51,899,893	$52,112,987	$213,093	0.4%
$12,967,007	$12,058,459	($908,549)	(7.5%)	14. Pharmacy Expense	$69,649,446	$68,740,897	($908,549)	(1.3%)
$34,383,314	$32,440,241	($1,943,073)	(6.0%)	15. Long Term Care Expense	$168,673,767	$166,730,694	($1,943,073)	(1.2%)
$166,993,808	$148,244,666	($18,749,142)	(12.6%)	16. Total Fee for Service Expense	$782,174,549	$763,425,407	($18,749,142)	(2.5%)
$8,284,077	$9,240,422	$956,345	10.3%	17. Other Benefits & Services	$24,589,265	$25,545,610	$956,345	3.7%
$352,844	$439,300	$86,456	19.7%	18. Reinsurance Expense	$638,482	$724,938	$86,456	11.9%
$194,704,598	**$174,930,382**	**($19,774,216)**	**(11.3%)**	**20. TOTAL MEDICAL EXPENSES**	**$898,816,941**	**$879,042,725**	**($19,774,216)**	**(2.2%)**
$43,163,676	**$61,868,150**	**($18,704,474)**	**(30.2%)**	**21. GROSS MARGIN**	**$360,062,137**	**$378,766,611**	**($18,704,474)**	**(4.9%)**
				ADMINISTRATIVE EXPENSES				
$5,070,267	$5,423,966	$353,699	6.5%	22. Personnel Expense	$28,101,202	$28,454,900	$353,699	1.2%
$77,450	$74,865	($2,585)	(3.5%)	23. Benefits Administration Expense	$382,305	$379,720	($2,585)	(0.7%)
$2,476,546	$2,941,795	$465,249	15.8%	24. Purchased & Professional Services	$11,320,663	$11,785,912	$465,249	3.9%
$1,417,485	$1,787,123	$369,637	20.7%	25. Other Administrative Expense	$8,412,386	$8,782,024	$369,637	4.2%
$9,041,748	**$10,227,748**	**$1,186,000**	**11.6%**	**26. TOTAL ADMINISTRATIVE EXPENSES**	**$48,216,556**	**$49,402,556**	**$1,186,000**	**2.4%**
$63,651,511	**$63,594,383**	**($57,128)**	**(0.1%)**	**27. MCO TAX EXPENSES**	**$415,403,919**	**$415,346,791**	**($57,128)**	**(0.0%)**
($29,529,583)	**($11,953,981)**	**($17,575,602)**	**(147.0%)**	**28. NET OPERATING INCOME / (LOSS)**	**($103,558,338)**	**($85,982,736)**	**($17,575,602)**	**(20.4%)**
				OTHER INCOME / EXPENSES				
$2,059,321	**$2,000,000**	**$59,321**	**3.0%**	**29. TOTAL OTHER INCOME / (EXPENSES)**	**$15,040,323**	**$14,981,002**	**$59,321**	**0.4%**
($27,470,263)	**($9,953,981)**	**($17,516,282)**	**(176.0%)**	**30. NET SURPLUS (DEFICIT)**	**($88,518,015)**	**($71,001,734)**	**($17,516,282)**	**(24.7%)**
$174,216,763	**$173,204,149**	**$1,012,614**	**0.6%**	**4. TOTAL REVENUE EXCLUDES MCO TAX RE**	**$843,475,159**	**$842,462,545**	**$1,012,614**	**0.1%**
$194,704,598	**$174,930,382**	**($19,774,216)**	**(11.3%)**	**18. TOTAL MEDICAL EXPENSES**	**$898,816,941**	**$879,042,725**	**($19,774,216)**	**(2.2%)**
111.76%	101.00%	-10.76%	-10.70%	31. Medical Loss Ratio	106.56%	104.34%	-2.22%	-2.10%
5.19%	5.91%	0.72%	12.20%	32. Administrative Expense Ratio	5.72%	5.86%	0.14%	2.40%
-11.55%	-4.20%	-7.35%	-175.00%	33. Net Surplus (Deficit) Ratio	-7.03%	-5.64%	-1.39%	-24.60%

ALAMEDA ALLIANCE FOR HEALTH
BALANCE SHEETS
CURRENT MONTH VS. PRIOR MONTH
FOR THE MONTH AND FISCAL YTD ENDED NOVEMBER 30, 2024

	11/30/2024	10/31/2024	Difference	% Difference
CURRENT ASSETS				
Cash and Cash Equivalent				
Cash	$21,075,966	$8,277,790	$12,798,176	154.61%
CNB Short-Term Investment	482,278,187	439,944,665	42,333,522	9.62%
Interest Receivable	4,717,269	5,190,880	(473,612)	-9.12%
Premium Receivables	496,737,349	476,503,745	20,233,604	4.25%
Reinsurance Recovery Receivable	7,263,899	6,581,946	681,953	10.36%
Other Receivables	1,171,706	4,916,251	(3,744,545)	-76.17%
Prepaid Expenses	749,760	788,964	(39,204)	-4.97%
TOTAL CURRENT ASSETS	**1,013,994,135**	**942,204,241**	**71,789,894**	**7.62%**
OTHER ASSETS				
CNB Long-Term Investment	44,162,073	44,106,913	55,161	0.13%
CalPERS Net Pension Asset	(6,144,132)	(6,144,132)	0	0.00%
Deferred Outflow	14,319,532	14,319,532	0	0.00%
Restricted Asset-Bank Note	350,000	350,000	0	0.00%
GASB 87-Lease Assets (Net)	477,356	543,269	(65,913)	-12.13%
GASB 96-SBITA Assets (Net)	3,886,019	3,563,561	322,458	9.05%
TOTAL OTHER ASSETS	**57,050,848**	**56,739,142**	**311,705**	**0.55%**
PROPERTY AND EQUIPMENT				
Land, Building & Improvements	9,842,648	9,842,648	0	0.00%
Furniture And Equipment	13,071,003	13,071,003	0	0.00%
Leasehold Improvement	902,447	902,447	0	0.00%
Internally Developed Software	14,824,002	14,824,002	0	0.00%
Fixed Assets at Cost	38,640,099	38,640,099	0	0.00%
Less: Accumulated Depreciation	(32,960,005)	(32,900,631)	(59,373)	0.18%
PROPERTY AND EQUIPMENT (NET)	**5,680,094**	**5,739,467**	**(59,373)**	**-1.03%**
TOTAL ASSETS	**1,076,725,077**	**1,004,682,851**	**72,042,226**	**7.17%**
CURRENT LIABILITIES				
Trade Accounts Payable	8,805,061	7,057,073	1,747,988	24.77%
Incurred But Not Reported Claims	329,821,855	300,812,101	29,009,755	9.64%
Other Medical Liabilities	116,406,026	109,795,018	6,611,008	6.02%
Pass-Through Liabilities	116,963,192	115,603,841	1,359,351	1.18%
MCO Tax Liabilities	324,249,751	260,598,240	63,651,511	24.43%
GASB 87 and 96 ST Liabilities	2,923,836	2,425,565	498,270	20.54%
Payroll Liabilities	6,996,340	10,358,458	(3,362,119)	-32.46%
TOTAL CURRENT LIABILITIES	**906,166,061**	**806,650,296**	**99,515,764**	**12.34%**
LONG TERM LIABILITIES				
GASB 87 and 96 LT Liabilities	374,358	377,634	(3,276)	-0.87%
Deferred Inflow	3,327,530	3,327,530	0	0.00%
TOTAL LONG TERM LIABILITIES	**3,701,888**	**3,705,163**	**(3,276)**	**-0.09%**
TOTAL LIABILITIES	**909,867,948**	**810,355,460**	**99,512,489**	**12.28%**
NET WORTH				
Contributed Capital	840,233	840,233	0	0.00%
Restricted & Unrestricted Funds	254,534,911	254,534,911	0	0.00%
Year-To-Date Net Surplus (Deficit)	(88,518,015)	(61,047,753)	(27,470,263)	45.00%
TOTAL NET WORTH	**166,857,128**	**194,327,391**	**(27,470,263)**	**-14.14%**
TOTAL LIABILITIES AND NET WORTH	**1,076,725,077**	**1,004,682,851**	**72,042,226**	**7.17%**
Cash Equivalents	503,354,153	448,222,455	55,131,698	12.30%
Pass-Through	116,963,192	115,603,841	1,359,351	1.18%
Uncommitted Cash	386,390,961	332,618,614	53,772,347	16.17%
Working Capital	107,828,074	135,553,945	(27,725,870)	-20.45%
Current Ratio	111.9%	116.8%	-4.9%	-4.2%

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED **November 30, 2024**

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM OPERATING ACTIVITIES				
Commercial Premium Cash Flows				
Commercial Premium Revenue	$3,156,099	$9,436,688	$18,235,947	$15,648,482
GroupCare Receivable	(3,156,049)	(3,122,333)	(3,679,416)	(6,216,586)
Total	50	6,314,355	14,556,531	9,431,896
Medi-Cal Premium Cash Flows				
Medi-Cal Revenue	234,712,174	815,355,588	1,493,575,877	1,243,230,597
Premium Receivable	(17,077,555)	(120,219,288)	(330,722,958)	(123,577,243)
Total	217,634,619	695,136,300	1,162,852,919	1,119,653,354
Investment & Other Income Cash Flows				
Other Revenues	611,567	835,780	1,864,046	2,092,973
Interest Income	1,460,317	7,055,228	16,360,614	13,008,335
Interest Receivable	473,612	(356,526)	(3,190,395)	(2,801,205)
Total	2,545,496	7,534,482	15,034,265	12,300,103
Medical & Hospital Cash Flows				
Total Medical Expenses	(194,704,597)	(546,450,071)	(1,091,134,224)	(898,816,946)
Other Health Care Receivables	3,060,850	1,866,270	2,158,346	2,525,100
Capitation Payable	-	-	-	-
IBNP Payable	29,009,755	22,465,358	84,134,362	33,517,597
Other Medical Payable	7,970,358	(89,446,002)	56,321,245	(102,471,538)
Risk Share Payable	-	(2,680,192)	(2,680,192)	(2,680,192)
New Health Program Payable	-	-	-	-
Total	(154,663,634)	(614,244,637)	(951,200,463)	(967,925,979)
Administrative Cash Flows				
Total Administrative Expenses	(9,054,311)	(27,944,518)	(57,875,804)	(48,277,540)
Prepaid Expenses	39,205	(493,588)	194,809	(511,143)
Other Receivables	1,742	7,157	(64,442)	33,837
CalPERS Pension	-	-	637,208	-
Trade Accounts Payable	1,747,988	2,851,486	2,012,691	2,314,765
Payroll Liabilities	(3,362,120)	(1,369,222)	(2,870,607)	(1,102,886)
GASB Assets and Liabilities	238,450	(568,304)	(383,360)	(563,696)
Depreciation Expense	59,373	183,004	347,879	297,332
Total	(10,329,673)	(27,333,985)	(58,001,626)	(47,809,331)
MCO Tax AB119 Cash Flows				
MCO Tax Expense AB119	(63,651,511)	(321,462,528)	(530,158,499)	(415,403,919)
MCO Tax Liabilities	63,651,511	195,993,778	279,207,500	164,466,237
Total	0	(125,468,750)	(250,950,999)	(250,937,682)
Net Cash Flows from Operating Activities	**55,186,858**	**(58,062,235)**	**(67,709,373)**	**(125,287,639)**

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED **November 30, 2024**

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM INVESTING ACTIVITIES				
Investment Cash Flows				
Long Term Investments	(55,161)	12,014,083	(17,413,405)	(11,169,824)
Total	(55,161)	12,014,083	(17,413,405)	(11,169,824)
Restricted Cash & Other Asset Cash Flows				
Restricted Assets-Treasury Account	-	-	-	-
Total	-	-	-	-
Fixed Asset Cash Flows				
Fixed Asset Acquisitions	-	-	(528,457)	(529,610)
Purchases of Property and Equipment	-	-	(528,457)	(529,610)
Net Cash Flows from Investing Activities	**(55,161)**	**12,014,083**	**(17,941,862)**	**(11,699,434)**
Net Change in Cash	**55,131,697**	**(46,048,152)**	**(85,651,235)**	**(136,987,073)**
Rounding	-	-	-	-
Cash @ Beginning of Period	448,222,456	549,402,305	589,005,388	640,341,226
Cash @ End of Period	**$503,354,153**	**$503,354,153**	**$503,354,153**	**$503,354,153**
Variance	-	-	-	-

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED **November 30, 2024**

	MONTH	3 MONTHS	6 MONTHS	YTD
NET INCOME RECONCILIATION				
Net Income / (Loss)	($27,470,262)	($63,173,833)	($149,132,044)	($88,518,018)
Add back: Depreciation & Amortization	59,373	183,004	347,879	297,332
Receivables				
Premiums Receivable	(17,077,555)	(120,219,288)	(330,722,958)	(123,577,243)
Interest Receivable	473,612	(356,526)	(3,190,395)	(2,801,205)
Other Health Care Receivables	3,060,850	1,866,270	2,158,346	2,525,100
Other Receivables	1,742	7,157	(64,442)	33,837
GroupCare Receivable	(3,156,049)	(3,122,333)	(3,679,416)	(6,216,586)
Total	(16,697,400)	(121,824,720)	(335,498,865)	(130,036,097)
Prepaid Expenses	39,205	(493,588)	194,809	(511,143)
Trade Payables	1,747,988	2,851,486	2,012,691	2,314,765
Claims Payable and Shared Risk Pool				
IBNP Payable	29,009,755	22,465,358	84,134,362	33,517,597
Capitation Payable & Other Medical Payable	7,970,358	(89,446,002)	56,321,245	(102,471,538)
Risk Share Payable	-	(2,680,192.00)	(2,680,192)	(2,680,192)
Claims Payable				
Total	36,980,113	(69,660,836)	137,775,415	(71,634,133)
Other Liabilities				
CalPERS Pension	-	-	637,208.00	-
Payroll Liabilities	(3,362,120)	(1,369,222)	(2,870,606)	(1,102,886)
GASB Assets and Liabilities	238,450	(568,304)	(383,360)	(563,696)
New Health Program	-	-	-	-
MCO Tax Liabilities	63,651,511	195,993,778	279,207,500	164,466,237
Total	60,527,841	194,056,252	276,590,742	162,799,655
Rounding	-	-	-	-
Cash Flows from Operating Activities	**55,186,858**	**(58,062,235)**	**(67,709,373)**	**(125,287,639)**
Variance	-	-	-	-

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED **November 30, 2024**

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOW STATEMENT:				
Cash Flows from Operating Activities:				
Cash Received				
Capitation Received from State of CA	$217,634,619	$695,136,300	$1,162,852,919	$1,119,653,354
Medicare Revenue	$0	$0	$0	$0
GroupCare Premium Revenue	50	6,314,355	14,556,531	9,431,896
Other Income	611,567	835,780	1,864,046	2,092,973
Interest Income	1,933,929	6,698,702	13,170,219	10,207,130
Less Cash Paid				
Medical Expenses	(154,663,634)	(614,244,637)	(951,200,463)	(967,925,979)
Vendor & Employee Expenses	(10,329,673)	(27,333,985)	(58,001,626)	(47,809,331)
MCO Tax Expense AB119	0	(125,468,750)	(250,950,999)	(250,937,682)
Net Cash Flows from Operating Activities	**55,186,858**	**(58,062,235)**	**(67,709,373)**	**(125,287,639)**
Cash Flows from Investing Activities:				
Long Term Investments	(55,161)	12,014,083	(17,413,405)	(11,169,824)
Restricted Assets-Treasury Account	0	0	0	0
Purchases of Property and Equipment	0	0	(528,457)	(529,610)
Net Cash Flows from Investing Activities	**(55,161)**	**12,014,083**	**(17,941,862)**	**(11,699,434)**
Net Change in Cash	**55,131,697**	**(46,048,152)**	**(85,651,235)**	**(136,987,073)**
Rounding	-	-	-	-
Cash @ Beginning of Period	448,222,456	549,402,305	589,005,388	640,341,226
Cash @ End of Period	**$503,354,153**	**$503,354,153**	**$503,354,153**	**$503,354,153**
Variance	$0	-	-	-
RECONCILIATION OF NET INCOME TO NET CASH FLOW FROM OPERATING ACTIVITIES:				
Net Income / (Loss)	($27,470,262)	($63,173,832)	($149,132,045)	($88,518,018)
Add Back: Depreciation	59,373	183,004	347,879	297,332
Net Change in Operating Assets & Liabilities				
Premium & Other Receivables	(16,697,400)	(121,824,720)	(335,498,865)	(130,036,097)
Prepaid Expenses	39,205	(493,589)	194,810	(511,143)
Trade Payables	1,747,988	2,851,486	2,012,691	2,314,765
Claims Payable, IBNP and Risk Sharing	36,980,113	(69,660,836)	137,775,415	(71,634,133)
Deferred Revenue	0	0	0	0
Other Liabilities	60,527,841	194,056,252	276,590,742	162,799,655
Total	55,186,858	(58,062,235)	(67,709,373)	(125,287,639)
Rounding	-	-	-	-
Cash Flows from Operating Activities	**$55,186,858**	**($58,062,235)**	**($67,709,373)**	**($125,287,639)**
Variance	$0	-	-	-

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE MONTH OF NOVEMBER 2024

	Medi-Cal Child	Medi-Cal Adult	Medi-Cal SPD	Medi-Cal ACA OE	Medi-Cal Duals	Medi-Cal LTC	Medi-Cal LTC Duals	Medi-Cal Total	Group Care	Medicare	Grand Total
Enrollments/Member Months	109,561	62,502	35,603	151,559	40,357	255	1,269	401,106	5,772	-	406,878
Revenue	$33,682,198	$32,721,612	$49,859,641	$82,934,361	$21,296,294	$2,951,231	$11,266,838	$234,712,175	$3,156,099	$0	$237,868,274
Medical Expense	$15,030,698	$23,642,874	$56,296,108	$65,319,095	$16,892,784	$3,409,896	$11,307,398	$191,898,853	$2,784,395	$21,350	$194,704,598
Gross Margin	$18,651,500	$9,078,738	($6,436,467)	$17,615,266	$4,403,509	($458,665)	($40,559)	$42,813,322	$371,704	($21,350)	$43,163,676
Administrative Expense	$466,825	$1,100,842	$2,319,566	$2,945,434	$812,065	$164,633	$760,707	$8,570,071	$143,855	$327,822	$9,041,748
MCO Tax Expense	$17,386,235	$9,918,442	$5,649,840	$24,050,898	$6,404,252	$40,466	$201,378	$63,651,511	$0	$0	$63,651,511
Operating Income / (Expense)	$798,439	($1,940,546)	($14,405,873)	($9,381,065)	($2,812,808)	($663,764)	($1,002,644)	($29,408,261)	$227,849	($349,172)	($29,529,583)
Other Income / (Expense)	$104,140	$257,930	$553,545	$704,102	$189,210	$39,827	$183,053	$2,031,808	$27,513	$0	$2,059,321
Net Income / (Loss)	$902,579	($1,682,616)	($13,852,328)	($8,676,963)	($2,623,598)	($623,937)	($819,591)	($27,376,452)	$255,362	($349,172)	($27,470,263)
PMPM Metrics:											
Revenue PMPM	$307.43	$523.53	$1,400.43	$547.21	$527.70	$11,573.45	$8,878.52	$585.16	$546.79	$0.00	$584.62
Medical Expense PMPM	$137.19	$378.27	$1,581.22	$430.98	$418.58	$13,372.14	$8,910.48	$478.42	$482.40	$0.00	$478.53
Gross Margin PMPM	$170.24	$145.26	($180.78)	$116.23	$109.11	($1,798.69)	($31.96)	$106.74	$64.40	$0.00	$106.09
Administrative Expense PMPM	$4.26	$17.61	$65.15	$19.43	$20.12	$645.62	$599.45	$21.37	$24.92	$0.00	$22.22
MCO Tax Expense PMPM	$158.69	$158.69	$158.69	$158.69	$158.69	$158.69	$158.69	$158.69	$0.00	$0.00	$156.44
Operating Income / (Expense) PMPM	$7.29	($31.05)	($404.63)	($61.90)	($69.70)	($2,603.00)	($790.11)	($73.32)	$39.47	$0.00	($72.58)
Other Income / (Expense) PMPM	$0.95	$4.13	$15.55	$4.65	$4.69	$156.19	$144.25	$5.07	$4.77	$0.00	$5.06
Net Income / (Loss) PMPM	$8.24	($26.92)	($389.08)	($57.25)	($65.01)	($2,446.81)	($645.86)	($68.25)	$44.24	$0.00	($67.51)
Ratio:											
Medical Loss Ratio	92.2%	103.7%	127.3%	110.9%	113.4%	117.1%	102.2%	112.2%	88.2%	0.0%	111.8%
Administrative Expense Ratio	2.9%	4.8%	5.2%	5.0%	5.5%	5.7%	6.9%	5.0%	4.6%	0.0%	5.2%
Net Income Ratio	2.7%	-5.1%	-27.8%	-10.5%	-12.3%	-21.1%	-7.3%	-11.7%	8.1%	0.0%	-11.5%

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE FISCAL YEAR TO DATE NOVEMBER 2024

	Medi-Cal Child	Medi-Cal Adult	Medi-Cal SPD	Medi-Cal ACA OE	Medi-Cal Duals	Medi-Cal LTC	Medi-Cal LTC Duals	Medi-Cal Total	Group Care	Medicare	Grand Total
Enrollments/Member Months	548,689	312,979	176,505	753,945	200,541	1,192	6,276	2,000,127	28,612	-	2,028,739
Revenue	$189,348,096	$174,265,900	$251,899,555	$443,271,098	$117,128,555	$12,970,703	$54,346,689	$1,243,230,596	$15,648,482	$0	$1,258,879,078
Medical Expense	$65,557,998	$105,111,531	$249,446,519	$314,787,101	$79,731,208	$14,661,535	$54,440,035	$883,735,927	$15,012,089	$68,926	$898,816,941
Gross Margin	$123,790,098	$69,154,369	$2,453,036	$128,483,997	$37,397,346	($1,690,832)	($93,345)	$359,494,669	$636,394	($68,926)	$360,062,137
Administrative Expense	$2,391,888	$5,691,951	$12,170,748	$15,437,943	$4,224,168	$864,607	$4,015,820	$44,797,125	$738,444	$2,680,987	$48,216,556
MCO Tax Expense	$114,204,555	$65,243,636	$36,609,507	$156,095,446	$41,690,992	$243,318	$1,316,465	$415,403,919	$0	$0	$415,403,919
Operating Income / (Expense)	$7,193,654	($1,781,218)	($46,327,220)	($43,049,392)	($8,517,813)	($2,798,757)	($5,425,630)	($100,706,375)	($102,051)	($2,749,913)	($103,558,338)
Other Income / (Expense)	$760,539	$1,884,673	$4,042,571	$5,142,096	$1,381,813	$290,861	$1,336,846	$14,839,397	$200,925	$0	$15,040,323
Net Income / (Loss)	$7,954,193	$103,455	($42,284,649)	($37,907,296)	($7,136,000)	($2,507,897)	($4,088,784)	($85,866,978)	$98,875	($2,749,913)	($88,518,015)
PMPM Metrics:											
Revenue PMPM	$345.09	$556.80	$1,427.15	$587.94	$584.06	$10,881.46	$8,659.45	$621.58	$546.92	$0.00	$620.52
Medical Expense PMPM	$119.48	$335.84	$1,413.25	$417.52	$397.58	$12,299.95	$8,674.32	$441.84	$524.68	$0.00	$443.04
Gross Margin PMPM	$225.61	$220.96	$13.90	$170.42	$186.48	($1,418.48)	($14.87)	$179.74	$22.24	$0.00	$177.48
Administrative Expense PMPM	$4.36	$18.19	$68.95	$20.48	$21.06	$725.34	$639.87	$22.40	$25.81	$0.00	$23.77
MCO Tax Expense PMPM	$208.14	$208.46	$207.41	$207.04	$207.89	$204.13	$209.76	$207.69	$0.00	$0.00	$204.76
Operating Income / (Expense) PMPM	$13.11	($5.69)	($262.47)	($57.10)	($42.47)	($2,347.95)	($864.50)	($50.35)	($3.57)	$0.00	($51.05)
Other Income / (Expense) PMPM	$1.39	$6.02	$22.90	$6.82	$6.89	$244.01	$213.01	$7.42	$7.02	$0.00	$7.41
Net Income / (Loss) PMPM	$14.50	$0.33	($239.57)	($50.28)	($35.58)	($2,103.94)	($651.50)	($42.93)	$3.46	$0.00	($43.63)
Ratio:											
Medical Loss Ratio	87.2%	96.4%	115.9%	109.6%	105.7%	115.2%	102.7%	106.8%	95.9%	0.0%	106.6%
Administrative Expense Ratio	3.2%	5.2%	5.7%	5.4%	5.6%	6.8%	7.6%	5.4%	4.7%	0.0%	5.7%
Net Income Ratio	4.2%	0.1%	-16.8%	-8.6%	-6.1%	-19.3%	-7.5%	-6.9%	0.6%	0.0%	-7.0%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED November 30, 2024

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)				
$5,070,267	$5,423,966	$353,699	6.5%	Personnel Expenses	$28,101,202	$28,454,900	$353,699	1.2%
$77,450	$74,865	($2,585)	(3.5%)	Benefits Administration Expense	$382,305	$379,720	($2,585)	(0.7%)
$2,476,546	$2,941,795	$465,249	15.8%	Purchased & Professional Services	$11,320,663	$11,785,912	$465,249	3.9%
$659,854	$598,355	($61,498)	(10.3%)	Occupancy	$2,644,152	$2,582,654	($61,498)	(2.4%)
$436,324	$846,394	$410,070	48.4%	Printing Postage & Promotion	$1,967,363	$2,377,433	$410,070	17.2%
$149,188	$156,013	$6,826	4.4%	Licenses Insurance & Fees	$2,862,191	$2,869,016	$6,826	0.2%
$172,119	$186,360	$14,241	7.6%	Other Administrative Expense	$938,680	$952,920	$14,241	1.5%
$3,971,481	$4,803,783	$832,302	17.3%	Total Other Administrative Expenses (excludes Personnel Expenses)	$20,115,354	$20,947,656	$832,301	4.0%
$9,041,748	$10,227,748	$1,186,000	11.6%	Total Administrative Expenses	$48,216,556	$49,402,556	$1,186,000	2.4%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED November 30, 2024

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
3,780,664	3,101,566	(679,098)	(21.9%)	Salaries & Wages	18,831,363	18,152,266	(679,098)	(3.7%)
291,980	519,802	227,823	43.8%	Paid Time Off	1,652,878	1,880,701	227,823	12.1%
5,950	7,755	1,805	23.3%	Compensated Incentives	11,739	13,544	1,805	13.3%
0	400,000	400,000	100.0%	Severence	0	400,000	400,000	100.0%
60,244	86,386	26,142	30.3%	Payroll Taxes	307,199	333,342	26,142	7.8%
42,512	25,460	(17,052)	(67.0%)	Overtime	357,131	340,079	(17,052)	(5.0%)
287,994	425,572	137,578	32.3%	CalPERS ER Match	1,570,027	1,707,605	137,578	8.1%
1,014,300	694,629	(319,672)	(46.0%)	Employee Benefits	4,846,496	4,526,825	(319,672)	(7.1%)
(1,380)	0	1,380	0.0%	Personal Floating Holiday	2,513	3,894	1,380	35.4%
17,823	56,250	38,427	68.3%	Language Pay	103,832	142,259	38,427	27.0%
(1,260)	0	1,260	0.0%	Med Ins Opted Out Stipend	14,750	16,010	1,260	7.9%
(648,810)	(248,810)	400,000	(160.8%)	Holiday Bonus	(400,000)	0	400,000	1,333,333,4…
121,928	0	(121,928)	0.0%	Sick Leave	392,656	270,728	(121,928)	(45.0%)
3,535	56,772	53,237	93.8%	Compensated Employee Relations	3,619	56,856	53,237	93.6%
20,280	25,150	4,870	19.4%	Work from Home Stipend	99,250	104,120	4,870	4.7%
759	11,733	10,974	93.5%	Mileage, Parking & LocalTravel	5,750	16,725	10,974	65.6%
2,527	38,958	36,430	93.5%	Travel & Lodging	14,844	51,274	36,430	71.0%
48,936	101,365	52,429	51.7%	Temporary Help Services	161,580	214,010	52,429	24.5%
15,959	100,737	84,778	84.2%	Staff Development/Training	59,217	143,995	84,778	58.9%
6,328	20,641	14,313	69.3%	Staff Recruitment/Advertisement	66,356	80,669	14,313	17.7%
5,070,267	**5,423,966**	**353,699**	**6.5%**	**Personnel Expense**	**28,101,202**	**28,454,900**	**353,699**	**1.2%**
24,843	22,018	(2,825)	(12.8%)	Pharmacy Administrative Fees	119,976	117,150	(2,825)	(2.4%)
52,607	52,847	240	0.5%	Telemedicine Admin. Fees	262,330	262,570	240	0.1%
77,450	**74,865**	**(2,585)**	**(3.5%)**	**Benefits Administration Expense**	**382,305**	**379,720**	**(2,585)**	**(0.7%)**
498,557	864,314	365,756	42.3%	Consultant Fees - Non Medical	2,977,681	3,343,438	365,756	10.9%
843,857	552,142	(291,715)	(52.8%)	Computer Support Services	2,912,527	2,620,812	(291,715)	(11.1%)
12,500	15,000	2,500	16.7%	Audit Fees	80,658	83,158	2,500	3.0%
16,350	17	(16,333)	(97,980.4%)	Consultant Fees - Medical	995	(15,338)	(16,333)	106.5%
235,717	280,157	44,440	15.9%	Other Purchased Services	1,253,169	1,297,610	44,440	3.4%
0	1,688	1,688	100.0%	Maint.&Repair-Office Equipment	0	1,688	1,688	100.0%
111,801	70,067	(41,734)	(59.6%)	Legal Fees	443,086	401,352	(41,734)	(10.4%)
0	0	0	0.0%	Member Health Education	320	320	0	0.0%
27,179	26,000	(1,179)	(4.5%)	Translation Services	114,242	113,064	(1,179)	(1.0%)
193,627	177,300	(16,327)	(9.2%)	Medical Refund Recovery Fees	1,308,998	1,292,671	(16,327)	(1.3%)
467,416	724,809	257,392	35.5%	Software - IT Licenses & Subsc	1,814,273	2,071,665	257,392	12.4%
22,313	181,602	159,289	87.7%	Hardware (Non-Capital)	179,371	338,659	159,289	47.0%
47,229	48,700	1,471	3.0%	Provider Credentialing	235,342	236,813	1,471	0.6%
2,476,546	**2,941,795**	**465,249**	**15.8%**	**Purchased & Professional Services**	**11,320,663**	**11,785,912**	**465,249**	**3.9%**
59,373	91,579	32,206	35.2%	Depreciation	297,332	329,538	32,206	9.8%
136,785	76,371	(60,414)	(79.1%)	Lease Building	386,186	325,772	(60,414)	(18.5%)
4,858	10,570	5,712	54.0%	Lease Rented Office Equipment	22,823	28,535	5,712	20.0%
29,853	19,188	(10,665)	(55.6%)	Utilities	92,926	82,261	(10,665)	(13.0%)
93,395	91,065	(2,330)	(2.6%)	Telephone	441,060	438,730	(2,330)	(0.5%)
23,266	60,447	37,181	61.5%	Building Maintenance	167,721	204,902	37,181	18.1%
312,323	249,136	(63,188)	(25.4%)	GASB96 SBITA Amort. Expense	1,236,104	1,172,916	(63,188)	(5.4%)
659,854	**598,355**	**(61,498)**	**(10.3%)**	**Occupancy**	**2,644,152**	**2,582,654**	**(61,498)**	**(2.4%)**

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED November 30, 2024

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
71,498	108,767	37,270	34.3%	Postage	348,269	385,538	37,270	9.7%
5,518	5,300	(218)	(4.1%)	Design & Layout	31,698	31,480	(218)	(0.7%)
140,691	111,590	(29,101)	(26.1%)	Printing Services	530,091	500,990	(29,101)	(5.8%)
8,998	6,910	(2,088)	(30.2%)	Mailing Services	43,382	41,293	(2,088)	(5.1%)
4,727	12,860	8,133	63.2%	Courier/Delivery Service	27,324	35,457	8,133	22.9%
0	0	0	0.0%	Pre-Printed Materials & Public	29	29	0	0.0%
0	0	0	0.0%	Promotional Products	43,118	43,118	0	0.0%
0	300	300	100.0%	Promotional Services	0	300	300	100.0%
204,893	600,667	395,774	65.9%	Community Relations	943,453	1,339,227	395,774	29.6%
436,324	**846,394**	**410,070**	**48.4%**	**Printing Postage & Promotion**	**1,967,363**	**2,377,433**	**410,070**	**17.2%**
0	0	0	0.0%	Regulatory Penalties	285,000	285,000	0	0.0%
24,198	31,600	7,402	23.4%	Bank Fees	157,179	164,581	7,402	4.5%
0	6,253	6,253	100.0%	Insurance Premium	976,663	982,916	6,253	0.6%
45,809	56,823	11,014	19.4%	License,Permits, & Fee - NonIT	1,008,682	1,019,696	11,014	1.1%
79,181	61,338	(17,843)	(29.1%)	Subscriptions and Dues - NonIT	434,667	416,824	(17,843)	(4.3%)
149,188	**156,013**	**6,826**	**4.4%**	**License Insurance & Fees**	**2,862,191**	**2,869,016**	**6,826**	**0.2%**
14,637	13,783	(854)	(6.2%)	Office and Other Supplies	47,011	46,158	(854)	(1.9%)
0	2,000	2,000	100.0%	Furniture & Equipment	0	2,000	2,000	100.0%
34,529	29,942	(4,588)	(15.3%)	Ergonomic Supplies	158,744	154,156	(4,588)	(3.0%)
7,094	15,785	8,691	55.1%	Meals and Entertainment	58,557	67,248	8,691	12.9%
0	0	0	0.0%	Miscellaneous	5,300	5,300	0	0.0%
0	4,850	4,850	100.0%	Member Incentive	0	4,850	4,850	100.0%
115,859	120,000	4,141	3.5%	Provider Interest (All Depts)	669,067	673,208	4,141	0.6%
172,119	**186,360**	**14,241**	**7.6%**	**Other Administrative Expense**	**938,680**	**952,920**	**14,241**	**1.5%**
3,971,481	**4,803,783**	**832,302**	**17.3%**	**Total Other Administrative ExpenseS (excludes Personnel Expenses)**	**20,115,354**	**20,947,656**	**832,301**	**4.0%**
9,041,748	**10,227,748**	**1,186,000**	**11.6%**	**TOTAL ADMINISTRATIVE EXPENSES**	**48,216,556**	**49,402,556**	**1,186,000**	**2.4%**

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	$ -	$ -	**$ -**	$ 150,000	$ 150,000
	Exagrid Immutable Storage	IT-FY25-07	$ -	$ -	**$ -**	$ 500,000	$ 500,000
	Network Cabling	IT-FY25-09	$ -	$ -	**$ -**	$ 40,000	$ 40,000
Hardware Subtotal			**$ 529,610**	**$ -**	**$ 529,610**	**$ 1,948,100**	**$ 1,418,490**
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			**$ 529,610**	**$ -**	**$ 529,610**	**$ 1,978,100**	**$ 1,448,490**

6. Reconciliation to Balance Sheet:

Fixed Assets @ Cost - 11/30/24	**$ 38,640,099**
Fixed Assets @ Cost - 6/30/24	**$ 38,110,489**
Fixed Assets Acquired YTD	**$ 529,610**

ALAMEDA ALLIANCE FOR HEALTH
TANGIBLE NET EQUITY (TNE) AND LIQUID TNE ANALYSIS
SUMMARY - FISCAL YEAR 2025

TANGIBLE NET EQUITY (TNE)	**QTR. END Jun-24**	**Jul-24**	**Aug-24**	**QTR. END Sep-24**	**Oct-24**	**Nov-24**
Current Month Net Income / (Loss)	($60,614,028)	($6,989,303)	($18,354,879)	($8,719,232)	($26,984,338)	($27,470,263)
YTD Net Income / (Loss)	($68,581,898)	($6,989,303)	($25,344,182)	($34,063,414)	($61,047,752)	($88,518,015)
Actual TNE						
Net Assets	$255,375,144	$248,385,841	$230,030,961	$221,311,730	$194,327,391	$166,857,128
Subordinated Debt & Interest	$0	$0	$0	$0	$0	$0
Total Actual TNE	**$255,375,144**	**$248,385,841**	**$230,030,961**	**$221,311,730**	**$194,327,391**	**$166,857,128**
Increase/(Decrease) in Actual TNE	($60,614,028)	($6,989,303)	($18,354,879)	($8,719,232)	($26,984,338)	($27,470,263)
Required TNE[(1)]	**$63,328,179**	**$68,750,939**	**$71,470,183**	**$70,224,330**	**$77,225,115**	**$78,852,430**
Min. Req'd to Avoid Monthly Reporting (Increased from 130% to 150% of Required TNE effective July-2022)	$94,992,268	$103,126,409	$107,205,274	$105,336,495	$115,837,673	$118,278,645
TNE Excess / (Deficiency)	$192,046,965	$179,634,902	$158,560,778	$151,087,400	$117,102,276	$88,004,698
Actual TNE as a Multiple of Required	**4.03**	**3.61**	**3.22**	**3.15**	**2.52**	**2.12**

Note 1: Required TNE reflects quarterly DMHC calculations for quarter-end months (underlined) and monthly DMHC calculations (not underlined). Quarterly and Monthly Required TNE calculations differ slightly in calculation methodology.

LIQUID TANGIBLE NET EQUITY						
Net Assets	$255,375,144	$248,385,841	$230,030,961	$221,311,730	$194,327,391	$166,857,128
Fixed Assets at Net Book Value	(5,447,816)	(5,662,370)	(5,863,098)	(5,803,725)	(5,739,467)	(5,680,094)
Net Lease Assets/Liabilities/Interest	(501,485)	(319,957)	(496,877)	(1,004,186)	(1,303,630)	(1,065,182)
CD Pledged to DMHC	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)
Liquid TNE (Liquid Reserves)	**$249,075,843**	**$242,053,514**	**$223,320,986**	**$214,153,819**	**$186,934,294**	**$159,761,852**
Liquid TNE as Multiple of Required	**3.93**	**3.52**	**3.12**	**3.05**	**2.42**	**2.03**

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								548,689
Adult	62,708	62,641	62,550	62,578	62,502								312,979
SPD	35,018	35,177	35,319	35,388	35,603								176,505
ACA OE	149,801	150,482	151,005	151,098	151,559								753,945
Duals	39,892	40,024	40,124	40,144	40,357								200,541
MCAL LTC	222	226	240	249	255								1,192
MCAL LTC Duals	1,241	1,247	1,254	1,265	1,269								6,276
Medi-Cal Program	398,833	399,581	400,223	400,384	401,106								2,000,127
Group Care Program	5,675	5,686	5,710	5,769	5,772								28,612
Total	**404,508**	**405,267**	**405,933**	**406,153**	**406,878**								**2,028,739**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	(173)	(167)	(53)	(69)	(101)								(563)
Adult	(38)	(67)	(91)	28	(76)								(244)
SPD	98	159	142	69	215								683
ACA OE	477	681	523	93	461								2,235
Duals	144	132	100	20	213								609
MCAL LTC	0	4	14	9	6								33
MCAL LTC Duals	(7)	6	7	11	4								21
Medi-Cal Program	501	748	642	161	722								2,774
Group Care Program	17	11	24	59	3								114
Total	**518**	**759**	**666**	**220**	**725**								**2,888**
Enrollment Percentages:													
Medi-Cal Program:													
Child % of Medi-Cal	27.6%	27.5%	27.4%	27.4%	27.3%								27.4%
Adult % of Medi-Cal	15.7%	15.7%	15.6%	15.6%	15.6%								15.6%
SPD % of Medi-Cal	8.8%	8.8%	8.8%	8.8%	8.9%								8.8%
ACA OE % of Medi-Cal	37.6%	37.7%	37.7%	37.7%	37.8%								37.7%
Duals % of Medi-Cal	10.0%	10.0%	10.0%	10.0%	10.1%								10.0%
Medi-Cal Program % of Total	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%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**								**100.0%**

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

Page 1	Actual Enrollment by Plan & Category of Aid
Page 2	Actual Delegated Enrollment Detail

	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								446,511
Alameda Health System	91,091	91,170	91,024	90,756	90,451								454,492
	179,071	179,688	180,658	180,480	181,106								901,003
Delegated:													
CFMG	44,087	43,956	43,837	43,910	44,029								219,819
CHCN	181,350	181,623	181,438	181,763	181,743								907,917
Delegated Subtotal	225,437	225,579	225,275	225,673	225,772								1,127,736
Total	**404,508**	**405,267**	**405,933**	**406,153**	**406,878**								**2,028,739**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	167	617	970	(178)	626								2,202
Delegated:													
CFMG	96	(131)	(119)	73	119								38
CHCN	255	273	(185)	325	(20)								648
Delegated Subtotal	351	142	(304)	398	99								686
Total	**518**	**759**	**666**	**220**	**725**								**2,888**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	44.3%	44.3%	44.5%	44.4%	44.5%								44.4%
Delegated:													
CFMG	10.9%	10.8%	10.8%	10.8%	10.8%								10.8%
CHCN	44.8%	44.8%	44.7%	44.8%	44.7%								44.8%
Delegated Subtotal	55.7%	55.7%	55.5%	55.6%	55.5%								55.6%
Total	**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 by Category of Aid:													
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	35,018	35,177	35,319	35,388	35,423	35,458	0	0	0	0	0	0	211,783
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
Duals	39,892	40,024	40,124	40,144	40,144	40,144	0	0	0	0	0	0	240,472
MCAL LTC	222	226	240	249	251	254	0	0	0	0	0	0	1,442
MCAL LTC Duals	1,241	1,247	1,254	1,265	1,266	1,267	0	0	0	0	0	0	7,540
Medi-Cal Program	398,833	399,581	400,223	400,384	400,746	401,109	324,420	324,745	325,070	325,395	325,720	326,046	4,352,272
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**	**330,189**	**330,514**	**330,839**	**331,164**	**331,489**	**331,815**	**4,421,264**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	(1,207)	(167)	(53)	(69)	110	110	220	110	110	110	110	111	(505)
Adult	(624)	(67)	(91)	28	63	63	63	63	63	63	63	63	(250)
SPD	(225)	159	142	69	35	35	0	0	0	0	0	0	215
ACA OE	(1,260)	681	523	93	151	151	151	152	152	152	152	152	1,250
Duals	(43)	132	100	20	0	0	0	0	0	0	0	0	209
MCAL LTC	(9)	4	14	9	2	3	0	0	0	0	0	0	23
MCAL LTC Duals	4	6	7	11	1	1	0	0	0	0	0	0	30
Medi-Cal Program	(3,364)	748	642	161	362	363	434	325	325	325	325	326	972
Group Care Program	(15)	11	24	59	0	0	0	0	0	0	0	0	79
Total	**(3,379)**	**759**	**666**	**220**	**362**	**363**	**434**	**325**	**325**	**325**	**325**	**326**	**1,051**
Enrollment Percentages:													
Medi-Cal Program:													
Child % (Medi-Cal)	27.6%	27.5%	27.4%	27.4%	27.4%	27.4%	33.9%	33.9%	33.9%	33.9%	33.9%	33.9%	30.4%
Adult % (Medi-Cal)	15.7%	15.7%	15.6%	15.6%	15.6%	15.6%	19.3%	19.3%	19.3%	19.3%	19.3%	19.3%	17.3%
SPD % (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%	4.9%
ACA OE % (Medi-Cal)	37.6%	37.7%	37.7%	37.7%	37.7%	37.7%	46.7%	46.7%	46.7%	46.7%	46.7%	46.7%	41.7%
Duals % (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%	5.5%
MCAL LTC % (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%
MCAL LTC Duals % (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%
Medi-Cal Program % of Total	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.3%	98.3%	98.3%	98.3%	98.3%	98.3%	98.4%
Group Care Program % of Total	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.7%	1.7%	1.7%	1.7%	1.7%	1.7%	1.6%
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							**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
	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**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted													
Directly Contracted (DCP)	305	538	1,116	90	62	63	395	386	386	385	385	385	4,496
Alameda Health System	(1,244)	79	(146)	(268)	87	87	21	9	8	8	8	8	(1,343)
	(939)	617	970	(178)	149	150	416	395	394	393	393	393	3,153
Delegated:													
CFMG	(441)	(131)	(119)	73	43	43	39	(2)	(3)	(3)	(3)	(3)	(507)
CHCN	(1,721)	273	(185)	325	170	170	18	(29)	(28)	(28)	(29)	(29)	(1,093)
Delegated Subtotal	(2,162)	142	(304)	398	213	213	57	(31)	(31)	(31)	(32)	(32)	(1,600)
Total	**(3,101)**	**759**	**666**	**220**	**362**	**363**	**473**	**364**	**363**	**362**	**361**	**361**	**1,553**
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%
	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)								(211)
Adult	0	0	0	0	(139)								(139)
SPD	0	0	0	0	180								180
ACA OE	0	0	0	0	310								310
Duals	0	0	0	0	213								213
MCAL LTC	0	0	0	0	4								4
MCAL LTC Duals	0	0	0	0	3								3
Medi-Cal Program	0	0	0	0	360								360
Group Care Program	0	0	0	0	3								3
Total	**0**	**0**	**0**	**0**	**363**								**363**
Current Direct/Delegate Enrollment Variance - Favorable/(Unfavorable)													
Directly-Contracted													
Directly Contracted (DCP)	0	0	0	0	869								869
Alameda Health System	0	0	0	0	(392)								(392)
	0	0	0	0	477								477
Delegated:													
CFMG	0	0	0	0	76								76
CHCN	0	0	0	0	(190)								(190)
Delegated Subtotal	0	0	0	0	(114)								(114)
Total	**0**	**0**	**0**	**0**	**363**								**363**

ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED NOVEMBER 30, 2024

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				CAPITATED MEDICAL EXPENSES				
$4,617,780	$1,713,478	($2,904,302)	(169.5%)	PCP Capitation	$19,293,389	$16,389,087	($2,904,302)	(17.7%)
6,158,415	6,529,667	371,252	5.7%	PCP Capitation FQHC	30,776,705	31,147,956	371,252	1.2%
387,030	447,053	60,023	13.4%	Specialty Capitation	1,893,594	1,953,617	60,023	3.1%
5,408,578	5,958,090	549,512	9.2%	Specialty Capitation FQHC	27,011,995	27,561,507	549,512	2.0%
753,426	712,388	(41,038)	(5.8%)	Laboratory Capitation	3,751,711	3,710,673	(41,038)	(1.1%)
340,074	339,952	(122)	0.0%	Vision Capitation	1,696,957	1,696,835	(122)	0.0%
112,611	130,066	17,455	13.4%	CFMG Capitation	551,055	568,510	17,455	3.1%
266,494	289,578	23,084	8.0%	ANC IPA Admin Capitation FQHC	1,332,024	1,355,108	23,084	1.7%
0	0	0	0.0%	Kaiser Capitation	(995)	(995)	0	0.0%
9,318	0	(9,318)	0.0%	Maternity Supplemental Expense	37,270	27,953	(9,318)	(33.3%)
1,020,145	885,723	(134,422)	(15.2%)	DME Capitation	5,070,941	4,936,519	(134,422)	(2.7%)
19,073,869	**17,005,995**	**(2,067,875)**	**(12.2%)**	**7. TOTAL CAPITATED EXPENSES**	**91,414,645**	**89,346,770**	**(2,067,875)**	**(2.3%)**
				FEE FOR SERVICE MEDICAL EXPENSES				
11,121,563	0	(11,121,563)	0.0%	IBNR Inpatient Services	7,818,400	(3,303,163)	(11,121,563)	336.7%
333,647	0	(333,647)	0.0%	IBNR Settlement (IP)	234,553	(99,094)	(333,647)	336.7%
889,725	0	(889,725)	0.0%	IBNR Claims Fluctuation (IP)	625,471	(264,254)	(889,725)	336.7%
46,034,047	51,184,287	5,150,240	10.1%	Inpatient Hospitalization FFS	246,912,130	252,062,369	5,150,240	2.0%
2,547,588	0	(2,547,588)	0.0%	IP OB - Mom & NB	15,087,751	12,540,164	(2,547,588)	(20.3%)
59,351	0	(59,351)	0.0%	IP Behavioral Health	1,129,658	1,070,307	(59,351)	(5.5%)
1,115,868	0	(1,115,868)	0.0%	Inpatient Facility Rehab FFS	6,886,605	5,770,736	(1,115,868)	(19.3%)
62,101,789	**51,184,287**	**(10,917,502)**	**(21.3%)**	**8. Inpatient Hospital Expense**	**278,694,568**	**267,777,065**	**(10,917,502)**	**(4.1%)**
458,097	0	(458,097)	0.0%	IBNR PCP	164,658	(293,439)	(458,097)	156.1%
13,744	0	(13,744)	0.0%	IBNR Settlement (PCP)	4,943	(8,801)	(13,744)	156.2%
36,647	0	(36,647)	0.0%	IBNR Claims Fluctuation (PCP)	81,438	44,791	(36,647)	(81.8%)
3,821,446	2,851,254	(970,192)	(34.0%)	PCP FFS	18,889,205	17,919,013	(970,192)	(5.4%)
330,147	802,716	472,569	58.9%	PCP FQHC FFS	1,968,569	2,441,138	472,569	19.4%
0	0	0	0.0%	Physician Extended Hrs. Incent	12,000	12,000	0	0.0%
(502,528)	877,651	1,380,179	157.3%	Prop 56 Physician Pmt	(5,123,131)	(3,742,952)	1,380,179	(36.9%)
66,817	0	(66,817)	0.0%	Prop 56 Hyde	131,740	64,923	(66,817)	(102.9%)
73,621	0	(73,621)	0.0%	Prop 56 Trauma Screening	183,754	110,133	(73,621)	(66.8%)
80,123	0	(80,123)	0.0%	Prop 56 Developmentl Screening	176,163	96,040	(80,123)	(83.4%)
701,565	0	(701,565)	0.0%	Prop 56 Family Planning	(66,101)	(767,666)	(701,565)	91.4%
0	0	0	0.0%	Prop 56 VBP	(2,718,741)	(2,718,741)	0	0.0%
5,079,679	**4,531,621**	**(548,058)**	**(12.1%)**	**9. Primary Care Physician Expense**	**13,704,496**	**13,156,438**	**(548,058)**	**(4.2%)**
730,209	0	(730,209)	0.0%	IBNR Specialist	(16,967)	(747,176)	(730,209)	97.7%
21,907	0	(21,907)	0.0%	IBNR Settlement (SCP)	(507)	(22,414)	(21,907)	97.7%
58,417	0	(58,417)	0.0%	IBNR Claims Fluctuation (SCP)	(1,358)	(59,775)	(58,417)	97.7%
380,396	0	(380,396)	0.0%	Psychiatrist FFS	1,939,467	1,559,071	(380,396)	(24.4%)
3,343,209	7,939,942	4,596,733	57.9%	Specialty Care FFS	18,597,635	23,194,367	4,596,733	19.8%
211,666	0	(211,666)	0.0%	Specialty Anesthesiology	1,272,671	1,061,004	(211,666)	(19.9%)
1,378,113	0	(1,378,113)	0.0%	Specialty Imaging FFS	8,221,150	6,843,037	(1,378,113)	(20.1%)
33,056	0	(33,056)	0.0%	Obstetrics FFS	214,263	181,208	(33,056)	(18.2%)
381,307	0	(381,307)	0.0%	Specialty IP Surgery FFS	2,060,806	1,679,499	(381,307)	(22.7%)
854,146	0	(854,146)	0.0%	Specialty OP Surgery FFS	5,207,598	4,353,452	(854,146)	(19.6%)
597,919	0	(597,919)	0.0%	Speciality IP Physician	3,141,752	2,543,833	(597,919)	(23.5%)
117,977	124,854	6,876	5.5%	Specialist FQHC FFS	648,860	655,737	6,876	1.0%
8,108,321	**8,064,795**	**(43,526)**	**(0.5%)**	**10. Specialty Care Physician Expense**	**41,285,369**	**41,241,843**	**(43,526)**	**(0.1%)**

ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED NOVEMBER 30, 2024

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
1,600,554	0	(1,600,554)	0.0%	IBNR Ancillary (ANC)	2,504,745	904,191	(1,600,554)	(177.0%)
48,017	0	(48,017)	0.0%	IBNR Settlement (ANC)	162,205	114,188	(48,017)	(42.1%)
128,042	0	(128,042)	0.0%	IBNR Claims Fluctuation (ANC)	364,290	236,248	(128,042)	(54.2%)
110,855	0	(110,855)	0.0%	IBNR Transportation FFS	318,711	207,856	(110,855)	(53.3%)
2,260,468	0	(2,260,468)	0.0%	Behavioral Health Therapy FFS	10,451,033	8,190,565	(2,260,468)	(27.6%)
1,731,400	0	(1,731,400)	0.0%	Psychologist & Other MH Prof	8,965,650	7,234,250	(1,731,400)	(23.9%)
430,384	0	(430,384)	0.0%	Other Medical Professional	2,296,219	1,865,835	(430,384)	(23.1%)
67,873	0	(67,873)	0.0%	Hearing Devices	742,430	674,558	(67,873)	(10.1%)
18,458	0	(18,458)	0.0%	ANC Imaging	246,606	228,147	(18,458)	(8.1%)
71,294	0	(71,294)	0.0%	Vision FFS	351,591	280,298	(71,294)	(25.4%)
6	0	(6)	0.0%	Family Planning	16	10	(6)	(64.6%)
1,552,472	0	(1,552,472)	0.0%	Laboratory FFS	8,145,928	6,593,456	(1,552,472)	(23.5%)
124,599	0	(124,599)	0.0%	ANC Therapist	768,861	644,262	(124,599)	(19.3%)
1,054,915	0	(1,054,915)	0.0%	Transp/Ambulance FFS	7,016,942	5,962,027	(1,054,915)	(17.7%)
3,458,066	0	(3,458,066)	0.0%	Non-ER Transportation FFS	11,984,549	8,526,483	(3,458,066)	(40.6%)
2,408,667	0	(2,408,667)	0.0%	Hospice FFS	11,659,628	9,250,960	(2,408,667)	(26.0%)
1,586,487	0	(1,586,487)	0.0%	Home Health Services	8,675,241	7,088,754	(1,586,487)	(22.4%)
0	13,764,086	13,764,086	100.0%	Other Medical FFS	128	13,764,214	13,764,086	100.0%
268,308	0	(268,308)	0.0%	Medical Refunds through HMS	558,501	290,192	(268,308)	(92.5%)
35,240	0	(35,240)	0.0%	DME & Medical Supplies FFS	223,073	187,833	(35,240)	(18.8%)
1,810,355	1,819,939	9,584	0.5%	ECM Base/Outreach FFS ANC	5,008,989	5,018,573	9,584	0.2%
99,233	93,757	(5,476)	(5.8%)	CS Housing Deposits FFS ANC	590,426	584,949	(5,476)	(0.9%)
544,147	766,230	222,083	29.0%	CS Housing Tenancy FFS ANC	3,757,353	3,979,436	222,083	5.6%
531,122	430,645	(100,478)	(23.3%)	CS Housing Navi Servic FFS ANC	2,439,195	2,338,717	(100,478)	(4.3%)
726,619	688,135	(38,484)	(5.6%)	CS Medical Respite FFS ANC	3,250,276	3,211,792	(38,484)	(1.2%)
138,909	159,340	20,431	12.8%	CS Med. Tailored Meals FFS ANC	1,016,778	1,037,209	20,431	2.0%
9,883	20,194	10,311	51.1%	CS Asthma Remediation FFS ANC	37,342	47,653	10,311	21.6%
0	9,864	9,864	100.0%	MOT Wrap Around (Non Med MOT)	0	9,864	9,864	100.0%
0	9,975	9,975	100.0%	CS Home Modifications FFS ANC	24,053	34,027	9,975	29.3%
107,113	527,789	420,676	79.7%	CS P.Care & Hmker Svcs FFS ANC	1,607,431	2,028,107	420,676	20.7%
0	19,965	19,965	100.0%	CS Cgiver Respite Svcs FFS ANC	42,347	62,311	19,965	32.0%
308,055	0	(308,055)	0.0%	CommunityBased Adult Svc(CBAS)	2,511,429	2,203,374	(308,055)	(14.0%)
17,394	25,000	7,606	30.4%	CS LTC Diversion FFS ANC	85,172	92,778	7,606	8.2%
0	7,470	7,470	100.0%	CS LTC Transition FFS ANC	0	7,470	7,470	100.0%
21,248,937	**18,342,387**	**(2,906,550)**	**(15.8%)**	**11. Ancillary Medical Expense**	**95,807,138**	**92,900,588**	**(2,906,550)**	**(3.1%)**
1,039,382	0	(1,039,382)	0.0%	IBNR Outpatient	1,271,011	231,629	(1,039,382)	(448.7%)
31,182	0	(31,182)	0.0%	IBNR Settlement (OP)	38,131	6,949	(31,182)	(448.7%)
83,150	0	(83,150)	0.0%	IBNR Claims Fluctuation (OP)	101,677	18,527	(83,150)	(448.8%)
2,110,640	11,442,136	9,331,496	81.6%	Outpatient FFS	12,598,750	21,930,246	9,331,496	42.6%
2,341,356	0	(2,341,356)	0.0%	OP Ambul Surgery FFS	13,935,315	11,593,959	(2,341,356)	(20.2%)
2,677,317	0	(2,677,317)	0.0%	Imaging Services FFS	12,807,720	10,130,403	(2,677,317)	(26.4%)
1,020,699	0	(1,020,699)	0.0%	Behavioral Health FFS	1,118,160	97,460	(1,020,699)	(1,047.3%)
677,152	0	(677,152)	0.0%	Outpatient Facility Lab FFS	3,540,576	2,863,424	(677,152)	(23.6%)
196,338	0	(196,338)	0.0%	Outpatient Facility Cardio FFS	1,040,791	844,453	(196,338)	(23.3%)
104,882	0	(104,882)	0.0%	OP Facility PT/OT/ST FFS	505,290	400,408	(104,882)	(26.2%)
2,855,014	0	(2,855,014)	0.0%	OP Facility Dialysis Ctr FFS	15,502,451	12,647,437	(2,855,014)	(22.6%)
13,137,113	**11,442,136**	**(1,694,977)**	**(14.8%)**	**12. Outpatient Medical Expense**	**62,459,872**	**60,764,895**	**(1,694,977)**	**(2.8%)**
1,500,319	0	(1,500,319)	0.0%	IBNR Emergency	1,334,516	(165,803)	(1,500,319)	904.9%
45,009	0	(45,009)	0.0%	IBNR Settlement (ER)	40,035	(4,974)	(45,009)	904.8%
120,027	0	(120,027)	0.0%	IBNR Claims Fluctuation (ER)	106,761	(13,266)	(120,027)	904.8%
7,245,900	10,180,741	2,934,841	28.8%	ER Facility	44,481,797	47,416,638	2,934,841	6.2%

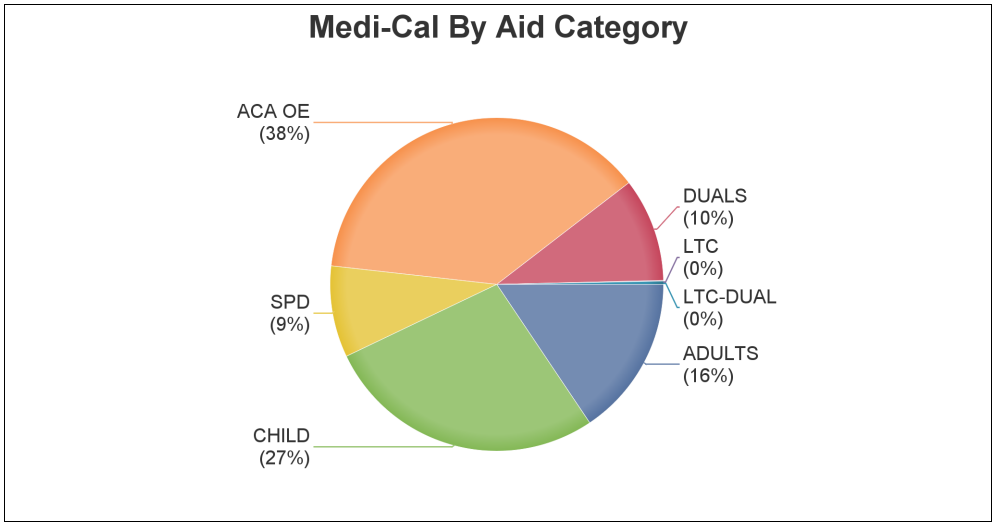
ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED NOVEMBER 30, 2024

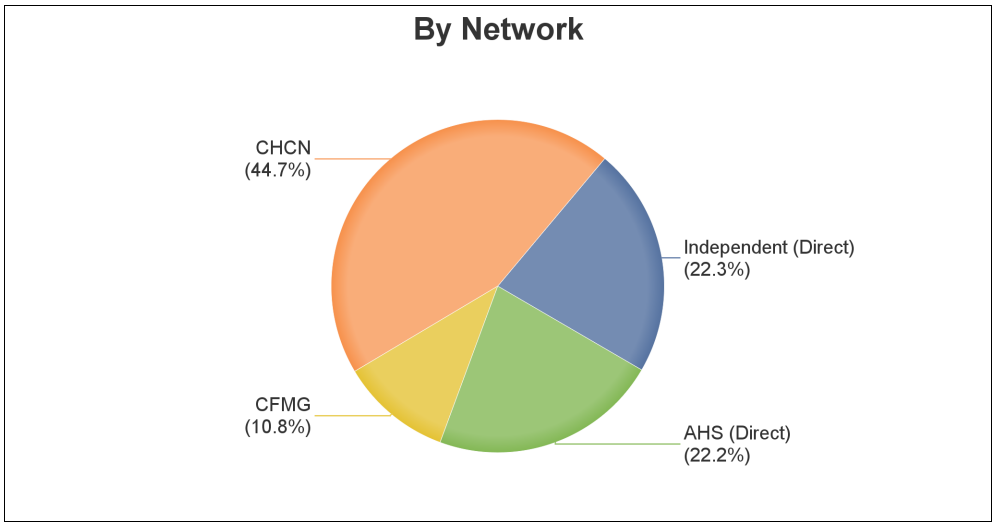
CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
1,056,393	0	(1,056,393)	0.0%	Specialty ER Physician FFS	5,936,785	4,880,392	(1,056,393)	(21.6%)
9,967,647	**10,180,741**	**213,093**	**2.1%**	**13. Emergency Expense**	**51,899,893**	**52,112,987**	**213,093**	**0.4%**
1,435,718	0	(1,435,718)	0.0%	IBNR Pharmacy (OP)	3,427,491	1,991,773	(1,435,718)	(72.1%)
43,072	0	(43,072)	0.0%	IBNR Settlement Rx (OP)	102,827	59,755	(43,072)	(72.1%)
114,859	0	(114,859)	0.0%	IBNR Claims Fluctuation Rx(OP)	274,201	159,342	(114,859)	(72.1%)
709,276	454,372	(254,903)	(56.1%)	Pharmacy FFS (OP)	3,749,210	3,494,307	(254,903)	(7.3%)
110,335	11,553,120	11,442,785	99.0%	Pharmacy Non PBM FFS Other-ANC	654,227	12,097,012	11,442,785	94.6%
8,565,577	0	(8,565,577)	0.0%	Pharmacy Non PBM FFS OP-FAC	47,892,133	39,326,556	(8,565,577)	(21.8%)
181,560	0	(181,560)	0.0%	Pharmacy Non PBM FFS PCP	1,167,123	985,563	(181,560)	(18.4%)
1,828,785	0	(1,828,785)	0.0%	Pharmacy Non PBM FFS SCP	12,446,512	10,617,727	(1,828,785)	(17.2%)
21,191	0	(21,191)	0.0%	Pharmacy Non PBM FFS FQHC	103,766	82,575	(21,191)	(25.7%)
10,634	0	(10,634)	0.0%	Pharmacy Non PBM FFS HH	102,263	91,629	(10,634)	(11.6%)
0	0	0	0.0%	RX Refunds HMS	(306)	(306)	0	0.0%
(54,000)	50,966	104,966	206.0%	Medical Expenses Pharm Rebate	(270,000)	(165,034)	104,966	(63.6%)
12,967,007	**12,058,459**	**(908,549)**	**(7.5%)**	**14. Pharmacy Expense**	**69,649,446**	**68,740,897**	**(908,549)**	**(1.3%)**
6,411,200	0	(6,411,200)	0.0%	IBNR LTC	2,654,264	(3,756,936)	(6,411,200)	170.6%
192,337	0	(192,337)	0.0%	IBNR Settlement (LTC)	79,628	(112,709)	(192,337)	170.6%
512,896	0	(512,896)	0.0%	IBNR Claims Fluctuation (LTC)	212,341	(300,555)	(512,896)	170.6%
1,250,714	0	(1,250,714)	0.0%	LTC - ICF/DD	8,006,440	6,755,726	(1,250,714)	(18.5%)
19,797,230	0	(19,797,230)	0.0%	LTC Custodial Care	119,480,519	99,683,289	(19,797,230)	(19.9%)
6,218,936	32,440,241	26,221,304	80.8%	LTC SNF	38,240,575	64,461,879	26,221,304	40.7%
34,383,314	**32,440,241**	**(1,943,073)**	**(6.0%)**	**15. Long Term Care Expense**	**168,673,767**	**166,730,694**	**(1,943,073)**	**(1.2%)**
166,993,808	**148,244,666**	**(18,749,142)**	**(12.6%)**	**16. TOTAL FFS MEDICAL EXPENSES**	**782,174,549**	**763,425,407**	**(18,749,142)**	**(2.5%)**
0	(1,389,434)	(1,389,434)	100.0%	Clinical Vacancy #102	0	(1,389,434)	(1,389,434)	100.0%
85,965	414,449	328,484	79.3%	Quality Analytics #123	675,331	1,003,815	328,484	32.7%
299,777	410,178	110,401	26.9%	LongTerm Services and Support #139	1,136,602	1,247,003	110,401	8.9%
874,269	1,130,287	256,018	22.7%	Utilization Management #140	4,940,738	5,196,756	256,018	4.9%
646,366	894,903	248,536	27.8%	Case & Disease Management #185	3,391,518	3,640,054	248,536	6.8%
5,181,846	5,471,904	290,058	5.3%	Medical Management #230	6,622,838	6,912,896	290,058	4.2%
753,897	1,375,977	622,080	45.2%	Quality Improvement #235	5,332,456	5,954,536	622,080	10.4%
286,869	443,639	156,771	35.3%	HCS Behavioral Health #238	1,585,709	1,742,480	156,771	9.0%
102,831	392,776	289,944	73.8%	Pharmacy Services #245	575,150	865,095	289,944	33.5%
52,257	95,744	43,487	45.4%	Regulatory Readiness #268	328,922	372,409	43,487	11.7%
8,284,077	**9,240,422**	**956,345**	**10.3%**	**17. Other Benefits & Services**	**24,589,265**	**25,545,610**	**956,345**	**3.7%**
(1,409,000)	(1,317,900)	91,100	(6.9%)	Reinsurance Recoveries	(8,120,986)	(8,029,886)	91,100	(1.1%)
1,761,844	1,757,200	(4,644)	(0.3%)	Reinsurance Premium	8,759,469	8,754,824	(4,644)	(0.1%)
352,844	**439,300**	**86,456**	**19.7%**	**18. Reinsurance Expense**	**638,482**	**724,938**	**86,456**	**11.9%**
194,704,598	**174,930,382**	**(19,774,216)**	**(11.3%)**	**20. TOTAL MEDICAL EXPENSES**	**898,816,941**	**879,042,725**	**(19,774,216)**	**(2.2%)**

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend

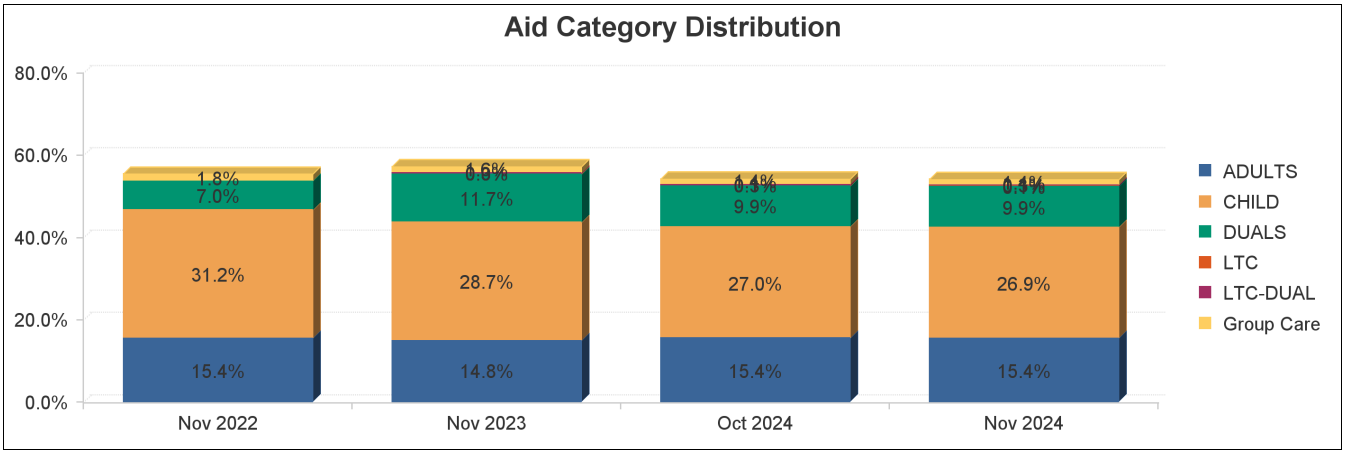
Category of Aid	Nov 2024	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN
ADULTS	62,533	16%	12,921	14,237	5	35,370
CHILD	109,574	27%	9,240	13,553	41,054	45,727
SPD	35,603	9%	11,685	5,651	1,430	16,837
ACA OE	151,559	38%	26,736	53,192	1,537	70,094
DUALS	40,360	10%	26,446	2,881	5	11,028
LTC	255	0%	239	7	0	9
LTC-DUAL	1,269	0%	1,268	0	0	1
Medi-Cal	401,153		88,535	89,521	44,031	179,066
Group Care	5,772		2,146	938	0	2,688
Total	**406,925**	**100%**	**90,681**	**90,459**	**44,031**	**181,754**
Medi-Cal %	98.6%		97.6%	99.0%	100.0%	98.5%
Group Care %	1.4%		2.4%	1.0%	0.0%	1.5%
	Network Distribution		**22.3%**	**22.2%**	**10.8%**	**44.7%**
			% Direct:	**45%**	**% Delegated:**	**55%**





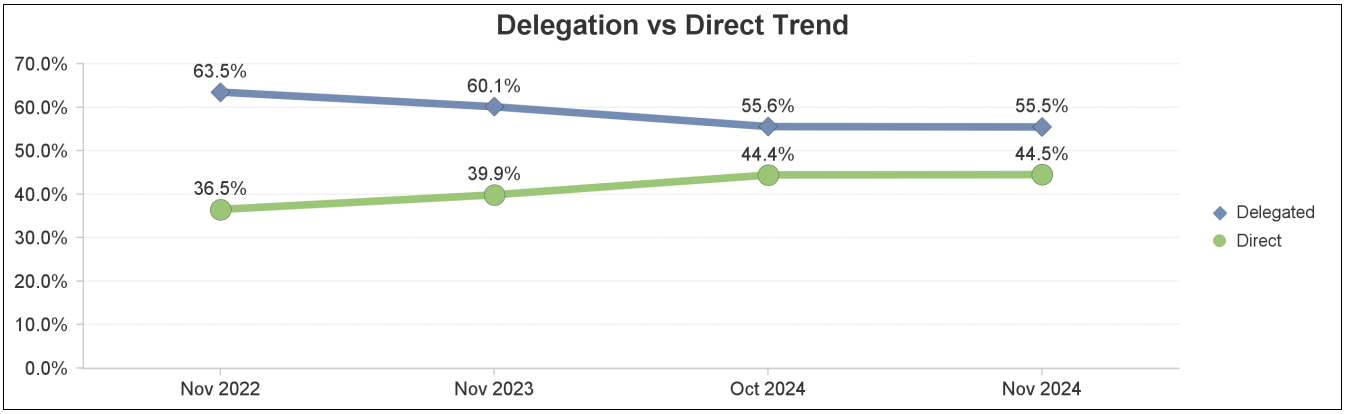
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Nov 2022	Nov 2023	Oct 2024	Nov 2024	Nov 2022	Nov 2023	Oct 2024	Nov 2024	Nov 2022 to Nov 2023	Nov 2023 to Nov 2024	Oct 2024 to Nov 2024
ADULTS	50,069	52,222	62,608	**62,533**	15.4%	14.8%	15.4%	15.4%	4.3%	19.7%	-0.1%
CHILD	101,653	101,557	109,680	**109,574**	31.2%	28.7%	27.0%	26.9%	-0.1%	7.9%	-0.1%
SPD	28,365	30,887	35,389	**35,603**	8.7%	8.7%	8.7%	8.7%	8.9%	15.3%	0.6%
ACA OE	117,328	120,666	151,098	**151,559**	36.0%	34.2%	37.2%	37.2%	2.8%	25.6%	0.3%
DUALS	22,719	41,217	40,144	**40,360**	7.0%	11.7%	9.9%	9.9%	81.4%	-2.1%	0.5%
LTC	0	139	249	**255**	0.0%	0.0%	0.1%	0.1%	0.0%	83.5%	2.4%
LTC-DUAL	0	980	1,265	**1,269**	0.0%	0.3%	0.3%	0.3%	0.0%	29.5%	0.3%
Medi-Cal	320,134	347,668	400,433	**401,153**	98.2%	98.4%	98.6%	98.6%	8.6%	15.4%	0.2%
Group Care	5,791	5,586	5,769	**5,772**	1.8%	1.6%	1.4%	1.4%	-3.5%	3.3%	0.1%
Total	**325,925**	**353,254**	**406,202**	**406,925**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**8.4%**	**15.2%**	**0.2%**



Delegation vs Direct Trend

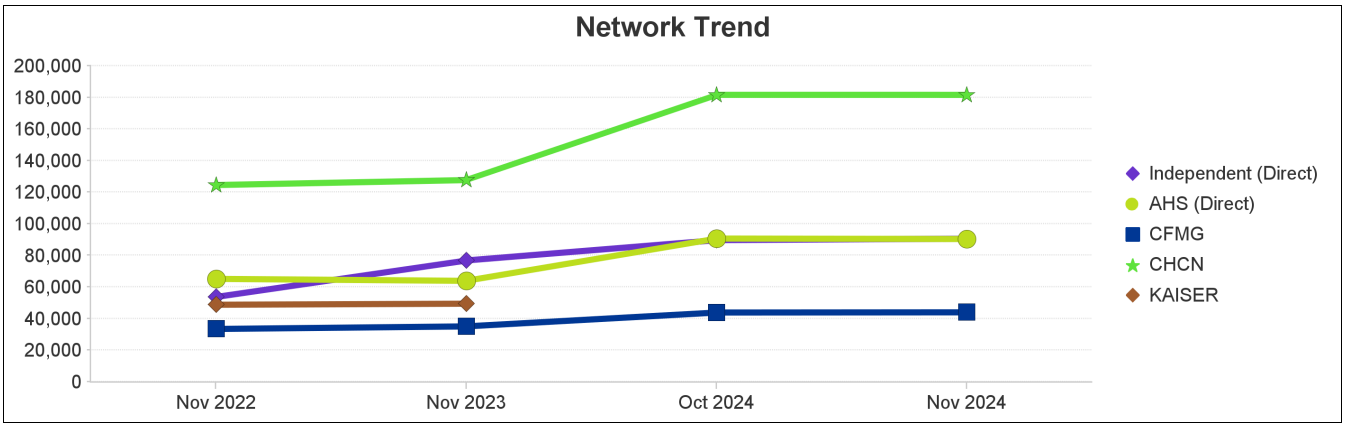
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	Nov 2022	Nov 2023	Oct 2024	Nov 2024	Nov 2022	Nov 2023	Oct 2024	Nov 2024	Nov 2022 to Nov 2023	Nov 2023 to Nov 2024	Oct 2024 to Nov 2024
Delegated	206,973	212,412	225,684	**225,785**	63.5%	60.1%	55.6%	55.5%	2.6%	6.3%	0.0%
Direct	118,952	140,842	180,518	**181,140**	36.5%	39.9%	44.4%	44.5%	18.4%	28.6%	0.3%
Total	**325,925**	**353,254**	**406,202**	**406,925**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**8.4%**	**15.2%**	**0.2%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

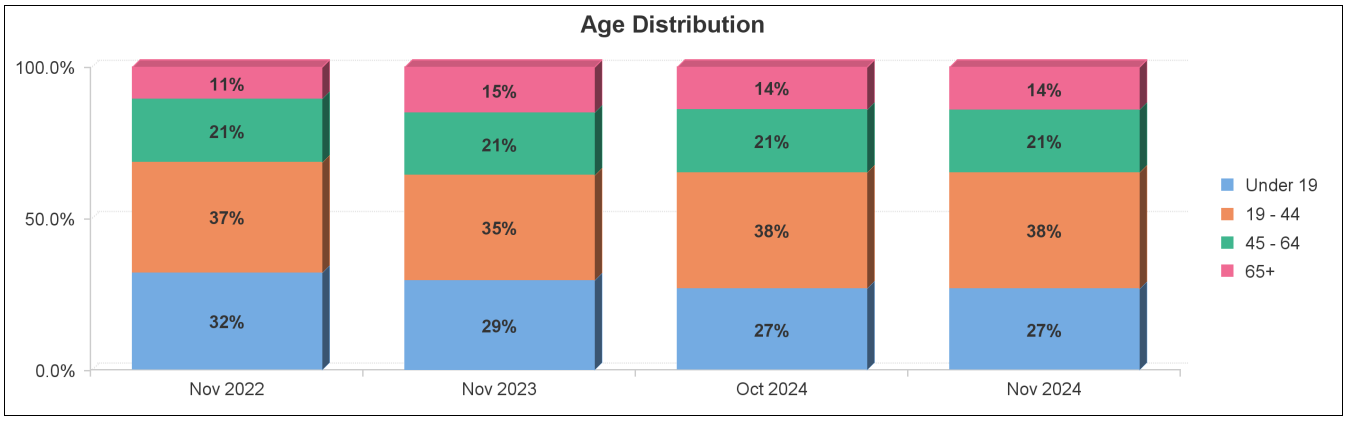
Network Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Nov 2022	Nov 2023	Oct 2024	Nov 2024	Nov 2022	Nov 2023	Oct 2024	Nov 2024	Nov 2022 to Nov 2023	Nov 2023 to Nov 2024	Oct 2024 to Nov 2024
Independent (Direct)	53,736	76,872	89,756	**90,681**	16.5%	21.8%	22.1%	22.3%	43.1%	18.0%	1.0%
AHS (Direct)	65,216	63,970	90,762	**90,459**	20.0%	18.1%	22.3%	22.2%	-1.9%	41.4%	-0.3%
CFMG	33,498	35,124	43,913	**44,031**	10.3%	9.9%	10.8%	10.8%	4.9%	25.4%	0.3%
CHCN	124,637	127,787	181,771	**181,754**	38.2%	36.2%	44.7%	44.7%	2.5%	42.2%	0.0%
KAISER	48,838	49,501	0	**0**	15.0%	14.0%	0.0%	0.0%	1.4%	-100.0%	0.0%
Total	**325,925**	**353,254**	**406,202**	**406,925**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**8.4%**	**15.2%**	**0.2%**



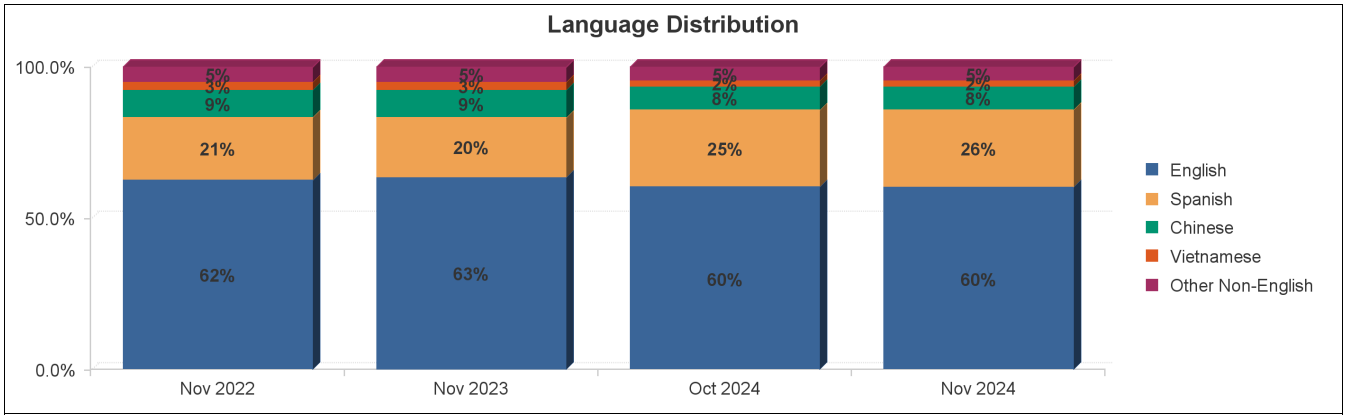
Age Category Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Nov 2022	Nov 2023	Oct 2024	Nov 2024	Nov 2022	Nov 2023	Oct 2024	Nov 2024	Nov 2022 to Nov 2023	Nov 2023 to Nov 2024	Oct 2024 to Nov 2024
Under 19	103,882	103,970	108,379	**108,407**	32%	29%	27%	27%	0%	4%	0%
19 - 44	119,055	122,671	155,783	**155,955**	37%	35%	38%	38%	3%	27%	0%
45 - 64	68,281	72,867	84,315	**84,411**	21%	21%	21%	21%	7%	16%	0%
65+	34,707	53,746	57,725	**58,152**	11%	15%	14%	14%	55%	8%	1%
Total	**325,925**	**353,254**	**406,202**	**406,925**	**100%**	**100%**	**100%**	**100%**	**8%**	**15%**	**0%**



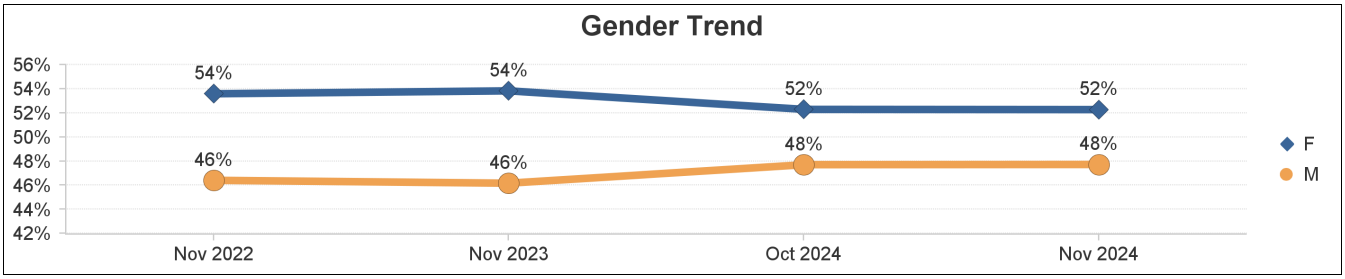
Language Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	Nov 2022	Nov 2023	Oct 2024	Nov 2024	ov 2022	ov 2023	Oct 2024	ov 2024	Nov 2022 to Nov 2023	Nov 2023 to Nov 2024	Oct 2024 to Nov 2024
English	203,441	223,617	244,693	**244,547**	62%	63%	60%	60%	10%	9%	0%
Spanish	67,653	69,914	103,228	**104,072**	21%	20%	25%	26%	3%	49%	1%
Chinese	29,111	32,047	30,669	**30,682**	9%	9%	8%	8%	10%	-4%	0%
Vietnamese	8,906	9,168	8,243	**8,223**	3%	3%	2%	2%	3%	-10%	0%
Other Non-English	16,814	18,508	19,369	**19,401**	5%	5%	5%	5%	10%	5%	0%
Total	**325,925**	**353,254**	**406,202**	**406,925**	**100%**	**100%**	**100%**	**100%**	**8%**	**15%**	**0%**



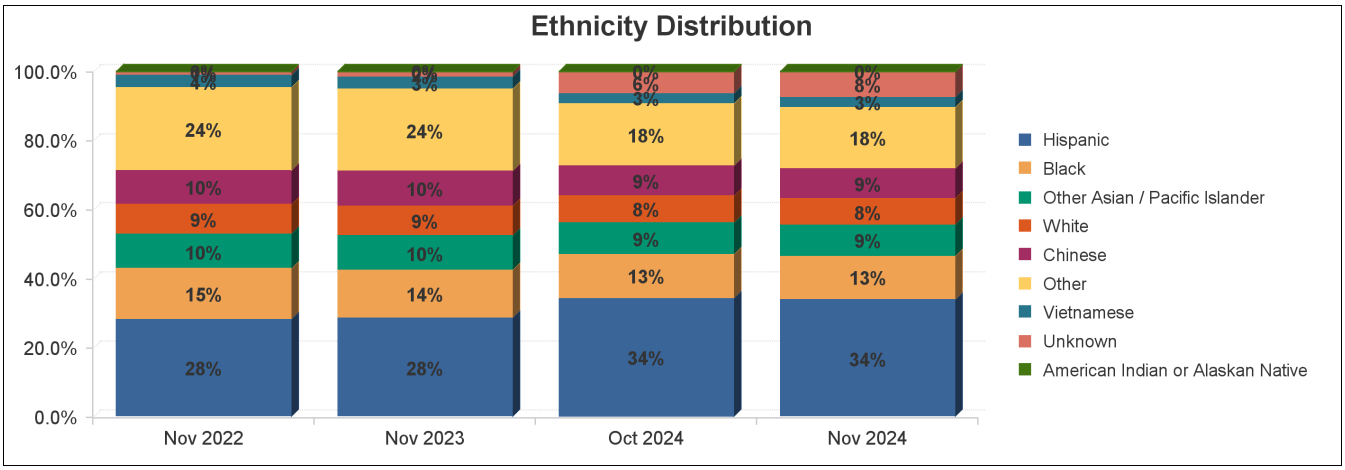
Gender Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Nov 2022	Nov 2023	Oct 2024	Nov 2024	Nov 2022	Nov 2023	Oct 2024	Nov 2024	Nov 2022 to Nov 2023	Nov 2023 to Nov 2024	Oct 2024 to Nov 2024
F	174,661	190,163	212,415	**212,721**	54%	54%	52%	52%	9%	12%	0%
M	151,264	163,091	193,787	**194,204**	46%	46%	48%	48%	8%	19%	0%
Total	**325,925**	**353,254**	**406,202**	**406,925**	**100%**	**100%**	**100%**	**100%**	**8%**	**15%**	**0%**



Ethnicity Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Nov 2022	Nov 2023	Oct 2024	Nov 2024	Nov 2022	Nov 2023	Oct 2024	Nov 2024	Nov 2022 to Nov 2023	Nov 2023 to Nov 2024	Oct 2024 to Nov 2024
Hispanic	91,418	100,583	138,637	**137,424**	28%	28%	34%	34%	10%	37%	-1%
Black	48,247	48,956	51,748	**51,258**	15%	14%	13%	13%	1%	5%	-1%
Other Asian / Pacific Islander	32,346	35,233	37,202	**36,733**	10%	10%	9%	9%	9%	4%	-1%
White	28,029	30,370	31,678	**31,272**	9%	9%	8%	8%	8%	3%	-1%
Chinese	31,699	35,686	35,243	**34,944**	10%	10%	9%	9%	13%	-2%	-1%
Other	78,525	84,093	73,399	**72,555**	24%	24%	18%	18%	7%	-14%	-1%
Vietnamese	11,442	12,048	11,527	**11,441**	4%	3%	3%	3%	5%	-5%	-1%
Unknown	3,526	5,553	25,982	**30,524**	1%	2%	6%	8%	57%	450%	17%
American Indian or Alaskan Native	693	732	786	**774**	0%	0%	0%	0%	6%	6%	-2%
Total	**325,925**	**353,254**	**406,202**	**406,925**	**100%**	**100%**	**100%**	**100%**	**8%**	**15%**	**0%**



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

Medi-Cal By City

City	Nov 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	160,468	40%	23,965	42,182	17,289	77,032
HAYWARD	64,606	16%	13,417	17,513	7,538	26,138
FREMONT	37,685	9%	15,533	6,660	2,264	13,228
SAN LEANDRO	33,226	8%	8,333	5,646	4,218	15,029
UNION CITY	14,719	4%	5,668	2,602	853	5,596
ALAMEDA	13,794	3%	3,313	2,473	2,068	5,940
BERKELEY	14,902	4%	4,018	2,253	1,765	6,866
LIVERMORE	13,069	3%	1,864	604	2,251	8,350
NEWARK	9,417	2%	2,748	4,113	544	2,012
CASTRO VALLEY	9,533	2%	2,616	1,616	1,420	3,881
SAN LORENZO	7,390	2%	1,478	1,660	864	3,388
PLEASANTON	7,646	2%	1,765	401	829	4,651
DUBLIN	7,549	2%	1,973	432	901	4,243
EMERYVILLE	2,832	1%	649	602	458	1,123
ALBANY	2,542	1%	658	301	581	1,002
PIEDMONT	479	0%	117	184	64	114
SUNOL	87	0%	26	14	7	40
ANTIOCH	20	0%	8	7	0	5
Other	1,189	0%	386	258	117	428
Total	401,153	100%	**88,535**	**89,521**	**44,031**	**179,066**

Group Care By City

City	Nov 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	1,815	31%	349	349	0	1,117
HAYWARD	664	12%	318	156	0	190
FREMONT	658	11%	432	80	0	146
SAN LEANDRO	612	11%	241	95	0	276
UNION CITY	298	5%	186	49	0	63
ALAMEDA	303	5%	87	26	0	190
BERKELEY	146	3%	47	11	0	88
LIVERMORE	102	2%	32	4	0	66
NEWARK	133	2%	79	29	0	25
CASTRO VALLEY	194	3%	82	32	0	80
SAN LORENZO	142	2%	45	28	0	69
PLEASANTON	71	1%	26	2	0	43
DUBLIN	116	2%	41	4	0	71
EMERYVILLE	35	1%	14	5	0	16
ALBANY	20	0%	10	1	0	9
PIEDMONT	8	0%	2	0	0	6
SUNOL	1	0%	1	0	0	0
ANTIOCH	24	0%	6	4	0	14
Other	430	7%	148	63	0	219
Total	**5,772**	**100%**	**2,146**	**938**	**0**	**2,688**

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

Total By City

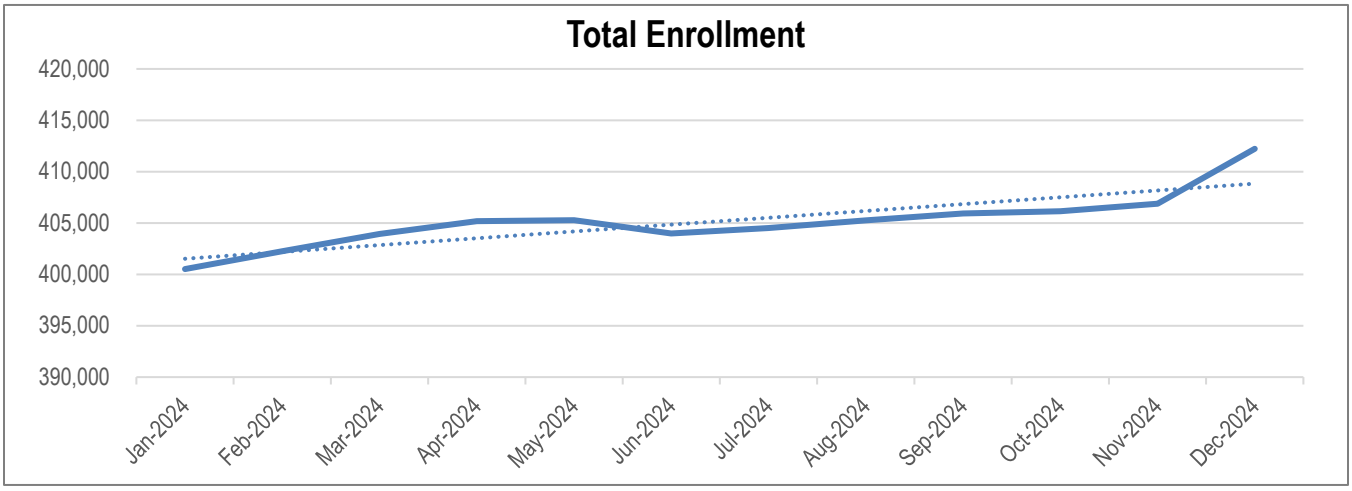
City	Nov 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	162,283	40%	24,314	42,531	17,289	78,149
HAYWARD	65,270	16%	13,735	17,669	7,538	26,328
FREMONT	38,343	9%	15,965	6,740	2,264	13,374
SAN LEANDRO	33,838	8%	8,574	5,741	4,218	15,305
UNION CITY	15,017	4%	5,854	2,651	853	5,659
ALAMEDA	14,097	3%	3,400	2,499	2,068	6,130
BERKELEY	15,048	4%	4,065	2,264	1,765	6,954
LIVERMORE	13,171	3%	1,896	608	2,251	8,416
NEWARK	9,550	2%	2,827	4,142	544	2,037
CASTRO VALLEY	9,727	2%	2,698	1,648	1,420	3,961
SAN LORENZO	7,532	2%	1,523	1,688	864	3,457
PLEASANTON	7,717	2%	1,791	403	829	4,694
DUBLIN	7,665	2%	2,014	436	901	4,314
EMERYVILLE	2,867	1%	663	607	458	1,139
ALBANY	2,562	1%	668	302	581	1,011
PIEDMONT	487	0%	119	184	64	120
SUNOL	88	0%	27	14	7	40
ANTIOCH	44	0%	14	11	0	19
Other	1,619	0%	534	321	117	647
Total	406,925	100%	**90,681**	**90,459**	**44,031**	**181,754**

To: **Alameda Alliance for Health, Board of Governors**
From: **Gil Riojas, Chief Financial Officer**
Date: **March 14th, 2025**
Subject: **Finance Report – December 2024 Financials**

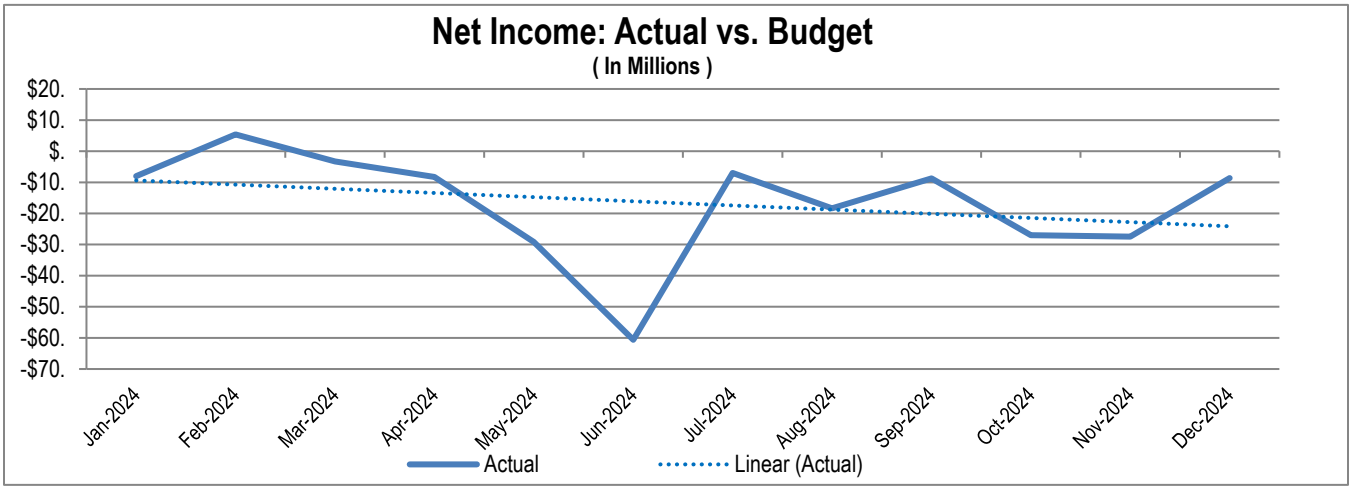
Executive Summary

For the month of December, the Alliance continued to see increases in enrollment, reaching 412,226 members. A Net Loss of $8.6 million was reported, and the Plan's Medical Expenses represented 101.0% of revenue. Alliance reserves decreased to 204% of required but continue to remain above minimum requirements.

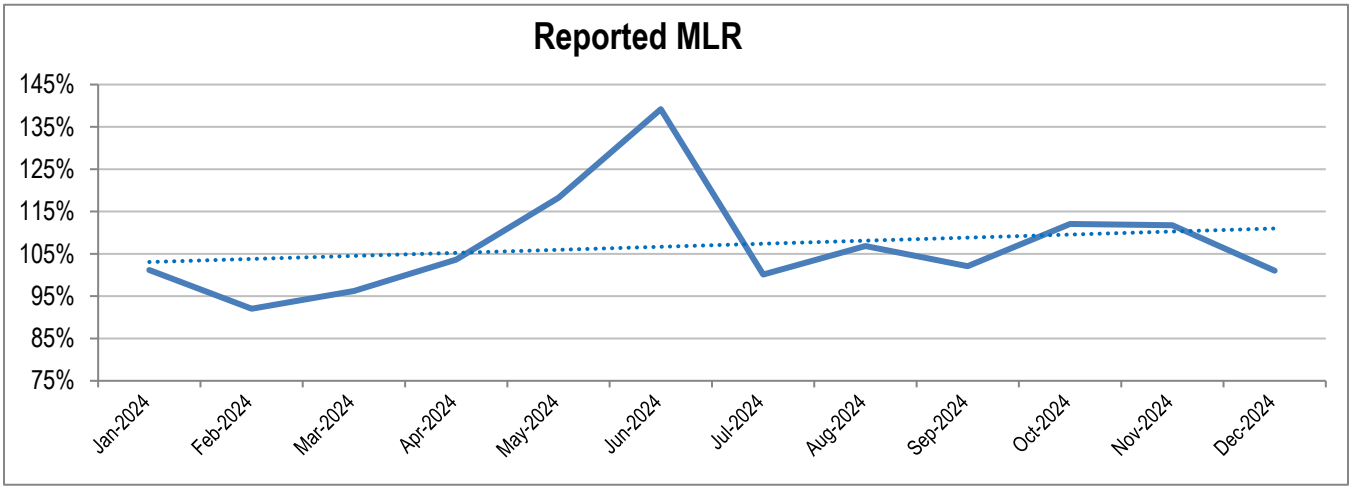
Enrollment – In December, Enrollment increased by 5,348 members.



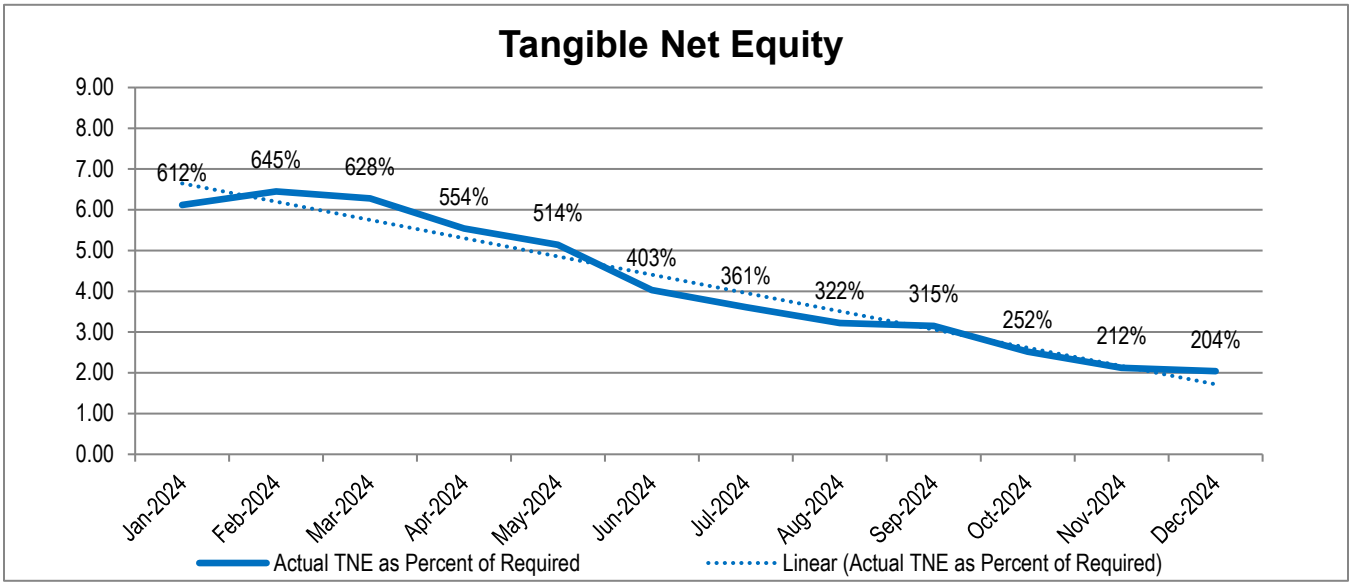
Net Income – For the month ended December 31st, 2024, actual Net Loss was $8.6 million vs. budgeted Net Loss of $26.8 million. For the fiscal YTD, actual Net Loss was $97.2 million vs. budgeted Net Loss of $97.8 million. For the month, Premium Revenue was favorable to budget, actual Revenue was $163.0 million vs. budgeted Revenue of $137.1 million.



Medical Loss Ratio (MLR) – The Medical Loss Ratio was 101.0% for the month, and 105.7% for fiscal YTD. The major variances include unfavorable Primary Care, Outpatient, Inpatient/SNF, Ancillary FFS, Outpatient FFS, and Long-Term Care.



Tangible Net Equity (TNE) - The Department of Managed Health Care (DMHC) required $77.6M in reserves, we reported $158.2M. Our overall TNE remains above DMHC requirements at 204%.



The Alliance continues to benefit from increased non-operating income. For Fiscal year-to-date investments show a gain of $17.5M. Capital assets acquired so far are $530k.

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

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

Date: **February 15th, 2025**

Subject: **Finance Report – December 2024**

Executive Summary

- For the month ended December 31st, 2024, the Alliance had enrollment of 412,226 members, a Net Loss of $8.6 million and 204% of required Tangible Net Equity (TNE).

Overall Results: (in Thousands)

	Month	YTD
Revenue	$227,458	$1,486,337
Medical Expense	164,647	1,063,464
Admin. Expense	9,438	57,654
MCO Tax Expense	64,497	479,901
Other Inc. / (Exp.)	2,481	17,522
Net Income	**($8,643)**	**($97,161)**

Net Income by Program: (in Thousands)

	Month	YTD
Medi-Cal	($6,413)	($92,280)
Group Care	(336)	(237)
Medicare	(1,893)	(4,643)
	($8,643)	**($97,161)**

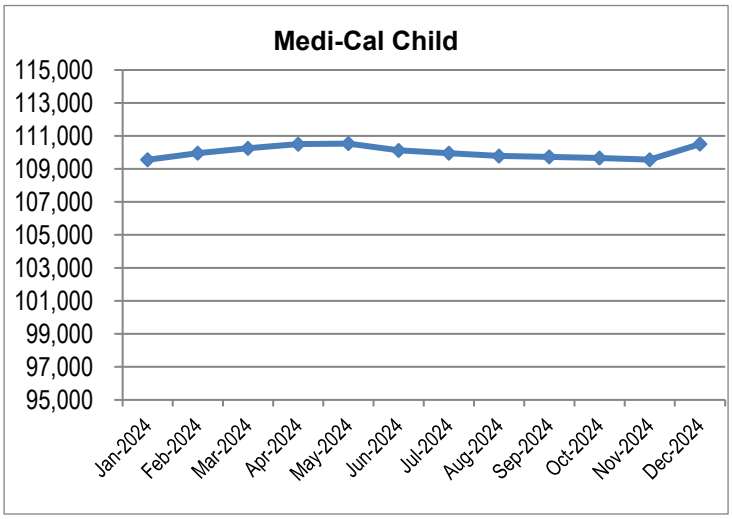
Enrollment

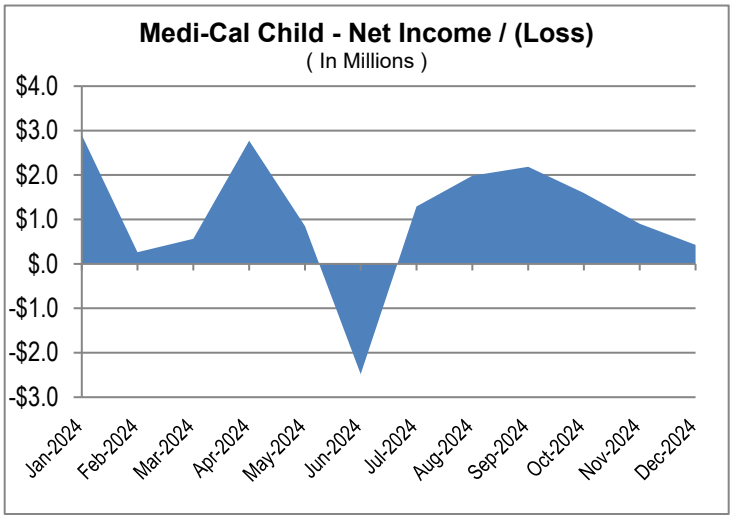
- Total enrollment increased by 5,348 members since November 2024.
- Total enrollment increased by 8,236 members since June 2024.

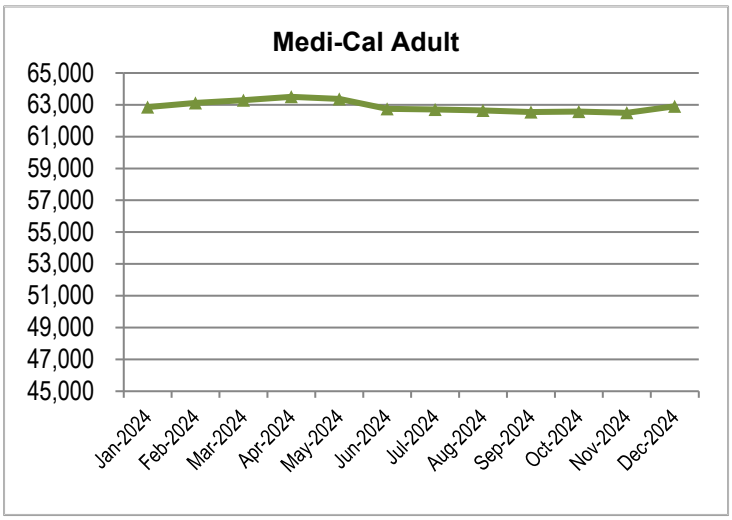
Monthly Membership and YTD Member Months
Actual vs. Budget
For the Month and Fiscal Year-to-Date

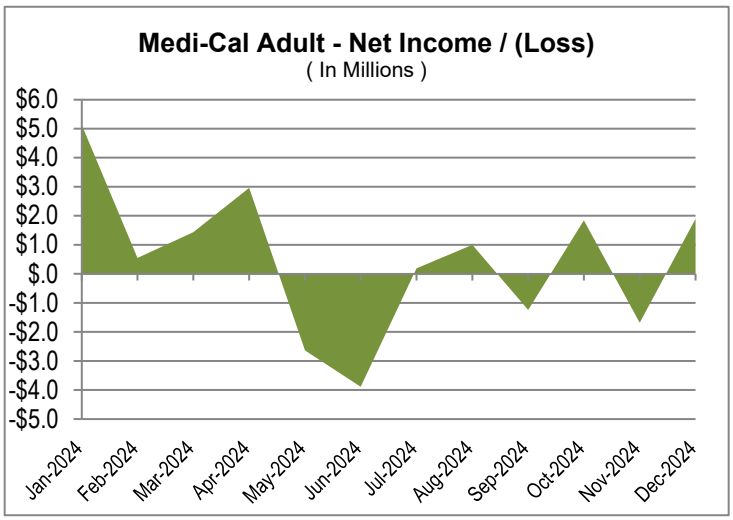
Enrollment					Member Months			
Current Month					Year-to-Date			
Actual	Budget	Variance	Variance %		Actual	Budget	Variance	Variance %
				Medi-Cal:				
62,905	62,704	201	0.3%	Adult	375,884	375,822	62	0.0%
110,506	109,882	624	0.6%	Child	659,195	658,782	413	0.1%
36,127	35,458	669	1.9%	SPD	212,632	211,783	849	0.4%
40,798	40,144	654	1.6%	Duals	241,339	240,472	867	0.4%
154,560	151,400	3,160	2.1%	ACA OE	908,505	905,035	3,470	0.4%
254	254	0	0.0%	LTC	1,446	1,442	4	0.3%
1,286	1,267	19	1.5%	LTC Duals	7,562	7,540	22	0.3%
406,436	**401,109**	**5,327**	**1.3%**	**Medi-Cal Total**	**2,406,563**	**2,400,876**	**5,687**	**0.2%**
5,790	5,769	21	0.4%	Group Care	34,402	34,378	24	0.1%
412,226	**406,878**	**5,348**	**1.3%**	**Total**	**2,440,965**	**2,435,254**	**5,711**	**0.2%**

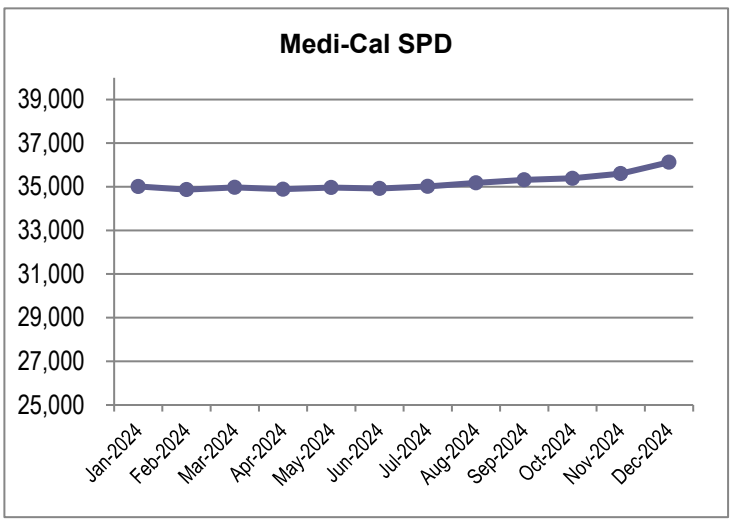
Enrollment and Profitability by Program and Category of Aid

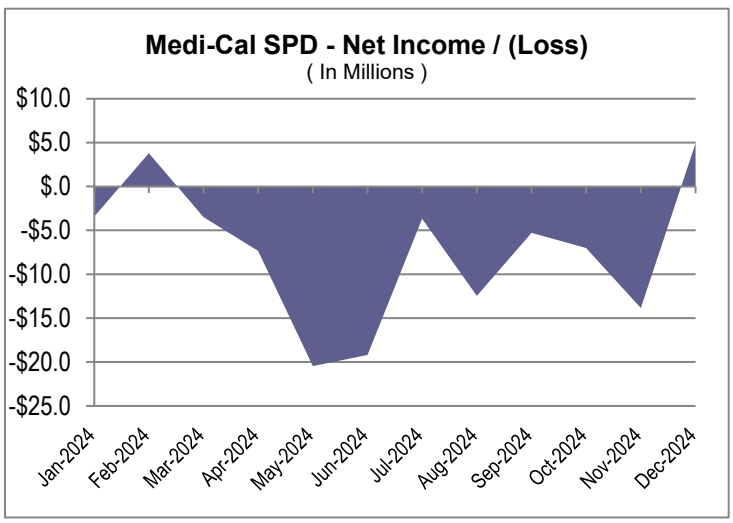




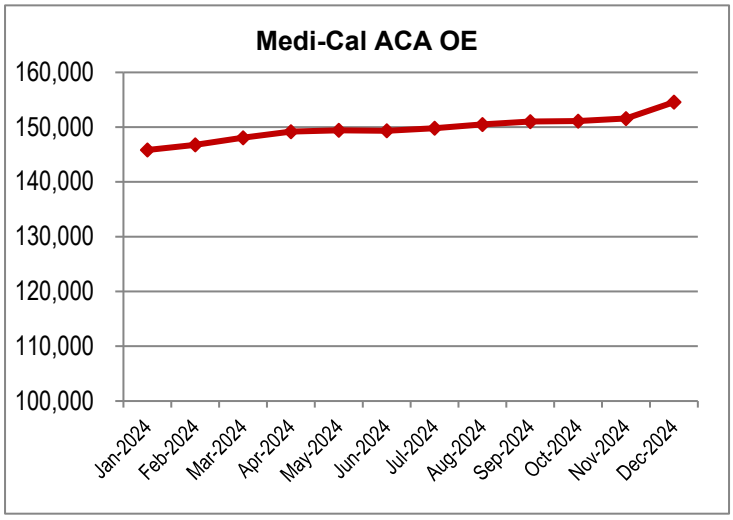


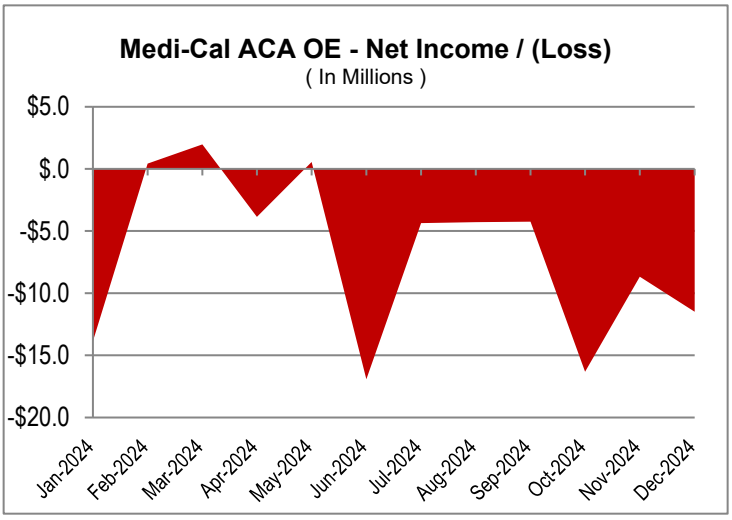


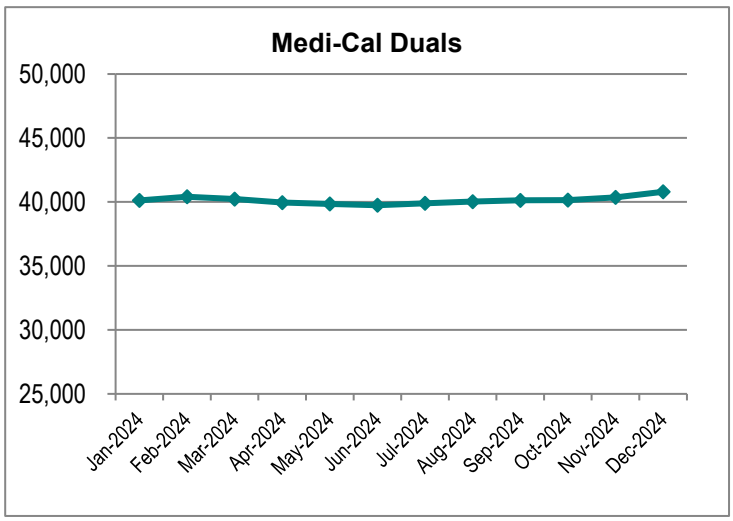


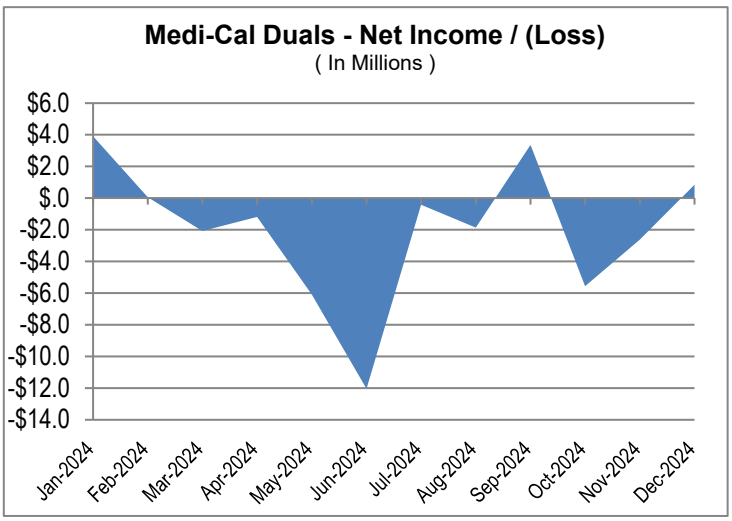


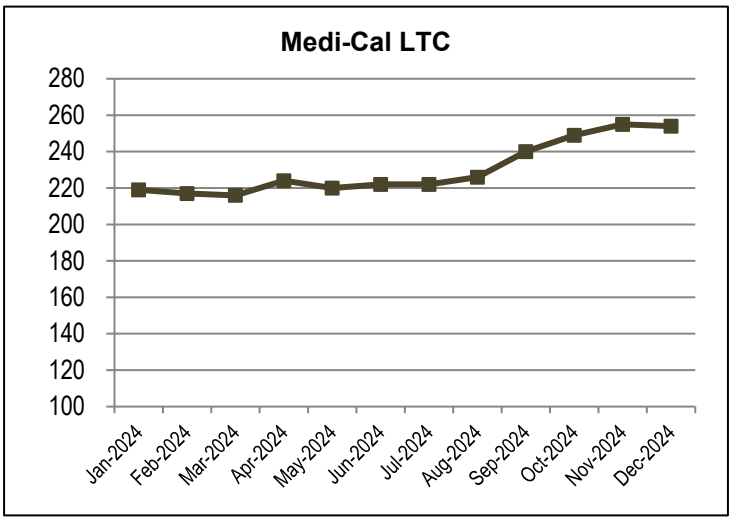
Enrollment and Profitability by Program and Category of Aid

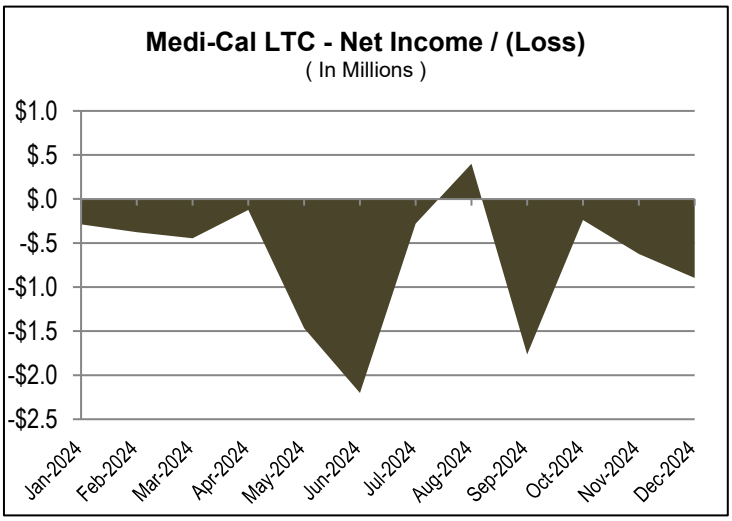




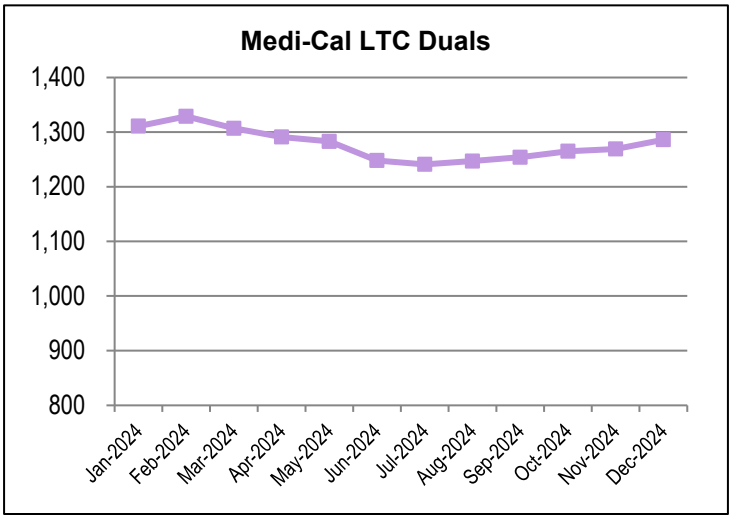


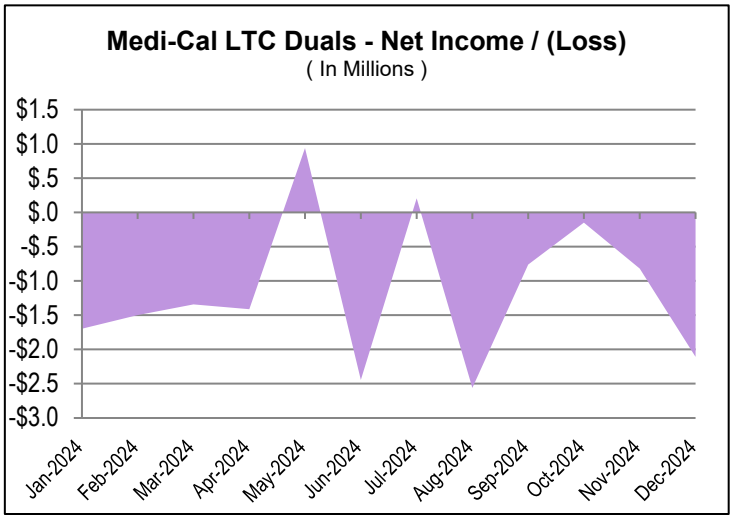


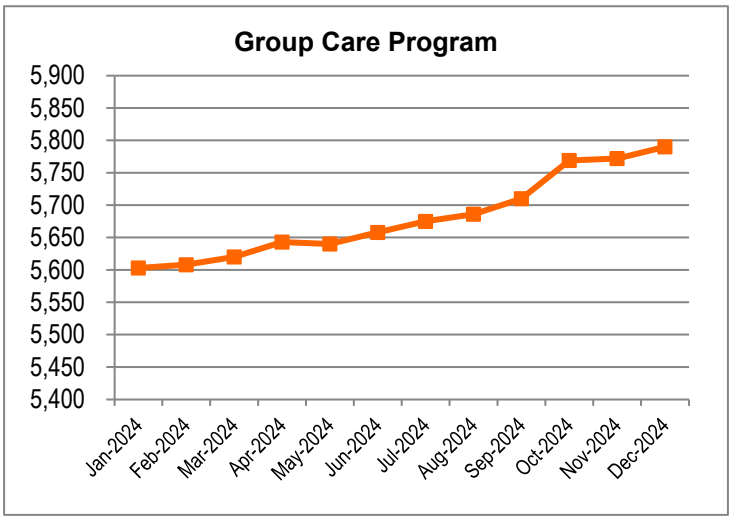


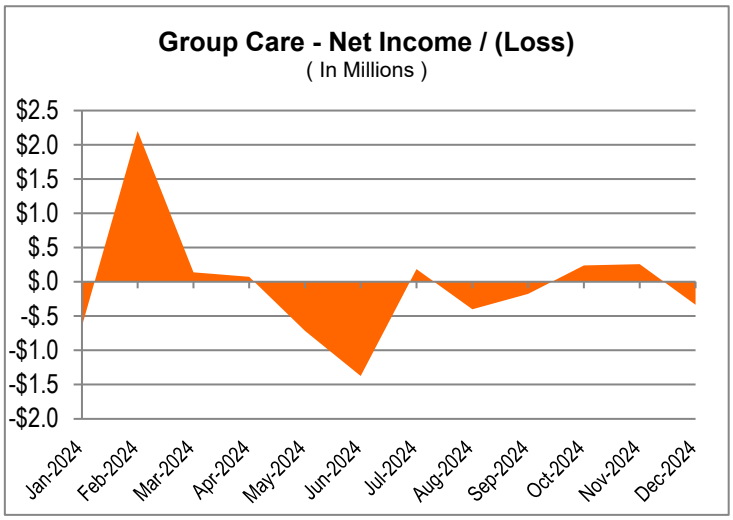


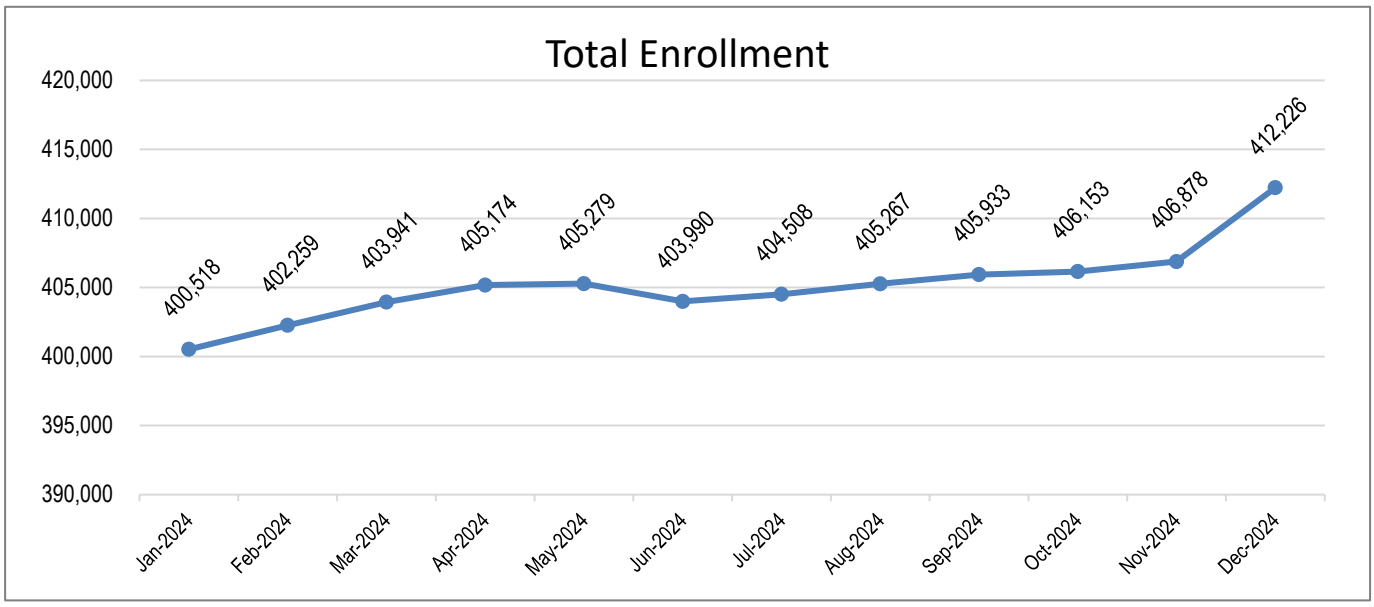
Enrollment and Profitability by Program and Category of Aid

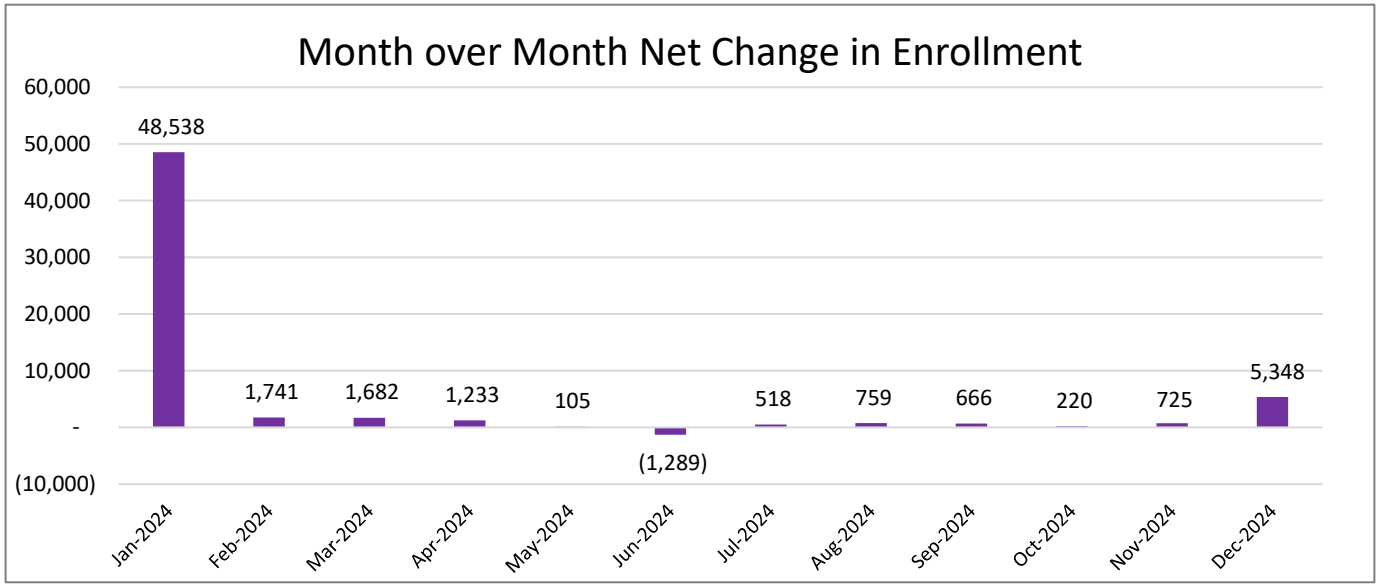








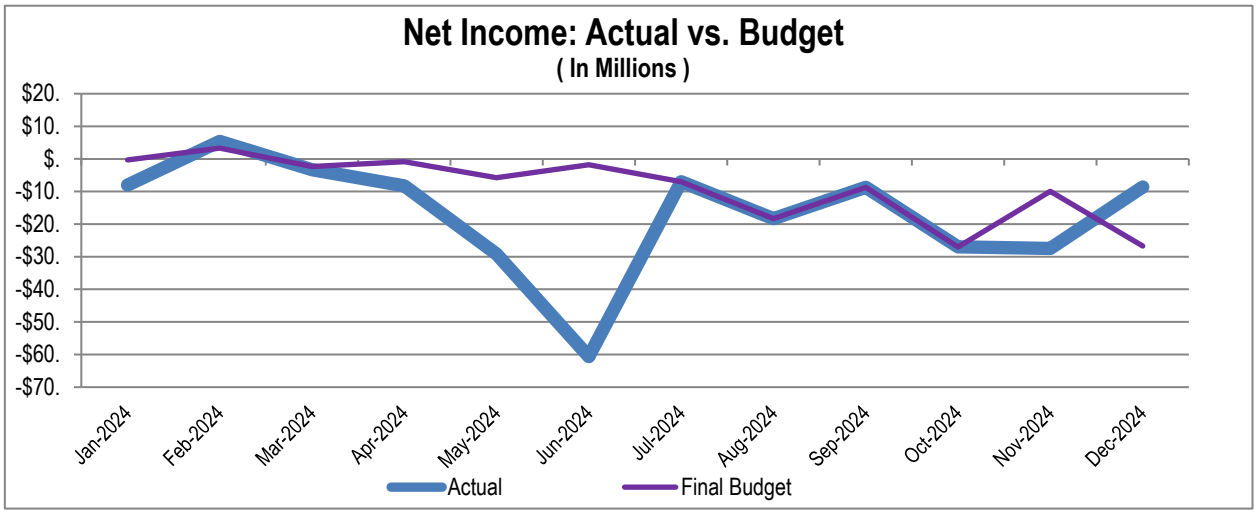




- The Public Health Emergency (PHE) ended May 2023. Disenrollments related to redetermination started July 2023 and ended May 2024. In preparation for the Single Plan Model, effective October 2023 DHCS no longer assigned members to Anthem, and instead new members were assigned to the Alliance.
- In January 2024, enrollment significantly increased due to transition to Single Plan Model and expansion of full scope Medi-Cal to California residents 26-49 regardless of immigration status. Kaiser's transition to a direct contract with the State resulted in a partially offsetting membership reduction.

Net Income

- For the month ended December 31st, 2024:
  - Actual Net Loss $8.6 million.
  - Budgeted Net Loss $26.8 million.
- For the fiscal YTD ended December 31st, 2024:
  - Actual Net Loss $97.2 million.
  - Budgeted Net Loss $97.8 million.

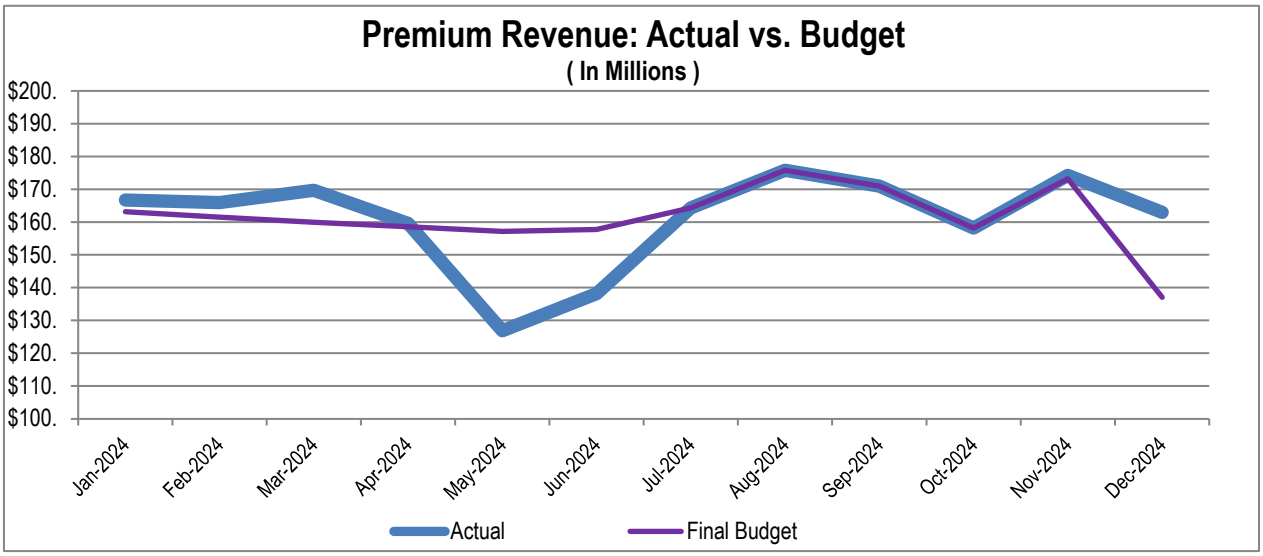


- The favorable variance of $18.1 million in the current month is primarily due to:
  - Favorable $25.9 million higher than anticipated Premium Revenue.
  - Favorable $1.9 million lower than anticipated Administrative Expense.
  - Unfavorable $10.1 million higher than anticipated Medical Expense.

Premium Revenue

- For the month ended December 31st, 2024:
  - Actual Revenue: $163.0 million.
  - Budgeted Revenue: $137.1 million.

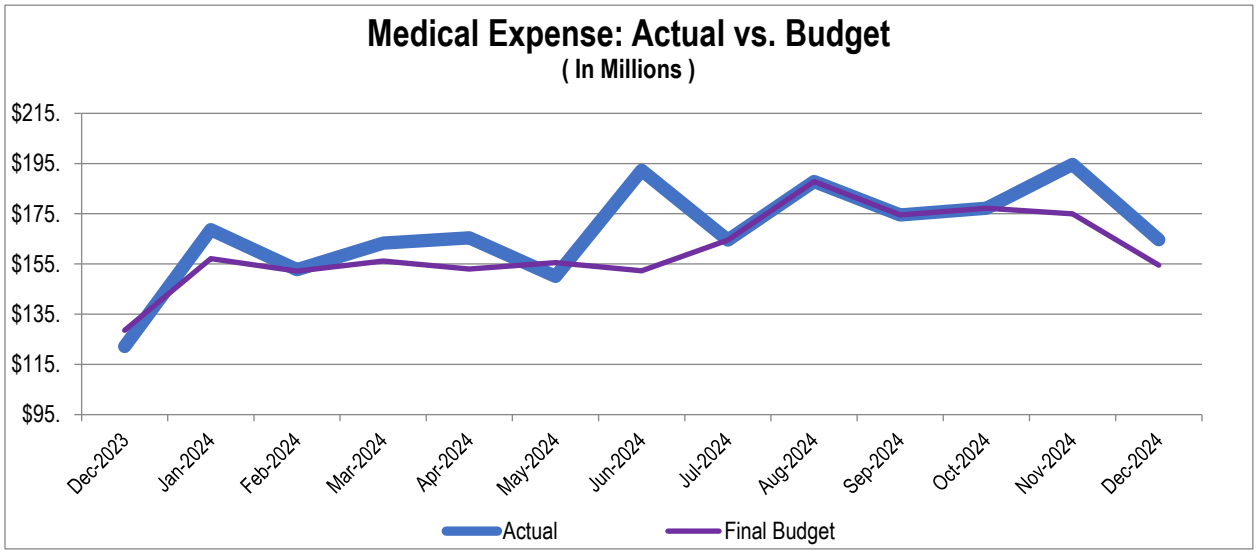
- For the fiscal YTD ended December 31st, 2024:
  - Actual Revenue: $1.0 billion
  - Budgeted Revenue: $979.5 million.



- For the month ended December 31st, 2024, the favorable Premium Revenue variance of $25.9 million is primarily due to the following:
  - Favorable CY2024 rate increase impact recorded.
  - Favorable volume variance for the current month.
  - Partially offset by a CY2022 to CY2024 Risk Corridor Adjustment recorded for MOT and ECM.

Medical Expense

- For the month ended December 31st, 2024:
  - Actual Medical Expense: $164.6 million.
  - Budgeted Medical Expense: $154.5 million.
- For the fiscal YTD ended December 31st, 2024:
  - Actual Medical Expense: $1.1 billion.
  - Budgeted Medical Expense: $1.0 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 December, updates to Fee-For-Service (FFS) decreased the estimate for prior period unpaid Medical Expenses by $523,000. Year to date, the estimate for prior years increased by $5.6 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	$101,867,753	$0	$101,867,753	$97,730,622	($4,137,131)	(4.2%)
Primary Care FFS	$21,177,085	$103,553	$21,280,638	$17,796,203	($3,380,883)	(19.0%)
Specialty Care FFS	$50,231,958	$225,513	$50,457,472	$49,467,511	($764,447)	(1.5%)
Outpatient FFS	$75,229,233	$372,476	$75,601,708	$72,449,386	($2,779,846)	(3.8%)
Ancillary FFS	$101,266,006	($392,708)	$100,873,298	$99,641,566	($1,624,440)	(1.6%)
Pharmacy FFS	$80,557,982	$236,838	$80,794,820	$81,015,415	$457,433	0.6%
ER Services FFS	$62,576,458	$139,638	$62,716,096	$62,536,828	($39,629)	(0.1%)
Inpatient Hospital FFS	$330,938,402	$3,251,176	$334,189,578	$320,106,876	($10,831,526)	(3.4%)
Long Term Care FFS Other	$204,581,218	$1,682,327	$206,263,545	$199,863,070	($4,718,148)	(2.4%)
Benefits & Services Net	$28,421,691	$0	$28,421,691	$31,797,343	$3,375,652	10.6%
Reinsurance	$997,634	$0	$997,634	$1,164,666	$167,032	14.3%
	$1,057,845,420	**$5,618,812**	**$1,063,464,232**	**$1,033,569,486**	**($24,275,934)**	**(2.3%)**

Medical Expense - Actual vs. Budget (Per Member Per Month)

Adjusted to Eliminate the Impact of Prior Year IBNP Estimates

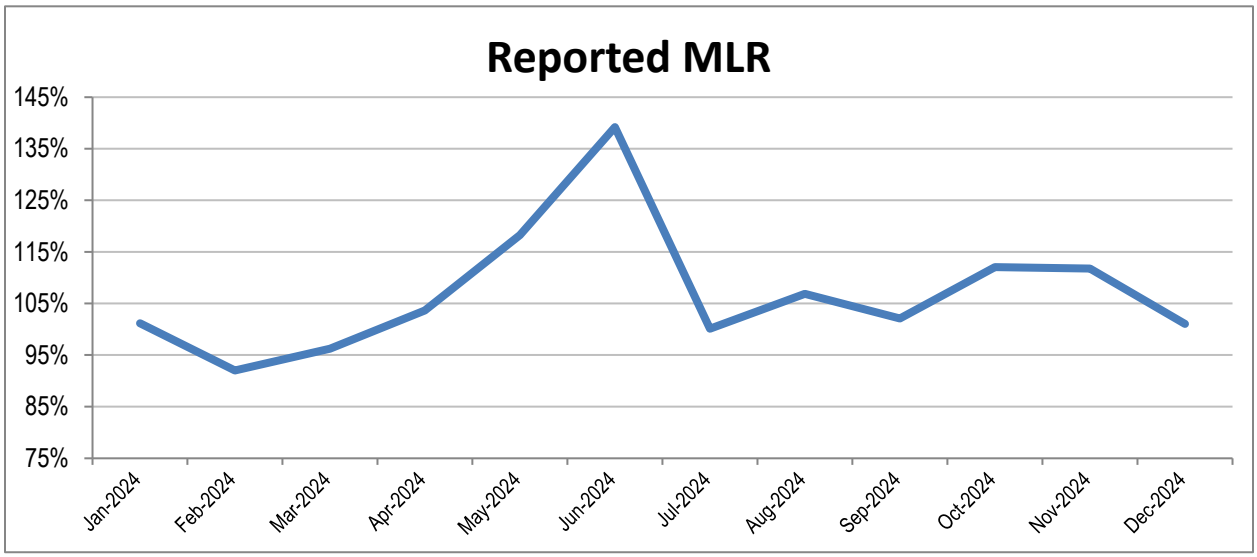
	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$41.73	$0.00	$41.73	$40.13	($1.60)	(4.0%)
Primary Care FFS	$8.68	$0.04	$8.72	$7.31	($1.37)	(18.7%)
Specialty Care FFS	$20.58	$0.09	$20.67	$20.31	($0.27)	(1.3%)
Outpatient FFS	$30.82	$0.15	$30.97	$29.75	($1.07)	(3.6%)
Ancillary FFS	$41.49	($0.16)	$41.33	$40.92	($0.57)	(1.4%)
Pharmacy FFS	$33.00	$0.10	$33.10	$33.27	$0.27	0.8%
ER Services FFS	$25.64	$0.06	$25.69	$25.68	$0.04	0.2%
Inpatient Hospital FFS	$135.58	$1.33	$136.91	$131.45	($4.13)	(3.1%)
Long Term Care FFS Other	$83.81	$0.69	$84.50	$82.07	($1.74)	(2.1%)
Benefits & Services Net	$11.64	$0.00	$11.64	$13.06	$1.41	10.8%
Reinsurance	$0.41	$0.00	$0.41	$0.48	$0.07	14.5%
	$433.37	**$2.30**	**$435.67**	**$424.42**	**($8.95)**	**(2.1%)**

- Excluding the impact of prior year estimates for IBNP, year-to-date medical expense variance is $24.3 million unfavorable to budget. On a PMPM basis, medical expense is 2.1% unfavorable to budget. For per-member-per-month expense:
    - Capitated Expense is over budget due to inclusion of Targeted Rate Increase (TRI) in capitation payments.
    - Primary Care Expense is over budget due to higher utilization and unit cost in the ACA OE and Child aid code categories.

- Specialty Care Expense is slightly above budget, driven by higher than expected SPD and ACA OE utilization.
- Outpatient Expense is over budget mostly driven by lab and radiology unit cost in the SPD, ACA OE and Adult aid code categories.
- Ancillary Expense is over budget due to higher Non-Emergency Transportation, lab and radiology, Behavioral Health, Home Health, DME, Medical Supplies and CBAS expense in the Child aid code category.
- Pharmacy Expense is under budget due to Non-PBM expense driven by lower utilization in the ACA OE aid code category.
- Emergency Room Expense is under budget driven by lower Child aid code category utilization and lower Dual member unit cost.
- Inpatient Expense is over budget driven by higher utilization in the SPD and ACA OE aid code categories.
- Long Term Care Expense is over budget due to higher unit cost in the SPD and ACA OE aid code categories.
- Other Benefits & Services is under budget, due to lower than expected purchased and professional services, community relations, licenses and insurance 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 101.0% for the month and 105.7% for the fiscal year-to-date.



Administrative Expense

- For the month ended December 31st, 2024:
  - Actual Administrative Expense: $9.4 million.
  - Budgeted Administrative Expense: $11.3 million.

- For the fiscal YTD ended December 31st, 2024:
  - Actual Administrative Expense: $57.7 million.
  - Budgeted Administrative Expense: $60.7 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 %**
$5,708,733	$5,951,534	$242,801	4.1%	Employee Expense	$33,809,934	$34,406,434	$596,500	1.7%
82,891	74,912	(7,979)	(10.7%)	Medical Benefits Admin Expense	465,196	454,633	(10,564)	(2.3%)
2,160,244	2,997,118	836,874	27.9%	Purchased & Professional Services	13,480,907	14,783,029	1,302,123	8.8%
1,486,030	2,281,317	795,287	34.9%	Other Admin Expense	9,898,416	11,063,341	1,164,924	10.5%
$9,437,898	$11,304,880	$1,866,983	16.5%	Total Administrative Expense	$57,654,453	$60,707,437	$3,052,983	5.0%

The year-to-date variances include:

- Favorable Employee and Temporary Services and delayed training, travel, and other employee-related expenses.
- Favorable in Purchased & Professional Services, primarily for the timing for Consulting Services and Other Purchased Services.
- Favorable Printing/Postage/Promotion and Supplies & Other Expenses.
- Favorable in Licenses, Insurance & Fees for IT-related Licenses and Subscriptions as well as reduction in Insurance Premiums.
- Favorable in Provider Interest, Supplies & Other Expenses
- Unfavorable Medical Benefit Admin Fees as well as Building Occupancy costs.

The Administrative Loss Ratio (ALR) is 5.8% of net revenue for the month and 5.7% 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 $775,000.

Other Income / (Expense)

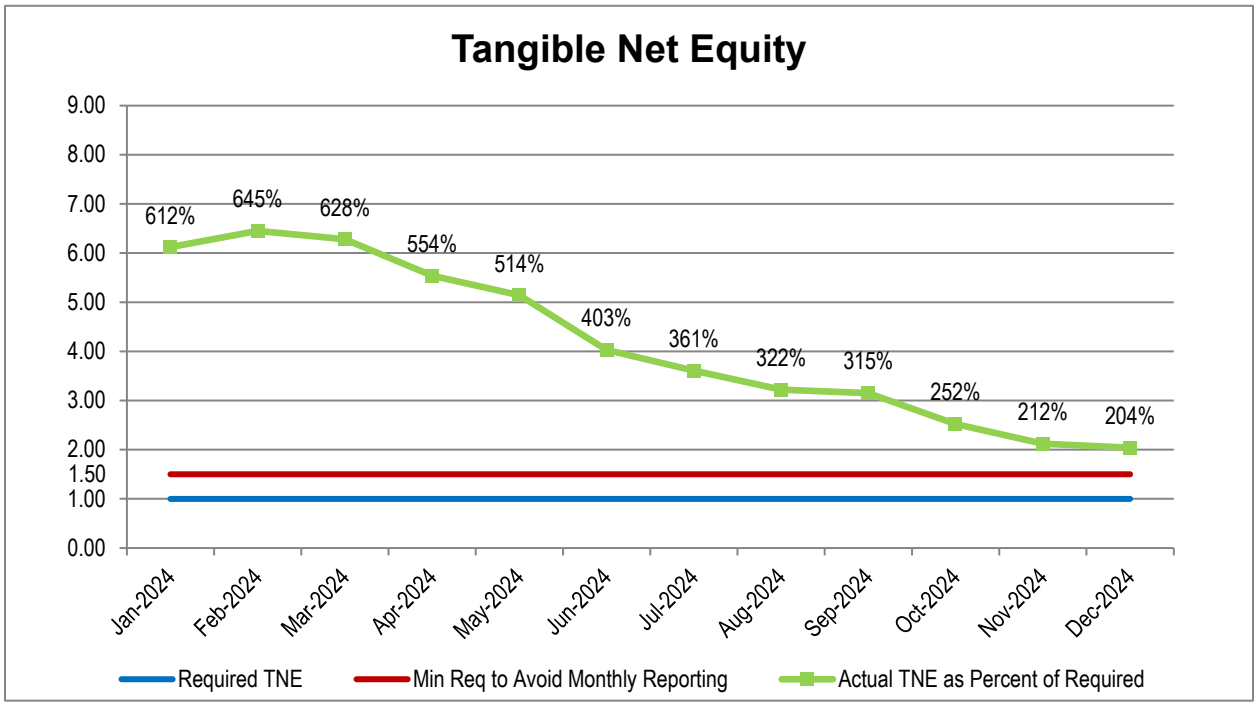
Other Income & Expense is comprised of investment income and claims interest. Fiscal year-to-date net investments show a gain of $17.5 million.

Managed Care Organization (MCO) Provider Tax

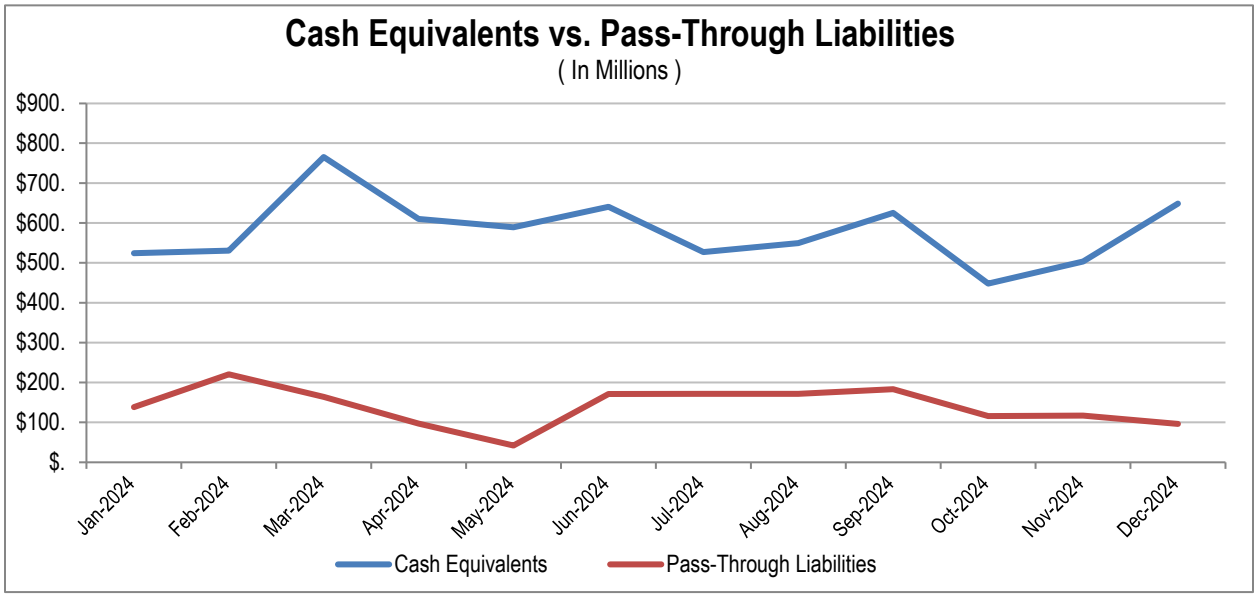
- Revenue:
  - For the month ended December 31st, 2024:
    - Actual: $64.5 million.
    - Budgeted: $63.7 million.
  - For the fiscal YTD ended December 31st, 2024:
    - Actual: $479.9 million.
    - Budgeted: $479.0 million.
- Expense:
  - For the month ended December 31st, 2024:
    - Actual: $64.5 million.
    - Budgeted: $63.7 million.
  - For the fiscal YTD ended December 31st, 2024:
    - Actual: $479.9 million.
    - Budgeted: $479.0 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 $77.6 million
  - Actual TNE $158.2 million
  - Excess TNE $80.6 million
  - TNE % of Required TNE 204%



- To ensure appropriate liquidity and limit risk, the majority of Alliance financial assets are kept in short-term investments.
- Key Metrics
    - Cash & Cash Equivalents $648.6 million
    - Pass-Through Liabilities $96.2 million
    - Uncommitted Cash $552.4 million
    - Working Capital $99.3 million
    - Current Ratio 1.10 (regulatory minimum is 1.00)



Capital Investment

- Fiscal year-to-date capital assets acquired: $530,000.
- 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 DECEMBER 31, 2024

CURRENT MONTH					FISCAL YEAR TO DATE			
		$ Variance	% Variance				$ Variance	% Variance
Actual	Budget	(Unfavorable)	(Unfavorable)	Account Description	Actual	Budget	(Unfavorable)	(Unfavorable)
				MEMBERSHIP				
406,436	401,109	5,327	1.3%	1. Medi-Cal	2,406,563	2,400,876	5,687	0.2%
5,790	5,769	21	0.4%	2. GroupCare	34,402	34,378	24	0.1%
412,226	**406,878**	**5,348**	**1.3%**	**3. TOTAL MEMBER MONTHS**	**2,440,965**	**2,435,254**	**5,711**	**0.2%**
				REVENUE				
$162,960,491	$137,079,292	$25,881,199	18.9%	4. Premium Revenue	$1,006,435,650	$979,541,837	$26,893,812	2.7%
$64,497,329	$63,651,987	$845,342	1.3%	5. MCO Tax Revenue AB119	$479,901,248	$478,998,778	$902,470	0.2%
$227,457,820	**$200,731,280**	**$26,726,540**	**13.3%**	**6. TOTAL REVENUE**	**$1,486,336,898**	**$1,458,540,615**	**$27,796,282**	**1.9%**
				MEDICAL EXPENSES				
				Capitated Medical Expenses				
$10,453,108	$8,383,852	($2,069,256)	(24.7%)	7. Capitated Medical Expense	$101,867,753	$97,730,622	($4,137,131)	(4.2%)
				Fee for Service Medical Expenses				
$55,495,011	$52,329,810	($3,165,200)	(6.0%)	8. Inpatient Hospital Expense	$334,189,578	$320,106,876	($14,082,702)	(4.4%)
$7,576,142	$4,639,765	($2,936,377)	(63.3%)	9. Primary Care Physician Expense	$21,280,638	$17,796,203	($3,484,435)	(19.6%)
$9,172,103	$8,225,668	($946,434)	(11.5%)	10. Specialty Care Physician Expense	$50,457,472	$49,467,511	($989,960)	(2.0%)
$5,066,160	$6,740,978	$1,674,818	24.8%	11. Ancillary Medical Expense	$100,873,298	$99,641,566	($1,231,732)	(1.2%)
$13,141,836	$11,684,491	($1,457,345)	(12.5%)	12. Outpatient Medical Expense	$75,601,708	$72,449,386	($3,152,322)	(4.4%)
$10,816,202	$10,423,842	($392,361)	(3.8%)	13. Emergency Expense	$62,716,096	$62,536,828	($179,268)	(0.3%)
$11,145,374	$12,274,518	$1,129,144	9.2%	14. Pharmacy Expense	$80,794,820	$81,015,415	$220,595	0.3%
$37,589,778	$33,132,376	($4,457,402)	(13.5%)	15. Long Term Care Expense	$206,263,545	$199,863,070	($6,400,475)	(3.2%)
$150,002,605	$139,451,449	($10,551,157)	(7.6%)	16. Total Fee for Service Expense	$932,177,155	$902,876,856	($29,300,299)	(3.2%)
$3,832,426	$6,251,734	$2,419,308	38.7%	17. Other Benefits & Services	$28,421,691	$31,797,343	$3,375,652	10.6%
$359,151	$439,727	$80,576	18.3%	18. Reinsurance Expense	$997,634	$1,164,666	$167,032	14.3%
$164,647,291	**$154,526,761**	**($10,120,530)**	**(6.5%)**	**20. TOTAL MEDICAL EXPENSES**	**$1,063,464,232**	**$1,033,569,486**	**($29,894,746)**	**(2.9%)**
$62,810,529	**$46,204,518**	**$16,606,011**	**35.9%**	**21. GROSS MARGIN**	**$422,872,666**	**$424,971,129**	**($2,098,464)**	**(0.5%)**
				ADMINISTRATIVE EXPENSES				
$5,708,733	$5,951,534	$242,801	4.1%	22. Personnel Expense	$33,809,934	$34,406,434	$596,500	1.7%
$82,891	$74,912	($7,979)	(10.7%)	23. Benefits Administration Expense	$465,196	$454,633	($10,564)	(2.3%)
$2,160,244	$2,997,118	$836,874	27.9%	24. Purchased & Professional Services	$13,480,907	$14,783,029	$1,302,123	8.8%
$1,486,030	$2,281,317	$795,287	34.9%	25. Other Administrative Expense	$9,898,416	$11,063,340	$1,164,924	10.5%
$9,437,898	**$11,304,880**	**$1,866,983**	**16.5%**	**26. TOTAL ADMINISTRATIVE EXPENSES**	**$57,654,453**	**$60,707,437**	**$3,052,983**	**5.0%**
$64,497,329	**$63,651,987**	**($845,342)**	**(1.3%)**	**27. MCO TAX EXPENSES**	**$479,901,248**	**$478,998,778**	**($902,470)**	**(0.2%)**
($11,124,698)	**($28,752,350)**	**$17,627,652**	**61.3%**	**28. NET OPERATING INCOME / (LOSS)**	**($114,683,036)**	**($114,735,085)**	**$52,050**	**0.0%**
				OTHER INCOME / EXPENSES				
$2,481,472	**$2,000,000**	**$481,472**	**24.1%**	**29. TOTAL OTHER INCOME / (EXPENSES)**	**$17,521,795**	**$16,981,002**	**$540,793**	**3.2%**
($8,643,226)	**($26,752,350)**	**$18,109,124**	**67.7%**	**30. NET SURPLUS (DEFICIT)**	**($97,161,241)**	**($97,754,083)**	**$592,842**	**0.6%**
101.0%	112.7%	11.7%	10.4%	31. Medical Loss Ratio	105.7%	105.5%	(0.2%)	(0.2%)
5.8%	8.2%	2.4%	29.3%	32. Administrative Expense Ratio	5.7%	6.2%	0.5%	8.1%
(3.8%)	(13.3%)	9.5%	71.4%	33. Net Surplus (Deficit) Ratio	(6.5%)	(6.7%)	0.2%	3.0%

ALAMEDA ALLIANCE FOR HEALTH
BALANCE SHEETS
CURRENT MONTH VS. PRIOR MONTH
FOR THE MONTH AND FISCAL YTD ENDED DECEMBER 31, 2024

	12/31/2024	11/30/2024	Difference	% Difference
CURRENT ASSETS				
Cash and Cash Equivalent				
Cash	$114,463,648	$21,075,966	$93,387,682	443.1%
CNB Short-Term Investment	534,091,532	482,278,187	51,813,345	10.7%
Interest Receivable	5,317,151	4,717,269	599,882	12.7%
Premium Receivables	444,009,126	496,737,349	(52,728,223)	(10.6%)
Reinsurance Recovery Receivable	7,287,219	7,263,899	23,320	0.3%
Other Receivables	1,450,111	1,171,706	278,406	23.8%
Prepaid Expenses	724,913	749,760	(24,847)	(3.3%)
TOTAL CURRENT ASSETS	**1,107,343,699**	**1,013,994,135**	**93,349,564**	**9.2%**
OTHER ASSETS				
CNB Long-Term Investment	44,130,301	44,162,073	(31,773)	(0.1%)
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	350,000	350,000	0	0.0%
GASB 87-Lease Assets (Net)	411,442	477,356	(65,913)	(13.8%)
GASB 96-SBITA Assets (Net)	3,829,974	3,886,019	(56,044)	(1.4%)
TOTAL OTHER ASSETS	**56,897,118**	**57,050,848**	**(153,730)**	**(0.3%)**
PROPERTY AND EQUIPMENT				
Land, Building & Improvements	9,842,648	9,842,648	0	0.0%
Furniture And Equipment	13,071,003	13,071,003	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	38,640,099	38,640,099	0	0.0%
Less: Accumulated Depreciation	(33,019,378)	(32,960,005)	(59,373)	0.2%
PROPERTY AND EQUIPMENT (NET)	**5,620,721**	**5,680,094**	**(59,373)**	**(1.0%)**
TOTAL ASSETS	**1,169,861,537**	**1,076,725,077**	**93,136,461**	**8.6%**
CURRENT LIABILITIES				
Trade Accounts Payable	9,791,559	8,805,061	986,499	11.2%
Incurred But Not Reported Claims	368,254,069	329,821,855	38,432,214	11.7%
Other Medical Liabilities	135,136,830	116,406,026	18,730,804	16.1%
Pass-Through Liabilities	96,151,184	116,963,192	(20,812,008)	(17.8%)
MCO Tax Liabilities	388,747,080	324,249,751	64,497,329	19.9%
GASB 87 and 96 ST Liabilities	1,248,045	2,923,836	(1,675,790)	(57.3%)
Payroll Liabilities	8,702,863	6,996,340	1,706,524	24.4%
TOTAL CURRENT LIABILITIES	**1,008,031,632**	**906,166,061**	**101,865,571**	**11.2%**
LONG TERM LIABILITIES				
GASB 87 and 96 LT Liabilities	288,473	374,358	(85,885)	(22.9%)
Deferred Inflow	3,327,530	3,327,530	0	0.0%
TOTAL LONG TERM LIABILITIES	**3,616,003**	**3,701,888**	**(85,885)**	**(2.3%)**
TOTAL LIABILITIES	**1,011,647,635**	**909,867,948**	**101,779,686**	**11.2%**
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)	(97,161,241)	(88,518,015)	(8,643,226)	9.8%
TOTAL NET WORTH	**158,213,903**	**166,857,128**	**(8,643,226)**	**(5.2%)**
TOTAL LIABILITIES AND NET WORTH	**1,169,861,538**	**1,076,725,077**	**93,136,461**	**8.6%**
Cash Equivalents	648,555,180	503,354,153	145,201,027	28.8%
Pass-Through	96,151,184	116,963,192	(20,812,008)	(17.8%)
Uncommitted Cash	552,403,995	386,390,961	166,013,034	43.0%
Working Capital	99,312,067	107,828,074	(8,516,007)	(7.9%)
Current Ratio	109.9%	111.9%	(2.0%)	(1.8%)

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED **December 31, 2024**

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM OPERATING ACTIVITIES				
Commercial Premium Cash Flows				
Commercial Premium Revenue	$3,168,126	$9,477,045	$18,816,609	$18,816,608
GroupCare Receivable	6,207,132	3,099,839	(9,453)	(9,453)
Total	9,375,258	12,576,884	18,807,156	18,807,155
Medi-Cal Premium Cash Flows				
Medi-Cal Revenue	224,289,692	677,551,411	1,467,520,289	1,467,520,287
Premium Receivable	46,521,091	17,255,907	(77,056,152)	(77,056,152)
Total	270,810,783	694,807,318	1,390,464,137	1,390,464,135
Investment & Other Income Cash Flows				
Other Revenues	523,512	77,403	2,616,485	2,616,485
Interest Income	1,981,933	6,567,049	14,990,268	14,990,268
Interest Receivable	(599,882)	(209,497)	(3,401,087)	(3,401,087)
Total	1,905,563	6,434,955	14,205,666	14,205,666
Medical & Hospital Cash Flows				
Total Medical Expenses	(164,647,290)	(536,574,274)	(1,063,464,232)	(1,063,464,237)
Other Health Care Receivables	(293,463)	3,415,656	2,231,637	2,231,637
Capitation Payable	-	-	-	-
IBNP Payable	38,432,214	52,821,323	71,949,810	71,949,810
Other Medical Payable	(2,081,202)	(60,679,631)	(104,552,742)	(104,552,742)
Risk Share Payable	-	(1,000)	(2,680,192)	(2,680,192)
New Health Program Payable	-	-	-	-
Total	(128,589,741)	(541,017,926)	(1,096,515,719)	(1,096,515,724)
Administrative Cash Flows				
Total Administrative Expenses	(9,461,873)	(28,510,684)	(57,739,412)	(57,739,414)
Prepaid Expenses	24,848	72,103	(486,296)	(486,296)
Other Receivables	(8,263)	(7,317)	25,574	25,574
CalPERS Pension	-	-	-	-
Trade Accounts Payable	986,498	4,534,128	3,301,264	3,301,264
Payroll Liabilities	1,706,524	(1,797,170)	603,638	603,638
GASB Assets and Liabilities	(1,639,719)	(1,700,712)	(2,203,413)	(2,203,413)
Depreciation Expense	59,373	183,004	356,706	356,706
Total	(8,332,612)	(27,226,648)	(56,141,939)	(56,141,941)
MCO Tax AB119 Cash Flows				
MCO Tax Expense AB119	(64,497,329)	(191,685,777)	(479,901,248)	(479,901,248)
MCO Tax Liabilities	64,497,329	66,217,027	228,963,566	228,963,566
Total	0	(125,468,750)	(250,937,682)	(250,937,682)
Net Cash Flows from Operating Activities	**145,169,251**	**20,105,833**	**19,881,619**	**19,881,609**

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED **December 31, 2024**

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM INVESTING ACTIVITIES				
Investment Cash Flows				
Long Term Investments	31,773	3,028,983	(11,138,055)	(11,138,052)
Total	31,773	3,028,983	(11,138,055)	(11,138,052)
Restricted Cash & Other Asset Cash Flows				
Restricted Assets-Treasury Account	-	-	-	-
Total	-	-	-	-
Fixed Asset Cash Flows				
Fixed Asset Acquisitions	-	-	(529,610)	(529,610)
Purchases of Property and Equipment	-	-	(529,610)	(529,610)
Net Cash Flows from Investing Activities	**31,773**	**3,028,983**	**(11,667,665)**	**(11,667,662)**
Net Change in Cash	**145,201,024**	**23,134,816**	**8,213,954**	**8,213,947**
Rounding	4.00	-	-	7.00
Cash @ Beginning of Period	503,354,152	625,420,364	640,341,226	640,341,226
Cash @ End of Period	**$648,555,180**	**$648,555,180**	**$648,555,180**	**$648,555,180**
Variance	-	-	-	-

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED **December 31, 2024**

	MONTH	3 MONTHS	6 MONTHS	YTD
NET INCOME RECONCILIATION				
Net Income / (Loss)	($8,643,229)	($63,097,827)	($97,161,241)	($97,161,251)
Add back: Depreciation & Amortization	59,373	183,004	356,706	356,706
Receivables				
Premiums Receivable	46,521,091	17,255,907	(77,056,152)	(77,056,152)
Interest Receivable	(599,882)	(209,497)	(3,401,087)	(3,401,087)
Other Health Care Receivables	(293,463)	3,415,656	2,231,637	2,231,637
Other Receivables	(8,263)	(7,317)	25,574	25,574
GroupCare Receivable	6,207,132	3,099,839	(9,453)	(9,453)
Total	51,826,615	23,554,588	(78,209,481)	(78,209,481)
Prepaid Expenses	24,848	72,103	(486,296)	(486,296)
Trade Payables	986,498	4,534,128	3,301,264	3,301,264
Claims Payable and Shared Risk Pool				
IBNP Payable	38,432,214	52,821,323	71,949,810	71,949,810
Capitation Payable & Other Medical Payable	(2,081,202)	(60,679,631)	(104,552,742)	(104,552,742)
Risk Share Payable	-	(1,000.00)	(2,680,192)	(2,680,192)
Claims Payable				
Total	36,351,012	(7,859,308)	(35,283,124)	(35,283,124)
Other Liabilities				
CalPERS Pension	-	-	-	-
Payroll Liabilities	1,706,524	(1,797,170)	603,639	603,638
GASB Assets and Liabilities	(1,639,719)	(1,700,712)	(2,203,413)	(2,203,413)
New Health Program	-	-	-	-
MCO Tax Liabilities	64,497,329	66,217,027	228,963,566	228,963,566
Total	64,564,134	62,719,145	227,363,792	227,363,791
Rounding	-	-	(1.00)	-
Cash Flows from Operating Activities	**145,169,251**	**20,105,833**	**19,881,619**	**19,881,609**
Variance	-	-	-	-

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED **December 31, 2024**

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOW STATEMENT:				
Cash Flows from Operating Activities:				
Cash Received				
Capitation Received from State of CA	$270,810,783	$694,807,318	$1,390,464,137	$1,390,464,135
Medicare Revenue	$0	$0	$0	$0
GroupCare Premium Revenue	9,375,258	12,576,884	18,807,156	18,807,155
Other Income	523,512	77,403	2,616,485	2,616,485
Interest Income	1,382,051	6,357,552	11,589,181	11,589,181
Less Cash Paid				
Medical Expenses	(128,589,741)	(541,017,926)	(1,096,515,719)	(1,096,515,724)
Vendor & Employee Expenses	(8,332,612)	(27,226,648)	(56,141,939)	(56,141,941)
MCO Tax Expense AB119	0	(125,468,750)	(250,937,682)	(250,937,682)
Net Cash Flows from Operating Activities	**145,169,251**	**20,105,833**	**19,881,619**	**19,881,609**
Cash Flows from Investing Activities:				
Long Term Investments	31,773	3,028,983	(11,138,055)	(11,138,052)
Restricted Assets-Treasury Account	0	0	0	0
Purchases of Property and Equipment	0	0	(529,610)	(529,610)
Net Cash Flows from Investing Activities	**31,773**	**3,028,983**	**(11,667,665)**	**(11,667,662)**
Net Change in Cash	**145,201,024**	**23,134,816**	**8,213,954**	**8,213,947**
Rounding	4.00	-	-	7.00
Cash @ Beginning of Period	503,354,152	625,420,364	640,341,226	640,341,226
Cash @ End of Period	**$648,555,180**	**$648,555,180**	**$648,555,180**	**$648,555,180**
Variance	$0	-	-	-
RECONCILIATION OF NET INCOME TO NET CASH FLOW FROM OPERATING ACTIVITIES:				
Net Income / (Loss)	($8,643,229)	($63,097,826)	($97,161,242)	($97,161,251)
Add Back: Depreciation	59,373	183,004	356,706	356,706
Net Change in Operating Assets & Liabilities				
Premium & Other Receivables	51,826,615	23,554,588	(78,209,481)	(78,209,481)
Prepaid Expenses	24,848	72,102	(486,295)	(486,296)
Trade Payables	986,498	4,534,128	3,301,264	3,301,264
Claims Payable, IBNP and Risk Sharing	36,351,012	(7,859,308)	(35,283,124)	(35,283,124)
Deferred Revenue	0	0	0	0
Other Liabilities	64,564,134	62,719,145	227,363,792	227,363,791
Total	145,169,251	20,105,833	19,881,620	19,881,609
Rounding	-	-	(1)	-
Cash Flows from Operating Activities	**$145,169,251**	**$20,105,833**	**$19,881,619**	**$19,881,609**
Variance	$0	-	-	-

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE MONTH OF DECEMBER 2024

	Medi-Cal Child	Medi-Cal Adult	Medi-Cal SPD	Medi-Cal ACA OE	Medi-Cal Duals	Medi-Cal LTC	Medi-Cal LTC Duals	Medi-Cal Total	Group Care	Medicare	Grand Total
Enrollments/Member Months	110,506	62,905	36,127	154,560	40,798	254	1,286	406,436	5,790	-	412,226
Revenue	$32,113,435	$31,568,085	$52,641,938	$75,388,591	$18,808,695	$2,544,021	$11,224,927	$224,289,693	$3,168,127	$0	$227,457,820
Medical Expense	$13,875,439	$19,051,471	$40,620,076	$60,587,461	$11,032,081	$3,302,767	$12,682,293	$161,151,588	$3,412,019	$83,684	$164,647,291
Gross Margin	$18,237,996	$12,516,614	$12,021,862	$14,801,130	$7,776,614	($758,746)	($1,457,366)	$63,138,105	($243,892)	($83,684)	$62,810,529
Administrative Expense	$399,192	$950,285	$2,029,051	$2,614,179	$695,663	$145,770	$668,352	$7,502,493	$125,597	$1,809,808	$9,437,898
MCO Tax Expense	$17,536,197	$9,982,394	$5,732,994	$24,527,126	$6,474,235	$40,307	$204,075	$64,497,329	$0	$0	$64,497,329
Operating Income / (Expense)	$302,607	$1,583,935	$4,259,817	($12,340,176)	$606,716	($944,823)	($2,329,793)	($8,861,717)	($369,489)	($1,893,492)	($11,124,698)
Other Income / (Expense)	$125,447	$311,506	$666,804	$848,166	$227,924	$47,976	$220,507	$2,448,330	$33,142	$0	$2,481,472
Net Income / (Loss)	$428,054	$1,895,441	$4,926,621	($11,492,010)	$834,640	($896,847)	($2,109,286)	($6,413,386)	($336,348)	($1,893,492)	($8,643,226)
PMPM Metrics:											
Revenue PMPM	$290.60	$501.84	$1,457.14	$487.76	$461.02	$10,015.83	$8,728.56	$551.85	$547.17	$0.00	$551.78
Medical Expense PMPM	$125.56	$302.86	$1,124.37	$392.00	$270.41	$13,003.02	$9,861.81	$396.50	$589.30	$0.00	$399.41
Gross Margin PMPM	$165.04	$198.98	$332.77	$95.76	$190.61	($2,987.19)	($1,133.25)	$155.35	($42.12)	$0.00	$152.37
Administrative Expense PMPM	$3.61	$15.11	$56.16	$16.91	$17.05	$573.90	$519.71	$18.46	$21.69	$0.00	$22.89
MCO Tax Expense PMPM	$158.69	$158.69	$158.69	$158.69	$158.69	$158.69	$158.69	$158.69	$0.00	$0.00	$156.46
Operating Income / (Expense) PMPM	$2.74	$25.18	$117.91	($79.84)	$14.87	($3,719.78)	($1,811.66)	($21.80)	($63.82)	$0.00	($26.99)
Other Income / (Expense) PMPM	$1.14	$4.95	$18.46	$5.49	$5.59	$188.88	$171.47	$6.02	$5.72	$0.00	$6.02
Net Income / (Loss) PMPM	$3.87	$30.13	$136.37	($74.35)	$20.46	($3,530.89)	($1,640.19)	($15.78)	($58.09)	$0.00	($20.97)
Ratio:											
Medical Loss Ratio	95.2%	88.3%	86.6%	119.1%	89.4%	131.9%	115.1%	100.9%	107.7%	0.0%	101.0%
Administrative Expense Ratio	2.7%	4.4%	4.3%	5.1%	5.6%	5.8%	6.1%	4.7%	4.0%	0.0%	5.8%
Net Income Ratio	1.3%	6.0%	9.4%	-15.2%	4.4%	-35.3%	-18.8%	-2.9%	-10.6%	0.0%	-3.8%

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE FISCAL YEAR TO DATE DECEMBER 2024

	Medi-Cal Child	Medi-Cal Adult	Medi-Cal SPD	Medi-Cal ACA OE	Medi-Cal Duals	Medi-Cal LTC	Medi-Cal LTC Duals	Medi-Cal Total	Group Care	Medicare	Grand Total
Enrollments/Member Months	659,195	375,884	212,632	908,505	241,339	1,446	7,562	2,406,563	34,402	-	2,440,965
Revenue	$221,461,531	$205,833,985	$304,541,493	$518,659,689	$135,937,249	$15,514,724	$65,571,617	$1,467,520,289	$18,816,609	$0	$1,486,336,898
Medical Expense	$79,433,437	$124,163,002	$290,066,595	$375,374,562	$90,763,289	$17,964,302	$67,122,328	$1,044,887,515	$18,424,107	$152,610	$1,063,464,232
Gross Margin	$142,028,094	$81,670,983	$14,474,898	$143,285,127	$45,173,960	($2,449,577)	($1,550,711)	$422,632,774	$392,501	($152,610)	$422,872,666
Administrative Expense	$2,791,080	$6,642,236	$14,199,799	$18,052,122	$4,919,831	$1,010,378	$4,684,171	$52,299,618	$864,041	$4,490,794	$57,654,453
MCO Tax Expense	$131,740,753	$75,226,030	$42,342,501	$180,622,572	$48,165,226	$283,625	$1,520,540	$479,901,248	$0	$0	$479,901,248
Operating Income / (Expense)	$7,496,261	($197,283)	($42,067,402)	($55,389,567)	($7,911,097)	($3,743,581)	($7,755,422)	($109,568,092)	($471,540)	($4,643,404)	($114,683,036)
Other Income / (Expense)	$885,986	$2,196,179	$4,709,375	$5,990,262	$1,609,737	$338,837	$1,557,352	$17,287,728	$234,067	$0	$17,521,795
Net Income / (Loss)	$8,382,247	$1,998,896	($37,358,028)	($49,399,306)	($6,301,360)	($3,404,744)	($6,198,070)	($92,280,364)	($237,473)	($4,643,404)	($97,161,241)
PMPM Metrics:											
Revenue PMPM	$335.96	$547.60	$1,432.25	$570.89	$563.26	$10,729.41	$8,671.20	$609.80	$546.96	$0.00	$608.91
Medical Expense PMPM	$120.50	$330.32	$1,364.17	$413.18	$376.08	$12,423.45	$8,876.27	$434.18	$535.55	$0.00	$435.67
Gross Margin PMPM	$215.46	$217.28	$68.07	$157.72	$187.18	($1,694.04)	($205.07)	$175.62	$11.41	$0.00	$173.24
Administrative Expense PMPM	$4.23	$17.67	$66.78	$19.87	$20.39	$698.74	$619.44	$21.73	$25.12	$0.00	$23.62
MCO Tax Expense PMPM	$199.85	$200.13	$199.14	$198.81	$199.57	$196.14	$201.08	$199.41	$0.00	$0.00	$196.60
Operating Income / (Expense) PMPM	$11.37	($0.52)	($197.84)	($60.97)	($32.78)	($2,588.92)	($1,025.58)	($45.53)	($13.71)	$0.00	($46.98)
Other Income / (Expense) PMPM	$1.34	$5.84	$22.15	$6.59	$6.67	$234.33	$205.94	$7.18	$6.80	$0.00	$7.18
Net Income / (Loss) PMPM	$12.72	$5.32	($175.69)	($54.37)	($26.11)	($2,354.59)	($819.63)	($38.35)	($6.90)	$0.00	($39.80)
Ratio:											
Medical Loss Ratio	88.5%	95.1%	110.6%	111.0%	103.4%	117.9%	104.8%	105.8%	97.9%	0.0%	105.7%
Administrative Expense Ratio	3.1%	5.1%	5.4%	5.3%	5.6%	6.6%	7.3%	5.3%	4.6%	0.0%	5.7%
Net Income Ratio	3.8%	1.0%	-12.3%	-9.5%	-4.6%	-21.9%	-9.5%	-6.3%	-1.3%	0.0%	-6.5%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED December 31, 2024

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)				
$5,708,733	$5,951,534	$242,801	4.1%	Personnel Expenses	$33,809,934	$34,406,434	$596,500	1.7%
$82,891	$74,912	($7,979)	(10.7%)	Benefits Administration Expense	$465,196	$454,633	($10,564)	(2.3%)
$2,160,244	$2,997,118	$836,874	27.9%	Purchased & Professional Services	$13,480,907	$14,783,029	$1,302,123	8.8%
$549,854	$587,515	$37,662	6.4%	Occupancy	$3,194,006	$3,170,170	($23,837)	(0.8%)
$4,388	$553,936	$549,548	99.2%	Printing Postage & Promotion	$1,971,751	$2,931,368	$959,617	32.7%
$796,143	$939,307	$143,163	15.2%	Licenses Insurance & Fees	$3,658,334	$3,808,323	$149,989	3.9%
$135,645	$200,559	$64,914	32.4%	Other Administrative Expense	$1,074,325	$1,153,480	$79,155	6.9%
$3,729,165	$5,353,347	$1,624,182	30.3%	Total Other Administrative Expenses (excludes Personnel Expenses)	$23,844,519	$26,301,002	$2,456,483	9.3%
$9,437,898	$11,304,880	$1,866,983	16.5%	Total Administrative Expenses	$57,654,453	$60,707,437	$3,052,983	5.0%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED December 31, 2024

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
3,827,008	4,173,013	346,005	8.3%	Salaries & Wages	22,658,371	22,325,279	(333,092)	(1.5%)
338,573	360,093	21,519	6.0%	Paid Time Off	1,991,451	2,240,793	249,342	11.1%
8,118	8,755	637	7.3%	Compensated Incentives	19,856	22,299	2,442	11.0%
0	0	0	0.0%	Severence	0	400,000	400,000	100.0%
62,341	63,982	1,641	2.6%	Payroll Taxes	369,541	397,324	27,783	7.0%
62,318	25,460	(36,858)	(144.8%)	Overtime	419,448	365,539	(53,910)	(14.7%)
284,106	287,826	3,721	1.3%	CalPERS ER Match	1,854,133	1,995,432	141,299	7.1%
937,034	606,154	(330,880)	(54.6%)	Employee Benefits	5,783,530	5,132,979	(650,551)	(12.7%)
3,450	0	(3,450)	0.0%	Personal Floating Holiday	5,963	3,894	(2,070)	(53.2%)
20,069	28,000	7,931	28.3%	Language Pay	123,901	170,259	46,359	27.2%
5,950	0	(5,950)	0.0%	Med Ins Opted Out Stipend	20,700	16,010	(4,690)	(29.3%)
0	0	0	0.0%	Holiday Bonus	(400,000)	0	400,000	1,333,333,4…
95,989	0	(95,989)	0.0%	Sick Leave	488,645	270,728	(217,917)	(80.5%)
2,791	46,733	43,942	94.0%	Compensated Employee Relations	6,410	103,589	97,179	93.8%
20,480	25,450	4,970	19.5%	Work from Home Stipend	119,730	129,570	9,840	7.6%
2,536	8,498	5,962	70.2%	Mileage, Parking & LocalTravel	8,286	25,223	16,937	67.1%
647	21,242	20,595	97.0%	Travel & Lodging	15,491	72,517	57,026	78.6%
27,401	113,365	85,964	75.8%	Temporary Help Services	188,981	327,374	138,393	42.3%
3,196	120,564	117,368	97.3%	Staff Development/Training	62,413	264,559	202,146	76.4%
6,726	62,398	55,672	89.2%	Staff Recruitment/Advertisement	73,082	143,067	69,985	48.9%
5,708,733	**5,951,534**	**242,801**	**4.1%**	**Personnel Expense**	**33,809,934**	**34,406,434**	**596,500**	**1.7%**
29,601	22,018	(7,583)	(34.4%)	Pharmacy Administrative Fees	149,576	139,168	(10,408)	(7.5%)
53,291	52,894	(396)	(0.7%)	Telemedicine Admin. Fees	315,620	315,464	(156)	0.0%
82,891	**74,912**	**(7,979)**	**(10.7%)**	**Benefits Administration Expense**	**465,196**	**454,633**	**(10,564)**	**(2.3%)**
627,145	850,019	222,875	26.2%	Consultant Fees - Non Medical	3,604,826	4,193,457	588,631	14.0%
184,139	693,299	509,160	73.4%	Computer Support Services	3,096,666	3,314,111	217,445	6.6%
65,500	15,000	(50,500)	(336.7%)	Audit Fees	146,158	98,158	(48,000)	(48.9%)
0	17	17	100.0%	Consultant Fees - Medical	995	(15,322)	(16,317)	106.5%
193,254	324,107	130,853	40.4%	Other Purchased Services	1,446,423	1,621,717	175,293	10.8%
0	1,688	1,688	100.0%	Maint.&Repair-Office Equipment	0	3,376	3,376	100.0%
159,257	70,067	(89,190)	(127.3%)	Legal Fees	602,343	471,419	(130,924)	(27.8%)
0	0	0	0.0%	Member Health Education	320	320	0	0.0%
41,204	26,000	(15,204)	(58.5%)	Translation Services	155,447	139,064	(16,383)	(11.8%)
395,191	177,300	(217,891)	(122.9%)	Medical Refund Recovery Fees	1,704,189	1,469,971	(234,218)	(15.9%)
438,525	684,684	246,159	36.0%	Software - IT Licenses & Subsc	2,252,798	2,756,349	503,551	18.3%
17,963	106,237	88,274	83.1%	Hardware (Non-Capital)	197,334	444,896	247,563	55.6%
38,067	48,700	10,633	21.8%	Provider Credentialing	273,409	285,513	12,105	4.2%
2,160,244	**2,997,118**	**836,874**	**27.9%**	**Purchased & Professional Services**	**13,480,907**	**14,783,029**	**1,302,123**	**8.8%**
59,373	91,579	32,205	35.2%	Depreciation	356,706	421,117	64,411	15.3%
62,638	76,371	13,733	18.0%	Lease Building	448,825	402,143	(46,681)	(11.6%)
4,464	10,570	6,106	57.8%	Lease Rented Office Equipment	27,288	39,105	11,817	30.2%
(8,182)	20,023	28,205	140.9%	Utilities	84,744	102,284	17,539	17.1%
79,345	91,065	11,720	12.9%	Telephone	520,404	529,795	9,391	1.8%
26,578	48,772	22,194	45.5%	Building Maintenance	194,299	253,674	59,375	23.4%
325,636	249,136	(76,501)	(30.7%)	GASB96 SBITA Amort. Expense	1,561,740	1,422,052	(139,689)	(9.8%)
549,854	**587,515**	**37,662**	**6.4%**	**Occupancy**	**3,194,006**	**3,170,170**	**(23,837)**	**(0.8%)**

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED December 31, 2024

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
(104,250)	130,213	234,463	180.1%	Postage	244,019	515,752	271,733	52.7%
5,517	5,300	(217)	(4.1%)	Design & Layout	37,214	36,780	(434)	(1.2%)
(94,940)	219,790	314,730	143.2%	Printing Services	435,152	720,780	285,629	39.6%
5,500	6,910	1,410	20.4%	Mailing Services	48,882	48,203	(678)	(1.4%)
4,410	12,735	8,325	65.4%	Courier/Delivery Service	31,734	48,193	16,458	34.2%
0	520	520	100.0%	Pre-Printed Materials & Public	29	549	520	94.7%
0	0	0	0.0%	Promotional Products	43,118	43,118	0	0.0%
0	300	300	100.0%	Promotional Services	0	600	600	100.0%
188,151	178,167	(9,984)	(5.6%)	Community Relations	1,131,604	1,517,394	385,790	25.4%
4,388	**553,936**	**549,548**	**99.2%**	**Printing Postage & Promotion**	**1,971,751**	**2,931,368**	**959,617**	**32.7%**
10,000	50,000	40,000	80.0%	Regulatory Penalties	295,000	335,000	40,000	11.9%
78,187	31,600	(46,587)	(147.4%)	Bank Fees	235,366	196,181	(39,185)	(20.0%)
65	0	(65)	0.0%	Insurance Premium	976,728	982,916	6,188	0.6%
684,529	782,810	98,281	12.6%	License,Permits, & Fee - NonIT	1,693,211	1,802,506	109,295	6.1%
23,363	74,896	51,534	68.8%	Subscriptions and Dues - NonIT	458,029	491,720	33,691	6.9%
796,143	**939,307**	**143,163**	**15.2%**	**License Insurance & Fees**	**3,658,334**	**3,808,323**	**149,989**	**3.9%**
1,441	13,042	11,601	89.0%	Office and Other Supplies	48,453	59,200	10,747	18.2%
0	2,000	2,000	100.0%	Furniture & Equipment	0	4,000	4,000	100.0%
10,137	30,192	20,055	66.4%	Ergonomic Supplies	168,881	184,348	15,467	8.4%
18,196	30,475	12,279	40.3%	Meals and Entertainment	76,753	97,724	20,971	21.5%
0	0	0	0.0%	Miscellaneous	5,300	5,300	0	0.0%
0	4,850	4,850	100.0%	Member Incentive	0	9,700	9,700	100.0%
105,871	120,000	14,129	11.8%	Provider Interest (All Depts)	774,938	793,208	18,270	2.3%
135,645	**200,559**	**64,914**	**32.4%**	**Other Administrative Expense**	**1,074,325**	**1,153,480**	**79,155**	**6.9%**
3,729,165	**5,353,347**	**1,624,182**	**30.3%**	**Total Other Administrative ExpenseS (excludes Personnel Expenses)**	**23,844,519**	**26,301,002**	**2,456,483**	**9.3%**
9,437,898	**11,304,880**	**1,866,983**	**16.5%**	**TOTAL ADMINISTRATIVE EXPENSES**	**57,654,453**	**60,707,437**	**3,052,983**	**5.0%**

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	$ -	$ -	**$ -**	$ 150,000	$ 150,000
	Exagrid Immutable Storage	IT-FY25-07	$ -	$ -	**$ -**	$ 500,000	$ 500,000
	Network Cabling	IT-FY25-09	$ -	$ -	**$ -**	$ 40,000	$ 40,000
Hardware Subtotal			**$ 529,610**	**$ -**	**$ 529,610**	**$ 1,948,100**	**$ 1,418,490**
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			**$ 529,610**	**$ -**	**$ 529,610**	**$ 1,978,100**	**$ 1,448,490**

6. Reconciliation to Balance Sheet:

Fixed Assets @ Cost - 12/31/24	**$ 38,640,099**
Fixed Assets @ Cost - 6/30/24	**$ 38,110,489**
Fixed Assets Acquired YTD	**$ 529,610**

ALAMEDA ALLIANCE FOR HEALTH
TANGIBLE NET EQUITY (TNE) AND LIQUID TNE ANALYSIS
FOR THE MONTH AND FISCAL YTD ENDED NOVEMBER 30, 2024

TANGIBLE NET EQUITY (TNE)	**QRT. END Jun-24**	**Jul-24**	**Aug-24**	**QRT. END Sep-24**	**Oct-24**	**Nov-24**	**QRT. END Dec-24**
Current Month Net Income / (Loss)	$(60,614,034)	$ (6,989,301)	$(18,354,880)	$ (8,719,238)	$(26,984,341)	$ (27,470,264)	$ (8,643,229)
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)
Net Assets	$255,375,143	$248,385,840	$230,030,961	$221,311,729	$194,327,390	$ 166,857,128	$ 158,213,902
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**
Increase/(Decrease) in Actual TNE	$(60,614,034)	$ (6,989,301)	$(18,354,880)	$ (8,719,238)	$(26,984,341)	$ (27,470,264)	$ (8,643,229)
Required TNE (1)	**$ 63,328,179**	**$ 68,750,939**	**$ 71,470,183**	**$ 70,224,330**	**$ 77,225,116**	**$ 78,852,430**	**$ 77,630,344**
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
TNE Excess / (Deficiency)	$192,046,964	$179,634,901	$158,560,778	$151,087,399	$117,102,274	$ 88,004,698	$ 80,583,558
Actual TNE as a Multiple of Required	**4.03**	**3.61**	**3.22**	**3.15**	**2.52**	**2.12**	**2.04**
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
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)	(5,620,720)
Net Lease Assets	(501,485)	(319,957)	(496,877)	(1,004,186)	(1,303,630)	(1,065,182)	(2,704,902)
CD Pledged to DMHC	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)
Liquid TNE (Liquid Reserves)	**$249,075,842**	**$242,053,513**	**$223,320,986**	**$214,153,818**	**$186,934,293**	**$ 159,761,852**	**$ 149,538,280**
Liquid TNE as Multiple of Required	**3.93**	**3.52**	**3.12**	**3.05**	**2.42**	**2.03**	**1.93**

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							659,195
Adult	62,708	62,641	62,550	62,578	62,502	62,905							375,884
SPD (retired Dec-24)	35,018	35,177	35,319	35,388	35,603	36,127							212,632
Duals (retired Dec-24)	39,892	40,024	40,124	40,144	40,357	40,798							241,339
ACA OE	149,801	150,482	151,005	151,098	151,559	154,560							908,505
MCAL LTC (retired Dec-24)	222	226	240	249	255	254							1,446
MCAL LTC Duals (retired Dec-24)	1,241	1,247	1,254	1,265	1,269	1,286							7,562
SPD with LTC (new Jan-25)	0	0	0	0	0	0							0
Duals with LTC (new Jan-25)	0	0	0	0	0	0							0
Medi-Cal Program	398,833	399,581	400,223	400,384	401,106	406,436							2,406,563
Group Care Program	5,675	5,686	5,710	5,769	5,772	5,790							34,402
Total	**404,508**	**405,267**	**405,933**	**406,153**	**406,878**	**412,226**							**2,440,965**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	(173)	(167)	(53)	(69)	(101)	945							382
Adult	(38)	(67)	(91)	28	(76)	403							159
SPD (retired Dec-24)	98	159	142	69	215	524							1,207
Duals (retired Dec-24)	144	132	100	20	213	441							1,050
ACA OE	477	681	523	93	461	3,001							5,236
MCAL LTC (retired Dec-24)	0	4	14	9	6	(1)							32
MCAL LTC Duals (retired Dec-24)	(7)	6	7	11	4	17							38
SPD with LTC (new Jan-25)	0	0	0	0	0	0							0
Duals with LTC (new Jan-25)	0	0	0	0	0	0							0
Medi-Cal Program	501	748	642	161	722	5,330							8,104
Group Care Program	17	11	24	59	3	18							132
Total	**518**	**759**	**666**	**220**	**725**	**5,348**							**8,236**
Enrollment Percentages:													
Medi-Cal Program:													
Child % of Medi-Cal	27.6%	27.5%	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%
SPD % of Medi-Cal	8.8%	8.8%	8.8%	8.8%	8.9%	8.9%							8.8%
Duals % of Medi-Cal	10.0%	10.0%	10.0%	10.0%	10.1%	10.0%							10.0%
ACA OE % of Medi-Cal	37.6%	37.7%	37.7%	37.7%	37.8%	38.0%							37.8%
MCAL LTC % of Medi-Cal	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%							0.1%
MCAL LTC Duals % of Medi-Cal	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%							0.3%
SPD with LTC % of Medi-Cal	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%							0.0%
Duals with LTC % of Medi-Cal	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%							0.0%
Medi-Cal Program % of Total	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%
Total	**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

Page 1	Actual Enrollment by Plan & Category of Aid
Page 2	Actual Delegated Enrollment Detail

	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							542,758
Alameda Health System	91,091	91,170	91,024	90,756	90,451	90,222							544,714
Directly-Contracted Subtotal	179,071	179,688	180,658	180,480	181,106	186,469							1,087,472
Delegated:													
CFMG	44,087	43,956	43,837	43,910	44,029	44,099							263,918
CHCN	181,350	181,623	181,438	181,763	181,743	181,658							1,089,575
Delegated Subtotal	225,437	225,579	225,275	225,673	225,772	225,757							1,353,493
Total	**404,508**	**405,267**	**405,933**	**406,153**	**406,878**	**412,226**							**2,440,965**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	167	617	970	(178)	626	5,363							7,565
Delegated:													
CFMG	96	(131)	(119)	73	119	70							108
CHCN	255	273	(185)	325	(20)	(85)							563
Delegated Subtotal	351	142	(304)	398	99	(15)							671
Total	**518**	**759**	**666**	**220**	**725**	**5,348**							**8,236**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	44.3%	44.3%	44.5%	44.4%	44.5%	45.2%							44.6%
Delegated:													
CFMG	10.9%	10.8%	10.8%	10.8%	10.8%	10.7%							10.8%
CHCN	44.8%	44.8%	44.7%	44.8%	44.7%	44.1%							44.6%
Delegated Subtotal	55.7%	55.7%	55.5%	55.6%	55.5%	54.8%							55.4%
Total	**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
MCAL LTC (retired Dec-24)	222	226	240	249	251	254	0	0	0	0	0	0	1,442
MCAL 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
MCAL LTC (retired Dec-24)	45	4	14	9	2	3	(254)	0	0	0	0	0	(177)
MCAL 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%
MCAL 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%
MCAL 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							413
Adult	0	0	0	0	(139)	201							62
SPD (retired Dec-24)	0	0	0	0	180	669							849
Duals (retired Dec-24)	0	0	0	0	213	654							867
ACA OE	0	0	0	0	310	3,160							3,470
MCAL LTC (retired Dec-24)	0	0	0	0	4	0							4
MCAL LTC Duals (retired Dec-24)	0	0	0	0	3	19							22
SPD with LTC (new Jan-25)	0	0	0	0	0	0							0
Duals with LTC (new Jan-25)	0	0	0	0	0	0							0
Medi-Cal Program	0	0	0	0	360	5,327							5,687
Group Care Program	0	0	0	0	3	21							24
Total	**0**	**0**	**0**	**0**	**363**	**5,348**							**5,711**
Current Direct/Delegate Enrollment Variance - Favorable/(Unfavorable)													
Directly-Contracted													
Directly Contracted (DCP)	0	0	0	0	869	6,398							7,267
Alameda Health System	0	0	0	0	(392)	(708)							(1,100)
Directly-Contracted Subtotal	0	0	0	0	477	5,690							6,167
Delegated:													
CFMG	0	0	0	0	76	103							179
CHCN	0	0	0	0	(190)	(445)							(635)
Delegated Subtotal	0	0	0	0	(114)	(342)							(456)
Total	**0**	**0**	**0**	**0**	**363**	**5,348**							**5,711**

ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED DECEMBER 31, 2024

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				CAPITATED MEDICAL EXPENSES				
$4,642,995	$1,715,115	($2,927,880)	(170.7%)	PCP Capitation	$23,936,384	$18,104,202	($5,832,182)	(32.2%)
6,129,483	6,535,937	406,454	6.2%	PCP Capitation FQHC	36,906,187	37,683,893	777,706	2.1%
381,239	447,488	66,249	14.8%	Specialty Capitation	2,274,832	2,401,105	126,272	5.3%
5,415,179	5,963,761	548,582	9.2%	Specialty Capitation FQHC	32,427,174	33,525,268	1,098,094	3.3%
767,862	713,010	(54,851)	(7.7%)	Laboratory Capitation	4,519,573	4,423,684	(95,889)	(2.2%)
344,449	340,265	(4,184)	(1.2%)	Vision Capitation	2,041,406	2,037,100	(4,306)	(0.2%)
110,915	130,192	19,278	14.8%	CFMG Capitation	661,970	698,703	36,733	5.3%
266,670	289,854	23,184	8.0%	ANC IPA Admin Capitation FQHC	1,598,694	1,644,961	46,268	2.8%
(8,638,183)	(8,638,182)	1	0.0%	Kaiser Capitation	(8,639,178)	(8,639,177)	1	0.0%
0	0	0	0.0%	Maternity Supplemental Expense	37,270	27,953	(9,318)	(33.3%)
1,032,499	886,412	(146,087)	(16.5%)	DME Capitation	6,103,440	5,822,931	(280,509)	(4.8%)
10,453,108	**8,383,852**	**(2,069,256)**	**(24.7%)**	**7. TOTAL CAPITATED EXPENSES**	**101,867,753**	**97,730,622**	**(4,137,131)**	**(4.2%)**
				FEE FOR SERVICE MEDICAL EXPENSES				
12,747,300	0	(12,747,300)	0.0%	IBNR Inpatient Services	20,565,700	(3,303,163)	(23,868,863)	722.6%
382,419	0	(382,419)	0.0%	IBNR Settlement (IP)	616,972	(99,094)	(716,066)	722.6%
1,019,783	0	(1,019,783)	0.0%	IBNR Claims Fluctuation (IP)	1,645,254	(264,254)	(1,909,508)	722.6%
35,434,270	52,329,810	16,895,540	32.3%	Inpatient Hospitalization FFS	282,346,399	304,392,180	22,045,780	7.2%
3,144,456	0	(3,144,456)	0.0%	IP OB - Mom & NB	18,232,207	12,540,164	(5,692,043)	(45.4%)
1,520,717	0	(1,520,717)	0.0%	IP Behavioral Health	2,650,375	1,070,307	(1,580,068)	(147.6%)
1,246,066	0	(1,246,066)	0.0%	Inpatient Facility Rehab FFS	8,132,671	5,770,736	(2,361,935)	(40.9%)
55,495,011	**52,329,810**	**(3,165,200)**	**(6.0%)**	**8. Inpatient Hospital Expense**	**334,189,578**	**320,106,876**	**(14,082,702)**	**(4.4%)**
331,293	0	(331,293)	0.0%	IBNR PCP	495,951	(293,439)	(789,390)	269.0%
9,938	0	(9,938)	0.0%	IBNR Settlement (PCP)	14,881	(8,801)	(23,682)	269.1%
26,503	0	(26,503)	0.0%	IBNR Claims Fluctuation (PCP)	107,941	44,791	(63,150)	(141.0%)
4,085,203	2,907,858	(1,177,345)	(40.5%)	PCP FFS	22,974,408	20,826,871	(2,147,537)	(10.3%)
354,733	816,198	461,465	56.5%	PCP FQHC FFS	2,323,303	3,257,336	934,033	28.7%
0	0	0	0.0%	Physician Extended Hrs. Incent	12,000	12,000	0	0.0%
1,655,989	915,709	(740,280)	(80.8%)	Prop 56 Physician Pmt	(3,467,142)	(2,827,243)	639,899	(22.6%)
16,492	0	(16,492)	0.0%	Prop 56 Hyde	148,232	64,923	(83,309)	(128.3%)
67,185	0	(67,185)	0.0%	Prop 56 Trauma Screening	250,939	110,133	(140,807)	(127.9%)
71,308	0	(71,308)	0.0%	Prop 56 Developmentl Screening	247,471	96,040	(151,431)	(157.7%)
644,849	0	(644,849)	0.0%	Prop 56 Family Planning	578,748	(767,666)	(1,346,414)	175.4%
312,647	0	(312,647)	0.0%	Prop 56 VBP	(2,406,095)	(2,718,741)	(312,647)	11.5%
7,576,142	**4,639,765**	**(2,936,377)**	**(63.3%)**	**9. Primary Care Physician Expense**	**21,280,638**	**17,796,203**	**(3,484,435)**	**(19.6%)**
1,819,484	0	(1,819,484)	0.0%	IBNR Specialist	1,802,517	(747,176)	(2,549,693)	341.2%
54,585	0	(54,585)	0.0%	IBNR Settlement (SCP)	54,078	(22,414)	(76,492)	341.3%
145,558	0	(145,558)	0.0%	IBNR Claims Fluctuation (SCP)	144,200	(59,775)	(203,975)	341.2%
396,347	0	(396,347)	0.0%	Psychiatrist FFS	2,335,814	1,559,071	(776,743)	(49.8%)
2,980,795	8,098,287	5,117,492	63.2%	Specialty Care FFS	21,578,430	31,292,654	9,714,225	31.0%
256,427	0	(256,427)	0.0%	Specialty Anesthesiology	1,529,098	1,061,004	(468,094)	(44.1%)
1,575,522	0	(1,575,522)	0.0%	Specialty Imaging FFS	9,796,671	6,843,037	(2,953,634)	(43.2%)
23,956	0	(23,956)	0.0%	Obstetrics FFS	238,219	181,208	(57,012)	(31.5%)
302,253	0	(302,253)	0.0%	Specialty IP Surgery FFS	2,363,059	1,679,499	(683,560)	(40.7%)
893,567	0	(893,567)	0.0%	Specialty OP Surgery FFS	6,101,165	4,353,452	(1,747,712)	(40.1%)
603,120	0	(603,120)	0.0%	Speciality IP Physician	3,744,872	2,543,833	(1,201,039)	(47.2%)
120,488	127,381	6,893	5.4%	Specialist FQHC FFS	769,349	783,118	13,769	1.8%
9,172,103	**8,225,668**	**(946,434)**	**(11.5%)**	**10. Specialty Care Physician Expense**	**50,457,472**	**49,467,511**	**(989,960)**	**(2.0%)**
1,341,272	0	(1,341,272)	0.0%	IBNR Ancillary (ANC)	3,846,017	904,191	(2,941,826)	(325.4%)
40,238	0	(40,238)	0.0%	IBNR Settlement (ANC)	202,443	114,188	(88,255)	(77.3%)

ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED DECEMBER 31, 2024

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
107,301	0	(107,301)	0.0%	IBNR Claims Fluctuation (ANC)	471,591	236,248	(235,343)	(99.6%)
329,244	0	(329,244)	0.0%	IBNR Transportation FFS	647,956	207,856	(440,100)	(211.7%)
2,349,434	0	(2,349,434)	0.0%	Behavioral Health Therapy FFS	12,800,467	8,190,565	(4,609,901)	(56.3%)
1,764,142	0	(1,764,142)	0.0%	Psychologist & Other MH Prof	10,729,793	7,234,250	(3,495,542)	(48.3%)
386,534	0	(386,534)	0.0%	Other Medical Professional	2,682,753	1,865,835	(816,918)	(43.8%)
87,847	0	(87,847)	0.0%	Hearing Devices	830,277	674,558	(155,719)	(23.1%)
18,060	0	(18,060)	0.0%	ANC Imaging	264,666	228,147	(36,518)	(16.0%)
103,666	0	(103,666)	0.0%	Vision FFS	455,257	280,298	(174,959)	(62.4%)
10	0	(10)	0.0%	Family Planning	26	10	(16)	(164.6%)
5,507	0	(5,507)	0.0%	Laboratory FFS	8,151,435	6,593,456	(1,557,979)	(23.6%)
139,067	0	(139,067)	0.0%	ANC Therapist	907,928	644,262	(263,665)	(40.9%)
1,442,827	0	(1,442,827)	0.0%	Transp/Ambulance FFS	8,459,769	5,962,027	(2,497,742)	(41.9%)
1,517,441	0	(1,517,441)	0.0%	Non-ER Transportation FFS	13,501,990	8,526,483	(4,975,507)	(58.4%)
1,960,017	0	(1,960,017)	0.0%	Hospice FFS	13,619,645	9,250,960	(4,368,685)	(47.2%)
1,765,012	0	(1,765,012)	0.0%	Home Health Services	10,440,253	7,088,754	(3,351,500)	(47.3%)
0	14,071,194	14,071,194	100.0%	Other Medical FFS	128	27,835,409	27,835,281	100.0%
0	0	0	0.0%	Medical Refunds through HMS	558,501	290,192	(268,308)	(92.5%)
26,315	0	(26,315)	0.0%	DME & Medical Supplies FFS	249,389	187,833	(61,555)	(32.8%)
(10,480,681)	(10,147,528)	333,153	(3.3%)	ECM Base/Outreach FFS ANC	(5,471,692)	(5,128,954)	342,737	(6.7%)
69,351	97,030	27,678	28.5%	CS Housing Deposits FFS ANC	659,777	681,979	22,202	3.3%
433,654	787,285	353,630	44.9%	CS Housing Tenancy FFS ANC	4,191,008	4,766,721	575,713	12.1%
180,248	440,728	260,479	59.1%	CS Housing Navi Servic FFS ANC	2,619,444	2,779,445	160,002	5.8%
437,941	702,773	264,833	37.7%	CS Medical Respite FFS ANC	3,688,217	3,914,565	226,348	5.8%
203,082	162,994	(40,088)	(24.6%)	CS Med. Tailored Meals FFS ANC	1,219,860	1,200,203	(19,657)	(1.6%)
8,043	20,377	12,334	60.5%	CS Asthma Remediation FFS ANC	45,385	68,030	22,645	33.3%
0	10,067	10,067	100.0%	MOT Wrap Around (Non Med MOT)	0	19,931	19,931	100.0%
0	10,014	10,014	100.0%	CS Home Modifications FFS ANC	24,053	44,042	19,989	45.4%
267,685	533,503	265,819	49.8%	CS P.Care & Hmker Svcs FFS ANC	1,875,115	2,561,610	686,495	26.8%
0	20,024	20,024	100.0%	CS Cgiver Respite Svcs FFS ANC	42,347	82,335	39,988	48.6%
540,921	0	(540,921)	0.0%	CommunityBased Adult Svc(CBAS)	3,052,350	2,203,374	(848,977)	(38.5%)
21,981	25,000	3,019	12.1%	CS LTC Diversion FFS ANC	107,153	117,778	10,625	9.0%
0	7,517	7,517	100.0%	CS LTC Transition FFS ANC	0	14,986	14,986	100.0%
5,066,160	**6,740,978**	**1,674,818**	**24.8%**	**11. Ancillary Medical Expense**	**100,873,298**	**99,641,566**	**(1,231,732)**	**(1.2%)**
591,362	0	(591,362)	0.0%	IBNR Outpatient	1,862,373	231,629	(1,630,744)	(704.0%)
17,743	0	(17,743)	0.0%	IBNR Settlement (OP)	55,874	6,949	(48,925)	(704.1%)
47,308	0	(47,308)	0.0%	IBNR Claims Fluctuation (OP)	148,985	18,527	(130,458)	(704.1%)
2,336,578	11,684,491	9,347,914	80.0%	Outpatient FFS	14,935,328	33,614,737	18,679,409	55.6%
2,789,704	0	(2,789,704)	0.0%	OP Ambul Surgery FFS	16,725,019	11,593,959	(5,131,060)	(44.3%)
2,270,679	0	(2,270,679)	0.0%	Imaging Services FFS	15,078,399	10,130,403	(4,947,996)	(48.8%)
1,025,581	0	(1,025,581)	0.0%	Behavioral Health FFS	2,143,741	97,460	(2,046,280)	(2,099.6%)
701,464	0	(701,464)	0.0%	Outpatient Facility Lab FFS	4,242,040	2,863,424	(1,378,616)	(48.1%)
213,151	0	(213,151)	0.0%	Outpatient Facility Cardio FFS	1,253,942	844,453	(409,489)	(48.5%)
99,099	0	(99,099)	0.0%	OP Facility PT/OT/ST FFS	604,390	400,408	(203,982)	(50.9%)
3,049,167	0	(3,049,167)	0.0%	OP Facility Dialysis Ctr FFS	18,551,618	12,647,437	(5,904,181)	(46.7%)
13,141,836	**11,684,491**	**(1,457,345)**	**(12.5%)**	**12. Outpatient Medical Expense**	**75,601,708**	**72,449,386**	**(3,152,322)**	**(4.4%)**
1,364,855	0	(1,364,855)	0.0%	IBNR Emergency	2,699,371	(165,803)	(2,865,174)	1,728.1%
40,944	0	(40,944)	0.0%	IBNR Settlement (ER)	80,979	(4,974)	(85,953)	1,727.9%
109,188	0	(109,188)	0.0%	IBNR Claims Fluctuation (ER)	215,949	(13,266)	(229,215)	1,727.8%
8,127,296	10,423,842	2,296,545	22.0%	ER Facility	52,609,093	57,840,480	5,231,386	9.0%
1,173,919	0	(1,173,919)	0.0%	Specialty ER Physician FFS	7,110,704	4,880,392	(2,230,312)	(45.7%)
10,816,202	**10,423,842**	**(392,361)**	**(3.8%)**	**13. Emergency Expense**	**62,716,096**	**62,536,828**	**(179,268)**	**(0.3%)**
1,264,091	0	(1,264,091)	0.0%	IBNR Pharmacy (OP)	4,691,582	1,991,773	(2,699,809)	(135.5%)
37,922	0	(37,922)	0.0%	IBNR Settlement Rx (OP)	140,749	59,755	(80,994)	(135.5%)
101,127	0	(101,127)	0.0%	IBNR Claims Fluctuation Rx(OP)	375,328	159,342	(215,986)	(135.5%)

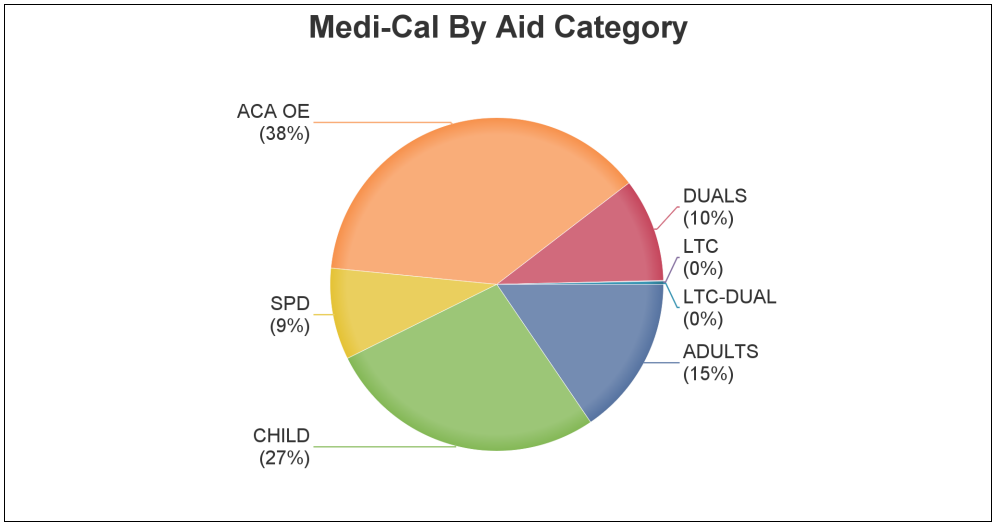
ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED DECEMBER 31, 2024

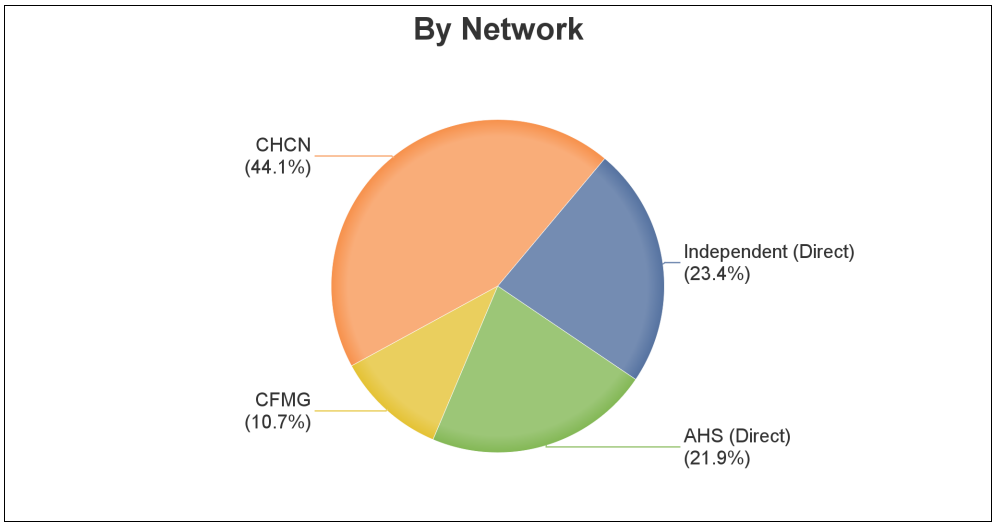
CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
679,026	462,419	(216,607)	(46.8%)	Pharmacy FFS (OP)	4,428,236	3,956,726	(471,510)	(11.9%)
92,290	11,760,238	11,667,948	99.2%	Pharmacy Non PBM FFS Other-ANC	746,517	23,857,250	23,110,733	96.9%
6,470,486	0	(6,470,486)	0.0%	Pharmacy Non PBM FFS OP-FAC	54,362,619	39,326,556	(15,036,063)	(38.2%)
212,978	0	(212,978)	0.0%	Pharmacy Non PBM FFS PCP	1,380,101	985,563	(394,538)	(40.0%)
1,996,413	0	(1,996,413)	0.0%	Pharmacy Non PBM FFS SCP	14,442,925	10,617,727	(3,825,198)	(36.0%)
21,964	0	(21,964)	0.0%	Pharmacy Non PBM FFS FQHC	125,730	82,575	(43,155)	(52.3%)
17,635	0	(17,635)	0.0%	Pharmacy Non PBM FFS HH	119,898	91,629	(28,269)	(30.9%)
0	0	0	0.0%	RX Refunds HMS	(306)	(306)	0	0.0%
251,443	51,861	(199,582)	(384.8%)	Medical Expenses Pharm Rebate	(18,557)	(113,173)	(94,616)	83.6%
11,145,374	**12,274,518**	**1,129,144**	**9.2%**	**14. Pharmacy Expense**	**80,794,820**	**81,015,415**	**220,595**	**0.3%**
12,927,529	0	(12,927,529)	0.0%	IBNR LTC	15,581,793	(3,756,936)	(19,338,729)	514.7%
387,825	0	(387,825)	0.0%	IBNR Settlement (LTC)	467,453	(112,709)	(580,162)	514.7%
1,034,202	0	(1,034,202)	0.0%	IBNR Claims Fluctuation (LTC)	1,246,543	(300,555)	(1,547,098)	514.7%
1,204,718	0	(1,204,718)	0.0%	LTC - ICF/DD	9,211,157	6,755,726	(2,455,431)	(36.3%)
15,458,053	0	(15,458,053)	0.0%	LTC Custodial Care	134,938,572	99,683,289	(35,255,283)	(35.4%)
6,577,452	33,132,376	26,554,925	80.1%	LTC SNF	44,818,027	97,594,256	52,776,229	54.1%
37,589,778	**33,132,376**	**(4,457,402)**	**(13.5%)**	**15. Long Term Care Expense**	**206,263,545**	**199,863,070**	**(6,400,475)**	**(3.2%)**
150,002,605	**139,451,449**	**(10,551,157)**	**(7.6%)**	**16. TOTAL FFS MEDICAL EXPENSES**	**932,177,155**	**902,876,856**	**(29,300,299)**	**(3.2%)**
0	203,323	203,323	100.0%	Clinical Vacancy #102	0	(1,186,111)	(1,186,111)	100.0%
175,237	361,258	186,021	51.5%	Quality Analytics #123	850,568	1,365,073	514,505	37.7%
321,184	306,063	(15,121)	(4.9%)	LongTerm Services and Support #139	1,457,786	1,553,066	95,280	6.1%
909,382	837,337	(72,045)	(8.6%)	Utilization Management #140	5,850,119	6,034,092	183,973	3.0%
746,074	650,615	(95,459)	(14.7%)	Case & Disease Management #185	4,137,592	4,290,669	153,077	3.6%
484,847	977,790	492,943	50.4%	Medical Management #230	7,107,685	7,890,686	783,001	9.9%
662,586	2,189,469	1,526,883	69.7%	Quality Improvement #235	5,995,042	8,144,005	2,148,963	26.4%
321,458	331,471	10,014	3.0%	HCS Behavioral Health #238	1,907,167	2,073,951	166,784	8.0%
155,410	332,288	176,878	53.2%	Pharmacy Services #245	730,561	1,197,383	466,822	39.0%
56,249	62,119	5,870	9.5%	Regulatory Readiness #268	385,171	434,528	49,357	11.4%
3,832,426	**6,251,734**	**2,419,308**	**38.7%**	**17. Other Benefits & Services**	**28,421,691**	**31,797,343**	**3,375,652**	**10.6%**
(1,431,000)	(1,319,182)	111,818	(8.5%)	Reinsurance Recoveries	(9,551,986)	(9,349,068)	202,919	(2.2%)
1,790,151	1,758,909	(31,242)	(1.8%)	Reinsurance Premium	10,549,620	10,513,733	(35,887)	(0.3%)
359,151	**439,727**	**80,576**	**18.3%**	**18. Reinsurance Expense**	**997,634**	**1,164,666**	**167,032**	**14.3%**
164,647,291	**154,526,761**	**(10,120,530)**	**(6.5%)**	**20. TOTAL MEDICAL EXPENSES**	**1,063,464,232**	**1,033,569,486**	**(29,894,746)**	**(2.9%)**

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend

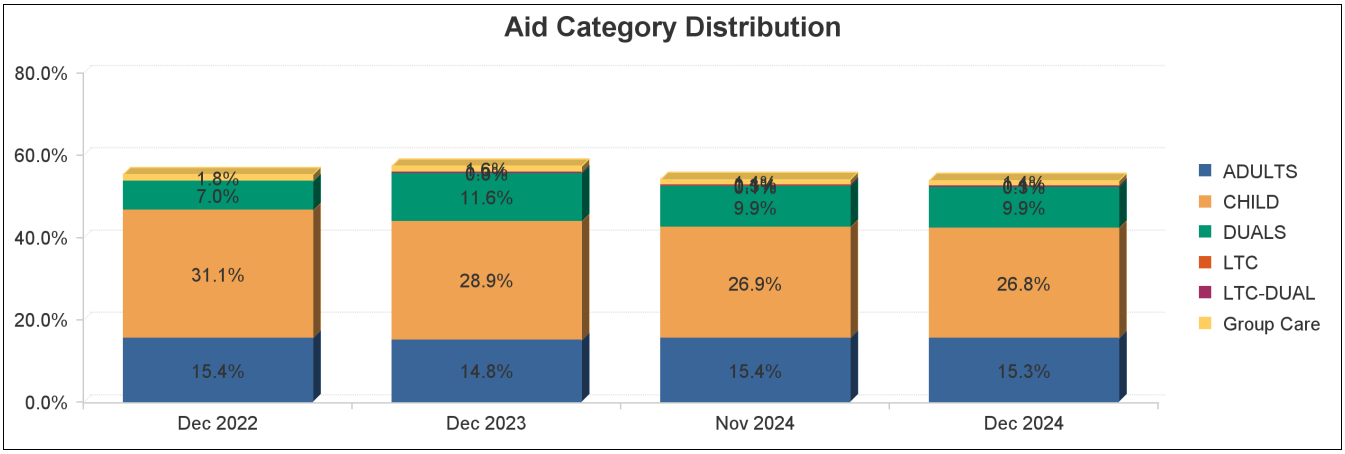
Category of Aid	Dec 2024	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN
ADULTS	62,957	15%	13,651	14,118	6	35,182
CHILD	110,547	27%	10,501	13,443	41,092	45,511
SPD	36,127	9%	12,122	5,685	1,433	16,887
ACA OE	154,565	38%	29,490	53,129	1,574	70,372
DUALS	40,812	10%	26,881	2,910	6	11,015
LTC	255	0%	240	7	0	8
LTC-DUAL	1,285	0%	1,284	0	0	1
Medi-Cal	406,548		94,169	89,292	44,111	178,976
Group Care	5,790		2,144	946	0	2,700
Total	**412,338**	**100%**	**96,313**	**90,238**	**44,111**	**181,676**
Medi-Cal %	98.6%		97.8%	99.0%	100.0%	98.5%
Group Care %	1.4%		2.2%	1.0%	0.0%	1.5%
	Network Distribution		**23.4%**	**21.9%**	**10.7%**	**44.1%**
			% Direct:	**45%**	**% Delegated:**	**55%**





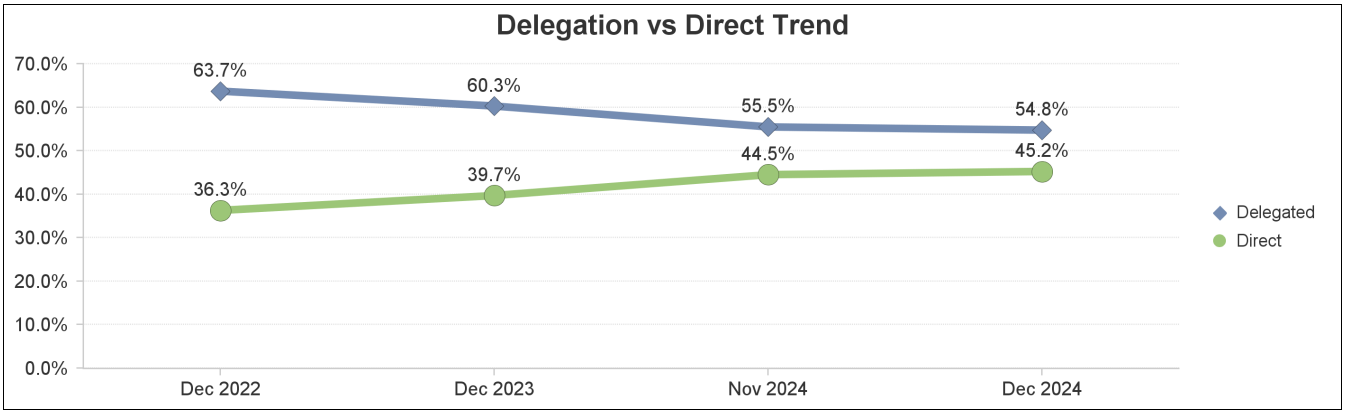
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Dec 2022	Dec 2023	Nov 2024	Dec 2024	Dec 2022	Dec 2023	Nov 2024	Dec 2024	Dec 2022 to Dec 2023	Dec 2023 to Dec 2024	Nov 2024 to Dec 2024
ADULTS	50,351	52,174	62,533	**62,957**	15.4%	14.8%	15.4%	15.3%	3.6%	20.7%	0.7%
CHILD	101,791	101,634	109,574	**110,547**	31.1%	28.9%	26.9%	26.8%	-0.2%	8.8%	0.9%
SPD	28,452	30,848	35,603	**36,127**	8.7%	8.8%	8.7%	8.8%	8.4%	17.1%	1.5%
ACA OE	118,397	119,669	151,559	**154,565**	36.1%	34.0%	37.2%	37.5%	1.1%	29.2%	2.0%
DUALS	23,028	40,976	40,360	**40,812**	7.0%	11.6%	9.9%	9.9%	77.9%	-0.4%	1.1%
LTC	0	135	255	**255**	0.0%	0.0%	0.1%	0.1%	0.0%	88.9%	0.0%
LTC-DUAL	0	951	1,269	**1,285**	0.0%	0.3%	0.3%	0.3%	0.0%	35.1%	1.3%
Medi-Cal	322,019	346,387	401,153	**406,548**	98.2%	98.4%	98.6%	98.6%	7.6%	17.4%	1.3%
Group Care	5,776	5,622	5,772	**5,790**	1.8%	1.6%	1.4%	1.4%	-2.7%	3.0%	0.3%
Total	**327,795**	**352,009**	**406,925**	**412,338**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**7.4%**	**17.1%**	**1.3%**



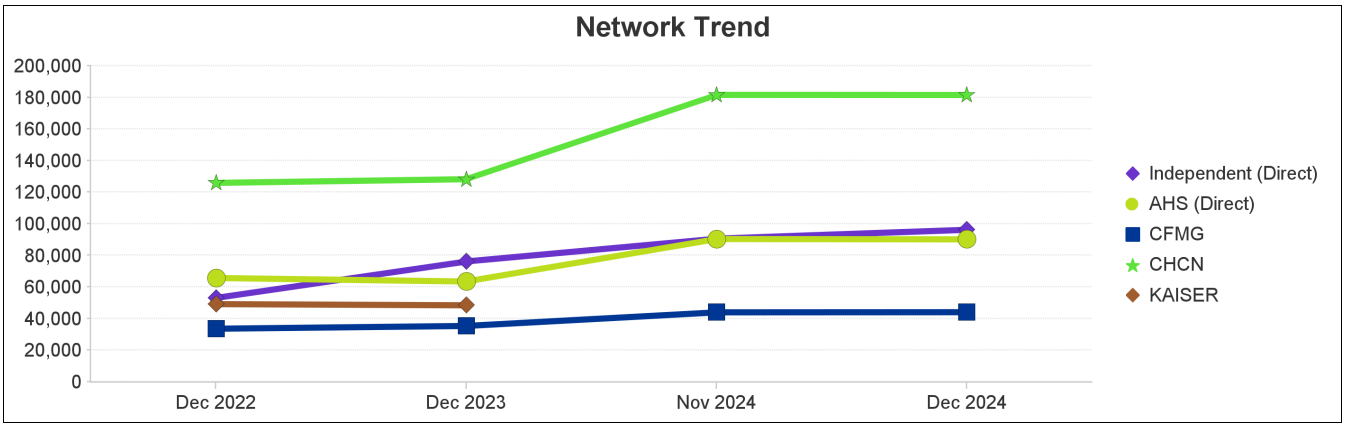
Delegation vs Direct Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	Dec 2022	Dec 2023	Nov 2024	Dec 2024	Dec 2022	Dec 2023	Nov 2024	Dec 2024	Dec 2022 to Dec 2023	Dec 2023 to Dec 2024	Nov 2024 to Dec 2024
Delegated	208,881	212,220	225,785	**225,787**	63.7%	60.3%	55.5%	54.8%	1.6%	6.4%	0.0%
Direct	118,914	139,789	181,140	**186,551**	36.3%	39.7%	44.5%	45.2%	17.6%	33.5%	3.0%
Total	**327,795**	**352,009**	**406,925**	**412,338**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**7.4%**	**17.1%**	**1.3%**



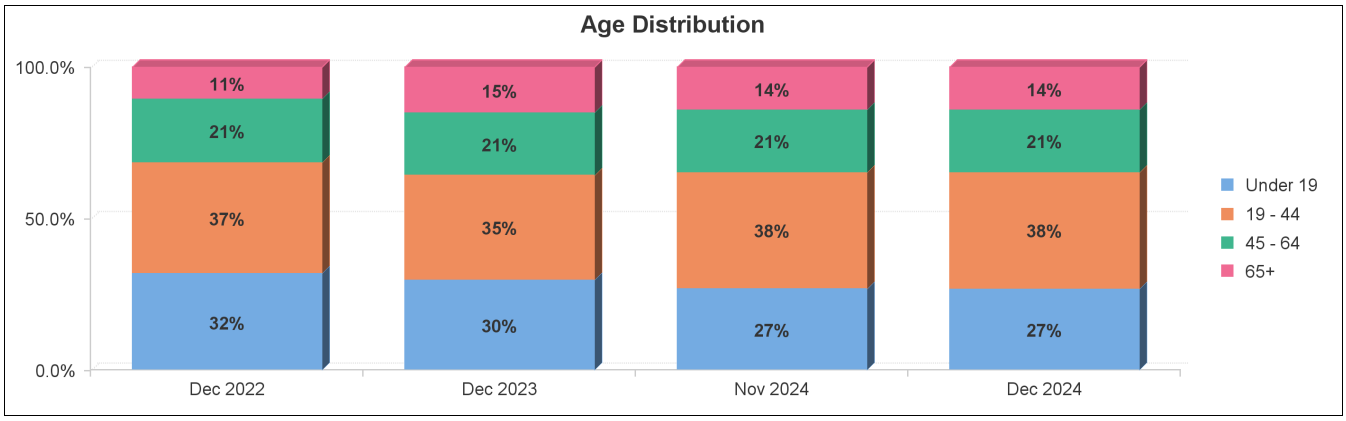
Network Trend

Network	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Dec 2022	Dec 2023	Nov 2024	Dec 2024	Dec 2022	Dec 2023	Nov 2024	Dec 2024	Dec 2022 to Dec 2023	Dec 2023 to Dec 2024	Nov 2024 to Dec 2024
Independent (Direct)	53,143	76,241	90,681	**96,313**	16.2%	21.7%	22.3%	23.4%	43.5%	26.3%	6.2%
AHS (Direct)	65,771	63,548	90,459	**90,238**	20.1%	18.1%	22.2%	21.9%	-3.4%	42.0%	-0.2%
CFMG	33,648	35,401	44,031	**44,111**	10.3%	10.1%	10.8%	10.7%	5.2%	24.6%	0.2%
CHCN	126,009	128,342	181,754	**181,676**	38.4%	36.5%	44.7%	44.1%	1.9%	41.6%	0.0%
KAISER	49,224	48,477	0	**0**	15.0%	13.8%	0.0%	0.0%	-1.5%	-100.0%	0.0%
Total	**327,795**	**352,009**	**406,925**	**412,338**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**7.4%**	**17.1%**	**1.3%**



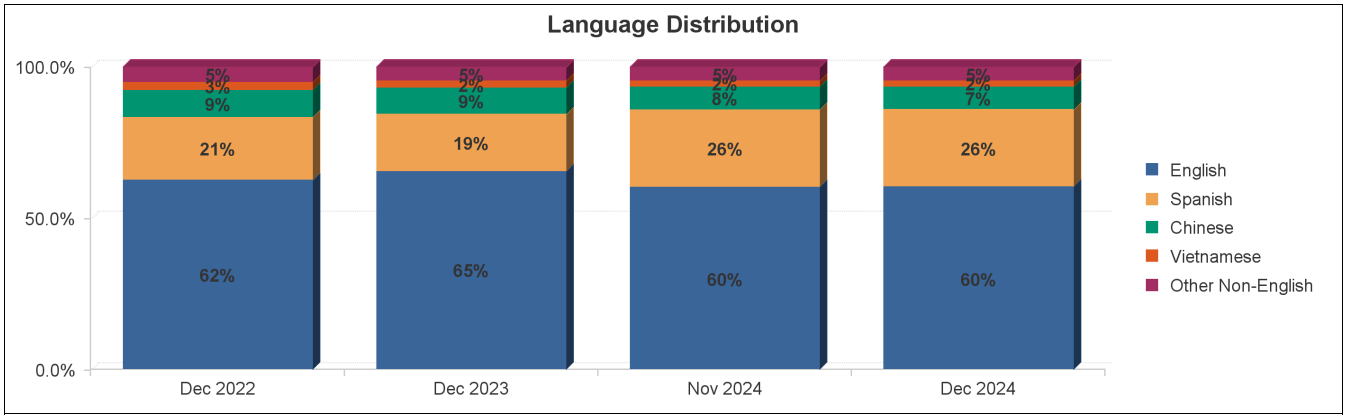
Age Category Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Dec 2022	Dec 2023	Nov 2024	Dec 2024	Dec 2022	Dec 2023	Nov 2024	Dec 2024	Dec 2022 to Dec 2023	Dec 2023 to Dec 2024	Nov 2024 to Dec 2024
Under 19	104,022	104,062	108,407	**109,506**	32%	30%	27%	27%	0%	5%	1%
19 - 44	119,997	121,694	155,955	**158,707**	37%	35%	38%	38%	1%	30%	2%
45 - 64	68,606	72,612	84,411	**85,272**	21%	21%	21%	21%	6%	17%	1%
65+	35,170	53,641	58,152	**58,853**	11%	15%	14%	14%	53%	10%	1%
Total	**327,795**	**352,009**	**406,925**	**412,338**	**100%**	**100%**	**100%**	**100%**	**7%**	**17%**	**1%**



Language Trend

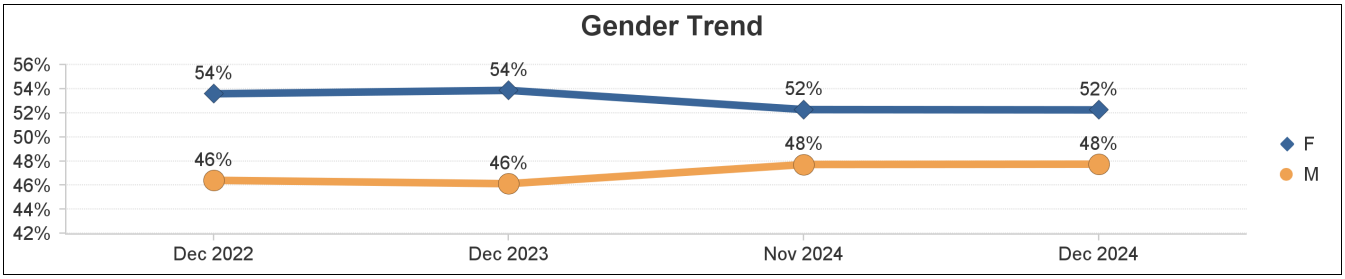
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	Dec 2022	Dec 2023	Nov 2024	Dec 2024	ec 2022	ec 2023	Nov 2024	ec 2024	Dec 2022 to Dec 2023	Dec 2023 to Dec 2024	Nov 2024 to Dec 2024
English	204,635	229,835	244,547	**248,451**	62%	65%	60%	60%	12%	8%	2%
Spanish	68,179	66,602	104,072	**105,234**	21%	19%	26%	26%	-2%	58%	1%
Chinese	29,182	30,505	30,682	**30,806**	9%	9%	8%	7%	5%	1%	0%
Vietnamese	8,904	8,507	8,223	**8,294**	3%	2%	2%	2%	-4%	-3%	1%
Other Non-English	16,895	16,560	19,401	**19,553**	5%	5%	5%	5%	-2%	18%	1%
Total	**327,795**	**352,009**	**406,925**	**412,338**	**100%**	**100%**	**100%**	**100%**	**7%**	**17%**	**1%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

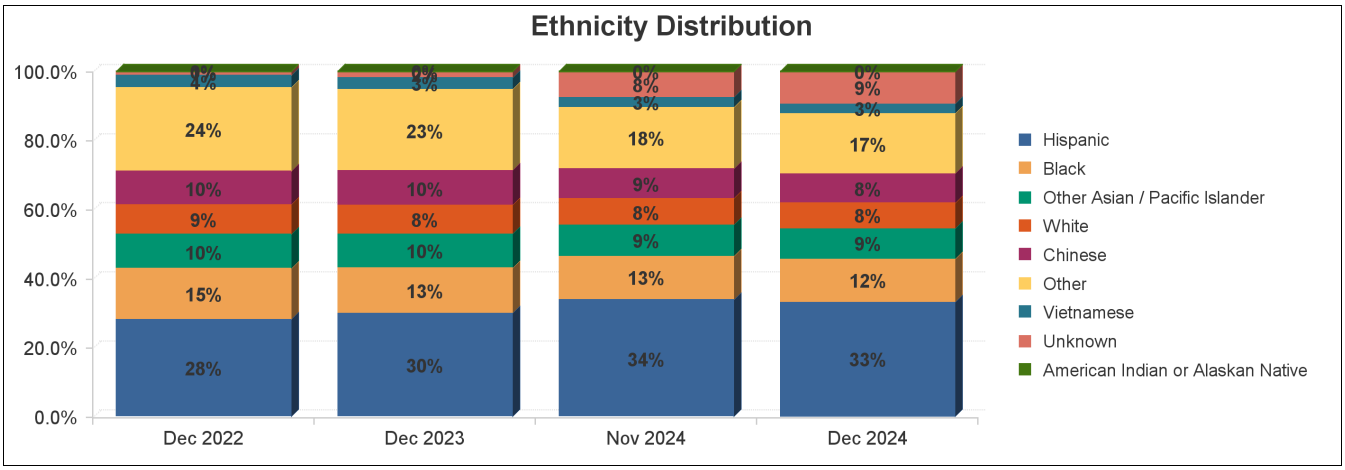
Gender Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Dec 2022	Dec 2023	Nov 2024	Dec 2024	Dec 2022	Dec 2023	Nov 2024	Dec 2024	Dec 2022 to Dec 2023	Dec 2023 to Dec 2024	Nov 2024 to Dec 2024
F	175,661	189,639	212,721	**215,451**	54%	54%	52%	52%	8%	14%	1%
M	152,134	162,370	194,204	**196,887**	46%	46%	48%	48%	7%	21%	1%
Total	**327,795**	**352,009**	**406,925**	**412,338**	**100%**	**100%**	**100%**	**100%**	**7%**	**17%**	**1%**



Ethnicity Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Dec 2022	Dec 2023	Nov 2024	Dec 2024	Dec 2022	Dec 2023	Nov 2024	Dec 2024	Dec 2022 to Dec 2023	Dec 2023 to Dec 2024	Nov 2024 to Dec 2024
Hispanic	92,030	104,945	137,424	**136,294**	28%	30%	34%	33%	14%	30%	-1%
Black	48,301	46,303	51,258	**51,323**	15%	13%	13%	12%	-4%	11%	0%
Other Asian / Pacific Islander	32,466	34,537	36,733	**36,322**	10%	10%	9%	9%	6%	5%	-1%
White	28,063	29,449	31,272	**30,931**	9%	8%	8%	8%	5%	5%	-1%
Chinese	31,839	35,470	34,944	**34,683**	10%	10%	9%	8%	11%	-2%	-1%
Other	79,375	82,447	72,555	**71,988**	24%	23%	18%	17%	4%	-13%	-1%
Vietnamese	11,505	11,943	11,441	**11,366**	4%	3%	3%	3%	4%	-5%	-1%
Unknown	3,531	6,228	30,524	**38,664**	1%	2%	8%	9%	76%	521%	27%
American Indian or Alaskan Native	685	687	774	**767**	0%	0%	0%	0%	0%	12%	-1%
Total	**327,795**	**352,009**	**406,925**	**412,338**	**100%**	**100%**	**100%**	**100%**	**7%**	**17%**	**1%**



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

Medi-Cal By City

City	Dec 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	162,231	40%	25,873	41,915	17,311	77,132
HAYWARD	65,187	16%	14,300	17,525	7,494	25,868
FREMONT	38,188	9%	16,105	6,638	2,252	13,193
SAN LEANDRO	33,420	8%	8,659	5,622	4,229	14,910
UNION CITY	14,789	4%	5,814	2,601	845	5,529
ALAMEDA	13,764	3%	3,382	2,444	2,038	5,900
BERKELEY	15,451	4%	4,479	2,274	1,760	6,938
LIVERMORE	13,237	3%	2,075	587	2,233	8,342
NEWARK	9,519	2%	2,855	4,099	553	2,012
CASTRO VALLEY	9,549	2%	2,754	1,555	1,422	3,818
SAN LORENZO	7,425	2%	1,541	1,662	860	3,362
PLEASANTON	7,807	2%	1,881	405	831	4,690
DUBLIN	7,641	2%	2,085	401	900	4,255
EMERYVILLE	2,887	1%	709	622	453	1,103
ALBANY	2,563	1%	698	302	570	993
PIEDMONT	482	0%	111	185	74	112
SUNOL	83	0%	24	14	6	39
ANTIOCH	63	0%	23	11	9	20
Other	2,262	1%	801	430	271	760
Total	406,548	100%	**94,169**	**89,292**	**44,111**	**178,976**

Group Care By City

City	Dec 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	1,825	32%	339	356	0	1,130
HAYWARD	664	11%	310	162	0	192
FREMONT	665	11%	442	80	0	143
SAN LEANDRO	609	11%	245	93	0	271
UNION CITY	289	5%	183	43	0	63
ALAMEDA	307	5%	88	27	0	192
BERKELEY	147	3%	48	10	0	89
LIVERMORE	100	2%	31	4	0	65
NEWARK	136	2%	80	31	0	25
CASTRO VALLEY	198	3%	86	31	0	81
SAN LORENZO	139	2%	45	28	0	66
PLEASANTON	71	1%	24	2	0	45
DUBLIN	119	2%	40	4	0	75
EMERYVILLE	35	1%	13	6	0	16
ALBANY	20	0%	10	1	0	9
PIEDMONT	8	0%	2	0	0	6
SUNOL	1	0%	1	0	0	0
ANTIOCH	24	0%	6	4	0	14
Other	433	7%	151	64	0	218
Total	**5,790**	**100%**	**2,144**	**946**	**0**	**2,700**

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

Total By City

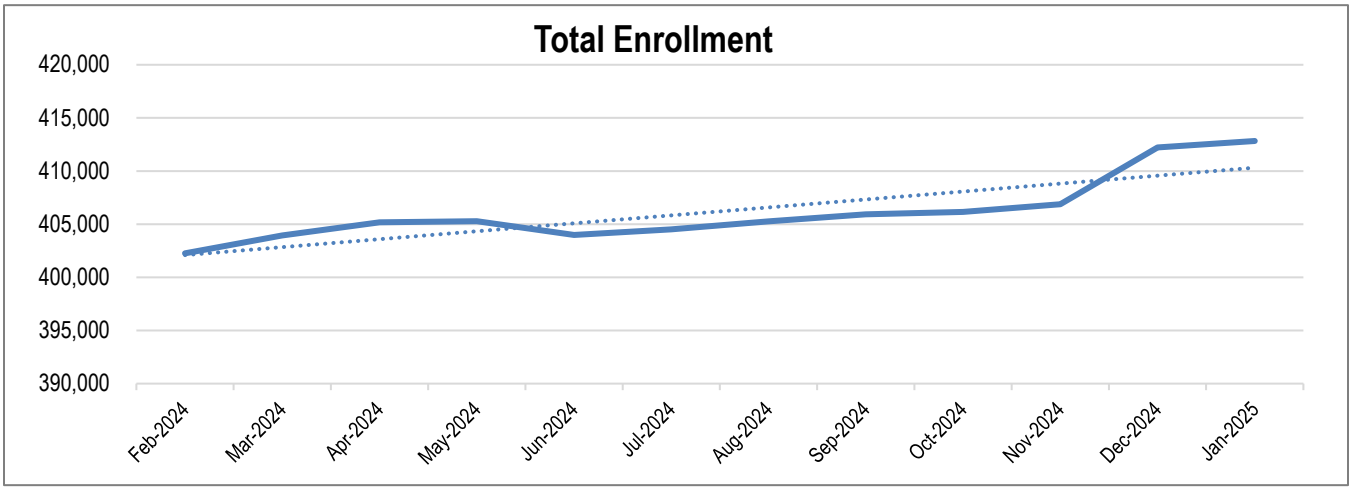
City	Dec 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	164,056	40%	26,212	42,271	17,311	78,262
HAYWARD	65,851	16%	14,610	17,687	7,494	26,060
FREMONT	38,853	9%	16,547	6,718	2,252	13,336
SAN LEANDRO	34,029	8%	8,904	5,715	4,229	15,181
UNION CITY	15,078	4%	5,997	2,644	845	5,592
ALAMEDA	14,071	3%	3,470	2,471	2,038	6,092
BERKELEY	15,598	4%	4,527	2,284	1,760	7,027
LIVERMORE	13,337	3%	2,106	591	2,233	8,407
NEWARK	9,655	2%	2,935	4,130	553	2,037
CASTRO VALLEY	9,747	2%	2,840	1,586	1,422	3,899
SAN LORENZO	7,564	2%	1,586	1,690	860	3,428
PLEASANTON	7,878	2%	1,905	407	831	4,735
DUBLIN	7,760	2%	2,125	405	900	4,330
EMERYVILLE	2,922	1%	722	628	453	1,119
ALBANY	2,583	1%	708	303	570	1,002
PIEDMONT	490	0%	113	185	74	118
SUNOL	84	0%	25	14	6	39
ANTIOCH	87	0%	29	15	9	34
Other	2,695	1%	952	494	271	978
Total	412,338	100%	**96,313**	**90,238**	**44,111**	**181,676**

To: **Alameda Alliance for Health, Board of Governors**
From: **Gil Riojas, Chief Financial Officer**
Date: **March 14th, 2025**
Subject: **Finance Report – January 2025 Financials**

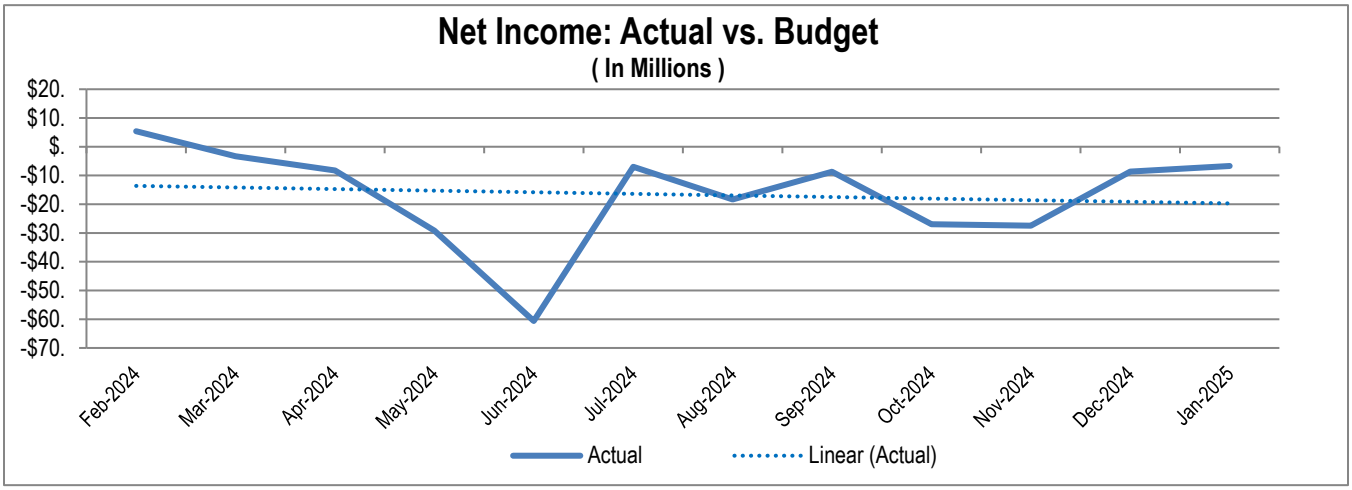
Executive Summary

For the month of January, the Alliance continues to see incremental increases in enrollment, reaching 412,828 members. A Net Loss of $6.7 million was reported, and the Plan's Medical Expenses represented 100.2% of revenue. Alliance reserves decreased to 186% of required but continue to remain above minimum requirements.

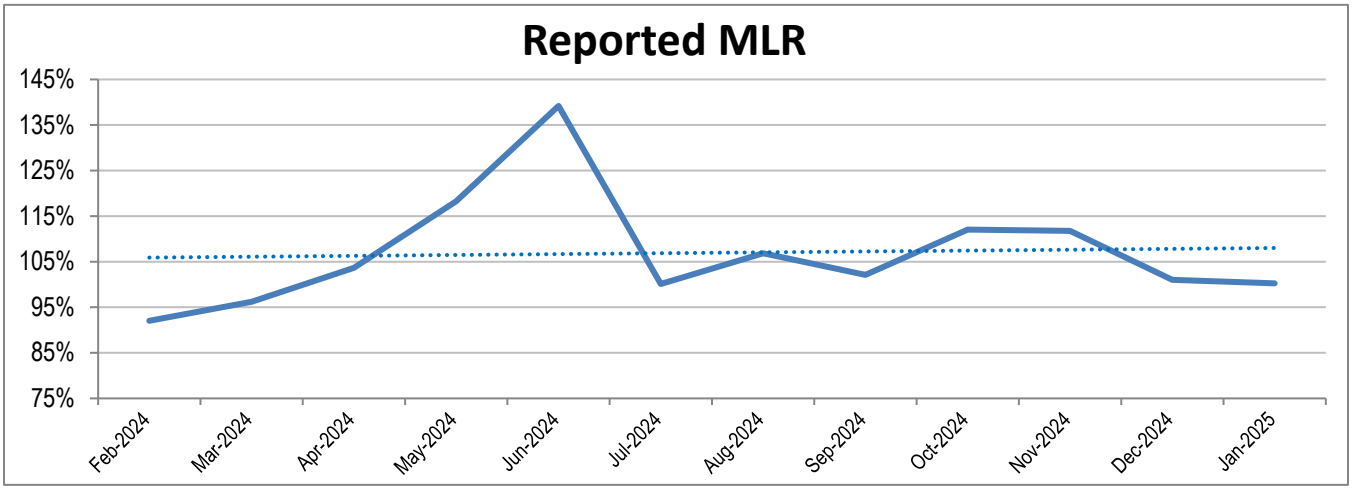
Enrollment – In January, Enrollment increased by 602 members.



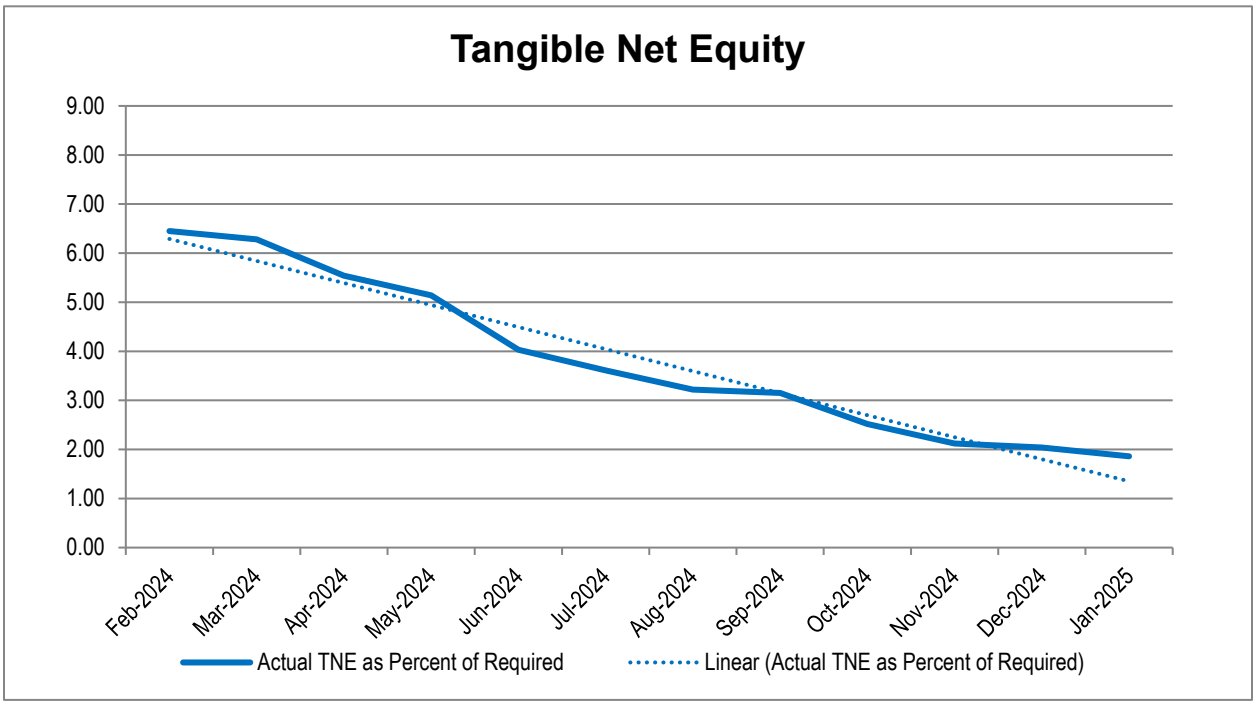
Net Income – For the month ended January 31st, 2025, actual Net Loss was $6.7 million vs. budgeted Net Loss of $3.2 million. For the fiscal YTD, actual Net Loss was $103.9 million vs. budgeted Net Loss of $94.6 million. For the month, Premium Revenue was unfavorable to budget, actual Revenue was $190.7 million vs. budgeted Revenue of $192.0 million. Premium Revenue variance of $1.3 million is primarily due to Medicare Part A Premium Buy-In, which resulted in a $3.6 million decrease to our revenue.



Medical Loss Ratio (MLR) – The Medical Loss Ratio was 100.2% for the month, and 104.8% for fiscal YTD. The major variances include unfavorable Primary Care, Outpatient, Inpatient/SNF, Ancillary FFS, Outpatient FFS, and Long-Term Care.



Tangible Net Equity (TNE) - The Department of Managed Health Care (DMHC) required $81.4M in reserves, we reported $151.5M. Our overall TNE remains just above DMHC requirements at 186.0%.



The Alliance continues to benefit from increased non-operating income. For Fiscal year-to-date investments show a gain of $20.1M. Capital assets acquired so far are $530k.

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

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

Date: **March 11th, 2025**

Subject: **Finance Report – January 2025**

Executive Summary

- For the month ended January 31st, 2025, the Alliance had enrollment of 412,828 members, a Net Loss of $6.7 million and 186% of required Tangible Net Equity (TNE).

Overall Results: (in Thousands)

	Month	YTD
Revenue	$256,432	$1,742,769
Medical Expense	191,121	1,254,585
Admin. Expense	8,859	66,513
MCO Tax Expense	65,763	545,664
Other Inc. / (Exp.)	2,622	20,144
Net Income	**($6,689)**	**($103,850)**

Net Income by Program: (in Thousands)

	Month	YTD
Medi-Cal	($5,663)	($97,943)
Group Care	(656)	(893)
Medicare	(371)	(5,014)
	($6,689)	**($103,850)**

Enrollment

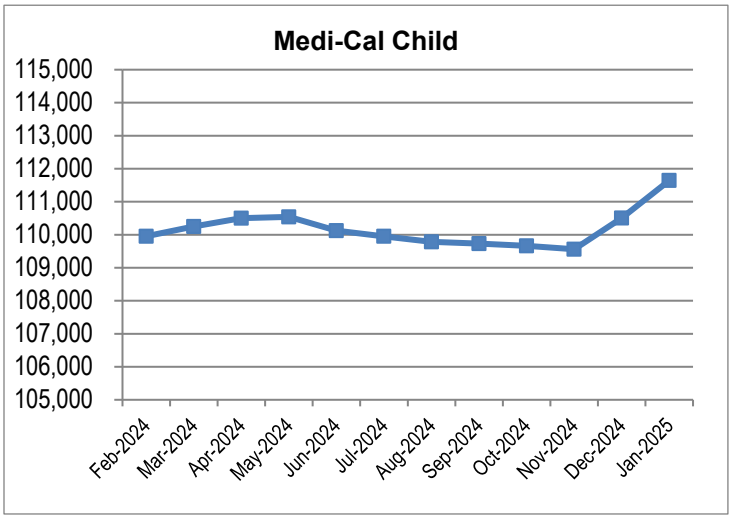
- Total enrollment increased by 602 members since December 2024.
- Total enrollment increased by 8,838 members since June 2024.

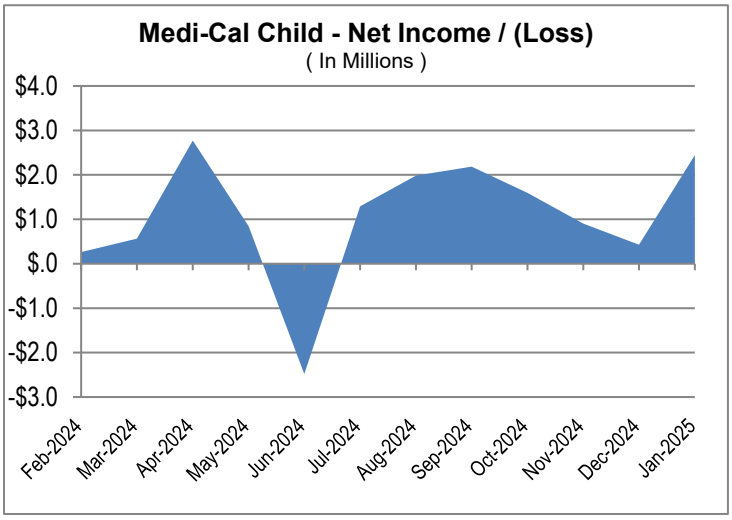
Monthly Membership and YTD Member Months
Actual vs. Budget

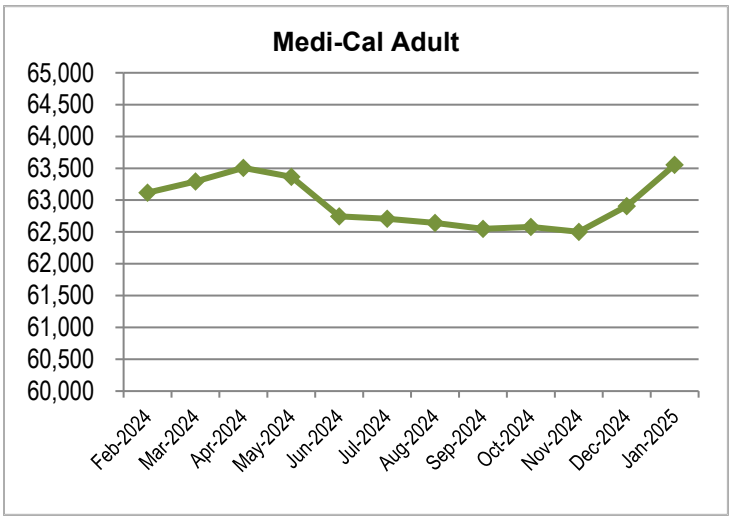
Enrollment					Member Months			
Current Month					Year-to-Date			
Actual	Budget	Variance	Variance %		Actual	Budget	Variance	Variance %
				Medi-Cal:				
111,643	110,102	1,541	1.4%	Child	770,838	768,884	1,954	0.3%
63,553	62,767	786	1.3%	Adult	439,437	438,589	848	0.2%
0	0	0	100.0%	SPD*	212,632	211,783	849	0.4%
0	0	0	100.0%	Duals*	241,339	240,472	867	0.4%
154,136	151,551	2,585	1.7%	ACA OE	1,062,641	1,056,586	6,055	0.6%
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%
29,564	34,750	(5,186)	(14.9%)	SPD with LTC	29,564	34,750	(5,186)	(14.9%)
48,153	42,412	5,741	13.5%	Duals with LTC	48,153	42,412	5,741	13.5%
407,049	**401,582**	**5,467**	**1.4%**	**Medi-Cal Total**	**2,813,612**	**2,802,458**	**11,154**	**0.4%**
5,779	5,769	10	0.2%	Group Care	40,181	40,147	34	0.1%
412,828	**407,351**	**5,477**	**1.3%**	**Total**	**2,853,793**	**2,842,605**	**11,188**	**0.4%**

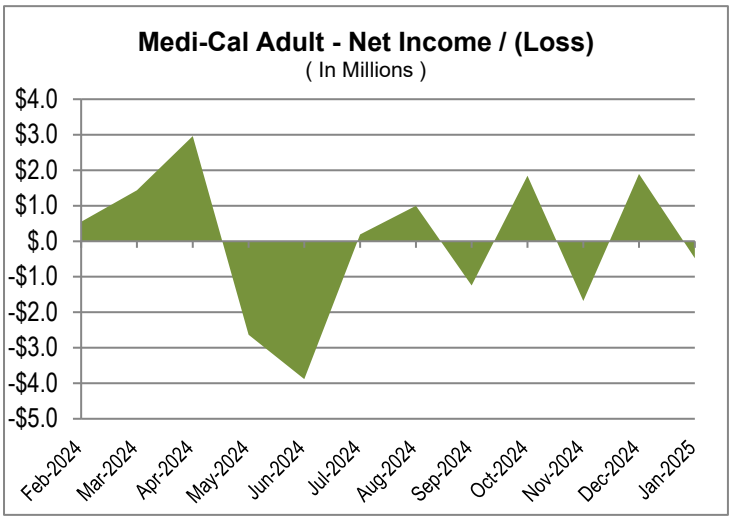
*As of January 2025, service month, "SPD", "Duals", "LTC", and "LTC Duals" will be discontinued. Effective January 2025 service month new consolidated groupings will be "SPD with LTC" and "Duals with LTC".

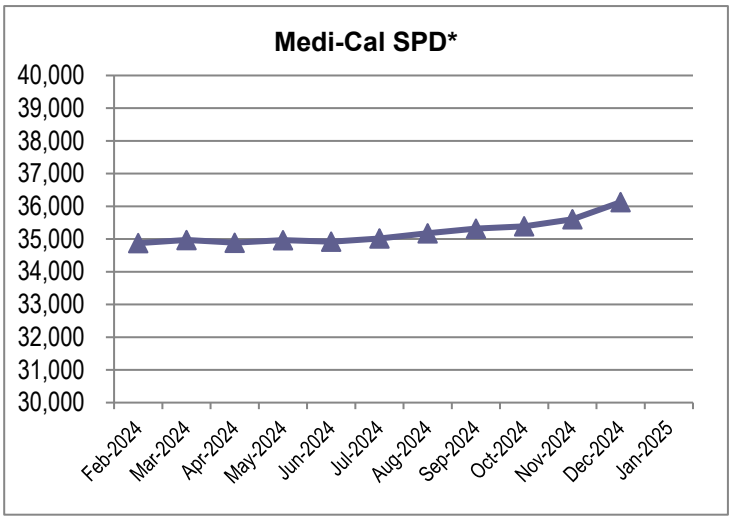
Enrollment and Profitability by Program and Category of Aid

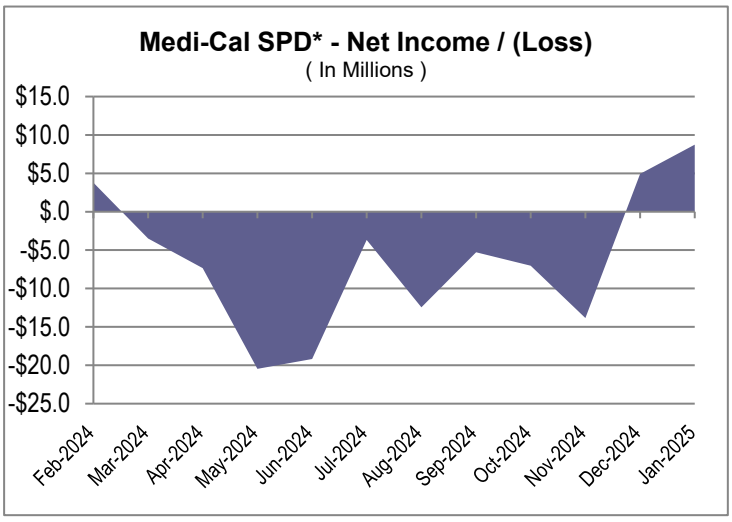




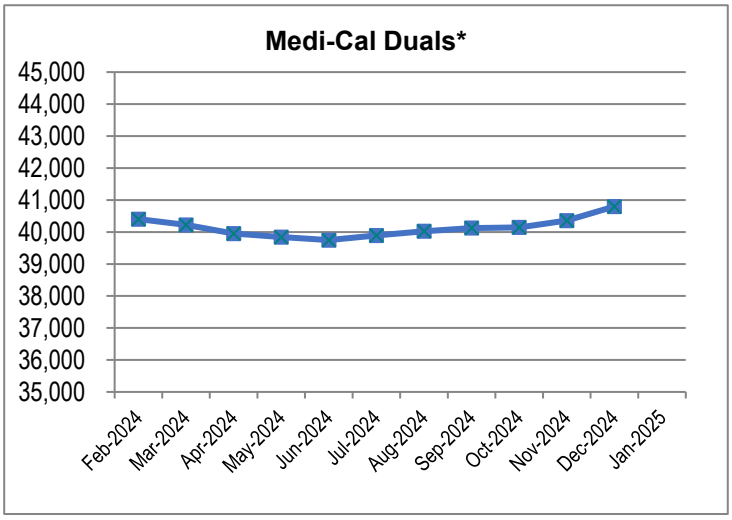


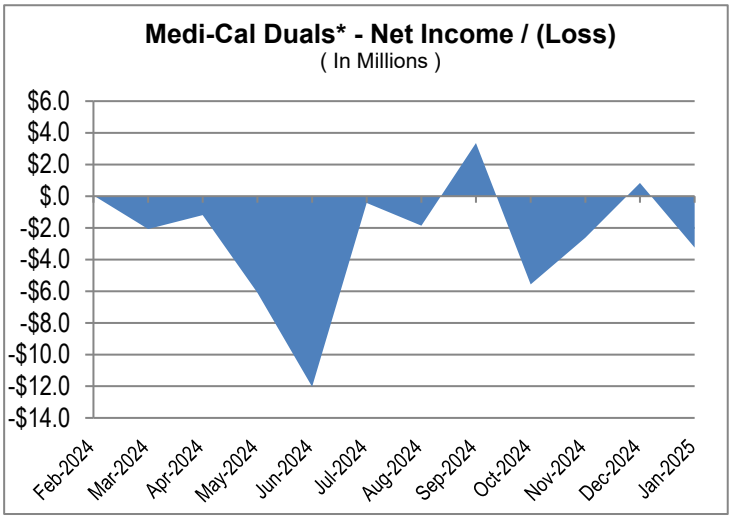


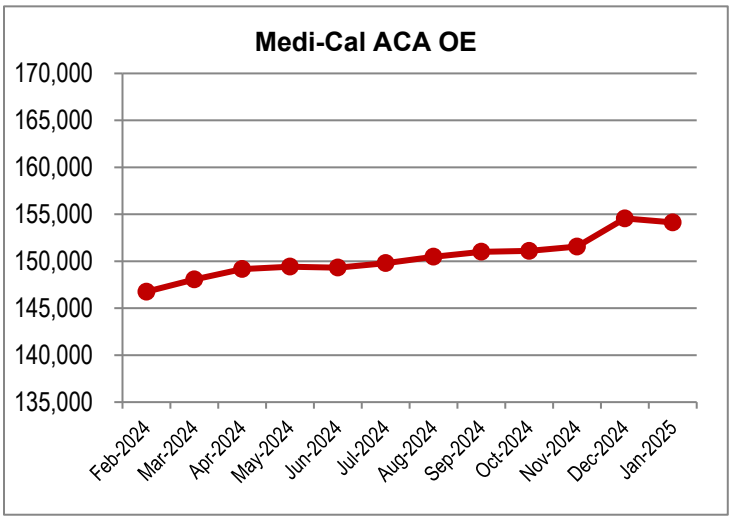


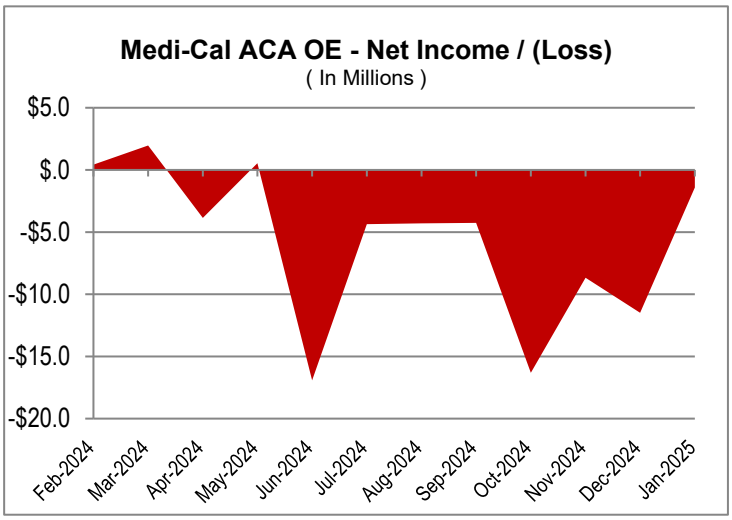


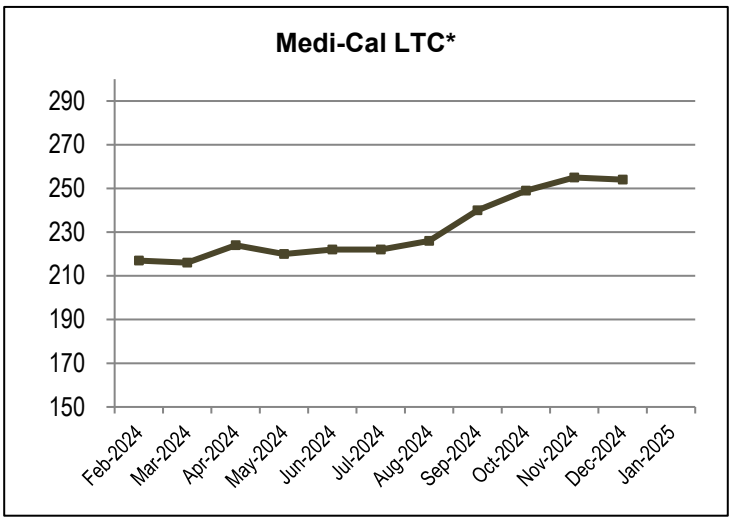
Enrollment and Profitability by Program and Category of Aid

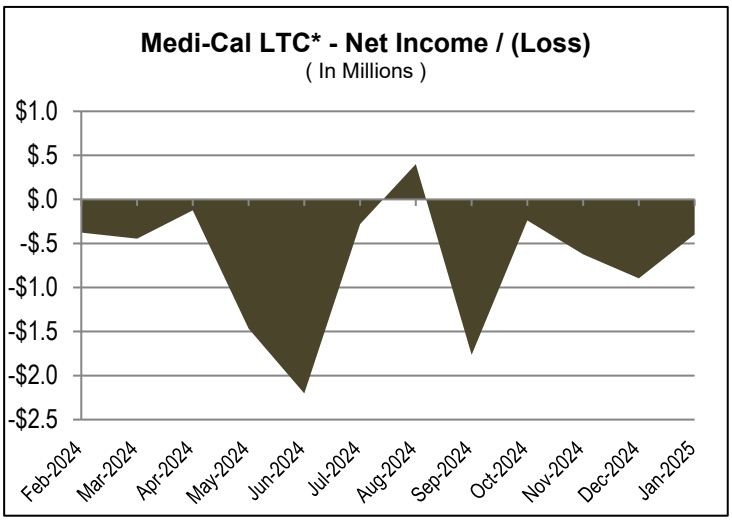




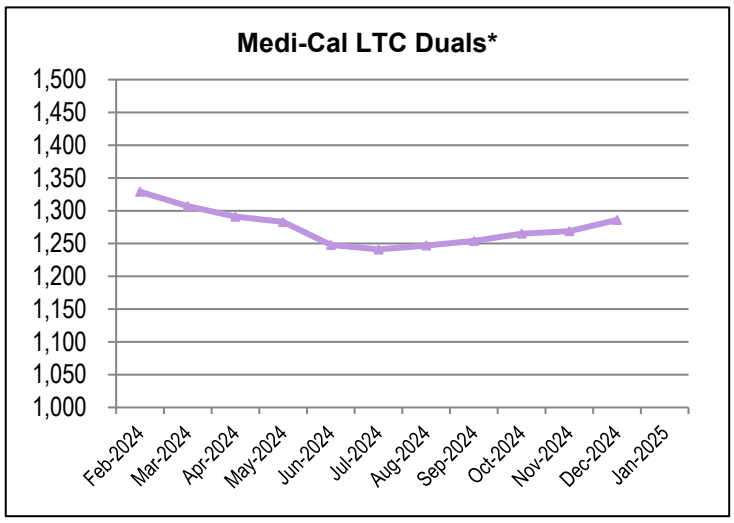


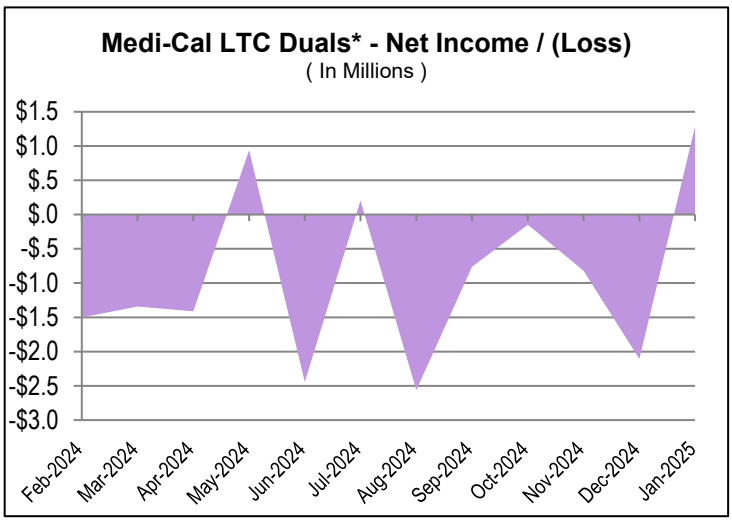


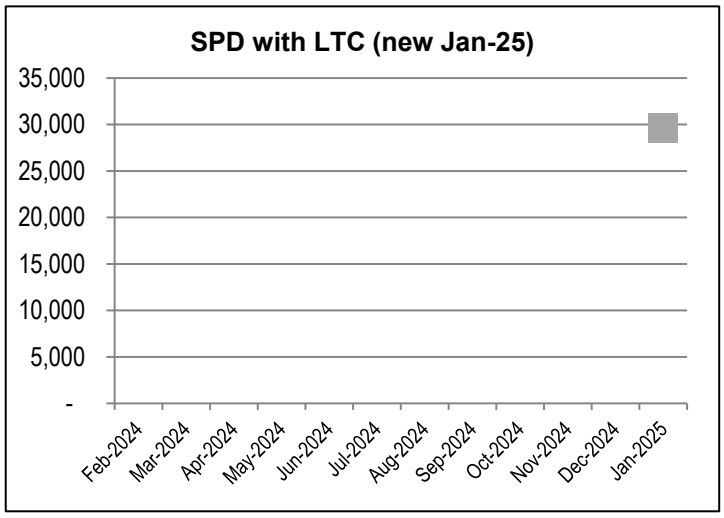


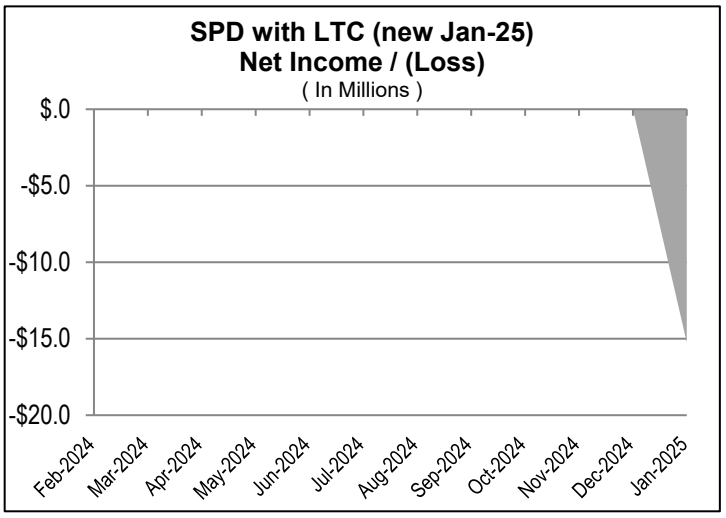


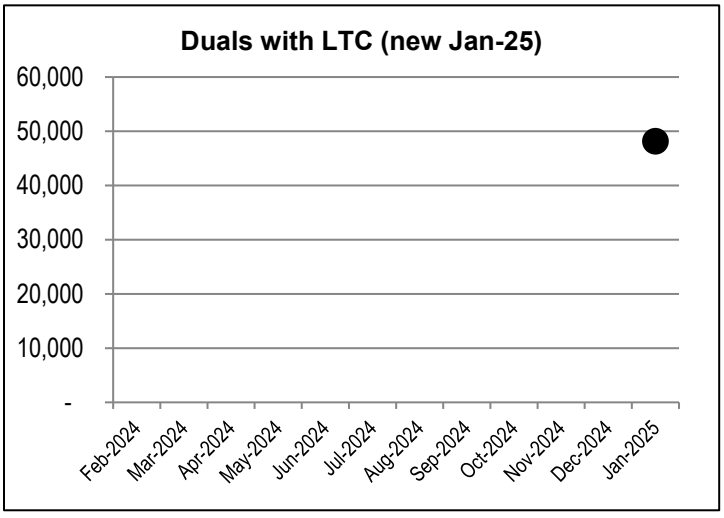
Enrollment and Profitability by Program and Category of Aid

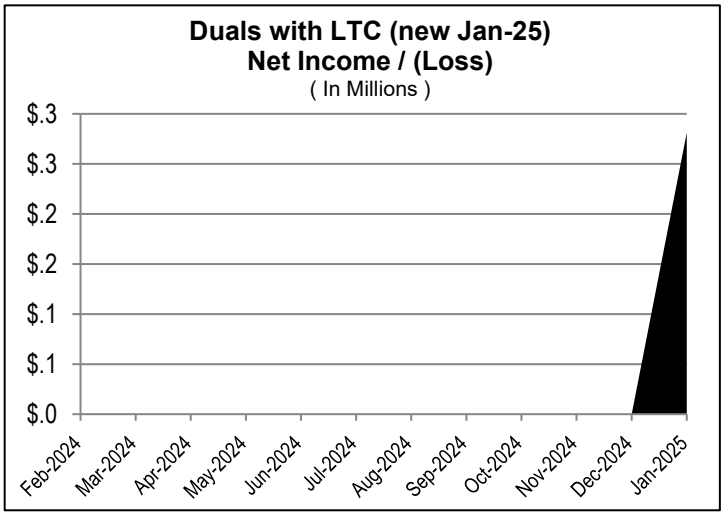




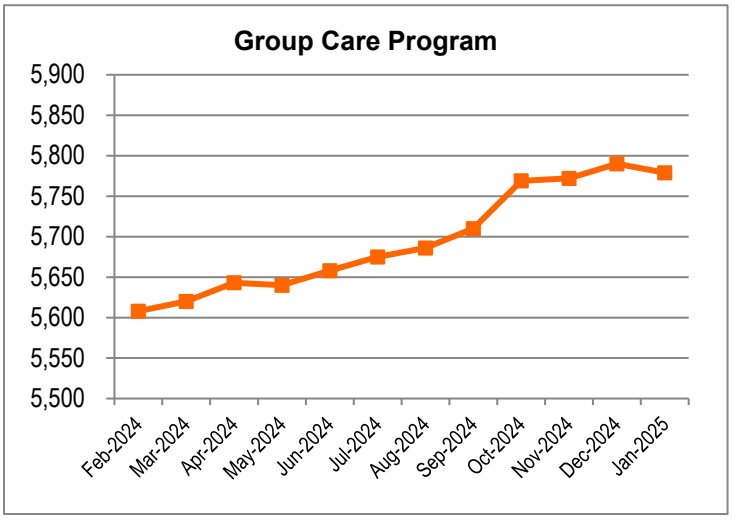


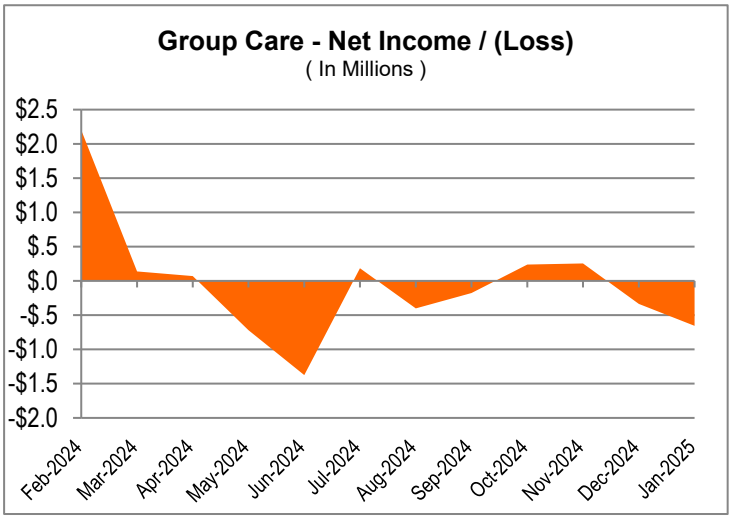


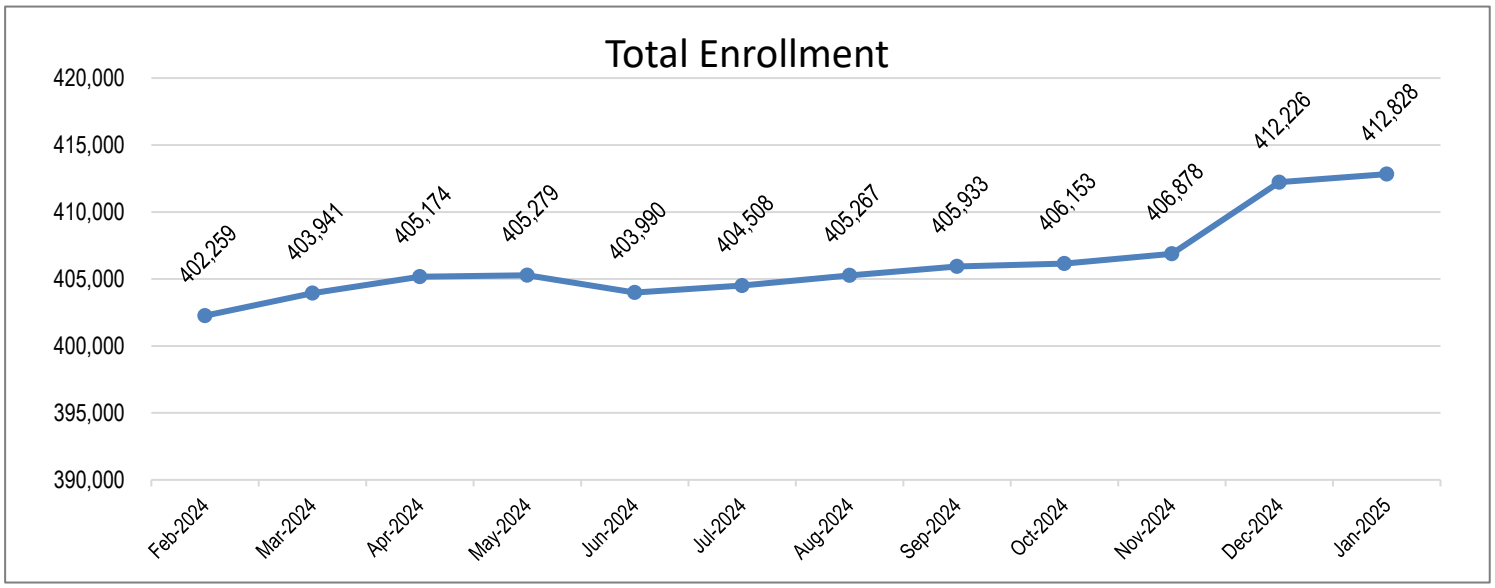


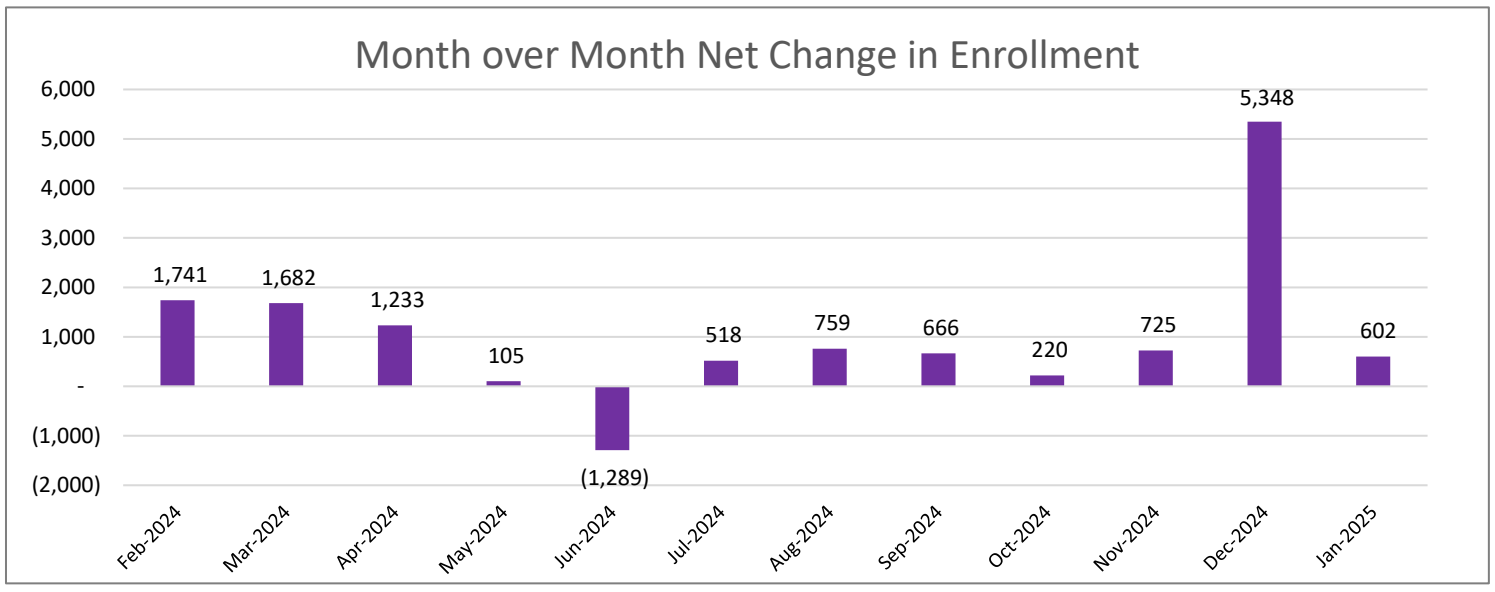


Enrollment and Profitability by Program and Category of Aid





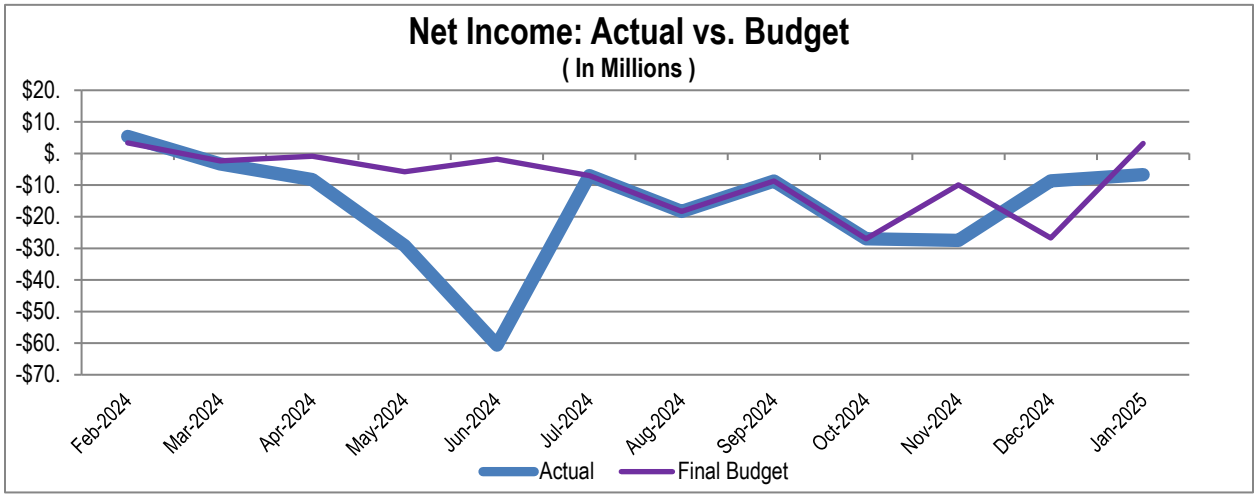




- The Public Health Emergency (PHE) ended May 2023. Disenrollments related to redetermination started July 2023 and ended May 2024. In preparation for the Single Plan Model, effective October 2023 DHCS no longer assigned members to Anthem, and instead new members were assigned to the Alliance.
- In January 2024, enrollment significantly increased due to transition to Single Plan Model and expansion of full scope Medi-Cal to California residents 26-49 regardless of immigration status. Kaiser's transition to a direct contract with the State resulted in a partially offsetting membership reduction.

Net Income

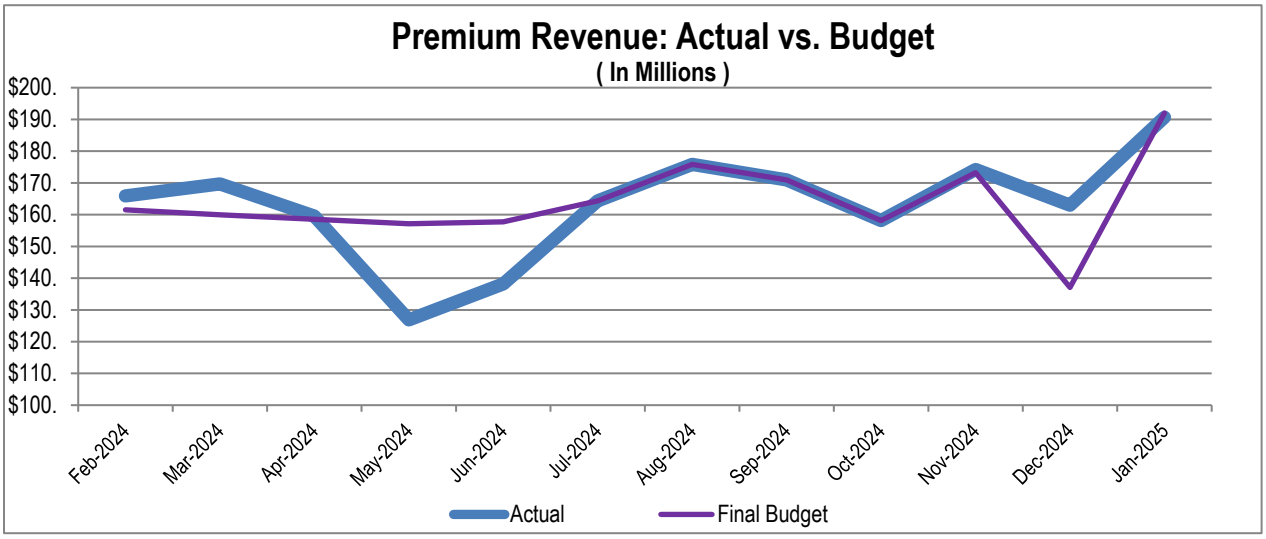
- For the month ended January 31st, 2025:
  - Actual Net Loss $6.7 million.
  - Budgeted Net Income $3.2 million.
- For the fiscal YTD ended January 31st, 2025:
  - Actual Net Loss $103.9 million.
  - Budgeted Net Loss $94.6 million.



- The unfavorable variance of $9.9 million in the current month is primarily due to:
  - Unfavorable $12.3 million higher than anticipated Medical Expense.
  - Unfavorable $1.3 million lower than anticipated Premium Revenue.
  - Favorable $2.7 million lower than anticipated Administrative Expense.
  - Favorable $1.1 million lower than anticipated Other Income and Expense.

Premium Revenue

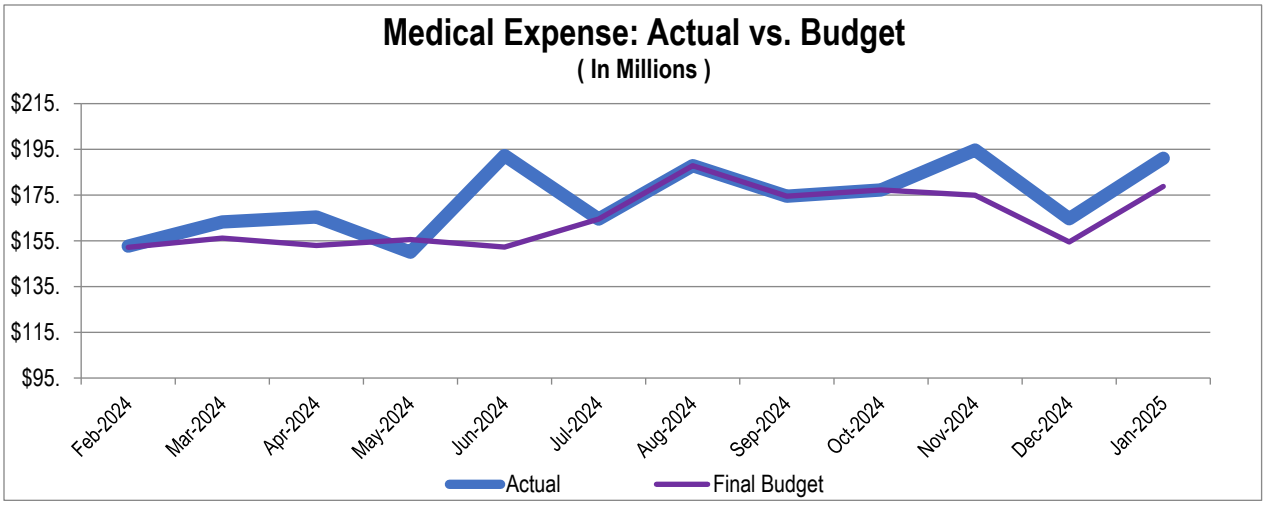
- For the month ended January 31st, 2025:
  - Actual Revenue: $190.7 million.
  - Budgeted Revenue: $192.0 million.
- For the fiscal YTD ended January 31st, 2025:
  - Actual Revenue: $1.2 billion.
  - Budgeted Revenue: $1.2 billion.
- For the month ended January 31st, 2025, the unfavorable Premium Revenue variance of $1.3 million is primarily due to the following:



- Medicare Part A Premium Buy In resulted in a $3.6 million decrease to our revenue as approximately 6,000 members moved from SPD to Duals
- Unfavorable volume variance for the current month.
- Unfavorable Supplemental Maternity Revenue.
- Partially offset by a combination of retroactive Medi-Cal member months, capitation rate variance, and the December estimate to actual true-up.

Medical Expense

- For the month ended January 31st, 2025:
  - Actual Medical Expense: $191.1 million.
  - Budgeted Medical Expense: $178.8 million.
- For the fiscal YTD ended January 31st, 2025:
  - Actual Medical Expense: $1.3 billion.
  - Budgeted Medical Expense: $1.2 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 January, updates to Fee-For-Service (FFS) increased the estimate for prior period unpaid Medical Expenses by $3.2 million. Year to date, the estimate for prior years increased by $6.0 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	$121,891,446	$0	$121,891,446	$115,006,241	($6,885,205)	(6.0%)
Primary Care FFS	$27,551,189	$129,879	$27,681,068	$22,617,607	($4,933,582)	(21.8%)
Specialty Care FFS	$58,893,158	$272,626	$59,165,784	$57,981,387	($911,772)	(1.6%)
Outpatient FFS	$90,060,099	$754,030	$90,814,129	$84,370,490	($5,689,609)	(6.7%)
Ancillary FFS	$123,064,222	($679,615)	$122,384,607	$119,727,045	($3,337,177)	(2.8%)
Pharmacy FFS	$94,231,888	$240,308	$94,472,196	$93,498,698	($733,190)	(0.8%)
ER Services FFS	$73,168,309	$256,016	$73,424,325	$73,215,693	$47,384	0.1%
Inpatient Hospital FFS	$387,730,024	$3,537,551	$391,267,576	$373,350,712	($14,379,312)	(3.9%)
Long Term Care FFS	$239,305,181	$1,475,764	$240,780,944	$233,843,089	($5,462,092)	(2.3%)
Other Benefits & Services	$34,185,496	$0	$34,185,496	$37,166,193	$2,980,697	8.0%
Net Reinsurance	($1,482,112)	$0	($1,482,112)	$1,601,111	$3,083,223	192.6%
	$1,248,598,901	**$5,986,558**	**$1,254,585,458**	**$1,212,378,266**	**($36,220,635)**	**(3.0%)**

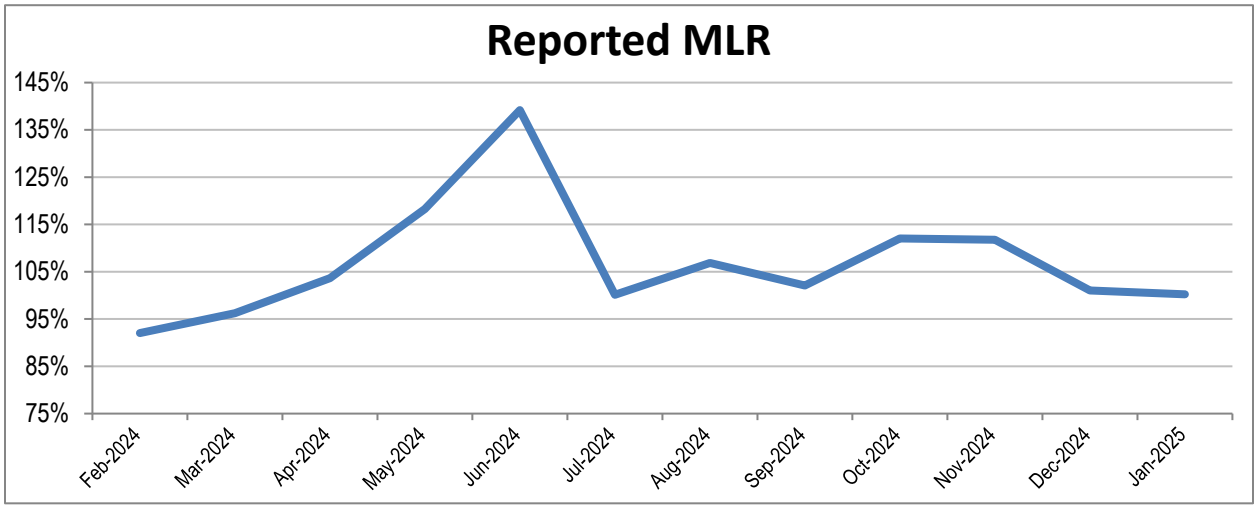
Medical Expense - Actual vs. Budget (Per Member Per Month)
Adjusted to Eliminate the Impact of Prior Year IBNP Estimates

	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$42.71	$0.00	$42.71	$40.46	($2.25)	(5.6%)
Primary Care FFS	$9.65	$0.05	$9.70	$7.96	($1.70)	(21.3%)
Specialty Care FFS	$20.64	$0.10	$20.73	$20.40	($0.24)	(1.2%)
Outpatient FFS	$31.56	$0.26	$31.82	$29.68	($1.88)	(6.3%)
Ancillary FFS	$43.12	($0.24)	$42.88	$42.12	($1.00)	(2.4%)
Pharmacy FFS	$33.02	$0.08	$33.10	$32.89	($0.13)	(0.4%)
ER Services FFS	$25.64	$0.09	$25.73	$25.76	$0.12	0.5%
Inpatient Hospital FFS	$135.86	$1.24	$137.10	$131.34	($4.52)	(3.4%)
Long Term Care FFS	$83.86	$0.52	$84.37	$82.26	($1.59)	(1.9%)
Other Benefits & Services	$11.98	$0.00	$11.98	$13.07	$1.10	8.4%
Net Reinsurance	($0.52)	$0.00	($0.52)	$0.56	$1.08	192.2%
	$437.52	**$2.10**	**$439.62**	**$426.50**	**($11.02)**	**(2.6%)**

- Excluding the impact of prior year estimates for IBNP, year-to-date medical expense variance is $36.2 million unfavorable to budget. On a PMPM basis, medical expense is 2.6% 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 over budget due to higher utilization and unit cost in the ACA OE and Child aid code categories.
    - Specialty Care Expense is slightly above budget, driven by higher than expected SPD and LTC utilization.
    - Outpatient Expense is over budget mostly driven by lab and radiology unit cost and dialysis and other facility utilization in the SPD, ACA OE, LTC and Adult aid code categories.
    - Ancillary Expense is over budget due to higher Behavioral Health utilization and unit cost in the Child aid code category.
    - Pharmacy Expense is over budget due to PBM expense driven by higher Group Care unit cost.
    - Emergency Room Expense is slightly under budget driven by lower Child aid code category unit cost and lower Dual member unit cost and utilization.
    - Inpatient Expense is over budget driven by higher utilization in the SPD, LTC and ACA OE aid code categories.
    - Long Term Care Expense is over budget due to higher unit cost in the SPD, LTC and ACA OE aid code categories.
    - Other Benefits & Services is under budget, due to lower than purchased and 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 100.2% for the month and 104.8% for the fiscal year-to-date.



Administrative Expense

- For the month ended January 31st, 2025:
  - Actual Administrative Expense: $8.9 million.
  - Budgeted Administrative Expense: $11.5 million.

- For the fiscal YTD ended January 31st, 2025:
  - Actual Administrative Expense: $66.5 million.
  - Budgeted Administrative Expense: $72.2 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 %**
$6,114,872	$6,879,261	$764,389	11.1%	Employee Expense	$39,924,806	$41,285,695	$1,360,889	3.3%
91,149	74,974	(16,175)	(21.6%)	Medical Benefits Admin Expense	556,345	529,606	(26,739)	(5.0%)
2,209,763	2,981,287	771,524	25.9%	Purchased & Professional Services	15,690,669	17,764,316	2,073,646	11.7%
443,014	1,580,916	1,137,901	72.0%	Other Admin Expense	10,341,430	12,644,256	2,302,826	18.2%
$8,858,797	$11,516,437	$2,657,639	23.1%	Total Administrative Expense	$66,513,251	$72,223,873	$5,710,623	7.9%

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 for the timing for Consulting Services and Other Purchased Services.
- Favorable Printing/Postage/Promotion and Supplies & Other Expenses.
- Favorable Licenses, Insurance & Fees - for IT-related Licenses and Subscriptions as well as reduction in Insurance Premiums and subscriptions.
- Favorable Building Occupancy costs, Provider Interest, Supplies & Other Expenses;
- Offset by the unfavorable Medical Benefit Admin Fees.

The Administrative Loss Ratio (ALR) is 4.6% of net revenue for the month and 5.6% 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 $873,000.

Other Income / (Expense)

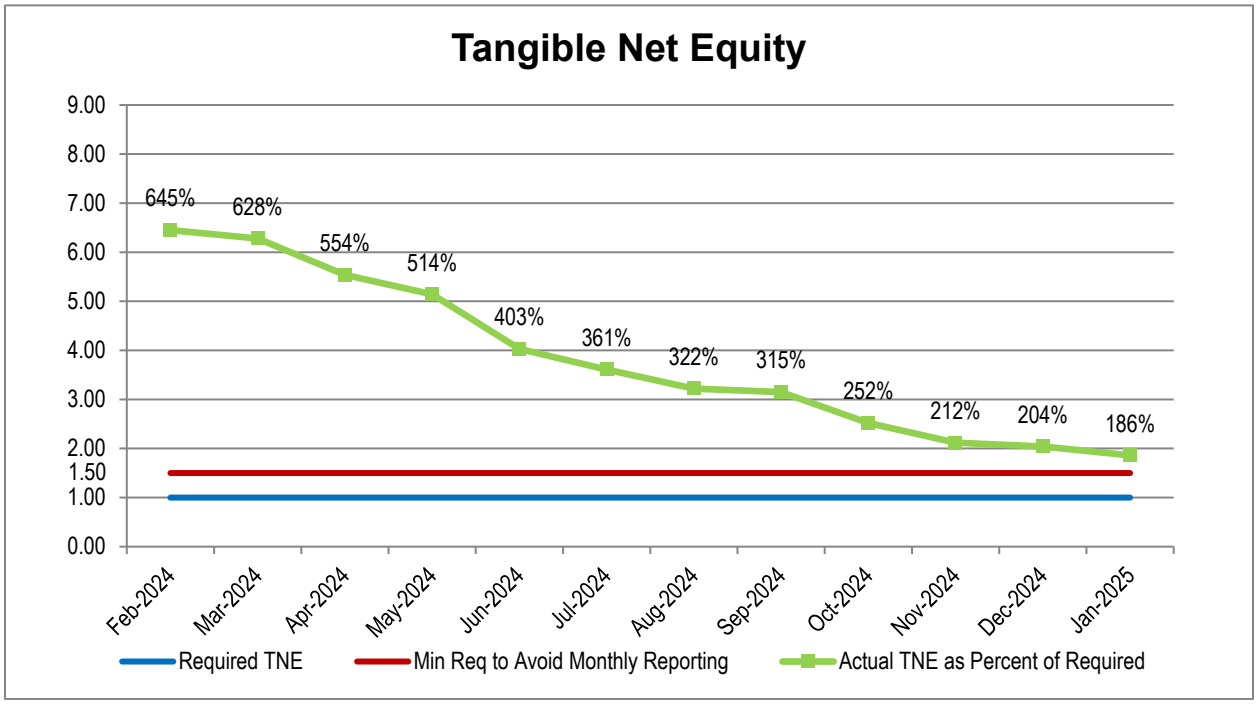
Other Income & Expense is comprised of investment income. Fiscal year-to-date net investments show a gain of $20.1 million.

Managed Care Organization (MCO) Provider Tax

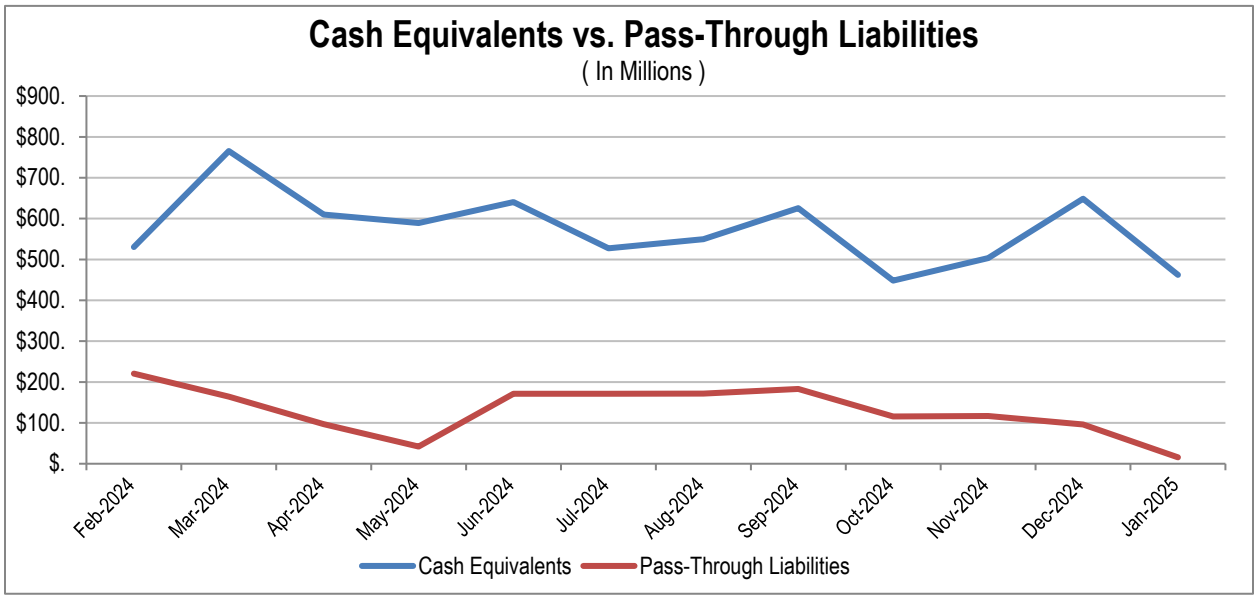
- Revenue:
  - For the month ended January 31st, 2025:
    - Actual: $65.8 million.
    - Budgeted: $63.7 million.
  - For the fiscal YTD ended January 31st, 2025:
    - Actual: $545.7 million.
    - Budgeted: $542.7 million.
- Expense:
  - For the month ended January 31st, 2025:
    - Actual: $65.8 million.
    - Budgeted: $63.7 million.
  - For the fiscal YTD ended January 31st, 2025:
    - Actual: $545.7 million.
    - Budgeted: $542.7 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 $81.4 million
  - Actual TNE $151.5 million
  - Excess TNE $70.2 million
  - TNE % of Required TNE 186%



- To ensure appropriate liquidity and limit risk, the majority of Alliance financial assets are kept in short-term investments.
- Key Metrics
    - Cash & Cash Equivalents $462.1 million
    - Pass-Through Liabilities $15.7 million
    - Uncommitted Cash $446.5 million
    - Working Capital $90.4 million
    - Current Ratio 1.10 (regulatory minimum is 1.00)



Capital Investment

- Fiscal year-to-date capital assets acquired: $530,000.
- 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 JANUARY 31, 2025

CURRENT MONTH					FISCAL YEAR TO DATE			
		$ Variance	% Variance				$ Variance	% Variance
Actual	Budget	(Unfavorable)	(Unfavorable)	Account Description	Actual	Budget	(Unfavorable)	(Unfavorable)
				MEMBERSHIP				
407,049	401,582	5,467	1.4%	1. Medi-Cal	2,813,612	2,802,458	11,154	0.4%
5,779	5,769	10	0.2%	2. GroupCare	40,181	40,147	34	0.1%
412,828	**407,351**	**5,477**	**1.3%**	**3. TOTAL MEMBER MONTHS**	**2,853,793**	**2,842,605**	**11,188**	**0.4%**
				REVENUE				
$190,668,893	$192,017,786	($1,348,893)	(0.7%)	4. Premium Revenue	$1,197,104,542	$1,171,559,623	$25,544,919	2.2%
$65,762,836	$63,727,048	$2,035,789	3.2%	5. MCO Tax Revenue AB119	$545,664,085	$542,725,826	$2,938,259	0.5%
$256,431,729	**$255,744,833**	**$686,896**	**0.3%**	**6. TOTAL REVENUE**	**$1,742,768,627**	**$1,714,285,449**	**$28,483,178**	**1.7%**
				MEDICAL EXPENSES				
				Capitated Medical Expenses				
$20,023,693	$17,275,620	($2,748,073)	(15.9%)	7. Capitated Medical Expense	$121,891,446	$115,006,241	($6,885,205)	(6.0%)
				Fee for Service Medical Expenses				
$57,077,998	$53,243,836	($3,834,161)	(7.2%)	8. Inpatient Hospital Expense	$391,267,576	$373,350,712	($17,916,864)	(4.8%)
$6,400,430	$4,821,404	($1,579,025)	(32.8%)	9. Primary Care Physician Expense	$27,681,068	$22,617,607	($5,063,461)	(22.4%)
$8,708,313	$8,513,876	($194,437)	(2.3%)	10. Specialty Care Physician Expense	$59,165,784	$57,981,387	($1,184,398)	(2.0%)
$21,511,309	$20,085,479	($1,425,830)	(7.1%)	11. Ancillary Medical Expense	$122,384,607	$119,727,045	($2,657,562)	(2.2%)
$15,212,420	$11,921,104	($3,291,316)	(27.6%)	12. Outpatient Medical Expense	$90,814,129	$84,370,490	($6,443,638)	(7.6%)
$10,708,229	$10,678,865	($29,364)	(0.3%)	13. Emergency Expense	$73,424,325	$73,215,693	($208,632)	(0.3%)
$13,677,376	$12,483,282	($1,194,093)	(9.6%)	14. Pharmacy Expense	$94,472,196	$93,498,698	($973,498)	(1.0%)
$34,517,400	$33,980,019	($537,381)	(1.6%)	15. Long Term Care Expense	$240,780,944	$233,843,089	($6,937,855)	(3.0%)
$167,813,473	$155,727,865	($12,085,608)	(7.8%)	16. Total Fee for Service Expense	$1,099,990,628	$1,058,604,720	($41,385,908)	(3.9%)
$5,763,805	$5,368,849	($394,956)	(7.4%)	17. Other Benefits & Services	$34,185,496	$37,166,193	$2,980,697	8.0%
($2,479,745)	$436,446	$2,916,191	668.2%	18. Reinsurance Expense	($1,482,112)	$1,601,111	$3,083,223	192.6%
$191,121,226	**$178,808,780**	**($12,312,447)**	**(6.9%)**	**20. TOTAL MEDICAL EXPENSES**	**$1,254,585,458**	**$1,212,378,266**	**($42,207,193)**	**(3.5%)**
$65,310,503	**$76,936,054**	**($11,625,551)**	**(15.1%)**	**21. GROSS MARGIN**	**$488,183,169**	**$501,907,183**	**($13,724,014)**	**(2.7%)**
				ADMINISTRATIVE EXPENSES				
$6,114,872	$6,879,261	$764,389	11.1%	22. Personnel Expense	$39,924,806	$41,285,695	$1,360,889	3.3%
$91,149	$74,974	($16,175)	(21.6%)	23. Benefits Administration Expense	$556,345	$529,606	($26,739)	(5.0%)
$2,209,763	$2,981,287	$771,524	25.9%	24. Purchased & Professional Services	$15,690,669	$17,764,316	$2,073,647	11.7%
$443,014	$1,580,916	$1,137,901	72.0%	25. Other Administrative Expense	$10,341,430	$12,644,256	$2,302,826	18.2%
$8,858,797	**$11,516,437**	**$2,657,639**	**23.1%**	**26. TOTAL ADMINISTRATIVE EXPENSES**	**$66,513,251**	**$72,223,873**	**$5,710,623**	**7.9%**
$65,762,836	**$63,727,048**	**($2,035,789)**	**(3.2%)**	**27. MCO TAX EXPENSES**	**$545,664,085**	**$542,725,826**	**($2,938,259)**	**(0.5%)**
($9,311,131)	**$1,692,569**	**($11,003,700)**	**(650.1%)**	**28. NET OPERATING INCOME / (LOSS)**	**($123,994,167)**	**($113,042,516)**	**($10,951,651)**	**(9.7%)**
				OTHER INCOME / EXPENSES				
$2,622,308	**$1,500,000**	**$1,122,308**	**74.8%**	**29. TOTAL OTHER INCOME / (EXPENSES)**	**$20,144,103**	**$18,481,002**	**$1,663,100**	**9.0%**
($6,688,823)	**$3,192,569**	**($9,881,393)**	**(309.5%)**	**30. NET SURPLUS (DEFICIT)**	**($103,850,064)**	**($94,561,514)**	**($9,288,550)**	**(9.8%)**
100.2%	93.1%	(7.1%)	(7.6%)	31. Medical Loss Ratio	104.8%	103.5%	(1.3%)	(1.3%)
4.6%	6.0%	1.4%	23.3%	32. Administrative Expense Ratio	5.6%	6.2%	0.6%	9.7%
(2.6%)	1.2%	(3.8%)	(316.7%)	33. Net Surplus (Deficit) Ratio	(6.0%)	(5.5%)	(0.5%)	(9.1%)

ALAMEDA ALLIANCE FOR HEALTH
BALANCE SHEETS
CURRENT MONTH VS. PRIOR MONTH
FOR THE MONTH AND FISCAL YTD ENDED JANUARY 31, 2025

	1/31/2025	12/31/2024	Difference	% Difference
CURRENT ASSETS				
Cash and Cash Equivalent				
Cash	$46,837,477	$114,463,648	($67,626,170)	(59.1%)
CNB Short-Term Investment	415,286,680	534,091,532	(118,804,852)	(22.2%)
Interest Receivable	3,816,285	5,317,151	(1,500,865)	(28.2%)
Premium Receivables	481,046,122	444,009,126	37,036,996	8.3%
Reinsurance Recovery Receivable	8,541,221	7,287,219	1,254,002	17.2%
Other Receivables	1,954,962	1,450,111	504,851	34.8%
Prepaid Expenses	695,119	724,913	(29,794)	(4.1%)
TOTAL CURRENT ASSETS	**958,177,866**	**1,107,343,699**	**(149,165,834)**	**(13.5%)**
OTHER ASSETS				
CNB Long-Term Investment	46,769,807	44,130,301	2,639,506	6.0%
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	350,000	350,000	0	0.0%
GASB 87-Lease Assets (Net)	345,529	411,442	(65,913)	(16.0%)
GASB 96-SBITA Assets (Net)	3,583,629	3,829,974	(246,345)	(6.4%)
TOTAL OTHER ASSETS	**59,224,365**	**56,897,118**	**2,327,247**	**4.1%**
PROPERTY AND EQUIPMENT				
Land, Building & Improvements	9,842,648	9,842,648	0	0.0%
Furniture And Equipment	13,071,003	13,071,003	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	38,640,099	38,640,099	0	0.0%
Less: Accumulated Depreciation	(33,078,751)	(33,019,378)	(59,373)	0.2%
PROPERTY AND EQUIPMENT (NET)	**5,561,348**	**5,620,721**	**(59,373)**	**(1.1%)**
TOTAL ASSETS	**1,022,963,578**	**1,169,861,537**	**(146,897,960)**	**(12.6%)**
CURRENT LIABILITIES				
Trade Accounts Payable	10,767,792	9,791,559	976,232	10.0%
Incurred But Not Reported Claims	365,147,051	368,254,069	(3,107,018)	(0.8%)
Other Medical Liabilities	137,453,300	135,136,830	2,316,470	1.7%
Pass-Through Liabilities	15,650,909	96,151,184	(80,500,275)	(83.7%)
MCO Tax Liabilities	329,041,166	388,747,080	(59,705,914)	(15.4%)
GASB 87 and 96 ST Liabilities	1,139,415	1,248,045	(108,631)	(8.7%)
Payroll Liabilities	8,626,137	8,702,863	(76,726)	(0.9%)
TOTAL CURRENT LIABILITIES	**867,825,770**	**1,008,031,632**	**(140,205,862)**	**(13.9%)**
LONG TERM LIABILITIES				
GASB 87 and 96 LT Liabilities	285,198	288,473	(3,275)	(1.1%)
Deferred Inflow	3,327,530	3,327,530	0	0.0%
TOTAL LONG TERM LIABILITIES	**3,612,728**	**3,616,003**	**(3,275)**	**(0.1%)**
TOTAL LIABILITIES	**871,438,498**	**1,011,647,635**	**(140,209,137)**	**(13.9%)**
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)	(103,850,064)	(97,161,241)	(6,688,823)	6.9%
TOTAL NET WORTH	**151,525,080**	**158,213,903**	**(6,688,823)**	**(4.2%)**
TOTAL LIABILITIES AND NET WORTH	**1,022,963,578**	**1,169,861,538**	**(146,897,960)**	**(12.6%)**
Cash Equivalents	462,124,157	648,555,180	(186,431,023)	(28.7%)
Pass-Through	15,650,909	96,151,184	(80,500,275)	(83.7%)
Uncommitted Cash	446,473,248	552,403,995	(105,930,747)	(19.2%)
Working Capital	90,352,095	99,312,067	(8,959,972)	(9.0%)
Current Ratio	110.4%	109.9%	0.5%	0.5%

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED **January 31, 2025**

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM OPERATING ACTIVITIES				
Commercial Premium Cash Flows				
Commercial Premium Revenue	$3,158,286	$9,482,512	$18,871,637	$21,974,895
GroupCare Receivable	2,137	3,053,220	3,079,024	(7,316)
Total	3,160,423	12,535,732	21,950,661	21,967,579
Medi-Cal Premium Cash Flows				
Medi-Cal Revenue	253,273,441	712,275,311	1,512,644,959	1,720,793,733
Premium Receivable	(37,039,134)	(7,595,597)	(115,054,057)	(114,095,286)
Total	216,234,307	704,679,714	1,397,590,902	1,606,698,447
Investment & Other Income Cash Flows				
Other Revenues	553,416	1,688,494	2,305,853	3,169,901
Interest Income	2,074,798	5,517,048	13,900,605	17,065,066
Interest Receivable	1,500,865	1,374,595	(302,921)	(1,900,222)
Total	4,129,079	8,580,137	15,903,537	18,334,745
Medical & Hospital Cash Flows				
Total Medical Expenses	(191,121,230)	(550,473,115)	(1,090,074,803)	(1,254,585,461)
Other Health Care Receivables	(1,765,699)	1,001,688	(382,239)	465,939
Capitation Payable	-	-	-	-
IBNP Payable	(3,107,018)	64,334,950	95,859,703	68,842,792
Other Medical Payable	(78,183,804)	(72,294,650)	(206,225,802)	(182,736,548)
Risk Share Payable	-	-	(2,680,192)	(2,680,192)
New Health Program Payable	-	-	-	-
Total	(274,177,751)	(557,431,127)	(1,203,503,333)	(1,370,693,470)
Administrative Cash Flows				
Total Administrative Expenses	(8,864,703)	(27,380,885)	(55,771,618)	(66,604,114)
Prepaid Expenses	29,795	93,845	(418,819)	(456,502)
Other Receivables	6,846	326	(3,158)	32,420
CalPERS Pension	-	-	-	-
Trade Accounts Payable	976,232	3,710,719	5,938,496	4,277,496
Payroll Liabilities	(76,725)	(1,732,321)	(100,043)	526,912
GASB Assets and Liabilities	200,353	(1,200,914)	(2,184,589)	(2,003,060)
Depreciation Expense	59,373	178,120	365,532	416,079
Total	(7,668,829)	(26,331,110)	(52,174,199)	(63,810,769)
MCO Tax AB119 Cash Flows				
MCO Tax Expense AB119	(65,762,836)	(193,911,676)	(498,737,394)	(545,664,085)
MCO Tax Liabilities	(59,705,914)	68,442,926	247,799,894	169,257,652
Total	(125,468,750)	(125,468,750)	(250,937,500)	(376,406,433)
Net Cash Flows from Operating Activities	**(183,791,521)**	**16,564,596**	**(71,169,932)**	**(163,909,901)**

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED **January 31, 2025**

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM INVESTING ACTIVITIES				
Investment Cash Flows				
Long Term Investments	(2,639,506)	(2,662,893)	6,369,764	(13,777,557)
Total	(2,639,506)	(2,662,893)	6,369,764	(13,777,557)
Restricted Cash & Other Asset Cash Flows				
Restricted Assets-Treasury Account	-	-	-	-
Total	-	-	-	-
Fixed Asset Cash Flows				
Fixed Asset Acquisitions	-	-	(264,510)	(529,610)
Purchases of Property and Equipment	-	-	(264,510)	(529,610)
Net Cash Flows from Investing Activities	**(2,639,506)**	**(2,662,893)**	**6,105,254**	**(14,307,167)**
Net Change in Cash	**(186,431,027)**	**13,901,703**	**(65,064,678)**	**(178,217,068)**
Rounding	4.00	(2.00)	1.00	(1.00)
Cash @ Beginning of Period	648,555,181	448,222,457	527,188,835	640,341,227
Cash @ End of Period	**$462,124,158**	**$462,124,158**	**$462,124,158**	**$462,124,158**
Variance	-	-	-	-

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED **January 31, 2025**

	MONTH	3 MONTHS	6 MONTHS	YTD
NET INCOME RECONCILIATION				
Net Income / (Loss)	($6,688,828)	($42,802,312)	($96,860,761)	($103,850,065)
Add back: Depreciation & Amortization	59,373	178,120	365,532	416,079
Receivables				
Premiums Receivable	(37,039,134)	(7,595,597)	(115,054,057)	(114,095,286)
Interest Receivable	1,500,865	1,374,595	(302,921)	(1,900,222)
Other Health Care Receivables	(1,765,699)	1,001,688	(382,239)	465,939
Other Receivables	6,846	326	(3,158)	32,420
GroupCare Receivable	2,137	3,053,220	3,079,024	(7,316)
Total	(37,294,985)	(2,165,768)	(112,663,351)	(115,504,465)
Prepaid Expenses	29,795	93,845	(418,819)	(456,502)
Trade Payables	976,232	3,710,719	5,938,496	4,277,496
Claims Payable and Shared Risk Pool				
IBNP Payable	(3,107,018)	64,334,950	95,859,703	68,842,792
Capitation Payable & Other Medical Payable	(78,183,804)	(72,294,650)	(206,225,802)	(182,736,548)
Risk Share Payable	-	-	(2,680,192)	(2,680,192)
Claims Payable				
Total	(81,290,822)	(7,959,700)	(113,046,291)	(116,573,948)
Other Liabilities				
CalPERS Pension	-	-	-	-
Payroll Liabilities	(76,725)	(1,732,321)	(100,042)	526,912
GASB Assets and Liabilities	200,353	(1,200,914)	(2,184,589)	(2,003,060)
New Health Program	-	-	-	-
MCO Tax Liabilities	(59,705,914)	68,442,926	247,799,894	169,257,652
Total	(59,582,286)	65,509,691	245,515,263	167,781,504
Rounding	-	1.00	(1.00)	-
Cash Flows from Operating Activities	**(183,791,521)**	**16,564,596**	**(71,169,932)**	**(163,909,901)**
Variance	-	-	-	-

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED **January 31, 2025**

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOW STATEMENT:				
Cash Flows from Operating Activities:				
Cash Received				
Capitation Received from State of CA	$216,234,307	$704,679,714	$1,397,590,902	$1,606,698,447
Medicare Revenue	$0	$0	$0	$0
GroupCare Premium Revenue	3,160,423	12,535,732	21,950,661	21,967,579
Other Income	553,416	1,688,494	2,305,853	3,169,901
Interest Income	3,575,663	6,891,643	13,597,684	15,164,844
Less Cash Paid				
Medical Expenses	(274,177,751)	(557,431,127)	(1,203,503,333)	(1,370,693,470)
Vendor & Employee Expenses	(7,668,829)	(26,331,110)	(52,174,199)	(63,810,769)
MCO Tax Expense AB119	(125,468,750)	(125,468,750)	(250,937,500)	(376,406,433)
Net Cash Flows from Operating Activities	**(183,791,521)**	**16,564,596**	**(71,169,932)**	**(163,909,901)**
Cash Flows from Investing Activities:				
Long Term Investments	(2,639,506)	(2,662,893)	6,369,764	(13,777,557)
Restricted Assets-Treasury Account	0	0	0	0
Purchases of Property and Equipment	0	0	(264,510)	(529,610)
Net Cash Flows from Investing Activities	**(2,639,506)**	**(2,662,893)**	**6,105,254**	**(14,307,167)**
Net Change in Cash	**(186,431,027)**	**13,901,703**	**(65,064,678)**	**(178,217,068)**
Rounding	4.00	(2.00)	1.00	(1.00)
Cash @ Beginning of Period	648,555,181	448,222,457	527,188,835	640,341,227
Cash @ End of Period	**$462,124,158**	**$462,124,158**	**$462,124,158**	**$462,124,158**
Variance	$0	-	-	-
RECONCILIATION OF NET INCOME TO NET CASH FLOW FROM OPERATING ACTIVITIES:				
Net Income / (Loss)	($6,688,828)	($42,802,311)	($96,860,762)	($103,850,065)
Add Back: Depreciation	59,373	178,120	365,532	416,079
Net Change in Operating Assets & Liabilities				
Premium & Other Receivables	(37,294,985)	(2,165,768)	(112,663,351)	(115,504,465)
Prepaid Expenses	29,795	93,844	(418,818)	(456,502)
Trade Payables	976,232	3,710,719	5,938,496	4,277,496
Claims Payable, IBNP and Risk Sharing	(81,290,822)	(7,959,700)	(113,046,291)	(116,573,948)
Deferred Revenue	0	0	0	0
Other Liabilities	(59,582,286)	65,509,691	245,515,263	167,781,504
Total	(183,791,521)	16,564,595	(71,169,931)	(163,909,901)
Rounding	-	1	(1)	-
Cash Flows from Operating Activities	**($183,791,521)**	**$16,564,596**	**($71,169,932)**	**($163,909,901)**
Variance	$0	-	-	-

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE MONTH OF JANUARY 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	111,643	63,553	-	-	154,136	-	-	29,564	48,153	407,049	5,779	-	412,828
Revenue	$36,578,388	$33,994,786	$714,799	$144,999	$92,647,203	($56,873)	$233,874	$47,497,006	$41,519,261	$253,273,443	$3,158,286	$0	$256,431,729
Medical Expense	$15,811,315	$23,543,602	($8,060,521)	$3,364,941	$67,265,541	$339,757	($1,057,623)	$56,249,940	$30,009,119	$187,466,072	$3,647,999	$7,155	$191,121,226
Gross Margin	$20,767,073	$10,451,184	$8,775,320	($3,219,941)	$25,381,662	($396,631)	$1,291,497	($8,752,934)	$11,510,141	$65,807,372	($489,713)	($7,155)	$65,310,503
Administrative Expense	$414,437	$964,010	$37,793	$23,771	$2,761,199	$986	$8,159	$2,520,600	$1,559,553	$8,290,507	$204,899	$363,391	$8,858,797
MCO Tax Expense	$18,037,043	$10,267,623	$0	$0	$24,902,212	$0	$0	$4,776,360	$7,779,599	$65,762,836	$0	$0	$65,762,836
Operating Income / (Expense)	$2,315,593	($780,448)	$8,737,527	($3,243,712)	($2,281,749)	($397,616)	$1,283,338	($16,049,894)	$2,170,990	($8,245,972)	($694,612)	($370,546)	($9,311,131)
Other Income / (Expense)	$127,443	$302,628	$0	$0	$862,997	$0	$0	$798,488	$491,680	$2,583,235	$39,072	$0	$2,622,308
Net Income / (Loss)	$2,443,036	($477,821)	$8,737,527	($3,243,712)	($1,418,753)	($397,616)	$1,283,338	($15,251,406)	$2,662,670	($5,662,737)	($655,540)	($370,546)	($6,688,823)
PMPM Metrics:													
Revenue PMPM	$327.64	$534.90	$0.00	$0.00	$601.07	$0.00	$0.00	$1,606.58	$862.24	$622.22	$546.51	$0.00	$621.16
Medical Expense PMPM	$141.62	$370.46	$0.00	$0.00	$436.40	$0.00	$0.00	$1,902.65	$623.20	$460.55	$631.25	$0.00	$462.96
Gross Margin PMPM	$186.01	$164.45	$0.00	$0.00	$164.67	$0.00	$0.00	($296.07)	$239.03	$161.67	($84.74)	$0.00	$158.20
Administrative Expense PMPM	$3.71	$15.17	$0.00	$0.00	$17.91	$0.00	$0.00	$85.26	$32.39	$20.37	$35.46	$0.00	$21.46
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	$159.30
Operating Income / (Expense) PMPM	$20.74	($12.28)	$0.00	$0.00	($14.80)	$0.00	$0.00	($542.89)	$45.09	($20.26)	($120.20)	$0.00	($22.55)
Other Income / (Expense) PMPM	$1.14	$4.76	$0.00	$0.00	$5.60	$0.00	$0.00	$27.01	$10.21	$6.35	$6.76	$0.00	$6.35
Net Income / (Loss) PMPM	$21.88	($7.52)	$0.00	$0.00	($9.20)	$0.00	$0.00	($515.88)	$55.30	($13.91)	($113.43)	$0.00	($16.20)
Ratio:													
Medical Loss Ratio	85.3%	99.2%	-1127.7%	2320.7%	99.3%	-597.4%	-452.2%	131.7%	88.9%	100.0%	115.5%	0.0%	100.2%
Administrative Expense Ratio	2.2%	4.1%	5.3%	16.4%	4.1%	-1.7%	3.5%	5.9%	4.6%	4.4%	6.5%	0.0%	4.6%
Net Income Ratio	6.7%	-1.4%	1222.4%	-2237.1%	-1.5%	699.1%	548.7%	-32.1%	6.4%	-2.2%	-20.8%	0.0%	-2.6%

*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".

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE FISCAL YEAR TO DATE JANUARY 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	770,838	439,437	212,632	241,339	1,062,641	1,446	7,562	29,564	48,153	2,813,612	40,181	-	2,853,793
Revenue	$258,039,920	$239,828,771	$305,256,292	$136,082,249	$611,306,892	$15,457,851	$65,805,491	$47,497,006	$41,519,261	$1,720,793,732	$21,974,895	$0	$1,742,768,627
Medical Expense	$95,244,753	$147,706,604	$282,006,075	$94,128,230	$442,640,102	$18,304,059	$66,064,705	$56,249,940	$30,009,119	$1,232,353,586	$22,072,107	$159,765	$1,254,585,458
Gross Margin	$162,795,167	$92,122,167	$23,250,217	$41,954,019	$168,666,790	($2,846,208)	($259,214)	($8,752,934)	$11,510,141	$488,440,146	($97,212)	($159,765)	$488,183,169
Administrative Expense	$3,205,518	$7,606,246	$14,237,592	$4,943,602	$20,813,322	$1,011,363	$4,692,330	$2,520,600	$1,559,553	$60,590,125	$1,068,941	$4,854,185	$66,513,251
MCO Tax Expense	$149,777,796	$85,493,653	$42,342,501	$48,165,226	$205,524,784	$283,625	$1,520,540	$4,776,360	$7,779,599	$545,664,085	$0	$0	$545,664,085
Operating Income / (Expense)	$9,811,854	($977,731)	($33,329,876)	($11,154,809)	($57,671,316)	($4,141,197)	($6,472,084)	($16,049,894)	$2,170,990	($117,814,064)	($1,166,152)	($5,013,951)	($123,994,167)
Other Income / (Expense)	$1,013,430	$2,498,807	$4,709,375	$1,609,737	$6,853,258	$338,837	$1,557,352	$798,488	$491,680	$19,870,963	$273,139	$0	$20,144,103
Net Income / (Loss)	$10,825,283	$1,521,075	($28,620,501)	($9,545,072)	($50,818,058)	($3,802,360)	($4,914,732)	($15,251,406)	$2,662,670	($97,943,100)	($893,013)	($5,013,951)	($103,850,064)
PMPM Metrics:													
Revenue PMPM	$334.75	$545.76	$1,435.61	$563.86	$575.27	$10,690.08	$8,702.13	$1,606.58	$862.24	$611.60	$546.90	$0.00	$610.69
Medical Expense PMPM	$123.56	$336.13	$1,326.26	$390.02	$416.55	$12,658.41	$8,736.41	$1,902.65	$623.20	$438.00	$549.32	$0.00	$439.62
Gross Margin PMPM	$211.19	$209.64	$109.34	$173.84	$158.72	($1,968.33)	($34.28)	($296.07)	$239.03	$173.60	($2.42)	$0.00	$171.06
Administrative Expense PMPM	$4.16	$17.31	$66.96	$20.48	$19.59	$699.42	$620.51	$85.26	$32.39	$21.53	$26.60	$0.00	$23.31
MCO Tax Expense PMPM	$194.31	$194.55	$199.14	$199.57	$193.41	$196.14	$201.08	$161.56	$161.56	$193.94	$0.00	$0.00	$191.21
Operating Income / (Expense) PMPM	$12.73	($2.22)	($156.75)	($46.22)	($54.27)	($2,863.90)	($855.87)	($542.89)	$45.09	($41.87)	($29.02)	$0.00	($43.45)
Other Income / (Expense) PMPM	$1.31	$5.69	$22.15	$6.67	$6.45	$234.33	$205.94	$27.01	$10.21	$7.06	$6.80	$0.00	$7.06
Net Income / (Loss) PMPM	$14.04	$3.46	($134.60)	($39.55)	($47.82)	($2,629.57)	($649.92)	($515.88)	$55.30	($34.81)	($22.22)	$0.00	($36.39)
Ratio:													
Medical Loss Ratio	88.0%	95.7%	107.3%	107.1%	109.1%	120.6%	102.8%	131.7%	88.9%	104.9%	100.4%	0.0%	104.8%
Administrative Expense Ratio	3.0%	4.9%	5.4%	5.6%	5.1%	6.7%	7.3%	5.9%	4.6%	5.2%	4.9%	0.0%	5.6%
Net Income Ratio	4.2%	0.6%	-9.4%	-7.0%	-8.3%	-24.6%	-7.5%	-32.1%	6.4%	-5.7%	-4.1%	0.0%	-6.0%

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ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED January 31, 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)				
$6,114,872	$6,879,261	$764,389	11.1%	Personnel Expenses	$39,924,806	$41,285,695	$1,360,889	3.3%
$91,149	$74,974	($16,175)	(21.6%)	Benefits Administration Expense	$556,345	$529,606	($26,739)	(5.0%)
$2,209,763	$2,981,287	$771,524	25.9%	Purchased & Professional Services	$15,690,669	$17,764,316	$2,073,647	11.7%
$453,010	$603,127	$150,117	24.9%	Occupancy	$3,647,016	$3,773,297	$126,280	3.3%
$579,260	$419,871	($159,389)	(38.0%)	Printing Postage & Promotion	$2,551,011	$3,351,239	$800,228	23.9%
($721,562)	$371,952	$1,093,514	294.0%	Licenses Insurance & Fees	$2,936,772	$4,180,275	$1,243,502	29.7%
$132,306	$185,966	$53,659	28.9%	Other Administrative Expense	$1,206,631	$1,339,445	$132,814	9.9%
$2,743,926	$4,637,176	$1,893,250	40.8%	Total Other Administrative Expenses (excludes Personnel Expenses)	$26,588,445	$30,938,178	$4,349,733	14.1%
$8,858,797	$11,516,437	$2,657,639	23.1%	Total Administrative Expenses	$66,513,251	$72,223,873	$5,710,623	7.9%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED January 31, 2025

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
3,966,603	4,682,865	716,262	15.3%	Salaries & Wages	26,624,975	27,008,145	383,170	1.4%
81,574	366,834	285,260	77.8%	Paid Time Off	2,073,025	2,607,627	534,602	20.5%
1,429	4,505	3,076	68.3%	Compensated Incentives	21,285	26,804	5,519	20.6%
0	0	0	0.0%	Severence	0	400,000	400,000	100.0%
165,984	289,718	123,734	42.7%	Payroll Taxes	535,525	687,042	151,517	22.1%
72,400	25,710	(46,690)	(181.6%)	Overtime	491,849	391,249	(100,600)	(25.7%)
392,514	306,741	(85,774)	(28.0%)	CalPERS ER Match	2,246,647	2,302,173	55,525	2.4%
1,061,014	657,904	(403,110)	(61.3%)	Employee Benefits	6,844,544	5,790,883	(1,053,661)	(18.2%)
186,087	199,072	12,985	6.5%	Personal Floating Holiday	192,051	202,966	10,915	5.4%
19,976	30,500	10,524	34.5%	Language Pay	143,877	200,759	56,883	28.3%
3,150	0	(3,150)	0.0%	Med Ins Opted Out Stipend	23,850	16,010	(7,840)	(49.0%)
0	0	0	0.0%	Holiday Bonus	(400,000)	0	400,000	1,333,333,4…
86,287	0	(86,287)	0.0%	Sick Leave	574,932	270,728	(304,204)	(112.4%)
1,365	18,025	16,660	92.4%	Compensated Employee Relations	7,775	121,614	113,838	93.6%
20,280	26,000	5,720	22.0%	Work from Home Stipend	140,010	155,570	15,560	10.0%
821	5,363	4,542	84.7%	Mileage, Parking & LocalTravel	9,107	30,586	21,479	70.2%
493	20,097	19,604	97.5%	Travel & Lodging	15,984	92,613	76,629	82.7%
27,553	137,325	109,772	79.9%	Temporary Help Services	216,534	464,699	248,165	53.4%
24,068	60,965	36,897	60.5%	Staff Development/Training	86,481	325,524	239,043	73.4%
3,272	47,637	44,364	93.1%	Staff Recruitment/Advertisement	76,354	190,704	114,350	60.0%
6,114,872	**6,879,261**	**764,389**	**11.1%**	**Personnel Expense**	**39,924,806**	**41,285,695**	**1,360,889**	**3.3%**
26,913	22,018	(4,895)	(22.2%)	Pharmacy Administrative Fees	176,489	161,186	(15,302)	(9.5%)
64,236	52,956	(11,281)	(21.3%)	Telemedicine Admin. Fees	379,856	368,420	(11,437)	(3.1%)
91,149	**74,974**	**(16,175)**	**(21.6%)**	**Benefits Administration Expense**	**556,345**	**529,606**	**(26,739)**	**(5.0%)**
721,840	793,968	72,128	9.1%	Consultant Fees - Non Medical	4,326,666	4,987,425	660,759	13.2%
448,267	728,361	280,094	38.5%	Computer Support Services	3,544,933	4,042,472	497,540	12.3%
12,500	15,000	2,500	16.7%	Audit Fees	158,658	113,158	(45,500)	(40.2%)
(8,500)	8	8,508	102,018.5%	Consultant Fees - Medical	(7,505)	(15,313)	(7,808)	51.0%
277,642	205,263	(72,379)	(35.3%)	Other Purchased Services	1,724,065	1,826,980	102,914	5.6%
0	1,688	1,688	100.0%	Maint.&Repair-Office Equipment	0	5,064	5,064	100.0%
87,836	70,067	(17,769)	(25.4%)	Legal Fees	690,178	541,486	(148,693)	(27.5%)
0	0	0	0.0%	Member Health Education	320	320	0	0.0%
21,734	26,000	4,266	16.4%	Translation Services	177,180	165,064	(12,117)	(7.3%)
92,100	157,650	65,550	41.6%	Medical Refund Recovery Fees	1,796,289	1,627,621	(168,668)	(10.4%)
512,047	880,117	368,070	41.8%	Software - IT Licenses & Subsc	2,764,845	3,636,466	871,621	24.0%
220	47,364	47,144	99.5%	Hardware (Non-Capital)	197,554	492,261	294,707	59.9%
44,078	55,800	11,722	21.0%	Provider Credentialing	317,486	341,313	23,827	7.0%
2,209,763	**2,981,287**	**771,524**	**25.9%**	**Purchased & Professional Services**	**15,690,669**	**17,764,316**	**2,073,647**	**11.7%**
59,373	91,579	32,206	35.2%	Depreciation	416,079	512,695	96,617	18.8%
62,638	76,371	13,733	18.0%	Lease Building	511,463	478,514	(32,949)	(6.9%)
8,092	10,570	2,478	23.4%	Lease Rented Office Equipment	35,379	49,675	14,296	28.8%
2,959	52,523	49,564	94.4%	Utilities	87,703	154,807	67,104	43.3%
88,609	91,065	2,456	2.7%	Telephone	609,013	620,860	11,846	1.9%
25,837	31,884	6,047	19.0%	Building Maintenance	220,136	285,558	65,422	22.9%
205,502	249,136	43,633	17.5%	GASB96 SBITA Amort. Expense	1,767,243	1,671,187	(96,055)	(5.7%)
453,010	**603,127**	**150,117**	**24.9%**	**Occupancy**	**3,647,016**	**3,773,297**	**126,280**	**3.3%**

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED January 31, 2025

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
132,805	109,578	(23,227)	(21.2%)	Postage	376,824	625,330	248,506	39.7%
2,899	5,300	2,402	45.3%	Design & Layout	40,113	42,080	1,968	4.7%
97,389	50,090	(47,299)	(94.4%)	Printing Services	532,540	770,870	238,330	30.9%
18,388	19,410	1,022	5.3%	Mailing Services	67,270	67,613	343	0.5%
5,561	12,641	7,081	56.0%	Courier/Delivery Service	37,295	60,834	23,539	38.7%
560	2,034	1,474	72.5%	Pre-Printed Materials & Public	589	2,583	1,994	77.2%
2,049	0	(2,049)	0.0%	Promotional Products	45,167	43,118	(2,049)	(4.8%)
0	150	150	100.0%	Promotional Services	0	750	750	100.0%
319,609	220,667	(98,942)	(44.8%)	Community Relations	1,451,213	1,738,061	286,848	16.5%
579,260	**419,871**	**(159,389)**	**(38.0%)**	**Printing Postage & Promotion**	**2,551,011**	**3,351,239**	**800,228**	**23.9%**
0	0	0	0.0%	Regulatory Penalties	295,000	335,000	40,000	11.9%
11,727	31,600	19,873	62.9%	Bank Fees	247,093	227,781	(19,312)	(8.5%)
0	0	0	0.0%	Insurance Premium	976,728	982,916	6,188	0.6%
(744,856)	274,138	1,018,994	371.7%	License,Permits, & Fee - NonIT	948,356	2,076,644	1,128,289	54.3%
11,567	66,214	54,647	82.5%	Subscriptions and Dues - NonIT	469,596	557,934	88,337	15.8%
(721,562)	**371,952**	**1,093,514**	**294.0%**	**License Insurance & Fees**	**2,936,772**	**4,180,275**	**1,243,502**	**29.7%**
3,568	17,208	13,640	79.3%	Office and Other Supplies	52,021	76,408	24,387	31.9%
0	2,000	2,000	100.0%	Furniture & Equipment	0	6,000	6,000	100.0%
31,964	29,942	(2,022)	(6.8%)	Ergonomic Supplies	200,845	214,290	13,445	6.3%
561	16,816	16,255	96.7%	Meals and Entertainment	77,314	114,540	37,225	32.5%
(1,841)	0	1,841	0.0%	Miscellaneous	3,459	5,300	1,841	34.7%
0	0	0	0.0%	Member Incentive	0	9,700	9,700	100.0%
98,053	120,000	21,947	18.3%	Provider Interest (All Depts)	872,992	913,208	40,216	4.4%
132,306	**185,966**	**53,659**	**28.9%**	**Other Administrative Expense**	**1,206,631**	**1,339,445**	**132,814**	**9.9%**
2,743,926	**4,637,176**	**1,893,250**	**40.8%**	**Total Other Administrative ExpenseS (excludes Personnel Expenses)**	**26,588,445**	**30,938,178**	**4,349,733**	**14.1%**
8,858,797	**11,516,437**	**2,657,639**	**23.1%**	**TOTAL ADMINISTRATIVE EXPENSES**	**66,513,251**	**72,223,873**	**5,710,623**	**7.9%**

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	$ -	$ -	**$ -**	$ 150,000	$ 150,000
	Exagrid Immutable Storage	IT-FY25-07	$ -	$ -	**$ -**	$ 500,000	$ 500,000
	Network Cabling	IT-FY25-09	$ -	$ -	**$ -**	$ 40,000	$ 40,000
Hardware Subtotal			**$ 529,610**	**$ -**	**$ 529,610**	**$ 1,948,100**	**$ 1,418,490**
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			**$ 529,610**	**$ -**	**$ 529,610**	**$ 1,978,100**	**$ 1,448,490**

6. Reconciliation to Balance Sheet:

Fixed Assets @ Cost - 1/31/25	**$ 38,640,099**
Fixed Assets @ Cost - 6/30/24	**$ 38,110,489**
Fixed Assets Acquired YTD	**$ 529,610**

ALAMEDA ALLIANCE FOR HEALTH

TANGIBLE NET EQUITY (TNE) AND LIQUID TNE ANALYSIS

FOR THE MONTH AND FISCAL YTD ENDED JANUARY 31, 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
Current Month Net Income / (Loss)	$ (60,614,034)	$ (6,989,301)	$ (18,354,880)	$ (8,719,238)	$ (26,984,341)	$ (27,470,264)	$ (8,643,229)	$ (6,688,826)
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)
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
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**
Increase/(Decrease) in Actual TNE	$ (60,614,034)	$ (6,989,301)	$ (18,354,880)	$ (8,719,238)	$ (26,984,341)	$ (27,470,264)	$ (8,643,229)	$ (6,688,826)
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**
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
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
Actual TNE as a Multiple of Required	**4.03**	**3.61**	**3.22**	**3.15**	**2.52**	**2.12**	**2.04**	**1.86**
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
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)
Net Lease Assets	(501,485)	(319,957)	(496,877)	(1,004,186)	(1,303,630)	(1,065,182)	(2,704,898)	(2,504,545)
CD Pledged to DMHC	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)
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**
Liquid TNE as Multiple of Required	**3.93**	**3.52**	**3.12**	**3.05**	**2.42**	**2.03**	**1.93**	**1.76**

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						770,838
Adult	62,708	62,641	62,550	62,578	62,502	62,905	63,553						439,437
SPD (retired Dec-24)*	35,018	35,177	35,319	35,388	35,603	36,127	0						212,632
Duals (retired Dec-24)*	39,892	40,024	40,124	40,144	40,357	40,798	0						241,339
ACA OE	149,801	150,482	151,005	151,098	151,559	154,560	154,136						1,062,641
LTC (retired Dec-24)*	222	226	240	249	255	254	0						1,446
LTC Duals (retired Dec-24)*	1,241	1,247	1,254	1,265	1,269	1,286	0						7,562
SPD with LTC (new Jan-25)	0	0	0	0	0	0	29,564						29,564
Duals with LTC (new Jan-25)	0	0	0	0	0	0	48,153						48,153
Medi-Cal Program	398,833	399,581	400,223	400,384	401,106	406,436	407,049						2,813,612
Group Care Program	5,675	5,686	5,710	5,769	5,772	5,790	5,779						40,181
Total	**404,508**	**405,267**	**405,933**	**406,153**	**406,878**	**412,226**	**412,828**						**2,853,793**

*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						1,519
Adult	(38)	(67)	(91)	28	(76)	403	648						807
SPD (retired Dec-24)	98	159	142	69	215	524	(36,127)						(34,920)
Duals (retired Dec-24)	144	132	100	20	213	441	(40,798)						(39,748)
ACA OE	477	681	523	93	461	3,001	(424)						4,812
LTC (retired Dec-24)	0	4	14	9	6	(1)	(254)						(222)
LTC Duals (retired Dec-24)	(7)	6	7	11	4	17	(1,286)						(1,248)
SPD with LTC (new Jan-25)	0	0	0	0	0	0	29,564						29,564
Duals with LTC (new Jan-25)	0	0	0	0	0	0	48,153						48,153
Medi-Cal Program	501	748	642	161	722	5,330	613						8,717
Group Care Program	17	11	24	59	3	18	(11)						121
Total	**518**	**759**	**666**	**220**	**725**	**5,348**	**602**						**8,838**

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%
Adult % of Medi-Cal	15.7%	15.7%	15.6%	15.6%	15.6%	15.5%	15.6%						15.6%
SPD % of Medi-Cal	8.8%	8.8%	8.8%	8.8%	8.9%	8.9%	0.0%						7.6%
Duals % of Medi-Cal	10.0%	10.0%	10.0%	10.0%	10.1%	10.0%	0.0%						8.6%
ACA OE % of Medi-Cal	37.6%	37.7%	37.7%	37.7%	37.8%	38.0%	37.9%						37.8%
LTC % of Medi-Cal	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.0%						0.1%
LTC Duals % of Medi-Cal	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.0%						0.3%
SPD with LTC % of Medi-Cal	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.3%						1.1%
Duals with LTC % of Medi-Cal	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	11.8%						1.7%
Medi-Cal Program % of Total	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%
Total	**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						637,147
Alameda Health System	91,091	91,170	91,024	90,756	90,451	90,222	91,158						635,872
Directly-Contracted Subtotal	179,071	179,688	180,658	180,480	181,106	186,469	185,547						1,273,019
Delegated:													
CFMG	44,087	43,956	43,837	43,910	44,029	44,099	44,982						308,900
CHCN	181,350	181,623	181,438	181,763	181,743	181,658	182,299						1,271,874
Delegated Subtotal	225,437	225,579	225,275	225,673	225,772	225,757	227,281						1,580,774
Total	**404,508**	**405,267**	**405,933**	**406,153**	**406,878**	**412,226**	**412,828**						**2,853,793**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	167	617	970	(178)	626	5,363	(922)						6,643
Delegated:													
CFMG	96	(131)	(119)	73	119	70	883						991
CHCN	255	273	(185)	325	(20)	(85)	641						1,204
Delegated Subtotal	351	142	(304)	398	99	(15)	1,524						2,195
Total	**518**	**759**	**666**	**220**	**725**	**5,348**	**602**						**8,838**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	44.3%	44.3%	44.5%	44.4%	44.5%	45.2%	44.9%						44.6%
Delegated:													
CFMG	10.9%	10.8%	10.8%	10.8%	10.8%	10.7%	10.9%						10.8%
CHCN	44.8%	44.8%	44.7%	44.8%	44.7%	44.1%	44.2%						44.6%
Delegated Subtotal	55.7%	55.7%	55.5%	55.6%	55.5%	54.8%	55.1%						55.4%
Total	**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						1,954
Adult	0	0	0	0	(139)	201	786						848
SPD (retired Dec-24)	0	0	0	0	180	669	0						849
Duals (retired Dec-24)	0	0	0	0	213	654	0						867
ACA OE	0	0	0	0	310	3,160	2,585						6,055
LTC (retired Dec-24)	0	0	0	0	4	0	0						4
LTC Duals (retired Dec-24)	0	0	0	0	3	19	0						22
SPD with LTC (new Jan-25)	0	0	0	0	0	0	(5,186)						(5,186)
Duals with LTC (new Jan-25)	0	0	0	0	0	0	5,741						5,741
Medi-Cal Program	0	0	0	0	360	5,327	5,467						5,687
Group Care Program	0	0	0	0	3	21	10						24
Total	**0**	**0**	**0**	**0**	**363**	**5,348**	**5,477**						**11,188**
Current Direct/Delegate Enrollment Variance - Favorable/(Unfavorable)													
Directly-Contracted													
Directly Contracted (DCP)	0	0	0	0	869	6,398	4,145						11,412
Alameda Health System	0	0	0	0	(392)	(708)	207						(893)
Directly-Contracted Subtotal	0	0	0	0	477	5,690	4,352						10,519
Delegated:													
CFMG	0	0	0	0	76	103	947						1,126
CHCN	0	0	0	0	(190)	(445)	178						(457)
Delegated Subtotal	0	0	0	0	(114)	(342)	1,125						669
Total	**0**	**0**	**0**	**0**	**363**	**5,348**	**5,477**						**11,188**

ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED JANUARY 31, 2025

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				CAPITATED MEDICAL EXPENSES				
$5,653,512	$1,749,194	($3,904,318)	(223.2%)	PCP Capitation	$29,589,897	$19,853,396	($9,736,500)	(49.0%)
6,095,425	6,649,214	553,789	8.3%	PCP Capitation FQHC	43,001,612	44,333,107	1,331,495	3.0%
501,350	456,542	(44,809)	(9.8%)	Specialty Capitation	2,776,183	2,857,646	81,464	2.9%
5,328,260	6,057,731	729,471	12.0%	Specialty Capitation FQHC	37,755,434	39,582,999	1,827,565	4.6%
756,182	714,035	(42,147)	(5.9%)	Laboratory Capitation	5,275,754	5,137,718	(138,036)	(2.7%)
236,367	340,667	104,299	30.6%	Vision Capitation	2,277,774	2,377,767	99,993	4.2%
114,031	132,825	18,794	14.1%	CFMG Capitation	776,001	831,528	55,527	6.7%
378,161	294,606	(83,554)	(28.4%)	ANC IPA Admin Capitation FQHC	1,976,855	1,939,568	(37,287)	(1.9%)
0	0	0	0.0%	Kaiser Capitation	(8,639,178)	(8,639,177)	1	0.0%
(65,356)	0	65,356	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%)
1,025,761	880,806	(144,955)	(16.5%)	DME Capitation	7,129,200	6,703,736	(425,464)	(6.3%)
20,023,693	**17,275,620**	**(2,748,073)**	**(15.9%)**	**7. TOTAL CAPITATED EXPENSES**	**121,891,446**	**115,006,241**	**(6,885,205)**	**(6.0%)**
				FEE FOR SERVICE MEDICAL EXPENSES				
2,859,883	0	(2,859,883)	0.0%	IBNR Inpatient Services	23,425,583	(3,303,163)	(26,728,746)	809.2%
85,796	0	(85,796)	0.0%	IBNR Settlement (IP)	702,768	(99,094)	(801,862)	809.2%
228,791	0	(228,791)	0.0%	IBNR Claims Fluctuation (IP)	1,874,045	(264,254)	(2,138,299)	809.2%
47,185,799	53,243,836	6,058,037	11.4%	Inpatient Hospitalization FFS	329,532,199	357,636,016	28,103,817	7.9%
3,362,856	0	(3,362,856)	0.0%	IP OB - Mom & NB	21,595,063	12,540,164	(9,054,899)	(72.2%)
2,085,416	0	(2,085,416)	0.0%	IP Behavioral Health	4,735,790	1,070,307	(3,665,483)	(342.5%)
1,269,457	0	(1,269,457)	0.0%	Inpatient Facility Rehab FFS	9,402,128	5,770,736	(3,631,392)	(62.9%)
57,077,998	**53,243,836**	**(3,834,161)**	**(7.2%)**	**8. Inpatient Hospital Expense**	**391,267,576**	**373,350,712**	**(17,916,864)**	**(4.8%)**
663,441	0	(663,441)	0.0%	IBNR PCP	1,159,392	(293,439)	(1,452,831)	495.1%
19,903	0	(19,903)	0.0%	IBNR Settlement (PCP)	34,784	(8,801)	(43,585)	495.2%
53,074	0	(53,074)	0.0%	IBNR Claims Fluctuation (PCP)	161,015	44,791	(116,224)	(259.5%)
4,418,447	2,985,760	(1,432,687)	(48.0%)	PCP FFS	27,392,855	23,812,631	(3,580,224)	(15.0%)
377,748	870,902	493,153	56.6%	PCP FQHC FFS	2,701,051	4,128,237	1,427,187	34.6%
7,000	0	(7,000)	0.0%	Physician Extended Hrs. Incent	19,000	12,000	(7,000)	(58.3%)
(1)	964,742	964,743	100.0%	Prop 56 Physician Pmt	(3,467,143)	(1,862,501)	1,604,642	(86.2%)
16,548	0	(16,548)	0.0%	Prop 56 Hyde	164,781	64,923	(99,858)	(153.8%)
78,021	0	(78,021)	0.0%	Prop 56 Trauma Screening	328,961	110,133	(218,828)	(198.7%)
93,268	0	(93,268)	0.0%	Prop 56 Developmentl Screening	340,739	96,040	(244,699)	(254.8%)
672,980	0	(672,980)	0.0%	Prop 56 Family Planning	1,251,728	(767,666)	(2,019,395)	263.1%
0	0	0	0.0%	Prop 56 VBP	(2,406,095)	(2,718,741)	(312,647)	11.5%
6,400,430	**4,821,404**	**(1,579,025)**	**(32.8%)**	**9. Primary Care Physician Expense**	**27,681,068**	**22,617,607**	**(5,063,461)**	**(22.4%)**
1,099,286	0	(1,099,286)	0.0%	IBNR Specialist	2,901,803	(747,176)	(3,648,979)	488.4%
32,979	0	(32,979)	0.0%	IBNR Settlement (SCP)	87,057	(22,414)	(109,471)	488.4%
87,943	0	(87,943)	0.0%	IBNR Claims Fluctuation (SCP)	232,143	(59,775)	(291,918)	488.4%
416,547	0	(416,547)	0.0%	Psychiatrist FFS	2,752,361	1,559,071	(1,193,290)	(76.5%)
3,084,068	8,383,895	5,299,827	63.2%	Specialty Care FFS	24,662,497	39,676,549	15,014,052	37.8%
244,485	0	(244,485)	0.0%	Specialty Anesthesiology	1,773,582	1,061,004	(712,578)	(67.2%)
1,599,803	0	(1,599,803)	0.0%	Specialty Imaging FFS	11,396,475	6,843,037	(4,553,438)	(66.5%)
37,475	0	(37,475)	0.0%	Obstetrics FFS	275,694	181,208	(94,486)	(52.1%)
430,746	0	(430,746)	0.0%	Specialty IP Surgery FFS	2,793,806	1,679,499	(1,114,307)	(66.3%)
962,421	0	(962,421)	0.0%	Specialty OP Surgery FFS	7,063,586	4,353,452	(2,710,134)	(62.3%)
598,983	0	(598,983)	0.0%	Speciality IP Physician	4,343,855	2,543,833	(1,800,022)	(70.8%)
113,577	129,981	16,404	12.6%	Specialist FQHC FFS	882,926	913,098	30,173	3.3%
8,708,313	**8,513,876**	**(194,437)**	**(2.3%)**	**10. Specialty Care Physician Expense**	**59,165,784**	**57,981,387**	**(1,184,398)**	**(2.0%)**
1,115,085	0	(1,115,085)	0.0%	IBNR Ancillary (ANC)	4,961,102	904,191	(4,056,911)	(448.7%)

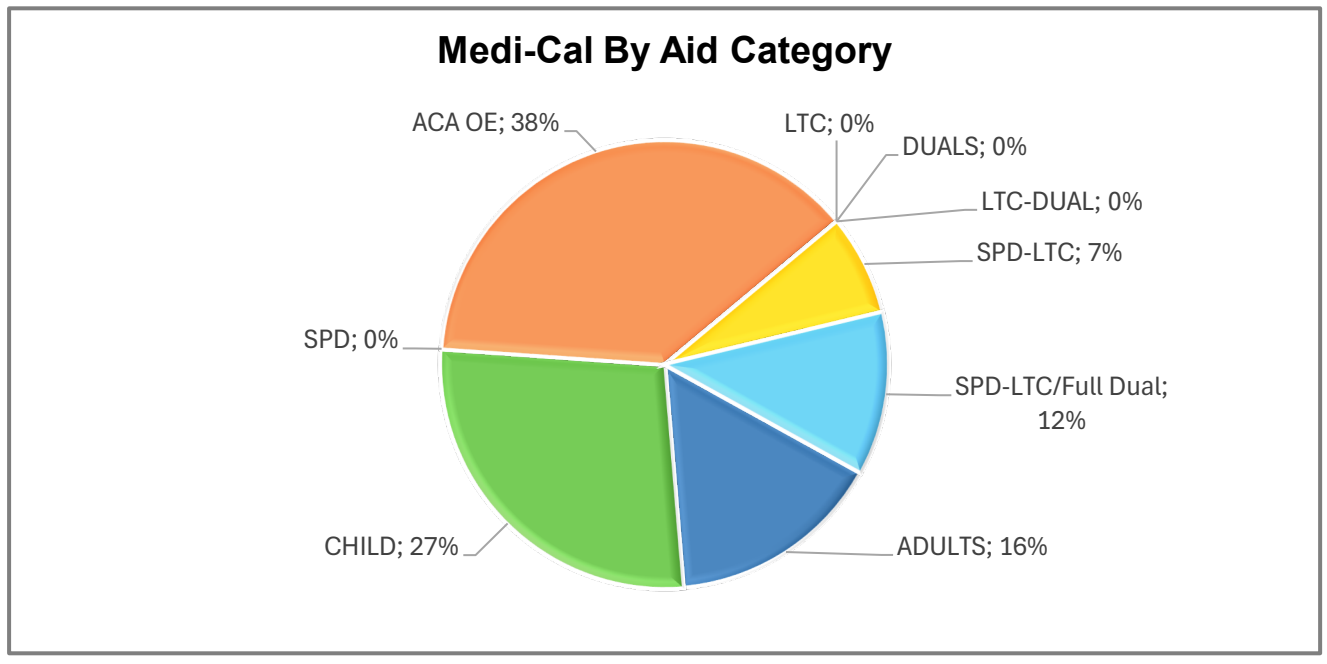
ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED JANUARY 31, 2025

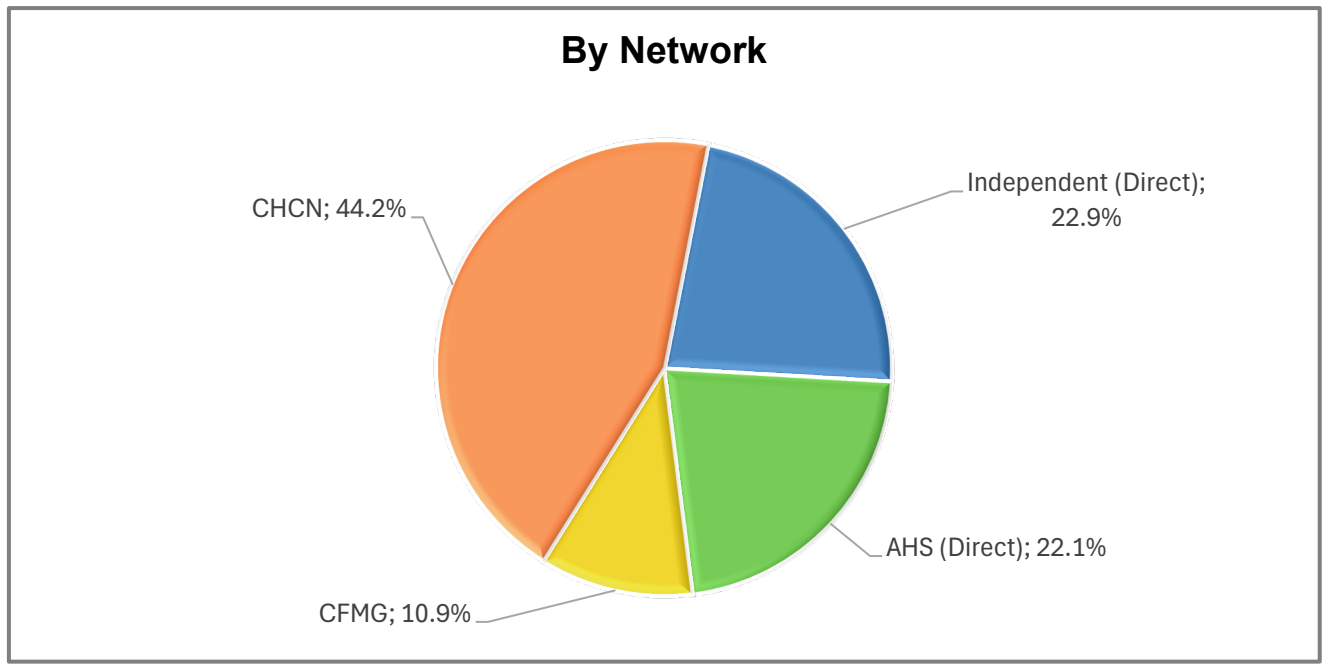
CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
33,454	0	(33,454)	0.0%	IBNR Settlement (ANC)	235,897	114,188	(121,709)	(106.6%)
89,207	0	(89,207)	0.0%	IBNR Claims Fluctuation (ANC)	560,798	236,248	(324,550)	(137.4%)
(342,703)	0	342,703	0.0%	IBNR Transportation FFS	305,253	207,856	(97,397)	(46.9%)
2,076,494	0	(2,076,494)	0.0%	Behavioral Health Therapy FFS	14,876,961	8,190,565	(6,686,396)	(81.6%)
1,987,845	0	(1,987,845)	0.0%	Psychologist & Other MH Prof	12,717,637	7,234,250	(5,483,387)	(75.8%)
511,733	0	(511,733)	0.0%	Other Medical Professional	3,194,486	1,865,835	(1,328,650)	(71.2%)
226,859	0	(226,859)	0.0%	Hearing Devices	1,057,136	674,558	(382,578)	(56.7%)
28,167	0	(28,167)	0.0%	ANC Imaging	292,832	228,147	(64,685)	(28.4%)
54,949	0	(54,949)	0.0%	Vision FFS	510,206	280,298	(229,908)	(82.0%)
20	0	(20)	0.0%	Family Planning	46	10	(36)	(364.6%)
593,575	0	(593,575)	0.0%	Laboratory FFS	8,745,010	6,593,456	(2,151,555)	(32.6%)
147,977	0	(147,977)	0.0%	ANC Therapist	1,055,905	644,262	(411,643)	(63.9%)
1,788,476	0	(1,788,476)	0.0%	Transp/Ambulance FFS	10,248,244	5,962,027	(4,286,218)	(71.9%)
2,429,959	0	(2,429,959)	0.0%	Non-ER Transportation FFS	15,931,949	8,526,483	(7,405,466)	(86.9%)
3,008,996	0	(3,008,996)	0.0%	Hospice FFS	16,628,640	9,250,960	(7,377,680)	(79.8%)
1,893,297	0	(1,893,297)	0.0%	Home Health Services	12,333,550	7,088,754	(5,244,797)	(74.0%)
0	14,827,938	14,827,938	100.0%	Other Medical FFS	128	42,663,346	42,663,218	100.0%
30,682	0	(30,682)	0.0%	Medical Refunds through HMS	589,182	290,192	(298,990)	(103.0%)
10,037	0	(10,037)	0.0%	Medical Refunds	10,037	0	(10,037)	0.0%
29,393	0	(29,393)	0.0%	DME & Medical Supplies FFS	278,781	187,833	(90,948)	(48.4%)
2,641,311	2,365,034	(276,277)	(11.7%)	ECM Base/Outreach FFS ANC	(2,830,380)	(2,763,920)	66,460	(2.4%)
126,723	100,741	(25,983)	(25.8%)	CS Housing Deposits FFS ANC	786,500	782,720	(3,780)	(0.5%)
844,036	812,026	(32,011)	(3.9%)	CS Housing Tenancy FFS ANC	5,035,044	5,578,746	543,702	9.7%
470,390	452,741	(17,650)	(3.9%)	CS Housing Navi Servic FFS ANC	3,089,834	3,232,186	142,352	4.4%
779,829	719,798	(60,031)	(8.3%)	CS Medical Respite FFS ANC	4,468,046	4,634,363	166,317	3.6%
246,184	167,527	(78,657)	(47.0%)	CS Med. Tailored Meals FFS ANC	1,466,044	1,367,730	(98,314)	(7.2%)
17,408	25,617	8,209	32.0%	CS Asthma Remediation FFS ANC	62,793	93,647	30,854	32.9%
0	10,330	10,330	100.0%	MOT Wrap Around (Non Med MOT)	0	30,260	30,260	100.0%
0	10,067	10,067	100.0%	CS Home Modifications FFS ANC	24,053	54,108	30,055	55.5%
219,157	540,980	321,823	59.5%	CS P.Care & Hmker Svcs FFS ANC	2,094,272	3,102,590	1,008,318	32.5%
3,810	20,103	16,293	81.0%	CS Cgiver Respite Svcs FFS ANC	46,156	102,437	56,281	54.9%
425,799	0	(425,799)	0.0%	CommunityBased Adult Svc(CBAS)	3,478,149	2,203,374	(1,274,776)	(57.9%)
18,158	25,000	6,842	27.4%	CS LTC Diversion FFS ANC	125,311	142,778	17,467	12.2%
5,003	7,579	2,576	34.0%	CS LTC Transition FFS ANC	5,003	22,565	17,562	77.8%
21,511,309	**20,085,479**	**(1,425,830)**	**(7.1%)**	**11. Ancillary Medical Expense**	**122,384,607**	**119,727,045**	**(2,657,562)**	**(2.2%)**
4,144,539	0	(4,144,539)	0.0%	IBNR Outpatient	6,006,912	231,629	(5,775,283)	(2,493.3%)
124,335	0	(124,335)	0.0%	IBNR Settlement (OP)	180,209	6,949	(173,260)	(2,493.3%)
331,563	0	(331,563)	0.0%	IBNR Claims Fluctuation (OP)	480,548	18,527	(462,021)	(2,493.7%)
2,589,748	11,921,104	9,331,356	78.3%	Outpatient FFS	17,525,076	45,535,841	28,010,766	61.5%
2,764,511	0	(2,764,511)	0.0%	OP Ambul Surgery FFS	19,489,530	11,593,959	(7,895,571)	(68.1%)
2,553,657	0	(2,553,657)	0.0%	Imaging Services FFS	17,632,055	10,130,403	(7,501,653)	(74.1%)
(1,977,946)	0	1,977,946	0.0%	Behavioral Health FFS	165,794	97,460	(68,334)	(70.1%)
835,481	0	(835,481)	0.0%	Outpatient Facility Lab FFS	5,077,521	2,863,424	(2,214,097)	(77.3%)
187,100	0	(187,100)	0.0%	Outpatient Facility Cardio FFS	1,441,042	844,453	(596,589)	(70.6%)
96,875	0	(96,875)	0.0%	OP Facility PT/OT/ST FFS	701,265	400,408	(300,857)	(75.1%)
3,562,559	0	(3,562,559)	0.0%	OP Facility Dialysis Ctr FFS	22,114,176	12,647,437	(9,466,739)	(74.9%)
15,212,420	**11,921,104**	**(3,291,316)**	**(27.6%)**	**12. Outpatient Medical Expense**	**90,814,129**	**84,370,490**	**(6,443,638)**	**(7.6%)**
(734,327)	0	734,327	0.0%	IBNR Emergency	1,965,044	(165,803)	(2,130,847)	1,285.2%
(22,029)	0	22,029	0.0%	IBNR Settlement (ER)	58,950	(4,974)	(63,924)	1,285.1%
(58,748)	0	58,748	0.0%	IBNR Claims Fluctuation (ER)	157,201	(13,266)	(170,467)	1,285.0%
10,148,402	10,678,865	530,462	5.0%	ER Facility	62,757,496	68,519,344	5,761,849	8.4%
1,374,931	0	(1,374,931)	0.0%	Specialty ER Physician FFS	8,485,635	4,880,392	(3,605,243)	(73.9%)
10,708,229	**10,678,865**	**(29,364)**	**(0.3%)**	**13. Emergency Expense**	**73,424,325**	**73,215,693**	**(208,632)**	**(0.3%)**
(1,729,159)	0	1,729,159	0.0%	IBNR Pharmacy (OP)	2,962,423	1,991,773	(970,650)	(48.7%)

ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED JANUARY 31, 2025

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
(51,875)	0	51,875	0.0%	IBNR Settlement Rx (OP)	88,874	59,755	(29,119)	(48.7%)
(138,332)	0	138,332	0.0%	IBNR Claims Fluctuation Rx(OP)	236,996	159,342	(77,654)	(48.7%)
650,035	472,997	(177,038)	(37.4%)	Pharmacy FFS (OP)	5,078,271	4,429,723	(648,548)	(14.6%)
101,676	11,957,247	11,855,571	99.1%	Pharmacy Non PBM FFS Other-ANC	848,193	35,814,497	34,966,305	97.6%
12,268,247	0	(12,268,247)	0.0%	Pharmacy Non PBM FFS OP-FAC	66,630,866	39,326,556	(27,304,310)	(69.4%)
159,499	0	(159,499)	0.0%	Pharmacy Non PBM FFS PCP	1,539,599	985,563	(554,037)	(56.2%)
2,418,403	0	(2,418,403)	0.0%	Pharmacy Non PBM FFS SCP	16,861,328	10,617,727	(6,243,601)	(58.8%)
29,333	0	(29,333)	0.0%	Pharmacy Non PBM FFS FQHC	155,063	82,575	(72,488)	(87.8%)
19,549	0	(19,549)	0.0%	Pharmacy Non PBM FFS HH	139,447	91,629	(47,818)	(52.2%)
0	0	0	0.0%	RX Refunds HMS	(306)	(306)	0	0.0%
(50,000)	53,038	103,038	194.3%	Medical Expenses Pharm Rebate	(68,557)	(60,135)	8,422	(14.0%)
13,677,376	**12,483,282**	**(1,194,093)**	**(9.6%)**	**14. Pharmacy Expense**	**94,472,196**	**93,498,698**	**(973,498)**	**(1.0%)**
(13,361,845)	0	13,361,845	0.0%	IBNR LTC	2,219,948	(3,756,936)	(5,976,884)	159.1%
(400,855)	0	400,855	0.0%	IBNR Settlement (LTC)	66,598	(112,709)	(179,307)	159.1%
(1,068,949)	0	1,068,949	0.0%	IBNR Claims Fluctuation (LTC)	177,594	(300,555)	(478,149)	159.1%
2,465,846	0	(2,465,846)	0.0%	LTC - ICF/DD	11,677,003	6,755,726	(4,921,277)	(72.8%)
38,732,689	0	(38,732,689)	0.0%	LTC Custodial Care	173,671,261	99,683,289	(73,987,972)	(74.2%)
8,150,514	33,980,019	25,829,505	76.0%	LTC SNF	52,968,541	131,574,275	78,605,734	59.7%
34,517,400	**33,980,019**	**(537,381)**	**(1.6%)**	**15. Long Term Care Expense**	**240,780,944**	**233,843,089**	**(6,937,855)**	**(3.0%)**
167,813,473	**155,727,865**	**(12,085,608)**	**(7.8%)**	**16. TOTAL FFS MEDICAL EXPENSES**	**1,099,990,628**	**1,058,604,720**	**(41,385,908)**	**(3.9%)**
0	407,740	407,740	100.0%	Clinical Vacancy #102	0	(778,371)	(778,371)	100.0%
724,910	235,927	(488,983)	(207.3%)	Quality Analytics #123	1,575,478	1,601,001	25,522	1.6%
328,063	326,614	(1,449)	(0.4%)	LongTerm Services and Support #139	1,785,849	1,879,680	93,831	5.0%
1,030,386	904,661	(125,725)	(13.9%)	Utilization Management #140	6,880,506	6,938,754	58,248	0.8%
789,014	694,158	(94,856)	(13.7%)	Case & Disease Management #185	4,926,606	4,984,827	58,222	1.2%
987,902	822,126	(165,776)	(20.2%)	Medical Management #230	8,095,587	8,712,812	617,225	7.1%
1,324,753	1,183,735	(141,018)	(11.9%)	Quality Improvement #235	7,319,795	9,327,740	2,007,945	21.5%
369,247	390,932	21,686	5.5%	HCS Behavioral Health #238	2,276,413	2,464,883	188,470	7.6%
144,338	337,873	193,536	57.3%	Pharmacy Services #245	874,899	1,535,256	660,358	43.0%
65,192	65,082	(110)	(0.2%)	Regulatory Readiness #268	450,363	499,611	49,247	9.9%
5,763,805	**5,368,849**	**(394,956)**	**(7.4%)**	**17. Other Benefits & Services**	**34,185,496**	**37,166,193**	**2,980,697**	**8.0%**
(4,166,567)	(1,309,337)	2,857,230	(218.2%)	Reinsurance Recoveries	(13,718,553)	(10,658,405)	3,060,149	(28.7%)
1,686,822	1,745,783	58,960	3.4%	Reinsurance Premium	12,236,442	12,259,516	23,074	0.2%
(2,479,745)	**436,446**	**2,916,191**	**668.2%**	**18. Reinsurance Expense**	**(1,482,112)**	**1,601,111**	**3,083,223**	**192.6%**
191,121,226	**178,808,780**	**(12,312,447)**	**(6.9%)**	**20. TOTAL MEDICAL EXPENSES**	**1,254,585,458**	**1,212,378,266**	**(42,207,193)**	**(3.5%)**

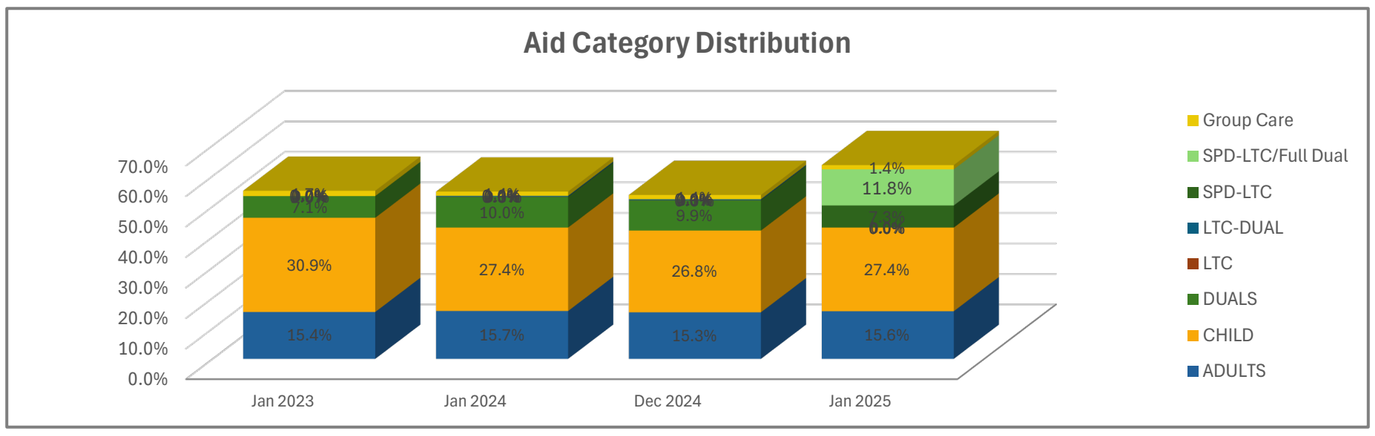
Category of Aid Trend						
Category of Aid	**Jan 2025**	**% of Medi-Cal**	**Independent (Direct)**	**AHS (Direct)**	**CFMG**	**CHCN**
ADULTS	63593	16%	14046	14198	10	35339
CHILD	111656	27%	10727	13453	41897	45579
SPD	0	0%	0	0	0	0
ACA OE	154136	38%	27642	54003	1621	70870
DUALS	1	0%	1	0	0	0
LTC	0	0%	0	0	0	0
LTC-DUAL	0	0%	0	0	0	0
SPD-LTC	29566	7%	8812	5061	1454	14239
SPD-LTC/Full Dual	48153	12%	31033	3515	6	13599
Medi-Cal	407105		92261	90230	44988	179626
Group Care	5779		2153	940	0	2686
Total	**412884**	**100%**	**94414**	**91170**	**44988**	**182312**
Medi-Cal %	98.6%		97.7%	99.0%	100.0%	98.5%
Group Care %	1.4%		2.3%	1.0%	0.0%	1.5%
	Network Distribution		**22.9%**	**22.1%**	**10.9%**	**44.2%**
			% Direct:	**45%**	**% Delegated:**	**55%**





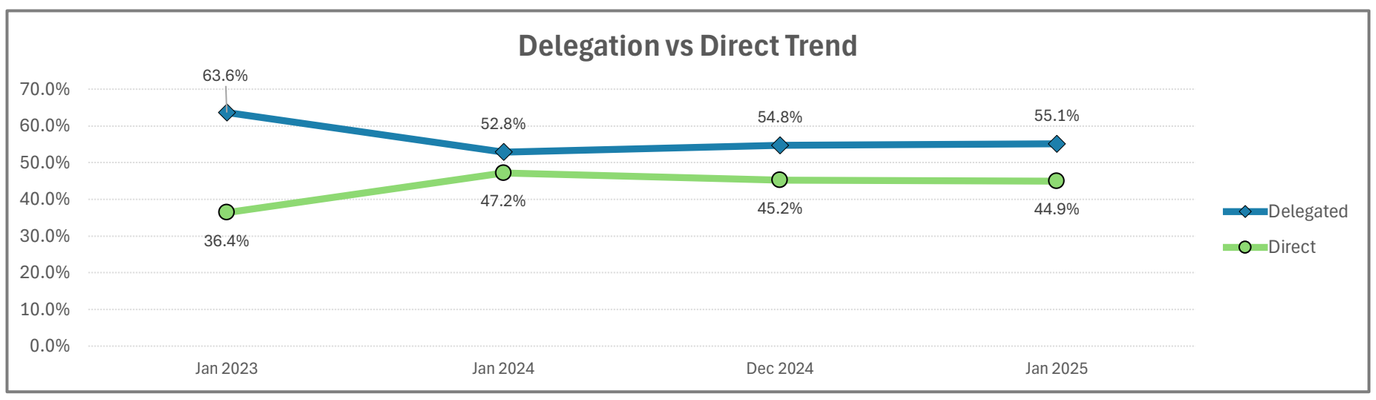
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Jan 2023	Jan 2024	Dec 2024	Jan 2025	Jan 2023	Jan 2024	Dec 2024	Jan 2025	Jan 2023 to Jan 2024	Jan 2024 to Jan 2025	Dec 2024 to Jan 2025
ADULTS	50687	62870	62957	**63593**	15.4%	15.7%	15.3%	15.6%	19.4%	1.1%	1.0%
CHILD	101914	109562	110547	**111656**	30.9%	27.4%	26.8%	27.4%	7.0%	1.9%	1.0%
SPD	28685	35013	36127	**0**	8.7%	8.7%	8.8%	0.0%	18.1%	-100.0%	-100.0%
ACA OE	119302	145842	154565	**154136**	36.2%	36.4%	37.5%	37.9%	18.2%	5.4%	-0.3%
DUALS	23444	40118	40812	**1**	7.1%	10.0%	9.9%	0.0%	41.6%	-100.0%	-100.0%
LTC	6	219	255	**0**	0.0%	0.1%	0.1%	0.0%	97.3%	-100.0%	-100.0%
LTC-DUAL	15	1311	1285	**0**	0.0%	0.3%	0.3%	0.0%	98.9%	-100.0%	-100.0%
SPD-LTC	0	0	0	**29566**	0.0%	0.0%	0.0%	7.3%	0.0%	0.0%	0.0%
SPD-LTC/Full Dual	0	0	0	**48153**	0.0%	0.0%	0.0%	11.8%	0.0%	0.0%	0.0%
Medi-Cal	324053	394935	406548	**407105**	98.3%	98.6%	98.6%	98.6%	17.9%	3.0%	0.1%
Group Care	5761	5603	5790	**5779**	1.7%	1.4%	1.4%	1.4%	-2.8%	3.0%	-0.2%
Total	**329814**	**400538**	**412338**	**412884**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**17.7%**	**3.0%**	**0.1%**



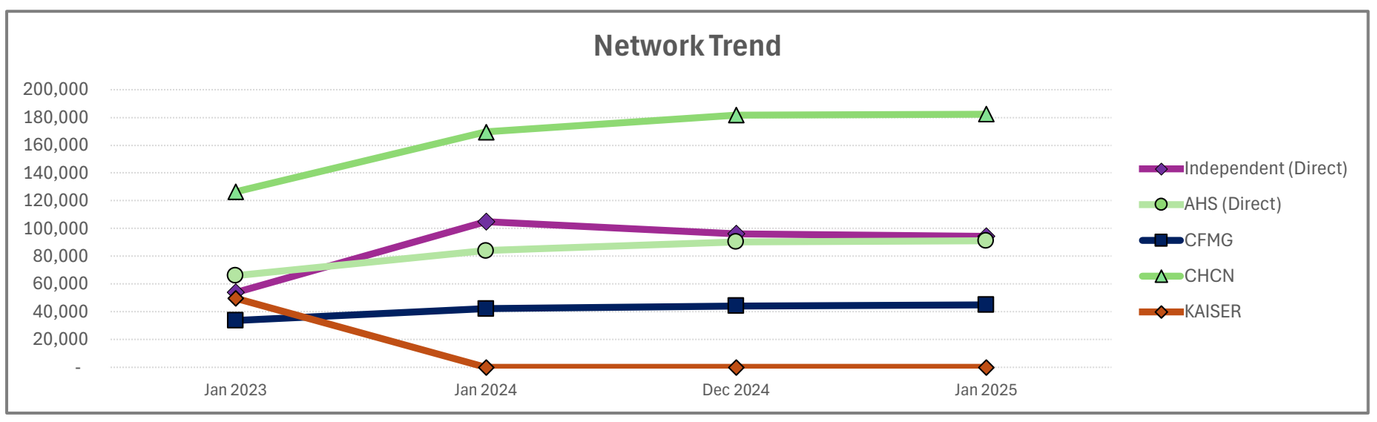
Delegation vs Direct Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	Jan 2023	Jan 2024	Dec 2024	Jan 2025	Jan 2023	Jan 2024	Dec 2024	Jan 2025	Jan 2023 to Jan 2024	Jan 2024 to Jan 2025	Dec 2024 to Jan 2025
Delegated	209892	211633	225787	**227300**	63.6%	52.8%	54.8%	55.1%	0.8%	6.9%	0.7%
Direct	119922	188905	186551	**185584**	36.4%	47.2%	45.2%	44.9%	36.5%	-1.8%	-0.5%
Total	**329814**	**400538**	**412338**	**412884**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**17.7%**	**2.9%**	**0.1%**



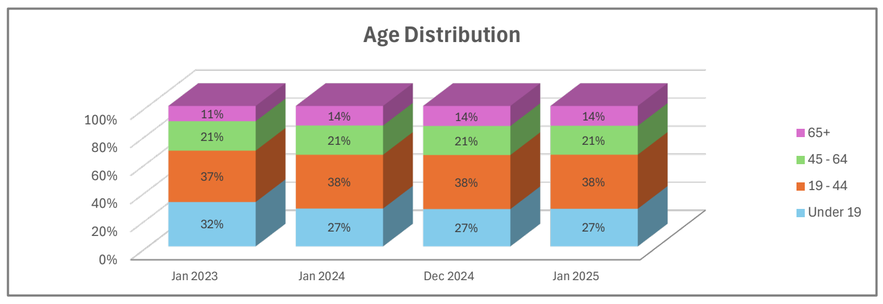
Network Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Jan 2023	Jan 2024	Dec 2024	Jan 2025	Jan 2023	Jan 2024	Dec 2024	Jan 2025	Jan 2023 to Jan 2024	Jan 2024 to Jan 2025	Dec 2024 to Jan 2025
Independent (Direct)	53870	104923	96313	**94414**	16.3%	26.2%	23.4%	22.9%	48.7%	-11.1%	-2.0%
AHS (Direct)	66052	83982	90238	**91170**	20.0%	21.0%	21.9%	22.1%	21.3%	7.9%	1.0%
CFMG	33741	42149	44111	**44988**	10.2%	10.5%	10.7%	10.9%	19.9%	6.3%	1.9%
CHCN	126433	169484	181676	**182312**	38.3%	42.3%	44.1%	44.2%	25.4%	7.0%	0.3%
KAISER	49718	0	0	**0**	15.1%	0.0%	0.0%	0.0%	-100.0%	0.0%	0.0%
Total	**329814**	**400538**	**412338**	**412884**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**17.7%**	**3.0%**	**0.1%**



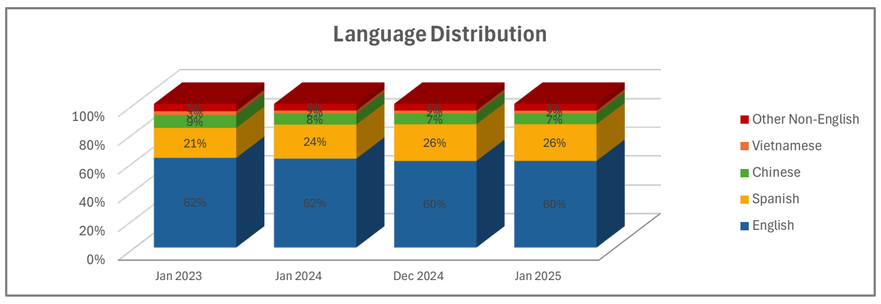
Age Category Trend

Age Category	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Jan 2023	Jan 2024	Dec 2024	Jan 2025	Jan 2023	Jan 2024	Dec 2024	Jan 2025	Jan 2023 to Jan 2024	Jan 2024 to Jan 2025	Dec 2024 to Jan 2025
Under 19	104152	107826	109506	**110492**	32%	27%	27%	27%	3%	2%	1%
19 - 44	120648	153381	158707	**158893**	37%	38%	38%	38%	21%	3%	0%
45 - 64	69127	83432	85272	**85072**	21%	21%	21%	21%	17%	2%	0%
65+	35887	55899	58853	**58427**	11%	14%	14%	14%	36%	4%	-1%
Total	**329814**	**400538**	**412338**	**412884**	**100%**	**100%**	**100%**	**100%**	**18%**	**3%**	**0%**



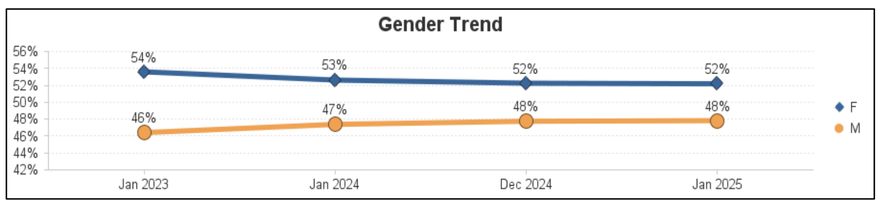
Language Trend

Language	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Jan 2023	Jan 2024	Dec 2024	Jan 2025	Jan 2023	Jan 2024	Dec 2024	Jan 2025	Jan 2023 to Jan 2024	Jan 2024 to Jan 2025	Dec 2024 to Jan 2025
English	205802	247662	248451	**248847**	62%	62%	60%	60%	17%	0%	0%
Spanish	68746	94894	105234	**105452**	21%	24%	26%	26%	28%	10%	0%
Chinese	29364	30650	30806	**30623**	9%	8%	7%	7%	4%	0%	-1%
Vietnamese	8924	8528	8294	**8263**	3%	2%	2%	2%	-5%	-3%	0%
Other Non-English	16978	18804	19553	**19699**	5%	5%	5%	5%	10%	5%	1%
Total	**329814**	**400538**	**412338**	**412884**	**100%**	**100%**	**100%**	**100%**	**18%**	**3%**	**0%**



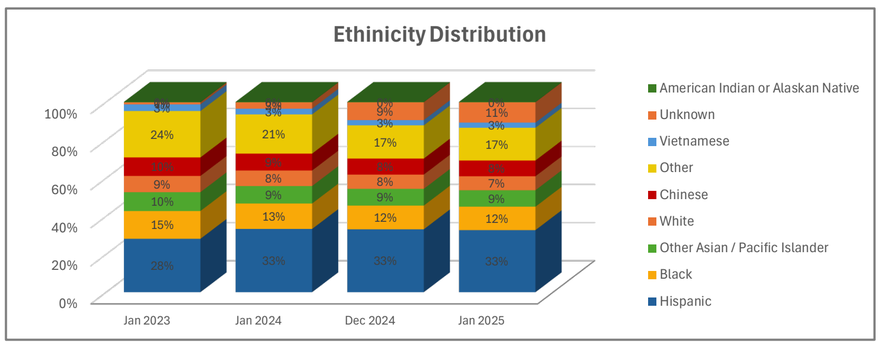
Gender Trend

Gender	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Jan 2023	Jan 2024	Dec 2024	Jan 2025	Jan 2023	Jan 2024	Dec 2024	Jan 2025	Jan 2023 to Jan 2024	Jan 2024 to Jan 2025	Dec 2024 to Jan 2025
F	176768	210770	215451	**215437**	54%	53%	52%	52%	16%	2%	0%
M	153046	189768	196887	**197447**	46%	47%	48%	48%	19%	4%	0%
Total	**329814**	**400538**	**412338**	**412884**	**100%**	**100%**	**100%**	**100%**	**18%**	**3%**	**0%**



Ethnicity Trend

Ethnicity	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Jan 2023	Jan 2024	Dec 2024	Jan 2025	Jan 2023	Jan 2024	Dec 2024	Jan 2025	Jan 2023 to Jan 2024	Jan 2024 to Jan 2025	Dec 2024 to Jan 2025
Hispanic	92528	133127	136294	**134750**	28%	33%	33%	33%	30%	1%	-1%
Black	48188	53587	51323	**50793**	15%	13%	12%	12%	10%	-6%	-1%
Other Asian / Pacific Islander	32634	36752	36322	**35742**	10%	9%	9%	9%	11%	-3%	-2%
White	28155	32654	30931	**30308**	9%	8%	8%	7%	14%	-8%	-2%
Chinese	32069	35545	34683	**34193**	10%	9%	8%	8%	10%	-4%	-1%
Other	80433	82586	71988	**70977**	24%	21%	17%	17%	3%	-16%	-1%
Vietnamese	11535	12000	11366	**11227**	3%	3%	3%	3%	4%	-7%	-1%
Unknown	3582	13480	38664	**44135**	1%	3%	9%	11%	73%	69%	12%
American Indian or Alaskan Native	690	807	767	**759**	0%	0%	0%	0%	14%	-6%	-1%
Total	**329814**	**400538**	**412338**	**412884**	**100%**	**100%**	**100%**	**100%**	**18%**	**3%**	**0%**



City	Jan 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	162418	40%	25040	42201	17622	77555
HAYWARD	65293	16%	13920	17966	7631	25776
FREMONT	38377	9%	16065	6691	2318	13303
SAN LEANDRO	33374	8%	8587	5638	4321	14828
UNION CITY	14794	4%	5789	2637	871	5497
ALAMEDA	13804	3%	3393	2454	2059	5898
BERKELEY	15544	4%	4308	2383	1810	7043
LIVERMORE	13296	3%	1978	580	2285	8453
NEWARK	9511	2%	2787	4127	572	2025
CASTRO VALLEY	9649	2%	2824	1544	1469	3812
SAN LORENZO	7350	2%	1499	1666	876	3309
PLEASANTON	7891	2%	1929	398	827	4737
DUBLIN	7699	2%	2150	399	913	4237
EMERYVILLE	2911	1%	668	610	468	1165
ALBANY	2574	1%	663	305	596	1010
PIEDMONT	487	0%	122	180	72	113
SUNOL	85	0%	25	14	7	39
ANTIOCH	58	0%	22	8	15	13
Other	1990	0%	492	429	256	813
Total	407105	100%	**92261**	**90230**	**44988**	**179626**

Group Care By City

City	Jan 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	1816	31%	335	356	0	1125
HAYWARD	667	12%	320	158	0	189
FREMONT	667	12%	438	81	0	148
SAN LEANDRO	604	10%	245	90	0	269
UNION CITY	290	5%	182	43	0	65
ALAMEDA	305	5%	87	26	0	192
BERKELEY	145	3%	49	9	0	87
LIVERMORE	100	2%	32	3	0	65
NEWARK	136	2%	78	33	0	25
CASTRO VALLEY	191	3%	84	31	0	76
SAN LORENZO	140	2%	47	27	0	66
PLEASANTON	68	1%	23	2	0	43
DUBLIN	123	2%	44	5	0	74
EMERYVILLE	34	1%	12	5	0	17
ALBANY	20	0%	10	1	0	9
PIEDMONT	9	0%	1	1	0	7
SUNOL	1	0%	1	0	0	0
ANTIOCH	26	0%	7	5	0	14
Other	437	8%	158	64	0	215
Total	**5779**	**100%**	**2153**	**940**	**0**	**2686**

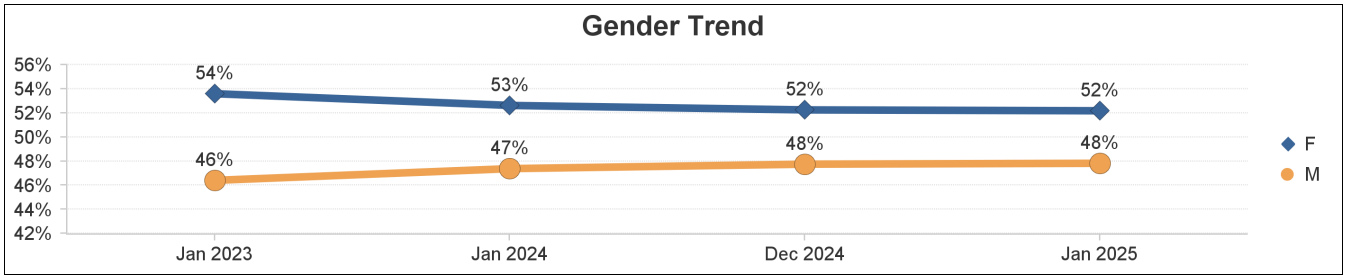
Total By City

City	Jan 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	164234	40%	25375	42557	17622	78680
HAYWARD	65960	16%	14240	18124	7631	25965
FREMONT	39044	9%	16503	6772	2318	13451
SAN LEANDRO	33978	8%	8832	5728	4321	15097
UNION CITY	15084	4%	5971	2680	871	5562
ALAMEDA	14109	3%	3480	2480	2059	6090
BERKELEY	15689	4%	4357	2392	1810	7130
LIVERMORE	13396	3%	2010	583	2285	8518
NEWARK	9647	2%	2865	4160	572	2050
CASTRO VALLEY	9840	2%	2908	1575	1469	3888
SAN LORENZO	7490	2%	1546	1693	876	3375
PLEASANTON	7959	2%	1952	400	827	4780
DUBLIN	7822	2%	2194	404	913	4311
EMERYVILLE	2945	1%	680	615	468	1182
ALBANY	2594	1%	673	306	596	1019
PIEDMONT	496	0%	123	181	72	120
SUNOL	86	0%	26	14	7	39
ANTIOCH	84	0%	29	13	15	27
Other	2427	1%	650	493	256	1028
Total	412884	100%	**94414**	**91170**	**44988**	**182312**

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

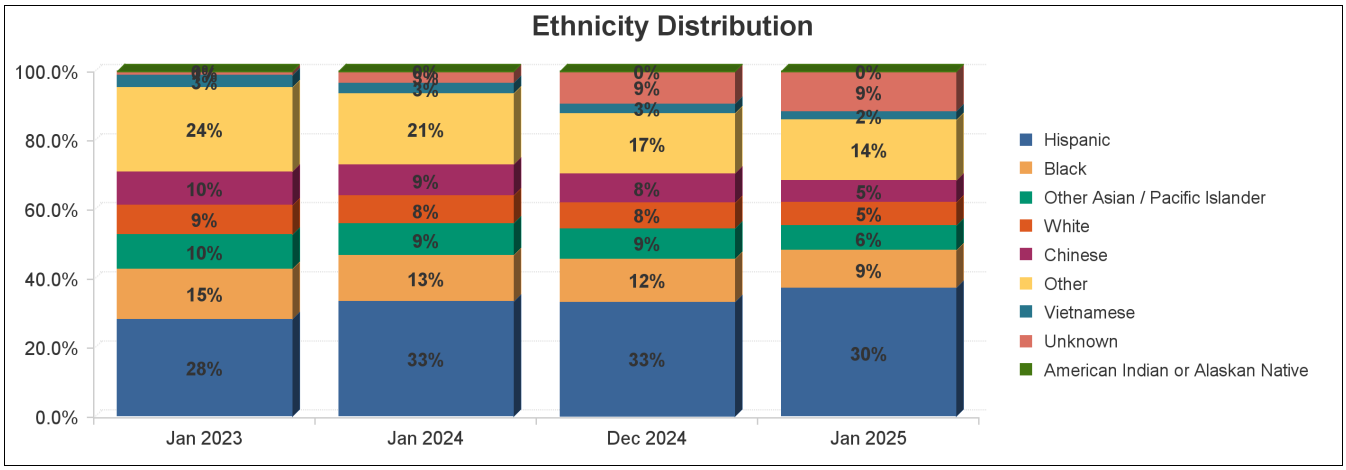
Gender Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Jan 2023	Jan 2024	Dec 2024	Jan 2025	Jan 2023	Jan 2024	Dec 2024	Jan 2025	Jan 2023 to Jan 2024	Jan 2024 to Jan 2025	Dec 2024 to Jan 2025
F	176,768	210,770	215,451	**215,437**	54%	53%	52%	52%	19%	-18%	-20%
M	153,046	189,768	196,887	**197,447**	46%	47%	48%	48%	24%	-14%	-18%
Total	**329,814**	**400,538**	**412,338**	**412,884**	**100%**	**100%**	**100%**	**100%**	**21%**	**-16%**	**-19%**



Ethnicity Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Jan 2023	Jan 2024	Dec 2024	Jan 2025	Jan 2023	Jan 2024	Dec 2024	Jan 2025	Jan 2023 to Jan 2024	Jan 2024 to Jan 2025	Dec 2024 to Jan 2025
Hispanic	92,528	133,127	136,294	**134,750**	28%	33%	33%	33%	44%	-6%	-9%
Black	48,188	53,587	51,323	**50,793**	15%	13%	12%	12%	11%	-32%	-29%
Other Asian / Pacific Islander	32,634	36,752	36,322	**35,742**	10%	9%	9%	9%	13%	-35%	-34%
White	28,155	32,654	30,931	**30,308**	9%	8%	8%	7%	16%	-31%	-27%
Chinese	32,069	35,545	34,683	**34,193**	10%	9%	8%	8%	11%	-40%	-39%
Other	80,433	82,586	71,988	**70,977**	24%	21%	17%	17%	3%	-29%	-18%
Vietnamese	11,535	12,000	11,366	**11,227**	3%	3%	3%	3%	4%	-33%	-29%
Unknown	3,582	13,480	38,664	**44,135**	1%	3%	9%	11%	276%	188%	0%
American Indian or Alaskan Native	690	807	767	**759**	0%	0%	0%	0%	17%	-30%	-26%
Total	**329,814**	**400,538**	**412,338**	**412,884**	**100%**	**100%**	**100%**	**100%**	**21%**	**-16%**	**-19%**



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

Medi-Cal By City

City	Jan 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	133,598	41%	13,576	38,228	16,947	64,847
HAYWARD	55,010	17%	7,953	16,373	7,456	23,228
FREMONT	29,061	9%	9,391	5,965	2,238	11,467
SAN LEANDRO	27,324	8%	5,433	5,082	4,202	12,607
UNION CITY	11,112	3%	3,074	2,339	840	4,859
ALAMEDA	10,493	3%	1,683	2,167	1,983	4,660
BERKELEY	12,074	4%	2,557	2,210	1,751	5,556
LIVERMORE	11,153	3%	1,031	532	2,229	7,361
NEWARK	7,552	2%	1,501	3,738	554	1,759
CASTRO VALLEY	7,820	2%	1,831	1,386	1,430	3,173
SAN LORENZO	6,003	2%	840	1,499	855	2,809
PLEASANTON	5,918	2%	1,075	354	792	3,697
DUBLIN	5,411	2%	1,155	349	880	3,027
EMERYVILLE	2,353	1%	366	562	457	968
ALBANY	2,263	1%	522	282	581	878
PIEDMONT	392	0%	72	166	68	86
SUNOL	64	0%	14	11	7	32
ANTIOCH	50	0%	16	7	14	13
Other	1,735	1%	326	404	244	761
Total	329,386	100%	**52,416**	**81,654**	**43,528**	**151,788**

Group Care By City

City	Jan 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	1,816	31%	335	356	0	1,125
HAYWARD	667	12%	320	158	0	189
FREMONT	667	12%	438	81	0	148
SAN LEANDRO	604	10%	245	90	0	269
UNION CITY	290	5%	182	43	0	65
ALAMEDA	305	5%	87	26	0	192
BERKELEY	145	3%	49	9	0	87
LIVERMORE	100	2%	32	3	0	65
NEWARK	136	2%	78	33	0	25
CASTRO VALLEY	191	3%	84	31	0	76
SAN LORENZO	140	2%	47	27	0	66
PLEASANTON	68	1%	23	2	0	43
DUBLIN	123	2%	44	5	0	74
EMERYVILLE	34	1%	12	5	0	17
ALBANY	20	0%	10	1	0	9
PIEDMONT	9	0%	1	1	0	7
SUNOL	1	0%	1	0	0	0
ANTIOCH	26	0%	7	5	0	14
Other	437	8%	158	64	0	215
Total	**5,779**	**100%**	**2,153**	**940**	**0**	**2,686**

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

Total By City

City	Jan 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	135,414	33%	13,911	38,584	16,947	65,972
HAYWARD	55,677	13%	8,273	16,531	7,456	23,417
FREMONT	29,728	7%	9,829	6,046	2,238	11,615
SAN LEANDRO	27,928	7%	5,678	5,172	4,202	12,876
UNION CITY	11,402	3%	3,256	2,382	840	4,924
ALAMEDA	10,798	3%	1,770	2,193	1,983	4,852
BERKELEY	12,219	3%	2,606	2,219	1,751	5,643
LIVERMORE	11,253	3%	1,063	535	2,229	7,426
NEWARK	7,688	2%	1,579	3,771	554	1,784
CASTRO VALLEY	8,011	2%	1,915	1,417	1,430	3,249
SAN LORENZO	6,143	1%	887	1,526	855	2,875
PLEASANTON	5,986	1%	1,098	356	792	3,740
DUBLIN	5,534	1%	1,199	354	880	3,101
EMERYVILLE	2,387	1%	378	567	457	985
ALBANY	2,283	1%	532	283	581	887
PIEDMONT	401	0%	73	167	68	93
SUNOL	65	0%	15	11	7	32
ANTIOCH	76	0%	23	12	14	27
Other	2,172	1%	484	468	244	976
Total	335,165	81%	**54,569**	**82,594**	**43,528**	**154,474**

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: **March 14th, 2025**

Subject: **Operations Report**

Member Services

- 12-Month Trend Blended Summary:

    - The Member Services Department received a 24% decrease in calls in February 2025, totaling 18,201 compared to 239,899 in February 2024.
    - The abandonment rate for February 2025 was 4%, compared to 9% in February 2024.
    - The Department's service level was 95% in February 2025, compared to 79% in February 2024. The average speed to answer (ASA) was twelve seconds (00:12) compared to fifty-eight seconds (00:58) in February 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 seconds (07:30) for February 2025 compared to six minutes and fifty-eight seconds (06:58) for February 2024.
    - 100% of calls were answered within 10 minutes for February 2025 and 98% of calls were answered within 10 minutes for February 2024.
    - Outbound calls totaled 9,066 in February 2025 compared to 8,814 in February 2024.
    - The top five call reasons for February 2025 were: 1). Eligibility/Enrollment; 2). Change of PCP; 3). Benefits; 4). Grievances/Appeals; 5). Provider Network. The top five call reasons for February 2024 were: 1). Change of PCP; 2). Eligibility/Enrollment; 3). Benefits; 4). ID Card Requests; 5). Provider Network.
    - February utilization for the member automated eligibility IVR system totaled 1,245 in February 2025 compared to 1,960 in February 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 1,073 web-based requests in February 2025 compared to 1,784 in February 2024. The top three web reason requests for February 2025 were: 1). Change of PCP; 2). ID Card Requests; 3). Update Contact Information. 53 members were assisted in-person in February 2025 compared to 63 in February 2024.

- Member Services Behavioral Health:

    - The Member Services Behavioral Health Unit received a total of 1,205 calls in February 2025 compared to 1,624 in February 2024.
    - The abandonment rate was 4% in February 2025 compared to 17% in February 2024.
    - The service level was 85% in February 2025 and 71% in February 2024.
    - The average speed to answer (ASA) was thirty-three seconds (00:33) in February 2025 compared to one minute and forty seconds (01:40) in February 2024.
    - Calls answered in 10 minutes were 100% in February 2025 compared to 96% in February 2024.
    - The Average Talk Time (ATT) in February 2025 was eight minutes and twenty-two seconds (08:22) compared to nine minutes and forty-five seconds (9:45) in February 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.
    - 1,240 outbound calls were completed in February 2025 compared to 1,463 in February 2024.
    - 115 screenings were completed in February 2025 compared to 192 in February 2024.
    - 55 outreach campaigns were completed in February 2025 compared to 247 in February 2024.
    - 39 referrals were made to the County (ACCESS) in February 2025 compared to 64 in February 2024.
    - 21 members were referred to Center Point for SUD services in February 2025 compared to 16 in February 2024.

Claims

- 12-Month Trend Summary:

    - The Claims Department received 339,840 claims in February 2025 compared to 266,339 in February 2024.
    - The Auto Adjudication rate was 85.8% in February 2025 compared to 81.0% in February 2024.
    - Claims compliance for the 30-day turn-around time was 91.7% in February 2025 compared to 91.4% in February 2024. The 45-day turn-around time was 94.9% in February 2025 compared to 99.9% in February 2024.

- Monthly Analysis:

    - In the month of February, we received a total of 339,840 claims in the HEALTHsuite system. This represents a minimal increase from January

2025 but is 27.6% higher than the number of claims received in February 2024 by 73,501.
  - Drivers of the higher volume of claims received includes:
    - Increased membership since February 2024 (Anthem member transition; Unsatisfactory Immigration Status member transition).
    - 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.
  - We received 90% of claims via EDI and 10% of claims via paper.
  - During the month of February, 94.9% of our claims were processed within 45 working days.
  - The Auto Adjudication rate was 85.8% for the month of February.

Provider Services

- 12-Month Trend Summary:

  - The Provider Services department's call volume in February 2025 was 8,885 calls compared to 9,359 calls in February 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 332 calls/visits during February 2025.
  - The Provider Services department answered 7,752 calls for February 2025 and made 1,162 outbound calls.

Credentialing

- 12-Month Trend Summary:

  - At the Peer Review and Credentialing (PRCC) meeting held on February 18th, 2025, there were 120 initial network providers approved; 5 primary care providers, 5 specialists, 6 ancillary providers, 6 midlevel providers, and 98 behavioral health providers. Additionally, 30 providers were re-credentialed at this meeting; 13 primary care providers, 9 specialists, 0 ancillary providers, and 8 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:
    - In February 2025, the Provider Dispute Resolution (PDR) team received 2,551 PDRs versus 2,064 in February 2024. This represents a decrease of 11.8% from January 2025 but is 23.6% higher than the number of PDRs received in February 2024 by 487.
    - The PDR team resolved 1,861 cases in February 2025 compared to 1,007 cases in February 2024.
    - In February 2025, the PDR team upheld 66% of cases versus 66% in February 2024.
    - The PDR team resolved 99.6% of cases within the compliance standard of 95% within 45 working days in February 2025, compared to 100.0% in February 2024.

- Monthly Analysis:
    - The Alliance received 2,551 PDRs in February 2025.
    - In the month of February, 1,861 PDRs were resolved. Out of the 1,861 PDRs, 1,222 were upheld, and 639 were overturned.
    - 1,854 out of 1,861 cases were resolved within 45 working days resulting in a 99.6% compliance rate.
    - The average turnaround time for resolving PDRs in February was 34 days.
    - There were 3,466 PDRs pending resolution as of 02/28/2025, with no cases older than 45 working days.
    - The overturn rate for PDRs was 34%, which did not meet our goal of 25% or less.
- The primary reason which caused the Department to miss their goal of 25% or less was:
    - Member OHC corrections – 141 cases that were denied incorrectly.
    - The full breakdown of all **639** overturned PDR's is:

Category	# of Cases	% of Cases	Comments
System Related Issues	**64**	**10%**	
General configuration issues	28	4%	Non-covered code, modifier, etc.
Financial responsibility	19	3%	MNF
Claims Editing System (CES)	17	3%	
OHC Issues	**140**	**22%**	Inaccurate OHC Member TPL data
Authorization Issues	**141**	**23%**	
Processor error	63	11%	Claim denied in error; authorization was on file
UM/retro auth review	52	8%	
Auth System error	26	4%	

Incorrect Rates	**160**	**25%**	
Incorrect rate - System	70	11%	AB1629 rate change,
Letter of Agreement (LOA)	7	1%	Underpaid; LOA on file
COB calculation	21	3%	Incorrectly calculated
Incorrect rate – Processor	62	10%	The processor did not calculate the rate correctly according to the contract or rate sheet
Claim Processing Error	**98**	**15%**	
Duplicate claim	36	6%	The claim was a duplicate; the processor paid it in error
Incorrect Manual Denial	31	5%	Claim manually priced incorrectly
Overpayment	3	0%	Provider request recoupment due to overpayment
Miscellaneous processing errors	28	4%	
Additional Documentation	**36**	**5%**	
Provider duplicate claim	28	4%	The documentation received confirmed claim was not a duplicate
Timely filing	2	0%	The documentation received confirmed claim was submitted on time
Provider billing	6	1%	Corrected claim due to provider error
PDR Overturn Totals	**639**	**100%**	

Community Relations and Outreach

- 12-Month Trend Summary:
    - In February 2025, the Alliance completed 868 member orientation outreach calls and 106 member orientations by phone.
    - The C&O Department reached 683 people (66% identified as Alliance members) during outreach activities, compared to 1,037 individuals (57% self-identified as Alliance members) in February 2024.
    - The C&O Department spent a total of $0 on donations, fees, and/or sponsorships, compared to $312.10 in February 2024.
    - The C&O Department reached members in 14 cities/unincorporated areas throughout Alameda County, compared to 13 cities in February 2024.

- Monthly Analysis:
    - In February 2025, the C&O Department completed 868 member orientation outreach calls and 106 member orientations by phone, one community event, four member education events, and 45 Alliance website inquiries.
    - Among the 683 people reached, 66% identified as Alliance members.
    - In February 2025, the C&O Department contacted members in 14 locations across Alameda County.

- Please see attached **Addendum A**.

Housing and Community Services Program Report – February Activities

Overview

The Housing and Community Services Program (HCSP) leads, develops, and implements a comprehensive housing and homelessness strategy for Alameda Alliance for Health (Alliance). HCSP will evaluate the current processes for members' access to the healthcare system, identify the barriers to achieving housing outcomes for members, and create a strategic plan to establish partnerships with various community stakeholders.

Project Status Updates:

- Denial Process Workflow in TruCare – in progress
- Developing Strengths, Weaknesses, Opportunities and Threats (SWOT) Analysis for the housing bundle – ongoing
- Development of Standard Operating Procedures (SOPs) for housing-related CS – completed and shared with Alameda County Health (AC Health)
- Housing Community Supports (CS) automation for member letters – completed
- Housing CS automation for referral eligibility – in progress
- ROI project for housing-related CS – ongoing
- Developed operating definitions for reasonable and necessary criteria – pending SLT approval
- Operationalizing new HCPCS code for Outreach billing – completed
- Updating Housing Job Descriptions – pending HR approval

Staffing:

- Housing Coordinator – Two positions; recruitment to begin in March

Interdepartmental Collaborations:

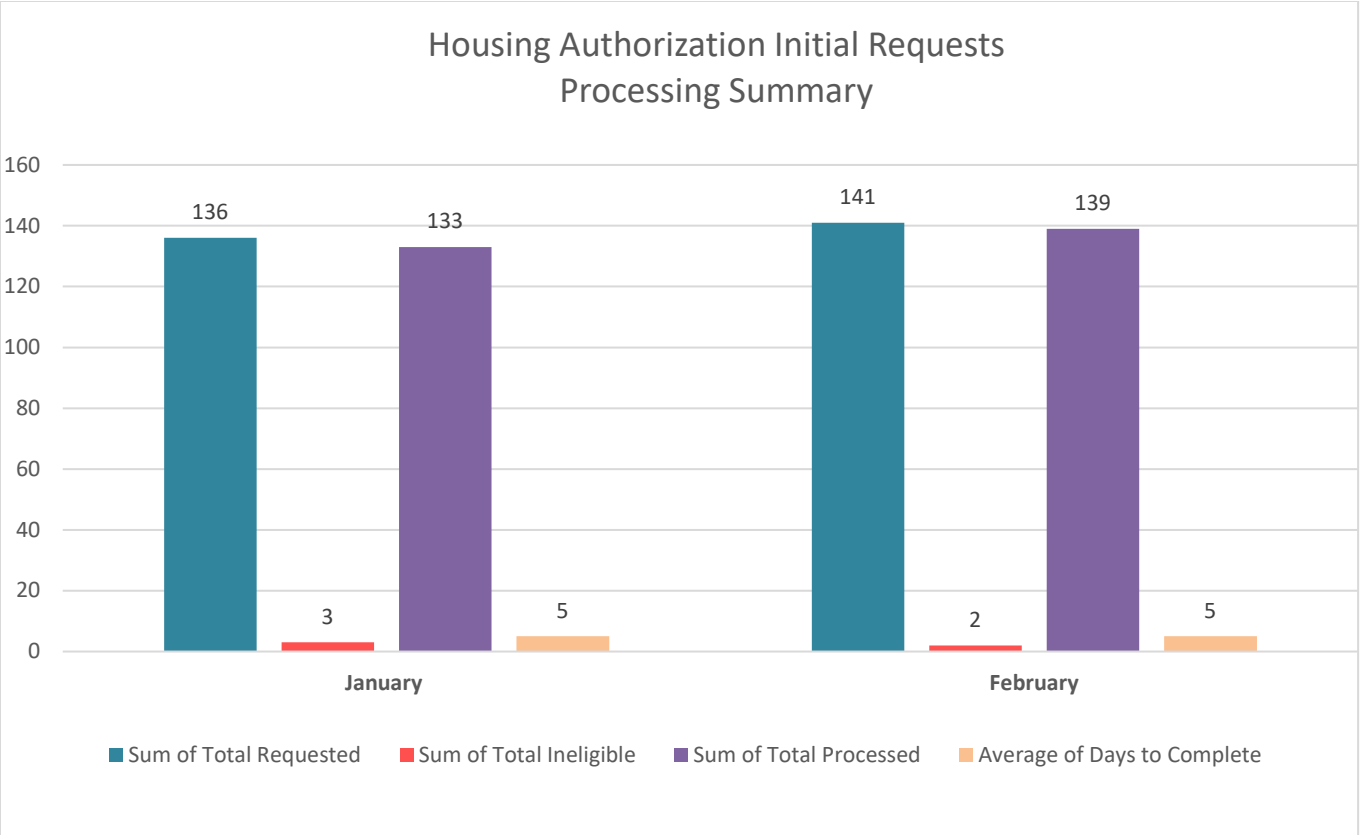
- Health Care Services and Housing Operations
  - ECM/CS Operational Efficiency Workgroup – ongoing
- TruCare Steering Committee Workgroup – ongoing
- CalAIM CS Hot Topics Workgroup – ongoing
- Alameda CalAIM Path Collaborative - ongoing

Community Networks and Partnership Development:

- Continued participation with various stakeholders throughout Alameda County, including the Continuum of Care (CoC), Racial Equity Committee, Outreach Access and Coordination Committee, Healthcare for the Homeless Oakland Regional Housing Meeting, Homeless Management Information System (HMIS) Committee, and Corporation for Supportive Housing Advisory Council.
  - Corporation for Supportive Housing Advisory Council – Transitional Rent Discussion
  - DHCS Transitional Rent Workgroup; next meeting scheduled for 03/05/2025
  - Housing Community Supports Implementation Learning Collaborative

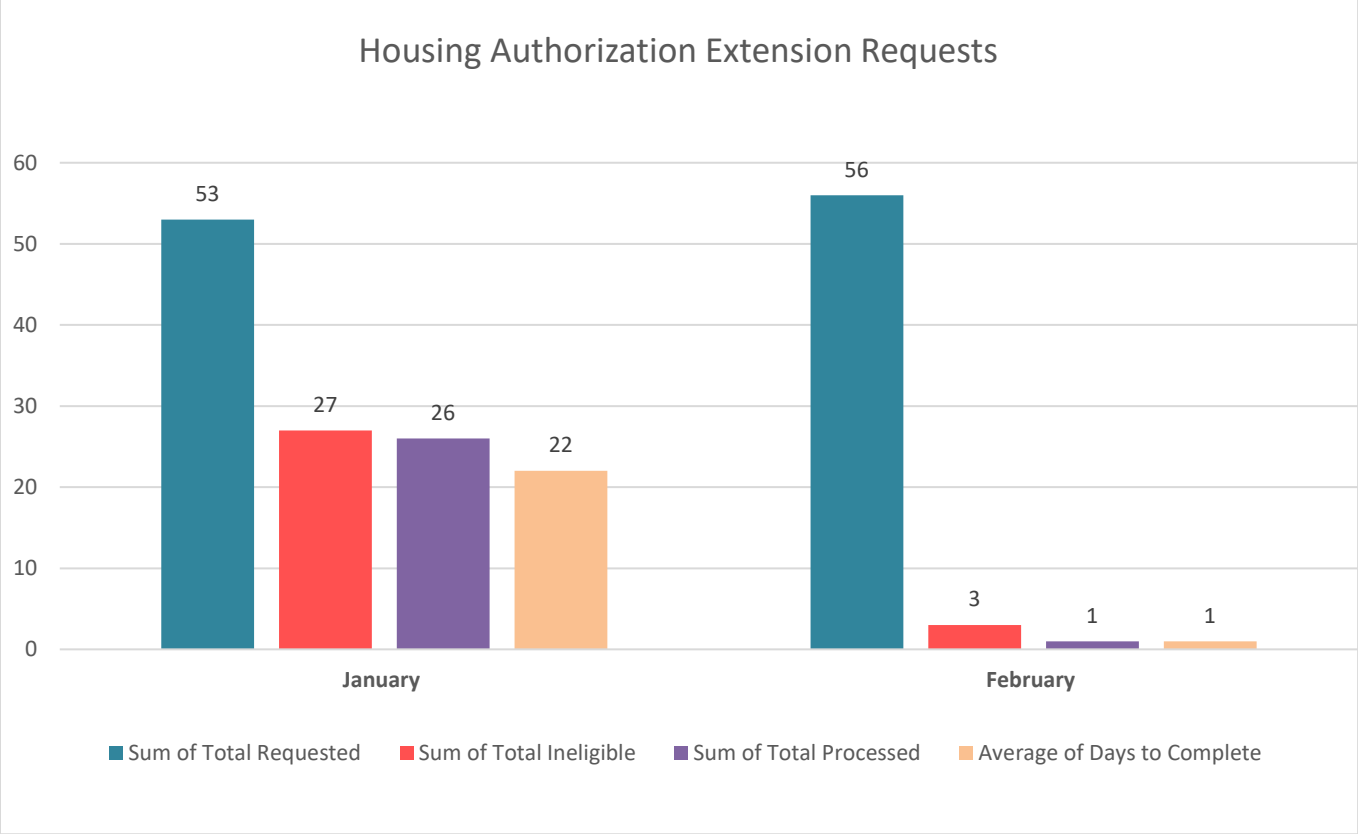
- Corporation for Supportive Housing, Medicaid, and Housing Related Services Workgroup – 03/21/2025

Initial Housing Authorization Requests Report:



The Initial Housing Authorization Request Report is a point-in-time report focusing on Initial Authorization completion for the Housing & Community Supports Department. The following provides an overview of Initial Authorization requests for January 2025 and February 2025:

- January 2025:
  - HCSD received 6 batches of initial housing authorizations requests which included 136 individual requests
    - 3 authorizations were determined to be ineligible due to members not meeting the criteria for the service
  - The team completed 133 authorizations, with an average completion time of 5 days per batch
- February 2025:
  - HCSD received 4 batches of initial housing authorizations requests which included 141 individual requests
    - 2 authorizations were determined to be ineligible due to members not meeting the criteria for the service
  - The team completed 139 authorizations, with an average completion time of 5 days per batch



- January 2025:
  - HCSD received 1 batch of extension authorization requests which included 53 individual requests
    - 27 requests were determined to be ineligible due to members not meeting the criteria for the service
    - The team completed 26 authorization extensions, with an average completion time of 22 days per batch; this exceeded the 30-day completion requirement by 8 days
- February 2025:
  - HCSD received 4 batches of extension authorization requests which included 56 individual requests
    - 3 requests were determined to be ineligible due to members not meeting the criteria for the service
    - The team completed 1 authorization extension, with an average completion time of 1 day per batch; this exceeded the 30-day completion requirement by 29 days
      - Please note that the February data for “total ineligible”, “total processed”, and “average days to complete” excludes 52 extensions that were submitted on 2/28/2025. HCSD will report on the completion of February initials during the next board report.

Community Health Worker Program – The Community Health Worker (CHW) Benefit aims to mitigate health disparities and improve health outcomes of Alliance members by bridging the gap between health and housing systems of care to support members' overall health and wellness through the deployment of preventative services that create positive outcomes on a member's social determinants of health.

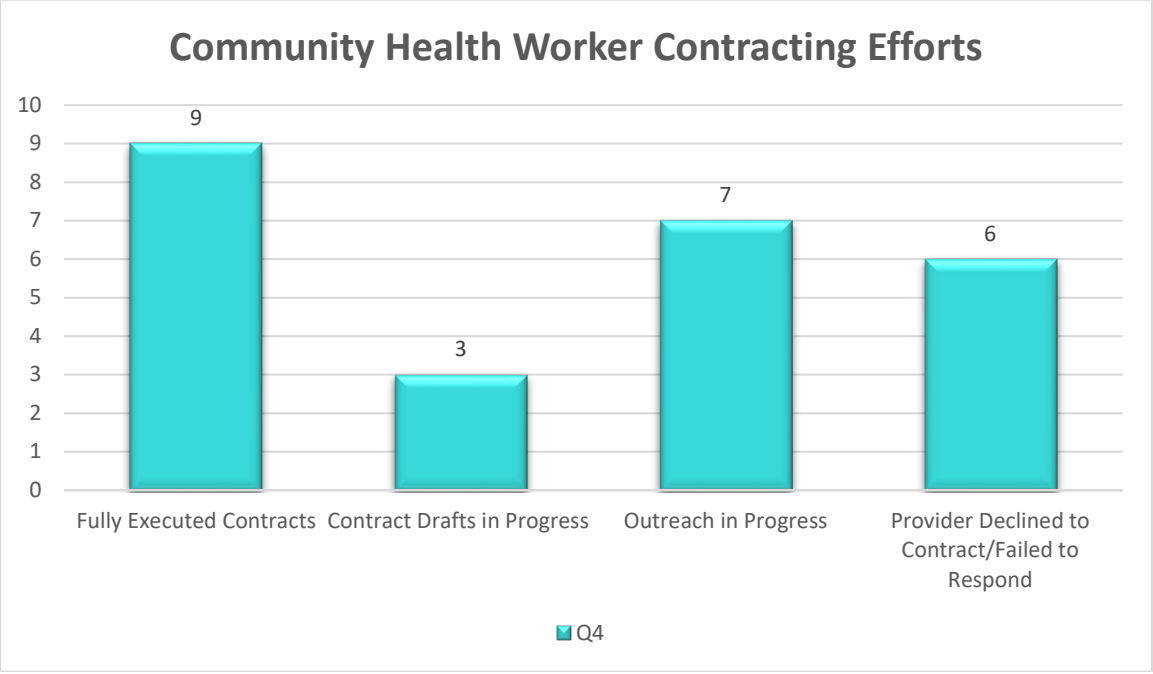
Project Status Updates:

- CHW Training Cohort – designed to engage public health professionals, community-based organizations, hospital partners, and other local health jurisdictions in the CHW work; go-live originally targeted for March 2025 but has been postponed
- CHW SR Module Development – postponed
- Revise CHW strategy – in process
- CHW Billing Report - completed

Staffing Updates:

- CHW Program Manager – anticipate recruiting to resume in March 2025

CHW End of Year Closing:
Alameda Alliance for Health concluded Q4 2024 with 9 fully executed Community Health Worker (CHW) contracts, 3 contract drafts in progress, and 7 providers remaining in the outreach phase. Additionally, 6 provider organizations either declined to contract with Alameda Alliance or did not respond by the end of the quarter.



As indicated by the data above, 6 providers either declined to contract or did not respond by the end of the reporting period. Contracting efforts for this target population remain challenging, primarily due to low reimbursement rates. Many practitioners who declined

participation cited the inability to support the administrative requirements necessary for Medi-Cal billing.

The Alliance remains committed to facilitating opportunities for providers to collaborate with more established organizations, fostering confidence in contracting with the health plan. For example, outreach efforts by Alameda Alliance resulted in engagement with 9 individual organizations. While 5 of these organizations lacked the necessary infrastructure for billing and staffing, they were able to subcontract independently with 2 established organizations, enabling them to begin delivering services to members. Understanding these challenges, the Alliance has strategically started referring to those organizations consistently in a warm handoff to create additional opportunities for collaboration.

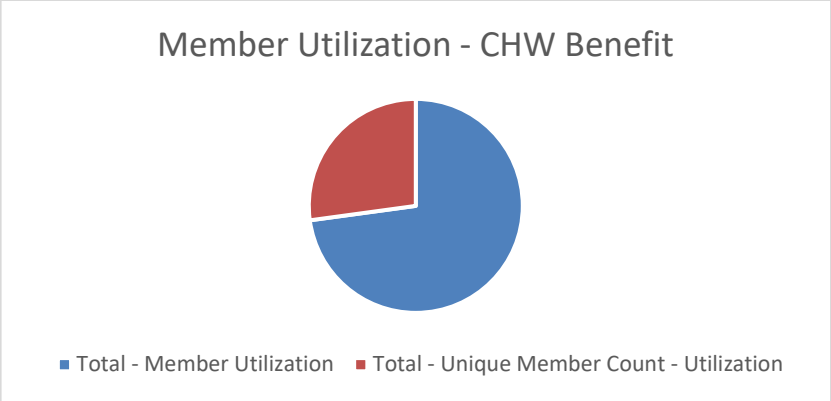
Here is a brief snapshot of partners Alameda Alliance welcomed by the close of 2024. CHW network:

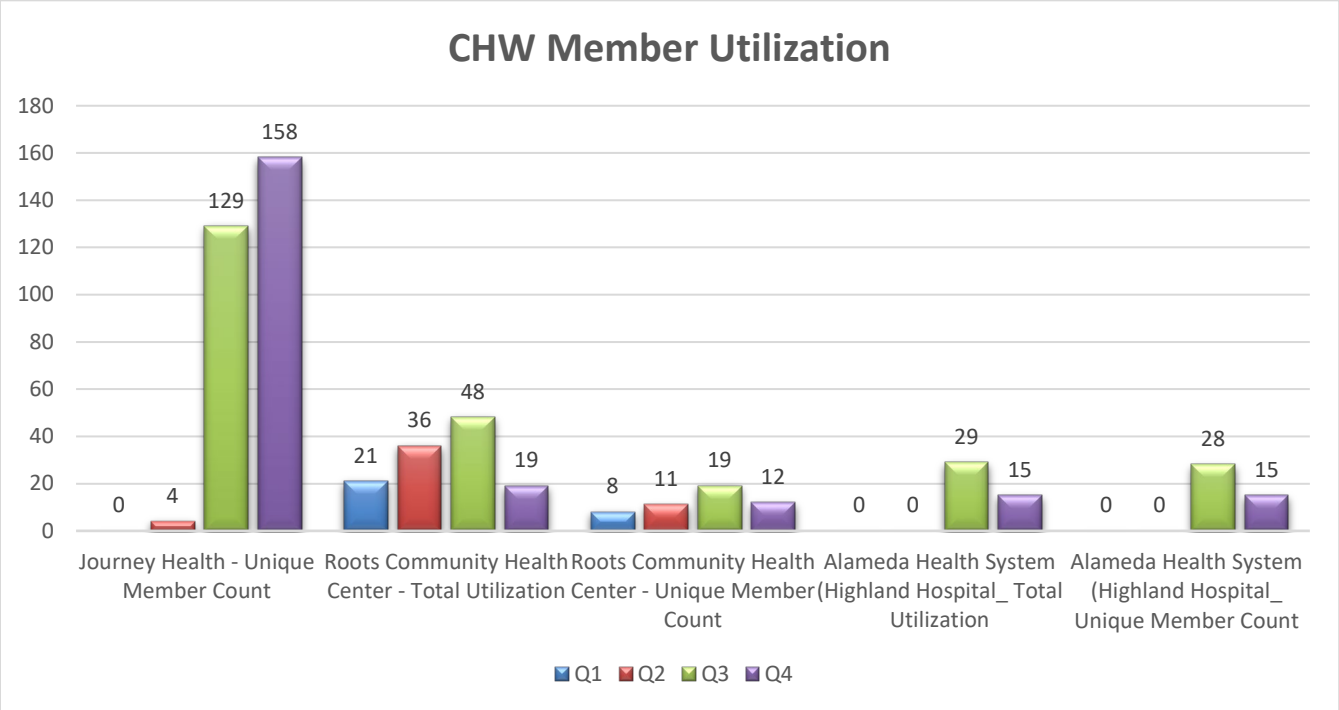
- **Alameda Health Systems**: (Highland Hospital) – developing evidence-based bridged care services at Highland Hospital, supporting clients with resource connections

- **First 5 of Alameda County:** Alameda Alliance has partnered with First 5 since 2020 and has now become a contracted CHW provider, focusing on pediatric members (ages 0-5), to conduct well-child visits, outreach screenings and assessments – contracting activities in progress
- **Journey Health Medical Group:** Medical Group and CHW provider specializing in eliminating health disparities through population health approach to member wellness and enhancing members' access to care for the most vulnerable patients and communities.
    - Areas of focus with the Alliance:
        - Member follow-up for Mental Health (FUM) Measures in Emergency Department (ED) – active project
        - Solving for care gaps and improving A1C and primary care follow-up for AAH members – go-live extended to Q2
        - Working with AAH on CHW organization recruitment in Hayward to assist in closing care gaps – in progress
    - Provider recruitment: Journey Health has been instrumental in supporting expansion of the provider network for AAH recruited CBOs who were not ready to contract with the health plan directly. The following updates highlight newly subcontracted provider organizations through Journey:
        - **Glad Tiding Community Development Corporation:** Specializing in spiritual health and wellness in Hayward California. Supporting community health education, housing and workforce development; active program will support AAH health education gaps in Hayward – Go live April 2025
        - **Good Life Path:** Specializing in health education courses such as healthy aging, cooking and nutrition, mindfulness meditation and open food panty and group exercise location; area of focus is on A1C
        - **Inspiring Communities:** Recognized by the CDC National Diabetes Prevention Program and American Diabetes Association for self-management education and support program, Inspiring Communities

supports improving health literacy and reducing populations-based health education disparities to increase members ability to make informed health decisions
        - **Youth Alive:** Specializing in breaking the cycle of violence through trauma informed practice focusing on saving lives and violence prevention and intervention – Go Live to serve members is March 2025
- **Pair Team Medical Group:** Specializing in community health education helping patients manage health condition and navigate the healthcare delivery systems and addressing social determinants of health
    - Provider recruitment: Pair Team has been instrumental in supporting the expansion of the provider network for AAH recruited CBOs who were not ready to contract with the health plan directly. The following updates highlight newly subcontracted provider organizations through Pair Team:
        - Dorothy Day House – specializing in working with unhoused populations to provide comprehensive wraparound services from medical linkage, housing assessments, meals, and shelter
- **Our Roots Organization**: Specializing in perinatal depression and mental wellness for under-resourced BIPOC women and other birthing communities impacted by poverty; currently in pre-contract phase.
    - Area of focus with the Alliance:
        - Outreach and health education services to approximately 600 high risk perinatal members – go live expected for March 2025
- **Roots Community Health Center**: Specializing in uplifting communities through medical, behavioral health care, health navigation, workforce enterprises, justice-involved specialties, housing, outreach, advocacy and Community Health work; Roots also has 2 new CHW providers, certified in asthma remediation, which brings on additional specialty services
    - Areas of focus with the Alliance:
        - Actively providing health education, health navigation, screening and assessment for Alameda Alliance members with Asthma
- **Zocalo Health**: Primary care group aimed to better patient experiences and access to behavioral health, health related social needs, and care. Zocalo Health also provides CHW services including health education, navigation, advocacy, screening and assessments. Zocalo Health specializes in serving the Latin(x)(o)(e) population with deep roots in cultural and linguistic competency. Currently in the pre-contract phase with Alameda Alliance.

In addition to the partnership engagement efforts made, Alameda Alliance is also excited to share that we closed 2024 with 1,030 CHW claims, for 384 unique members.





In 2025, the Alliance is committed to implementing the following strategies to address operational barriers to Community Health Worker (CHW) programs:

1. **Advocate for Enhanced Reimbursement Rates** – Collaborate with the Department of Health Care Services (DHCS) to advocate for increased reimbursement rates by actively participating in policy-making discussions and workgroups where stakeholder feedback is encouraged.
2. **Demonstrate Return on Investment (ROI)** – Develop and present scope-of-work projects that highlight the financial and health equity benefits of CHW programs, with a particular focus on cost savings in emergency care and other critical areas of improved health outcomes.
3. **Expand Training Opportunities** – Establish standardized training programs to equip contracted and prospective providers with the knowledge and confidence needed to navigate Medi-Cal billing processes effectively.

4. **Enhance Outreach and Strategic Partnerships** – Strengthen outreach initiatives and collaborate with existing contractors who have demonstrated success in CHW program implementation, leveraging their expertise to encourage broader provider participation with the Alliance.

During February 2025, HCSD focused on recruitment to strengthen partnership development and finalizing the SR module for CHW programming. Our goal is to focus on increasing awareness and utilization of the Medi-Cal benefit by conducting outreach campaigns. By implementing these strategies, the Alliance aims to promote the sustainability and effectiveness of CHW programs while improving access to essential community-based care.

Incentives & Reporting Board Report – February 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; the Alliance is awaiting approval from DHCS, and payment is anticipated by April 2025
        - DHCS requested clarification on three (3) of the five (5) PORs on February 10th; the Alliance worked with the LEAs and Kaiser to update the PORs and responded to DHCS on February 14th
- To date, $8.9M has been awarded to the Alliance by DHCS for completed deliverables, and a total of $7.9M has been paid to LEA and SBHIP partners

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

- Total eligible dollars available to the Alliance under this program was $44M
- The Alliance earned a total of $38M based on submission of deliverables and achievement of DHCS-defined metrics
    - $20.0M 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 continues
- 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

- MOUs are in place or underway for projects related to capacity building, innovation, diversity and health equity, and housing stability

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

- Program highlights:
  - Launched on June 1st, 2024
  - Fifteen (15) applications received totaling $6M in funding requests
  - $2M in funding awarded to 13 provider partners, pending finalization of MOUs and related program deliverables for the following:
    - Nineteen (19) providers in total, six (6) of which are bilingual, including:
      - Six (6) Mid-Level Providers
      - Five (5) Behavioral Health Clinicians
      - Five (5) MD/DOs
      - Three (3) OB/GYNs
  - Grants were provided to five (5) practices to support Community Health Worker (CHW) training certificate costs for thirty-three (33) CHWs
  - The Incentives & Reporting team met with PRI awardees, as needed, to provide assistance with understanding MOU requirements and tracking necessary to complete required program materials
    - 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 has implemented a one-time primary care provider practice transformation program 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 was the only Alliance-associated applicant selected by DHCS to participate
- 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 launched this program in December 2024 to grow the Doula provider network to increase access to these services for members

- 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, and payment is underway for 10 of the awardees that have submitted required deliverables
- 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 selected a grant management software system, Submittable, to support the various grant and incentive programs the Alliance participates in; the team is in month four (4) of implementing the system
    - 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 submitted an application on January 14th to participate in an opportunity through the California Improvement Network (CIN), 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
    - Decisions are expected in early March for this two-year program which, if selected, would involve the Alliance participating in an equity focused learning network
    - There is no funding available for the initial CIN opportunity; however, it is an opportunity to partner and connect with other organizations that are also working to improve health equity
        - Those selected to participate in the above activities will be eligible to apply for a $40k action project award to support implementation efforts for partners
- 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
- A Letter of Inquiry (LOI) was submitted to the California Endowment on January 31st to be considered for their grant opportunities; a response is pending
- A LOI has been drafted for a California Health Care Foundation opportunity that focuses on the need for funding to support Behavioral Health (BH) workforce needs, as well as infrastructure support for CBOs to bill for Medi-Cal; once finalized, the LOI will be submitted for consideration
- 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

- A collaboration is underway with the Health Equity and Population Health team to pursue a data-focused grant, which is due in March

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

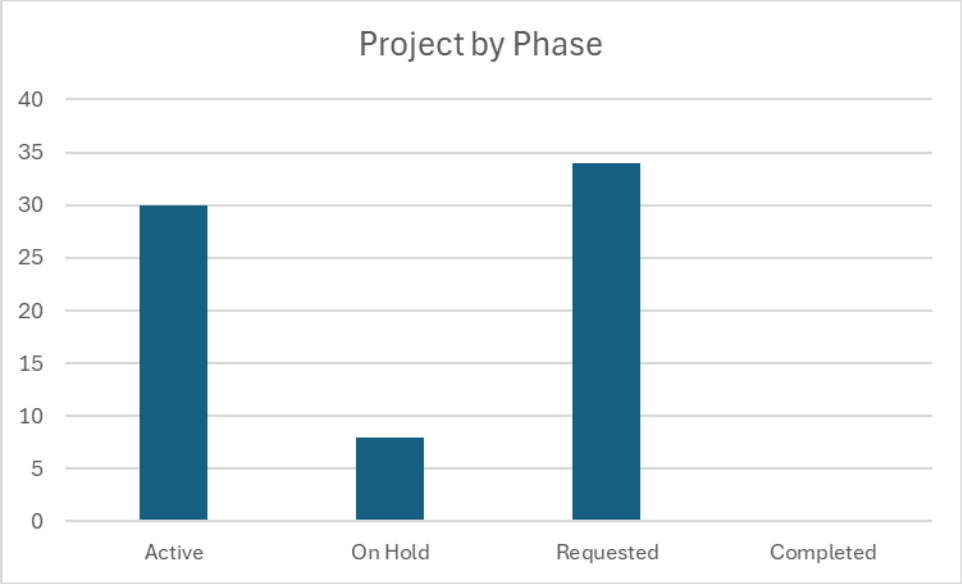
Doula Scholarship Program – program launched in December 2024 to grow the Doula provider network to increase access to these services for members.

Integrated Planning

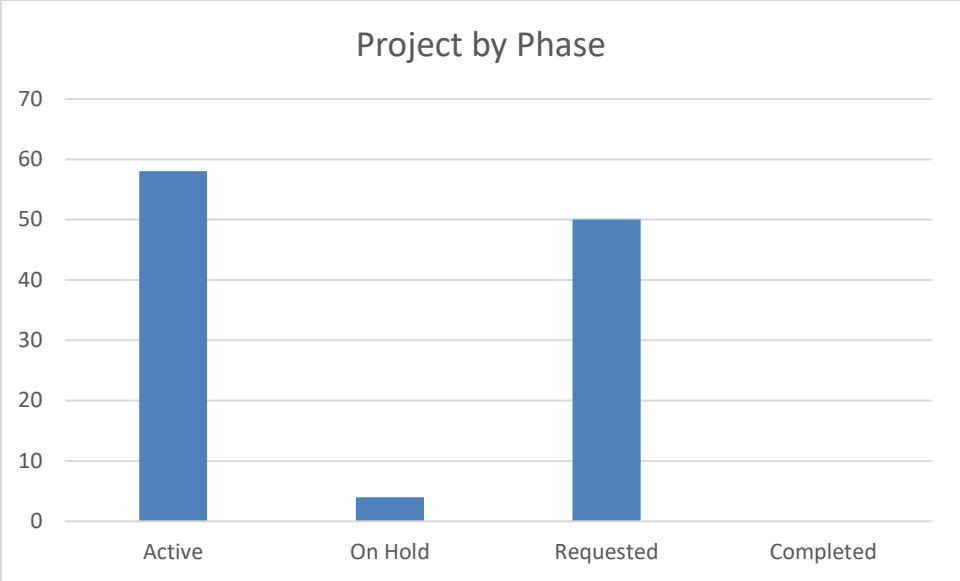
Ruth Watson

INTEGRATED PLANNING DIVISION BOARD REPORT – FEBRUARY 2025 ACTIVITIES

- Enterprise Portfolio
    - 72 projects currently on the Alameda Alliance for Health (AAH) enterprise-wide portfolio
        - 30 Active projects (discovery, initiation, planning, execution, warranty)
        - 8 On Hold projects
        - 34 Requested and Approved Projects
        - 0 Completed Projects (Last month)



- D-SNP Portfolio
    - 112 projects currently on the Alameda Alliance for Health (AAH) enterprise-wide portfolio
        - 58 Active projects (discovery, initiation, planning, execution, warranty)
        - 50 Requested Projects
        - 4 On Hold



- D-SNP Key Initiatives and Dates
  - DMHC Material Modification Submission – MA Service Area Expansion – March 2024
  - DMHC Material Modification Submission – DSNP Product – August 2024
  - CMS Notice of Intent to Apply – November 2024
  - CMS Application Submission including MOC, Provider Network Adequacy & DMHC Approval – February 2025
  - CMS Formulary & Bid Submission (Benefit Determination) – June 2025
  - CMS SMAC Submission – July 7th, 2025
  - Rebate Allocation with CMS and Health Plan – July / August 2025
  - Annual Enrollment Period (AEP) – October thru December 2025
  - IT System Readiness – December 15th,2025
  - Open Enrollment Period (OEP) Begins – January 1st, 2026
- D-SNP Activities – January 2025
  - Provider Services & Contracting
    - Provider Contracting
      - LOI Conversion Project with outreach list has been assigned to our Contractor and she has started outreach to convert 116 LOIs to full amendments
        - There are 2 Inpatient Psychiatric Centers that have signed LOIs that are being worked by internal staff
      - After passing CMS adequacy in the Q1 February 2025 submission, we are now refocusing our efforts to drill down on the remaining 9 specialties that need to be brought to 90% adequacy by July 2025:
        - Gastroenterology
        - Urology
        - Acute Inpatient Hospitals
        - Critical Care Services - ICUs

                - Surgical Services (Outpatient or ASC)
                - Physical Therapy
                - Occupational Therapy
                - Speech Therapy
                - Inpatient Psychiatric Facility Services
            - We are currently pursuing an agreement with a large medical group that would cover a number of professional services.
        - Provider Rates and Reimbursement
            - Work continued with Milliman on the development of Capitation Rates and Rates Analysis
- Product
    - Submitted CMS Application via HPMS on February 12th, 2025
        - Submission included Part C (MA), Part D, and SNP Attestations and Supporting Documentation, Model of Care (MOC), Model of Care (MOC) Matrix, and Provider Network Adequacy
    - Completed Model of Care (MOC), California Specific MOC Matrix, and Health Risk Assessment (HRA) submissions to DHCS
    - CMS Bid Submission
        - Continued benefit structure design discussions with Milliman
    - Continued integrated member materials requirements development for Evidence of Coverage (EOC), Summary of Benefits (SOB), and Member Letters.
- Sales
    - Continued Sales System, Hearing, and Flex Card implementation planning with Nations CRM
    - Finalized Enrollment Data file (OEC+) requirements with HEALTHsuite vendor (RAM)
    - Confirmed October 1st, 2025 go live
- Vendor Management
    - Continued engagement with the following vendors to support Supplemental Benefit Offering(s):
        - Dental – in Pre-Del / Contracting
        - Vision – in Pre-Del / Contracting
        - Hearing – in Pre-Del / Contracting / Project Kickoff
        - Flex Card – in Pre-Del / Contracting / Project Kickoff
        - MTM – Contracted with Outcomes MTM
        - HRA – scoring in process
- Quality
    - Model of Care
        - MOC document and Matrixes submitted on February 12th, 2025, with application to CMS and DHCS.
            - 4/14/25 Scoring results are uploaded by CMS to HPMs
            - 4/17/25 Cure Technical Assistance Call (CMS)

        - DHCS is currently reviewing MOC submissions. No feedback or requests for additional information received.
    - Quality Program
        - Quality Program Description draft edits for DSNP completed.
        - Policy owners identified new and existing policies that will require edits
    - Policy revisions are underway
    - Future state PQI workflow draft has been completed, and requirements have been identified
    - Care Services (HCS) and Behavioral Health (BH)
        - Continuing policy development and revisions (130 policies)
        - Redlining UM and CM Program Descriptions for DSNP elements
        - DSNP Prior Authorization Forms drafts are complete and approved
        - HRA draft was submitted to DHCS with application
        - Continuing to finalize future State DSNP CM Global Workflow draft – Outlining process flows for new DSNP components to include Face-to-Face visit, Palliative Care Program, and Dementia Care Program
        - Continuing to define structure for California Integrated Care Management (CICM) to include new requirements outlined in the CY2026 Program Guide
        - Working with Provider Network to establish network of CBO's for CICM
        - Review and edits of existing CM and UM artifacts including assessments and notes to identify needs BH UM Future State (DSNP) Business Process Documentation in progress – Defining program model and IT needs as this will be a new process for DSNP
        - BH CM – Continuing to document proposed DSNP CM program structure. Beginning initial discussion of CBO integrations for BH CM Programs
        - BH programs policy and procedure development and revisions underway
        - I Edit made to DSNP Member and Provider letters for DSNP additional letters created to support CMS and DHCS requirements
        - 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
- Finance
    - Continued Finance policy review for approval at the AOC on April 16th, 2025

- Completed the following Finance training
    - Bid 101
    - Revenue and Medical Expense
- Finance Training scheduled for March 2025
    - Admin Expense / Regulatory / Budgeting and Forecasting

- 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
    - Completed process flow development supporting enterprise HPMS access requests
    - Continued Compliance policy review for approval at AOC in August 2025
- Enrollment and Eligibility
    - Decision to use HEALTHsuite to support generation of the member enrollment and disenrollment letters confirmed.
    - Discussions with RAM (HEALTHsuite) and KP (AAH Print Vendor) on the management of member enrollment and disenrollment letters.
    - Pharmacy
        - Pre-delegation audit for MTM is completed.
        - PBM and MTM contracting negotiations are completed.
        - 11 P&P reviewed and approved by P&T committee. 4 P&Ps are on the pipeline for review and approval in the next upcoming P&T committee session. Reconciliation of remaining P&Ps are actively being conducted by Rebellis.
        - Members who enroll in Part C D-SNP Plan will automatically be enrolled in Part D
        - AAH will delegate Part D appeals to PerformRx (PBM) and AAH will own Part D grievances
- Operations (Claims / Member Services / Mailroom / IVR)
    - Continue development of Claims, Member Services, Mailroom, and IVR business process and requirements
- IT
    - TruCare: 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.
    - HEALTHsuite: Workstream sessions are in progress. RAM provided with 4 options for Plan Structure. Leadership engaged to decide on the best option for AAH. Project Charter approved by Executive Sponsor (Ruth). High and Medium priority Enrollment model letters submitted. Engaging KP and Nations to determine project plan dependencies.

- QualitySuite: Upgrade planned during weekend of March 22nd. Grievances and Appeals (G&A) – requirements complete. Appeals requirements will be sent out for approval. Appeals reporting requirements in progress.

- Policies / SOPs / KPIs
  - Continued policy review within all workstreams
  - Continued development of KPI strategy and tracking documents for all workstreams
- Stars
  - Phase 1 of Star strategy underway
    - Phase 1 is defined as HEDIS measures already supported under the Medi-Cal line of business and Operational measures that will impact Star ratings on day 1
    - Discovery of existing AAH initiatives from the Quality team is complete and moving to the next step of documentation of workflow processes to include the D-SNP population
    - Discovery of initiatives that target the Grievances & Appeals measures is complete. The G & A Workgroup is developing policies and procedures that will target the measures
    - Discovery of initiatives with Analytics, Member Services and Healthcare Services is scheduled for mid-March
  - Reviewing concurrent development of 4 foundational initiatives (as discovery allows)
    - TruCare Star gap integration
    - Pay-for-Performance and Pay-for-Reporting program
    - EMR Data feeds
    - Prospective Chart Review
- D-SNP Program Decisions Reviewed
  - Grievance & Appeals
  - Health Care Services
  - Existing UM Phone Lines and will internally triage the calls according to the various departments (IP, OP, LTC, BH). This is to avoid provider confusion and operational efficiency (staff and cross training). Operations
    - Provider Dispute Resolution (PDR) process will be owned and managed by Claims, not G&A
  - Product
    - Member data shared with NationsCRM will be filtered by AAH so only pertinent data will be shared
    - NationsCRM will conduct the first layer of eligibility verification, while HealthSuite will conduct the final eligibility check before enrollment files are sent to CMS

CalAIM Initiatives:

- 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 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, 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
- AAH/Roots JI Pilot Project:
    - Project closeout processes are in progress and expected to close the project on 12/6.
- 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
    - DHCS continues holding a series of meetings with Cohort participants; these include Onboarding Sessions for the LEAs as well as Technical Office Hours each Thursday of the month
        - The meetings held have been heavily focused on the LEA process
    - The Alliance will utilize Carelon as the Third-Party Administrator (TPA)
    - The Claims submission date has been extended from April 1st, 2024, to July 1st, 2024
        - It may not be true that all MCPs or LEAs have systems set up, however, LEAs may submit claims for up to 180 days from the date of service
        - Claims may be submitted retroactively back to July 1st, 2024, as long as they are submitted by end of the year
    - DHCS Health Plan Work Group (HPWG were to meet every week, Fridays between August and September 10-11am, however, most meetings were cancelled Q4 2024 but have since restarted
        - High Level Timeline provided by Carelon for Claims Processing without solid Go Live Date
            - MOU for Interim Model with AAH Stakeholder for review and feedback.

- Edits with questions were posed and submitted to LHPC 2/28.
- Due date for MOU submission is 3/14

Recruiting and Staffing

- Integrated Planning Open position(s):
  - Supervisor, Business Analyst - Active recruitment
  - Backfill Business Analyst – Integrated Planning – Candidate in background
  - Backfill Business Analyst – Integrated Planning – Position targeted to start March 3, 2025

Integrated Planning

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 and 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	February 2025
Incoming Calls (R/V)	18,201
Abandoned Rate (R/V)	4%
Answered Calls (R/V)	17,449
Average Speed to Answer (ASA)	00:12
Calls Answered in 30 Seconds (R/V)	95%
Average Talk Time (ATT)	07:30
Calls Answered in 10 minutes	100%
Outbound Calls	9,066

Top 5 Call Reasons (Medi-Cal and Group Care) February 2025
Eligibility/Enrollment
Change of PCP
Benefits
Grievances/Appeals
Provider Network Info

Top 3 Web-Based Request Reasons (Medi-Cal and Group Care) February 2025
Change PCP
ID Card Requests
Update Contact Info

MSBH	February 2025
Incoming Calls (R/V)	1,205
Abandoned Rate (R/V)	4%
Answered Calls (R/V)	1,152
Average Speed to Answer (ASA)	00:33
Calls Answered in 30 Seconds (R/V)	85%
Average Talk Time (ATT)	08:22
Calls Answered in 10 minutes	100%
Outbound Calls	1,240
Screenings Completed	115
ACBH Referrals	39
SUD referrals to Center Point	21

Claims Department
January 2025 Final and February 2025 Final

METRICS

Claims Compliance	Jan-25	Feb-25
90% of clean claims processed within 30 calendar days	90.1%	91.7%
95% of all claims processed within 45 working days	98.9%	94.9%
Claims Volume (Received)	**Jan-25**	**Feb-25**
Paper claims	37,398	34,889
EDI claims	302,362	304,951
Claim Volume Total	**339,760**	**339,840**
Percentage of Claims Volume by Submission Method	**Jan-25**	**Feb-25**
% Paper	11.01%	10.27%
% EDI	88.99%	89.73%
Claims Processed	**Jan-25**	**Feb-25**
HEALTHsuite Paid (original claims)	261,048	223,831
HEALTHsuite Denied (original claims)	84,279	75,164
HEALTHsuite Original Claims Sub-Total	**345,327**	**298,995**
HEALTHsuite Adjustments	31,665	4,835
HEALTHsuite Total	**376,992**	**303,830**
Claims Expense	**Jan-25**	**Feb-25**
Medical Claims Paid	$166,817,056	$124,917,616
Interest Paid	$98,259	$178,657
Auto Adjudication	**Jan-25**	**Feb-25**
Claims Auto Adjudicated	297,645	256,648
% Auto Adjudicated	86.2%	85.8%
Average Days from Receipt to Payment	**Jan-25**	**Feb-25**
HEALTHsuite	16	16
Pended Claim Age	**Jan-25**	**Feb-25**
0-30 calendar days	56,182	46,504
HEALTHsuite		
31-61 calendar days	37,974	37,124
HEALTHsuite		
Over 62 calendar days	15,275	32,723
HEALTHsuite		

*Pended claims over 31 days are high due to investigation of 3 providers for FWA

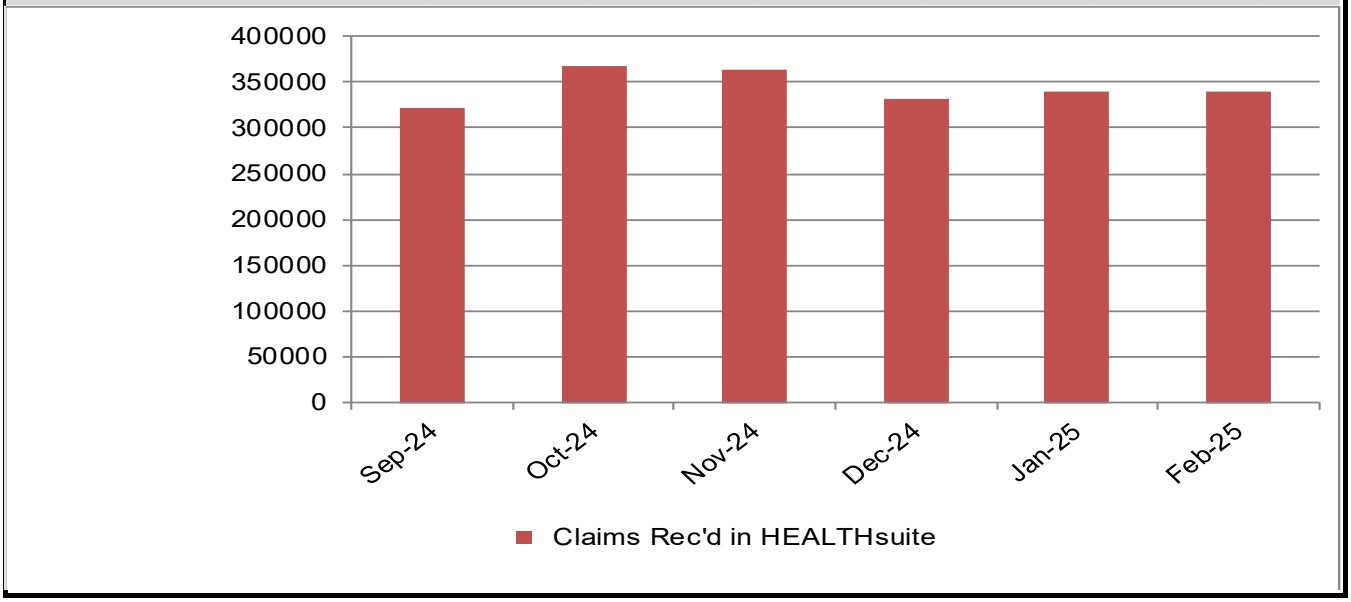
Overall Denial Rate	Jan-25	Feb-25
Claims denied in HEALTHsuite	84,279	75,164
% Denied	22.4%	24.7%

Claims Department
January 2025 Final and February 2025 Final

Feb-25 Top 5 HEALTHsuite Denial Reasons	% of all denials
Responsibility of Provider	27%
No Benefits Found For Dates of Service	12%
Non-Covered Benefit For This Plan	9%
Duplicate Claims	9%
Must Submit Paper Claim With Copy of Primary Payor EOB	7%
% Total of all denials	**64%**

Claims Received By Month

Run Date	10/1/2024	11/1/2024	12/1/2024	1/1/2025	2/1/2025	3/1/2025
Claims Received Through	**Sep-24**	**Oct-24**	**Nov-24**	**Dec-24**	**Jan-25**	**Feb-25**
aims Rec'd in HEALTHsuite	322,196	367,989	364,130	332,108	339,760	339,840



Claims Year Over Year Summary

Monthly Results	Regulatory Requirement	AAH Goal
Claims Compliance - comparing February 2025 to February 2024 as follows: 30 Days - 91.7% (2025) vs 91.4% (2024) 45 Days - 94.9% (2025) vs 99.9% (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 339,840 claims in February 2025 vs 266,339 in February 2024	N/A	N/A
EDI - the volume of EDI submissions was 85.8% which exceeded our normal month to month range of ~77% - 87%	N/A	N/A
Original Claims Processed - AAH processed 298,995 in February 2025 (19 working days) vs 269,278 in February 2024 (20 working days)	N/A	N/A
Medical Claims Expense - the amount of paid claims in February 2025 was $124,917,616 (4 check runs) vs $113,271,742 in February 2024 (4 check runs)	N/A	N/A
Interest Expense - the amount of interest paid in February 2025 was $178,657 vs $115,387 in February 2024	N/A	< $496,000 per fiscal year or $30,000 per month
Auto Adjudication - the AAH rate in February 2025 was 85.8% vs 81.0% in February 2024	N/A	85% or higher
Average Days from Receipt to Payment - the average # of days from receipt to payment in February 2025 was 16 days vs 15 days in February 2024	N/A	<= 25 days
Pended Claim Age - comparing February 2025 to February 2024 as follows: 0-30 calendar days - 46,504 (2025) vs 30,078 (2024) 31-61 calendar days - 37,124 (2025) vs 208 (2024) Over 62 calendar days - 32,723 (2025) vs 27 (2024) *Pended claims over 31 days are high due to 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 February 2025 to February 2024	N/A	N/A

Provider Relations Dashboard February 2025

Alliance Provider Relations Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Incoming Calls (PR)	10977	8885										
Abandoned Calls	3600	1133										
Answered Calls (PR)	7377	7752										
Recordings/Voicemails	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Incoming Calls (R/V)	2910	2140										
Abandoned Calls (R/V)												
Answered Calls (R/V)	2910	2140										
Outbound Calls	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Outbound Calls	868	1162										
N/A												
Outbound Calls	868	1162										
Totals	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Total Incoming, R/V, Outbound Calls	14755	12187										
Abandoned Calls	3600	1133										
Total Answered Incoming, R/V, Outbound Calls	11155	11054										

Provider Relations Dashboard February 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%										
Benefits	5.1%	3.7%										
Claims Inquiry	39.4%	43.9%										
Change of PCP	2.5%	2.7%										
Check Tracer	0.7%	0.6%										
Complaint/Grievance (includes PDR's)	5.8%	6.7%										
Contracts/Credentialing	0.8%	0.8%										
Demographic Change	0.0%	0.0%										
Eligibility - Call from Provider	21.0%	17.4%										
Exempt Grievance/ G&A	0.0%	0.1%										
General Inquiry/Non member	0.0%	0.0%										
Health Education	0.0%	0.0%										
Intrepreter Services Request	0.5%	0.5%										
Provider Portal Assistance	3.4%	3.2%										
Pharmacy	0.1%	0.2%										
Prop 56	0.1%	0.0%										
Provider Network Info	0.0%	0.0%										
Transportation Services	0.0%	0.2%										
Transferred Call	0.0%	0.0%										
All Other Calls	15.5%	14.4%										
TOTAL	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										
Contracting/Credentialing	29	41										
Drop-ins	127	83										
JOM's	2	2										
New Provider Orientation	100	134										
Quarterly Visits	0	0										
UM Issues	0	0										
Total Field Visits	286	332	0	0	0	0	0	0	0	0	0	0

ALLIANCE NETWORK SUMMARY, CURRENTLY CREDENTIALED PRACTITIONERS - FEBRUARY 2025						
Practitioners		PCP 392	SPEC 760	AHP 647	BH/ABA 2,677	PCP/SPEC 13
Direct Network vs Delegated Network Breakdown			AAH 3,241	AHS 298	CHCN 612	COMBINATION OF GROUPS 338
Facilities	433					

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	87	2	Y	Y	Y
Recred Files in Process	38	0	Y	Y	Y
Expirables updated **Insurance, License, DEA, Board Certifications**					Y
Files currently in process	**125**				
		*** 25 business days = 35 calendar days**			

February 2025 Peer Review and Credentialing Committee Approvals	
Initial Credentialing	**Number**
PCP	5
SPEC	5
ANCILLARY	6
MIDLEVEL/AHP	6
BH/ABA	98
Sub-total	**120**
Recredentialing	
PCP	13
SPEC	9
ANCILLARY	0
MIDLEVEL/AHP	8
Sub-total	**30**
TOTAL	**150**

February 2025 Facility Approvals	
Initial Credentialing	3
Recredentialing	6
Sub-total	**9**
Facility Files in Process	**45**

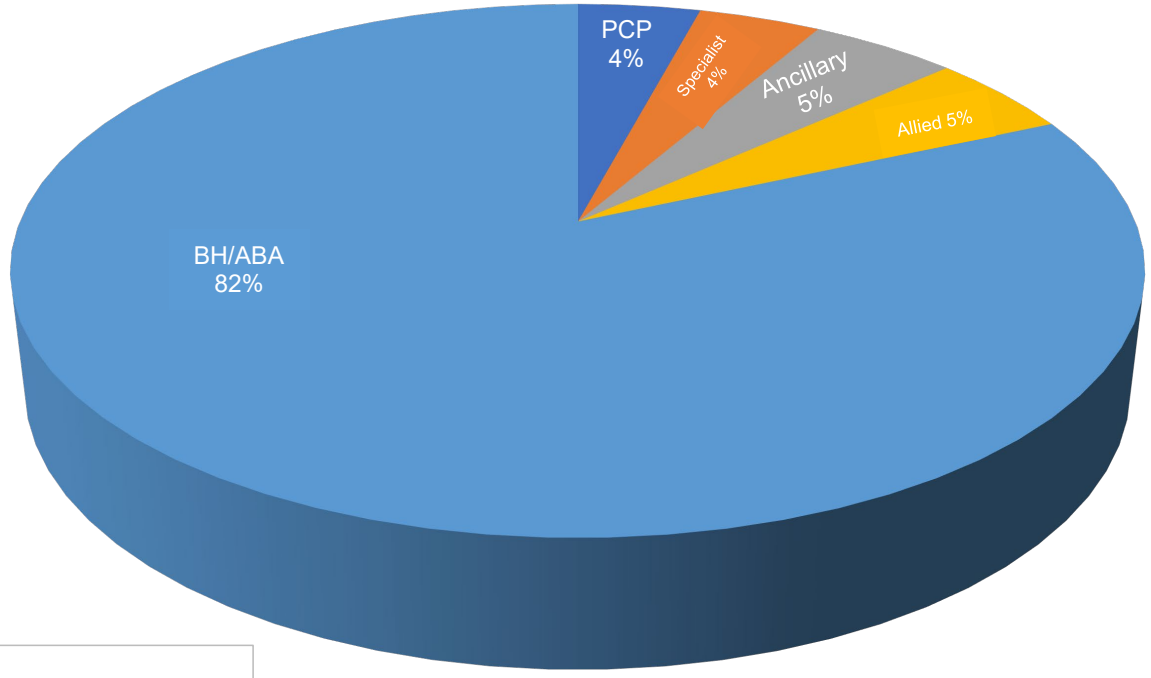
February 2025 Employee Metrics (6 FTEs)	**Goal**		**Met (Y/N)**
File Processing	Timely processing within 3 days of receipt		Y
Credentialing Accuracy	<3% error rate		Y
DHCS, DMHC, CMS, NCQA Compliant	98%		Y
MBC Monitoring	Timely processing within 3 days of receipt		Y

LAST NAME	FIRST NAME	CATEGORY	INITIAL / RE-CRED	CRED DATE
Abrazado	Berlinda	BH-Telehealth	INITIAL	2/18/2025
Acklin	Rihana	BH-Telehealth	INITIAL	2/18/2025
Aguilar	Robert	BH-Telehealth	INITIAL	2/18/2025
Albuquerque	Anna	BH	INITIAL	2/18/2025
Arballo	Elizabeth	BH-Telehealth	INITIAL	2/18/2025
Asrani	Hiya	Primary Care Physician	INITIAL	2/18/2025
Bachu	Meghana	Allied Health	INITIAL	2/18/2025
Banyas	Carol	BH	INITIAL	2/18/2025
Bergman	Ronnie	BH-Telehealth	INITIAL	2/18/2025
Berg-Martinez	Rachael	BH-Telehealth	INITIAL	2/18/2025
Blalack	Carly	BH-Telehealth	INITIAL	2/18/2025
Brody	Helen	BH	INITIAL	2/18/2025
Brooks	Tamra	Ancillary	INITIAL	2/18/2025
Brosof	Leigh	BH	INITIAL	2/18/2025
Burgers	Crystal	BH	INITIAL	2/18/2025
Carr	Candice	BH	INITIAL	2/18/2025
Chavez	Antuanete	ABA	INITIAL	2/18/2025
Cheifetz	Karrin	Ancillary	INITIAL	2/18/2025
Chua	Lauren	BH-Telehealth	INITIAL	2/18/2025
Corona	Marrisa	BH	INITIAL	2/18/2025
Corritore	Carly	BH-Telehealth	INITIAL	2/18/2025
Curley	Erin	ABA	INITIAL	2/18/2025
Davda	Rajesh	Specialist	INITIAL	2/18/2025
Davis	Helen	BH-Telehealth	INITIAL	2/18/2025
De La Cruz	Caroline	BH-Telehealth	INITIAL	2/18/2025
De la Pena	Antonio	ABA-Telehealth	INITIAL	2/18/2025
Delano	Christina	BH-Telehealth	INITIAL	2/18/2025
Der Sarkissian	Alissa	BH	INITIAL	2/18/2025
Dib	Dina	ABA-Telehealth	INITIAL	2/18/2025
Dickerson	Cameda	BH-Telehealth	INITIAL	2/18/2025
Douglass	Barbara Jean	BH	INITIAL	2/18/2025
East	Tracy	BH-Telehealth	INITIAL	2/18/2025
Elzie	Jordan	BH	INITIAL	2/18/2025
Evans	Deidre	ABA-Telehealth	INITIAL	2/18/2025
Fahr	Alicia	BH-Telehealth	INITIAL	2/18/2025
Garfield	Jennifer	ABA-Telehealth	INITIAL	2/18/2025
Gayle	Michelle	BH	INITIAL	2/18/2025
Genone	Sophia	BH-Telehealth	INITIAL	2/18/2025
Gereis	Angela	BH	INITIAL	2/18/2025
Gerenraich	Andrew	Specialist	INITIAL	2/18/2025
Gonzalez	Donnalyn	ABA-Telehealth	INITIAL	2/18/2025
Gonzalez Romero	Yarixa	ABA-Telehealth	INITIAL	2/18/2025
Gutierrez	Diane	BH-Telehealth	INITIAL	2/18/2025
Hartley	Zamira	ABA-Telehealth	INITIAL	2/18/2025
Hastie	Jordan	Specialist	INITIAL	2/18/2025
Ho	Jennifer	BH	INITIAL	2/18/2025
Honath	Casey	Ancillary	INITIAL	2/18/2025
Hua	Sarah	BH	INITIAL	2/18/2025
Jackson	April	Ancillary	INITIAL	2/18/2025
Javid	Athiya	Specialist	INITIAL	2/18/2025
Kangas	Kristi	BH-Telehealth	INITIAL	2/18/2025
Katsivas	Theodoros	Primary Care Physician	INITIAL	2/18/2025
Kinder	Shelly	BH	INITIAL	2/18/2025
Kolovos	Valorie	Allied Health	INITIAL	2/18/2025
Krage	Amy	ABA-Telehealth	INITIAL	2/18/2025
Lakshumanan	Chitra	Ancillary	INITIAL	2/18/2025

LAST NAME	FIRST NAME	CATEGORY	INITIAL / RE-CRED	CRED DATE
Lal	Shevani	ABA	INITIAL	2/18/2025
Larrazabal Martinez	Luis	BH	INITIAL	2/18/2025
Lavian	Melody	BH	INITIAL	2/18/2025
Lopez	Maria Guadalupe	BH-Telehealth	INITIAL	2/18/2025
Lopez	Raul	ABA-Telehealth	INITIAL	2/18/2025
Luisa	Michelle	ABA-Telehealth	INITIAL	2/18/2025
Lund	Kate	BH	INITIAL	2/18/2025
Lynch	Xifeng	Ancillary	INITIAL	2/18/2025
Maini	Ruby	Specialist	INITIAL	2/18/2025
Moreno Murillo	Miguel	ABA-Telehealth	INITIAL	2/18/2025
Mroskey	Mekenna	Allied Health	INITIAL	2/18/2025
Mulligan	Dana	ABA-Telehealth	INITIAL	2/18/2025
Murase	Satoko	BH-Telehealth	INITIAL	2/18/2025
Nguyen	Jacqueline	BH	INITIAL	2/18/2025
Oberling	Vivian	BH	INITIAL	2/18/2025
Ornelas	Sandra	Allied Health	INITIAL	2/18/2025
Ortiz	Angel	BH-Telehealth	INITIAL	2/18/2025
Pepiton	Morgan	BH-Telehealth	INITIAL	2/18/2025
Perez	Aida	BH-Telehealth	INITIAL	2/18/2025
Perez	Brittany	BH	INITIAL	2/18/2025
Pham	Mylan	ABA	INITIAL	2/18/2025
Pinzon	Susana	ABA-Telehealth	INITIAL	2/18/2025
Plancher	Daryn	BH-Telehealth	INITIAL	2/18/2025
Poli	Ron	BH-Telehealth	INITIAL	2/18/2025
Preciado	Daushae	BH	INITIAL	2/18/2025
Preston	Erisa	BH-Telehealth	INITIAL	2/18/2025
Pulley	Monica	BH-Telehealth	INITIAL	2/18/2025
Quick	Ellen	BH-Telehealth	INITIAL	2/18/2025
Rai	Manpreet	BH-Telehealth	INITIAL	2/18/2025
Rajagopal	Nalini	Primary Care Physician	INITIAL	2/18/2025
Ramos	Audrey	BH-Telehealth	INITIAL	2/18/2025
Rios	Martha	BH-Telehealth	INITIAL	2/18/2025
Rivard	Serena	ABA-Telehealth	INITIAL	2/18/2025
Rivera	Daniel	ABA-Telehealth	INITIAL	2/18/2025
Robbins	Ayaka	BH-Telehealth	INITIAL	2/18/2025
Rodriguez	Maritrini	BH	INITIAL	2/18/2025
Rodriguez	Summer	ABA-Telehealth	INITIAL	2/18/2025
Romo	Fernie	ABA-Telehealth	INITIAL	2/18/2025
Salera	Kristine	BH	INITIAL	2/18/2025
Sanchez	Saul	ABA	INITIAL	2/18/2025
Santiago	Roberto	BH	INITIAL	2/18/2025
Saverino	Mark	BH-Telehealth	INITIAL	2/18/2025
Schauer	Kate	BH	INITIAL	2/18/2025
Selman	Amanda	BH-Telehealth	INITIAL	2/18/2025
Sepulveda	Linda	BH	INITIAL	2/18/2025
Shaboti	Nadia	BH-Telehealth	INITIAL	2/18/2025
Smartt	Ashley	BH	INITIAL	2/18/2025
Smith	Jasmin	BH-Telehealth	INITIAL	2/18/2025
Stanton	Kathleen	BH	INITIAL	2/18/2025
Stern	Nathan	Primary Care Physician	INITIAL	2/18/2025
Storlie	Karen	Allied Health	INITIAL	2/18/2025
Strickland	Holly	BH	INITIAL	2/18/2025
Tatapudy	Meera	Primary Care Physician	INITIAL	2/18/2025
Tomas	Joanna	Allied Health	INITIAL	2/18/2025
Tong	Lindsey	BH-Telehealth	INITIAL	2/18/2025
Vargas-Dominguez	Marisol	BH-Telehealth	INITIAL	2/18/2025
Waters-Roman	Debra	BH-Telehealth	INITIAL	2/18/2025

LAST NAME	FIRST NAME	CATEGORY	INITIAL / RE-CRED	CRED DATE
Weiser	Lee	BH-Telehealth	INITIAL	2/18/2025
Wertheimer	Beverly	BH	INITIAL	2/18/2025
White	Tracie	BH	INITIAL	2/18/2025
Whitmore	Alina	BH	INITIAL	2/18/2025
Yidi	Diana	BH-Telehealth	INITIAL	2/18/2025
Zarrabi	Maryam	BH-Telehealth	INITIAL	2/18/2025
Zolnierek	Gina	BH	INITIAL	2/18/2025
Aggarwal	Sonal	Primary Care Physician	RE-CRED	2/18/2025
Alvarez-Nutting	Mary	Allied Health	RE-CRED	2/18/2025
Asfour	Fareed	Specialist	RE-CRED	2/18/2025
Bonnel	Galadriel	Allied Health	RE-CRED	2/18/2025
Chan	Edward	Primary Care Physician	RE-CRED	2/18/2025
Cheng	Joseph	Specialist	RE-CRED	2/18/2025
Davis-Marten	Rita	Allied Health	RE-CRED	2/18/2025
Eichel	James	Primary Care Physician	RE-CRED	2/18/2025
Eisenberg	Emily	Allied Health	RE-CRED	2/18/2025
Estakhri	Mary	Specialist	RE-CRED	2/18/2025
Flores	Joan	Allied Health	RE-CRED	2/18/2025
Gray	Gia	Primary Care Physician	RE-CRED	2/18/2025
Hanavan	Caitlin	Allied Health	RE-CRED	2/18/2025
Ibrahimi	Said	Specialist	RE-CRED	2/18/2025
Jones	Sharon	Primary Care Physician	RE-CRED	2/18/2025
Lin	Jennifer	Primary Care Physician	RE-CRED	2/18/2025
McEntee	Rebecca	Primary Care Physician	RE-CRED	2/18/2025
Motamed	Soheil	Specialist	RE-CRED	2/18/2025
Mouratoff	John	Specialist	RE-CRED	2/18/2025
Rowe	Aimee	Primary Care Physician	RE-CRED	2/18/2025
Sadeh	Sivan	Allied Health	RE-CRED	2/18/2025
Saxena	Meeta	Primary Care Physician	RE-CRED	2/18/2025
Sengupta	Geetika	Primary Care Physician	RE-CRED	2/18/2025
Stanten	Steven	Specialist	RE-CRED	2/18/2025
Sung	Michael	Specialist	RE-CRED	2/18/2025
Tang	Michele	Primary Care Physician	RE-CRED	2/18/2025
Taylor	Brittany	Allied Health	RE-CRED	2/18/2025
Valencia	Benito	Primary Care Physician	RE-CRED	2/18/2025
Wu	Monte	Specialist	RE-CRED	2/18/2025
Zhu	Li	Primary Care Physician	RE-CRED	2/18/2025

FEBRUARY PEER REVIEW AND CREDENTIALING
INITIAL APPROVALS BY SPECIALTY



PCP	5
SPECIALIST	5
ANCILLARY	6
ALLIED	6
BH/ABA	98
TOTAL	120

Provider Dispute Resolution
January 2025 and February 2025

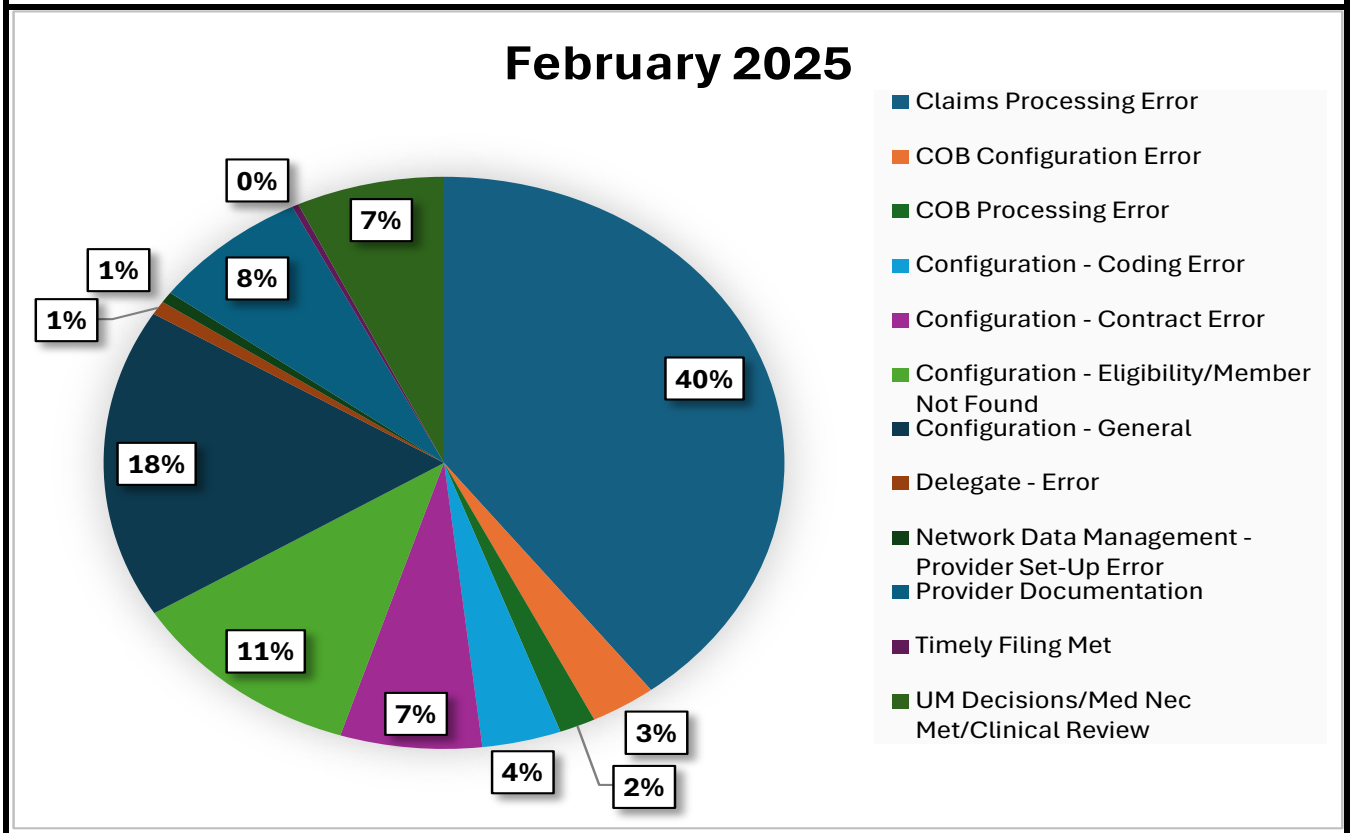
METRICS

PDR Compliance	Jan-25	Feb-25
# of PDRs Resolved	2,635	1,861
# Resolved Within 45 Working Days	2,632	1,854
% of PDRs Resolved Within 45 Working Days	99.9%	99.6%
PDRs Received	**Jan-25**	**Feb-25**
# of PDRs Received	2,843	2,551
PDR Volume Total	**2,843**	**2,551**
PDRs Resolved	**Jan-25**	**Feb-25**
# of PDRs Upheld	1,678	1,222
% of PDRs Upheld	64%	66%
# of PDRs Overturned	957	639
% of PDRs Overturned	36%	34%
Total # of PDRs Resolved	**2,635**	**1,861**
Average Turnaround Time	**Jan-25**	**Feb-25**
Average # of Days to Resolve PDRs	38	34
Oldest Resolved PDR in Days	242	286
Unresolved PDR Age	**Jan-25**	**Feb-25**
0-45 Working Days	3,377	3,466
Over 45 Working Days	0	0
Total # of Unresolved PDRs	**3,377**	**3,466**

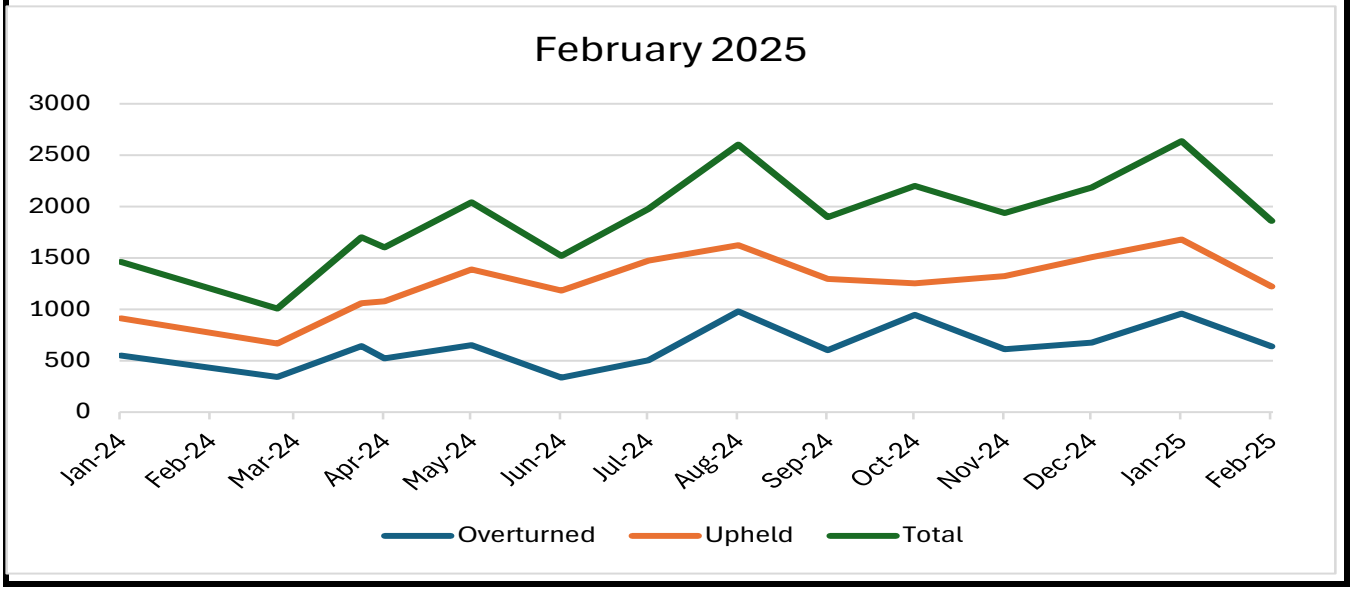
Provider Dispute Resolution
January 2025 and February 2025

Feb-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 - 1,861 in February 2025 vs 1,007 in February 2024	N/A	N/A
# of PDRs Received - 2,465 in February 2025 vs 2,064 in February 2024	N/A	N/A
# of PDRs Resolved within 45 working days - 1,854 in February 2025 vs 1,007 in February 2024	N/A	N/A
% of PDRs Resolved within 45 working days - 99.6% in February 2025 vs 100.0% in February 2024	95%	95%
Average # of Days to Resolve PDRs - 34 days in February 2025 vs 44 days in February 2024	N/A	30
Oldest Resolved PDR in Days - 286 days in February 2025 vs 44 days February 2024	N/A	N/A
# of PDRs Upheld - 1,222 in February 2025 vs 666 in February 2024	N/A	N/A
% of PDRs Upheld - 66% in February 2025 vs 66% in February 2024	N/A	> 75%
# of PDRs Overturned - 639 in February 2025 vs 341 in February 2024	N/A	N/A
% of PDRs Overturned - 34% in February 2025 vs 34% in February 2024	N/A	< 25%
PDR Overturn Reasons: Claims processing errors - 40% (2025) vs 32% (2024) Configuration errors - 40% (2025) vs 34% (2024) COB - 5% (2025) vs 22% (2024) Clinical Review/UM Decisions/Medical Necessity Met - 15% (2025) vs 11% (2024)	N/A	N/A

In February 2025, the Alliance conducted **868** member orientation outreach calls to new and non-utilizer members. This effort resulted in a **12%** participation rate, with **106** member orientations successfully completed. In addition, the Outreach team completed **45** Alliance website inquiries, **4** service requests, **1** community event, and **4** member education events. The Alliance reached a total of **577** people and spent a total of $0 on donations, fees, and/or sponsorships at the Tzu Chi Lunar New Year Celebration, Kid's Educational Expo, Rainbow Recreation Center Community Health & Resource Fair, Resource Fair Know Your Rights, and the McClymonds High School Black Health Fair.*

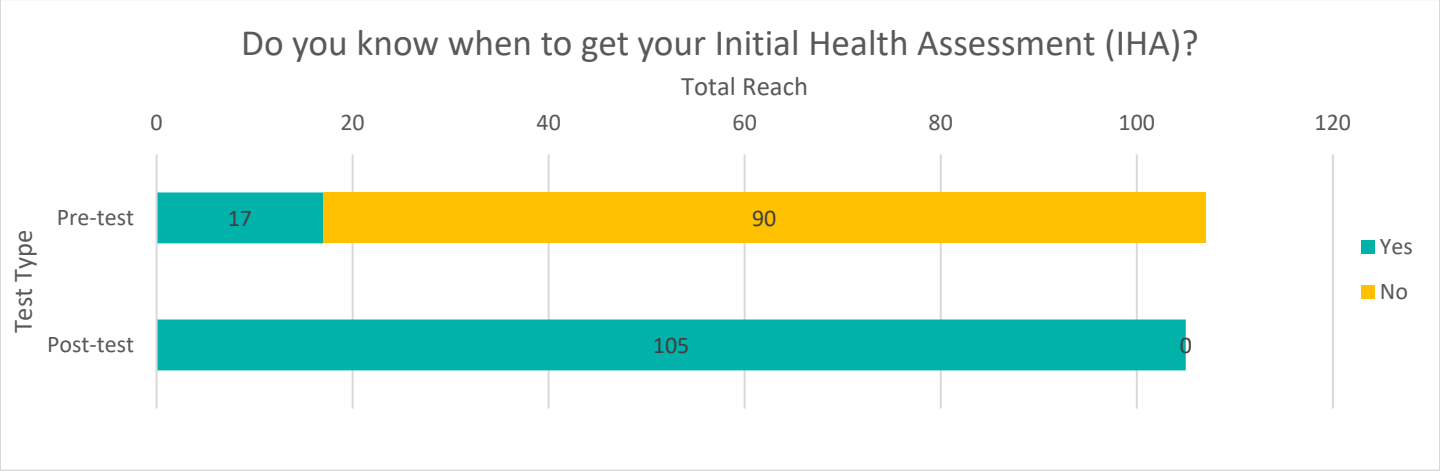
The Communications & Outreach Department began reporting the number of members reached during outreach activities in late February 2018. Since July 2018, **37,371** self-identified Alliance members have been reached during outreach activities.

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. By February 28, 2025, the Outreach Team made **46,765** orientation calls and conducted **9,468** orientations, achieving a **20.2%** 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. In 2019, the average monthly participation rate over a six-month period was **111** members. Between February 1, and February 28, 2025 (19 working days) – **106** members completed an MO by phone.

After completing the MO **100%** of members who completed the post-test survey in February 2025 reported knowing when to get their IHA, compared to only **15.9%** 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\Q3\2. February 2025**

FY 2023-2024 FEBRUARY 2024 TOTALS

- 2 COMMUNITY EVENTS
- 2 MEMBER EDUCATION EVENTS
- 142 MEMBER ORIENTATIONS
- 0 MEETINGS/ PRESENTATIONS/
- 0 COMMUNITY TRAINING
- 6 TOTAL INITIATED/ INVITED EVENTS
- **146 TOTAL COMPLETED EVENTS**

13 CITIES**

Alameda
Antioch
Berkeley
Castro Valley
Fremont
Hayward
Livermore
Oakland
Pittsburg
Pleasanton
San Leandro
San Lorenzo
Union City

- 335 TOTAL REACHED AT COMMUNITY EVENTS
- 560 TOTAL REACHED AT MEMBER EDUCATION EVENTS
- 142 TOTAL REACHED AT MEMBER ORIENTATIONS
- 0 TOTAL REACHED AT MEETINGS/PRESENTATIONS
- 0 TOTAL REACHED AT COMMUNITY TRAINING
- 586 MEMBERS REACHED AT ALL EVENTS
- **1037 TOTAL REACHED AT ALL EVENTS**

$312.10
TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

FY 2024-2025 FEBRUARY 2025 TOTALS

- 1 COMMUNITY EVENTS
- 4 MEMBER EDUCATION EVENTS
- 106 MEMBER ORIENTATIONS
- 0 MEETINGS/ PRESENTATIONS
- 0 COMMUNITY TRAINING
- 7 TOTAL INITIATED/ INVITED EVENTS
- 111 TOTAL COMPLETED **EVENTS**

14 CITIES**

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

- 309 TOTAL REACHED AT COMMUNITY EVENTS
- 268 TOTAL REACHED AT MEMBER EDUCATION EVENTS
- 106 TOTAL REACHED AT MEMBER ORIENTATIONS
- 0 TOTAL REACHED AT MEETINGS/PRESENTATIONS
- 0 COMMUNITY TRAINING
- 452 MEMBERS REACHED AT ALL EVENTS
- **683 TOTAL REACHED AT ALL EVENTS**

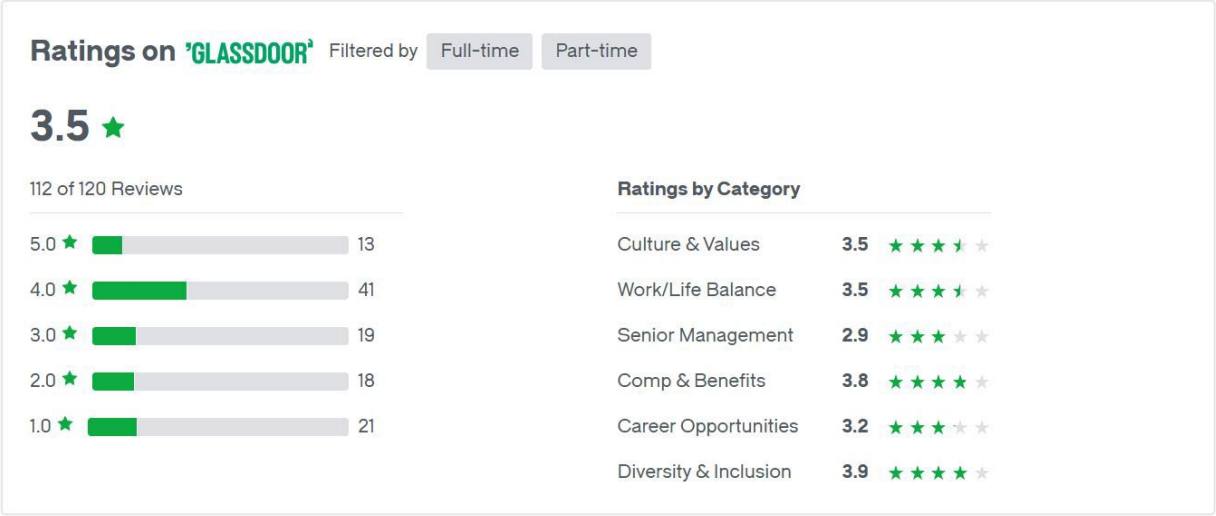
$0.00
TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

***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.*

The Alliance Communications and Outreach (C&O) Department created the social media and website activity (SM&WA) Report to provide a high-level overview of stakeholder engagement through various digital media platforms. Between **February 1, 2025**, and **February 28, 2025**:

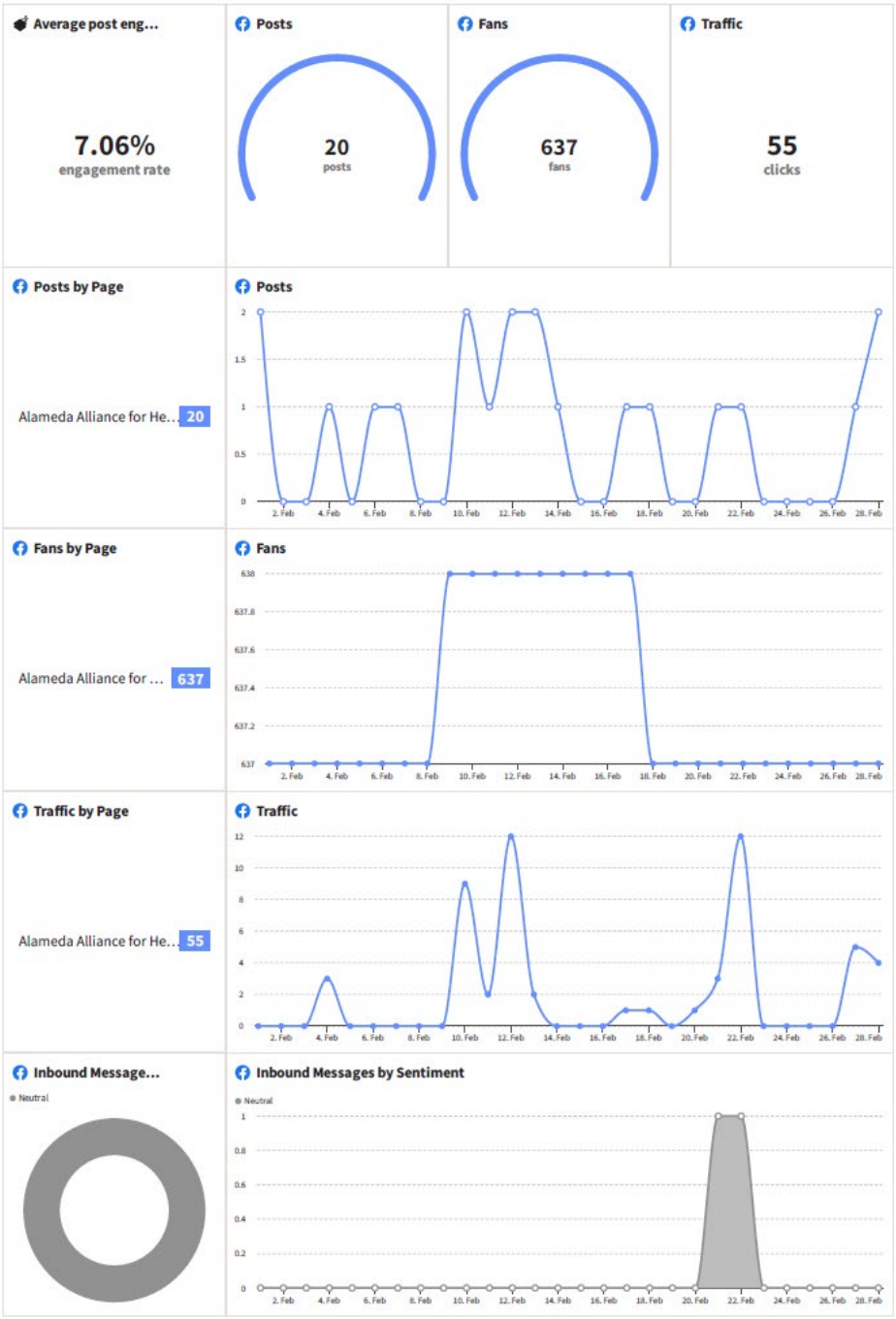
1. Alliance Website:
    - Received **24,000** unique visits
    - Received **20,000** new user visits
    - The top **10** website page visits were:
        i. Homepage
        ii. Provider Page
        iii. Find a Doctor
        iv. Benefits and Covered Services
        v. Members Medi-Cal
        vi. Careers
        vii. Contact Us
        viii. Members
        ix. Provider Portal
        x. Get a New ID Card
2. Facebook Page:
    - Maintained fans at **637**
    - Did not receive any reviews in **February 2025**
3. Glassdoor Page:
    - **3.5** out of a **5-star** overall rating
    - Did not receive any reviews in **February 2025**
4. Instagram Page:
    - Page debuted **June 10, 2021**
    - Increased in followers from **598** to **600**
5. X (previously Twitter) Page:
    - Maintained followers at **359**
6. LinkedIn Page:
    - Increased followers from **6.1k to 6.3k**
    - Received **139-**page clicks
7. Yelp Page:
    - Page visits **98**
    - Appeared in Yelp searches **111** times
    - Received 2 (two) reviews in **February 2025**
8. Google Page:
    - **2,107** website clicks were made from the business profile
    - **1,546** calls made from the business profile
    - Received 1 (one) review in **February 2025**

GLASSDOOR OVERVIEW



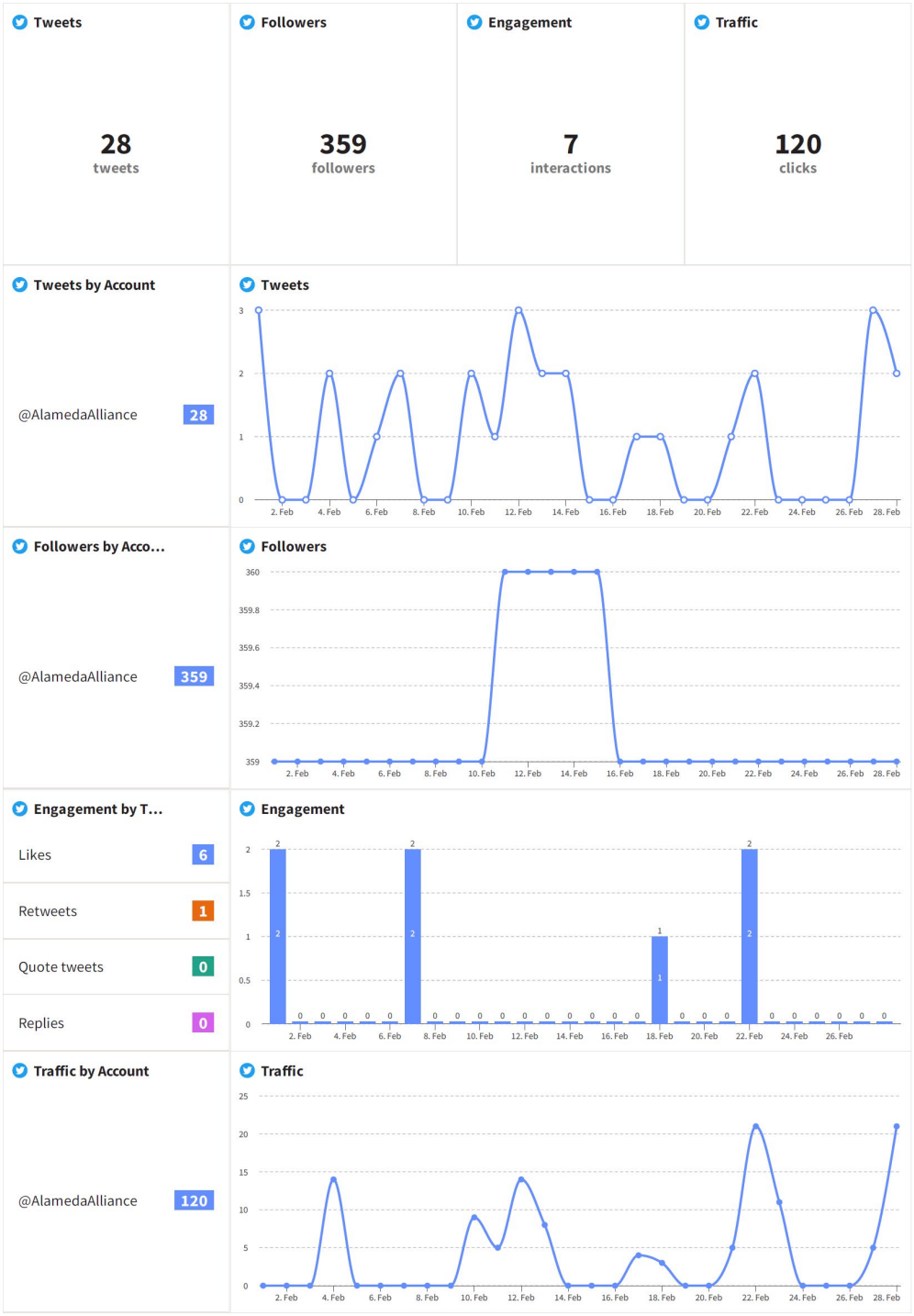
All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2024-2025\Q3\2. February 2025

FACEBOOK OVERVIEW



All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2024-2025\Q3\2. February 2025

X (previously TWITTER) OVERVIEW



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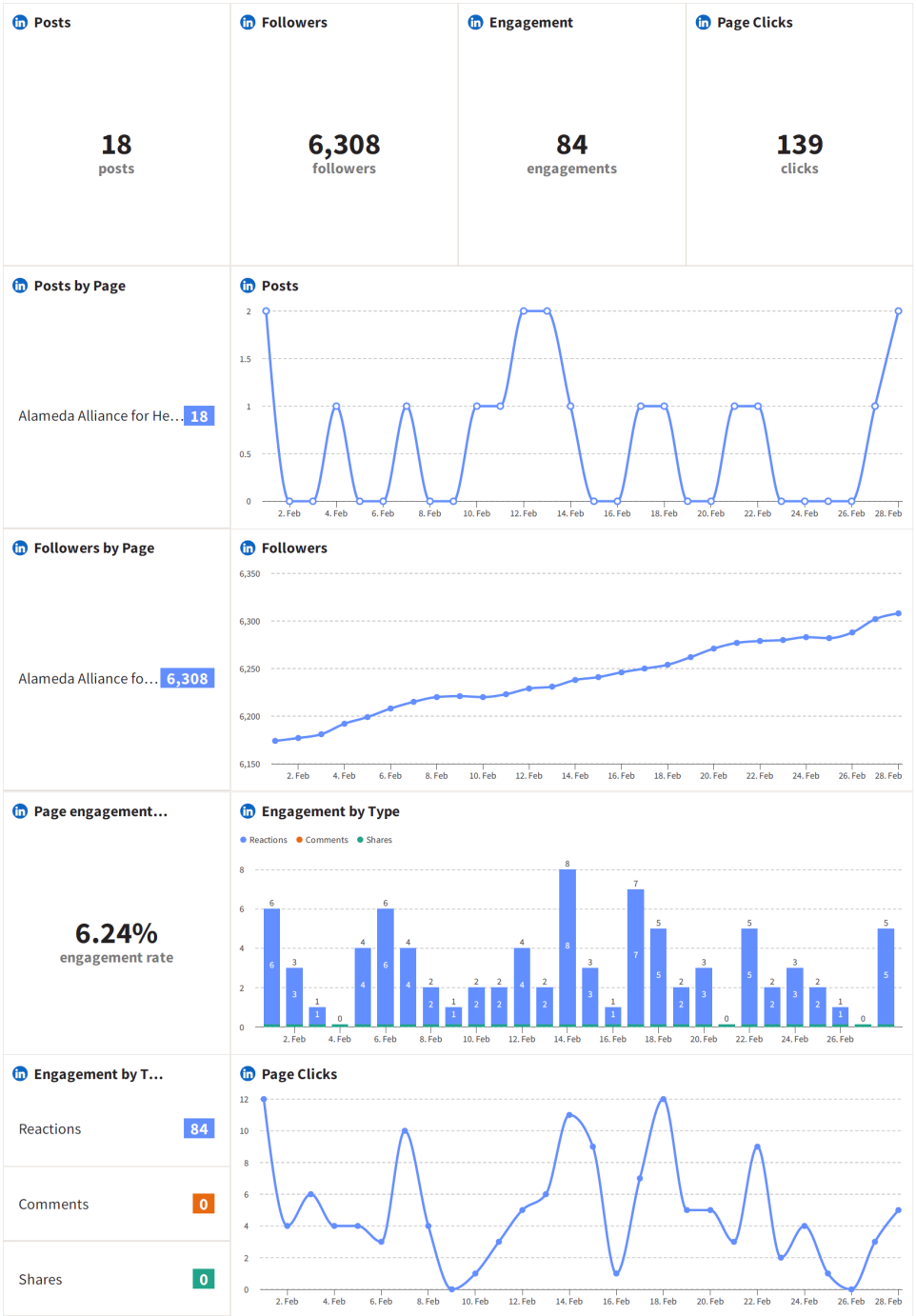
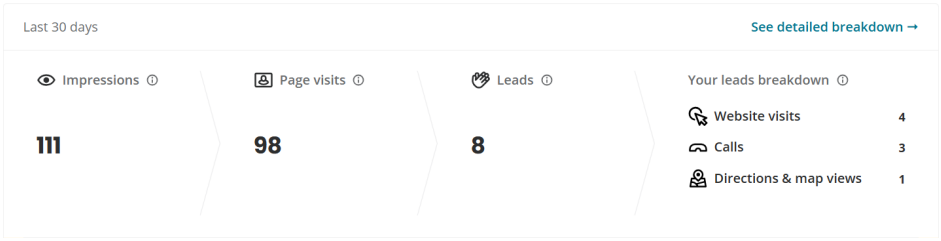
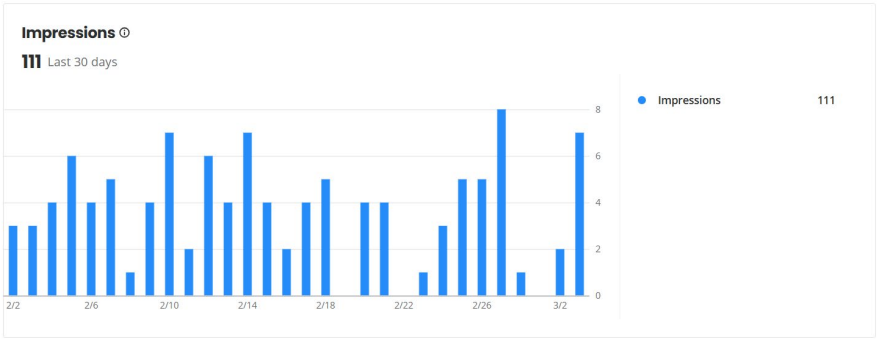
LINKEDIN OVERVIEW

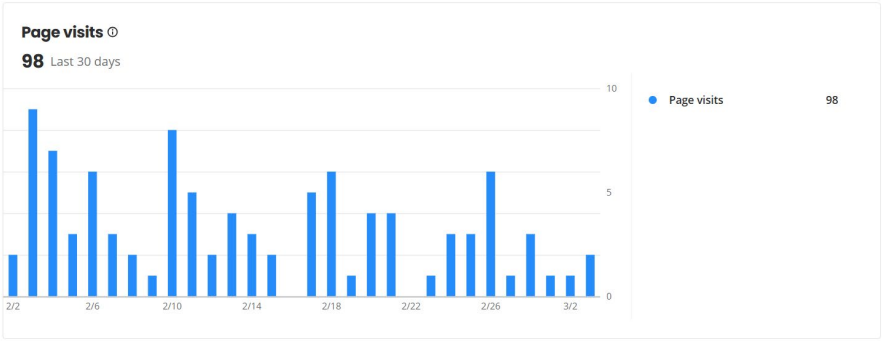


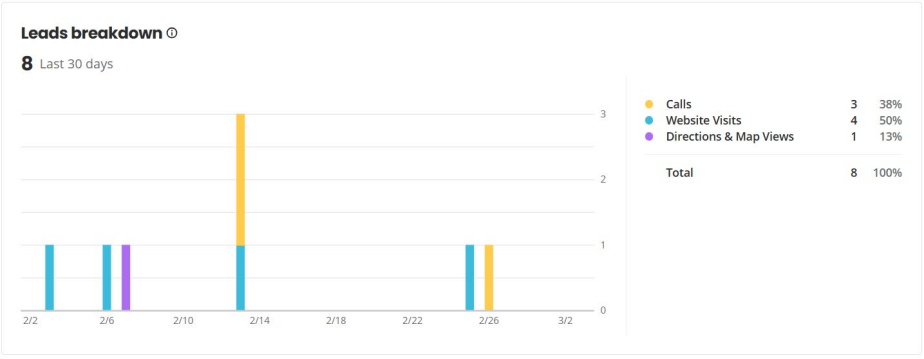
All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2024-2025\Q3\2. February 2025

YELP OVERVIEW









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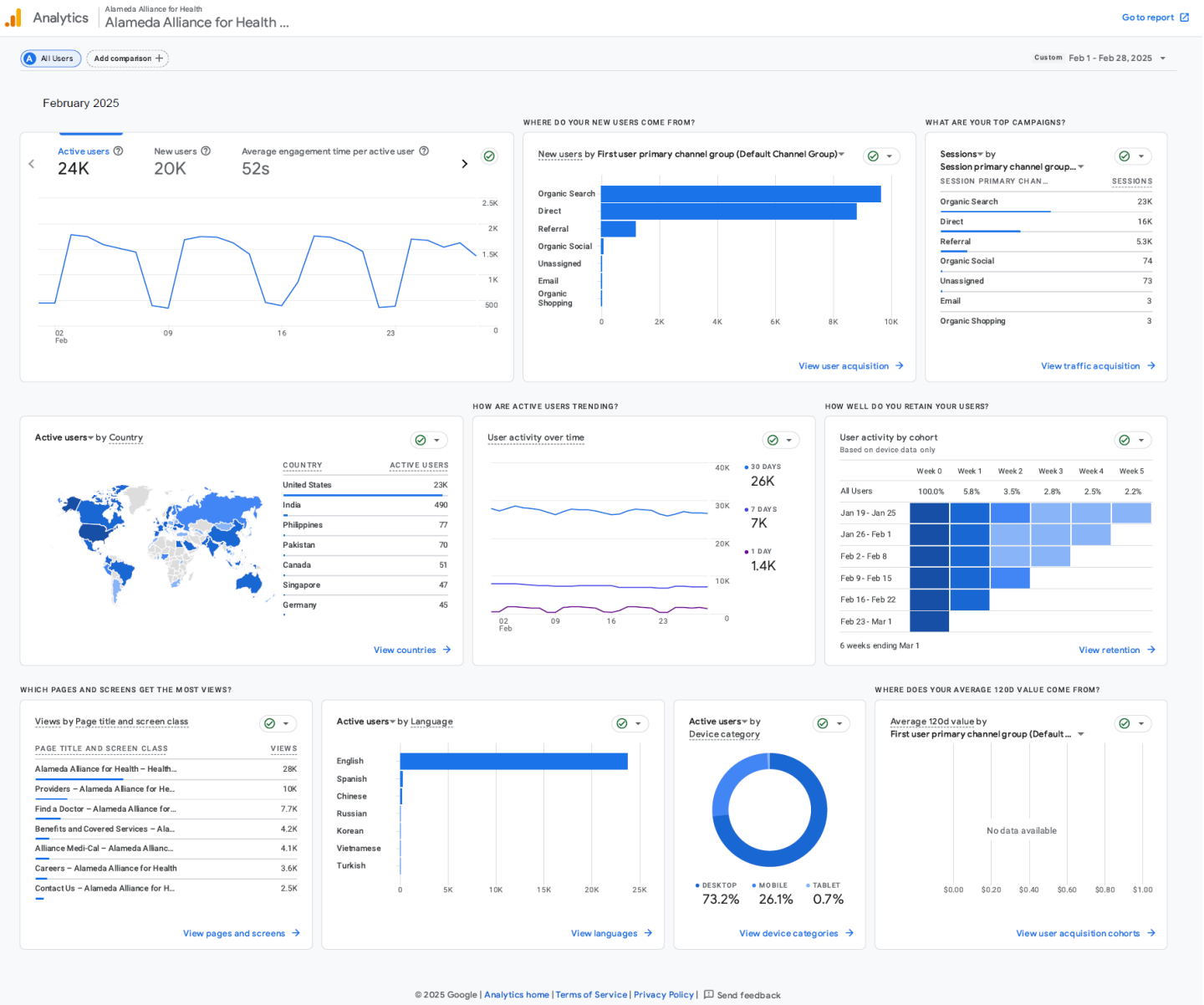
ALLIANCE WEBSITE OVERVIEW:



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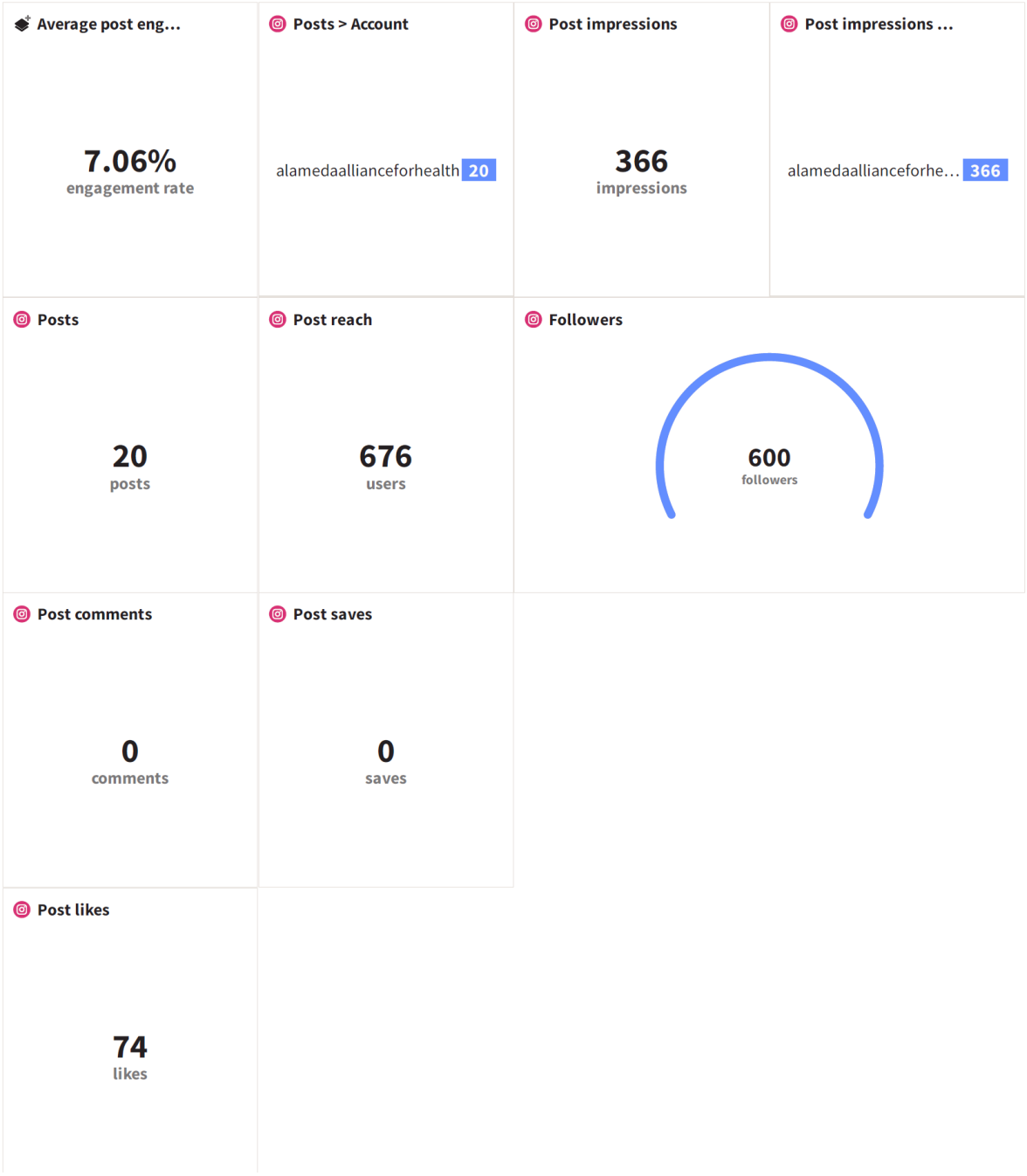
INSTAGRAM OVERVIEW:



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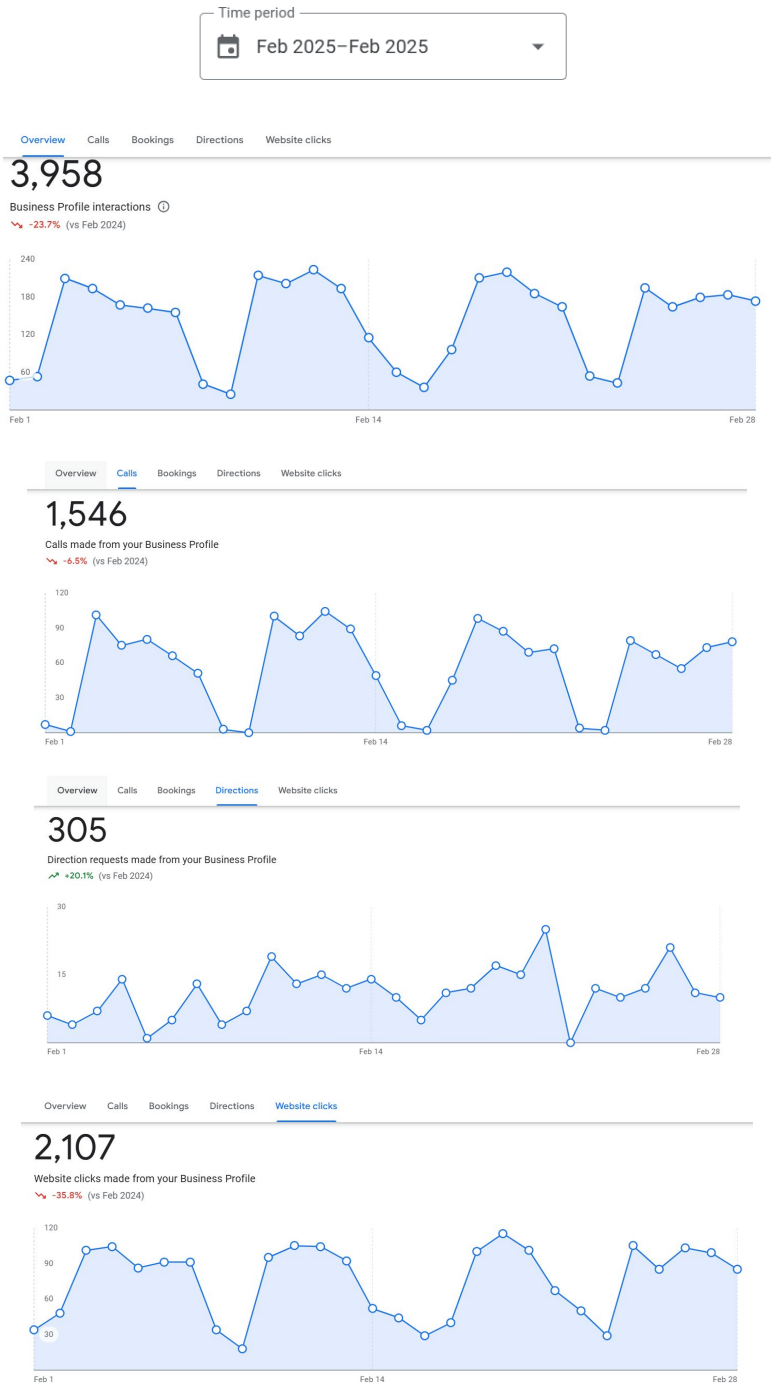
GOOGLE OVERVIEW:



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Compliance

Richard Golfin III

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

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

Date: **March 14th, 2025**

Subject: **Compliance Division Report**

Compliance Audit Updates

- 2025 Department of Managed Health Care (DMHC) and Department of Health Care Services (DHCS) Routine Full Medical Survey (Joint Audit)

    - On October 3rd, 2024, the Plan received notification from DMHC stating it will conduct a joint routine survey with the DHCS beginning March 3rd, 2025. The lookback period is from October 1st, 2022, through September 30th, 2024. On December 23rd, 2024, the Plan received DMHC case file selections. Seven hundred and seventy-three (773) cases were selected across the following areas:

        - Member Services,
        - Grievance & Appeals,
        - Utilization Management,
        - Pharmacy, Claims, and
        - Quality Improvement

      All Plan case files have been submitted as of January 17th, 2025. CHCN and CFMG case files have been submitted as of January 29th, 2025. Carelon's case files were submitted on February 4th, 2025. The audit will be held onsite March 3rd, 2025, through March 7th, 2025, with virtual follow-up meetings to continue through March 14th, 2025.

    - On December 16th, 2024, the Plan received notification from DHCS regarding the joint routine survey along with the Pre-Audit Request. The lookback period is from June 1st, 2024, through February 28th, 2025. The DHCS will be reviewing the following areas: Utilization Management, Case Management and Coordination of Care, and State Supported Services. The pre-audit materials have been submitted on January 19th, 2025. The department likewise requested supplemental information related to Access and Availability with a focus on transportation services. The materials were submitted timely on January 22nd, 2025.

- On January 28th, 2025, the Plan received an additional request from the DHCS for Post Stabilization Authorization information. The materials were submitted timely to the department on February 5th, 2025.

- As of February 24th, 2025, the Plan has received an additional 12 follow-up requests from DHCS and 32 follow-up requests from DMHC. Except for the last 22 requests from DMHC, which are due on February 27th, 2025, all other requests have been submitted.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. CAP updates are provided to the DHCS on the 15th of each month. The next CAP update is due on February 28th, 2025, and is on track. There is one (1) Access & Availability response that was not accepted by DHCS. The SMEs are working on an updated response.

- 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, one (1) has been accepted and eight (8) have been partially accepted. The Plan submitted the update for February ahead of schedule on February 4th, 2025. The next update is due on March 10th, 2025.

- 2024 Department of Health Care Services (DHCS) Facility Site Review (FSR) and Medical Record Review (MRR)

    - On February 10th, 2025, the Plan received notification from the Department of Health Care Services (DHCS) Managed Care Quality and Monitoring Division (MCQMD), Site Review Unit (SRU) stating the onsite Primary Care Provider Facility Site and Medical Record Reviews conducted from September 17th through September 19th, 2024, is now closed. On December 6th, 2024 and January 6th, 2025, the Plan provided DHCS with the providers' Corrective Action Plans (CAP), which addressed all findings in the report. All aspects of the CAP have been corrected, and the review is now considered closed.

Compliance Activity Updates

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

    - On February 12th, 2025, representatives from Compliance, Integrated Planning Division and the Executive Director of Medicare Programs met to

successfully submit the CMS Medicare Advantage Dual Eligible Special Needs Plan application via CMS' Health Plan Management System (HPMS).

- Department of Health Care Services (DHCS)
  - During the CMS application submission meeting held on February 12th, 2025, representatives from Compliance, Integrated Planning Division and the Executive Director of Medicare Programs also submitted the State Specific Model of Care Matrix and Health Risk Assessment to DHCS. The Plan is awaiting DHCS feedback.
- Department of Managed Health Care (DMHC) Medicare Filings – CY26 Medicare, 2024 EAE D-SNP Material Modification Filing (E-Filing *No. 20244060*):
  - DMHC is currently reviewing the Plan's responses to its January 7th comments. The Plan anticipates that DMHC will approve and close out this filing by March 6th, 2025.
- New Legislation
  - DMHC's annual Newly Enacted Statutes (APL 24-023) includes Seventeen newly enacted statutes that impact the Plan's Medi-Cal and/or Group Care lines of business. Compliance has begun partnering with impacted areas to identify implementation steps and submit an e-Filing with DMHC by March 21st. Compliance anticipates that the following will be most impactful on plan operations:
    - Effective January 1st, 2026, AB 3275 requires health plans to reimburse claims within 30 *calendar* days after receipt of claims. The current requirement is 45 *business* days. This change reduces the number of days within which health plans must process claims by approximately 50%.
    - Effective July 1st, 2025, SB 729 requires large group health plans (excluding Medi-Cal) to provide coverage for the diagnosis and treatment of infertility and fertility services. Except when a covered treatment may cause infertility, treatment of infertility is currently an excluded benefit.
- 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, eleven (61%) have either completed their training or submitted sufficient proof of equivalent outside training. One member (6%) has training in progress and six (33%) have not started. The Plan continues coordination with the Board Clerk and the Board Chair to improve Board training rates of compliance.
- Confidentiality Agreements

- As required by the Code of Conduct and Compliance Plan, all Board Members must sign Confidentiality Agreements. Of the eighteen Board Members, seventeen (94%) have signed.

Compliance

Supporting Documents

Q4 2024 - PRESENT APL IMPLEMENTATION TRACKING LIST						
#	Date Released	Regulatory Agency	APL #	APL Title	LOB	APL Purpose Summary
Q4 2024						
35	10/30/2024	DMHC	24-019	Amendments to Rule 1300.67.2.2 and the Incorporated Annual Network Submission Instruction Manual and Annual Network Report Forms for Reporting Year 2025	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC) issues this All-Plan Letter (APL) to inform health care service plans (health plans) of new amendments to 28 CCR § 1300.67.2.2 and the incorporated Annual Network Submission Instruction Manual and Annual Network Report Forms for the reporting year (RY) 2025 Annual Network Report submission.
36	10/31/2024	DHCS	18-022	Access Requirements for Freestanding Birth Centers and the Provision of Midwife Services (TECHNICAL CHANGE)	MEDI-CAL	The purpose of this All Plan Letter (APL) is to clarify the requirements for Medi-Cal managed care health plans (MCPs) regarding their responsibilities to provide members with access to freestanding birth centers (FBCs) as well as to services provided by Certified Nurse Midwives (CNMs) and Licensed Midwives (LMs).
37	11/3/2024	DHCS	23-024	Doula Services (TECHNICAL CHANGE)	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with guidance regarding the qualifications for providing doula services, effective for dates of service on or after January 1, 2023.
38	11/13/2024	DMHC	24-020	RY 2026/MY 2025 Provider Availability Survey Manual and Report Form Amendments	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) to provide notice to health care service plans (health plans) of amendments to Rule 1300.67.2.2 and the following reporting year (RY) 2026/measurement year (MY) 2025 Timely Access Compliance Report documents: Provider Appointment Availability Survey (PAAS) Manual, PAAS Report Forms and the Timely Access Submission Instruction Manual (TA Instruction Manual).
39	12/5/2024	DHCS	24-016	Diversity, Equity, and Inclusion Training Program Requirements	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with guidance regarding the Diversity, Equity, and Inclusion (DEI) training program requirements.
40	12/5/2024	DHCS	24-017	Transgender, Gender Diverse or Intersex Cultural Competency Training Program and Provider Directory Requirements	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with guidance regarding the transgender, gender diverse, intersex (TGI) cultural competency training program and Provider Directory changes required by Senate Bill (SB) 923 (Chapter 822, Statutes of 2022) for the purpose of providing trans-inclusive health care to MCP Members.
41	12/12/2024	DMHC	24-021	Notice of Amendments to Rules 1300.67.2.1, 1300.67.2 and Incorporated Documents – Network Adequacy Standards and Methodology for RY 2025	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) to notice amendments to 28 CCR § 1300.67.2.1, 28 CCR § 1300.67.2, and documents incorporated by reference. References to "Rule" refer to the California Code of Regulations (CCR), title 28. The amendments are noticed pursuant to Senate Bill (SB) 225 (Wiener, Chapter 601, Statutes of 2022).
42	12/13/2024	DHCS	24-018	Medical Loss Ratio Requirements For Subcontractors And Downstream Subcontractors	MEDI-CAL	The purpose of this All-Plan Letter (APL) is to provide guidance to Medi-Cal managed care plans (MCPs) on the Medical Loss Ratio (MLR) requirements set forth by the federal Centers for Medicare & Medicaid Services (CMS) in the California Advancing & Innovating Medi-Cal (CalAIM) Section 1915(b) waiver's Special Terms and Conditions (STCs) and pursuant to the MCPs' contractual requirements in Exhibit A, Attachment III, Provision 3.1.5(B)(31).
43	12/13/2024	DMHC	24-022	Children and Youth Behavioral Health Initiative, Certified Wellness Coaches	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC), together with the Department of Health Care Access and Information (HCAI), issues this All-Plan Letter (APL) 24-022 - Children and Youth Behavioral Health Initiative, Certified Wellness Coaches to provide health care service plans with information regarding the establishment of the state Wellness Coach certification program and encourage health plans to provide access to Wellness Coach services as a means of increasing behavioral health resources to health plan members.
44	12/20/2024	DMHC	24-023	Newly Enacted Statutes Impacting Health Plans (2024 Legislative Session)	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC) issues this All-Plan Letter (APL) 24-023, which outlines the newly enacted statutory requirements for health care service plans (plans) regulated by the Department of Managed Health Care (DMHC).
45	12/31/2024	DHCS	24-019	Minor Consent to Outpatient Mental Health Treatment or Counseling	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care plans (MCPs) regarding the provision of non-specialty mental health outpatient treatment or counseling services to minors as a result of Assembly Bill (AB) 665 (Chapter 338, Statutes of 2023)1 which amended Family Code (Fam. Code) section 6924.
Q1 2025						
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).

#	Date Released	Regulatory Agency	APL #	APL Title	LOB	APL Purpose Summary
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.

Health Care Services

Donna Carey, MD

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

From: **Dr. Donna Carey, Chief Medical Officer**

Date: **March 14th, 2025**

Subject: **Health Care Services Report**

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 99.6%, above goal
    - BH: overall 82%, below 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 January to February 2025.

Total Authorization Volume (Medical Services)			
Authorization Type	**December 2024**	**January 2025**	**February 2025**
Inpatient	3346	3,436	3,107
Outpatient	4,090	4,310	3,660
Long-Term Care	918	917	935
Total	**8,354**	**8,663**	**7,702**

***Source**: #02569_AuthTAT_Summary*

The following sections provide additional detail on utilization management trends in each department.

Utilization Management: Outpatient

- Anthem-transition authorization activity 1 yr. Post CoC is running between 7-10% of active authorizations daily.

- Foster care CoC cases are averaging 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 3,660 authorizations in the month of February.

- OP Turnaround times continue to exceed the benchmark of 95% with the average being 98% in the month of February.

- The top 5 categories remain Radiology, OP Rehab, TQ, Home Health and Outpatient facility.

Total Outpatient Authorization Volume			
Authorization Status	**December 2024**	**January 2025**	**February 2025**
Approvals	4,088	4,351	3,530
Partial Approvals	28	20	20
Denials	194	161	110
Total	**4,090**	**4,310**	**3,660**

***Source**: #02569_AuthTAT_Summary*

Outpatient Authorization Denial Rates			
Denial Rate Type	**December 2024**	**January 2025**	**February 2025**
Overall Denial Rate	**3.8%**	**3.5%**	**3.0%**
Denial Rate Excluding Partial Denials	**3.5%**	**3.1%**	**2.7%**
Partial Denial Rate	**0.3%**	**0.4%**	**0.2%**

***Source**: #03690_Executive_Dashboard*

Outpatient Turn Around Time Compliance			
Line of Business	**December 2024**	**January 2025**	**February 2025**
Overall	99%	100%	97.9%
Medi-Cal	99%	100%	99%
IHSS	100%	100%	95.7%
Benchmark	*95%*	*95%*	*95%*

***Source**: #02569_AuthTAT_Summary*

Utilization Management: Inpatient

- Total inpatient auth volume decreased from 3,436 authorizations processed in January 2025 to 3,107 in the month of February.

- Inpatient overall average LOS decreased from 5.9 in December to 5.4 in January. Similar pattern seen in both admits per thousand and days per thousand: 56.4 in December falling to 50.8 in January Days per thousand aligned with admits per 1,000 with decreasing from 331.5 in December to 274.1 in January. The trend is consistent among Child, Adult, ACA and SPD categories.

- IP overall denial rate was 1.7% in December, 0.7% in January, and 2.5% in February.

- IP Auth TAT compliance continues to meet or surpass 95% benchmark, with overall TAT of 97% in December, 96% in January and February.

- 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	**December 2024**	**January 2025**	**February 2025**
Approvals	3281	3412	3032
Partial Approvals	0	0	0
Denials	65	24	75
Total	**3346**	**3,436**	**3,107**

Source: #02569_AuthTAT_Summary

Inpatient Med-Surg Utilization			
Total All Aid Categories			
Actuals (excludes Maternity)			
Metric	**November 2024**	**December 2024**	**December 2024***
Authorized LOS	5.7	5.9	5.4
Admits/1,000	52.9	56.4	50.8
Days/1,000	302.5	331.5	274.1

Source: #01034_AuthUtilizationStatistics – *data only available through December 2024

Inpatient Authorization Denial Rates			
Denial Rate Type	**December 2024**	**January 2025**	**February 2025**
Full Denials Rate	1.2%	0.0%	2.5 %
Partial Denials	0.3%	0.7%	0%
All Types of Denials Rate	1.5%	0.7%	2.5%

Source: #01292_AllAuthDenialsRates

Inpatient Turn Around Time Compliance			
Line of Business	**December 2024**	**January 2025**	**February 2025**
Overall	96%	96%	95%
Medi-Cal	95%	95%	95%
IHSS	97%	100%	100%
Benchmark	*95%*	*95%*	*95%*

Source: #02569_AuthTAT_Summary

Utilization Management: Long-Term Care

- LTC census during February 2025 was 2,092 members. This is a decrease of 8.04% from January 2025.

- Month to Month, the admissions, days and readmissions are decreasing. From November to January the admissions decreased by 48.63%, the days decreased by 64.83% and the readmissions also decreased by 51.52%. Some of this could be due to a lag in claims data being available, but we are seeing a decrease overall.

Totals	November 2024	December 2024	January 2025*
Admissions	146	136	75
Days	1,197	760	421
Readmissions	33	36	16

Source: #14236_LTC_Dashboard - *data only available through February 2025

- 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 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 continues 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 increased in January, compared to October 2024 and about the same compared to December.

- Authorization processing turn-around time (TAT) did dip in December to 94%, but January and February are both at 99%, which is exceeding the threshold of 95%. We currently have a temporary nurse working to assist with the volume and are interviewing for a regular LTC Nurse position.

Total LTC Authorization Volume			
Authorization Status	**December 2024**	**January 2025**	**February 2025**
Approvals	863	881	905
Partial Approvals	0	0	0
Denials	36	36	30
Total	**918**	**917**	**935**

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	**December 2024**	**January 2025**	**February 2025**
Medi-Cal	**94%**	**99%**	**99.6%**
Benchmark	*95%*	*95%*	*95%*

Source: #02569_AuthTAT_Summary

Behavioral Health

- In January, The Behavioral Health Department processed 648 authorizations, 376 Care Coordination referrals, and 187 Mental Health Screenings.

Total BH Authorization Volume			
	24-Dec	**25-Jan**	**25-Feb**
Approvals	634	685	646
Partial Approval	0	0	0
Denials	2	6	2
Total	636	691	648

Source: 14939_BH_AuthTAT

Mental Health Turnaround Times

MH TAT			
**Goal ≥95%*	**24-Dec**	**25-Jan**	**25-Feb**
Determination TAT%	98%	75%	97%
Notification TAT%	97%	99%	92%

- Ankhesenamun Ball, PsyD, has 11 authorizations for which notification was not sent on time. TruCare did not have a fax number on file for the automatic correspondence. A manual process has been initiated. We are working with the IT department to resolve the system issue.

Behavioral Health Therapies (BHT/ABA) Turnaround Times

BHT TAT			
**Goal ≥95%*	**24-Dec**	**25-Jan**	**25-Feb**
Determination TAT%	100%	99%	99%
Notification TAT%	96%	100%	100%

Behavioral Health Denial Rates

**Goal ≤ 5%*	BH Denial Rates	
24-Dec	**25-Jan**	**25-Feb**
0.01%	0.01%	0.01%

Source: 14939_BH_AuthTAT

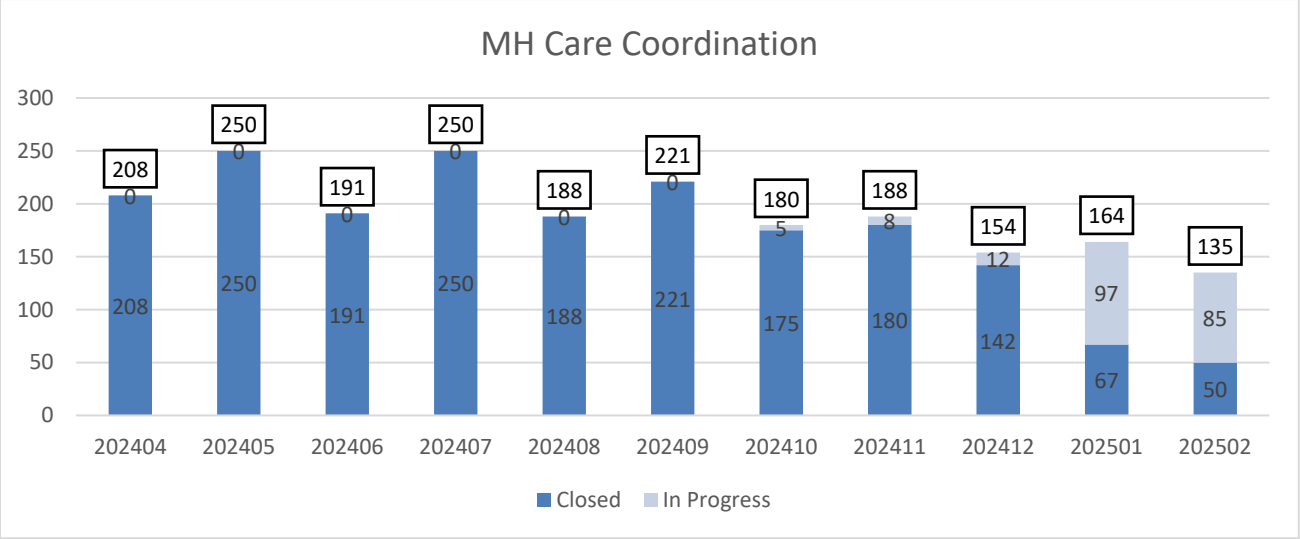
Mental Health Care Coordination

- 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 Screening Tools			
	24-Dec	25-Jan	25-Feb
Youth Screenings	69	77	88
Adults Screenings	134	157	146

Source: PBI_14460 – MLS BH TruCare Assessments

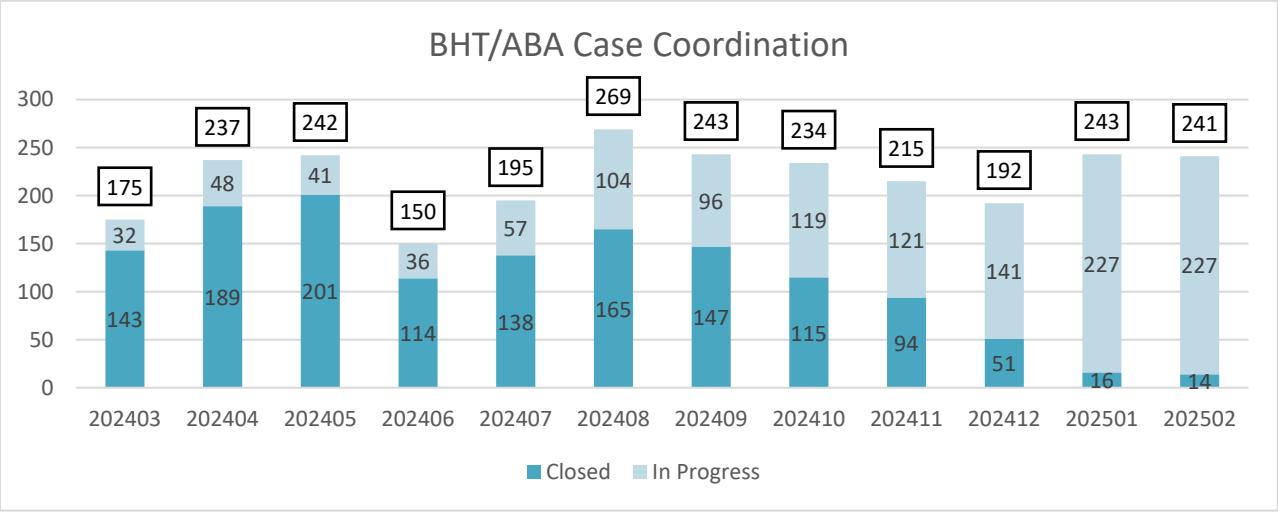
- Alliance licensed mental health clinicians, psychiatric nurses, and behavioral health navigators provide care coordination for members who need assistance accessing the mental health treatment services they need.



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 needed services. The Alliance manages each child's unique needs and follows up with parents and caregivers to resolve barriers to care.

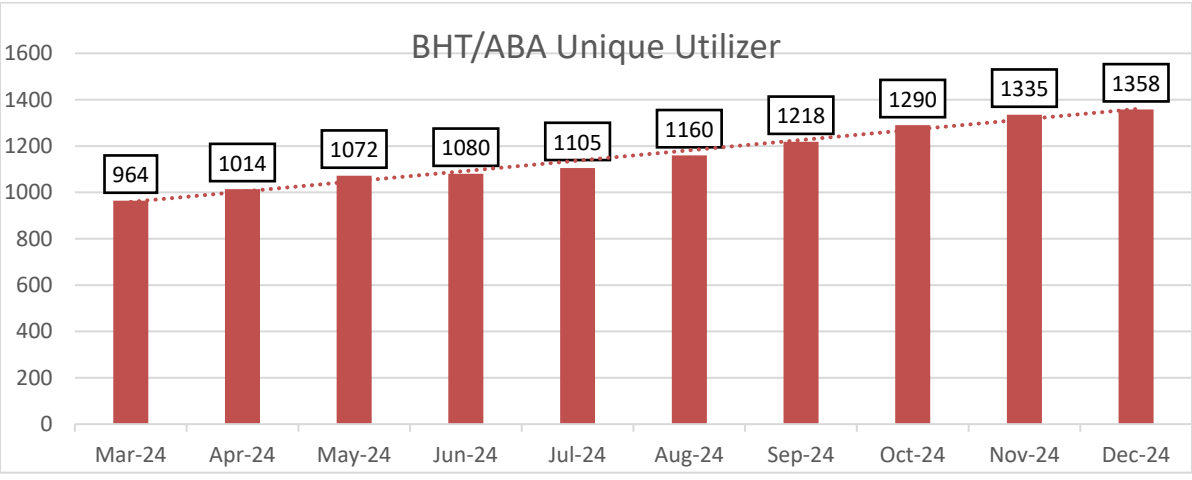


Source: 14665_BH_Cases

Behavioral Health Unique Utilizers

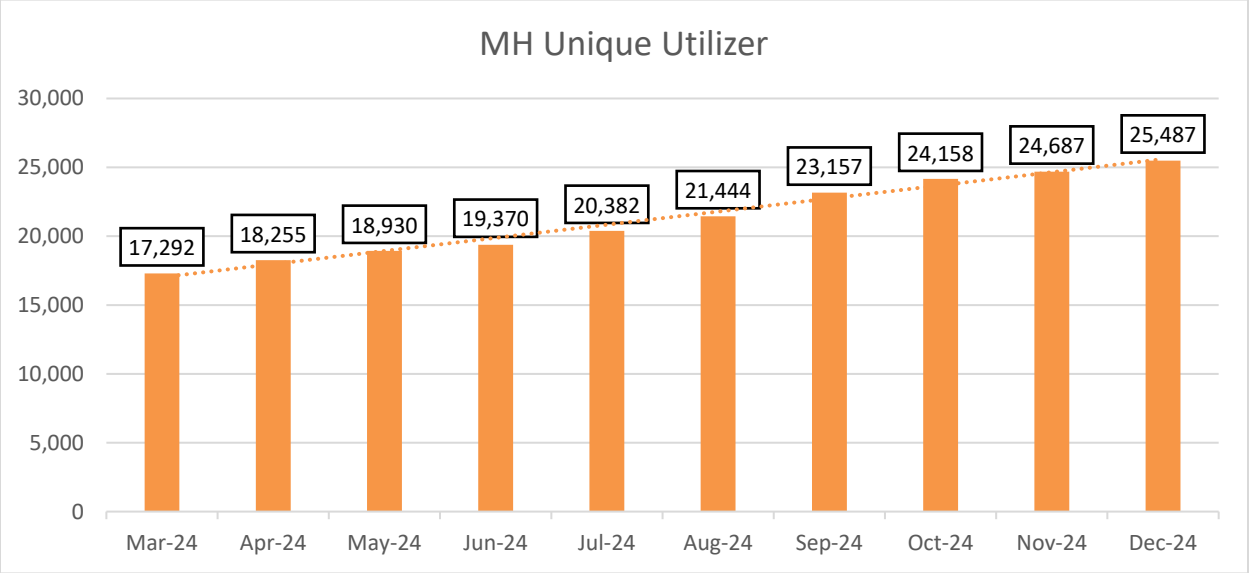
- Removing barriers to accessing BHT/ABA services remains a primary goal for the Alliance Behavioral Health team. One way to measure that is to monitor unique utilizers who are accessing care when interventions are implemented.

- We observed a continuing rise in unique utilizers of BHT/ABA services, reflecting a 2% increase compared to the previous month.



Source: PBI 14621 BHT Utilization Report

- The number of unique utilizers of mental health services has increased by 3% 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 February, 2025:

LOB	Quarterly Number of Outpatient PAs Processed	Quarterly Turn Around Rate Compliance (%)
GroupCare	143	100%

Decisions	Number of PAs Processed in February, 2025
Approved	35
Denied	91
Closed	17
Total	**143**

- Medications for weight management, nerve pain, type 2 diabetes, hepatic encephalopathy and infertility are in the top ten categories for denials.

February Ranking	Drug Name	Common Use	Common Denial Reason
1	WEGOVY Soln Auto-inj 0.25MG/0.5ML	Weight Management	Criteria for approval not met
2	LIDOCAINE Patch 5%	Nerve Pain	Criteria for approval not met
3	JARDIANCE Tablet 10MG	Type 2 Diabetes	Criteria for approval not met
4	ZEPBOUND Soln Auto-inj 5MG/0.5ML	Weight Management	Criteria for approval not met
5	XIFAXAN Tablet 550MG	Hepatic Encephalopathy	Greater than 30-day supply
6	CETROTIDE Kit 0.25MG	Infertility	Criteria for approval not met
7	ZORYVE Cream 0.15%	Eczema	Criteria for approval not met
8	ZEPBOUND Soln Auto-inj 2.5MG/0.5ML	Weight Management	Criteria for approval not met
9	WEGOVY Soln Auto-inj 0.5MG/0.5ML	Weight Management	Criteria for approval not met
10	CONTRAVE Tablet ER 12HR 8;90MG	Weight Management	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	240
J9035	INJECTION BEVACIZUMAB 10 MG	151
J7030	INFUS NORMAL SALINE SOL 1000 CC	82
J0585	BOTULINUM TOXIN TYPE A PER UNIT	77
J0897	INJECTION DENOSUMAB 1 MG	64
J0178	INJECTION AFLIBERCEPT 1 MG	60
J1100	INJ DEXMETHOSON SODIM PHOSHATE 1 MG	56
J2405	INJECTION ONDANSETRON HCL PER 1 MG	49
J2997	INJ ALTEPLASE RECOMBINANT 1 MG	42
J2469	INJECTION PALONOSETRON HCL 25 MCG	42

Authorization Overview[1]

Line of Business	October 2024	November 2024	December 2024
IHSS	11	12	19
Medi-Cal	513	391	457

[1] Includes closed authorizations

Turnaround Time and Determinations By Line of Business[2]

LOB	Determination	October 2024	November 2024	December 2024
Medi-Cal	Approved	422	343	349
	Denied/Partials	12	4	4
	TAT	100.00%	99.14%	99.72%
IHSS	Approved	9	8	18
	Denied/Partials	0	0	0
	TAT	100.0%	100.0%	100.0%

Case and Disease Management

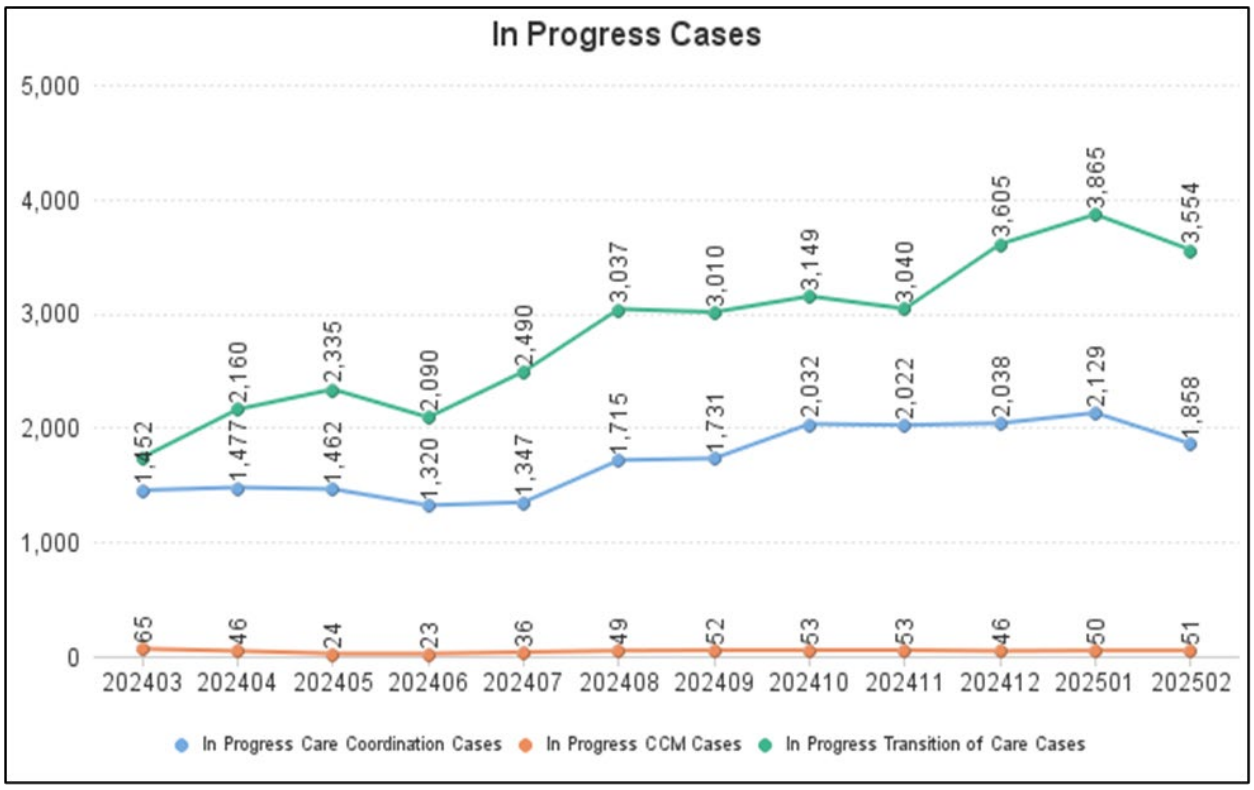
- The CM Team is assisting with coordination of continuity of care for the incoming foster youth population.

- The CM team continues to assist the high volume of all 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).

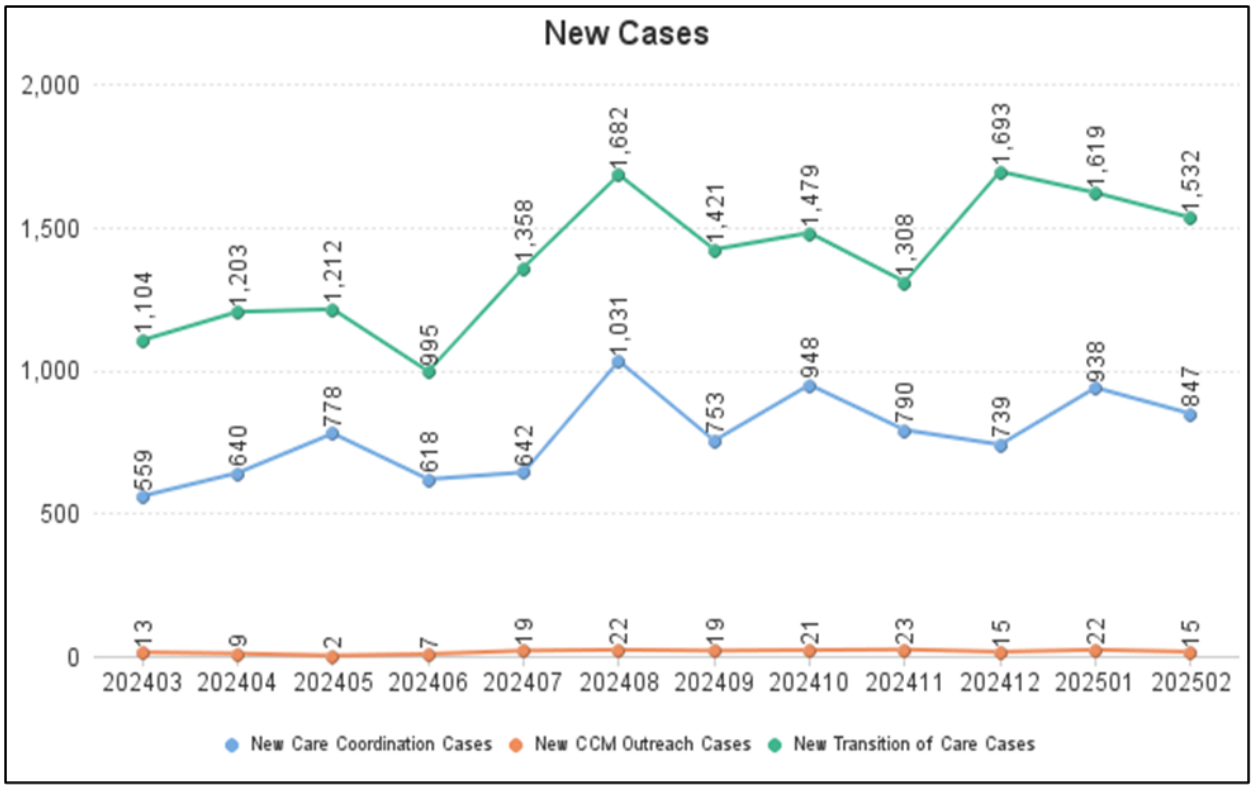
- The CM team continues to collaborate with clinic partners to ensure the TCS requirements are met, including but not limited to scheduling and ensuring follow-up appointments for members, informing members of CM services, notifying appropriate individuals of TCS services (hospital discharge planners, 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.

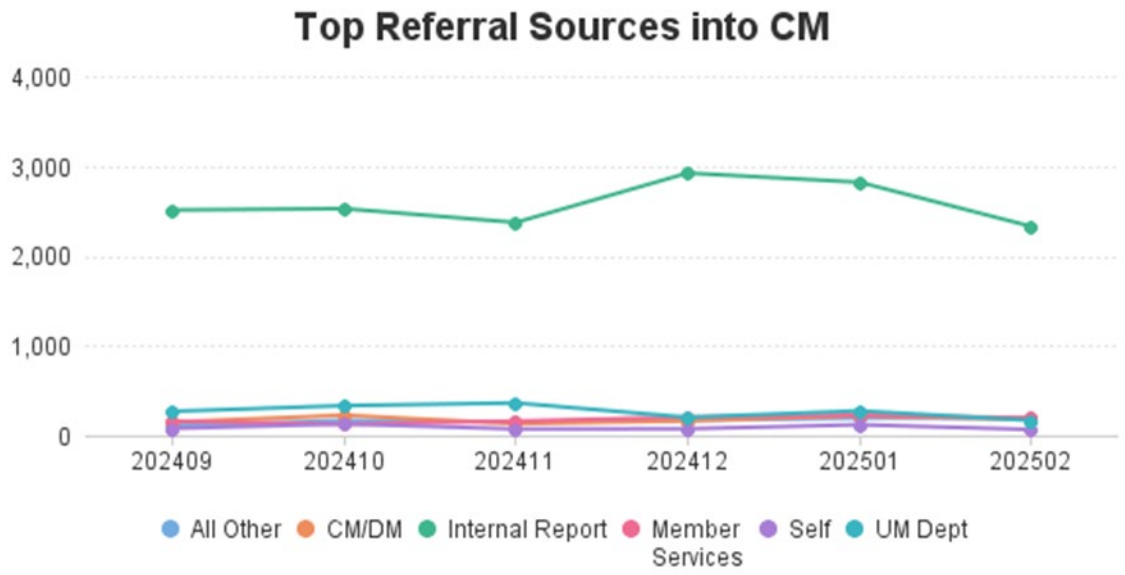
- CM is responsible for acquiring Physician Certification Statement (PCS) forms before Non-Emergency Medical Transportation (NEMT) trips to better align with DHCS requirements for members who need that higher level of transportation (former completed by Transportation broker, Modivcare). CM continues to educate the provider network, including hospital discharge planners, and dialysis centers about PCS form requirements.



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 September 2024

CalAIM

Enhanced Case Management

- All Populations of Focus have been live since January 1, 2024.

- 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.

- The ECM team improved the ECM provider audit process to further understand key areas of member engagement for improvement. Examples of improvements are systematic audit measures to focus on transitional care services, person-centered care plan development, change in condition triggers and overlapping populations of focus (Justice-involved).

- 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 are 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 we meet the regulatory requirements.

	November 2024		**December 2024**		**January 2025**	
ECM Providers	**Outreach**	**Enrolled**	**Outreach**	**Enrolled**	**Outreach**	**Enrolled**
ACBH	-	14	-	14	-	14
Alameda Health System (AHS)	14	199	16	207	22	181
Bay Area Community Services (BACS)	-	122	-	121	-	120
California Cardiovascular Consultants	-	169	-	165	-	165
California Children's Services (CCS)	11	23	8	22	7	23
CHCN	87	971	78	985	111	953
East Bay Innovations (EBI)	2	115	-	115	-	113
Full Circle	1	204	26	194	-	185
Institute on Aging	571	225	549	239	23	230
La Familia	53	36	76	38	55	32
MedZed	49	544	35	519	24	492
Roots Community Health Center	2	214	3	222	5	214
Seneca Family Services	41	56	-	56	10	56
Pair Team	453	623	823	705	396	684
Titanium Health Care	790	507	186	603	965	588
Tiburcio Vasquez Health Center (Street Medicine)	-	97	-	98	-	98
BACH (Street Medicine)	-	73	-	75	-	74
Lifelong (Street Medicine)	5	219	1	234	10	239
Roots Community Health Center (Street Medicine)	Combined with Roots 'traditional' ECM program					

***Source**: #13360 ECM Dashboard*

Community Supports (CS)

- The team implemented new authorization criteria and Utilization Management processes effective 12/1/2024. The changes were needed to ensure full compliance with regulatory and contractual expectations. We continue to meet with CS providers to address questions about the new processes and support this change. Additional criteria revisions will be coming soon due to the new policy guide being released.
- 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)
    - Nursing Facility Transition/Diversion to Assisted Living Facilities
    - Community Transition Services/Nursing Facility Transition to a Home
- 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 outlined new closed loop referral requirements and moved the closed loop referral target date to 07/01/25. AAH is working on requirements to comply with the new DHCS requirements.
- Housing-related community support has transitioned to the Operations team effective 10/01/24. The Health Care Services and Operations teams coordinate to ensure communication and process alignment, where possible.

Community Supports	Services Authorized in November 2024	Services Authorized in December 2024	Services Authorized in January 2025
Housing Navigation	921	922	861
Housing Deposits	236	230	240
Housing Tenancy	1,009	1,006	935
Asthma Remediation	100	103	112
Meals	1,510	1,446	1,399
Medical Respite	112	92	86
Transition to Home	22	23	24
Nursing Facility	30	26	22
Home Modifications	0	0	0
Homemaker Services	97	79	52
Caregiver Respite	0	5	4
Total	**4,042**	**3,932**	**3,735**

***Source**: #13581 Community Support Auths Dashboard*

Grievances & Appeals

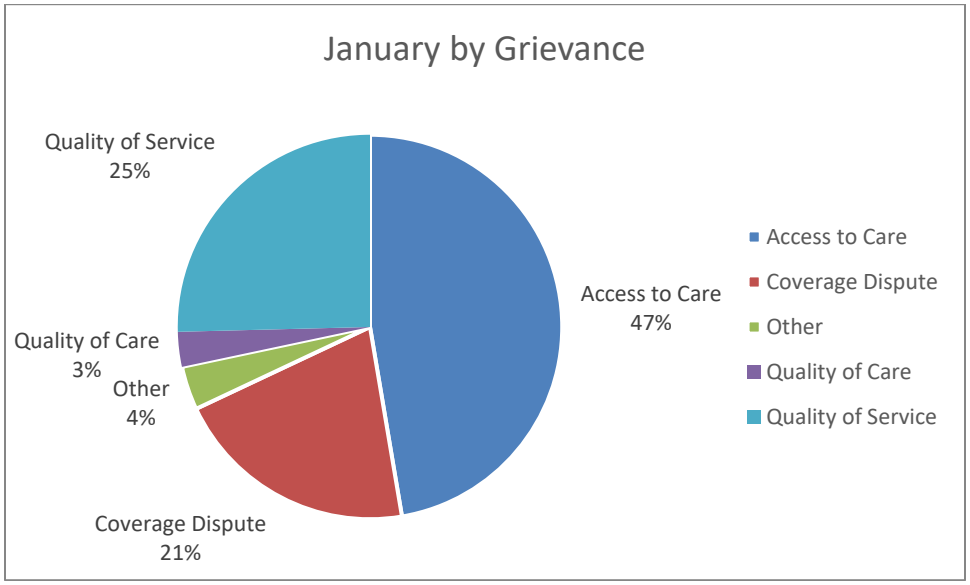
- Grievances cases were resolved within the goal of 95% of regulatory timeframes.
- Appeal cases were not resolved within the 95% of regulatory timeframes.
- Total Unique grievances resolved in February were 7.5 complaints per 1,000 members.

February 2025 Cases	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate	Per 1,000 Members*
Standard Grievance	1,878	30 Calendar Days	95% compliance within standard	1,803	96.01%	3.94
Expedited Grievance	0	72 Hours	95% compliance within standard	0	100.00%	N/A
Exempt Grievance	1,715	Next Business Day	95% compliance within standard	1,715	100.00%	3.56
Standard Appeal	40	30 Calendar Days	95% compliance within standard	33	82.50%	0.09
Expedited Appeal	2	72 Hours	95% compliance within standard	2	100.00%	0.004
Total Cases:	3,635		95% compliance within standard	3,553	97.74%	7.61

*Calculation: the sum of all unique grievances for the month divided by the sum of all enrollment for the month multiplied by 1000.

Standard Grievances:

- There were 1,629 unique grievance cases resolved during the reporting period, with a total of 1,878 grievances including all 279 shadow cases.



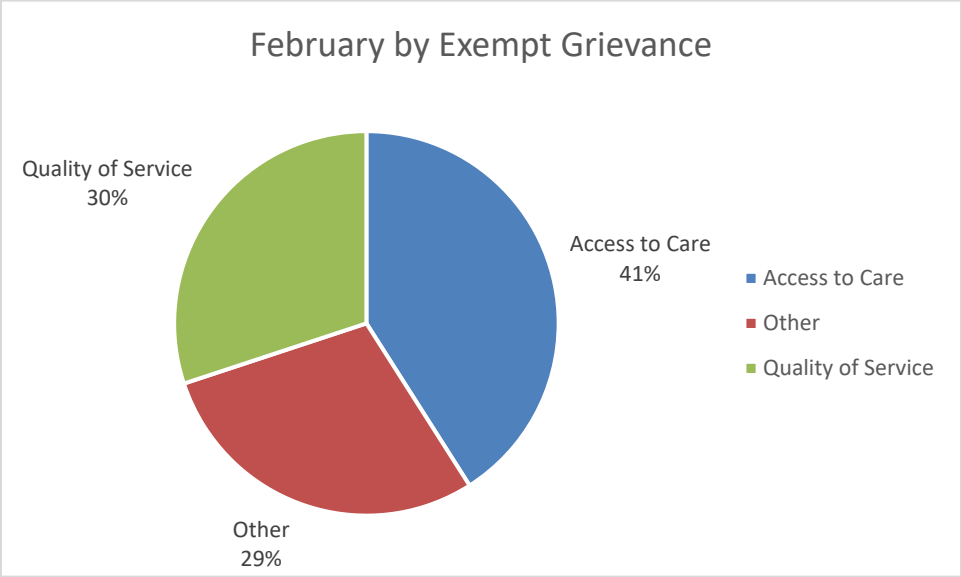
- **889** of 1,878 (47%) cases were related to Access to Care, the top 4 grievance categories are:
  - (285) Timely Access
  - (260) Technology/Telephone
  - (139) Provider Availability
  - (128) Authorization

- **477** of 1,878 (25%) cases were related to Quality of Service, the top 3 categories are:
  - (140) Plan Customer Service
  - (82) Provider/Staff Attitude
  - (63) Transportation

- **388** of 1,878 (21%) cases were related to Coverage Dispute, the top 3 grievance categories are:
  - (174) Provider Direct Member Billing
  - (109) Provider Balance Billing
  - (59) Reimbursement

Exempt Grievances:

- There were 1,473 unique exempt grievance cases resolved during the reporting period, with a total of 1,696 exempt grievances including all 223 shadow cases.



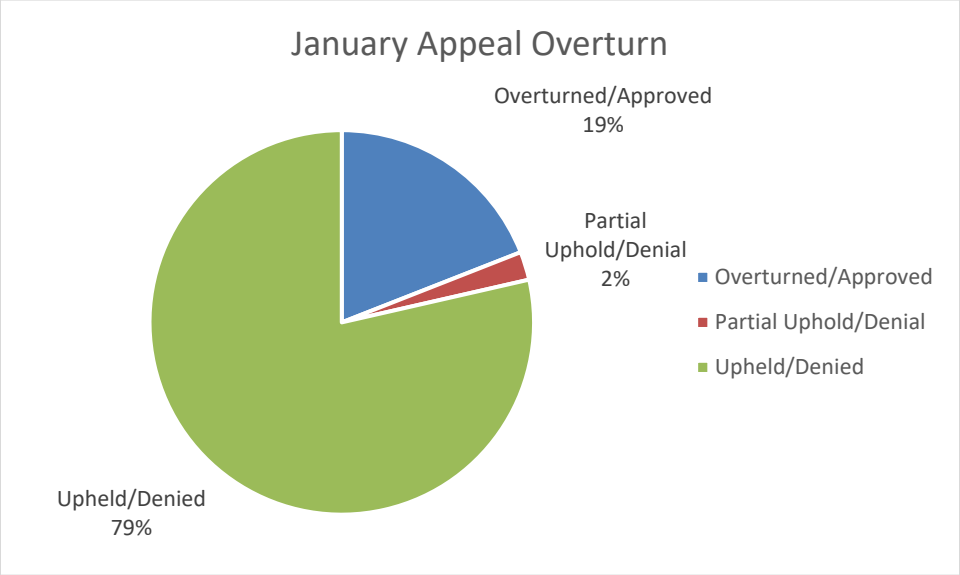
- 695 of 1,696 (41%) cases were related to Access to Care, the top 3 categories were:
  - (335) Telephone/Technology
  - (189) Provider Availability
  - (91) Geographic Access

- 510 of 1,696 (30%) cases were related to Quality of Service, the top 2 categories were:
  - (297) Plan Customer Service
  - (177) Provider/Staff Attitude

- 491 of 1,696 (29%) cases were related to Other, the 2 categories were:
  - (456) Enrollment
  - (35) Eligibility

Appeals:

- The Alliance's goal is to have an overturn rate of less than 25%, for the reporting period of February 2025, we met our goal with a 19% overturn rate



- **8** out of 42 (19%) cases were overturned for the month of January 2025:
  - (5) Out of Network (no INN)
  - (3) Disputes Involving Medical Necessity

- **1** out of 42 (2%) cases were partially overturned for the month of January 2025:
  - (1) Disputes Involving Medical Necessity

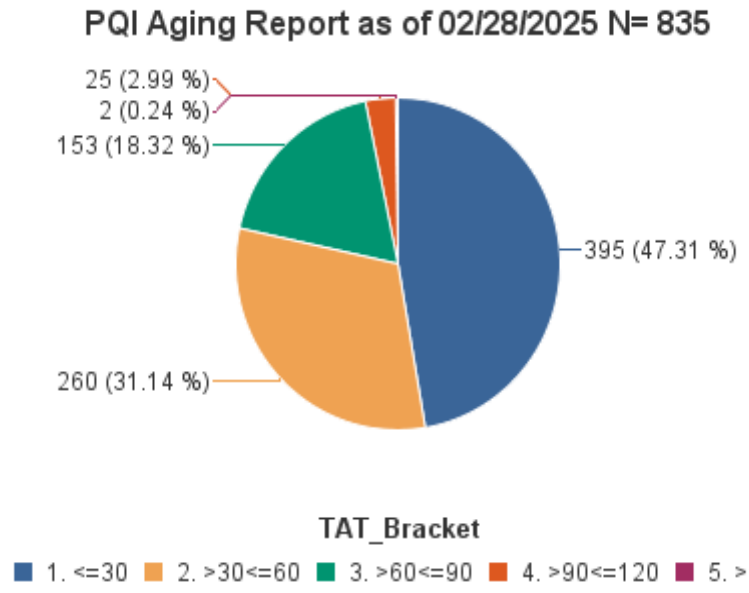
Quality

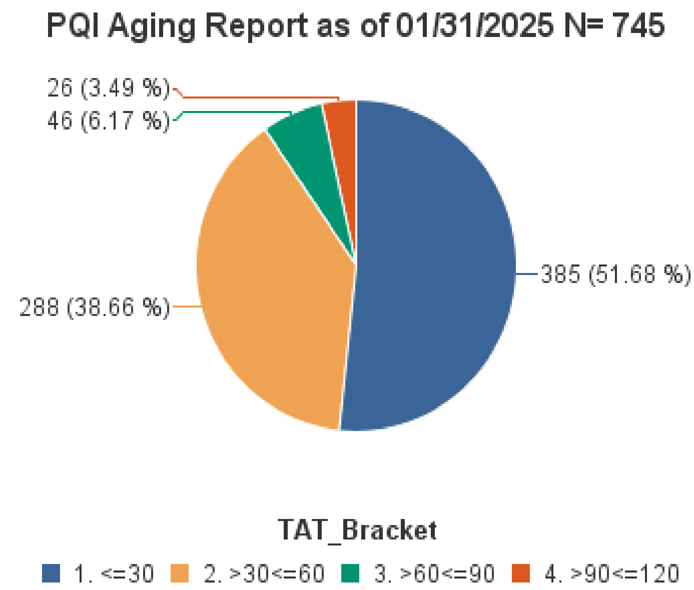
- Quality Improvement continues to track and trend PQI Turn-Around-Time (TAT) compliance. Our goal is closure of PQI cases within 120 days from receipt to resolution via nurse investigation and procurement of medical records and/or provider responses followed by final MD review when applicable.

- 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.
- 100% of cases in January 2025 and 99.76% of cases in February 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.

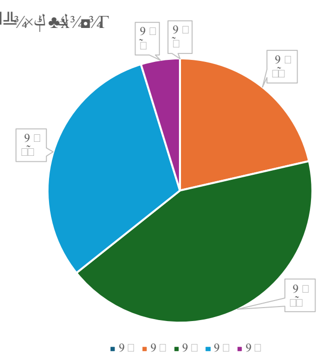
- The total number of PQIs including all categories increased by 90 referrals from January to February 2025. TATs are closely monitored on a weekly basis to ensure timely closure of cases within the standard 95%.





- Total number of Corrective Action Plans (CAPs) issued during 2024 was 42. 21% were leveled as a severity level of C1; 43% as C2, 31% as C3 and 5% as C4. (see following CAP dashboard).

[illegible]	Q1	[illegible]	[illegible]	[illegible]	Total
[illegible]	0	0	0	0	0
[illegible]	1	0	6	2	9
[illegible]	1	2	10	5	18
[illegible]	4	1	6	2	13
[illegible]	0	1	0	1	2
[illegible]	6	4	22	10	42



Quality Performance Updates

- 2024 Quality Improvement Initiatives to Improve HEDIS/MCAS Measures

- In 2024, the Quality Performance team continued striving for higher rates on HEDIS/MCAS measures. By focusing on a three-pronged approach—provider education, member outreach, and data analysis—the preliminary 2024 HEDIS/MCAS rates show improvement over MY2023 in multiple measures.

Highlights of 2024 Quality Performance Measures

- Improvement Academy – In MY2024, the Alliance conducted 15 webinars covering topics such as the Pay for Performance Program, Fundamentals of Quality Improvement (QI), Documentation and Coding, and various HEDIS measures.

- Provider Collaboration – On a monthly to quarterly basis, the QI Performance team met with providers to discuss HEDIS/MCAS rates and collaborate on QI projects.

- DHCS Performance Improvement Project (PIP) – The health equity project assigned to the Alliance in 2024 focused on well-child visits for African American children aged 0–15 months. To better understand barriers to care, the Alliance partnered with First 5 Alameda to conduct a member survey. Among those surveyed, 20% were African American families, with transportation identified as a key barrier to completing well visits. In response, the Alliance and First 5 conducted outreach calls to African American families with children in this age group who were assigned to CFMG. These calls provided education on well-child visits and offered transportation services as part of member benefits. As a result, 10 members completed at least one well visit, 7 members utilized transportation services, and preliminary data indicates month-over-month improvement in well-child visit rates for African American children compared to MY2023.

- Lead Screening – In MY2024, the Alliance initially fell below the Minimum Performance Level (MPL) for lead screening. To address this, multiple initiatives were implemented, including provider education, funding for point-of-care testing units, member incentives, and improved coordination of lab draw and pickup services between providers and Quest Labs. As a result, preliminary data shows the administrative rate for lead screening has reached 66.72%, surpassing the 63.84% MPL.

- As a result of these efforts and various other QI initiatives, preliminary MY2024 administrative data shows that 13 out of 18 measures are now above the MPL.

Health Equity

Lao Paul Vang

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

From: **Lao Paul Vang, Chief Health Equity Officer**

Date: **March 14th, 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**
  - A cross-functional stakeholder workgroup, Faith-Based Community Engagement (FBCE), was created in Dec 2024 as part of the broader strategic effort to fulfill our milestone # 5 in our Health Equity Roadmap.
  - Monthly Meetings are scheduled to foster collaboration among internal stakeholders and develop strategies that will lead to partnerships with faith-based organizations.
  - We rely on three (3) critical factors to identify priority FBOs and guide our work: 1) members' relationships with the faith-based organization, 2) the health disparity gap, and 3) available funding and resources.
  - Subgroups have been formed to address specific aspects of the FBO's partnership, specifically we collaborate with PHM and QI teams to develop culturally appropriate education with specific ethnic minority FBOs.
  - Health Equity is collaborating with QI and PHM to develop an education seminar that addresses the three high disparity areas that impact the BIPOC community:
    - Women's health preventive screenings such as Breast cancer and Cervical cancer screenings
    - Child well-visits
    - Doula Services

- **SOGI Data Workgroup**
  - In view of the new federal executive order, the SOGI data committee made a decision to temporarily suspend our work until April.

- **NCQA-Health Equity Accreditation**
  - We continue to participate in the NCQA team to address health equity-related issues relating to the state accreditation.

- **PHM Workgroup**
  - Health Equity continues to collaborate with PHM, participating in their weekly workgroup.

- **Over/Under Utilization Workgroup**
    - As of December 2024, we joined the Healthcare Service unit in their 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 for 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**
    - DHCS CHEO and MCPs CHEOs met 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 for MCPs to ask questions, update each other on curriculum information, and assist with moving the DEI Training forward**.**

- **CIN (California Improvement Network)**
    - Health Equity Division participated in competitive membership application to California Improvement Network (CIN) and was successfully selected to be a partner as of March 6, 2025.
    - The CIN consists of 25 leaders from major healthcare, managed care and public health organizations across California. The term of service is 2 years from 2025-2027.
    - As a CIN partner, our Alliance is now part of a diverse learning and action network focused on advancing equitable healthcare experiences and outcomes in California.
    - Additionally, Alliance would have an opportunity to apply for a grant to advance specific health equity among our Medicaid members.

- **First-5**
  - HE participated in an exploration discussion with First-5, along with the CEO, CMO on January 8, 2025.

- **American Heart Association**
  - We initiated discussion with AHA on Feb 26 to explore potential collaboration to close health disparity gaps in the cardiovascular diseases incidence among the BIPOC (Blacks, Indigenous, Persons-of-Color).

Alliance Health Equity Strategic Roadmap Update

- The Alliance Health Equity Roadmap was presented in December 2024:

Alliance Health Equity Roadmap Milestone	Strategies
1. Organization Transformation	a) CHEO works collaboratively with SLT to facilitate system-wide organization transformation that supports long term vision of health equity for the Alliance.
2. Data-Driven	a) Collaboration with UM, PHM, QI and Analytic. b) Utilize grant-funded health equity projects to gather data that will augment the alliance 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 C&L (Culture and Linguistic), PHM, QI, and other stakeholders to ensure all our policies, services, 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

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) Non-Utilization study b) Health Equity Grant application, see below for more details**

- **Application to Health-Equity Grants ****
    - The Health Equity Division works with the Incentives and Reporting unit to actively pursue grant opportunities that will allow us to provide and implement health equity measures that mitigate specific SDOHs.
        1. California Improvement Network (CIN) program
        2. RWJF (Robert Wood Johnson Foundation) grant programs

<u>DHCS-DMCS APL Update</u>

- **DEI Training APL 23-025 Update**

  We received approval from DHCS regarding the DEI training curriculum.
    - Updated Timeline:
        - April 2025: DEI Provider's Pilot launched. California Cardiovascular Consultants (CCC) has been selected to receive the pilot training.
        - April – 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 TGI (Transgender, Gender diverse, intersex) Cultural Sensitive Training was provided to all alliance staff who have direct contact with Medi-Cal Members.

    - Timeline:
        - Dec 2024: confirmation of vendor
        - Jan-Feb 2025: implementation of training for all Alliance staff
        - Feb 14: Almost all staff (95%) completed the mandatory training. The 5% of non-completion comes from staff who were on vacation or medical leaves. They will have up to 30 days to complete the training upon return to the office.
        - Feb 14, 2025: submission of documents as per APL to the State, which include 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

Diversity, Equity, Inclusion, and Belonging Committee (DEIBC) and Values in Action Committee (VIAC):

- **DEIB Committee Update**
  - The DEIB Committee met on February 7th and discussed Health Equity and DEI Activities and the Community Engagement Update.

- **VIA Committee Update**
  - At the Feb 19th VIA meeting, the committee discussed the national and cultural events in March of 2025. The committee decided that Dr Ang will contribute to articles in celebration of the National Nutrition Month.
  - The Spring Social Event is confirmed to be on April 22nd. This will be one of the three social events for the Alliance Staff in 2025.

ALAMEDA Alliance FOR HEALTH

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

Information Technology

Sasikumar Karaiyan

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

From: **Sasi Karaiyan, Chief Information & Security Officer**

Date: **March 14th, 2025**

Subject: **Information Technology Report**

Call Center System Availability

- In February 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. Our call center applications now support English speech-to-text functionality. Additionally, 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 March 2025.

Encounter Data

- In the month of February 2025, the Alliance submitted 156 encounter files to the Department of Health Care Services (DHCS) with a total of 376,918 encounters.

Enrollment

- The Medi-Cal Enrollment file for the month of February 2025 was received and loaded to HEALTHsuite.

HEALTHsuite

- The Alliance received 339,840 claims in the month of February 2025

- A total of 298,995 claims were finalized during the month out of which 256,648 claims auto adjudicated. This sets the auto-adjudication rate for this period to 85.8%.

TruCare

- A total of 17,740 authorizations were loaded and processed in the TruCare application.

- TruCare Application Uptime – 99.9%.

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.

- Alliance completed annual IT Security Risk Management (SRA) and now working towards remediation efforts.

- IT vulnerability scanning activity has officially begun. The current beginning phases will focus on capturing data points on infrastructure components such as the network fabric and servers that host mission-critical applications.

- The Cyber Incident Response policy has been updated.

Microsoft InTune roll-out

- To enhance workstation security, Alliance is deploying Microsoft Intune on our workstations and mobile devices. This cloud-based service specializes in mobile device and application management, allowing the Alliance to secure and manage access to corporate data on mobile devices while protecting information. Intune enables device and app management, data protection, and policy compliance.

    - The engineering team has finished the core technical setups and is currently supporting the IT Service Desk on user migrations. Emails have been dispatched to all staff members as part of the campaign and rollout plan.

    - 649 migrations were completed, covering 8 departments, bringing project completion to 97%. Migrations are ramping up and remaining waves will be scheduled.

    - Manual pre-check tasks have been automated for efficiency.

Information Technology

Supporting Documents

Enrollment

- See Table 1-1 “Summary of Medi-Cal and Group Care member enrolment in the month of February 2025”.
- See Table 1-2 “Summary of Primary Care Physician (PCP) Auto-assignment in the month of February 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 February 2025

Month	Total MC[1]	MC[1] - Add/ Reinstatements	MC[1] - Terminated	Total GC[2]	GC[2] - Add/ Reinstatements	GC[2]- Terminated
December	413,332	8,134	8,487	5,813	166	131

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 February 2025

Auto-Assignments	Member Count
Auto-assignments MC	2,690
Auto-assignments Expansion	2,264
Auto-assignments GC	61
PCP Changes (PCP Change Tool) Total	5,015

TruCare Application

- See Table 2-1 “Summary of TruCare Authorizations for the month of February 2025”.
- There were 17,740 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 February 2025*

Transaction Type	Total Auths Received
Paper Fax to Scan (DocuStream)	2,199
Provider Portal Requests (Zipari)	5,643
EDI (CHCN)	5,998
Provider Portal to AAH Online (Long Term Care)	11
ADT	1151
Behavioral Health COC Update - Online	69
Behavioral initial evaluation - Online	33
Manual Entry (all other not automated or faxed vs portal use)	2,636
Total	17,740

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 January 2025

Group	Individual User Accounts	Individual User Accounts Accessed	Total Logins	New Users
Provider	8,006	5,929	540,288	649
MCAL	122,639	4,581	11,233	1,198
IHSS	3,933	82	366	18
Total	134,578	10,592	551,887	1,865

Table 3-2 Top Pages Viewed for the Month of February 2025

Category	Page Name	Page Views
Provider - eligibility/claim	Member Eligibility	1,402,716
Provider - Claims	Claim Status	224,257
Provider - eligibility/claim	Claim Status	26,339
Provider - authorizations	Auth Submit	15,475
Provider - authorizations	Auth Search	7,840
Member Config	Provider Directory	7,739
Directory Config	Provider Directory	4,531
Provider - Claims	Submit professional claims	4,526
Member My Care	Member Eligibility	4,266
Member Help Resources	Find a Doctor or Hospital	3,204
Member Help Resources	ID Card	2,452
Provider - eligibility/claim	Member Roster	2,094
Member Help Resources	Select or Change Your PCP	1,956
Member Home	MC ID Card	1,443
Member My Care	My Claims Services	1,235
Provider - Provider Directory	Provider Directory 2019	1,039
Provider - reports	Reports	851
Member My Care	Authorization	610
Member My Care	My Pharmacy Medication Benefits	431
Provider - Home	Behavior Health Forms SSO	422
Provider - Home	Forms	401
Member Help Resources	FAQs	387
Member My Care	Member Benefits Materials	343
Provider - Provider Directory	Instruction Guide	315
Member Help Resources	Forms Resources	309

Call Center – Call Volume Overview:

Members - Call Center Statistics			
Month	Calls Presented	Calls Handled	Calls Abandoned
October	8437	7798	269
November	7427	6186	390
December	8438	6912	414
January	14078	10705	1483
February	11335	9026	869

Providers - Call Center Statistics			
Month	Calls Presented	Calls Handled	Calls Abandoned
October	10863	8972	1751
November	8931	6786	2007
December	9598	7285	2152
January	13400	8682	3822
February	10986	7586	1931

- Calls Presented: Total number of calls received.
- Calls Handled: Total number of calls answered.
- Calls Abandoned: Calls abandoned before being completely answered.

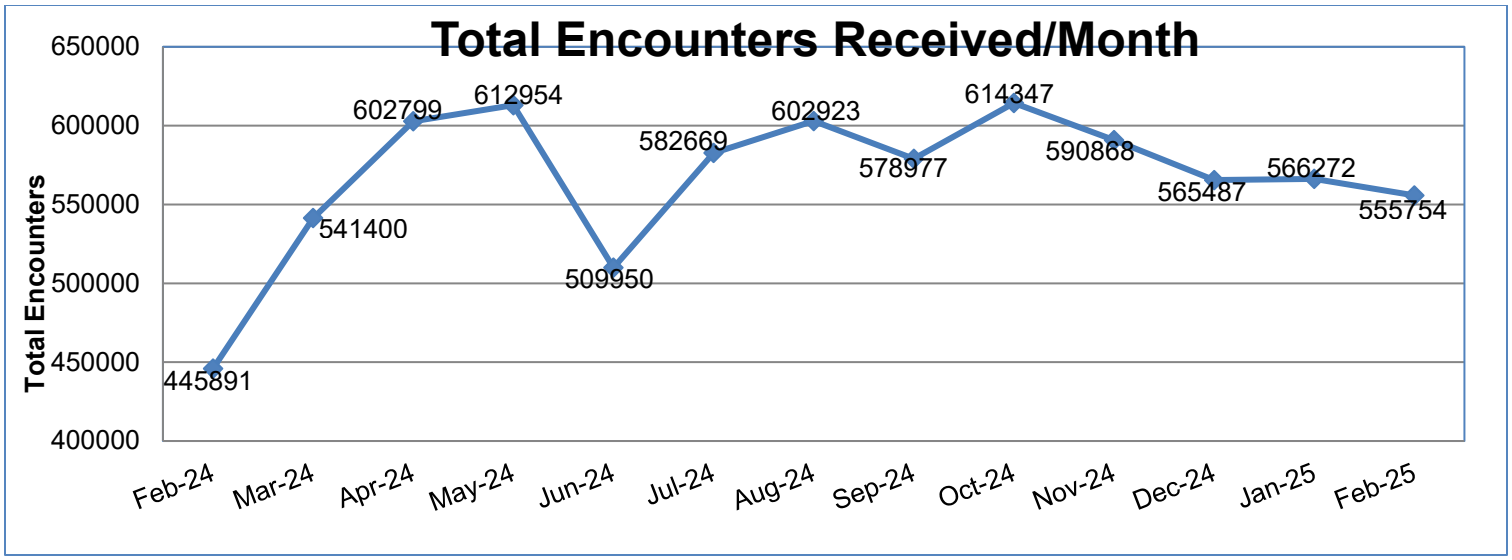
Note: It is important to note that there is a slight discrepancy between the number of calls presented, handled, and abandoned. This discrepancy is due to calls being rerouted to the XAQT vendor, which are not included in the calls handled or abandoned statistics. This rerouting can account for some of the differences observed in the totals.

Encounter Data from Trading Partners 2025

- **AHS**: February weekly files (8,654 records) were received on time.
- **BACH**: February monthly files (0 records) were received on time.
- **BACS**: February monthly files (113 records) were received on time.
- **CHCN**: February weekly files (118,972 records) were received on time.
- **CHME**: February monthly files (7,553 records) were received on time.
- **CFMG**: February monthly files (17,329 records) were received on time.
- **Docustream**: February monthly files (808 records) were received on time.
- **EBI**: February monthly files (1,597 records) were received on time.
- **FULLCIR**: February monthly files (1,534 records) were received on time.
- **HCSA**: February monthly files (2,725 records) were received on time.
- **IOA**: February monthly files (933 records) were received on time.
- **Kaiser**: February bi-weekly files (0 records) were received on time.
- **LAFAM**: February monthly files (96 records) were received on time.
- **LIFE**: February monthly files (267 records) were received on time
- **LogistiCare**: February weekly files (32,550 records) were received on time.
- **March Vision**: February monthly files (0 records) were received on time.
- **MED**: February monthly files (1,182 records) were received on time.
- **OMATOCHI**: February monthly files (0 records) were received on time.
- **PAIRTEAM**: February monthly files (0 records) were received on time.
- **Quest Diagnostics**: February weekly files (18,001 records) were received on time.
- **SENECA**: February monthly files (69 records) were received on time.
- **SERENE**: February monthly files (0 records) were received on time.
- **TITANIUM**: February monthly files (3,531 records) were received on time.
- **TVHC**: February monthly files (0 records) were received on time.
- **Magellan**: February monthly files (449,979 records) were received on time.

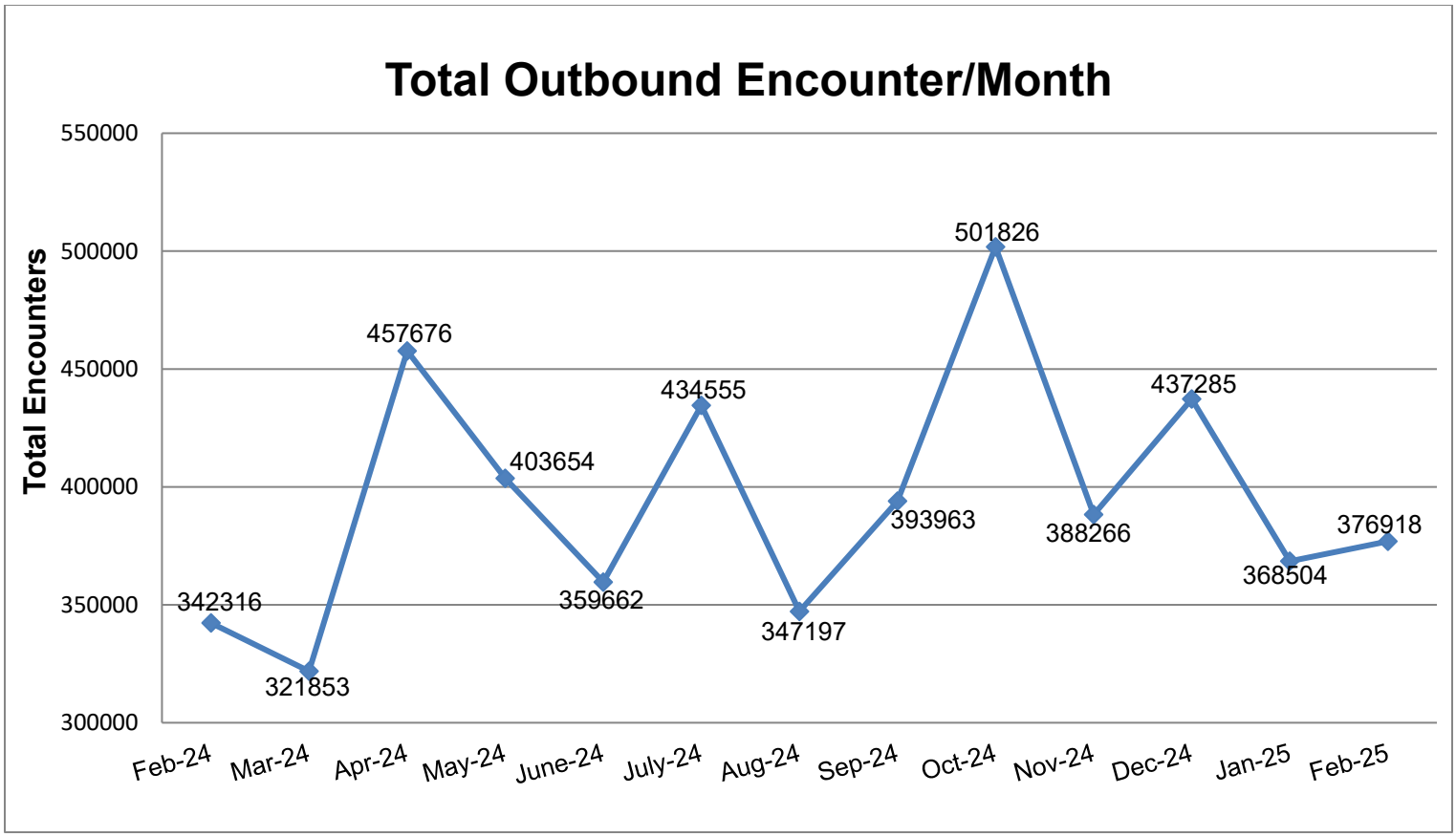
Trading Partner Encounter Inbound Submission History

Trading Partners	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
Health Suite	266339	308453	322786	375454	297267	332150	368235	322196	367989	364130	332108	339760	339840
AHS	7736	7005	6573	8412	13316	7296	8859	7498	8309	10535	7261	9709	8654
BACH										795		426	
BACS	57	55	64	70	77	88	86	85	76	98	104	93	113
CHCN	103674	122217	170653	122445	110650	135444	122293	155825	125042	127223	127327	117483	118972
CHME	5560	6022	7969	7107	7449	7242	6902	7680	7102	7589	7458	7781	7553
CFMG	10557	12651	16394	15934	21143	10776	22335	16421	16045	21352	16696	13536	17329
Docustream	814	698	302	1589	749	934	1102	1067	704	678	828	694	808
EBI	2903	1625	1700	184	2043	1623	1825	3394	1640	1725	1476	1440	1597
FULLCIR	1586	213	2261	8478	2842	1362	1798	3809	2523	2038	1085	806	1534
HCSA	2097	2822	7118	5535	3663	6841	3256	3386	2389	3423	2335	2432	2725
IOA	1233	1054	1925	1163	1280	847	752	4227	588	1064		3008	933
Kaiser	3725	9966	2286	886	1079	2052	172	236	159				
LAFAM	60	39	105	116	86	70	88	63	89	76	83	112	96
LIFE					1694		614	168	119	335	997	228	267
LogistiCare	20774	35600	32632	27531	16205	43038	29732	16139	49941	16183	34122	28671	32550
March Vision		6183	3633	8546	7092	6404	7719	5769	5143	6016	6285	15146	
MED	742	683	633	722	744	615	608	610	645	656	619	758	1182
OMATOCHI			29				2						
PAIRTEAM			5344	7582		5763		9359	1108	2204	5816	3436	
Quest	17658	22306	18000	18001	22500	18000	22502	18004	18002	22501	18003	18002	18001
SENECA	222	112	159	113	71	109	129	101	105	117	131	1	69
SERENE											654	107	
TITANIUM	154	3696	2233	3086		2015	3914	2815	6192	1537	2099	2487	3531
TVHC								125	437	593		156	
Total	445891	541400	602799	612954	509950	582669	602923	578977	614347	590868	565487	566272	555754



Outbound Encounter Submission

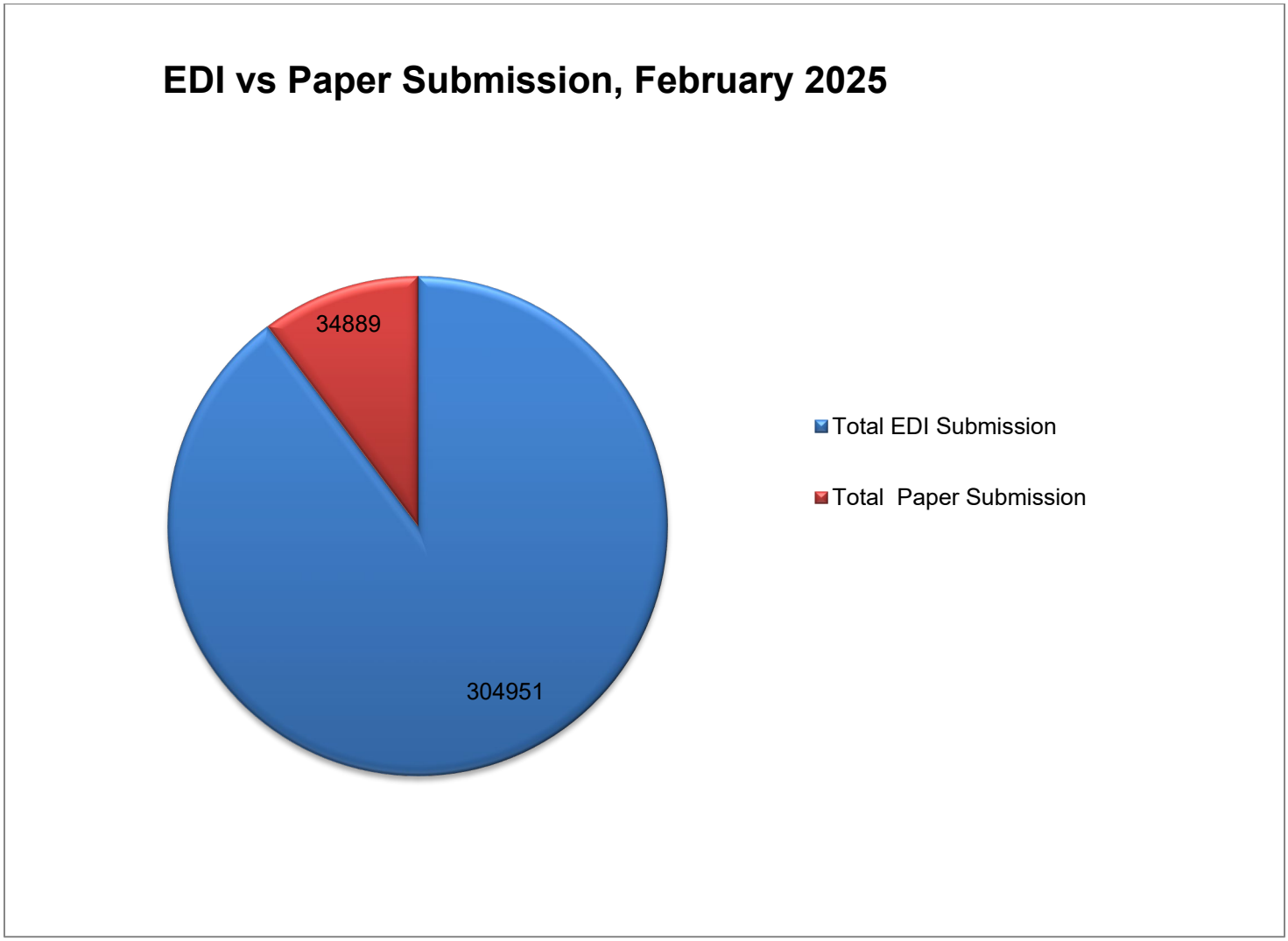
Trading Partners	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
Health Suite	177658	147776	250835	198595	204068	230706	183371	210971	276473	218194	263242	182192	205804
AHS	7497	6968	6524	7002	10684	6703	7101	8727	8201	10403	6850	7710	8135
BACH										739	6	407	
BACS	55	47	59	66	72	80	80	78	74	79	41	128	87
CHCN	74336	80498	104625	107577	77200	94476	87485	87806	108806	88573	84649	85439	82973
CHME	5470	5889	7558	6749	7310	7095	6762	6994	6974	7474	7342	7426	7167
CFMG	7730	6757	13467	11561	11506	9994	4	24076	13152	13882	11342	9362	11960
Docustream	600	377	267	839	570	725	806	715	545	482	239	634	559
EBI	1347	1002	1589	60	1835	1443	1727	3242	1559	1641	494	2208	1475
FULLCIR	540	116	1636	5401	2410	1084	674	1515	1767	1470	79	1298	1251
HCSA	2013	2769	4710	5363	3493	6757	3171	3310	2376	3394	2255	2497	2693
IOA	1156	1000	1868	1029	1221	749	680	1374	549	949		2783	781
Kaiser	3542	9650	1905	1292	812	1404	113	216	62		23		
LAFAM		16	92	103	58	66	81	58	86	62	3	178	89
LIFE					28		598	159	91	76	202	508	63
LogistiCare	40529	34931	32247	27487	16221	43019	30006	16046	49705	15235	34035	28502	32441
March Vision	2616	3736	2407	5719	4553	3766	3482	4066	3543	3980	4156	9586	371
MED	624	528	518	579	654	552	540	514	579	568	55	546	1083
OMATOCHI			56										
PAIRTEAM			4279	4422		3246		4617	782	1960	994	6334	
Quest	16589	16333	20983	16912	16898	20898	16854	16937	21144	16909	21044	16828	16855
SENECA	14	199	140	109	69	108	127	94	91	100	6	112	60
SERENE												82	
TITANIUM		3261	1911	2789		1684	3535	2332	5267	1278	228	3600	3071
TVHC								116		818		144	
Total	342316	321853	457676	403654	359662	434555	347197	393963	501826	388266	437285	368504	376918


Total Outbound Encounter/Month
Total Encounters
550000
500000
450000
400000
350000
300000
342316
321853
457676
403654
359662
434555
347197
393963
501826
388266
437285
368504
376918
Feb-24
Mar-24
Apr-24
May-24
June-24
July-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25

HealthSuite Paper vs EDI Claims Submission Breakdown

Period	Total EDI Submission	Total Paper Submission	Total claims
25-Feb	304951	34889	339840

Key: EDI – Electronic Data Interchange

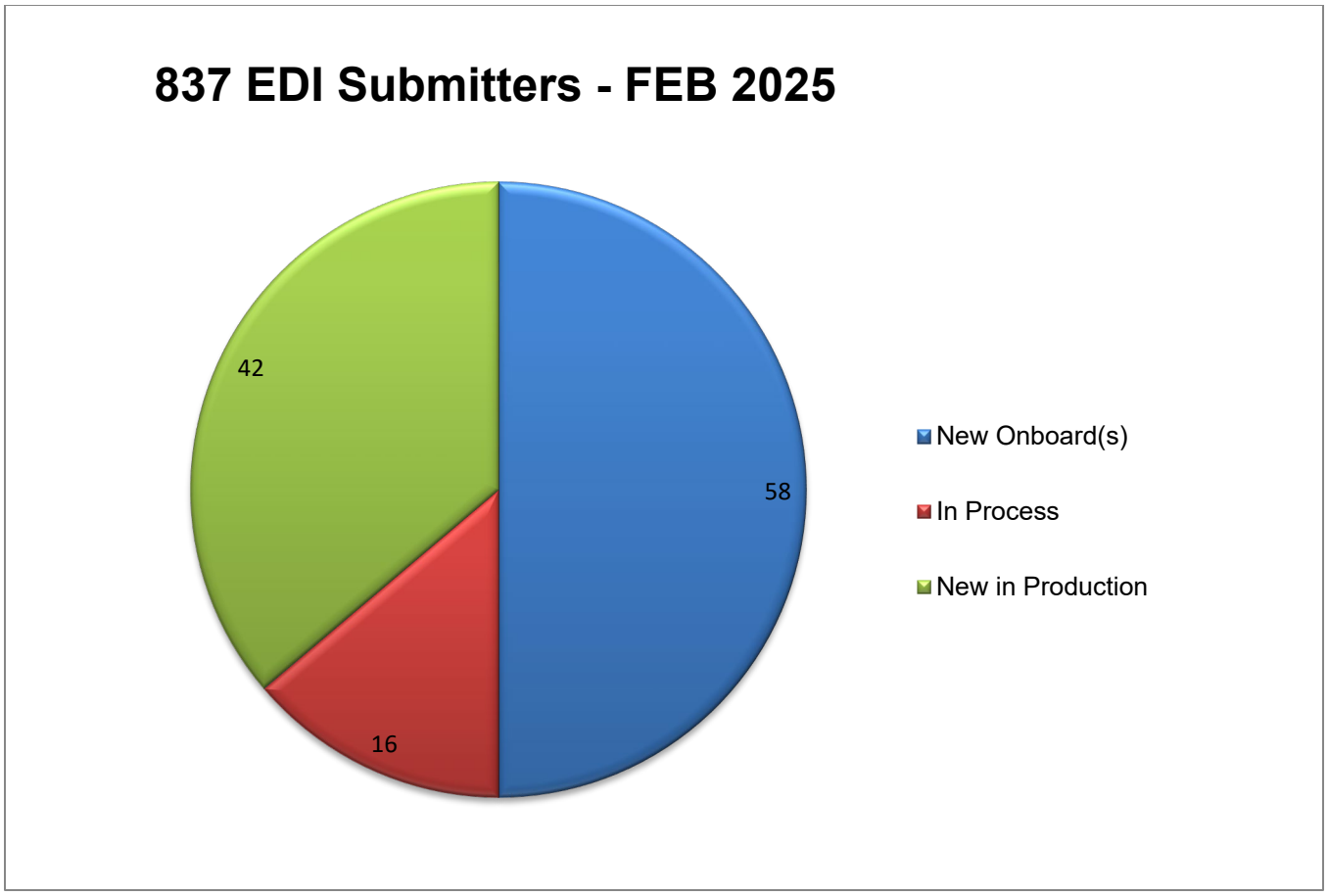


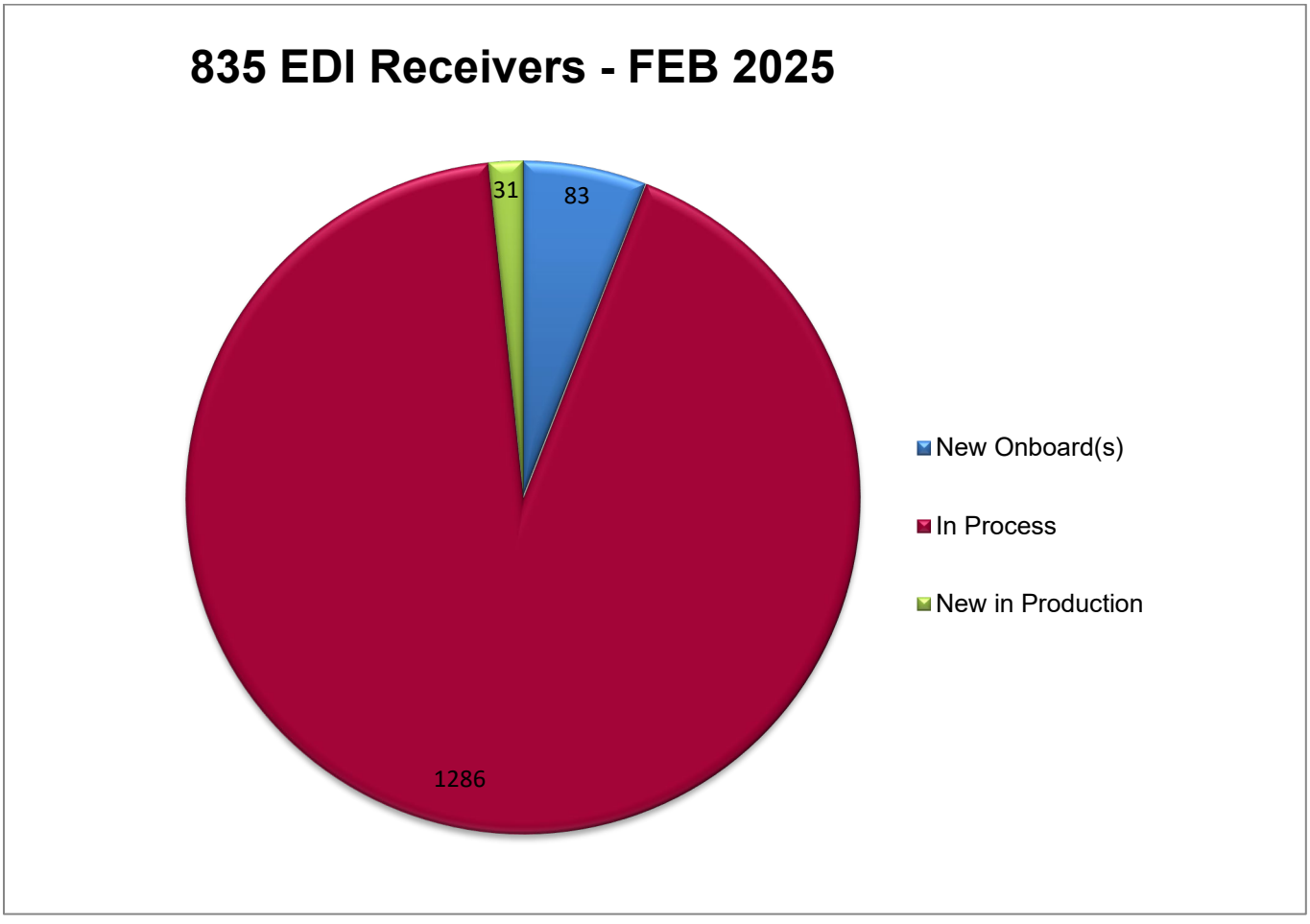
Onboarding EDI Providers – Updates

- FEB 2025 EDI Claims:
  - A total of 2914 new EDI submitters have been added since October 2015, with 42 added in February 2025.
  - The total number of EDI submitters is 3654 providers.

- FEB 2025 EDI Remittances (ERA):
  - A total of 1320 new ERA receivers have been added since October 2015, with 31 added in February 2025.
  - The total number of ERA receivers is 1307 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
Mar-24	111	25	86	2900	60	822	21	958
Apr-24	120	3	117	3017	83	851	54	1012
May-24	81	13	68	3085	63	874	40	1052
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


837 EDI Submitters - FEB 2025
42
58
16
New Onboard(s)
In Process
New in Production


835 EDI Receivers - FEB 2025
31
83
1286
New Onboard(s)
In Process
New in Production

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 **February** 2025.

File Type	Feb-25
837 I Files	33
837 P Files	123
Total Files	156

Lag-time Metrics/Key Performance Indicators (KPI)

AAH Encounters: Outbound 837	Jan-25	Target
Timeliness-% Within Lag Time - Institutional 0-90 days	92%	60%
Timeliness-% Within Lag Time - Institutional 0-180 days	98%	80%
Timeliness-% Within Lag Time - Professional 0-90 days	91%	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**

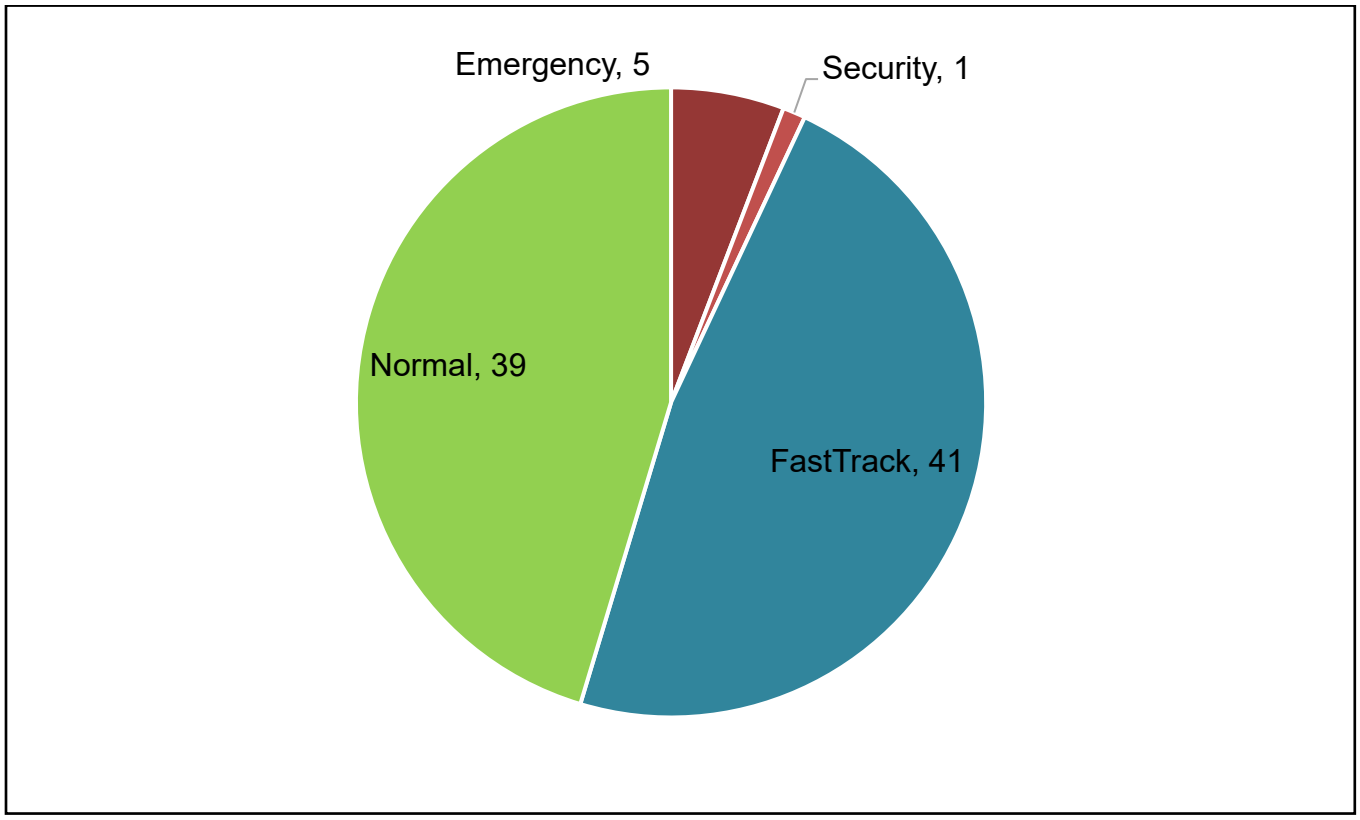
Encounter Data

In the month of **February** 2025, the Alliance submitted **156** encounter files to the Department of Health Care Services (DHCS) with a total of **376,918** encounters.

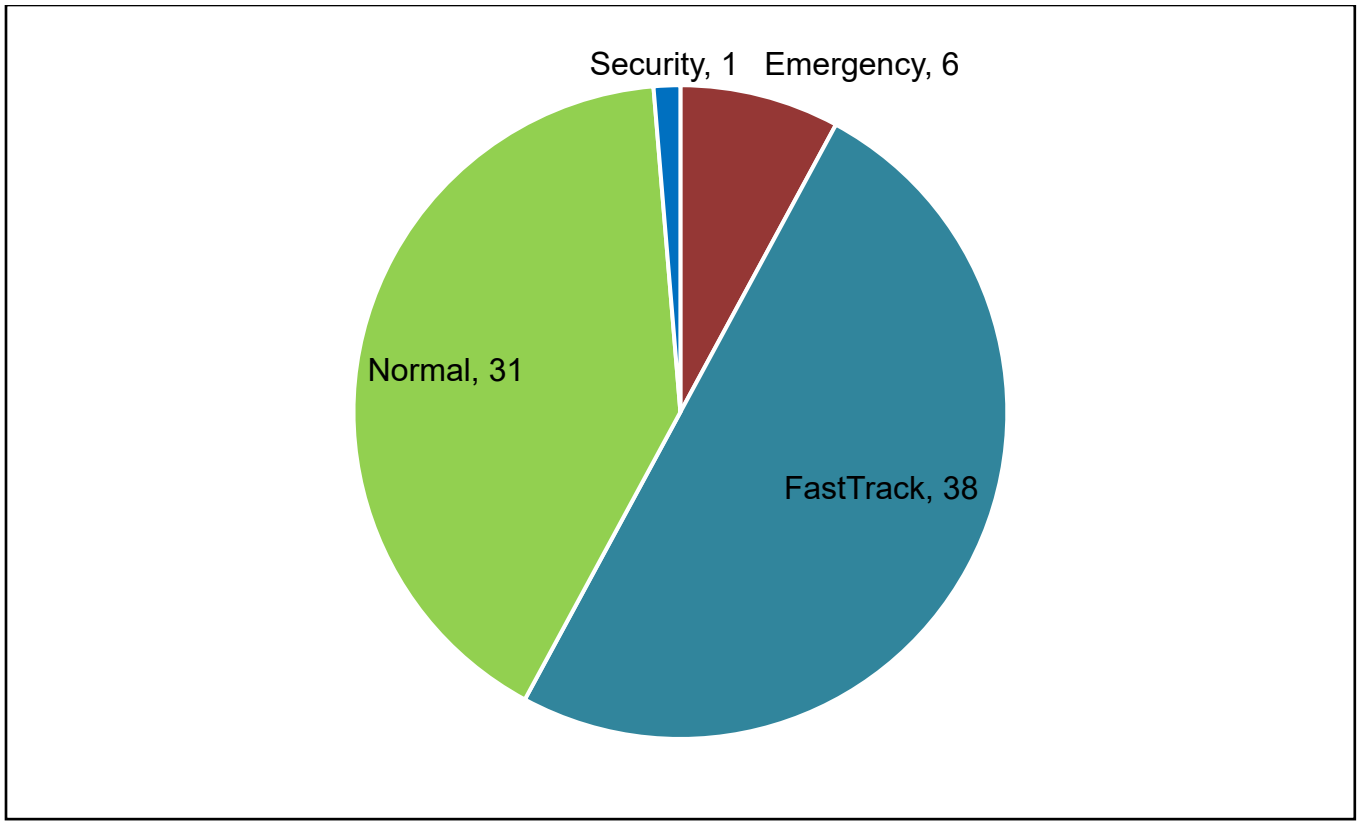
Change Management Key Performance Indicator (KPI)

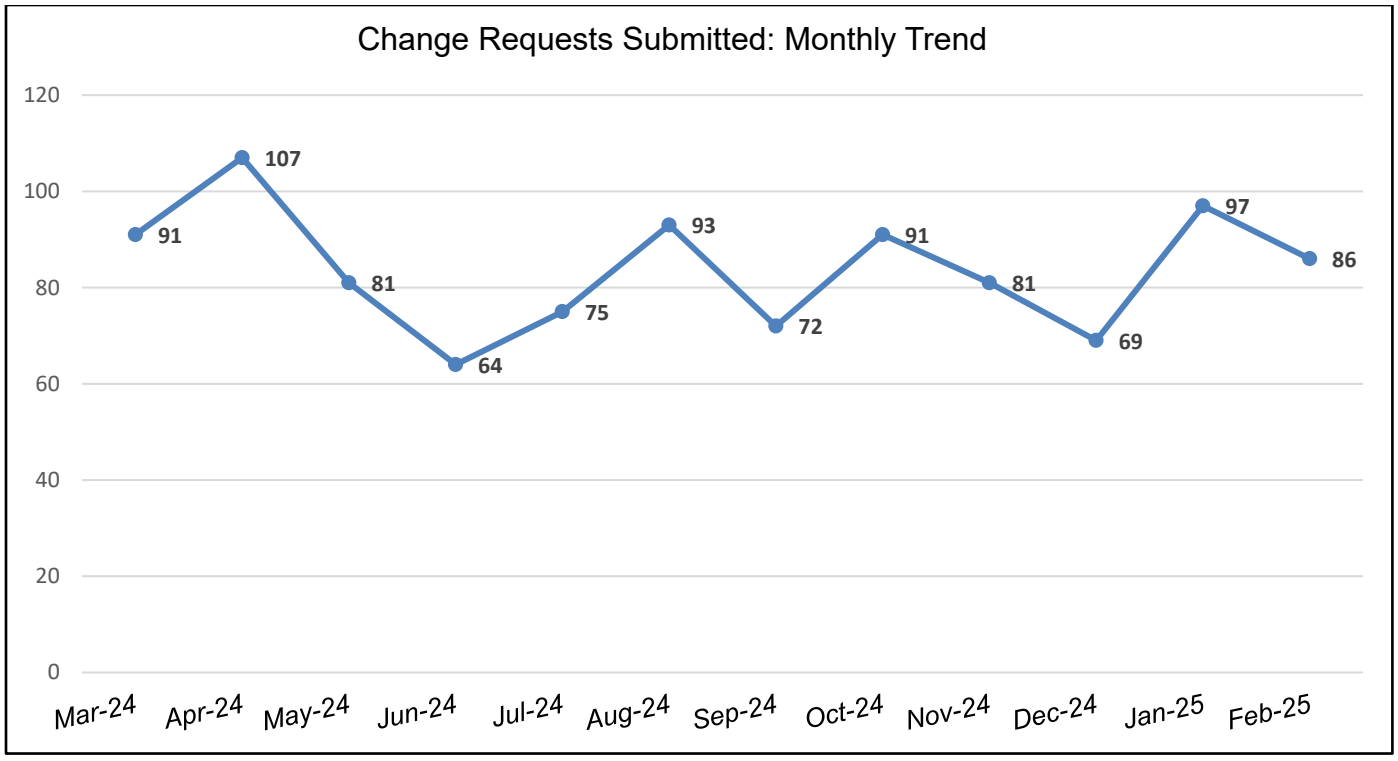
- Change Request Overall Summary in the month of February 2025 KPI:
  - 86 Changes Submitted.
  - 76 Changes Completed and Closed.
  - 96 Active Change Requests in pipeline.
  - 5 Change Requests Cancelled or Rejected.

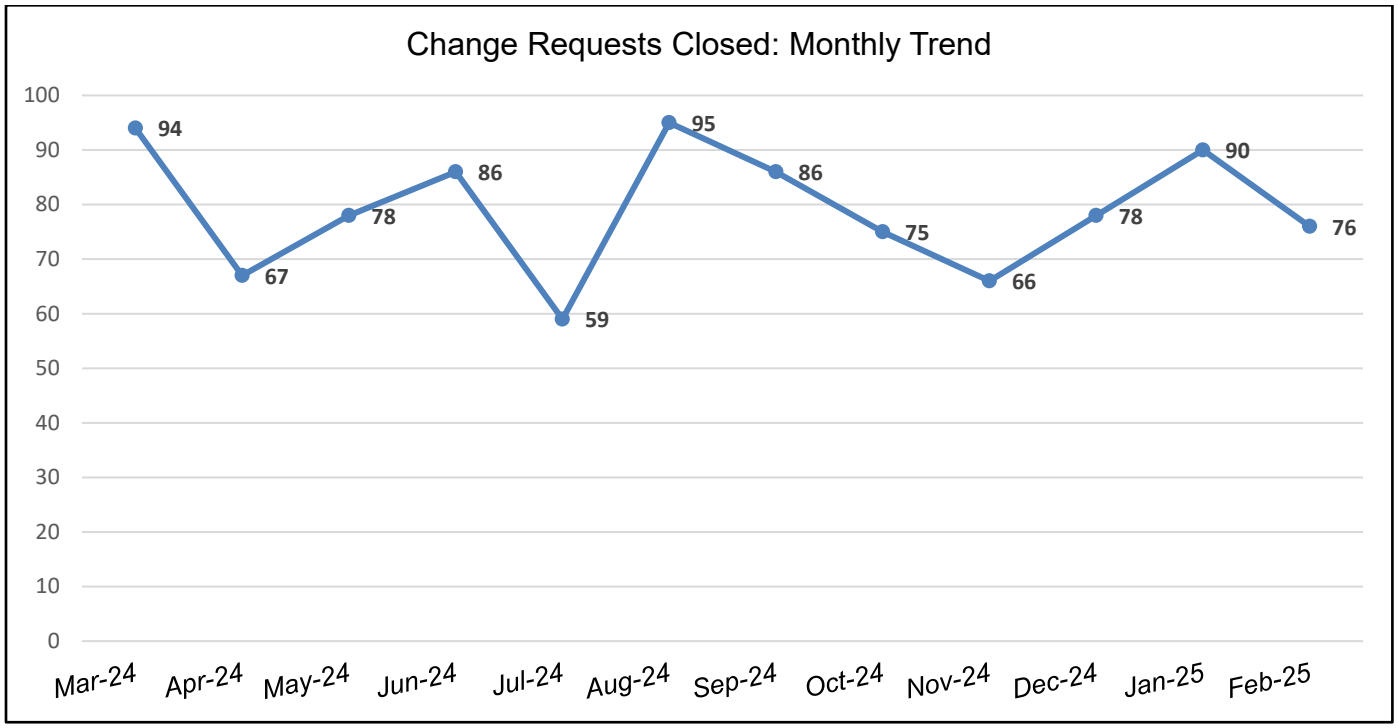
- 86 Change Requests Submitted/Logged in the month of February 2025



- 76 Change Requests Closed in the month of February 2025




Change Requests Submitted: Monthly Trend
120
100
80
60
40
20
0
91
107
81
64
75
93
72
91
81
69
97
86
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25


Change Requests Closed: Monthly Trend
100
90
80
70
60
50
40
30
20
10
0
94
67
78
86
59
95
86
75
66
78
90
76
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25

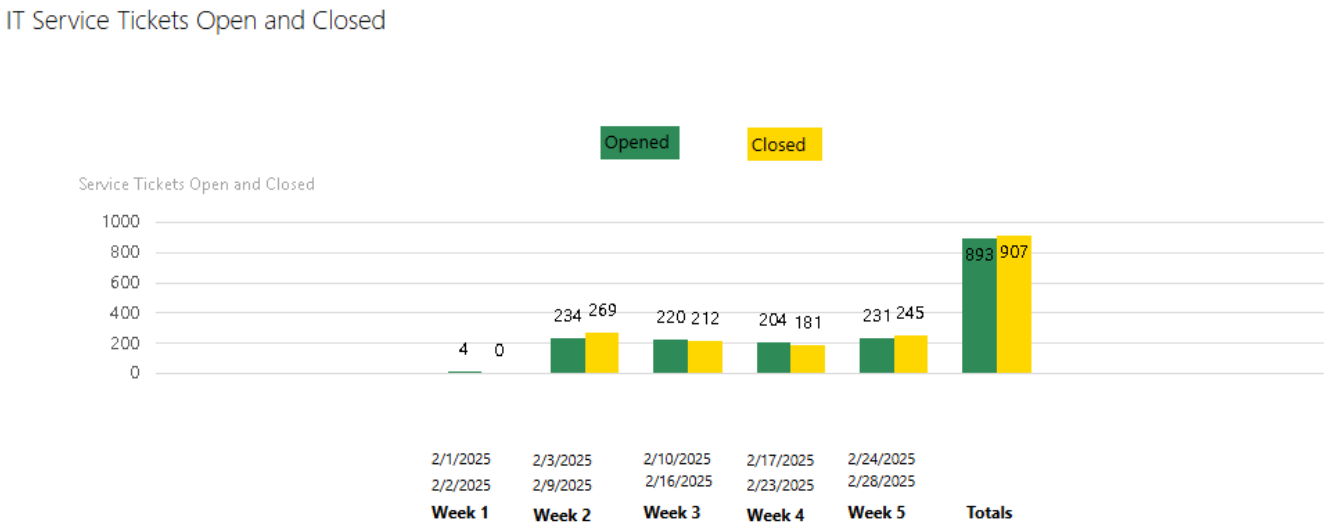
IT Stats: Infrastructure

Application Server Uptimes - February 2025

Data View	HEALTHsuite Claims and Membership System	TruCare Care Management System	All Other Applications and Systems	Timeliness of file submitted by Due Date
MTD	100.00%	100%	100.00%	100.00%
GOAL	99.50%	99.50%	99.50%	99.50%
PERCENTAGE	0	0	0	0

- All mission critical applications are monitored and managed thoroughly.
- There were no outages experienced in the month of February.

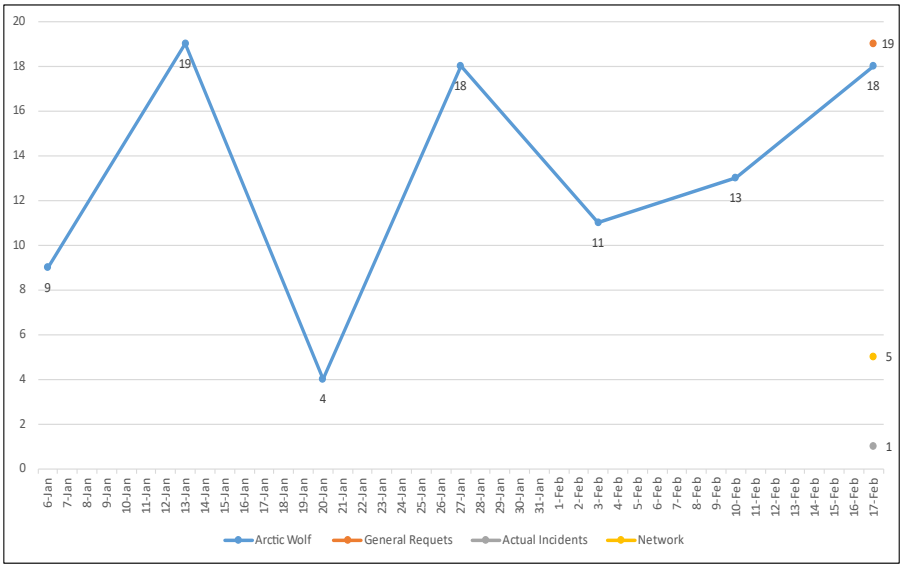
IT Stats: Service Desk



- 893 Service Desk tickets were opened in the month of February 2025, which is 27.22% lower than the previous month (1227) and 6.78% lower than the previous 3-month average of 958.
- 907 Service Desk tickets were closed in the month of February 2025, which is 29.14% lower than the previous month (1228) and 4.52% lower than the previous 3-month average of 950.

IT Stats: Security

Security + Network Events
(Feb 7-21)



- Arctic Wolf
  - Lockouts, OoC, Operational Changes, etc.
- General Requests
  - Internal (e.g. spam, etc)
  - PII/PHI Analysis
  - Vendor (e.g. SecureLink)
- Actual Incidents
  - Finance ACH with Alameda Health Systems
- Network
  - VPN outage
  - General requests

Security + Network Updates

Areas	Item Status	Next Step(s)
Ops.	• **Security Risk Assessment (Intentional Cyber)** ○ Executive Summary (finalized)	• **Security Risk Assessment (Intentional Cyber)** ○ (Phase 2) Remediation prioritization w/ teams NEW • **ProCircular Penetration Test Follow-up Items** ○ Capture with Nessus scans
Projects	• **Nessus (Vuln. Mgmt.)** ○ Authenticated scans (non-prod) – scheduled for Feb. 27th, 2025 ○ Consolidating vulns from pen test, Nessus, and SRA (Rajesh – PM) ○ Finalized scanning policy and ancillary documents NEW • **Cert. Collection** • Captured additional certs from two parties. Effort continues. ○ **Network** ○ DIA circuit is in installation phase in Roseville ○ Working with AT&T to upgrade 3x Internet circuits in Alameda and Roseville from 1gb to 5gb with significant cost savings ○ Contract with AT&T for a new 10gb WAN Circuit between Alameda and Roseville.	• **Nessus (Vuln. Mgmt.)** ○ Continue auth. scan with remaining non-prod ○ Assess completed auth. non-prod results ○ Stage network auth. scan ○ Investigating Defender for (remote) endpoints • **Network** • WAN contract reviewed by Sasi and forwarded to Shava for further processing. • DIA circuit install date for Alameda TBD
GRC	• Incident Response policy completed • Copilot SOP v2 reviewed w/ Debbie • Project upstream involvement (Infra + Network)	

ALAMEDA Alliance FOR HEALTH

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

Analytics

Tiffany Cheang

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

From: **Tiffany Cheang, Chief Analytics Officer**

Date: **March 14th, 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: Dec 2023 – Nov 2024 dates of service
Prior reporting period: Dec 2022 – Nov 2023 dates of service
(Note: Data excludes Kaiser membership data.)

- For the Current reporting period, the top 10.1% of members account for 89.4% of total costs.
- In comparison, the Prior reporting period was slightly lower at 9.8% of members accounting for 83.6% of total costs.
- Characteristics of the top utilizing population remained fairly consistent between the reporting periods:
    - The SPD (non duals) and ACA OE categories of aid decreased to account for 55.3% of the members, with SPDs accounting for 20.6%and ACA OE's at 34.6%.
    - The percent of members with costs >= $30K saw no change from 2.7% to 2.7%.
    - Of those members with costs >= $100K, the percentage of total members has slightly increased to 0.9%.
        - For these members, non-trauma/pregnancy inpatient costs continue to comprise the majority of costs, decreasing to 32.0%.
    - 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 10.1% is more concentrated in the 45-66 year old category (36.0%) compared to the overall population (20.6%).

Analytics

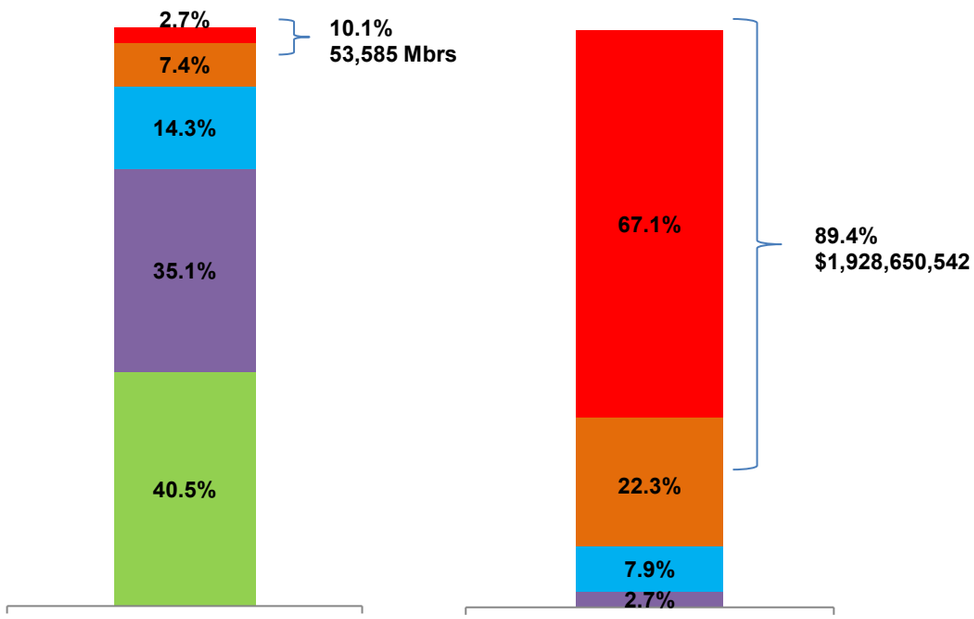
Supporting Documents

Alameda Alliance for Health - Analytics Supporting Documentation: Member - Cost Analysis
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Dec 2023 - Nov 2024

Note: Data incomplete due to claims lag

Run Date: 02/28/2025

Member Cost Distribution



Cost Range	Members	% of Members	Costs	% of Costs
$30K+	14,073	2.7%	$ 1,447,470,043	67.1%
$5K - $30K	39,512	7.4%	$ 481,180,499	22.3%
$1K - $5K	75,917	14.3%	$ 170,186,745	7.9%
< $1K	186,151	35.1%	$ 59,338,344	2.7%
$0	214,928	40.5%	$ -	0.0%
Totals	**530,581**	**100.0%**	**$ 2,158,175,632**	**100.0%**

Top 10.1% of Members = 89.4% of Costs

Cost Range	Members	% of Total Members	Costs	% of Total Costs
$100K+	4,526	0.9%	$ 927,505,174	43.0%
$75K to $100K	1,852	0.3%	$ 161,957,325	7.5%
$50K to $75K	2,689	0.5%	$ 164,188,004	7.6%
$40K to $50K	2,050	0.4%	$ 91,589,787	4.2%
$30K to $40K	2,956	0.6%	$ 102,229,753	4.7%
SubTotal	***14,073***	***2.7%***	***$ 1,447,470,043***	***67.1%***
$20K to $30K	5,461	1.0%	$ 133,061,932	6.2%
$10K to $20K	15,174	2.9%	$ 213,394,067	9.9%
$5K to $10K	18,877	3.6%	$ 134,724,500	6.2%
SubTotal	***39,512***	***7.4%***	***$ 481,180,499***	***22.3%***
Total	**53,585**	***10.1%***	**$ 1,928,650,542**	***89.4%***

Enrollment Status	Members	Total Costs
Still Enrolled as of Nov 2024	407,036	$ 1,960,748,566
Dis-Enrolled During Year	123,545	$ 197,427,065
Totals	**530,581**	**$ 2,158,175,632**

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
10.1% of Members = 89.4% of Costs
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Dec 2023 - Nov 2024
Note: Data incomplete due to claims lag
Run Date: 02/28/2025

10.1% of Members = 89.4% of Costs
20.6% of members are SPDs and account for 26.8% of costs.
34.6% of members are ACA OE and account for 32.6% of costs.
8.2% of members disenrolled as of Nov 2024 and account for 9.4% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Members	% of Members
IHSS	IHSS	195	891	1,086	2.0%
MCAL	MCAL - ADULT	1,253	7,408	8,661	16.2%
	MCAL - BCCTP	-	-	-	0.0%
	MCAL - CHILD	615	3,748	4,363	8.1%
	MCAL - ACA OE	4,475	14,086	18,561	34.6%
	MCAL - SPD	3,853	7,194	11,047	20.6%
	MCAL - DUALS	1,032	3,086	4,118	7.7%
	MCAL - LTC	213	11	224	0.4%
	MCAL - LTC-DUAL	1,046	77	1,123	2.1%
Not Eligible	Not Eligible	1,391	3,011	4,402	8.2%
Total		**14,073**	**39,512**	**53,585**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Costs	% of Costs
IHSS	IHSS	$ 16,184,614	$ 10,076,738	$ 26,261,353	1.4%
MCAL	MCAL - ADULT	$ 118,460,269	$ 89,025,538	$ 207,485,808	10.8%
	MCAL - BCCTP	$ -	$ -	$ -	0.0%
	MCAL - CHILD	$ 47,352,233	$ 41,972,230	$ 89,324,464	4.6%
	MCAL - ACA OE	$ 457,260,177	$ 171,464,811	$ 628,724,989	32.6%
	MCAL - SPD	$ 423,544,051	$ 93,737,662	$ 517,281,713	26.8%
	MCAL - DUALS	$ 95,930,177	$ 36,772,270	$ 132,702,447	6.9%
	MCAL - LTC	$ 33,744,106	$ 173,995	$ 33,918,101	1.8%
	MCAL - LTC-DUAL	$ 111,118,404	$ 1,232,147	$ 112,350,551	5.8%
Not Eligible	Not Eligible	$ 143,876,010	$ 36,725,107	$ 180,601,117	9.4%
Total		**$ 1,447,470,043**	**$ 481,180,499**	**$ 1,928,650,542**	**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%	13%	38%	1%	11%	2%	2%	32%
$75K to $100K	4%	0%	1%	18%	24%	2%	5%	4%	4%	42%
$50K to $75K	5%	0%	2%	25%	29%	5%	6%	5%	4%	26%
$40K to $50K	7%	0%	2%	33%	28%	8%	6%	7%	1%	18%
$30K to $40K	10%	0%	3%	32%	23%	14%	5%	7%	1%	18%
$20K to $30K	3%	1%	5%	36%	24%	7%	7%	7%	1%	17%
$10K to $20K	0%	0%	11%	35%	24%	6%	9%	9%	1%	16%
$5K to $10K	0%	0%	6%	31%	13%	11%	13%	13%	1%	20%
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

Highest Cost Members; Cost Per Member >= $100K
29.9% of members are SPDs and account for 31.2% of costs.
26.2% of members are ACA OE and account for 31.0% of costs.
8.6% of members disenrolled as of Nov 2024 and account for 9.5% of costs.

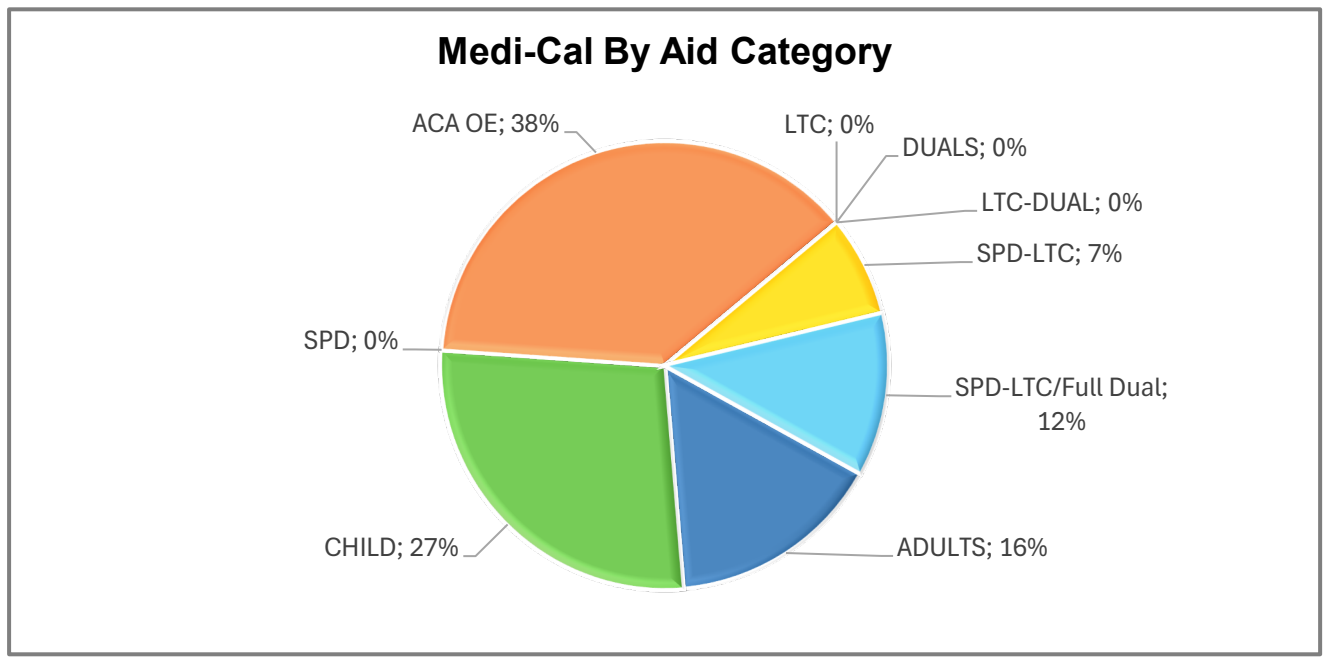
Member Breakout by LOB

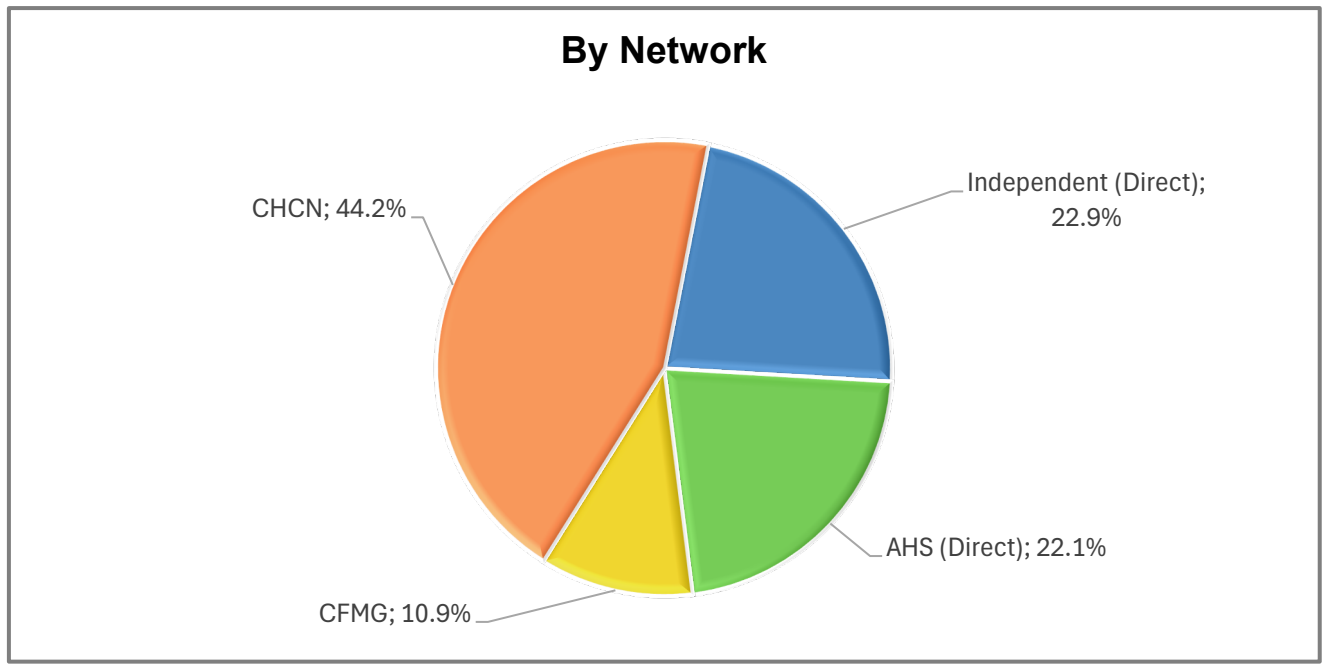
LOB	Eligibility Category	Total Members	% of Members
IHSS	IHSS	44	1.0%
MCAL	MCAL - ADULT	277	6.1%
	MCAL - BCCTP	-	0.0%
	MCAL - CHILD	88	1.9%
	MCAL - ACA OE	1,187	26.2%
	MCAL - SPD	1,352	29.9%
	MCAL - DUALS	442	9.8%
	MCAL - LTC	170	3.8%
	MCAL - LTC-DUAL	575	12.7%
Not Eligible	Not Eligible	391	8.6%
Total		**4,526**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Total Costs	% of Costs
IHSS	IHSS	$ 8,479,009	0.9%
MCAL	MCAL - ADULT	$ 67,906,675	7.3%
	MCAL - BCCTP	$ -	0.0%
	MCAL - CHILD	$ 21,341,388	2.3%
	MCAL - ACA OE	$ 287,601,694	31.0%
	MCAL - SPD	$ 289,565,901	31.2%
	MCAL - DUALS	$ 59,427,738	6.4%
	MCAL - LTC	$ 30,829,014	3.3%
	MCAL - LTC-DUAL	$ 73,950,856	8.0%
Not Eligible	Not Eligible	$ 88,402,899	9.5%
Total		**$ 927,505,174**	**100.0%**

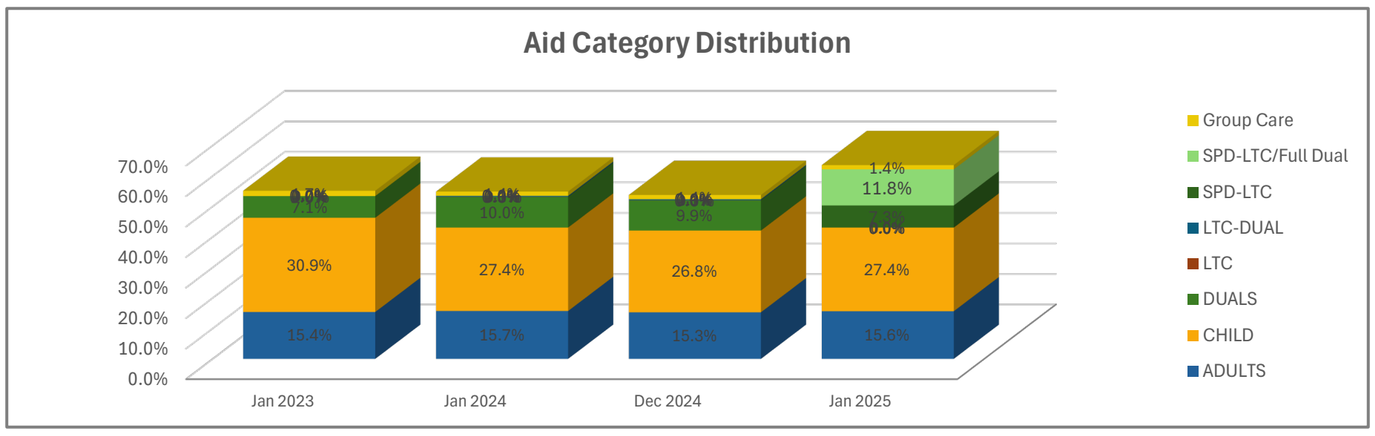
Category of Aid Trend						
Category of Aid	**Jan 2025**	**% of Medi-Cal**	**Independent (Direct)**	**AHS (Direct)**	**CFMG**	**CHCN**
ADULTS	63593	16%	14046	14198	10	35339
CHILD	111656	27%	10727	13453	41897	45579
SPD	0	0%	0	0	0	0
ACA OE	154136	38%	27642	54003	1621	70870
DUALS	1	0%	1	0	0	0
LTC	0	0%	0	0	0	0
LTC-DUAL	0	0%	0	0	0	0
SPD-LTC	29566	7%	8812	5061	1454	14239
SPD-LTC/Full Dual	48153	12%	31033	3515	6	13599
Medi-Cal	407105		92261	90230	44988	179626
Group Care	5779		2153	940	0	2686
Total	**412884**	**100%**	**94414**	**91170**	**44988**	**182312**
Medi-Cal %	98.6%		97.7%	99.0%	100.0%	98.5%
Group Care %	1.4%		2.3%	1.0%	0.0%	1.5%
	Network Distribution		**22.9%**	**22.1%**	**10.9%**	**44.2%**
			% Direct:	**45%**	**% Delegated:**	**55%**





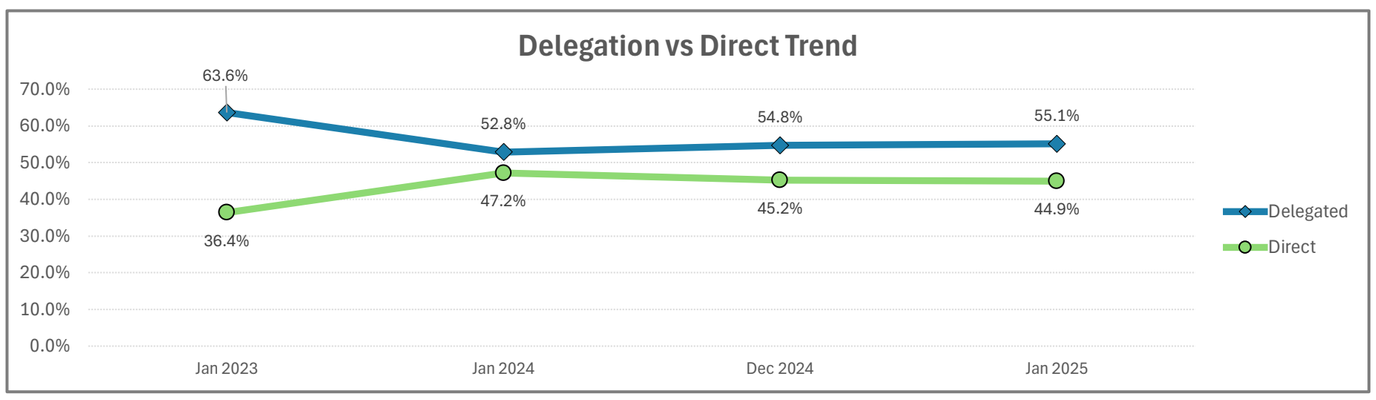
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Jan 2023	Jan 2024	Dec 2024	Jan 2025	Jan 2023	Jan 2024	Dec 2024	Jan 2025	Jan 2023 to Jan 2024	Jan 2024 to Jan 2025	Dec 2024 to Jan 2025
ADULTS	50687	62870	62957	**63593**	15.4%	15.7%	15.3%	15.6%	19.4%	1.1%	1.0%
CHILD	101914	109562	110547	**111656**	30.9%	27.4%	26.8%	27.4%	7.0%	1.9%	1.0%
SPD	28685	35013	36127	**0**	8.7%	8.7%	8.8%	0.0%	18.1%	-100.0%	-100.0%
ACA OE	119302	145842	154565	**154136**	36.2%	36.4%	37.5%	37.9%	18.2%	5.4%	-0.3%
DUALS	23444	40118	40812	**1**	7.1%	10.0%	9.9%	0.0%	41.6%	-100.0%	-100.0%
LTC	6	219	255	**0**	0.0%	0.1%	0.1%	0.0%	97.3%	-100.0%	-100.0%
LTC-DUAL	15	1311	1285	**0**	0.0%	0.3%	0.3%	0.0%	98.9%	-100.0%	-100.0%
SPD-LTC	0	0	0	**29566**	0.0%	0.0%	0.0%	7.3%	0.0%	0.0%	0.0%
SPD-LTC/Full Dual	0	0	0	**48153**	0.0%	0.0%	0.0%	11.8%	0.0%	0.0%	0.0%
Medi-Cal	324053	394935	406548	**407105**	98.3%	98.6%	98.6%	98.6%	17.9%	3.0%	0.1%
Group Care	5761	5603	5790	**5779**	1.7%	1.4%	1.4%	1.4%	-2.8%	3.0%	-0.2%
Total	**329814**	**400538**	**412338**	**412884**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**17.7%**	**3.0%**	**0.1%**



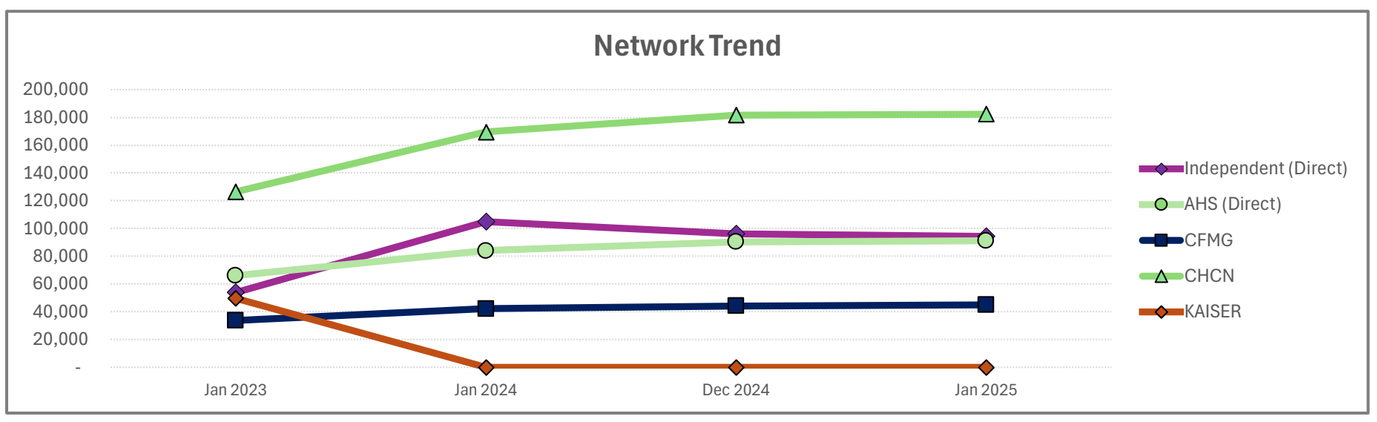
Delegation vs Direct Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	Jan 2023	Jan 2024	Dec 2024	Jan 2025	Jan 2023	Jan 2024	Dec 2024	Jan 2025	Jan 2023 to Jan 2024	Jan 2024 to Jan 2025	Dec 2024 to Jan 2025
Delegated	209892	211633	225787	**227300**	63.6%	52.8%	54.8%	55.1%	0.8%	6.9%	0.7%
Direct	119922	188905	186551	**185584**	36.4%	47.2%	45.2%	44.9%	36.5%	-1.8%	-0.5%
Total	**329814**	**400538**	**412338**	**412884**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**17.7%**	**2.9%**	**0.1%**



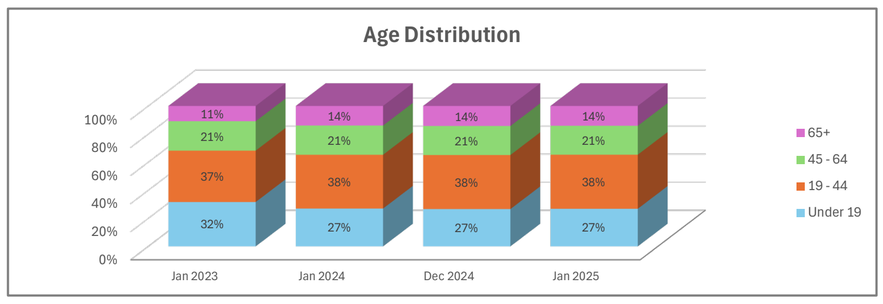
Network Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Jan 2023	Jan 2024	Dec 2024	Jan 2025	Jan 2023	Jan 2024	Dec 2024	Jan 2025	Jan 2023 to Jan 2024	Jan 2024 to Jan 2025	Dec 2024 to Jan 2025
Independent (Direct)	53870	104923	96313	**94414**	16.3%	26.2%	23.4%	22.9%	48.7%	-11.1%	-2.0%
AHS (Direct)	66052	83982	90238	**91170**	20.0%	21.0%	21.9%	22.1%	21.3%	7.9%	1.0%
CFMG	33741	42149	44111	**44988**	10.2%	10.5%	10.7%	10.9%	19.9%	6.3%	1.9%
CHCN	126433	169484	181676	**182312**	38.3%	42.3%	44.1%	44.2%	25.4%	7.0%	0.3%
KAISER	49718	0	0	**0**	15.1%	0.0%	0.0%	0.0%	-100.0%	0.0%	0.0%
Total	**329814**	**400538**	**412338**	**412884**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**17.7%**	**3.0%**	**0.1%**



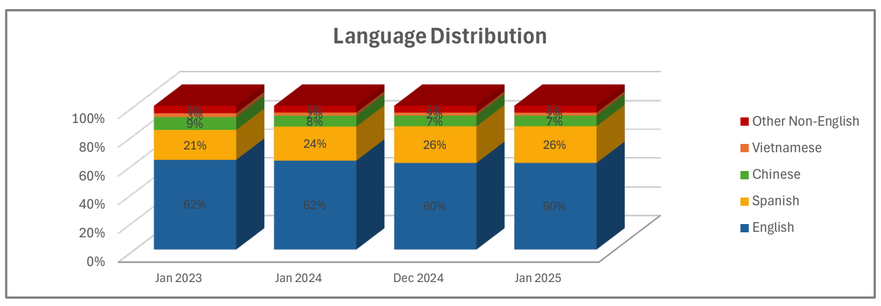
Age Category Trend

Age Category	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Jan 2023	Jan 2024	Dec 2024	Jan 2025	Jan 2023	Jan 2024	Dec 2024	Jan 2025	Jan 2023 to Jan 2024	Jan 2024 to Jan 2025	Dec 2024 to Jan 2025
Under 19	104152	107826	109506	**110492**	32%	27%	27%	27%	3%	2%	1%
19 - 44	120648	153381	158707	**158893**	37%	38%	38%	38%	21%	3%	0%
45 - 64	69127	83432	85272	**85072**	21%	21%	21%	21%	17%	2%	0%
65+	35887	55899	58853	**58427**	11%	14%	14%	14%	36%	4%	-1%
Total	**329814**	**400538**	**412338**	**412884**	**100%**	**100%**	**100%**	**100%**	**18%**	**3%**	**0%**



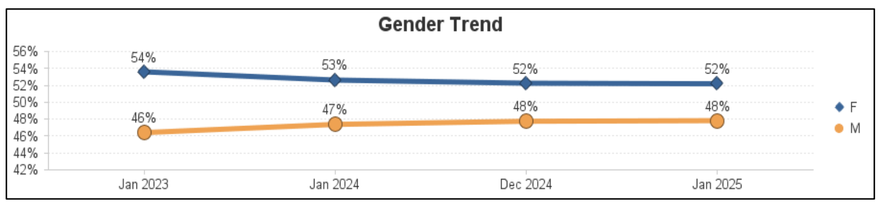
Language Trend

Language	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Jan 2023	Jan 2024	Dec 2024	Jan 2025	Jan 2023	Jan 2024	Dec 2024	Jan 2025	Jan 2023 to Jan 2024	Jan 2024 to Jan 2025	Dec 2024 to Jan 2025
English	205802	247662	248451	**248847**	62%	62%	60%	60%	17%	0%	0%
Spanish	68746	94894	105234	**105452**	21%	24%	26%	26%	28%	10%	0%
Chinese	29364	30650	30806	**30623**	9%	8%	7%	7%	4%	0%	-1%
Vietnamese	8924	8528	8294	**8263**	3%	2%	2%	2%	-5%	-3%	0%
Other Non-English	16978	18804	19553	**19699**	5%	5%	5%	5%	10%	5%	1%
Total	**329814**	**400538**	**412338**	**412884**	**100%**	**100%**	**100%**	**100%**	**18%**	**3%**	**0%**



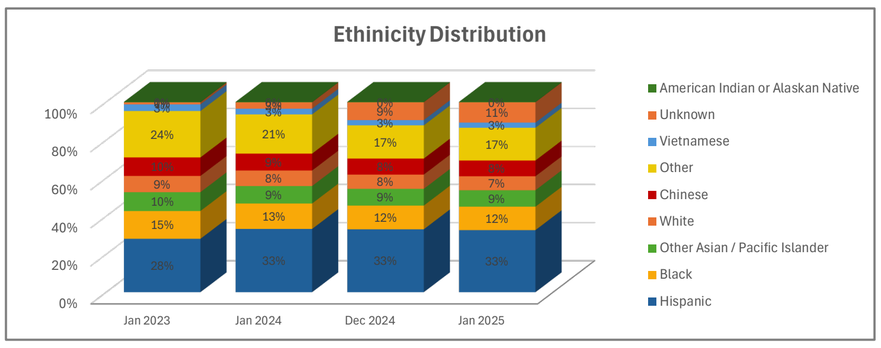
Gender Trend

Gender	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Jan 2023	Jan 2024	Dec 2024	Jan 2025	Jan 2023	Jan 2024	Dec 2024	Jan 2025	Jan 2023 to Jan 2024	Jan 2024 to Jan 2025	Dec 2024 to Jan 2025
F	176768	210770	215451	**215437**	54%	53%	52%	52%	16%	2%	0%
M	153046	189768	196887	**197447**	46%	47%	48%	48%	19%	4%	0%
Total	**329814**	**400538**	**412338**	**412884**	**100%**	**100%**	**100%**	**100%**	**18%**	**3%**	**0%**



Ethnicity Trend

Ethnicity	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Jan 2023	Jan 2024	Dec 2024	Jan 2025	Jan 2023	Jan 2024	Dec 2024	Jan 2025	Jan 2023 to Jan 2024	Jan 2024 to Jan 2025	Dec 2024 to Jan 2025
Hispanic	92528	133127	136294	**134750**	28%	33%	33%	33%	30%	1%	-1%
Black	48188	53587	51323	**50793**	15%	13%	12%	12%	10%	-6%	-1%
Other Asian / Pacific Islander	32634	36752	36322	**35742**	10%	9%	9%	9%	11%	-3%	-2%
White	28155	32654	30931	**30308**	9%	8%	8%	7%	14%	-8%	-2%
Chinese	32069	35545	34683	**34193**	10%	9%	8%	8%	10%	-4%	-1%
Other	80433	82586	71988	**70977**	24%	21%	17%	17%	3%	-16%	-1%
Vietnamese	11535	12000	11366	**11227**	3%	3%	3%	3%	4%	-7%	-1%
Unknown	3582	13480	38664	**44135**	1%	3%	9%	11%	73%	69%	12%
American Indian or Alaskan Native	690	807	767	**759**	0%	0%	0%	0%	14%	-6%	-1%
Total	**329814**	**400538**	**412338**	**412884**	**100%**	**100%**	**100%**	**100%**	**18%**	**3%**	**0%**



City	Jan 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	162418	40%	25040	42201	17622	77555
HAYWARD	65293	16%	13920	17966	7631	25776
FREMONT	38377	9%	16065	6691	2318	13303
SAN LEANDRO	33374	8%	8587	5638	4321	14828
UNION CITY	14794	4%	5789	2637	871	5497
ALAMEDA	13804	3%	3393	2454	2059	5898
BERKELEY	15544	4%	4308	2383	1810	7043
LIVERMORE	13296	3%	1978	580	2285	8453
NEWARK	9511	2%	2787	4127	572	2025
CASTRO VALLEY	9649	2%	2824	1544	1469	3812
SAN LORENZO	7350	2%	1499	1666	876	3309
PLEASANTON	7891	2%	1929	398	827	4737
DUBLIN	7699	2%	2150	399	913	4237
EMERYVILLE	2911	1%	668	610	468	1165
ALBANY	2574	1%	663	305	596	1010
PIEDMONT	487	0%	122	180	72	113
SUNOL	85	0%	25	14	7	39
ANTIOCH	58	0%	22	8	15	13
Other	1990	0%	492	429	256	813
Total	407105	100%	**92261**	**90230**	**44988**	**179626**

Group Care By City

City	Jan 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	1816	31%	335	356	0	1125
HAYWARD	667	12%	320	158	0	189
FREMONT	667	12%	438	81	0	148
SAN LEANDRO	604	10%	245	90	0	269
UNION CITY	290	5%	182	43	0	65
ALAMEDA	305	5%	87	26	0	192
BERKELEY	145	3%	49	9	0	87
LIVERMORE	100	2%	32	3	0	65
NEWARK	136	2%	78	33	0	25
CASTRO VALLEY	191	3%	84	31	0	76
SAN LORENZO	140	2%	47	27	0	66
PLEASANTON	68	1%	23	2	0	43
DUBLIN	123	2%	44	5	0	74
EMERYVILLE	34	1%	12	5	0	17
ALBANY	20	0%	10	1	0	9
PIEDMONT	9	0%	1	1	0	7
SUNOL	1	0%	1	0	0	0
ANTIOCH	26	0%	7	5	0	14
Other	437	8%	158	64	0	215
Total	**5779**	**100%**	**2153**	**940**	**0**	**2686**

Total By City

City	Jan 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	164234	40%	25375	42557	17622	78680
HAYWARD	65960	16%	14240	18124	7631	25965
FREMONT	39044	9%	16503	6772	2318	13451
SAN LEANDRO	33978	8%	8832	5728	4321	15097
UNION CITY	15084	4%	5971	2680	871	5562
ALAMEDA	14109	3%	3480	2480	2059	6090
BERKELEY	15689	4%	4357	2392	1810	7130
LIVERMORE	13396	3%	2010	583	2285	8518
NEWARK	9647	2%	2865	4160	572	2050
CASTRO VALLEY	9840	2%	2908	1575	1469	3888
SAN LORENZO	7490	2%	1546	1693	876	3375
PLEASANTON	7959	2%	1952	400	827	4780
DUBLIN	7822	2%	2194	404	913	4311
EMERYVILLE	2945	1%	680	615	468	1182
ALBANY	2594	1%	673	306	596	1019
PIEDMONT	496	0%	123	181	72	120
SUNOL	86	0%	26	14	7	39
ANTIOCH	84	0%	29	13	15	27
Other	2427	1%	650	493	256	1028
Total	412884	100%	**94414**	**91170**	**44988**	**182312**

Human Resources

Anastacia Swift

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

From: **Anastacia Swift, Chief Human Resources Officer**

Date: **March 14th, 2025**

Subject: **Human Resources Report**

Staffing

- As of March 1st, 2025, the Alliance had 648 full time employees and 0-part time employee.

- On March 1st, 2025, the Alliance had 66 open positions in which 13 signed offer acceptance letters have been received with start dates in the near future resulting in a total of 53 positions open to date. The Alliance is actively recruiting for the remaining 53 positions and several of these positions are in the interviewing or job offer stage.

- Summary of open positions by division:

Division	Open Position March 1st	Signed Offers Accepted by Department	Remaining Recruitment Positions
Healthcare Services	10	5	5
Operations	38	7	31
Healthcare Analytics	2	0	2
Information Technology	8	1	7
Finance	2	0	2
Compliance	3	0	3
Human Resources	3	0	3
Health Equity	0	0	0
Executive	0	0	0
Total	66	13	53

- Our current recruitment rate is 9%.

Employee Recognition

- Employees reaching major milestones in their length of service at the Alliance in February 2025 included:

  5 years:
  - Leslie M (Vendor Management)
  - Rachel M (Case/Disease Management)

  7 years:
  - Ashley A (Quality Management)
  - Karina R (Operations)

  8 years:
  - Katrina V (Marketing & Communications)
  - Christine C (Finance)

  9 years:
  - Anna A (Grievance and Appeals)
  - Arwyn G (IT Infrastructure)
  - Sharanjit K (IT Ops and Quality Apps Mgt)
  - Megan C (Human Resources)

  10 years:
  - Andre M (IT – Apps Management, IT Quality & Process Improvement)
  - Errin P (Provider Services)

  12 years:
  - Tiffany C (Healthcare Analytics)

  14 years:
  - Judy R (Member Services)

  21 years:
  - Eric V (Finance)