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Board of Governors

Regular Meeting

Friday, October 10th, 2025
12:00 p.m. – 2:00 p.m.

Video Conference Call and

1240 South Loop Road, Alameda, CA 94502

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AGENDA

BOARD OF GOVERNORS
Regular Meeting
Friday, October 10th, 2025
12:00 p.m. – 2:00 p.m.

In-Person and Video Conference Call

1240 S. Loop Road
Alameda, CA 94502

7830 MacArthur Blvd.
Oakland, CA 94605

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 585126346#. If you use the link and participate via computer, you may use the chat function, and request an opportunity to speak on any agendized item, including general public comment. Your request to speak must be received before the item is called on the agenda. If you participate by telephone, please submit your comments to the Clerk of the Board at the email address listed above or by providing your comments during the meeting at the end of each agenda item. Oral comments to address the Board of Governors are limited to three (3) minutes per person. Whenever possible, the board would appreciate it if public comment communication was provided prior to the commencement of the meeting.

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

1. CALL TO ORDER

(A regular meeting of the Alameda Alliance for Health Board of Governors will be called to order on October 10th, 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) SEPTEMBER 9th, 2025, FINANCE COMMITTEE MEETING MINUTES

b) **SEPTEMBER 12th, 2025, COMPLIANCE ADVISORY COMMITTEE MEETING MINUTES**

c) **SEPTEMBER 12th, 2025, BOARD OF GOVERNORS MEETING MINUTES**

d) **APPROVE RESOLUTION FOR QIHEC NOMINEES**

6. **BOARD MEMBER REPORTS**

a) **ANNOUNCEMENT: NOMINATIONS TO THE HOSPITAL COUNCIL OF NORTHERN AND CENTRAL CA HOSPITAL SEAT**

b) **COMPLIANCE ADVISORY COMMITTEE**

c) **FINANCE COMMITTEE**

7. **CEO UPDATE**

8. **BOARD BUSINESS**

a) **REVIEW AND APPROVE BAKERTILLY FINANCIAL AUDIT REVIEW**

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

c) **INFORMATION TECHNOLOGY ANNUAL UPDATE**

d) **HEDIS UPDATE**

9. **STAFF UPDATES**

10. **UNFINISHED BUSINESS**

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

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

13. **ADJOURNMENT**

NOTICE TO THE PUBLIC

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

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

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

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

Supplemental Material Received After the Posting of the Agenda: Any supplemental materials or documents distributed to a majority of the Board regarding any item on this agenda after the posting of the agenda will be available for public review. To obtain a document, please call the Clerk of the Board at (510) 747-6160.

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

Americans With Disabilities Act (ADA): It is the intention of the Alameda Alliance for Health to comply with the Americans with Disabilities Act (ADA) in all respects. If, as an attendee or a participant at this meeting, you will need special assistance beyond what is normally provided, the Alameda Alliance for Health will attempt to accommodate you in every reasonable manner. Please contact the Clerk of the Board, Brenda Martinez, at (510) 747-6160 at least 48 hours prior to the meeting to inform us of your needs and to determine if accommodation is feasible. Please advise us at that time if you will need accommodations to attend or participate in meetings on a regular basis.

I hereby certify that the agenda for the Board of Governors was posted on the Alameda Alliance for Health's web page at www.alamedaalliance.org by October 7th, 2025, by 12:00 p.m.

Brenda Martinez, Clerk of the Board

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EXECUTIVE SUMMARY APPENDIX

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

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PRESENTATIONS APPENDIX

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

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SUPPORTING MATERIALS APPENDIX

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

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Consent Calendar

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Finance Committee Meeting Minutes

ALAMEDA ALLIANCE FOR HEALTH
FINANCE COMMITTEE
REGULAR MEETING

September 9th, 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, Yeon Park, Gil Riojas
Committee Members by Teleconference: None
Committee Members Excused: James Jackson
Board of Governors members in-person and on Conference Call:

Alliance Staff in-person and on Conference Call: Matt Woodruff, Tiffany Cheang, Sasi Karaiyan, Anastasia Swift, Lao Paul Vang, Ruth Watson, Yen Ang, Christine Corpus, Pritika Dutt, 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

Pritika Dutt was introduced as the new Controller, coming from the Department of Managed Healthcare with over twenty years of experience.

CONSENT CALENDAR

Dr. Ferguson presented the Consent Calendar.

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

COMMITTEE BUSINESS

a) CEO UPDATE

Federal Audit Concerns and Statewide Strategy: Mr. Woodruff provided an update on ongoing state and federal regulatory challenges, including a federal accusation of fraudulent use of tax dollars by California, particularly around benefits and programs. All seventeen sister plans in California are seeking legal advice and plan to draft a letter to state regulators affirming compliance with state contracts and requesting clarification on which regulations to follow when state and federal requirements diverge.

Local Alameda County Actions: Mr. Woodruff has been in discussions with Alameda County Board of Supervisors and assembly members about legal constraints. There is a focus on forming partnerships and convening groups across the county to address these challenges, especially in light of federal cuts to Women's Health services.

Question: Ms. Gebhart asked if county conversations cover only reproductive health or also broader topics.

Response: Mr. Woodruff clarified that reproductive health was used as an example, but legal challenges (like those in Texas) mean any funding for such services could make the plan legally vulnerable. The Alliance must be very careful and ensure nothing they do is illegal.

Question: Ms. Gebhart asked if the seventeen plans are working with the state on the federal audit issue, or is it just the plans' responsibility?

Response: Mr. Woodruff explained that the main concern is the state potentially recouping money from plans if the federal government demands repayment. The plans are looking at legal options to protect themselves and have had conversations with the state, which insists plans must follow their state contracts. The focus is on protecting reserves and T&E.

Question: Dr. Ferguson inquired whether the Alliance would be able to provide a loan if Planned Parenthood made such a request.

Response: Mr. Woodruff responded that the Alliance does not give loans but could consider grants. However, grants cannot be used for restricted services; they could be for things like buildings, but the use must be clearly documented.

b) REVIEW AND APPROVE THE JUNE AND JULY 2025 MONTHLY FINANCIAL STATEMENTS

JUNE 2025 Financial Statement Summary

Enrollment:

Enrollment increased by 2,025 members since May 2025.

Net Income:

For the month ended June 30th, 2025, the Alliance reported a Net Income of $4.9 million (versus budgeted Net Income of $2.7 million). For the year-to-date, the Alliance recorded a Net Loss of $86.1 million versus a budgeted Net Loss of $65.3 million.

Premium Revenue:

For the month ended June 30th, 2025, actual Revenue was $189.2 million vs. our budgeted amount of $189.1 million.

Medical Expense:

Actual Medical Expenses for the month were $175.2 million, vs. budgeted amount of $175.1 million. For the year-to-date, actual Medical Expenses were $2.1 billion vs. budgeted Medical Expense of $2.1 billion.

Medical Loss Ratio:

Our MLR ratio for this month was reported as 92.6%. The year-to-date MLR was 99.9%.

Administrative Expense:

Actual YTD Administrative Expenses for the month ending June 30th, 2025, were $115.8 million vs. our budgeted amount of $119.9 million. Our Administrative Loss Ratio (ALR) is 6.0% of our Revenue for the month, and 5.4% of Net Revenue for year-to-date.

Other Income / (Expense):

As of June 30th, 2025, our YTD interest income from investments show a gain of $32.2 million.

Managed Care Organization (MCO) Provider Tax:

For the month ending June 30th, 2025, we reported $66.9 million MCO Tax Revenue vs. budgeted MCO Tax Revenue of $64.0 million. Our MCO Tax Expense was $66.9 million vs. budgeted MCO Tax Expense of $67.0 million.

Tangible Net Equity (TNE):

For June, the DMHC requires that we have $80.7 million in TNE, and we reported $169.3 million, leaving an excess of $88.6 million. As a percentage we are at 210%, which remains above the minimum required.

Cash and Cash Equivalents:

We reported $533.0 million in cash; $380.6 million is uncommitted. Our current ratio is above the minimum required at 1.12 compared to regulatory minimum of 1.0.

Capital Investments:

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

Question: Dr. Ferguson inquired about the difference in June's administrative expenses and the reason for the month's loss in this category.

Response: Mr. Riojas noted the favorable outcome came from lower IT consulting and software license costs than budgeted. The loss was due to more invoices arriving in June than anticipated, affecting the monthly budget.

Question: Ms. Gebhart asked the status of the $8 million set aside for COVID test fraud.

Response: Mr. Riojas explained that the funds are still set aside. The DOJ has indicted the company owner, but there is no conviction yet. The Alliance is consulting with auditors and will release the funds when comfortable. It likely will not affect the current year’s budget but may help next year.

Question: Dr. Ferguson asked whether the accrual for fraud will be released in FY25 or FY26.

Response: Mr. Riojas stated that most likely the auditors will recommend rolling it into FY26 since the amount is small compared to total revenue.

Question: Dr. Ferguson inquired about the federal government's position regarding the MCO tax.

Response: Mr. Woodruff stated that the federal government believes California’s MCO tax violates equal taxation rules for managed care plans. California has requested an exemption, which is under federal review, and Governor Newsom is withholding funds until official approval is received.

Question: Dr. Ferguson asked what the state is saying about monthly reporting requirements?

Response: Mr. Riojas explained that the state required six months of positive net income to be released from monthly reporting. The Alliance now meets this and will request to be let off monthly reporting, but the state can keep them on if deemed necessary.

JULY 2025 Financial Statement Summary

Enrollment:

Enrollment increased by 236 members since June 2025.

Net Income:

For the month ending July 31st, 2025, the Alliance reported a Net Income of $1.7 million (versus budgeted Net Income of $7.2 million).

Premium Revenue:

For the month ending July 31st, 2025, actual Revenue was $192.1 million vs. our budgeted amount of $187.2 million.

Medical Expense:

Actual Medical Expenses for the month were $184.3 million, vs. budgeted amount of $170.6 million.

Medical Loss Ratio:

Our MLR ratio for this month was reported as 96.0%.

Administrative Expense:

Actual YTD Administrative Expenses for the month ending July 31st, 2025, were $8.9 million vs. our budgeted amount of $11.4 million. Our Administrative Loss Ratio (ALR) is 4.6% of our Revenue for the month and for year-to-date.

Other Income / (Expense):

As of July 31st, 2025, our YTD interest income from investments show a gain of $2.8 million.

Managed Care Organization (MCO) Provider Tax:

For the month ending July 31st, 2025, we reported $65.5 million MCO Tax Revenue vs. budgeted MCO Tax Revenue of $64.9 million. Our MCO Tax Expense was $65.5 million vs. budgeted MCO Tax Expense of $64.9 million.

Tangible Net Equity (TNE):

For July, the DMHC requires that we have $81.2 million in TNE, and we reported $171.0 million, leaving an excess of $89.8 million. As a percentage we are at 211%, which remains above the minimum required.

Cash and Cash Equivalents:

We reported $530.3 million in cash; $377.6 million is uncommitted. Our current ratio is above the minimum required at 1.15 compared to regulatory minimum of 1.0.

Capital Investments:

We have acquired $0 in Capital Assets year-to-date. Our annual capital budget is $1.4 million.

Question: Dr. Ferguson asked what caused the unfavorable net income of $13.7 million in July.

Response: Mr. Riojas explained that the main reason was higher-than-budgeted capitated medical expenses due to accruals for targeted rate increases (TRI). There was uncertainty about a possible increase to the TRI fee schedule, but it was later confirmed there would be no increase.

Question: Dr. Ferguson asked if the increase in medical expenses in July is due to actual costs or accruals?

Response: Mr. Riojas stated that the increase was mainly due to accruals for TRI, not actual medical expense increases. Inpatient hospital length of stay went down, but unit costs increased. Other benefits and services were related to incentive programs, offset by earned revenue.

Question: Ms. Gebhart asked about the other benefits and services expenses for July.

Response: Mr. Riojas stated that these are incentive program expenses (housing and homeless, Cal AIM), already offset by earned revenue, so they are not a problem area.

Question: Ms. Park inquired about how the Alliance is preparing for future financial challenges.

Response: Mr. Riojas stated that gradual increases in tangible net equity, maximizing investment returns, controlling medical costs, monitoring for fraud, and improving operational efficiencies are key approaches.

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

Motion Passed

No opposition or abstentions.

UNFINISHED BUSINESS

There was no unfinished business.

PUBLIC COMMENTS

There were no public comments.

ADJOURNMENT

Dr. Ferguson adjourned the meeting at 8:54 a.m.

Compliance Advisory Committee Meeting Minutes

Compliance Advisory Committee
Regular Meeting Minutes
Friday, July 11th, 2025
10:30 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 10:30 am.

2. ROLL CALL

A roll call of Committee Members was taken, quorum was confirmed at 10:31 am.

3. AGENDA APPROVAL OR MODIFICATIONS

None

4. PUBLIC COMMENT (NON-AGENDA ITEMS)

None

5. CONSENT CALENDAR

a) June 13th, 2025, 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. 2023 DHCS Focused Audit: Open CAPs Update

- The Plan has unresolved 2023 audit findings related to Universal Release of Information forms at initial member contact, which are critical for care coordination.
- While the Plan has some influence, resolving the findings primarily depends on collaboration with the County.
- The County is implementing improved processes to identify members needing specialty mental health services, which will enhance coordination with the Plan.
- The Plan has informed the State about the need for County collaboration and noted that other plans face similar challenges. Written guidance from the State may be requested.

2. 2024 DHCS Audit: Final CAP Update

- The four (4) partially accepted findings are still under state review. The findings relate to the Plan providing documentation of internal audits for the findings.
- Some of these internal audit activities have target completion dates later in the year.
- Full acceptance of all findings is anticipated by the summer.

3. 2025 DMHC and DHCS Audit Reports

- The Plan is still awaiting audit findings from DMHC.
- DHCS issued one (1) finding related to the post-stabilization process: out-of-network emergency facilities must confirm admissions with the Plan.
- Currently, a nurse conducts the initial medical necessity review. If denied, the on-call Medical Director (MD) reviews the case for accuracy.
- DMHC finding alludes that all post-stabilization requests should be reviewed first by a MD.
- The Plan is seeking clarification from DHCS on whether all post-stabilization calls must be reviewed by a MD, or only those initially denied by a nurse.
- It is possible that the DHCS finding is remediated through the preliminary process, resulting in a compliant audit.

Question: Does the plan have a Policy & Procedure in place to delegate the first Call Nurse to a Medical Director?

Answer: Yes, this process is outlined in our official Policy & Procedure.

4. 2025 DMHC Finance Audit: Audit Planning Update

- The finance audit is scheduled to begin the week of August 4 and will be conducted virtually.
- The Plan is creating presentation materials to formally introduce the Plan's involved teams.
- No issues have been identified by Compliance in preparation for the audit.

5. 2025 HSAG NAV Audit: Audit Schedule

- The Network Validation Audit (NAV) will be conducted by the Health Services Advisory Group (HSAG) on August 11th, 2025.
- The audit is expected to last the entire day. No issues have been identified by Compliance in preparation for the audit.

6. 2024 Compliance Risk Assessment Closure

- The Board of Governors requested a Comprehensive Risk Assessment (CRA) to evaluate growth demand and leadership changes.
- CRA was conducted by third-party consultant RGP (Dec 2022 – May 2023).
- Final report identified twenty-two (22) findings across fourteen (14) areas of opportunity.
- Remaining open findings relate to Conflict-of-Interest (COI) policies and procedures.
- A draft COI policy is in development and will undergo committee review.
- These findings will be provisionally closed due to ongoing COI policy work.
- Addressing findings required extensive collaboration between Compliance and all divisions/teams.
- Although this CRA was externally conducted, a new Risk Assessment and Management department has been established to internalize future assessments.

Question: How will the new department stay up to date with industry trends and risk management best practices?

Answer: The division encourages self-advancement and ongoing education in industry best practices.

Question: Where does the Risk Management unit fall within the organizational structure?

Answer: Historically, the Internal Audit unit operated under General Compliance. With the establishment of Risk Management, Internal Audit will now transition under its

oversight. This realignment enhances accountability by ensuring independent oversight of the Compliance department

ii. Compliance Dashboard

1. 2025 DHCS Audit Finding

- Since our last meeting, the Plan received the preliminary audit report and held the exit conference with DHCS on June 23, 2025.
- The report included one finding in Utilization Management (UM):
- The Plan did not ensure that a medical director—or a licensed physician acting on their behalf—reviewed post-stabilization authorization requests for medical necessity.
- The Plan submitted its response on July 9, 2025, noting that medical directors are available 24/7, supported by an on-call schedule submitted to DHCS.
- We are now awaiting DHCS's response and the final audit report.

2. 2023 and 2024 DHCS Audit Open Findings Update

- The DHCS audit resulted in 20 findings; 16 have been closed, and 4 remain open pending DHCS review.
- The final CAP update, addressing DHCS's follow-up questions, was submitted on June 23, 2025.
- The 4 open CAPs include:
    1. (4.1.2) – Grievances not fully resolved.
    2. (4.1.3) – Resolution letters lacked clear, concise explanations.
    3. (4.1.4) – Missing updated Non-Discrimination Notice (NDN) and Language Assistance Tagline (LAT) in grievance letters.
    4. (5.3.1) – Non-compliance with provider termination reporting and member notification requirements.
- G&A continues monthly audits on these items, with findings shared for retraining as needed.
- The Plan is using the Potential Provider Terminations Log and Adverse Event Report to improve tracking and reporting.

Question: What does the validation audit process include?

Answer: We review previously closed findings to ensure Corrective Action Plans (CAPs) have been fully implemented and are supported by data. This process verifies that the actions taken are effectively addressing the root issues, helping to prevent recurrence in future audits. All CAP activities are tracked and regularly reviewed as part of the internal audit process.

Question: Although we started this process 4 years ago, why was this process implemented?

Answer: This process was implemented in response to repeat findings. This process has dramatically reduced recurring findings.

Question: Can you walk through the Audit Roll-up findings for the last 4 years?

Answer: The audit roll-up includes summaries of each audit conducted over the past four years, sorted by most recent date. The data shows a clear downward trend in findings—from thirty-eight (38) in 2018 to just one (1) in 2025—demonstrating continuous improvement and effective corrective actions.

b) Medi-Cal Program Updates

i. None

7. COMPLIANCE ADVISORY COMMITTEE BUSINESS

a) None

8. STAFF UPDATES

a) Senior Director, Risk Management

- Sr. Director of Enterprise Risk Management and Operational Oversight.

9. UNFINISHED BUSINESS

a) None

10. STAFF ADVISORIES ON COMPLIANCE BUSINESS FOR FUTURE MEETINGS

a) None

11. ADJOURNMENT

- Meeting adjourned at 10:59 am.

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Board of Governors Meeting Minutes

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

Video Conference Call and

1240 S. Loop Road
Alameda, CA 94502

1. CALL TO ORDER

Board of Governors Present: Rebecca Gebhart (Chair), Dr. Noha Aboelata (Vice-Chair), Aarondeep Basrai, Dr. Kathleen Clanon, Dr. Rollington Ferguson, Andrea Ford, James Jackson, Byron Lopez, Dr. Marty Lynch, Andie Martinez Patterson, Dr. Kelley Meade, Jody Moore, Supervisor Lena Tam

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

Board of Governors Excused: Dr. Kelley Meade, Yeon Park, Natalie Williams

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 12:01 p.m.

2. ROLL CALL

Roll call was taken, and a quorum was established.

3. AGENDA APPROVAL

There were no modifications to the agenda.

4. INTRODUCTIONS

Two representatives from 24 Hour Home Care, Shawna Day and Lars Erickson, were introduced as guests and welcomed at the meeting.

5. CONSENT CALENDAR

a) JULY 8th, 2025, FINANCE COMMITTEE MEETING MINUTES

b) JULY 11th, 2025, COMPLIANCE ADVISORY COMMITTEE MEETING MINUTES

c) JULY 11th, 2025, BOARD OF GOVERNORS MEETING MINUTES

d) AUGUST 22nd, 2025, JOINT EXECUTIVE & FINANCE COMMITTEE MEETING MINUTES

e) REVIEW AND APPROVE RESOLUTION RE-APPOINTING DR. NOHA ABOELATA TO DESIGNATED BOARD OF GOVERNORS SEAT (ACCMA/SMMA PHYSICIAN)

f) REVIEW AND APPROVE RESOLUTION RE-APPOINTING ANDREA SCHWAB-GALINDO TO DESIGNATED BOARD OF GOVERNORS SEAT (PRIVATE/PUBLIC COMMUNITY CLINIC-ALAMEDA HEALTH CONSORTIUM)

Motion: A motion was made by Dr. Rollington Ferguson and seconded by Supervisor Lena Tam to approve the Consent Calendar.

Vote: The motion was passed unanimously.

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

No opposition or abstentions.

6. BOARD MEMBER REPORTS

a) COMPLIANCE ADVISORY COMMITTEE

Mr. Lopez reported on the Compliance Advisory Committee meeting, which was informational due to the lack of a quorum. He provided updates on various audits, including the 2023 DHCS and 2024 audits, the 2025 DMHC finance audit, and the 2025 HSAG network access validation audit. He also mentioned the review of the compliance dashboard, as well as the Medicare implementation readiness, enterprise risk management, and vendor management activities.

b) FINANCE COMMITTEE

Doctor Ferguson provided an update on the Finance Committee, highlighting positive trends in the plan's financials. He mentioned improvements in the MLR, net income, and current ratio. He also discussed the MCO tax and its potential impact on the plan.

c) CAC SELECTION COMMITTEE

Chair Gebhart reported on the Consumer Advisory Committee selection committee's work, including the approval of seven new members and the review of the committee's demographics. She also mentioned changes to the committee's charter to align with a new all-plan letter from DHCS and to address absences.

7. CEO UPDATE

CEO Matt Woodruff discussed ongoing regulatory challenges, anticipated membership losses, federal scrutiny of core benefits, and the need for legal and operational strategies to protect members, with active board engagement on these issues.

Regulatory Environment and Membership Loss: The organization anticipates losing about 30,000 members this fiscal year, with larger impacts expected in fiscal years 2027 and 2028 due to federal and state policy changes.

Core Benefits and Program Risks: Federal authorities are requiring states to focus on core benefits, with uncertainty about what qualifies; programs like housing, rental assistance, and community supports are at risk of losing funding.

Coordinated County Response: The CEO and board members are working to coordinate county-wide meetings and data sharing to develop legal and operational strategies for maintaining coverage and supporting affected populations.

Community Support for Disenrolled Members: Board members discussed the importance of organizing support networks for members losing coverage, with suggestions for community-based solutions and leveraging county resources.

Question: Ms. Moore asked if the federal government uses lists of undocumented people who receive services from organizations like the Alliance to find undocumented individuals.

Response: Mr. Woodruff confirmed that states are required to report Medicaid program participants to CMS, so it is likely that CMS already has this information.

Question: Chair Gebhardt asked for clarification about the financial segregation of services for members with unsatisfactory immigration status (UIS) versus satisfactory immigration status (SIS).?

Response: Mr. Woodruff and Mr. Riojas explained that the feds are concerned about mixing funds between these groups, and if commingling is found, there is a risk of funding recoupment. The specifics of how to segregate funds are still unclear.

Question: Dr. Clanon asked if services for recently incarcerated (justice-involved) people are at risk under federal directives.

Response: Mr. Riojas clarified that the justice-involved population under the 1115 waiver is one of the areas highlighted as a risk, and the state is advising plans to look at this. Risks include programs going away or the need to separate funding for undocumented members.

Question: Dr. Clanon asked what kind of guidance is expected from the state regarding risk and program continuation.

Response: Mr. Woodruff said the state is still working through the guidance and has asked all plans for ideas, including the possibility of the state assuming risk for certain programs.

Question: Ms. Ford asked if lawful permanent residents (LPRs) are affected by these changes and about the implications for eligibility and program outreach.

Response: Mr. Woodruff said there are several categories (undocumented, refugee, etc.), but the Alliance does not have detailed data on these subgroups; the plan will follow state guidance.

Question: Dr. Seevak asked if there has been an observed impact on utilization by undocumented or UIS patients.

Response: Mr. Woodruff noted that while there is anecdotal evidence of fear, the data does not show a significant drop in utilization in Alameda, though this may change.

Question: Chair Gebhart asked about the status of a work group to develop a plan to respond to federal changes.

Response: Mr. Woodruff described ongoing meetings among various county and alliance groups and the need for coordinated forecasting and planning, possibly led by the Alliance and Alameda County Health.

Comment: Supervisor Tam provided information on county efforts and funding to address safety net losses and suggested leveraging existing working groups rather than creating new ones.

8. BOARD BUSINESS

a) REVIEW AND APPROVE FINANCIAL STATEMENTS

a. YEAR-END
b. JUNE CLOSE
c. JULY CLOSE
d. AUGUST PREVIEW

JUNE 2025 Financial Statement Summary

Enrollment:

Enrollment increased by 2,025 members since May 2025.

Net Income:

For the month ended June 30th, 2025, the Alliance reported a Net Income of $4.9 million (versus budgeted Net Income of $2.7 million). For the year-to-date, the Alliance recorded a Net Loss of $86.1 million versus a budgeted Net Loss of $65.3 million.

Premium Revenue:

For the month ended June 30th, 2025, actual Revenue was $189.2 million vs. our budgeted amount of $189.1 million.

Medical Expense:

Actual Medical Expenses for the month were $175.2 million, vs. budgeted amount of $175.1 million. For the year-to-date, actual Medical Expenses were $2.1 billion vs. budgeted Medical Expense of $2.1 billion.

Medical Loss Ratio:

Our MLR ratio for this month was reported as 92.6%. The year-to-date MLR was 99.9%.

Administrative Expense:

Actual YTD Administrative Expenses for the month ending June 30th, 2025, were $115.8 million vs. our budgeted amount of $119.9 million. Our Administrative Loss Ratio (ALR) is 6.0% of our Revenue for the month, and 5.4% of Net Revenue for the year-to-date.

Other Income / (Expense):

As of June 30th, 2025, our YTD interest income from investments shows a gain of $32.2 million.

Managed Care Organization (MCO) Provider Tax:

For the month ending June 30th, 2025, we reported $66.9 million MCO Tax Revenue vs. budgeted MCO Tax Revenue of $64.0 million. Our MCO Tax Expense was $66.9 million vs. budgeted MCO Tax Expense of $67.0 million.

Tangible Net Equity (TNE):

For June, the DMHC requires that we have $80.7 million in TNE, and we reported $169.3 million, leaving an excess of $88.6 million. As a percentage, we are at 210%, which remains above the minimum required.

Cash and Cash Equivalents:

We reported $533.0 million in cash; $380.6 million is uncommitted. Our current ratio is above the minimum required at 1.12 compared to the regulatory minimum of 1.0.

Capital Investments:

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

JULY 2025 Financial Statement Summary

Enrollment:

Enrollment increased by 236 members since June 2025.

Net Income:

For the month ending July 31st, 2025, the Alliance reported a Net Income of $1.7 million (versus budgeted Net Income of $7.2 million).

Premium Revenue:

For the month ending July 31st, 2025, actual Revenue was $192.1 million vs. our budgeted amount of $187.2 million.

Medical Expense:

Actual Medical Expenses for the month were $184.3 million, vs. budgeted amount of $170.6 million.

Medical Loss Ratio:

Our MLR ratio for this month was reported as 96.0%.

Administrative Expense:

Actual YTD Administrative Expenses for the month ending July 31st, 2025, were $8.9 million vs. our budgeted amount of $11.4 million. Our Administrative Loss Ratio (ALR) is 4.6% of our Revenue for the month and for the year-to-date.

Other Income / (Expense):

As of July 31st, 2025, our YTD interest income from investments shows a gain of $2.8 million.

Managed Care Organization (MCO) Provider Tax:

For the month ending July 31st, 2025, we reported $65.5 million MCO Tax Revenue vs. budgeted MCO Tax Revenue of $64.9 million. Our MCO Tax Expense was $65.5 million vs. budgeted MCO Tax Expense of $64.9 million.

Tangible Net Equity (TNE):

For July, the DMHC requires that we have $81.2 million in TNE, and we reported $171.0 million, leaving an excess of $89.8 million. As a percentage, we are at 211%, which remains above the minimum required.

Cash and Cash Equivalents:

We reported $530.3 million in cash; $377.6 million is uncommitted. Our current ratio is above the minimum required at 1.15 compared to the regulatory minimum of 1.0.

Capital Investments:

- We have acquired $0 in Capital Assets year-to-date. Our annual capital budget is $1.4 million.

Question: Dr. Seevak asked about the impact of the August enrollment decrease of 4,000 members on rates compared to the budget.

Answer: Mr. Riojas explained that while the decrease was higher than expected for the month, it aligns with the anticipated annual decline of 30,000 members, so revenue impacts are expected to be in line with the current budget.

Question: Dr. Seevak's asked about the reason for the increase in group care numbers and whether the payment for group care is a fixed annual amount.

Answer: Mr. Riojas clarified that the group care rate is negotiated with the county on a two-year cycle, and the goal is to break even, not make a profit. The actuaries are working on new proposed rates for the next cycle.

Motion: A motion was made by Dr. Rollington Ferguson and seconded by Dr. Evan Seevak to approve the June and July 2025 Monthly Financial Statements.

Vote: The motion was passed unanimously.

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

No opposition or abstentions.

b) MEDICAL MANAGEMENT

Inpatient Interventions

- Ongoing
- Monthly Over/Under Utilization Workgroup– deep dives into ED, Pharmacy, Inpatient, Non-Utilizers
- Weekly Hospital partner rounds

- Transitional Care Services (TCS) w/CHWs; vendor: Journey Health- ABSMC/Eden Hospitals IP units; Upward Health – contracting in progress
- Fund CHCN's CTRN program (11 RN FTEs, 3.5 coordinator FTEs) @Alta Bates
- Targeted enrollment in ECM– MIF prioritization to ECM providers
- Inpatient RN on-site at Washington Hosp (Aug 2025)

Member Impact
- Decreasing LOS (5.8 April◊ 5.2 June)
- Decreasing admits/1000 (48.8 April ◊ 46.2 June)
- Hosp days/1000 (290.0 April ◊ 237.9 June)
- Increase ECM enrollment by 4680 members since August 2024 (total enrollment =6144)
    - 18 providers; 36 provider sites

Long-Term Support Services Interventions
- On-going
    - LTC rounds (LTC/IP/ECM) – virtual
    - On-site visitation in LTC facilities
    - Quarterly rounds with RCEB
    - LTC liaison meets with facilities with claims issues
    - TCS after acute stay or transition to LTC
    - Sitter parameters

Emergency Department Interventions
- Ongoing
    - Member education campaign-increase Telehealth and Urgent Care utilization; New brochures to members
    - Community Health Workers (CHW) program; care coordination in EDs (Highland, Sutter, Eden)
    - 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 high 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

CHW Program
- Community-based (12 CBOs)
    - Ex- re-entry, violence prevention, families, health ed ω
- Vendor contract (Journey Health)- ED/IP
- Pilot programs
    - Fatty liver/metabolic syndrome – disease management/lifestyle changes
    - Perinatal/maternal mental health- peer support

Pharmacy Interventions
- Ongoing
    - Formulary/Prior Authorization (PA) review
    - Process change: "pend not pay" for new medications not on PA (e.g., gene therapy)
    - Process change: "pend not pay" new J codes
    - New policy regarding self-injectables administered in office (June 2025)
    - TCS medication reconciliation @ Stanford, AHS, ABSMC, Washington hospitals

Member/Alliance Impact

- TCS: Med reconciliation. Screened 400+ members w/discharge dx of CHF or Sepsis at discharge→outreach to members
- Improved pharmacy pricing w/larger network (Optum)
- New PA process: prevented high cost meds from auto pay (prevented ~$3.1M payment)
- Alliance no longer pays for drugs carved out to the State (cost saving)
- PA process helping to prevent FWA for self-administered medications (cost saving)

Question: Dr. Evan Seevak inquired about the population aged 65 and older, asking whether their absence from the top 5% of expenses is due to most being on Medicare, meaning the Alliance does not incur these costs.

Response: Dr. Carey confirmed that the Alliance currently does not bear these expenses, but this will change with the implementation of DSNP.

Comment: Mr. Jackson recommends displaying the goals alongside the results to compare progress effectively for future presentations.

Question: Dr. Ferguson asked why Washington Hospital was chosen for the inpatient nurse position instead of another facility with higher readmission rates.

Response: Dr. Carey explained that it was a combination of high patient volume and increased readmission rates.

Question: Dr. Ferguson inquired about the self-injectable medications and wanted to know which specific medications are included.

Response: Dr. Carey mentioned it was primarily a medication for rheumatology, but the specific name was not recalled.

Question: Dr. Seevak inquired about situations requiring a warm transfer to county behavioral health and the nature of that partnership.

Response: Dr. Carey stated that there is a partnership with the county, which involves monthly meetings; however, some data-sharing issues persist.

Question: Ms. Moore inquired about the behavioral support organizations that are met with monthly.

Response: Dr. Carey stated that the meetings are with the Alameda County Behavioral Health Department team, rather than specific entities.

Question: Mr. Jackson asked about the rise in avoidable emergency department visits at Children's Hospital. Is there any explanation for this?

Response: Dr. Carey stated that there is no clear explanation yet. They are investigating with UCSF partners but suspect access issues outside of normal hours.

Comment: Dr. Seevak and Chair Gebhardt suggested possibly a future presentation on the removal of GLP-1 coverage for non-diabetics and how that will impact the population.

Informational Item Only.

c) COMMUNITY SUPPORTS OPERATIONS UPDATE

Matt Woodruff presented a detailed report on community supports operations, focusing on provider audits, authorization and denial trends, and efforts to reduce denials through provider education and process improvements.

Provider Audits and Training: The organization is preparing to audit all community support programs, with provider training sessions scheduled to ensure understanding of audit criteria and processes.

Authorization and Denial Trends: Monthly authorization volumes and approval/denial rates were reviewed, with analysis of trends over the past year and identification of high-denial programs and service categories.

Denial Reasons and Appeals: Most denials are due to 'criteria not met,' often related to missing information; the appeals process includes internal and external reviews, with an overturn rate below 20%.

Process Improvement Initiatives: Efforts are underway to improve reporting, enhance provider education, and streamline referral and authorization processes, particularly for food-related services, to reduce unnecessary denials and administrative burden.

Federal Program Uncertainty: The future of certain community support programs depends on federal and state decisions regarding 1115 and 1915 waivers, with ongoing monitoring and advocacy to maintain services.

Question: Dr. Lynch inquired about the measures in place to assist programs with high denial rates in enhancing their data or information to decrease denials. Additionally, clarification was requested regarding how there could be zero denials and 3,600 approvals for the Healthcare Services Agency.

Response: Mr. Woodruff explained that the Alliance meets with all community support providers to review denials and provide information. For Healthcare Services Agency, most denials are administrative (e.g., missing information), not clinical, and the housing program is based on housing data, not clinical assessment.

Question: Dr. Clanon asked whether the Alliance receives a report from the state regarding the reasons for the reversal or upholding of Alliance decisions on appeals.

Response: Mr. Woodruff stated that there are two processes: provider appeals are reviewed by another physician at the Alliance, while state appeals are referred to an outside agency. The Alliance's overturn rate is below 20%, which is considered good.

Question: Dr. Clanon asked where the opportunities are for the system to learn from denials—are there misunderstandings about criteria or differences in assessment?

Response: Mr. Woodruff said that most outside overturns happen when the Alliance did not receive clinical documentation that was later provided to the outside reviewer. The Alliance is working to improve this process and communication with providers.

Question: Dr. Aboelata inquired whether high denial rates are concentrated in specific service categories, such as food or housing. Additionally, she asked about the responsibilities of a food

provider when a medical provider certifies that a patient meets the criteria for food support. Is it necessary for the food provider to verify this, and what documentation is required?

Answer: Mr. Woodruff stated that many denials occur in the food category. Although the criteria are clear, a disconnect may exist between referring providers and community support providers. The Alliance is exploring ways to provide more education and making process improvements. He also mentioned that the Alliance expects food providers to train their teams on the criteria and offer feedback on referring providers. Additionally, the plan may not always include all necessary data, such as lab results, so further discussion is needed to streamline the process.

Question: Dr. Ferguson asked how community services align with federal directives and what the future direction is.

Answer: Mr. Woodruff said services under the 1915 waiver are likely to be on solid ground, while those under the 1115 waiver are at risk. The goal is to move 1115 services into 1915 if possible.

Informational Item Only.

9. STAFF UPDATES

There were no staff updates.

10. UNFINISHED BUSINESS

None.

11. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS

None.

12. PUBLIC COMMENT (NON-AGENDA ITEMS)

There were no public comments for non-agenda items.

13. ADJOURNMENT

Chair Gebhart adjourned the meeting at 1:59 p.m.

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Resolution for QIHEC Nominees

RESOLUTION NO. 2025-XX

A RESOLUTION OF ALAMEDA ALLIANCE FOR HEALTH APPOINTING DR. LISA LAURENT, DR. STEPHANI BROWN, and DR. PARAG SHARMA 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 voting members representing common medical specialties and Alliance Medical Directors;

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:

Lisa Laurent, MD (Chief Medical Officer, AHS)

Stephanie Brown, MD (Medical Director, AAH)

Parag Sharma, MD (Medical Director, Utilization Management, AAH)

PASSED AND ADOPTED by the Board at a meeting held on the 10th day of October 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: **October 10th, 2025**

Subject: **CEO Report**

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

	August	YTD
Medi-Cal	$4.0M	$6.1M
Group Care	($231K)	($217K)
Medicare	($835K)	($1.2M)
Total	$3.0M	$4.7M

  - **Revenue was $188.9 million in August 2025 and $381.0 million Year-to-Date (YTD)**.
    - Medical expenses were $176.5 million in August and $360.9 million for the fiscal year-to-date; the medical loss ratio is 93.4% for the month and 94.7% for the fiscal year-to-date.
    - Administrative expenses were $11.9 million in August and $20.8 million for the fiscal year-to-date; the administrative loss ratio is 6.3% of net revenue for the month and 5.4% of net revenue year-to-date.
  - **Tangible Net Equity (TNE)**: Financial reserves are 217% of the required DMHC minimum, representing $93.7 million in excess TNE.
  - **Total enrollment in August 2025 was 407,561**, decreased by 4,075 Medi-Cal members compared to July 2025.

- **Key Performance Indicators:**
  - **Regulatory Metrics:**
    - Grievances scored 93% compliance instead of the regulatory standard of 95%.
    - Authorization turn around scored 93% instead of the regulatory standard of 95%.
  - **Non-Regulatory Metrics:**
    - All non-regulatory metrics were met for May.
- **Alliance Updates:**
  - **State And Federal Updates**
    - Brief legislative update.

- **Board Follow Up**
    - Board of Supervisors Health Committee
    - Board of Supervisors Meeting
    - Next Steps
        - Board Members at the meetings:
            - Supervisor Tam's Office
            - Dr. Clanon
            - Andie Martinez Patterson
            - Andrea Schwab Galindo
            - Andrea Ford
- **Medicare Overview:**
    - 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 75 projects, of which 70 are active, one (1) requested, one (1) on hold, and one (3) complete.
    - Provider outreach and support includes:
        - Five (5) onsite health center road shows that were two (2) hours with Executive Director, Medicare Programs, Sr. Director, Health Care Services, and Manager, Member Experience & Program management where the agenda consisted of D-SNP overview, product overview, eligibility / sales process, clinical authorization / referral process, Model of Care (MOC) review, member experience / Medicare Stars, member journey, annual wellness visits (AWV) / Welcome to Medicare visits, and health center tool kits / resource open discussions.
        - Chief Medical Officer and her leadership team, Executive Director, Medicare Programs, and external consultants also performed a four (4) hour onsite Model of Care (MOC) training with health centers.
        - Executive Director, Medicare Programs, Sr. Director, Member Services, and Manager, Medicare Sales & Retention presented a 90-minute presentation to Health Insurance Counseling and Advocacy Program (HICAP).
        - Chief Operating Officer (COO) presented at California Association of Health Plans (CAPH) on "How Medicare Changes in California Impacts Health Plans and FQHCs."
    - On September 19th, 2025, the Centers for Medicare & Medicaid Services (CMS) has reviewed and approved all 2026 contracting documents and post-application requirements for Contract ID H2035. On September 25th, 2025, the Department of Managed Health Care (DMHC) has officially approved the Notice of Material Modification, which confirms the addition of the specific D-SNP product to our license, including approval of all associated member communications (letters and notices).
    - AEP readiness IT deployments were successfully executed for 10/1/2025 and 10/15/2025 go-lives deliverables.
    - Highlights of the Alameda Alliance Wellness (HMO D-SNP) benefits include:
        - Dental Benefits – preventive, restorative, prosthodontics, and adjunctive general services that wrap around Medi-Cal dental benefits.

        - Vision Benefits – annual routine eye exam with $150 every 2 years towards eyeglasses or contacts.
        - Hearing Benefits – annual hearing exam to diagnose hearing and balance issues and $775 allowance per ear annually towards hearing aids.
        - Over-the-Counter Flex Card - $50 monthly allowance for OTC items such as cough medicine, vitamins, pain relievers, bandages, and other eligible items.
        - Worldwide Emergency Care - $25,000 annual benefit for emergency care services received worldwide.
        - Member Incentives Flex Card - $175 dollars annually for achieving healthy activities.
    - Three (3) HMO D-SNPs that include Elevance Health / Anthem Blue Cross, CVS / Aetna, and Imperial Health Plan of California exited Alameda County for PY2026.
        - Participating in PY2026 HMO D-SNPs include Kaiser, Alameda Alliance for Health, and Molina, and due to regulations, Molina is unable to grow the product and add members in PY2026.
        - Kaiser benefits include vision, acupuncture, fitness, OTC, telehealth, and worldwide emergency.

- **Medi-Cal Incentive Programs:**
    - **<u>Overview</u>**
        - The Medi-Cal incentive programs are funded by the State of California/DHCS and authorized through the American Rescue Plan Act, Home- and Community-Based Services, State general funds, and other waivers.
        - Participation in the incentive programs is voluntary, and the incentive funding paid by the DHCS can be recouped if performance outcomes and measures are not met.
        - Funding is allocated to build capacity in local health systems and is intended to establish sustainable operations to continue functioning after the incentive programs are completed. Alameda Alliance will also be applying incentive funds to expand current infrastructure, and to develop more resources for members, providers, and community-based organizations.
        - Leveraging the available guidance from State agencies, the managed care health plans are responsible for developing an evaluation, selection, and payment process.
        - Incentive payments are aligned with the payment tranches from the State of California. Periodically, required performance reports are assessed by the DHCS, and are used to calculate the awarded amounts. The DHCS assesses the program's performance by examining the actual outcomes and changes in quality metrics.
        - Alameda Alliance has developed additional incentive/grant programs outside of DHCS-sponsored programs.

- The Incentives & Reporting department reports into Operations and is responsible for managing the programs, enterprise reporting of outcomes (quality, performance), generating reports, and coordinating directly with program participants.

Section 2. Incentive Program Summary (2022 – 2025)

Incentive Program	Duration	Maximum	Awarded	Paid Out
1) Behavioral Health Integration	2021-2022	$3.2M	$3.2M	$3.0M
2) COVID-19 Vaccine	2021-2022	$8.4M	$3.0M	$1.4M
3) CalAIM IPP	2022-2024	$29.9M	$19.4M	$17.0M
4) Student Behavioral Health	2022-2024	$9.7M	$9.7M	$8.9M
5) Housing and Homelessness	2022-2023	$44.3M	$38.0M	$24.8M
6) Provider Recruitment Initiative	2024-2025	$2.0M	$2.0M	$294,976
7) Doula Scholarship Program	2024-2025	$20K	$20K	$14,000
	Totals	**$97.5M***	**$75.3M**	**$55.4M**

Program – Provider Recruitment Initiative Program

- Description & Purpose:

  The Alliance Provider Recruitment Initiative (PRI) was launched in June 2024. The program 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, as well as provide training scholarships for community health workers and housing grants for providers relocating to the area. 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
- Program Years: **6/1/2024 - 6/30/2025 and 7/1/2025 - 6/30/2026**
- Maximum available from Alameda Alliance: **$4 million**

- Payments issued: **$294,976**
- Current Status:

  The program launched on June 1st, 2024. Two million ($2M) in funding was available for the fiscal year 2024-2025; an additional $2M will be available for fiscal year 2025-2026. $2M in funding was awarded to 13 provider partners which included Mid-Level providers, Behavioral Health Clinicians, MDs/DOs, and OB/GYNs. Additionally, grants were provided to five (5) practices to support Community Health Worker (CHW) training certificate costs for 33 CHWs. The Alliance launched Year Two of the program on July 1st, which included the addition of Certified Medical Assistant training support. Unused funds in the amount of $94,250 will be rolled over into Year Two funding.

Program – Doula Scholarship Program

- Description & Purpose:

  The Alliance; Health Care Services department launched this program in December 2024 to grow the Doula provider network to increase access to these services for members. Scholarships of up to $1,000 per person for FY 2024-25 were available for Doulas both intending to contract with the Alliance and Doulas already contracted with the Alliance. Scholarships are intended to offset costs related to 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.
- Program Years: **7/1/2024 - 6/30/2025**
- Maximum available from Alameda Alliance: **$20,000**
- Payments issued: **$14,000**
- Current Status:

  For the FY 2024-25, 20 scholarships were awarded totaling $20K, and $14,000 was paid out at the conclusion of the funding period Seven (7) awardees were contracted with the Alliance and 13 awardees intended to contract with the Alliance. One (1) awardee withdrew from the program and one (1) awardee indicated they will not complete the funding deliverables required for the final payment of $500. Planning efforts are underway to launch the FY 2025-26 Doula Scholarship program which will be open to Doulas that intend to contract with the Alliance; up to $40,000 will be available for doula scholarships with a portion ($8,500) being earmarked for remaining deliverables from the 2024-25 funding cycle.

Program - Providing Access and Transforming Health (PATH)

Providing Access and Transforming Health (PATH): Comprising 5 initiatives, PATH funding supports Enhanced Care Management (ECM) and Community Support (CS) providers. $1.85 billion will be available statewide. Initiatives include:

- **WPC Services & Transition to Managed Care Mitigation Initiative**: Direct funding for WPC Pilot Lead Entities to sustain existing WPC Pilot services that “map to” ECM/Community Supports until an MCP covers the service. Services that will not continue under CalAIM—either because they are not included in

CalAIM or will not be picked up by any MCP in the future—are not eligible for this funding.

- **Technical Assistance Initiative**: Providers will have access to a statewide marketplace for ECM/Community Supports related technical assistance.
- **Collaborative Planning & Implementation Initiative**: Support for regional collaborative planning and implementation efforts across entities essential to the success of CalAIM. BluePath Health was selected by DHCS as the facilitator for Alameda County and the initial kick-off meeting was held on January 27th, 2023. BluePath Health is conducting monthly meetings with all Collaborative participants. BluePath Health also conducted two informational meetings with AAH in January and February. Health Care Services continues to represent Alameda Alliance in the monthly collaborative meetings.
- **Capacity & Infrastructure Transition, Expansion, and Development Initiative (CITED)**: Funding for providers, community-based organizations, counties, Lead Entities, tribes and others for capacity and infrastructure development activities that support the implementation of ECM and Community Supports. Round 1A CITED recipients were announced by DHCS on January 31st, 2023, and Round 1B CITED recipients were announced on March 24th, 2023; a total of $207M was awarded to 139 recipients during Round 1. The CITED Round 2 application period closed on May 31st, 2023, and DHCS announced the recipients on October 30th, awarding $144M to 145 providers across California. The CITED Round 3 application period closed on February 15th, 2024, and DHCS announced the recipients on August 30th, awarding $146.6M to 133 providers across California. The CITED Round 4 application period opened on January 6th, 2025, and will close on May 2nd, 2025.
- **Justice-Involved Capacity Building**: Funding to maintain and build pre-release and post-release services to support implementation of the CalAIM justice-involved population, including capacity and infrastructure to support services, including EHR systems. Round 1 grants in the amount of $4.55M were awarded statewide in November 2022. The application period for Round 2 closed on March 31st, 2023; grants in the amount of $64.5M were awarded in January 2024. The application period for Round 3 opened on May 1st, 2023, and closed on July 31st, 2023; awards have yet to be announced.

Alameda County Health Care Services Agency has applied for the PATH Mitigation funds to continue the following WPC services under CalAIM:

- **Sobering Center services**
- **Street Health Outreach**

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Legislative Tracking

2025 –2026 Legislative Tracking List

September 12th marked the last day for each house to pass bills with the exception of 2-year bills. The Governor now has until October 13th to sign or veto bills on his desk. Of the 123 bills that the Alliance tracked this year, 50 made it to the Governor's desk and 7 of those bills have been signed, while 43 await a signature or veto.

On June 30th, the Governor signed into law the Budget Act of 2025 which was followed by a Budget Bill Jr. and a Budget Clean Up bill. AB 105 (Budget Bill Jr.) was signed into law on September 17th, and it appropriated $1.25 million to the Department of Health Care Services for technical assistance support to ensure alignment with H.R.1 provisions specific to "verification of citizenship and immigration status of Medi-Cal members pursuant to August 2025 federal direction or related federal direction." AB 144 was also signed into law on September 17th. The health trailer bill focuses on eligibility, benefits, and administrative processes within the Medi-Cal delivery system with specific attention to expanded vaccine coverage, abortion services and family planning, and modified exemptions for the UIS population.

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. Public Affairs will provide a final legislative report focused on priority signed and vetoed bills in the next Board of Governors meeting packet.

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

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

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

AB 29 **(Arambula D) Medi-Cal: Adverse Childhood Experiences trauma screenings: providers.**
Current Text: Amended: 3/19/2025 html pdf

Introduced: 12/2/2024
Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 4/23/2025)(May be acted upon Jan 2026)

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

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

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

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

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

AB 40 **(Bryan D) Redistricting: congressional districts.**
Current Text: Amended: 8/21/2025 html pdf
Introduced: 12/2/2024
Status: 9/13/2025-Ordered to inactive file at the request of Senator Grayson.

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

Summary: The California Constitution requires the Citizens Redistricting Commission to adjust the boundary lines of the congressional, State Senate, Assembly, and State Board of Equalization districts in each year ending in 1. If approved by the electors, ACA 8 of the 2025–26 Regular Session would temporarily adopt new congressional district boundaries until 2031. The new congressional district boundaries are set forth in AB 604 of the 2025–26 Regular Session, which specifies that those district boundaries would become operative only if ACA 8 is approved by the electors. This bill would instead make the congressional district boundaries in AB 604 operative only if ACA 8 is approved by the electors and another state adopts a new congressional district map that takes effect after August 1, 2025, and before January 1, 2031, and that was not required by a federal court order. This bill would declare that it is to take effect immediately as an urgency statute.

AB 45 **(Bauer-Kahan D) Privacy: health data: location and research.**
Current Text: Chaptered: 9/26/2025 html pdf
Introduced: 12/2/2024
Status: 9/26/2025-Chaptered by Secretary of State - Chapter 134, Statutes of 2025

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 prohibits a person or business from selling or sharing this personal information. 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 specifies the 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 under certain circumstances, including, among others, for the collection or use as necessary to perform the services or provide the goods requested. The bill would also provide that these provisions do not alter applicable law regarding use by a law enforcement agency, as defined, of personal information generated by an electronic monitoring device. The bill would authorize an aggrieved person to institute and prosecute a civil action against a natural person, association, proprietorship, corporation, trust, foundation, partnership, or any other organization or group of people acting in concert for a violation of these provisions. The bill would also make other nonsubstantive changes. This bill contains other related provisions and other existing laws.

AB 49 **(Muratsuchi D) Schoolsites: immigration enforcement.**
Current Text: Chaptered: 9/20/2025 html pdf
Introduced: 12/2/2024
Status: 9/20/2025-Chaptered by Secretary of State - Chapter 122, Statutes of 2025

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

Summary: (1)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 nonpublic area of a schoolsite, as defined, for any purpose without being presented with a valid judicial warrant, judicial subpoena, or a court order. The bill would require school officials and employees of a local

educational agency, to the extent practicable, to request valid identification of any officer or employee of an agency conducting immigration enforcement seeking to enter a nonpublic area of a schoolsite. The bill would also prohibit a local educational agency and its personnel from disclosing or providing, in writing, verbally, or in any other manner, the education records of or any information about a pupil or a pupil's family and household without the pupil's parents' or guardians' written consent, a school employee, or a teacher to an officer or employee of an agency conducting immigration enforcement without a valid judicial warrant or judicial subpoena, or court order directing the local educational agency or its personnel to do so. 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: Chaptered: 9/26/2025 html pdf
Introduced: 12/2/2024
Status: 9/26/2025-Chaptered by Secretary of State - Chapter 135, Statutes of 2025

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 followup care, as specified. Existing law requires the pharmacist to provide the recipient of the drug with a standardized factsheet that includes the indications and contraindications for use of the drug, the appropriate method for using the drug, the need for medical followup, and other appropriate information. Existing law authorizes a pharmacist furnishing an FDA-approved, self-administered hormonal contraceptive pursuant to the above-described protocols to furnish, at the patient's request, up to a 12-month supply at one time. This bill would limit the application of those requirements to self-administered hormonal contraceptives that are prescription-only, and would authorize a pharmacist to furnish over-the-counter contraceptives without following those standardized procedures or protocols. The bill would additionally authorize a pharmacist to furnish up to a 12-month supply at one time of over-the-counter contraceptives at the patient's request. The bill would make related conforming changes. This bill contains other related provisions.

AB 54 **(Krell D) Access to Safe Abortion Care Act.**
Current Text: Amended: 7/1/2025 html pdf
Introduced: 12/2/2024
Status: 9/11/2025-Failed Deadline pursuant to Rule 61(a)(14). (Last location was INACTIVE FILE on 9/10/2025)(May be acted upon Jan 2026)

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	2 year	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 brand name or generic mifepristone or any drug used for medication abortion that is lawful under the laws of the state, 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: Enrollment: 9/16/2025 html pdf
Introduced: 12/2/2024
Status: 9/16/2025-Enrolled and presented to the Governor at 2 p.m.

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 perinatal services that are comprehensive in nature, as specified, consistent with certain standards. The bill would remove the above-described proximity requirement and would instead require a written policy for hospital transfer. The bill would require the policy to include certain requirements relating to, among other things, arrangements for the referral of a complication, arrangements for the transfer of care, provision of medical records, information about the estimated transfer time, and a clear explanation of the facility's overall emergency transfer plan, as specified. This bill contains other related provisions and other existing laws.

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

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

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

enforcement of act. This bill contains other related provisions and other existing laws.

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

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

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

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

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

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

AB 96 **(Jackson D) Community health workers.**
Current Text: Amended: 2/11/2025 html pdf
Introduced: 1/7/2025

Status: 5/1/2025-Failed Deadline pursuant to Rule 61(a)(2). (Last location was HEALTH on 2/3/2025)(May be acted upon Jan 2026)

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

Summary: Existing law required the Department of Health Care Access and Information, on or before July 1, 2023, to develop and approve statewide requirements for community health worker certificate programs. Existing law requires the department, as part of developing those requirements, to, among other things, determine the necessary curriculum to meet certificate program objectives. Existing law defines "community health worker" for these purposes to mean a liaison, link, or intermediary between health and social services and the community to facilitate access to services and to improve the access and cultural competence of service delivery. Existing law specifies that "community health worker" include Promotores, Promotores de Salud, Community Health Representatives, navigators, and other nonlicensed health workers with the qualifications developed by the department. This bill would also specify for these purposes that a "community health worker" includes a peer support specialist and would deem a certified peer support specialist to have satisfied all education and training requirements developed by the department for certification as a community health worker.

AB 220 **(Jackson D) Medi-Cal: subacute care services.**
Current Text: Amended: 7/8/2025 html pdf
Introduced: 1/8/2025
Status: 9/11/2025-Failed Deadline pursuant to Rule 61(a)(14). (Last location was DESK on 9/4/2025)(May be acted upon Jan 2026)

Desk	Policy	Fiscal	Floor	2 year	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 provider seeking authorization for 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 prohibit a Medi-Cal managed care plan from requiring a subsequent treatment authorization request upon a patient's return from a bed hold for acute hospitalization. The bill would authorize the department to impose sanctions on Medi-Cal managed care plans for violations of these provisions, as specified.

AB 224 **(Bonta D) Health care coverage: essential health benefits.**
Current Text: Enrollment: 9/15/2025 html pdf
Introduced: 1/9/2025
Status: 9/15/2025-Enrolled and presented to the Governor at 4:30 p.m.

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

Summary: Existing law requires the Department of Insurance to regulate health insurers. Existing law requires an individual or small group 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 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 for health insurers. 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 for health insurers to include certain additional benefits, including coverage for specified fertility services and specified durable medical equipment.

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: 7/17/2025-Failed Deadline pursuant to Rule 61(a)(10). (Last location was HEALTH on 5/7/2025)(May be acted upon Jan 2026)

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

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

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

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

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

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

4/23/2025)(May be acted upon Jan 2026)

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

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

AB 260 **(Aguiar-Curry D) Sexual and reproductive health care.**
Current Text: Chaptered: 9/26/2025 html pdf
Introduced: 1/16/2025
Status: 9/26/2025-Chaptered by Secretary of State - Chapter 136, Statutes of 2025

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

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

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

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

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

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

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

Summary: Existing law establishes the Office of Health Care Affordability within the Department of Health Care Access and Information to analyze the health care market for cost trends and drivers of spending, develop data-informed policies for lowering health care costs for consumers and purchasers, and create a state strategy for controlling the cost of health care. Existing law establishes the Health Care Affordability Board to establish, among other things, a statewide health care cost target and the standards necessary to meet exemptions from health care cost targets or submitting data to the office. Existing law authorizes the office to establish advisory or technical committees, as necessary, in order to support the board's decisionmaking. This bill would require the board, on or before June 1, 2026, to establish a Patient Advocate Advisory Standing Committee, as specified, that is required to publicly meet, and receive public comments, at least 4 times annually. The bill would require the committee to include specified data from the meetings to the board as part of its annual report.

AB 280 **(Aguiar-Curry D) Health care coverage: provider directories.**
Current Text: Amended: 7/15/2025 html pdf
Introduced: 1/21/2025
Status: 9/11/2025-Failed Deadline pursuant to Rule 61(a)(14). (Last location was INACTIVE FILE on 9/8/2025)(May be acted upon Jan 2026)

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan and a health insurer that contracts with providers for alternative rates of payment to publish and maintain a provider directory or directories with information on contracting providers that deliver health care services enrollees or insureds, and requires a health care service plan and health insurer to regularly update its printed and online provider directory or directories, as specified. Existing law authorizes the departments to require a plan or insurer to provide coverage for all covered health care services provided to an enrollee or insured who reasonably relied on materially inaccurate, incomplete, or misleading information contained in a plan's or insurer's provider directory or directories. This bill would require a plan or insurer to annually verify and delete inaccurate listings from its provider directories, and would require a provider directory to be 60% accurate on July 1, 2026, with increasing required percentage accuracy benchmarks to be met each year until the directories are 95% accurate on or before July 1, 2029. The bill would subject a plan or insurer to administrative penalties for failure to meet the prescribed benchmarks. The bill would require a plan or insurer to provide coverage for all covered health care services provided to an enrollee or insured who reasonably relied on inaccurate, incomplete, or misleading information contained in a health plan or policy's provider directory or directories and to reimburse the provider the out-of-network amount for those services. The bill would prohibit a provider from collecting an additional amount from an enrollee or insured other than the applicable in-network cost sharing, which would count toward the in-network deductible and out-of-pocket maximum. The bill would require a plan or insurer to provide information about in-network providers to enrollees and insureds upon request, including whether the provider is accepting new patients at the time, 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. The bill would authorize a health care service plan or insurer to include a specified statement in the provider listing before removing the provider from the directory if the provider does not respond within 5 calendar days of the plan or insurer's annual notification. 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: 9/12/2025-Failed Deadline pursuant to Rule 61(a)(14). (Last location was INACTIVE FILE on 6/12/2025)(May be acted upon Jan 2026)

Desk	Policy	Fiscal	2 year	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: Enrollment: 9/24/2025 html pdf
Introduced: 1/22/2025
Status: 9/24/2025-Enrolled and presented to the Governor at 3 p.m.

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 calendar days before the policy will be canceled for nonpayment. This bill, on or before April 1, 2026, would require the California FAIR Plan Association to create an automatic payment system and accept automatic payments for premiums from policyholders. The bill would prohibit cancellation or nonrenewal of a FAIR Plan policy solely because the policyholder is not enrolled in automatic payments. The bill would provide a period for the policyholder to pay any outstanding installment premium, in accordance with the existing 10-calendar-day notice requirement.

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

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law limits the copayment, coinsurance, deductible, and other cost sharing that may be imposed for specified health care services. This bill would prohibit a health care service plan contract or health insurance policy issued,

amended, or renewed on or after January 1, 2026, from imposing a deductible, coinsurance, copayment, or other cost-sharing requirement for in-network health care services, as defined, provided to an enrollee or insured under 21 years of age, except as otherwise specified. The bill would prohibit an individual or entity from billing or seeking reimbursement for in-network health care services provided to an enrollee or insured under 21 years of age, except as otherwise specified. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 302 **(Bauer-Kahan D) Data brokers: elected officials and judges.**
Current Text: Amended: 7/17/2025 html pdf
Introduced: 1/23/2025
Status: 8/29/2025-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/18/2025)(May be acted upon Jan 2026)

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

Summary: The California Consumer Privacy Act of 2018 (CCPA) grants a consumer various rights with respect to personal information, as defined, that is collected or sold by a business, as defined, including the right to request that a business delete any personal information about the consumer that the business has collected from the consumer. The California Privacy Rights Act of 2020, 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 the agency to establish an accessible deletion mechanism that, among other things, allows a consumer to request the deletion of all personal information related to that consumer through a single deletion request. Existing law requires, beginning August 1, 2026, a data broker to access the accessible deletion mechanism at least once every 45 days and, within 45 days after receiving a request, process all deletion requests and delete all personal information related to the consumers making the requests, as prescribed. Existing law requires a data broker to delete all personal information of the consumer at least once every 45 days unless the consumer requests otherwise, as prescribed. Existing law defines “data broker” to mean a business, as defined, that knowingly collects and sells to third parties the personal information of a consumer with whom the business does not have a direct relationship, except as provided. This bill would require the agency to obtain a list of all state and local elected officials, would require the Judicial Council to provide the agency with a list of all California judges, and would require the agency to allow elected officials or a judges to remove their information from those lists, as prescribed. The bill would require the lists to be kept confidential, as specified. The bill would also require the agency to upload the lists to the accessible deletion mechanism described above and, beginning August 1, 2026, require an entity receiving a notification that a deletion is required to do so within 5 days. This bill would authorize an elected official or judge who is on a list described above, the Attorney General, a county counsel, or a city attorney to bring an action for a violation of the bill, as prescribed. This bill contains other related provisions and other existing laws.

AB 309 **(Zbur D) Hypodermic needles and syringes.**
Current Text: Enrollment: 9/9/2025 html pdf
Introduced: 1/23/2025
Status: 9/9/2025-Enrolled and presented to the Governor at 3 p.m.

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

Summary: Existing law, the Pharmacy Law, provides for the licensure and regulation of pharmacists and pharmacies by the California State Board of Pharmacy. Existing law, until January 1, 2026, authorizes a physician or pharmacist to, without a prescription or permit, furnish hypodermic needles and syringes for human use to a person 18 years of age or older, and authorizes a person 18 years of age or older to, without a prescription or license, obtain hypodermic needles and syringes solely for personal use from a physician or pharmacist, as a public health measure, as specified. Existing law, until January 1, 2026, requires a pharmacy that furnishes nonprescription syringes to provide written information or verbal counseling to consumers, as specified, at the time of furnishing or sale of nonprescription hypodermic needles or syringes. Existing law, when no other penalty is provided, makes a knowing violation of the Pharmacy Law a

misdemeanor and, in all other instances, makes a violation punishable as an infraction. This bill would delete the January 1, 2026, repeal date, thereby extending those provisions indefinitely, and would make other conforming changes. By indefinitely extending an existing requirement under the Pharmacy Law, the violation of which is a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

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

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

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

AB 316 **(Krell D) Artificial intelligence: defenses.**
Current Text: Enrollment: 9/16/2025 html pdf
Introduced: 1/24/2025
Status: 9/16/2025-Enrolled and presented to the Governor at 2 p.m.

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.

AB 322 **(Ward D) Precise geolocation information.**
Current Text: Amended: 6/23/2025 html pdf
Introduced: 1/24/2025
Status: 8/28/2025-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/18/2025)(May be acted upon Jan 2026)

Desk	Policy	Fiscal	Floor	Desk	Policy	2 year	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, as defined, that is collected or sold by a business, as defined, including the right to direct a business that collects sensitive personal information about the consumer to limit its use, as prescribed. Existing law defines "sensitive personal information" to mean, among other things, personal information that reveals a consumer's precise geolocation. Existing law, the California Privacy Rights Act of 2020, approved by the voters as Proposition 24 at the November 3, 2020, statewide general election, amended, added to, and reenacted the CCPA. This bill would require a business that collects precise geolocation information to prominently display, when information is being collected, a notice to the consumer whose information is being collected that states certain information related to the collection of the information and its use by the business, including the goods or services requested by the consumer for which the business is collecting, processing, or disclosing the geolocation information and a description of how the business will process the geolocation information to carry out those purposes. This bill would prohibit a business that collects precise geolocation information from, among other things, retaining the information longer than necessary to provide the goods or services requested by the consumer or longer than one year after the consumer's last intentional interaction with the business, whichever is earlier. This bill would declare that its provisions further the purposes and intent of the California Privacy Rights Act of 2020.

AB 350 **(Bonta D) Health care coverage: fluoride treatments.**
Current Text: Amended: 9/5/2025 html pdf
Introduced: 1/29/2025
Status: 9/11/2025-Failed Deadline pursuant to Rule 61(a)(14). (Last location was INACTIVE FILE on 9/10/2025)(May be acted upon Jan 2026)

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	2 year	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 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 an essential health benefit to be provided only to the extent that federal law does not require the state to defray the costs of the benefit. This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2026, that provides coverage for the application of fluoride varnish as a pediatric oral care benefit to provide coverage without cost sharing for the application of fluoride varnish as medically necessary regardless of whether the service is billed as a dental benefit or as a medical benefit. If this coverage requirement creates an obligation for the state to defray costs for an individual, the bill would not require coverage unless there is an appropriation for this purpose, as specified. 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 360 **(Papan D) Menopause.**
Current Text: Amended: 4/9/2025 html pdf
Introduced: 1/30/2025
Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 4/23/2025)(May be acted upon Jan 2026)

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

Summary: Existing law establishes the Department of Health Care Access and Information to oversee and administer various health programs and to collect health data. Existing law establishes the Medical Board of California and the

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

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

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

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

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

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

Summary: Existing law, the Medical Practice Act, establishes the Medical Board of California and charges it with administrative and enforcement duties related to the provision of medical services under the act. Existing law establishes requirements for the delivery of medical services, including via telehealth by specified health care providers. A violation of the act is a crime. Under existing law, a "health care provider," for purpose of the act, includes a qualified autism

service provider or a qualified autism service professional that is certified by a national entity, as specified. This bill would expand that definition of "health care provider" to also include a qualified autism service paraprofessional. By expanding the scope of a crime under the act, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

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

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

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

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

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

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

AB 408 **(Berman D) Physician Health and Wellness Program.**
Current Text: Amended: 7/8/2025 html pdf
Introduced: 2/4/2025

Status: 7/17/2025-Failed Deadline pursuant to Rule 61(a)(10). (Last location was JUD. on 7/7/2025)(May be acted upon Jan 2026)

Desk	Policy	Fiscal	Floor	Desk	2 year	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 current or former program participants from disclosure under the California Public Records Act, except as specified. The bill would authorize the board to establish advisory committees to assist in carrying out the duties of the administering entity, and would establish duties and responsibilities authorized to be performed by a committee. The bill would rename the Physician and Surgeon Health and Wellness Program Account as the Physician Health and Wellness Program Account, and would authorize the board to seek and use grant funds and gifts from public or private sources to pay any cost associated with the program. The bill would require the board to annually report to the Legislature and make available to the public the amount and source of funds. The bill would require a licensee to report a license to the administering entity or the board if they believe the licensee is impaired. By expanding the scope of a crime under the Medical Practice Act, the bill would impose a state-mandated local program. The bill would make a person who reports information or takes action in connection with the bill's provisions immune from civil liability for reporting information or taking the action, except as specified. The bill would make the program inapplicable to the Osteopathic Medical Board of California. This bill contains other related provisions and other existing laws.

AB 412 **(Bauer-Kahan D) Generative artificial intelligence: training data: copyrighted materials.**
Current Text: Amended: 5/7/2025 html pdf
Introduced: 2/4/2025
Status: 7/17/2025-Failed Deadline pursuant to Rule 61(a)(10). (Last location was JUD. on 5/21/2025)(May be acted upon Jan 2026)

Desk	Policy	Fiscal	Floor	Desk	2 year	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 by the developer to train the model. The bill would require the developer to make available a mechanism on the developer's internet website allowing a rights owner to submit a request for information about the developer's use of covered materials that would allow the rights owner to provide the developer with, among other things, registration, preregistration, or index numbers and fingerprints for one or more covered materials. The bill would, subject to specified exceptions, require a developer to, within 30 days of receiving that request from the rights owner, assess whether the covered material represented by a fingerprint provided by the rights owner is likely to be present in the developer's dataset and provide the rights owner with a list of their covered materials that were used to train the model and are likely to be present in the developer's dataset, as specified. The bill would provide that each day following the 30-day period that a developer fails to provide a rights owner with that information constitutes a discrete violation. The bill would authorize a rights owner who complies with specified requirements for submitting a request that is not provided with information according to these provisions to bring a civil action against the developer for specified relief. The bill would provide that the bill's requirements do not apply to a model that meets certain criteria, including, among other things, being trained exclusively using data the developer makes publicly available at no cost, as specified. The bill would define various terms for these purposes. This bill contains other existing laws.

AB 416 **(Krell D) Involuntary commitment.**
Current Text: Enrollment: 9/11/2025 html pdf
Introduced: 2/5/2025
Status: 9/11/2025-Enrolled and presented to the Governor at 4 p.m.

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

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

AB 423 **(Davies R) Alcoholism or drug abuse recovery or treatment programs and facilities: disclosures.**
Current Text: Amended: 4/2/2025 html pdf
Introduced: 2/5/2025
Status: 5/1/2025-Failed Deadline pursuant to Rule 61(a)(2). (Last location was HEALTH on 2/18/2025)(May be acted upon Jan 2026)

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

Summary: Existing law grants the sole authority in state government to the State Department of Health Care Services to certify alcohol or other drug programs and to license adult alcoholism or drug abuse recovery or treatment facilities. Existing law requires certified programs and licensed facilities to disclose to the department if any of its agents, partners, directors, officers, or owners own or have a financial interest in a recovery residence and whether it has contractual

relationships with entities that provide recovery services to clients of certified programs or licensed facilities if the entity is not a part of a certified program or a licensed facility. Existing law defines “recovery residence” as a residential dwelling that provides primary housing for individuals who seek a cooperative living arrangement that supports personal recovery from a substance use disorder and that does not require licensure by the department or does not provide licensable services. This bill would require a business-operated recovery residence to register its location with the department. The bill would define a business-operated recovery residence as a recovery residence in which a business, in exchange for compensation, provides more than one service beyond those of a typical tenancy arrangement to more than one occupant, including, but not limited to, drug testing, supervision, scheduling, rule setting, rule enforcement, room assignment, entertainment, gym memberships, transportation, laundry, or meal preparation and coordination.

AB 432 **(Bauer-Kahan D) Menopause.**
Current Text: Enrollment: 9/22/2025 html pdf
Introduced: 2/5/2025
Status: 9/22/2025-Enrolled and presented to the Governor at 3 p.m.

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. The bill would require, beginning July 1, 2026, and until July 1, 2032, a qualifying physician and surgeon, as defined, who completes continuing medical education courses in perimenopause, menopause, and postmenopausal care to receive 2 hours of credit for each hour completed of that coursework, as specified. 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: Enrollment: 9/15/2025 html pdf
Introduced: 2/10/2025
Status: 9/15/2025-Enrolled and presented to the Governor at 4:30 p.m.

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, care, reports, or assessments being provided through AI or GenAI is being provided by a natural person with the appropriated health care license or certificate. This bill would make a violation of these provisions subject to the jurisdiction of the appropriate health care profession board, and would make each use of a prohibited term, letter, or phrase punishable as a separate violation. This bill contains other related provisions and other existing laws.

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

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

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

AB 512 **(Harabedian D) Health care coverage: prior authorization.**
Current Text: Enrollment: 9/22/2025 html pdf
Introduced: 2/10/2025
Status: 9/22/2025-Enrolled and presented to the Governor at 3 p.m.

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 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, including pursuant to contracts with various types of managed care plans. Existing law generally authorizes a health care service plan, including a Medi-Cal managed care 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 change the timeline for prior or concurrent authorization requests to no more than 3 business days from the plan's or insurer's receipt via electronic submission, or 5 business days from receipt via submission that is not electronic, of the information reasonably necessary and requested by the plan or insurer to make the determination. The bill would require a utilization review decision to be made within 24 hours from receipt of a prior or concurrent authorization request via electronic submission, or 48 hours from receipt via submission that is not electronic, 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. 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. The bill would exclude Medi-

Cal managed care plans from the above-described timeline changes. This bill contains other related provisions and other existing laws.

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

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

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

AB 534 **(Schiavo D) Transitional housing placement providers.**
Current Text: Amended: 5/23/2025 html pdf
Introduced: 2/11/2025
Status: 8/29/2025-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/18/2025)(May be acted upon Jan 2026)

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

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

AB 536 **(Patterson R) Health care coverage: colorectal cancer screening.**
Current Text: Amended: 3/24/2025 html pdf
Introduced: 2/11/2025
Status: 8/29/2025-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 7/14/2025)(May be acted upon Jan 2026)

Desk	Policy	Fiscal	Floor	Desk	Policy	2 year	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: 7/17/2025-Failed Deadline pursuant to Rule 61(a)(10). (Last location was HEALTH on 5/21/2025)(May be acted upon Jan 2026)

Desk	Policy	Fiscal	Floor	Desk	2 year	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: field medicine.**
Current Text: Enrollment: 9/22/2025 html pdf
Introduced: 2/11/2025
Status: 9/22/2025-Enrolled and presented to the Governor at 3 p.m.

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. This bill would set forth provisions regarding field 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 field 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 authorize a Medi-Cal managed care plan to elect to offer Medi-Cal covered services through a field medicine provider, as defined. Under the bill, a managed care plan that elects to do so would be required to allow a Medi-Cal member who is experiencing homelessness to receive those services directly from an in-network, contracted field medicine provider, regardless of the member's in-network assignment, as specified. The bill would also require the managed care plan to allow an in-network, contracted field medicine provider enrolled in Medi-Cal to directly refer a member who is experiencing homelessness for covered services within the appropriate network, as specified. This bill contains other related provisions and other existing laws.

AB 546 **(Caloza D) Health care coverage: portable HEPA purifiers.**
Current Text: Enrollment: 9/16/2025 html pdf
Introduced: 2/11/2025
Status: 9/16/2025-Enrolled and presented to the Governor at 2 p.m.

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 large group health care service plan contract or large group health insurance policy, except a specialized health care service plan contract or health insurance policy, that is issued, amended, or renewed on or after January 1, 2026, to include coverage for one portable high-efficiency particulate air (HEPA) purifier for an enrollee or insured who is pregnant or diagnosed with asthma or chronic obstructive pulmonary disease if the enrollee or insured is residing in or displaced from a county where a local or state emergency has been declared due to wildfires and the HEPA purifier is prescribed by the enrollee's or insured's health care provider. The bill would prohibit the cost of the HEPA purifier from exceeding $500, adjusted for inflation, as specified. 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: Enrollment: 9/22/2025 html pdf
Introduced: 2/11/2025
Status: 9/22/2025-Enrolled and presented to the Governor at 3 p.m.

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 medically necessary for the prevention of HIV/AIDS, to prior authorization or step therapy, but would authorize prior authorization or step therapy if at least one therapeutically equivalent version is covered without prior authorization or step therapy. The bill would specify that, for therapeutically equivalent coverage purposes, a long-acting drug, drug device, or drug product is not therapeutically equivalent to a long-acting drug, drug device, or drug product with a different duration. The bill would require a plan or insurer that covers non-self-administered antiretroviral drugs, drug devices, or drug products that are approved by the United States Food and Drug Administration (FDA) for the prevention of HIV/AIDS as a medical benefit to also include those non-self-administered antiretroviral drugs, drug devices, or drug products as an outpatient prescription drug benefit. This bill contains other related provisions and other existing laws.

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

upon Jan 2026)

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act's requirements a crime. Existing law provides for the regulation of disability and health insurers by the Department of Insurance. Existing law sets forth specified coverage requirements for plan contracts and insurance policies. This bill, the Obesity Prevention Treatment Parity Act, would require an individual or group health care service plan contract or health insurance policy that provides coverage for outpatient prescription drug benefits, as specified, and is issued, amended, or renewed on or after January 1, 2026, to include coverage for at least one specified anti-obesity medication and intensive behavioral therapy for the treatment of obesity without prior authorization. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

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

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

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

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

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

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

This bill would make a nonsubstantive change to those provisions.

AB 602 **(Haney D) Public postsecondary education: student behavior: drug and alcohol use: rehabilitation programs.**
Current Text: Chaptered: 10/1/2025 html pdf
Introduced: 2/13/2025
Status: 10/1/2025-Chaptered by Secretary of State - Chapter 159, Statutes of 2025

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. Existing federal law requires, as a condition of receiving federal funds or other forms of financial assistance, institutions of higher education to annually distribute to each student and employee standards of conduct that clearly prohibit unlawful possession, use, or distribution of illicit drugs or alcohol, as provided, and a clear statement that the institution will impose sanctions for violations of the standards of conduct. Existing federal law characterizes the completion of an appropriate rehabilitation program as a permissible form of the required sanctions. This bill would require the Regents of the University of California and the Trustees of the California State University, in adopting the above-described rules and regulations, to place in the highest priority the health, safety, and well-being of the campus community. The bill would also require those entities, on or before July 1, 2026, to adopt, or provide for the adoption of, rules and regulations that (1) prohibit students receiving medical treatment for the personal use of drugs or alcohol in violation of the rules and regulations governing student behavior from being subject to disciplinary action for that use of drugs or alcohol if they complete an appropriate rehabilitation program, as defined, and (2) require students who receive medical treatment for the personal use of drugs or alcohol in a manner that violates the rules or regulations of the university to be offered the chance to complete an appropriate rehabilitation program, as provided. The bill would establish that this prohibition on disciplinary action, and the requirement that the university offer an appropriate rehabilitation program, only apply to a student once in an academic semester, quarter, or term, as provided. This bill contains other existing laws.

AB 618 **(Krell D) Medi-Cal: behavioral health: data sharing.**
Current Text: Amended: 6/23/2025 html pdf
Introduced: 2/13/2025
Status: 8/29/2025-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 7/7/2025)(May be acted upon Jan 2026)

Desk	Policy	Fiscal	Floor	Desk	Policy	2 year	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 the department by January 1, 2027, in compliance with privacy laws.

AB 636 **(Ortega D) Medi-Cal: diapers.**

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

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

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

AB 669 **(Haney D) Substance use disorder coverage.**
Current Text: Amended: 7/15/2025 html pdf
Introduced: 2/14/2025
Status: 8/29/2025-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/18/2025)(May be acted upon Jan 2026)

Desk	Policy	Fiscal	Floor	Desk	Policy	2 year	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 a treatment plan for inpatient or residential substance use disorder stay at a specified licensed facility during each plan or policy year or (2) for outpatient services provided by specified certified programs for substance use disorder visits, except as specified. The bill would authorize, after the 29th day, in-network health care services and benefits for inpatient or residential 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 authorize concurrent or retrospective review for day 29 and days thereafter of that stay or service. With respect to health care service plans, the bill would specify that its provisions do not apply to Medi-Cal behavioral health delivery systems or Medi-Cal managed care plan contracts. Because a willful violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other existing laws.

AB 676 **(Gonzalez, Jeff R) Medi-Cal: unrecovered payments: interest rate.**
Current Text: Amended: 4/9/2025 html pdf

Introduced: 2/14/2025
Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 4/30/2025)(May be acted upon Jan 2026)

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

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

AB 682 **(Ortega D) Health care coverage reporting.**
Current Text: Enrollment: 9/22/2025 html pdf
Introduced: 2/14/2025
Status: 9/22/2025-Enrolled and presented to the Governor at 3 p.m.

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 to file various reports with the relevant regulating department. This bill would require a health care service plan or health insurer that imposes prior authorization to report specified prior authorization data from the previous calendar year on its internet website on or before February 1, 2026,for health care service plans, on or before February 1, 2028, for health insurers, and annually on or before February 1 thereafter. The bill would require a health care service plan or health insurer to annually report specified claims and prior authorization data to the relevant department by February 1 of each year, beginning February 1,2027, for health care service plans and February 1, 2028, for health insurers. The bill would require the departments to post this information, disaggregated by plan or insurer, on their internet websites by April 15 of each year, beginning April 15, 2027, for health care service plans and April 15, 2028, for health insurers. The bill would authorize the Director of the Department of Managed Health Care and the Insurance Commissioner to reject a report required pursuant to these provisions, and would authorize the commissioner to assess an administrative penalty against a health insurer for a failure to correct a deficiency in the report. The bill would authorize the director and commissioner to make rules and regulations specifying the form and content of the reports posted online and submitted to the relevant department, as specified. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other existing laws.

AB 787 **(Papan D) Provider directory disclosures.**
Current Text: Amended: 6/23/2025 html pdf
Introduced: 2/18/2025
Status: 8/29/2025-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 7/7/2025)(May be acted upon Jan 2026)

Desk	Policy	Fiscal	Floor	Desk	Policy	2 year	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 or dental plan, health insurer, or specialized mental health or dental insurer to include in its provider directory or directories a statement advising an enrollee or insured to contact the plan or insurer for assistance finding an in-network provider and for an explanation of their rights regarding out-of-network coverage, and would specify the format of the statement. The bill would require the plan or insurer to acknowledge the request 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 for a request deemed urgent by the enrollee or insured and 5 business days for a request deemed nonurgent by an enrollee or insured. 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) Political Reform Act of 1974: security expenses.**
Current Text: Enrollment: 9/24/2025 html pdf
Introduced: 2/18/2025
Status: 9/24/2025-Enrolled and presented to the Governor at 3 p.m.

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

Summary: The Political Reform Act of 1974 regulates the use of campaign funds held by candidates for elective office, elected officers, and campaign committees. The act authorizes a candidate or elected officer to use campaign funds to pay or reimburse the state for the reasonable costs of installing and monitoring a home or office electronic security system or for another tangible item related to security, and for the reasonable costs of providing personal security to a candidate, elected officer, or the immediate family or staff of a candidate or elected officer, provided that the threat or potential threat to safety arises from the candidate's or elected officer's activities, duties, or status as a candidate or elected officer or from staff's position as staff of the candidate or elected officer. The act permits a candidate or elected officer to expend a maximum of $10,000 of campaign funds for these purposes during their lifetime. This bill would eliminate that monetary cap until January 1, 2029. Beginning January 1, 2029, the bill would instead permit a candidate or elected officer to expend a maximum of $10,000 of campaign funds for these purposes per calendar year. This bill contains other related provisions and other existing laws.

AB 798 **(Calderon D) State Emergency Food Bank Reserve Program: diapers and wipes.**
Current Text: Enrollment: 9/23/2025 html pdf
Introduced: 2/18/2025
Status: 9/23/2025-Enrolled and presented to the Governor at 4 p.m.

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. This bill contains other existing laws.

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

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

Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law, subject to implementation of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, authorizes a Medi-Cal managed care plan to elect to cover community supports approved by the department as cost effective and medically appropriate in a comprehensive risk contract that are in lieu of applicable Medi-Cal state plan services. Under existing law, community supports that the department is authorized to approve include, among other things, housing transition navigation services, housing deposits, and housing tenancy sustaining services. Existing law, subject to an appropriation, requires the department to complete an independent analysis to determine whether network adequacy exists to obtain federal approval for a covered Medi-Cal benefit that provides housing support services. Existing law requires that the analysis take into consideration specified information, including the number of providers in relation to each region's or county's number of people experiencing homelessness. Existing law requires the department to report the outcomes of the analysis to the Legislature by January 1, 2024. This bill would delete the requirement for the department to complete that analysis, and instead would make housing support services for specified populations a covered Medi-Cal benefit when the Legislature has made an appropriation for purposes of the housing support services. The bill would require the department to seek federal approval for the housing support services benefit, as specified. Under the bill, subject to an appropriation by the Legislature, a Medi-Cal beneficiary would be eligible for those services if they either experience homelessness or are at risk of homelessness. Under the bill, the services would include housing transition navigation services, housing deposits, and housing tenancy sustaining services, as defined. This bill contains other related provisions and other existing laws.

AB 836 **(Stefani D) Midwifery Workforce Training Act.**
Current Text: Enrollment: 9/16/2025 html pdf
Introduced: 2/19/2025
Status: 9/16/2025-Enrolled and presented to the Governor at 2 p.m.

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

Summary: Existing law requires the Office of Statewide Health Planning and Development to establish a program to contract with programs that train certified nurse-midwives and programs that train licensed midwives in accordance with the global standards for midwifery education and the international definition of "midwife" as established by the International Confederation of Midwives in order to increase the number of students receiving quality education and training as a certified nurse-midwife or as a licensed midwife. Existing law requires these provisions to be implemented only upon an appropriation by the Legislature for these purposes in the annual Budget Act or another act. This bill would

require the Department of Health Care Access and Information, upon appropriation from the Legislature for this purpose, to administer funding for a statewide study on midwifery education. The bill would require the study to be conducted by an outside consultant familiar with the health care and midwifery landscapes and workforce in California that would, among other things, identify viable education programs that can serve both rural and urban geographic areas. The bill would require the department to submit a report from the study's findings to the Legislature, to post the report on the department's internet website, and to notify all persons in the department's reproductive health and maternity care electronic mailing list, as specified. The bill would define "reproductive health care professionals" as, among others, medical doctors and licensed midwives.

AB 843 **(Garcia D) Health care coverage: language access.**
Current Text: Vetoed: 10/1/2025 html pdf
Introduced: 2/19/2025
Status: 10/1/2025-Vetoed by the Governor

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 administrative penalties, as specified. This bill contains other related provisions and other existing laws.

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

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

Summary: Existing law provides for the regulation of health care service plans by the Department of Managed Health Care and health insurers by the Department of Insurance. Existing law requires a health care service plan contract or disability insurance policy to provide coverage for medically necessary treatment of mental health and substance use disorders, as defined, under the same terms and conditions applied to other medical conditions. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive medically necessary health care services, including specified mental health and substance use disorder services, pursuant to a schedule of benefits. Existing law provides for the regulation of community care facilities that provide nonmedical care, including residential facilities, short-term residential therapeutic programs, and group homes by the State Department of Social Services. Existing law requires the care and supervision provided by a short-term residential therapeutic program or group home to be nonmedical, except as otherwise permitted

by law. This bill would require the Department of Managed Health Care, the Department of Insurance, and the State Department of Health Care Services to prepare and send one letter to each chief financial officer of a health care service plan, health insurer, or Medi-Cal managed care plan that provides coverage, including out-of-network benefits, in California for substance use disorder in residential facilities, as defined. The bill would require the letter to include, among other things, a statement informing the plan or insurer that substance use disorder treatment in licensed or unlicensed residential facilities is almost exclusively nonmedical, with rare exceptions. The bill would authorize the Department of Managed Health Care, the Department of Insurance, and the State Department of Health Care Services to consult with each other, and would require those departments to consult with the State Department of Social Services, when preparing the contents of the letter. The bill would require the letters to be sent on or before October 1, 2026. The bill would repeal these provisions on January 1, 2027.

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

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

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

AB 951 **(Ta R) Health care coverage: behavioral diagnoses.**
Current Text: Chaptered: 7/30/2025 html pdf
Introduced: 2/20/2025
Status: 7/30/2025-Chaptered by Secretary of State - Chapter 84, Statutes of 2025

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

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

AB 960 **(Garcia D) Patient visitation.**
Current Text: Chaptered: 10/1/2025 html pdf
Introduced: 2/20/2025
Status: 10/1/2025-Chaptered by Secretary of State - Chapter 172, Statutes of 2025

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 prohibit restrictions to patient visitation policies implemented during a state of emergency declared by the Governor, a health emergency declared by the State Public Health Officer, or a local health emergency declared by a local health officer, as specified. The bill would specify that its provisions do not create any new civil or criminal liability, including, but not limited to, liability for any illness, infection, or injury experienced by a patient or visitor on the part of a hospital that complies with its requirements. By expanding the scope of a crime, this bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

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

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

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

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

Current Text: Enrollment: 9/24/2025 html pdf
Introduced: 2/20/2025
Status: 9/24/2025-Enrolled and presented to the Governor at 3 p.m.

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 January 1, 2027, 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 cyber and artificial intelligence communities and to strengthen collective cyber defenses against emerging threats. The bill would require the center to review federal requirements, standards, and industry best practices, as specified, and to use those resources to inform the development of the California AI Cybersecurity Collaboration Playbook. Except as specified, the bill would provide that any information related to cyber threat indicators or defensive measures for a cybersecurity purpose shared in accordance with the California AI Cybersecurity Collaboration Playbook is confidential and would prohibit that information from being disclosed, except as specified. The bill would also make findings and declarations related to its provisions. This bill contains other related provisions and other existing laws.

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

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or health insurance policy to provide coverage for medically necessary treatment of mental health and substance use disorders under the same terms and conditions applied to other medical conditions, as specified. Existing law generally authorizes a health care service plan or health insurer to use utilization review to approve, modify, delay, or deny requests for health care services based on medical necessity. This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2026, to provide coverage for medically necessary treatment of physical conditions and diseases under the same terms and conditions applied to other medical conditions, as specified. The bill would require the delivery of medically necessary services out of network if those services are not available within geographic and timely access standards. The bill would require a plan or insurer to apply specified clinical criteria and guidelines in conducting utilization review of the covered health care services and benefits for physical conditions and diseases. The bill would authorize the Director of the Department of Managed Health Care or the Insurance Commissioner, as applicable, to assess administrative or civil penalties, as specified, for violation of the requirements relating to utilization review. Because a willful violation of these requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program. This bill contains other existing laws.

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

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

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

AB 1018 **(Bauer-Kahan D) Automated decision systems.**
Current Text: Amended: 9/5/2025 html pdf
Introduced: 2/20/2025
Status: 9/13/2025-Failed Deadline pursuant to Rule 61(a)(14). (Last location was INACTIVE FILE on 9/13/2025)(May be acted upon Jan 2026)

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

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

AB 1032 **(Harabedian D) Coverage for behavioral health visits.**
Current Text: Enrollment: 9/24/2025 html pdf
Introduced: 2/20/2025
Status: 9/24/2025-Enrolled and presented to the Governor at 3 p.m.

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

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

requires a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2021, to provide coverage for medically necessary treatment of mental health and substance use disorders, as defined, under the same terms and conditions applied to other medical conditions. This bill would generally require a large group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2026, to reimburse an eligible enrollee or insured for up to 12 visits with a behavioral health provider if the enrollee or insured lives in a county where a local or state emergency has been declared due to wildfires and the enrollee or insured has experienced a loss, trauma, or displacement because of the fire. The bill would prohibit these benefits from being subject to utilization review. The bill would require a health care service plan contract or health insurer to provide notice to all affected enrollees of these provisions, as specified. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

AB 1037 **(Elhawary D) Public health: substance use disorder.**
Current Text: Enrollment: 9/22/2025 html pdf
Introduced: 2/20/2025
Status: 9/22/2025-Enrolled and presented to the Governor at 3 p.m.

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

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

AB 1041 **(Bennett D) Health care coverage: health care provider credentials.**
Current Text: Enrollment: 9/16/2025 html pdf
Introduced: 2/20/2025
Status: 9/16/2025-Enrolled and presented to the Governor at 2 p.m.

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. This bill would require every full service health care service plan or health insurer, or its delegate, to subscribe to and use the Council for Affordable Quality Healthcare credentialing form on and after January 1, 2028, except as specified.

AB 1090 **(Davies R) Alcoholism or drug abuse treatment facilities: County of Orange pilot program.**
Current Text: Amended: 3/24/2025 html pdf
Introduced: 2/20/2025

Status: 5/1/2025-Failed Deadline pursuant to Rule 61(a)(2). (Last location was HEALTH on 3/24/2025)(May be acted upon Jan 2026)

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

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

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

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

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

AB 1129 **(Rodriguez, Celeste D) Birth defects monitoring.**
Current Text: Amended: 7/17/2025 html pdf
Introduced: 2/20/2025
Status: 9/9/2025-Ordered to inactive file at the request of Senator Gonzalez.

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

Summary: Existing law states that it is the intent of the Legislature to maintain an ongoing program of birth defects monitoring statewide, and requires the State Public Health Officer to maintain a system for the collection of information

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

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

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

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

AB 1328 **(Rodriguez, Michelle D) Medi-Cal reimbursements: nonemergency ambulance and other transportation.**
Current Text: Amended: 7/17/2025 html pdf
Introduced: 2/21/2025
Status: 8/29/2025-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/18/2025)(May be acted upon Jan 2026)

Desk	Policy	Fiscal	Floor	Desk	Policy	2 year	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 July 1, 2027, and subject to an appropriation, Medi-Cal fee-for-service reimbursement for nonemergency ambulance transportation services, as defined, would be in an amount equal to 80% of the amount set forth in the federal Medicare ambulance fee schedule for the corresponding level of service, adjusted by the Geographic Practice Cost Index, as specified. The bill would require the department to establish a Medi-Cal managed care directed payment program for nonemergency ambulance transportation services, with

the reimbursement rates set in an amount equal to at least the amount set forth under fee-for-service reimbursement. 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. This bill contains other related provisions and other existing laws.

AB 1405 **(Bauer-Kahan D) Artificial intelligence: auditors: enrollment.**
Current Text: Amended: 7/9/2025 html pdf
Introduced: 2/21/2025
Status: 8/29/2025-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/18/2025)(May be acted upon Jan 2026)

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

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

AB 1415 **(Bonta D) California Health Care Quality and Affordability Act.**
Current Text: Enrollment: 9/15/2025 html pdf
Introduced: 2/21/2025
Status: 9/15/2025-Enrolled and presented to the Governor at 4:30 p.m.

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 entities delivering or furnishing health care services. The bill would include additional definitions, including, but not limited to, 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 and other information 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: Enrollment: 9/24/2025 html pdf
Introduced: 2/21/2025
Status: 9/24/2025-Enrolled and presented to the Governor at 3 p.m.

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

Summary: Existing law requires the Department of Health Care Access and Information to establish a health care workforce research and data center to serve as the central source of health care workforce and educational data in the state. Existing law requires the department to prepare an annual report to the Legislature that, among other things, identifies education and employment trends in the health care profession and describes the health care workforce program outcomes and effectiveness. Existing law requires health facilities and clinics, among others, to annually report to the department specified information on forms supplied by the department. This bill would require health facilities, clinics, home health agencies, and hospices, as defined, to additionally report whether their health care employees eligible for employer-sponsored health care are eligible for health care coverage at the commencement of employment without a waiting period, as defined. If not all employees are eligible without a waiting period, the bill would require the entities listed above to report the length of the waiting period if it applies to all eligible employees, and, if different waiting periods apply to different classifications of employees, as specified, the length of the waiting period for each classification. The bill would require the department to integrate this reporting obligation with existing reports and would not require those specified entities to report if they are not required to file reports with the department. The bill would require the department to post this information on its internet website on at least an annual basis.

SB 7 **(McNerney D) Employment: automated decision systems.**
Current Text: Enrollment: 9/23/2025 html pdf
Introduced: 12/2/2024
Status: 9/23/2025-Enrolled and presented to the Governor at 2 p.m.

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. This bill would require an employer to provide a written notice that an ADS, for the purpose of making employment-related decisions, not including hiring, is in use at the workplace to all workers that will foreseeably be directly affected by the ADS, as specified. The bill would require the employer to maintain an updated list of all ADS currently in use. The bill would require an employer to notify, as provided, a job applicant that the employer utilizes an ADS when making hiring decisions, if the employer will use the ADS in making decisions for that position. The bill would prohibit an employer 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 authorize a worker to request, and require an employer to provide, a copy of the most recent 12 months of the worker's own data primarily used by an ADS to make a discipline, termination, or deactivation decision, as specified. The bill would require an employer that primarily relied on an ADS to make a discipline, termination, or deactivation decision to provide the affected worker with a written notice, as specified. This bill contains other related provisions and other existing laws.

SB 12 **(Gonzalez D) State government: Immigrant and Refugee Affairs Agency: Office of Immigrant and Refugee Affairs.**
Current Text: Amended: 4/10/2025 html pdf
Introduced: 12/2/2024

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

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

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

SB 27 **(Umberg D) Community Assistance, Recovery, and Empowerment (CARE) Court Program.**
Current Text: Enrollment: 9/23/2025 html pdf
Introduced: 12/2/2024
Status: 9/23/2025-Enrolled and presented to the Governor at 2 p.m.

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. Existing law requires the court, if it determines the parties have entered or are likely to enter into a CARE agreement, to either approve or modify the CARE agreement and continue the matter at a progress hearing in 60 days, or continue the matter for 14 days to allow the parties additional time to enter into an agreement. Existing law prohibits a person from being tried or adjudged to punishment while that person is mentally incompetent. Existing law authorizes a court to refer an individual from, among other things, assisted outpatient treatment or conservatorship proceedings, as specified, to CARE Act proceedings. Existing law provides that if the individual is referred from assisted outpatient treatment, the county behavioral health director or their designee shall be the petitioner, whereas if the referral is from conservatorship proceedings, the conservator or proposed conservator is the petitioner. This bill would allow the court to make a prima facie determination without conducting a hearing. The bill, in

the first hearing to determine competence to stand trial, would authorize the court to consider the petitioner's eligibility for both diversion and the CARE program. The bill would authorize the court to refer the petitioner to the CARE Act court if the defendant or counsel for the defendant agrees to the referral and the court has reason to believe the petitioner may be eligible for the CARE program. If the petitioner is not accepted into the CARE program or if the CARE Act court refers the petitioner back to criminal court, as specified, the bill would require the criminal court to conduct a hearing to determine whether the petitioner is eligible for a diversion program. The bill would authorize the county behavioral health agency and jail medical providers to share confidential medical records and other relevant information with the court for the purpose of determining likelihood of eligibility for behavioral health services and programs. This bill contains other related provisions and other existing laws.

SB 32 **(Weber Pierson D) Health care coverage: timely access to care.**
Current Text: Amended: 6/19/2025 html pdf
Introduced: 12/2/2024
Status: 8/28/2025-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 7/16/2025)(May be acted upon Jan 2026)

Desk	Policy	Fiscal	Floor	Desk	Policy	2 year	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. Because a violation by a health care service plan of a standard adopted by the Department of Managed Health Care would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

SB 40 **(Wiener D) Health care coverage: insulin.**
Current Text: Enrollment: 9/16/2025 html pdf
Introduced: 12/3/2024
Status: 9/16/2025-Enrolled and presented to the Governor at 3 p.m.

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 prohibit a large group health care service plan contract or health insurance policy issued, amended, delivered, or renewed on or after January 1, 2026, or an individual or small group health care service plan contract or health insurance policy 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, and, for a large group health care service plan contract or health insurance policy, would require at least one insulin for a given drug type in all forms and concentrations to be on the prescription drug formulary. The bill would limit the $35 cap for an individual or small group health care service plan contract or health insurance policy to only Tier 1 and Tier 2 insulin if the drug formulary is grouped into tiers, 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: Enrollment: 9/17/2025 html pdf
Introduced: 12/3/2024
Status: 9/17/2025-Enrolled and presented to the Governor at 2 p.m.

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a pharmacy benefit manager engaging in business with a health care service plan or health insurer to secure a license from the Department of Managed Health Care on or after January 1, 2027, or the date on which the department has established the licensure process, whichever is later. This bill would prohibit a pharmacy benefit manager from, among other things, requiring use of only an affiliated pharmacy, as specified, and from imposing requirements, conditions, or exclusions that discriminate against a nonaffiliated pharmacy in connection with dispensing drugs. The bill would limit a pharmacy benefit manager's income to that derived from a pharmacy benefit management fee for pharmacy benefit management services provided, and would require a pharmacy benefit manager to use a passthrough pricing model. The bill would authorize the Attorney General to recover specified civil penalties and receive equitable relief for violations of the pharmacy benefit manager licensing provisions. Because a violation of these provisions would be a crime, the bill would impose a state-mandated local program. The bill would also require a contract between a health insurer and a pharmacy benefit manager issued, amended, or renewed on or after January 1, 2027, or the date on which the Department of Managed Health Care has established the pharmacy benefit manager licensure process, whichever is later, to require the pharmacy benefit manager to be licensed and in good standing with the Department of Managed Health Care. This bill contains other related provisions and other existing laws.

SB 53 **(Wiener D) Artificial intelligence models: large developers.**
Current Text: Chaptered: 9/29/2025 html pdf
Introduced: 1/7/2025
Status: 9/29/2025-Chaptered by Secretary of State - Chapter 138, Statutes of 2025

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

Summary: Existing law generally regulates artificial intelligence, including by requiring, on or before January 1, 2026, and before each time thereafter, that a generative artificial intelligence system or service, or a substantial modification to a generative artificial intelligence system or service, released on or after January 1, 2022, is made publicly available to Californians for use, the developer of the system or service 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, as prescribed. This bill would enact the Transparency in Frontier Artificial Intelligence Act (TFAIA) that would, among other things related to ensuring the safety of a foundation model, as defined, developed by a frontier developer, require a large frontier developer to write, implement, and clearly and conspicuously publish on its internet website a frontier AI framework that applies to the large frontier developer's frontier models and describes how the large frontier developer approaches, among other things, incorporating national standards, international standards, and industry-consensus best practices into its frontier AI framework. The TFAIA would also require a large frontier developer to transmit to the Office of Emergency Services a summary of any assessment of catastrophic risk, as defined, resulting from internal use of its frontier models, as specified. The TFAIA would require the Office of Emergency Services to establish a mechanism to be used by a frontier developer or a member of the public to report, as prescribed, a critical safety incident,

as defined, and would also require the Office of Emergency Services to establish a mechanism to be used by a large frontier developer to confidentially submit summaries of any assessments of the potential for catastrophic risk resulting from internal use of its frontier models, as prescribed. This bill contains other related provisions and other existing laws.

SB 62 **(Menjivar D) Health care coverage: essential health benefits.**
Current Text: Enrollment: 9/16/2025 html pdf
Introduced: 1/9/2025
Status: 9/16/2025-Enrolled and presented to the Governor at 3 p.m.

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 an individual or small group health care service plan contract 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 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 for health care service plans. 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 for health care service plans 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 related provisions and other existing laws.

SB 81 **(Arreguín D) Health and care facilities: information sharing.**
Current Text: Chaptered: 9/20/2025 html pdf
Introduced: 1/17/2025
Status: 9/20/2025-Chaptered by Secretary of State - Chapter 123, Statutes of 2025

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

Summary: The Confidentiality of Medical Information Act (CMIA) prohibits a provider of health care, a health care service plan, a contractor, or a corporation and its subsidiaries and affiliates from intentionally sharing, selling, using for marketing, or otherwise using any medical information, as defined, for any purpose not necessary to provide health care services to a patient, except as provided. The CMIA prohibits a provider of health care, health care service plan, or contractor from disclosing medical information regarding a patient of the provider of health care or an enrollee or subscriber of a health care service plan without first obtaining authorization from the patient, except if the disclosure is compelled by, among other things, a search warrant lawfully issued to a governmental law enforcement agency or a court order. 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, if that information is known or collected, as specified, 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 law 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 shall disclose medical information regarding a patient of the provider of health care or an enrollee or subscriber or a health care service plan pursuant to a valid search warrant issued by a judicial officer, including a magistrate, to a governmental law enforcement agency, or pursuant to a state or federal court order issued by a court of this state or a federal court. The bill would also prohibit, except to the extent expressly authorized by a patient, enrollee, or subscriber, or as otherwise permitted or required, a provider of health care, health care service plan, contractor, or corporation and its subsidiaries and affiliates from disclosing medical information for immigration enforcement. Because the bill would expand the scope of a crime, it would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

SB 85 **(Umberg D) Civil actions: service of summons.**
Current Text: Enrollment: 9/2/2025 html pdf
Introduced: 1/21/2025
Status: 9/2/2025-Enrolled and presented to the Governor at 11 a.m.

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, exercising reasonable diligence, has been unable to serve the summons using methods prescribed by statute. The bill would authorize a court, upon motion, to direct service of the summons by electronic means, if such service is reasonably calculated to give actual notice. The bill would require a plaintiff seeking to establish reasonable diligence under this section to set forth facts that detail, as specified, the attempts to effect service pursuant to the methods prescribed by statute. The bill would also except actions against public entities or agents or employees of public entities from these provisions.

SB 228 **(Cervantes D) Comprehensive Perinatal Services Program.**
Current Text: Amended: 5/23/2025 html pdf
Introduced: 1/28/2025
Status: 8/28/2025-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/20/2025)(May be acted upon Jan 2026)

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

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

SB 238 **(Smallwood-Cuevas D) Workplace surveillance tools.**
Current Text: Amended: 5/1/2025 html pdf
Introduced: 1/29/2025
Status: 7/17/2025-Failed Deadline pursuant to Rule 61(a)(10). (Last location was P. & C.P. on 6/26/2025)(May be acted upon Jan 2026)

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

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

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

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

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

from an issuer, as specified. The bill would require the open enrollment period to be a guaranteed issue period. The bill would authorize premium rates offered to applicants during the open enrollment period to vary based on the applicants' age at the time of issue, as specified, but would prohibit the premiums from varying based on age after the contract is issued. This bill contains other related provisions and other existing laws.

SB 246 **(Grove R) Medi-Cal: graduate medical education payments.**
Current Text: Enrollment: 9/10/2025 html pdf
Introduced: 1/30/2025
Status: 9/10/2025-Enrolled and presented to the Governor at 2 p.m.

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

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

SB 250 **(Ochoa Bogh R) Medi-Cal: provider directory: skilled nursing facilities.**
Current Text: Enrollment: 9/17/2025 html pdf
Introduced: 1/30/2025
Status: 9/17/2025-Enrolled and presented to the Governor at 2 p.m.

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. The bill would require the department to annually update that provider directory to ensure that information is accurate and readily accessible to the public.

SB 257 **(Wahab D) PARENT Act.**
Current Text: Enrollment: 9/17/2025 html pdf
Introduced: 2/3/2025
Status: 9/17/2025-Enrolled and presented to the Governor at 2 p.m.

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. This bill, the PARENT Act, would make pregnancy a triggering event for purposes of enrollment or changing a health benefit plan. 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.

SB 278 **(Cabaldon D) Health data: HIV test results.**
Current Text: Enrollment: 9/16/2025 html pdf
Introduced: 2/4/2025
Status: 9/16/2025-Enrolled and presented to the Governor at 3 p.m.

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 generally imposes penalties on a person who negligently, willfully, or maliciously discloses the results of a human immunodeficiency virus (HIV) test to a third party in a manner that identifies or provides identifying characteristics of the person to whom the test results apply, as specified. Existing law, notwithstanding the above-described restrictions, authorizes the recording of the HIV test results by the physician who ordered the test in the test subject's medical record and authorizes other disclosure of the results without written authorization of the test subject, or the subject's representative, to the test subject's providers of health care, excluding a regulated health care service plan, for purposes of diagnosis, care, or treatment of the patient. This bill would authorize a provider of health care to disclose the results of an HIV test that identifies or provides identifying characteristics of a Medi-Cal beneficiary without written authorization of the test subject, or the subject's representative, to the Medi-Cal managed care plan to which the beneficiary is assigned, if applicable, and to external quality review organizations conducting external quality reviews of Medi-Cal managed care plans, for the purpose of administering quality improvement programs, including, but not limited to, value-based payment programs and healthy behavior incentive programs, designed to improve HIV care for Medi-Cal beneficiaries. This bill contains other related provisions and other existing laws.

SB 306 **(Becker D) Health care coverage: prior authorizations.**
Current Text: Enrollment: 9/16/2025 html pdf
Introduced: 2/10/2025
Status: 9/16/2025-Enrolled and presented to the Governor at 3 p.m.

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. This bill would require the departments to issue instructions on or before July 1, 2026, to health care service plans and health insurers to report statistics regarding covered health care services subject to prior authorization and the percentage rate at which they are approved or modified, among other things. The bill would require a health care service plan or health insurer to report those statistics, including information from another entity to which the plan or insurer delegates responsibility for prior authorization decisions, to the appropriate department on or before December 31, 2026. The bill would require the departments to evaluate these reports, identify the health care services approved at a rate that meets or exceeds the threshold rate of 90%, and, on or before July 1, 2027, publish a list of the services identified. Beginning on the date specified by the relevant department, but no later than January 1, 2028, the bill would require a plan or insurer, or its delegated entities, to cease requiring prior authorization for the most frequently approved covered health care services. The bill would authorize a plan or insurer to reinstate prior authorization for a specific health care provider if it determines that the provider has engaged in fraudulent activity or clinically inappropriate care, as specified. No later than 4 years after the cessation of prior authorization requirements, the bill would require the departments to publish reports regarding the impact of that cessation using information reported by plans and insurers, including data on reinstatements of prior authorization for specific providers. The bill would repeal these provisions on January 1, 2034. 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: 7/3/2025 html pdf
Introduced: 2/11/2025
Status: 8/28/2025-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/20/2025)(May be acted upon Jan 2026)

Desk	Policy	Fiscal	Floor	Desk	Policy	2 year	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, that can demonstrate that they are capable of providing access and meeting quality requirements in accordance with Medi-Cal guidelines. In determining which community providers to contract with, the bill would authorize Medi-Cal managed care plans to take into consideration whether those providers are available in the respective county and have experience in providing the applicable ECM or community support. The bill would require the department, for purposes of enforcing these provisions, to require Medi-Cal managed care plans to set goals every other year for the level of contracting and utilization of community providers and local entities, as defined. The bill would require these goals to be established in consultation with the department, as specified. This bill contains other related provisions and other existing laws.

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

5/12/2025)(May be acted upon Jan 2026)

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

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

SB 363 **(Wiener D) Health care coverage: independent medical review.**
Current Text: Amended: 7/17/2025 html pdf
Introduced: 2/13/2025
Status: 8/28/2025-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/20/2025)(May be acted upon Jan 2026)

Desk	Policy	Fiscal	Floor	Desk	Policy	2 year	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. For a health care service plan or health insurer with 10 or more independent medical reviews in a given year, the bill would make the 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: Enrollment: 9/22/2025 html pdf
Introduced: 2/14/2025
Status: 9/22/2025-Enrolled and presented to the Governor at 2 p.m.

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. This bill contains other related provisions.

SB 418 **(Menjivar D) Health care coverage: prescription hormone therapy and nondiscrimination.**
Current Text: Enrollment: 9/22/2025 html pdf
Introduced: 2/18/2025
Status: 9/22/2025-Enrolled and presented to the Governor at 2 p.m.

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 also 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 pursuant to a schedule of benefits. This bill would require a health care service plan contract or health insurance policy issued, amended, renewed, or delivered on or after the bill's operative date that provides outpatient prescription drug benefits to cover up to a 12-month supply of a United States Food and Drug Administration (FDA)-approved prescription hormone therapy, and the necessary supplies for self-administration, that is prescribed by a network provider within their scope of practice and dispensed at one time, as specified. The bill would make the same prescription hormone therapy a covered benefit under the Medi-Cal program, as specified. The bill would prohibit a plan or an insurer from imposing utilization controls or other forms of medical management limiting the supply of this hormone therapy to an amount that is less than a 12-month supply, but would not prohibit a contract, a policy, or the Medi-Cal program from limiting refills that may be obtained in the last quarter of the plan, policy, or coverage year if a 12-month supply of the prescription hormone therapy has already been dispensed during that year. The bill would exclude a Medi-Cal managed care plan contracting with the State Department of Health Care Services from these requirements. The bill would repeal these provisions on January 1, 2035. This bill contains other related provisions and other existing laws.

SB 439 **(Weber Pierson D) California Health Benefit Review Program: extension.**
Current Text: Enrollment: 9/9/2025 html pdf
Introduced: 2/18/2025
Status: 9/9/2025-Enrolled and presented to the Governor at 2 p.m.

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

Summary: Existing law establishes the Health Care Benefits Fund to support the University of California's implementation of the California Health Benefit Review Program. Under the program, the University of California assesses legislation proposing to repeal or mandate a benefit or service requirement on health care insurance plans or health insurers. Under the program, the University of California provides a written analysis that includes, among other data, financial impacts of legislation on publicly funded state health insurance programs, including the Medi-Cal program and the Healthy Families Program. Existing law imposes an annual charge on health care service plans and

health insurers for the 2022–23 to 2026–27 fiscal years, inclusive, as specified, to be deposited into the fund. Existing law prohibits the total annual assessment on health care service plans and health insurers from exceeding $2,200,000. Under existing law, the fund and the program become inoperative on July 1, 2027, and are repealed as of January 1, 2028. This bill would extend the operation of the California Health Benefit Review Program and the Health Care Benefits Fund through July 1, 2033, and would authorize the continued assessment of the annual charge on health care service plans and health insurers for that purpose for the 2026–27 to 2032–33 fiscal years, inclusive. The bill would increase the allowable total annual assessment on health care service plans and health insurers to $3,200,000. The bill would remove the Healthy Families Program as an example of the publicly funded state health insurance programs within an analysis of financial impacts of legislation. This bill contains other related provisions.

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

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

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

SB 466 **(Caballero D) Drinking water: primary standard for hexavalent chromium: exemption.**
Current Text: Enrollment: 9/22/2025 html pdf
Introduced: 2/19/2025
Status: 9/22/2025-Enrolled and presented to the Governor at 2 p.m.

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

Summary: The California Safe Drinking Water Act provides for the operation of public water systems and imposes on the State Water Resources Control Board various duties and responsibilities for the regulation and control of drinking water in the State of California. The act requires the state board to adopt primary drinking water standards for contaminants in drinking water based upon specified criteria, and requires a primary drinking water standard to be established for hexavalent chromium. Existing law authorizes the state board to grant a variance from primary drinking water standards to a public water system. This bill would prohibit a public water system that meets the total chromium maximum contaminant level (MCL) enforceable standard for drinking water in California from being determined, held, considered, or otherwise deemed in violation of the primary drinking water standard for hexavalent chromium while implementing a state board approved compliance plan or while state board action on the proposed and submitted compliance plan is pending, except as provided.

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

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

Summary: Existing law, the California Consumer Privacy Act of 2018 (CCPA), grants a consumer various rights with respect to personal information that is collected or sold by a business. The CCPA defines various terms for these purposes. The California Privacy Rights Act of 2020 (CPRA), approved by the voters as Proposition 24 at the November 3, 2020, statewide general election, amended, added to, and reenacted the CCPA and establishes the California Privacy

Protection Agency (agency) and vests the agency with full administrative power, authority, and jurisdiction to enforce the CCPA. Existing law requires, on or before January 1, 2026, and before each time thereafter that a generative artificial intelligence system or service, as defined, or a substantial modification to a generative artificial intelligence system or service, released on or after January 1, 2022, is made available to Californians for use, regardless of whether the terms of that use include compensation, a developer of the system or service to post on the developer's internet website documentation, as specified, regarding the data used to train the generative artificial intelligence system or service. This bill would impose a duty on a covered deployer, defined as a business that deploys a high-risk artificial intelligence system that processes personal information, to protect personal information held by the covered deployer, subject to certain requirements. In this regard, the bill would require a covered deployer whose high-risk artificial intelligence systems process personal information to develop, implement, and maintain a comprehensive information security program, as specified, that contains administrative, technical, and physical safeguards that are appropriate for, among other things, the covered deployer's size, scope, and type of business. The bill would require the program described above to meet specified requirements, including, among other things, that the program incorporates safeguards that are consistent with the safeguards for the protection of personal information and information of a similar character under applicable state or federal laws and regulations. This bill contains other related provisions and other existing laws.

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

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

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

SB 528 **(Weber Pierson D) Health care: maintenance and expansion.**
Current Text: Amended: 5/5/2025 html pdf
Introduced: 2/20/2025
Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/19/2025)(May be acted upon Jan 2026)

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

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

SB 530 **(Richardson D) Medi-Cal: time and distance standards.**
Current Text: Enrollment: 9/22/2025 html pdf
Introduced: 2/20/2025
Status: 9/22/2025-Enrolled and presented to the Governor at 11 a.m.

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 law establishes, until January 1, 2026, certain time and distance and appointment time standards for specified Medi-Cal managed care covered services, consistent with federal regulations relating to network adequacy standards, to ensure that those services are available and accessible to enrollees of Medi-Cal managed care plans in a timely manner, as specified. This bill would extend the operation of those standards to January 1, 2029. 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 require a plan to demonstrate to the department each subcontractor network's compliance with time or distance and appointment time standards, as specified. This bill contains other related provisions and other existing laws.

SB 535 **(Richardson D) Obesity Care Access Act.**
Current Text: Amended: 7/17/2025 html pdf
Introduced: 2/20/2025
Status: 8/28/2025-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/20/2025)(May be acted upon Jan 2026)

Desk	Policy	Fiscal	Floor	Desk	Policy	2 year	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 sets forth specified coverage requirements for plan contracts. This bill, the Obesity Care Access 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 bariatric surgery and at least one antiobesity medication approved by the United States Food and Drug Administration. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

SB 579 **(Padilla D) Mental health and artificial intelligence working group.**
Current Text: Amended: 3/26/2025 html pdf
Introduced: 2/20/2025
Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 4/21/2025)(May be acted upon Jan 2026)

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

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

SB 626 **(Smallwood-Cuevas D) Perinatal health screenings and treatment.**

Current Text: Amended: 7/17/2025 html pdf
Introduced: 2/20/2025
Status: 9/11/2025-Failed Deadline pursuant to Rule 61(a)(14). (Last location was INACTIVE FILE on 9/3/2025)(May be acted upon Jan 2026)

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

Summary: Current 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 authorize a licensed health care practitioner to satisfy the above-described requirement by referring the patient or client to another licensed health care practitioner who is authorized to screen, diagnose, and treat the patient or client for a perinatal mental health condition. The bill would require a licensed health care practitioner who provides perinatal care for a patient or client to diagnose and treat the patient or client for a perinatal mental health condition in accordance with the standards appropriate to the provider's license, training, and scope of practice, as specified.

SB 660 **(Menjivar D) California Health and Human Services Data Exchange Framework.**
Current Text: Enrollment: 9/22/2025 html pdf
Introduced: 2/20/2025
Status: 9/22/2025-Enrolled and presented to the Governor at 11 a.m.

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 related to health care infrastructure, such as health policy and planning, health professions development, and facilities design review and construction, among others. Existing law requires the California Health and Human Services Agency to establish the California Health and Human Services Data Exchange Framework to require the exchange of health information among health care entities and government agencies in the state, among other things. Existing law requires the agency to convene a stakeholder advisory group to advise on the development of implementation of the California Health and Human Services Data Exchange Framework. This bill would require the Department of Health Care Access and Information, on or before January 1, 2026, to take over the establishment, implementation, and all of the functions related to the California Health and Human Services Data Exchange Framework, including the data sharing agreement and policies and procedures, from the agency. The bill would expand the entities that are specifically required to execute a data sharing agreement with the California Health and Human Services Data Exchange Framework. The bill would require the department, no later than July 1, 2026, to establish a process to designate qualified health information organizations as data sharing intermediaries that have demonstrated their ability to meet requirements of the California Health and Human Services Data Exchange Framework. The bill would require the department, by July 1, 2027, and in collaboration with the stakeholder advisory group, to develop and submit a report to the Legislature on the California Health and Human Services Data Exchange Framework, including compliance with data sharing agreements. The bill would expand the membership of the stakeholder advisory group, as specified.

SB 812 **(Allen D) Qualified youth drop-in center health care coverage.**
Current Text: Amended: 7/17/2025 html pdf
Introduced: 2/21/2025
Status: 8/28/2025-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/20/2025)(May be acted upon Jan 2026)

Desk	Policy	Fiscal	Floor	Desk	Policy	2 year	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 expand the definition of schoolsite to 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: artificial intelligence systems: human oversight.**
Current Text: Amended: 7/17/2025 html pdf
Introduced: 2/21/2025
Status: 8/28/2025-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/20/2025)(May be acted upon Jan 2026)

Desk	Policy	Fiscal	Floor	Desk	Policy	2 year	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, on or before July 1, 2026, an operator, defined as a state agency responsible for operating, managing, overseeing, or controlling access to critical infrastructure, that deploys a covered artificial intelligence (AI) system, as defined, to establish a human oversight mechanism that ensures a human monitors the system's operations in real time and reviews and approves any plan or action proposed by the covered AI system before execution, except as provided. The bill would require the Department of Technology to develop specialized training in AI safety protocols and risk management techniques to oversight personnel. The bill would require oversight personnel for an operator to conduct an annual assessment of its covered AI systems, as specified, and to submit a summary of the findings to the department. The bill would make findings and declarations related to its provisions. This bill contains other related provisions and other existing laws.

SB 862 **(Committee on Health) Health.**
Current Text: Chaptered: 10/1/2025 html pdf
Introduced: 3/17/2025
Status: 10/1/2025-Chaptered by Secretary of State - Chapter 243, Statutes of 2025

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

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

provisions and other existing laws.

Total Measures: 123

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OPERATIONS DASHBOARD

OCTOBER 2025

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Financials

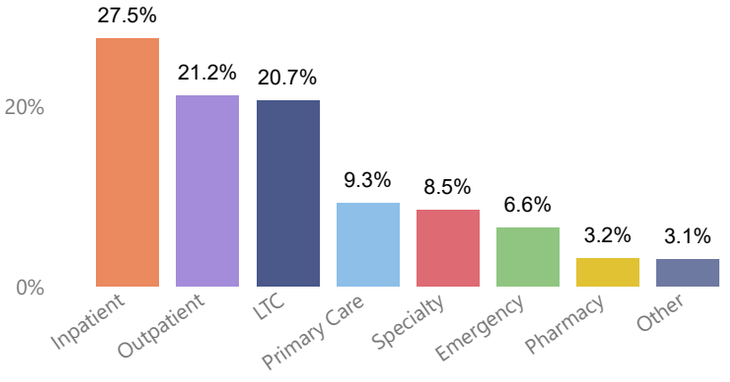
Income & Expenses

	AUGUST 2025	FISCAL YTD
REVENUE	$ 189.1 M	$ 446.7 M
MEDICAL EXPENSE	$ (176.5) M	$ (360.9) M
ADMIN EXPENSE	$ (11.9) M	$ (20.8) M
OTHER/TAX	$ 2.3 M	$ (60.4) M
NET INCOME	$ 3.0 M	$ 4.7 M

Medical Loss % (Fiscal YTD)

93.4%

Medical Expenses



Liquid Reserves

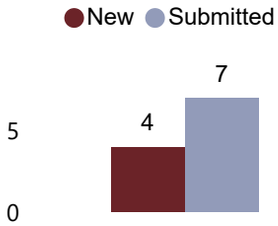
TNE %

216.8%

TNE $

$174.0M

Reinsurance Cases



Balance Sheet

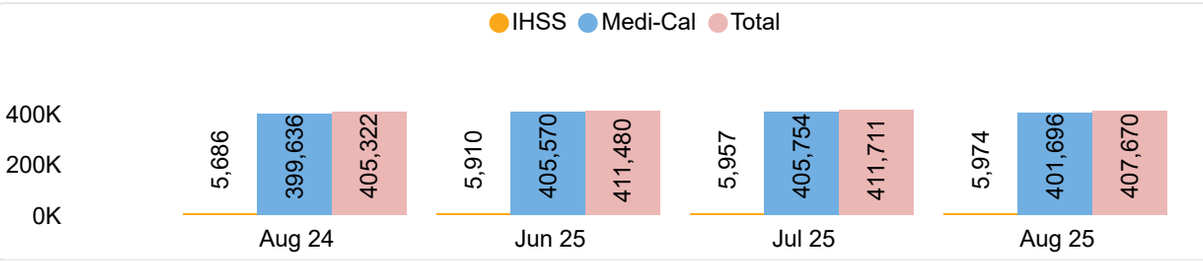
Cash Equivalents	$599.2M
Pass-Through Liabilities	$315.2M
Uncommitted Cash	$284.0M
Working Capital	$122.3M

Current Ratio

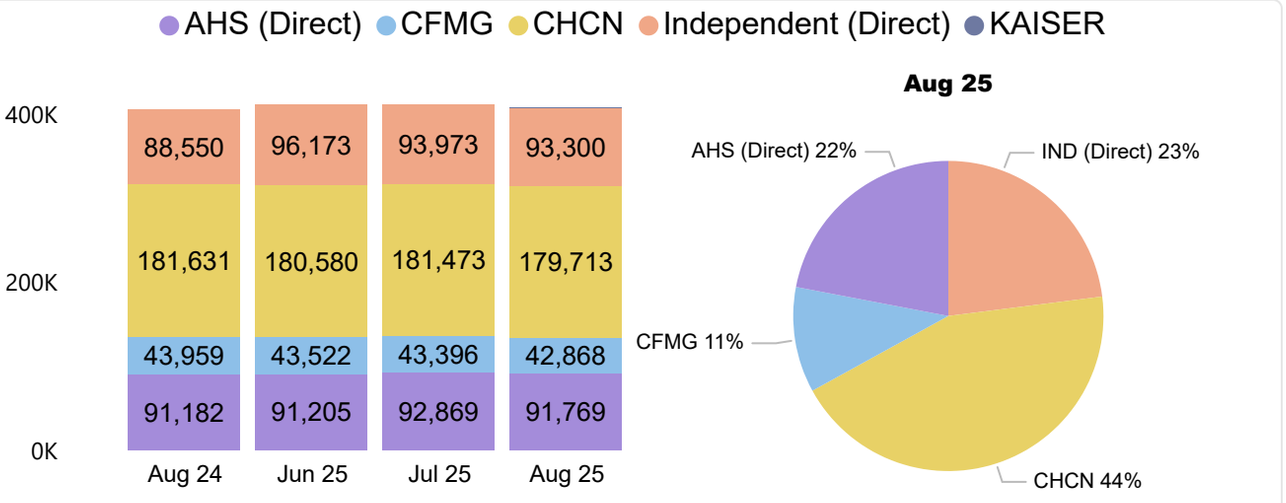
1.13

Membership

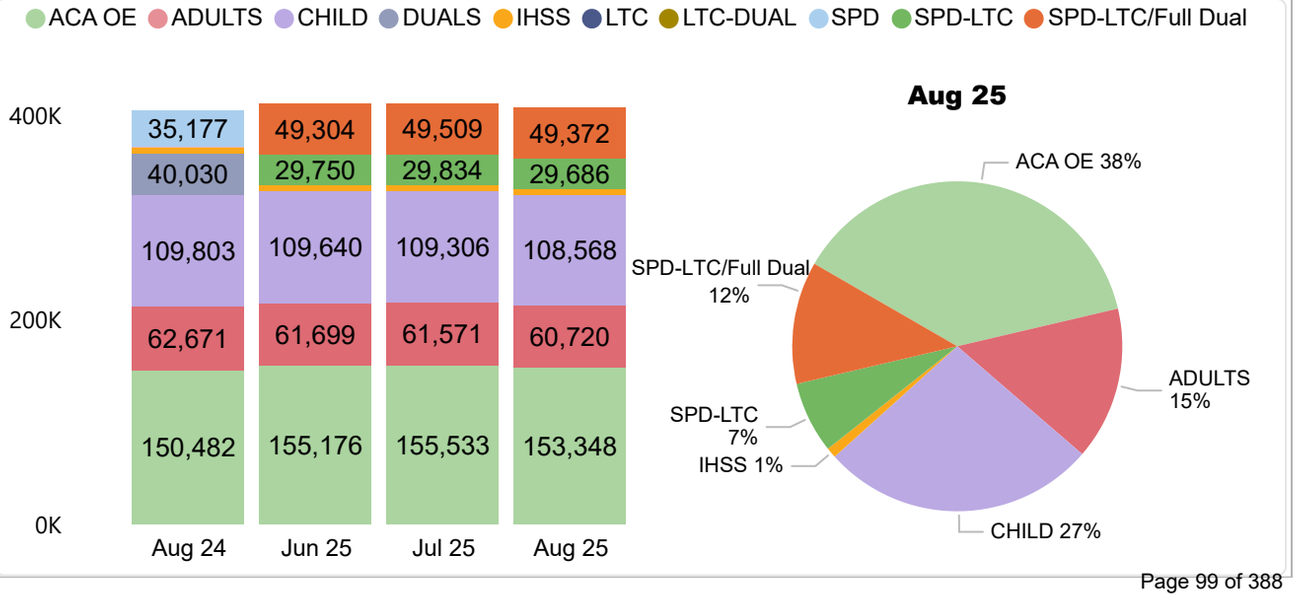
By Plan



By Network



By Category



OPERATIONS DASHBOARD

OCTOBER 2025

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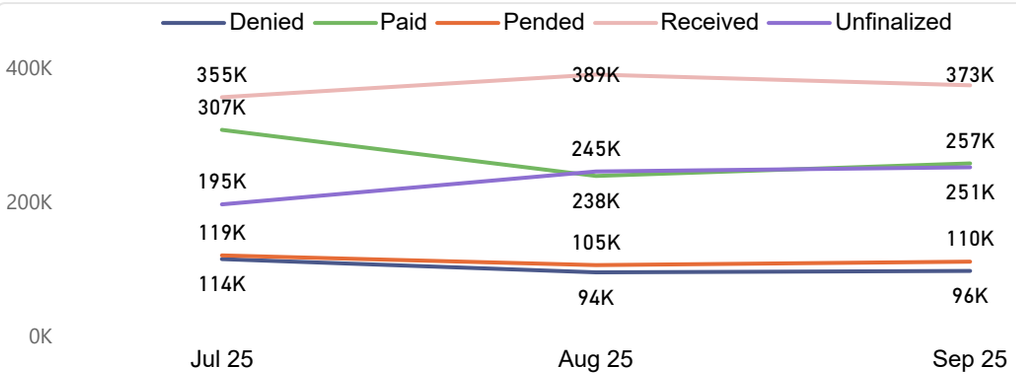
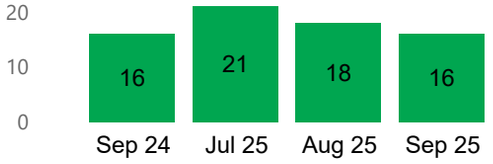
Claims

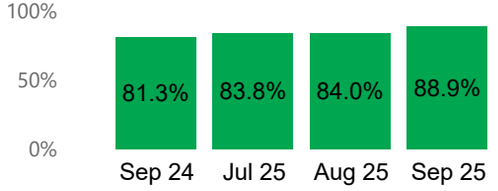
Claims Processing



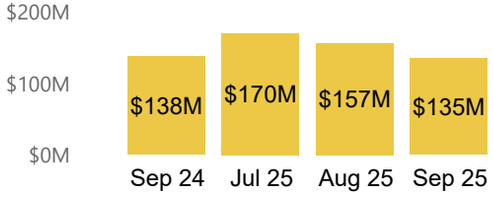
Average Payment TAT (Days)



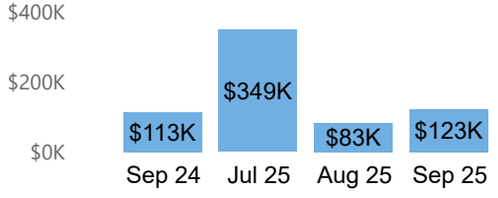
Auto Adjudication Rate (%)



Claims Paid ($)

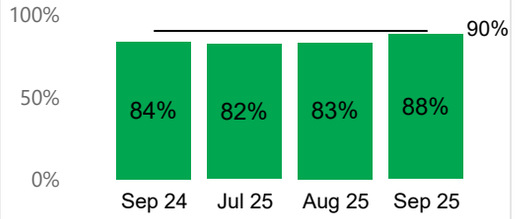


Interest Paid ($)

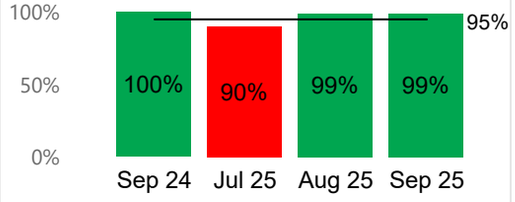


Claims Compliance

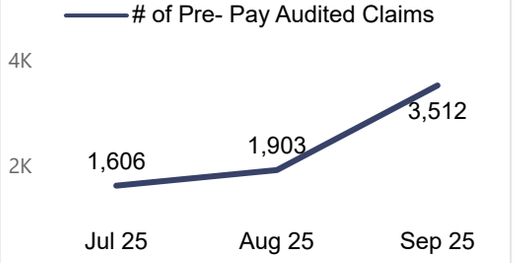
Processed 30 Cal Days (%)



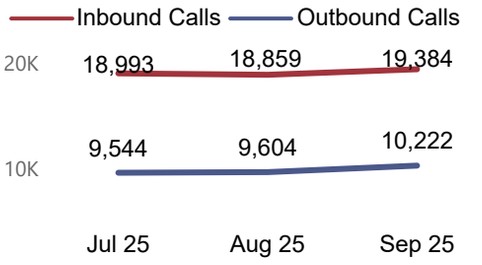
Processed 45 Work Days (%)



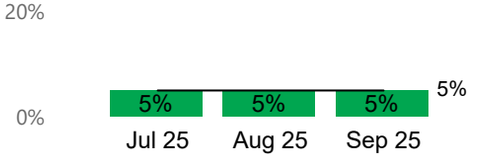
Claims Auditing



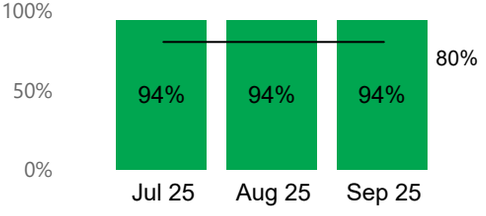
Member Services



Abandoned Call Rate (%)

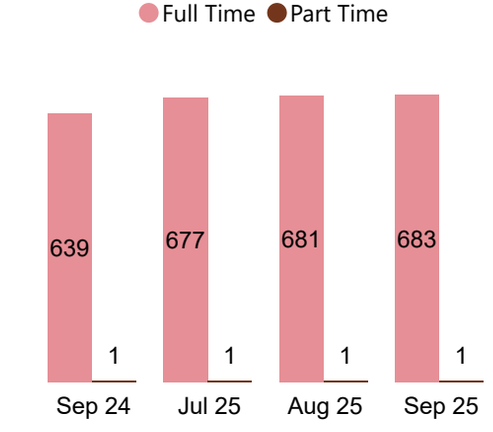


Calls Answered in 30 Seconds (%)

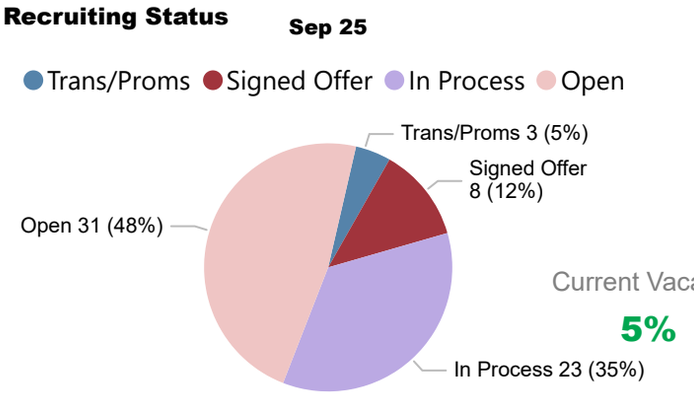


Average Call Times	Jul 25	Aug 25	Sep 25
Wait Time	00:13	00:13	00:12
Call Duration	07:39	07:47	07:26

Human Resources

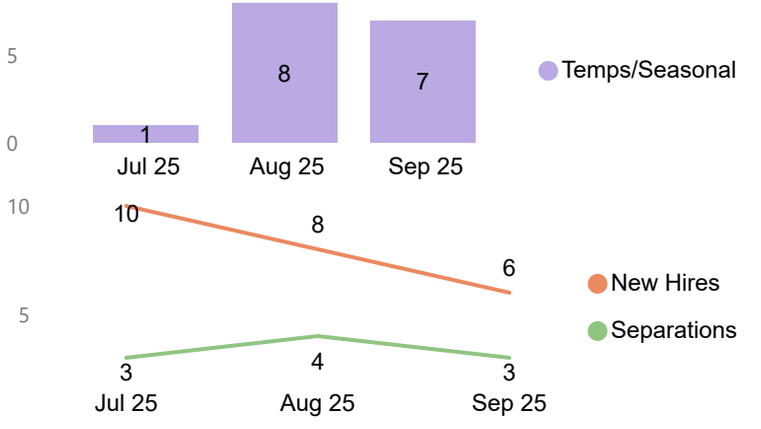


Recruiting Status Sep 25



Current Vacancy

5%



OPERATIONS DASHBOARD

OCTOBER 2025

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Provider Services

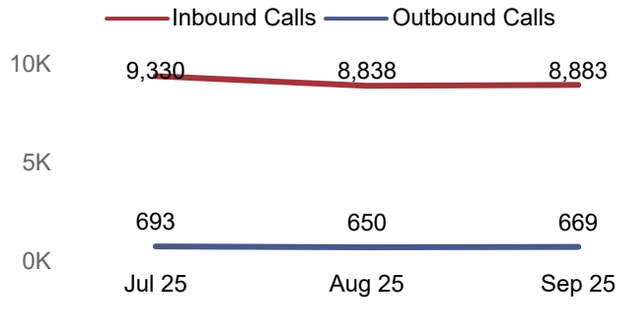
Provider Network

Hospital	17
Specialist	11,669
Primary Care Physician	762
Skilled Nursing Facility	108
Urgent Care	16
Health Centers (FQHCs and Non-FQHCs)	87
TOTAL	**12,659**

Provider Credentialing

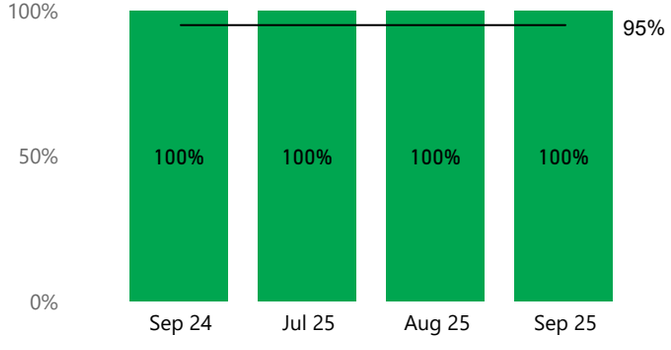
5,187

Provider Call Center



Provider Disputes & Resolutions

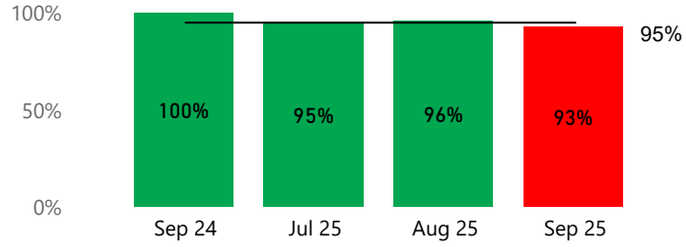
Turnaround Compliance (45 business days)



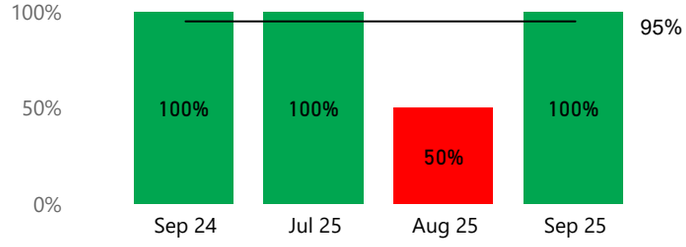
Compliance

Member Grievances

Standard (30 calendar days)

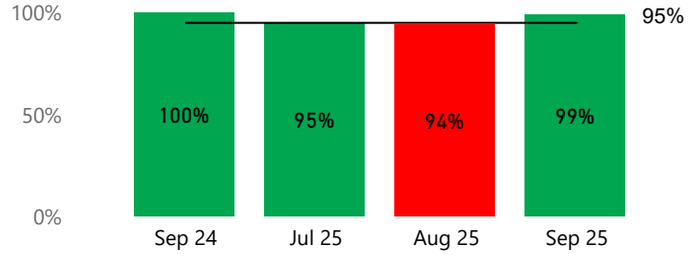


Expedited (3 calendar days)

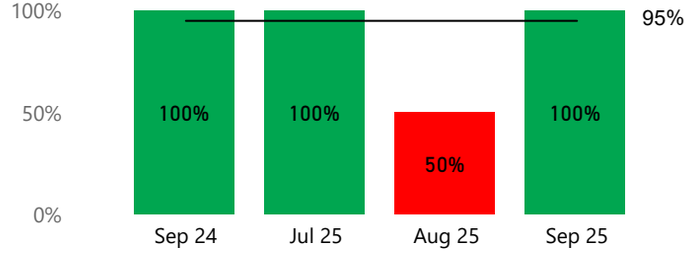


Member Appeals

Standard (30 calendar days)

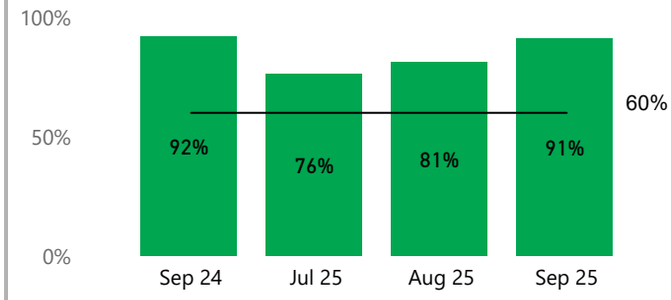


Expedited (3 calendar days)

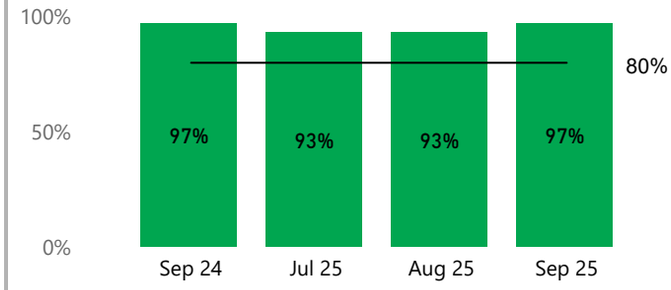


Encounter Data

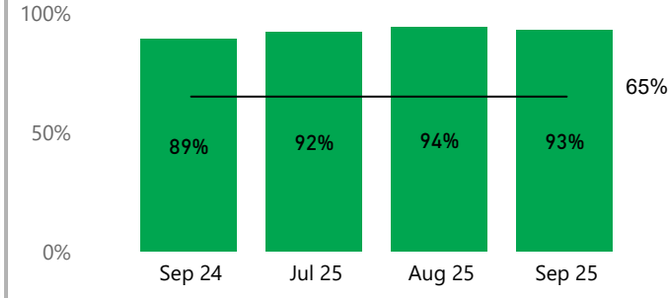
Institutional 0-90 days



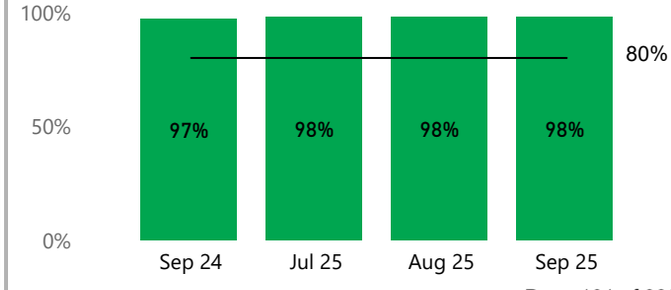
Institutional 0-180 days



Professional 0-90 days

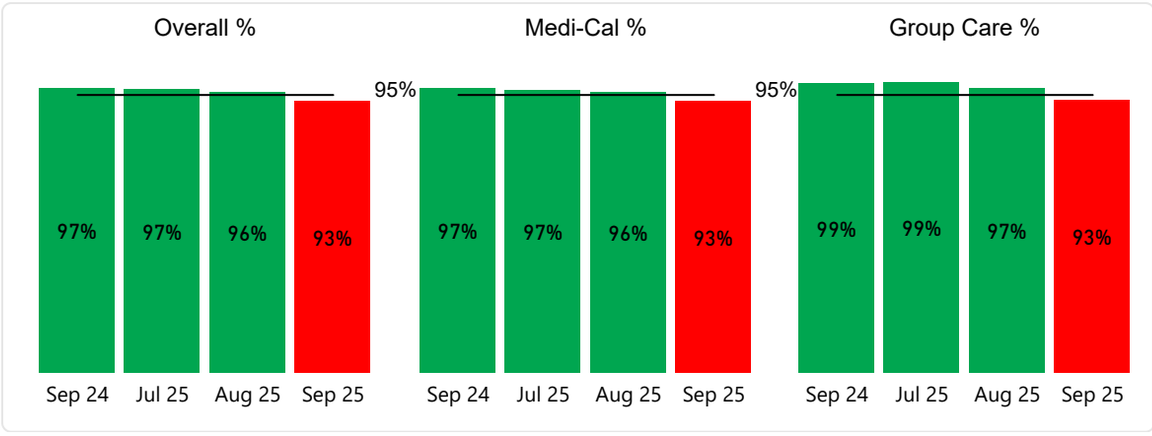


Professional 0-180 days

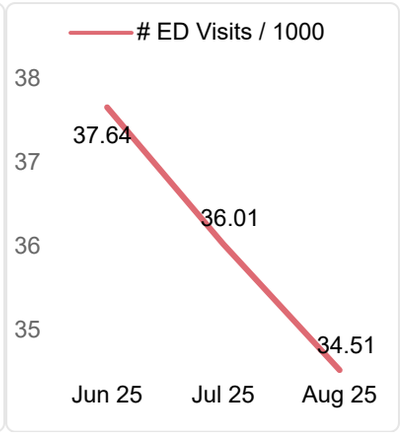


Health Care Services

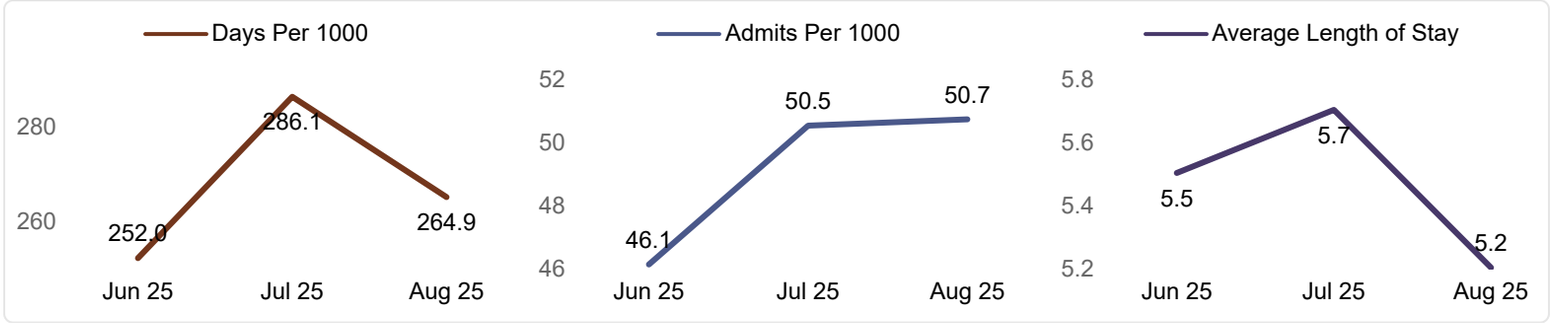
Authorization Turnaround



ED Utilization

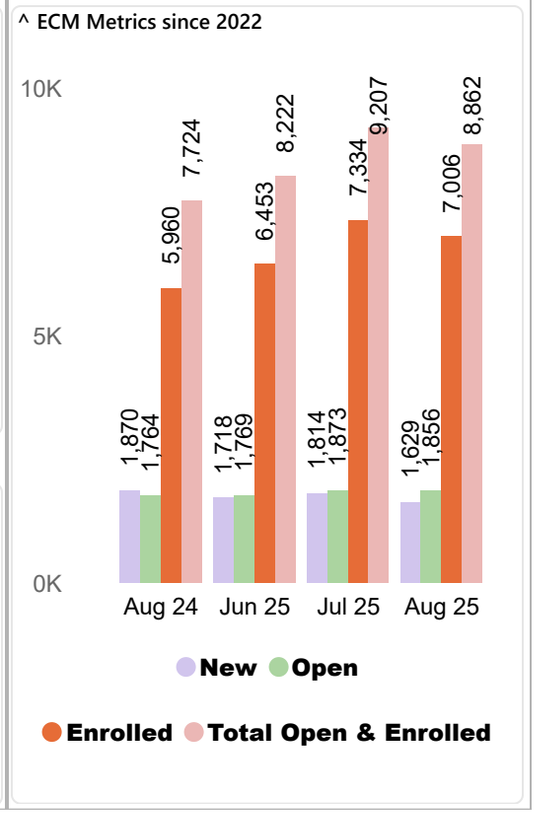


Inpatient Utilization

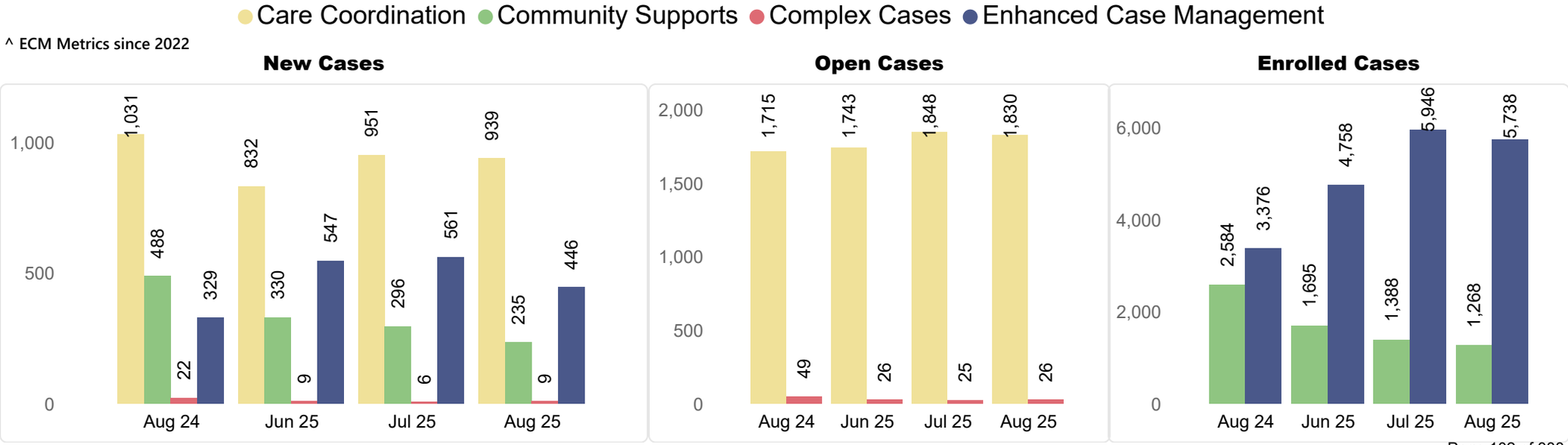


Case Management

Total Cases^



Case Management^



Technology (Business Availability)

Applications	Sep 24	Jul 25	Aug 25	Sep 25
HEALTHsuite System	100.0%	100.0%	99.9%	100.0%
Other Applications	100.0%	100.0%	99.9%	100.0%
TruCare System	100.0%	100.0%	100.0%	100.0%

Outpatient Authorization Denial Rates *

OP Authorization Denial Rates	Sep 24	Jul 25	Aug 25	Sep 25
Denial Rate Excluding Partial Denials (%)	3.4%	3.6%	3.5%	2.8%
Overall Denial Rate (%)	3.6%	4.0%	3.8%	3.1%
Partial Denial Rate (%)	0.2%	0.5%	0.3%	0.3%

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

Pharmacy Authorizations

Authorizations	Sep 24	Jul 25	Aug 25	Sep 25
Approved Prior Authorizations	39	43	31	48
Closed Prior Authorizations	74	9	21	19
Denied Prior Authorizations	57	90	107	82
Total Prior Authorizations	170	142	159	149

ALAMEDA Alliance FOR HEALTH

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

Board Business

ALAMEDA Alliance FOR HEALTH

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

Financial Audit Review

2025 Audit Results: Alameda Alliance for Health

Report of Independent Auditors

Rianne Suico
Health Care and Insurance Services Principal

Chris Pritchard
Health Care and Insurance Services Principal

Gordon Lam
Health Care and Insurance Services Senior Manager

2025 Audit Objectives

- Opinion on whether the financial statements are reasonably stated and free of material misstatement in accordance with accounting principles generally accepted in the United States of America
- Consideration of internal controls

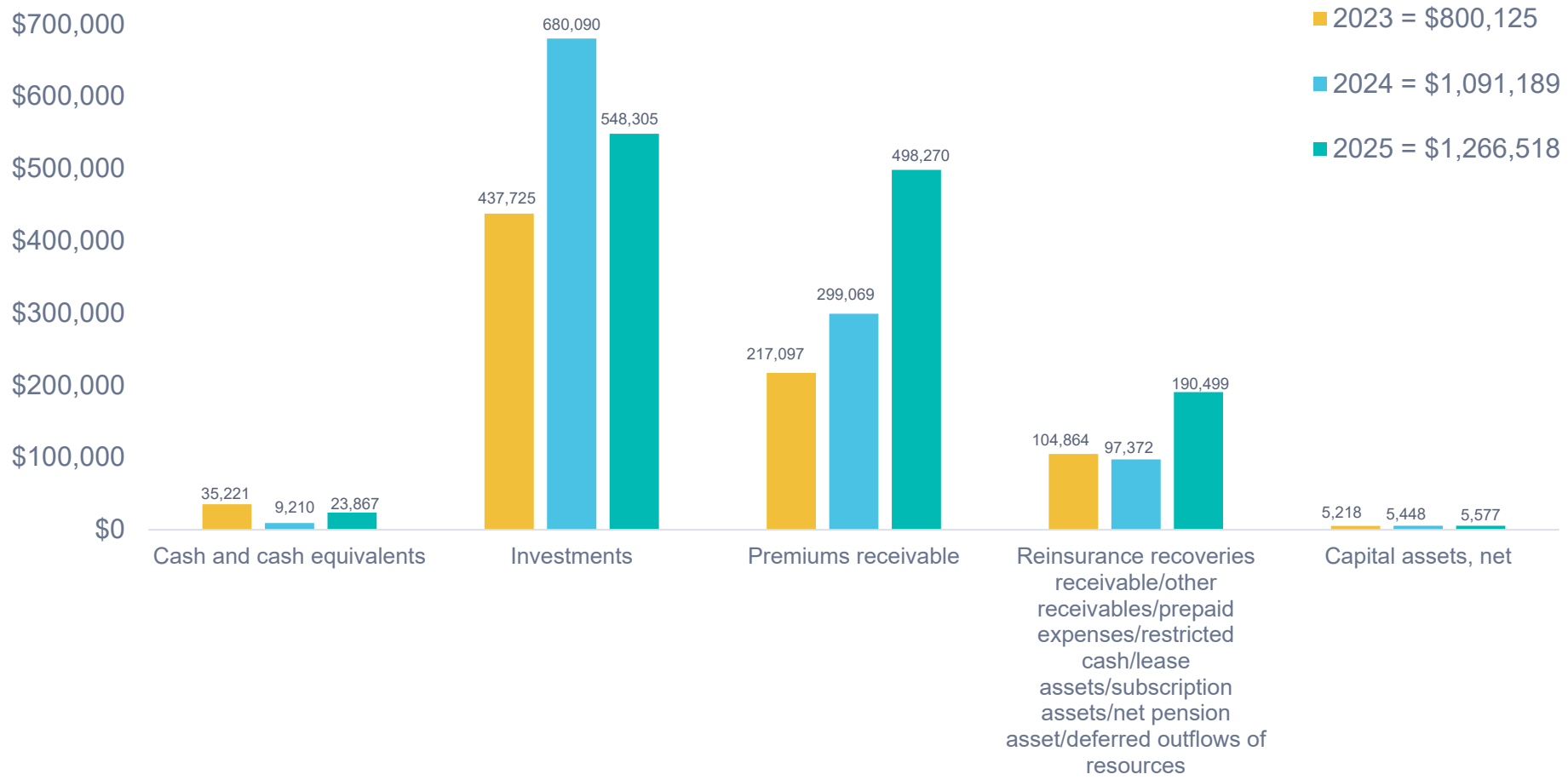
Report of Independent Auditors

Unmodified Opinion

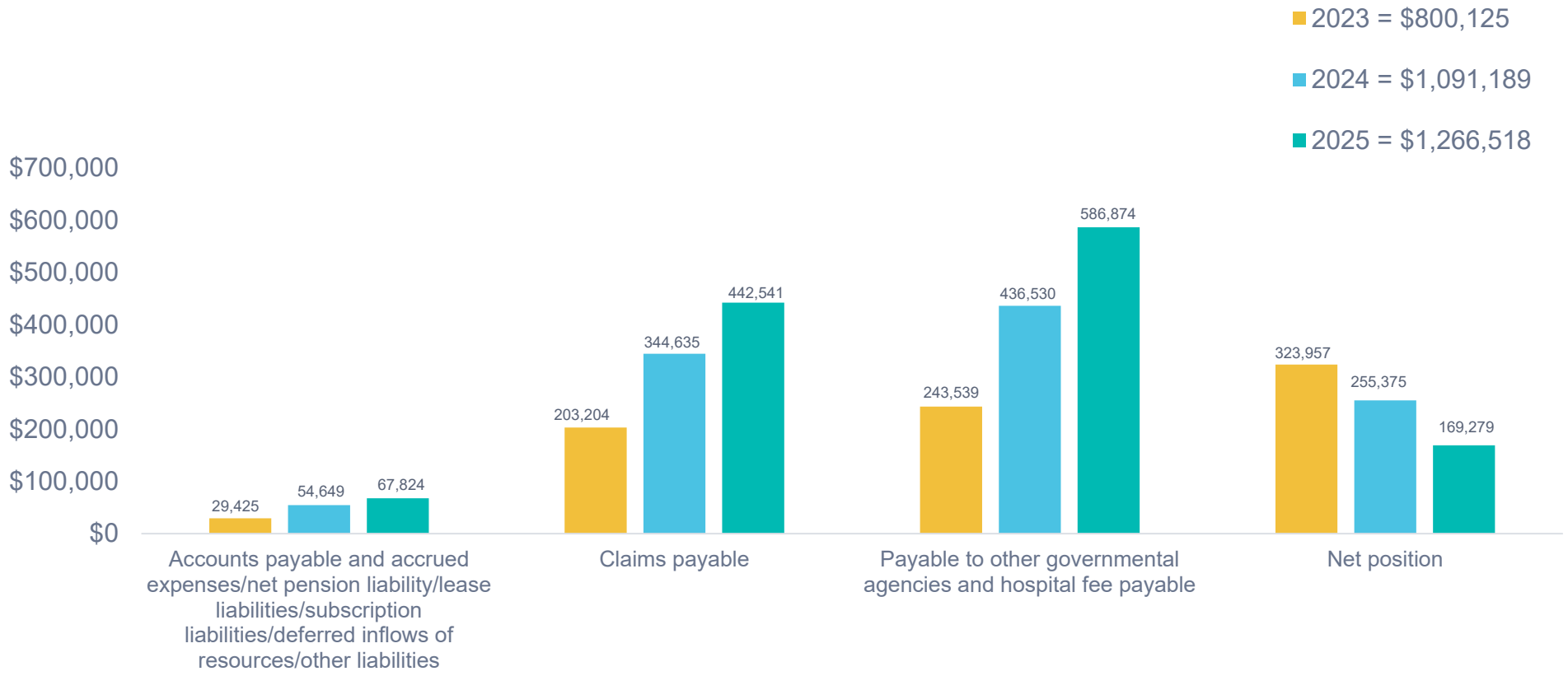
- Financial statements are fairly presented in accordance with accounting principles generally accepted in the United States of America

Statements of Net Position

Assets and Deferred Outflows of Resources Composition (in thousands)



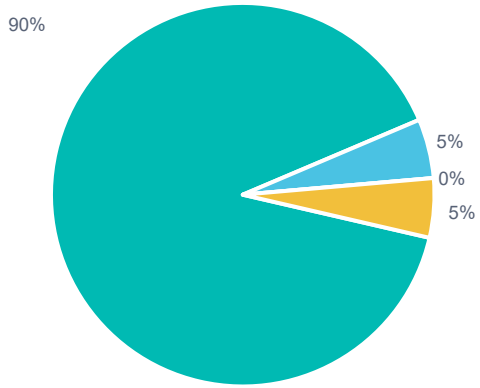
Liabilities, Deferred Inflows of Resources, and Net Position (in thousands)



Operations

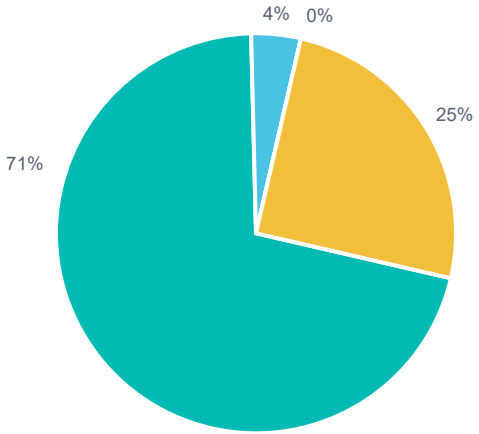
Operating Expenses (in thousands)

June 30, 2023
$1,437,257

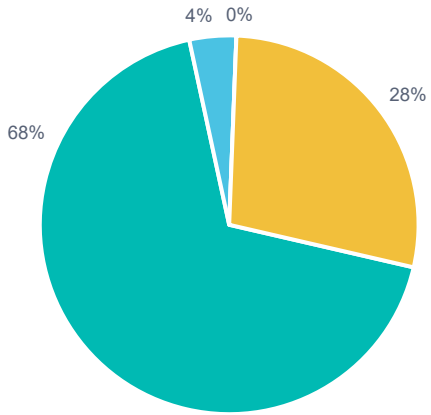


- Medical services
- Marketing, general, and administrative expenses
- Depreciation and amortization expense
- Premium tax

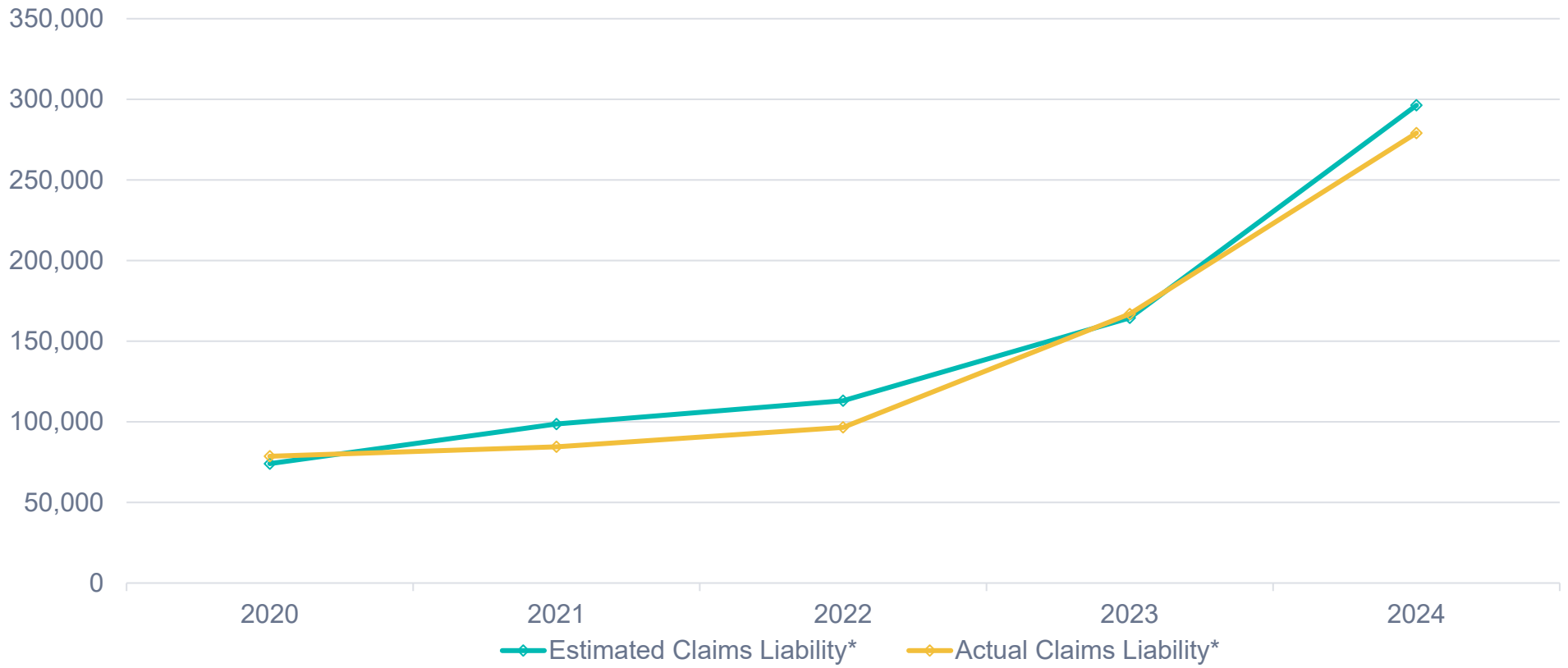
June 30, 2024
$2,454,484



June 30, 2025
$3,133,172



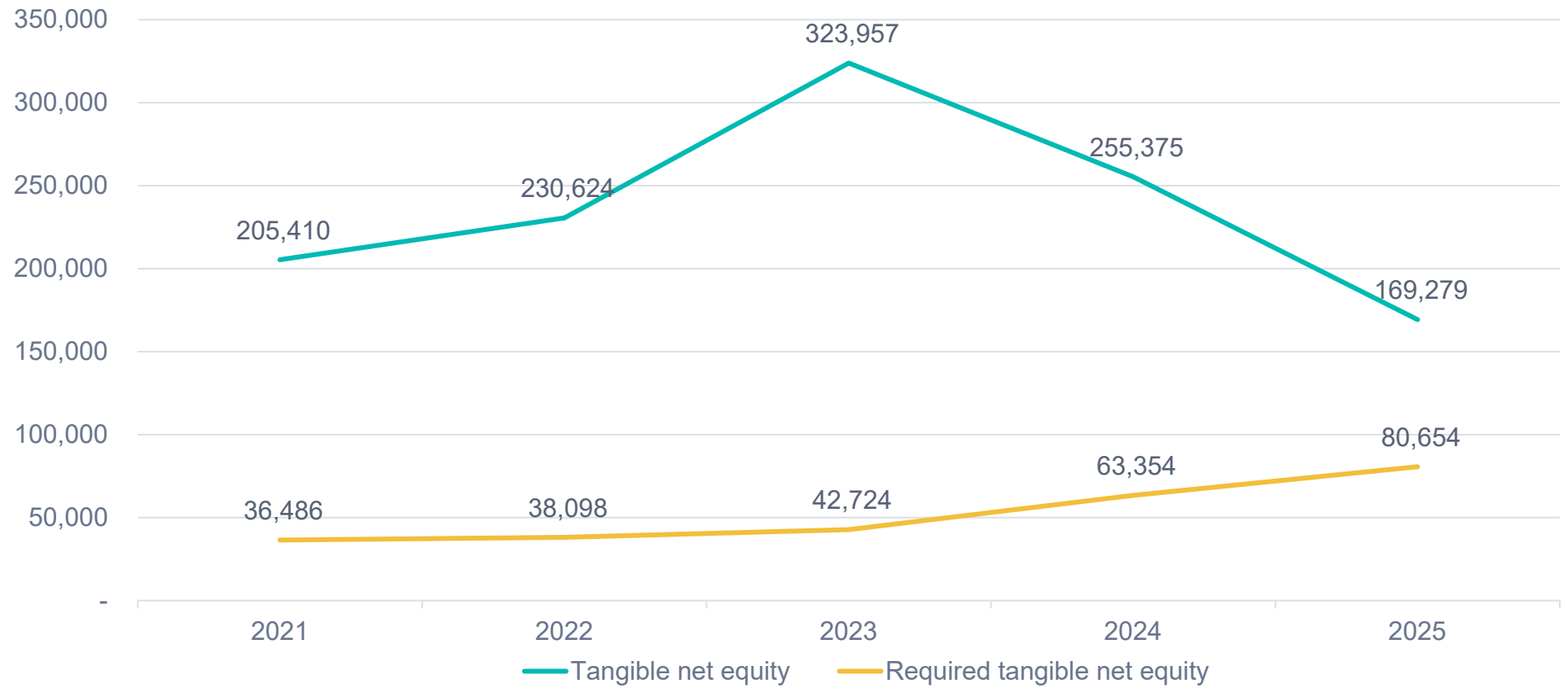
Historic Estimated Claims Liability and Historic Actual Claims Liability (in thousands)



* Estimated claims liability and actual claims liability excludes non-hospital claims.

Source: Alliance's internal reports

Tangible Net Equity (in thousands)



Source: Annual Department of Managed Health Care Filing

Important Board Communications

- AU-C Section 260 – *The Auditor's Communication with Those Charged with Governance*
- Significant accounting policies
- Accounting estimates are reasonable
- No audit adjustment
- No issues discussed prior to our retention as auditors
- No disagreements with management
- No awareness of instances of material fraud or noncompliance with laws and regulations

Questions

THANK YOU

ALAMEDA Alliance FOR HEALTH

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

Information Technology Annual Update

Cyber Security Operations Progress Report

Sasi Karaiyan, Chief Information Security Officer

Friday, October 10, 2025

ALAMEDA Alliance FOR HEALTH

Security Strategies

- ✓ Zero Trust Strategy – "Never Trust, Always verify"
- ✓ Continue Awareness, Internal Human Element and Training
- ✓ NIST Process – Identify, Protect, Detect, Respond, Recover, and Govern
- ✓ End to End 24/7 Security Monitoring, Alerts, Notification and Review/Closure.
- ✓ Partner, Delegate and Vendor Coloration to Promote Resilience, Communication and Monitoring of any Cyber-Security Breaches.
- ✓ Security Command Center to Support Incident Response Management.
- ✓ IT Security audits, Risk Assessment and Remediation.
- ✓ AI Security Framework and Governance (Work In-Progress)

Accomplishments

- ✓ Automate vulnerability management system using Nessus.
- ✓ Stood up IT Governance and Security Command Center
- ✓ Migrated to new Immutable Cloud Storage
- ✓ Disaster Recovery Procedure and Business Continuity Plan for Core processes.
- ✓ Completed End to End penetration test and IT Security Risk Assessment
- ✓ Total 67 vulnerability patches/upgrades to Alliance IT Ecosystems.
- ✓ Phishing Monitoring and Response 98% (Average 460+ inquires)
- ✓ Renewed Cybersecurity insurance coverage.
- ✓ Continued to support state of the art in resilient networked systems.
- ✓ Intune remote management capabilities for workstations.
- ✓ Trued up certificate collection effort into IT Glue (internal + external, SSO apps WIP).

Inflight Initiatives

- ➢ Centralized cyber security dashboard.
- ➢ Lateral Micro Segmentation.
- ➢ IT Security Program 2025/26 (Remediation Effort)
- ➢ AI Security Strategy and Governance
- ➢ Strengthen Security Awareness and Training

Healthcare Incidents in US

- ✓ Hospital & Healthcare Cyberattacks In 2025
- ✓ 330 Cyber attacks (reported) – 16% more than 2024 .
- ✓ The records of ~ 650 million individuals have been stolen or compromised.
- ✓ ~ $7 billion financial losses.

Top 4 major reason for these cyber attacks are:

- ✓ Lack of awareness and training.
- ✓ Weaker password and no Multi Factor Authentication.
- ✓ Lateral Micro Segementation.
- ✓ Others (Vendors, Partners Incidents)

Security Training and Awareness

- ✓ Penetration Test and Phishing Awareness Training
- ✓ AAH employees, contractors, and temp resources are required training upon hire.
- ✓ Mandatory Security training consist of 5 exercises and videos, and these training will be revised each year.
- ✓ The FY2026 training are:
  - ❖ Safe Surfing with Quiz Training Module
  - ❖ Corporate Email Tips with Quiz Training
  - ❖ Mobile Phishing Mobile-First Module
  - ❖ Artificial Intelligence Awareness Training
  - ❖ Human Firewalls in Action: Social Engineering Training
  - ❖ Managing Your Digital Footprint Mobile-First

24/7 Monitoring Quarterly Report

- ✓ Arctic Wolf Monthly Security Incident Reporting
- ✓ An effective security monitoring program will collect and analyze endpoint telemetry, network and security event logs "Observations", filter the observations to identify potentially malicious events "Investigations", and request human interventions that will be actioned by Arctic Wolf and/or AAH "Ticketed Incidents".

Coverage Score

65%

Detected Ports

Services in your network that are visible to the Internet.

14

Vulnerabilities

Outstanding security risks identified by Arctic Wolf external scanning.

10	8	0	0
LOW	MED	HIGH	CRIT

Observations

Events parsed, enriched, and analyzed for security value.

823 M

Investigations

Number of potential incidents that were examined from your environment.

544

Reported Incidents

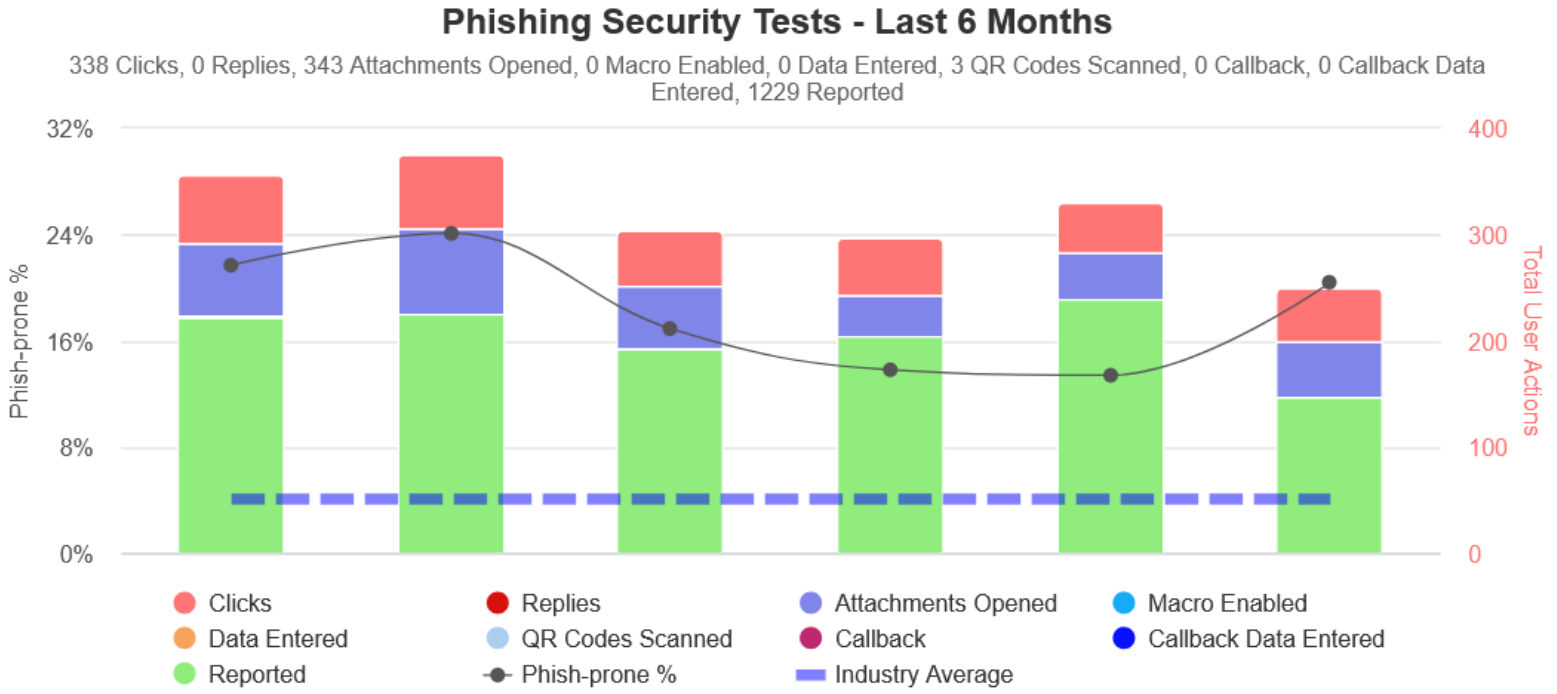
Security incidents that were brought to your attention.

416

Reported Incident Breakdown

- Restricted Country Login (113)
- Azure Firewall Rule or Resource Group Change (94)
- Potentially Malicious URL Click (41)
- Cisco Secure Endpoint Alert (30)
- Admin Account Lockout (24)
- User Locked Out (13)
- User Added/Deleted (10)
- Authorization Group Assigned (10)
- Multiple Logon Failures (9)
- Duo Alert (9)
- Other (63)

Phishing Effectiveness



Your Organization	
Account Average Phish-prone %	14%
Last Campaign Phish-prone %	20.4%

Industry Benchmark Data	Show in chart
Industry Phish-prone %	4.1%
Industry	Healthcare & Pharr
Organization Size	Medium (250-999 u
Program Age	2 Years

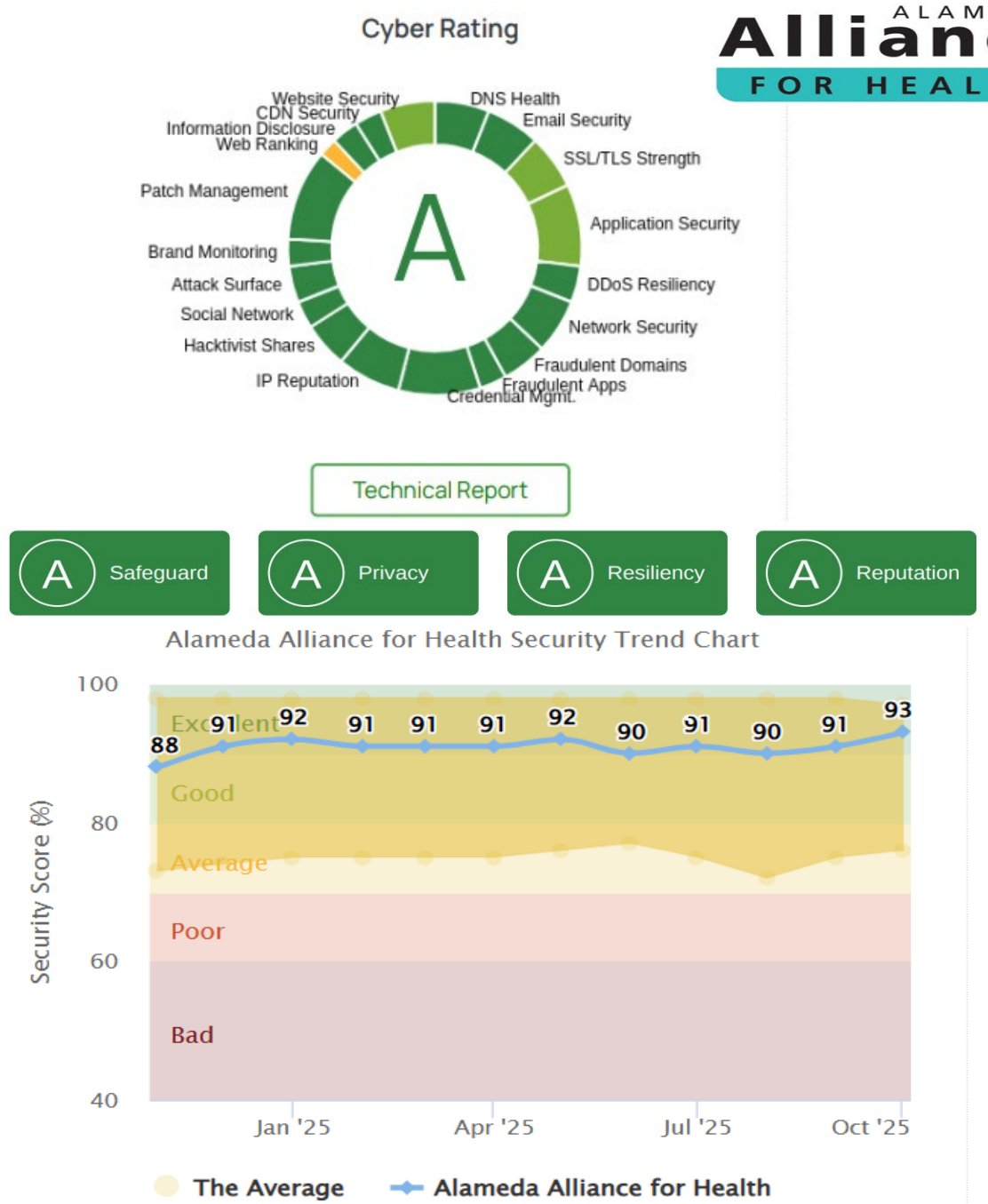
Key Highlights

- At one point, % of users prone to clicking on phishing emails decreased for three consecutive months.
- Within industry, we are at 96% percentile on clicking phishing emails.
- Sustained use of the Phishing Alert Report button (green bar)

AAH Security Scorecard

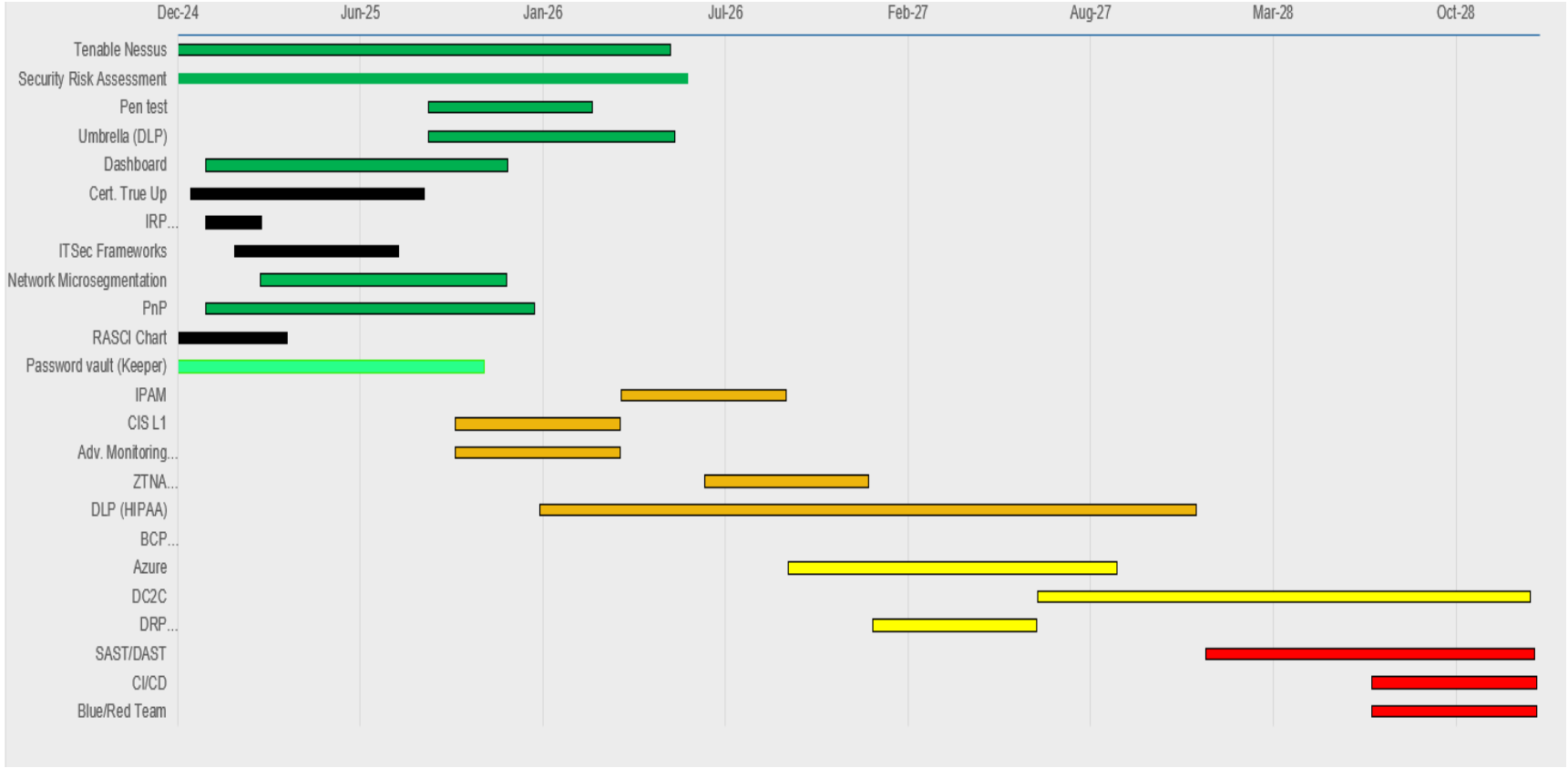
The purpose of this score (from BlackKite) is to give organizations a **continuous, external-facing measurement of AAH's cybersecurity posture**. It works like a *credit score for cybersecurity*.

In maintaining a healthy score, those who work or will work with AAH could rest assured the organization takes its cyber security very seriously.



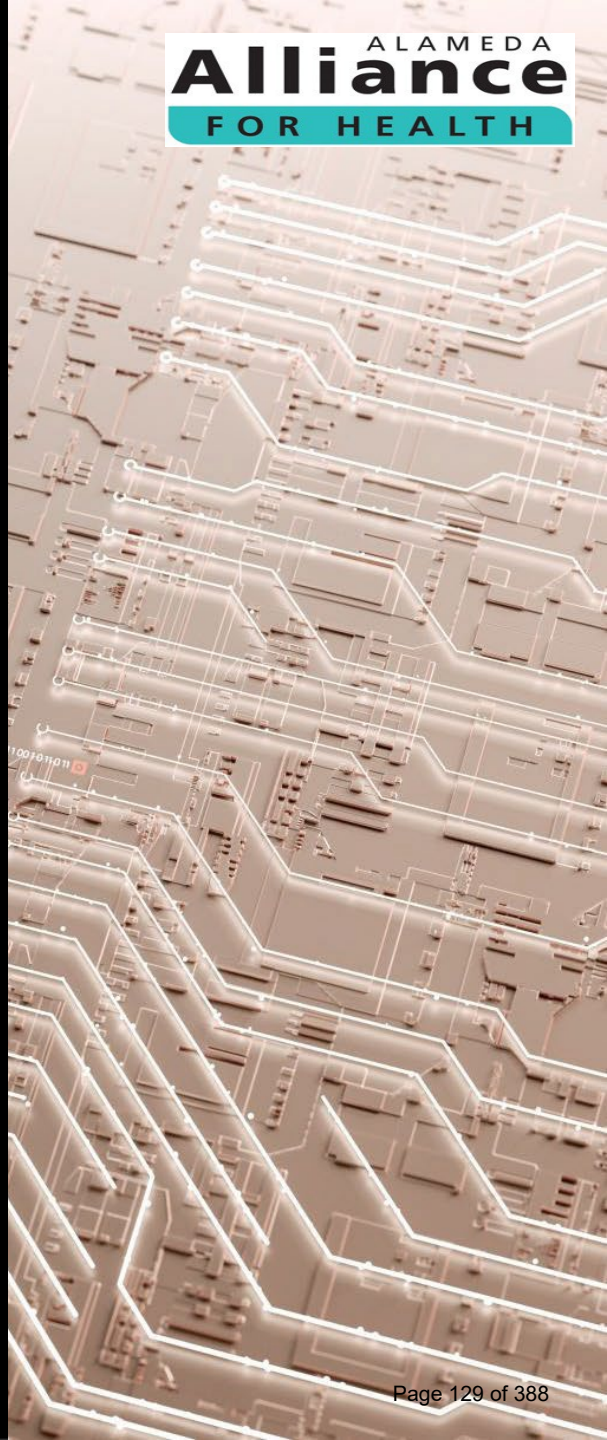
IT Security Roadmap

ITSec 2025 - 2028			DURATION (days)	Yr
START DATE	END DATE	DESCRIPTION		
Dec-24	Jun-26	Tenable Nessus	540	1
Nov-25	Jun-26	Security Risk Assessment	224	1
Sep-25	Mar-26	Pen test	180	1
Sep-25	Jun-26	Umbrella (DLP)	270	1
Jan-25	Dec-25	Dashboard	330	1
Dec-24	Sep-25	Cert. True Up	256	1
Jan-25	Mar-25	IRP (Incident Response Plan)	60	1
Feb-25	Jul-25	ITSec Frameworks	180	1
Mar-25	Dec-25	Network Microsegmentation	270	1
Jan-25	Dec-25	PnP	360	1
Dec-24	Apr-25	RASCI Chart	120	1
Nov-25	Feb-25	Password vault (Keeper)	-245	1
Apr-26	Oct-26	IPAM	180	2
Oct-25	Apr-26	CIS L1	180	2
Oct-25	Apr-26	Adv. Monitoring (UBA/AI/ML)	180	2
Jul-26	Dec-26	ZTNA (accessing HIPAA)	180	2
Jan-26	Jan-28	DLP (HIPAA)	720	2
Jan-26	Jul-26	BCP (Business Continuity Plan)		3
Oct-26	Oct-27	Azure	360	3
Jul-27	Dec-28	DC2C	540	3
Jan-27	Jul-27	DRP (Disaster Recovery Plan)	180	3
Jan-28	Dec-28	SAST/DAST	360	4
Jul-28	Dec-28	CI/CD	180	4
Jul-28	Dec-28	Blue/Red Team	180	4



- ✓ Roadmap is to establishing a foundational security stack
- ✓ Dependencies include fundamental restructuring of IT to include the security function – at all levels.
- ✓ Frontload 2025-2026 to (1) reduce technical debt (2) establish meaningful PnP (3) define swim lanes

Thank You!



Automation and Artificial Intelligence (AI) Approach at Alameda Alliance for Health

Sasi Karaiyan, Chief Information Officer

Friday, October 10, 2025

ALAMEDA Alliance FOR HEALTH

ALAMEDA Alliance FOR HEALTH

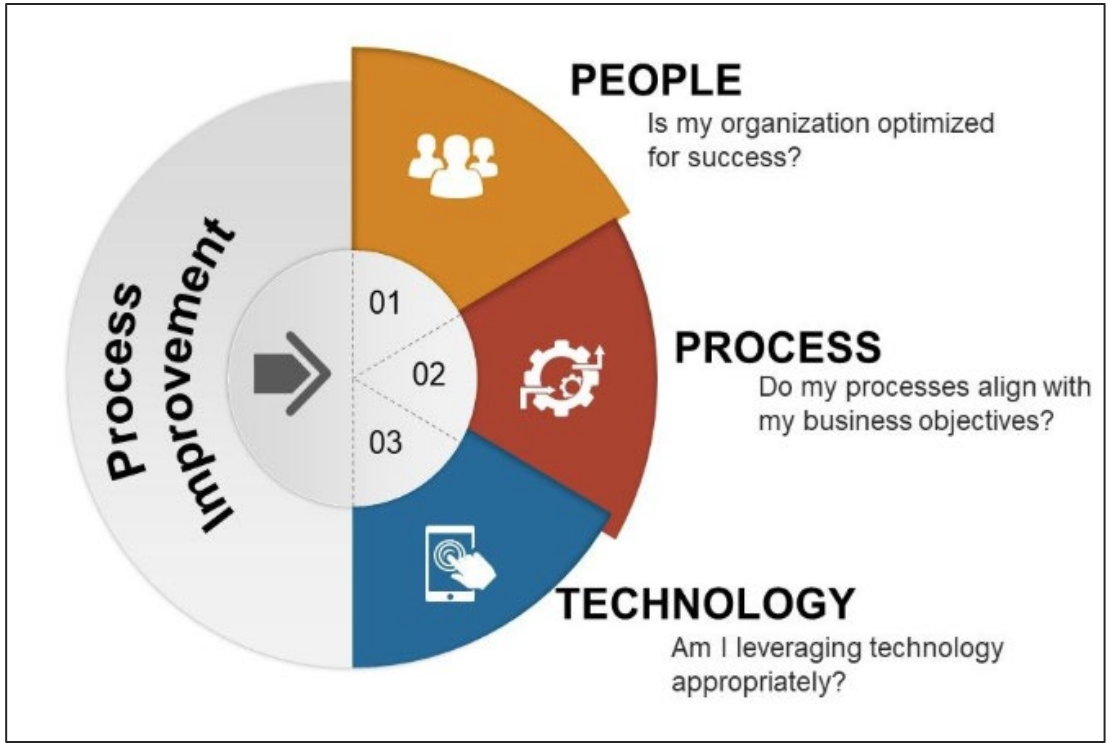
Agenda

- Objective
- Our Approach and Life Cycle
- Solutions
- AI Governance Strategy & Structure
- Success Stories
- Workflow Automation Roadmap

Our Objective

- Quality and Continuity of Care
- Customer Service
- Operational Efficiency
- Cost Reduction
- Better Place to Work

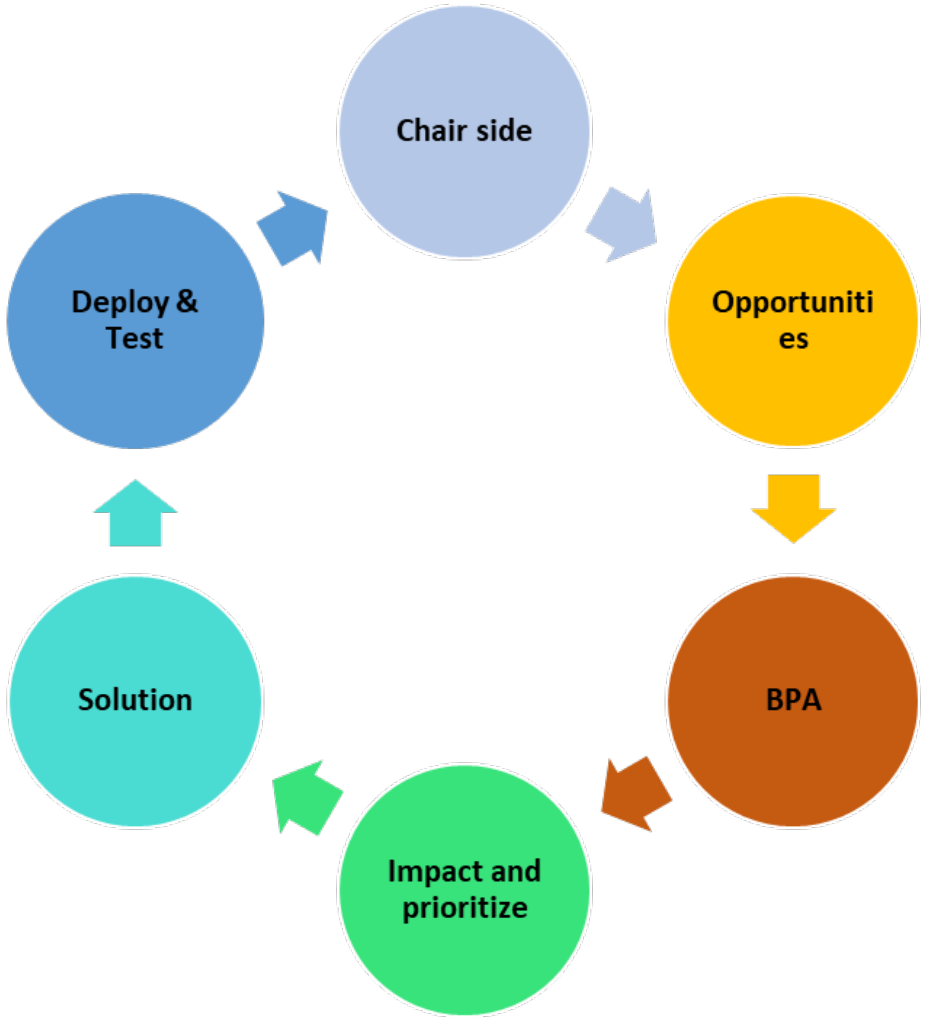
Note: Use of AI related to Clinical Decisions are out of scope for this initiative.



Our Approach and Life Cycle

- Launched in May 2024.
- Conducted chairside meetings
- Discovered 19 opportunities within the initial 4 months
- Candidate for Business Process Automation (BPA)
- Evaluated impact and set priorities
- Brainstormed technology solutions
- Created Delivery Roadmap

Note: New use cases are identified during each phase of chairside meetings.

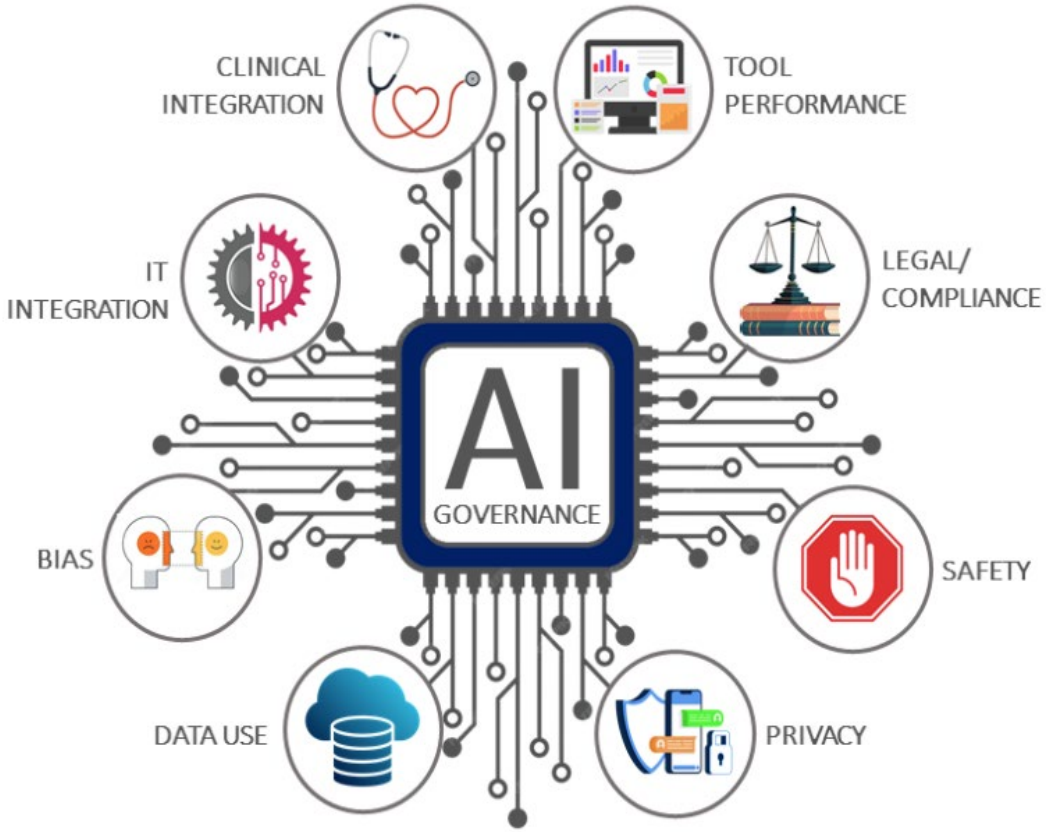


Technology Solution Assessment

- Analyze use cases for business process automation
- Identify the necessity for an AI solution
- Evaluate internal capabilities compared to external market options
- Decide on the final approach (Build or Buy)

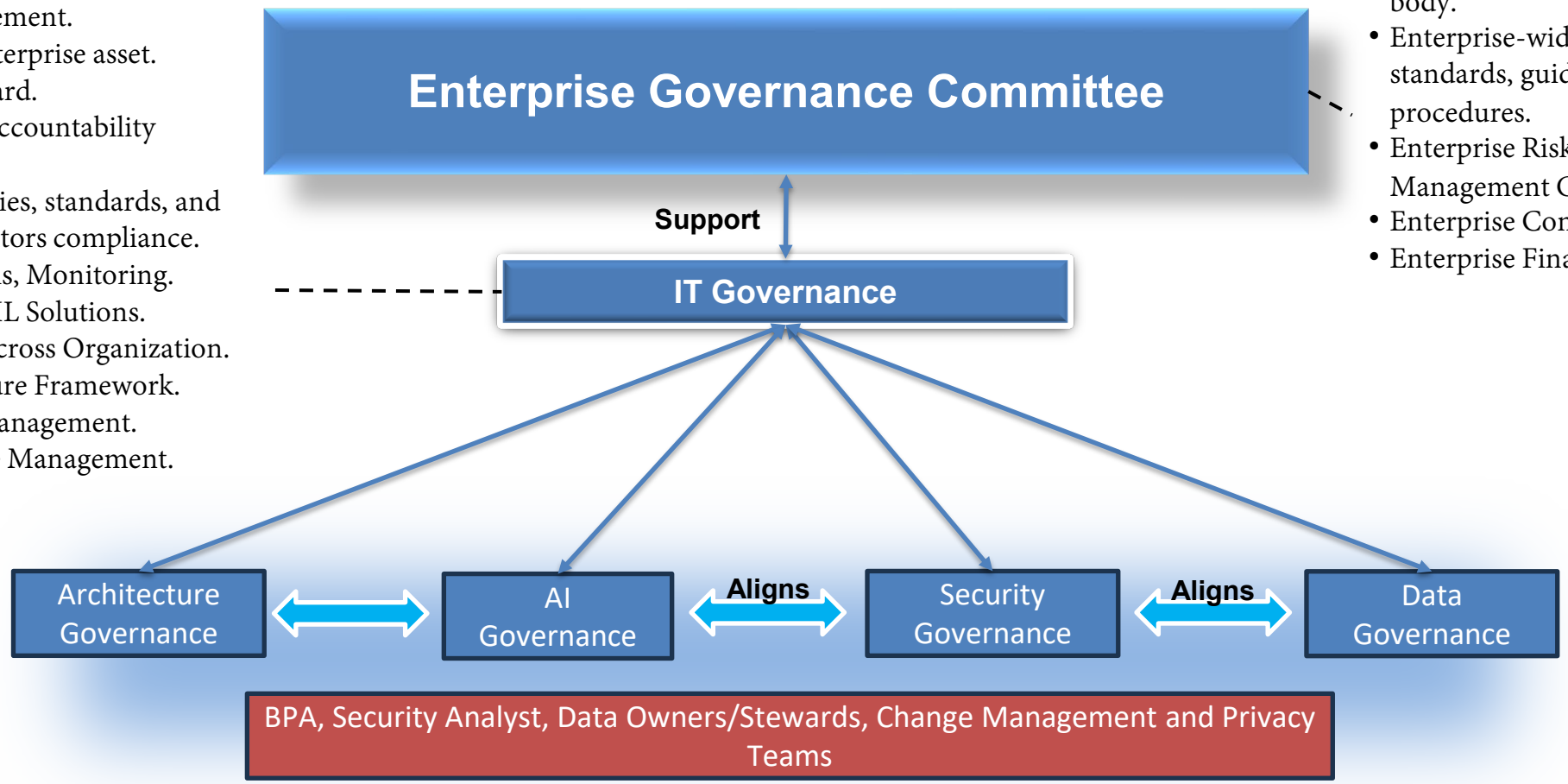
AI Governance Strategy

- AI Policy & Procedure
- AI Methodology & Governance
- Identification of AI Models
- Accountability & Decision Making
- Monitoring and Surveillance
- Regulatory Compliance Requirements
- Annual Risk Assessment and Remediation
- Awareness and Training



AI Governance Structure (Work in Progress)

- Security & AI Framework.
- Security Risk Management.
- Managing data as Enterprise asset.
- Change Advisory Board.
- Decision rights and accountability framework.
- Formalizes data policies, standards, and procedures and monitors compliance.
- Adoptions of AI Tools, Monitoring.
- Performance of AI/ML Solutions.
- Define AI activities across Organization.
- Enterprise Architecture Framework.
- Enterprise Release Management.
- IT Product Life Cycle Management.
- DevOps/SDLC.



- Approval and decision-making body.
- Enterprise-wide principles, policies, standards, guidelines, and procedures.
- Enterprise Risk & Compliance Management Committee.
- Enterprise Consumer Committee.
- Enterprise Finance Committee.

Note: Based on Gartner AI Framework tailored for AAH and currently in Development phase.

** SDLC - Software Development Life Cycle ; * ML- Machine Language*

Workflow Automation Success Stories

- Roll-out Co-pilot to 140+ staff members
- Inpatient (IP) and Outpatient (OP) authorization paper/fax integration using OpenAI solution
- Regression Testing of Core Systems and Process
- G&A and PDR Letter Generation and Mailing
- Auto Authorization via Provider Portal
- Member Enrollment and Engagement workflow
- HIF/MET & AOR Form Mailing
- Health Education and Interpreter Services Automation
- AI powered real time monitoring of network traffic
- ML algorithm to reduce vulnerability, security threats and notifications
- IT assets management (Pilot)

Workflow Automation Efficiency Metrics

Uses Case 1: Co-Pilot Rollout

Features and Capabilities:

- ✓ Draft, edit and summarization of documents
- ✓ Coverts users spoken idea into dynamic slideshow
- ✓ Analyzes the data and generates advanced visualization
- ✓ Manages your emails efficiently and drafts communication.
- ✓ Summarizes minutes of meeting and outlines actional tasks.
- ❖ Accelerating Code development
- ❖ Natural Language Integration within SDLC
- ❖ Security Workflow Integration

Engagement: Total Rolled Out

140+ Staff

Efficiency Usage in Percentage

63%

Savings in Hrs/Month

1500 Hrs

Workflow Automation Efficiency Metrics

Uses Case 2: Paper to Electronic AI Integrated Solution

Features and Capabilities:

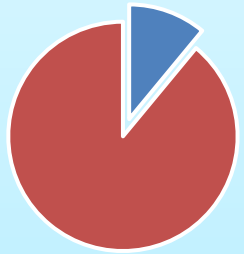
- ✓ Inpatient Authorization Intake
- ✓ Interpreter Services
- ✓ DSNP Enrollment Form
- ✓ FaceSheet Forms (Replace DocuStream in 90 days)
- ✓ Outpatient Authorization Intake
- ❖ DSNP Enrollment and Consumer Engagement Forms
- ❖ AOR and HIF/MET Member Correspondence Forms

Total Intakes Processed in Last 6 months

~15,000 Units

Efficiency Usage in Percentage

89%



Savings in Hrs/Month

1100 Hrs

In-Addition Potential Cost Savings

$115K Annually

Workflow Automation Efficiency Metrics

Uses Case 3: System Quality Testing Automation

Features and Capabilities:

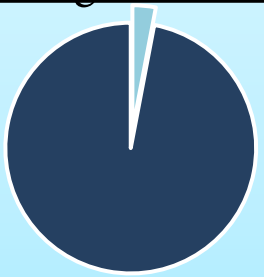
- ✓ Regression Testing
- ✓ Smoke Testing
- ✓ Test Case Dictionary

Systems Included

7 Core Systems

Execution Efficiency Usage in Percentage

97%



Savings in Hrs/Month

~400+ Hrs

Our 3 Years Road Map

ALAMEDA Alliance FOR HEALTH

- Member and Provider Service Call Center AI ecosystem
- Call Center and Member 360 Automation
- IT Service Desk Chat Bot
- Accelerating Code development
- Data Exchange Ecosystem Workflow Processes
- Predictive Modeling
- Predictive Modeling
- Finance Division Workflow Automation
- AI Natural Language Integration within SDLC, Structured and Unstructured Date Process
- Compliance/Regulatory AI Tool
- Claims Refund Check Automation
- Advanced Cyber-AI Dashboard
- Mail Room OCR integration using OpenAI
- AI Chat to Interact with Rational Database (Prototype)

Thank You!

ALAMEDA Alliance FOR HEALTH

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

HEDIS Update

HEDIS Update

Board of Governors (BOG) Meeting

October 10, 2025

Tiffany Cheang, Chief Analytics Officer
Dr. Donna Carey, Chief Medical Officer

Oversight & Accountability

- DHCS Medi-Cal Accountability Set (MCAS)
  - Quality Component Withhold & Incentive Program
  - Sanctions
  - Auto-Assignment
- DMHC Health Equity & Quality Measure Set (HEQMS)
- NCQA Accreditation – Health Plan
- Future: CMS and Stars Measures

DHCS Medi-Cal Accountability Set (MCAS)

- Measures held to MPL fall into 5 domains:
  - Behavioral Health
  - Children's Health
  - Chronic Disease
  - Reproductive Health
  - Cancer Prevention

Measurement Year (MY)	Measures Reported	Measures Held to MPL
MY 2021	36	15
MY 2022	39	15
MY 2023	42	18
MY 2024	41	18
MY 2025	31	18

Decrease in MY2025 measures is for "Report Only" measures.

- As of MY2022, DHCS will no longer calculate the Aggregated Quality Factor Score (AQFS).
  - This score was previously used by DHCS to compare all Medi-Cal plans.

Minimum Performance Level (MPL) is the 50th percentile.

MCAS MPL Measures by Domain

Domain	Measurement Year						
	2022		2023		2024		2025
	Total Measures	Measures Met	Total Measures	Measures Met	Total Measures	Measures Met	Total Measures
Behavioral Health	2	1	2	1	2	2	2
Children's Health	6	4	8	6	8	7	8
Chronic Disease Managemer	2	1	3	3	3	1	3
Reproductive Health	3	3	3	3	3	3	3
Cancer Prevention	2	1	2	2	2	2	2
All Domains	**15**	**10**	**18**	**15**	**18**	**15**	**18**
% Met MPL		67%		83%		83%	

AAH MCAS Performance – MY2023

- Three (3) measures did not meet MPL
  - Lead Screening in Children
  - Topical Fluoride in Children
  - 30-day follow-up After ED Visit for Mental Illness
- Medical Record Retrievals (MRR) completed rate was 98%
- DHCS Quality Sanction imposed
  - Triggered by 2 measures within a single domain (Children's Health)
  - Original sanction amount $72,000 was reduced to $37,500 based on AAH's supporting rationale/evidence for missing the TFL measure.

AAH MCAS Performance – MY2024

- Three (3) measures did not meet MPL
  - Controlling High Blood Pressure
  - Asthma Medication Ratio
  - Topical Fluoride in Children
- Medical Record Retrievals (MRR) completed rate was 97%
- DHCS Quality Sanction
  - Official sanction not yet received from DHCS
  - Projected sanction:
    - Triggered by 2 measures within a single domain (Chronic Disease Management)
    - Sanction amount = ~$80,000

AAH MCAS Performance – MY2025

- As of 9/10/2025, 6 measures are not meeting MPL
  - 4 months remaining in the measurement year
  - 2 are hybrid measures
- Year-round Medical Record Retrievals (MRR) in progress
- NCQA and DHCS HEDIS audits passed successfully
- Rates will be finalized in June 2026

MCAS MY2025 By Measure

Measure Description		MY2024	MY2025 As of 9/10/2025	50th Pctl (MPL)
Behavioral Health	Follow-Up After Emergency Department Visit for Substance Use (30-Day)	44.48%	52.86%	36.18%
	Follow-Up After Emergency Department Visit for Mental Illness (30-Day)	66.38%	72.57%	53.82%
Children's Health	Childhood Immunization Status—Combination 10	43.80%	34.30%	24.34%
	Developmental Screening in the First Three Years of Life	64.63%	61.71%	35.70%
	Immunizations for Adolescents—Combination 2	47.45%	44.85%	33.31%
	Lead Screening in Children	67.88%	68.82%	63.84%
	Topical Fluoride for Children	17.74%	3.38%	19.00%
	Well-Child Visits in the First 15 Months - Six or More Well-Child Visits	66.69%	53.58%	60.38%
	Well-Child Visits for Age 15 Months to 30 Months -Two or More Well-Child Visits	77.73%	74.88%	69.43%
	Child and Adolescent Well-Care Visits	55.88%	39.61%	51.81%
Chronic Disease Management	Asthma Medication Ratio	63.18%	69.38%	66.24%
	Controlling High Blood Pressure	60.10%	50.23%	64.48%
	Hemoglobin A1c Control for Patients with Diabetes—HbA1c Poor Control >9%	28.95%	42.46%	33.33%
Reproductive Health	Chlamydia Screening in Women	70.04%	61.82%	55.95%
	Prenatal and Postpartum Care - Timeliness of Prenatal Care	91.28%	85.43%	84.55%
	Prenatal and Postpartum Care - Postpartum Care	92.44%	83.58%	80.23%
Cancer Prevention	Breast Cancer Screening	59.62%	56.66%	52.68%
	Cervical Cancer Screening	59.37%	49.95%	51.88%

Initiatives/Activities

- Member Mailers -> Birthday cards, Breast Cancer Screening (BCS) flyers
- Member Outreach calls -> CCS, BCS, TFL, CBP
- Member Incentives -> HEDIS Crunch, Well-child, CCS, BCS
- Provider webinars/training -> self-collection for HPV, training with Pharmacy on AMR, CBP and Diabetes
- Provider incentives -> After hours, Office staff, Fluoride Varnish, P4P, grant funded QI projects
- Provider Support -> Practice Facilitation, Coding Support, Workflow Optimization, Enhanced reporting
- Provider collaborations -> Mobile mammography, Pap clinics, CHW navigators for ED follow-up, Lead screening point of care testing
- Campaigns -> Colorectal cancer screening (COL) home kits, Community health fair education on health screenings with focus on African American community
- Expanded year-round record retrievals
- EHR extract improvements
- Inclusion of HIE NCQA DAV certified data
- Actionable care gap reports; pharmacy reports for AMR, CBP and A1c

Questions??

Definitions

- MY = Measurement Year
- HEDIS = Healthcare Effectiveness Data and Information Set
- MCAS = Medi-Cal Accountability Set (DHCS)
- HEQMS = Health Equity and Quality Measure Set (DMHC)
- AQFS = Aggregated Quality Factor Score (DHCS)
- MPL = Minimum Performance Level
- HPL = High Performance Level
- NCQA = National Committee for Quality Assurance
- P4P = Pay for Performance
- MRR = Medical Record Retrieval

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**

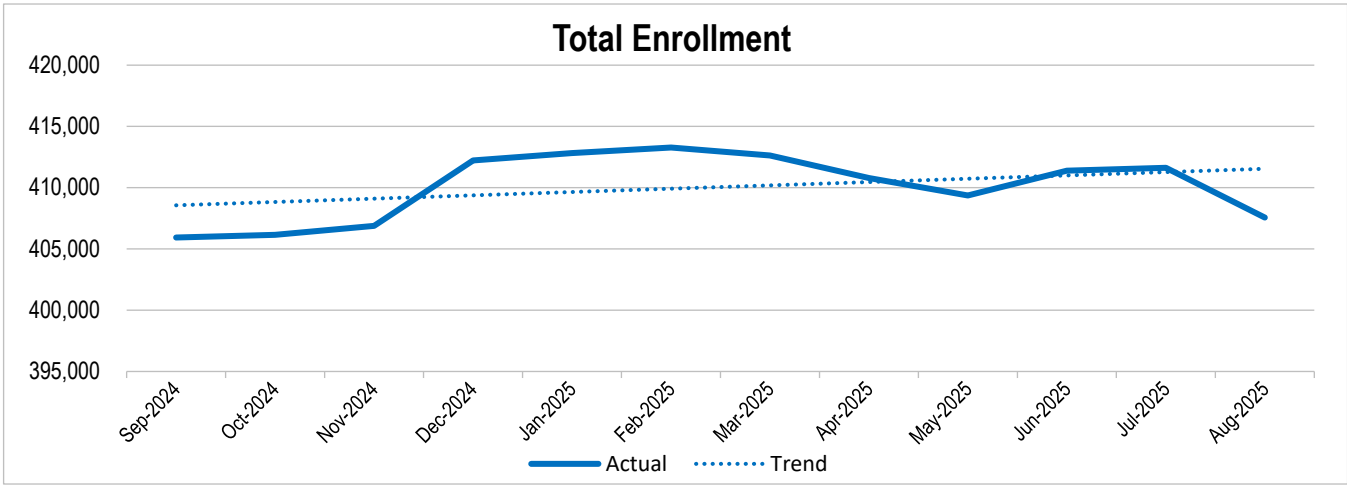
Date: **October 10, 2025**

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

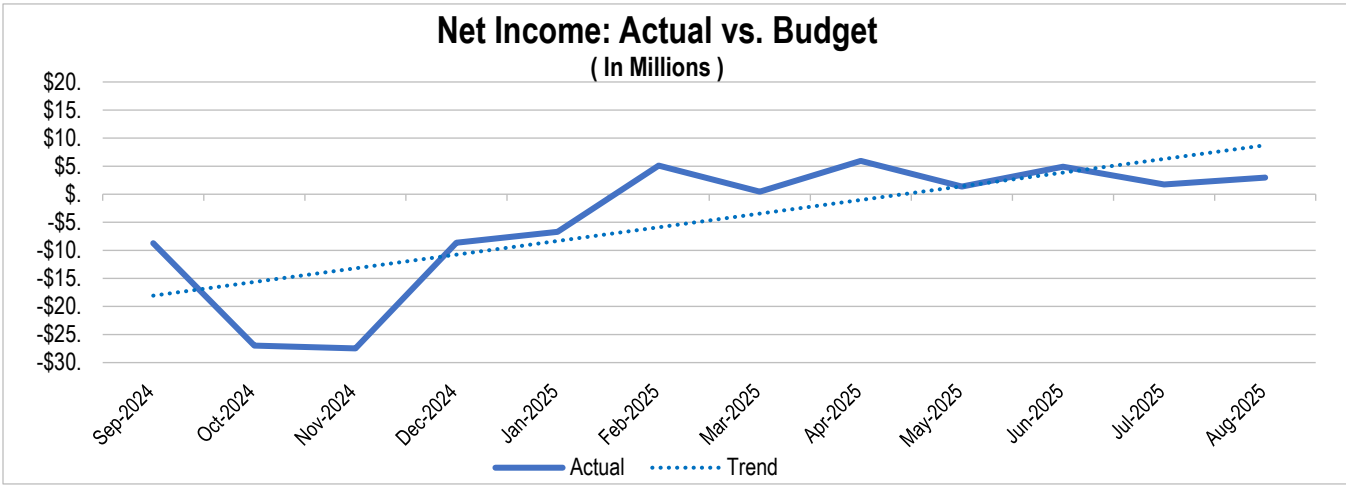
Executive Summary

For the month of August, the Alliance increased in enrollment, reaching 407,561 members. Net Income of $3.0 million was reported, and the Plan's Medical Expenses represented 93.4% of Premium Revenue. Alliance reserves increased slightly to 217% of required and continue to remain above minimum requirements.

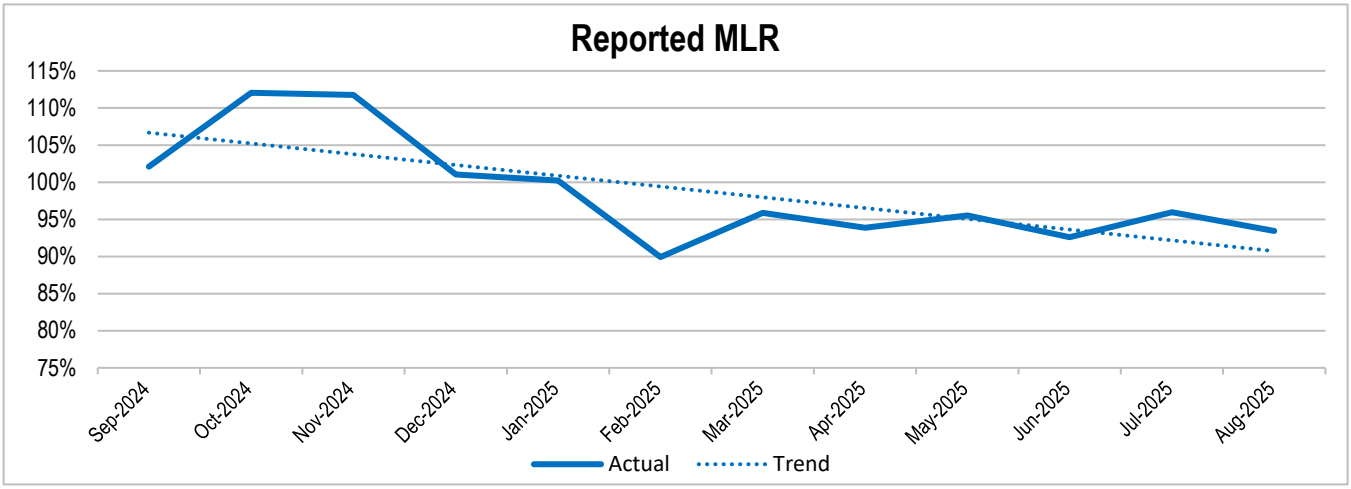
Enrollment – In August, Enrollment decreased by 4,058 members.



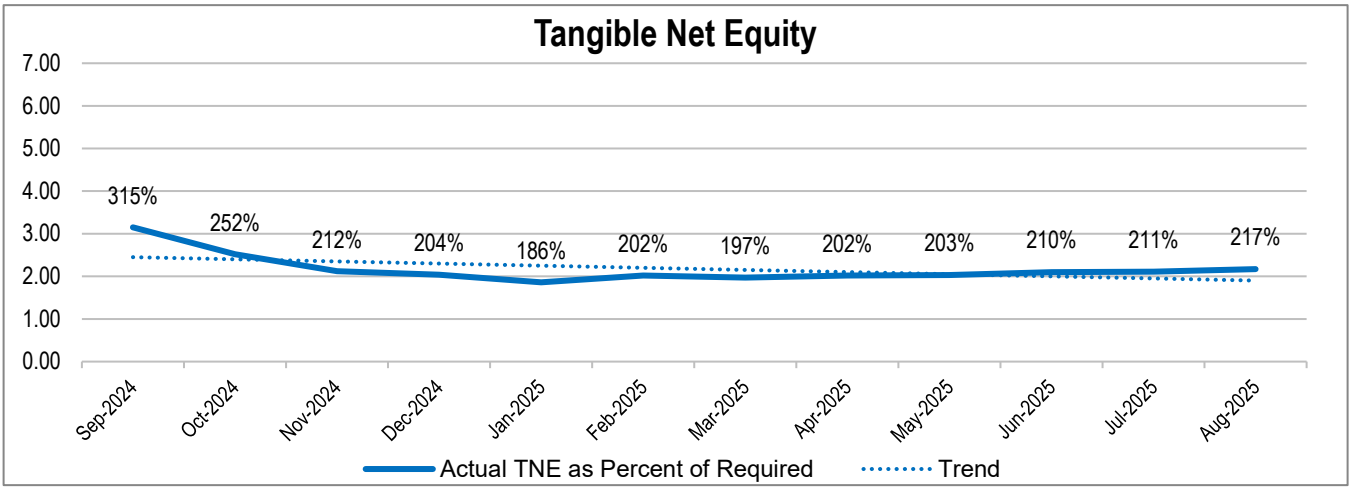
Net Income – For the month ended August, actual Net Income was $3.0 million vs. budgeted Net Loss of $540,000. For the fiscal YTD, actual Net Income was $4.7 million vs. budgeted Net Income of $6.6 million. For the month, Premium Revenue was favorable to budget, actual Revenue was $188.9 million vs. budgeted Revenue of $186.8 million. Premium Revenue favorable variance of $2.1 million is primarily due to rate variance for the current month, retroactive member months, and volume variance for the current month.



Medical Loss Ratio (MLR) – The Medical Loss Ratio was 93.4% for the month, and 94.7% for fiscal YTD. The major unfavorable variances include Other Benefits & Services and Capitated Expenses. The major favorable variances include Inpatient Hospital Expense and Pharmacy Expense.



Tangible Net Equity (TNE) - The Department of Managed Health Care (DMHC) required $80.2 million in reserves, we reported $174.0 million. Our overall TNE remains above DMHC requirements at 217%.



The Alliance continues to benefit from increased non-operating income. For Fiscal year-to-date, investments show a gain of $5.3 million and capital assets acquired are $0.

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

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

Date: **October 7th, 2025**

Subject: **Finance Report – August 2025**

Executive Summary

- For the month ended August 31st, 2025, the Alliance had enrollment of 407,561 members, a Net Income of $3.0 million and 217% of required Tangible Net Equity (TNE).

Overall Results: (in Thousands)

	Month	YTD
Revenue	$189,091	$446,735
Medical Expense	176,531	360,873
Admin. Expense	11,884	20,757
MCO Tax Expense	173	65,712
Other Inc. / (Exp.)	2,448	5,286
Net Income	**$2,950**	**$4,678**

Net Income by Program: (in Thousands)

	Month	YTD
Medi-Cal	$4,016	$6,123
Group Care	(231)	(217)
Medicare	(835)	(1,228)
	$2,950	**$4,678**

Enrollment

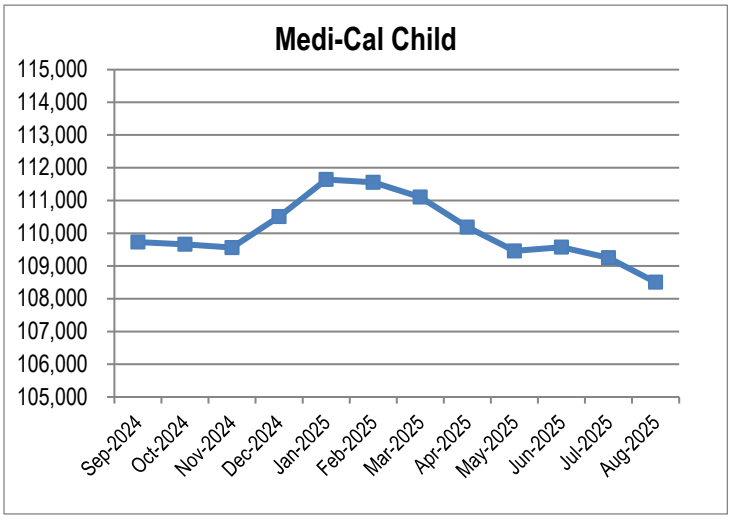
- Total enrollment decreased by 4,058 members since July 2025.
- Total enrollment decreased by 3,822 members since June 2025.

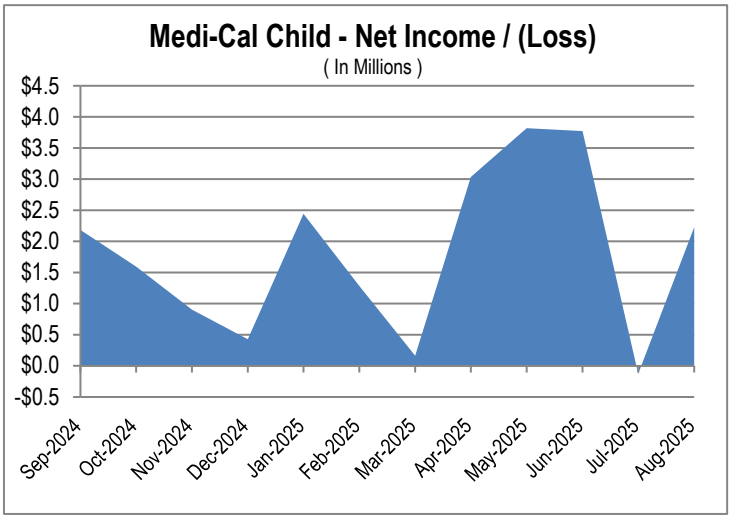
Monthly Membership and YTD Member Months
Actual vs. Budget

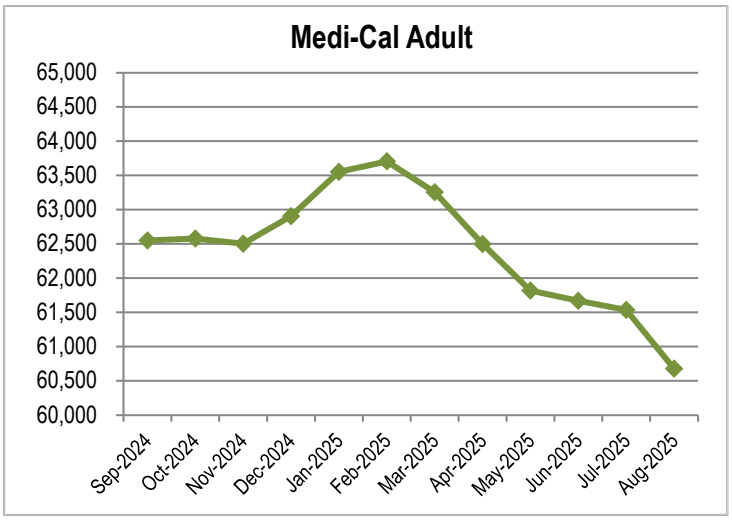
Enrollment					Member Months			
Current Month					Year-to-Date			
Actual	Budget	Variance	Variance %		Actual	Budget	Variance	Variance %
				Medi-Cal:				
108,503	108,602	(99)	(0.1%)	Child	217,754	217,442	312	0.1%
60,679	61,331	(652)	(1.1%)	Adult	122,215	122,753	(538)	(0.4%)
153,348	153,025	323	0.2%	ACA OE	308,881	306,342	2,539	0.8%
29,686	29,276	410	1.4%	SPD with LTC*	59,519	58,611	908	1.5%
49,371	48,566	805	1.7%	Duals with LTC*	98,880	97,253	1,627	1.7%
401,587	**400,800**	**787**	**0.2%**	**Medi-Cal Total**	**807,249**	**802,401**	**4,848**	**0.6%**
5,974	5,887	87	1.5%	Group Care	11,931	11,774	157	1.3%
407,561	**406,687**	**874**	**0.2%**	**Total**	**819,180**	**814,175**	**5,005**	**0.6%**

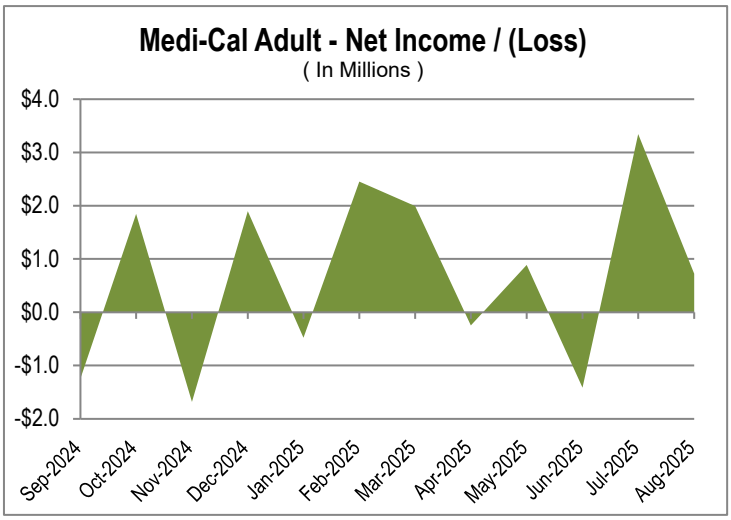
*As of January 2025, service month, "SPD", "Duals", "LTC", and "LTC Duals" will be discontinued. Effective January 2025 service month new consolidated groupings will be "SPD with LTC" and "Duals with LTC".

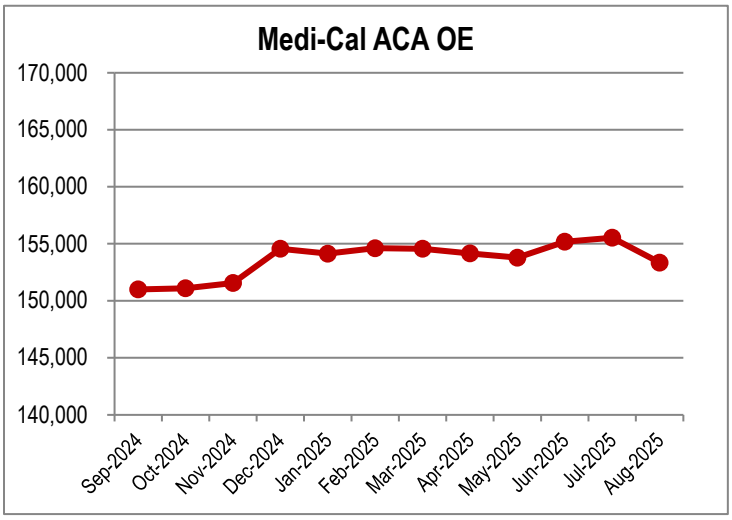
Enrollment and Profitability by Program and Category of Aid

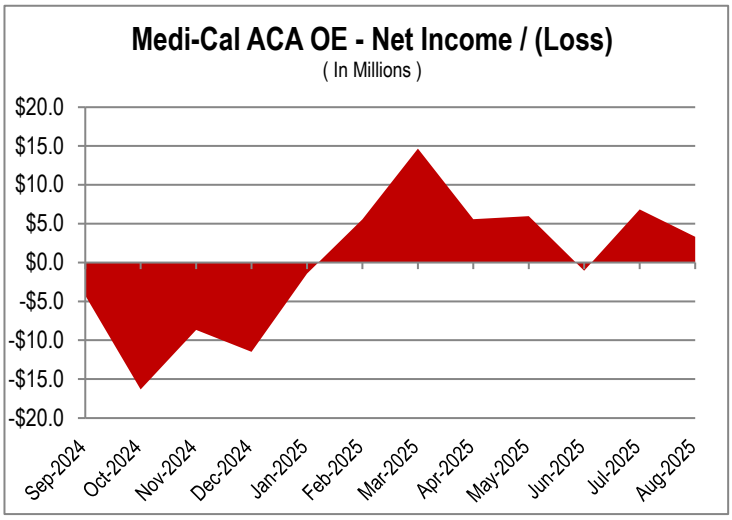




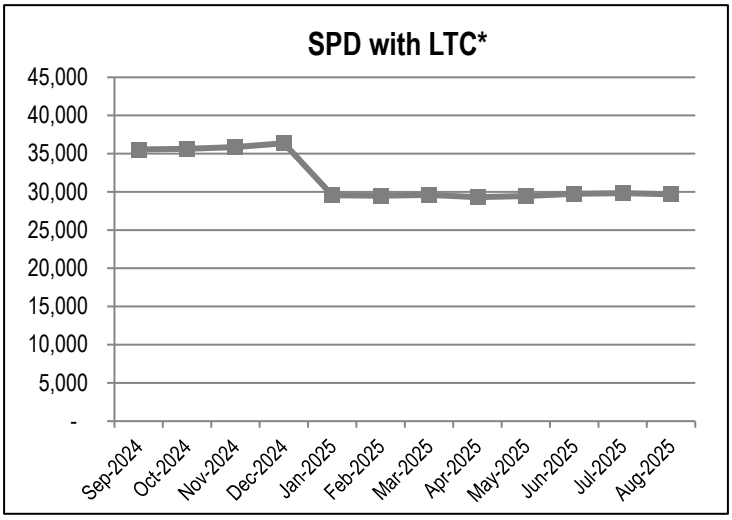


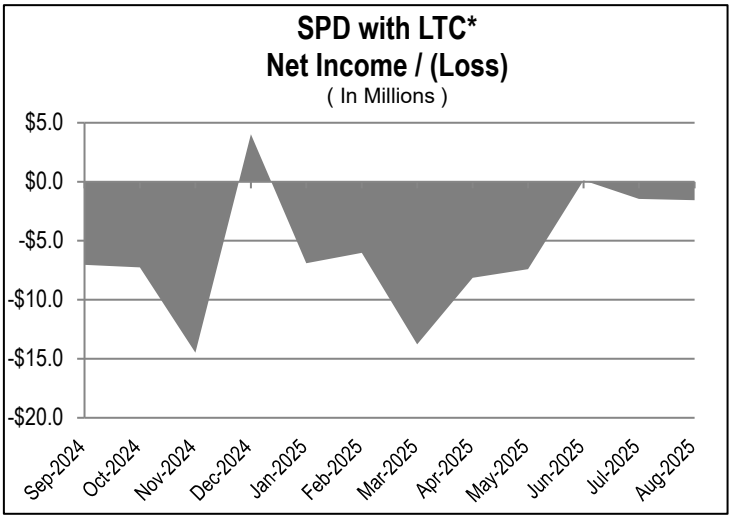


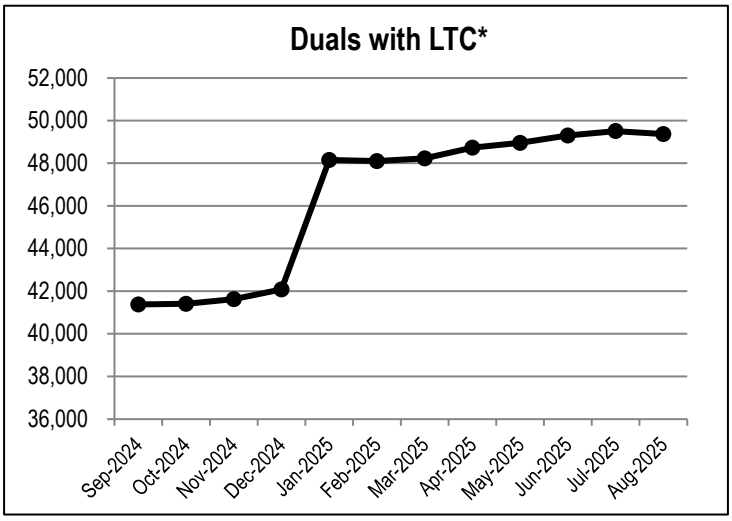


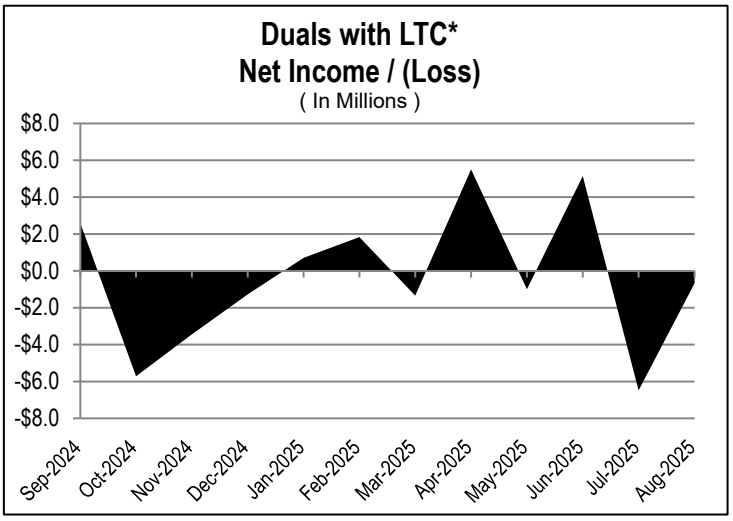


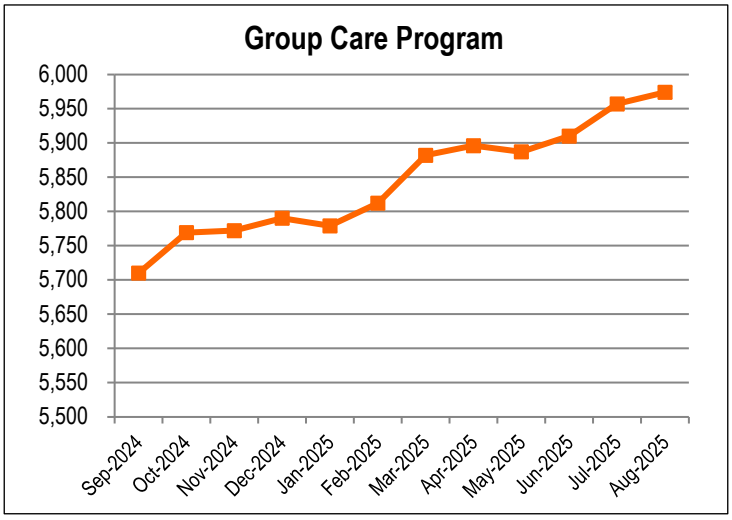
Enrollment and Profitability by Program and Category of Aid

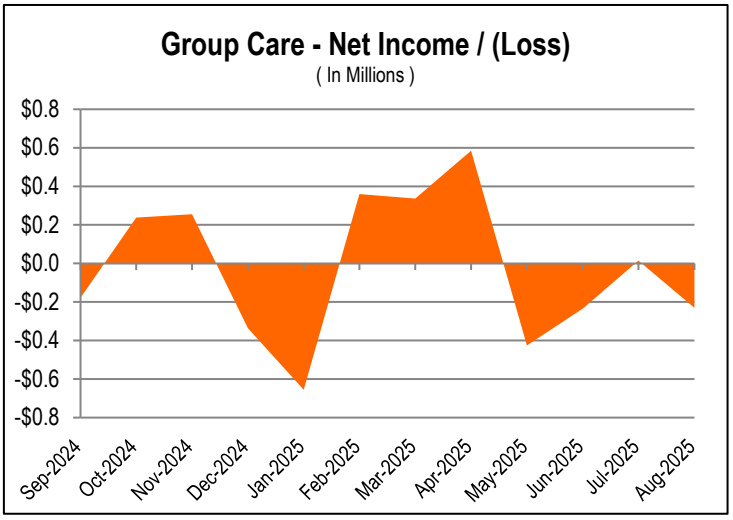




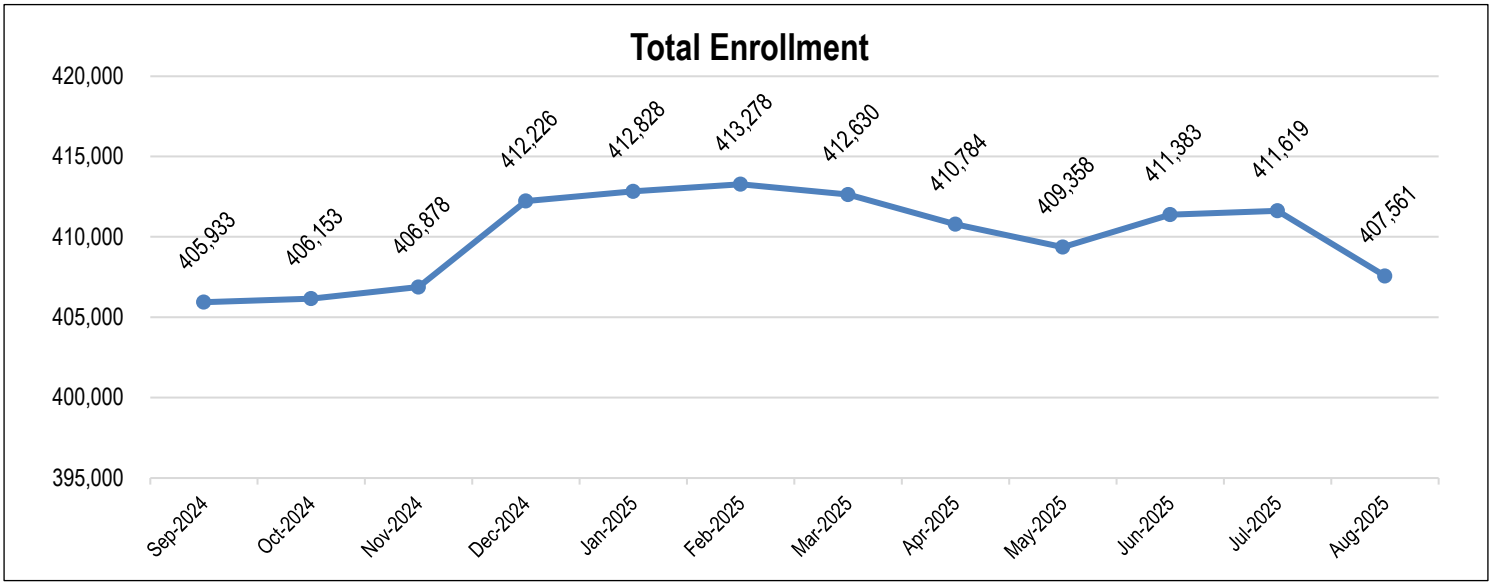


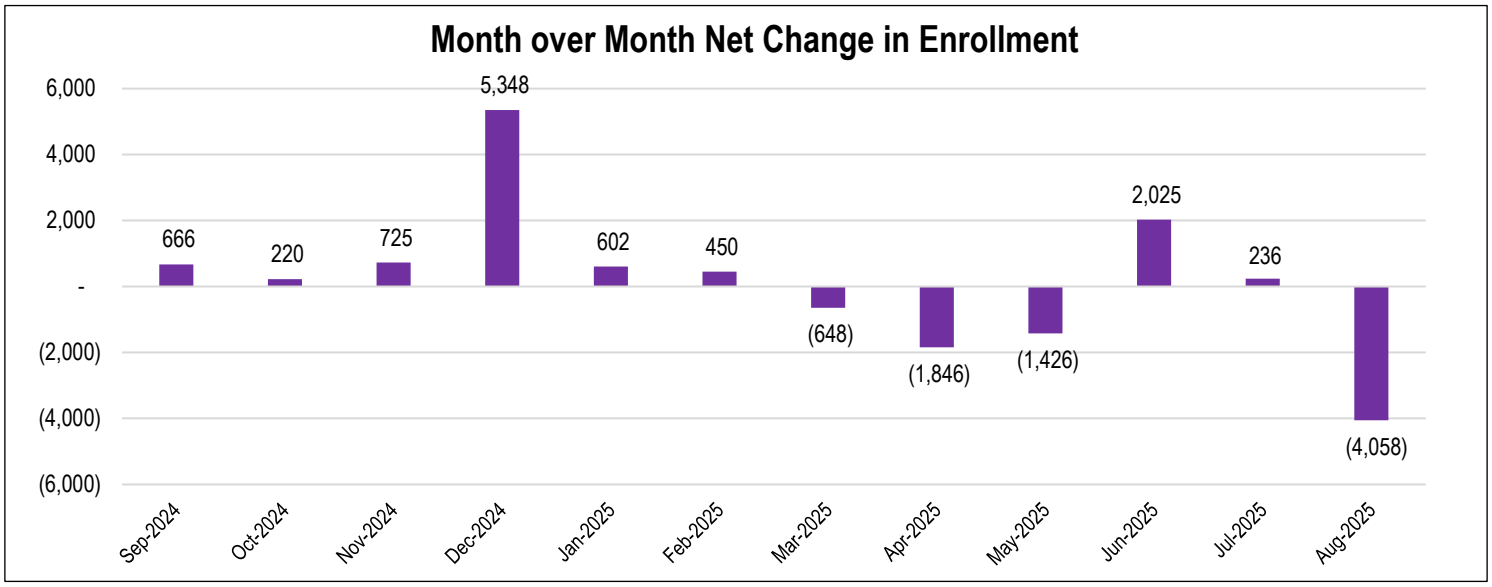






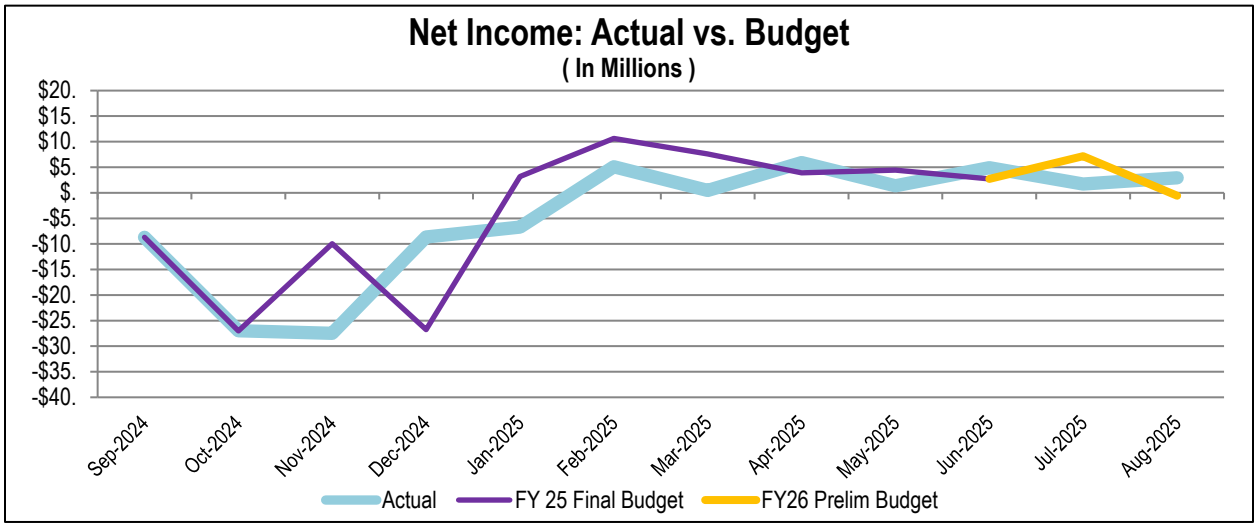
Enrollment and Profitability by Program and Category of Aid





Net Income

- For the month ended August 31st, 2025:
  - Actual Net Income: $3.0 million.
  - Budgeted Net Loss: $540,000.
- For the fiscal YTD ended August 31st, 2025:
  - Actual Net Income $4.7 million.
  - Budgeted Net Income $6.6 million.

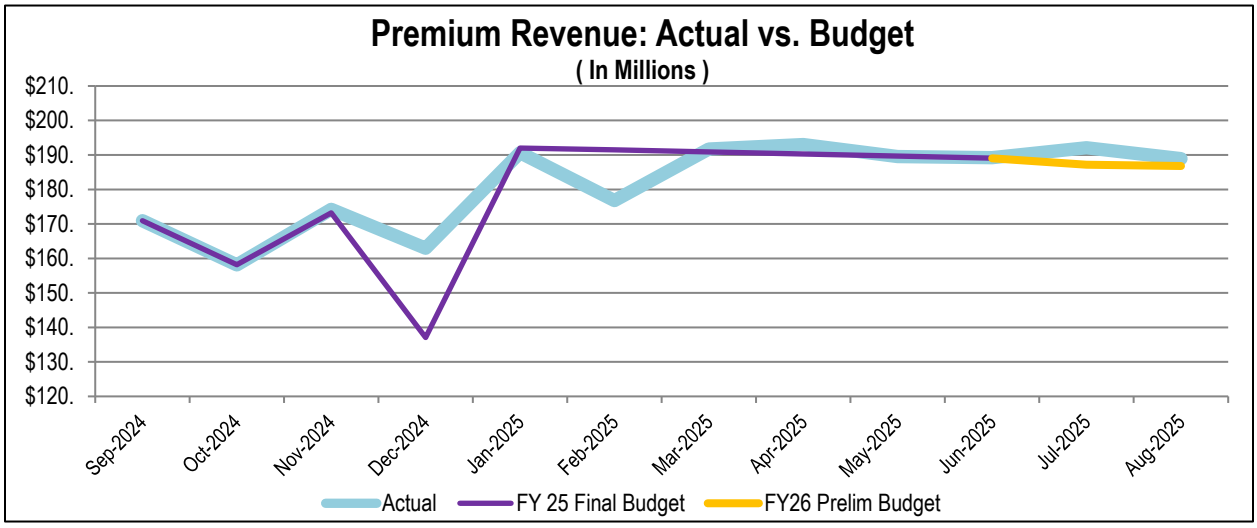


The favorable variance of $3.5 million in the current month is primarily due to:

- Favorable $3.2 million lower than anticipated Medical Expense.
- Favorable $2.1 million higher than anticipated Premium Revenue.
- Unfavorable $2.3 million higher than anticipated Administrative Expense.

Premium Revenue

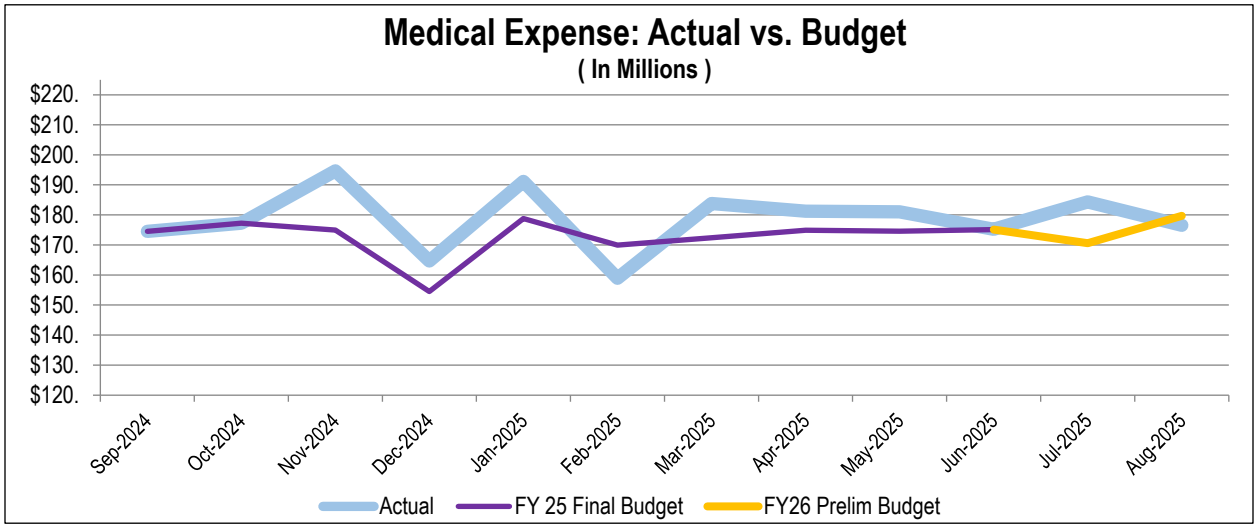
- For the month YTD ended August 31st, 2025:
  - Actual Revenue: $188.9 million.
  - Budgeted Revenue: $186.8 million.
- For the fiscal YTD ended August 31st, 2025:
  - Actual Revenue: $381.0 million.
  - Budgeted Revenue: $374.0 million.



- For the month ended August 31st, 2025, the favorable Premium Revenue variance of $2.1 million is primarily due to the following:
    - Favorable Volume Variance for current month.
    - Favorable Retroactive member months.

Medical Expense

- For the month ended August 31st, 2025:
    - Actual Medical Expense: $176.5 million.
    - Budgeted Medical Expense: $179.7 million.
- For the fiscal YTD ended August 31st, 2025:
    - Actual Medical Expense: $360.9 million.
    - Budgeted Medical Expense: $350.3 million.



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

- For August, updates to Fee-For-Service (FFS) decreased the estimate for prior period unpaid Medical Expenses by $6.3 million. Year to date, the estimate for prior years decreased by $6.5 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	$40,706,193	$0	$40,706,193	$34,530,662	($6,175,531)	(17.9%)
Primary Care FFS	$11,111,029	($81,139)	$11,029,890	$8,870,605	($2,240,424)	(25.3%)
Specialty Care FFS	$17,708,751	$1,057,516	$18,766,267	$16,372,762	($1,335,989)	(8.2%)
Outpatient FFS	$27,977,566	$4,156,228	$32,133,794	$25,614,150	($2,363,416)	(9.2%)
Ancillary FFS	$37,608,350	$521,715	$38,130,065	$38,945,833	$1,337,483	3.4%
Pharmacy FFS	$11,669,724	($290,127)	$11,379,598	$17,720,154	$6,050,430	34.1%
ER Services FFS	$22,415,391	$1,311,074	$23,726,465	$22,083,050	($332,340)	(1.5%)
Inpatient Hospital FFS	$114,262,215	($14,912,139)	$99,350,075	$109,359,392	($4,902,823)	(4.5%)
Long Term Care & SNF FFS	$72,866,602	$1,723,550	$74,590,152	$77,077,021	$4,210,419	5.5%
Other Benefits & Services	$7,021,865	$0	$7,021,865	($1,276,904)	($8,298,769)	(649.9%)
Net Reinsurance	$1,379,699	$0	$1,379,699	$1,025,062	($354,636)	(34.6%)
Provider Incentive	$2,659,099	$0	$2,659,099	$0	($2,659,099)	-
	$367,386,484	**($6,513,322)**	**$360,873,162**	**$350,321,789**	**($17,064,694)**	**(4.9%)**

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

Adjusted to Eliminate the Impact of Prior Year IBNP Estimates

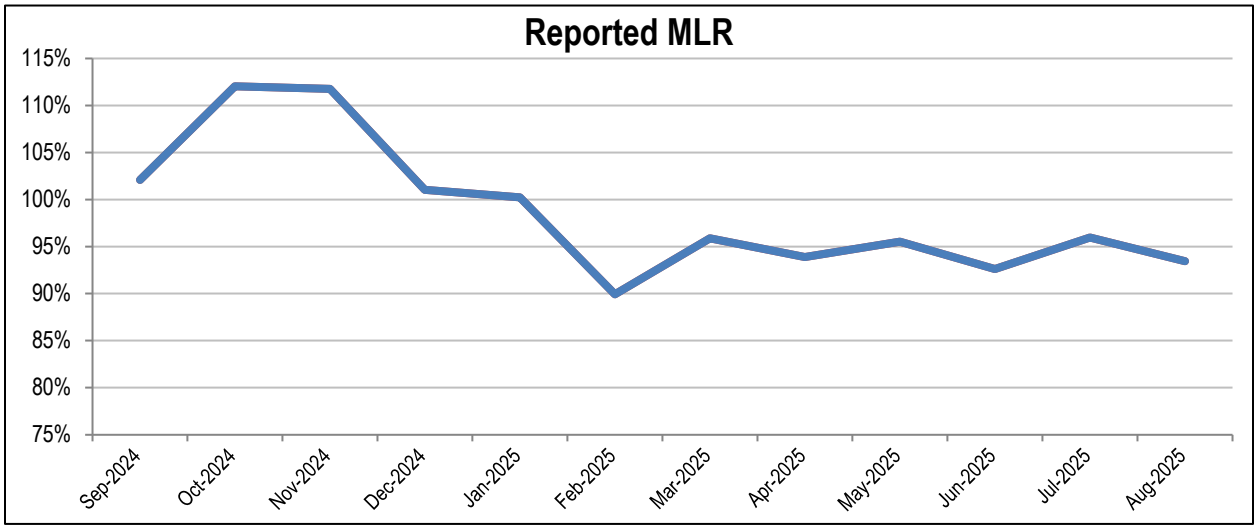
	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$49.69	$0.00	$49.69	$42.41	($7.28)	(17.2%)
Primary Care FFS	$13.56	($0.10)	$13.46	$10.90	($2.67)	(24.5%)
Specialty Care FFS	$21.62	$1.29	$22.91	$20.11	($1.51)	(7.5%)
Outpatient FFS	$34.15	$5.07	$39.23	$31.46	($2.69)	(8.6%)
Ancillary FFS	$45.91	$0.64	$46.55	$47.83	$1.92	4.0%
Pharmacy FFS	$14.25	($0.35)	$13.89	$21.76	$7.52	34.5%
ER Services FFS	$27.36	$1.60	$28.96	$27.12	($0.24)	(0.9%)
Inpatient Hospital & SNF FFS	$139.48	($18.20)	$121.28	$134.32	($5.16)	(3.8%)
Long Term Care & SNF FFS	$88.95	$2.10	$91.05	$94.67	$5.72	6.0%
Other Benefits & Services	$8.57	$0.00	$8.57	($1.57)	($10.14)	(646.6%)
Net Reinsurance	$1.68	$0.00	$1.68	$1.26	($0.43)	(33.8%)
Provider Incentive	$3.25	$0.00	$3.25	$0.00	($3.25)	-
	$448.48	**($7.95)**	**$440.53**	**$430.28**	**($18.20)**	**(4.2%)**

- Excluding the impact of prior year estimates for IBNP, year-to-date medical expense variance is $17.1 million unfavorable to budget. On a PMPM basis, medical expense is 4.2% unfavorable to budget. For per-member-per-month expense:
    - Capitated Expense is over budget due to inclusion of Targeted Rate Increases (TRI) in capitation payments.
    - Primary Care Expense is over budget due to the exclusion of Targeted Rate Increases (TRI) from FFS expense.

- Specialty Care Expense is above budget, driven by higher utilization in the SPD with LTC aid code category offset by lower utilization in the Duals categories of aid.
- Outpatient Expense is over budget mostly driven by lab and radiology unit cost and facility other and dialysis utilization.
- Ancillary Expense is over budget due to low utilization and unit cost in the Duals with LTC category of aid.
- Pharmacy Expense is under budget due to an accrual for recoveries related to hospital administered drug overpayments made to UCSF.
- Emergency Expense is slightly under budget driven by high utilization in the SPD with LTC category of aid.
- Inpatient Expense is over budget driven by utilization in the Adult and SPD with LTC categories of aid and ACA OE category of aid unit cost.
- Long Term Care Expense is under budget due to low utilization in the Duals with LTC Duals categories of aid.
- Other Benefits & Services is over budget, due to higher than expected CalAIM and HHIP expense.
- Net Reinsurance is over budget because less recoveries were received than expected.

Medical Loss Ratio (MLR)

The Medical Loss Ratio (total reported Medical Expense divided by Premium Revenue) was 93.4% for the month and 94.7% for the fiscal year-to-date.



Administrative Expense

- For the month ended August 31st, 2025:
  - Actual Administrative Expense: $11.9 million.
  - Budgeted Administrative Expense: $9.6 million.
- For the fiscal YTD ended August 31st, 2025:
  - Actual Administrative Expense: $20.8 million.
  - Budgeted Administrative Expense: $21.0 million.

o

Summary of Administrative Expense (In Dollars) For the Month and Fiscal Year-to-Date Favorable/(Unfavorable)								
Current Month					Year-to-Date			
Actual	Budget	Variance $	Variance %		Actual	Budget	Variance $	Variance %
$6,535,600	$5,865,349	($670,251)	(11.4%)	Personnel Expense	$12,385,536	$11,543,292	($842,244)	(7.3%)
78,907	81,952	3,044	3.7%	Medical Benefits Admin Expense	156,413	164,008	7,595	4.6%
2,675,222	2,043,378	(631,844)	(30.9%)	Purchased & Professional Services	3,590,502	4,382,541	792,038	18.1%
2,593,944	1,638,095	(955,850)	(58.4%)	Other Admin Expense	4,624,245	4,957,455	333,210	6.7%
$11,883,674	$9,628,773	($2,254,901)	(23.4%)	Total Administrative Expense	$20,756,696	$21,047,296	$290,600	1.4%

The year-to-date variances include:

- Favorable in Purchased & Professional Services, primarily for the timing of Consulting Services and Other Purchased Services.
- Favorable Medical Benefit Admin Fees, primarily for the decreases in Pharmacy Admin Fees.
- Favorable Licenses, Insurance & Fees.
- Favorable Building Occupancy costs.
- Favorable Printing/Postage/Promotions.
- Partially offset by the unfavorable Employee Expense for overtime, sick leave, and benefits, as well as staffing changes including new hires and leaves of absence impacting the overall figures.
- Partially offset by Supplies & Other Expenses, primarily for the increased Provider Interest costs.

The Administrative Loss Ratio (ALR) is 6.3% of net revenue for the month and 5.4% of 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 $433,000.

Other Income / (Expense)

Other Income & Expense is comprised primarily of investment income. Fiscal year-to-date net investments show a gain of $5.3 million.

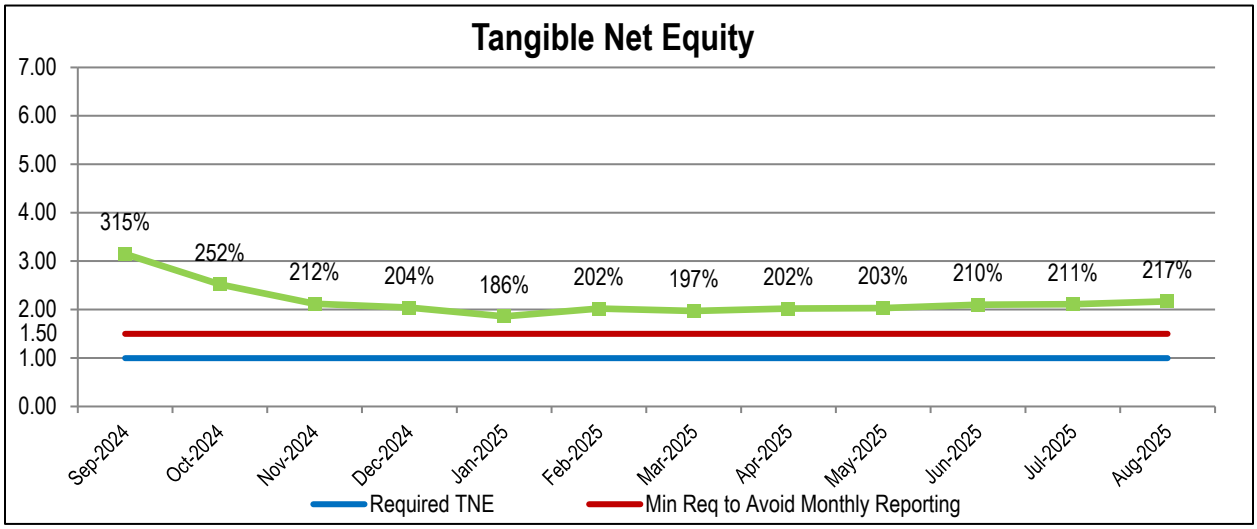
Managed Care Organization (MCO) Provider Tax

- Revenue:
  - For the month ended August 31st, 2025:
    - Actual: $173,000.
    - Budgeted: $64.8 million.
  - For the fiscal YTD ended August 31st, 2025:
    - Actual: $65.7 million.
    - Budgeted: $129.6 million.
- Expense:
  - For the month ended August 31st, 2025:
    - Actual: $173,000.
    - Budgeted: $64.8 million.

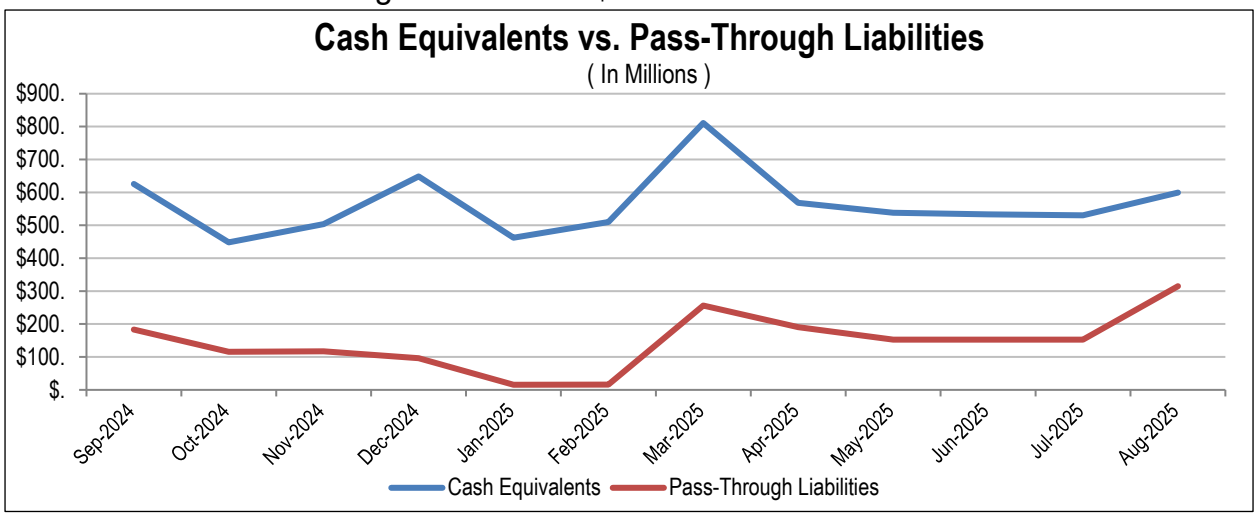
- For the fiscal YTD ended August 31st, 2025:
  - Actual: $65.7 million.
  - Budgeted: $129.6 million.

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 total liabilities divided by a percentage of fee-for-service medical expenses. The Alliance exceeds DMHC's required TNE.
  - Required TNE $80.2 million
  - Actual TNE $174.0 million
  - Excess TNE $93.7 million
  - TNE % of Required TNE 217%



- To ensure appropriate liquidity and limit risk, the majority of Alliance financial assets are kept in short-term investments.
- Key Metrics
  - Cash & Cash Equivalents $599.2 million
  - Pass-Through Liabilities $315.2 million



- Uncommitted Cash $284.0 million
- Working Capital $122.3 million
- Current Ratio 1.13 (regulatory minimum is 1.00)

Capital Investment

- Fiscal year-to-date capital assets acquired: $0.
- Annual capital budget: $1.4 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 31 AUGUST, 2025

CURRENT MONTH					FISCAL YEAR TO DATE			
		$ Variance	% Variance				$ Variance	% Variance
Actual	Budget	(Unfavorable)	(Unfavorable)	Account Description	Actual	Budget	(Unfavorable)	(Unfavorable)
				MEMBERSHIP				
401,587	400,800	787	0.2%	1. Medi-Cal	807,249	802,401	4,848	0.6%
5,974	5,887	87	1.5%	2. GroupCare	11,931	11,774	157	1.3%
407,561	**406,687**	**874**	**0.2%**	**3. TOTAL MEMBER MONTHS**	**819,180**	**814,175**	**5,005**	**0.6%**
				REVENUE				
$188,917,345	$186,809,907	$2,107,438	1.1%	4. Premium Revenue	$381,022,629	$373,995,384	$7,027,245	1.9%
$173,186	$64,753,248	($64,580,062)	(99.7%)	5. MCO Tax Revenue AB119	$65,711,939	$129,635,906	($63,923,967)	(49.3%)
$189,090,531	**$251,563,155**	**($62,472,624)**	**(24.8%)**	**6. TOTAL REVENUE**	**$446,734,568**	**$503,631,290**	**($56,896,722)**	**(11.3%)**
				MEDICAL EXPENSES				
				Capitated Medical Expenses				
$19,749,513	$17,248,868	($2,500,646)	(14.5%)	7. Capitated Medical Expense	$40,706,193	$34,530,662	($6,175,531)	(17.9%)
				Fee for Service Medical Expenses				
$43,527,298	$54,711,984	$11,184,686	20.4%	8. Inpatient Hospital Expense	$99,350,075	$109,359,392	$10,009,317	9.2%
$5,496,530	$4,433,657	($1,062,873)	(24.0%)	9. Primary Care Physician Expense	$11,029,890	$8,870,605	($2,159,285)	(24.3%)
$9,510,360	$8,186,730	($1,323,629)	(16.2%)	10. Specialty Care Physician Expense	$18,766,267	$16,372,762	($2,393,505)	(14.6%)
$19,861,534	$19,482,102	($379,432)	(1.9%)	11. Ancillary Medical Expense	$38,130,065	$38,945,833	$815,768	2.1%
$17,592,202	$12,810,263	($4,781,939)	(37.3%)	12. Outpatient Medical Expense	$32,133,794	$25,614,150	($6,519,644)	(25.5%)
$10,707,623	$11,057,465	$349,841	3.2%	13. Emergency Expense	$23,726,465	$22,083,050	($1,643,415)	(7.4%)
$6,826,649	$13,348,433	$6,521,784	48.9%	14. Pharmacy Expense	$11,379,598	$17,720,154	$6,340,556	35.8%
$36,816,506	$38,547,713	$1,731,207	4.5%	15. Long Term Care Expense	$74,590,152	$77,077,021	$2,486,869	3.2%
$150,338,703	$162,578,348	$12,239,645	7.5%	16. Total Fee for Service Expense	$309,106,307	$316,042,969	$6,936,663	2.2%
$3,781,840	($618,586)	($4,400,426)	711.4%	17. Other Benefits & Services	$7,021,865	($1,276,904)	($8,298,769)	649.9%
$1,002,331	$512,034	($490,296)	(95.8%)	18. Reinsurance Expense	$1,379,699	$1,025,062	($354,636)	(34.6%)
$1,659,099	$0	($1,659,099)	0.0%	19. Risk Pool Distribution	$2,659,099	$0	($2,659,099)	0.0%
$176,531,485	**$179,720,664**	**$3,189,179**	**1.8%**	**20. TOTAL MEDICAL EXPENSES**	**$360,873,162**	**$350,321,789**	**($10,551,373)**	**(3.0%)**
$12,559,046	**$71,842,491**	**($59,283,445)**	**(82.5%)**	**21. GROSS MARGIN**	**$85,861,406**	**$153,309,501**	**($67,448,094)**	**(44.0%)**
				ADMINISTRATIVE EXPENSES				
$6,535,600	$5,865,349	($670,251)	(11.4%)	22. Personnel Expense	$12,385,536	$11,543,292	($842,244)	(7.3%)
$78,907	$81,952	$3,044	3.7%	23. Benefits Administration Expense	$156,413	$164,008	$7,595	4.6%
$2,675,222	$2,043,378	($631,844)	(30.9%)	24. Purchased & Professional Services	$3,590,502	$4,382,541	$792,038	18.1%
$2,593,944	$1,638,095	($955,850)	(58.4%)	25. Other Administrative Expense	$4,624,245	$4,957,455	$333,211	6.7%
$11,883,674	**$9,628,773**	**($2,254,901)**	**(23.4%)**	**26. TOTAL ADMINISTRATIVE EXPENSES**	**$20,756,696**	**$21,047,296**	**$290,600**	**1.4%**
$173,186	**$64,753,248**	**$64,580,062**	**99.7%**	**27. MCO TAX EXPENSES**	**$65,711,939**	**$129,635,906**	**$63,923,967**	**49.3%**
$502,186	**($2,539,531)**	**$3,041,716**	**119.8%**	**28. NET OPERATING INCOME / (LOSS)**	**($607,228)**	**$2,626,299**	**($3,233,527)**	**(123.1%)**
				OTHER INCOME / EXPENSES				
$2,448,176	**$2,000,000**	**$448,176**	**22.4%**	**29. TOTAL OTHER INCOME / (EXPENSES)**	**$5,285,528**	**$4,000,000**	**$1,285,528**	**32.1%**
$2,950,362	**($539,531)**	**$3,489,892**	**646.8%**	**30. NET SURPLUS (DEFICIT)**	**$4,678,300**	**$6,626,299**	**($1,947,999)**	**(29.4%)**
93.4%	96.2%	2.8%	2.9%	31. Medical Loss Ratio	94.7%	93.7%	(1.0%)	(1.1%)
6.3%	5.2%	(1.1%)	(21.2%)	32. Administrative Expense Ratio	5.4%	5.6%	0.2%	3.6%
1.6%	(0.2%)	1.8%	900.0%	33. Net Surplus (Deficit) Ratio	1.0%	1.3%	(0.3%)	(23.1%)

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

	8/31/2025	7/31/2025	Difference	% Difference
CURRENT ASSETS				
Cash and Cash Equivalent				
Cash	$20,648,539	$16,231,455	$4,417,084	27.2%
CNB Short-Term Investment	578,525,850	514,099,832	64,426,019	12.5%
Interest Receivable	3,913,861	4,421,442	(507,582)	(11.5%)
Premium Receivables	455,917,019	363,526,281	92,390,738	25.4%
Reinsurance Recovery Receivable	10,362,567	10,202,337	160,230	1.6%
Other Receivables	15,759,224	8,237,768	7,521,455	91.3%
Prepaid Expenses	690,295	1,434,890	(744,595)	(51.9%)
TOTAL CURRENT ASSETS	**1,085,817,354**	**918,154,005**	**167,663,349**	**18.3%**
OTHER ASSETS				
CNB Long-Term Investment	37,462,245	39,082,971	(1,620,725)	(4.1%)
CalPERS Net Pension Asset	(6,465,233)	(6,465,233)	0	0.0%
Deferred Outflow	15,271,214	15,271,214	0	0.0%
Restricted Asset-Bank Note	355,847	354,839	1,008	0.3%
GASB 87-Lease Assets (Net)	72,050	75,325	(3,275)	(4.3%)
GASB 96-SBITA Assets (Net)	2,987,837	3,258,685	(270,847)	(8.3%)
TOTAL OTHER ASSETS	**49,683,961**	**51,577,800**	**(1,893,839)**	**(3.7%)**
PROPERTY AND EQUIPMENT				
Land, Building & Improvements	9,842,648	9,842,648	0	0.0%
Furniture And Equipment	13,400,309	13,400,309	0	0.0%
Leasehold Improvement	902,447	902,447	0	0.0%
Internally Developed Software	14,824,002	14,824,002	0	0.0%
Fixed Assets at Cost	38,969,405	38,969,405	0	0.0%
Less: Accumulated Depreciation	(33,516,296)	(33,454,445)	(61,851)	0.2%
PROPERTY AND EQUIPMENT (NET)	**5,453,109**	**5,514,960**	**(61,851)**	**(1.1%)**
TOTAL ASSETS	**1,140,954,424**	**975,246,766**	**165,707,658**	**17.0%**
CURRENT LIABILITIES				
Trade Accounts Payable	11,250,951	11,001,645	249,306	2.3%
Incurred But Not Reported Claims	403,728,967	406,067,986	(2,339,019)	(0.6%)
Other Medical Liabilities	119,518,596	117,655,180	1,863,416	1.6%
Pass-Through Liabilities	315,169,862	152,718,921	162,450,940	106.4%
MCO Tax Liabilities	103,155,342	102,982,156	173,186	0.2%
GASB 87 and 96 ST Liabilities	1,156,487	1,098,722	57,765	5.3%
Payroll Liabilities	9,551,305	9,218,402	332,903	3.6%
TOTAL CURRENT LIABILITIES	**963,531,509**	**800,743,011**	**162,788,498**	**20.3%**
LONG TERM LIABILITIES				
GASB 87 and 96 LT Liabilities	224,949	256,150	(31,202)	(12.2%)
Deferred Inflow	3,240,306	3,240,306	0	0.0%
TOTAL LONG TERM LIABILITIES	**3,465,255**	**3,496,456**	**(31,202)**	**(0.9%)**
TOTAL LIABILITIES	**966,996,764**	**804,239,467**	**162,757,296**	**20.2%**
NET WORTH				
Contributed Capital	840,233	840,233	0	0.0%
Restricted & Unrestricted Funds	168,439,128	168,439,128	0	0.0%
Year-To-Date Net Surplus (Deficit)	4,678,300	1,727,938	2,950,362	170.7%
TOTAL NET WORTH	**173,957,660**	**171,007,298**	**2,950,362**	**1.7%**
TOTAL LIABILITIES AND NET WORTH	**1,140,954,424**	**975,246,766**	**165,707,658**	**17.0%**
Cash Equivalents	599,174,389	530,331,287	68,843,102	13.0%
Pass-Through	315,169,862	152,718,921	162,450,940	106.4%
Uncommitted Cash	284,004,528	377,612,366	(93,607,838)	(24.8%)
Working Capital	122,285,845	117,410,994	4,874,851	4.2%
Current Ratio	112.7%	114.7%	(2.0%)	(1.7%)

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

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM OPERATING ACTIVITIES				
Commercial Premium Cash Flows				
Commercial Premium Revenue	$3,271,999	$9,748,208	$19,396,916	$6,518,304
GroupCare Receivable	(3,792)	(8,478)	(1,605)	(2,699)
Total	3,268,207	9,739,730	19,395,311	6,515,605
Medi-Cal Premium Cash Flows				
Medi-Cal Revenue	185,818,531	693,035,042	1,456,756,842	440,216,264
Premium Receivable	(92,386,946)	(28,141,515)	62,985,750	42,358,352
Total	93,431,585	664,893,527	1,519,742,592	482,574,616
Investment & Other Income Cash Flows				
Other Revenues	168,836	910,690	423,098	353,356
Interest Income	2,281,703	6,690,002	14,879,820	4,937,496
Interest Receivable	507,582	(1,177,999)	(365,721)	(326,903)
Total	2,958,121	6,422,693	14,937,197	4,963,949
Medical & Hospital Cash Flows				
Total Medical Expenses	(176,531,489)	(536,075,640)	(1,082,122,033)	(360,873,167)
Other Health Care Receivables	(7,539,658)	(16,454,744)	(14,656,301)	(15,797,974)
Capitation Payable	-	-	-	-
IBNP Payable	(2,339,019)	155,564	15,574,523	(8,388,328)
Other Medical Payable	162,655,259	146,981,326	287,722,292	161,626,650
Risk Share Payable	1,659,099	2,659,099	2,659,099	2,659,099
New Health Program Payable	-	-	-	-
Total	(22,095,808)	(402,734,395)	(790,822,420)	(220,773,720)
Administrative Cash Flows				
Total Administrative Expenses	(11,886,035)	(32,147,421)	(60,319,037)	(20,762,022)
Prepaid Expenses	744,595	62,675	(24,970)	27,516
Other Receivables	(142,027)	(126,789)	(84,526)	(142,691)
CalPERS Pension	-	(630,580)	(630,580)	-
Trade Accounts Payable	249,305	684,795	1,820,274	(265,972)
Payroll Liabilities	332,903	1,295,608	743,005	187,391
GASB Assets and Liabilities	300,685	436,387	186,114	393,698
Depreciation Expense	61,851	185,554	377,128	123,702
Total	(10,338,723)	(30,239,771)	(57,932,592)	(20,438,378)
MCO Tax AB119 Cash Flows				
MCO Tax Expense AB119	(173,186)	(132,570,361)	(331,672,543)	(65,711,939)
MCO Tax Liabilities	173,186	(55,818,214)	(296,716,032)	(122,663,061)
Total	0	(188,388,575)	(628,388,575)	(188,375,000)
Net Cash Flows from Operating Activities	**67,223,382**	**59,693,209**	**76,931,513**	**64,467,072**

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

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM INVESTING ACTIVITIES				
Investment Cash Flows				
Long Term Investments	1,620,728	1,557,728	12,566,314	1,693,127
Total	1,620,728	1,557,728	12,566,314	1,693,127
Restricted Cash & Other Asset Cash Flows				
Restricted Assets-Treasury Account	(1,008.00)	(2,984.00)	(5,847.00)	(1,981.00)
Total	(1,008.00)	(2,984.00)	(5,847.00)	(1,981.00)
Fixed Asset Cash Flows				
Fixed Asset Acquisitions	-	-	(266,709)	-
Purchases of Property and Equipment	-	-	(266,709)	-
Net Cash Flows from Investing Activities	**1,619,720**	**1,554,744**	**12,293,758**	**1,691,146**
Net Change in Cash	**68,843,102**	**61,247,953**	**89,225,271**	**66,158,218**
Rounding	-	-	-	-
Cash @ Beginning of Period	530,331,289	537,926,438	509,949,120	533,016,173
Cash @ End of Period	**$599,174,391**	**$599,174,391**	**$599,174,391**	**$599,174,391**
Variance	-	-	-	-

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

	MONTH	3 MONTHS	6 MONTHS	YTD
NET INCOME RECONCILIATION				
Net Income / (Loss)	$2,950,359	$9,590,519	$17,343,062	$4,678,292
Add back: Depreciation & Amortization	61,851	185,554	377,128	123,702
Receivables				
Premiums Receivable	(92,386,946)	(28,141,515)	62,985,750	42,358,352
Interest Receivable	507,582	(1,177,999)	(365,721)	(326,903)
Other Health Care Receivables	(7,539,658)	(16,454,744)	(14,656,301)	(15,797,974)
Other Receivables	(142,027)	(126,789)	(84,526)	(142,691)
GroupCare Receivable	(3,792)	(8,478)	(1,605)	(2,699)
Total	(99,564,841)	(45,909,525)	47,877,597	26,088,085
Prepaid Expenses	744,595	62,675	(24,970)	27,516
Trade Payables	249,305	684,795	1,820,274	(265,972)
Claims Payable and Shared Risk Pool				
IBNP Payable	(2,339,019)	155,564	15,574,523	(8,388,328)
Capitation Payable & Other Medical Payable	162,655,259	146,981,326	287,722,292	161,626,650
Risk Share Payable	1,659,099.00	2,659,099.00	2,659,099	2,659,099
Claims Payable				
Total	161,975,339	149,795,989	305,955,914	155,897,421
Other Liabilities				
CalPERS Pension	-	(630,580.00)	(630,580.00)	-
Payroll Liabilities	332,903	1,295,609	743,005	187,391
GASB Assets and Liabilities	300,685	436,387	186,114	393,698
New Health Program	-	-	-	-
MCO Tax Liabilities	173,186	(55,818,214)	(296,716,032)	(122,663,061)
Total	806,774	(54,716,798)	(296,417,493)	(122,081,972)
Rounding	-	-	1.00	-
Cash Flows from Operating Activities	**67,223,382**	**59,693,209**	**76,931,513**	**64,467,072**
Variance	-	-	-	-

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

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOW STATEMENT:				
Cash Flows from Operating Activities:				
Cash Received				
Capitation Received from State of CA	$93,431,585	$664,893,527	$1,519,742,592	$482,574,616
Medicare Revenue	$0	$0	$0	$0
GroupCare Premium Revenue	3,268,207	9,739,730	19,395,311	6,515,605
Other Income	168,836	910,690	423,098	353,356
Interest Income	2,789,285	5,512,003	14,514,099	4,610,593
Less Cash Paid				
Medical Expenses	(22,095,808)	(402,734,395)	(790,822,420)	(220,773,720)
Vendor & Employee Expenses	(10,338,723)	(30,239,771)	(57,932,592)	(20,438,378)
MCO Tax Expense AB119	0	(188,388,575)	(628,388,575)	(188,375,000)
Net Cash Flows from Operating Activities	**67,223,382**	**59,693,209**	**76,931,513**	**64,467,072**
Cash Flows from Investing Activities:				
Long Term Investments	1,620,728	1,557,728	12,566,314	1,693,127
Restricted Assets-Treasury Account	(1,008)	(2,984)	(5,847)	(1,981)
Purchases of Property and Equipment	0	0	(266,709)	0
Net Cash Flows from Investing Activities	**1,619,720**	**1,554,744**	**12,293,758**	**1,691,146**
Net Change in Cash	**68,843,102**	**61,247,953**	**89,225,271**	**66,158,218**
Rounding	-	-	-	-
Cash @ Beginning of Period	530,331,289	537,926,438	509,949,120	533,016,173
Cash @ End of Period	**$599,174,391**	**$599,174,391**	**$599,174,391**	**$599,174,391**
Variance	$0	-	-	-
RECONCILIATION OF NET INCOME TO NET CASH FLOW FROM OPERATING ACTIVITIES:				
Net Income / (Loss)	$2,950,359	$9,590,520	$17,343,061	$4,678,292
Add Back: Depreciation	61,851	185,554	377,128	123,702
Net Change in Operating Assets & Liabilities				
Premium & Other Receivables	(99,564,841)	(45,909,525)	47,877,597	26,088,085
Prepaid Expenses	744,595	62,674	(24,969)	27,516
Trade Payables	249,305	684,795	1,820,274	(265,972)
Claims Payable, IBNP and Risk Sharing	161,975,339	149,795,989	305,955,914	155,897,421
Deferred Revenue	0	0	0	0
Other Liabilities	806,774	(54,716,798)	(296,417,493)	(122,081,972)
Total	67,223,382	59,693,209	76,931,512	64,467,072
Rounding	-	-	1	-
Cash Flows from Operating Activities	**$67,223,382**	**$59,693,209**	**$76,931,513**	**$64,467,072**
Variance	$0	-	-	-

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE MONTH OF AUGUST 2025

	Medi-Cal Child	Medi-Cal Adult	Medi-Cal ACA OE	Medi-Cal SPD with LTC*	Medi-Cal Duals with LTC*	Medi-Cal Total	Group Care	Medicare	Grand Total
Enrollments/Member Months	108,503	60,679	153,348	29,686	49,371	401,587	5,974	-	407,561
Revenue	$17,620,586	$22,783,776	$66,624,222	$43,675,866	$35,114,081	$185,818,532	$3,272,000	$0	$189,090,531
Medical Expense	$14,925,720	$21,099,129	$60,313,986	$42,549,864	$34,318,070	$173,206,770	$3,324,715	$0	$176,531,485
Gross Margin	$2,694,866	$1,684,647	$6,310,236	$1,126,001	$796,012	$12,611,762	($52,716)	$0	$12,559,046
Administrative Expense	$558,873	$1,260,938	$3,880,571	$3,351,330	$1,782,089	$10,833,800	$214,435	$835,439	$11,883,674
MCO Tax Expense	$28,749	($15,009)	($71,611)	$83,513	$147,545	$173,186	$0	$0	$173,186
Operating Income / (Expense)	$2,107,244	$438,718	$2,501,276	($2,308,841)	($1,133,622)	$1,604,775	($267,151)	($835,439)	$502,186
Other Income / (Expense)	$118,976	$282,605	$805,611	$745,439	$459,076	$2,411,707	$36,469	$0	$2,448,176
Net Income / (Loss)	$2,226,220	$721,323	$3,306,887	($1,563,403)	($674,545)	$4,016,482	($230,681)	($835,439)	$2,950,362
PMPM Metrics:									
Revenue PMPM	$162.40	$375.48	$434.46	$1,471.26	$711.23	$462.71	$547.71	$0.00	$463.96
Medical Expense PMPM	$137.56	$347.72	$393.31	$1,433.33	$695.11	$431.31	$556.53	$0.00	$433.14
Gross Margin PMPM	$24.84	$27.76	$41.15	$37.93	$16.12	$31.40	($8.82)	$0.00	$30.82
Administrative Expense PMPM	$5.15	$20.78	$25.31	$112.89	$36.10	$26.98	$35.89	$0.00	$29.16
MCO Tax Expense PMPM	$0.26	($0.25)	($0.47)	$2.81	$2.99	$0.43	$0.00	$0.00	$0.42
Operating Income / (Expense) PMPM	$19.42	$7.23	$16.31	($77.78)	($22.96)	$4.00	($44.72)	$0.00	$1.23
Other Income / (Expense) PMPM	$1.10	$4.66	$5.25	$25.11	$9.30	$6.01	$6.10	$0.00	$6.01
Net Income / (Loss) PMPM	$20.52	$11.89	$21.56	($52.66)	($13.66)	$10.00	($38.61)	$0.00	$7.24
Ratio:									
Medical Loss Ratio	84.8%	92.5%	90.4%	97.6%	98.1%	93.3%	101.6%	0.0%	93.4%
Administrative Expense Ratio	3.2%	5.5%	5.8%	7.7%	5.1%	5.8%	6.6%	0.0%	6.3%
Net Income Ratio	12.6%	3.2%	5.0%	-3.6%	-1.9%	2.2%	-7.1%	0.0%	1.6%

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

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE FISCAL YEAR TO DATE AUGUST 2025

	Medi-Cal Child	Medi-Cal Adult	Medi-Cal ACA OE	Medi-Cal SPD with LTC*	Medi-Cal Duals with LTC*	Medi-Cal Total	Group Care	Medicare	Grand Total
Enrollments/Member Months	217,754	122,215	308,881	59,519	98,880	807,249	11,931	-	819,180
Revenue	$51,002,932	$57,293,352	$165,003,269	$90,749,229	$76,167,481	$440,216,264	$6,518,304	$0	$446,734,568
Medical Expense	$30,492,735	$41,678,284	$124,626,133	$84,488,105	$72,951,494	$354,236,751	$6,436,410	$200,000	$360,873,162
Gross Margin	$20,510,197	$15,615,068	$40,377,136	$6,261,124	$3,215,988	$85,979,513	$81,894	($200,000)	$85,861,406
Administrative Expense	$989,070	$2,231,298	$6,931,178	$5,990,531	$3,209,740	$19,351,817	$377,283	$1,027,596	$20,756,696
MCO Tax Expense	$17,679,340	$9,926,747	$25,056,300	$4,903,332	$8,146,219	$65,711,939	$0	$0	$65,711,939
Operating Income / (Expense)	$1,841,787	$3,457,022	$8,389,657	($4,632,740)	($8,139,971)	$915,757	($295,389)	($1,227,596)	($607,228)
Other Income / (Expense)	$256,858	$610,089	$1,739,234	$1,609,332	$991,282	$5,206,795	$78,733	$0	$5,285,528
Net Income / (Loss)	$2,098,646	$4,067,111	$10,128,892	($3,023,407)	($7,148,689)	$6,122,552	($216,656)	($1,227,596)	$4,678,300
PMPM Metrics:									
Revenue PMPM	$234.22	$468.79	$534.20	$1,524.71	$770.30	$545.33	$546.33	$0.00	$545.34
Medical Expense PMPM	$140.03	$341.02	$403.48	$1,419.51	$737.78	$438.82	$539.47	$0.00	$440.53
Gross Margin PMPM	$94.19	$127.77	$130.72	$105.20	$32.52	$106.51	$6.86	$0.00	$104.81
Administrative Expense PMPM	$4.54	$18.26	$22.44	$100.65	$32.46	$23.97	$31.62	$0.00	$25.34
MCO Tax Expense PMPM	$81.19	$81.22	$81.12	$82.38	$82.38	$81.40	$0.00	$0.00	$80.22
Operating Income / (Expense) PMPM	$8.46	$28.29	$27.16	($77.84)	($82.32)	$1.13	($24.76)	$0.00	($0.74)
Other Income / (Expense) PMPM	$1.18	$4.99	$5.63	$27.04	$10.03	$6.45	$6.60	$0.00	$6.45
Net Income / (Loss) PMPM	$9.64	$33.28	$32.79	($50.80)	($72.30)	$7.58	($18.16)	$0.00	$5.71
Ratio:									
Medical Loss Ratio	91.5%	88.0%	89.1%	98.4%	107.2%	94.6%	98.7%	0.0%	94.7%
Administrative Expense Ratio	3.0%	4.7%	5.0%	7.0%	4.7%	5.2%	5.8%	0.0%	5.4%
Net Income Ratio	4.1%	7.1%	6.1%	-3.3%	-9.4%	1.4%	-3.3%	0.0%	1.0%

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

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				ADMINISTRATIVE EXPENSES SUMMARY (ADMIN. DEPT. ONLY)				
$6,535,600	$5,865,349	($670,251)	(11.4%)	Personnel Expenses	$12,385,536	$11,543,292	($842,244)	(7.3%)
$78,907	$81,952	$3,044	3.7%	Benefits Administration Expense	$156,413	$164,008	$7,595	4.6%
$2,675,222	$2,043,378	($631,844)	(30.9%)	Purchased & Professional Services	$3,590,502	$4,382,541	$792,038	18.1%
$462,610	$477,424	$14,814	3.1%	Occupancy	$953,622	$970,797	$17,175	1.8%
$111,093	$574,962	$463,870	80.7%	Printing Postage & Promotion	$452,975	$877,332	$424,357	48.4%
$1,585,773	$330,070	($1,255,703)	(380.4%)	Licenses Insurance & Fees	$2,400,363	$2,676,865	$276,503	10.3%
$434,468	$255,638	($178,830)	(70.0%)	Other Administrative Expense	$817,285	$432,461	($384,824)	(89.0%)
$5,348,074	$3,763,424	($1,584,650)	(42.1%)	Total Other Administrative Expenses (excludes Personnel Expenses)	$8,371,160	$9,504,004	$1,132,844	11.9%
$11,883,674	$9,628,773	($2,254,901)	(23.4%)	Total Administrative Expenses	$20,756,696	$21,047,296	$290,600	1.4%

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
4,066,267	3,969,294	(96,973)	(2.4%)	Salaries & Wages	8,243,833	7,822,103	(421,731)	(5.4%)
679,054	382,508	(296,546)	(77.5%)	Paid Time Off	926,846	753,913	(172,933)	(22.9%)
100	28,252	28,152	99.6%	Compensated Incentives	5,930	53,429	47,499	88.9%
69,871	64,579	(5,293)	(8.2%)	Payroll Taxes	141,483	132,074	(9,409)	(7.1%)
75,385	48,845	(26,539)	(54.3%)	Overtime	162,410	97,691	(64,719)	(66.2%)
362,849	331,230	(31,619)	(9.5%)	CalPERS ER Match	729,724	654,884	(74,840)	(11.4%)
1,082,615	753,202	(329,413)	(43.7%)	Employee Benefits	2,178,010	1,486,886	(691,124)	(46.5%)
3,680	0	(3,680)	0.0%	Personal Floating Holiday	1,883	0	(1,883)	0.0%
20,792	32,500	11,708	36.0%	Language Pay	43,328	64,500	21,172	32.8%
4,160	0	(4,160)	0.0%	Med Ins Opted Out Stipend	8,900	0	(8,900)	0.0%
97,161	0	(97,161)	0.0%	Sick Leave	(190,940)	0	190,940	0.0%
300	22,535	22,235	98.7%	Compensated Employee Relations	(2,557)	44,220	46,777	105.8%
20,820	27,540	6,720	24.4%	Work from Home Stipend	41,440	53,980	12,540	23.2%
707	2,916	2,209	75.8%	Mileage, Parking & LocalTravel	2,292	7,155	4,863	68.0%
3,715	9,937	6,222	62.6%	Travel & Lodging	9,265	24,747	15,482	62.6%
23,675	115,320	91,645	79.5%	Temporary Help Services	25,634	230,640	205,006	88.9%
15,662	52,663	37,001	70.3%	Staff Development/Training	48,518	85,746	37,228	43.4%
8,787	24,028	15,241	63.4%	Staff Recruitment/Advertisement	9,537	31,325	21,789	69.6%
6,535,600	**5,865,349**	**(670,251)**	**(11.4%)**	**Personnel Expense**	**12,385,536**	**11,543,292**	**(842,244)**	**(7.3%)**
26,206	29,082	2,876	9.9%	Pharmacy Administrative Fees	50,440	58,165	7,725	13.3%
52,701	52,869	168	0.3%	Telemedicine Admin. Fees	105,973	105,843	(130)	(0.1%)
78,907	**81,952**	**3,044**	**3.7%**	**Benefits Administration Expense**	**156,413**	**164,008**	**7,595**	**4.6%**
830,085	719,617	(110,467)	(15.4%)	Consultant Fees - Non Medical	374,741	1,538,417	1,163,677	75.6%
357,096	259,324	(97,772)	(37.7%)	Computer Support Services	842,623	598,592	(244,031)	(40.8%)
12,925	11,750	(1,175)	(10.0%)	Audit Fees	26,166	23,500	(2,666)	(11.3%)
0	8,333	8,333	100.0%	Consultant Fees - Medical	17,593	16,667	(926)	(5.6%)
212,279	286,373	74,094	25.9%	Other Purchased Services	217,204	566,243	349,039	61.6%
0	1,879	1,879	100.0%	Maint.&Repair-Office Equipment	0	3,758	3,758	100.0%
11,854	64,767	52,913	81.7%	Legal Fees	100,377	129,530	29,153	22.5%
90,640	26,000	(64,640)	(248.6%)	Translation Services	92,566	52,000	(40,566)	(78.0%)
227,212	151,900	(75,312)	(49.6%)	Medical Refund Recovery Fees	562,700	303,800	(258,900)	(85.2%)
812,812	414,469	(398,343)	(96.1%)	Software - IT Licenses & Subsc	1,216,215	956,582	(259,633)	(27.1%)
116,260	38,065	(78,195)	(205.4%)	Hardware (Non-Capital)	136,260	74,802	(61,458)	(82.2%)
4,058	60,900	56,842	93.3%	Provider Credentialing	4,058	118,650	114,592	96.6%
2,675,222	**2,043,378**	**(631,844)**	**(30.9%)**	**Purchased & Professional Services**	**3,590,502**	**4,382,541**	**792,038**	**18.1%**
61,851	64,293	2,442	3.8%	Depreciation	123,702	126,811	3,108	2.5%
8,092	10,570	2,478	23.4%	Lease Rented Office Equipment	16,183	21,140	4,957	23.4%
6,922	18,565	11,643	62.7%	Utilities	29,127	34,730	5,603	16.1%
93,290	108,156	14,866	13.7%	Telephone	226,355	216,312	(10,043)	(4.6%)
19,896	25,840	5,944	23.0%	Building Maintenance	13,289	71,804	58,515	81.5%
272,560	250,000	(22,560)	(9.0%)	GASB96 SBITA Amort. Expense	544,964	500,000	(44,964)	(9.0%)
462,610	**477,424**	**14,814**	**3.1%**	**Occupancy**	**953,622**	**970,797**	**17,175**	**1.8%**
102,883	119,855	16,972	14.2%	Postage	145,777	160,390	14,613	9.1%
5,797	5,700	(97)	(1.7%)	Design & Layout	5,797	11,400	5,603	49.1%
125,087	220,793	95,706	43.3%	Printing Services	288,793	263,086	(25,707)	(9.8%)

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
11,296	15,600	4,304	27.6%	Mailing Services	(22,722)	31,200	53,922	172.8%
7,863	13,844	5,981	43.2%	Courier/Delivery Service	9,492	27,916	18,424	66.0%
0	853	853	100.0%	Pre-Printed Materials & Public	0	1,707	1,707	100.0%
0	15,000	15,000	100.0%	Promotional Products	(187)	15,000	15,187	101.2%
0	150	150	100.0%	Promotional Services	0	300	300	100.0%
(141,834)	183,167	325,000	177.4%	Community Relations	26,025	366,333	340,309	92.9%
111,093	**574,962**	**463,870**	**80.7%**	**Printing Postage & Promotion**	**452,975**	**877,332**	**424,357**	**48.4%**
37,398	45,500	8,102	17.8%	Bank Fees	110,601	91,000	(19,601)	(21.5%)
1,329,980	200	(1,329,780)	(664,889.9%)	Insurance Premium	1,420,545	1,366,400	(54,145)	(4.0%)
626	104,939	104,312	99.4%	License,Permits, & Fee - NonIT	626,087	1,001,036	374,948	37.5%
217,769	179,431	(38,338)	(21.4%)	Subscriptions and Dues - NonIT	243,130	218,430	(24,700)	(11.3%)
1,585,773	**330,070**	**(1,255,703)**	**(380.4%)**	**License Insurance & Fees**	**2,400,363**	**2,676,865**	**276,503**	**10.3%**
1,941	5,785	3,844	66.4%	Office and Other Supplies	2,468	11,570	9,102	78.7%
0	1,000	1,000	100.0%	Furniture & Equipment	0	2,000	2,000	100.0%
9,996	80,652	70,656	87.6%	Ergonomic Supplies	13,685	102,438	88,753	86.6%
5,354	27,077	21,722	80.2%	Meals and Entertainment	33,817	34,203	386	1.1%
0	0	0	0.0%	Miscellaneous	689	0	(689)	0.0%
0	3,125	3,125	100.0%	Member Incentive	0	6,250	6,250	100.0%
83,843	138,000	54,157	39.2%	Provider Interest (All Depts)	433,293	276,000	(157,293)	(57.0%)
333,334	0	(333,334)	0.0%	Community Reinvestment Expense	333,334	0	(333,334)	0.0%
434,468	**255,638**	**(178,830)**	**(70.0%)**	**Other Administrative Expense**	**817,285**	**432,461**	**(384,824)**	**(89.0%)**
5,348,074	**3,763,424**	**(1,584,650)**	**(42.1%)**	**Total Other Administrative ExpenseS (excludes Personnel Expenses)**	**8,371,160**	**9,504,004**	**1,132,844**	**11.9%**
11,883,674	**9,628,773**	**(2,254,901)**	**(23.4%)**	**TOTAL ADMINISTRATIVE EXPENSES**	**20,756,696**	**21,047,296**	**290,600**	**1.4%**

ALAMEDA ALLIANCE FOR HEALTH
CAPITAL SPENDING INCLUDING CONSTRUCTION-IN-PROCESS
ACTUAL VS. BUDGET
FOR THE FISCAL YEAR-TO-DATE ENDED JUNE 30, 2026

		Project ID	Prior YTD Acquisitions	Current Month Acquisitions	Fiscal YTD Acquisitions	Capital Budget Total	$ Variance Fav/(Unf.)
1. Hardware:							
	Cisco Routers	IT-FY26-01	$ -	$ -	**$ -**	$ 45,000	$ 45,000
	Firewall AAH Location	IT-FY26-02	$ -	$ -	**$ -**	$ 110,000	$ 110,000
	Firewall Roseville Location	IT-FY26-03	$ -	$ -	**$ -**	$ 110,000	$ 110,000
	VPN Device	IT-FY26-04	$ -	$ -	**$ -**	$ 115,000	$ 115,000
	CISCO UCS Blades	IT-FY26-05	$ -	$ -	**$ -**	$ 300,000	$ 300,000
	CISCO UCS Blades	IT-FY26-05	$ -	$ -	**$ -**	$ 275,000	$ 275,000
	Pure Storage	IT-FY26-06	$ -	$ -	**$ -**	$ 150,000	$ 150,000
	Teams Meeting Hardware	IT-FY26-07	$ -	$ -	**$ -**	$ 100,000	$ 100,000
	Network Cabeling and WIFI Access	IT-FY26-08	$ -	$ -	**$ -**	$ 40,000	$ 40,000
Hardware Subtotal			**$ -**	**$ -**	**$ -**	**$ 1,245,000**	**$ 1,245,000**
3. Building Improvement:							
	1240 Exterior lighting update	FA-FY26-01	**$ -**	$ -	**$ -**	$ 30,000	$ 30,000
	1240 Secured Fencing for Warehouse	FA-FY26-02	**$ -**	$ -	**$ -**	$ 30,000	$ 30,000
	1240 Heating/Cooling HVAC Units upgrades	FA-FY26-03	**$ -**	$ -	**$ -**	$ 10,000	$ 10,000
	1240 Heating/Cooling HVAC Units upgrades	FA-FY26-03	**$ -**	$ -	**$ -**	$ 5,000	$ 5,000
	1240 Heating/Cooling HVAC Units upgrades	FA-FY26-03	**$ -**	$ -	**$ -**	$ 10,000	$ 10,000
	1240 Exterior Landscaping	FA-FY26-04	**$ -**	$ -	**$ -**	$ 6,500	$ 6,500
	1240 Exterior Landscaping	FA-FY26-04	**$ -**	$ -	**$ -**	$ 15,000	$ 15,000
	1240 Exterior Landscaping	FA-FY26-04	**$ -**	$ -	**$ -**	$ 15,000	$ 15,000
Building Improvement Subtotal			**$ -**	**$ -**	**$ -**	**$ 121,500**	**$ 121,500**
GRAND TOTAL			**$ -**	**$ -**	**$ -**	**$ 1,366,500**	**$ 1,366,500**

6. Reconciliation to Balance Sheet:

Fixed Assets @ Cost - 8/31/25	**$ 38,969,405**
Fixed Assets @ Cost - 6/30/25	**$ 38,969,405**
Fixed Assets Acquired YTD	**$ -**

ALAMEDA ALLIANCE FOR HEALTH
TANGIBLE NET EQUITY (TNE) AND LIQUID TNE ANALYSIS
FOR THE MONTH AND FISCAL YTD ENDED August 31, 2025

TANGIBLE NET EQUITY (TNE)	**QRT. END Jun-25**	**Jul-25**	**Aug-25**
Current Month Net Income / (Loss)	$ 4,912,222	$ 1,727,933	$ 2,950,359
YTD Net Income / (Loss)	$ (86,095,783)	$ 1,727,938	$ 4,678,300
Net Assets	$ 169,279,360	$ 171,007,298	$ 173,957,660
Subordinated Debt & Interest	-	-	-
Total Actual TNE	**$ 169,279,360**	**$ 171,007,298**	**$ 173,957,660**
Increase/(Decrease) in Actual TNE	$ 4,912,222	$ 1,727,933	$ 2,950,359
Required TNE (1)	**$ 80,653,661**	**$ 81,235,858**	**$ 80,224,390**
Min. Req'd to Avoid Monthly Reporting at 150% of Required TNE	$ 120,980,491	$ 121,853,786	$ 120,336,585
TNE Excess / (Deficiency)	$ 88,625,699	$ 89,771,440	$ 93,733,270
Actual TNE as a Multiple of Required	**2.10**	**2.11**	**2.17**
LIQUID TANGIBLE NET EQUITY			
Net Assets	$ 169,279,360	$ 171,007,298	$ 173,957,660
Less: Fixed Assets at Net Book Value	(5,576,811)	(5,514,960)	(5,453,108)
Net Lease Assets	(2,072,151)	(1,979,137)	(1,678,452)
CD Pledged to DMHC	(353,866)	(354,839)	(355,847)
Liquid TNE (Liquid Reserves)	**$ 161,276,532**	**$ 163,158,362**	**$ 166,470,253**
Liquid TNE as Multiple of Required	**2.00**	**2.01**	**2.08**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2026

	Actual Jul-25	Actual Aug-25	Actual Sep-25	Actual Oct-25	Actual Nov-25	Actual Dec-25	Actual Jan-26	Actual Feb-26	Actual Mar-26	Actual Apr-26	Actual May-26	Actual Jun-26	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program:													
Child	109,251	108,503											217,754
Adult	61,536	60,679											122,215
ACA OE	155,533	153,348											308,881
SPD with LTC*	29,833	29,686											59,519
Duals with LTC*	49,509	49,371											98,880
Medi-Cal Program	405,662	401,587											807,249
Group Care Program	5,957	5,974											11,931
Total	**411,619**	**407,561**											**819,180**

*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	(323)	(748)											(1,071)
Adult	(133)	(857)											(990)
ACA OE	357	(2,185)											(1,828)
SPD with LTC	83	(147)											(64)
Duals with LTC	205	(138)											67
Medi-Cal Program	189	(4,075)											(3,886)
Group Care Program	47	17											64
Total	**236**	**(4,058)**											**(3,822)**

Enrollment Percentages:													
Medi-Cal Program:													
Child % of Medi-Cal	26.9%	27.0%											27.0%
Adult % of Medi-Cal	15.2%	15.1%											15.1%
ACA OE % of Medi-Cal	38.3%	38.2%											38.3%
SPD with LTC % of Medi-Cal	7.4%	7.4%											7.4%
Duals with LTC % of Medi-Cal	12.2%	12.3%											12.2%
Medi-Cal Program % of Total	98.6%	98.5%											98.5%
Group Care Program % of Total	1.4%	1.5%											1.5%
Total	**100.0%**	**100.0%**											**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2026

	Actual Jul-25	Actual Aug-25	Actual Sep-25	Actual Oct-25	Actual Nov-25	Actual Dec-25	Actual Jan-26	Actual Feb-26	Actual Mar-26	Actual Apr-26	Actual May-26	Actual Jun-26	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted													
Directly Contracted (DCP)	93,933	93,268											187,201
Alameda Health System	92,861	91,758											184,619
Directly-Contracted Subtotal	186,794	185,026											371,820
Delegated:													
CFMG	43,381	42,852											86,233
CHCN	181,444	179,683											361,127
Delegated Subtotal	224,825	222,535											447,360
Total	**411,619**	**407,561**											**819,180**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	(518)	(1,768)											(2,286)
Delegated:													
CFMG	(128)	(529)											(657)
CHCN	882	(1,761)											(879)
Delegated Subtotal	754	(2,290)											(1,536)
Total	**236**	**(4,058)**											**(3,822)**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	45.4%	45.4%											45.4%
Delegated:													
CFMG	10.5%	10.5%											10.5%
CHCN	44.1%	44.1%											44.1%
Delegated Subtotal	54.6%	54.6%											54.6%
Total	**100.0%**	**100.0%**											**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING

FOR THE FISCAL YEAR 2026	PRELIMINARY BUDGET												
	Budget Jul-25	Budget Aug-25	Budget Sep-25	Budget Oct-25	Budget Nov-25	Budget Dec-25	Budget Jan-26	Budget Feb-26	Budget Mar-26	Budget Apr-26	Budget May-26	Budget Jun-26	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program:													
Child	108,840	108,602	108,365	108,128	107,892	107,656	106,737	105,853	105,000	104,178	103,387	102,624	1,277,262
Adult	61,422	61,331	61,240	61,150	61,060	60,970	59,626	58,346	57,125	55,960	54,849	53,791	706,870
ACA OE	153,317	153,025	152,734	152,443	152,153	151,864	149,741	147,711	145,769	143,909	142,130	140,426	1,785,222
SPD with LTC	29,335	29,276	29,217	29,158	29,099	29,040	28,702	28,378	28,067	27,769	27,483	27,208	342,732
Duals with LTC	48,687	48,566	48,445	48,324	48,203	48,082	47,948	47,817	47,686	47,557	47,428	47,300	576,043
Medi-Cal Program	401,601	400,800	400,001	399,203	398,407	397,612	392,754	388,105	383,647	379,373	375,277	371,349	4,688,129
Group Care Program	5,887	5,887	5,887	5,887	5,887	5,887	5,887	5,887	5,887	5,887	5,887	5,887	70,644
Total	**407,488**	**406,687**	**405,888**	**405,090**	**404,294**	**403,499**	**398,641**	**393,992**	**389,534**	**385,260**	**381,164**	**377,236**	**4,758,773**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	(1,813)	(238)	(237)	(237)	(236)	(236)	(919)	(884)	(853)	(822)	(791)	(763)	(8,029)
Adult	(1,660)	(91)	(91)	(90)	(90)	(90)	(1,344)	(1,280)	(1,221)	(1,165)	(1,111)	(1,058)	(9,291)
ACA OE	1,006	(292)	(291)	(291)	(290)	(289)	(2,123)	(2,030)	(1,942)	(1,860)	(1,779)	(1,704)	(11,885)
SPD with LTC	(595)	(59)	(59)	(59)	(59)	(59)	(338)	(324)	(311)	(298)	(286)	(275)	(2,722)
Duals with LTC	1,270	(121)	(121)	(121)	(121)	(121)	(134)	(131)	(131)	(129)	(129)	(128)	(117)
Medi-Cal Program	(1,792)	(801)	(799)	(798)	(796)	(795)	(4,858)	(4,649)	(4,458)	(4,274)	(4,096)	(3,928)	(32,044)
Group Care Program	118	0	0	0	0	0	0	0	0	0	0	0	118
Total	**(1,674)**	**(801)**	**(799)**	**(798)**	**(796)**	**(795)**	**(4,858)**	**(4,649)**	**(4,458)**	**(4,274)**	**(4,096)**	**(3,928)**	**(31,926)**
													0
Enrollment Percentages:													
Medi-Cal Program:													
Child % of Medi-Cal	27.1%	27.1%	27.1%	27.1%	27.1%	27.1%	27.2%	27.3%	27.4%	27.5%	27.5%	27.6%	27.2%
Adult % of Medi-Cal	15.3%	15.3%	15.3%	15.3%	15.3%	15.3%	15.2%	15.0%	14.9%	14.8%	14.6%	14.5%	15.1%
ACA OE % of Medi-Cal	38.2%	38.2%	38.2%	38.2%	38.2%	38.2%	38.1%	38.1%	38.0%	37.9%	37.9%	37.8%	38.1%
SPD with LTC % of Medi-Cal	7.3%	7.3%	7.3%	7.3%	7.3%	7.3%	7.3%	7.3%	7.3%	7.3%	7.3%	7.3%	7.3%
Duals with LTC % of Medi-Cal	12.1%	12.1%	12.1%	12.1%	12.1%	12.1%	12.2%	12.3%	12.4%	12.5%	12.6%	12.7%	12.3%
Medi-Cal Program % of Total	98.6%	98.6%	98.5%	98.5%	98.5%	98.5%	98.5%	98.5%	98.5%	98.5%	98.5%	98.4%	98.5%
Group Care Program % of Total	1.4%	1.4%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.6%	1.5%
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 2026	PRELIMINARY BUDGET												
	Budget Jul-25	Budget Aug-25	Budget Sep-25	Budget Oct-25	Budget Nov-25	Budget Dec-25	Budget Jan-26	Budget Feb-26	Budget Mar-26	Budget Apr-26	Budget May-26	Budget Jun-26	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted													
Directly Contracted (DCP)	93,784	93,589	93,394	93,199	93,004	92,810	92,130	91,379	90,657	89,994	89,331	88,695	1,101,966
Alameda Health System	90,381	90,213	90,046	89,879	89,712	89,545	88,277	87,055	85,885	84,770	83,701	82,677	1,052,141
Directly-Contracted Subtotal	184,165	183,802	183,440	183,078	182,716	182,355	180,407	178,434	176,542	174,764	173,032	171,372	2,154,107
Delegated:													
CFMG	43,578	43,477	43,377	43,277	43,177	43,077	42,797	42,526	42,263	42,008	41,762	41,524	512,843
CHCN	179,745	179,408	179,071	178,735	178,401	178,067	175,703	173,402	171,201	169,108	167,094	165,166	2,095,101
Delegated Subtotal	223,323	222,885	222,448	222,012	221,578	221,144	218,500	215,928	213,464	211,116	208,856	206,690	2,607,944
Total	**407,488**	**406,687**	**405,888**	**405,090**	**404,294**	**403,499**	**398,907**	**394,362**	**390,006**	**385,880**	**381,888**	**378,062**	**4,762,051**
													0
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted													
Directly Contracted (DCP)	1,613	(195)	(195)	(195)	(195)	(194)	(680)	(751)	(722)	(663)	(663)	(636)	(3,476)
Alameda Health System	(611)	(168)	(167)	(167)	(167)	(167)	(1,268)	(1,222)	(1,170)	(1,115)	(1,069)	(1,024)	(8,315)
Directly-Contracted Subtotal	1,002	(363)	(362)	(362)	(362)	(361)	(1,948)	(1,973)	(1,892)	(1,778)	(1,732)	(1,660)	(11,791)
Delegated:													
CFMG	(443)	(101)	(100)	(100)	(100)	(100)	(280)	(271)	(263)	(255)	(246)	(238)	(2,497)
CHCN	(2,233)	(337)	(337)	(336)	(334)	(334)	(2,364)	(2,301)	(2,201)	(2,093)	(2,014)	(1,928)	(16,812)
Delegated Subtotal	(2,676)	(438)	(437)	(436)	(434)	(434)	(2,644)	(2,572)	(2,464)	(2,348)	(2,260)	(2,166)	(19,309)
Total	**(1,674)**	**(801)**	**(799)**	**(798)**	**(796)**	**(795)**	**(4,592)**	**(4,545)**	**(4,356)**	**(4,126)**	**(3,992)**	**(3,826)**	**(31,100)**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted													
Directly Contracted (DCP)	23.0%	23.0%	23.0%	23.0%	23.0%	23.0%	23.1%	23.2%	23.2%	23.3%	23.4%	23.5%	23.1%
Alameda Health System	22.2%	22.2%	22.2%	22.2%	22.2%	22.2%	22.1%	22.1%	22.0%	22.0%	21.9%	21.9%	22.1%
Directly-Contracted Subtotal	45.2%	45.2%	45.2%	45.2%	45.2%	45.2%	45.2%	45.2%	45.3%	45.3%	45.3%	45.3%	45.2%
Delegated:													
CFMG	10.7%	10.7%	10.7%	10.7%	10.7%	10.7%	10.7%	10.8%	10.8%	10.9%	10.9%	11.0%	10.8%
CHCN	44.1%	44.1%	44.1%	44.1%	44.1%	44.1%	44.0%	44.0%	43.9%	43.8%	43.8%	43.7%	44.0%
Delegated Subtotal	54.8%	54.8%	54.8%	54.8%	54.8%	54.8%	54.8%	54.8%	54.7%	54.7%	54.7%	54.7%	54.8%
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 2026

	Variance Jul-25	Variance Aug-25	Variance Sep-25	Variance Oct-25	Variance Nov-25	Variance Dec-25	Variance Jan-26	Variance Feb-26	Variance Mar-26	Variance Apr-26	Variance May-26	Variance Jun-26	YTD Member Month Variance
Enrollment Variance by Plan & Aid Category - Favorable/(Unfavorable)													
Medi-Cal Program:													
Child	411	(99)											312
Adult	114	(652)											(538)
ACA OE	2,216	323											2,539
SPD with LTC	498	410											908
Duals with LTC	822	805											1,627
Medi-Cal Program	4,061	787											4,848
Group Care Program	70	87											157
Total	**4,131**	**874**											**5,005**
Current Direct/Delegate Enrollment Variance - Favorable/(Unfavorable)													
Directly-Contracted													
Directly Contracted (DCP)	149	(321)											(172)
Alameda Health System	2,480	1,545											4,025
Directly-Contracted Subtotal	2,629	1,224											3,853
Delegated:													
CFMG	(197)	(625)											(822)
CHCN	1,699	275											1,974
Delegated Subtotal	1,502	(350)											1,152
Total	**4,131**	**874**											**5,005**

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				CAPITATED MEDICAL EXPENSES				
$4,455,753	$1,608,584	($2,847,168)	(177.0%)	PCP Capitation	$10,009,532	$3,220,830	($6,788,702)	(210.8%)
6,222,018	6,422,417	200,399	3.1%	PCP Capitation FQHC	12,494,102	12,856,513	362,411	2.8%
475,226	476,319	1,094	0.2%	Specialty Capitation	956,981	953,744	(3,237)	(0.3%)
5,475,996	5,690,580	214,584	3.8%	Specialty Capitation FQHC	10,990,983	11,391,557	400,574	3.5%
800,530	752,506	(48,024)	(6.4%)	Laboratory Capitation	1,609,091	1,506,513	(102,578)	(6.8%)
340,530	338,466	(2,064)	(0.6%)	Vision Capitation	684,552	677,616	(6,936)	(1.0%)
108,091	108,338	247	0.2%	CFMG Capitation	217,666	216,927	(739)	(0.3%)
836,504	871,995	35,491	4.1%	ANC IPA Admin Capitation FQHC	1,679,267	1,745,576	66,308	3.8%
0	0	0	0.0%	Kaiser Capitation	(12,511)	0	12,511	0.0%
1,034,866	979,662	(55,204)	(5.6%)	DME Capitation	2,076,529	1,961,386	(115,144)	(5.9%)
19,749,513	**17,248,868**	**(2,500,646)**	**(14.5%)**	**7. TOTAL CAPITATED EXPENSES**	**40,706,193**	**34,530,662**	**(6,175,531)**	**(17.9%)**
				FEE FOR SERVICE MEDICAL EXPENSES				
(9,434,583)	0	9,434,583	0.0%	IBNR Inpatient Services	(6,280,076)	0	6,280,076	0.0%
(283,037)	0	283,037	0.0%	IBNR Settlement (IP)	(188,402)	0	188,402	0.0%
(754,767)	0	754,767	0.0%	IBNR Claims Fluctuation (IP)	(502,406)	0	502,406	0.0%
48,509,657	49,437,047	927,390	1.9%	Inpatient Hospitalization FFS	96,255,398	98,818,901	2,563,503	2.6%
3,462,107	3,682,483	220,376	6.0%	IP OB - Mom & NB	6,880,180	7,357,950	477,770	6.5%
159,414	125,898	(33,516)	(26.6%)	IP Behavioral Health	461,070	251,651	(209,420)	(83.2%)
1,868,507	1,466,556	(401,951)	(27.4%)	Inpatient Facility Rehab FFS	2,724,312	2,930,891	206,580	7.0%
43,527,298	**54,711,984**	**11,184,686**	**20.4%**	**8. Inpatient Hospital Expense**	**99,350,075**	**109,359,392**	**10,009,317**	**9.2%**
381,990	0	(381,990)	0.0%	IBNR PCP	(235,551)	0	235,551	0.0%
11,459	0	(11,459)	0.0%	IBNR Settlement (PCP)	(7,067)	0	7,067	0.0%
30,560	0	(30,560)	0.0%	IBNR Claims Fluctuation (PCP)	(18,842)	0	18,842	0.0%
3,837,666	3,201,743	(635,922)	(19.9%)	PCP FFS	8,760,746	6,405,187	(2,355,560)	(36.8%)
0	0	0	0.0%	Special Needs Medical Expense	278	0	(278)	0.0%
398,559	408,949	10,391	2.5%	PCP FQHC FFS	847,195	818,025	(29,169)	(3.6%)
16,110	0	(16,110)	0.0%	Prop 56 Hyde	32,427	0	(32,427)	0.0%
75,904	0	(75,904)	0.0%	Prop 56 Trauma Screening	152,357	0	(152,357)	0.0%
90,462	0	(90,462)	0.0%	Prop 56 Developmentl Screening	181,356	0	(181,356)	0.0%
653,820	822,965	169,145	20.6%	Prop 56 Family Planning	1,316,991	1,647,393	330,402	20.1%
5,496,530	**4,433,657**	**(1,062,873)**	**(24.0%)**	**9. Primary Care Physician Expense**	**11,029,890**	**8,870,605**	**(2,159,285)**	**(24.3%)**
1,219,428	0	(1,219,428)	0.0%	IBNR Specialist	329,486	0	(329,486)	0.0%
36,582	0	(36,582)	0.0%	IBNR Settlement (SCP)	9,885	0	(9,885)	0.0%
97,555	0	(97,555)	0.0%	IBNR Claims Fluctuation (SCP)	26,358	0	(26,358)	0.0%
709,036	0	(709,036)	0.0%	Psychiatrist FFS	1,311,807	0	(1,311,807)	0.0%
3,454,019	8,052,678	4,598,659	57.1%	Specialty Care FFS	7,749,015	16,104,660	8,355,644	51.9%
320,963	0	(320,963)	0.0%	Specialty Anesthesiology	751,857	0	(751,857)	0.0%
1,548,994	0	(1,548,994)	0.0%	Specialty Imaging FFS	3,409,079	0	(3,409,079)	0.0%
51,427	0	(51,427)	0.0%	Obstetrics FFS	127,053	0	(127,053)	0.0%
452,614	0	(452,614)	0.0%	Specialty IP Surgery FFS	987,106	0	(987,106)	0.0%
880,899	0	(880,899)	0.0%	Specialty OP Surgery FFS	2,286,608	0	(2,286,608)	0.0%
579,206	0	(579,206)	0.0%	Speciality IP Physician	1,467,364	0	(1,467,364)	0.0%
159,637	134,052	(25,584)	(19.1%)	Specialist FQHC FFS	310,648	268,102	(42,546)	(15.9%)
9,510,360	**8,186,730**	**(1,323,629)**	**(16.2%)**	**10. Specialty Care Physician Expense**	**18,766,267**	**16,372,762**	**(2,393,505)**	**(14.6%)**
504,373	0	(504,373)	0.0%	IBNR Ancillary (ANC)	(2,092,435)	0	2,092,435	0.0%
15,131	0	(15,131)	0.0%	IBNR Settlement (ANC)	(62,774)	0	62,774	0.0%
40,351	0	(40,351)	0.0%	IBNR Claims Fluctuation (ANC)	(167,395)	0	167,395	0.0%
(637,253)	0	637,253	0.0%	IBNR Transportation FFS	(613,049)	0	613,049	0.0%
2,889,242	2,198,261	(690,980)	(31.4%)	Behavioral Health Therapy FFS	6,455,015	4,392,148	(2,062,866)	(47.0%)

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
2,728,028	0	(2,728,028)	0.0%	Psychologist & Other MH Prof	5,248,096	0	(5,248,096)	0.0%
457,664	0	(457,664)	0.0%	Other Medical Professional	1,085,186	0	(1,085,186)	0.0%
182,744	0	(182,744)	0.0%	Hearing Devices	337,852	0	(337,852)	0.0%
54,253	0	(54,253)	0.0%	ANC Imaging	89,386	0	(89,386)	0.0%
82,127	0	(82,127)	0.0%	Vision FFS	154,312	0	(154,312)	0.0%
614,872	1,312,575	697,702	53.2%	Laboratory FFS	1,390,260	2,623,064	1,232,804	47.0%
146,941	0	(146,941)	0.0%	ANC Therapist	305,964	0	(305,964)	0.0%
1,653,534	1,629,657	(23,877)	(1.5%)	Transp/Ambulance FFS	3,565,965	3,256,625	(309,339)	(9.5%)
1,771,060	2,774,986	1,003,927	36.2%	Non-ER Transportation FFS	3,334,696	5,546,205	2,211,509	39.9%
2,150,837	2,677,989	527,151	19.7%	Hospice FFS	4,201,520	5,354,274	1,152,754	21.5%
2,334,569	0	(2,334,569)	0.0%	Home Health Services	4,813,715	0	(4,813,715)	0.0%
0	2,659,058	2,659,058	100.0%	Other Medical FFS	0	5,314,010	5,314,010	100.0%
18,920	0	(18,920)	0.0%	Medical Refunds through HMS	(261,392)	0	261,392	0.0%
28,109	2,101,321	2,073,212	98.7%	DME & Medical Supplies FFS	59,925	4,199,355	4,139,431	98.6%
2,600,103	2,109,591	(490,512)	(23.3%)	ECM Base/Outreach FFS ANC	5,208,521	4,223,450	(985,071)	(23.3%)
157,604	93,588	(64,016)	(68.4%)	CS Housing Deposits FFS ANC	399,735	187,179	(212,556)	(113.6%)
891,979	453,821	(438,157)	(96.5%)	CS Housing Tenancy FFS ANC	1,667,840	907,667	(760,173)	(83.8%)
560,363	318,427	(241,937)	(76.0%)	CS Housing Navi Servic FFS ANC	1,067,933	636,868	(431,065)	(67.7%)
334,012	278,999	(55,013)	(19.7%)	CS Medical Respite FFS ANC	712,656	558,021	(154,635)	(27.7%)
138,976	129,848	(9,127)	(7.0%)	CS Med. Tailored Meals FFS ANC	360,957	259,706	(101,251)	(39.0%)
35,620	1,024	(34,596)	(3,377.0%)	CS Asthma Remediation FFS ANC	48,650	2,049	(46,601)	(2,274.0%)
0	2,620	2,620	100.0%	CS Home Modifications FFS ANC	0	5,240	5,240	100.0%
62,153	196,832	134,680	68.4%	CS P.Care & Hmker Svcs FFS ANC	89,503	393,677	304,173	77.3%
0	6,221	6,221	100.0%	CS Cgiver Respite Svcs FFS ANC	0	12,442	12,442	100.0%
0	18	18	100.0%	CS ST PostHospital Housing FFS	0	36	36	100.0%
350	312	(38)	(12.3%)	CS Housing Outreach	960	624	(336)	(53.9%)
19,877	521,120	501,243	96.2%	CommunityBased Adult Svc(CBAS)	682,671	1,041,524	358,853	34.5%
17,870	10,831	(7,038)	(65.0%)	CS LTC Diversion FFS ANC	31,354	21,663	(9,692)	(44.7%)
7,128	5,003	(2,125)	(42.5%)	CS LTC Transition FFS ANC	14,441	10,006	(4,435)	(44.3%)
19,861,534	**19,482,102**	**(379,432)**	**(1.9%)**	**11. Ancillary Medical Expense**	**38,130,065**	**38,945,833**	**815,768**	**2.1%**
3,344,002	0	(3,344,002)	0.0%	IBNR Outpatient	3,304,296	0	(3,304,296)	0.0%
100,319	0	(100,319)	0.0%	IBNR Settlement (OP)	99,128	0	(99,128)	0.0%
267,521	0	(267,521)	0.0%	IBNR Claims Fluctuation (OP)	264,345	0	(264,345)	0.0%
2,910,176	5,982,025	3,071,849	51.4%	Outpatient FFS	6,219,560	11,961,429	5,741,869	48.0%
3,186,476	0	(3,186,476)	0.0%	OP Ambul Surgery FFS	6,538,204	0	(6,538,204)	0.0%
3,544,305	0	(3,544,305)	0.0%	Imaging Services FFS	6,895,400	0	(6,895,400)	0.0%
117,129	0	(117,129)	0.0%	Behavioral Health FFS	241,837	0	(241,837)	0.0%
817,478	3,535,064	2,717,586	76.9%	Outpatient Facility Lab FFS	1,733,481	7,067,910	5,334,430	75.5%
224,382	0	(224,382)	0.0%	Outpatient Facility Cardio FFS	529,559	0	(529,559)	0.0%
121,530	0	(121,530)	0.0%	OP Facility PT/OT/ST FFS	238,642	0	(238,642)	0.0%
2,958,884	3,293,174	334,291	10.2%	OP Facility Dialysis Ctr FFS	6,069,344	6,584,811	515,467	7.8%
17,592,202	**12,810,263**	**(4,781,939)**	**(37.3%)**	**12. Outpatient Medical Expense**	**32,133,794**	**25,614,150**	**(6,519,644)**	**(25.5%)**
1,136,327	0	(1,136,327)	0.0%	IBNR Emergency	632,766	0	(632,766)	0.0%
34,091	0	(34,091)	0.0%	IBNR Settlement (ER)	18,985	0	(18,985)	0.0%
90,905	0	(90,905)	0.0%	IBNR Claims Fluctuation (ER)	50,621	0	(50,621)	0.0%
8,370,432	11,057,465	2,687,033	24.3%	ER Facility	20,599,994	22,083,050	1,483,057	6.7%
1,075,869	0	(1,075,869)	0.0%	Specialty ER Physician FFS	2,424,099	0	(2,424,099)	0.0%
10,707,623	**11,057,465**	**349,841**	**3.2%**	**13. Emergency Expense**	**23,726,465**	**22,083,050**	**(1,643,415)**	**(7.4%)**
1,209,519	0	(1,209,519)	0.0%	IBNR Pharmacy (OP)	(895,188)	0	895,188	0.0%
36,287	0	(36,287)	0.0%	IBNR Settlement Rx (OP)	(26,854)	0	26,854	0.0%
96,762	0	(96,762)	0.0%	IBNR Claims Fluctuation Rx(OP)	(71,614)	0	71,614	0.0%
683,611	679,077	(4,534)	(0.7%)	Pharmacy FFS (OP)	1,405,889	1,358,155	(47,735)	(3.5%)
111,166	12,618,242	12,507,077	99.1%	Pharmacy Non PBM FFS Other-ANC	251,405	16,259,772	16,008,368	98.5%
1,953,684	0	(1,953,684)	0.0%	Pharmacy Non PBM FFS OP-FAC	4,301,625	0	(4,301,625)	0.0%

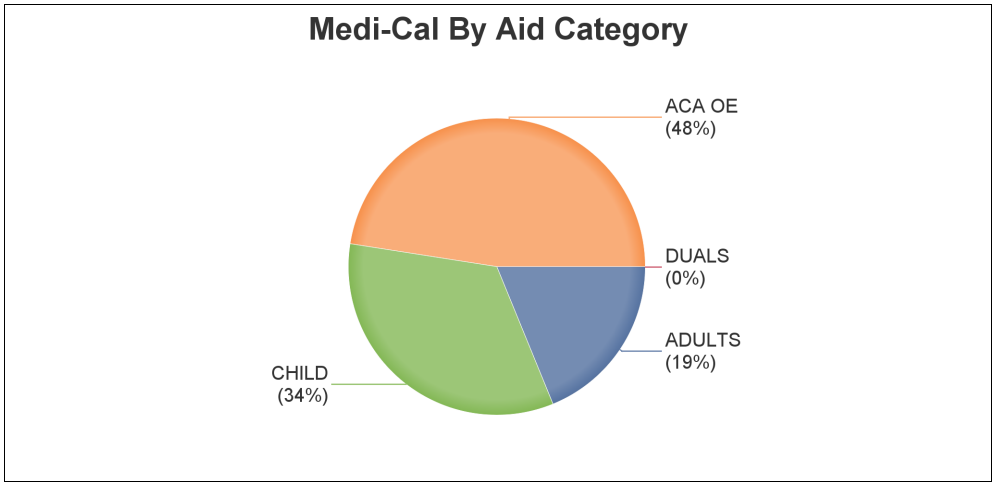
ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 31 AUGUST, 2025

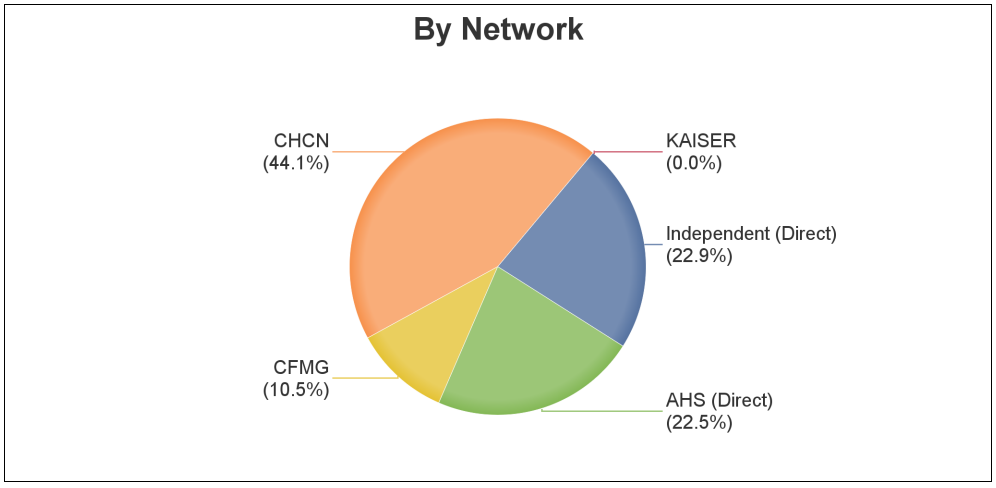
CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
284,943	0	(284,943)	0.0%	Pharmacy Non PBM FFS PCP	606,943	0	(606,943)	0.0%
2,443,540	0	(2,443,540)	0.0%	Pharmacy Non PBM FFS SCP	5,824,339	0	(5,824,339)	0.0%
52,334	0	(52,334)	0.0%	Pharmacy Non PBM FFS FQHC	65,701	0	(65,701)	0.0%
4,803	0	(4,803)	0.0%	Pharmacy Non PBM FFS HH	25,937	0	(25,937)	0.0%
(50,000)	51,113	101,113	197.8%	Medical Expenses Pharm Rebate	(108,585)	102,227	210,811	206.2%
6,826,649	**13,348,433**	**6,521,784**	**48.9%**	**14. Pharmacy Expense**	**11,379,598**	**17,720,154**	**6,340,556**	**35.8%**
(3,146,926)	0	3,146,926	0.0%	IBNR LTC	(8,796,005)	0	8,796,005	0.0%
(94,408)	0	94,408	0.0%	IBNR Settlement (LTC)	(263,881)	0	263,881	0.0%
(251,754)	0	251,754	0.0%	IBNR Claims Fluctuation (LTC)	(703,681)	0	703,681	0.0%
1,961,001	27,688	(1,933,312)	(6,982.4%)	LTC - ICF/DD	4,377,743	55,353	(4,322,390)	(7,808.8%)
29,486,160	28,075,408	(1,410,752)	(5.0%)	LTC Custodial Care	59,420,744	56,140,500	(3,280,244)	(5.8%)
8,862,433	10,444,617	1,582,183	15.1%	LTC SNF	20,555,233	20,881,168	325,936	1.6%
36,816,506	**38,547,713**	**1,731,207**	**4.5%**	**15. Long Term Care Expense**	**74,590,152**	**77,077,021**	**2,486,869**	**3.2%**
150,338,703	**162,578,348**	**12,239,645**	**7.5%**	**16. TOTAL FFS MEDICAL EXPENSES**	**309,106,307**	**316,042,969**	**6,936,663**	**2.2%**
0	(432,517)	(432,517)	100.0%	Clinical Vacancy #102	0	(790,858)	(790,858)	100.0%
102,942	212,862	109,920	51.6%	Quality Analytics #123	202,207	316,614	114,407	36.1%
356,089	368,610	12,521	3.4%	LongTerm Services and Support #139	743,203	734,342	(8,861)	(1.2%)
966,208	868,305	(97,903)	(11.3%)	Utilization Management #140	1,841,391	1,695,117	(146,274)	(8.6%)
757,381	825,605	68,224	8.3%	Case & Disease Management #185	1,427,294	1,797,086	369,792	20.6%
(119,263)	(4,360,045)	(4,240,782)	97.3%	Medical Management #230	(296,130)	(8,753,036)	(8,456,906)	96.6%
1,182,332	1,217,149	34,816	2.9%	Quality Improvement #235	2,101,535	2,368,752	267,217	11.3%
390,581	454,943	64,362	14.1%	HCS Behavioral Health #238	734,005	896,962	162,957	18.2%
143,265	226,502	83,236	36.7%	Pharmacy Services #245	265,814	458,117	192,302	42.0%
2,304	0	(2,304)	0.0%	Regulatory Readiness #268	2,546	0	(2,546)	0.0%
3,781,840	**(618,586)**	**(4,400,426)**	**711.4%**	**17. Other Benefits & Services**	**7,021,865**	**(1,276,904)**	**(8,298,769)**	**649.9%**
(1,467,000)	(1,536,103)	(69,103)	4.5%	Reinsurance Recoveries	(3,583,887)	(3,075,187)	508,700	(16.5%)
2,469,331	2,048,138	(421,193)	(20.6%)	Reinsurance Premium	4,963,586	4,100,250	(863,336)	(21.1%)
1,002,331	**512,034**	**(490,296)**	**(95.8%)**	**18. Reinsurance (Net)**	**1,379,699**	**1,025,062**	**(354,636)**	**(34.6%)**
1,659,099	0	(1,659,099)	0.0%	P4P Risk Pool Provider Incenti	2,659,099	0	(2,659,099)	0.0%
1,659,099	**0**	**(1,659,099)**	**0.0%**	**19. Risk Pool Distribution**	**2,659,099**	**0**	**(2,659,099)**	**0.0%**
176,531,485	**179,720,664**	**3,189,179**	**1.8%**	**20. TOTAL MEDICAL EXPENSES**	**360,873,162**	**350,321,789**	**(10,551,373)**	**(3.0%)**

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend

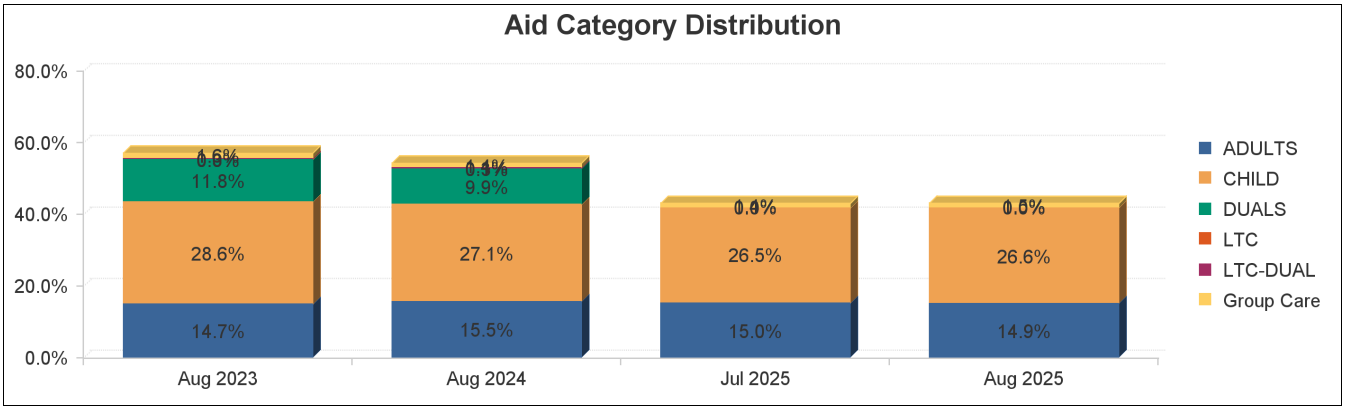
Category of Aid	Aug 2025	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN
ADULTS	60,712	15%	12,562	14,438	0	33,712
CHILD	108,557	27%	10,092	13,678	39,816	44,971
SPD	0	0%	0	0	0	0
ACA OE	153,348	38%	27,779	53,591	1,549	70,429
DUALS	2	0%	2	0	0	0
LTC	0	0%	0	0	0	0
LTC-DUAL	0	0%	0	0	0	0
SPD-LTC	29,685	7%	8,649	5,430	1,500	14,106
SPD-LTC/Full Dual	49,372	12%	32,034	3,557	3	13,778
Medi-Cal	401,676		91,118	90,694	42,868	176,996
Group Care	5,974		2,182	1,075	0	2,717
Total	**407,650**	**100%**	**93,300**	**91,769**	**42,868**	**179,713**
Medi-Cal %	98.5%		97.7%	98.8%	100.0%	98.5%
Group Care %	1.5%		2.3%	1.2%	0.0%	1.5%
	Network Distribution		**22.9%**	**22.5%**	**10.5%**	**44.1%**
			% Direct:	**45%**	**% Delegated:**	**55%**





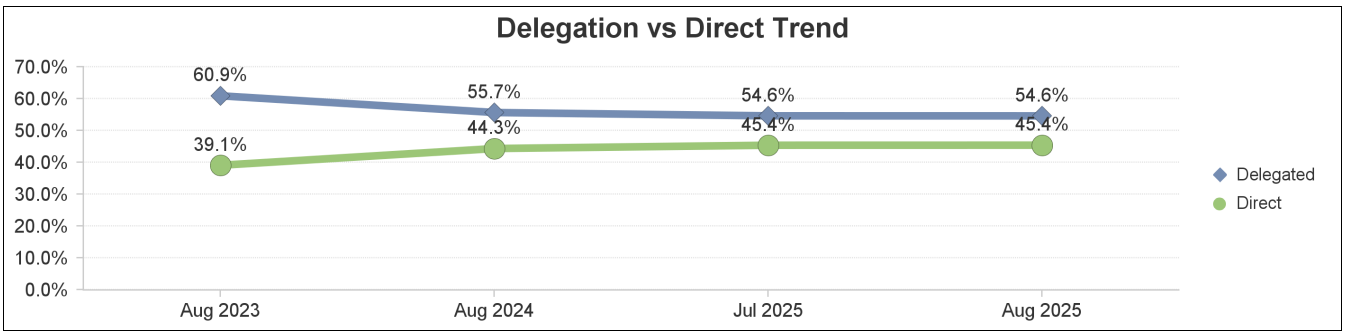
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Aug 2023	Aug 2024	Jul 2025	Aug 2025	Aug 2023	Aug 2024	Jul 2025	Aug 2025	Aug 2023 to Aug 2024	Aug 2024 to Aug 2025	Jul 2025 to Aug 2025
ADULTS	52,176	62,671	61,571	**60,720**	14.7%	15.5%	15.0%	14.9%	16.7%	-3.2%	-1.4%
CHILD	101,555	109,803	109,306	**108,568**	28.6%	27.1%	26.5%	26.6%	7.5%	-1.1%	-0.7%
SPD	30,864	35,177	0	**0**	8.7%	8.7%	0.0%	0.0%	12.3%	0.0%	0.0%
ACA OE	121,928	150,482	155,533	**153,348**	34.3%	37.1%	37.8%	37.6%	19.0%	1.9%	-1.4%
DUALS	41,722	40,030	1	**2**	11.8%	9.9%	0.0%	0.0%	-4.2%	##########	50.0%
LTC	138	226	0	**0**	0.0%	0.1%	0.0%	0.0%	38.9%	0.0%	0.0%
LTC-DUAL	1,020	1,247	0	**0**	0.3%	0.3%	0.0%	0.0%	18.2%	0.0%	0.0%
SPD-LTC	0	0	29,834	**29,686**	0.0%	0.0%	7.2%	7.3%	0.0%	100.0%	-0.5%
SPD-LTC/ Full Dual	0	0	49,509	**49,372**	0.0%	0.0%	12.0%	12.1%	0.0%	100.0%	-0.3%
Medi-Cal	349,403	399,636	405,754	**401,696**	98.4%	98.6%	98.6%	98.5%	12.6%	0.5%	-1.0%
Group Care	5,645	5,686	5,957	**5,974**	1.6%	1.4%	1.4%	1.5%	0.7%	4.8%	0.3%
Total	**355,048**	**405,322**	**411,711**	**407,670**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**12.4%**	**0.6%**	**-1.0%**



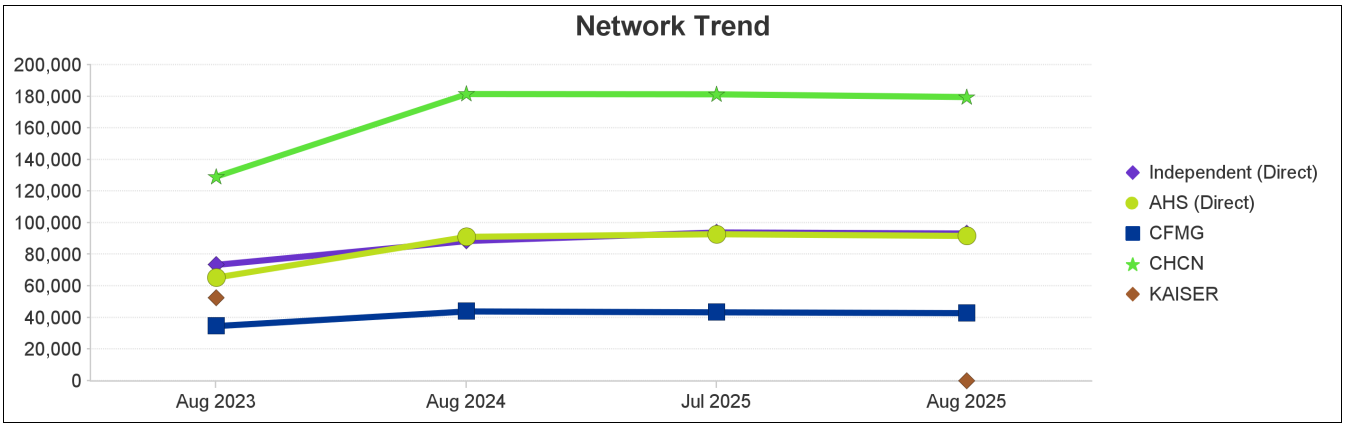
Delegation vs Direct Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	Aug 2023	Aug 2024	Jul 2025	Aug 2025	Aug 2023	Aug 2024	Jul 2025	Aug 2025	Aug 2023 to Aug 2024	Aug 2024 to Aug 2025	Jul 2025 to Aug 2025
Delegated	216,300	225,590	224,869	**222,601**	60.9%	55.7%	54.6%	54.6%	4.1%	-1.3%	-1.0%
Direct	138,748	179,732	186,842	**185,069**	39.1%	44.3%	45.4%	45.4%	22.8%	2.9%	-1.0%
Total	**355,048**	**405,322**	**411,711**	**407,670**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**12.4%**	**0.6%**	**-1.0%**



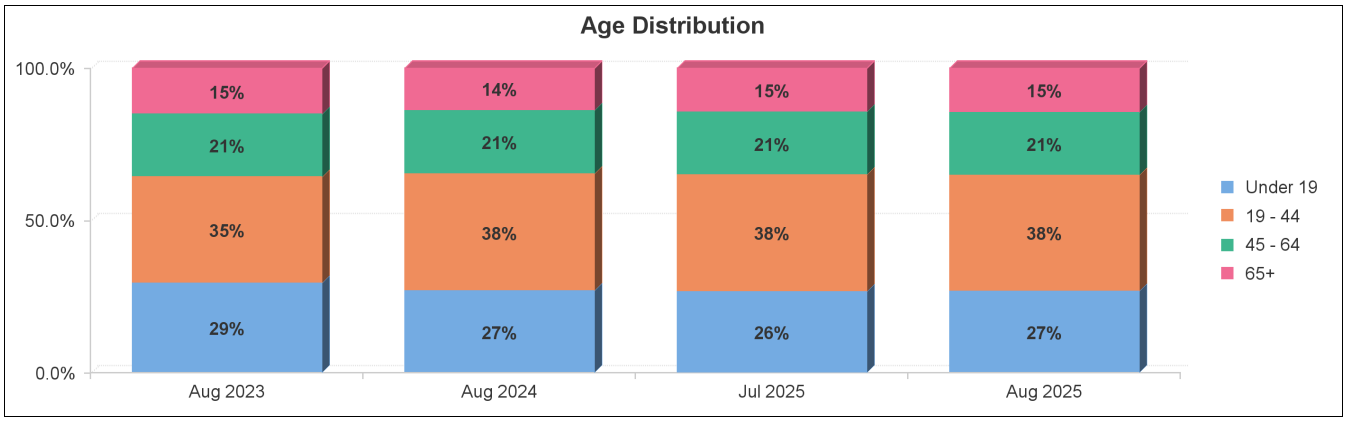
Network Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Aug 2023	Aug 2024	Jul 2025	Aug 2025	Aug 2023	Aug 2024	Jul 2025	Aug 2025	Aug 2023 to Aug 2024	Aug 2024 to Aug 2025	Jul 2025 to Aug 2025
Independent (Direct)	73,404	88,550	93,973	**93,300**	20.7%	21.8%	22.8%	22.9%	17.1%	5.1%	-0.7%
AHS (Direct)	65,344	91,182	92,869	**91,769**	18.4%	22.5%	22.6%	22.5%	28.3%	0.6%	-1.2%
CFMG	34,649	43,959	43,396	**42,868**	9.8%	10.8%	10.5%	10.5%	21.2%	-2.5%	-1.2%
CHCN	129,183	181,631	181,473	**179,713**	36.4%	44.8%	44.1%	44.1%	28.9%	-1.1%	-1.0%
KAISER	52,468	0	0	**20**	14.8%	0.0%	0.0%	0.0%	0.0%	100.0%	100.0%
Total	**355,048**	**405,322**	**411,711**	**407,670**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**12.4%**	**0.6%**	**-1.0%**



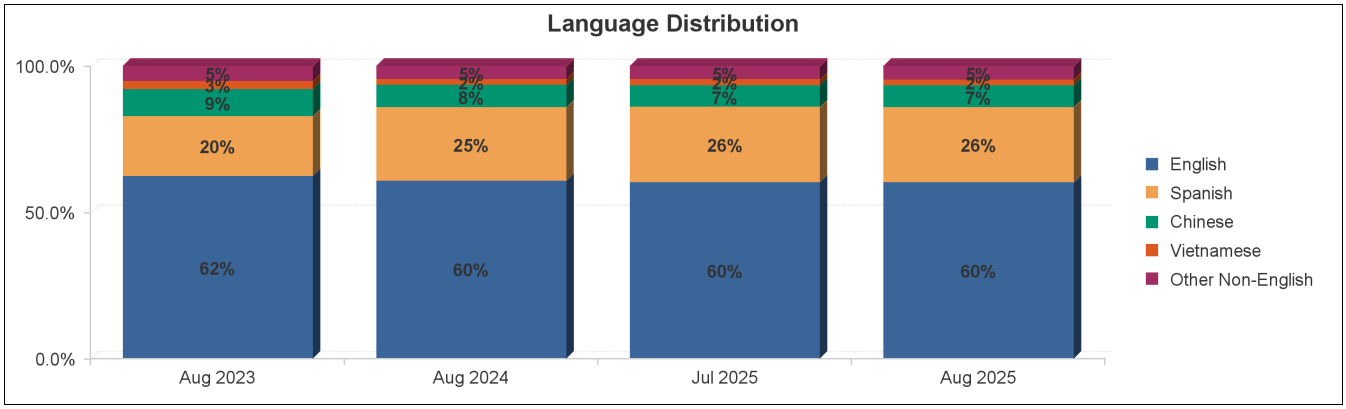
Age Category Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Aug 2023	Aug 2024	Jul 2025	Aug 2025	Aug 2023	Aug 2024	Jul 2025	Aug 2025	Aug 2023 to Aug 2024	Aug 2024 to Aug 2025	Jul 2025 to Aug 2025
Under 19	103,911	108,349	109,080	**108,381**	29%	27%	26%	27%	4%	0%	-1%
19 - 44	123,789	155,686	157,765	**155,276**	35%	38%	38%	38%	20%	0%	-2%
45 - 64	73,289	84,199	84,946	**84,220**	21%	21%	21%	21%	13%	0%	-1%
65+	54,059	57,088	59,920	**59,793**	15%	14%	15%	15%	5%	5%	0%
Total	**355,048**	**405,322**	**411,711**	**407,670**	**100%**	**100%**	**100%**	**100%**	**12%**	**1%**	**-1%**



Language Trend

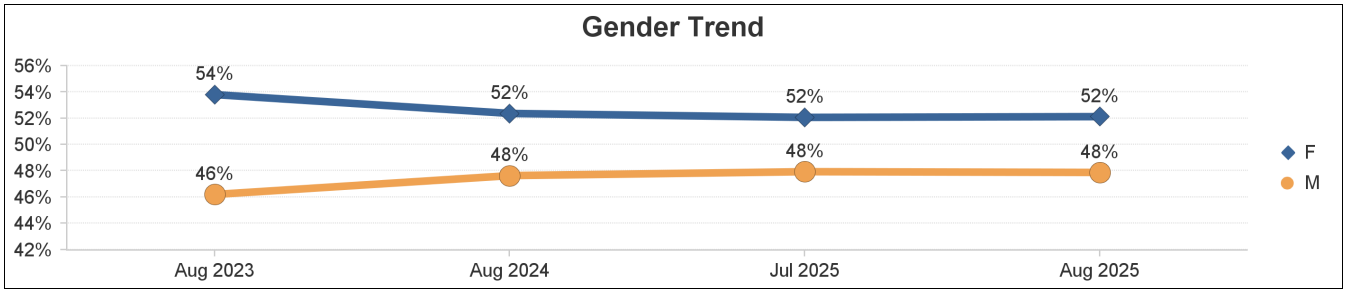
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	Aug 2023	Aug 2024	Jul 2025	Aug 2025	ug 2023	ug 2024	Jul 2025	ug 2025	Aug 2023 to Aug 2024	Aug 2024 to Aug 2025	Jul 2025 to Aug 2025
English	220,565	245,150	247,005	**244,403**	62%	60%	60%	60%	10%	0%	-1%
Spanish	72,596	102,034	106,160	**104,959**	20%	25%	26%	26%	29%	3%	-1%
Chinese	33,152	30,695	30,487	**30,355**	9%	8%	7%	7%	-8%	-1%	0%
Vietnamese	9,609	8,310	8,135	**8,083**	3%	2%	2%	2%	-16%	-3%	-1%
Other Non-English	19,126	19,133	19,924	**19,870**	5%	5%	5%	5%	0%	4%	0%
Total	**355,048**	**405,322**	**411,711**	**407,670**	**100%**	**100%**	**100%**	**100%**	**12%**	**1%**	**-1%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

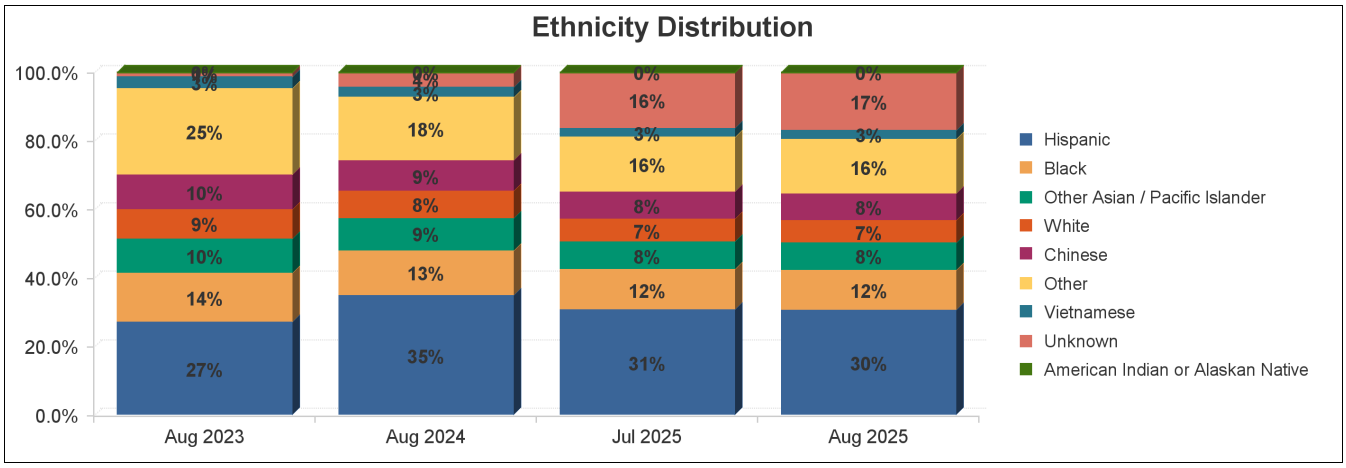
Gender Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Aug 2023	Aug 2024	Jul 2025	Aug 2025	Aug 2023	Aug 2024	Jul 2025	Aug 2025	Aug 2023 to Aug 2024	Aug 2024 to Aug 2025	Jul 2025 to Aug 2025
F	191,038	212,258	214,374	**212,501**	54%	52%	52%	52%	10%	0%	-1%
M	164,010	193,064	197,337	**195,169**	46%	48%	48%	48%	15%	1%	-1%
Total	**355,048**	**405,322**	**411,711**	**407,670**	**100%**	**100%**	**100%**	**100%**	**12%**	**1%**	**-1%**



Ethnicity Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Aug 2023	Aug 2024	Jul 2025	Aug 2025	Aug 2023	Aug 2024	Jul 2025	Aug 2025	Aug 2023 to Aug 2024	Aug 2024 to Aug 2025	Jul 2025 to Aug 2025
Hispanic	95,902	141,075	126,223	**124,198**	27%	35%	31%	30%	32%	-14%	-2%
Black	50,614	52,860	48,250	**47,397**	14%	13%	12%	12%	4%	-12%	-2%
Other Asian / Pacific Islander	35,566	38,062	33,175	**32,594**	10%	9%	8%	8%	7%	-17%	-2%
White	30,577	32,586	27,523	**26,772**	9%	8%	7%	7%	6%	-22%	-3%
Chinese	35,715	35,869	32,254	**31,878**	10%	9%	8%	8%	0%	-13%	-1%
Other	89,524	74,954	65,984	**64,699**	25%	18%	16%	16%	-19%	-16%	-2%
Vietnamese	12,104	11,804	10,544	**10,438**	3%	3%	3%	3%	-3%	-13%	-1%
Unknown	4,327	17,310	67,042	**69,002**	1%	4%	16%	17%	75%	75%	3%
American Indian or Alaskan Native	719	802	716	**692**	0%	0%	0%	0%	10%	-16%	-3%
Total	**355,048**	**405,322**	**411,711**	**407,670**	**100%**	**100%**	**100%**	**100%**	**12%**	**1%**	**-1%**



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

Medi-Cal By City

City	Aug 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	159,999	40%	24,213	42,897	16,826	76,063
HAYWARD	52,638	13%	11,929	15,132	5,632	19,945
FREMONT	38,487	10%	15,986	6,858	2,258	13,385
SAN LEANDRO	25,308	6%	6,837	4,340	3,043	11,088
UNION CITY	14,460	4%	5,724	2,669	825	5,242
ALAMEDA	13,693	3%	3,390	2,547	2,034	5,722
BERKELEY	16,262	4%	3,954	2,488	1,778	8,042
LIVERMORE	13,101	3%	2,009	471	2,120	8,501
NEWARK	9,317	2%	2,747	4,008	521	2,041
CASTRO VALLEY	11,230	3%	3,294	1,822	1,741	4,373
SAN LORENZO	6,088	2%	1,256	1,443	709	2,680
PLEASANTON	8,026	2%	2,181	341	843	4,661
DUBLIN	7,704	2%	2,391	349	872	4,092
EMERYVILLE	3,022	1%	620	671	493	1,238
ALBANY	2,548	1%	605	276	530	1,137
PIEDMONT	487	0%	104	187	80	116
SUNOL	81	0%	28	10	7	36
ANTIOCH	27	0%	4	13	3	7
Other	19,198	5%	3,846	4,172	2,553	8,627
Total	401,676	100%	**91,118**	**90,694**	**42,868**	**176,996**

Group Care By City

City	Aug 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	1,845	31%	332	420	0	1,093
HAYWARD	683	11%	317	178	0	188
FREMONT	678	11%	442	79	0	157
SAN LEANDRO	624	10%	252	100	0	272
UNION CITY	286	5%	176	42	0	68
ALAMEDA	315	5%	88	35	0	192
BERKELEY	145	2%	41	14	0	90
LIVERMORE	103	2%	31	4	0	68
NEWARK	143	2%	79	36	0	28
CASTRO VALLEY	219	4%	96	31	0	92
SAN LORENZO	155	3%	47	28	0	80
PLEASANTON	71	1%	23	3	0	45
DUBLIN	135	2%	48	8	0	79
EMERYVILLE	41	1%	13	7	0	21
ALBANY	23	0%	12	2	0	9
PIEDMONT	5	0%	1	1	0	3
SUNOL	1	0%	1	0	0	0
ANTIOCH	27	0%	9	7	0	11
Other	475	8%	174	80	0	221
Total	**5,974**	**100%**	**2,182**	**1,075**	**0**	**2,717**

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

Total By City

City	Aug 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	161,844	40%	24,545	43,317	16,826	77,156
HAYWARD	53,321	13%	12,246	15,310	5,632	20,133
FREMONT	39,165	10%	16,428	6,937	2,258	13,542
SAN LEANDRO	25,932	6%	7,089	4,440	3,043	11,360
UNION CITY	14,746	4%	5,900	2,711	825	5,310
ALAMEDA	14,008	3%	3,478	2,582	2,034	5,914
BERKELEY	16,407	4%	3,995	2,502	1,778	8,132
LIVERMORE	13,204	3%	2,040	475	2,120	8,569
NEWARK	9,460	2%	2,826	4,044	521	2,069
CASTRO VALLEY	11,449	3%	3,390	1,853	1,741	4,465
SAN LORENZO	6,243	2%	1,303	1,471	709	2,760
PLEASANTON	8,097	2%	2,204	344	843	4,706
DUBLIN	7,839	2%	2,439	357	872	4,171
EMERYVILLE	3,063	1%	633	678	493	1,259
ALBANY	2,571	1%	617	278	530	1,146
PIEDMONT	492	0%	105	188	80	119
SUNOL	82	0%	29	10	7	36
ANTIOCH	54	0%	13	20	3	18
Other	19,673	5%	4,020	4,252	2,553	8,848
Total	407,650	100%	**93,300**	**91,769**	**42,868**	**179,713**

ALAMEDA Alliance FOR HEALTH

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

Operations

Ruth Watson

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

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

Date: **October 10th, 2025**

Subject: **Operations Report**

Member Services

- 12-Month Trend Blended Summary:
    - The Member Services Department received 19,384 calls in September 2025 compared to 17,028 in September 2024 and represents a 14% increase in calls.
    - The abandonment rate for September 2025 was 5% compared to 3% in September 2024.
    - The Department's service level was 94% in September 2025, compared to 95% in September 2024. The average speed to answer (ASA) was twelve seconds (00:12) compared to fourteen seconds (00:14) in September 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-six seconds (07:26) for September 2025, compared to seven minutes and eleven seconds (07:11) for September 2024.
    - 100% of calls were answered within 10 minutes for September 2025 and 100% of calls were answered within 10 minutes for September 2024.
    - Outbound calls totaled 10,222 in September 2025 compared to 7,955 in September 2024.
    - The top five call reasons for September 2025 were 1) Eligibility/Enrollment, 2) Change of PCP, 3) Grievances/Appeals, 4) Benefits, 5) Provider Network Information. The top five call reasons for September 2024 were: 1) Change of PCP, 2) Eligibility/Enrollment, 3) Benefits, 4) Grievances/Appeals, and 5) Provider Network Information.
    - September utilization for the member automated eligibility IVR system totaled 1,454 in September 2025 compared to 1,191 in September 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 1,310 web-based requests in September 2025 compared to 1,158 in September 2024. The top three web reason requests for September 2025 were: 1). Change of PCP, 2) ID Card Requests, and 3) Update Contact Information. 68 members were assisted in-person in September 2025 compared to 64 in 2024.

- MS Behavioral Health:

    - The Member Services Behavioral Health (MS BH) Unit received a total of 1,250 calls in September 2025 compared to 1,346 in September 2024.
    - The abandonment rate was 6% in September 2025 compared to 10% in September 2024.
    - The service level was 80% in September 2025 and 73% in September 2024.
    - The average speed to answer (ASA) was forty-eight seconds (00:48) compared to one minute and twenty seconds (01:20) in September 2024.
    - Calls answered in 10 minutes were 100% in September 2025 compared to 98% in September 2024.
    - The Average Talk Time (ATT) was nine minutes and forty-three seconds (09:43) compared to nine minutes and nine seconds (09:09) in September 2024. The 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.
    - 1,624 outbound calls were completed in September 2025 compared to 1,187 in September 2024.
    - 80 screenings were completed in September 2025 compared to 130 in September 2024.
    - 17 outreach campaigns were completed in September 2025 compared to 133 in September 2024.
    - 27 referrals were made to the County (ACCESS) in September 2025 compared to 33 in September 2024.
    - 10 members were referred to Center Point for SUD services in September 2025 compared to 14 in September 2024.

Claims

- 12-Month Trend Summary:
    - The Claims Department received 373,025 claims in September 2025 compared to 322,196 in September 2024.
    - The Auto Adjudication rate was 89% in September 2025 compared to 84.6% in September 2024.
    - Claims compliance for the 30-day turn-around time was 88.4% in September 2025 compared to 87.5% in September 2024. The 45-day turn-around time was 99.4% in September 2025 compared to 99.9% in September 2024.
- Monthly Analysis:
    - In September, we received a total of 373,025 claims in the HEALTHsuite system; this reflects a decrease of 4.1% from August 2025. It is also higher than the number of claims received in September 2024 by 50,829.
    - Drivers of the higher volume of claims received includes:
        - Increased membership and corresponding 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 and/or EDI claims even though we receive the same claim in our COBA file.
    - 87% of claims were received via EDI and 13% of claims via paper during September.
    - 99.4% of our claims were processed within 45 working days during the month.
    - The Auto Adjudication rate was 89% for September.

Provider Dispute Resolution

- 12-Month Trend Summary:
    - In September 2025, the Provider Dispute Resolution (PDR) team received 3,266 PDRs versus 2,340 in September 2024. This represents an increase of 18.2% from August 2025 and is 39.6% higher than the number of PDRs received in September 2024, by 926.
    - The PDR team resolved 2,823 cases in September 2025 compared to 2,769 cases in September 2024.
        - In September 2025, the PDR team upheld 87% of cases versus 75% in September 2024.
        - The PDR team resolved 99.7% of cases within the compliance standard of 95% within 45 working days in September 2025, compared to 99.7% in September 2024.
- Monthly Analysis
    - The Alliance received 3,266 PDRs in September 2025.
    - In the month of September, 2,823 PDRs were resolved, with 2,467 being upheld and 356 being overturned.
    - 2,823 of 2,816 cases were resolved within 45 working days, resulting in a 99.7% compliance rate.
    - The average turnaround time for resolving PDRs in September was 40 days.
    - There were 5,669 PDRs pending resolution as of 09/30/2025, with no cases older than 45 working days.
    - The overturn rate for PDRs was 13%, which did meet our goal of 25% or less.

Grievances & Appeals

- Standard Grievance cases were not resolved within the goal of 95% of regulatory timeframes.
- Expedited Grievance cases were resolved within the goal of 95% of regulatory timeframes.
- Exempt Grievance cases were resolved within the goal of 95% of regulatory timeframes.
- Standard Appeal cases were resolved within the goal of 95% of regulatory timeframes.

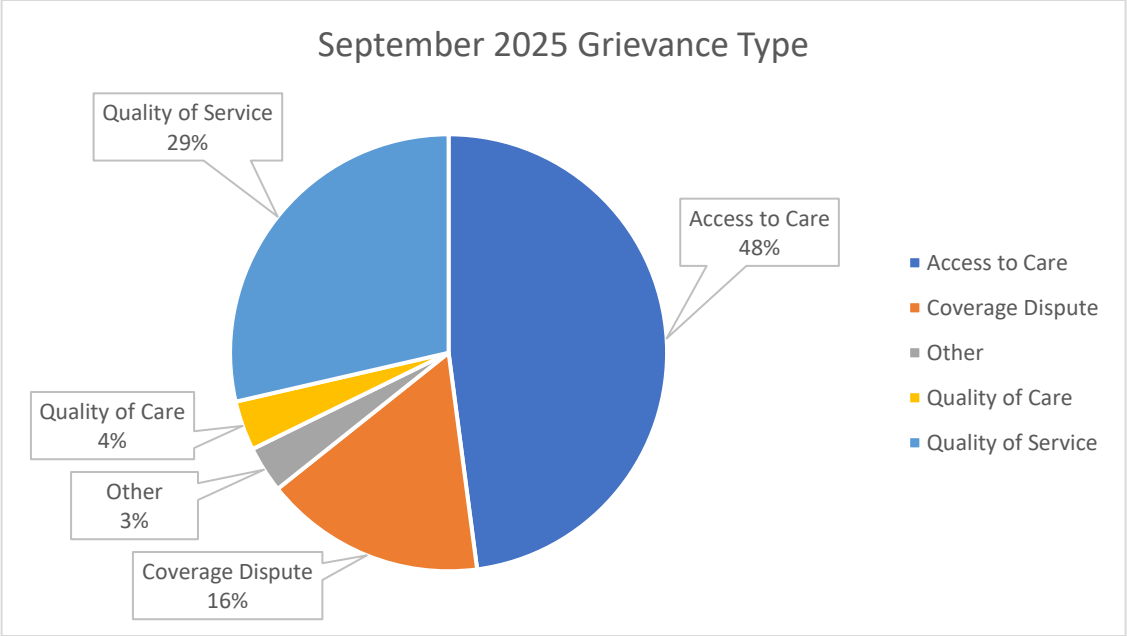
- Total Unique grievances resolved in September were 8.40 complaints per 1,000 members.

September 2025 Cases	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate	Per 1,000 Members*
Standard Grievance	2,584	30 Calendar Days	95% compliance within standard	2,402	93.0%	5.12
Expedited Grievance	4	72 Hours	95% compliance within standard	4	100.0%	0.00
Exempt Grievance	1,505	Next Business Day	95% compliance within standard	1,505	100.0%	3.62
Standard Appeal	77	30 Calendar Days	95% compliance within standard	76	99.0%	0.19
Expedited Appeal	0	72 Hours	95% compliance within standard	0	N/A	N/A
Total Cases:	4,170		95% compliance within standard	3,987	96.0%	8.40

*Calculation: the sum of all unique grievances for the month divided by the sum of all enrollment for the month multiplied by 1,000.

Standard Grievances:

There were 2,077 unique grievance cases resolved during the reporting period, with a total of 2,584 grievances including 507 shadow cases.



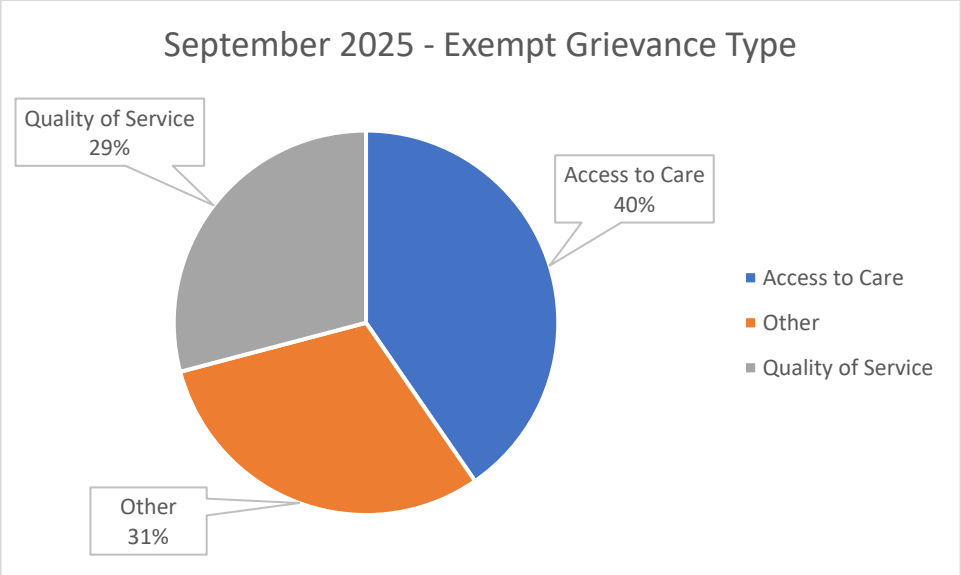
- **1,240** of 2,588 (48%) cases were related to Access to Care; the following are the top four (4) categories:
  - Technology/Telephone – 393
  - Timely Access – 359
  - Authorization – 160
  - Provider Availability – 157

- **740** of 2,588 (29%) cases were related to Quality of Service; the following are the top four (4) categories:
  - Referral – 203
  - Plan Customer Service – 135
  - Provider/Staff Attitude – 119
  - Authorization – 115

- **424** of 2,588 (16%) cases were related to Coverage Dispute; the following are the top two (2) categories:
  - Provider Direct Member Billing – 220
  - Provider Balance Billing – 129

Exempt Grievances:

There were 1,330 unique exempt grievance cases resolved during the reporting period, with a total of 1,505 exempt grievances including 175 shadow cases.



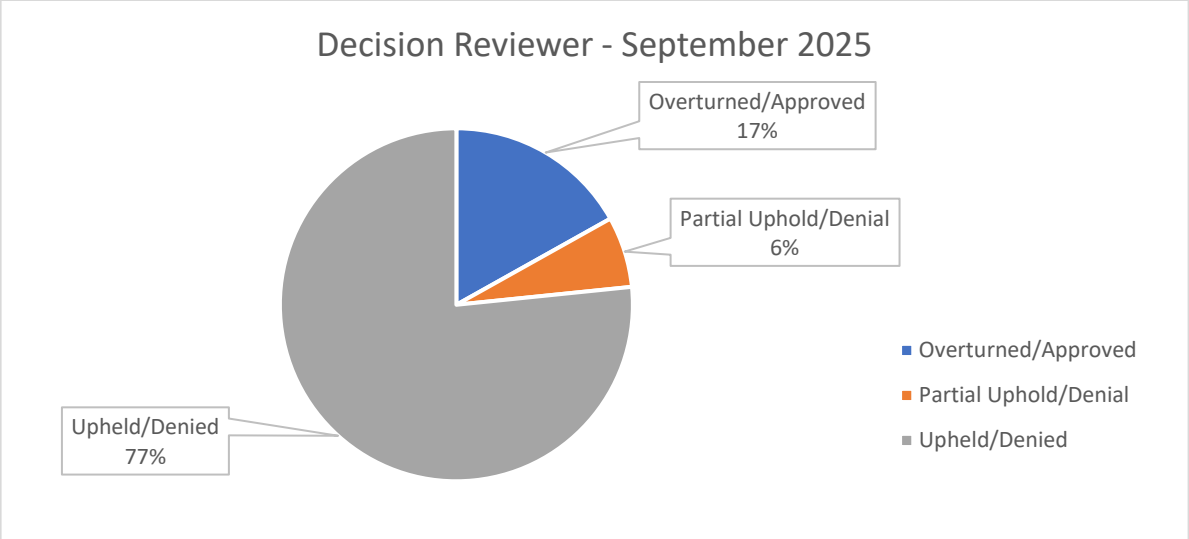
- **608** of 1,505 (40%) cases were related to Access to Care; the following are the top three (3) categories:
  - Telephone/Technology – 332
  - Provider Availability – 144
  - Geographic Access – 75

- **459** of 1,505 (31%) cases were related to Other; the following are the top two (2) categories:
  - Enrollment – 407
  - Eligibility – 52

- **438** of 1,505 (29%) cases were related to Quality of Service; the following are the top two (2) categories:
  - Plan Customer Service – 266
  - Provider/Staff Attitude – 147

Appeals:

The Alliance's goal is to have an overturn rate of less than 25%; for the reporting period of September 2025, we met our goal with a 17% overturn rate.



- **59** out of 77 (77%) cases were upheld/denied for the month of September 2025:
  - Disputes Involving Medical Necessity – 59

- **13** out of 77 (17%) cases were overturned for the month of September 2025:
  - Disputes Involving Medical Necessity – 12
  - Out of Network – 1

- **5** out of 77 (6%) cases were partially upheld/denied for the month of September 2025:
  - Disputes Involving Medical Necessity – 5

Provider Services

- 12-Month Trend Summary:

  - The Provider Services department's call volume in September 2025 was 8,883 calls compared to 7,634 calls in September 2024.

- Monthly Analysis:
  - The Provider Services department completed 532 calls/visits during September 2025.
  - The Provider Services department answered 6,794 calls for September 2025 and made 669 outbound calls.
  - Provider Services continuously works to achieve first call resolution and reduction of the abandonment rates. Efforts to promote provider satisfaction is our first priority.

Credentialing

- Monthly Analysis:

    - At the Peer Review and Credentialing (PRCC) meeting held on September 16th, 2025, there were 155 initial network providers approved; 5 primary care providers, 9 specialists, 20 ancillary providers, 4 midlevel providers, and 117 behavioral health providers. Additionally, 43 providers were re-credentialed at this meeting; 2 primary care providers, 8 specialists, 1 ancillary provider, 3 midlevel providers and 29 behavioral health 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 Q1 2025, the Alliance completed 2,796 member orientation outreach calls and 170 net new and 19 non-utilizer member orientations by phone.
    - The C&O Department reached 4,912 people, 52% identified as Alliance members, compared to 2,068 (53%) individuals who identified as Alliance members in Q1 2024.
    - The C&O Department spent a total of $1,075.00 on donations, fees, and/or sponsorships, compared to $1,115.70 in Q1 2024.
    - The C&O Department reached members in 17 cities/unincorporated areas throughout Alameda County, and Bay Area, compared to 19 locations in Q1 2024.

- Quarterly Analysis:

    - In Q1 2025, the C&O Department completed 2,796 member orientation outreach calls, 189 member orientations by phone, 12 community events, 9 member education events, and 1 community presentation.
    - Among the 4,912 people reached, 52% identified as Alliance members.
    - In Q1 2025, the C&O Department reached members in 17 locations throughout Alameda County and the Bay Area.

- Monthly Analysis:

    - In September 2025, the C&O Department completed 777 member orientation outreach calls and 49 new and 8 non-utilizer member orientations by phone, and 40 Alliance website inquiries.
    - Among the 1,322 people reached, 27% identified as Alliance members.
    - In September 2025, the C&O Department reached members in 11 locations throughout Alameda County and the Bay Area.

- Please see attached **Addendum A**.

Housing and Community Services Program Report

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

Incentives & Reporting

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 earned a total of $9.7M (100% of eligible funds) based on submission of DHCS deliverables and achievement of milestones
  - A total of $8.9M has been paid to date to Local Education Agencies (LEAs) and SBHIP partners
  - SBHIP program dollars have been reviewed, and additional payments are being prepared ($265,328 total available) to distribute to the LEAs; these funds were not included in our initial payment methodology, which was intentionally conservative to avoid overspending in case full funding was not secured

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

- The Alliance earned $38M out of $44M available under this program based on submission of deliverables and achievement of DHCS-defined metrics
  - $24.8M 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 continue with activities taking place through 2028 related to capacity building, innovation, diversity and health equity, and housing stability
- The Alliance continues to review partner project deliverables prior to payment and meet with partners to discuss program activities and barriers

- One partner withdrew from the program as they could not reach an agreement with an external partner to complete the work; the unused funding is being reviewed by the Alliance and is pending confirmation from a community partner of their ability to fulfill the original scope of work to consider reinvesting in the project

Provider Recruitment Initiative (PRI) – internal Alliance program with funding up to $2M in FY 2024-25 and FY 2025-26

- 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
  - $294,976 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
  - Unused funds for the 2024-25 FY are currently $94,250; these funds will be rolled into the 2025-26 FY funding cycle
    - Unused funds resulted from hiring plan changes such as inability to hire a bilingual provider as planned, change in type of provider hired, and no longer pursuing hiring of a position

- 2025-26 Program status:
  - PRI program was renewed for FY 2025-26 and launched July 1st, 2025
  - $2M in funding is available for FY 2025-26 fiscal year
    - Reimbursement for Certified Medical Assistant training was added to the program
    - 16 organizations have expressed interest in the program to date
    - Six (6) informational sessions have been held
    - Program materials have been updated and were shared with interested organizations
  - The I&R team has been preparing the internal evaluation process, including prepping materials to facilitate review via the new grant software system, Submittable

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

- The original funding was $700 million over five (5) years; however, due to state budget constraints, the funding was reduced to $140 million over three (3) years
- Alameda Health System (AHS) was the only Alliance-associated applicant selected by DHCS to participate

- AHS submitted their latest program deliverables that were due to DHCS on May 1st and earned $302k from DHCS for their work

- The Population Health Learning Center (PHLC) requested MCPs sign a Data Sharing Agreement (DSA) so they can work with a third-party vendor to help calculate Healthcare Effectiveness Data and Information Set (HEDIS) rates; the DSA was fully executed on September 11th and the Analytics team submitted the required data to the secure site on September 18th
- At a September All MCP webinar, PHLC notified MCPs that beginning in January 2026, they will be paying MCPs via the monthly capitation to facilitate more timely payment to practices

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

- Scholarships are intended to offset costs related to the following:
  - Medi-Cal Provider Application and Validation for Enrollment (PAVE)
  - Contracting and credentialing with the Alliance
  - Continued education, training, and administrative and operational support required to be a Doula
- FY 2024-25 Program highlights:
  - Scholarships of up to $1,000 per person were available for Doulas both intending to contract with the Alliance and Doulas already contracted with the Alliance
  - MOUs for the 20 scholarship awardees were signed, including seven (7) awards to support currently contracted Doulas and 13 awards for Doulas that intend to contract with the Alliance
  - $14,000 of the available $20,000 in scholarships has been paid to program participants for completion of scholarship deliverables
    - One (1) awardee withdrew from the program and one (1) awardee indicated they will not complete the deliverables required for their final payment
- FY 2025-26 Program status:
  - I&R is working with the Health Care Services team to launch a new funding cycle
    - $40K will be available for Doulas that intend to contract with the Alliance with $8,500 earmarked for outstanding deliverables from the FY 2024-25 program
    - Program materials have been updated and are in the process of being finalized

Grant Program Updates

- The Incentives and Reporting (I&R) team implemented a grant management software system, Submittable, to support the various grant and incentive programs in which the Alliance participates

    - 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 worked with the Vendor Management team to finalize a Statement of Work with Submittable to create a dashboard to manage and track program related deliverables, including fund distribution
        - Project activities kicked off on September 24th, 2025
- California Improvement Network – the Alliance was selected, along with 24 other partners, to participate in an opportunity through the California Improvement Network (CIN), which is a learning and action community that advances equitable health care experiences and outcomes for Californians through cross-sector connections, spreading good ideas, and implementing improvements
    - CIN participation provides the Alliance with an opportunity to partner and connect with other organizations that are also working to improve health equity
    - The Director, Health Equity is participating in the equity focused learning network and leading project initiatives; I&R provides program management support
        - The Alliance received a $4,500 grant to cover costs related to travel for participating in program activities; the grant award was received on September 22nd
    - Participants are eligible to apply for an Action Project award to support implementation efforts for partners
        - An application for a $20,000 CIN Action Projects grant was submitted on behalf of the Health Equity team on August 21st
- Foundation updates include the following:
    - 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 but that we may apply with a partner, such as a Community Based Organization (CBO), as the lead applicant
    - California Endowment – a Letter of Inquiry (LOI) was submitted to the California Endowment on January 31st to be considered for their grant opportunities; a response is still pending
    - California Health Care Foundation (CHCF) – a LOI was submitted to the California Health Care Foundation on March 21st, in collaboration with support from Behavioral Health (BH) leads from Operations and Health Care Services, for two proposals focusing on the need for funding to support BH workforce needs, as well as infrastructure support for CBOs to bill for Medi-Cal covered services
    - Robert Wood Johnson Foundation (RWJF) – In collaboration with True Vine Ministries, Health and Human Resource Center, and the Alliance Health Equity department, an application for a research grant was submitted to the Robert Wood Johnson Foundation on June 4th

        - Unfortunately, the Alliance was not selected as the RWJF received an exceptionally large number of applications from across the nation
        - The I&R team met with the RWJF on September 19th for a post-award debrief and shared findings with relevant team members
    - The Alliance submitted an application on August 21st for the California Maternal Health Task Force Doula Organization Awards Grant Application to offer ongoing doula scholarships to expand access to members; the Alliance was notified on August 28th that we were not selected for funding
    - The Alliance met with East Bay Innovations and CHCF to determine alignment with foundation priorities prior to alignment
- The Alliance continued to meet with internal and external stakeholders to begin to develop the framework for a grant for First 5 for the 2025-2026 fiscal year

Recruiting and Staffing

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

Incentive and Grant Program Descriptions

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

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

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

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

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

Integrated Planning

Ruth Watson

care to increase accessibility and to reflect the diversity of Alliance members. Program goals include:

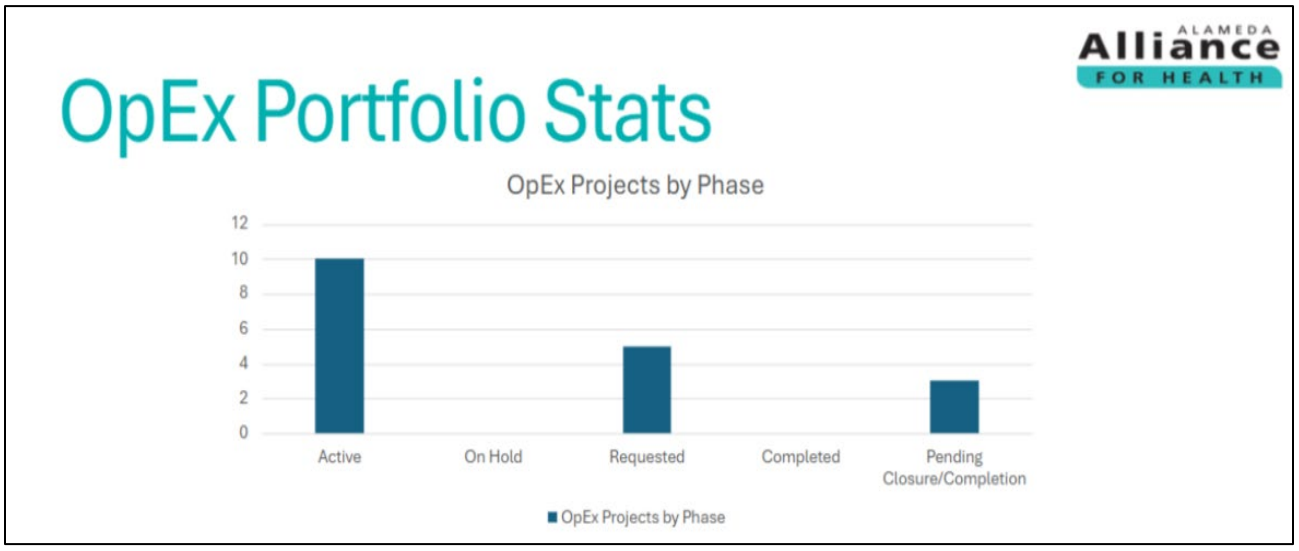
- Expanding the Alameda Alliance Provider network
- Improving member access to Primary Care Providers, Specialists, and Behavioral Health professionals
- Promoting diverse and culturally inclusive care reflective of Alliance members

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

Integrated Planning

- Enterprise Portfolio
  - 56 projects currently on the Alameda Alliance for Health (AAH) enterprise-wide portfolio
    - 16 Active projects (discovery, initiation, planning, execution, warranty)
    - 12 On Hold projects
    - 25 Requested and Approved Projects
    - 3 Completed Projects (Last month)

- Operational Excellence (OpEx) Portfolio
  - 15 projects currently on the Alameda Alliance for Health (AAH) OpEx portfolio
    - 10 Active projects (discovery, initiation, planning, execution, warranty)
    - 5 Requested Projects
    - 0 On Hold
    - 3 Closing



- D-SNP Portfolio
  - 75 projects currently on the Alameda Alliance for Health (AAH) enterprise-wide portfolio
    - 70 Active projects (discovery, initiation, planning, execution, warranty)

        - 1 Requested Projects
        - 1 On Hold
        - 3 Complete

- <u>D-SNP Key Initiatives and Dates:</u>
    - 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 2nd, 2025 - COMPLETE
    - Medication Therapy Management (MTM) program submission – June 4th, 2025 - COMPLETE
    - CMS SMAC Submission – July 7th, 2025 - COMPLETE
    - Rebate Allocation with CMS and Health Plan – July / August 2025 – COMPLETE
    - Annual Enrollment Period (AEP) – October thru December 2025
    - IT System Readiness – December 15th, 2025
    - Open Enrollment Period (OEP) Begins – January 1st, 2026

- **D-SNP Activities – September 2025**
    - <u>01 – Provider Services & Contracting:</u>
        - Provider Contracting
            - Continued outreach to AAH provider network to complete the execution of the D-SNP Provider Amendment.
                - As of September 24th, 268 contracts are fully executed, which equates to 75% completion.
            - Continued contract negotiations with Brown & Toland, Teladoc, and Quest.
            - Continued Provider Repository updates for the executed D-SNP Provider Amendments supporting D-SNP Provider Network Adequacy.
        - Provider Services
            - Provider Manual approved and ready for publishing on Alameda Alliance Public website.
            - Provider Directory
                - Printed: pharmacy data received from PerformRx to support KP Corp development.
                - Online: completed development and user acceptance testing (UAT) for 10/1 production deployment.
        - Provider Rates and Reimbursement
            - Continued development of the Pay4Performance (P4P) program.

    - <u>02 – Quality:</u>
        - Model of Care
            - MOC has been approved by both DHCS and CMS.

        - 96.25% earning three (3) year approval.
        - MOC Provider Training – Deck has been finalized and being developed in Articulate.
        - MOC Internal Training – Draft is complete and sent for CMO review.
    - Quality Program
        - Quality Improvement Health Equity P&Ps continue to be updated/developed to align with D-SNP.
            - 52 policies – All policies are drafted and are at multiple stages of committee review.
        - Quality Workplan
            - Aligning QI Workplan and Stars Playbook.
            - Developing BRDs for reporting requirements related to QI Workplan.
        - Establishing new committees:
            - New D-SNP Utilization Management committee will align with QIHEC committee members and cadence.
            - D-SNP Community Advisory Committee will be combined as a joint Medi-Cal and DSNP committee.
            - Charter redlines have been completed (Seven Quality Committees) and are in various stages of committee approval.

- <u>03 - Health Care Services (HCS) and 04 - Behavioral Health (BH):</u>
    - Continuing policy development and revisions (130 policies).
        - CM policies progressing to final edits and beginning to move forward to committee reviews.
        - UM policies moving through final edits and committee reviews.
    - UM Committee Charter presented at UMC on 09/24/2025. Revised to include D-SNP as a new service line.
    - Finalizing reporting requirements for UM, CM, and BH. Creating analytics requests and workflows.
    - UM and CM letter inventory complete and under final review by C&O.
    - Redlining UM and CM Program Descriptions for D-SNP elements.
        - Projected completion date October 2025.
    - Prior authorization code list has been finalized. The combined PA Code List + Benefit Criteria grid includes all 3 lines of business.
    - HRA Implementation Workgroup underway with Cotiviti. Identifying and defining data feeds/elements and assessment administration.
        - Defining key components of how data will be exported from AAH to Cotiviti and how data will be ingested into TruCare from Cotiviti.
        - Work to begin configuring HRA assessment in Cotiviti.
        - HRA Cotiviti scripts finalized
    - 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 new net processes for California Integrated Care Management (CICM) to include new requirements outlined in the CY2026 Program Guide.
- D-SNP CM Assessment/HRA mapping to care plan for rules generation.
- Other assessments SRD to TruCare Team for configuration.
- Continuing to build out system rules documents for D-SNP TruCare to submit to IT for configuration – Finalizing Tru-Care Core Feeds SRD.
- D-SNP authorization workstream in building out requirements and work efforts for stand-up.
- UM customer set up requirements for configuration have been finalized.
- BH CM – D-SNP CM program structure has been finalized and will mirror PH CM
- Finalizing BH specific workflows to support BH UM and CM.
- Collaboration has been completed to establish structure to coordinate Medicare non-covered services with Alameda County Behavioral Health (ACBH).
- BH programs policy and procedure development and revisions complete and awaiting committee approvals.
- Completing BH call flow and intersections with Member Services.
- Completed edits for D-SNP Member and Provider letters; additional letters created to support CMS and DHCS requirements.
- Risk Stratification model alignment with Medi-Cal model.
- Working to establish a framework for identification of populations of focus for CICM, Palliative Care, and Most Vulnerable Populations.
- BH UM – establishing additional levels of care for D-SNP population and documenting design requirements for TruCare.
- Developing content for UM, CM and BH staff departmental trainings.
- Developing SOPs.

- <u>05 – Finance:</u>
  - Finalized Part D and Payment Reconciliation policy development.
  - Finalized Finance Standard Operating Procedure (SOP).
  - Initial discussion supporting KPI development.
  - Continued development of Finance Medicare Reporting and Board of Governor presentations.
  - Continued requirements development and mapping of Finance related CMS data submission.

- <u>06 – Product:</u>
  - 6A – Bid and Benefit Design
    - Continued development of the Product View Tool allowing frontline staff to compare benefit coverage between D-SNP and Medi-Cal, including during the 3-month deeming period when a D-SNP member loses Medi-Cal eligibility but must remain temporarily enrolled for deployment in October.
    - Policies approved at AOC.

- Continued development of Standard Operating Procedures (SOPs) to standardize departmental operations and ensure adherence to best practices annually.

- 6C – Enrollment and Eligibility
  - Confirmed Decision: For the 10/15/2025 AEP initial lead load, Sales (Medicare Ops) and IT will manually load 1,250 dual-eligible leads into Cirrus using the tested/approved file format.
- 6G – Organizational Training
  - Organization Training
  - AEP 10/15 Go live departmental trainings in various stages of development
    - 6 trainings under development and to be completed 10/3/2025 with launch to staff 10/6/2025
    - Business completing content development, final edits, and conversions.
    - General Medicare and MOC Internal and External Trainings are under review with final edits being made. Proposed launch to staff is 10/20/2025 and to providers 11/03/2025.
    - 1/1 Departmental Trainings under content development and review.
- 6J – Liberty Dental
  - Working sessions in progress with IT to confirm Eligibility and Encounter testing schedule.
  - Confirmed that AAH IT will host SFTP site for file transfer and it will be push/pull setup. Folder structure finalized and test files exchanged.
  - Grievances and Appeals scope confirmed that Liberty Dental isn't delegated for verbal intake. Calls will be warm-transferred to AAH Member Services. G&A SOPs finalized and submitted for AAH review.
  - Medicare Reporting package shared and review in progress by Compliance, Member Services and Medicare Operations Team.
  - Engaged Finance Team to complete W9 ACH enrollment form and Certificate of Insurance (COI).
  - Logo use agreement to be signed to use Liberty Logo – work in progress.
  - Shared Evidence of Coverage (EOC) and Plan Benefit Package (PBP) filing for Medicare dental benefits.

- <u>07 – Compliance:</u>
  - DMHC Material Modification – D-SNP Product (Filing #20244060)
    - Received DMHC Material Modification Approval on 09/25/2025 which confirms the addition of the specific D-SNP product to our license, including approval of all associated member communications (letters and notices).
  - DMHC Contract Filing – VSP (Filing # 20253841)

- Comment table received on 9/25/2025 with responses due on 10/25/2025.

- On September 18th, 2025, the Centers for Medicare & Medicaid Services (CMS) announced the publication of the Medicare and Medicaid Programs Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All Inclusive Care for the Elderly (PACE) –- Finalization of Format Provider Directories for Medicare Plan Finder (CMS 4208-F2) final rule.
- D-SNP Compliance Policies
  - Policy Review Updates
    - Nine (9) policies approved.
    - Three (3) policies submitted for review in September.
    - Three (3) policies will be submitted for approval in October.
  - Initial development of the enterprise Compliance AEP training program and alignment with the D-SNP Compliance training program.

- <u>08 - Operations (Claims / Member Services / Mailroom / IVR):</u>
  - 8A – Claims
    - Continued Claims requirements review and refinement.
  - 8B – Member Services / Call Center / IVR
    - Completed UAT for HEALTHsuite Add, Delete, Update, and Add New Queues required for the 9/30 D-SNP deployment.
    - Finalized the HEALTHsuite Service Request (SR) categories for the 09/30/2025 D-SNP deployment.
    - Completed all IVR recorded translations for AAH Main, AAH Member Services, D-SNP Sales, and D-SNP Member Services.
    - Reviewed and responded to DHCS AIR for the Member Services IVR main line requiring TTY information.
  - 8H – Policies, SOPs, and KPIs
    - Continued development of policies to support Claims and Member Services.
    - Member Services policies submitted to AOC for review.

- <u>09 – Sales:</u>
  - 9A – Sales Implementation
    - Confirmed Decision: Compliance and CMS indicated on 9/16/2025 that Plan Certifications do not require CMS approval for internal Sales agents. As a result, Sales agents will complete internal training managed by Sales (Hamid), rather than via a Cirrus-based onboarding module.
    - Continued CHCN referral process discussion, identifying requirements for referring leads from FQHC's.
    - Appointment process through NIPR started, this is a requirement to have before selling MA plans in California.
    - Launch of Cirrus production site, macros built inside sales script.

- Scheduled training with PerformRx, identifying how to access formulary as well as sales compliance requirements (step therapy, quantity limits, prior authorization).
- Standard Operating Procedure created outlining the Pre-AEP sales process and the Member Services transfer process to Sales.
- Service Request categories created for Sales in HEALTHSuite.
- Pre-Enrollment Kit configuration completed in Cirrus, kits sent for quality assurance testing.
- UAT testing complete for D-SNP sales phone line.
- UAT testing complete for Cirrus production site.

- 9D – Medicare Marketing & Brand Strategy
  - Prospect & on-boarding marketing materials: Enrollment Kit, Welcome Kit, Member OTC Debit Card.
    - Enrollment Kit materials are complete and are available for sales to order through Nations/KP beginning 10/1. A small set of enrollment kits have been delivered to the Alameda office for walk-ins. Translations in progress for translated kits to be available by 10/15/2025.
    - Welcome kit materials due from C&O review 10/16/2025. Enrollment team will send kits to new members in December.
    - OTC Debit Card has been reviewed by C&O and submitted to Compliance to submit to CMS as file & use.
    - D-SNP website URLs were filed with CMS as File & Use 9/24/2025. Live testing is scheduled to occur on the official go-live date 10/1/2025.

- 9E – Retention:
  - Continued discussion to support development of project scope and goals and objectives.
    - Project Phases Identified
      - Phase 1 (by 1/1/2026): Implement Excel dashboards and extracts combining Nations reporting with AAH data sources (grievances, CTMs, address/coverage changes, DTRR codes). Finalize retention policy and scripts.
      - Phase 2 (in 2026): Expand reporting, validate incentive alignment, and scale outreach and engagement (newsletter, education, case management). Begin evaluating Power BI or another reporting platform in Q2 2026.
    - Project Goals and Objectives Identified:
      - (1) Deliver a retention reporting foundation (Excel based to start) by 1/1/2026.

- (2) Finalize and approve a formal retention policy by Dec 2025, aligned with CMS standards.
- (3) Establish compliant outreach playbooks for voluntary vs involuntary disenrollment.
- (4) Launch a quarterly member newsletter starting Q1 2026 to build engagement from day one.
- Requirements for commission reporting identified commission structure sent to Nations.

- 10 – Pharmacy:
  - PBM Technical and Operational workgroup meetings are in progress. Topics covered in the month of September include Part B vs. Part D determinations, prior authorizations, drug management program, and formulary.
  - Formulary updates were submitted to CMS via PerformRx during the September Limited Window on September 12th.
  - M3P program in AAH will be managed by PerformRx; contract will be amended to reflect this decision. M3P Program scope is in review and project plan development has initiated.
  - CMS Part D Model materials and letters are under review with Pharmacy and C&O teams. English versions have been delivered and translations into threshold languages expected by October 1st.
  - Printed Formulary, List of Covered Drugs, and Printed Provider Directory are in development in partnership with PerformRx, MedicareOps, and Provider Services teams.
  - MTM program development in progress with Outcomes. Pharmacy and Outcomes team are currently reviewing CMR letter requirements and TIP library.
  - Eligibility test files shared with both PerformRx and Outcomes to support vendor configuration activities. Revisions to test files for both vendors has been shared to correct errors in the initial test files. Currently in review with PerformRx and Outcomes.
  - AAH will delegate Part D appeals to the PBM and AAH will own Part D grievances; contract will be amended to reflect this decision.
  - D-SNP Policies and Procedures are all in review with internal pharmacy team or at various levels of committee approval; targeting to complete and approve all policies and procedures by 01/01/2026.
  - Development of standard operating procedures for D-SNP will begin in Q4 2025.

- 12 - Vendor Management:
  - Continued engagement with the following vendors:
    - Behavioral Health After Hours pre-delegation in process.
    - Health Risk Assessment (HRA) pre-delegation/contracting in process.
    - Medicare Prescription Payment (M3P) Plan contracting in process.

- Pharmacy Consultant pre-delegation / contracting in process.
- Risk Adjustment contracting complete.
- UM Guidelines (Clinical Policy Methodology) contracting in process.

- 13 – Health Equity:
  - Policies edited for D-SNP and in various stages of committee approval.
  - Identified need for five (5) new policies to support HE.
    - One (1) policy is in progress and four (4) have not been started.
  - Phase 2 of plan to develop monitoring process and procedures that HE team will oversee.
    - Gap analysis completed and reviewed with workgroup. Interventions provided for D-SNP Health Equity Launch 01/01/2026.
    - Health Equity Workplan for quality improvement interventions drafted and awaiting workgroup approval.
    - Oversight policy and procedure in 1st draft and workgroup review complete.

- 15 - Grievance and Appeals:
  - D-SNP Policies and procedures were approved by the QIHEC committee on August 8th and approved by the AOC committee on September 17th.
  - Development of the Standard operating procedures for D-SNP has been initiated in September 2025.
  - G&A Letters have all been created, reviewed, and approved by C&O. Translations were received on August 25th and will be configured into QualitySuite over the next 2 weeks.
  - CMS five (5) levels of appeal are currently being configured in QualitySuite.
  - Grievance and CTM modules were deployed to QualitySuite system on September 27th with Appeals module in development starting in October with a 01/01/26 go-live.

- 16 – IT:
  - TruCare: Program is 77% complete. Core feeds (Member, Provider and Network) development complete. Working with Zyter TruCare to resolve issues related to Member Data discrepancies between eligibility and audit tables. Engaged Zyter Technical Consultant to co-ordinate core feeds end-to-end testing with HEALTHsuite (HS) platform.
  - HEALTHsuite: HEALTHsuite completed deployment to support end-to-end D-SNP enrollment, membership and eligibility workflows for the upcoming D-SNP launch. Key capabilities and changes include Deploy all English enrollment letter templates (standard and large print, all priorities) to the production templates directory; update batch job component; configuration scripts, data layouts, and control files to support; CMS BEQ/DTRR batch processing; Welcome Kit/ID Card fulfillment file generations; Enrollment letter automation; OEC+

enrollment file from Cirrus. Pre-processor will be updated to direct authorization to the correct contract.

- QualitySuite: Grievance module and CTM module development nearing completion; awaiting configuration of letters in all threshold languages. Appeals Module user stories are ready for sprint planning and Provider Dispute Resolution (PDR) user stories are actively in the grooming process in partnership with the Claims business team and QS technical team.
- 16B – Enrollment Process & Nations Benefits / D-SNP Member Incentives Implementation
    - Cirrus production deployment for D-SNP enrollment was completed on 9/19/25
    - Identification of D-SNP Member Incentives scope and requirements development
    - Mitigation decision confirmed to use KP Corp to support Farsi translation of member letters
    - Confirmed Decision: Sales OCR will be deferred until after AEP (10/15/2025)

- <u>17 – Stars:</u>
    - Optum and Episource kick-off meeting occurred in September, and implementation is underway.
    - 3 Risk Adjustment Policy & Procedures approved by AOC and 2 are in progress. Two additional drafts expected to be approved prior to the 1/1/2026 go-live.
    - Phase 1 of Star strategy:
        - Identified initiatives for the HEDIS measures supported in the Medi-Cal line of business and Operational measures that will impact Star ratings on Day 1.
        - Aligning interventions to Quality Workplan.
        - Process flow documentation for the measures is underway with Quality, Health Care Services, and Analytics. We will plan to implement foundational initiatives to support Star gap closure.
            - TruCare Star gap integration in process to track Admission, Discharge, and Transfer Star measures.
            - Pay-for-Performance and Pay-for-Reporting program – In process of finalizing the measure scope. Confirmed with CHCN that they will not have their own P4P Program.
            - Data feeds – This is already in production and will be slightly modified to ensure support for D-SNP measures.
            - Prospective Chart Review – This is already in production and will be slightly modified to ensure support for D-SNP measures Phase 1 of Star strategy.
            - Stars Education – Internal and external training to provide a clear understanding of how Star measures impact quality ratings. Internal training has begun.

External training with CHCN Clinic SME's has been completed. Quality discovery sessions are in progress.
        - Provider facing Stars and Risk tips and best practices documentation development is in progress.
    - We plan to implement operational initiatives to support Star gap closure.
        - Concierge Care Gap Closure Program – Beginning development of a member/provider outreach program for members with 2+ care gaps. Currently documenting the internal member touchpoints we have as an organization to reduce member abrasion.
        - Awareness Campaign – Beginning development of ad hoc awareness campaigns to deploy in 2026 (medication adherence and preventative services).
            - Welcome Postcard with checklist of preventative screenings.
        - Preventive Physical Exam (IPPE) & Annual Wellness Visit (AWV) – Discussions continued to ensure providers are engaged in the development of the IPPE & AWV program to ensure members are seen for gap closure and accurate diagnosis capture.
            - Individual sessions with each clinic have been completed. Clinics were introduced to new Star measures, discovery into clinical workflows, and HEDIS measures interventions that align with Star measures.
            - Star measure tip sheets and best practice documents are being developed to support providers at the point of care.
            - Member incentive program in development with Nations to promote gap closure for Star measures. This program is to be launched on January 1st, 2026.

- **<u>CalAIM Initiatives:</u>**
    - Community Supports (CS)
        - Due to Budget Constraints, all CS enhancements and/or expansions are on hold.
    - Justice-Involved (JI) Initiative:
    - CalAIM Re-entry: Project on hold pending direction from the State.
        - 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 10/01/2024, 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 the decision 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: Project on hold pending direction from the State.
        - Effective January 1st, 2024, the Alliance is partnering with Carelon (formerly known as Beacon) to implement the CYBHI Fee Schedule.
        - Cohort 1 is intended to be a "learning" cohort."
        - The Alliance was not selected to participate in the permanent ASO Model and will participate in an interim solution until further notice from Carelon and DHCS.
    - MOU
        - Interim Model MOU has been executed by AAH CEO 4/29/2025 and returned to Carelon.
        - AAH Finance Team shall receive Invoice File from Carelon for billing purposes via secured file transfer process and process payments manually.
            - This includes checking member eligibility internally to deliver payments when services have been rendered.
            - SFTP File Exchange template executed and resubmitted to Carelon 6/2/2025.
        - Banking information with Carelon has been established and ready for invoice payments.
        - Final stages of testing data with Carelon and DHCS.
            - Test file from Carelon via SFTP picked up successfully.
        - Project Close Activities
            - Upon completion of file transfer validation, the AAH business stakeholders propose closing this project.
            - Anticipate project close in June 2025.
            - Warranty period through end of July to monitor stabilization of potential incoming invoices.

- **<u>Recruiting and Staffing</u>**
    - Integrated Planning Open position(s):
        - Backfill Business Analyst, Integrated Planning – Posting reactivated
        - Backfill Business Process Analyst, Integrated Planning – on hold

Supporting Documents Project Descriptions

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

Operations

Supporting Documents

Member Services

Blended Call Results

Blended Results	September 2025
Incoming Calls (R/V)	19,384
Abandoned Rate (R/V)	5%
Answered Calls (R/V)	18,448
Average Speed to Answer (ASA)	00:12
Calls Answered in 30 Seconds (R/V)	94%
Average Talk Time (ATT)	07:26
Calls Answered in 10 minutes	100%
Outbound Calls	10,222

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

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

Member Services Behavioral Health	September 2025
Incoming Calls (R/V)	1,250
Abandoned Rate (R/V)	6%
Answered Calls (R/V)	1,173
Average Speed to Answer (ASA)	00:48
Calls Answered in 30 Seconds (R/V)	80%
Average Talk Time (ATT)	09:43
Calls Answered in 10 minutes	100%
Outbound Calls	1,624
Screenings Completed	80
ACBH Referrals	27
SUD referrals to Center Point	10

Claims Department
August 2025 Final and September 2025 Final

METRICS

Claims Compliance	Aug-25	Sep-25
90% of clean claims processed within 30 calendar days	83.3%	88.4%
95% of all claims processed within 45 working days	99.4%	99.4%

Claims Volume (Received)	Aug-25	Sep-25
Paper claims	36,440	47,152
EDI claims	352,642	325,873
Claim Volume Total	**389,082**	**373,025**

Percentage of Claims Volume by Submission Method	Aug-25	Sep-25
% Paper	9.37%	12.64%
% EDI	90.63%	87.36%

Claims Processed	Aug-25	Sep-25
HEALTHsuite Paid (original claims)	237,848	256,555
HEALTHsuite Denied (original claims)	94,089	96,203
HEALTHsuite Original Claims Sub-Total	**331,937**	**352,758**
HEALTHsuite Adjustments	6,357	3,802
HEALTHsuite Total	**338,294**	**356,560**

Claims Expense	Aug-25	Sep-25
Medical Claims Paid	$156,801,791	$135,164,354
Interest Paid	$83,462	$122,638

Auto Adjudication	Aug-25	Sep-25
Claims Auto Adjudicated	278,912	313,683
% Auto Adjudicated	84.0%	88.9%

Average Days from Receipt to Payment	Aug-25	Sep-25
HEALTHsuite	18	16

Pended Claim Age	Aug-25	Sep-25
0-30 calendar days	37,073	44,263
HEALTHsuite		
31-61 calendar days	19,922	17,934
HEALTHsuite		
Over 62 calendar days	47,872	47,834
HEALTHsuite		

*Pended claims over 31 days are high due to investigation of 3 providers for FWA

Overall Denial Rate	Aug-25	Sep-25
Claims denied in HEALTHsuite	94,089	96,203
% Denied	27.8%	27.0%

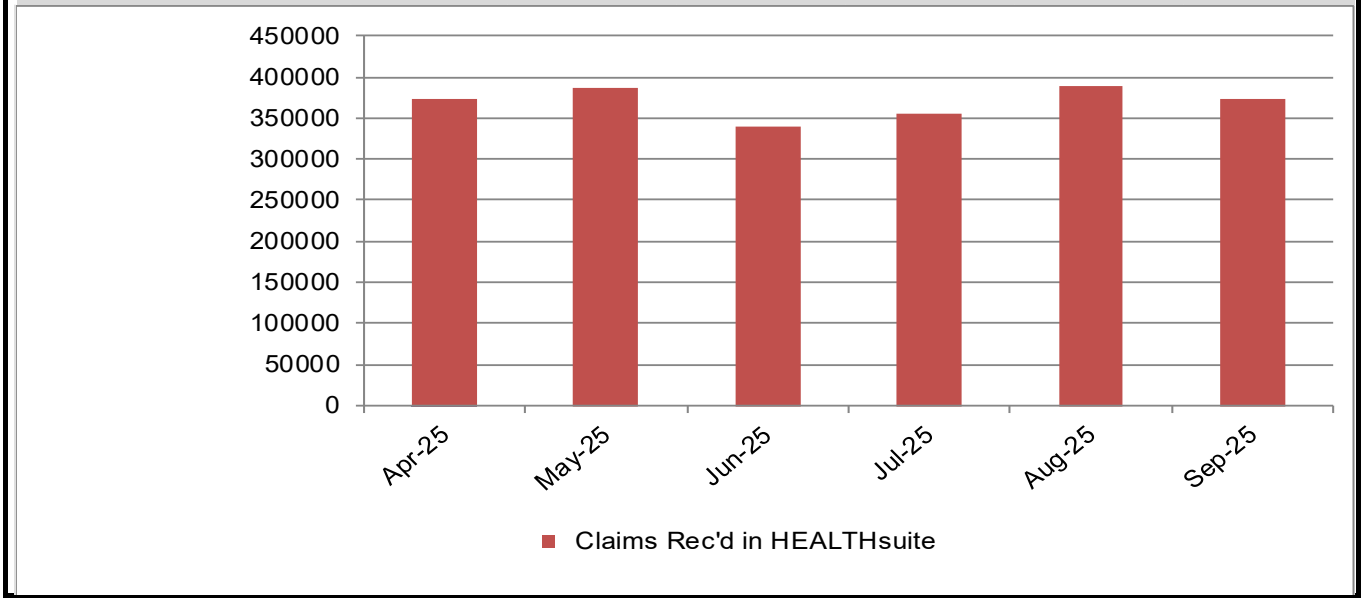
Claims Department
August 2025 Final and September 2025 Final

Sep-25

Top 5 HEALTHsuite Denial Reasons	% of all denials
Responsibility of Provider	24%
No Benefits Found For Dates of Service	14%
Must Submit Paper Claim With Copy of Primary Payor EOB	13%
Non-Covered Benefit For This Plan	11%
Duplicate Claim	8%
% Total of all denials	**70%**

Claims Received By Month

	5/1/2025	6/1/2025	7/1/2025	8/1/2025	9/1/2025	10/1/2025
Claims Received Through	**Apr-25**	**May-25**	**Jun-25**	**Jul-25**	**Aug-25**	**Sep-25**
Claims Rec'd in HEALTHsuite	372,126	387,564	340,224	355,255	389,082	373,025



Claims Year Over Year Summary

Claims Compliance - comparing September 2025 to September 2024 as follows: 30 Days - 88.4% (2025) vs 83.5% (2024) 45 Days - 99.4% (2025) vs 99.9% (2024) 90 Days - 99.9% (2025) vs 99.9% (2024)	90% of clean claims in 30 calendar days 95% of all claims in 45 working days 99% of all claims in 90 calendar days	90% of clean claims in 30 calendar days 95% of all claims in 45 working days 99% of all claims in 90 calendar days
Claims Received - AAH received 373,025 claims in September 2025 vs 322,196 in September 2024	N/A	N/A
EDI - the volume of EDI submissions was 87% which is the high end of the normal month to month range of ~77% - 87%	N/A	N/A
Original Claims Processed - AAH processed 352,758 in September 2025 (21 working days) vs 304,806 in September 2024 (21 working days)	N/A	N/A
Medical Claims Expense - the amount of paid claims in September 2025 was $135,164,354 (4 check runs) vs $137,769,061 in September 2024 (4 check runs)	N/A	N/A
Interest Expense - the amount of interest paid in September 2025 was $122,638 vs $113,022 in September 2024	N/A	.05% - .075% of the monthly medical expense
Auto Adjudication - the AAH rate in September 2025 was 88.9% vs 81.3% in September 2024	N/A	85% or higher
Average Days from Receipt to Payment - the average # of days from receipt to payment in September 2025 was 16 days vs 16 days in September 2024	N/A	<= 25 days
Pended Claim Age - comparing September 2025 to September 2024 as follows: 0-30 calendar days - 44,263 (2025) vs 42,285 (2024) 31-61 calendar days - 17,934 (2025) vs 7,187 (2024) Over 62 calendar days - 47,834 (2025) vs 4 (2024) *Pended claims over 62 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 September 2025 to September 2024	N/A	N/A

Provider Dispute Resolution
August 2025 and September 2025

METRICS

PDR Compliance	Aug-25	Sep-25
# of PDRs Resolved	2,769	2,823
# Resolved Within 45 Working Days	2,761	2,816
% of PDRs Resolved Within 45 Working Days	99.7%	99.7%

PDRs Received	Aug-25	Sep-25
# of PDRs Received	2,762	3,266
PDR Volume Total	**2,762**	**3,266**

PDRs Resolved	Aug-25	Sep-25
# of PDRs Upheld	2,071	2,467
% of PDRs Upheld	75%	87%
# of PDRs Overturned	698	356
% of PDRs Overturned	25%	13%
Total # of PDRs Resolved	**2,769**	**2,823**

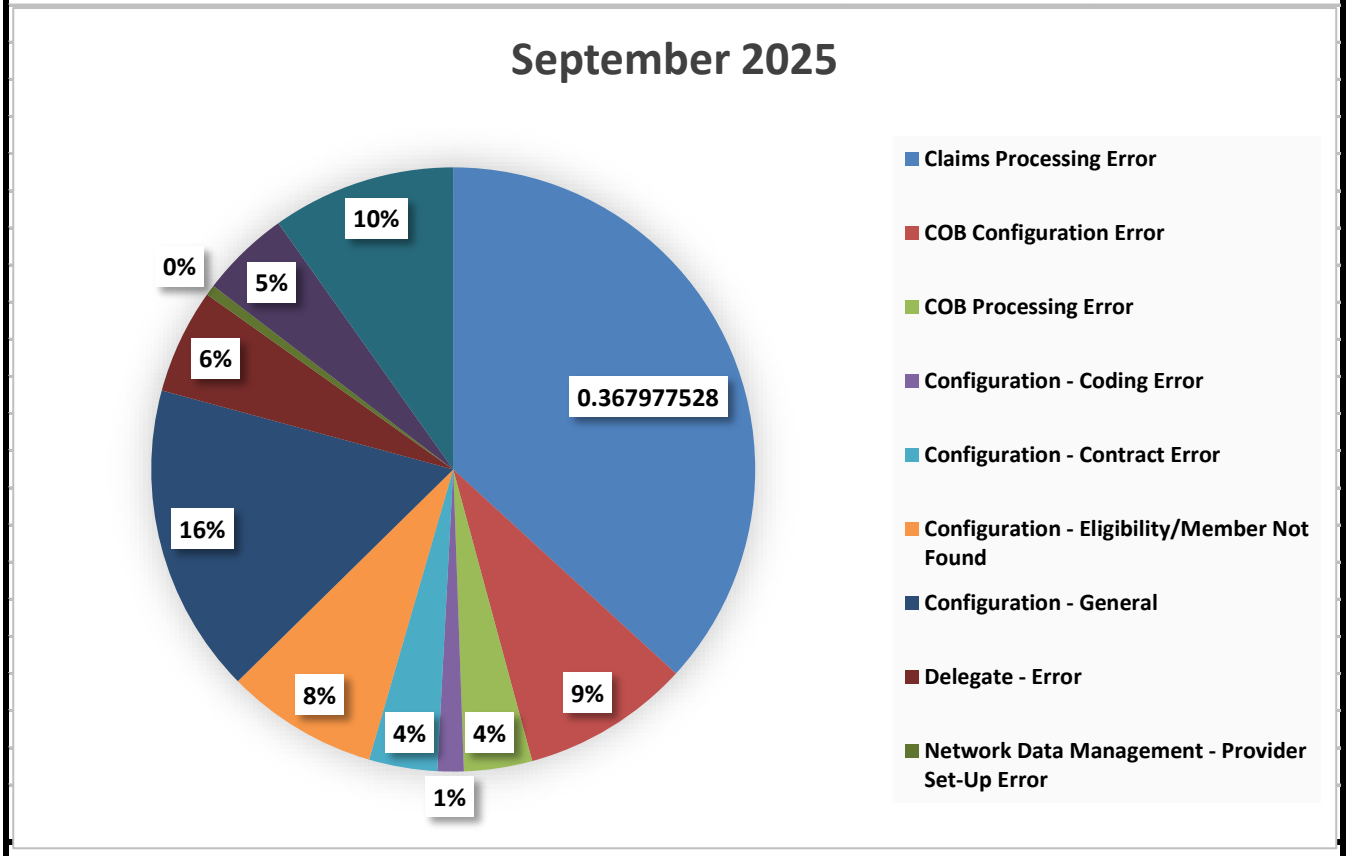
Average Turnaround Time	Aug-25	Sep-25
Average # of Days to Resolve PDRs	37	40
Oldest Resolved PDR in Days	124	268

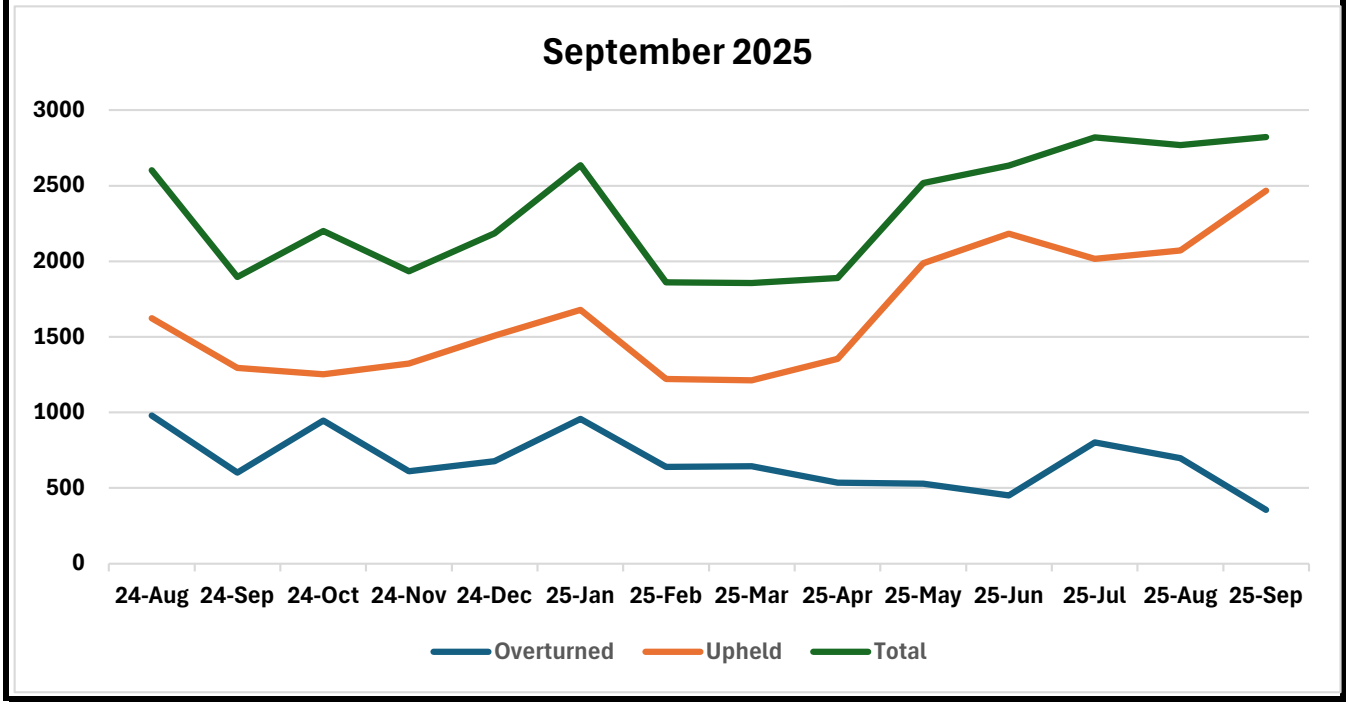
Unresolved PDR Age	Aug-25	Sep-25
0-45 Working Days	5,648	5,669
Over 45 Working Days	0	0
Total # of Unresolved PDRs	**5,648**	**5,669**

Provider Dispute Resolution
August 2025 and September 2025

Sep-25

PDR Resolved Case Overturn Reasons





Provider Dispute Resolution Year Over Year Summary

# of PDRs Resolved - 2,823 in September 2025 vs 1,897 in September 2024	N/A	N/A
# of PDRs Received - 3,266 in September 2025 vs 2,340 in September2024	N/A	N/A
# of PDRs Resolved within 45 working days -2,816 in September 2025 vs 1,889 in September 2024	N/A	N/A
% of PDRs Resolved within 45 working days -99.7% in September 2025 vs 99.6% in September 2024	95%	95%
Average # of Days to Resolve PDRs - 40 days in September 2025 vs 40 days in September 2024	N/A	30
Oldest Resolved PDR in Days -268 days in September 2025 vs 112 days in September 2024	N/A	N/A
# of PDRs Upheld - 2,467 in September 2025 vs 1,295 in September 2024	N/A	N/A
% of PDRs Upheld - 87% in September 2025 vs 68% in September2024	N/A	> 75%
# of PDRs Overturned - 356 in September 2025 vs 602 in September 2024	N/A	N/A
% of PDRs Overturned - 13% in September 2025 vs 32% in September 2024	N/A	< 25%
PDR Overturn Reasons: Claims processing errors - 37% (2025) vs 31% (2024) Configuration errors - 40% (2025) vs 45% (2024) COB - 13% (2025) vs 9% (2024) Clinical Review/UM Decisions/Medical Necessity Met - 10% (2025) vs 10% (2024)	N/A	N/A

Provider Relations Dashboard September 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	7,861	9,214	9,330	8,838	8,883			
Abandoned Calls	3,600	1,133	1,434	1,685	1,254	2,245	1,545	1,857	2,089			
Answered Calls (PR)	7,377	7,752	6,869	7,024	6,607	6,969	7,785	6,981	6,794			
Recordings/Voicemails	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Incoming Calls (R/V)	2,910	2,140	13	15	12	6	14	9	5			
Abandoned Calls (R/V)												
Answered Calls (R/V)	2,910	2,140	13	15	12	6	14	9	5			
Outbound Calls	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Outbound Calls	868	1,162	434	602	570	520	693	650	669			
N/A												
Outbound Calls	868	1,162	434	602	570	520	693	650	669			
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	8,443	9,740	10,037	9,497	9,557			
Abandoned Calls	3,600	1,133	1,434	1,685	1,254	2,245	1,545	1,857	2,089			
Total Answered Incoming, R/V, Outbound Calls	11,155	11,054	7,316	7,641	7,189	7,495	8,492	7,640	7,468			

Provider Relations Dashboard September 2025

Call Reasons (Medi-Cal and Group Care)

Category	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Authorizations	5.1%	5.8%	5.4%	5.0%	5.2%	5.4%	5.7%	5.3%	6.3%			
Benefits	5.1%	3.7%	3.4%	3.9%	6.4%	3.4%	3.2%	3.3%	2.9%			
Claims Inquiry	39.4%	43.9%	43.7%	46.3%	47.7%	48.5%	46.8%	45.2%	42.1%			
Change of PCP	2.5%	2.7%	2.4%	2.9%	2.8%	2.0%	2.2%	1.9%	2.5%			
Check Tracer	0.7%	0.6%	1.0%	0.9%	0.7%	1.0%	0.6%	0.6%	0.6%			
Complaint/Grievance (includes PDRs)	5.8%	6.7%	6.8%	6.5%	7.6%	7.1%	8.6%	9.1%	9.8%			
Contracts/Credentialing	0.8%	0.8%	0.7%	0.8%	0.8%	0.8%	0.8%	0.8%	0.9%			
Demographic Change	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%			
Eligibility - Call from Provider	21.0%	17.4%	17.0%	17.9%	16.5%	17.2%	16.3%	17.7%	18.8%			
Exempt Grievance/ G&A	0.0%	0.1%	6.8%	0.0%	0.1%	0.0%	0.1%	0.0%	0.0%			
General Inquiry/Non member	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%			
Health Education	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%			
Intrepreter Services Request	0.5%	0.5%	0.6%	0.4%	0.4%	0.4%	0.4%	0.5%	0.5%			
Provider Portal Assistance	3.4%	3.2%	3.9%	3.4%	3.4%	3.4%	3.6%	3.9%	3.9%			
Pharmacy	0.1%	0.2%	0.1%	0.0%	0.1%	0.1%	0.0%	0.2%	0.2%			
Prop 56	0.1%	0.0%	0.0%	0.1%	0.1%	0.1%	0.1%	0.0%	0.0%			
Provider Information Updates/ W9	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%			
Transportation Services	0.0%	0.2%	0.2%	0.2%	0.3%	0.1%	0.1%	0.2%	0.1%			
Transferred Call	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%			
All Other Calls	15.5%	14.4%	7.9%	11.4%	7.9%	10.4%	11.2%	11.1%	11.2%			
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			

Field Visit Activity Details

Alliance Provider Relations Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Claims Issues	28	72	89	54	60	41	48	25	77			
Contracting/Credentialing	29	41	50	59	150	66	53	51	88			
Drop-ins	127	83	141	146	149	96	220	189	227			
JOM's	2	2	3	2	3	1	3	1	2			
New Provider Orientation	100	134	118	173	143	182	154	102	132			
Quarterly Visits	0	0	0	82	0	0	0	0	0			
UM Issues	0	0	3	1	1	5	3	0	6			
Total Field Visits	286	332	404	517	506	391	481	368	532	0	0	0

ALLIANCE NETWORK SUMMARY, CURRENTLY CREDENTIALED PRACTITIONERS - September 2025						
Practitioners		PCP 396	SPEC 765	AHP 718	BH/ABA 3,296	PCP/SPEC 12
Direct Network vs Delegated Network Breakdown			AAH 3,922	AHS 295	CHCN 611	COMBINATION OF GROUPS 359
Facilities	452					

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	277	14	Y	Y	Y
Recred Files in Process	255	0	Y	Y	Y
Expirables updated **Insurance, License, DEA, Board Certifications**					Y
Files currently in process	**532**				
		*** 25 business days = 35 calendar days**			

September 2025 Peer Review and Credentialing Committee Approvals	
Initial Credentialing	**Number**
PCP	5
SPEC	9
ANCILLARY	20
MIDLEVEL/AHP	4
BH/ABA	117
Sub-total	**155**
Recredentialing	
PCP	2
SPEC	8
ANCILLARY	1
MIDLEVEL/AHP	3
BH/ABA	29
Sub-total	**43**
TOTAL	**198**

September 2025 Facility Approvals	
Initial Credentialing	5
Recredentialing	23
Sub-total	**28**
Facility Files in Process	**49**

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

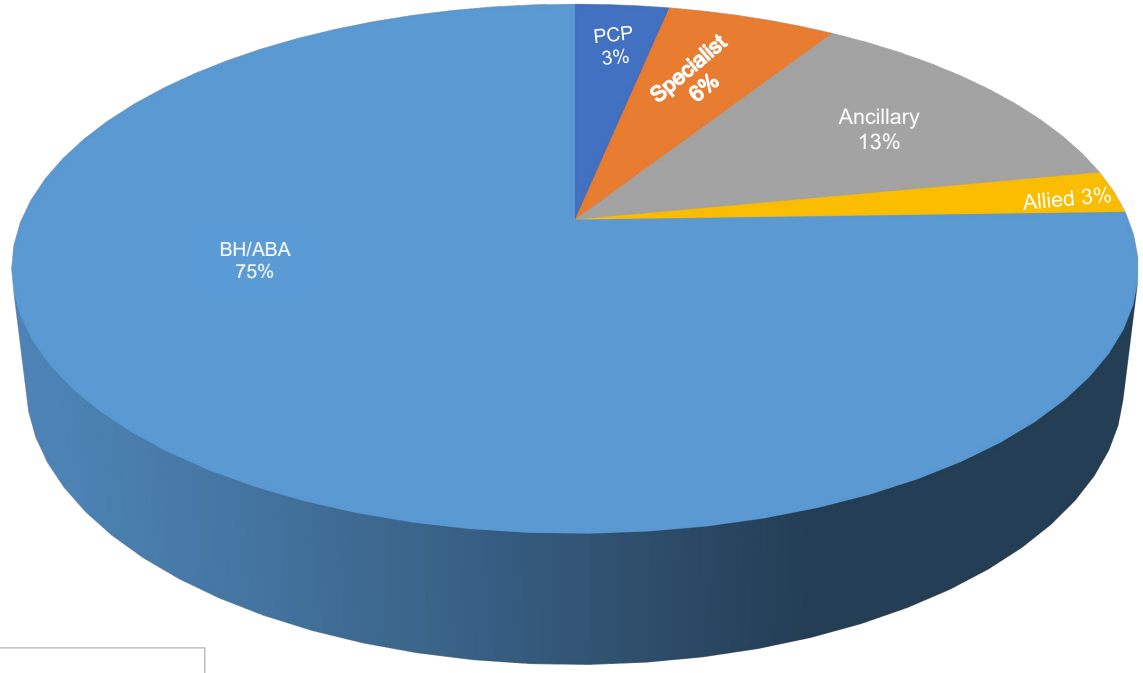
LAST NAME	FIRST NAME	CATEGORY	INITIAL / RE-CRED	CRED DATE
Abreu	Claudia	BH-Telehealth	INITIAL	9/16/2025
Abubakkar Mohammad Hussain	Saleena	ABA-Telehealth	INITIAL	9/16/2025
Adair	Jamie	BH	INITIAL	9/16/2025
Adamczyk	Debra	BH-Telehealth	INITIAL	9/16/2025
Adewale	Omotoke	BH-Telehealth	INITIAL	9/16/2025
Agonafer	Edden	BH-Telehealth	INITIAL	9/16/2025
Ali	Faheemah	Doula	INITIAL	9/16/2025
Alkhudari	Tala	ABA-Telehealth	INITIAL	9/16/2025
Allen	Amante	ABA-Telehealth	INITIAL	9/16/2025
Arana	Christine	ABA-Telehealth	INITIAL	9/16/2025
Bailey	Emma	BH	INITIAL	9/16/2025
Bales	Michelle	BH-Telehealth	INITIAL	9/16/2025
Barhorst	Nicole	BH-Telehealth	INITIAL	9/16/2025
Barriga	Jessica	BH-Telehealth	INITIAL	9/16/2025
Bautista	Johann	BH	INITIAL	9/16/2025
Beavers-Silva	Priscilla	BH	INITIAL	9/16/2025
Beltran	Karianne	Ancillary	INITIAL	9/16/2025
Bhatter	Param	Specialist	INITIAL	9/16/2025
Biton	Juliet	ABA-Telehealth	INITIAL	9/16/2025
Boetger	Raymond	Ancillary	INITIAL	9/16/2025
Bonsall	Theodora	BH	INITIAL	9/16/2025
Brown	Pamela	BH-Telehealth	INITIAL	9/16/2025
Brown	Stephanie	Specialist	INITIAL	9/16/2025
Bui	Vinh	Specialist	INITIAL	9/16/2025
Bulaclac	Camille	BH-Telehealth	INITIAL	9/16/2025
Burch Barnikel	Taylor	Specialist	INITIAL	9/16/2025
Cativo-Zetino	Michelle	BH-Telehealth	INITIAL	9/16/2025
Cavellier	Sharyl	BH-Telehealth	INITIAL	9/16/2025
Celi	Mylynne	BH-Telehealth	INITIAL	9/16/2025
Centeno	Diego	BH-Telehealth	INITIAL	9/16/2025
Chirumamilla	Yashitha	Primary Care Physician	INITIAL	9/16/2025
Chong	Adriana	Ancillary	INITIAL	9/16/2025
Chu	Anita	BH-Telehealth	INITIAL	9/16/2025
Davila Corona	Ana	ABA-Telehealth	INITIAL	9/16/2025
De Leon	Jessica	ABA-Telehealth	INITIAL	9/16/2025
Deacon	Cassie	BH-Telehealth	INITIAL	9/16/2025
D'Morias	Samantha	BH-Telehealth	INITIAL	9/16/2025
Dobbins	Arnita	Doula	INITIAL	9/16/2025
Duran	Daisee	BH-Telehealth	INITIAL	9/16/2025
Durbin	Cara	BH-Telehealth	INITIAL	9/16/2025
Elster	Rebecca	BH-Telehealth	INITIAL	9/16/2025
Enav	Emma	BH	INITIAL	9/16/2025
Enworom	Ozioma	BH-Telehealth	INITIAL	9/16/2025
Gallardo	Alejandra	BH	INITIAL	9/16/2025
Galliano	Lynn	ABA	INITIAL	9/16/2025
Garza	Brenda	BH-Telehealth	INITIAL	9/16/2025
Gay	Breanna	Doula	INITIAL	9/16/2025
Go	Christopher	BH-Telehealth	INITIAL	9/16/2025
Godbole	Shehla	Ancillary	INITIAL	9/16/2025
Golding	Maxwell	BH-Telehealth	INITIAL	9/16/2025
Gomez	Noemi	ABA-Telehealth	INITIAL	9/16/2025
Gosvener	Mitchell	BH-Telehealth	INITIAL	9/16/2025
Griesheimer	Stacy	Ancillary	INITIAL	9/16/2025
Gupta	Anuj	Specialist	INITIAL	9/16/2025
Hanaway	Sharlene	BH-Telehealth	INITIAL	9/16/2025
Hanson	Anne	BH-Telehealth	INITIAL	9/16/2025

LAST NAME	FIRST NAME	CATEGORY	INITIAL / RE-CRED	CRED DATE
Henning	Talyce	Doula	INITIAL	9/16/2025
Hill	Roxanne	ABA	INITIAL	9/16/2025
Ho	Stacey	BH-Telehealth	INITIAL	9/16/2025
Hobson	Lisa	BH	INITIAL	9/16/2025
Igwe	Amarachi	BH-Telehealth	INITIAL	9/16/2025
Jackson	Ollie	Specialist	INITIAL	9/16/2025
Jaggi	Akash	BH-Telehealth	INITIAL	9/16/2025
Jayadevan	Syamjith	BH-Telehealth	INITIAL	9/16/2025
Jean-Felix	Carla	BH-Telehealth	INITIAL	9/16/2025
Johnson	Marti	BH	INITIAL	9/16/2025
Johnson	Trenice	BH-Telehealth	INITIAL	9/16/2025
Jones	Kennedy	BH	INITIAL	9/16/2025
Kang	Di	Ancillary	INITIAL	9/16/2025
Khokhar	Nazurah	ABA-Telehealth	INITIAL	9/16/2025
Kim	Grace	BH-Telehealth	INITIAL	9/16/2025
Kral	Stefanie	BH-Telehealth	INITIAL	9/16/2025
La Torre	Gabriela	ABA-Telehealth	INITIAL	9/16/2025
Lanns	Cherysse	Ancillary	INITIAL	9/16/2025
LaPorta	Lauren	BH	INITIAL	9/16/2025
Lee	Hyun Kyung	BH-Telehealth	INITIAL	9/16/2025
Leung	Lai	Ancillary	INITIAL	9/16/2025
Lim	Russell	BH-Telehealth	INITIAL	9/16/2025
Lopez	Lilia	BH	INITIAL	9/16/2025
Lopez-Flores	Jenifer	ABA	INITIAL	9/16/2025
Lowery	Brianne	BH-Telehealth	INITIAL	9/16/2025
Lujan	Sandra	BH-Telehealth	INITIAL	9/16/2025
Lum	Selena	ABA-Telehealth	INITIAL	9/16/2025
Maldonado	Kristin	ABA-Telehealth	INITIAL	9/16/2025
Mammini	Christine	BH-Telehealth	INITIAL	9/16/2025
Manzo	Angelica	ABA-Telehealth	INITIAL	9/16/2025
Mayes	Donald	BH-Telehealth	INITIAL	9/16/2025
Meraz	Jaqueline	BH	INITIAL	9/16/2025
Miles	Kelsey	ABA-Telehealth	INITIAL	9/16/2025
Miller	Jaclyn	BH-Telehealth	INITIAL	9/16/2025
Mironenko	Tatiana	Doula	INITIAL	9/16/2025
Mitchell	Jennifer	BH-Telehealth	INITIAL	9/16/2025
Miyakawa	Sandra	BH-Telehealth	INITIAL	9/16/2025
Mogannam	John	Primary Care Physician	INITIAL	9/16/2025
Mojica	Elizabeth	BH	INITIAL	9/16/2025
Morabia	Siddhi	Ancillary	INITIAL	9/16/2025
Moran	Sofia	BH-Telehealth	INITIAL	9/16/2025
Moua	Nancy	Allied Health	INITIAL	9/16/2025
Nair	Karun	Specialist	INITIAL	9/16/2025
Neupane	Shubhechha	Allied Health	INITIAL	9/16/2025
Niedzwiecki	Matthew	BH-Telehealth	INITIAL	9/16/2025
Nord	Alexandra	BH-Telehealth	INITIAL	9/16/2025
Norena Velasquez	Jairo	Specialist	INITIAL	9/16/2025
Ochoa	Briana	ABA-Telehealth	INITIAL	9/16/2025
Oran	Diane	BH-Telehealth	INITIAL	9/16/2025
Ortiz	Leslie	BH-Telehealth	INITIAL	9/16/2025
Oshinuga-Atere	Ebunoluwa	Primary Care Physician	INITIAL	9/16/2025
Pangilinan	John Simon	BH-Telehealth	INITIAL	9/16/2025
Pascual	Margarita	ABA	INITIAL	9/16/2025
Patel	Savan	ABA	INITIAL	9/16/2025
Patton	Larissa	BH-Telehealth	INITIAL	9/16/2025
Qreini	Sami	BH	INITIAL	9/16/2025
Rahimi	Shabnam	BH-Telehealth	INITIAL	9/16/2025

LAST NAME	FIRST NAME	CATEGORY	INITIAL / RE-CRED	CRED DATE
Reams	Starr	ABA-Telehealth	INITIAL	9/16/2025
Redd	Andrea	BH-Telehealth	INITIAL	9/16/2025
Rocha	Lucimara	BH-Telehealth	INITIAL	9/16/2025
Rodriguez	Diane	BH-Telehealth	INITIAL	9/16/2025
Rojas	Elizabeth	BH-Telehealth	INITIAL	9/16/2025
Romero	Mila	Doula	INITIAL	9/16/2025
Rose	Victoria	BH-Telehealth	INITIAL	9/16/2025
Saenz	Daniela	Ancillary	INITIAL	9/16/2025
Santiago	Pearlita	Allied Health	INITIAL	9/16/2025
Sekhon	Gaurav	BH-Telehealth	INITIAL	9/16/2025
Self	Leanne	BH-Telehealth	INITIAL	9/16/2025
Shapiro	Margaret	BH-Telehealth	INITIAL	9/16/2025
Shen	Amanda	ABA	INITIAL	9/16/2025
Singer	Carol	BH	INITIAL	9/16/2025
Slapik	Stephanie	BH	INITIAL	9/16/2025
Smith	Darrell De'Mario	BH	INITIAL	9/16/2025
Smith	Rochelle	BH-Telehealth	INITIAL	9/16/2025
Smith	Theresa	Ancillary	INITIAL	9/16/2025
Sola	Patrick	BH-Telehealth	INITIAL	9/16/2025
Stanley	Elizabeth	BH-Telehealth	INITIAL	9/16/2025
Suarez	Casandra	BH-Telehealth	INITIAL	9/16/2025
Syed	Hamid	Primary Care Physician	INITIAL	9/16/2025
Tang	Hai-Tao	Primary Care Physician	INITIAL	9/16/2025
Tegenkamp	Katherine	BH	INITIAL	9/16/2025
Teng	Teshu	Ancillary	INITIAL	9/16/2025
Thomas	Paula	BH-Telehealth	INITIAL	9/16/2025
Tillmon	Jenny	ABA-Telehealth	INITIAL	9/16/2025
Tiwari	Mariana	BH-Telehealth	INITIAL	9/16/2025
Torres	Luis	BH-Telehealth	INITIAL	9/16/2025
Troitskaia-Williams	Svetlana	BH-Telehealth	INITIAL	9/16/2025
Tur	Marianne	BH-Telehealth	INITIAL	9/16/2025
Valencia	Rilee	BH-Telehealth	INITIAL	9/16/2025
Valle	Melissa	BH-Telehealth	INITIAL	9/16/2025
Velasco	Itzel	BH-Telehealth	INITIAL	9/16/2025
Villavicencio	Maryah	BH-Telehealth	INITIAL	9/16/2025
Weaver	Andrea	Doula	INITIAL	9/16/2025
Williams	LaKia	Doula	INITIAL	9/16/2025
Wongk	Belen	BH-Telehealth	INITIAL	9/16/2025
Woodall	Jasha	ABA-Telehealth	INITIAL	9/16/2025
Xie	Yun-Yi	Allied Health	INITIAL	9/16/2025
Yim	Daniel	BH-Telehealth	INITIAL	9/16/2025
Yun	Nicole	Specialist	INITIAL	9/16/2025
Chu	Stefanie	Primary Care Physician	RE-CRED	9/16/2025
Hansra	Haramrit	Specialist	RE-CRED	9/16/2025
Hernandez	Cheri	ABA-Telehealth	RE-CRED	9/16/2025
Ho	Stephanie	Specialist	RE-CRED	9/16/2025
Hopper	Marie	BH	RE-CRED	9/16/2025
Hurtado	Jose	BH	RE-CRED	9/16/2025
James	Anne	BH	RE-CRED	9/16/2025
Jensen	Mariah	ABA-Telehealth	RE-CRED	9/16/2025
Jones-Kazan	Denise	BH-Telehealth	RE-CRED	9/16/2025
Kahane	Bonnie	BH	RE-CRED	9/16/2025
Kayler	Kira	BH-Telehealth	RE-CRED	9/16/2025
Khan	Sana	ABA-Telehealth	RE-CRED	9/16/2025
Kibira	Catharine	BH	RE-CRED	9/16/2025
Kim	Eric	Specialist	RE-CRED	9/16/2025

LAST NAME	FIRST NAME	CATEGORY	INITIAL / RE-CRED	CRED DATE
Kumar	Pradeep	BH	RE-CRED	9/16/2025
Lane	Briana	ABA-Telehealth	RE-CRED	9/16/2025
Lawton	Diana	BH	RE-CRED	9/16/2025
Le	Vuong	ABA	RE-CRED	9/16/2025
Liebert	Neil	BH	RE-CRED	9/16/2025
Macias	Margaret	BH	RE-CRED	9/16/2025
Marpo	Alicia	BH	RE-CRED	9/16/2025
Saad	Joyce	BH	RE-CRED	9/16/2025
Santa Maria	Kimberli	ABA-Telehealth	RE-CRED	9/16/2025
Shadman	Chehrzad	BH	RE-CRED	9/16/2025
Shah	Hema	BH	RE-CRED	9/16/2025
Shamszad	Laila	BH	RE-CRED	9/16/2025
Shaw	Maurice	BH	RE-CRED	9/16/2025
Sohn	Jessica	BH	RE-CRED	9/16/2025
Stacey	Michael	Primary Care Physician	RE-CRED	9/16/2025
Sudermann	Annemarie	BH	RE-CRED	9/16/2025
Tang	Kit	BH	RE-CRED	9/16/2025
Vincent	Pamela	BH-Telehealth	RE-CRED	9/16/2025
Wang	Sabrina	Allied Health	RE-CRED	9/16/2025
Welty	Kathryn	Specialist	RE-CRED	9/16/2025
Wilkinson	Nathan	Allied Health	RE-CRED	9/16/2025
Winkle	Daniel	Specialist	RE-CRED	9/16/2025
Wong	Victoria	Allied Health	RE-CRED	9/16/2025
Wood	Kathryn	BH	RE-CRED	9/16/2025
Xu	Junhui	Ancillary	RE-CRED	9/16/2025
Yang	Xin	Specialist	RE-CRED	9/16/2025
Yee	Cynthia	BH	RE-CRED	9/16/2025
Yogam	Kris	Specialist	RE-CRED	9/16/2025
Zourabian	Steven	Specialist	RE-CRED	9/16/2025

SEPTEMBER PEER REVIEW AND CREDENTIALING
INITIAL APPROVALS BY SPECIALTY



PCP	5
SPECIALIST	9
ANCILLARY	20
ALLIED	4
BH/ABA	117
TOTAL	155

Between July 2025 and September 2025, the Alliance completed **2,796** member orientation outreach calls among net new members and non-utilizers and conducted **170** net new member orientations and **19** non-utilizer member orientations (**6.8%** member participation rate). In addition, the Outreach team completed **108** Alliance website inquiries, **22** service requests, **12** community events, **9** member education events and **1** Community Meeting/Presentation events in Q1.

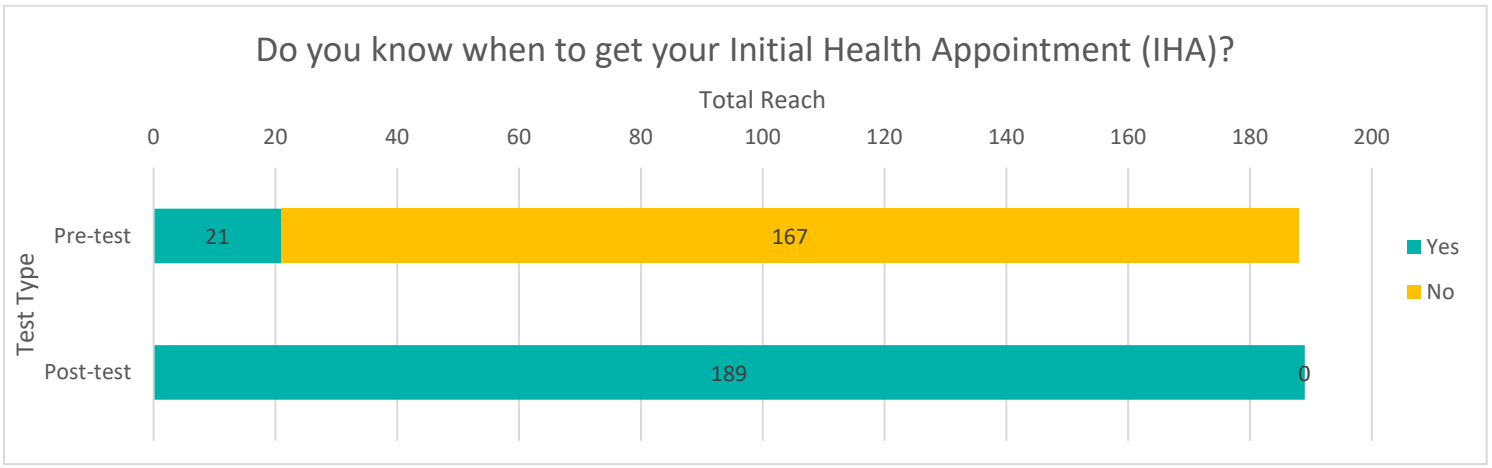
The Communications & Outreach Department began reporting the number of members reached during outreach activities in late February 2018. Since July 2018, approximately **41,905** self-identified Alliance members have been reached during outreach activities.

On **Monday, March 16, 2020**, the Alliance began assisting members by telephone only, following the statewide Shelter-in-Place (SIP) guidance to protect the general public from the Coronavirus Disease (COVID-19). As a result, the Alliance proactively postponed all face-to-face member orientations and community events until further notice.

On **Wednesday, March 18, 2020,** the Alliance began conducting member orientations by phone. As of **Monday, June 30, 2025**, the Outreach Team has completed **53,070** member orientation outreach calls and conducted **10,054** orientations, achieving a **18.9%** participation rate.

The Alliance Member Orientation (MO) program has been in place since August 2016. In 2019, the program was recognized as a promising practice to increase member knowledge and awareness about the Initial Health Appointment, 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 March 18, 2020, through September 30, 2025, **10,054** members completed our MO program by phone.

After completing a MO, **100%** of members who completed the post-test survey in Q1 FY 25-26 reported knowing when to get their IHA, compared to only **11.2%** 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 25-26\Q1\September 2025**

Q1 FY 2025-2026 TOTALS

12	COMMUNITY EVENTS	2762	TOTAL REACHED AT COMMUNITY EVENTS
9	MEMBER EDUCATION EVENTS	1861	TOTAL REACHED AT MEMBER EDUCATION EVENTS
189	MEMBER ORIENTATIONS	189	TOTAL REACHED AT MEMBER ORIENTATIONS
1	MEETINGS/ PRESENTATIONS	100	TOTAL REACHED AT MEETINGS/PRESENTATIONS
26	TOTAL INITIATED/INVITED EVENTS	2581	TOTAL MEMBERS REACHED AT EVENTS
211	TOTAL EVENTS	4912	TOTAL REACHED AT ALL EVENTS

ALAMEDA
ASHLAND
BERKELEY
CASTRO VALLEY
DUBLIN
FREMONT
HAYWARD
LIVERMORE
NEWARK
OAKLAND
PLEASANTON
SAN LEANDRO
SAN LORENZO
UNION CITY

TOTAL REACH 17 CITIES

Cities represent the mailing addresses for members who completed a Member Orientation by phone. The following cities had <1% reach during Q1 2025: Cherryland, Emeryville, San Jose, and Winchester. The C&O Department started including these cities in the Q3 FY21 Outreach Report.

$1075.00

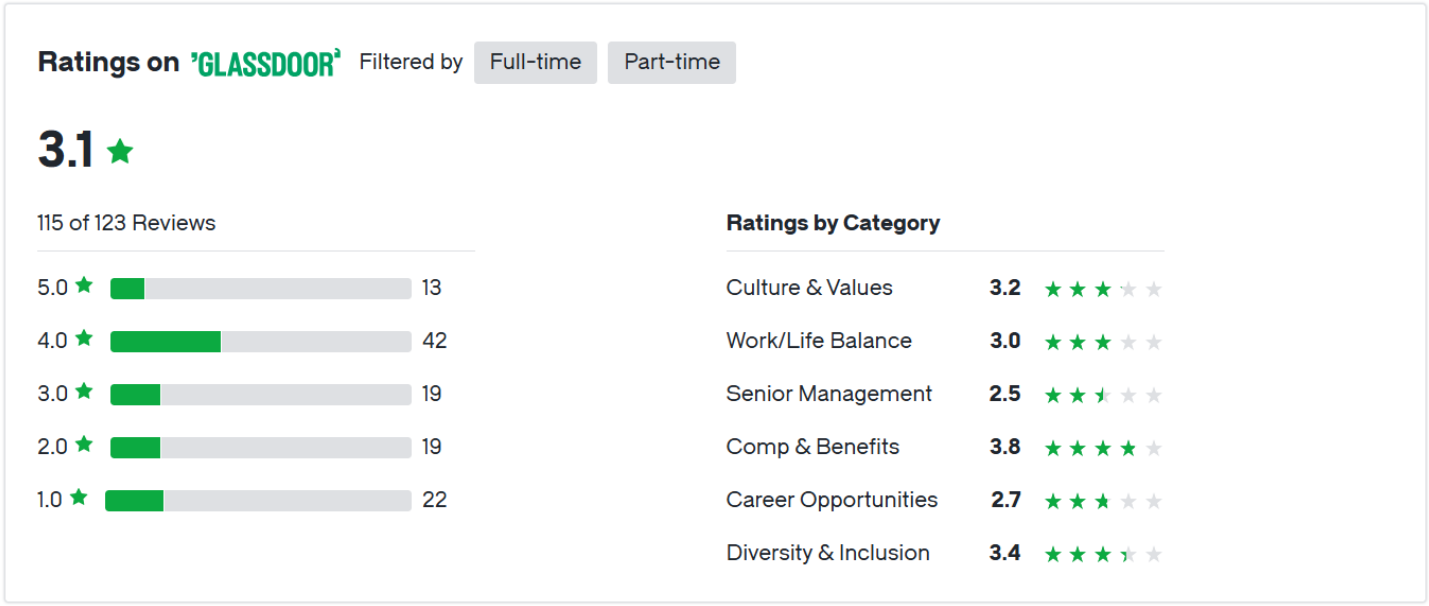
TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

** Includes refundable deposit.*

The Alliance Communications and Outreach (C&O) Department created the social media and website activity (SM&WA) Report to provide a high-level overview of stakeholder engagement through various digital media platforms. Between **September 1, 2025**, and **September 30, 2025**:

1. Alliance Website:
    - Received **99,783** unique visits
    - Served more than **650,000** page visits
2. Facebook Page:
    - The number of fans increased from **638** to **681** throughout this period.
    - Did not receive any reviews in **September 2025**
3. Glassdoor Page:
    - Maintained **3.1** out of a **5-star** overall rating
    - Did not receive any reviews in **September 2025**
4. Google Page:
    - **1,746** website clicks were made from the business profile
    - **1,613** calls were made from the business profile
    - Received 2 reviews in **September 2025**
5. Instagram Page:
    - Increased in followers from **661** to **675**
6. LinkedIn Page:
    - Increased followers from **6.9k to 7k**
    - Received **207-**page clicks
7. X (previously Twitter) Page:
    - Increased in followers from **355** to **356**
8. Yelp Page:
    - Page visits **57**
    - Appeared in Yelp searches **206** times
    - Received 1 review in **September 2025**

GLASSDOOR OVERVIEW

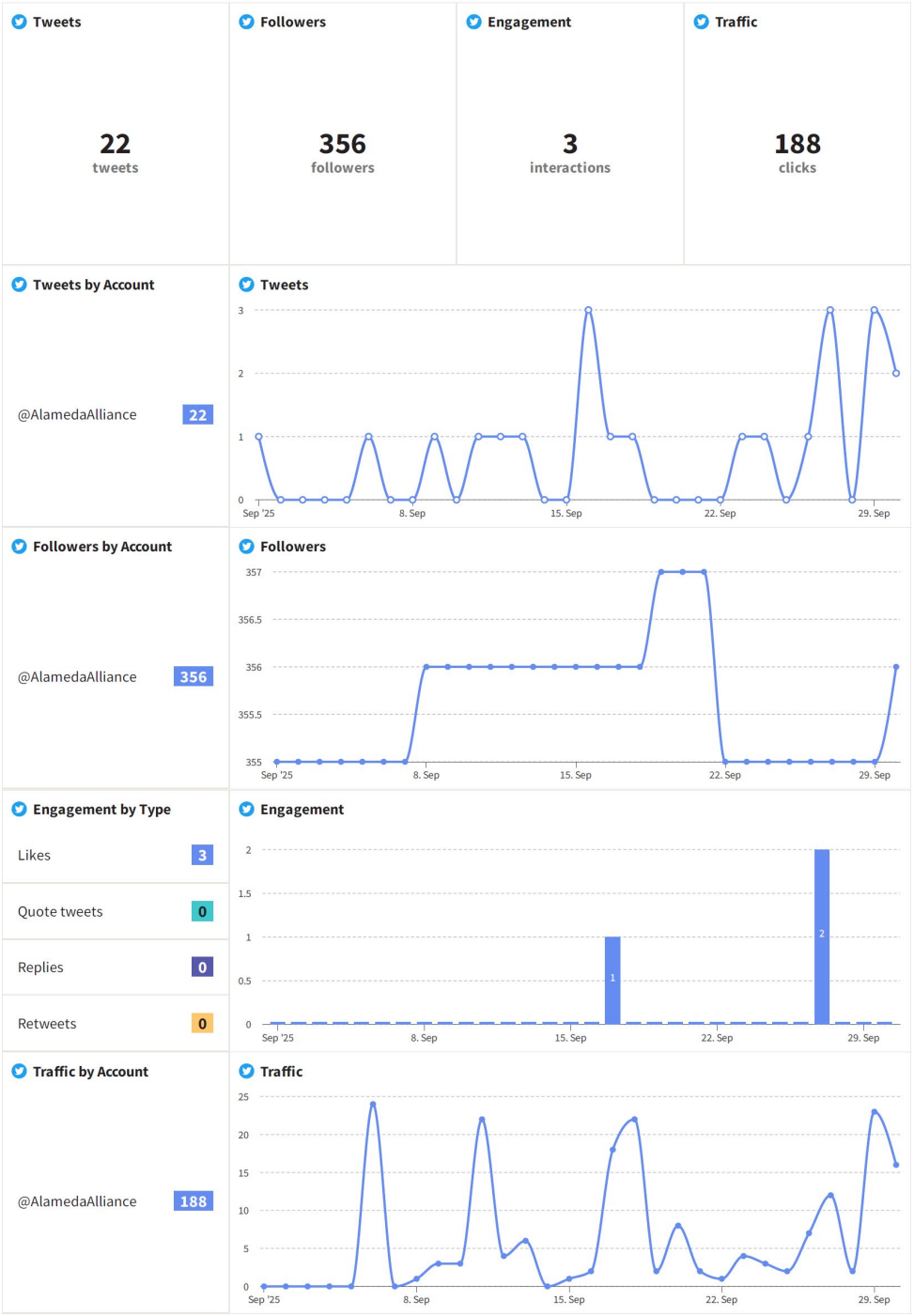


All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2025-2026\Q1\3. September 2025

FACEBOOK OVERVIEW

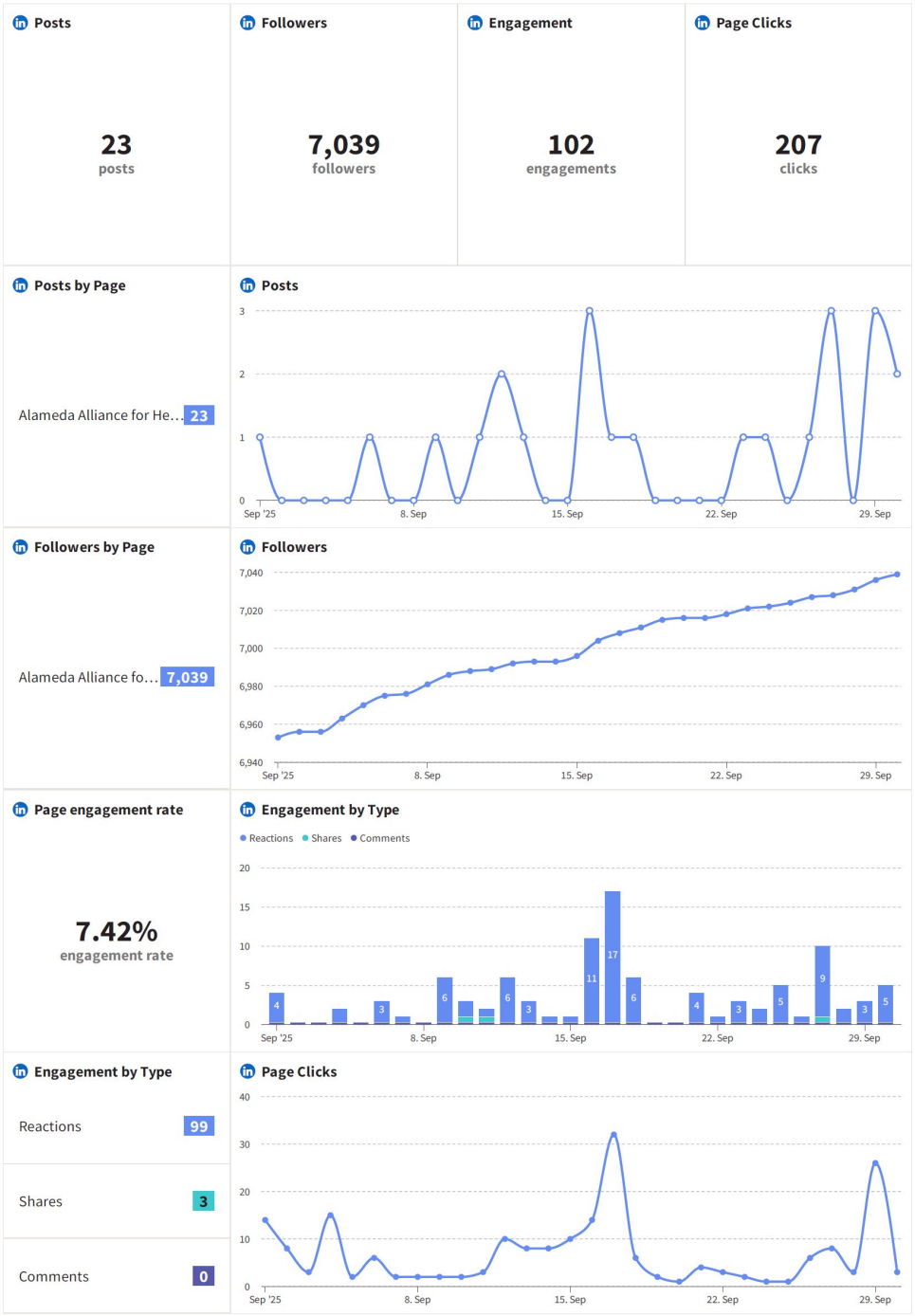
All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2025-2026\Q1\3. September 2025

X (previously TWITTER) OVERVIEW



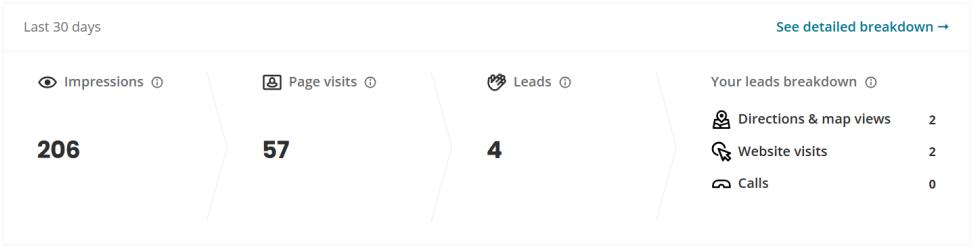
All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2025-2026\Q1\3. September 2025

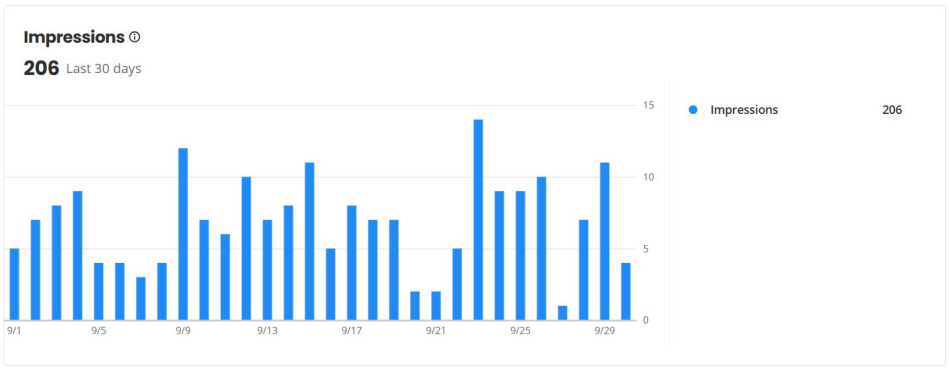
LINKEDIN OVERVIEW

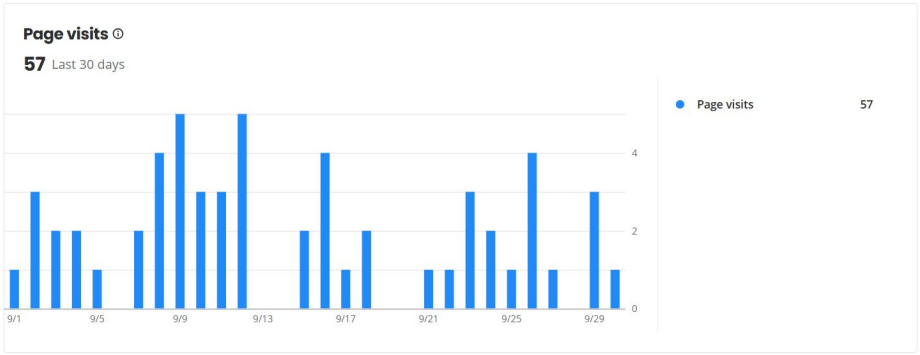


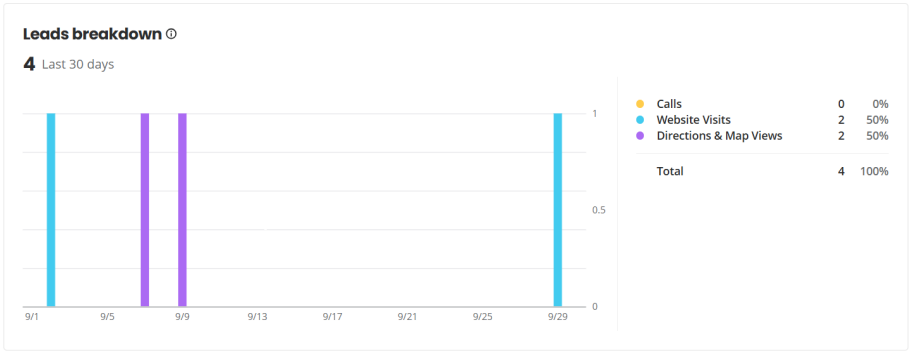
All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2025-2026\Q1\3. September 2025

YELP OVERVIEW



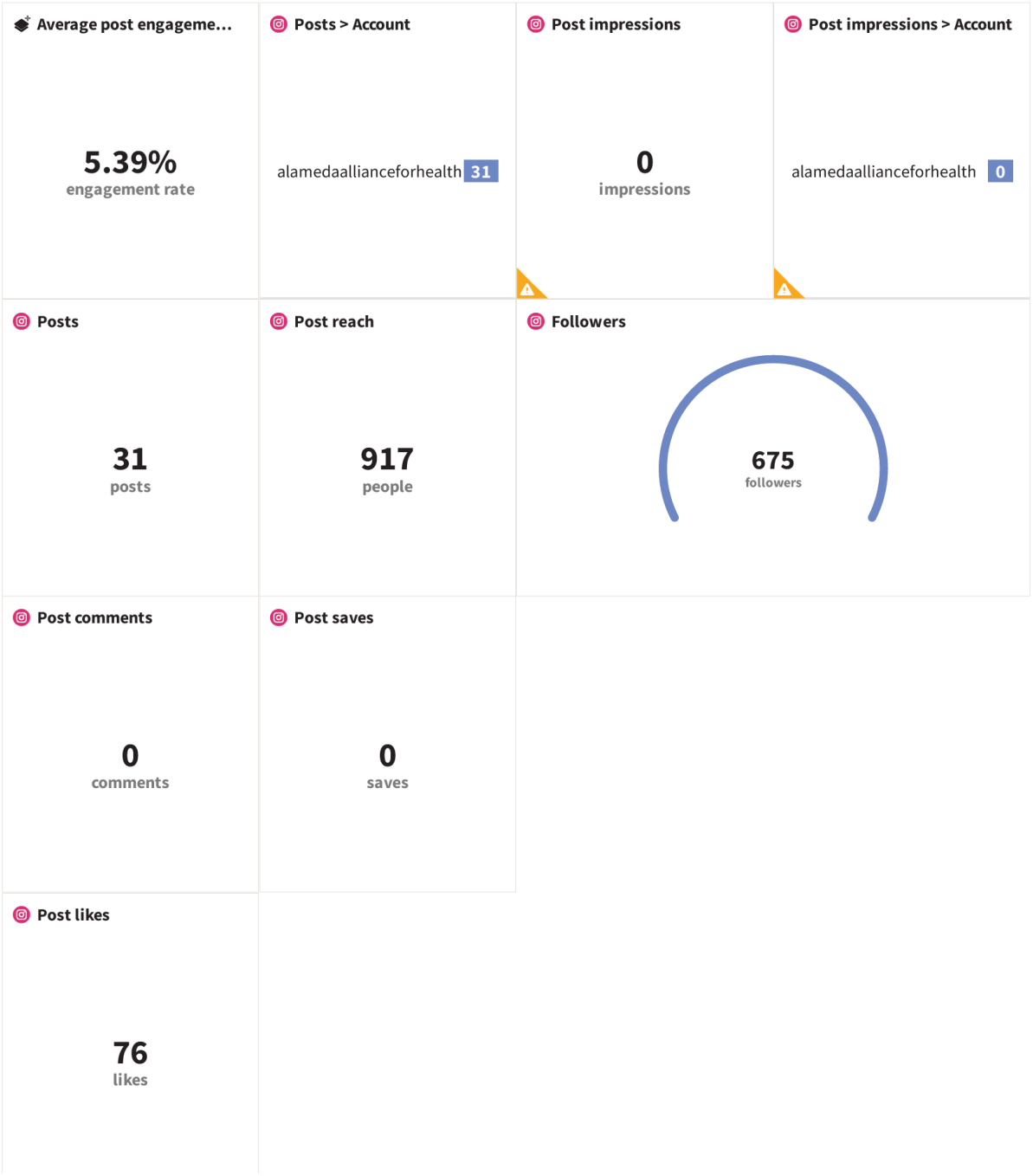






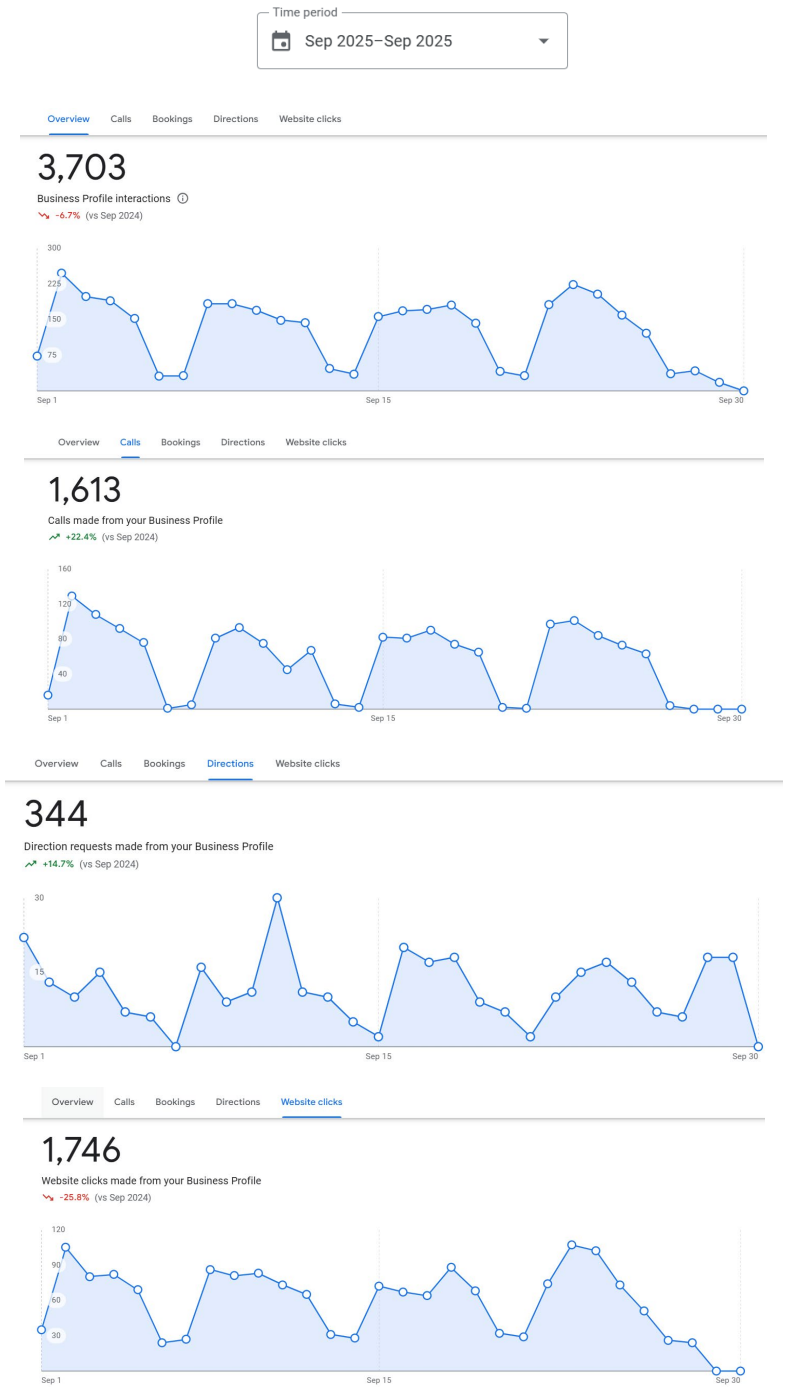
All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2025-2026\Q1\3. September 2025

INSTAGRAM OVERVIEW:



All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2025-2026\Q1\3. September 2025

GOOGLE OVERVIEW:



All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2025-2026\Q1\3. September 2025

Compliance

Richard Golfin III

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

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

Date: **October 10th, 2025**

Subject: **Compliance Division Report**

Enterprise Audit Updates

- 2023 Department of Health Care Services (DHCS) Focused Medical Survey
    - Nine (9) Corrective Action Plans (CAP) were identified related to Behavioral Health Care Services and Transportation Services (NEMT & NMT). To date, six (6) CAPs have been accepted. There are three (3) CAPs that have been partially accepted; The Plan continues to collaborate with Alameda County Behavioral Health (ACBH) for coordination of care. The Plan is awaiting DHCS guidance/response.
- 2023 Department of Managed Health Care (DMHC) Health Equity and Quality Performance CAP
    - The Plan received the 2023 Health Equity and Quality Performance Findings Report from the Department of Managed Health Care (DMHC) on September 2nd, 2025. The report identified benchmark deficiencies across multiple populations and product lines, requiring submission of a formal CAP.
    - The CAP must address each population with benchmark deficiencies across both Group Care and Medi-Cal lines of business. The CAP is due to DMHC on December 1st, 2025. A weekly workgroup meeting is held to address concerns and track progress of the deliverables.
- 2024 Department of Health Care Services (DHCS) Routine Full Medical Survey
    - The Plan received a total of twenty (20) findings. Sixteen (16) CAPs were accepted; four (4) CAPs were partially accepted. The Plan's final CAP update was submitted on June 23rd, 2025. The Plan is currently awaiting further guidance from DHCS.
- 2025 Department of Managed Health Care (DMHC) Routine Full Medical Survey
    - The DMHC lookback period spanned October 1st, 2022, through September 30th, 2024, and the onsite interview sessions occurred from March 3rd to March 7th, 2025. The Plan is still waiting to receive DMHC's preliminary report.

- 2025 Department of Managed Health Care (DMHC) Financial Examination

    - The DMHC conducted their daily conference calls from August 4th, 2025, through August 29th, 2025. The Plan is awaiting the DMHC's preliminary report.

- 2025 Health Services Advisory Group, Inc. (HSAG) Network Adequacy Validation Audit (NAV)

    - The Plan's virtual interviews were conducted on August 11th, 2025. On September 15th, 2025, HSAG issued a request for additional documentation. The Plan submitted the additional requested materials on September 19th, 2025. HSAG's review of the submission remains in progress.

Compliance Program Activity – All LOBs

- CMS Bid and Formulary Submission and Application

    - On June 2nd, 2025, the Alliance successfully submitted its CY2026 Medicare Bid and Formulary to CMS by the required deadline. The Alliance received approval of its CMS MAPD D-SNP Application on September 19th, 2025.

- Department of Managed Health Care (DMHC) Medicare Filings

    - On Thursday September 25th, 2025, DMHC issued an Order of Approval which granted approval for the Alliance's Dual Special Needs Plan product and any associated documents filed within E-Filing No. 20244060.

- New Legislation

    - On March 21st, 2025, Compliance submitted DMHC's 2024 Annual Newly Enacted Statutes All Plan Letter (APL 24-023) filing. This APL includes seventeen newly enacted laws that impact the Plan's Medi-Cal and/or Group Care lines of business. As of September 30th, 2025, the Plan has received three comment tables from DMHC, with the newest response due by October 10th, 2025, Senate Bill (SB) 729 (Health Care Coverage: Treatment for Infertility and Fertility Services) included in APL 24-023 was intended to become effective on July 1st, 2025. However, AB 116 (Health Omnibus Trailer Bill to delay the implementation to January 1st, 2026, has been approved by the legislature and has been signed by the Governor. The Plan received and provided feedback on a draft APL from DMHC related to SB 729 and awaits a final version.

    - On April 1st, 2025, DMHC published APL 25-007 which provides guidance and outlines compliance requirements related to AB 3275. The bill, effective January 1st, 2025, adjusts the claims reimbursement timeframe from 45 working days to 30 calendar days. As of September 30th, 2025, the Plan received and responded to one Comment Table from DMHC. Compliance continues to lead the internal workstreams focused on updating operational

workflows and system updates to ensure compliance prior to the effective date.

- H.R. 1 – Federal Payments to Prohibited Entities

  - On July 3rd, 2025, DHCS published APL 25-011 related to the implementation of H.R. 1, which restricts payments to Medi-Cal and Family Planning, Access Care, and Treatment Program (Family PACT) providers that meet the definition of "Prohibited Entity". In response, Compliance convened an ad-hoc meeting on July 7th, 2025, with impacted departments to assess the impact and coordinate next steps. Compliance shared the feedback with the Associations to support their advocacy and clarification efforts. On July 24th, 2025, this APL became an IPD-led and supported project. DHCS released an additional update to the APL on September 17th, 2025. The Plan has updated its claims system to align with the requirements based on the guidance received to date.

Alameda Alliance Privacy Office Operational Updates

- Notice of Privacy Practices (NPP) Update, All Lines of Business

  - The Alliance's Notice of Privacy Practices has been revised and finalized to reflect regulatory requirements for all lines of business. All associated sources, including member-facing PDFs and the Alliance website, are being updated to ensure consistency and compliance. The DHCS previously approved updates in May 2025. The DMHC filing was submitted on September 10th, 2025. The CMS filing was submitted on September 15th, 2025. The translation into threshold languages began on September 20th, 2025.

    This update ensures that members and stakeholders have access to the most current privacy information across all lines of business, reinforcing our commitment to transparency, compliance, and member trust.

- Authorized Representative Form (AOR), Updated for all Lines of Business

  - The updated AOR Form has been reviewed and approved by DHCS as of September 4th, 2025, and is being translated into all threshold languages. The form has undergone multiple rounds of review and consensus across Compliance, DMHC, CMS, and internal stakeholders to resolve outstanding comments and align with regulatory requirements across all lines of business. This update ensures the AOR Form is compliant, consistent with regulatory standards, and ready for member-facing implementation.

- Minimum Necessary Standard – Policy & Procedure Update

    - In September 2025, the Alameda Alliance Privacy Office submitted revisions to the Minimum Necessary Policy and Procedure for Administrative Oversight Committee (AOC) review. These updates are designed to ensure continued compliance with federal and state requirements, including new regulatory standards for the Dual Eligible Special Needs Plan (D-SNP). The updated policy will be presented for discussion and approval at the upcoming Administrative Oversight Committee meeting scheduled for October 15th, 2025. Adoption of these revisions will strengthen the Alliance's safeguards around the use and disclosure of protected health information, reinforcing our ongoing commitment to regulatory compliance and member privacy.

- CMP-042 Authorized Representative Workflow Policy & Procedure

    - In September 2025, the Alameda Alliance Privacy Office completed substantive revisions to the Authorized Representative Workflow Policy (CMP-042) for Administrative Oversight Committee (AOC) review. These updates expand the policy to include the D-SNP line of business, clarify the process for members to obtain and submit the Authorized Representative (AOR) form, and establish procedures for addressing incomplete or defective submissions. The revisions also strengthen document-retention requirements, incorporate Medicare Part D standards (including PBM coordination), enhance protections for sensitive services, and codify training requirements for staff on recognition and handling of AOR forms. In addition, the policy now specifies that an AOR remains valid for one (1) year and automatically terminates upon the member's death. The updated policy will be presented for discussion and approval at the upcoming Administrative Oversight Committee meeting on October 15th, 2025 (9:00–10:20 AM, Microsoft Teams). Adoption will reinforce consistent, member-centered practices across all departments with Privacy oversight while ensuring compliance with federal and state regulatory standards.

- CMP-026 Compliance Training Policy & Procedure

    - In September 2025, the Alameda Alliance Privacy Office completed the annual review of the Compliance Training Policy and Procedure (CMP-026) for the Administrative Oversight Committee (AOC) review. The updated policy reflects the current structure of the Alliance's compliance training program, including updated training schedules for new hires and annual training requirements, and clarifies additional details to ensure consistency and alignment across departments. The revised policy will be presented for discussion and approval at the upcoming Administrative Oversight Committee meeting on October 15th, 2025 (9:00–10:20 AM, Microsoft Teams). Adoption will reinforce the Alliance's ongoing commitment to a strong culture of compliance by ensuring staff training remains timely, comprehensive, and aligned with regulatory expectations.

- Annual Compliance Training Rollout
    - On September 8th, 2025, the Alliance successfully launched the Annual Compliance Training for all staff. This required training reinforces the organization's commitment to compliance, ethics, and regulatory standards, ensuring that every team member remains informed of their responsibilities under federal and state guidelines. Participation is being tracked, and completion rates will be reported to leadership to confirm timely adherence. The rollout reflects the Alliance's continued focus on cultivating a culture of compliance and accountability across the organization.
- 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 voting Board members, seventeen (17) have either completed their training or submitted sufficient proof of equivalent outside training, and one (1) has not started. The Plan continues coordination efforts with the Board Clerk and the Board Chair to improve Board training rates of compliance and will be scheduling an in-person training opportunity in October for the one (1) Board of Governors member still needing to complete the training.

Compliance

Supporting Documents

2025 APL IMPLEMENTATION TRACKING LIST						
#	Date Released	Regulatory Agency	APL #	APL Title	LOB	APL Purpose Summary
1	1/9/2025	DMHC	25-001	Southern California Fires and Enrollees' Continued Access to Health Care Services	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) 25-001, which provides information regarding Health and Safety Code section 1368.7.
2	1/17/2025	DHCS	25-001	2024-2025 Medi-Cal Managed Care Health Plan Meds/834 Cutoff and Processing Scheduling	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with the 2024-2025 Medi-Cal Eligibility Data System (MEDS)/834 cutoff and processing schedule.
3	1/13/2025	DHCS	25-002	Skilled Nursing Facility Workforce Quality Incentive Program	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with instructions on the payment and data sharing process required for the Skilled Nursing Facility (SNF) Workforce and Quality Incentive Program (WQIP) for Rating Periods between January 1, 2023, and December 31, 2026. The Calendar Year (CY) 2023 Rating Period is referred to as Program Year (PY) 1, CY 2024 Rating Period as PY 2, and so forth.
4	1/15/2025	DHCS	25-003	Establishing D-SNPs by 2026	DSNP	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with information regarding the Department of Health Care Services' (DHCS) enforcement of California Welfare and Institutions Code (W&I) section 14184.208, related to the requirement for MCPs to operate or be affiliated with a Dual Eligible Special Needs Plan (D-SNP) by 2026, to provide integrated care through affiliated MCPs and D-SNPs for dually eligible Medicare and Medi-Cal Members.
5	1/28/2025	DMHC	25-002	Plan Year 2026 QHP, QDP, and Off-Exchange Filing Requirements	N/A	The Department of Managed Health Care (Department) issues this All Plan Letter (APL) 25-002 to assist in the preparation of Plan Year 2026 regulatory submissions, in compliance with the Knox-Keene Act at California Health and Safety Code sections 1340 et seq. (Act) and regulations promulgated by the Department at California Code of Regulations, title 28 (Rules).
6	2/5/2025	DMHC	25-003	Large Group Renewal Notice Requirements	GROUP CARE	The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 25-003 to provide guidance to plans on the timing and content requirements for renewal notices to large group contractholders under HSC section 1374.21 and HSC section 1385.046.
7	2/7/2025	DHCS	25-004	Community Reinvestments Requirements	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with guidance regarding the MCP Contract's requirement that MCPs reinvest a minimum level of their net income into their local communities.
8	2/12/2025	DHCS	25-005	Standards For Determining Threshold Languages, Nondiscrimination Requirements, Language Assistance Services, And Alternative Formats	MEDI-CAL	This All Plan Letter (APL) serves to inform all Medi-Cal managed care plans (MCPs) of the dataset for threshold and concentration languages and clarifies the threshold and concentration standards specified in state and federal law and the MCP Contract. This dataset identifies the threshold and concentration languages in which, at a minimum, MCPs must provide written translated Member information. This APL also provides guidance on federal and state requirements regarding nondiscrimination, discrimination grievance procedures, language assistance, and communications with individuals with disabilities as set forth in the federal regulations implementing Section 1557 of the Patient Protection and Affordable Care Act (ACA), Title 42 of the Code of Federal Regulations (CFR) Part 438, Senate Bill (SB) 223 (Atkins, Chapter 771, Statutes of 2017), and SB 1423 (Hernandez, Chapter 568, Statutes of 2018)
9	3/12/2025	DMHC	25-004	AB 118: Part 1 - Compliance with Large Group Standardized Evidence of Coverage/Disclosure Form	GROUP CARE	Assembly Bill (AB) 118 (Ting, Chapter 42, Statutes of 2023) added Health and Safety Code section 1363.3 and revised Sections 1352.1, 1363, 1367.041, and 1367.24, effective January 1, 2025. These statutory changes apply to all commercial full-service health care service plans (plans), and require the Department of Managed Health Care (DMHC) to develop standardized templates for various documents describing health plan member benefits, such as the Evidence of Coverage (EOC), Disclosure Form (DF), Schedule of Benefits (SOB), Explanation of Benefits (EOB), and Cost-Share Summary (CSS). The DMHC's work to implement AB 118's requirement to develop standardized templates will be an iterative process. The first part of the standardized EOC/DF will be the following template components: (1) Exclusions and Limitations, (2) Members' Rights and Responsibilities, and (3) Definitions, for use in large group health care service plan contracts issued, amended, or renewed on or after January 1, 2026. This All Plan Letter (APL) and its accompanying attachments set out the filing requirements needed to demonstrate compliance with each template component.
10	3/19/2025	DMHC	25-005	Southern California Fires and Flexibilities to Impacted Providers	GROUP CARE & MEDI-CAL	On January 7, 2025, California Governor Gavin Newsom declared a State of Emergency in Los Angeles and Ventura Counties due to wildfires. The fires destroyed homes and businesses and displaced enrollees and health care providers. After the Governor declares a state of emergency, Health and Safety Code section 1368.7 allows the DMHC to take actions to help mitigate the impact to enrollees and providers.
11	3/21/2025	DMHC	25-006	Health Plan Coverage of Mobile Crisis Services	GROUP CARE	This APL provides guidance regarding the obligations of health plans related to behavioral health crisis services provided to an enrollee by a 988 center or mobile crisis team.
12	4/1/2025	DMHC	25-007	Assembly Bill 3275 Guidance (Claim Reimbursement)	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) under the Knox-Keene Health Care Service Plan Act of 1975, as amended, to provide guidance to health care service plans (plans) on requirements for the processing and reimbursement of claims for health care services with a date of receipt on or after January 1, 2026. Assembly Bill 3275 (Soria, 2024) amended Health and Safety Code sections 1371 and 1371.35 relating to reimbursement of claims for health care services, and enacted Health and Safety Code section 1371.34 enhancing consumer protections relating to grievances about claims for health care services.
13	4/9/2025	DMHC	25-008	Provider Directory Annual Filing Requirements	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (the Department) issues this All Plan Letter (APL) to remind health care service plans (plans) of California Health and Safety Code section 1367.27, subdivision (m)'s requirement to annually submit provider directory policies and procedures to the Department. In addition, the Department reminds plans to submit the changes to their provider directory policies and procedures as instructed in APL 24-018 – Compliance with Senate Bill 923.

#	Date Released	Regulatory Agency	APL #	APL Title	LOB	APL Purpose Summary
14	4/15/2025	DMHC	25-009	2025 Health Plan Annual Assessments	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) to provide information to health care service plans (health plans) pertaining to the DMHC's fiscal year (FY) 2025-26 annual assessment.
15	4/25/2025	DHCS	25-006	Timely Access Requirements	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with guidance regarding the ongoing requirement to meet timely access standards as outlined in Health and Safety Code (H&S) section 1367.03, as set forth by Senate Bill (SB) 221 (Chapter 724, Statutes of 2021) and SB 225 (Chapter 601, Statutes of 2022). MCPs are required to comply with these requirements pursuant to Welfare and Institutions Code (W&I) section 14197(d)(1)(a).1 Additionally, this APL outlines the required minimum performance levels (MPLs) as set by the Department of Health Care Services (DHCS) which go into effect Measurement Year (MY) 2025 for the Timely Access Survey.
16	4/25/2025	DHCS	25-007	Enforcement Actions: Corrective Action Plans, Administrative and Monetary Sanctions	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide clarification to Medi-Cal managed care plans (MCPs) of the Department of Health Care Services' (DHCS) policy regarding the imposition of enforcement actions, including corrective action plans, and administrative and monetary sanctions, which are among the enforcement actions DHCS may take to enforce compliance with MCP contractual provisions and applicable state and federal laws.
17	5/5/2025	DHCS	25-008	Hospice Services and Medi-Cal Managed Care	MEDI-CAL	The purpose of this All Plan Letter (APL) is to highlight contractual, regulatory, and statutory requirements applicable to Medi-Cal managed care plans (MCPs) with respect to their responsibilities to provide Medically Necessary hospice services to their MCP Members.
18	5/12/2025	DHCS	25-009	Commyunity Advisory Committee	MEDI-CAL	The purpose of this All Plan Letter (APL) is to summarize the Community Advisory Committee (CAC) requirements and provide Medi-Cal managed care plans (MCP) with information and guidance regarding their responsibility to implement, maintain, and maximize Member, family, and community engagement through the CAC.
19	5/20/2025	DMHC	25-010	Sections 1357.503 and 1357.505 MEWA Registration and Annual Compliance Requirements	N/A	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) to inform health care service plans (Plans) and association of employers defined as multiple employer welfare arrangements (MEWAs) of the requirements of AB 2072 (Weber, Ch. 374, Stats. 2024) and AB 2434 (Grayson, Ch. 398, Stats. 2024). This APL discusses the requirements on Plans and MEWAs for the initial MEWA registration pursuant to Section 1357.505. This APL also discusses the ongoing compliance requirements for Plans and registered MEWAs pursuant to Section 1357.503. Plans are asked to disseminate this information to their contracted MEWAs.
20	5/23/2025	DMHC	25-011	Health Plan Coverage of HIV Preexposure Prophylaxis (PrEP)	GROUP CARE & MEDI-CAL	On July 8, 2020 and July 6, 2021, the Department of Managed Health Care (DMHC) issued All Plan Letter (APL) 20-026 and 21-018 regarding health plans' obligations to cover Human Immunodeficiency Virus (HIV) antiretroviral drugs and preexposure prophylaxis (PrEP). This APL supplements the two prior APLs and gives further guidance to ensure health plans meet their obligations to cover PrEP with no prior authorization or cost-sharing.
21	6/3/2025	DHCS	25-010	Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services	MEDI-CAL	This All Plan Letter (APL) provides guidance to Medi-Cal managed care plans (MCP) on standardized, statewide Adult and Youth Screening and Transition of Care Tools to guide referrals of adult and youth Members to the appropriate Medi-Cal mental health delivery system and guide timely care coordination for Members requiring transition between delivery systems.
22	6/9/2025	DMHC	25-012	Closure of Rite Aid Pharmacies	GROUP CARE	In May 2025, Rite Aid announced it would be closing numerous pharmacies across multiple states as it moves through bankruptcy proceedings. This APL reminds health plans that they have an ongoing obligation to ensure their enrollees have timely access to prescription drugs. The APL also requires health plans to file with the DMHC a description of how the plans will ensure on-going access to prescription drugs within the access standards required by the Knox-Keene Health Care Service Plan Act (KnoxKeene Act).
21	7/3/2025	DHCS	25-011	H.R.1 -- Federal Payments to Prohibited Entities	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care plans (MCPs) on handling of payments to Medi-Cal and Family Planning, Access, Care, and Treatment Program (Family PACT) Providers who may be impacted by H.R. 1 that was enacted on July 4, 2025 (Public Law No: 119-21). This APL also provides guidance pertaining to a recent Temporary Restraining Order (TRO) blocking immediate implementation of Section 71113 in H.R. 1, which will expire in 14 days of issuance, unless modified, extended, or stayed.
22	8/19/2025	DHCS	25-012	Targeted Provider Rate Increases	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with guidance on eligible Network Provider1,2 payment requirements applicable to Medi-Cal Targeted Rate Increases (TRI), as defined herein, effective for dates of service on or after January 1, 2024. Provisions of this APL regarding augmented reimbursement rates for comprehensive family planning services enacted through Senate Bill (SB) 94 (Chapter 636, Statutes of 2007) supersede APLs 10-003 and 10- 014 with retroactive effect for dates of service not included in TRI. Furthermore, provisions of this APL apply to out-of-Network providers outlined in Exhibit A, Attachment III, Subsection 3.3 (Provider Compensation Agreements) of the MCP Contract (including, but not limited to, family planning services, sexually transmitted diseases services, human immunodeficiency virus testing and counseling, and Minor Consent Services).

#	Date Released	Regulatory Agency	APL #	APL Title	LOB	APL Purpose Summary
23	9/4/2025	DMHC	25-013	Amendments to Rules 1300.51, 1300.52, 1300.52.4, 1300.67.2.2 and the Incorporated Annual Network Submission Instruction Manual and Annual Network Report Forms for Reporting Year 2026 and Continuing Thereafter	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC) issues this All-Plan Letter (APL) to notice new amendments to 28 CCR §§ 1300.51, 1300.52, 1300.52.4, 1300.67.2.2, and the incorporated Annual Network Submission Instruction Manual and Annual Network Report Forms for the reporting year (RY) 2026 Annual Network Report submission and continuing thereafter. The amendments described in this APL and attached documents impact health care service plan (health plan) Annual Network Report submission requirements and the Annual Network Review under Health and Safety Code sections 1367.03 and 1367.035 and Title 28 CCR § 1300.67.2.2. These changes also impact general network filing requirements under Title 28 CCR §§ 1300.51, 1300.52, and 1300.52.4. Amendments are noticed in accordance with sections 1367.03(f)(3) & (5).
23	9/4/2025	DMHC	25-014	Provider Appointment Availability Survey Manual and Report Form Amendments Beginning RY 2027/MY 2026 and Continuing Thereafter	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 Timely Access Compliance Report documents: Provider Appointment Availability Survey (PAAS) Manual, PAAS Report Forms and the Timely Access Submission Instruction Manual (TA Instruction Manual). Please note: this APL is effective beginning in measurement year (MY) 2026 for reporting due in 2027 and will remain in effect thereafter. This APL does not make any changes to the MY 2025 Timely Access Compliance Report that is due on May 1, 2026.
24	9/18/2025	DMHC	25-015	Assembly Bill 144 and Coverage of Preventive Care Services	GROUP CARE & MEDI-CAL	On September 17, 2025, Governor Gavin Newsom signed Assembly Bill 144, to ensure California enrollees can continue to access necessary preventive care services. AB 144 directs health plans to cover preventive care items and services, including immunizations, if such care was recommended by existing federal bodies (e.g., the CDC) as of January 1, 2025, or is recommended by the California Department of Public Health (CDPH). This APL outlines the obligations of health plans to cover preventive care items and services prior to enactment of AB 144 and summarizes AB 144's new requirements regarding coverage of preventive care items and services. The APL also highlights recent recommendations by CDPH regarding immunizations to protect against COVID19, RSV, and influenza.
25	9/18/2025	DHCS	25-013	Medi-Cal Rx Pharmacy Benefits, and Cell and Gene Therapy Coverage	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with guidance on the oversight and administration of the Medi-Cal pharmacy benefit. Effective January 1, 2022, Governor Gavin Newsom's Executive Order N-01-19, required the Department of Health Care Services (DHCS) to transition Medi-Cal pharmacy services from the managed care delivery system to the Fee-For-Service (FFS) delivery system, which is collectively known as "Medi-Cal Rx".
26	9/26/2025	DHCS	24-014	Update to Provider Directory Requirements	MEDI-CAL	This All Plan Letter (APL) provides Medi-Cal managed care plans (MCPs) with guidance on updated Provider Directory requirements pursuant to the Consolidated Appropriations Act, 2023 (Pub.L. No. 117-328, section 5123 (Dec. 29, 2022) 136 Stat. 4459, 5944) (CAA, 2023); State Health Official Letter (SHO) 24-003, pages 4-5; and 42 Code of Federal Regulations (CFR) section 438.10(h)(1).

COMPLIANCE DASHBOARD SUMMARY												
	Resource	Type									TOTAL	% Completed
			2018	2019	2020	2021	2022	2023	2024	2025		
OVERALL FINDINGS	DHCS	Total State Audit Findings	38	28	7	33	15	24	20	0	165	
		Total Self-Identified Issues	12	0	0	2	0	2	6	3	25	
		Total Findings	**50**	**28**	**7**	**35**	**15**	**26**	**26**	**3**	**190**	
		Total In Progress	0	0	0	0	0	8	25	3	36	
		Total Completed	50	28	7	35	15	18	1	0	154	**81%**
		Total Findings	**50**	**28**	**7**	**35**	**15**	**26**	**26**	**3**	**190**	
	DMHC	Total State Audit Findings			5	6	8	3		TBD	22	
		Total Self-Identified Issues			3	0	0	0		6	9	
		Total Findings			**8**	**6**	**8**	**3**		**6**	**3 1**	
		Total In Progress			0	0	0	3		6	9	
		Total Completed			8	6	8	0		6	2 2	**88%**
		Total Findings	**NA**	**NA**	**8**	**6**	**8**	**3**	**NA**	**TBD**	**3 1**	
	DMHC Financial Services	Total State Audit Findings		5			4			TBD	9	
		Total Self-Identified Issues		0			0			TBD	0	
		Total Findings		**5**			**4**			**TBD**	**9**	
		Total In Progress		0			0			TBD	0	
		Total Completed		5			4			TBD	9	**100%**
		Total Findings	**NA**	**5**	**NA**	**NA**	**4**	**NA**	**NA**	**TBD**	**9**	
STATE AUDIT FINDINGS		In Progress	0	0	0	0	0	10	19	TBD	29	
		Completed	38	33	12	39	27	17	1	0	167	**85%**
		Total Findings	**38**	**33**	**12**	**39**	**27**	**27**	**20**	**0**	**196**	
SELF-IDENTIFIED FINDINGS		In Progress	0	0	0	0	0	0	6	3	9	
		Completed	12	0	3	2	0	2	0	0	19	**76%**
		Total Findings	**12**	**0**	**3**	**2**	**0**	**2**	**6**	**0**	**25**	
TOTAL OVERALL FINDINGS			**50**	**33**	**15**	**41**	**27**	**29**	**26**	**3**	**236**	

Compliance Dashboard Summary

COMPLIANCE DASHBOARD SUMMARY			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	Total State Audit Findings	196	89%
	Total Self-Identified Issues	25	11%
	Total Findings	**221**	
	Total In Progress	36	16%
	Total Completed	185	84%
	Total Findings	**221**	
STATE AUDIT FINDINGS	In Progress	29	15%
	Completed	167	85%
	Total Findings	**196**	
SELF-IDENTIFIED FINDINGS	In Progress	9	32%
	Completed	19	68%
	Total Findings	**28**	

2025 DHCS Audit Summary			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	Total State Audit Findings	0	0%
	Total Self-Identified Issues	3	100%
	Total Findings	**3**	
	Total In Progress	3	100%
	Total Completed	0	0%
	Total Findings	**3**	

Compliance Dashboard Summary

2024 DHCS Audit Summary			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	Total State Audit Findings	20	77%
	Total Self-Identified Issues	6	23%
	Total Findings	**26**	
	Total In Progress	25	96%
	Total Completed	1	4%
	Total Findings	**26**	

2023 DMHC Follow-Up Review			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	Total State Audit Findings	3	100%
	Total Self-Identified Issues	0	0%
	Total Findings	**3**	
	Total In Progress	3	100%
	Total Completed	0	0%
	Total Findings	**3**	

Compliance Dashboard Summary

2023 DHCS Focused Audit Summary			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	Total State Audit Findings	9	100%
	Total Self-Identified Issues	0	0%
	Total Findings	**9**	
	Total In Progress	8	89%
	Total Completed	1	11%
	Total Findings	**9**	

2023 DHCS Audit Summary			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	Total State Audit Findings	15	88%
	Total Self-Identified Issues	2	12%
	Total Findings	**17**	
	Total In Progress	0	0%
	Total Completed	17	100%
	Total Findings	**17**	

Compliance Dashboard Summary

2022 DMHC BHI Audit Summary			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	Total State Audit Findings	2	100%
	Total Self-Identified Issues	0	0%
	Total Findings	**2**	
	Total In Progress	0	0%
	Total Completed	2	100%
	Total Findings	**2**	

2022 DMHC RBO Audit: Delegate			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	Total State Audit Findings	3	100%
	Total Self-Identified Issues	0	0%
	Total Findings	**3**	
	Total In Progress	0	0%
	Total Completed	3	100%
	Total Findings	**3**	

Compliance Dashboard Summary

2022 DMHC RBO Audit: Delegate			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	Total State Audit Findings	3	100%
	Total Self-Identified Issues	0	0%
	Total Findings	**3**	
	Total In Progress	0	0%
	Total Completed	3	100%
	Total Findings	**3**	

2022 DMHC Financial Serviceds Summary			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	Total State Audit Findings	4	100%
	Total Self-Identified Issues	0	0%
	Total Findings	**4**	
	Total In Progress	0	0%
	Total Completed	4	100%
	Total Findings	**4**	

Compliance Dashboard Summary

2022 DHCS Audit Summary			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	Total State Audit Findings	15	100%
	Total Self-Identified Issues	0	0%
	Total Findings	**15**	
	Total In Progress	0	0%
	Total Completed	15	100%
	Total Findings	**15**	

2021 DMHC Joint Audit Summary			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	Total State Audit Findings	6	100%
	Total Self-Identified Issues	0	0%
	Total Findings	**6**	
	Total In Progress	0	0%
	Total Completed	6	100%
	Total Findings	**6**	

Compliance Dashboard Summary

2021 DHCS Joint Audit Summary			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	Total State Audit Findings	33	94%
	Total Self-Identified Issues	2	6%
	Total Findings	**35**	
	Total In Progress	0	0%
	Total Completed	35	100%
	Total Findings	**35**	

2020 DHCS Focused Audit Summary			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	Total State Audit Findings	7	100%
	Total Self-Identified Issues	0	0%
	Total Findings	**7**	
	Total In Progress	0	0%
	Total Completed	7	100%
	Total Findings	**7**	

Compliance Dashboard Summary

2020 DMHC Medical Services Audit Summary			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	Total State Audit Findings	5	63%
	Total Self-Identified Issues	3	38%
	Total Findings	**8**	
	Total In Progress	0	0%
	Total Completed	8	100%
	Total Findings	**8**	

2019 DMHC Financial Services Audit Summary			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	Total State Audit Findings	5	100%
	Total Self-Identified Issues	0	0%
	Total Findings	**5**	
	Total In Progress	0	0%
	Total Completed	5	100%
	Total Findings	**5**	

Compliance Dashboard Summary

2019 DHCS Medical Services Audit Summary			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	Total State Audit Findings	28	100%
	Total Self-Identified Issues	0	0%
	Total Findings	**28**	
	Total In Progress	0	0%
	Total Completed	28	100%
	Total Findings	**28**	

2018 DHCS Medical Services Audit Summary			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	Total State Audit Findings	38	76%
	Total Self-Identified Issues	12	24%
	Total Findings	**50**	
	Total In Progress	0	0%
	Total Completed	50	100%
	Total Findings	**50**	

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

KEY
Yellow = Plan Observations
White = State Finding in the final report that was not a Plan Observation
R = Repeat Findings

2025 DHCS Audit - *Audit Review Period* 6/1/2023 - 5/31/2024 *Audit Onsite Dates - March 3, 2025 to March 7, 2025*			
#	**Category**	**DHCS Exit Conference March 20,2025**	**Department Responsible**
1	UM	The Plan did not consistently secure timely authorization for medically necessary PSA or ensure contractors' compliance with APL 23-009.	UM
2	UM	The Plan did not adequately ensure the availability of a Medical Director or licensed physician 24/7 to coordinate care and respond to authorizations.	UM
3	UM	The Plan did not transfer out-of-network hospitalized members to in-network providers as required.	UM

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

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Orange = Plan Observations (Not Included in the final report)
White = State Finding in the final report that was not a Plan Observation
R = Repeat Findings

2024 DHCS Audit - *Audit Review Period* 6/1/2023 - 5/31/2024
Audit Onsite Dates - June 17, 2024 - June 28, 2024

#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible
1	UM	(1.2.1) Referral to Transplant Program Within 72 Hours The Plan did not directly refer an adult member to a transplant program for evaluation within 72 hours of the member's specialist identifying the member as a potential candidate for MOT.	1. The Plan's Standard Operating Procedures (SOP) were updated to reflect the 72 hours MOT TAT and all UM staff were re-trained on 6/20/2024. 2. The UM team instituted a formal internal review process to ensure all operating procedures align with Policy & Procedures. A Standard Operating Procedures (SOP) was developed and staff were trained on the internal review process. 3. Policy & Procedure Tracker developed to ensure at least annual and ad-hoc updates to P&Ps are monitored and aligned with regulatory guidance. The Plan monitors MOT turnaround times via daily operational reports.	1/15/2025	Completed	UM
2	UM	(1.2.2) Centers of Excellence (COE) for Major Organ Transplants The Plan did not ensure that all MOT procedures were performed in a Medi-Cal approved COE transplant program. The Plan did not confirm that its COEs were unable to perform a MOT surgery before arranging the MOT at a transplant program that is not a Medi-Cal approved COE.	1. On 6/27/2024 The Plans Medical Directors were notified that Bone Marrow Transplant (BMT) and other regulatory Major Organ Transplants (MOT) are only managed in-network unless Continuity Of Care (COC) or related to urgent/emergent hospitalization. In addition, The Plan took the following actions: On 6/27/2024 the MOT workflows were updated to include Chief Medical Officer (CMO) Denial oversight. On 8/14/2024 The Plan conducted Delegate training for the new CHCN Medical Director and CHCN Utilization Management Director. On 8/1/2024 a copy of the current DHCS Centers Of Excellence list was distributed to staff. The Plan updated policy UM-071 and submitted to Utilization Management Committee on 8/30/2024. 2. The Plan updated Standard Operating Procedures to include DHCS Center Of Excellence requirements. 3. The UM team instituted a formal internal review process to ensure all operating procedures align with Policy & Procedures. A Standard Operating Procedures was developed, and staff were trained on the internal review process. Update 2/15/2025: Operation Major Organ Transplant reported created and being used to monitor the appropriate use of Medi-Cal COEs.	In Progress	1. Completed 6/27/2024 2. Completed 6/27/2024 3. In Progress	UM
3	UM	(1.3.1) Written Member Consent The Plan did not obtain members' written consent when providers requested appeals on behalf of members.	1. The Plan updated G&A-008 Adverse Benefit Determination Appeal Process to meet the requirements of Member Written Consent in accordance with The Plan's DHCS contract. The workflow was updated and staff training completed on 11/6/2024 2. Internal audits for requirement of written member consent started in January 2024 and will continue.	In Progress	1. Completed 11/6/2024 2. In Progress	G&A
4	UM	(1.3.2) Appeals Letters: Nondiscrimination Notice (NDN) and Language Assistance Taglines (LAT) The Plan did not send NDN and LAT information that met the minimum requirements in APL 21-004 with member notifications for appeals.	1. CLS-003 Non-discrimination Language Assistance Services and Effective Communication for Individuals with Disabilities has been submitted to the MCOD for approval. 2. The Your Rights Package was updated with the current Non-Discrimination Notice (NDN) and Language Assistance Tagline (LAT). The NDN and LAT were added to the Member Rights package and updated in the G&A system. 3. The G&A Department in conjunction with the Compliance Department will review all enclosures on an annual basis to ensure compliance. G&A is completing an Internal Audit SOP that outlines the self monitoring / internal audit process.	In Progress	1. In Progress 2. Completed 1/15/2025 3. In Progress	G&A

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

KEY
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Orange = Plan Observations (Not Included in the final report)
White = State Finding in the final report that was not a Plan Observation
R = Repeat Findings

2024 DHCS Audit - *Audit Review Period* 6/1/2023 - 5/31/2024
Audit Onsite Dates - June 17, 2024 - June 28, 2024

#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible
5	UM	(1.5.1) Overutilization of Subacute Level of Facility Care The Plan did not ensure that its delegate had mechanisms to detect overutilization of subacute level of facility care; the delegate inappropriately approved higher levels of subacute care for members who required lower levels of regular skilled nursing facility care.	1. The delegate reports over/under-utilization measures in their quarterly HICE report. The Plan has instituted a Standardized Operating Procedure that delineates roles and responsibilities for reviewing delegate reports, including a formal sign-off process, to be used in conjunction with P&P UM-060 Delegation Management and Oversight. 2. The Plan will request the delegate include post-acute cases in their annual UM audit universe and monthly internal UM audit reports. Update 1/15/2025: The Plan received the delegate's internal UM audit report submission on 12/27/2024 and completed a review of the delegate's audit results on 12/31/2024, and noted adequate strategies to address findings. 3. The Plan has requested the delegate include nursing facility utilization as part of their over/under utilization measures, reported in the Quarterly HICE report (auth volume by facility levels of care). The Q4 2024 HICE report is pending. 4. The Plan shares all newly issued DHCS APLs and guidance, including billing instructions related to revenue codes, and collects attestations from delegates	In Progress	1. Completed 10/1/2024 2. Completed 12/31/2024 3. In Progress 4. In Progress	UM
6	UM	(1.5.2) Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services The Plan did not ensure that its delegate provided medically necessary EPSDT services, care coordination, and appointment scheduling assistance to members under the age of 21.	1. The delegate created a new policy and procedure specific to EPSDT care coordination. This policy will be reviewed by the delegate's internal committee on 1/22/2025 and then the policy will be submitted to the Plan for review. 2. The Plan requested the delegate identify EPSDT cases in their monthly internal Case Management audit reports, as well as identifying EPSDT cases in their annual UM audit universe and monthly internal UM audit reports. The Plan will audit EPSDT cases to evaluate whether members are receiving appropriate EPSDT services, care coordination, and appointment scheduling as needed. Updated 1/15/2025: The Plan received confirmation that the delegate updated their internal audit tool to include the appropriate EPSDT elements. The Plan will review the delegate's next internal audit to verify use of the revised audit tool. Update 2/15/2025: The Plan received the delegate's internal audit tool and has confirmed it reflects the EPSDT elements were added appropriately. 3. The Plan will report the delegate's CM and UM audit outcomes at the UM Committee, upon receipt of reports.	In Progress	1. In Progress 2. In Progress 3. In Progress	UM
7	CM and CoC	(2.1.1) Provision of Blood Lead Screening The Plan did not ensure that blood lead screening tests were conducted for members up to six years of age.	1. The Plan updated Policy QI-125 to include a requirement for providers to follow up on lab orders. Policy QI-125 will be approved in Quality Committee by 2/30/2025 and the Administrative Oversight Committee by 4/16/2025. 2. Funding for point-of-care testing units was provided in January 2024 to the delegate. These units aim to eliminate the need for members to make an additional visit to the lab. The Plan conducted member outreach and member incentives; members were offered a gift card to complete their services at the lab. 3. The Plan continues to monitor the HEDIS lead screening rates. Monitoring includes tracking of the documentation of lead level results by providers for ordered blood lead tests and any necessary follow-up activities and services for members, which is done through IHA audits and facility site reviews. 4. The Plan has conducted provider education through webinars, 1:1 meetings, CLPP training 1) Healthcare Services All-Staff meeting, 2) Provider webinar (live) and video (posted on Alliance website) and Measure Highlight tools. 5. The Plan previously conducted annual IHA audits to review provider charts for completion of preventive screenings. The frequency of these audits has now increased to twice a year. Additionally, during Facility Site Reviews (FSRs), charts are monitored for lead screening compliance. An audit is conducted for Blood Lead Screening, and charts are reviewed for evidence of discussion, orders/refusal and results. When evidence of	In Progress	1. In Progress 4/16/2025 2. Completed 1/2025 3. Completed 1/15/2025 4. Completed 12/21/2024 5. In Progress	QI

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			Screening, and charts are reviewed for evidence of discussion, orders/refusal and results. When evidence of lead screening is not found, the Plan sends education letters to providers indicating the discrepancy. Update 2/15/2025: The Plan conducted an IHA audit Q3 2024 for IHA period 10/1/2023-05/31/2024. 6. Lead screening rates and IHA results are revied at the Quality Improvement Health Equity Committee meetings.		6. Completed 12/21/2024	
9	CM and CoC	(2.3.1) Provision of Behavioral Health Therapy (BHT) Services The Plan did not ensure the provision of BHT services in accordance with approved BHT treatment plans for members under the age of 21.	1. The Plan's existing policies support BHT services in accordance with BHT plans for members under the age of 21. The Plan insourced BHT services on 4/1/23 with the goal of increasing member access to care. The Plan has a dedicated team of care coordinators and BCBAs to support access to care. The Plan continues to explore opportunities to improve access to BHT care. This includes interventions to enhance the network and incentivize agencies to prioritize AAH members for services. The Plan continues to authorize out-of-network services whenever possible. 2. The Plan authorizes care within the required timeframes as requests are received. To monitor this issue, The Plan has established a metric to track the number of authorized hours to bill services. This functions as an indicator of the need for additional provider resources. This is a continuous process that started 5/10/2024. The Plan has ongoing efforts to onboard and contract additional BHT/ABA providers as additional resources are necessary. A monitoring and reporting process has been put in place to show the monthly authorized services for each member receiving BHT/ABA Treatment and for each QASP. The plan compares the # of authorized hours of BHT/ABA to the # of hours delivered based on claims data to monitor, track and report the % of authorized hours that are delivered. The plan reports these findings to the UM committee and identifies the QASPs with the lowest delivered services for outreach and intervention. 3. The Plan has drafted parent advisement that is scripted and provided to each parent/guardian when BHT/ABA services are authorized that asks for parents/guardians to call the Alliance BHT/ABA case management team if they experience disruption or barriers in receiving the BHT/ABA services that have been authorized for their child.	In Progress	1. Completed 1/15/2025 2. In Progress 3. In Progress	Behavioral Health
8	CM and CoC	(2.3.2) Timely Access to Behavioral Health Therapy (BHT) Services The Plan did not arrange and coordinate BHT services for members under the age of 21 within 60 calendar days.	1. The Plan established an EPSDT Policy & Procedure QI-135. The Plan established care coordination guidelines for staff providing care coordination with expectations. The Plan has a dedicated team of care coordinators and BCBAs to support access to care. The Plan has increased staffing to better support member' access to care. 2. BH Navigators are required to conduct monthly follow-up with parents or guardians to inform them of the status of Mental Health (MH), Behavioral Health Treatment (BHT), or Comprehensive Diagnostic Evaluation (CDE) referrals. This process ensures timely communication and continuity of care for families. 3. Mandatory training was provided to the BH Navigators with written standard work. 4. The Plan is developing a report that will be utilized in an ongoing manner to monitor compliance with current case management protocols and DHCS requirements. The implementation is scheduled for the end of the first quarter of 2025. Update 2/15/2025: Fields are undergoing validation to ensure accuracy with a goal to have a functional report ready by March 31, 2025 for monitoring and oversight. 5. BH will conduct biweekly reviews to confirm that follow-ups are performed consistently and on-schedule. Feedback loops will be established to address any barriers encountered during follow-ups and adjust the protocol accordingly. BH Navigators will undergo mandatory training to reinforce the importance of	In Progress	1. Completed 8/1/2024 2. Completed 8/1/2024 3. Completed 8/1/2024 4. In Progress 3/31/2025 5. In Progress	Behavioral Health

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			consistent monthly follow-ups, effective communication with parents, and accurate documentation.			
10	CM and CoC	(2.4.1) Notice of Action (NOA) Letters for Continuity of Care (COC) Requests The Plan did not ensure that NOAs for COC requests that were sent to members contained a clear explanation of the reason for the denial decision.	1. Policy UM-054 Notice of Action supports the process to ensure NOAs contain clear explanations of denial reasons. SOPs were updated to reflect utilization of new CoC NOA in a single letter, Medical Directors were trained, and all impacted staff were notified on 8/14/2024. 2. The Plan will include CoC denial notices in the monthly operational NOA audits, reported quarterly at UMC.	In Progress	1. Completed 8/14/2024 2. In Progress	UM
11	Access and Availability	(3.1.1) Appointment Waitlist Timeliness The Plan did not ensure members were able to obtain medically necessary appointments within established timely access standards. One of the Plan's medical groups placed members on an appointment waitlist and had members waiting up to six months to make an appointment.	1. The Plan worked with the provider to close their panel in September, preventing additional wait listed members. (9/1/2024). The Plan met with the provider related to access in an On-going manner during Joint Operating Meetings (JOM) and Plan/provider Access Meetings. The provider actively outreached to members on the wait list. Progress reports were reviewed at Plan/provider Access meetings. In September 2024 the provider brought in two new providers to support with provider wait list. In review of grievances data, the number of grievances declined for timely access at this provider's location. The Plan has implemented QI initiatives to improve access to care, including pay for performance (P4P), extended office hours incentives and provider recruitment/retention incentives (AAH provider grant live as of 6/1/2024). 2. Provider access data shows outreach efforts have been effective in getting new members schedule for appointments and off the waitlist. The Plan is working on outreach reports from the provider to show continues self-monitoring as well as written procedures to support.	In Progress	1. Completed 10/21/2024 2. In Progress	QI
12	Access and Availability	(3.1.2) Monitoring In-Office Wait Times for Specialty and Behavioral Health Services The Plan did not monitor in-office wait time for specialists and behavioral health providers.	1. The Plan added in-office wait times measure to CG-CAHPS survey for BH providers on 5/6/2024. The finalized report was presented at the Access & Availability Committee in September. Specialist providers will be added to the CG-CAHPS survey starting on 1/21/2025. The final report is expected to be completed by Q2, 6/30/2025 QI-114 Monitoring of Access and Availability Standards was revised to include monitoring of in-office wait times for specialist and behavioral health providers.	In Progress	1. In Progress 6/30/2025	Behavioral Health
13	Access and Availability	(3.1.3) Monitoring Telephone Calls for Specialty and Behavioral Health Services The Plan did not monitor wait times for specialty and behavioral health providers to answer and return telephone calls.	1. The Plan added telephone wait times measure to CG-CAHPS survey for BH providers. The finalized report was presented at the Access & Availability Committee in September. Specialist providers will be added to the CG-CAHPS survey starting on 1/21/2025. The final report is expected to be completed by Q2, 6/30/2025. QI-114 Monitoring of Access and Availability Standards was revised to include monitoring of telephone wait times for specialist and behavioral health providers	In Progress	1. In Progress 6/30/2025	Behavioral Health

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14	Member Rights	(4.1.1) Grievances Involving Clinical Issues The Plan did not ensure that a person with clinical expertise in treating a member's condition made the resolution decision for grievances involving clinical issues.	1. Policy G&A-003 Grievance and Appeals Receipt, Review, and Resolution was updated to require grievances with clinical issues, such as access or QOS grievances with clinical issues, to be resolved by the Medical Director. 2. The G&A Department will provide additional training to ensure that a person with clinical expertise in treating a member's condition made the resolution decision for grievances involving clinical issues. The Timeline will also need to be updated to include the contractual language. 3. The G&A Department will begin to conduct monthly internal audits in January 2025 to ensure that the requirement for grievances involving clinical issues is being met. 4. The G&A Department will provide an Internal Audit Standard Operating Procedure that outlines our self-monitoring/internal auditing processes.	In Progress	1. Completed 1/15/2025 2. In Progress 3. In Progress 4. In Progress	G&A
15	Member Rights	(4.1.2) Resolution of Grievances The Plan did not completely resolve the members' grievances.	1. The QA Grievance Audit Tool was reviewed to outline the future monitoring process to ensure that all grievances are resolved prior to being closed. 2. The G&A Department will begin to conduct monthly internal audits in January 2025 to ensure that the requirement for resolution of grievances is being met. 3. Staff training completed for the grievance timeline procedure.	TBD	1. Completed 1/15/2025 2. In Progress 3. Completed 2/15/2025	G&A
16	Member Rights	(4.1.3) Clear and Concise Resolution Letters The Plan's written resolution did not contain a clear and concise explanation of the Plan's decision.	1. The QA Grievance Audit Tool was reviewed to outline the future monitoring process to ensure that all grievances have clear and concise resolution letters prior to being closed. The G&A Department will provide additional training to ensure that the Plan's written resolution contains a clear and concise explanation. 2. The G&A Department will begin to conduct monthly internal audits in January 2025 to ensure that the requirement for Clear and Concise Resolution Letters is being met	TBD	1. In Progress 2. In Progress	G&A
17	Member Rights	(4.1.4) Grievance Letters: Non-Discrimination Notice (NDN) and Language Assistance Tagline (LAT) The Plan did not include updated NDN and LAT information with grievance acknowledgement and resolution letters.	1. Current LAT and NDN were added to the Member's Rights package and updated in the G&A system. 2. The G&A Department in conjunction with the Compliance Department will review all enclosures on an annual basis to ensure compliance	TBD	1. Completed 7/25/2024 2. In Progress	G&A
18	Member Rights	(4.2.1) Monitoring of Linguistic Performance The Plan did not assess the performance of its vendors' staff that provided linguistic services such as interpreter services.	1. The Plan has completed updates of Policy and Procedure (P&P) CLS-011-CLS Program Monitoring to include additional language on monitoring information collected and reporting. The Plan anticipates approval date of the updated draft by Alliance Administrative Oversight Committee (AOC) for 4/16/2025. 2. The Plan anticipates that updates to vendor contracts to include reporting requirements for vendor interpreter qualifications and cadence will be implemented by 3/31/2025. 3. The Plan anticipates the implementation of monthly vendor interpreter qualifications reporting by 1/31/2025. The Plan anticipates implementation of a monthly attestation of monthly vendor interpreter qualifications review by 1/31/2025. The Plan will review and address concerns with vendor interpreter qualifications at Quarterly Vendor Joint Operations Meeting (JOM) by 3/31/2025. The Plan will report and address concerns with vendor interpreter qualifications at Quarterly Cultural and Linguistic Services Subcommittee (CLSS) meeting by 4/30/2025.	TBD	1. In Progress 4/16/2025 2. In Progress 3/31/2025 3. In Progress 4/30/2025	Cultural and Linguistic Services

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19	Member Rights	(4.3.1) Notification to DHCS The Plan did not notify DHCS within 24 hours upon discovery of any suspected breach or security incident, unauthorized access, use or disclosure of PHI or PI.	1. The Plan updated CMP-013 "HIPAA Privacy Reporting" in September 2024 to include verbiage addressing the gap that contributed to the audit finding: "Referrals must be made immediately upon discovery, and no later than 24 hours after." Additional updates included a Corrective Action section to address late referrals: "Corrective actions will be taken for delayed referrals, including but not limited to education, training, and / or Corrective Action Plans (CAP)." CMP-013 also states, "The Alliance will investigate the incident and submit an Initial Privacy Incident Report (PIR) to DHCS within 24 hours of discovery of a breach, suspected breach or security incident." Verbiage of Privacy Incident Investigation and Reporting Procedure updated to formalize education and corrective action for late referrals. 2. Implement new monitoring process to address the gap in referrals from G&A and internally within Compliance that contributed to the audit finding: "The Privacy Office will monitor the Compliance inbox, Compliance hotline, Privacy Compliance Inbox, and HealthSuite system for referral of any HIPAA Privacy reporting incidents. Each will be checked daily at minimum." 3. The Privacy Office is conducting weekly audits of HealthSuite referrals to ensure privacy concerns reported by members are appropriately categorized by the Member Services Department. Appropriate categorization will enable timely reporting of privacy incidents. 4. The Plan will include review of the Internal Audit results at the Compliance Committee meetings.	In Progress	1. Completed 9/18/2024 2. Completed 12/13/2024 3. Completed 7/15/2024 4. In Progress	Compliance
			1. The Plan will review and update the following impacted P&Ps as needed: PRV-005 & CRE-002. **3/14/2025**: PRV-005 was reviewed and confirmed the information was present in the policy and no additional updates were identified. 2. The Plan will provide an advisory to delegates and/or providers that delegated for credentialing functions about timely reporting requirements. **3/14/2025**: The Plan notified providers delegated for Credentialing functions about timely adverse termination reporting requirements by email and provided a PowerPoint Reminder Notice and a Adverse Reporting Template. In addition, the information was also shared with Teladoc during the Q1 2025 Joint Operations Meeting (JOM) on 02/04/2025. 3. The Plan conducts monthly review of the exclusion and suspension lists and this is an ongoing process that will support ongoing monitoring and the identification and reporting of adverse provider termination. This is ongoing. There are no changes to the Plan's provider notice templates and member notice templates. 4. The Plan's provider manual will be updated in Q1 2025. 5. The Plan will develop a log that will track Provider terminations, provider notification, and member notification including date of reports received and submitted to DHCS and date members were notified		1. In Progress 2. In Progress 3. In Progress 4. In Progress 5. In Progress	

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20	Quality Management	(5.3.1) Notification of Provider Terminations The Plan did not meet DHCS reporting and member notification requirements for provider terminations.	6. The Plan will develop a reporting template/instruction for Providers/Delegate/Subcontractor for reporting adverse terminations to the Plan. **2/15/2025:** The Plan has developed a reporting template that includes instructions on how to complete for providers/delegates to use when reporting adverse terminations. The information was shared with providers delegated for Credentialing functions on 02/07/2025. 7. The Plan will review the quarterly HICE Credentialing report and confirm against the adverse termination log to determine if provider suspended/termed for quality of care has been reported during the month of termination. During this review, if providers are identified as having been suspended or terminated due to quality of care, the Plan will confirm submission of the 805 report to DHCS. 8. The Plan will include review of the reports/logs during Subcontractor Delegation Oversight Committee meetings. 9. The Plan will include review of the Internal Audit results at the Compliance Committee meetings.	In Progress	6. In Progress 7. In Progress 8. In Progress 9. In Progress	Operations

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1	BH	(2.1) Case Management and Care Coordination The Plan did not ensure the provision of coordination of care to deliver mental health care services to its members. Recommendation: Revise and implement policies and procedures to ensure the Plan coordinates care with the MHP.	1. On April 1, 2023 the Plan insourced behavioral health. The Plan met with the County to identify mechanisms for care coordination. A process was identified for data sharing for mental health, pending system implementation. To support care coordination, and MOU was executed on 4/2023. A manual process has been put in place to include by-weekly case discussions and TOC tools. 2. Policy BH-005 has been updated for written procedure for care coordinators role in care coordination and is going through the committee approval process. Update 12/13/2024: Policy BH-005 was approved at QIHEC on 11/15/2024, and will be presented for review and approval at the Administrative Oversight Committee (AOC) on 12/18/2024. **Update 3/14/2025:** Policy BH-005 approved at AOC on 12/18/2024	In Progress	1. In Progress 2. In Progress	Behavioral H UM Provider Ser
2	BH	(2.2) Information Exchange with the County Mental Health Plan (MHP) The Plan did not follow the written policies and procedures in its MOU for the timely sharing of medical information with the MHP. Recommendation: Implement policies and procedures to ensure the Plan follows agreed upon written policies and procedures in its MOU for the timely exchange of medical information with the MHP.	1. The Plan and the County collaborated to revise the agreed-upon MOU for multiple state and federal requirements, including information exchange between both systems for state mental health services with implementation date of 04/04/2023. 2. The Plan and the County established a plan for data exchange to support coordination of care and closed-loop referrals, which is currently in the final stages. We have continued to monitor the county's progress with data issues caused by its new electronic health management system. Update 12/13/2024: The Plan and the County continue to work together on the data sharing and electronic health systems. **Update 3/14/2025:** File exchange testing in process and bi-weekly case conferences continue.	In Progress	1. Completed 4/4/2023 2. In Progress TBD	Behavioral H UM Privacy IT
3	BH	(2.3) Confirmation of Referred Treatments for Substance Use Disorder (SUD) The Plan did not make good faith efforts to confirm whether members received referred treatment for SUD and document when and where treatment was received, and any next steps following treatment. Recommendation: Revise and implement policies and procedures to ensure the Plan makes good faith efforts to confirm whether members received referred SUD treatment and document when and where treatment was received, and any next steps following treatment.	1. The Behavioral Health Department has developed and implemented a department-specific policy for the care of coordination for SUD on 3/19/2024. Update 11/10/2024: Care coordination policies for MH and SUD members have been combined into policy BH-005. Update 12/13/2024: Policy BH-005 has been approved by QIHEC, and is scheduled to go to AOC on 12/18/2024 for final review and approval. **Update 3/14/2025:** Policy approved at AOC on 12/18/2024. 2. The issue of 42 CFR posing a barrier to care coordination for individuals with SUD is a standing agenda item in leadership meetings with the Plan and the County. Issues with signed releases from members are preventing confirmation of SUD referrals, however a newly established MOU has a written policy to encourage Medi-Cal Managed Care beneficiaries for signed release for members starting or currently in treatment until this has been operationalized at the county. Update 12/13/2024: Discussions around universal release forms for SUD members are continuing. **Update 3/14/2025:** Continuing work to integrate operations to increase care coordination activities, with an estimated completion date of June 2026. 3. Update MOU to include an agreement that Medi-Cal managed care beneficiaries will be encouraged to complete the form. 4. Establish and implement process for regular exchange of information between the Plan and the County to ensure compliance with 42 CFR. **Update 3/14/2025:** Continuing work to integrate operations to increase care coordination activities, with an estimated completion date of June 2026.	In Progress	1. Completed 12/18/2024 2. In Progress 6/30/2026 3. Completed 11/10/2024 4. In Progress 6/30/2026	Behavioral H UM Continuity o

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4	BH	(2.4) Follow Up for Referred Substance Use Disorder Treatments The Plan did not follow up with members who did not receive referred treatments to understand barriers and make subsequent adjustments to referrals. Recommendation: Revise and implement policies and procedures to ensure the Plan awareness of members who did not receive referred SUD treatments, to understand barriers and make subsequent adjustment to referrals, if warranted.	1. Develop form in coordination with county efforts for Enhanced Care Management for disclosure to support care coordination between the County, the MCP, and practitioners providing SUD and physical health services to the beneficiary.Update 12/13/2024: Discussion continues regarding universal release forms to accomplish care coordination for SUD members. **Update 3/14/2025:** Continuing work to integrate operations to increase care coordination activities, with an estimated completion date of June 2026. 2. Information regarding the Plan's PCP legal process for coordination of care for SUD members was included in P&P BH-006.Update 12/13/2024: Policy BH-005 and BH-006 were combined, and BH-005 was approved at QIHEC on 11/15/2024, and will be presented for review and approval at the Administrative Oversight Committee on 12/18/2024. **Update 3/14/2025:** Policy approved at AOC on 12/18/2024. 3. When the BH department identifies a member who needs to be referred for SUD treatment, a referral is completed and the receip of the referral is confirmed and communicated during routine coordination meetings with the Plan and the County, as well as front line staff. There are reporting challenges with SUD treatment due to 42 CFR and the County and the Plan are working to address this. Update 12/14/2024: Ongoing Bi-weekly case discussions, TOC tools with the County regarding SUD members. **Update 3/14/2025:** Continuing work to integrate operations to increase care coordination activities, with an estimated completion date of June 2026.	In Progress	1. In Progress 6/30/2026 2. Completed 12/18/2024 3. In Progress 6/30/2026	Behavioral H UM Case Manage
5	NMT & NEMT	(3.1) Door-to-Door Assistance The Plan did not have a process in place to ensure that door-to-door assistance was provided for all members receiving NEMT services. Recommendation: Revise and implement policies and procedures to ensure door-to-door assistance is being provided for all members receiving NEMT services.	1. Remediating this involves an Alliance policy update and additional training of our transportation vendor. The Transportation Vendor has training and oversight in place in the form of repeat random audits of their transportation providers. Since the 2023 audit, this process was updated by the transportation provider. Additionally, AAH will participate in at least five (5) transportation trips per quarter with the broker to ensure door-to-door assistance is being provided when applicable. Update 12/13/2024: The Alliance participated in at least 5 transportation trips for Q4 2024, on November 4, 2024. The Alliance is planning 2025 Q1 field observation audits of trips. **Update 3/14/2025:** Q1 2025 field audit and training completed. No additional training was needed based on the observed field observations.	In Progress	1. In Progress TBD	Vendor Manag
6	NMT & NEMT	(3.2) Monitoring of Door-to-Door Assistance The Plan did not conduct monitoring activities to verify NEMT providers were providing door-to-door assistance for members receiving NEMT services, per APL 22-008 Recommendation: Revise and implement policies and procedures to ensure the Plan conducts monitoring activities, to ensure providers provide door-to-door assistance, for all members receiving NEMT services.	1. This is a policy and process update. To ensure that the broker is appropriately spot checking NEMT and NMT transportation providers for the correct level of service, AAH will participate in at least five (5) transportation trips per quarter with the broker. Update 12/13/2024: The Alliance participated in at least 5 transportation trips for Q4 2024, on November 4, 2024. The Alliance is planning 2025 Q1 field observation audits of trips. **Update 3/14/2025:** Q1 2025 field audit and training completed. No additional training was needed based on the observed field observations.	In Progress	1. In Progress TBD	Vendor Manag

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7	NMT & NEMT	(3.3) Transportation Liaison The Plan did not have a direct line to the transportation liaison that it provided to providers and members, and the transportation liaison did not process authorizations after business hours. Recommendation: Revise and implement policies and procedures to ensure there is a direct line to the transportation liaison and authorizations are processed after business hours.	To improve member access to transportation services and ensure that after-hours authorizations are being properly handled, the Plan will implement the following measures: Inclusion of Transportation Liaison Contact Information: The Plan will include the transportation liaison's phone number in the member handbook and on the Health Plan's website. This will ensure that members have easy access to contact information for transportation-related inquiries and support. Reporting of After-Hours Trip Reservations: The Plan will require subcontractors to report any trip reservations that could not be completed or authorized during after-hours periods. This reporting requirement will help the Plan track issues and address them effectively. Follow-Up with Members: The Transportation Liaison and the Case Management Team will follow up with members regarding any issues related to trip reservations that were not completed or authorized after hours. This proactive approach will ensure that members receive the support they need and that any problems are resolved in a timely manner. Update 12/13/2024: On track and awaiting publication of the new edition of member handbook with liaison contact number.	In Progress	In Progress TBD	CM
8	NMT & NEMT	(3.4) **R** Physician Certification Statement Forms The Plan did not ensure that members had the required PCS forms for NEMT services, nor did the Plan ensure that PCS forms contained all required components. Recommendation: Implement policies and procedures to ensure PCS forms are on file for all members receiving NEMT services and that the forms contain all the required components.	1. The PCS form intake was insourced beginning 3/1/2023, and AAH staff was hired to coordinate the PCS form effort and transportation.	3/1/2023	Completed	CM
9	NMT & NEMT	(3.5) Ambulatory Door-to-Door The Plan did not ensure its delegate, provided the appropriate level of service for members requiring ambulatory door-to-door service. Recommendation: Revise and implement policies and procedures to ensure its delegate provides the appropriate level of service for members requiring ambulatory door-to-door service.	. Remediating this involves an Alliance policy update and additional training of our transportation vendor. The Transportation Vendor has training and oversight in place in the form of repeat random audits of their transportation providers. Since the 2023 audit, this process was updated by the transportation provider. Additionally, the Plan will participate in at least five (5) transportation trips per quarter with the broker to ensure door-to-door assistance is being provided when applicable. Update 12/13/2024: The Alliance participated in at least 5 transportation trips for Q4 2024, on November 4, 2024. The Alliance is planning 2025 Q1 field observation audits of trips. **Update 3/14/2025:** Q1 2025 field audit and training completed. No additional training was needed based on the observed field observations.	In Progress	1. In Progress TBD	Vendor Manag

ALAMEDA ALLIANCE FOR HEALTH
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2023 DMHC Follow-Up Review : *Audit Review Period 11/1/2022 - 05/31/2023* *Audit Onsite Dates* - 10/23/2023 - 10/27/2023				INTERNAL AUDITS				
#	**Category**	**Deficiency**	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**	**Status**
1	Grievances & Appeals	When the Plan has notice of a case requiring expedited review, the Plan does not immediately inform complainants of their right to contact the Department.	G&A		State	DMHC	2023	
3	Grievances & Appeals	The Plan does not correctly display the statement required by Section 1368.02(b) in all required enrollee communications.	G&A Member Services UM Rx		State	DMHC	2023	
6	Prescription (Rx) Drug Coverage	The Plan does not display its formularies in a manner consistent with the Department's standard formulary template.	Rx		State	DMHC	2023	

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2023 DHCS Audit - *Audit Review Period* 4/1/2022 - 3/31/2023 *Audit Onsite Dates - April 17, 2023 - April 28, 2023*							INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
1	UM	(1.5.1) Notice of Action (NOA) Letters The Plan did not ensure a delegate sent NOA letters to providers and members.	The Plan received the delegate's Root Cause Analysis (RCA) and CAP on 04/14/2023. After review and evaluation of the delegate's document the Plan issued a formal CAP on 05/31/2023 and received the delegate's CAP response on 06/27/2023. The initial corrective actions completed by the delegate includes updating their IT script and ensuring the identified missing NOA letters were sent out to the member and that outreach was completed to confirm that services approved or had denial modification authorizations were utilized by members. The delegate also developed workflows to detect and mitigate failures. The CAP includes the delegate's implementation of a remediation plan. The remediation plan includes updates in their workflow, training, and an internal monthly audit- with results submitted to The Alliance for review. The Plan reviewed and evaluated the delegate's CAP implementation and progress during the interim and provided guidance. The CAP was approved and closed on 09/25/2023. (Completed) The delegate is expected to continue its internal monthly audit for the NOA letters and fax confirmation. The Plan will continue to monitor the audit results for compliance. Please see document 1.5.1_AAH Response for full details. (On Track) Additionally, the Plan will review the UM delegates' P&P's to ensure that preventative, detective, and oversight measures are in place for internal NOA letter generation and fax confirmation and these will be evaluated annually at minimum. (On Track) 1a. Monitoring of the delegate's monthly internal audit is ongoing. (On Track) 2. Review the UM delegates' policies and procedures to ensure that preventative, detective, and oversight measures are in place for internal NOA letter generation and fax confirmation. (On Track) Update 3/8/2024 P&P review complete and P&P deemed adequate. Review of the delegate's P&P regarding NOAs is ongoing and The Alliance will continue to meet with the delegate to have P&P appropriately updated. **Update 4/5/2024** The delegates have submitted all requested policies for review. The policies have been reviewed and the delegates have made all necessary revisions.	**3/31/2024**	Completed	Compliance UM		State	DHCS	2023

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2023 DHCS Audit - *Audit Review Period* 4/1/2022 - 3/31/2023 *Audit Onsite Dates - April 17, 2023 - April 28, 2023*							INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
2	QI	(2.1.1) Provision of an Initial Health Assessment (IHA) The Plan did not ensure the provision of a complete IHA for new members.	1. Update IHA policy QI-124 (On Track) **Update 4/5/2024:** Policy updated and approved at Compliance Committee on 3/19/2024 1a. Update IHA policy 124 to include requirement regarding outreach attempts (On Track) **Update 4/5/2024**: Policy updated and approved at Compliance Committee on 3/19/2024 2. Provider education and feedback through Joint Operational Meetings (On going) Update 4/5/2024: Presented at JOMs with delegates in December 2023 2a. Deliver provider education webinars with information about IHA requirements (On Track) **Update 4/5/2024**: Webinars with delegates scheduled through May 2024 2b. Develop a "Measure Highlights" tool for providers. This tool will encompass outreach requirements, IHA elements, USPSTF screenings, and claim codes used to account for IHA completion 3. Expand code set to include additional codes for capturing IHA-related activities (On Track) Update 3/8/2024: Codes updated and included in policy QI-124. 3a. Communicate and provide code sets to providers (On Track)**Update 4/5/2024:** Codes updated and included in policy QI-124 4. Monitor IHA rates (Ongoing)**Update 4/5/2024**: Non-compliance providers and missing elements identified, CAPs issued. 5. Enhance the volume of medical records subjected to review for completeness, including review of USPSTF requirements. (On Track)	**3/31/2024**	Completed	Quality		State	DHCS	2023
3	BHT	(2.3.1) Behavioral Health Treatment (BHT) Plan Elements The Plan did not ensure members' BHT treatment plans contained all the required elements.	1. The Behavioral Heath team developed the attached Treatment Plan Guidelines for our ABA Providers (please see attachment). This document outlines the treatment plan elements that are listed in APL 23-010. All treatment plans and prior-authorization requests for ABA services are reviewed by Board Certified Behavior Analysts (BCBA).The guidelines were emailed to all providers and will also be available on-line for providers to access. In addition to the document, the ABA clinicians worked with the Provider communication team to send out updates/reminders to providers regarding the treatment plan guidelines. Our team is also available to meet with providers and educate them on how to apply the guidelines to their treatment plan templates. (Completed) 1a. Pending Project: We are currently developing an on-line treatment plan template/form that will be utilized by our ABA providers when completing the initial assessment and subsequent progress reports. This form includes the treatment plan elements required in APL 23-010 and providers will be required to complete this form when submitting the initial assessment/FBA and subsequent progress reports. This will ensure that all ABA providers use the same template and include the required elements in their reports/assessments. (On Track) In the interim while the project is pending, if information is missing from the Treatment Plan, the Plan will inform the provider and ask that they add the information and re-submit. Update 4/5/2024: Policy BH-004 is scheduled to be approved at April Compliance Committee.**Update 5/10/2024:** Policy BH-004 was approved at Compliance Committee on 4/10/2024. 1b. The Plan intends to conduct audits on our Treatment Review documentation to ensure that all required elements are covered in the review process in compliance with the requirements in the APL. The expected implementation date of this audit is Q1 of 2024. **Update 5/10/2024**: Q1 2024 treatment plan audits are in progress pending completion at end of March. The next audit period (Q2) will go through June. 1c. The Provider/PCP Manual is also pending updates that will include a FAQ for PCPs, provider education regarding the prior authorization process, and the referral process. This is currently under review-pending completion**Update 5/10/2024:** Provider Manual revised and submitted to DHCS Plan Communications Department, who is reviewing proposed revisions and once completed will be made available via the provider portal	5/10/2024	Completed	Behavioral Health		State	DHCS	2023

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2023 DHCS Audit - *Audit Review Period* 4/1/2022 - 3/31/2023 *Audit Onsite Dates - April 17, 2023 - April 28, 2023*							INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
4	Access and Availability	(3.1.1) First Prenatal Visit The Plan's policies and procedures for a first prenatal visit for a pregnant member is not compliant with the standard of two weeks upon request.	The Plan has edited Timely Access Standard table, policy QI-107 and QI-114 to reflect the first prenatal visit standard within 2 weeks of the request. (Completed)	Q4 2023	Completed	Quality		State	DHCS	2023
5	Family Planning and State Supported Services	(3.6.1) Non-contracted Provider Payments The Plan did not pay non-contracted providers at the appropriate Medi-Cal fee-for-service rate.	A Change Request was entered to change non-contract mid-level providers reimbursements to 100% of the Medi-Cal rate moving forward. (Completed)	11/16/2023	Completed	Claims		State	DHCS	2023
6	Family Planning and State Supported Services	(3.6.2) Proposition 56 Family Planning Payments The Plan did not distribute add-on payments for institutional family planning service claims as required by APL 22-011.	1. P&P has been revised to ensure that Family Planning services paid on institutiona claims are paid As part of Prop 56 payments. 1a. The Plan's Analytics Team is in the midst of preparing the payment details for the retro payment on the FP institutional data and looking to complete by 11/30/2023 timeline. (On Track) 2. The Analytics dept has calculated the retroactive payments due to facilities as a result of finding 3.6.2, APL 22-011 and APL 23-008. (On Track) 2a. Payments will be distributed to providers prior to or latest by Nov 30, 2023. (On Track) 2b. Facility providers with qualifying Family Planning services as per APL 23-008 will be included as part of our monthly Prop 56 payment processing going forward starting Dec 2023. (On Track)	1/15/2024	Completed	Claims		State	DHCS	2023
7	NMT & NEMT	(3.8.1) R Physician Certificate Statement (PCS) Forms The Plan did not ensure PCS forms were on file for members receiving NEMT services.	1.The Plan made the decision to no longer allow courtesy NEMT trips for members without a PCS form on file and the decision to insource PCS form acquisition to the Plan's Case Management Department beginning 3/1/23. Working alongside the Plan's transportation subcontractor, the Plan created new workflows to ensure the transportation subcontractor was not scheduling NEMT trips for members unless there was a confirmed valid PCS form on file, or the Plan provided a verbal authorization due to a trip being of an urgent nature. The Plan hired two transportation coordinators to focus on PCS acquisition leveraging the Plan's preexisting relationships with the provider network and access to EHR's. Through the end of 2022 and beginning of 2023, the Plan's transportation subcontractor trained its call center agents on the new workflow. On 2/14/23, the Plan trained its transportation coordinators on PCS acquisition. On 2/21/23, the Plan trained its entire case management team, that participates in phone shifts for the Plan's case management phone line, on the parameters for verbal authorizations for NEMT trips of an urgent nature. The Plan continues to report on the success of the new workflows at the Plan's UM Committee. (On Track) 1a.The Plan is working with its analytics team to create a report using PCS data elements to match up against subcontractor's report of all NEMT trips taken each month. This report will assist in finding any gaps in PCS compliance. The Plan estimates this report to go live 12/1/2023. (On Track)	12/15/2023	Completed	Case Management		State	DHCS	2023
8	NMT & NEMT	(3.8.2) Transportation Providers' Medi-Cal Enrollment Status The Plan did not ensure all transportation providers were enrolled in the Medi-Cal program.	The Plan has updated the P&P VMG-005 from reviewing the Transportation Providers (TP) on a quarterly review to a monthly review. Attached for reference is the updated P&P. The Plan began reviewing the TP monthly for the utilization from April 2023 to current. (Completed and Ongoing)	4/1/2023	Completed	Vendor Management		State	DHCS	2023

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2023 DHCS Audit - *Audit Review Period* 4/1/2022 - 3/31/2023 *Audit Onsite Dates - April 17, 2023 - April 28, 2023*							INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
9	Member Rights	(4.1.1) R Grievance Acknowledgement and Resolution Letter Timeframes The Plan did not send acknowledgement and resolution letters within the required timeframes.	A grievance processing timeline was created to outline the grievance 30 calendar day process, day by day. The timeline outlines that by day 5, acknowledgement letters will be sent out. We will continue to monitor the daily aging report to ensure that acknowledgement letters are sent in a timely manner. The timeline also outlines that on Day 20, "If response is not received, after at least two follow-up attempts, task to a Medical Director in Quality Suite." Complying with this process will ensure that the Medical Director has sufficient time to reach out to the provider or facility to assist in obtaining a response. The Grievance and Appeals staff were trained on the new timeline on 8/1/2023, copies of the timeline were distributed to the department. (Completed and Ongoing)	8/1/2023	Completed	G&A		State	DHCS	2023
10	Member Rights	(4.1.2) R Grievance Letters in Threshold Languages The Plan did not send acknowledgement, resolution delay, and resolution letters in threshold languages.	The Plan's Grievance and Appeals Department has created a reporting mechanism in our daily aging reports to monitor what cases are still pending translation and when was the request for translation sent out, this was implemented on 4/12/2023 We have then assigned one specific team member to be responsible for following up on translation letters to ensure that they are getting the attention that they nee to be completed in a timely manner. The Grievance Processing Timeline will be updated to include when a request for translation needs to be sent out and the Grievance and Appeals staff will be provided with the updated timeline and a refresher training will be conducted on 10/10/2023. (Completed and ongoing)	10/10/2023	Completed	G&A		State	DHCS	2023
11	Member Rights	(4.1.3) R Written Notification of Grievance Resolution Delays The Plan did not notify members of resolution delays in writing for grievances not resolved within 30 calendar days and did not resolve grievances by the estimated resolution date in the delay letters.	The Plan's Grievance and Appeals Department will be updating our system, Quality Suite, to better capture data on if and/or when a delay letter is sent out. Once the system is updated, we will be able to create a reporting mechanism in our daily aging reports to monitor for when a case needs a delay letter and if the letter was sent out. The Grievance Processing Timeline will also be updated to include the process for sending out a delay letter and the Grievance and Appeals staff will be provided with the updated timeline and a refresher training will be conducted. (Completed and Ongoing)	12/1/2023	Completed	G&A		State	DHCS	2023
12	Member Rights	(4.1.4) Grievance Delay Timeframes The Plan inappropriately utilized a 14 calendar day delay timeframe for grievance resolutions.	In review of our current policy and procedures, and workflows; they were in line with the APL requirements. There was miscommunication in the staff training to us 14 calendar days instead of an estimated resolution date in the delay letters. There was a refresher training for the Grievance and Appeals staff held on 4/18/2023, the staff was provided the requirement and were reminded to provide an estimated resolution date in the delay letters if a resolution is not reached within 30 calendar days. (Completed)	4/18/2023	Completed	G&A		State	DHCS	2023
13	Member Rights	(4.1.5) Exempt Grievance Resolution The Plan did not resolve exempt grievances by close of the next business day.	In conjunction with the Grievance Department, the Member Services Grievance Guide was revised on 10/9/2023. (Completed) Training was provided to all Member Services staff on these revisions by 11/1/2023. (Completed)	11/1/2023	Completed	Member Services		State	DHCS	2023
14	Member Rights	(4.1.6) Grievance Identification The Plan did not process and resolve all member expressions of dissatisfaction as grievances.	Member Services has implemented a process to identify expressions of dissatisfaction that were not classified appropriately. (Completed) A Member Services Supervisor works with the agent to ensure the case is classified accurately and resolved in a timely manner. (Completed)	3/15/2023	Completed	Member Services		State	DHCS	2023
15	State Supported Services	(SSS.1) Minimum Proposition 56 Payments The Plan did not distribute minimum payments for a State Supported Services claim as described in APL 1 013.	The claims system configuration team has corrected the fee schedule for the provider and adjusted the impacted claims to pay the correct rate. (Completed)	4/26/2023	Completed	Claims		State	DHCS	2023
16	CM	(2.2) PCP and members are not consistently notified of Case Management case closures	Configuration made in TruCare to ensure consistent notification	4/26/2023	Completed	Case Management		Self	DHCS	2023

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#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
17	Fraud and Abuse	(6.2) The Plan did not report preliminary investigations of all suspected cases of fraud and abuse to DHCS within 10 working days of the Plan receiving notification of the incident.	The Plan has created an interdepartmental team working in collaboration to develop a reporting process for timely submissions of possible HIPAA and FWA incidents to Compliance. Six points of entry for possible incidents have been identified. The team is utilizing technological improvements as well as developing staff training to be able to identify a possible incident for immediate reporting to compliance. At the initiation of the Reporting Process Enhancement, the FWA Specialist will conduct training designed for each department identified as a point of entry. The FWA Specialist will be responsible to track and monitor all privacy related referrals to the compliance department for timeliness Training provided to staff and new tools being used consistently	4/26/2023	Completed	Compliance		Self	DHCS	2023

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2022 DMHC Behavioral Health Investigation - *Audit Review Period* 4/1/2020 - 4/30/2022 *Audit Onsite Dates - September 7, 2022 - September 8, 2022*							INTERNAL AUDITS		
#	**Category**	**Deficiency**	**Corrective Action Plan (CAP)**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**
1	UM	The Plan failed to timely implement the requirements of Sections 1374.72 and 1374.721 (SB 855)	The Alliance reviews and/or updates all policy and procedures at least annually, to ensure our policy and procedures content is reflective of current regulatory requirements. All UM policy and procedures including any updates and the UM Program Description, are reviewed in the Utilization Management Committee (UMC), subsequently reviewed, and approved at our Board Delegated Quality Improvement Health Equity Committee (QIHEC) which reports directly to the Alliance Board of Governors. In response and in compliance with SB 855, The Alliance has updated UM-063 - Gender Affirmation Surgery and Transgender Services and the Alliance UM Program Description. Both bodies of work are aligned with current WPATH Standards of Care. The Alliance is contracted with WPATH to provide training on WPATH Standards of Care - all UM decision makers (including RNs and physicians) are required to complete WPATH training to ensure the most current WPATH standards required by SB 855 are used for medical necessity decision-making. 100% of current UM reviewers will complete WPATH Training by Q2 2024 & 100% of newly hired UM reviewers will complete WPATH Training within 90-days of their start date**Update 3/14/2025:** WPATH trainings completed 9/23/2024. The Alliance also conducts annual Inter-Rater Reliability Studies (IRR) with all UM decision makers to ensure that documented criteria is being applied consistently and accurately by decision makers. Additional training and testing is conducted when a passing score is not met. Annual IRR: 100% of UM reviewers will complete the Annual IRR Studies by Q3 2024**Update 3/14/2025:** IRR completed 9/24/2024. Passing rate 98% for UM reviewers.	9/27/2024	**Completed**	UM Behavioral Health		State	DMHC
2	Quality Assurance	The Plan does not ensure its delegate consistently documents quality of care provided is being reviewed, problems are being identified, effective action is taken to improve care where deficiencies are identified, and follow-up is planned where indicated.	As of 4/1/2023, The Alliance has terminated its contract with the delegate. Since termination, The Alliance has insourced all mental and behavioral health services and processes all quality of care issues identified. The Alliance follows its internal policy and procedures and workflows to ensure that all quality of care problems are identified, reviewed and further, that effective action is taken to improve care whe deficiencies are identified, and that follow-up is planned where indicated.	4/1/2023	Completed	UM Quality Assurance Behavioral Health Compliance		State	DMHC
#	**Category**	**Barriers to Care**	**Plan Response**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**
1	Pharmacy Services	The Plan has limited ability to provide Office Based Opioid Treatment (OBOT) and Opioid Treatment Program (OTP) therapy and lacks policies and procedures for these treatments.	Members access OBOT and OTP therapy through Medication Assisted Treatment (MAT) providers in primary care, inpatient hospitals, emergency departments, and other contracted medical settings per BH-005. PCPs, BH, and ED providers are responsible for identifying members with substance abuse disorder issues and arranging the MAT services; under the CA Bridge Program EDs can provide immediate access to MAT. If members contact the Alliance's MSD or BHD, it will provide appropriate referrals to MAT providers. MAT providers are providers that can prescribe opioid use disorder medications and have current Drug Enforcement Administration registration with Schedule III authority.	12/31/2024	Completed	UM Behavioral Health Pharmacy Provider Contracting	✓	State	DMHC
2	Cultural Competency and Health Equity	Neither the Plan nor its delegate conduct assessments pertaining to cultural competency and health equit specific to the Plan's enrollee population.	The Alliance conducts the following assessments for cultural competency and health equity: Annual NCQA population assessment, membe experience surveys (i.e. CG CAHPS, CAHPS, and TAR), provider satisfaction survey. Additionally, the Alliance utilizes various data sources to identify and determine intervention and quality activities to improve health needs and health disparities. Data sources include, but are not limited to, member demographic data, DHCS Alliance Specific health disparity data, claims, and encounter data. The Alliance monitors and addresses disparities, QIPs,and PIPs. These projects are driven by quantitative and qualitative data and are included in the QIHP Work Plan and Evaluation which is approved by the QIHEC. The QIHE Work Plan identifies which activities and initiatives ar	12/31/2024	Completed	Quality Assurance Behavioral Health	✓	State	DMHC
3	Enrollee Experience	Enrollees experience difficulties obtaining appointments.	The Alliance started insourcing behavioral health services on April 1, 2023, and no longer delegates behavioral health services. The Alliance does not require prior authorization for behavioral health services (except for psychological and neuropsychological testing), and members can directly contact Alliance behavioral health providers to schedule appointments.	4/1/2023	Completed	Quality Assurance Behavioral Health	✓	State	DMHC

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2022 DMHC RBO Audit: Delegate - *Audit Review Period* 1/1/2022 - 3/31/2022							INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
1	Claims Payment Accuracy	The Department's examination disclosed that the RBO failed to reimburse one paid claim correctly due to a systematic error. The claims system failed to classify the provider as a contracted provider. The claim was paid incorrectly at the non-contracted rate, which was less than the contracted rate. The RBO represented to the Department that this deficiency was due to a contract amendment, effective February 1, 2021, that was not updated in their claims system. This deficiency was noted in paid claims sample number P-18.	Delegate updated claims system to accurately reflect all providers listed on the provider roster as contracted with the effective date of 2/1/2021 to align with the contract amendment. A claims sweep was completed with a lookback to 2/1/2021. All claims previously paid noncontracted were reprocessed as contract and have been paid with any accrued interest and/or penalties associate with each claim reprocessed on 10/12/2022. Evidence of the complete claims audit sweep associated with members was sent to The Alliance on 1/19/2023 via secure email. Draft policy was created to ensure provider contracts and rosters are appropriately loaded within delegate's claims system. Draft policy will be presented to the delegate's Compliance Committee on 3/29/2023 for review and approval. Update 4/14/2023: The delegate's Compliance Committee rescheduled to 4/26/2023. The updated policy will be approved at that time. Update 5/12/2023: The delegate approved the policy at their Compliance Committee	5/12/2023	Completed	Claims Compliance		State	DMHC	2022
2	Claims Payment Accuracy	The Department's examination disclosed that the RBO failed to reimburse two high dollar claims correctly due to a systematic error. The contracted provider was not paid per contract for laboratory procedures. The RBO stated the laboratory procedures were based on an old boiler plate and should not have been included in the contract. The contract was amended on 9/1/2022. This deficiency was noted in high dollar claims sample numbers HD-18 and HD-24	There were no Alliance members impacted by this deficiency. Effective 10/12/2022 all claims were reprocessed and paid.	10/12/2022	Completed	Claims Compliance		State	DMHC	2022
3	Incorrect Claim Denials	The Department's examination disclosed that the RBO failed to reimburse one denied claim correctly due to a systematic error. The RBO incorrectly denied claims for podiatric and chiropractic services at federally qualified health centers and rural health clinics. The denial reason instructed the provider to bill "Medi-Cal EDS" when it should have been paid. This deficiency was noted in denied claims sample number D-29.	There were no Alliance members impacted by this deficiency. Effective 10/12/2022 all claims were reprocessed and paid.	10/12/2022	Completed	Claims Compliance		State	DMHC	2022

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#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
1	Claims Payment Accuracy	The Department's examination disclosed that one of 30 high dollar claims were not reimbursed correctly. The claims billed with Current Procedural Terminology (CPT) codes 93005 were underpaid. This deficiency was noted in high dollar claim sample number 28.	The RBO is reprocessing all claims with code 93005 underpaid from January 2021 to present and will upload corrected explanations of benefits upon completion. Corrected explanations of benefits showing additional payment (plus interest and penalty where applicable) as well as the requested report and policies will be submitted to DMHC on or before 1/30/2023.	1/30/2023	Completed	Claims Compliance		State	DMHC	2022
2	Misdirected Claims	The Department's examination disclosed that five out of 40 denied claims were not forwarded. This deficiency was noted in the following denied claims sample numbers: 3, 6, 20, 34, and 37. This deficiency was also noted in the high dollar claim sample numbers: 3, 5, 9, 10, and 25.	There is a system limitation (i.e. mapping issue) where some of the claims (837I encounters) are not being forwarded through our claims processing system. Because of this issue, 837I claims are not being forwarded to health plans. 837I misdirected claims are denied as health plan responsibility and providers are notified via weekly explanations of benefits. The mapping issue was discovered Q1 2022 and tests began at that time with health plans and clearinghouses. 837P files continue to be submitted successfully. The delegate is working with IT to upgrade the server so that updates provided by our software vendors can be implemented for the mapping issue to be resolved. The expected compliance date will be on or before 2/28/2023. 1/26/2023: server updates completed, system updates happening this week. 1/27/2023: system consultant met with the software vendor and their development team to identify and resolve issues so that system updates can happen successfully. 1/30/2023: all system updates completed successfully on test environment	1/30/2023	Completed	Claims Compliance		State	DMHC	2022
3	Reimbursement of Claims Overpayments	The Department's examination disclosed that the RBO failed to send a written request for overpayment reimbursement to the provider. This deficiency was noted in the following late claim sample numbers: 16, 32, and 35.	Examiner error. When the claims examiner reprocessed these claims, the overpayment was reversed instead of a refund request letter being sent to the provider. Compliance met September 27, 2022 when the claims examiner was reminded in a verbal meeting of the above rule as well as the Delegate's internal policy on overpayments. Also, there is a report run prior to the weekly check run to ensure compliance. Because the overpayment was reversed in the adjusted claims, a refund request was not sent for the original claims.	1/30/2023	Completed	Claims Compliance		State	DMHC	2022

ALAMEDA ALLIANCE FOR HEALTH
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2022 DMHC FINANCIAL SERVICES : *Audit Review Period 1/1/2022 - 3/31/2022*							INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
1	Provider Dispute Resolutions	The Department's examination disclosed that the Plan failed to timely acknowledge receipt of 12 out of 71 provider disputes reviewed.	1. Policies and procedures, including internal claims audit procedures, implemented to ensure provider disputes are acknowledged timely. Update 2/13/2023: Policy updated and will be approved at Committee 3/25/2023 2. Staff training completed January 2023 and created a audit workflow effective 01/01/2023. 3. Claims Operations Support Manager and PDR Supervisor. PDR Supervisor will monitor all incoming PDR mail. A daily audit will be conducted before the 15th due date to assure all cases are acknowledged timely.	2/24/2023	Completed	Claims		State	DMHC	2022
2	Claims	The Department's examination disclosed that, due to systemic issues, claims were not reimbursed accurately, including interest and penalties.	CORRECTIVE ACTION TAKEN DURING EXAMINATION The Plan submitted evidence on October 28, 2022, that the Plan reprocessed and paid claims previously paid incorrectly. This correction and remediation resulted in the additional payment of $5,742.29, plus interest of $7,675.43, on 742 claims. In addition, the Plan submitted evidence on October 28, 2022, that the Plan reprocessed and paid claims previously denied incorrectly. This correction and remediation resulted in the additional payment of $64,718.77, plus interest of $6,002.98, on 750 claims. The Plan corrected the deficiencies noted above and completed the required remediation during the course of the examination; therefore, no additional response is required.	10/28/2022	Completed	Claims		State	DMHC	2022
3	Changes in Plan Personnel	R The Department's examination disclosed that the Plan did not timely file changes in plan personnel.	1. The Plan revised its Desktop Procedure to define the Key Personnel as "Persons holding official positions that are responsible for the conduct of the Plan including but not limited to all Senior Leadership, all members of the BOG and other principal officers." The Desktop Procedure further clarifies the activities that will constitute an official personnel change event for Senior Leadership versus Board of Governors members. Finally, the Desktop Procedure was revised reflect that Key Personnel Change filings must be submitted within five (5) calendar days. 2. We have taken steps to improve the communication with the internal stakeholders to ensure personnel change events are routed to the Regulatory Affairs and Compliance team in a timely manner. The Board Clerk is responsible to immediately notify the Compliance Department of any Board Member changes. To ensure no updates are missed, each month the Compliance Specialist will email the Board Clerk and the Human Resources Department to confirm whether the BOG or SLT has experienced any personnel changes. The Compliance Specialist also maintains a log of Key Personnel Changes. Furthermore, once a personnel change event is anticipated, the Compliance Specialist immediately begins an electronic file and begins preparation of the necessary documents for submission.	1/13/2023	Completed	Compliance		State	DMHC	2022
4	Fidelity Bond	The Department's examination disclosed that the Plan's fidelity bond did not have a provision for 30 days' notice to the Department prior to cancellation.	Immediately after receiving the DMHC's audit request, The Alliance finance staff requested its insurance broker to work with the insurer in adding the requested provision. Before the DMHC's audit exit conference, such requested provision was provided to the DMHC auditor, and the auditor expressed that the supplied document was satisfactory. The Alliance has also created a new Policy & Procedure effective 1/11/2023.	1/11/2023	Completed	Finance		State	DMHC	2022

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2022 DHCS AUDIT FINDINGS: *Audit Review Period 1/1/2021 - 3/31/2022*							INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
1	G&A	(1.3.1) The Plan did not send acknowledgement letters for standard appeals within the required timeframe of five calendar days.	1. The Daily Clerk Report is received daily by Grievance & Appeals Clerks and Leadership. The report will be reviewed by the Grievance & Appeals Leadership team to ensure acknowledgment letters are mailed timely. 2. The Plan provided training to the Grievance & Appeals staff to review the regulatory requirements for mailing of acknowledgement letters.	10/1/2022	Completed	G&A		State	DHCS	2022
2	G&A	(1.3.2) The Plan did not comply with existing APLs to notify members receiving a NAR that upholds an adverse benefit determination that they have an additional 120 days in addition to the initial 120 days allowed to request a SFH.	1. Your Rights enclosure was updated to reflect enrollees have 240 days to request a State Fair Hearing 2. Policy & Procedure G&A-007 State Hearings has been updated to reflect the member has 240 calendar days to request a State Hearing. The policy will go to committee for review and approval in December. Update 03/10/2022: Plan submitted draft policy G&A-007 State Fair Hearings that reflects current timeframe to request a SFH (240 calendar days) per the PHE. Policy pending internal committee approval. Plan will need to monitor end of PHE in order to revise policy to reflect normal regulatory requirement of 120 calendar days. PHE was extended through 1/11/23.Update 4/14/2023: The updated policy was approved at Compliance Committee on 3/21/2023	3/21/2023	Completed	G&A		State	DHCS	2022
3	Provider Relations	**R** (1.5.1) The Plan did not ensure that its subcontractors submitted complete ownership and control disclosure information.	1. The Alliance has made updates to its Provider Services Standard Operating Procedure (SOP) – Ownership and Control Disclosure Reviews for Delegates. This includes an additional layer of review from the Alliance Compliance Department when ownership and control forms are received from delegates. The SOP and tracking sheet has been updated. 2. The findings specifically mentioned two (2) forms: • The delegate who provided the Alliance with the email confirming that the form they submitted to the Alliance is the same form that it files with DHCS. According to the delegate, DHCS confirmed acknowledgement of the form with no additional feedback. • Another delegate who does not have a sole owner and provided a list of their leadership team with the FEIN for each of the clinics. The Alliance will notify the impacted delegates of the findings to receive forms that meet requirements by DHCS. 3. The Alliance will collect the new forms starting Q1 2023Update 03/10/2023: Delegate has submitted an updated form and delegate is currently working toward completion of the form for submission to the Plan. Provider Services and Compliance will review to validate all fields are complete once all forms are received Update 4/15/2023: The other delegate's form received on 3/2/2023, and two levels of review completed 3/10/2023.	3/10/2023	Completed	Provider Relations		State	DHCS	2022

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2022 DHCS AUDIT FINDINGS: *Audit Review Period 1/1/2021 - 3/31/2022*							INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
4	QI	(2.1.1) The Plan did not document attempts to contact members and schedule the IHA.	1. The plan will continue to inform members of the IHA through the EOC, welcome letters to all new members, and videos. - In addition, all members are eligible for a new member orientation (including a financial incentive). - Information regarding the IHA will be included in the member newsletter. The Alliance will initiate a new phone campaign where all new members will receive a phone call encouraging the member to receive an IHA. This phone log will be appropriately documented. The Alliance will create a call script for new member phone calls. 2. The plan will create a report to identify new plan membersUpdate 5/12/2023: Fulfillment Report created to track mailing of member Orientation reports that contain reminder to schedule IHA to new members. Member Orientation Service Request tracking report tracks outreach attempts to members to complete new member orientation, which includes communication about scheduling IHAs 3. The plan will create workflows for informing members of the IHAUpdate 5/12/2023: Clinical QI Program Coordinator will review IVR reports to determine all new members have received an outreach call. 4. The plan will update the IHA P&P to reflect the updated workflowsUpdate 3/10/2023: Draft policy QI-124 completed, IVR outreach is pending DHCS approval of script. Upon DHCS approval we will continue to develop the process for IVR outreach and develop desktop procedures. Update 4/15/2023: The updated P&P was approved at Compliance Committee 3/21/2023 5. The plan will create a phone call campaign, create a script, and work with the state for approvalUpdate 3/10/2023: Awaiting DHCS approval of script. Update 6/9/2023: Final documents submitted to DHCS for review. Awaiting DHCS response. The Plan will continue to ensure accurate documentation of IHA outreach attempts via providers, by reviewing documentation as part of FSRs.	9/8/2023	Completed	QI		State	DHCS	2022
5	CM	**R** (2.5.1) The Plan's MOU with the county MHP did not include the responsibility for the review of disputes between the Plan and the MHP.	1. The Alliance has made several updates to the MOU and incorporated APL 18-015, as well as APL 21-013 Dispute Resolution Process Between Mental Health Plans and Medi-Cal Managed Care Health Plans. The Alliance has had a series of meetings with the MHP to review redline changes to the MOU. The MHP is currently under review of the redline changes and will notify the Alliance when they can move forward wit signing the MOU. The MHP MOU vetting process includes County Board of Supervisor (BOS) approval. Therefore, the Alliance is hoping to execute the MOU by the end of 2022.	12/31/2023	Completed	Provider Relations		State	DHCS	2022
6	Provider Relations	**R** (3.1.1) The Plan did not monitor the network providers' compliance with requirements for when appointments were extended.	1. The Provider Manual was edited to update the requirements, providers were advised in the Quarterly Provider Packet, and The Alliance Provider Representatives advised providers during PCP visits. Additionally, fax blasts were sent to providers regarding the updated requirements, and the Provider Education document was updated to reflect the requirements. 2. Edit P&P and Quality of Access Workflow to ensure all cases are reviewed by a QI Nurse. If a case is determined to be related to access, QI / A&A staff will review data for ED / Inpatient Stays as a result of delay in appointment. If the member does have an ED / IP Claim, the QI RN will then work the case up as a PQI / Quality of Care. This will be reviewed by the Medical Director and follow the PQI process. Finally, all QOA cases with available MRs will be reviewed to ensure the appropriate provider documentation. Update 03/10/2023: Policy QI-114 has been updated and is awaiting approval at committee Update 4/14/2023: P&P Q1-114 was approved at Compliance Committee 3/21/2023	3/21/2023	Completed	Provider Relations QI		State	DHCS	2022

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2022 DHCS AUDIT FINDINGS: *Audit Review Period 1/1/2021 - 3/31/2022*							INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
7	Claims	(3.6.1) The Plan improperly denied emergency services claims.	1. Case #7 – The claim was paid on 8/11/2021. The vendor was notified of the finding on 5/19/2022 and asked to review their internal process to ensure that codes on claims are captured correctly. They acknowledged they reviewed their internal processes and stated that poor claim imaging may have cause the issue, but they will increase the resolution to help ensure better results in the future. 2. Case #20 –The vender was notified of the issue on 5/19/2022 and asked to review their internal process to ensure that dates on clams are captured correctly. They acknowledged they reviewed their internal processes and stated that poor claim imaging may have cause the issue, but they will increase the resolution to help ensure better results in the future. In addition, an edit was enhanced to ensure that the date range order is correct. 3. The claim was paid on 1/5/2022 correctly. The Claims Processor was shown the claim finding for review along with the correct workflow document that shows the correct process to help ensure moving forward this does not occur again. This workflow was also reviewed by the Claim Processor team and training occurred.	10/11/2022	Completed	Claims		State	DHCS	2022
8	Access and Availability	**R** (3.8.1) The Plan did not use PCS forms for NEMT services.	1. The Plan will educate providers on PCS requirements. Update 3/10/2023: Provider Alert PCS Form Reminder and Form was sent out to Providers in a fax blast on Tuesday, 12/27/22. 2. Refine PCS workflows to meet all regulatory requirements. Update 3/10/2023: Workflow updated. 3. The Plan will conduct staff trainings on process workflow changes.Update 4/15/2023: Training completed 1/31/2023. 4. The Plan will ensure that the transportation subcontractor trains their staff on the PCS process workflow changes. The transportation subcontractor will provide training materials and sign in sheetsUpdate 4/15/2023: Training completed 1/31/2023. 5. The Plan will develop reports on PCS form outcomes using both transportation subcontractor information and the Plan's process to obtain PCS forms.Update 4/15/2023: Reports developed and presented at UM Committee Q4 2022. 6. The Plan will monitor process workflows from the transportation subcontractor and the Plan to obtain missing PCS forms Update 4/15/2023: Reports developed and presented at UM Committee Q4 2022. 7. The Plan will analyze trends in provider practices and provide feedback to providers regarding PCS form requirements. Update 4/15/2023: Reports developed and presented at UM Committee Q4 2022, where trends analyzed. 8. The plan will evaluate whether to continue having the transportation subcontractor manage the PCS forms or take the direct management of PCS forms back into the Plan.Update 4/15/2023: Reports developed and presented at UM Committee Q4 2022. Will continue to analyze quarterly. 9. The Plan will provide a quarterly report to UM CommitteeUpdate 4/15/2023: Reports developed and presented at UM Committee Q4 2022.	4/1/2023	Completed	UM		State	DHCS	2022
9	Member Rights	**R** (4.1.1) The Plan did not send acknowledgement and resolution letters within the required timeframes.	1. The G & A Department Leadership and Quality Assurance Specialist will reference the daily reports to ensure the acknowledgment and resolution letters are sent timely 2. The Plan provided training to the Grievance & Appeals staff to review the regulatory requirements for mailing of acknowledgement and resolution letters. 3. The Quality Assurance Specialist will audit 5 appeals cases and 5 grievances cases per Grievance & Appeals Coordinator per month.	10/1/20222	Completed	G&A		State	DHCS	2022

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2022 DHCS AUDIT FINDINGS: *Audit Review Period 1/1/2021 - 3/31/2022*							INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
10	Member Rights	**R** (4.1.2) The Plan did not send acknowledgement and resolution letters in threshold languages.	1. Updated our system of record to capture the dates the resolution letter was submitted for translation and the date it was mailed to the member. 2. The Plan provided training to the Grievance & Appeals staff on the updates made to the system of record. 3. The Quality Assurance Specialist will audit 5 appeals cases and 5 grievances cases per Grievance & Appeals Coordinator per month.	9/20/2022	Completed	G&A		State	DHCS	2022
11	Member Rights	(4.1.3) The Plan was not compliant with grievance extension letter timeframes; in some cases, it did not send extension letters for grievances that were not resolved within 30 calendar days and in other cases it did not resolve grievances by the estimated completion date specified in the extension letter	1. The Plan provided training to the Grievance & Appeals staff on the system updates to capture extension letters. 2. The Quality Assurance Specialist will audit 5 appeals cases and 5 grievances cases per Grievance & Appeals Coordinator per month. 3. Updated Policy & Procedure G&A- 003: Grievance and Appeals, Receipt, Review and Resolution. The policy will be sent to Committee for approval. Update 03/10/2023: Draft policy updated and awaiting approval at committee. Update 4/15/2023: P&P G&A-003 was approved at Compliance Committee on 3/21/2023	3/21/2023	Completed	G&A		State	DHCS	2022
12	Member Rights	**R** (4.1.4) The Plan did not thoroughly investigate and resolve grievances prior to sending resolution letters	1. The Alliance will review resolution letters prior to mailing to the member. 2. The Alliance provided training to the Grievance & Appeals staff to ensure the resolution letter clearly addresses all of the member's concerns 3. The Quality Assurance Specialist will audit 5 appeals cases and 5 grievances cases per Grievance & Appeals Coordinator per month.	10/1/2022	Completed	G&A		State	DHCS	2022
13	Member Rights	**R** (4.3.1) The Plan did not report suspected security incidents or unauthorized disclosures of PHI to DHCS within the required timeframes.	The Plan has created an interdepartmental team to work in collaboration to develop a reporting process for timely submissions of possible HIPAA and FWA incidents to Compliance. Six points of entry for possible incidents have been identified. The team is utilizing technological improvements as well as developing staff training to be able to identify HIPAA and FWA incidents and the method for immediate reporting to compliance. Update 03/10/2023: Training created and provided to The Alliance staff; new referral tracking implemented and tool created.	3/10/2023	Completed	Compliance		State	DHCS	2022
14	Member Rights	(4.3.2) The Plan did not notify the DHCS Program Contract Manager and DHCS ISO of suspected security incidents or unauthorized disclosure of PHI or PI.	Due to human error, reporting to the three (3) entities at DHCS; DHCS Program Contract Manager, the DHCS Privacy Officer and the DHCS Information Security Officer was not completed for all possible HIPAA incidents. Reporting Policy CMP-013 has been updated to reflect the current reporting email address for possible HIPAA incidents to DHCS incidents@dhcs.ca.gov. This change was reviewed and approved by the Compliance Committee on 11/23/2021.	11/23/2021	Completed	Compliance		State	DHCS	2022
15	Fraud and Abuse	**R** (6.2.1) The Plan did not report preliminary investigations of all suspected cases of fraud and abuse to DHCS within 10 working days of the Plan receiving notification of the incident.	The Plan has created an interdepartmental team working in collaboration to develop a reporting process for timely submissions of possible HIPAA and FWA incidents to Compliance. Six points of entry for possible incidents have been identified. The team is utilizing technological improvements as well as developing staff training to be able to identify a possible incident for immediate reporting to compliance. At the initiation of the Reporting Process Enhancement, the FWA Specialist will conduct training designed for each department identified as a point of entry. The FWA Specialist will be responsible to track and monitor all privacy related referrals to the compliance department for timeliness. Update 03/10/2023: Training created and provided to The Alliance staff; new referral tracking implemented and tool created.	3/10/2023	Completed	Compliance		State	DHCS	2022

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2021 DMHC JOINT AUDIT FINDINGS : *Audit Review Period 11/1/2018 - 10/31/2020*							INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
1	Grievances & Appeals	When the Plan has notice of a case requiring expedited review, the Plan does not immediately inform complainants of their right to contact the Department.	The Plan updated the process to state when a call is received by the Member Services Department and it is categorized as a potential expedite, the call is transferred to the Grievance & Appeals Department queue and the Clerk will provide the member with their DMHC rights.	5/3/2022	Completed	G&A		State	DMHC	2021
2	Grievances & Appeals	The Plan's online grievance submission procedure is not accessible through a hyperlink clearly identified as "GRIEVANCE FORM," does not allow a member to preview and edit the form before submission, and does not include the required disclosure.	The Plan has worked with our internal Information Technology (IT) Department to have the updates made to the website to include the GRIEVANCE FORM hyperlink, the edit/preview functionality and to update the disclosure statement. Exhibit 2A_Preview_Edit_Disclosure shows the updates on the testing site. Regarding the disclosure statement, the Plan identified an outdated version of the statement. The Plan has updated the disclosure statement so that it is in alignment with the verbiage from Knox-Keene (see attached Exhibit 2B_Knox-Keene).	8/11/2022	Completed	G&A		State	DMHC	2021
3	Grievances & Appeals	The Plan does not correctly display the statement required by Section 1368.02(b) in all required enrollee communications.	The Plan identified an outdated version of the statement. The Plan has updated the disclosure statement so that it is in alignment with the verbiage from Knox-Keene (see attached Exhibit 3A_Knox-Keene). Exhibit 3F will apply to both the appeals and grievance letters. The Plan's UM materials were likewise updated to reflect compliance with the verbiage. Revised Your Rights attachments for NOAs and NARs were implemented in TruCare on 1/18/2022. The Plan's Pharmacy templates are being drafted and copies will be provided on 12/30/2022 for the following: •4A_GroupCare NOA template •5A_ GroupCare NOA template •6A_ Full Group Care Formulary/Template **12/30/2022**:Template letters completed and submitted to DMHC	12/30/2022	Completed	G&A Member Services UM Rx		State	DMHC	2021
4	Prescription (Rx) Drug Coverage	The Plan's prescription drug denial and modification letters to enrollees do not include accurate information about their grievance rights.	The plan will update/ensure prescription drug denial and modification letters to the enrollees include accurate information about their grievance rights. Templates are being drafted and copies will be provided on December 30, 2022.**12/30/2022:**Template letters completed and submitted to DMHC	12/30/2022	Completed	Rx		State	DMHC	2021
5	Prescription (Rx) Drug Coverage	The Plan does not inform enrollees of their right to seek an external exception request review in formulary exception request denial letters.	The plan will insert external exception request review in formulary exception request denial letters as seen below: "EXTERNAL REVIEWS You have the right to request an external review when the Alliance denies a prior authorization request for a drug that is not covered by the plan or for an investigational drug or therapy. A request for an external review will not prevent you from filing a Grievance or Independent Medical Review (IMR) with the California Department of Managed Health Care. You may request an external review through the Alliance contact information listed above." •Templates are being drafted and copies will be provided on December 30, 2022.**12/30/2022:T**emplate letters completed and submitted to DMHC	12/30/2022	Completed	Rx		State	DMHC	2021
6	Prescription (Rx) Drug Coverage	The Plan does not display its formularies in a manner consistent with the Department's standard formulary template.	The Plan will update formularies in a manner consistent with the Department's standard formulary template. **12/30/2022:** The formulary template has been updated.	12/30/2022	Completed	Rx		State	DMHC	2021

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2021 DHCS JOINT AUDIT FINDINGS: *Audit Review Period 6/1/2019 - 3/31/2021*								INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Risk Category (High, Medium, Low)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
1	UM	(1.2.1) The Plan did not have appropriate processes to ensure that limitations on speech therapy services would not be imposed. In addition to using Medi-Cal guidelines, the Plan used MCG as its evidence-based criteria to make decisions. MCG criteria dictates the amount of visits that can be approved based on a diagnosis and therefore imposes limits.	1. The Plan developed workflow outlining standard review process for speech therapy Prior Authorization (PA) requests, ensuring that no limitations on speech therapy would be imposed on members under age 21. 2. The Plan will conduct a current staff training on standard process, and include it in new staff training. Update 10/8/2021: Training complete 9/29/2021 3. The Plan will revise 10748 Daily Auth Denial report to incorporate service type to capture PA requests for Speech Therapy. Update 11/12/2021: The report request has been submitted, estimated completion is 11/15/2021. Update 12/10/2021: Report has been created and is being completed weekly. 4. The Plan will monitor PA requests for Speech Therapy on a quarterly basis. Update 11/12/2021: The report request has been submitted, estimated completion is 11/15/2021. Update 12/10/2021: Requests for Speech Therapy are being monitored quarterly. 5. The Plan will report results quarterly to UMC. Update 12/10/2021: The first report will be given to the UMC in January 2022. Update 09/09/2022: Speech therapy is now being tracked on a quarterly basis and was reported out at the Q1 2022 UM Committee	Medium	Q1 2022	Completed	UM		State	DHCS	2021
2	UM	(1.2.2) The Plan did not ensure that a qualified health care professional reviewed dental anesthesia prior authorization requests which includes a review of clinical data. The Plan did not ensure the use of appropriate criteria/guidelines when reviewing dental anesthesia requests.	1. The Plan developed workflow outlining standard review process for dental anesthesia Prior Authorization (PA) requests. 2. The Plan will develop mitigation plan until auto auth programming is removed. Update 10/8/2021: Mitigation plan developed and put into place 9/29/2021 3. The Plan will conduct a staff training on the mitigation plan to identify and use standard UM review process for dental anesthesia (DA) and include it in new staff training. Update 10/8/2021 Training complete 9/29/2021 4. The Plan's UM and IT teams will collaborate to remove DA requests from Auto Authorization programming in TruCare (TC). Update 12/10/2021: DA requests have been removed from Auto Authorization programming in TruCare as of 10/1/2021 5. The Plan will develop a Tracking Report to capture and report on PA requests for Dental Anesthesia. Update 12/10/2021: The quarterly report (03127) Dental General Anesthesia Report will be utilized for monitoring 6. The Plan will monitor PA requests for Dental Anesthesia quarterly. Update 10/14/2022: PA requests for Dental Anesthesia are now being monitored quarterly 7. The Plan will report results quarterly to UMC. Update 10/14/2022: PA requests for Dental Anesthesia are now being tracked on a quarterly basis and was reported out at the Q1 2022 UM Committee	High	Q1 2022	Completed	UM		State	DHCS	2021
3	UM	(1.5.1) The Plan did not ensure the delegate met standards set forth by the Plan and DHCS. The Delegate inappropriately denied medical prior authorization requests.	1.The Plan will inform Delegate 1 of DHCS findings about inappropriately denied medical prior authorization requests. Update 11/12/2021: On 10/8/2021 a letter was sent to the delegate to advise of the audit findings. 2.The Plan will re-educate delegates on requirements for standard UM processes, including application of appropriate criteria guidelines. Update 11/12/2021: On 10/12/2021 a meeting was held with Delegate 1 leadership do educate on requirements for the standard UM process. 3.The Plan will audit Delegate 1's denied cases for appropriateness of denial elements using annual audit tool. Update 2/11/2022: The annual Delegate 1 delegation audit began 12/17/2021 and includes an audit of denied cases for appropriateness of denial elements. 4.The Plan will review denied cases at monthly Delegate 1 meeting for education. Update 2/11/2022: Denied cases are now being reviewed at the monthly Delegate 1 meeting for education. Update 5/13/2022: The Q1 2022 audit has commenced as of 5/5/2022. Update 08/09/2022: The Delegate 1 audit is in progress and is expected to be completed by 8/12/2022 Update 09/06/2022: The audit for Q2 2022 is in progress, preliminary findings have been submitted to Delegate 1. The audit for Q3 2022 is beginning. There will be four total quarters of reviews completed in order to close out this finding. 4/3/2023: Four quarters of the audit have been completed. Results under review. Update 6/9/2023: A Trend Report for 2022 Quarterly Focused Audit findings regarding medical necessity denials was issued to Delegate 1 along with the Final Report for their Annual Audit on 4/11/23. Delegate 1 CAP response due 6/16/2023. **Update 9/8/2023:** The 2022 CAP is ongoing. Delegate 1's CAP included updates to UM workflows, staff training, and internal audits. The CAP is in progress. Workflows, trainings, and internal audits have been completed and are under review by Alliance SMEs.	Medium	Q4 2023	Completed	UM		State	DHCS	2021

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2021 DHCS JOINT AUDIT FINDINGS: *Audit Review Period 6/1/2019 - 3/31/2021*								INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Risk Category (High, Medium, Low)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
4	UM	(1.5.2) The Plan did not ensure the delegate met standards set forth by the Plan and DHCS. The delegate did not ensure that requests to see out of network providers were reviewed and decisions were made by a qualified health care professional. It did not include the decision-maker's name in the NOA.	1.The Plan will inform Delegate of DHCS findings about qualified health care professional did not always make decisions to deny or only authorized an amount, duration, or scope that was less than requested, and the lack of name and contact information on the NOA of the decision-maker. Update 11/12/2021: On 10/8/2021 a letter was sent to delegate to advise of the audit findings. 2.The Plan will re-educate delegates on standard UM requirement that only qualified health care professionals make decisions to deny or authorize an amount, duration, or scope that is less than requested, including out of network requests, and on the requirement to have the decision-makers' name and contact information on the NOA. Update 11/12/2021: The Alliance met with the delegate on 10/28/2021 to provide re-education. 3.The Plan will audit delegate's cases during the annual audit to ensure that only qualified health care professionals make decisions on denials and authorizations of the amount, duration, and scope less than requested, and contact information for the decision maker. Update 02/11/2022: The annual delegation audit started on 12/20/2021 and is in progress. The audit is expected to be completed on 4/1/2022. Update 09/09/2022: The delegate audit is in progress. And is expected to be completed by 9/23/2022	Medium	12/20/2021	Completed	UM Compliance		State	DHCS	2021
5	UM	**R** (1.5.3) The Plan did not ensure complete ownership and control disclosure information were collected from its delegates.	1.The Plan has updated its documentation, Provider Services Standard Operating Procedure – Ownership and Control Disclosure Reviews for Delegates, to include collecting required disclosures from the managing employees, or board of directors and senior management team in cases where the entity is a non-profit with no majority ownership and/or owned by physician shareholders.	Low	9/14/2021	Completed	Provider Network Vendor Management		State	DHCS	2021
6	UM	(1.5.4) The Plan did not ensure the written agreements with its delegates included the requirement to allow specified departments, agencies, and officials to audit, inspect, and evaluate the Plan's facilities, records, and systems related to good and services provided to Medi-Cal members.	1.The Plan is adding the Comptroller General in the Behavioral Health contract, Amendment 7. Update 11/12/2021: The Comptroller General was added to the contract, Amendment 7, as of 10/13/2021 2.The Plan is currently working with its delegate on a new contract and delegation agreement which will include the provision and requirement to allow governmental and specified agencies and officials to audit records and systems. Update 1/14/2022: The draft agreement has been completed and is expected to be fully executed in January 2022. Update 2/11/2022: Full execution of the draft agreement is still in progress. Update 09/09/2022: Full execution of the draft agreement is expected by the end of September 2022 3.The Plan will conduct a review of all of its delegated agreements and update the agreements to ensure that all of the language requirements are included. Update 1/14/2022: The agreement has been reviewed and updated. Update 2/11/2022: The Plan conducts annual oversight of its Delegates via an Annual Delegation Audit, as described in CMP-019 – Delegation Oversight. The Plan has updated its Compliance Audit tool to ensure the audit includes a review of the Delegation Agreement to confirm it contains the required language.	Medium	12/31/2022	Completed	Provider Network Vendor Management Compliance		State	DHCS	2021
7	UM	(1.5.5) The Plan did not have policies and procedures for imposing financial sanctions on its delegate and delegated entities.	1.The Plan has created a new Policy, CMP-030 Sanction and Escalation. This Policy describes the standards by which the Plan may impose sanctions against Delegated Entities (DE), providers and vendors for non-compliance or failure to comply with Corrective Actions Plan (CAP) deficiencies, or for breach of any material term, covenant or condition of an agreement and/or for failure to comply with applicable federal or state statutes, regulations, and rules. Update 12/10/2021: Policy CMP-030 was approved at Compliance Committee on 11/23/2021	Low	12/1/2021	Completed	Compliance		State	DHCS	2021
8	Case Management	**R** (2.1.1) The Plan did not conduct HRAs within the required timeframes for newly enrolled SPD members in 2019 and 2020.	1. The Plan revised the HRA process to track all incoming HRAs via a Log, documenting date of receipt. 2. The Plan revised current process for HRAs received past due to be entered into the system of record TruCare (TC) during the month of receipt. 2.a. The Plan updated workflows. 3. The Plan re-trained staff on the HRA process. 4. The Plan will monitor the Log weekly to ensure adherence to the new process. Update 10/8/2021: The log has been created and is being monitored weekly 5. The Plan will report outcomes up to UMC quarterly. Update 2/11/2022: As of the December UM Committee meeting, outcomes are now being reported at the UMC.	Low	12/31/2021	Completed	Case Management		State	DHCS	2021

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2021 DHCS JOINT AUDIT FINDINGS: *Audit Review Period 6/1/2019 - 3/31/2021*								INTERNAL AUDITS			
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9	Case Management	(2.1.2) The Plan did not ensure coordination of care in certain cases where EPSDT services were medically necessary.	1.The Plan will develop training on EPSDT PA requests to identify and refer members who need coordination of their care. Update 11/12/2021: Training developed 2.The Plan will provide training to UM and CM staff. Update 11/12/2021: Training completed for UM and CM staff 3.The Plan will create a reporting system to capture referrals to CM and the provision of care coordination. Update 11/12/2021: Reporting system to capture referrals has been created, change in reporting will be reflected mid-December 4.The Plan will report outcomes at UMC on a quarterly basis. Update 5/13/2022: Outcomes reported at January and March 2022 UMC Meetings.	Medium	5/13/2022	Completed	Case Management		State	DHCS	2021
10	Case Management	(2.2.1) The Plan did not ensure the completion of Individualized Care Plans for members enrolled in Complex Case Management.	1. The Plan revised its CCM ICP workflow and added the requirement that all staff complete ICPs for all members in CCM. 2. The Plan re-trained staff to complete ICPs for all members in CCM. 3. The Plan will revise its CM Aging Report to capture completion of ICPs for daily management and reporting outcomes. Update 10/8/2021: Aging report has been updated to capture completion of ICPs 4. The Plan will develop a monitoring workflow. Update 10/8/2021: The monitoring workflow has been completed 5. The Plan will routinely monitor completion of the ICPs. Update 10/8/2021: The log has been created and is being monitored weekly 6. The Plan will report outcomes at UMC quarterly. Update 09/09/2022: Monitoring of the ICPs is now being tracked and reported out quarterly at UM Committee.	Low	3/25/2022	Completed	Case Management		State	DHCS	2021
11	Case Management	(2.2.2) The Plan did not ensure development of care plans in collaboration with the PCP.	1. The Plan re-trained staff on policy regarding developing care plans in collaboration with PCP. 2. The Plan will revise its CM Aging Report to capture the date the letter regarding Care Plans was sent to the PCP.10/8/2021: The CM Aging Report has been updated to capture the date the letter regarding Care Plans was sent to the PCP 3. The Plan will monitor, on an ongoing basis, the CM Aging Report to ensure CP letters are being sent to PCPs. Update 10/8/2021: Monitoring has begun, automation of this report is in progress 4. The Plan will report outcomes to UMC quarterly. Update 09/09/2022: Monitoring of the development of care plans with the PCP is now being tracked and reported out quarterly at UM Committee.	Low	3/25/2022	Completed	Case Management		State	DHCS	2021
12	Case Management	(2.2.3) The Plan did not conduct periodic evaluations to ensure the provision of complex case management based on the member's medical needs. The Plan did not implement procedures for monitoring time frame standards or maintaining monthly contact with members.	1. The Plan developed a workflow to maintain regular contact with members and ensure that the continuation of CCM is based on medical needs by using the Complex Criteria Checklist. 2. The Plan conducted staff training. 3. The Plan will revise its CM Aging Report to capture provision of CCM and maintaining monthly contact with member. 10/8/2021: The CM Aging Report has been revised to capture the provision of CCM and maintaining monthly contact with member 4. The Plan will monitor, on an ongoing basis, the CM Aging Report. 10/8/2021: Monitoring has begun, automation of this report is in progress 5. The Plan will report outcomes quarterly to UMC. Update 09/09/2022: Monitoring of the CM Aging Report is now being tracked and reported out quarterly at UM Committee.	Low	3/25/2022	Completed	Case Management		State	DHCS	2021

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13	Case Management	(2.2.4) The Plan did not ensure that interdisciplinary team assessments were included in the updating of members' care plans. The Plan did not ensure timely documentation of the interdisciplinary team meeting notes.	1. The Plan created an additional column in the Complex Case Log to monitor timely entry of IDT Round note into system of record. 2. The Plan will develop a workflow for staff to include the IDT note in the updated care plans. Update 10/8/2021: The workflow has been updated to include the IDT note in the updated care plans. 3. The Plan will develop a monitoring workflow. Monitoring will be done on a bi-weekly basis. Update 9/9/2022: Monitoring is now being completed on a bi-weekly basis 4. The Plan conducted a staff training on the process. 5. The Plan will use Complex Case Log to monitor adherence to procedure. Update 11/12/2021: The Plan is now using the Complex Case Log to monitor adherence 6. The Plan will report outcomes quarterly to UMC. Update 09/09/2022: Monitoring of the IDT assessments is now being tracked and reported out quarterly at UM Committee.	Low	3/25/2022	Completed	UM		State	DHCS	2021
14	Case Management	(2.5.1) The Plan's MOU with the County MHP did not meet all the requirements specified in APL 18-015.	1. The Plan will conduct annual meetings with the County to ensure that the MOU is being updated (when appropriate). Update 1/14/2022: Due to staffing availability, the meeting with the County to review the MOU was not able to take place in December, and will be scheduled for early 2022. Update 2/11/2022: The first meeting with the county took place on 1/31/2022. 1.a. The Plan will develop meeting minutes to demonstrate topic of discussions. The Plan will submit meeting minutes to DHCS. Update 2/11/2022: Meeting minutes completed for first meeting on 1/31/2022. 2. The Plan's internal departments will work together to ensure clinical and quality components that are not present be updated in the MOU to reflect the requirements in APL-018. Update 2/11/2022: MOU has been updated to ensure clinical and quality components reflected.	Low	1/31/2022	Completed	Case Management Provider Network		State	DHCS	2021
15	Case Management	(2.5.2) The Plan's MOU with the County MHP did not specify policies, procedures, and reports to address quality improvements requirements specified in APL 18-015. The Plan did not conduct semi-annual calendar year reviews of referral and care coordination processes, generate semi-annual reports, or develop performance measures and quality improvement initiatives during the audit period.	1. The Plan will establish a cross-functional workgroup to develop specific P&Ps and QI performance metrics, in addition to referral and care coordination reports. Update 12/10/2021: The cross-functional workgroup was established and held it's first meeting on 10/20/2021. County JOMs will begin January 2022.	High	12/10/2021	Completed	Case Management Provider Network		State	DHCS	2021
16	Access	(3.1.1) The Plan did not enforce and monitor providers' compliance with the requirement to document when timeframes for appointments were extended.	1. The Plan revised P&P QI-107 to include appointment extension language and will be submitted to committee for approval. Update 11/12/2021: The P&P has been revised and is awaiting approval at committee on 11/23/2021. Update 12/10/2021: The policy was approved at Compliance Committee on 11/23/2021. 2. The Plan revised Timely Access Standards Provider Communication Sheet and will be submitted to committee for approval. Update 11/12/2021: The Timely Access Standards Provider Communication Sheet has been revised and is awaiting approval at committee on 11/18/2021. Update 12/10/2021: The Timely Access Standards Provider Communication Sheet was approved at HCQC on 11/18/2021.	Low	11/23/2021	Completed	QI		State	DHCS	2021
17	Access	(3.1.2) The Plan did not continuously review, evaluate and improve access to and availability of the first prenatal appointment.	1.The Plan revised P&P QI-107 to indicate current Access Standards for First Prenatal Appointment from 2 weeks from date of request to 10 days for PCP OB/GYN and 15 days from request for OB/GYN Specialty Care. P&P will be submitted to committee for approval. Update 11/12/2021: Awaiting clarification and further guidance from DHCS Contract Manager. Update 12/10/2021: QI-107 was approved at the Compliance Committee on 11/23/2021. 2.The Plan revised Timely Access Standards Provider Communications Sheet. Update 11/12/2021: Awaiting clarification and further guidance from DHCS Contract Manager. Update 12/10/2021: The Timely Access Standards Provider Communication Sheet was approved at HCQC on 11/18/2021. 3.The Plan will be implementing a tracking and trending report of First Prenatal PQIs. Update 11/12/2021: Awaiting clarification and further guidance from DHCS Contract Manager. Update 12/10/2021: The Tracking and Trending report of First Prenatal PQIs has been implemented	Medium	11/23/2021	Completed	QI		State	DHCS	2021

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18	Access	(3.4.1) The Plan did not ensure standing referral determinations and processing were made within the required timeframes.	1. The Plan will develop a standing referral workflow. 11/12/2021: Standing referral workflow has been developed 2. The Plan will update The Alliance system of record for UM and CM, TruCare (TC) to add user define field in order to identify standing referral status to ensure correct TAT, which would include a reportable field for monthly reporting. Update 12/10/2021: TruCare has been updated to add the user defined field. 3. The Plan will revise TruCare (TC) to capture timeframes for processing Standing Referrals. Update 12/10/2021: The reporting TAT has been scheduled to begin in December, with the first report, containing December data, due in January. 4. The Plan will revise Authorization Aging report for day to day management and to report on timeframes for Standing Referrals. Update 01/14/2022: Revision of aging report complete 5. The Plan will conduct staff training on standard work for Standing Referrals. Update 01/14/2022: Staff training on standing referrals completed 11/16/2021 6. The Plan will monitor Standing Referral timeframes with the daily Authorization Aging report. 7. The Plan will report results quarterly to UMC. Update 09/09/2022: Standing referrals are now being tracked and reported on during UM Committee quarterly	High	3/25/2022	Completed	UM Case Management	Completed	State	DHCS	2021
19	Access	(3.6.1) The Plan improperly denied emergency services claims and family planning claims.	1.The Plan updated its monitoring report criteria to include a denial code (code:0630) which would allow us to identify claims prior to finalizing adjudication.	Low	3/26/2021	Completed	Claims IT (Config)		State	DHCS	2021
20	Access	(3.6.2) The Plan did not pay interest for family planning claims not completely reimbursed within 45 working days of receipt.	1. The Plan reviewed the issue thru Claims Processor & Specialist training to ensure staff understands the issue that resulted in no interest. The trainings were completed in May 2021.	Low	5/1/2021	Completed	Claims		State	DHCS	2021
21	Access	(3.8.1) The Plan did not ensure its transportation broker's NEMT providers were enrolled in the Medi-Cal program.	1. The Plan notified its transportation broker that remaining unenrolled NEMT providers need to complete PAVE application by 12/01/2021. Update 12/10/2021: The notification letter was sent to the transportation broker on 12/1/2021, 2. The Plan will audit transportation broker providers to ensure drivers are enrolled in the Medi-Cal program. This was last completed August 27, 2021. Monitoring will be conducted on an annual basis.	Low	12/31/2022	Completed	Vendor Management		State	DHCS	2021
22	Access	(3.8.2) The Plan did not require PCS forms for NEMT services.	1. The Plan will require transportation broker to provide ongoing reports on rates of obtaining PCS forms from providers: Update 11/12/2021: UM Team working with Vendor Management and the transportation broker to obtain needed reports. Update 12/10/2021: The report was received from transportation broker on 10/28/2021. 2. The Plan will analyze trends in provider practices on a quarterly basis. Update 12/10/2021: The first report will be given at UMC in January 2022. Update 2/11/2022: Awaiting reports from the transportation broker 3. The Plan will educate providers on PCS requirements and provide data on their performance: Update 2/11/2022: Awaiting reports from the transportation broker 3.a. Provider newsletter. Update 2/11/2022: Awaiting reports from the transportation broker 3.b. Individual office contacts 4. The Plan will finalize process workflow to obtain missing PCS forms. Update 11/12/2021: UM Team working with Vendor Management and the transportation broker to obtain needed reports. Update 12/10/2021: The workflow has been finalized based on the reports received from the transportation broker 5. The Plan will conduct staff trainings on process workflow. Update 12/10/2021: Training was completed 11/8/2021. 6. The Plan will provide a quarterly report to UMC. Update 01/14/2021: Reporting will begin at UMC in Q1 2022. Update 2/11/2022: Awaiting reports from the transportation broker Update 09/09/2022: NEMT services are now being tracked and reported quarterly at the UM Committee.	Medium	12/31/2022	Completed	Vendor Management UM		State	DHCS	2021
23	Member Rights	(4.1.1) The Plan did not ensure that the medical director fully resolved QOC grievances prior to sending resolution letters.	1. The Plan updated G&A-003 Grievance and Appeals Receipt, Review and Resolution to include the process for the medical director's review and resolution of all levels of quality of care grievances prior to sending a resolution letter to members. The policy will be reviewed at the Health Care Quality Committee on November 18, 2021 and the Compliance Committee Meeting on November 23, 2021. Update 12/10/2021: G&A-003 was approved at the Compliance Committee meeting on 11/23/2021 2. The Plan will provide training to the medical directors to review G&A-003 Grievance and Appeals Receipt, Review and Resolution by November 30, 2021. Update 3/11/2022: Training was completed 1/12/2022	Medium	1/12/2022	Completed	G&A		State	DHCS	2021
24	Member Rights	(4.1.2) The Plan did not consistently implement its procedure for processing grievances. The Plan considered member's grievances resolved and classified as exempt without conducting investigation.	1. The Plan is updating its policy and procedures for processing Exempt Grievances to reflect its current process. The policy MBR-0024 will be reviewed at the Compliance Committee Meeting on November 23, 2021. Update 12/10/2021: MBR-024 was approved at Compliance Committee on 11/23/2021 2. The Plan will provide staff training by November 30, 2021. Update 1/14/2022: Training was completed 11/19/2021	Low	11/30/2021	Completed	Member Services		State	DHCS	2021

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25	Member Rights	(4.1.3) The Plan did not send acknowledgement and resolution letters within the required timeframes. The Plan did not promptly notify the members that expedited grievances would not be resolved within the required timeframe.	1. The Plan provided training to the Grievance and Appeals staff to review G&A-003 Grievance and Appeals Receipt, Review and Resolution and G&A-005 Expedited Review of Urgent Grievances. The staff attested that they understood the requirements and will ensure that acknowledgement and resolution letters are sent within the required timeframes, and to also notify members when expedited grievances would not be resolved within the required timeframe.	Low	9/21/2021	Completed	G&A		State	DHCS	2021
26	Member Rights	(4.1.4) The Plan did not send acknowledgement and resolution letters in threshold languages.	1. The Plan provided training to the Grievance and Appeals staff to review G&A-001 Grievance and Appeals System Description and CLS-003 Language Assistance Services. The staff attested that they understood the requirements and will ensure that acknowledgement and resolution letters are sent to members in their threshold languages.	Low	9/21/2021	Completed	G&A		State	DHCS	2021
27	Member Rights	**R** (4.1.5) The Plan did not consistently resolve grievances prior to sending resolution letters.	1. The Plan provided training to the Grievance and Appeals staff to review G&A-001 Grievance and Appeals System Description. The staff attested that they understood the requirements and will ensure that grievances are fully resolved prior to sending resolution letters.	Low	9/21/2021	Completed	G&A		State	DHCS	2021
28	Member Rights	(4.3.1) The Plan did not report suspected security incidents or unauthorized disclosures of PHI to DHCS within 24 hours of discovery, did not provide an updated investigation report within 72 hours, and did not submit a complete report of the investigation within 10 working days.	1. To address staffing needs, the Plan has streamlined its Compliance Department and now has a dedicated staff member who focuses on Privacy. This FTE was hired on February 22, 2021. 2. The Plan reviewed and updated CMP-013 HIPAA Privacy Reporting to reflect the 24hr, 72hr and 10-day reporting requirements. This policy is scheduled to be reviewed and approved at the Compliance Committee on November 23, 2021. Update 12/10/2021: CMP-013 was approved at Compliance Committee on 11/23/2021	Low	11/30/2021	Completed	Compliance		State	DHCS	2021
29	Compliance	**R** (6.2.1) The Plan did not conduct and report preliminary investigations of all suspected cases of fraud and abuse to DHCS within ten working days.	1. The Plan has a dedicated staff member in the Special Investigations Unit (SIU) to focus on Fraud, Waste and Abuse FWA cases. This FTE was hired on 6/25/2021. 2. The plan updated CMP-002 to reflect reporting requirements. This policy is scheduled to be re-approved at the Compliance Committee on Nov 23, 2021. Update 12/10/2021: CMP-002 was approved at the 11/23/2021 Compliance Committee	Low	12/1/2021	Completed	Compliance		State	DHCS	2021
30	Compliance	(6.2.2) The Plan did not report recoveries of overpayments to DHCS annually.	After internal review, the Plan found that an update to CMP-002 was not necessary as the reporting of overpayments is addressed in CLM-008: Overpayment Recovery. The Plan has validated that reports were submitted appropriately to the Department.	Low	2/11/2022	Completed	Compliance		State	DHCS	2021
31	Claims	(SSS.1) The Plan did not distribute payments for state supported services claims within 90 calendar days as described in APL 19-013.	1. The Plan made changes to the claims system on 2/17/2021 and re-adjudicated all the previous claims paid incorrectly to pay the balance to the Prop 56 rate.	Low	2/17/2021	Completed	Claims		State	DHCS	2021
32	Claims	(SSS.2) The Plan did not pay interest for state supported services claims processed beyond the 90-calendar day timeframe specified in APL 19-013.	1. The Plan made changes to the claims system on 2/17/2021 and re-adjudicated all the previous claims paid incorrectly to pay the balance to the Prop 56 rate. The claim system was also updated to pay interest at the normal timeline of claims adjudicated after 45 work days from the received date.	Low	2/17/2021	Completed	Claims		State	DHCS	2021
33	Claims	(SSS.3) The Plan improperly denied state supported services claims.	1. As of 8/7/2020 the Plan reconfigured the system to no longer re-suspend the delegate's Non-Emergency Out of Area processed claims. In addition, the Claims workflow has been updated to accommodate the system change.	Low	8/7/2020	Completed	Claims		State	DHCS	2021
34	Compliance	The Plan should have a policy and workflow for tracking discrimination grievances	1. The Plan has created the Special Cases Incident Log for tracking discrimination grievances 2. The Plan will update the policy and create a workflow regarding tracking of discrimination grievances. Update 12/1/2021: The policy has been created and was approved at the Compliance Committee on 11/23/2021	Medium	12/1/2021	Completed	Compliance		Self Identified	AAH	2021
35	Quality Management	The Plan should ensure that PQIs are appropriately classified (as QOS / QOA / QOC)	1. Sr. Dir. Of Quality and the QI Supervisor conduct quarterly audits of QOA and QOS case files 2. QOC files are reviewed and leveled by Quality Medical Director weekly	Low	2/28/2021	Completed	QM		Self Identified	AAH	2021

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

2020 DHCS STATE AUDIT FINDINGS - *Audit Review Period: 10/01/2018 - 9/30/2020*					INTERNAL AUDITS						
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
1	Claims	The Plan denied payment to a contracted hospital for continued treatment of Plan members with chronic medical conditions. The Plan did not provide for all medically necessary covered services for members	1. The Plan and the hospital renegotiated its hospital agreement with an effective date of February 1, 2021. The Alliance and the hospital agreed to a step down approach where The Alliance will authorize care at the appropriate level and work in conjunction with the hospital toward an appropriate discharge. The rate paid by Plan will be equal to the medical surgical rate. Please see Section 3.6 Utilization Management of The Alliance and hospital Contract Amendment. 2. The Plan and the hospital have a meeting set up for 4/6/2021 at 3:30 PM. The goal of this meeting is to finalize the cases in arbitration and any other outstanding claims. Update 5/14/21 The legal team is continuing to review which claims to pay. Update 6/11/21 The Alliance is working with the provider on evaluating and assessing the claims from the audit. Senior level discussions are in process between the hospital and the Alliance. Update 10/8/2021 The Plan paid the hospital for all claims in Arbitration on the 7/22/2021 check run. The hospital had some additional claims they wanted reviewed and we met on 7/27/2021 to review them. The Plan agreed to pay these claims, as well, and they were paid out on the 8/25/2021 and 9/1/2021 check runs. Update 5/13/2022: DHCS advised The Alliance they consider the findings of this audit closed as of 4/19/2022	9/1/2021	Completed	UM / Claims		State	DHCS	2020	Completed
2	UM	The Plan did not apply written criteria for each concurrent review of continued long term acute care (LTAC) services throughout members' hospital stays	1. The Plan reviewed and revised the following P&P: a. UM-003 Concurrent Review and Discharge Planning Process to reflect frequency of reviews throughout the members' hospital stay, including after a NOA is sent, and the use of standard Utilization Review procedures. Policy and Procedure will be approved at the HCQC on 5/20/2021. b. The Plan's standard review procedures include applying written criteria for each review. The Plan's standard utilization review procedures are reflected in Plan's P&P UM-057 and in UM-054 Notice of Action. 2. The Plan will train its Utilization Management staff involved in the Concurrent Review process of the change. The training will be documented with training materials and attendance records. Update 5/14/21: Training was completed on 3/31/21 3. The Plan will audit the Concurrent review process after Q2 2021 to ensure that process are followed and implemented accordingly. Update 5/14/21: Manual audit in place, automated report in development. Update 7/9/2021: Manual tracking continues, nearing completion of automated report. Update 10/8/2021: Manual tracking continues, awaiting completion of automated report 4. The Plan will report the results of the Concurrent review process to the UM Committee on a quarterly basis, starting Q4 2021. Update 10/8/2021: First report to UMC on 8/24/2021. 100% compliance. Update 12/10/2021: The most recent audit concluded in November with a passing score for each factor reviewed. The results were reported at the UM Committee on 12/3/2021. Update 04/08/2022: The most recent audit encompassed NOA letters from January and February 2022 with a passing score for each factor reviewed. The results were reported at the UM Committee on 03/25/2022. Update 5/13/2022: DHCS advised The Alliance they consider the findings of this audit closed as of 4/19/2022	3/25/2022	Completed	UM		State	DHCS	2020	In Progress
3	UM	The Plan did not document that qualified physicians reviewed all denials of continued long term acute care (LTAC) services throughout members' hospital stays	1. The Plan reviewed and revised the following P&P: a. UM-003 Concurrent Review and Discharge Planning Process to reflect frequency of reviews throughout the members' hospital stay, including after a NOA is sent, and the use of standard Utilization Review procedures. Policy and Procedure will be approved at the HCQC on 5/20/2021. b. The Plan's standard review procedures include applying written criteria for each review. The Plan's standard utilization review procedures are reflected in Plan's P&P UM-057 and in UM-054 Notice of Action. 2. The Plan will train its Utilization Management staff involved in the Concurrent Review process of the change. The training will be documented with training materials and attendance records. Update 5/14/21: Training was completed on 3/31/21 3. The Plan will audit the Concurrent review process after Q2 2021 to ensure that process are followed and implemented accordingly. Update 5/14/21: Manual audit in place, automated report in development. Update 7/9/2021: Manual tracking continues, nearing completion of automated report. Update 10/8/2021: Manual tracking continues, awaiting completion of automated report 4. The Plan will report the results of the Concurrent review process to the UM Committee on a quarterly basis, starting Q4 2021. Update 10/8/2021: First report to UMC on 8/24/2021. 100% compliance. Update 11/12/2021: The results of the next quarterly audit will be presented at the November UM Committee. Update 12/10/2021: The results of the next quarterly audit will be reported at the December UM Committee. Update 04/08/2022: The most recent audit encompassed NOA letters from January and February 2022 with a passing score for each factor reviewed. The results were reported at the UM Committee on 03/25/2022. Update 5/13/2022: DHCS advised The Alliance they consider the findings of this audit closed as of 4/19/2022	3/25/2022	Completed	UM		State	DHCS	2020	In Progress

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

2020 DHCS STATE AUDIT FINDINGS - *Audit Review Period: 10/01/2018 - 9/30/2020*					INTERNAL AUDITS						
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
4	UM	The Plan did not notify members and the hospital of continued denial of long term acute care (LTAC) services through NOA letters and "Your Rights" attachments for each concurrent review throughout the members' hospital stays	1. The Plan reviewed and revised the following P&P: a. UM-003 Concurrent Review and Discharge Planning Process to reflect frequency of reviews throughout the members' hospital stay, including after a NOA is sent, and the use of standard Utilization Review procedures. Policy and Procedure will be approved at the HCQC on 5/20/2021. b. The Plan's standard review procedures include applying written criteria for each review. The Plan's standard utilization review procedures are reflected in Plan's P&P UM-057 and in UM-054 Notice of Action. 2. The Plan will train its Utilization Management staff involved in the Concurrent Review process of the change. The training will be documented with training materials and attendance records. Update 5/14/21: Training was completed on 3/31/21 3. The Plan will audit the Concurrent review process after Q2 2021 to ensure that process are followed and implemented accordingly. Update 5/14/21: Manual audit in place, automated report in development. Update 7/9/2021: Manual tracking continues, nearing completion of automated report. Update 10/8/2021 Manual tracking continues, awaiting completion of automated report 4. The Plan will report the results of the Concurrent review process to the UM Committee on a quarterly basis, starting Q4 2021. Update 10/8/2021: First report to UMC on 8/24/2021. 100% compliance. Update 11/12/2021: The results of the next quarterly audit will be presented at the November UM Committee. Update 12/10/2021: The most recent audit concluded in November with a passing score for each factor reviewed. The results were reported at the UM Committee on 12/3/2021. Update 04/08/2022: The most recent audit encompassed NOA letters from January and February 2022 with a passing score for each factor reviewed. The results were reported at the UM Committee on 03/25/2022. Update 5/13/2022: DHCS advised The Alliance they consider the findings of this audit closed as of 4/19/2022	3/25/2022	Completed	UM		State	DHCS	2020	In Progress
5	UM	The Plan provided unclear information about the Plan's decision for denial of long term acute care (LTAC) services in the only NOA letters that were issued to members and the Hospital. Letters contained inaccurate information about denied dates and requesting providers.	1. The automated section of the NOA letter generated by the Plan's system of record, TruCare, was incorrectly configured and displayed inaccurate information about the requesting LTAC provider and the dates of denial. The Plan's system of record, TruCare, was re-configured to display the correct dates and correct requesting provider in the automated portion of the NOA letters. 2. The Plan's In-Patient Utilization Management Leadership will continue to audit the NOA letters to ensure that they contain accurate information and meet the regulatory requirements. Update 5/15/2021: Identified deficiencies have been added to the audit tool and audits of inpatient NOA letters are currently taking place. 3. The Plan will report the results of NOA letter audit at Utilization Management Committee on a quarterly basis, starting Q3 2021. Update 7/9/2021: Manual tracking continues, report will be provided starting in Q3 2021 Update 10/8/2021: Manual tracking continues, awaiting completion of automated report. First report to UMC on 8/24/2021. 100% compliance. Update 11/12/2021: The results of the next quarterly audit will be presented at the November UM Committee. Update 12/10/2021: The most recent audit concluded in November with a passing score for each factor reviewed. The results were reported at the UM Committee on 12/3/2021. Update 04/08/2022: The most recent audit encompassed NOA letters from January and February 2022 with a passing score for each factor reviewed. The results were reported at the UM Committee on 03/25/2022. Update 5/13/2022: DHCS advised The Alliance they consider the findings of this audit closed as of 4/19/2022	3/25/2022	Completed	UM		State	DHCS	2020	In Progress

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

2020 DHCS STATE AUDIT FINDINGS - *Audit Review Period: 10/01/2018 - 9/30/2020*					INTERNAL AUDITS						
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
6	Delegation	The Plan did not ensure the Delegate met standards set forth by the Plan and DHCS. The Delegate did not ensure that concurrent review denials were reviewed and made by a qualified physician. It did not send NOA letters with "Your Rights" information for denial of services that occurred after initial denial. It did not include the decisions maker's name in the initial and only NOA sent to providers.	1. The Plan's revised policy UM-003 Concurrent Review and Discharge Planning Process and the revised process expectations were shared with Delegate on 3/26/2021. 2. The Plan will require the Delegate to do the following: a. Adopt the Plan's policies, to reflect that the concurrent review denials are reviewed and made by a qualified physician, that the clinical case is reviewed using the regulatory requirements on a regular cadence after the initial denial, that NOA letters with "Your Rights" information are sent after every subsequent review, and that the decision-maker's name is on each NOA. Update 6/11/2021 The Alliance's Health Care Services is working with the delegate to update the policies. b. Provide evidence of policy and procedure approval. Update 7/9/2021: Delegate has provided evidence that the revised policy was approved on 6/23/2021 c. Train its staff on the new Concurrent review process. Update 7/9/2021: Delegate states they are developing the training for their staff and are on track to provide the documents to The Alliance. Update 9/10/2021: Staff training completed, training documents provided. d. Provide evidence of the training, including the training materials and the attendance records. Update 9/10/2021: Delegate provided attestations to show training completed 6/23/2021 3. The Plan will audit the Delegate on a quarterly basis to ensure that the process is implemented, starting at the end of Q3 2021, and report the results of the audit at the Plan's UM Committee on a quarterly basis. Update 10/8/2021: Q3 2021 audit completed 9/29/2021, and initial audit results provided to the Delegate; final audit report will be issued to the Delegate by 10/13/2021. Update 11/12/2021: The next quarterly audit is scheduled for 12/17/2021. Update 04/08/2022: The next quarterly audit is scheduled to be completed in May 2022 4. At annual Delegate oversight audits, concurrent reviews and letters will be examined to ensure compliance. Update 11/12/2021: The next annual Delegation Oversight Audit is scheduled for February 2022. Concurrent reviews and letters will be reviewed at that time. Update 04/08/2022: The next quarterly audit is scheduled to be completed in May 2022. Update 5/13/2022: DHCS advised The Alliance they consider the findings of this audit closed as of 4/19/2022. Update 5/13/2022: The delegate does not have any cases that meet the criteria for audit for Q1 2022. DHCS advised The Alliance they consider the findings of this audit closed as of 4/19/2022. Update 07/08/2022: The Alliance is currently in the process of quarterly delegate audit. Update 09/09/2022: The quarterly delegate audit is in progress and is expected to be completed by October 2022. Update 10/14/2022: The quarterly delegate audit has been completed, there were no findings. This audit will be closed and the findings noted by DHCS will continue to be reviewed during the annual audit.	9/23/2022	Completed	UM		State	DHCS	2020	In Progress

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2020 DHCS STATE AUDIT FINDINGS - *Audit Review Period: 10/01/2018 - 9/30/2020*					INTERNAL AUDITS						
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
7	Delegation	The Plan did not ensure the Delegate met standards set forth by the Plan and DHCS. The Delegate denied medically necessary services.	1. The Plan's revised policy UM-003 Concurrent Review and Discharge Planning Process and the revised process expectations were shared with Delegate on 3/26/2021. 2. The Plan will require the Delegate to do the following: a. Adopt the Plan's policies, to reflect that the concurrent review denials are reviewed and made by a qualified physician, that the clinical case is reviewed using the regulatory requirements on a regular cadence after the initial denial, that NOA letters with "Your Rights" information are sent after every subsequent review, and that the decision-maker's name is on each NOA. Update 6/11/2021 The Alliance's Health Care Services is working with the delegate to update the policies. b. Provide evidence of policy and procedure approval. Update 7/9/2021: Delegate has provided evidence that the revised policy was approved on 6/23/2021 c. Train its staff on the new Concurrent review process. Update 7/9/2021: Delegate states they are developing the training for their staff and are on track to provide the documents to The Alliance. Update 9/10/2021: Staff training completed, training documents provided. d. Provide evidence of the training, including the training materials and the attendance records. Update 9/10/2021: Delegate provided attestations to show training completed 6/23/2021 3. The Plan will audit the Delegate on a quarterly basis to ensure that the process is implemented, starting at the end of Q3 2021, and report the results of the audit at the Plan's UM Committee on a quarterly basis. Update 10/8/2021: Q3 2021 audit completed 9/29/2021, and initial audit results provided to the Delegate; final audit report will be issued to the Delegate by 10/13/2021. Update 11/12/2021: The next quarterly audit is scheduled for 12/17/2021. Update 04/08/2022: The next quarterly audit is scheduled to be completed in May 2022 4. At annual Delegate oversight audits, concurrent reviews and letters will be examined to ensure compliance. Update 11/12/2021: The next annual Delegation Oversight Audit is scheduled for February 2022. Concurrent reviews and letters will be reviewed at that time. Update 04/08/2022: The next quarterly audit is scheduled to be completed in May 2022. Update 5/13/2022: The delegate does not have any cases that meet the criteria for audit for Q1 2022. DHCS advised The Alliance they consider the findings of this audit closed as of 4/19/2022. Update 07/08/2022: The Alliance is currently in the process of quarterly delegate audit. Update 09/09/2022: The quarterly delegate audit is in progress and is expected to be completed by October 2022. Update 10/14/2022: The quarterly delegate audit has been completed, there were no findings. This audit will be closed and the findings noted by DHCS will continue to be reviewed during the annual audit.	9/23/2022	Completed	UM		State	DHCS	2020	In Progress

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ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

2020 DMHC STATE AUDIT FINDINGS - *Audit Review Period: 1/01/2019 - 9/30/2019*					INTERNAL AUDITS						
#	**Category**	**Deficiency**	**Corrective Action Plan (CAP)**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**	**Status**
1	Grievances & Appeals	The Plan failed to accurately and consistently identify grievances received by telephone. Coverage Dispute issues were processed as an exempt grievance and not a standard grievance as required.	The G&A current procedures appropriately process coverage disputes as a standard grievance. Member Services will provide a refresher staff training of the procedures by 3/31/2020 to ensure coverage disputes are processed appropriately. Update as of 4/10/2020 Refresher training for benefits coverage disputes was completed on 3/12/2020.	3/12/2020	Completed	Member Services/ G&A	✓	State	DMHC	2020	Completed
2	Grievances & Appeals	The Plan does not consistently provide immediate notification to complainants of their right to contact the Department regarding expedited appeals.	G&A staff training was conducted to review regulations on 1/30/2020. G&A application was updated to include a new log type for expedited DMHC rights notification that was implemented on 2/6/2020.	2/6/2020	Completed	G&A	✓	State	DMHC	2020	Completed
3	UM	The Plan does not include the statement required by Section 1363.5(c) when disclosing medical necessity criteria for UM decisions.	Cover sheet being created in the TruCare system for all requests by providers for clinical criteria used to adjudicate requests. Creation of tracking log, workflow and training to be completed by 3/31/2020. Update as of 4/10/2020: Tracking log workflow and training completed as of 3/12/2020.	3/12/2020	Completed	UM	✓	State	DMHC	2020	Completed
4	Access to Emergency Services	The Plan does not provide all non-contracting hospitals in the state with Plan contact information needed to request authorization of post-stabilization care. DMHC expects the onus to be on the Plan to reach out to the hospitals and notices should be mailed at least annually.	The Plan is working with the Hospital Association to assist in sending out the notices to non-contracted hospitals. Update as of 6/12/2020: Notices were mailed to non-contracted hospital providers on May 26.	5/31/2020	Completed	Provider Relations	✓	State	DMHC	2020	Completed
5	Access & Availability	The Plan failed to adequately review and address access issues as part of its quality assurance (QA) program.	The QI Team and Member Services team perform an annual training to ensure that the appropriate process is followed. The Alliance is working on additional training to ensure the appropriate referral of PQIs. All access-related exempt grievances are compiled in a track and trend report and referred to Quality Improvement via the Access and Availability Sub-Committee	4/30/2020	Completed	Quality Management	✓	State	DMHC	2020	Completed
#	**Category**	**Deficiency**	**Corrective Action Plan (CAP)**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**Compliance Internal Audit**	**State/Self Identified**	**Agency**	**Year**	**Status**
1	Quality Assurance	The Plan failed to ensure that all potential quality of care issues were identified and processed in accordance with its Quality Assurance (QA) Program. Cases were found to misclassified and include documentation issues.	1. RN Staff In-Service on PQI definition, classification, review, processing and documentation conducted by Quality Sr. Director on 2/7/2020. 2. Deleted "Not a PQI" from classification drop down selections. 3. All new PQI submissions are reviewed and classified (as QOS/QOA/QOC) by Quality Director. 4. RN PQI Classification IRR conducted by Quality Director on 2/25/2020. 5.Department wide IRR Conducted by Medical Director on 2/27/2020 6.Quality Director to process all QOAs and QOSs 7. Medical Director is auditing random sample of QOA and QOS cases processed by nurse management staff as of 4/6/2020. 8. Quality Director to conduct weekly auditing of RN documentation of all QOCs as of 3/5/2020. 9. Medical Director continues to level and audit all QOC cases 10. Ongoing weekly team meeting continues to ensure case discussion and review Update as of 4/30/2020: QI team has completed all steps listed above.	4/30/2020	Completed	Quality Improvement	✓	Self Identified	AAH	2020	Completed
2	UM	The Plan does not consistently provide enrollees with a clear and concise reason for denials based in whole or in part on medical necessity.	Quality checklist for review of NOA letters for all requirements prior to being sent out to be developed, then train staff, by 3/31. Quality checks of all NOAs by management before sending out continues. Weekly review by external consultants continue with MDs to improve decision notices. Update as of 4/10/2020: NOA checklist training and implementation done as of 4/2/2020. Weekly review by external consultants continues.	4/2/2020	Completed	UM	✓	Self Identified	AAH	2020	Completed
3	UM	In letters to providers denying or modifying requested services on the basis of medical necessity, the Plan does not include a direct telephone number or extension of the professional responsible for the decision. The peer to peer process to improve its oversight and tracking process.	Phone numbers in all UM template letters being checked for accuracy and corrected in TruCare as needed. Standardized tracking workflow of Peer to Peer communication is being developed, trained and implemented by 3/31/2020. Update as of 4/10/2020: Training and tracking implemented as of 3/12/2020.	3/12/2020	Completed	UM	✓	Self Identified	AAH	2020	Completed

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COMPLIANCE DASHBOARD

2019 DMHC AUDIT FINDINGS - *Audit Review Period: 10/1/2017-9/30/2019*					INTERNAL AUDITS						
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
1	Payment Accuracy	Three out of 50 late paid claims (a compliance rate of 94 percent). This deficiency was caused by the Plan using the incorrect date to calculate interest on improperly denied and reprocessed claims. Three out of 30 high dollar claims. The deficiency was caused by the Plan not paying interest on a claim improperly denied for missing authorization when the independent practice association (IPA) authorized services but did not forward the authorization to the Plan, and underpaying claims due to processor error.	Late Claims – processing errors identified in this finding are attributable to human error by one specific individual. The incorrect handling was addressed verbally with the employee at the time of the audit. Refresher training on CLM-001 Claims Processing, CLM-003 Emergency Services Claims Processing and Claims Change Alert Clean Claim Interest Workflow was completed on March 13, 2020 to ensure that all staff who handles adjustments are using the appropriate received date for adjusted claims. Update 5/1/2020: At the Department's request, the Plan created a report to identify claims where the incorrect received date was used on an adjusted claim. The report was provided to the Department on 4/21/2020. The identified claims have been adjusted and the report has been updated to add the check date, check # and the amount of interest and penalties paid. Current policies and procedures do not require changes and meet compliance requirements. High Dollar Claims – processing errors identified in this finding are attributable to human error. Refresher training on CLM-001 Claims Processing and Claims Change Alert - Clean Claim Interest Workflow was completed on 3/13/2020 to ensure that all staff who handles adjustments are using the appropriate received date for adjusted claims.	4/29/2020	Completed	Claims	✓	State	DMHC	2019	Completed
2	Incorrect Claim Denials	Claims were improperly denied and should have been paid in three out of 50 denied claims (a compliance rate of 94 percent). The deficiency was caused by the Plan not re-processing retro enrollment, incorrectly denying a claim as duplicate and a system configuration issue that incorrectly denied claims as not the financial responsibility of the Plan.	Retro Eligibility Denial – The Plan's Claims management is working with its Information Technology/Analytics Department to create a retroactive eligibility report to identify claims that were denied correctly at the time of processing, but may be impacted due to the retroactive reinstatement of eligibility. Once the report is completed, the Plan will make sure to adjudicate any claims found to be improperly denied since 5/29/2018, and provide evidence that the claims were adjudicated appropriately. Update 5/1/2020: Report was put into production on 5/1/2020 and will be run weekly. Claims is working with IT to identify impacted claims from 5/29/2018-9/30/2019 and will adjust impacted claims and provide the final spreadsheet to the Department by 5/15/2020. Division Of Financial Responsibility (DOFR) Denial - this issue was identified as a configuration error for one specific service, and corrected in October 2019 prior to the audit. Update 5/1/2020: At the Department's request, the Plan created a report to identify claims where the service had been denied incorrectly. The report was provided to the Department on 4/21/2020. The identified claims are being adjusted and should be complete by 5/15/2020. The report will then be updated to add the check date, check # and the amount of interest paid. Duplicate Denial - duplicate claims refresher training on HS-004 Duplicate Claims was completed on 3/13/2020 for all staff that handles adjustments. Due to the unique cause of this non-system related error, a remediation report cannot be run.	~~4/15/2020~~ 5/15/2020	Completed	Claims	✓	State	DMHC	2019	Completed
3	Clear & Accurate Denial Explanation	Plan provided an incorrect denial explanation in three out of 50 denied claims (a compliance rate of 94 percent).	The Plan reviewed the deficient cases and found that the three denial errors identified in the audit were related to Division of Financial Responsibility (DOFR) issues. The Plan will review the services where there are DOFR conflicts, come to agreement with the delegates, and make any required configuration changes to the system. Update 5/1/2020: System changes for the delegate were completed and put into production on 4/16/2020. The claims were originally denied correctly as the responsibility of another delegate but contained an additional incorrect message that they were forwarded to delegate. These claims do not need to be re-adjudicated and re-denied again. Due to the Coronavirus Pandemic, meetings with delegate have been put on hold. The Plan has updated the system to correct the configuration with out of area office visits that was identified during the audit. At the Department's request, the Plan created a report to identify claims where these services had been denied incorrectly. The report was provided to the Department on 4/21/2020. The identified claims are being adjusted and should be complete by 5/15/2020. The report will then be updated to add the check date, check # and the amount of interest paid.	~~6/30/2020~~ 5/15/2020	Completed	Claims	✓	State	DMHC	2019	Completed

ALAMEDA ALLIANCE FOR HEALTH
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2019 DMHC AUDIT FINDINGS - *Audit Review Period: 10/1/2017-9/30/2019*					INTERNAL AUDITS						
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
4	Change in Plan Personnel	Plan shall within five days, file an amendment when there are changes in personnel of the plan. Plan did not file the Board of Governors changes for three members.	The Plan has updated its internal procedures to ensure key personnel requirements are met. The Plan implemented a monthly quality check capturing any changes with the Plan's Board of Governor member seats. The Plan's Compliance team staff completed updated training for key personnel filing procedures on March 30, 2020. As of 3/31/2020, the Plan has also completed updates to the filings for three Board members as requested: Member 1: DMHC Filing #20201241 Member 2: DMHC Filing #20200184/#20201243 Member 3: DMHC Filing #20200644	4/1/2020	Completed	Compliance	✓	State	DMHC	2019	Completed
5	Control over Mailroom Claims Processing	Plan does not have sufficient control over its mailroom claims processing as the mailroom staff does not stamp the date of receipt on paper claims. In addition, the Plan's mailroom staff does not count the number of claims sent to vendors for further processing, impeding the Plan's ability to reconcile the number of claims received and processed.	The Plan has an established process for receiving claims in its onsite mailroom for capturing receipt dates. The Plan performs quality checks for reconciliations of claims count scanned and received to ensure all claims are captured for processing. The Plan has daily logs of professional and facility claims received and scanned. The logs have the original claim count, the claim count successfully scanned, the rejected claim count and the merged claim count. The Plan utilizes the daily log counts to perform reconciliation when the files are received and loaded. Included with the CAP response is the weekly reconciliation sample report and sample logs of claims as evidence of this quality internal control process for counting the number of claims.	4/1/2020	Completed	Support Services/ Claims	✓	State	DMHC	2019	Completed

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2019 DHCS AUDIT FINDINGS - *Audit Review Period: 6/1/2018-5/31/2019*						INTERNAL AUDITS						
#	Category	Deficiency	Corrective Action Plan (CAP)	Repeat Finding (Yes/No)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
1	UM Delegation	The Plan did not ensure a delegate complied with all contractual and regulatory requirements. The delegate required PA for an initial visit with a mental health provider to determine if the member had mild-to-moderate mental health issues, which the contract does not allow.	The Alliance scheduled a meeting with the delegate to discuss the findings and will put a corrective action plan in place. Update as of 12/5/2019: The delegate has revised policy, and submitted to The Alliance for review. The Alliance will review and discuss changes with the delegate on the next Operations call. Update as of 1/8/2020: Plan reviewed documents and agree with the changes for member self-referral process. Discussing with DHCS prior to final CAP submission.	No	1/8/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed
2	UM Delegation	The Plan did not ensure a delegate complied with all contractual and regulatory requirements. The delegate required a two-step prior authorization (PA) process for BHT services, which is allowed, but did not send written notification when it denied services at the first step. The delegate did not consistently apply criteria for approving BHT.	The Alliance scheduled a meeting with the delegate to discuss the findings and will put a corrective action plan in place. Update as of 12/5/2019: The delegate has revised policy, and submitted to The Alliance for review. The Alliance will review and discuss changes with the delegate on the next Operations call. Update as of 1/8/2020: Plan reviewed documents and still have open items not documented. Plan will be meeting with the delegate to discuss criteria and procedures for further documentation needed. Update as of 2/7/2020: Met with the delegate to review their criteria and approval process. Requested policy language changes to meet the regulatory requirements. Policy was approved by Committee on 1/27/20. Updated CAP response submitted to DHCS on 2/7/2020.	No	2/7/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed
3	UM Delegation	(1.1.3) The Plan did not review ownership and control disclosure information for their Utilization Management (UM) delegates	The Plan will ensure that its delegated providers complete the Ownership and Control disclosure forms. The Plan will create a tracking log and document any follow up attempts made with the delegate to ensure accuracy. Update as of 12/2/2019: PR has created a tracking log and is working on a desktop procedure.	Yes	1/1/2020	Completed	Provider Services	✓	State	DHCS	2019	Completed
4	UM Delegation	The Plan did not ensure receipt of all contractual and regulatory reports during the audit period.	The Plan will conduct staff retraining of delegation reporting procedures to ensure all are tracked and monitored for receipt and review. Update as of 12/5/2019: Staff training was conducted on 12/3/2019.	Yes	12/1/2019	Completed	Compliance	✓	State	DHCS	2019	Completed
5	UM Delegation	The Plan's oversight of its delegate did not identify unclear NOA letters, and incorrect appeal and SFH information	The Alliance scheduled a meeting with the delegate to discuss the findings and will put a corrective action plan in place. Update as of 12/5/2019: The delegate has developed on a new process regarding NOA letters, appeal rights and SFH Information. The Alliance will review and discuss changes with the delegate on the next Operations call. Update as of 1/8/2020: Plan reviewed documents and agreed with changes of procedure checklist and training materials.	No	1/15/2020	Completed	Utilization Management		State	DHCS	2019	Completed
6	Referral Tracking process	The Plan did not track all approved PAs; the specialty referral tracking process did not include modified PAs and in-network approved services.	The UM Department is working with analytics to expand the routine referral tracking report to include all approved authorizations. Update as of 12/5/19: Clarity is being sought from DHCS on the scope of specialty referral tracking. Update as of 1/8/20: An updated referral tracking report is being developed to include all decision types and specialty services that require authorization. Update as of 2/7/20. Updated report sample generated and submitted to DHCS. Working with Analytics to create routine report that captures all needed data elements. Update as of 3/5/2020 UM met with Analytics to create the routine report capturing all needed elements. Report is in development. Update as of 5/8/20 Specialty Tracking Report has been created by Analytics, including all required elements, and will now be routinely reported quarterly through UMC and HCQC. Reported at HCQC on 5/21/20. Update as of 6/12/20: Report sent to HCQC on 5/21/20 and reviewed at UMC at 5/29/20.	Yes	5/21/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed
7	Prior Authorizations	A review of PA data showed non-qualified Plan staff denied retrospective cases for administrative reasons other than non-eligibility for membership. The Plan denied retrospective service requests without review by a medical director if the provider submitted the request more than 30 days after the service delivery date, or if requests did not meet Plan-imposed conditions. The Plan's contract did not specify submission timeframes or other conditions that, if not met, allowed eliminating medical necessity review of retrospective requests for covered services.	Policy and procedure UM-001 Utilization Management will be updated to comply with the contractual requirements. Workflows will be updated to have all retrospective requests reviewed by a medical director. Workflows have been updated to have all retrospective requests reviewed by a medical director. Update as of 12/5/2019: Clarity is being sought from DHCS on allowing a time limit of 30 days. Update as of 1/8/2020: Plan received clarity from DHCS and is updating internal procedures. Update as of 2/7/2020: P&Ps updated to reflect that only an MD can deny retro PA requests. P&Ps approved at HCQC on 1/16/2020.	Yes	1/16/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed
8	Prior Authorizations	(1.2.2) The Plan did not ensure it used appropriate processes to review and approve medically necessary covered services when it did not ensure that qualified medical personnel rendered medical decisions. Dependent practitioners reviewed, assessed and approved requests for continued hospital stays	The process for ensuring LVNs perform only within their scope of practice was updated and implemented on 10/2/2019. Additional changes to the UM systems to better track the change in process are being developed. Update as of 12/5/2019: Changes to the UM systems to better track the RN oversight role with the LVNs completed. Other Managed Medi-Cal plans have LVNs performing UM. Clarity is being sought from DHCS on the use of LVNs in UM. Policies and procedures and job descriptions are being reviewed to be aligned with the updated oversight process. Update as of 1/8/2020: Plan received clarity from DHCS and updated procedures for RN oversight.	No	1/8/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed
9	Prior Authorizations (UM and Rx)	The Plan's notice of action (NOA) letters did not follow specifications in Health and Safety Code Section 1367.01. Provider letters in medical cases did not include the decision makers' direct phone number or contained the incorrect number. Letters did not explain the reasons for the denial. Pharmacy NOAs were not concise.	Accurate phone numbers for the decision makers are on the NOA, monitoring will be conducted through internal audits. UM NOA template letters were updated and implemented on 11/4/2019, internal auditing will be conducted monthly to ensure that the letters are clear and concise and explain the reasons for denial. Pharmacy NOA template letters were updated and implemented in April 2019, internal auditing will be conducted at least monthly to ensure that the letters are clear and concise and explain the reasons for denial. The pharmacy team also meets with the PBM on a weekly basis to optimize PA review process, NOA letter language and reasons for denial.	Yes	11/4/2019	Completed	Utilization Management /Pharmacy		State	DHCS	2019	Completed

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#	Category	Deficiency	Corrective Action Plan (CAP)	Repeat Finding (Yes/No)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
10	Prior Authorizations	The Plan did not ensure that all contracting practitioners were aware of the procedures for orthotic items; the Plan provided inaccurate information about authorization requirements for orthotic items	The Alliance's Authorization Grid will be updated to include the accurate information about authorization requirements for orthotics. The updated grid will be uploaded on the website. Update as of 12/5/2019: A meeting will be scheduled the week of 12/9 to discuss changes. Update as of 1/8/2020: Meeting was conducted and PA grid will be updated to reflect corrections. Update as of 2/7/2020. PA grid is being updated for all services requiring PA, so that MDs do not receive repeat communication about changes to the PA grid. Orthotics will be included in the comprehensive update. Update as of 3/5/2020 Prior Auth requirement for Orthotics was added to the PA grid on the Provider Portal	No	3/2/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed
11	Appeals	The Plan's appeal notification letters did not comply with contractual regulations. NAR letters were not clear or concise, and contained inaccurate information	The G&A staff will attend additional training to review contractual regulations. Internal audits will be conducted monthly by the manager or director to monitor compliance. Update as of 12/5/2019: Training conducted on 11/14/2019.	No	11/22/2019	Completed	G&A		State	DHCS	2019	Completed
12	Case Management & Care Coordination - HRAs	The Plan did not follow the specified timeframes required for completion of the HRAs for newly enrolled SPD members. The Plan did not ensure that HRAs were completed within 45 calendar days of enrollment for those identified by the risk stratification mechanism as higher risk, and within 105 calendar days of enrollment for those identified as lower risk.	HRA tracking had been implemented in early 2019, and continues at present. HRAs are sent out within the required timeframes. Robo calls are made to low risk members to encourage them to complete and send in the HRA within the timeframe. Direct calls are made by CM staff on high risk members to encourage them to complete and send in the HRA within the timeframe. A tracking log is kept to ensure that the required timelines are met.	No	9/16/2019	Completed	Case Management		State	DHCS	2019	Completed
13	Case Management & Care Coordination - Initial Health Assessment (IHA)	The Plan did not ensure that all providers documented all required components of an IHA. Preventive services identified as USPSTF "A" and "B" recommended services were not provided, or status of these recommended services was not documented	The QI Department revised its provider medical record request letter to include: all categories that support IHA completion; a hyperlink and/or copy of the SHA/IHEBA form; and sample documentation of a compliant SHA/IHEBA. Providers were re-educated on the SHA/IHEBA requirements.	No	9/30/2019	Completed	Quality		State	DHCS	2019	Completed
14	Complex Case Management (CCM)	2.2.1 The Plan did not implement its monitoring of the CCM program to address member needs. The Plan did not close its CCM cases after 90 days, or present them at Case Rounds as stated in its policy	Existing aging reports are being utilized by the Case Management Department in CCM Rounds to ensure that members' cases are either reviewed and closed, or extended past 90 days.	Yes	10/14/2019	Completed	Case Management	✓	State	DHCS	2019	Completed
15	Access & Availability	3.1.1 The Plan did not maintain an accurate provider directory.	The Plan will continue to verify 10 providers per week and has added the following two processes to continuously maintain an accurate provider directory: 1. Provider Data Comparison to manually review provider data received from our delegates started September 2019 and 2. Provider Data Validation Yearly Project to review directly contracted providers who appear in the Provider Directory. In addition, the Provider Relations Department includes a Provider Demographic form in all provider quarterly packets and work with providers to obtain the completed forms during provider visits.	Yes	11/1/2019	Completed	Provider Services	✓	State	DHCS	2019	Completed
16	Emerg Family Planning Claims/SSS	The Plan paid non-contracted family planning services at less than the Medi-Cal Fee-For-Service rate. The Plan's claim system misclassified non-contracted family services as non-billable. The Plan is required to pay all covered family planning services regardless if these services are contracted with the Plan.	This finding is specific to one provider based on the list of services identified in the contract. No other provider was impacted by this issue. The claims system has been re-configured to reimburse services as follows: * services listed in the provider contract will be reimbursed at the contracted rate * covered Medi-Cal services not listed in the contract will be reimbursed at 100% of the prevailing Medi-Cal rate	No	9/5/2019	Completed	Claims	✓	State	DHCS	2019	Completed
17	Emerge Family Planning Claims	The Plan did not inform members of the correct minor consent provision for family planning services in its Evidence of Coverage (EOC).	The Plan has updated its 2020 EOC to include the appropriate minor consent provisions. The EOC was submitted to DHCS for review and approval on 10/7/2019.	No	10/7/2019	Completed	Compliance	✓	State	DHCS	2019	Completed
18	Access to Pharm Services	The Plan did not monitor the provision of drugs prescribed in emergency situations.	The Pharmacy Department is working with the PBM to create routine monitoring reports of drugs prescribed in emergency situations. Update as of 1/8/20: Internal meeting was conducted to ensure requirements are clear and next steps for updating policy and monitoring reports. Update as of 2/11/2020: Draft P&P and monitoring log have been created and are under review. Update as of 4/10/2020: The P&P and monitoring log were approved at the most recent P&T Committee meeting.	Yes	3/17/2020	Completed	Pharmacy	✓	State	DHCS	2019	Completed
19	Grievances	4.1.1 The Plan did not document review and final resolution of clinical grievances by a qualified health care professional	The G&A workflow for Quality of Care review was updated and implemented on 4/15/2019 to include the CMOs review and final resolution.	Yes	4/15/2019	Completed	G&A	✓	State	DHCS	2019	Completed
20	Grievances	4.1.2 The Plan's grievance system did not capture all complaints and expressions of dissatisfaction reported by members.	The G&A staff will attend additional training to review contractual regulations. Internal audits will be conducted monthly by the manager or director to monitor compliance. Update as of 12/5/2019: Training was conducted on 11/14/2019.	No	11/22/2019	Completed	G&A		State	DHCS	2019	Completed
21	Grievances	The Plan's grievance system did not capture all complaints and expressions of dissatisfaction filed through Plan providers.	The Plan provided training to its delegated entities of the Plan's grievance process to ensure the Plan's system receives and resolves all complaints of dissatisfaction. Clinics will be trained by the delegate to ensure that the Alliance is capturing all complaints. Update as of 1/8/2020: Medical group provided training sign in sheet. The delegate is working on next steps of educating providers. Update as of 2/7/2020: the delegate provided an attestation to complete its provider training by the end of Q1 2020. Update as of 4/10/2020: Meeting medical group week of 4/6 to discuss implementation. Update as of 4/20/2020: Process for forwarding complaints received by medical group has been implemented as of 4/20/2020.	Yes	~~3/31/2020~~ 5/1/2020	Completed	G&A/Provider Services/ Compliance	✓	State	DHCS	2019	Completed
22	Grievances	4.1.4 The Plan sent member resolution letters without completely resolving all complaints.	The G&A staff will attend additional training to review contractual regulations. Internal audits will be conducted monthly by the manager or director to monitor compliance. Update as of 12/5/2019: Training was conducted on 11/14/2019.	Yes	11/22/2019	Completed	G&A		State	DHCS	2019	Completed

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23	Quality Program	The QIPD did not list the individuals' qualifications, which was inconsistent with Plan policy.	The 2019 Annual Quality Improvement Program Description (QIPD) was revised to include the leadership positions and their qualifications (Licensure, Education, Work Exp) The program description was presented and approved in the July 18, 2019 Health Care Service oversight committee.	No	7/18/2019	Completed	Quality	✓	State	DHCS	2019	Completed
24	Provider Training	The Plan did not ensure provider training was conducted within 10 working days	During the last review period of June 2017 through May 2018, the Plan acknowledged deficiencies in the NPO process to be corrected by the end of December 2018. Since January 2019, the plan is meeting its goal of conducting training with the 10 day working timeframe 100% of the time.	Yes	1/1/2019	Completed	Provider Services	✓	State	DHCS	2019	Completed
25	Fraud, Waste, and Abuse (FWA)	The Plan did not conduct preliminary investigations of all suspected cases of fraud and abuse.	FWA reporting procedures will be revised to include the preliminary investigation details to DHCS within 10 working days. Staff training of the revised procedure will be completed by 12/01/2019. Update as of 12/5/2019: Staff training will be conducted on 12/11/2019 to review the updated procedure. Update as of 1/8/2020: Staff training was conducted on 12/11/2019	Yes	12/11/2019	Completed	Compliance		State	DHCS	2019	Completed
26	Fraud, Waste, and Abuse (FWA)	The Plan did not investigate all suspected fraud and abuse incidents promptly. The Plan did not conduct a preliminary or follow-up investigation of 4 of 12 suspected fraud and abuse cases until two to six months after it became aware of the incidents.	FWA reporting procedures will be revised to include the preliminary investigation details to DHCS within 10 working days. All cases will be resolved and closed within 90 days of receipt. Staff training of the revised procedure will be completed by 12/01/2019. Update as of 12/5/2019: Staff training will be conducted on 12/11/2019 to review the updated procedure. Update as of 1/8/2020: Staff training was conducted on 12/11/2019	Yes	12/11/2019	Completed	Compliance		State	DHCS	2019	Completed
27	Fraud, Waste, and Abuse (FWA)	The Plan's compliance officer did not develop and implement fraud, waste, and abuse policies and procedures	The Plan's designated compliance officer will develop and attest to all new and updated policies and procedures prior to committee review.	No	12/13/2019	Completed	Compliance	✓	State	DHCS	2019	Completed
28	State Supportive Services Claims	The Plan did not forward all misdirected claims within 10 working days.	The post-adjudication script that adds the forwarding action was corrected and deployed.	No	7/11/2019	Completed	IT/ Claims	✓	State	DHCS	2019	Completed

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1	Utilization Management (UM) Program	1.1.1 The Plan did not continuously update and improve its UM program during the audit period.	The Plan's policy and procedure UM-001 includes the annual review process of the UM program. The 2018 UM program was approved by Committee timely this year on 3/20/2018. The Plan will continue to update its UM program annually and track for a timely approval by Committee.	3/31/2018	Completed	Utilization Management	✓	State	DHCS	2018	Completed
2	Prior Authorizations	1.2.1 The Plan did not conduct IRR testing to evaluate the consistency of UM criteria application during the audit period.	The Plan has implemented an IRR testing policy and procedure to ensure clinical staff is evaluated on an annual basis to ensure consistency in decision making and criteria application. - UM/Appeals IRR conducted on 5/25/2018 - Pharmacy IRR conducted on 12/17/2018 Update as of 1/31/2019: IRR testing for Health Care Services (Pharmacy & UM) has been completed as of 1/31/2019.	12/17/2018	Completed	Utilization Management/ Pharmacy	✓	State	DHCS	2018	Completed
3	Prior Authorizations	1.2.2 The Plan did not use appropriate processes to determine medical necessity for PA requests. The Plan's UM staff used outdated criteria and criteria that did not meet the case details.	The Plan has updated its policy and procedure to ensure the Plan's criteria is reviewed at least annually. IRR testing of clinical staff is completed annually to ensure consistency in decision making and criteria application. - UM/Appeals IRR conducted on 5/25/2018 - Pharmacy IRR conducted on 12/17/2018 Update as of 1/31/2019: IRR testing for Health Care Services (Pharmacy & UM) has been completed as of 1/31/2019.	12/17/2018	Completed	Utilization Management	✓	State	DHCS	2018	Completed
4	Prior Authorizations	1.2.3 The Plan denied retrospective service requests for medical services without documentation of a qualified health care professional's review for medical necessity.	The Plan updated its policy and procedure for the retrospective authorization request process to include details of the review process. The P&P and workflow will be reviewed and approved on 1/17/2019. Staff training will then be conducted on 1/22/2019. Update as of 1/31/2019: Updated P&P and workflow retro authorization request processes were approved at HCQC on 1/17/2019. Staff training was conducted on 1/29/2019.	1/22/2019	Completed	Utilization Management	✓	State	DHCS	2018	Completed
5	Prior Authorizations	1.2.4 The Plan did not respond to pharmacy requests within 24 hours or one business day.	The Plan monitors pharmacy authorization request timeframes by a daily aging report. Staff training of the turnaround timeframe requirements was provided on 10/02/2018. Update as of 1/07/2019: The Plan has determined that timeframe requirements were not consistently met due to a lack of coverage on weekends and holidays. The Plan has updated its Pharmacy Benefit Management contract to include coverage for weekends and holidays as of 12/1/2018. Staff training of the updated procedures will be completed by 1/22/2019. Update as of 1/31/2019: Staff training was completed on 1/23/2019.	1/22/2019	Completed	Pharmacy	✓	State	DHCS	2018	Completed
6	Prior Authorizations	1.2.5 The Plan's NOA letters were not clear and concise, or at sixth grade reading level.	Update as of 3/5/2019: Continuing internal audits revealed issues with how TruCare generates letters, leading to potentially confusing language for members. A team is working on a plan to mitigate the issues. Once the TruCare issues are resolved, staff will be retrained on the mitigation procedures. In the meantime, audits continue to ensure that the language is clear and concise and a process for final review before sending out is being developed. The updated timeline for completion is 4/30/2019. Update as of 4/10/2019: Denial rationale language has been updated. Staff training was completed on 3/29/2019.	4/30/2019	Completed	Utilization Management/ Pharmacy		State	DHCS	2018	Completed
7	Prior Authorizations	1.2.6 The Plan provided incorrect appeal, grievance, and state fair hearing information in translated pharmacy member notifications. The translated "Your Rights" attachments did not follow the required format.	The Plan will update its pharmacy member notifications to ensure the translated versions are in the required format with updated member rights information by 1/25/2019. Update as of 2/4/2019: Updated translated versions of the "Your Rights" attachments have been provided to the Pharmacy Benefits Manager. Update as of 2/19/2019: Updated translated versions of the "Your Rights" attachments have been placed into production by the Pharmacy Benefits Manager.	1/25/2019	Completed	Pharmacy	✓	State	DHCS	2018	Completed
8	Prior Authorizations	1.2.7 The Plan provided conflicting information to providers about podiatry benefits, which required PA; it therefore did not communicate to providers the services that required PA.	The Plan will be updating its Prior Authorization Grid and Provider Training Presentation to include clear communication of the prior authorization process including clarification of the podiatry benefit.Update as of 1/07/2019: The Plan will be updating its prior authorization grid and provider training materials by 1/25/2019. Update as of 1/31/2019: The PA Grid and Provider Training Presentation have been updated. The PA Grid and updated Provider Manual have been posted to the Plan website.	1/25/2019	Completed	Utilization Management	✓	State	DHCS	2018	Completed
9	Referral Tracking process	1.3.1 The Plan did not track authorized PAs to completion and inform providers of the referral tracking process.	The Plan has updated its referral tracking policy and procedure. Routine reporting has been developed to track authorization PAs to completion. The Plan's provider manual has been updated to include information on the Plan's referral tracking process for providers. Update as of 1/07/2019: The Plan will be uploading the provider manual to the website by 1/25/19. Update as of 1/31/2019: The updated Provider Manual has been posted to the Plan website.	1/25/2019	Completed	Utilization Management	✓	State	DHCS	2018	Completed
10	Appeal	1.4.1 The Plan did not ensure health care professionals with appropriate clinical expertise in treating the member's condition resolved pharmacy appeals. The Plan allowed the Pharmacy Director to resolve appeals for medication requests instead of requiring a clinical professional with expertise in treating the member's condition.	The Plan updated its appeal procedures to reflect MD review for final decision for pharmacy appeals on 09/26/2018 and conducted staff training on 10/30/2018.	10/30/2018	Completed	Health Care Services	✓	State	DHCS	2018	Completed

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11	Appeal	1.4.2 The Plan did not translate acknowledgement and resolution appeal letters into the required threshold languages.	The Plan's appeal policies and procedures in place are compliant with the translation requirements. Staff training refresher of translation of letters was conducted on 10/30/2018.	10/30/2018	Completed	Grievance & Appeals	✓	State	DHCS	2018	Completed
12	Appeal	1.4.3 The Plan did not update its provider manual to include the new timeframes for filing a state fair hearing that became effective July 1, 2017.	The Plan updated its provider manual on 12/25/2018 to include the correct new SFH filing timeframes. Update as of 1/07/2019: The Manual is scheduled to be uploaded on our website on 1/25/2019. Update as of 1/31/2019: The updated Provider Manual has been posted to the Plan website.	1/25/2019	Completed	Grievance & Appeals/ Provider Relations	✓	State	DHCS	2018	Completed
13	Delegation Oversight	1.5.1 The Plan did not collect and review ownership and control disclosure information for their UM delegates.	The Plan's subcontractor policy & procedure addresses the ownership and control disclosure information requirements. Update as of 1/07/2019: The Plan has requested ownership and control disclosure information of its UM delegates as of 1/4/2019. Update as of 1/30/2019: All forms from the Plan's UM delegates have been received as of 1/31/2019 with the exception of the Plan Pharmacy Benefits Manager (PBM). Update as of 3/6/2019: All forms from the Plan's UM delegates have been received.	3/15/2019	Completed	Provider Relations	✓	State	DHCS	2018	Completed
14	Delegation Oversight	1.5.2 The Plan did not require corrective action for all identified deficiencies as a part of their annual oversight audits.	The Plan updated its corrective action plan policy and procedure on 11/8/2018 to ensure all identified deficiencies are a part of annual audits such as policy and procedure deficiencies. UM annual delegation audits conducted for 2018 reflect the policy and procedure deficiencies in the corrective action.	11/8/2018	Completed	Compliance	✓	State	DHCS	2018	Completed
15	Delegation Oversight	1.5.3 The Plan did not continuously monitor and evaluate the functions of its UM delegates. The Plan did not ensure receipt of all contractual and regulatory reports during the audit period.	The Plan has updated its monitoring of UM delegates to ensure all contractual and regulatory reports are being tracked for review. The Plan's delegation reporting tracking log has been updated to document all UM delegation reporting.Update as of 1/7/2019: The Plan will update the desktop procedure and conduct staff training on the monitoring process by 1/22/2019. Update as of 1/31/2019: The Plan completed staff training on 12/20/2018.	1/22/2019	Completed	Compliance	✓	State	DHCS	2018	Completed
16	Initial Health Assessment (IHA)	2.4.1 The Plan did not ensure that new members receive an IHA within 120 days from enrollment. The Plan's IHA completion records were inaccurate.	The Plan updated its procedures to monitor IHA completion and validate the procedure codes. Medical record auditing procedures will be conducted to monitor IHA completion and conduct validity testing.Update as of 1/07/2019: The Plan completed the audit and is completing the summary report for Committee by 1/17/2019.	1/17/2019	Completed	Quality Management	✓	State	DHCS	2018	Completed
17	Complex Case Management (CCM)	2.5.1 The Plan did not implement its policy and did not consistently monitor its CCM program.	The Plan monitors its daily aging report to ensure compliance with its CCM program.	12/1/2018	Completed	Health Services	✓	State	DHCS	2018	Completed
18	Complex Case Management (CCM)	2.5.2 The Plan did not ensure PCP participation in the provision of CCM services to each eligible member.	The Plan's updated CCM policy and procedure includes a process for PCP participation. The PCP Input Form was implemented for use on 5/31/2018.	5/31/2018	Completed	Health Services	✓	State	DHCS	2018	Completed
19	Access & Availability	3.1.1 The Plan did not initiate and implement steps to monitor wait times for providers to answer members' telephone calls.	The Plan will be updating its policy and procedure to include the telephone wait times standards for answering and returning calls. The Plan will monitor wait times for providers and answering member telephone calls through a quarterly survey. Update as of 1/31/2019: The Plan has updated its P&P to include all wait time standards. The Plan conducted a survey in January 2019 to assess and monitor wait times as required.	1/31/2019	Completed	Quality Management	✓	State	DHCS	2018	Completed
20	Access & Availability	3.1.2 The Plan did not maintain an accurate and complete provider directory.	The Plan implemented an audit process of the provider directory. The Plan expanded its annual audit for its Pharmacy Benefit Manager (PBM) to include monitoring its provider data included in the directory.Update as of 1/30/2019: Provider Directory Data P&P and desktop procedure for internal auditing have been updated.	2/28/2019	Completed	Provider Services/ Pharmacy	✓	State	DHCS	2018	Completed
21	Emergency & Family Planning Claims	3.5.1 The Plan denied emergency room (ER) service and family planning (FP) claims containing procedures that normally require prior authorization outside of an ER or FP setting.	The Plan updated its system configuration to ensure ER and FP claim procedure codes were updated and will not be denied for services not being authorized. Monitoring reports have been implemented to review any claims denied incorrectly that are adjusted the following week.	11/30/2018	Completed	Claims	✓	State	DHCS	2018	Completed
22	Emergency & Family Planning Claims	3.5.2 The Plan did not pay the greater of $15 or 15 percent interest annually for emergency service claims not reimbursed within 45 working days of receipt.	The Plan updated its system to ensure interest is paid based on the greater of the $15 or 15 percent interest annually for emergency services not reimbursed timely. Update as of 1/07/2019: The Plan will run a pre-payment monitoring report prior to each check run to ensure interest is paid based on the greater of the $15 or 15% per annum for emergency services claims not adjudicated timely. Update as of 1/31/2019: The Plan's pre-payment monitoring report process is now in place prior to each check run to ensure interest is paid accurately for emergency services claims when interest is required. All claims identified on the weekly report are manually adjusted as needed prior to payment to providers.	1/25/2019	Completed	Claims	✓	State	DHCS	2018	Completed

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23	Emergency & Family Planning Claims	3.5.3 The Plan improperly denied family planning claims for out of network, non-contracted providers. These claims were denied based on edits in the Plan's claims system and subsequent review by claims analysts.	The Plan provided staff training on 6/11/2018 to ensure FP claims edits for out of network claims are reviewed and not inappropriately denied. Monitoring reports have been implemented to review any claims denied incorrectly. Any claims identified as denied incorrectly are adjusted the following week manually.	12/31/2018	Completed	Claims	✓	State	DHCS	2018	Completed
24	Emergency & Family Planning Claims	3.5.4 The Plan did not disclose the specific rationale used in determining why claims are rejected.	Update as of 3/6/2019: The Plan will send via fax blast to the provider network training materials for reading remittance advice forms from Alliance claims by March 31. The training materials will also be included in all provider quarterly packets by May 31, 2019. Update 4/8/2019: The training guide created by the Claims director for providers has been sent to the entire Alliance network via fax as of 4/1/2019; the guide was also posted to the Alliance website as of 4/1/2019. The guide is currently also being hand-delivered by the Provider Relations team via the 2nd quarter provider packets.	4/1/2019	Completed	Claims	✓	State	DHCS	2018	Completed
25	Emergency Pharmacy Provisions	3.6.1 The Plan did not ensure the provision of sufficient amounts of drugs prescribed in emergency situations.	The Plan updated its policy and procedure to ensure emergency provisions of drugs are prescribed in emergency situations. The monitoring report was updated to include all supply claims to ensure members have access to medically necessary drugs.	12/11/2018	Completed	Pharmacy	✓	State	DHCS	2018	Completed
26	Grievances	4.1.1 The Plan's process omitted medical director review of QOC grievances prior to sending resolution letters.	The Plan updated its grievance procedures and letters to include MD review for quality of care grievances.Update as of 1/7/2019: Implementation will be completed by 3/31/2019 once RN staff are on board and trained on the updated process. Update as of 3/5/2019: Health Care Services has successfully recruited one nurse, and is in the process of filling the remaining vacancy. Update as of 4/10/2019: Training is to be completed by 4/11/2019. The checklist for standard and expedited grievances has been updated. Update as of 5/8/2019: The review process for QOC grievances was implemented on 4/15/2019.	4/15/2019	Completed	Health Care Services	✓	State	DHCS	2018	Completed
27	Grievances	4.1.2 The Plan sent member resolution letters without completely resolving all complaints.	The Plan updated its grievance procedure to include a process for resolving all complaints and resolutions resolved outside the 30 day timeframe. Staff training was conducted on 7/17/2018.	7/17/2018	Completed	Grievance & Appeals		State	DHCS	2018	Completed
28	Grievances	4.1.3 The Plan did not update its provider manual to include the new timeframes for filing grievances that became effective July 1, 2017.	The Plan updated its Provider Manual on 12/25/2018 to include the correct new grievance filing timeframes. Update as of 1/07/19: The Manual is scheduled to be uploaded on our website on 1/25/2019. Update as of 1/25/2019: The Plan has posted the updated Provider Manual to its website.	1/25/2019	Completed	Grievance & Appeals/ Provider Relations	✓	State	DHCS	2018	Completed
29	Grievances	4.1.4 The Plan's grievance system did not capture and process all complaints and expressions of dissatisfaction	The Plan provided training to its delegated entities of the Plan's grievance process to ensure the Plan's system receives and resolves all complaints of dissatisfaction. New provider orientation materials and the provider manual will include education materials of the Plan's grievance process for new and existing providers. Update as of 1/7/2019: The Plan will be uploading the provider manual to the website by 1/25/19. Update as of 1/25/2019: The Plan has posted the updated Provider Manual to its website.	1/25/2019	Completed	Grievance & Appeals/ Provider Relations	✓	State	DHCS	2018	Completed
30	HIPAA	4.3.1 The Plan did not report the discovery of PHI breaches to the DHCS Information Security Officer.	The Plan updated its procedures to ensure reporting of PHI incidents are reported to all DHCS contacts including the DHCS Information Security Officer. Staff training on updated procedures was conducted on 8/22/2018 and 10/3/2018.	10/3/2018	Completed	Compliance	✓	State	DHCS	2018	Completed
31	HIPAA	4.3.2 The Plan did not report all suspected security incidents or unauthorized disclosures of PHI to DHCS within 24 hours of discovery.	The Plan updated its procedures and tracking log to ensure monitoring of reporting to DHCS occurs timely. Staff training on updated procedures was conducted on 8/22/2018 and 10/3/2018.	10/3/2018	Completed	Compliance	✓	State	DHCS	2018	Completed
32	Provider Training	5.2.1 The Plan did not ensure provider training was conducted within 10 working days.	The Plan monitors its tracking log to ensure provider training is conducted within 10 working days. Staff training of the required timeframe was conducted on 12/17/2018.	12/31/2018	Completed	Provider Services	✓	State	DHCS	2018	Completed
33	Provider Training	5.2.2 The Plan did not specify in its written agreement provider training responsibilities for two delegated entities.	The Plan updated its contract with the two delegated entities to ensure provider training requirements.Update 12/31/2018: The Plan has updated its contract with one of the delegates to include delegation of provider training requirements. The other delegate's contract is in progress to be finalized. Estimated time for contract to be completed is 2/28/2019.Update as of 3/4/2019: The remaining delegate has agreed to the provider training responsibilities; the final contract will be signed once the delegate agrees to terms for non-related items. Update as of 8/5/2019: Both delegates involved in the finding delegation agreements were updated. Another delegate's contract still needs to be finalized.	6/30/2019	Completed	Provider Services	✓	State	DHCS	2018	Completed
34	Provider Training	5.2.3 The Plan did not ensure training materials provided by two delegated entities included information on Plan policies, procedures, services, and member rights and responsibilities.	The Plan's delegated entities have updated their training materials to include the required information. Update 12/31/2018: The Plan is currently working with the delegate to incorporate this information. Target date for materials to be updated is 1/31/19. Update as of 1/30/2019: Both delegates have revised their training materials to include member rights and responsibilities, grievances and services.	1/31/2019	Completed	Provider Services	✓	State	DHCS	2018	Completed

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2018 DHCS FINAL AUDIT REPORT FINDINGS - *Audit Review Period: 6/1/2017-5/31/2018*					INTERNAL AUDITS						
#	**Category**	**Deficiency**	**Corrective Action Plan (CAP)**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**	**Status**
35	Fraud, Waste, and Abuse (FWA)	6.3.1 The Plan did not conduct and report preliminary investigations of all suspected cases of fraud and abuse to DHCS within 10-working days.	The Plan updated its fraud and abuse policy and procedure as of 7/17/2018 to ensure timely reporting of incidents to DHCS. Staff training on updated procedures was conducted on 7/17/2018. The Plan updated its monitoring tracking log to monitor the reporting timeframe requirement.	7/17/2018	Completed	Compliance	✓	State	DHCS	2018	Completed
36	Fraud, Waste, and Abuse (FWA)	6.3.2 The Plan did not conduct prompt and complete investigations of all suspected fraud and abuse incidents.	The Plan updated its fraud and abuse policy and procedure as of 7/17/2018 to investigate all suspected incidents and update DHCS until the case closure. Standardized investigation form for documentation was implemented as of 7/17/2018. Staff training on updated procedures was conducted on 7/17/2018.	7/17/2018	Completed	Compliance	✓	State	DHCS	2018	Completed
37	State Supportive Services	SSS.1 The Plan denied state supported services (SSS) claims containing procedures that normally require prior authorization outside of a SSS setting. These claims were denied based on edits in the Plan's claims system and review by claims analysts; the Plan's process did not include exceptions for FP or ER services.	The Plan updated its system configuration to ensure SSS claim procedure codes were updated and will not be denied for services not being authorized. Monitoring reports have been implemented to review any claims denied incorrectly that are adjusted the following week.	11/30/2018	Completed	Claims	✓	State	DHCS	2018	Completed
38	State Supportive Services	SSS.2 The Plan did not disclose the specific rationale used in determining why claims are rejected.	The Plan's Remittance Advice (RA) includes the specific rationale for claims denials. Denial codes can be applied at the Header level, line level or both. The Plan's claims processing system edits each claims and assigns all denial or informational codes that are applicable to the claim. Update as of 1/31/2019: The Plan will provide training to providers to ensure comprehension concerning the remittance advice set-up. Update as of 3/6/19: The Plan will send via fax blast to the provider network training materials for reading remittance advice forms from Alliance claims by March 31. The training materials will also be included in all provider quarterly packets by 5/31/2019. Update 4/8/2019: The training guide created by the Claims director for providers has been sent to the entire Alliance network via fax as of 4/1/2019; the guide was also posted to the Alliance website as of 4/1/2019. The guide is currently also being hand-delivered by the Provider Relations team via the 2nd quarter provider packets.	4/1/2019	Completed	Claims	✓	State	DHCS	2018	Completed
1	Prior Authorizations	Authorizations were auto-approved for hospital.	Effective 9/17/2018, the Plan started to review and impose standard UM authorization guidelines for hospital authorizations.	9/17/2018	Completed	Utilization Management	✓	Self Identified	AAH	2018	Completed
2	Appeal	The Plan's expedited appeals checklist does not include a reminder to call the member when the case is de-escalated from urgent to routine.	The expedited appeals checklist has been updated. Staff training will be conducted by 10/1/2018. Checklist includes requirements of De-expedited: Decision to de-expedite must be made within 24 hours. Send ack letter within 3 calendar days notifying of priority change and right to contact DMHC. Follow standard appeal process. If 24 hour TAT is not met, proceed with expedited appeal.	10/1/2018	Completed	Grievance & Appeals	✓	Self Identified	AAH	2018	Completed
3	Delegation Oversight	Some authorization cases included many errors with subcontractor's notices of actions. Plan oversight of authorizations and notices is in process.	Reestablished bi weekly meetings with subcontractors and conducted monthly focused file audit which included NOAs, conducted clinical case rounds for overturned appeals. The plan will continue to monitor during annual audit review process. The Plan will be terminating services subcontractor and consuming this function to review authorization effective 4/1/2019.	12/1/2018	Completed	Utilization Management	✓	Self Identified	AAH	2018	Completed
4	Care Coordination	The Plan did not annually review the County MOU for CCS services.	Update 9/27/2019: MOUs have transitioned to Provider Services. Provider Services is in discussion with the county on review MOUS, including CCS. Update as of 12/2/2019: The MOUs have been transitioned to the Provider Services team. The MOU was executed with an effective date of 8/1/2019	8/1/2019	Completed	Provider Services	✓	Self Identified	AAH	2018	Completed
5	Care Coordination	The Plan did not annually review the County MOU for Early intervention/development disabilities.	Update 9/27/2019: MOUs have been transitioned to Provider Services. Provider Services is in discussion with the county on review MOUS, including EI/DD services. Update as of 12/2/2019: The Plan is currently working on developing a full county MOU to include services for early intervention and development disabilities services Update 7/10/2020: The MOU was sent to the County for review on6/16/2020. Update 10/9/2020: The County has accepted the Alliance's edits and the MOU is currently under review for final approval with the County.Update 11/10/2020: The County has cancelled the November 3rd meeting. This agenda item will be carried over to the December 15th docket.**Update 5/14/2021**: The MOU was approved by the county board on 4/6/2021.	~~2/28/20~~ TBD	Completed	Provider Services	✓	Self Identified	AAH	2018	Completed
6	Initial Health Assessment (IHA)	The Plan did not have a process for validating the procedure codes used for IHA completion.	P&P will be updated to include the detail of the process for annual validation and codes. The validated for this year will occur prior to 11/1/2018. Update 11/6/2018: Codes were validated and updated by QM department.	11/1/2018	Completed	Quality Management	✓	Self Identified	AAH	2018	Completed
7	Initial Health Assessment (IHA)	The Plan does not have a system in place for monitoring member's missed appointments.	Missed appointments are identified during the Medical Record Review that is part of a FSR. The criteria for missed primary care appointments and outreach efforts, which is part of DHCS's tool. The FSR review nurse evaluates this information and if a deficiency is identified the provider is educated on the importance of outreaching to the member and that documentation of the outreach attempts is required.	11/26/2019	Completed	Quality Management	✓	Self Identified	AAH	2018	Completed
8	Access & Availability	The Plan did not monitor appointment wait times.	Policy and procedure is in place for monitoring appointment wait time standards. Standardized process for monitoring and corrective action plan in place as of 9/20/2018.	9/20/2018	Completed	Quality Management	✓	Self Identified	AAH	2018	Completed
9	Grievances	Some exempt grievance cases were not resolved within the next business day timeframe (applied to 1 3 cases).	Policies and procedures in place are compliant with the exempt grievance resolution timeframe requirements. Staff training refresher of resolving all exempt grievances by close of next business day was conducted on 10/12/2018.	10/12/2018	Completed	Member Services	✓	Self Identified	AAH	2018	Completed

ALAMEDA ALLIANCE FOR HEALTH
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2018 DHCS FINAL AUDIT REPORT FINDINGS - *Audit Review Period: 6/1/2017-5/31/2018*					INTERNAL AUDITS						
#	**Category**	**Deficiency**	**Corrective Action Plan (CAP)**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**	**Status**
10	Quality Improvement	Reporting of the HCQC was not consistently reported to the Board.	The Chief Medical Officer will provide HCQC summary updates to the Board starting in November. The meeting minutes will be included in the Board materials.	11/9/2018	Completed	Quality Management	✓	Self Identified	AAH	2018	Completed
11	Utilization Management	The Plan did not routinely review overturned UM denials for trends & to develop plans for intervention where needed.	The Plan will pull reporting of UM denial trends that will be presented at the UM committee. The first UM committee for presenting the overturn UM denial trends at UM committee will be on 9/28/2018. These findings will be presented to the HCQC and subsequently to the Board of Governors.	9/28/2018	Completed	Utilization Management	✓	Self Identified	AAH	2018	Completed
12	Utilization Management	The Plan did not have a clear process for peer-to-peer clinician discussions concerning denied services.	Steps Plan took or will take to correct deficiency: 1.Plan develop a desktop procedure on peer to peer discussion by 9/14/2018. 2. Plan to train physicians and pharmacists of desktop procedure and when and how to document peer-to-peer clinician discussions by 9/26/2018. 3.Plan has started a weekly meeting with physicians and pharmacist for peer to peer discussions as of 7/17/2018.	9/26/2018	Completed	Utilization Management	✓	Self Identified	AAH	2018	Completed

DASHBOARD KEY

Internal CAP Status Performance Measures	
Indicator	**Criteria**
Green	CAP responses have been completed and fully address the findings

Notes
1) **Potential Self-Identified findings** are developed by the Alliance from regulatory agency feedback or self identification of a deficiency found. They are monitored internally by the Alliance.
2) **State Audit Findings** have been issued by the regulatory agencies in a audit report that requires a corrective action.
3) **Compliance Internal Audit** is conducted as the last step once the item has been fully resolved and all actions have been completed.

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 White Carey, Chief Medical Officer**

Date: **October 10th, 2025**

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

Standing Committee Meeting Reports

- Quality Improvement Health Equity Committee – May 9, 2025
    - Approved 8 policies and procedures
    - QI Trilogy Documents approved
    - Reviewed 2024 DHCS Audi CAPs

- Quality Improvement Health Equity Committee – Aug 8, 2025
    - Approved 83 policy and procedures
    - External partner update: CFMG HEDIS updates
    - Updates on the following:
        - HEDIS scores
        - Geo-Access/Provider Capacity
        - Potential Quality Issues (PQI)
        - Survey results: PASS/QMRT
        - FSR Caps
        - Behavioral Health Program

- P&T Committee meeting – June 17, 2025
    - Reviewed 11 Therapeutic categories and drug monographs
    - Reviewed 3 Group Care policies
    - Reviewed 7 DSNP policies
    - Reviewed 4 new Group care guidelines
    - Reviewed 4 new PAD guidelines
    - 13 formulary modifications
        - Added 13 medications to formulary w/PA (prior authorization) requirement
    - Updated 19 Group Care PA guidelines
    - Reviewed 33 Group Care PA guidelines with no updates
    - Updated 5 PAD guidelines
    - Reviewed 8 PAD guidelines

- Peer Review/Credentialing Committee – September 16, 2025
    - At the Peer Review and Credentialing (PRCC) meetings held on September 16, 2025, there were one hundred and fifty-five (155) initial network providers approved; Fiver (5) primary care providers, nine (9) specialists, twenty (20) ancillary providers, four (4) midlevel providers, and one hundred and seventeen (117) behavioral health providers.
    - Additionally, forty-three (43) providers were re-credentialed at this meeting; two (2) primary care providers, eight (8) specialists, one (1) ancillary provider, three (3) midlevel providers, and twenty-nine (29) behavioral health providers.

Utilization Management (UM)

(Summary of 2024 UM Program Evaluation)

- Denial Rates
    - Overall, 2.31% *(0.04% decrease from 2023)*

- Authorization Turn-Around Times (goal = 95%)
    - Inpatient/outpatient: overall 99%, above goal
    - LTC: overall 96%, above goal
    - BH: overall 96%, above goal

- Pharmacy:
    - Outpatient RX: overall 99.8%, above goal
    - Physician Administered Medications/Injections: overall 99.4%, above goal

- Over/Under Utilization Measures
    - ER visits: average 491.6 visits/K *(-33.4 visits/K compared to 2023)*
    - Acute Inpatient Hospitalization Readmission Rate: 21.1% *(+1.1% compared to 2023)*

- Opportunities incorporated into 2025 Program/Workplan:
    - Explore Community Health Workers and Bridge Programs embedded in Emergency Departments to decrease Emergency Department Utilization

    - Continue referral processes for Enhanced Care Management, Complex Case Management and Community Supports to link members to appropriate resources for next level of care

    - Streamline and improve accessibility of prior authorization information to providers, including increase visibility of authorization details online

    - Provide regular training and share best practices with delegated entities, particularly around Enhanced Care Management, Community Supports, Transitional Care Services

Overall Authorization Volumes *(inpatient, outpatient, and long-term care):*

- Total authorization volume increased month-over-month from August to September 2025.

Total Authorization Volume (Medical Services)			
Authorization Type	**July 2025**	**August 2025**	**September 2025**
Inpatient	2,527	2,809	2,955
Outpatient	4,615	4,685	6,053
Long-Term Care	670	864	878
Total	**7,237**	**8,288**	**9,886**

***Source**: #02569_AuthTAT_Summary*

The following sections provide additional detail on utilization management trends in each department.

Utilization Management: Outpatient

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

- Revision of prior authorization and benefits grid is in progress, to create a more provider-friendly reference document to delineate code-specific authorization rules. Development of an online searchable code database is also under development, with anticipated release in Q4 2025.

- OP processed a total of 6,053 for the month of Sept. We also processed 420 CCS referrals, of which 88 cases were submitted to our regional CCS office for review. 36 cases were approved; 17 denied, 135 pending.

- OP Turnaround times continue to exceed the benchmark of 95%, with the average being 98% in the month of September.

- The top 5 categories remain unchanged Radiology, OP Rehab, TQ, Home Health and Outpatient facility. Radiology and Rehab representing 60% of this volume.

- Launched pilot authorization process for select Home Health codes, streamlining the submission process for home health agencies by allowing access to and guiding providers through clinical guidelines at the time of authorization submission. The pilot is being monitored, and if successful, will be expanded.

- DSNP staff training has begun and will continue weekly over 14 weeks.

Total Outpatient Authorization Volume			
Authorization Status	**July 2025**	**August 2025**	**September 2025**
Approvals	4,682	4,677	5,624
Partial Approvals	10	7	44
Denials	124	155	385
Total	**4,816**	**4,839**	**6,053**

***Source**: #02569_AuthTAT_Summary*

Outpatient Authorization Denial Rates			
Denial Rate Type	**July 2025**	**August 2025**	**September 2025**
Overall Denial Rate	**4.0%**	**2.9%**	**3.2%**
Denial Rate Excluding Partial Denials	**3.6%**	**2.6%**	**2.9%**
Partial Denial Rate	**0.5%**	**0.3%**	**0.3%**

***Source**: #03690_Executive_Dashboard*

Outpatient Turn Around Time Compliance *(benchmark: 95%)*			
Line of Business	**July 2025**	**August 2025**	**September 2025**
Overall	99.2%	97.0%	99.8%
Medi-Cal	99.1%	97.0%	99.8%
IHSS	100%	97.5%	97.4%

***Source**: #02569_AuthTAT_Summary*

Utilization Management: Inpatient

- Total inpatient auth volume (including all IP authorization types processed by department: Acute, LTACH, Skilled SNF, and OP auths related to discharge) increased slightly from 2881 authorizations processed in August 2025 to 2955 in September.

- Inpatient overall average LOS stayed consistent at 5.4 in June and July. Admits per thousand increased from 46.0 in June to 50.5 in July. Days per thousand increased from 248.3 in June to 273.6 in July. The trend is consistent among Child, Adult, ACA and SPD categories.

- IP overall denial rate went up from 1.7% in June, to 3.5% in July, then fell to 2.1% in August.

- IP Auth TAT compliance met 95% benchmark, in July, August, and September.

- IP Concurrent clinical review standard process of validating appropriate acute level of care being provided to members in: including ICU, Telemetry/Intermediate/ICU step-down, Med/Surg and Administrative stay levels in Acute care and Long Term Acute Care hospitals. Recent implementation of process change involved matching appropriate authorized level of care in Auth system TruCare with Claims system HealthSuite. This change resulted in improved payment integrity.

- 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 and continue monthly, with the goal of supporting AAH members at Kaiser facilities who have complex discharge needs and high ER utilization. Members delegated to CHCN are also reviewed in this forum.

- IP UM RN onsite nurse at Washington Hospital is in training and onboarding process. AAH Leadership is working with Washington Care Management leadership team with next steps for implementing the onsite nurse program in the coming months.

Total Inpatient Authorization Volume			
Authorization Status	**July2025**	**August 2025**	**September 2025**
Approvals	3,051	2,821	2,900
Partial Approvals	0	0	0
Denials	77	60	55
Total	**3,128**	**2,881**	**2,955**

Source: #02569_AuthTAT_Summary

Inpatient Med-Surg Utilization			
Total All Aid Categories			
Actuals (excludes Maternity)			
Metric	**June 2025**	**July 2025**	**August 2025***
Authorized LOS	5.6	5.4	5.4
Admits/1,000	48.3	46.0	50.5
Days/1,000	270.2	248.3	273.6

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

Inpatient Authorization Denial Rates			
Denial Rate Type	**July 2025**	**August 2025**	**September 2025**
Full Denials Rate	1.7%	1.8%	1.1%
Partial Denials	3.0%	2.4%	1.8%
All Types of Denials	4.7%	4.2%	2.9%

Source: #01292_AllAuthDenialsRates

Inpatient Turn Around Time Compliance *(benchmark: 95%)*			
Line of Business	**July 2025**	**August 2025**	**September 2025**
Overall	95%	95%	95%
Medi-Cal	95%	95%	95%
IHSS	100%	100%	100%

Source: #02569_AuthTAT_Summary

Utilization Management: Long-Term Care

- LTC census during September 2025 was 2,268 members. This is an increase of 5.06% (121 members) from August 2025.

- Month to Month, the admissions, days and readmissions are decreasing. From June to August the admissions decreased by 83.76%, the days decreased by 91.63% and the readmissions also decreased by 80.65%. Some of this could be due to a lag in claims data being available, but we are seeing a decrease overall.

Totals	**June 2025**	**July 2025**	**August 2025**
Admissions	117	90	19
Days	872	520	73
Readmissions	31	23	6

Source: #14236_LTC_Dashboard – data only available through August 2025

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

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

- LTC Team continues to meet individually with multiple facilities to discuss collaboration with discharge planning and submitting proper documentation for requests.

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

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

- Social Workers continue visiting LTC facilities in person, on a monthly and quarterly basis depending on census, to assist with discharge planning and access to other

resources. The team continues referrals to TCS and other internal/external programs to provide wraparound support to members preparing to discharge from an LTC custodial facility.

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

- Health Navigator and dedicated RN continue to assist with TCS for members coming back from an acute stay or transitioning from acute into long-term care. The new Health Navigator started on September 8, 2025 and currently is in training.

- Authorization volume had a dip in August, but has gone back up in September.

- Authorization processing turn-around time (TAT) has remained between 98%- 99%, which is exceeding the threshold of 95%.

Total LTC Authorization Volume			
Authorization Status	**July 2025**	**August 2025**	**September 2025**
Approvals	792	710	833
Partial Approvals	0	0	0
Denials	51	40	45
Total	**843**	**750**	**878**

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 *(benchmark: 95%)*			
Line of Business	**July 2025**	**August 2025**	**September 2025**
Medi-Cal	99%	98%	98%

Source: #02569_AuthTAT_Summary

Behavioral Health

- In September, the Behavioral Health Department processed 490 authorizations, 395 Care Coordination referrals, and 184 mental health screenings and transition of care tools.

Total BH Authorization Volume			
	25-July	**25-Aug**	**25-Sep**
Approvals	575	455	477
Partial Approval	1	2	0
Denials	29	9	13
Total	605	466	490

Source: 14939_BH_AuthTAT

Mental Health Turnaround Times

MH TAT			
*Goal ≥95%	25-July	25-Aug	25-Sep
Determination TAT%	97%	99%	99%
Notification TAT%	98%	96%	99%

Behavioral Health Therapies (BHT/ABA) Turnaround Times

BHT TAT			
*Goal ≥95%	25-July	25-Aug	25-Sep
Determination TAT%	96%	99%	99%
Notification TAT%	100%	100%	100%

Behavioral Health Denial Rates

*Goal ≤ 5%	BH Denial Rates	
25-July	25-Aug	25-Sep
<1%	<1%	<1%

Source: 14939_BH_AuthTAT

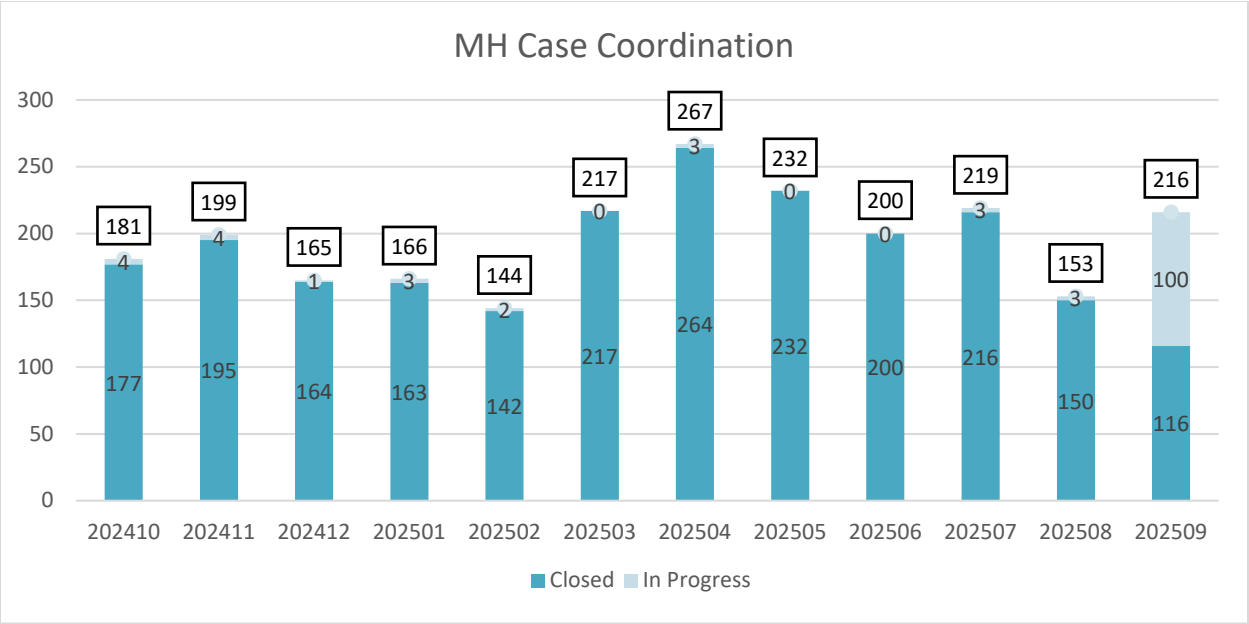
Mental Health Care Coordination

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

Total # Medi-Cal Screenings & TOC Tools			
	25-July	25-Aug	25-Sep
Total Youth Screenings	75	84	66
➢ Youths referred to ACBHD	8	22	9
Total Adult Screenings	153	127	115
➢ Adults referred to ACBHD	37	31	20
Transition of Care Tools to ACBHD	3	1	3

Source:16015_MH_Assessments

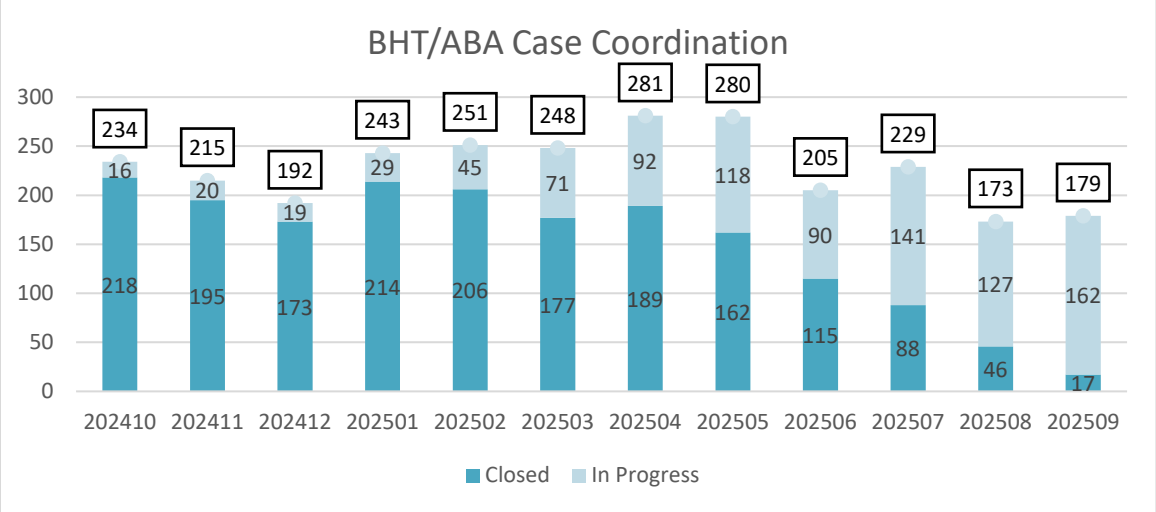
- Alliance licensed mental health clinicians, psychiatric nurses, and behavioral health navigators provide care coordination for members who need assistance accessing the mental health treatment services they need.



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.

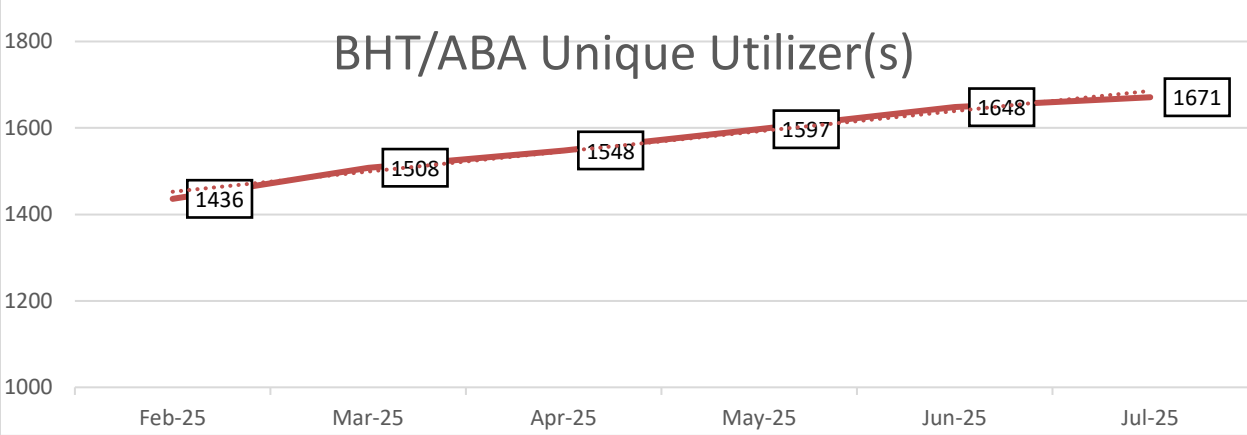


Source: 14665_BH_Cases

Behavioral Health Unique Utilizers

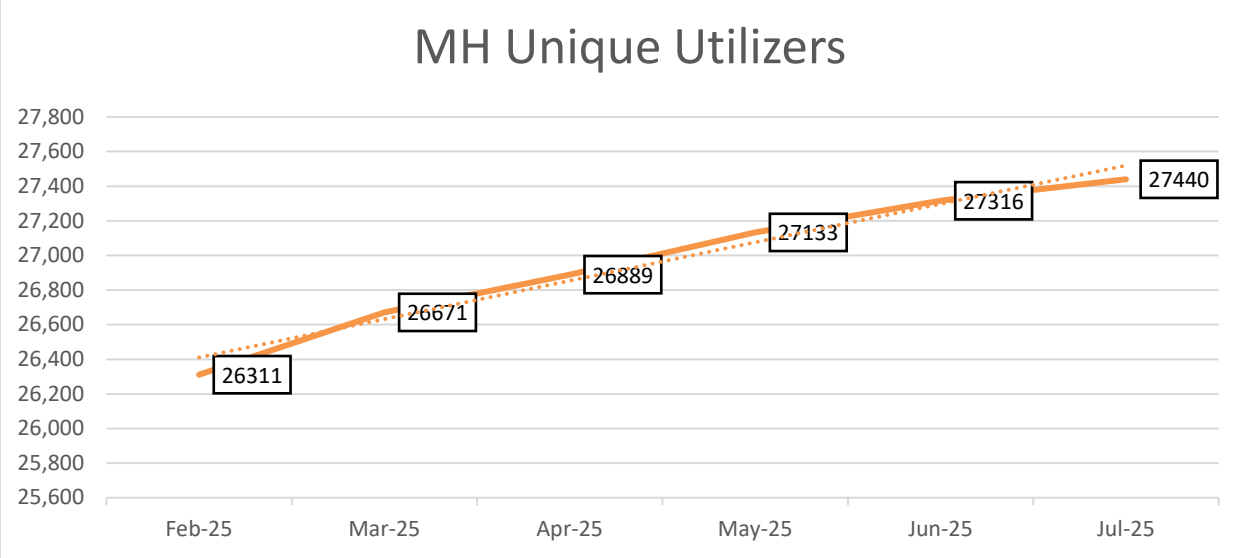
- Removing barriers to accessing BHT/ABA services remains a primary goal for the Alliance Behavioral Health team. One way to measure that is to monitor unique utilizers who are accessing care when interventions are implemented.

- We observed a continuing rise in unique utilizers of BHT/ABA services, reflecting a 1.3% increase compared to the previous month.



Source: PBI 14621 BHT Utilization Report

- The number of unique utilizers of mental health services has increased by 0.45% compared to the previous month.



Source: PBI 14637 BH12M Report

Pharmacy

- The Pharmacy Transitional Care Services (TCS) program has screened 23 Heart failure cases, 42 Sepsis cases, and received 1 direct referral for the month of September 2025.

Case and Disease Management

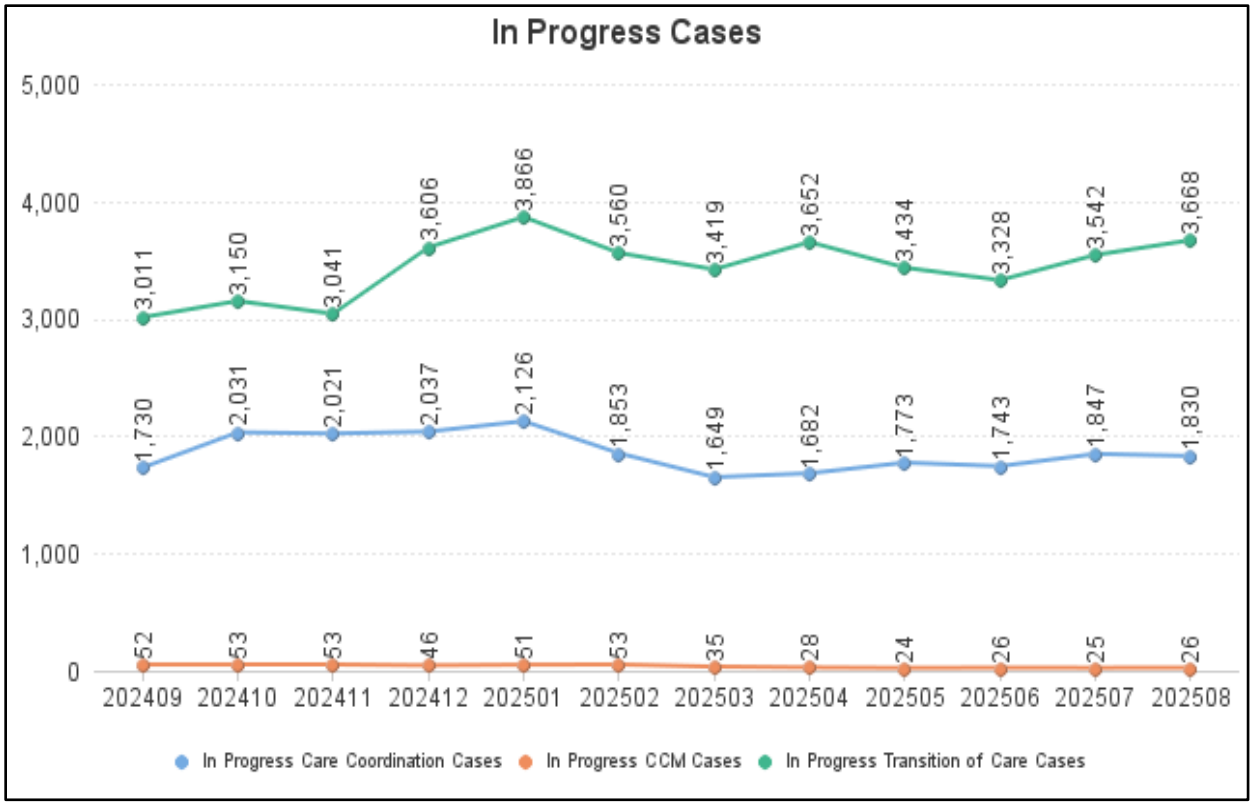
- The CM team is working hard to assist the high volume of members needing Transitional Care Services (TCS) as they transition from one level of care to another. This includes outreaching to members who are still hospitalized and following up post-discharge to help meet the member's needs.

- 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.).

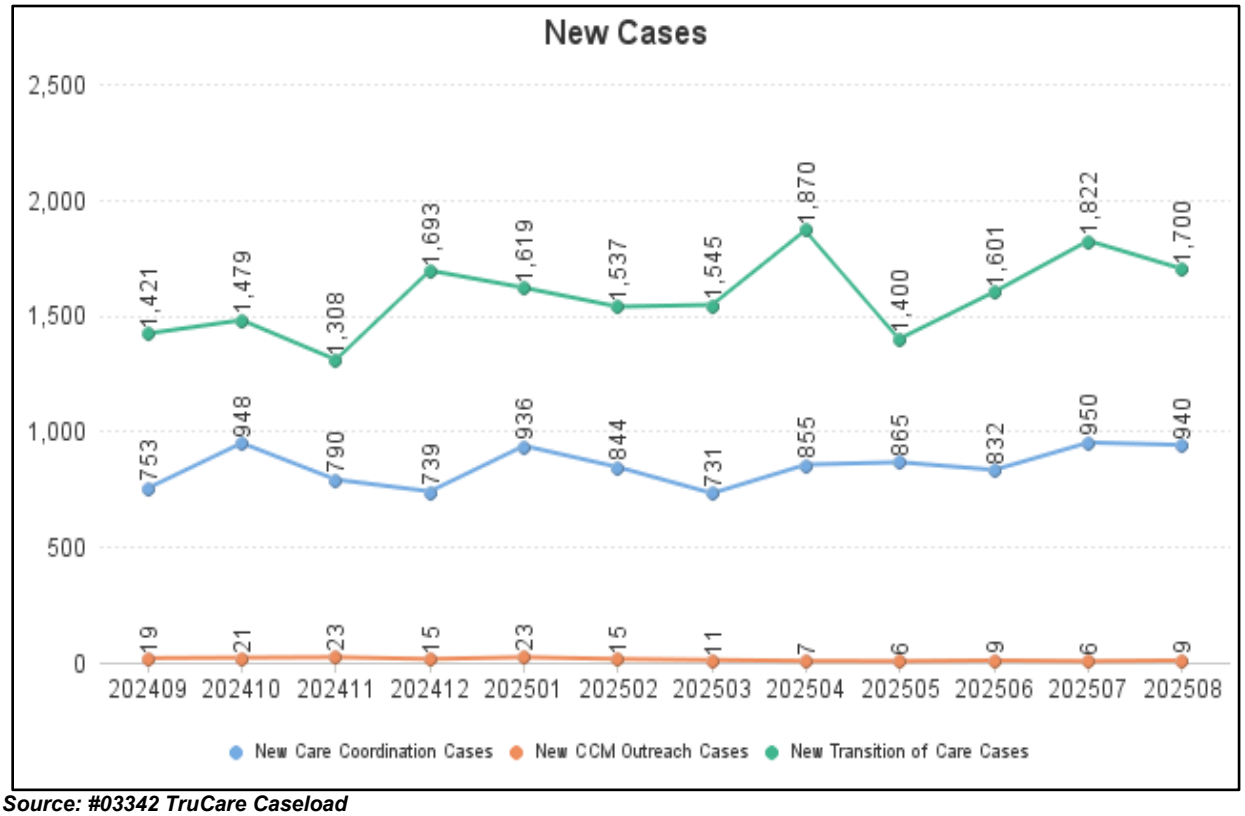
- CM is collaborating with UM and LTC to support members at hospitals with long-length stays and complex discharge barriers, including facilitating referrals to Community Supports, ECM and other community resources, as needed.

- 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. The transportation liaison has also increased oversight of ModivCare's facility transportation services, including making onsite visits with hospitals to address transportation concerns.

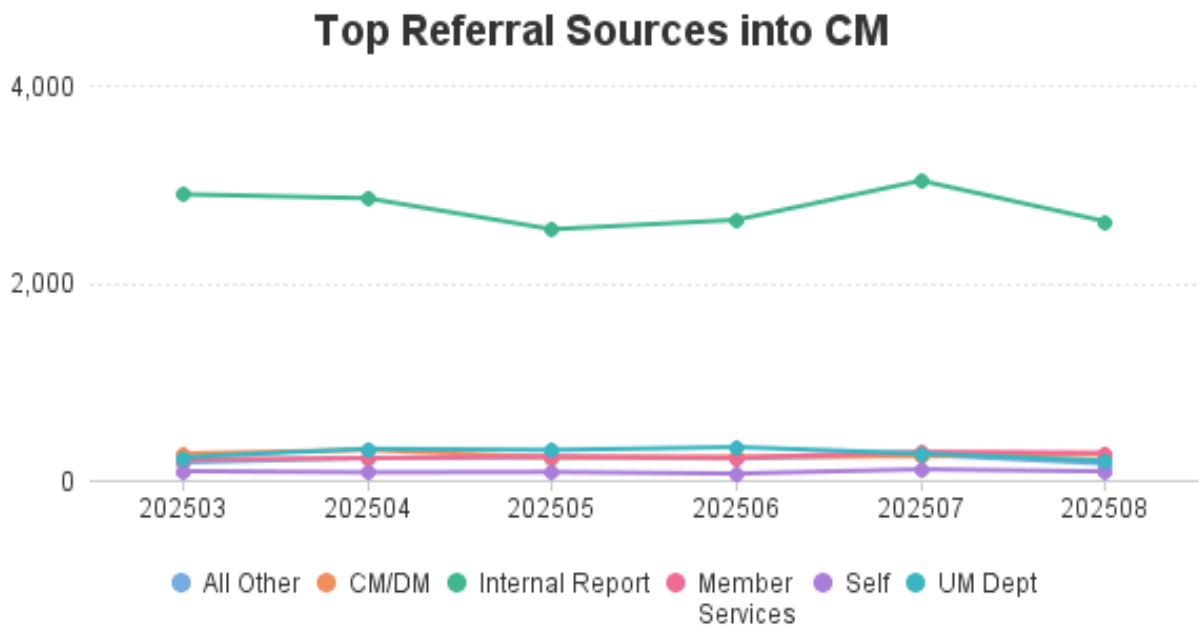
- Preparation continues for DSNP case management. The Case Management (CM) leadership team is developing training for the internal CM team as well as informative overviews of CM for other teams and entities.



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 available through August 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 other areas of ECM. This will improve the processing time of authorizations and free up the team to work on other areas of ECM (ie: graduating or assisting with stepping members down to a lower level of care).

- Efforts to expand the ECM provider network have re-started. The screening panel reviews provider applications based on capacity to serve targeted Populations of Focus, demonstrated operational excellence in programming, and quality benchmarks.

- The Standardized ECM referral form and ECM eligibility information is now visible to providers on the provider portal. Network-wide provider training started in July. Some providers have been trained already on an ad-hoc basis.

- The ECM team continues to build rapport with the ECM providers, meeting to discuss specific cases and work with the ECM providers to assist with moving members through the ECM program by addressing care plan barriers and offer supports and services ECM providers may not be aware of. This has led to more collaboration and community referrals to additional resources. Additional meetings are scheduled with ECM providers for individual case conference as needed.

- ECM and CS teams have begun a collaborative meeting to confirm communication is occurring between Community Supports providers and ECM lead care managers. The collaboration further enhances coordination of care, ensuring non-duplicative services and members receive appropriate services to meet their needs.

- As a result of the 2024 fall's audit of ECM providers, the ECM team continues to develop training for the ECM providers to re-educate the ECM provider network on the various topics applicable to ECM. The ECM team was successful in providing monthly training sessions for all ECM providers' frontline staff to reinforce ECM requirements and expectations. There will be more training for the ECM provider network starting in November.

- 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.

- Closed-Loop Referral (CLR) requirements went live on July 1, 2025. The closed-loop referral framework is designed to ensure that members, healthcare providers and ECM/CS providers are aware of the status of referrals from beginning to end.

	June 2025		July 2025		August 2025	
ECM Providers	**Outreach**	**Enrolled**	**Outreach**	**Enrolled**	**Outreach**	**Enrolled**
ACBH	-	13	-	13	-	13
Alameda Health System (AHS)	27	221	36	230	41	225
Bay Area Community Services (BACS)	9	129	3	132	7	139
California Cardiovascular Consultants	-	148	24	148	-	148
California Children's Services (CCS)	5	35	6	39	9	46
CHCN	87	1,057	130	1,105	127	1,121
East Bay Innovations (EBI)	14	125	1	137	4	142
Full Circle	183	228	180	199	205	175
Institute on Aging	36	223	-	220	175	206
La Familia	48	42	40	45	34	39
MedZed	40	711	64	791	24	806
Roots Community Health Center	-	709	-	656	-	677
Seneca Family Services	27	67	-	64	-	51
Pair Team	630	1,825	412	2,007	29	1,994
Titanium Health Care	584	1,006	659	1,066	189	1,217
Tiburcio Vasquez Health Center (Street Medicine)	-	127	-	127	-	121
BACH (Street Medicine)	-	84	-	82	-	73
Lifelong (Street Medicine)	-	315	4	337	2	333
Roots Community Health Center (Street Medicine)	Combined with Roots 'traditional' ECM program					

Source: #13360 ECM Dashboard

Community Supports (CS)

- Guidance for the Housing-related Community Supports guidance will be shared in Fall 2025, with an effective date of 01/01/26, per DHCS regulations.
- 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
    - Transitional Rent (coming 01/01/26)

- The Alliance is working to identify gaps in current service capacity and member access to Community Supports; this will inform future targeted efforts for CS network expansion.
- 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. Provider training has also started to review the new auditing and oversight requirements.
- DHCS Closed Loop Referral requirements became effective on 07/01/25.
- Oversight of Community Supports providers started this month to align with requirements in the new DHCS policy guides. The oversight will be through audits of providers and the services they provide.

Community Supports	Services Authorized in June 2025	Services Authorized in July 2025	Services Authorized in August 2025
Housing Navigation	964	967	937
Housing Deposits	372	414	460
Housing Tenancy	859	943	950
Asthma Remediation	147	150	141
Meals	550	578	595
Medical Respite	66	57	58
Transition to Home	19	14	10
Nursing Facility	9	7	6
Home Modifications	3	4	4
Homemaker Services	22	29	46
Caregiver Respite	0	0	0
Total	**3,011**	**3,163**	**3,207**

Source: #13581 Community Supports Auth Dashboard

Community Health Strategy (CHS) – September

- The Community Health Worker (CHW) Benefit aims to mitigate health disparities and improve outcomes for Alliance members by bridging health and housing systems of care. CHWs support overall wellness through preventative services that positively impact members' social determinants of health.

Staffing Updates:

- **Manager, Community Health Initiatives** – Pending Human Resources

September Program Summary:

- September was a busy and impactful month for our Community Health Strategy. We focused on strengthening interdepartmental collaboration with Provider Services, Claims, and Compliance to streamline processes and lay the groundwork for greater CHW program efficiency. We closed the month on a high note with an energizing design thinking session for Community Health Worker (CHW) services, where Alameda County partners—including Eden I&R, the City of Oakland, Spectrum, Crisis Support Services, the Senior Services Coalition, and many other committed organizations—came together to share bold ideas, explore innovative ways to strengthen member programming, and advance strategies for equitable CHW service coordination.

- The session sparked creative conversations around system alignment, particularly on how to connect the trusted, relationship-based work of CHWs with the referral infrastructure of Eden I&R and other county partners. This exploration opened the door to new approaches for bridging health and social services. Using design-thinking methods, participants co-created solutions to address priority community needs—such as housing, behavioral health, safety, and access to care—while identifying SDOH information gaps that the Alliance may not yet be capturing. Partners also examined opportunities to innovate referral pathways through closed-loop models and enhanced data-sharing practices, ensuring that members are not just referred to services but meaningfully connected. Importantly, the session emphasized member experience and shared learning, bringing CHWs, navigators, and community organizations together to shape system-level design, guide workforce development, and identify future opportunities for collaboration.

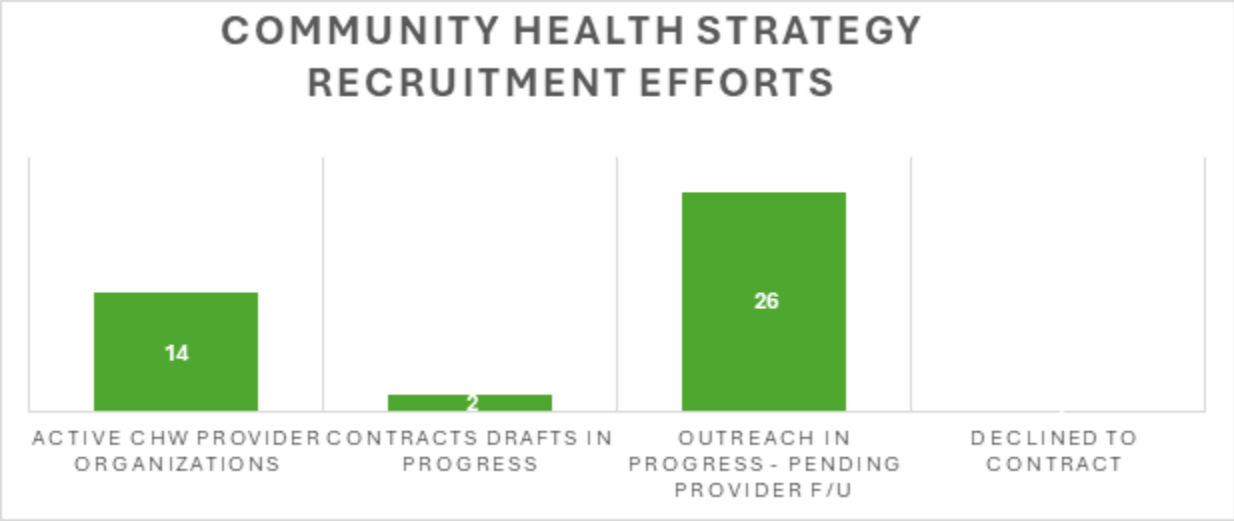
- In addition, our Community Health Strategy and Population Health teams completed our first CHW-led pilot on controlling blood pressure and hypertension. The pilot surfaced valuable opportunities for refinement while generating critical insights on how to better stratify member needs and strengthen engagement. We have already begun phase 2 of the project incorporating refinements. Together, these efforts underscore the momentum we are building with both internal teams and community partners to expand the impact of CHW services across Alameda County.

Project Status Updates:

CHW 12+ Unit SR Module Development Project	✏ In Progress
CHW Billing Mitigation Reports	🌀 Ongoing
CHW Program Integration Strategy – Revisions	✏ In Review
CHW Hiring Process	📌 Pending
CHW Eden I&R Design Thinking Session 1	✅ Complete
CHW Benefit Cross Walk Interdepartmental Project	✅ Complete
Member facing Materials Design	✏ In Progress

CHW Program – Recruitment Efforts:

- As of this reporting month, there are no new changes to Community Health Strategy program recruitment. The program has successfully recruited fourteen (14) Community Health Worker (CHW) provider organizations to deliver CHW interventions for Alliance members, with two (2) contracts still pending and twenty-five (25) provider organizations in the outreach phase awaiting follow-up. Importantly, no providers have declined to contract or been deemed ineligible, underscoring the continued strong interest in joining the CHW network.



- At present, we are experiencing minor delays in contract execution and application review, largely due to the operational complexities of implementing the new G-Codes. While recruitment efforts have not advanced further during this period, the team's focus has been on cultivating relationships with existing providers and untangling the new implementation requirements. Once resolved, these efforts will enable a smoother path forward and support a stronger onboarding cadence in the months ahead.

- Health Care Services and Alliance leaders continue to press forward with deep coordination and courageous spirit to keep pace with the high volume and strong interest from new CHW providers. Together, we remain eager and dedicated to expanding our reach across Alameda County, strengthening partnerships, and advancing health access for our members.

CHW Program – Program Highlights:

- Community Health Strategy & Population Health have exciting pilots on the horizon to address health disparities.

- Project 1: Addressing Fatty Liver – CHW Health Education Pilot
    - Status: Pending Executed Agreement
        - Quick Summary: The Fatty Liver Equity Pilot is a partnership between Alameda Alliance, MacArthur GI (Medical Group /CHW provider) and Journey Health (Medical Group/CHW provider) designed to address non-alcoholic fatty liver disease (NAFLD) among Alameda Alliance for Health members. The program integrates clinical screening and CHW-led interventions to identify members at risk, engage them in lifestyle modifications, and reduce progression to costly, high-intensity treatments.

- Project 2: Addressing Perinatal Depression – CHS & PHM Health Education Pilot
    - Status: Go Live Scheduled for October, pending contract signatures
        - Quick Summary: The Alameda Alliance for Health is partnering with Our Roots Organization to launch a perinatal depression pilot aimed at addressing maternal mental health disparities. Through CHW interventions, this program aims to provide culturally responsive outreach, peer navigation, and psychosocial support to build trust and reduce stigma and increase care coordination by connecting birthing people to behavioral health providers, social supports, and community resources

Quality

- The clinical team in QI is responsible for triaging all PQI types as they are received. This process involves assignment to an appropriate reviewer for assessment, planning, intervention and evaluation. Quality of Access issues are reviewed by the Access & Availability team and Quality of Language issues by the Cultural & Linguistics Services 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 Medical Director.

- Quality Improvement continues to track and trend PQI Turn-Around-Time (TAT) compliance. Per the recommendation of the CMO, the TAT goal for all PQIs was approved in August for change from 120 to 150 days from receipt to resolution. QOC cases involve nurse investigation and procurement of medical records and/or provider responses followed by final MD review when applicable. Corrective Action Plans are issued after the case is closed and where applicable.

- When cases are open past TAT, the reason is typically 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.

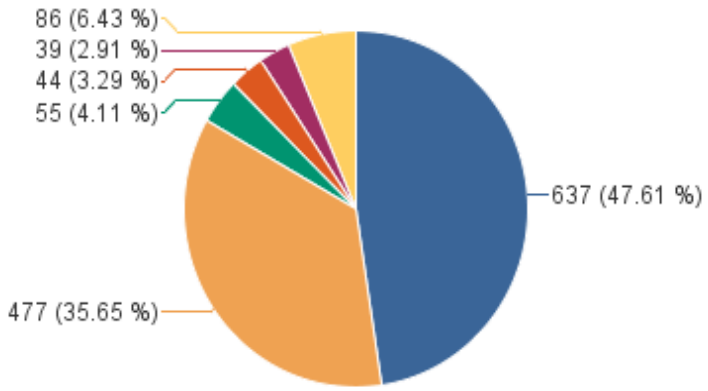
- Since November 2024, there has been a slower rate of MD case closure of Quality of Care (QOC) cases due to the vacancy of the QI Medical Director role. The Plan has been actively seeking a replacement since that time, and a new QI Medical Director was hired since the last BOG report was issued.

- The PQI Aging Reports shown below for August was based on the original 120-day TAT. The new TAT was increased to 150 days in September 2025 and are reflected as such. The August rate was 92.73% and in September, the rate was 93.57%, which are both below the standard of 95%. With the addition of the new QI Medical Director in October, it is expected that TATs will come back into compliance.

- To ensure appropriate and timely care coordination, upon initial assessment, the RN case owner makes necessary referrals when appropriate to CMDM and/or alerts QI leadership concerning issues or trends that need to be addressed prior to final MD review to prevent delays in necessary interventions and/or prevent future similar incidents.

- As always, the PQI process aims to support best practices in providing the highest level of care to Alliance members.

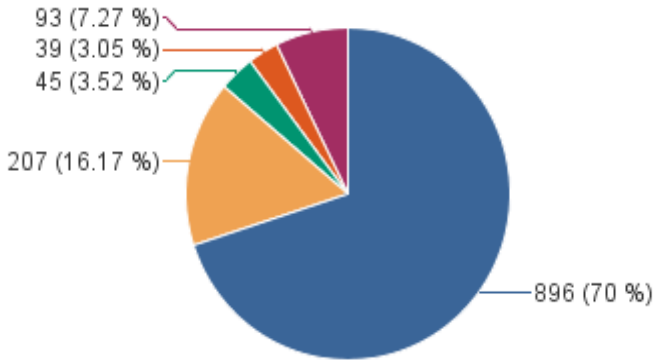
PQI Aging Report as of 09/30/2025 N= 1,338



TAT_Bracket

1. <=30 2. >30<=60 3. >60<=90 4. >90<=120 5. >120<=150 6. >150

PQI Aging Report as of 08/31/2025 N= 1,280



TAT_Bracket

1. <=30 2. >30<=60 3. >60<=90 4. >90<=120 5. >120

Provider Satisfaction Survey

- Survey Objective: The Provider Satisfaction Survey targets providers to measure their satisfaction with Alameda Alliance for Health. Information obtained from these surveys allows plans to measure how well they are meeting their providers' expectations and needs. The Provider Satisfaction Survey typically fielding from September to November of each year.

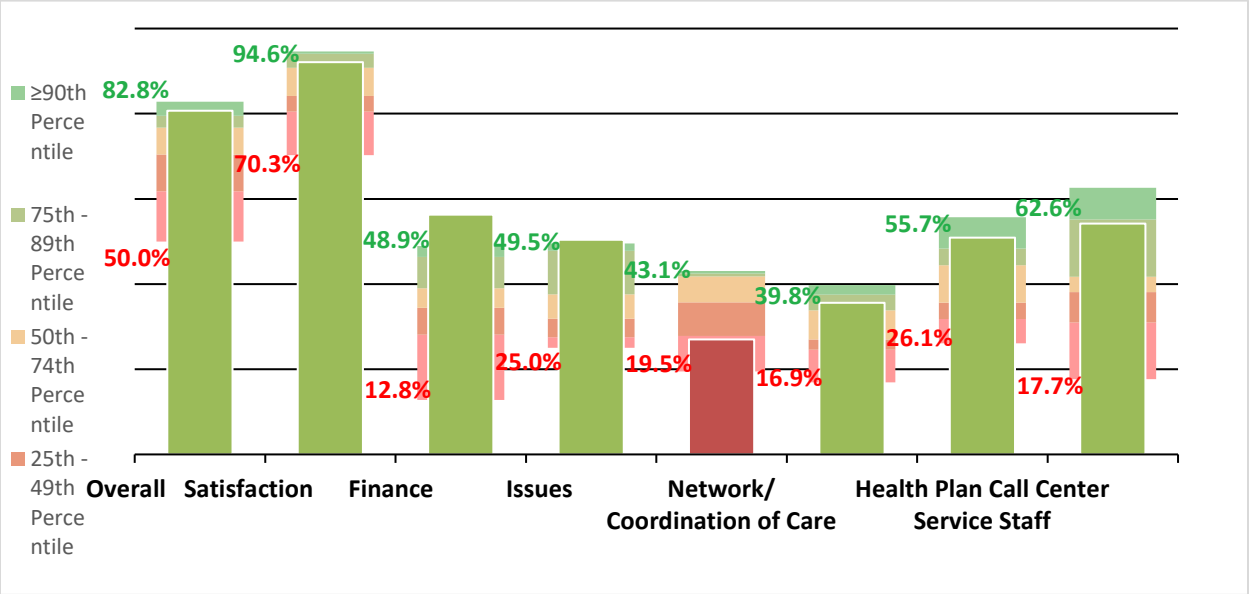
Provider Satisfaction Composite Scores

Composite	MY 2024 Result	Variance Compared to Previous Year	Variance Compared to PG Commercial Benchmark BoB	MY 2023 Result	MY 2022 Result
Overall Satisfaction	**80.7%**	Higher	Significantly Higher	78.4%	86.3%
All Other Plans (Comparative Rating)	**64.1%**	Higher	Significantly Higher	55.3%	53.5%
Finance Issues (Claims)	**56.3%**	Higher	Significantly Higher	49.0%	44.3%
Utilization and Quality Management	**50.4%**	Higher	Significantly Higher	47.5%	50.6%
Network/Coordination of Care	**27.0%**	Lower	N/A	41.7%	31.2%
Pharmacy	**35.6%**	Lower	N/A	38.1%	31.6%
Health Plan Call Center Service Staff	**50.9%**	Higher	Significantly Higher	49.2%	51.3%
Provider Relations	**54.2%**	Lower	Significantly Higher	62.7%	56.7%

- The Alliance identified higher composite scores in 5 of 8 measures compared to MY 2023 scores.

- Six (6) of the 8 composites scores are significantly higher than the vendor (PG) commercial BoB scores.

Comparison Relative to PG Book of Business



Green bar = AAH performing at or above the 75th percentile
Red bar = AAH performing below the 25th percentile

- Survey results indicate that the Alliance is performing above the 75th percentile for all except one measure. The remaining measure performs below the 25th percentile.

Key Drivers of Overall Satisfaction with Health Plan

SRS: 80.7% %tile: 95th	SRS: 92.1% %tile: 83rd	SRS: 56.3% %tile: 100th	SRS: 50.4% %tile: 100th	SRS: 27.0% %tile: 12th	SRS: 35.6% %tile: 83rd	SRS: 50.9% %tile: 95th	SRS: 54.2% %tile: 89th

Power: Promote and leverage Strengths (Top 5 Listed)

- Timeliness of plan decisions on urgent prior authorization request
- Timeliness of plan decisions on routine prior authorization requests
- Procedures for obtaining pre-certification/referral/authorization information
- Health Plan call center staff helpfulness in assisting with the referral process or referral network
- Timeliness of obtaining pre-certification/referral/authorization information

Health Equity

Lao Paul Vang

From: **Lao Paul Vang, Chief Health Equity Officer**

Date: **October 10th, 2025**

Subject: **Health Equity Report**

Internal Collaboration

- **Ongoing 1x1 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**
  - The monthly meetings continue to foster collaboration and partnership across various functional groups within AAH. As a result of the workgroup, potential partnership projects are in the pipeline:
    - Allen Temple Baptist Church
    - Glad Tidings International Church of God

- **NCQA Health Equity Related Issues**
  - As of August 2025, the Alliance is officially NCQA accredited for Health Equity (HE) for both Medi-Cal and Group Care lines of business for a period of three years.

- **PHM Workgroup**
  - The Health Equity team continues to collaborate with the PHM team and participates in the weekly PHM workgroup, including reviewing new PHM strategies for the upcoming 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 on overcoming over- and underutilization.

External Collaboration

- **Bi-weekly meetings with Local Health Plans' Chief Health Equity Officers (CHEOs) Update**
  - Ongoing discussions regarding health equity-related issues and DEI training curriculum.

- **Monthly Meetings with DHCS' Chief Health Equity Officer (DHCS CHEO) Update**
  - The DHCS CHEO and MCPs CHEOs meet to collaborate on Health Equity and DEI initiatives.
  - The meeting included updates from DHCS and CHEO.

- **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, discuss potential risks and assist with moving the DEI Training forward**.**

Alliance Health Equity Strategic Roadmap Update

- The Health Equity Team is currently assessing and planning to implement two initial milestones for FY25-26. As milestones are implemented, updates will be available to show all activities and achievements accordingly.

- NEW initiatives:

  A) SDOH Mitigation exploration with Direct Engagement with Providers; beginning Sept 2025, Health Equity, in partnership with the QI team, began direct engagement with providers in the bimonthly quality meeting series, with the goal to explore potential partnerships for SDOH Mitigation Measures (Milestone # 6), specifically food-is-medicine.
    - Tiburcio Vasquez: 9-11-2025
    - La-Clinica St Antonia Health Center 9-12-2025
    - Axis: 9-24-2025

  B) Collaboration with Alameda Health System (AHS) to address HEDIS measures through the lens of Health Equity
    - Through the $20,000 grant awarded by the California Healthcare Foundation, the Health Equity team will collaborate with the AHS pediatric team to implement their Beloved Black Baby.
    - The grant intervention is 10 months from October 2025 to August 2026.

  Below, please find the six milestones for your reference:

Milestone	Goals
1. Organization Transformation	a) CHEO collaborates with SLT to facilitate a system-wide organizational 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 24-016 (APL 23-025) and APL 24-017 TGI-SB 923 training. b) Collaboration with Culture and Linguistics, 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 the Community and Outreach to develop effective communications for all aspects of health equity activities to ensure that staff and members are fully informed.
5. Community Engagement	a) Initiated Provider's meetings, in partnership with QI team. b) The Faith-Based Community Engagement workgroup was established in December 2024 and was recently renamed the Community Engagement Workgroup to reflect more accurately our broader mission. c) CIN membership (2025-2027). d) Allen Temple Baptist church: potential collaboration in health education and outreach e) Oakland Unified School District: potential joint parents survey to identify SDOHs for food insecurity and healthcare access. f) Native American Health Center: supported the annual Indigenous Red Market event on July 6. g) Glad Tidings International Church of God: initiated conversation on July 24.
6. SDOH Mitigation Measures	a) Exploration of potential collaboration with selected providers to initiate Food-is-Medicine services. b) Collaborate with QI and PHM to identify high-value clinical partners who would co-develop a relevant intervention to address specific SDOH. c) Collaborate with CMO and HCS team to assess and analyze non-utilization data aimed at identifying health disparities.

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 with California Cardiovascular Consultants (CCC)
  - May – June 2025: pilot training completed.
  - July to Dec 2025: training given to subcontractors, downstream subcontractors, and network providers.

- **APL 24-018: TGI-SB 923 Update**
  - The Transgender, Gender Diverse, and Intersex (TGI) Cultural Competency Training was provided to all the Alliance staff.
  - The next step is to train our member-facing vendors, contractors, and downstream subcontractors, followed by training our providers.
    Timeline and completion rate:
  - Dec 2024: confirmation of vendor.
    - Jan-Feb 2025: Implementation of training for all Alliance staff.
    - Feb 14: 97% of the Alliance 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.
    - June 2025 to date: HE Team is working with the TGI work group to implement phase 2 and phase 3 of the training, which is member-facing vendors, contractors, and downstream subcontractors.

Diversity, Equity, Inclusion, and Belonging Committee (DEIBC) and Values in Action Committee (VIAC)

- **DEIB Committee Update**
  - The DEIB Committee met on September 5th and discussed its role and purpose, including integrating DEIB with VIA into a single committee that can effectively address all health equity and staff DEI-related issues. The committee voted unanimously in favor of doing so.

- **VIA Committee Update**
  - At the September 9th VIA committee meeting, the committee discussed the integration of VIA and DEIB into one committee. The committee requested that both the VIA and DEIB charters be sent to them before taking a vote at the next meeting.

Calendar of Community Engagements

CBO /FBO		Services	Status
1	California Improvement Network	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.	• AAH became one of the 25 lead agency partners to CIN in the grant cycle 2025-2027 • In-person meetings 5 times in 2 years • Attended the first in-person meeting in May 2025 • Received a one-time $4500 “education” grant in March 2025 • Successfully identified a partner, e.g., Alameda Health System, to apply for a mini grant of $20K for a Health Equity action project in August 2025 • Collaborator: QI
2	Oakland Catholic Workers	Provides transitional housing and resettlement resources to Central American refugees and immigrants.	• Collaboration began in March 2025 • Resource sharing • Collaborator: PHM
3	Black Women's Health Forum	Annual event to raise awareness about healthy living resources available to Black women in the Bay Area.	• Table event April 8th, 2025 • Collaborator: C&O
4	True Vine Ministries Church	Serves predominantly African Americans in the West Oakland area.	• RWJF Grant application of $250K submitted in June 2025 for a potential one-year grant-funded intervention to advance

			mental health healing through the arts. • The grant application was unsuccessful.
5	Native American Health Center	Native Americans and other PCP services, WIC, and dental.	• Collaboration began in December 2024 • Table at the annual Indigenous Red Market event on July 6th, 2025 • Collaborators: QI team
6	Allen Temple Baptist Church	A predominantly African American church established in 1919. They serve approximately 3,000 members and the broader community.	• Collaboration began in June 2025 • *Potential collaboration:* Co-design community survey with the church to identify needs and SDOHs • Collaborators: church, QI team
7	Oakland Unified School District (OUSD)	The largest school district in Alameda County, serving about 33,000 students in about 75 schools, K-12.	• Collaboration began in April 2025 • *Potential collaboration*: Co-design Parent Survey with OUSD to study food insecurity and SDOHs
8.	Glad Tidings International Church of God	The church was established in 1978 and is well-known in the Hayward community.	• Initiated meeting on July 24th • *Potential collaboration:* promoting resources in health education, e.g., Doula services, diabetes, and other chronic diseases.
9.	School-based Health Center in Madison Park Academy, Oakland	One of the eight school-based health centers operated by Native Americans.	• Visited the school clinic on July 8th • *Potential collaboration:* promote child health • Collaborator: QI
10.	Alameda Health System	One of the pediatricians who works predominantly with Black mothers and children.	• Successful grant application of $20K to implement a 10-month Beloved Black Baby Initiative (BBB) • Collaboration with the pediatrician to implement BBB: a culturally appropriate program designed to improve Well-Child measures and post-partum depression • Target start date: October 2025

ALAMEDA Alliance FOR HEALTH

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

Information Technology

Sasikumar Karaiyan

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

From: **Sasi Karaiyan, Chief Information & Security Officer**

Date: **October 10th, 2025**

Subject: **Information Technology Report**

Call Center System

- In August 2025, AAH phone systems and call center applications maintained 100% availability even as they supported 97% of employees working remotely.

- Starting October 1st, Call Center applications for DSNP Members and Providers are live and available daily from 8:00am to 8:00pm.

Encounter Data

- In the month of August 2025, the Alliance submitted 138 encounter files to the Department of Health Care Services (DHCS) with a total of 424,385 encounters.

Enrollment

- The Medi-Cal Enrollment file for the month of October 2025 was received and loaded to HEALTHsuite.

HEALTHsuite

- The Alliance received 373,025 claims in the month of September 2025.

- A total of 352,758 claims were finalized during the month out of which 313,683 claims auto adjudicated. This sets the auto-adjudication rate for this period to 88.9%.

TruCare

- A total of 23,329 authorizations were loaded and processed in the TruCare application.

- TruCare Application Uptime – 99.9%.

Intune Mobile Migration

- Intune mobile migration initiative is currently in progress.
- Standardized mobile device management under Microsoft Intune for improved security. The scope includes corporate mobile devices across all departments.
- Enrollment phase underway with 5% of devices migrated and the plan is to complete the migration before December 31, 2025.

Conference Room Upgrade

- Alliance is adding four new conference rooms, and these conference rooms are integrated with Microsoft Teams rooms, Zoom and/or any ad-hoc meeting.
- Expansion work is in progress and our plan is to complete them before October 15th, 2025.

SQL Server Upgrade to version 2022

- 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:

  - The Windows OS upgrade from 2016 to 2019 was successfully completed on September 20th for both SQLPROD and DBR1PROD. Phase 1 is complete.

  Phase 2:

  - SQL server migration from 2016 to 2022 needs to be completed.
  - This is being targeted for Q3 of 2025 and to be planned after phase 1 is completed.
  - Post compatibility monitoring stabilization will take place until end of June.

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.

- Remediation efforts for the annual IT penetration test findings are underway.

- Email authentication progress (Red Sift) – largest internal sender, M365, has been authenticated.

- IT hardening – remote desktop session timeout and deprecation of unsecure protocols (TLS 1.1 or lower).

Information Technology

Supporting Documents

Enrollment

- See Table 1-1 “Summary of Medi-Cal and Group Care member enrollment in the month of September 2025”.
- See Table 1-2 “Summary of Primary Care Physician (PCP) Auto-assignment in the month of September 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 September 2025

Month	Total MC[1]	MC[1] - Add/ Reinstatements	MC[1] - Terminated	Total GC[2]	GC[2] - Add/ Reinstatements	GC[2]- Terminated
September	405,445	6,903	10,128	5,975	190	110

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 September 2025

Auto-Assignments	Member Count
Auto-assignments MC	2,301
Auto-assignments Expansion	2,229
Auto-assignments GC	62
PCP Changes (PCP Change Tool) Total	4,592

TruCare Application

- See Table 2-1 “Summary of TruCare Authorizations for the month of September 2025”.
- There were 23,329 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 September 2025*

Transaction Type	Total Auths Received
Paper Fax to Scan (DocuStream)	2,924
Provider Portal Requests (Zipari)	6,176
EDI (CHCN)	7,547
Provider Portal to AAH Online (Long Term Care)	5
ADT	1,350
Behavioral Health COC Update - Online	46
Behavioral initial evaluation - Online	69
Manual Entry	3,289
OCR Face sheets	1,923
Total	23,329

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 August 2025

Group	Individual User Accounts	Individual User Accounts Accessed		Total Logins	New Users
Provider	8,872	6,498		519.430	863
MCAL	131,664	4,439		10,840	1,498
IHSS	4,124	77		906	18
Total	144,660	11,014		531,176	2,379

Table 3-2 Top Pages Viewed for the Month of August 2025

Category	Page Name	Page Views
Provider - eligibility/claim	Member Eligibility	1690469
Provider - Claims	Claim Status	262537
Directory Config	Provider Directory	10622
Provider - authorizations	Auth Search	10237
Provider - authorizations	Auth Submit	7676
Provider - Claims	Submit professional claims	7035
Member My Care	Member Eligibility	5781
Member Help Resources	Find a Doctor or Hospital	3905
Member Help Resources	ID Card	3632
Member Config	Provider Directory	3461
Provider - eligibility/claim	Member Roster	2768
Member Home	MC ID Card	2456
Member Help Resources	Select or Change Your PCP	2390
Member My Care	My Claims Services	1571
Provider - Home	Behavior Health Forms SSO	1526
Provider - Provider Directory	Provider Directory 2019	1017
Member My Care	Authorization	972
Provider - Home	Long Term Care Forms SSO	764
Provider - Home	Forms	599
Member My Care	My Pharmacy Medication Benefits	552
Provider - reports	Reports	547
Member My Care	Member Benefits Materials	456
Member Help Resources	Forms Resources	369
Member Help Resources	FAQs	355
Member Help Resources	Authorizations Referrals	351

Call Center – Call Volume Overview:

Members - Call Center Statistics			
Month	Calls Presented	Calls Handled	Calls Abandoned
April	15436	10925	1420
May	13306	10204	999
June	12594	9969	969
July	14228	10876	1389
August	13903	10487	1291
September	14280	11457	1253

Providers - Call Center Statistics			
Month	Calls Presented	Calls Handled	Calls Abandoned
April	11128	8864	1768
May	10018	8263	1328
June	11255	8140	2323
July	11601	9503	1629
August	11243	8692	1926
September	11421	8473	2182

- Calls Presented: Total number of calls received.
- Calls Handled: Total number of calls answered.
- Calls Abandoned: Calls abandoned before being completely answered.

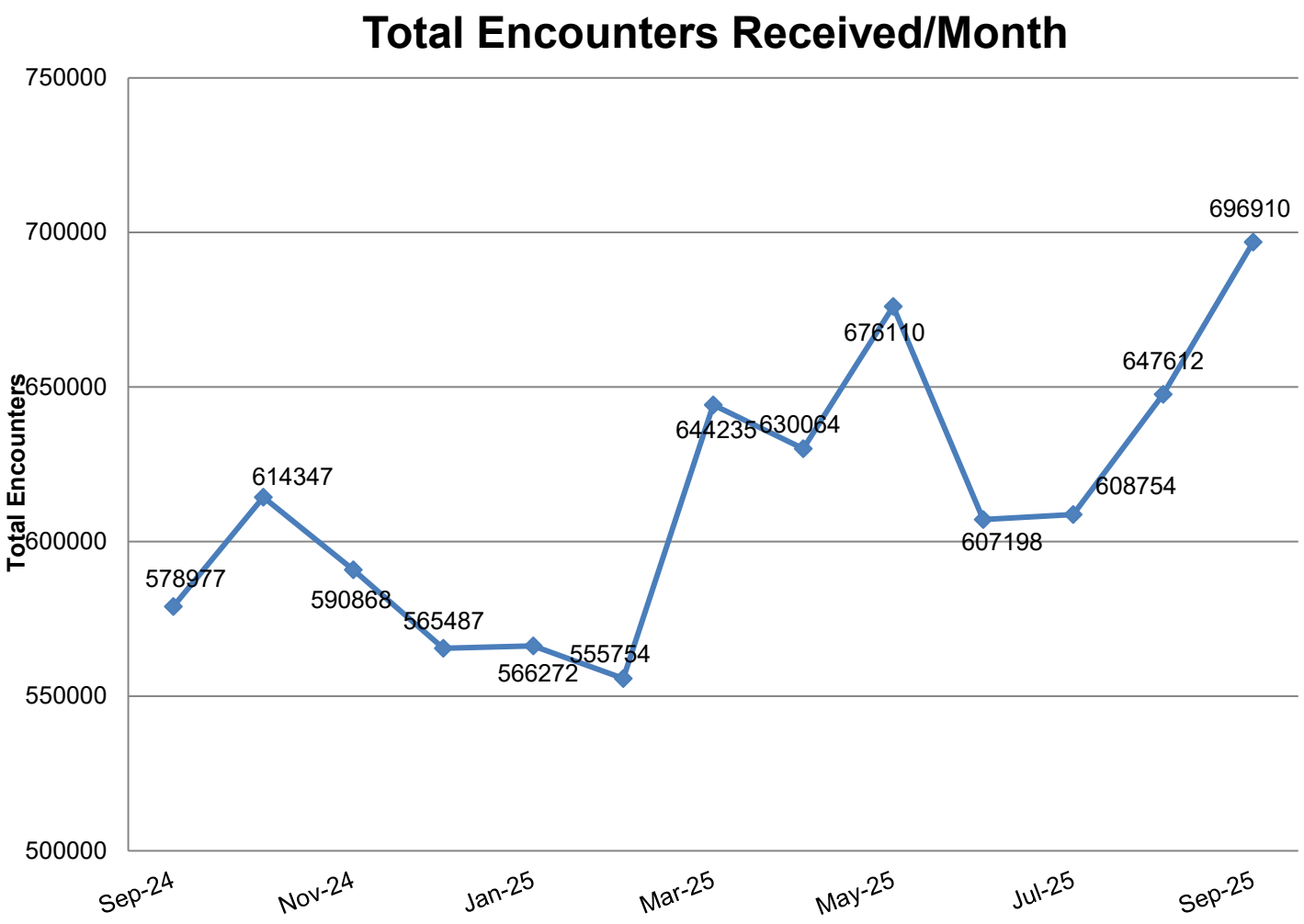
Note: It is important to note that there is a slight discrepancy between the number of calls presented, handled, and abandoned. This discrepancy is due to calls being rerouted to the XAQT vendor, which are not included in the calls handled or abandoned statistics. This rerouting can account for some of the differences observed in the totals.

Encounter Data from Trading Partners 2025

- **AHS**: September weekly files (8,455 records) were received on time.
- **BACH**: September monthly files (180 records) were received on time.
- **BACS**: September monthly files (100 records) were received on time.
- **CHCN**: September weekly files (170,744 records) were received on time.
- **CHME**: September monthly files (8,228 records) were received on time.
- **CFMG**: September weekly files (20,280 records) were received on time.
- **Docustream**: September monthly files (423 records) were received on time.
- **EBI**: September monthly files (1,800 records) were received on time.
- **FULLCIR**: September monthly files (5,006 records) were received on time.
- **HCSA**: September monthly files (2,930 records) were received on time.
- **IOA**: September monthly files (1,377 records) were received on time.
- **Kaiser**: September bi-weekly files (0 records) were received on time.
- **LAFAM**: September monthly files (74 records) were received on time.
- **LIFE**: September monthly files (245 records) were received on time
- **LogistiCare**: September weekly files (62,760 records) were received on time.
- **March Vision**: September monthly files (8,374 records) were received on time.
- **MED**: September monthly files (1,172 records) were received on time.
- **OMATOCHI**: September monthly files (0 records) were received on time.
- **PAIRTEAM**: September monthly files (9,446 records) were received on time.
- **Quest Diagnostics**: September weekly files (18,001 records) were received on time.
- **SENECA**: September monthly files (188 records) were received on time.
- **SERENE**: September monthly files (0 records) were received on time.
- **TITANIUM**: September monthly files (4,102 records) were received on time.
- **TVHC**: September monthly files (0 records) were received on time.
- **Magellan**: September monthly files (498,214 records) were received on time.

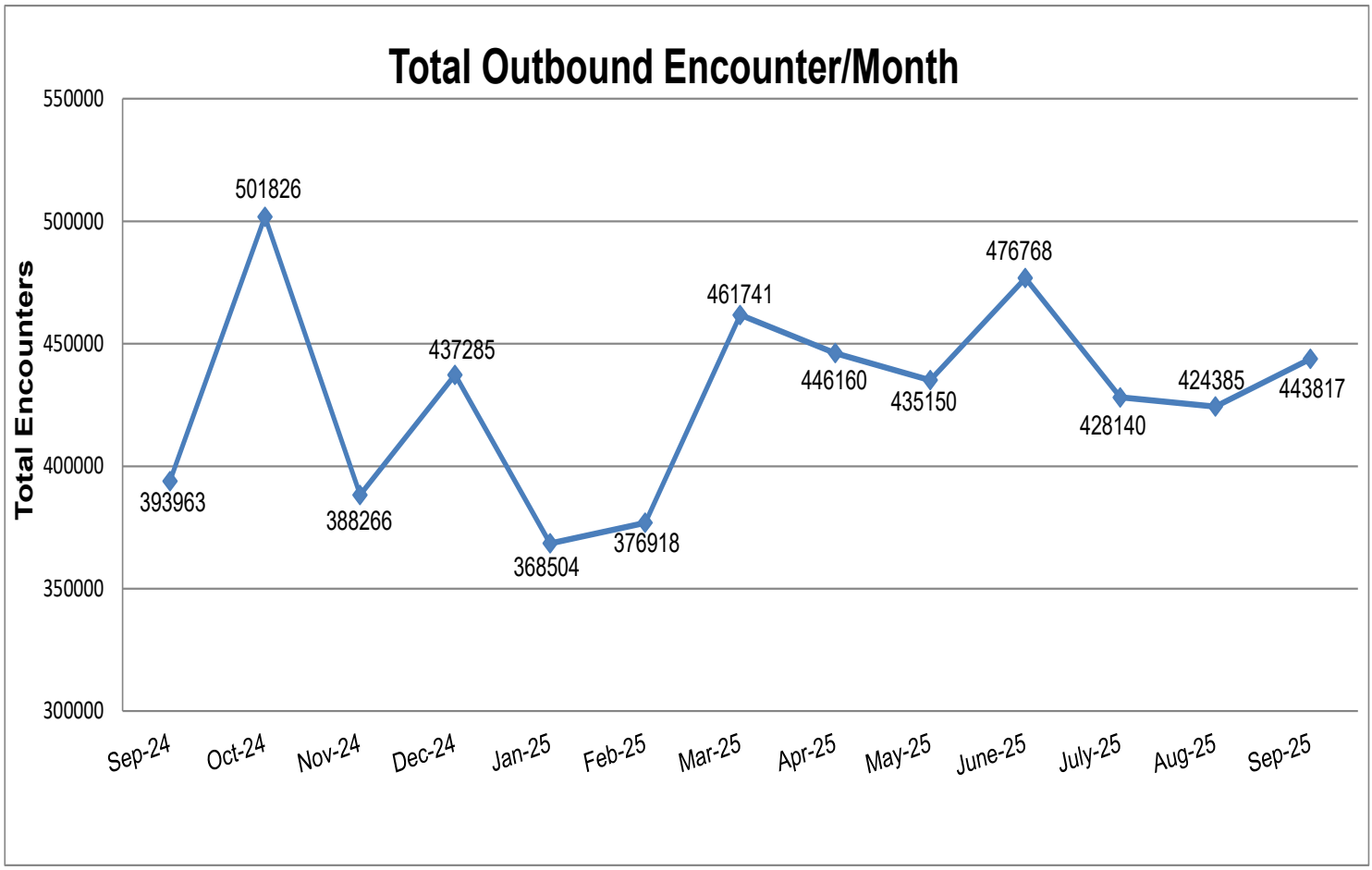
Trading Partner Encounter Inbound Submission History

Trading Partners	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Health Suite	322196	367989	364130	332108	339760	339840	347469	372126	387564	340224	355255	389082	372025
AHS	7498	8309	10535	7261	9709	8654	9273	8211	15875	7712	7880	10257	8455
BACH			795		426		291	131		296	172	172	180
BACS	85	76	98	104	93	113	81	72	88	128	81	82	100
CHCN	155825	125042	127223	127327	117483	118972	181049	117350	151416	170810	125697	132885	170744
CHME	7680	7102	7589	7458	7781	7553	6794	8293	9045	8638	8115	8368	8228
CFMG	16421	16045	21352	16696	13536	17329	21767	15856	21443	15710	13266	13336	20280
Docustream	1067	704	678	828	694	808	770	891	1068	1052	1216	707	423
EBI	3394	1640	1725	1476	1440	1597	1390	2926	1457	1381	2946	1940	1800
FULLCIR	3809	2523	2038	1085	806	1534	2099	2025	1479	1441	3266	3972	5006
HCSA	3386	2389	3423	2335	2432	2725	2118	2384	2628	2467	2671	2453	2930
IOA	4227	588	1064		3008	933	736		2068	3083	1851	635	1377
Kaiser	236	159											
LAFAM	63	89	76	83	112	96	85	93	101	81	85	83	74
LIFE	168	119	335	997	228	267	431	317	1274	412	388	541	245
LogistiCare	16139	49941	16183	34122	28671	32550	33754	55059	35875	15025	38834	34040	62760
March Vision	5769	5143	6016	6285	15146		6985	6704	7929	8100	6914	7877	8374
MED	610	645	656	619	758	1182	775		1581	958	2722	1246	1172
OMATOCHI													
PAIRTEAM	9359	1108	2204	5816	3436		2055	16360	9244	7724	15956	14426	9446
Quest	18004	18002	22501	18003	18002	18001	22502	18003	22501	18000	18000	22500	18001
SENECA	101	105	117	131	1	69	129	108	109	160	76		188
SERENE				654	107		209				581		
TITANIUM	2815	6192	1537	2099	2487	3531	2855	3039	2970	3792	2782	3010	4102
TVHC	125	437	593		156		618	116	395				
Total	578977	614347	590868	565487	566272	555754	644235	630064	676110	607194	608754	647612	696910


Total Encounters Received/Month
Total Encounters
750000
700000
650000
600000
550000
500000
578977
614347
590868
565487
566272
555754
644235
630064
676110
607198
608754
647612
696910
Sep-24
Nov-24
Jan-25
Mar-25
May-25
Jul-25
Sep-25

Outbound Encounter Submission

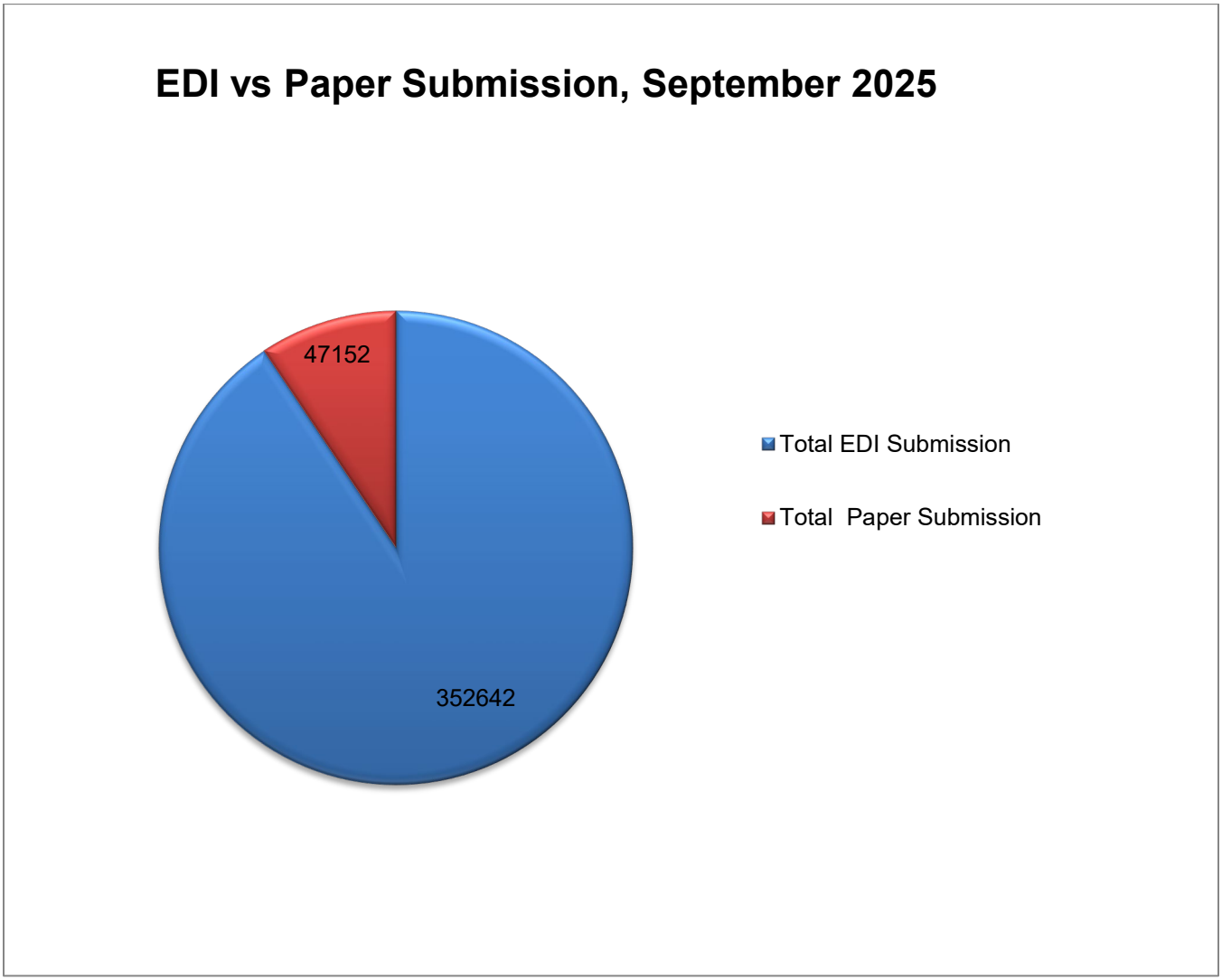
Trading Partners	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Health Suite	210971	276473	218194	263242	182192	205804	264948	210745	226401	284779	212832	228707	246133
AHS	8727	8201	10403	6850	7710	8135	7952	4510	9326	14010	7038	10166	8358
BACH			739	6	407		272	110		270	138		147
BACS	78	74	79	41	128	87	59	23	51	59	60	52	82
CHCN	87806	108806	88573	84649	85439	82973	95918	115571	106733	98329	106648	92163	89837
CHME	6994	6974	7474	7342	7426	7167	6682	8156	8914	8471	7991	8232	8090
CFMG	24076	13152	13882	11342	9362	11960	15008	11394	12430	13853	9238	9252	10764
Docustream	715	545	482	239	634	559	478	551	540	385	381	192	131
EBI	3242	1559	1641	494	2208	1475	1308	1493	1346	1328	1885	1745	1634
FULLCIR	1515	1767	1470	79	1298	1251	1823	1658	1155	1236	2889	3407	2713
HCSA	3310	2376	3394	2255	2497	2693	2103	2332	2603	2448	2637	2430	2871
IOA	1374	549	949		2783	781	626		48	1836	1732	551	1176
Kaiser	216	62		23									
LAFAM	58	86	62	3	178	89	80	84	90	67	80	76	69
LIFE	159	91	76	202	508	63	65	116	93	202	122	142	152
LogistiCare	16046	49705	15235	34035	28502	32441	33656	54971	35829	15010	38763	33974	36968
March Vision	4066	3543	3980	4156	9586	371	4354	3870	4591	4657	3888	4183	4724
MED	514	579	568	55	546	1083	731		595	553	2471	1124	974
PAIRTEAM	4617	782	1960	994	6334		1489	10873	4670	4549	9364	8386	8229
Quest	16937	21144	16909	21044	16828	16855	21048	16795	16853	21031	16774	16903	16855
SENECA	94	91	100	6	112	60	116	101	98	139	63		164
SERENE					82		20				569		
TITANIUM	2332	5267	1278	228	3600	3071	2551	2764	2714	3556	2577	2700	3746
TVHC	116		818		144		454	43	70				
Total	393963	501826	388266	437285	368504	376918	461741	446160	435150	476768	428140	424385	443817


Total Outbound Encounter/Month
Total Encounters
550000
500000
450000
400000
350000
300000
393963
501826
388266
437285
368504
376918
461741
446160
435150
476768
428140
424385
443817
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25
Apr-25
May-25
June-25
July-25
Aug-25
Sep-25

HealthSuite Paper vs EDI Claims Submission Breakdown

Period	Total EDI Submission	Total Paper Submission	Total claims
25-Sep	325,873	47,152	373025

Key: EDI – Electronic Data Interchange

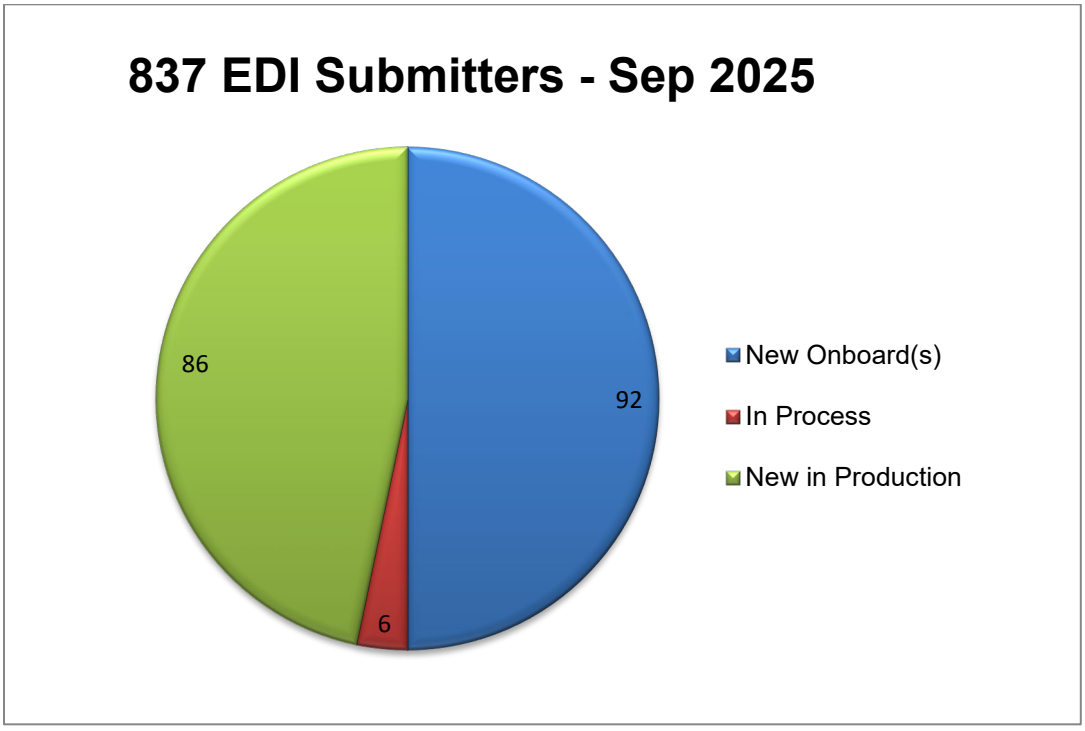


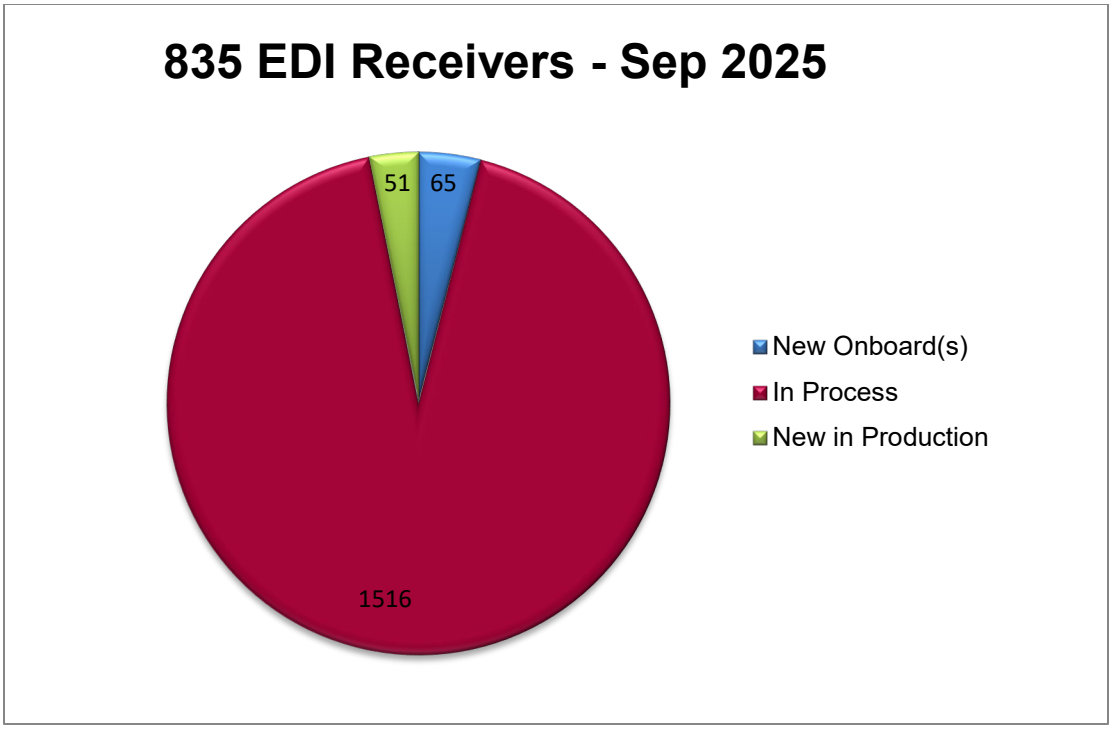
Onboarding EDI Providers – Updates

- September 2025 EDI Claims:
  - A total of 3206 new EDI submitters have been added since October 2015, with 86 added in September 2025.
  - The total number of EDI submitters is 3946 providers.

- September 2025 EDI Remittances (ERA):
  - A total of 1504 new ERA receivers have been added since October 2015, with 51 added in September 2025.
  - The total number of ERA receivers is 1520 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
Oct-24	60	4	56	3479	80	1071	36	1174
Nov-24	61	20	41	3520	89	1131	29	1203
Dec-24	61	22	39	3559	97	1177	51	1254
Jan-25	61	8	53	3612	79	1234	22	1276
Feb-25	58	16	42	3654	83	1286	31	1307
Mar-25	46	3	43	3697	74	1328	32	1339
Apr-25	38	14	24	3721	63	1370	26	1365
May-25	47	3	44	3765	77	1402	45	1410
Jun-25	52	25	27	3792	62	1445	19	1429
Jul-25	52	0	52	3844	60	1487	18	1447
Aug-25	35	19	16	3860	37	1502	22	1469
Sep-25	92	6	86	3946	65	1516	51	1520





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 **September** 2025.

File Type	Sep-25
837 I Files	27
837 P Files	108
Total Files	135

Lag-time Metrics/Key Performance Indicators (KPI)

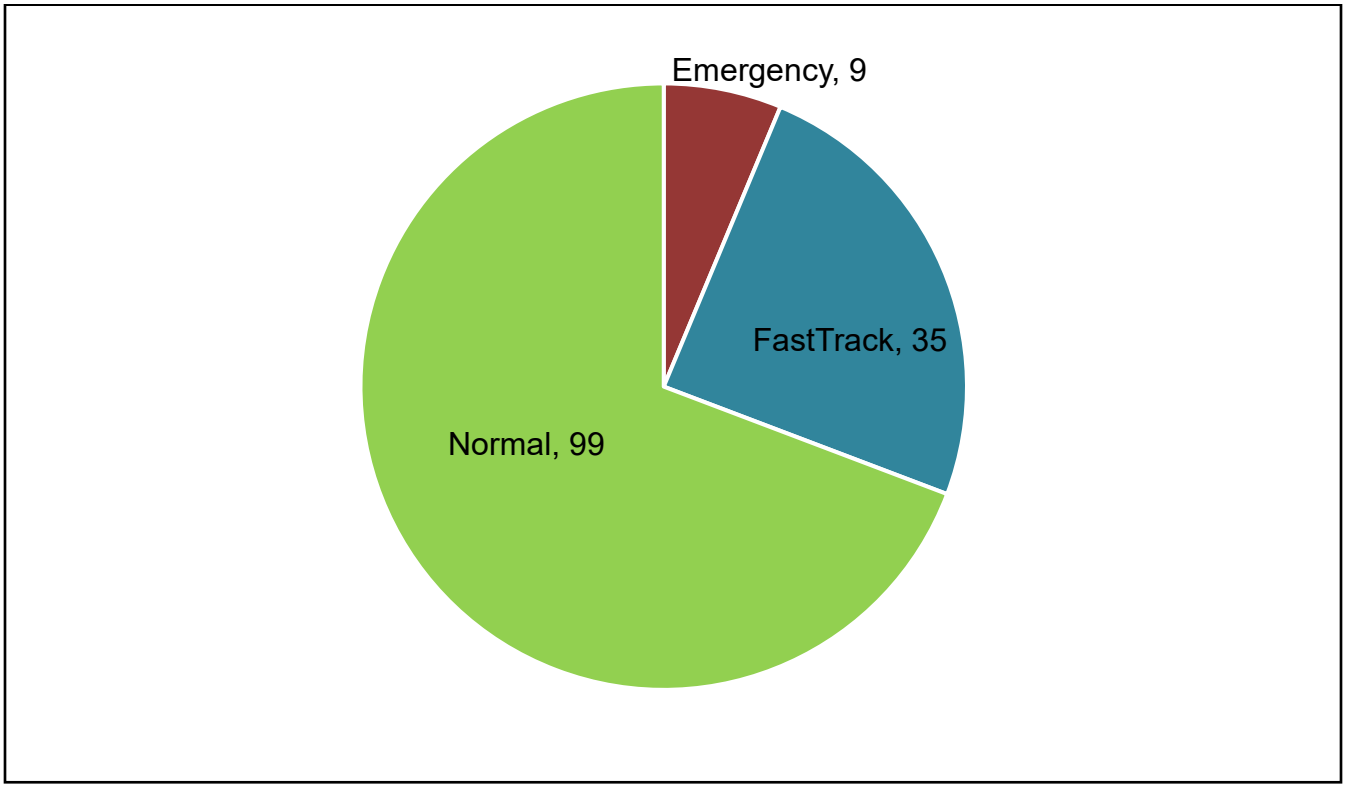
AAH Encounters: Outbound 837	Sep-25	Target
Timeliness-% Within Lag Time - Institutional 0-90 days	91%	60%
Timeliness-% Within Lag Time - Institutional 0-180 days	97%	80%
Timeliness-% Within Lag Time - Professional 0-90 days	93%	65%
Timeliness-% Within Lag Time – Professional 0-180 days	98%	80%

*Note, the Number of Encounters comes from: Total at bottom of this chart: **Outbound Encounter Submission**

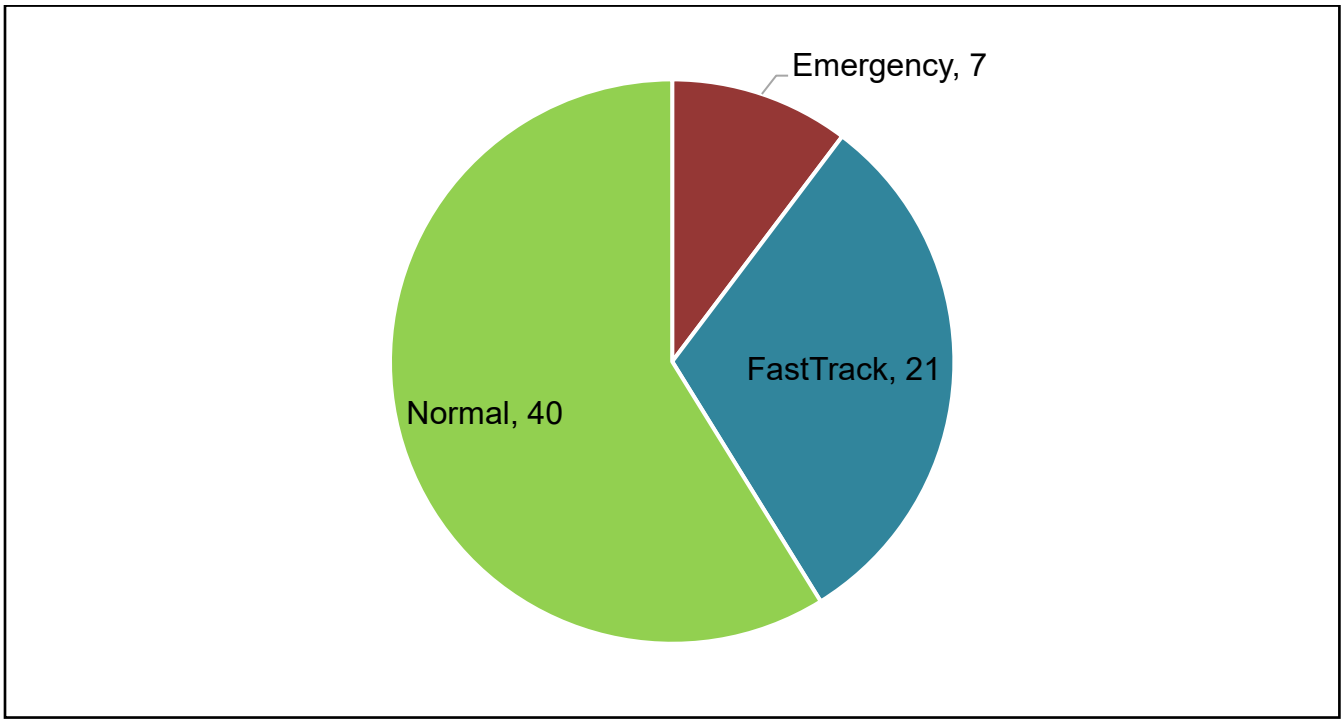
Change Management Key Performance Indicator (KPI)

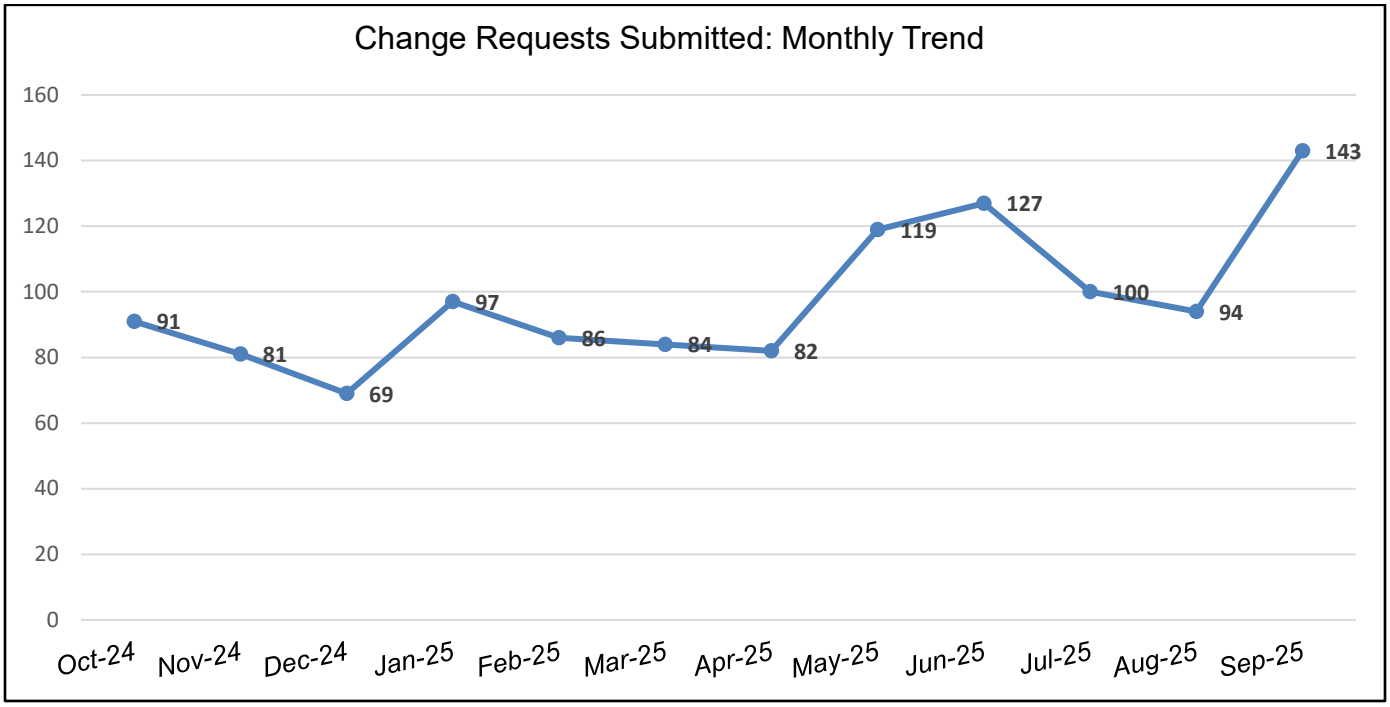
- Change Request Overall Summary in the month of September 2025 KPI:
  - 143 Changes Submitted.
  - 68 Changes Completed and Closed.
  - 188 Active Change Requests in pipeline.
  - 4 Change Requests Cancelled or Rejected.

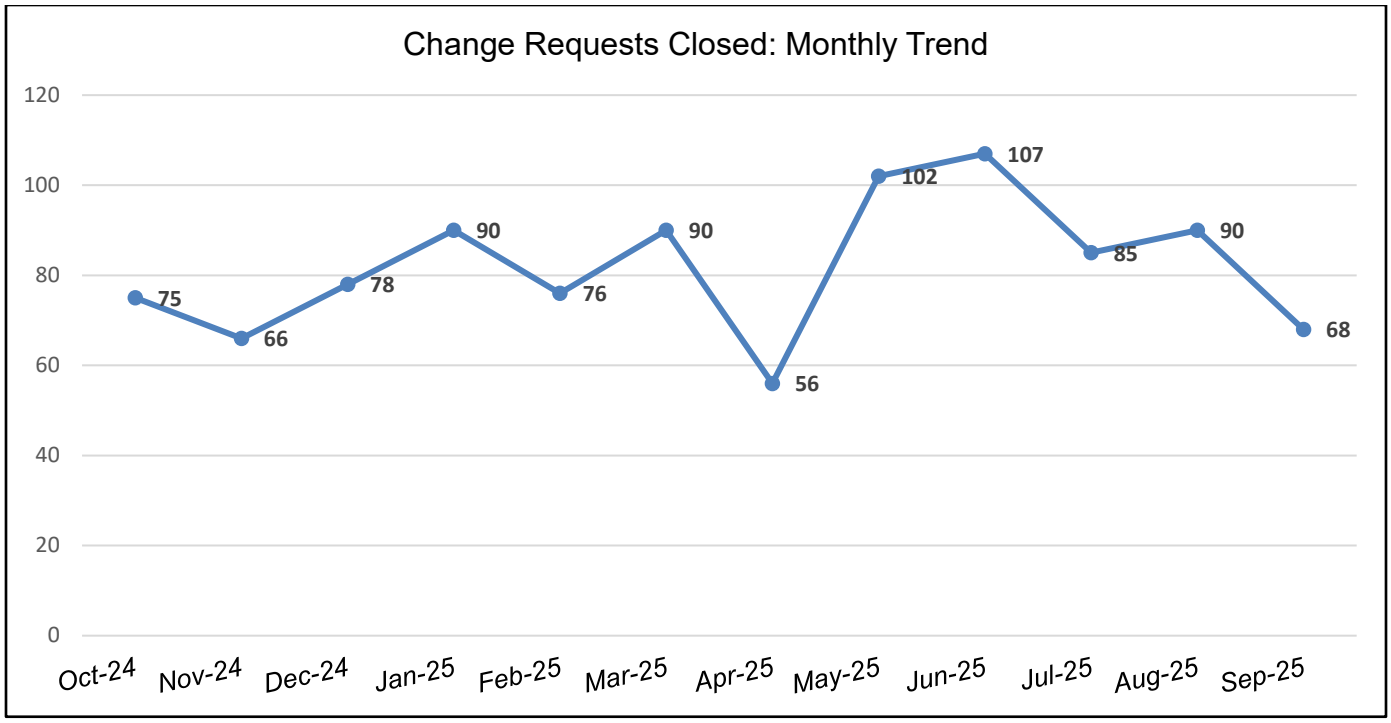
- 143 Change Requests Submitted/Logged in the month of September 2025



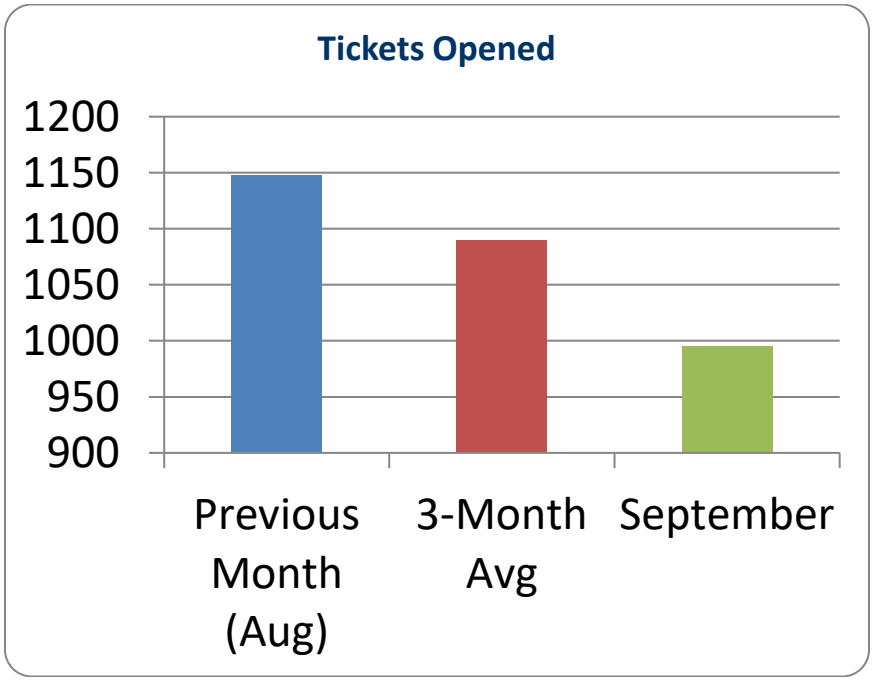
- 68 Change Requests Closed in the month of September 2025



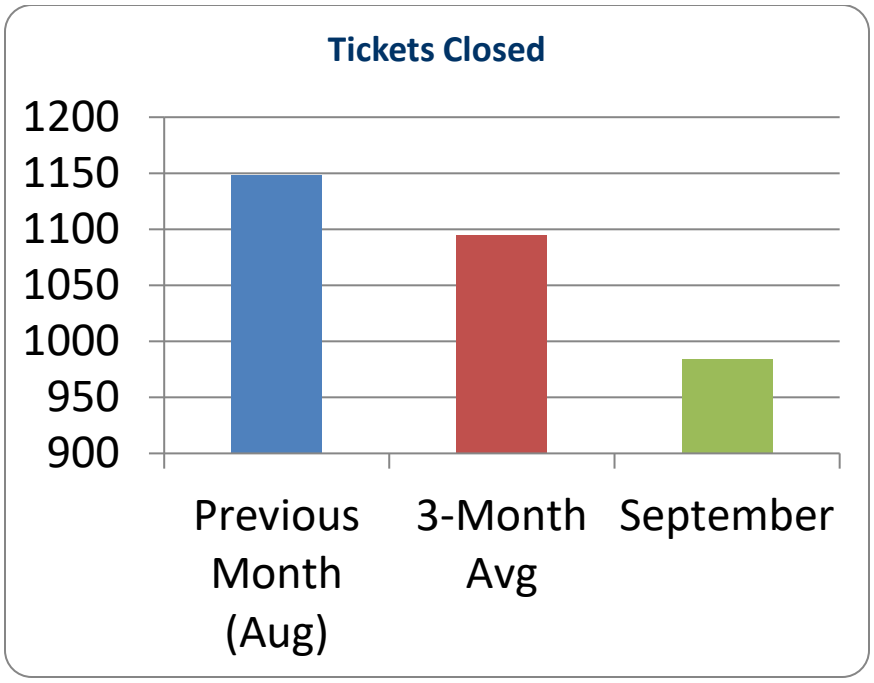




IT Stats: Service Desk



- Tickets Opened: 995 in September, ↓13.33% vs. last month (1148) and ↓8.71% vs. 3-month avg (1090).



Tickets Closed: 984 in September, ↓14.29% vs. last month (1148) and ↓10.14% vs. 3-month avg (1095).

IT Stats: Security

Areas	Item Status
Ops.	• Completed ○ Established remediation framework for Nessus (JIRA), penetration test, and SRA. ○ Updated DNS for AAH's communication's webpage. ○ IT-006 policy drafted completed by ITSec. ○ Trued-up DUO license usage and renewal. • Upcoming/Underway ○ Resume work on SRA findings ○ Troubleshooting Bloodhound service account. ○ Continued effort EoL/EoS software removal (3rd party). ○ Arctic Wolf working on aligning security dashboard mockup.
Projects	• Network Segmentation (JIRA established) • PKI – prioritizing for Infra. (paused) • OKTA (SSO) and DUO (MFA) true-up.
GRC	• TrackIT for ops. and JIRA for project-based items • Continuation of policy revisions • Staging discussions with SLT regarding security reviews of new services/platforms.

ALAMEDA Alliance FOR HEALTH

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

Analytics

Tiffany Cheang

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

From: **Tiffany Cheang, Chief Analytics Officer**

Date: **October 10th, 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: July 2024 – June 2025 dates of service
Prior reporting period: July 2023 – June 2024 dates of service
(Note: Data excludes Kaiser membership data.)

- For the Current reporting period, the top 12.0% of members account for 89.6% of total costs.

- In comparison, the Prior reporting period was lower at 8.9% of members accounting for 83.6% of total costs.

- Characteristics of the top utilizing population remained fairly consistent between the reporting periods:

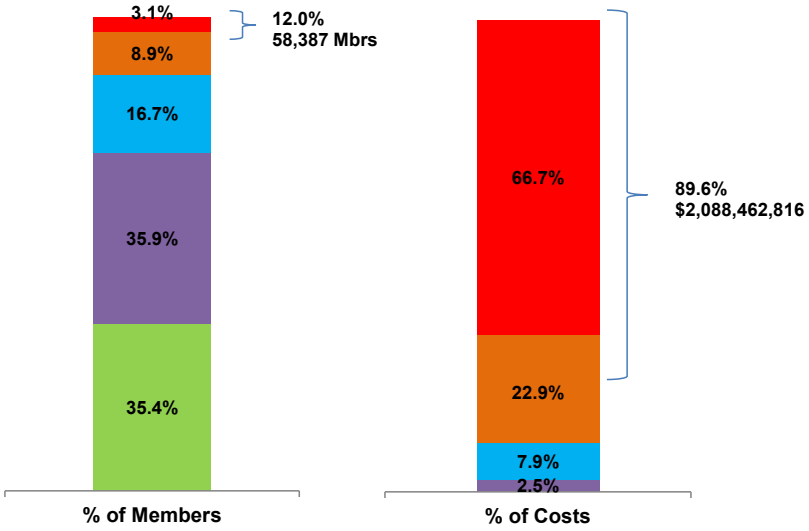
    - The SPD/LTC (non duals) and ACA OE categories of aid decreased to account for 54.0% of the members, with SPD/LTCs accounting for 18.3% and ACA OE's at 35.7%.
    - The percent of members with costs >= $30K increased from 2.4% to 3.1%.
    - Of those members with costs >= $100K, the percentage of total members has increased to 1.0%.
        - For these members, non-trauma/pregnancy inpatient costs continue to comprise the majority of costs, decreasing to 30.2%.
    - 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 12.0% is more concentrated in the 45-66 year old category (34.2%) compared to the overall population (20.7%).

Analytics

Supporting Documents

Alameda Alliance for Health - Analytics Supporting Documentation: Member - Cost Analysis
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Jul 2024 - Jun 2025
Note: Data incomplete due to claims lag
Run Date: 09/29/2025

Member Cost Distribution



Cost Range	Members	% of Members	Costs	% of Costs
$30K+	14,970	3.1%	$ 1,554,858,712	66.7%
$5K - $30K	43,417	8.9%	$ 533,604,104	22.9%
$1K - $5K	81,324	16.7%	$ 184,281,086	7.9%
< $1K	175,317	35.9%	$ 59,073,263	2.5%
$0	172,783	35.4%	$ -	0.0%
Totals	**487,811**	**100.0%**	**$ 2,331,817,166**	**100.0%**

Top 12.0% of Members = 89.6% of Costs

Cost Range	Members	% of Total Members	Costs	% of Total Costs
$100K+	4,960	1.0%	$ 1,016,482,700	43.6%
$75K to $100K	1,781	0.4%	$ 155,755,702	6.7%
$50K to $75K	2,891	0.6%	$ 175,872,822	7.5%
$40K to $50K	2,169	0.4%	$ 97,090,776	4.2%
$30K to $40K	3,169	0.6%	$ 109,656,713	4.7%
SubTotal	***14,970***	***3.1%***	***$ 1,554,858,712***	***66.7%***
$20K to $30K	6,282	1.3%	$ 152,084,879	6.5%
$10K to $20K	16,684	3.4%	$ 236,267,873	10.1%
$5K to $10K	20,451	4.2%	$ 145,251,353	6.2%
SubTotal	***43,417***	***8.9%***	***$ 533,604,104***	***22.9%***
Total	**58,387**	***12.0%***	**$ 2,088,462,817**	***89.6%***

Enrollment Status	Members	Total Costs
Still Enrolled as of Jun 2025	411,963	$ 2,105,296,118
Dis-Enrolled During Year	75,848	$ 226,521,048
Totals	**487,811**	**$ 2,331,817,166**

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
12.0% of Members = 89.6% of Costs
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Jul 2024 - Jun 2025
Note: Data incomplete due to claims lag
Run Date: 09/29/2025

12.0% of Members = 89.6% of Costs
18.3% of members are SPD/LTCs and account for 24.5% of costs.
35.7% of members are ACA OE and account for 33.0% of costs.
7.8% of members disenrolled as of Jun 2025 and account for 9.9% of costs.

Highest Cost Members: Cost Per Member >= $100K
26.6% of members are SPD/LTCs and account for 28.6% of costs.
27.2% of members are ACA OE and account for 30.5% of costs.
8.9% of members disenrolled as of Jun 2025 and account for 10.8% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Members	% of Members
IHSS	IHSS	205	997	1,202	2.1%
MCAL	MCAL - ADULT	1,300	8,027	9,327	16.0%
	MCAL - BCCTP	-	-	-	0.0%
	MCAL - CHILD	711	4,026	4,737	8.1%
	MCAL - ACA OE	4,886	15,978	20,864	35.7%
	MCAL - DUALS	-	-	-	0.0%
	MCAL - SPD-LTC	3,753	6,926	10,679	18.3%
	MCAL - SPD-LTC/Full Dual	2,614	4,403	7,017	12.0%
Not Eligible	Not Eligible	1,501	3,060	4,561	7.8%
Total		**14,970**	**43,417**	**58,387**	**100.0%**

Member Breakout by LOB

LOB	Eligibility Category	Total Members	% of Members
IHSS	IHSS	52	1.0%
MCAL	MCAL - ADULT	291	5.9%
	MCAL - BCCTP	-	0.0%
	MCAL - CHILD	88	1.8%
	MCAL - ACA OE	1,350	27.2%
	MCAL - DUALS	-	0.0%
	MCAL - SPD-LTC	1,318	26.6%
	MCAL - SPD-LTC/Full Dual	1,422	28.7%
Not Eligible	Not Eligible	439	8.9%
Total		**4,960**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Costs	% of Costs
IHSS	IHSS	$ 16,429,736	$ 11,785,748	$ 28,215,484	1.4%
MCAL	MCAL - ADULT	$ 126,858,341	$ 98,611,291	$ 225,469,632	10.8%
	MCAL - BCCTP	$ -	$ -	$ -	0.0%
	MCAL - CHILD	$ 54,499,204	$ 45,061,355	$ 99,560,559	4.8%
	MCAL - ACA OE	$ 493,346,138	$ 195,968,066	$ 689,314,204	33.0%
	MCAL - DUALS	$ -	$ -	$ -	0.0%
	MCAL - SPD-LTC	$ 421,391,410	$ 89,895,294	$ 511,286,704	24.5%
	MCAL - SPD-LTC/Full Dual	$ 273,340,507	$ 53,944,331	$ 327,284,838	15.7%
Not Eligible	Not Eligible	$ 168,993,377	$ 38,338,019	$ 207,331,396	9.9%
Total		**$ 1,554,858,712**	**$ 533,604,104**	**$ 2,088,462,817**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Total Costs	% of Costs
IHSS	IHSS	$ 8,598,934	0.8%
MCAL	MCAL - ADULT	$ 76,718,394	7.5%
	MCAL - BCCTP	$ -	0.0%
	MCAL - CHILD	$ 23,817,255	2.3%
	MCAL - ACA OE	$ 309,809,641	30.5%
	MCAL - DUALS	$ -	0.0%
	MCAL - SPD-LTC	$ 290,360,438	28.6%
	MCAL - SPD-LTC/Full Dual	$ 197,753,847	19.5%
Not Eligible	Not Eligible	$ 109,424,190	10.8%
Total		**$ 1,016,482,700**	**100.0%**

% of Total Costs By Service Type

Breakout by Service Type/Location

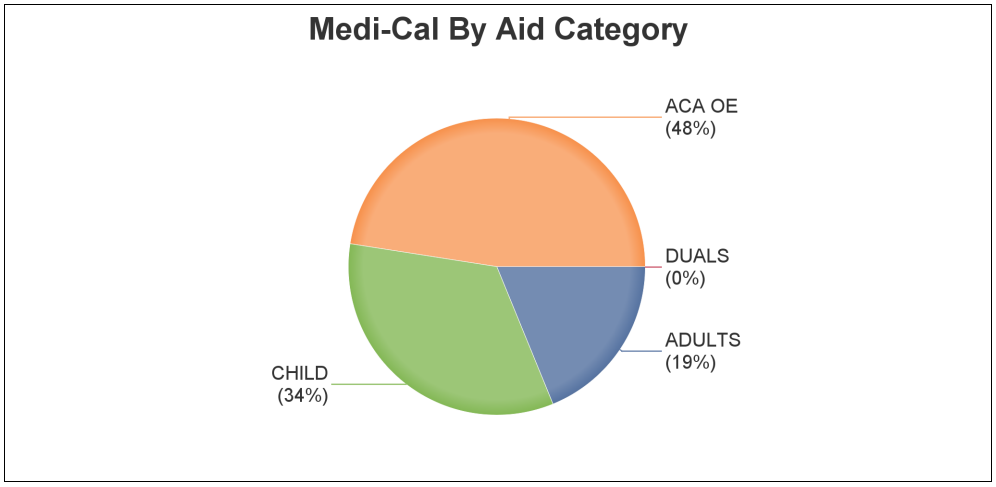
Cost Range	Trauma Costs	Hep C Rx Costs	Pregnancy, Childbirth & Newborn Related Costs	Pharmacy Costs	Inpatient Costs (POS 21)	ER Costs (POS 23)	Outpatient Costs (POS 22)	Office Costs (POS 11)	Dialysis Costs (POS 65)	Other Costs (All Other POS)
$100K+	5%	0%	1%	14%	35%	1%	11%	3%	2%	34%
$75K to $100K	3%	0%	1%	20%	25%	3%	6%	5%	5%	36%
$50K to $75K	5%	0%	2%	26%	29%	5%	6%	5%	4%	25%
$40K to $50K	6%	0%	1%	34%	26%	8%	5%	7%	1%	19%
$30K to $40K	10%	0%	3%	32%	22%	13%	6%	7%	1%	19%
$20K to $30K	2%	1%	5%	37%	22%	7%	8%	8%	1%	17%
$10K to $20K	0%	0%	11%	36%	23%	7%	9%	10%	1%	15%
$5K to $10K	1%	0%	5%	31%	11%	11%	13%	14%	1%	19%
Total	**4%**	**0%**	**3%**	**23%**	**29%**	**4%**	**9%**	**5%**	**2%**	**27%**

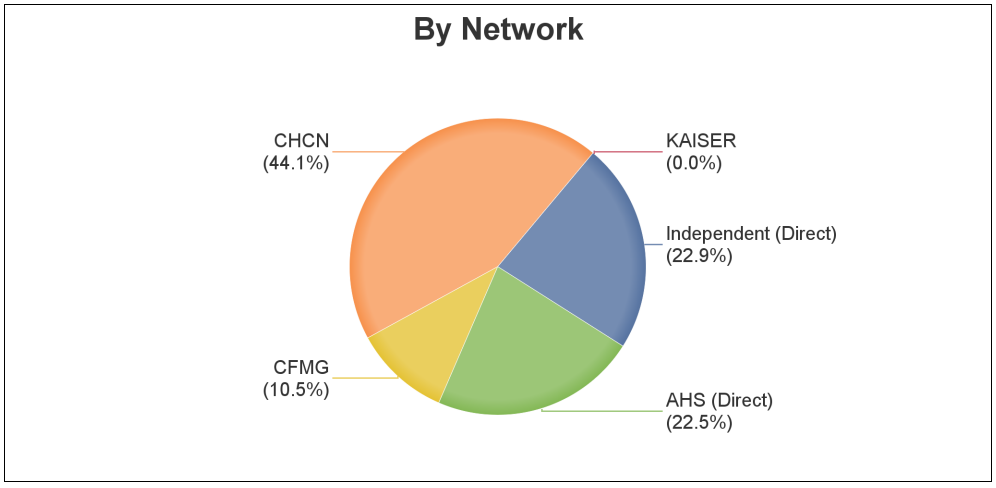
Notes:
- Report includes medical costs (HS & Diamond Claims, Beacon, Logisticare FFS, CHCN FFS Preventive Services, CHME) and pharmacy costs. IBNP factors are not applied.
- CFMG and CHCN encounter data has been priced out.
- Report excludes Capitation Expense

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend

Category of Aid	Aug 2025	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN
ADULTS	60,712	15%	12,562	14,438	0	33,712
CHILD	108,557	27%	10,092	13,678	39,816	44,971
SPD	0	0%	0	0	0	0
ACA OE	153,348	38%	27,779	53,591	1,549	70,429
DUALS	2	0%	2	0	0	0
LTC	0	0%	0	0	0	0
LTC-DUAL	0	0%	0	0	0	0
SPD-LTC	29,685	7%	8,649	5,430	1,500	14,106
SPD-LTC/Full Dual	49,372	12%	32,034	3,557	3	13,778
Medi-Cal	401,676		91,118	90,694	42,868	176,996
Group Care	5,974		2,182	1,075	0	2,717
Total	**407,650**	**100%**	**93,300**	**91,769**	**42,868**	**179,713**
Medi-Cal %	98.5%		97.7%	98.8%	100.0%	98.5%
Group Care %	1.5%		2.3%	1.2%	0.0%	1.5%
	Network Distribution		**22.9%**	**22.5%**	**10.5%**	**44.1%**
			% Direct:	**45%**	**% Delegated:**	**55%**

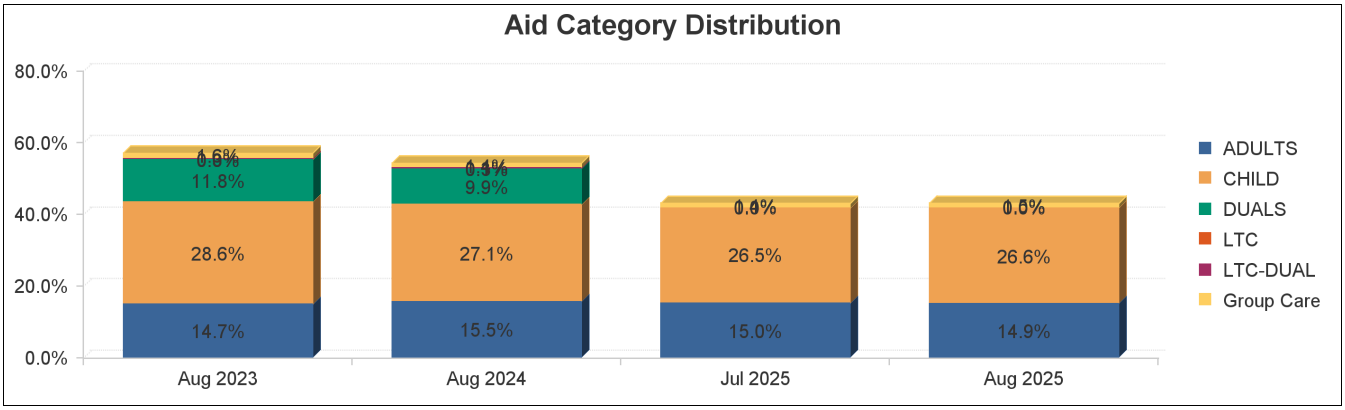




Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

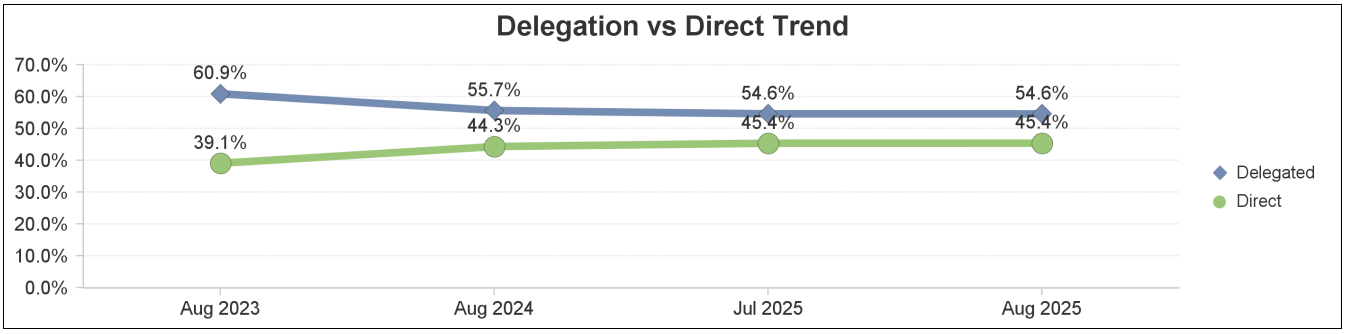
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Aug 2023	Aug 2024	Jul 2025	Aug 2025	Aug 2023	Aug 2024	Jul 2025	Aug 2025	Aug 2023 to Aug 2024	Aug 2024 to Aug 2025	Jul 2025 to Aug 2025
ADULTS	52,176	62,671	61,571	**60,720**	14.7%	15.5%	15.0%	14.9%	16.7%	-3.2%	-1.4%
CHILD	101,555	109,803	109,306	**108,568**	28.6%	27.1%	26.5%	26.6%	7.5%	-1.1%	-0.7%
SPD	30,864	35,177	0	**0**	8.7%	8.7%	0.0%	0.0%	12.3%	0.0%	0.0%
ACA OE	121,928	150,482	155,533	**153,348**	34.3%	37.1%	37.8%	37.6%	19.0%	1.9%	-1.4%
DUALS	41,722	40,030	1	**2**	11.8%	9.9%	0.0%	0.0%	-4.2%	##########	50.0%
LTC	138	226	0	**0**	0.0%	0.1%	0.0%	0.0%	38.9%	0.0%	0.0%
LTC-DUAL	1,020	1,247	0	**0**	0.3%	0.3%	0.0%	0.0%	18.2%	0.0%	0.0%
SPD-LTC	0	0	29,834	**29,686**	0.0%	0.0%	7.2%	7.3%	0.0%	100.0%	-0.5%
SPD-LTC/ Full Dual	0	0	49,509	**49,372**	0.0%	0.0%	12.0%	12.1%	0.0%	100.0%	-0.3%
Medi-Cal	349,403	399,636	405,754	**401,696**	98.4%	98.6%	98.6%	98.5%	12.6%	0.5%	-1.0%
Group Care	5,645	5,686	5,957	**5,974**	1.6%	1.4%	1.4%	1.5%	0.7%	4.8%	0.3%
Total	**355,048**	**405,322**	**411,711**	**407,670**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**12.4%**	**0.6%**	**-1.0%**



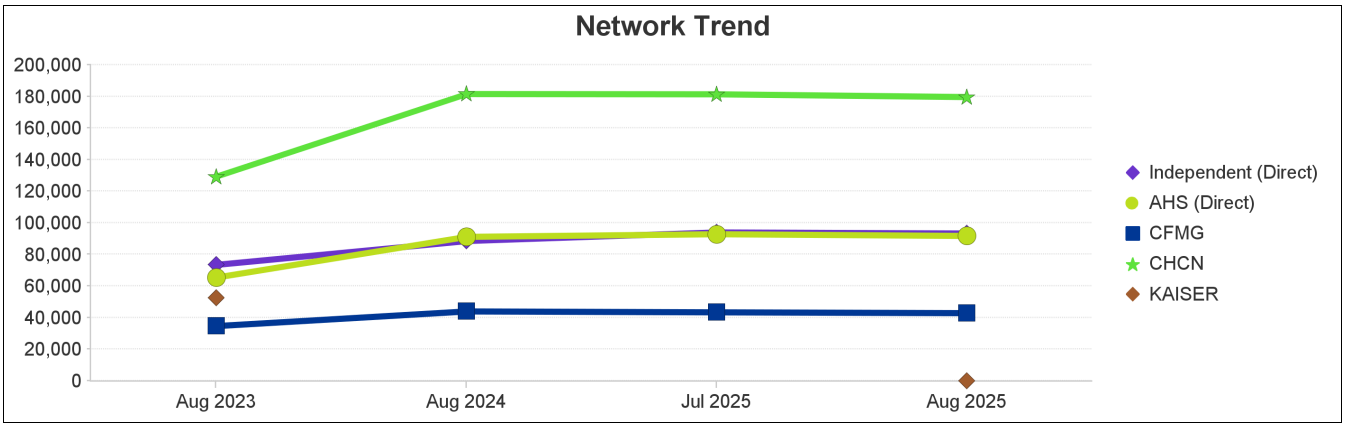
Delegation vs Direct Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	Aug 2023	Aug 2024	Jul 2025	Aug 2025	Aug 2023	Aug 2024	Jul 2025	Aug 2025	Aug 2023 to Aug 2024	Aug 2024 to Aug 2025	Jul 2025 to Aug 2025
Delegated	216,300	225,590	224,869	**222,601**	60.9%	55.7%	54.6%	54.6%	4.1%	-1.3%	-1.0%
Direct	138,748	179,732	186,842	**185,069**	39.1%	44.3%	45.4%	45.4%	22.8%	2.9%	-1.0%
Total	**355,048**	**405,322**	**411,711**	**407,670**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**12.4%**	**0.6%**	**-1.0%**



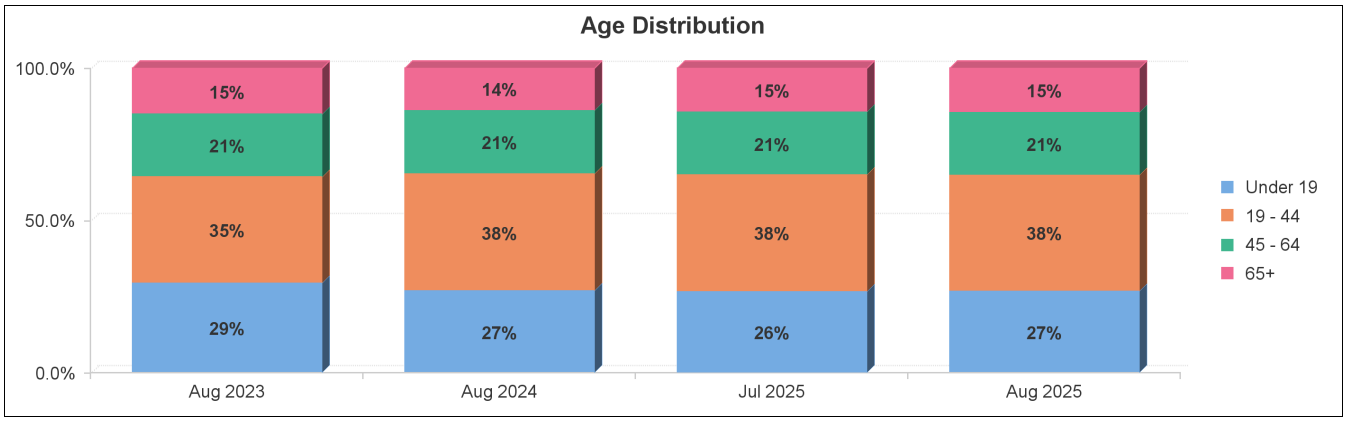
Network Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Aug 2023	Aug 2024	Jul 2025	Aug 2025	Aug 2023	Aug 2024	Jul 2025	Aug 2025	Aug 2023 to Aug 2024	Aug 2024 to Aug 2025	Jul 2025 to Aug 2025
Independent (Direct)	73,404	88,550	93,973	**93,300**	20.7%	21.8%	22.8%	22.9%	17.1%	5.1%	-0.7%
AHS (Direct)	65,344	91,182	92,869	**91,769**	18.4%	22.5%	22.6%	22.5%	28.3%	0.6%	-1.2%
CFMG	34,649	43,959	43,396	**42,868**	9.8%	10.8%	10.5%	10.5%	21.2%	-2.5%	-1.2%
CHCN	129,183	181,631	181,473	**179,713**	36.4%	44.8%	44.1%	44.1%	28.9%	-1.1%	-1.0%
KAISER	52,468	0	0	**20**	14.8%	0.0%	0.0%	0.0%	0.0%	100.0%	100.0%
Total	**355,048**	**405,322**	**411,711**	**407,670**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**12.4%**	**0.6%**	**-1.0%**



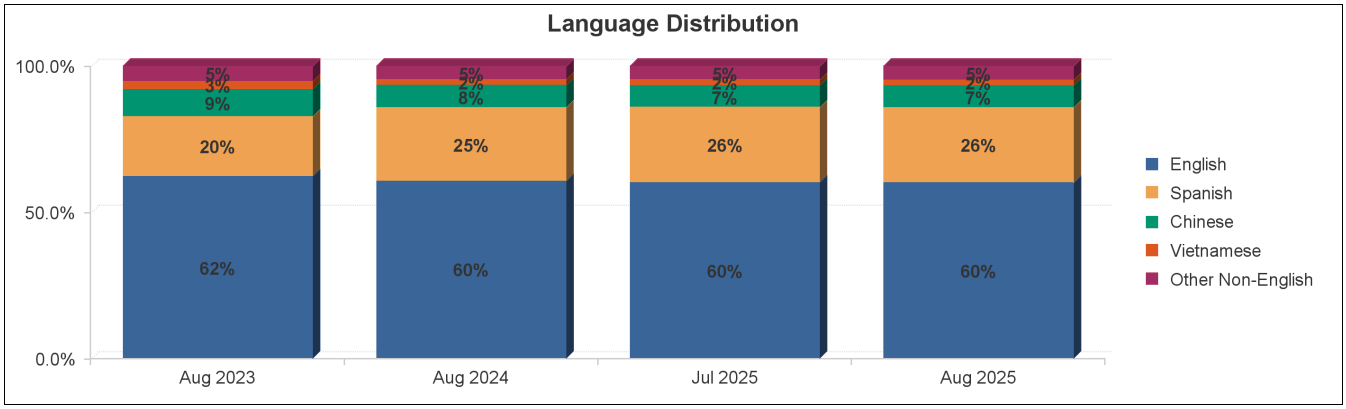
Age Category Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Aug 2023	Aug 2024	Jul 2025	Aug 2025	Aug 2023	Aug 2024	Jul 2025	Aug 2025	Aug 2023 to Aug 2024	Aug 2024 to Aug 2025	Jul 2025 to Aug 2025
Under 19	103,911	108,349	109,080	**108,381**	29%	27%	26%	27%	4%	0%	-1%
19 - 44	123,789	155,686	157,765	**155,276**	35%	38%	38%	38%	20%	0%	-2%
45 - 64	73,289	84,199	84,946	**84,220**	21%	21%	21%	21%	13%	0%	-1%
65+	54,059	57,088	59,920	**59,793**	15%	14%	15%	15%	5%	5%	0%
Total	**355,048**	**405,322**	**411,711**	**407,670**	**100%**	**100%**	**100%**	**100%**	**12%**	**1%**	**-1%**



Language Trend

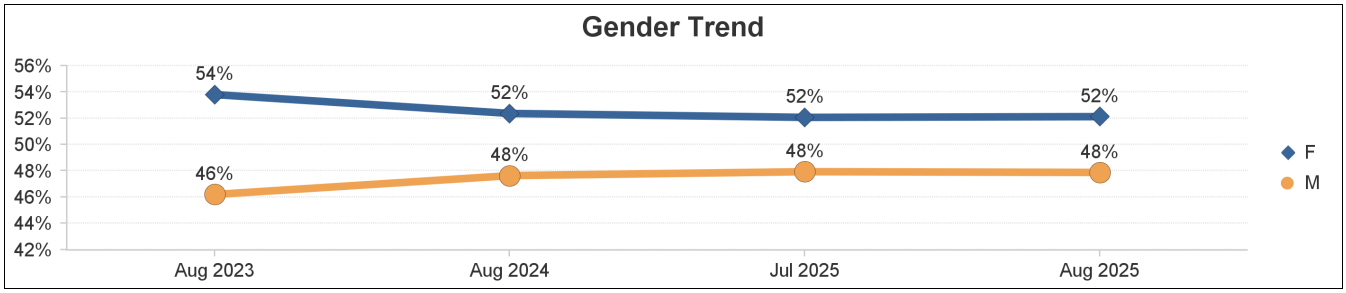
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	Aug 2023	Aug 2024	Jul 2025	Aug 2025	ug 2023	ug 2024	Jul 2025	ug 2025	Aug 2023 to Aug 2024	Aug 2024 to Aug 2025	Jul 2025 to Aug 2025
English	220,565	245,150	247,005	**244,403**	62%	60%	60%	60%	10%	0%	-1%
Spanish	72,596	102,034	106,160	**104,959**	20%	25%	26%	26%	29%	3%	-1%
Chinese	33,152	30,695	30,487	**30,355**	9%	8%	7%	7%	-8%	-1%	0%
Vietnamese	9,609	8,310	8,135	**8,083**	3%	2%	2%	2%	-16%	-3%	-1%
Other Non-English	19,126	19,133	19,924	**19,870**	5%	5%	5%	5%	0%	4%	0%
Total	**355,048**	**405,322**	**411,711**	**407,670**	**100%**	**100%**	**100%**	**100%**	**12%**	**1%**	**-1%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

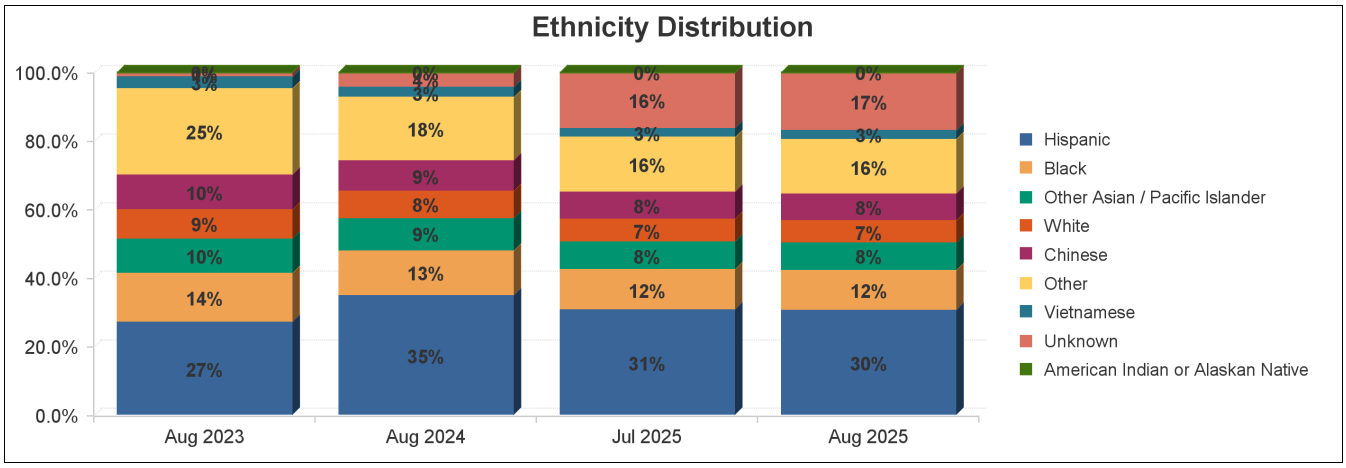
Gender Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Aug 2023	Aug 2024	Jul 2025	Aug 2025	Aug 2023	Aug 2024	Jul 2025	Aug 2025	Aug 2023 to Aug 2024	Aug 2024 to Aug 2025	Jul 2025 to Aug 2025
F	191,038	212,258	214,374	**212,501**	54%	52%	52%	52%	10%	0%	-1%
M	164,010	193,064	197,337	**195,169**	46%	48%	48%	48%	15%	1%	-1%
Total	**355,048**	**405,322**	**411,711**	**407,670**	**100%**	**100%**	**100%**	**100%**	**12%**	**1%**	**-1%**



Ethnicity Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Aug 2023	Aug 2024	Jul 2025	Aug 2025	Aug 2023	Aug 2024	Jul 2025	Aug 2025	Aug 2023 to Aug 2024	Aug 2024 to Aug 2025	Jul 2025 to Aug 2025
Hispanic	95,902	141,075	126,223	**124,198**	27%	35%	31%	30%	32%	-14%	-2%
Black	50,614	52,860	48,250	**47,397**	14%	13%	12%	12%	4%	-12%	-2%
Other Asian / Pacific Islander	35,566	38,062	33,175	**32,594**	10%	9%	8%	8%	7%	-17%	-2%
White	30,577	32,586	27,523	**26,772**	9%	8%	7%	7%	6%	-22%	-3%
Chinese	35,715	35,869	32,254	**31,878**	10%	9%	8%	8%	0%	-13%	-1%
Other	89,524	74,954	65,984	**64,699**	25%	18%	16%	16%	-19%	-16%	-2%
Vietnamese	12,104	11,804	10,544	**10,438**	3%	3%	3%	3%	-3%	-13%	-1%
Unknown	4,327	17,310	67,042	**69,002**	1%	4%	16%	17%	75%	75%	3%
American Indian or Alaskan Native	719	802	716	**692**	0%	0%	0%	0%	10%	-16%	-3%
Total	**355,048**	**405,322**	**411,711**	**407,670**	**100%**	**100%**	**100%**	**100%**	**12%**	**1%**	**-1%**



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

Medi-Cal By City

City	Aug 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	159,999	40%	24,213	42,897	16,826	76,063
HAYWARD	52,638	13%	11,929	15,132	5,632	19,945
FREMONT	38,487	10%	15,986	6,858	2,258	13,385
SAN LEANDRO	25,308	6%	6,837	4,340	3,043	11,088
UNION CITY	14,460	4%	5,724	2,669	825	5,242
ALAMEDA	13,693	3%	3,390	2,547	2,034	5,722
BERKELEY	16,262	4%	3,954	2,488	1,778	8,042
LIVERMORE	13,101	3%	2,009	471	2,120	8,501
NEWARK	9,317	2%	2,747	4,008	521	2,041
CASTRO VALLEY	11,230	3%	3,294	1,822	1,741	4,373
SAN LORENZO	6,088	2%	1,256	1,443	709	2,680
PLEASANTON	8,026	2%	2,181	341	843	4,661
DUBLIN	7,704	2%	2,391	349	872	4,092
EMERYVILLE	3,022	1%	620	671	493	1,238
ALBANY	2,548	1%	605	276	530	1,137
PIEDMONT	487	0%	104	187	80	116
SUNOL	81	0%	28	10	7	36
ANTIOCH	27	0%	4	13	3	7
Other	19,198	5%	3,846	4,172	2,553	8,627
Total	401,676	100%	**91,118**	**90,694**	**42,868**	**176,996**

Group Care By City

City	Aug 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	1,845	31%	332	420	0	1,093
HAYWARD	683	11%	317	178	0	188
FREMONT	678	11%	442	79	0	157
SAN LEANDRO	624	10%	252	100	0	272
UNION CITY	286	5%	176	42	0	68
ALAMEDA	315	5%	88	35	0	192
BERKELEY	145	2%	41	14	0	90
LIVERMORE	103	2%	31	4	0	68
NEWARK	143	2%	79	36	0	28
CASTRO VALLEY	219	4%	96	31	0	92
SAN LORENZO	155	3%	47	28	0	80
PLEASANTON	71	1%	23	3	0	45
DUBLIN	135	2%	48	8	0	79
EMERYVILLE	41	1%	13	7	0	21
ALBANY	23	0%	12	2	0	9
PIEDMONT	5	0%	1	1	0	3
SUNOL	1	0%	1	0	0	0
ANTIOCH	27	0%	9	7	0	11
Other	475	8%	174	80	0	221
Total	**5,974**	**100%**	**2,182**	**1,075**	**0**	**2,717**

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

Total By City

City	Aug 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	161,844	40%	24,545	43,317	16,826	77,156
HAYWARD	53,321	13%	12,246	15,310	5,632	20,133
FREMONT	39,165	10%	16,428	6,937	2,258	13,542
SAN LEANDRO	25,932	6%	7,089	4,440	3,043	11,360
UNION CITY	14,746	4%	5,900	2,711	825	5,310
ALAMEDA	14,008	3%	3,478	2,582	2,034	5,914
BERKELEY	16,407	4%	3,995	2,502	1,778	8,132
LIVERMORE	13,204	3%	2,040	475	2,120	8,569
NEWARK	9,460	2%	2,826	4,044	521	2,069
CASTRO VALLEY	11,449	3%	3,390	1,853	1,741	4,465
SAN LORENZO	6,243	2%	1,303	1,471	709	2,760
PLEASANTON	8,097	2%	2,204	344	843	4,706
DUBLIN	7,839	2%	2,439	357	872	4,171
EMERYVILLE	3,063	1%	633	678	493	1,259
ALBANY	2,571	1%	617	278	530	1,146
PIEDMONT	492	0%	105	188	80	119
SUNOL	82	0%	29	10	7	36
ANTIOCH	54	0%	13	20	3	18
Other	19,673	5%	4,020	4,252	2,553	8,848
Total	407,650	100%	**93,300**	**91,769**	**42,868**	**179,713**

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: **October 10th, 2025**

Subject: **Human Resources Report**

Staffing

- As of October 1st, 2025, the Alliance had 683 full time employees and 1 part time employee.

- On October 1st, 2025, the Alliance had 31 open positions in which 8 signed offer acceptance letters have been received with start dates in the near future resulting in a total of 23 positions open to date. The Alliance is actively recruiting for the remaining 23 positions and several of these positions are in the interviewing or job offer stage.

- Summary of open positions by division:

Division	Open Position October 1st	Signed Offers Accepted by Department	Remaining Recruitment Positions
Healthcare Services	7	1	6
Operations	13	4	9
Healthcare Analytics	2	1	1
Information Technology	4	1	3
Finance	0	0	0
Compliance	2	1	1
Human Resources	3	0	3
Health Equity	0	0	0
Executive	0	0	0
Total	31	8	23

- Our current recruitment rate is 5%.

Employee Recognition

- Employees reaching major milestones in their length of service at the Alliance in September 2025 included:

  5 years:
  - Heidi T (Quality Management)
  - Misha C (Quality Management)
  - Angel V (Apps Management, IT Quality & Process Improvement)
  - Gayla H (Case/Disease Management)
  - Homaira M (Quality Management)

  6 years:
  - Gabby F (Grievance and Appeals)
  - Komal B (Utilization Management)
  - Monique L (Utilization Management)
  - Ramces C (Claims)

  7 years:
  - Katherine E (Quality Management)
  - Cynthia C (Member Services)
  - Cynthia R (Claims)

  8 years:
  - Jennifer L (Facilities & Support Services)
  - Benita O (Pharmacy Services)

  9 years:
  - Sasi K (Information Technology)
  - Natalie M (Utilization Management)
  - Anthony T (Finance)
  - Sankar R (IT Development)
  - Pandiyarajan S (IT Development)
  - Tami L (Operations Support)
  - Ed D (IT Infrastructure)

  10 years:
  - Smita K (IT Ops and Quality Apps Mgt)
  - Dacheng P (IT Development)

  12 years:
  - Catie P (Case/Disease Management)
  - Alexandra L (Grievance and Appeals)
  - Hellai M (Quality Management)

  23 years:
  - Steve L (Marketing & Communications)