ALAMEDA Alliance FOR HEALTH

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Board of Governors

Regular Meeting

Friday, May 9th, 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, May 9th, 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 407926431#. If you use the link and participate via computer, you may use the chat function, and request an opportunity to speak on any agendized item, including general public comment. Your request to speak must be received before the item is called on the agenda. If you participate by telephone, please submit your comments to the Clerk of the Board at the email address listed above or by providing your comments during the meeting at the end of each agenda item. Oral comments to address the Board of Governors are limited to two (2) 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 May 9th, 2025, at 12:00 p.m. in Alameda County, California, by Rebecca Gebhart, Presiding Officer. This meeting is to take place in person and by video conference call)

2. ROLL CALL

3. AGENDA APPROVAL

4. INTRODUCTIONS

5. CONSENT CALENDAR

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

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

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

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

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

e) APPROVE RESOLUTION FOR QIHEC NOMINEE

6. BOARD MEMBER REPORTS

a) COMPLIANCE ADVISORY COMMITTEE

b) FINANCE COMMITTEE

7. CEO UPDATE

8. BOARD BUSINESS

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

b) COMMUNITY SUPPORTS INFORMATIONAL UPDATE

i. PUBLIC COMMENT

c) MEDICAL MANAGEMENT UPDATE

9. STANDING COMMITTEE UPDATES

a) PEER REVIEW AND CREDENTIALING COMMITTEE

b) QUALITY IMPROVEMENT HEALTH EQUITY COMMITTEE

10. STAFF UPDATES

11. UNFINISHED BUSINESS

12. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS

13. PUBLIC COMMENT (NON-AGENDA ITEMS)

14. 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) 995-1207.

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

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

I hereby certify that the agenda for the Board of Governors was posted on the Alameda Alliance for Health's web page at www.alamedaalliance.org by May 6th, 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.

ALAMEDA Alliance FOR HEALTH

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Consent Calendar

ALAMEDA Alliance FOR HEALTH

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Board of Governors Meeting Minutes

BOARD OF GOVERNORS
Regular Meeting Minutes
Friday, March 14th, 2025
12:00 p.m. – 2:00 p.m.

Video Conference Call and

1240 S. Loop Road
Alameda, CA 94502

1. CALL TO ORDER

Board of Governors Present: Rebecca Gebhart (Chair), Dr. Noha Aboelata (Vice-Chair), Dr. Kathleen Clanon, Dr. Rollington Ferguson, James Jackson, Byron Lopez, Dr. Marty Lynch, Andie Martinez Patterson, Dr. Kelley Meade, Jody Moore, Wendy Peterson, Andrea Schwab-Galindo, Dr. Evan Seevak, Supervisor Lena Tam, Natalie Williams

Board of Governors Remote: Andrea Ford (Traditional Brown Act), Jody Moore (Just Cause)

Board of Governors Excused: Aaron Basrai, Tosan Boyo, Yeon Park

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 12:02 p.m.

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

Chair Gebhart formally welcomed Dr. Kathleen Clanon as a duly appointed voting board member. Additionally, Mr. Troy Szabo, the General Counsel, was also introduced.

5. CLOSED SESSION
PERSONNEL MATTER: PUBLIC EMPLOYEE EVALUATION – CHIEF EXECUTIVE OFFICER (GOV. CODE SECTION 54957(b)(1)).

6. CONSENT CALENDAR

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**

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

Vote: The motion passed unanimously.

Ayes: Dr. Kathleen Clanon, Dr. Rollington Ferguson, Andrea Ford, James Jackson, Byron Lopez, Dr. Marty Lynch, Andie Martinez Patterson, Dr. Kelley Meade, Jody Moore, 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.

7. REPORT OUT: CLOSED SESSION

The Board of Governors convened in a closed session at 12:10 p.m. and reconvened in an open session at 1:03 p.m. Mr. Troy Szabo stated that there were no reportable items to disclose from the closed session.

8. BOARD MEMBER REPORTS

a) BOARD CHAIR REPORT

i. **FORM 700 SUBMISSION**

Chair Gebhart reminded the board members who have not yet submitted their Form 700 forms that the deadline for submission is April 1st. The forms may be submitted electronically or in hard copy and can be delivered to the Board Clerk.

b) COMPLIANCE ADVISORY COMMITTEE

Dr. Kelley Meade provided an update on the Compliance Advisory Committee meeting that occurred on March 14th. The committee addressed internal audit processes concerning fraud, waste, and abuse. The joint audit from DMHC and DHC has been postponed, and further updates will be shared in a future meeting.

c) FINANCE COMMITTEE

Dr. Ferguson provided an update on the Finance Committee meeting held on March 11th. The committee reviewed the financial results and highlights for January and discussed the Fiscal Year 2025 Quarter 2 forecast. The committee recommended limiting spending Community Supports to the budgeted amount approved by the State and authorized the Executive Team to discontinue services if necessary to manage the financial situation. However, any service discontinuation must be brought back to the full board for a vote.

9. CEO UPDATE

In the CEO Update, Matthew Woodruff corrected a statement from the Finance Committee meeting, clarifying that CMS retroactively cut the social determinants of health guidance, not DHCS. He also mentioned the uncertainty of future approvals for community support.

10. BOARD BUSINESS

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

Chief Financial Officer Gil Riojas presented the financial statements for November 2024, December 2024, and January 2025, noting net losses and changes in enrollment.

November 2024 Financial Statement

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 the required but continued to remain above minimum requirements.

Enrollment

In November, Enrollment increased by 725 members.

Net Income

For the month ended November 30th, 2024, the actual Net Loss was $27.5 million vs. budgeted Net Loss of $10.0 million. For the fiscal YTD, the 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.

December 2024 Financial Statement

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 the required but continued to remain above minimum requirements.

Enrollment

In December, Enrollment increased by 5,348 members.

Net Income

For the month ended December 31st, 2024, the actual Net Loss was $8.6 million vs. budgeted Net Loss of $26.8 million. For the fiscal YTD, the 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.

January 2025 Financial Statement

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 the required but continued to remain above minimum requirements.

Enrollment

In January, Enrollment increased by 602 members.

Net Income

For the month ended January 31st, 2025, the actual Net Loss was $6.7 million vs. budgeted Net Loss of $3.2 million. For the fiscal YTD, the 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 in 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.

Question: Dr. Lynch asked if the plan would keep tracking SPD costs outside of long-term care.

Response: Mr. Riojas confirmed that the plan will continue to capture the category of service for long-term care costs and will work on identifying SPD costs separately.

Question: Dr. Seevak asked why the state combined SPD and long-term care categories.

Response: Mr. Riojas indicated that the speculation is that it was intended to facilitate rate development for the state and Mercer.

Question: Dr. Ferguson asked about the timeline for UIS's impact on financials.

Response: Mr. Riojas and Mr. Woodruff indicated that the impact is being evaluated for next year's budget rather than this year's. The exact timing remains uncertain, but it is anticipated to begin next fiscal year.

Question: Dr. Lynch inquired whether the monthly trend would remain positive.

Response: Mr. Riojas mentioned that the forecast is near break-even, with some months reporting slight net losses and others showing slight net income.

Motion: A motion was made by Natalie Williams and seconded by Dr. Kelley Meade to approve the November 2024, December 2024 and January 2025 financial statements.

Vote: The motion was passed unanimously.

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

b) FISCAL YEAR 2025 SECOND QUARTER FORECAST

Highlights:

- 2024 Projected Net Loss of $97.8 million.
- The projected excess Tangible Net Equity at 6/30/25 of $75.8 million is 193% of the required TNE.
- Year-end enrollment is 415,000.
- The Forecast now includes MCO Tax Revenue and Expenses 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 from 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 and consultant expenses.

Question: Dr. Lynch inquired whether the monthly trend would remain positive.

Response: Mr. Riojas mentioned that the forecast is near break-even, with some months reporting slight net losses and others showing slight net income.

Motion: A motion was made by Dr. Seevak and seconded by James Jackson to approve the Fiscal Year 2025 Second Quarter Forecast.

Vote: The motion passed unanimously.

Ayes: Dr. Kathleen Clanon, Dr. Rollington Ferguson, Andrea Ford, James Jackson, Byron Lopez, Dr. Marty Lynch, Andie Martinez Patterson, Dr. Kelley Meade, Jody Moore, 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 THE FINANCE COMMITTEE'S RECOMMENDATION TO REDUCE COMMUNITY SUPPORT DOLLARS

CEO Matt Woodruff presented an analysis of the potential savings associated with the discontinuation of community support programs. The Board then discussed the Finance Committee's recommendation to reduce spending on the Community Supports Program to the amount provided by the state, which is $14 million.

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). The original FY 25 budget estimate was $35M.

CS Discontinuation Considerations

- DHCS requires 90-day notification before termination.
- Contract changes require 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 on community benefit organizations currently offering the services.

Question: Supervisor Tam asked which community support will be the most impacted by the cuts.

Response: Mr. Woodruff said that housing will likely be the most impacted, but the exact proportions are still being evaluated.

Question: Ms. Peterson asked if the capacity will be available for ECM providers to access and utilize community support to stabilize a person.

Response: Dr. Carey mentioned that the team is assessing additional resources within the community that could replace any services discontinued within community support.

Question: Ms. Peterson asked if the forecast included spending the $14 million.

Response: Mr. Riojas stated that the forecast did not account for this as a savings. It will be revised in the Q3 forecast.

Comment: Dr. Ferguson emphasized the financial necessity of reducing spending on Community Support, highlighting the need to preserve the institution of the Alliance.

Comment: Dr. Lynch expressed the need to analyze the eleven programs funded and their impact on medical management, particularly hospital days, and suggested involving community partners in the decision-making process.

Comment: Dr. Canon stressed the importance of preserving the infrastructure built over nearly a decade and involving providers in understanding the consequences of changes.

Comment: Ms. Peterson mentioned the potential impact on community partners and the need for a thoughtful approach, considering the blended funding of some programs.

Comment: Supervisor Tam expressed concerns about the blunt nature of the proposed cuts and emphasized the need to better understand their impact on small programs.

Motion: A motion was made by Dr. Ferguson and seconded by Dr. Kelley Meade to end the ongoing discussion and proceed to vote on the original motion.

Vote: The motion passed unanimously.

Ayes: Aarondeep Basrai, Colleen Chawla, Andrea Ford, Byron Lopez, Dr. Marty Lynch, Dr. Michael Marchiano, Andie Martinez Patterson, Dr. Kelley Meade, Jody Moore, Supervisor Lena Tam, Vice Chair Dr. Noha Aboelata, Chair Rebecca Gebhart.

No opposition or abstentions.

Motion: A motion was made by Dr. Ferguson and seconded by Natalie Williams to approve the Finance Committee's recommendation to reduce spending on the Community Supports Program to the amount provided by the state, which is $14 million, and that if any services need to be terminated, the decision must come back to the full board for a vote.

Vote: The motion passed with eight (8) in favor, six (6) against, and one (1) abstention.

Ayes: Dr. Rollington Ferguson, James Jackson, Byron Lopez, Andie Martinez Patterson, Jody Moore, Andrea Schwab-Galindo, Dr. Evan Seevak, Natalie Williams.

Nays: Dr. Kathleen Clanon, Dr. Marty Lynch, Dr. Kelley Meade, Wendy Peterson, Vice Chair Dr. Noha Aboelata, Chair Rebecca Gebhart.

Abstain: Supervisor Lena Tam

d) MEDICAL MANAGEMENT UPDATE

Due to time constraints, the Medical Management Update will be presented at the next board meeting.

11. STANDING COMMITTEE UPDATES

a) PEER REVIEW AND CREDENTIALING COMMITTEE

b) PHARMACY & THERAPEUTICS

c) QUALITY IMPROVEMENT HEALTH EQUITY COMMITTEE

d) COMMUNITY ADVISORY COMMITTEE

All updates from the standing committees have been included as reports in the board packet.

12. STAFF UPDATES

There were no staff updates.

13. UNFINISHED BUSINESS

The Medical Management presentation has been rescheduled for the upcoming board meeting.

14. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS

None.

15. PUBLIC COMMENT (NON-AGENDA ITEMS)

There were no public comments for non-agenda items.

16. ADJOURNMENT

Chair Gebhart adjourned the meeting at 2:24 p.m.

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Finance Committee Meeting Minutes

ALAMEDA ALLIANCE FOR HEALTH
FINANCE COMMITTEE
REGULAR MEETING

March 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, Gil Riojas
Committee Members by Teleconference: None
Committee Members Excused: Yeon Park
Board of Governor members in-person and on Conference Call: Dr. Kathleen Clanon, Andie Martinez Patterson, Dr. Kelley Meade

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

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 a CEO Update.

b) REVIEW AND APPROVE JANUARY 2025 MONTHLY FINANCIAL STATEMENTS

<u>JANUARY 2025 Financial Statement Summary</u>

Enrollment:

Enrollment increased by 602 members since December and an overall increase of 8,838 members since June 2024.

Net Income:

For the month ending January 31st, 2025, the Alliance reported a Net Loss of $6.7 million (versus budgeted Net Income of $3.2 million). For the year-to-date, the Alliance recorded a Net Loss of $103.9 million versus a budgeted Net Loss of $94.6 million.

Premium Revenue:

For the month ending January 31st, 2025, actual Revenue was $190.7 million vs. our budgeted amount of $192.0 million.

Medical Expense:

Actual Medical Expenses for the month were $191.1 million, vs. budgeted amount of $178.8 million. For the year-to-date, actual Medical Expenses were $1.3 billion vs. budgeted Medical Expense of $1.2 billion.

Medical Loss Ratio:

Our MLR ratio for this month was reported as 100.2%. The year-to-date MLR was 104.8%.

Administrative Expense:

Actual Administrative Expenses for the month ending January 31st, 2025, were $8.9 million vs. our budgeted amount of $11.5 million. Our Administrative Loss Ratio (ALR) is 4.6% of our Revenue for the month, and 5.6% of Net Revenue for year-to-date.

Other Income / (Expense):

As of January 31st, 2025, our YTD interest income from investments show a gain of $20.1 million.

Managed Care Organization (MCO) Provider Tax:

For the month ending January 31st, 2025, we reported $65.8 million MCO Tax Revenue vs. budgeted MCO Tax Revenue of $63.7 million. Our MCO Tax Expense was $65.8 million vs. budgeted MCO Tax Expense of $63.7 million.

Tangible Net Equity (TNE):

For January, the DMHC requires that we have $81.4 million in TNE, and we reported $151.5 million, leaving an excess of $70.2 million. As a percentage we are at 186%, which remains above the minimum required.

Cash and Cash Equivalents:

We reported $462.1 million in cash; $446.5 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.

Question: Mr. Jackson inquired about the next quarter and whether Gil believes we will continue to trend downward or if he anticipates a turnaround.

Response: Gil mentions he notices a slight curve and believes we will finish the year with a somewhat higher TNE than what we are currently reporting.

Motion: A motion was made by James Jackson, and seconded by Dr. Rollington Ferguson, to accept and approve the January 2025 Financial Statements.

Motion Passed

No opposed or abstained.

c) REVIEW AND APPROVE Q2 FORECAST

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.

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.

Question: Dr. Ferguson asked a question about the year-end enrollment, which is anticipated to be 415,000. However, based on the percentages that Gil described, that figure is nearly 100,000. He inquired about the impact of that.

Response: Mr. Riojas stated that we are not expecting any impact this fiscal year. We examined potential revenue, and it could be upwards of six to seven hundred million in revenue impact. We are currently analyzing this, and we continue to model the population concerning revenue and expenses.

Question: Ms. Gebhart had a question regarding the targeted rate increase, specifically whether there is a net possible gain or loss to the Alliance.

Response: Mr. Riojas stated that it's a risk-based program, indicating there could be favorable or unfavorable outcomes for drivers.

Motion: A motion was made by James Jackson and seconded by Rebecca Gebhart to accept and approve the FY 2025 Q2 Forecast.

Motion Passed

No opposed or abstained.

d) REVIEW AND APPROVE COMMUNITY SUPPORTS REVENUE AND EXPENSE ANALYSIS

Chief Financial Officer Gil Riojas presented an analysis of the potential savings associated with the discontinuation of community support programs and examined the implications of expenditure on overall revenue. Two scenarios were outlined for consideration.

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 FY 25 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

Comment: Dr. Carey remarked that the community support we've considered cutting is poorly utilized. Additionally, the vendors we currently contract with are pulling back from that specific community support due to its structure. This is why it is one of the community supports we would consider terminating.

Comment: Dr. Clanon highlighted that community organizations have invested significant time, effort, and funds into creating community supports. If these services were cut, rebuilding the

existing infrastructure would be incredibly challenging. Acknowledging the current hardships and future challenges, she emphasized the importance of maintaining services to ensure they can be expanded later. She suggested that the committee consider temporary limitations on the number of individuals served, with the understanding that these measures could be reassessed in the future as the organization's financial situation improves, thereby preventing disproportionate impacts from proposed cuts.

Comment: Dr. Ferguson emphasized the urgent need for a balanced budget, given the limited time available for extensive interventions. Although program cuts are undesirable, the challenges posed by declining TNE, rising MLR, and increasing expenses require prompt action. He further stated that relying solely on projections is insufficient and that we must aim for a more balanced fiscal year-end. A $96 million loss is detrimental, and we should focus on minimizing it wherever possible. He further stated that while we are not discontinuing programs, we will assess them as needed and that it is crucial to acknowledge that past challenges stemmed from inadequate state funding and ineffective management. The state expects us to operate within our means, necessitating difficult decisions and essential reductions.

After discussion and amendment, the following motion was adopted.

Motion: A motion was made by James Jackson and seconded by Dr. Rollington Ferguson to spend to the anticipated revenue of $14 million, with the executive team having the ability to consider the termination of community-based programs, but the full board must approve any termination.

Motion Approved

Opposition: Rebecca Gebhart

No abstentions.

e) MEDICAL EXPENSES UPDATE

AAH Top 5%

- Top 5% of AAH members account for ~80% of total costs
    - ~26K members
    - Top Cost categories:
        - Inpatient = 32%
        - SNF/ICF/DD = 5.5%
        - ER = 3.6%
        - Pharmacy = 20%

Inpatient Interventions

- On-going
    - Over/Under Utilization Workgroup – started in Dec 2024 – meets monthly
    - Receive real time information/Hospital partner rounds - weekly
    - Transitional Care Services (TCS); close follow up of members discharged from a facility/hospital
    - Expanded Pharmacy outreach to members with a 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
- 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 Interventions

- On-going
    - Contract amendments: Sitter criteria (being evaluated by contracting team)
    - Alliance staff on-site visitation in LTC facilities
    - LTC rounds (LTC/IP/ECM) – weekly
    - Ensuring claims paid at the appropriate level of care
    - Monitor payment of non-covered MediCal benefits, such as Congregate Living Health Facilities
    - Ensure definitions are appropriate and appropriate categorized in Finance Systems
    - Refine Community Supports Criteria – Dec 2024
- Future
    - Ensure members have appropriate DHCS LTC aid code
    - Further refine Community Supports criteria – March 2025 (effective ~July 2025)

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 Interventions

- On-going
    - Formulary/Prior Authorization (PA) review (ex – Anticoagulants)
    - Monitor new claims for carve out drugs/PAD 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 Strategies

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

Strategies for Other Members

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

Question: Ms. Gebhart asked about the capacity for long-term support services and how much of it is contracted out.

Response: Dr. Carey stated they lack contracted assistance for long-term care. They have a small team of three and a liaison who collaborates with facilities, while social workers focus on staff and member interactions. Onsite visits are prioritized by member location.

Question: Ms. Gebhart asked Dr. Carey if she could address the capacity of the community health workers (CHW), including the size of the team and what kind of capacity we have.

Response: Dr. Carey stated that in the Highland Emergency Department (ED), we have one full-time equivalent (FTE) hired by Alameda Health System. However, the community health workers (CHWs) in the Sutter ED are limited to two FTEs. Additionally, our quality team comprises two navigators focusing on quality. This is also the reason we pursued the new contract, which will take two months to implement.

Comment: Ms. Gebhart appreciates Dr. Carey's update on infrastructure development with our partners and suggests that executive leadership consider expanding team capacity for greater impact. She acknowledges the associated medical costs, noted by Mr. Riojas as part of our MLR, but wonders if enhancing medical management infrastructure could yield significant savings.

Informational only. No action taken.

UNFINISHED BUSINESS

There was no unfinished business.

PUBLIC COMMENTS

There were no public comments.

ADJOURNMENT

Dr. Ferguson adjourned the meeting at 9:03 a.m.

ALAMEDA ALLIANCE FOR HEALTH
FINANCE COMMITTEE
REGULAR MEETING

April 22nd, 2025
7:30 am – 9:00 am

SUMMARY OF PROCEEDINGS

Meeting Conducted in-person and by Teleconference.

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

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

CALL TO ORDER

Dr. Ferguson convened the Finance Committee meeting at 7:30 a.m.

ROLL CALL

Roll call was conducted and confirmed.

INTRODUCTIONS

Allison Lam was introduced as the presenter for the Medical Management update in place of Dr. Carey.

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 regarding the committee receiving positive feedback from DHCS and DMHC on the board letters sent. They discussed the possibility of meeting in person towards the end of May to review the first four months of financials and the new budget. Matt emphasized the importance of planning for this meeting to discuss financials and the new budget.

b) REVIEW AND APPROVE FEBRUARY 2025 MONTHLY FINANCIAL STATEMENTS

FEBRUARY 2025 Financial Statement Summary

Enrollment:

Enrollment increased by 450 members since January and an overall increase of 9,288 members since June 2024.

Net Income:

For the month ending February 28th, 2025, the Alliance reported a Net Income of $5.1 million (versus budgeted Net Income of $10.6 million). For the year-to-date, the Alliance recorded a Net Loss of $98.8 million versus a budgeted Net Loss of $83.9 million.

Premium Revenue:

For the month ending February 28th, 2025, actual Revenue was $176.8 million vs. our budgeted amount of $191.5 million.

Medical Expense:

Actual Medical Expenses for the month were $159.0 million, vs. budgeted amount of $170.0 million. For the year-to-date, actual Medical Expenses were $1.4 billion vs. budgeted Medical Expense of $1.4 billion.

Medical Loss Ratio:

Our MLR ratio for this month was reported as 89.9%. The year-to-date MLR was 102.9%.

Administrative Expense:

Actual Administrative Expenses for the month ending February 28th, 2025, were $9.8 million vs. our budgeted amount of $9.4 million. Our Administrative Loss Ratio (ALR) is 5.5% of our Revenue for the month, and 5.6% of Net Revenue for year-to-date.

Other Income / (Expense):

As of February 28th, 2025, our YTD interest income from investments show a gain of $22.2 million.

Managed Care Organization (MCO) Provider Tax:

For the month ending February 28th, 2025, we reported $65.8 million MCO Tax Revenue vs. budgeted MCO Tax Revenue of $63.8 million. Our MCO Tax Expense was $70.8 million vs. budgeted MCO Tax Expense of $66.8 million.

Tangible Net Equity (TNE):

For February, the DMHC requires that we have $77.7 million in TNE, and we reported $156.6 million, leaving an excess of $78.9 million. As a percentage we are at 202%, which remains above the minimum required.

Cash and Cash Equivalents:

We reported $509.9 million in cash; $493.9 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 $592,000 in Capital Assets year-to-date. Our annual capital budget is $2.0 million.

Question: Ms. Gebhart inquired about the effects of the state's cash challenges on the MCO tax payments.

Response: Mr. Riojas stated that the state is postponing MCO tax revenue payments until July, which impacts cash flow but does not affect the budgeted expenses.

Question: Dr. Ferguson inquired about our annual expenses for the undocumented population. We are trying to put this into perspective as we anticipate a budget cut in the future. How do these expenses compare?

Response: Mr. Riojas stated that we are currently assessing the potential financial impact from both our revenue and expense perspectives. Our estimates suggest that the total impact could range from $300 million to $500 million in expenses, with possible revenue reaching up to $600 million, depending on utilization and current trends. Losing the undocumented population would significantly affect us, and this remains a concern at the state level.

Question: Dr. Ferguson asked a question regarding our current ratio, assuming it trends toward one as a direct consequence of the MCO. Since this will be reportable at that point, are we proactively informing them about this direction and its potential impact?

Response: Mr. Riojas had a call with DMHC last week, during which he spoke with the Deputy Director of Financial Review, who is responsible for overseeing financial solvency. They discussed various challenges, including the MCO tax issue, so she is aware of the situation.

Question: Ms. Gebhart asked about the consolidation of long-term care in relation to the duals rate. She noted that when the state often realigns programs, these adjustments tend to be given to jurisdictions with fewer overall resources. Are we consolidating those two aspects? Were we at a disadvantage in any way? Could you provide clarification on this and explain the reasons behind the decision?

Response: Mr. Riojas believes that plans should include separate long-term care rates instead of bundling them with the SPDs. Currently, states are being told that this change will take effect starting in January, leaving them with no option to opt out. This creates challenges in distinguishing the long-term care components of the rate from the SPD components. As a result, it has become increasingly difficult for plans to identify which portions of the rates pertain to long-term care and which relate to SPDs. All plans are facing these challenges, and we have communicated our concerns to the state. Although they are unlikely to change their approach, they are requesting more up-to-date information on long-term care to inform them of these rates. Additionally, there will be one more rate adjustment for CY 2025, likely occurring in the fall. The information we provide to the state may influence this adjustment, potentially leading to either a positive or negative impact.

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

Motion Passed

No opposed or abstained.

c) REVIEW MARCH 2025 MONTHLY FINANCIAL STATEMENTS (VERBAL UPDATE ONLY)

Gil Riojas provided a brief verbal update on the March 2025 Financials, reporting a small net income of $450,000. Gil expressed optimism for future positive results and optimism about achieving six consecutive months of positive net income to be removed from enhanced financial reporting.

Question: Ms. Gebhart asked if there is knowledge that plans across the state that had a robust TNE 18 months ago have experienced similar declines in TNE due to 24 rates?

Response: Mr. Riojas noted that most plans have experienced declines in TNE, and tangible net equity has decreased across the state.

Question: Ms. Gebhart asked if the state understands the implications of the decline in TNE on the community supports programs that the state wanted us to engage in.

Response: Mr. Riojas stated that the state understands the implications, but the level of detail remains uncertain. Plans have conveyed the challenges to the state.

Informational Only. No action taken.

d) MEDICAL MANAGEMENT UPDATE

AAH Top 5%

- Top 5% of AAH members account for ~80% of total costs
    - ~26K members
    - Top Cost categories:
        - Inpatient = 32%
        - SNF/ICF/DD = 5.5%
        - ER = 3.6%
        - Pharmacy = 20%

Inpatient Interventions

- On-going
    - Over/Under Utilization Workgroup – started in Dec 2024 – meets monthly
    - Receive real time information/Hospital partner rounds - weekly
    - Transitional Care Services (TCS); close follow up of members discharged from a facility/hospital
    - Expanded Pharmacy outreach to members with a 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
- 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 Interventions

- On-going
  - Contract amendments: Sitter criteria (being evaluated by contracting team)
  - Alliance staff on-site visitation in LTC facilities
  - LTC rounds (LTC/IP/ECM) – weekly
  - Ensuring claims paid at the appropriate level of care
  - Monitor payment of non-covered MediCal benefits, such as Congregate Living Health Facilities
  - Ensure definitions are appropriate and appropriate categorized in Finance Systems
  - Refine Community Supports Criteria – Dec 2024
- Future
  - Ensure members have appropriate DHCS LTC aid code
  - Further refine Community Supports criteria – March 2025 (effective ~July 2025)

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 Interventions

- On-going
  - Formulary/Prior Authorization (PA) review (ex – Anticoagulants)
  - Monitor new claims for carve out drugs/PAD 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 Strategies

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

Strategies for Other Members

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

Question: Ms. Park asked whether we are tailoring our interventions based on the variations in ethnicities represented in the data that influence these costs. Specifically, she inquired if we are based on ethnicity and age gap data to guide our approaches.

Response: Ms. Lam confirmed this is exactly how the data is used.

Question: Ms. Gebhart inquired whether the interventions are primarily contracted out and whether we have enough capacity to carry them out.

Response: Ms. Lam states that we are adopting a mixed approach. Some interventions will be contracted out, but it is important to note that we will retain ultimate responsibility and oversight. Alongside these discussions, we are developing plans to ensure proper oversight and to verify that all contracted parties are fully aligned with our expectations.

Question: Ms. Gebhart asked what the cost implications are of members going to Kaiser for ER visits?

Response: Ms. Lam stated that the cost is determined by a state-set rate, so there is no significant cost disadvantage.

Question: Dr. Ferguson asked if we had considered the rates rather than just percentages for demographics.

Response: Ms. Lam said the analysis focused on the top 5% within categories, but a more thoughtful approach to comparing it to the overall membership can be considered.

Informational Only. No action taken.

e) COMMUNITY SUPPORTS UPDATE

Approach to Criteria Changes

Goal: Community Support(s) are available to our most vulnerable members, with greatest disease severity who are at greatest risk of ED to hospital admission or hospital/nursing facility readmission within 30 days of discharge

- Person-Centered & Community-Centered
- Compliant
- Sustainable

Current State: AAH reviewing CS provider recommendations

Timeframe	Activity
4/1/2025 – 4/16/2025	CS Providers submitted criteria recommendations to AAH
4/14/2025 – 4/21/2025	AAH reviews recommendations
	AAH sends criteria to CS Providers for final comments: 4/21/2025
4/21/2025 – 4/25/2025	CS Providers submit final comments
4/30/2025	AAH announces new criteria (with effective date: 7/1/2025)

Question: Ms. Gebhart asked if the providers give recommendations regarding restricted criteria.

Response: Ms. Lam described the feedback as mixed. Many individuals referred us back to the community supports policy guide provided by DHCS. It's important to note that the guidance in this policy guide allows for considerable flexibility and interpretation. One of the challenges in navigating these conversations with providers has been reaching a common understanding and interpretation, especially since we all approach these discussions from different backgrounds and perspectives within the community. That is why the recommendations were valuable. Many providers offered insightful suggestions and alternative strategies for community supports that we had not previously considered. All this input was carefully considered.

Question: Dr. Ferguson asked about the results of the recent audit by DHCS and DMHC.

Response: Mr. Woodruff stated that the DHCS audit revealed favorable results with one to three potential findings. The DMHC audit results are still pending.

Informational only. No action taken.

UNFINISHED BUSINESS

There was no unfinished business.

PUBLIC COMMENTS

There were no public comments.

ADJOURNMENT

Dr. Ferguson adjourned the meeting at 8:47 a.m.

ALAMEDA Alliance FOR HEALTH

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

Compliance Advisory Committee Meeting Minutes

Compliance Advisory Committee
Regular Meeting Minutes
Friday, March 14th, 2025
11:00 a.m. – 11:30 a.m.

Video Conference Call or
1240 South 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 11:00 am.

2. ROLL CALL

A roll call of Committee Members was taken, quorum was confirmed at 11:02 am.

3. AGENDA APPROVAL OR MODIFICATIONS

Agenda modifications include:
1.) reduction of committee meeting length to 30 minutes, and
2.) limit today's discussion to section 6, sub sections A and B.

Rational for modifications: due to a last-minute rescheduling of the Joint DHCS and DMHC Survey (audit) Exit Conference, staff slated to present may not be available.

Motion:
A motion was made by Richard Golfin III to approve agenda modifications and; seconded by Byron Lopez.

Vote:
All voting members in attendance approved.
Motion passed.

4. PUBLIC COMMENT (NON-AGENDA ITEMS)

None

5. CONSENT CALENDAR

a) December 13th, 2024, Compliance Advisory Committee Minutes

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

Vote:
All voting members in attendance approved.
Motion passed.

6. COMPLIANCE MEMBER REPORTS

a) Compliance Activity Report

i. Plan Audits and State Regulatory Oversight
   1. 2025 DMHC and DHCS Routine Full Medical Survey (Joint) – Post-Audit Update

- The committee engaged in an informal discussion to provide a post survey update.
- The Plan expected to have materials to present following the survey Exit Conference, however the conference was rescheduled.
- The Survey began with an Entrance Conference on Monday March 3rd, 2025, at 1:00pm. The on-site portion of the audit concluded on March 7th, 2025.
- Although survey interviews were scheduled for up to 3 hours, on most occasions, the interviews adjourned early.
- On several occasions, the surveyors (auditors) shared there were no preliminary findings following file review. It is rare to receive direct feedback during the audit.
- The Plan was asked to share not only operational challenges but also accomplishments and learnings.
- The collaborative feel between the surveyors and the Plan alludes to minimum concerns.
- The surveyors reported no preliminary findings in the following areas, following file review and Plan interviews:
  - Behavioral Health
  - Provider Services
  - Initial Health Appointments
  - Enhanced Care Management
  - Provider Certification Statements
  - Outpatient Utilization Management
- This was the Plan's first year surveyed for Enhanced Care Management.
- This was the Plan's first on-site audit in 6 years.
- Coordination and execution of the logistics for the survey took tremendous collaboration between all departments, with an emphasis on support from Facilities.

- Consensus from the Plan's Compliance and Health Care Servies leadership was a successful effort to meet the expectations of the DMHC and DHCS surveyors.
- Preliminary survey findings are expected for the week of March 17th, 2025.
- The following agenda items were not covered, and will be discussed at the next Committee meeting, scheduled for April 11th, 2025:

2. 2024 Compliance Risk Assessment (Progress/Closure)
3. Compliance Dashboard
    a. 2024 DHCS Routine Full Medical Survey CAP
    b. 2023 DHCS Focused Medical Survey CAP
    c. Validation Audits
        i. AAH BHCA Audit

b) Medi-Cal Program Updates

i. 2025 Focus on Bolstering FWA and SIU Operations

- The current Federal Administration is focused on Fraud, Waste and Abuse (FWA).
- Compliance will be emphasizing the following efforts to meet the expectations of federal government:
    - Additional collaboration between Special Investigation Unit and Finance department for transparency as to current investigations.
    - Investment into staff development of industry knowledge.
    - Increasing the depth of FWA investigations.
    - Increase leads provided by FWA vendor. Currently 5-7 case referrals a month, to increase to 7-10.

Question: What kind of scenarios are the 5-7 monthly case referrals the Plan receives?

Answer: The plan utilizes a vendor that provides referrals based on claims analysis. The vendor notifies the Plan of any anomalies related to FWA. The plan will need to allocate staff resources to increase the volume of referrals currently provided monthly.

- The plan also investigates referrals from Health Care Services and Claims, usually for high dollar amounts.

Question: On average, how many FWA referrals from the vendor result in recoupment processes or reporting requirements?

Answer: There have been no recent cases that have resulted in recoupment processing. We have cases open now which may lead to recoupment, but cases investigated tend to be complex and require extensive time.

Question: Are there any entities which have established standards or protocols related to FWA management and oversight?

Answer: Yes. There are certifications that are related to FWA. These certifications are

exceedingly difficult to obtain. Compliance leadership has begun to share a variety of certificates with associates to encourage development of industry knowledge. Approximately 75% of associates have obtained at least 1 certification.

7. COMPLIANCE ADVISORY COMMITTEE BUSINESS

a) None

8. STAFF UPDATES

a) None

9. UNFINISHED BUSINESS

a) None

10. STAFF ADVISORIES ON COMPLIANCE BUSINESS FOR FUTURE MEETINGS

a) None

- Agenda not covered at today's meeting will be brought to the following Committee agenda.

11. ADJOURNMENT

- Meeting adjourned at 11:25am

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

NOTICE TO THE PUBLIC

At 10:15 a.m., the Compliance Advisory Committee (Committee, CAC) will determine which of the remaining agenda items can be considered and acted upon prior to 10:30 a.m. and will continue all other items on which additional time is required until a future Committee meeting. All meetings are scheduled to terminate at 11:30 a.m.

The Committee meets regularly on the second Friday of each month. This meeting is held both in person and as a video conference call. Meetings begin at 10:30 a.m. unless otherwise noted. Meeting agendas and approved minutes are kept current on the Alameda Alliance for Health's website at www.alamedaalliance.org

An agenda is provided for each Compliance Advisory Committee meeting, which lists the items submitted for consideration. Prior to the listed agenda items, the Committee may hold a study session to receive information or meet with another committee. A study session is open to the public; however, no public testimony is taken, and no decisions are made. Following a study session, the regular meeting will begin at 10:30 a.m. At this time, the Committee allows oral communications from the public to address the Committee on items NOT listed on the agenda. Oral comments to address the Compliance Advisory Committee are limited to three minutes per person.

Staff Reports are available. To obtain a document, please call 510-995-1207.

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 Committee 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 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 Committee 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 Compliance Advisory Committee. **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 Committee at or before the hearing. **Committee Business:** Items in this category are general in nature and may require Committee action. Public input will be received on each item of Committee Business.

Public Input: If you are interested in addressing the Committee, you may submit comments on any agenda item or on any item not on the agenda, in writing via mail to "Attn: Alliance Compliance Advisory

Committee," 1240 S. Loop Road, Alameda, CA 94502; or through e-comment at brmartinez@alamedaalliance.org. You may also provide comment during the meeting at the end of each topic.

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

Submittal of Information by Members of the Public for Dissemination or Presentation at Public Meetings (Written Materials/handouts): Any member of the public who desires to submit documentation in hard copy form may do so prior to the meeting by sending to the 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 Brenda Martinez, at 510-995-1207 at least 48 hours prior to the meeting to inform us of your needs and to determine if accommodation is feasible. Please advise us at that time if you will need accommodations to attend or participate in meetings on a regular basis.

I hereby certify that the agenda for the Compliance Advisory Committee was posted on the Alameda Alliance for Health's web page at www.alamaedaalliance.org on March 10th, 2025, by 12:00 p.m.

Brenda Martinez, Clerk of the Board

QIHEC Nominees Resolution

RESOLUTION NO. 2025-XX

A RESOLUTION OF ALAMEDA ALLIANCE FOR HEALTH APPOINTING DR. RAJ DAVDA AND DESIGNEE, DR. KEESARA TO QUALITY IMPROVEMENT AND HEALTH EQUITY COMMITTEE

WHEREAS, pursuant to Section 7.A.1. of the Alameda Alliance for Health ("Alliance") *Bylaws*, the frequency, composition, number, terms, and nominations of members of standing committees shall be as set forth by resolution; and

WHEREAS, the Alliance Board of Governors (the "Board") on September 8, 2023, passed Resolution 2023-07, creating the Quality Improvement and Health Equity Committee (the "QIHEC") as a standing committee of the Board; and

WHEREAS, pursuant to Resolution 2023-07 appointments to the QIHEC shall be for two (2) year terms, and members may be reappointed to additional terms by Board approval; and

WHEREAS, the QIHEC charter requires a voting member representing *common medical specialties* and the former Chief Medical Officer of Community Health Center Network "CHCN" Dr. Do has left CHCN and has provided his replacement(s)

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

SECTION 1. That the Alliance Board appoints the following individual(s) to serve as member(s) of the QIHEC for two (2) year terms:

Raj Davda, MD (Chief Medical Officer, CHCN)

Sirina Keesara, MD (Medical Director, CHCN – designee).

PASSED AND ADOPTED by the Board at a meeting held on the 9th day of May 2025.

_____
CHAIR, BOARD OF GOVERNORS

ATTEST:

_____
Secretary

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CEO Update

Matthew Woodruff

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

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

Date: **May 9th, 2025**

Subject: **CEO Report**

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

	March	YTD
Medi-Cal	$1.7M	($91.2M)
Group Care	$337K	($196K)
Medicare	($1.58M)	($6.95M)
Total	$458K	($98.3M)

  - **Revenue was $191.7 million in March 2025 and $1.6 billion Year-to-Date (YTD)**.
    - Medical expenses were $183.8 million in March and $1.6 billion for the fiscal year-to-date; the medical loss ratio is 95.9% for the month and 102.0% for the fiscal year-to-date.
    - Administrative expenses were $10.5 million in March and $86.8 million for the fiscal year-to-date; the administrative loss ratio is 5.5% of net revenue for the month and 5.5% of net revenue year-to-date.
  - **Tangible Net Equity (TNE)**: Financial reserves are 197% of the required DMHC minimum, representing $77.3 million in excess TNE.
  - **Total enrollment in March 2025 was 412,630**, decreased by 648 Medi-Cal members compared to February 2025.

- **BUDGET UPDATES**
  - **Alliance**
  - **County**
  - **State and Federal**

- **Key Performance Indicators:**
  - **Regulatory Metrics:**
    - The G&A team currently faces challenges in managing a high volume of cases along with staffing shortages. During the month of April, the team missed the expedited case criteria for both grievances and appeals. The criteria is that these cases be resolved in 3 calendar days. The staffing shortages resulted in the teams being 93% compliant instead of 95%.

- **Non-Regulatory Metrics:**
  - The Member Service team missed answering calls within 30 seconds. The team was at 6% compliance and not the required 5%. As a reminder the State criteria is answering calls withing 10 minutes.

- **Alliance Updates:**
  - **Demographics**
    - Please see the attached PowerPoint describing the demographics of the Alliance employees.
- **COMMUNITY SUPPORTS**
  - There will be an update later in the Board meeting
- **STRATEGIC PLANNING**
  - Next steps
- **AUTOMATION AND AI**
  - There will be an update at a future Board meeting
- **Medicare Overview**
  - **<u>D-SNP Readiness</u>**
    - Alameda Alliance for Health (AAH) Medicare Advantage (MA) Duals Eligible Special Needs Plan (D-SNP) will begin serving members on January 1st, 2026. Currently, there are 17 different departmental workstreams and a total of 111 projects, 69 of which are active, 40 requested, and two (2) on hold.
    - The Alliance received a 96.25% score on the Model of Care (MOC), which provides approval for three (3) years. Four (4) new staff were onboarded on 4/28.
    - The Alliance D-SNP Town Hall occurred on April 23rd, 2025, and was a huge success with many community partners in attendance. Anastasia Dodson, Deputy Director of the California Department of Health Care Services (DHCS) was in attendance and provided a presentation, as well.
    - A new brand, logo, and colors were selected for all three (3) product lines with D-SNP launching 1/1/2026 and Medi-Cal/Group Care launching in Q12026.
    - Medication Management Therapy (MTM) kick-off has started.
    - The Alliance, in partnership with Milliman, has chosen benefits for vision, dental, hearing, and flex card and is working on keying in the bid, which is due to CMS on June 2nd, 2025.
    - Continuing to collaborate with IT in updating Core Claims / Medical Management Systems; 321 requirements have been identified and collected within Microsoft List.

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Demographics

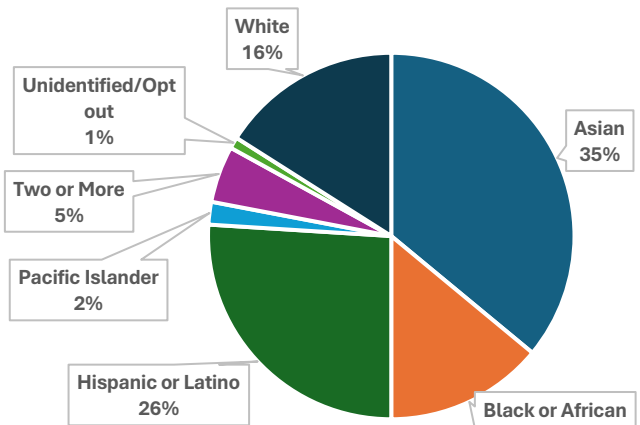
The purpose of this report is to conduct a comparative analysis of the demographic composition of Alameda Alliance for Health's workforce and the population distribution of Alameda County. The primary focus of this comparison will be on key metrics, including race/ethnicity, gender, and age distribution.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

The demographic data for the county, including the total population and demographic breakdown, is sourced from Healthy Alameda County, which is sponsored by the Alameda County Public Health Department. This site serves as a central repository of information related to Alameda County, providing the most current data and over 250 community wellbeing indicators (Healthy Alameda County :: Demographics :: County :: Alameda). The information presented in this report was last updated in April 2024. Additionally, the data used for Alameda Alliance for Health was last updated in April 2025 and is collected and maintained monthly by the Human Resources Department internally.

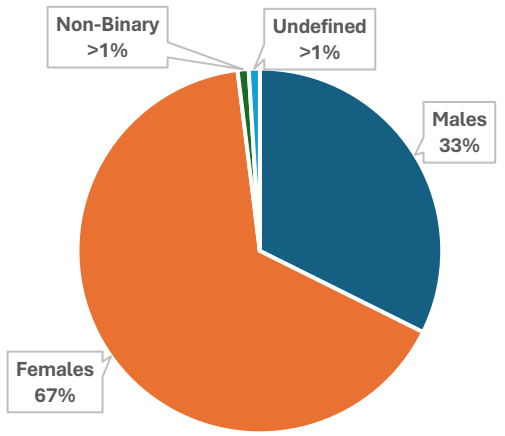
Category	**Alameda Alliance for Health** (Workforce information last updated April 2025)	**Alameda County** (Population Information last updated in April 2024)
Population/Total Employees	658	1,634,785
Race & Ethnicity		
Asian	35%	34.68%
Hispanic	26%	23.95%
White	16%	28.75%
Black/African American	14%	9.27%
Native Hawaiian/Pacific Islander	2%	0.85%
Two or More Races	5%	11.68%
Unidentified/Opt Out	1%	
Gender		
Male	33%	48.98%
Female	67%	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 April 2025

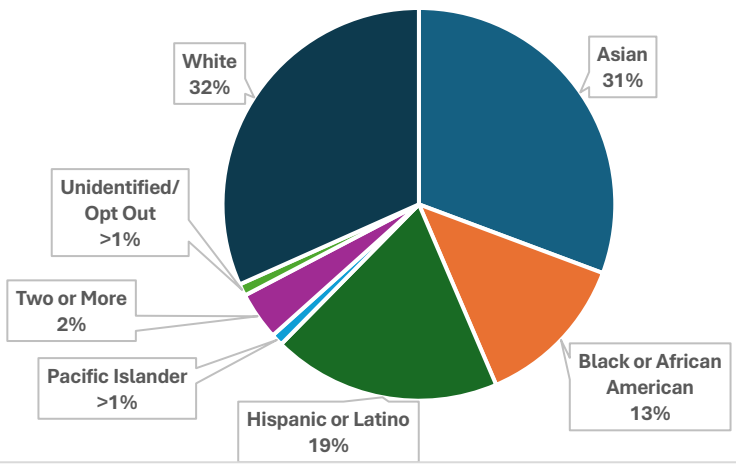
Employee Ethnicity - 658
April 2025



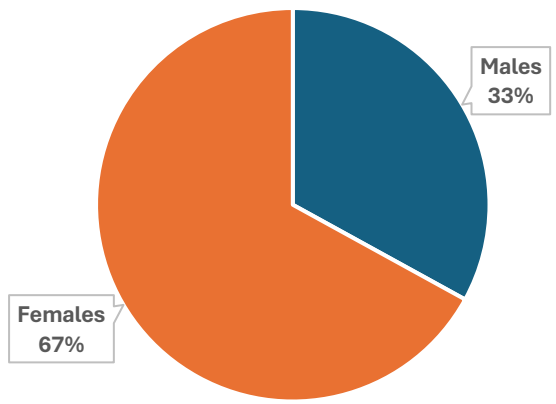
Employee Gender - 658
April 2025

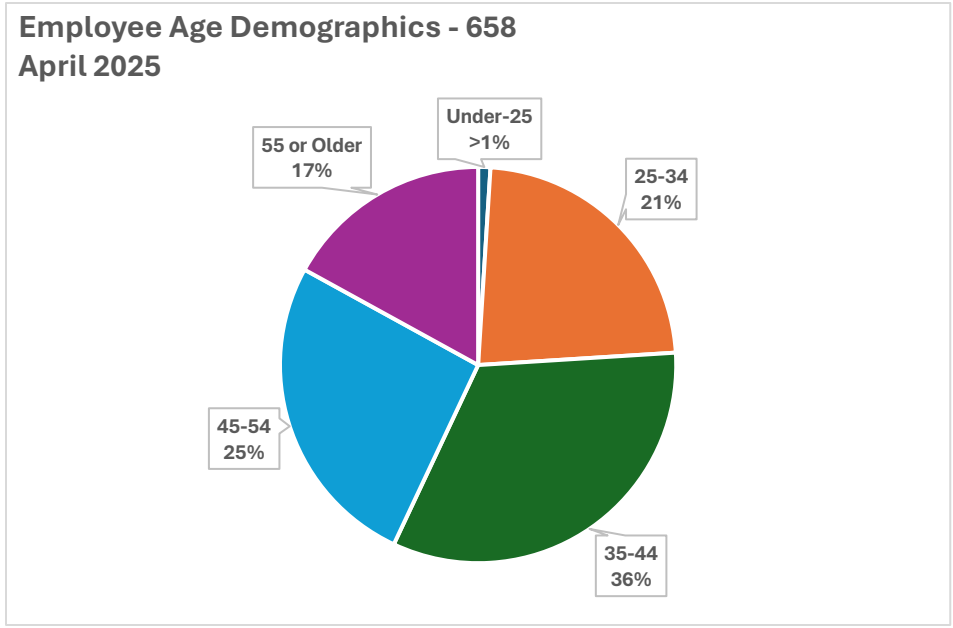


Managers Ethnicity - 135
April 2025



Managers Gender - 135
April 2025




Employee Age Demographics - 658
April 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

Since their return from spring break in early April, state legislators have remained busy discussing and amending hundreds of bills at policy committees. Since then, we have approached May 2nd – a major deadline when policy committees must hear and report bills to fiscal committees with a fiscal impact introduced in their house. Additionally, the upcoming May Revise must be released by May 14th and will include changes to the Governor's Proposed Budget based upon the latest economic forecasts and which will give us a better understanding of the state's financial situation.

Public Affairs will provide a summary of the Medi-Cal program and relevant health care items included in the Governor's May Revise in the next Board of Governors meeting packet.

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: 4/23/2025-In committee: Set, first hearing. Referred to suspense file.

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

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

AB 29 **(Arambula D) Medi-Cal: Adverse Childhood Experiences trauma screenings: providers.**
Current Text: Amended: 3/19/2025 html pdf
Introduced: 12/2/2024
Status: 4/23/2025-In committee: Set, first hearing. Referred to suspense file.

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 that Medi-Cal provider

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

AB 37 **(Elhawary D) Workforce development: mental health service providers: homelessness.**
Current Text: Amended: 3/13/2025 html pdf
Introduced: 12/2/2024
Status: 3/17/2025-Re-referred to Com. on L. & E.

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. Existing law requires the board to assist the Governor in certain activities, including the review and technical assistance of statewide policies, programs, and recommendations to support workforce development systems in the state, as specified. This bill would require the board to study how to expand the workforce of mental health service providers who provide services to homeless persons.

AB 40 **(Bonta D) Emergency services and care.**
Current Text: Amended: 3/5/2025 html pdf
Introduced: 12/2/2024
Status: 4/21/2025-Read third time. Urgency clause adopted. Passed. Ordered to the Senate. (Ayes 58. Noes 9.). In Senate. Read first time. To Com. on RLS. for assignment.

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

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

other things. This bill would additionally define “emergency services and care” for the above-described purposes to mean reproductive health services, including abortion. By expanding the applicability of a crime with respect to health facilities and health care service plans, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 45 **(Bauer-Kahan D) Privacy: health data: location and research.**
Current Text: Amended: 4/9/2025 html pdf
Introduced: 12/2/2024
Status: 4/30/2025-Coauthors revised. From committee: Do pass and re-refer to Com. on APPR. (Ayes 9. Noes 2.) (April 29). Re-referred to Com. on APPR.

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

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

AB 49 **(Muratsuchi D) Schoolsites: immigration enforcement.**
Current Text: Amended: 4/21/2025 html pdf
Introduced: 12/2/2024
Status: 4/30/2025-Coauthors revised. From committee: Do pass and re-refer to Com. on APPR. (Ayes 8. Noes 2.) (April 29). Re-referred to Com. on APPR.

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 an agency conducting immigration enforcement to enter a schoolsite for any purpose without providing valid identification and a valid judicial warrant, a court order, or exigent circumstances necessitating immediate action. The bill would require the local educational agency, if the officer or employee meets those requirements, to limit access to facilities where pupils are not present. By imposing additional duties on local educational agencies, the bill would impose a state-mandated local program. This bill

contains other related provisions and other existing laws.

AB 50 **(Bonta D) Pharmacists: furnishing contraceptives.**
Current Text: Amended: 4/2/2025 html pdf
Introduced: 12/2/2024
Status: 4/29/2025-In Senate. Read first time. To Com. on RLS. for assignment.

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

Summary: Existing law, the 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. Existing law authorizes a pharmacist furnishing an FDA-approved, self-administered hormonal contraceptive pursuant to the above-described protocols to furnish, at the patient's request, up to a 12-month supply at one time. This bill would limit the application of those requirements to self-administered hormonal contraceptives that are prescription-only, and would authorize a pharmacist to furnish over-the-counter contraceptives without following those standardized procedures or protocols. The bill would additionally authorize a pharmacist to furnish up to a 12-month supply at one time of over-the-counter contraceptives at the patient's request. The bill would make related conforming changes. This bill contains other related provisions.

AB 54 **(Krell D) Access to Safe Abortion Care Act.**
Current Text: Amended: 3/17/2025 html pdf
Introduced: 12/2/2024
Status: 4/30/2025-Coauthors revised. From committee: Do pass and re-refer to Com. on APPR. (Ayes 8. Noes 1.) (April 29). Re-referred to Com. on APPR.

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

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

AB 55 **(Bonta D) Alternative birth centers: licensing and Medi-Cal reimbursement.**
Current Text: Amended: 4/10/2025 html pdf
Introduced: 12/2/2024
Status: 4/29/2025-In Senate. Read first time. To Com. on RLS. for assignment.

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

Summary: Existing law provides for the licensure and regulation of various types of clinics, including alternative birth

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

AB 67 **(Bauer-Kahan D) Attorney General: Reproductive Privacy Act: enforcement.**
Current Text: Amended: 4/23/2025 html pdf
Introduced: 12/4/2024
Status: 4/24/2025-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 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 and other existing laws.

AB 73 **(Jackson D) Mental Health: Black Mental Health Navigator Certification.**
Current Text: Introduced: 12/12/2024 html pdf
Introduced: 12/12/2024
Status: 4/9/2025-In committee: Set, first hearing. Referred to APPR. suspense file.

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: 4/9/2025-In committee: Hearing postponed by committee.

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

Summary: Existing law 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. Conc.	Enrolled	Vetoed	Chaptered
1st House				2nd House							

Summary: Existing law required the Department of Health Care Access and Information, on or before July 1, 2023, to develop and approve statewide requirements for community health worker certificate programs. Existing law requires the department, as part of developing those requirements, to, among other things, determine the necessary curriculum to meet certificate program objectives. Existing law defines "community health worker" for these purposes to mean a liaison, link, or intermediary between health and social services and the community to facilitate access to services and to improve the access and cultural competence of service delivery. Existing law specifies that "community health worker" include Promotores, Promotores de Salud, Community Health Representatives, navigators, and other non-licensed 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: 4/23/2025-From committee: Do pass and re-refer to Com. on APPR. (Ayes 16. Noes 0.) (April 22). Re-referred

to Com. on APPR.

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

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

AB 224 **(Bonta D) Health care coverage: essential health benefits.**
Current Text: Amended: 4/23/2025 html pdf
Introduced: 1/9/2025
Status: 4/30/2025-From committee: Do pass and re-refer to Com. on APPR. (Ayes 14. Noes 0.) (April 29). Re-referred to Com. on APPR.

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

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

AB 225 **(Bonta D) State hospitals for persons with mental health disorders: patient funds.**
Current Text: Introduced: 1/9/2025 html pdf
Introduced: 1/9/2025
Status: 4/24/2025-Read third time. Passed. Ordered to the Senate. (Ayes 75. Noes 0.) In Senate. Read first time. To Com. on RLS. for assignment.

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

Summary: Existing law 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: 4/9/2025-In committee: Set, first hearing. Referred to APPR. suspense file.

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: 4/23/2025-In committee: Set, first hearing. Referred to suspense file.

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 establish a program for the development, provision, and evaluation of genetic disease testing. This bill would require the department to expand statewide screening of newborns to include screening for Duchenne muscular dystrophy as soon as possible, but no later than January 1, 2027. By expanding the purposes for which moneys from the Genetic Disease Testing Fund (GDTF) may be expended, this bill would make an appropriation. This bill contains other existing laws.

AB 260 **(Aguiar-Curry D) Sexual and reproductive health care.**
Current Text: Amended: 3/17/2025 html pdf
Introduced: 1/16/2025
Status: 4/29/2025-Coauthors revised. From committee: Do pass and re-refer to Com. on APPR. (Ayes 14. Noes 1.) (April 29). Re-referred to Com. on APPR.

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

Summary: The California Constitution provides for the fundamental rights of privacy and to choose to have an abortion. Existing law, the Reproductive Privacy Act, prohibits the state from denying or interfering with a pregnant person's right to choose or obtain an abortion before the viability of the fetus, or when the abortion is necessary to protect the life or health of the pregnant person. Existing law prohibits conditions or restrictions from being imposed on abortion access for

incarcerated persons and committed juveniles. Existing laws requiring parental consent for abortion and making assisting in or advertising abortion a crime have been held to be unconstitutional. This bill would repeal those unconstitutional provisions and delete obsolete references to criminal abortion penalties. The bill would make technical changes to provisions authorizing abortion for incarcerated and committed persons.

AB 277 **(Alanis R) Behavioral health centers, facilities, and programs: background checks.**
Current Text: Amended: 4/22/2025 html pdf
Introduced: 1/21/2025
Status: 4/23/2025-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 related provisions and other existing laws.

AB 278 **(Ransom D) Health care affordability.**
Current Text: Introduced: 1/21/2025 html pdf
Introduced: 1/21/2025
Status: 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: 4/23/2025-In committee: Set, first hearing. Referred to suspense file.

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 insurer's provider directory or directories and to reimburse the provider the out-of-network amount for those services. The bill would prohibit a provider from collecting an additional amount from an enrollee or insured other than the applicable in-network cost sharing. The bill would require a plan or insurer to provide information about in-network providers to enrollees and insureds upon request, and would limit the cost-sharing amounts an enrollee or insured is required to pay for services from those providers under specified circumstances. The bill would require the health care service plan or the insurer, as applicable, to ensure the accuracy of a request to add back a provider who was previously removed from a directory and approve the request within 10 business days of receipt, if accurate. Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 281

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

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

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

AB 290

(Bauer-Kahan D) California FAIR Plan Association: automatic payments.
Current Text: Amended: 4/21/2025 html pdf
Introduced: 1/22/2025
Status: 4/30/2025-From committee: Amend, and do pass as amended and re-refer to Com. on APPR. (Ayes 16. Noes 0.) (April 30).

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

Summary: Existing law establishes the California FAIR Plan Association, a joint reinsurance association in which all insurers licensed to write basic property insurance participate to administer a program for the equitable apportionment of basic property insurance for persons who are unable to obtain that coverage through normal channels. Existing law authorizes cancellation of an insurance policy for nonpayment of premium, and requires an insurer to notify a policyholder at least 10 business days before the policy will be canceled for nonpayment. This bill would require the California FAIR Plan Association to create an automatic payment system and accept automatic payments for premiums from policyholders. The bill would prohibit an automatic payment amount from being different than if the policyholder

made a payment through another method. The bill would prohibit cancellation or nonrenewal of a FAIR Plan policy solely because the policyholder is not enrolled in automatic payments, except as specified, or because the policyholder failed to confirm a payment when making a one-time payment on the association's internet website, as specified. The bill would provide for a 15-day grace period for late premium payments.

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: 4/30/2025-From committee: Amend, and do pass as amended and re-refer to Com. on APPR. (Ayes 9. Noes 3.) (April 29).

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: 4/24/2025-Read second time. Ordered to third reading.

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

1st House	2nd House	Conc.			

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: 4/9/2025-In committee: Set, first hearing. Referred to APPR. suspense file.

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: Amended: 4/28/2025 html pdf
Introduced: 1/24/2025
Status: 4/29/2025-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 law provides that everyone is responsible not only for the result of their willful acts, but also for an injury occasioned to another by their want of ordinary care or skill in the management of their property or person. Existing law requires the developer of a generative artificial intelligence system or service that is released on or after January 1, 2022, and made publicly available to Californians for use, to post on the developer's internet website documentation regarding the data used by the developer to train the generative artificial intelligence system or service. Existing law defines “artificial intelligence” for these purposes. This bill would prohibit a defendant who developed, modified, or used artificial intelligence, as defined, from asserting a defense that the artificial intelligence autonomously caused the harm to the plaintiff. This bill contains other existing laws.

AB 322 **(Ward D) Pupil health: school-based health services and school-based mental health services.**
Current Text: Introduced: 1/24/2025 html pdf
Introduced: 1/24/2025
Status: 4/21/2025-Read third time. Passed. Ordered to the Senate. (Ayes 62. Noes 0.) In Senate. Read first time. To Com. on RLS. for assignment.

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

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

AB 350 **(Bonta D) Health care coverage: fluoride treatments.**
Current Text: Amended: 4/24/2025 html pdf
Introduced: 1/29/2025
Status: 4/28/2025-Re-referred to Com. on APPR.

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

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

AB 360 **(Papan D) Menopause.**
Current Text: Amended: 4/9/2025 html pdf
Introduced: 1/30/2025
Status: 4/23/2025-In committee: Set, first hearing. Referred to suspense file.

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 and to collect health data. Existing law establishes the Medical Board of California and the Osteopathic Medical Board of California for the licensure and regulation of physicians and surgeons and osteopathic physicians and surgeons. Existing law requires the boards to adopt and administer standards, including for the continuing education of those licensees. This bill would require the department to work with the Medical Board of California, the

Osteopathic Medical Board of California, and state higher education entities to assess, among other things, physicians and surgeons' education and training, as specified, relating to menopause diagnosis and treatment. The bill would require the department to prepare a report to the Legislature on or before January 1, 2027, that, among other things, identifies gaps in medical education and training related to menopause and in menopause diagnosis and management practices among physicians and surgeons.

AB 371 **(Haney D) Dental coverage.**
Current Text: Amended: 4/24/2025 html pdf
Introduced: 2/3/2025
Status: 4/28/2025-Re-referred to Com. on APPR.

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

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

AB 375 **(Nguyen D) Medical Practice Act: health care providers: qualified autism service paraprofessionals.**
Current Text: Introduced: 2/3/2025 html pdf
Introduced: 2/3/2025
Status: 4/30/2025-In committee: Set, first hearing. Hearing canceled at the request of author.

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: Amended: 3/17/2025 html pdf
Introduced: 2/3/2025
Status: 4/23/2025-From committee: Do pass and re-refer to Com. on APPR. (Ayes 13. Noes 0.) (April 22). Re-referred to Com. on APPR.

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: Amended: 3/17/2025 html pdf
Introduced: 2/4/2025
Status: 4/9/2025-In committee: Set, first hearing. Referred to APPR. suspense file.

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 conduct an analysis of the CHW services benefit, submit the analysis to the Legislature, and publish the analysis on the department's internet website, with the first analysis due July 1, 2027. This bill contains other related provisions and other existing laws.

AB 408 **(Berman D) Physician Health and Wellness Program.**
Current Text: Amended: 4/21/2025 html pdf
Introduced: 2/4/2025
Status: 4/30/2025-From committee: Do pass and re-refer to Com. on APPR. (Ayes 10. Noes 0.) (April 29). Re-referred to Com. on APPR.

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 and licensed midwives by the Medical Board of California. A violation of the act is a crime. Existing law authorizes the board to establish a Physician and Surgeon Health and Wellness Program to support a physician and surgeon in their rehabilitation from substance abuse to ensure the physician and surgeon remains able to practice medicine in a manner

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

AB 412 **(Bauer-Kahan D) Generative artificial intelligence: training data: copyrighted materials.**

Current Text: Amended: 4/28/2025 html pdf

Introduced: 2/4/2025

Status: 4/29/2025-Re-referred to Com. on JUD.

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 federal law provides that sound recordings fixed before February 15, 1972, are not subject to copyright, but are subject to similar rights and protections under the Classics Protection and Access Act. Existing law requires, on or before January 1, 2026, and before each time thereafter that a generative artificial intelligence system or service, as defined, or a substantial modification to a generative artificial intelligence system or service, released on or after January 1, 2022, is made available to Californians for use, regardless of whether the terms of that use include compensation, a developer of the system or service to post on the developer's internet website documentation, as specified, regarding the data used to train the generative artificial intelligence system or service. This bill would require a developer of a generative artificial intelligence model to, among other things, document any covered materials that the developer knows were used to train the model. The bill would require the developer to make available a mechanism on the developer's internet website allowing a rights owner to submit a request for information about the developer's use of covered materials that would allow the rights owner to provide the developer with, among other things, registration, preregistration, or index numbers and fingerprints for one or more covered materials. The bill would require a developer to, within 7 days of receiving that request from the rights owner, assess whether the covered material represented by a fingerprint provided by the rights owner is likely to be present in the developer's dataset and provide the rights owner with a list of their covered materials that were used to train the model and are likely to be present in the developer's dataset, as specified. The bill would provide that each day following the 7-day period that a developer fails to provide a rights owner with that information constitutes a discrete violation. The bill would authorize a rights owner that is not provided with information according to these provisions to bring a civil action against the developer for specified relief. The bill would provide that the bill's

requirements do not apply to a developer that makes all of the data used to train the model publicly available at no cost, as specified. The bill would define various terms for these purposes. This bill contains other existing laws.

AB 416 **(Krell D) Involuntary commitment.**
Current Text: Introduced: 2/5/2025 html pdf
Introduced: 2/5/2025
Status: 4/2/2025-Coauthors revised. From committee: Do pass and re-refer to Com. on JUD. (Ayes 15. Noes 0.) (April 1). Re-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 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) Alcoholism or drug abuse recovery or treatment programs and facilities: disclosures.**
Current Text: Amended: 4/2/2025 html pdf
Introduced: 2/5/2025
Status: 4/3/2025-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 grants the sole authority in state government to the State Department of Health Care Services to certify alcohol or other drug programs and to license adult alcoholism or drug abuse recovery or treatment facilities. Existing law requires certified programs and licensed facilities to disclose to the department if any of its agents, partners, directors, officers, or owners own or have a financial interest in a recovery residence and whether it has contractual relationships with entities that provide recovery services to clients of certified programs or licensed facilities if the entity is not a part of a certified program or a licensed facility. Existing law defines “recovery residence” as a residential dwelling that provides primary housing for individuals who seek a cooperative living arrangement that supports personal recovery from a substance use disorder and that does not require licensure by the department or does not provide licensable services. This bill would require a business-operated recovery residence to register its location with the department. The bill would define a business-operated recovery residence as a recovery residence in which a business, in exchange for compensation, provides more than one service beyond those of a typical tenancy arrangement to more than one occupant, including, but not limited to, drug testing, supervision, scheduling, rule setting, rule enforcement, room assignment, entertainment, gym memberships, transportation, laundry, or meal preparation and coordination.

AB 432 **(Bauer-Kahan D) Menopause.**
Current Text: Amended: 4/23/2025 html pdf
Introduced: 2/5/2025
Status: 4/30/2025-Coauthors revised. From committee: Do pass and re-refer to Com. on APPR. (Ayes 15. Noes 0.) (April 29). Re-referred to Com. on APPR.

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

Summary: Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California and requires the board to adopt and administer standards for the continuing education

of those licensees. Existing law requires the board, in determining its continuing education requirements, to consider including a course in menopausal mental or physical health. This bill would delete that requirement of the board and, instead, require specified physicians who have a patient population composed of 25% or more of adult women under 65 years of age to complete at least 10% of all mandatory continuing medical education hours in a course in perimenopause, menopause, and postmenopausal care. This bill contains other related provisions and other existing laws.

AB 489 **(Bonta D) Health care professions: deceptive terms or letters: artificial intelligence.**
Current Text: Amended: 4/10/2025 html pdf
Introduced: 2/10/2025
Status: 4/23/2025-From committee: Do pass and re-refer to Com. on APPR. with recommendation: To Consent Calendar. (Ayes 14. Noes 0.) (April 22). Re-referred to Com. on APPR.

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

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

AB 510 **(Addis D) Health care coverage: utilization review: peer-to-peer review.**
Current Text: Amended: 4/28/2025 html pdf
Introduced: 2/10/2025
Status: 4/29/2025-Re-referred to Com. on APPR.

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. This bill, upon communication of a decision by a health care service plan or health insurer delaying, denying, or modifying a health care service based in whole or in part on medical necessity, would authorize a provider to request review of the decision by a licensed physician, or a licensed health care professional under specified circumstances, who is competent to evaluate the specific clinical issues involved in the health care service being requested, and is of the same or similar specialty as the requesting provider. The bill would authorize a licensed health care professional to be the reviewer if the provider requesting peer-to-peer review is not a physician. The bill, notwithstanding any other law, would require these reviews to occur within 2 business days, or if an enrollee or insured

faces an imminent and serious threat to their health, within a timely fashion appropriate for the nature of the enrollee's or insured's condition, as specified. If a health care service plan or health insurer fails to meet those timelines, the bill would deem the request for the health care service as approved and supersede any prior delay, denial, or modification. This bill contains other related provisions and other existing laws.

AB 512 **(Harabedian D) Health care coverage: prior authorization.**
Current Text: Amended: 4/28/2025 html pdf
Introduced: 2/10/2025
Status: 4/29/2025-Re-referred to Com. on APPR.

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

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

AB 517 **(Krell D) Medi-Cal: complex rehabilitation technology: wheelchairs.**
Current Text: Introduced: 2/10/2025 html pdf
Introduced: 2/10/2025
Status: 4/30/2025-In committee: Set, first hearing. Referred to suspense file.

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: 4/23/2025-In committee: Set, first hearing. Referred to suspense file.

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: Amended: 3/24/2025 html pdf
Introduced: 2/11/2025
Status: 4/24/2025-Read second time. Ordered to third reading.

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law generally requires a health care service plan contract or a health insurance policy issued, amended, or renewed on or after January 1, 2022, to provide coverage without cost sharing for a colorectal cancer screening test assigned either a grade of A or a grade of B by the United States Preventive Services Task Force and for a required colonoscopy for a positive result on a test with those grades. This bill would additionally require that coverage if the screening test is approved by the United States Food and Drug Administration and either meets requirements for coverage established by the federal Centers for Medicare and Medicaid Services, as specified, or is included in the most recently published guidelines from the American Cancer Society.

AB 539 **(Schiavo D) Health care coverage: prior authorizations.**
Current Text: Amended: 4/28/2025 html pdf
Introduced: 2/11/2025
Status: 4/29/2025-Re-referred to Com. on APPR.

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

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

AB 543 **(González, Mark D) Medi-Cal: street medicine.**
Current Text: Amended: 4/8/2025 html pdf
Introduced: 2/11/2025
Status: 4/23/2025-Coauthors revised. From committee: Do pass and re-refer to Com. on APPR. (Ayes 16. Noes 0.) (April 22). Re-referred to Com. on APPR.

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: 4/30/2025-From committee: Amend, and do pass as amended and re-refer to Com. on APPR. (Ayes 14. Noes 0.) (April 29).

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: 4/30/2025-From committee: Do pass and re-refer to Com. on APPR. (Ayes 14. Noes 0.) (April 29). Re-referred to Com. on APPR.

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law generally prohibits a health care service plan, excluding a Medi-Cal managed care plan, or health insurer from subjecting antiretroviral drugs that are medically necessary for the prevention of HIV/AIDS, including preexposure prophylaxis or postexposure prophylaxis, to prior authorization or step therapy. Under existing law, a health care service plan or health insurer is not required to cover all the therapeutically equivalent versions of those drugs without prior authorization or step therapy if at least one is covered without prior authorization or step therapy. This bill, the Protecting Rights,

Expanding Prevention, and Advancing Reimbursement for Equity (PrEPARE) Act of 2025, would instead prohibit a health care service plan, excluding a Medi-Cal managed care plan, or health insurer from subjecting antiretroviral drugs, drug devices, or drug products that are either approved by the United States Food and Drug Administration (FDA) or recommended by the federal Centers for Disease Control and Prevention (CDC) for the prevention of HIV/AIDS, to prior authorization, step therapy, or any other protocol designed to delay treatment, but would authorize prior authorization or step therapy if at least one therapeutically equivalent version is covered without prior authorization or step therapy and the plan or insurer provides coverage for a noncovered therapeutic equivalent antiretroviral drug, drug device, or drug product without cost sharing pursuant to an exception request. The bill would specify that, for therapeutically equivalent coverage purposes, a long-acting injectable drug is not therapeutically equivalent to a long-acting injectable drug with a different duration. The bill would require a plan or insurer to provide coverage under the outpatient prescription drug benefit for those drugs, drug devices, or drug products, including by supplying participating providers directly with a drug, drug device, or drug product, as specified. This bill contains other related provisions and other existing laws.

AB 575 **(Arambula D) Obesity Prevention Treatment Parity Act.**
Current Text: Amended: 3/12/2025 html pdf
Introduced: 2/12/2025
Status: 4/28/2025-In committee: Set, first hearing. Hearing canceled at the request of author.

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 specified anti-obesity medication and intensive behavioral therapy for the treatment of obesity without prior authorization. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 577 **(Wilson D) Health care coverage: antisteering.**
Current Text: Amended: 4/21/2025 html pdf
Introduced: 2/12/2025
Status: 4/30/2025-From committee: Amend, and do pass as amended and re-refer to Com. on APPR. (Ayes 12. Noes 0.) (April 29).

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 non-substantive change to those provisions.

AB 602 **(Haney D) Public postsecondary education: student conduct: controlled substances.**
Current Text: Amended: 3/13/2025 html pdf
Introduced: 2/13/2025
Status: 4/30/2025-From committee: Amend, and do pass as amended and re-refer to Com. on APPR. (Ayes 6. Noes 3.) (April 29).

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

Summary: Existing law, known as the Donahoe Higher Education Act, establishes the California Community Colleges, the California State University, and the University of California as the public segments of postsecondary education in the state. Existing law requires the Regents of the University of California, the Trustees of the California State University, and the governing board of every community college district to adopt or provide for the adoption of specific rules and regulations governing student behavior and to adopt procedures by which all students are informed of the rules and regulations, with applicable penalties, as provided. Provisions of the act apply to the University of California only to the extent that the Regents of the University of California, by appropriate resolution, act to make a provision applicable. This bill would prohibit the Chancellor of the California Community Colleges, the Trustees of the California State University, the Regents of the University of California, and every administrator at any campus of those institutions from adopting or enforcing a rule that imposes disciplinary sanctions on a student solely on the basis of acts of being under the influence of, or possessing for personal use, a controlled substance, controlled substance analog, or drug paraphernalia, under certain circumstances related to a drug-related overdose that prompted the seeking of medical assistance, and would prohibit those acts from being documented in a student's disciplinary file, as provided. The bill would authorize the Chancellor of the California Community Colleges, the Trustees of the California State University, the Regents of the University of California, and every administrator at any campus of those institutions to require a student who has committed one of those acts to complete an assigned activity, as specified, and would authorize them to document the act and any assigned activity imposed in a student's administrative file, as provided.

AB 618 **(Krell D) Medi-Cal: behavioral health: data sharing.**
Current Text: Introduced: 2/13/2025 html pdf
Introduced: 2/13/2025
Status: 4/30/2025-In committee: Set, first hearing. Referred to suspense file.

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: Amended: 3/13/2025 html pdf
Introduced: 2/13/2025
Status: 4/23/2025-In committee: Set, first hearing. Referred to suspense file.

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. The bill would require the department to update the Medi-Cal provider manual, as applicable, in the course of implementing these provisions.

AB 669 **(Haney D) Substance use disorder coverage.**
Current Text: Amended: 4/28/2025 html pdf
Introduced: 2/14/2025
Status: 4/29/2025-Re-referred to Com. on APPR.

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

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

AB 676 **(Gonzalez, Jeff R) Medi-Cal: unrecovered payments: interest rate.**
Current Text: Amended: 4/9/2025 html pdf
Introduced: 2/14/2025
Status: 4/30/2025-In committee: Set, first hearing. Referred to suspense file.

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

1st House	2nd House	Conc.			

Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law requires the Director of Health Care Services to establish administrative appeal processes to review grievances or complaints arising from the findings of an audit or examination. Under existing law, if recovery of a disallowed payment has been made by the department, a provider who prevails in an appeal of that payment is entitled to interest at the rate equal to the monthly average received on investments in the Surplus Money Investment Fund, or simple interest at the rate of 7% per annum, whichever is higher. Under existing law, with exceptions, interest at that same rate is assessed against any unrecovered overpayment due to the department. In the case of an assessment against any unrecovered overpayment due to the department, this bill would require the department to waive the interest, as part of a repayment agreement entered into with the provider, if the latest date of service for a retroactive payment adjustment or audit period end date for the unrecovered overpayment occurred 4 or more years before the issuance of the first statement of account status or demand for repayment, and the department determines that certain factors apply. Under the bill, those factors would include, among others, the impact of the repayment amounts on the fiscal solvency of the provider, and whether the overpayment was caused by a policy change or departmental error that was not caused by the billing provider. The bill would preserve the rights of the department to seek all remedies available at law if a provider defaults on a repayment plan. This bill would authorize the department to implement, interpret, or make specific these provisions, in whole or in part, by means of information notices, all-county letters, or other similar instructions without taking regulatory action.

AB 682 **(Ortega D) Health care coverage reporting.**
Current Text: Introduced: 2/14/2025 html pdf
Introduced: 2/14/2025
Status: 4/30/2025-From committee: Do pass and re-refer to Com. on APPR. with recommendation: To Consent Calendar. (Ayes 16. Noes 0.) (April 29). Re-referred to Com. on APPR.

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

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

AB 787 **(Papan D) Provider directory disclosures.**
Current Text: Amended: 4/7/2025 html pdf
Introduced: 2/18/2025
Status: 4/24/2025-Read second time. Ordered to third reading.

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires specified health care service plans and health insurers to publish and maintain a provider directory or directories with information on contracting providers that deliver health care services to enrollees or insureds, and requires a health care service plan or health insurer to regularly update its printed and online provider directory or directories, as specified. Existing law requires provider directories to include specified information and disclosures. This bill would require a full service health care service plan, specialized mental health plan, health insurer, or specialized mental health insurer to

include in its provider directory or directories a statement at the top of the directory advising an enrollee or insured to contact the plan or insurer for assistance in finding an in-network provider. The bill would require the plan or insurer to respond within one business day if contacted for that assistance, and to provide a list of in-network providers confirmed to be accepting new patients within 2 business days. Because a violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 789 **(Bonta D) Health care coverage: unreasonable rate increases.**
Current Text: Amended: 3/17/2025 html pdf
Introduced: 2/18/2025
Status: 4/21/2025-Read third time. Passed. Ordered to the Senate. (Ayes 59. Noes 4.) In Senate. Read first time. To Com. on RLS. for assignment.

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

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

AB 798 **(Calderon D) State Emergency Food Bank Reserve Program: diapers and wipes.**
Current Text: Amended: 4/22/2025 html pdf
Introduced: 2/18/2025
Status: 4/30/2025-From committee: Do pass and re-refer to Com. on APPR. with recommendation: To Consent Calendar. (Ayes 7. Noes 0.) (April 29). Re-referred to Com. on APPR.

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

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

AB 804 **(Wicks D) Medi-Cal: housing support services.**
Current Text: Introduced: 2/18/2025 html pdf
Introduced: 2/18/2025
Status: 4/30/2025-In committee: Set, first hearing. Referred to suspense file.

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: 4/23/2025-In committee: Set, first hearing. Referred to suspense file.

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

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

AB 877 **(Dixon R) Health care coverage: substance use disorder: residential facilities.**
Current Text: Amended: 4/21/2025 html pdf
Introduced: 2/19/2025
Status: 4/22/2025-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 regulation of health care service plans by the Department of Managed Health Care and health insurers by the Department of Insurance. Existing law requires a health care service plan contract or disability insurance policy to provide coverage for medically necessary treatment of mental health and substance use disorders, as defined, under the same terms and conditions applied to other medical conditions. Existing law establishes

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

AB 910 **(Bonta D) Pharmacy benefit management.**
Current Text: Amended: 4/10/2025 html pdf
Introduced: 2/19/2025
Status: 4/23/2025-From committee: Do pass and re-refer to Com. on APPR. (Ayes 13. Noes 0.) (April 22). Re-referred to Com. on APPR.

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 modify the above-described requirement that the pharmacy benefit manager exercise good faith and fair dealing to instead require the pharmacy benefit manager to hold a fiduciary duty in the performance of its contractual duties and carry out that duty in accordance with state and federal law. The bill would require the pharmacy benefit manager to remit 100% of specified rebates, fees, alternative discounts, and other remuneration received to the health care service plan and would prohibit the pharmacy benefit manager from entering into any contract for pharmacy benefit management services that is contrary to that requirement. This bill contains other related provisions and other existing laws.

AB 951 **(Ta R) Health care coverage: behavioral diagnoses.**
Current Text: Introduced: 2/20/2025 html pdf
Introduced: 2/20/2025
Status: 4/24/2025-Read third time. Passed. Ordered to the Senate. (Ayes 75. Noes 0.) In Senate. Read first time. To Com. on RLS. for assignment.

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

Summary: Existing law, 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 re-diagnosis to maintain coverage for behavioral health treatment for their condition. The bill would require a treatment plan to be made available to the plan or insurer upon request. Because a willful violation of this provision by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 960 **(Garcia D) Patient visitation.**
Current Text: Amended: 4/24/2025 html pdf
Introduced: 2/20/2025
Status: 4/28/2025-Re-referred to Com. on APPR.

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

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

AB 974 **(Patterson R) Medi-Cal managed care plans: enrollees with other health care coverage.**
Current Text: Amended: 3/24/2025 html pdf
Introduced: 2/20/2025
Status: 4/30/2025-In committee: Set, first hearing. Referred to suspense file.

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

AB 979 **(Irwin D) California Cybersecurity Integration Center: artificial intelligence.**

Current Text: Amended: 4/23/2025 html pdf
Introduced: 2/20/2025
Status: 4/24/2025-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 law requires the Office of Emergency Services to establish and lead the California Cybersecurity Integration Center. Existing law states that the center's mission is to reduce the likelihood and severity of cyber incidents that could damage California's economy, its critical infrastructure, or public and private sector computer networks in the state. Existing law requires the center to serve as the central organizing hub of state government's cybersecurity activities and coordinate information sharing with specified entities, including local, state, and federal agencies. This bill would require the California Cybersecurity Integration Center to develop, on or before July 1, 2026, in consultation with the Office of Information Security and the Government Operations Agency, a California AI Cybersecurity Collaboration Playbook, as specified, to facilitate information sharing across the artificial intelligence community and to strengthen collective cyber defenses against emerging threats. The bill would require the center to review federal requirements, standards, and industry best practices, as specified, and to use those resources to inform the development of the California AI Cybersecurity Collaboration Playbook. Except as specified, the bill would provide that any information related to cyber threat indicators or defensive measures for a cybersecurity purpose shared in accordance with the California AI Cybersecurity Collaboration Playbook is confidential and would prohibit that information from being disclosed, except as specified. The bill would also make findings and declarations related to its provisions. This bill contains other related provisions and other existing laws.

AB 980 **(Arambula D) Health care: medically necessary treatment.**
Current Text: Amended: 4/21/2025 html pdf
Introduced: 2/20/2025
Status: 4/22/2025-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 requires a health care service plan contract or health insurance policy to provide coverage for medically necessary treatment of mental health and substance use disorders under the same terms and conditions applied to other medical conditions, as specified. Existing law generally authorizes a health care service plan or health insurer to use utilization review to approve, modify, delay, or deny requests for health care services based on medical necessity. This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2026, to provide coverage for medically necessary treatment of physical conditions and diseases under the same terms and conditions applied to other medical conditions, as specified. The bill would require the delivery of medically necessary services out of network if those services are not available within geographic and timely access standards. The bill would require a plan or insurer to apply specified clinical criteria and guidelines in conducting utilization review of the covered health care services and benefits for physical conditions and diseases. The bill would authorize the Director of the Department of Managed Health Care or the Insurance Commissioner, as applicable, to assess administrative or civil penalties, as specified, for violation of the requirements relating to utilization review. Because a willful violation of these requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program. This bill contains other existing laws.

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

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

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

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

AB 1018 **(Bauer-Kahan D) Automated decision systems.**
Current Text: Amended: 4/10/2025 html pdf
Introduced: 2/20/2025
Status: 4/30/2025-From committee: Amend, and do pass as amended and re-refer to Com. on APPR. (Ayes 8. Noes 3.) (April 29).

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

Summary: The California Fair Employment and Housing Act establishes the Civil Rights Department within the Business, Consumer Services, and Housing Agency and requires the department to, among other things, bring civil actions to enforce the act. Existing law requires, on or before September 1, 2024, the Department of Technology to conduct, in coordination with other interagency bodies as it deems appropriate, a comprehensive inventory of all high-risk automated decision systems that have been proposed for use, development, or procurement by, or are being used, developed, or procured by, any state agency. This bill would generally regulate the development and deployment of an automated decision system (ADS) used to make consequential decisions, as defined. The bill would define "automated decision system" to mean a computational process derived from machine learning, statistical modeling, data analytics, or artificial intelligence that issues simplified output, including a score, classification, or recommendation, that is designed or used to assist or replace human discretionary 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: 4/29/2025-VOTE: Do pass as amended and be re-referred to the Committee on [Appropriations] (PASS)

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: health care provider credentials.**
Current Text: Amended: 4/7/2025 html pdf
Introduced: 2/20/2025
Status: 4/23/2025-In committee: Set, first hearing. Referred to suspense file.

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 provider 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) Alcoholism or drug abuse treatment facilities: County of Orange pilot program.**
Current Text: Amended: 3/24/2025 html pdf
Introduced: 2/20/2025
Status: 3/25/2025-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 that the State Department of Health Care Services has the sole authority in state government to license adult alcoholism or drug abuse recovery or treatment facilities, as defined. Existing law authorizes the department to conduct announced or unannounced site visits to licensed facilities to review compliance with all applicable statutes and regulations. This bill would require the State Department of Health Care Services to establish a pilot program to locate an investigator within a participating county to investigate complaints against licensed adult alcoholism or drug abuse recovery or treatment facilities within the county. The participating county would be the County of Orange if the Orange County Board of Supervisors elects to participate in the pilot program. The bill would require the department to implement the pilot program by executing a contract with the County of Orange providing that the department will assign an investigator and the county will reimburse the department for the costs associated with the pilot program, including, but not limited to, the administrative costs and the investigator's compensation and benefits. The bill would require the pilot program to be completed no later than December 31, 2029, and would require the county to submit a report of the results of the pilot program, as specified, to the Legislature no later than December 31, 2030. The provisions of this bill would be repealed on December 31, 2034.

AB 1129 **(Rodriguez, Celeste D) Birth defects monitoring.**
Current Text: Amended: 4/22/2025 html pdf
Introduced: 2/20/2025
Status: 4/30/2025-From committee: Do pass and re-refer to Com. on APPR. (Ayes 13. Noes 0.) (April 29). Re-referred to Com. on APPR.

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 requires the officer to use the birth

defects information described above to conduct studies to investigate the causes of birth defects, stillbirths, and miscarriages, 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 conditions, as defined, that occur during the 12-month period after an individual's birth. The bill would authorize a local health officer to require providers and laboratories, as specified, in addition to the facilities listed above, to either make available or to transmit to the local health department information related to birth defects and conditions, as specified. The bill would additionally require the officer to use birth defects and conditions information gathered by local health officers to conduct the studies described above. The bill would authorize a local health officer to enter into contracts for implementation of programs to collect information regarding, and to monitor, birth defects and conditions in their jurisdiction. This bill contains other related provisions and other existing laws.

AB 1137 **(Krell D) Reporting mechanism: child sexual abuse material.**
Current Text: Amended: 4/21/2025 html pdf
Introduced: 2/20/2025
Status: 4/30/2025-Coauthors revised. From committee: Do pass and re-refer to Com. on APPR. (Ayes 11. Noes 0.) (April 29). Re-referred to Com. on APPR.

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

Summary: Existing law requires a social media platform to take certain actions with respect to child sexual abuse material on the social media platform, including by requiring the social media platform to provide, in a mechanism that is reasonably accessible to users, a means for a user who is a California resident to report material to the social media platform that the user reasonably believes meets certain criteria, including that the reported material is child sexual abuse material and that the reporting user is depicted in the material. Existing law also requires the social media platform to collect information reasonably sufficient to enable the social media platform to contact, as specified, a reporting user. This bill would delete the requirement for reporting material that the reporting user be depicted in the material, would require that the depicted individual be depicted as a minor, and would additionally require the mechanism to be clear and conspicuous. The bill would require a social media platform to ensure that any report submitted using the reporting mechanism is reviewed through a hash matching process and would require a social media company to ensure review by a natural person if there is not an established or known hash match to child sexual abuse material with respect to the reported material and the reported material is not otherwise blocked. This bill contains other related provisions and other existing laws.

AB 1328 **(Rodriguez, Michelle D) Medi-Cal reimbursements: nonemergency ambulance transportation.**
Current Text: Amended: 4/28/2025 html pdf
Introduced: 2/21/2025
Status: 4/29/2025-Re-referred to Com. on APPR.

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

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

AB 1405 **(Bauer-Kahan D) Artificial intelligence: auditors: enrollment.**
Current Text: Amended: 4/3/2025 html pdf
Introduced: 2/21/2025
Status: 4/23/2025-In committee: Set, first hearing. Referred to suspense file.

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, retain specified reports for as long as the auditor remains enrolled, plus 10 years, and share reports submitted by persons reporting misconduct with other state agencies as necessary for enforcement purposes. This bill contains other related provisions and other existing laws.

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

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

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

AB 1418 **(Schiavo D) Department of Health Care Access and Information.**
Current Text: Introduced: 2/21/2025 html pdf
Introduced: 2/21/2025
Status: 4/23/2025-In committee: Set, first hearing. Referred to suspense file.

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

1st House	2nd House	Conc.			

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) Employment: automated decision systems.
Current Text: Amended: 3/6/2025 html pdf
Introduced: 12/2/2024
Status: 4/30/2025-From committee: Do pass as amended and re-refer to Com. on APPR. (Ayes 11. Noes 2.) (April 29).

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

Summary: Existing law requires the Department of Technology to conduct, in coordination with other interagency bodies as it deems appropriate, a comprehensive inventory of all high-risk automated decision systems (ADS) that have been proposed for use, development, or procurement by, or are being used, developed, or procured by, any state agency. Existing law establishes the Labor and Workforce Development Agency, which is composed of various departments responsible for protecting and promoting the rights and interests of workers in California, including the Division of Labor Standards Enforcement, led by the Labor Commissioner, within the Department of Industrial Relations. This bill would require an employer, or a vendor engaged by the employer, to provide a written notice that an ADS, for the purpose of making employment-related decisions, is in use at the workplace to all workers that will be directly or indirectly affected by the ADS, as specified. The bill would require the employer or vendor to maintain a list of all ADS currently in use and would require the notice to include the updated list. The bill would prohibit an employer or vendor from using an ADS that does certain functions and would limit the purposes and manner in which an ADS may be used to make decisions. The bill would require an employer to allow a worker to access data collected or used by an ADS and to correct errors in data, as specified. This bill would require an employer or vendor to provide a written notice to a worker that has been affected by an employment-related decision made by an ADS, and provide that worker with a form or a link to an electronic form to appeal the decision within 30 days of the notification. The bill would require an employer or vendor to respond to an appeal within 14 business days, designate a human reviewer who meets specified criteria to objectively evaluate all evidence, and rectify the decision within 21 business days if the human reviewer determines that the employment-related decision should be overturned.

SB 12

(Gonzalez D) State government: Immigrant and Refugee Affairs Agency: Office of Immigrant and Refugee Affairs.
Current Text: Amended: 4/10/2025 html pdf
Introduced: 12/2/2024
Status: 4/25/2025-Set for hearing May 5.

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 and refugee inclusion into the social, cultural, economic, and civic life of the state. The bill would authorize the secretary to, among other things, assist other state agencies in evaluating their programs for accessibility and effectiveness in providing services to immigrants and refugees and recommending policy and budget mechanisms for meeting immigrant and refugee inclusion. This bill

would establish the Office of Immigrant and Refugee Affairs within the agency, under the direction of the Statewide Director of Immigrant and Refugee Inclusion. The bill would declare the intent to incorporate existing and future programs created to assist immigrants and refugees into the office. The bill would transfer to the office the property of any other office, agency, or department that relates to functions concerning immigrant and refugee affairs. The bill would require every officer and employee who is performing a function at another office, agency, or department that is transferred to the Office of Immigrant and Refugee Affairs to also be transferred to the office, and would provide that every officer and employee who is serving in the state civil service who is transferred to the office shall retain their status, position, and rights, except as specified. The bill would create the Immigrant and Refugee Inclusion Fund within the State Treasury, and would make the moneys in the fund available to the office upon appropriation by the Legislature. The bill would transfer to the office any unencumbered balance of any appropriation or other funds that were available for use in connection with any function transferred to the office. This bill contains other related provisions and other existing laws.

SB 27 **(Umberg D) Community Assistance, Recovery, and Empowerment (CARE) Court Program.**
Current Text: Introduced: 12/2/2024 html pdf
Introduced: 12/2/2024
Status: 4/10/2025-Read second time. Ordered to third reading.

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

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

SB 32 **(Weber Pierson D) Health care coverage: timely access to care.**
Current Text: Amended: 3/25/2025 html pdf
Introduced: 12/2/2024
Status: 4/4/2025-Set for hearing April 30.

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

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

would become inoperative on July 1, 2033, and would be repealed on January 1, 2034. This bill contains other existing laws.

SB 40 **(Wiener D) Health care coverage: insulin.**
Current Text: Amended: 4/7/2025 html pdf
Introduced: 12/3/2024
Status: 4/21/2025-April 21 hearing: Placed on APPR. suspense file.

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

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

SB 41 **(Wiener D) Pharmacy benefits.**
Current Text: Amended: 3/17/2025 html pdf
Introduced: 12/3/2024
Status: 4/30/2025-From committee: Do pass and re-refer to Com. on APPR. (Ayes 13. Noes 0.) (April 29). Re-referred to Com. on APPR.

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: 3/27/2025 html pdf
Introduced: 1/7/2025
Status: 4/21/2025-April 21 hearing: Placed on APPR. suspense file.

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

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

SB 62 **(Menjivar D) Health care coverage: essential health benefits.**
Current Text: Amended: 4/23/2025 html pdf
Introduced: 1/9/2025
Status: 4/23/2025-From committee with author's amendments. Read second time and amended. 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, requires the Department of Managed Health Care to license and regulate health care service plans and makes a willful violation of the act a crime. Existing law requires the Department of Insurance to regulate health insurers. Existing law requires an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2017, to include, at a minimum, coverage for essential health benefits pursuant to the federal Patient Protection and Affordable Care Act. Existing law requires a health care service plan contract or health insurance policy to cover the same health benefits that the benchmark plan, the Kaiser Foundation Health Plan Small Group HMO 30 plan, offered during the first quarter of 2014, as specified. This bill would express the intent of the Legislature to review California's essential health benefits benchmark plan and establish a new benchmark plan for the 2027 plan year. The bill would require, commencing January 1, 2027, if the United States Department of Health and Human Services approves a new essential health benefits benchmark plan for the state, as specified, the benchmark plan to include certain additional benefits, including coverage for specified fertility services and specified durable medical equipment. Because a violation of the bill by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other existing laws.

SB 81 **(Arreguín D) Health and care facilities: information sharing.**
Current Text: Amended: 3/24/2025 html pdf
Introduced: 1/17/2025
Status: 4/30/2025-From committee: Do pass as amended and re-refer to Com. on APPR. (Ayes 11. Noes 0.) (April 29).

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

Summary: (1)The Confidentiality of Medical Information Act (CMIA) prohibits a provider of health care, a health care service plan, a contractor, or a corporation and its subsidiaries and affiliates from intentionally sharing, selling, using for marketing, or otherwise using any medical information, as defined, for any purpose not necessary to provide health care services to a patient, except as provided. The CMIA authorizes a provider of health care, health care service plan, or contractor to disclose medical information regarding a patient of the provider of health care or an enrollee or subscriber of a health care service plan with authorization from the patient or pursuant to a search warrant lawfully issued to a governmental law enforcement agency. Existing law makes a violation of these provisions that results in economic loss or personal injury to a patient punishable as a misdemeanor. This bill would revise the definition of "medical information" to include immigration status, including current and prior immigration status, and place of birth, and would define "immigration enforcement" to mean any and all efforts to investigate, enforce, or assist in the investigation or

enforcement of any federal civil immigration law, and also includes any and all efforts to investigate, enforce, or assist in the investigation or enforcement of any federal criminal immigration that penalizes a person's presence in, entry or reentry to, or employment in, the United States. The bill would specify that a provider of health care, health care service plan, or contractor may disclose medical information regarding a patient of the provider of health care or an enrollee or subscriber or a health care service plan pursuant to a search warrant lawfully issued and signed by a judge, including a magistrate judge, to a governmental law enforcement agency. The bill would also prohibit, except to the extent expressly authorized by a patient, enrollee, or subscriber, or as otherwise required, a provider of health care, health care service plan, contractor, or corporation and its subsidiaries and affiliates from disclosing medical information for immigration enforcement. The bill would prohibit, to the extent permitted by state and federal law, and to the extent possible, a provider of health care, health care service plan, contractor, or employer from allowing access to a patient for immigration enforcement. Because the bill would expand the scope of a crime, it would impose a state-mandated local program.

SB 85 **(Umberg D) Civil actions: service of summons.**
Current Text: Amended: 4/8/2025 html pdf
Introduced: 1/21/2025
Status: 4/8/2025-Set for hearing May 6. From committee with author's amendments. Read second time and amended. Re-referred to Com. on JUD.

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

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

SB 238 **(Smallwood-Cuevas D) Workplace surveillance tools.**
Current Text: Amended: 3/26/2025 html pdf
Introduced: 1/29/2025
Status: 4/30/2025-From committee: Do pass as amended and re-refer to Com. on APPR. (Ayes 11. Noes 2.) (April 29).

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

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

SB 242 **(Blakespear D) Medicare supplement coverage: open enrollment periods.**
Current Text: Introduced: 1/30/2025 html pdf
Introduced: 1/30/2025
Status: 4/4/2025-Set for hearing April 30.

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: 4/21/2025-April 21 hearing: Placed on APPR. suspense file.

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: 4/7/2025-April 7 hearing: Placed on APPR. suspense file.

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: 4/24/2025-From committee: Do pass and re-refer to Com. on APPR. (Ayes 11. Noes 0.) (April 23). Re-referred to Com. on APPR.

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: Amended: 3/28/2025 html pdf
Introduced: 2/4/2025
Status: 4/21/2025-April 21 hearing: Placed on APPR. suspense file.

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 law, in the form of exceptions, certain disclosures of the information are authorized for the purpose of facilitating appropriate HIV/AIDS medical care and treatment, including disclosures by state or local public health agency staff to agency staff, the designated health care provider, or the HIV-positive person who is the subject of the record, as specified. This bill would additionally authorize state public health agency HIV surveillance staff to disclose the information to State Department of Health Care Services staff, followed by authorized disclosures to the Medi-Cal managed care plan if applicable, the HIV-positive person who is the subject of the record, and the designated health care provider, for the purpose of proactively offering and coordinating care and treatment services to the person or for the purpose of administering quality improvement programs, as specified, designed to improve HIV care for Medi-Cal beneficiaries. The bill would require the State Department of Health Care Services, in consultation with the State Department of Public Health, to develop a mechanism by which a Medi-Cal beneficiary would be authorized to opt out of the disclosure of personally identifying information in public health records relating to HIV or AIDS to State Department of Health Care Services staff or the Medi-Cal managed care plan for the above-described purposes. This bill contains other related provisions and other existing laws.

SB 306 **(Becker D) Health care coverage: prior authorizations.**
Current Text: Amended: 4/28/2025 html pdf
Introduced: 2/10/2025
Status: 4/28/2025-Read second time and amended. Re-referred to Com. on APPR.

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

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

SB 324 **(Menjivar D) Medi-Cal: enhanced care management and community supports.**
Current Text: Amended: 4/7/2025 html pdf
Introduced: 2/11/2025
Status: 4/21/2025-April 21 hearing: Placed on APPR. suspense file.

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

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

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

SB 339 **(Cabaldon D) Medi-Cal: laboratory rates.**
Current Text: Amended: 4/9/2025 html pdf
Introduced: 2/12/2025
Status: 4/30/2025-From committee: Do pass and re-refer to Com. on APPR. with recommendation: To consent calendar. (Ayes 13. Noes 0.) (April 29). Re-referred to Com. on APPR.

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 instead require the above-described Medi-Cal reimbursement to equal the lowest of those metrics. The bill would carve out, from the above-described provision, for dates of service on or after July 1, 2027, or when funding is appropriated to implement this provision, whichever is sooner, Medi-Cal reimbursement to providers for clinical laboratory or laboratory services related to the diagnosis and treatment of sexually transmitted infections, and would apply that threshold but excluding the reimbursement rate described in clause (4) above. This bill contains other related provisions and other existing laws.

SB 363 **(Wiener D) Health care coverage: independent medical review.**
Current Text: Amended: 4/10/2025 html pdf
Introduced: 2/13/2025
Status: 4/28/2025-April 28 hearing: Placed on APPR. suspense file.

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law establishes the Independent Medical Review System within each department, under which an enrollee or insured may seek review if a health care service has been denied, modified, or delayed by a health care service plan or health insurer and the enrollee or insured has previously filed a grievance that remains unresolved after 30 days. This bill would require a health care service plan or health insurer to annually report to the appropriate department the total number of claims processed by the health care service plan or health insurer for the prior year and its number of treatment denials or modifications, separated and disaggregated as specified, commencing on or before June 1, 2026. The bill would require

the departments to compare the number of a health care service plan's or health insurer's treatment denials and modifications to (1) the number of successful independent medical review overturns of the plan's or insurer's treatment denials or modifications and (2) the number of treatment denials or modifications reversed by a plan or insurer after an independent medical review for the denial or modification is requested, filed, or applied for. The bill would make a health care service plan or health insurer liable for an administrative penalty, as specified, if more than 50% of the independent medical reviews filed with a health care service plan or health insurer result in an overturning or reversal of a treatment denial or modification in any one individual category of specified general types of care. The bill would make a health care service plan or health insurer liable for additional administrative penalties for each independent medical review resulting in an additional overturned or reversed denial or modification in excess of that threshold. The bill would require the departments to annually include data, analysis, and conclusions relating to these provisions in specified reports. 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: 4/22/2025-Read second time. Ordered to third reading.

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

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

SB 418 **(Menjivar D) Health care coverage: nondiscrimination.**
Current Text: Amended: 4/24/2025 html pdf
Introduced: 2/18/2025
Status: 4/29/2025-Set for hearing May 5.

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plans and health insurers, as specified, within 6 months after the relevant department issues specified guidance, or no later than March 1, 2025, to require all of their staff who are in direct contact with enrollees or insureds in the delivery of care or enrollee or insured services to complete evidence-based cultural competency training for the purpose of providing trans-inclusive health care for individuals who identify as transgender, gender diverse, or intersex. This bill would prohibit a subscriber, enrollee, policyholder, or insured from being excluded from enrollment or participation in, being denied the benefits of, or being subjected to discrimination by, any health care service plan or health insurer licensed in this state, on the basis of race, color, national origin, age, disability, or sex. The bill would define discrimination on the basis of sex for those purposes to include, among other things, sex characteristics, including intersex traits, pregnancy, and gender identity. The bill would prohibit a health care service plan or health insurer from taking specified actions relating to providing access to health programs and activities, including, but not limited to, denying or limiting health care services to an individual based upon the individual's sex assigned at birth, gender identity, or gender otherwise recorded. The bill would prohibit a health care service plan or health insurer, in specified circumstances, from taking various actions, including, but not limited to, denying, canceling, limiting, or refusing to issue or renew health care service plan enrollment, health insurance coverage, or other health-related

coverage, or denying or limiting coverage of a claim, or imposing additional cost sharing or other limitations or restrictions on coverage, on the basis of race, color, national origin, sex, age, disability, as specified. Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

SB 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, non-substantive changes to those provisions.

SB 466 **(Caballero D) Drinking water: hexavalent chromium: civil liability: exemption.**
Current Text: Amended: 3/24/2025 html pdf
Introduced: 2/19/2025
Status: 4/30/2025-From committee: Do pass as amended and re-refer to Com. on APPR. (Ayes 13. Noes 0.) (April 29).

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

Summary: The California Safe Drinking Water Act provides for the operation of public water systems and imposes on the State Water Resources Control Board various duties and responsibilities for the regulation and control of drinking water in the State of California. The act requires the state board to adopt primary drinking water standards for contaminants in drinking water based upon specified criteria, and requires a primary drinking water standard to be established for hexavalent chromium. Existing law authorizes the state board to grant a variance from primary drinking water standards to a public water system. This bill would prohibit a public water system from being held liable in any civil action related to hexavalent chromium in drinking water while implementing a state board-approved hexavalent chromium maximum contaminant level (MCL) compliance plan, or during the period between when it has submitted a hexavalent chromium MCL compliance plan for approval to the state board and action on the proposed compliance plan by the state board is pending, except as specified.

SB 468 **(Becker D) High-risk artificial intelligence systems: duty to protect personal information.**
Current Text: Introduced: 2/19/2025 html pdf
Introduced: 2/19/2025
Status: 4/25/2025-Set for hearing May 5.

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, non-substantive changes to those provisions.

SB 528 **(Weber Pierson D) Health care: maintenance and expansion.**
Current Text: Amended: 3/25/2025 html pdf
Introduced: 2/20/2025
Status: 4/4/2025-Set for hearing April 30.

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

Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law establishes, under the Medi-Cal program, the Family Planning, Access, Care, and Treatment (Family PACT) Program. If Family PACT becomes inoperative, existing law requires all persons who have received, or are eligible to receive, comprehensive clinical family planning services pursuant to Family PACT to receive family planning services under other specified provisions of the Medi-Cal program or under the State-Only Family Planning Program, which is also established within the department for purposes of family planning services. This bill would require the department, subject to an appropriation, to expand any existing state-only-funded health programs, including, but not limited to, the State-Only Family Planning Program, to provide to Medi-Cal beneficiaries certain services or benefits that are otherwise covered under the Medi-Cal program but for any lack of, elimination of, reduction in, or limitation on, federal financial participation. For purposes of the expansion above, the bill would require the department to determine the services or benefits, which may include, but are not limited to, abortion and gender-affirming care, based on the levels of federal financial participation, as specified. This bill contains other related provisions and other existing laws.

SB 530 **(Richardson D) Medi-Cal: time and distance standards.**
Current Text: Amended: 4/10/2025 html pdf
Introduced: 2/20/2025
Status: 4/28/2025-April 28 hearing: Placed on APPR. suspense file.

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

Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, under fee-for-service or managed care delivery systems. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. This bill would extend the operation of those standards indefinitely. The bill would also require a managed

care plan to ensure that each subcontractor network complies with certain appointment time standards unless already required to do so. The bill would set forth related reporting requirements with regard to subcontractor networks.

SB 535 **(Richardson D) Obesity Treatment Parity Act.**
Current Text: Introduced: 2/20/2025 html pdf
Introduced: 2/20/2025
Status: 4/4/2025-Set for hearing April 30.

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: Amended: 3/26/2025 html pdf
Introduced: 2/20/2025
Status: 4/21/2025-April 21 hearing: Placed on APPR. suspense file.

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

SB 626 **(Smallwood-Cuevas D) Perinatal health screenings and treatment.**
Current Text: Amended: 3/24/2025 html pdf
Introduced: 2/20/2025
Status: 4/4/2025-Set for hearing April 30.

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

Summary: Existing law requires a licensed health care practitioner who provides prenatal, postpartum, or interpregnancy care for a patient to offer to screen or appropriately screen a mother for maternal mental health conditions. For purposes of that requirement, existing law defines "maternal mental health condition" to mean a mental health condition that occurs during pregnancy, the postpartum period, or interpregnancy, as specified. This bill would modify the term "maternal mental health condition" to "perinatal mental health condition" and additionally include in its definition a mental health condition that occurs during the perinatal period. The bill would require a licensed health care practitioner who provides perinatal care for a patient to screen, diagnose, and treat the patient for a perinatal mental health condition 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: Amended: 4/8/2025 html pdf
Introduced: 2/21/2025
Status: 4/25/2025-Set for hearing April 30.

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

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

SB 833 **(McNerney D) Critical infrastructure: automated decision systems: human oversight.**
Current Text: Amended: 3/26/2025 html pdf
Introduced: 2/21/2025
Status: 4/25/2025-Set for hearing May 5.

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

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

Total Measures: 116

Total Tracking Forms: 116

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Executive Dashboard

OPERATIONS DASHBOARD

MAY 2025

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Financials

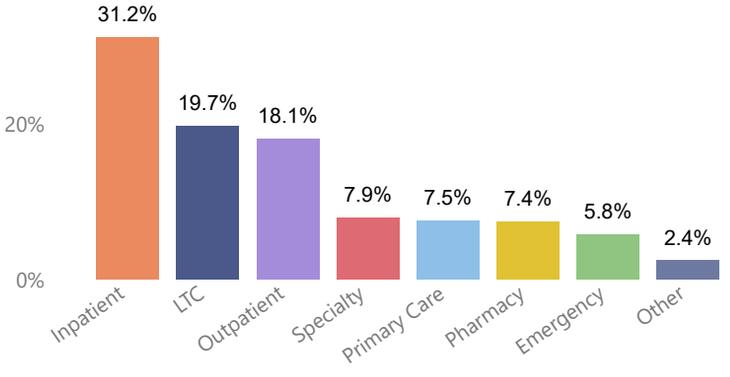
Income & Expenses

	MARCH 2025	FISCAL YTD
REVENUE	$ 260.2 M	$ 2.2 B
MEDICAL EXPENSE	$ (183.8) M	$ (1.6) B
ADMIN EXPENSE	$ (10.5) M	$ (86.8) M
OTHER/TAX	$ (65.4) M	$ (659.7) M
NET INCOME	$ 458 K	$ (98.3) M

Medical Loss % (Fiscal YTD)

102.0%

Medical Expenses



Liquid Reserves

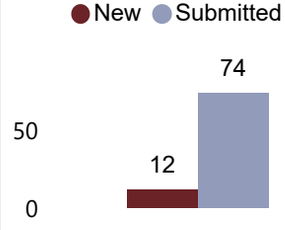
TNE %

196.9%

TNE $

$157.1M

Reinsurance Cases



Balance Sheet

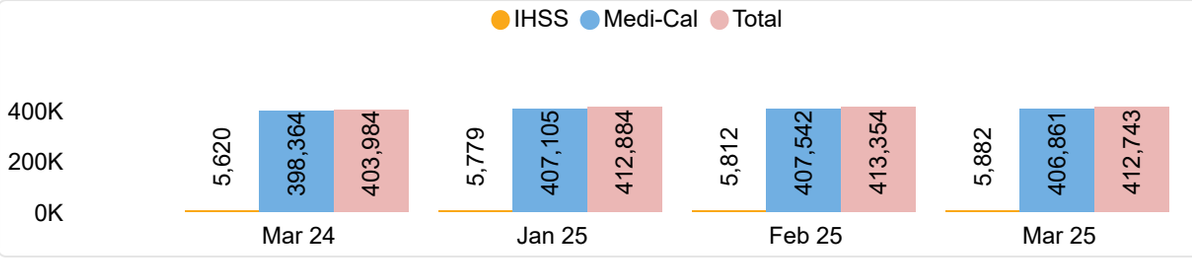
Cash Equivalents	$811.1M
Pass-Through Liabilities	$256.1M
Uncommitted Cash	$555.0M
Working Capital	$76.3M

Current Ratio

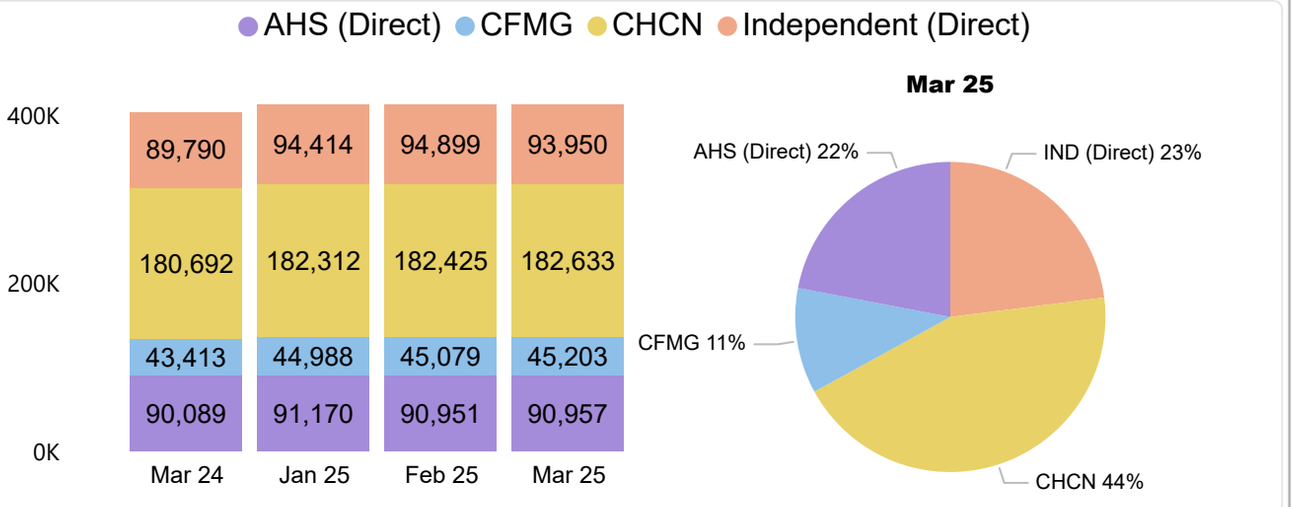
1.08

Membership

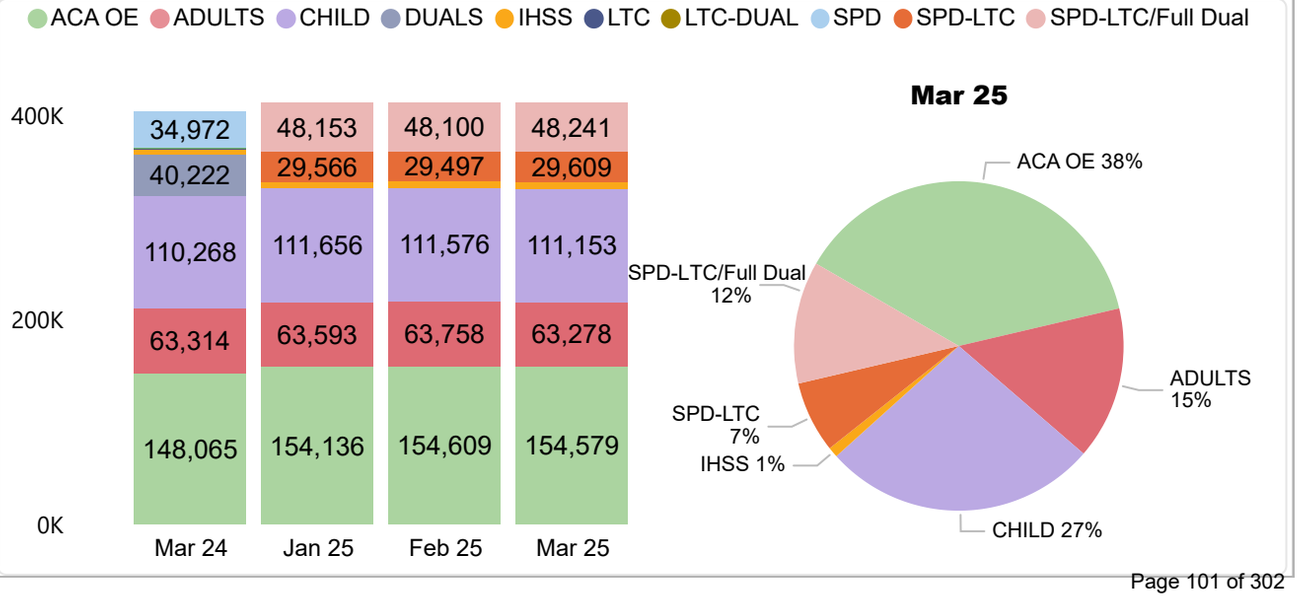
By Plan



By Network



By Category



OPERATIONS DASHBOARD

MAY 2025

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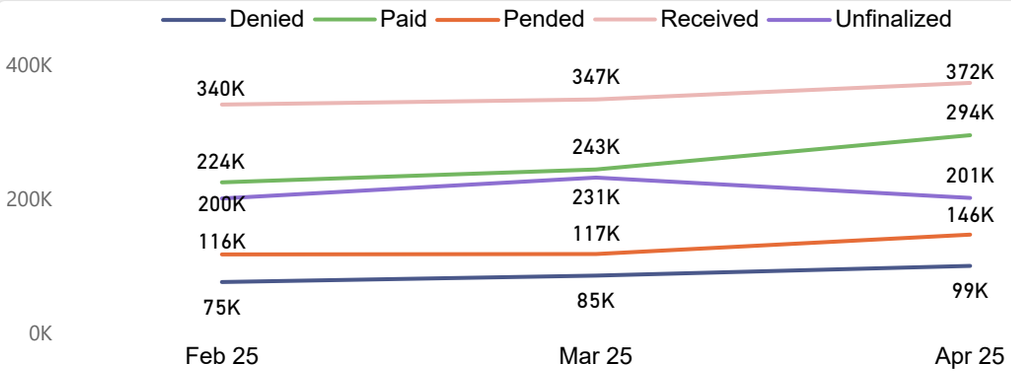
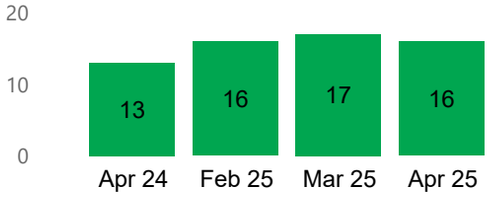
Claims

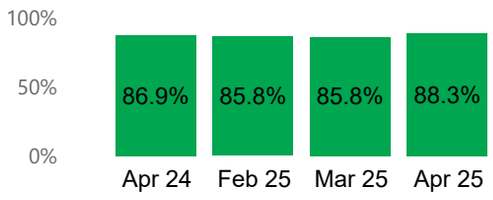
Claims Processing



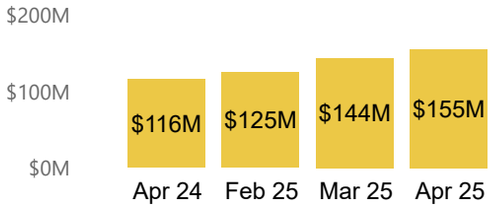
Average Payment TAT (Days)



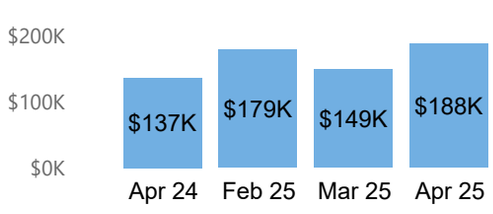
Auto Adjudication Rate (%)



Claims Paid ($)

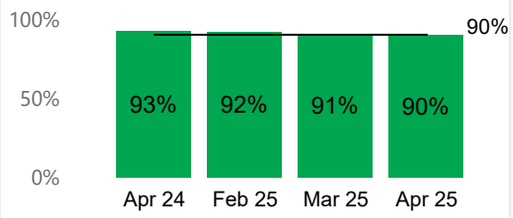


Interest Paid ($)

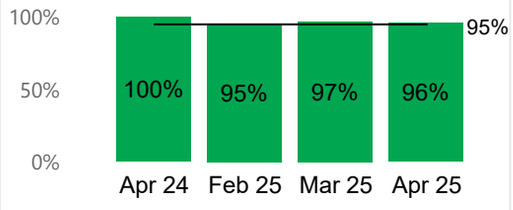


Claims Compliance

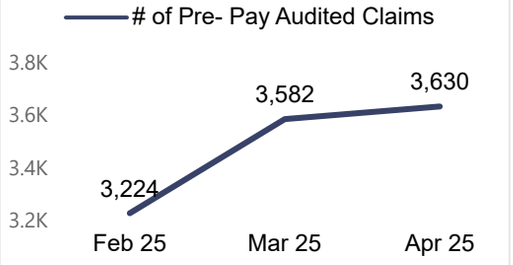
Processed 30 Cal Days (%)



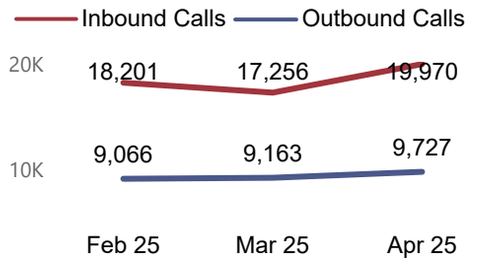
Processed 45 Work Days (%)



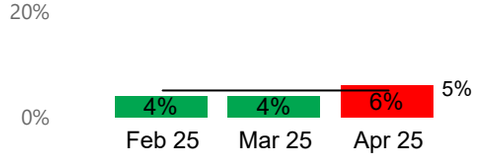
Claims Auditing



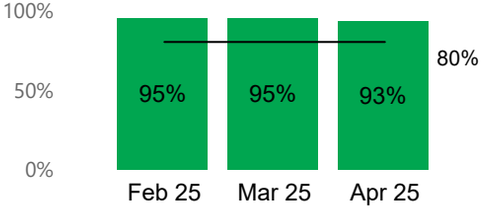
Member Services



Abandoned Call Rate (%)

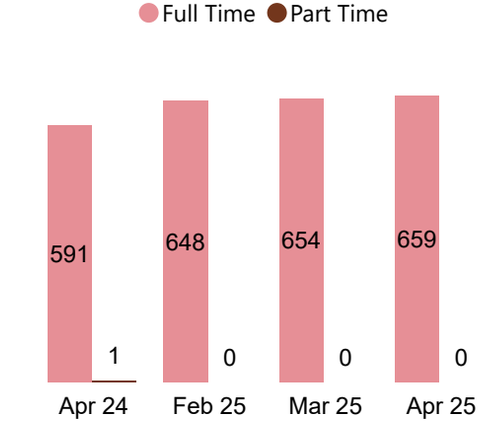


Calls Answered in 30 Seconds (%)

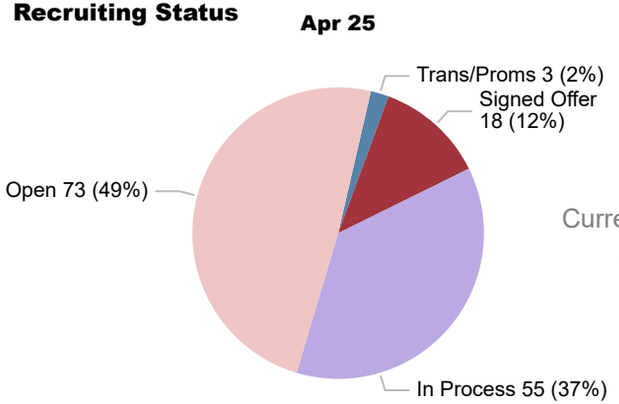


Average Call Times	Feb 25	Mar 25	Apr 25
Wait Time	00:12	00:11	00:15
Call Duration	07:30	07:29	07:25

Human Resources

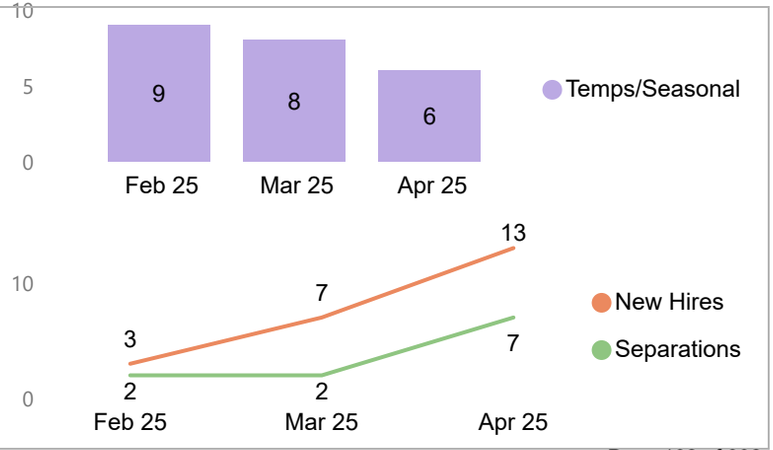


Recruiting Status Apr 25



Current Vacancy

10%



OPERATIONS DASHBOARD

MAY 2025

5/5/2025 11:20:52 AM

Provider Services

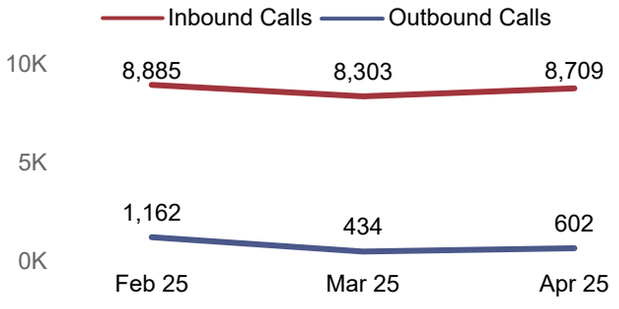
Provider Network

Hospital	17
Specialist	11,158
Primary Care Physician	793
Skilled Nursing Facility	107
Urgent Care	16
Health Centers (FQHCs and Non-FQHCs)	86
TOTAL	**12,177**

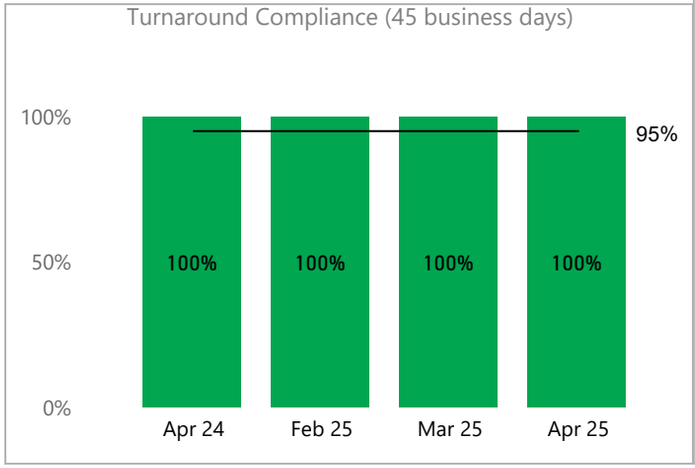
Provider Credentialing

4,693

Provider Call Center

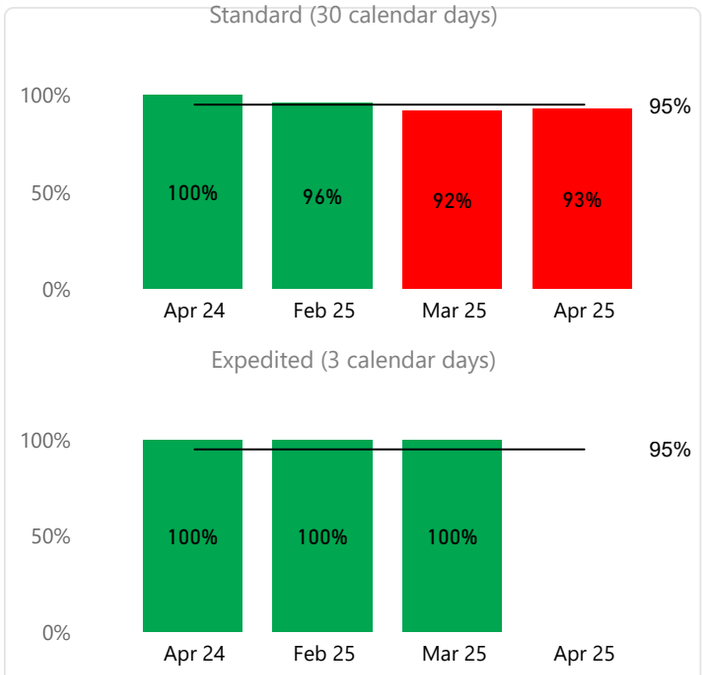


Provider Disputes & Resolutions

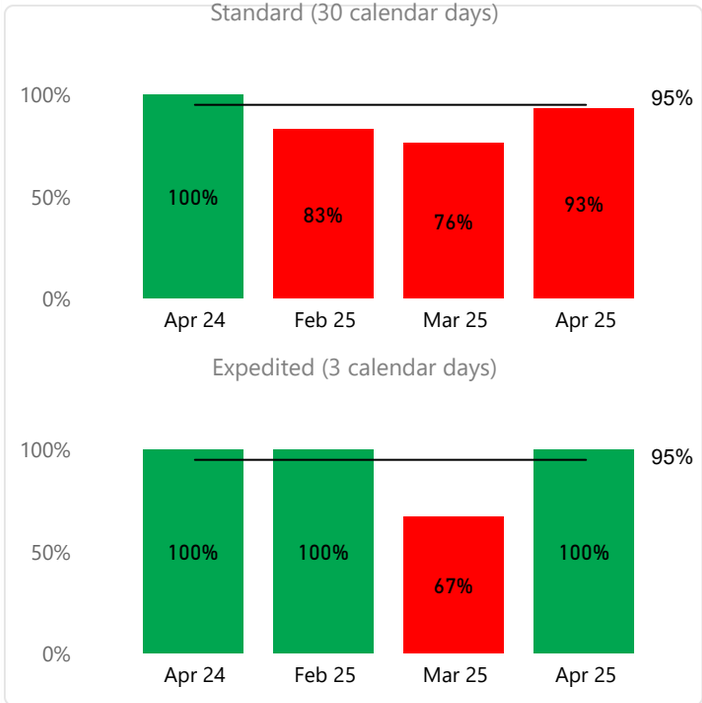


Compliance

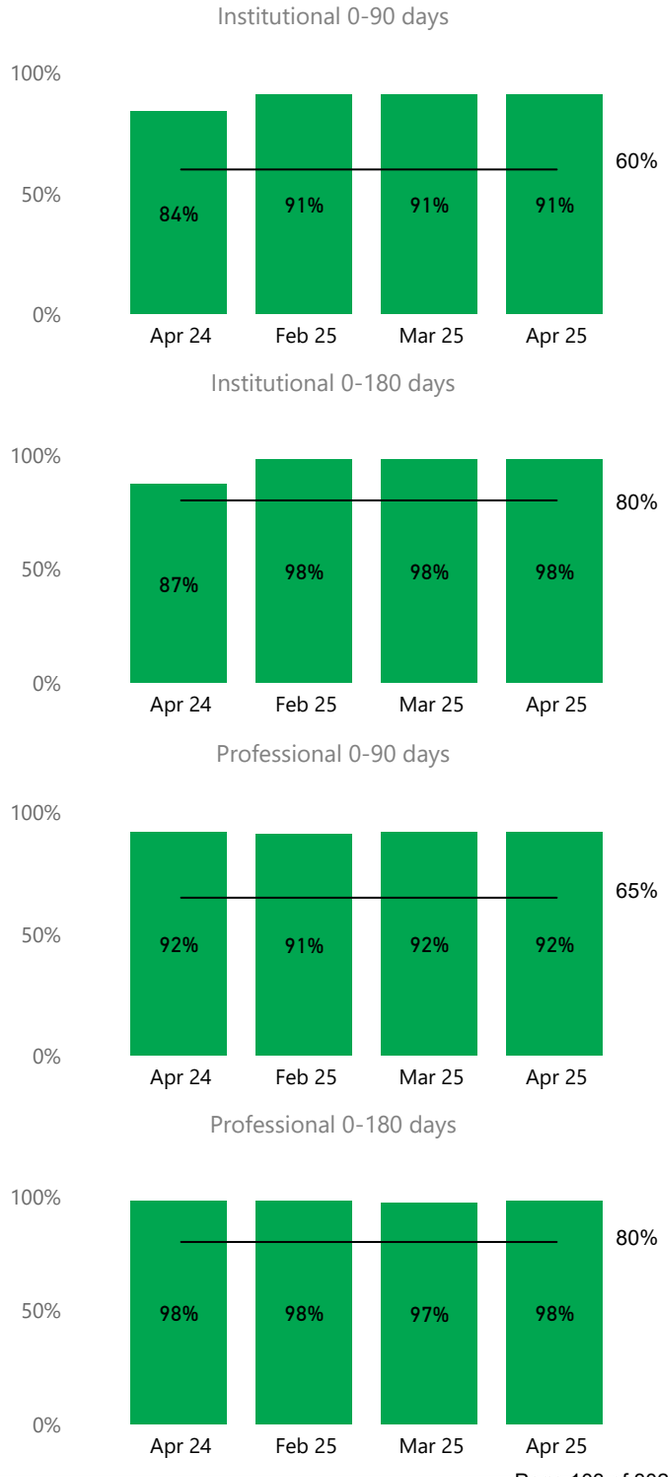
Member Grievances



Member Appeals

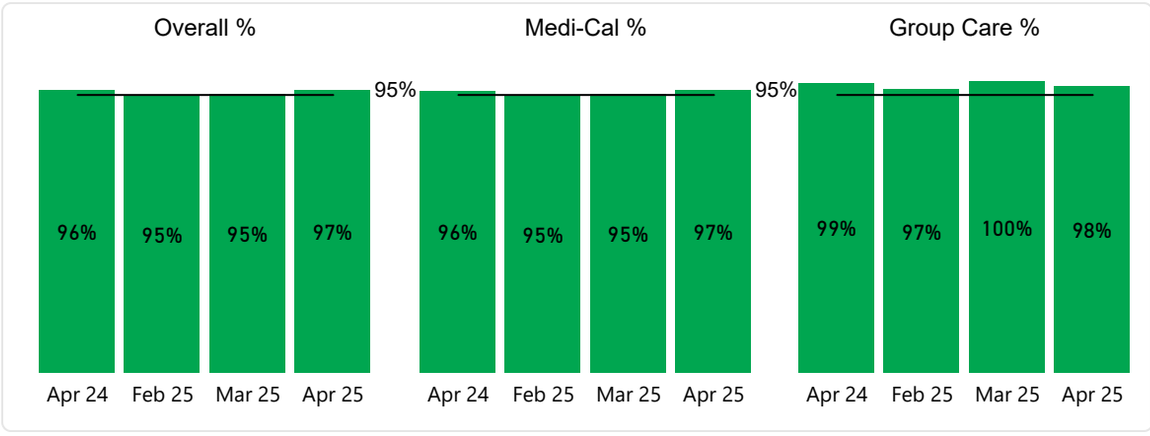


Encounter Data

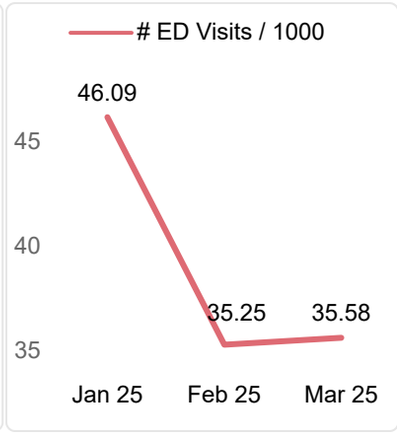


Health Care Services

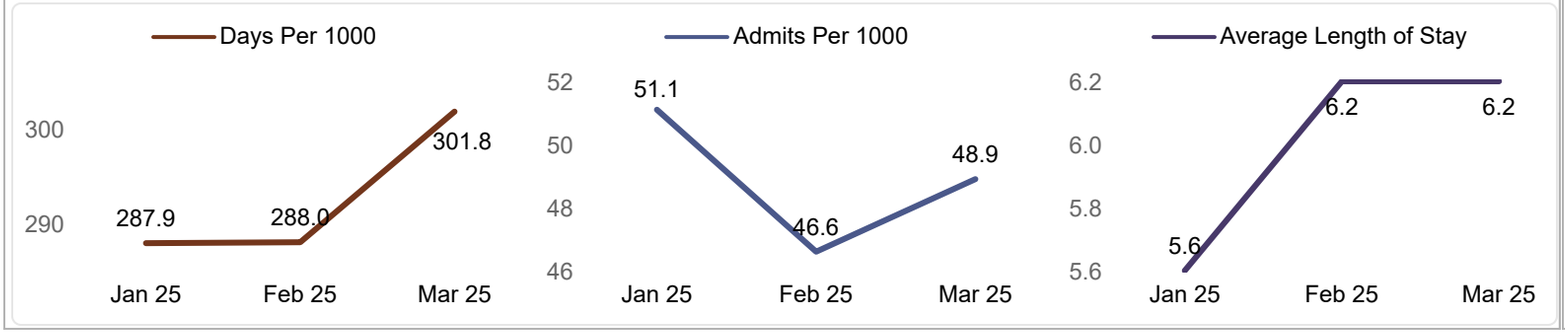
Authorization Turnaround



ED Utilization

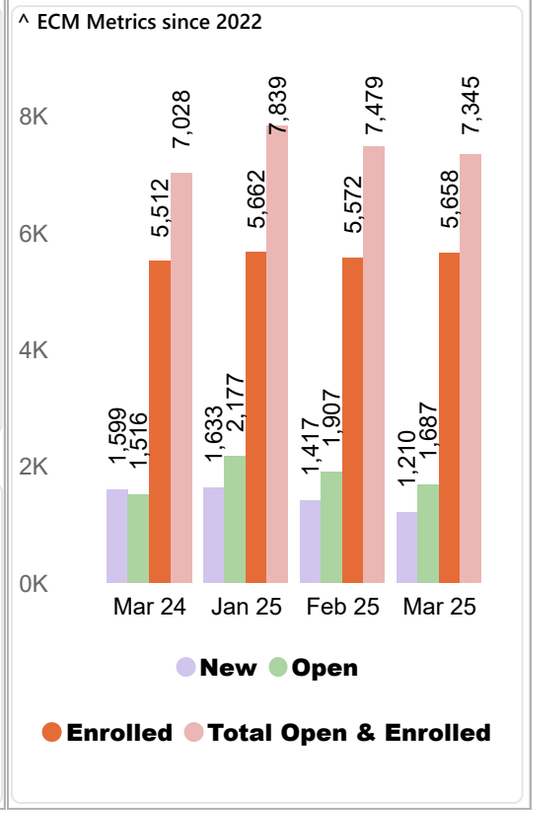


Inpatient Utilization

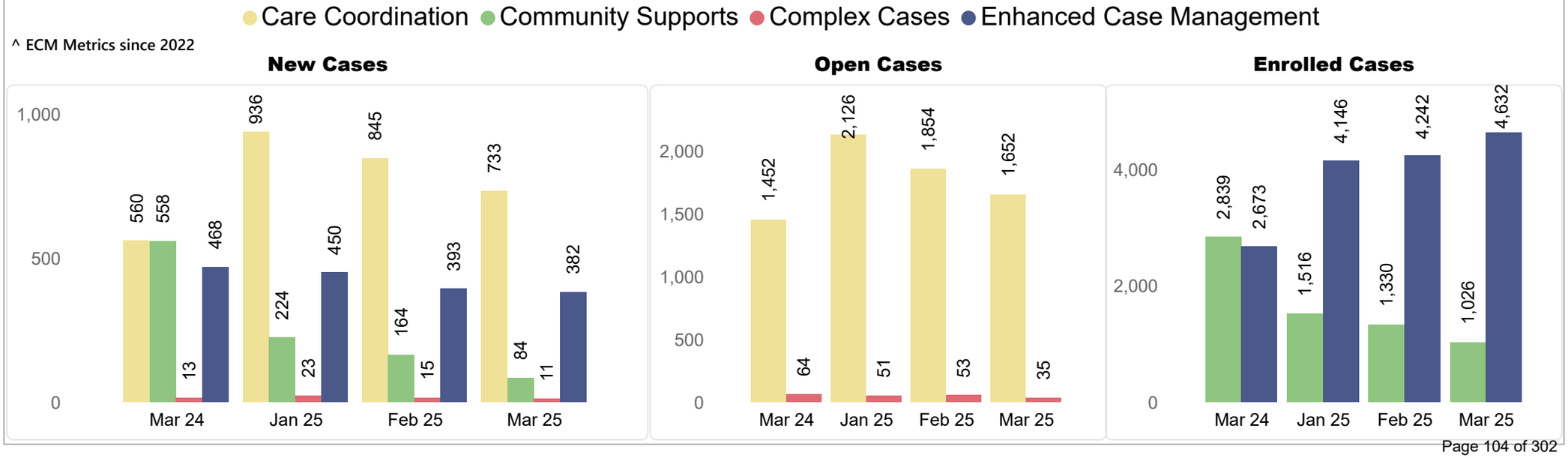


Case Management

Total Cases^



Case Management^



Technology (Business Availability)

Applications	Apr 24	Feb 25	Mar 25	Apr 25
HEALTHsuite System	97.8%	99.9%	100.0%	99.5%
Other Applications	100.0%	100.0%	100.0%	99.5%
TruCare System	98.0%	100.0%	100.0%	100.0%

Outpatient Authorization Denial Rates *

OP Authorization Denial Rates	Apr 24	Feb 25	Mar 25	Apr 25
Denial Rate Excluding Partial Denials (%)	3.4%	3.5%	3.9%	3.7%
Overall Denial Rate (%)	3.6%	3.7%	4.1%	4.1%
Partial Denial Rate (%)	0.2%	0.2%	0.2%	0.4%

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

Pharmacy Authorizations

Authorizations	Apr 24	Feb 25	Mar 25	Apr 25
Approved Prior Authorizations	35	35	43	37
Closed Prior Authorizations	76	17	27	26
Denied Prior Authorizations	43	91	83	92
Total Prior Authorizations	154	143	153	155

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Service you can trust.

Board Business

ALAMEDA Alliance FOR HEALTH

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Medical Management Update

Medical Management

Donna White Carey, MD, MS
Chief Medical Officer

5/9/25

ALAMEDA Alliance FOR HEALTH

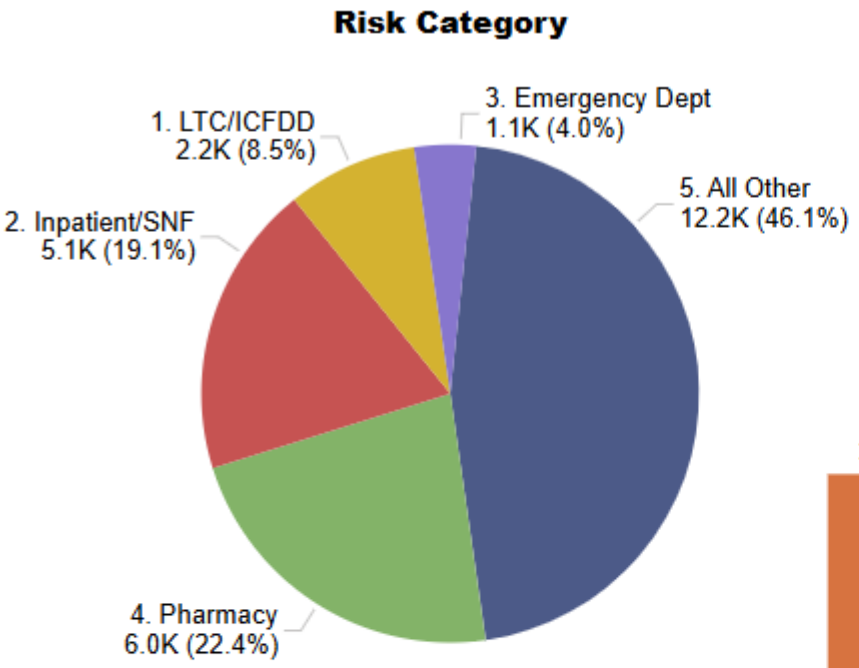
AAH Top 5%

- 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%

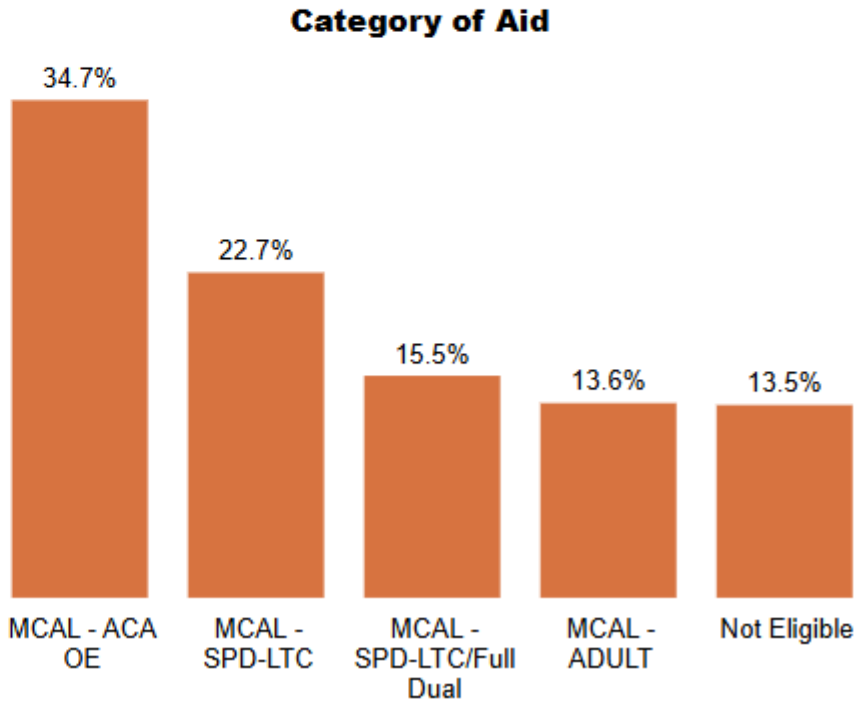
*Total Costs include claims paid, priced encounters and DHCS pharmacy costs.

**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

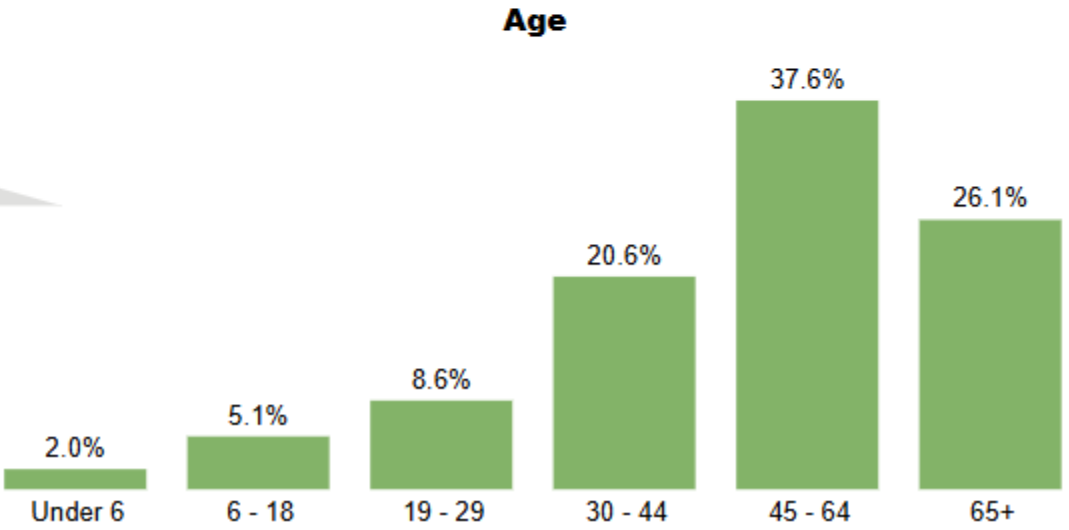
31.68%

% ECM Enrolled

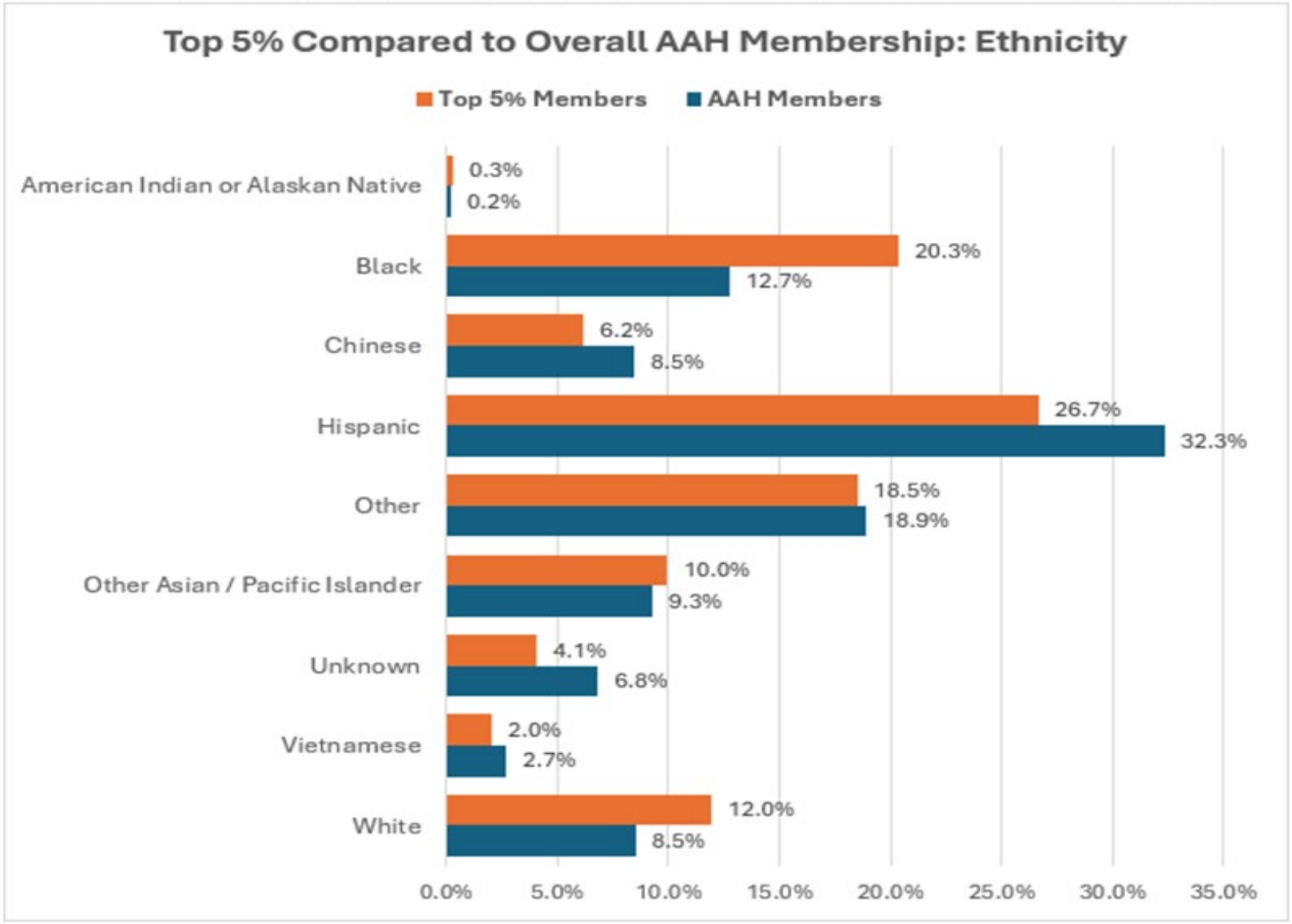
4.82%

% CS Enrolled

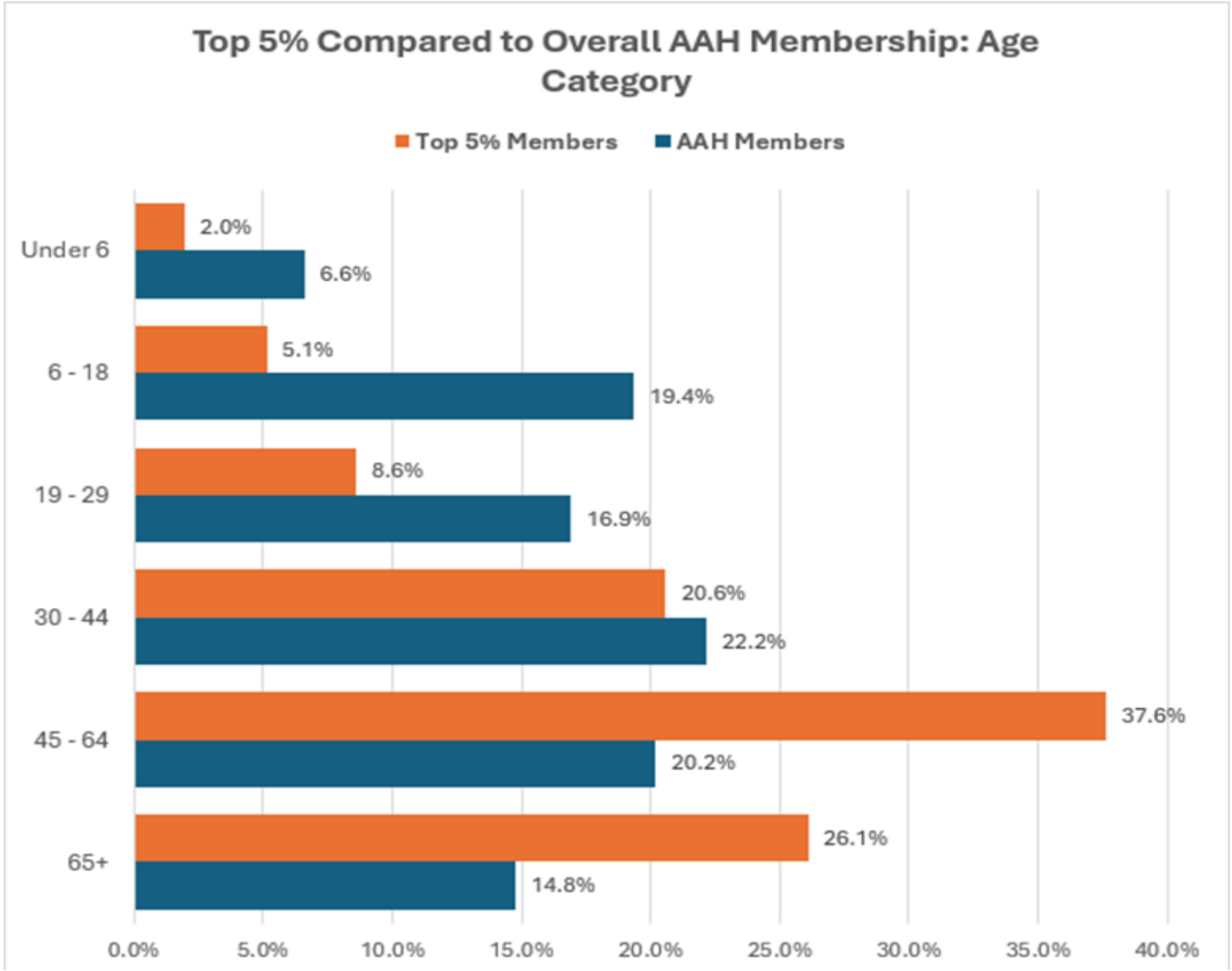
3.20%

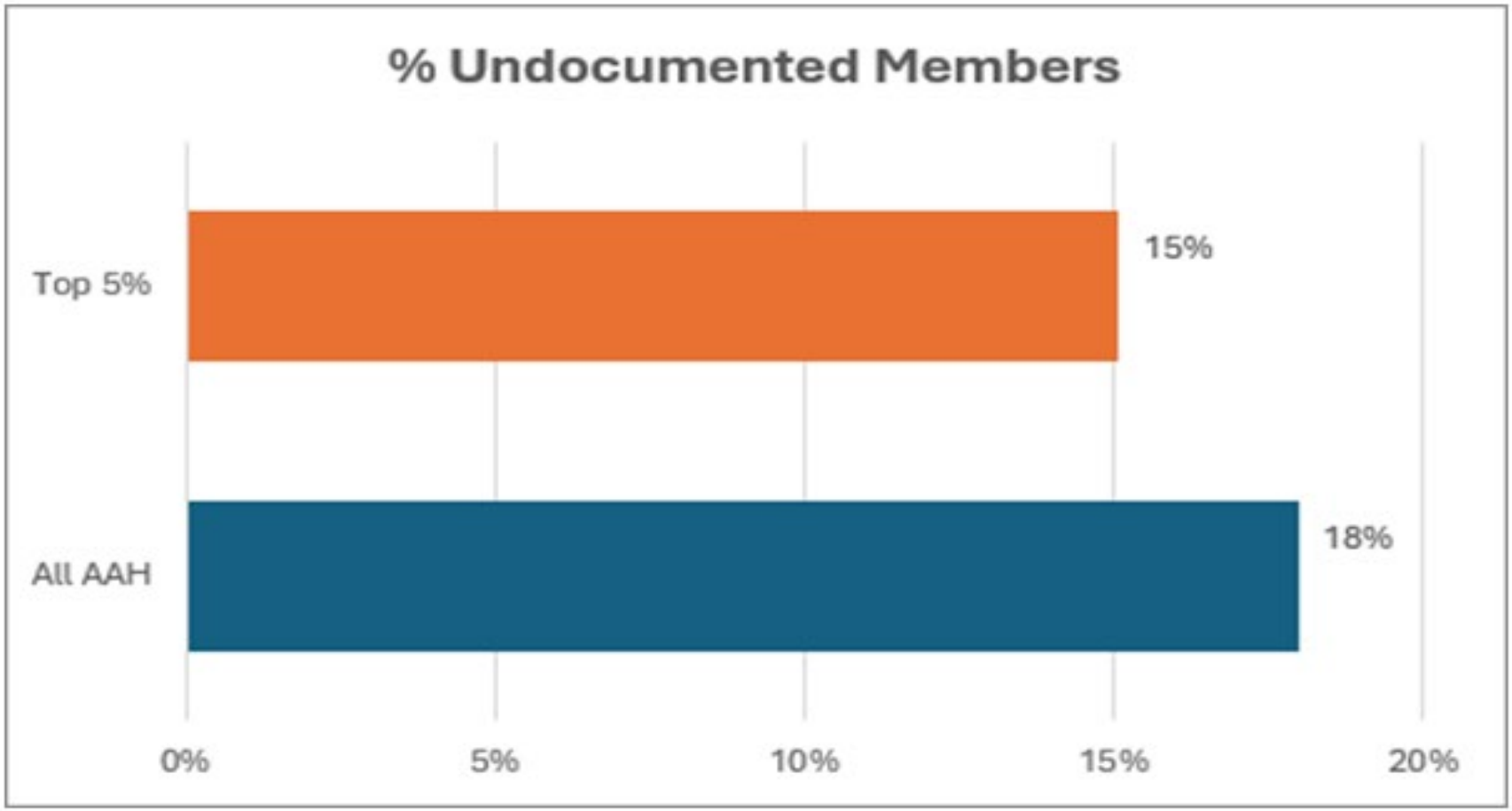


Ethnicity: higher percentages in Black and White in the Top 5% population compared to overall population.



Age: Higher percentages in the 45+ age groups compared to overall. (makes sense b/c the younger population has CCS)

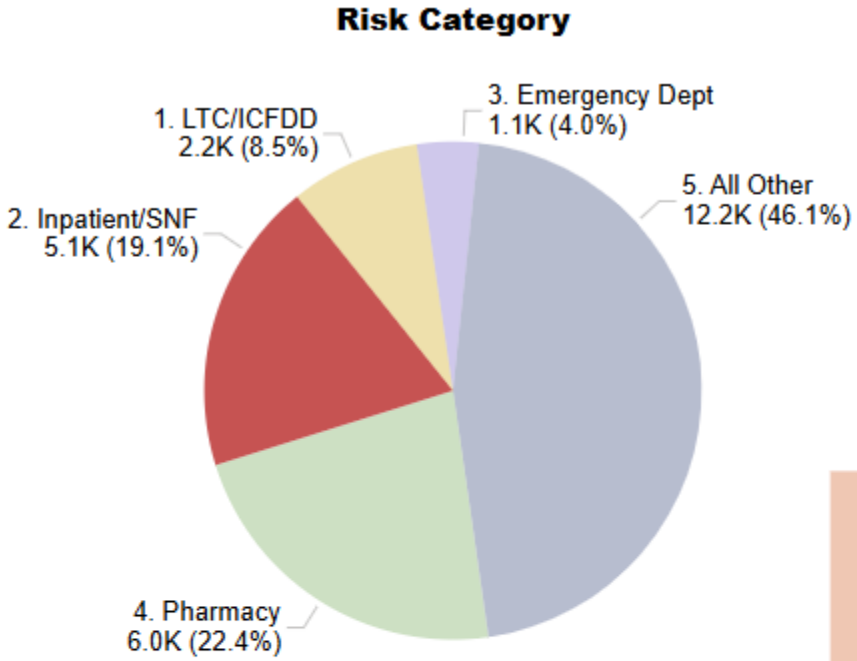



% Undocumented Members
Top 5%
15%
All AAH
18%
0%
5%
10%
15%
20%

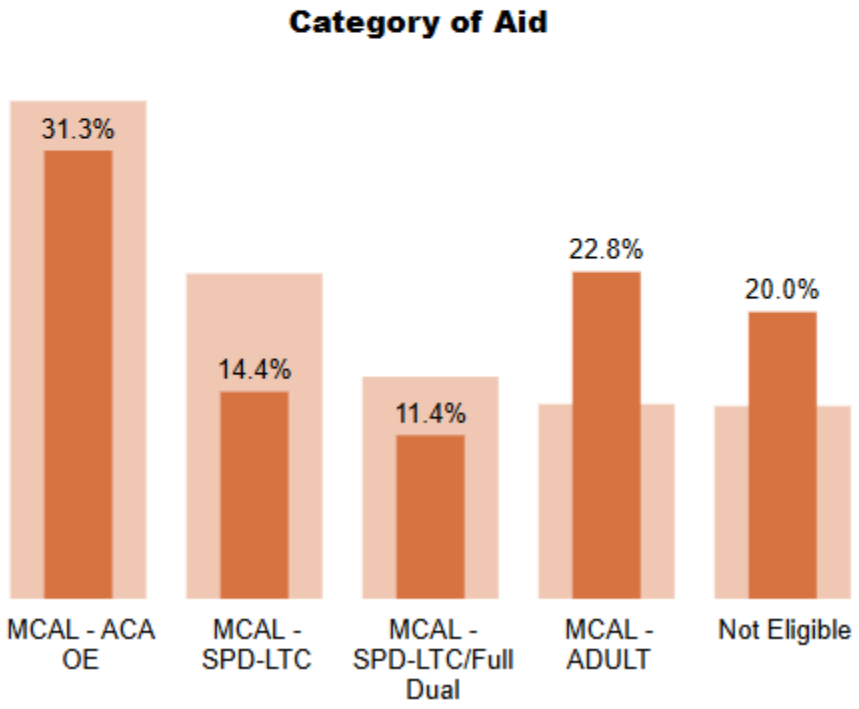
Inpatient Data & Strategy

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

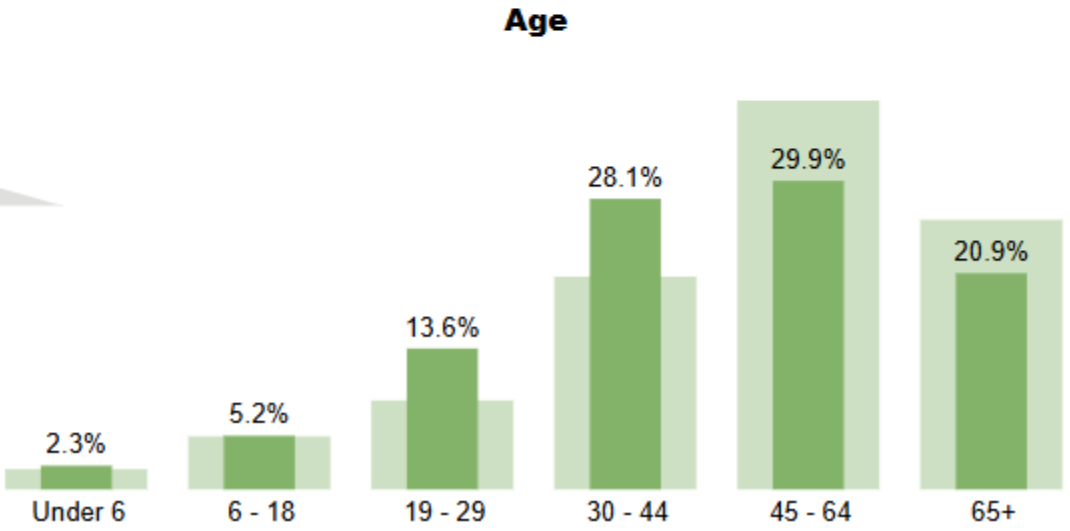
39.61%

% ECM Enrolled

6.00%

% CS Enrolled

3.58%



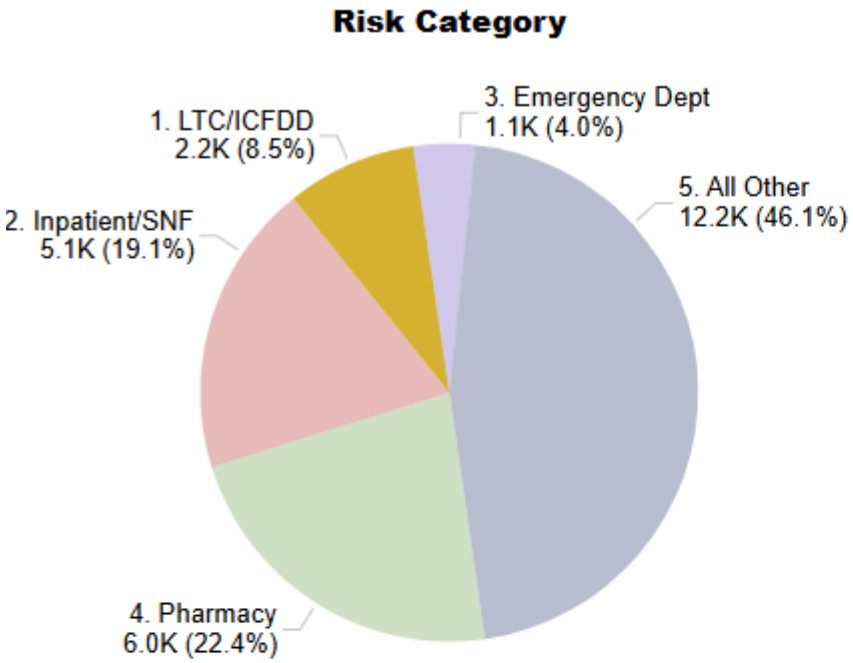
Inpatient Interventions

- 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)
  - 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)
  - Delegate P4P incentive for reduced unplanned readmissions
- Future
  - Targeted enrollment in ECM– MIF prioritization to ECM providers (June 2025)
  - TCS vendor for high-risk members to assist with PCP follow up (~Summer 2025)
  - Further expand Pharmacy outreach to include additional hospitals (~Summer 2025)
  - Inpatient-focused interventions with largest delegate (~Summer 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.

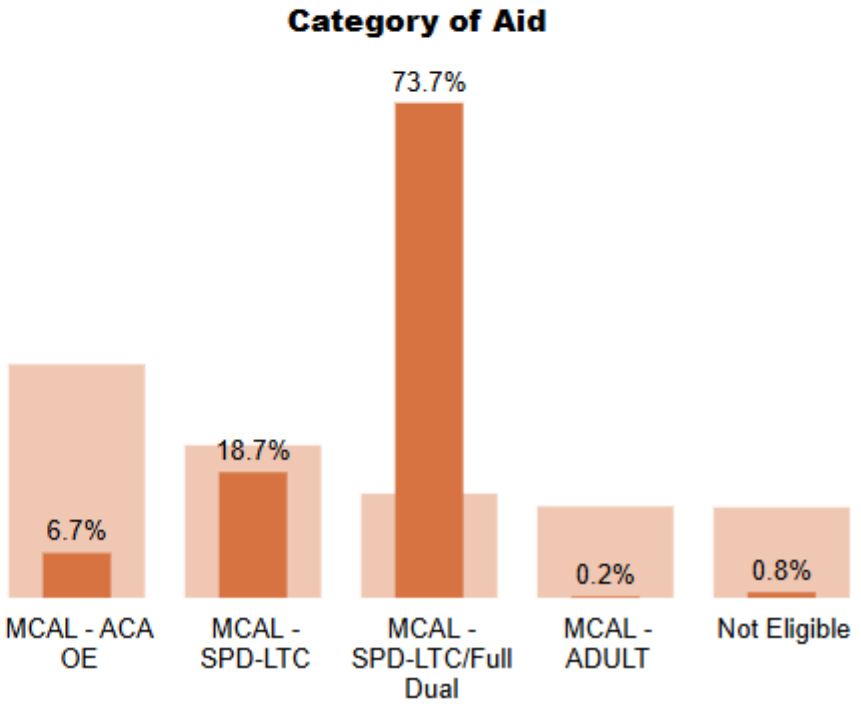
Long Term Support Services Data and Strategy

ALAMEDA Alliance FOR HEALTH

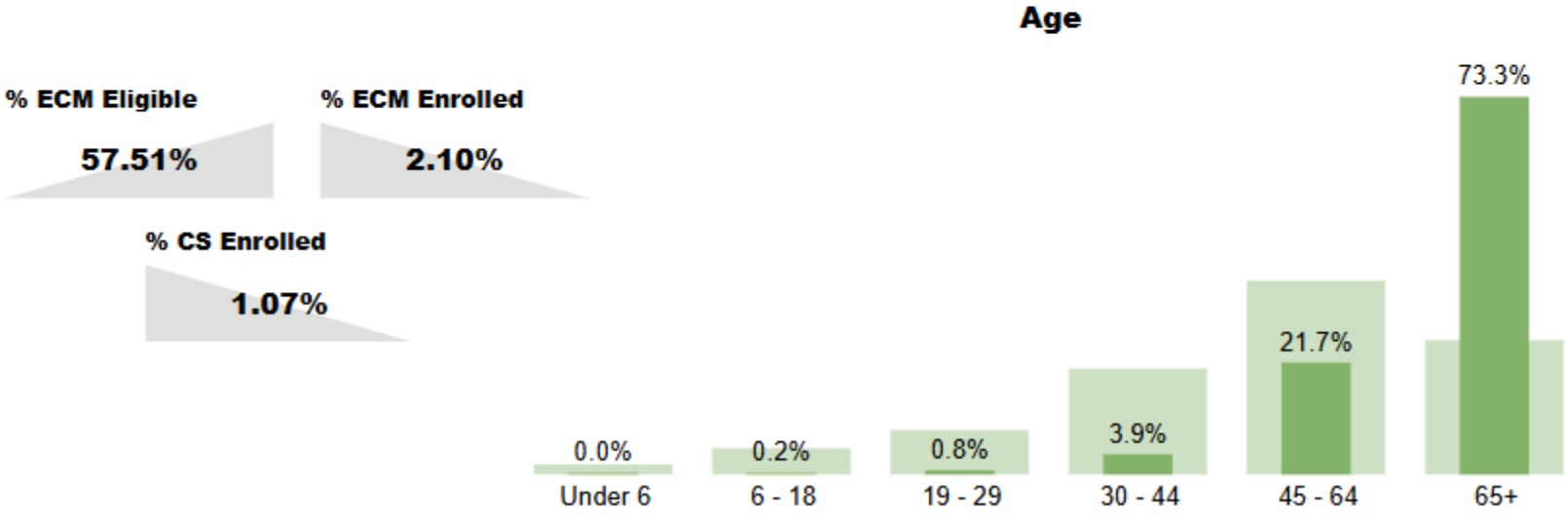
LTC and ICF/DD



- 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

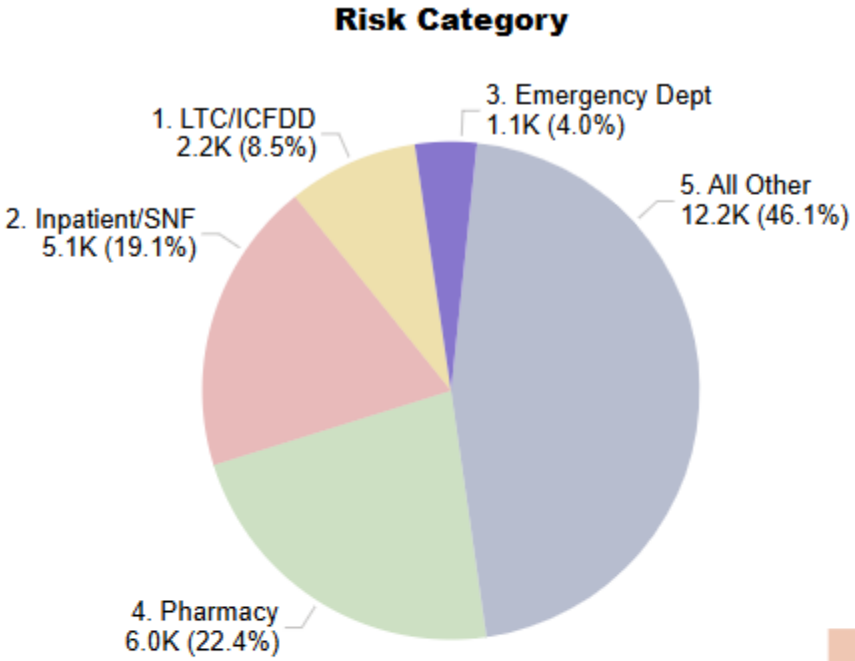
- On-going
  - → Sitter program restructure with contracting
  - → On-site visitation in LTC facilities
  - → LTC rounds (LTC/IP/ECM) – weekly
  - → Monitor payment of non-covered MediCal benefits, such as Congregate Living Health Facilities
  - → Updated Community Supports Criteria – Dec 2024

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

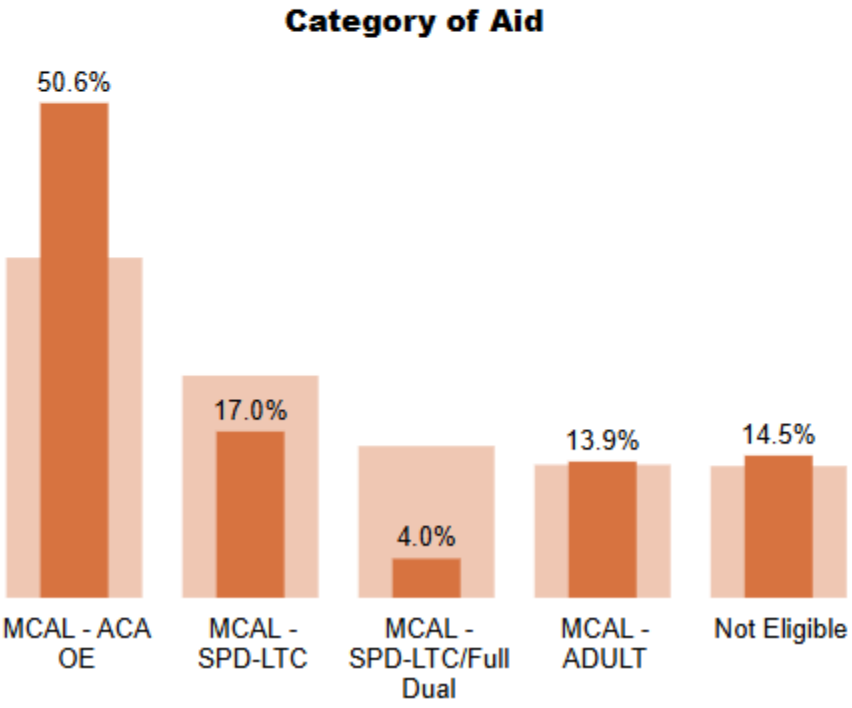
ED Data and Strategy

ALAMEDA Alliance FOR HEALTH

Emergency Department



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



Emergency Department

% ECM Eligible

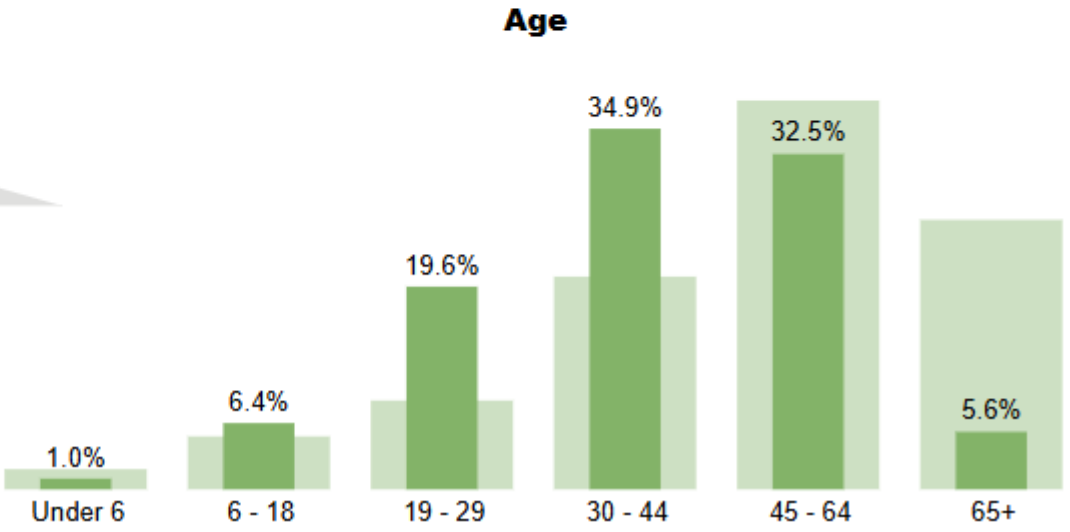
52.26%

% ECM Enrolled

5.66%

% CS Enrolled

4.72%



Emergency Department Interventions

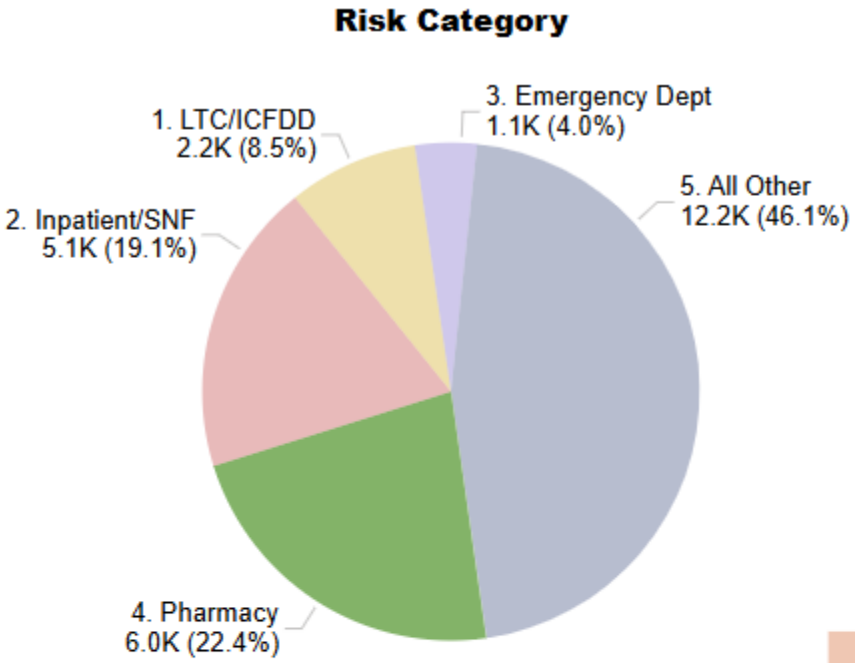
- On-going
  - → Member education campaign-increase Telehealth and Urgent Care utilization; New brochures to members
  - → Community Health Workers (CHW) care coordination in EDs (Highland, Sutter) – Aug/Sept 2024
  - → QI navigators (2) f/u ED visits (AHS) for Mental Health (MH) or Substance Use Disorder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

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

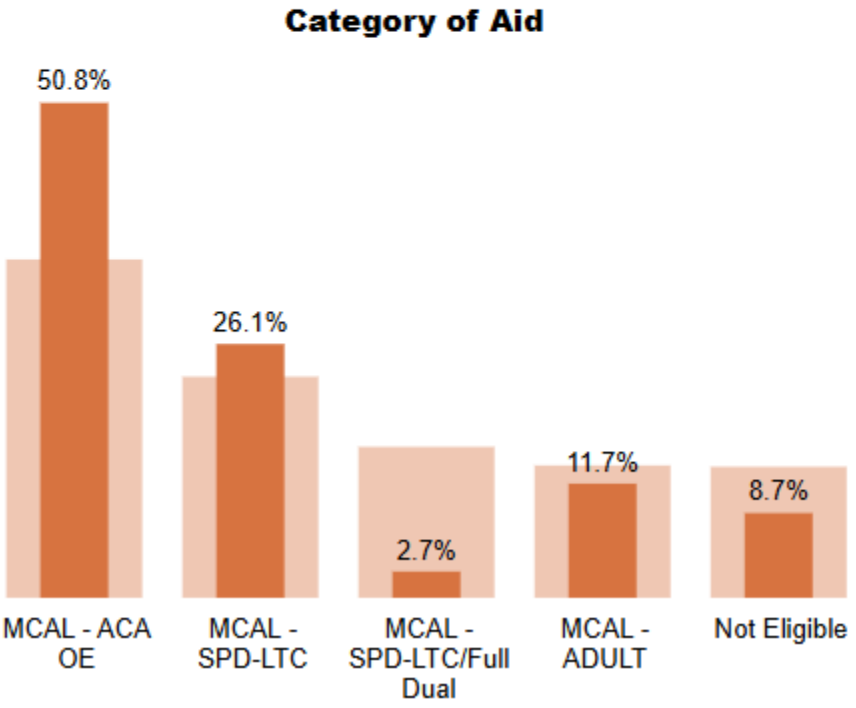
Pharmacy Data and Strategy

ALAMEDA Alliance FOR HEALTH

Pharmacy



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



Pharmacy

% ECM Eligible

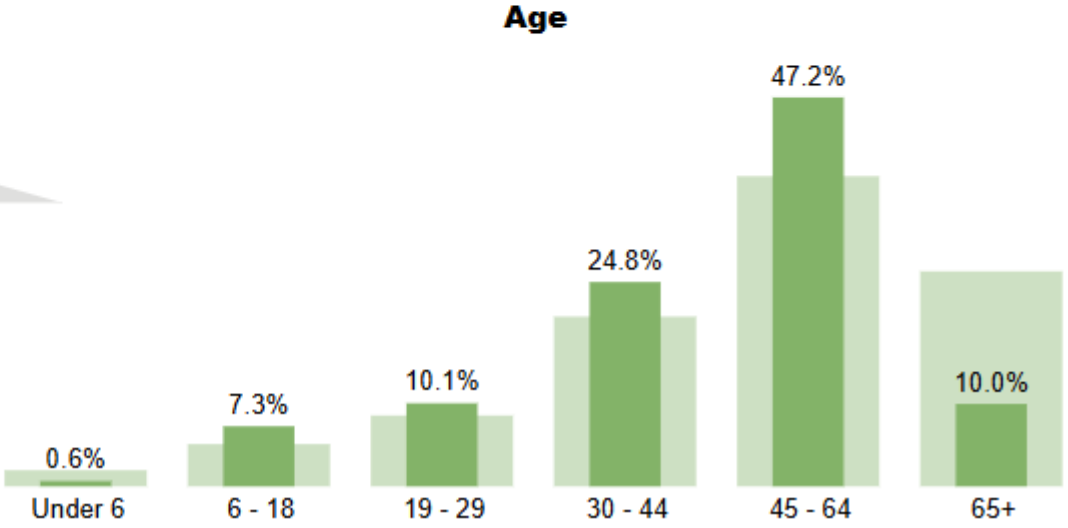
10.44%

% ECM Enrolled

2.00%

% CS Enrolled

2.03%

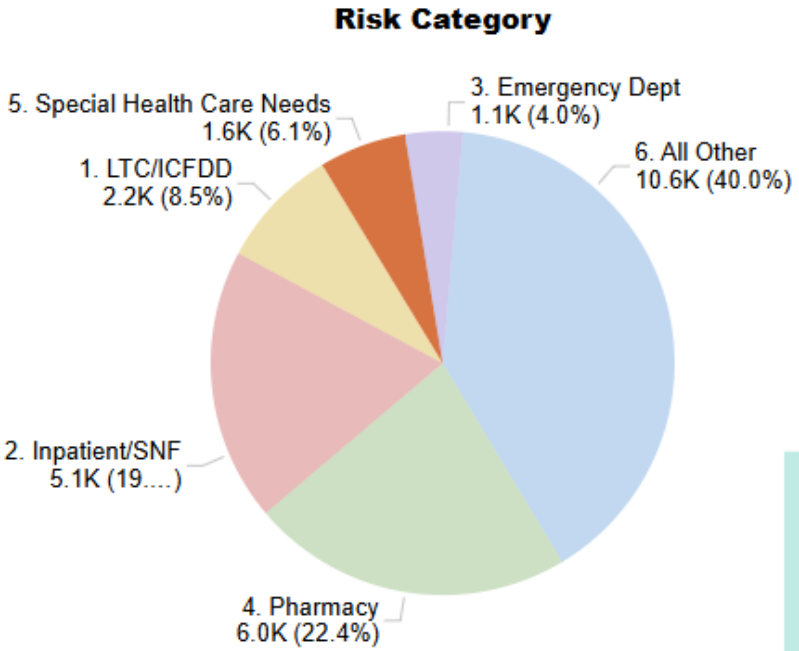


Pharmacy Interventions

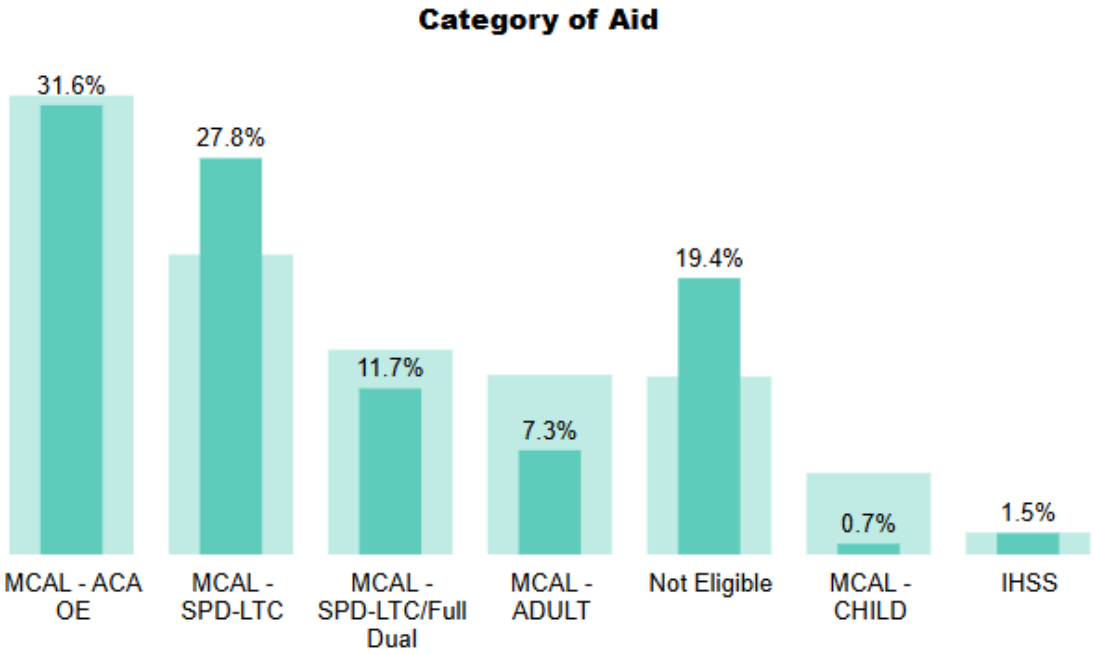
- Ongoing
  - → Formulary/Prior Authorization (PA) review (ex – Anticoagulants)
  - → Monitor new claims for carve out drugs/Physician Administered Drugs process – Oct 2024
  - → Process change: logic for payment of new J codes/PA– Feb 2025 (pend not pay); UM impact
  - → Monitor drug rebate opportunities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

Special Health Care Needs

Special Health Care Needs



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



Special Health Care Needs

% ECM Eligible

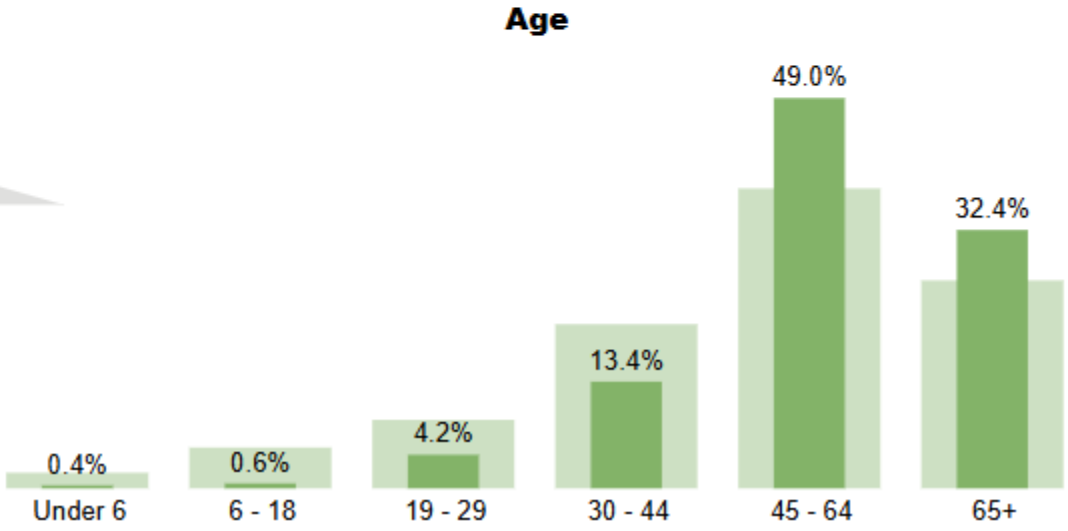
43.34%

% ECM Enrolled

7.81%

% CS Enrolled

6.26%

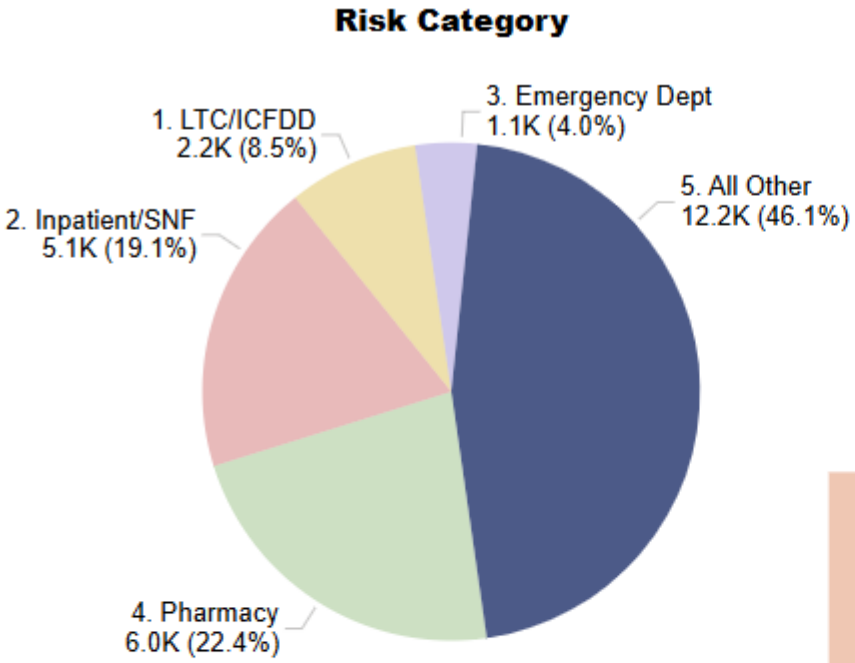


Special Health Care Strategies

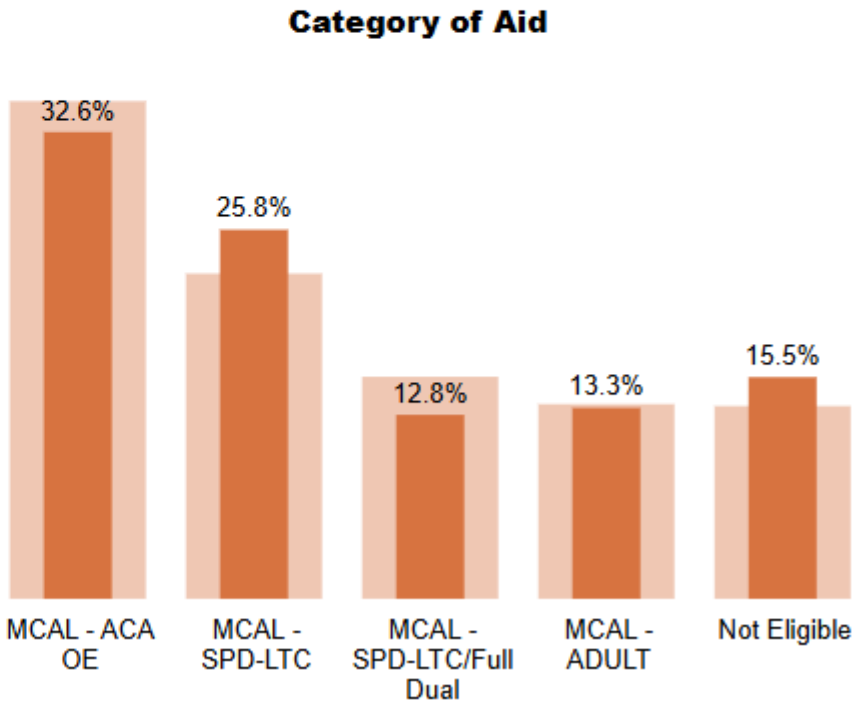
- Identify members with special health care needs.
- Work closely with members and PCP to assist with education and care coordination.
- Enroll members in ECM to coordinate care.
- Create and monitor a report.

Other Members

All Other Members



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



All Other Members

% ECM Eligible

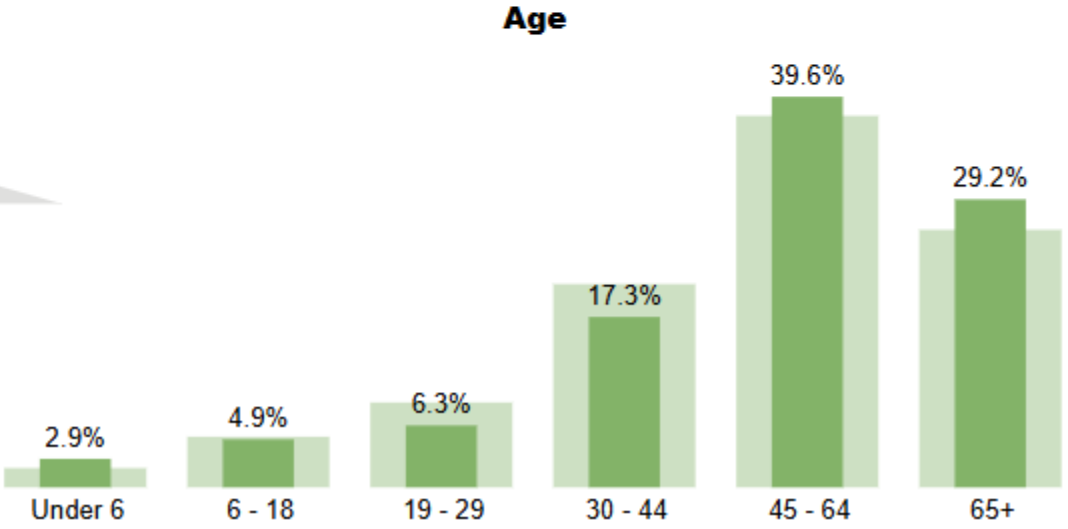
32.22%

% 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

Thank You!

Questions?

ALAMEDA Alliance FOR HEALTH

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**

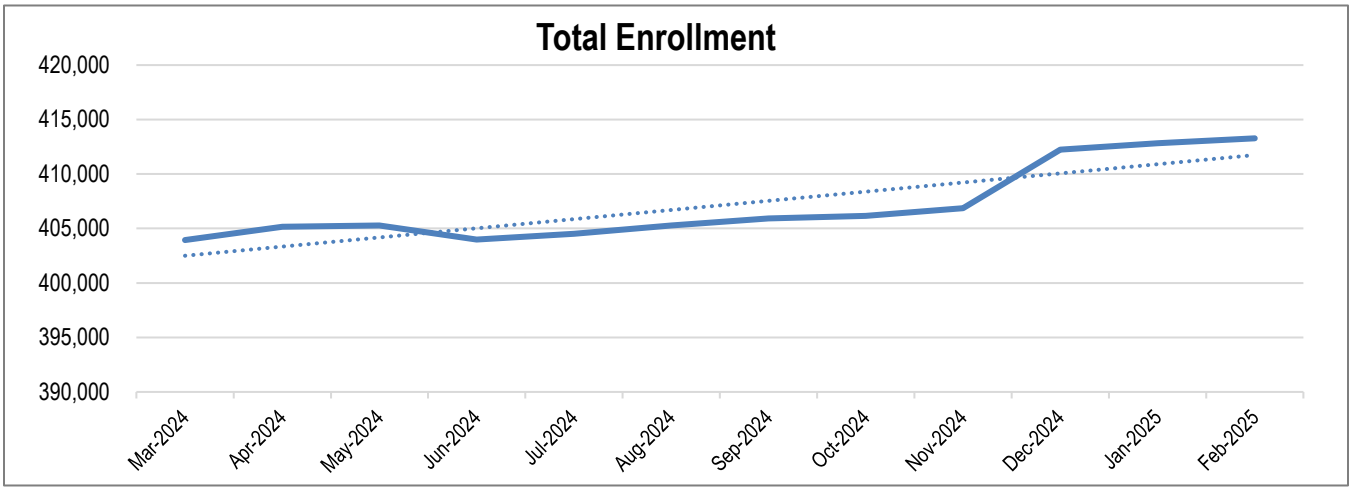
Date: **May 9th, 2025**

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

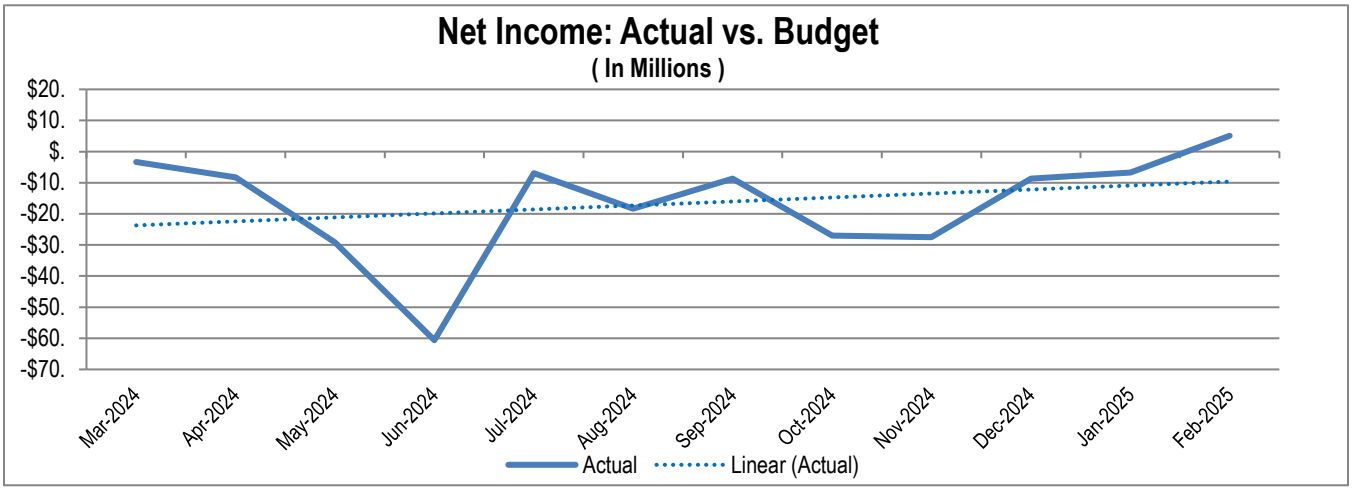
Executive Summary

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

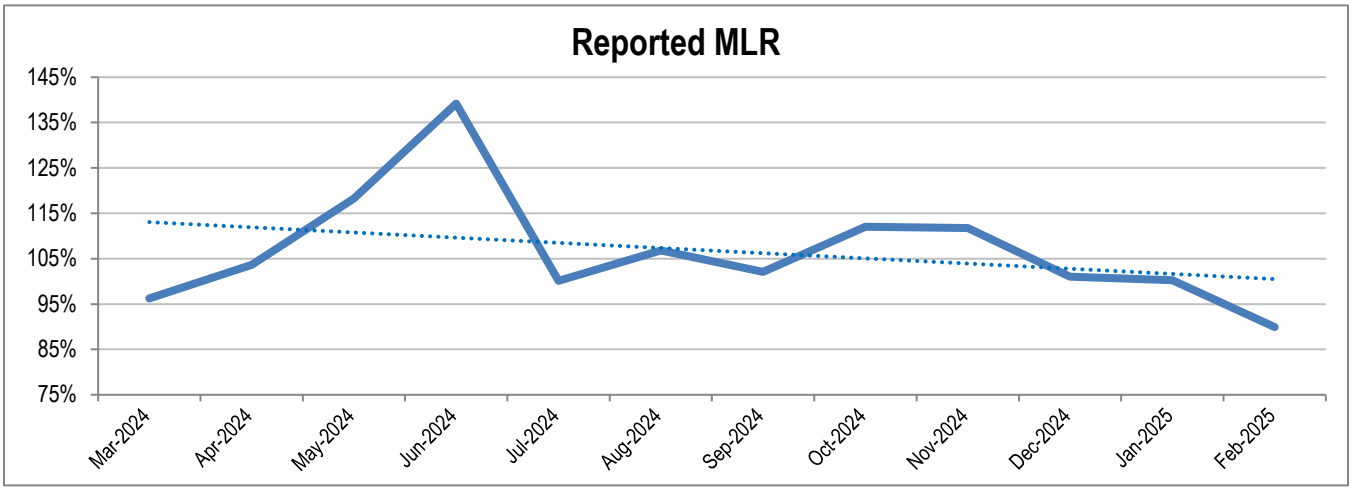
Enrollment – In February, Enrollment increased by 450 members.



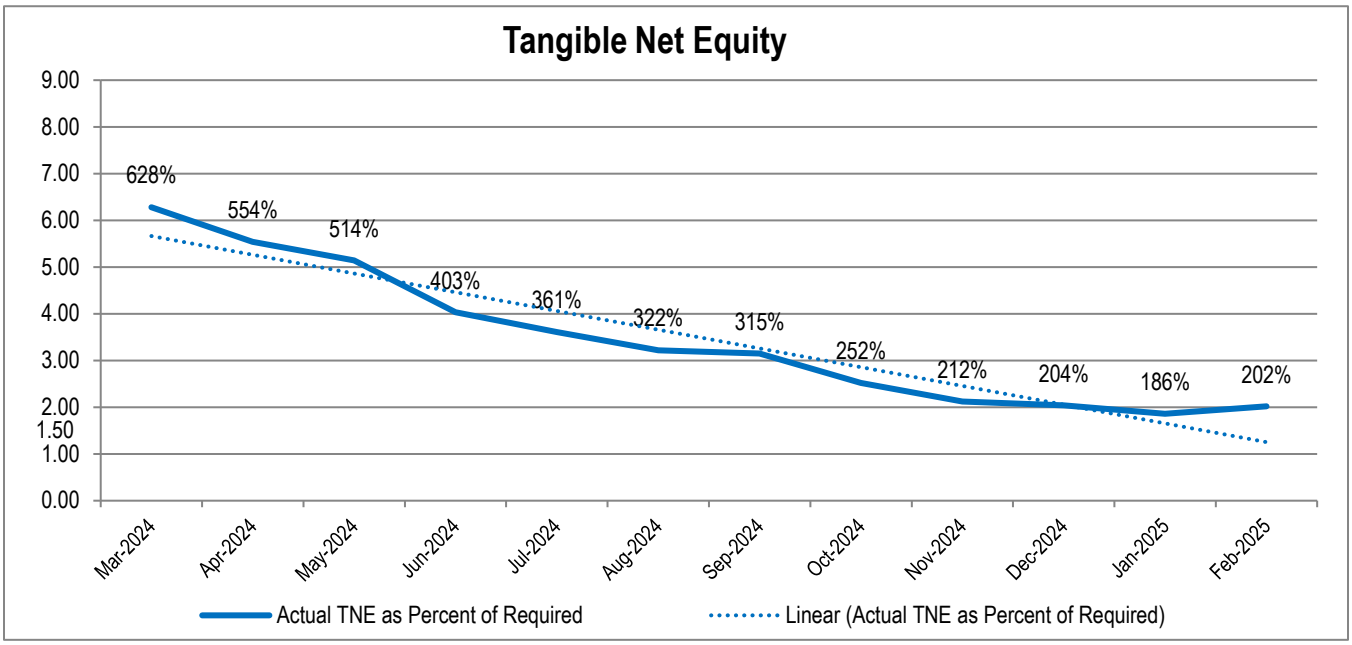
Net Income – For the month ended February 28th, 2025, actual Net Income was $5.1 million vs. budgeted Net Income of $10.6 million. For the fiscal YTD, actual Net Loss was $98.8 million vs. budgeted Net Loss of $83.9 million. For the month, Premium Revenue was unfavorable to budget, actual Revenue was $176.8 million vs. budgeted Revenue of $191.5 million. Premium Revenue variance of $14.7 million is primarily due to reconciliation of CY2022 Prop56 MEP, which led to a $13.8 million reduction in revenue.



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



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



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

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

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

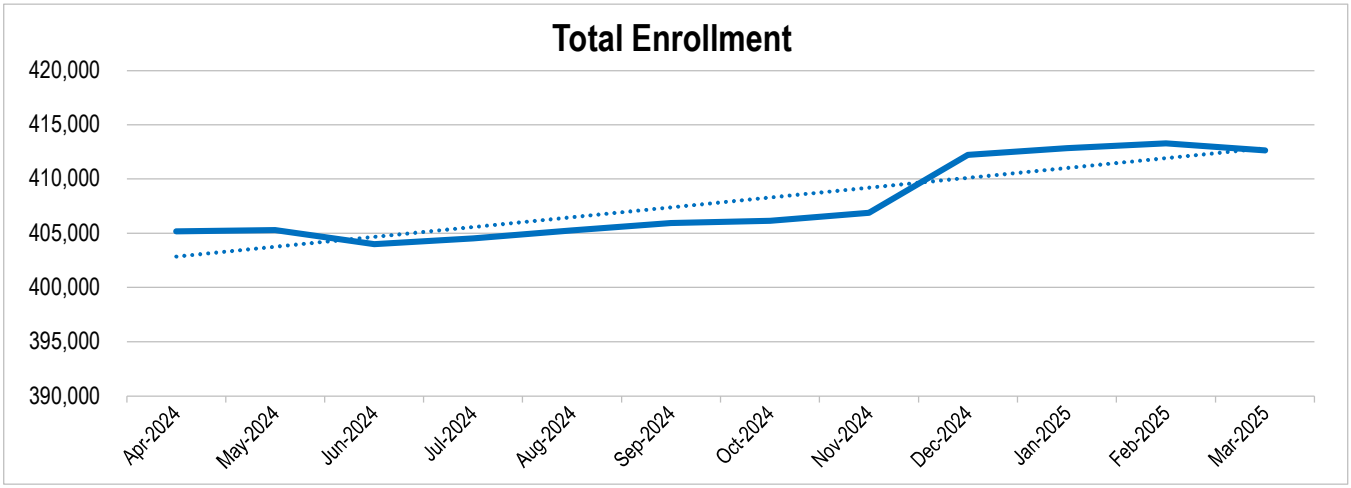
Date: **May 9th, 2025**

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

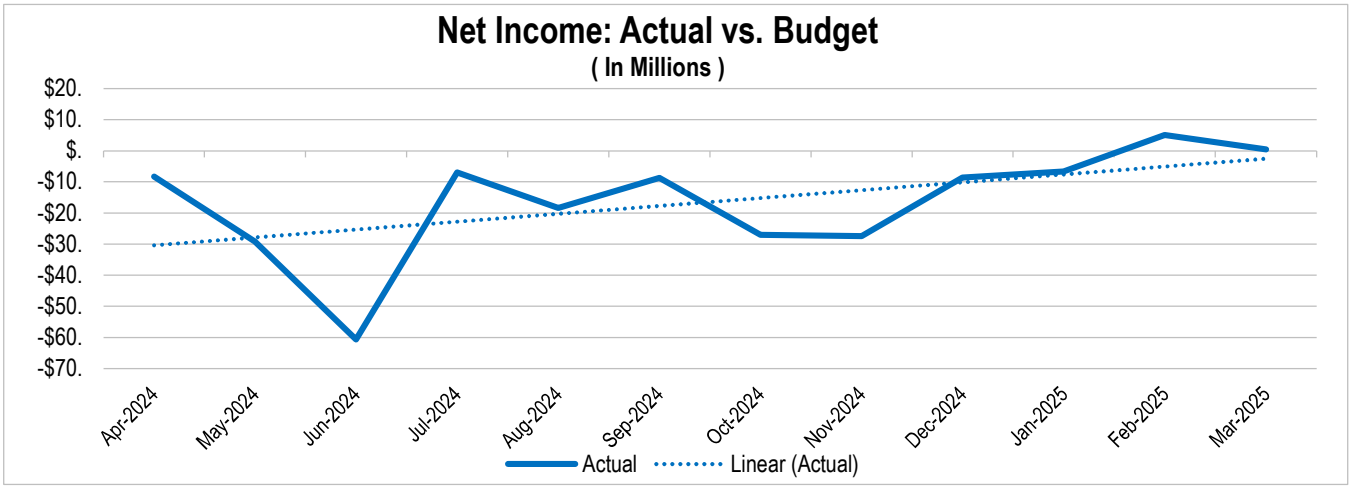
Executive Summary

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

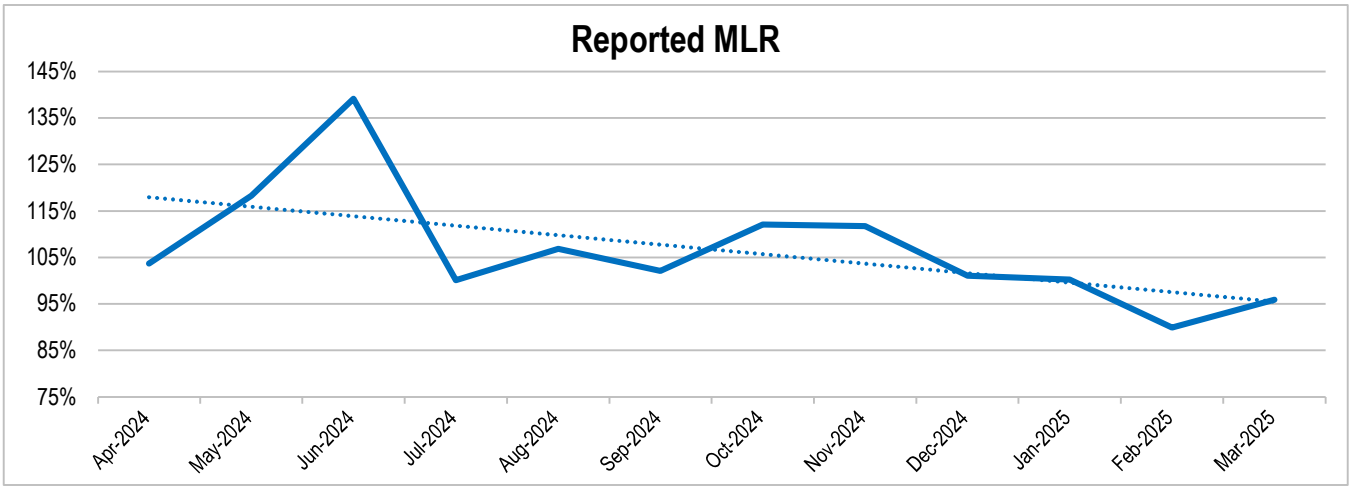
Enrollment – In March, Enrollment decreased by 648 members.



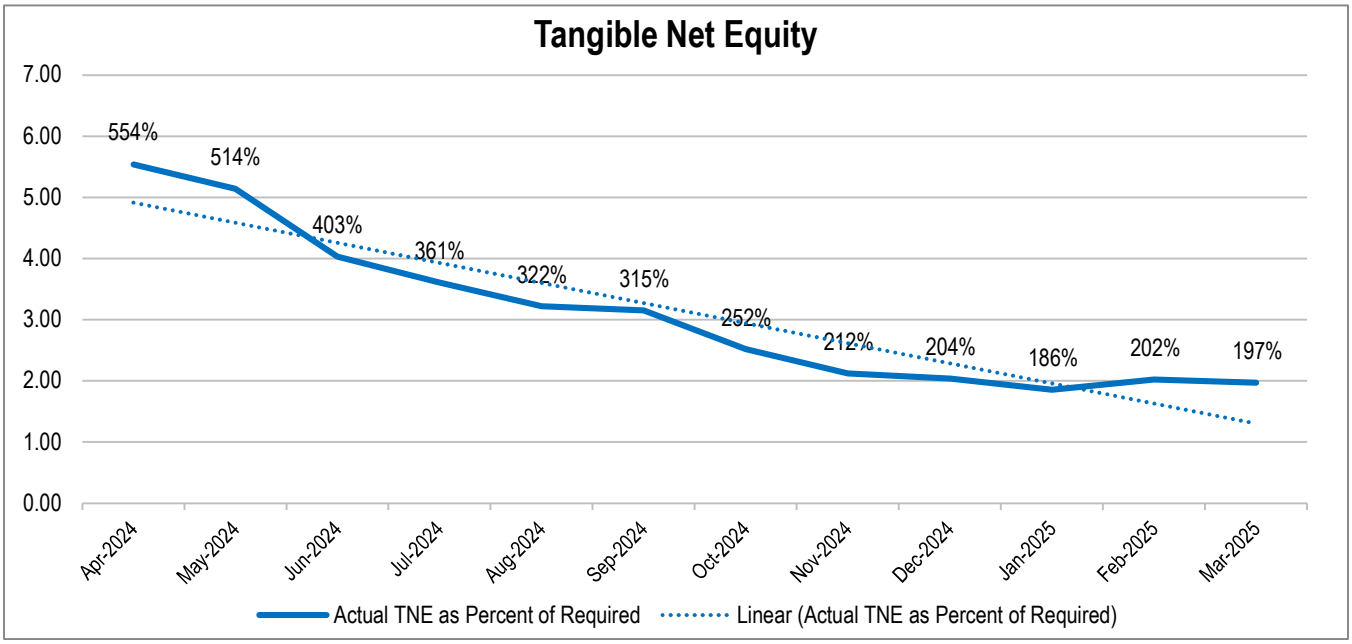
Net Income – For the month ended March, actual Net Income was $458,000 vs. budgeted Net Income of $7.6 million. For the fiscal YTD, actual Net Loss was $98.3 million vs. budgeted Net Loss of $76.3 million. For the month, Premium Revenue was favorable to budget, actual Revenue was $191.7 million vs. budgeted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



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



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



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

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

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

Date: **May 2nd, 2025**

Subject: **Finance Report – March 2025**

Executive Summary

- For the month ended March 31st, 2025, the Alliance had enrollment of 412,630 members, a Net Income of $458,000 and 197% of required Tangible Net Equity (TNE).

Overall Results: (in Thousands)

	Month	YTD
Revenue	$260,209	$2,245,577
Medical Expense	183,791	1,597,338
Admin. Expense	10,530	86,798
MCO Tax Expense	68,504	684,998
Other Inc. / (Exp.)	3,073	25,254
Net Income	**$458**	**($98,303)**

Net Income by Program: (in Thousands)

	Month	YTD
Medi-Cal	$1,700	($91,155)
Group Care	337	(196)
Medicare	(1,579)	(6,951)
	$458	**($98,303)**

Enrollment

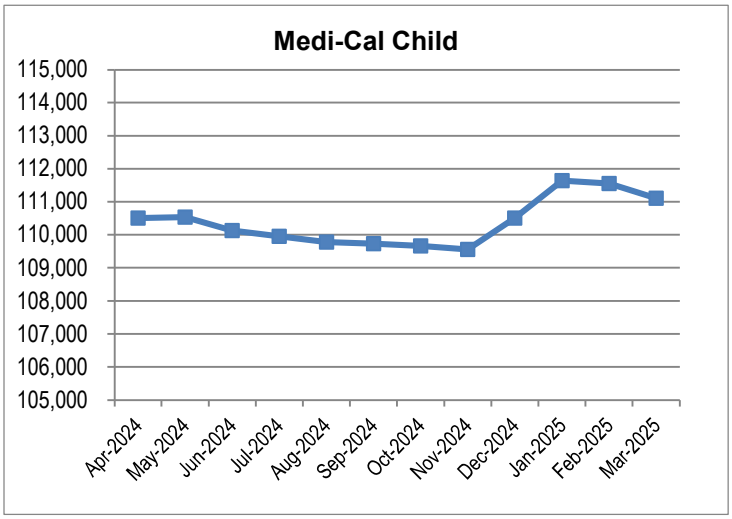
- Total enrollment decreased by 648 members since February 2025.
- Total enrollment increased by 8,640 members since June 2024.

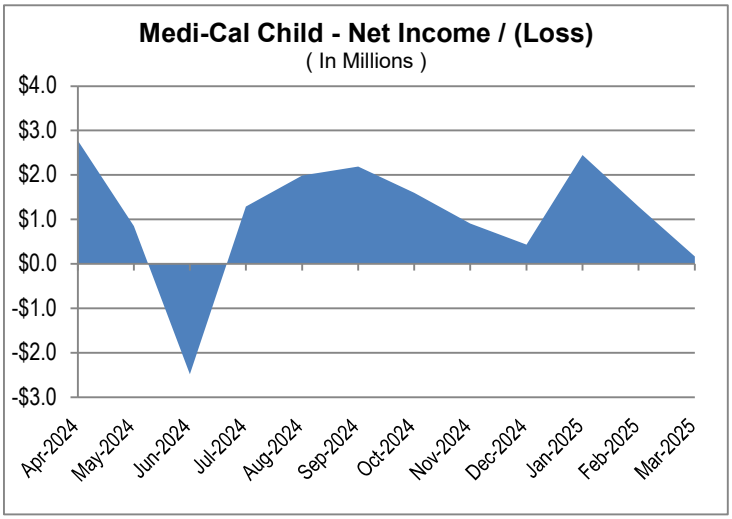
Monthly Membership and YTD Member Months
Actual vs. Budget

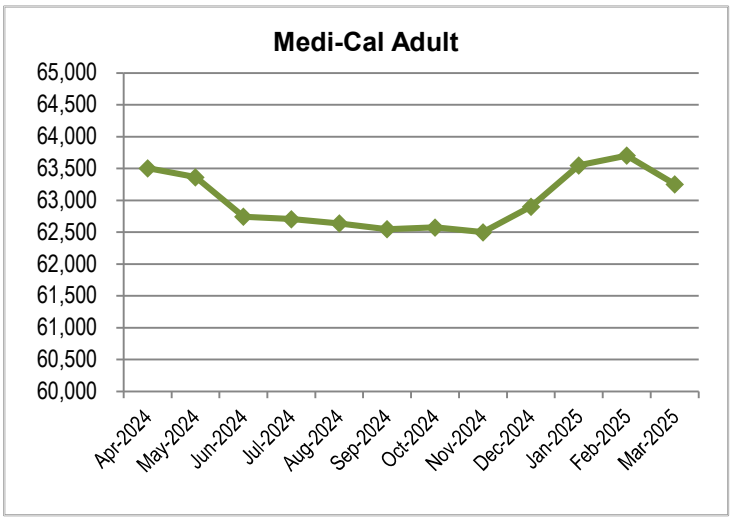
Enrollment					Member Months			
Current Month					Year-to-Date			
Actual	Budget	Variance	Variance %		Actual	Budget	Variance	Variance %
				Medi-Cal:				
111,103	110,322	781	0.7%	Child	993,495	989,418	4,077	0.4%
63,255	62,893	362	0.6%	Adult	566,398	564,312	2,086	0.4%
0	0	0	100.0%	SPD*	212,632	211,783	849	0.4%
0	0	0	100.0%	Duals*	241,339	240,472	867	0.4%
154,559	151,855	2,704	1.8%	ACA OE	1,371,809	1,360,144	11,665	0.9%
0	0	0	100.0%	MCAL LTC*	1,446	1,442	4	0.3%
0	0	0	100.0%	MCAL LTC Duals*	7,562	7,540	22	0.3%
29,605	32,825	(3,220)	(9.8%)	SPD with LTC	88,666	101,363	(12,697)	(12.5%)
48,226	44,414	3,812	8.6%	Duals with LTC	144,479	130,239	14,240	10.9%
406,748	**402,309**	**4,439**	**1.1%**	**Medi-Cal Total**	**3,627,826**	**3,606,713**	**21,113**	**0.6%**
5,882	5,769	113	2.0%	Group Care	51,875	51,685	190	0.4%
412,630	**408,078**	**4,552**	**1.1%**	**Total**	**3,679,701**	**3,658,398**	**21,303**	**0.6%**

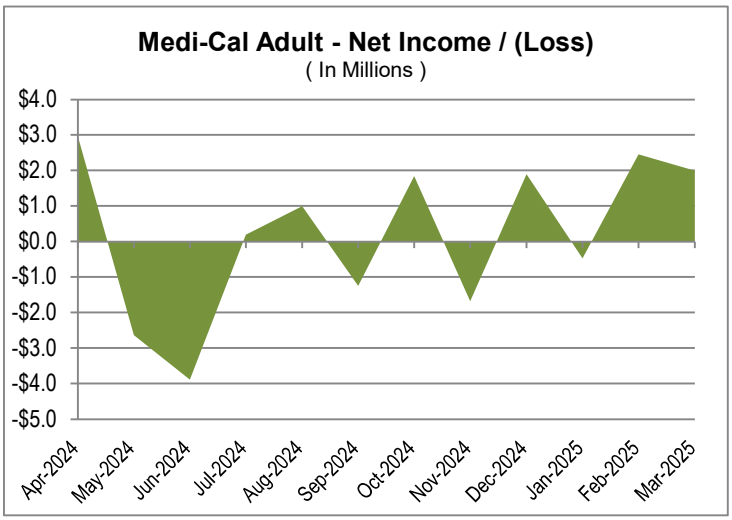
*As of January 2025, service month, "SPD", "Duals", "LTC", and "LTC Duals" will be discontinued. Effective January 2025 service month new consolidated groupings will be "SPD with LTC" and "Duals with LTC".

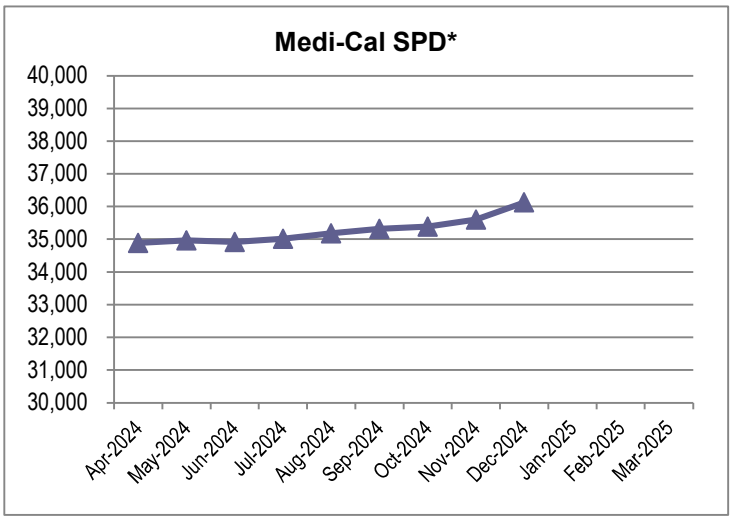
Enrollment and Profitability by Program and Category of Aid

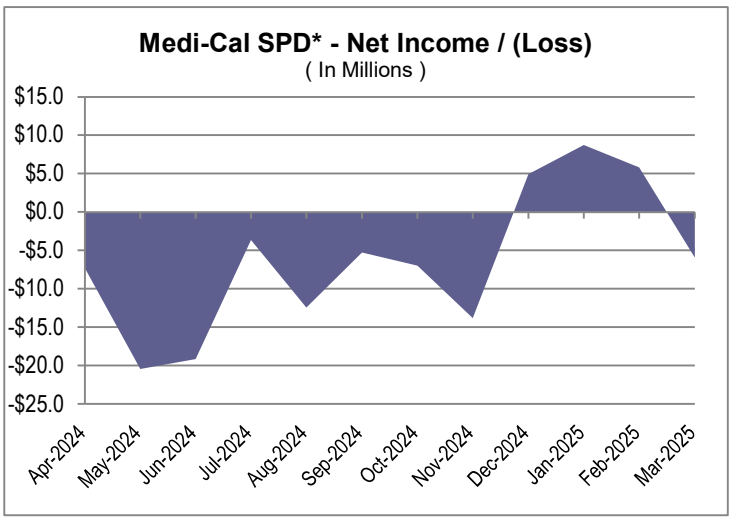




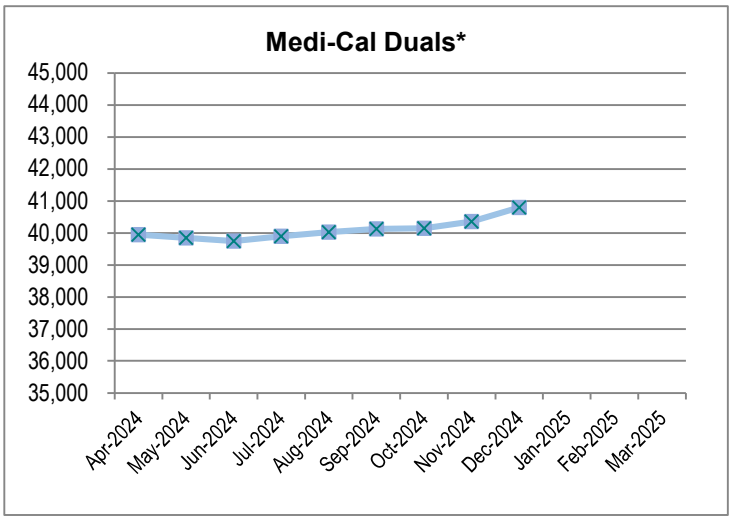


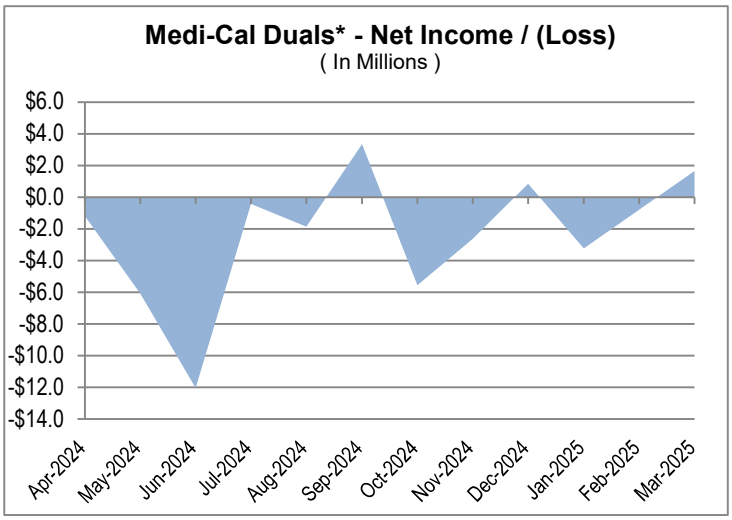


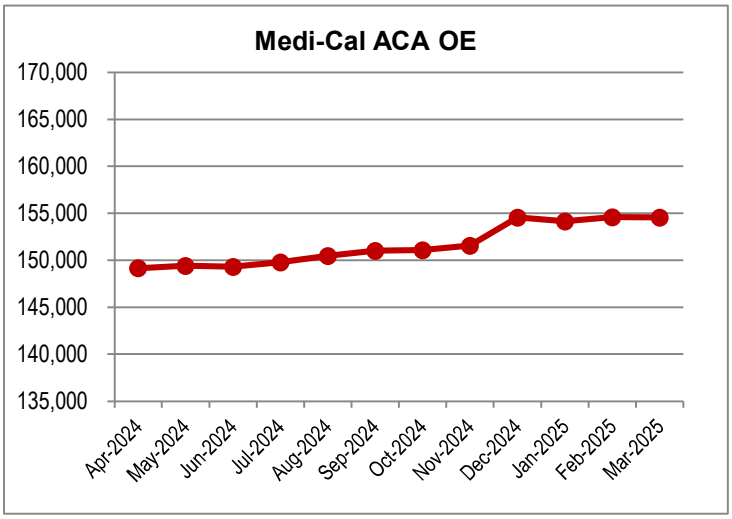


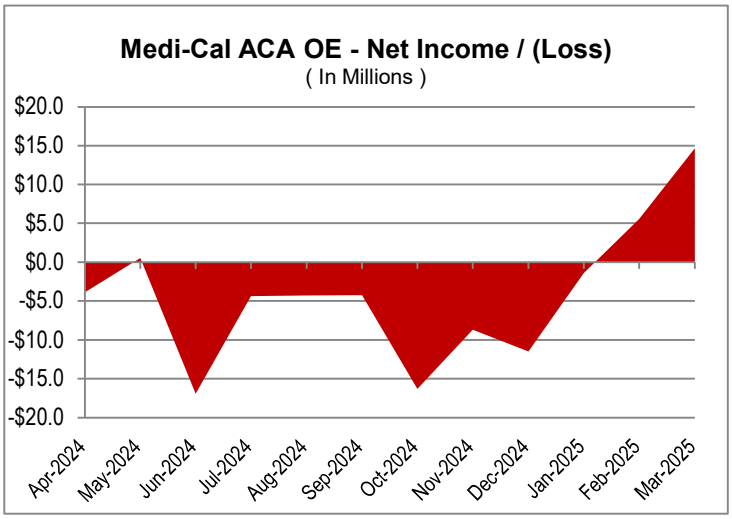


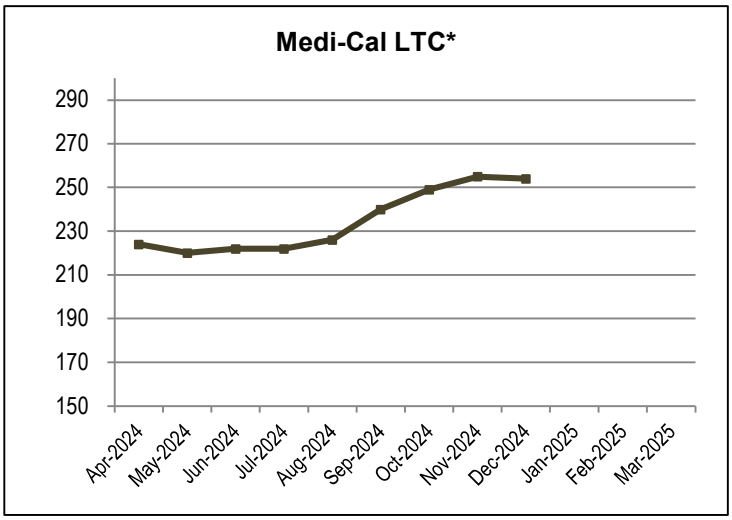
Enrollment and Profitability by Program and Category of Aid

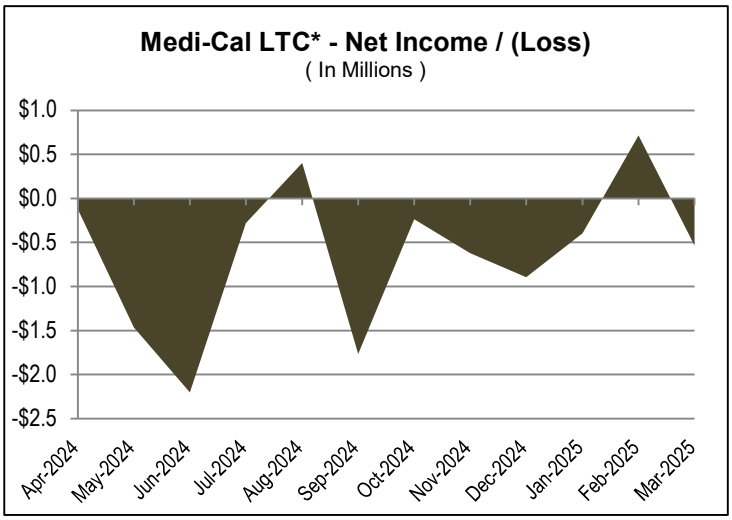




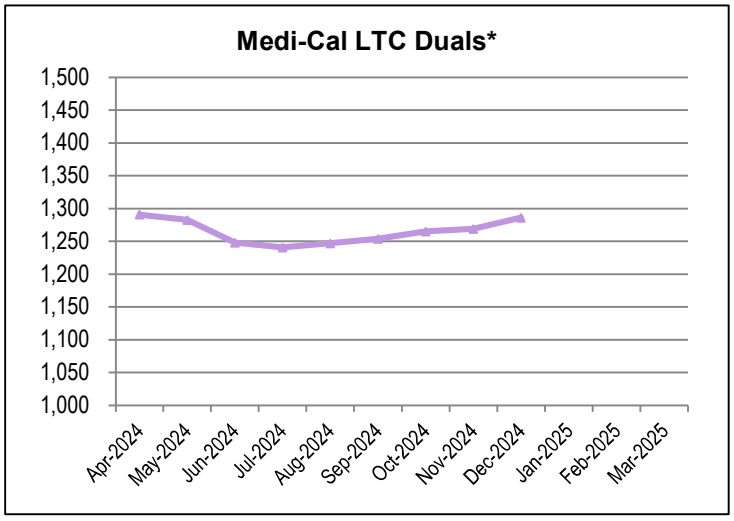


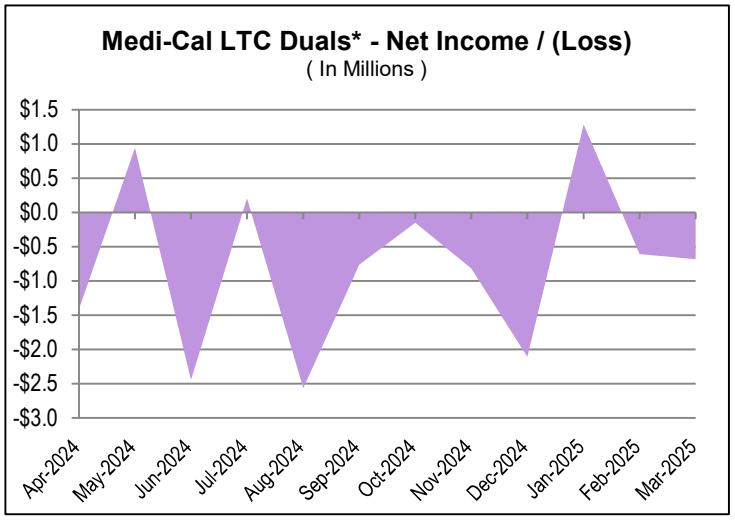


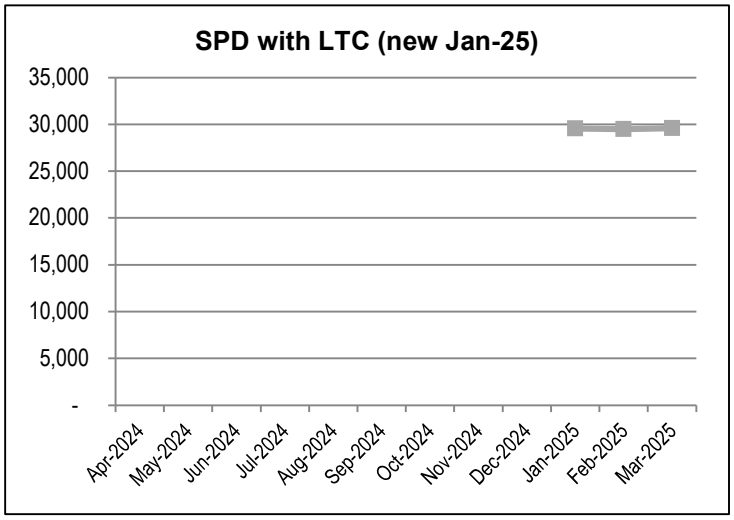


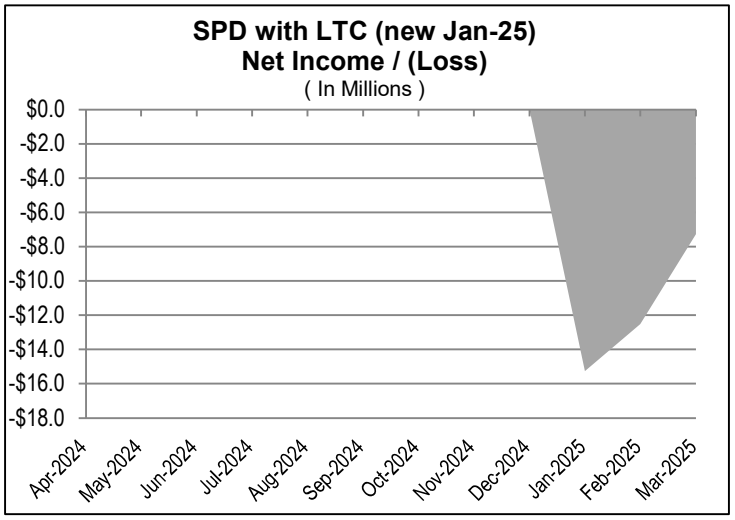


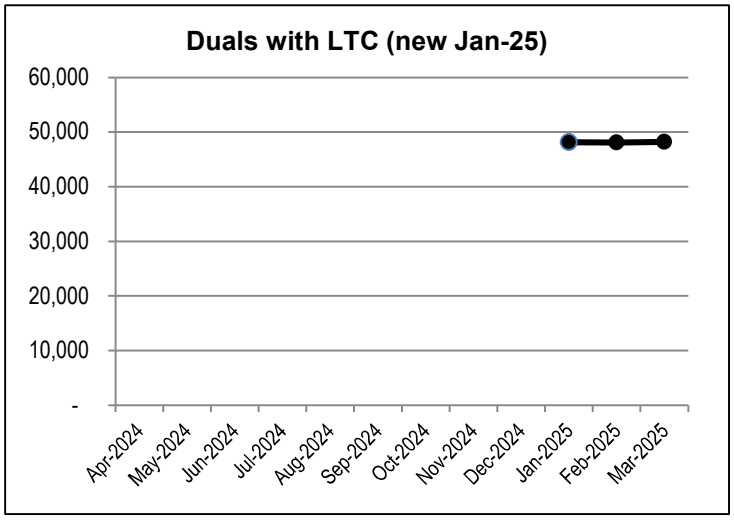
Enrollment and Profitability by Program and Category of Aid

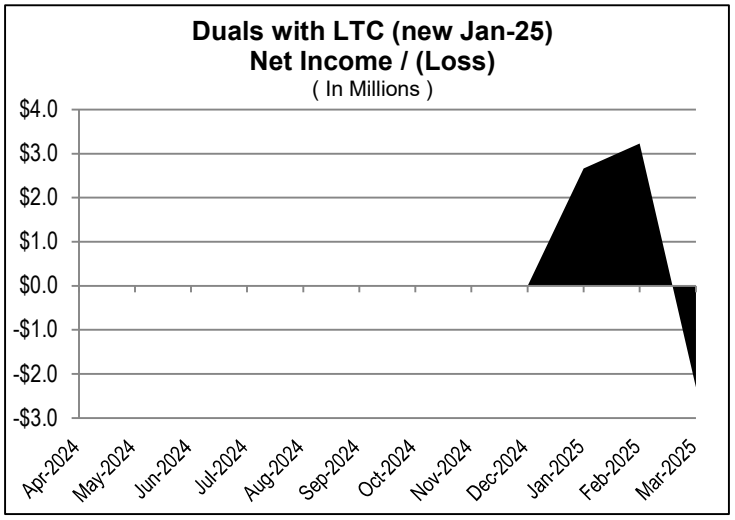




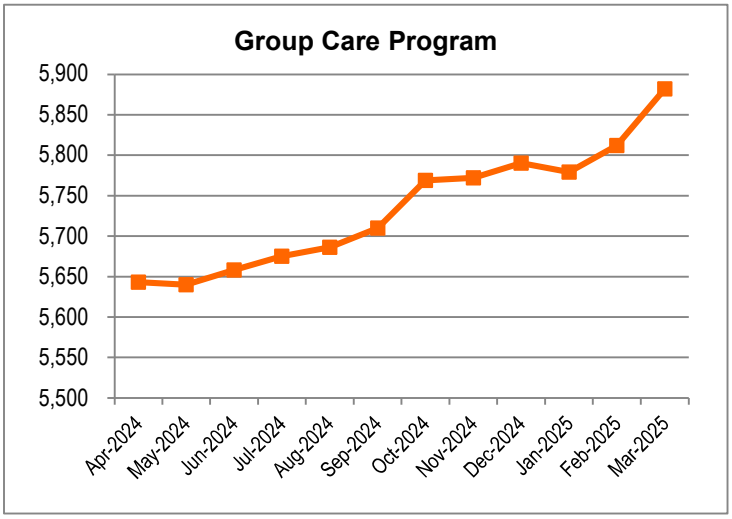


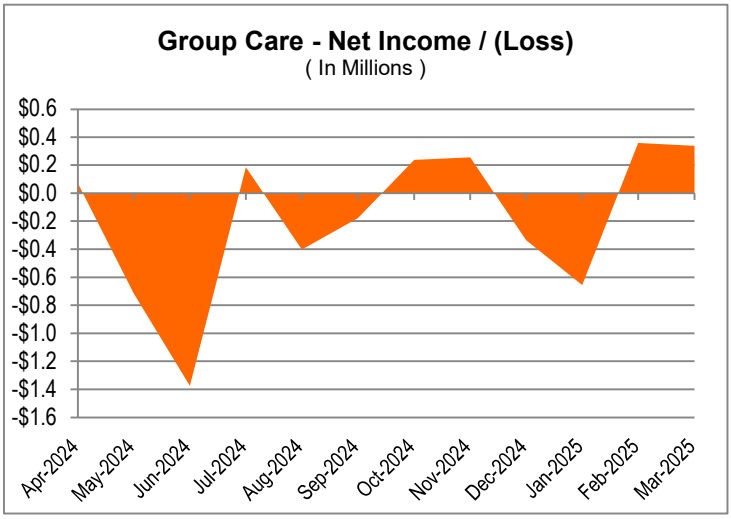


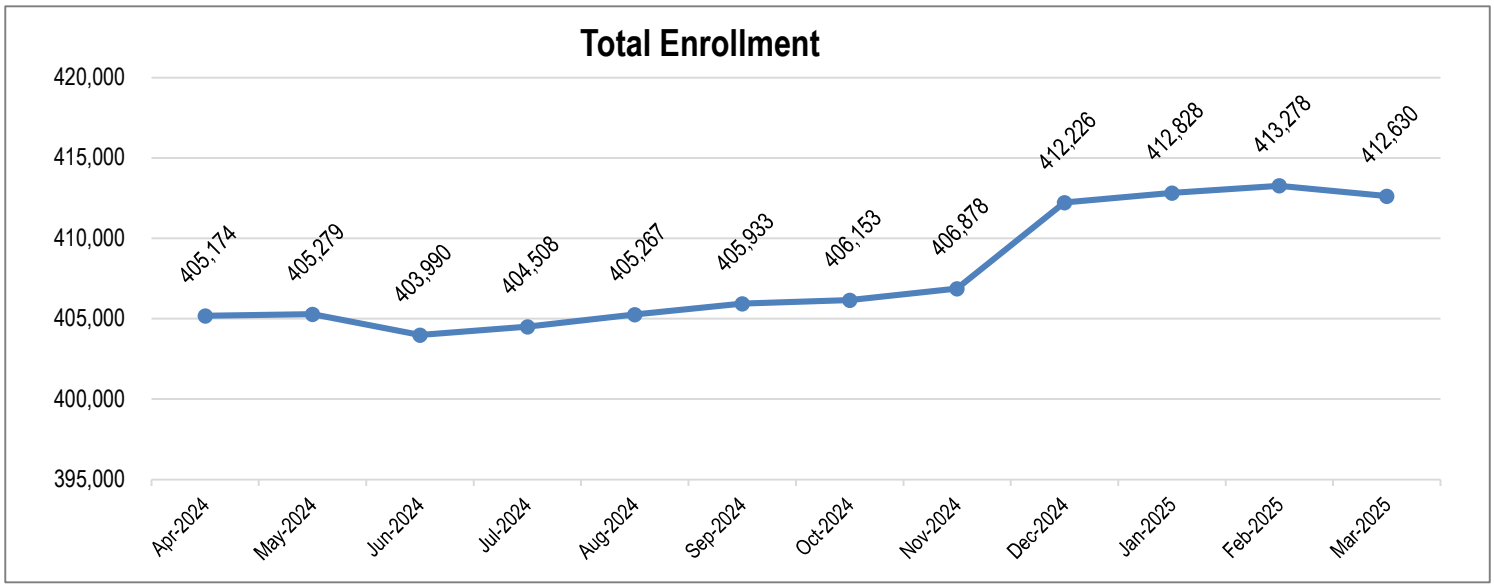


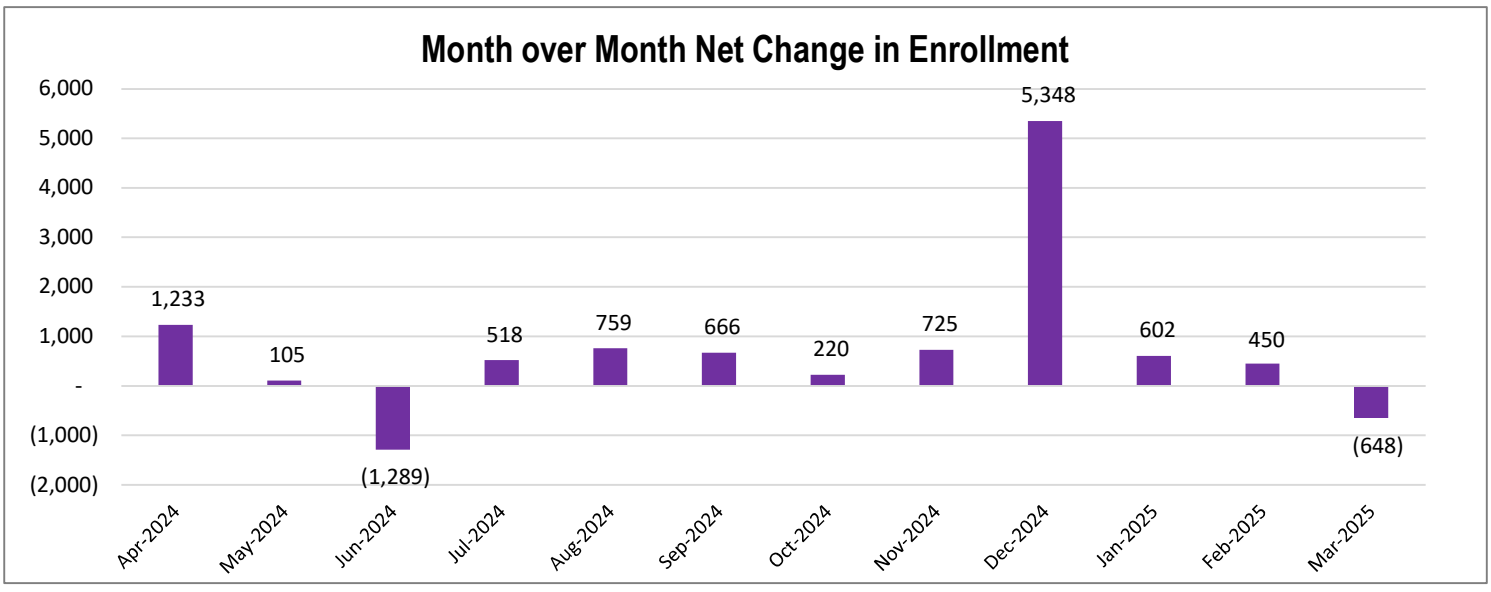


Enrollment and Profitability by Program and Category of Aid



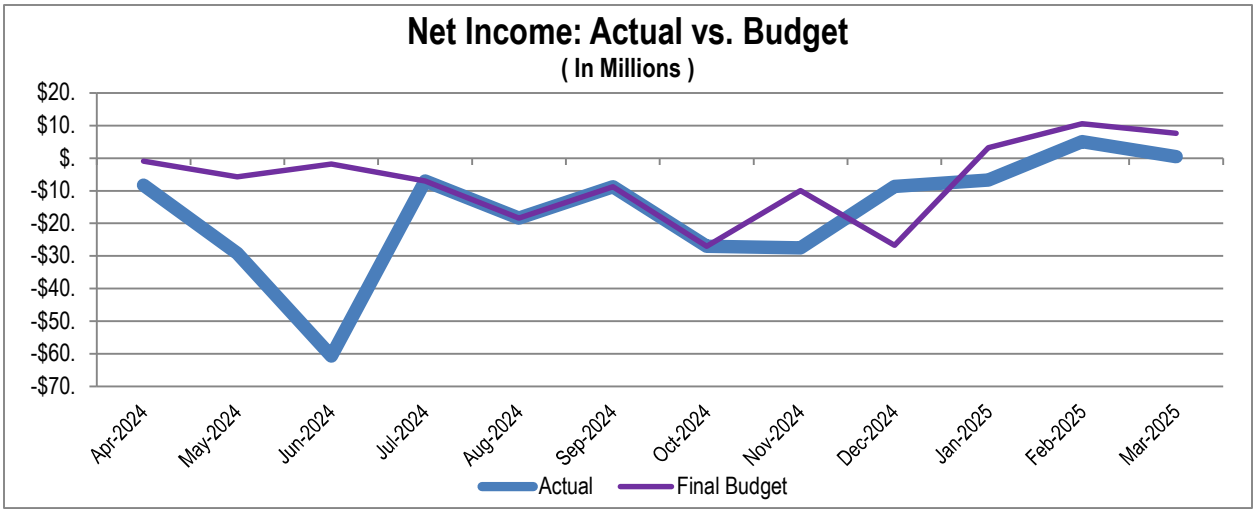






Net Income

- For the month ended March 31st, 2025:
  - Actual Net Income $458,000.
  - Budgeted Net Income $7.6 million.
- For the fiscal YTD ended March 31st, 2025:
  - Actual Net Loss $98.3 million.
  - Budgeted Net Loss $76.3 million.

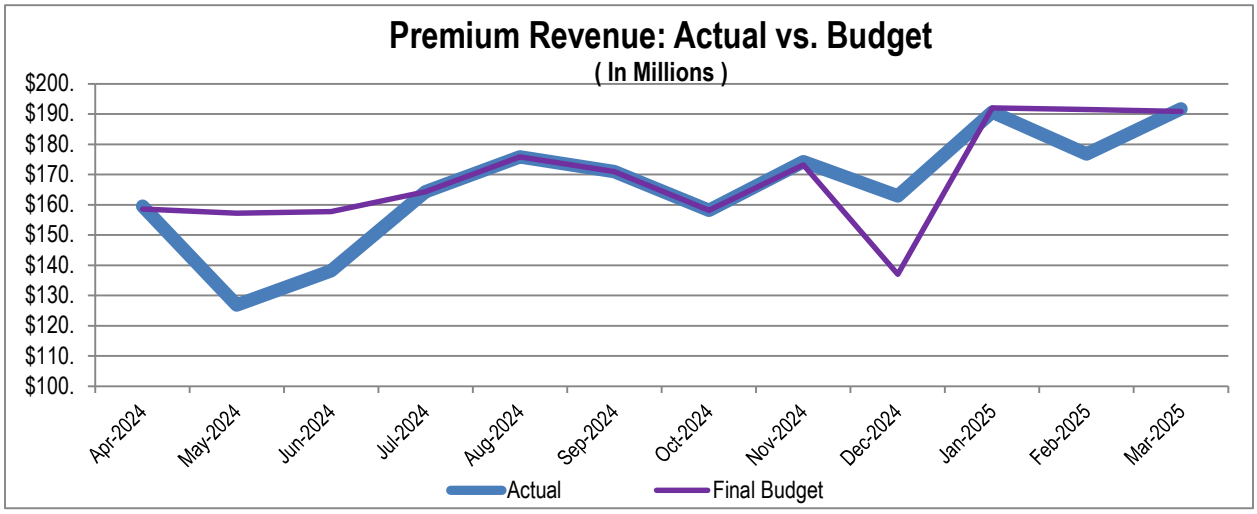


- The unfavorable variance of $7.1 million in the current month is primarily due to:
  - Unfavorable $11.4 million higher than anticipated Medical Expense.
  - Unfavorable $1.7 million higher than anticipated MCO Tax Expense.
  - Unfavorable $1.1 million higher than anticipated Administrative Expense.
  - Favorable $4.7 million higher than anticipated MCO Tax Revenue.
  - Favorable $1.6 million higher than anticipated Other Income.

Premium Revenue

- For the month ended March 31st, 2025:
  - Actual Revenue: $191.7 million.
  - Budgeted Revenue: $190.9 million.

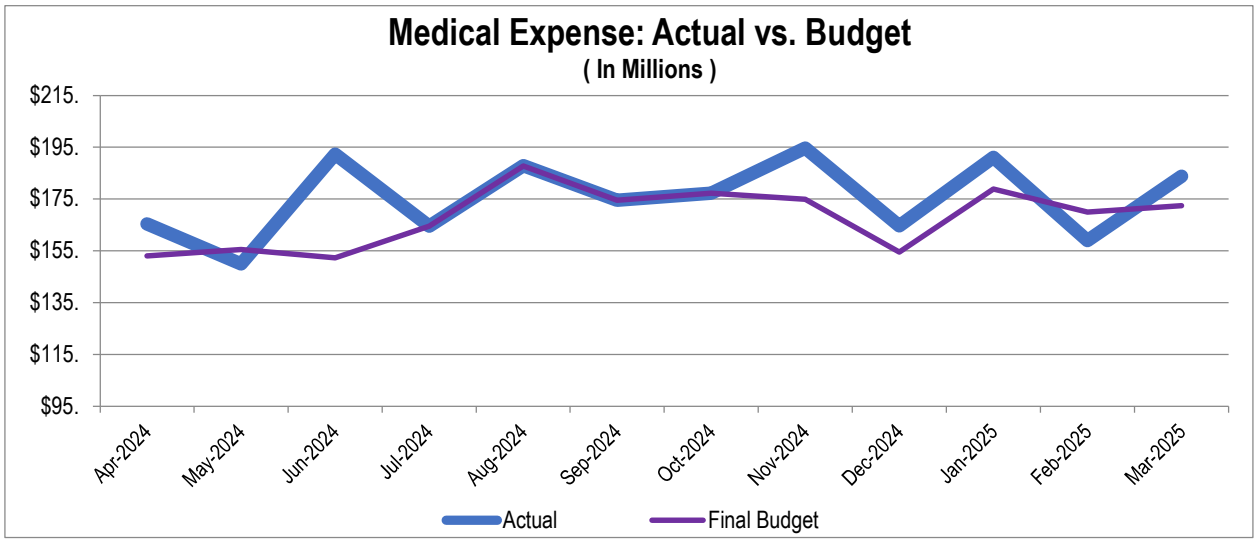
- For the fiscal YTD ended March 31st, 2025:
  - Actual Revenue: $1.6 billion.
  - Budgeted Revenue: $1.6 billion.



- For the month ended March 31st, 2025, the favorable Premium Revenue variance of $811,000 is primarily due to the following:
  - Favorable CY2024 rate adjustments.
  - Favorable current month rate variances.
  - Unfavorable current month volume variance.

Medical Expense

- For the month ended March 31st, 2025:
  - Actual Medical Expense: $183.8 million.
  - Budgeted Medical Expense: $172.4 million.
- For the fiscal YTD ended March 31st, 2025:
  - Actual Medical Expense: $1.6 billion.
  - Budgeted Medical Expense: $1.6 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 March, updates to Fee-For-Service (FFS) decreased the estimate for prior period unpaid Medical Expenses by $3.6 million. Year to date, the estimate for prior years increased by $10.6 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	$162,789,175	$0	$162,789,175	$149,397,036	($13,392,139)	(9.0%)
Primary Care FFS	$24,310,642	$128,215	$24,438,857	$31,719,091	$7,408,448	23.4%
Specialty Care FFS	$73,324,058	$425,196	$73,749,254	$74,265,395	$941,337	1.3%
Outpatient FFS	$112,017,667	$937,951	$112,955,618	$107,147,315	($4,870,352)	(4.5%)
Ancillary FFS	$161,436,770	($417,320)	$161,019,450	$158,438,885	($2,997,885)	(1.9%)
Pharmacy FFS	$118,621,741	$321,642	$118,943,383	$117,163,241	($1,458,500)	(1.2%)
ER Services FFS	$92,466,521	$397,340	$92,863,861	$93,844,779	$1,378,258	1.5%
Inpatient Hospital FFS	$492,116,715	$5,696,729	$497,813,444	$474,733,712	($17,383,003)	(3.7%)
Long Term Care FFS	$311,057,539	$3,129,811	$314,187,350	$299,572,387	($11,485,152)	(3.8%)
Other Benefits & Services	$41,735,757	$0	$41,735,757	$45,973,367	$4,237,610	9.2%
Net Reinsurance	($3,158,613)	$0	($3,158,613)	$2,464,057	$5,622,670	228.2%
	$1,586,717,973	**$10,619,563**	**$1,597,337,536**	**$1,554,719,266**	**($31,998,707)**	**(2.1%)**

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

Adjusted to Eliminate the Impact of Prior Year IBNP Estimates

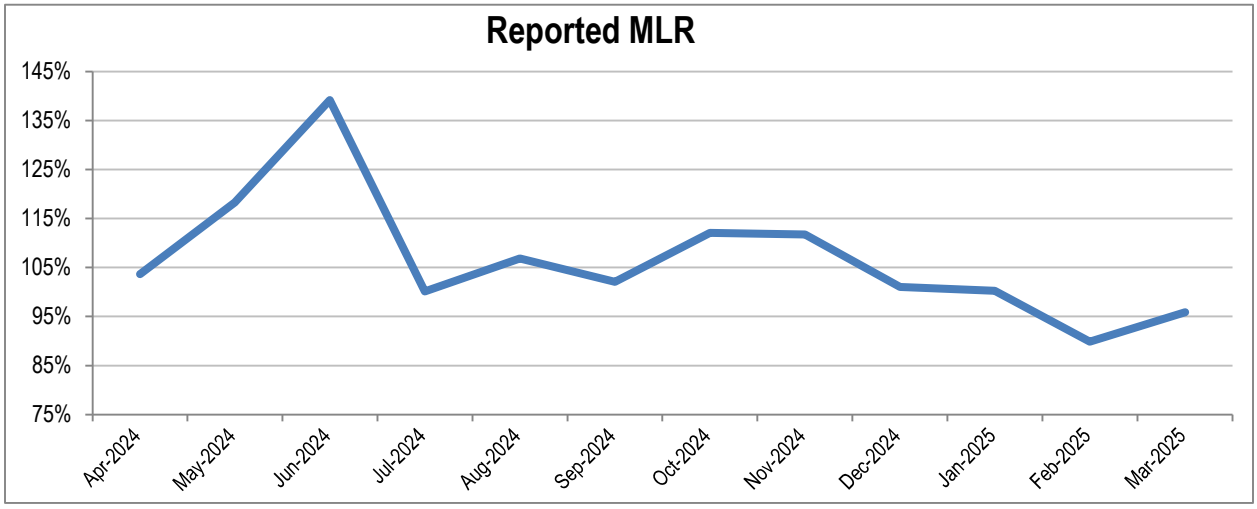
	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$44.24	$0.00	$44.24	$40.84	($3.40)	(8.3%)
Primary Care FFS	$6.61	$0.03	$6.64	$8.67	$2.06	23.8%
Specialty Care FFS	$19.93	$0.12	$20.04	$20.30	$0.37	1.8%
Outpatient FFS	$30.44	$0.25	$30.70	$29.29	($1.15)	(3.9%)
Ancillary FFS	$43.87	($0.11)	$43.76	$43.31	($0.56)	(1.3%)
Pharmacy FFS	$32.24	$0.09	$32.32	$32.03	($0.21)	(0.7%)
ER Services FFS	$25.13	$0.11	$25.24	$25.65	$0.52	2.0%
Inpatient Hospital & SNF FFS	$133.74	$1.55	$135.29	$129.77	($3.97)	(3.1%)
Long Term Care FFS	$84.53	$0.85	$85.38	$81.89	($2.65)	(3.2%)
Other Benefits & Services	$11.34	$0.00	$11.34	$12.57	$1.22	9.7%
Net Reinsurance	($0.86)	$0.00	($0.86)	$0.67	$1.53	227.4%
	$431.21	**$2.89**	**$434.09**	**$424.97**	**($6.24)**	**(1.5%)**

- Excluding the impact of prior year estimates for IBNP, year-to-date medical expense variance is $32.0 million unfavorable to budget. On a PMPM basis, medical expense is 1.5% unfavorable to budget. For per-member-per-month expense:

- Capitated Medical Expense is over budget due to inclusion of Targeted Rate Increases (TRI) in capitation payments.
- Primary Care Expense is under budget due to lower utilization in the ACA OE, Child, Adult and SPD aid code categories.
- Specialty Care Expense is slightly below budget, driven by lower than expected SPD, Child and ACA OE unit cost and Adult utilization.
- Outpatient Expense is over budget mostly driven by lab and radiology unit cost and dialysis utilization in the SPD and LTC, ACA OE and Adult aid code categories.
- Ancillary Expense is over budget due to higher Behavioral Health utilization in the Child aid code category.
- Pharmacy Expense is over budget due to PBM expense driven by higher Group Care unit cost offset by lower Non-PBM utilization in the ACA OE and SPD categories of aid.
- Emergency Room Expense is slightly under budget driven by lower than expected utilization across most populations.
- 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 ACA OE, SPD LTC and Dual LTC Duals aid code categories.
- Other Benefits & Services is under budget, due to lower than 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 95.9% for the month and 102.0% for the fiscal year-to-date.



Administrative Expense

- For the month ended March 31st, 2025:
  - Actual Administrative Expense: $10.5 million.
  - Budgeted Administrative Expense: $9.4 million.

- For the fiscal YTD ended March 31st, 2025:
  - Actual Administrative Expense: $86.8 million.
  - Budgeted Administrative Expense: $91.1 million.

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

Current Month					Year-to-Date			
Actual	Budget	Variance $	Variance %		Actual	Budget	Variance $	Variance %
$5,838,008	$5,792,313	($45,695)	(0.8%)	Employee Expense	$51,648,160	$52,388,278	$740,118	1.4%
78,926	75,068	(3,858)	(5.1%)	Medical Benefits Admin Expense	703,959	679,695	(24,264)	(3.6%)
1,940,936	2,158,579	217,643	10.1%	Purchased & Professional Services	19,328,852	22,709,649	3,380,797	14.9%
2,671,707	1,409,512	(1,262,195)	(89.5%)	Other Admin Expense	15,117,185	15,273,850	156,666	1.0%
$10,529,577	$9,435,472	($1,094,105)	(11.6%)	Total Administrative Expense	$86,798,156	$91,051,473	$4,253,317	4.7%

The favorable year-to-date variance is primarily driven by timing of consulting services and other purchased services.

The Administrative Loss Ratio (ALR) is 5.5% of net revenue for the month and 5.5% of net revenue year-to-date. Fiscal year-to-date claims interest expense, due to delayed payment of certain claims, or recalculated interest on previously paid claims is $1.2 million.

Other Income / (Expense)

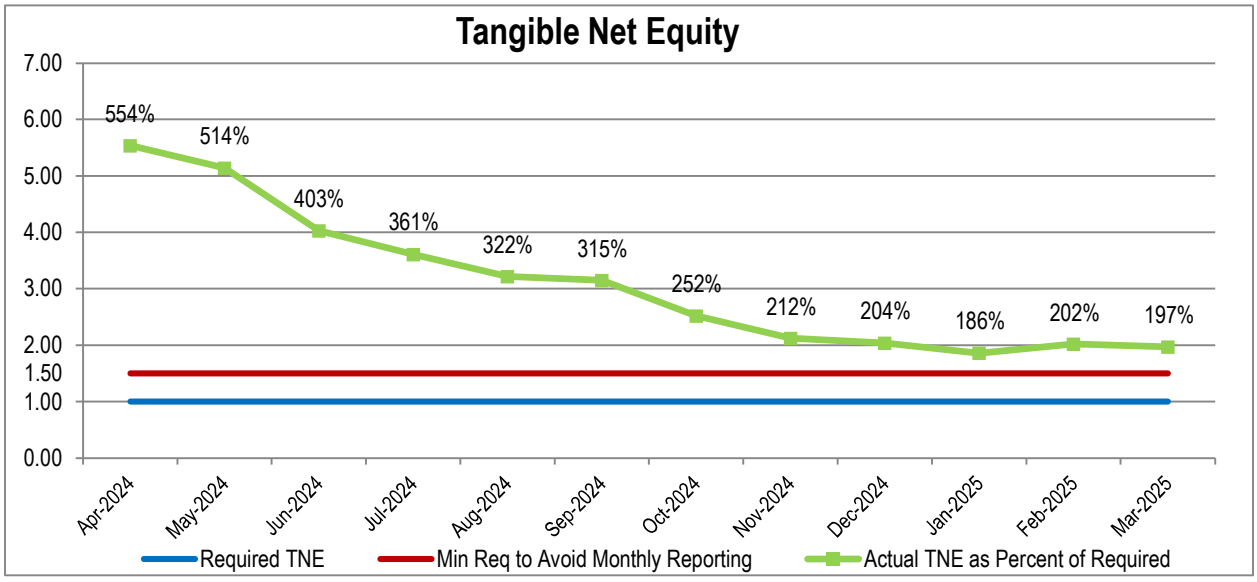
Other Income & Expense is comprised of investment income. Fiscal year-to-date net investments show a gain of $25.3 million.

Managed Care Organization (MCO) Provider Tax

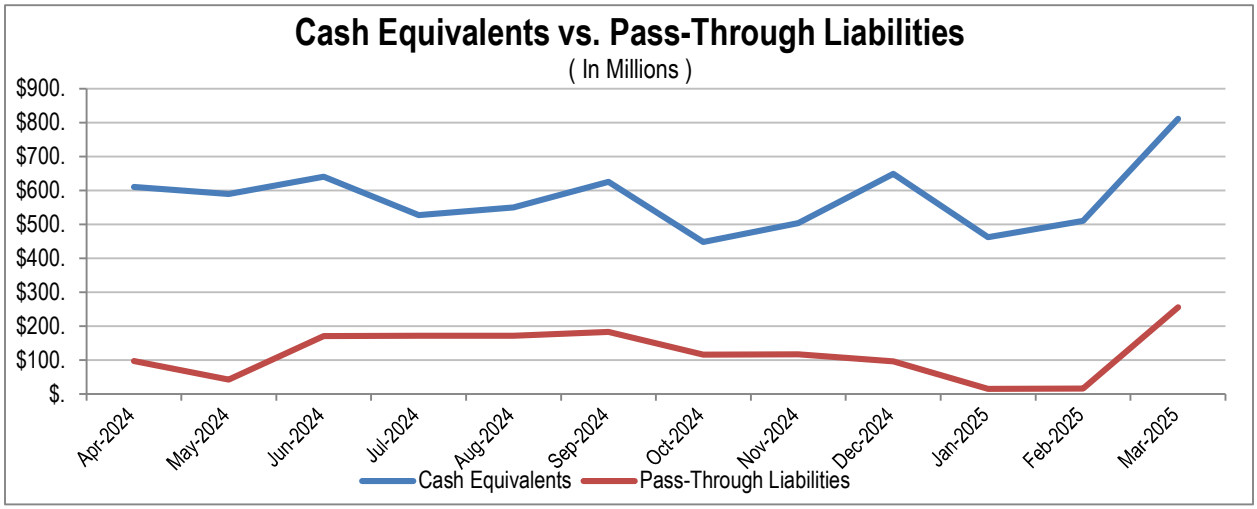
- Revenue:
  - For the month ended March 31st, 2025:
    - Actual: $68.5 million.
    - Budgeted: $63.8 million.
  - For the fiscal YTD ended March 31st, 2025:
    - Actual: $680.0 million.
    - Budgeted: $670.4 million.
- Expense:
  - For the month ended March 31st, 2025:
    - Actual: $68.5 million.
    - Budgeted: $66.8 million.
  - For the fiscal YTD ended March 31st, 2025:
    - Actual: $685.0 million.
    - Budgeted: $676.4 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 $79.8 million
    - Actual TNE $157.1 million
    - Excess TNE $77.3 million
    - TNE % of Required TNE 197%



- To ensure appropriate liquidity and limit risk, the majority of Alliance financial assets are kept in short-term investments.
- Key Metrics
    - Cash & Cash Equivalents $811.1 million
    - Pass-Through Liabilities $256.1 million
    - Uncommitted Cash $555.0 million
    - Working Capital $76.3 million
    - Current Ratio 1.08 (regulatory minimum is 1.00)



Capital Investment

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

Caveats to Financial Statements

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

Finance

Supporting Documents

ALAMEDA ALLIANCE FOR HEALTH
STATEMENT OF REVENUE & EXPENSES
ACTUAL VS. BUDGET
COMBINED BASIS (RESTRICTED & UNRESTRICTED FUNDS)
FOR THE MONTH AND FISCAL YTD ENDED MARCH 31, 2025

CURRENT MONTH					FISCAL YEAR TO DATE			
		$ Variance	% Variance				$ Variance	% Variance
Actual	Budget	(Unfavorable)	(Unfavorable)	Account Description	Actual	Budget	(Unfavorable)	(Unfavorable)
				MEMBERSHIP				
406,748	402,309	4,439	1.1%	1. Medi-Cal	3,627,826	3,606,713	21,113	0.6%
5,882	5,769	113	2.0%	2. GroupCare	51,875	51,685	190	0.4%
412,630	**408,078**	**4,552**	**1.1%**	**3. TOTAL MEMBER MONTHS**	**3,679,701**	**3,658,398**	**21,303**	**0.6%**
				REVENUE				
$191,705,784	$190,895,204	$810,580	0.4%	4. Premium Revenue	$1,565,579,327	$1,553,958,702	$11,620,625	0.7%
$68,503,702	$63,842,415	$4,661,287	7.3%	5. MCO Tax Revenue AB119	$679,997,994	$670,353,052	$9,644,942	1.4%
$260,209,486	**$254,737,619**	**$5,471,867**	**2.1%**	**6. TOTAL REVENUE**	**$2,245,577,321**	**$2,224,311,753**	**$21,265,567**	**1.0%**
				MEDICAL EXPENSES				
				Capitated Medical Expenses				
$20,785,110	$17,168,664	($3,616,446)	(21.1%)	7. Capitated Medical Expense	$162,789,175	$149,397,036	($13,392,139)	(9.0%)
				Fee for Service Medical Expenses				
$55,130,053	$50,970,413	($4,159,640)	(8.2%)	8. Inpatient Hospital Expense	$497,813,444	$474,733,712	($23,079,732)	(4.9%)
$4,913,171	$4,591,058	($322,113)	(7.0%)	9. Primary Care Physician Expense	$24,438,857	$31,719,091	$7,280,233	23.0%
$7,047,398	$8,196,427	$1,149,030	14.0%	10. Specialty Care Physician Expense	$73,749,254	$74,265,395	$516,141	0.7%
$21,273,884	$19,503,930	($1,769,954)	(9.1%)	11. Ancillary Medical Expense	$161,019,450	$158,438,885	($2,580,565)	(1.6%)
$11,061,642	$11,466,421	$404,779	3.5%	12. Outpatient Medical Expense	$112,955,618	$107,147,315	($5,808,303)	(5.4%)
$9,545,220	$10,408,431	$863,211	8.3%	13. Emergency Expense	$92,863,861	$93,844,779	$980,918	1.0%
$14,191,005	$11,893,814	($2,297,191)	(19.3%)	14. Pharmacy Expense	$118,943,383	$117,163,241	($1,780,142)	(1.5%)
$35,711,564	$33,184,441	($2,527,123)	(7.6%)	15. Long Term Care Expense	$314,187,350	$299,572,387	($14,614,963)	(4.9%)
$158,873,937	$150,214,935	($8,659,001)	(5.8%)	16. Total Fee for Service Expense	$1,395,971,217	$1,356,884,805	($39,086,412)	(2.9%)
$3,833,565	$4,562,623	$729,058	16.0%	17. Other Benefits & Services	$41,735,757	$45,973,367	$4,237,610	9.2%
$298,887	$429,814	$130,927	30.5%	18. Reinsurance Expense	($3,158,613)	$2,464,057	$5,622,670	228.2%
$183,791,498	**$172,376,037**	**($11,415,461)**	**(6.6%)**	**20. TOTAL MEDICAL EXPENSES**	**$1,597,337,536**	**$1,554,719,266**	**($42,618,270)**	**(2.7%)**
$76,417,988	**$82,361,582**	**($5,943,594)**	**(7.2%)**	**21. GROSS MARGIN**	**$648,239,785**	**$669,592,488**	**($21,352,703)**	**(3.2%)**
				ADMINISTRATIVE EXPENSES				
$5,838,008	$5,792,313	($45,695)	(0.8%)	22. Personnel Expense	$51,648,160	$52,388,278	$740,118	1.4%
$78,926	$75,068	($3,858)	(5.1%)	23. Benefits Administration Expense	$703,959	$679,695	($24,264)	(3.6%)
$1,940,936	$2,158,579	$217,643	10.1%	24. Purchased & Professional Services	$19,328,852	$22,709,650	$3,380,797	14.9%
$2,671,707	$1,409,512	($1,262,195)	(89.5%)	25. Other Administrative Expense	$15,117,185	$15,273,850	$156,666	1.0%
$10,529,577	**$9,435,472**	**($1,094,105)**	**(11.6%)**	**26. TOTAL ADMINISTRATIVE EXPENSES**	**$86,798,156**	**$91,051,473**	**$4,253,317**	**4.7%**
$68,503,702	**$66,842,415**	**($1,661,287)**	**(2.5%)**	**27. MCO TAX EXPENSES**	**$684,997,994**	**$676,353,052**	**($8,644,942)**	**(1.3%)**
($2,615,291)	**$6,083,694**	**($8,698,986)**	**(143.0%)**	**28. NET OPERATING INCOME / (LOSS)**	**($123,556,365)**	**($97,812,037)**	**($25,744,328)**	**(26.3%)**
				OTHER INCOME / EXPENSES				
$3,073,227	**$1,500,000**	**$1,573,227**	**104.9%**	**29. TOTAL OTHER INCOME / (EXPENSES)**	**$25,253,755**	**$21,481,002**	**$3,772,753**	**17.6%**
$457,936	**$7,583,694**	**($7,125,759)**	**(94.0%)**	**30. NET SURPLUS (DEFICIT)**	**($98,302,610)**	**($76,331,035)**	**($21,971,575)**	**(28.8%)**
95.9%	90.3%	(5.6%)	(6.2%)	31. Medical Loss Ratio	102.0%	100.0%	(2.0%)	(2.0%)
5.5%	4.9%	(0.6%)	(12.2%)	32. Administrative Expense Ratio	5.5%	5.9%	0.4%	6.8%
0.2%	3.0%	(2.8%)	(93.3%)	33. Net Surplus (Deficit) Ratio	(4.4%)	(3.4%)	(1.0%)	(29.4%)

ALAMEDA ALLIANCE FOR HEALTH
BALANCE SHEETS
CURRENT MONTH VS. PRIOR MONTH
FOR THE MONTH AND FISCAL YTD ENDED MARCH 31, 2025

	3/31/2025	2/28/2025	Difference	% Difference
CURRENT ASSETS				
Cash and Cash Equivalent				
Cash	$31,325,120	$20,900,148	$10,424,972	49.9%
CNB Short-Term Investment	779,790,546	489,048,970	290,741,577	59.5%
Interest Receivable	4,004,280	3,548,140	456,140	12.9%
Premium Receivables	258,180,311	518,901,164	(260,720,853)	(50.2%)
Reinsurance Recovery Receivable	10,087,857	9,404,743	683,114	7.3%
Other Receivables	1,598,669	1,976,221	(377,552)	(19.1%)
Prepaid Expenses	823,287	665,325	157,962	23.7%
TOTAL CURRENT ASSETS	**1,085,810,070**	**1,044,444,710**	**41,365,359**	**4.0%**
OTHER ASSETS				
CNB Long-Term Investment	66,730,524	50,028,558	16,701,966	33.4%
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	350,898	350,000	898	0.3%
GASB 87-Lease Assets (Net)	213,702	279,615	(65,913)	(23.6%)
GASB 96-SBITA Assets (Net)	3,093,815	3,337,285	(243,470)	(7.3%)
TOTAL OTHER ASSETS	**78,564,339**	**62,170,859**	**16,393,481**	**26.4%**
PROPERTY AND EQUIPMENT				
Land, Building & Improvements	9,842,648	9,842,648	0	0.0%
Furniture And Equipment	13,400,309	13,133,600	266,709	2.0%
Leasehold Improvement	902,447	902,447	0	0.0%
Internally Developed Software	14,824,002	14,824,002	0	0.0%
Fixed Assets at Cost	38,969,405	38,702,696	266,709	0.7%
Less: Accumulated Depreciation	(33,204,029)	(33,139,168)	(64,862)	0.2%
PROPERTY AND EQUIPMENT (NET)	**5,765,376**	**5,563,529**	**201,847**	**3.6%**
TOTAL ASSETS	**1,170,139,784**	**1,112,179,098**	**57,960,687**	**5.2%**
CURRENT LIABILITIES				
Trade Accounts Payable	9,068,994	9,430,678	(361,684)	(3.8%)
Incurred But Not Reported Claims	387,146,912	388,154,443	(1,007,531)	(0.3%)
Other Medical Liabilities	130,204,088	128,224,738	1,979,351	1.5%
Pass-Through Liabilities	256,119,187	16,082,329	240,036,858	1,492.6%
MCO Tax Liabilities	216,750,076	399,871,373	(183,121,298)	(45.8%)
GASB 87 and 96 ST Liabilities	1,391,062	1,470,410	(79,348)	(5.4%)
Payroll Liabilities	8,809,211	8,721,076	88,135	1.0%
TOTAL CURRENT LIABILITIES	**1,009,489,529**	**951,955,047**	**57,534,483**	**6.0%**
LONG TERM LIABILITIES				
GASB 87 and 96 LT Liabilities	250,192	281,923	(31,732)	(11.3%)
Deferred Inflow	3,327,530	3,327,530	0	0.0%
TOTAL LONG TERM LIABILITIES	**3,577,721**	**3,609,453**	**(31,732)**	**(0.9%)**
TOTAL LIABILITIES	**1,013,067,251**	**955,564,500**	**57,502,751**	**6.0%**
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)	(98,302,610)	(98,760,546)	457,936	(0.5%)
TOTAL NET WORTH	**157,072,534**	**156,614,598**	**457,936**	**0.3%**
TOTAL LIABILITIES AND NET WORTH	**1,170,139,785**	**1,112,179,098**	**57,960,687**	**5.2%**
Cash Equivalents	811,115,666	509,949,118	301,166,548	59.1%
Pass-Through	256,119,187	16,082,329	240,036,858	1,492.6%
Uncommitted Cash	554,996,479	493,866,789	61,129,690	12.4%
Working Capital	76,320,540	92,489,664	(16,169,124)	(17.5%)
Current Ratio	107.6%	109.7%	(2.1%)	(1.9%)

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED **March 31, 2025**

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM OPERATING ACTIVITIES				
Commercial Premium Cash Flows				
Commercial Premium Revenue	$3,206,942	$9,543,742	$19,020,786	$28,360,350
GroupCare Receivable	(3,192,181)	(3,188,951)	(89,112)	(3,198,404)
Total	14,761	6,354,791	18,931,674	25,161,946
Medi-Cal Premium Cash Flows				
Medi-Cal Revenue	257,002,545	749,696,681	1,427,248,093	2,217,216,972
Premium Receivable	263,913,034	189,017,766	206,273,673	111,961,613
Total	520,915,579	938,714,447	1,633,521,766	2,329,178,585
Investment & Other Income Cash Flows				
Other Revenues	(131,814)	(226,245)	(148,842)	2,390,241
Interest Income	3,210,244	7,974,870	14,541,920	22,965,138
Interest Receivable	(456,140)	1,312,871	1,103,374	(2,088,216)
Total	2,622,290	9,061,496	15,496,452	23,267,163
Medical & Hospital Cash Flows				
Total Medical Expenses	(183,791,499)	(533,873,304)	(1,070,447,578)	(1,597,337,539)
Other Health Care Receivables	(347,765)	(2,993,623)	422,033	(761,986)
Capitation Payable	-	-	-	-
IBNP Payable	(1,007,531)	18,892,843	71,714,166	90,842,653
Other Medical Payable	242,016,210	155,035,261	94,355,629	50,482,519
Risk Share Payable	-	-	(1,000)	(2,680,192)
New Health Program Payable	-	-	-	-
Total	56,869,415	(362,938,823)	(903,956,750)	(1,459,454,545)
Administrative Cash Flows				
Total Administrative Expenses	(10,534,783)	(29,160,367)	(57,671,051)	(86,899,776)
Prepaid Expenses	(157,961)	(98,374)	(26,271)	(584,669)
Other Receivables	42,203	44,428	37,110	70,002
CalPERS Pension	-	-	-	-
Trade Accounts Payable	(361,685)	(722,566)	3,811,563	2,578,698
Payroll Liabilities	88,135	106,348	(1,690,823)	709,985
GASB Assets and Liabilities	198,303	1,038,635	(662,077)	(1,164,778)
Depreciation Expense	64,862	184,651	367,656	541,357
Total	(10,660,926)	(28,607,245)	(55,833,893)	(84,749,181)
MCO Tax AB119 Cash Flows				
MCO Tax Expense AB119	(68,503,702)	(205,096,746)	(396,782,523)	(684,997,994)
MCO Tax Liabilities	(183,121,298)	(171,997,004)	(105,779,978)	56,966,561
Total	(251,625,000)	(377,093,750)	(502,562,501)	(628,031,433)
Net Cash Flows from Operating Activities	**318,136,119**	**185,490,916**	**205,596,748**	**205,372,535**

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED **March 31, 2025**

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM INVESTING ACTIVITIES				
Investment Cash Flows				
Long Term Investments	(16,701,963)	(22,600,225)	(19,571,241)	(33,738,280)
Total	(16,701,963)	(22,600,225)	(19,571,241)	(33,738,280)
Restricted Cash & Other Asset Cash Flows				
Restricted Assets-Treasury Account	(898.00)	(898.00)	(898.00)	(898.00)
Total	(898.00)	(898.00)	(898.00)	(898.00)
Fixed Asset Cash Flows				
Fixed Asset Acquisitions	(266,709)	(329,306)	(329,306)	(858,916)
Purchases of Property and Equipment	(266,709)	(329,306)	(329,306)	(858,916)
Net Cash Flows from Investing Activities	**(16,969,570)**	**(22,930,429)**	**(19,901,445)**	**(34,598,094)**
Net Change in Cash	**301,166,549**	**162,560,487**	**185,695,303**	**170,774,441**
Rounding	-	-	-	-
Cash @ Beginning of Period	509,949,116	648,555,178	625,420,362	640,341,224
Cash @ End of Period	**$811,115,665**	**$811,115,665**	**$811,115,665**	**$811,115,665**
Variance	-	-	-	-

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED **March 31, 2025**

	MONTH	3 MONTHS	6 MONTHS	YTD
NET INCOME RECONCILIATION				
Net Income / (Loss)	$457,933	($1,141,369)	($64,239,196)	($98,302,608)
Add back: Depreciation & Amortization	64,862	184,651	367,656	541,357
Receivables				
Premiums Receivable	263,913,034	189,017,766	206,273,673	111,961,613
Interest Receivable	(456,140)	1,312,871	1,103,374	(2,088,216)
Other Health Care Receivables	(347,765)	(2,993,623)	422,033	(761,986)
Other Receivables	42,203	44,428	37,110	70,002
GroupCare Receivable	(3,192,181)	(3,188,951)	(89,112)	(3,198,404)
Total	259,959,151	184,192,491	207,747,078	105,983,009
Prepaid Expenses	(157,961)	(98,374)	(26,271)	(584,669)
Trade Payables	(361,685)	(722,566)	3,811,563	2,578,698
Claims Payable and Shared Risk Pool				
IBNP Payable	(1,007,531)	18,892,843	71,714,166	90,842,653
Capitation Payable & Other Medical Payable	242,016,210	155,035,261	94,355,629	50,482,519
Risk Share Payable	-	-	(1,000)	(2,680,192)
Claims Payable				
Total	241,008,679	173,928,104	166,068,795	138,644,980
Other Liabilities				
CalPERS Pension	-	-	-	-
Payroll Liabilities	88,135	106,348	(1,690,822)	709,985
GASB Assets and Liabilities	198,303	1,038,635	(662,077)	(1,164,778)
New Health Program	-	-	-	-
MCO Tax Liabilities	(183,121,298)	(171,997,004)	(105,779,978)	56,966,561
Total	(182,834,860)	(170,852,021)	(108,132,877)	56,511,768
Rounding	-	-	-	-
Cash Flows from Operating Activities	**318,136,119**	**185,490,916**	**205,596,748**	**205,372,535**
Variance	-	-	-	-

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED **March 31, 2025**

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOW STATEMENT:				
Cash Flows from Operating Activities:				
Cash Received				
Capitation Received from State of CA	$520,915,579	$938,714,447	$1,633,521,766	$2,329,178,585
Medicare Revenue	$0	$0	$0	$0
GroupCare Premium Revenue	14,761	6,354,791	18,931,674	25,161,946
Other Income	(131,814)	(226,245)	(148,842)	2,390,241
Interest Income	2,754,104	9,287,741	15,645,294	20,876,922
Less Cash Paid				
Medical Expenses	56,869,415	(362,938,823)	(903,956,750)	(1,459,454,545)
Vendor & Employee Expenses	(10,660,926)	(28,607,245)	(55,833,893)	(84,749,181)
MCO Tax Expense AB119	(251,625,000)	(377,093,750)	(502,562,501)	(628,031,433)
Net Cash Flows from Operating Activities	**318,136,119**	**185,490,916**	**205,596,748**	**205,372,535**
Cash Flows from Investing Activities:				
Long Term Investments	(16,701,963)	(22,600,225)	(19,571,241)	(33,738,280)
Restricted Assets-Treasury Account	(898)	(898)	(898)	(898)
Purchases of Property and Equipment	(266,709)	(329,306)	(329,306)	(858,916)
Net Cash Flows from Investing Activities	**(16,969,570)**	**(22,930,429)**	**(19,901,445)**	**(34,598,094)**
Net Change in Cash	**301,166,549**	**162,560,487**	**185,695,303**	**170,774,441**
Rounding	-	-	-	-
Cash @ Beginning of Period	509,949,116	648,555,178	625,420,362	640,341,224
Cash @ End of Period	**$811,115,665**	**$811,115,665**	**$811,115,665**	**$811,115,665**
Variance	$0	-	-	-
RECONCILIATION OF NET INCOME TO NET CASH FLOW FROM OPERATING ACTIVITIES:				
Net Income / (Loss)	$457,933	($1,141,368)	($64,239,197)	($98,302,608)
Add Back: Depreciation	64,862	184,651	367,656	541,357
Net Change in Operating Assets & Liabilities				
Premium & Other Receivables	259,959,151	184,192,491	207,747,078	105,983,009
Prepaid Expenses	(157,961)	(98,375)	(26,270)	(584,669)
Trade Payables	(361,685)	(722,566)	3,811,563	2,578,698
Claims Payable, IBNP and Risk Sharing	241,008,679	173,928,104	166,068,795	138,644,980
Deferred Revenue	0	0	0	0
Other Liabilities	(182,834,860)	(170,852,021)	(108,132,877)	56,511,768
Total	318,136,119	185,490,916	205,596,748	205,372,535
Rounding	-	-	-	-
Cash Flows from Operating Activities	**$318,136,119**	**$185,490,916**	**$205,596,748**	**$205,372,535**
Variance	$0	-	-	-

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE MONTH OF MARCH 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	111,103	63,255	-	-	154,559	-	-	29,605	48,226	406,748	5,882	-	412,630
Revenue	$33,798,323	$35,540,365	($4,958,462)	$2,023,866	$103,025,090	($251,212)	($1,128,393)	$47,305,305	$41,647,663	$257,002,544	$3,206,942	$0	$260,209,486
Medical Expense	$14,818,825	$22,844,622	$648,970	$75,805	$60,429,285	$280,896	($459,206)	$47,799,321	$34,634,622	$181,073,141	$2,598,015	$120,343	$183,791,498
Gross Margin	$18,979,498	$12,695,743	($5,607,431)	$1,948,060	$42,595,804	($532,108)	($669,187)	($494,017)	$7,013,041	$75,929,403	$608,928	($120,343)	$76,417,988
Administrative Expense	$452,790	$1,047,673	$110,933	$14,157	$2,944,833	$829	$3,374	$2,674,236	$1,650,379	$8,899,205	$171,795	$1,458,577	$10,529,577
MCO Tax Expense	$18,718,445	$10,656,904	$246,842	$284,624	$26,011,935	$1,451	$9,125	$4,782,984	$7,791,393	$68,503,702	$0	$0	$68,503,702
Operating Income / (Expense)	($191,738)	$991,166	($5,965,207)	$1,649,279	$13,639,037	($534,388)	($681,686)	($7,951,236)	($2,428,731)	($1,473,504)	$437,133	($1,578,920)	($2,615,291)
Other Income / (Expense)	$355,106	$1,002,934	$0	$0	$1,021,539	$0	$0	$671,895	$122,125	$3,173,599	($100,372)	$0	$3,073,227
Net Income / (Loss)	$163,368	$1,994,100	($5,965,207)	$1,649,279	$14,660,576	($534,388)	($681,686)	($7,279,341)	($2,306,606)	$1,700,095	$336,761	($1,578,920)	$457,936
PMPM Metrics:													
Revenue PMPM	$304.21	$561.86	$0.00	$0.00	$666.57	$0.00	$0.00	$1,597.88	$863.59	$631.85	$545.21	$0.00	$630.61
Medical Expense PMPM	$133.38	$361.15	$0.00	$0.00	$390.98	$0.00	$0.00	$1,614.57	$718.17	$445.17	$441.69	$0.00	$445.41
Gross Margin PMPM	$170.83	$200.71	$0.00	$0.00	$275.60	$0.00	$0.00	($16.69)	$145.42	$186.67	$103.52	$0.00	$185.20
Administrative Expense PMPM	$4.08	$16.56	$0.00	$0.00	$19.05	$0.00	$0.00	$90.33	$34.22	$21.88	$29.21	$0.00	$25.52
MCO Tax Expense PMPM	$168.48	$168.48	$0.00	$0.00	$168.30	$0.00	$0.00	$161.56	$161.56	$168.42	$0.00	$0.00	$166.02
Operating Income / (Expense) PMPM	($1.73)	$15.67	$0.00	$0.00	$88.24	$0.00	$0.00	($268.58)	($50.36)	($3.62)	$74.32	$0.00	($6.34)
Other Income / (Expense) PMPM	$3.20	$15.86	$0.00	$0.00	$6.61	$0.00	$0.00	$22.70	$2.53	$7.80	($17.06)	$0.00	$7.45
Net Income / (Loss) PMPM	$1.47	$31.52	$0.00	$0.00	$94.85	$0.00	$0.00	($245.88)	($47.83)	$4.18	$57.25	$0.00	$1.11
Ratio:													
Medical Loss Ratio	98.3%	91.8%	-12.5%	4.4%	78.5%	-111.2%	40.4%	112.4%	102.3%	96.1%	81.0%	0.0%	95.9%
Administrative Expense Ratio	3.0%	4.2%	-2.1%	0.8%	3.8%	-0.3%	-0.3%	6.3%	4.9%	4.7%	5.4%	0.0%	5.5%
Net Income Ratio	0.5%	5.6%	120.3%	81.5%	14.2%	212.7%	60.4%	-15.4%	-5.5%	0.7%	10.5%	0.0%	0.2%

*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 MARCH 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	993,495	566,398	212,632	241,339	1,371,809	1,446	7,562	88,666	144,479	3,627,826	51,875	-	3,679,701
Revenue	$324,015,861	$307,212,526	$299,355,850	$138,335,121	$801,813,069	$15,150,239	$64,554,238	$142,173,662	$124,606,405	$2,217,216,970	$28,360,351	$0	$2,245,577,321
Medical Expense	$120,916,911	$188,159,228	$275,365,669	$94,442,143	$556,126,790	$17,811,747	$66,073,982	$157,032,657	$93,754,410	$1,569,683,536	$27,368,157	$285,843	$1,597,337,536
Gross Margin	$203,098,951	$119,053,298	$23,990,181	$43,892,978	$245,686,278	($2,661,507)	($1,519,745)	($14,858,995)	$30,851,994	$647,533,435	$992,193	($285,843)	$648,239,785
Administrative Expense	$4,138,774	$9,736,594	$14,452,509	$4,956,757	$26,857,274	$1,013,105	$4,701,674	$7,967,275	$4,917,096	$78,741,059	$1,391,684	$6,665,413	$86,798,156
MCO Tax Expense	$188,155,031	$107,086,071	$43,043,470	$49,233,964	$257,987,010	$285,308	$1,540,232	$14,324,879	$23,342,027	$684,997,994	$0	$0	$684,997,994
Operating Income / (Expense)	$10,805,145	$2,230,633	($33,505,798)	($10,297,743)	($39,158,005)	($3,959,921)	($7,761,651)	($37,151,149)	$2,592,871	($116,205,618)	($399,491)	($6,951,256)	($123,556,365)
Other Income / (Expense)	$1,467,500	$3,736,850	$4,709,375	$1,609,737	$8,544,946	$338,837	$1,557,352	$2,090,438	$995,612	$25,050,647	$203,108	$0	$25,253,755
Net Income / (Loss)	$12,272,645	$5,967,483	($28,796,424)	($8,688,006)	($30,613,059)	($3,621,084)	($6,204,298)	($35,060,711)	$3,588,483	($91,154,971)	($196,382)	($6,951,256)	($98,302,610)
PMPM Metrics:													
Revenue PMPM	$326.14	$542.40	$1,407.86	$573.20	$584.49	$10,477.34	$8,536.66	$1,603.47	$862.45	$611.17	$546.71	$0.00	$610.26
Medical Expense PMPM	$121.71	$332.20	$1,295.03	$391.33	$405.40	$12,317.94	$8,737.63	$1,771.06	$648.91	$432.68	$527.58	$0.00	$434.09
Gross Margin PMPM	$204.43	$210.19	$112.82	$181.87	$179.10	($1,840.60)	($200.97)	($167.58)	$213.54	$178.49	$19.13	$0.00	$176.17
Administrative Expense PMPM	$4.17	$17.19	$67.97	$20.54	$19.58	$700.63	$621.75	$89.86	$34.03	$21.70	$26.83	$0.00	$23.59
MCO Tax Expense PMPM	$189.39	$189.07	$202.43	$204.00	$188.06	$197.31	$203.68	$161.56	$161.56	$188.82	$0.00	$0.00	$186.16
Operating Income / (Expense) PMPM	$10.88	$3.94	($157.58)	($42.67)	($28.54)	($2,738.53)	($1,026.40)	($419.00)	$17.95	($32.03)	($7.70)	$0.00	($33.58)
Other Income / (Expense) PMPM	$1.48	$6.60	$22.15	$6.67	$6.23	$234.33	$205.94	$23.58	$6.89	$6.91	$3.92	$0.00	$6.86
Net Income / (Loss) PMPM	$12.35	$10.54	($135.43)	($36.00)	($22.32)	($2,504.21)	($820.46)	($395.42)	$24.84	($25.13)	($3.79)	$0.00	($26.71)
Ratio:													
Medical Loss Ratio	87.9%	93.7%	107.2%	105.1%	102.0%	119.8%	104.8%	122.8%	92.6%	102.1%	96.5%	0.0%	102.0%
Administrative Expense Ratio	3.0%	4.8%	5.6%	5.5%	4.9%	6.8%	7.5%	6.2%	4.9%	5.1%	4.9%	0.0%	5.5%
Net Income Ratio	3.8%	1.9%	-9.6%	-6.3%	-3.8%	-23.9%	-9.6%	-24.7%	2.9%	-4.1%	-0.7%	0.0%	-4.4%

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ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED March 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)				
$5,838,008	$5,792,313	($45,695)	(0.8%)	Personnel Expenses	$51,648,160	$52,388,278	$740,118	1.4%
$78,926	$75,068	($3,858)	(5.1%)	Benefits Administration Expense	$703,959	$679,695	($24,264)	(3.6%)
$1,940,936	$2,158,579	$217,643	10.1%	Purchased & Professional Services	$19,328,852	$22,709,650	$3,380,797	14.9%
$509,163	$580,846	$71,683	12.3%	Occupancy	$4,668,959	$4,930,775	$261,817	5.3%
$691,527	$548,691	($142,836)	(26.0%)	Printing Postage & Promotion	$3,973,774	$4,201,774	$228,000	5.4%
$390,052	$105,218	($284,834)	(270.7%)	Licenses Insurance & Fees	$3,986,904	$4,445,233	$458,329	10.3%
$1,080,965	$174,757	($906,207)	(518.6%)	Other Administrative Expense	$2,487,548	$1,696,068	($791,479)	(46.7%)
$4,691,569	$3,643,159	($1,048,409)	(28.8%)	Total Other Administrative Expenses (excludes Personnel Expenses)	$35,149,996	$38,663,195	$3,513,199	9.1%
$10,529,577	$9,435,472	($1,094,105)	(11.6%)	Total Administrative Expenses	$86,798,156	$91,051,473	$4,253,317	4.7%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED March 31, 2025

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
3,779,762	3,969,594	189,832	4.8%	Salaries & Wages	33,918,512	34,453,044	534,532	1.6%
313,401	379,776	66,376	17.5%	Paid Time Off	3,094,672	3,361,575	266,903	7.9%
125	6,955	6,830	98.2%	Compensated Incentives	22,360	37,564	15,204	40.5%
0	0	0	0.0%	Severence	0	400,000	400,000	100.0%
70,790	63,165	(7,625)	(12.1%)	Payroll Taxes	653,062	839,549	186,487	22.2%
59,936	26,210	(33,726)	(128.7%)	Overtime	618,117	443,169	(174,948)	(39.5%)
337,884	311,544	(26,340)	(8.5%)	CalPERS ER Match	2,907,426	2,923,228	15,802	0.5%
1,057,105	693,233	(363,872)	(52.5%)	Employee Benefits	8,930,020	7,158,756	(1,771,264)	(24.7%)
(7,822)	0	7,822	0.0%	Personal Floating Holiday	187,967	202,966	14,999	7.4%
33,788	37,000	3,212	8.7%	Language Pay	197,418	271,259	73,842	27.2%
3,140	0	(3,140)	0.0%	Med Ins Opted Out Stipend	32,190	16,010	(16,180)	(101.1%)
0	0	0	0.0%	Holiday Bonus	(400,000)	0	400,000	1,333,333,4…
90,687	0	(90,687)	0.0%	Sick Leave	736,296	270,728	(465,568)	(172.0%)
350	22,150	21,800	98.4%	Compensated Employee Relations	8,513	196,939	188,426	95.7%
20,250	26,700	6,450	24.2%	Work from Home Stipend	180,540	208,670	28,130	13.5%
2,949	7,213	4,264	59.1%	Mileage, Parking & LocalTravel	13,059	43,587	30,527	70.0%
11,104	39,997	28,893	72.2%	Travel & Lodging	27,397	163,258	135,861	83.2%
33,665	141,445	107,780	76.2%	Temporary Help Services	285,472	731,469	445,996	61.0%
25,254	31,830	6,577	20.7%	Staff Development/Training	150,234	410,167	259,933	63.4%
5,639	35,500	29,861	84.1%	Staff Recruitment/Advertisement	84,904	256,340	171,436	66.9%
5,838,008	**5,792,313**	**(45,695)**	**(0.8%)**	**Personnel Expense**	**51,648,160**	**52,388,278**	**740,118**	**1.4%**
25,559	22,018	(3,541)	(16.1%)	Pharmacy Administrative Fees	228,140	205,222	(22,918)	(11.2%)
53,368	53,050	(317)	(0.6%)	Telemedicine Admin. Fees	475,819	474,473	(1,347)	(0.3%)
78,926	**75,068**	**(3,858)**	**(5.1%)**	**Benefits Administration Expense**	**703,959**	**679,695**	**(24,264)**	**(3.6%)**
43,793	587,537	543,744	92.5%	Consultant Fees - Non Medical	4,867,488	6,327,678	1,460,190	23.1%
652,721	436,441	(216,281)	(49.6%)	Computer Support Services	4,421,539	5,181,914	760,375	14.7%
12,500	15,000	2,500	16.7%	Audit Fees	183,658	143,158	(40,500)	(28.3%)
0	8	8	100.0%	Consultant Fees - Medical	(7,505)	(15,297)	(7,792)	50.9%
223,051	227,801	4,750	2.1%	Other Purchased Services	2,197,927	2,246,094	48,167	2.1%
6,161	844	(5,317)	(630.0%)	Maint.&Repair-Office Equipment	6,161	7,596	1,435	18.9%
0	0	0	0.0%	Maint.&Repair-Computer Hardwar	2,018	0	(2,018)	0.0%
(12,484)	70,067	82,551	117.8%	Legal Fees	839,153	681,619	(157,534)	(23.1%)
0	0	0	0.0%	Member Health Education	320	320	0	0.0%
25,017	26,000	983	3.8%	Translation Services	235,406	217,064	(18,343)	(8.5%)
163,525	157,650	(5,875)	(3.7%)	Medical Refund Recovery Fees	2,063,641	1,942,921	(120,720)	(6.2%)
792,894	527,847	(265,047)	(50.2%)	Software - IT Licenses & Subsc	3,915,129	4,930,461	1,015,332	20.6%
(25,770)	53,584	79,354	148.1%	Hardware (Non-Capital)	176,255	593,208	416,953	70.3%
59,527	55,800	(3,727)	(6.7%)	Provider Credentialing	427,662	452,913	25,251	5.6%
1,940,936	**2,158,579**	**217,643**	**10.1%**	**Purchased & Professional Services**	**19,328,852**	**22,709,650**	**3,380,797**	**14.9%**
64,862	105,220	40,359	38.4%	Depreciation	541,357	711,994	170,637	24.0%
62,638	76,371	13,733	18.0%	Lease Building	636,740	631,256	(5,484)	(0.9%)
8,419	5,960	(2,459)	(41.3%)	Lease Rented Office Equipment	52,325	66,205	13,880	21.0%
10,206	20,023	9,817	49.0%	Utilities	115,728	194,853	79,125	40.6%
73,378	91,065	17,687	19.4%	Telephone	778,871	802,990	24,118	3.0%
46,189	33,071	(13,117)	(39.7%)	Building Maintenance	286,880	354,018	67,138	19.0%
243,471	249,136	5,665	2.3%	GASB96 SBITA Amort. Expense	2,257,057	2,169,458	(87,599)	(4.0%)

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED March 31, 2025

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
509,163	**580,846**	**71,683**	**12.3%**	**Occupancy**	**4,668,959**	**4,930,775**	**261,817**	**5.3%**
96,364	117,058	20,695	17.7%	Postage	610,135	780,702	170,567	21.8%
3,179	5,300	2,121	40.0%	Design & Layout	48,060	52,680	4,620	8.8%
352,962	176,790	(176,172)	(99.7%)	Printing Services	1,191,214	992,800	(198,414)	(20.0%)
27,555	19,410	(8,145)	(42.0%)	Mailing Services	103,926	106,433	2,507	2.4%
5,989	11,796	5,806	49.2%	Courier/Delivery Service	48,642	84,591	35,948	42.5%
0	520	520	100.0%	Pre-Printed Materials & Public	589	3,103	2,514	81.0%
0	0	0	0.0%	Promotional Products	111,069	54,020	(57,049)	(105.6%)
0	150	150	100.0%	Promotional Services	0	1,050	1,050	100.0%
205,479	217,667	12,188	5.6%	Community Relations	1,860,139	2,126,395	266,256	12.5%
691,527	**548,691**	**(142,836)**	**(26.0%)**	**Printing Postage & Promotion**	**3,973,774**	**4,201,774**	**228,000**	**5.4%**
0	0	0	0.0%	Regulatory Penalties	295,000	385,000	90,000	23.4%
32,553	31,600	(953)	(3.0%)	Bank Fees	361,807	290,981	(70,826)	(24.3%)
0	0	0	0.0%	Insurance Premium	976,728	982,916	6,188	0.6%
351,833	31,650	(320,183)	(1,011.7%)	License,Permits, & Fee - NonIT	1,780,139	2,122,566	342,427	16.1%
5,666	41,968	36,302	86.5%	Subscriptions and Dues - NonIT	573,230	663,770	90,539	13.6%
390,052	**105,218**	**(284,834)**	**(270.7%)**	**License Insurance & Fees**	**3,986,904**	**4,445,233**	**458,329**	**10.3%**
4,520	11,058	6,538	59.1%	Office and Other Supplies	63,050	99,074	36,024	36.4%
0	1,000	1,000	100.0%	Furniture & Equipment	0	9,000	9,000	100.0%
17,622	26,483	8,862	33.5%	Ergonomic Supplies	225,471	270,465	44,994	16.6%
14,911	11,366	(3,545)	(31.2%)	Meals and Entertainment	100,022	144,472	44,449	30.8%
895,358	0	(895,358)	0.0%	Miscellaneous	898,817	5,300	(893,517)	(16,858.8%)
0	4,850	4,850	100.0%	Member Incentive	0	14,550	14,550	100.0%
148,554	120,000	(28,554)	(23.8%)	Provider Interest (All Depts)	1,200,188	1,153,208	(46,980)	(4.1%)
1,080,965	**174,757**	**(906,207)**	**(518.6%)**	**Other Administrative Expense**	**2,487,548**	**1,696,068**	**(791,479)**	**(46.7%)**
4,691,569	**3,643,159**	**(1,048,409)**	**(28.8%)**	**Total Other Administrative ExpenseS (excludes Personnel Expenses)**	**35,149,996**	**38,663,195**	**3,513,199**	**9.1%**
10,529,577	**9,435,472**	**(1,094,105)**	**(11.6%)**	**TOTAL ADMINISTRATIVE EXPENSES**	**86,798,156**	**91,051,473**	**4,253,317**	**4.7%**

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

		Project ID	Prior YTD Acquisitions	Current Month Acquisitions	Fiscal YTD Acquisitions	Capital Budget Total	$ Variance Fav/(Unf.)
1. Hardware:							
	Cisco UCS-X M6 or M7 Blades x 6	IT-FY24-04	$ 265,100	$ -	**$ 265,100**	$ 265,100	$ 0
	Cisco Routers	IT-FY25-01	$ -	$ -	**$ -**	$ 120,000	$ 120,000
	Cisco UCS Blades	IT-FY25-04	$ 264,510	$ -	**$ 264,510**	$ 873,000	$ 608,490
	PURE Storage	IT-FY25-06	$ -	$ 266,709	**$ 266,709**	$ 150,000	$ (116,709)
	Exagrid Immutable Storage	IT-FY25-07	$ -	$ -	**$ -**	$ 500,000	$ 500,000
	Network Cabling	IT-FY25-09	$ 62,598	$ -	**$ 62,598**	$ 40,000	$ (22,598)
Hardware Subtotal			**$ 592,208**	**$ 266,709**	**$ 858,916**	**$ 1,948,100**	**$ 1,089,184**
2. Software:							
	Zerto renewal and Tier 2 add		$ -	$ -	**$ -**	$ -	$ -
Software Subtotal			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
3. Building Improvement:							
	1240 Exterior lighting update	FA-FY25-03	**$ -**	$ -	**$ -**	$ 30,000	$ 30,000
Building Improvement Subtotal			**$ -**	**$ -**	**$ -**	**$ 30,000**	**$ 30,000**
4. Furniture & Equipment:							
	Office desks, cabinets, shelvings (all building/suites: new or replacement)		$ -	$ -	**$ -**	$ -	$ -
	Replace, reconfigure, re-design workstations		$ -	$ -	**$ -**	$ -	$ -
Furniture & Equipment Subtotal			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
5. Leasehold Improvement:							
	ExacqVision NVR Upgrade, Cameras/Video System upgrade		$ -		**$ -**	$ -	$ -
Leasehold Improvement Subtotal			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
6. Contingency:							
			$ -		**$ -**	$ -	$ -
Contingency Subtotal			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
GRAND TOTAL			**$ 592,208**	**$ 266,709**	**$ 858,916**	**$ 1,978,100**	**$ 1,119,184**

6. Reconciliation to Balance Sheet:

Fixed Assets @ Cost - 3/31/25	**$ 38,969,405**
Fixed Assets @ Cost - 6/30/24	**$ 38,110,489**
Fixed Assets Acquired YTD	**$ 858,916**

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

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

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

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

	Actual Jul-24	Actual Aug-24	Actual Sep-24	Actual Oct-24	Actual Nov-24	Actual Dec-24	Actual Jan-25	Actual Feb-25	Actual Mar-25	Actual Apr-25	Actual May-25	Actual Jun-25	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program:													
Child	109,951	109,784	109,731	109,662	109,561	110,506	111,643	111,554	111,103				993,495
Adult	62,708	62,641	62,550	62,578	62,502	62,905	63,553	63,706	63,255				566,398
SPD (retired Dec-24)*	35,018	35,177	35,319	35,388	35,603	36,127	0	0	0				212,632
Duals (retired Dec-24)*	39,892	40,024	40,124	40,144	40,357	40,798	0	0	0				241,339
ACA OE	149,801	150,482	151,005	151,098	151,559	154,560	154,136	154,609	154,559				1,371,809
LTC (retired Dec-24)*	222	226	240	249	255	254	0	0	0				1,446
LTC Duals (retired Dec-24)*	1,241	1,247	1,254	1,265	1,269	1,286	0	0	0				7,562
SPD with LTC (new Jan-25)	0	0	0	0	0	0	29,564	29,497	29,605				88,666
Duals with LTC (new Jan-25)	0	0	0	0	0	0	48,153	48,100	48,226				144,479
Medi-Cal Program	398,833	399,581	400,223	400,384	401,106	406,436	407,049	407,466	406,748				3,627,826
Group Care Program	5,675	5,686	5,710	5,769	5,772	5,790	5,779	5,812	5,882				51,875
Total	**404,508**	**405,267**	**405,933**	**406,153**	**406,878**	**412,226**	**412,828**	**413,278**	**412,630**				**3,679,701**

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

Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	(173)	(167)	(53)	(69)	(101)	945	1,137	(89)	(451)				979
Adult	(38)	(67)	(91)	28	(76)	403	648	153	(451)				509
SPD (retired Dec-24)	98	159	142	69	215	524	(36,127)	0	0				(34,920)
Duals (retired Dec-24)	144	132	100	20	213	441	(40,798)	0	0				(39,748)
ACA OE	477	681	523	93	461	3,001	(424)	473	(50)				5,235
LTC (retired Dec-24)	0	4	14	9	6	(1)	(254)	0	0				(222)
LTC Duals (retired Dec-24)	(7)	6	7	11	4	17	(1,286)	0	0				(1,248)
SPD with LTC (new Jan-25)	0	0	0	0	0	0	29,564	(67)	108				29,605
Duals with LTC (new Jan-25)	0	0	0	0	0	0	48,153	(53)	126				48,226
Medi-Cal Program	501	748	642	161	722	5,330	613	417	(718)				8,416
Group Care Program	17	11	24	59	3	18	(11)	33	70				224
Total	**518**	**759**	**666**	**220**	**725**	**5,348**	**602**	**450**	**(648)**				**8,640**

Enrollment Percentages:													
Medi-Cal Program:													
Child % of Medi-Cal	27.6%	27.5%	27.4%	27.4%	27.3%	27.2%	27.4%	27.4%	27.3%				27.4%
Adult % of Medi-Cal	15.7%	15.7%	15.6%	15.6%	15.6%	15.5%	15.6%	15.6%	15.6%				15.6%
SPD % of Medi-Cal	8.8%	8.8%	8.8%	8.8%	8.9%	8.9%	0.0%	0.0%	0.0%				5.9%
Duals % of Medi-Cal	10.0%	10.0%	10.0%	10.0%	10.1%	10.0%	0.0%	0.0%	0.0%				6.7%
ACA OE % of Medi-Cal	37.6%	37.7%	37.7%	37.7%	37.8%	38.0%	37.9%	37.9%	38.0%				37.8%
LTC % of Medi-Cal	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.0%	0.0%	0.0%				0.0%
LTC Duals % of Medi-Cal	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.0%	0.0%	0.0%				0.2%
SPD with LTC % of Medi-Cal	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.3%	7.2%	7.3%				2.4%
Duals with LTC % of Medi-Cal	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	11.8%	11.8%	11.9%				4.0%
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%
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%
Total	**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

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	94,389	94,869	93,866				825,882
Alameda Health System	91,091	91,170	91,024	90,756	90,451	90,222	91,158	90,932	90,950				817,754
Directly-Contracted Subtotal	179,071	179,688	180,658	180,480	181,106	186,469	185,547	185,801	184,816				1,643,636
Delegated:													
CFMG	44,087	43,956	43,837	43,910	44,029	44,099	44,982	45,072	45,190				399,162
CHCN	181,350	181,623	181,438	181,763	181,743	181,658	182,299	182,405	182,624				1,636,903
Delegated Subtotal	225,437	225,579	225,275	225,673	225,772	225,757	227,281	227,477	227,814				2,036,065
Total	**404,508**	**405,267**	**405,933**	**406,153**	**406,878**	**412,226**	**412,828**	**413,278**	**412,630**				**3,679,701**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	167	617	970	(178)	626	5,363	(922)	254	(985)				5,912
Delegated:													
CFMG	96	(131)	(119)	73	119	70	883	90	118				1,199
CHCN	255	273	(185)	325	(20)	(85)	641	106	219				1,529
Delegated Subtotal	351	142	(304)	398	99	(15)	1,524	196	337				2,728
Total	**518**	**759**	**666**	**220**	**725**	**5,348**	**602**	**450**	**(648)**				**8,640**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	44.3%	44.3%	44.5%	44.4%	44.5%	45.2%	44.9%	45.0%	44.8%				44.7%
Delegated:													
CFMG	10.9%	10.8%	10.8%	10.8%	10.8%	10.7%	10.9%	10.9%	11.0%				10.8%
CHCN	44.8%	44.8%	44.7%	44.8%	44.7%	44.1%	44.2%	44.1%	44.3%				44.5%
Delegated Subtotal	55.7%	55.7%	55.5%	55.6%	55.5%	54.8%	55.1%	55.0%	55.2%				55.3%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**				**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING

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

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING

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

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

	Variance Jul-24	Variance Aug-24	Variance Sep-24	Variance Oct-24	Variance Nov-24	Variance Dec-24	Variance Jan-25	Variance Feb-25	Variance Mar-25	Variance Apr-25	Variance May-25	Variance Jun-25	YTD Member Month Variance
Enrollment Variance by Plan & Aid Category - Favorable/(Unfavorable)													
Medi-Cal Program:													
Child	0	0	0	0	(211)	624	1,541	1,342	781				4,077
Adult	0	0	0	0	(139)	201	786	876	362				2,086
SPD (retired Dec-24)	0	0	0	0	180	669	0	0	0				849
Duals (retired Dec-24)	0	0	0	0	213	654	0	0	0				867
ACA OE	0	0	0	0	310	3,160	2,585	2,906	2,704				11,665
LTC (retired Dec-24)	0	0	0	0	4	0	0	0	0				4
LTC Duals (retired Dec-24)	0	0	0	0	3	19	0	0	0				22
SPD with LTC (new Jan-25)	0	0	0	0	0	0	(5,186)	(4,291)	(3,220)				(12,697)
Duals with LTC (new Jan-25)	0	0	0	0	0	0	5,741	4,687	3,812				14,240
Medi-Cal Program	0	0	0	0	360	5,327	5,467	5,520	4,439				5,687
Group Care Program	0	0	0	0	3	21	10	43	113				24
Total	**0**	**0**	**0**	**0**	**363**	**5,348**	**5,477**	**5,563**	**4,552**				**21,303**
Current Direct/Delegate Enrollment Variance - Favorable/(Unfavorable)													
Directly-Contracted													
Directly Contracted (DCP)	0	0	0	0	869	6,398	4,145	4,239	2,850				18,501
Alameda Health System	0	0	0	0	(392)	(708)	207	(28)	(18)				(939)
Directly-Contracted Subtotal	0	0	0	0	477	5,690	4,352	4,211	2,832				17,562
Delegated:													
CFMG	0	0	0	0	76	103	947	1,039	1,160				3,325
CHCN	0	0	0	0	(190)	(445)	178	313	560				416
Delegated Subtotal	0	0	0	0	(114)	(342)	1,125	1,352	1,720				3,741
Total	**0**	**0**	**0**	**0**	**363**	**5,348**	**5,477**	**5,563**	**4,552**				**21,303**

ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED MARCH 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				
$5,327,843	$1,746,771	($3,581,072)	(205.0%)	PCP Capitation	$40,578,549	$23,348,182	($17,230,368)	(73.8%)
6,289,004	6,610,176	321,172	4.9%	PCP Capitation FQHC	55,379,094	57,572,960	2,193,867	3.8%
502,908	455,898	(47,010)	(10.3%)	Specialty Capitation	3,779,976	3,769,772	(10,203)	(0.3%)
5,556,672	6,004,546	447,874	7.5%	Specialty Capitation FQHC	48,641,743	51,618,642	2,976,899	5.8%
767,761	715,645	(52,116)	(7.3%)	Laboratory Capitation	6,823,468	6,568,203	(255,265)	(3.9%)
345,087	341,214	(3,873)	(1.1%)	Vision Capitation	3,077,651	3,059,922	(17,729)	(0.6%)
114,386	132,635	18,250	13.8%	CFMG Capitation	1,004,312	1,096,895	92,583	8.4%
849,753	292,350	(557,403)	(190.7%)	ANC IPA Admin Capitation FQHC	2,974,421	2,525,395	(449,026)	(17.8%)
0	0	0	0.0%	Kaiser Capitation	(8,639,235)	(8,639,177)	57	0.0%
0	0	0	0.0%	BHT Supplemental Expense	(65,356)	0	65,356	0.0%
0	0	0	0.0%	Maternity Supplemental Expense	37,270	27,953	(9,318)	(33.3%)
1,031,696	869,429	(162,267)	(18.7%)	DME Capitation	9,197,282	8,448,289	(748,993)	(8.9%)
20,785,110	**17,168,664**	**(3,616,446)**	**(21.1%)**	**7. TOTAL CAPITATED EXPENSES**	**162,789,175**	**149,397,036**	**(13,392,139)**	**(9.0%)**
				FEE FOR SERVICE MEDICAL EXPENSES				
4,908,634	0	(4,908,634)	0.0%	IBNR Inpatient Services	30,635,167	(3,303,163)	(33,938,330)	1,027.4%
147,258	0	(147,258)	0.0%	IBNR Settlement (IP)	919,054	(99,094)	(1,018,148)	1,027.5%
392,691	0	(392,691)	0.0%	IBNR Claims Fluctuation (IP)	2,450,812	(264,254)	(2,715,066)	1,027.4%
43,789,469	50,970,413	7,180,944	14.1%	Inpatient Hospitalization FFS	418,706,686	459,019,016	40,312,330	8.8%
4,521,034	0	(4,521,034)	0.0%	IP OB - Mom & NB	28,423,239	12,540,164	(15,883,075)	(126.7%)
207,761	0	(207,761)	0.0%	IP Behavioral Health	5,220,184	1,070,307	(4,149,876)	(387.7%)
1,163,206	0	(1,163,206)	0.0%	Inpatient Facility Rehab FFS	11,458,303	5,770,736	(5,687,567)	(98.6%)
55,130,053	**50,970,413**	**(4,159,640)**	**(8.2%)**	**8. Inpatient Hospital Expense**	**497,813,444**	**474,733,712**	**(23,079,732)**	**(4.9%)**
(521,148)	0	521,148	0.0%	IBNR PCP	727,437	(293,439)	(1,020,876)	347.9%
(15,633)	0	15,633	0.0%	IBNR Settlement (PCP)	21,826	(8,801)	(30,627)	348.0%
(41,692)	0	41,692	0.0%	IBNR Claims Fluctuation (PCP)	126,457	44,791	(81,666)	(182.3%)
4,217,502	2,867,955	(1,349,547)	(47.1%)	PCP FFS	35,957,096	29,511,340	(6,445,755)	(21.8%)
406,880	843,965	437,085	51.8%	PCP FQHC FFS	3,468,456	5,806,017	2,337,561	40.3%
0	0	0	0.0%	Physician Extended Hrs. Incent	19,000	12,000	(7,000)	(58.3%)
0	879,138	879,138	100.0%	Prop 56 Physician Pmt	(12,256,206)	(137,506)	12,118,700	(8,813.2%)
16,497	0	(16,497)	0.0%	Prop 56 Hyde	197,782	64,923	(132,858)	(204.6%)
83,250	0	(83,250)	0.0%	Prop 56 Trauma Screening	182,651	110,133	(72,518)	(65.8%)
84,124	0	(84,124)	0.0%	Prop 56 Developmentl Screening	149,526	96,040	(53,486)	(55.7%)
683,391	0	(683,391)	0.0%	Prop 56 Family Planning	(1,749,072)	(767,666)	981,405	(127.8%)
0	0	0	0.0%	Prop 56 VBP	(2,406,095)	(2,718,741)	(312,647)	11.5%
4,913,171	**4,591,058**	**(322,113)**	**(7.0%)**	**9. Primary Care Physician Expense**	**24,438,857**	**31,719,091**	**7,280,233**	**23.0%**
(1,076,266)	0	1,076,266	0.0%	IBNR Specialist	1,971,994	(747,176)	(2,719,170)	363.9%
(32,288)	0	32,288	0.0%	IBNR Settlement (SCP)	59,164	(22,414)	(81,578)	364.0%
(86,102)	0	86,102	0.0%	IBNR Claims Fluctuation (SCP)	157,758	(59,775)	(217,533)	363.9%
444,805	0	(444,805)	0.0%	Psychiatrist FFS	3,620,736	1,559,071	(2,061,665)	(132.2%)
3,577,515	8,071,334	4,493,820	55.7%	Specialty Care FFS	31,469,771	55,712,107	24,242,336	43.5%
203,078	0	(203,078)	0.0%	Specialty Anesthesiology	2,128,442	1,061,004	(1,067,438)	(100.6%)
1,803,771	0	(1,803,771)	0.0%	Specialty Imaging FFS	14,738,792	6,843,037	(7,895,755)	(115.4%)
30,226	0	(30,226)	0.0%	Obstetrics FFS	336,540	181,208	(155,332)	(85.7%)
490,970	0	(490,970)	0.0%	Specialty IP Surgery FFS	3,614,248	1,679,499	(1,934,749)	(115.2%)
885,407	0	(885,407)	0.0%	Specialty OP Surgery FFS	8,816,265	4,353,452	(4,462,813)	(102.5%)
677,934	0	(677,934)	0.0%	Speciality IP Physician	5,717,539	2,543,833	(3,173,706)	(124.8%)
128,348	125,093	(3,255)	(2.6%)	Specialist FQHC FFS	1,118,005	1,161,549	43,544	3.7%
7,047,398	**8,196,427**	**1,149,030**	**14.0%**	**10. Specialty Care Physician Expense**	**73,749,254**	**74,265,395**	**516,141**	**0.7%**
(553,240)	0	553,240	0.0%	IBNR Ancillary (ANC)	3,703,729	904,191	(2,799,538)	(309.6%)

ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED MARCH 31, 2025

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
(16,597)	0	16,597	0.0%	IBNR Settlement (ANC)	198,175	114,188	(83,987)	(73.6%)
(44,261)	0	44,261	0.0%	IBNR Claims Fluctuation (ANC)	460,210	236,248	(223,962)	(94.8%)
676,639	0	(676,639)	0.0%	IBNR Transportation FFS	624,048	207,856	(416,193)	(200.2%)
2,245,037	0	(2,245,037)	0.0%	Behavioral Health Therapy FFS	19,180,338	8,190,565	(10,989,773)	(134.2%)
2,284,141	0	(2,284,141)	0.0%	Psychologist & Other MH Prof	17,003,024	7,234,250	(9,768,774)	(135.0%)
524,886	0	(524,886)	0.0%	Other Medical Professional	4,158,195	1,865,835	(2,292,360)	(122.9%)
103,388	0	(103,388)	0.0%	Hearing Devices	1,312,858	674,558	(638,300)	(94.6%)
23,100	0	(23,100)	0.0%	ANC Imaging	340,209	228,147	(112,062)	(49.1%)
68,213	0	(68,213)	0.0%	Vision FFS	658,952	280,298	(378,654)	(135.1%)
0	0	0	0.0%	Family Planning	56	10	(46)	(464.6%)
615,358	0	(615,358)	0.0%	Laboratory FFS	9,872,600	6,593,456	(3,279,145)	(49.7%)
139,041	0	(139,041)	0.0%	ANC Therapist	1,329,356	644,262	(685,093)	(106.3%)
2,177,962	0	(2,177,962)	0.0%	Transp/Ambulance FFS	13,992,420	5,962,027	(8,030,394)	(134.7%)
3,547,359	0	(3,547,359)	0.0%	Non-ER Transportation FFS	21,863,842	8,526,483	(13,337,358)	(156.4%)
1,704,528	0	(1,704,528)	0.0%	Hospice FFS	20,615,497	9,250,960	(11,364,537)	(122.8%)
1,723,897	0	(1,723,897)	0.0%	Home Health Services	15,905,293	7,088,754	(8,816,540)	(124.4%)
0	14,368,901	14,368,901	100.0%	Other Medical FFS	128	71,180,177	71,180,049	100.0%
87,078	0	(87,078)	0.0%	Medical Refunds through HMS	695,849	290,192	(405,657)	(139.8%)
0	0	0	0.0%	Medical Refunds	10,037	0	(10,037)	0.0%
35,807	0	(35,807)	0.0%	DME & Medical Supplies FFS	342,627	187,833	(154,794)	(82.4%)
2,814,265	2,278,027	(536,238)	(23.5%)	ECM Base/Outreach FFS ANC	2,622,960	1,772,809	(850,152)	(48.0%)
146,299	101,957	(44,342)	(43.5%)	CS Housing Deposits FFS ANC	1,003,222	983,374	(19,848)	(2.0%)
957,292	804,299	(152,993)	(19.0%)	CS Housing Tenancy FFS ANC	6,797,366	7,167,262	369,896	5.2%
537,728	446,560	(91,169)	(20.4%)	CS Housing Navi Servic FFS ANC	4,010,860	4,115,795	104,935	2.5%
339,510	716,333	376,823	52.6%	CS Medical Respite FFS ANC	5,245,108	6,053,068	807,960	13.3%
251,338	162,595	(88,743)	(54.6%)	CS Med. Tailored Meals FFS ANC	2,193,299	1,689,569	(503,730)	(29.8%)
12,822	25,195	12,373	49.1%	CS Asthma Remediation FFS ANC	88,734	143,874	55,141	38.3%
0	9,868	9,868	100.0%	MOT Wrap Around (Non Med MOT)	0	49,817	49,817	100.0%
0	9,974	9,974	100.0%	CS Home Modifications FFS ANC	24,053	74,021	49,968	67.5%
92,597	527,790	435,193	82.5%	CS P.Care & Hmker Svcs FFS ANC	2,286,983	4,153,083	1,866,100	44.9%
4,826	19,963	15,137	75.8%	CS Cgiver Respite Svcs FFS ANC	53,775	142,309	88,534	62.2%
755,948	0	(755,948)	0.0%	CommunityBased Adult Svc(CBAS)	4,256,721	2,203,374	(2,053,347)	(93.2%)
18,923	25,000	6,077	24.3%	CS LTC Diversion FFS ANC	163,922	192,778	28,857	15.0%
0	7,469	7,469	100.0%	CS LTC Transition FFS ANC	5,003	37,461	32,458	86.6%
21,273,884	**19,503,930**	**(1,769,954)**	**(9.1%)**	**11. Ancillary Medical Expense**	**161,019,450**	**158,438,885**	**(2,580,565)**	**(1.6%)**
(541,848)	0	541,848	0.0%	IBNR Outpatient	4,843,804	231,629	(4,612,175)	(1,991.2%)
(16,254)	0	16,254	0.0%	IBNR Settlement (OP)	145,319	6,949	(138,370)	(1,991.2%)
(43,349)	0	43,349	0.0%	IBNR Claims Fluctuation (OP)	387,499	18,527	(368,971)	(1,991.5%)
2,121,494	11,466,421	9,344,927	81.5%	Outpatient FFS	21,828,411	68,312,666	46,484,254	68.0%
2,745,731	0	(2,745,731)	0.0%	OP Ambul Surgery FFS	24,589,472	11,593,959	(12,995,513)	(112.1%)
2,330,038	0	(2,330,038)	0.0%	Imaging Services FFS	22,971,409	10,130,403	(12,841,007)	(126.8%)
122,154	0	(122,154)	0.0%	Behavioral Health FFS	409,493	97,460	(312,032)	(320.2%)
800,375	0	(800,375)	0.0%	Outpatient Facility Lab FFS	6,689,576	2,863,424	(3,826,152)	(133.6%)
216,889	0	(216,889)	0.0%	Outpatient Facility Cardio FFS	1,876,385	844,453	(1,031,932)	(122.2%)
89,343	0	(89,343)	0.0%	OP Facility PT/OT/ST FFS	891,221	400,408	(490,813)	(122.6%)
3,237,070	0	(3,237,070)	0.0%	OP Facility Dialysis Ctr FFS	28,323,029	12,647,437	(15,675,592)	(123.9%)
11,061,642	**11,466,421**	**404,779**	**3.5%**	**12. Outpatient Medical Expense**	**112,955,618**	**107,147,315**	**(5,808,303)**	**(5.4%)**
374,334	0	(374,334)	0.0%	IBNR Emergency	2,561,864	(165,803)	(2,727,667)	1,645.1%
11,231	0	(11,231)	0.0%	IBNR Settlement (ER)	76,857	(4,974)	(81,831)	1,645.1%
29,946	0	(29,946)	0.0%	IBNR Claims Fluctuation (ER)	204,945	(13,266)	(218,211)	1,644.9%
7,905,570	10,408,431	2,502,861	24.0%	ER Facility	79,051,235	89,148,430	10,097,195	11.3%
1,224,139	0	(1,224,139)	0.0%	Specialty ER Physician FFS	10,968,960	4,880,392	(6,088,568)	(124.8%)
9,545,220	**10,408,431**	**863,211**	**8.3%**	**13. Emergency Expense**	**92,863,861**	**93,844,779**	**980,918**	**1.0%**
2,019,069	0	(2,019,069)	0.0%	IBNR Pharmacy (OP)	4,088,446	1,991,773	(2,096,673)	(105.3%)

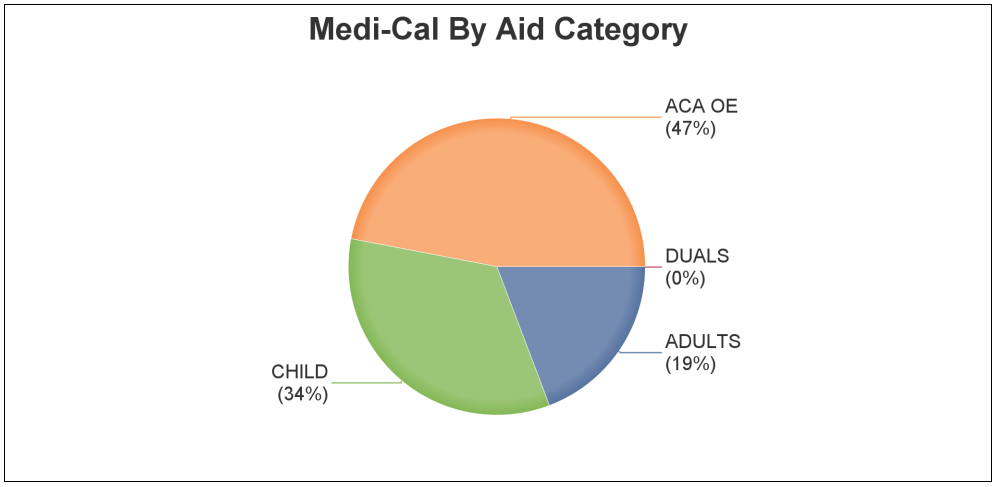
ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED MARCH 31, 2025

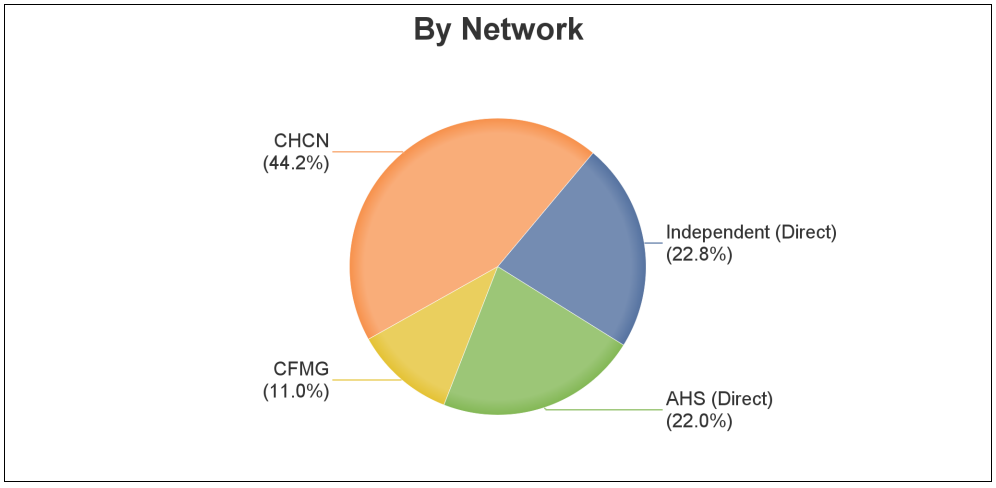
CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
60,572	0	(60,572)	0.0%	IBNR Settlement Rx (OP)	122,654	59,755	(62,899)	(105.3%)
161,527	0	(161,527)	0.0%	IBNR Claims Fluctuation Rx(OP)	327,079	159,342	(167,737)	(105.3%)
656,183	454,372	(201,811)	(44.4%)	Pharmacy FFS (OP)	6,358,501	5,331,265	(1,027,236)	(19.3%)
246,521	11,388,475	11,141,955	97.8%	Pharmacy Non PBM FFS Other-ANC	1,168,448	58,476,368	57,307,920	98.0%
8,421,147	0	(8,421,147)	0.0%	Pharmacy Non PBM FFS OP-FAC	83,037,524	39,326,556	(43,710,968)	(111.1%)
303,850	0	(303,850)	0.0%	Pharmacy Non PBM FFS PCP	2,113,294	985,563	(1,127,731)	(114.4%)
2,331,248	0	(2,331,248)	0.0%	Pharmacy Non PBM FFS SCP	21,679,654	10,617,727	(11,061,927)	(104.2%)
25,028	0	(25,028)	0.0%	Pharmacy Non PBM FFS FQHC	192,095	82,575	(109,520)	(132.6%)
15,899	0	(15,899)	0.0%	Pharmacy Non PBM FFS HH	170,605	91,629	(78,976)	(86.2%)
(39)	0	39	0.0%	RX Refunds HMS	(345)	(306)	39	(12.6%)
(50,000)	50,966	100,966	198.1%	Medical Expenses Pharm Rebate	(314,571)	40,996	355,568	867.3%
14,191,005	**11,893,814**	**(2,297,191)**	**(19.3%)**	**14. Pharmacy Expense**	**118,943,383**	**117,163,241**	**(1,780,142)**	**(1.5%)**
656,138	0	(656,138)	0.0%	IBNR LTC	18,763,707	(3,756,936)	(22,520,643)	599.4%
19,685	0	(19,685)	0.0%	IBNR Settlement (LTC)	562,911	(112,709)	(675,620)	599.4%
52,491	0	(52,491)	0.0%	IBNR Claims Fluctuation (LTC)	1,501,095	(300,555)	(1,801,650)	599.4%
1,829,758	0	(1,829,758)	0.0%	LTC - ICF/DD	14,352,809	6,755,726	(7,597,083)	(112.5%)
26,143,811	0	(26,143,811)	0.0%	LTC Custodial Care	211,158,617	99,683,289	(111,475,328)	(111.8%)
7,009,681	33,184,441	26,174,760	78.9%	LTC SNF	67,848,212	197,303,573	129,455,361	65.6%
35,711,564	**33,184,441**	**(2,527,123)**	**(7.6%)**	**15. Long Term Care Expense**	**314,187,350**	**299,572,387**	**(14,614,963)**	**(4.9%)**
158,873,937	**150,214,935**	**(8,659,001)**	**(5.8%)**	**16. TOTAL FFS MEDICAL EXPENSES**	**1,395,971,217**	**1,356,884,805**	**(39,086,412)**	**(2.9%)**
0	49,772	49,772	100.0%	Clinical Vacancy #102	0	(958,464)	(958,464)	100.0%
177,496	293,123	115,627	39.4%	Quality Analytics #123	1,854,426	2,031,812	177,386	8.7%
338,613	325,975	(12,638)	(3.9%)	LongTerm Services and Support #139	2,392,813	2,532,296	139,483	5.5%
893,288	859,148	(34,140)	(4.0%)	Utilization Management #140	8,645,920	8,644,368	(1,551)	0.0%
737,538	640,000	(97,538)	(15.2%)	Case & Disease Management #185	6,359,843	6,268,665	(91,177)	(1.5%)
329,198	799,977	470,779	58.8%	Medical Management #230	8,687,038	10,311,670	1,624,632	15.8%
805,523	968,786	163,263	16.9%	Quality Improvement #235	9,127,185	11,258,229	2,131,044	18.9%
339,206	364,431	25,225	6.9%	HCS Behavioral Health #238	2,944,092	3,197,377	253,285	7.9%
154,675	200,653	45,977	22.9%	Pharmacy Services #245	1,152,347	2,066,459	914,112	44.2%
58,027	60,759	2,731	4.5%	Regulatory Readiness #268	572,093	620,955	48,862	7.9%
3,833,565	**4,562,623**	**729,058**	**16.0%**	**17. Other Benefits & Services**	**41,735,757**	**45,973,367**	**4,237,610**	**9.2%**
(1,390,769)	(1,289,443)	101,327	(7.9%)	Reinsurance Recoveries	(18,773,427)	(13,247,243)	5,526,184	(41.7%)
1,689,656	1,719,257	29,600	1.7%	Reinsurance Premium	15,614,814	15,711,300	96,486	0.6%
298,887	**429,814**	**130,927**	**30.5%**	**18. Reinsurance Expense**	**(3,158,613)**	**2,464,057**	**5,622,670**	**228.2%**
183,791,498	**172,376,037**	**(11,415,461)**	**(6.6%)**	**20. TOTAL MEDICAL EXPENSES**	**1,597,337,536**	**1,554,719,266**	**(42,618,270)**	**(2.7%)**

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend

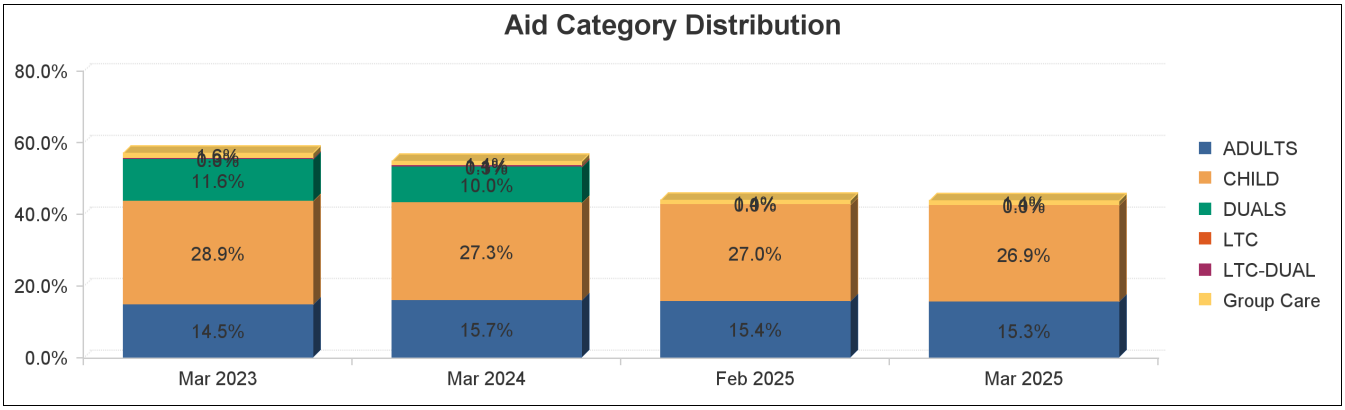
Category of Aid	Mar 2025	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN
ADULTS	63,278	16%	13,812	14,115	6	35,345
CHILD	111,153	27%	10,070	13,460	42,206	45,417
SPD	0	0%	0	0	0	0
ACA OE	154,579	38%	27,917	53,816	1,517	71,329
DUALS	1	0%	1	0	0	0
LTC	0	0%	0	0	0	0
LTC-DUAL	0	0%	0	0	0	0
SPD-LTC	29,609	7%	8,816	5,067	1,470	14,256
SPD-LTC/Full Dual	48,241	12%	31,127	3,526	4	13,584
Medi-Cal	406,861		91,743	89,984	45,203	179,931
Group Care	5,882		2,207	973	0	2,702
Total	**412,743**	**100%**	**93,950**	**90,957**	**45,203**	**182,633**
Medi-Cal %	98.6%		97.7%	98.9%	100.0%	98.5%
Group Care %	1.4%		2.3%	1.1%	0.0%	1.5%
	Network Distribution		**22.8%**	**22.0%**	**11.0%**	**44.2%**
			% Direct:	**45%**	**% Delegated:**	**55%**





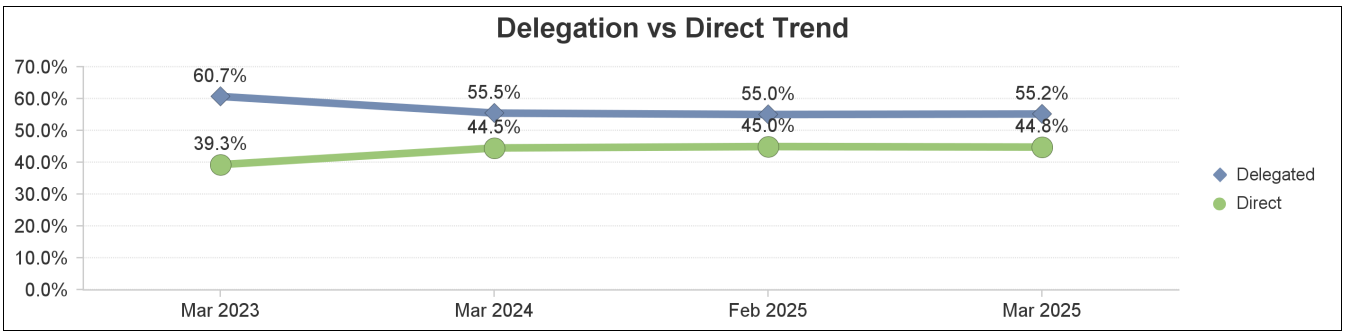
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Mar 2023	Mar 2024	Feb 2025	Mar 2025	Mar 2023	Mar 2024	Feb 2025	Mar 2025	Mar 2023 to Mar 2024	Mar 2024 to Mar 2025	Feb 2025 to Mar 2025
ADULTS	51,516	63,314	63,758	**63,278**	14.5%	15.7%	15.4%	15.3%	18.6%	-0.1%	-0.8%
CHILD	102,510	110,268	111,576	**111,153**	28.9%	27.3%	27.0%	26.9%	7.0%	0.8%	-0.4%
SPD	31,021	34,972	0	**0**	8.7%	8.7%	0.0%	0.0%	11.3%	0.0%	0.0%
ACA OE	121,852	148,065	154,609	**154,579**	34.3%	36.7%	37.4%	37.5%	17.7%	4.2%	0.0%
DUALS	41,246	40,222	2	**1**	11.6%	10.0%	0.0%	0.0%	-2.5%	##########	-100.0%
LTC	143	216	0	**0**	0.0%	0.1%	0.0%	0.0%	33.8%	0.0%	0.0%
LTC-DUAL	948	1,307	0	**0**	0.3%	0.3%	0.0%	0.0%	27.5%	0.0%	0.0%
SPD-LTC	0	0	29,497	**29,609**	0.0%	0.0%	7.1%	7.2%	0.0%	100.0%	0.4%
SPD-LTC/ Full Dual	0	0	48,100	**48,241**	0.0%	0.0%	11.6%	11.7%	0.0%	100.0%	0.3%
Medi-Cal	349,236	398,364	407,542	**406,861**	98.4%	98.6%	98.6%	98.6%	12.3%	2.1%	-0.2%
Group Care	5,723	5,620	5,812	**5,882**	1.6%	1.4%	1.4%	1.4%	-1.8%	4.5%	1.2%
Total	**354,959**	**403,984**	**413,354**	**412,743**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**12.1%**	**2.1%**	**-0.1%**



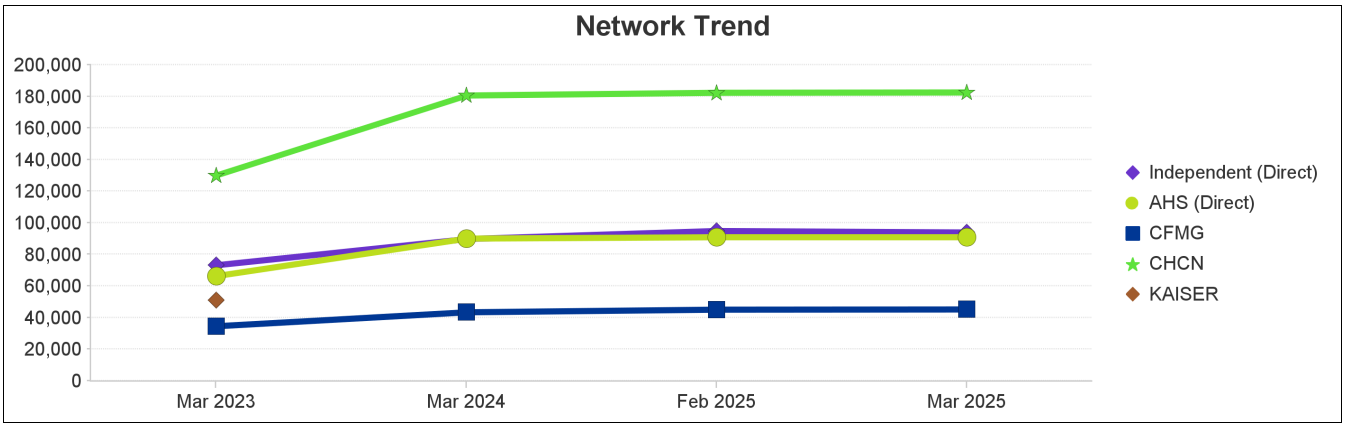
Delegation vs Direct Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	Mar 2023	Mar 2024	Feb 2025	Mar 2025	Mar 2023	Mar 2024	Feb 2025	Mar 2025	Mar 2023 to Mar 2024	Mar 2024 to Mar 2025	Feb 2025 to Mar 2025
Delegated	215,530	224,105	227,504	**227,836**	60.7%	55.5%	55.0%	55.2%	3.8%	1.6%	0.1%
Direct	139,429	179,879	185,850	**184,907**	39.3%	44.5%	45.0%	44.8%	22.5%	2.7%	-0.5%
Total	**354,959**	**403,984**	**413,354**	**412,743**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**12.1%**	**2.1%**	**-0.1%**



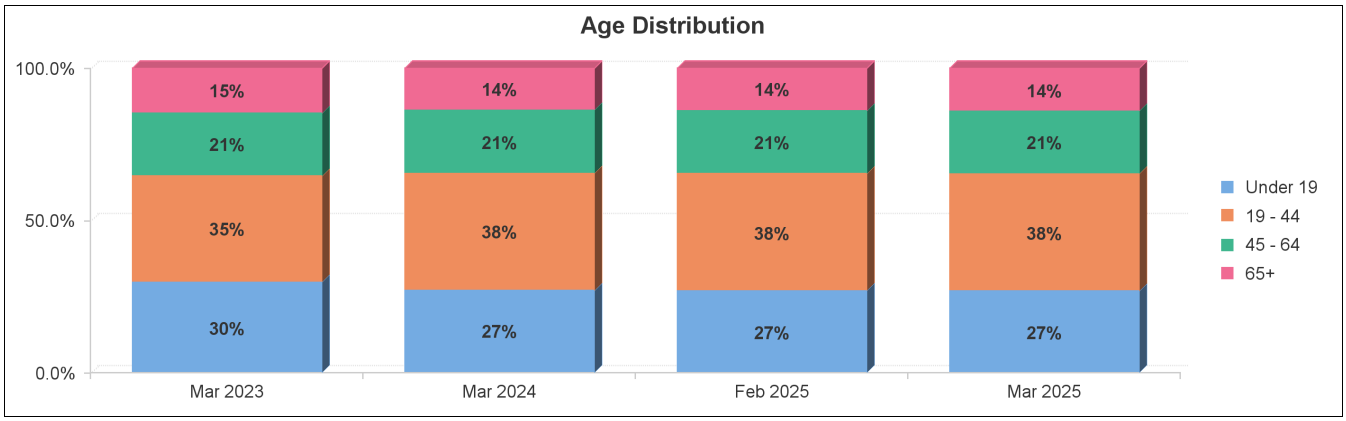
Network Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Mar 2023	Mar 2024	Feb 2025	Mar 2025	Mar 2023	Mar 2024	Feb 2025	Mar 2025	Mar 2023 to Mar 2024	Mar 2024 to Mar 2025	Feb 2025 to Mar 2025
Independent (Direct)	73,153	89,790	94,899	**93,950**	20.6%	22.2%	23.0%	22.8%	18.5%	4.4%	-1.0%
AHS (Direct)	66,276	90,089	90,951	**90,957**	18.7%	22.3%	22.0%	22.0%	26.4%	1.0%	0.0%
CFMG	34,547	43,413	45,079	**45,203**	9.7%	10.7%	10.9%	11.0%	20.4%	4.0%	0.3%
CHCN	129,908	180,692	182,425	**182,633**	36.6%	44.7%	44.1%	44.2%	28.1%	1.1%	0.1%
KAISER	51,075	0	0	**0**	14.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	**354,959**	**403,984**	**413,354**	**412,743**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**12.1%**	**2.1%**	**-0.1%**



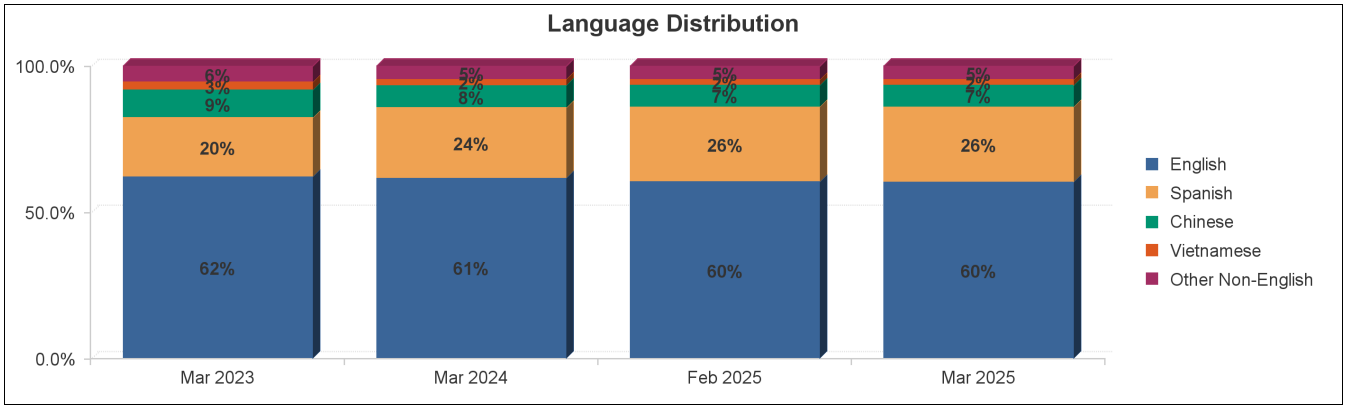
Age Category Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Mar 2023	Mar 2024	Feb 2025	Mar 2025	Mar 2023	Mar 2024	Feb 2025	Mar 2025	Mar 2023 to Mar 2024	Mar 2024 to Mar 2025	Feb 2025 to Mar 2025
Under 19	104,866	108,522	110,599	**110,282**	30%	27%	27%	27%	3%	2%	0%
19 - 44	124,034	155,233	159,068	**158,678**	35%	38%	38%	38%	20%	2%	0%
45 - 64	72,979	83,951	85,271	**85,158**	21%	21%	21%	21%	13%	1%	0%
65+	53,080	56,278	58,416	**58,625**	15%	14%	14%	14%	6%	4%	0%
Total	**354,959**	**403,984**	**413,354**	**412,743**	**100%**	**100%**	**100%**	**100%**	**12%**	**2%**	**0%**



Language Trend

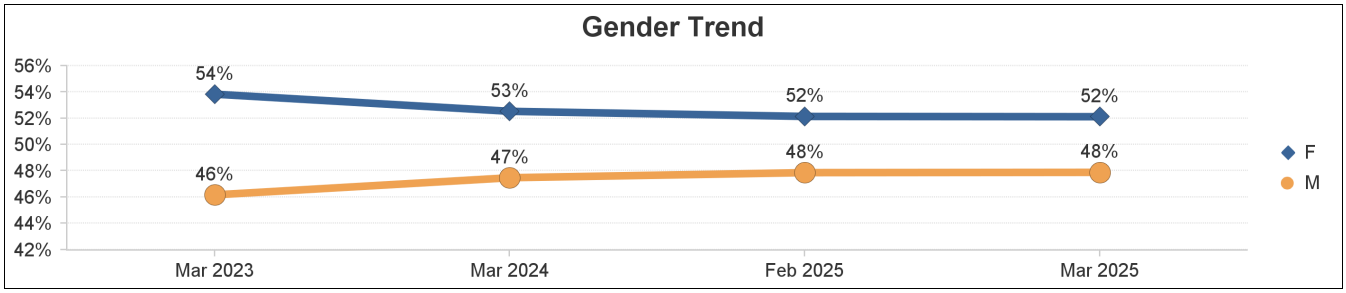
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	Mar 2023	Mar 2024	Feb 2025	Mar 2025	ar 2023	ar 2024	Feb 2025	ar 2025	Mar 2023 to Mar 2024	Mar 2024 to Mar 2025	Feb 2025 to Mar 2025
English	219,911	248,207	248,996	**248,349**	62%	61%	60%	60%	11%	0%	0%
Spanish	71,737	97,569	105,721	**105,898**	20%	24%	26%	26%	26%	8%	0%
Chinese	33,645	30,760	30,594	**30,544**	9%	8%	7%	7%	-9%	-1%	0%
Vietnamese	9,773	8,536	8,238	**8,209**	3%	2%	2%	2%	-14%	-4%	0%
Other Non-English	19,893	18,912	19,805	**19,743**	6%	5%	5%	5%	-5%	4%	0%
Total	**354,959**	**403,984**	**413,354**	**412,743**	**100%**	**100%**	**100%**	**100%**	**12%**	**2%**	**0%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

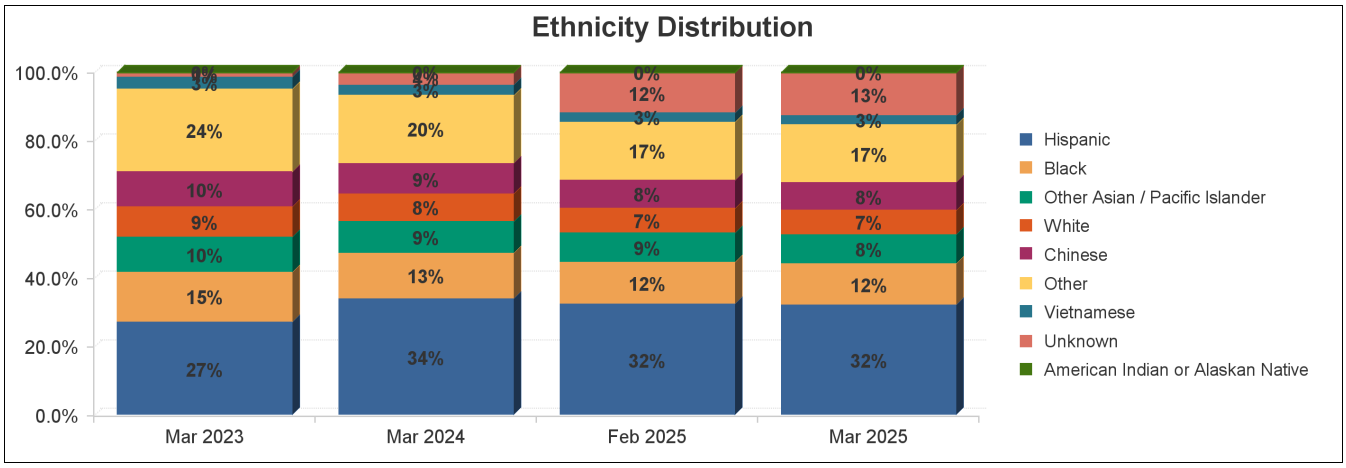
Gender Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Mar 2023	Mar 2024	Feb 2025	Mar 2025	Mar 2023	Mar 2024	Feb 2025	Mar 2025	Mar 2023 to Mar 2024	Mar 2024 to Mar 2025	Feb 2025 to Mar 2025
F	191,101	212,211	215,525	**215,119**	54%	53%	52%	52%	10%	1%	0%
M	163,858	191,773	197,829	**197,624**	46%	47%	48%	48%	15%	3%	0%
Total	**354,959**	**403,984**	**413,354**	**412,743**	**100%**	**100%**	**100%**	**100%**	**12%**	**2%**	**0%**



Ethnicity Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Mar 2023	Mar 2024	Feb 2025	Mar 2025	Mar 2023	Mar 2024	Feb 2025	Mar 2025	Mar 2023 to Mar 2024	Mar 2024 to Mar 2025	Feb 2025 to Mar 2025
Hispanic	95,858	136,557	133,402	**132,032**	27%	34%	32%	32%	30%	-3%	-1%
Black	51,755	53,627	50,373	**49,884**	15%	13%	12%	12%	3%	-8%	-1%
Other Asian / Pacific Islander	36,336	37,287	35,321	**34,933**	10%	9%	9%	8%	3%	-7%	-1%
White	31,596	32,857	29,853	**29,347**	9%	8%	7%	7%	4%	-12%	-2%
Chinese	36,098	35,796	33,774	**33,490**	10%	9%	8%	8%	-1%	-7%	-1%
Other	85,859	80,230	70,242	**69,451**	24%	20%	17%	17%	-7%	-16%	-1%
Vietnamese	12,260	12,036	11,084	**10,972**	3%	3%	3%	3%	-2%	-10%	-1%
Unknown	4,460	14,794	48,550	**51,888**	1%	4%	12%	13%	70%	71%	6%
American Indian or Alaskan Native	737	800	755	**746**	0%	0%	0%	0%	8%	-7%	-1%
Total	**354,959**	**403,984**	**413,354**	**412,743**	**100%**	**100%**	**100%**	**100%**	**12%**	**2%**	**0%**



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

Medi-Cal By City

City	Mar 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	162,499	40%	24,887	42,220	17,615	77,777
HAYWARD	54,388	13%	12,155	15,314	6,097	20,822
FREMONT	38,681	10%	16,167	6,758	2,462	13,294
SAN LEANDRO	26,625	7%	7,156	4,427	3,351	11,691
UNION CITY	14,711	4%	5,766	2,654	879	5,412
ALAMEDA	13,868	3%	3,350	2,486	2,085	5,947
BERKELEY	15,752	4%	4,044	2,378	1,830	7,500
LIVERMORE	13,306	3%	1,987	550	2,270	8,499
NEWARK	9,527	2%	2,776	4,145	591	2,015
CASTRO VALLEY	11,134	3%	3,176	1,793	1,767	4,398
SAN LORENZO	6,309	2%	1,312	1,429	732	2,836
PLEASANTON	8,036	2%	2,018	387	870	4,761
DUBLIN	7,747	2%	2,195	383	934	4,235
EMERYVILLE	2,956	1%	642	624	483	1,207
ALBANY	2,596	1%	635	299	592	1,070
PIEDMONT	496	0%	119	172	82	123
SUNOL	86	0%	26	14	7	39
ANTIOCH	21	0%	6	7	5	3
Other	18,123	4%	3,326	3,944	2,551	8,302
Total	406,861	100%	**91,743**	**89,984**	**45,203**	**179,931**

Group Care By City

City	Mar 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	1,829	31%	341	367	0	1,121
HAYWARD	663	11%	314	169	0	180
FREMONT	670	11%	446	82	0	142
SAN LEANDRO	611	10%	252	88	0	271
UNION CITY	296	5%	188	42	0	66
ALAMEDA	307	5%	87	26	0	194
BERKELEY	147	2%	48	11	0	88
LIVERMORE	102	2%	33	3	0	66
NEWARK	143	2%	83	35	0	25
CASTRO VALLEY	201	3%	86	30	0	85
SAN LORENZO	146	2%	46	28	0	72
PLEASANTON	70	1%	23	4	0	43
DUBLIN	127	2%	43	6	0	78
EMERYVILLE	41	1%	17	5	0	19
ALBANY	22	0%	11	1	0	10
PIEDMONT	8	0%	1	1	0	6
SUNOL	1	0%	1	0	0	0
ANTIOCH	25	0%	9	4	0	12
Other	473	8%	178	71	0	224
Total	**5,882**	**100%**	**2,207**	**973**	**0**	**2,702**

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

Total By City

City	Mar 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	164,328	40%	25,228	42,587	17,615	78,898
HAYWARD	55,051	13%	12,469	15,483	6,097	21,002
FREMONT	39,351	10%	16,613	6,840	2,462	13,436
SAN LEANDRO	27,236	7%	7,408	4,515	3,351	11,962
UNION CITY	15,007	4%	5,954	2,696	879	5,478
ALAMEDA	14,175	3%	3,437	2,512	2,085	6,141
BERKELEY	15,899	4%	4,092	2,389	1,830	7,588
LIVERMORE	13,408	3%	2,020	553	2,270	8,565
NEWARK	9,670	2%	2,859	4,180	591	2,040
CASTRO VALLEY	11,335	3%	3,262	1,823	1,767	4,483
SAN LORENZO	6,455	2%	1,358	1,457	732	2,908
PLEASANTON	8,106	2%	2,041	391	870	4,804
DUBLIN	7,874	2%	2,238	389	934	4,313
EMERYVILLE	2,997	1%	659	629	483	1,226
ALBANY	2,618	1%	646	300	592	1,080
PIEDMONT	504	0%	120	173	82	129
SUNOL	87	0%	27	14	7	39
ANTIOCH	46	0%	15	11	5	15
Other	18,596	5%	3,504	4,015	2,551	8,526
Total	412,743	100%	**93,950**	**90,957**	**45,203**	**182,633**

Operations

Ruth Watson

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

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

Date: **May 9th, 2025**

Subject: **Operations Report**

Member Services

- 12-Month Trend Blended Summary:
    - The Member Services (MS) Department received 19,970 calls in April 2025 compared to 20,951 in April 2024 and represents a 5% decrease in calls.
    - The abandonment rate for April 2025 was 6% compared to 9% in April 2024. The Secure Link outage on April 21, 2025, impacted the abandonment rate. The vendor was unable to access internal systems for most of the day, leading to a pause in calls to the overflow vendor. Consequently, all calls were handled by Member Services. The issue was escalated to the IT Department for further investigation and troubleshooting.
    - The Department's service level was 93% in April 2025, compared to 84% in April 2024. The average speed to answer (ASA) was fifteen seconds (00:15) compared to nineteen seconds (00:19) in April 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 twenty-five seconds (07:25) for April 2025 compared to six minutes and fifty-seven seconds (06:57) for April 2024.
    - 100% of calls were answered within 10 minutes for April 2025 and 98% of calls were answered within 10 minutes for April 2024.
    - Outbound calls totaled 9,727 in April 2025 compared to 9,098 in April 2024.
    - The top five call reasons for April 2025 were: 1) Change of PCP, 2) Eligibility/Enrollment, 3) Grievances/Appeals, 4) Benefits, 5) Provider Network. The top five call reasons for April 2024 were: 1) Change of PCP, 2) Eligibility/Enrollment 3) Benefits, 4) Provider Network, 5) Grievances/Appeals.
    - April utilization for the member automated eligibility IVR system totaled 1,400 in April 2025 compared to 1,492 in April 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 1,226) web-based requests in April 2025 compared to 1,182) in April 2024. The top three web reason requests for April 2025 were: 1) Change of PCP, 2) ID Card Requests, 3) Update Contact Information. 45 members were assisted in-person in April 2025 compared to 38 in 2024.

- Member Services Behavioral Health:

    - The Member Services Behavioral Health (BH) Unit received a total of 1,369 calls in April 2025 compared to 1,614 in April 2024.
    - The abandonment rate was 4% in April 2025 compared to 27% in 2024.
    - The service level was 92% in April 2025 and 57% in April 2024.
    - The average speed to answer (ASA) was twenty-four seconds (00:24) compared to three minutes and six seconds (03:06) in April 2024.
    - Calls answered in 10 minutes were 100% in April 2025 compared to 90% in April 2024.
    - The Average Talk Time (ATT) was eight minutes and thirty seconds (08:30) compared to nine minutes and thirty-four seconds (09:34) in April 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.
    - 1,287 outbound calls were completed in April 2025 compared to 1,446 in April 2024.
    - 136 screenings were completed in April 2025 compared to 166 in April 2024.
    - 29 outreach campaigns were completed in April 2025 compared to 312 in April 2024; the decrease was due to process change. The BH Team is managing provider referrals.
    - 31 referrals were made to the County (ACCESS) in April 2025 compared to 52 in April 2024.
    - 21 members were referred to Center Point for SUD services in April 2025 compared to nineteen 19 in April 2024.

Claims

- 12-Month Trend Summary:

    - The Claims Department received 372,126 claims in April 2025 compared to 322,786 in April 2024.
    - The Auto Adjudication rate was 88.3% in April 2025 compared to 83.4% in April 2024.
    - Claims compliance for the 30-day turn-around time was 90.4% in April 2025 compared to 92.5% in April 2024. The 45-day turn-around time was 95.5% in April 2025 compared to 100% in April 2024.

- Monthly Analysis:
    - In the month of April, we received a total of 372,126 claims in the HEALTHsuite system; this reflects a 7% increase from March 2025. It is also higher than the number of claims received in April 2024 by 49,340.
    - Drivers of the higher volume of claims received includes:
        - Increased membership and higher utilization of services
        - Certain provider types that bill more frequently, e.g., LTC facilities that bill weekly or bi-weekly
        - Providers with dual eligible members who are submitting paper claims even though we receive the same claim in our COBA file.
    - 88% of claims were received via EDI and 12% of claims via paper during April.
    - 95.5% of our claims were processed within 45 working days during the month.
    - The Auto Adjudication rate was 88.3% for the month of April.

Provider Dispute Resolution

- 12-Month Trend Summary:
    - In April 2025, the Provider Dispute Resolution (PDR) team received 3,411 PDRs; this reflects a decrease of 37.9% from March 2025. It does, however, represent an increase of 1,486 PDRs (77%) from April 2024.
    - The PDR team resolved 1,889 cases in April 2025 compared to 1,601 cases in April 2024.
    - In April 2025, the PDR team upheld 72% of cases versus 67% in April 2024.
    - The PDR team resolved 99.7% of cases within the compliance standard of 95% within 45 working days in April 2025, compared to 99.6% in April 2024.
- Monthly Analysis:
    - The Alliance received 3,411 PDRs in April 2025.
    - In the month of April, 1,889, PDRs were resolved with 1,354 being upheld and 535 being overturned.
    - 1,883 out of 1,889 cases were resolved within 45 working days, resulting in a 99.7% compliance rate.
    - The average turnaround time for resolving PDRs in April was 37 days.
    - There were 4,923 PDRs pending resolution as of 04/30/2025, with no cases older than 45 working days.
    - The overturn rate for PDRs was 28%, which did not meet our 25% or less goal.

- The primary reason that caused the Department to miss their goal of 25% or less was:
    - Member OHC corrections – 128 cases that were denied incorrectly. The Alliance will be mitigating this issue by eliminating the use of the data file that is providing inaccurate OHC information.
    - Authorization issues – 142 cases that were denied incorrectly (claim denied in error; authorization was on file).
    - The full breakdown of all **535** overturned PDRs is:

Category	# of Cases	% of Cases	Comments
System Related Issues	**81**	**14%**	
General configuration issues	30	5%	Non-covered code, modifier, etc.
Financial responsibility	37	6%	MNF
Claims Editing System (CES)	14	3%	
Authorization Issues	**142**	**26%**	
Processor error	92	17%	Claim denied in error; authorization was on file
UM/retro auth review	45	8%	Retro medical necessity review
Auth System error	5	1%	
OHC Issues	**128**	**24%**	Inaccurate OHC Member TPL data
Incorrect Rates	**122**	**23%**	
Incorrect rate – System	88	16%	AB1629 rate change, contract update
Letter of Agreement (LOA)	10	2%	Underpaid; LOA on file
COB calculation	9	2%	Incorrectly calculated
Incorrect rate – Processor	15	3%	The processor did not calculate the rate correctly according to the contract or rate sheet.
Claim Processing Error	**38**	**7%**	
Duplicate claim	14	3%	The claim was a duplicate; the processor paid it in error
Incorrect Manual Denial	16	3%	The claim was manually denied incorrectly
Overpayment	8	1%	Provider request recoupment due to overpayment
Additional Documentation	**24**	**6%**	
Provider duplicate claim	19	4%	The documentation received confirmed claim was not a duplicate
Timely filing	1	1%	The documentation received confirmed that the claim was submitted on time
Provider billing	4	1%	Corrected claim due to provider error
PDR Overturn Totals	**535**	**100%**	

Grievances & Appeals

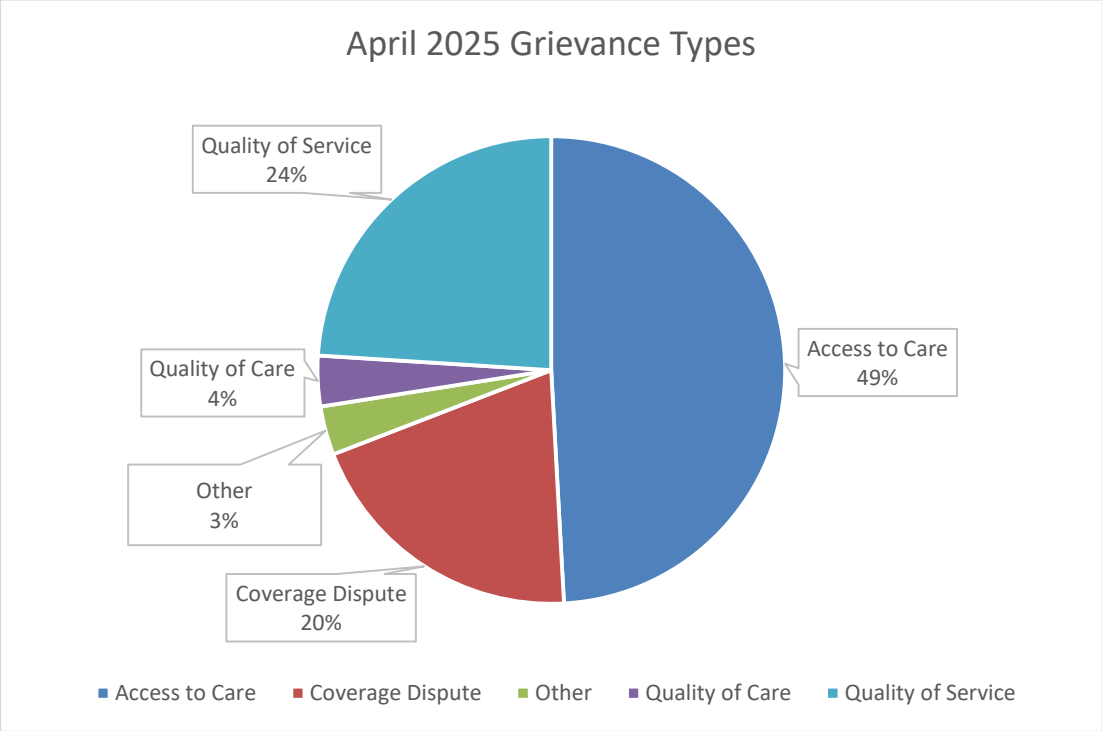
- Standard Grievance cases were not resolved within the goal of 95% of regulatory timeframes.
- Standard Appeal cases were not resolved within the 95% of regulatory timeframes.
- Total Unique grievances resolved in April were 8.62 complaints per 1,000 members.

April 2025 Cases	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate	Per 1,000 Members*
Standard Grievance	2,345	30 Calendar Days	95% compliance within standard	2,178	92.9%	3.81
Expedited Grievance	1	72 Hours	95% compliance within standard	1	100.00%	0.002
Exempt Grievance	1,804	Next Business Day	95% compliance within standard	1,799	99.7%	3.75
Standard Appeal	56	30 Calendar Days	95% compliance within standard	52	92.8%	0.13
Expedited Appeal	3	72 Hours	95% compliance within standard	3	100.00%	0.007
Total Cases:	4,209		95% compliance within standard	4,033	95.8%	8.62

*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 1,998 unique grievance cases resolved during the reporting period, with a total of 2,345 grievances including all 347 shadow cases.



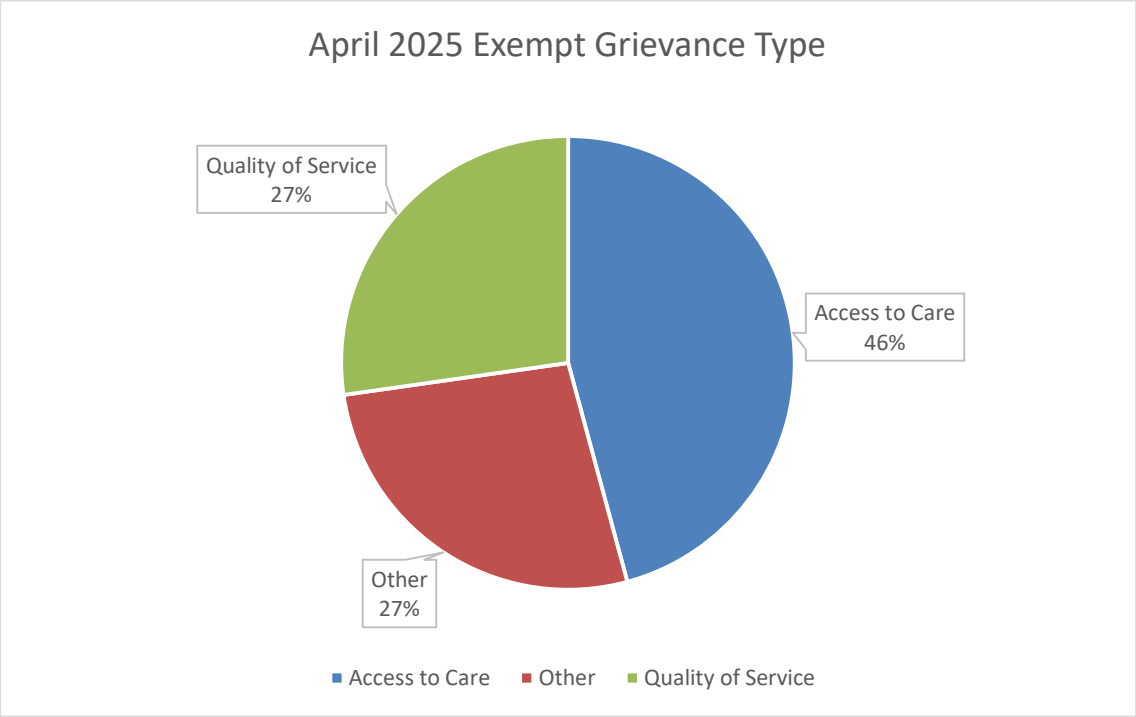
- **1,153** of 2,346 (49%) cases were related to Access to Care; the top four (4) grievance categories are:
  - (380) Timely Access
  - (359) Technology/Telephone
  - (166) Authorization
  - (150) Provider Availability

- **563** of 2,346 (24%) cases were related to Quality of Service; the top three (3) categories are:
  - (122) Plan Customer Service
  - (97) Provider/Staff Attitude
  - (90) Transportation

- **469** of 2,346 (20%) cases were related to Coverage Dispute; the top two (2) grievance categories are:
  - (22) Provider Direct Member Billing
  - (133) Provider Balance Billing

Exempt Grievances:

There were 1,544 unique exempt grievance cases resolved during the reporting period, with a total of 1,804 exempt grievances including all 260 shadow cases.



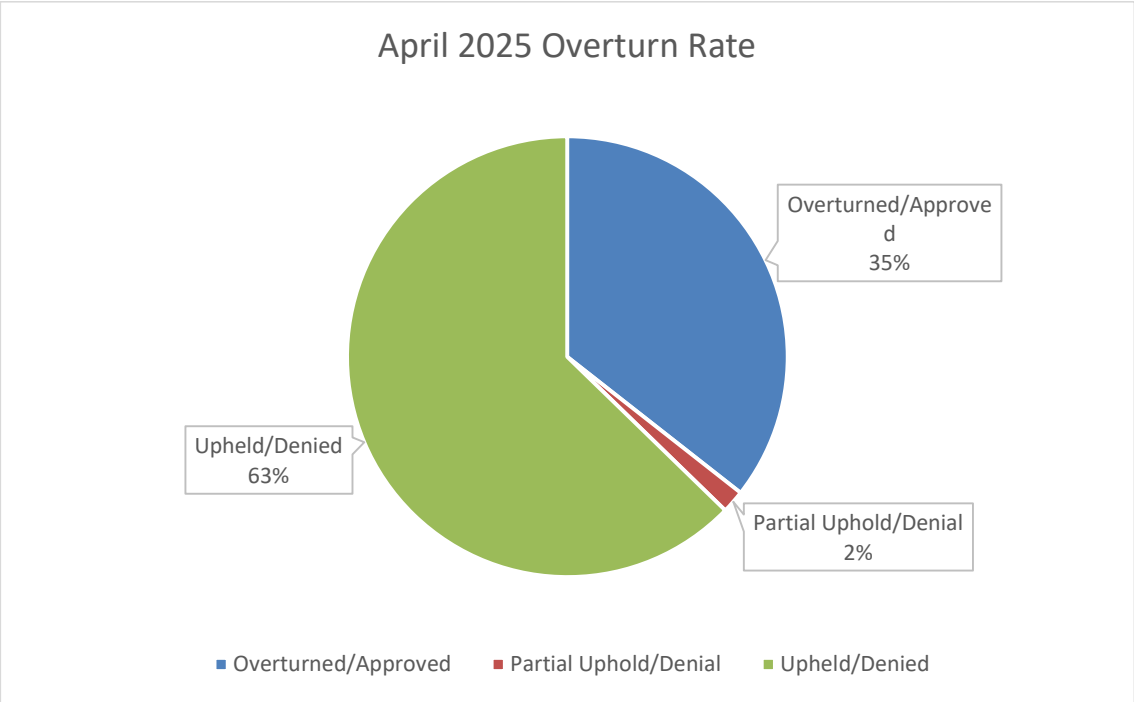
- 826 of 1,804 (46%) cases were related to Access to Care; the top three (3) categories were:
  - (406) Telephone/Technology
  - (236) Provider Availability
  - (107) Geographic Access

- 492 of 1,804 (27%) cases were related to Quality of Service; the top two (2) categories were:
  - (284) Plan Customer Service
  - (178) Provider/Staff Attitude

- 486 of 1,804 (27%) cases were related to Other; the two (2) categories were:
  - (434) Enrollment
  - (52) Eligibility

Appeals:

The Alliance's goal is to have an overturn rate of less than 25%; for the reporting period of April 2025, we did not meet our goal with a 35% overturn rate.



- **21** out of 59 (35%) cases were overturned for the month of April 2025:
  - (19) Disputes Involving Medical Necessity
  - (2) Out of Network

- **1** out of 59 (2%) cases were partially overturned for the month of April 2025:
  - (1) Disputes Involving Medical Necessity

- **37** out of 59 (63%) cases were upheld/denied for the month of April 2025:
  - (25) Disputes Involving Medical Necessity
  - (9) Coverage Disputes
  - (3) Retro

Provider Services

- 12-Month Trend Summary:
    - The Provider Services department's call volume in April 2025 was 8,709 calls compared to 8,064 calls in April 2024; this represents an increase of 8%.
    - Provider Services continuously works to achieve first-call resolution and reduction of the abandonment rates. Efforts to promote provider satisfaction are our first priority.
    - The Provider Services department completed 517 calls/visits during April 2025.
    - The Provider Services department answered 7,024 calls for April 2025 and made 602 outbound calls.

Credentialing

- 12-Month Trend Summary:
    - At the Peer Review and Credentialing (PRCC) meetings held on April 15, 2025, there were 150 initial network providers approved; five (5) primary care providers, six (6) specialists, 11 ancillary providers, three (3) midlevel providers, and 125 behavioral health providers. Additionally, 48 providers were re-credentialed at this meeting; 13 primary care providers, 23 specialists, two (2) ancillary providers, and 10 midlevel providers.
    - Please refer to the Credentialing charts and graphs located in the Operations supporting documentation for more information.

Community Relations and Outreach

- 12-Month Trend Summary:
    - In April 2025, the Alliance completed 933 member orientation outreach calls and 114 member orientations by phone.
    - The C&O Department reached 370 people (46% identified as Alliance members) during outreach activities, compared to 586 individuals (87% self-identified as Alliance members) in April 2024.
    - The C&O Department spent a total of $100.00 on donations, fees, and/or sponsorships, compared to $0 in April 2024.
    - The C&O Department reached members in 14 cities/unincorporated areas throughout Alameda County, and the Bay Area compared to 12 cities in April 2024.
- Monthly Analysis:
    - In April 2025, the C&O Department completed 933 member orientation outreach calls and 114 member orientations by phone, 2 community events, 1 member education event, and 60 Alliance website inquiries.
    - Among the 370 people reached, 46% identified as Alliance members.
    - In April 2025, the C&O Department reached members in 14 locations throughout Alameda County and the Bay Area.
    - Please see attached **Addendum A**.

Incentives & Reporting Board Report – April 2025 Activities

Current Incentive and Grant Programs

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

- The Alliance worked with Local Education Agencies (LEAs) and program partners on the Project Outcome Report (POR), which was submitted to DHCS on December 19th
    - The POR was the final SBHIP report for the entire program measurement period of January 1st, 2022, to December 31st, 2024;
        - On April 18th, DHCS notified the Alliance that the POR was approved and that we earned the full amount of eligible dollars (12.5% or $1.1M) for this final report; payment was received April 24th
- The Alliance earned a total of $9.7M (100% of eligible funds) based on submission of DHCS deliverables and achievement of milestones
    - A total of $7.9M has been paid to LEA and SBHIP partners; the Alliance is currently preparing to pay partners for the POR submission

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
    - $23.4M 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
    - Projects are underway with activities taking place through 2028 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
    - 15 applications received totaling $6M in funding requests
    - $2M in funding awarded to 13 provider partners for the following:
        - Nineteen providers in total, six (6) of which are bi-lingual, including:
            - Six (6) Mid-Level Providers
            - Five (5) Behavioral Health Clinicians
            - Five (5) MD/DOs
            - Three (3) OB/GYNs

- $168,000 has been awarded to our PRI partners to date
- Grants were provided to five (5) practices to support Community Health Worker (CHW) training certificate costs for 33 CHWs
- PRI deliverable trackers, to assist with program requirements, have been created and distributed to all awardees with signed MOUs

Equity and Practice Transformation (EPT) Payments Program – DHCS 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 (AHS) was the only Alliance-associated applicant selected by DHCS to participate
  - The Alliance last met with AHS on April 15th to discuss the EPT program
- The Alliance submitted EPT MCP Practice numerators, denominators, and rates for Alameda Health System, the contracted EPT practices, for the Healthcare Effectiveness Data and Information Set (HEDIS) like key performance indicators (28 measures total) for MY 2023

Doula Scholarship Program – the Alliance Health Care Services team launched this program in December 2024 to grow the Doula provider network to increase access to these services for members, and I&R is providing administrative support.

- Scholarships are intended to offset costs related to the following:
  - Medi-Cal Provider Application and Validation for Enrollment (PAVE)
  - Contracting and credentialing with the Alliance
  - Continued education, training, and administrative and operational support required to be a Doula
- Scholarships of up to $1,000 per person are available for Doulas both intending to contract with the Alliance and Doulas already contracted with the Alliance
- MOUs for the 20 scholarship awardees have been signed, including seven (7) awards to support currently contracted Doulas and 13 awards for Doulas that intend to contract with the Alliance
  - To date, $11,500 of the available $20,000 in scholarships has been paid to program participants for completion of scholarship deliverables
  - The Alliance continues to receive interest in the scholarship program, although all scholarship funds have been expended
- Training materials were created and distributed to all Doulas that completed their MOUs to provide assistance with deliverable submission via the new grant software system, Submittable
  - Additional coordination is being done among internal teams to help the Doulas who intend to contract understand internal processes

Grant Program Updates

- The Incentives and Reporting team selected a grant management software system, Submittable, to support the various grant and incentive programs the Alliance participates in

    - Submittable creates an online application process for community partners, an electronic evaluation process, reporting for fund management, and awardee deliverable tracking
    - The Doula Scholarship Program application was piloted within Submittable in December and continues to be used for partner communications and deliverable tracking
    - The Alliance is currently working with Submittable on a Statement of Work to potentially create a dashboard to manage and track program related deliverables, including fund distribution
- California Improvement Network (CIN) - the Alliance submitted an application on January 14th to participate in an opportunity through the California Improvement Network (CIN), which is a learning and action community that advances equitable health care experiences and outcomes for Californians through cross-sector connections, spreading good ideas, and implementing improvements
    - On March 6th, the Alliance was selected, along with 24 other partners, to participate in this two-year program
    - The Director of Health Equity will be participating in the equity focused learning network and leading project initiatives
    - 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
- The California Wellness Foundation – a meeting with The California Wellness Foundation was held on January 23rd to discuss funding opportunities and eligibility criteria; however, the Foundation confirmed in February that MCPs are not eligible for funding
    - Future funding may be attainable by partnering with a Community Based Organization (CBO) as the lead applicant
- California Endowment - a Letter of Inquiry (LOI) was submitted to the California Endowment on January 31st to be considered for their grant opportunities; a response is pending
- California Health Care Foundation – a LOI was submitted to the California Health Care Foundation on March 21st, in collaboration with support from Behavioral Health (BH) leads from Operations and Health Care Services, for two proposals focusing on the need for funding to support BH workforce needs, as well as infrastructure support for CBOs to bill for Medi-Cal
- Robert Wood Johnson – planning is underway, in collaboration with a community partner and the Alliance Health Equity and Health Care Services departments, for an application to a Robert Wood Johnson research grant
    - Funding is for a new cohort of community-led pilot studies to produce new, actionable evidence about how to help medical, social, and public health systems work together to address forms of systemic racism
- The I&R team met with First 5 Alameda County to discuss areas of need for grant funding and collaboration
- Meetings continue with internal teams such as Health Equity, Health Care Services, and Behavioral Health (clinical and operational) leads to further develop and pursue grant seeking strategies

- On April 4th, Incentives & Reporting shared a Grants Administration overview presentation with the Senior Leadership Team to bring awareness to the work

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

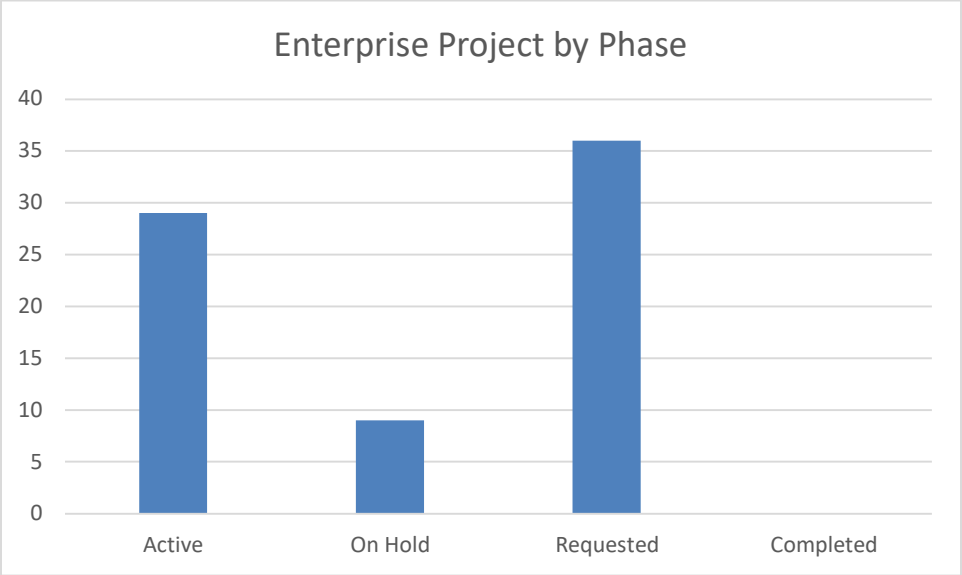
Doula Scholarship Program – program launched in December 2024 to grow the Doula provider network to increase access to these services for members.

Integrated Planning

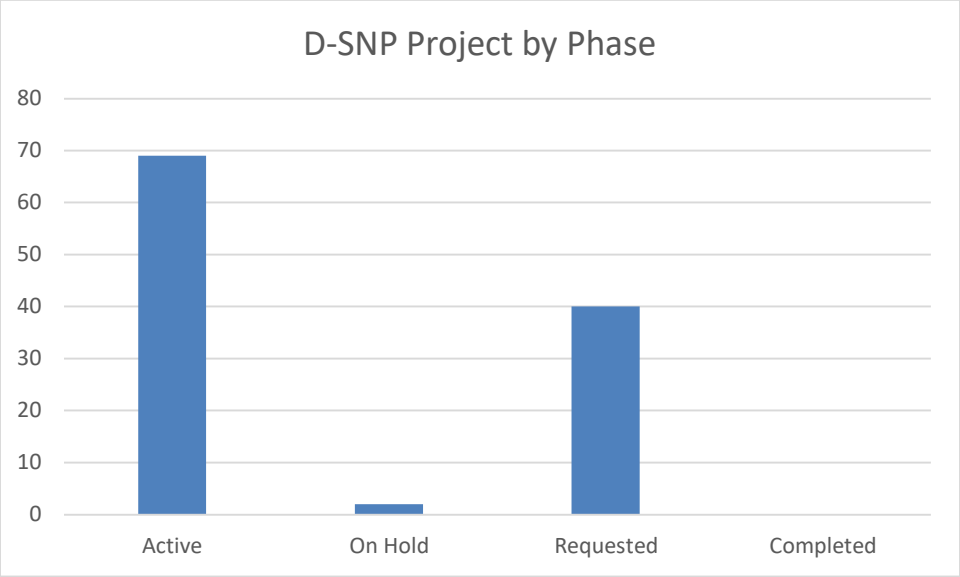
Ruth Watson

Integrated Planning Division Board Report – March 2025 Activities

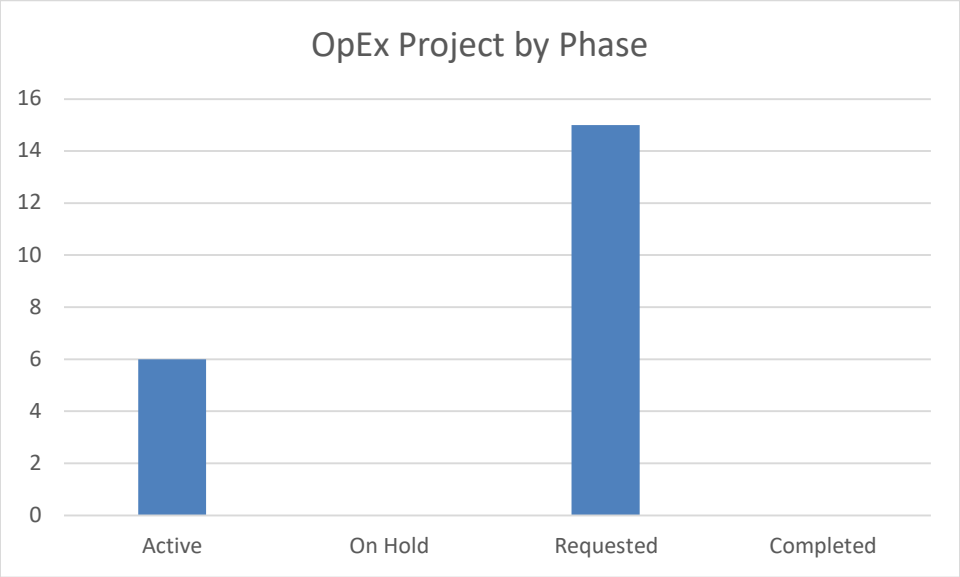
- Enterprise Portfolio
  - 74 projects currently on the Alameda Alliance for Health (AAH) enterprise-wide portfolio
    - 29 Active projects (discovery, initiation, planning, execution, warranty)
    - 9 On Hold projects
    - 36 Requested and Approved Projects
    - 0 Completed Projects (Last month)



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



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



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

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

- D-SNP Activities – **April 2025**
  - Provider Services & Contracting
    - Provider Contracting
      - Added the Lesser of Language to the D-SNP Provider Amendment
      - Developed the cover letter to be included with the updated D-SNP Provider Amendment
    - Provider Services
      - In-person D-SNP Townhall Planning held April 23, 2025, at AAH
      - Decision confirmed: AAH will have one Provider Manual; D-SNP related content will be included in the existing manual
    - Provider Rates and Reimbursement
      - Continued work with Milliman on the development of capitation rates and capitation rate analysis
      - Pay4Performance planning initiated by Analytics
  - Product
    - Onboarding of the following new Medicare Operations staff
      - Dona Doran – Manager, Risk Adjustment
      - Hamid Noori – Manager, Medicare Sales & Retention
      - MyLe Hillard – Manager, HEDIS Strategy and Program Management
      - Stacey Steffire – Medicare Product Manager
    - Continued development of the Bid Design to support the 2nd pass development and AAH review
    - CMS Application submitted February 12, 2025
      - Second Cure Notice received April 14th with AAH responses submitted before the April 24th due date
    - 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
  - Communications and Outreach
    - Initiated communication with AAH Legal on the process for Trademark filing for AAH logos and brand name
  - Vendor Management

- Continued engagement with the following vendors to support Supplemental Benefit Offering(s)
    - Dental – In Implementation with Liberty Dental
    - Vision – in Pre-Del / Contracting with VSP
    - Hearing – In Implementation with Nations
    - Flex Card – In Implementation with Nations
    - Sales System – In Implementation with Nations

- Quality
    - Model of Care
        - MOC has been approved by both DHCS and CMS
            - 96.25% earning three (3) year approval
    - Quality Program
        - Quality Improvement Health Equity P&Ps continue to be updated/developed to align with D-SNP
        - Quality Workplan
            - Reviewing measures with analytics, cross walking QI workplan and Stars measures
        - Quality Committees
            - Charter redlines
            - Establishing new committees for Utilization Management and Community Advisory Committee
- Health Care Services (HCS) and Behavioral Health (BH)
        - Continuing policy development and revisions (130 policies)
        - Redlining UM and CM Program Descriptions for D-SNP elements
        - Finalizing D-SNP Prior authorization code list
        - HRA draft was submitted to DHCS and was approved
        - Final stages of future State D-SNP CM Global Workflow draft – Outlining process flows for new D-SNP components to include Face-to-Face visit, Palliative Care Program, and Dementia Care Program
        - Continuing to define structure and net new processes for California Integrated Care Management (CICM) to include new requirements outlined in the CY2026 Program Guide
        - Working with Provider Network to establish network of CBOs for CICM and Community Support Services
        - D-SNP CM Assessment/HRA mapping to care plan for rules generation
            - Other assessments SRD to TruCare Team for configuration
        - Continuing to build out system rules documents for D-SNP TruCare to submit to IT for configuration

        - D-SNP authorization workstream in building out requirements and work efforts for stand-up
            - Finalizing UM customer set up requirements for configuration
        - BH CM – D-SNP CM program structure finalizing structure
        - Continued discussions of CBO integrations for BH CM Programs
        - BH programs policy and procedure development and revisions underway
        - Completing BH call flow and intersections with Member Services
        - Completed edits for D-SNP Member and Provider letters; additional letters created to support CMS and DHCS requirements
        - Final stages of development of risk stratification model
        - BH UM – establishing additional levels of care for D-SNP population and documenting design requirements for TruCare
        - Initial stages of collaboration outline with ACBH for carve out BH services; first meeting with ACBH occurred on 03/26/2025 with additional follow-up meetings being scheduled
- Finance
    - Finance policies were reviewed for approval at the Administrative Oversight Committee meeting on April 16th
    - New Finance Policy for Premium Billing in review
- Compliance
    - DMHC Material Modification – D-SNP Product (Filing #20244060)
        - Initial AAH responses submitted to DMHC on 9/9/24
        - DMHC Comment Table received 1/7/25; responses submitted 2/6/25; no further comments received from DMHC
    - DHCS Local Plan 2026 D-SNP Readiness Checklist
        - Received April 16th
        - Responses due May 16th
        - Development of responses are in process
    - D-SNP Compliance Policies
        - Twenty-one (21) in review with projected review at the Administrative Oversight Committee (AOC) on August 5th
    - HPMS User Access Form (aka CARE Form)
        - Completed form development
        - User testing is in process

- Confirmed Decision: The existing Compliance Committee will support all lines of business, including D-SNP

- Enrollment and Eligibility
  - D-SNP Enrollment Form is pending approval
  - Continued discussions with RAM (HEALTHsuite) and KP (AAH Print Vendor) documenting process flow and requirements
- Pharmacy
  - PBM Technical and Operations meetings are in progress
  - MTM Operations are scheduled to begin
  - 1 Tier Formulary from PBM will be implemented for AAH
  - Part D benefit design package in progress and is being led by the Operations workgroup
  - Call Center functionalities for member calls and technical calls are in progress
  - 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
- Integrated Grievance and Appeals
    - Policies and Procedures are under review by SMEs
    - G&A Letter inventory completed
    - Grooming sessions are active with the business and IT partners to implement business requirements
    - Waiver of Liability (WOL) process for out of network provider will be owned and managed by the Grievance and Appeals team
    - Payment Reconsideration workgroup is active
    - CMS five (5) levels of appeals are currently being configured in Quality Suite
- Operations (Claims / Member Services / Mailroom / IVR)
  - Continue development of Claims, Member Services, Mailroom, and IVR business process and requirements
- IT
  - TruCare: 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. Core feeds requirements in progress
  - HEALTHsuite: Plan Structure decision finalized. Enrollment Letters High and Medium priority configuration is completed. Enrollment Testing strategy reviewed with RAM team. Membership and Eligibility workflow configuration in progress
  - QualitySuite: Upgrade completed. Grievances and Appeals (G&A) – requirements complete. Appeals requirements out for approval. Appeals reporting requirements in progress

- Stars
    - Phase 1 of Star strategy
        - 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
        - Identified initiatives for the HEDIS measures supported in the Medi-Cal line of business and Operational measures that will impact Star ratings on day 1
            - Building out Stars playbook to align interventions to D-SNP for day 1
            - Aligning interventions to Quality Workplan
        - Process flow documentation for the measures is underway with Quality, Health Care Services, and Analytics
    - We will plan to implement foundational initiatives to support Star gap closure.
        - TruCare Star gap integration – This is ongoing
        - Pay-for-Performance and Pay-for-Reporting program – This is ongoing. Confirmed with CHCN that they will not have their own P4P Program
        - EMR Data feeds – This is already in production and will be slightly modified to ensure support for D-SNP measures
        - Prospective Chart Review – This is already in production and will be slightly modified to ensure support for D-SNP measures

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 2024 and continues through January 2025. These collaborative sessions include correctional facilities, county behavioral health agencies, probation, managed care plans, and ECM providers
        - On 10/28/24, AAH SLT approved to place CalAIM JI Re-Entry project on hold until July 2025 to await final policy guide from DHCS and give Alameda County partners time to develop their internal processes and readiness

- CYBHI Fee Schedule – Effective January 1st, 2024, the Alliance is partnering with Carelon (formerly known as Beacon) to implement the CYBHI Fee Schedule
    - Cohort 1 is intended to be a "learning" cohort
    - 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 1, 2024, to July 1, 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
    - MCP/DHCS/Carelon weekly workgroup meetings cancelled 5/2/25
- MOU & Supporting Documentation
    - Final Interim Model MOU, Draft Fee Schedule Program Requirements (Guidance Document) and SOW Amendment delivered by DHCS on 4/22/25 to Payers
    - Interim Model MOU has been executed by AAH CEO 4/29/25 and returned to Carelon
    - AAH Finance Team shall receive Invoice File from Carelon for billing purposes via secured file transfer process and process payments manually
        - This includes checking member eligibility internally to deliver payments when services have been rendered

Recruiting and Staffing

- Integrated Planning Open position(s):
    - Supervisor, Business Analyst - Active recruitment
    - Backfill Business Analyst, Integrated Planning – Posting reactivated
    - Backfill Business Process Analyst, Integrated Planning – Posted

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	April 2025
Incoming Calls (R/V)	19,970
Abandoned Rate (R/V)	6%
Answered Calls (R/V)	18,707
Average Speed to Answer (ASA)	00:15
Calls Answered in 30 Seconds (R/V)	93%
Average Talk Time (ATT)	07:25
Calls Answered in 10 minutes	100%
Outbound Calls	9,727

Top 5 Call Reasons (Medi-Cal and Group Care) April 2025
Change of PCP
Eligibility/Enrollment
Grievances/Appeals
Benefits
Provider Network Info

Top 3 Web-Based Request Reasons (Medi-Cal and Group Care) April 2025
Change PCP
ID Card Requests
Update Contact Info

MSBH	April 2025
Incoming Calls (R/V)	1,369
Abandoned Rate (R/V)	4%
Answered Calls (R/V)	1,320
Average Speed to Answer (ASA)	00:24
Calls Answered in 30 Seconds (R/V)	92%
Average Talk Time (ATT)	08:30
Calls Answered in 10 minutes	100%
Outbound Calls	1,287
Screenings Completed	136
ACBH Referrals	31
SUD referrals to Center Point	21

Claims Department
March 2025 Final and April 2025 Final

METRICS

Claims Compliance	Mar-25	Apr-25
90% of clean claims processed within 30 calendar days	90.5%	90.4%
95% of all claims processed within 45 working days	96.9%	95.5%
Claims Volume (Received)	**Mar-25**	**Apr-25**
Paper claims	37,076	43,656
EDI claims	310,393	328,470
Claim Volume Total	**347,469**	**372,126**
Percentage of Claims Volume by Submission Method	**Mar-25**	**Apr-25**
% Paper	10.67%	11.73%
% EDI	89.33%	88.27%
Claims Processed	**Mar-25**	**Apr-25**
HEALTHsuite Paid (original claims)	243,052	293,807
HEALTHsuite Denied (original claims)	84,743	99,135
HEALTHsuite Original Claims Sub-Total	**327,795**	**392,942**
HEALTHsuite Adjustments	7,839	20,719
HEALTHsuite Total	**335,634**	**413,661**
Claims Expense	**Mar-25**	**Apr-25**
Medical Claims Paid	$143,774,747	$154,887,607
Interest Paid	$148,561	$187,359
Auto Adjudication	**Mar-25**	**Apr-25**
Claims Auto Adjudicated	281,086	347,343
% Auto Adjudicated	85.8%	88.3%
Average Days from Receipt to Payment	**Mar-25**	**Apr-25**
HEALTHsuite	17	16
Pended Claim Age	**Mar-25**	**Apr-25**
0-30 calendar days	44,970	63,587
HEALTHsuite		
31-61 calendar days	22,786	34,105
HEALTHsuite		
Over 62 calendar days	49,196	48,172
HEALTHsuite		
*Pended claims over 31 days are high due to investigation of 3 providers for FWA		
Overall Denial Rate	**Mar-25**	**Apr-25**
Claims denied in HEALTHsuite	84,743	99,135
% Denied	25.2%	24.0%

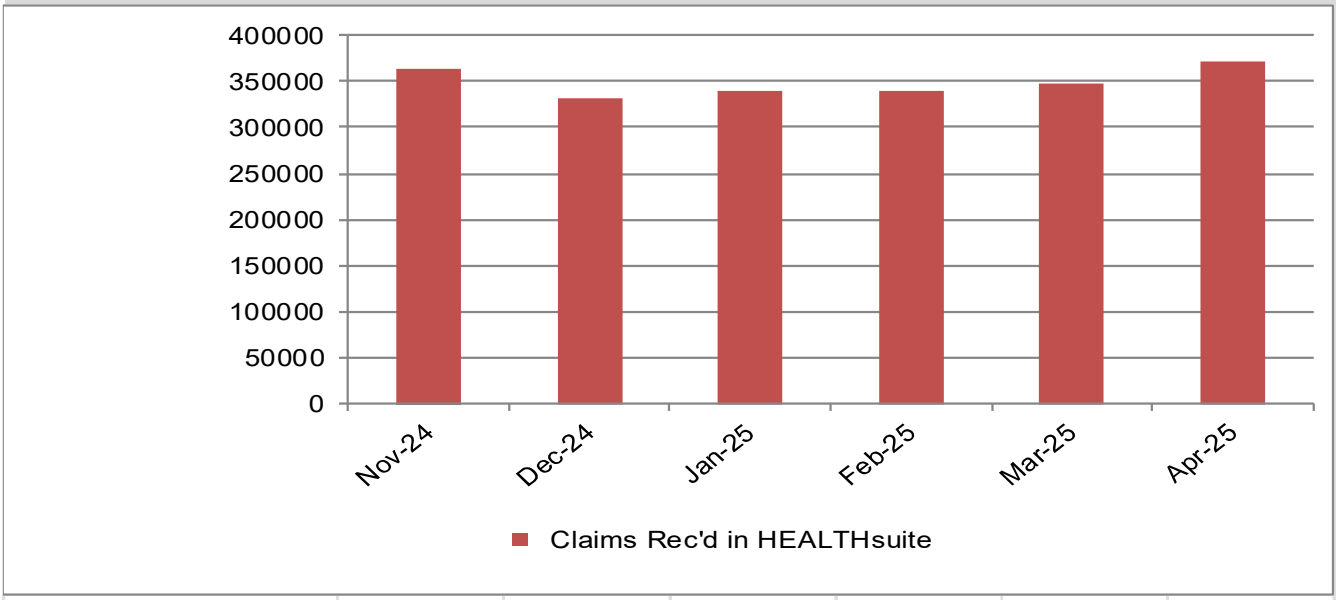
Claims Department
March 2025 Final and April 2025 Final

Apr-25

Top 5 HEALTHsuite Denial Reasons	% of all denials
Responsibility of Provider	28%
No Benefits Found For Dates of Service	13%
Must Submit Paper Claim With Copy of Primary Payor EOB	10%
Non-Covered Benefit For This Plan	9%
Duplicate Claims	7%
% Total of all denials	**67%**

Claims Received By Month

Run Date	12/1/2024	1/1/2025	2/1/2025	3/1/2025	4/1/2025	5/1/2025
Claims Received Through	**Nov-24**	**Dec-24**	**Jan-25**	**Feb-25**	**Mar-25**	**Apr-25**
aims Rec'd in HEALTHsuite	364,130	332,108	339,760	339,840	347,469	372,126



Claims Year Over Year Summary		
Monthly Results	**Regulatory Requirement**	**AAH Goal**
Claims Compliance - comparing April 2025 to April 2024 as follows: 30 Days - 90.4% (2025) vs 92.5% (2024) 45 Days - 95.5% (2025) vs 100% (2024) 90 Days - 99.9% (2025) vs 99.9% (2024)	90% of clean claims in 30 calendar days 95% of all claims in 45 working days 99% of all claims in 90 calendar days	90% of clean claims in 30 calendar days 95% of all claims in 45 working days 99% of all claims in 90 calendar days
Claims Received - AAH received 372,126 claims in April 2025 vs 322,786 in April 2024	N/A	N/A
EDI - the volume of EDI submissions was 85.8% which falls within our normal month to month range of ~77% - 87%	N/A	N/A
Original Claims Processed - AAH processed 392,942 in April 2025 (22 working days) vs 290,131 in April 2024 (22 working days)	N/A	N/A
Medical Claims Expense - the amount of paid claims in April 2025 was $154,887,607 (5 check runs) vs $115,809,477 in April 2024 (4 check runs)	N/A	N/A
Interest Expense - the amount of interest paid in April 2025 was $187,359 vs $136,578 in April 2024	N/A	.05% - .075% of the monthly medical expense
Auto Adjudication - the AAH rate in April 2025 was 88.3% vs 83.4% in April 2024	N/A	85% or higher
Average Days from Receipt to Payment - the average # of days from receipt to payment in April 2025 was 16 days vs 13 days in April 2024	N/A	<= 25 days
Pended Claim Age - comparing April 2025 to April 2024 as follows: 0-30 calendar days - 63,587 (2025) vs 38,453 (2024) 31-61 calendar days - 34,105 (2025) vs 572 (2024) Over 62 calendar days - 48,172 (2025) vs 3 (2024) *Pended claims over 31 days are high due to the investigation of 3 providers for FWA	N/A	N/A
Top 5 Denial Reasons - the claim denial reasons remain consistent from month to month so there is no significant changes to report from April 2025 to April 2024	N/A	N/A

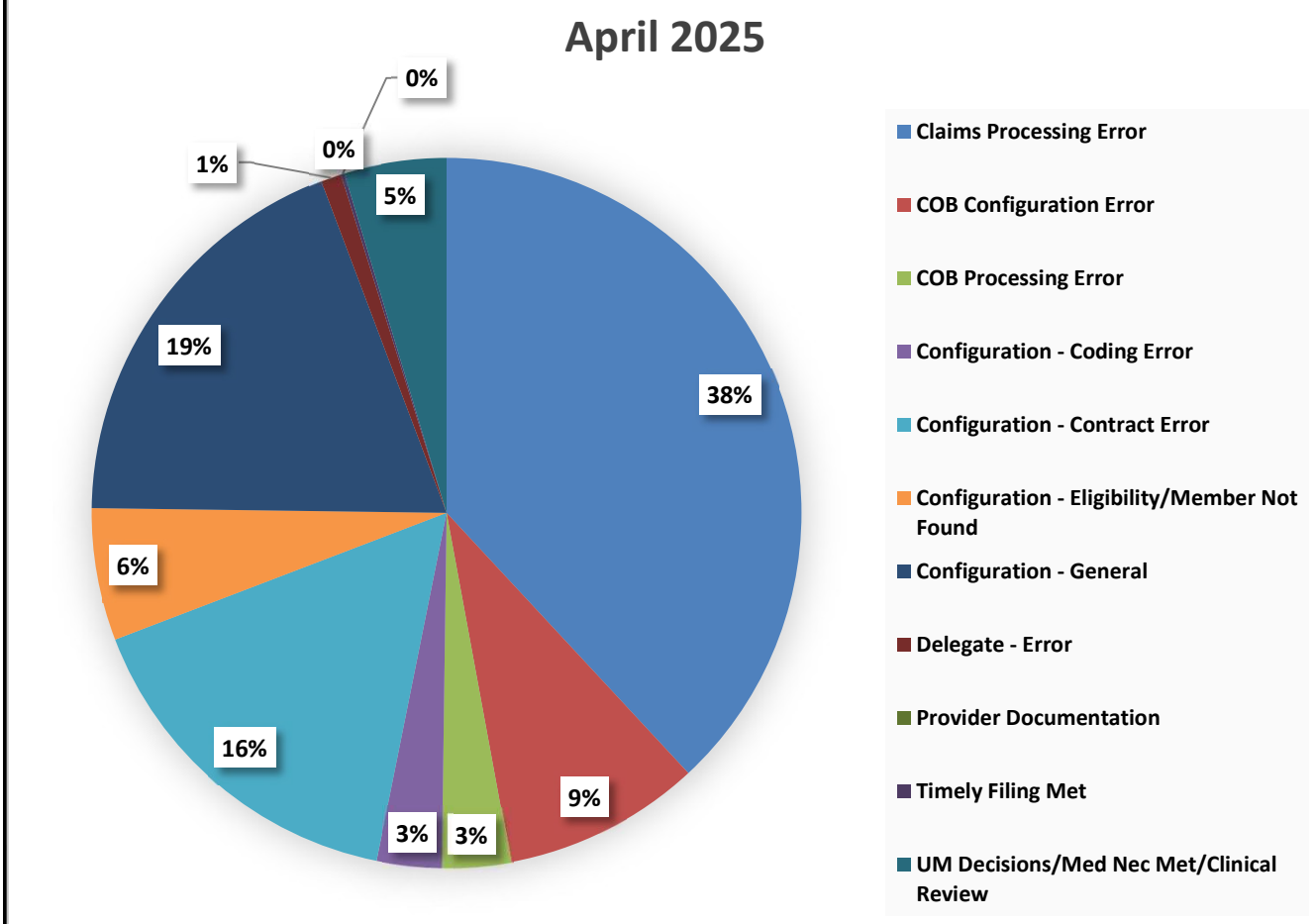
Provider Dispute Resolution
March 2025 and April 2025

METRICS		
PDR Compliance	**Mar-25**	**Apr-25**
# of PDRs Resolved	1,857	1,889
# Resolved Within 45 Working Days	1,849	1,883
% of PDRs Resolved Within 45 Working Days	99.5%	99.7%
PDRs Received	**Mar-25**	**Apr-25**
# of PDRs Received	4,707	3,411
PDR Volume Total	**4,707**	**3,411**
PDRs Resolved	**Mar-25**	**Apr-25**
# of PDRs Upheld	1,212	1,354
% of PDRs Upheld	65%	72%
# of PDRs Overturned	645	535
% of PDRs Overturned	35%	28%
Total # of PDRs Resolved	**1,857**	**1,889**
Average Turnaround Time	**Mar-25**	**Apr-25**
Average # of Days to Resolve PDRs	37	37
Oldest Resolved PDR in Days	124	199
Unresolved PDR Age	**Mar-25**	**Apr-25**
0-45 Working Days	4,162	4,923
Over 45 Working Days	0	0
Total # of Unresolved PDRs	**4,162**	**4,923**

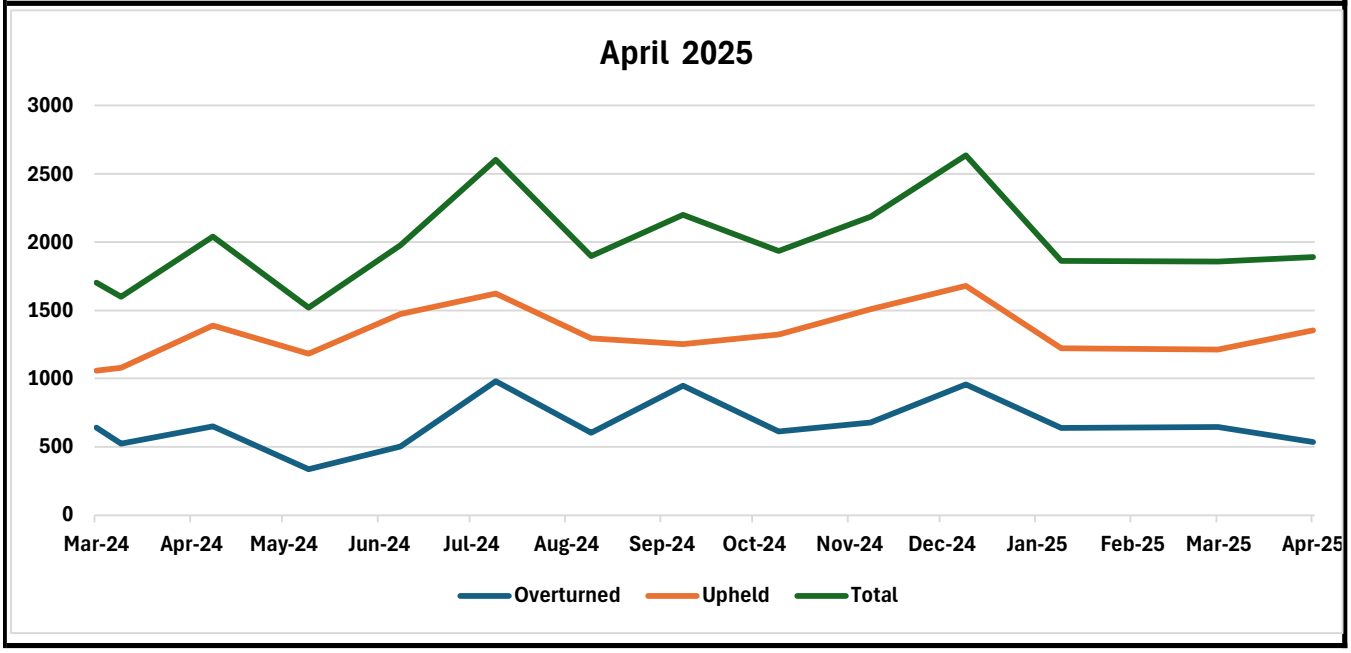
Provider Dispute Resolution
March 2025 and April 2025

Apr-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 - 1,889 in April 2025 vs 1,601 in April 2024	N/A	N/A
# of PDRs Received - 3,411 in April 2025 vs 1,925 in April 2024	N/A	N/A
# of PDRs Resolved within 45 working days - 1,883 in April 2025 vs 1,596 in April 2024	N/A	N/A
% of PDRs Resolved within 45 working days - 99.7% in April 2025 vs 99.6% in April 2024	95%	95%
Average # of Days to Resolve PDRs - 37 days in April 2025 vs 43 days in April 2024	N/A	30
Oldest Resolved PDR in Days - 199 days in April 2025 vs 89 days April 2024	N/A	N/A
# of PDRs Upheld -1,354 in April 2025 vs 1,078 in April 2024	N/A	N/A
% of PDRs Upheld - 72% in April 2025 vs 67% in April 2024	N/A	> 75%
# of PDRs Overturned - 535 in April 2025 vs 523 in April 2024	N/A	N/A
% of PDRs Overturned - 28% in April 2025 vs 33% in April 2024	N/A	< 25%
PDR Overturn Reasons: Claims processing errors - 38% (2025) vs 47% (2024) Configuration errors -44% (2025) vs 31% (2024) COB - 12% (2025) vs 11% (2024) Clinical Review/UM Decisions/Medical Necessity Met - 6% (2025) vs 9% (2024)	N/A	N/A

Provider Relations Dashboard April 2025

Alliance Provider Relations Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Incoming Calls (PR)	10,977	8,885	8,303	8,709								
Abandoned Calls	3,600	1,133	1,434	1,685								
Answered Calls (PR)	7,377	7,752	6,869	7,024								
Recordings/Voicemails	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Incoming Calls (R/V)	2,910	2,140	13	15								
Abandoned Calls (R/V)												
Answered Calls (R/V)	2,910	2,140	13	15								
Outbound Calls	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Outbound Calls	868	1,162	434	602								
N/A												
Outbound Calls	868	1,162	434	602								
Totals	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Total Incoming, R/V, Outbound Calls	14,755	12,187	8,750	9,326								
Abandoned Calls	3,600	1,133	1,434	1,685								
Total Answered Incoming, R/V, Outbound Calls	11,155	11,054	7,316	7,641								

Provider Relations Dashboard April 2025

Call Reasons (Medi-Cal and Group Care)

Category	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Authorizations	5.1%	5.8%	5.4%	5.0%								
Benefits	5.1%	3.7%	3.4%	3.9%								
Claims Inquiry	39.4%	43.9%	43.7%	46.3%								
Change of PCP	2.5%	2.7%	2.4%	2.9%								
Check Tracer	0.7%	0.6%	1.0%	0.9%								
Complaint/Grievance (includes PDR's)	5.8%	6.7%	6.8%	6.5%								
Contracts/Credentialing	0.8%	0.8%	0.7%	0.8%								
Demographic Change	0.0%	0.0%	0.0%	0.0%								
Eligibility - Call from Provider	21.0%	17.4%	17.0%	17.9%								
Exempt Grievance/ G&A	0.0%	0.1%	6.8%	0.0%								
General Inquiry/Non member	0.0%	0.0%	0.0%	0.0%								
Health Education	0.0%	0.0%	0.0%	0.0%								
Intrepreter Services Request	0.5%	0.5%	0.6%	0.4%								
Provider Portal Assistance	3.4%	3.2%	3.9%	3.4%								
Pharmacy	0.1%	0.2%	0.1%	0.0%								
Prop 56	0.1%	0.0%	0.0%	0.1%								
Provider Network Info	0.0%	0.0%	0.0%	0.0%								
Transportation Services	0.0%	0.2%	0.2%	0.2%								
Transferred Call	0.0%	0.0%	0.0%	0.0%								
All Other Calls	15.5%	14.4%	7.9%	11.4%								
TOTAL	100.0%	100.0%	100.0%	100.0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Field Visit Activity Details

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

ALLIANCE NETWORK SUMMARY, CURRENTLY CREDENTIALED PRACTITIONERS - April 2025						
Practitioners		PCP 395	SPEC 753	AHP 660	BH/ABA 2,873	PCP/SPEC 12
Direct Network vs Delegated Network Breakdown			AAH 3,454	AHS 296	CHCN 607	COMBINATION OF GROUPS 336
Facilities	440					

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	23	7	Y	Y	Y
Recred Files in Process	79	0	Y	Y	Y
Expirables updated **Insurance, License, DEA, Board Certifications**					Y
Files currently in process	**102**				
		*** 25 business days = 35 calendar days**			

April 2025 Peer Review and Credentialing Committee Approvals	
Initial Credentialing	**Number**
PCP	5
SPEC	6
ANCILLARY	11
MIDLEVEL/AHP	3
BH/ABA	125
Sub-total	**150**
Recredentialing	
PCP	13
SPEC	23
ANCILLARY	2
MIDLEVEL/AHP	10
Sub-total	**48**
TOTAL	**198**

April 2025 Facility Approvals	
Initial Credentialing	5
Recredentialing	11
Sub-total	**16**
Facility Files in Process	**54**

April 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-CREDS	CRED_DATE
Abary	Brian	BH-Telehealth	INITIAL	4/15/2025
Addes	Irina	BH-Telehealth	INITIAL	4/15/2025
Alabaso	Alvin	ABA-Telehealth	INITIAL	4/15/2025
Alberty	Janetria	ABA-Telehealth	INITIAL	4/15/2025
Altan	Zeynep	BH-Telehealth	INITIAL	4/15/2025
Andrade	Genevieve	BH-Telehealth	INITIAL	4/15/2025
Arthur	Grace	BH-Telehealth	INITIAL	4/15/2025
Ashley	Michelle	BH-Telehealth	INITIAL	4/15/2025
Avila	Fernando	BH-Telehealth	INITIAL	4/15/2025
Baker	Olga	Doula	INITIAL	4/15/2025
Barnes	Melanie	BH	INITIAL	4/15/2025
Barragan	Melina	ABA-Telehealth	INITIAL	4/15/2025
Bartholomew	Kate	BH	INITIAL	4/15/2025
Basu	Suparna	BH-Telehealth	INITIAL	4/15/2025
Bedford	Ronald	Allied Health	INITIAL	4/15/2025
Behl	Rajesh	Specialist	INITIAL	4/15/2025
Bell	Jedidiah	Primary Care Physician	INITIAL	4/15/2025
Bennett	Melanie	BH-Telehealth	INITIAL	4/15/2025
Bermudez Wagner	Karla	Specialist	INITIAL	4/15/2025
Brum	Alec	ABA-Telehealth	INITIAL	4/15/2025
Bugas	John	BH-Telehealth	INITIAL	4/15/2025
Call	John	ABA-Telehealth	INITIAL	4/15/2025
Casademunt	Claire	ABA	INITIAL	4/15/2025
Chaidez	Michelle	ABA-Telehealth	INITIAL	4/15/2025
Charles	Leslie	BH-Telehealth	INITIAL	4/15/2025
Chilingaryan	Vardui	ABA-Telehealth	INITIAL	4/15/2025
Chun	Doris	BH-Telehealth	INITIAL	4/15/2025
Comito	Theresa	BH	INITIAL	4/15/2025
Conde	Annette	ABA	INITIAL	4/15/2025
Cooper	Anne	BH-Telehealth	INITIAL	4/15/2025
De la Garza	Elizabeth	ABA	INITIAL	4/15/2025
Diaz	Melissa	BH-Telehealth	INITIAL	4/15/2025
Dragomanovich	Hannah	Primary Care Physician	INITIAL	4/15/2025
Duffy	David	BH-Telehealth	INITIAL	4/15/2025
Dugan	Geraldine	BH-Telehealth	INITIAL	4/15/2025
Edwards	Krystal	Doula	INITIAL	4/15/2025
Egbufoama	Jane	BH-Telehealth	INITIAL	4/15/2025
Elaog	Athena Abegail	ABA-Telehealth	INITIAL	4/15/2025
Estevez	Gilda	BH-Telehealth	INITIAL	4/15/2025
Ewing	Catherine	BH-Telehealth	INITIAL	4/15/2025
Farasat	Sadaf	Specialist	INITIAL	4/15/2025
Farokhzad	Elaina	BH-Telehealth	INITIAL	4/15/2025
Fleishman	Scott	BH-Telehealth	INITIAL	4/15/2025
Garcia	Abigail	ABA-Telehealth	INITIAL	4/15/2025
Gill	Amruta	BH	INITIAL	4/15/2025
Gomez	Ashley	ABA-Telehealth	INITIAL	4/15/2025
Grigoryan	Tatevik	BH-Telehealth	INITIAL	4/15/2025
Hagan	Michael	BH-Telehealth	INITIAL	4/15/2025
Hankee	Lisa	BH-Telehealth	INITIAL	4/15/2025
Hansen	Julie	BH-Telehealth	INITIAL	4/15/2025
Harber	Jordan	BH-Telehealth	INITIAL	4/15/2025
Hartzog-Anley	Michelle	BH	INITIAL	4/15/2025
Hernandez	Grace	BH	INITIAL	4/15/2025
Hickey	Tracey	BH	INITIAL	4/15/2025
Hicks	Tatiana	BH	INITIAL	4/15/2025
Higgins	Jenna	BH-Telehealth	INITIAL	4/15/2025

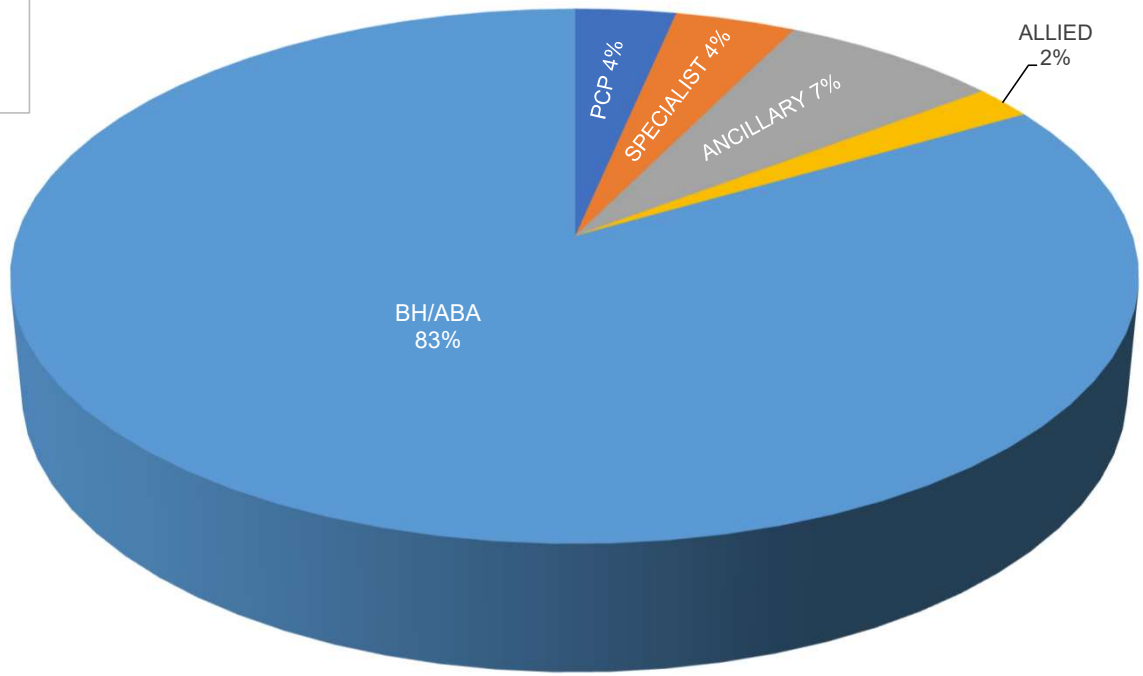
LAST_NAME	FIRST_NAME	CATEGORY	INITIAL/RE-CREDS	CRED_DATE
Hirsch	Norma	BH-Telehealth	INITIAL	4/15/2025
Hoban	Sheila	BH-Telehealth	INITIAL	4/15/2025
Hopkins	Julianna	BH-Telehealth	INITIAL	4/15/2025
Howell	Allison	ABA-Telehealth	INITIAL	4/15/2025
Ilani	Dorit	BH	INITIAL	4/15/2025
Iribarren	Francisco	BH-Telehealth	INITIAL	4/15/2025
Jaramillo	Carla	BH-Telehealth	INITIAL	4/15/2025
Jayasuriya	Samanthi	ABA-Telehealth	INITIAL	4/15/2025
Jikamo	Kifle	BH-Telehealth	INITIAL	4/15/2025
Johnson	Amber	BH-Telehealth	INITIAL	4/15/2025
Jones	Janae	Doula	INITIAL	4/15/2025
Juarez	Jose	BH-Telehealth	INITIAL	4/15/2025
Kaku	Janine	Allied Health	INITIAL	4/15/2025
Khalitchi-Alavi	Marjaneh-Marcia	BH-Telehealth	INITIAL	4/15/2025
Kidd	Dia'Nisha	BH	INITIAL	4/15/2025
Ko Roberson	Celine	BH-Telehealth	INITIAL	4/15/2025
Krall	Teresa	BH-Telehealth	INITIAL	4/15/2025
Labanca	Valerie	BH-Telehealth	INITIAL	4/15/2025
Larsson	Elizabeth	BH-Telehealth	INITIAL	4/15/2025
Lee	Inez	ABA-Telehealth	INITIAL	4/15/2025
Lieu	Vinson	Ancillary	INITIAL	4/15/2025
Lomeli	Belen	ABA	INITIAL	4/15/2025
Maas	Michele	BH	INITIAL	4/15/2025
Macias	Sara	ABA-Telehealth	INITIAL	4/15/2025
Magana	Verenice	BH-Telehealth	INITIAL	4/15/2025
Mallory	Anna	ABA-Telehealth	INITIAL	4/15/2025
Manoff	Hannah	BH-Telehealth	INITIAL	4/15/2025
Mercedes Walters	Emily	ABA-Telehealth	INITIAL	4/15/2025
Mohammed	Larai	Doula	INITIAL	4/15/2025
Molina	Leslie	ABA-Telehealth	INITIAL	4/15/2025
Moss	Sara	BH	INITIAL	4/15/2025
Murcia	Aleida	BH-Telehealth	INITIAL	4/15/2025
Myers	Michelle	BH-Telehealth	INITIAL	4/15/2025
Nambisan	Maya	Specialist	INITIAL	4/15/2025
Navarro-Marin	Imelda	BH-Telehealth	INITIAL	4/15/2025
Nekbeen	Mitra	BH	INITIAL	4/15/2025
Nguyen	Lili	BH-Telehealth	INITIAL	4/15/2025
Osorio Huerta	Guillermo	ABA-Telehealth	INITIAL	4/15/2025
Ouidiani	Danielle	ABA-Telehealth	INITIAL	4/15/2025
Papazoglou	Mary Adelaide	Allied Health	INITIAL	4/15/2025
Paredes	Sara	BH-Telehealth	INITIAL	4/15/2025
Park	Russell	BH-Telehealth	INITIAL	4/15/2025
Pattanaik	Anjalika	Specialist	INITIAL	4/15/2025
Pcholinski	Eric	BH-Telehealth	INITIAL	4/15/2025
Pelletier	Allyson	BH-Telehealth	INITIAL	4/15/2025
Pena	Jennifer	ABA-Telehealth	INITIAL	4/15/2025
Perez	Daniel	BH-Telehealth	INITIAL	4/15/2025
Peterson	Kelly	BH	INITIAL	4/15/2025
Planty	Michelle	ABA-Telehealth	INITIAL	4/15/2025
Pring	Kindra	ABA-Telehealth	INITIAL	4/15/2025
Reed	Danielle	BH	INITIAL	4/15/2025
Reeder	Emily	BH-Telehealth	INITIAL	4/15/2025
Reininga	Eric	BH-Telehealth	INITIAL	4/15/2025
Roberts	Carla	BH	INITIAL	4/15/2025
Rodriguez	Jose	BH	INITIAL	4/15/2025
Rodriguez	Nidia	BH-Telehealth	INITIAL	4/15/2025
Roe	Alexander	BH	INITIAL	4/15/2025

LAST_NAME	FIRST_NAME	CATEGORY	INITIAL/RE-CREDS	CRED_DATE
Rowden	Monica	BH	INITIAL	4/15/2025
Rubio	Maria	ABA	INITIAL	4/15/2025
Sadiq	Shah	BH	INITIAL	4/15/2025
Saeteurn	Yienpoo	BH	INITIAL	4/15/2025
Sato	Sara	ABA-Telehealth	INITIAL	4/15/2025
Schultz-Hickerson	Charleen	BH-Telehealth	INITIAL	4/15/2025
Seer	Unknown	Primary Care Physician	INITIAL	4/15/2025
Shah	Nishit	Primary Care Physician	INITIAL	4/15/2025
Siauw	Jenny	ABA	INITIAL	4/15/2025
Signer	Stephen	BH-Telehealth	INITIAL	4/15/2025
Singh	Jashneel	BH	INITIAL	4/15/2025
Smith	Vilka	BH-Telehealth	INITIAL	4/15/2025
Solano-Rojas	Natalia	Ancillary	INITIAL	4/15/2025
Stevenson	Rhamell	BH	INITIAL	4/15/2025
Stewart	Seth	BH	INITIAL	4/15/2025
Stokes	Aysha-Samon	Doula	INITIAL	4/15/2025
Sumner	Sarah	ABA	INITIAL	4/15/2025
Sussman	Ann	BH	INITIAL	4/15/2025
Tarantino	David	ABA-Telehealth	INITIAL	4/15/2025
Thakur	Vijaya	Primary Care Physician	INITIAL	4/15/2025
Tokar	Ephraim	BH-Telehealth	INITIAL	4/15/2025
Torres	Angelina	BH-Telehealth	INITIAL	4/15/2025
Trehan	Malu	Ancillary	INITIAL	4/15/2025
Tse	Holly	BH-Telehealth	INITIAL	4/15/2025
Umiten	Kristine	BH-Telehealth	INITIAL	4/15/2025
Vasquez	Veronica	ABA-Telehealth	INITIAL	4/15/2025
Vuong	Tu	BH-Telehealth	INITIAL	4/15/2025
Wang	Jackie	BH	INITIAL	4/15/2025
Wang	Julie	Ancillary	INITIAL	4/15/2025
Wardell Larson	Julia	Doula	INITIAL	4/15/2025
Welch	Courtney	BH	INITIAL	4/15/2025
Wesbrook	Hayley	ABA-Telehealth	INITIAL	4/15/2025
Whitaker	Dakoda	ABA-Telehealth	INITIAL	4/15/2025
Yang	Christine	Specialist	INITIAL	4/15/2025
Youdon	Tenzin	BH-Telehealth	INITIAL	4/15/2025
Zelco	Laura	Ancillary	INITIAL	4/15/2025
Zhong	Xiaoyin	BH	INITIAL	4/15/2025
Aarabi	Shahram	Specialist	RE-CREDS	4/15/2025
Achanta	Kranthi	Specialist	RE-CREDS	4/15/2025
Ally	Zahora	Specialist	RE-CREDS	4/15/2025
Barash	Muni	Specialist	RE-CREDS	4/15/2025
Chawla	Harman	Specialist	RE-CREDS	4/15/2025
Chen	Enna	Allied Health	RE-CREDS	4/15/2025
Chen	Xiaoshuang	Primary Care Physician	RE-CREDS	4/15/2025
Cheung	Ka	Specialist	RE-CREDS	4/15/2025
Coleman	Dione	Allied Health	RE-CREDS	4/15/2025
Collins-Pallett	Thomas	Primary Care Physician	RE-CREDS	4/15/2025
Conderman	Christian	Specialist	RE-CREDS	4/15/2025
DeBree	Olivia	Allied Health	RE-CREDS	4/15/2025
Enriquez	Christopher	Specialist	RE-CREDS	4/15/2025
Gwalani	Tulsidas	Specialist	RE-CREDS	4/15/2025
Halio	Amy	Primary Care Physician	RE-CREDS	4/15/2025
Hana	Anas	Primary Care Physician	RE-CREDS	4/15/2025
Hoang	Vay	Allied Health	RE-CREDS	4/15/2025
Hom	Melanie	Specialist	RE-CREDS	4/15/2025
Horoupian	Rupert	Specialist	RE-CREDS	4/15/2025

LAST_NAME	FIRST_NAME	CATEGORY	INITIAL/RE-CREDS	CRED_DATE
Kao	Samuel	Specialist	RE-CREDS	4/15/2025
Khalsa	Prabhjot	Specialist	RE-CREDS	4/15/2025
Kwok-Oleksy	Christina	Specialist	RE-CREDS	4/15/2025
Le	Carolyn	Primary Care Physician	RE-CREDS	4/15/2025
Lee	Diane	Specialist	RE-CREDS	4/15/2025
Lee	Min-Wei	Specialist	RE-CREDS	4/15/2025
Ma	Aye Moe Thu	Specialist	RE-CREDS	4/15/2025
Majarian	Jennifer	Allied Health	RE-CREDS	4/15/2025
Marriner	Ken	Primary Care Physician	RE-CREDS	4/15/2025
Moazed	Farzad	Specialist	RE-CREDS	4/15/2025
Monroe	Lisa	Allied Health	RE-CREDS	4/15/2025
Nathan	Manjari	Specialist	RE-CREDS	4/15/2025
Palakurthy	Prasad	Specialist	RE-CREDS	4/15/2025
Phung	Stephanie	Allied Health	RE-CREDS	4/15/2025
Porwal	Nivin	Specialist	RE-CREDS	4/15/2025
Riley	Jenny	Primary Care Physician	RE-CREDS	4/15/2025
Shah	Shaista	Primary Care Physician	RE-CREDS	4/15/2025
Shrestha	Swechha	Allied Health	RE-CREDS	4/15/2025
Simon-Weisberg	Deborah	Primary Care Physician	RE-CREDS	4/15/2025
Smart	Monica	Allied Health	RE-CREDS	4/15/2025
Suozzi	Melanie	Allied Health	RE-CREDS	4/15/2025
Truong	Kenneth	Primary Care Physician	RE-CREDS	4/15/2025
Tsang	Michelle	Primary Care Physician	RE-CREDS	4/15/2025
Vaghani	Drashti	Ancillary	RE-CREDS	4/15/2025
Valdes	Ann	Primary Care Physician	RE-CREDS	4/15/2025
Vesga	Liana	Specialist	RE-CREDS	4/15/2025
Wu	YongYi	Ancillary	RE-CREDS	4/15/2025
Zaka	Jamal	Specialist	RE-CREDS	4/15/2025
Zonner	Steven	Primary Care Physician	RE-CREDS	4/15/2025

April PEER REVIEW AND CREDENTIALING
INITIAL APPROVALS BY SPECIALTY

PCP	5
SPECIALIST	6
ANCILLARY	11
ALLIED	3
BH/ABA	125
TOTAL	150



In April 2025, the Alliance completed **933** member orientation outreach calls among net new and non-utilizer members and conducted **114** member orientations (**12%** member participation rate). In addition, in April 2025, the Outreach team completed **60** Alliance website inquiries, **4** service requests, **2** community events, **1** member education event, and **1** community Meeting/Presentation event. The Alliance reached approximately **370** people and spent a total of $100 on donations, fees, and/or sponsorships at Black Women's Health Forum, Celebrating Black Motherhood, the 2025 Spring Eggstravaganza, and the 2025 VACCEB Spring Health Fair community engagement activities.*

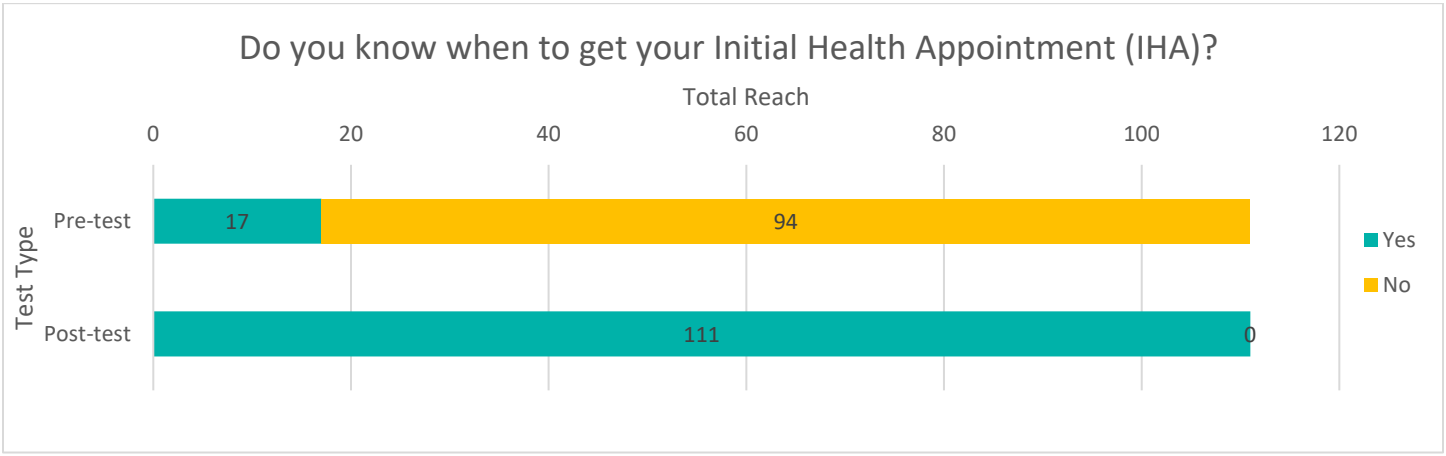
The Communications & Outreach Department began reporting the number of members reached during outreach activities in late February 2018. Since July 2018, approximately **38,256** self-identified Alliance members have been reached during outreach activities.

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

On **Wednesday, March 18, 2020,** the Alliance began conducting member orientations by phone. As of April 30, 2025, the Outreach Team has completed **48,430** member orientation outreach calls and conducted **9,705** member orientations (**20%** member participation rate).

The Alliance Member Orientation (MO) program has existed since August 2016. In 2019, the program was recognized as a promising practice to increase member knowledge and awareness about the Initial Health Appointment (IHA) by the Department of Health Care Services (DHCS), Managed Care Quality and Monitoring Division (MCQMD). We have steadily increased program participation. Our 2019 6-month average participation rate was **111** members per month. Between April 1, through April 30, 2025 (22 working days) – **114** members completed an MO by phone.

After completing the MO, **100%** of members who completed the post-test survey in April 2025 reported knowing when to get their IHA, compared to only **15.3%** of members knowing when to get their IHA in the pre-test survey.



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

FY 2023-2024 APRIL 2024 TOTALS

- 0 COMMUNITY EVENTS
- 3 MEMBER EDUCATION EVENTS
- 142 MEMBER ORIENTATIONS
- 0 MEETINGS/ PRESENTATIONS/
- 0 COMMUNITY TRAINING
- 9 TOTAL INITIATED/ INVITED EVENTS
- **145 TOTAL COMPLETED EVENTS**

12 CITIES**

Alameda
Berkeley
Castro Valley
Dublin
Fremont
Hayward
Livermore
Newark
Oakland
Pleasanton
San Leandro
San Ramon

- 0 TOTAL REACHED AT COMMUNITY EVENTS
- 444 TOTAL REACHED AT MEMBER EDUCATION EVENTS
- 142 TOTAL REACHED AT MEMBER ORIENTATIONS
- 0 TOTAL REACHED AT MEETINGS/PRESENTATIONS
- 0 TOTAL REACHED AT COMMUNITY TRAINING
- 509 MEMBERS REACHED AT ALL EVENTS
- **586 TOTAL REACHED AT ALL EVENTS**

$0.00
TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

FY 2024-2025 APRIL 2025 TOTALS

- 2 COMMUNITY EVENTS
- 1 MEMBER EDUCATION EVENTS
- 114 MEMBER ORIENTATIONS
- 1 MEETINGS/ PRESENTATIONS
- 0 COMMUNITY TRAINING
- 8 TOTAL INITIATED/ INVITED EVENTS
- 118 TOTAL COMPLETED **EVENTS**

14 CITIES**

Alameda
Albany
Berkeley
Castro Valley
Cherryland
Dublin
Fremont
Hayward
Moraga
Newark
Oakland
Pleasanton
San Leandro
San Lorenzo

- 225 TOTAL REACHED AT COMMUNITY EVENTS
- 65 TOTAL REACHED AT MEMBER EDUCATION EVENTS
- 114 TOTAL REACHED AT MEMBER ORIENTATIONS
- 0 TOTAL REACHED AT MEETINGS/PRESENTATIONS
- 0 COMMUNITY TRAINING
- 223 MEMBERS REACHED AT ALL EVENTS
- **484 TOTAL REACHED AT ALL EVENTS**

$100.00
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.*

ALAMEDA Alliance FOR HEALTH

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

Compliance

Richard Golfin III

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

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

Date: **May 9th, 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
    - The DMHC lookback period is from October 1st, 2022, through September 30th, 2024. The DHCS lookback period is from June 1st, 2024, through February 28th, 2025. From March 3rd to March 7th, 2025, both agencies conducted onsite interview sessions.
    - The DHCS conducted an exit conference on March 20th, 2025, during which the department raised three concerns regarding Post-Stabilization Authorization (PSA):
        1. The Plan did not consistently secure timely authorization for medically necessary PSA or ensure contractors' compliance with APL 23-009.
        2. The Plan did not adequately ensure the availability of a Medical Director or licensed physician 24/7 to coordinate care and respond to authorizations.
        3. The Plan did not transfer out-of-network hospitalized members to in-network providers as required.
    - The department informed the Plan that these observations are preliminary and may be revised upon further review. Additional documentation requested on March 24th, 2025, was submitted timely by the Plan on March 25th, 2025.
    - The DMHC preliminary report is due to the Plan 90 days from completion of the survey (June 2025).
- 2024 Department of Health Care Services (DHCS) Routine Full Medical Survey
    - The DHCS conducted its 2024 Routine Full Medical Survey from June 17th, 2024, through June 28th, 2024. The Plan received its Final Audit Report on November 18th, 2024, citing twenty (20) final audit findings. Monthly CAP updates are due to the DHCS on the 15th of each month. To date eight (8) CAPs have been accepted, nine (9) CAPs have been partially accepted, one (1) CAP has a question, and two (2) CAPs are pending deliverables. The last CAP

update was submitted timely on April 15th, 2025. The May CAP update is due on May 21st, 2025.

- 2023 Department of Health Care Services (DHCS) Focused Medical Survey

    - On September 4th, 2024, the DHCS issued the Final Medical Survey Audit Report and CAP Request for the 2023 DHCS Focused Medical Survey. The DHCS identified findings related to Behavioral Health Services and Transportation Services. Nine (9) CAPs were identified. To date six (6) CAPs have been accepted and three (3) CAPs have been partially accepted. The Plan submitted the last update on April 15th, 2025. The Plan is awaiting DHCS' review and response. The Plan's next update is due on May 18th, 2025.

- 2025 Department of Managed Health Care (DMHC) Fiscal Survey

    - On April 14th, 2025, the DMHC notified the Plan of its intent to conduct a routine examination of the Plan's fiscal and administrative affairs, including an examination of the financial report for the quarter ended March 31st, 2025. The pre-audit materials are due to the department on June 16th, 2025.

    - The examination will begin on August 4th, 2025, and will be conducted remotely.

- 2025 Health Services Advisory Group, Inc. (HSAG) Network Adequacy Validation Audit (NAV)
    - On April 16th, 2025, the Plan received an invitation from HSAG to attend the CA 2024-25 MCP & PSP NAV TA Webinar. The California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG), to conduct the 2025 Network Adequacy Validation (NAV) in accordance with the Centers for Medicare & Medicaid Services (CMS) External Quality Review (EQR) Protocol 4. As part of the NAV activity, HSAG will evaluate the Plan's ability to collect reliable and valid network adequacy monitoring data.
    - A technical assistance webinar is scheduled for June 5th, 2025, to discuss the audit activities as well as the document request packet. The HSAG is expected to issue the formal document request before the scheduled webinar.

Compliance Activity Updates

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

    - On April 14th, 2025, the Alliance received a CMS cure notice indicating, CMS the Plan's contracted network of facilities did not meet CMS network standards. Because this issue was anticipated, a revised Network Table was submitted to CMS on April 15th, 2025, and the Plan is awaiting CMS' conditional letter of approval.

- Department of Health Care Services (DHCS)
    - The State Specific MOC and HRA were submitted on February 12th, 2025. To date, the Compliance Division has not received any DHCS feedback on the State Specific MOC Matrix and Health Risk Assessment (HRA) to DHCS.
    - Department of Managed Health Care (DMHC) Medicare Filings – CY26 Medicare, 2024 EAE D-SNP Material Modification Filing (E-Filing *No. 20244060*). On April 10th, DMHC provided one comment related to the status of CMS application deficiencies and DHCS submissions. The Plan response included:
        - (A) a status update on the Plan's process in rectifying the above-identified issues, and
        - (B) clarification if there are any currently any outstanding issues with CMS or DHCS regarding the Plan's submission.
- New Legislation
    - On March 21st Compliance submitted DMHC's 2024 Annual Newly Enacted Statutes All Plan Letter (APL 24-023) filing. This APL includes seventeen newly enacted laws that impact the Plan's Medi-Cal and/or Group Care lines of business. On April 17th DMHC sent 24 comments. Compliance is currently coordinating with subject matter experts to develop comment responses.
- DMHC Timely Access Review/Annual Network Review
    - Annually on May 1st the Plan is required to submit a Timely Access Compliance Report (TAR) that includes information related to monitoring the Plans' network compliance with timely access standards, including network rates of compliance with the appointment wait-time standards during the previous year. The Plan is also required to annually submit information confirming the status of each network and its enrollment, including a complete list of the plan's contracted providers, hospitals, and number of enrollees within each network. Since January, Compliance has been partnering with representatives from Analytics, Provider Services, Health Education and Quality to gather & prepare materials for this submission. These materials were submitted timely on May 1st, 2025.
- 2024 Board of Governors Training
    - As outlined in the Compliance Plan, the Plan has assigned HIPAA and FWA training to all new and standing members of the Board. Of the eighteen Board members, fifteen (83%) have either completed their training or submitted sufficient proof of equivalent outside training and three (17%) have not started. The Plan continues efforts to encourage Board of Governors to complete the required 2024 BOG Training. The Plan continues coordination with the Board Clerk and the Board Chair to improve Board training rates of compliance.

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).
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.

#	Date Released	Regulatory Agency	APL #	APL Title	LOB	APL Purpose Summary
7	2/7/2025	DHCS	25-004	Community Reinvestments Requirements	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with guidance regarding the MCP Contract's requirement that MCPs reinvest a minimum level of their net income into their local communities.
8	3/12/2025	DMHC	24-004	AB 118: Part 1 - Compliance with Large Group Standardized Evidence of Coverage/Disclosure Form	GROUP CARE	Assembly Bill (AB) 118 (Ting, Chapter 42, Statutes of 2023) added Health and Safety Code section 1363.3 and revised Sections 1352.1, 1363, 1367.041, and 1367.24, effective January 1, 2025. These statutory changes apply to all commercial full-service health care service plans (plans), and require the Department of Managed Health Care (DMHC) to develop standardized templates for various documents describing health plan member benefits, such as the Evidence of Coverage (EOC), Disclosure Form (DF), Schedule of Benefits (SOB), Explanation of Benefits (EOB), and Cost-Share Summary (CSS). The DMHC's work to implement AB 118's requirement to develop standardized templates will be an iterative process. The first part of the standardized EOC/DF will be the following template components: (1) Exclusions and Limitations, (2) Members' Rights and Responsibilities, and (3) Definitions, for use in large group health care service plan contracts issued, amended, or renewed on or after January 1, 2026. This All Plan Letter (APL) and its accompanying attachments set out the filing requirements needed to demonstrate compliance with each template component.
9	3/19/2025	DMHC	25-005	Southern California Fires and Flexibilities to Impacted Providers	GROUP CARE & MEDI-CAL	On January 7, 2025, California Governor Gavin Newsom declared a State of Emergency in Los Angeles and Ventura Counties due to wildfires. The fires destroyed homes and businesses and displaced enrollees and health care providers. After the Governor declares a state of emergency, Health and Safety Code section 1368.7 allows the DMHC to take actions to help mitigate the impact to enrollees and providers.
10	3/21/2025	DMHC	25-006	Health Plan Coverage of Mobile Crisis Services	GROUP CARE	This APL provides guidance regarding the obligations of health plans related to behavioral health crisis services provided to an enrollee by a 988 center or mobile crisis team.
11	4/1/2025	DMHC	25-007	Assembly Bill 3275 Guidance (Claim Reimbursement)	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) under the Knox-Keene Health Care Service Plan Act of 1975, as amended, to provide guidance to health care service plans (plans) on requirements for the processing and reimbursement of claims for health care services with a date of receipt on or after January 1, 2026. Assembly Bill 3275 (Soria, 2024) amended Health and Safety Code sections 1371 and 1371.35 relating to reimbursement of claims for health care services, and enacted Health and Safety Code section 1371.34 enhancing consumer protections relating to grievances about claims for health care services.
12	4/9/2025	DMHC	25-008	Provider Directory Annual Filing Requirements	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (the Department) issues this All Plan Letter (APL) to remind health care service plans (plans) of California Health and Safety Code section 1367.27, subdivision (m)'s requirement to annually submit provider directory policies and procedures to the Department. In addition, the Department reminds plans to submit the changes to their provider directory policies and procedures as instructed in APL 24-018 – Compliance with Senate Bill 923.
13	4/15/2025	DMHC	25-009	2025 Health Plan Annual Assessments	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) to provide information to health care service plans (health plans) pertaining to the DMHC's fiscal year (FY) 2025-26 annual assessment.
14	4/25/2025	DHCS	25-006	Timely Access Requirements	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with guidance regarding the ongoing requirement to meet timely access standards as outlined in Health and Safety Code (H&S) section 1367.03, as set forth by Senate Bill (SB) 221 (Chapter 724, Statutes of 2021) and SB 225 (Chapter 601, Statutes of 2022). MCPs are required to comply with these requirements pursuant to Welfare and Institutions Code (W&I) section 14197(d)(1)(a).1 Additionally, this APL outlines the required minimum performance levels (MPLs) as set by the Department of Health Care Services (DHCS) which go into effect Measurement Year (MY) 2025 for the Timely Access Survey.
15	4/25/2025	DHCS	25-007	Enforcement Actions: Corrective Action Plans, Administrative and Monetary Sanctions	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide clarification to Medi-Cal managed care plans (MCPs) of the Department of Health Care Services' (DHCS) policy regarding the imposition of enforcement actions, including corrective action plans, and administrative and monetary sanctions, which are among the enforcement actions DHCS may take to enforce compliance with MCP contractual provisions and applicable state and federal laws.

ALAMEDA Alliance FOR HEALTH

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

Health Care Services

Donna Carey, MD

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

From: **Dr. Donna Carey, Chief Medical Officer**

Date: **May 9th, 2025**

Subject: **Health Care Services (HCS) Report**

Operational Updates:

- Changes were made in HCS and Operations to better align divisions to increase efficiency and reduce redundancy.
    - G&A operational leadership and team moved to Operations Department
    - G&A RNs remained in HCS and moved under Quality Improvement (QI) Division
    - NCQA team remained in HCS and moved under QI Division
    - Housing Community Supports team moved from Operations to HCS under the LTSS Division
    - Community Health Worker team moved from Operations to HCS
- Criteria changes to Community Supports paused due to two new policy guides released by DHCS on April 30, 2025 and the potential to create a tiered payment system much like ECM.

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%, 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 increased significantly month-over-month from March to April 2025.

Total Authorization Volume (Medical Services)			
Authorization Type	**February 2025**	**March 2025**	**April 2025**
Inpatient	3,107	2,963	3,688
Outpatient	3,660	4,008	5,597
Long-Term Care	935	1,124	909
Total	**7,702**	**8,095**	**10,194**

***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 continue to average 3-5/day. We are reviewing pended claims each week to identify CoC services and ensure there are no delays in the care for this population. With each case, we are reviewing for any potential care coordination or case management needs and referring to CM as needed.

- We continue to partner with our Medical Directors to review current prior authorization rules and evaluate which services should continue to require prior authorization, and which services should have prior authorization requirements removed (to decrease provider administrative burden).

- OP processed a total of 5,597 authorizations in the month of April which is a significant increase (+1,589 auths) from March 2025.

- OP Turnaround times continue to exceed the benchmark of 95% with the average being 99% in the month of April.

- The top 5 categories remain unchanged Radiology, OP Rehab, TQ, Home Health and Outpatient facility.

Total Outpatient Authorization Volume			
Authorization Status	**February 2025**	**March 2025**	**April 2025**
Approvals	3,530	3,728	5,253
Partial Approvals	20	79	36
Denials	210	201	308
Total	**3,660**	**4,008**	**5,597**

***Source**: #02569_AuthTAT_Summary*

Outpatient Authorization Denial Rates			
Denial Rate Type	**February 2025**	**March 2025**	**April 2025**
Overall Denial Rate	**3.0%**	**3.5%**	**2.7%**
Denial Rate Excluding Partial Denials	**2.7%**	**3.3%**	**2.3%**
Partial Denial Rate	**0.2%**	**0.1%**	**0.4%**

***Source**: #03690_Executive_Dashboard*

Outpatient Turn Around Time Compliance			
Line of Business	**February 2025**	**March 2025**	**April 2025**
Overall	97.9%	97.8%	99.2%
Medi-Cal	99%	98%	99.5%
IHSS	95.7%	100%	98.9%
Benchmark	95%	*95%*	*95%*

***Source**: #02569_AuthTAT_Summary*

Utilization Management: Inpatient

- Total inpatient auth volume increased from 3,107 authorizations processed in March 2025 to 3,688 in the month of April.

- Inpatient overall average LOS decreased from 6.1 in December to 5.5 in January but went back up to 5.8 in February. For admits per thousand and days per thousand: 56.3 in December falling to 50.9 in January and 46.7 in February. Days per thousand aligned with admits per 1,000 with decreasing from 341.7 in December to 280.0 in January and then 269.4 in February. The trend is consistent among Child, Adult, ACA and SPD categories.

- IP overall denial rate was 5.3% in February, and 2.9% in March, and 0.8% in April.

- IP Auth TAT compliance continues to meet or surpass 95% benchmark, with overall TAT of 95% in February, 97% in March and 95% in April.

- There was a fall out for IP TAT in the month of April 2025 with 2 of the 34 IHSS cases missing TAT causing the score to be below benchmark at 94%. There has been remediation with the staff as the corrective action.

- 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	**February 2025**	**March 2025**	**April 2025**
Approvals	3,032	3,023	3,613
Partial Approvals	0	0	0
Denials	75	62	75
Total	**3,107**	**2,963**	**3,688**

Source: #02569_AuthTAT_Summary

Inpatient Med-Surg Utilization			
Total All Aid Categories			
Actuals (excludes Maternity)			
Metric	**December 2024**	**January 2025**	**February 2025**
Authorized LOS	6.1	5.5	5.8
Admits/1,000	56.3	50.9	46.7
Days/1,000	341.7	280.0	269.4

Source: #01034_AuthUtilizationStatistics – *data only available through February 2025

Inpatient Authorization Denial Rates			
Denial Rate Type	**February 2025**	**March 2025**	**April 2025**
Full Denials Rate	1.6%	1.0%	0.8 %
Partial Denials	2.8%	2.0%	0%
All Types of Denials Rate	4.4%	3.0%	0.8%

Source: #01292_AllAuthDenialsRates

Inpatient Turn Around Time Compliance			
Line of Business	**February 2025**	**March 2025**	**April 2025**
Overall	95%	97%	95%
Medi-Cal	95%	97%	95%
IHSS	100%	97%	94%
Benchmark	*95%*	*95%*	*95%*

Source: #02569_AuthTAT_Summary

Utilization Management: Long-Term Care

- LTC census during April 2025 was 2,311 members. This is an increase of 0.07% from March 2025.

- Month to Month, the admissions, days and readmissions are decreasing. From January to March the admissions decreased by 62.58%, the days decreased by 79.85% and the readmissions also decreased by 70.73%. Some of this could be due to a lag in claims data being available, but we are seeing a decrease overall.

Totals	January 2025	February 2025	March 2025*
Admissions	163	122	61
Days	1,355	702	273
Readmissions	41	22	12

Source: #14236_LTC_Dashboard – data only available through March

- LTC Staff continue to participate in SNF collaboratives around the county to ensure that our facility partners are updated with the processes and program enhancements.

- Having virtual rounds with AHS, San Leandro, Kyakameena, Elmwood, Jones Convalescent and Eden LTC facilities to coordinate on complex cases

- Quarterly rounds with Regional Center of Easy Bay to discuss any ICF/DD members.

- Continued internal Long Term Care rounds to discuss members coming into and leaving a long-term care setting.

- Social Workers continue visiting LTC facilities in person, on a monthly and quarterly basis depending on census, to assist with discharge planning and access to other resources. The team continues referrals to TCS and other internal/external programs to provide wraparound support to members preparing to discharge from an LTC custodial facility.

- LTSS Liaison is visiting and meeting with facilities to discuss any claims issues and educating on processes.

- Health Navigator 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 decreased in April, compared to February and March.

- Authorization processing turn-around time (TAT) has remained at 99%, which is exceeding the threshold of 95%.

Total LTC Authorization Volume			
Authorization Status	**February 2025**	**March 2025**	**April 2025**
Approvals	905	1079	877
Partial Approvals	0	0	0
Denials	30	45	32
Total	**935**	**1124**	**909**

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	**February 2025**	**March 2025**	**April 2025**
Medi-Cal	**99.6%**	**99%**	**99%**
Benchmark	*95%*	*95%*	*95%*

Source: #02569_AuthTAT_Summary

Behavioral Health

- In April, the Behavioral Health Department processed 749 authorizations, 392 Care Coordination referrals, and 255 mental health screenings and transition of care tools.

Total BH Authorization Volume			
	25-Feb	**25-Mar**	**25-Apr**
Approvals	646	680	741
Partial Approval	0	0	0
Denials	2	9	8
Total	648	689	749

Source: 14939_BH_AuthTAT

Mental Health Turnaround Times

MH TAT			
	25-Feb	**25-Mar**	**25-Apr**
Determination TAT%	97%	99%	97%
Notification TAT%	92%	96%	99%

Behavioral Health Therapies (BHT/ABA) Turnaround Times

BHT TAT			
**Goal ≥95%*	**25-Feb**	**25-Mar**	**25-Apr**
Determination TAT%	99%	100%	100%
Notification TAT%	100%	100%	100%

Behavioral Health Denial Rates

**Goal ≤ 5%*	**BH Denial Rates**

25-Feb	25-Mar	25-Apr
0.01%	1%	1%

Source: 14939_BH_AuthTAT

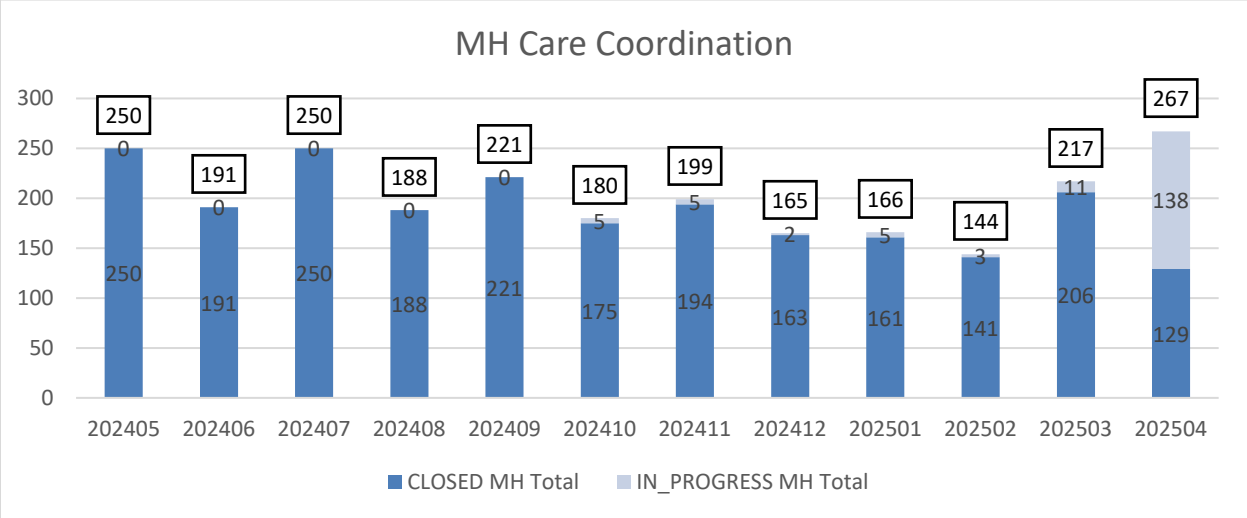
Mental Health Care Coordination

- In compliance with the No Wrong Door policy, the Alliance completes the DHCS-required screening tools when members are seeking to start new mental health services. The screening tools determine if members meet the criteria to be referred to ACBH for Specialty Mental Health Services.

Total # Medi-Cal Screenings & TOC			
	25-Feb	25-Mar	25-Apr
Youth Screenings	88	81	90
Adults Screenings	146	130	164
Transition of Care Tools	2	2	1

Source: 16015_MH_Assessments

- Alliance licensed mental health clinicians, psychiatric nurses, and behavioral health navigators provide care coordination for members who need assistance accessing the mental health treatment services they need.

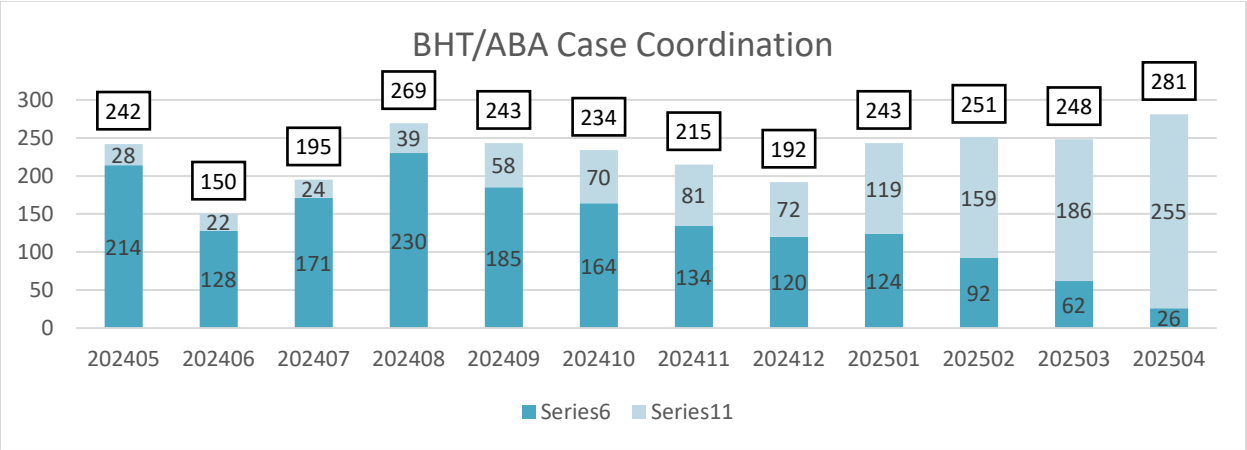


Source: 14665_BH_Cases

Behavioral Health Therapies (BHT/ABA)

- Children and youth referred for BHT/ABA services, including Applied Behavioral Analysis (ABA) and Comprehensive Diagnostic Evaluations (CDE), require Care Coordination to access the services needed. The Alliance manages each child's

unique needs and follows up with parents and caregivers to resolve barriers to care.

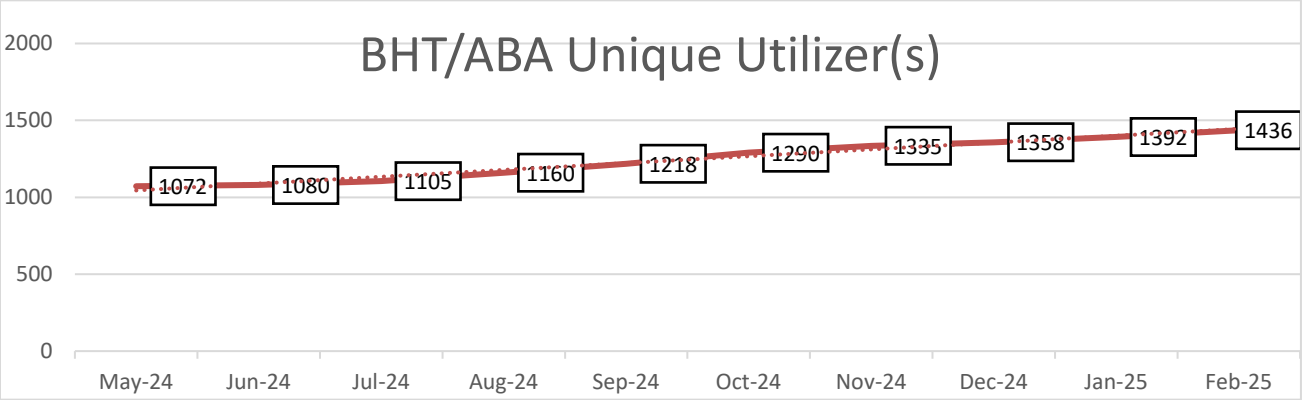


Source: 14665_BH_Cases

Behavioral Health Unique Utilizers

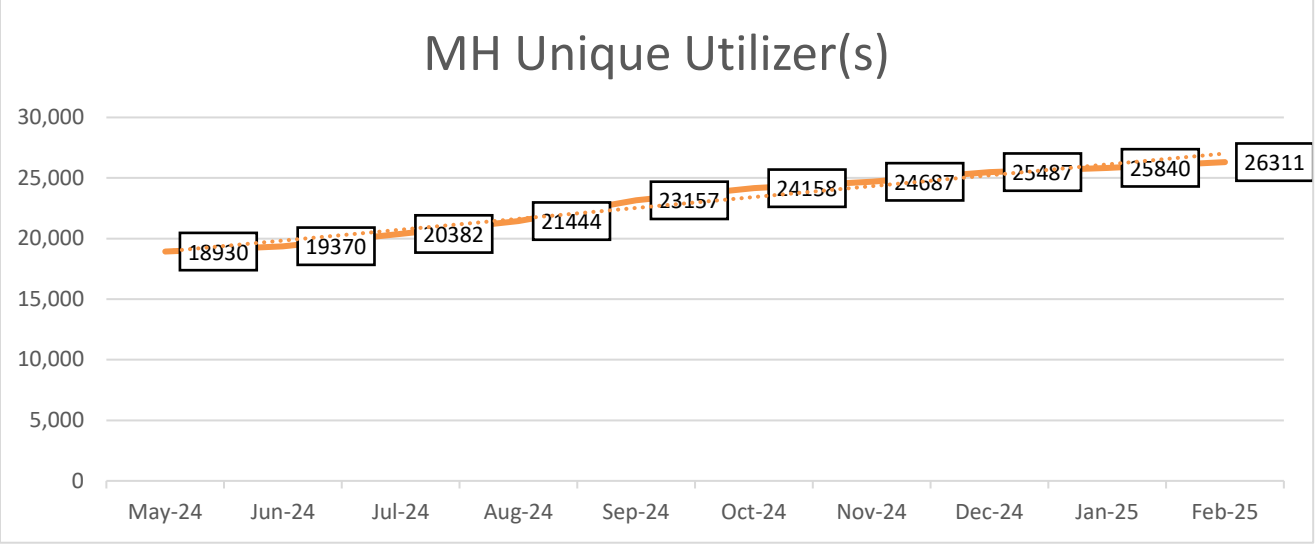
Removing barriers to accessing BHT/ABA services remains a primary goal for the Alliance Behavioral Health team. One way to measure that is to monitor unique utilizers who are accessing care when interventions are implemented.

- We observed a continuing rise in unique utilizers of BHT/ABA services, reflecting a 3% increase compared to the previous month.



Source: PBI 14621 BHT Utilization Report

- The number of unique utilizers of mental health services has increased by 2% compared to the previous month.



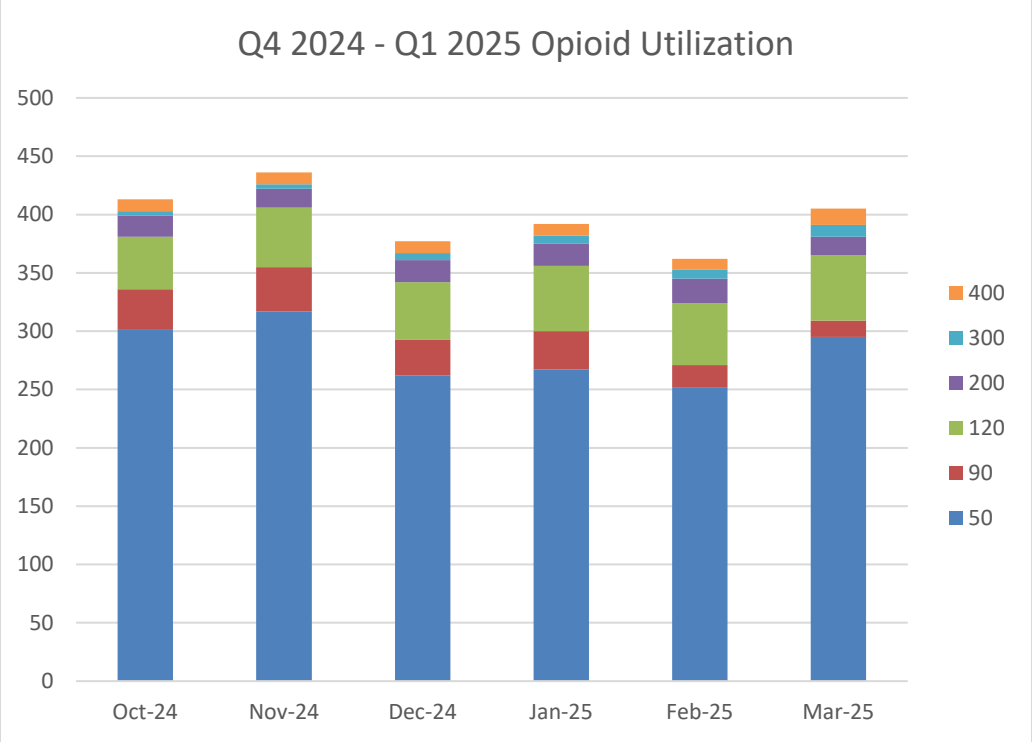
Source: PBI 14637 BH12M Report

Pharmacy

- Pharmacy is collaborating with population health, QI, and disease management on creating clinical programs for HEDIS measures for high blood pressure, asthma, and diabetes.

- The Pharmacy Department continues to monitor members on use of opioids. We send bi-annual mailings to at risk members and their providers. Impacted members receive handouts on medication assisted treatment for opioid dependance, an opioid safety guide, and alternative pain management strategies. Their assigned PCPs receive guides to benzodiazepine and opioid tapering, formulary alternatives to opioids, and opioid dependence treatment approaches.

- We measure the use of opioid medications using Morphine Milligram Equivalents (MME). Less than 90 MME increased from January to March. 90 to 119 MME significantly decreased, while 120 MME or higher slightly increased.



MME	IHSS	MCAL	Total
January			**392**
50	15	252	267
90	6	27	33
120	5	51	56
200	2	17	19
300		7	7
400		10	10
February			**362**
50	13	239	252
90	3	16	19
120	4	49	53
200	1	20	21
300		8	8
400		9	9
March			**405**
50	14	281	295
90		14	14
120	9	47	56
200		16	16
300		10	10
400	1	13	14

Case and Disease Management

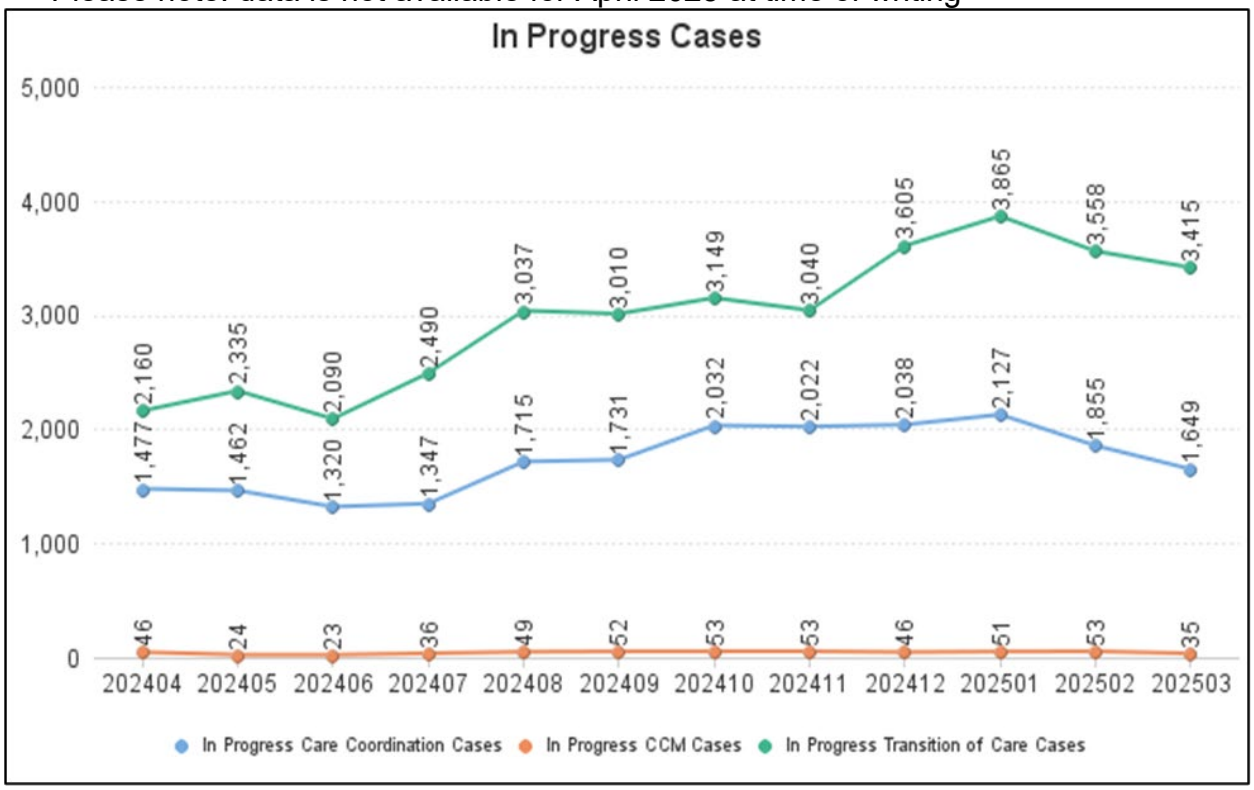
- The CM team continues to assist the high volume of members needing Transitional Care Services (TCS) as they transition from one level of care to another. This includes member transitions where the Alliance is not the primary payor (such as members with Medicare primary insurance).

- The CM team continues to collaborate with clinic partners to ensure the TCS requirements are met, including but not limited to scheduling and ensuring follow-up appointments for members, informing members of CM services, notifying appropriate individuals of TCS services (hospital discharge planners, members, caregivers, support teams, etc.).

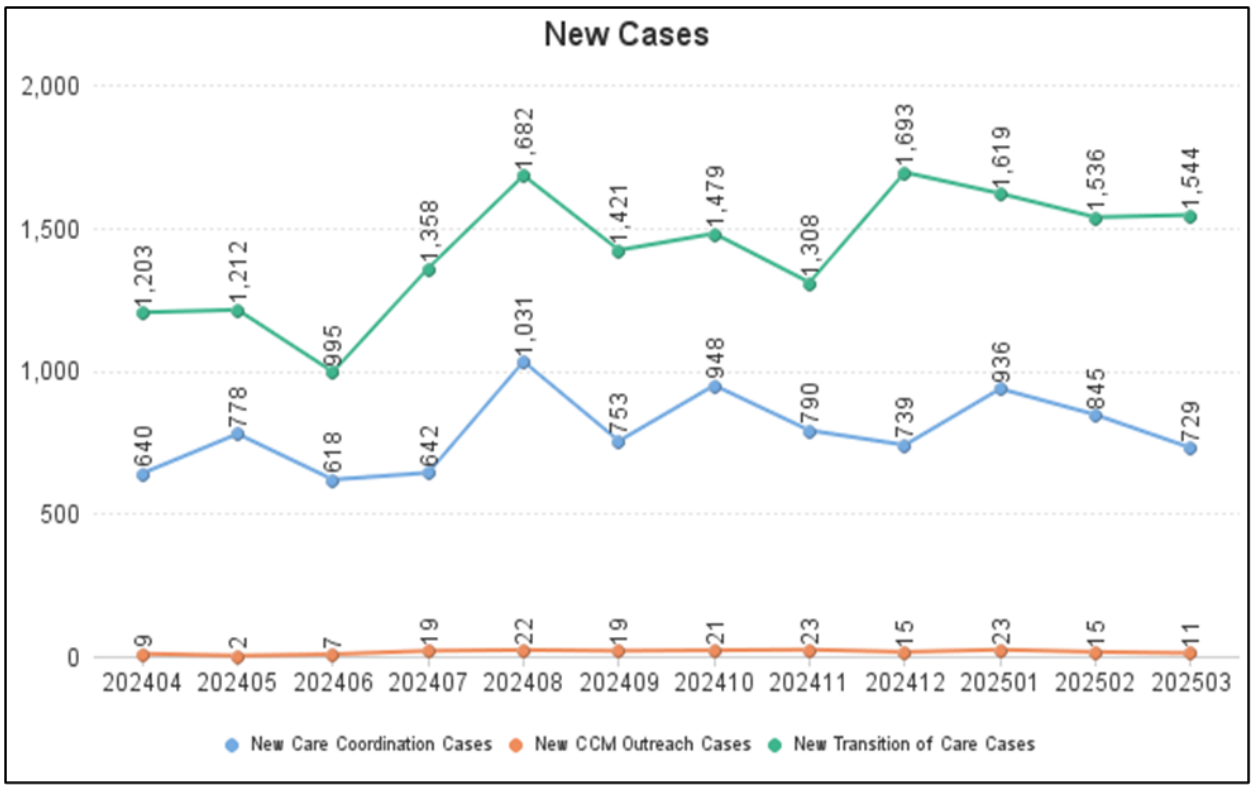
- CM is collaborating with UM and LTC to support members at hospitals with long-length stays and complex discharge barriers, including facilitating referrals to Community Supports, ECM and other community resources, as needed.

- CM is responsible for acquiring Physician Certification Statement (PCS) forms before Non-Emergency Medical Transportation (NEMT) trips to better align with DHCS requirements for members who need that higher level of transportation (former completed by Transportation broker, Modivcare). CM continues to educate the provider network, including hospital discharge planners, and dialysis centers about PCS form requirements. Transportation liaison has also increased oversight of ModivCare's facility transportation services, including making onsite visits with hospitals to address transportation concerns.

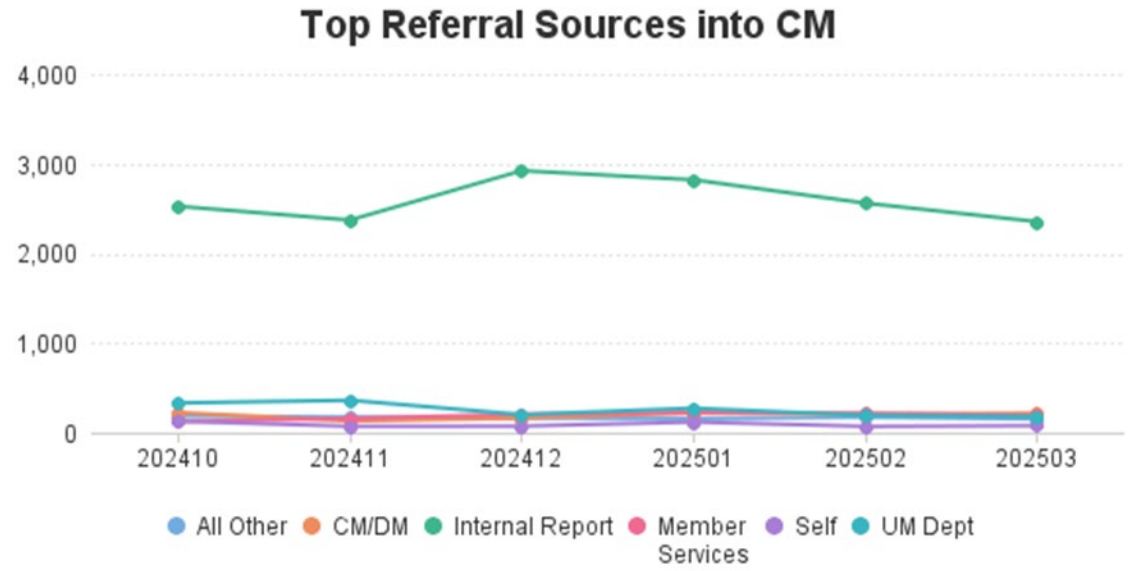
  Please note: data is not available for April 2025 at time of writing



Source: #03342 TruCare Caseload



Source: #03342 TruCare Caseload



*Internal Report represents Transitional Care Services (TCS) data for recently admitted patients via Admissions Discharges Transfers (ADT) feed from hospital / skilled nursing facility partners

Source: #03881 Case and Disease Management Dashboard - *data only available through March 2025

CalAIM

Enhanced Case Management

- All Populations of Focus have been live since January 1, 2024.

- The ECM team is working closely with IT and IPD to automate creation of authorizations and potential other areas of ECM. This will improve processing time of authorizations and free up the team to work on other areas of ECM like graduating or stepping members down into a lower level of care.

- The ECM team continues to build rapport with the ECM providers, meeting at a minimum twice a month: once to discuss specific cases and once to discuss operational issues. This is leading to more collaboration and community referrals to additional resources. Additional meetings are scheduled with ECM providers for case conferencing as needed.

- ECM and CS are beginning a collaboration to confirm communication is occurring between Community Supports providers and ECM lead care managers. Further ensuring non-duplicative services and members are receiving appropriate services to meet their needs.

- As a result of this fall's audit of ECM providers, the ECM team has developed training for the ECM providers to re-educate the ECM provider network on the core services DHCS is requiring for ECM. The ECM team has scheduled monthly training sessions for all ECM providers' frontline staff to reinforce ECM requirements and expectations. Trainings have been scheduled to occur from February through July 2025.

- AAH continues to collaborate with Alameda County (AC) Health to discuss Street Medicine alignment. The ECM team works closely with the Street Team providers to make sure encounters are submitted and billed appropriately.

- ECM staff, including the Foster Care/Child Welfare Liaison continue to participate in DHCS Foster Care Youth Transition Stakeholder meetings and work with county foster youth programs. This has led to the initial training of the Foster Care Youth Liaisons, which occurred in early February.

- MCPs are required to implement Closed-Loop Referral (CLR) requirements starting on July 1, 2025. The closed-loop referral framework is designed to ensure that referrals between healthcare providers are completed efficiently and effectively. The ECM team is partnering with IPD to make sure Alameda Alliance can meet the regulatory requirements.

	January 2025		February 2025		March 2025	
ECM Providers	**Outreach**	**Enrolled**	**Outreach**	**Enrolled**	**Outreach**	**Enrolled**
ACBH	-	14	-	14	-	14
Alameda Health System (AHS)	22	205	24	209	27	213
Bay Area Community Services (BACS)	-	125	-	125	-	130
California Cardiovascular Consultants	-	158	-	159	-	158
California Children's Services (CCS)	9	24	6	25	5	25
CHCN	121	1,035	114	1,038	86	1,020
East Bay Innovations (EBI)	3	117	2	119	8	118
Full Circle	1	188	-	179	1	173
Institute on Aging	24	247	16	259	-	257
La Familia	54	38	44	42	57	35
MedZed	24	514	262	529	1	565
Roots Community Health Center	1	301	9	310	11	303
Seneca Family Services	14	65	61	64	38	65
Pair Team	448	802	207	803	796	850
Titanium Health Care	966	697	643	795	932	864
Tiburcio Vasquez Health Center (Street Medicine)	-	117	-	117		112
BACH (Street Medicine)	-	77	-	76	-	77
Lifelong (Street Medicine)	1	239	-	227	-	224
Roots Community Health Center (Street Medicine)	Combined with Roots 'traditional' ECM program					

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.

- DHCS released new policy guides for all Community Supports on 04/30/25. The team is reviewing them to identify impact on current processes and potential criteria changes.

- CS services are focused on offering services or settings that are medically appropriate and cost-effective alternatives. The Alliance offers the following community supports:

    - Housing Navigation
    - Housing Deposits
    - Tenancy Sustaining Services
    - Medical Respite
    - Medically Tailored/Supportive Meals
    - Asthma Remediation
    - (Caregiver) Respite Services
    - Personal Care & Homemaker Services
    - Environmental Accessibility Adaptations (Home Modifications)

    - Assisted Living Facility Transition
    - Community or Home Transition Services

- Further CS service & network expansion is paused; potential providers have been notified.

- AAH CS staff continue to meet with CS providers to work through logistical issues as they arise, including referral management, claims payment and member throughput.

- DHCS 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 supports have transitioned back under the LTSS Director effective 04/13/25, to better align with the broader community support services, and plan for the transitional rent and medical respite overlap services.

Community Supports	Services Authorized in January 2025	Services Authorized in February 2025	Services Authorized in March 2025
Housing Navigation	893	901	905
Housing Deposits	244	238	211
Housing Tenancy	948	786	758
Asthma Remediation	115	128	133
Meals	1,400	1,344	1,156
Medical Respite	93	81	72
Transition to Home	24	24	24
Nursing Facility	22	20	16
Home Modifications	0	0	0
Homemaker Services	52	53	49
Caregiver Respite	4	3	1
Total	**3,795**	**3,578**	**3,325**

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.

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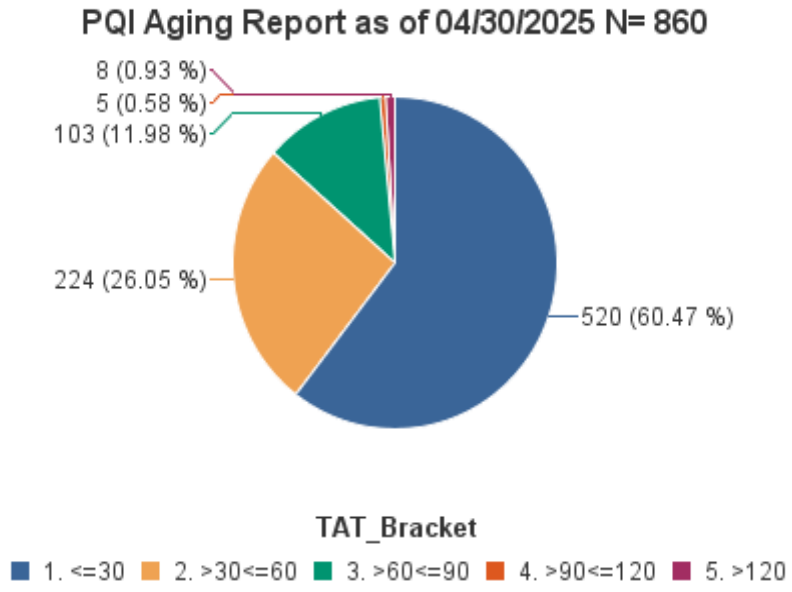
- Quality of Access issues are reviewed by the Access & Availability team and Quality of Language issues by the Cultural & Linguistics Services team after they are triaged by the QI Clinical team. Quality of Care and Service issues are reviewed by the QI RN Reviewers. Final leveling for Quality-of-Care cases is determined by the Sr Medical

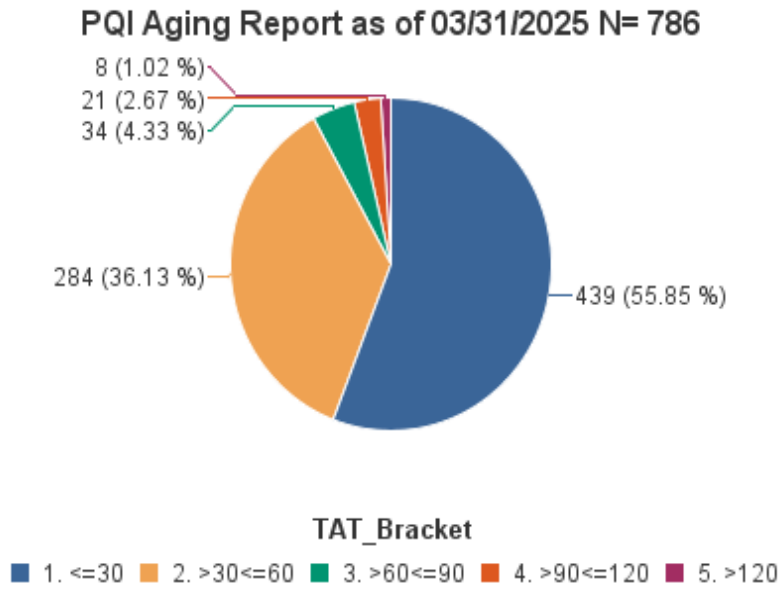
Director of Quality after RN review is completed. Weekly meetings are scheduled for the purpose of Quality-of-Care case review with the Sr Medical Director.

- 99% of cases in March 2025 and 99% of cases in April 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 74 referrals from March to April 2025. TATs are closely monitored on a weekly basis to ensure timely closure of cases within the standard 95%.





Interpreter Services Overview

- In 2024, over 97,000 interpreter services (in-person, telephonic, and video) were provided across 135 languages.
- Top 10 languages requested in 2024 included threshold languages, American Sign Language, Mam, and other languages. See table 1 below.

Table 1. Top 10 Languages Requested by Modality, 2024

2024 Top 10 Languages		
In-Person	**Telephonic**	**Video**
Spanish	Spanish	Spanish
Cantonese	Cantonese	Cantonese
Vietnamese	Vietnamese	Vietnamese
Mandarin	Mandarin	American Sign Language
Mam	Mam	Arabic
Arabic	Arabic	Mandarin
American Sign Language	Dari	Hindi
Russian	Khmer	Russian
Dari	Farsi	Farsi
Farsi	Mien	Mam

- Interpreter utilization increased 70% from 2023 due to the Adult Expansion and Anthem members.
- 2025 Q1, we saw a 40% increase over 2024 Q1, with a 99% fulfillment rate, exceeding our 95% target.

- 75% of interpreter services utilized in 2025 Q1 were on-demand (Phone 99%, Video 1%); 25% were prescheduled (In-person 86%, Phone 2%, and Video 2%).
- See table 2 below for the top 10 languages requested in 2025 Q1.

Table 2. Top 10 Languages Requests, 2025 Q1

Language	%
Spanish	43%
Cantonese	16%
Vietnamese	12%
Mandarin	7%
Mam	4%
Arabic	3%
Dari	2%
Farsi	1%
Khmer	1%
Punjabi	1%

- The Alliance is implementing efficiency/enhancement projects aimed at streamlining internal workflows for scheduling and coordination of interpreter services, and ensuring members receive the most appropriate interpreter service modality through collaboration with providers.

Quality of Language (QOL)-Potential Quality Issues (PQI)

- In 2024, the CLS team addressed a total of 398 QOL-PQIs.

- In 2025 Q1, the CLS team addressed a total of 87 QOL-PQIs ensuring members connected with needed language services, providing member and provider education on accessing interpreters, and following-up with interpreter service vendors on quality assurance concerns.

Member Satisfaction with Language Services

Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS)

- In 2024, we experienced a percentage decrease in child and increase in adults in favorable responses on the Member Satisfaction Survey, CG-CAHPS to the survey question: *"Were you able to communicate with your doctor and clinic staff in your preferred language?"*

Table 2. Favorable Responses, CG-CAHPS, 2023-2024

Favorable Response Rate	2023	2024	% Change 2023 vs 2024
Adult	85.2%	87.3%	2.5%
Child	95.4%	92.5%	-3.0%

Timely Access Requirement (TAR) Survey

- In 2024 (MY2023), we launched the annual TAR Survey to:
  - Gather enrollees' feedback on access to timely appointments and interpreter services.
  - Inform members of their rights to timely care and interpreter access.
  - Assess Limited English Proficient (LEP) members' experiences with scheduling, interpreter availability, and the quality of interpreter services.
- The survey was offered in English and translated into 15 languages.
- Response Rates
  - MY2023: 110 responses (3.4%)
  - MY2024: 259 responses (5%), 1.6% increase
  - Respondents completed the survey in all Alliance threshold languages along with several additional languages.
- Key Findings-MY2023 vs. MY2024. See table 3 below.

Table 3. Member Satisfaction Comparison, MY2023-MY2024

Member Satisfaction	MY2023	MY2024	Change
Scheduling with an Interpreter	87%	89%	2%
Interpreter Spoke Preferred Language	89%	89%	No Change
Interpreter Knowledge & Skill	90%	88%	-2%

- Member satisfaction remained favorable even with the slight decrease in “Member Satisfaction with Knowledge, Skill, and Quality of Interpreters”.
    - The CLS team will continue to review member grievances and investigate PQIs related to interpreter services.
    - Additionally, we will continue to review and monitor vendors’ training curriculum and interpreter linguistic assessments. If any deficiencies are found, we will address these with the vendor and at the quarterly vendor Joint Operation Meetings (JOMs).
- Response rate low for Spanish-speaking members.
    - The Alliance will focus efforts to increase participation among Spanish-speaking members through provider education and engagement.

Cultural Sensitivity Training

- Achieved a 100% staff completion. The Training was also shared with providers in 2025 Q1.

Community Engagement and Input

- In 2024, the Alliance welcomed one (1) new Community Advisory Committee (CAC) member.
- The CLS team collaborated with internal stakeholders to implement 2024 DHCS contract requirements for the CAC. Some of these efforts have included the following:
    - Established a CAC Selection Committee.
    - Completing the 2025 CAC Demographic Report.
    - Targeted CAC member recruitment to address representation gaps.

2025 CLS Workplan Focus Areas

- Language Assistance Services: Continue to monitor utilization of interpreter services and ensure we reach or exceed an average fulfillment rate of 95%. We will also work towards increasing on-demand usage.

- Member Satisfaction for Language Services: Through the CG-CAHPS and Timely Access Requirement (TAR) Survey, monitor Alliance members’ satisfaction related to language services, including scheduling, availability, and quality of interpreter services.

- Provider Network: Continue to monitor provider language capacity and race/ethnicity to ensure the Alliance offers a practitioner network that meets our members’ cultural, ethnic, racial, and linguistic needs. Also, based on 2024 Availability of Practitioners to Meet the Cultural Needs and Preferences of

Members Report, implement actions focused on members and practitioners.

- Community Engagement and Input: Focus on recruiting at least one (1) member in our identified areas of representation gaps.

- Potential Quality Issues: Continue to monitor and conduct appropriate interventions to address quality of language services.

Community Health Worker Program

- 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 has been postponed
  - CHW Service Request Module development – postponed
  - Revise CHW strategy – in process
  - CHW Billing Mitigation Reports – ongoing
  - DHCS CHW Emergency Department Policy updates – completed
  - CHW Standing Recommendation Revisions – in progress
  - Strengthening pathways to and From ECM Project – in progress
  - CHW closed loop referral Process – in progress

- Staffing Updates:
  - Manager, Community Health Worker Program – recruitment in progress

CHW Program April Summary:

- As part of our continued commitment to health equity and improved member outcomes, April's efforts have focused on drafting, revamping, and reimagining how departments coordinate to deliver seamless, whole-person care. The goal is to move beyond siloed operations and toward a unified, accountable framework—one that ensures members experience consistent access and continuity of care across the entire health continuum, no matter where they enter the system.

- A key element of this work includes the strategic reorganization of the Community Health Worker (CHW) program under the Health Care Services team, along with expanded efforts to socialize the CHW benefit across departments. CHWs serve as a

vital link between clinical and non-clinical services, providing culturally responsive, community-based support that enhances traditional care models. We are actively engaging internal teams to build understanding of the CHW role and reinforce the value of integrating this benefit into our broader care ecosystem.

- By strengthening coordination across clinical, operational, and community-facing teams, we are laying a strong foundation for a more equitable, connected, and sustainable system—one that prioritizes access, continuity, and trust at every step of the member journey.

- CHW Interdepartmental Collaboration & Scope of Work Project Highlights:
    - April has been an exciting month for CHW services and interdepartmental collaboration. Below are a few highlights of CHW Program, Quality Teams and Populations Health joint efforts:

- Journey Health Medical Group – Community Health Worker (CHW) Provider: Journey Health Medical Group serves as both a medical group and CHW provider, with a core focus on integrating clinical and non-clinical services to eliminate health disparities. Their model leverages a population health approach to promote whole-person wellness, while enhancing access to care for our most vulnerable members and communities. Journey Health exemplifies how trusted relationships and care coordination can work in tandem to advance equity and improve outcomes
    - CHW Scope of work: Addressing A1C and CBP for Alameda Alliance members through assessing critical SDOH needs, pre-post assessments and a 12-week curriculum amplifying members choice through skill development and tangible tools to address their diagnosis. – Go Live 05/1/2025

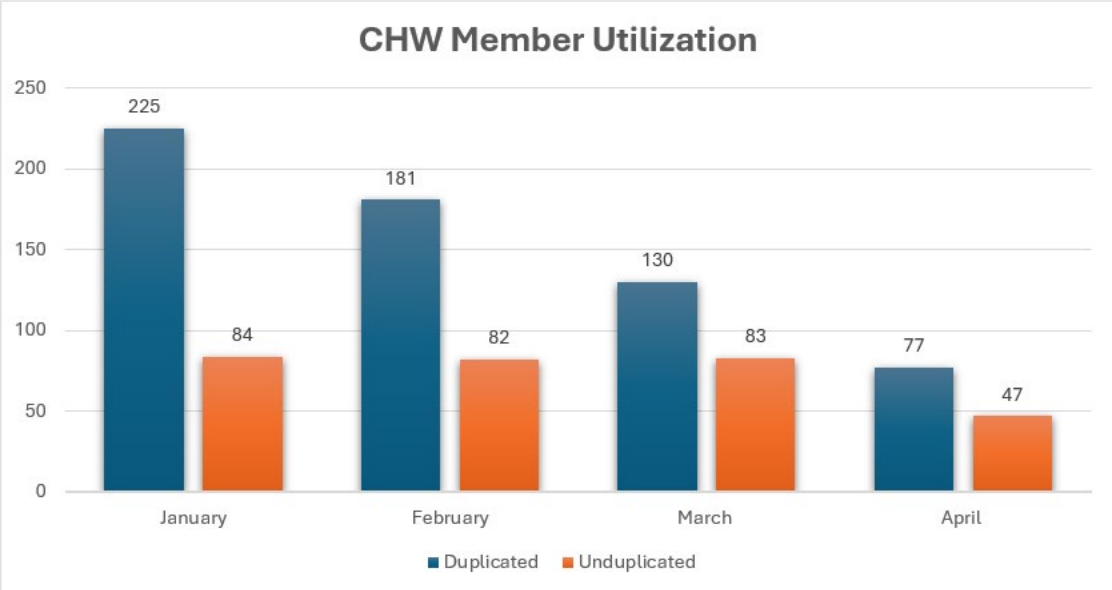
- Our Roots Organization: Our Roots is a community-based mental wellness partner with specialized expertise in perinatal depression and the mental health needs of under-resourced BIPOC women and birthing people impacted by poverty. Through a culturally responsive and trauma-informed approach, they address critical gaps often overlooked in traditional systems. Our Roots aligns with the Alliance's strategic focus on advancing maternal health equity by strengthening access to culturally affirming community-rooted mental health services across the perinatal continuum.
    - CHW Scope of Work: The provider is on track to finalize a contract agreement by the first week of May 2025. Their scope of work will focus on supporting perinatal members through targeted interventions including perinatal depression screening, culturally responsive health education, peer coaching, care navigation, and connection to behavioral health resources. Members will also benefit from continuity of engagement and wraparound support aimed at improving outcomes across the perinatal journey. – Go Live 05/12/2025

CHW Program – Recruitment Efforts:

- Alameda Alliance for Health has 10 fully executed CHW contracts, with three (3) contracts in progress and three (7) providers still in the outreach phase. Additionally, two (2) provider organizations either declined to contract, did not pass AAH entity interest process or did not respond by the end of the reporting period.

CHW Program – Member Utilization Snapshot

- Working Definitions:
  - Duplicated: Refers to instances where a member received CHW services more than once within the reporting period.
  - Unduplicated: Represents the count of unique individuals who accessed CHW services, ensuring each member is counted only once, regardless of the number of visits.



- The data presented reflects CHW member utilization trends from January through April 2025. A consistent decline in duplicated utilizations, i.e., instances where members received services more than once within a month, was observed over the reporting period:
    - January: 225 duplicated encounters
    - February: 181 duplicated encounters
    - March: 130 duplicated encounters
    - April: 77 duplicated encounters

- In contrast, unduplicated utilization reflects the number of unique individuals receiving services, which remained relatively stable throughout the three months:
    - January: 84 unique members
    - February: 82 unique members
    - March: 83 unique members
    - April: 47 unique members

- Community Health Worker (CHW) program evaluation, focus will shift from only monitoring utilization trends to driving measurable outcomes and uncovering deeper analytical insights.

- In Phase II, of the program standup we will emphasize linking CHW interventions to improved member outcomes, enabling us to draw more meaningful correlations from the data. For example, since partnering with Alameda Health Systems (AHS), in August 2024, claims data shows that 80 members received CHW services during an emergency department (ED) visit. Remarkably, only one of those members returned to the ED between August 2024 and March 2025 — a promising early indicator of impact.

- As the CHW program continues to evolve, we will strategically expand our provider network and deploy targeted interventions that advance health equity, improve member outcomes, and inform data-driven decisions. This next phase presents an exciting opportunity to not only scale the program, but to also elevate the role of CHWs as a critical bridge between clinical care and community-based support.

ALAMEDA Alliance FOR HEALTH

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

Health Equity

Lao Paul Vang

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

From: **Lao Paul Vang, Chief Health Equity Officer**

Date: **May 9th, 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**
  - In collaboration with C&O, members of the Health Equity team participated in the Black Women's Health Forum (BWHF) on April 8th in downtown Oakland.
  - The team provided health education/promotional materials to attendees.

- **SOGI Data Workgroup**
  - Given the new federal executive order, the SOGI data committee decided to temporarily suspend our work until further guidance or possibly a new advisory from NCQA regarding potential changes in this area.

- **NCQA-Health Equity Accreditation**
  - The Health Equity team continues to participate in the NCQA working group to address health equity-related standards relating to AAH's application for NCQA Accreditation by January 2026.

- **PHM Workgroup**
  - The Health Equity team continues to collaborate with PHM team and participates in the weekly PHM work group, including reviewing the new PHM strategies for the coming year.

- **Over/Under Utilization Workgroup**
  - The Health Equity team continues to engage in ongoing meetings with the Healthcare Service workgroup to discuss and share best practices relating to ways to overcome over- and underutilization.

- **Alliance Publication Workgroup**
  - As part of the Health Equity Roadmap milestone # 4 Communication, the Health Equity joined the Alliance Publication workgroup organized by Communication & Outreach to help create content for social media postings and articles.

- The aim is to position the Alliance as the champion 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 meet to collaborate on Health Equity and DEI initiatives.
  - The meeting consisted of DHCS and CHEO Updates.

- **Local Initiatives DEI Training Monthly Collaborative Meeting**
  - Local MCPs continue to meet to update, share, and collaborate on the DEI Training Program. The monthly collaborative allows MCPs to ask questions, update each other on curriculum information, and assist with moving the DEI Training forward**.**

Alliance Health Equity Strategic Roadmap Update

- The Alliance Health Equity Roadmap was presented in December 2024:

Milestone	Goals
1. Organization Transformation	a) CHEO works collaboratively with SLT to facilitate system-wide organization transformation that supports the long-term vision of health equity for the Alliance.
2. Data-Driven	a) Collaboration with UM, PHM, QI, and Analytics. b) Utilize grant-funded health equity projects to gather data that will augment the Alliance's claim data depository to formulate a comprehensive understanding of the SDOHs that perpetuate the health disparities faced by our Medicaid members.
3. Education	a) Lead in the development of DEI Training APL 23-025 and APL 24-018 TGI-SB 923 training.

	b) Collaboration with Culture and Linguistic, PHM, QI, and other stakeholders to ensure all our policies, services, and programs are rooted in the core foundation of health equity. c) Participation in various Functional Area Delegate (FAD) workgroups to ensure the Alliance work supports the health equity vision and mission
4. Communication	a) Collaboration with Alliance Publication Workgroup to develop effective communications on all aspects of health equity activities to ensure that staff and members are fully informed.
5. Community Engagement	a) Faith-Based Community Engagement (FBCE) workgroup b) CIN membership c) Other CBO, and national or local organizations such as AHA, First-5.
6. SDOH Mitigation Measures	a) Collaborate with CMO and HCS team to assess and analyze non-utilization data aimed at identifying health disparities.

Recommendations:

1. BOG review and provide feedback regarding the above milestones and goals.
2. BOG can add additional milestones and goals and or revise the current milestones and goals.
3. Upon receiving BOG's feedback, the final milestones and goals will be established, and the HE Team will begin the implementation process of the Alliance Health Equity Roadmap.

DHCS-DMCS APL Update

- **DEI Training APL 23-025 Update**

  We received approval from DHCS regarding the DEI training curriculum.
  - Updated Timeline:
    - May 2025: DEI Provider's Pilot will launch. California Cardiovascular Consultants (CCC) has been selected to receive the pilot training.
    - May – June 2025: pilot training completed
    - July to Dec 2025: training given to downstream network providers and vendors.

- **APL 24-018: TGI-SB 923 Update**
    - The TGI (Transgender, Gender diverse, intersex) Cultural Sensitive Training was provided to AAH staff who are directly working and communicating with our members.

    - Timeline:
        - Dec 2024: confirmation of vendor
        - Jan-Feb 2025: Implementation of training for all Alliance staff
        - Feb 14: 97% of AAH staff completed the mandatory training. The 3% of non-completion represents staff who were on vacation or medical leave. Upon returning to the office, they will have up to 30 days to complete the training.
        - Feb 14, 2025: submission of documents per APL to the State, including evidence-based TGI training curriculum, updated online Providers Directory for gender-confirming services, G&A, and Policy and Procedures.
        - Feb 28, 2025: Attestation was submitted to DHCS.
        - HE Team is working with TGI working group to develop plans to train member-facing vendors as part of the next step in this APL.

Diversity, Equity, Inclusion, and Belonging Committee (DEIBC) and Values in Action Committee (VIAC):

- **DEIB Committee Update**
    - The DEIB Committee met on April 4th and discussed Health Equity and DEI Activities and the upcoming Spring Social.

- **VIA Committee Update**
    - At the April 21st VIA Committee meeting, the committee discussed the upcoming April 22nd Spring Social event.
    - The Holidays and Cultural Celebrations PPT was approved.

- **Alliance Spring Social –**

    - At this event, the proposed headcount given to vendors was 200-250, and approximately 200 of our Alliance team attended.

    - In collaboration with Facilities, we ordered more tents for sun relief for our next event(s). The new tents were displayed for shade throughout the area.

    - Shoutouts & Big Thank–You to help make this event possible for our staff:

        - Facilities & Support Services
        - Vendor Management
        - Finance

- Health Equity Department
- our CEO and
- VIA Committee

We are mindful to select vendors that align with cultural or holiday celebrations. For example, March was Greek American Heritage Month and April was Arab American Heritage Month, so we selected a vendor that served and honored traditional selections like gyros and falafel. The following food was available at the Spring Social:

- **Halal Bites of Chicago**
  - Greek Gyros! (Greek pita bread with salad on top and choices of protein such as Lamb, Beef, Chicken, and Falafel) topped off with our signature white dressing. They also have veggie and vegan gyros.
  - Mediterranean Rice Platters! (Afghan basmati rice served with salad and choice of protein such as Lamb, Beef, Chicken, and Falafel) topped off with our signature white dressing. They also have veggie and vegan platters.
  - Garden Salad Mix (choice of protein such as Lamb, Beef, Chicken, and Falafel) topped off with our signature white dressing. They also have veggie and vegan options.
- **Waffle Roost**
  - 2Legit: fried chicken + waffle
  - Spicy & I Know It: split waffle sandwich stuffed with fried chicken, crispy melted cheddar, & serrano peppers
  - The ECP (vegetarian): split waffle sandwich with egg, cheese, & peppers
  - (all items served with shoestring french fries)

- **Grillzillas Food Truck**
  - Cheeseburger (Black Angus beef, cheese, red onions, lettuce, tomatoes & mayo)
  - Veggie Burger (Garden patty, cheese, lettuce, tomatoes, red onion & mayo)
  - Chicken Tenders with fries (3-piece tenders & fries)
  - California Burger (Black Angus beef, cheese, red onions, lettuce, tomatoes, Applewood bacon, & Avocado

- **FroGo Yogurt**
  - Chocolate,
  - Vanilla,
  - Strawberry,
  - Pineapple,
  - Chocolate, Strawberry, or Pineapple Creamsicle.
  - (all flavors are vegan, dairy/lactose free, kosher, and halal considerations)

ALAMEDA Alliance FOR HEALTH

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Information Technology

Sasikumar Karaiyan

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

From: **Sasi Karaiyan, Chief Information & Security Officer**

Date: **May 9th, 2025**

Subject: **Information Technology Report**

Call Center System Availability

- In April 2024, AAH phone systems and call center applications maintained 100% availability even as they supported 97% of employees working remotely.

- Alliance continues to introduce new features to enhance efficiency. Alliance is working on extending this system to include Spanish language support. The project to enable the Spanish language pack for Calabrio is currently in progress, including the preparation of installation scripts. Selected Member Services staff will conduct translation reviews and phrase tuning, with this phase expected to commence by the end of June 2025.

Encounter Data

- In the month of April 2025, the Alliance submitted 145 encounter files to the Department of Health Care Services (DHCS) with a total of 446,160 encounters

Enrollment

- The Medi-Cal Enrollment file for the month of April 2025 was received and loaded to HEALTHsuite.

HEALTHsuite

- The Alliance received 372,126 claims in the month of April 2025.

- A total of 393,355 claims were finalized during the month out of which 347,343 claims auto adjudicated. This sets the auto-adjudication rate for this period to 88.3%.

TruCare

- A total of 21,486 authorizations were loaded and processed in the TruCare application.

- TruCare Application Uptime – 99.9%.

SQL Server Upgrade to version 2022

Objective:

- To upgrade SQL server from 2016 to 2022 for SQLPROD/DBR1PROD by end of Q1 2026

Execution Plan:

- The upgrade is divided into two phases as Phase 1 and Phase 2

Phase 1:

- Database compatibility upgrade from 2012 to 2016 is in progress.
- This is completed in SQLDEV and SQLTEST.
- Post upgrade monitoring is going on and any work related to stabilization and optimization is in progress in SQLTEST.
- This work is targeted to be complete by the end of May.
- After that database compatibility needs to be completed in SQLPROD and monitored for about 2-3 weeks.

Phase 2:

- SQL server migration from 2016 to 2022 version needs to be completed.
- This is being targeted for Q3 of 2025 and to be planned after phase 1 is completed.

Challenges:

- Once the database compatibility upgrade was moved from 2012 to 2016, we noticed few jobs performance got degraded.
- We have been working on those, and two CR were implemented for improving the performance of those jobs and deployed to SQLPROD.

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.

- Prioritized vulnerability remediation efforts around technical debt – in essence accumulated obsolete and vulnerable software/applications that pose the most risk to the organization.

- Completed “server certificate collection” exercise, reducing potential down time for mission-critical services.

- PHI/PII “self-attestation” process has gone live. This process alleviates administrative overhead created by false-positive detections.

Information Technology

Supporting Documents

Enrollment

- See Table 1-1 “Summary of Medi-Cal and Group Care member enrolment in the month of April 2025”.
- See Table 1-2 “Summary of Primary Care Physician (PCP) Auto-assignment in the month of April 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 April 2025

Month	Total MC[1]	MC[1] - Add/ Reinstatements	MC[1] - Terminated	Total GC[2]	GC[2] - Add/ Reinstatements	GC[2]- Terminated
April	410,773	7,211	9,824	5,896	152	138

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 April 2025

Auto-Assignments	Member Count
Auto-assignments MC	2,403
Auto-assignments Expansion	2,181
Auto-assignments GC	78
PCP Changes (PCP Change Tool) Total	4,662

TruCare Application

- See Table 2-1 “Summary of TruCare Authorizations for the month of April 2025”.
- There were 21,486 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 April 2025*

Transaction Type	Total Auths Received
Paper Fax to Scan (DocuStream)	2,695
Provider Portal Requests (Zipari)	6,358
EDI (CHCN)	6,286
Provider Portal to AAH Online (Long Term Care)	6
ADT	1279
Behavioral Health COC Update - Online	57
Behavioral initial evaluation - Online	43
Manual Entry	3,073
OCR Face sheets	1,689
Total	21,486

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 March 2025

Group	Individual User Accounts	Individual User Accounts Accessed	Total Logins	New Users
Provider	8,186	6,040	603,679	813
MCAL	125,122	4,025	9,246	1,290
IHSS	4,008	80	675	39
Total	137,316	10,145	613,600	2,142

Table 3-2 Top Pages Viewed for the Month of March 2025

Category	Page Name	Page Views
Provider - eligibility/claim	Member Eligibility	1942162
Provider - Claims	Claim Status	288897
Provider - authorizations	Auth Submit	17130
Directory Config	Provider Directory	9484
Provider - authorizations	Auth Search	8858
Provider - Claims	Submit professional claims	5514
Member My Care	Member Eligibility	4971
Member Config	Provider Directory	4636
Member Help Resources	Find a Doctor or Hospital	3278
Member Help Resources	ID Card	2556
Member Help Resources	Select or Change Your PCP	2003
Provider - eligibility/claim	Member Roster	1945
Member My Care	My Claims Services	1658
Member Home	MC ID Card	1568
Member My Care	Authorization	1158
Provider - Home	Behavior Health Forms SSO	1044
Provider - Provider Directory	Provider Directory 2019	969
Provider - reports	Reports	907
Provider - Home	Forms	678
Member My Care	My Pharmacy Medication Benefits	533
Provider - eligibility/claim	Claim Status	402
Member My Care	Member Benefits Materials	383
Member Help Resources	Forms Resources	375
Member Help Resources	FAQs	361

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
March	11867	11151	709
April	15436	10925	1420

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
March	8303	6869	1434
April	11128	8864	1768

- Calls Presented: Total number of calls received.
- Calls Handled: Total number of calls answered.
- Calls Abandoned: Calls abandoned before being completely answered.

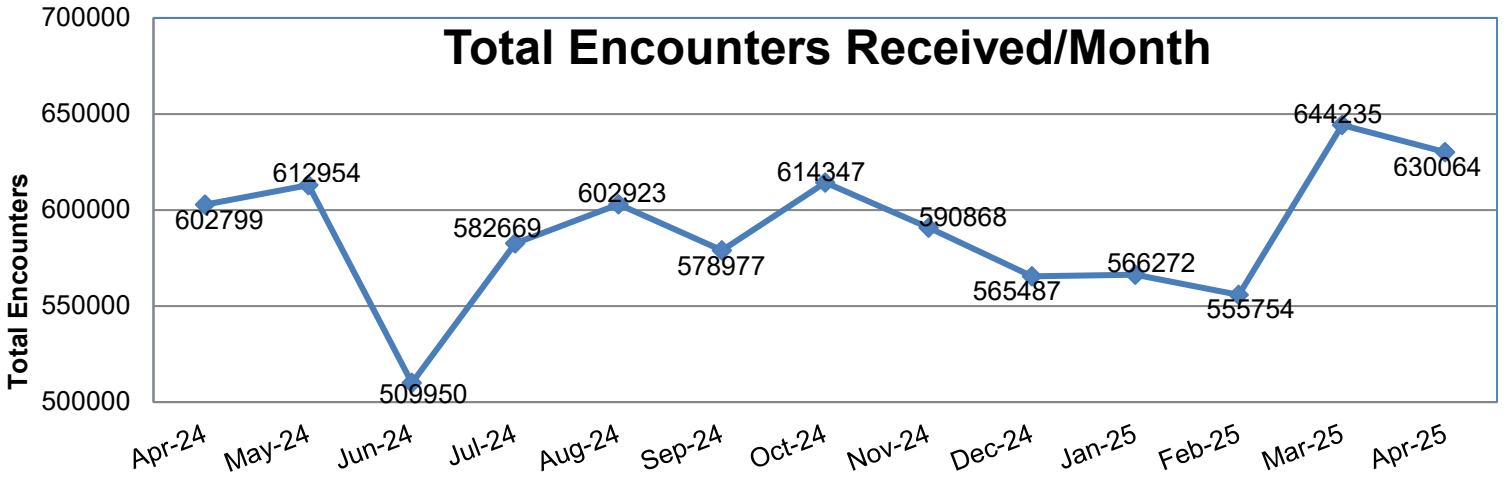
Note: It is important to note that there is a slight discrepancy between the number of calls presented, handled, and abandoned. This discrepancy is due to calls being rerouted to the XAQT vendor, which are not included in the calls handled or abandoned statistics. This rerouting can account for some of the differences observed in the totals.

Encounter Data from Trading Partners 2025

- **AHS**: April weekly files (8,211 records) were received on time.
- **BACH**: April monthly files (131 records) were received on time.
- **BACS**: April monthly files (72 records) were received on time.
- **CHCN**: April weekly files (117,350 records) were received on time.
- **CHME**: April monthly files (8,293 records) were received on time.
- **CFMG**: April weekly files (15,856 records) were received on time.
- **Docustream**: April monthly files (891 records) were received on time.
- **EBI**: April monthly files (2,926 records) were received on time.
- **FULLCIR**: April monthly files (2,025 records) were received on time.
- **HCSA**: April monthly files (2,384 records) were received on time.
- **IOA**: April monthly files (0 records) were received on time.
- **Kaiser**: April bi-weekly files (0 records) were received on time.
- **LAFAM**: April monthly files (93 records) were received on time.
- **LIFE**: April monthly files (317 records) were received on time
- **LogistiCare**: April weekly files (55,059 records) were received on time.
- **March Vision**: April monthly files (6,704 records) were received on time.
- **MED**: April monthly files (0 records) were received on time.
- **OMATOCHI**: April monthly files (0 records) were received on time.
- **PAIRTEAM**: April monthly files (16,360 records) were received on time.
- **Quest Diagnostics**: April weekly files (18,003 records) were received on time.
- **SENECA**: April monthly files (108 records) were received on time.
- **SERENE**: April monthly files (0 records) were received on time.
- **TITANIUM**: April monthly files (3,039 records) were received on time.
- **TVHC**: April monthly files (116 records) were received on time.
- **Magellan**: April monthly files (481,564 records) were received on time.

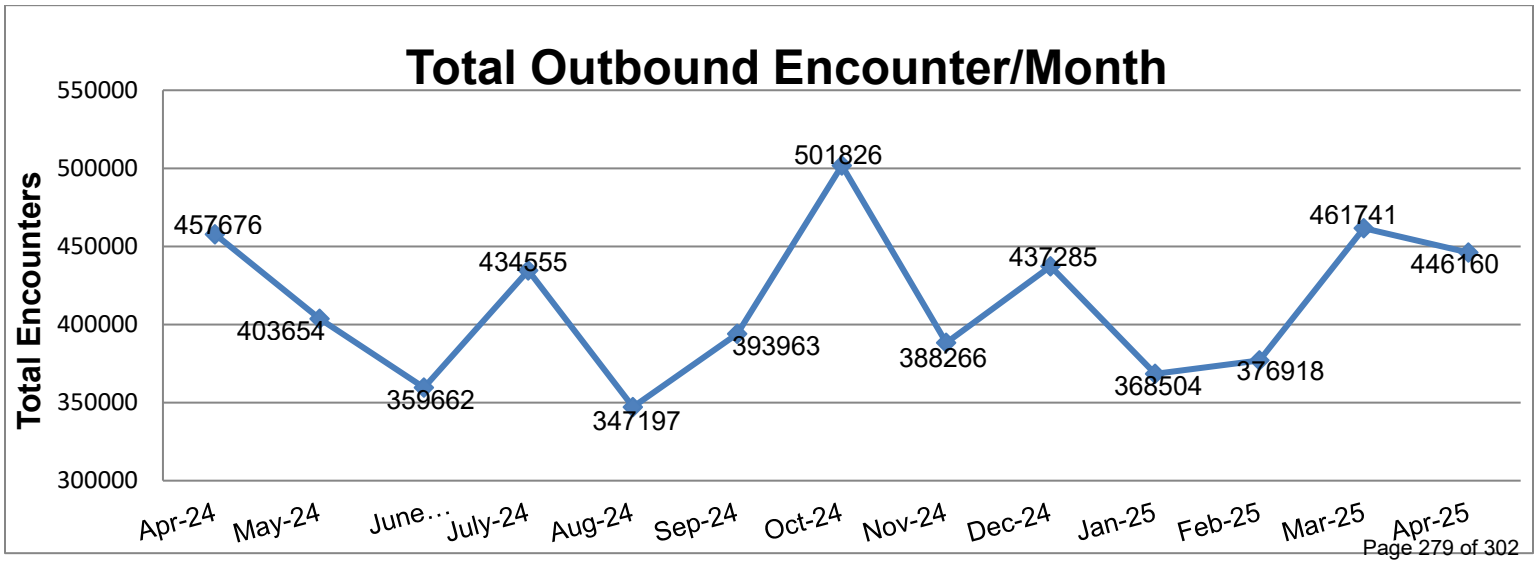
Trading Partner Encounter Inbound Submission History

Trading Partners	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
Health Suite	322786	375454	297267	332150	368235	322196	367989	364130	332108	339760	339840	347469	372126
AHS	6573	8412	13316	7296	8859	7498	8309	10535	7261	9709	8654	9273	8211
BACH								795		426		291	131
BACS	64	70	77	88	86	85	76	98	104	93	113	81	72
CHCN	170653	122445	110650	135444	122293	155825	125042	127223	127327	117483	118972	181049	117350
CHME	7969	7107	7449	7242	6902	7680	7102	7589	7458	7781	7553	6794	8293
CFMG	16394	15934	21143	10776	22335	16421	16045	21352	16696	13536	17329	21767	15856
Docustream	302	1589	749	934	1102	1067	704	678	828	694	808	770	891
EBI	1700	184	2043	1623	1825	3394	1640	1725	1476	1440	1597	1390	2926
FULLCIR	2261	8478	2842	1362	1798	3809	2523	2038	1085	806	1534	2099	2025
HCSA	7118	5535	3663	6841	3256	3386	2389	3423	2335	2432	2725	2118	2384
IOA	1925	1163	1280	847	752	4227	588	1064		3008	933	736	
Kaiser	2286	886	1079	2052	172	236	159						
LAFAM	105	116	86	70	88	63	89	76	83	112	96	85	93
LIFE			1694		614	168	119	335	997	228	267	431	317
LogistiCare	32632	27531	16205	43038	29732	16139	49941	16183	34122	28671	32550	33754	55059
March Vision	3633	8546	7092	6404	7719	5769	5143	6016	6285	15146		6985	6704
MED	633	722	744	615	608	610	645	656	619	758	1182	775	
OMATOCHI	29				2								
PAIRTEAM	5344	7582		5763		9359	1108	2204	5816	3436		2055	16360
Quest	18000	18001	22500	18000	22502	18004	18002	22501	18003	18002	18001	22502	18003
SENECA	159	113	71	109	129	101	105	117	131	1	69	129	108
SERENE									654	107		209	
TITANIUM	2233	3086		2015	3914	2815	6192	1537	2099	2487	3531	2855	3039
TVHC						125	437	593		156		618	116
Total	602799	612954	509950	582669	602923	578977	614347	590868	565487	566272	555754	644235	630064



Outbound Encounter Submission

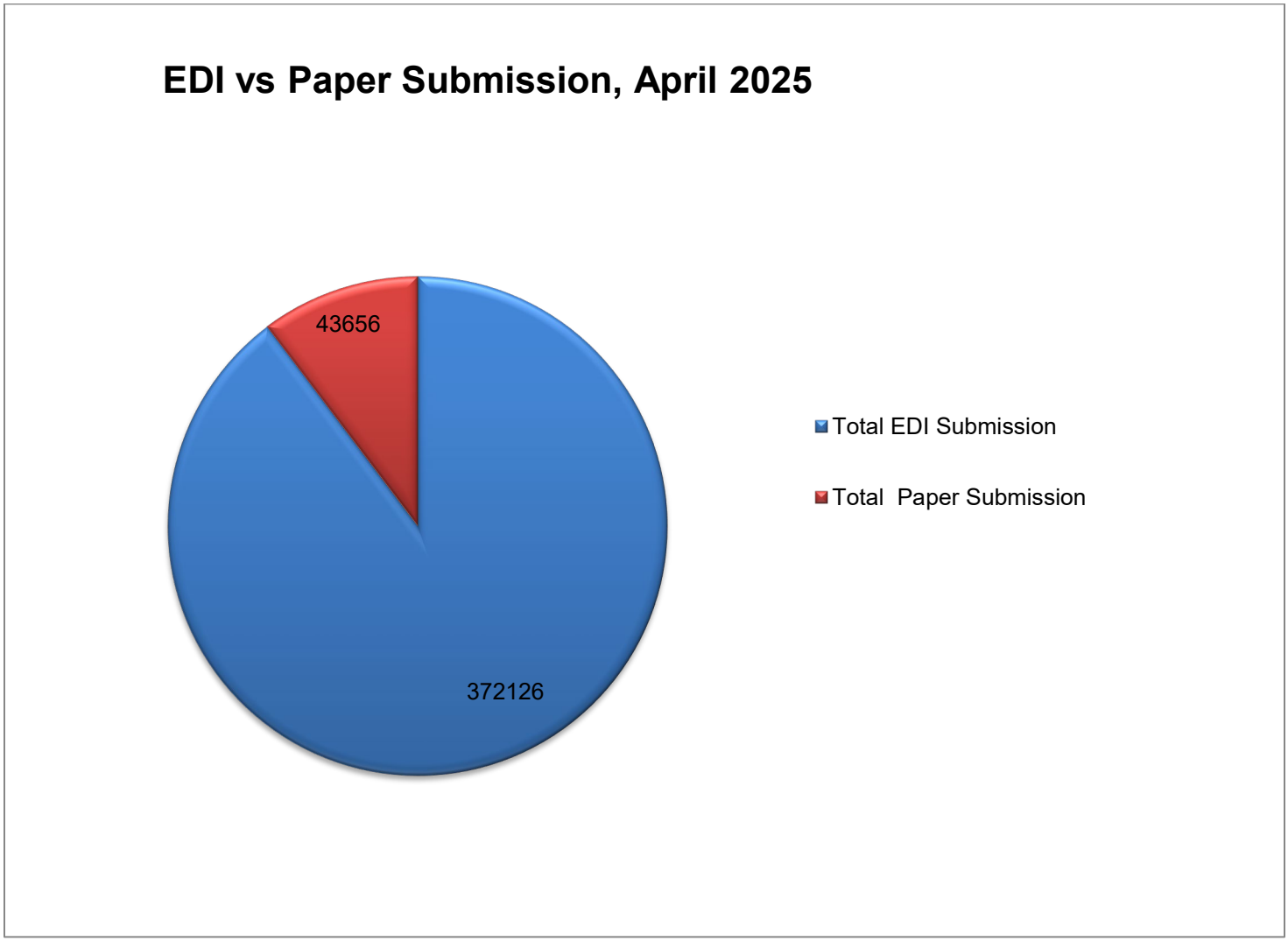
Trading Partners	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
Health Suite	250835	198595	204068	230706	183371	210971	276473	218194	263242	182192	205804	264948	210745
AHS	6524	7002	10684	6703	7101	8727	8201	10403	6850	7710	8135	7952	4510
BACH								739	6	407		272	110
BACS	59	66	72	80	80	78	74	79	41	128	87	59	23
CHCN	104625	107577	77200	94476	87485	87806	108806	88573	84649	85439	82973	95918	115571
CHME	7558	6749	7310	7095	6762	6994	6974	7474	7342	7426	7167	6682	8156
CFMG	13467	11561	11506	9994	4	24076	13152	13882	11342	9362	11960	15008	11394
Docustream	267	839	570	725	806	715	545	482	239	634	559	478	551
EBI	1589	60	1835	1443	1727	3242	1559	1641	494	2208	1475	1308	1493
FULLCIR	1636	5401	2410	1084	674	1515	1767	1470	79	1298	1251	1823	1658
HCSA	4710	5363	3493	6757	3171	3310	2376	3394	2255	2497	2693	2103	2332
IOA	1868	1029	1221	749	680	1374	549	949		2783	781	626	
Kaiser	1905	1292	812	1404	113	216	62		23				
LAFAM	92	103	58	66	81	58	86	62	3	178	89	80	84
LIFE			28		598	159	91	76	202	508	63	65	116
LogistiCare	32247	27487	16221	43019	30006	16046	49705	15235	34035	28502	32441	33656	54971
March Vision	2407	5719	4553	3766	3482	4066	3543	3980	4156	9586	371	4354	3870
MED	518	579	654	552	540	514	579	568	55	546	1083	731	
OMATOCHI	56												
PAIRTEAM	4279	4422		3246		4617	782	1960	994	6334		1489	10873
Quest	20983	16912	16898	20898	16854	16937	21144	16909	21044	16828	16855	21048	16795
SENECA	140	109	69	108	127	94	91	100	6	112	60	116	101
SERENE										82		20	
TITANIUM	1911	2789		1684	3535	2332	5267	1278	228	3600	3071	2551	2764
TVHC						116		818		144		454	43
Total	457676	403654	359662	434555	347197	393963	501826	388266	437285	368504	376918	461741	446160



HealthSuite Paper vs EDI Claims Submission Breakdown

Period	Total EDI Submission	Total Paper Submission	Total claims
25-Apr	328470	43656	372126

Key: EDI – Electronic Data Interchange



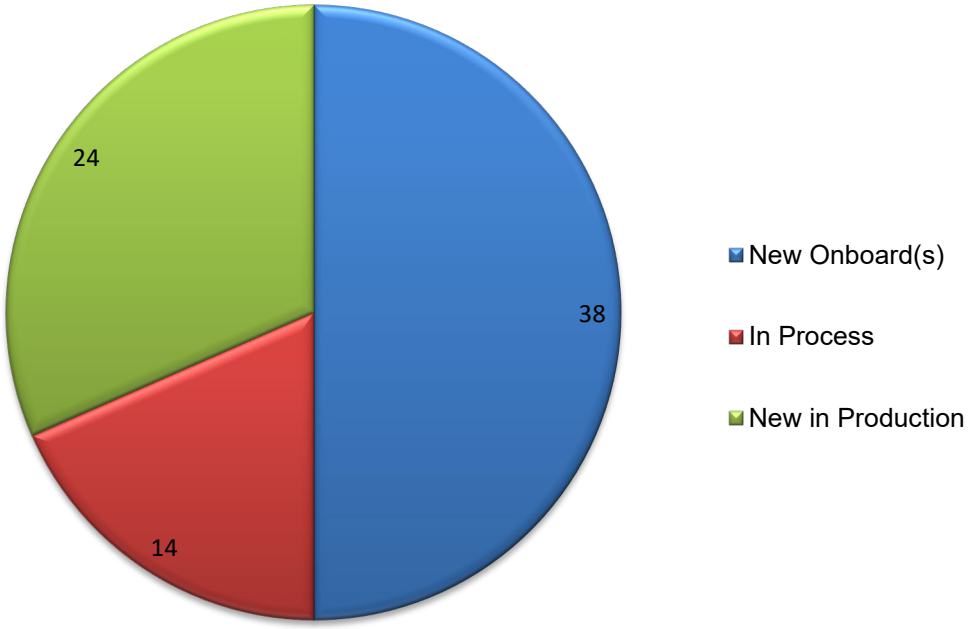
Onboarding EDI Providers – Updates

- Apr 2025 EDI Claims:
  - A total of 2981 new EDI submitters have been added since October 2015, with 24 added in April 2025.
  - The total number of EDI submitters is 3721 providers.

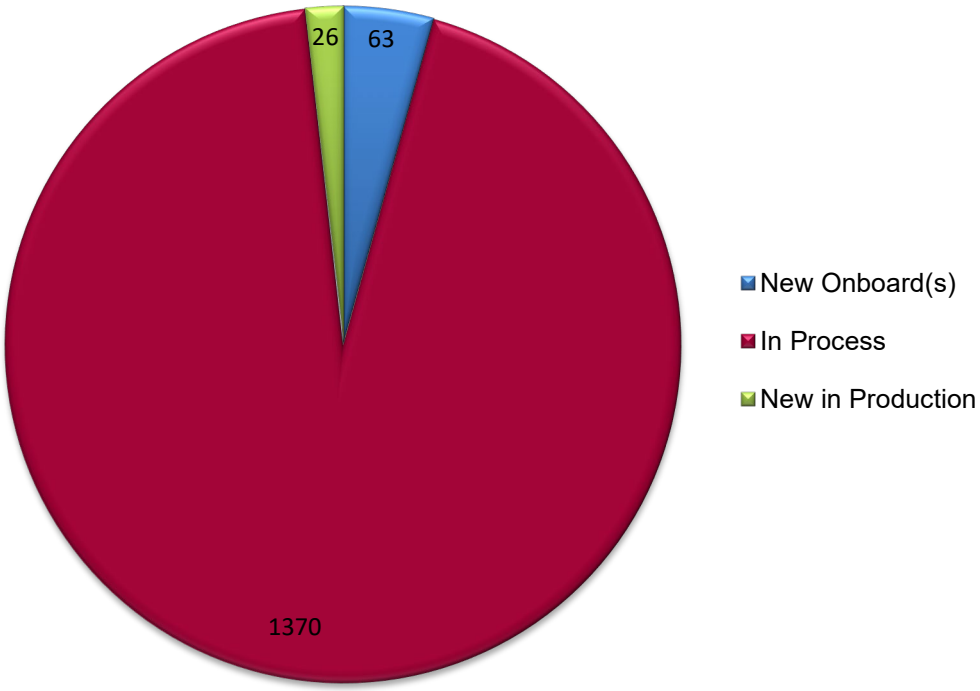
- Apr 2025 EDI Remittances (ERA):
  - A total of 1378 new ERA receivers have been added since October 2015, with 26 added in April 2025.
  - The total number of ERA receivers is 1365 providers.

	837				835			
	New on Boards	In Process	New In Production	Total in Production	New on Boards	In Process	New In Production	Total in Production
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
Mar-25	46	3	43	3697	74	1328	32	1339
Apr-25	38	14	24	3721	63	1370	26	1365

837 EDI Submitters - Apr 2025



835 EDI Receivers - Apr 2025



Encounter Data Submission Reconciliation Form (EDSRF) and File Reconciliations

- EDSRF Submission: Below is the total number of encounter files that AAH submitted in the month of **April** 2025.

File Type	Apr-25
837 I Files	28
837 P Files	117
Total Files	145

Lag-time Metrics/Key Performance Indicators (KPI)

AAH Encounters: Outbound 837	Mar-25	Target
Timeliness-% Within Lag Time - Institutional 0-90 days	91%	60%
Timeliness-% Within Lag Time - Institutional 0-180 days	98%	80%
Timeliness-% Within Lag Time - Professional 0-90 days	92%	65%
Timeliness-% Within Lag Time – Professional 0-180 days	97%	80%

*Note, the Number of Encounters comes from: Total at bottom of this chart: **Outbound Encounter Submission**

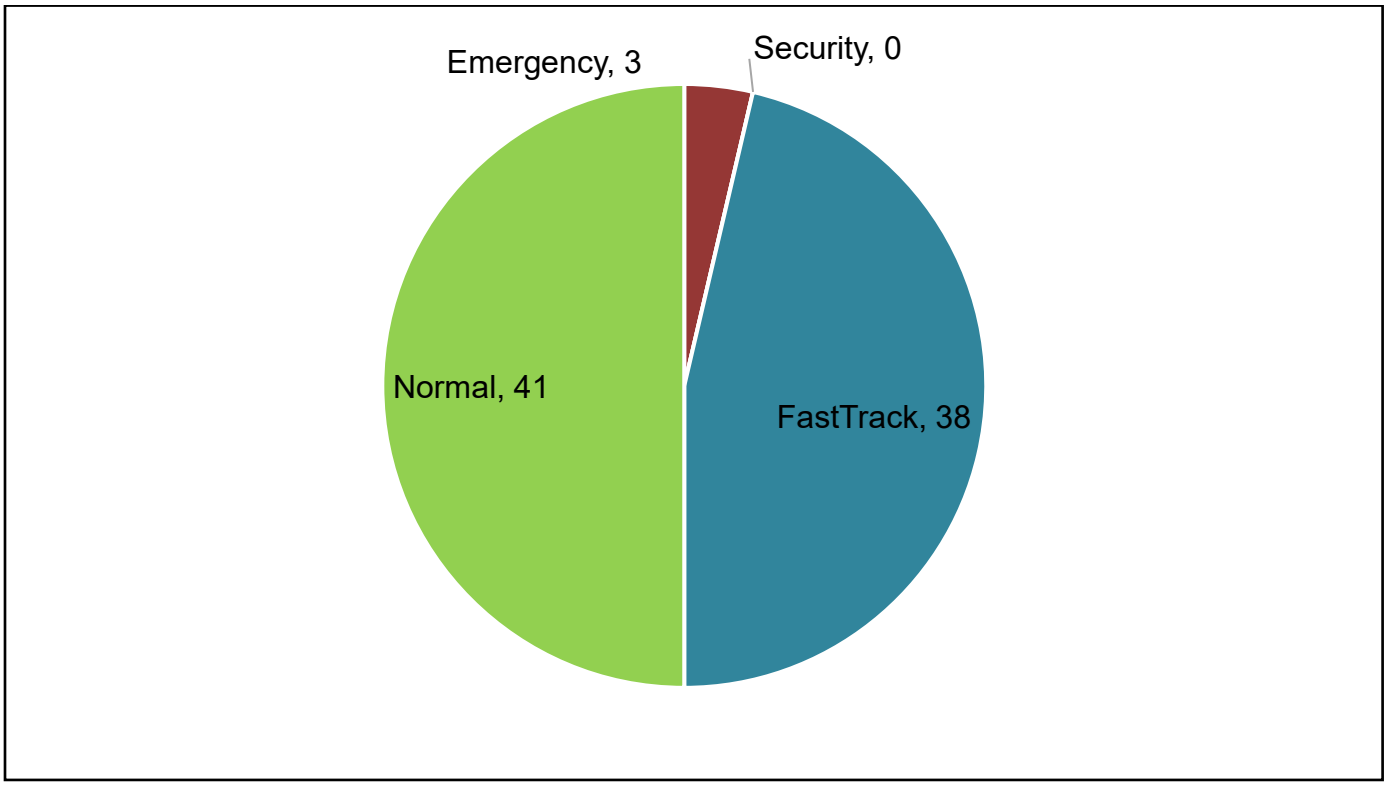
Encounter Data

- In the month of **April** 2025, the Alliance submitted **145** encounter files to the Department of Health Care Services (DHCS) with a total of **446,160** encounters

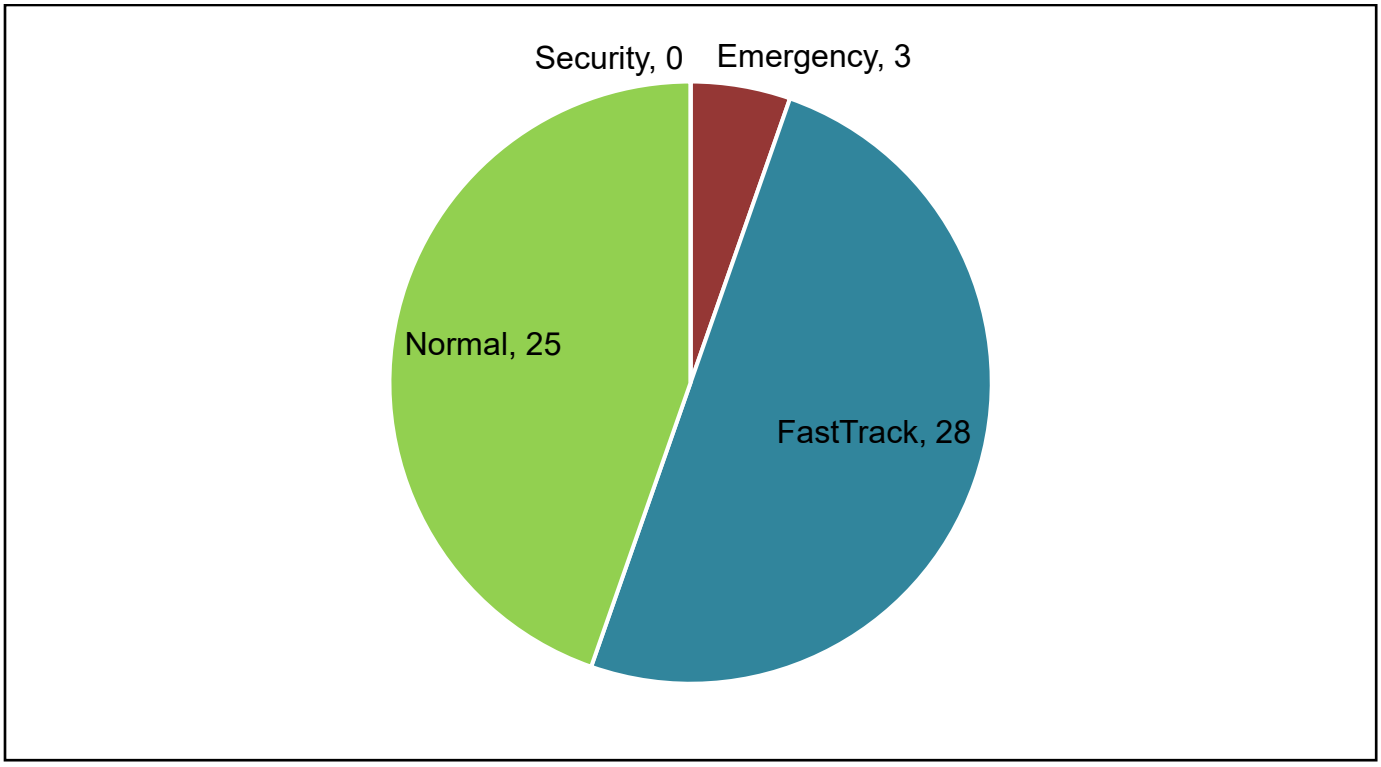
Change Management Key Performance Indicator (KPI)

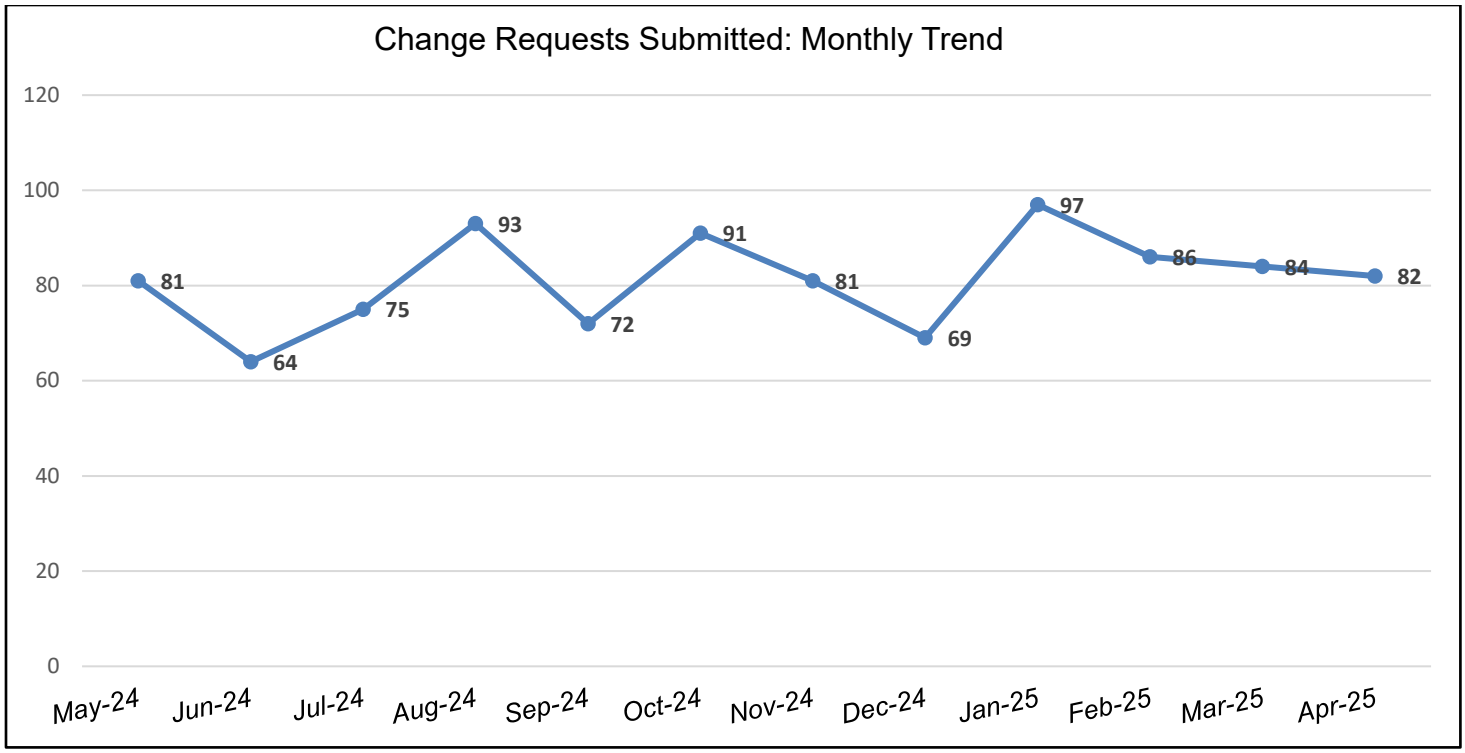
- Change Request Overall Summary in the month of April 2025 KPI:
  - 82 Changes Submitted.
  - 56 Changes Completed and Closed.
  - 110 Active Change Requests in pipeline.
  - 4 Change Requests Cancelled or Rejected.

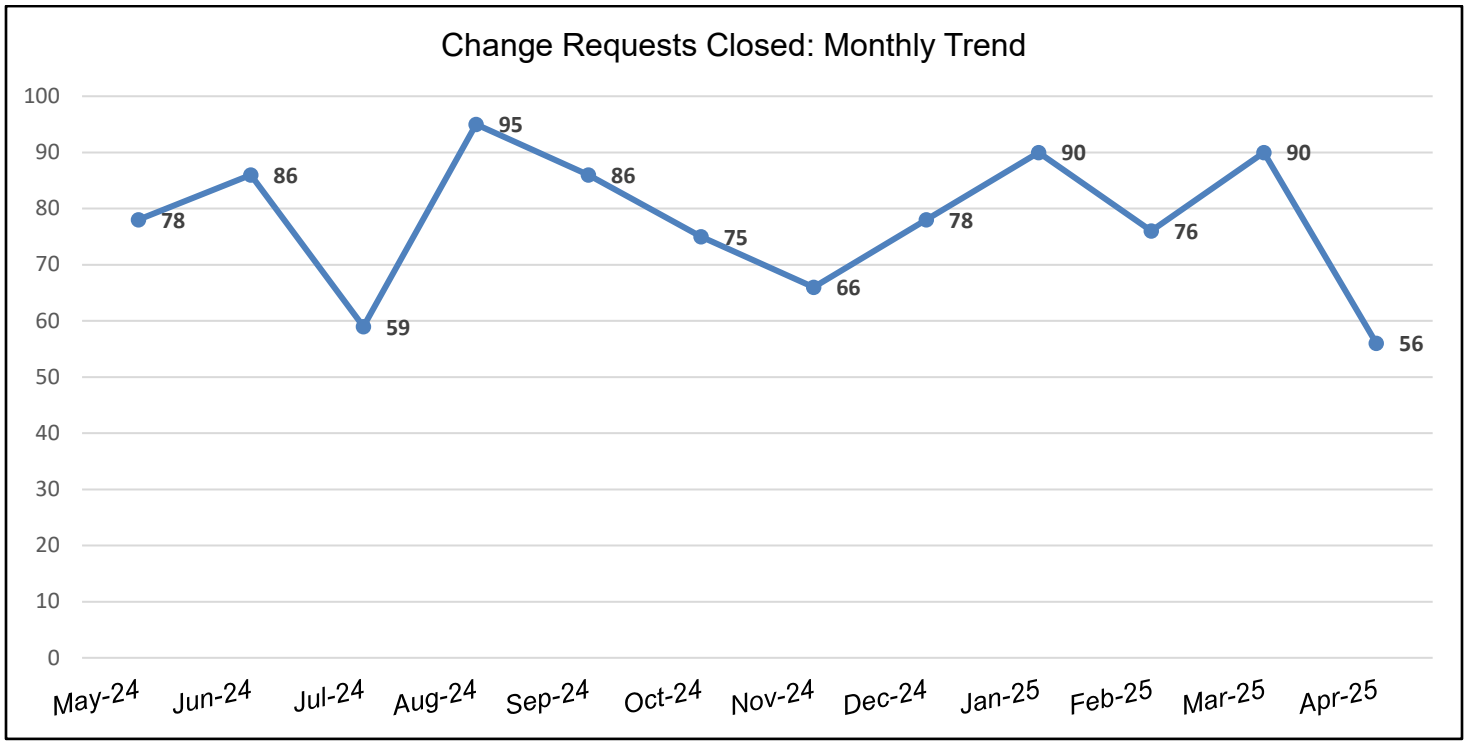
- 82 Change Requests Submitted/Logged in the month of April 2025



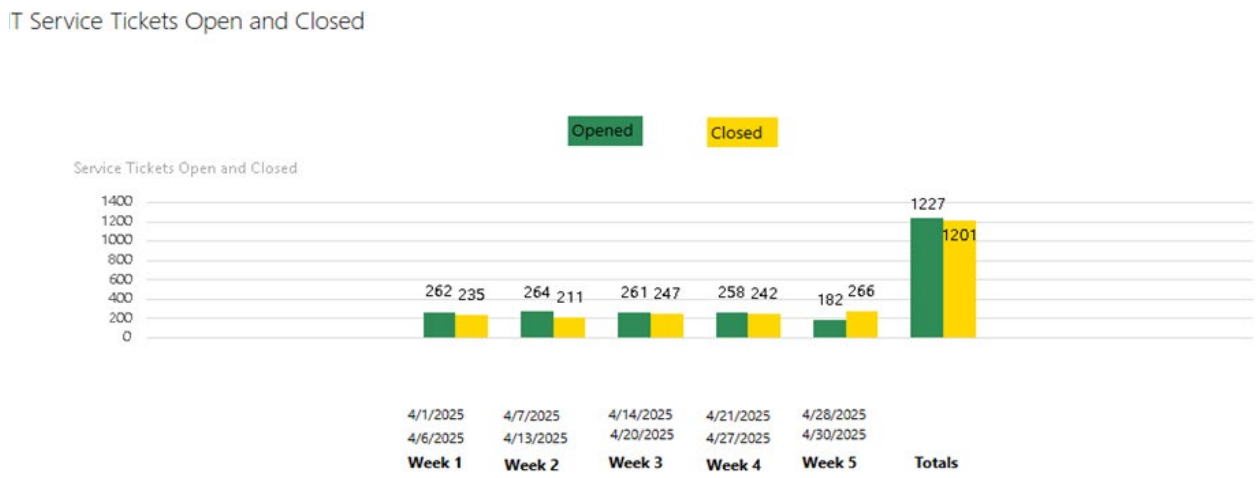
- 56 Change Requests Closed in the month of April 2025




Change Requests Submitted: Monthly Trend
120
100
80
60
40
20
0
81
64
75
93
72
91
81
69
97
86
84
82
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25
Apr-25


Change Requests Closed: Monthly Trend
100
90
80
70
60
50
40
30
20
10
0
78
86
59
95
86
75
66
78
90
76
90
56
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25
Apr-25

IT Stats: Service Desk



- 1227 Service Desk tickets were opened in the month of March 2025, which is 15.07% higher than the previous month (1042) and 14.09% higher than the previous 3-month average of 1054.

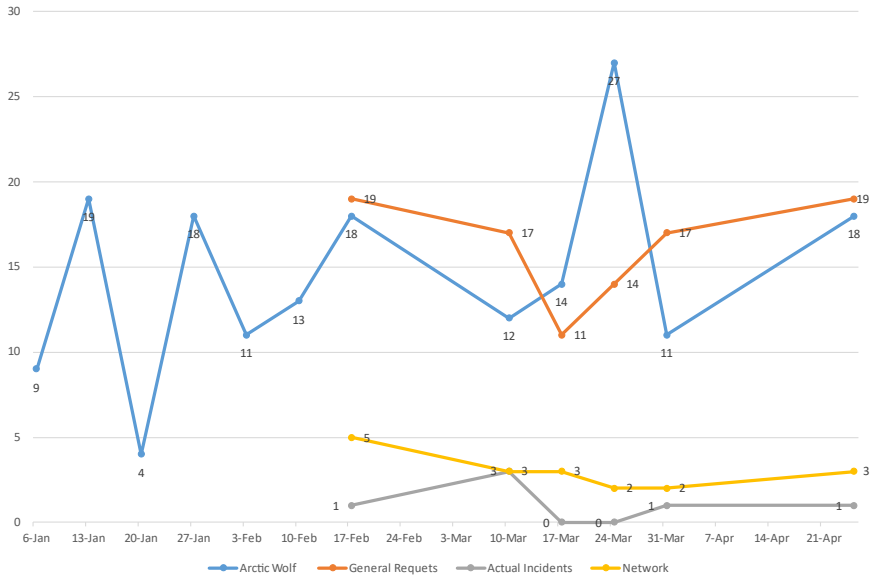
- 1201 Service Desk tickets were closed in the month of March 2025, which is 12.23% higher than the previous month (1054) and 16.81% higher than the previous 3-month average of 999.

IT Stats: Security

Security + Network Updates

Areas	Item Status
Ops.	• Completed ○ Server certificate collection exercise ○ PHI/PII "self attestation" process ○ Various ops. ○ Arctic Wolf agent re-up ○ Jim has access to core switches NEW • Underway ○ SecureLink true up and various activity (Xaqt) ○ SecureLink IntelliSwift set up ○ Network switch update ○ Network strip down for old building
Projects	• Symplr - aligning various security best practices as project continues to be integrated into environment
GRC	• Defining outage SLA and communications with various business functions (XaQt) • Infra - scanning provisioned systems before release • Continue work on SRA findings and policy revisions

Security + Network Activity



- Arctic Wolf
  - Numerous false-positives around out-of-country users
- General Requests
  - Review
  - Various
- Actual Incidents
  - Xaqt server outage
- Network
  - Switch replacement
  - New site decomm.

Analytics

Tiffany Cheang

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

From: **Tiffany Cheang, Chief Analytics Officer**

Date: **May 9th, 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: Feb 2024 – Jan 2025 dates of service
Prior reporting period: Feb 2023 – Jan 2024 dates of service
(Note: Data excludes Kaiser membership data.)

- For the Current reporting period, the top 11.4% of members account for 89.6% of total costs.
- In comparison, the Prior reporting period was lower at 7.6% of members accounting for 83.6% of total costs.
- Characteristics of the top utilizing population remained fairly consistent between the reporting periods:
    - The SPD/LTC (non duals) and ACA OE categories of aid slightly increased to account for 53.7% of the members, with SPD/LTCs accounting for 18.6% and ACA OE's at 35.1%.
    - The percent of members with costs >= $30K increased from 2.0% to 3.0%.
    - Of those members with costs >= $100K, the percentage of total members has increased to 1.0%.
        - For these members, non-trauma/pregnancy inpatient costs continue to comprise the majority of costs, decreasing to 31.2%.
    - Demographics for member city and gender for members with costs >= $30K follow the same distribution as the overall Alliance population.
    - However, the age distribution of the top 11.4% is more concentrated in the 45-66 year old category (35.8%) compared to the overall population (20.6%).

Analytics

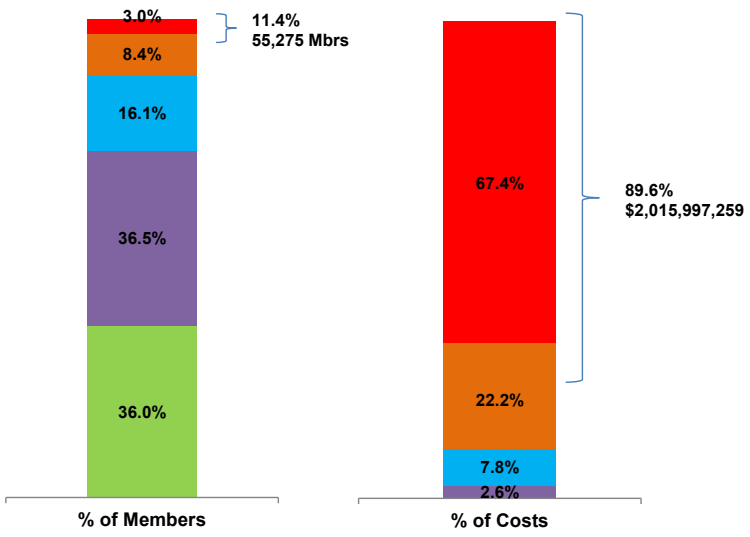
Supporting Documents

Alameda Alliance for Health - Analytics Supporting Documentation: Member - Cost Analysis
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Feb 2024 - Jan 2025

Note: Data incomplete due to claims lag

Run Date: 04/28/2025

Member Cost Distribution



Cost Range	Members	% of Members	Costs	% of Costs
$30K+	14,526	3.0%	$ 1,516,613,296	67.4%
$5K - $30K	40,749	8.4%	$ 499,383,963	22.2%
$1K - $5K	77,932	16.1%	$ 175,185,566	7.8%
< $1K	176,797	36.5%	$ 58,812,589	2.6%
$0	174,390	36.0%	$ -	0.0%
Totals	**484,394**	**100.0%**	**$ 2,249,995,414**	**100.0%**

Top 11.4% of Members = 89.6% of Costs

Cost Range	Members	% of Total Members	Costs	% of Total Costs
$100K+	4,774	1.0%	$ 989,173,786	44.0%
$75K to $100K	1,810	0.4%	$ 158,306,476	7.0%
$50K to $75K	2,752	0.6%	$ 167,814,294	7.5%
$40K to $50K	2,145	0.4%	$ 96,012,172	4.3%
$30K to $40K	3,045	0.6%	$ 105,306,568	4.7%
SubTotal	***14,526***	***3.0%***	***$ 1,516,613,296***	***67.4%***
$20K to $30K	5,736	1.2%	$ 139,640,957	6.2%
$10K to $20K	15,683	3.2%	$ 221,578,966	9.8%
$5K to $10K	19,330	4.0%	$ 138,164,040	6.1%
SubTotal	***40,749***	***8.4%***	***$ 499,383,963***	***22.2%***
Total	**55,275**	***11.4%***	**$ 2,015,997,259**	***89.6%***

Enrollment Status	Members	Total Costs
Still Enrolled as of Jan 2025	413,527	$ 2,041,254,199
Dis-Enrolled During Year	70,867	$ 208,741,215
Totals	**484,394**	**$ 2,249,995,414**

Notes:
- Report includes medical costs (HS & Diamond Claims, Beacon, Logisticare FFS, CHCN FFS Preventive Services, CHME) and pharmacy costs. IBNP factors are not applied.
- CFMG and CHCN encounter data has been priced out.

Alameda Alliance for Health - Analytics Supporting Documentation: Member - Cost Analysis
11.4% of Members = 89.6% of Costs
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Feb 2024 - Jan 2025
Note: Data incomplete due to claims lag
Run Date: 04/28/2025

11.4% of Members = 89.6% of Costs
18.6% of members are SPD/LTCs and account for 24.7% of costs.
35.1% of members are ACA OE and account for 32.4% of costs.
7.7% of members disenrolled as of Jan 2025 and account for 9.5% of costs.

Highest Cost Members; Cost Per Member >= $100K
26.9% of members are SPD/LTCs and account for 29.0% of costs.
26.7% of members are ACA OE and account for 29.9% of costs.
8.9% of members disenrolled as of Jan 2025 and account for 10.1% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Members	% of Members
IHSS	IHSS	193	932	1,125	2.0%
MCAL	MCAL - ADULT	1,262	7,743	9,005	16.3%
	MCAL - BCCTP	-	-	-	0.0%
	MCAL - CHILD	663	3,878	4,541	8.2%
	MCAL - ACA OE	4,714	14,682	19,396	35.1%
	MCAL - DUALS	1	1	2	0.0%
	MCAL - SPD-LTC	3,604	6,665	10,269	18.6%
	MCAL - SPD-LTC/Full Dual	2,635	4,024	6,659	12.0%
Not Eligible	Not Eligible	1,454	2,824	4,278	7.7%
Total		**14,526**	**40,749**	**55,275**	**100.0%**

Member Breakout by LOB

LOB	Eligibility Category	Total Members	% of Members
IHSS	IHSS	42	0.9%
MCAL	MCAL - ADULT	291	6.1%
	MCAL - BCCTP	-	0.0%
	MCAL - CHILD	89	1.9%
	MCAL - ACA OE	1,273	26.7%
	MCAL - DUALS	-	0.0%
	MCAL - SPD-LTC	1,284	26.9%
	MCAL - SPD-LTC/Full Dual	1,368	28.7%
Not Eligible	Not Eligible	427	8.9%
Total		**4,774**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Costs	% of Costs
IHSS	IHSS	$ 16,786,689	$ 10,626,656	$ 27,413,345	1.4%
MCAL	MCAL - ADULT	$ 132,540,808	$ 94,226,893	$ 226,767,701	11.2%
	MCAL - BCCTP	$ -	$ -	$ -	0.0%
	MCAL - CHILD	$ 50,302,506	$ 43,525,577	$ 93,828,084	4.7%
	MCAL - ACA OE	$ 473,569,834	$ 179,463,187	$ 653,033,021	32.4%
	MCAL - DUALS	$ 41,765	$ 5,403	$ 47,167	0.0%
	MCAL - SPD-LTC	$ 411,256,294	$ 86,318,314	$ 497,574,608	24.7%
	MCAL - SPD-LTC/Full Dual	$ 274,828,527	$ 50,042,536	$ 324,871,063	16.1%
Not Eligible	Not Eligible	$ 157,286,872	$ 35,175,397	$ 192,462,269	9.5%
Total		**$ 1,516,613,296**	**$ 499,383,963**	**$ 2,015,997,259**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Total Costs	% of Costs
IHSS	IHSS	$ 8,730,689	0.9%
MCAL	MCAL - ADULT	$ 82,434,491	8.3%
	MCAL - BCCTP	$ -	0.0%
	MCAL - CHILD	$ 22,433,718	2.3%
	MCAL - ACA OE	$ 296,124,697	29.9%
	MCAL - DUALS	$ -	0.0%
	MCAL - SPD-LTC	$ 286,471,745	29.0%
	MCAL - SPD-LTC/Full Dual	$ 193,498,072	19.6%
Not Eligible	Not Eligible	$ 99,480,374	10.1%
Total		**$ 989,173,786**	**100.0%**

% of Total Costs By Service Type

Breakout by Service Type/Location

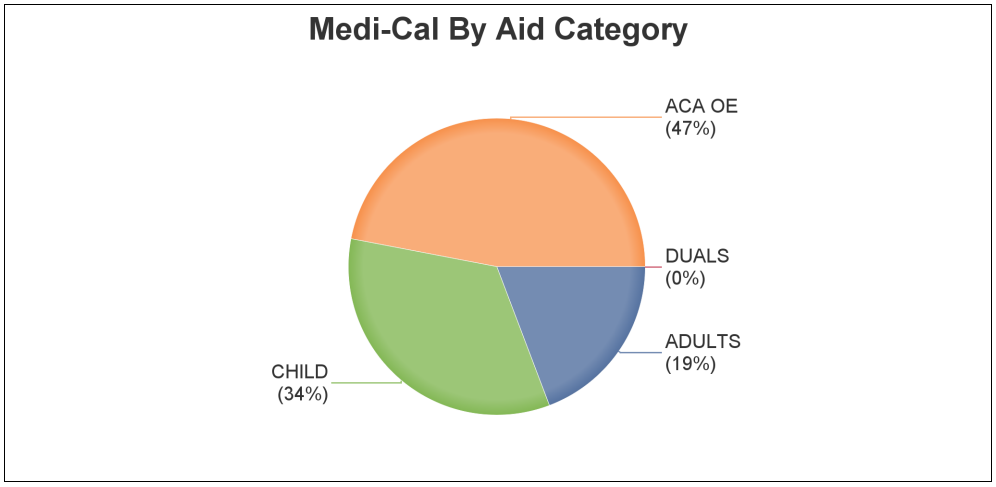
Cost Range	Trauma Costs	Hep C Rx Costs	Pregnancy, Childbirth & Newborn Related Costs	Pharmacy Costs	Inpatient Costs (POS 21)	ER Costs (POS 23)	Outpatient Costs (POS 22)	Office Costs (POS 11)	Dialysis Costs (POS 65)	Other Costs (All Other POS)
$100K+	5%	0%	1%	14%	37%	1%	11%	2%	2%	33%
$75K to $100K	4%	0%	1%	18%	26%	3%	5%	4%	5%	39%
$50K to $75K	5%	0%	2%	26%	29%	5%	6%	6%	4%	25%
$40K to $50K	7%	0%	2%	32%	28%	8%	5%	7%	1%	18%
$30K to $40K	10%	0%	3%	33%	23%	13%	5%	7%	1%	18%
$20K to $30K	3%	1%	6%	36%	24%	8%	8%	7%	1%	17%
$10K to $20K	0%	0%	12%	35%	24%	7%	9%	9%	1%	16%
$5K to $10K	0%	0%	5%	30%	12%	11%	13%	14%	0%	19%
Total	**4%**	**0%**	**3%**	**22%**	**30%**	**4%**	**9%**	**5%**	**2%**	**27%**

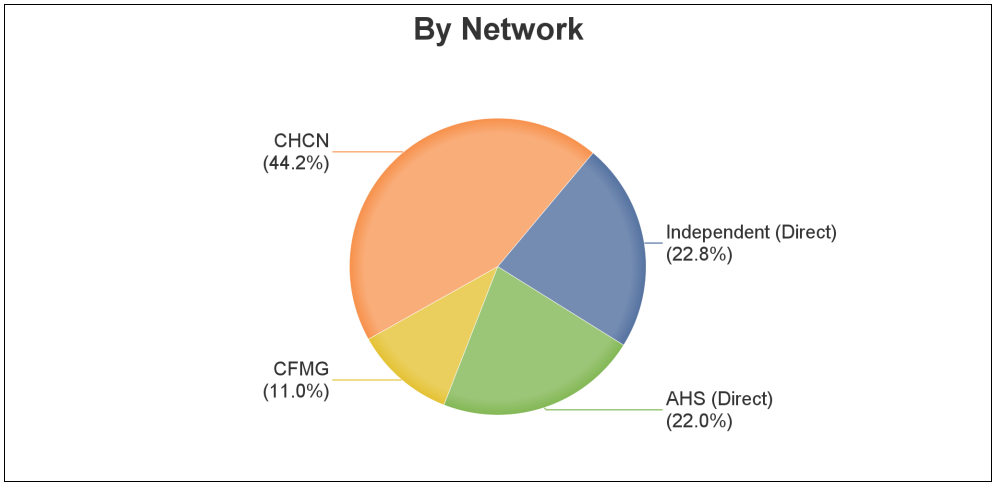
Notes:
- Report includes medical costs (HS & Diamond Claims, Beacon, Logisticare FFS, CHCN FFS Preventive Services, CHME) and pharmacy costs. IBNP factors are not applied.
- CFMG and CHCN encounter data has been priced out.
- Report excludes Capitation Expense

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend

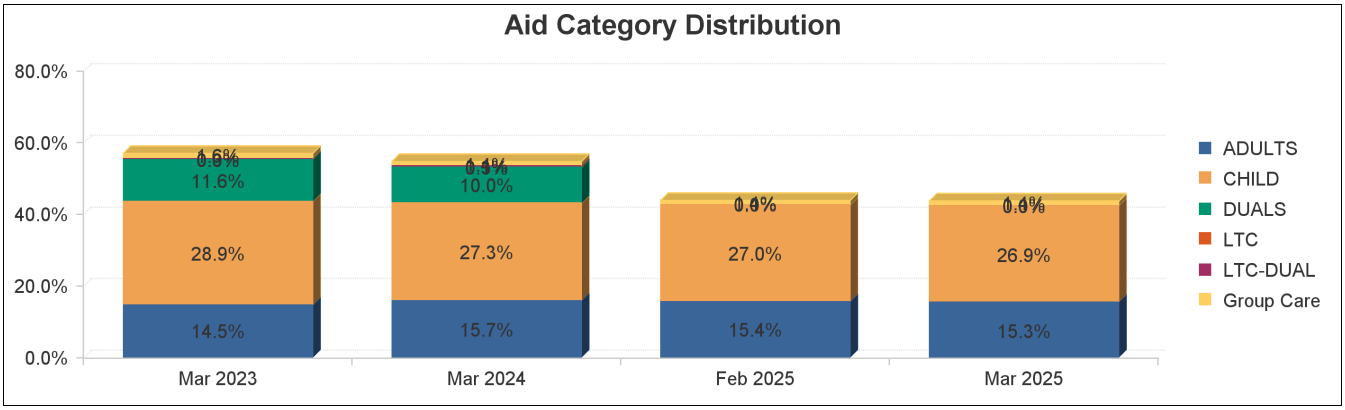
Category of Aid	Mar 2025	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN
ADULTS	63,278	16%	13,812	14,115	6	35,345
CHILD	111,153	27%	10,070	13,460	42,206	45,417
SPD	0	0%	0	0	0	0
ACA OE	154,579	38%	27,917	53,816	1,517	71,329
DUALS	1	0%	1	0	0	0
LTC	0	0%	0	0	0	0
LTC-DUAL	0	0%	0	0	0	0
SPD-LTC	29,609	7%	8,816	5,067	1,470	14,256
SPD-LTC/Full Dual	48,241	12%	31,127	3,526	4	13,584
Medi-Cal	406,861		91,743	89,984	45,203	179,931
Group Care	5,882		2,207	973	0	2,702
Total	**412,743**	**100%**	**93,950**	**90,957**	**45,203**	**182,633**
Medi-Cal %	98.6%		97.7%	98.9%	100.0%	98.5%
Group Care %	1.4%		2.3%	1.1%	0.0%	1.5%
	Network Distribution		**22.8%**	**22.0%**	**11.0%**	**44.2%**
			% Direct:	**45%**	**% Delegated:**	**55%**





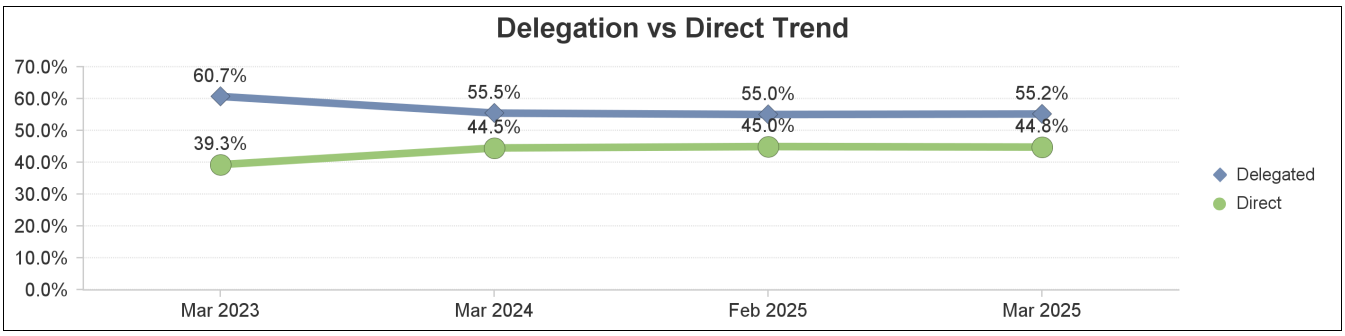
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Mar 2023	Mar 2024	Feb 2025	Mar 2025	Mar 2023	Mar 2024	Feb 2025	Mar 2025	Mar 2023 to Mar 2024	Mar 2024 to Mar 2025	Feb 2025 to Mar 2025
ADULTS	51,516	63,314	63,758	**63,278**	14.5%	15.7%	15.4%	15.3%	18.6%	-0.1%	-0.8%
CHILD	102,510	110,268	111,576	**111,153**	28.9%	27.3%	27.0%	26.9%	7.0%	0.8%	-0.4%
SPD	31,021	34,972	0	**0**	8.7%	8.7%	0.0%	0.0%	11.3%	0.0%	0.0%
ACA OE	121,852	148,065	154,609	**154,579**	34.3%	36.7%	37.4%	37.5%	17.7%	4.2%	0.0%
DUALS	41,246	40,222	2	**1**	11.6%	10.0%	0.0%	0.0%	-2.5%	##########	-100.0%
LTC	143	216	0	**0**	0.0%	0.1%	0.0%	0.0%	33.8%	0.0%	0.0%
LTC-DUAL	948	1,307	0	**0**	0.3%	0.3%	0.0%	0.0%	27.5%	0.0%	0.0%
SPD-LTC	0	0	29,497	**29,609**	0.0%	0.0%	7.1%	7.2%	0.0%	100.0%	0.4%
SPD-LTC/ Full Dual	0	0	48,100	**48,241**	0.0%	0.0%	11.6%	11.7%	0.0%	100.0%	0.3%
Medi-Cal	349,236	398,364	407,542	**406,861**	98.4%	98.6%	98.6%	98.6%	12.3%	2.1%	-0.2%
Group Care	5,723	5,620	5,812	**5,882**	1.6%	1.4%	1.4%	1.4%	-1.8%	4.5%	1.2%
Total	**354,959**	**403,984**	**413,354**	**412,743**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**12.1%**	**2.1%**	**-0.1%**



Delegation vs Direct Trend

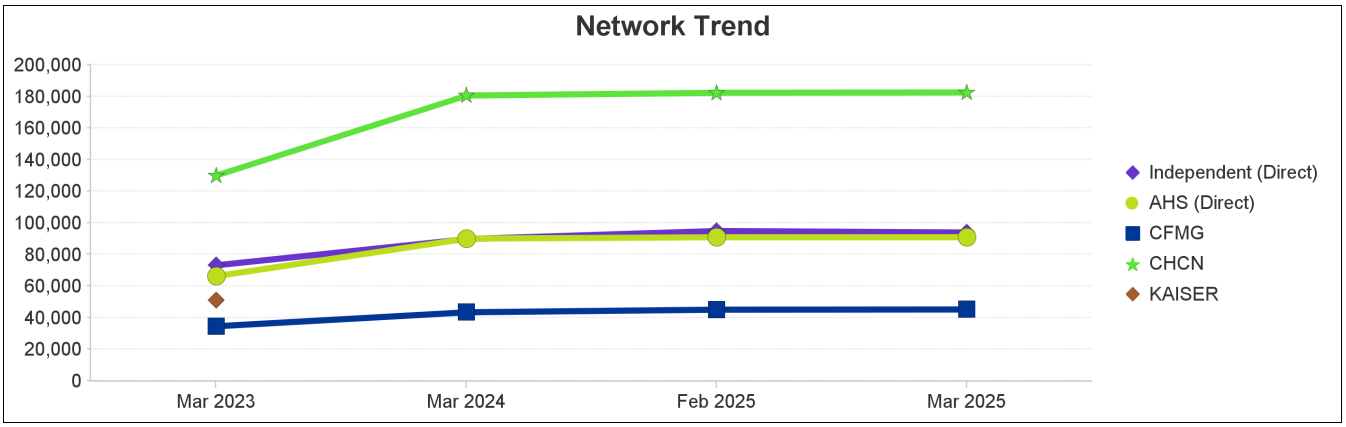
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	Mar 2023	Mar 2024	Feb 2025	Mar 2025	Mar 2023	Mar 2024	Feb 2025	Mar 2025	Mar 2023 to Mar 2024	Mar 2024 to Mar 2025	Feb 2025 to Mar 2025
Delegated	215,530	224,105	227,504	**227,836**	60.7%	55.5%	55.0%	55.2%	3.8%	1.6%	0.1%
Direct	139,429	179,879	185,850	**184,907**	39.3%	44.5%	45.0%	44.8%	22.5%	2.7%	-0.5%
Total	**354,959**	**403,984**	**413,354**	**412,743**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**12.1%**	**2.1%**	**-0.1%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

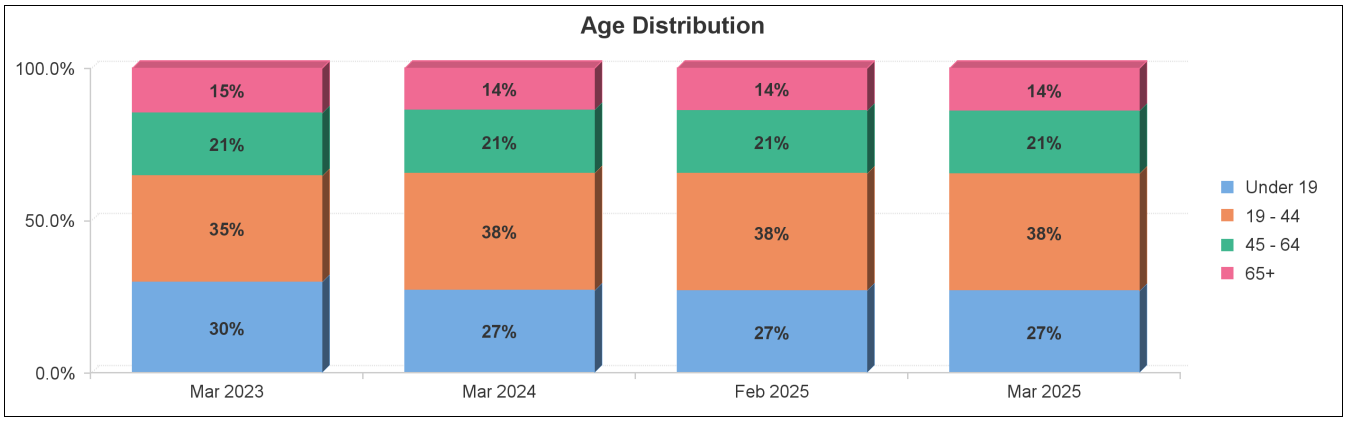
Network Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Mar 2023	Mar 2024	Feb 2025	Mar 2025	Mar 2023	Mar 2024	Feb 2025	Mar 2025	Mar 2023 to Mar 2024	Mar 2024 to Mar 2025	Feb 2025 to Mar 2025
Independent (Direct)	73,153	89,790	94,899	**93,950**	20.6%	22.2%	23.0%	22.8%	18.5%	4.4%	-1.0%
AHS (Direct)	66,276	90,089	90,951	**90,957**	18.7%	22.3%	22.0%	22.0%	26.4%	1.0%	0.0%
CFMG	34,547	43,413	45,079	**45,203**	9.7%	10.7%	10.9%	11.0%	20.4%	4.0%	0.3%
CHCN	129,908	180,692	182,425	**182,633**	36.6%	44.7%	44.1%	44.2%	28.1%	1.1%	0.1%
KAISER	51,075	0	0	**0**	14.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	**354,959**	**403,984**	**413,354**	**412,743**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**12.1%**	**2.1%**	**-0.1%**



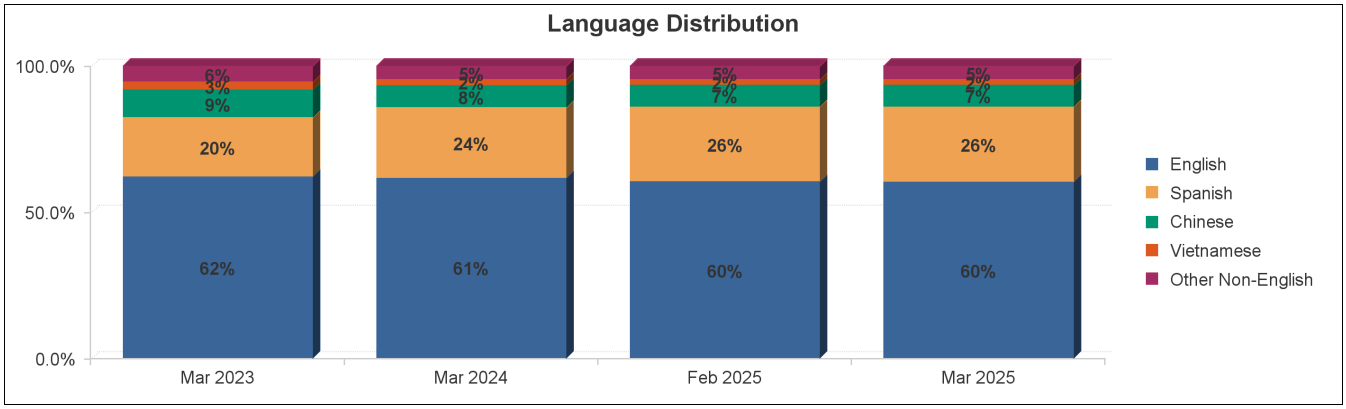
Age Category Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Mar 2023	Mar 2024	Feb 2025	Mar 2025	Mar 2023	Mar 2024	Feb 2025	Mar 2025	Mar 2023 to Mar 2024	Mar 2024 to Mar 2025	Feb 2025 to Mar 2025
Under 19	104,866	108,522	110,599	**110,282**	30%	27%	27%	27%	3%	2%	0%
19 - 44	124,034	155,233	159,068	**158,678**	35%	38%	38%	38%	20%	2%	0%
45 - 64	72,979	83,951	85,271	**85,158**	21%	21%	21%	21%	13%	1%	0%
65+	53,080	56,278	58,416	**58,625**	15%	14%	14%	14%	6%	4%	0%
Total	**354,959**	**403,984**	**413,354**	**412,743**	**100%**	**100%**	**100%**	**100%**	**12%**	**2%**	**0%**



Language Trend

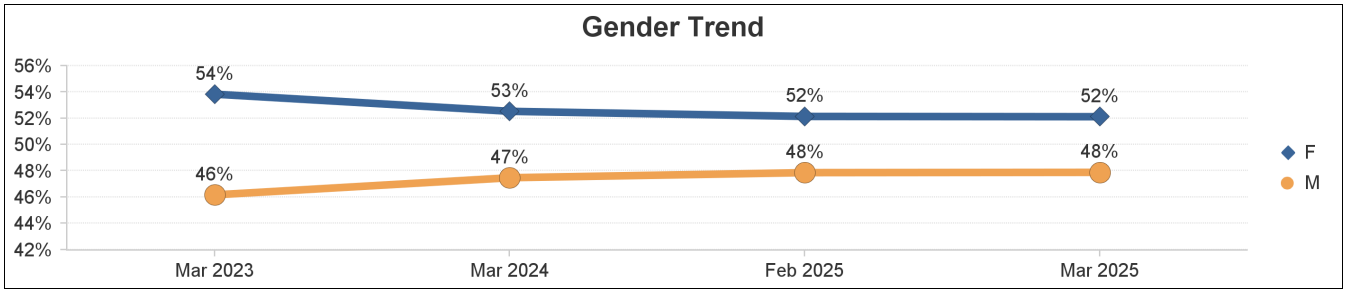
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	Mar 2023	Mar 2024	Feb 2025	Mar 2025	ar 2023	ar 2024	Feb 2025	ar 2025	Mar 2023 to Mar 2024	Mar 2024 to Mar 2025	Feb 2025 to Mar 2025
English	219,911	248,207	248,996	**248,349**	62%	61%	60%	60%	11%	0%	0%
Spanish	71,737	97,569	105,721	**105,898**	20%	24%	26%	26%	26%	8%	0%
Chinese	33,645	30,760	30,594	**30,544**	9%	8%	7%	7%	-9%	-1%	0%
Vietnamese	9,773	8,536	8,238	**8,209**	3%	2%	2%	2%	-14%	-4%	0%
Other Non-English	19,893	18,912	19,805	**19,743**	6%	5%	5%	5%	-5%	4%	0%
Total	**354,959**	**403,984**	**413,354**	**412,743**	**100%**	**100%**	**100%**	**100%**	**12%**	**2%**	**0%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

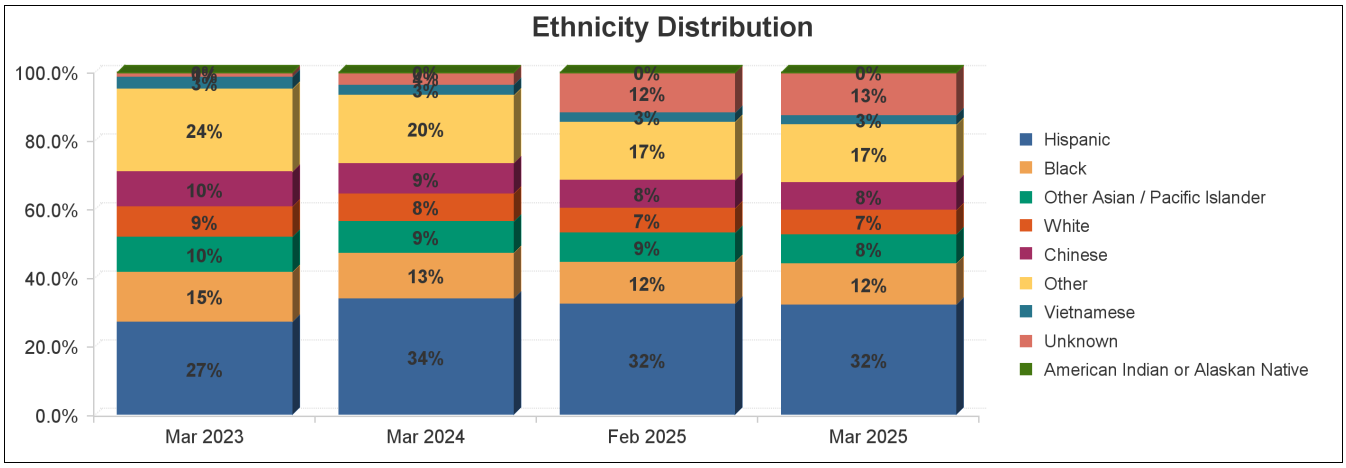
Gender Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Mar 2023	Mar 2024	Feb 2025	Mar 2025	Mar 2023	Mar 2024	Feb 2025	Mar 2025	Mar 2023 to Mar 2024	Mar 2024 to Mar 2025	Feb 2025 to Mar 2025
F	191,101	212,211	215,525	**215,119**	54%	53%	52%	52%	10%	1%	0%
M	163,858	191,773	197,829	**197,624**	46%	47%	48%	48%	15%	3%	0%
Total	**354,959**	**403,984**	**413,354**	**412,743**	**100%**	**100%**	**100%**	**100%**	**12%**	**2%**	**0%**



Ethnicity Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Mar 2023	Mar 2024	Feb 2025	Mar 2025	Mar 2023	Mar 2024	Feb 2025	Mar 2025	Mar 2023 to Mar 2024	Mar 2024 to Mar 2025	Feb 2025 to Mar 2025
Hispanic	95,858	136,557	133,402	**132,032**	27%	34%	32%	32%	30%	-3%	-1%
Black	51,755	53,627	50,373	**49,884**	15%	13%	12%	12%	3%	-8%	-1%
Other Asian / Pacific Islander	36,336	37,287	35,321	**34,933**	10%	9%	9%	8%	3%	-7%	-1%
White	31,596	32,857	29,853	**29,347**	9%	8%	7%	7%	4%	-12%	-2%
Chinese	36,098	35,796	33,774	**33,490**	10%	9%	8%	8%	-1%	-7%	-1%
Other	85,859	80,230	70,242	**69,451**	24%	20%	17%	17%	-7%	-16%	-1%
Vietnamese	12,260	12,036	11,084	**10,972**	3%	3%	3%	3%	-2%	-10%	-1%
Unknown	4,460	14,794	48,550	**51,888**	1%	4%	12%	13%	70%	71%	6%
American Indian or Alaskan Native	737	800	755	**746**	0%	0%	0%	0%	8%	-7%	-1%
Total	**354,959**	**403,984**	**413,354**	**412,743**	**100%**	**100%**	**100%**	**100%**	**12%**	**2%**	**0%**



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

Medi-Cal By City

City	Mar 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	162,499	40%	24,887	42,220	17,615	77,777
HAYWARD	54,388	13%	12,155	15,314	6,097	20,822
FREMONT	38,681	10%	16,167	6,758	2,462	13,294
SAN LEANDRO	26,625	7%	7,156	4,427	3,351	11,691
UNION CITY	14,711	4%	5,766	2,654	879	5,412
ALAMEDA	13,868	3%	3,350	2,486	2,085	5,947
BERKELEY	15,752	4%	4,044	2,378	1,830	7,500
LIVERMORE	13,306	3%	1,987	550	2,270	8,499
NEWARK	9,527	2%	2,776	4,145	591	2,015
CASTRO VALLEY	11,134	3%	3,176	1,793	1,767	4,398
SAN LORENZO	6,309	2%	1,312	1,429	732	2,836
PLEASANTON	8,036	2%	2,018	387	870	4,761
DUBLIN	7,747	2%	2,195	383	934	4,235
EMERYVILLE	2,956	1%	642	624	483	1,207
ALBANY	2,596	1%	635	299	592	1,070
PIEDMONT	496	0%	119	172	82	123
SUNOL	86	0%	26	14	7	39
ANTIOCH	21	0%	6	7	5	3
Other	18,123	4%	3,326	3,944	2,551	8,302
Total	406,861	100%	**91,743**	**89,984**	**45,203**	**179,931**

Group Care By City

City	Mar 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	1,829	31%	341	367	0	1,121
HAYWARD	663	11%	314	169	0	180
FREMONT	670	11%	446	82	0	142
SAN LEANDRO	611	10%	252	88	0	271
UNION CITY	296	5%	188	42	0	66
ALAMEDA	307	5%	87	26	0	194
BERKELEY	147	2%	48	11	0	88
LIVERMORE	102	2%	33	3	0	66
NEWARK	143	2%	83	35	0	25
CASTRO VALLEY	201	3%	86	30	0	85
SAN LORENZO	146	2%	46	28	0	72
PLEASANTON	70	1%	23	4	0	43
DUBLIN	127	2%	43	6	0	78
EMERYVILLE	41	1%	17	5	0	19
ALBANY	22	0%	11	1	0	10
PIEDMONT	8	0%	1	1	0	6
SUNOL	1	0%	1	0	0	0
ANTIOCH	25	0%	9	4	0	12
Other	473	8%	178	71	0	224
Total	**5,882**	**100%**	**2,207**	**973**	**0**	**2,702**

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

Total By City

City	Mar 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	164,328	40%	25,228	42,587	17,615	78,898
HAYWARD	55,051	13%	12,469	15,483	6,097	21,002
FREMONT	39,351	10%	16,613	6,840	2,462	13,436
SAN LEANDRO	27,236	7%	7,408	4,515	3,351	11,962
UNION CITY	15,007	4%	5,954	2,696	879	5,478
ALAMEDA	14,175	3%	3,437	2,512	2,085	6,141
BERKELEY	15,899	4%	4,092	2,389	1,830	7,588
LIVERMORE	13,408	3%	2,020	553	2,270	8,565
NEWARK	9,670	2%	2,859	4,180	591	2,040
CASTRO VALLEY	11,335	3%	3,262	1,823	1,767	4,483
SAN LORENZO	6,455	2%	1,358	1,457	732	2,908
PLEASANTON	8,106	2%	2,041	391	870	4,804
DUBLIN	7,874	2%	2,238	389	934	4,313
EMERYVILLE	2,997	1%	659	629	483	1,226
ALBANY	2,618	1%	646	300	592	1,080
PIEDMONT	504	0%	120	173	82	129
SUNOL	87	0%	27	14	7	39
ANTIOCH	46	0%	15	11	5	15
Other	18,596	5%	3,504	4,015	2,551	8,526
Total	412,743	100%	**93,950**	**90,957**	**45,203**	**182,633**

ALAMEDA Alliance FOR HEALTH

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

Human Resources

Anastacia Swift

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

From: **Anastacia Swift, Chief Human Resources Officer**

Date: **May 9th, 2025**

Subject: **Human Resources Report**

Staffing

- As of May 1st, 2025, the Alliance had 659 full time employees and 0 part time employee.
- On May 1st, 2025, the Alliance had 73 open positions in which 18 signed offer acceptance letters have been received with start dates in the near future resulting in a total of 55 positions open to date. The Alliance is actively recruiting for the remaining 55 positions and several of these positions are in the interviewing or job offer stage.
- Summary of open positions by division:

Division	Open Position May 1st	Signed Offers Accepted by Department	Remaining Recruitment Positions
Healthcare Services	13	2	11
Operations	33	7	26
Healthcare Analytics	3	1	2
Information Technology	13	5	8
Finance	3	1	2
Compliance	5	2	3
Human Resources	3	0	3
Health Equity	0	0	0
Executive	0	0	0
Total	73	18	55

- Our current recruitment rate is 10%.

Employee Recognition

- Employees reaching major milestones in their length of service at the Alliance in April 2025 included:

  5 years:
  - Juan S (Information Technology)
  - Kiranjit K (Utilization Management)
  - Tristina J (HCS Behavioral Health)

  6 years:
  - Natalie H (Utilization Management)
  - Jessica P (Quality Analytics)
  - Jennifer S (Case/Disease Management)

  7 years:
  - Idy V (Member Services)
  - Bob H (Quality Management)

  8 years:
  - Ramon T (Pharmacy Services)

  9 years:
  - Sonia S (Quality Analytics)
  - Maria B (Utilization Management)
  - Tanisha L (Quality Management)
  - Junaid G (IT Ops and Quality Apps Mgt)

  10 years:
  - Paris H (Claims)
  - Christine R (Utilization Management)

  13 years:
  - Christine R (Quality Management)
  - Elsa G (Case/Disease Management)

  15 years:
  - Marlowe W (Claims)

  16 years:
  - Tyisha P (Claims)

  17 years:
  - Ed S (IT Infrastructure)
  - Kristy N (Finance)

  23 years:
  - Mandy G (Marketing & Communications)

  24 years:
  - Teresa C (Claims)