ALAMEDA Alliance FOR HEALTH

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

Board of Governors

Regular Meeting

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

Video Conference Call and

1240 South Loop Road, Alameda, CA 94502

AGENDA

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

In-Person and Video Conference Call

1240 S. Loop Road
Alameda, CA 94502

828 I Street
Sacramento, CA 95814

PUBLIC COMMENTS: Public Comments can be submitted for any agendized item or for any item not listed on the agenda, by mailing your comment to: "Attn: Clerk of the Board," 1240 S. Loop Road, Alameda, CA 94502 or by emailing the Clerk of the Board at brmartinez@alamedaalliance.org. You may attend meetings in person or by computer by logging in to the following link: Click here to join the meeting. You may also listen to the meeting by calling in to the following telephone number: 1-510-210-0967 conference id 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 September 12th, 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) 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)

6. BOARD MEMBER REPORTS

a) COMPLIANCE ADVISORY COMMITTEE

b) FINANCE COMMITTEE

c) CAC SELECTION COMMITTEE

7. CEO UPDATE

8. BOARD BUSINESS

a) REVIEW AND APPROVE FINANCIAL STATEMENTS

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

b) MEDICAL MANAGEMENT

c) COMMUNITY SUPPORTS OPERATIONS 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 September 9th, 2025, by 12:00 p.m.

Brenda Martinez, Clerk of the Board

ALAMEDA Alliance FOR HEALTH

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

EXECUTIVE SUMMARY APPENDIX

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

ALAMEDA Alliance FOR HEALTH

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

PRESENTATIONS APPENDIX

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

ALAMEDA Alliance FOR HEALTH

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

SUPPORTING MATERIALS APPENDIX

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

ALAMEDA Alliance FOR HEALTH

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

Consent Calendar

ALAMEDA Alliance FOR HEALTH

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

Finance Committee Meeting Minutes

ALAMEDA ALLIANCE FOR HEALTH
FINANCE COMMITTEE
REGULAR MEETING

July 8th, 2025
8:00 am – 9:00 am

SUMMARY OF PROCEEDINGS

Meeting conducted in person and by Teleconference.

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

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

CALL TO ORDER

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

ROLL CALL

Roll call was conducted and confirmed.

INTRODUCTIONS

There were no introductions.

CONSENT CALENDAR

Dr. Ferguson presented the Consent Calendar.

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

a) CEO UPDATE

Mr. Woodruff provided updates on the federal and state budgets, highlighting the meeting in Sacramento to discuss community supports and 2026 rates.

Mr. Woodruff also explained the impact of House Resolution One, which prohibits payments to 501(c)(3) entities for specific services related to women's health, including family planning, abortion, and contraception. This change will affect California and the Alliance's providers, and the state is expected to provide guidance on implementing these changes.

The state requested plans to implement a dental plan based on the findings from San Mateo Health Plan. This request is part of an effort to improve dental care services. The Alliance decided not to participate in the first wave of dental plan implementation due to the high IT implementation costs and other factors.

Question: Ms. Gebhart asked how long it will take to determine the scope of those services currently.

Response: Mr. Riojas explained that it will probably take a couple of weeks to determine the exact codes that cannot be reimbursed and to analyze historical payments for those codes.

b) REVIEW AND APPROVE MAY 2025 MONTHLY FINANCIAL STATEMENTS

MAY 2025 Financial Statement Summary

Enrollment:

Enrollment decreased by 1,426 members since April and an overall increase of 5,368 members since June 2024.

Net Income:

For the month ending May 31st, 2025, the Alliance reported a Net Income of $1.4 million (versus budgeted Net Income of $4.4 million). For the year-to-date, the Alliance recorded a Net Loss of $91.0 million versus a budgeted Net Loss of $68.0 million.

Premium Revenue:

For the month ending May 31st, 2025, actual Revenue was $189.5 million vs. our budgeted amount of $189.7 million.

Medical Expense:

Actual Medical Expenses for the month were $181.0 million, vs. budgeted amount of $174.6 million. For the year-to-date, actual Medical Expenses were $2.0 billion vs. budgeted Medical Expense of $1.9 billion.

Medical Loss Ratio:

Our MLR ratio for this month was reported as 95.5%. The year-to-date MLR was 100.6%.

Administrative Expense:

Actual YTD Administrative Expenses for the month ending May 31st, 2025, were $104.4 million vs. our budgeted amount of $110.2 million. Our Administrative Loss Ratio (ALR) is 4.7% of our Revenue for the month, and 5.4% of Net Revenue for year-to-date.

Other Income / (Expense):

As of May 31st, 2025, our YTD interest income from investments show a gain of $29.9 million.

Managed Care Organization (MCO) Provider Tax:

For the month ending May 31st, 2025, we reported $65.2 million MCO Tax Revenue vs. budgeted MCO Tax Revenue of $64.0 million. Our MCO Tax Expense was $65.2 million vs. budgeted MCO Tax Expense of $67.0 million.

Tangible Net Equity (TNE):

For May, the DMHC requires that we have $80.9 million in TNE, and we reported $164.4 million, leaving an excess of $83.5 million. As a percentage we are at 203%, which remains above the minimum required.

Cash and Cash Equivalents:

We reported $537.9 million in cash; $385.6 million is uncommitted. Our current ratio is above the minimum required at 1.13 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: Mr. Jackson requested more details about the unexpectedly high medical expenses.

Response: Mr. Riojas explained that the higher costs are mainly caused by increased inpatient services, long-term care expenses, and capitated medical costs. Inpatient service use is roughly 5% above projections, with unit costs about 1% higher. Long-term care costs are also elevated due to greater utilization, though this is partially offset by more favorable unit costs.

Question: Mr. Jackson asked what favorable building occupancy cost meant.

Response: Mr. Riojas explained that favorable building occupancy costs refer to the costs associated with managing the building being less than anticipated.

Question: Dr. Ferguson inquired about the timeline for ending monthly financial reporting as required by the state.

Response: Mr. Riojas mentioned that if the Alliance consistently reports positive net income for six consecutive months, they may be exempt from monthly financial reporting. However, the state has indicated that monthly reporting may continue for other reasons, such as monitoring the effects of new business initiatives or adjustments in state and federal budgets.

Question: Dr. Ferguson asked Mr. Riojas about his overall forecast regarding our financial statements and financial liabilities if we stop reporting to the state.

Response: Mr. Riojas stated that the overall financial outlook is uncertain because of state and federal budgets. The alliance expects to incur a net loss for the fiscal year, and it will be necessary to closely monitor changes in enrollment, revenue, and expenses. The greatest risk lies in potential changes to eligibility and enrollment, which could lead to a population that is sicker and more costly.

Motion: A motion was made by Rebecca Gebhart, and seconded by James Jackson, to accept and approve the May 2025 Financial Statements.

Motion Passed

No opposition or abstentions.

c) VERBAL UPDATE ON GRANT POLICY AND PROCEDURE

Mr. Woodruff mentioned that no comments were received on the grant policy after it was sent out. Mr. Woodruff resent the policy and asked for feedback. The policy will be open for discussion and vote at the July 11th Board meeting.

Informational Item only.

UNFINISHED BUSINESS

There was no unfinished business.

PUBLIC COMMENTS

There were no public comments.

ADJOURNMENT

Dr. Ferguson adjourned the meeting at 8:45 a.m.

ALAMEDA ALLIANCE FOR HEALTH
JOINT EXECUTIVE AND FINANCE COMMITTEE MEETING

August 22nd, 2025
11:00 am – 12:30 pm

SUMMARY OF PROCEEDINGS

Meeting conducted in person and by Teleconference.

Committee Members in-person: Rebecca Gebhart, Gil Riojas
Committee Members by Teleconference: Dr. Noha Aboelata, Dr. Rollington Ferguson, James Jackson, Dr. Marty Lynch, Yeon Park, Dr. Evan Seevak
Committee Members Excused: None
Board of Governors members in-person and on Conference Call: Tosan Boyo, Wendy Peterson, Andrea Schwab-Galindo, Dr. Kelley Meade

Alliance Staff in-person and on Conference Call: Matt Woodruff, Dr. Donna Carey, Tiffany Cheang, Richard Golfin III, Anastasia Swift, Lao Paul Vang, Ruth Watson, Pritika Dutt, Linda Ly, Brenda Martinez, Tome Meyers, Renan Ramirez, Karina Rivera, Felix Rodriguez, Danube Serri, Carol VanOosterwijk

CALL TO ORDER

Ms. Gebhart convened the Joint Executive and Finance Committee meeting at 11:00 a.m.

ROLL CALL

Roll call was conducted and confirmed.

INTRODUCTIONS

The new controller, Pritika Dutt was introduced.

CONSENT CALENDAR

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

a) JUNE & YEAR-END FINANCIALS UPDATE

<u>JUNE 2025 Financial Summary</u>

Enrollment:

Enrollment increased by 2,025 members since May

Net Income:

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

Medical Loss Ratio:

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

Tangible Net Equity (TNE):

For May, the DMHC requires that we have $80.7 million in TNE, and we reported $169.3 million. Our overall TNE remains above DMHC requirements at 210%.

Capital Investments:

We have acquired $859,000 in Capital Assets year-to-date.

Question: Dr. Ferguson asked if we are accounting for the MCO tax, and how we will handle it if we must pay it back.

Response: Mr. Riojas explained that all required payments have been made, and all expected revenue has been received, so the position is net zero. As long as the state does not request further payments without providing cash, the Alliance is okay.

Question: Dr. Seevak inquired about the future impact of the MCO tax.

Response: Mr. Riojas stated that the primary impact is a reduced cash position, resulting in less cash available for investment and lower investment returns. The forecast and budget will be revised as more information becomes available, contingent upon federal approval.

Question: Ms. Gebhart asked whether we have consistently ended up positive with the MCO tax in previous years.

Response: Mr. Riojas stated that the Alliance has experienced both positive and negative outcomes in different years. At times, the Alliance has lost money, while other times it has gained. Overall, it is expected to break even.

Informational Item Only.

b) COMMUNITY SUPPORTS UPDATE

HR-1 Financial Analysis

H.R.1 Section 71113 Overview:

- Section 71113 of H.R. 1 restricts Federal Medicaid funding to certain health care providers labeled as “Prohibited Entities” for one year following the law’s enactment on July 4, 2025.
- To be classified as a Prohibited Entity, an organization must:
    - Be an essential community provider primarily engaged in family planning and reproductive health services.
    - Be a 501(c)(3) nonprofit.
    - Provide abortions, except in cases of rape, incest, or life endangerment.
    - Have received over $800,000 in Medicaid payments in fiscal year 2023.
- A preliminary injunction was issued temporarily blocking enforcement of Section 71113 against Planned Parenthood affiliates.

Potential Financial Impact:

- DHCS APL 25-011 outlines services covered and reimbursed by the State general fund.

- With the temporary injunction existing funding should be paid out until the end of calendar year 2025.
- Funds paid out related to non-State funded services are at risk of not being considered medical expenses and not included in rate development modeling by DHCS.
- $2M represents less than 1% of current expenses.

Community Supports Revenue and Expenses:

- Community Supports program to date losses (CY22-CY24) exceed $20M.
- In Lieu of losses for CY24 estimated at $15M, assumed similar results for CY25.
- CY25 revenue based on estimates.
- CY25 expense includes January-May actuals and June-December projections.
- Members utilizing multiple CS are counted as unique members.

Community Supports Revenue and Expenses Analysis:

- Impact of CY25 rate acuity adjustment may reduce estimated CS revenue.
- New DHCS guidance impacts currently implemented medical management requirements causing higher expense in the second half of the calendar year and beyond.
- Provider rate negotiations may drive up existing expense estimates. Numbers reported assume current provider rates are maintained.
- Membership declines in the future will lead to lower revenue, impacts to expense are unclear.
- Some managed care plans have begun the phase out of CS.

Question: Dr. Ferguson asked if we cannot add these numbers to our medical expenses, will the state continue to give us the money, or will we have to find it elsewhere to cover these services?

Response: The state will continue payments through the injunction (end of year). If the lawsuit fails, the state will not reimburse the $2 million, and the Alliance may need to decide whether to fund these services from its own general fund, which would be brought to the board for discussion.

Question: Dr. Ferguson asked for a definition of utilizers versus non-utilizers.

Response: Ms. Cheang explained that utilizers are those who are authorized and used the service (claims/encounters received), while non-utilizers are those who were authorized but did not use the service.

Question: Dr. Ferguson raised the question of whether there is an inherent bias, suggesting that those who use the service may have more issues.

Response: Ms. Cheang acknowledged some bias but stated that utilizing authorized members aids in meeting the criteria.

Question: Ms. Gebhart sought clarification on the statement regarding the lack of funding and its implications for Community Supports.

Response: Mr. Woodruff clarified that the state announced there will be no significant increases for Community Supports. Plans may receive a modest step increase or retain current funding, but nothing more.

Question: Ms. Gebhart asked a question about the control group versus the active group. Are the counts very disparate, and does that affect the effectiveness of the results?

Response: Ms. Cheang said yes, the control group is much smaller, which limits statistical significance. The data is presented as-is, but small numbers mean results are not highly reliable.

Question: Dr. Aboelata inquired about the time period between the intervention and the measurement. Are all individuals housed, and how is the time frame determined?

Response: Ms. Cheang stated that the measurement begins after enrollment in the program, with the requirement that members must remain enrolled for a minimum duration, although the exact period is not specified.

Question: Ms. Gebhart raised a question regarding the food program, as the loss calculation appears questionable. Is the 'in lieu of' calculation appropriate?

Response: Dr. Carey stated that the measures used reflect the state's evaluation, which includes inpatient admissions, days, and emergency room visits; however, further analysis may be necessary.

Question: Ms. Gebhart inquired whether a decline in membership would also lead to a proportional decrease in the number of Community Supports users.

Response: Mr. Riojas stated that sicker members may remain, so revenue could decrease while expenses remain unchanged.

Informational Item Only.

c) MEDICAL MANAGEMENT UPDATE

Dr. Carey presented an update on medical management strategies, including inpatient, long-term care, emergency department, and pharmacy interventions, with data showing positive trends.

Inpatient Interventions:

- On-going
    - 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 →46.2June)
- 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

Emergency Department Interventions:

- On-going
    - 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
- 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.
    - 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 paying for drugs carved out to the State (cost saving)
- PA process helping to prevent FWA for self-administered medications (cost saving)

Question: Dr. Ferguson inquired whether the data from previous years or comparable seasons and months had been analyzed to account for monthly and seasonal variability in the results.

Response: Dr. Carey stated that the analysis is not complete yet; it focused on recent interventions, but future reviews will include historical and seasonal comparisons to establish baselines.

Question: Dr. Aboelata asked if the CHWs shown in the data are employed by the plan or by CBOs?

Response: Dr. Carey stated that all CHWs referenced are employed by CBOs, not directly by the plan.

Question: Dr. Aboelata asked if the providers can bill for CHW services?

Response: Dr. Carey confirmed that providers can bill for CHW services as a benefit.

Informational Item only.

d) LEGISLATIVE BUDGET IMPACT UPDATE

UNFINISHED BUSINESS

There was no unfinished business.

PUBLIC COMMENTS

There were no public comments.

ADJOURNMENT

Dr. Ferguson adjourned the meeting at 12:40 p.m.

ALAMEDA Alliance FOR HEALTH

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

Compliance Advisory Committee Meeting Minutes

Compliance Advisory Committee
Regular Meeting Minutes
Friday, 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.

ALAMEDA Alliance FOR HEALTH

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

Board of Governors Meeting Minutes

BOARD OF GOVERNORS
Regular Meeting Minutes
Friday, July 11th, 2025
12:00 p.m. – 2:00 p.m.

Video Conference Call and

1240 S. Loop Road
Alameda, CA 94502

1. CALL TO ORDER

Board of Governors Present: Rebecca Gebhart (Chair), Dr. Noha Aboelata (Vice Chair), Dr. Kathleen Clanon, Dr. Rollington Ferguson, Andrea Ford, James Jackson, Byron Lopez, Dr. Marty Lynch, Dr. Kelley Meade, Yeon Park, Wendy Peterson, Andrea Schwab-Galindo, Natalie Williams

Board of Governors Remote: Tosan Boyo ("Just Cause"), Andie Martinez-Patterson ("Just Cause")

Board of Governors Excused: Aaron Basrai, Jody Moore, Dr. Evan Seevak, Supervisor Lena Tam

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 12:00 p.m.

2. ROLL CALL

Roll call was taken, and a quorum was established.

3. AGENDA APPROVAL

There were no modifications to the agenda.

4. INTRODUCTIONS

There were no introductions.

5. CONSENT CALENDAR

a) JUNE 10th, 2025, FINANCE COMMITTEE MEETING MINUTES

b) JUNE 13th, 2025, COMPLIANCE ADVISORY COMMITTEE MEETING MINUTES

c) JUNE 13th, 2025, BOARD OF GOVERNORS MEETING MINUTES

d) REVIEW AND APPROVE RESOLUTION RE-APPOINTING DR. MARTY LYNCH TO DESIGNATED BOARD OF GOVERNORS SEAT (AT-LARGE SPD POPULATION)

e) 2024 CASE MANAGEMENT & CARE COORDINATION, COMPLEX CASE MANAGEMENT & DISEASE MANAGEMENT PROGRAM EVALUATION

f) 2025 CASE MANAGEMENT & CARE COORDINATION, COMPLEX CASE MANAGEMENT & DISEASE MANAGEMENT PROGRAM DESCRIPTION

g) 2024 UTILIZATION MANAGEMENT PROGRAM EVALUATION

h) 2025 UTILIZATION MANAGEMENT PROGRAM DESCRIPTION

i) 2024 QUALITY IMPROVEMENT – PROGRAM EVALUATION

j) 2025 QUALITY IMPROVEMENT – PROGRAM DESCRIPTION

Motion: A motion was made by Natalie Williams and seconded by Dr. Kelley Meade to approve the Consent Calendar.

Vote: The motion was passed unanimously.

Ayes: Tosan Boyo, Dr. Kathleen Clanon, Dr. Rollington Ferguson, Andrea Ford, James Jackson, Byron Lopez, Dr. Marty Lynch, Dr. Kelley Meade, Yeon Park, Wendy Peterson, Andrea Schwab-Galindo, Natalie Williams, Chair Rebecca Gebhart.

No opposition or abstentions.

6. BOARD MEMBER REPORTS

a) CAC SELECTION COMMITTEE

Chair Rebecca Gebhart reported on the CAC Selection Committee meeting held on June 30th. The committee reviewed member attendance requirements, recruitment priorities, and approved a slate of six new members representing diverse backgrounds.

b) COMPLIANCE ADVISORY COMMITTEE

Dr. Kelley Meade provided an update on the Compliance Advisory Committee meeting, highlighting the significant decrease in audit findings since 2018, noting the progress made in compliance infrastructure, and an internal compliance risk assessment process was introduced, led by Anne Beech, the new Senior Director for Risk Management. This process was previously vendorized.

c) FINANCE COMMITTEE

Dr. Rollington Ferguson reported on the Finance Committee meeting, noting a net income of $1.4 million for May 2025, with a TNE of 202% and an MLR of 95%. He noted that financials have stabilized, but medical expenses continue to outpace budgeted numbers. Dr. Ferguson also discussed the potential adverse impact of the recent federal bill on the Alliance, highlighting the need for further analysis and preparation for the changes. Despite the improved financials, the Alliance is still required to report monthly to the state due to its financial status. The duration of this requirement is uncertain.

7. CEO UPDATE

CEO Matt Woodruff provided an update on the recent federal bill H.R.1, which includes changes to Medicaid eligibility, retroactive coverage, work requirements, and restrictions on payments to entities providing abortions.

Eligibility Changes: Starting in 2027, beneficiaries will need to provide their address and Social Security number to be eligible for Medicaid, impacting homeless individuals. Redeterminations for the adult expansion population will occur every six months starting December 2027.

Coverage Limitations: The bill limits retroactive coverage to one month for expansion enrollees and two months for non-expansion beneficiaries, starting in 2027. It also restricts coverage for certain immigrant groups.

Work Requirements: Work requirements will start in 2027, requiring 80 hours of qualifying activity per month for individuals aged 19 to 64. States can request a good-faith exemption until the end of 2028.

Abortion Service: The bill includes a one-year ban on Medicaid payments to certain nonprofits providing abortion services. Planned Parenthood has filed a lawsuit in response to this provision.

Provider Payments: The bill affects managed care taxes and state-directed payments, potentially reducing provider payments and impacting hospitals in Alameda County. The Alliance has never taken its percentage of directed payments, so its bottom line will not be affected.

Question: Ms. Williams inquired about potential loopholes or ways for the Alliance to reduce medical losses under the new federal bill.

Response: Mr. Woodruff explained that the Alliance will convene groups, possibly starting in August, to assess the situation and prepare for upcoming changes, but no definitive answers are available yet.

Comment: Mr. Boyo emphasized that all hospitals, especially in the East Bay, where one out of three patients are on Medi-Cal, will face significant challenges due to the upcoming changes, particularly in 2026, and highlighted the need for awareness of the magnitude of these impacts.

Comment: Ms. Schwab-Galindo stressed the importance of understanding recent changes' broad effects on members, providers, and the plan, especially regarding equity, access, and safety-net issues. She noted restrictions could limit patient clinic access, pushing them to hospitals, impacting trust and connectedness. She urged dedicated time or smaller groups to develop solutions for compliance, operational, and financial challenges before the 2026 deadlines. She emphasized the need for clarity and timely action amid evolving guidance.

Comment: Dr. Lynch and Chair Gebhart supported Andrea's idea to form a group to strategize on this issue.

8. BOARD BUSINESS

a) REVIEW AND APPROVE MAY 2025 MONTHLY FINANCIAL STATEMENTS

MAY 2025 Financial Statement Summary

Enrollment:

Enrollment decreased by 1,426 members since April and has increased by 5,368 members overall since June 2024.

Net Income:

For the month ending May 31st, 2025, the Alliance reported a Net Income of $1.4 million (versus budgeted Net Income of $4.4 million). For the year-to-date, the Alliance recorded a Net Loss of $91.0 million versus a budgeted Net Loss of $68.0 million.

Premium Revenue:

For the month ending May 31st, 2025, actual Revenue was $189.5 million vs. our budgeted amount of $189.7 million.

Medical Expense:

Actual Medical Expenses for the month were $181.0 million, vs. budgeted amount of $174.6 million. For the year-to-date, actual Medical Expenses were $2.0 billion vs. budgeted Medical Expense of $1.9 billion.

Medical Loss Ratio:

Our MLR ratio for this month was reported as 95.5%. The year-to-date MLR was 100.6%.

Administrative Expense:

Actual YTD Administrative Expenses for the month ending May 31st, 2025, were $104.4 million vs. our budgeted amount of $110.2 million. Our Administrative Loss Ratio (ALR) is 4.7% of our Revenue for the month, and 5.4% of Net Revenue for year-to-date.

Other Income / (Expense):

As of May 31st, 2025, our YTD interest income from investments show a gain of $29.9 million.

Managed Care Organization (MCO) Provider Tax:

For the month ending May 31st, 2025, we reported $65.2 million MCO Tax Revenue vs. budgeted MCO Tax Revenue of $64.0 million. Our MCO Tax Expense was $65.2 million vs. budgeted MCO Tax Expense of $67.0 million.

Tangible Net Equity (TNE):

For May, the DMHC requires that we have $80.9 million in TNE, and we reported $164.4 million, leaving an excess of $83.5 million. As a percentage we are at 203%, which remains above the minimum required.

Cash and Cash Equivalents:

We reported $537.9 million in cash with $385.6 million uncommitted. Our current ratio is above the minimum required at 1.13 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.

Question: Dr. Lynch inquired whether there are any projections regarding the policy changes for members.

Response: Mr. Riojas mentioned that the previous year's budget included a total decrease of 30,000 members. More details on the comparison between UIS and members with satisfactory immigration status might be shared in future meetings. The team is analyzing changes at the state and federal levels, with federal H.R.1 passed and the state expected to respond, possibly making further adjustments for underfunding. They are working with current data, which could change as the state budget updates. More information will be shared with the board as it becomes available.

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

Vote: The motion was passed unanimously.

Ayes: Tosan Boyo, Dr. Kathleen Clanon, Dr. Rollington Ferguson, Andrea Ford, James Jackson, Byron Lopez, Dr. Marty Lynch, Andie Martinez Patterson, Dr. Kelley Meade, Yeon Park, Wendy Peterson, Andrea Schwab-Galindo, Natalie Williams, Vice Chair Dr. Noha Aboelata, Chair Rebecca Gebhart.

No opposition or abstentions.

b) REVIEW AND APPROVE GRANT POLICY & PROCEDURE

Mr. Woodruff discussed the updated grant policy, which now mirrors the CEO's signing authority, requiring board approval for grants of $1.5 million or more. Board members with a conflict of interest must recuse themselves from the discussion and vote.

Motion: A motion was made by Yeon Park and seconded by Dr. Marty Lynch to approve the Grant Policy & Procedure.

Vote: The motion was passed unanimously.

Ayes: Tosan Boyo, Dr. Kathleen Clanon, Dr. Rollington Ferguson, Andrea Ford, James Jackson, Byron Lopez, Dr. Marty Lynch, Andie Martinez Patterson, Dr. Kelley Meade, Yeon Park, Wendy Peterson, Andrea Schwab-Galindo, Natalie Williams, Vice Chair Dr. Noha Aboelata, Chair Rebecca Gebhart.

No opposition or abstentions.

c) MEDICARE UPDATE

Ms. Ruth Watson, Mr. Tome Meyers, and Ms. Jaini Goradia presented an update on Medicare.

- D-SNP CMS Application successfully submitted on February 12th, 2025.
    - CMS Plan Benefit Package (PBP) = H2035-001-000
- Model of Care score was 96.25%.
    - Approval for 3 years
- California Health Care Foundation (CHCF) Joint D-SNP planning occurred on February 28th, 2025.
- Provider & Community D-SNP Townhall occurred on April 23rd, 2025.
- CMS Medicare Advantage Bid successfully submitted on June 2nd, 2025.
    - CMS desk review & actuarial audit is underway.
- Medication Therapy Management (MTM) program was successfully submitted on June 4th, 2025.
- State Medicaid Agency Contract (SMAC) successfully submitted on July 7th, 2025.
- Some new supporting vendors include Health Risk Assessment (HRA), Sales Customer Relationship Management (CRM) Tool, and new branding/logo.

Question: Chair Gebhart asked whether the SMAC contract is negotiable or if it has already been finalized upon submission.

Response: Ms. Watson stated that the contract is non-negotiable and must be complied with. The submission outlines how compliance will be achieved. There is a period for health plan comments, and the state utilizes a basic template.

Question: Chair Gebhart asked a question regarding her understanding that Kaiser changed some of their benefits within the past year. She inquired about the reasons behind this change and whether it has any implications for the comparison process. Did they make these adjustments to influence the comparison process?

Response: Mr. Meyers mentioned that he can only speculate, but he believes that if Kaiser observes the Alameda Alliance for Health entering the market, they may choose to make their benefits less comprehensive in order to concentrate on different service areas. This would impact how rebates are allocated, as benefits need to be competitive and actuarially sound. The team is ready to adjust the benefits as necessary.

Question: Dr. Lynch mentioned that he understands Kaiser has no restrictions on enrolling dual-eligible individuals in the counties where they hold a state contract. Is it possible to discuss voluntary actions with them regarding their marketing practices, specifically to avoid targeting the Alliance's standard clientele for their dual's product?

Response: Mr. Woodruff stated that Kaiser still has permission to enroll any Medi-Cal beneficiary. For those who are dual eligible, it operates in an open market and can market to anyone within their service area. At present, Kaiser is not seeking significant growth in Alameda County.

Question: Dr. Ferguson inquired about the current status of network adequacy.

Response: Ms. Watson stated that the current status of the plan is at 35% completion regarding contracts for network adequacy. The objective is to achieve full adequacy by August 31st, aiming for forty-eight executed amendments each week. Additional support will include in-person visits,

phone outreach, and open office hours. The assistance of board members is encouraged and appreciated.

Question: Dr. Clanon inquired about the projection of 1,500 members by 2026 and whether that indicates a cap at that number. Where does this projection originate, considering there are already 40,000 people in-house?

Response: Mr. Meyers stated that the projection is based on an analysis by Milliman consultants for new plans with limited marketing. The estimate of 1,500 is considered conservative, and contingency plans are in place in case enrollment exceeds expectations. The emphasis is on ensuring quality before expanding.

Question: Mr. Jackson inquired whether it would be beneficial for the board to receive a projection of the expected growth over the next few years.

Response: The team requests a few months to get established before providing projections. They plan to start building projections in January.

Question: Dr. Ferguson inquired whether the team has assessed how the changes to the care program from July 3rd will affect the numbers.

Response: Mr. Meyers stated that an analytics request is being prepared to assess the impact, but no projections are available yet.

Question: Ms. Williams asked if the team could give a vague projection of how fast improvement in growth would be seen.

Response: Mr. Woodruff and Ms. Watson stated that once the initial members are enrolled and processes are established, the aim is to enroll as many of the 42,000 potential members as quickly as possible. The growth will depend on the quality of services and risk adjustment performance. Previous experiences, such as with Cal Optima, indicate that breaking even can take up to six years unless the star ratings are strong.

Question: Dr. Lynch inquired about the contracting process and the incentives for providers to improve star ratings.

Response: The team indicated they are working on a pilot pay-for-performance (P4P) program in partnership with analytics and quality teams to boost provider engagement in enhancing star ratings.

Question: Dr. Lynch asked what the plans are for getting providers up to speed on risk coding.

Response: The team announced a partnership with provider groups to offer training sessions, explore in-home assessments, and collaborate with OCHIN Epic for point-of-care coding support. A risk adjustment manager has been appointed to lead these initiatives.

Follow-Up: Ms. Watson and Mr. Meyers will send the list of providers that need to be contacted for network adequacy to the entire board and request their assistance with outreach.

Informational Item Only.

9. CLOSED SESSION

a) PUBLIC EMPLOYEE PERFORMANCE EVALUATION: CHIEF EXECUTIVE OFFICER (GOV. CODE SECTION 54957)

The Board reconvened into open session at 2:15 p.m.

10. READ OUT FROM CLOSED SESSION AND DISCUSSION

There were no reportable actions from Closed Session.

11. STAFF UPDATES

There were no staff updates.

12. UNFINISHED BUSINESS

None.

13. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS

None.

14. PUBLIC COMMENT (NON-AGENDA ITEMS)

There were no public comments for non-agenda items.

15. ADJOURNMENT

Chair Gebhart adjourned the meeting at 2:16 p.m.

ALAMEDA Alliance FOR HEALTH

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

Resolutions

RESOLUTION NO. 2025-

A RESOLUTION OF THE ALAMEDA ALLIANCE FOR HEALTH RECOMMENDING THAT THE ALAMEDA COUNTY BOARD OF SUPERVISORS REAPPOINT DR. NOHA ABOELATA TO THE REGULAR #3 PHYSICIAN IN ALAMEDA COUNTY MEDICAL COMMUNITY SEAT TO THE ALAMEDA ALLIANCE FOR HEALTH BOARD OF GOVERNORS

WHEREAS, Dr. Noha Aboelata's current term as an Alameda Alliance for Health (Alliance) Board of Governors member, in the Physician in Alameda County Medical Community Seat (Regular #3), expires December 20, 2025 and

WHEREAS, the Alliance Chief Executive Officer recommends that the Alliance Board of Governors nominate Dr. Noha Aboelata for reappointment to the Physician in Alameda County Medical Community Seat (Regular #3), pursuant to Section 3.D.2 of the Alliance *Bylaws*; and

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

WHEREAS, the Alliance Board of Governors desires to nominate Dr. Noha Aboelata for reappointment to the Alliance Board of Governors (Regular #3); and

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

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

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

SECTION 1. That the Alliance Board of Governors approves the Chief Executive Officer's recommendation to nominate Dr. Noha Aboelata for reappointment to the Physician in Alameda County Medical Community Seat (Regular #3) pursuant to Section 3.D.2 of the Alliance *Bylaws*.

SECTION 2. The Alliance Board of Governors hereby recommends that the Alameda County Board of Supervisors, by majority vote, reappoint Dr. Noha Aboelata to the Physician in Alameda County Medical Community Seat (Regular #3), on the Alliance Board of Governors.

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

PASSED AND ADOPTED by the Board at a meeting held on the 12th day of September 2025.

_____
CHAIR, BOARD OF GOVERNORS

ATTEST:

_____
Secretary

RESOLUTION NO. 2025-

A RESOLUTION OF THE ALAMEDA ALLIANCE FOR HEALTH RECOMMENDING THAT THE ALAMEDA COUNTY BOARD OF SUPERVISORS REAPPOINT ANDREA SCHWAB-GALINDO TO THE REGULAR #8 PRIVATE OR PUBLIC COMMUNITY CLINIC SEAT TO THE ALAMEDA ALLIANCE FOR HEALTH BOARD OF GOVERNORS

WHEREAS, Andrea Schwab-Galindo's current term as an Alameda Alliance for Health (Alliance) Board of Governors member, in the Private or Public Community Clinic Seat (Regular #8), expires December 20, 2025, and

WHEREAS, the Alliance Chief Executive Officer recommends that the Alliance Board of Governors nominate Andrea Schwab-Galindo for reappointment to the Private or Public Community Clinic Seat (Regular #8), pursuant to Section 3.D.4 of the Alliance *Bylaws*; and

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

WHEREAS, the Alliance Board of Governors desires to nominate Andrea Schwab-Galindo for reappointment to the Alliance Board of Governors (Regular #8); and

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

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

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

SECTION 1. That the Alliance Board of Governors approves the Chief Executive Officer's recommendation to nominate Andrea Schwab-Galindo for reappointment to the Private or Public Community Clinic Seat (Regular #8), pursuant to Section 3.D.4 of the Alliance *Bylaws*.

SECTION 2. The Alliance Board of Governors hereby recommends that the Alameda County Board of Supervisors, by majority vote Andrea Schwab-Galindo for reappointment to the Private or Public Community Clinic Seat (Regular #8) on the Alliance Board of Governors.

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

PASSED AND ADOPTED by the Board at a meeting held on the 12th day of September 2025.

_____
CHAIR, BOARD OF GOVERNORS

ATTEST:

_____
Secretary

ALAMEDA Alliance FOR HEALTH

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

CEO Update

Matthew Woodruff

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

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

Date: **September 12th 2025**

Subject: **CEO Report**

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

	July	YTD
Medi-Cal	$2.1M	$2.1M
Group Care	$14K	$14K
Medicare	($392K)	($392K)
Total	$1.7M	$1.7M

  - **Revenue was $192.1 million in July 2025 and for the fiscal Year-to-Date (YTD)**.
    - Medical expenses were $184.3 million in July and fiscal year-to-date; the medical loss ratio is 96.0% for the month and for the fiscal year-to-date.
    - Administrative expenses were $8.9 million in July and fiscal year-to-date; the administrative loss ratio is 4.6% of net revenue for the month and for the fiscal year-to-date.
  - **Tangible Net Equity (TNE)**: Financial reserves are 211% of the required DMHC minimum, representing $89.8 million in excess TNE.
  - **Total enrollment in July 2025 was 411,619**, increased by 189 Medi-Cal members compared to June 2025.

- **Key Performance Indicators:**
  - **Regulatory Metrics:**
    - The Claims team missed processing timelines. The team processed 83% of claims within 30 calendar days. Both metrics should be at 95% to be considered compliant.
      - The team experienced a change in leadership in June and July which caused a slowdown in overall processing.
    - Member appeals scored 94% processing time, which is 1% below the 95% compliance mark.
    - Expedited appeals scored 50% however, only 2 expedited appeals were received, and one was processed in the required 3 days, and the other was processed in 4 days.

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

- **Alliance Updates:**
    - **State And Federal Updates**
        - Brief legislative update.

- **COMMUNITY SUPPORTS**
    - Operations presentation in the packet

- **STRATEGIC PLANNING**
    - At the October or December Board meeting we will review the current draft of the new strategic plan.

- **AUTOMATION AND AI**
    - At the October Board meeting we will review our IT work and present monthly ongoing updates

- **Alliance in the Community**
    - This will be a new section focused on partnership work in the community

- **Medicare Overview:**
    - **<u>D-SNP Readiness</u>**

      Alameda Alliance for Health (AAH) Medicare Advantage (MA) Duals Eligible Special Needs Plan (D-SNP) will begin serving members on January 1st, 2026. Currently, there are 17 different departmental workstreams and a total of 107 projects, 75 of which are active, 31 requested, one (1) on hold, and zero (0) complete.
        - On August 20, 2025, CMS confirmed that the HPMS Bid Desk Review process for AAH's CY2026 D-SNP bid under contract H2035 has been successfully completed. This milestone confirms that CMS has accepted the submitted bid. On Aug 25, 2025, AAH executed our H-contract with CMS by completing an electronic signature. The final step in the process is to receive a counter signature of the contract by CMS.
        - Outreach to the AAH provider network to complete the execution of the D-SNP Provider Amendment is ongoing. Progress is being monitored, and the amendments are being returned on a steady basis.
        - Completed a 3rd onsite meeting with CHCN, the leadership from 5 FQHCs, and AHC on 8/25. Also, completed the 1st health center road show in the community on 8/27.
        - All required integrated materials were approved by DMHC and DHCS on 8/27/25. These materials include:
            1. Member ID Card
            2. Summary of Benefits
            3. List of Covered Drugs (Formulary)
            4. Provider & Pharmacy Directory
            5. EOC/Member Handbook
        - Grievance and Appeals Policies and Procedures were approved by the QIHEC committee on August 8 and were submitted for review and approval to the AOC committee in August 2025.

- D-SNP microsite content has been developed and finalized. It is currently being prepared for website launch on 10/1.

ALAMEDA Alliance FOR HEALTH

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

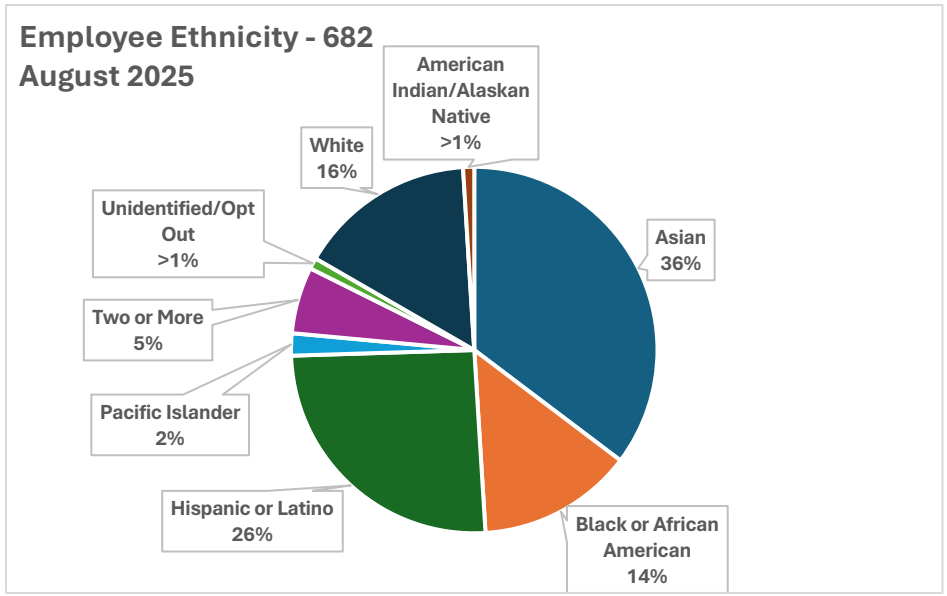
Demographics

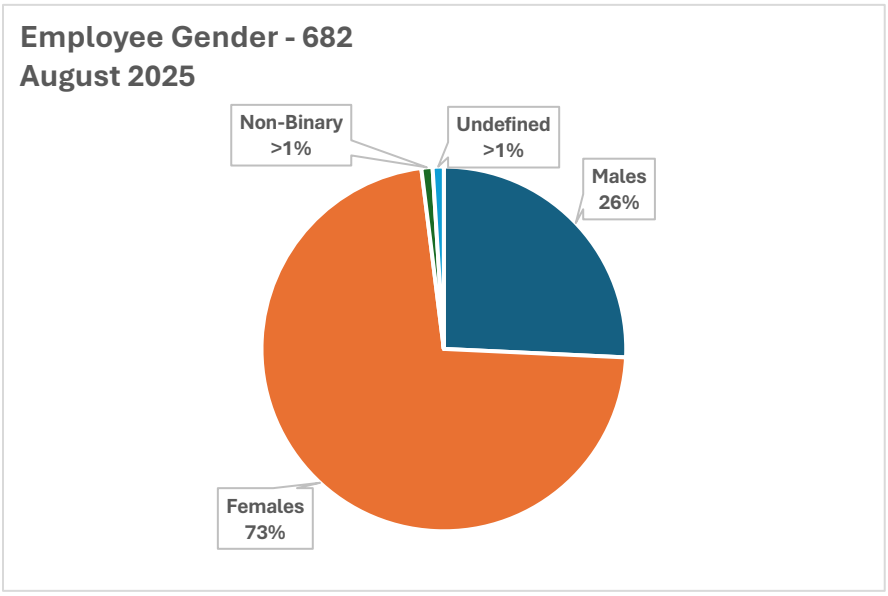
The purpose of this report is to conduct a comparative analysis of the demographic composition of Alameda Alliance for Health's workforce and the population distribution of Alameda County. The primary focus of this comparison will be on key metrics, including race/ethnicity, gender, and age distribution.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

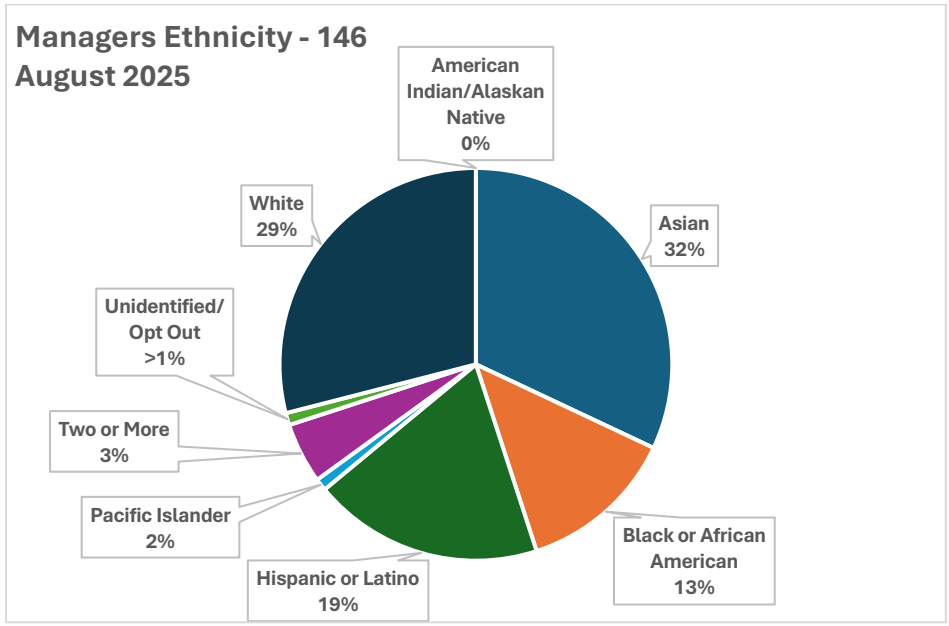
The demographic data for the county, including the total population and demographic breakdown, is sourced from Healthy Alameda County, which is sponsored by the Alameda County Public Health Department. This site serves as a central repository of information related to Alameda County, providing the most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

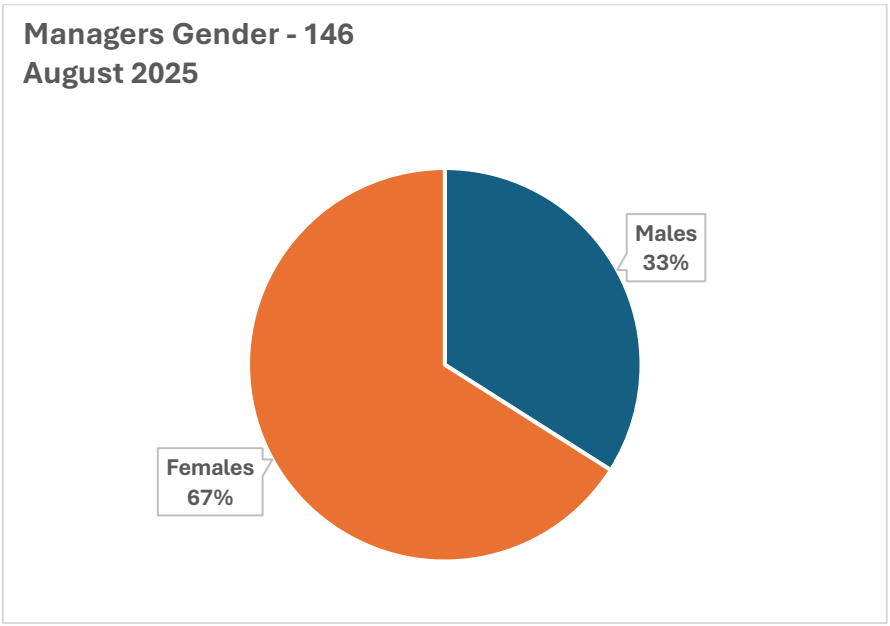
Category	**Alameda Alliance for Health** (Workforce information last updated August 2025)	**Alameda County** (Population Information last updated in May 2025)
Population/Total Employees	682	1,626,575
Race & Ethnicity		
Asian	36%	35.39%
Hispanic	26%	23.94%
White	16%	28.26%
Black/African American	14%	9.15%
Native Hawaiian/Pacific Islander	2%	0.82%
American Indian/Alaskan Native	>1%	1.18%
Two or More Races	5%	11.62%
Unidentified/Opt Out	>1%	-
Gender		
Male	26%	49.67%
Female	73%	50.33%
Non-Binary	>1%	-
Undefined	>1%	-
Age Distribution		
Under 25	>1%	8.33%
25-34	20%	13.92%
35-44	36%	16.13%
45-54	26%	13.59%
55-Older	17%	29.03%

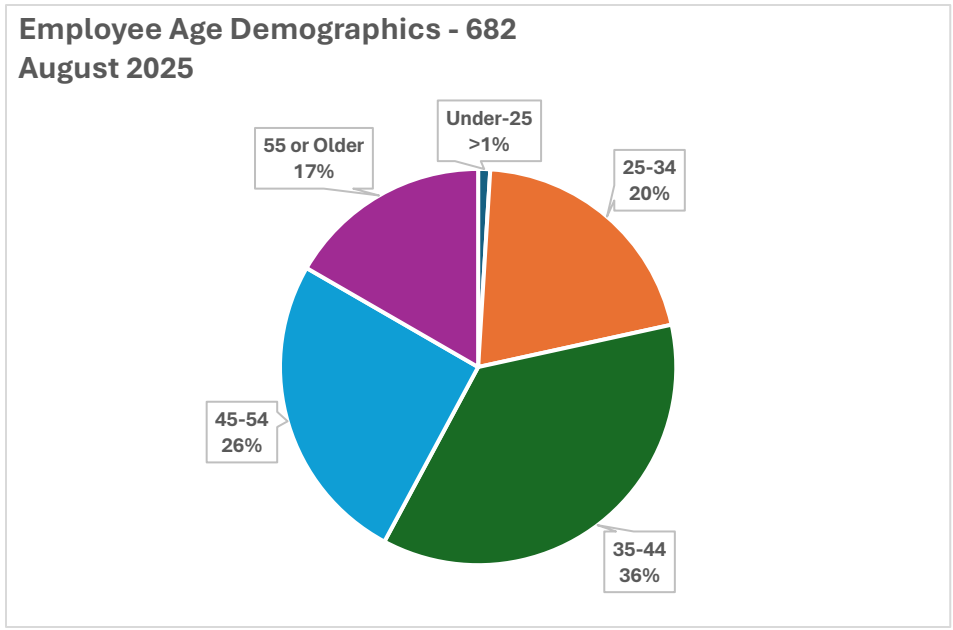
AAH Employee Demographics Data Report August 2025










Employee Age Demographics - 682
August 2025
Under-25
>1%
25-34
20%
35-44
36%
45-54
26%
55 or Older
17%

ALAMEDA Alliance FOR HEALTH

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

Legislative Tracking

2025 –2026 Legislative Tracking List

The state legislature returned from their summer recess on August 18th and quickly joined Governor Newsom in efforts to redraw California's congressional maps. The approved proposal will call for a special election on November 4th that would suspend the state's existing congressional district – and replace them with a redrawn map that favor Democrats. The focus has now shifted to moving bills through the legislative process as they work toward the September 12th deadline which is the last day for each house to pass bills.

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

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

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

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

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

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

Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is,

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

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

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

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

AB 40 **(Bryan D) Redistricting: congressional districts.**
Current Text: Amended: 8/21/2025 html pdf
Introduced: 12/2/2024
Status: 8/25/2025-Read second time. Ordered to third reading.

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

Summary: The California 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: Amended: 4/9/2025 html pdf
Introduced: 12/2/2024
Status: 8/29/2025-From committee: Do pass. (Ayes 5. Noes 2.) (August 29). Read second time. Ordered to third reading.

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

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

AB 49 **(Muratsuchi D) Schoolsites: immigration enforcement.**
Current Text: Enrollment: 9/2/2025 html pdf
Introduced: 12/2/2024
Status: 9/2/2025-Read third time. Urgency clause adopted. Passed. Ordered to the Assembly. (Ayes 32. Noes 0.). In Assembly. Concurrence in Senate amendments pending. Assembly Rule 63 suspended. Senate amendments concurred in. To Engrossing and Enrolling. (Ayes 61. Noes 7.).

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: Amended: 4/2/2025 html pdf
Introduced: 12/2/2024
Status: 6/24/2025-Read second time. Ordered to third reading.

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

Summary: Existing law, the 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: 8/20/2025-Read second time. Ordered to third reading.

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

Summary: Existing law 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: Amended: 9/2/2025 html pdf
Introduced: 12/2/2024
Status: 9/3/2025-Read second time. Ordered to third reading.

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

Summary: Existing law 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	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered

	year							Conc.			
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: 9/2/2025-Ordered to special consent calendar.

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

Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law requires the department to establish a subacute care program in health facilities, as specified, to be available to patients in health facilities who meet subacute care criteria. Existing law requires that medical necessity for pediatric subacute care be substantiated by specified conditions. Existing regulations require a treatment authorization request for each admission to a subacute unit. This bill would require a 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: Amended: 7/8/2025 html pdf
Introduced: 1/9/2025
Status: 9/3/2025-Read third time. Passed. Ordered to the Assembly. (Ayes 39. Noes 0.). In Assembly. Concurrence in Senate amendments pending.

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: Amended: 6/18/2025 html pdf
Introduced: 1/16/2025
Status: 8/29/2025-From committee: Do pass. (Ayes 5. Noes 2.) (August 29). Read second time. Ordered to third reading.

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

Summary: The California 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: 8/29/2025-From committee: Do pass. (Ayes 5. Noes 0.) (August 29). Read second time. Ordered to third reading.

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires 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: 6/12/2025-Ordered to inactive file at the request of Assembly Member Gallagher.

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

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

AB 290 **(Bauer-Kahan D) California FAIR Plan Association: automatic payments.**
Current Text: Amended: 8/25/2025 html pdf
Introduced: 1/22/2025
Status: 8/26/2025-Read second time. Ordered to third reading.

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

Summary: Existing law 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 require the amount charged for a policy to remain the same regardless of whether the policyholder opts for automatic payments or another method, but would authorize a reasonable fee for the convenience and increased cost associated with using the automatic payment system. 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: 8/28/2025-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: 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: 9/3/2025 html pdf
Introduced: 1/23/2025
Status: 9/3/2025-Read third time. Passed. Ordered to the Assembly. (Ayes 27. Noes 11.). In Assembly. Ordered to Engrossing and Enrolling.

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

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

indefinitely extending an existing requirement under the Pharmacy Law, the violation of which is a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

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

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

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

AB 316 **(Krell D) Artificial intelligence: defenses.**
Current Text: Amended: 9/2/2025 html pdf
Introduced: 1/24/2025
Status: 9/3/2025-Read second time. Ordered to third reading.

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

Summary: Existing law 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: 7/7/2025 html pdf
Introduced: 1/29/2025
Status: 8/29/2025-From committee: Do pass. (Ayes 7. Noes 0.) (August 29). Read second time. Ordered to third reading.

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

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

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

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

Summary: Existing law establishes the Department of Health Care Access and Information to oversee and administer various health programs and to collect health data. Existing law establishes the Medical Board of California and the Osteopathic Medical Board of California for the licensure and regulation of physicians and surgeons and osteopathic

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

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

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

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

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

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

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

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

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

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

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

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

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

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

AB 408 **(Berman D) Physician Health and Wellness Program.**
Current Text: Amended: 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: Amended: 7/17/2025 html pdf
Introduced: 2/5/2025
Status: 9/4/2025-Set for Hearing Supplemental File 9/4/2025

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: Amended: 8/29/2025 html pdf
Introduced: 2/5/2025
Status: 9/2/2025-Read second time. Ordered to third reading.

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

Summary: Existing law, the 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, a physician and surgeon 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: Amended: 7/8/2025 html pdf
Introduced: 2/10/2025
Status: 9/4/2025-Set for Hearing Supplemental File 9/4/2025

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: Amended: 7/14/2025 html pdf
Introduced: 2/10/2025
Status: 8/29/2025-From committee: Do pass. (Ayes 5. Noes 0.) (August 29). Read second time. Ordered to third reading.

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of disability insurers by the Department of Insurance. Existing law generally authorizes a health care service plan or disability insurer to use utilization review, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. For a request prior to or concurrent with the provision of health care services, existing law requires utilization review decisions to be made within 5 business days from the plan's or insurer's receipt of the information reasonably necessary and requested by the plan or insurer to make the determination, or within 72 hours if the enrollee or insured faces an imminent and serious threat to their health or the normal timeframe would be detrimental to their life or health, as specified. This bill would 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. 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: 8/28/2025-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 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: 8/28/2025-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: street medicine.**
Current Text: Amended: 8/29/2025 html pdf
Introduced: 2/11/2025
Status: 9/2/2025-Read second time. Ordered to third reading.

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

Summary: Existing law 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 street medicine, as defined, under the Medi-Cal program for persons experiencing homelessness, as defined. The bill would state the intent of the Legislature that the street medicine-related provisions coexist with, and not duplicate, other Medi-Cal provisions, including, but not limited to, those regarding community health worker services, enhanced care management, and community supports. The bill would authorize a Medi-Cal managed care plan to elect to offer Medi-Cal covered services through a street medicine provider, as defined. Under the bill, a managed care plan that elects to do so would be required to allow a Medi-Cal beneficiary who is experiencing homelessness to receive those services directly from a contracted street medicine provider, regardless of the beneficiary's network assignment, as specified. The bill would also require the managed care plan to allow a contracted street medicine provider enrolled in Medi-Cal to directly refer the beneficiary 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: Amended: 9/3/2025 html pdf
Introduced: 2/11/2025
Status: 9/3/2025-Read third time and amended. Ordered to second reading.

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act'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: Amended: 7/17/2025 html pdf
Introduced: 2/11/2025
Status: 8/29/2025-From committee: Do pass. (Ayes 6. Noes 0.) (August 29). Read second time. Ordered to third reading.

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law 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, step therapy, or any other protocol designed to delay treatment, but would authorize prior authorization or step therapy if at least one therapeutically equivalent version is covered without prior authorization or step therapy. 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: Amended: 6/16/2025 html pdf
Introduced: 2/13/2025
Status: 9/3/2025-Read third time. Passed. Ordered to the Assembly. (Ayes 31. Noes 6.). In Assembly. Concurrence in Senate amendments pending.

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: 8/28/2025-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: 8/28/2025-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 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: Amended: 7/17/2025 html pdf
Introduced: 2/14/2025
Status: 8/29/2025-From committee: Do pass. (Ayes 6. Noes 0.) (August 29). Read second time. Ordered to third reading.

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

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

AB 787 **(Papan D) Provider directory disclosures.**
Current Text: Amended: 6/23/2025 html pdf

Introduced: 2/18/2025
Status: 8/28/2025-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: Amended: 9/3/2025 html pdf
Introduced: 2/18/2025
Status: 9/3/2025-Read third time and amended. Ordered to second reading.

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: Amended: 8/29/2025 html pdf
Introduced: 2/18/2025
Status: 9/2/2025-Read second time. Ordered to third reading.

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

Summary: Existing law 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: Amended: 9/3/2025 html pdf
Introduced: 2/19/2025
Status: 9/3/2025-From special consent calendar. Ordered to third reading. Read third time and amended. Ordered to second reading.

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: Amended: 7/7/2025 html pdf
Introduced: 2/19/2025
Status: 8/29/2025-From committee: Do pass. (Ayes 5. Noes 0.) (August 29). Read second time. Ordered to third reading.

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

Summary: (1)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: Amended: 8/25/2025 html pdf
Introduced: 2/20/2025
Status: 9/3/2025-Read third time. Passed. Ordered to the Assembly. (Ayes 39. Noes 0.). In Assembly. Concurrence in Senate amendments pending.

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: Amended: 9/3/2025 html pdf
Introduced: 2/20/2025
Status: 9/3/2025-Read third time and amended. Ordered to second reading.

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: 7/17/2025 html pdf
Introduced: 2/20/2025
Status: 8/29/2025-From committee: Do pass. (Ayes 5. Noes 2.) (August 29). Read second time. Ordered to third reading.

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

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

AB 1032 **(Harabedian D) Coverage for behavioral health visits.**
Current Text: Amended: 8/29/2025 html pdf
Introduced: 2/20/2025
Status: 9/2/2025-Read second time. Ordered to third reading.

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires 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: Amended: 8/29/2025 html pdf
Introduced: 2/20/2025
Status: 9/2/2025-Read second time. Ordered to third reading.

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

Summary: (1)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.

AB 1041 **(Bennett D) Health care coverage: health care provider credentials.**
Current Text: Amended: 8/29/2025 html pdf
Introduced: 2/20/2025
Status: 9/2/2025-Read second time. Ordered to third reading.

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act'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: 8/18/2025-From Consent Calendar. Ordered to third reading.

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: 8/28/2025-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 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: 8/28/2025-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 establishes the Department of Technology within the Government Operations Agency. Existing law requires the department to conduct, in coordination with other interagency bodies as it deems appropriate, a comprehensive inventory of all high-risk automated decision systems that have been proposed for use, development, or procurement by, or are being used, developed, or procured by, any state agency. Existing law defines "automated decision system" as a computational process derived from machine learning, statistical modeling, data analytics, or artificial intelligence that issues simplified output, including a score, classification, or recommendation, that is used to assist or replace human discretionary decision making and materially impacts natural persons. Existing law defines "artificial intelligence" as an engineered or machine-based system that varies in its level of autonomy and that can, for explicit or implicit objectives, infer from the input it receives how to generate outputs that can influence physical or virtual environments. This bill would require the Government Operations Agency, by January 1, 2027, to establish a mechanism on the agency's internet website allowing AI auditors to enroll with the agency and allowing natural persons to report misconduct by an enrolled AI auditor. The bill would require the agency, commencing January 1, 2027, to publish information provided by an enrolled AI auditor on the agency's internet website, retain specified reports for as long as the auditor remains enrolled, plus 10 years, and share reports submitted by persons reporting misconduct with other state agencies as necessary for enforcement purposes. This bill 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: Amended: 8/21/2025 html pdf
Introduced: 2/21/2025
Status: 9/4/2025-Set for Hearing Supplemental File 9/4/2025

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: Amended: 8/29/2025 html pdf
Introduced: 2/21/2025
Status: 9/2/2025-Read second time. Ordered to third reading.

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

Summary: Existing law 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 which classifications of health care employees, as specified, employed by the entities above are eligible for health care coverage at the commencement of employment without a waiting period, those not so eligible, and the waiting period for those so not eligible. 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 already required to do so.

SB 7 **(McNerney D) Employment: automated decision systems.**
Current Text: Amended: 9/2/2025 html pdf
Introduced: 12/2/2024
Status: 9/3/2025-Read second time. Ordered to third reading.

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

Summary: Existing law requires the Department of Technology to conduct, in coordination with other interagency bodies as it deems appropriate, a comprehensive inventory of all high-risk automated decision systems (ADS) that have been proposed for use, development, or procurement by, or are being used, developed, or procured by, any state agency. Existing law establishes the Labor and Workforce Development Agency, which is composed of various departments responsible for protecting and promoting the rights and interests of workers in California, including the Division of Labor Standards Enforcement, led by the Labor Commissioner, within the Department of Industrial Relations. This bill would require an employer 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 in 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 require an employer to allow a worker to access their data collected or used by an ADS and to correct errors in the worker's data, 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: Amended: 9/2/2025 html pdf
Introduced: 12/2/2024
Status: 9/3/2025-Read second time. Ordered to third reading.

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

Summary: Existing law, the Community Assistance, Recovery, and Empowerment (CARE) Act, authorizes specified adult persons to petition a civil court to create a voluntary CARE agreement or a court-ordered CARE plan and implement services, to be provided by county behavioral health agencies, to provide behavioral health care, including stabilization medication, housing, and other enumerated services, to adults who are currently experiencing a severe mental illness and have a diagnosis identified in the disorder class schizophrenia and other psychotic disorders, and who meet other specified criteria. Existing law authorizes a specified individual to commence the CARE process, known as the original petitioner. Existing law authorizes the court to dismiss a case without prejudice when the court finds that a petitioner has not made a prima facie showing that they qualify for the CARE process. Existing law requires the court to take prescribed actions if it finds that a prima facie showing has been made, including, but not limited to, setting the matter for an initial appearance on the petition. 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: Amended: 8/29/2025 html pdf
Introduced: 12/3/2024
Status: 9/3/2025-Read third time. Passed. Ordered to the Senate. In Senate. Concurrence in Assembly amendments pending.

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: Amended: 9/2/2025 html pdf
Introduced: 12/3/2024
Status: 9/3/2025-Read second time. Ordered to third reading.

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. This bill contains other related provisions and other existing laws.

SB 53 **(Wiener D) Artificial intelligence models: large developers.**
Current Text: Amended: 9/2/2025 html pdf
Introduced: 1/7/2025
Status: 9/3/2025-Read second time. Ordered to third reading.

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 developed by a large developer, require a large developer to write, implement, and clearly and conspicuously publish on its internet website a safety and security protocol that describes in specific detail, among other things, the testing procedures that the large developer uses to assess catastrophic risks from its foundation models, as specified. The TFAIA would define "foundation model" to mean an artificial intelligence model that is trained on a broad data set, designed for generality of output, and adaptable to a wide range of distinctive tasks. The TFAIA would require the Attorney General to establish a mechanism to be used by a large developer or a member of the public to report, as prescribed, a critical safety incident, as defined, and would authorize the Attorney General to periodically update the definition of "foundation model," as specified. This bill contains other related provisions and other existing laws.

SB 62 **(Menjivar D) Health care coverage: essential health benefits.**
Current Text: Amended: 7/1/2025 html pdf
Introduced: 1/9/2025
Status: 9/3/2025-Read third time. Passed. Ordered to the Senate. In Senate. Concurrence in Assembly amendments pending.

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, requires the Department of Managed Health Care to license and regulate health care service plans 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: Enrollment: 9/2/2025 html pdf
Introduced: 1/17/2025
Status: 9/2/2025-Read third time. Urgency clause adopted. Passed. Ordered to the Senate. In Senate. Concurrence in Assembly amendments pending. Assembly amendments concurred in. (Ayes 30. Noes 7.) Ordered to engrossing and enrolling.

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

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: Introduced: 1/30/2025 html pdf
Introduced: 1/30/2025
Status: 9/2/2025-Read second time. Ordered to third reading.

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

Summary: Existing law 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: Amended: 6/17/2025 html pdf
Introduced: 1/30/2025
Status: 7/3/2025-Read second time. Ordered to third reading.

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

Summary: Existing law 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) Pregnancy As a Recognized Event for Nondiscriminatory Treatment (PARENT) Act.**
Current Text: Amended: 7/17/2025 html pdf
Introduced: 2/3/2025
Status: 9/2/2025-Read second time. Ordered to third reading.

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

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

SB 278 **(Cabaldon D) Health data: HIV test results.**
Current Text: Amended: 9/2/2025 html pdf
Introduced: 2/4/2025
Status: 9/3/2025-Read second time. Ordered to third reading.

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

Summary: Existing law 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: Amended: 9/2/2025 html pdf
Introduced: 2/10/2025
Status: 9/3/2025-Read second time. Ordered to third reading.

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

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

act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law 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 most frequently approved, 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: Amended: 8/27/2025 html pdf
Introduced: 2/14/2025
Status: 8/27/2025-Read third time and amended. Ordered to third reading.

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or a health insurance policy to provide coverage for behavioral health treatment for pervasive developmental disorder or autism and defines "behavioral health treatment" to mean specified services and treatment programs, including treatment provided pursuant to a treatment plan that is prescribed by a qualified autism service provider and administered either by a qualified autism service provider or by a qualified autism service professional or qualified autism service paraprofessional. Existing law defines "qualified autism service provider," "qualified autism service professional," and "qualified autism service paraprofessional" for those purposes. Those definitions are contained in the Health and Safety Code and the Insurance Code. This bill would move those definitions to the Business and Professions Code. The bill would also make technical and conforming changes. This bill would incorporate additional changes to Section 1374.73 of the Health and Safety Code and Section 10144.51 of the Insurance Code proposed by AB 951 to be operative only if this bill and AB 951 are enacted and this bill is enacted last.

SB 418 **(Menjivar D) Health care coverage: prescription hormone therapy and nondiscrimination.**
Current Text: Amended: 7/9/2025 html pdf
Introduced: 2/18/2025
Status: 9/2/2025-Read second time. Ordered to third reading.

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act'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. Existing law sets forth specified coverage requirements for health care service plan contracts and health insurance policies. Existing law generally authorizes a health care service plan or health insurer to use utilization controls to approve, modify, delay, or deny requests for health care services based on medical necessity. Existing law requires health care service plans and health insurers, as specified, within 6 months after the relevant department issues specified guidance, or no later than March 1, 2025, to require all of their staff who are in direct contact with enrollees or insureds in the delivery of care or enrollee or insured services to complete evidence-based cultural competency training for the purpose of providing trans-inclusive health care for individuals who identify as transgender, gender diverse, or intersex. This bill would require a health care service plan contract or health insurance policy issued, amended, renewed, or delivered on or after the bill's operative date 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, an insurer, or the Medi-Cal program 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 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: Amended: 4/10/2025 html pdf
Introduced: 2/18/2025

Status: 9/3/2025-Read third time. Passed. Ordered to the Senate.

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: Amended: 8/25/2025 html pdf
Introduced: 2/19/2025
Status: 9/3/2025-In Senate. Concurrence in Assembly amendments pending.

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: Amended: 7/9/2025 html pdf
Introduced: 2/20/2025
Status: 9/2/2025-Read second time. Ordered to third reading.

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

Summary: Existing law 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 set forth related reporting requirements with regard to subcontractor networks. This bill contains other related provisions and other existing laws.

SB 535 **(Richardson D) Obesity 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 anti obesity medication approved by the United States Food and Drug Administration. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

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: 9/3/2025-Ordered to inactive file on request of Senator Smallwood-Cuevas.

Desk	Policy	Fiscal	Floor	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: Amended: 9/2/2025 html pdf
Introduced: 2/20/2025
Status: 9/3/2025-Read second time. Ordered to third reading.

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

Summary: Existing law 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. This bill contains other related provisions.

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 school site. This bill would expand the definition of school site 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: Amended: 8/25/2025 html pdf
Introduced: 3/17/2025
Status: 9/3/2025-Read third time. Passed. Ordered to the Senate. In Senate. Concurrence in Assembly amendments pending.

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

Total Tracking Forms: 123

ALAMEDA Alliance FOR HEALTH

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

Executive Dashboard

OPERATIONS DASHBOARD

SEPTEMBER 2025

9/3/2025 11:54:41 AM

Financials

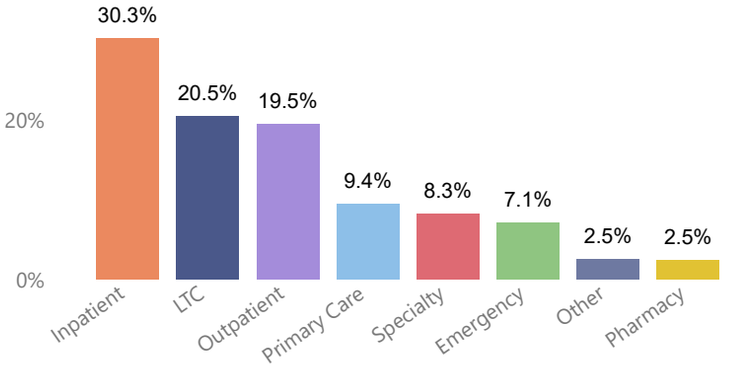
Income & Expenses

	JULY 2025	FISCAL YTD
REVENUE	$ 257.6 M	$ 257.6 M
MEDICAL EXPENSE	$ (184.3) M	$ (184.3) M
ADMIN EXPENSE	$ (8.9) M	$ (8.9) M
OTHER/TAX	$ (62.7) M	$ (62.7) M
NET INCOME	$ 1.7 M	$ 1.7 M

Medical Loss % (Fiscal YTD)

96.0%

Medical Expenses



Liquid Reserves

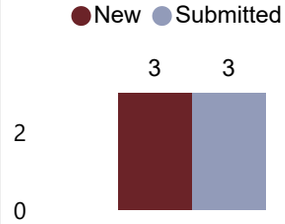
TNE %

210.5%

TNE $

$171.0M

Reinsurance Cases



Balance Sheet

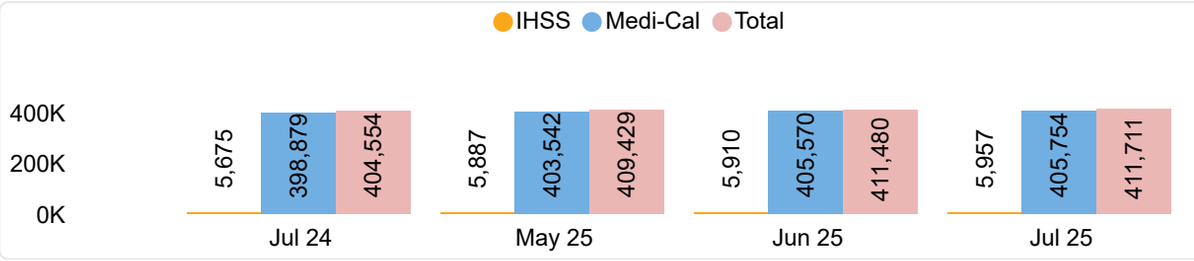
Cash Equivalents	$530.3M
Pass-Through Liabilities	$152.7M
Uncommitted Cash	$377.6M
Working Capital	$117.4M

Current Ratio

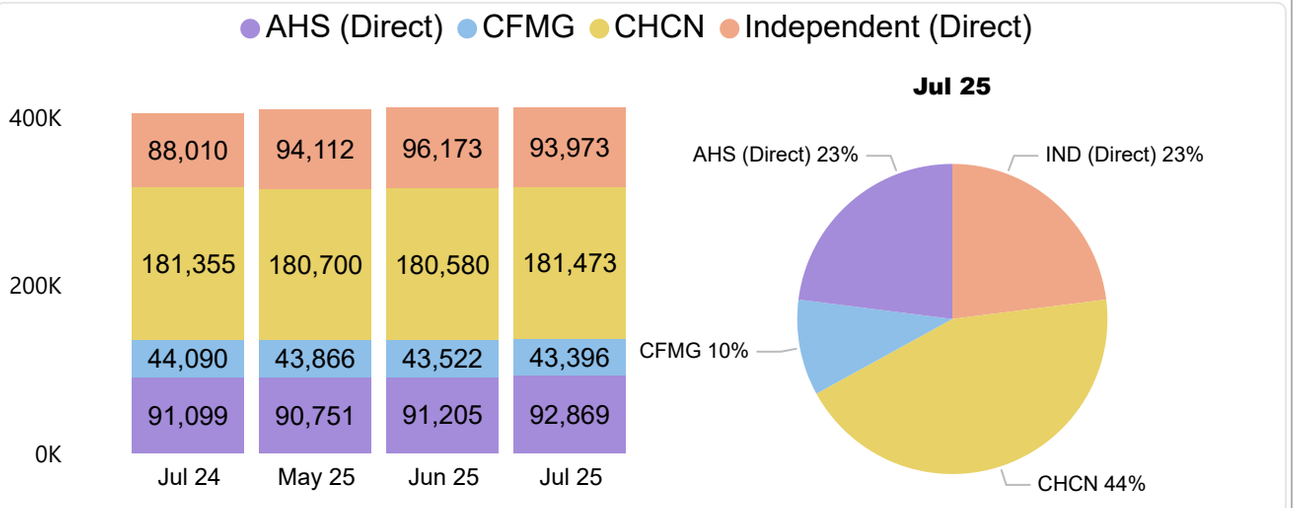
1.15

Membership

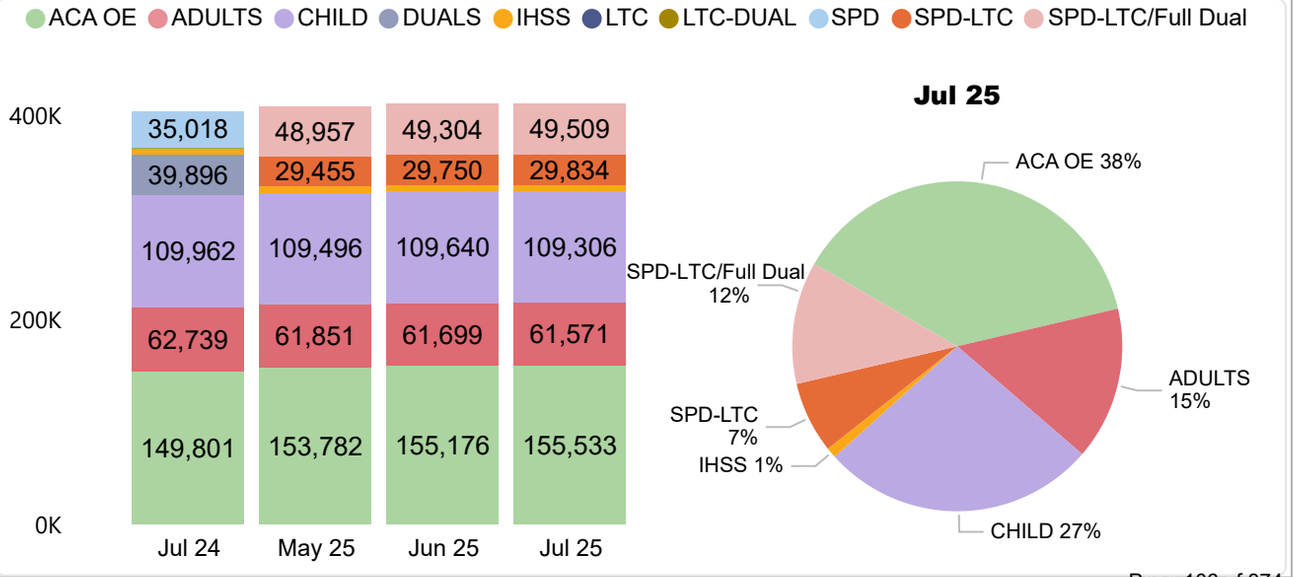
By Plan



By Network



By Category



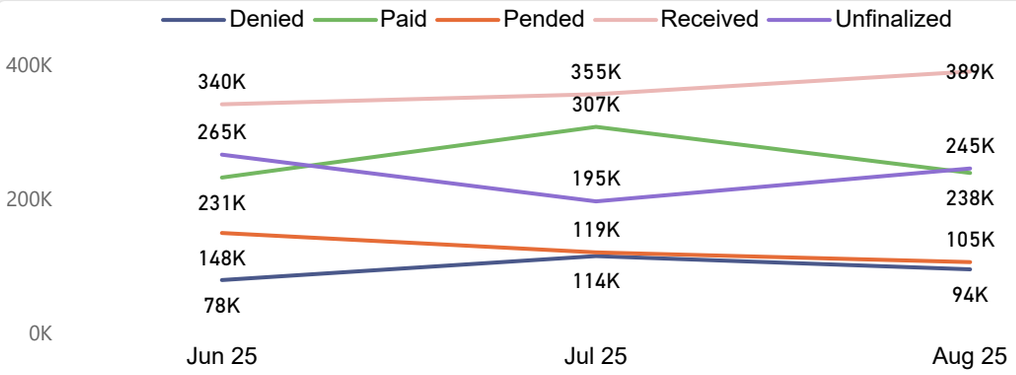
OPERATIONS DASHBOARD

SEPTEMBER 2025

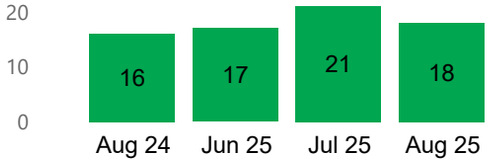
9/3/2025 11:54:41 AM

Claims

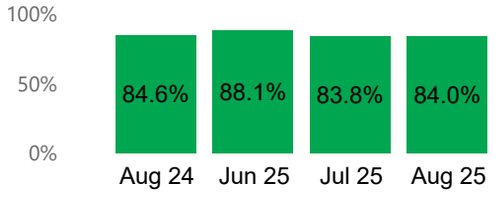
Claims Processing



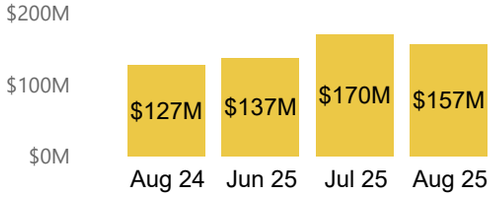
Average Payment TAT (Days)



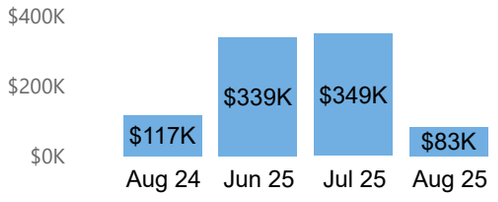
Auto Adjudication Rate (%)



Claims Paid ($)

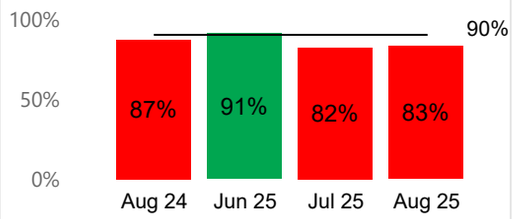


Interest Paid ($)

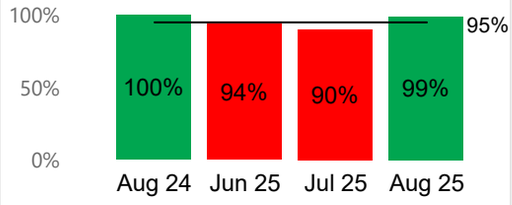


Claims Compliance

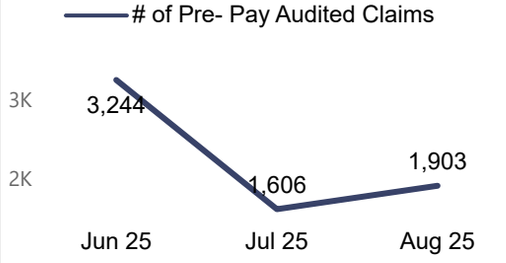
Processed 30 Cal Days (%)



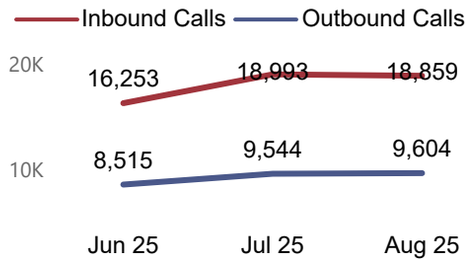
Processed 45 Work Days (%)



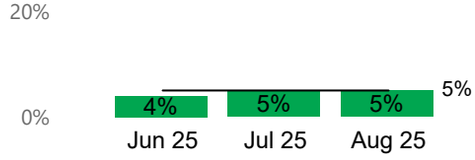
Claims Auditing



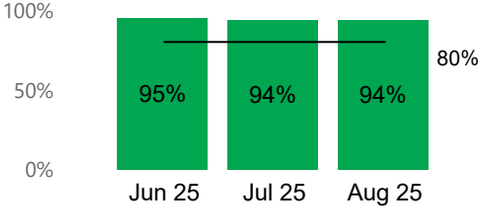
Member Services



Abandoned Call Rate (%)

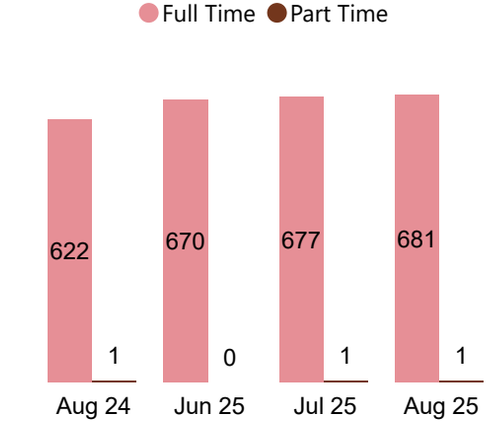


Calls Answered in 30 Seconds (%)

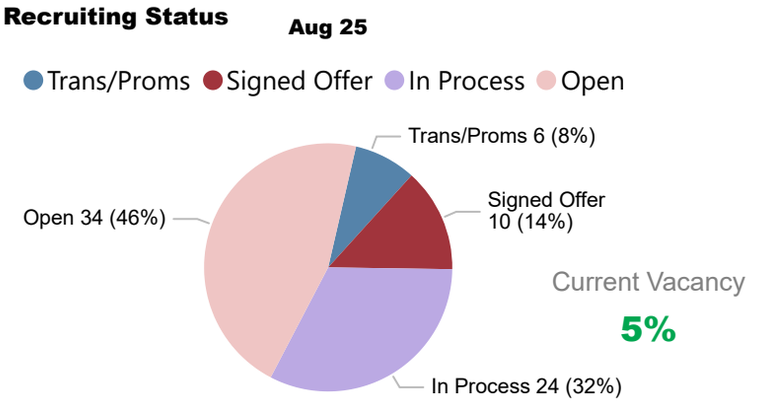


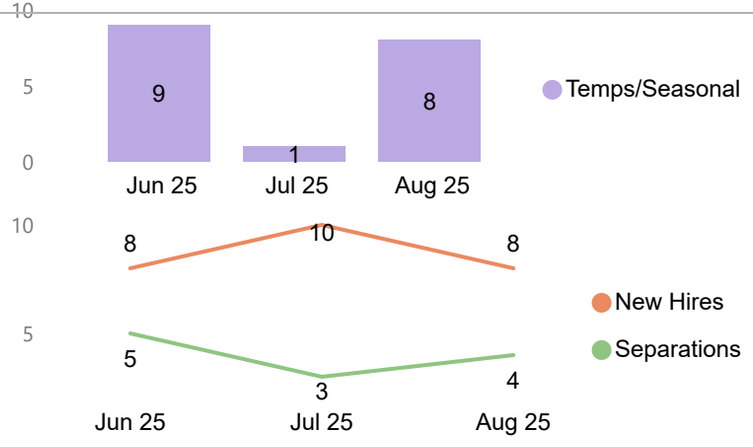
Average Call Times	Jun 25	Jul 25	Aug 25
Wait Time	00:11	00:13	00:13
Call Duration	07:50	07:39	07:47

Human Resources



Recruiting Status Aug 25





OPERATIONS DASHBOARD

SEPTEMBER 2025

9/3/2025 11:54:41 AM

Provider Services

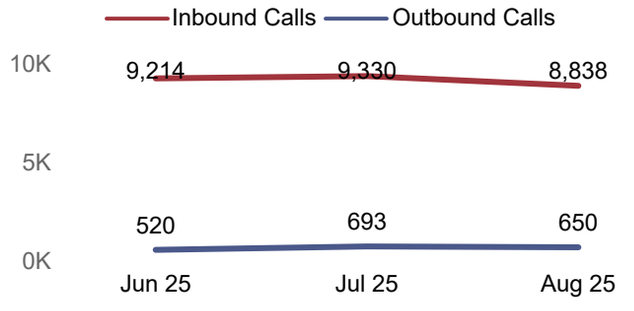
Provider Network

Hospital	17
Specialist	11,554
Primary Care Physician	762
Skilled Nursing Facility	107
Urgent Care	16
Health Centers (FQHCs and Non-FQHCs)	87
TOTAL	**12,543**

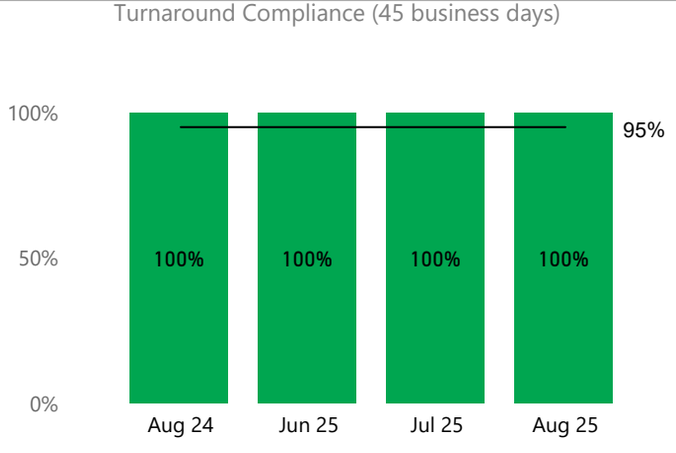
Provider Credentialing

5,080

Provider Call Center

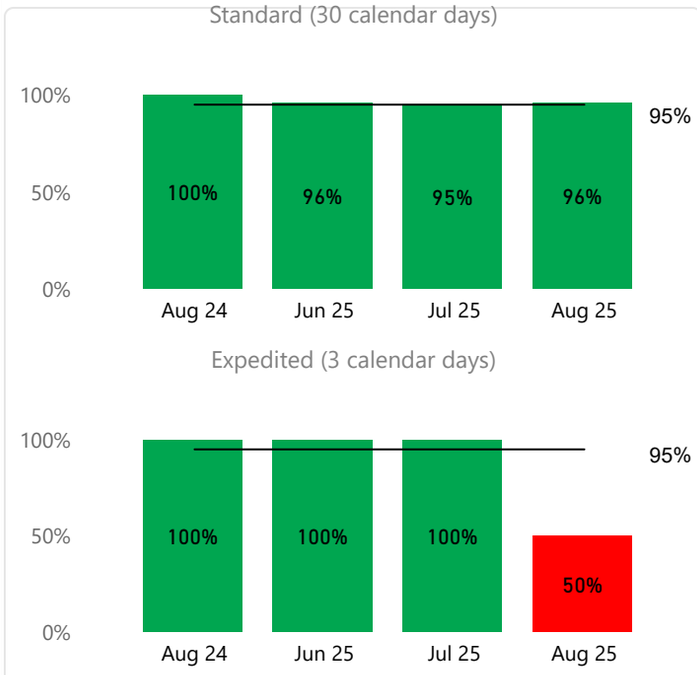


Provider Disputes & Resolutions

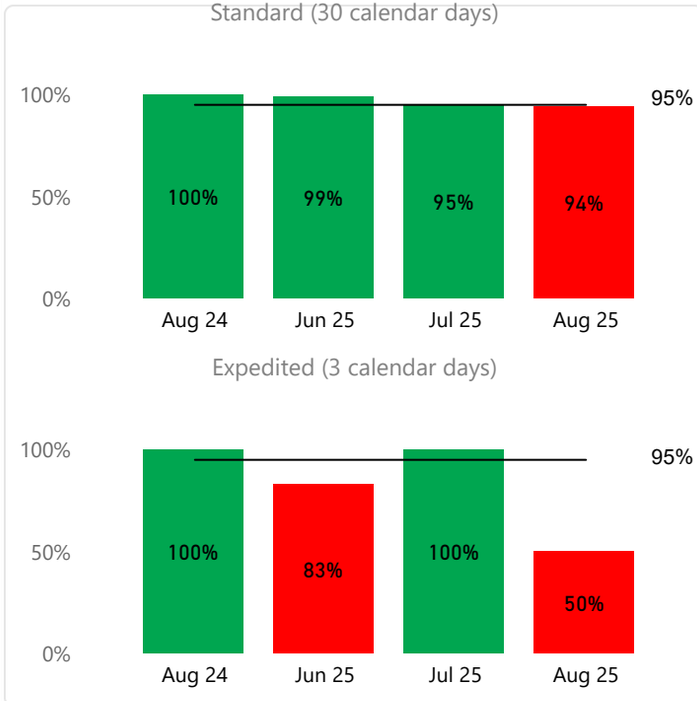


Compliance

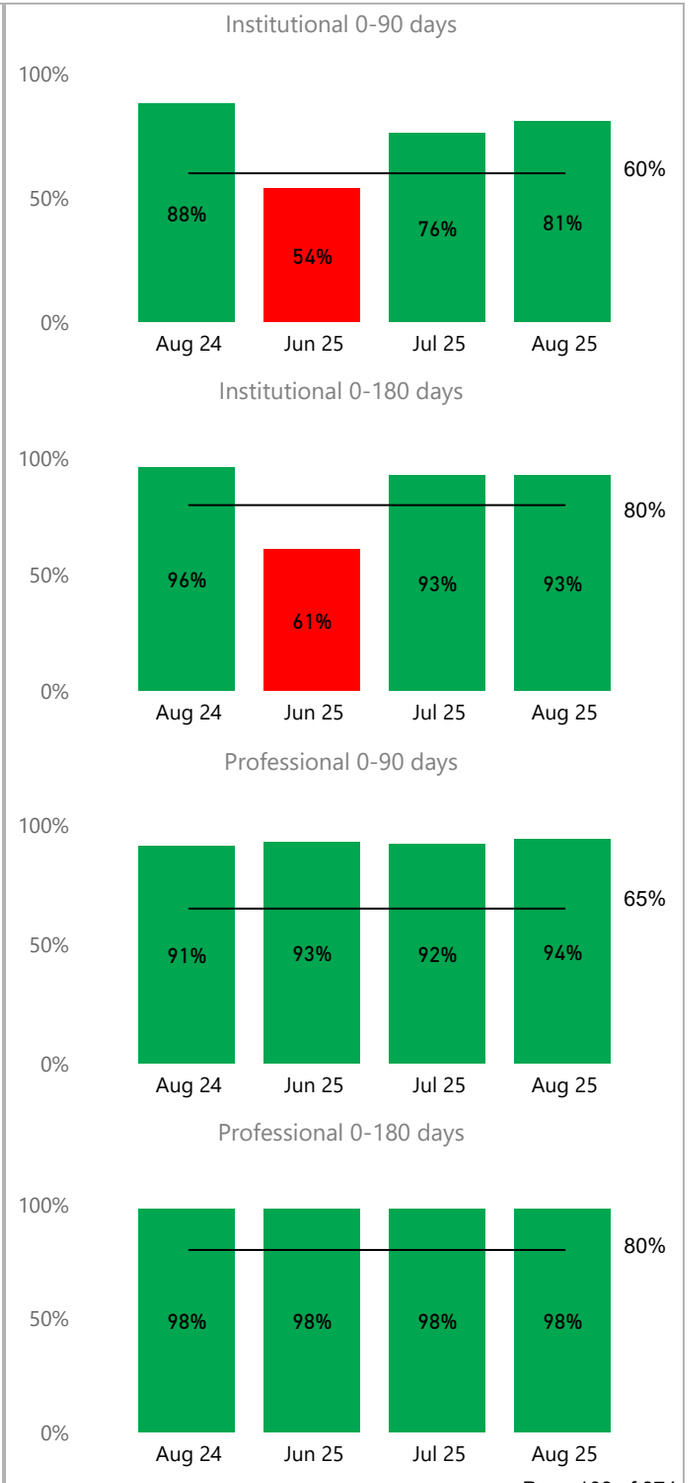
Member Grievances



Member Appeals



Encounter Data



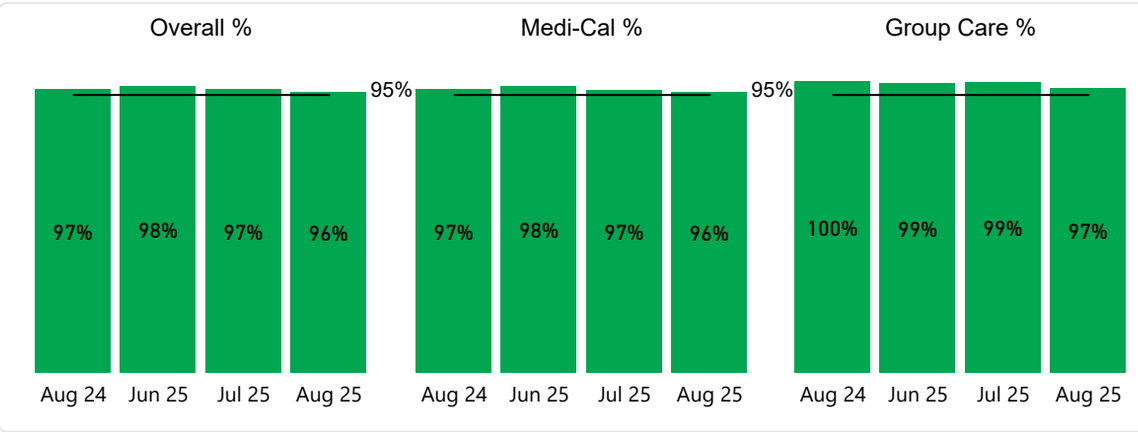
OPERATIONS DASHBOARD

SEPTEMBER 2025

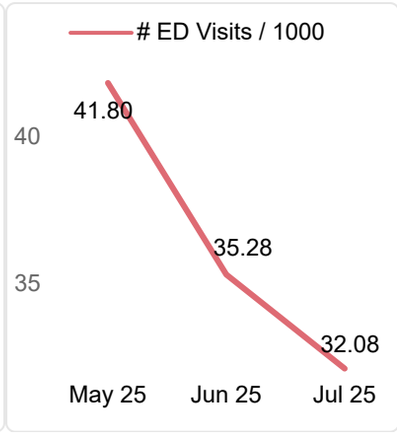
9/3/2025 11:54:41 AM

Health Care Services

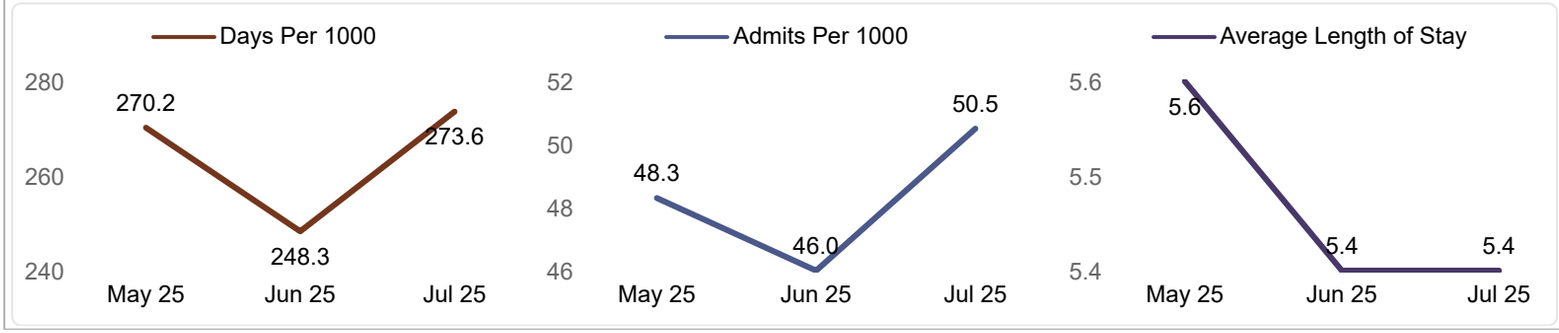
Authorization Turnaround



ED Utilization

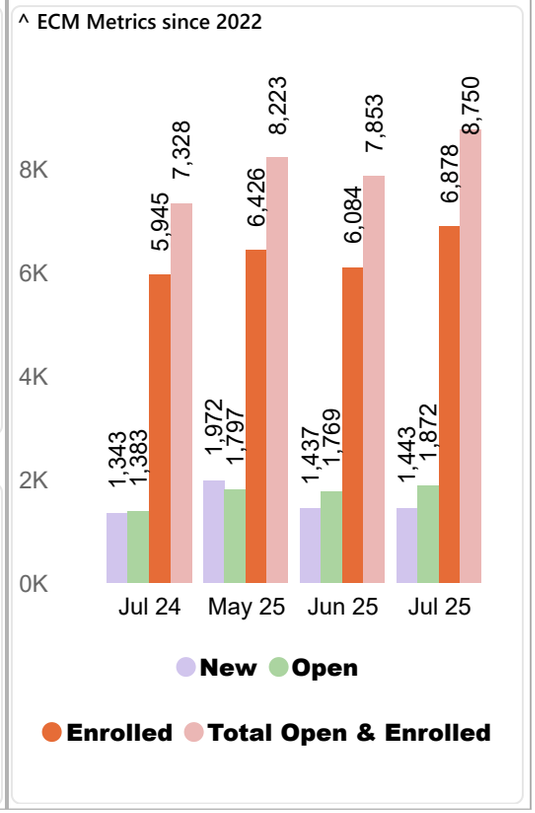


Inpatient Utilization

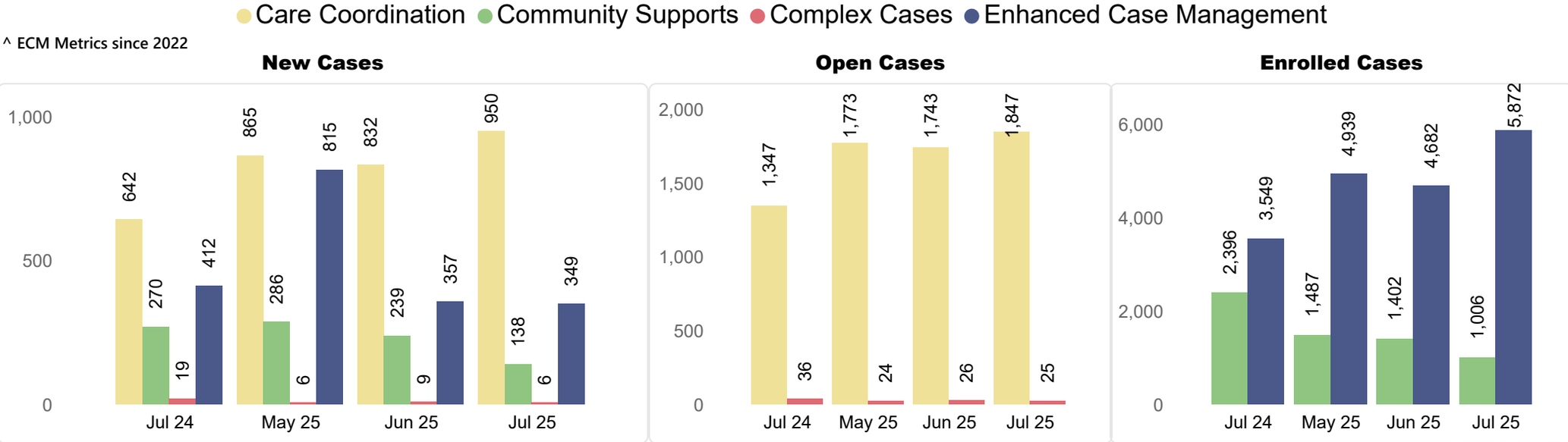


Case Management

Total Cases^



Case Management^



Technology (Business Availability)

Applications	Aug 24	Jun 25	Jul 25	Aug 25
HEALTHsuite System	99.9%	99.9%	100.0%	99.9%
Other Applications	100.0%	99.6%	100.0%	99.9%
TruCare System	100.0%	100.0%	100.0%	100.0%

Outpatient Authorization Denial Rates *

OP Authorization Denial Rates	Aug 24	Jun 25	Jul 25	Aug 25
Denial Rate Excluding Partial Denials (%)	3.4%	4.5%	3.6%	2.6%
Overall Denial Rate (%)	3.7%	5.0%	4.0%	2.9%
Partial Denial Rate (%)	0.3%	0.5%	0.5%	0.3%

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

Pharmacy Authorizations

Authorizations	Aug 24	Jun 25	Jul 25	Aug 25
Approved Prior Authorizations	46	37	43	31
Closed Prior Authorizations	97	17	9	21
Denied Prior Authorizations	51	78	90	107
Total Prior Authorizations	194	132	142	159

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.

Finance

Gil Riojas

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

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

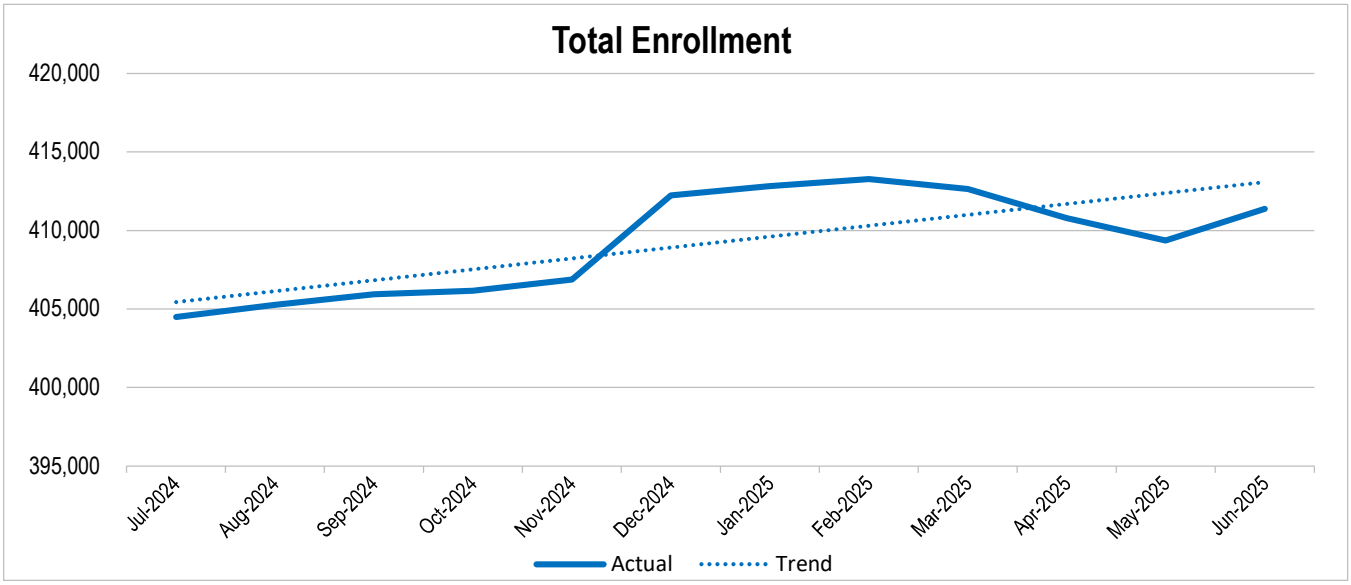
Date: **August 12th, 2025**

Subject: Finance Report – June 2025 Financials (Pre-Audit)

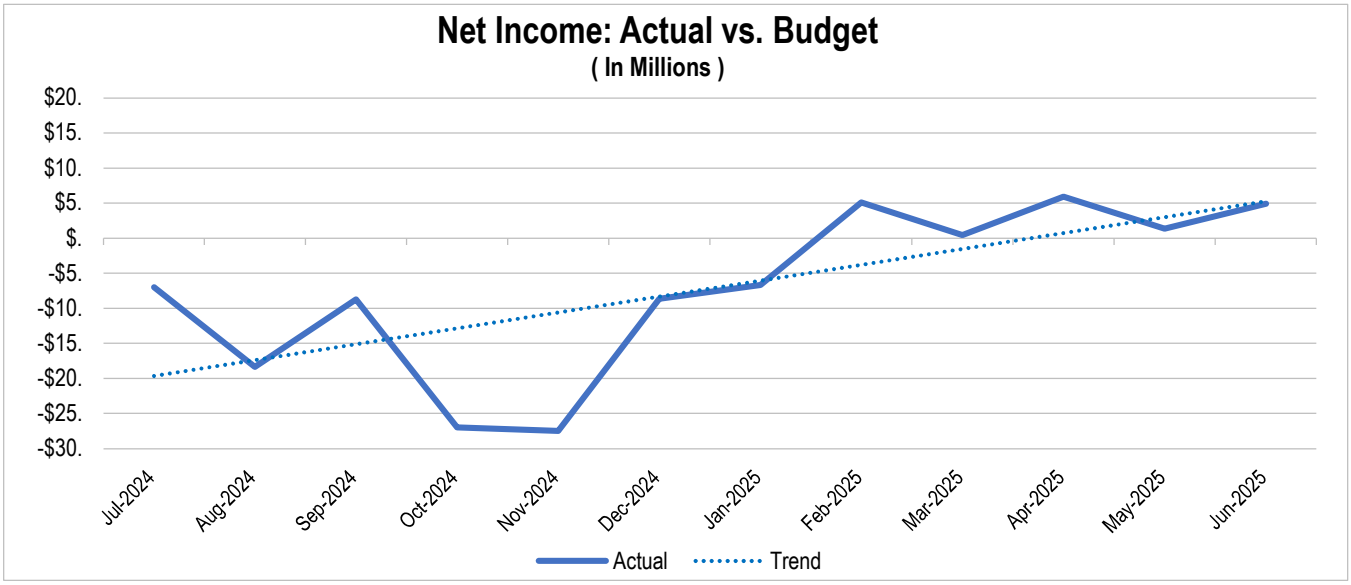
Executive Summary

For the month of June, the Alliance increased in enrollment, reaching 411,383 members. Net Income of $4.9 million was reported, and the Plan's Medical Expenses represented 92.6% of Premium Revenue. Alliance reserves increased slightly to 210% of required and continue to remain above minimum requirements.

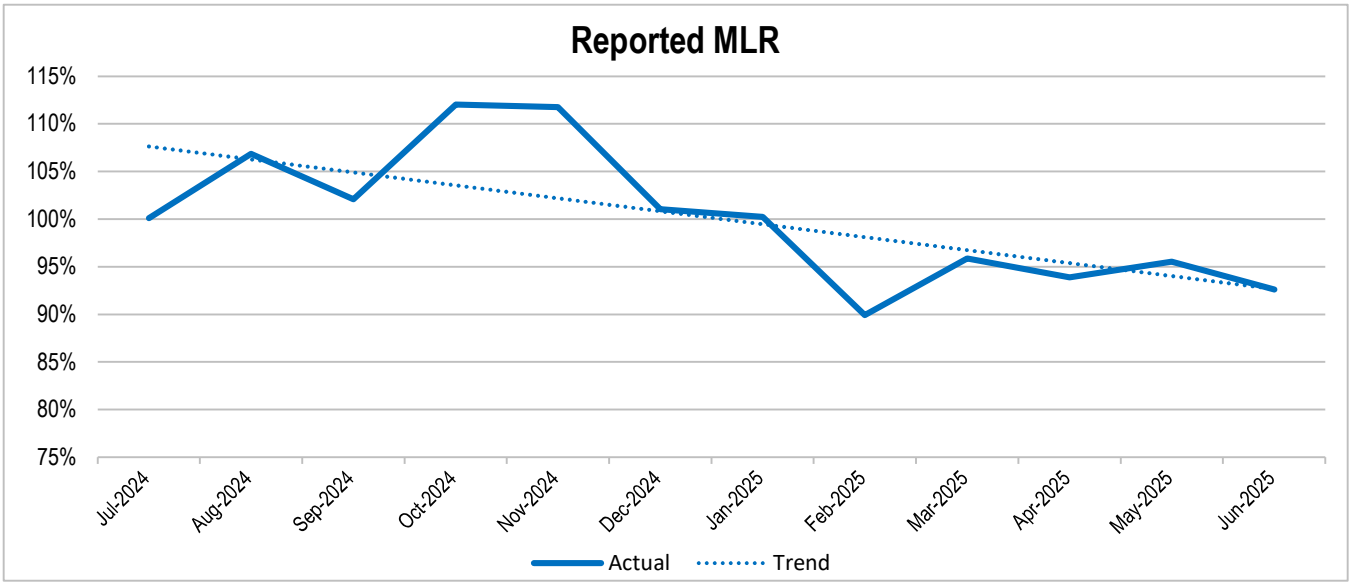
Enrollment – In June, Enrollment increased by 2,025 members.



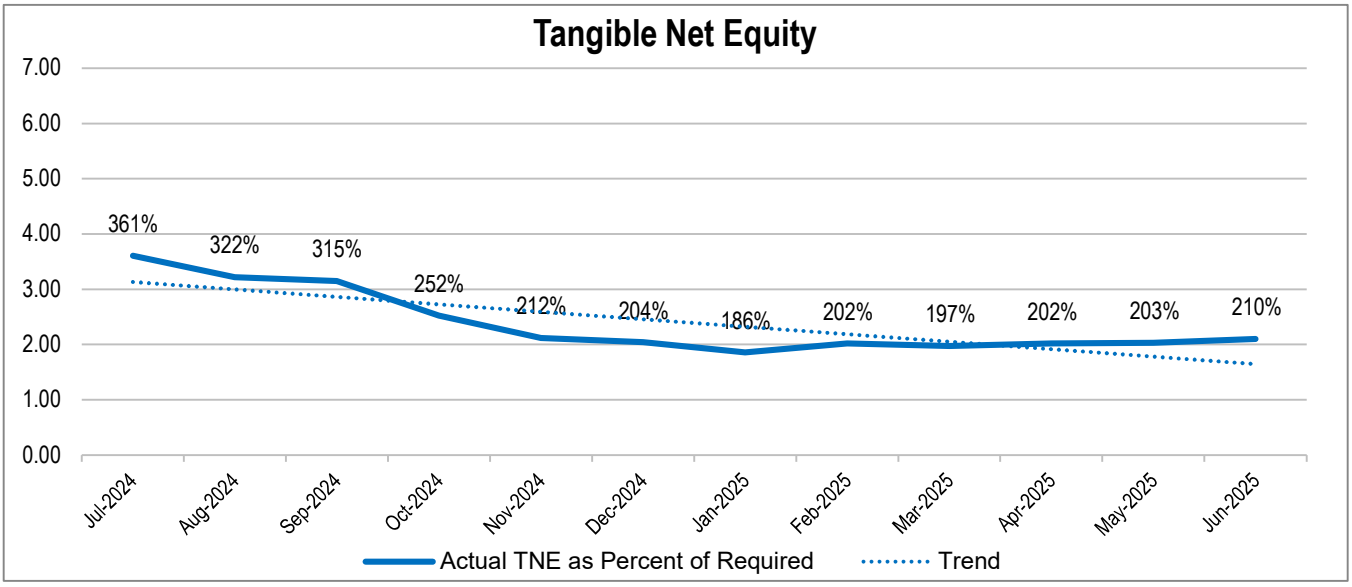
Net Income – For the month ended June, actual Net Income was $4.9 million vs. budgeted Net Income of $2.7 million. For the fiscal YTD, actual Net Loss was $86.1 million vs. budgeted Net Loss of $65.3 million. For the month, Premium Revenue was favorable to budget, actual Revenue was $189.2 million vs. budgeted Revenue of $189.1 million. Premium Revenue favorable variance of $129,000 is primarily due to retroactive member months and volume variance for the current month.



Medical Loss Ratio (MLR) – The Medical Loss Ratio was 92.6% for the month, and 99.9% for fiscal YTD. The major unfavorable variances include Inpatient Hospital FFS and Outpatient Medical Expense. The major favorable variances include Long Term Care Expense, Risk Pool Expense, and Primary Care Expense.



Tangible Net Equity (TNE) - The Department of Managed Health Care (DMHC) required $80.7 million in reserves, we reported $169.3 million. Our overall TNE remains above DMHC requirements at 210%.



The Alliance continues to benefit from increased non-operating income. For Fiscal year-to-date, investments show a gain of $32.2 million and capital assets acquired are $859,000.

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

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

Date: **August 12th, 2025**

Subject: **Finance Report – June 2025 (Pre-Audit)**

Executive Summary

- For the month ended June 30th, 2025, the Alliance had enrollment of 411,383 members, a Net Income of $4.9 million and 210% of required Tangible Net Equity (TNE).

Overall Results: (in Thousands)

	Month	YTD
Revenue	$256,049	$3,014,787
Medical Expense	175,202	2,134,795
Admin. Expense	11,381	115,803
MCO Tax Expense	66,858	882,455
Other Inc. / (Exp.)	2,305	32,170
Net Income	**$4,912**	**($86,096)**

Net Income by Program: (in Thousands)

	Month	YTD
Medi-Cal	$6,556	($76,592)
Group Care	(235)	(273)
Medicare	(1,409)	(9,231)
	$4,912	**($86,096)**

Enrollment

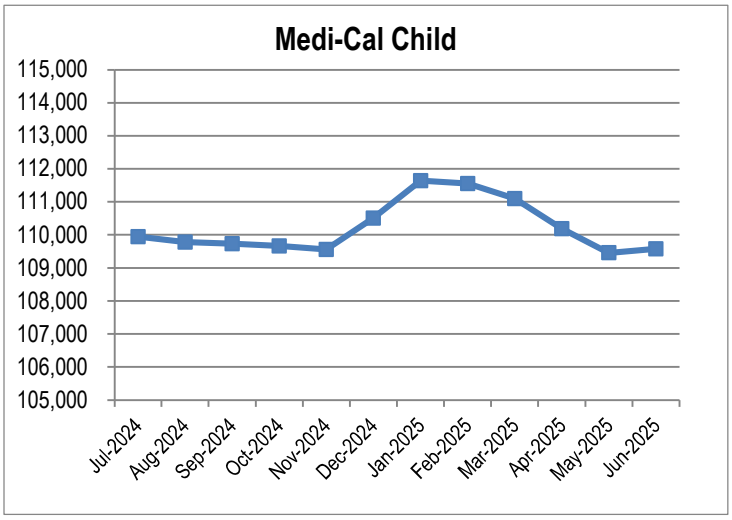
- Total enrollment increased by 2,025 members since May 2025.
- Total enrollment increased by 7,393 members since June 2024.

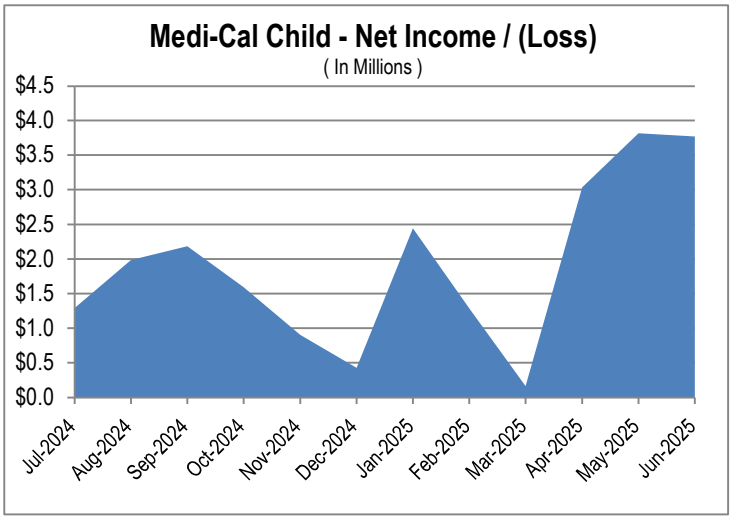
Monthly Membership and YTD Member Months
Actual vs. Budget

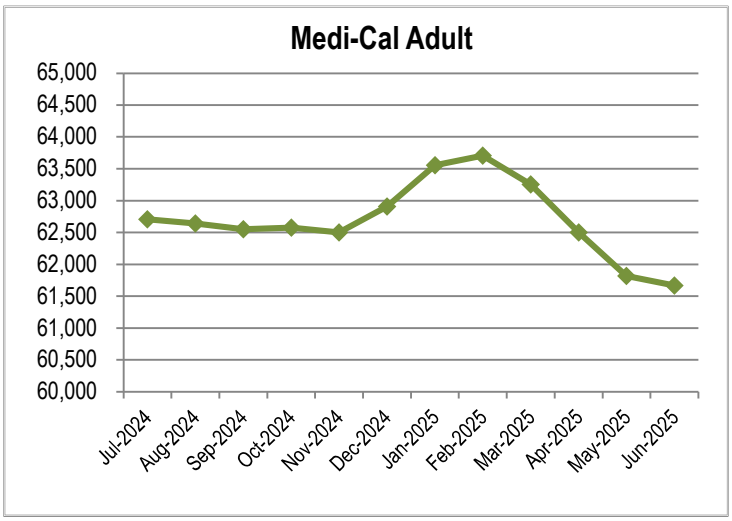
Enrollment					Member Months			
Current Month					Year-to-Date			
Actual	Budget	Variance	Variance %		Actual	Budget	Variance	Variance %
				Medi-Cal:				
109,574	110,653	(1,079)	(1.0%)	Child	1,322,714	1,321,045	1,669	0.1%
61,669	63,082	(1,413)	(2.2%)	Adult	752,384	753,369	(985)	(0.1%)
0	0	0	100.0%	SPD*	212,632	211,783	849	0.4%
0	0	0	100.0%	Duals*	241,339	240,472	867	0.4%
155,176	152,311	2,865	1.9%	ACA OE	1,834,921	1,816,621	18,300	1.0%
0	0	0	100.0%	MCAL LTC*	1,446	1,442	4	0.3%
0	0	0	100.0%	MCAL LTC Duals*	7,562	7,540	22	0.3%
29,750	29,930	(180)	(0.6%)	SPD with LTC	177,187	194,050	(16,863)	(8.7%)
49,304	47,417	1,887	4.0%	Duals with LTC	291,473	269,487	21,986	8.2%
405,473	**403,393**	**2,080**	**0.5%**	**Medi-Cal Total**	**4,841,658**	**4,815,809**	**25,849**	**0.5%**
5,910	5,769	141	2.4%	Group Care	69,568	68,992	576	0.8%
411,383	**409,162**	**2,221**	**0.5%**	**Total**	**4,911,226**	**4,884,801**	**26,425**	**0.5%**

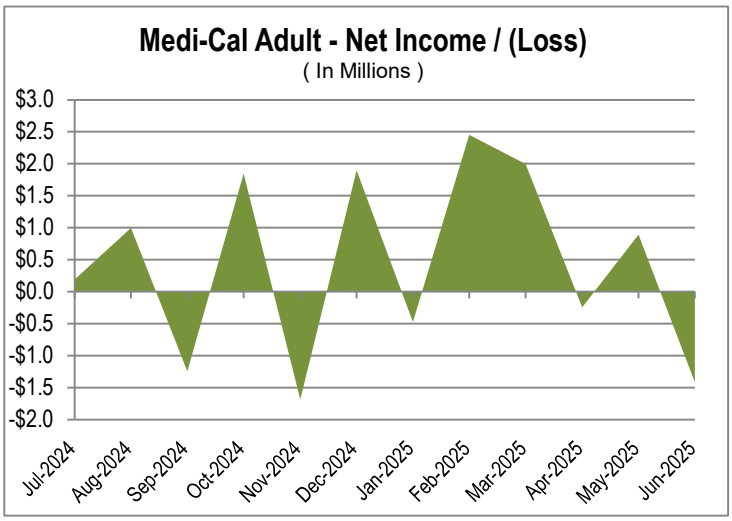
*As of January 2025, service month, "SPD", "Duals", "LTC", and "LTC Duals" will be discontinued. Effective January 2025 service month new consolidated groupings will be "SPD with LTC" and "Duals with LTC".

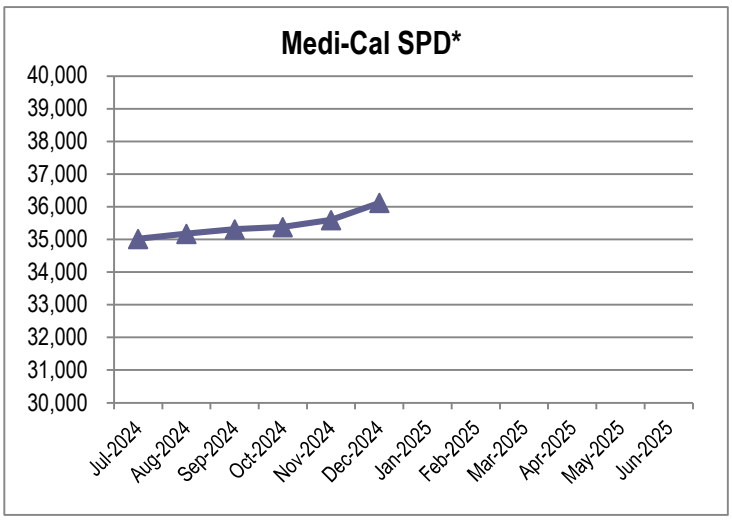
Enrollment and Profitability by Program and Category of Aid

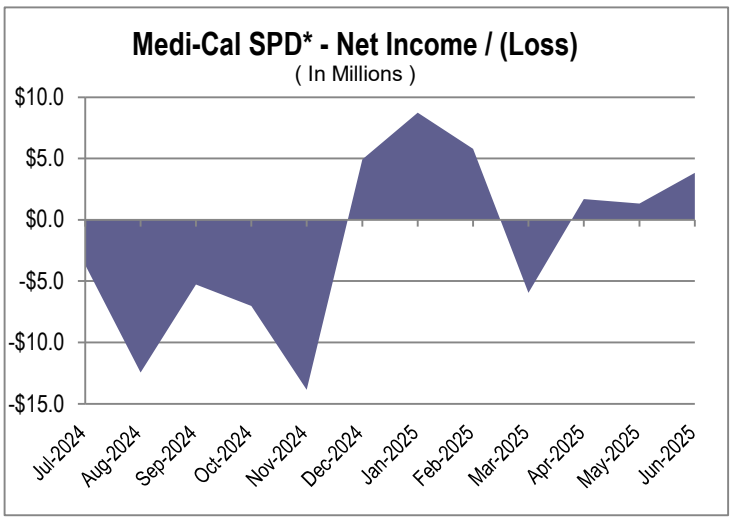




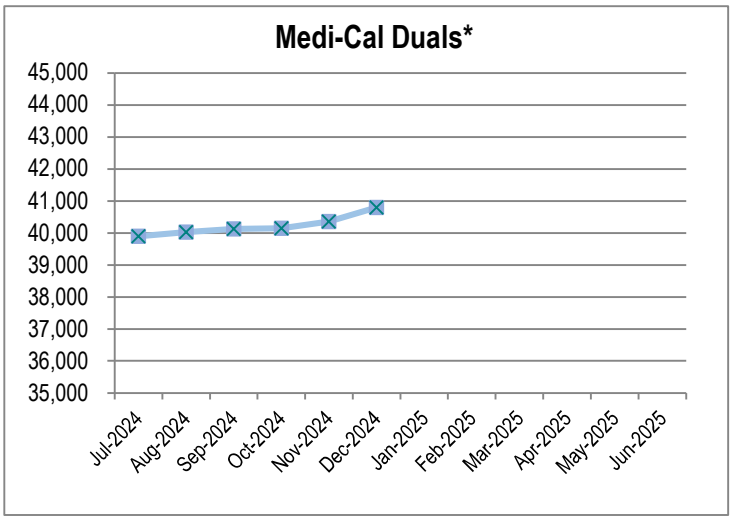


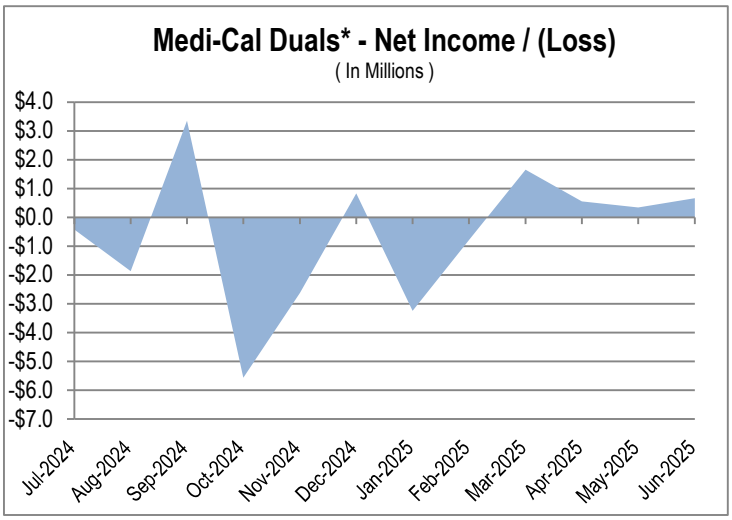


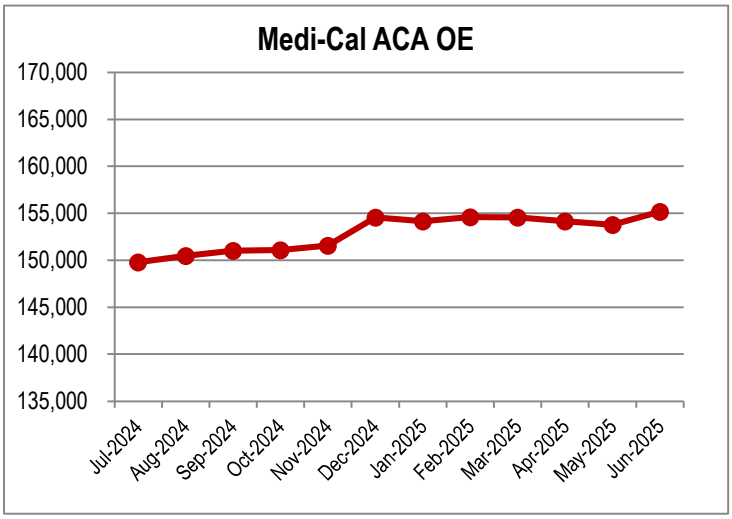


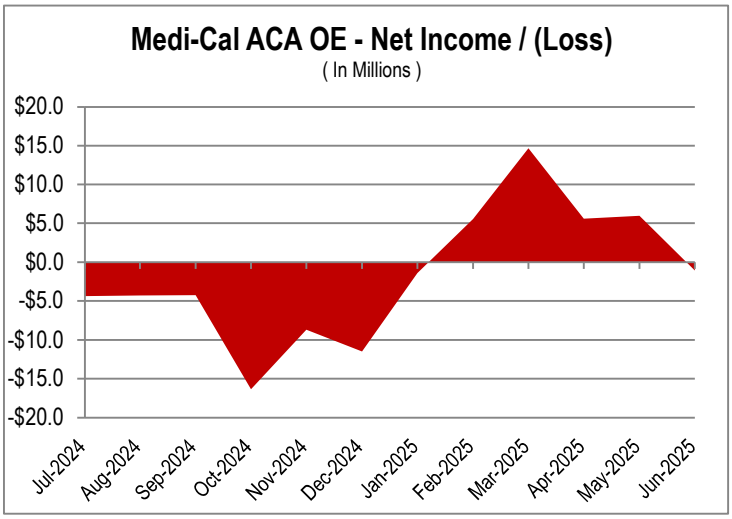


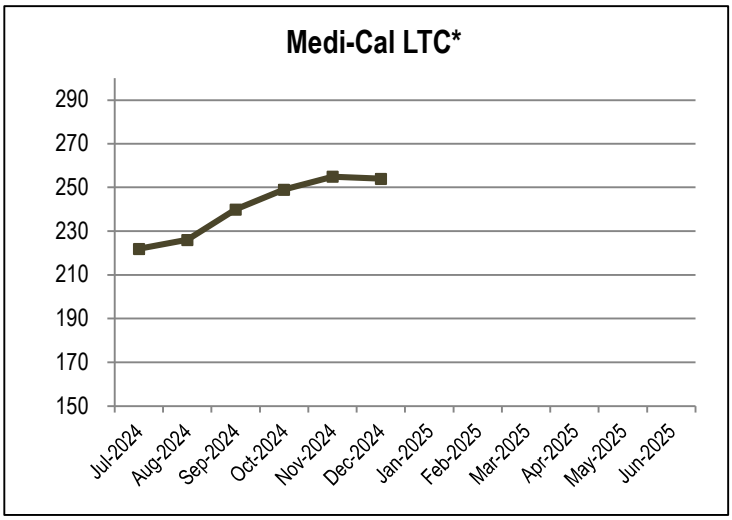
Enrollment and Profitability by Program and Category of Aid

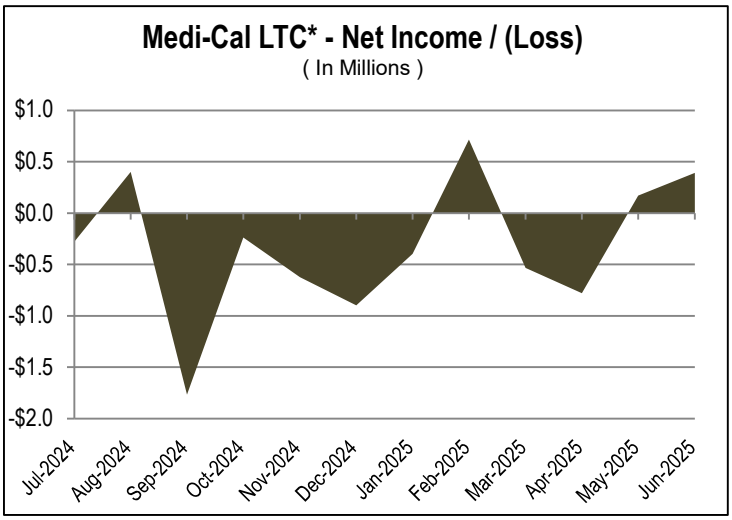




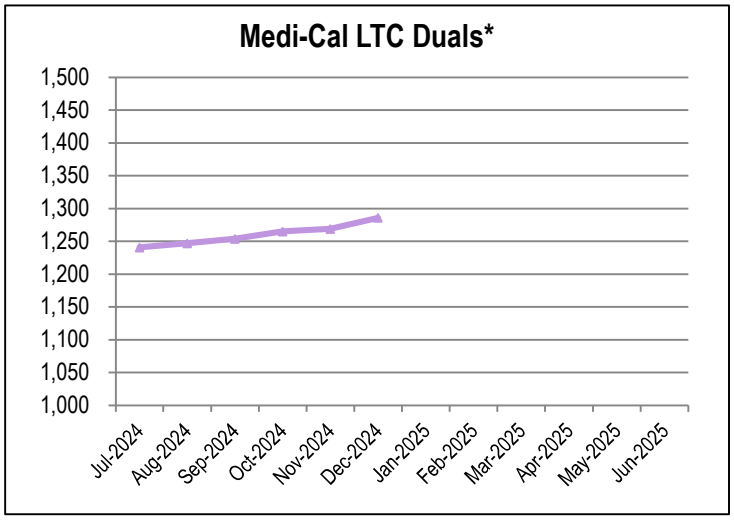


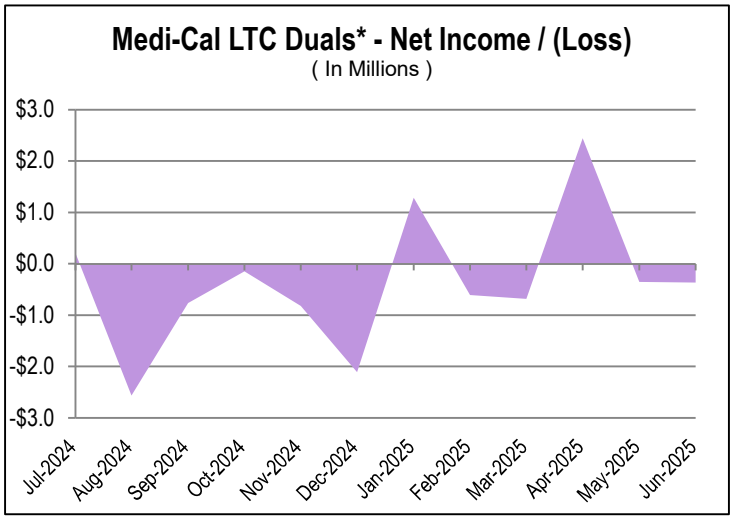


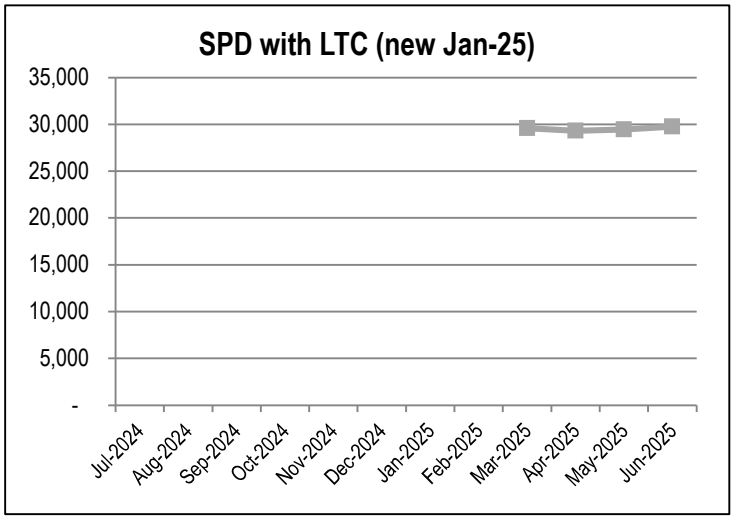


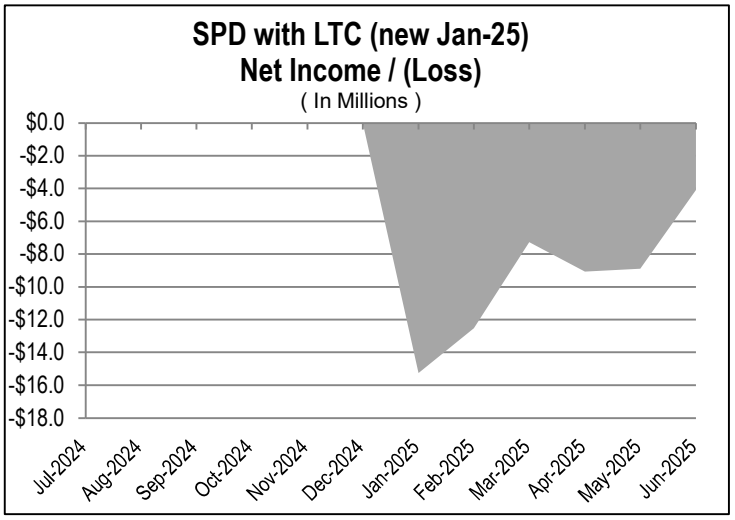


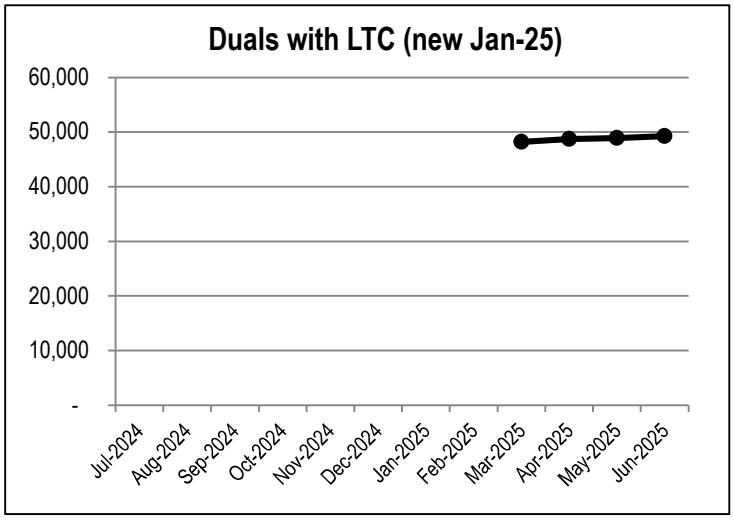
Enrollment and Profitability by Program and Category of Aid

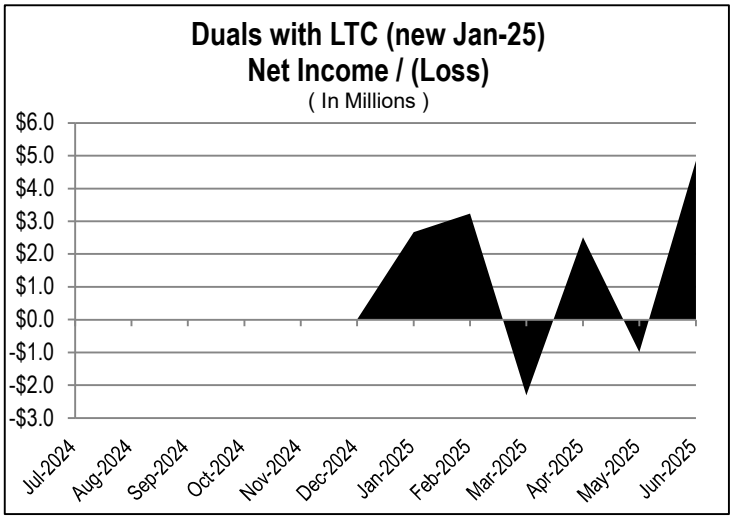




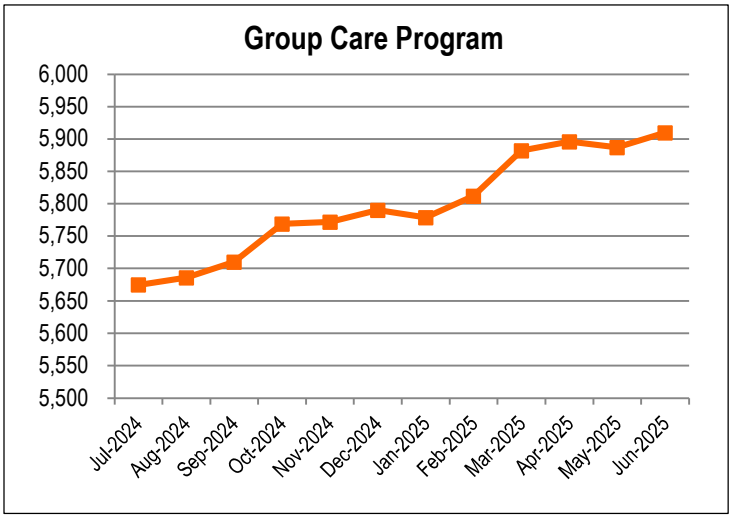


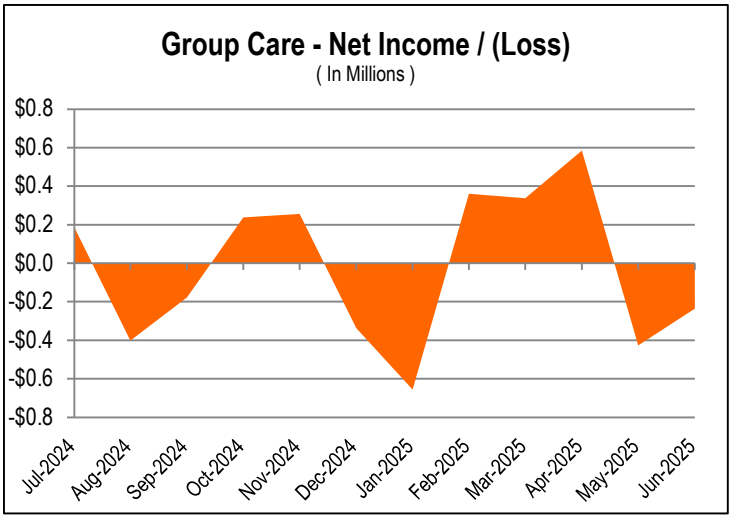


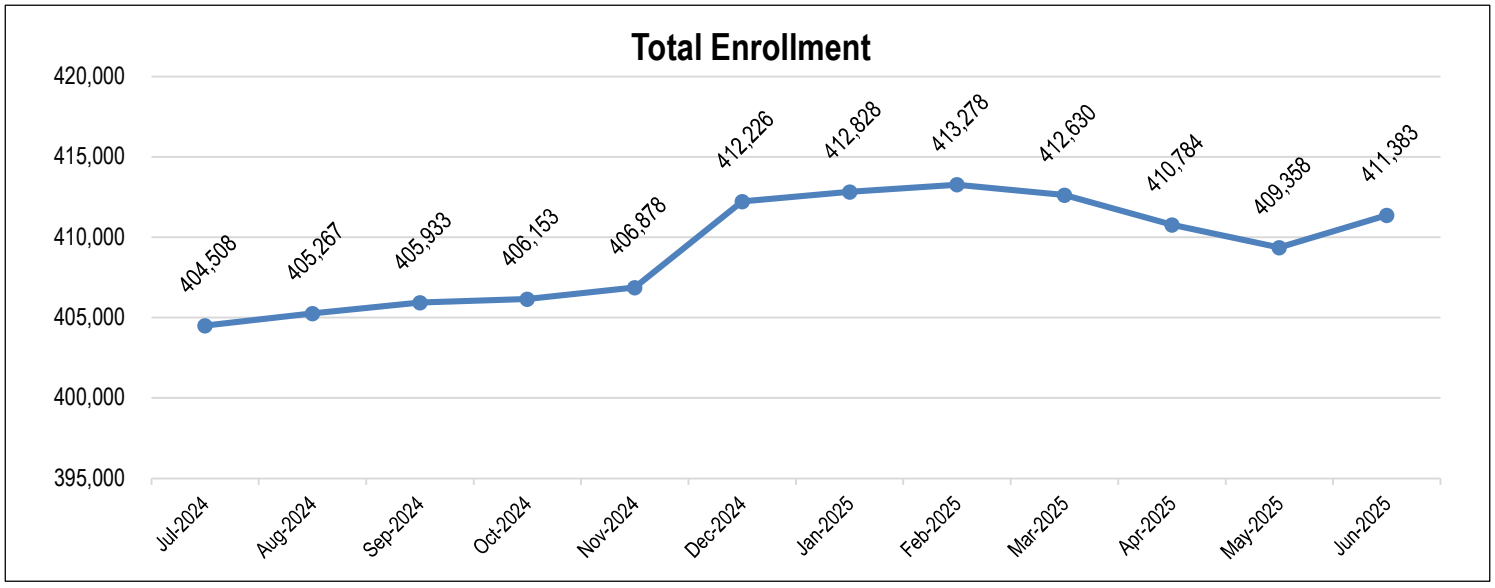


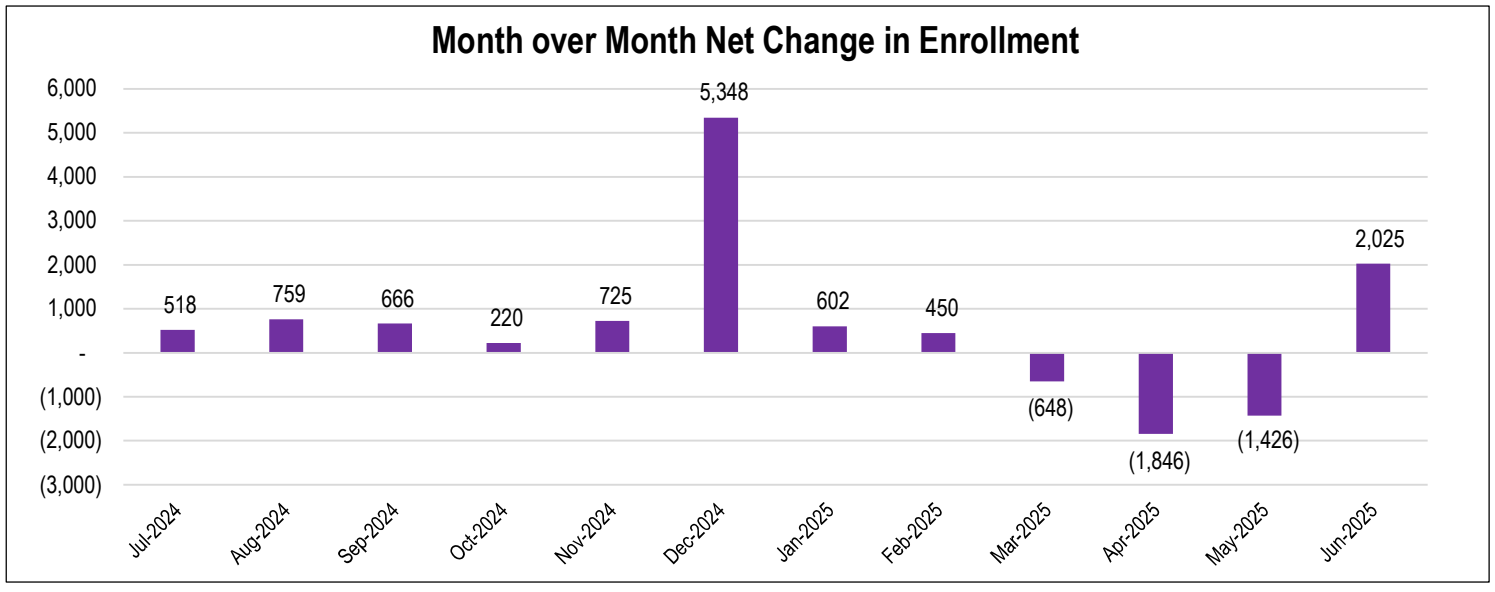


Enrollment and Profitability by Program and Category of Aid



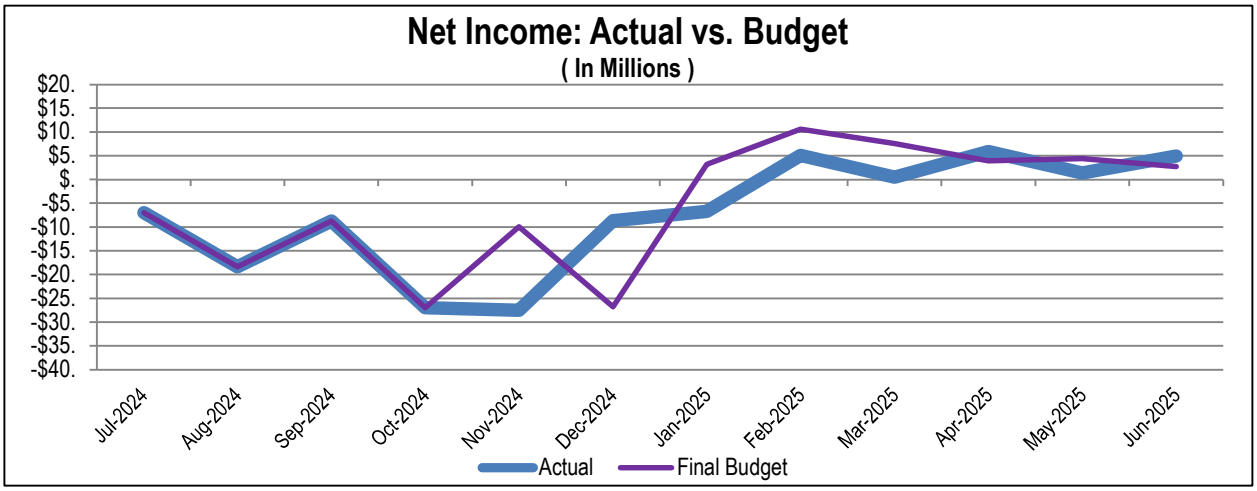






Net Income

- For the month ended June 30th, 2025:
  - Actual Net Income: $4.9 million.
  - Budgeted Net Income: $2.7 million.
- For the fiscal YTD ended June 30th, 2025:
  - Actual Net Loss: $86.1 million.
  - Budgeted Net Loss: $65.3 million.

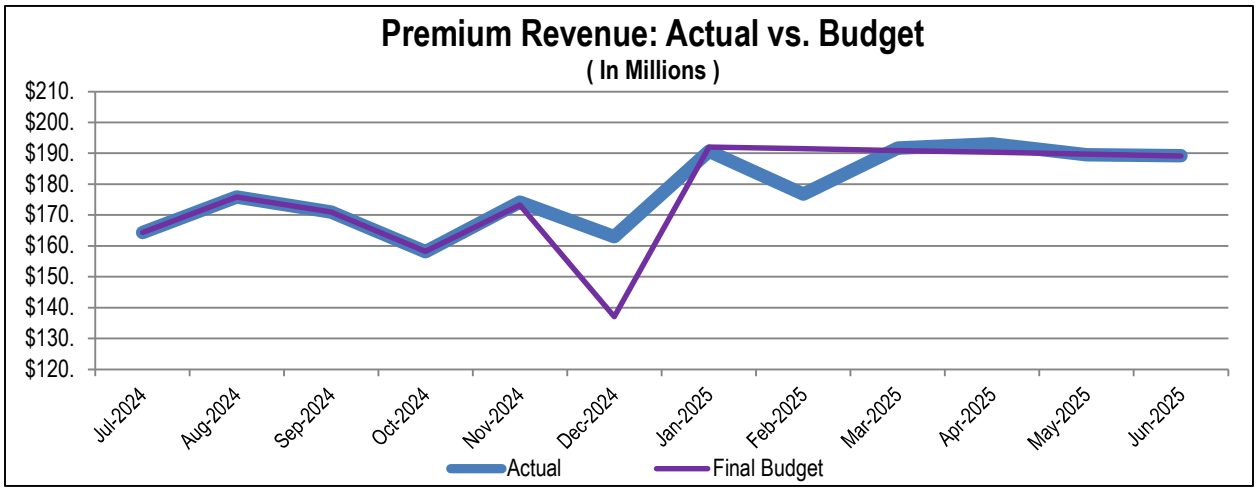


- The favorable variance of $2.2 million in the current month is primarily due to:
  - Favorable $2.8 million higher than anticipated MCO Tax Revenue.
  - Unfavorable $1.7 million higher than anticipated Administrative Expense.

Premium Revenue

- For the month ended June 30th, 2025:
  - Actual Revenue: $189.2 million.
  - Budgeted Revenue: $189.1 million.

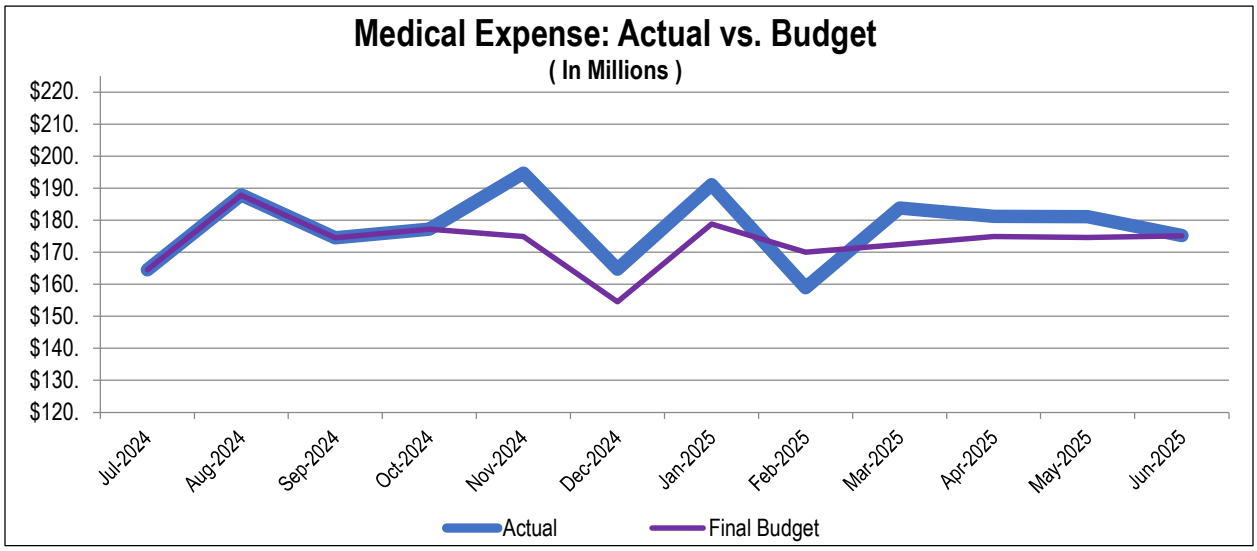
- For the fiscal YTD ended June 30th, 2025:
  - Actual Revenue: $2.1 billion.
  - Budgeted Revenue: $2.1 billion.



- For the month ended June 30th, 2025, the favorable Premium Revenue variance of $129,000 is primarily due to the following:
    - Favorable Retroactive Medi-Cal Member Months.
    - Favorable Volume Variance for current month.
    - Unfavorable CY2025 Rate Acuity Reserve.

Medical Expense

- For the month ended June 30th, 2025:
    - Actual Medical Expense: $175.2 million.
    - Budgeted Medical Expense: $175.1 million.
- For the fiscal YTD ended June 30th, 2025:
    - Actual Medical Expense: $2.1 billion.
    - Budgeted Medical Expense: $2.1 billion.



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

- For June, updates to Fee-For-Service (FFS) decreased the estimate for prior period unpaid Medical Expenses by $5.2 million. Year to date, the estimate for prior years increased by $12.2 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	$213,141,247	$0	$213,141,247	$200,581,538	($12,559,708)	(6.3%)
Primary Care FFS	$34,822,717	$164,799	$34,987,516	$45,652,180	$10,829,462	23.7%
Specialty Care FFS	$98,087,291	$489,779	$98,577,070	$99,066,587	$979,296	1.0%
Outpatient FFS	$149,478,123	$1,000,308	$150,478,431	$141,845,015	($7,633,108)	(5.4%)
Ancillary FFS	$221,506,899	($293,764)	$221,213,134	$217,757,585	($3,749,314)	(1.7%)
Pharmacy FFS	$152,536,943	$345,527	$152,882,471	$152,893,100	$356,157	0.2%
ER Services FFS	$125,602,946	$651,895	$126,254,841	$125,666,221	$63,275	0.1%
Inpatient Hospital FFS	$661,107,563	$6,286,340	$667,393,903	$628,142,064	($32,965,499)	(5.2%)
Long Term Care & SNF FFS	$411,005,870	$3,548,288	$414,554,158	$401,279,568	($9,726,301)	(2.4%)
Other Benefits & Services	$57,191,500	$0	$57,191,500	$59,675,048	$2,483,548	4.2%
Net Reinsurance	($1,885,647)	$0	($1,885,647)	$3,733,553	$5,619,201	150.5%
	$2,122,595,451	**$12,193,172**	**$2,134,788,623**	**$2,079,292,460**	**($43,302,990)**	**(2.1%)**

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

Adjusted to Eliminate the Impact of Prior Year IBNP Estimates

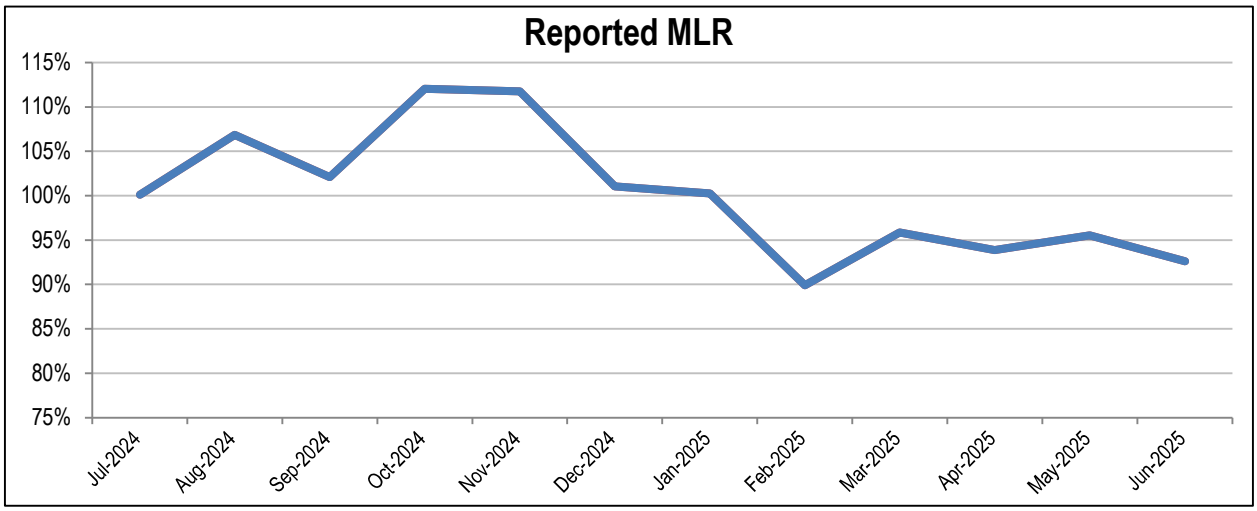
	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$43.40	$0.00	$43.40	$41.06	($2.34)	(5.7%)
Primary Care FFS	$7.09	$0.03	$7.12	$9.35	$2.26	24.1%
Specialty Care FFS	$19.97	$0.10	$20.07	$20.28	$0.31	1.5%
Outpatient FFS	$30.44	$0.20	$30.64	$29.04	($1.40)	(4.8%)
Ancillary FFS	$45.10	($0.06)	$45.04	$44.58	($0.52)	(1.2%)
Pharmacy FFS	$31.06	$0.07	$31.13	$31.30	$0.24	0.8%
ER Services FFS	$25.57	$0.13	$25.71	$25.73	$0.15	0.6%
Inpatient Hospital & SNF FFS	$134.61	$1.28	$135.89	$128.59	($6.02)	(4.7%)
Long Term Care & SNF FFS	$83.69	$0.72	$84.41	$82.15	($1.54)	(1.9%)
Other Benefits & Services	$11.65	$0.00	$11.65	$12.22	$0.57	4.7%
Net Reinsurance	($0.38)	$0.00	($0.38)	$0.76	$1.15	150.2%
	$432.19	**$2.48**	**$434.68**	**$425.67**	**($6.53)**	**(1.5%)**

- Excluding the impact of prior year estimates for IBNP, year-to-date medical expense variance is $43.3 million unfavorable to budget. On a PMPM basis, medical expense is 1.5% unfavorable to budget. For per-member-per-month expense:
    - Capitated Expense is over budget due to inclusion of Targeted Rate Increases (TRI) in capitation payments.
    - Primary Care Expense is under budget due to lower unit cost in the ACA OE, Child, Adult, and SPD aid code categories.

- Specialty Care Expense is slightly below budget, driven by lower SPD, Child, and ACA OE unit cost and Adult utilization.
- Outpatient Expense is over budget mostly driven by lab and radiology unit cost and dialysis and facility other utilization in the SPD with LTC, ACA OE and Adult aid code categories and the Group Care population.
- Ancillary Expense is over budget due to higher Behavioral Health utilization in the Child aid code category.
- Pharmacy Expense is under budget due to lower Non-PBM utilization in the SPD and ACA OE categories of aid.
- Emergency Room Expense is slightly under budget driven by lower than expected unit cost across most populations.
- Inpatient Expense is over budget driven by higher utilization in the SPD with LTC, Duals with LTC, Adult, and ACA OE aid code categories.
- Long Term Care Expense is over budget due to higher unit cost in the Duals with LTC Duals aid code category.
- Other Benefits & Services is under budget, due to lower than expected Employee, Professional Services, and Community Relations, Supplies, and Other expense.
- Net Reinsurance is under budget because more recoveries were received than expected.

Medical Loss Ratio (MLR)

The Medical Loss Ratio (total reported Medical Expense divided by Premium Revenue) was 92.6% for the month and 99.9% for the fiscal year-to-date.



Administrative Expense

- For the month ended June 30th, 2025:
  - Actual Administrative Expense: $11.4 million.
  - Budgeted Administrative Expense: $9.7 million.

- For the fiscal YTD ended June 30th, 2025:
  - Actual Administrative Expense: $115.8 million.
  - Budgeted Administrative Expense: $119.9 million.

Summary of Administrative Expense (In Dollars) For the Month and Fiscal Year-to-Date Favorable/(Unfavorable)								
Current Month					Year-to-Date			
Actual	Budget	Variance $	Variance %		Actual	Budget	Variance $	Variance %
$6,166,263	$6,188,330	$22,067	0.4%	Personnel Expense	$70,037,574	$70,720,853	$683,279	1.0%
79,397	75,209	(4,188)	(5.6%)	Medical Benefits Admin Expense	944,610	905,182	(39,429)	(4.4%)
4,088,763	2,075,962	(2,012,800)	(97.0%)	Purchased & Professional Services	26,256,454	28,646,273	2,389,819	8.3%
1,046,243	1,366,640	320,396	23.4%	Other Admin Expense	18,563,905	19,670,036	1,106,131	5.6%
$11,380,667	$9,706,141	($1,674,525)	(17.3%)	Total Administrative Expense	$115,802,543	$119,942,344	$4,139,801	3.5%

The year-to-date variances include:

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

The Administrative Loss Ratio (ALR) is 6.0% of net revenue for the month and 5.4% of net revenue year-to-date. Fiscal year-to-date claims interest expense, due to delayed payment of certain claims, or recalculated interest on previously paid claims is $1.8 million.

Other Income / (Expense)

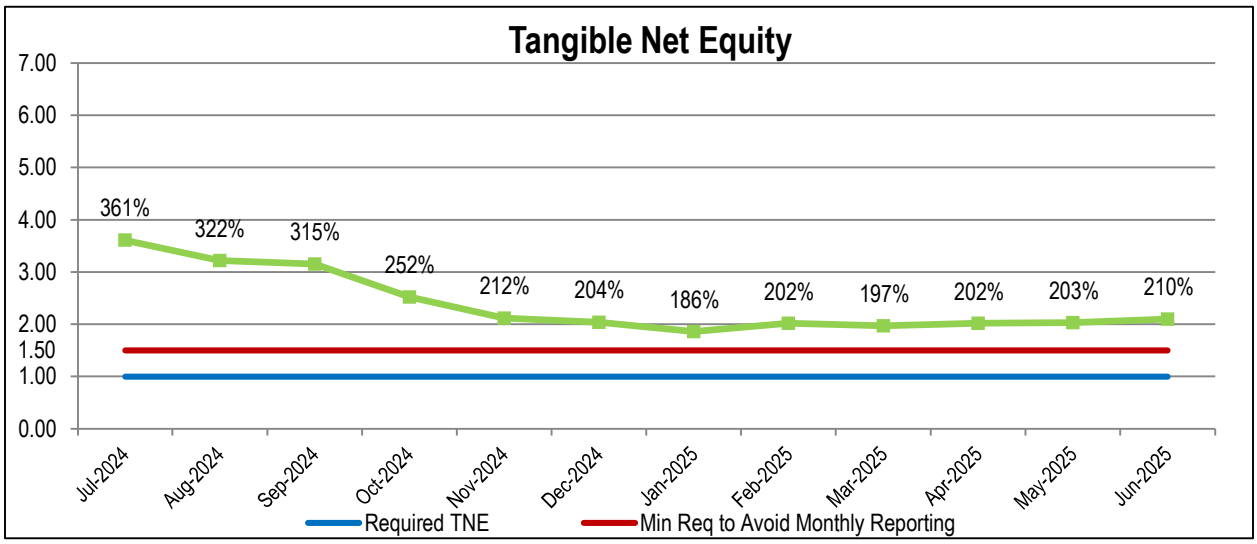
Other Income & Expense is comprised primarily of investment income. Fiscal year-to-date net investments show a gain of $32.2 million.

Managed Care Organization (MCO) Provider Tax

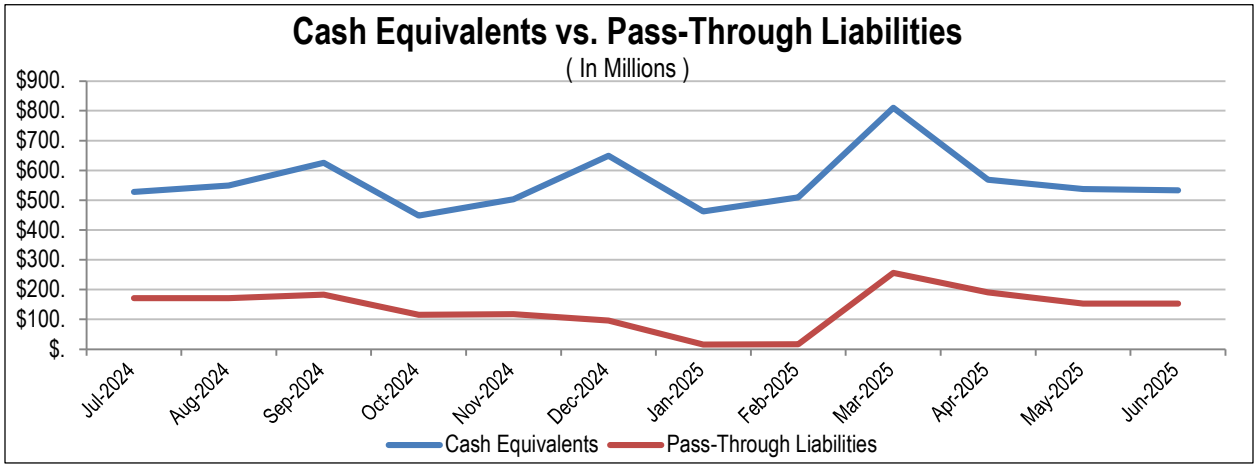
- Revenue:
  - For the month ended June 30th, 2025:
    - Actual: $66.9 million.
    - Budgeted: $64.0 million.
  - For the fiscal YTD ended June 30th, 2025:
    - Actual: $877.5 million.
    - Budgeted: $862.2 million.
- Expense:
  - For the month ended June 30th, 2025:
    - Actual: $66.9 million.
    - Budgeted: $67.0 million.
  - For the fiscal YTD ended June 30th, 2025:
    - Actual: $882.5 million.
    - Budgeted: $877.2 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 $80.7 million
    - Actual TNE $169.3 million
    - Excess TNE $88.6 million
    - TNE % of Required TNE 210%



- To ensure appropriate liquidity and limit risk, the majority of Alliance financial assets are kept in short-term investments.
- Key Metrics
    - Cash & Cash Equivalents $533.0 million
    - Pass-Through Liabilities $152.4 million
    - Uncommitted Cash $380.6 million
    - Working Capital $115.4 million
    - Current Ratio 1.12 (regulatory minimum is 1.00)



Capital Investment

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

Caveats to Financial Statements

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

Finance

Supporting Documents

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

CURRENT MONTH					FISCAL YEAR TO DATE			
		$ Variance	% Variance				$ Variance	% Variance
Actual	Budget	(Unfavorable)	(Unfavorable)	Account Description	Actual	Budget	(Unfavorable)	(Unfavorable)
				MEMBERSHIP				
405,473	403,393	2,080	0.5%	1. Medi-Cal	4,841,658	4,815,809	25,849	0.5%
5,910	5,769	141	2.4%	2. GroupCare	69,568	68,992	576	0.8%
411,383	**409,162**	**2,221**	**0.5%**	**3. TOTAL MEMBER MONTHS**	**4,911,226**	**4,884,801**	**26,425**	**0.5%**
				REVENUE				
$189,190,259	$189,061,215	$129,044	0.1%	4. Premium Revenue	$2,137,332,129	$2,122,978,872	$14,353,257	0.7%
$66,858,422	$64,014,435	$2,843,987	4.4%	5. MCO Tax Revenue AB119	$877,454,896	$862,224,496	$15,230,400	1.8%
$256,048,681	**$253,075,650**	**$2,973,031**	**1.2%**	**6. TOTAL REVENUE**	**$3,014,787,025**	**$2,985,203,368**	**$29,583,657**	**1.0%**
				MEDICAL EXPENSES				
				Capitated Medical Expenses				
$16,501,156	$17,007,776	$506,620	3.0%	7. Capitated Medical Expense	$213,141,247	$200,581,538	($12,559,708)	(6.3%)
				Fee for Service Medical Expenses				
$57,059,592	$50,409,410	($6,650,182)	(13.2%)	8. Inpatient Hospital Expense	$667,393,903	$628,142,064	($39,251,839)	(6.2%)
$3,275,063	$4,576,273	$1,301,209	28.4%	9. Primary Care Physician Expense	$34,987,516	$45,652,180	$10,664,664	23.4%
$8,170,540	$8,173,633	$3,092	0.0%	10. Specialty Care Physician Expense	$98,577,070	$99,066,587	$489,517	0.5%
$19,736,774	$19,624,791	($111,983)	(0.6%)	11. Ancillary Medical Expense	$221,213,134	$217,757,585	($3,455,549)	(1.6%)
$13,986,023	$11,430,917	($2,555,106)	(22.4%)	12. Outpatient Medical Expense	$150,478,431	$141,845,015	($8,633,416)	(6.1%)
$10,754,019	$10,550,665	($203,355)	(1.9%)	13. Emergency Expense	$126,254,841	$125,666,221	($588,620)	(0.5%)
$11,499,302	$11,717,419	$218,117	1.9%	14. Pharmacy Expense	$152,882,471	$152,893,100	$10,630	0.0%
$29,074,415	$33,756,261	$4,681,846	13.9%	15. Long Term Care Expense	$414,554,158	$401,279,568	($13,274,589)	(3.3%)
$153,555,729	$150,239,368	($3,316,361)	(2.2%)	16. Total Fee for Service Expense	$1,866,341,523	$1,812,302,320	($54,039,203)	(3.0%)
$5,019,556	$4,464,888	($554,668)	(12.4%)	17. Other Benefits & Services	$57,197,787	$59,675,048	$2,477,262	4.2%
$126,037	$419,837	$293,800	70.0%	18. Reinsurance Expense	($1,885,647)	$3,733,553	$5,619,201	150.5%
$0	$3,000,000	$3,000,000	100.0%	19. Risk Pool Distribution	$0	$3,000,000	$3,000,000	100.0%
$175,202,479	**$175,131,869**	**($70,609)**	**(0.0%)**	**20. TOTAL MEDICAL EXPENSES**	**$2,134,794,909**	**$2,079,292,460**	**($55,502,449)**	**(2.7%)**
$80,846,203	**$77,943,781**	**$2,902,422**	**3.7%**	**21. GROSS MARGIN**	**$879,992,116**	**$905,910,908**	**($25,918,792)**	**(2.9%)**
				ADMINISTRATIVE EXPENSES				
$6,166,263	$6,188,330	$22,067	0.4%	22. Personnel Expense	$70,037,574	$70,720,853	$683,279	1.0%
$79,397	$75,209	($4,188)	(5.6%)	23. Benefits Administration Expense	$944,610	$905,182	($39,429)	(4.4%)
$4,088,763	$2,075,962	($2,012,800)	(97.0%)	24. Purchased & Professional Services	$26,256,454	$28,646,273	$2,389,819	8.3%
$1,046,243	$1,366,640	$320,396	23.4%	25. Other Administrative Expense	$18,563,905	$19,670,036	$1,106,131	5.6%
$11,380,667	**$9,706,141**	**($1,674,525)**	**(17.3%)**	**26. TOTAL ADMINISTRATIVE EXPENSES**	**$115,802,543**	**$119,942,344**	**$4,139,801**	**3.5%**
$66,858,422	**$67,014,435**	**$156,013**	**0.2%**	**27. MCO TAX EXPENSES**	**$882,454,896**	**$877,224,496**	**($5,230,400)**	**(0.6%)**
$2,607,114	**$1,223,205**	**$1,383,909**	**113.1%**	**28. NET OPERATING INCOME / (LOSS)**	**($118,265,324)**	**($91,255,932)**	**($27,009,392)**	**(29.6%)**
				OTHER INCOME / EXPENSES				
$2,305,105	**$1,500,000**	**$805,105**	**53.7%**	**29. TOTAL OTHER INCOME / (EXPENSES)**	**$32,169,541**	**$25,981,002**	**$6,188,538**	**23.8%**
$4,912,219	**$2,723,205**	**$2,189,015**	**80.4%**	**30. NET SURPLUS (DEFICIT)**	**($86,095,783)**	**($65,274,930)**	**($20,820,853)**	**(31.9%)**
92.6%	92.6%	0.0%	0.0%	31. Medical Loss Ratio	99.9%	97.9%	(2.0%)	(2.0%)
6.0%	5.1%	(0.9%)	(17.6%)	32. Administrative Expense Ratio	5.4%	5.6%	0.2%	3.6%
1.9%	1.1%	0.8%	72.7%	33. Net Surplus (Deficit) Ratio	(2.9%)	(2.2%)	(0.7%)	(31.8%)

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

	6/30/2025	5/31/2025	Difference	% Difference
CURRENT ASSETS				
Cash and Cash Equivalent				
Cash	$23,866,602	$34,937,836	($11,071,234)	(31.7%)
CNB Short-Term Investment	509,149,570	502,988,601	6,160,969	1.2%
Interest Receivable	3,586,958	2,735,862	851,096	31.1%
Premium Receivables	498,272,672	427,767,025	70,505,646	16.5%
Reinsurance Recovery Receivable	9,085,369	8,332,832	752,537	9.0%
Other Receivables	1,095,756	1,207,426	(111,670)	(9.2%)
Prepaid Expenses	717,811	752,970	(35,159)	(4.7%)
TOTAL CURRENT ASSETS	**1,045,774,738**	**978,722,551**	**67,052,186**	**6.9%**
OTHER ASSETS				
CNB Long-Term Investment	39,155,365	39,019,975	135,390	0.3%
CalPERS Net Pension Asset	(6,465,233)	(6,144,132)	(321,101)	5.2%
Deferred Outflow	15,271,214	14,319,532	951,681	6.6%
Restricted Asset-Bank Note	353,866	352,863	1,003	0.3%
GASB 87-Lease Assets (Net)	78,600	81,875	(3,275)	(4.0%)
GASB 96-SBITA Assets (Net)	3,531,090	3,803,493	(272,404)	(7.2%)
TOTAL OTHER ASSETS	**51,924,901**	**51,433,607**	**491,294**	**1.0%**
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	(33,392,594)	(33,330,742)	(61,851)	0.2%
PROPERTY AND EQUIPMENT (NET)	**5,576,811**	**5,638,663**	**(61,851)**	**(1.1%)**
TOTAL ASSETS	**1,103,276,450**	**1,035,794,821**	**67,481,629**	**6.5%**
CURRENT LIABILITIES				
Trade Accounts Payable	11,516,923	10,566,156	950,767	9.0%
Incurred But Not Reported Claims	412,117,295	403,573,402	8,543,893	2.1%
Other Medical Liabilities	117,997,376	132,691,974	(14,694,598)	(11.1%)
Pass-Through Liabilities	152,405,332	152,356,058	49,274	0.0%
MCO Tax Liabilities	225,818,403	158,973,556	66,844,847	42.0%
GASB 87 and 96 ST Liabilities	1,147,713	1,326,682	(178,969)	(13.5%)
Payroll Liabilities	9,363,915	8,168,474	1,195,441	14.6%
TOTAL CURRENT LIABILITIES	**930,366,958**	**867,656,302**	**62,710,656**	**7.2%**
LONG TERM LIABILITIES				
GASB 87 and 96 LT Liabilities	389,826	443,848	(54,022)	(12.2%)
Deferred Inflow	3,240,306	3,327,530	(87,224)	(2.6%)
TOTAL LONG TERM LIABILITIES	**3,630,132**	**3,771,378**	**(141,246)**	**(3.7%)**
TOTAL LIABILITIES	**933,997,089**	**871,427,679**	**62,569,410**	**7.2%**
NET WORTH				
Contributed Capital	840,233	840,233	0	0.0%
Restricted & Unrestricted Funds	254,534,911	254,534,911	0	0.0%
Year-To-Date Net Surplus (Deficit)	(86,095,783)	(91,008,002)	4,912,219	(5.4%)
TOTAL NET WORTH	**169,279,361**	**164,367,141**	**4,912,219**	**3.0%**
TOTAL LIABILITIES AND NET WORTH	**1,103,276,450**	**1,035,794,821**	**67,481,629**	**6.5%**
Cash Equivalents	533,016,172	537,926,437	(4,910,265)	(0.9%)
Pass-Through	152,405,332	152,356,058	49,274	0.0%
Uncommitted Cash	380,610,840	385,570,378	(4,959,539)	(1.3%)
Working Capital	115,407,780	111,066,250	4,341,530	3.9%
Current Ratio	112.4%	112.8%	(0.4%)	(0.4%)

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

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM OPERATING ACTIVITIES				
Commercial Premium Cash Flows				
Commercial Premium Revenue	$3,229,904	$9,671,670	$19,215,412	$38,032,020
GroupCare Receivable	(5,779)	3,193,275	4,324	(5,129)
Total	3,224,125	12,864,945	19,219,736	38,026,891
Medi-Cal Premium Cash Flows				
Medi-Cal Revenue	252,818,778	759,538,034	1,509,234,716	2,976,755,006
Premium Receivable	(70,499,868)	(243,285,635)	(54,267,870)	(131,324,022)
Total	182,318,910	516,252,399	1,454,966,846	2,845,430,984
Investment & Other Income Cash Flows				
Other Revenues	557,333	201,554	(24,691)	2,591,795
Interest Income	1,752,506	6,732,080	14,706,950	29,697,218
Interest Receivable	(851,096)	417,322	1,730,193	(1,670,895)
Total	1,458,743	7,350,956	16,412,452	30,618,118
Medical & Hospital Cash Flows				
Total Medical Expenses	(175,202,477)	(537,457,373)	(1,071,330,677)	(2,134,794,918)
Other Health Care Receivables	(656,770)	1,489,438	(1,504,185)	727,452
Capitation Payable	-	-	-	-
IBNP Payable	8,543,893	24,970,383	43,863,226	115,813,036
Other Medical Payable	(14,645,323)	(115,920,567)	39,114,694	(65,438,048)
Risk Share Payable	-	-	-	(2,680,192)
New Health Program Payable	-	-	-	-
Total	(181,960,677)	(626,918,119)	(989,856,942)	(2,086,372,670)
Administrative Cash Flows				
Total Administrative Expenses	(11,385,400)	(29,022,236)	(58,182,603)	(115,922,018)
Prepaid Expenses	35,159	105,476	7,102	(479,194)
Other Receivables	15,903	15,963	60,390	85,964
CalPERS Pension	(630,580)	(630,580)	(630,580)	(630,580)
Trade Accounts Payable	950,767	2,447,930	1,725,364	5,026,628
Payroll Liabilities	1,108,219	467,480	573,827	1,177,465
GASB Assets and Liabilities	42,689	(405,888)	632,748	(1,570,666)
Depreciation Expense	61,851	188,564	373,216	729,921
Total	(9,801,392)	(26,833,291)	(55,440,536)	(111,582,480)
MCO Tax AB119 Cash Flows				
MCO Tax Expense AB119	(66,858,422)	(197,456,902)	(402,553,648)	(882,454,896)
MCO Tax Liabilities	66,844,847	9,068,328	(162,928,677)	66,034,889
Total	(13,575)	(188,388,574)	(565,482,325)	(816,420,007)
Net Cash Flows from Operating Activities	**(4,773,866)**	**(305,671,684)**	**(120,180,769)**	**(100,299,164)**

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

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM INVESTING ACTIVITIES				
Investment Cash Flows				
Long Term Investments	(135,396)	27,575,157	4,974,933	(6,163,108)
Total	(135,396)	27,575,157	4,974,933	(6,163,108)
Restricted Cash & Other Asset Cash Flows				
Restricted Assets-Treasury Account	(1,003.00)	(2,968.00)	(3,866.00)	(3,866.00)
Total	(1,003.00)	(2,968.00)	(3,866.00)	(3,866.00)
Fixed Asset Cash Flows				
Fixed Asset Acquisitions	-	-	(329,306)	(858,916)
Purchases of Property and Equipment	-	-	(329,306)	(858,916)
Net Cash Flows from Investing Activities	**(136,399)**	**27,572,189**	**4,641,761**	**(7,025,890)**
Net Change in Cash	**(4,910,265)**	**(278,099,495)**	**(115,539,008)**	**(107,325,054)**
Rounding	-	-	-	-
Cash @ Beginning of Period	537,926,437	811,115,667	648,555,180	640,341,226
Cash @ End of Period	**$533,016,172**	**$533,016,172**	**$533,016,172**	**$533,016,172**
Variance	-	-	-	-

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

	MONTH	3 MONTHS	6 MONTHS	YTD
NET INCOME RECONCILIATION				
Net Income / (Loss)	$4,912,222	$12,206,827	$11,065,458	($86,095,793)
Add back: Depreciation & Amortization	61,851	188,564	373,216	729,921
Receivables				
Premiums Receivable	(70,499,868)	(243,285,635)	(54,267,870)	(131,324,022)
Interest Receivable	(851,096)	417,322	1,730,193	(1,670,895)
Other Health Care Receivables	(656,770)	1,489,438	(1,504,185)	727,452
Other Receivables	15,903	15,963	60,390	85,964
GroupCare Receivable	(5,779)	3,193,275	4,324	(5,129)
Total	(71,997,610)	(238,169,637)	(53,977,148)	(132,186,630)
Prepaid Expenses	35,159	105,476	7,102	(479,194)
Trade Payables	950,767	2,447,930	1,725,364	5,026,628
Claims Payable and Shared Risk Pool				
IBNP Payable	8,543,893	24,970,383	43,863,226	115,813,036
Capitation Payable & Other Medical Payable	(14,645,323)	(115,920,567)	39,114,694	(65,438,048)
Risk Share Payable	-	-	0	(2,680,192)
Claims Payable				
Total	(6,101,430)	(90,950,184)	82,977,920	47,694,796
Other Liabilities				
CalPERS Pension	(630,580.00)	(630,580.00)	(630,580.00)	(630,580.00)
Payroll Liabilities	1,108,219	467,480	573,828	1,177,465
GASB Assets and Liabilities	42,689	(405,888)	632,748	(1,570,666)
New Health Program	-	-	-	-
MCO Tax Liabilities	66,844,847	9,068,328	(162,928,677)	66,034,889
Total	67,365,175	8,499,340	(162,352,681)	65,011,108
Rounding	-	-	-	-
Cash Flows from Operating Activities	**(4,773,866)**	**(305,671,684)**	**(120,180,769)**	**(100,299,164)**
Variance	-	-	-	-

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

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOW STATEMENT:				
Cash Flows from Operating Activities:				
Cash Received				
Capitation Received from State of CA	$182,318,910	$516,252,399	$1,454,966,846	$2,845,430,984
Medicare Revenue	$0	$0	$0	$0
GroupCare Premium Revenue	3,224,125	12,864,945	19,219,736	38,026,891
Other Income	557,333	201,554	(24,691)	2,591,795
Interest Income	901,410	7,149,402	16,437,143	28,026,323
Less Cash Paid				
Medical Expenses	(181,960,677)	(626,918,119)	(989,856,942)	(2,086,372,670)
Vendor & Employee Expenses	(9,801,392)	(26,833,291)	(55,440,536)	(111,582,480)
MCO Tax Expense AB119	(13,575)	(188,388,574)	(565,482,325)	(816,420,007)
Net Cash Flows from Operating Activities	**(4,773,866)**	**(305,671,684)**	**(120,180,769)**	**(100,299,164)**
Cash Flows from Investing Activities:				
Long Term Investments	(135,396)	27,575,157	4,974,933	(6,163,108)
Restricted Assets-Treasury Account	(1,003)	(2,968)	(3,866)	(3,866)
Purchases of Property and Equipment	0	0	(329,306)	(858,916)
Net Cash Flows from Investing Activities	**(136,399)**	**27,572,189**	**4,641,761**	**(7,025,890)**
Net Change in Cash	**(4,910,265)**	**(278,099,495)**	**(115,539,008)**	**(107,325,054)**
Rounding	-	-	-	-
Cash @ Beginning of Period	537,926,437	811,115,667	648,555,180	640,341,226
Cash @ End of Period	**$533,016,172**	**$533,016,172**	**$533,016,172**	**$533,016,172**
Variance	$0	-	-	-
RECONCILIATION OF NET INCOME TO NET CASH FLOW FROM OPERATING ACTIVITIES:				
Net Income / (Loss)	$4,912,222	$12,206,828	$11,065,457	($86,095,793)
Add Back: Depreciation	61,851	188,564	373,216	729,921
Net Change in Operating Assets & Liabilities				
Premium & Other Receivables	(71,997,610)	(238,169,637)	(53,977,148)	(132,186,630)
Prepaid Expenses	35,159	105,475	7,103	(479,194)
Trade Payables	950,767	2,447,930	1,725,364	5,026,628
Claims Payable, IBNP and Risk Sharing	(6,101,430)	(90,950,184)	82,977,920	47,694,796
Deferred Revenue	0	0	0	0
Other Liabilities	67,365,175	8,499,340	(162,352,681)	65,011,108
Total	(4,773,866)	(305,671,684)	(120,180,769)	(100,299,164)
Rounding	-	-	-	-
Cash Flows from Operating Activities	**($4,773,866)**	**($305,671,684)**	**($120,180,769)**	**($100,299,164)**
Variance	$0	-	-	-

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE MONTH OF JUNE 2025

	Medi-Cal Child	Medi-Cal Adult	Medi-Cal SPD*	Medi-Cal Duals*	Medi-Cal ACA OE	Medi-Cal LTC*	Medi-Cal LTC Duals*	Medi-Cal SPD with LTC	Medi-Cal Duals with LTC	Medi-Cal Total	Group Care	Medicare	Grand Total
Enrollments/Member Months	109,574	61,669	-	-	155,176	-	-	29,750	49,304	405,473	5,910	-	411,383
Revenue	$35,932,503	$32,699,355	$816,774	$211,582	$91,221,467	$14,064	$78,086	$48,040,659	$43,804,288	$252,818,778	$3,229,904	$0	$256,048,681
Medical Expense	$14,007,689	$23,117,692	($3,095,678)	($518,362)	$64,263,321	($390,347)	$352,889	$44,677,916	$29,340,342	$171,755,464	$3,303,831	$143,183	$175,202,479
Gross Margin	$21,924,814	$9,581,663	$3,912,452	$729,944	$26,958,145	$404,411	($274,804)	$3,362,743	$14,463,945	$81,063,313	($73,927)	($143,183)	$80,846,203
Administrative Expense	$496,322	$1,141,670	$69,030	$63,533	$3,250,848	$11,013	$82,111	$2,960,406	$1,844,675	$9,919,608	$195,423	$1,265,636	$11,380,667
MCO Tax Expense	$17,769,506	$10,122,313	$23,077	$7,888	$25,522,392	$1,660	$7,631	$5,197,576	$8,206,379	$66,858,422	$0	$0	$66,858,422
Operating Income / (Expense)	$3,658,986	($1,682,320)	$3,820,345	$658,523	($1,815,095)	$391,738	($364,546)	($4,795,240)	$4,412,891	$4,285,283	($269,351)	($1,408,819)	$2,607,114
Other Income / (Expense)	$112,022	$266,129	$0	$0	$758,566	$0	$0	$701,864	$432,182	$2,270,761	$34,344	$0	$2,305,105
Net Income / (Loss)	$3,771,008	($1,416,192)	$3,820,345	$658,523	($1,056,529)	$391,738	($364,546)	($4,093,376)	$4,845,073	$6,556,045	($235,007)	($1,408,819)	$4,912,219
PMPM Metrics:													
Revenue PMPM	$327.93	$530.24	$0.00	$0.00	$587.86	$0.00	$0.00	$1,614.81	$888.45	$623.52	$546.51	$0.00	$622.41
Medical Expense PMPM	$127.84	$374.87	$0.00	$0.00	$414.13	$0.00	$0.00	$1,501.78	$595.09	$423.59	$559.02	$0.00	$425.89
Gross Margin PMPM	$200.09	$155.37	$0.00	$0.00	$173.73	$0.00	$0.00	$113.03	$293.36	$199.92	($12.51)	$0.00	$196.52
Administrative Expense PMPM	$4.53	$18.51	$0.00	$0.00	$20.95	$0.00	$0.00	$99.51	$37.41	$24.46	$33.07	$0.00	$27.66
MCO Tax Expense PMPM	$162.17	$164.14	$0.00	$0.00	$164.47	$0.00	$0.00	$174.71	$166.44	$164.89	$0.00	$0.00	$162.52
Operating Income / (Expense) PMPM	$33.39	($27.28)	$0.00	$0.00	($11.70)	$0.00	$0.00	($161.18)	$89.50	$10.57	($45.58)	$0.00	$6.34
Other Income / (Expense) PMPM	$1.02	$4.32	$0.00	$0.00	$4.89	$0.00	$0.00	$23.59	$8.77	$5.60	$5.81	$0.00	$5.60
Net Income / (Loss) PMPM	$34.42	($22.96)	$0.00	$0.00	($6.81)	$0.00	$0.00	($137.59)	$98.27	$16.17	($39.76)	$0.00	$11.94
Ratio:													
Medical Loss Ratio	77.1%	102.4%	-390.0%	-254.5%	97.8%	-3146.9%	500.9%	104.3%	82.4%	92.4%	102.3%	0.0%	92.6%
Administrative Expense Ratio	2.7%	5.1%	8.7%	31.2%	4.9%	88.8%	116.5%	6.9%	5.2%	5.3%	6.1%	0.0%	6.0%
Net Income Ratio	10.5%	-4.3%	467.7%	311.2%	-1.2%	2785.3%	-466.9%	-8.5%	11.1%	2.6%	-7.3%	0.0%	1.9%

*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 JUNE 2025

	Medi-Cal Child	Medi-Cal Adult	Medi-Cal SPD*	Medi-Cal Duals*	Medi-Cal ACA OE	Medi-Cal LTC*	Medi-Cal LTC Duals*	Medi-Cal SPD with LTC	Medi-Cal Duals with LTC	Medi-Cal Total	Group Care	Medicare	Grand Total
Enrollments/Member Months	1,322,714	752,384	212,632	241,339	1,834,921	1,446	7,562	177,187	291,473	4,841,658	69,568	-	4,911,226
Revenue	$432,175,415	$406,677,939	$302,989,680	$139,420,670	$1,077,299,069	$14,797,097	$66,439,204	$283,844,946	$253,110,984	$2,976,755,005	$38,032,020	$0	$3,014,787,025
Medical Expense	$163,992,867	$255,278,800	$271,974,735	$93,865,476	$739,395,735	$17,665,109	$66,135,845	$300,532,977	$188,744,774	$2,097,586,319	$36,775,436	$433,154	$2,134,794,909
Gross Margin	$268,182,548	$151,399,139	$31,014,945	$45,555,194	$337,903,334	($2,868,012)	$303,359	($16,688,031)	$64,366,211	$879,168,685	$1,256,585	($433,154)	$879,992,116
Administrative Expense	$5,479,172	$12,813,320	$14,608,794	$5,050,402	$35,608,720	$1,025,042	$4,788,945	$15,908,499	$9,845,116	$105,128,010	$1,876,449	$8,798,084	$115,802,543
MCO Tax Expense	$241,410,383	$137,293,039	$43,066,547	$49,241,852	$333,259,542	$286,969	$1,547,863	$29,017,498	$47,331,202	$882,454,896	$0	$0	$882,454,896
Operating Income / (Expense)	$21,292,992	$1,292,779	($26,660,397)	($8,737,060)	($30,964,929)	($4,180,023)	($6,033,450)	($61,614,027)	$7,189,893	($108,414,221)	($619,864)	($9,231,238)	($118,265,324)
Other Income / (Expense)	$1,603,004	$3,899,118	$4,709,375	$1,609,737	$10,846,163	$338,837	$1,557,352	$4,492,429	$2,766,274	$31,822,290	$347,251	$0	$32,169,541
Net Income / (Loss)	$22,895,997	$5,191,898	($21,951,022)	($7,127,322)	($20,118,766)	($3,841,186)	($4,476,097)	($57,121,599)	$9,956,167	($76,591,931)	($272,614)	($9,231,238)	($86,095,783)
PMPM Metrics:													
Revenue PMPM	$326.73	$540.52	$1,424.95	$577.70	$587.11	$10,233.12	$8,785.93	$1,601.95	$868.39	$614.82	$546.69	$0.00	$613.86
Medical Expense PMPM	$123.98	$339.29	$1,279.09	$388.94	$402.96	$12,216.53	$8,745.81	$1,696.13	$647.55	$433.24	$528.63	$0.00	$434.68
Gross Margin PMPM	$202.75	$201.23	$145.86	$188.76	$184.15	($1,983.41)	$40.12	($94.18)	$220.83	$181.58	$18.06	$0.00	$179.18
Administrative Expense PMPM	$4.14	$17.03	$68.70	$20.93	$19.41	$708.88	$633.29	$89.78	$33.78	$21.71	$26.97	$0.00	$23.58
MCO Tax Expense PMPM	$182.51	$182.48	$202.54	$204.04	$181.62	$198.46	$204.69	$163.77	$162.39	$182.26	$0.00	$0.00	$179.68
Operating Income / (Expense) PMPM	$16.10	$1.72	($125.38)	($36.20)	($16.88)	($2,890.75)	($797.86)	($347.73)	$24.67	($22.39)	($8.91)	$0.00	($24.08)
Other Income / (Expense) PMPM	$1.21	$5.18	$22.15	$6.67	$5.91	$234.33	$205.94	$25.35	$9.49	$6.57	$4.99	$0.00	$6.55
Net Income / (Loss) PMPM	$17.31	$6.90	($103.23)	($29.53)	($10.96)	($2,656.42)	($591.92)	($322.38)	$34.16	($15.82)	($3.92)	$0.00	($17.53)
Ratio:													
Medical Loss Ratio	85.2%	94.5%	104.5%	103.2%	99.2%	121.7%	101.9%	117.9%	91.7%	99.9%	96.7%	0.0%	99.9%
Administrative Expense Ratio	2.8%	4.7%	5.6%	5.6%	4.8%	7.1%	7.4%	6.2%	4.8%	5.0%	4.9%	0.0%	5.4%
Net Income Ratio	5.3%	1.3%	-7.2%	-5.1%	-1.9%	-26.0%	-6.7%	-20.1%	3.9%	-2.6%	-0.7%	0.0%	-2.9%

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

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 30 June, 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)				
$6,166,263	$6,188,330	$22,067	0.4%	Personnel Expenses	$70,037,574	$70,720,853	$683,279	1.0%
$79,397	$75,209	($4,188)	(5.6%)	Benefits Administration Expense	$944,610	$905,182	($39,429)	(4.4%)
$4,088,763	$2,075,962	($2,012,800)	(97.0%)	Purchased & Professional Services	$26,256,454	$28,646,273	$2,389,819	8.3%
$436,826	$539,528	$102,702	19.0%	Occupancy	$6,248,516	$6,642,809	$394,292	5.9%
$393,690	$412,878	$19,189	4.6%	Printing Postage & Promotion	$5,181,788	$5,547,122	$365,334	6.6%
($174,372)	$237,543	$411,915	173.4%	Licenses Insurance & Fees	$3,905,930	$5,252,840	$1,346,910	25.6%
$390,100	$176,691	($213,410)	(120.8%)	Other Administrative Expense	$3,227,671	$2,227,265	($1,000,405)	(44.9%)
$5,214,403	$3,517,811	($1,696,592)	(48.2%)	Total Other Administrative Expenses (excludes Personnel Expenses)	$45,764,969	$49,221,491	$3,456,522	7.0%
$11,380,667	$9,706,141	($1,674,525)	(17.3%)	Total Administrative Expenses	$115,802,543	$119,942,344	$4,139,801	3.5%

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
3,839,584	4,291,666	452,082	10.5%	Salaries & Wages	45,532,965	46,668,247	1,135,282	2.4%
337,026	415,106	78,080	18.8%	Paid Time Off	4,246,619	4,778,745	532,126	11.1%
825	8,816	7,991	90.6%	Compensated Incentives	28,379	53,964	25,586	47.4%
0	0	0	0.0%	Severence	38,168	400,000	361,832	90.5%
68,662	63,124	(5,538)	(8.8%)	Payroll Taxes	879,657	1,058,876	179,219	16.9%
46,072	25,460	(20,612)	(81.0%)	Overtime	773,023	521,049	(251,974)	(48.4%)
242,898	334,967	92,069	27.5%	CalPERS ER Match	3,868,485	4,071,312	202,827	5.0%
1,094,689	743,171	(351,518)	(47.3%)	Employee Benefits	12,182,808	9,468,946	(2,713,862)	(28.7%)
(681)	0	681	0.0%	Personal Floating Holiday	192,862	202,966	10,104	5.0%
19,118	38,500	19,382	50.3%	Language Pay	253,850	406,009	152,160	37.5%
5,600	0	(5,600)	0.0%	Med Ins Opted Out Stipend	40,850	16,010	(24,840)	(155.2%)
0	0	0	0.0%	Holiday Bonus	(400,000)	0	400,000	1,333,333,4…
445,849	0	(445,849)	0.0%	Sick Leave	1,395,848	270,728	(1,125,119)	(415.6%)
273	30,692	30,418	99.1%	Compensated Employee Relations	9,111	278,139	269,028	96.7%
20,920	27,000	6,080	22.5%	Work from Home Stipend	242,030	289,270	47,240	16.3%
1,673	12,463	10,790	86.6%	Mileage, Parking & LocalTravel	16,879	67,286	50,407	74.9%
8,125	22,832	14,707	64.4%	Travel & Lodging	49,632	231,949	182,317	78.6%
8,416	79,965	71,548	89.5%	Temporary Help Services	331,627	1,016,563	684,936	67.4%
17,777	31,555	13,779	43.7%	Staff Development/Training	210,201	515,410	305,209	59.2%
9,438	63,015	53,577	85.0%	Staff Recruitment/Advertisement	144,581	405,384	260,803	64.3%
6,166,263	**6,188,330**	**22,067**	**0.4%**	**Personnel Expense**	**70,037,574**	**70,720,853**	**683,279**	**1.0%**
26,127	22,018	(4,109)	(18.7%)	Pharmacy Administrative Fees	309,472	271,276	(38,195)	(14.1%)
53,270	53,191	(79)	(0.1%)	Telemedicine Admin. Fees	635,139	633,905	(1,234)	(0.2%)
79,397	**75,209**	**(4,188)**	**(5.6%)**	**Benefits Administration Expense**	**944,610**	**905,182**	**(39,429)**	**(4.4%)**
1,521,864	509,030	(1,012,834)	(199.0%)	Consultant Fees - Non Medical	7,392,691	7,738,269	345,578	4.5%
760,675	406,014	(354,661)	(87.4%)	Computer Support Services	5,643,835	6,257,889	614,053	9.8%
(43,099)	15,000	58,099	387.3%	Audit Fees	209,974	188,158	(21,816)	(11.6%)
(19,393)	8	19,401	232,630.7%	Consultant Fees - Medical	(11,708)	(15,272)	(3,564)	23.3%
589,877	215,081	(374,797)	(174.3%)	Other Purchased Services	3,279,493	3,002,336	(277,157)	(9.2%)
6,876	844	(6,032)	(714.7%)	Maint.&Repair-Office Equipment	15,581	10,128	(5,453)	(53.8%)
0	0	0	0.0%	Maint.&Repair-Computer Hardwar	2,018	0	(2,018)	0.0%
(53,772)	75,067	128,839	171.6%	Legal Fees	1,043,634	896,819	(146,815)	(16.4%)
0	0	0	0.0%	Member Health Education	312	320	8	2.6%
61,723	26,000	(35,723)	(137.4%)	Translation Services	356,990	295,064	(61,926)	(21.0%)
46,393	157,650	111,257	70.6%	Medical Refund Recovery Fees	2,292,835	2,415,871	123,036	5.1%
1,046,887	526,884	(520,002)	(98.7%)	Software - IT Licenses & Subsc	5,015,493	6,427,419	1,411,926	22.0%
64,664	88,584	23,920	27.0%	Hardware (Non-Capital)	364,666	808,960	444,295	54.9%
106,067	55,800	(50,267)	(90.1%)	Provider Credentialing	650,641	620,313	(30,327)	(4.9%)
4,088,763	**2,075,962**	**(2,012,800)**	**(97.0%)**	**Purchased & Professional Services**	**26,256,454**	**28,646,273**	**2,389,819**	**8.3%**
61,851	111,710	49,859	44.6%	Depreciation	729,921	1,048,301	318,380	30.4%
0	0	0	0.0%	Lease Building	762,017	783,998	21,982	2.8%
7,764	5,960	(1,804)	(30.3%)	Lease Rented Office Equipment	78,184	84,085	5,901	7.0%
6,715	18,073	11,358	62.8%	Utilities	154,523	249,342	94,819	38.0%
27,758	91,065	63,307	69.5%	Telephone	991,709	1,076,185	84,476	7.8%
60,332	63,584	3,252	5.1%	Building Maintenance	443,173	484,033	40,859	8.4%
272,405	249,136	(23,270)	(9.3%)	GASB96 SBITA Amort. Expense	3,088,990	2,916,865	(172,125)	(5.9%)

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
436,826	**539,528**	**102,702**	**19.0%**	**Occupancy**	**6,248,516**	**6,642,809**	**394,292**	**5.9%**
65,973	38,568	(27,405)	(71.1%)	Postage	797,046	893,732	96,686	10.8%
7,419	5,300	(2,119)	(40.0%)	Design & Layout	61,089	93,580	32,491	34.7%
66,956	50,290	(16,666)	(33.1%)	Printing Services	1,509,166	1,207,320	(301,845)	(25.0%)
44,036	16,810	(27,226)	(162.0%)	Mailing Services	179,710	162,063	(17,647)	(10.9%)
16,831	15,348	(1,483)	(9.7%)	Courier/Delivery Service	80,303	130,686	50,383	38.6%
0	749	749	100.0%	Pre-Printed Materials & Public	589	4,329	3,740	86.4%
4,758	0	(4,758)	0.0%	Promotional Products	120,585	56,520	(64,065)	(113.3%)
0	150	150	100.0%	Promotional Services	0	1,500	1,500	100.0%
187,716	285,663	97,947	34.3%	Community Relations	2,433,300	2,997,392	564,091	18.8%
393,690	**412,878**	**19,189**	**4.6%**	**Printing Postage & Promotion**	**5,181,788**	**5,547,122**	**365,334**	**6.6%**
0	50,000	50,000	100.0%	Regulatory Penalties	315,000	535,000	220,000	41.1%
21,961	31,600	9,639	30.5%	Bank Fees	409,544	385,781	(23,763)	(6.2%)
0	0	0	0.0%	Insurance Premium	1,076,688	1,102,916	26,228	2.4%
(211,198)	119,806	331,004	276.3%	License,Permits, & Fee - NonIT	1,488,886	2,451,849	962,963	39.3%
14,865	36,137	21,272	58.9%	Subscriptions and Dues - NonIT	615,812	777,294	161,482	20.8%
(174,372)	**237,543**	**411,915**	**173.4%**	**License Insurance & Fees**	**3,905,930**	**5,252,840**	**1,346,910**	**25.6%**
5,059	11,558	6,499	56.2%	Office and Other Supplies	79,327	132,748	53,421	40.2%
0	1,000	1,000	100.0%	Furniture & Equipment	0	12,000	12,000	100.0%
19,326	26,483	7,157	27.0%	Ergonomic Supplies	274,924	349,915	74,991	21.4%
18,105	12,799	(5,305)	(41.4%)	Meals and Entertainment	147,257	194,695	47,437	24.4%
(689)	0	689	0.0%	Miscellaneous	897,937	5,300	(892,637)	(16,842.2%)
9,500	4,850	(4,650)	(95.9%)	Member Incentive	9,500	19,400	9,900	51.0%
338,800	120,000	(218,800)	(182.3%)	Provider Interest (All Depts)	1,818,726	1,513,208	(305,518)	(20.2%)
390,100	**176,691**	**(213,410)**	**(120.8%)**	**Other Administrative Expense**	**3,227,671**	**2,227,265**	**(1,000,405)**	**(44.9%)**
5,214,403	**3,517,811**	**(1,696,592)**	**(48.2%)**	**Total Other Administrative ExpenseS (excludes Personnel Expenses)**	**45,764,969**	**49,221,491**	**3,456,522**	**7.0%**
11,380,667	**9,706,141**	**(1,674,525)**	**(17.3%)**	**TOTAL ADMINISTRATIVE EXPENSES**	**115,802,543**	**119,942,344**	**4,139,801**	**3.5%**

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

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

6. Reconciliation to Balance Sheet:

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

ALAMEDA ALLIANCE FOR HEALTH
TANGIBLE NET EQUITY (TNE) AND LIQUID TNE ANALYSIS
FOR THE MONTH AND FISCAL YTD ENDED June 30, 2025

TANGIBLE NET EQUITY (TNE)	**QRT. END Jun-24**	**Jul-24**	**Aug-24**	**QRT. END Sep-24**	**Oct-24**	**Nov-24**	**QRT. END Dec-24**	**Jan-25**	**Feb-25**	**QRT. END Mar-25**	**Apr-25**	**May-25**	**QRT. END Jun-25**
Current Month Net Income / (Loss)	$ (60,612,285)	$ (6,989,301)	$ (18,354,880)	$ (8,719,238)	$ (26,984,341)	$ (27,470,264)	$ (8,643,229)	$ (6,688,826)	$ 5,089,524	$ 457,935	$ 5,938,872	$ 1,355,735	$ 4,912,222
YTD Net Income / (Loss)	$ (68,581,898)	$ (6,989,303)	$ (25,344,182)	$ (34,063,414)	$ (61,047,753)	$ (88,518,015)	$ (97,161,241)	$ (103,850,064)	$ (98,760,546)	$ (98,302,610)	$ (92,363,740)	$ (91,008,002)	$ (86,095,783)
Net Assets	$ 255,375,143	$ 248,385,840	$ 230,030,961	$ 221,311,729	$ 194,327,390	$ 166,857,128	$ 158,213,902	$ 151,525,079	$ 156,614,597	$ 157,072,533	$ 163,011,403	$ 164,367,141	$ 169,279,360
Subordinated Debt & Interest	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Actual TNE	**$ 255,375,143**	**$ 248,385,840**	**$ 230,030,961**	**$ 221,311,729**	**$ 194,327,390**	**$ 166,857,128**	**$ 158,213,902**	**$ 151,525,079**	**$ 156,614,597**	**$ 157,072,533**	**$ 163,011,403**	**$ 164,367,141**	**$ 169,279,360**
Increase/(Decrease) in Actual TNE	$ (60,612,285)	$ (6,989,301)	$ (18,354,880)	$ (8,719,238)	$ (26,984,341)	$ (27,470,264)	$ (8,643,229)	$ (6,688,826)	$ 5,089,524	$ 457,935	$ 5,938,872	$ 1,355,735	$ 4,912,222
Required TNE (1)	**$ 63,328,179**	**$ 68,750,939**	**$ 71,470,183**	**$ 70,224,330**	**$ 77,225,116**	**$ 78,852,430**	**$ 77,630,344**	**$ 81,350,675**	**$ 77,665,855**	**$ 79,764,820**	**$ 80,840,793**	**$ 80,854,653**	**$ 80,653,661**
Min. Req'd to Avoid Monthly Reporting at 150% of Required TNE	$ 94,992,268	$ 103,126,409	$ 107,205,275	$ 105,336,495	$ 115,837,673	$ 118,278,645	$ 116,445,516	$ 122,026,012	$ 116,498,783	$ 119,647,230	$ 121,261,190	$ 121,281,980	$ 120,980,491
TNE Excess / (Deficiency)	$ 192,046,964	$ 179,634,901	$ 158,560,778	$ 151,087,399	$ 117,102,274	$ 88,004,698	$ 80,583,558	$ 70,174,404	$ 78,948,742	$ 77,307,713	$ 82,170,610	$ 83,512,488	$ 88,625,699
Actual TNE as a Multiple of Required	**4.03**	**3.61**	**3.22**	**3.15**	**2.52**	**2.12**	**2.04**	**1.86**	**2.02**	**1.97**	**2.02**	**2.03**	**2.10**
LIQUID TANGIBLE NET EQUITY													
Net Assets	$ 255,375,143	$ 248,385,840	$ 230,030,961	$ 221,311,729	$ 194,327,390	$ 166,857,128	$ 158,213,902	$ 151,525,079	$ 156,614,597	$ 157,072,533	$ 163,011,403	$ 164,367,141	$ 169,279,360
Less: Fixed Assets at Net Book Value	(5,447,816)	(5,662,370)	(5,863,098)	(5,803,725)	(5,739,467)	(5,680,094)	(5,620,721)	(5,561,346)	(5,563,528)	(5,765,375)	(5,700,514)	(5,638,663)	(5,576,811)
Net Lease Assets	(501,485)	(319,957)	(496,877)	(1,004,186)	(1,303,630)	(1,065,182)	(2,704,898)	(2,504,545)	(1,864,566)	(1,666,263)	(1,393,164)	(2,114,839)	(2,072,151)
CD Pledged to DMHC	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,898)	(351,895)	(352,863)	(353,866)
Liquid TNE (Liquid Reserves)	**$ 249,075,842**	**$ 242,053,513**	**$ 223,320,986**	**$ 214,153,818**	**$ 186,934,293**	**$ 159,761,852**	**$ 149,538,283**	**$ 143,109,188**	**$ 148,836,503**	**$ 149,289,997**	**$ 155,565,830**	**$ 156,260,776**	**$ 161,276,532**
Liquid TNE as Multiple of Required	**3.93**	**3.52**	**3.12**	**3.05**	**2.42**	**2.03**	**1.93**	**1.76**	**1.92**	**1.87**	**1.92**	**1.93**	**2.00**

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

	Actual Jul-24	Actual Aug-24	Actual Sep-24	Actual Oct-24	Actual Nov-24	Actual Dec-24	Actual Jan-25	Actual Feb-25	Actual Mar-25	Actual Apr-25	Actual May-25	Actual Jun-25	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program:													
Child	109,951	109,784	109,731	109,662	109,561	110,506	111,643	111,554	111,103	110,186	109,459	109,574	1,322,714
Adult	62,708	62,641	62,550	62,578	62,502	62,905	63,553	63,706	63,255	62,499	61,818	61,669	752,384
SPD (retired Dec-24)*	35,018	35,177	35,319	35,388	35,603	36,127	0	0	0	0	0	0	212,632
Duals (retired Dec-24)*	39,892	40,024	40,124	40,144	40,357	40,798	0	0	0	0	0	0	241,339
ACA OE	149,801	150,482	151,005	151,098	151,559	154,560	154,136	154,609	154,559	154,154	153,782	155,176	1,834,921
LTC (retired Dec-24)*	222	226	240	249	255	254	0	0	0	0	0	0	1,446
LTC Duals (retired Dec-24)*	1,241	1,247	1,254	1,265	1,269	1,286	0	0	0	0	0	0	7,562
SPD with LTC (new Jan-25)	0	0	0	0	0	0	29,564	29,497	29,605	29,316	29,455	29,750	177,187
Duals with LTC (new Jan-25)	0	0	0	0	0	0	48,153	48,100	48,226	48,733	48,957	49,304	291,473
Medi-Cal Program	398,833	399,581	400,223	400,384	401,106	406,436	407,049	407,466	406,748	404,888	403,471	405,473	4,841,658
Group Care Program	5,675	5,686	5,710	5,769	5,772	5,790	5,779	5,812	5,882	5,896	5,887	5,910	69,568
Total	**404,508**	**405,267**	**405,933**	**406,153**	**406,878**	**412,226**	**412,828**	**413,278**	**412,630**	**410,784**	**409,358**	**411,383**	**4,911,226**

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

Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	(173)	(167)	(53)	(69)	(101)	945	1,137	(89)	(451)	(917)	(727)	115	(550)
Adult	(38)	(67)	(91)	28	(76)	403	648	153	(451)	(756)	(681)	(149)	(1,077)
SPD (retired Dec-24)	98	159	142	69	215	524	(36,127)	0	0	0	0	0	(34,920)
Duals (retired Dec-24)	144	132	100	20	213	441	(40,798)	0	0	0	0	0	(39,748)
ACA OE	477	681	523	93	461	3,001	(424)	473	(50)	(405)	(372)	1,394	5,852
LTC (retired Dec-24)	0	4	14	9	6	(1)	(254)	0	0	0	0	0	(222)
LTC Duals (retired Dec-24)	(7)	6	7	11	4	17	(1,286)	0	0	0	0	0	(1,248)
SPD with LTC (new Jan-25)	0	0	0	0	0	0	29,564	(67)	108	(289)	139	295	29,750
Duals with LTC (new Jan-25)	0	0	0	0	0	0	48,153	(53)	126	507	224	347	49,304
Medi-Cal Program	501	748	642	161	722	5,330	613	417	(718)	(1,860)	(1,417)	2,002	7,141
Group Care Program	17	11	24	59	3	18	(11)	33	70	14	(9)	23	252
Total	**518**	**759**	**666**	**220**	**725**	**5,348**	**602**	**450**	**(648)**	**(1,846)**	**(1,426)**	**2,025**	**7,393**

Enrollment Percentages:													
Medi-Cal Program:													
Child % of Medi-Cal	27.6%	27.5%	27.4%	27.4%	27.3%	27.2%	27.4%	27.4%	27.3%	27.2%	27.1%	27.0%	27.3%
Adult % of Medi-Cal	15.7%	15.7%	15.6%	15.6%	15.6%	15.5%	15.6%	15.6%	15.6%	15.4%	15.3%	15.2%	15.5%
SPD % of Medi-Cal	8.8%	8.8%	8.8%	8.8%	8.9%	8.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	4.4%
Duals % of Medi-Cal	10.0%	10.0%	10.0%	10.0%	10.1%	10.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	5.0%
ACA OE % of Medi-Cal	37.6%	37.7%	37.7%	37.7%	37.8%	38.0%	37.9%	37.9%	38.0%	38.1%	38.1%	38.3%	37.9%
LTC % of Medi-Cal	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
LTC Duals % of Medi-Cal	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%
SPD with LTC % of Medi-Cal	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.3%	7.2%	7.3%	7.2%	7.3%	7.3%	3.7%
Duals with LTC % of Medi-Cal	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	11.8%	11.8%	11.9%	12.0%	12.1%	12.2%	6.0%
Medi-Cal Program % of Total	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%
Group Care Program % of Total	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

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

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

	Actual Jul-24	Actual Aug-24	Actual Sep-24	Actual Oct-24	Actual Nov-24	Actual Dec-24	Actual Jan-25	Actual Feb-25	Actual Mar-25	Actual Apr-25	Actual May-25	Actual Jun-25	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted													
Directly Contracted (DCP)	87,980	88,518	89,634	89,724	90,655	96,247	94,389	94,869	93,866	94,804	94,078	96,116	1,110,880
Alameda Health System	91,091	91,170	91,024	90,756	90,451	90,222	91,158	90,932	90,950	90,450	90,739	91,196	1,090,139
Directly-Contracted Subtotal	179,071	179,688	180,658	180,480	181,106	186,469	185,547	185,801	184,816	185,254	184,817	187,312	2,201,019
Delegated:													
CFMG	44,087	43,956	43,837	43,910	44,029	44,099	44,982	45,072	45,190	44,318	43,854	43,509	530,843
CHCN	181,350	181,623	181,438	181,763	181,743	181,658	182,299	182,405	182,624	181,212	180,687	180,562	2,179,364
Delegated Subtotal	225,437	225,579	225,275	225,673	225,772	225,757	227,281	227,477	227,814	225,530	224,541	224,071	2,710,207
Total	**404,508**	**405,267**	**405,933**	**406,153**	**406,878**	**412,226**	**412,828**	**413,278**	**412,630**	**410,784**	**409,358**	**411,383**	**4,911,226**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	167	617	970	(178)	626	5,363	(922)	254	(985)	438	(437)	2,495	8,408
Delegated:													
CFMG	96	(131)	(119)	73	119	70	883	90	118	(872)	(464)	(345)	(482)
CHCN	255	273	(185)	325	(20)	(85)	641	106	219	(1,412)	(525)	(125)	(533)
Delegated Subtotal	351	142	(304)	398	99	(15)	1,524	196	337	(2,284)	(989)	(470)	(1,015)
Total	**518**	**759**	**666**	**220**	**725**	**5,348**	**602**	**450**	**(648)**	**(1,846)**	**(1,426)**	**2,025**	**7,393**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	44.3%	44.3%	44.5%	44.4%	44.5%	45.2%	44.9%	45.0%	44.8%	45.1%	45.1%	45.5%	44.8%
Delegated:													
CFMG	10.9%	10.8%	10.8%	10.8%	10.8%	10.7%	10.9%	10.9%	11.0%	10.8%	10.7%	10.6%	10.8%
CHCN	44.8%	44.8%	44.7%	44.8%	44.7%	44.1%	44.2%	44.1%	44.3%	44.1%	44.1%	43.9%	44.4%
Delegated Subtotal	55.7%	55.7%	55.5%	55.6%	55.5%	54.8%	55.1%	55.0%	55.2%	54.9%	54.9%	54.5%	55.2%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING

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

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING

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

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

	Variance Jul-24	Variance Aug-24	Variance Sep-24	Variance Oct-24	Variance Nov-24	Variance Dec-24	Variance Jan-25	Variance Feb-25	Variance Mar-25	Variance Apr-25	Variance May-25	Variance Jun-25	YTD Member Month Variance
Enrollment Variance by Plan & Aid Category - Favorable/(Unfavorable)													
Medi-Cal Program:													
Child	0	0	0	0	(211)	624	1,541	1,342	781	(246)	(1,083)	(1,079)	1,669
Adult	0	0	0	0	(139)	201	786	876	362	(457)	(1,201)	(1,413)	(985)
SPD (retired Dec-24)	0	0	0	0	180	669	0	0	0	0	0	0	849
Duals (retired Dec-24)	0	0	0	0	213	654	0	0	0	0	0	0	867
ACA OE	0	0	0	0	310	3,160	2,585	2,906	2,704	2,147	1,623	2,865	18,300
LTC (retired Dec-24)	0	0	0	0	4	0	0	0	0	0	0	0	4
LTC Duals (retired Dec-24)	0	0	0	0	3	19	0	0	0	0	0	0	22
SPD with LTC (new Jan-25)	0	0	0	0	0	0	(5,186)	(4,291)	(3,220)	(2,545)	(1,441)	(180)	(16,863)
Duals with LTC (new Jan-25)	0	0	0	0	0	0	5,741	4,687	3,812	3,318	2,541	1,887	21,986
Medi-Cal Program	0	0	0	0	360	5,327	5,467	5,520	4,439	2,217	439	2,080	25,849
Group Care Program	0	0	0	0	3	21	10	43	113	127	118	141	576
Total	**0**	**0**	**0**	**0**	**363**	**5,348**	**5,477**	**5,563**	**4,552**	**2,344**	**557**	**2,221**	**26,425**
Current Direct/Delegate Enrollment Variance - Favorable/(Unfavorable)													
Directly-Contracted													
Directly Contracted (DCP)	0	0	0	0	869	6,398	4,145	4,239	2,850	3,403	2,292	3,945	28,141
Alameda Health System	0	0	0	0	(392)	(708)	207	(28)	(18)	(526)	(245)	204	(1,506)
Directly-Contracted Subtotal	0	0	0	0	477	5,690	4,352	4,211	2,832	2,877	2,047	4,149	26,635
Delegated:													
CFMG	0	0	0	0	76	103	947	1,039	1,160	291	(170)	(512)	2,934
CHCN	0	0	0	0	(190)	(445)	178	313	560	(824)	(1,320)	(1,416)	(3,144)
Delegated Subtotal	0	0	0	0	(114)	(342)	1,125	1,352	1,720	(533)	(1,490)	(1,928)	(210)
Total	**0**	**0**	**0**	**0**	**363**	**5,348**	**5,477**	**5,563**	**4,552**	**2,344**	**557**	**2,221**	**26,425**

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				CAPITATED MEDICAL EXPENSES				
$1,211,656	$1,743,041	$531,386	30.5%	PCP Capitation	$44,995,559	$28,581,035	($16,414,523)	(57.4%)
6,221,825	6,551,517	329,691	5.0%	PCP Capitation FQHC	74,079,538	77,286,266	3,206,727	4.1%
482,351	454,907	(27,444)	(6.0%)	Specialty Capitation	5,237,874	5,135,484	(102,390)	(2.0%)
5,486,949	5,924,652	437,703	7.4%	Specialty Capitation FQHC	65,141,241	69,472,649	4,331,408	6.2%
764,905	718,050	(46,855)	(6.5%)	Laboratory Capitation	9,112,488	8,719,950	(392,538)	(4.5%)
344,220	342,030	(2,190)	(0.6%)	Vision Capitation	4,107,207	4,085,197	(22,009)	(0.5%)
109,711	132,343	22,632	17.1%	CFMG Capitation	1,335,913	1,494,216	158,303	10.6%
839,025	288,961	(550,063)	(190.4%)	ANC IPA Admin Capitation FQHC	5,498,378	3,395,675	(2,102,703)	(61.9%)
0	0	0	0.0%	Kaiser Capitation	(8,639,235)	(8,639,177)	57	0.0%
0	0	0	0.0%	BHT Supplemental Expense	(65,356)	0	65,356	0.0%
2	0	(2)	0.0%	Maternity Supplemental Expense	37,273	27,953	(9,320)	(33.3%)
1,040,511	852,274	(188,237)	(22.1%)	DME Capitation	12,300,366	11,022,290	(1,278,076)	(11.6%)
16,501,156	**17,007,776**	**506,620**	**3.0%**	**7. TOTAL CAPITATED EXPENSES**	**213,141,247**	**200,581,538**	**(12,559,708)**	**(6.3%)**
				FEE FOR SERVICE MEDICAL EXPENSES				
13,475,826	0	(13,475,826)	0.0%	IBNR Inpatient Services	60,274,939	(3,303,163)	(63,578,102)	1,924.8%
404,276	0	(404,276)	0.0%	IBNR Settlement (IP)	1,808,248	(99,094)	(1,907,342)	1,924.8%
1,078,066	0	(1,078,066)	0.0%	IBNR Claims Fluctuation (IP)	4,821,992	(264,254)	(5,086,246)	1,924.8%
37,931,838	50,409,410	12,477,572	24.8%	Inpatient Hospitalization FFS	541,017,412	612,427,368	71,409,956	11.7%
2,707,003	0	(2,707,003)	0.0%	IP OB - Mom & NB	37,316,954	12,540,164	(24,776,790)	(197.6%)
125,223	0	(125,223)	0.0%	IP Behavioral Health	6,598,359	1,070,307	(5,528,051)	(516.5%)
1,337,360	0	(1,337,360)	0.0%	Inpatient Facility Rehab FFS	15,556,000	5,770,736	(9,785,264)	(169.6%)
57,059,592	**50,409,410**	**(6,650,182)**	**(13.2%)**	**8. Inpatient Hospital Expense**	**667,393,903**	**628,142,064**	**(39,251,839)**	**(6.2%)**
76,545	0	(76,545)	0.0%	IBNR PCP	554,757	(293,439)	(848,196)	289.1%
2,296	0	(2,296)	0.0%	IBNR Settlement (PCP)	16,644	(8,801)	(25,445)	289.1%
6,123	0	(6,123)	0.0%	IBNR Claims Fluctuation (PCP)	112,642	44,791	(67,851)	(151.5%)
1,972,245	2,853,146	880,901	30.9%	PCP FFS	42,905,058	38,178,500	(4,726,559)	(12.4%)
367,162	843,571	476,409	56.5%	PCP FQHC FFS	4,719,126	8,360,055	3,640,929	43.6%
0	0	0	0.0%	Physician Extended Hrs. Incent	13,000	12,000	(1,000)	(8.3%)
0	879,555	879,555	100.0%	Prop 56 Physician Pmt	(12,256,206)	2,574,386	14,830,592	576.1%
16,407	0	(16,407)	0.0%	Prop 56 Hyde	246,800	64,923	(181,877)	(280.1%)
77,181	0	(77,181)	0.0%	Prop 56 Trauma Screening	413,487	110,133	(303,355)	(275.4%)
92,000	0	(92,000)	0.0%	Prop 56 Developmentl Screening	424,763	96,040	(328,723)	(342.3%)
665,104	0	(665,104)	0.0%	Prop 56 Family Planning	243,540	(767,666)	(1,011,206)	131.7%
0	0	0	0.0%	Prop 56 VBP	(2,406,095)	(2,718,741)	(312,647)	11.5%
3,275,063	**4,576,273**	**1,301,209**	**28.4%**	**9. Primary Care Physician Expense**	**34,987,516**	**45,652,180**	**10,664,664**	**23.4%**
607,299	0	(607,299)	0.0%	IBNR Specialist	2,123,719	(747,176)	(2,870,895)	384.2%
18,220	0	(18,220)	0.0%	IBNR Settlement (SCP)	63,717	(22,414)	(86,131)	384.3%
48,584	0	(48,584)	0.0%	IBNR Claims Fluctuation (SCP)	169,896	(59,775)	(229,671)	384.2%
484,230	0	(484,230)	0.0%	Psychiatrist FFS	5,227,191	1,559,071	(3,668,121)	(235.3%)
3,398,066	8,048,793	4,650,727	57.8%	Specialty Care FFS	42,104,854	80,134,496	38,029,642	47.5%
263,517	0	(263,517)	0.0%	Specialty Anesthesiology	2,903,526	1,061,004	(1,842,521)	(173.7%)
1,472,331	0	(1,472,331)	0.0%	Specialty Imaging FFS	19,739,003	6,843,037	(12,895,966)	(188.5%)
34,787	0	(34,787)	0.0%	Obstetrics FFS	432,160	181,208	(250,952)	(138.5%)
348,902	0	(348,902)	0.0%	Specialty IP Surgery FFS	4,838,654	1,679,499	(3,159,154)	(188.1%)
771,717	0	(771,717)	0.0%	Specialty OP Surgery FFS	11,425,887	4,353,452	(7,072,435)	(162.5%)
582,020	0	(582,020)	0.0%	Speciality IP Physician	8,005,710	2,543,833	(5,461,876)	(214.7%)
140,867	124,840	(16,027)	(12.8%)	Specialist FQHC FFS	1,542,754	1,540,353	(2,402)	(0.2%)
8,170,540	**8,173,633**	**3,092**	**0.0%**	**10. Specialty Care Physician Expense**	**98,577,070**	**99,066,587**	**489,517**	**0.5%**
1,085,104	0	(1,085,104)	0.0%	IBNR Ancillary (ANC)	5,606,431	904,191	(4,702,240)	(520.0%)

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
32,552	0	(32,552)	0.0%	IBNR Settlement (ANC)	255,253	114,188	(141,065)	(123.5%)
86,808	0	(86,808)	0.0%	IBNR Claims Fluctuation (ANC)	612,425	236,248	(376,177)	(159.2%)
45,148	0	(45,148)	0.0%	IBNR Transportation FFS	788,974	207,856	(581,118)	(279.6%)
2,505,580	0	(2,505,580)	0.0%	Behavioral Health Therapy FFS	27,557,368	8,190,565	(19,366,802)	(236.5%)
2,068,403	0	(2,068,403)	0.0%	Psychologist & Other MH Prof	24,265,931	7,234,250	(17,031,681)	(235.4%)
491,620	0	(491,620)	0.0%	Other Medical Professional	5,783,111	1,865,835	(3,917,275)	(209.9%)
147,049	0	(147,049)	0.0%	Hearing Devices	1,739,919	674,558	(1,065,362)	(157.9%)
39,730	0	(39,730)	0.0%	ANC Imaging	423,249	228,147	(195,101)	(85.5%)
76,112	0	(76,112)	0.0%	Vision FFS	903,439	280,298	(623,142)	(222.3%)
0	0	0	0.0%	Family Planning	56	10	(46)	(464.6%)
663,006	0	(663,006)	0.0%	Laboratory FFS	11,931,387	6,593,456	(5,337,932)	(81.0%)
144,596	0	(144,596)	0.0%	ANC Therapist	1,779,491	644,262	(1,135,229)	(176.2%)
1,421,780	0	(1,421,780)	0.0%	Transp/Ambulance FFS	19,798,158	5,962,027	(13,836,131)	(232.1%)
2,814,555	0	(2,814,555)	0.0%	Non-ER Transportation FFS	29,852,221	8,526,483	(21,325,738)	(250.1%)
1,692,648	0	(1,692,648)	0.0%	Hospice FFS	25,863,943	9,250,960	(16,612,983)	(179.6%)
1,721,827	0	(1,721,827)	0.0%	Home Health Services	21,278,946	7,088,754	(14,190,192)	(200.2%)
0	14,440,703	14,440,703	100.0%	Other Medical FFS	128	114,865,596	114,865,468	100.0%
90,059	0	(90,059)	0.0%	Medical Refunds through HMS	(1,388,066)	290,192	1,678,258	578.3%
0	0	0	0.0%	Medical Refunds	10,037	0	(10,037)	0.0%
27,710	0	(27,710)	0.0%	DME & Medical Supplies FFS	419,114	187,833	(231,280)	(123.1%)
2,640,021	2,253,944	(386,077)	(17.1%)	ECM Base/Outreach FFS ANC	10,492,394	8,618,993	(1,873,401)	(21.7%)
155,377	108,571	(46,806)	(43.1%)	CS Housing Deposits FFS ANC	1,376,621	1,304,917	(71,704)	(5.5%)
734,614	834,091	99,477	11.9%	CS Housing Tenancy FFS ANC	9,172,803	9,662,416	489,614	5.1%
466,826	458,885	(7,942)	(1.7%)	CS Housing Navi Servic FFS ANC	5,394,464	5,492,161	97,697	1.8%
288,888	738,249	449,361	60.9%	CS Medical Respite FFS ANC	6,297,581	8,260,643	1,963,062	23.8%
124,938	165,083	40,145	24.3%	CS Med. Tailored Meals FFS ANC	2,785,041	2,187,909	(597,132)	(27.3%)
28,320	25,196	(3,124)	(12.4%)	CS Asthma Remediation FFS ANC	185,281	219,827	34,547	15.7%
0	9,871	9,871	100.0%	MOT Wrap Around (Non Med MOT)	0	79,816	79,816	100.0%
0	9,974	9,974	100.0%	CS Home Modifications FFS ANC	24,053	104,024	79,971	76.9%
91,361	527,793	436,433	82.7%	CS P.Care & Hmker Svcs FFS ANC	2,533,273	5,747,734	3,214,462	55.9%
6,688	19,961	13,273	66.5%	CS Cgiver Respite Svcs FFS ANC	61,651	202,320	140,670	69.5%
200	0	(200)	0.0%	CS Housing Outreach	1,080	0	(1,080)	0.0%
26,058	0	(26,058)	0.0%	CommunityBased Adult Svc(CBAS)	5,180,189	2,203,374	(2,976,815)	(135.1%)
18,158	25,000	6,842	27.4%	CS LTC Diversion FFS ANC	218,397	267,778	49,382	18.4%
1,038	7,469	6,431	86.1%	CS LTC Transition FFS ANC	8,795	59,964	51,169	85.3%
19,736,774	**19,624,791**	**(111,983)**	**(0.6%)**	**11. Ancillary Medical Expense**	**221,213,134**	**217,757,585**	**(3,455,549)**	**(1.6%)**
2,354,748	0	(2,354,748)	0.0%	IBNR Outpatient	4,930,081	231,629	(4,698,452)	(2,028.4%)
70,642	0	(70,642)	0.0%	IBNR Settlement (OP)	147,905	6,949	(140,956)	(2,028.4%)
188,379	0	(188,379)	0.0%	IBNR Claims Fluctuation (OP)	394,399	18,527	(375,871)	(2,028.7%)
2,459,075	11,430,917	8,971,842	78.5%	Outpatient FFS	29,564,958	103,010,366	73,445,407	71.3%
2,638,476	0	(2,638,476)	0.0%	OP Ambul Surgery FFS	32,455,714	11,593,959	(20,861,755)	(179.9%)
2,285,252	0	(2,285,252)	0.0%	Imaging Services FFS	31,469,362	10,130,403	(21,338,959)	(210.6%)
123,522	0	(123,522)	0.0%	Behavioral Health FFS	788,289	97,460	(690,829)	(708.8%)
795,294	0	(795,294)	0.0%	Outpatient Facility Lab FFS	9,243,961	2,863,424	(6,380,537)	(222.8%)
202,144	0	(202,144)	0.0%	Outpatient Facility Cardio FFS	2,617,996	844,453	(1,773,543)	(210.0%)
122,737	0	(122,737)	0.0%	OP Facility PT/OT/ST FFS	1,229,456	400,408	(829,048)	(207.1%)
2,745,755	0	(2,745,755)	0.0%	OP Facility Dialysis Ctr FFS	37,636,311	12,647,437	(24,988,874)	(197.6%)
13,986,023	**11,430,917**	**(2,555,106)**	**(22.4%)**	**12. Outpatient Medical Expense**	**150,478,431**	**141,845,015**	**(8,633,416)**	**(6.1%)**
1,697,010	0	(1,697,010)	0.0%	IBNR Emergency	5,034,673	(165,803)	(5,200,476)	3,136.5%
50,910	0	(50,910)	0.0%	IBNR Settlement (ER)	151,040	(4,974)	(156,014)	3,136.4%
135,762	0	(135,762)	0.0%	IBNR Claims Fluctuation (ER)	402,770	(13,266)	(416,036)	3,136.1%
0	0	0	0.0%	ER Global	3,850	0	(3,850)	0.0%
7,743,634	10,550,665	2,807,031	26.6%	ER Facility	105,870,290	120,969,873	15,099,582	12.5%
1,126,704	0	(1,126,704)	0.0%	Specialty ER Physician FFS	14,792,218	4,880,392	(9,911,826)	(203.1%)
10,754,019	**10,550,665**	**(203,355)**	**(1.9%)**	**13. Emergency Expense**	**126,254,841**	**125,666,221**	**(588,620)**	**(0.5%)**

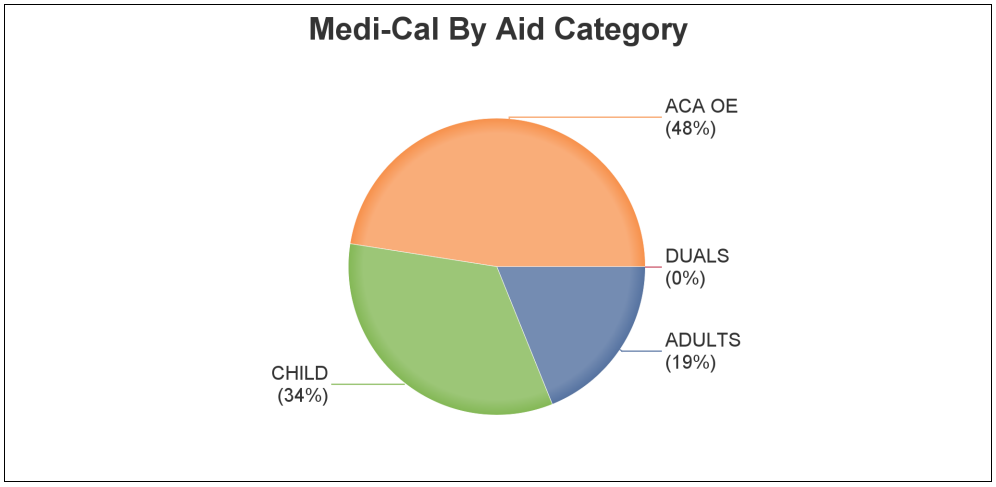
ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 30 JUNE, 2025

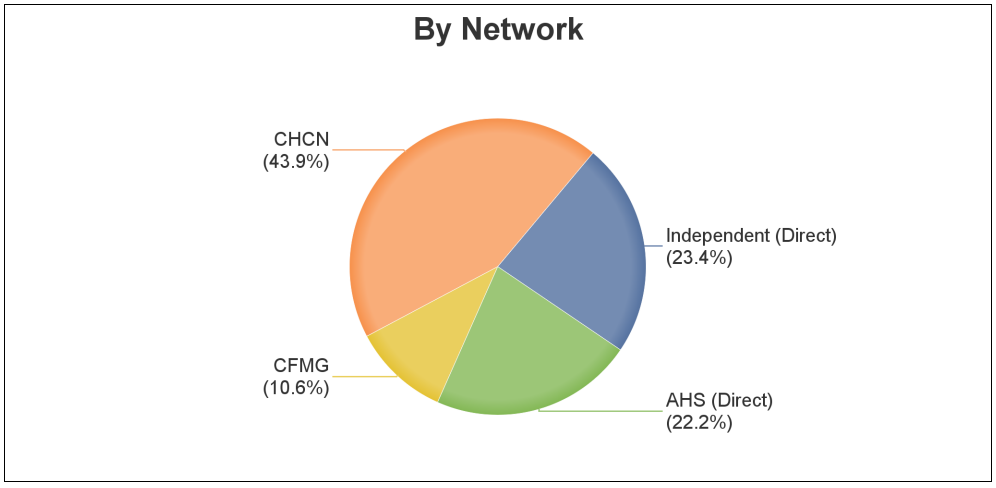
CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
1,301,621	0	(1,301,621)	0.0%	IBNR Pharmacy (OP)	4,440,848	1,991,773	(2,449,075)	(123.0%)
39,049	0	(39,049)	0.0%	IBNR Settlement Rx (OP)	133,226	59,755	(73,471)	(123.0%)
104,128	0	(104,128)	0.0%	IBNR Claims Fluctuation Rx(OP)	355,268	159,342	(195,926)	(123.0%)
743,910	454,372	(289,538)	(63.7%)	Pharmacy FFS (OP)	8,450,514	6,710,475	(1,740,040)	(25.9%)
58,338	11,212,081	11,153,743	99.5%	Pharmacy Non PBM FFS Other-ANC	1,463,239	92,672,328	91,209,089	98.4%
6,914,692	0	(6,914,692)	0.0%	Pharmacy Non PBM FFS OP-FAC	106,210,510	39,326,556	(66,883,954)	(170.1%)
258,292	0	(258,292)	0.0%	Pharmacy Non PBM FFS PCP	2,968,501	985,563	(1,982,938)	(201.2%)
2,104,928	0	(2,104,928)	0.0%	Pharmacy Non PBM FFS SCP	29,286,175	10,617,727	(18,668,447)	(175.8%)
14,151	0	(14,151)	0.0%	Pharmacy Non PBM FFS FQHC	254,134	82,575	(171,559)	(207.8%)
10,193	0	(10,193)	0.0%	Pharmacy Non PBM FFS HH	172,639	91,629	(81,010)	(88.4%)
0	0	0	0.0%	RX Refunds HMS	(345)	(306)	39	(12.6%)
(50,000)	50,966	100,966	198.1%	Medical Expenses Pharm Rebate	(852,237)	195,685	1,047,922	535.5%
11,499,302	**11,717,419**	**218,117**	**1.9%**	**14. Pharmacy Expense**	**152,882,471**	**152,893,100**	**10,630**	**0.0%**
(11,111,660)	0	11,111,660	0.0%	IBNR LTC	11,518,892	(3,756,936)	(15,275,828)	406.6%
(333,350)	0	333,350	0.0%	IBNR Settlement (LTC)	345,566	(112,709)	(458,275)	406.6%
(888,934)	0	888,934	0.0%	IBNR Claims Fluctuation (LTC)	921,508	(300,555)	(1,222,063)	406.6%
1,638,353	0	(1,638,353)	0.0%	LTC - ICF/DD	19,588,232	6,755,726	(12,832,506)	(190.0%)
32,501,023	0	(32,501,023)	0.0%	LTC Custodial Care	291,686,370	99,683,289	(192,003,082)	(192.6%)
7,268,983	33,756,261	26,487,278	78.5%	LTC SNF	90,493,590	299,010,754	208,517,165	69.7%
29,074,415	**33,756,261**	**4,681,846**	**13.9%**	**15. Long Term Care Expense**	**414,554,158**	**401,279,568**	**(13,274,589)**	**(3.3%)**
153,555,729	**150,239,368**	**(3,316,361)**	**(2.2%)**	**16. TOTAL FFS MEDICAL EXPENSES**	**1,866,341,523**	**1,812,302,320**	**(54,039,203)**	**(3.0%)**
0	101,783	101,783	100.0%	Clinical Vacancy #102	0	(1,984,210)	(1,984,210)	100.0%
253,169	322,084	68,915	21.4%	Quality Analytics #123	2,348,384	2,871,496	523,111	18.2%
389,390	327,635	(61,756)	(18.8%)	LongTerm Services and Support #139	3,569,237	3,640,045	70,808	1.9%
963,592	842,976	(120,616)	(14.3%)	Utilization Management #140	11,686,969	11,575,887	(111,082)	(1.0%)
804,550	639,991	(164,559)	(25.7%)	Case & Disease Management #185	8,652,252	8,471,415	(180,837)	(2.1%)
331,845	621,356	289,510	46.6%	Medical Management #230	10,278,365	12,613,405	2,335,041	18.5%
1,718,932	987,319	(731,614)	(74.1%)	Quality Improvement #235	14,323,789	14,486,275	162,486	1.1%
395,473	362,402	(33,071)	(9.1%)	HCS Behavioral Health #238	4,081,733	4,435,063	353,330	8.0%
143,553	198,236	54,683	27.6%	Pharmacy Services #245	1,618,576	2,737,488	1,118,912	40.9%
19,051	61,108	42,057	68.8%	Regulatory Readiness #268	638,482	828,184	189,702	22.9%
5,019,556	**4,464,888**	**(554,668)**	**(12.4%)**	**17. Other Benefits & Services**	**57,197,787**	**59,675,048**	**2,477,262**	**4.2%**
(1,567,257)	(1,259,511)	307,746	(24.4%)	Reinsurance Recoveries	(22,554,885)	(17,055,730)	5,499,155	(32.2%)
1,693,294	1,679,348	(13,946)	(0.8%)	Reinsurance Premium	20,669,238	20,789,284	120,046	0.6%
126,037	**419,837**	**293,800**	**70.0%**	**18. Reinsurance (Net)**	**(1,885,647)**	**3,733,553**	**5,619,201**	**150.5%**
0	3,000,000	3,000,000	100.0%	P4P Risk Pool Provider Incenti	0	3,000,000	3,000,000	100.0%
0	**3,000,000**	**3,000,000**	**100.0%**	**19. Risk Pool Distribution**	**0**	**3,000,000**	**3,000,000**	**100.0%**
175,202,479	**175,131,869**	**(70,609)**	**0.0%**	**20. TOTAL MEDICAL EXPENSES**	**2,134,794,909**	**2,079,292,460**	**(55,502,449)**	**(2.7%)**

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend

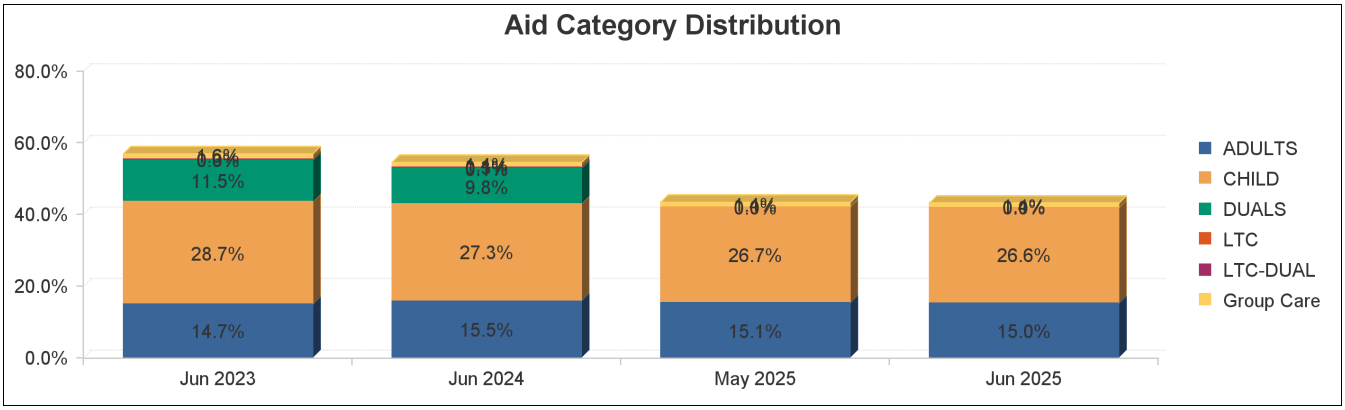
Category of Aid	Jun 2025	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN
ADULTS	61,699	15%	13,085	14,293	0	34,321
CHILD	109,640	27%	10,695	13,501	40,490	44,954
SPD	0	0%	0	0	0	0
ACA OE	155,176	38%	29,385	53,537	1,546	70,708
DUALS	1	0%	1	0	0	0
LTC	0	0%	0	0	0	0
LTC-DUAL	0	0%	0	0	0	0
SPD-LTC	29,750	7%	8,824	5,299	1,484	14,143
SPD-LTC/Full Dual	49,304	12%	32,016	3,544	2	13,742
Medi-Cal	405,570		94,006	90,174	43,522	177,868
Group Care	5,910		2,167	1,031	0	2,712
Total	**411,480**	**100%**	**96,173**	**91,205**	**43,522**	**180,580**
Medi-Cal %	98.6%		97.7%	98.9%	100.0%	98.5%
Group Care %	1.4%		2.3%	1.1%	0.0%	1.5%
	Network Distribution		**23.4%**	**22.2%**	**10.6%**	**43.9%**
			% Direct:	**46%**	**% Delegated:**	**54%**





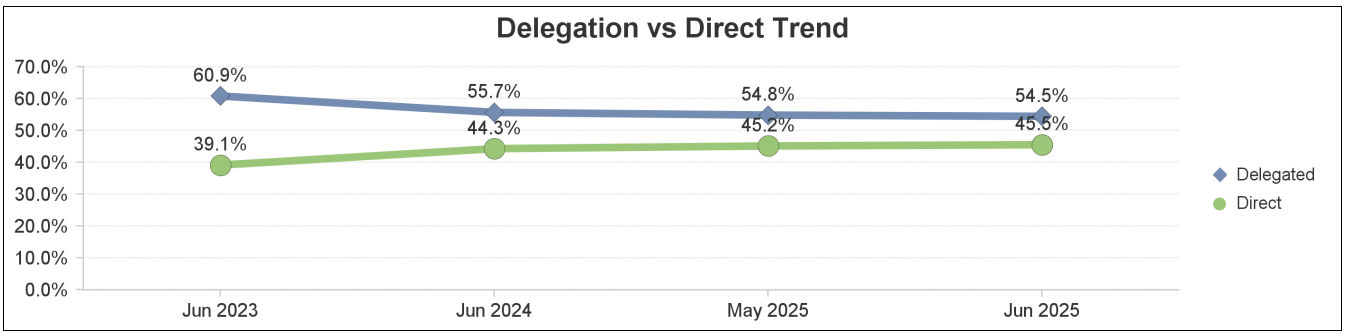
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Jun 2023	Jun 2024	May 2025	Jun 2025	Jun 2023	Jun 2024	May 2025	Jun 2025	Jun 2023 to Jun 2024	Jun 2024 to Jun 2025	May 2025 to Jun 2025
ADULTS	53,174	62,786	61,851	**61,699**	14.7%	15.5%	15.1%	15.0%	15.3%	-1.8%	-0.2%
CHILD	103,670	110,164	109,496	**109,640**	28.7%	27.3%	26.7%	26.6%	5.9%	-0.5%	0.1%
SPD	31,280	34,935	0	**0**	8.6%	8.6%	0.0%	0.0%	10.5%	0.0%	0.0%
ACA OE	124,967	149,359	153,782	**155,176**	34.6%	37.0%	37.6%	37.7%	16.3%	3.7%	0.9%
DUALS	41,731	39,789	1	**1**	11.5%	9.8%	0.0%	0.0%	-4.9%	##########	0.0%
LTC	150	224	0	**0**	0.0%	0.1%	0.0%	0.0%	33.0%	0.0%	0.0%
LTC-DUAL	1,029	1,250	0	**0**	0.3%	0.3%	0.0%	0.0%	17.7%	0.0%	0.0%
SPD-LTC	0	0	29,455	**29,750**	0.0%	0.0%	7.2%	7.2%	0.0%	100.0%	1.0%
SPD-LTC/ Full Dual	0	0	48,957	**49,304**	0.0%	0.0%	12.0%	12.0%	0.0%	100.0%	0.7%
Medi-Cal	356,001	398,507	403,542	**405,570**	98.4%	98.6%	98.6%	98.6%	10.7%	1.7%	0.5%
Group Care	5,684	5,658	5,887	**5,910**	1.6%	1.4%	1.4%	1.4%	-0.5%	4.3%	0.4%
Total	**361,685**	**404,165**	**409,429**	**411,480**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**10.5%**	**1.8%**	**0.5%**



Delegation vs Direct Trend

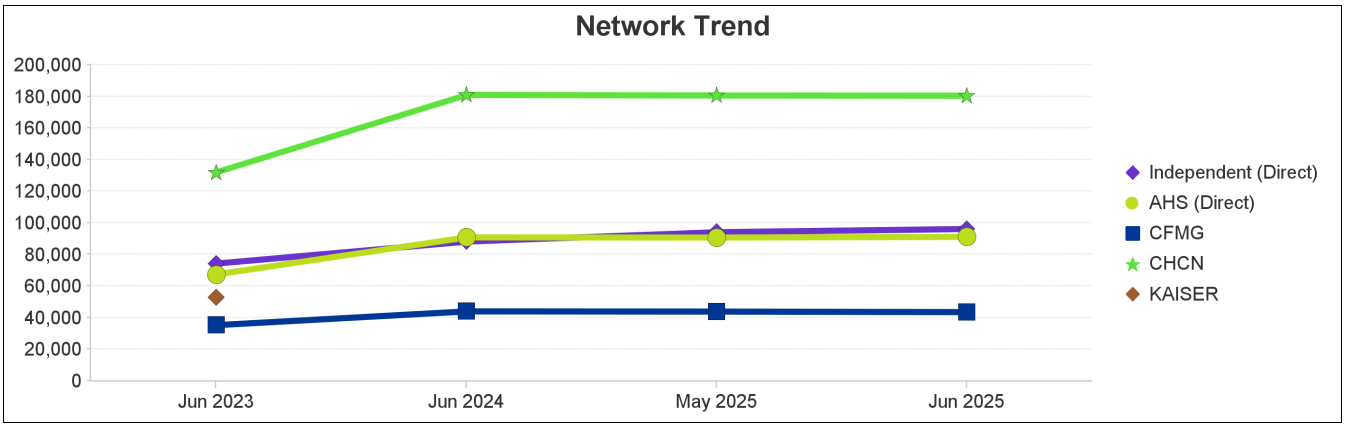
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	Jun 2023	Jun 2024	May 2025	Jun 2025	Jun 2023	Jun 2024	May 2025	Jun 2025	Jun 2023 to Jun 2024	Jun 2024 to Jun 2025	May 2025 to Jun 2025
Delegated	220,110	225,091	224,566	**224,102**	60.9%	55.7%	54.8%	54.5%	2.2%	-0.4%	-0.2%
Direct	141,575	179,074	184,863	**187,378**	39.1%	44.3%	45.2%	45.5%	20.9%	4.4%	1.3%
Total	**361,685**	**404,165**	**409,429**	**411,480**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**10.5%**	**1.8%**	**0.5%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

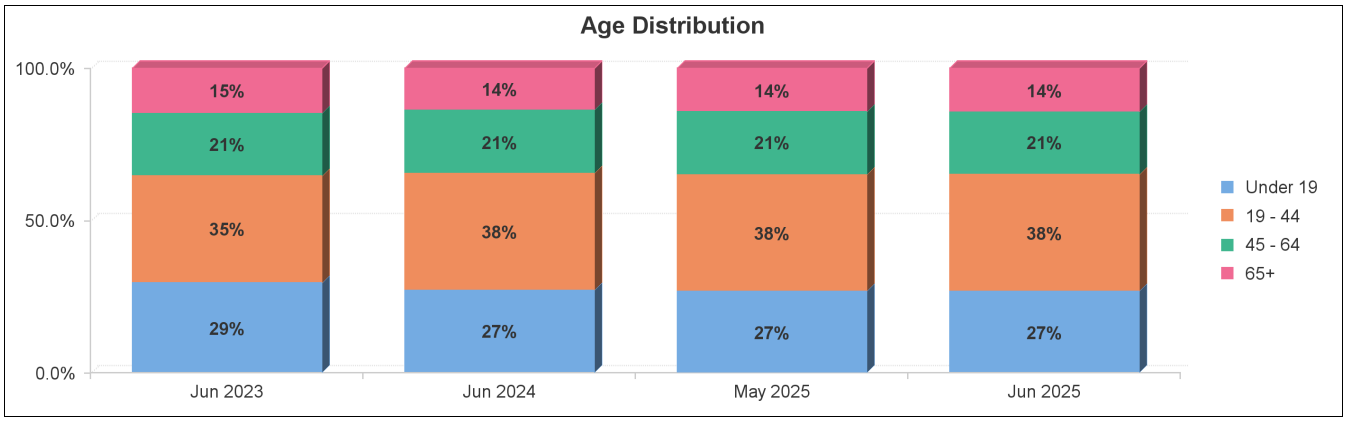
Network Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Jun 2023	Jun 2024	May 2025	Jun 2025	Jun 2023	Jun 2024	May 2025	Jun 2025	Jun 2023 to Jun 2024	Jun 2024 to Jun 2025	May 2025 to Jun 2025
Independent (Direct)	74,242	88,206	94,112	**96,173**	20.5%	21.8%	23.0%	23.4%	15.8%	8.3%	2.1%
AHS (Direct)	67,333	90,868	90,751	**91,205**	18.6%	22.5%	22.2%	22.2%	25.9%	0.4%	0.5%
CFMG	35,251	43,991	43,866	**43,522**	9.7%	10.9%	10.7%	10.6%	19.9%	-1.1%	-0.8%
CHCN	131,951	181,100	180,700	**180,580**	36.5%	44.8%	44.1%	43.9%	27.1%	-0.3%	-0.1%
KAISER	52,908	0	0	**0**	14.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	**361,685**	**404,165**	**409,429**	**411,480**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**10.5%**	**1.8%**	**0.5%**



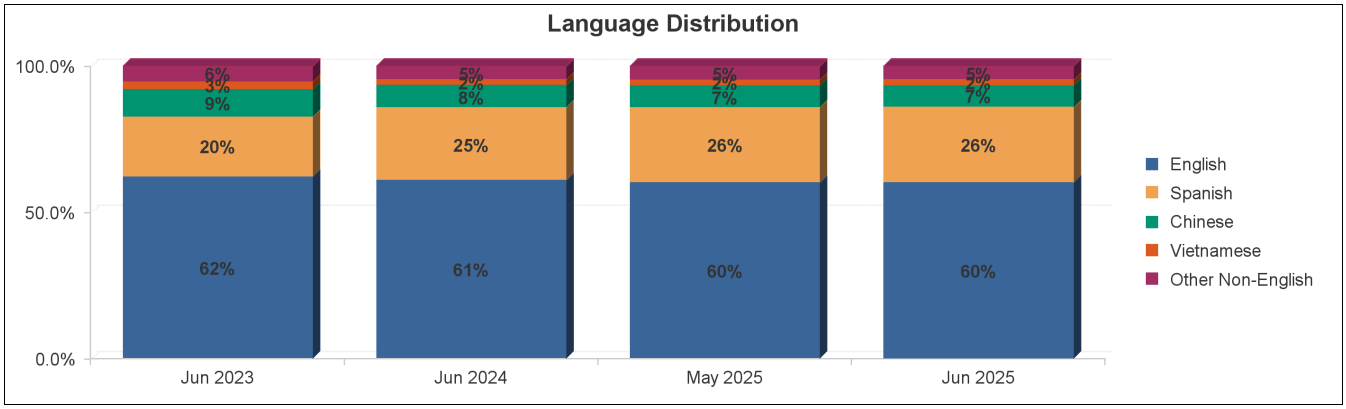
Age Category Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Jun 2023	Jun 2024	May 2025	Jun 2025	Jun 2023	Jun 2024	May 2025	Jun 2025	Jun 2023 to Jun 2024	Jun 2024 to Jun 2025	May 2025 to Jun 2025
Under 19	106,040	108,701	109,093	**109,396**	29%	27%	27%	27%	2%	1%	0%
19 - 44	127,085	155,198	156,608	**157,686**	35%	38%	38%	38%	18%	2%	1%
45 - 64	74,391	83,870	84,588	**84,758**	21%	21%	21%	21%	11%	1%	0%
65+	54,169	56,396	59,140	**59,640**	15%	14%	14%	14%	4%	5%	1%
Total	**361,685**	**404,165**	**409,429**	**411,480**	**100%**	**100%**	**100%**	**100%**	**11%**	**2%**	**0%**



Language Trend

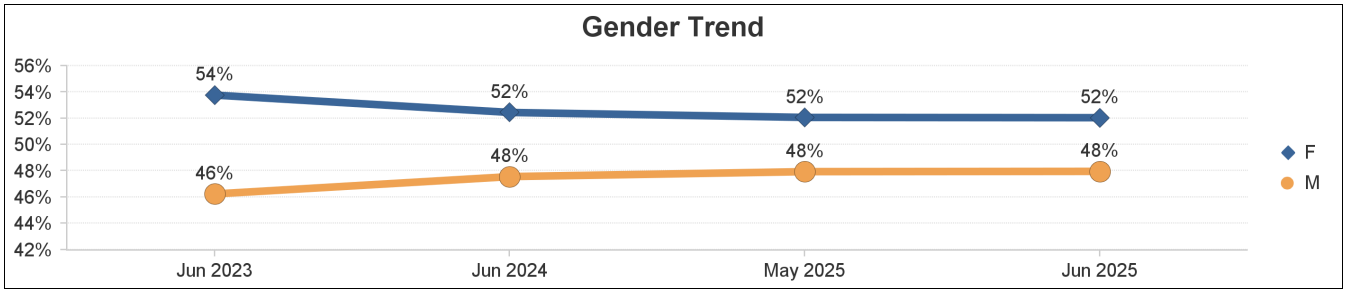
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	Jun 2023	Jun 2024	May 2025	Jun 2025	un 2023	un 2024	May 2025	un 2025	Jun 2023 to Jun 2024	Jun 2024 to Jun 2025	May 2025 to Jun 2025
English	223,993	245,593	245,363	**247,110**	62%	61%	60%	60%	9%	1%	1%
Spanish	74,012	100,576	105,584	**105,889**	20%	25%	26%	26%	26%	5%	0%
Chinese	33,860	30,660	30,483	**30,503**	9%	8%	7%	7%	-10%	-1%	0%
Vietnamese	9,838	8,386	8,131	**8,135**	3%	2%	2%	2%	-17%	-3%	0%
Other Non-English	19,982	18,950	19,868	**19,843**	6%	5%	5%	5%	-5%	5%	0%
Total	**361,685**	**404,165**	**409,429**	**411,480**	**100%**	**100%**	**100%**	**100%**	**11%**	**2%**	**0%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

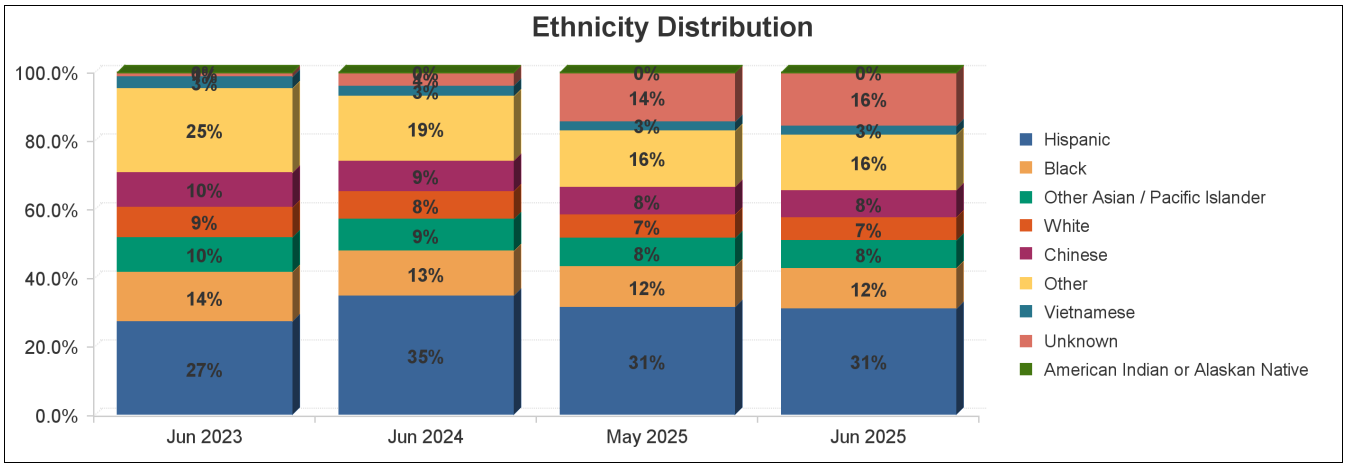
Gender Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Jun 2023	Jun 2024	May 2025	Jun 2025	Jun 2023	Jun 2024	May 2025	Jun 2025	Jun 2023 to Jun 2024	Jun 2024 to Jun 2025	May 2025 to Jun 2025
F	194,470	211,959	213,172	**214,154**	54%	52%	52%	52%	8%	1%	0%
M	167,215	192,206	196,257	**197,326**	46%	48%	48%	48%	13%	3%	1%
Total	**361,685**	**404,165**	**409,429**	**411,480**	**100%**	**100%**	**100%**	**100%**	**11%**	**2%**	**0%**



Ethnicity Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Jun 2023	Jun 2024	May 2025	Jun 2025	Jun 2023	Jun 2024	May 2025	Jun 2025	Jun 2023 to Jun 2024	Jun 2024 to Jun 2025	May 2025 to Jun 2025
Hispanic	98,185	139,887	128,260	**127,002**	27%	35%	31%	31%	30%	-10%	-1%
Black	52,097	53,044	48,641	**48,489**	14%	13%	12%	12%	2%	-9%	0%
Other Asian / Pacific Islander	36,735	37,615	33,892	**33,457**	10%	9%	8%	8%	2%	-12%	-1%
White	31,823	32,738	28,217	**27,820**	9%	8%	7%	7%	3%	-18%	-1%
Chinese	36,522	35,855	32,710	**32,481**	10%	9%	8%	8%	-2%	-10%	-1%
Other	88,825	76,430	67,243	**66,579**	25%	19%	16%	16%	-16%	-15%	-1%
Vietnamese	12,366	11,893	10,702	**10,610**	3%	3%	3%	3%	-4%	-12%	-1%
Unknown	4,397	15,906	59,045	**64,320**	1%	4%	14%	16%	72%	75%	8%
American Indian or Alaskan Native	735	797	719	**722**	0%	0%	0%	0%	8%	-10%	0%
Total	**361,685**	**404,165**	**409,429**	**411,480**	**100%**	**100%**	**100%**	**100%**	**11%**	**2%**	**0%**



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

Medi-Cal By City

City	Jun 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	161,701	40%	25,225	42,410	17,028	77,038
HAYWARD	53,228	13%	12,311	15,177	5,759	19,981
FREMONT	38,795	10%	16,346	6,805	2,344	13,300
SAN LEANDRO	25,582	6%	6,919	4,353	3,101	11,209
UNION CITY	14,564	4%	5,825	2,672	847	5,220
ALAMEDA	13,711	3%	3,402	2,515	2,015	5,779
BERKELEY	16,479	4%	4,619	2,357	1,796	7,707
LIVERMORE	13,214	3%	1,993	493	2,177	8,551
NEWARK	9,422	2%	2,844	4,019	549	2,010
CASTRO VALLEY	11,385	3%	3,347	1,850	1,760	4,428
SAN LORENZO	6,101	2%	1,275	1,449	700	2,677
PLEASANTON	8,032	2%	2,095	363	841	4,733
DUBLIN	7,778	2%	2,339	375	898	4,166
EMERYVILLE	3,045	1%	676	640	488	1,241
ALBANY	2,572	1%	631	283	551	1,107
PIEDMONT	512	0%	110	191	90	121
SUNOL	82	0%	27	11	7	37
ANTIOCH	48	0%	21	12	4	11
Other	19,319	5%	4,001	4,199	2,567	8,552
Total	405,570	100%	**94,006**	**90,174**	**43,522**	**177,868**

Group Care By City

City	Jun 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	1,823	31%	334	393	0	1,096
HAYWARD	667	11%	303	179	0	185
FREMONT	670	11%	442	80	0	148
SAN LEANDRO	628	11%	256	97	0	275
UNION CITY	292	5%	181	44	0	67
ALAMEDA	301	5%	83	29	0	189
BERKELEY	149	3%	42	13	0	94
LIVERMORE	99	2%	31	4	0	64
NEWARK	145	2%	78	39	0	28
CASTRO VALLEY	217	4%	90	32	0	95
SAN LORENZO	151	3%	46	26	0	79
PLEASANTON	70	1%	23	3	0	44
DUBLIN	132	2%	47	9	0	76
EMERYVILLE	44	1%	14	6	0	24
ALBANY	21	0%	11	1	0	9
PIEDMONT	6	0%	1	1	0	4
SUNOL	1	0%	1	0	0	0
ANTIOCH	28	0%	9	7	0	12
Other	466	8%	175	68	0	223
Total	**5,910**	**100%**	**2,167**	**1,031**	**0**	**2,712**

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

Total By City

City	Jun 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	163,524	40%	25,559	42,803	17,028	78,134
HAYWARD	53,895	13%	12,614	15,356	5,759	20,166
FREMONT	39,465	10%	16,788	6,885	2,344	13,448
SAN LEANDRO	26,210	6%	7,175	4,450	3,101	11,484
UNION CITY	14,856	4%	6,006	2,716	847	5,287
ALAMEDA	14,012	3%	3,485	2,544	2,015	5,968
BERKELEY	16,628	4%	4,661	2,370	1,796	7,801
LIVERMORE	13,313	3%	2,024	497	2,177	8,615
NEWARK	9,567	2%	2,922	4,058	549	2,038
CASTRO VALLEY	11,602	3%	3,437	1,882	1,760	4,523
SAN LORENZO	6,252	2%	1,321	1,475	700	2,756
PLEASANTON	8,102	2%	2,118	366	841	4,777
DUBLIN	7,910	2%	2,386	384	898	4,242
EMERYVILLE	3,089	1%	690	646	488	1,265
ALBANY	2,593	1%	642	284	551	1,116
PIEDMONT	518	0%	111	192	90	125
SUNOL	83	0%	28	11	7	37
ANTIOCH	76	0%	30	19	4	23
Other	19,785	5%	4,176	4,267	2,567	8,775
Total	411,480	100%	**96,173**	**91,205**	**43,522**	**180,580**

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

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

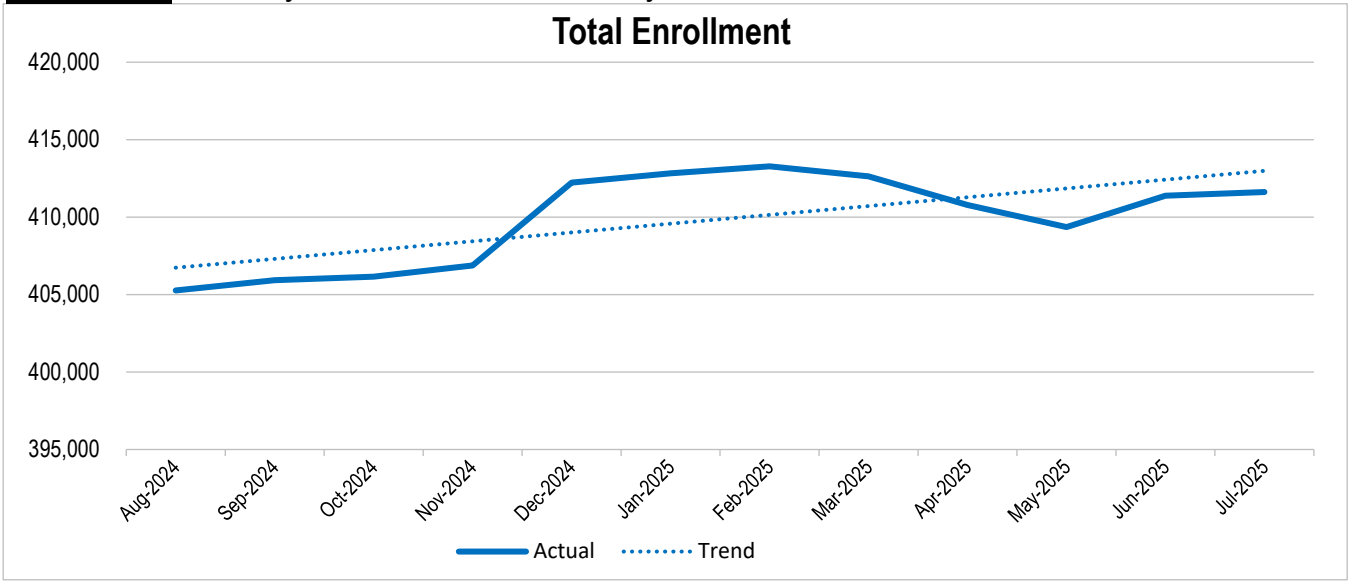
Date: **September 12th, 2025**

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

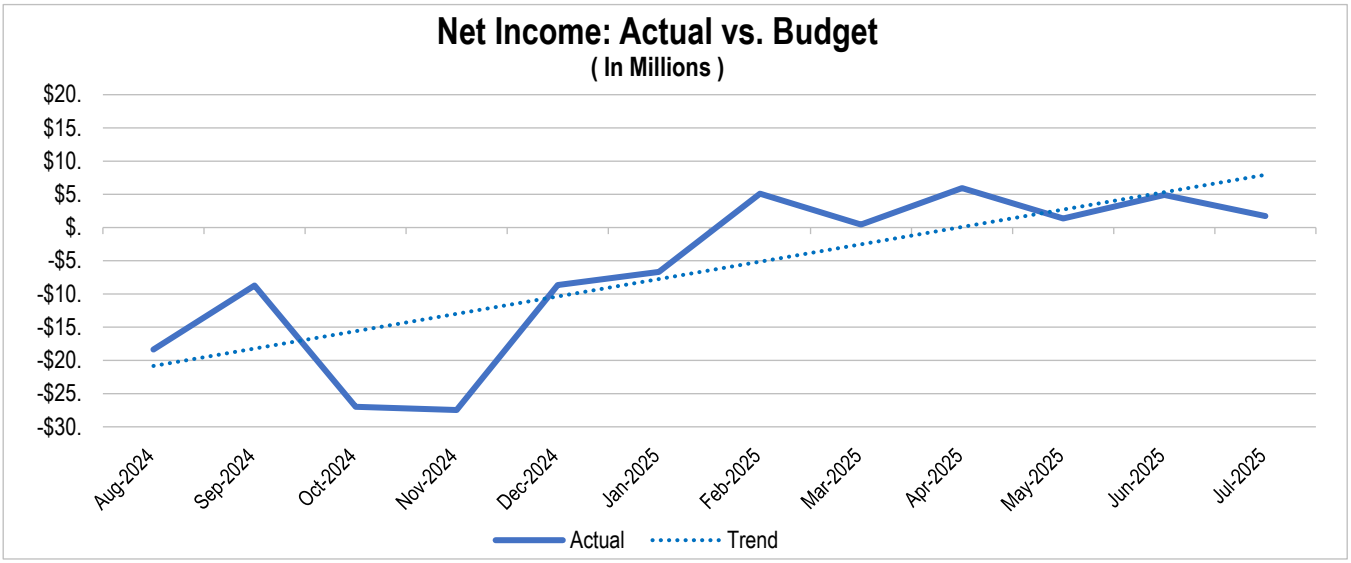
Executive Summary

For the month of July, the Alliance increased in enrollment, reaching 411,619 members. Net Income of $1.7 million was reported, and the Plan's Medical Expenses represented 96.0% of Premium Revenue. Alliance reserves increased slightly to 211% of required and continue to remain above minimum requirements.

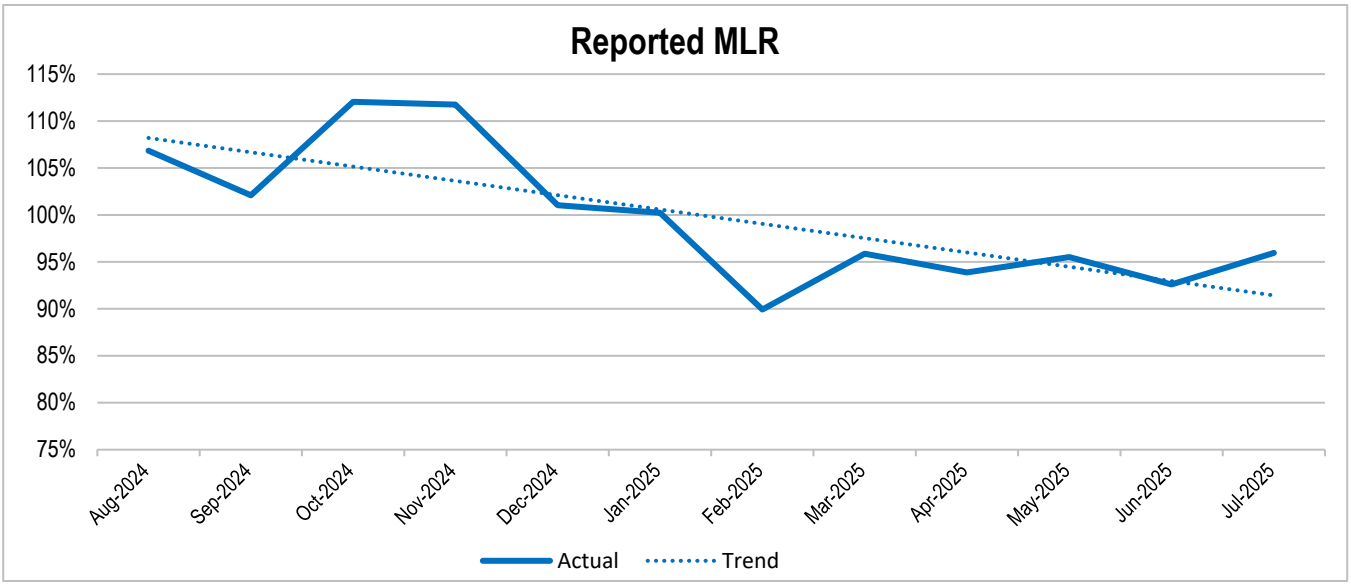
Enrollment – In July, Enrollment increased by 236 members.



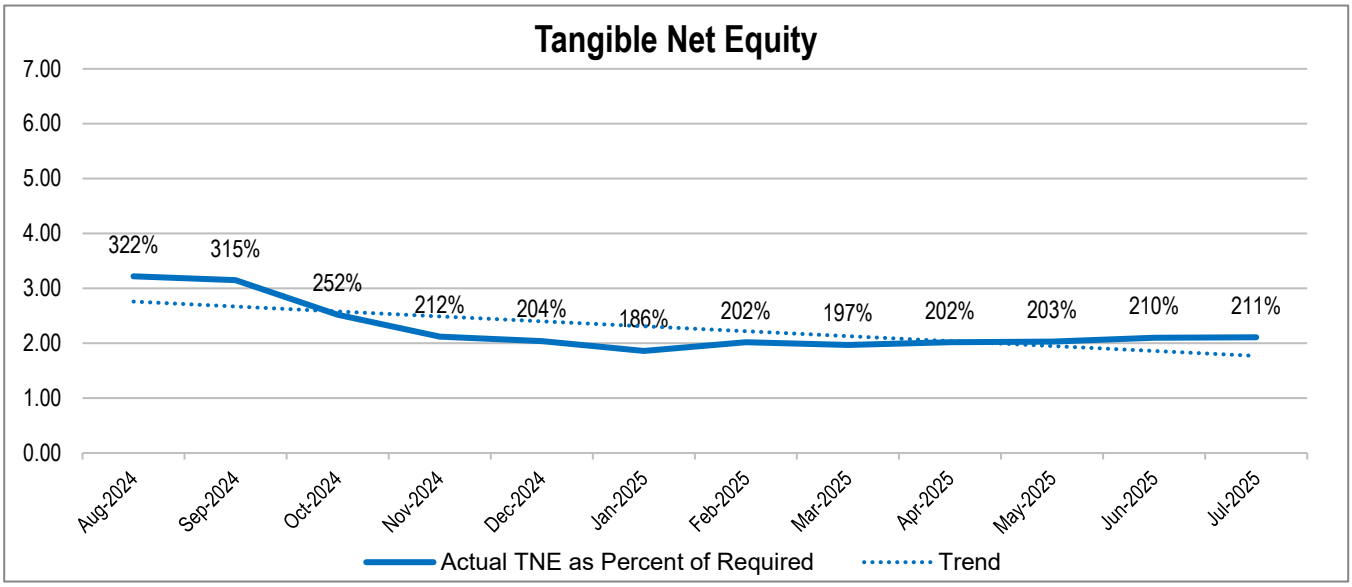
Net Income – For the month ended July and fiscal YTD, actual Net Income was $1.7 million vs. budgeted Net Income of $7.2 million. For the month and fiscal YTD, Premium Revenue was favorable to budget, actual Revenue was $192.1 million vs. budgeted Revenue of $187.2 million. Premium Revenue favorable variance of $4.9 million is primarily due to blended Medi-Cal capitation rate variance and volume variance for the current month.



Medical Loss Ratio (MLR) – The Medical Loss Ratio was 96.0% for the month and fiscal YTD. The major unfavorable variances include Other Benefits & Services, Capitated Medical Expense, and Emergency Expense. The major favorable variance is Ancillary Medical Expense.



Tangible Net Equity (TNE) – The Department of Managed Health Care (DMHC) required $81.2 million in reserves, we reported $171.0 million. Our overall TNE remains above DMHC requirements at 211%.



The Alliance continues to benefit from increased non-operating income. For Fiscal year-to-date, investments show a gain of $2.8 million and capital assets acquired are $0.

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

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

Date: **September 12th, 2025**

Subject: **Finance Report – July 2025**

Executive Summary

- For the month ended July 31st, 2025, the Alliance had enrollment of 411,619 members, a Net Income of $1.7 million and 211% of required Tangible Net Equity (TNE).

Overall Results: (in Thousands)

	Month	YTD
Revenue	$257,644	$257,644
Medical Expense	184,342	184,342
Admin. Expense	8,873	8,873
MCO Tax Expense	65,539	65,539
Other Inc. / (Exp.)	2,837	2,837
Net Income	**$1,728**	**$1,728**

Net Income by Program: (in Thousands)

	Month	YTD
Medi-Cal	$2,106	$2,106
Group Care	14	14
Medicare	(392)	(392)
	$1,728	**$1,728**

Enrollment

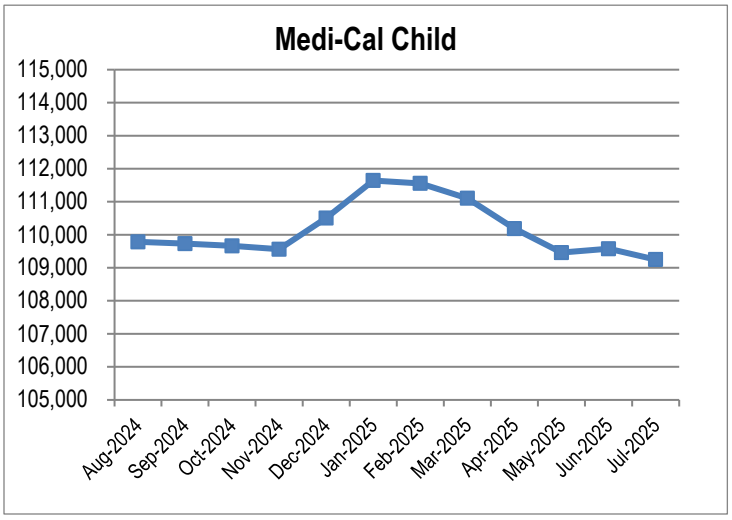
- Total enrollment increased by 236 members since June 2025.

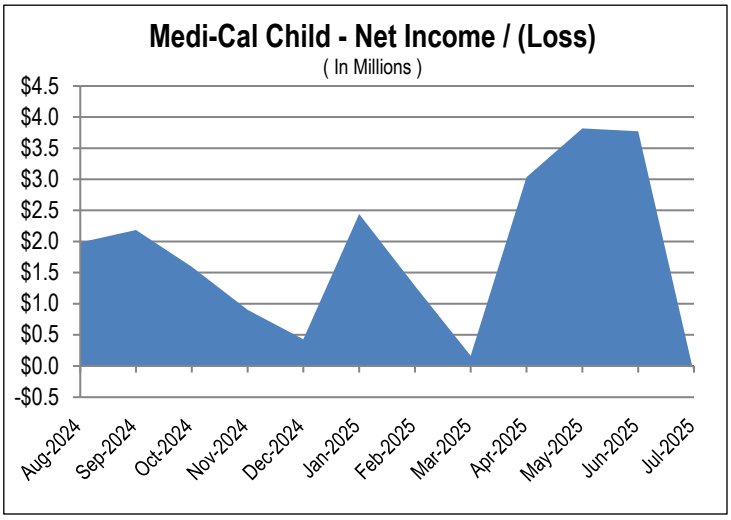
Monthly Membership and YTD Member Months
Actual vs. Budget

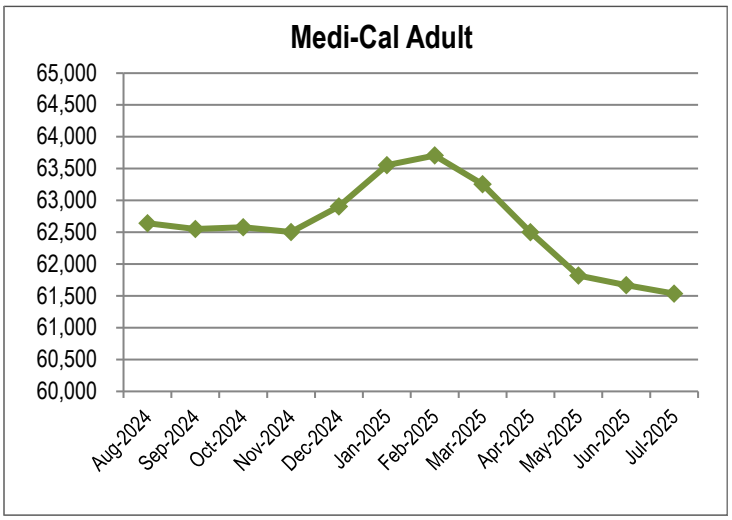
Enrollment					Member Months			
Current Month					Year-to-Date			
Actual	Budget	Variance	Variance %		Actual	Budget	Variance	Variance %
				Medi-Cal:				
109,251	108,840	411	0.4%	Child	109,251	108,840	411	0.4%
61,536	61,422	114	0.2%	Adult	61,536	61,422	114	0.2%
155,533	153,317	2,216	1.4%	ACA OE	155,533	153,317	2,216	1.4%
29,833	29,335	498	1.7%	SPD with LTC*	29,833	29,335	498	1.7%
49,509	48,687	822	1.7%	Duals with LTC*	49,509	48,687	822	1.7%
405,662	**401,601**	**4,061**	**1.0%**	**Medi-Cal Total**	**405,662**	**401,601**	**4,061**	**1.0%**
5,957	5,887	70	1.2%	Group Care	5,957	5,887	70	1.2%
411,619	**407,488**	**4,131**	**1.0%**	**Total**	**411,619**	**407,488**	**4,131**	**1.0%**

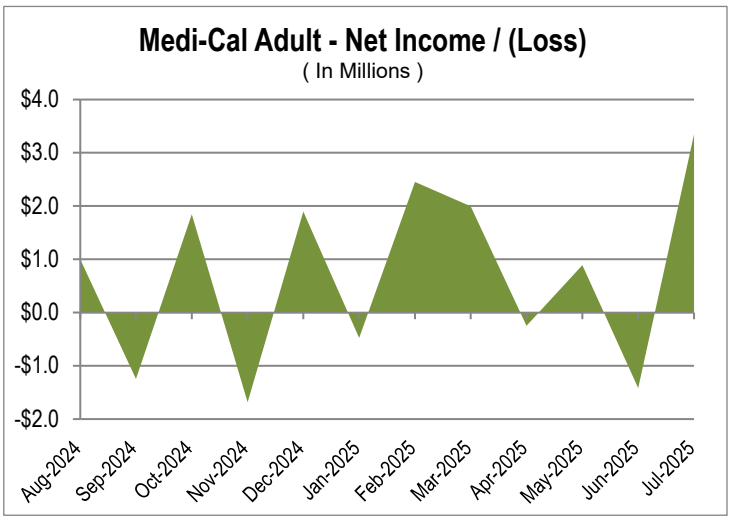
*As of January 2025, service month, "SPD", "Duals", "LTC", and "LTC Duals" will be discontinued. Effective January 2025 service month new consolidated groupings will be "SPD with LTC" and "Duals with LTC".

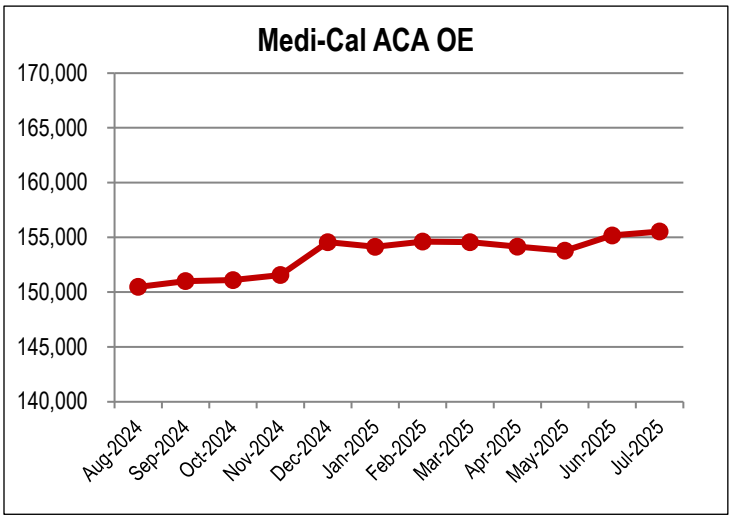
Enrollment and Profitability by Program and Category of Aid

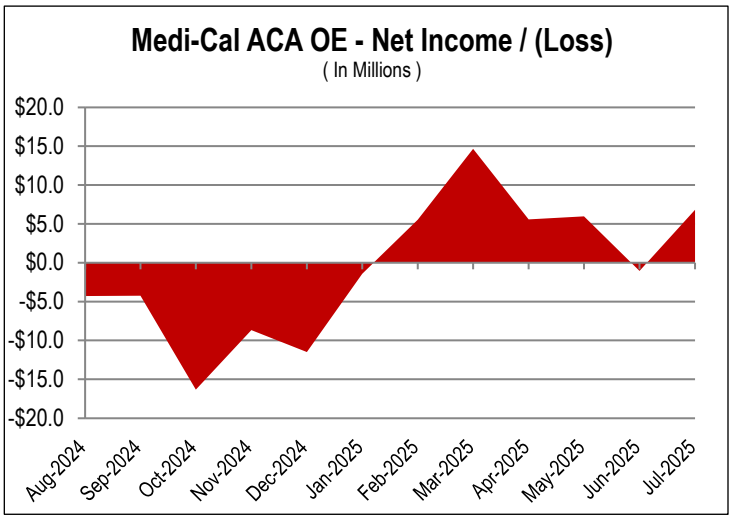




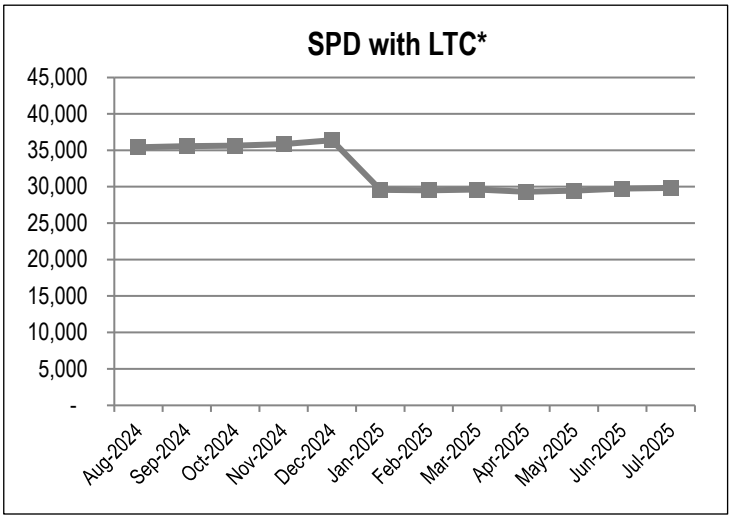


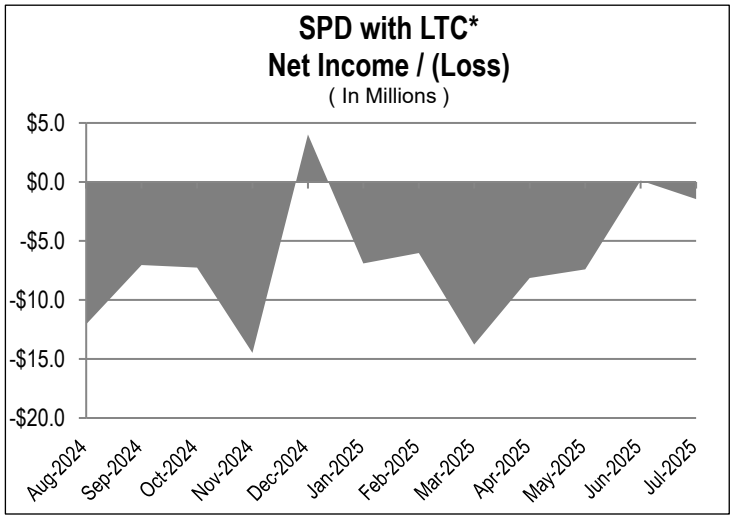


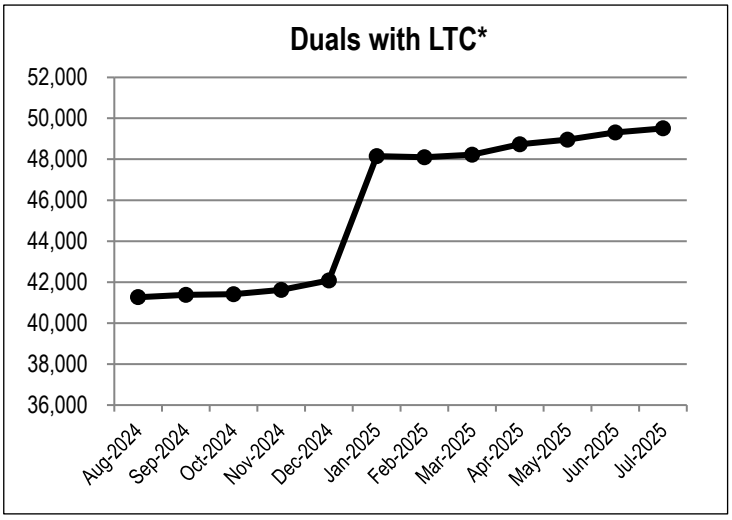


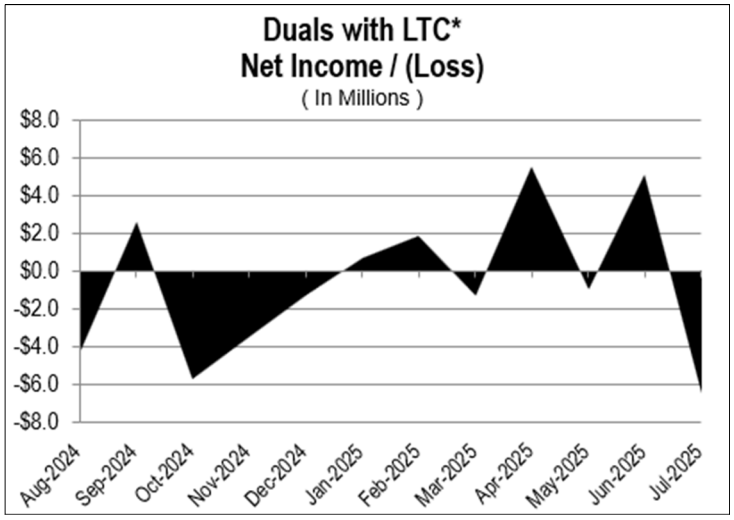


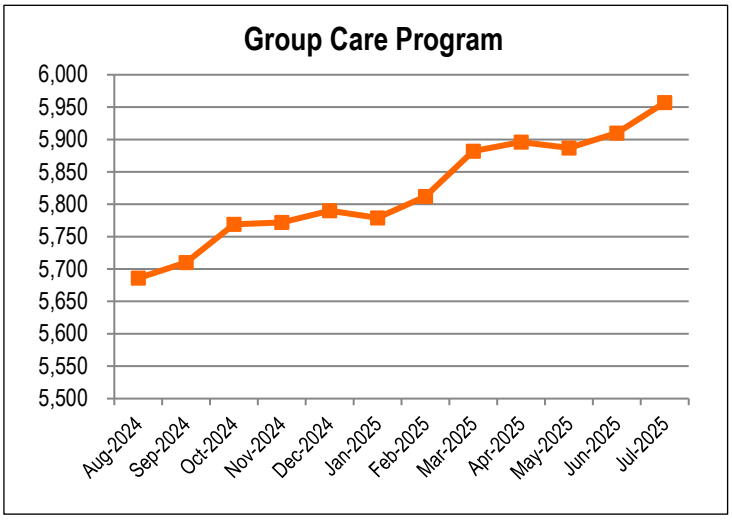
Enrollment and Profitability by Program and Category of Aid

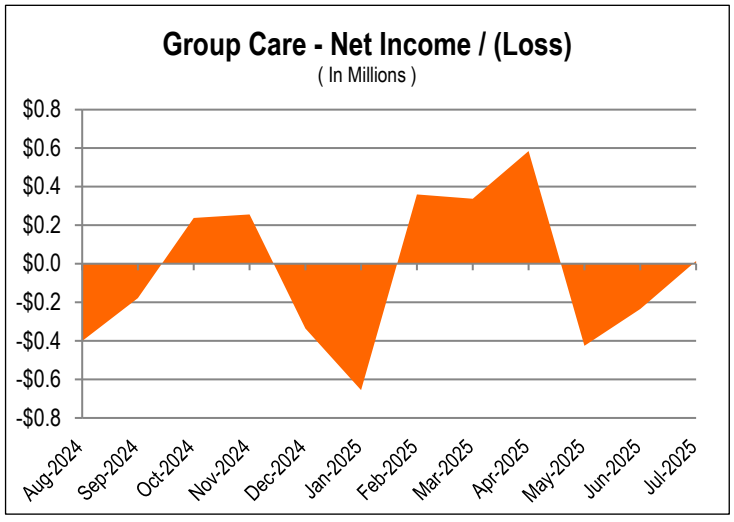




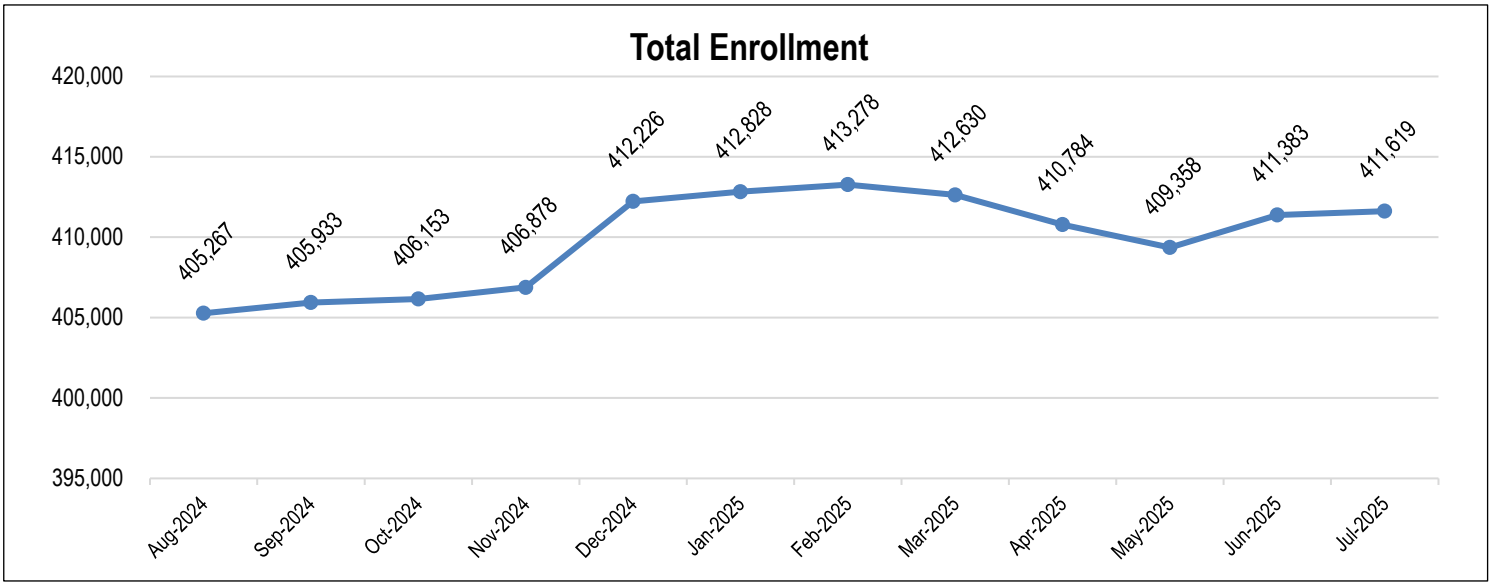


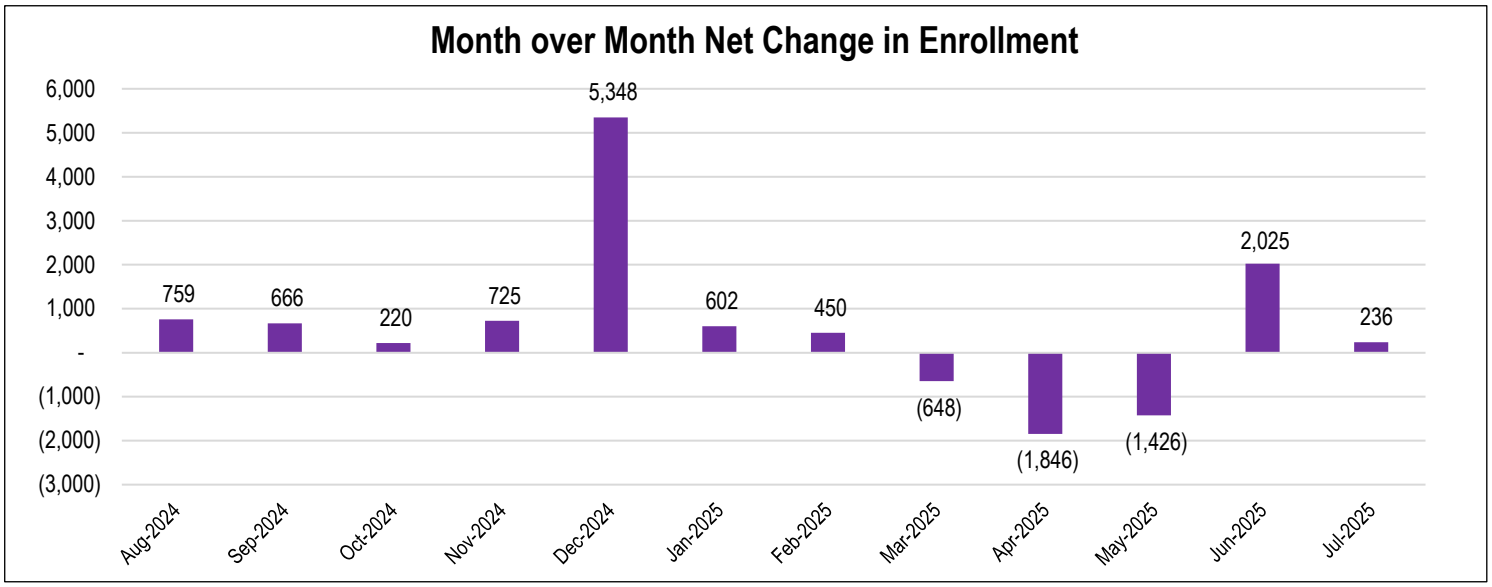






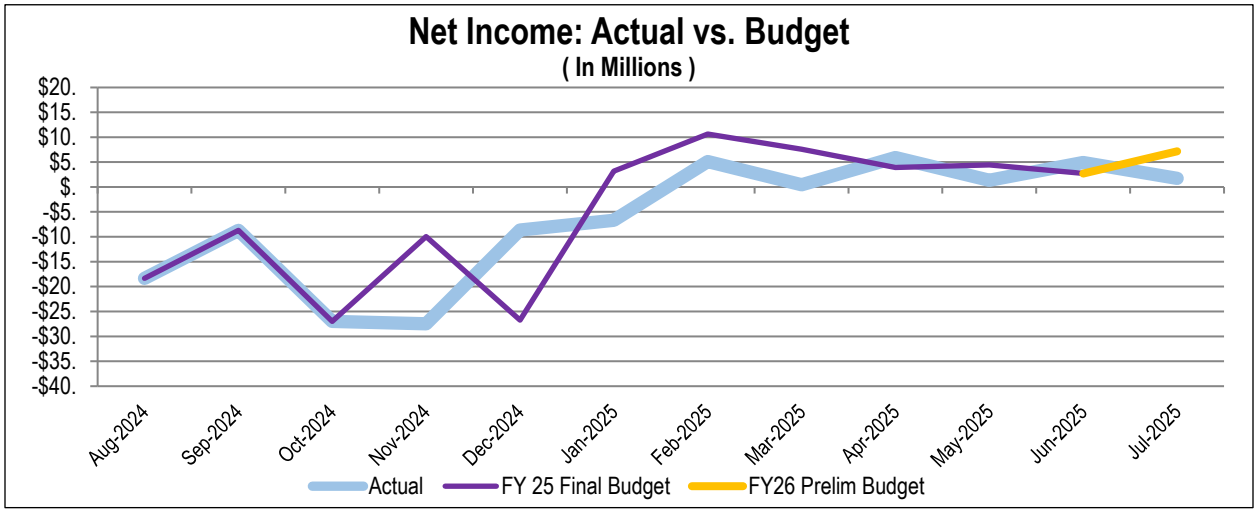
Enrollment and Profitability by Program and Category of Aid





Net Income

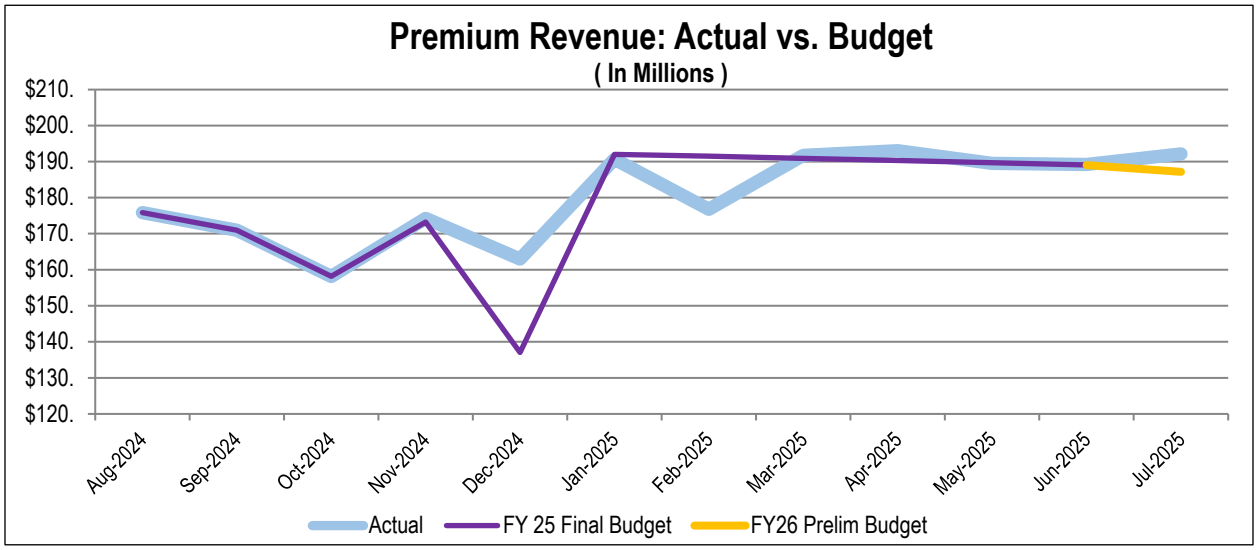
- For the month and fiscal YTD ended July 31st, 2025:
  - Actual Net Income: $1.7 million.
  - Budgeted Net Income: $7.2 million.



- The unfavorable variance of $5.4 million in the current month is primarily due to:
  - Unfavorable $13.7 million higher than anticipated Medical Expense.
  - Favorable $2.5 million lower than anticipated Administrative Expense.
  - Favorable $4.9 million higher than anticipated Premium Revenue.

Premium Revenue

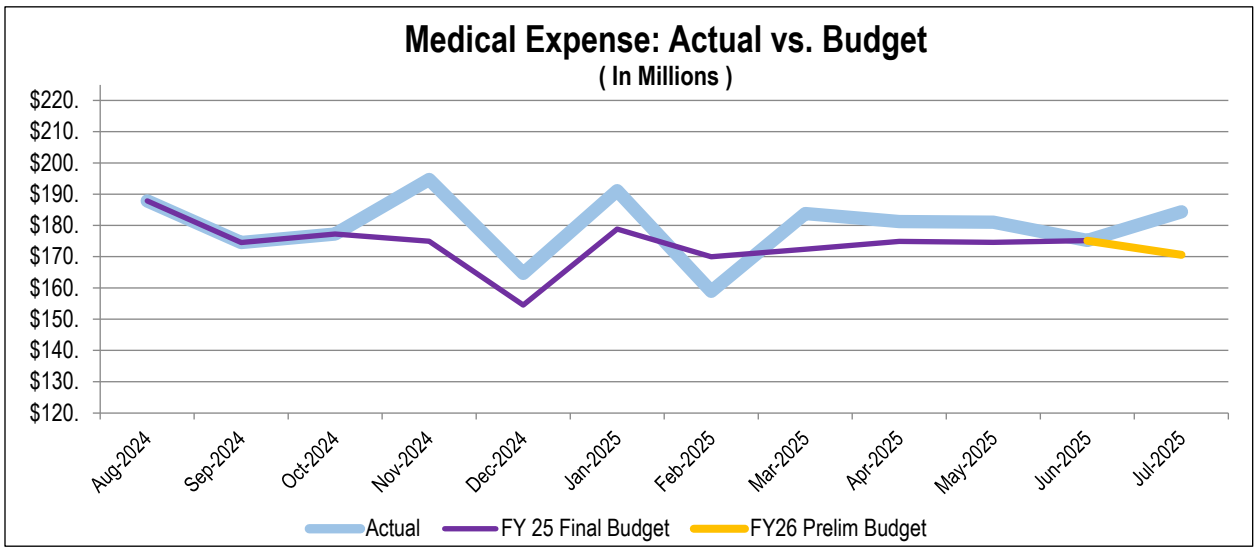
- For the month and fiscal YTD ended July 31st, 2025:
  - Actual Revenue: $192.1 million.
  - Budgeted Revenue: $187.2 million.



- For the month ended July 31st, 2025, the favorable Premium Revenue variance of $4.9 million is primarily due to the following:
  - Favorable Blended Medi-Cal Capitation Rate Variance.
  - Favorable Volume Variance for current month.

Medical Expense

- For the month and fiscal YTD ended July 31st, 2025:
  - Actual Medical Expense: $184.3 million.
  - Budgeted Medical Expense: $170.6 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 July, updates to Fee-For-Service (FFS) increased the estimate for prior period unpaid Medical Expenses by $4.8 million. Year to date, the estimate for prior years increased by $4.8 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	$20,956,680	$0	$20,956,680	$17,281,794	($3,674,886)	(21.3%)
Primary Care FFS	$5,634,062	($100,702)	$5,533,360	$4,436,948	($1,197,114)	(27.0%)
Specialty Care FFS	$8,399,629	$856,278	$9,255,907	$8,186,032	($213,598)	(2.6%)
Outpatient FFS	$13,234,310	$1,307,282	$14,541,592	$12,803,887	($430,423)	(3.4%)
Ancillary FFS	$17,812,723	$455,808	$18,268,531	$19,463,731	$1,651,009	8.5%
Pharmacy FFS	$4,771,899	($218,950)	$4,552,949	$4,371,721	($400,178)	(9.2%)
ER Services FFS	$11,165,126	$1,853,716	$13,018,842	$11,025,586	($139,540)	(1.3%)
Inpatient Hospital FFS	$56,960,456	($1,137,679)	$55,822,777	$54,647,408	($2,313,047)	(4.2%)
Long Term Care & SNF FFS	$35,994,066	$1,779,580	$37,773,646	$38,529,308	$2,535,242	6.6%
Other Benefits & Services	$3,240,025	$0	$3,240,025	($658,318)	($3,898,343)	(592.2%)
Net Reinsurance	$377,368	$0	$377,368	$513,028	$135,660	26.4%
Provider Incentive	$1,000,000	$0	$1,000,000	$0	($1,000,000)	-
	$179,546,344	**$4,795,333**	**$184,341,677**	**$170,601,125**	**($8,945,218)**	**(5.2%)**

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

Adjusted to Eliminate the Impact of Prior Year IBNP Estimates

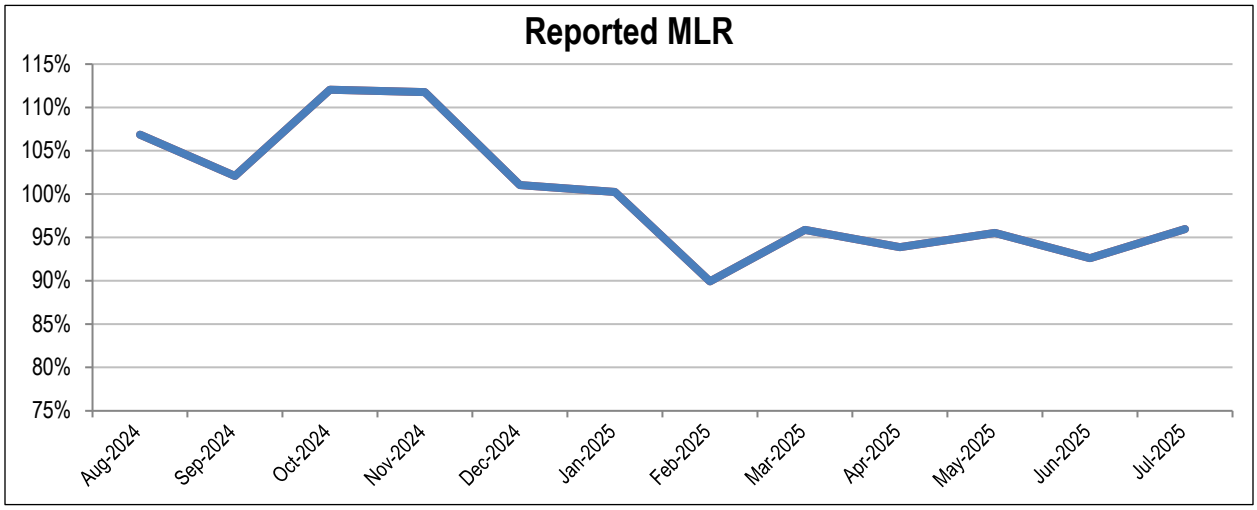
	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$50.91	$0.00	$50.91	$42.41	($8.50)	(20.0%)
Primary Care FFS	$13.69	($0.24)	$13.44	$10.89	($2.80)	(25.7%)
Specialty Care FFS	$20.41	$2.08	$22.49	$20.09	($0.32)	(1.6%)
Outpatient FFS	$32.15	$3.18	$35.33	$31.42	($0.73)	(2.3%)
Ancillary FFS	$43.27	$1.11	$44.38	$47.77	$4.49	9.4%
Pharmacy FFS	$11.59	($0.53)	$11.06	$10.73	($0.86)	(8.1%)
ER Services FFS	$27.12	$4.50	$31.63	$27.06	($0.07)	(0.2%)
Inpatient Hospital & SNF FFS	$138.38	($2.76)	$135.62	$134.11	($4.27)	(3.2%)
Long Term Care & SNF FFS	$87.45	$4.32	$91.77	$94.55	$7.11	7.5%
Other Benefits & Services	$7.87	$0.00	$7.87	($1.62)	($9.49)	(587.2%)
Net Reinsurance	$0.92	$0.00	$0.92	$1.26	$0.34	27.2%
Provider Incentive	$2.43	$0.00	$2.43	$0.00	($2.43)	-
	$436.20	**$11.65**	**$447.85**	**$418.67**	**($17.53)**	**(4.2%)**

- Excluding the impact of prior year estimates for IBNP, year-to-date medical expense variance is $8.9 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 higher unit cost across most aid code categories.
- Specialty Care Expense is slightly above budget, driven by higher utilization in the SPD with LTC aid code category.
- Outpatient Expense is over budget mostly driven by lab and radiology unit cost and facility other utilization.
- Ancillary Expense is under budget due to low utilization in the Duals with LTC and ACA OE aid code categories.
- Pharmacy Expense is over budget driven by higher unit cost offset by lower utilization.
- Emergency Room Expense is slightly under budget driven by low utilization in the SPD with LTC, Adult and Child populations.
- Inpatient Expense is over budget driven by utilization in the SPD with LTC aid code category, and Adult and ACA OE unit cost.
- Long Term Care Expense is under budget due to low utilization in the Duals with LTC Duals aid code category.
- Other Benefits & Services is over budget, due to higher than expected CalAIM and HHIP expense.
- Net Reinsurance is under budget because more recoveries were received than expected.

Medical Loss Ratio (MLR)

The Medical Loss Ratio (total reported Medical Expense divided by Premium Revenue) was 96.0% for the month and for the fiscal year-to-date.



Administrative Expense

- For the month and fiscal YTD ended July 31st, 2025:
  - Actual Administrative Expense: $8.9 million.
  - Budgeted Administrative Expense: $11.4 million.

Summary of Administrative Expense (In Dollars) **For the Month and Fiscal Year-to-Date** **Favorable/(Unfavorable)**								
Current Month					**Year-to-Date**			
Actual	**Budget**	**Variance $**	**Variance %**		**Actual**	**Budget**	**Variance $**	**Variance %**
$5,849,935	$5,677,943	($171,992)	(3.0%)	Personnel Expense	$5,849,935	$5,677,943	($171,992)	(3.0%)
77,505	82,056	4,550	5.5%	Medical Benefits Admin Expense	77,505	82,056	4,550	5.5%
915,280	2,339,163	1,423,883	60.9%	Purchased & Professional Services	915,280	2,339,163	1,423,883	60.9%
2,030,301	3,319,361	1,289,060	38.8%	Other Admin Expense	2,030,301	3,319,361	1,289,060	38.8%
$8,873,022	$11,418,523	$2,545,501	22.3%	Total Administrative Expense	$8,873,022	$11,418,523	$2,545,501	22.3%

The year-to-date variances include:

- Favorable Temporary Services and delayed training, travel, and other employee-related expenses.
- Favorable Medical Benefit Admin Fees, primarily for the decreases in Pharmacy Admin Fees.
- Favorable in Purchased & Professional Services, primarily for the timing of Consulting Services and Other Purchased Services.
- Favorable Licenses, Insurance & Fees.
- Favorable Building Occupancy costs.
- Partially offset by the unfavorable Employee Expense for overtime and benefits, as well as increased staffing despite personnel on LOA.
- Partially offset by increased postage needs Printing/Postage/Promotion.
- Partially offset by Supplies & Other Expenses, primarily for the increased Provider Interest costs.

The Administrative Loss Ratio (ALR) is 4.6% of net revenue for the month and 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 $349,000.

Other Income / (Expense)

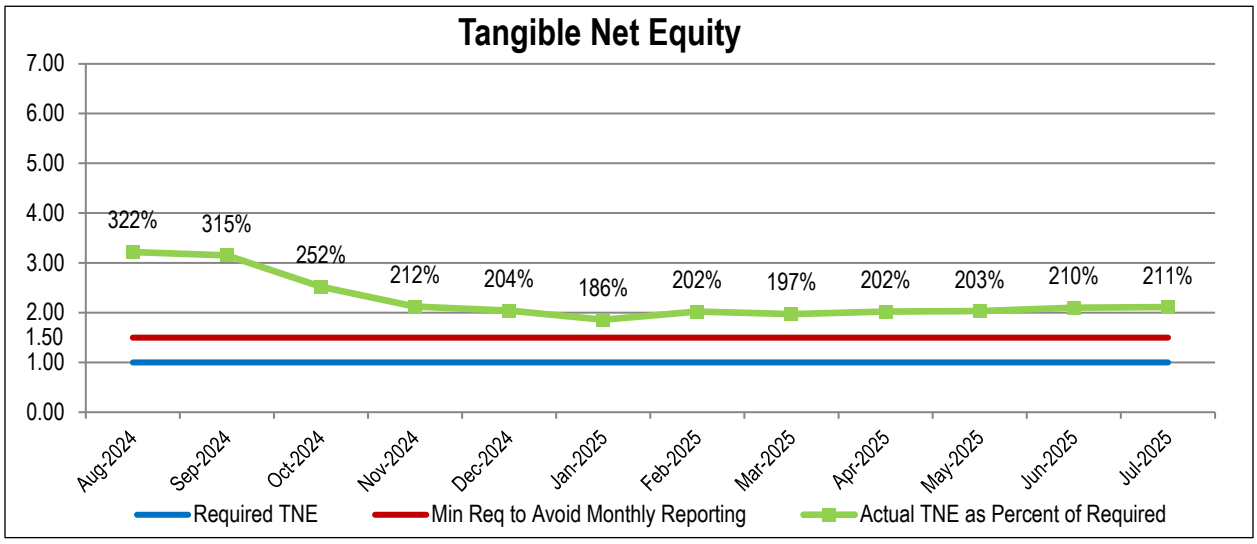
Other Income & Expense is comprised primarily of investment income. Fiscal year-to-date net investments show a gain of $2.8 million.

Managed Care Organization (MCO) Provider Tax

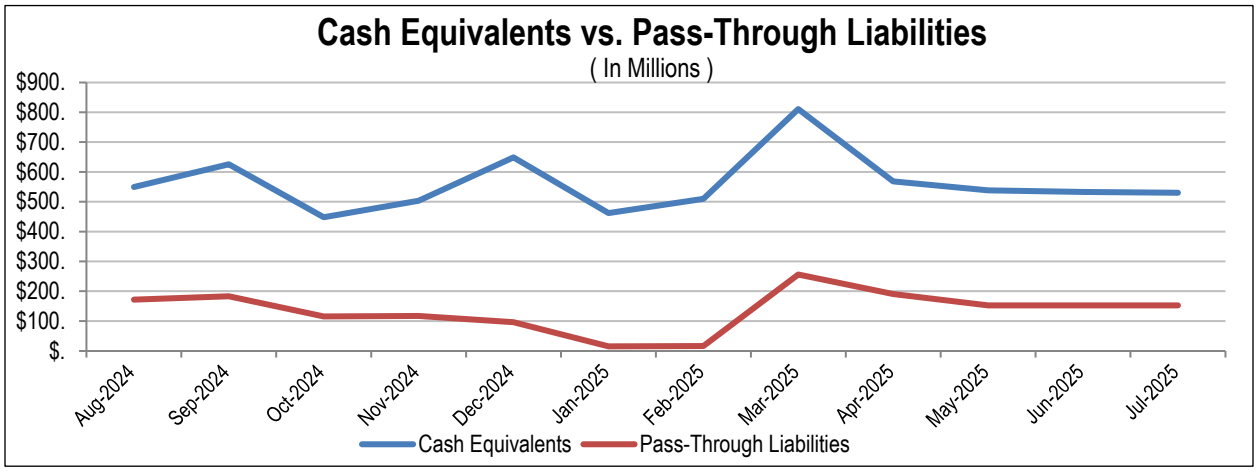
- Revenue:
  - For the month and fiscal YTD ended July 31st, 2025:
    - Actual: $65.5 million.
    - Budgeted: $64.9 million.
- Expense:
  - For the month and fiscal YTD ended July 31st, 2025:
    - Actual: $65.5 million.
    - Budgeted: $64.9 million.

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 $81.2 million
    - Actual TNE $171.0 million
    - Excess TNE $89.8 million
    - TNE % of Required TNE 211%



- To ensure appropriate liquidity and limit risk, the majority of Alliance financial assets are kept in short-term investments.
- Key Metrics
    - Cash & Cash Equivalents $530.3 million
    - Pass-Through Liabilities $152.7 million
    - Uncommitted Cash $377.6 million
    - Working Capital $117.4 million
    - Current Ratio 1.15 (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 JULY, 2025

CURRENT MONTH					FISCAL YEAR TO DATE			
		$ Variance	% Variance				$ Variance	% Variance
Actual	Budget	(Unfavorable)	(Unfavorable)	Account Description	Actual	Budget	(Unfavorable)	(Unfavorable)
				MEMBERSHIP				
405,662	401,601	4,061	1.0%	1. Medi-Cal	405,662	401,601	4,061	1.0%
5,957	5,887	70	1.2%	2. GroupCare	5,957	5,887	70	1.2%
411,619	**407,488**	**4,131**	**1.0%**	**3. TOTAL MEMBER MONTHS**	**411,619**	**407,488**	**4,131**	**1.0%**
				REVENUE				
$192,105,285	$187,185,478	$4,919,807	2.6%	4. Premium Revenue	$192,105,285	$187,185,478	$4,919,807	2.6%
$65,538,753	$64,882,658	$656,095	1.0%	5. MCO Tax Revenue AB119	$65,538,753	$64,882,658	$656,095	1.0%
$257,644,037	**$252,068,135**	**$5,575,902**	**2.2%**	**6. TOTAL REVENUE**	**$257,644,037**	**$252,068,135**	**$5,575,902**	**2.2%**
				MEDICAL EXPENSES				
				Capitated Medical Expenses				
$20,956,680	$17,281,794	($3,674,886)	(21.3%)	7. Capitated Medical Expense	$20,956,680	$17,281,794	($3,674,886)	(21.3%)
				Fee for Service Medical Expenses				
$55,822,777	$54,647,408	($1,175,369)	(2.2%)	8. Inpatient Hospital Expense	$55,822,777	$54,647,408	($1,175,369)	(2.2%)
$5,533,360	$4,436,948	($1,096,412)	(24.7%)	9. Primary Care Physician Expense	$5,533,360	$4,436,948	($1,096,412)	(24.7%)
$9,255,907	$8,186,032	($1,069,876)	(13.1%)	10. Specialty Care Physician Expense	$9,255,907	$8,186,032	($1,069,876)	(13.1%)
$18,268,531	$19,463,731	$1,195,201	6.1%	11. Ancillary Medical Expense	$18,268,531	$19,463,731	$1,195,201	6.1%
$14,541,592	$12,803,887	($1,737,705)	(13.6%)	12. Outpatient Medical Expense	$14,541,592	$12,803,887	($1,737,705)	(13.6%)
$13,018,842	$11,025,586	($1,993,256)	(18.1%)	13. Emergency Expense	$13,018,842	$11,025,586	($1,993,256)	(18.1%)
$4,552,949	$4,371,721	($181,228)	(4.1%)	14. Pharmacy Expense	$4,552,949	$4,371,721	($181,228)	(4.1%)
$37,773,646	$38,529,308	$755,662	2.0%	15. Long Term Care Expense	$37,773,646	$38,529,308	$755,662	2.0%
$158,767,604	$153,464,621	($5,302,983)	(3.5%)	16. Total Fee for Service Expense	$158,767,604	$153,464,621	($5,302,983)	(3.5%)
$3,240,025	($658,318)	($3,898,343)	592.2%	17. Other Benefits & Services	$3,240,025	($658,318)	($3,898,343)	592.2%
$377,368	$513,028	$135,660	26.4%	18. Reinsurance Expense	$377,368	$513,028	$135,660	26.4%
$1,000,000	$0	($1,000,000)	0.0%	19. Risk Pool Distribution	$1,000,000	$0	($1,000,000)	0.0%
$184,341,677	**$170,601,125**	**($13,740,552)**	**(8.1%)**	**20. TOTAL MEDICAL EXPENSES**	**$184,341,677**	**$170,601,125**	**($13,740,552)**	**(8.1%)**
$73,302,360	**$81,467,010**	**($8,164,650)**	**(10.0%)**	**21. GROSS MARGIN**	**$73,302,360**	**$81,467,010**	**($8,164,650)**	**(10.0%)**
				ADMINISTRATIVE EXPENSES				
$5,849,935	$5,677,943	($171,992)	(3.0%)	22. Personnel Expense	$5,849,935	$5,677,943	($171,992)	(3.0%)
$77,505	$82,056	$4,550	5.5%	23. Benefits Administration Expense	$77,505	$82,056	$4,550	5.5%
$915,280	$2,339,163	$1,423,883	60.9%	24. Purchased & Professional Services	$915,280	$2,339,163	$1,423,883	60.9%
$2,030,301	$3,319,361	$1,289,060	38.8%	25. Other Administrative Expense	$2,030,301	$3,319,361	$1,289,060	38.8%
$8,873,022	**$11,418,523**	**$2,545,501**	**22.3%**	**26. TOTAL ADMINISTRATIVE EXPENSES**	**$8,873,022**	**$11,418,523**	**$2,545,501**	**22.3%**
$65,538,753	**$64,882,658**	**($656,095)**	**(1.0%)**	**27. MCO TAX EXPENSES**	**$65,538,753**	**$64,882,658**	**($656,095)**	**(1.0%)**
($1,109,414)	**$5,165,830**	**($6,275,244)**	**(121.5%)**	**28. NET OPERATING INCOME / (LOSS)**	**($1,109,414)**	**$5,165,830**	**($6,275,244)**	**(121.5%)**
				OTHER INCOME / EXPENSES				
$2,837,352	**$2,000,000**	**$837,352**	**41.9%**	**29. TOTAL OTHER INCOME / (EXPENSES)**	**$2,837,352**	**$2,000,000**	**$837,352**	**41.9%**
$1,727,938	**$7,165,830**	**($5,437,892)**	**(75.9%)**	**30. NET SURPLUS (DEFICIT)**	**$1,727,938**	**$7,165,830**	**($5,437,892)**	**(75.9%)**
96.0%	91.1%	(4.9%)	(5.4%)	31. Medical Loss Ratio	96.0%	91.1%	(4.9%)	(5.4%)
4.6%	6.1%	1.5%	24.6%	32. Administrative Expense Ratio	4.6%	6.1%	1.5%	24.6%
0.7%	2.8%	(2.1%)	(75.0%)	33. Net Surplus (Deficit) Ratio	0.7%	2.8%	(2.1%)	(75.0%)

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

	7/31/2025	6/30/2025	Difference	% Difference
CURRENT ASSETS				
Cash and Cash Equivalent				
Cash	$16,231,455	$23,866,602	($7,635,147)	(32.0%)
CNB Short-Term Investment	514,099,832	509,149,570	4,950,262	1.0%
Interest Receivable	4,421,442	3,586,958	834,484	23.3%
Premium Receivables	363,526,281	498,272,672	(134,746,391)	(27.0%)
Reinsurance Recovery Receivable	10,202,337	9,085,369	1,116,968	12.3%
Other Receivables	8,237,768	1,095,756	7,142,012	651.8%
Prepaid Expenses	1,434,890	717,811	717,079	99.9%
TOTAL CURRENT ASSETS	**918,154,005**	**1,045,774,738**	**(127,620,732)**	**(12.2%)**
OTHER ASSETS				
CNB Long-Term Investment	39,082,971	39,155,365	(72,394)	(0.2%)
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	354,839	353,866	973	0.3%
GASB 87-Lease Assets (Net)	75,325	78,600	(3,275)	(4.2%)
GASB 96-SBITA Assets (Net)	3,258,685	3,531,090	(272,405)	(7.7%)
TOTAL OTHER ASSETS	**51,577,800**	**51,924,901**	**(347,101)**	**(0.7%)**
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	(33,454,445)	(33,392,594)	(61,851)	0.2%
PROPERTY AND EQUIPMENT (NET)	**5,514,960**	**5,576,811**	**(61,851)**	**(1.1%)**
TOTAL ASSETS	**975,246,766**	**1,103,276,450**	**(128,029,684)**	**(11.6%)**
CURRENT LIABILITIES				
Trade Accounts Payable	11,001,645	11,516,923	(515,278)	(4.5%)
Incurred But Not Reported Claims	406,067,986	412,117,295	(6,049,309)	(1.5%)
Other Medical Liabilities	117,655,180	117,997,376	(342,197)	(0.3%)
Pass-Through Liabilities	152,718,921	152,405,332	313,589	0.2%
MCO Tax Liabilities	102,982,156	225,818,403	(122,836,247)	(54.4%)
GASB 87 and 96 ST Liabilities	1,098,722	1,147,713	(48,992)	(4.3%)
Payroll Liabilities	9,218,402	9,363,915	(145,513)	(1.6%)
TOTAL CURRENT LIABILITIES	**800,743,011**	**930,366,958**	**(129,623,947)**	**(13.9%)**
LONG TERM LIABILITIES				
GASB 87 and 96 LT Liabilities	256,150	389,826	(133,676)	(34.3%)
Deferred Inflow	3,240,306	3,240,306	0	0.0%
TOTAL LONG TERM LIABILITIES	**3,496,456**	**3,630,132**	**(133,676)**	**(3.7%)**
TOTAL LIABILITIES	**804,239,467**	**933,997,089**	**(129,757,622)**	**(13.9%)**
NET WORTH				
Contributed Capital	840,233	840,233	0	0.0%
Restricted & Unrestricted Funds	168,439,128	254,534,911	(86,095,783)	(33.8%)
Year-To-Date Net Surplus (Deficit)	1,727,938	(86,095,783)	87,823,721	(102.0%)
TOTAL NET WORTH	**171,007,298**	**169,279,361**	**1,727,938**	**1.0%**
TOTAL LIABILITIES AND NET WORTH	**975,246,766**	**1,103,276,450**	**(128,029,684)**	**(11.6%)**
Cash Equivalents	530,331,287	533,016,172	(2,684,885)	(0.5%)
Pass-Through	152,718,921	152,405,332	313,589	0.2%
Uncommitted Cash	377,612,366	380,610,840	(2,998,474)	(0.8%)
Working Capital	117,410,994	115,407,780	2,003,214	1.7%
Current Ratio	114.7%	112.4%	2.3%	2.0%

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

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM OPERATING ACTIVITIES				
Commercial Premium Cash Flows				
Commercial Premium Revenue	$3,246,305	$9,693,538	$19,303,430	$3,246,305
GroupCare Receivable	1,093	3,210,769	3,280	1,093
Total	3,247,398	12,904,307	19,306,710	3,247,398
Medi-Cal Premium Cash Flows				
Medi-Cal Revenue	254,397,733	758,711,059	1,510,359,005	254,397,733
Premium Receivable	134,745,298	(1,690,795)	117,516,561	134,745,298
Total	389,143,031	757,020,264	1,627,875,566	389,143,031
Investment & Other Income Cash Flows				
Other Revenues	184,520	913,450	(393,586)	184,520
Interest Income	2,655,793	6,076,674	15,287,945	2,655,793
Interest Receivable	(834,484)	(1,292,321)	(605,157)	(834,484)
Total	2,005,829	5,697,803	14,289,202	2,005,829
Medical & Hospital Cash Flows				
Total Medical Expenses	(184,341,679)	(540,578,865)	(1,064,551,128)	(184,341,679)
Other Health Care Receivables	(8,258,317)	(9,070,998)	(7,996,803)	(8,258,316)
Capitation Payable	-	-	-	-
IBNP Payable	(6,049,309)	19,474,012	40,920,935	(6,049,309)
Other Medical Payable	(1,028,608)	(72,042,985)	116,269,892	(1,028,608)
Risk Share Payable	1,000,000	1,000,000	1,000,000	1,000,000
New Health Program Payable	-	-	-	-
Total	(198,677,913)	(601,218,836)	(914,357,104)	(198,677,912)
Administrative Cash Flows				
Total Administrative Expenses	(8,875,983)	(29,238,011)	(58,193,884)	(8,875,983)
Prepaid Expenses	(717,078)	(646,762)	(739,771)	(717,079)
Other Receivables	(664)	15,554	52,880	(664)
CalPERS Pension	-	(630,580)	(630,580)	-
Trade Accounts Payable	(515,278)	1,485,484	233,853	(515,278)
Payroll Liabilities	(145,512)	358,553	505,040	(145,513)
GASB Assets and Liabilities	93,013	(585,974)	525,407	93,012
Depreciation Expense	61,851	185,554	375,694	61,851
Total	(10,099,651)	(29,056,182)	(57,871,361)	(10,099,654)
MCO Tax AB119 Cash Flows				
MCO Tax Expense AB119	(65,538,753)	(197,581,950)	(402,329,564)	(65,538,753)
MCO Tax Liabilities	(122,836,247)	9,193,375	(226,059,011)	(122,836,247)
Total	(188,375,000)	(188,388,575)	(628,388,575)	(188,375,000)
Net Cash Flows from Operating Activities	**(2,756,306)**	**(43,041,219)**	**60,854,438**	**(2,756,308)**

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

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM INVESTING ACTIVITIES				
Investment Cash Flows				
Long Term Investments	72,395	4,935,647	7,686,837	72,396
Total	72,395	4,935,647	7,686,837	72,396
Restricted Cash & Other Asset Cash Flows				
Restricted Assets-Treasury Account	(973.00)	(2,944.00)	(4,839.00)	(973.00)
Total	(973.00)	(2,944.00)	(4,839.00)	(973.00)
Fixed Asset Cash Flows				
Fixed Asset Acquisitions	-	-	(329,306)	-
Purchases of Property and Equipment	-	-	(329,306)	-
Net Cash Flows from Investing Activities	**71,422**	**4,932,703**	**7,352,692**	**71,423**
Net Change in Cash	**(2,684,884)**	**(38,108,516)**	**68,207,130**	**(2,684,885)**
Rounding	-	-	-	-
Cash @ Beginning of Period	533,016,171	568,439,803	462,124,157	533,016,172
Cash @ End of Period	**$530,331,287**	**$530,331,287**	**$530,331,287**	**$530,331,287**
Variance	-	-	-	-

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

	MONTH	3 MONTHS	6 MONTHS	YTD
NET INCOME RECONCILIATION				
Net Income / (Loss)	$1,727,936	$7,995,894	$19,482,219	$1,727,936
Add back: Depreciation & Amortization	61,851	185,554	375,694	61,851
Receivables				
Premiums Receivable	134,745,298	(1,690,795)	117,516,561	134,745,298
Interest Receivable	(834,484)	(1,292,321)	(605,157)	(834,484)
Other Health Care Receivables	(8,258,317)	(9,070,998)	(7,996,803)	(8,258,316)
Other Receivables	(664)	15,554	52,880	(664)
GroupCare Receivable	1,093	3,210,769	3,280	1,093
Total	125,652,926	(8,827,791)	108,970,761	125,652,927
Prepaid Expenses	(717,078)	(646,762)	(739,771)	(717,079)
Trade Payables	(515,278)	1,485,484	233,853	(515,278)
Claims Payable and Shared Risk Pool				
IBNP Payable	(6,049,309)	19,474,012	40,920,935	(6,049,309)
Capitation Payable & Other Medical Payable	(1,028,608)	(72,042,985)	116,269,892	(1,028,608)
Risk Share Payable	1,000,000.00	1,000,000.00	1,000,000	1,000,000
Claims Payable				
Total	(6,077,917)	(51,568,973)	158,190,827	(6,077,917)
Other Liabilities				
CalPERS Pension	-	(630,580.00)	(630,580.00)	-
Payroll Liabilities	(145,512)	358,553	505,041	(145,513)
GASB Assets and Liabilities	93,013	(585,974)	525,407	93,012
New Health Program	-	-	-	-
MCO Tax Liabilities	(122,836,247)	9,193,375	(226,059,011)	(122,836,247)
Total	(122,888,746)	8,335,374	(225,659,143)	(122,888,748)
Rounding	-	1.00	(2.00)	-
Cash Flows from Operating Activities	**(2,756,306)**	**(43,041,219)**	**60,854,438**	**(2,756,308)**
Variance	-	-	-	-

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR MONTH AND THE FISCAL YEAR TO DATE JULY 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	109,251	61,536	155,533	29,833	49,509	405,662	5,957	-	411,619
Revenue	$33,382,346	$34,509,576	$98,379,047	$47,073,363	$41,053,400	$254,397,733	$3,246,305	$0	$257,644,037
Medical Expense	$15,567,015	$20,579,155	$64,312,147	$41,938,241	$38,633,424	$181,029,982	$3,111,695	$200,000	$184,341,677
Gross Margin	$17,815,331	$13,930,421	$34,066,900	$5,135,123	$2,419,976	$73,367,751	$134,609	($200,000)	$73,302,360
Administrative Expense	$430,197	$970,360	$3,050,607	$2,639,201	$1,427,651	$8,518,016	$162,848	$192,157	$8,873,022
MCO Tax Expense	$17,650,592	$9,941,756	$25,127,911	$4,819,819	$7,998,674	$65,538,753	$0	$0	$65,538,753
Operating Income / (Expense)	($265,457)	$3,018,304	$5,888,381	($2,323,898)	($7,006,349)	($689,018)	($28,239)	($392,157)	($1,109,414)
Other Income / (Expense)	$137,882	$327,484	$933,623	$863,894	$532,206	$2,795,088	$42,264	$0	$2,837,352
Net Income / (Loss)	($127,575)	$3,345,788	$6,822,004	($1,460,004)	($6,474,143)	$2,106,070	$14,025	($392,157)	$1,727,938
PMPM Metrics:									
Revenue PMPM	$305.56	$560.80	$632.53	$1,577.90	$829.21	$627.12	$544.96	$0.00	$625.93
Medical Expense PMPM	$142.49	$334.42	$413.50	$1,405.77	$780.33	$446.26	$522.36	$0.00	$447.85
Gross Margin PMPM	$163.07	$226.38	$219.03	$172.13	$48.88	$180.86	$22.60	$0.00	$178.08
Administrative Expense PMPM	$3.94	$15.77	$19.61	$88.47	$28.84	$21.00	$27.34	$0.00	$21.56
MCO Tax Expense PMPM	$161.56	$161.56	$161.56	$161.56	$161.56	$161.56	$0.00	$0.00	$159.22
Operating Income / (Expense) PMPM	($2.43)	$49.05	$37.86	($77.90)	($141.52)	($1.70)	($4.74)	$0.00	($2.70)
Other Income / (Expense) PMPM	$1.26	$5.32	$6.00	$28.96	$10.75	$6.89	$7.09	$0.00	$6.89
Net Income / (Loss) PMPM	($1.17)	$54.37	$43.86	($48.94)	($130.77)	$5.19	$2.35	$0.00	$4.20
Ratio:									
Medical Loss Ratio	99.0%	83.8%	87.8%	99.3%	116.9%	95.9%	95.9%	0.0%	96.0%
Administrative Expense Ratio	2.7%	3.9%	4.2%	6.2%	4.3%	4.5%	5.0%	0.0%	4.6%
Net Income Ratio	-0.4%	9.7%	6.9%	-3.1%	-15.8%	0.8%	0.4%	0.0%	0.7%

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

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				ADMINISTRATIVE EXPENSES SUMMARY (ADMIN. DEPT. ONLY)				
$5,849,935	$5,677,943	($171,992)	(3.0%)	Personnel Expenses	$5,849,935	$5,677,943	($171,992)	(3.0%)
$77,505	$82,056	$4,550	5.5%	Benefits Administration Expense	$77,505	$82,056	$4,550	5.5%
$915,280	$2,339,163	$1,423,883	60.9%	Purchased & Professional Services	$915,280	$2,339,163	$1,423,883	60.9%
$491,011	$493,373	$2,362	0.5%	Occupancy	$491,011	$493,373	$2,362	0.5%
$341,882	$302,370	($39,512)	(13.1%)	Printing Postage & Promotion	$341,882	$302,370	($39,512)	(13.1%)
$814,590	$2,346,796	$1,532,206	65.3%	Licenses Insurance & Fees	$814,590	$2,346,796	$1,532,206	65.3%
$382,817	$176,823	($205,995)	(116.5%)	Other Administrative Expense	$382,817	$176,823	($205,995)	(116.5%)
$3,023,086	$5,740,580	$2,717,493	47.3%	Total Other Administrative Expenses (excludes Personnel Expenses)	$3,023,086	$5,740,580	$2,717,493	47.3%
$8,873,022	$11,418,523	$2,545,501	22.3%	Total Administrative Expenses	$8,873,022	$11,418,523	$2,545,501	22.3%

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
4,177,567	3,852,808	(324,758)	(8.4%)	Salaries & Wages	4,177,567	3,852,808	(324,758)	(8.4%)
247,792	371,405	123,613	33.3%	Paid Time Off	247,792	371,405	123,613	33.3%
5,830	25,177	19,347	76.8%	Compensated Incentives	5,830	25,177	19,347	76.8%
71,611	67,495	(4,116)	(6.1%)	Payroll Taxes	71,611	67,495	(4,116)	(6.1%)
87,025	48,845	(38,179)	(78.2%)	Overtime	87,025	48,845	(38,179)	(78.2%)
366,875	323,654	(43,221)	(13.4%)	CalPERS ER Match	366,875	323,654	(43,221)	(13.4%)
1,095,395	733,684	(361,711)	(49.3%)	Employee Benefits	1,095,395	733,684	(361,711)	(49.3%)
(1,797)	0	1,797	0.0%	Personal Floating Holiday	(1,797)	0	1,797	0.0%
22,536	32,000	9,464	29.6%	Language Pay	22,536	32,000	9,464	29.6%
4,740	0	(4,740)	0.0%	Med Ins Opted Out Stipend	4,740	0	(4,740)	0.0%
(288,100)	0	288,100	0.0%	Sick Leave	(288,100)	0	288,100	0.0%
(2,857)	21,685	24,542	113.2%	Compensated Employee Relations	(2,857)	21,685	24,542	113.2%
20,620	26,440	5,820	22.0%	Work from Home Stipend	20,620	26,440	5,820	22.0%
1,585	4,239	2,654	62.6%	Mileage, Parking & LocalTravel	1,585	4,239	2,654	62.6%
5,550	14,810	9,260	62.5%	Travel & Lodging	5,550	14,810	9,260	62.5%
1,958	115,320	113,362	98.3%	Temporary Help Services	1,958	115,320	113,362	98.3%
32,856	33,083	227	0.7%	Staff Development/Training	32,856	33,083	227	0.7%
750	7,297	6,547	89.7%	Staff Recruitment/Advertisement	750	7,297	6,547	89.7%
5,849,935	**5,677,943**	**(171,992)**	**(3.0%)**	**Personnel Expense**	**5,849,935**	**5,677,943**	**(171,992)**	**(3.0%)**
24,234	29,082	4,849	16.7%	Pharmacy Administrative Fees	24,234	29,082	4,849	16.7%
53,272	52,973	(298)	(0.6%)	Telemedicine Admin. Fees	53,272	52,973	(298)	(0.6%)
77,505	**82,056**	**4,550**	**5.5%**	**Benefits Administration Expense**	**77,505**	**82,056**	**4,550**	**5.5%**
(455,344)	818,800	1,274,144	155.6%	Consultant Fees - Non Medical	(455,344)	818,800	1,274,144	155.6%
485,527	339,268	(146,259)	(43.1%)	Computer Support Services	485,527	339,268	(146,259)	(43.1%)
13,241	11,750	(1,491)	(12.7%)	Audit Fees	13,241	11,750	(1,491)	(12.7%)
17,593	8,333	(9,260)	(111.1%)	Consultant Fees - Medical	17,593	8,333	(9,260)	(111.1%)
4,925	279,870	274,945	98.2%	Other Purchased Services	4,925	279,870	274,945	98.2%
0	1,879	1,879	100.0%	Maint.&Repair-Office Equipment	0	1,879	1,879	100.0%
88,523	64,763	(23,760)	(36.7%)	Legal Fees	88,523	64,763	(23,760)	(36.7%)
1,925	26,000	24,075	92.6%	Translation Services	1,925	26,000	24,075	92.6%
335,488	151,900	(183,588)	(120.9%)	Medical Refund Recovery Fees	335,488	151,900	(183,588)	(120.9%)
403,403	542,113	138,710	25.6%	Software - IT Licenses & Subsc	403,403	542,113	138,710	25.6%
20,000	36,737	16,737	45.6%	Hardware (Non-Capital)	20,000	36,737	16,737	45.6%
0	57,750	57,750	100.0%	Provider Credentialing	0	57,750	57,750	100.0%
915,280	**2,339,163**	**1,423,883**	**60.9%**	**Purchased & Professional Services**	**915,280**	**2,339,163**	**1,423,883**	**60.9%**
61,851	62,518	667	1.1%	Depreciation	61,851	62,518	667	1.1%
8,092	10,570	2,478	23.4%	Lease Rented Office Equipment	8,092	10,570	2,478	23.4%
22,206	16,165	(6,041)	(37.4%)	Utilities	22,206	16,165	(6,041)	(37.4%)
133,066	108,156	(24,910)	(23.0%)	Telephone	133,066	108,156	(24,910)	(23.0%)
(6,607)	45,964	52,571	114.4%	Building Maintenance	(6,607)	45,964	52,571	114.4%
272,404	250,000	(22,404)	(9.0%)	GASB96 SBITA Amort. Expense	272,404	250,000	(22,404)	(9.0%)
491,011	**493,373**	**2,362**	**0.5%**	**Occupancy**	**491,011**	**493,373**	**2,362**	**0.5%**
42,894	40,535	(2,359)	(5.8%)	Postage	42,894	40,535	(2,359)	(5.8%)
0	5,700	5,700	100.0%	Design & Layout	0	5,700	5,700	100.0%
163,706	42,293	(121,413)	(287.1%)	Printing Services	163,706	42,293	(121,413)	(287.1%)

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
(34,018)	15,600	49,618	318.1%	Mailing Services	(34,018)	15,600	49,618	318.1%
1,629	14,072	12,443	88.4%	Courier/Delivery Service	1,629	14,072	12,443	88.4%
0	853	853	100.0%	Pre-Printed Materials & Public	0	853	853	100.0%
(187)	0	187	0.0%	Promotional Products	(187)	0	187	0.0%
0	150	150	100.0%	Promotional Services	0	150	150	100.0%
167,858	183,167	15,308	8.4%	Community Relations	167,858	183,167	15,308	8.4%
341,882	**302,370**	**(39,512)**	**(13.1%)**	**Printing Postage & Promotion**	**341,882**	**302,370**	**(39,512)**	**(13.1%)**
73,203	45,500	(27,703)	(60.9%)	Bank Fees	73,203	45,500	(27,703)	(60.9%)
90,565	1,366,200	1,275,635	93.4%	Insurance Premium	90,565	1,366,200	1,275,635	93.4%
625,461	896,097	270,636	30.2%	License,Permits, & Fee - NonIT	625,461	896,097	270,636	30.2%
25,361	38,999	13,638	35.0%	Subscriptions and Dues - NonIT	25,361	38,999	13,638	35.0%
814,590	**2,346,796**	**1,532,206**	**65.3%**	**License Insurance & Fees**	**814,590**	**2,346,796**	**1,532,206**	**65.3%**
527	5,785	5,258	90.9%	Office and Other Supplies	527	5,785	5,258	90.9%
0	1,000	1,000	100.0%	Furniture & Equipment	0	1,000	1,000	100.0%
3,689	21,786	18,097	83.1%	Ergonomic Supplies	3,689	21,786	18,097	83.1%
28,463	7,127	(21,336)	(299.4%)	Meals and Entertainment	28,463	7,127	(21,336)	(299.4%)
689	0	(689)	0.0%	Miscellaneous	689	0	(689)	0.0%
0	3,125	3,125	100.0%	Member Incentive	0	3,125	3,125	100.0%
349,449	138,000	(211,449)	(153.2%)	Provider Interest (All Depts)	349,449	138,000	(211,449)	(153.2%)
382,817	**176,823**	**(205,995)**	**(116.5%)**	**Other Administrative Expense**	**382,817**	**176,823**	**(205,995)**	**(116.5%)**
3,023,086	**5,740,580**	**2,717,493**	**47.3%**	**Total Other Administrative ExpenseS (excludes Personnel Expenses)**	**3,023,086**	**5,740,580**	**2,717,493**	**47.3%**
8,873,022	**11,418,523**	**2,545,501**	**22.3%**	**TOTAL ADMINISTRATIVE EXPENSES**	**8,873,022**	**11,418,523**	**2,545,501**	**22.3%**

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 - 7/31/25	**$ 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 July 31, 2025

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

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												109,251
Adult	61,536												61,536
ACA OE	155,533												155,533
SPD with LTC*	29,833												29,833
Duals with LTC*	49,509												49,509
Medi-Cal Program	405,662												405,662
Group Care Program	5,957												5,957
Total	**411,619**												**411,619**

*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)												(323)
Adult	(133)												(133)
ACA OE	357												357
SPD with LTC	83												83
Duals with LTC	205												205
Medi-Cal Program	189												189
Group Care Program	47												47
Total	**236**												**236**
Enrollment Percentages:													
Medi-Cal Program:													
Child % of Medi-Cal	26.9%												26.9%
Adult % of Medi-Cal	15.2%												15.2%
ACA OE % of Medi-Cal	38.3%												38.3%
SPD with LTC % of Medi-Cal	7.4%												7.4%
Duals with LTC % of Medi-Cal	12.2%												12.2%
Medi-Cal Program % of Total	98.6%												98.6%
Group Care Program % of Total	1.4%												1.4%
Total	**100.0%**												**100.0%**

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

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

	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												93,933
Alameda Health System	92,861												92,861
Directly-Contracted Subtotal	186,794												186,794
Delegated:													
CFMG	43,381												43,381
CHCN	181,444												181,444
Delegated Subtotal	224,825												224,825
Total	**411,619**												**411,619**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	(518)												(518)
Delegated:													
CFMG	(128)												(128)
CHCN	882												882
Delegated Subtotal	754												754
Total	**236**												**236**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	45.4%												45.4%
Delegated:													
CFMG	10.5%												10.5%
CHCN	44.1%												44.1%
Delegated Subtotal	54.6%												54.6%
Total	**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												411
Adult	114												114
ACA OE	2,216												2,216
SPD with LTC	498												498
Duals with LTC	822												822
Medi-Cal Program	4,061												4,061
Group Care Program	70												70
Total	**4,131**												**4,131**
Current Direct/Delegate Enrollment Variance - Favorable/(Unfavorable)													
Directly-Contracted													
Directly Contracted (DCP)	149												149
Alameda Health System	2,480												2,480
Directly-Contracted Subtotal	2,629												2,629
Delegated:													
CFMG	(197)												(197)
CHCN	1,699												1,699
Delegated Subtotal	1,502												1,502
Total	**4,131**												**4,131**

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				CAPITATED MEDICAL EXPENSES				
$5,553,780	$1,612,246	($3,941,534)	(244.5%)	PCP Capitation	$5,553,780	$1,612,246	($3,941,534)	(244.5%)
6,272,085	6,434,096	162,011	2.5%	PCP Capitation FQHC	6,272,085	6,434,096	162,011	2.5%
481,755	477,425	(4,330)	(0.9%)	Specialty Capitation	481,755	477,425	(4,330)	(0.9%)
5,514,987	5,700,977	185,990	3.3%	Specialty Capitation FQHC	5,514,987	5,700,977	185,990	3.3%
808,560	754,007	(54,554)	(7.2%)	Laboratory Capitation	808,560	754,007	(54,554)	(7.2%)
344,022	339,150	(4,872)	(1.4%)	Vision Capitation	344,022	339,150	(4,872)	(1.4%)
109,576	108,589	(986)	(0.9%)	CFMG Capitation	109,576	108,589	(986)	(0.9%)
842,763	873,581	30,817	3.5%	ANC IPA Admin Capitation FQHC	842,763	873,581	30,817	3.5%
(12,511)	0	12,511	0.0%	Kaiser Capitation	(12,511)	0	12,511	0.0%
1,041,663	981,723	(59,940)	(6.1%)	DME Capitation	1,041,663	981,723	(59,940)	(6.1%)
20,956,680	**17,281,794**	**(3,674,886)**	**(21.3%)**	**7. TOTAL CAPITATED EXPENSES**	**20,956,680**	**17,281,794**	**(3,674,886)**	**(21.3%)**
				FEE FOR SERVICE MEDICAL EXPENSES				
3,154,507	0	(3,154,507)	0.0%	IBNR Inpatient Services	3,154,507	0	(3,154,507)	0.0%
94,635	0	(94,635)	0.0%	IBNR Settlement (IP)	94,635	0	(94,635)	0.0%
252,361	0	(252,361)	0.0%	IBNR Claims Fluctuation (IP)	252,361	0	(252,361)	0.0%
47,745,741	49,381,854	1,636,113	3.3%	Inpatient Hospitalization FFS	47,745,741	49,381,854	1,636,113	3.3%
3,418,073	3,675,467	257,394	7.0%	IP OB - Mom & NB	3,418,073	3,675,467	257,394	7.0%
301,656	125,752	(175,904)	(139.9%)	IP Behavioral Health	301,656	125,752	(175,904)	(139.9%)
855,804	1,464,335	608,531	41.6%	Inpatient Facility Rehab FFS	855,804	1,464,335	608,531	41.6%
55,822,777	**54,647,408**	**(1,175,369)**	**(2.2%)**	**8. Inpatient Hospital Expense**	**55,822,777**	**54,647,408**	**(1,175,369)**	**(2.2%)**
(617,541)	0	617,541	0.0%	IBNR PCP	(617,541)	0	617,541	0.0%
(18,526)	0	18,526	0.0%	IBNR Settlement (PCP)	(18,526)	0	18,526	0.0%
(49,402)	0	49,402	0.0%	IBNR Claims Fluctuation (PCP)	(49,402)	0	49,402	0.0%
4,923,081	3,203,444	(1,719,637)	(53.7%)	PCP FFS	4,923,081	3,203,444	(1,719,637)	(53.7%)
278	0	(278)	0.0%	Special Needs Medical Expense	278	0	(278)	0.0%
448,636	409,076	(39,560)	(9.7%)	PCP FQHC FFS	448,636	409,076	(39,560)	(9.7%)
16,317	0	(16,317)	0.0%	Prop 56 Hyde	16,317	0	(16,317)	0.0%
76,453	0	(76,453)	0.0%	Prop 56 Trauma Screening	76,453	0	(76,453)	0.0%
90,894	0	(90,894)	0.0%	Prop 56 Developmentl Screening	90,894	0	(90,894)	0.0%
663,171	824,429	161,258	19.6%	Prop 56 Family Planning	663,171	824,429	161,258	19.6%
5,533,360	**4,436,948**	**(1,096,412)**	**(24.7%)**	**9. Primary Care Physician Expense**	**5,533,360**	**4,436,948**	**(1,096,412)**	**(24.7%)**
(889,942)	0	889,942	0.0%	IBNR Specialist	(889,942)	0	889,942	0.0%
(26,697)	0	26,697	0.0%	IBNR Settlement (SCP)	(26,697)	0	26,697	0.0%
(71,197)	0	71,197	0.0%	IBNR Claims Fluctuation (SCP)	(71,197)	0	71,197	0.0%
602,771	0	(602,771)	0.0%	Psychiatrist FFS	602,771	0	(602,771)	0.0%
4,294,996	8,051,982	3,756,985	46.7%	Specialty Care FFS	4,294,996	8,051,982	3,756,985	46.7%
430,894	0	(430,894)	0.0%	Specialty Anesthesiology	430,894	0	(430,894)	0.0%
1,860,085	0	(1,860,085)	0.0%	Specialty Imaging FFS	1,860,085	0	(1,860,085)	0.0%
75,627	0	(75,627)	0.0%	Obstetrics FFS	75,627	0	(75,627)	0.0%
534,492	0	(534,492)	0.0%	Specialty IP Surgery FFS	534,492	0	(534,492)	0.0%
1,405,708	0	(1,405,708)	0.0%	Specialty OP Surgery FFS	1,405,708	0	(1,405,708)	0.0%
888,158	0	(888,158)	0.0%	Speciality IP Physician	888,158	0	(888,158)	0.0%
151,012	134,050	(16,962)	(12.7%)	Specialist FQHC FFS	151,012	134,050	(16,962)	(12.7%)
9,255,907	**8,186,032**	**(1,069,876)**	**(13.1%)**	**10. Specialty Care Physician Expense**	**9,255,907**	**8,186,032**	**(1,069,876)**	**(13.1%)**
(2,596,808)	0	2,596,808	0.0%	IBNR Ancillary (ANC)	(2,596,808)	0	2,596,808	0.0%
(77,905)	0	77,905	0.0%	IBNR Settlement (ANC)	(77,905)	0	77,905	0.0%
(207,746)	0	207,746	0.0%	IBNR Claims Fluctuation (ANC)	(207,746)	0	207,746	0.0%
24,205	0	(24,205)	0.0%	IBNR Transportation FFS	24,205	0	(24,205)	0.0%
3,565,773	2,193,887	(1,371,886)	(62.5%)	Behavioral Health Therapy FFS	3,565,773	2,193,887	(1,371,886)	(62.5%)

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
2,520,068	0	(2,520,068)	0.0%	Psychologist & Other MH Prof	2,520,068	0	(2,520,068)	0.0%
627,522	0	(627,522)	0.0%	Other Medical Professional	627,522	0	(627,522)	0.0%
155,108	0	(155,108)	0.0%	Hearing Devices	155,108	0	(155,108)	0.0%
35,133	0	(35,133)	0.0%	ANC Imaging	35,133	0	(35,133)	0.0%
72,185	0	(72,185)	0.0%	Vision FFS	72,185	0	(72,185)	0.0%
775,387	1,310,489	535,102	40.8%	Laboratory FFS	775,387	1,310,489	535,102	40.8%
159,024	0	(159,024)	0.0%	ANC Therapist	159,024	0	(159,024)	0.0%
1,912,431	1,626,969	(285,462)	(17.5%)	Transp/Ambulance FFS	1,912,431	1,626,969	(285,462)	(17.5%)
1,563,636	2,771,218	1,207,582	43.6%	Non-ER Transportation FFS	1,563,636	2,771,218	1,207,582	43.6%
2,050,682	2,676,285	625,603	23.4%	Hospice FFS	2,050,682	2,676,285	625,603	23.4%
2,479,146	0	(2,479,146)	0.0%	Home Health Services	2,479,146	0	(2,479,146)	0.0%
0	2,654,952	2,654,952	100.0%	Other Medical FFS	0	2,654,952	2,654,952	100.0%
(280,312)	0	280,312	0.0%	Medical Refunds through HMS	(280,312)	0	280,312	0.0%
31,815	2,098,034	2,066,219	98.5%	DME & Medical Supplies FFS	31,815	2,098,034	2,066,219	98.5%
2,608,418	2,113,859	(494,559)	(23.4%)	ECM Base/Outreach FFS ANC	2,608,418	2,113,859	(494,559)	(23.4%)
242,132	93,591	(148,540)	(158.7%)	CS Housing Deposits FFS ANC	242,132	93,591	(148,540)	(158.7%)
775,861	453,845	(322,016)	(71.0%)	CS Housing Tenancy FFS ANC	775,861	453,845	(322,016)	(71.0%)
507,569	318,441	(189,128)	(59.4%)	CS Housing Navi Servic FFS ANC	507,569	318,441	(189,128)	(59.4%)
378,644	279,022	(99,622)	(35.7%)	CS Medical Respite FFS ANC	378,644	279,022	(99,622)	(35.7%)
221,982	129,858	(92,124)	(70.9%)	CS Med. Tailored Meals FFS ANC	221,982	129,858	(92,124)	(70.9%)
13,030	1,025	(12,005)	(1,171.4%)	CS Asthma Remediation FFS ANC	13,030	1,025	(12,005)	(1,171.4%)
0	2,620	2,620	100.0%	CS Home Modifications FFS ANC	0	2,620	2,620	100.0%
27,351	196,844	169,494	86.1%	CS P.Care & Hmker Svcs FFS ANC	27,351	196,844	169,494	86.1%
0	6,221	6,221	100.0%	CS Cgiver Respite Svcs FFS ANC	0	6,221	6,221	100.0%
0	18	18	100.0%	CS ST PostHospital Housing FFS	0	18	18	100.0%
610	312	(298)	(95.4%)	CS Housing Outreach	610	312	(298)	(95.4%)
662,794	520,404	(142,390)	(27.4%)	CommunityBased Adult Svc(CBAS)	662,794	520,404	(142,390)	(27.4%)
13,485	10,831	(2,653)	(24.5%)	CS LTC Diversion FFS ANC	13,485	10,831	(2,653)	(24.5%)
7,313	5,003	(2,310)	(46.2%)	CS LTC Transition FFS ANC	7,313	5,003	(2,310)	(46.2%)
18,268,531	**19,463,731**	**1,195,201**	**6.1%**	**11. Ancillary Medical Expense**	**18,268,531**	**19,463,731**	**1,195,201**	**6.1%**
(39,706)	0	39,706	0.0%	IBNR Outpatient	(39,706)	0	39,706	0.0%
(1,191)	0	1,191	0.0%	IBNR Settlement (OP)	(1,191)	0	1,191	0.0%
(3,176)	0	3,176	0.0%	IBNR Claims Fluctuation (OP)	(3,176)	0	3,176	0.0%
3,309,384	5,979,404	2,670,020	44.7%	Outpatient FFS	3,309,384	5,979,404	2,670,020	44.7%
3,351,728	0	(3,351,728)	0.0%	OP Ambul Surgery FFS	3,351,728	0	(3,351,728)	0.0%
3,351,095	0	(3,351,095)	0.0%	Imaging Services FFS	3,351,095	0	(3,351,095)	0.0%
124,707	0	(124,707)	0.0%	Behavioral Health FFS	124,707	0	(124,707)	0.0%
916,002	3,532,846	2,616,844	74.1%	Outpatient Facility Lab FFS	916,002	3,532,846	2,616,844	74.1%
305,177	0	(305,177)	0.0%	Outpatient Facility Cardio FFS	305,177	0	(305,177)	0.0%
117,112	0	(117,112)	0.0%	OP Facility PT/OT/ST FFS	117,112	0	(117,112)	0.0%
3,110,460	3,291,637	181,176	5.5%	OP Facility Dialysis Ctr FFS	3,110,460	3,291,637	181,176	5.5%
14,541,592	**12,803,887**	**(1,737,705)**	**(13.6%)**	**12. Outpatient Medical Expense**	**14,541,592**	**12,803,887**	**(1,737,705)**	**(13.6%)**
(503,561)	0	503,561	0.0%	IBNR Emergency	(503,561)	0	503,561	0.0%
(15,106)	0	15,106	0.0%	IBNR Settlement (ER)	(15,106)	0	15,106	0.0%
(40,284)	0	40,284	0.0%	IBNR Claims Fluctuation (ER)	(40,284)	0	40,284	0.0%
12,229,562	11,025,586	(1,203,977)	(10.9%)	ER Facility	12,229,562	11,025,586	(1,203,977)	(10.9%)
1,348,230	0	(1,348,230)	0.0%	Specialty ER Physician FFS	1,348,230	0	(1,348,230)	0.0%
13,018,842	**11,025,586**	**(1,993,256)**	**(18.1%)**	**13. Emergency Expense**	**13,018,842**	**11,025,586**	**(1,993,256)**	**(18.1%)**
(2,104,707)	0	2,104,707	0.0%	IBNR Pharmacy (OP)	(2,104,707)	0	2,104,707	0.0%
(63,141)	0	63,141	0.0%	IBNR Settlement Rx (OP)	(63,141)	0	63,141	0.0%
(168,376)	0	168,376	0.0%	IBNR Claims Fluctuation Rx(OP)	(168,376)	0	168,376	0.0%
722,278	679,077	(43,201)	(6.4%)	Pharmacy FFS (OP)	722,278	679,077	(43,201)	(6.4%)
140,239	3,641,530	3,501,291	96.1%	Pharmacy Non PBM FFS Other-ANC	140,239	3,641,530	3,501,291	96.1%
2,347,941	0	(2,347,941)	0.0%	Pharmacy Non PBM FFS OP-FAC	2,347,941	0	(2,347,941)	0.0%

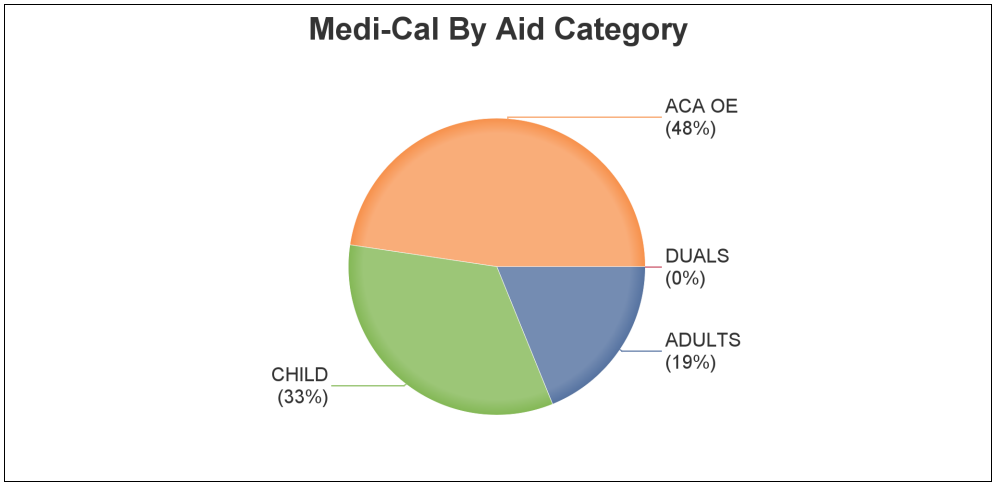
ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 31 JULY, 2025

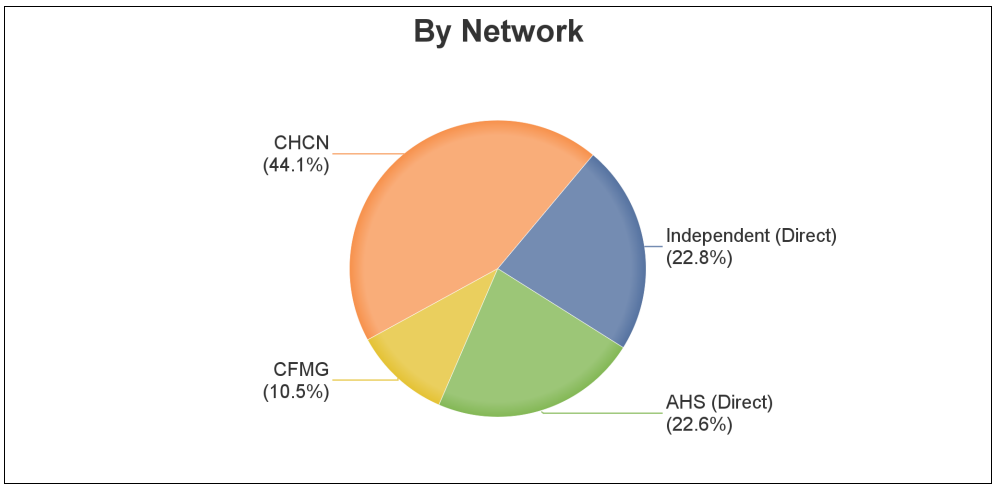
CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
321,999	0	(321,999)	0.0%	Pharmacy Non PBM FFS PCP	321,999	0	(321,999)	0.0%
3,380,799	0	(3,380,799)	0.0%	Pharmacy Non PBM FFS SCP	3,380,799	0	(3,380,799)	0.0%
13,367	0	(13,367)	0.0%	Pharmacy Non PBM FFS FQHC	13,367	0	(13,367)	0.0%
21,133	0	(21,133)	0.0%	Pharmacy Non PBM FFS HH	21,133	0	(21,133)	0.0%
(58,585)	51,113	109,698	214.6%	Medical Expenses Pharm Rebate	(58,585)	51,113	109,698	214.6%
4,552,949	**4,371,721**	**(181,228)**	**(4.1%)**	**14. Pharmacy Expense**	**4,552,949**	**4,371,721**	**(181,228)**	**(4.1%)**
(5,649,079)	0	5,649,079	0.0%	IBNR LTC	(5,649,079)	0	5,649,079	0.0%
(169,473)	0	169,473	0.0%	IBNR Settlement (LTC)	(169,473)	0	169,473	0.0%
(451,927)	0	451,927	0.0%	IBNR Claims Fluctuation (LTC)	(451,927)	0	451,927	0.0%
2,416,742	27,665	(2,389,077)	(8,635.9%)	LTC - ICF/DD	2,416,742	27,665	(2,389,077)	(8,635.9%)
29,934,584	28,065,092	(1,869,492)	(6.7%)	LTC Custodial Care	29,934,584	28,065,092	(1,869,492)	(6.7%)
11,692,799	10,436,552	(1,256,247)	(12.0%)	LTC SNF	11,692,799	10,436,552	(1,256,247)	(12.0%)
37,773,646	**38,529,308**	**755,662**	**2.0%**	**15. Long Term Care Expense**	**37,773,646**	**38,529,308**	**755,662**	**2.0%**
158,767,604	**153,464,621**	**(5,302,983)**	**(3.5%)**	**16. TOTAL FFS MEDICAL EXPENSES**	**158,767,604**	**153,464,621**	**(5,302,983)**	**(3.5%)**
0	(358,341)	(358,341)	100.0%	Clinical Vacancy #102	0	(358,341)	(358,341)	100.0%
99,265	103,752	4,487	4.3%	Quality Analytics #123	99,265	103,752	4,487	4.3%
387,114	365,732	(21,382)	(5.8%)	LongTerm Services and Support #139	387,114	365,732	(21,382)	(5.8%)
875,183	826,811	(48,371)	(5.9%)	Utilization Management #140	875,183	826,811	(48,371)	(5.9%)
669,913	971,481	301,568	31.0%	Case & Disease Management #185	669,913	971,481	301,568	31.0%
(176,867)	(4,392,991)	(4,216,124)	96.0%	Medical Management #230	(176,867)	(4,392,991)	(4,216,124)	96.0%
919,203	1,151,604	232,401	20.2%	Quality Improvement #235	919,203	1,151,604	232,401	20.2%
343,425	442,020	98,595	22.3%	HCS Behavioral Health #238	343,425	442,020	98,595	22.3%
122,549	231,615	109,066	47.1%	Pharmacy Services #245	122,549	231,615	109,066	47.1%
242	0	(242)	0.0%	Regulatory Readiness #268	242	0	(242)	0.0%
3,240,025	**(658,318)**	**(3,898,343)**	**592.2%**	**17. Other Benefits & Services**	**3,240,025**	**(658,318)**	**(3,898,343)**	**592.2%**
(2,116,887)	(1,539,084)	577,803	(37.5%)	Reinsurance Recoveries	(2,116,887)	(1,539,084)	577,803	(37.5%)
2,494,255	2,052,112	(442,143)	(21.5%)	Reinsurance Premium	2,494,255	2,052,112	(442,143)	(21.5%)
377,368	**513,028**	**135,660**	**26.4%**	**18. Reinsurance (Net)**	**377,368**	**513,028**	**135,660**	**26.4%**
1,000,000	0	(1,000,000)	0.0%	P4P Risk Pool Provider Incenti	1,000,000	0	(1,000,000)	0.0%
1,000,000	**0**	**(1,000,000)**	**0.0%**	**19. Risk Pool Distribution**	**1,000,000**	**0**	**(1,000,000)**	**0.0%**
184,341,677	**170,601,125**	**(13,740,552)**	**(8.1%)**	**20. TOTAL MEDICAL EXPENSES**	**184,341,677**	**170,601,125**	**(13,740,552)**	**(8.1%)**

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend

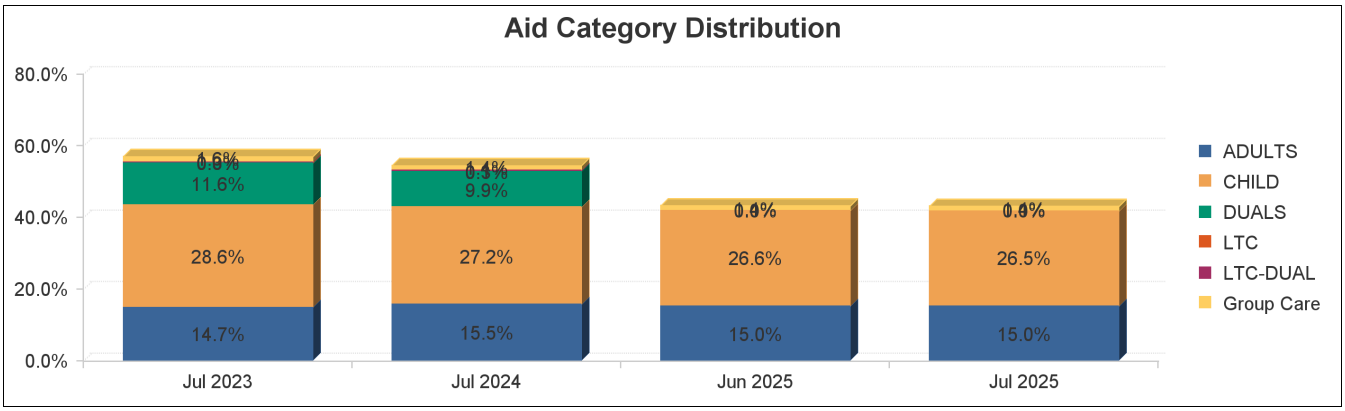
Category of Aid	Jul 2025	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN
ADULTS	61,571	15%	12,753	14,567	2	34,249
CHILD	109,306	27%	10,161	13,631	40,316	45,198
SPD	0	0%	0	0	0	0
ACA OE	155,533	38%	27,988	54,633	1,573	71,339
DUALS	1	0%	1	0	0	0
LTC	0	0%	0	0	0	0
LTC-DUAL	0	0%	0	0	0	0
SPD-LTC	29,834	7%	8,711	5,426	1,502	14,195
SPD-LTC/Full Dual	49,509	12%	32,188	3,546	3	13,772
Medi-Cal	405,754		91,802	91,803	43,396	178,753
Group Care	5,957		2,171	1,066	0	2,720
Total	**411,711**	**100%**	**93,973**	**92,869**	**43,396**	**181,473**
Medi-Cal %	98.6%		97.7%	98.9%	100.0%	98.5%
Group Care %	1.4%		2.3%	1.1%	0.0%	1.5%
	Network Distribution		**22.8%**	**22.6%**	**10.5%**	**44.1%**
			% Direct:	**45%**	**% Delegated:**	**55%**





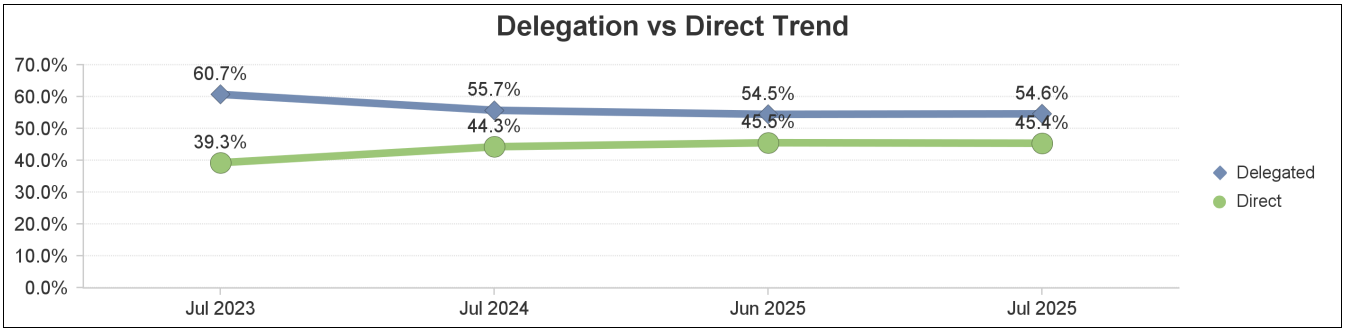
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Jul 2023	Jul 2024	Jun 2025	Jul 2025	Jul 2023	Jul 2024	Jun 2025	Jul 2025	Jul 2023 to Jul 2024	Jul 2024 to Jul 2025	Jun 2025 to Jul 2025
ADULTS	52,550	62,739	61,699	**61,571**	14.7%	15.5%	15.0%	15.0%	16.2%	-1.9%	-0.2%
CHILD	102,463	109,962	109,640	**109,306**	28.6%	27.2%	26.6%	26.5%	6.8%	-0.6%	-0.3%
SPD	31,055	35,018	0	**0**	8.7%	8.7%	0.0%	0.0%	11.3%	0.0%	0.0%
ACA OE	123,707	149,801	155,176	**155,533**	34.5%	37.0%	37.7%	37.8%	17.4%	3.7%	0.2%
DUALS	41,688	39,896	1	**1**	11.6%	9.9%	0.0%	0.0%	-4.5%	##########	0.0%
LTC	141	222	0	**0**	0.0%	0.1%	0.0%	0.0%	36.5%	0.0%	0.0%
LTC-DUAL	1,033	1,241	0	**0**	0.3%	0.3%	0.0%	0.0%	16.8%	0.0%	0.0%
SPD-LTC	0	0	29,750	**29,834**	0.0%	0.0%	7.2%	7.2%	0.0%	100.0%	0.3%
SPD-LTC/ Full Dual	0	0	49,304	**49,509**	0.0%	0.0%	12.0%	12.0%	0.0%	100.0%	0.4%
Medi-Cal	352,637	398,879	405,570	**405,754**	98.4%	98.6%	98.6%	98.6%	11.6%	1.7%	0.0%
Group Care	5,669	5,675	5,910	**5,957**	1.6%	1.4%	1.4%	1.4%	0.1%	4.7%	0.8%
Total	**358,306**	**404,554**	**411,480**	**411,711**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**11.4%**	**1.7%**	**0.1%**



Delegation vs Direct Trend

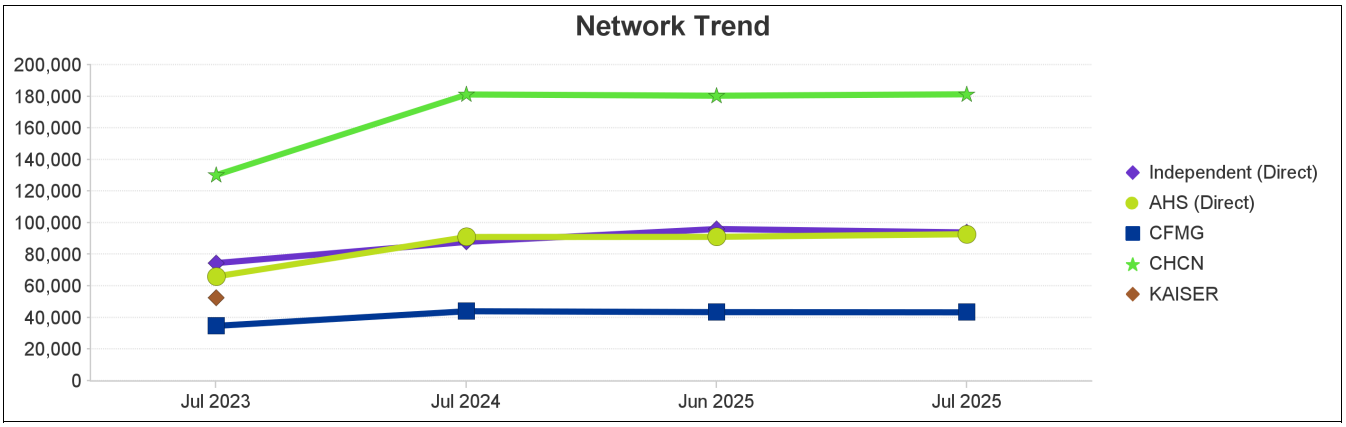
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	Jul 2023	Jul 2024	Jun 2025	Jul 2025	Jul 2023	Jul 2024	Jun 2025	Jul 2025	Jul 2023 to Jul 2024	Jul 2024 to Jul 2025	Jun 2025 to Jul 2025
Delegated	217,670	225,445	224,102	**224,869**	60.7%	55.7%	54.5%	54.6%	3.4%	-0.3%	0.3%
Direct	140,636	179,109	187,378	**186,842**	39.3%	44.3%	45.5%	45.4%	21.5%	4.1%	-0.3%
Total	**358,306**	**404,554**	**411,480**	**411,711**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**11.4%**	**1.7%**	**0.1%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

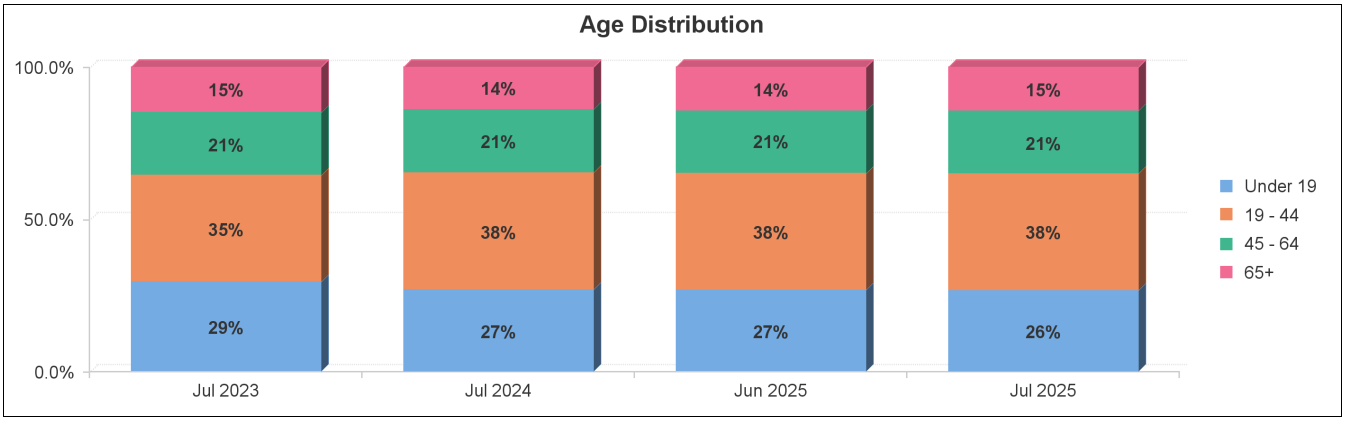
Network Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Jul 2023	Jul 2024	Jun 2025	Jul 2025	Jul 2023	Jul 2024	Jun 2025	Jul 2025	Jul 2023 to Jul 2024	Jul 2024 to Jul 2025	Jun 2025 to Jul 2025
Independent (Direct)	74,547	88,010	96,173	**93,973**	20.8%	21.8%	23.4%	22.8%	15.3%	6.3%	-2.3%
AHS (Direct)	66,089	91,099	91,205	**92,869**	18.4%	22.5%	22.2%	22.6%	27.5%	1.9%	1.8%
CFMG	34,810	44,090	43,522	**43,396**	9.7%	10.9%	10.6%	10.5%	21.0%	-1.6%	-0.3%
CHCN	130,230	181,355	180,580	**181,473**	36.3%	44.8%	43.9%	44.1%	28.2%	0.1%	0.5%
KAISER	52,630	0	0	**0**	14.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	**358,306**	**404,554**	**411,480**	**411,711**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**11.4%**	**1.7%**	**0.1%**



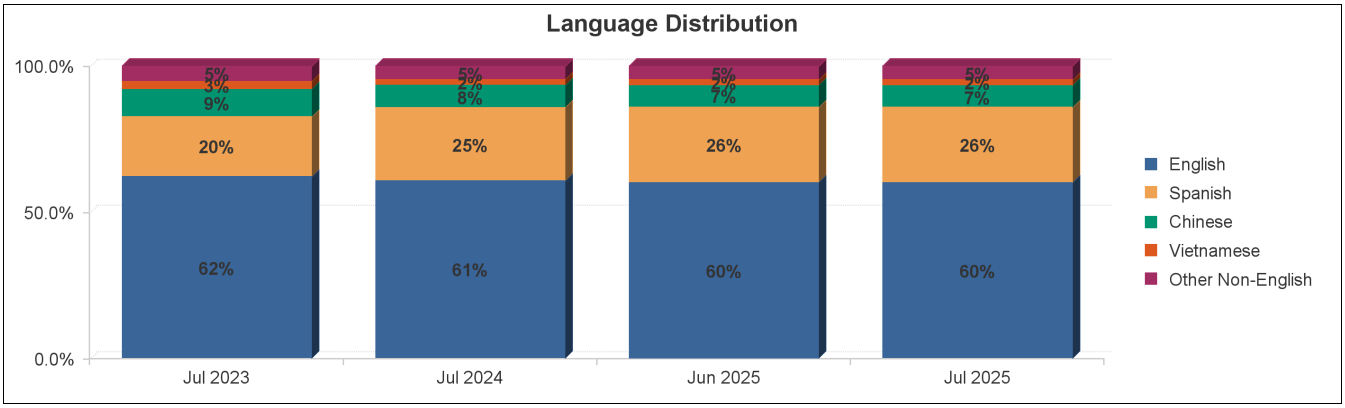
Age Category Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Jul 2023	Jul 2024	Jun 2025	Jul 2025	Jul 2023	Jul 2024	Jun 2025	Jul 2025	Jul 2023 to Jul 2024	Jul 2024 to Jul 2025	Jun 2025 to Jul 2025
Under 19	104,832	108,451	109,396	**109,080**	29%	27%	27%	26%	3%	1%	0%
19 - 44	125,554	155,339	157,686	**157,765**	35%	38%	38%	38%	19%	2%	0%
45 - 64	73,866	84,037	84,758	**84,946**	21%	21%	21%	21%	12%	1%	0%
65+	54,054	56,727	59,640	**59,920**	15%	14%	14%	15%	5%	5%	0%
Total	**358,306**	**404,554**	**411,480**	**411,711**	**100%**	**100%**	**100%**	**100%**	**11%**	**2%**	**0%**



Language Trend

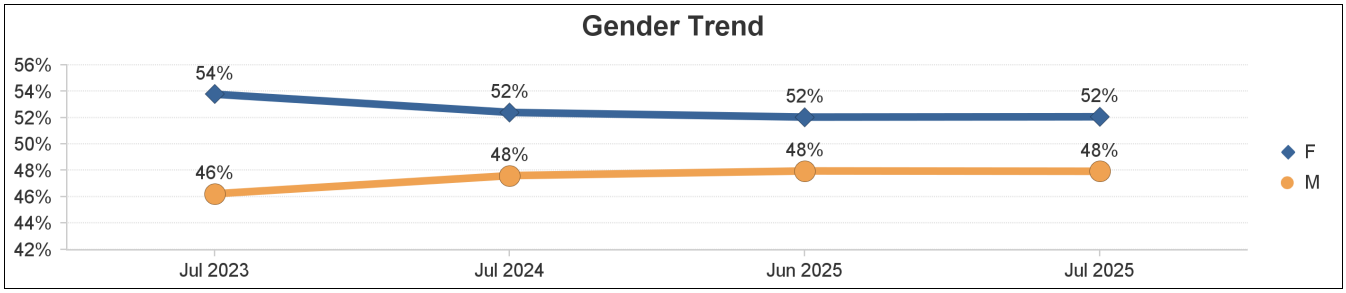
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	Jul 2023	Jul 2024	Jun 2025	Jul 2025	Jul 2023	Jul 2024	Jun 2025	Jul 2025	Jul 2023 to Jul 2024	Jul 2024 to Jul 2025	Jun 2025 to Jul 2025
English	222,387	245,137	247,110	**247,005**	62%	61%	60%	60%	9%	1%	0%
Spanish	73,273	101,314	105,889	**106,160**	20%	25%	26%	26%	28%	5%	0%
Chinese	33,455	30,651	30,503	**30,487**	9%	8%	7%	7%	-9%	-1%	0%
Vietnamese	9,733	8,353	8,135	**8,135**	3%	2%	2%	2%	-17%	-3%	0%
Other Non-English	19,458	19,099	19,843	**19,924**	5%	5%	5%	5%	-2%	4%	0%
Total	**358,306**	**404,554**	**411,480**	**411,711**	**100%**	**100%**	**100%**	**100%**	**11%**	**2%**	**0%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

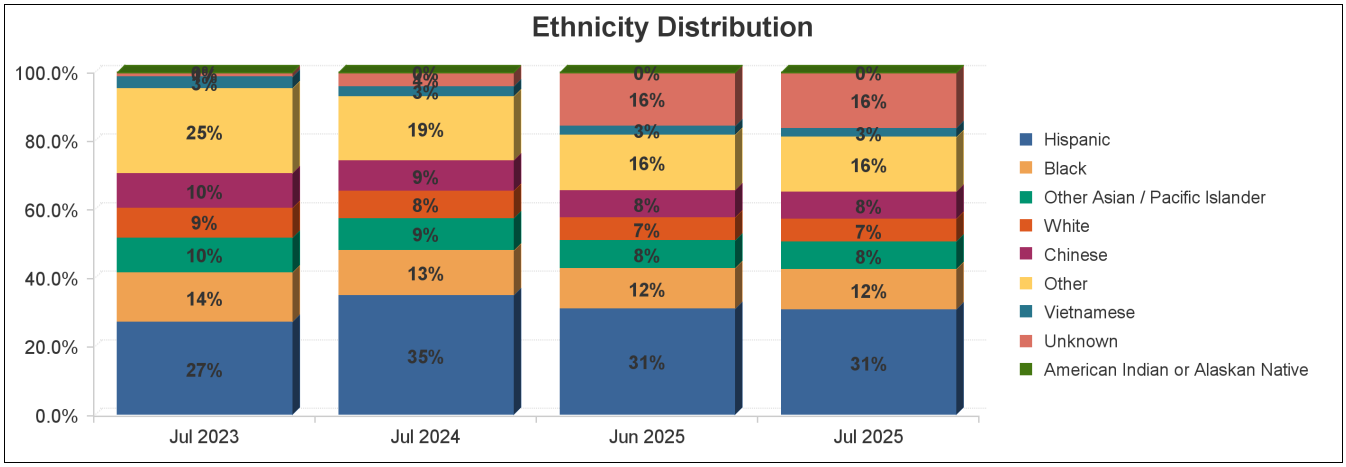
Gender Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Jul 2023	Jul 2024	Jun 2025	Jul 2025	Jul 2023	Jul 2024	Jun 2025	Jul 2025	Jul 2023 to Jul 2024	Jul 2024 to Jul 2025	Jun 2025 to Jul 2025
F	192,702	211,979	214,154	**214,374**	54%	52%	52%	52%	9%	1%	0%
M	165,604	192,575	197,326	**197,337**	46%	48%	48%	48%	14%	2%	0%
Total	**358,306**	**404,554**	**411,480**	**411,711**	**100%**	**100%**	**100%**	**100%**	**11%**	**2%**	**0%**



Ethnicity Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Jul 2023	Jul 2024	Jun 2025	Jul 2025	Jul 2023	Jul 2024	Jun 2025	Jul 2025	Jul 2023 to Jul 2024	Jul 2024 to Jul 2025	Jun 2025 to Jul 2025
Hispanic	96,921	140,570	127,002	**126,223**	27%	35%	31%	31%	31%	-11%	-1%
Black	51,522	53,042	48,489	**48,250**	14%	13%	12%	12%	3%	-10%	0%
Other Asian / Pacific Islander	36,301	37,878	33,457	**33,175**	10%	9%	8%	8%	4%	-14%	-1%
White	31,347	32,713	27,820	**27,523**	9%	8%	7%	7%	4%	-19%	-1%
Chinese	36,209	35,841	32,481	**32,254**	10%	9%	8%	8%	-1%	-11%	-1%
Other	88,676	75,541	66,579	**65,984**	25%	19%	16%	16%	-17%	-14%	-1%
Vietnamese	12,243	11,830	10,610	**10,544**	3%	3%	3%	3%	-3%	-12%	-1%
Unknown	4,360	16,341	64,320	**67,042**	1%	4%	16%	16%	73%	76%	4%
American Indian or Alaskan Native	727	798	722	**716**	0%	0%	0%	0%	9%	-11%	-1%
Total	**358,306**	**404,554**	**411,480**	**411,711**	**100%**	**100%**	**100%**	**100%**	**11%**	**2%**	**0%**



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

Medi-Cal By City

City	Jul 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	161,760	40%	24,475	43,118	17,057	77,110
HAYWARD	53,293	13%	12,062	15,450	5,713	20,068
FREMONT	38,848	10%	16,125	6,994	2,303	13,426
SAN LEANDRO	25,567	6%	6,873	4,396	3,075	11,223
UNION CITY	14,557	4%	5,746	2,727	829	5,255
ALAMEDA	13,725	3%	3,396	2,536	2,025	5,768
BERKELEY	16,455	4%	3,965	2,519	1,799	8,172
LIVERMORE	13,196	3%	2,000	487	2,154	8,555
NEWARK	9,443	2%	2,776	4,077	536	2,054
CASTRO VALLEY	11,361	3%	3,326	1,869	1,757	4,409
SAN LORENZO	6,102	2%	1,256	1,480	701	2,665
PLEASANTON	8,093	2%	2,150	359	851	4,733
DUBLIN	7,788	2%	2,373	373	886	4,156
EMERYVILLE	3,045	1%	641	653	495	1,256
ALBANY	2,569	1%	600	286	545	1,138
PIEDMONT	498	0%	101	189	88	120
SUNOL	79	0%	26	10	7	36
ANTIOCH	26	0%	14	1	6	5
Other	19,349	5%	3,897	4,279	2,569	8,604
Total	405,754	100%	**91,802**	**91,803**	**43,396**	**178,753**

Group Care By City

City	Jul 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	1,844	31%	335	413	0	1,096
HAYWARD	673	11%	308	178	0	187
FREMONT	679	11%	449	81	0	149
SAN LEANDRO	623	10%	241	103	0	279
UNION CITY	288	5%	175	44	0	69
ALAMEDA	312	5%	90	30	0	192
BERKELEY	149	3%	44	14	0	91
LIVERMORE	100	2%	30	4	0	66
NEWARK	145	2%	80	37	0	28
CASTRO VALLEY	220	4%	93	33	0	94
SAN LORENZO	154	3%	47	27	0	80
PLEASANTON	69	1%	21	3	0	45
DUBLIN	134	2%	47	8	0	79
EMERYVILLE	40	1%	13	6	0	21
ALBANY	21	0%	11	1	0	9
PIEDMONT	6	0%	1	1	0	4
SUNOL	1	0%	1	0	0	0
ANTIOCH	27	0%	9	7	0	11
Other	472	8%	176	76	0	220
Total	**5,957**	**100%**	**2,171**	**1,066**	**0**	**2,720**

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

Total By City

City	Jul 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	163,604	40%	24,810	43,531	17,057	78,206
HAYWARD	53,966	13%	12,370	15,628	5,713	20,255
FREMONT	39,527	10%	16,574	7,075	2,303	13,575
SAN LEANDRO	26,190	6%	7,114	4,499	3,075	11,502
UNION CITY	14,845	4%	5,921	2,771	829	5,324
ALAMEDA	14,037	3%	3,486	2,566	2,025	5,960
BERKELEY	16,604	4%	4,009	2,533	1,799	8,263
LIVERMORE	13,296	3%	2,030	491	2,154	8,621
NEWARK	9,588	2%	2,856	4,114	536	2,082
CASTRO VALLEY	11,581	3%	3,419	1,902	1,757	4,503
SAN LORENZO	6,256	2%	1,303	1,507	701	2,745
PLEASANTON	8,162	2%	2,171	362	851	4,778
DUBLIN	7,922	2%	2,420	381	886	4,235
EMERYVILLE	3,085	1%	654	659	495	1,277
ALBANY	2,590	1%	611	287	545	1,147
PIEDMONT	504	0%	102	190	88	124
SUNOL	80	0%	27	10	7	36
ANTIOCH	53	0%	23	8	6	16
Other	19,821	5%	4,073	4,355	2,569	8,824
Total	411,711	100%	**93,973**	**92,869**	**43,396**	**181,473**

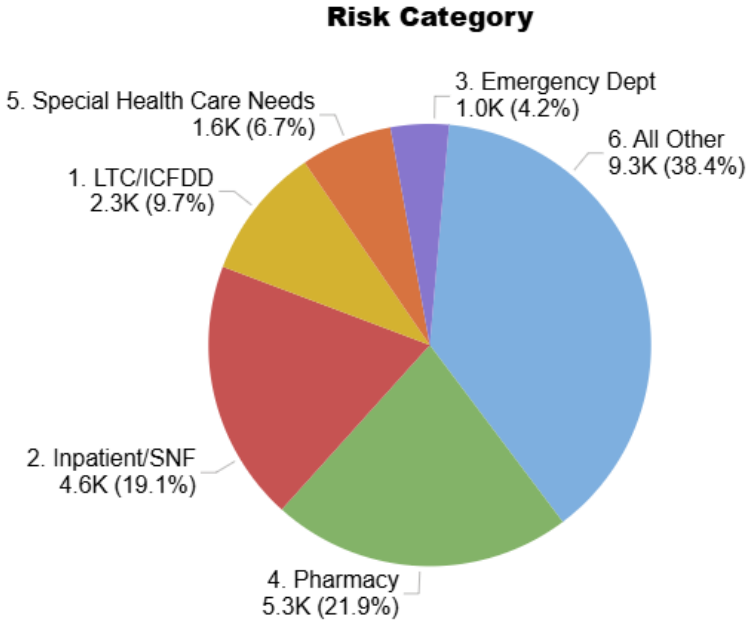
Medical Management

Medical Management Update

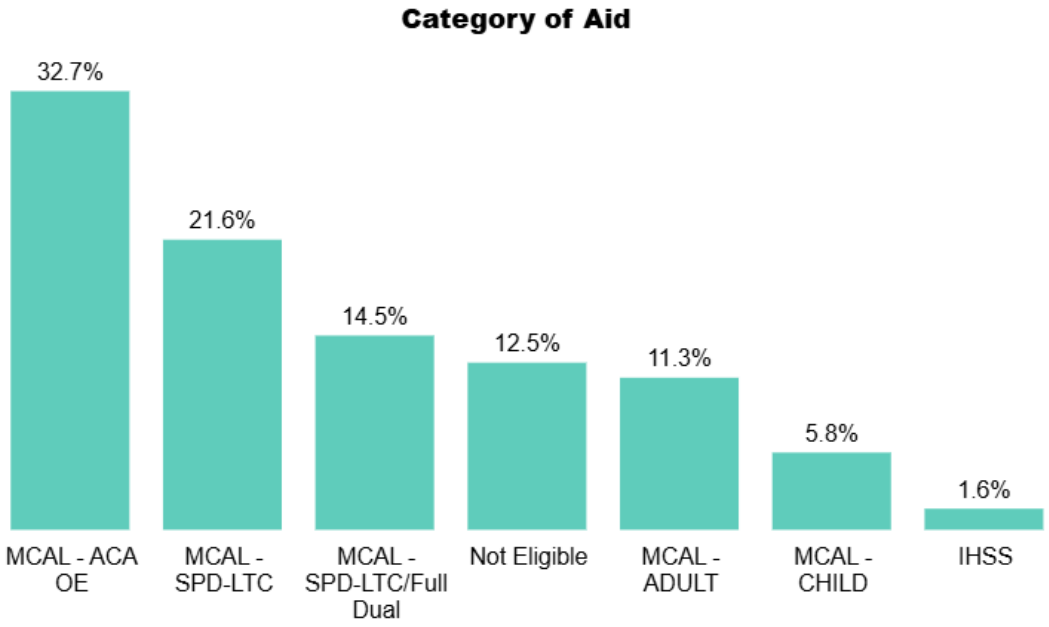
Donna White Carey, MD, MS
Chief Medical Officer
9/9/25

ALAMEDA Alliance FOR HEALTH

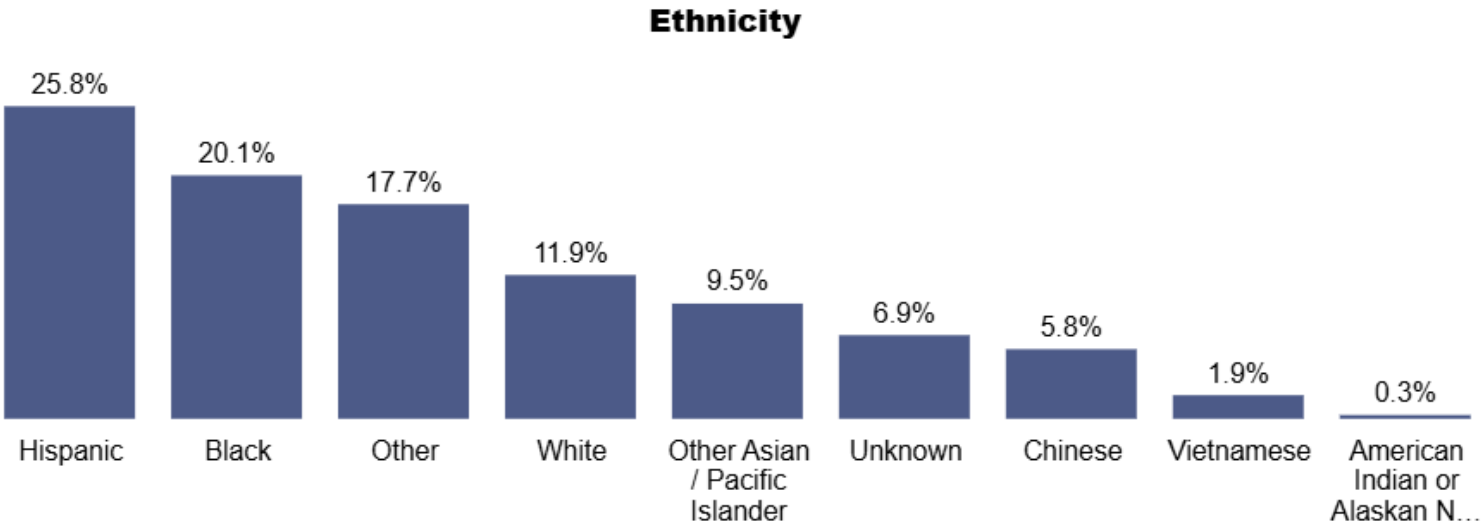
AAH Top 5%



- Members were assigned a risk category based on utilization and/or cost to help focus the initiatives for Top 5%.
- ~33% of the members are in the ACA OE aid category.



AAH Top 5%



% ECM Eligible

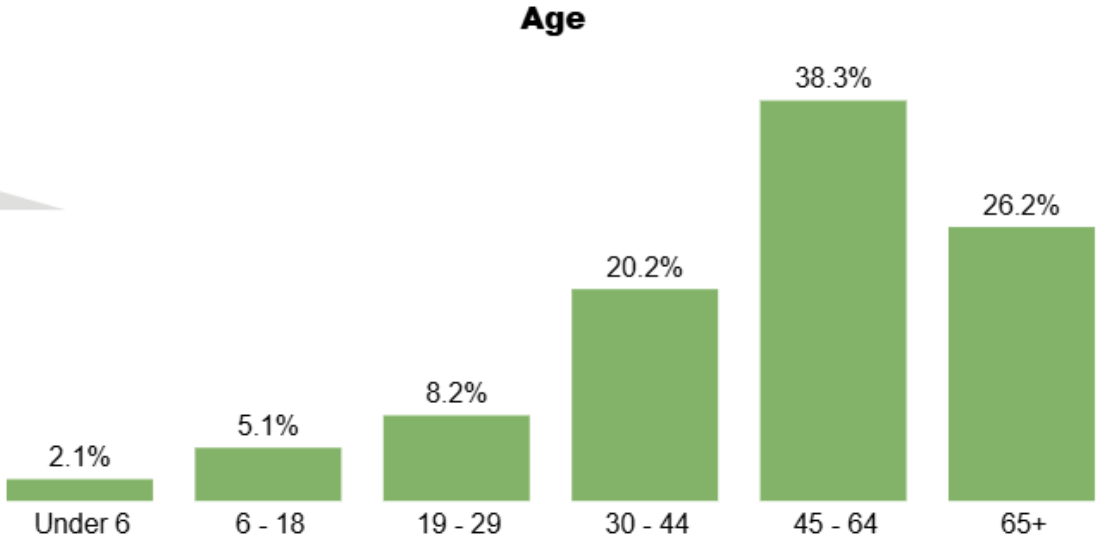
34.20%

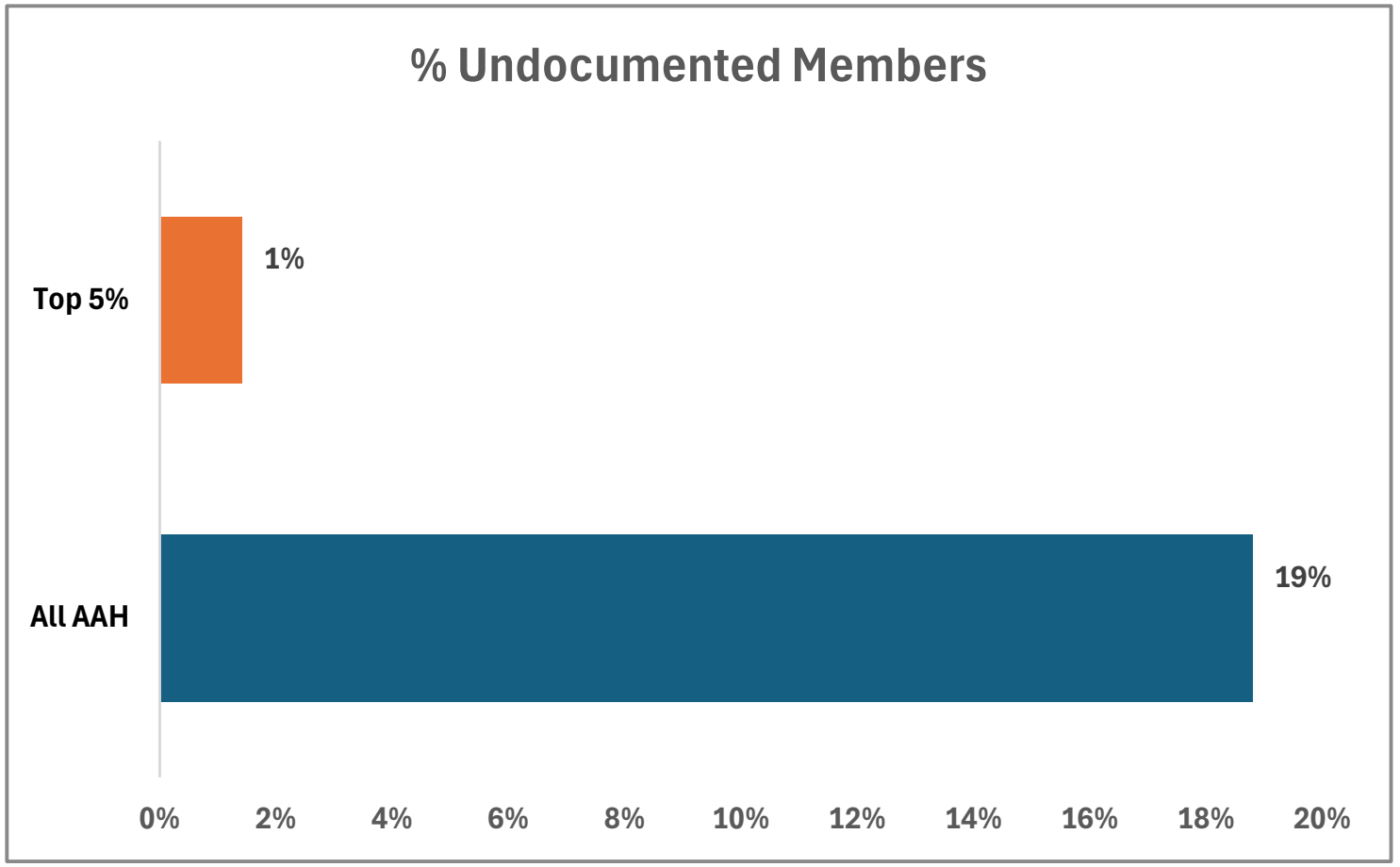
% ECM Enrolled

5.21%

% CS Enrolled

2.68%



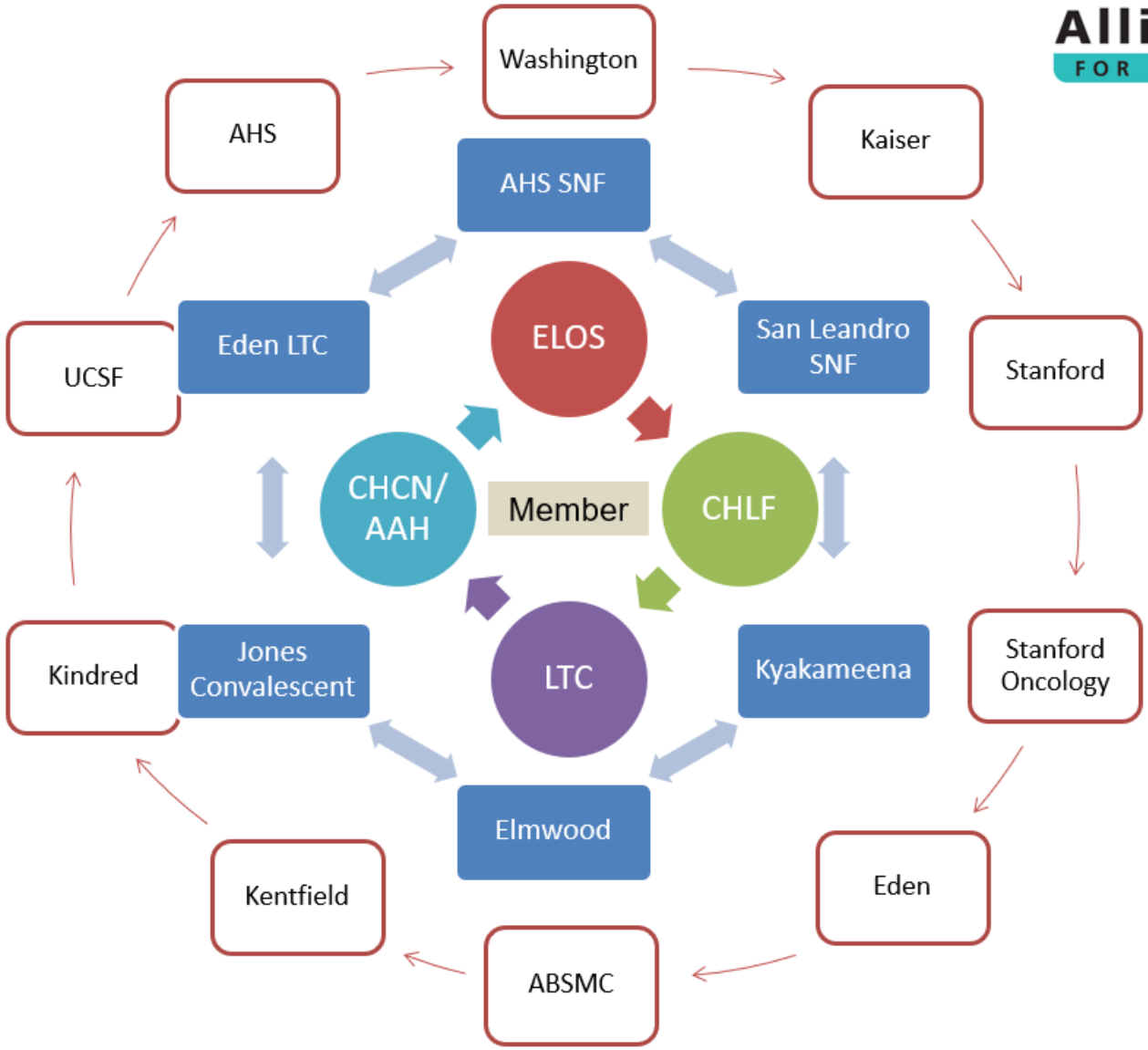

% Undocumented Members
Top 5%
1%
All AAH
19%
0%
2%
4%
6%
8%
10%
12%
14%
16%
18%
20%

Inpatient Strategy

ALAMEDA Alliance FOR HEALTH

Inpatient Interventions

- On-going
  - → 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)


Washington
Kaiser
Stanford
Stanford Oncology
Eden
ABSMC
Kentfield
Kindred
UCSF
AHS
AHS SNF
San Leandro SNF
Kyakameena
Elmwood
Jones Convalescent
Eden LTC
ELOS
CHCN/ AAH
Member
CHLF
LTC

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

Metrics by Facility

Facility	Readmission Rate	ALOS	ER/1000	Admits/1000	Ave Daily Census
Washington	22.6	5.9	55.2	15.9	32
Highland	22.0	5.8	87.4	16.4	50
San Leandro	21.2	3.9	30.4	6.8	21
Alameda	24.5	4.4	21.5	5.6	12
Summit	22.0	5.0	38.2	13.1	24
Alta Bates	19.8	5.4	21.8	4.7	11
Eden	20.5	5.4	42.5	10.2	21
St. Rose	26.7	4.1	34.2	6.2	15

1ST HIGHEST PRIORITY, 2ND HIGHEST PRIORITY, 3RD HIGHEST PRIORITY

Long Term Support Services Strategy

ALAMEDA Alliance FOR HEALTH

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

Member impact

Totals	November 2024	December 2024	January 2025*
Admissions	146	136	75
Days	1,197	760	421
Readmissions	33	36	16

*Source: #14236_LTC_Dashboard - *data only available through February 2025*

Totals	April 2025	May2025	June 2025*
Admissions	146	105	52
Days	950	530	312
Readmissions	35	28	13

**Source: #14236_LTC_Dashboard – data only available through June 2025*

ED Strategy

ALAMEDA Alliance FOR HEALTH

Emergency Department Interventions

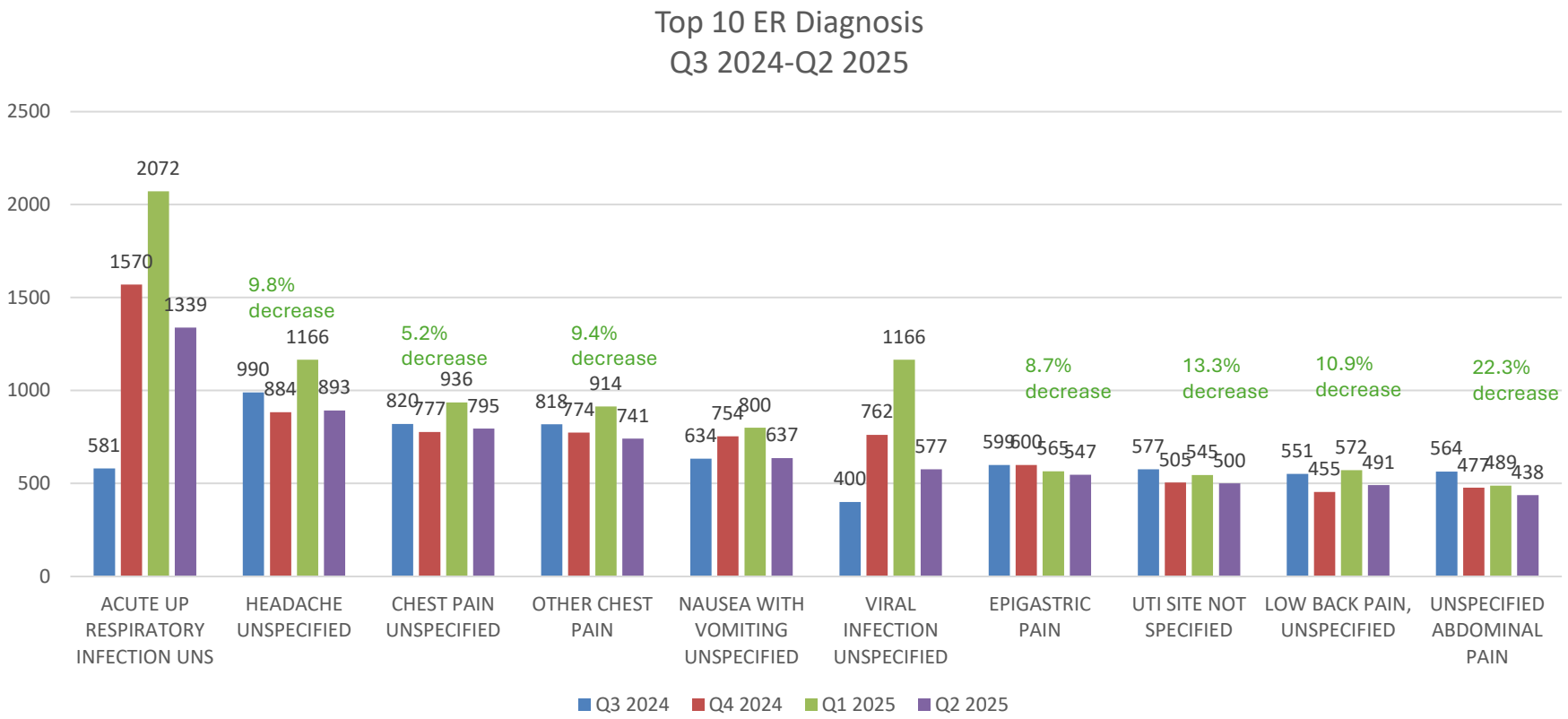
- On-going
  - → Member education campaign-increase Telehealth and Urgent Care utilization; New brochures to members
  - → Community Health Workers (CHW) program; care coordination in EDs (Highland, Sutter, Eden)
  - → QI navigators (2) f/u ED visits (AHS) for Mental Health (MH) or Substance Use Disorder (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

ED Visits Per 1000 – By Facility

	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2024 to Q2 2025 Percent Change
Highland General Hospital	89.5	84.9	91.1	82.9	7.4% decrease
DBA Alameda Hospital	23.1	20.9	23.0	20.8	10.0% decrease
DBA San Leandro	30.9	30.0	33.1	28.5	7.8% decrease
Alta Bates Campus	24.5	21.1	26.3	21.4	12.7% decrease
Summit Campus	41.6	36.4	43.6	34.5	17.1% decrease
Eden Medical	41.7	41.1	47.6	41.3	1.0% decrease
UCSF Benioff	36.8	48.6	52.2	43.7	18.8% increase
St. Rose	32.9	32.9	36.4	31.9	3.0% decrease
Livermore-Pleasanton	20.8	18.5	22.6	20.8	No change
Washington Hospital	54.9	53.6	58.8	50.0	8.9% decrease
OON	82.4	75.6	90.1	75.1	8.9% decrease
AVERAGE	43.6	42.1	47.7	41.0	5.3% decrease

- Overall **decrease of -5.3%** from Q3 2024 – Q2 2025
- Notable reductions at Summit (-17.1%), Alta Bates (-12.7%), Alameda (-10.0%), OON (-9%), Highland (-7.4%),

#03046_ERVisits_ByNetwork



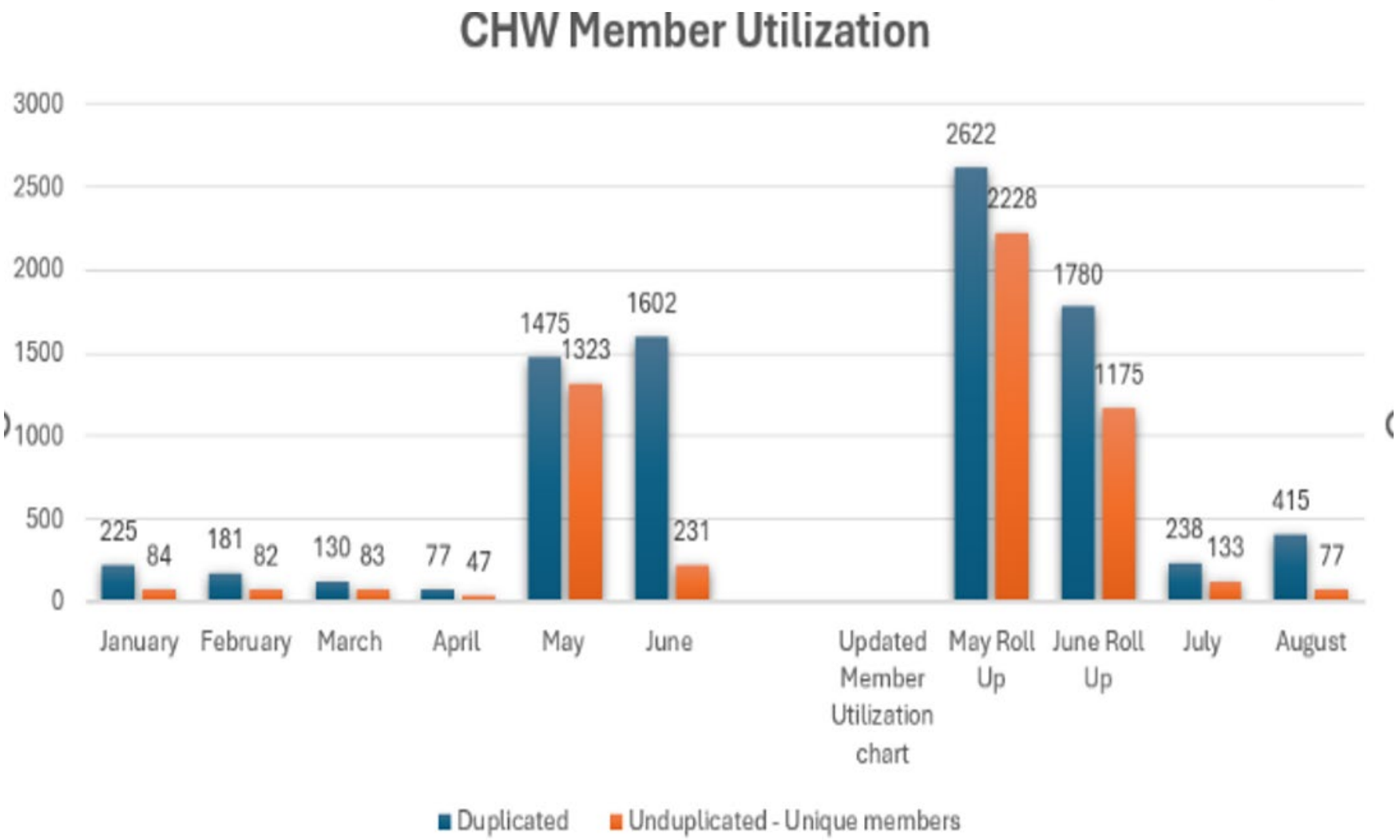
- After peaking in Q1 2025, ER visits for these diagnoses dropped by **2,285 cases (-24.8%)** from Q1 to Q2 2025.
- Most pain-related conditions (headache, chest pain, abdominal pain, back pain, epigastric pain, UTI) declined by Q2 2025.

#03046_ERVisits_ByNetwork

CHW Program

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

CHW


CHW Member Utilization
3000
2500
2000
1500
1000
500
0
225
84
181
82
130
83
77
47
1475
1323
1602
231
2622
2228
1780
1175
238
133
415
77
January
February
March
April
May
June
Updated Member Utilization chart
May Roll Up
June Roll Up
July
August
Duplicated
Unduplicated - Unique members

Pharmacy Strategy

ALAMEDA Alliance FOR HEALTH

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 paying for drugs carved out to the State (cost saving)
- PA process helping to prevent FWA for self-administered medications (cost saving)

Thank You!

Questions?

ALAMEDA Alliance FOR HEALTH

ALAMEDA Alliance FOR HEALTH

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

Community Supports Operations Update

Community Supports Operations Update

September 12, 2025

Overview

- CS April 2025 Policy Guide Communications
- CS Authorizations
- CS Approval vs Denial Rates
- CS Approvals vs Denials
  - By Service Provider
  - By Service Type

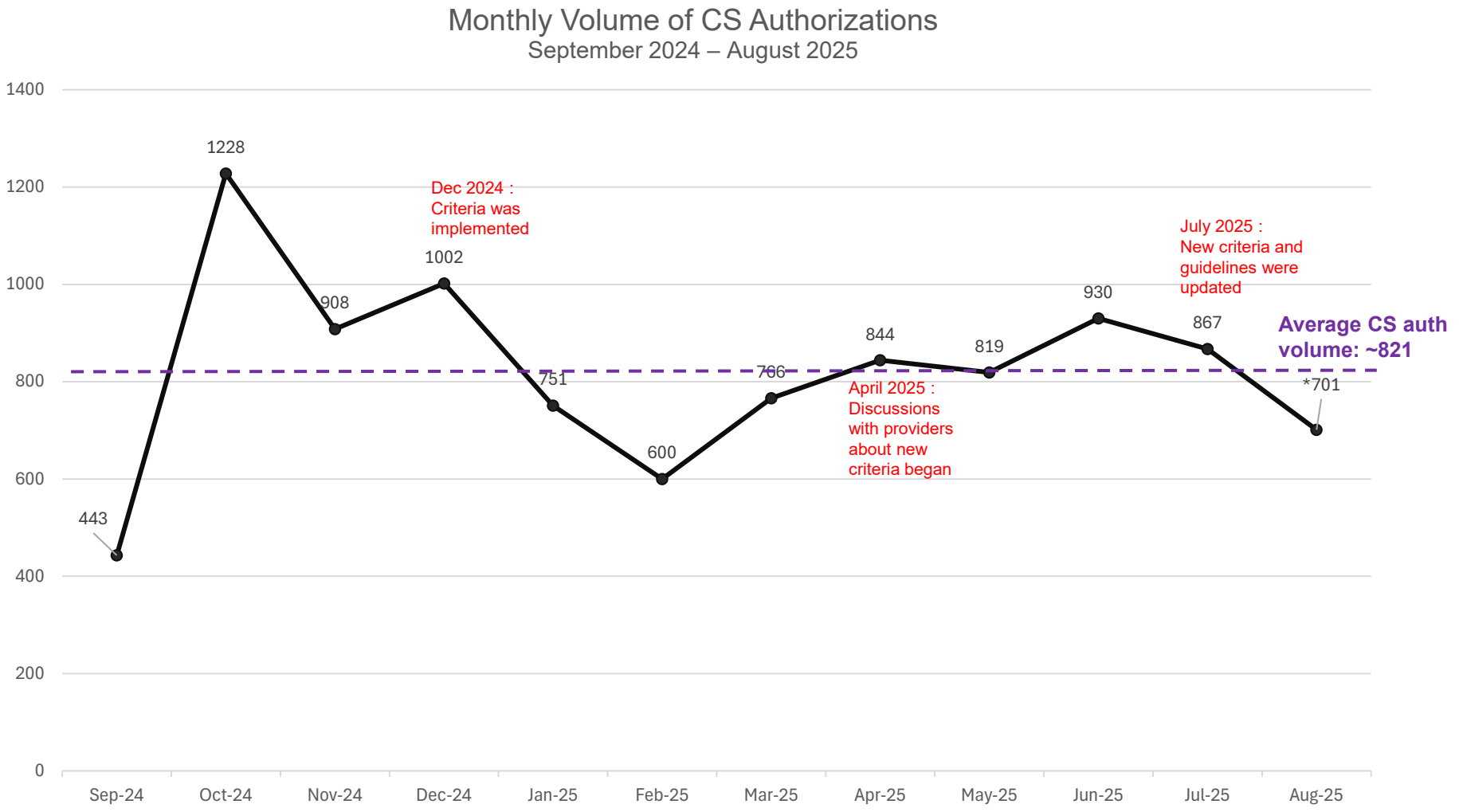
Key CS Provider Communications

- April 30, 2025: DHCS releases new Community Supports Policy Guides, volumes 1 and 2
- May 5, 2025: CEO communication addressing Community Supports including acknowledgement of new Policy Guides
- May 7, 2025: CEO communication addressing Community Supports acknowledging updating criteria and programs due to new Policy Guides
- June 10, 2025: providers encouraged to read new policy guides. Communication highlighted new documentation, monitoring, and oversight expectations and timelines
- June 27, 2025: new criteria and oversight expectations for volume 1 programs and medical respite released. Projected timelines for housing bundle criteria and implementation reviewed.
- Aug 28, 2025: communication regarding appeals rights and implementation timeline for housing bundle

Provider Audit Training Schedule

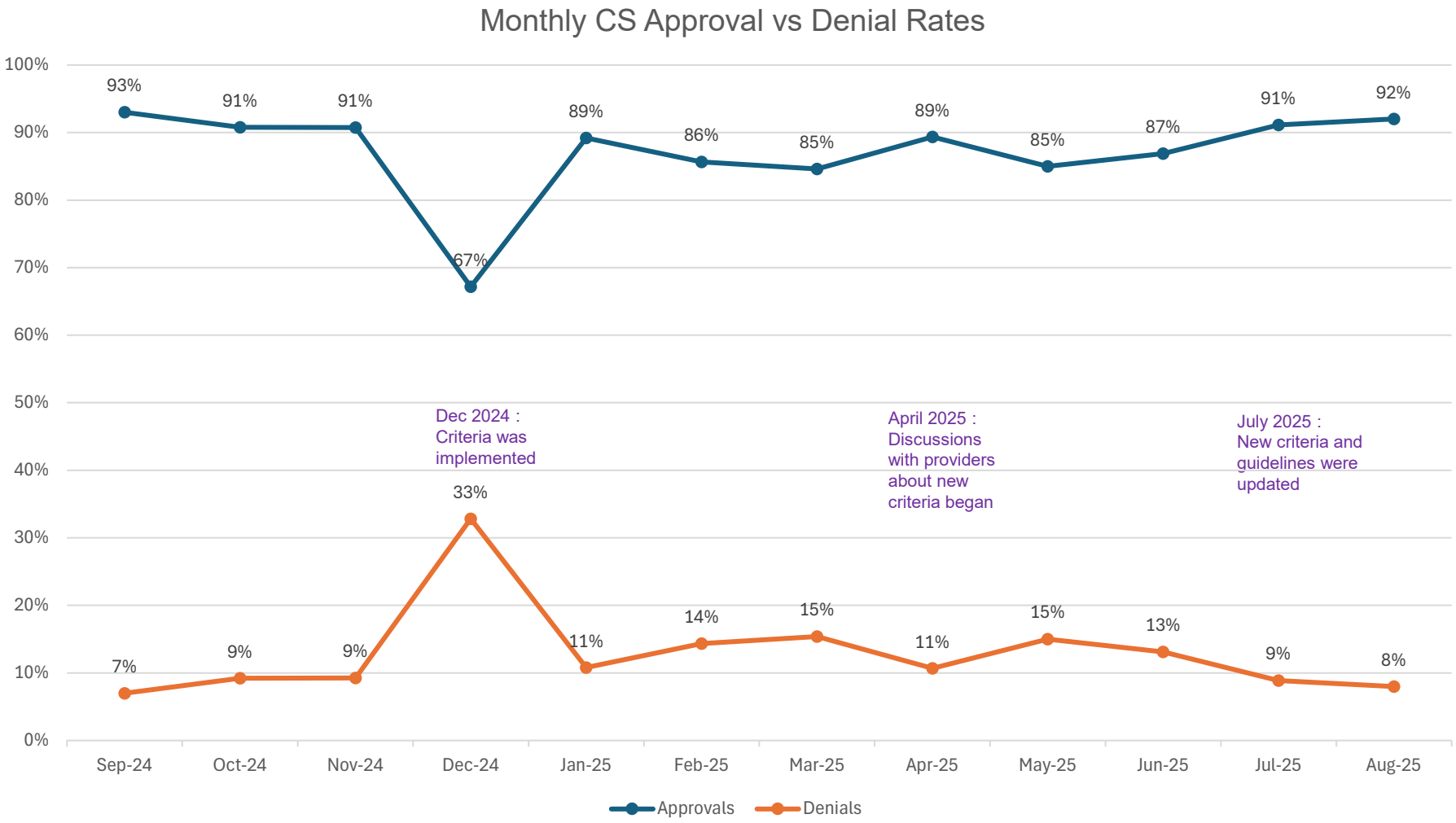
AC Health Leadership	6/12/25
AC Health Housing staff*	TBD
Asthma Start	10/6/25
Front Door	10/6/25
24 Hour Home Care	8/12/25
Roots	9/15/25
BACS	8/6/25
Adeline (LifeLong)	8/5/25
Cardea	9/18/25
EBI	9/4/25
Project Open Hand	7/28/25
Omatochi	8/20/25
AC Food Bank	8/14/25
R4H	7/28/25

CS Authorizations



Note: Data for August 2025 is incomplete

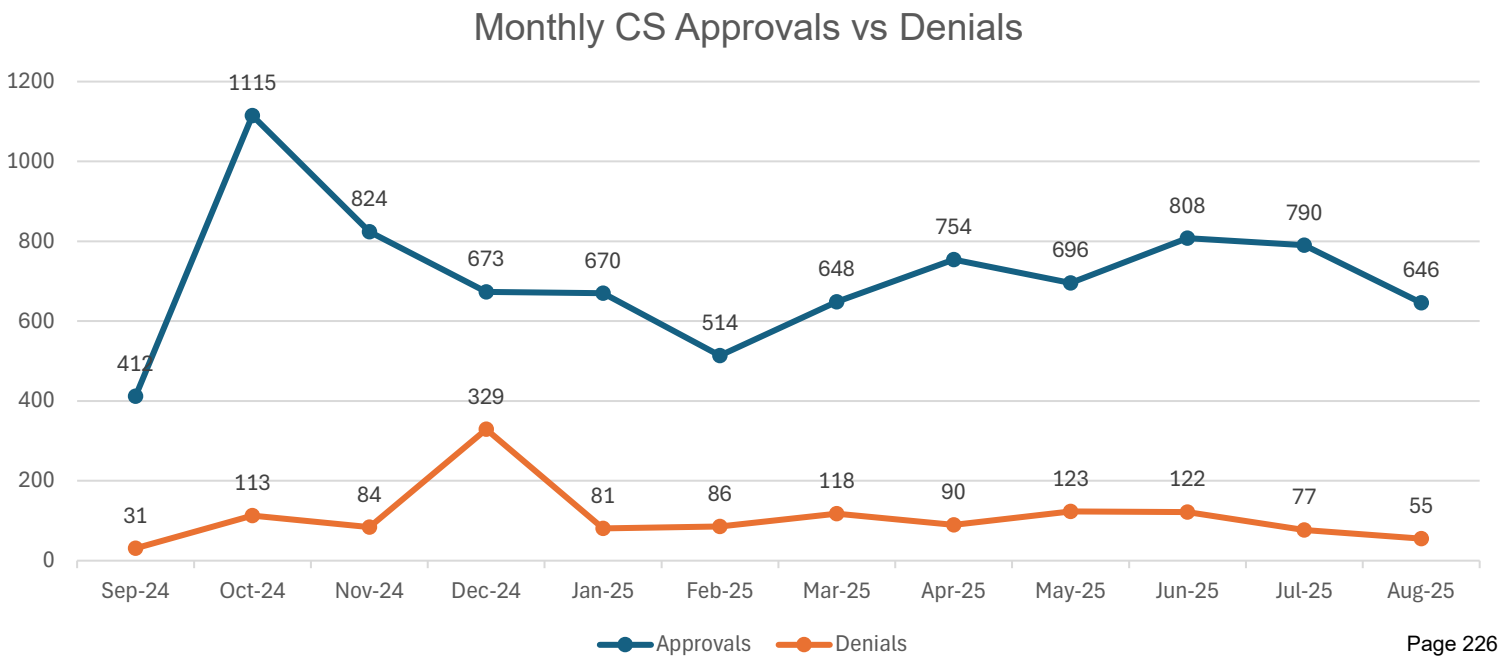
CS Approval vs Denial Rates



Note: Data for August 2025 is incomplete

CS Approvals vs Denials

	Sept 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	March 2025	April 2025	May 2025	June 2025	July 2025	Aug 2025	Total
Approvals	412	1115	824	673	670	514	648	754	696	808	790	646	8550
Denials	31	113	84	329	81	86	118	90	123	122	77	55	1309



CS Approvals vs. Denials by Servicing Provider

Sep 2024 – Aug 2025

CS Approvals vs Denials by Service Provider

Servicing Provider Sep 2024 - Aug 2025	Approvals	Denials	TOTAL AUTHORIZATIONS
24HR Homecare	183	126	309
Adeline Recuperative	25	6	31
Community Food Bank	143	51	194
Health Care Services Agency	3,628	0	3628
Public Health Asthma	442	3	445
Recipe4Health	2106	525	2631
Bay Area Community Services	24	5	29
East Bay Innovation	52	15	67
Cardea	162	123	285
LifeLong Medical Care	90	24	114
Omatochi Corp	36	7	43
Project Open Hand	1632	423	2055
Roots Community	27	0	27
TOTAL AUTHORIZATIONS	8550	1308	9858

CS Approvals vs Denials by Service Provider

Servicing Provider CY2024*	Approvals	Denials	TOTAL AUTHORIZATIONS
24HR Homecare	81	63	144
Adeline Recuperative	2	1	3
Community Food Bank	22	4	26
Health Care Services Agency	936	0	936
Public Health Asthma	115	3	118
Recipe4Health	1066	379	1445
Bay Area Community Services	6	1	7
East Bay Innovation	21	1	22
Cardea	64	14	78
LifeLong Medical Care	25	9	34
Omatochi Corp	10	3	13
Project Open Hand	668	78	746
Roots Community	8	0	8
TOTAL AUTHORIZATIONS	3024	556	3580

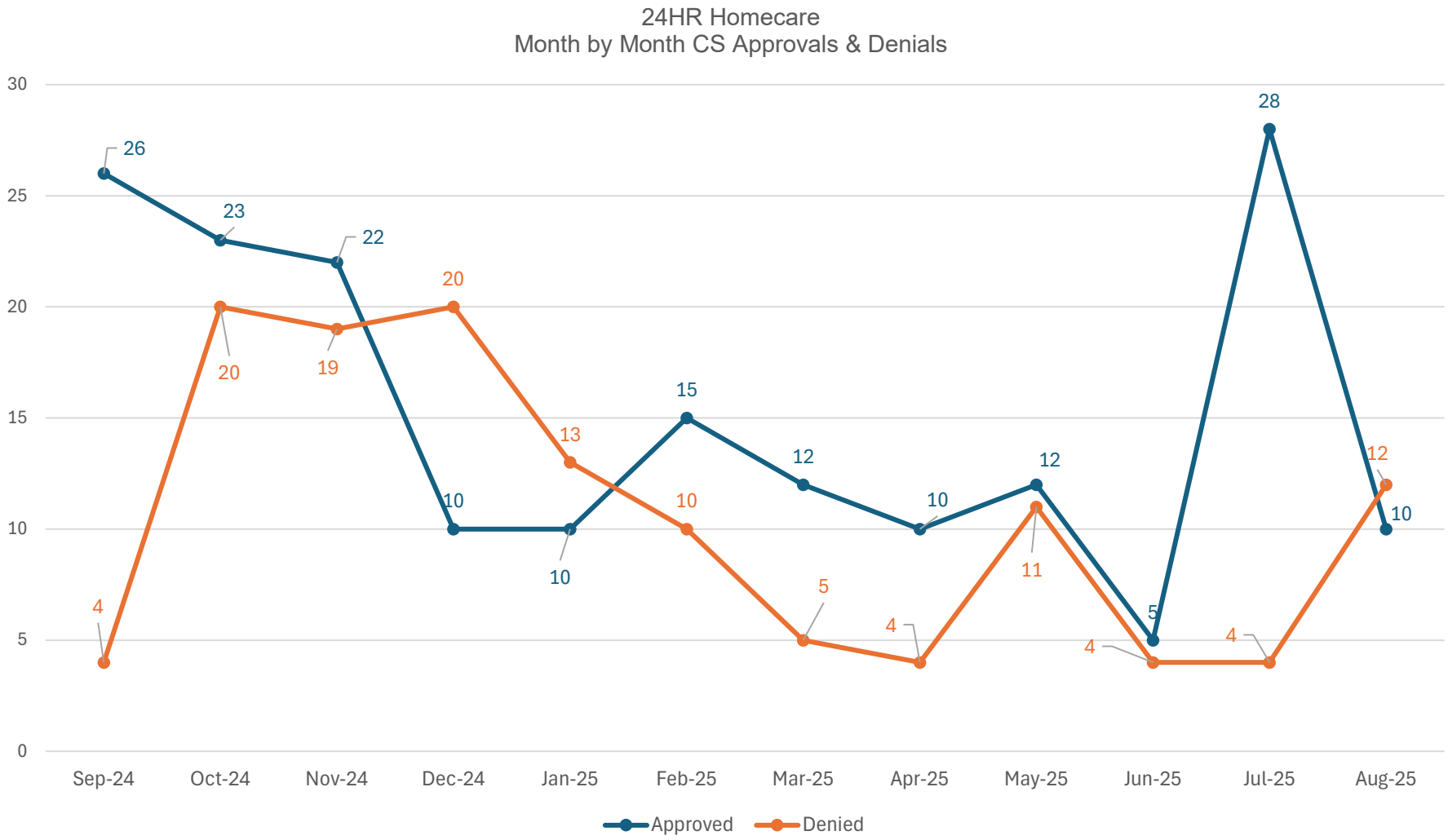
CS Approvals vs Denials by Service Provider

Servicing Provider CY2025	Approvals	Denials	TOTAL AUTHORIZATIONS
24HR Homecare	102	63	165
Adeline Recuperative + Lifelong	88	20	108
Community Food Bank	121	47	168
Health Care Services Agency	2692	0	2692
Public Health Asthma	327	0	327
Recipe4Health	1040	146	1186
Bay Area Community Services	18	4	22
East Bay Innovation	31	14	45
Cardea	98	110	208
Omatochi Corp	26	4	30
Project Open Hand	964	345	1309
Roots Community	19	0	19
TOTAL AUTHORIZATIONS	5526	753	6279

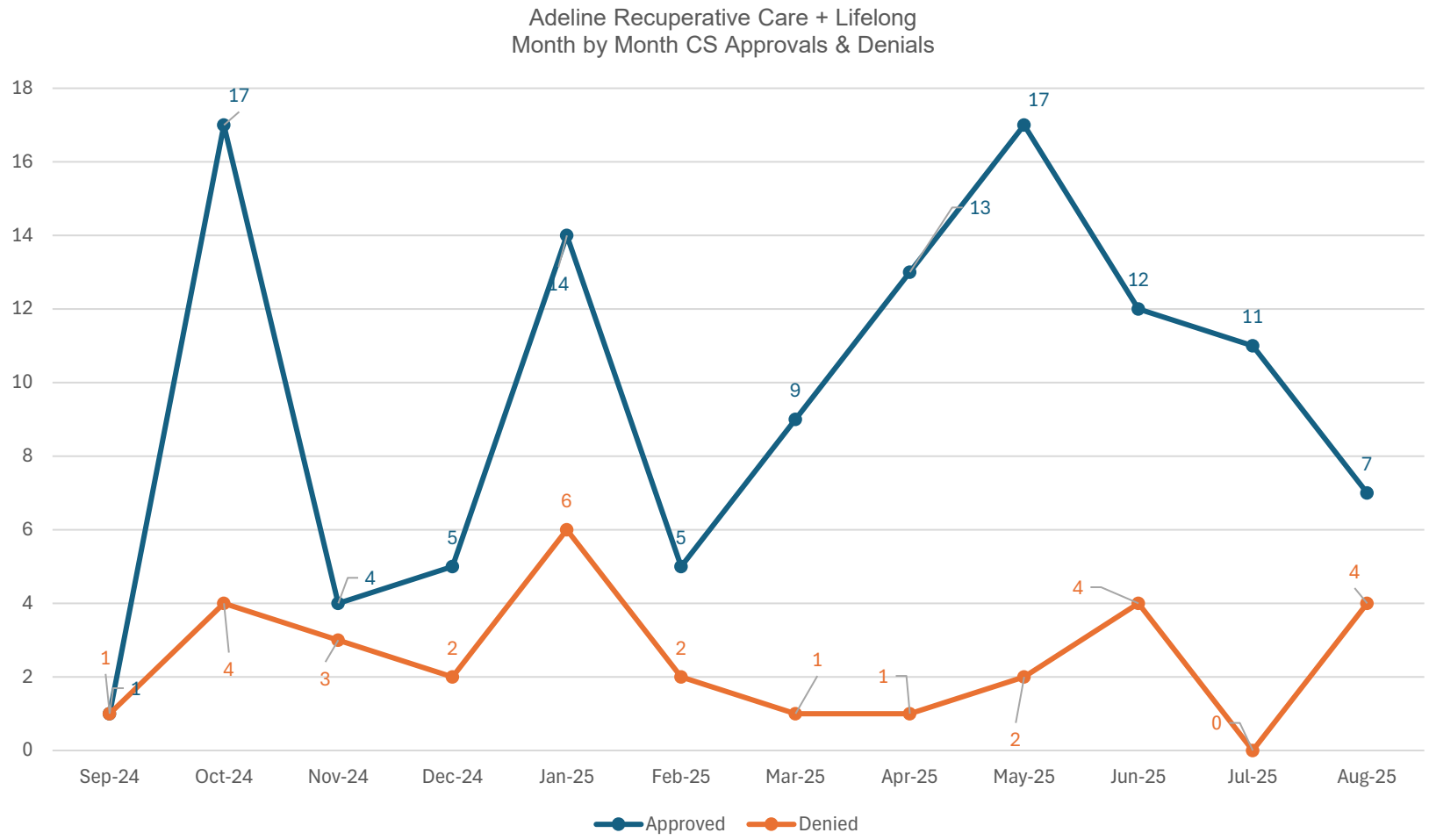
CS Denial Reasons by Service Provider

Servicing Provider CY2025	Total Denials	Criteria Not Met	Information Not Received *Reason available in June 2025
24HR Homecare	63	58	1
Adeline Recuperative + Lifelong	20	20	0
Community Food Bank	47	44	3
Health Care Services Agency	0	0	0
Public Health Asthma	0	0	0
Recipe4Health	146	135	0
Bay Area Community Services	4	4	0
East Bay Innovation	14	14	0
Cardea	110	98	0
Omatochi Corp	4	4	0
Project Open Hand	345	308	26
Roots Community	0	0	0
Serene Health	0	0	0
TOTAL AUTHORIZATIONS	753	685	30

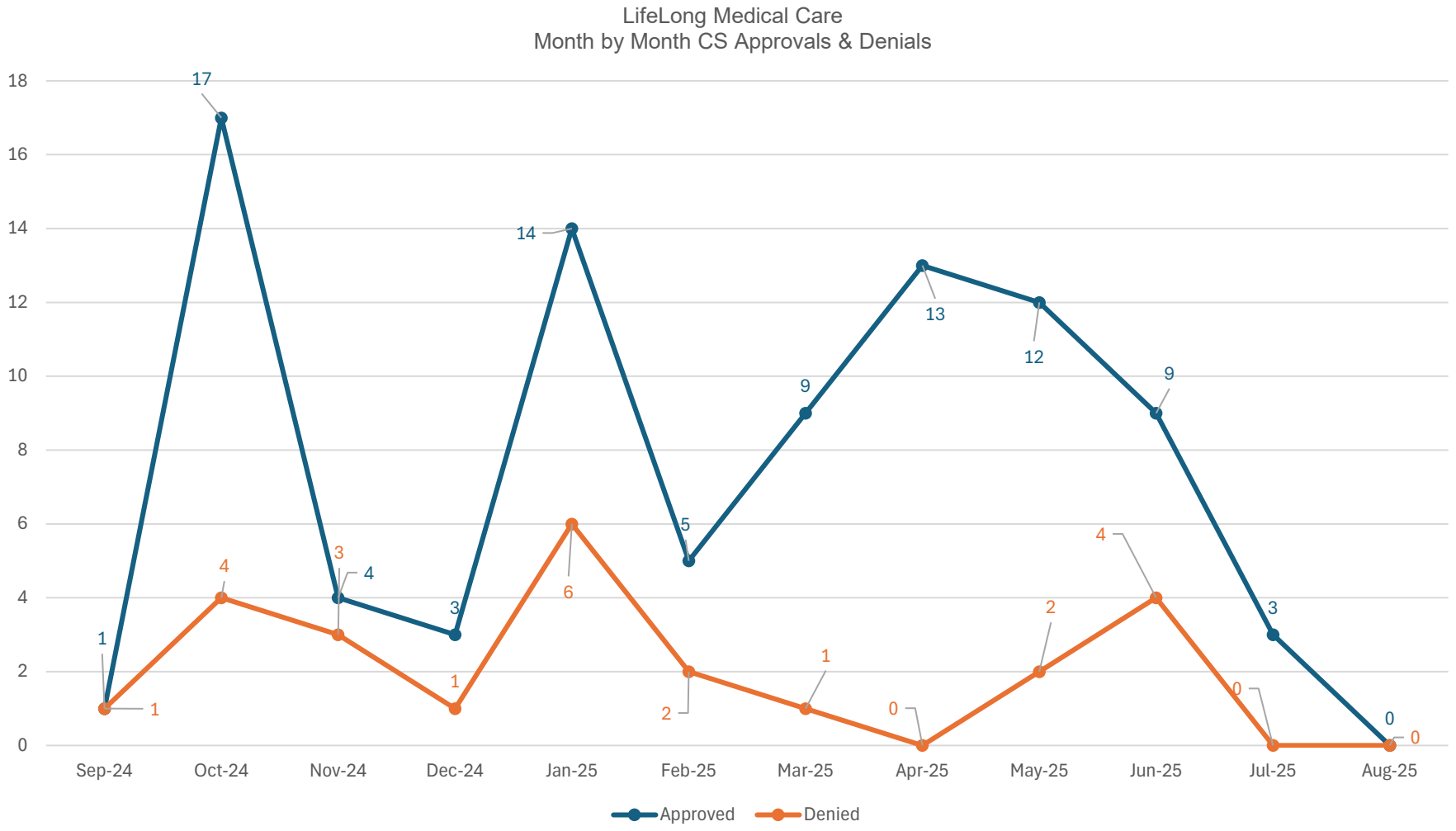
24HR Homecare



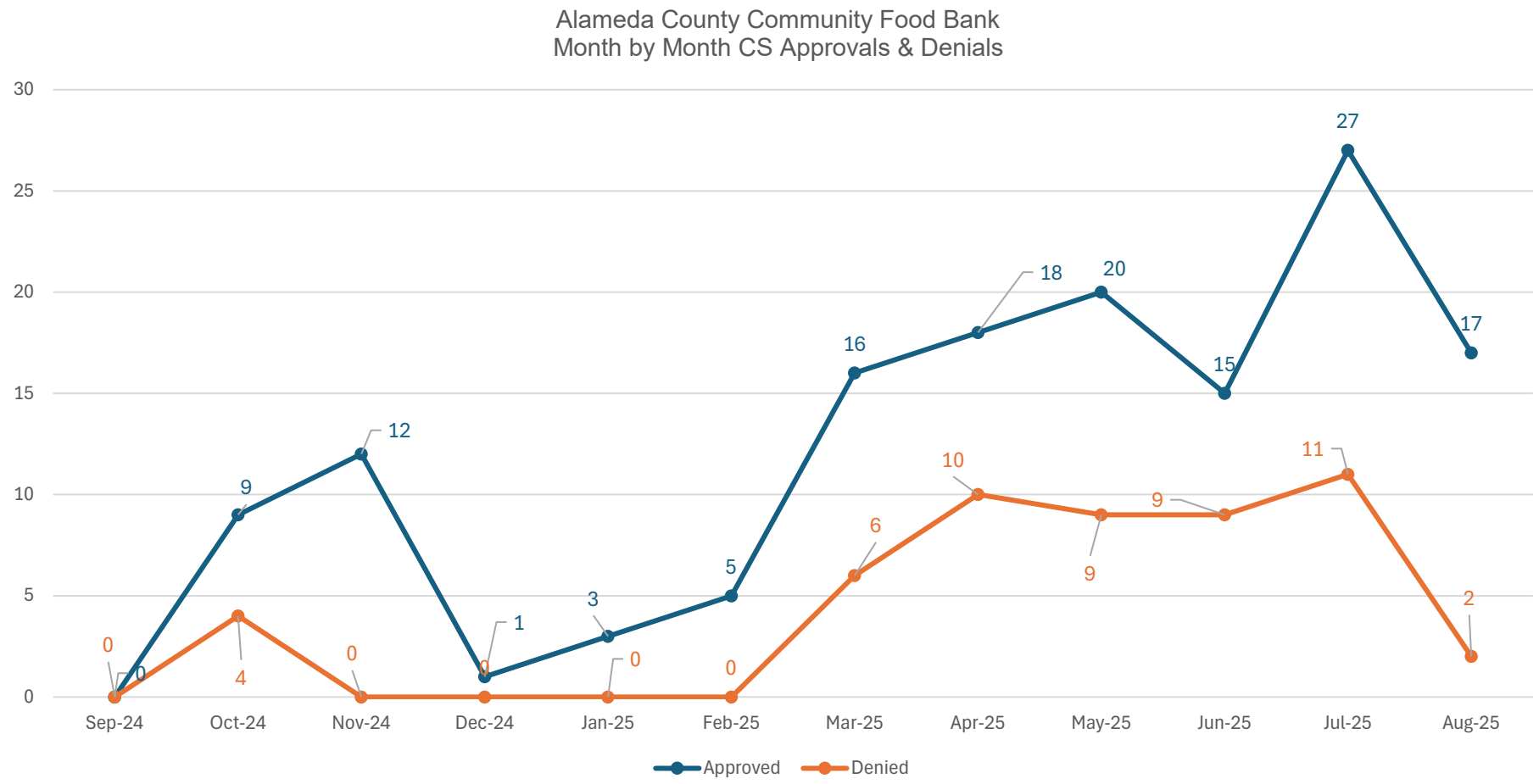
Adeline Recuperative Care + Lifelong



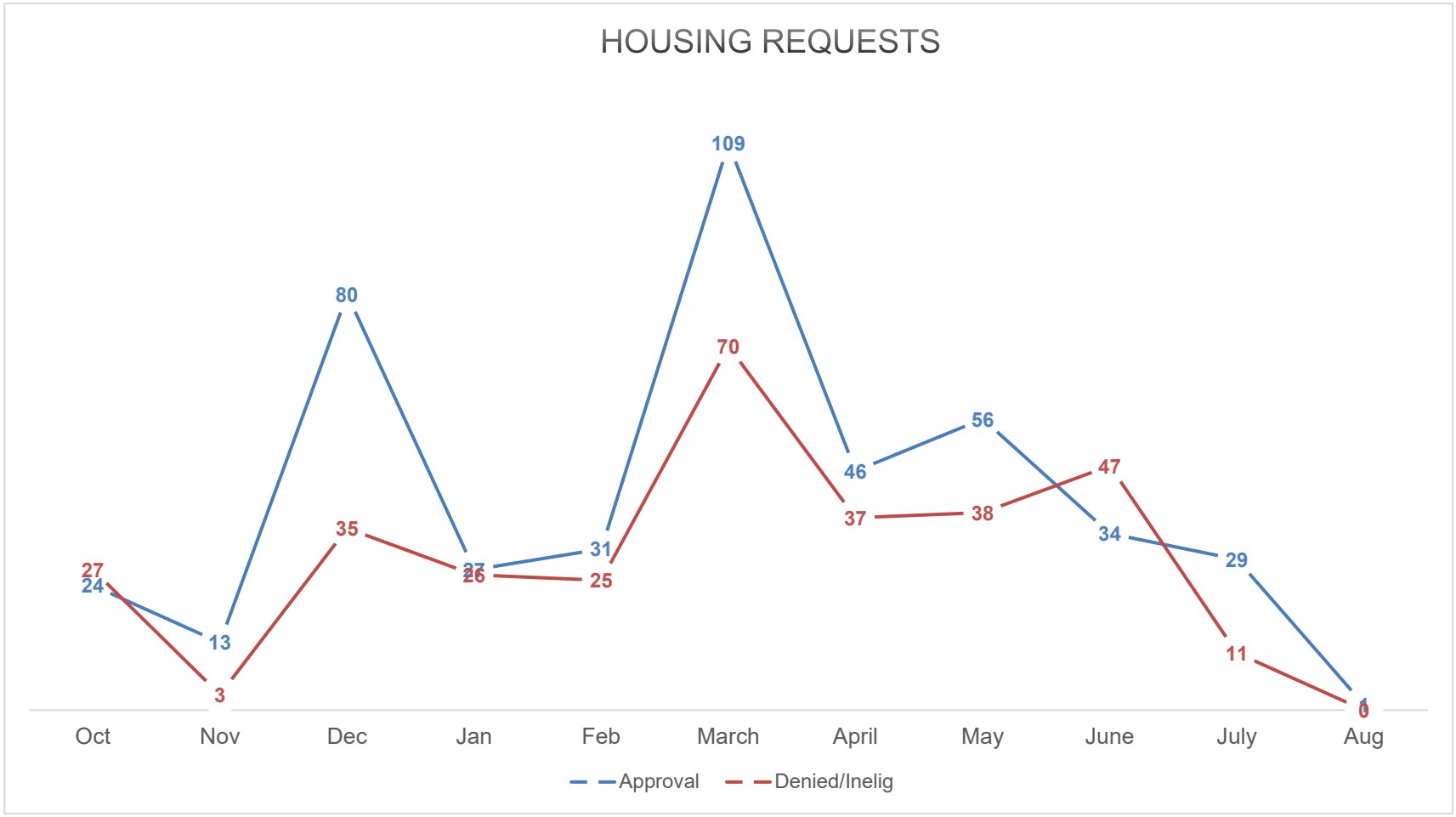
LifeLong Medical Care



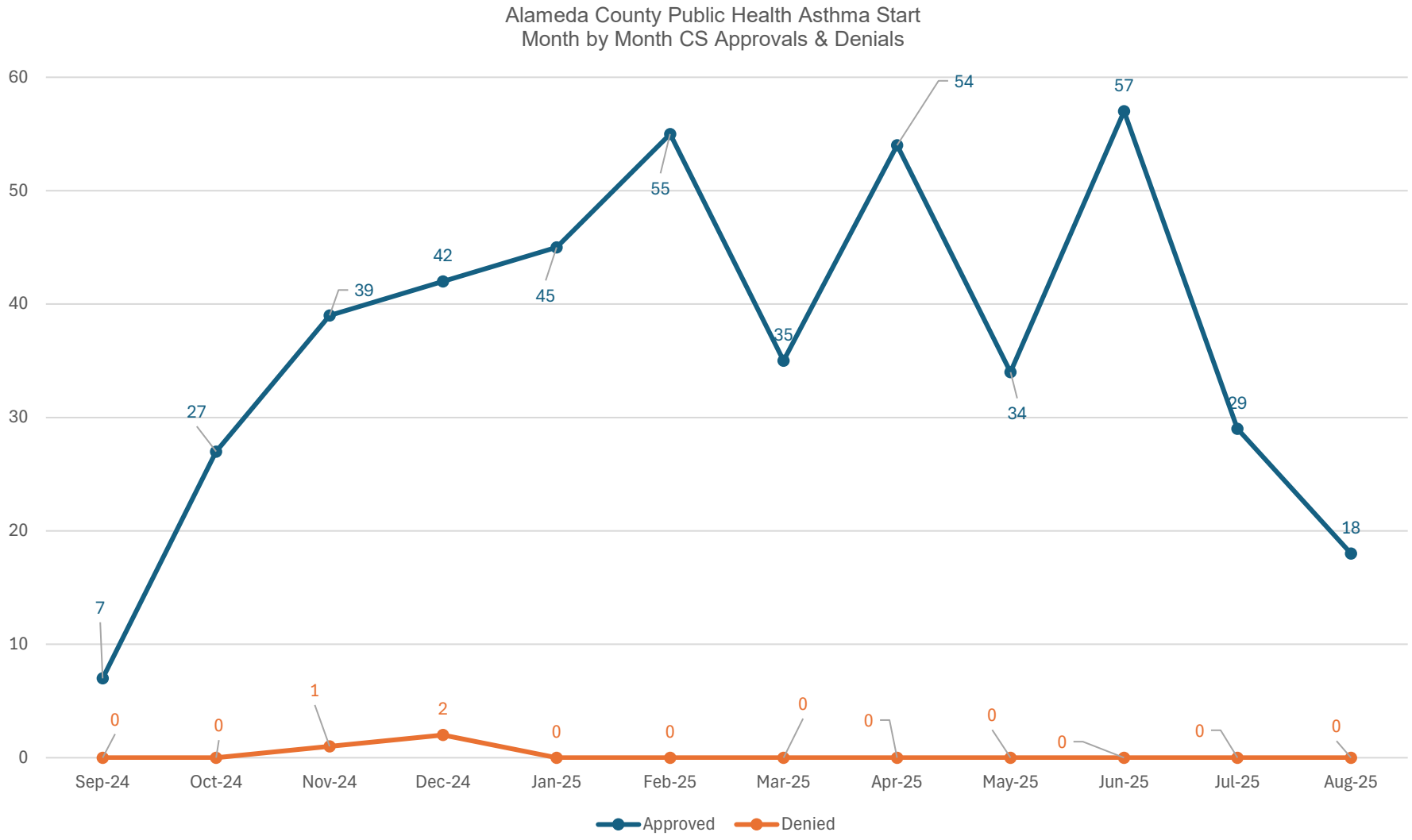
Alameda County Community Food Bank



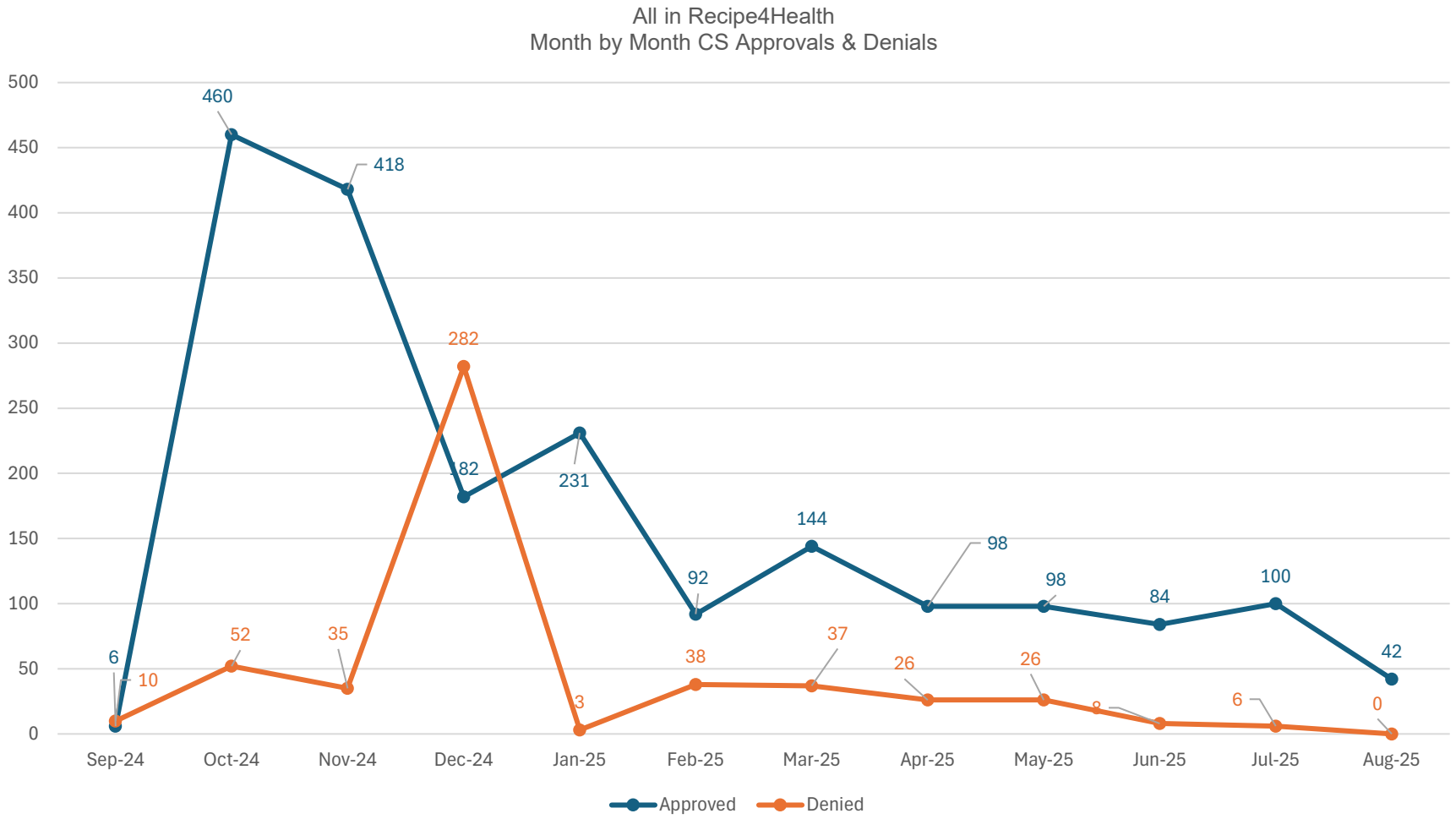
Alameda County Health Care Services Agency - Housing



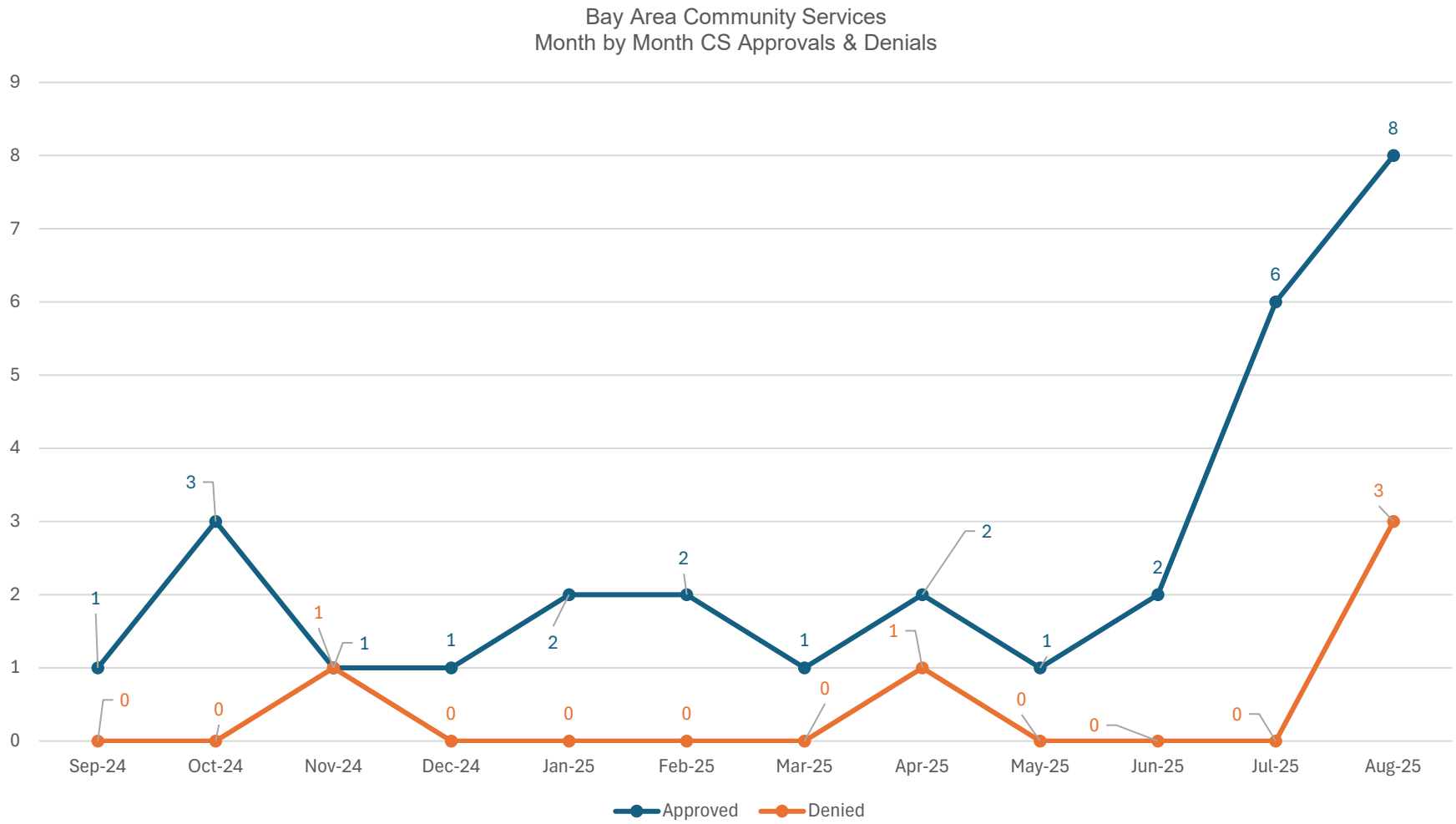
Alameda County Public Health Asthma Start



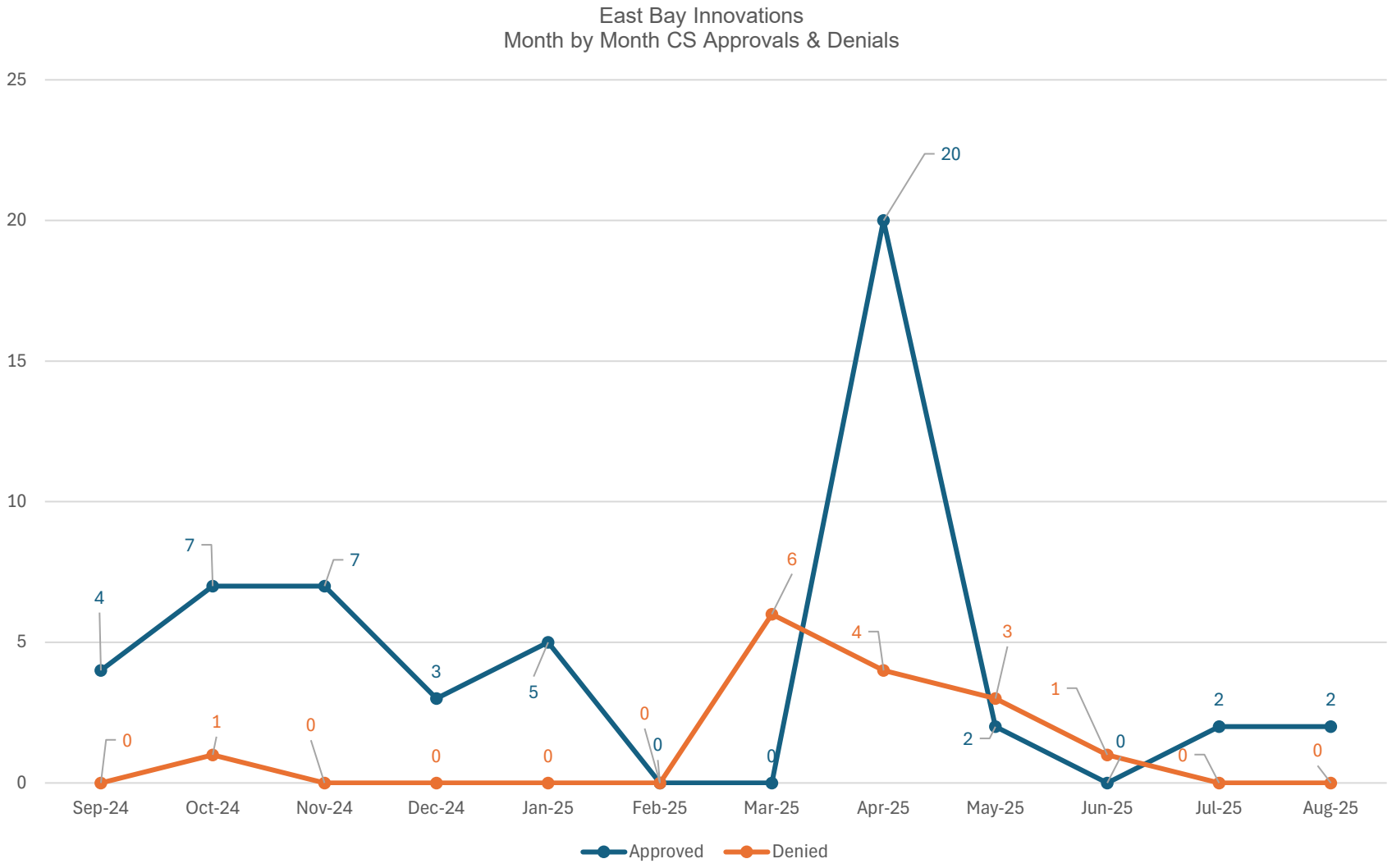
All in Recipe4Health



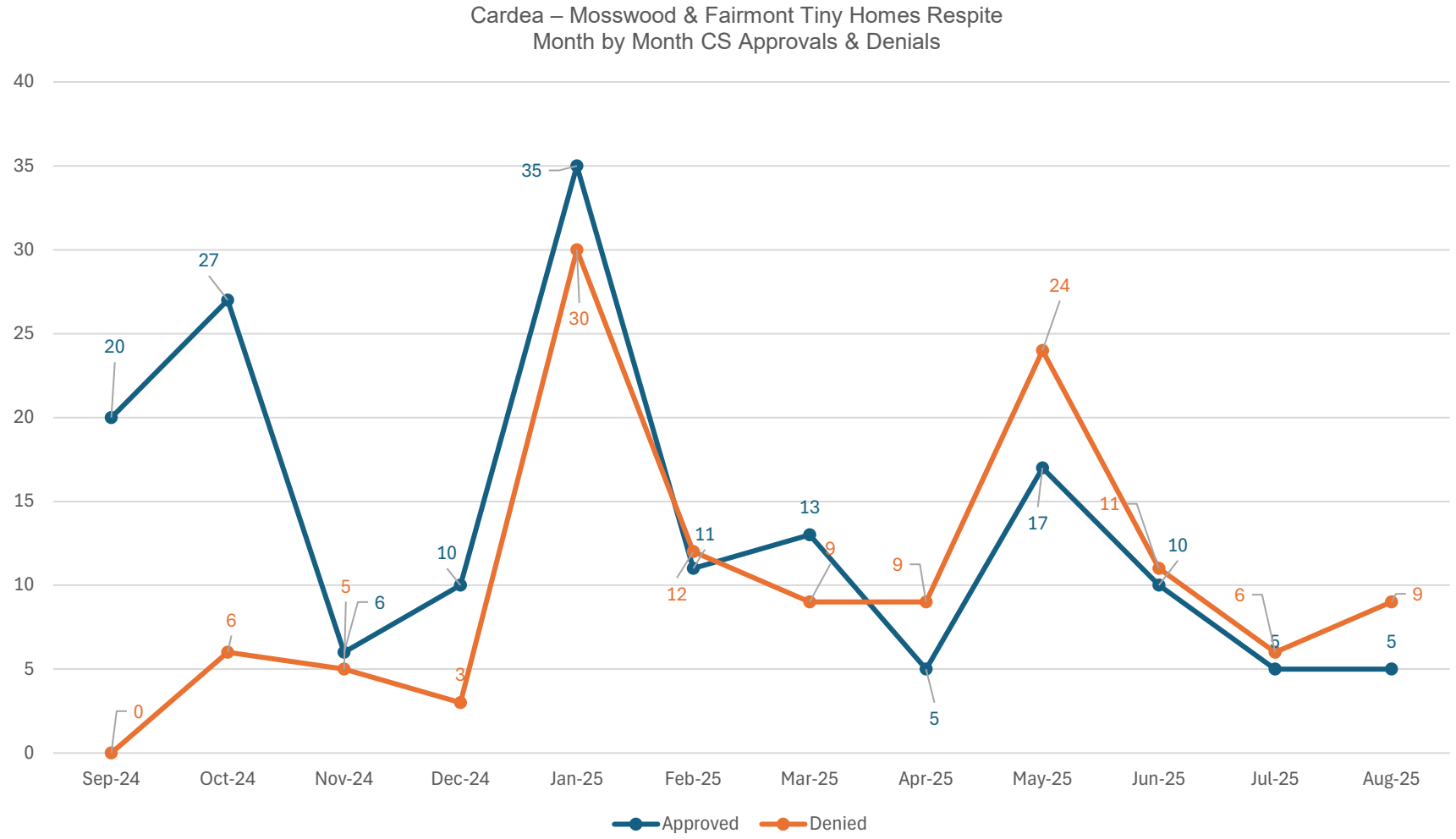
Bay Area Community Services



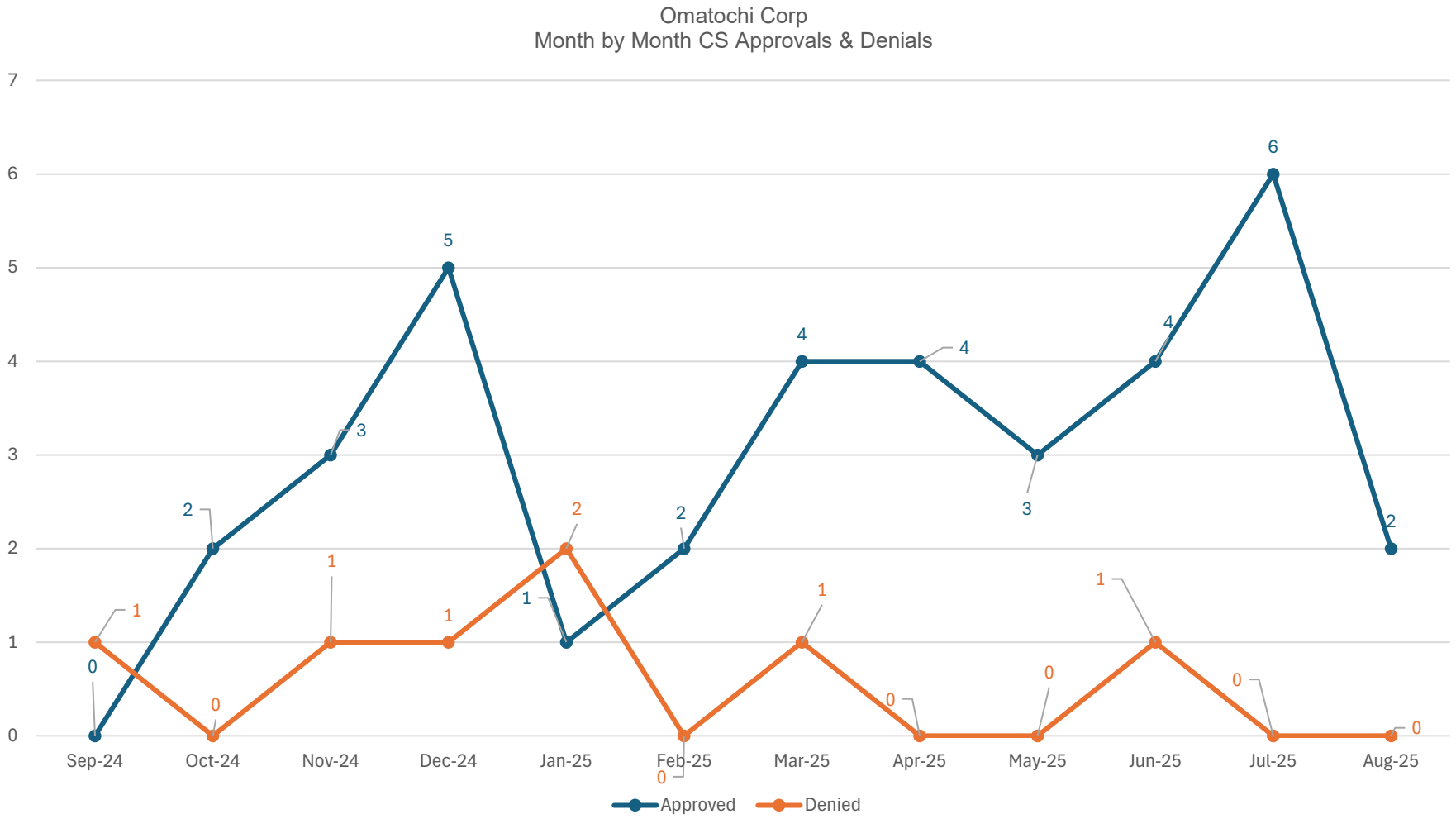
East Bay Innovations



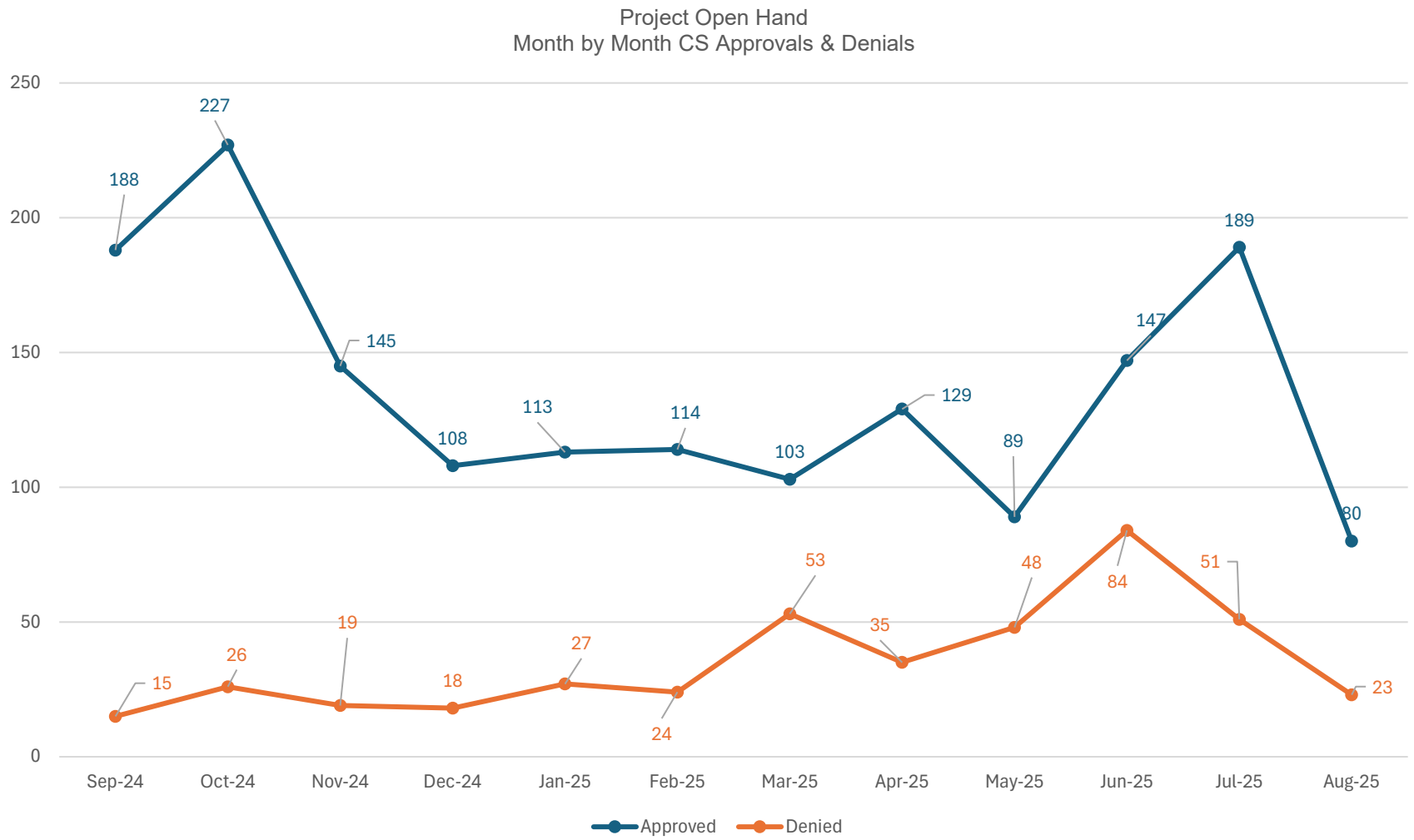
Cardea – Mosswood & Fairmont Tiny Homes Respite



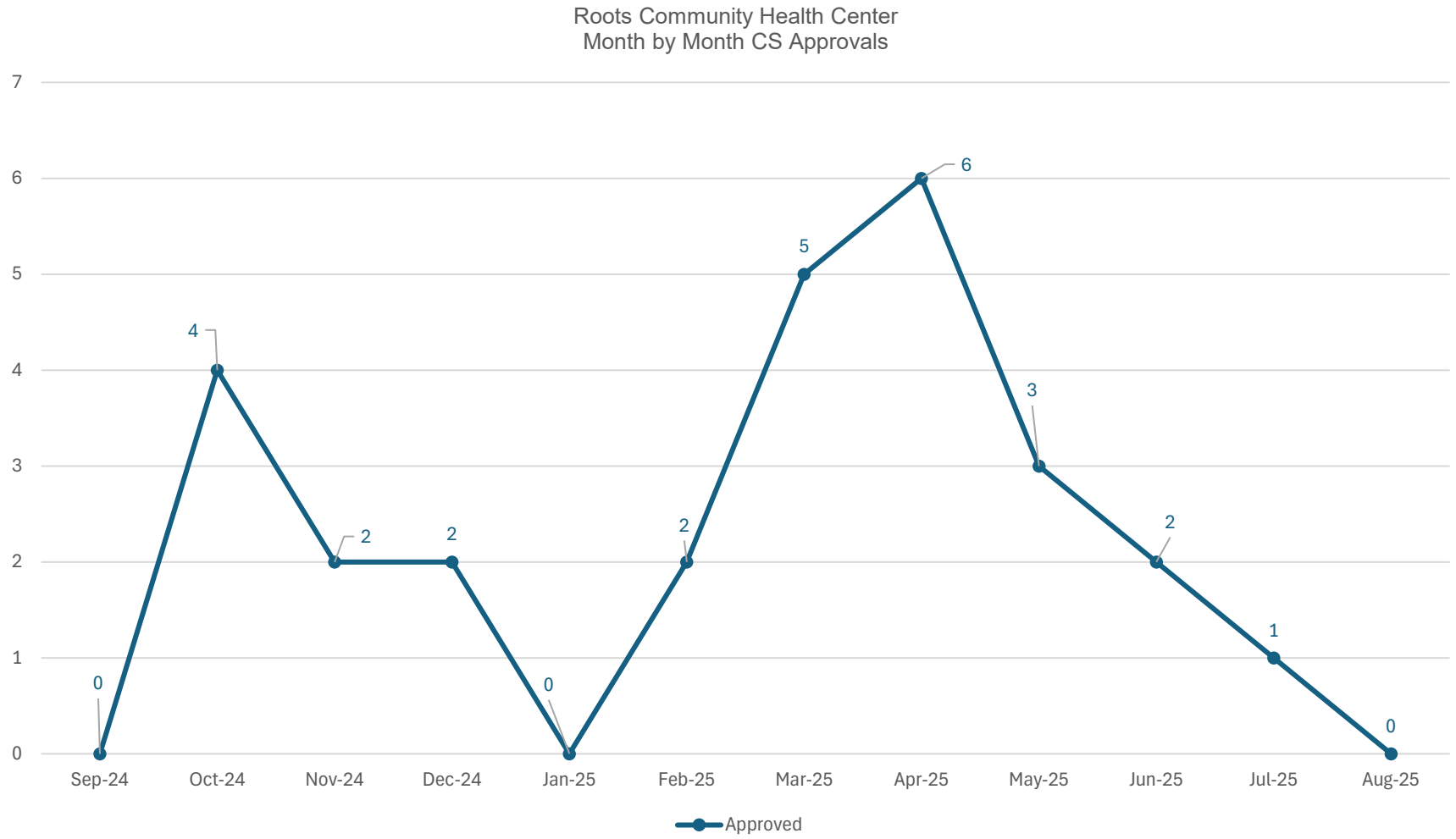
Omatochi Corp



Project Open Hand



Roots Community Health Center



CS Approvals vs Denials by Servicing Type

Sep 2024 – Aug 2025

CS Approvals vs Denials by Service Type

Service Type Sep 2024 – Aug 2025	Approvals	Denials	TOTAL AUTHORIZATIONS
Asthma Remediation	469	4	473
Caregiver Respite	4	19	23
Diversion	4	6	10
Home Modifications	6	4	10
Housing Deposits	570	1	571
Housing Navigation	984	0	984
Housing Tenancy	2102	0	2102
Medical Respite	301	158	459
Medically Tailored Food & Meals	3879	999	4878
Personal Care & Homemaker Services	218	113	331
Transition to Home	13	5	18
TOTAL AUTHORIZATIONS	8550	1309	9859

CS Approvals vs Denials by Service Type

Service Type CY2024	Approvals	Denials	TOTAL AUTHORIZATIONS
Asthma Remediation	123	3	126
Caregiver Respite	2	5	7
Diversion	4	1	5
Home Modifications	0	0	0
Housing Deposits	103	1	104
Housing Navigation	263	0	263
Housing Tenancy	582	0	582
Medical Respite	97	25	122
Medically Tailored Food & Meals	1755	461	2216
Personal Care & Homemaker Services	91	61	152
Transition to Home	4	0	4
TOTAL AUTHORIZATIONS	3024	557	3581

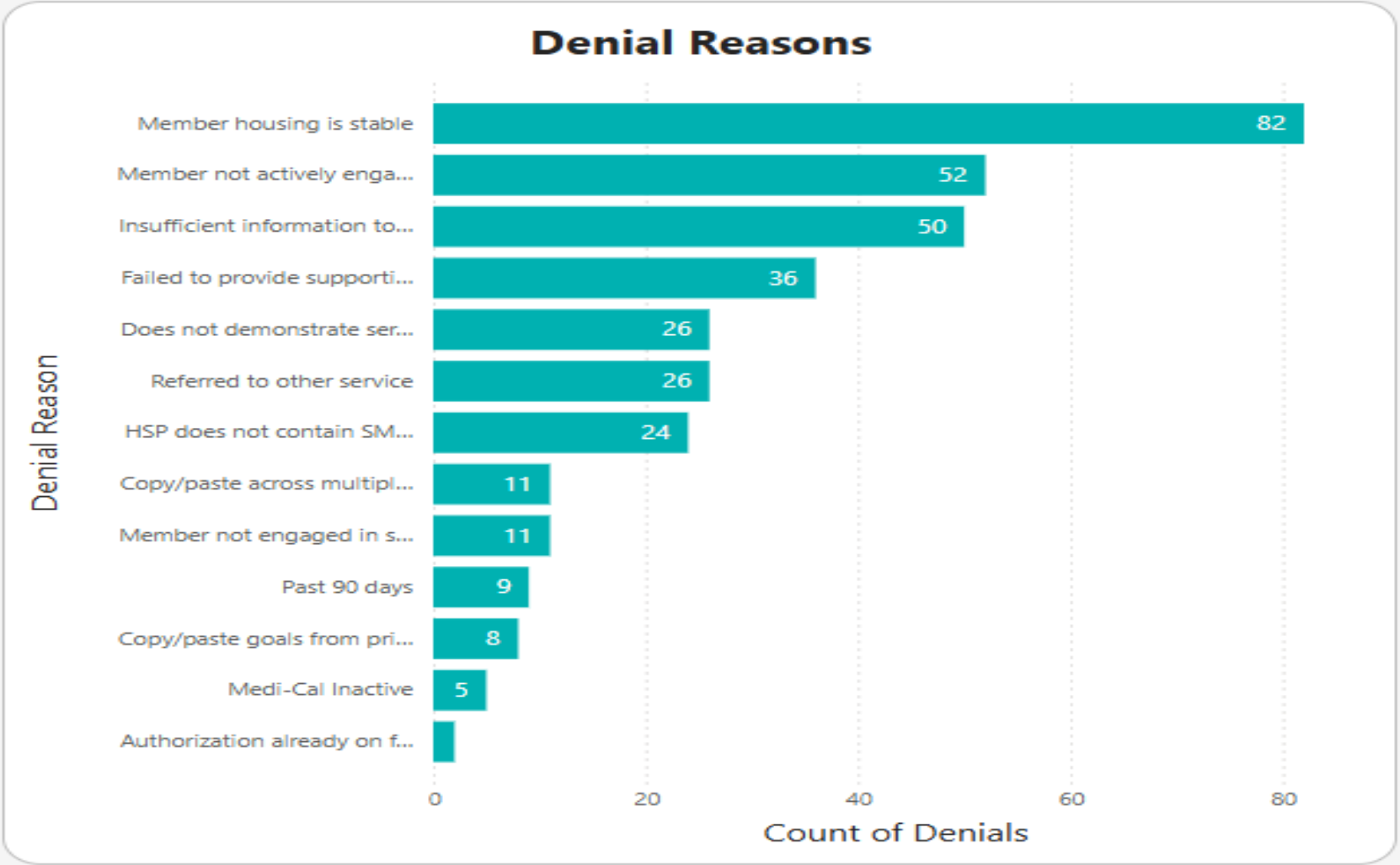
CS Approvals vs Denials by Service Type

Service Type CY2025	Approvals	Denials	TOTAL AUTHORIZATIONS
Asthma Remediation	346	1	347
Caregiver Respite	2	14	16
Diversion	0	5	5
Home Modifications	6	4	10
Housing Deposits	467	0	467
Housing Navigation	721	0	721
Housing Tenancy	1520	0	1520
Medical Respite	204	133	337
Medically Tailored Food & Meals	2124	538	2662
Personal Care & Homemaker Services	127	52	179
Transition to Home	9	5	144
TOTAL AUTHORIZATIONS	5526	752	6278

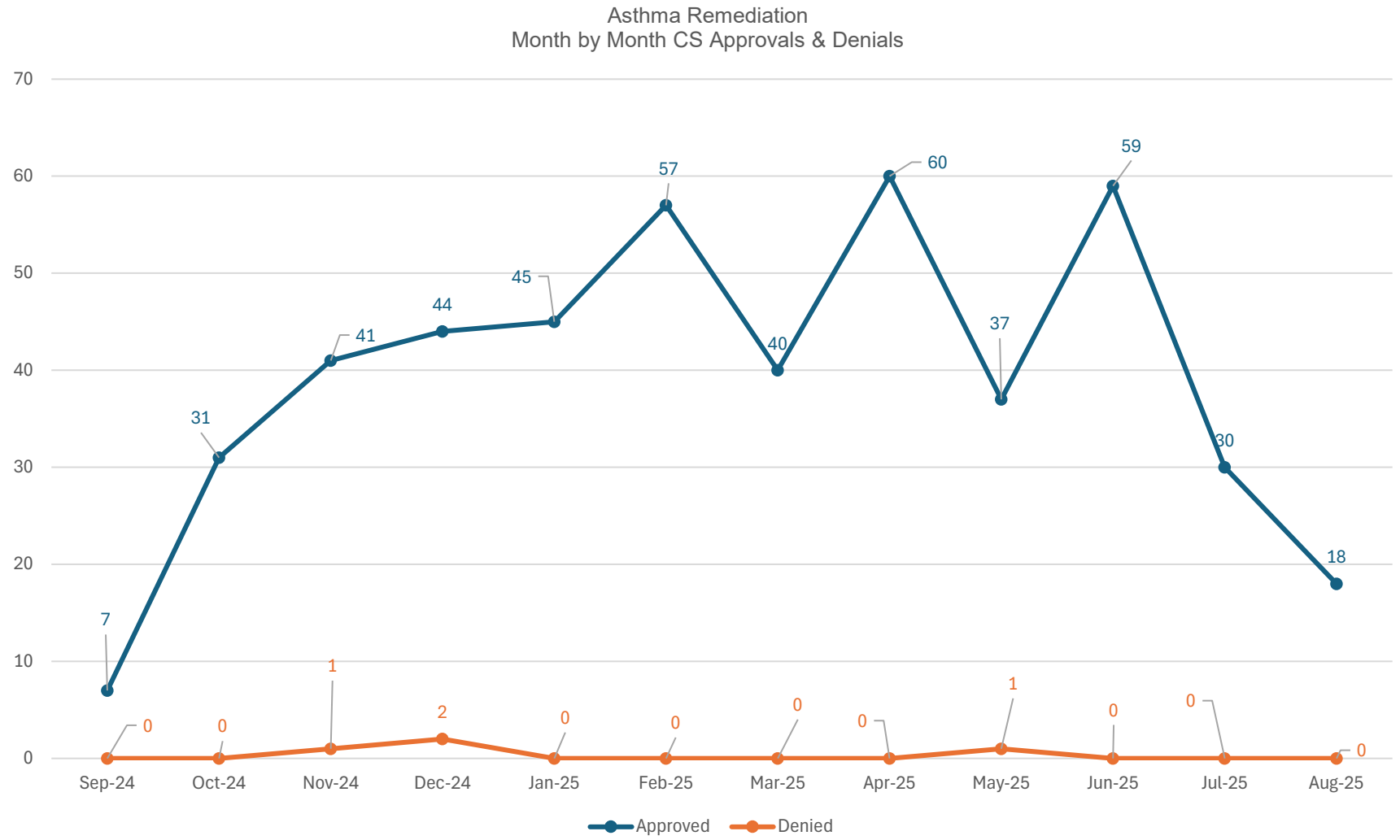
CS Denial Reasons by Service Type

Service Type CY2025	Total Denials	Criteria Not Met	Information Not Received *Reason available in June 2025
Asthma Remediation	1	1	0
Caregiver Respite	14	13	0
Diversion	5	5	0
Home Modifications	4	4	0
Housing Deposits	0	0	0
Housing Navigation	0	0	0
Housing Tenancy	0	0	0
Medical Respite	133	122	0
Medically Tailored Food & Meals	538	487	29
Personal Care & Homemaker Services	52	48	1
Transition to Home	5	5	0
Total Denials	752	685	30

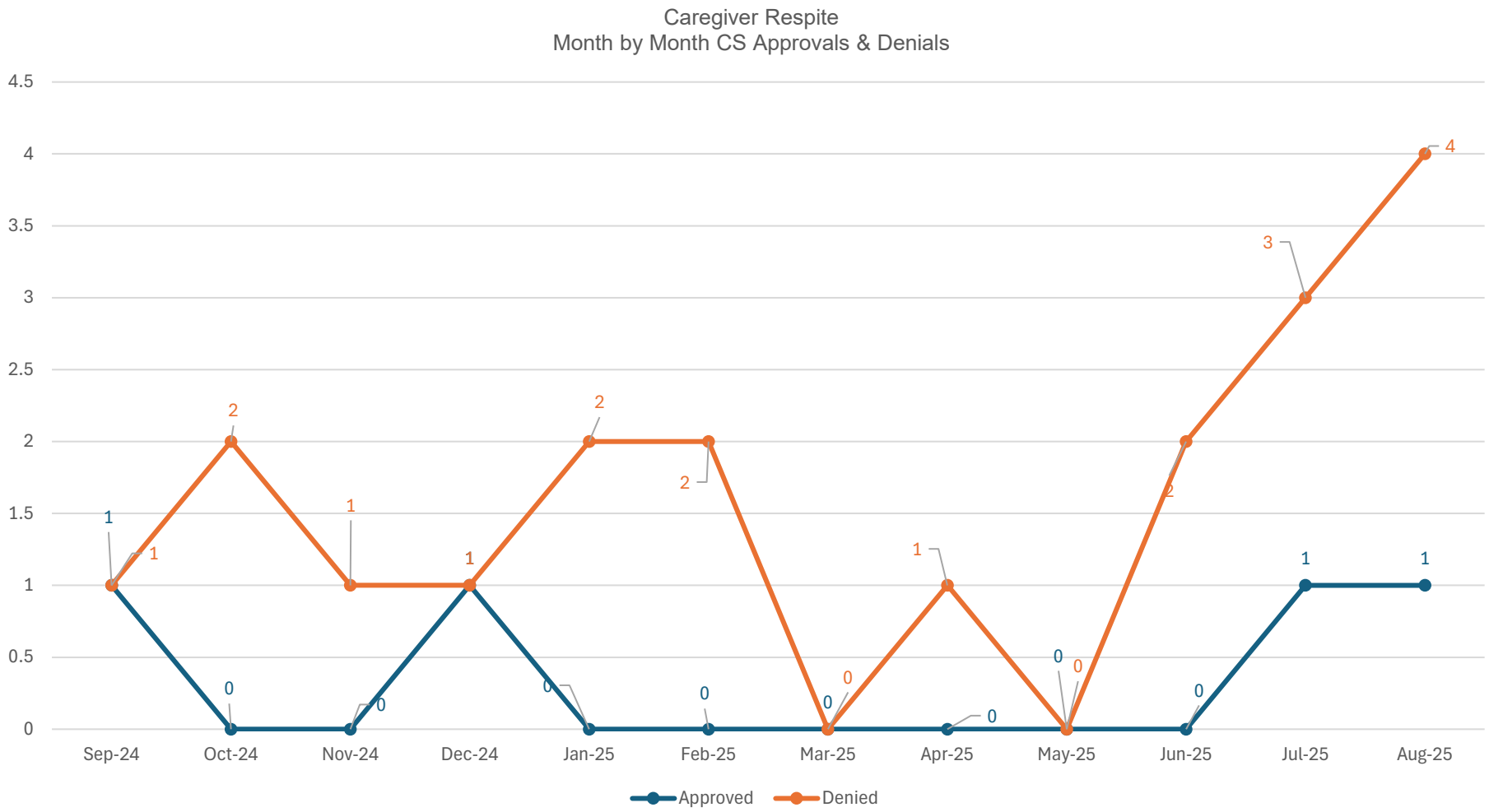
CS Denial Reasons Housing



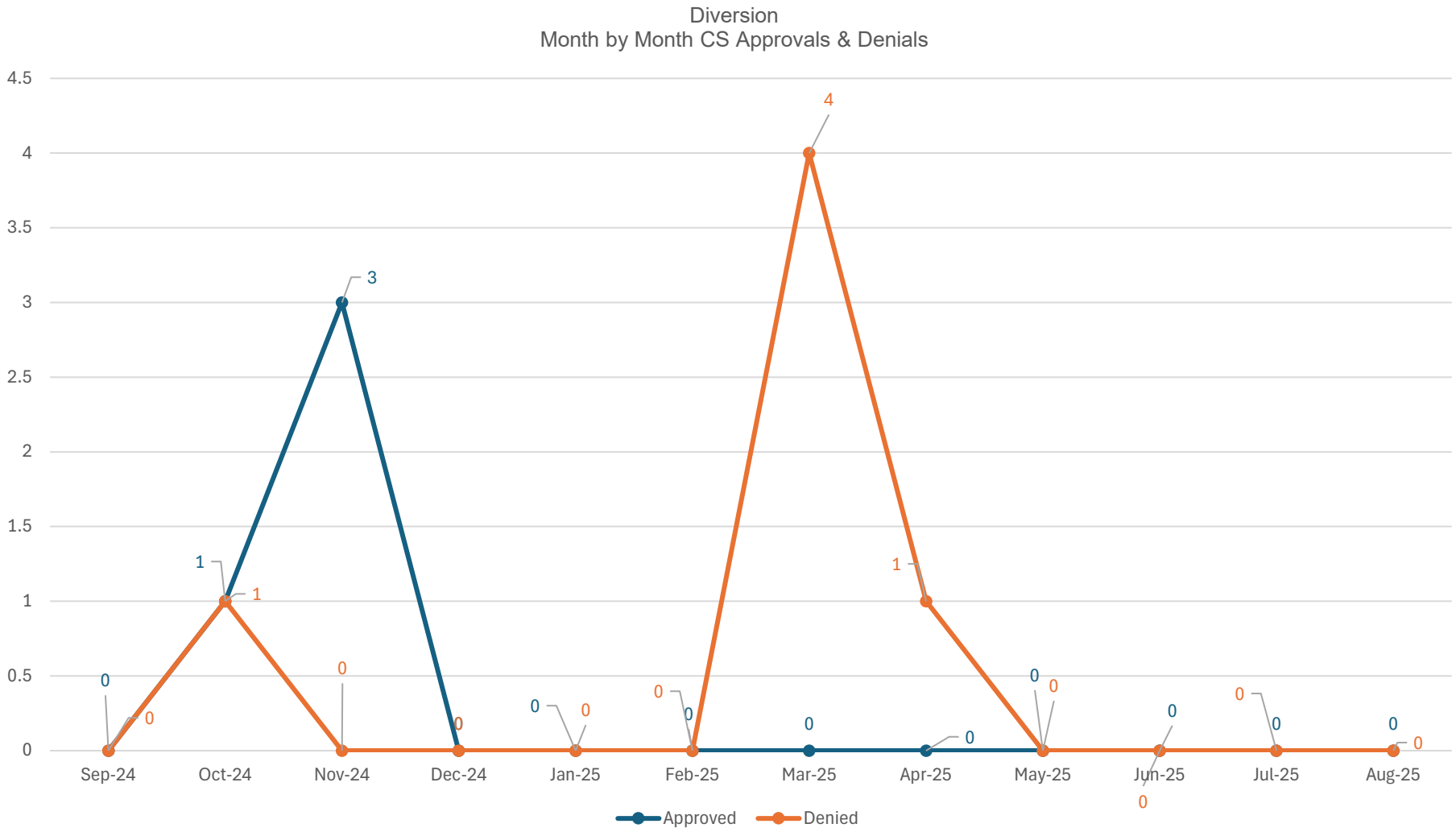
Asthma Remediation



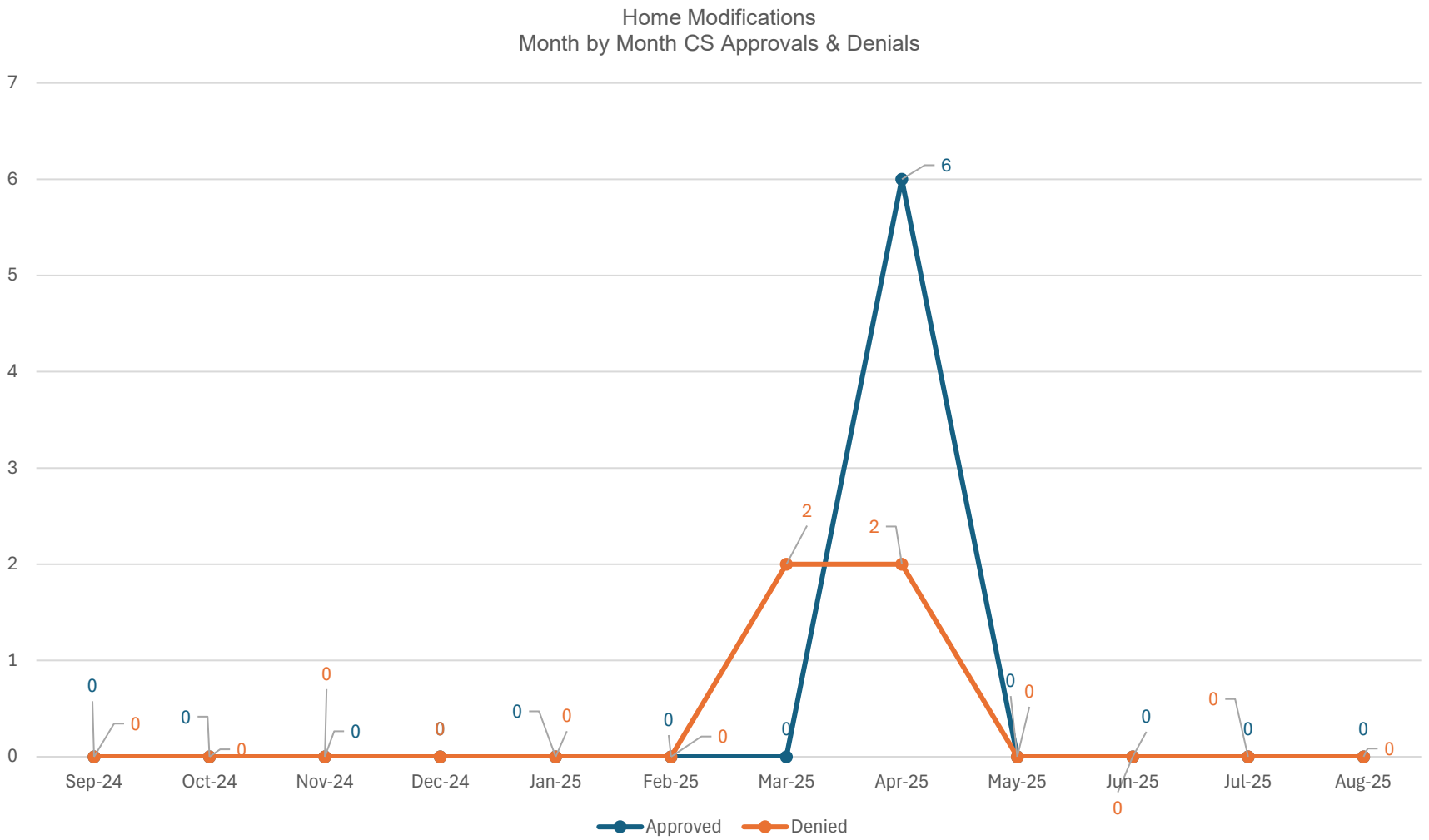
Caregiver Respite



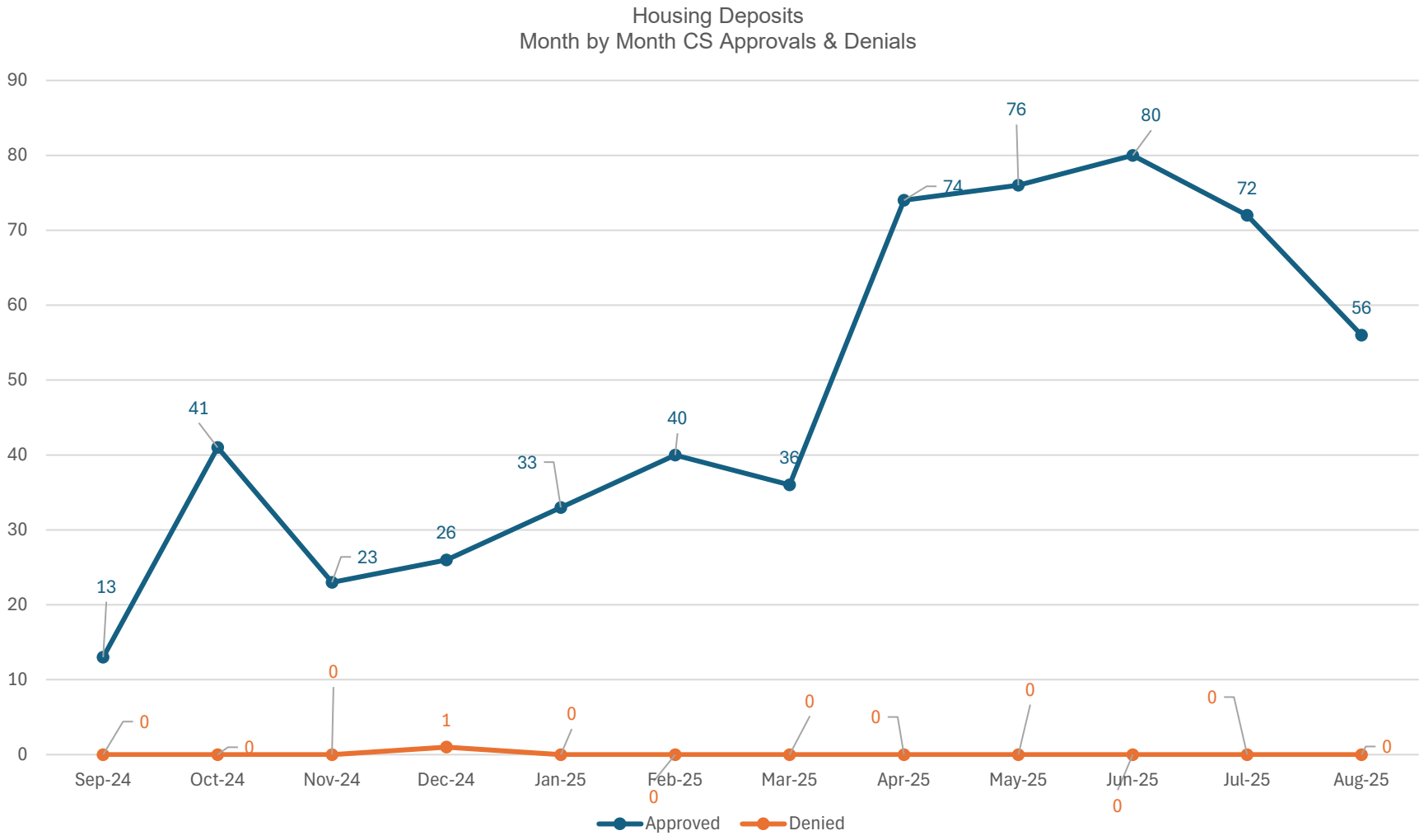
Diversion


Diversion
Month by Month CS Approvals & Denials
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25
Apr-25
May-25
Jun-25
Jul-25
Aug-25
Approved
Denied

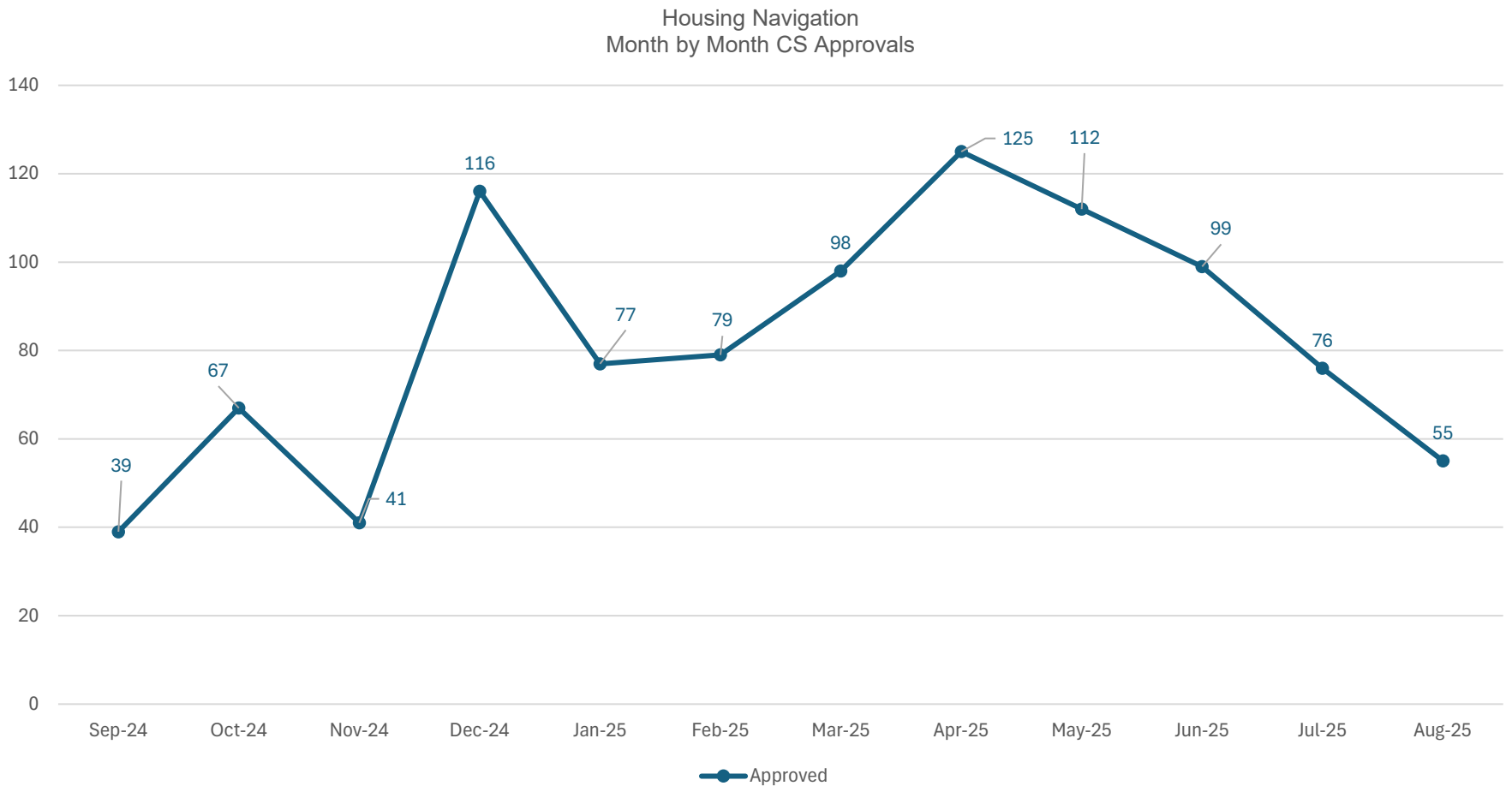
Home Modifications



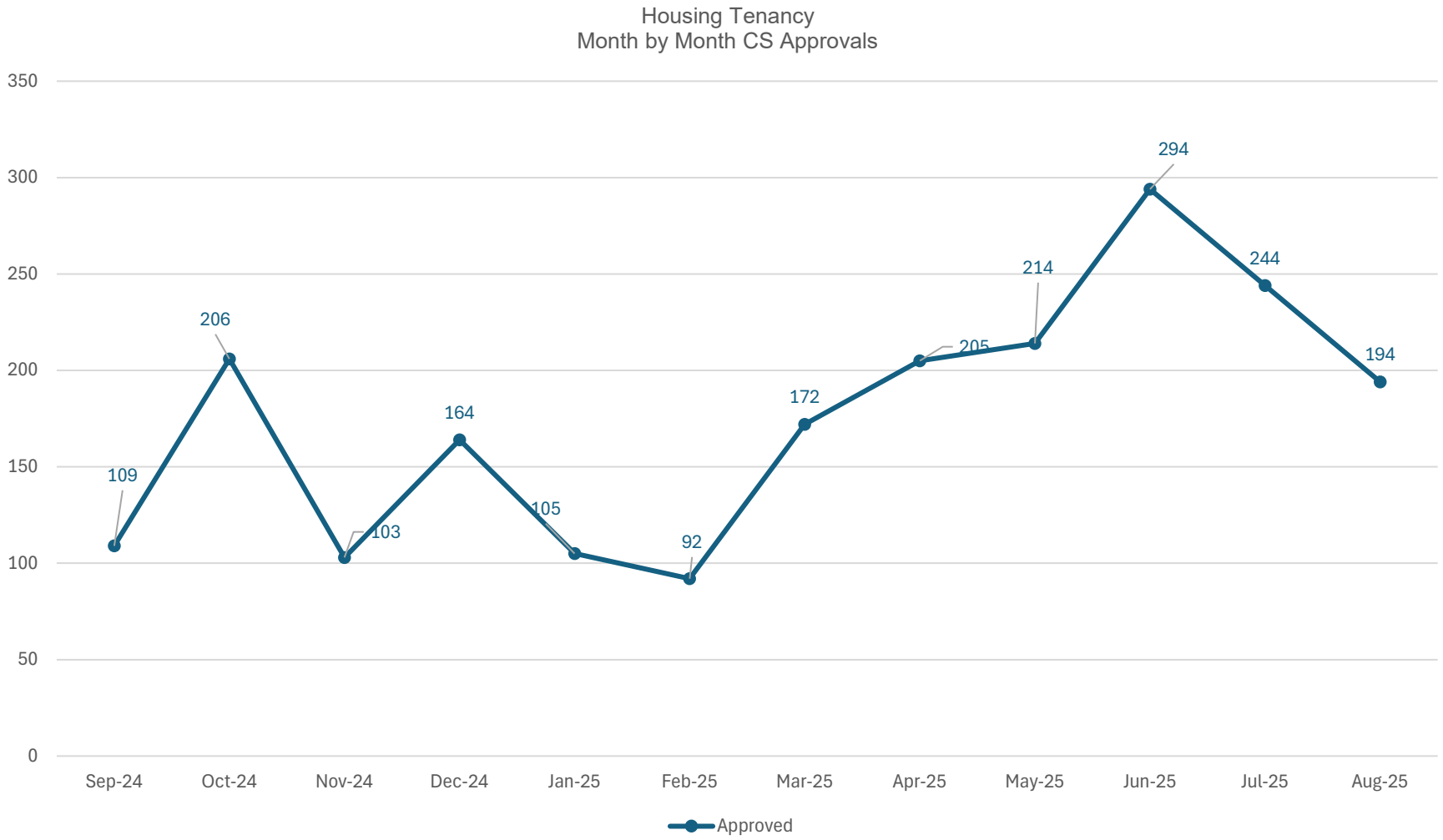
Housing Deposits



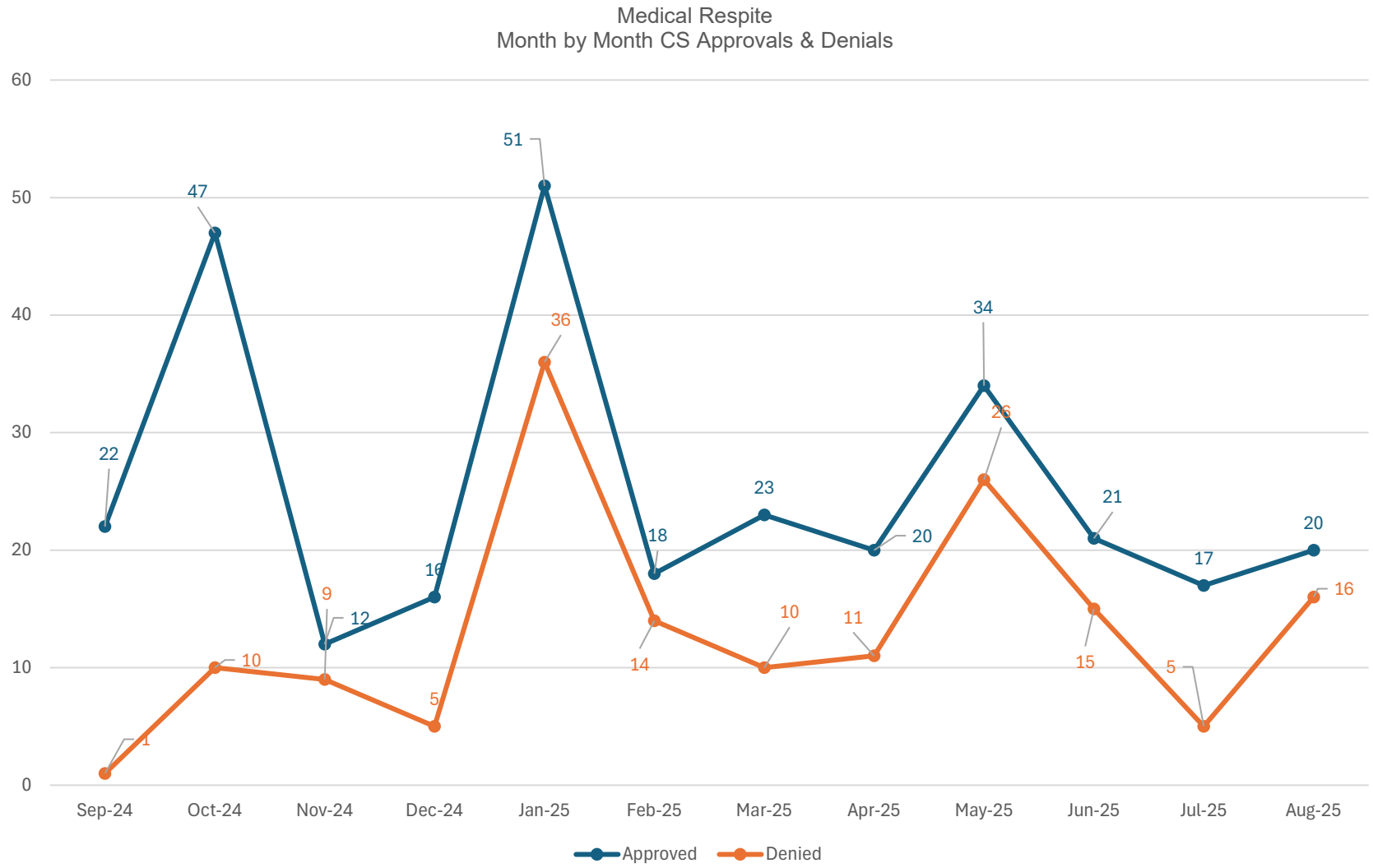
Housing Navigation



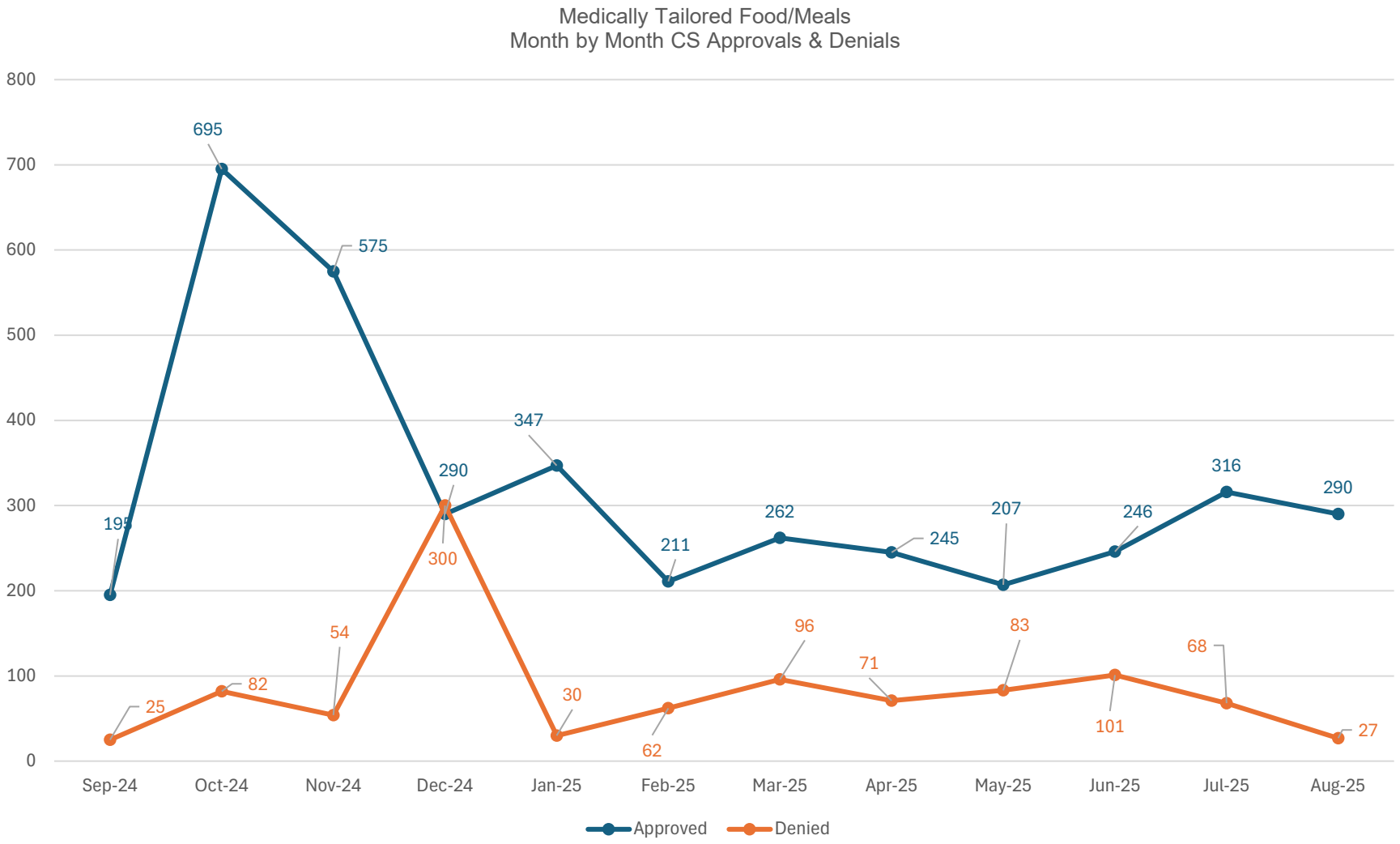
Housing Tenancy



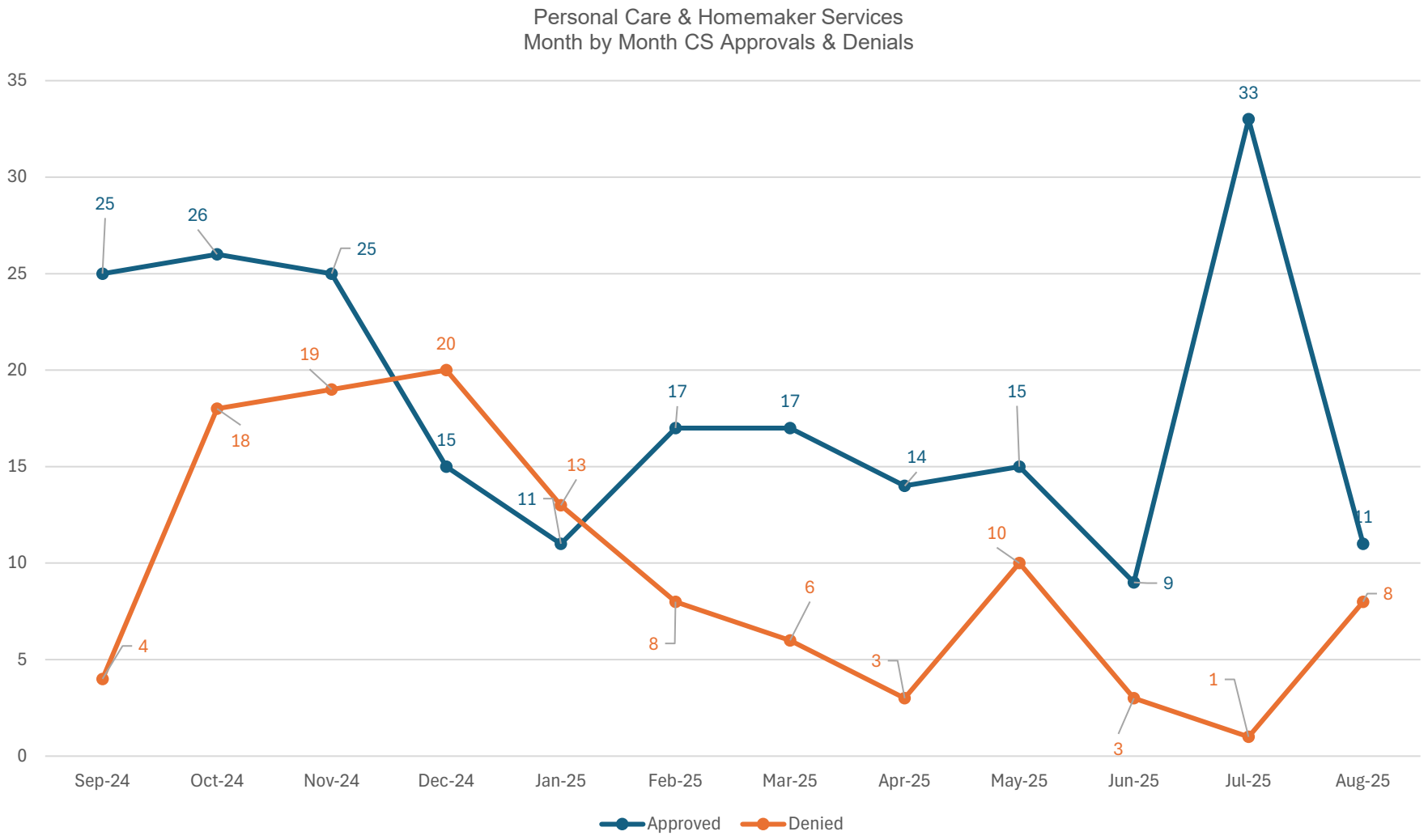
Medical Respite



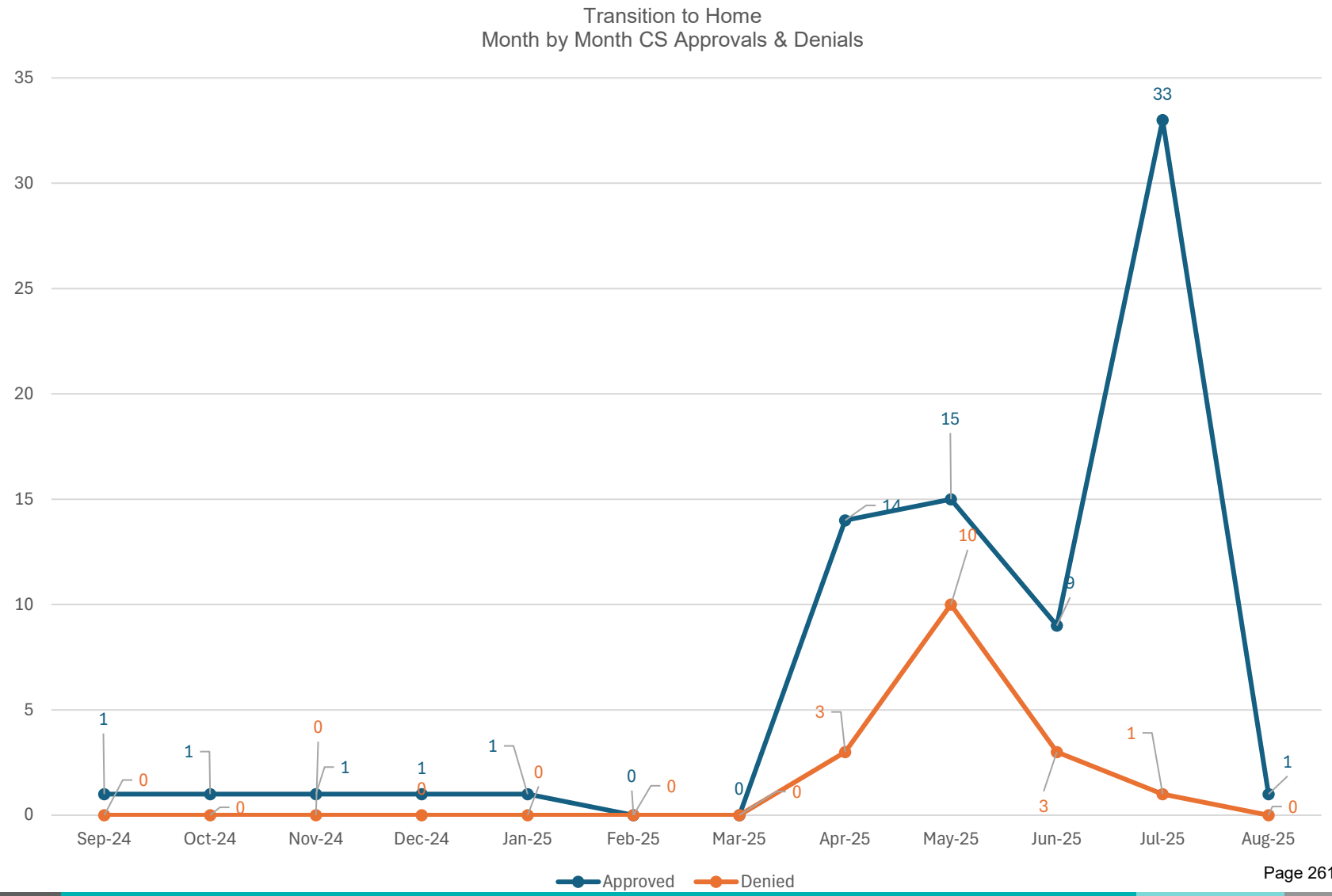
Medically Tailored Food/Meals



Personal Care & Homemaker Services



Transition to Home



Thanks!

Questions?

You can contact me at:

dlo@alamedaalliance.org
kglasby@alamedaalliance.org

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: **September 12th, 2025**

Subject: **Operations Report**

Member Services

- 12-Month Trend Blended Summary:
    - The Member Services Department received 18,859 calls in August 2025 compared to 18,855 in August 2024 and represents a .02% increase in calls.
    - The abandonment rate for August 2025 was 5% compared to 3% in August 2024.
    - The Department's service level was 94% in August 2025, compared to 94% in August 2024. The average speed to answer (ASA) was thirteen seconds (00:13) compared to thirteen seconds (00:13) in August 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 forty-seven seconds (07:47) for August 2025 compared to seven minutes and ten seconds (07:10) for August 2024.
    - 100% of calls were answered within 10 minutes for August 2025 and 100% of calls were answered within 10 minutes for August 2024.
    - Outbound calls totaled 9,604 in August 2025 compared to 8,537 in August 2024.
    - The top five call reasons for August 2025 were 1) Eligibility/Enrollment, 2) Change of PCP, 3) Grievances/Appeals, 4) Benefits, 5) ID Card Requests. The top five call reasons for August 2024 were: 1) Change of PCP, 2) Eligibility/Enrollment, 3) Benefits, 4) Grievances/Appeals, and 5) Provider Network.
    - August utilization for the member automated eligibility IVR system totaled 1,398 in August 2025 compared to 1,337 in August 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 1,496 web-based requests in August 2025 compared to 1,323 in August 2024. The top three web reason requests for August 2025 were: 1). Change of PCP, 2) ID Card Requests, and 3) Update Contact Information. 45 members were assisted in-person in August 2025 compared to 73 in 2024.

- Member Services Behavioral Health:

    - The Member Services Behavioral Health (MS BH) Unit received a total of 1,161 calls in August 2025 compared to 1,512 in August 2024.
    - The abandonment rate was 7% in August 2025 compared to 8% in 2024. The service level was 77% in August 2025 and 74% in August 2024.
    - The average speed to answer (ASA) was fifty-five seconds (00:55) compared to one minute and nine seconds (01:09) in August 2024. Service levels were affected by several staff leaves. Two (2) new representatives are in training.
    - Calls answered in 10 minutes were 99% in August 2025 compared to 99% in August 2024.
    - The Average Talk Time (ATT) was nine minutes and forty-four seconds (09:44) compared to eight minutes and twenty-seven seconds (08:27) in August 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.
    - 1,266 outbound calls were completed in August 2025 compared to 1,450 in August 2024.
    - 138 screenings were completed in August 2025 compared to 127 in August 2024.
    - 19 outreach campaigns were completed in August 2025 compared to 95 in August 2024.
    - 52 referrals were made to the County (ACCESS) in August 2025 compared to 31 in August 2024.
    - 21 members were referred to Center Point for SUD services in August 2025 compared to 24 in August 2024.

Claims

- 12-Month Trend Summary:
    - The Claims Department received 389,082 claims in August 2025 compared to 368,235 in August 2024.
    - The Auto Adjudication rate was 84% in August 2025 compared to 84.6% in August 2024.
    - Claims compliance for the 30-day turn-around time was 83.3% in August 2025 compared to 87.1% in August 2024. The 45-day turn-around time was 99.4% in August 2025 compared to 99.9% in August 2024.
- Monthly Analysis:
    - In August, we received a total of 389,082 claims in the HEALTHsuite system; this reflects a 9.52% increase from July 2025. It is also higher than the number of claims received in August 2024 by 20,847.
    - 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.
    - 91% of claims were received via EDI and 9% of claims via paper during August.
    - 99.4% of our claims were processed within 45 working days during the month.
    - The Auto Adjudication rate was 84% for August.

Provider Dispute Resolution

- 12-Month Trend Summary:
    - In August 2025, the Provider Dispute Resolution (PDR) team received 2,762 PDRs versus 2,193 in August 2024. This represents a decrease of -37.6% from July 2025 but is 25.9% higher than the number of PDRs received in August 2024.
    - The PDR team resolved 2,769 cases in August 2025 compared to 2,602 cases in August 2024.
        - In August 2025, the PDR team upheld 75% of cases versus 62% in August 2024.
        - The PDR team resolved 99.7% of cases within the compliance standard of 95% within 45 working days in August 2025, compared to 99.5% in August 2024.
- Monthly Analysis
    - The Alliance received 2,762 PDRs in August 2025.
    - In the month of August, 2,769 PDRs were resolved, with 2,071 being upheld and 698 being overturned.
    - 2,761 out of 2,769 cases were resolved within 45 working days, resulting in a 99.7% compliance rate.
    - The average turnaround time for resolving PDRs in August was 37 days.
    - There were 5,648 PDRs pending resolution as of 08/31/2025, with no cases older than 45 working days.
    - The overturn rate for PDRs was 25%, which did meet our goal of 25% or less.

Grievances & Appeals

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

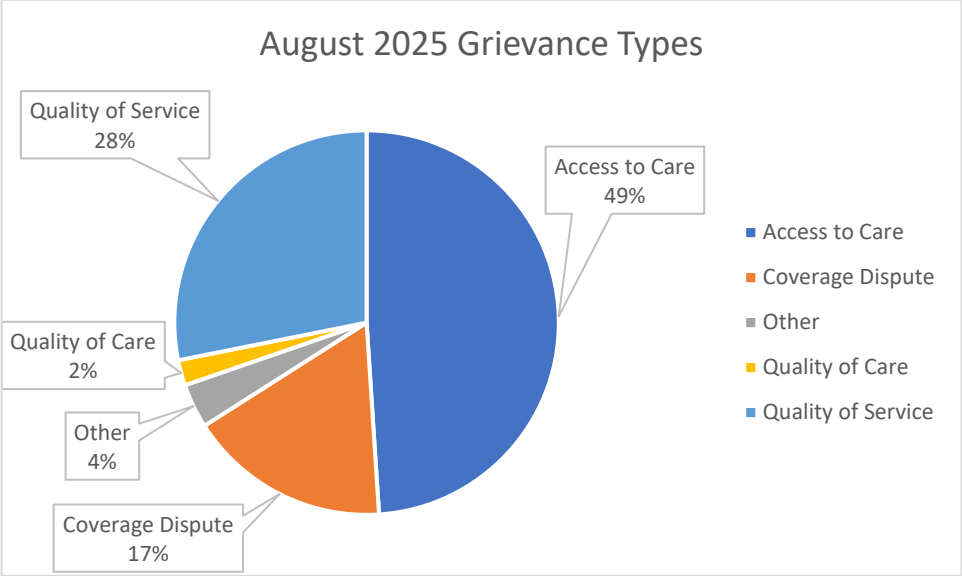
- Total Unique grievances resolved in August were 8.50 complaints per 1,000 members.

August 2025 Cases	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate	Per 1,000 Members*
Standard Grievance	2,565	30 Calendar Days	95% compliance within standard	2,461	95.9%	5.05
Expedited Grievance	4	72 Hours	95% compliance within standard	2	50.0%	0.00
Exempt Grievance	1,613	Next Business Day	95% compliance within standard	1,612	99.9%	3.44
Standard Appeal	117	30 Calendar Days	95% compliance within standard	111	94.9%	0.27
Expedited Appeal	2	72 Hours	95% compliance within standard	1	50.0%	0.00
Total Cases:	4,301		95% compliance within standard	4,187	97.3%	8.50

*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 2,059 unique grievance cases resolved during the reporting period, with a total of 2,565 grievances including 506 shadow cases.



- **1,258** of 2,569 (49%) cases were related to Access to Care; the following are the top four (4) categories:
  - Technology/Telephone – 369

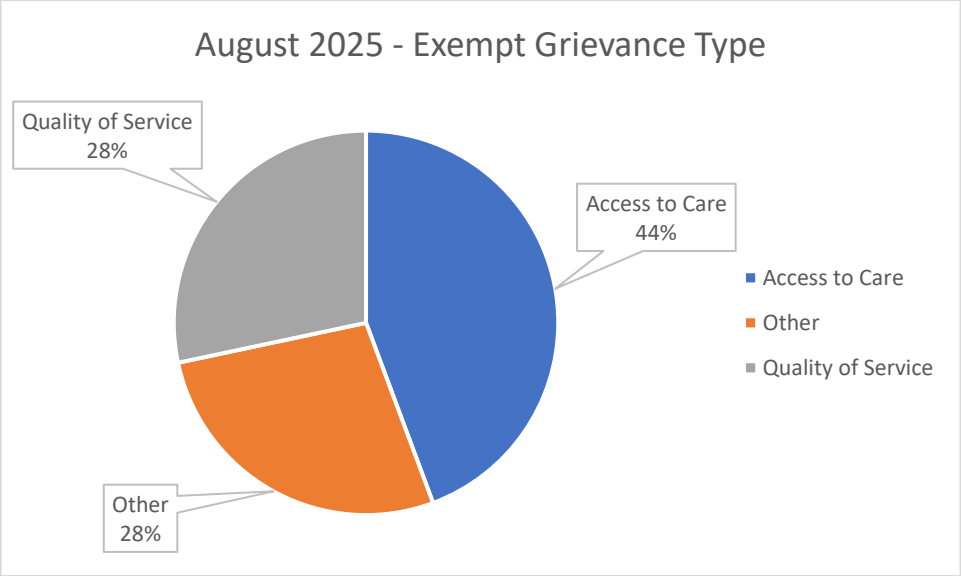
- Timely Access – 357
- Provider Availability – 208
- Authorization – 151

- **723** of 2,569 (28%) cases were related to Quality of Service; the following are the top four (4) categories:
  - Plan Customer Service – 156
  - Referral – 136
  - Authorization – 125
  - Provider/Staff Attitude – 111

- **437** of 2,569 (17%) cases were related to Coverage Dispute; the following are the top two (2) categories:
  - Provider Direct Member Billing – 219
  - Provider Balance Billing – 133

Exempt Grievances:

There were 1,612 unique exempt grievance cases resolved during the reporting period, with a total of 1,613 exempt grievances including 1 shadow case.



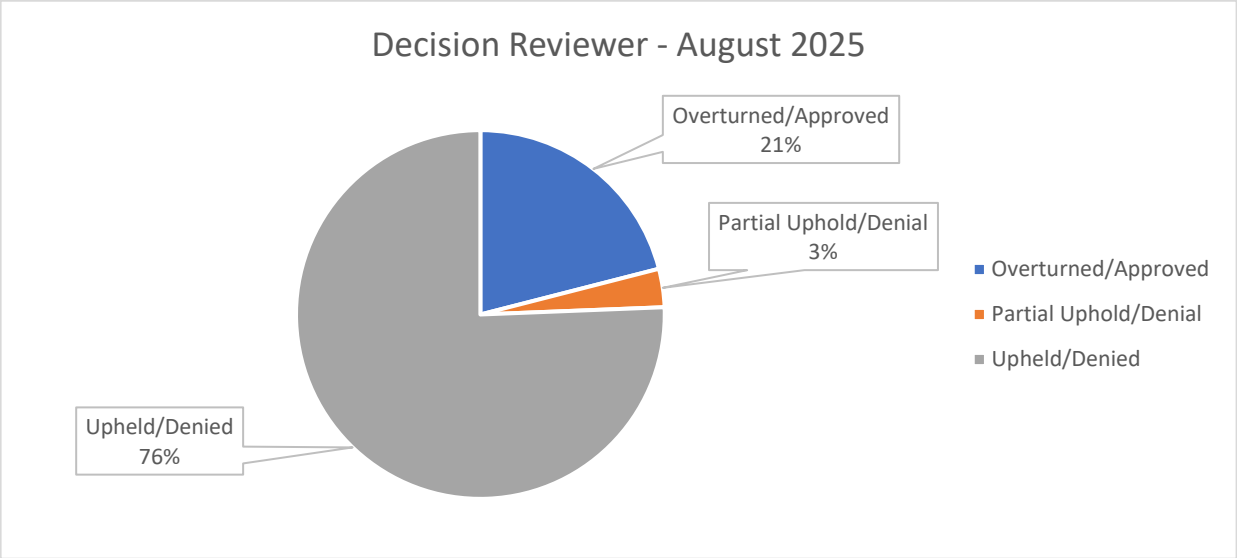
- **715** of 1,613 (44%) cases were related to Access to Care; the following are the top three (3) categories:
  - Telephone/Technology – 398
  - Provider Availability – 158
  - Geographic Access – 104

- **457** of 1,613 (28%) cases were related to Quality of Service; the following are the top two (2) categories:
  - Plan Customer Service – 356
  - Provider/Staff Attitude – 167

- **441** of 1,613 (28%) cases were related to Other; the following are the top two (2) categories:
  - Enrollment – 389
  - Eligibility – 52

Appeals:

The Alliance's goal is to have an overturn rate of less than 25%; for the reporting period of August 2025, we met our goal with a 24% overturn rate.



- **90** out of 119 (76%) cases were upheld/denied for the month of August 2025:
  - Disputes Involving Medical Necessity – 70
  - Out of Network – 20

- **25** out of 119 (21%) cases were overturned for the month of August 2025:
  - Disputes Involving Medical Necessity – 22
  - Out of Network – 2
  - Coverage Dispute – 1

- **4** out of 119 (3%) cases were partially upheld/denied for the month of August 2025:
  - Disputes Involving Medical Necessity – 2
  - Out of Network – 2

Provider Services

- 12-Month Trend Summary:

- The Provider Services department's call volume in August 2025 was 8,838 calls compared to 8,233 calls in August 2024.
- Provider Services continuously works to achieve first call resolution and reduction of the abandonment rates. Efforts to promote provider satisfaction is our first priority.
- The Provider Services department completed 368 calls/visits during August 2025.
- The Provider Services department answered 6,981 calls for August 2025 and made 650 outbound calls.

Credentialing

- 12-Month Trend Summary:

  - At the Peer Review and Credentialing (PRCC) meeting held on August 19h, 2025, there were 104 initial network providers approved; 4 primary care providers, 6 specialists, 9 ancillary providers, 12 midlevel providers, and 103 behavioral health providers. Additionally, 84 providers were re-credentialed at this meeting; 8 primary care providers, 13 specialists, 1 ancillary provider, 8 midlevel providers and 54 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 August 2025, the Alliance completed 866 member orientation outreach calls and 58 member orientations by phone.
  - The C&O Department reached 1,805 people (1,048 identified as Alliance members) during outreach activities, compared to 1,707 individuals (59% self-identified as Alliance members) in August 2024.
  - The C&O Department spent a total of $685.00 on donations, fees, and/or sponsorships, compared to $820 in August 2025.
  - The C&O Department reached members in 10 cities/unincorporated areas throughout Alameda County, compared to 13 cities in August 2024.

- Monthly Analysis:

  - In August 2025, the C&O Department completed 866 member orientation outreach calls and 58 member orientations by phone, 10 Alliance website inquiries, 10 service requests, 6 community and 2 member education events.
  - Among the 1,805 people reached, 58% identified as Alliance members.
  - In August 2025, the C&O Department reached members in 10 locations throughout Alameda County.

- 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 Board Report – August 2025 Activities

Current Incentive and Grant Programs

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

- The Alliance earned a total of $9.7M (100% of eligible funds) based on submission of DHCS deliverables and achievement of milestones
  - A total of $8.9M has been paid to LEA and SBHIP partners; in May 2025, the Alliance completed all payments to partners for the POR submission

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

- The Alliance earned $38M out of $44M available under this program based on submission of deliverables and achievement of DHCS-defined metrics
  - $24.5M has been awarded to our HHIP partners to date
- A HHIP funding opportunity was released in June 2024 to SBHIP LEAs to address the challenges of students experiencing homelessness and associated behavioral health needs (i.e., anxiety, depression, etc.)
  - The Alliance received applications from 10 LEAs totaling $1.3M in requests; all submitted applications were approved and work on the funded programs continued
- In a separate HHIP-funded initiative, the Alliance awarded $11.2M in funding to 10 community partners through a program that supports the HHIP goals of reducing and preventing homelessness
  - Projects are underway with activities taking place through 2028 related to capacity building, innovation, diversity and health equity, and housing stability
- The Alliance continues to review partner project deliverables prior to payment and meet with partners to discuss program activities and barriers
  - One partner has withdrawn from the program as they could not reach an agreement with an external partner to complete the work; the unused funding 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
    - $244,976 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
- 2025-26 Program status:
    - PRI program has been 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 has been 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

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
    - The Alliance received $302,463.84 from DHCS that AHS earned for their work and passed that payment on to AHS
- The Population Health Learning Center (PHLC) has requested MCPs sign a Data Sharing Agreement so they can work with a third-party vendor to help calculate Healthcare Effectiveness Data and Information Set (HEDIS) rates; the DSA is currently under review by the Alliance

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

- Scholarships are intended to offset costs related to the following:
    - Medi-Cal Provider Application and Validation for Enrollment (PAVE)
    - Contracting and credentialing with the Alliance
    - Continued education, training, and administrative and operational support required to be a Doula
- Scholarships of up to $1,000 per person are available for Doulas both intending to contract with the Alliance and Doulas already contracted with the Alliance

- MOUs for the 20 scholarship awardees were signed, including seven (7) awards to support currently contracted Doulas and 13 awards for Doulas that intend to contract with the Alliance
    - To date, $14,000 of the available $20,000 in scholarships has been paid to program participants for completion of scholarship deliverables
        - One (1) awardee has withdrawn from the program and one (1) awardee has indicated they will not complete the deliverables required for their final payment; with these changes, the Alliance expects to expend a total of $18,500 instead of $20,000

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 the Alliance participates in
    - Submittable creates an online application process for community partners, an electronic evaluation process, reporting for fund management, and awardee deliverable tracking
    - The Doula Scholarship Program application was piloted within Submittable in December and continues to be used for partner communications and deliverable tracking
    - The Alliance is currently negotiating with Submittable on a Statement of Work to potentially create a dashboard to manage and track program related deliverables, including fund distribution
- California Improvement Network – the Alliance was selected, along with 24 other partners, to participate in an opportunity through the California Improvement Network (CIN), which is a learning and action community that advances equitable health care experiences and outcomes for Californians through cross-sector connections, spreading good ideas, and implementing improvements
    - CIN participation provides the Alliance with an opportunity to partner and connect with other organizations that are also working to improve health equity
    - The Director, Health Equity will be participating in the equity focused learning network and leading project initiatives; I&R will provide program management support
        - The Alliance is receiving a small grant to cover the costs related to travel for participating in program activities
    - Participants are eligible to apply for 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 – 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, the application for a research grant was submitted to the Robert Wood Johnson Foundation on June 4th
    - Unfortunately, the Alliance was informed on August 26th that the RWJF received an exceptionally larger number of applications from across the nation and that we were not selected for funding
- 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 internal and external stakeholders to begin developing 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

Integrated Planning

Ruth Watson

Behavioral Health in an integrated primary care setting. The original program was a $700 million, five (5) year program; however, due to state budget constraints, the program was revised to a $140 million, three (3) year program.

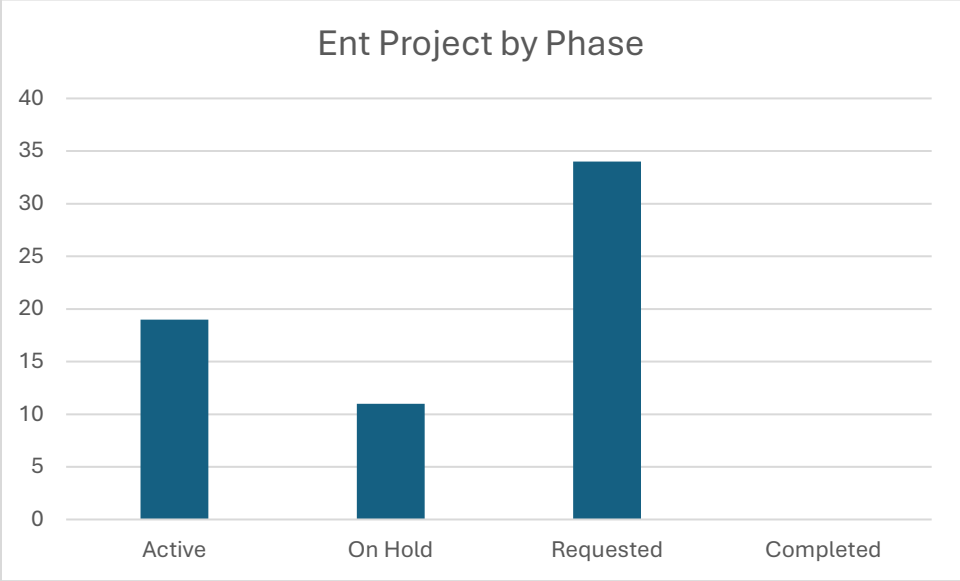
The Provider Recruitment Initiative (PRI) – program launched on June 1st, 2024, and is designed to provide grants to support the Alameda County Safety Net and community-based organizations to hire and retain healthcare professionals who serve the Alameda County Medi-Cal population The PRI aims to grow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

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

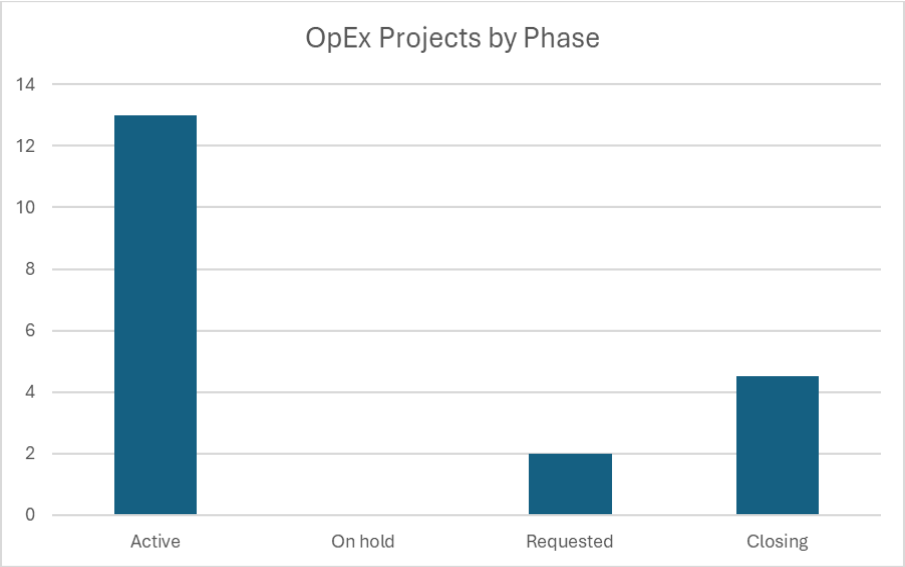
Doula Scholarship Program – program launched in December 2024 to grow the Doula provider network to increase access to these services for members.

INTEGRATED PLANNING DIVISION BOARD REPORT – AUGUST 2025 ACTIVITIES

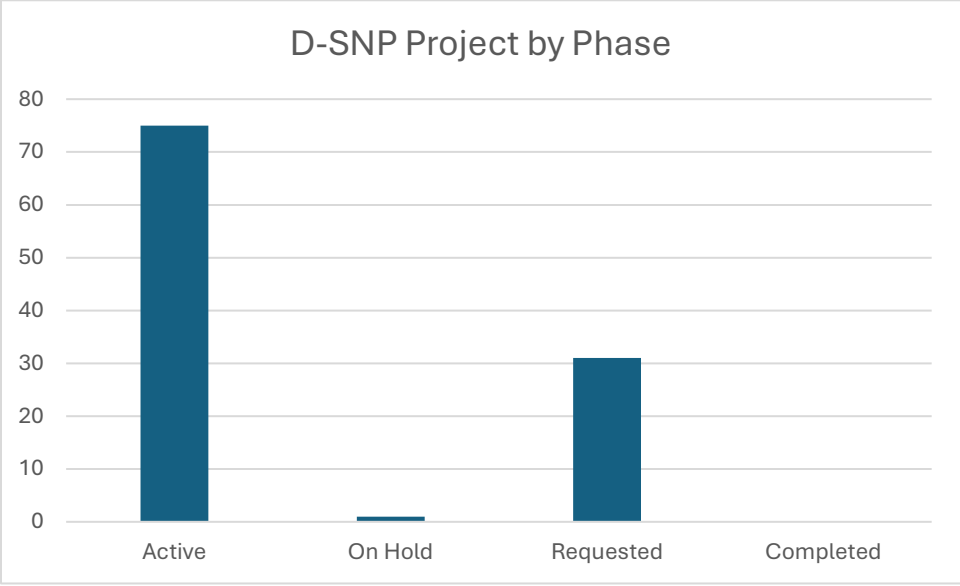
- Enterprise Portfolio
  - 64 projects currently on the Alameda Alliance for Health (AAH) enterprise-wide portfolio
    - 19 Active projects (discovery, initiation, planning, execution, warranty)
    - 11 On Hold projects
    - 34 Requested and Approved Projects
    - 0 Completed Projects (Last month)



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



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



- D-SNP Key Initiatives and Dates:
  - DMHC Material Modification Submission – MA Service Area Expansion – March 2024 - COMPLETE
  - DMHC Material Modification Submission – D-SNP Product – August 2024
  - CMS Notice of Intent to Apply – November 2024 - COMPLETE
  - CMS Application Submission including MOC, Provider Network Adequacy & DMHC Approval – February 2025 - COMPLETE
  - CMS Formulary & Bid Submission (Benefit Determination) – June 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 – August 2025**
  - 01 – Provider Services & Contracting:
    - Provider Contracting
      - Continued outreach to AAH provider network to complete the execution of the D-SNP Provider Amendment.
        - As of August 27th, 251 contracts are fully executed, which equates to 67% completion.
      - Continued contract negotiations with Brown & Toland, Teladoc, and Quest.
      - ClearLink resource engaged for additional provider outreach support.
      - Provider Directory Front Matter Approved by DHCS on August 21st.
    - Provider Services
      - Provider Manual contents submitted by required business areas to support inclusion of D-SNP requirements.
        - Provider Manual reviewed at QIHEC Committee and approved on August 11th.
        - CAC Review scheduled for September 11th.
      - Requirements developed for the online and printed D-SNP Provider Directory have been completed and internal development efforts are in progress.
        - mPulse vendor for online directory actively working on requirements that were submitted
        - KP vendor for printed directory actively working on requirements that were submitted
      - Continued Provider Repository updates for the executed D-SNP Provider Amendments supporting D-SNP Provider Network Adequacy.
    - Provider Rates and Reimbursement
      - Continued development of the Pay4Performance (P4P) program.

- 02 – Quality:
  - 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 complete and 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 DSNP Utilization Management committee will align with QIHEC committee members and cadence.
      - DSNP 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.

- 03 - Health Care Services (HCS) and 04 - Behavioral Health (BH):
  - Continuing policy development and revisions (130 policies)
    - CM policies still under draft.
    - UM policies first drafts are complete and in various stages of committee review.
  - UM Committee Charter draft complete to include D-SNP as an additional service line.
  - Identifying and documenting reporting requirements for UM, CM, and BH.
    - Utilizing multiple CMS and DHCS reference guides to create reporting request
  - 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 Kickoff with Vendor. Initial discussions on 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 and Cirus once final approvals are received on HRA revisions.
        - HRA has been revised to remove several questions to downsized in an effort to cause less member abrasion.
    - 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.
    - Finalizing UM customer set up requirements for configuration.
    - BH CM – D-SNP CM program structure has been finalized and will mirror PH 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.

- <u>05 – Finance:</u>
    - Continued Part D and Payment Reconciliation policy development.
    - Continued development of the Finance Standard Operating Procedure (SOP).
    - 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
        - CY2026 State Medicaid Agency Contract (SMAC)
            - On Aug 27, 2025, CMS issued conditional approval of the CY2026 D-SNP State Medicaid Agency Contract (SMAC) for Contract H2035, PBP ID 001

        - Integration Status: Coordination Only (CO) with Applicable Integrated Plan (AIP) designation
    - *Approval is contingent upon CMS approval of the D-SNP bid (approved 8/20) & formulary (approved 8/19), and completion of all required pre-implementation activities including system and data testing (in progress).
    - On Aug 25, 2025, AAH executed the H-contract with CMS by completing an electronic signature. The final step in the process is to receive a counter signature of the contract by CMS.
    - CY2026 CMS Formulary and Bid Submission (Benefit Determination)
        - On 8/20/2025, CMS confirmed that the HPMS Bid Desk Review process for AAH's CY2026 D-SNP bid under contract H2035 has been successfully completed. This milestone confirms that CMS has accepted the submitted bid, but this does not constitute contract approval.
        - CMS has conditionally approved AAH's CY2026 formulary submission, including submitted drug list, formulary tiering, and utilization management (UM) edits.
        - AAH approved a late change to the CY2026 DSNP bid design, reducing the annual limit for the Worldwide Emergency benefit. This change was made on August 6, 2025, as part of a final update to the CMS bid submission to address potential issues flagged by the rebate reallocation validation in the CMS Bid Pricing Tool (BPT).
        - CMS has formally approved AAH's Medication Therapy Management (MTM) Program for CY2026 on August 5, 2025. This approval is a required component of the Part D bid.
    - Submitted Policies to AOC for review.
    - Continued development of Standard Operating Procedures (SOPs) to standardize departmental operations and ensure adherence to best practices annually.
- 6G – Organizational Training
    - Organization Training Workgroup kick-off meeting completed.
        - Development of process for training content collections.
        - Development of process to convert content provided by business areas into LMS.
        - Meetings with each business area for content discovery and gathering have kicked off.
- 6J – Liberty Dental
    - Liberty Dental confirmed that Enrollment Group Data survey submitted by AAH is complete.
    - 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 to be finalized.

- Grievances and Appeals scope confirmed that Liberty Dental isn't delegated for verbal intake. Calls will be warm-transferred to AAH Member Services. Meeting scheduled to review SOP.
- Working session completed with AAH Provider Services Leadership and confirmed Liberty Dental will leverage established Medicare network (Liberty's CA Duals Choice Network) and no recruitment or network build is required for rollout.

- 07 – Compliance:
  - DMHC Material Modification – D-SNP Product (Filing #20244060).
    - Initial AAH responses submitted to DMHC on 9/9/2024.
    - DMHC Comment Table received 6/5/2025; responses submitted on 7/3. No additional feedback from DMHC to date, response was expected in early August.
  - D-SNP Compliance Policies
    - Policy Review Updates
      - Eight (8) policies approved
      - Four (4) policies to be submitted for review in September
      - Three (3) policies will be submitted for approval in September
      - One (1) policy will be moved into November for review
  - HPMS User Access Form (aka CARE Form)
  - Development completed and being utilized internally as necessary

- 08 - Operations (Claims / Member Services / Mailroom / IVR):
  - 8A – Claims
    - Completed development of a day in the life of a claim process flow.
  - Continued Claims requirements review and refinement8B – Member Services / Call Center / IVR
    - Completed IVR call tree development and initiated testing.
  - 8H – Policies, SOPs, and KPIs
    - Continued development of policies to support Claims.
    - Member Services policies submitted to AOC for review.

- 09 – Sales:
  - 9D – Medicare Marketing & Brand Strategy
    - DMHC and DHCS have approved all integrated member materials on 8/27/25 (CMS review was not required). DHCS approvals are conditional until the CY2026 contract is executed on 1/1/26.
      - Integrated member materials include:
        - 1. Member ID Card
        - 2. Summary of Benefits
        - 3. List of Covered Drugs (Formulary)
        - 4. Provider & Pharmacy Directory
        - 5. EOC/Member Handbook

- Inbound and Outbound Sales scripts approved, beginning implementation into Cirrus.
- CHCN referral process initial discussion, identifying requirements for referring leads from FQHC's.
- Other marketing materials (prospect and on-boarding): Enrollment Kit, Welcome Kit, Member OTC Debit Card.
    - Requirement sessions to identify materials to develop, budget, and timeline is complete.
    - Enrollment Kit materials have been developed and under C&O review and on-track to file with CMS as file and use and release final artwork to print vendor 9/5.
    - Welcome kit materials are under SME review and will be sent to C&O 9/3 for review. Kits will be sent to new members in December.
    - OTC Debit Card is still under C&O review.
- D-SNP website content was submitted to C&O 8/15, enabling the start of microsite framework construction to submit test site link to CMS for file and use prior to 10/1.
- Marketing and Compliance reviews of Enrollment Letters have been completed and include material IDs.

- 9E – Retention
    - Initial discussion to outline 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:
        - 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
- 16B – Enrollment Process & Nations Benefits Implementation
    - Confirmed Decision: The reporting process for completed healthy activities under the D-SNP Member Incentive Program will follow a member self-attestation model. (1) Members will attest to

completing eligible healthy activities directly in the Nations portal. (2) Incentive funds will be made available to the member's flex card after attestation. (3) Nations will perform back-end reconciliation by validating claims and/or data feeds to confirm completion and maintain program integrity. Nations indicated this is the industry standard in Medicare.

- Confirmed Decision: The D-SNP Member Incentive Program, which includes rewards for completing healthy activities, will be incorporated into the existing Nations Benefits implementation
- Confirmed Decision: AAH will not cover the manufacturer loss/damage deductible for replacement hearing aids (typically ranges $150-$225 per aid), and will not cover the provider refitting fees (up to $125 per aid). These costs remain the member's responsibility when the Medicare Advantage benefit is used. If Medi-Cal is the payer (Medi-Cal is payer of last resort), State rules apply.

- 10 – Pharmacy:
  - PBM Technical and Operational workgroup meetings are in progress.
  - Formulary updates were submitted to CMS via PerformRx during the 2026 Summer Limited Window period. The next submission opportunity is September Limited Window which is expected by September 12.
  - 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.
  - 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. Claims test file was also shared with 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 1/1/2026.
  - 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 pre-delegation / contracting in process.
- UM Guidelines (Clinical Policy Methodology) contracting in process.

- 13 – Health Equity:
  - Completed 1st draft redline of policies to include Health Equity (HE) initiatives and requirements.
  - Identified need for five (5) new policies to support HE.
    - One (1) policy is in progress and four (4) have not been started.
  - Beginning phase 2 of plan to develop monitoring process and procedures that HE team will oversee.
    - Discovery and project plan development.
    - Kick-off with HE Workgroup phase 2.
    - Health Equity Workplan for quality improvement interventions 1st draft.
    - Oversight policy and procedure 1st draft and workgroup review complete.

- 15 - Grievance and Appeals:
  - D-SNP Policies and Procedures have been reviewed and revised by external D-SNP SMEs. Policies and procedures were approved by the QIHEC committee on August 8 and were also submitted for review and approval to AOC committee in August 2025.
  - Development of the Standard operating procedures for D-SNP will begin in September 2025.
  - G&A Letters have all been created, reviewed, and approved by C&O. Translations were received on August 25 and will be configured into QualitySuite over the next 2 weeks.
  - CMS five (5) levels of appeal are currently being configured in QualitySuite.

- 16 – IT:
  - TruCare: Project is 75% complete. Assessments: Three critical Scope Items identified for go-live.1) HRA 2) Full Assessment and 3) New Dementia care assessment. Customer Setup configuration and unit testing is in progress. 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.
  - HEALTHsuite: OEC+ File testing with Nations completed as a part of QA testing confirming all prior issues are resolved. Membership/eligibility QA testing is completed. Enrollment configuration in stage environment successfully moved to test region to support UAT execution. AAH Operations HEALTHsuite training completed to support UAT execution.

High Priority English letters configuration is complete (model letters w/CMS changes). IT presented Provider contract setup training for claims process to business resources. IT is working on a solution to resolve issues related to D-SNP authorizations for services not covered by Medi-Care but covered under Medi-Cal. HEALTHsuite platform Production upgrade to version 25.00.00 completed.

- 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
    - Initial letter testing with RAM (HEALTHsuite) and KP (AAH Print Vendor).

- 17 – Stars:
    - Optum and Episource contracts fully executed 8/27/2025
        - Implementation efforts underway
        - 3 Policy & Procedures presented to AOC on 8/20/2025
    - Phase 1 of Star strategy
        - Identified initiatives for the HEDIS measures supported in the Medi-Cal line of business and Operational measures that will impact Star ratings on Day 1.
        - Building out Stars playbook to align interventions to D-SNP for Day 1.
        - Aligning interventions to Quality Workplan.
        - Process flow documentation for the measures is underway with Quality, Health Care Services, and Analytics. We will plan to implement foundational initiatives to support Star gap closure.
            - TruCare Star gap integration in process 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 SMES 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.
        - Member Birthday Cards.
    - Preventive Physical Exam (IPPE) & Annual Wellness Visit (AWV) – Beginning development of IPPE & AWV program to engage providers and members for gap closure and accurate diagnosis capture. Individual sessions with each clinic have been completed and best practices are being developed.

- **<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 October 1st, 2024, even if facilities in their county will go-live later.
        - JI project team is developing a contact list for the counties going live with pre-release to support coordination of referrals for any AAH members being released from these counties.
        - DHCS has indicated they intend to release a revised JI Policy Guide; impacts to project scope and schedule will be assessed once this is released.
        - DHCS JI Learning Collaboratives initiated in August 2024 and continues through January 2025. These collaborative sessions include correctional facilities, county behavioral health agencies, probation, managed care plans, and ECM providers.
        - On 10/28/24, AAH SLT approved to place CalAIM JI Re-Entry project on hold until July 2025 to await final policy guide from

DHCS and give Alameda County partners time to develop their internal processes and readiness.

- CYBHI Fee Schedule: 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 – coding out and will revisit later

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 they 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	August 2025
Incoming Calls (R/V)	18,859
Abandoned Rate (R/V)	5%
Answered Calls (R/V)	17,875
Average Speed to Answer (ASA)	00:13
Calls Answered in 30 Seconds (R/V)	94%
Average Talk Time (ATT)	07:47
Calls Answered in 10 minutes	100%
Outbound Calls	9,604

Top 5 Call Reasons (Medi-Cal and Group Care) August 2025
Eligibility/Enrollment
Change of PCP
Grievances/Appeals
Benefits
ID Card Requests

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

Member Services Behavioral Health	August 2025
Incoming Calls (R/V)	1,161
Abandoned Rate (R/V)	7%
Answered Calls (R/V)	1,079
Average Speed to Answer (ASA)	00:55
Calls Answered in 30 Seconds (R/V)	75%
Average Talk Time (ATT)	09:44
Calls Answered in 10 minutes	99%
Outbound Calls	1,266
Screenings Completed	138
ACBH Referrals	52
SUD referrals to Center Point	21

Claims Department
July 2025 Final and August 2025 Final

METRICS

Claims Compliance	Jul-25	Aug-25
90% of clean claims processed within 30 calendar days	81.8%	83.3%
95% of all claims processed within 45 working days	89.9%	99.4%

Claims Volume (Received)	Jul-25	Aug-25
Paper claims	42,409	36,440
EDI claims	312,846	352,642
Claim Volume Total	**355,255**	**389,082**

Percentage of Claims Volume by Submission Method	Jul-25	Aug-25
% Paper	11.94%	9.37%
% EDI	88.06%	90.63%

Claims Processed	Jul-25	Aug-25
HEALTHsuite Paid (original claims)	306,576	237,848
HEALTHsuite Denied (original claims)	113,868	94,089
HEALTHsuite Original Claims Sub-Total	**420,444**	**331,937**
HEALTHsuite Adjustments	23,715	6,357
HEALTHsuite Total	**444,159**	**338,294**

Claims Expense	Jul-25	Aug-25
Medical Claims Paid	$169,869,293	$156,801,791
Interest Paid	$349,476	$83,462

Auto Adjudication	Jul-25	Aug-25
Claims Auto Adjudicated	352,354	278,912
% Auto Adjudicated	83.8%	84.0%

Average Days from Receipt to Payment	Jul-25	Aug-25
HEALTHsuite	21	18

Pended Claim Age	Jul-25	Aug-25
0-30 calendar days	38,206	37,073
HEALTHsuite		
31-61 calendar days	33,385	19,922
HEALTHsuite		
Over 62 calendar days	47,767	47,872
HEALTHsuite		

*Pended claims over 31 days are high due to investigation of 3 providers for FWA

Overall Denial Rate	Jul-25	Aug-25
Claims denied in HEALTHsuite	113,868	94,089
% Denied	25.6%	27.8%

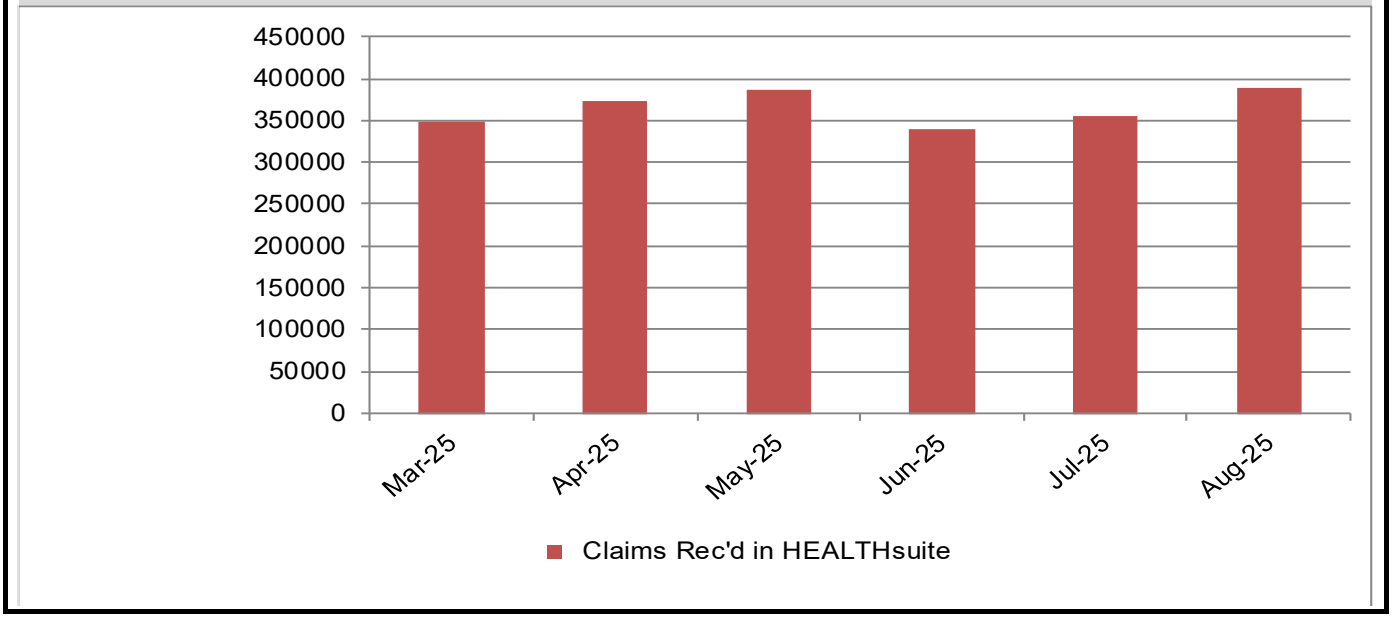
Claims Department
July 2025 Final and August 2025 Final

Aug-25

Top 5 HEALTHsuite Denial Reasons	% of all denials
Responsibility of Provider	19%
Must Submit Paper Claim With Copy of Primary Payor EOB	17%
Duplicate Claim	13%
No Benefits Found For Dates of Service	10%
Non-Covered Benefit For This Plan	9%
% Total of all denials	**68%**

Claims Received By Month

	4/1/2025	5/1/2025	6/1/2025	7/1/2025	8/1/2025	9/1/2025
Claims Received Through	**Mar-25**	**Apr-25**	**May-25**	**Jun-25**	**Jul-25**	**Aug-25**
Claims Rec'd in HEALTHsuite	347,469	372,126	387,564	340,224	355,255	389,082



Claims Year Over Year Summary

Claims Compliance - comparing August 2025 to August 2024 as follows: 30 Days - 83.3% (2025) vs 87.1% (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 389,082 claims in August 2025 vs 368,235 in August 2024	N/A	N/A
EDI - the volume of EDI submissions was 90.63% which exceeds our normal month to month range of ~77% - 87%	N/A	N/A
Original Claims Processed - AAH processed 331,937 in August 2025 (21 working days) vs 304,304 in August 2024 (23 working days)	N/A	N/A
Medical Claims Expense - the amount of paid claims in August 2025 was $156,801,791 (4 check runs) vs $127,162,733 in August 2024 (4 check runs)	N/A	N/A
Interest Expense - the amount of interest paid in August 2025 was $83,462 vs $117,294 in August 2024	N/A	.05% - .075% of the monthly medical expense
Auto Adjudication - the AAH rate in August 2025 was 84% vs 84.6% in August 2024	N/A	85% or higher
Average Days from Receipt to Payment - the average # of days from receipt to payment in August 2025 was 18 days vs 16 days in August 2024	N/A	<= 25 days
Pended Claim Age - comparing August 2025 to August 2024 as follows: 0-30 calendar days - 37,073 (2025) vs 43,863 (2024) 31-61 calendar days - 19,922 (2025) vs 19,456 (2024) Over 62 calendar days - 47,872 (2025) vs 16 (2024) *Pended claims over 31 days are high due to the investigation of 3 providers for FWA	N/A	N/A
Top 5 Denial Reasons - the claim denial reasons remain consistent from month to month so there is no significant changes to report from August 2025 to August 2024	N/A	N/A

Provider Dispute Resolution
July 2025 and August 2025

METRICS

PDR Compliance	Jul-25	Aug-25
# of PDRs Resolved	2,819	2,769
# Resolved Within 45 Working Days	2,816	2,761
% of PDRs Resolved Within 45 Working Days	99.8%	99.7%

PDRs Received	Jul-25	Aug-25
# of PDRs Received	4,426	2,762
PDR Volume Total	**4,426**	**2,762**

PDRs Resolved	Jul-25	Aug-25
# of PDRs Upheld	2,017	2,071
% of PDRs Upheld	72%	75%
# of PDRs Overturned	802	698
% of PDRs Overturned	28%	25%
Total # of PDRs Resolved	**2,819**	**2,769**

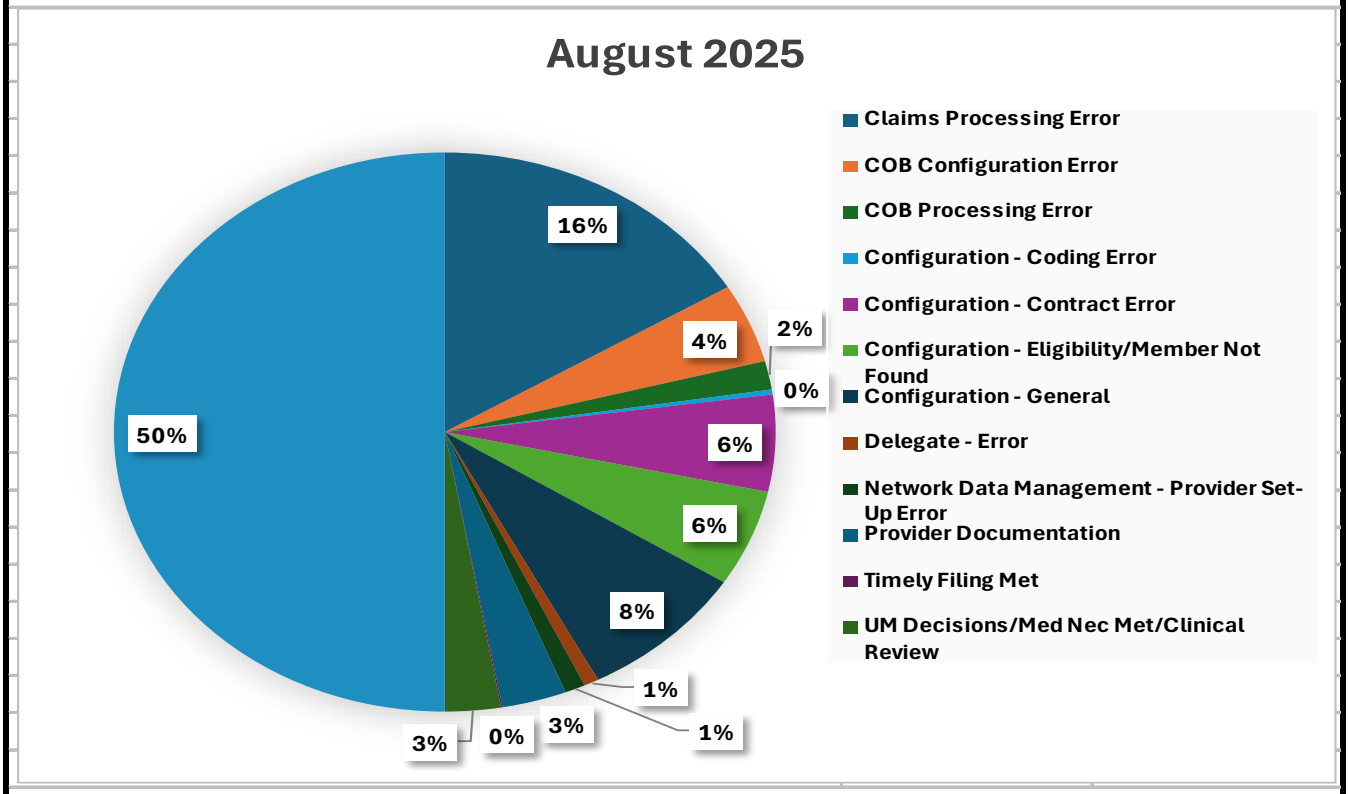
Average Turnaround Time	Jul-25	Aug-25
Average # of Days to Resolve PDRs	37	37
Oldest Resolved PDR in Days	92	124

Unresolved PDR Age	Jul-25	Aug-25
0-45 Working Days	6,165	5,648
Over 45 Working Days	0	0
Total # of Unresolved PDRs	**6,165**	**5,648**

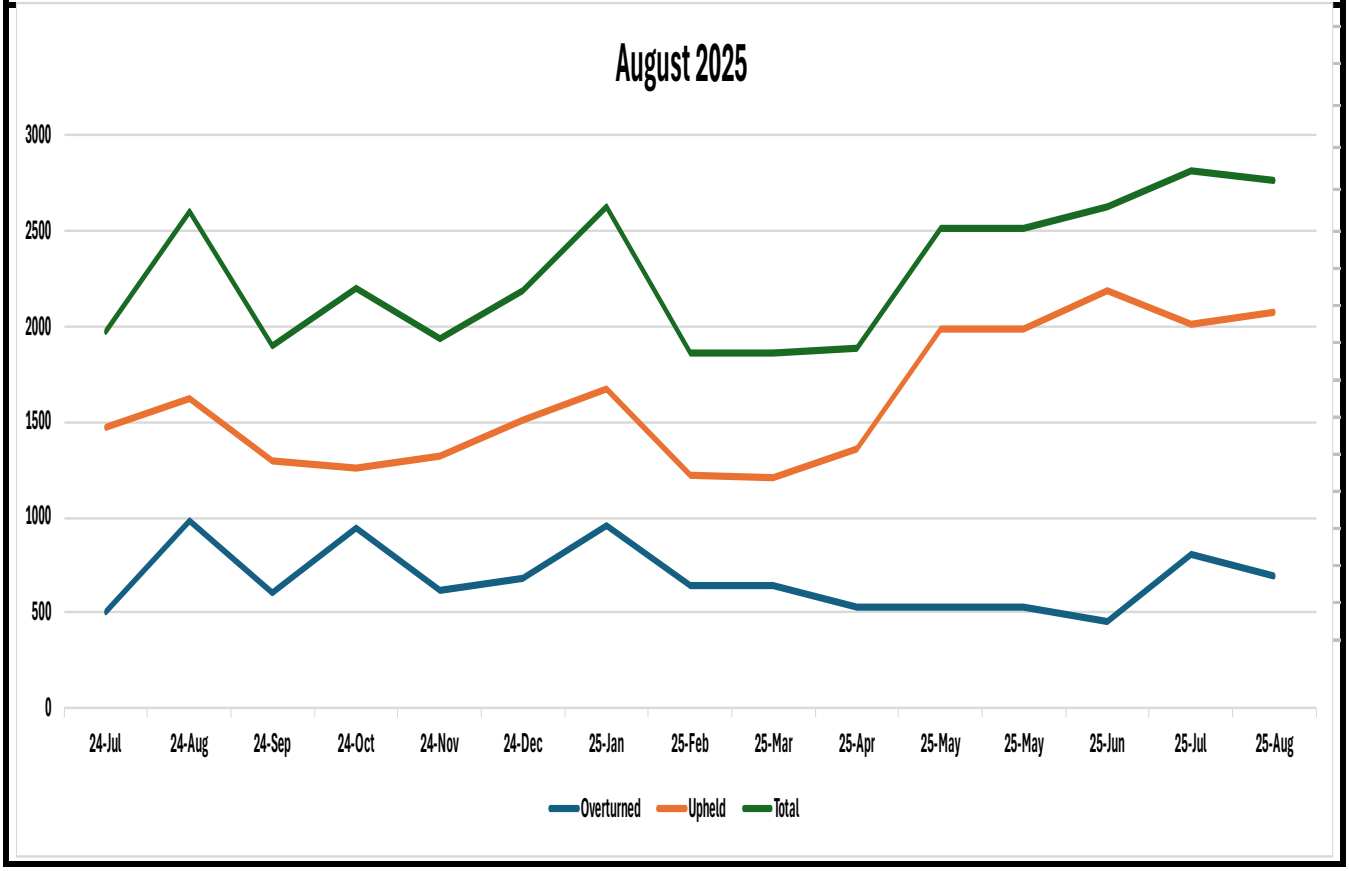
Provider Dispute Resolution
July 2025 and August 2025

Aug-25

PDR Resolved Case Overturn Reasons



Rolling 12-Month PDR Trend Line



Provider Dispute Resolution Year Over Year Summary		
Monthly Results	**Regulatory Requirements**	**AAH Goal**
# of PDRs Received - 2,762 in August 2025 vs 2,193 in August 2024	N/A	N/A
# of PDRs Resolved within 45 working days - 2,761 in August 2025 vs 2,591 in August 2024	N/A	N/A
% of PDRs Resolved within 45 working days -99.7% in August 2025 vs 99.5% in August 2024	95%	95%
Average # of Days to Resolve PDRs - 37 days in August 2025 vs 43 days in August 2024	N/A	30
Oldest Resolved PDR in Days -124 days in August 2025 vs 75 days in August 2024	N/A	N/A
# of PDRs Upheld - 2,071 in August 2025 vs 1,623 in August 2024	N/A	N/A
% of PDRs Upheld - 75% in August 2025 vs 62% in August 2024	N/A	> 75%
# of PDRs Overturned - 698 in August 2025 vs 979 in August 2024	N/A	N/A
% of PDRs Overturned - 25% in August 2025 vs 38% in August 2024	N/A	< 25%
PDR Overturn Reasons: Claims processing errors - 33% (2025) vs 22% (2024) Configuration errors - 43% (2025) vs 54% (2024) COB - 12% (2025) vs 8% (2024) Clinical Review/UM Decisions/Medical Necessity Met - 12% (2025) vs 10% (2024)	N/A	N/A

Provider Relations Dashboard August 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				
Abandoned Calls	3,600	1,133	1,434	1,685	1,254	2,245	1,545	1,857				
Answered Calls (PR)	7,377	7,752	6,869	7,024	6,607	6,969	7,785	6,981				
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				
Abandoned Calls (R/V)												
Answered Calls (R/V)	2,910	2,140	13	15	12	6	14	9				
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				
N/A												
Outbound Calls	868	1,162	434	602	570	520	693	650				
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				
Abandoned Calls	3,600	1,133	1,434	1,685	1,254	2,245	1,545	1,857				
Total Answered Incoming, R/V, Outbound Calls	11,155	11,054	7,316	7,641	7,189	7,495	8,492	7,640				

Provider Relations Dashboard August 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%				
Benefits	5.1%	3.7%	3.4%	3.9%	6.4%	3.4%	3.2%	3.3%				
Claims Inquiry	39.4%	43.9%	43.7%	46.3%	47.7%	48.5%	46.8%	45.2%				
Change of PCP	2.5%	2.7%	2.4%	2.9%	2.8%	2.0%	2.2%	1.9%				
Check Tracer	0.7%	0.6%	1.0%	0.9%	0.7%	1.0%	0.6%	0.6%				
Complaint/Grievance (includes PDR's)	5.8%	6.7%	6.8%	6.5%	7.6%	7.1%	8.6%	9.1%				
Contracts/Credentialing	0.8%	0.8%	0.7%	0.8%	0.8%	0.8%	0.8%	0.8%				
Demographic Change	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%				
Exempt Grievance/ G&A	0.0%	0.1%	6.8%	0.0%	0.1%	0.0%	0.1%	0.0%				
General Inquiry/Non member	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%				
Intrepreter Services Request	0.5%	0.5%	0.6%	0.4%	0.4%	0.4%	0.4%	0.5%				
Provider Portal Assistance	3.4%	3.2%	3.9%	3.4%	3.4%	3.4%	3.6%	3.9%				
Pharmacy	0.1%	0.2%	0.1%	0.0%	0.1%	0.1%	0.0%	0.2%				
Prop 56	0.1%	0.0%	0.0%	0.1%	0.1%	0.1%	0.1%	0.0%				
Provider Network Info	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%				
Transportation Services	0.0%	0.2%	0.2%	0.2%	0.3%	0.1%	0.1%	0.2%				
Transferred Call	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%				
All Other Calls	15.5%	14.4%	7.9%	11.4%	7.9%	10.4%	11.2%	11.1%				
TOTAL	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				
Contracting/Credentialing	29	41	50	59	150	66	53	51				
Drop-ins	127	83	141	146	149	96	220	189				
JOM's	2	2	3	2	3	1	3	1				
New Provider Orientation	100	134	118	173	143	182	154	102				
Quarterly Visits	0	0	0	82	0	0	0	0				
UM Issues	0	0	3	1	1	5	3	0				
Total Field Visits	286	332	404	517	506	391	481	368	0	0	0	0

ALLIANCE NETWORK SUMMARY, CURRENTLY CREDENTIALED PRACTITIONERS - August 2025						
Practitioners		PCP 386	SPEC 760	AHP 706	BH/ABA 3,221	PCP/SPEC 12
Direct Network vs Delegated Network Breakdown			AAH 3,826	AHS 293	CHCN 607	COMBINATION OF GROUPS 359
Facilities	447					

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	265	5	Y	Y	Y
Recred Files in Process	229	0	Y	Y	Y
Expirables updated **Insurance, License, DEA, Board Certifications**					Y
Files currently in process	**494**				
		*** 25 business days = 35 calendar days**			

August 2025 Peer Review and Credentialing Committee Approvals	
Initial Credentialing	**Number**
PCP	4
SPEC	6
ANCILLARY	9
MIDLEVEL/AHP	12
BH/ABA	103
Sub-total	**134**
Recredentialing	
PCP	8
SPEC	13
ANCILLARY	1
MIDLEVEL/AHP	8
BH/ABA	54
Sub-total	**84**
TOTAL	**218**

August 2025 Facility Approvals	
Initial Credentialing	6
Recredentialing	12
Sub-total	**18**
Facility Files in Process	**59**

August 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

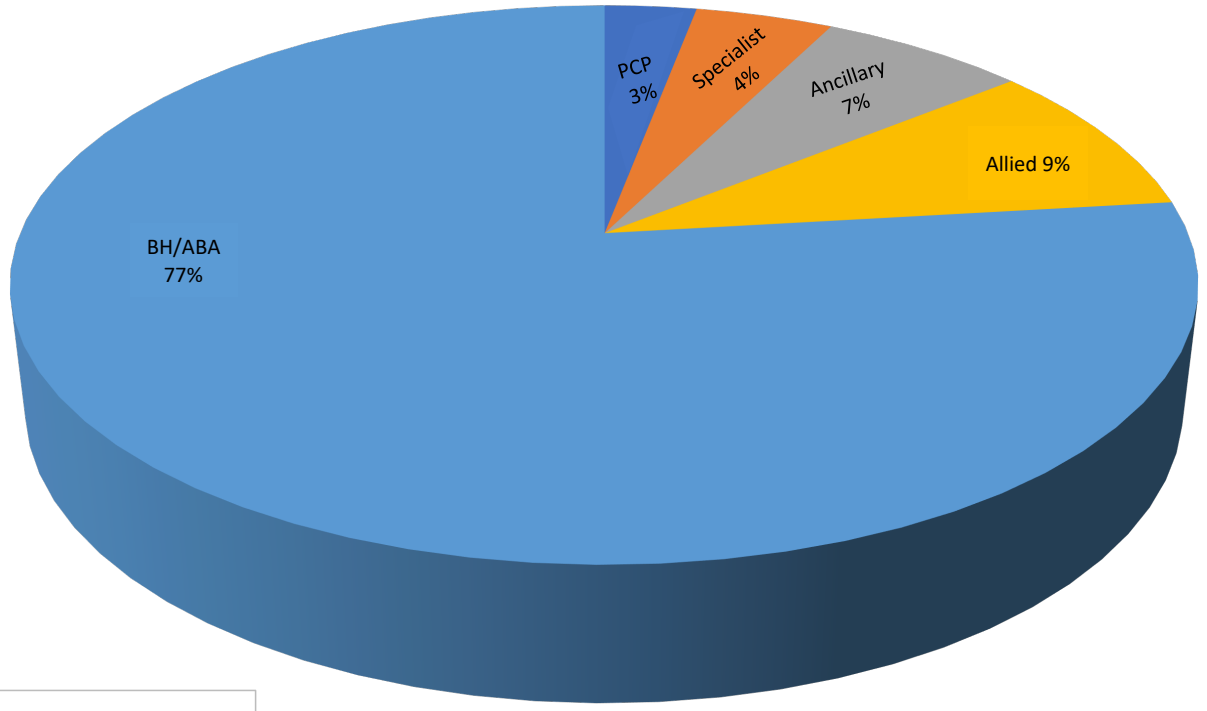
LAST NAME	FIRST NAME	CATEGORY	INITIAL/RE-CRED	CRED DATE
Adcox	Courtney	BH/ABA-Telehealth	INITIAL	8/19/2025
Alexander	Samyra	BH/ABA-Telehealth	INITIAL	8/19/2025
Bader	Brianna	BH/ABA	INITIAL	8/19/2025
Baer-Modena	Isabel	Doula	INITIAL	8/19/2025
Balliet	Anna	BH/ABA-Telehealth	INITIAL	8/19/2025
Berg	Elley Taylor	BH/ABA-Telehealth	INITIAL	8/19/2025
Berlin	Beatrice	BH/ABA-Telehealth	INITIAL	8/19/2025
Bippus	Peter	BH/ABA-Telehealth	INITIAL	8/19/2025
Borunda	Kathrine	BH/ABA-Telehealth	INITIAL	8/19/2025
Botelho	Hannah	Doula	INITIAL	8/19/2025
Boyd-McGhee	Gwendolyn	BH/ABA-Telehealth	INITIAL	8/19/2025
Bryant	Megan	BH/ABA-Telehealth	INITIAL	8/19/2025
Bullock	Regina	BH/ABA	INITIAL	8/19/2025
Busby	Emma	BH/ABA-Telehealth	INITIAL	8/19/2025
Byun	Se-ri	BH/ABA-Telehealth	INITIAL	8/19/2025
Cabiglio	Chiara	BH/ABA-Telehealth	INITIAL	8/19/2025
Cameron	Danielle	BH/ABA-Telehealth	INITIAL	8/19/2025
Carino	Zoe	BH/ABA-Telehealth	INITIAL	8/19/2025
Carpio	Yuriana	BH/ABA-Telehealth	INITIAL	8/19/2025
Carr	Dena	BH/ABA-Telehealth	INITIAL	8/19/2025
Carroll	Crystal	BH/ABA-Telehealth	INITIAL	8/19/2025
Cervantes	Rosella	BH/ABA-Telehealth	INITIAL	8/19/2025
Chavez	Vanessa	BH/ABA-Telehealth	INITIAL	8/19/2025
Chow	June	BH/ABA-Telehealth	INITIAL	8/19/2025
Compehos	Tara	Doula	INITIAL	8/19/2025
Cortave	Jefferson	BH/ABA	INITIAL	8/19/2025
Cortes	Yesenia	BH/ABA-Telehealth	INITIAL	8/19/2025
Cutaran	Megan	BH/ABA	INITIAL	8/19/2025
Da Paixao Passos Waian	Valderene	BH/ABA-Telehealth	INITIAL	8/19/2025
Davis	Fionna	BH/ABA-Telehealth	INITIAL	8/19/2025
Dawes	Sarah	BH/ABA-Telehealth	INITIAL	8/19/2025
Delaplane-Yusem	Naomi	Doula	INITIAL	8/19/2025
Deng	Junjian	Allied Health	INITIAL	8/19/2025
Diflorio	Daniella	BH/ABA-Telehealth	INITIAL	8/19/2025
Du	Jiazhong	Ancillary	INITIAL	8/19/2025
Duncan	Joseph	BH/ABA-Telehealth	INITIAL	8/19/2025
Dunn	Katherine	BH/ABA	INITIAL	8/19/2025
Eldereiny	Hanaa	BH/ABA-Telehealth	INITIAL	8/19/2025
Ellison	Kelsey	Ancillary	INITIAL	8/19/2025
Esquivel	Harriet	BH/ABA-Telehealth	INITIAL	8/19/2025
Estante	Maria	BH/ABA	INITIAL	8/19/2025
Fisher-Carrington	Sonja	BH/ABA-Telehealth	INITIAL	8/19/2025
Flores	Diane	Allied Health	INITIAL	8/19/2025
Foster	Steven	BH/ABA	INITIAL	8/19/2025
Fulcher	Tanisha	BH/ABA-Telehealth	INITIAL	8/19/2025
Garcia	April	BH/ABA-Telehealth	INITIAL	8/19/2025
Garcia	Vanessa	BH/ABA-Telehealth	INITIAL	8/19/2025
Garcia Martinez	Maria	Doula	INITIAL	8/19/2025
Gonzalez	Elizabeth	BH/ABA-Telehealth	INITIAL	8/19/2025
Grimes	Tiffany	BH/ABA	INITIAL	8/19/2025
Harrison	Lisa	Specialist	INITIAL	8/19/2025
Hershberger	Jessica	BH/ABA-Telehealth	INITIAL	8/19/2025
Heydari	Zahra	BH/ABA-Telehealth	INITIAL	8/19/2025
Hirsch	Marissa	BH/ABA-Telehealth	INITIAL	8/19/2025
Hoang	Khai	BH/ABA-Telehealth	INITIAL	8/19/2025
Humphreys	Nicole	BH/ABA-Telehealth	INITIAL	8/19/2025

LAST NAME	FIRST NAME	CATEGORY	INITIAL/RE-CRED	CRED DATE
Hurd	Manton	Allied Health	INITIAL	8/19/2025
Isom	Akia	BH/ABA-Telehealth	INITIAL	8/19/2025
Iwanciow	Stephanie	BH/ABA	INITIAL	8/19/2025
Jain	Neha	Specialist	INITIAL	8/19/2025
Jennings	Robyn	BH/ABA-Telehealth	INITIAL	8/19/2025
Jimenez	Elsie	Allied Health	INITIAL	8/19/2025
Johnson	Jack	BH/ABA-Telehealth	INITIAL	8/19/2025
Johnson	Joy	BH/ABA	INITIAL	8/19/2025
Kerdman	Samantha	BH/ABA-Telehealth	INITIAL	8/19/2025
Khanolkar	Adrianne	Primary Care Physician	INITIAL	8/19/2025
Khosrawi	Sweeta	BH/ABA-Telehealth	INITIAL	8/19/2025
Kingsmore	Kelsey	BH/ABA-Telehealth	INITIAL	8/19/2025
Knoll	Nathaniel	Allied Health	INITIAL	8/19/2025
Kocharian	Heidi	BH/ABA-Telehealth	INITIAL	8/19/2025
Kompella	Suvarchala	Primary Care Physician	INITIAL	8/19/2025
Kulthia	Arun	Primary Care Physician	INITIAL	8/19/2025
Lane	Francesca	BH/ABA	INITIAL	8/19/2025
Lee	Derek	BH/ABA	INITIAL	8/19/2025
Lee	Jeffrey	BH/ABA	INITIAL	8/19/2025
LeJeune	Michelle	BH/ABA-Telehealth	INITIAL	8/19/2025
Levin	Giselle	BH/ABA	INITIAL	8/19/2025
Liao	Winnie	BH/ABA-Telehealth	INITIAL	8/19/2025
Loo	Aiko	Allied Health	INITIAL	8/19/2025
Lopez Duff	Imani	Doula	INITIAL	8/19/2025
Maddox	Jazmine	BH/ABA-Telehealth	INITIAL	8/19/2025
Mamaradlo Enerio	Leizel	Allied Health	INITIAL	8/19/2025
Mander	Christina	BH/ABA-Telehealth	INITIAL	8/19/2025
Manly	Cynthia	BH/ABA-Telehealth	INITIAL	8/19/2025
Marsh	Jennifer	BH/ABA-Telehealth	INITIAL	8/19/2025
Mayorga	Karla	BH/ABA	INITIAL	8/19/2025
Merlan-Davidson	Janet	BH/ABA-Telehealth	INITIAL	8/19/2025
Meyer	Hannah	BH/ABA-Telehealth	INITIAL	8/19/2025
Miller	Belinda	BH/ABA-Telehealth	INITIAL	8/19/2025
Moses	Jennie	BH/ABA-Telehealth	INITIAL	8/19/2025
Neyer	Wendy	BH/ABA-Telehealth	INITIAL	8/19/2025
Nezifort	Adeline	Allied Health	INITIAL	8/19/2025
Nies	Jason	Allied Health	INITIAL	8/19/2025
Nwogu	Niekachi	BH/ABA	INITIAL	8/19/2025
O'Connor	Michael	Specialist	INITIAL	8/19/2025
Okieme	Princess	BH/ABA	INITIAL	8/19/2025
Oliver	Bentley	BH/ABA-Telehealth	INITIAL	8/19/2025
Peterson	Candice	BH/ABA-Telehealth	INITIAL	8/19/2025
Pinhassian	Tamara	BH/ABA-Telehealth	INITIAL	8/19/2025
Pinon	Michelle	BH/ABA-Telehealth	INITIAL	8/19/2025
Pirillo	Christiane	BH/ABA-Telehealth	INITIAL	8/19/2025
Quintanilla	Michelle	BH/ABA-Telehealth	INITIAL	8/19/2025
Rasmusen	Samantha	BH/ABA-Telehealth	INITIAL	8/19/2025
Rayas	Penelope	BH/ABA-Telehealth	INITIAL	8/19/2025
Raynaud	Juliette	BH/ABA-Telehealth	INITIAL	8/19/2025
Reading	Angela	BH/ABA-Telehealth	INITIAL	8/19/2025
Roller	Katherine	Primary Care Physician	INITIAL	8/19/2025
Ruiz	Ruben	BH/ABA	INITIAL	8/19/2025
Sahebghalam	Nikki	Allied Health	INITIAL	8/19/2025
Salisbury	Alina	BH/ABA-Telehealth	INITIAL	8/19/2025
Samady	Lila	BH/ABA-Telehealth	INITIAL	8/19/2025
Santana	Rebecca	BH/ABA-Telehealth	INITIAL	8/19/2025
Schilling	Katherine	BH/ABA-Telehealth	INITIAL	8/19/2025

LAST NAME	FIRST NAME	CATEGORY	INITIAL/RE-CRED	CRED DATE
Scholz	Catherine	BH/ABA-Telehealth	INITIAL	8/19/2025
Shipp Estes	Darlene	BH/ABA-Telehealth	INITIAL	8/19/2025
Simpson	Tiffany	Doula	INITIAL	8/19/2025
Slavin	Taylor	BH/ABA-Telehealth	INITIAL	8/19/2025
Solomon	Mahedere	Allied Health	INITIAL	8/19/2025
Stambook	Jeffrey	BH/ABA-Telehealth	INITIAL	8/19/2025
Stoudemire	Iyanna	BH/ABA-Telehealth	INITIAL	8/19/2025
Thompson	Michaela	BH/ABA	INITIAL	8/19/2025
Torres	Valentina	BH/ABA	INITIAL	8/19/2025
Trinh	Thao-Chau	BH/ABA	INITIAL	8/19/2025
Turner	Traci	BH/ABA-Telehealth	INITIAL	8/19/2025
Usami	Chihiro	BH/ABA-Telehealth	INITIAL	8/19/2025
Valdivia	Alexandro	BH/ABA-Telehealth	INITIAL	8/19/2025
Villanueva	Olga	BH/ABA-Telehealth	INITIAL	8/19/2025
Weiss	Morgan	BH/ABA-Telehealth	INITIAL	8/19/2025
Weiss	Stefan	Specialist	INITIAL	8/19/2025
Williams	Natasha	BH/ABA	INITIAL	8/19/2025
Wong	Reynold	Specialist	INITIAL	8/19/2025
Woodruff	Lauryn	Allied Health	INITIAL	8/19/2025
Wright	Stephanie	BH/ABA-Telehealth	INITIAL	8/19/2025
Yeager	Violet	Specialist	INITIAL	8/19/2025
Arpaci	Carol	BH/ABA	RE-CRED	8/19/2025
Asher	Ava	BH/ABA	RE-CRED	8/19/2025
Azghadi	Soheila	Specialist	RE-CRED	8/19/2025
Bakshi	Nandini	Specialist	RE-CRED	8/19/2025
Barua	Upama	Primary Care Physician	RE-CRED	8/19/2025
Ben-Zvy	Leigh	Primary Care Physician	RE-CRED	8/19/2025
Beyer	Yvonne	BH/ABA	RE-CRED	8/19/2025
Bowden	Haydee	BH/ABA	RE-CRED	8/19/2025
Brooks	Adam	Specialist	RE-CRED	8/19/2025
Bryson-Alderman	Jennifer	Allied Health	RE-CRED	8/19/2025
Cain	Whitney	BH/ABA-Telehealth	RE-CRED	8/19/2025
Caldwell	Alicia	BH/ABA	RE-CRED	8/19/2025
Camarena	Evangelina	BH/ABA	RE-CRED	8/19/2025
Canfield	Jasmin	BH/ABA	RE-CRED	8/19/2025
Carter	Jack	BH/ABA-Telehealth	RE-CRED	8/19/2025
Chandran	Jessica	BH/ABA	RE-CRED	8/19/2025
Chao	Kuang-Hwa	Specialist	RE-CRED	8/19/2025
De La Torre Villegas	Lorena	BH/ABA	RE-CRED	8/19/2025
Dolgoff	Robert	BH/ABA	RE-CRED	8/19/2025
Escobar Correa	Adriana	BH/ABA	RE-CRED	8/19/2025
Farrohi	Parisa	BH/ABA	RE-CRED	8/19/2025
Fleisig	Sarah	Specialist	RE-CRED	8/19/2025
Flores	Jessica	BH/ABA	RE-CRED	8/19/2025
Forsberg	Michael	BH/ABA-Telehealth	RE-CRED	8/19/2025
Freedman	Julie	Specialist	RE-CRED	8/19/2025
Fuentes	Alicia	BH/ABA	RE-CRED	8/19/2025
Gage	Caitlin	BH/ABA-Telehealth	RE-CRED	8/19/2025
Gersten-Rothenberg	Karen	Allied Health	RE-CRED	8/19/2025
Goldrich	Michael	Primary Care Physician	RE-CRED	8/19/2025
Guardado	Luana	BH/ABA-Telehealth	RE-CRED	8/19/2025
Haimowitz	Carla	BH/ABA-Telehealth	RE-CRED	8/19/2025
Hall	Darah	BH/ABA-Telehealth	RE-CRED	8/19/2025
Hardy	Tangia	BH/ABA	RE-CRED	8/19/2025
Harris	Jennifer	BH/ABA-Telehealth	RE-CRED	8/19/2025
Hart	Naima	BH/ABA	RE-CRED	8/19/2025

LAST NAME	FIRST NAME	CATEGORY	INITIAL/RE-CRED	CRED DATE
Hoang	Sylvia	Primary Care Physician	RE-CRED	8/19/2025
Iota-Herbei	Claudia	Specialist	RE-CRED	8/19/2025
Iqbal	Wurda	BH/ABA-Telehealth	RE-CRED	8/19/2025
Jaramillo	Briana	BH/ABA-Telehealth	RE-CRED	8/19/2025
Kamlot	Andreas	Specialist	RE-CRED	8/19/2025
Kamper	Lorraine	BH/ABA-Telehealth	RE-CRED	8/19/2025
Kapoor	Shilpa	BH/ABA	RE-CRED	8/19/2025
Kern	Anna	BH/ABA	RE-CRED	8/19/2025
Kim	Grace	BH/ABA	RE-CRED	8/19/2025
King-Angell	Joan	Primary Care Physician	RE-CRED	8/19/2025
Lavelle	Laura	Allied Health	RE-CRED	8/19/2025
Lawrence	Alison	BH/ABA-Telehealth	RE-CRED	8/19/2025
Lazarin	Margaux	Specialist	RE-CRED	8/19/2025
Leslie	Kathleen	BH/ABA	RE-CRED	8/19/2025
Lorenz	Phyllis	BH/ABA	RE-CRED	8/19/2025
Lyandres	Polina	BH/ABA-Telehealth	RE-CRED	8/19/2025
Maisel	Richard	BH/ABA	RE-CRED	8/19/2025
Malcolm	Tyronda	Specialist	RE-CRED	8/19/2025
Marcella	Hillary	BH/ABA-Telehealth	RE-CRED	8/19/2025
Marcotrigiano	Leanne	Primary Care Physician	RE-CRED	8/19/2025
Marin	Andres	Primary Care Physician	RE-CRED	8/19/2025
McCabe	Patrick	Specialist	RE-CRED	8/19/2025
Mcglashan	Kate	Allied Health	RE-CRED	8/19/2025
Meyer	Karen	Allied Health	RE-CRED	8/19/2025
Montgomery-Telfor	Brenda	BH/ABA	RE-CRED	8/19/2025
Montiel	Kelly	BH/ABA	RE-CRED	8/19/2025
Ni	Huan	Allied Health	RE-CRED	8/19/2025
Nordhues	Juliana	BH/ABA-Telehealth	RE-CRED	8/19/2025
Norris	Claire	BH/ABA-Telehealth	RE-CRED	8/19/2025
Novak	Nicole	BH/ABA	RE-CRED	8/19/2025
Ocampo-Wong	Myla	Ancillary	RE-CRED	8/19/2025
Perswain	Lorena	BH/ABA-Telehealth	RE-CRED	8/19/2025
Piazza	Fred	BH/ABA	RE-CRED	8/19/2025
Rasheed	Sabiha	Specialist	RE-CRED	8/19/2025
Shem	Tiffany	Allied Health	RE-CRED	8/19/2025
Solomon	Theodore	BH/ABA-Telehealth	RE-CRED	8/19/2025
Specht	Amanda	BH/ABA	RE-CRED	8/19/2025
Spielvogel	Brianna	BH/ABA-Telehealth	RE-CRED	8/19/2025
Stauffer	Stephen	BH/ABA	RE-CRED	8/19/2025
Swanier	Ivy	BH/ABA-Telehealth	RE-CRED	8/19/2025
Taguchi-Solorio	Natalie	BH/ABA-Telehealth	RE-CRED	8/19/2025
Taylor	Nicholas	Primary Care Physician	RE-CRED	8/19/2025
Thakur	Sonica	BH/ABA-Telehealth	RE-CRED	8/19/2025
Waissbluth	Alvaro	Specialist	RE-CRED	8/19/2025
Walia	Monika	Allied Health	RE-CRED	8/19/2025
Wolfe	Martha	BH/ABA	RE-CRED	8/19/2025
Wright-Fong	Taryn	BH/ABA	RE-CRED	8/19/2025
Yeo	Monica	BH/ABA-Telehealth	RE-CRED	8/19/2025
Yoon	Jin Hee	BH/ABA	RE-CRED	8/19/2025

AUGUST PEER REVIEW AND CREDENTIALING
INITIAL APPROVALS BY SPECIALTY



PCP	4
SPECIALIST	6
ANCILLARY	9
ALLIED	12
BH/ABA	103
TOTAL	134

In August 2025, the Alliance completed **866** member orientation outreach calls among net new and non-utilizer members and conducted **52** net new member orientations and **6** non-utilizer member orientations (**7%** member participation rate). In addition, in August 2025, the Outreach team completed **10** Alliance website inquiries, **10** service requests, **6** community events, and **2** member education events. The Alliance reached a total of **1,757** people and spent a total of **$685.00** on donations, fees, and/or sponsorships at the 2025 Oakland Chinatown Chamber of Commerce (OCCC) 36th StreetFest, Helping Hands Expo: A community Resource and Volunteer Fair, Laney's Welcome Back Week Resource Fair, Back to School Health & Resource Fair, 45Th Annual Holistic Health Fair, Hayward Unified Annual Backpack Giveaway and Health Resource Fair event, and the World Breastfeeding Week community events and activities.*

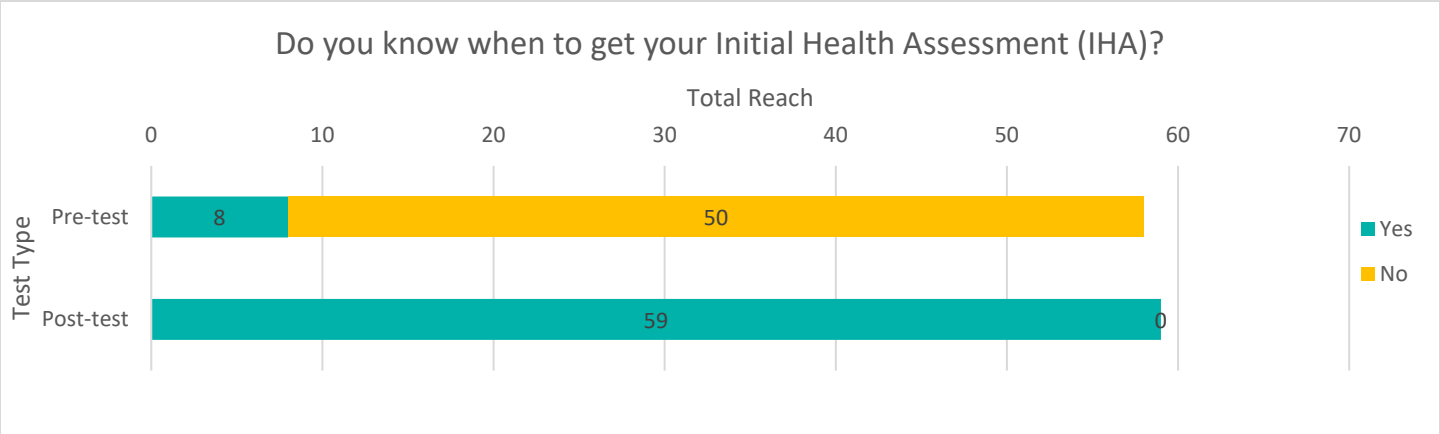
The Communications & Outreach Department began reporting the number of members reached during outreach activities in late February 2018. Since July 2018, **41,485** self-identified Alliance members have been reached during outreach activities.

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

On **Wednesday, March 18, 2020,** the Alliance began conducting member orientations by phone. As of August 31, 2025, the Outreach Team has completed **52,293** member orientation outreach calls and conducted **9,997** member orientations (**19.1%** member participation rate).

The Alliance Member Orientation (MO) program has existed since August 2016. In 2019, the program was recognized as a promising practice to increase member knowledge and awareness about the Initial Health Appointment (IHA) by the Department of Health Care Services (DHCS), Managed Care Quality and Monitoring Division (MCQMD). Our 2019 6-month average participation rate was **111** members per month. Between August 1, through August 31, 2025 (22 working days) – **58** members completed an MO by phone.

After completing the MO, **100%** of members who completed the post-test survey in August 2025 reported knowing when to get their IHA, compared to only **14%** 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\August 2025**

FY 2024-2025 AUGUST 2024 TOTALS

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

13 CITIES**

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

- 1431 TOTAL REACHED AT COMMUNITY EVENTS
- 179 TOTAL REACHED AT MEMBER EDUCATION EVENTS
- 97 TOTAL REACHED AT MEMBER ORIENTATIONS
- 0 TOTAL REACHED AT MEETINGS/PRESENTATIONS
- 0 TOTAL REACHED AT COMMUNITY TRAINING
- 1014 MEMBERS REACHED AT ALL EVENTS
- **1707 TOTAL REACHED AT ALL EVENTS**

$820.00 TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

FY 2025-2026 AUGUST 2025 TOTALS

- 6 COMMUNITY EVENTS
- 2 MEMBER EDUCATION EVENTS
- 58 MEMBER ORIENTATIONS
- 0 MEETINGS/ PRESENTATIONS
- 0 COMMUNITY TRAINING
- 11 TOTAL INITIATED/ INVITED EVENTS
- 66 TOTAL COMPLETED **EVENTS**

10 CITIES**

- Alameda
- Ashland
- Berkeley
- Castro Valley
- Cherryland
- Hayward
- Oakland
- Pleasanton
- San Leandro
- Union City

- 1421 TOTAL REACHED AT COMMUNITY EVENTS
- 336 TOTAL REACHED AT MEMBER EDUCATION EVENTS
- 58 TOTAL REACHED AT MEMBER ORIENTATIONS
- 0 TOTAL REACHED AT MEETINGS/PRESENTATIONS
- 0 COMMUNITY TRAINING
- 1048 MEMBERS REACHED AT ALL EVENTS
- **1815 TOTAL REACHED AT ALL EVENTS**

$685.00 TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

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

Compliance

Richard Golfin III

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

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

Date: **September 12th, 2025**

Subject: **Compliance Division Report**

Enterprise Audit Updates

- 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 awaiting the DMHC's preliminary report.
- 2024 Department of Health Care Services (DHCS) Routine Full Medical Survey
    - The Department of Health Care Services (DHCS) conducted its Routine Full Medical Survey from June 17th to June 28th, 2024. The Plan received a total of twenty (20) findings. The Plan completed its final CAP update on June 23rd, 2025, and is currently awaiting further guidance from DHCS.
- 2023 Department of Health Care Services (DHCS) Focused Medical Survey
    - On September 4th, 2024, the DHCS issued the Final Medical Survey Audit Report and CAP Request for the 2023 DHCS Focused Medical Survey. Nine (9) CAPs 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 data exchange between the Alliance and Alameda County Behavioral Health (ACBH) remains to have challenges with the Release of Information (ROI) barriers and incomplete SmartCare system migration. DHCS confirmed receipt of the Plan's last update, submitted on June 16th, 2025. "Attachment A" CAP document. The Plan submitted the revised "Attachment A" on August 15th, 2025, and is currently awaiting DHCS' review and response.
- 2025 Department of Managed Health Care (DMHC) Financial Examination
    - The DMHC held its entrance conference and began its routine examination of the Plan's fiscal and administrative affairs, including an examination of the financial report for the quarter ending March 31st, 2025 on August 4th, 2025. DMHC's review remains ongoing with daily conference calls with questions regarding the case files that they have reviewed. Written daily requests continue to be coordinated.

- 2025 Health Services Advisory Group, Inc. (HSAG) Network Adequacy Validation Audit (NAV)

    - The Plan's virtual interviews were conducted on August 11th, 2025. On August 12th, 2025, HSAG issued a request for additional documentation. The Plan submitted the requested materials on August 14th, 2025, in advance of the September 2nd, 2025, deadline. HSAG's review of the submission remains in progress.

Compliance Program Activity – All LOBs

- Bid and Formulary Submission

    - On June 2nd, 2025, the Alliance successfully submitted its CY2026 Medicare Bid and Formulary to CMS by the required deadline. The CMS Desk Review—a standard, post-submission process in which CMS analysts evaluate the bid for accuracy, completeness, and compliance with regulatory requirements—has been completed. The Alliance awaits approval of its Bid Pricing Tool, a spreadsheet-based tool used to calculate plan pricing, including premiums, cost-sharing, and subsidies that must be actuarially certified. In prior years CMS has completed this review by August 12th; however, CMS staffing reductions may delay this to late August.

- Department of Managed Health Care (DMHC) Medicare Filings

    - CY26 Medicare, 2024 EAE D-SNP Material Modification Filing (E-Filing No. 20244060). Per the DMHC EAE D-SNP Checklist, if Plans develop member facing notices, they must submit them as an amendment to its Material Modification filing. On August 1st, 2025, the Plan submitted several Case Management and Disease management letters for DMHC's review. On August 25th, 2025, the Plan received a new Comment Table from DMHC containing feedback related to member notification letters that are due by September 24th, 2025.

- New Legislation

    - On March 21st, 2025, Compliance submitted DMHC's 2024 Annual Newly Enacted Statutes All Plan Letter (APL 24-023) filing. This APL includes seventeen newly enacted laws that impact the Plan's Medi-Cal and/or Group Care lines of business. As of August 15th, 2025, the Plan has received and responded to two comment tables from DMHC. Senate Bill 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. Compliance is awaiting further guidance in a new APL to be issued by the DMHC.

- On April 1st, 2025, DMHC published APL 25-007 which provides guidance and outlines compliance requirements related to Assembly Bill 3275. The bill, effective January 1st, 2025, adjusts the claims reimbursement timeframe from 45 working days to 30 calendar days. Compliance has created several workstreams to identify implementation activities and submitted an e-Filing to DMHC on August 1st, 2025. 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. The most pressing issue remains the need for DHCS to provide a definitive list of impacted "Prohibited Entities." Compliance will continue to actively support IPD and the impacted SMEs.

- Alameda Alliance Privacy Office Operational Updates

  - Notice of Privacy Practices

    - In September 2025, the Alameda Alliance Privacy Office submitted an update to the NPP Policy and Procedure for Administrative Oversight Committee (AOC) review to support compliance with Dual Eligible Special Needs Plan (D-SNP) regulatory requirements. The Policy and Procedure updates were intended to align with current federal and state guidelines and to ensure appropriate communication of members' privacy rights.

  - Authorized Representative Form

    - In September 2025, the Alameda Alliance Privacy Office submitted an update to the AOR Policy and Procedure for AOC review to support compliance with Dual Eligible Special Needs Plan (D-SNP) regulatory requirements. These updates were intended to align with current federal and state guidelines and to ensure appropriate communication of members' AOR rights, including Part D and sensitive services.

  - HIPAA Incident Reporting & Handling

        - In September 2025, the Privacy Office submitted updated HIPAA Incident Reporting and Handling Policy and Procedure to AOC as part of its ongoing efforts to strengthen organizational readiness for Dual Eligible Special Needs Plan (D-SNP) implementation. These revisions were designed to ensure alignment with applicable federal and state privacy regulations, clarify internal reporting procedures, and enhance the Plan's ability to promptly identify, assess, and respond to potential privacy breaches in accordance with HIPAA requirements.

    - Minimum Necessary Standard

        - In September 2025, the Alameda Alliance Privacy Office submitted an update to the Minimum Necessary Policy and Procedure for AOC review to support compliance with Dual Eligible Special Needs Plan (D-SNP) regulatory requirements. The Policy and Procedure updates align with current federal and state guidelines.

    - Q2 Executive Summaries

        - Q2 Executive Summary for HIPAA Incidents was submitted to the Chief Compliance and Privacy Officer; the overview showed a decrease in the overall number of incidents and an increase in timely reporting. The categories of verified incidents with the highest volume are unsecured emails with PHI, misdirected mail due to address updates required, and expired AORs. No State or Federal reportable breaches occurred in Q2.

        - Q2 Executive Summary for Privacy Rounds conducted at the Alameda Alliance for Health office was submitted to the Chief Compliance and Privacy Officer. All work devices were appropriately locked and secured when not in use. The number of identified PHI printouts unsecured in work areas was significantly reduced. Securing printed PHI continues to be a focal point of the audits, and meetings with facilities and department leaders are underway.

- 2024 Board of Governors Training

    - As outlined in the Compliance Plan, the Plan has assigned HIPAA and FWA training to all new and standing members of the Board. Of the eighteen Board members, sixteen (16) have either completed their training or submitted sufficient proof of equivalent outside training, and two (2) have 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 or virtual training opportunity in September for the two Board of Governors members 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).

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: **September 12th, 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

a. 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 – August 19,2025

At the Peer Review and Credentialing (PRCC) meetings held on August 19, 2025, there were one hundred and thirty-four (134) initial network providers approved; Four (4) primary care providers, six (6) specialists, nine (9) ancillary providers, twelve (12) midlevel providers, and one hundred and three (103) behavioral health providers.

Additionally, eight-four (84) providers were re-credentialed at this meeting; eight (8) primary care providers, thirteen (13) specialists, one (1) ancillary provider, eight (8) midlevel providers, and fifty-four (54) 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 decreased month-over-month from July to August 2025.

Total Authorization Volume (Medical Services)			
Authorization Type	**June 2025**	**July 2025**	**August 2025**
Inpatient	2,527	2,809	2,656
Outpatient	4,040	4,615	4,685
Long-Term Care	670	864	789
Total	**7,237**	**8,288**	**8,130**

***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 4,608 for the month of July. We also processed 453 CCS referrals, of which 128 cases were submitted to our regional CCS office for review. 64 cases were approved; 39 denied, 26 pending.

- OP Turnaround times continue to exceed the benchmark of 95%, with the average being 99.67.1% 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.

Total Outpatient Authorization Volume			
Authorization Status	**June 2025**	**July 2025**	**August 2025**
Approvals	3,866	4,420	4,462
Partial Approvals	23	23	23
Denials	151	172	200
Total	**4,040**	**4,615**	**4,685**

***Source**: #02569_AuthTAT_Summary*

Outpatient Authorization Denial Rates			
Denial Rate Type	**June 2025**	**July 2025**	**August 2025**
Overall Denial Rate	**5.0%**	**4.0%**	**2.9%**
Denial Rate Excluding Partial Denials	**4.5%**	**3.6%**	**2.6%**
Partial Denial Rate	**0.%**	**0.5%**	**0.3%**

***Source**: #03690_Executive_Dashboard*

Outpatient Turn Around Time Compliance *(benchmark: 95%)*			
Line of Business	**June 2025**	**July 2025**	**August 2025**
Overall	99.7%	99.5%	97.1%
Medi-Cal	99.7%	99.4%	97.1%
IHSS	99.4%	100%	97.0%

***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) decreased slightly from 2809 authorizations processed in July 2025 to 2656 in August.

- Inpatient overall average LOS stayed consistent at 5.4in 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 continues to meet or surpass 95% benchmark, with overall TAT of 97% in June, and 95% in July and August.

- 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	**June 2025**	**July 2025**	**August 2025**
Approvals	2,464	2,735	2,598
Partial Approvals	0	0	0
Denials	63	74	58
Total	**2,527**	**2,809**	**2,656**

Source: #02569_AuthTAT_Summary

Inpatient Med-Surg Utilization			
Total All Aid Categories			
Actuals (excludes Maternity)			
Metric	**May2025**	**June 2025**	**July 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 July 2025

Inpatient Authorization Denial Rates			
Denial Rate Type	**June 2025**	**July 2025**	**August 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	**June 2025**	**July 2025**	**August 2025**
Overall	97%	95%	95%
Medi-Cal	97%	95%	95%
IHSS	100%	100%	95%

Source: #02569_AuthTAT_Summary

Utilization Management: Long-Term Care

- LTC census during August 2025 was 2,389 members. This is an increase of 0.54% (13 members) from July 2025.

- Month to Month, the admissions, days and readmissions are decreasing. From May to July the admissions decreased by 57.45%, the days decreased by 68.64% and the readmissions also decreased by 57.14%. Some of this could be due to a lag in claims data being available, but we are seeing a decrease overall.

Totals	**May 2025**	**June2025**	**July 2025**
Admissions	141	1112	60
Days	995	783	312
Readmissions	35	29	15

****Source: #14236_LTC_Dashboard – data only available through July 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 has met 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 current Health Navigator position is currently open and the new employee will start September 8, 2025.

- Authorization volume increased in July, compared to May and slightly decreased in August compared to July.

- Authorization processing turn-around time (TAT) has remained between 98%- 99%, which is exceeding the threshold of 95%.

Total LTC Authorization Volume			
Authorization Status	**June 2025**	**July 2025**	**August 2025**
Approvals	626	813	749
Partial Approvals	0	0	0
Denials	44	51	40
Total	**670**	**864**	**789**

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	**June 2025**	**July 2025**	**August 2025**
Medi-Cal	99%	99%	98%

Source: #02569_AuthTAT_Summary

Behavioral Health

- In August, the Behavioral Health Department processed 593 authorizations, 392 Care Coordination referrals, and 212 mental health screenings and transition of care tools.

Total BH Authorization Volume			
	25-June	**25-July**	**25-Aug**
Approvals	642	726	582
Partial Approval	0	1	2
Denials	9	29	9
Total	651	756	593

Source: 14939_BH_AuthTAT

Mental Health Turnaround Times

MH TAT

*Goal ≥95%	25-June	25-July	25-Aug
Determination TAT%	96%	97%	99%
Notification TAT%	96%	98%	96%

Behavioral Health Therapies (BHT/ABA) Turnaround Times

BHT TAT			
*Goal ≥95%	25-June	25-July	25-Aug
Determination TAT%	95%	96%	99%
Notification TAT%	100%	100%	100%

Behavioral Health Denial Rates

*Goal ≤ 5%	BH Denial Rates	
25-June	25-July	25-Aug
1%	<1%	<1%

Source: 14939_BH_AuthTAT

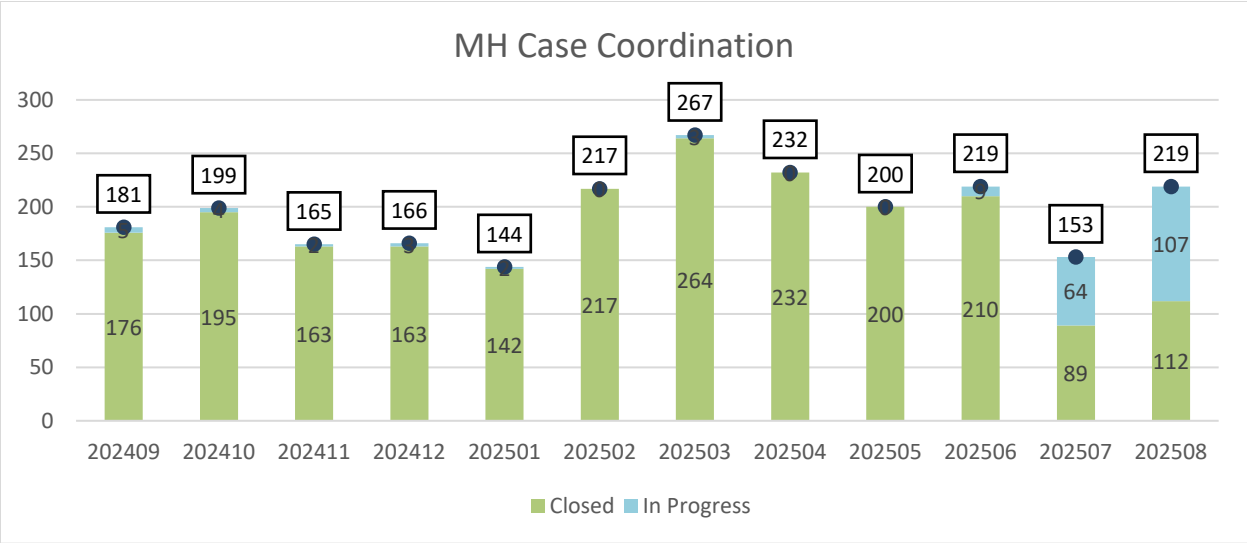
Mental Health Care Coordination

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

Total # Medi-Cal Screenings & TOC			
	25-June	25-July	25-Aug
Youth Screenings	59	75	84
Adults Screenings	131	153	127
Transition of Care Tools	2	3	1

Source: 16015_MH_Assessments

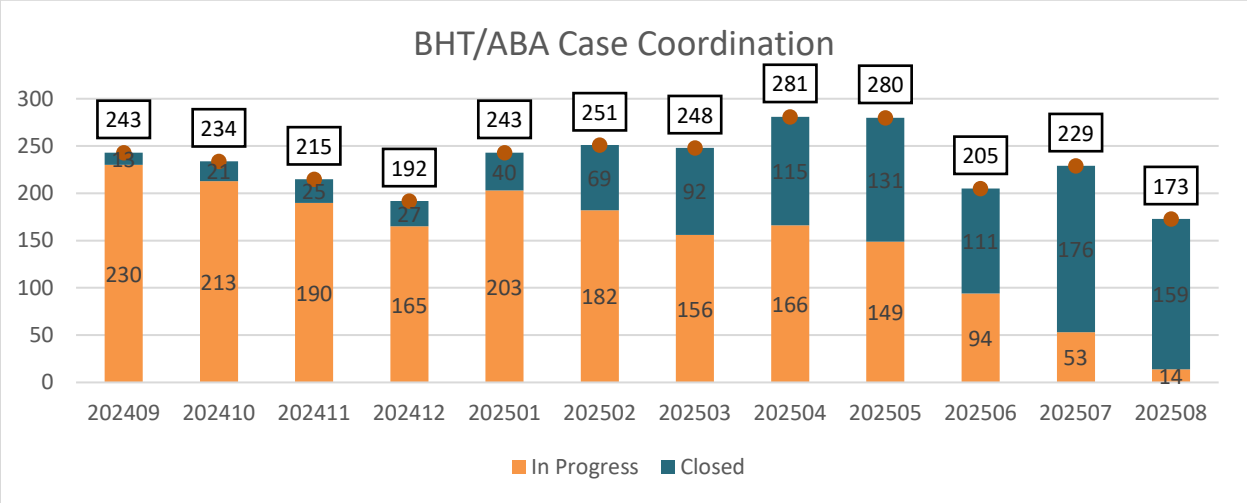
- Alliance licensed mental health clinicians, psychiatric nurses, and behavioral health navigators provide care coordination for members who need assistance accessing the mental health treatment services they need.



Source: 14665_BH_Cases

Behavioral Health Therapies (BHT/ABA)

- Children and youth referred for BHT/ABA services, including Applied Behavioral Analysis (ABA) and Comprehensive Diagnostic Evaluations (CDE), require Care Coordination to access the services needed. The Alliance manages each child's unique needs and follows up with parents and caregivers to resolve barriers to care.

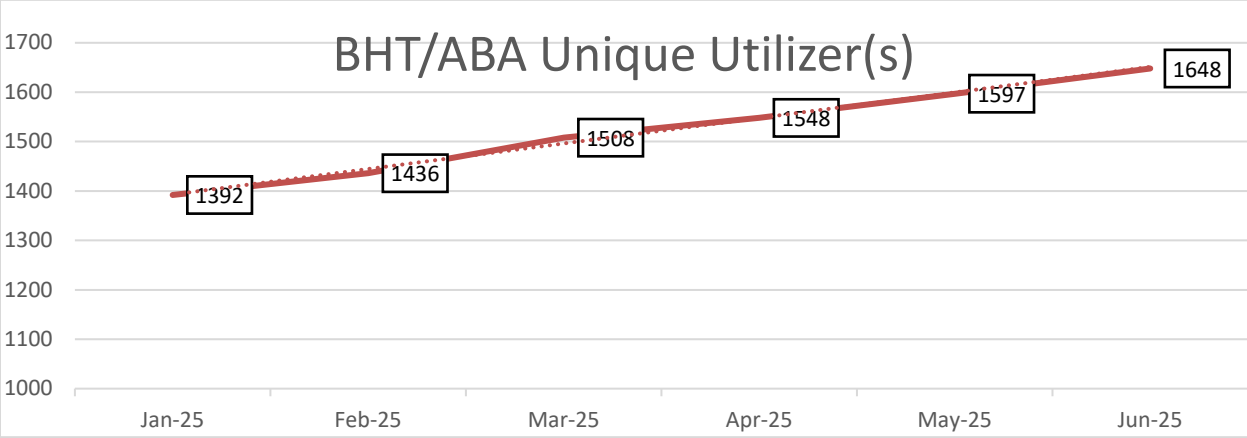


Source: 14665_BH_Cases

Behavioral Health Unique Utilizers

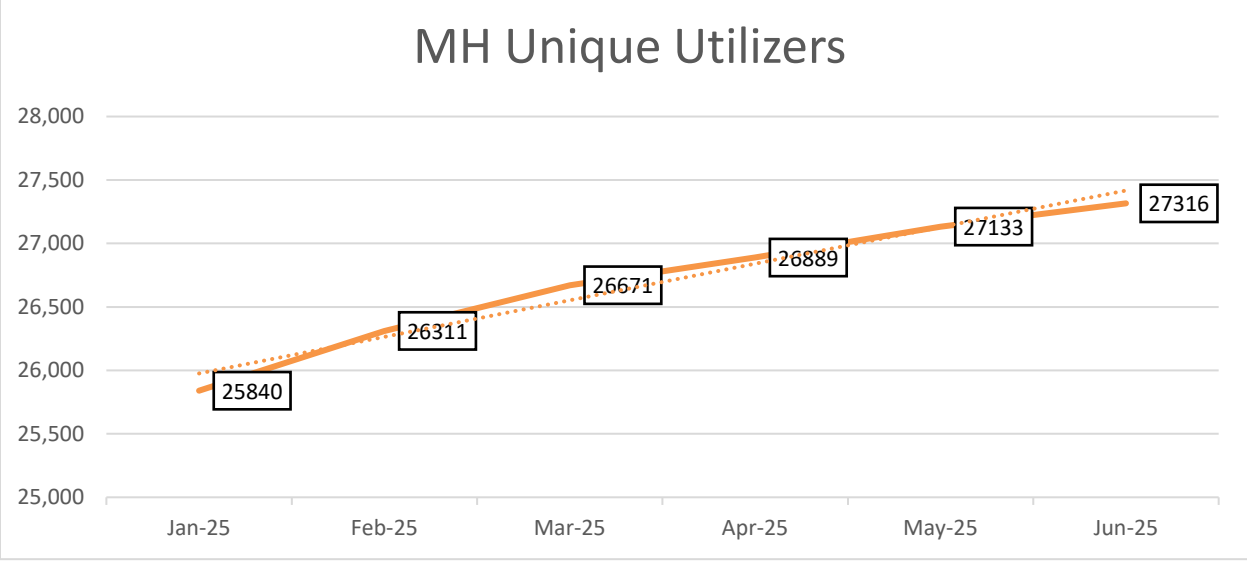
- Removing barriers to accessing BHT/ABA services remains a primary goal for the Alliance Behavioral Health team. One way to measure that is to monitor unique utilizers who are accessing care when interventions are implemented.

- We observed a continuing rise in unique utilizers of BHT/ABA services, reflecting a 3.1% increase compared to the previous month.



Source: PBI 14621 BHT Utilization Report

- The number of unique utilizers of mental health services has increased by 0.7% compared to the previous month.



Source: PBI 14637 BH12M Report

Pharmacy

- Pharmacy Services process outpatient pharmacy claims, and pharmacy prior authorization (PA) has met turn-around time compliance for Group Care line of business (LOB) for August 2025:

LOB	Number of Outpatient PAs Processed	Turn Around Rate Compliance (%)
GroupCare	159	100%

Decisions	Number of PAs Processed in August, 2025
Approved	31
Denied	107
Closed	21
Total	**159**

- Medications for diabetes, weight management, nerve pain, diabetes and asthma are in the top 10 categories for denials.

August Ranking	Drug Name	Common Use	Common Denial Reason
1	WEGOVY Soln Auto-inj 0.25MG/0.5ML	Weight Management	Criteria for approval not met
2	LIDOCAINE PATCH 5%	Nerve Pain	Criteria for approval not met
3	ZEPBOUND Soln Auto-inj. 2.5MG/0.5ML	Weight Management	Criteria for approval not met
4	JARDIANCE Tablet 10MG	Diabetes	Criteria for approval not met
5	TRELEGY ELLIPTA Aero Pow Br Act 100;62.5;25MCG/ACT	Asthma	Criteria for approval not met
6	ZEPBOUND Soln Auto-inj. 5MG/0.5ML	Weight Management	Criteria for approval not met
7	WEGOVY Soln Auto-inj. 2.4MG/0.75ML	Weight Management	Criteria for approval not met
8	JARDIANCE 25MG	Type 2 Diabetes	Criteria for approval not met
9	WEGOVY Soln Auto-inj. 1MG/0.5ML	Weight Management	Criteria for approval not met
10	MOUNJARO Soln Auto-inj. 2.5MG/0.5ML	Type 2 Diabetes	Criteria for approval not met

- The Pharmacy Transitional Care Services (TCS) program has screened 29 Heart failure cases, 48 Sepsis cases, and received 1 direct referral for the month of August 2025.

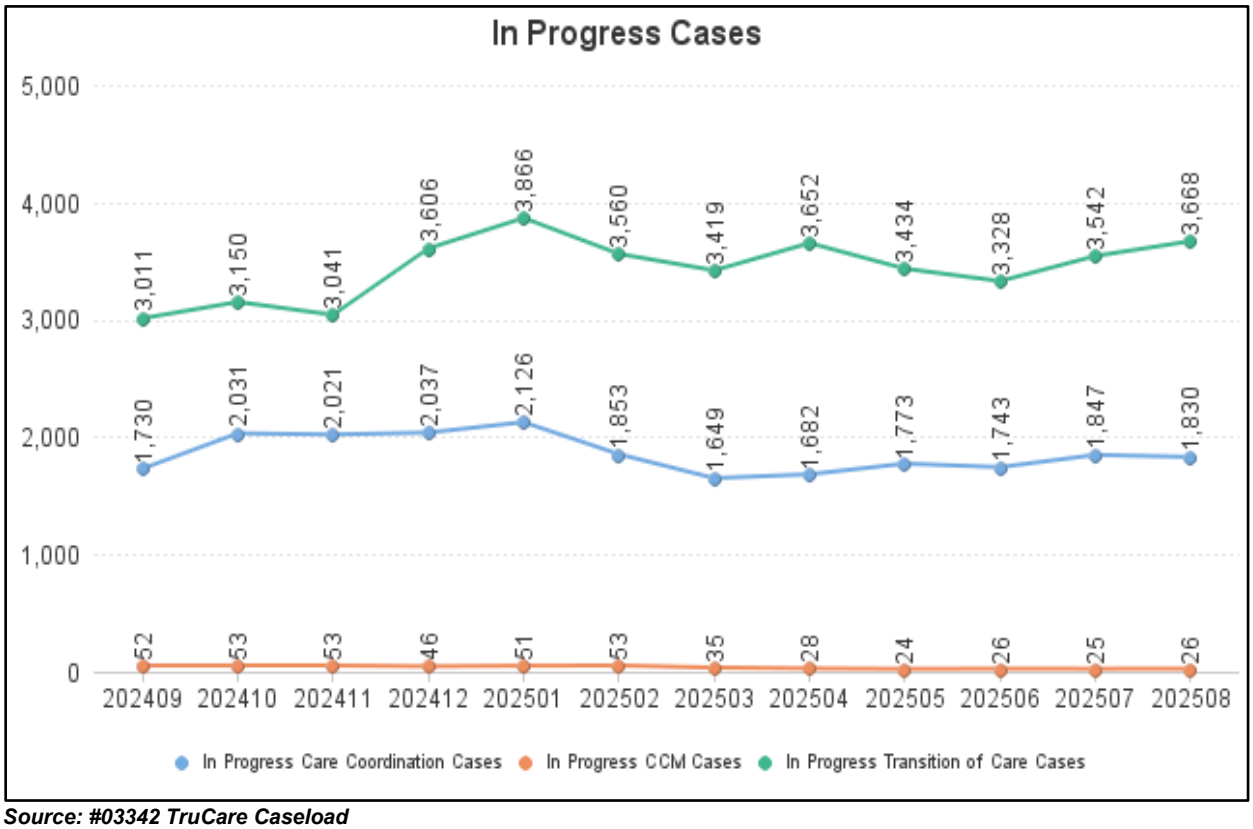
Case and Disease Management

- 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.

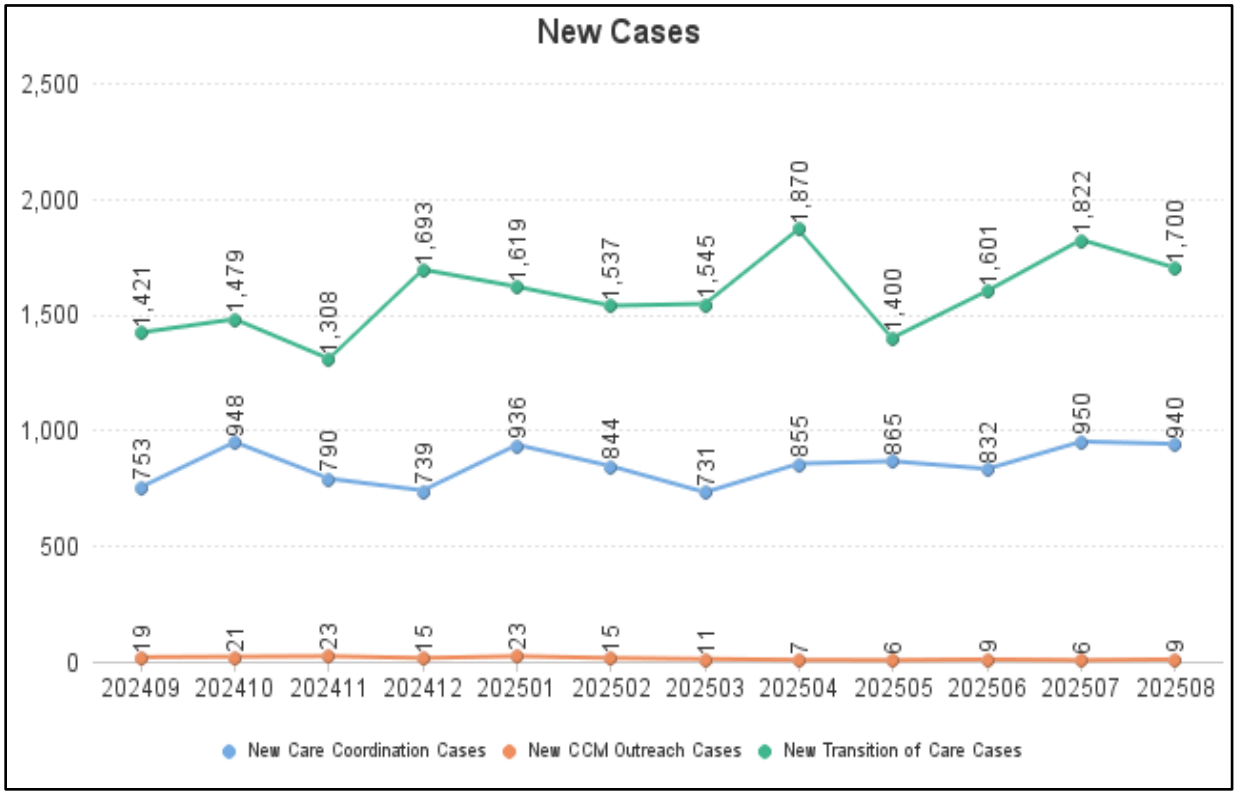
- The CM team continues to collaborate with clinic partners to ensure the TCS requirements are met, including but not limited to scheduling and ensuring follow-up appointments for members, informing members of CM services, notifying appropriate individuals of TCS services (hospital discharge planners,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

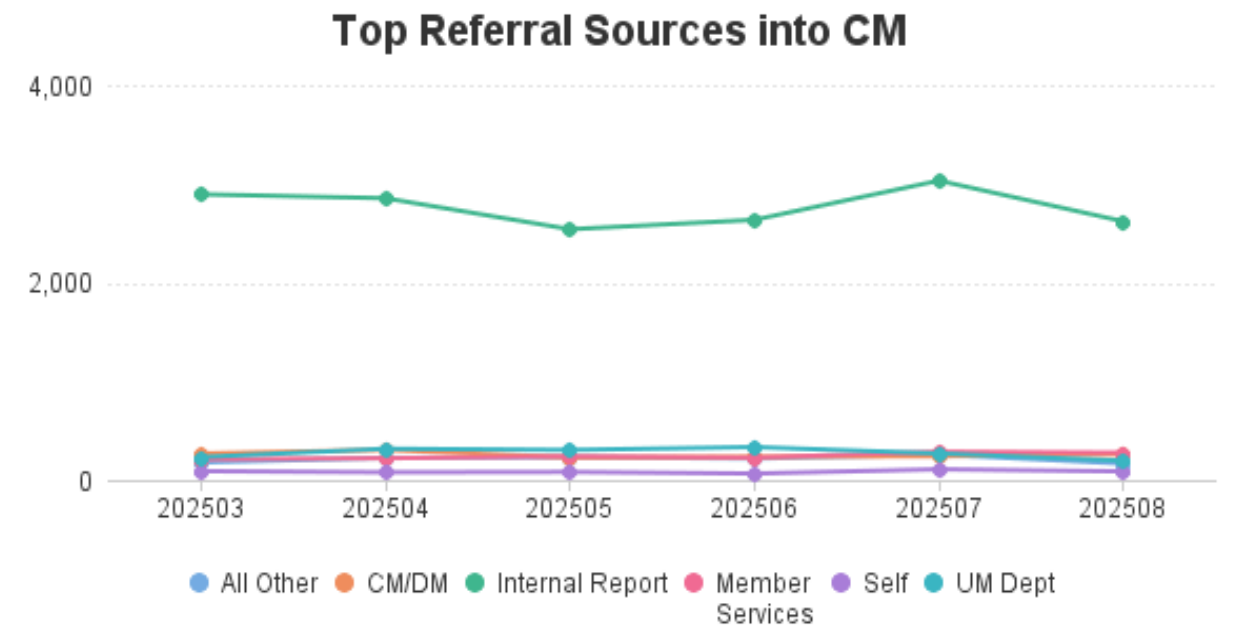
- CM is responsible for acquiring Physician Certification Statement (PCS) forms before Non-Emergency Medical Transportation (NEMT) trips to better align with DHCS requirements for members who need that higher level of transportation (former completed by Transportation broker, Modivcare). CM continues 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.



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 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 begun. 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 at a minimum twice a month: once to discuss specific cases and once to discuss operational issues. This has led to more collaboration and community referrals to additional resources. Additional meetings are scheduled with ECM providers for case conferencing 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 developed training for the ECM providers to re-educate the ECM provider network on the core services DHCS is requiring for ECM. The ECM team scheduled monthly training sessions for all ECM providers' frontline staff to reinforce ECM requirements and expectations. The last training was held Friday, July 11, 2025.

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

- 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.

	May 2025		June 2025		July 2025	
ECM Providers	**Outreach**	**Enrolled**	**Outreach**	**Enrolled**	**Outreach**	**Enrolled**
ACBH	-	13	-	13	-	13
Alameda Health System (AHS)	28	222	29	216	-28	219
Bay Area Community Services (BACS)	-	129	-9	129	3	132
California Cardiovascular Consultants	-	149	-	148	-	148
California Children's Services (CCS)	6	32	5	35	6	39
CHCN	104	1,046	77	1,048	87	1,060
East Bay Innovations (EBI)	20	124	14	125	2	130
Full Circle	5	218	184	225	24	194
Institute on Aging	121	253	36	223	-	221
La Familia	32	43	48	42	40	45
MedZed	16	659	40	710	64	788
Roots Community Health Center	1	689	-	707	-	650
Seneca Family Services	75	65	27	68	-	64
Pair Team	753	1601	629	1654	416	1685
Titanium Health Care	508	961	584	1007	659	1068
Tiburcio Vasquez Health Center (Street Medicine)	-	50	-	49		49
BACH (Street Medicine)	40	232	37	226	24	230
Lifelong (Street Medicine)	9	539	12	609	14	634
Roots Community Health Center (Street Medicine)	Combined with Roots 'traditional' ECM program					

Source: #13360 ECM Dashboard

Community Supports (CS)

- DHCS released new policy guides for all Community Supports on 04/30/25. The Alliance's Community Supports guidance was sent to providers, with an effective date of 07/01/25 for all non-housing Community Supports. 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 will start October 2025, aligned 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 May 2025	Services Authorized in June 2025	Services Authorized in July 2025
Housing Navigation	963	957	958
Housing Deposits	335	372	412
Housing Tenancy	790	859	941
Asthma Remediation	155	148	147
Meals	643	552	582
Medical Respite	69	64	57
Transition to Home	18	18	13
Nursing Facility	11	9	7
Home Modifications	3	3	3
Homemaker Services	37	22	29
Caregiver Respite	0	0	0
Total	**3,024**	**3,004**	**3,149**

Source: #13581 Community Supports Auth Dashboard

Community Health Strategy (CHS) – August

- 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** – final interviews completed

August Program Summary:

- The month of August brought meaningful opportunities for collaboration and partnership with both internal and external stakeholders. Through close coordination with colleagues in Quality, Health Equity, Compliance, Housing, Public Affairs, and other Alliance teams, the Community Health Strategy (CHS) department successfully completed final interviews for the Manager, Community Health Initiatives role. We are especially grateful to our outstanding Human Resources team for their partnership and look forward to welcoming a new leader to the Alliance family in September.

- This month also offered important space for reflection, as CHS continues to ground its work in the principles of cultural humility, serving as a responsive partner to providers while addressing member needs. We successfully convened a Transitional Care Partnership meeting with Sutter Health to refresh and strengthen CHW, Emergency Department collaboration, and we look forward to carrying this momentum into September with Alameda Health System CHW teams, who are working tirelessly to deliver culturally and linguistically responsive interventions for our members. In addition, CHS was invited by the Population Health team to participate in CHA/CHIP discussions with Alameda County Public Health, ensuring that Alliance remains aligned with public health priorities and positioned as a unified system addressing both clinical and non-clinical solutions for our members.

- Finally, thanks to the vision and commitment of our Executive and Senior Health Care Services leadership, CHS engaged in cross-functional collaboration across HCS teams, advancing cross-training in care planning, complex case management, and leadership development. These shared efforts are building stronger connections across our organization and reinforcing Alliance's collective commitment to member well-being.

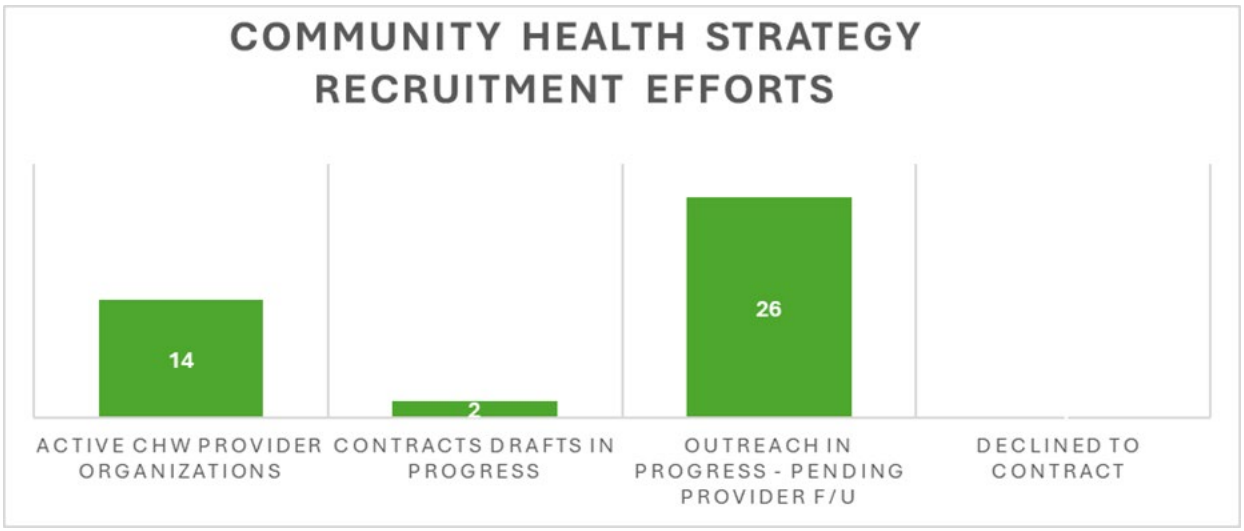
Project Status Updates:

CHW 12+ Unit SR Module Development Project	In Progress
CHW Billing Mitigation Reports	Ongoing
CHW Program Integration Strategy – Revisions	In Progress
CHW Hiring Interview Process	Completed

CHW Program – Recruitment Efforts:

- As of this reporting period, the Community Health Strategy program has successfully recruited fourteen (14) Community Health Worker (CHW) provider organizations to deliver CHW interventions for Alliance members. Two (2) contracts remain pending, and twenty-five (25) provider organizations are currently in the outreach phase awaiting follow-up.

- Importantly, no providers declined to contract or were deemed ineligible during this period, reflecting strong interest and alignment in expanding the CHW network. While provider pre-screening has experienced a slight delay due to capacity constraints, these efforts remain on track. A more rapid onboarding cadence is anticipated in late September through early October, positioning CHS to support the timely integration of new provider partners into the network efficiently and effectively.



Community Health Strategy August - Community Engagement Highlights:

- Eden I&R 211 Alameda Alliance For Health – Scheduled Onsight Design Thinking Session to join forces on opportunities to expand our community impact through collaborative service models, technology and CHW interventions. The group has successfully convened and will have its first design session in September 2025. Design thinking brings opportunities to:
    - Explore Systems Alignment – Opportunity to bring together CHWs' trusted, relational care with Eden I&R's information and referral infrastructure to test new ways of bridging health and social services.
    - Co-Design to strengthen SDOH – Use design-thinking approaches to generate ideas that could better address priority community needs (housing, behavioral health, safety, access) highlighted in local assessments with SDOH information Alliance may not be capturing.
    - Innovate Referral Pathways – Explore models for closed-loop referrals and data sharing that ensure members are successfully connected to services, not just referred.
    - Foster Shared Learning – Create space for CHWs, navigators, and community partners to inform system-level design, workforce development, and future collaborative opportunities.

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.

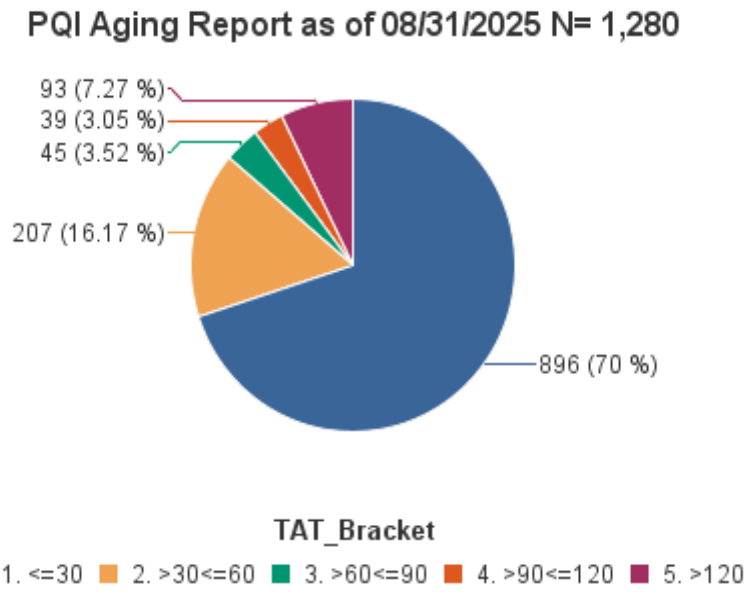
- When cases are open past TAT, the reason is typically due to delay in receipt of medical records and/or provider responses. As part of the escalation process of obtaining medical records and/or responses, efforts are made to identify barriers with specific providers to find ways to better collaborate to achieve resolution.

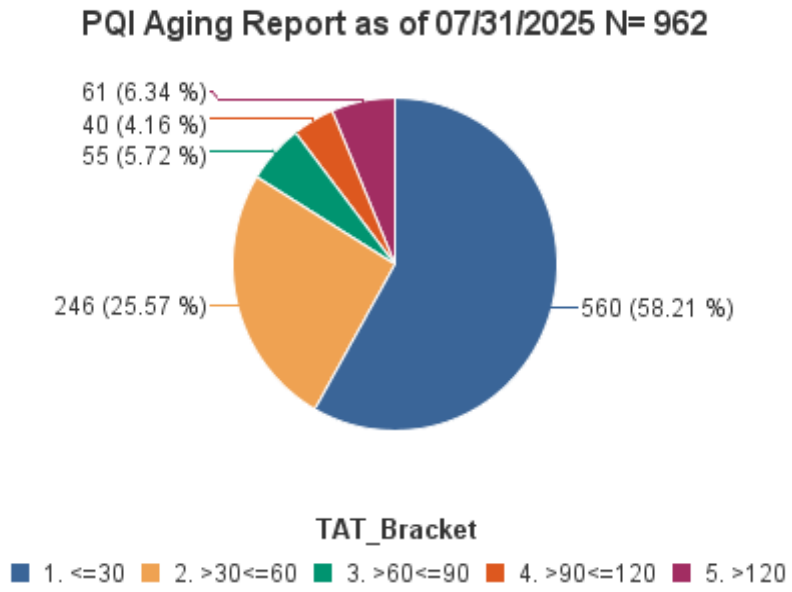
- Since November 2024, there has been a slower rate of MD case closure of Quality of Care (QOC) cases due to the vacancy of the QI Medical Director role. The Plan has been actively seeking a replacement since that time.

- The PQI Aging Reports shown below for July and August 2025 are based on a TAT of 120 days and both months were below the compliance rate of 95%. The July rate was 93.66% and in August it was 92.73%. The new rates based on 150-day TAT will be reflected starting in September 2025.

- 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 07/31/2025 N= 962
61 (6.34 %)
40 (4.16 %)
55 (5.72 %)
246 (25.57 %)
560 (58.21 %)
TAT_Bracket
1. <=30
2. >30<=60
3. >60<=90
4. >90<=120
5. >120

2024 Final HEDIS Rates – Managed Care Accountability Set

	2023		2024		Benchmarks	
Measure Description	**Admin Rate**	**Hybrid Rate**	**Admin Rate**	**Hybrid Rate**	**MPL**	**90th Pctl**
Behavioral Health						
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 30 Day	38.90%		44.48%		36.18%	49.40%
Follow-Up After Emergency Department Visit for Mental Illness - 30 Day	54.69%		66.38%		53.82%	73.12%
Cancer Prevention						
Breast Cancer Screening - ECDS	59.59%		59.62%		52.68%	63.48%
Cervical Cancer Screening	58.33%	60.58%	52.91%	59.37%	57.18%	67.46%
Chronic Disease						
Asthma Medication Ratio	69.88%		63.18%		66.24%	76.65%
Controlling High Blood Pressure	48.85%	65.21%	52.03%	60.10%	64.48%	72.75%
Glycemic Status >9.0%	32.06%		33.08%	28.95%	33.33%	27.01%
Reproductive Health						
Chlamydia Screening in Women	67.14%		70.04%		55.95%	69.07%
Timeliness of Prenatal Care	85.90%	90.87%	86.21%	91.28%	84.55%	91.85%
Timeliness of Postpartum Care	86.74%	89.95%	86.28%	92.44%	80.23%	86.62%
Well Child						
Childhood Immunization Status - Combo 10	41.24%	45.74%	38.20%	43.80%	27.49%	42.34%
Immunizations for Adolescents - Combo 2	49.27%	47.69%	47.92%	47.45%	34.30%	48.66%
Developmental Screening in the First Three Years of Life Total	54.39%		64.63%		35.70%	
Lead Screening in Children	60.78%	61.31%	66.75%	67.88%	63.84%	79.51%
Topical Fluoride for Children Rate1 - dental or oral health services	14.13%		17.74%		19.00%	
Well-Child Visits in the First 15 Months of Life - 6 or More Visits	58.67%		66.69%		60.38%	69.67%
Well-Child Visits for Age 15 Months to 30 Months - Two or More Visits	74.03%		77.73%		69.43%	79.94%
Child and Adolescent Well-Care Visits	56.30%		55.88%		51.81%	64.74%

- The chart above summarizes the 2024 Managed Care Accountability Set (MCAS) measures held to the Minimum Performance Level (MPL). Of the 18 measures that Alameda Alliance was accountable for against the MPL/50th percentile, 15 achieved or exceeded the target, while 3 fell below the MPL.

- Several factors contributed to this overall success, including provider education through webinars and 1:1 meetings, tools to support understanding of MCAS specifications, and best practice sharing. Internal staffing improvements also enhanced coordination of member outreach and incentive programs. Additionally, expanded data sharing, medical record retrieval, and coverage exclusions supported the Alliance in reaching its goals.

- The three measures that fell below the MPL were Asthma Medication Ratio (AMR), Controlling Blood Pressure (CBP), and Topical Fluoride for Children (TFL). Key barriers included verification challenges with AMR medications, DHCS payment and coding issues for TFL, and lifestyle-related challenges impacting blood pressure control.

- To address these gaps, the Quality Department has launched targeted improvement initiatives. These include enhanced data sharing and provider education for AMR and CBP, meetings with FQHC dental providers to increase understanding of the TFL measure, offering PCPs incentive payments and care gap alerts for in-clinic fluoride applications, and reinforcing accurate coding practices. With these strategies, the Alliance is confident in its ability to improve these measures and meet or exceed the MPL in future cycles.

Health Equity

Lao Paul Vang

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

From: **Lao Paul Vang, Chief Health Equity Officer**

Date: **September 12th, 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, several 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 3 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, 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.

  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 23-025 and APL 24-018 TGI-SB 923 training. b) Collaboration with Culture and Linguistic, PHM, QI, and other stakeholders to ensure all our policies, services, and programs are rooted in the core foundation of health equity. c) Participation in various Functional Area Delegate (FAD) workgroups to ensure the Alliance work supports the health equity vision and mission.

4. Communication	a) Collaboration with the Community and Outreach to develop effective communications on all aspects of health equity activities to ensure that staff and members are fully informed.
5. Community Engagement	a) The Faith-Based Community Engagement workgroup was established in December 2024, but was renamed the Community Engagement Workgroup to reflect more accurately our broader mission b) CIN membership (2025-2027). c) Allen Temple Baptist church: potential collaboration in health education and outreach d) Oakland Unified School District: potential joint parents survey to identify SDOHs for food insecurity and healthcare access. e) Native American Health Center: supported the annual Indigenous Red Market event on July 6. f) Glad Tidings International Church of God: initiated conversation on July 24.
6. SDOH Mitigation Measures	a) Collaborate with CMO and HCS team to assess and analyze non-utilization data aimed at identifying health disparities. b) Collaborate with QI and PHM to identify high-value clinical partners who would co-develop a relevant intervention to address specific SDOH.

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 of the Alliance staff.
  - The next step is to train our member-facing vendors, 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.
  - HE Team is working with the TGI work group to develop plans to train member-facing vendors as part of the next step in this APL.
  - Our overall goal is to achieve 90+% on both DEI and TGI training programs.

Diversity, Equity, Inclusion, and Belonging Committee (DEIBC) and Values in Action Committee (VIAC)

- **DEIB Committee Update**
  - The DEIB Committee met on August 1st and discussed the committee's role and purpose, including discussions regarding integrating DEIB with VIA into one holistic committee that can sufficiently address all health equity and staff DEI-related issues.

- **VIA Committee Update**
  - At the August 12th VIA Committee meeting, the committee brainstormed many ways to recognize staff.
  - VIA Committee members will also engage in discussions and decisions to support the integration of VIA and DEIB into one committee. Once a decision has been reached, there will be an update to the CEO and BOG.

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 the resources available to Black women in the Bay Area.	• Table event April 8, 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. • *Potential collaboration*, one-year grant-funded intervention to advance mental health healing through the arts. •
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 6, 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 • Table event at their 45th annual Holistic Health Fair on August 9 • Collaborators: church, QI team
7	Oakland Unified School District (OUSD)	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 24 • *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 8 • *Potential collaboration:* promote child health • Collaborator: QI
10.	Alameda Health System	One of pediatricians who work predominantly with Black mothers and children	• Potential partnership with pediatrician in Beloved Black Baby Initiative—culturally appropriate program designed to improve Well-Child measures and post-partum depression

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: **September 12th, 2025**

Subject: **Information Technology Report**

Call Center System Availability

- In August 2025, AAH phone systems and call center applications maintained 100% availability even as they supported 97% of employees working remotely.

- Alliance is working on extending this system to include Spanish language support for speech to text. The project to enable the Spanish language pack for Calabrio is currently in progress, including the preparation of installation scripts. Selected Member Services staff will conduct translation reviews and phrase tuning, with this phase expected to commence by the end of September 2025.

Encounter Data

- In the month of 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 August 2025 was received and loaded to HEALTHsuite.

HEALTHsuite

- The Alliance received 389,082 claims in the month of August 2025.

- A total of 331,937 claims were finalized during the month out of which 278,912 claims auto adjudicated. This sets the auto-adjudication rate for this period to 84.0%.

TruCare

- A total of 22,564 authorizations were loaded and processed in the TruCare application.

- TruCare Application Uptime – 99.9%.

SQL Server Upgrade to version 2022

Objective:

- To upgrade SQL server from 2016 to 2022 for SQLPROD/DBR1PROD by end of Q1 2026

Execution Plan:

- The upgrade is divided into two phases as Phase 1 and Phase 2

Phase 1:

- The Infra team has recommended conducting OS upgrade testing on a cloned server for this cycle. The tentative upgrade dates for deployment are currently set for September 20.

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.

- Renewed AAH's Top-Level-Domain for 9 more years.

- As part of our efforts to prevent ex-filtration of sensitive data, IT Security has implemented blocking uploading to top 3rd party email and cloud storage solutions.

- Vulnerability Management
  - Vulnerability scans are cadenced to be every 2 calendar weeks that begin on Sundays at 3pm PT.
  - Remediation roadmap provided by Gurpreet for patching of sensitive servers (ECS)
  - Efforts continue to reduce technical debt with End-of-Life/End-of-Service software

Information Technology

Supporting Documents

Enrollment

- See Table 1-1 “Summary of Medi-Cal and Group Care member enrollment in the month of August 2025”.
- See Table 1-2 “Summary of Primary Care Physician (PCP) Auto-assignment in the month of August 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 August 2025

Month	Total MC[1]	MC[1] - Add/ Reinstatements	MC[1] - Terminated	Total GC[2]	GC[2] - Add/ Reinstatements	GC[2]- Terminated
August	407,592	6,754	11,465	5,975	156	139

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 August 2025

Auto-Assignments	Member Count
Auto-assignments MC	1,900
Auto-assignments Expansion	2,128
Auto-assignments GC	68
PCP Changes (PCP Change Tool) Total	4,122

TruCare Application

- See Table 2-1 “Summary of TruCare Authorizations for the month of August 2025”.
- There were 22,564 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 August 2025*

Transaction Type	Total Auths Received
Paper Fax to Scan (DocuStream)	2,976
Provider Portal Requests (Zipari)	6,266
EDI (CHCN)	6,955
Provider Portal to AAH Online (Long Term Care)	3
ADT	1,343
Behavioral Health COC Update - Online	37
Behavioral initial evaluation - Online	42
Manual Entry	2,929
OCR Face sheets	2,013
Total	22,564

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	8,839	6,555		450,901	963
MCAL	130,177	4,197		10,301	1,340
IHSS	4,104	73		777	21
Total	143,120	10,825		461,979	2,324

Table 3-2 Top Pages Viewed for the Month of August 2025

Category	Page Name	Page Views
Provider - eligibility/claim	Member Eligibility	1,585,727
Provider - Claims	Claim Status	296,663
Directory Config	Provider Directory	10,583
Provider - authorizations	Auth Search	9,556
Provider - authorizations	Auth Submit	8,638
Provider - Claims	Submit professional claims	6,175
Member My Care	Member Eligibility	5,620
Member Config	Provider Directory	4,052
Member Help Resources	Find a Doctor or Hospital	3,533
Member Help Resources	ID Card	3,432
Provider - eligibility/claim	Member Roster	2,617
Member Home	MC ID Card	2,264
Member Help Resources	Select or Change Your PCP	2,100
Provider - Home	Behavior Health Forms SSO	2,040
Provider - Home	Long Term Care Forms SSO	1,668
Member My Care	My Claims Services	1,592
Provider - Provider Directory	Provider Directory 2019	1,065
Member My Care	Authorization	1,028
Provider - Home	Forms	791
Provider - reports	Reports	663
Member My Care	My Pharmacy Medication Benefits	537
Member My Care	Member Benefits Materials	452
Member Help Resources	FAQs	345
Provider - Provider Directory	Manual	321
Member Help Resources	Forms Resources	296

Call Center – Call Volume Overview:

Members - Call Center Statistics			
Month	Calls Presented	Calls Handled	Calls Abandoned
March	11867	11151	709
April	15436	10925	1420
May	13306	10204	999
June	12594	9969	969
July	14228	10876	1389
August	13903	10487	1291

Providers - Call Center Statistics			
Month	Calls Presented	Calls Handled	Calls Abandoned
March	8303	6869	1434
April	11128	8864	1768
May	10018	8263	1328
June	11255	8140	2323
July	11601	9503	1629
August	11243	8692	1926

- Calls Presented: Total number of calls received.
- Calls Handled: Total number of calls answered.
- Calls Abandoned: Calls abandoned before being completely answered.

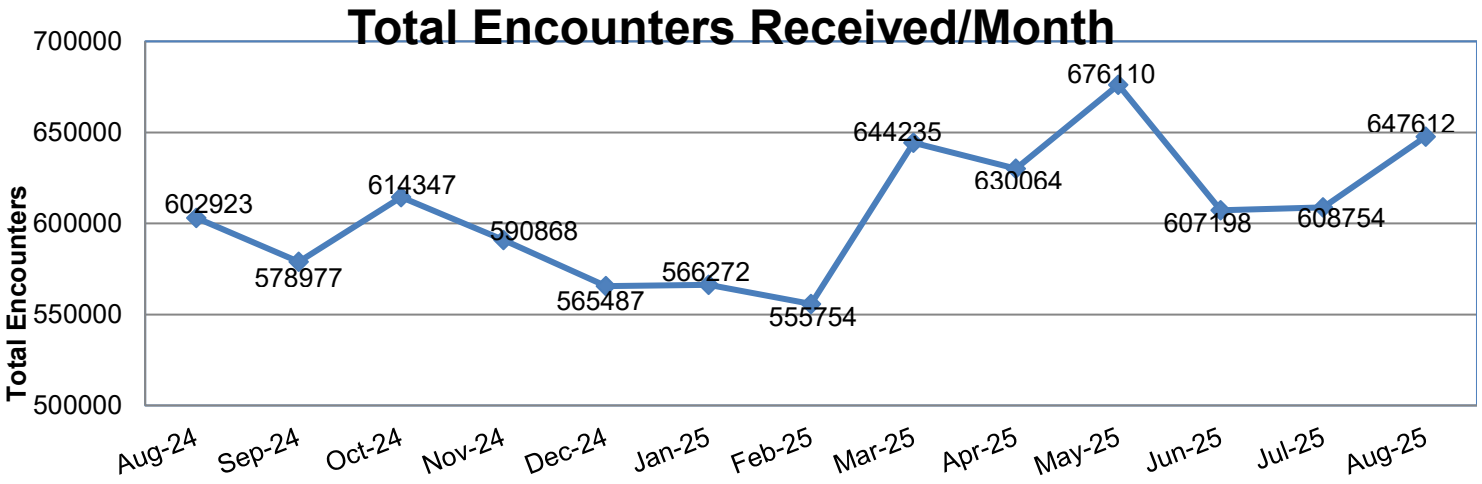
Note: It is important to note that there is a slight discrepancy between the number of calls presented, handled, and abandoned. This discrepancy is due to calls being rerouted to the XAQT vendor, which are not included in the calls handled or abandoned statistics. This rerouting can account for some of the differences observed in the totals.

Encounter Data from Trading Partners 2025

- **AHS**: August weekly files (10,257 records) were received on time.
- **BACH**: August monthly files (172 records) were received on time.
- **BACS**: August monthly files (82 records) were received on time.
- **CHCN**: August weekly files (132,885 records) were received on time.
- **CHME**: August monthly files (8,368 records) were received on time.
- **CFMG**: August weekly files (13,336 records) were received on time.
- **Docustream**: August monthly files (707 records) were received on time.
- **EBI**: August monthly files (1,940 records) were received on time.
- **FULLCIR**: August monthly files (3,972 records) were received on time.
- **HCSA**: August monthly files (2,453 records) were received on time.
- **IOA**: August monthly files (635 records) were received on time.
- **Kaiser**: August bi-weekly files (0 records) were received on time.
- **LAFAM**: August monthly files (83 records) were received on time.
- **LIFE**: August monthly files (541 records) were received on time
- **LogistiCare**: August weekly files (34,040 records) were received on time.
- **March Vision**: August monthly files (7,877 records) were received on time.
- **MED**: August monthly files (1,246 records) were received on time.
- **OMATOCHI**: August monthly files (0 records) were received on time.
- **PAIRTEAM**: August monthly files (14,426 records) were received on time.
- **Quest Diagnostics**: August weekly files (22,500 records) were received on time.
- **SENECA**: August monthly files (0 records) were received on time.
- **SERENE**: August monthly files (0 records) were received on time.
- **TITANIUM**: August monthly files (3,010 records) were received on time.
- **TVHC**: August monthly files (0 records) were received on time.
- **Magellan**: August monthly files (493,803 records) were received on time.

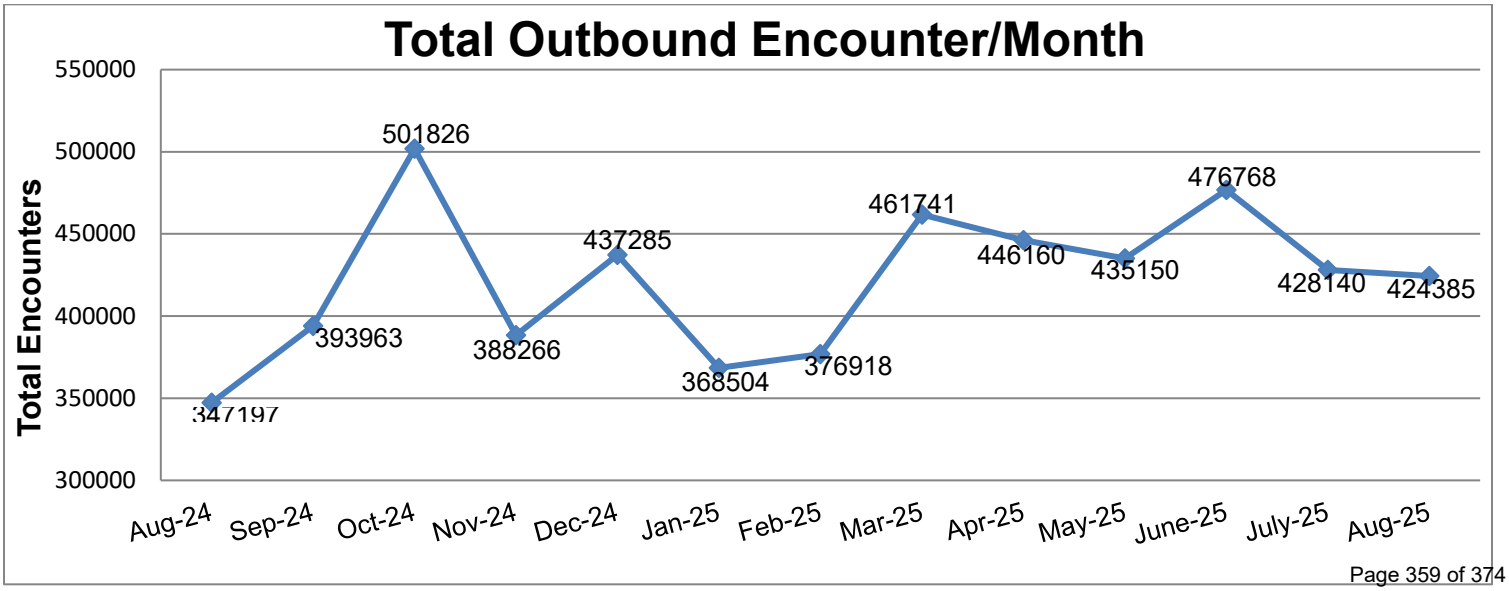
Trading Partner Encounter Inbound Submission History

Trading Partners	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
Health Suite	368235	322196	367989	364130	332108	339760	339840	347469	372126	387564	340224	355255	389082
AHS	8859	7498	8309	10535	7261	9709	8654	9273	8211	15875	7712	7880	10257
BACH				795		426		291	131		296	172	172
BACS	86	85	76	98	104	93	113	81	72	88	128	81	82
CHCN	122293	155825	125042	127223	127327	117483	118972	181049	117350	151416	170810	125697	132885
CHME	6902	7680	7102	7589	7458	7781	7553	6794	8293	9045	8638	8115	8368
CFMG	22335	16421	16045	21352	16696	13536	17329	21767	15856	21443	15710	13266	13336
Docustream	1102	1067	704	678	828	694	808	770	891	1068	1052	1216	707
EBI	1825	3394	1640	1725	1476	1440	1597	1390	2926	1457	1381	2946	1940
FULLCIR	1798	3809	2523	2038	1085	806	1534	2099	2025	1479	1441	3266	3972
HCSA	3256	3386	2389	3423	2335	2432	2725	2118	2384	2628	2467	2671	2453
IOA	752	4227	588	1064		3008	933	736		2068	3083	1851	635
Kaiser	172	236	159										
LAFAM	88	63	89	76	83	112	96	85	93	101	81	85	83
LIFE	614	168	119	335	997	228	267	431	317	1274	412	388	541
LogistiCare	29732	16139	49941	16183	34122	28671	32550	33754	55059	35875	15025	38834	34040
March Vision	7719	5769	5143	6016	6285	15146		6985	6704	7929	8100	6914	7877
MED	608	610	645	656	619	758	1182	775		1581	958	2722	1246
OMATOCHI	2												
PAIRTEAM		9359	1108	2204	5816	3436		2055	16360	9244	7724	15956	14426
Quest	22502	18004	18002	22501	18003	18002	18001	22502	18003	22501	18000	18000	22500
SENECA	129	101	105	117	131	1	69	129	108	109	160	76	
SERENE					654	107		209				581	
TITANIUM	3914	2815	6192	1537	2099	2487	3531	2855	3039	2970	3792	2782	3010
TVHC		125	437	593		156		618	116	395			
Total	602923	578977	614347	590868	565487	566272	555754	644235	630064	676110	607194	608754	647612



Outbound Encounter Submission

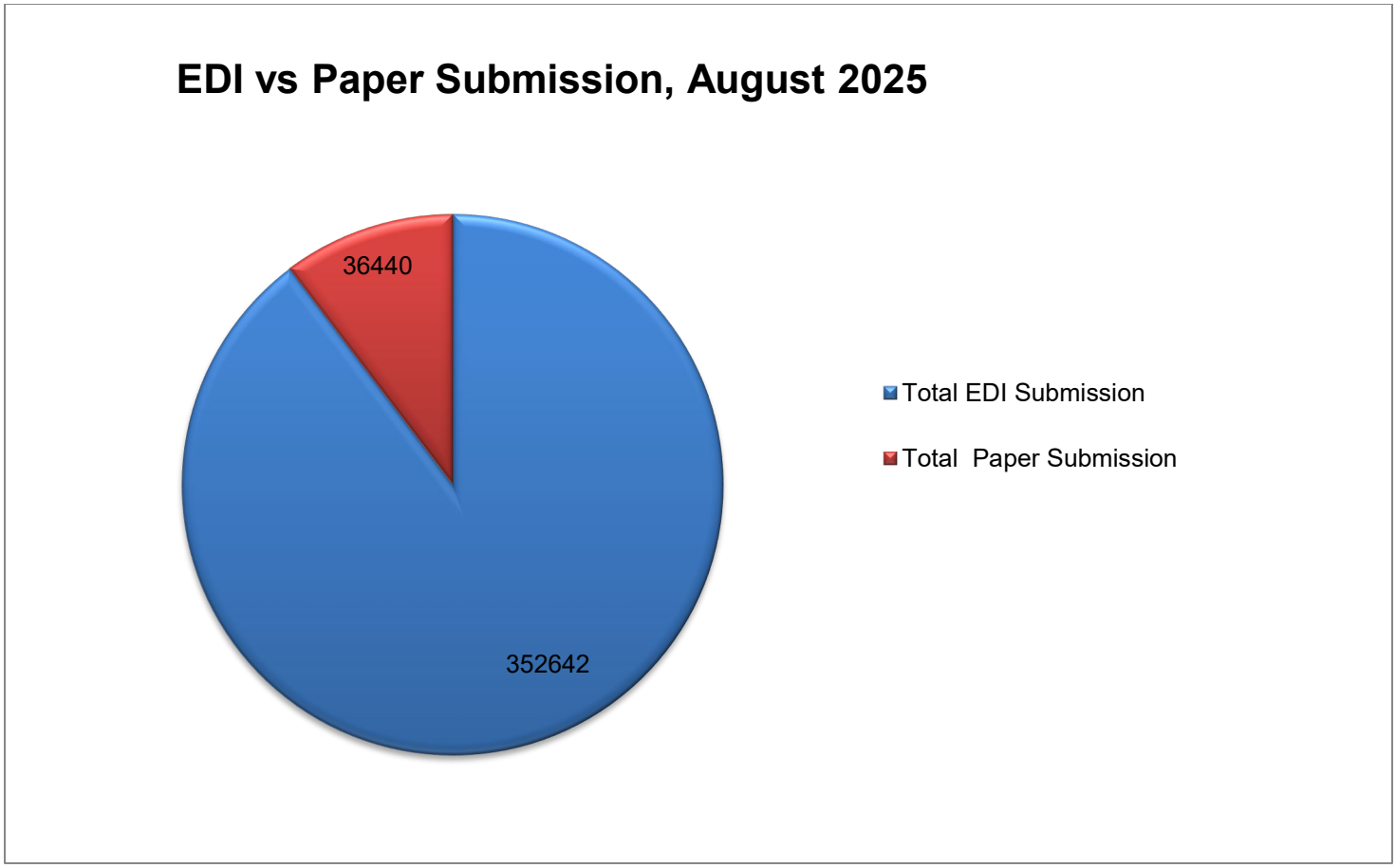
Trading Partners	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
Health Suite	183371	210971	276473	218194	263242	182192	205804	264948	210745	226401	284779	212832	228707
AHS	7101	8727	8201	10403	6850	7710	8135	7952	4510	9326	14010	7038	10166
BACH				739	6	407		272	110		270	138	
BACS	80	78	74	79	41	128	87	59	23	51	59	60	52
CHCN	87485	87806	108806	88573	84649	85439	82973	95918	115571	106733	98329	106648	92163
CHME	6762	6994	6974	7474	7342	7426	7167	6682	8156	8914	8471	7991	8232
CFMG	4	24076	13152	13882	11342	9362	11960	15008	11394	12430	13853	9238	9252
Docustream	806	715	545	482	239	634	559	478	551	540	385	381	192
EBI	1727	3242	1559	1641	494	2208	1475	1308	1493	1346	1328	1885	1745
FULLCIR	674	1515	1767	1470	79	1298	1251	1823	1658	1155	1236	2889	3407
HCSA	3171	3310	2376	3394	2255	2497	2693	2103	2332	2603	2448	2637	2430
IOA	680	1374	549	949		2783	781	626		48	1836	1732	551
Kaiser	113	216	62		23								
LAFAM	81	58	86	62	3	178	89	80	84	90	67	80	76
LIFE	598	159	91	76	202	508	63	65	116	93	202	122	142
LogistiCare	30006	16046	49705	15235	34035	28502	32441	33656	54971	35829	15010	38763	33974
March Vision	3482	4066	3543	3980	4156	9586	371	4354	3870	4591	4657	3888	4183
MED	540	514	579	568	55	546	1083	731		595	553	2471	1124
PAIRTEAM		4617	782	1960	994	6334		1489	10873	4670	4549	9364	8386
Quest	16854	16937	21144	16909	21044	16828	16855	21048	16795	16853	21031	16774	16903
SENECA	127	94	91	100	6	112	60	116	101	98	139	63	
SERENE						82		20				569	
TITANIUM	3535	2332	5267	1278	228	3600	3071	2551	2764	2714	3556	2577	2700
TVHC		116		818		144		454	43	70			
Total	347197	393963	501826	388266	437285	368504	376918	461741	446160	435150	476768	428140	424385



HealthSuite Paper vs EDI Claims Submission Breakdown

Period	Total EDI Submission	Total Paper Submission	Total claims
25-Aug	352642	36440	389082

Key: EDI – Electronic Data Interchange

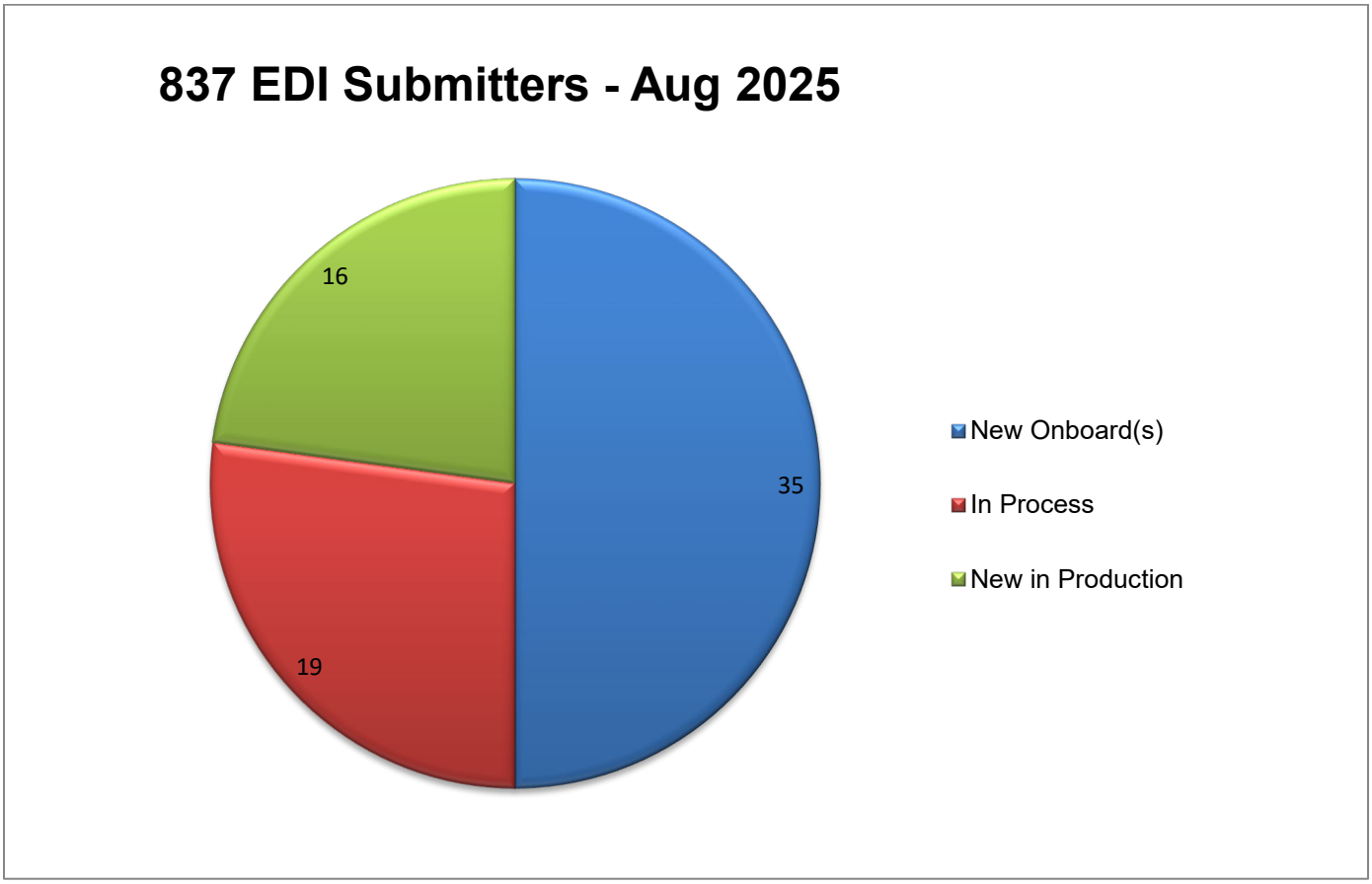


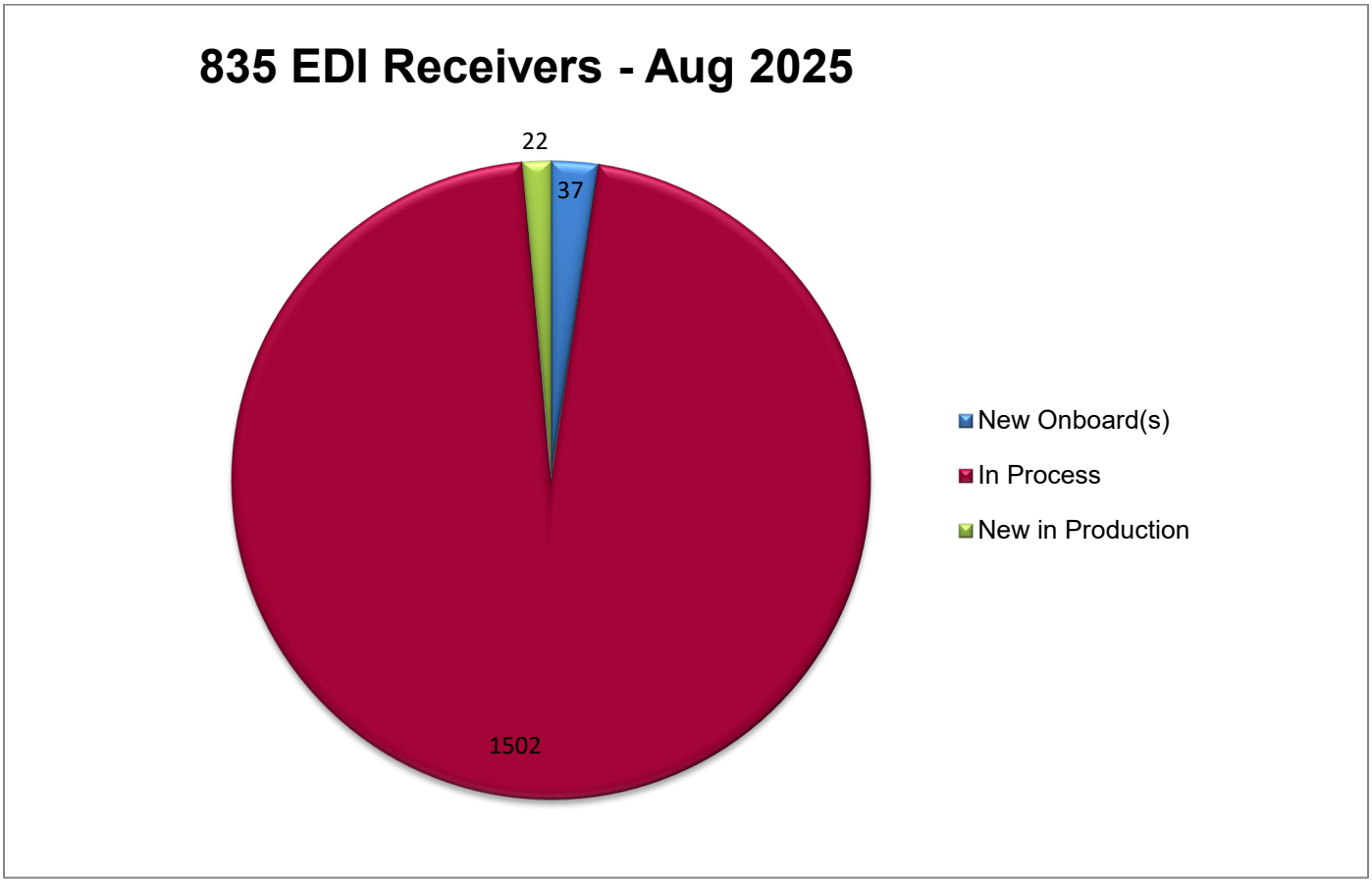
Onboarding EDI Providers – Updates

- August 2025 EDI Claims:
  - A total of 3120 new EDI submitters have been added since October 2015, with 16 added in August 2025.
  - The total number of EDI submitters is 3860 providers.

- August 2025 EDI Remittances (ERA):
  - A total of 1482 new ERA receivers have been added since October 2015, with 22 added in August 2025.
  - The total number of ERA receivers is 1469 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
Sep-24	46	5	41	3423	73	1027	28	1138
Oct-24	60	4	56	3479	80	1071	36	1174
Nov-24	61	20	41	3520	89	1131	29	1203
Dec-24	61	22	39	3559	97	1177	51	1254
Jan-25	61	8	53	3612	79	1234	22	1276
Feb-25	58	16	42	3654	83	1286	31	1307
Mar-25	46	3	43	3697	74	1328	32	1339
Apr-25	38	14	24	3721	63	1370	26	1365
May-25	47	3	44	3765	77	1402	45	1410
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


837 EDI Submitters - Aug 2025
16
35
19
New Onboard(s)
In Process
New in Production


835 EDI Receivers - Aug 2025
22
37
1502
New Onboard(s)
In Process
New in Production

Encounter Data Submission Reconciliation Form (EDSRF) and File Reconciliations

- EDSRF Submission: Below is the total number of encounter files that AAH submitted in the month of **August** 2025.

File Type	Jul-25
837 I Files	30
837 P Files	108
Total Files	138

Lag-time Metrics/Key Performance Indicators (KPI)

AAH Encounters: Outbound 837	Aug-25	Target
Timeliness-% Within Lag Time - Institutional 0-90 days	81%	60%
Timeliness-% Within Lag Time - Institutional 0-180 days	93%	80%
Timeliness-% Within Lag Time - Professional 0-90 days	94%	65%
Timeliness-% Within Lag Time – Professional 0-180 days	98%	80%

*Note, the Number of Encounters comes from: Total at bottom of this chart: **Outbound Encounter Submission**

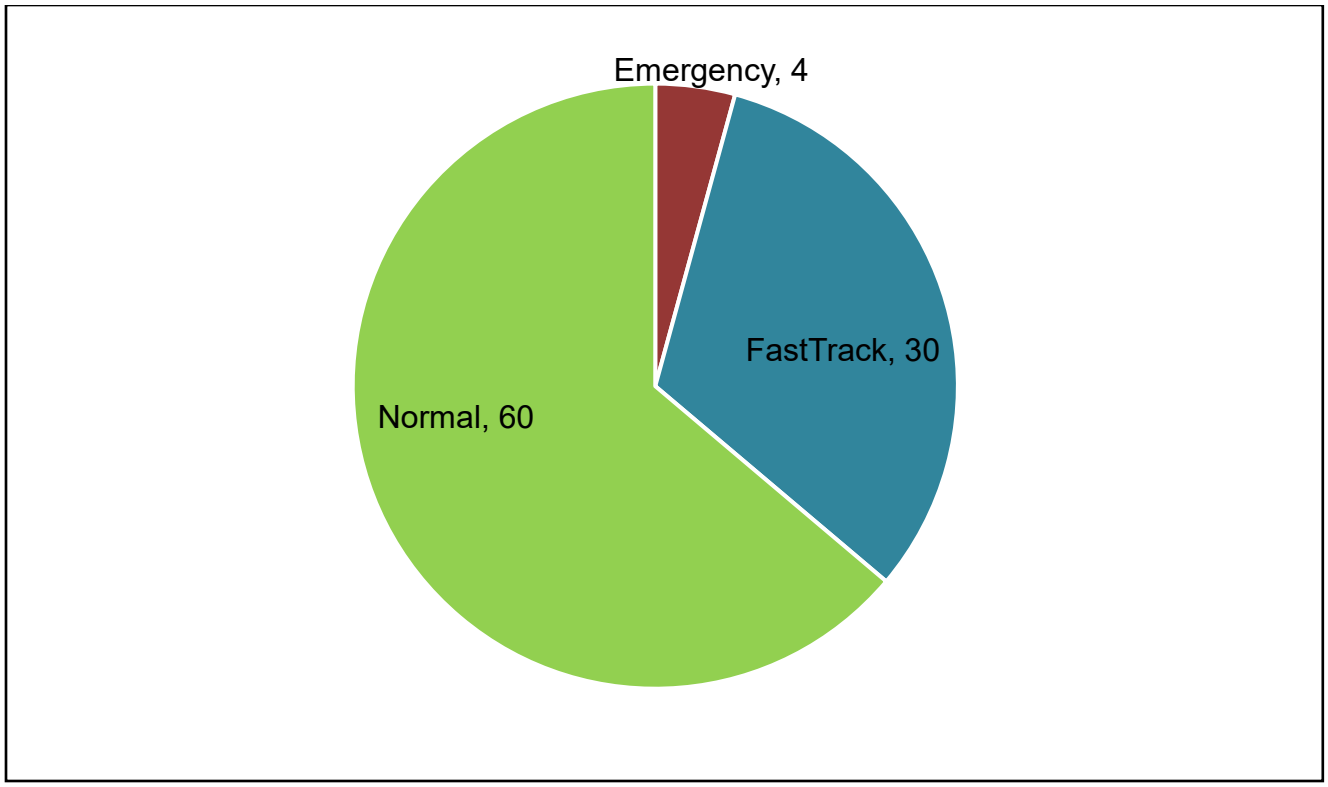
Encounter Data

- In the month of August 2025, the Alliance submitted 138 encounter files to the Department of Health Care Services (DHCS) with a total of 424,385 encounters.

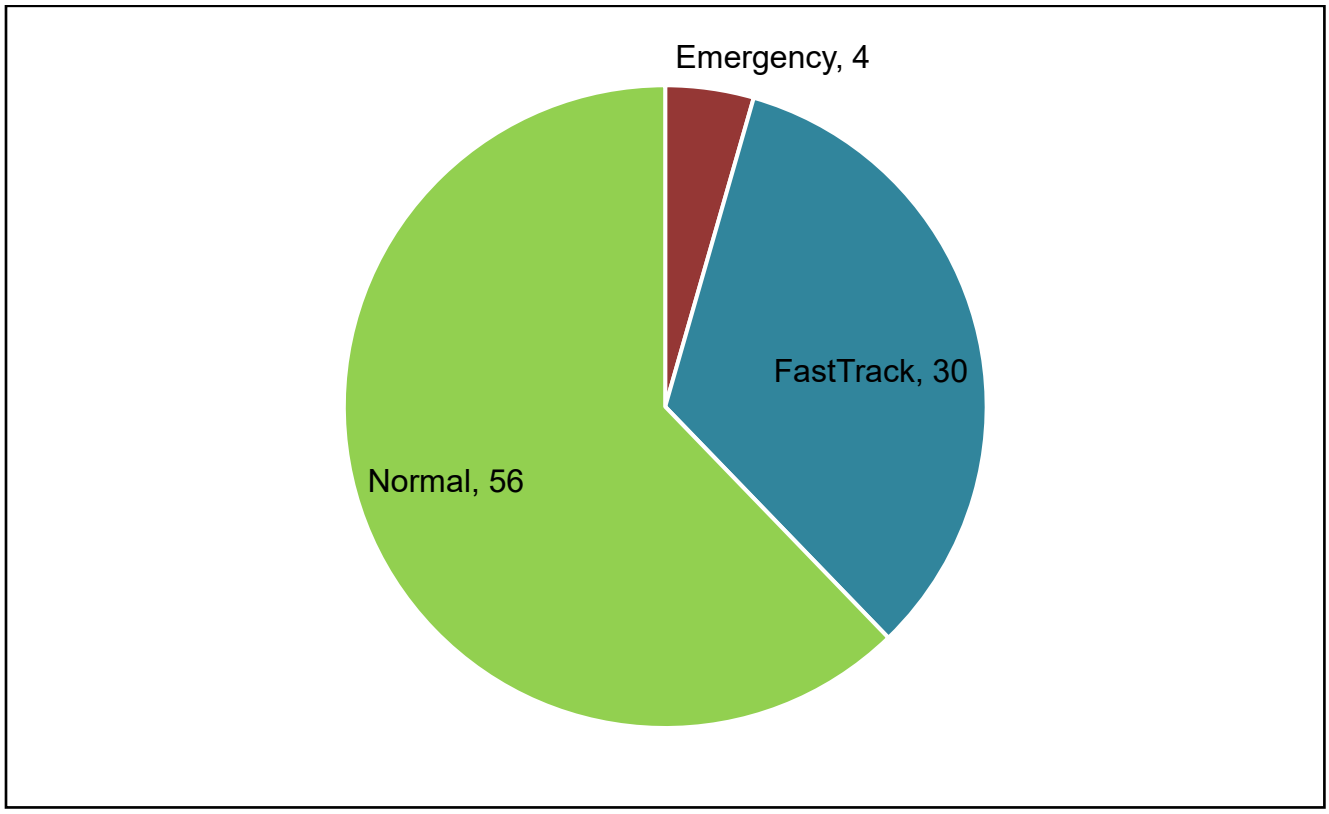
Change Management Key Performance Indicator (KPI)

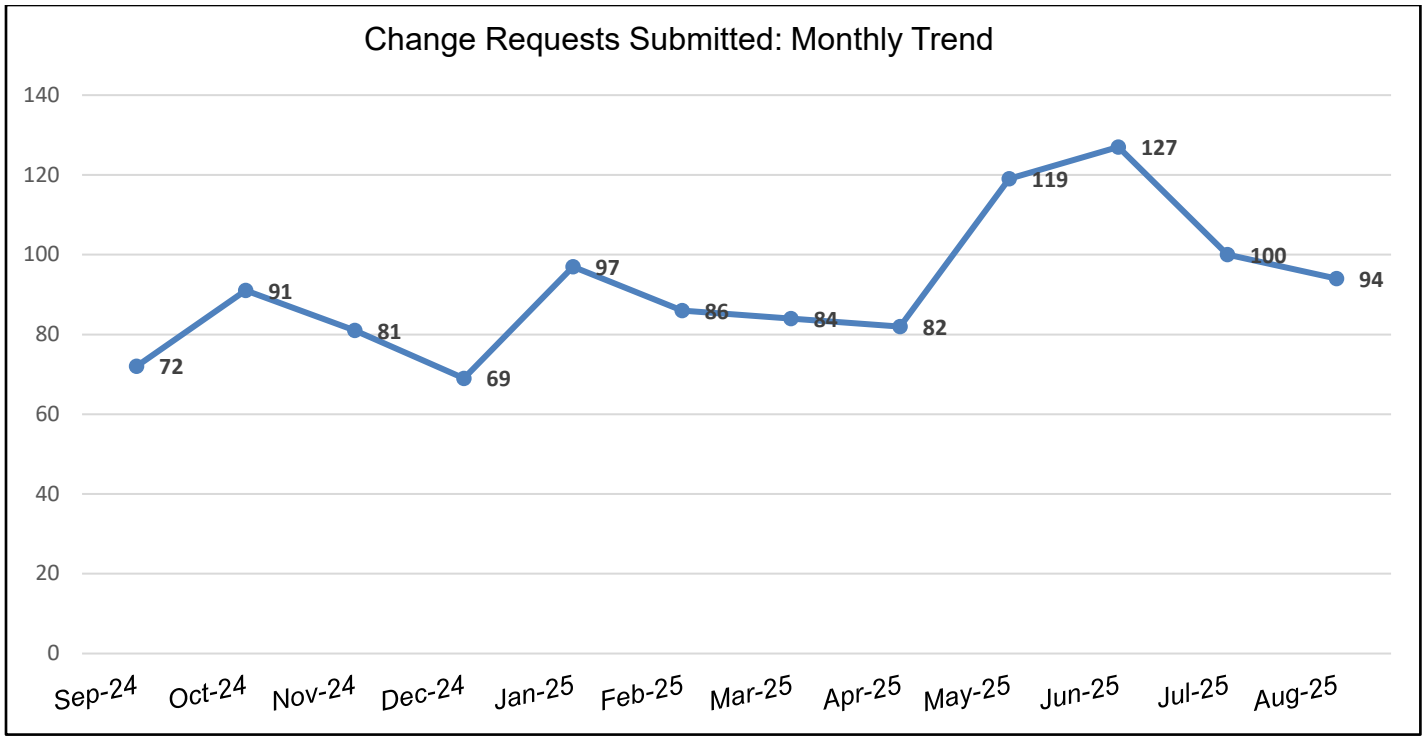
- Change Request Overall Summary in the month of August 2025 KPI:
  - 94 Changes Submitted.
  - 90 Changes Completed and Closed.
  - 131 Active Change Requests in pipeline.
  - 1 Change Requests Cancelled or Rejected.

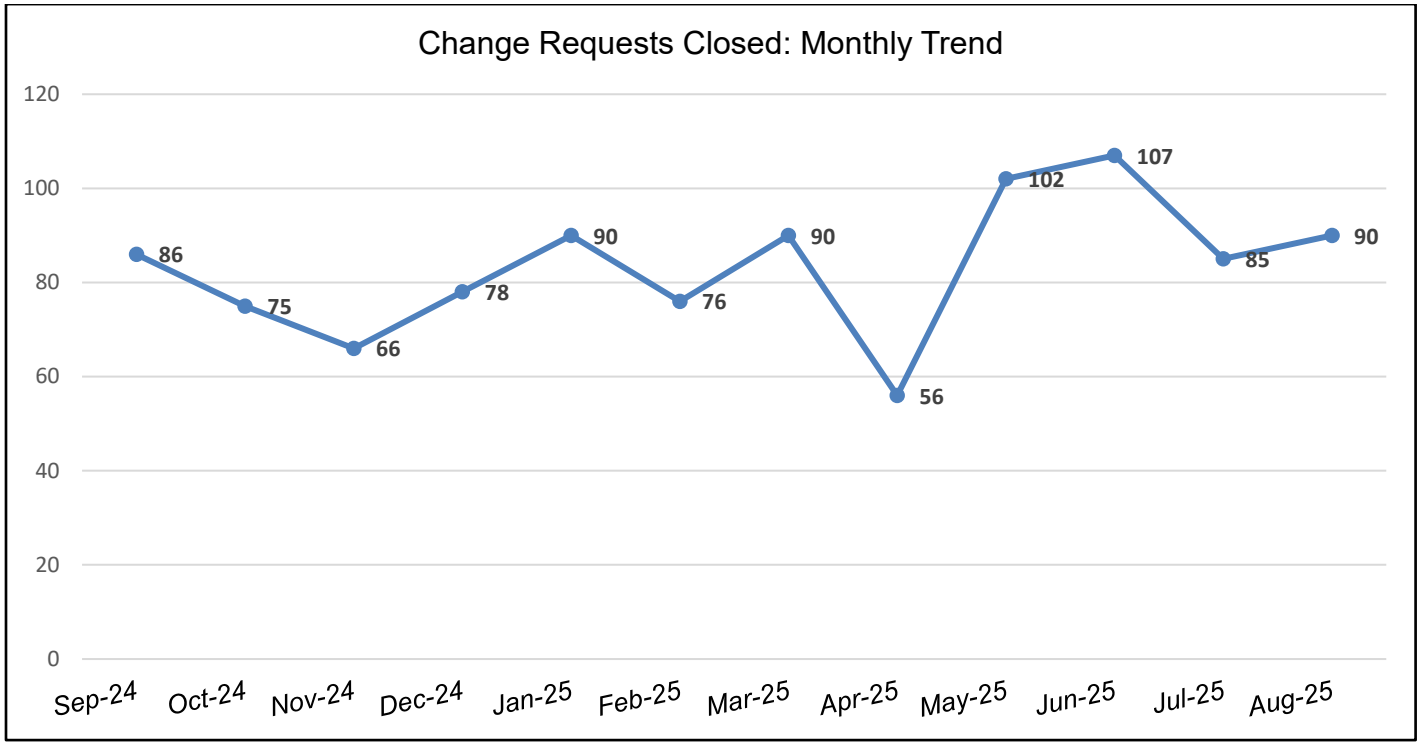
- 94 Change Requests Submitted/Logged in the month of August 2025



- 90 Change Requests Closed in the month of August 2025

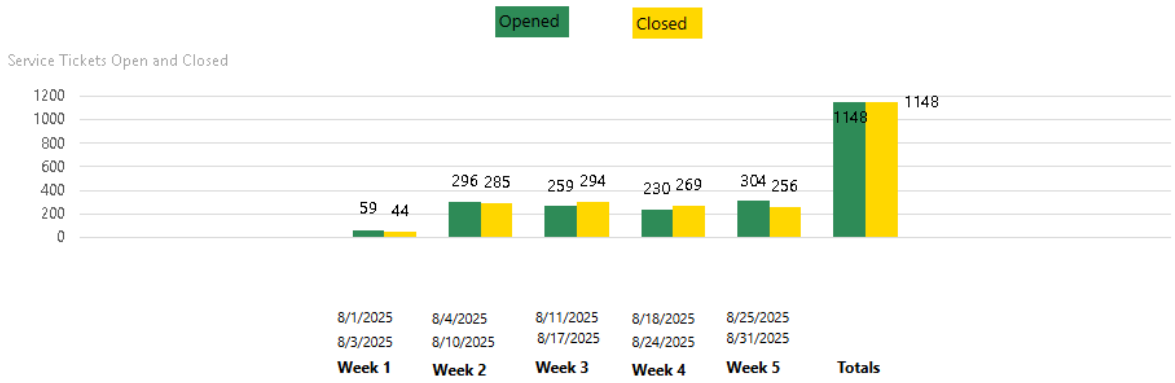



Change Requests Submitted: Monthly Trend
140
120
100
80
60
40
20
0
72
91
81
69
97
86
84
82
119
127
100
94
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25
Apr-25
May-25
Jun-25
Jul-25
Aug-25


Change Requests Closed: Monthly Trend
120
100
80
60
40
20
0
86
75
66
78
90
76
90
56
102
107
85
90
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25
Apr-25
May-25
Jun-25
Jul-25
Aug-25

IT Stats: Service Desk

IT Service Tickets Open and Closed



- 1148 Service Desk tickets were opened in the month of August 2025, which is 2.09% higher than the previous month (1124) and 6.18% higher than the previous 3-month average of 1077.

- 1148 Service Desk tickets were closed in the month of August 2025, which is 0.26% higher than the previous month (1145) and 6.88% higher than the previous 3-month average of 1069.

IT Stats: Security

Areas	Item Status
Ops.	• Completed ○ Established remediation framework for Nessus (JIRA), penetration test, and SRA. ○ Renewed AAH's Top-Level-Domain for 9 more years. ○ Blocked uploading to top 3rd party email and cloud storage solutions. ○ Vish, under Anthony's supervision, completed migration of cert smartsheet into IT Glue. • Upcoming/Underway ○ Working with Gurpreet on remediating server vulnerabilities (sensitive) – ETC 10/1/25 ○ Continuing work on security dashboard with Arctic Wolf (today) – ETC 10/1/25 ○ Juan working on whitepaper (from Blackhat conference) – ETC 9/15/25 ○ Finalize Xaqt escalation SOP – ETC 9/15/25 ○ Evaluating Keeper (password vault)
Projects	• Email Security: discovering email relay information from environment to prevent spoofing. • Network Segmentation – solution decision to be made. • OKTA (SSO) and DUO (MFA) - true-up. • Penetration test completing on Friday August 28th, 2025.
GRC	• TrackIT for ops. and JIRA for project-based items • Continuation of policy revisions • Working on high SRA items

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: **September 12th, 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: June 2024 – May 2025 dates of service
Prior reporting period: June 2023 – May 2024 dates of service
(Note: Data excludes Kaiser membership data.)

- For the Current reporting period, the top 11.8% of members account for 89.5% of total costs.

- In comparison, the Prior reporting period was lower at 8.6% of members accounting for 83.6% of total costs.

- Characteristics of the top utilizing population remained fairly consistent between the reporting periods:

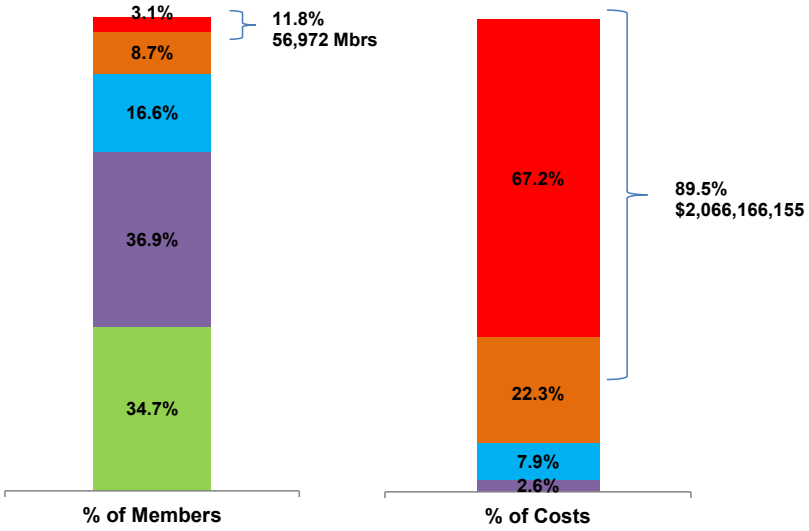
    - The SPD/LTC (non duals) and ACA OE categories of aid decreased to account for 53.5% of the members, with SPD/LTCs accounting for 18.3% and ACA OE's at 35.2%.
    - The percent of members with costs >= $30K increased from 2.3% to 3.1%.
    - Of those members with costs >= $100K, the percentage of total members has increased to 1.0%.
        - For these members, non-trauma/pregnancy inpatient costs continue to comprise the majority of costs, decreasing to 30.9%.
    - Demographics for member city and gender for members with costs >= $30K follow the same distribution as the overall Alliance population.
    - However, the age distribution of the top 11.8% is more concentrated in the 45-66 year old category (34.9%) compared to the overall population (20.6%).

Analytics

Supporting Documents

Alameda Alliance for Health - Analytics Supporting Documentation: Member - Cost Analysis
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Jun 2024 - May 2025
Note: Data incomplete due to claims lag
Run Date: 08/29/2025

Member Cost Distribution



Cost Range	Members	% of Members	Costs	% of Costs
$30K+	14,843	3.1%	$ 1,550,409,153	67.2%
$5K - $30K	42,129	8.7%	$ 515,757,002	22.3%
$1K - $5K	80,621	16.6%	$ 182,323,181	7.9%
< $1K	178,869	36.9%	$ 59,796,416	2.6%
$0	167,841	34.7%	$ -	0.0%
Totals	**484,303**	**100.0%**	**$ 2,308,285,752**	**100.0%**

Top 11.8% of Members = 89.5% of Costs

Cost Range	Members	% of Total Members	Costs	% of Total Costs
$100K+	4,938	1.0%	$ 1,018,865,472	44.1%
$75K to $100K	1,751	0.4%	$ 153,004,067	6.6%
$50K to $75K	2,836	0.6%	$ 173,044,460	7.5%
$40K to $50K	2,158	0.4%	$ 96,316,769	4.2%
$30K to $40K	3,160	0.7%	$ 109,178,385	4.7%
SubTotal	***14,843***	***3.1%***	***$ 1,550,409,153***	***67.2%***
$20K to $30K	5,985	1.2%	$ 144,974,339	6.3%
$10K to $20K	16,143	3.3%	$ 228,440,308	9.9%
$5K to $10K	20,001	4.1%	$ 142,342,355	6.2%
SubTotal	***42,129***	***8.7%***	***$ 515,757,002***	***22.3%***
Total	**56,972**	***11.8%***	**$ 2,066,166,155**	***89.5%***

Enrollment Status	Members	Total Costs
Still Enrolled as of May 2025	410,058	$ 2,074,144,499
Dis-Enrolled During Year	74,245	$ 234,141,253
Totals	**484,303**	**$ 2,308,285,752**

Notes:
- Report includes medical costs (HS & Diamond Claims, Beacon, Logisticare FFS, CHCN FFS Preventive Services, CHME) and pharmacy costs. IBNP factors are not applied.
- CFMG and CHCN encounter data has been priced out.

Alameda Alliance for Health - Analytics Supporting Documentation: Member - Cost Analysis
11.8% of Members = 89.5% of Costs
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Jun 2024 - May 2025
Note: Data incomplete due to claims lag
Run Date: 08/29/2025

11.8% of Members = 89.5% of Costs
18.3% of members are SPD/LTCs and account for 24.4% of costs.
35.2% of members are ACA OE and account for 32.4% of costs.
8.2% of members disenrolled as of May 2025 and account for 10.4% of costs.

Highest Cost Members: Cost Per Member >= $100K
26.6% of members are SPD/LTCs and account for 28.7% of costs.
27.0% of members are ACA OE and account for 30.0% of costs.
9.1% of members disenrolled as of May 2025 and account for 11.2% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Members	% of Members
IHSS	IHSS	208	979	1,187	2.1%
MCAL	MCAL - ADULT	1,261	7,795	9,056	15.9%
	MCAL - BCCTP	-	-	-	0.0%
	MCAL - CHILD	707	3,930	4,637	8.1%
	MCAL - ACA OE	4,770	15,283	20,053	35.2%
	MCAL - DUALS	-	-	-	0.0%
	MCAL - SPD-LTC	3,653	6,746	10,399	18.3%
	MCAL - SPD-LTC/Full Dual	2,683	4,281	6,964	12.2%
Not Eligible	Not Eligible	1,561	3,115	4,676	8.2%
Total		**14,843**	**42,129**	**56,972**	**100.0%**

Member Breakout by LOB

LOB	Eligibility Category	Total Members	% of Members
IHSS	IHSS	52	1.1%
MCAL	MCAL - ADULT	283	5.7%
	MCAL - BCCTP	-	0.0%
	MCAL - CHILD	89	1.8%
	MCAL - ACA OE	1,335	27.0%
	MCAL - DUALS	-	0.0%
	MCAL - SPD-LTC	1,312	26.6%
	MCAL - SPD-LTC/Full Dual	1,417	28.7%
Not Eligible	Not Eligible	450	9.1%
Total		**4,938**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Costs	% of Costs
IHSS	IHSS	$ 17,087,214	$ 11,476,907	$ 28,564,121	1.4%
MCAL	MCAL - ADULT	$ 124,851,287	$ 95,049,190	$ 219,900,477	10.6%
	MCAL - BCCTP	$ -	$ -	$ -	0.0%
	MCAL - CHILD	$ 52,905,478	$ 44,093,113	$ 96,998,591	4.7%
	MCAL - ACA OE	$ 483,322,986	$ 187,103,383	$ 670,426,369	32.4%
	MCAL - DUALS	$ -	$ -	$ -	0.0%
	MCAL - SPD-LTC	$ 417,430,331	$ 87,196,095	$ 504,626,426	24.4%
	MCAL - SPD-LTC/Full Dual	$ 278,470,389	$ 51,703,747	$ 330,174,137	16.0%
Not Eligible	Not Eligible	$ 176,341,467	$ 39,134,567	$ 215,476,034	10.4%
Total		**$ 1,550,409,153**	**$ 515,757,002**	**$ 2,066,166,155**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Total Costs	% of Costs
IHSS	IHSS	$ 9,086,310	0.9%
MCAL	MCAL - ADULT	$ 76,102,103	7.5%
	MCAL - BCCTP	$ -	0.0%
	MCAL - CHILD	$ 22,777,468	2.2%
	MCAL - ACA OE	$ 305,293,878	30.0%
	MCAL - DUALS	$ -	0.0%
	MCAL - SPD-LTC	$ 292,205,821	28.7%
	MCAL - SPD-LTC/Full Dual	$ 199,394,254	19.6%
Not Eligible	Not Eligible	$ 114,005,638	11.2%
Total		**$ 1,018,865,472**	**100.0%**

% of Total Costs By Service Type

Breakout by Service Type/Location

Cost Range	Trauma Costs	Hep C Rx Costs	Pregnancy, Childbirth & Newborn Related Costs	Pharmacy Costs	Inpatient Costs (POS 21)	ER Costs (POS 23)	Outpatient Costs (POS 22)	Office Costs (POS 11)	Dialysis Costs (POS 65)	Other Costs (All Other POS)
$100K+	5%	0%	1%	14%	36%	1%	11%	2%	2%	33%
$75K to $100K	4%	0%	1%	19%	26%	3%	5%	4%	5%	38%
$50K to $75K	5%	0%	2%	25%	29%	5%	6%	6%	4%	25%
$40K to $50K	6%	0%	2%	33%	27%	8%	6%	7%	1%	18%
$30K to $40K	10%	0%	3%	32%	22%	13%	6%	7%	1%	19%
$20K to $30K	2%	1%	6%	36%	23%	8%	8%	8%	1%	17%
$10K to $20K	0%	0%	11%	35%	24%	7%	9%	9%	1%	15%
$5K to $10K	0%	0%	5%	30%	11%	11%	13%	14%	0%	20%
Total	**4%**	**0%**	**3%**	**22%**	**30%**	**4%**	**9%**	**5%**	**2%**	**27%**

Notes:
- Report includes medical costs (HS & Diamond Claims, Beacon, Logisticare FFS, CHCN FFS Preventive Services, CHME) and pharmacy costs. IBNP factors are not applied.
- CFMG and CHCN encounter data has been priced out.
- Report excludes Capitation Expense

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: **September 12th, 2025**

Subject: **Human Resources Report**

Staffing

- As of September 1st, 2025, the Alliance had 681 full time employees and 1 part time employee.

- On September 1st, 2025, the Alliance had 34 open positions in which 10 signed offer acceptance letters have been received with start dates in the near future resulting in a total of 24 positions open to date. The Alliance is actively recruiting for the remaining 24 positions and several of these positions are in the interviewing or job offer stage.

- Summary of open positions by division:

Division	Open Position September 1st	Signed Offers Accepted by Department	Remaining Recruitment Positions
Healthcare Services	10	5	5
Operations	17	4	13
Healthcare Analytics	1	0	1
Information Technology	2	1	1
Finance	0	0	0
Compliance	1	0	1
Human Resources	3	0	3
Health Equity	0	0	0
Executive	0	0	0
Total	34	10	24

- Our current recruitment rate is 5%.

Employee Recognition

- Employees reaching major milestones in their length of service at the Alliance in August 2025 included:

  5 years:
  - Renee D (Case/Disease Management)
  - Nicole W (Case/Disease Management)
  - Richard C (Quality Management)

  6 years:
  - Linda Y (IT Data Exchange)

  7 years:
  - Rithy K (Utilization Management)

  8 years:
  - Linda C (IT Development)
  - Kishor K (IT Data Exchange)
  - Dinesh K (IT Development)

  9 years:
  - Gigi N (Case/Disease Management)
  - Nancy V (Utilization Management)

  11 years:
  - Christina L (Member Services)

  13 years:
  - Hyacinth J (IT Ops and Quality Apps Mgt)
  - Tina T (Accounting & Payroll)

  14 years:
  - Helen H (IT Ops and Quality Apps Mgt)

  18 years:
  - Vanessa S (Member Services)

  20 years:
  - Catherine C. (Finance)