ALAMEDA Alliance FOR HEALTH

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Board of Governors

PACKET

April 11th, 2025

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EXECUTIVE SUMMARY APPENDIX

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

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SUPPORTING MATERIALS APPENDIX

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

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CEO Update

Matthew Woodruff

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

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

Date: **April 11th, 2025**

Subject: **CEO Report**

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

	February	YTD
Medi-Cal	$5.1M	($92.9M)
Group Care	$360K	($533K)
Medicare	($358K)	($5.4M)
Total	($5.1M)	($98.8M)

  - **Revenue was $176.8 million in February 2025 and $1.4 billion Year-to-Date (YTD)**.
    - Medical expenses were $159.0 million in February and $1.4 billion for the fiscal year-to-date; the medical loss ratio is 89.9% for the month and 102.9% for the fiscal year-to-date.
    - Administrative expenses were $9.8 million in February and $76.3 million for the fiscal year-to-date; the administrative loss ratio is 5.5% of net revenue for the month and 5.6% of net revenue year-to-date.
  - **Tangible Net Equity (TNE)**: Financial reserves are 202% of the required DMHC minimum, representing $78.9 million in excess TNE.
  - **Total enrollment in February 2025 was 413,278**, an increase of 450 Medi-Cal members compared to January 2025.

- **Key Performance Indicators:**
  - **Regulatory Metrics:**
    - The G&A team currently faces challenges in managing a high volume of cases due to staffing shortages. These shortages result from staff transferring to different departments (1 Coordinator), approved leaves of absence (4 Coordinators), approved PTO, which has left only one RN to handle all cases, and an unexpected medical leave of absence (1 RN).
    - There are three temp coordinator positions (one temp starting 4/14/25) and one temp RN position open.
    - The FY 2026 budget includes: 2 Supervisors, 1 RN & 4 Coordinators.
  - **Non-Regulatory Metrics:**
    - Nothing to report

- **Alliance Updates:**
    - **Demographics**
        - Please see the attached PowerPoint describing the demographics of the Alliance employees.

- **Medicare Overview**
    - **<u>D-SNP Readiness</u>**
        - Alameda Alliance for Health (AAH) Medicare Advantage (MA) Duals Eligible Special Needs Plan (D-SNP) will begin serving members on January 1st, 2026. Currently, there are 17 different departmental workstreams and a total of 112 projects, 62 of which are active, 48 requested, and 2 on hold.
        - The Alliance received notice from CMS regarding the CMS D-SNP application on March 13th and passed 5 sub-sections and the SNP section. AAH reviewed the deficiencies and successfully submitted information back to CMS on March 24th.
        - Notices were sent out to network providers and Alameda County community-based organizations regarding the in-person townhall meeting being held at the Alliance on April 23rd, 2025. Anastasia Dodson, Deputy Director of the California Department of Health Care Services (DHCS), will be in attendance. The goal of this meeting is to provide an overview of the D-SNP program and increase our engagement with our providers and the community as we roll out this new product for our dual eligible population.
        - Ongoing implementation activities:
            - Risk Adjustment vendor was chosen through an RFI process;
            - Staff continues to work with Medicare supplemental benefit vendors;
            - The first pass of the bid design pricing was completed with our actuarial consultants, Milliman, to prepare for the bid submission on June 2nd.
        - Continuing to collaborate with IT in updating Core Claims / Medical Management Systems and identified 321 requirements collected within Microsoft List.

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

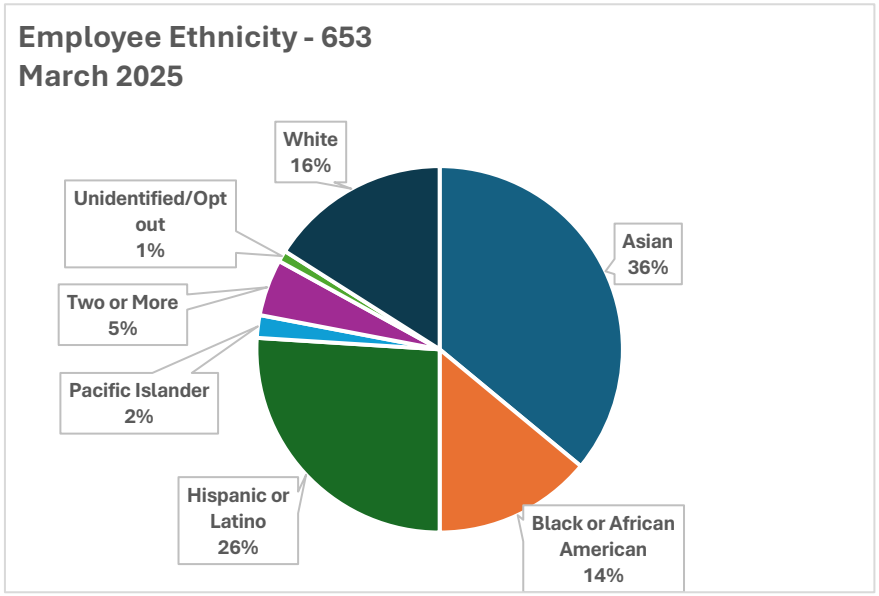
Demographics

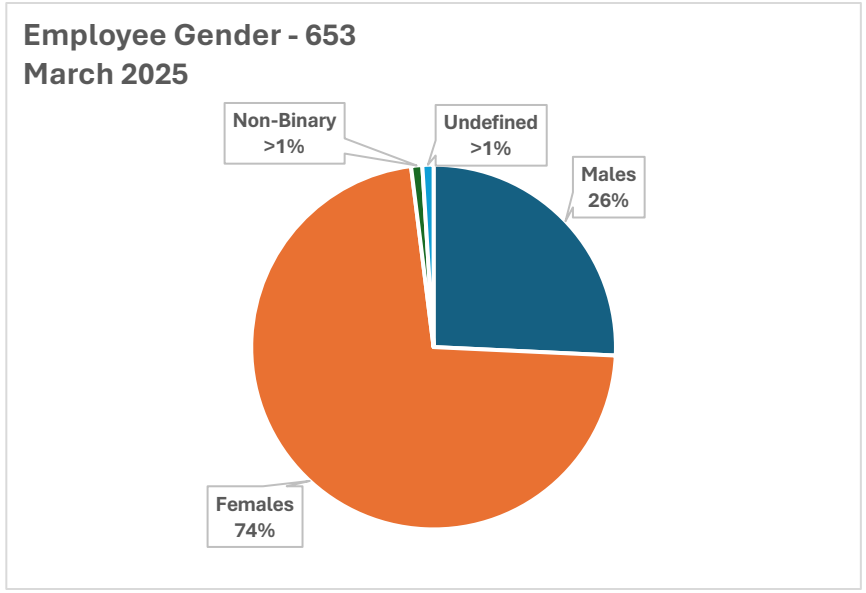
The purpose of this report is to conduct a comparative analysis of the demographic composition of Alameda Alliance for Health's workforce and the population distribution of Alameda Count. The primary focus of this comparison will be on key metrics, including race/ethnicity, gender, and age distribution.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

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

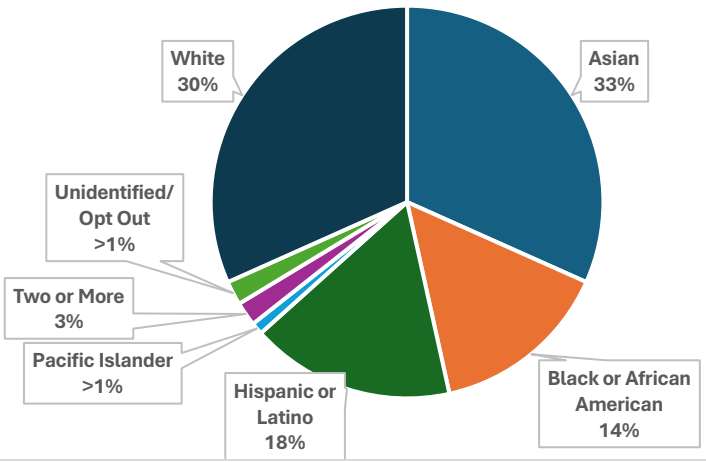
Category	**Alameda Alliance for Health** (Workforce information last updated March 2025)	**Alameda County** (Population Information last updated in April 2024)
Population/Total Employees	653	1,634,785
Race & Ethnicity		
Asian	36%	34.68%
Hispanic	26%	23.95%
White	16%	28.75%
Black/African American	14%	9.27%
Native Hawaiian/Pacific Islander	2%	0.85%
Two or More Races	5%	11.68%
Unidentified/Opt Out	1%	
Gender		
Male	26%	48.98%
Female	74%	51.02%
Non-Binary	>1%	0%
Undefined	>1%	0%
Age Distribution		
Under 25	>1%	12.47%
25-34	21%	14.34%
35-44	36%	15.89%
45-54	25%	13.44%
55-Older	17%	27.65%

AAH Employee Demographics Data Report March 2025

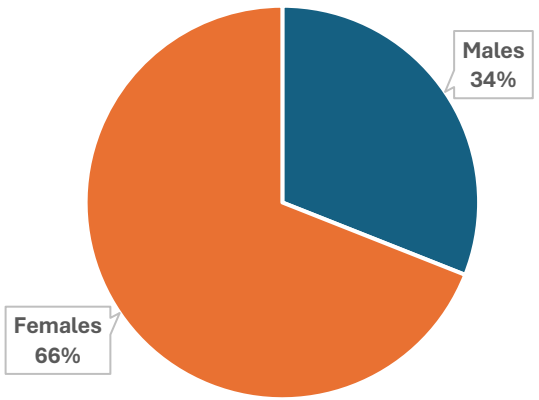




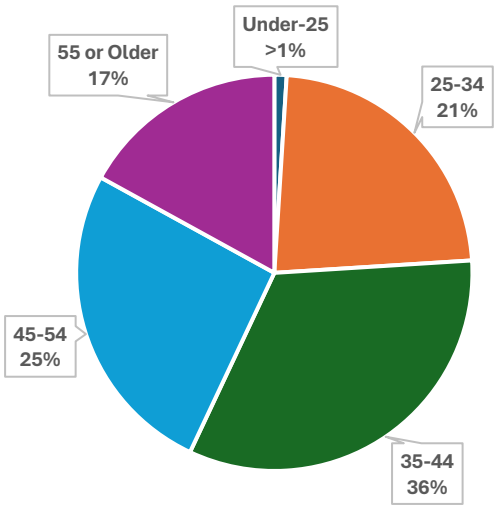
Managers Ethnicity - 131
March 2025



Managers Gender - 131
March 2025



Employee Age Demographics - 653
March 2025



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Legislative Tracking

2025 –2026 Legislative Tracking List

The 2024 California State Legislative Session is in full swing, and lawmakers continue to discuss hundreds of bills at policy committee hearings, including the notable SB 100/AB 100, a "Budget Bill Jr." which increases Medi-Cal's 2024-25 General Fund appropriation by $2.8 billion so the program can keep paying its bills to providers, hospitals, and others through June. Spring Recess will begin April 10th and run through the 21st. Upon their return, lawmakers will have until May 2nd to hear bills with fiscal impacts.

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

AB 4 **(Arambula D) Covered California expansion.**
Current Text: Introduced: 12/2/2024 html pdf
Introduced: 12/2/2024
Status: 4/2/2025-From committee: Do pass and re-refer to Com. on APPR. (Ayes 11. Noes 2.) (April 1). Re-referred to Com. on APPR.

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

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

AB 29 **(Arambula D) Medi-Cal: Adverse Childhood Experiences trauma screenings: providers.**
Current Text: Amended: 3/19/2025 html pdf
Introduced: 12/2/2024
Status: 4/2/2025-From committee: Do pass and re-refer to Com. on APPR. (Ayes 15. Noes 0.) (April 1). Re-referred to Com. on APPR.

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

Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law requires that Medi-Cal provider payments and payments for specified non-Medi-Cal programs be reduced by 10% for dates of service on and after June

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

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

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

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

AB 40 **(Bonta D) Emergency services and care.**
Current Text: Amended: 3/5/2025 html pdf
Introduced: 12/2/2024
Status: 3/26/2025-From committee: Do pass and re-refer to Com. on APPR. (Ayes 12. Noes 0.) (March 25). Re-referred to Com. on APPR.

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

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

mean reproductive health services, including abortion. By expanding the applicability of a crime with respect to health facilities and health care service plans, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 45 **(Bauer-Kahan D) Privacy: health.**

Current Text: Amended: 3/28/2025 html pdf

Introduced: 12/2/2024

Status: 4/1/2025-Re-referred to Com. on P. & C.P.

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

Summary: Existing law 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 existing laws.

AB 49 **(Muratsuchi D) Schoolsites: immigration enforcement.**

Current Text: Amended: 4/2/2025 html pdf

Introduced: 12/2/2024

Status: 4/3/2025-Re-referred to Com. on ED.

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

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

AB 50 **(Bonta D) Pharmacists: furnishing contraceptives.**
Current Text: Amended: 4/2/2025 html pdf
Introduced: 12/2/2024
Status: 4/3/2025-Re-referred to Com. on Health.

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

Summary: Existing law, 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: 3/17/2025 html pdf
Introduced: 12/2/2024
Status: 3/18/2025-Re-referred to Com. on Health.

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

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

AB 55 **(Bonta D) Alternative birth centers: licensing and Medi-Cal reimbursement.**
Current Text: Amended: 2/25/2025 html pdf
Introduced: 12/2/2024
Status: 2/26/2025-Re-referred to Com. on Health.

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

Summary: Existing law provides for the licensure and regulation of various types of clinics, including alternative birth centers, by the State Department of Public Health, and makes a violation of those provisions a crime. Existing law defines an alternative birth center as a clinic that is not part of a hospital and that provides comprehensive perinatal services and delivery care to pregnant women who remain less than 24 hours at the facility. Existing law requires a

licensed alternative birth center specialty clinic, and a licensed primary care clinic that provides services as an alternative birth center, to meet certain criteria, including, among others, being located in proximity to a facility with the capacity for management of obstetrical and neonatal emergencies. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law sets forth certain criteria for Medi-Cal reimbursement to alternative birth centers for facility-related delivery costs. Under existing law, as a criterion under both the licensing provisions and the Medi-Cal reimbursement provisions described above, the facility is required to be a provider of comprehensive perinatal services as defined in the Medi-Cal provisions. This bill would remove, under both sets of criteria, the certification condition of being a provider of comprehensive perinatal services as defined in the Medi-Cal provisions. The bill would delete the above-described proximity requirement and instead require a written policy for hospital transfer, as provided. The bill would also make a technical change to an obsolete reference within a related provision. By creating a new requirement for an alternative birth center or a primary care clinic that provides services as an alternative birth center, the violation of which is a crime, the bill would impose a state-mandated local program. This bill contains other existing laws.

AB 67 **(Bauer-Kahan D) Attorney General: Reproductive Privacy Act: enforcement.**
Current Text: Introduced: 12/4/2024 html pdf
Introduced: 12/4/2024
Status: 3/24/2025-Referred to Coms. on JUD. and P. & C.P.

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

Summary: Existing law, the Reproductive Privacy Act, prohibits a person from being subject to civil or criminal liability, or otherwise deprived of their rights, based on their actions or omissions with respect to their pregnancy or actual, potential, or alleged pregnancy outcome or based solely on their actions to aid or assist a woman or pregnant person who is exercising their reproductive rights as specified in the act. Existing law authorizes a party whose rights are protected by the Reproductive Privacy Act to bring a civil action against an offending state actor when those rights are interfered with by conduct or by statute, ordinance, or other state or local rule, regulation, or enactment in violation of the act, as specified, and require a court, upon a motion, to award reasonable attorneys' fees and costs to a prevailing plaintiff. This bill would authorize the Attorney General, if it appears to them that a person has engaged, or is about to engage, in any act or practice constituting a violation of the Reproductive Privacy Act, to bring an action in the name of the people of the State of California in the superior court to enjoin the acts or practices or to enforce compliance with the act, as specified. In this context, the bill would authorize the Attorney General to make public or private investigations, publish information concerning violation of the Reproductive Privacy Act, and subpoena witnesses, compel their attendance, take evidence, and require the production of documents or records that they deem relevant or material to the inquiry. This bill contains other related provisions.

AB 73 **(Jackson D) Mental Health: Black Mental Health Navigator Certification.**
Current Text: Introduced: 12/12/2024 html pdf
Introduced: 12/12/2024
Status: 3/26/2025-From committee: Do pass and re-refer to Com. on APPR. (Ayes 14. Noes 0.) (March 25). Re-referred to Com. on APPR.

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

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

make these provisions subject to an appropriation by the Legislature.

AB 92 **(Gallagher R) Patient visitation.**
Current Text: Introduced: 1/6/2025 html pdf
Introduced: 1/6/2025
Status: 2/3/2025-Referred to Com. on Health.

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

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

AB 96 **(Jackson D) Community health workers.**
Current Text: Amended: 2/11/2025 html pdf
Introduced: 1/7/2025
Status: 2/12/2025-Re-referred to Com. on Health.

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

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

AB 220 **(Jackson D) Medi-Cal: subacute care services.**
Current Text: Introduced: 1/8/2025 html pdf
Introduced: 1/8/2025
Status: 2/3/2025-Referred to Com. on Health.

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

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

AB 224 **(Bonta D) Health care coverage: essential health benefits.**
Current Text: Introduced: 1/9/2025 html pdf
Introduced: 1/9/2025
Status: 2/3/2025-Referred to Com. on Health.

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

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

AB 225 **(Bonta D) State hospitals for persons with mental health disorders: patient funds.**
Current Text: Introduced: 1/9/2025 html pdf
Introduced: 1/9/2025
Status: 3/26/2025-From committee: Do pass and re-refer to Com. on APPR. with recommendation: To Consent Calendar. (Ayes 15. Noes 0.) (March 25). Re-referred to Com. on APPR.

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

Summary: Existing law sets forth 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: 3/13/2025-From committee: Do pass and re-refer to Com. on APPR. (Ayes 8. Noes 0.) (March 12). Re-referred to Com. on APPR.

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

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

AB 242 **(Boerner D) Genetic disease screening.**
Current Text: Introduced: 1/14/2025 html pdf
Introduced: 1/14/2025
Status: 4/2/2025-From committee: Do pass and re-refer to Com. on APPR. with recommendation: To Consent Calendar. (Ayes 15. Noes 0.) (April 1). Re-referred to Com. on APPR.

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

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

AB 260 **(Aguiar-Curry D) Sexual and reproductive health care.**
Current Text: Amended: 3/17/2025 html pdf
Introduced: 1/16/2025
Status: 3/18/2025-Re-referred to Com. on Health.

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

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

AB 277 **(Alanis R) Behavioral health centers, facilities, and programs: background checks.**
Current Text: Amended: 2/20/2025 html pdf

Introduced: 1/21/2025
Status: 2/21/2025-Re-referred to Com. on HUM. S.

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

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

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

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

Summary: Existing law establishes the Office of Health Care Affordability within the Department of Health Care Access and Information to analyze the health care market for cost trends and drivers of spending, develop data-informed policies for lowering health care costs for consumers and purchasers, and create a state strategy for controlling the cost of health care. Existing law establishes the Health Care Affordability Board to establish, among other things, a statewide health care cost target and the standards necessary to meet exemptions from health care cost targets or submitting data to the office. Existing law authorizes the office to establish advisory or technical committees, as necessary, in order to support the board's 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: Introduced: 1/21/2025 html pdf
Introduced: 1/21/2025
Status: 4/2/2025-From committee: Do pass and re-refer to Com. on APPR. (Ayes 11. Noes 0.) (April 1). Re-referred to Com. on APPR.

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan and a health insurer that contracts with providers for alternative rates of payment to publish and maintain a provider directory or directories with information on contracting providers that deliver health care services enrollees or insureds, and requires a health care service plan and health insurer to regularly update its printed and online provider directory or directories, as specified. Existing law authorizes the departments to require a plan or insurer to provide coverage for all covered health care services provided to an enrollee or insured who reasonably relied on materially inaccurate, incomplete, or misleading information contained in a plan's or insurer's provider directory or directories. This bill would require a plan or insurer to annually verify and delete inaccurate listings from its provider directories, and would require a provider directory to be 60% accurate on July 1, 2026, with increasing required percentage accuracy benchmarks to be met each year until the directories are 95% accurate on or before July 1, 2029. The bill would subject a plan or insurer to administrative penalties for failure to meet the prescribed benchmarks. The

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

AB 281 **(Gallagher R) Comprehensive sexual health education and human immunodeficiency virus (HIV) prevention education: outside consultants.**
Current Text: Amended: 3/17/2025 html pdf
Introduced: 1/22/2025
Status: 3/26/2025-In committee: Hearing postponed by committee.

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

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

AB 290 **(Bauer-Kahan D) California FAIR Plan Association: automatic payments.**
Current Text: Amended: 4/3/2025 html pdf
Introduced: 1/22/2025
Status: 4/3/2025-From committee chair, with author's amendments: Amend, and re-refer to Com. on Health. Read second time and amended.

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

Summary: Existing law establishes the California FAIR Plan Association, a joint reinsurance association in which all insurers licensed to write basic property insurance participate to administer a program for the equitable apportionment of basic property insurance for persons who are unable to obtain that coverage through normal channels. Existing law authorizes cancellation of an insurance policy for nonpayment of premium, and requires an insurer to notify a policyholder at least 10 business days before the policy will be canceled for nonpayment. This bill would require the California FAIR Plan Association to create an automatic payment system and accept automatic payments for premiums from policyholders. The bill would prohibit an automatic payment amount from being different than if the policyholder made a payment through another method. The bill would prohibit cancellation or nonrenewal of a FAIR Plan policy solely because the policyholder is not enrolled in automatic payments or because the policyholder failed to confirm a payment when making a one-time payment on the association's internet website. The bill would provide for a 15-day grace period for late premium payments.

AB 298 **(Bonta D) Health care coverage cost sharing.**

Current Text: Amended: 3/4/2025 html pdf
Introduced: 1/23/2025
Status: 3/5/2025-Re-referred to Com. on Health.

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

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

AB 302 **(Bauer-Kahan D) Confidentiality of Medical Information Act.**
Current Text: Introduced: 1/23/2025 html pdf
Introduced: 1/23/2025
Status: 3/28/2025-Referred to Coms. on Health and JUD.

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

Summary: Existing law, the Confidentiality of Medical Information Act, prohibits a provider of health care, a health care service plan, or a contractor from disclosing medical information, as defined, regarding a patient of the provider of health care or an enrollee or subscriber of the health care service plan without first obtaining an authorization, except as prescribed. The act punishes a violation of its provisions that results in economic loss or personal injury to a patient as a misdemeanor. Existing law requires a provider of health care, a health care service plan, or a contractor to disclose medical information when specifically required by law or if the disclosure is compelled by, among other things, a court order or a search warrant lawfully issued to a governmental law enforcement agency. This bill would instead require a provider of health care, a health care service plan, or a contractor to disclose medical information when specifically required by California law. The bill would revise the disclosure requirement relating to a court order to require disclosure if compelled by a California state court pursuant to an order of that court or a court order from another state based on another state's law so long as that law does not interfere with California law, as specified. The bill would revise the disclosure requirement relating to a search warrant to require disclosure if compelled by a warrant from another state based on another state's law so long as that law does not interfere with California law. By narrowing the exceptions for disclosing medical information, and thereby expanding the crime of violating the act, this bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 309 **(Zbur D) Hypodermic needles and syringes.**
Current Text: Introduced: 1/23/2025 html pdf
Introduced: 1/23/2025
Status: 2/10/2025-Referred to Com. on Health.

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

Summary: Existing law, the Pharmacy Law, provides for the licensure and regulation of pharmacists and pharmacies by the California State Board of Pharmacy. Existing law, until January 1, 2026, authorizes a physician or pharmacist to, without a prescription or permit, furnish hypodermic needles and syringes for human use to a person 18 years of age or older, and authorizes a person 18 years of age or older to, without a prescription or license, obtain hypodermic needles and syringes solely for personal use from a physician or pharmacist, as a public health measure, as specified. Existing law, until January 1, 2026, requires a pharmacy that furnishes nonprescription syringes to provide written information or verbal counseling to consumers, as specified, at the time of furnishing or sale of nonprescription hypodermic needles or

syringes. Existing law, when no other penalty is provided, makes a knowing violation of the Pharmacy Law a misdemeanor and, in all other instances, makes a violation punishable as an infraction. This bill would delete the January 1, 2026, repeal date, thereby extending those provisions indefinitely, and would make other conforming changes. By indefinitely extending an existing requirement under the Pharmacy Law, the violation of which is a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 315 **(Bonta D) Medi-Cal: Home and Community-Based Alternatives Waiver.**
Current Text: Introduced: 1/23/2025 html pdf
Introduced: 1/23/2025
Status: 3/26/2025-Coauthors revised. From committee: Do pass and re-refer to Com. on APPR. (Ayes 14. Noes 0.) (March 25). Re-referred to Com. on APPR.

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

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

AB 316 **(Krell D) Artificial intelligence: defenses.**
Current Text: Introduced: 1/24/2025 html pdf
Introduced: 1/24/2025
Status: 3/26/2025-From committee: Do pass and re-refer to Com. on P. & C.P. (Ayes 12. Noes 0.) (March 25). Re-referred to Com. on P. & C.P.

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

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

AB 322 **(Ward D) Pupil health: school-based health services and school-based mental health services.**
Current Text: Introduced: 1/24/2025 html pdf
Introduced: 1/24/2025
Status: 3/13/2025-From committee: Do pass and re-refer to Com. on APPR. with recommendation: To Consent Calendar. (Ayes 8. Noes 0.) (March 12). Re-referred to Com. on APPR.

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

1st House	2nd House	Conc.			

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

AB 350 **(Bonta D) Health care coverage: fluoride treatments.**
Current Text: Introduced: 1/29/2025 html pdf
Introduced: 1/29/2025
Status: 2/18/2025-Referred to Com. on Health.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. 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 for the application of fluoride varnish in the primary care setting for children under 21 years of age. Because a willful violation of this provision by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill would make the application of fluoride or other appropriate fluoride treatment, including fluoride varnish, a covered benefit under the Medi-Cal program for children under 21 years of age. The bill would require the State Department of Health Care Services to establish and promulgate a policy governing billing and reimbursement for the application of fluoride varnish, as specified. This bill contains other related provisions and other existing laws.

AB 360 **(Papan D) Physicians and surgeons: menopause surveys.**
Current Text: Amended: 3/10/2025 html pdf
Introduced: 1/30/2025
Status: 3/28/2025-In committee: Set, first hearing. Hearing canceled at the request of author.

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

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

AB 371 **(Haney D) Dental coverage.**
Current Text: Amended: 3/13/2025 html pdf
Introduced: 2/3/2025
Status: 3/17/2025-Re-referred to Com. on Health.

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law prohibits a contract between a plan or insurer and a dentist from requiring a dentist to accept an amount set by the plan or insurer as payment for dental care services provided to an enrollee or insured that are not covered services under the enrollee's contract or the insured's policy. Existing law requires a plan or insurer to make specified disclosures to an enrollee or insured regarding noncovered dental services. Existing law requires a health care service plan or health insurer to comply with specified timely access requirements. For a specified plan or insurer offering coverage for dental services, existing law requires urgent dental appointments to be offered within 72 hours of a request, nonurgent dental appointments to be offered within 36 business days of a request, and preventive dental care appointments to be offered within 40 business days of a request, as specified. Existing law requires a contract between a health care service plan and health care provider to ensure compliance with network adequacy standards and to require reporting by providers to plans to ensure compliance. Under existing law, a health care service plan is required to annually report to the Department of Managed Health Care on this compliance. Existing law authorizes the Department of Insurance to issue guidance to insurers regarding annual timely access and network reporting methodologies. If a health care service plan or health insurer pays a contracting dental provider directly for covered services, this bill would require the plan or insurer to pay a noncontracting dental provider directly for covered services if the noncontracting provider submits to the plan or insurer a written assignment of benefits form signed by the enrollee or insured. The bill would require the plan or insurer to provide a predetermination or prior authorization to the dental provider and to reimburse the provider for not less than that amount, except as specified. The bill would require the plan or insurer to notify the enrollee or insured that the provider was paid and that the out-of-network cost may count towards their annual or lifetime maximum. The bill would require a noncontracting dental provider to make specified disclosures to an enrollee or insured before accepting an assignment of benefits. This bill contains other related provisions and other existing laws.

AB 375 **(Nguyen D) Medical Practice Act: health care providers: qualified autism service paraprofessionals.**
Current Text: Introduced: 2/3/2025 html pdf
Introduced: 2/3/2025
Status: 2/18/2025-Referred to Com. on B. & P.

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

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

AB 384 **(Connolly D) Health care coverage: mental health and substance use disorders: inpatient admissions.**
Current Text: Amended: 3/17/2025 html pdf
Introduced: 2/3/2025
Status: 3/18/2025-Re-referred to Com. on Health.

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and

regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan 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: 3/26/2025-From committee: Do pass and re-refer to Com. on APPR. with recommendation: To Consent Calendar. (Ayes 15. Noes 0.) (March 25). Re-referred to Com. on APPR.

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

Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. 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: 3/24/2025 html pdf
Introduced: 2/4/2025
Status: 3/25/2025-Re-referred to Com. on B. & P.

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

Summary: Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons and licensed midwives by the Medical Board of California. A violation of the act is a crime. Existing law authorizes the board to establish a Physician and Surgeon Health and Wellness Program to support a physician and surgeon in their rehabilitation from substance abuse to ensure the physician and surgeon remains able to practice medicine in a manner that will not endanger the public health and safety and that will maintain the integrity of the medical profession. Existing law requires the board to contract with a third party for the program's administration in accordance with specified provisions of the Public Contract Code. Existing law provides that participation in the program shall not be a defense to any disciplinary action that may be taken by the board. Existing law requires the program to comply with the Uniform Standards Regarding Substance-Abusing Healing Arts Licensees adopted by the Substance Abuse Coordination Committee of the Department of Consumer Affairs. Existing law establishes the Physician and Surgeon Health and Wellness Program Account in the Contingent Fund of the Medical Board of California for the support of the program. This bill would revise and recast those provisions and would instead authorize the board to establish a Physician Health and Wellness Program to support, treat, monitor, and rehabilitate physicians and surgeons and other professionals

licensed by the board with impairing physical and mental health conditions that may impact their ability to practice their profession in a reasonably safe, competent, and professional manner. The bill would require the administering entity to be a nonprofit entity and would require the contract with the administering entity to include procedures on specified topics. The bill would exempt the program from the Uniform Standards Regarding Substance-Abusing Healing Arts Licensees. The bill would exempt program records relating to program participants from disclosure under the California Public Records Act, except as specified. The bill would authorize the board to establish advisory committees to assist in carrying out the duties of the administering entity, and would establish duties and responsibilities authorized to be performed by a committee. The bill would rename the Physician and Surgeon Health and Wellness Program Account as the Physician Health and Wellness Program Account, and would authorize the board to seek and use grant funds and gifts from public or private sources to pay any cost associated with the program. The bill would require the board to annually report to the Legislature and make available to the public the amount and source of funds. The bill would require a licensee to report a license to the administering entity or the board if they believe the licensee is impaired. By expanding the scope of a crime under the Medical Practice Act, the bill would impose a state-mandated local program. The bill would make a person who, in good faith, reports information or takes action in connection with the bill's provisions immune from civil liability for reporting information or taking the action. The bill would make the program inapplicable to the Osteopathic Medical Board of California. This bill contains other existing laws.

AB 412 **(Bauer-Kahan D) Generative artificial intelligence: training data: copyrighted materials.**
Current Text: Amended: 3/20/2025 html pdf
Introduced: 2/4/2025
Status: 3/28/2025-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 federal law, through copyright, provides authors of original works of authorship, as defined, with certain rights and protections. Existing federal law generally gives the owner of the copyright the right to reproduce the work in copies or phonorecords and the right to distribute copies or phonorecords of the work to the public. Existing law requires, on or before January 1, 2026, and before each time thereafter that a generative artificial intelligence system or service, as defined, or a substantial modification to a generative artificial intelligence system or service, released on or after January 1, 2022, is made available to Californians for use, regardless of whether the terms of that use include compensation, a developer of the system or service to post on the developer's internet website documentation, as specified, regarding the data used to train the generative artificial intelligence system or service. This bill would require a developer, as defined, of a generative artificial intelligence model to, among other things, document any copyrighted materials that the developer knows were used to train the model. The bill would authorize a copyright owner to request information about a developer's use of copyrighted materials held by the copyright owner by providing the developer with specified information, and would require the developer to make available a mechanism on the developer's internet website allowing a copyright owner to submit that request. The bill would require a developer to provide a copyright owner with a complete list of their copyrighted materials that were used to train the model within 7 days of receiving that request from the copyright owner, and would provide that each day following the 7-day period that a developer fails to provide a copyright owner with that list of copyrighted materials constitutes a discrete violation. The bill would authorize a copyright owner that is not provided with a list of copyrighted materials according to these provisions to bring a civil action against the developer for specified relief. The bill would provide that the bill's requirements do not apply to a developer that makes all of the data used to train the model publicly available at no cost, as specified. This bill contains other existing laws.

AB 416 **(Krell D) Involuntary commitment.**
Current Text: Introduced: 2/5/2025 html pdf
Introduced: 2/5/2025
Status: 4/2/2025-Coauthors revised. From committee: Do pass and re-refer to Com. on JUD. (Ayes 15. Noes 0.) (April 1). Re-referred to Com. on JUD.

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

Summary: Existing law, the Lanterman-Petris-Short Act, authorizes the involuntary commitment and treatment of persons with specified mental disorders. Under the act, when a person, as a result of a mental health disorder, is a danger

to self or others, or gravely disabled, the person may, upon probable cause, be taken into custody by specified individuals, including, among others, by a peace officer and a designated member of a mobile crisis team, and placed in a facility designated by the county and approved by the State Department of Health Care Services for up to 72 hours for evaluation and treatment. Existing law exempts specified individuals, including a peace officer responsible for the detainment of a person under these provisions from criminal and civil liability for an action by a person who is released at or before the end of the period for which they were detained. This bill would additionally authorize a person to be taken into custody, pursuant to those provisions, by an emergency physician, as defined. The bill would also exempt an emergency physician who is responsible for the detainment of a person under those provisions from criminal and civil liability, as specified.

AB 423 **(Davies R) Alcoholism or drug abuse recovery or treatment programs and facilities: disclosures.**
Current Text: Amended: 4/2/2025 html pdf
Introduced: 2/5/2025
Status: 4/3/2025-Re-referred to Com. on Health.

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

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

AB 432 **(Bauer-Kahan D) Menopause.**
Current Text: Introduced: 2/5/2025 html pdf
Introduced: 2/5/2025
Status: 3/27/2025-In committee: Set, first hearing. Hearing canceled at the request of author.

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

Summary: Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California and requires the board to adopt and administer standards for the continuing education of those licensees. Existing law requires the board, in determining its continuing education requirements, to consider including a course in menopausal mental or physical health. This bill would instead require the board, in determining its continuing education requirements, to include a course in menopausal mental or physical health. The bill would require physicians who have a patient population composed of 25% or more of women to complete a mandatory continuing medical education course in perimenopause, menopause, and postmenopausal care. This bill contains other related provisions and other existing laws.

AB 489 **(Bonta D) Health care professions: deceptive terms or letters: artificial intelligence.**
Current Text: Introduced: 2/10/2025 html pdf
Introduced: 2/10/2025
Status: 4/1/2025-Coauthors revised. From committee: Do pass and re-refer to Com. on P. & C.P. (Ayes 17. Noes 0.) (April 1). Re-referred to Com. on P. & C.P.

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

1st House	2nd House	Conc.			

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

AB 510 **(Addis D) Health care coverage: utilization review: appeals and grievances.**
Current Text: Introduced: 2/10/2025 html pdf
Introduced: 2/10/2025
Status: 2/24/2025-Referred to Com. on Health.

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of disability insurers by the Department of Insurance. Existing law generally authorizes a health care service plan or disability insurer to use prior authorization and other utilization review or utilization management functions, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. Existing law requires a health care service plan or disability insurer to include in a response regarding decisions to deny, delay, or modify health care services, among other things, information on how the provider, enrollee, or insured may file a grievance or appeal with the plan or insurer. Existing law requires a health care service plan's grievance system to resolve grievances within 30 days, except as specified. Existing law requires a contract between a health insurer and a provider to contain provisions requiring a dispute resolution mechanism, and requires an insurer to resolve each provider dispute within 45 working days, as specified. This bill would, upon request, require that an appeal or grievance regarding a decision by a health care service plan or disability insurer delaying, denying, or modifying a health care service based in whole or in part on medical necessity, be reviewed by a licensed physician who is competent to evaluate the specific clinical issues involved in the health care service being requested, and of the same or similar specialty as the requesting provider. The bill, notwithstanding the above-described timelines, would require these reviews to occur within 2 business days, or if an enrollee or insured faces an imminent and serious threat to their health, within a timely fashion appropriate for the nature of the enrollee's or insured's condition, as specified. If a health care service plan or disability insurer fails to meet those timelines, the bill would deem the prior authorization request as approved and supersede any prior delay, denial, or modification. The bill would make conforming changes to related provisions. Because a violation of these provisions by a health care service plan would be a crime, this bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

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

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

1st House	2nd House	Conc.			

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

AB 517 **(Krell D) Medi-Cal: complex rehabilitation technology: wheelchairs.**
Current Text: Introduced: 2/10/2025 html pdf
Introduced: 2/10/2025
Status: 2/24/2025-Referred to Com. on Health.

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

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

AB 534 **(Schiavo D) Transitional housing placement providers.**
Current Text: Introduced: 2/11/2025 html pdf
Introduced: 2/11/2025
Status: 3/26/2025-From committee: Do pass and re-refer to Com. on APPR. (Ayes 7. Noes 0.) (March 25). Re-referred to Com. on APPR.

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

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

AB 536 **(Patterson R) Health care coverage: colorectal cancer screening.**
Current Text: Amended: 3/24/2025 html pdf
Introduced: 2/11/2025
Status: 3/25/2025-Re-referred to Com. on Health.

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

Summary: Existing law, 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: Introduced: 2/11/2025 html pdf
Introduced: 2/11/2025
Status: 2/24/2025-Referred to Com. on Health.

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

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

AB 543 **(González, Mark D) Medi-Cal: street medicine.**
Current Text: Amended: 3/11/2025 html pdf
Introduced: 2/11/2025
Status: 3/24/2025-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 establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law sets forth various provisions for Medi-Cal coverage of community health worker services, enhanced care management, and community supports, subject to any necessary federal approvals. Under existing law, these benefits are designed to, respectively, provide a link between health and social services and the community; address the clinical and nonclinical needs on a whole-person-care basis for certain target populations of Medi-Cal beneficiaries, including individuals experiencing homelessness; and provide housing transition navigation services, among other supports. Existing law establishes mechanisms for Medi-Cal presumptive eligibility for certain target populations, including, among others, pregnant persons, children, and patients of qualified hospitals, for purposes of Medi-Cal coverage while other Medi-Cal eligibility determination procedures are pending, as specified. This bill would set forth provisions regarding street medicine, as defined, under the Medi-Cal program for persons experiencing homelessness, as defined. The bill would state the intent of the Legislature that the street medicine-related provisions coexist with, and not duplicate, other Medi-Cal provisions, including, but not limited to, those regarding community health worker services, enhanced care management, and community supports. The bill

would require the department to implement a program of presumptive eligibility for persons experiencing homelessness for purposes of full-scope Medi-Cal benefits without a share of cost. The bill would authorize an enrolled Medi-Cal provider to make a presumptive eligibility determination for those persons. This bill contains other related provisions and other existing laws.

AB 546 **(Caloza D) Health care coverage: portable HEPA purifiers and filters.**
Current Text: Introduced: 2/11/2025 html pdf
Introduced: 2/11/2025
Status: 2/24/2025-Referred to Com. on Health.

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law sets forth specified coverage requirements for plan contracts and insurance policies, and limits the copayment, coinsurance, deductible, and other cost sharing that may be imposed for specified health care services. This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2026, to include coverage for portable high-efficiency particulate air (HEPA) purifiers and filters for enrollees or insureds who are pregnant or diagnosed with asthma or chronic obstructive pulmonary disease. The bill would prohibit a portable HEPA purifier and filter covered pursuant to these provisions from being subject to a deductible, coinsurance, or copayment requirement. Because a willful violation of these provisions by a health care service plan would be a crime, this bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 554 **(González, Mark D) Health care coverage: antiretroviral drugs, drug devices, and drug products.**
Current Text: Amended: 3/3/2025 html pdf
Introduced: 2/11/2025
Status: 3/4/2025-Re-referred to Com. on Health.

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

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

AB 575 **(Arambula D) Obesity Prevention Treatment Parity Act.**
Current Text: Amended: 3/12/2025 html pdf
Introduced: 2/12/2025
Status: 3/13/2025-Re-referred to Com. on Health.

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act's requirements a crime. Existing law provides for the regulation of 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: Introduced: 2/12/2025 html pdf
Introduced: 2/12/2025
Status: 2/24/2025-Referred to Com. on Health.

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

Summary: Existing law provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes the willful violation of its provisions a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or health insurance policy that provides coverage for outpatient prescription drugs to cover medically necessary prescription drugs. For a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2026, this bill would prohibit a health care service plan, health insurer, or pharmacy benefit manager from engaging in specified steering practices, including, among others, requiring an enrollee or insured to use a retail pharmacy for dispensing prescription oral medications, as specified, and imposing any requirements, conditions, or exclusions that discriminate against a physician in connection with dispensing prescription oral medications. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other existing laws.

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

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

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

AB 602 **(Haney D) Public postsecondary education: student conduct: controlled substances.**
Current Text: Amended: 3/13/2025 html pdf
Introduced: 2/13/2025
Status: 3/28/2025-Re-referred to Com. on Higher ED. pursuant to Assembly Rule 96.

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

1st House	2nd House	Conc.			

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

AB 618 **(Krell D) Medi-Cal: behavioral health: data sharing.**
Current Text: Introduced: 2/13/2025 html pdf
Introduced: 2/13/2025
Status: 4/2/2025-Coauthors revised. From committee: Do pass and re-refer to Com. on APPR. with recommendation: To Consent Calendar. (Ayes 15. Noes 0.) (April 1). Re-referred to Com. on APPR.

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

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

AB 636 **(Ortega D) Medi-Cal: diapers.**
Current Text: Amended: 3/13/2025 html pdf
Introduced: 2/13/2025
Status: 4/2/2025-From committee: Do pass and re-refer to Com. on APPR. (Ayes 15. Noes 0.) (April 1). Re-referred to Com. on APPR.

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

Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed 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: Introduced: 2/14/2025 html pdf
Introduced: 2/14/2025
Status: 3/3/2025-Referred to Com. on Health.

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

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

AB 676 **(Gonzalez, Jeff R) Medi-Cal: unrecovered payments: interest rate.**
Current Text: Introduced: 2/14/2025 html pdf
Introduced: 2/14/2025
Status: 4/3/2025-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 establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law requires the Director of Health Care Services to establish administrative appeal processes to review grievances or complaints arising from the findings of an audit or examination. Under existing law, if recovery of a disallowed payment has been made by the department, a provider who prevails in an appeal of that payment is entitled to interest at the rate equal to the monthly average received on investments in the Surplus Money Investment Fund, or simple interest at the rate of 7% per annum, whichever is higher. Under existing law, with exceptions, interest at that same rate is assessed against any unrecovered overpayment due to the department. In the case of an assessment against any unrecovered overpayment due to the department, this bill would authorize the department to waive the interest, as part of a repayment agreement entered into with the provider, if the unrecovered overpayment occurred 4 or more years before the issuance of the first statement of account status or demand for repayment, after taking into account specified factors. Under the bill, those factors would include, among others, the impact of the repayment amounts on the fiscal solvency of the provider, and whether the overpayment was caused by a policy change or departmental error that was not the fault of the billing provider.

AB 682 **(Ortega D) Health care coverage reporting.**
Current Text: Introduced: 2/14/2025 html pdf
Introduced: 2/14/2025
Status: 3/3/2025-Referred to Com. on Health.

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

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

AB 787 **(Papan D) Provider directory disclosures.**
Current Text: Amended: 3/17/2025 html pdf
Introduced: 2/18/2025
Status: 4/3/2025-From committee: Amend, and do pass as amended and re-refer to Com. on APPR. (Ayes 15. Noes 0.) (April 1).

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires specified health care service plans and health insurers to publish and maintain a provider directory or directories with information on contracting providers that deliver health care services to enrollees or insureds, and requires a health care service plan or health insurer to regularly update its printed and online provider directory or directories, as specified. Existing law requires provider directories to include specified information and disclosures. This bill would require a full service health care service plan, specialized mental health plan, health insurer, or specialized mental health insurer to include in its provider directory or directories a statement at the top of the directory advising an enrollee or insured to contact the plan or insurer for assistance in finding an in-network provider. The bill would require the plan or insurer to respond within 24 hours if contacted for that assistance, and to provide a list of in-network providers confirmed to be accepting new patients within 2 business days. Because a violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

AB 789 **(Bonta D) Health care coverage: unreasonable rate increases.**
Current Text: Amended: 3/17/2025 html pdf
Introduced: 2/18/2025
Status: 4/3/2025-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 health care service plans by the Department of Managed Health Care and the regulation of health insurers by the Department of Insurance. For these purposes, existing law defines “unreasonable rate increase” to have the same meaning as in the federal Patient Protection and Affordable Care Act, which is that an unreasonable rate increase exists when the federal Centers for Medicare and Medicaid Services makes a determination that a rate increase is excessive, unjustified, or unfairly discriminatory, among other things. This bill would instead provide that an “unreasonable rate increase” exists if the Director of the Department of Managed Health Care or the Insurance Commissioner, as applicable, makes a determination that a rate increase is excessive, unjustified, unfairly discriminatory, or otherwise unreasonable.

AB 798 **(Calderon D) Emergency Diaper and Wipe Distribution Program.**
Current Text: Amended: 3/17/2025 html pdf
Introduced: 2/18/2025
Status: 3/18/2025-Re-referred to Com. on HUM. S.

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

Summary: Existing law requires the State Department of Social Services to administer various public social services programs, including, among others, the California Work Opportunity and Responsibility to Kids (CalWORKs) program, the CalFresh program, and the State Emergency Food Assistance Program (CalFood). Under existing law, a CalWORKs recipient 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 require the department to establish and administer the Emergency Diaper and Wipe Distribution Program for families with infants or toddlers impacted by a natural disaster that is the subject of a state of emergency proclaimed by the Governor, as specified. Under the bill, in the case of a qualifying state of emergency, the program would be implemented for a period of at least one year following the proclamation, and would resume in implementation to the extent necessary to serve the needs of those families. The bill would require the department to determine eligibility criteria for entities to participate in the program, as specified, and to conduct outreach to, and consider applications from, eligible entities. The bill would require all participating entities to report on a quarterly basis to the department, at a minimum, certain quantitative information, including the numbers of diapers and wipes distributed and the total dollars expended. 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: 3/3/2025-Referred to Com. on Health.

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

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

AB 843 **(Garcia D) Health care coverage: language access.**
Current Text: Introduced: 2/19/2025 html pdf
Introduced: 2/19/2025

Status: 3/26/2025-From committee: Do pass and re-refer to Com. on APPR. (Ayes 13. Noes 0.) (March 25). Re-referred to Com. on APPR.

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

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

AB 877 **(Dixon R) Health care coverage: substance use disorder: residential facilities.**
Current Text: Introduced: 2/19/2025 html pdf
Introduced: 2/19/2025
Status: 3/3/2025-Referred to Com. on Health.

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

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

AB 910 **(Bonta D) Pharmacy benefit management.**
Current Text: Amended: 3/24/2025 html pdf
Introduced: 2/19/2025

Status: 3/25/2025-Re-referred to Com. on Health.

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

Summary: Existing law provides 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. Existing law provides for the registration and regulation of pharmacy benefit managers, as defined, that contract with health care service plans to manage their prescription drug coverage. Under existing law, a pharmacy benefit manager is required to submit specified information to the department to apply to register with the department. This bill would require a pharmacy benefit manager to, beginning October 1, 2026, annually report specified information to the department regarding the covered drugs dispensed at a pharmacy and specified information about the pharmacy benefit manager's revenue, expenses, health care service plan contracts, the scope of services provided to the health care service plan, and the number of enrollees that the pharmacy benefit manager serves. The bill would require the department to compile this reported information and make the report publicly available, as specified, but would exempt records other than the report from public disclosure. The bill would include in the requirements that health care service plans are required to impose on a pharmacy benefit manager with which they contract, the requirement that the pharmacy benefit manager comply with these reporting requirements. 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.

AB 951 **(Ta R) Health care coverage: behavioral diagnoses.**
Current Text: Introduced: 2/20/2025 html pdf
Introduced: 2/20/2025
Status: 3/26/2025-Coauthors revised. From committee: Do pass and re-refer to Com. on APPR. with recommendation: To Consent Calendar. (Ayes 15. Noes 0.) (March 25). Re-referred to Com. on APPR.

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

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

AB 960 **(Garcia D) Patient visitation.**
Current Text: Introduced: 2/20/2025 html pdf
Introduced: 2/20/2025
Status: 3/10/2025-Referred to Com. on Health.

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

Summary: Existing law provides for the licensure and regulation by the State Department of Public Health of health facilities, as defined. Existing law requires a health facility to allow a patient's domestic partner, the children of the patient's domestic partner, and the domestic partner of the patient's parent or child to visit unless no visitors are allowed, the facility reasonably determines that the presence of a particular visitor would endanger the health or safety of a patient, a member of the health facility staff, or other visitor to the health facility, or would significantly disrupt the operations of a facility, or the patient has indicated to the health facility staff that the patient does not want this person to visit. A violation of this provision is a misdemeanor. This bill would require a health facility to allow a patient with

demonstrated dementia needs to have a family or friend caregiver with them as needed unless specified conditions are met, including, but not limited to, that the facility reasonably determines that the presence of a particular visitor would endanger the health or safety of the visitor, a patient, a member of the health facility staff, or other visitor to the health facility, or would significantly disrupt the operations of the facility. The bill would authorize a health facility to require visitors to adhere to personal protective equipment and testing protocols, as specified, and does not prohibit a health facility from otherwise establishing reasonable restrictions upon visitation. The bill would specify that its provisions do not create any new civil or criminal liability, including, but not limited to, liability for any illness, infection, or injury experienced by a patient or visitor on the part of a facility that complies with its requirements. By expanding the scope of a crime, this bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 974 **(Patterson R) Medi-Cal managed care plans: enrollees with other health care coverage.**
Current Text: Amended: 3/24/2025 html pdf
Introduced: 2/20/2025
Status: 3/25/2025-Re-referred to Com. on Health.

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

Summary: Existing law 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: 3/28/2025 html pdf
Introduced: 2/20/2025
Status: 4/1/2025-Re-referred to Com. on P. & C.P.

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

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

related to cyber threat indicators or defensive measures for a cybersecurity purpose shared in accordance with the California AI Cybersecurity Collaboration Playbook is confidential and would prohibit that information from being disclosed, except as specified. The bill would also make findings and declarations related to its provisions. This bill contains other existing laws.

AB 980 **(Arambula D) Health care service plan: managed care entity: duty of care.**
Current Text: Introduced: 2/20/2025 html pdf
Introduced: 2/20/2025
Status: 3/26/2025-In committee: Set, first hearing. Hearing canceled at the request of author.

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

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

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

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

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

AB 1018 **(Bauer-Kahan D) Automated decision systems.**
Current Text: Introduced: 2/20/2025 html pdf
Introduced: 2/20/2025
Status: 3/28/2025-In committee: Set, first hearing. Hearing canceled at the request of author.

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

Summary: The California Fair Employment and Housing Act establishes the Civil Rights Department within the Business, Consumer Services, and Housing Agency and requires the department to, among other things, bring civil actions to enforce the act. Existing law requires, on or before September 1, 2024, the Department of Technology to conduct, in coordination with other interagency bodies as it deems appropriate, a comprehensive inventory of all high-risk automated decision systems that have been proposed for use, development, or procurement by, or are being used,

developed, or procured by, any state agency. This bill would generally regulate the development and deployment of an automated decision system (ADS) used to make consequential decisions, as defined. The bill would define "automated decision system" to mean a computational process derived from machine learning, statistical modeling, data analytics, or artificial intelligence that issues simplified output, including a score, classification, or recommendation, that is used to assist or replace human discretionary 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: Introduced: 2/20/2025 html pdf
Introduced: 2/20/2025
Status: 3/10/2025-Referred to Com. on Health.

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

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

AB 1041 **(Bennett D) Health care coverage: physician and provider credentials.**
Current Text: Introduced: 2/20/2025 html pdf
Introduced: 2/20/2025
Status: 4/3/2025-From committee: Amend, and do pass as amended and re-refer to Com. on APPR. (Ayes 12. Noes 0.) (April 1).

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. This bill would require those departments to review specified credentialing requirements and adopt regulations to establish minimum standards or policies and processes that can streamline and reduce redundancy and delay in physician credentialing. The bill would also require those departments to adopt regulations to develop, on or before July 1, 2027, a standardized credentialing form to be used by health care service plans and health insurers for credentialing and recredentialing purposes. The bill would require every health care service plan or health insurer to use the standardized credentialing form on and after July 1, 2027, or six months after the form is completed, whichever is later. The bill would require those departments to update the form every three years, or as necessary to comply with changes in laws, regulations, and guidelines, as specified. This bill contains other related provisions and other existing laws.

AB 1090 **(Davies R) Alcoholism or drug abuse treatment facilities: County of Orange pilot program.**
Current Text: Amended: 3/24/2025 html pdf
Introduced: 2/20/2025
Status: 3/25/2025-Re-referred to Com. on Health.

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

1st House	2nd House	Conc.			

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

AB 1129 **(Rodriguez, Celeste D) Birth defects monitoring.**
Current Text: Introduced: 2/20/2025 html pdf
Introduced: 2/20/2025
Status: 3/10/2025-Referred to Com. on Health.

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

Summary: Existing law requires the State Public Health Officer to maintain a system for the collection of information related to birth defects, as specified. Existing law requires the officer to require general acute care hospitals and physician-owned or physician-operated clinics that regularly provide services for the diagnosis or treatment of birth defects, genetic counseling, or prenatal diagnostic services to make available to the department the medical records of children suspected or diagnosed as having birth defects, as specified. Existing law authorizes the department to enter into a contract for the establishment and implementation of the birth defects monitoring program. This bill would authorize a local health officer to maintain a system for the collection of information related to birth defects and other birth anomalies. The bill would authorize a local health officer to require laboratories, as specified, in addition to the facilities listed above, to either make available or to transmit to the local health department birth defects and other birth anomalies information, as specified. The bill would authorize a local health officer to enter into contracts for implementation of programs to collect and monitor birth anomalies in their jurisdiction. This bill contains other related provisions and other existing laws.

AB 1137 **(Krell D) Reporting mechanism: child sexual abuse material.**
Current Text: Amended: 3/24/2025 html pdf
Introduced: 2/20/2025
Status: 3/25/2025-Re-referred to Com. on P. & C.P.

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

Summary: Existing law requires 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 additionally require the mechanism to be clear and conspicuous, and would require a social media platform to ensure that any report submitted using the reporting mechanism receives a review by a natural person. Existing law makes a noncomplying social media company liable to a reporting user for actual damages and statutory damages, as specified. This bill would also impose a civil penalty on a noncomplying social media company to be collected in a civil action by certain public attorneys, including the Attorney General. The bill would make a social media company liable to a depicted user, as defined, for specified violations. Existing law prohibits a social media

platform from knowingly facilitating, aiding, or abetting commercial sexual exploitation, as defined, and exempts a social media platform from being deemed in violation of that prohibition if it instituted a specified audit program and provided to each member of its board of directors a true and correct copy of each audit, as prescribed. This bill would revise those provisions to, instead, require a social media platform to submit to third-party audits and release audit reports to the public in order to be exempt from being deemed in violation that prohibition, as prescribed. This bill would declare that its provisions are severable.

AB 1328 **(Rodriguez, Michelle D) Medi-Cal reimbursements: ambulance transports.**
Current Text: Amended: 3/24/2025 html pdf
Introduced: 2/21/2025
Status: 3/25/2025-Re-referred to Com. on Health.

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

Summary: Existing law 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. This bill would require the Medi-Cal fee-for-service reimbursement rates for nonemergency ambulance transports and for interfacility ambulance transports, as defined, to be 100% of the amounts set forth in the federal Medicare ambulance fee schedule for the appropriate level of service billed, as specified. This bill contains other related provisions and other existing laws.

AB 1405 **(Bauer-Kahan D) Artificial intelligence: auditors: enrollment.**
Current Text: Amended: 4/3/2025 html pdf
Introduced: 2/21/2025
Status: 4/3/2025-Read second time and amended.

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

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

AB 1415 **(Bonta D) California Health Care Quality and Affordability Act.**
Current Text: Introduced: 2/21/2025 html pdf
Introduced: 2/21/2025
Status: 4/3/2025-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, the California Health Care Quality and Affordability Act, establishes within the Department of

Health Care Access and Information the Office of Health Care Affordability to analyze the health care market for cost trends and drivers of spending, develop data-informed policies for lowering health care costs for consumers and purchasers, set and enforce cost targets, and create a state strategy for controlling the cost of health care and ensuring affordability for consumers and purchasers. Existing law defines multiple terms relating to these provisions, including a health care entity to mean a payer, provider, or a fully integrated delivery system and a provider to mean specified entities delivering or furnishing health care services. This bill would update the definitions applying to these provisions to include a management services organization, as defined, as a health care entity. The bill would also update a provider to mean specified private or public health care providers and would include a health system, as defined, and an entity that owns, operates, or controls an entity specified in the existing definition, regardless of whether it is currently operating, providing services, or has a pending or suspended license. The bill would include additional definitions, including, but not limited to, a health system to mean specified entities under common ownership or control and a hedge fund to mean a pool of funds managed by investors for the purpose of earning a return on those funds, regardless of strategies used to manage the funds, subject to certain exceptions. This bill contains other related provisions and other existing laws.

AB 1418 **(Schiavo D) Department of Health Care Access and Information.**
Current Text: Introduced: 2/21/2025 html pdf
Introduced: 2/21/2025
Status: 3/13/2025-Referred to Com. on Health.

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

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

SB 7 **(McNerney D) Employment: automated decision systems.**
Current Text: Amended: 3/6/2025 html pdf
Introduced: 12/2/2024
Status: 3/26/2025-Set for hearing April 9.

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

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

SB 12 **(Gonzalez D) State government: Immigrant and Refugee Affairs Agency: Office of Immigrant and Refugee Affairs.**

Current Text: Amended: 3/12/2025 html pdf

Introduced: 12/2/2024

Status: 4/3/2025-Set for hearing April 22.

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

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

SB 27 **(Umberg D) Community Assistance, Recovery, and Empowerment (CARE) Court Program.**

Current Text: Introduced: 12/2/2024 html pdf

Introduced: 12/2/2024

Status: 4/1/2025-Set for hearing April 8.

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

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

SB 32 **(Weber Pierson D) Health care coverage: timely access to care.**

Current Text: Amended: 3/25/2025 html pdf

Introduced: 12/2/2024
Status: 4/2/2025-Re-referred to Com. on HEALTH.

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

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

SB 40 **(Wiener D) Health care coverage: insulin.**
Current Text: Amended: 3/17/2025 html pdf
Introduced: 12/3/2024
Status: 4/3/2025-From committee: Do pass as amended and re-refer to Com. on APPR. (Ayes 11. Noes 0.) (April 2).

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or disability insurance policy issued, amended, delivered, or renewed on or after January 1, 2000, that covers prescription benefits to include coverage for insulin if it is determined to be medically necessary. This bill would generally prohibit a health care service plan contract or health insurance policy issued, amended, delivered, or renewed on or after January 1, 2026, 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. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

SB 41 **(Wiener D) Pharmacy benefits.**
Current Text: Amended: 3/17/2025 html pdf
Introduced: 12/3/2024
Status: 4/2/2025-Set for hearing April 23.

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law requires a pharmacy benefit manager under contract with a health care service plan to, among other things, register with the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance. This bill would additionally require a pharmacy benefit manager to apply for

and obtain a license from the Department of Insurance to operate as a pharmacy benefit manager no later than January 1, 2027. The bill would establish application qualifications and requirements, and would require initial license and renewal fees to be collected into the newly created Pharmacy Benefit Manager Account in the Insurance Fund to be available to the department for use, upon appropriation by the Legislature, as specified, for costs related to licensing and regulating pharmacy benefit managers. The bill would impose specified duties on pharmacy benefit managers and requirements for pharmacy benefit manager services and pharmacy benefit manager contracts, including requiring a pharmacy benefit manager to file specified reports with the department, the contents of which are not to be disclosed to the public. The bill would require the department, at specified intervals, to submit reports to the Legislature based on the reports submitted by pharmacy benefit managers, and would require the department to post the reports on the department's internet website. This bill would make a violation of these provisions subject to specified civil penalties. The bill would create the Pharmacy Benefit Manager Fines and Penalties Account in the General Fund, into which fines and administrative penalties would be deposited. This bill contains other related provisions and other existing laws.

SB 53 **(Wiener D) CalCompute: foundation models: whistleblowers.**
Current Text: Amended: 3/27/2025 html pdf
Introduced: 1/7/2025
Status: 4/1/2025-Set for hearing April 8.

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

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

SB 62 **(Menjivar D) Health care coverage: essential health benefits.**
Current Text: Introduced: 1/9/2025 html pdf
Introduced: 1/9/2025
Status: 1/29/2025-Referred to Com. on HEALTH.

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

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

SB 81 **(Arreguín D) Health and care facilities: information sharing.**
Current Text: Amended: 3/24/2025 html pdf
Introduced: 1/17/2025
Status: 4/2/2025-Re-referred to Coms. on HEALTH and JUD.

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

Summary: (1)The Confidentiality of Medical Information Act (CMIA) prohibits a provider of health care, a health care service plan, a contractor, or a corporation and its subsidiaries and affiliates from intentionally sharing, selling, using for marketing, or otherwise using any medical information, as defined, for any purpose not necessary to provide health care services to a patient, except as provided. The CMIA authorizes a provider of health care, health care service plan, or contractor to disclose medical information regarding a patient of the provider of health care or an enrollee or subscriber of a health care service plan with authorization from the patient or pursuant to a search warrant lawfully issued to a governmental law enforcement agency. Existing law makes a violation of these provisions that results in economic loss or personal injury to a patient punishable as a misdemeanor. This bill would revise the definition of "medical information" to include immigration status, including current and prior immigration status, and place of birth, and would define "immigration enforcement" to mean any and all efforts to investigate, enforce, or assist in the investigation or enforcement of any federal civil immigration law, and also includes any and all efforts to investigate, enforce, or assist in the investigation or enforcement of any federal criminal immigration that penalizes a person's presence in, entry or reentry to, or employment in, the United States. The bill would specify that a provider of health care, health care service plan, or contractor may disclose medical information regarding a patient of the provider of health care or an enrollee or subscriber or a health care service plan pursuant to a search warrant lawfully issued and signed by a judge, including a magistrate judge, to a governmental law enforcement agency. The bill would also prohibit, except to the extent expressly authorized by a patient, enrollee, or subscriber, or as otherwise required, a provider of health care, health care service plan, contractor, or corporation and its subsidiaries and affiliates from disclosing medical information for immigration enforcement. The bill would prohibit, to the extent permitted by state and federal law, and to the extent possible, a provider of health care, health care service plan, contractor, or employer from allowing access to a patient for immigration enforcement. Because the bill would expand the scope of a crime, it would impose a state-mandated local program.

SB 85 **(Umberg D) Civil actions: service of summons.**
Current Text: Amended: 3/25/2025 html pdf
Introduced: 1/21/2025
Status: 4/2/2025-Re-referred to Com. on JUD.

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

Summary: Existing law prescribes specified methods for the service of a summons in a civil action. Under existing law, if no provision is made in statute for the service of summons, a court may direct a summons to be served in a manner that is reasonably calculated to give actual notice to the party to be served. This bill would also authorize a court to direct a summons to be served in a manner that is reasonably calculated to give actual notice to the party to be served if a plaintiff, using due diligence, has been unable to serve the summons using methods prescribed by statute. The bill would specify that service of a summons by electronic mail or other electronic technology is reasonably calculated to give actual notice to the party to be served.

SB 238 **(Smallwood-Cuevas D) Workplace surveillance tools.**
Current Text: Amended: 3/26/2025 html pdf
Introduced: 1/29/2025
Status: 4/2/2025-Re-referred to Coms. on L., P.E. & R. and JUD.

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

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

specified.

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

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

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

SB 246 **(Grove R) Medi-Cal: graduate medical education payments.**
Current Text: Introduced: 1/30/2025 html pdf
Introduced: 1/30/2025
Status: 4/3/2025-From committee: Do pass and re-refer to Com. on APPR. with recommendation: To consent calendar. (Ayes 11. Noes 0.) (April 2). Re-referred to Com. on APPR.

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

Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law requires the department, subject to any necessary federal approvals and the availability of federal financial participation, to make Medi-Cal payments to designated public hospitals (DPHs) and their affiliated government entities, as defined, in recognition of the Medi-Cal managed care share of graduate medical education (GME) costs. Existing law requires that the payments consist of direct and indirect GME payments made in recognition and support of the direct costs incurred in the operation of GME programs and the increased operating and patient care costs associated with teaching programs, respectively. Under existing law, the nonfederal share of these payments consist of voluntary intergovernmental transfers (IGTs) of funds

provided by DPHs or their affiliated government entities, or other eligible public entities, as specified. Under existing law, the continuously appropriated DPH GME Special Fund is established for these purposes. This bill would require the department, subject to any necessary federal approvals and the availability of federal financial participation, to make additional Medi-Cal payments to district and municipal public hospitals (DMPHs), defined as nondesignated public hospitals, and to their affiliated government entities, in recognition of the Medi-Cal managed care share of GME costs. Under the bill, these payments would be made in a manner consistent with the methodology for GME payments to DPHs and their affiliated government entities and would consist of the above-described direct and indirect GME payment components. The bill would authorize the department to seek federal approval for other forms of GME payments to DMPHs and their affiliated government entities, as specified. This bill contains other related provisions and other existing laws.

SB 250 **(Ochoa Bogh R) Medi-Cal: provider directory: skilled nursing facilities.**
Current Text: Introduced: 1/30/2025 html pdf
Introduced: 1/30/2025
Status: 3/28/2025-Set for hearing April 7.

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

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

SB 257 **(Wahab D) Pregnancy As a Recognized Event for Nondiscriminatory Treatment (PARENT) Act.**
Current Text: Introduced: 2/3/2025 html pdf
Introduced: 2/3/2025
Status: 2/14/2025-Referred to Com. on HEALTH.

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

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

SB 278 **(Cabaldon D) Health data: HIV test results.**
Current Text: Amended: 3/28/2025 html pdf
Introduced: 2/4/2025
Status: 4/1/2025-Set for hearing April 8.

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

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

SB 306 **(Becker D) Health care coverage: prior authorizations.**
Current Text: Introduced: 2/10/2025 html pdf
Introduced: 2/10/2025
Status: 4/2/2025-Set for hearing April 23.

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

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

SB 324 **(Menjivar D) Medi-Cal: enhanced care management and community supports.**
Current Text: Amended: 3/24/2025 html pdf
Introduced: 2/11/2025
Status: 4/3/2025-From committee: Do pass as amended and re-refer to Com. on APPR. (Ayes 11. Noes 0.) (April 2).

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

Summary: Current 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 require a Medi-Cal managed care plan, for purposes of covering the ECM benefit, or if it elects to cover a community support, to contract with community providers, as defined, whenever those providers are available in the respective county and have experience in providing the applicable ECM or community support, and can demonstrate that they are capable of providing access and meeting quality requirements in accordance with Medi-Cal guidelines.

SB 339 **(Cabaldon D) Medi-Cal: laboratory rates.**
Current Text: Introduced: 2/12/2025 html pdf
Introduced: 2/12/2025
Status: 4/2/2025-April 2 hearing postponed by committee.

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

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

SB 363 **(Wiener D) Health care coverage: independent medical review.**
Current Text: Amended: 3/26/2025 html pdf
Introduced: 2/13/2025
Status: 3/26/2025-From committee with author's amendments. Read second time and amended. Re-referred to Com. on HEALTH. Set for hearing April 9. April 2 hearing postponed by committee.

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

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

insurer's treatment denials and modifications to (1) the number of successful independent medical review overturns of the plan's or insurer's treatment denials or modifications and (2) the number of treatment denials or modifications reversed by a plan or insurer after an independent medical review for the denial or modification is requested, filed, or applied for. The bill would make a health care service plan or health insurer liable for an administrative penalty, as specified, if more than 40% of the independent medical reviews filed with a health care service plan or health insurer result in an overturning or reversal of a treatment denial or modification in any one individual category of the specified general types of care. The bill would make a health care service plan or health insurer liable for additional administrative penalties for each independent medical review resulting in an additional overturned or reversed denial or modification in excess of that threshold. The bill would require the departments to annually include data, analysis, and conclusions relating to these provisions in specified reports. This bill contains other related provisions and other existing laws.

SB 402 **(Valladares R) Health care coverage: autism.**
Current Text: Introduced: 2/14/2025 html pdf
Introduced: 2/14/2025
Status: 3/18/2025-Set for hearing April 21.

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

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

SB 418 **(Menjivar D) Health care coverage: nondiscrimination.**
Current Text: Amended: 3/27/2025 html pdf
Introduced: 2/18/2025
Status: 4/1/2025-Set for hearing April 22 in JUD. pending receipt.

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

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

restrictions on coverage, on the basis of race, color, national origin, sex, age, disability, as specified. Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other existing laws.

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

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

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

SB 466 **(Caballero D) Drinking water: hexavalent chromium: civil liability: exemption.**
Current Text: Amended: 3/24/2025 html pdf
Introduced: 2/19/2025
Status: 4/2/2025-Re-referred to Coms. on E.Q. and JUD.

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

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

SB 468 **(Becker D) High-risk artificial intelligence systems: duty to protect personal information.**
Current Text: Introduced: 2/19/2025 html pdf
Introduced: 2/19/2025
Status: 3/25/2025-Set for hearing April 22.

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

Summary: Existing law, the California Consumer Privacy Act of 2018 (CCPA), grants a consumer various rights with respect to personal information that is collected or sold by a business. The CCPA defines various terms for these purposes. The California Privacy Rights Act of 2020 (CPRA), approved by the voters as Proposition 24 at the November 3, 2020, statewide general election, amended, added to, and reenacted the CCPA and establishes the California Privacy Protection Agency (agency) and vests the agency with full administrative power, authority, and jurisdiction to enforce the CCPA. Existing law requires, on or before January 1, 2026, and before each time thereafter that a generative artificial intelligence system or service, as defined, or a substantial modification to a generative artificial intelligence system or service, released on or after January 1, 2022, is made available to Californians for use, regardless of whether the terms of that use include compensation, a developer of the system or service to post on the developer's internet website documentation, as specified, regarding the data used to train the generative artificial intelligence system or service. This bill would impose a duty on a covered deployer, defined as a business that deploys a high-risk artificial intelligence system that processes personal information, to protect personal information held by the covered deployer, subject to

certain requirements. In this regard, the bill would require a covered deployer whose high-risk artificial intelligence systems process personal information to develop, implement, and maintain a comprehensive information security program, as specified, that contains administrative, technical, and physical safeguards that are appropriate for, among other things, the covered deployer's size, scope, and type of business. The bill would require the program described above to meet specified requirements, including, among other things, that the program incorporates safeguards that are consistent with the safeguards for the protection of personal information and information of a similar character under applicable state or federal laws and regulations. This bill contains other related provisions and other existing laws.

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

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

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

SB 528 **(Weber Pierson D) Health care: maintenance and expansion.**
Current Text: Amended: 3/25/2025 html pdf
Introduced: 2/20/2025
Status: 4/2/2025-Re-referred to Com. on HEALTH.

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

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

SB 530 **(Richardson D) Medi-Cal: time and distance standards.**
Current Text: Amended: 3/25/2025 html pdf
Introduced: 2/20/2025
Status: 3/26/2025-Set for hearing April 9.

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 indefinitely. The bill would also require a managed care plan to ensure that each subcontractor network complies with certain appointment time standards unless already required to do so. The bill would set forth related reporting requirements with regard to subcontractor networks. This bill contains other related provisions and other existing laws.

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

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

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

SB 579 **(Padilla D) Mental health and artificial intelligence working group.**
Current Text: Amended: 3/26/2025 html pdf
Introduced: 2/20/2025
Status: 3/26/2025-Read second time and amended. Re-referred to Com. on APPR.

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

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

SB 626 **(Smallwood-Cuevas D) Perinatal health screenings and treatment.**
Current Text: Amended: 3/24/2025 html pdf
Introduced: 2/20/2025
Status: 3/24/2025-From committee with author's amendments. Read second time and amended. Re-referred to Com. on HEALTH.

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

Summary: Existing law requires a licensed health care practitioner who provides prenatal, postpartum, or interpregnancy care for a patient to offer to screen or appropriately screen a mother for maternal mental health conditions. For purposes of that requirement, existing law defines "maternal mental health condition" to mean a mental health condition that occurs during pregnancy, the postpartum period, or interpregnancy, as specified. This bill would

modify the term “maternal mental health condition” to “perinatal mental health condition” and additionally include in its definition a mental health condition that occurs during the perinatal period. The bill would require a licensed health care practitioner who provides perinatal care for a patient to screen, diagnose, and treat the patient for a perinatal mental health condition according to the clinical guidelines from the American College of Obstetricians and Gynecologists. This bill contains other related provisions and other existing laws.

SB 812 **(Allen D) Qualified youth drop-in center health care coverage.**
Current Text: Introduced: 2/21/2025 html pdf
Introduced: 2/21/2025
Status: 4/2/2025-Set for hearing April 23.

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

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

SB 833 **(McNerney D) Critical infrastructure: automated decision systems: human oversight.**
Current Text: Amended: 3/26/2025 html pdf
Introduced: 2/21/2025
Status: 4/2/2025-Re-referred to Com. on G.O.

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

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

Total Measures: 116

Total Tracking Forms: 116

Executive Dashboard

OPERATIONS DASHBOARD

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Financials

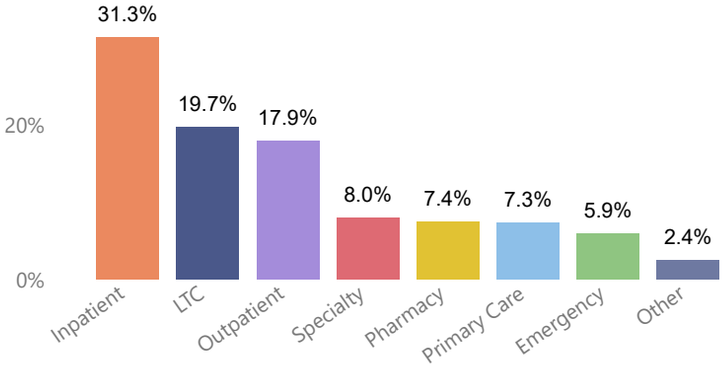
Income & Expenses

	FEBRUARY 2025	FISCAL YTD
REVENUE	$ 242.6 M	$ 2.0 B
MEDICAL EXPENSE	$ (159.0) M	$ (1.4) B
ADMIN EXPENSE	$ (9.8) M	$ (76.3) M
OTHER/TAX	$ (68.8) M	$ (594.3) M
NET INCOME	$ 5.1 M	$ (98.8) M

Medical Loss % (Fiscal YTD)

102.9%

Medical Expenses



Liquid Reserves

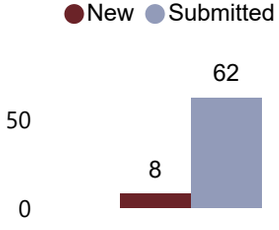
TNE %

201.7%

TNE $

$156.6M

Reinsurance Cases



Balance Sheet

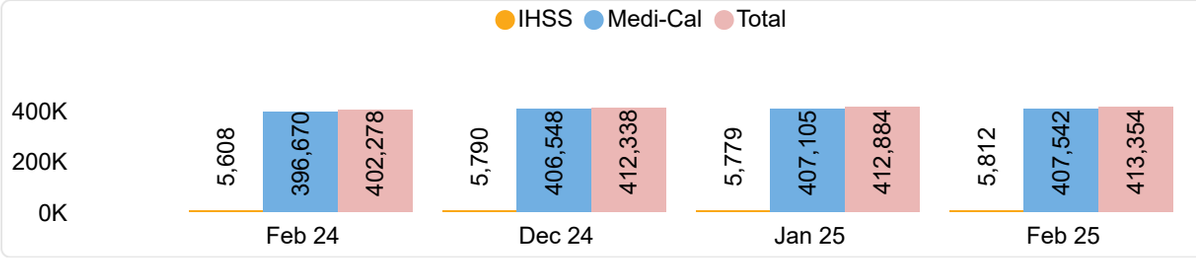
Cash Equivalents	$509.9M
Pass-Through Liabilities	$16.1M
Uncommitted Cash	$493.9M
Working Capital	$92.5M

Current Ratio

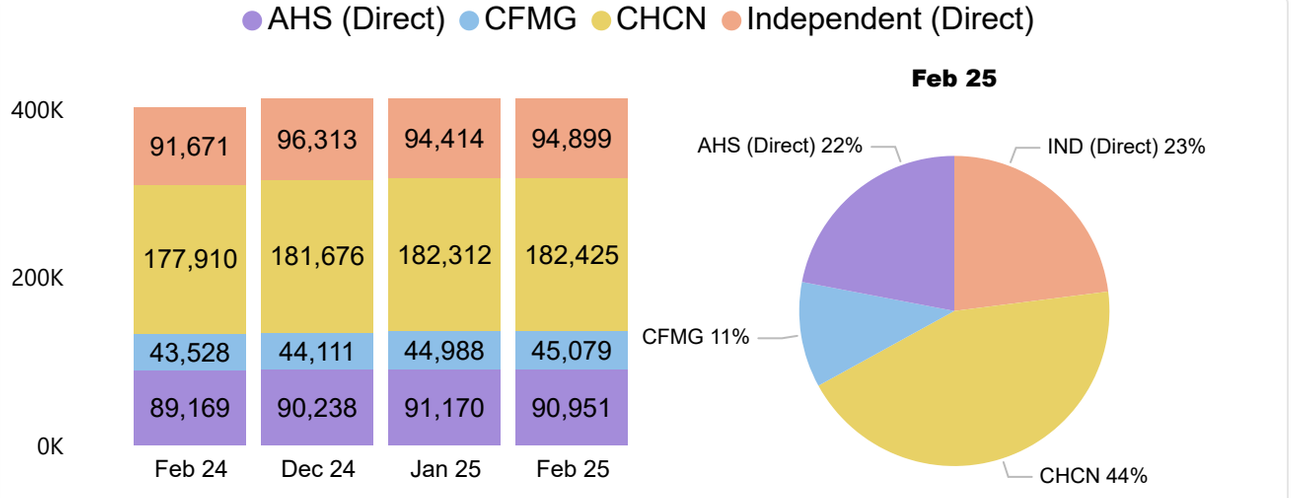
1.10

Membership

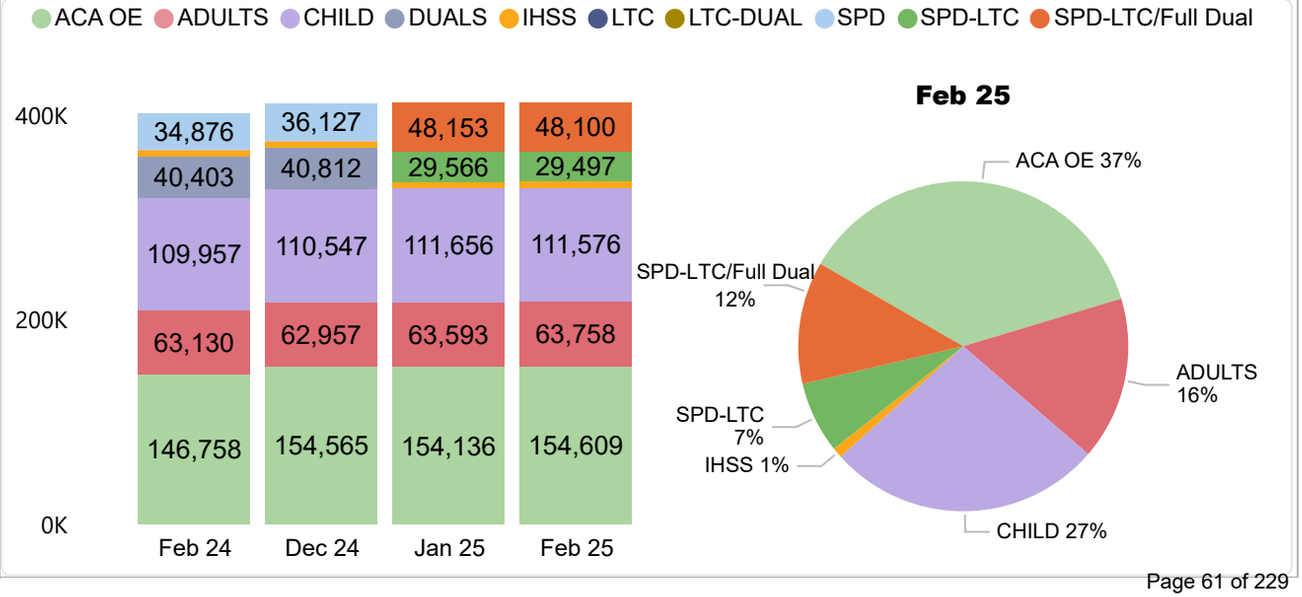
By Plan



By Network



By Category



OPERATIONS DASHBOARD

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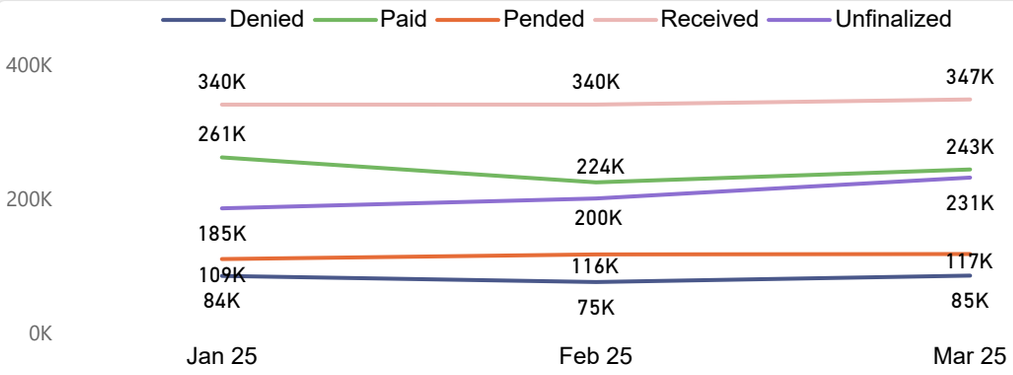
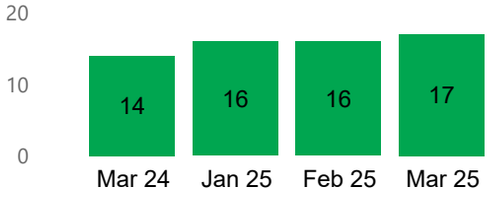
Claims

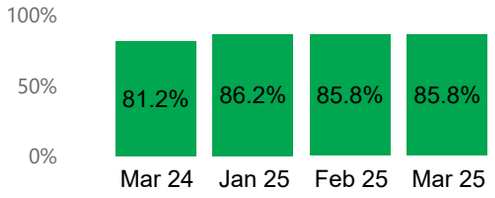
Claims Processing



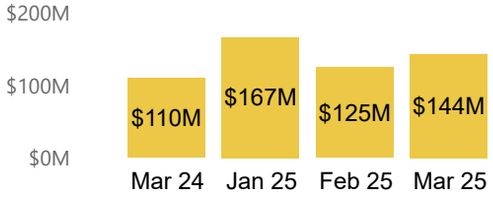
Average Payment TAT (Days)



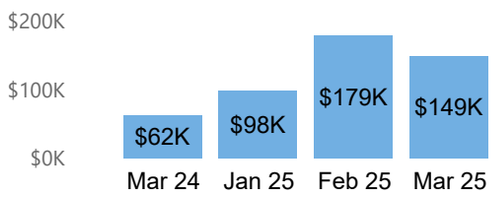
Auto Adjudication Rate (%)



Claims Paid ($)

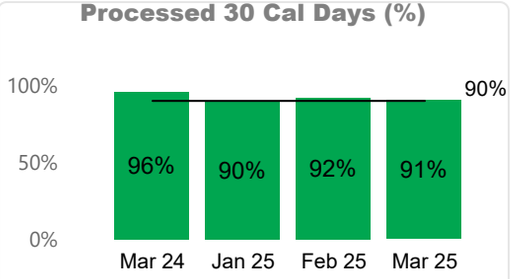


Interest Paid ($)

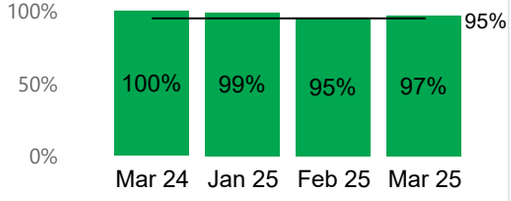


Claims Compliance

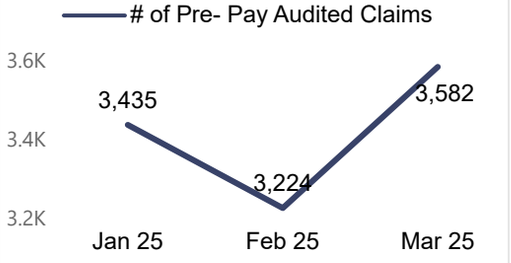
Processed 30 Cal Days (%)



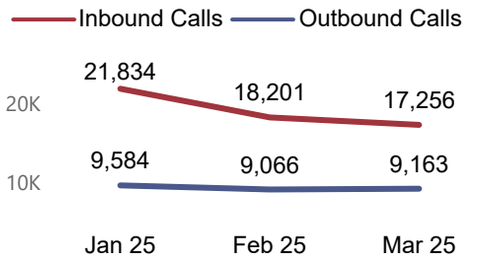
Processed 45 Work Days (%)



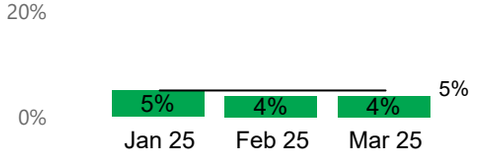
Claims Auditing



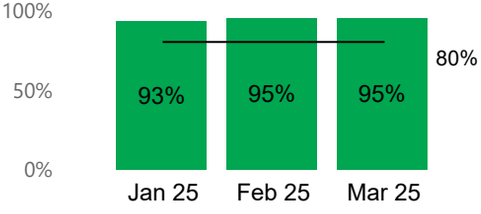
Member Services



Abandoned Call Rate (%)

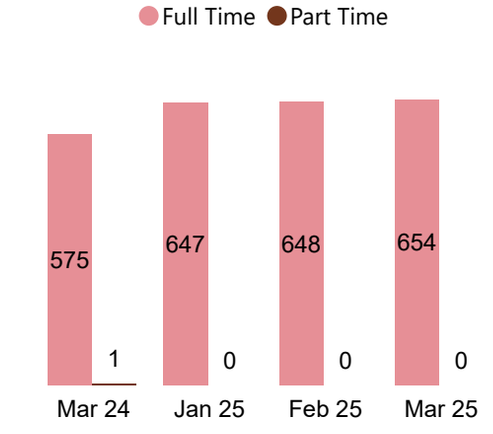


Calls Answered in 30 Seconds (%)



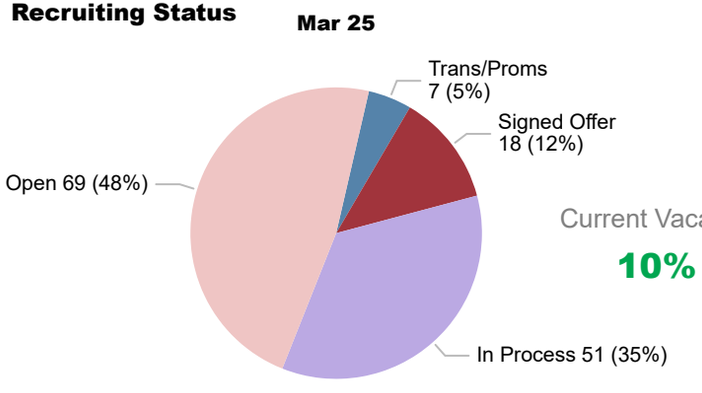
Average Call Times	Jan 25	Feb 25	Mar 25
Wait Time	00:16	00:12	00:11
Call Duration	07:34	07:30	07:29

Human Resources



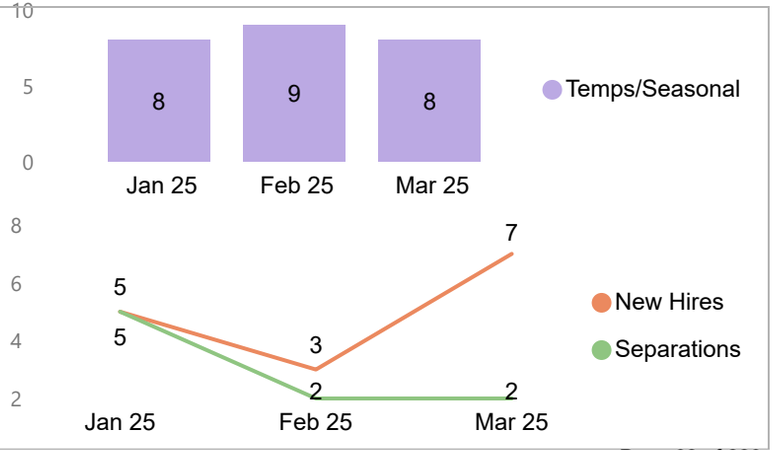
Recruiting Status

Mar 25



Current Vacancy

10%



OPERATIONS DASHBOARD

APRIL 2025

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Provider Services

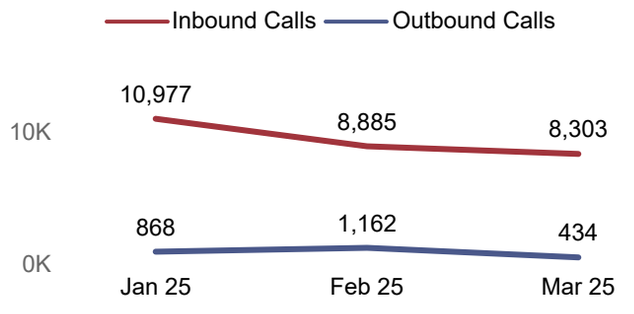
Provider Network

Hospital	17
Specialist	11,177
Primary Care Physician	792
Skilled Nursing Facility	106
Urgent Care	16
Health Centers (FQHCs and Non-FQHCs)	85
TOTAL	**12,193**

Provider Credentialing

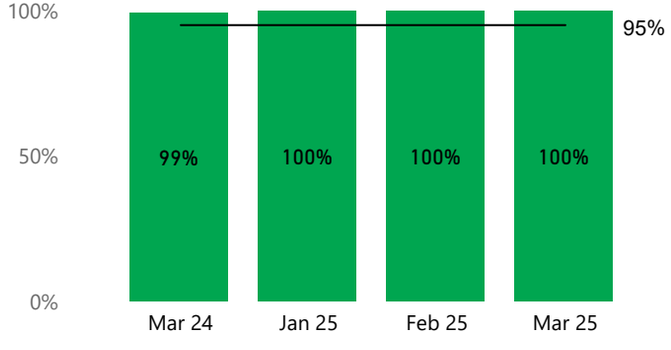
4,594

Provider Call Center



Provider Disputes & Resolutions

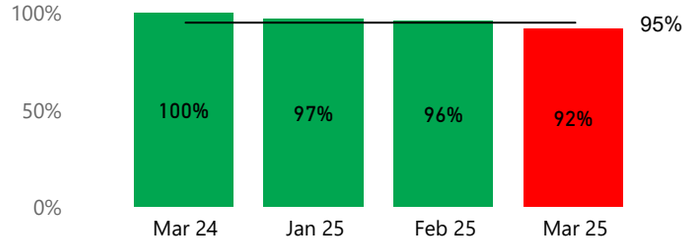
Turnaround Compliance (45 business days)



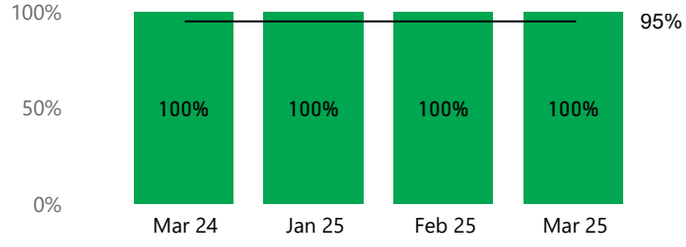
Compliance

Member Grievances

Standard (30 calendar days)

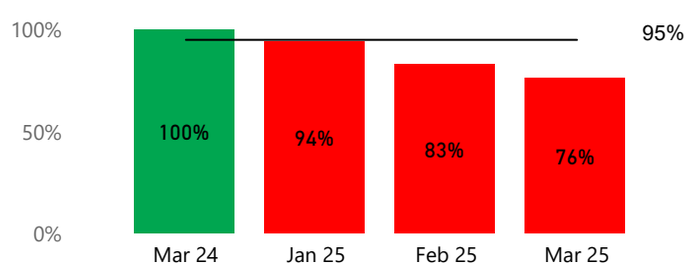


Expedited (3 calendar days)

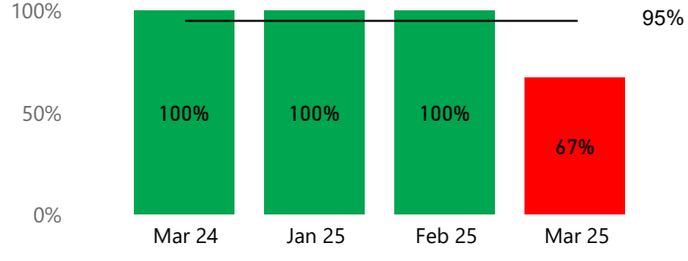


Member Appeals

Standard (30 calendar days)

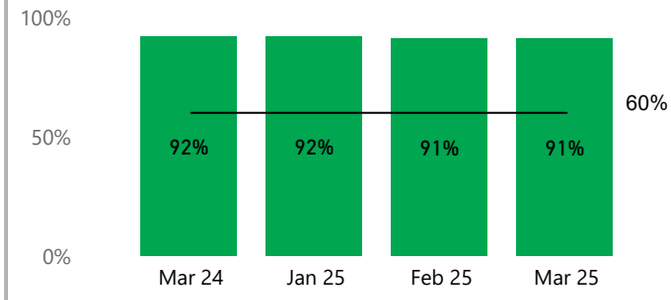


Expedited (3 calendar days)

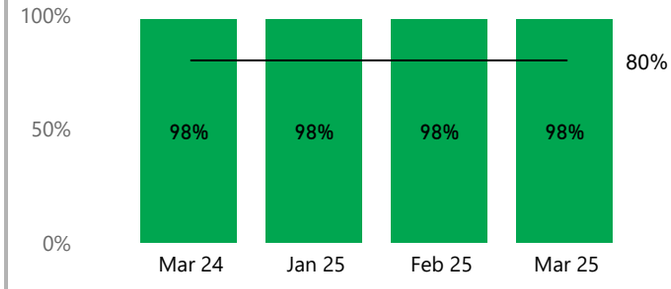


Encounter Data

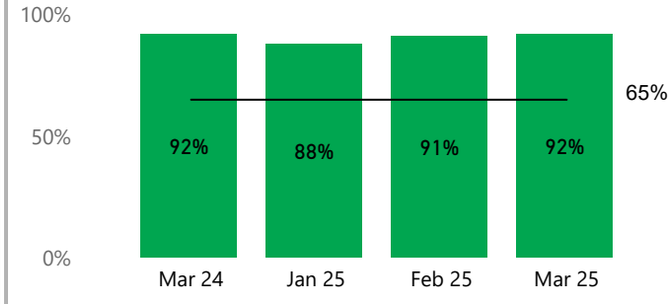
Institutional 0-90 days



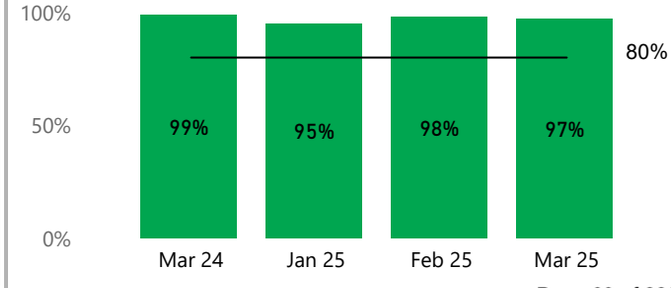
Institutional 0-180 days



Professional 0-90 days

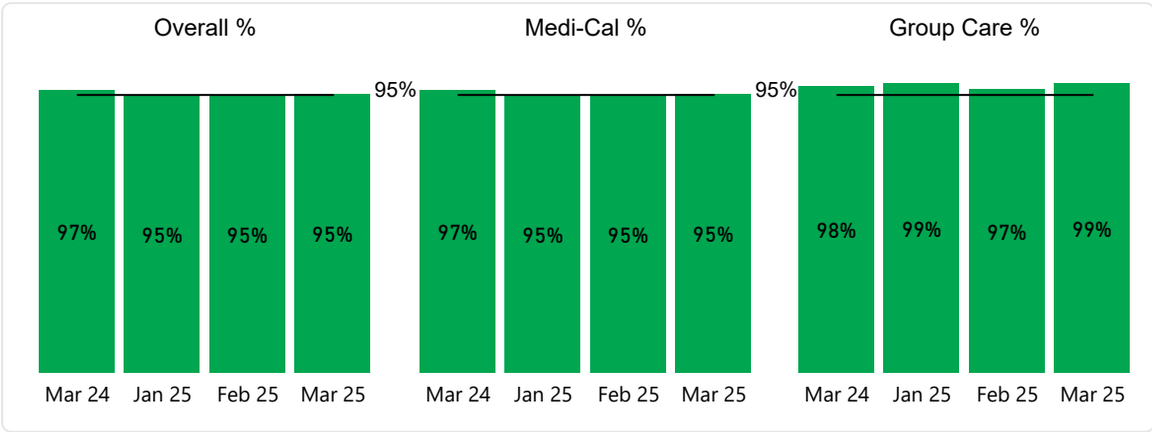


Professional 0-180 days

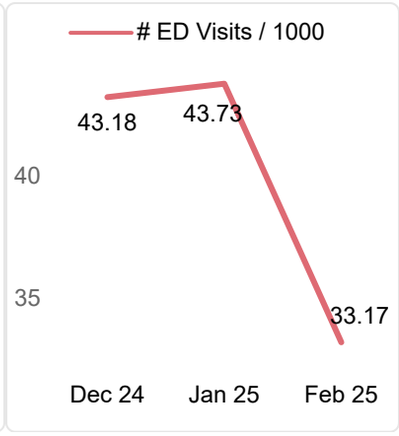


Health Care Services

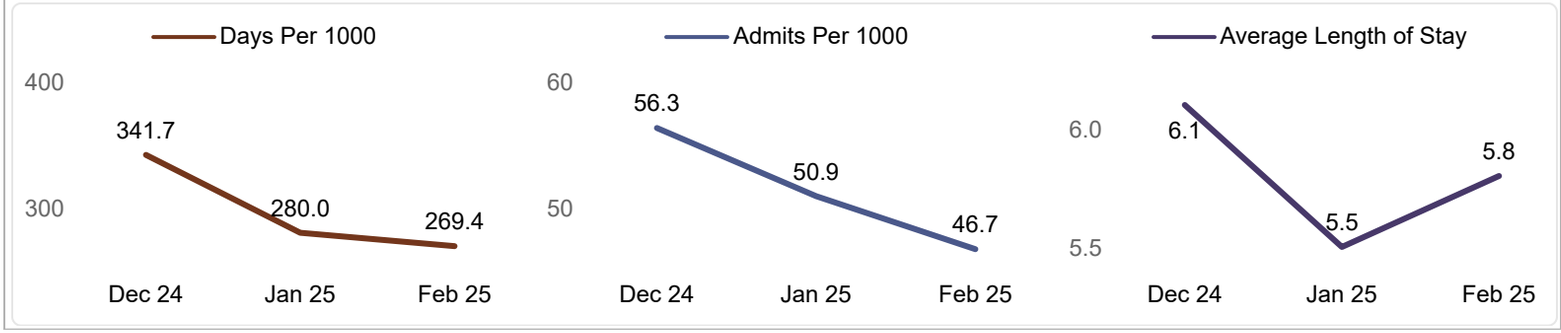
Authorization Turnaround



ED Utilization

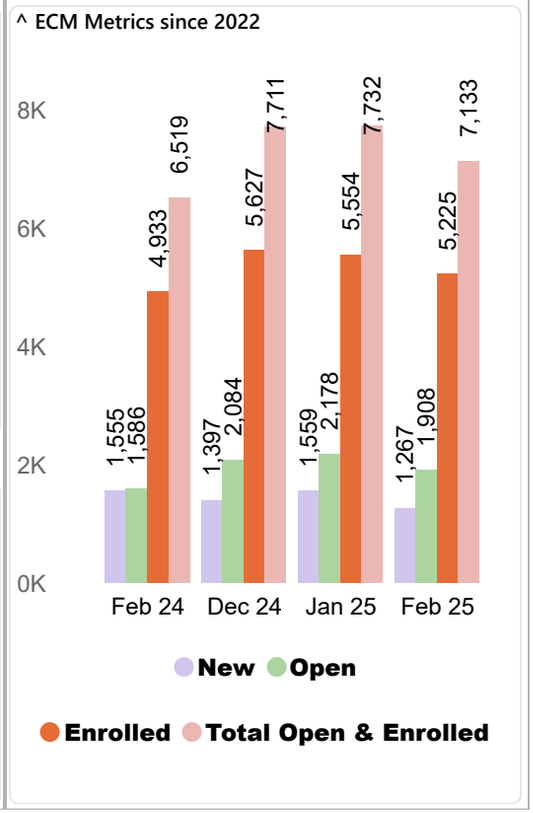


Inpatient Utilization

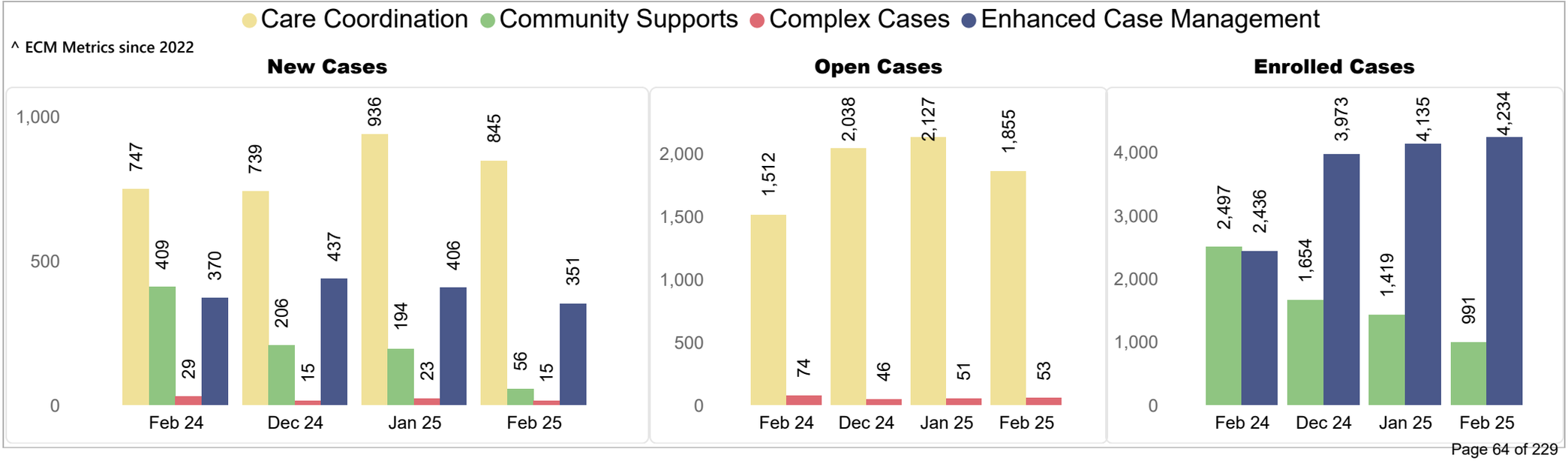


Case Management

Total Cases^



Case Management^



Technology (Business Availability)

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

Outpatient Authorization Denial Rates *

OP Authorization Denial Rates	Mar 24	Jan 25	Feb 25	Mar 25
Denial Rate Excluding Partial Denials (%)	4.2%	3.6%	3.2%	3.3%
Overall Denial Rate (%)	4.5%	4.0%	3.3%	3.5%
Partial Denial Rate (%)	0.4%	0.4%	0.2%	0.1%

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

Pharmacy Authorizations

Authorizations	Mar 24	Jan 25	Feb 25	Mar 25
Approved Prior Authorizations	34	49	35	43
Closed Prior Authorizations	109	23	17	27
Denied Prior Authorizations	80	77	91	83
Total Prior Authorizations	223	149	143	153

ALAMEDA Alliance FOR HEALTH

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

Finance

Gil Riojas

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

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

Date: **April 11th, 2025**

Subject: **Finance Report – February 2025**

Executive Summary

- For the month ended February 28th, 2025, the Alliance had enrollment of 413,278 members, a Net Income of $5.1 million and 202% of required Tangible Net Equity (TNE).

Overall Results: (in Thousands)

	Month	YTD
Revenue	$242,599	$1,985,368
Medical Expense	158,961	1,413,546
Admin. Expense	9,755	76,269
MCO Tax Expense	70,830	616,494
Other Inc. / (Exp.)	2,036	22,181
Net Income	**$5,090**	**($98,761)**

Net Income by Program: (in Thousands)

	Month	YTD
Medi-Cal	$5,088	($92,855)
Group Care	360	(533)
Medicare	(358)	(5,372)
	$5,090	**($98,761)**

Enrollment

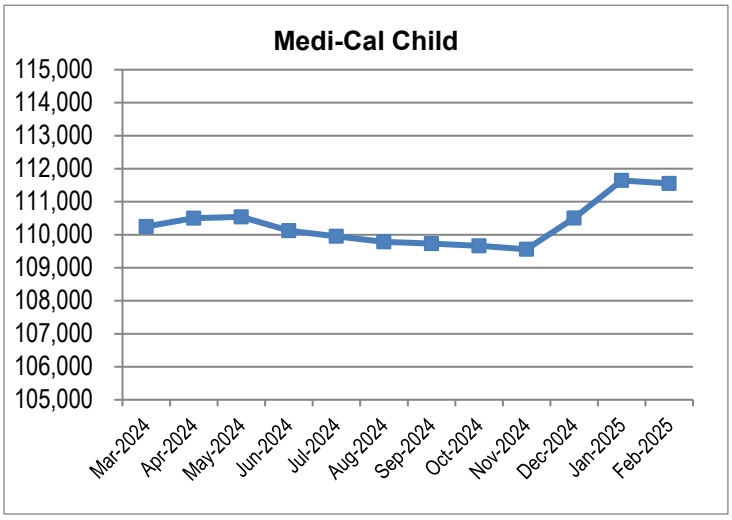
- Total enrollment increased by 450 members since January 2025.
- Total enrollment increased by 9,288 members since June 2024.

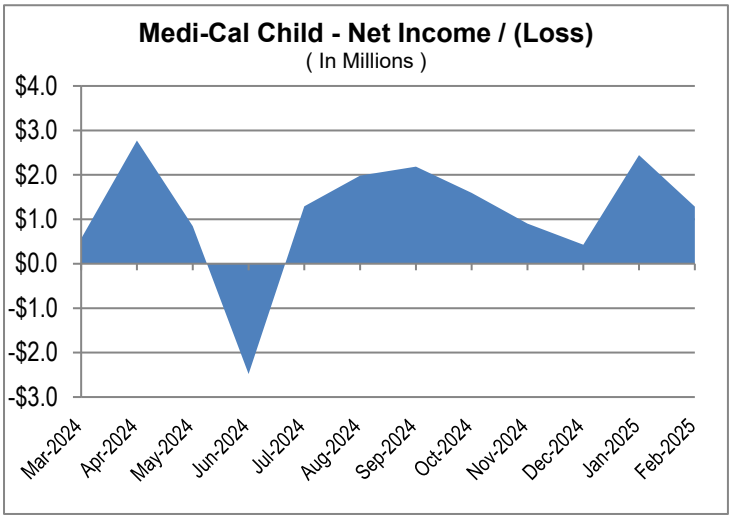
Monthly Membership and YTD Member Months
Actual vs. Budget

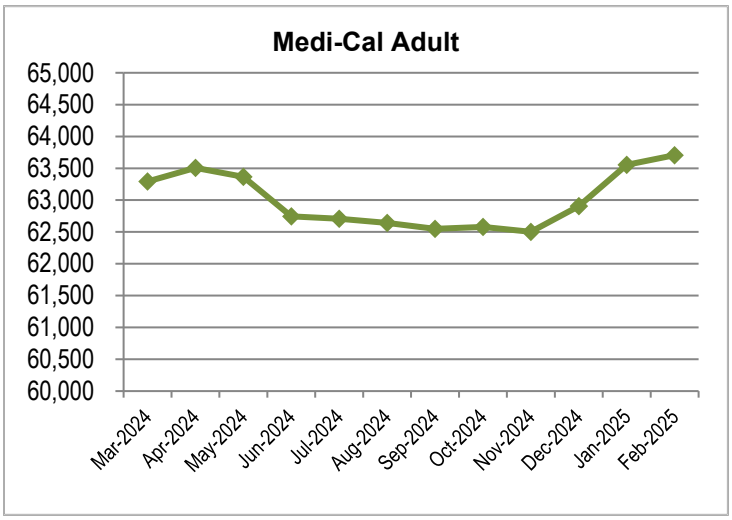
Enrollment					Member Months			
Current Month					Year-to-Date			
Actual	Budget	Variance	Variance %		Actual	Budget	Variance	Variance %
				Medi-Cal:				
111,554	110,212	1,342	1.2%	Child	882,392	879,096	3,296	0.4%
63,706	62,830	876	1.4%	Adult	503,143	501,419	1,724	0.3%
0	0	0	100.0%	SPD*	212,632	211,783	849	0.4%
0	0	0	100.0%	Duals*	241,339	240,472	867	0.4%
154,609	151,703	2,906	1.9%	ACA OE	1,217,250	1,208,289	8,961	0.7%
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%
29,497	33,788	(4,291)	(12.7%)	SPD with LTC	59,061	68,538	(9,477)	(13.8%)
48,100	43,413	4,687	10.8%	Duals with LTC	96,253	85,825	10,428	12.2%
407,466	**401,946**	**5,520**	**1.4%**	**Medi-Cal Total**	**3,221,078**	**3,204,404**	**16,674**	**0.5%**
5,812	5,769	43	0.7%	Group Care	45,993	45,916	77	0.2%
413,278	**407,715**	**5,563**	**1.4%**	**Total**	**3,267,071**	**3,250,320**	**16,751**	**0.5%**

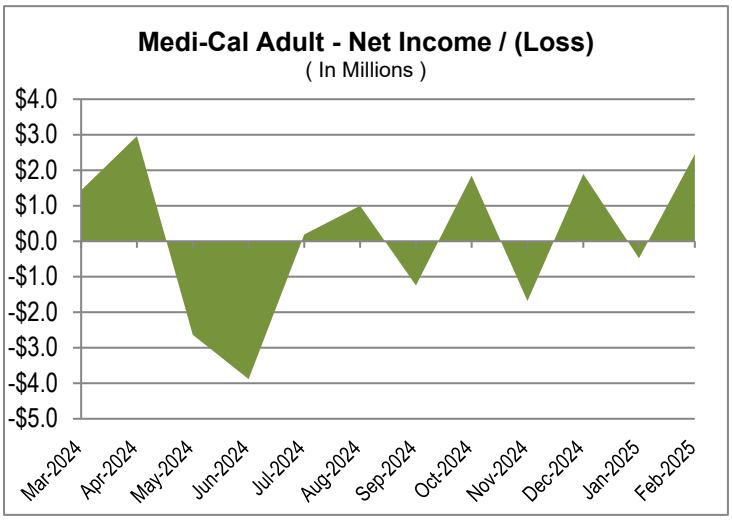
*As of January 2025, service month, "SPD", "Duals", "LTC", and "LTC Duals" will be discontinued. Effective January 2025 service month new consolidated groupings will be "SPD with LTC" and "Duals with LTC".

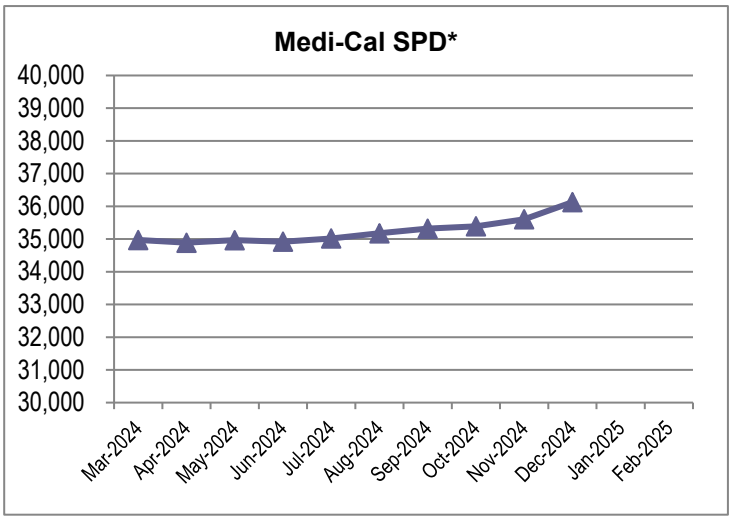
Enrollment and Profitability by Program and Category of Aid

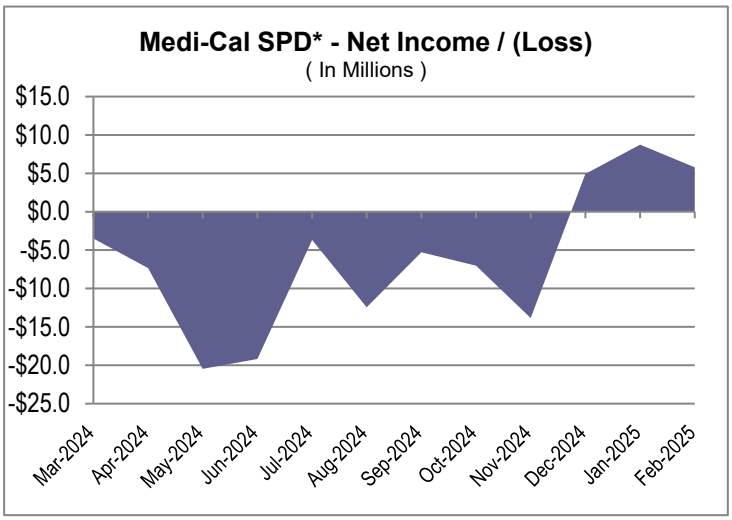




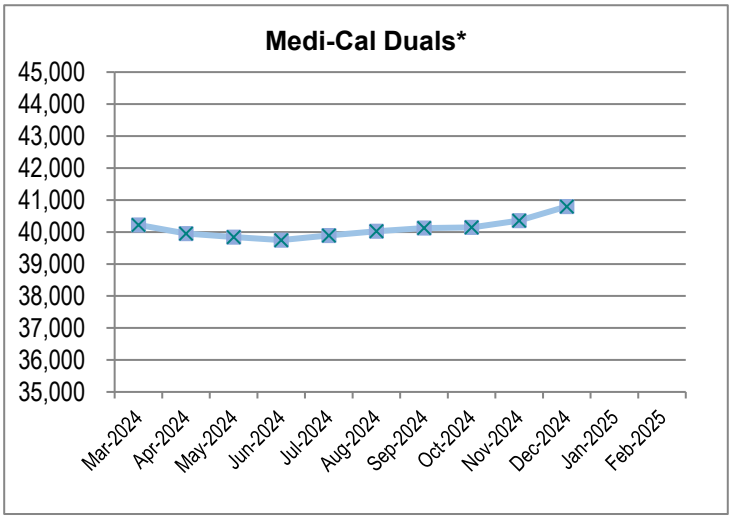


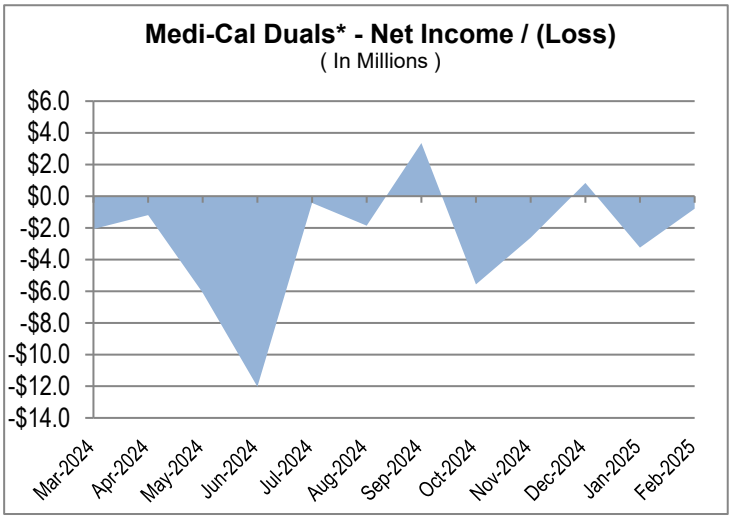


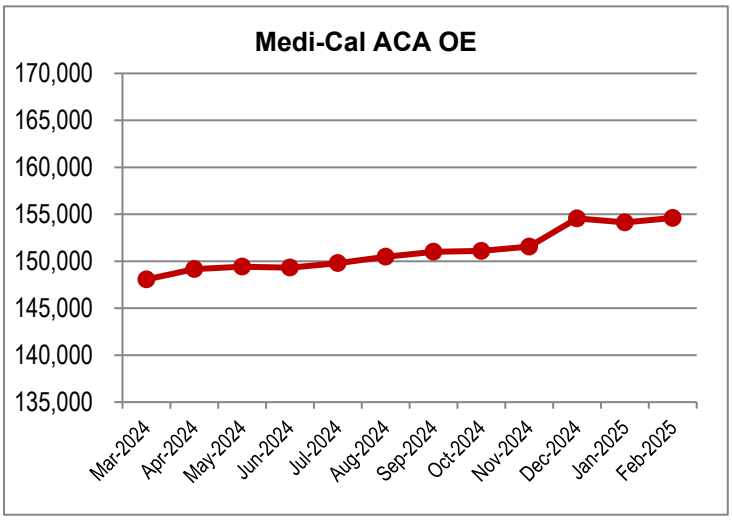


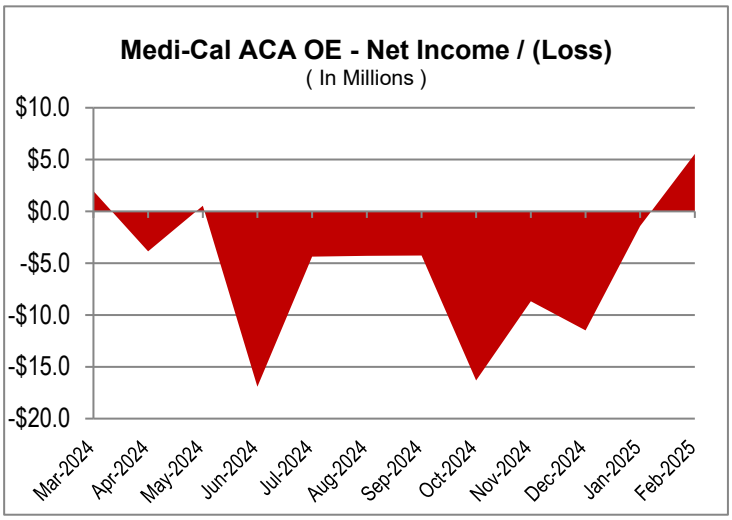


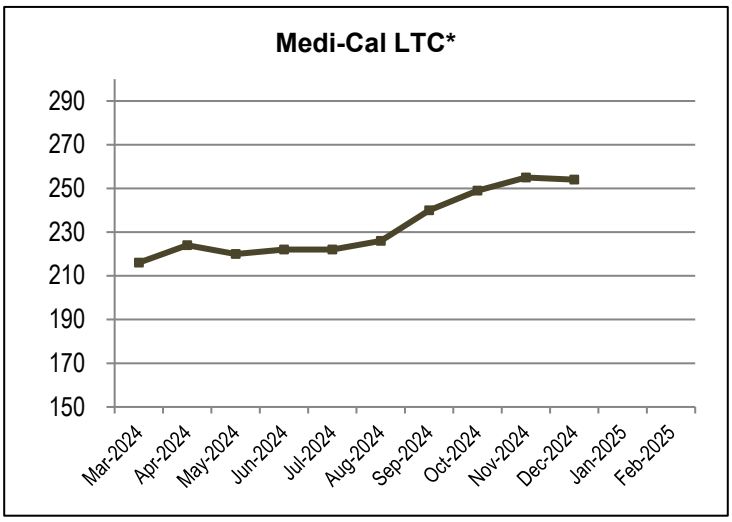
Enrollment and Profitability by Program and Category of Aid

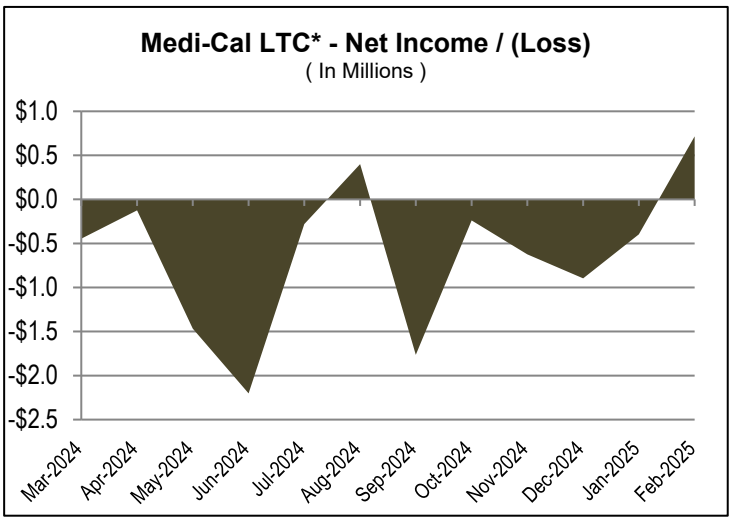




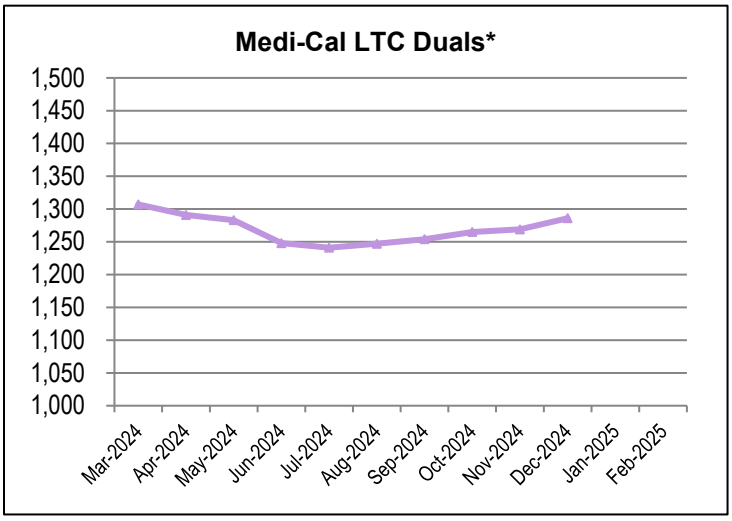


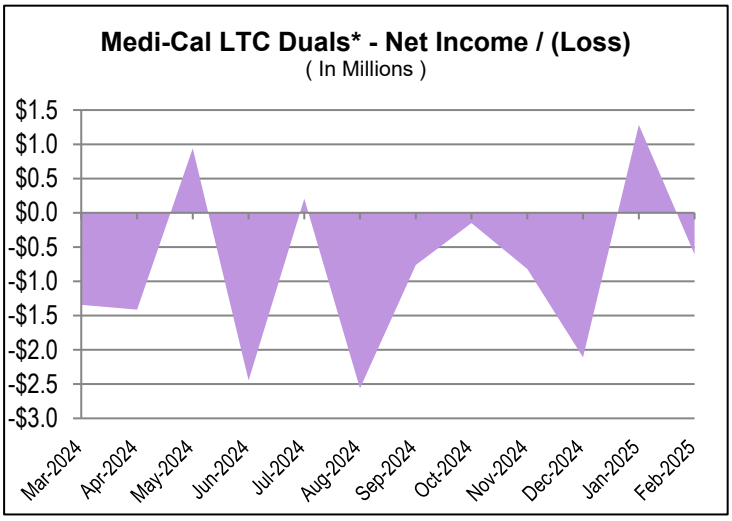


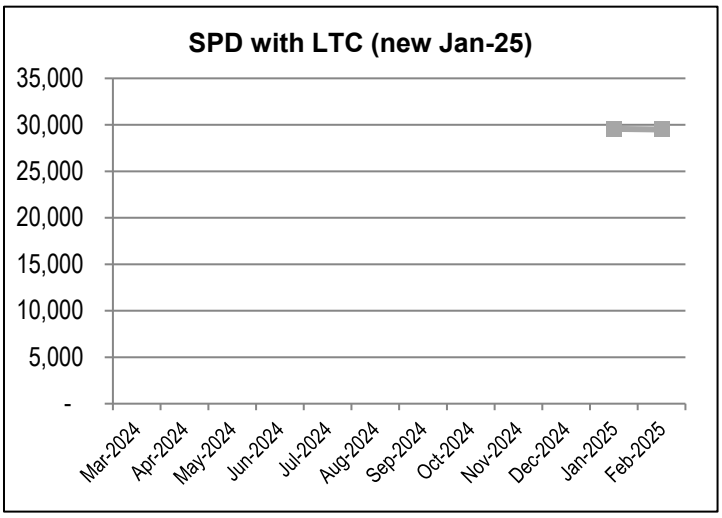


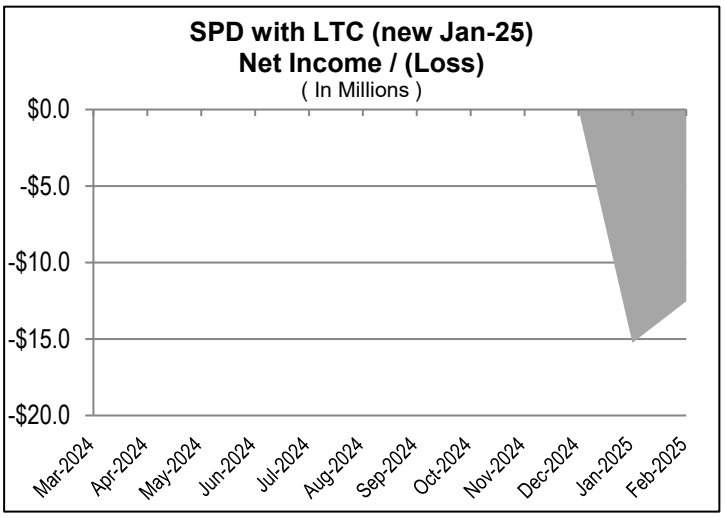


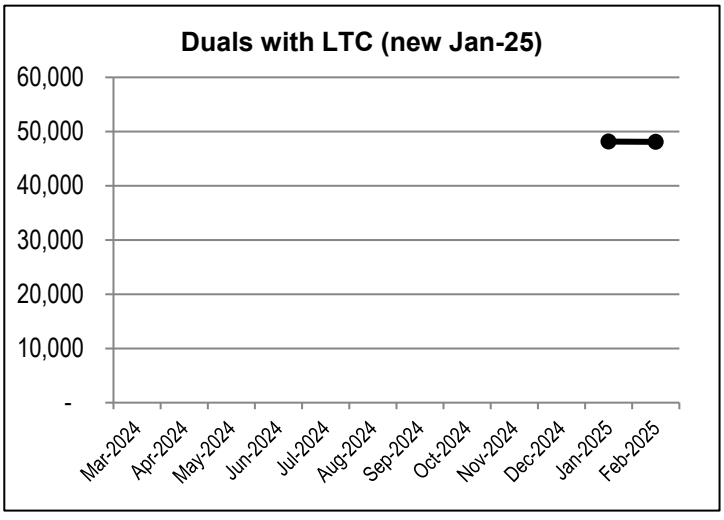
Enrollment and Profitability by Program and Category of Aid

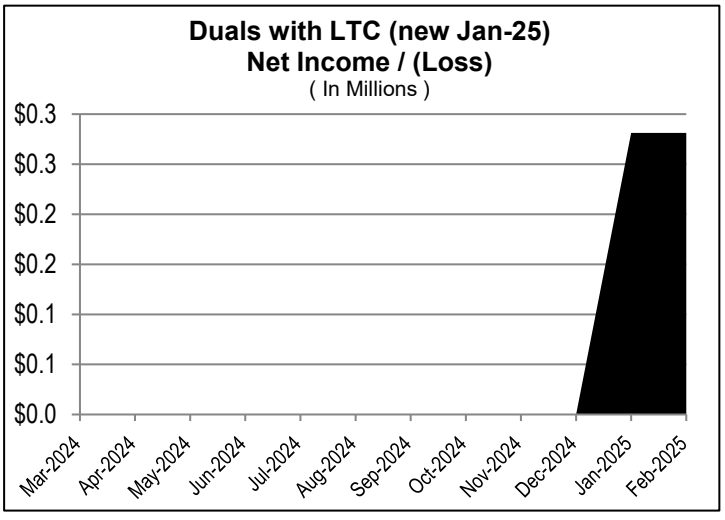


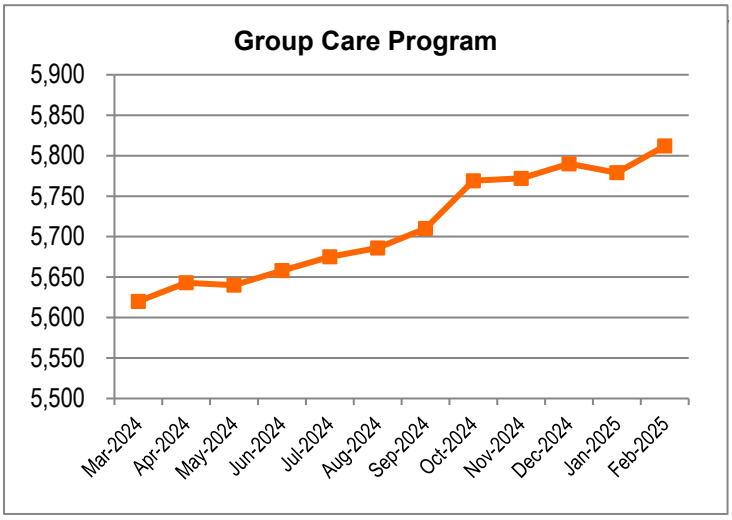




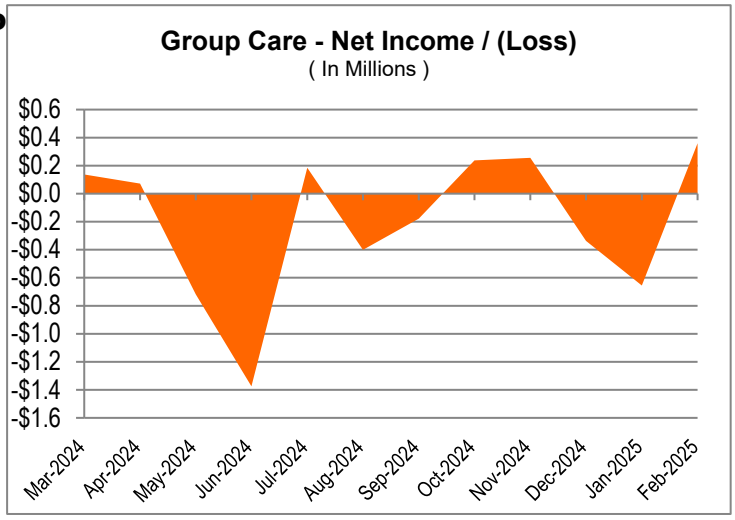


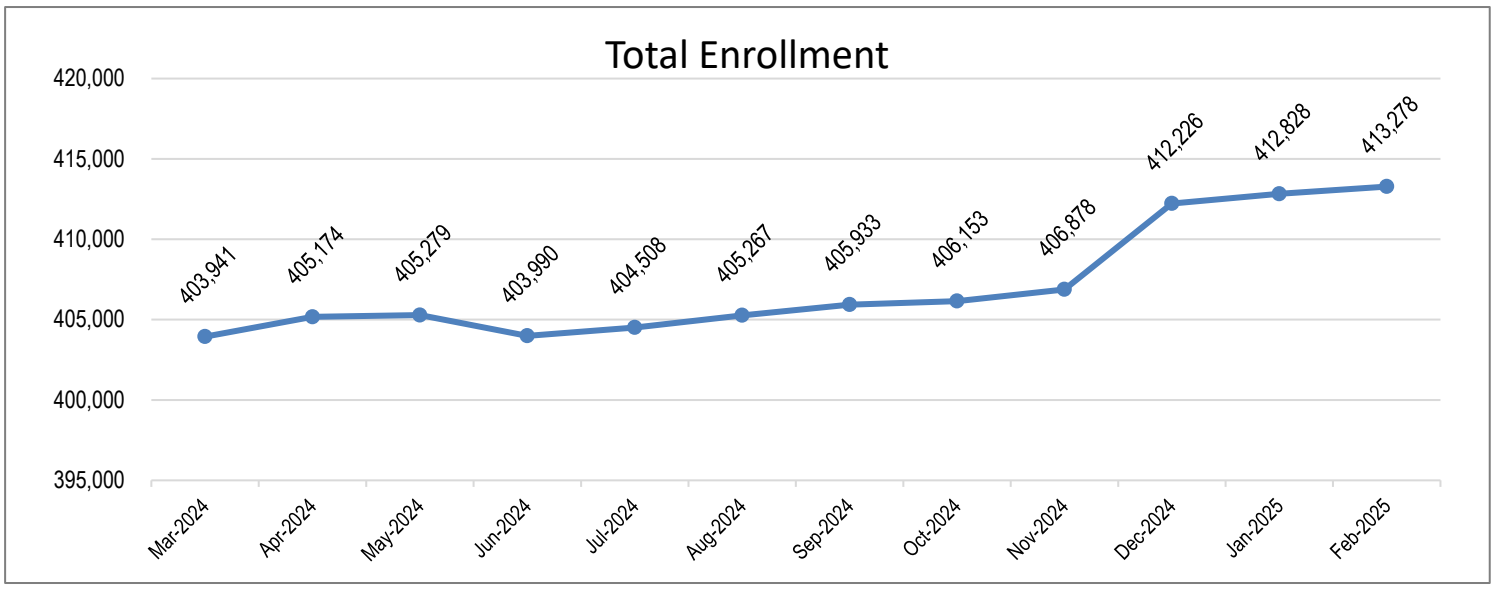


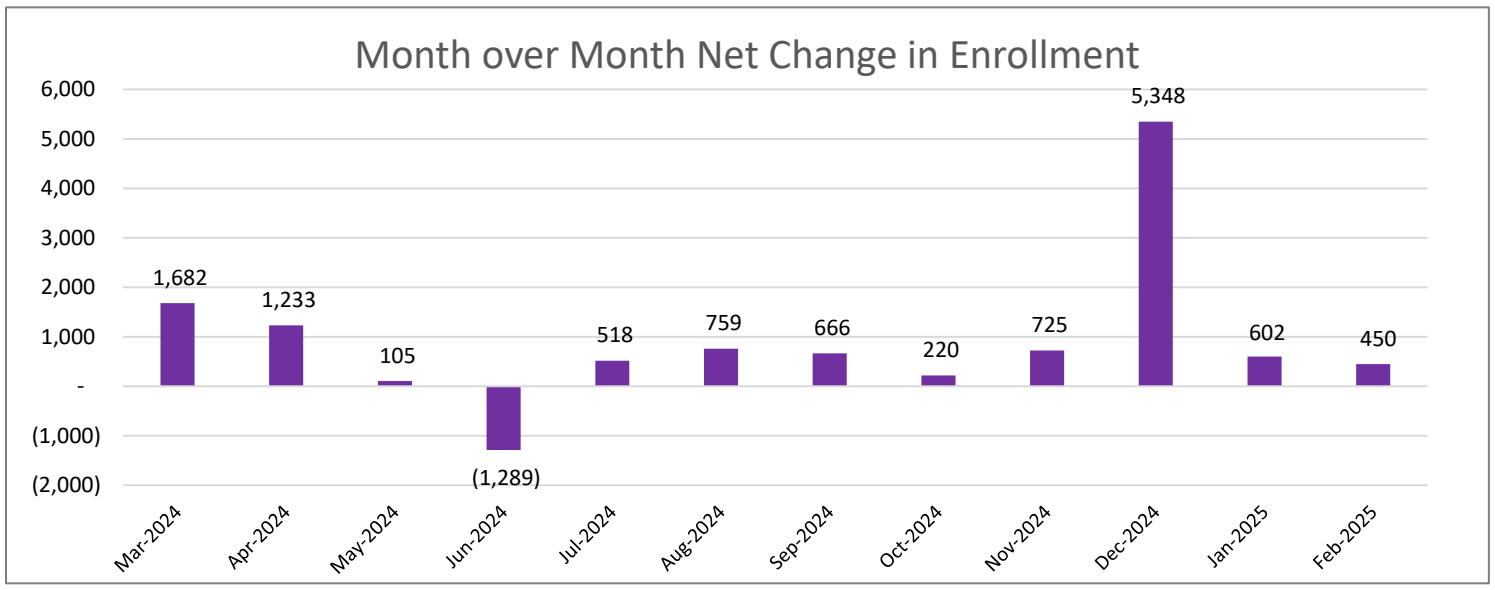



Group Care Program
5,900
5,850
5,800
5,750
5,700
5,650
5,600
5,550
5,500
Mar-2024
Apr-2024
May-2024
Jun-2024
Jul-2024
Aug-2024
Sep-2024
Oct-2024
Nov-2024
Dec-2024
Jan-2025
Feb-2025

P


Group Care - Net Income / (Loss)
(In Millions)
$0.6
$0.4
$0.2
$0.0
-$0.2
-$0.4
-$0.6
-$0.8
-$1.0
-$1.2
-$1.4
-$1.6
Mar-2024
Apr-2024
May-2024
Jun-2024
Jul-2024
Aug-2024
Sep-2024
Oct-2024
Nov-2024
Dec-2024
Jan-2025
Feb-2025

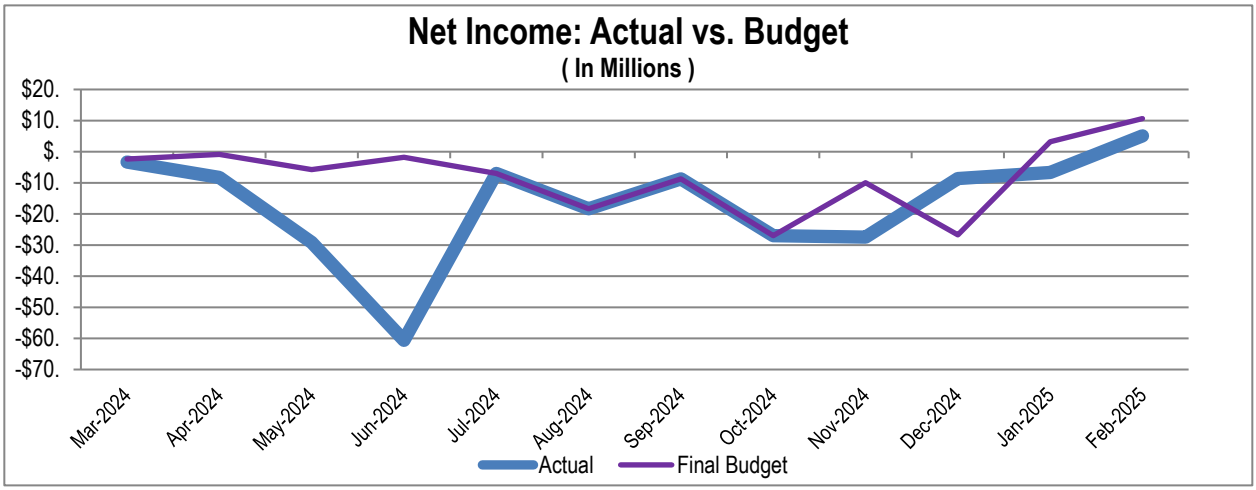

Total Enrollment
420,000
415,000
410,000
405,000
400,000
395,000
403,941
405,174
405,279
403,990
404,508
405,267
405,933
406,153
406,878
412,226
412,828
413,278
Mar-2024
Apr-2024
May-2024
Jun-2024
Jul-2024
Aug-2024
Sep-2024
Oct-2024
Nov-2024
Dec-2024
Jan-2025
Feb-2025


Month over Month Net Change in Enrollment
6,000
5,000
4,000
3,000
2,000
1,000
-
(1,000)
(2,000)
1,682
1,233
105
(1,289)
518
759
666
220
725
5,348
602
450
Mar-2024
Apr-2024
May-2024
Jun-2024
Jul-2024
Aug-2024
Sep-2024
Oct-2024
Nov-2024
Dec-2024
Jan-2025
Feb-2025

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

Net Income

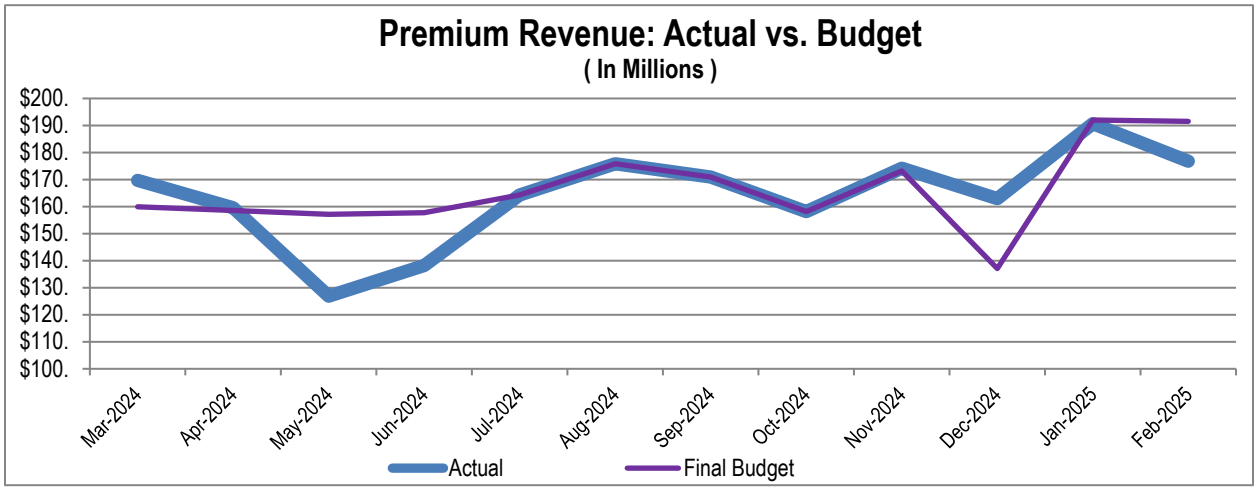
- For the month ended February 28th, 2025:
  - Actual Net Income $5.1 million.
  - Budgeted Net Income $10.6 million.
- For the fiscal YTD ended February 28th, 2025:
  - Actual Net Loss $98.8 million.
  - Budgeted Net Loss $83.9 million.



- The unfavorable variance of $5.6 million in the current month is primarily due to:
  - Unfavorable $14.8 million lower than anticipated Premium Revenue.
  - Unfavorable $4.0 million higher than anticipated MCO Tax Expense.
  - Favorable $11.0 million lower than anticipated Medical Expense.
  - Favorable $2.0 million higher than anticipated MCO Tax Revenue.

Premium Revenue

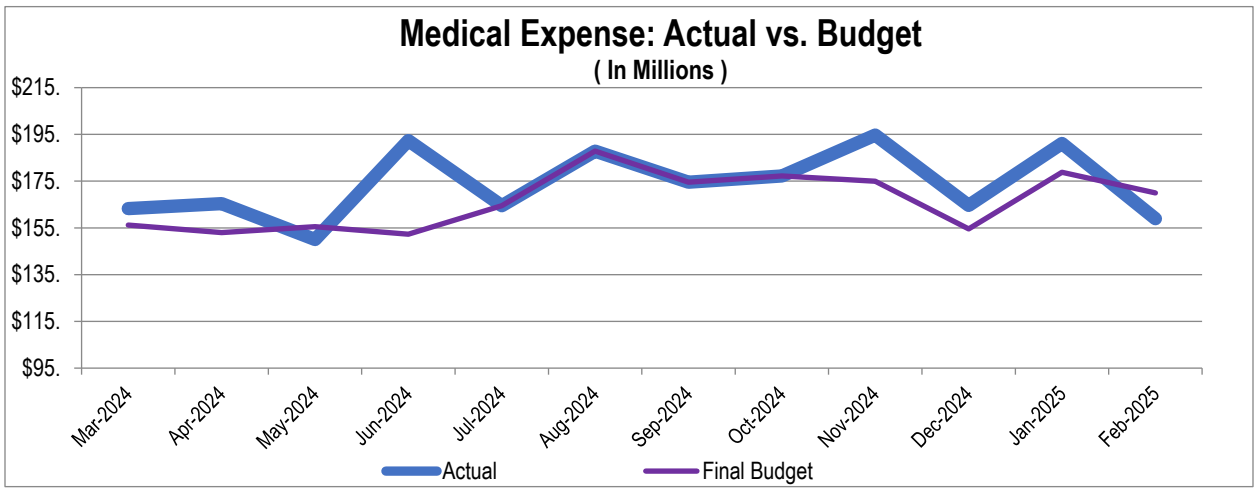
- For the month ended February 28th, 2025:
  - Actual Revenue: $176.8 million.
  - Budgeted Revenue: $191.5 million.
- For the fiscal YTD ended February 28th, 2025:
  - Actual Revenue: $1.4 billion.
  - Budgeted Revenue: $1.4 billion.



- For the month ended February 28th, 2025, the unfavorable Premium Revenue variance of $14.7 million is primarily due to the following:
  - $13.8 million reduction in revenue was recorded in CY2022 Prop56 MEP (Medical Expenditure Percentage) reconciliation.
  - Unfavorable volume variance for the current month.
  - Unfavorable Supplemental Maternity Revenue.

Medical Expense

- For the month ended February 28th, 2025:
  - Actual Medical Expense: $159.0 million.
  - Budgeted Medical Expense: $170.0 million.
- For the fiscal YTD ended February 28th, 2025:
  - Actual Medical Expense: $1.4 billion.
  - Budgeted Medical Expense: $1.4 billion.



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

- For February, updates to Fee-For-Service (FFS) decreased the estimate for prior period unpaid Medical Expenses by $7.3 million. Year to date, the estimate for prior years increased by $7.2 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	$142,004,065	$0	$142,004,065	$132,228,372	($9,775,693)	(7.4%)
Primary Care FFS	$19,399,950	$125,736	$19,525,686	$27,128,033	$7,728,083	28.5%
Specialty Care FFS	$66,369,354	$332,502	$66,701,856	$66,068,968	($300,386)	(0.5%)
Outpatient FFS	$101,113,026	$780,950	$101,893,975	$95,680,894	($5,432,132)	(5.7%)
Ancillary FFS	$140,403,836	($658,270)	$139,745,566	$138,934,955	($1,468,881)	(1.1%)
Pharmacy FFS	$104,504,905	$247,474	$104,752,378	$105,269,428	$764,523	0.7%
ER Services FFS	$82,944,985	$373,656	$83,318,641	$83,436,348	$491,363	0.6%
Inpatient Hospital FFS	$438,962,401	$3,720,990	$442,683,391	$423,763,299	($15,199,102)	(3.6%)
Long Term Care FFS	$276,152,712	$2,323,074	$278,475,786	$266,387,946	($9,764,766)	(3.7%)
Other Benefits & Services	$37,902,192	$0	$37,902,192	$41,410,743	$3,508,552	8.5%
Net Reinsurance	($3,457,500)	$0	($3,457,500)	$2,034,243	$5,491,743	270.0%
	$1,406,299,926	**$7,246,112**	**$1,413,546,038**	**$1,382,343,229**	**($23,956,697)**	**(1.7%)**

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

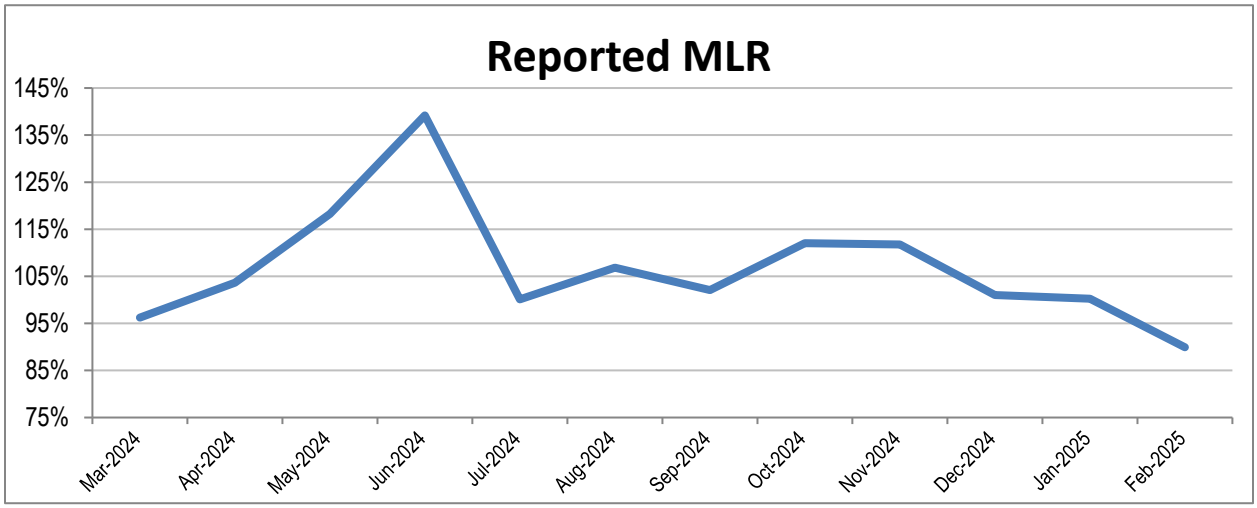
	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$43.47	$0.00	$43.47	$40.68	($2.78)	(6.8%)
Primary Care FFS	$5.94	$0.04	$5.98	$8.35	$2.41	28.9%
Specialty Care FFS	$20.31	$0.10	$20.42	$20.33	$0.01	0.1%
Outpatient FFS	$30.95	$0.24	$31.19	$29.44	($1.51)	(5.1%)
Ancillary FFS	$42.98	($0.20)	$42.77	$42.75	($0.23)	(0.5%)
Pharmacy FFS	$31.99	$0.08	$32.06	$32.39	$0.40	1.2%
ER Services FFS	$25.39	$0.11	$25.50	$25.67	$0.28	1.1%
Inpatient Hospital FFS	$134.36	$1.14	$135.50	$130.38	($3.98)	(3.1%)
Long Term Care FFS	$84.53	$0.71	$85.24	$81.96	($2.57)	(3.1%)
Other Benefits & Services	$11.60	$0.00	$11.60	$12.74	$1.14	8.9%
Net Reinsurance	($1.06)	$0.00	($1.06)	$0.63	$1.68	269.1%
	$430.45	**$2.22**	**$432.66**	**$425.29**	**($5.15)**	**(1.2%)**

- Excluding the impact of prior year estimates for IBNP, year-to-date medical expense variance is $24.0 million unfavorable to budget. On a PMPM basis, medical expense is 1.2% unfavorable to budget. For per-member-per-month expense:
    - Capitated Medical Expense is over budget due to inclusion of Targeted Rate Increases (TRI) in capitation payments.

- Primary Care Expense is under budget due to lower utilization in the ACA OE, Child, Adult and SPD aid code categories.
- Specialty Care Expense is slightly below budget, driven by lower-than-expected SPD, Child and ACA OE unit cost and Adult utilization.
- Outpatient Expense is over budget mostly driven by lab and radiology unit cost and dialysis utilization in the ACA OE and Adult aid code categories.
- Ancillary Expense is over budget due to higher Behavioral Health utilization in the Child aid code category.
- Pharmacy Expense is under budget due to Non-PBM expense driven by higher Group Care unit cost and low PBM utilization in the ACA OE and Adult categories of aid.
- Emergency Room Expense is slightly under budget driven by lower-than-expected utilization.
- Inpatient Expense is over budget driven by higher utilization and unit cost in the SPD LTC and ACA OE aid code categories.
- Long Term Care Expense is over budget due to higher unit cost in the ACA OE, SPD LTC and Dual LTC aid code categories.
- Other Benefits & Services is under budget, due to lower than professional services and community relations expense.
- Net Reinsurance is under budget because more recoveries were received than expected.

Medical Loss Ratio (MLR)

The Medical Loss Ratio (total reported medical expense divided by Premium revenue) was 89.9% for the month and 102.9% for the fiscal year-to-date.



Administrative Expense

- For the month ended February 28th, 2025:
  - Actual Administrative Expense: $9.8 million.
  - Budgeted Administrative Expense: $9.4 million.
- For the fiscal YTD ended February 28th, 2025:
  - Actual Administrative Expense: $76.3 million.
  - Budgeted Administrative Expense: $81.6 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 %
$5,885,346	$5,310,271	($575,076)	(10.8%)	Employee Expense	$45,810,152	$46,595,966	$785,814	1.7%
68,688	75,021	6,333	8.4%	Medical Benefits Admin Expense	625,033	604,627	(20,406)	(3.4%)
1,697,247	2,786,755	1,089,507	39.1%	Purchased & Professional Services	17,387,916	20,551,070	3,163,154	15.4%
2,104,047	1,220,082	(883,965)	(72.5%)	Other Admin Expense	12,445,478	13,864,338	1,418,860	10.2%
$9,755,329	$9,392,128	($363,201)	(3.9%)	Total Administrative Expense	$76,268,579	$81,616,001	$5,347,422	6.6%

The year-to-date variances include:

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

The Administrative Loss Ratio (ALR) is 5.5% of net revenue for the month and 5.6% of net revenue year-to-date. Fiscal year-to-date claims interest expense, due to delayed payment of certain claims, or recalculated interest on previously paid claims is $1.1 million.

Other Income / (Expense)

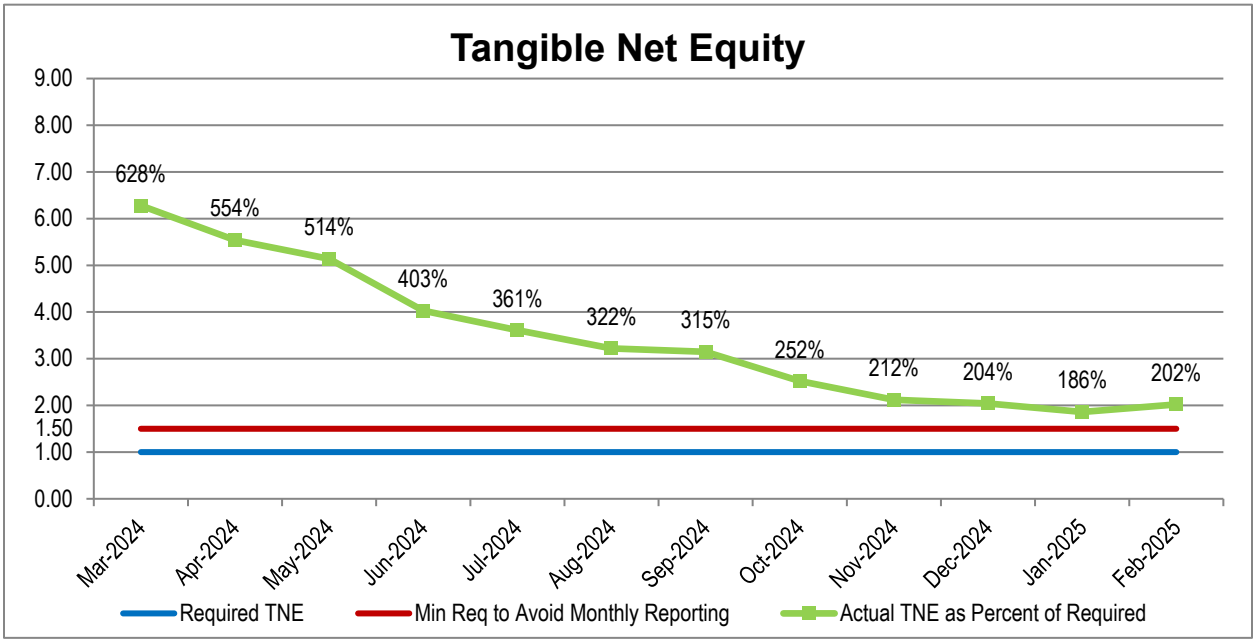
Other Income & Expense is comprised of investment income. Fiscal year-to-date net investments show a gain of $22.2 million.

Managed Care Organization (MCO) Provider Tax

- Revenue:
  - For the month ended February 28th, 2025:
    - Actual: $65.8 million.
    - Budgeted: $63.8 million.
  - For the fiscal YTD ended February 28th, 2025:
    - Actual: $611.5 million.
    - Budgeted: $606.5 million.
- Expense:
  - For the month ended February 28th, 2025:
    - Actual: $70.8 million.
    - Budgeted: $66.8 million.
  - For the fiscal YTD ended February 28th, 2025:
    - Actual: $616.5 million.
    - Budgeted: $609.5 million.

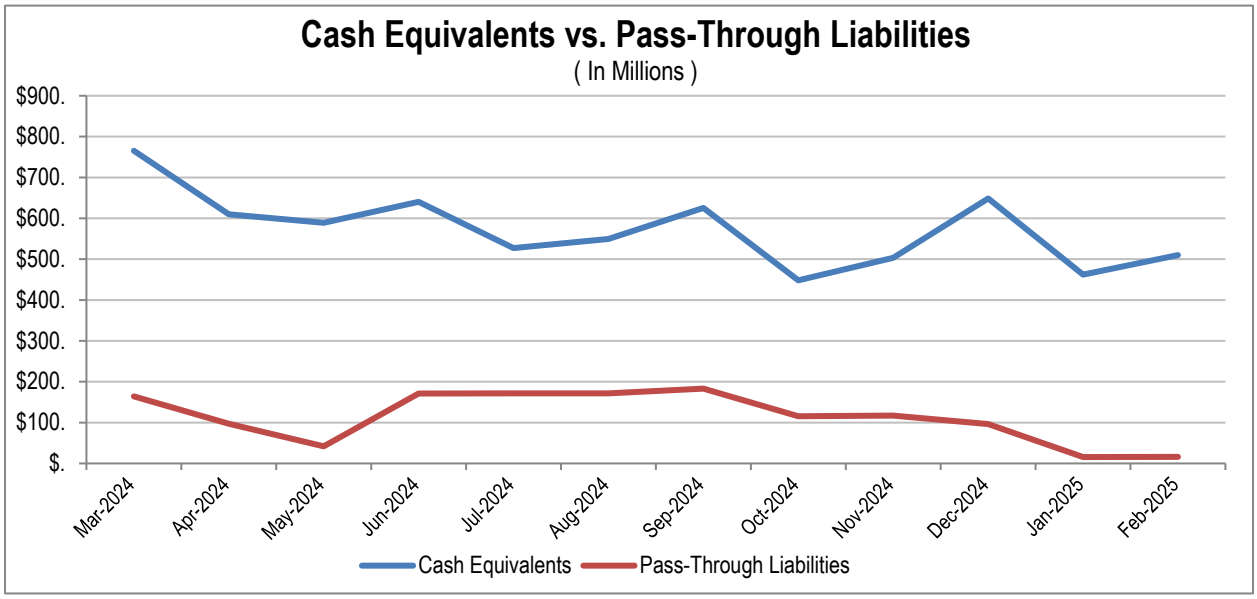
Tangible Net Equity (TNE)

- The Department of Managed Health Care (DMHC) monitors the financial stability of health plans to ensure that they can meet their financial obligations to providers. TNE is a calculation of a company's total tangible assets minus a percentage of fee-for-service medical expenses. The Alliance exceeds DMHC's required TNE.
    - Required TNE $77.7 million
    - Actual TNE $156.6 million
    - Excess TNE $78.9 million
    - TNE % of Required TNE 202%



- To ensure appropriate liquidity and limit risk, the majority of Alliance financial assets are kept in short-term investments.
- Key Metrics
    - Cash & Cash Equivalents $509.9 million
    - Pass-Through Liabilities $16.1 million
    - Uncommitted Cash $493.9 million
    - Working Capital $92.5 million

- Current Ratio 1.10 (regulatory minimum is 1.00)



Capital Investment

- Fiscal year-to-date capital assets acquired: $592,000.
- 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 28 FEBRUARY, 2025

CURRENT MONTH					FISCAL YEAR TO DATE			
		$ Variance	% Variance				$ Variance	% Variance
Actual	Budget	(Unfavorable)	(Unfavorable)	Account Description	Actual	Budget	(Unfavorable)	(Unfavorable)
				MEMBERSHIP				
407,466	401,946	5,520	1.4%	1. Medi-Cal	3,221,078	3,204,404	16,674	0.5%
5,812	5,769	43	0.7%	2. GroupCare	45,993	45,916	77	0.2%
413,278	**407,715**	**5,563**	**1.4%**	**3. TOTAL MEMBER MONTHS**	**3,267,071**	**3,250,320**	**16,751**	**0.5%**
				REVENUE				
$176,769,001	$191,503,875	($14,734,874)	(7.7%)	4. Premium Revenue	$1,373,873,544	$1,363,063,498	$10,810,045	0.8%
$65,830,207	$63,784,811	$2,045,396	3.2%	5. MCO Tax Revenue AB119	$611,494,292	$606,510,636	$4,983,655	0.8%
$242,599,208	**$255,288,686**	**($12,689,478)**	**(5.0%)**	**6. TOTAL REVENUE**	**$1,985,367,835**	**$1,969,574,135**	**$15,793,700**	**0.8%**
				MEDICAL EXPENSES				
				Capitated Medical Expenses				
$20,112,619	$17,222,131	($2,890,488)	(16.8%)	7. Capitated Medical Expense	$142,004,065	$132,228,372	($9,775,693)	(7.4%)
				Fee for Service Medical Expenses				
$51,415,815	$50,412,587	($1,003,228)	(2.0%)	8. Inpatient Hospital Expense	$442,683,391	$423,763,299	($18,920,092)	(4.5%)
($8,155,381)	$4,510,426	$12,665,807	280.8%	9. Primary Care Physician Expense	$19,525,686	$27,128,033	$7,602,346	28.0%
$7,536,072	$8,087,581	$551,509	6.8%	10. Specialty Care Physician Expense	$66,701,856	$66,068,968	($632,889)	(1.0%)
$17,360,959	$19,207,910	$1,846,951	9.6%	11. Ancillary Medical Expense	$139,745,566	$138,934,955	($810,611)	(0.6%)
$11,079,847	$11,310,404	$230,557	2.0%	12. Outpatient Medical Expense	$101,893,975	$95,680,894	($6,213,081)	(6.5%)
$9,894,316	$10,220,655	$326,339	3.2%	13. Emergency Expense	$83,318,641	$83,436,348	$117,707	0.1%
$10,280,183	$11,770,730	$1,490,547	12.7%	14. Pharmacy Expense	$104,752,378	$105,269,428	$517,049	0.5%
$37,694,842	$32,544,857	($5,149,985)	(15.8%)	15. Long Term Care Expense	$278,475,786	$266,387,946	($12,087,840)	(4.5%)
$137,106,653	$148,065,149	$10,958,497	7.4%	16. Total Fee for Service Expense	$1,237,097,281	$1,206,669,870	($30,427,411)	(2.5%)
$3,716,696	$4,244,551	$527,855	12.4%	17. Other Benefits & Services	$37,902,192	$41,410,743	$3,508,552	8.5%
($1,975,388)	$433,132	$2,408,520	556.1%	18. Reinsurance Expense	($3,457,500)	$2,034,243	$5,491,743	270.0%
$158,960,579	**$169,964,963**	**$11,004,383**	**6.5%**	**20. TOTAL MEDICAL EXPENSES**	**$1,413,546,038**	**$1,382,343,229**	**($31,202,809)**	**(2.3%)**
$83,638,629	**$85,323,723**	**($1,685,095)**	**(2.0%)**	**21. GROSS MARGIN**	**$571,821,797**	**$587,230,906**	**($15,409,109)**	**(2.6%)**
				ADMINISTRATIVE EXPENSES				
$5,885,346	$5,310,271	($575,076)	(10.8%)	22. Personnel Expense	$45,810,152	$46,595,966	$785,814	1.7%
$68,688	$75,021	$6,333	8.4%	23. Benefits Administration Expense	$625,033	$604,627	($20,406)	(3.4%)
$1,697,247	$2,786,755	$1,089,507	39.1%	24. Purchased & Professional Services	$17,387,916	$20,551,071	$3,163,154	15.4%
$2,104,047	$1,220,082	($883,965)	(72.5%)	25. Other Administrative Expense	$12,445,478	$13,864,338	$1,418,860	10.2%
$9,755,329	**$9,392,128**	**($363,201)**	**(3.9%)**	**26. TOTAL ADMINISTRATIVE EXPENSES**	**$76,268,579**	**$81,616,001**	**$5,347,422**	**6.6%**
$70,830,207	**$66,784,811**	**($4,045,396)**	**(6.1%)**	**27. MCO TAX EXPENSES**	**$616,494,292**	**$609,510,636**	**($6,983,655)**	**(1.1%)**
$3,053,093	**$9,146,785**	**($6,093,692)**	**(66.6%)**	**28. NET OPERATING INCOME / (LOSS)**	**($120,941,074)**	**($103,895,731)**	**($17,045,342)**	**(16.4%)**
				OTHER INCOME / EXPENSES				
$2,036,425	**$1,500,000**	**$536,425**	**35.8%**	**29. TOTAL OTHER INCOME / (EXPENSES)**	**$22,180,528**	**$19,981,002**	**$2,199,526**	**11.0%**
$5,089,519	**$10,646,785**	**($5,557,266)**	**(52.2%)**	**30. NET SURPLUS (DEFICIT)**	**($98,760,546)**	**($83,914,729)**	**($14,845,816)**	**(17.7%)**
89.9%	88.8%	(1.1%)	(1.2%)	31. Medical Loss Ratio	102.9%	101.4%	(1.5%)	(1.5%)
5.5%	4.9%	(0.6%)	(12.2%)	32. Administrative Expense Ratio	5.6%	6.0%	0.4%	6.7%
2.1%	4.2%	(2.1%)	(50.0%)	33. Net Surplus (Deficit) Ratio	(5.0%)	(4.3%)	(0.7%)	(16.3%)

ALAMEDA ALLIANCE FOR HEALTH
BALANCE SHEETS
CURRENT MONTH VS. PRIOR MONTH
FOR THE MONTH AND FISCAL YTD ENDED 28 FEBRUARY, 2025

	2/28/2025	1/31/2025	Difference	% Difference
CURRENT ASSETS				
Cash and Cash Equivalent				
Cash	$20,900,148	$46,837,477	($25,937,329)	(55.4%)
CNB Short-Term Investment	489,048,970	415,286,680	73,762,290	17.8%
Interest Receivable	3,548,140	3,816,285	(268,145)	(7.0%)
Premium Receivables	518,901,164	481,046,122	37,855,042	7.9%
Reinsurance Recovery Receivable	9,404,743	8,541,221	863,523	10.1%
Other Receivables	1,976,221	1,954,962	21,259	1.1%
Prepaid Expenses	665,325	695,119	(29,794)	(4.3%)
TOTAL CURRENT ASSETS	**1,044,444,710**	**958,177,866**	**86,266,845**	**9.0%**
OTHER ASSETS				
CNB Long-Term Investment	50,028,558	46,769,807	3,258,752	7.0%
CalPERS Net Pension Asset	(6,144,132)	(6,144,132)	0	0.0%
Deferred Outflow	14,319,532	14,319,532	0	0.0%
Restricted Asset-Bank Note	350,000	350,000	0	0.0%
GASB 87-Lease Assets (Net)	279,615	345,529	(65,913)	(19.1%)
GASB 96-SBITA Assets (Net)	3,337,285	3,583,629	(246,344)	(6.9%)
TOTAL OTHER ASSETS	**62,170,859**	**59,224,365**	**2,946,494**	**5.0%**
PROPERTY AND EQUIPMENT				
Land, Building & Improvements	9,842,648	9,842,648	0	0.0%
Furniture And Equipment	13,133,600	13,071,003	62,598	0.5%
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	38,702,696	38,640,099	62,598	0.2%
Less: Accumulated Depreciation	(33,139,168)	(33,078,751)	(60,417)	0.2%
PROPERTY AND EQUIPMENT (NET)	**5,563,529**	**5,561,348**	**2,181**	**0.0%**
TOTAL ASSETS	**1,112,179,098**	**1,022,963,578**	**89,215,520**	**8.7%**
CURRENT LIABILITIES				
Trade Accounts Payable	9,430,678	10,767,792	(1,337,114)	(12.4%)
Incurred But Not Reported Claims	388,154,443	365,147,051	23,007,392	6.3%
Other Medical Liabilities	128,224,738	137,453,300	(9,228,562)	(6.7%)
Pass-Through Liabilities	16,082,329	15,650,909	431,420	2.8%
MCO Tax Liabilities	399,871,373	329,041,166	70,830,207	21.5%
GASB 87 and 96 ST Liabilities	1,470,410	1,139,415	330,995	29.0%
Payroll Liabilities	8,721,076	8,626,137	94,939	1.1%
TOTAL CURRENT LIABILITIES	**951,955,047**	**867,825,770**	**84,129,276**	**9.7%**
LONG TERM LIABILITIES				
GASB 87 and 96 LT Liabilities	281,923	285,198	(3,275)	(1.1%)
Deferred Inflow	3,327,530	3,327,530	0	0.0%
TOTAL LONG TERM LIABILITIES	**3,609,453**	**3,612,728**	**(3,275)**	**(0.1%)**
TOTAL LIABILITIES	**955,564,500**	**871,438,498**	**84,126,001**	**9.7%**
NET WORTH				
Contributed Capital	840,233	840,233	0	0.0%
Restricted & Unrestricted Funds	254,534,911	254,534,911	0	0.0%
Year-To-Date Net Surplus (Deficit)	(98,760,546)	(103,850,064)	5,089,519	(4.9%)
TOTAL NET WORTH	**156,614,598**	**151,525,080**	**5,089,519**	**3.4%**
TOTAL LIABILITIES AND NET WORTH	**1,112,179,098**	**1,022,963,578**	**89,215,520**	**8.7%**
Cash Equivalents	509,949,118	462,124,157	47,824,961	10.3%
Pass-Through	16,082,329	15,650,909	431,420	2.8%
Uncommitted Cash	493,866,789	446,473,248	47,393,541	10.6%
Working Capital	92,489,664	90,352,095	2,137,569	2.4%
Current Ratio	109.7%	110.4%	(0.7%)	(0.6%)

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED **February 28, 2025**

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM OPERATING ACTIVITIES				
Commercial Premium Cash Flows				
Commercial Premium Revenue	$3,178,514	$9,504,926	$18,941,614	$25,153,408
GroupCare Receivable	1,093	6,210,363	3,088,030	(6,223)
Total	3,179,607	15,715,289	22,029,644	25,147,185
Medi-Cal Premium Cash Flows				
Medi-Cal Revenue	239,420,695	716,983,831	1,532,339,418	1,960,214,428
Premium Receivable	(37,856,134)	(28,374,178)	(148,593,466)	(151,951,420)
Total	201,564,561	688,609,653	1,383,745,952	1,808,263,008
Investment & Other Income Cash Flows				
Other Revenues	(647,847)	429,081	1,264,860	2,522,054
Interest Income	2,689,828	6,746,559	13,801,787	19,754,894
Interest Receivable	268,145	1,169,129	812,603	(1,632,076)
Total	2,310,126	8,344,769	15,879,250	20,644,872
Medical & Hospital Cash Flows				
Total Medical Expenses	(158,960,575)	(514,729,097)	(1,061,179,168)	(1,413,546,042)
Other Health Care Receivables	(880,160)	(2,939,321)	(1,073,051)	(414,221)
Capitation Payable	-	-	-	-
IBNP Payable	23,007,392	58,332,588	80,797,946	91,850,184
Other Medical Payable	(8,797,144)	(89,062,152)	(178,508,153)	(191,533,690)
Risk Share Payable	-	-	(2,680,192)	(2,680,192)
New Health Program Payable	-	-	-	-
Total	(145,630,487)	(548,397,982)	(1,162,642,618)	(1,516,323,961)
Administrative Cash Flows				
Total Administrative Expenses	(9,760,885)	(28,087,458)	(56,031,976)	(76,364,997)
Prepaid Expenses	29,795	84,435	(409,153)	(426,707)
Other Receivables	(4,622)	(6,038)	1,119	27,799
CalPERS Pension	-	-	-	-
Trade Accounts Payable	(1,337,114)	625,617	3,477,103	2,940,382
Payroll Liabilities	94,937	1,724,736	355,515	621,850
GASB Assets and Liabilities	639,977	(799,386)	(1,367,691)	(1,363,081)
Depreciation Expense	60,417	179,163	362,167	476,495
Total	(10,277,495)	(26,278,931)	(53,612,916)	(74,088,259)
MCO Tax AB119 Cash Flows				
MCO Tax Expense AB119	(70,830,207)	(201,090,372)	(522,552,900)	(616,494,292)
MCO Tax Liabilities	70,830,207	75,621,622	271,615,400	240,087,859
Total	0	(125,468,750)	(250,937,500)	(376,406,433)
Net Cash Flows from Operating Activities	**51,146,312**	**12,524,048**	**(45,538,188)**	**(112,763,588)**

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED **February 28, 2025**

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM INVESTING ACTIVITIES				
Investment Cash Flows				
Long Term Investments	(3,258,754)	(5,866,485)	6,147,600	(17,036,312)
Total	(3,258,754)	(5,866,485)	6,147,600	(17,036,312)
Restricted Cash & Other Asset Cash Flows				
Restricted Assets-Treasury Account	-	-	-	-
Total	-	-	-	-
Fixed Asset Cash Flows				
Fixed Asset Acquisitions	(62,598)	(62,598)	(62,598)	(592,208)
Purchases of Property and Equipment	(62,598)	(62,598)	(62,598)	(592,208)
Net Cash Flows from Investing Activities	**(3,321,352)**	**(5,929,083)**	**6,085,002**	**(17,628,520)**
Net Change in Cash	**47,824,960**	**6,594,965**	**(39,453,186)**	**(130,392,108)**
Rounding	-	-	-	-
Cash @ Beginning of Period	462,124,158	503,354,153	549,402,304	640,341,226
Cash @ End of Period	**$509,949,118**	**$509,949,118**	**$509,949,118**	**$509,949,118**
Variance	-	-	-	-

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED **February 28, 2025**

	MONTH	3 MONTHS	6 MONTHS	YTD
NET INCOME RECONCILIATION				
Net Income / (Loss)	$5,089,523	($10,242,530)	($73,416,363)	($98,760,547)
Add back: Depreciation & Amortization	60,417	179,163	362,167	476,495
Receivables				
Premiums Receivable	(37,856,134)	(28,374,178)	(148,593,466)	(151,951,420)
Interest Receivable	268,145	1,169,129	812,603	(1,632,076)
Other Health Care Receivables	(880,160)	(2,939,321)	(1,073,051)	(414,221)
Other Receivables	(4,622)	(6,038)	1,119	27,799
GroupCare Receivable	1,093	6,210,363	3,088,030	(6,223)
Total	(38,471,678)	(23,940,045)	(145,764,765)	(153,976,141)
Prepaid Expenses	29,795	84,435	(409,153)	(426,707)
Trade Payables	(1,337,114)	625,617	3,477,103	2,940,382
Claims Payable and Shared Risk Pool				
IBNP Payable	23,007,392	58,332,588	80,797,946	91,850,184
Capitation Payable & Other Medical Payable	(8,797,144)	(89,062,152)	(178,508,153)	(191,533,690)
Risk Share Payable	-	-	(2,680,192)	(2,680,192)
Claims Payable				
Total	14,210,248	(30,729,564)	(100,390,399)	(102,363,698)
Other Liabilities				
CalPERS Pension	-	-	-	-
Payroll Liabilities	94,937	1,724,736	355,513	621,850
GASB Assets and Liabilities	639,977	(799,386)	(1,367,691)	(1,363,081)
New Health Program	-	-	-	-
MCO Tax Liabilities	70,830,207	75,621,622	271,615,400	240,087,859
Total	71,565,121	76,546,972	270,603,222	239,346,628
Rounding	-	-	-	-
Cash Flows from Operating Activities	**51,146,312**	**12,524,048**	**(45,538,188)**	**(112,763,588)**
Variance	-	-	-	-

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED **February 28, 2025**

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOW STATEMENT:				
Cash Flows from Operating Activities:				
Cash Received				
Capitation Received from State of CA	$201,564,561	$688,609,653	$1,383,745,952	$1,808,263,008
Medicare Revenue	$0	$0	$0	$0
GroupCare Premium Revenue	3,179,607	15,715,289	22,029,644	25,147,185
Other Income	(647,847)	429,081	1,264,860	2,522,054
Interest Income	2,957,973	7,915,688	14,614,390	18,122,818
Less Cash Paid				
Medical Expenses	(145,630,487)	(548,397,982)	(1,162,642,618)	(1,516,323,961)
Vendor & Employee Expenses	(10,277,495)	(26,278,931)	(53,612,916)	(74,088,259)
MCO Tax Expense AB119	0	(125,468,750)	(250,937,500)	(376,406,433)
Net Cash Flows from Operating Activities	**51,146,312**	**12,524,048**	**(45,538,188)**	**(112,763,588)**
Cash Flows from Investing Activities:				
Long Term Investments	(3,258,754)	(5,866,485)	6,147,600	(17,036,312)
Restricted Assets-Treasury Account	0	0	0	0
Purchases of Property and Equipment	(62,598)	(62,598)	(62,598)	(592,208)
Net Cash Flows from Investing Activities	**(3,321,352)**	**(5,929,083)**	**6,085,002**	**(17,628,520)**
Net Change in Cash	**47,824,960**	**6,594,965**	**(39,453,186)**	**(130,392,108)**
Rounding	-	-	-	-
Cash @ Beginning of Period	462,124,158	503,354,153	549,402,304	640,341,226
Cash @ End of Period	**$509,949,118**	**$509,949,118**	**$509,949,118**	**$509,949,118**
Variance	$0	-	-	-
RECONCILIATION OF NET INCOME TO NET CASH FLOW FROM OPERATING ACTIVITIES:				
Net Income / (Loss)	$5,089,523	($10,242,529)	($73,416,364)	($98,760,547)
Add Back: Depreciation	60,417	179,163	362,167	476,495
Net Change in Operating Assets & Liabilities				
Premium & Other Receivables	(38,471,678)	(23,940,045)	(145,764,765)	(153,976,141)
Prepaid Expenses	29,795	84,434	(409,152)	(426,707)
Trade Payables	(1,337,114)	625,617	3,477,103	2,940,382
Claims Payable, IBNP and Risk Sharing	14,210,248	(30,729,564)	(100,390,399)	(102,363,698)
Deferred Revenue	0	0	0	0
Other Liabilities	71,565,121	76,546,972	270,603,222	239,346,628
Total	51,146,312	12,524,048	(45,538,188)	(112,763,588)
Rounding	-	-	-	-
Cash Flows from Operating Activities	**$51,146,312**	**$12,524,048**	**($45,538,188)**	**($112,763,588)**
Variance	$0	-	-	-

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE MONTH OF FEBRUARY 2025

	Medi-Cal Child	Medi-Cal Adult	Medi-Cal SPD*	Medi-Cal Duals*	Medi-Cal ACA OE	Medi-Cal LTC*	Medi-Cal LTC Duals*	Medi-Cal SPD with LTC	Medi-Cal Duals with LTC	Medi-Cal Total	Group Care	Medicare	Grand Total
Enrollments/Member Months	111,554	63,706	-	-	154,609	-	-	29,497	48,100	407,466	5,812	-	413,278
Revenue	$32,177,619	$31,843,389	($941,980)	$229,007	$87,481,087	($56,399)	($122,860)	$47,371,351	$41,439,481	$239,420,694	$3,178,514	$0	$242,599,208
Medical Expense	$10,853,333	$17,608,001	($7,289,375)	$238,108	$53,057,403	($773,208)	$468,484	$52,983,395	$29,110,669	$156,256,808	$2,698,036	$5,735	$158,960,579
Gross Margin	$21,324,286	$14,235,388	$6,347,395	($9,101)	$34,423,684	$716,809	($591,344)	($5,612,044)	$12,328,812	$83,163,886	$480,478	($5,735)	$83,638,629
Administrative Expense	$480,466	$1,082,676	$103,984	($1,002)	$3,099,118	$913	$5,970	$2,772,440	$1,707,164	$9,251,729	$150,948	$352,651	$9,755,329
MCO Tax Expense	$19,658,791	$10,935,514	$454,127	$784,114	$26,450,291	$232	$10,567	$4,765,535	$7,771,036	$70,830,207	$0	$0	$70,830,207
Operating Income / (Expense)	$1,185,029	$2,217,198	$5,789,284	($792,212)	$4,874,275	$715,664	($607,880)	($13,150,019)	$2,850,612	$3,081,950	$329,529	($358,386)	$3,053,093
Other Income / (Expense)	$98,964	$235,110	$0	$0	$670,148	$0	$0	$620,055	$381,807	$2,006,085	$30,341	$0	$2,036,425
Net Income / (Loss)	$1,283,993	$2,452,308	$5,789,284	($792,212)	$5,544,423	$715,664	($607,880)	($12,529,964)	$3,232,419	$5,088,034	$359,870	($358,386)	$5,089,519
PMPM Metrics:													
Revenue PMPM	$288.45	$499.85	$0.00	$0.00	$565.82	$0.00	$0.00	$1,605.97	$861.53	$587.58	$546.89	$0.00	$587.01
Medical Expense PMPM	$97.29	$276.39	$0.00	$0.00	$343.17	$0.00	$0.00	$1,796.23	$605.21	$383.48	$464.22	$0.00	$384.63
Gross Margin PMPM	$191.16	$223.45	$0.00	$0.00	$222.65	$0.00	$0.00	($190.26)	$256.32	$204.10	$82.67	$0.00	$202.38
Administrative Expense PMPM	$4.31	$16.99	$0.00	$0.00	$20.04	$0.00	$0.00	$93.99	$35.49	$22.71	$25.97	$0.00	$23.60
MCO Tax Expense PMPM	$176.23	$171.66	$0.00	$0.00	$171.08	$0.00	$0.00	$161.56	$161.56	$173.83	$0.00	$0.00	$171.39
Operating Income / (Expense) PMPM	$10.62	$34.80	$0.00	$0.00	$31.53	$0.00	$0.00	($445.81)	$59.26	$7.56	$56.70	$0.00	$7.39
Other Income / (Expense) PMPM	$0.89	$3.69	$0.00	$0.00	$4.33	$0.00	$0.00	$21.02	$7.94	$4.92	$5.22	$0.00	$4.93
Net Income / (Loss) PMPM	$11.51	$38.49	$0.00	$0.00	$35.86	$0.00	$0.00	($424.79)	$67.20	$12.49	$61.92	$0.00	$12.31
Ratio:													
Medical Loss Ratio	76.7%	81.7%	773.8%	104.0%	84.9%	1371.0%	-381.3%	124.4%	86.5%	90.0%	84.9%	0.0%	89.9%
Administrative Expense Ratio	3.4%	5.0%	-11.0%	-0.4%	5.0%	-1.6%	-4.9%	6.5%	5.1%	5.3%	4.7%	0.0%	5.5%
Net Income Ratio	4.0%	7.7%	-614.6%	-345.9%	6.3%	-1268.9%	494.8%	-26.5%	7.8%	2.1%	11.3%	0.0%	2.1%

*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 FEBRUARY 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	882,392	503,143	212,632	241,339	1,217,250	1,446	7,562	59,061	96,253	3,221,078	45,993	-	3,267,071
Revenue	$290,217,539	$271,672,161	$304,314,312	$136,311,255	$698,787,979	$15,401,452	$65,682,631	$94,868,357	$82,958,741	$1,960,214,427	$25,153,408	$0	$1,985,367,835
Medical Expense	$106,098,086	$165,314,605	$274,716,699	$94,366,337	$495,697,505	$17,530,851	$66,533,188	$109,233,335	$59,119,788	$1,388,610,395	$24,770,143	$165,500	$1,413,546,038
Gross Margin	$184,119,453	$106,357,555	$29,597,613	$41,944,918	$203,090,474	($2,129,399)	($850,557)	($14,364,978)	$23,838,953	$571,604,032	$383,266	($165,500)	$571,821,797
Administrative Expense	$3,685,984	$8,688,921	$14,341,576	$4,942,600	$23,912,440	$1,012,276	$4,698,300	$5,293,040	$3,266,717	$69,841,854	$1,219,889	$5,206,837	$76,268,579
MCO Tax Expense	$169,436,586	$96,429,167	$42,796,628	$48,949,340	$231,975,075	$283,857	$1,531,107	$9,541,895	$15,550,635	$616,494,292	$0	$0	$616,494,292
Operating Income / (Expense)	$10,996,883	$1,239,467	($27,540,592)	($11,947,022)	($52,797,042)	($3,425,532)	($7,079,965)	($29,199,913)	$5,021,602	($114,732,114)	($836,623)	($5,372,337)	($120,941,074)
Other Income / (Expense)	$1,112,394	$2,733,916	$4,709,375	$1,609,737	$7,523,406	$338,837	$1,557,352	$1,418,543	$873,487	$21,877,048	$303,480	$0	$22,180,528
Net Income / (Loss)	$12,109,277	$3,973,383	($22,831,217)	($10,337,284)	($45,273,635)	($3,086,696)	($5,522,612)	($27,781,370)	$5,895,089	($92,855,066)	($533,143)	($5,372,337)	($98,760,546)
PMPM Metrics:													
Revenue PMPM	$328.90	$539.95	$1,431.18	$564.81	$574.07	$10,651.07	$8,685.88	$1,606.28	$861.88	$608.56	$546.90	$0.00	$607.69
Medical Expense PMPM	$120.24	$328.56	$1,291.98	$391.01	$407.23	$12,123.69	$8,798.36	$1,849.50	$614.21	$431.10	$538.56	$0.00	$432.66
Gross Margin PMPM	$208.66	$211.39	$139.20	$173.80	$166.84	($1,472.61)	($112.48)	($243.22)	$247.67	$177.46	$8.33	$0.00	$175.03
Administrative Expense PMPM	$4.18	$17.27	$67.45	$20.48	$19.64	$700.05	$621.30	$89.62	$33.94	$21.68	$26.52	$0.00	$23.34
MCO Tax Expense PMPM	$192.02	$191.65	$201.27	$202.82	$190.57	$196.31	$202.47	$161.56	$161.56	$191.39	$0.00	$0.00	$188.70
Operating Income / (Expense) PMPM	$12.46	$2.46	($129.52)	($49.50)	($43.37)	($2,368.97)	($936.26)	($494.40)	$52.17	($35.62)	($18.19)	$0.00	($37.02)
Other Income / (Expense) PMPM	$1.26	$5.43	$22.15	$6.67	$6.18	$234.33	$205.94	$24.02	$9.07	$6.79	$6.60	$0.00	$6.79
Net Income / (Loss) PMPM	$13.72	$7.90	($107.37)	($42.83)	($37.19)	($2,134.64)	($730.31)	($470.38)	$61.25	($28.83)	($11.59)	$0.00	($30.23)
Ratio:													
Medical Loss Ratio	86.7%	94.0%	104.9%	107.1%	105.9%	116.0%	103.7%	128.0%	87.7%	103.0%	98.5%	0.0%	102.9%
Administrative Expense Ratio	3.0%	4.9%	5.5%	5.6%	5.1%	6.7%	7.3%	6.2%	4.8%	5.2%	4.8%	0.0%	5.6%
Net Income Ratio	4.2%	1.5%	-7.5%	-7.6%	-6.5%	-20.0%	-8.4%	-29.3%	7.1%	-4.7%	-2.1%	0.0%	-5.0%

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ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 28 February, 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)				
$5,885,346	$5,310,271	($575,076)	(10.8%)	Personnel Expenses	$45,810,152	$46,595,966	$785,814	1.7%
$68,688	$75,021	$6,333	8.4%	Benefits Administration Expense	$625,033	$604,627	($20,406)	(3.4%)
$1,697,247	$2,786,755	$1,089,507	39.1%	Purchased & Professional Services	$17,387,916	$20,551,071	$3,163,154	15.4%
$512,779	$576,632	$63,853	11.1%	Occupancy	$4,159,796	$4,349,929	$190,133	4.4%
$731,236	$301,843	($429,393)	(142.3%)	Printing Postage & Promotion	$3,282,247	$3,653,083	$370,836	10.2%
$660,080	$159,740	($500,340)	(313.2%)	Licenses Insurance & Fees	$3,596,852	$4,340,015	$743,163	17.1%
$199,952	$181,866	($18,086)	(9.9%)	Other Administrative Expense	$1,406,583	$1,521,311	$114,728	7.5%
$3,869,982	$4,081,857	$211,875	5.2%	Total Other Administrative Expenses (excludes Personnel Expenses)	$30,458,427	$35,020,035	$4,561,608	13.0%
$9,755,329	$9,392,128	($363,201)	(3.9%)	Total Administrative Expenses	$76,268,579	$81,616,001	$5,347,422	6.6%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 28 February, 2025

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
3,513,775	3,475,306	(38,469)	(1.1%)	Salaries & Wages	30,138,750	30,483,450	344,701	1.1%
708,246	374,171	(334,075)	(89.3%)	Paid Time Off	2,781,271	2,981,798	200,527	6.7%
950	3,805	2,855	75.0%	Compensated Incentives	22,235	30,609	8,374	27.4%
0	0	0	0.0%	Severence	0	400,000	400,000	100.0%
46,747	89,342	42,595	47.7%	Payroll Taxes	582,272	776,384	194,112	25.0%
66,332	25,710	(40,622)	(158.0%)	Overtime	558,181	416,959	(141,222)	(33.9%)
322,895	309,512	(13,384)	(4.3%)	CalPERS ER Match	2,569,543	2,611,684	42,142	1.6%
1,028,371	674,640	(353,731)	(52.4%)	Employee Benefits	7,872,915	6,465,523	(1,407,392)	(21.8%)
3,738	0	(3,738)	0.0%	Personal Floating Holiday	195,789	202,966	7,177	3.5%
19,752	33,500	13,748	41.0%	Language Pay	163,629	234,259	70,630	30.2%
5,200	0	(5,200)	0.0%	Med Ins Opted Out Stipend	29,050	16,010	(13,040)	(81.4%)
0	0	0	0.0%	Holiday Bonus	(400,000)	0	400,000	1,333,333,4…
70,677	0	(70,677)	0.0%	Sick Leave	645,609	270,728	(374,881)	(138.5%)
387	53,175	52,788	99.3%	Compensated Employee Relations	8,163	174,789	166,626	95.3%
20,280	26,400	6,120	23.2%	Work from Home Stipend	160,290	181,970	21,680	11.9%
1,003	5,788	4,785	82.7%	Mileage, Parking & LocalTravel	10,110	36,374	26,264	72.2%
309	30,648	30,339	99.0%	Travel & Lodging	16,293	123,261	106,968	86.8%
35,273	125,325	90,052	71.9%	Temporary Help Services	251,808	590,024	338,216	57.3%
38,500	52,813	14,313	27.1%	Staff Development/Training	124,981	378,337	253,356	67.0%
2,911	30,137	27,226	90.3%	Staff Recruitment/Advertisement	79,265	220,840	141,576	64.1%
5,885,346	**5,310,271**	**(575,076)**	**(10.8%)**	**Personnel Expense**	**45,810,152**	**46,595,966**	**785,814**	**1.7%**
26,092	22,018	(4,075)	(18.5%)	Pharmacy Administrative Fees	202,581	183,204	(19,377)	(10.6%)
42,595	53,003	10,408	19.6%	Telemedicine Admin. Fees	422,452	421,423	(1,029)	(0.2%)
68,688	**75,021**	**6,333**	**8.4%**	**Benefits Administration Expense**	**625,033**	**604,627**	**(20,406)**	**(3.4%)**
497,029	752,715	255,687	34.0%	Consultant Fees - Non Medical	4,823,695	5,740,141	916,446	16.0%
223,885	703,001	479,116	68.2%	Computer Support Services	3,768,818	4,745,474	976,656	20.6%
12,500	15,000	2,500	16.7%	Audit Fees	171,158	128,158	(43,000)	(33.6%)
0	8	8	100.0%	Consultant Fees - Medical	(7,505)	(15,305)	(7,800)	51.0%
250,810	191,313	(59,497)	(31.1%)	Other Purchased Services	1,974,876	2,018,293	43,417	2.2%
0	1,688	1,688	100.0%	Maint.&Repair-Office Equipment	0	6,752	6,752	100.0%
2,018	0	(2,018)	0.0%	Maint.&Repair-Computer Hardwar	2,018	0	(2,018)	0.0%
161,459	70,067	(91,392)	(130.4%)	Legal Fees	851,637	611,552	(240,085)	(39.3%)
0	0	0	0.0%	Member Health Education	320	320	0	0.0%
33,209	26,000	(7,209)	(27.7%)	Translation Services	210,389	191,064	(19,326)	(10.1%)
103,827	157,650	53,823	34.1%	Medical Refund Recovery Fees	1,900,116	1,785,271	(114,845)	(6.4%)
357,390	766,148	408,758	53.4%	Software - IT Licenses & Subsc	3,122,235	4,402,614	1,280,379	29.1%
4,472	47,364	42,892	90.6%	Hardware (Non-Capital)	202,025	539,625	337,599	62.6%
50,649	55,800	5,151	9.2%	Provider Credentialing	368,135	397,113	28,978	7.3%
1,697,247	**2,786,755**	**1,089,507**	**39.1%**	**Purchased & Professional Services**	**17,387,916**	**20,551,071**	**3,163,154**	**15.4%**
60,417	94,079	33,662	35.8%	Depreciation	476,495	606,774	130,279	21.5%
62,638	76,371	13,733	18.0%	Lease Building	574,102	554,885	(19,216)	(3.5%)
8,526	10,570	2,044	19.3%	Lease Rented Office Equipment	43,906	60,245	16,339	27.1%
17,818	20,023	2,205	11.0%	Utilities	105,521	174,830	69,309	39.6%
96,480	91,065	(5,415)	(5.9%)	Telephone	705,494	711,925	6,431	0.9%
20,556	35,389	14,833	41.9%	Building Maintenance	240,692	320,947	80,255	25.0%
246,344	249,136	2,792	1.1%	GASB96 SBITA Amort. Expense	2,013,586	1,920,323	(93,264)	(4.9%)

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 28 February, 2025

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
512,779	**576,632**	**63,853**	**11.1%**	**Occupancy**	**4,159,796**	**4,349,929**	**190,133**	**4.4%**
136,947	38,313	(98,633)	(257.4%)	Postage	513,771	663,643	149,872	22.6%
4,769	5,300	532	10.0%	Design & Layout	44,881	47,380	2,499	5.3%
305,712	45,140	(260,572)	(577.3%)	Printing Services	838,252	816,010	(22,242)	(2.7%)
9,101	19,410	10,309	53.1%	Mailing Services	76,371	87,023	10,652	12.2%
5,358	11,961	6,603	55.2%	Courier/Delivery Service	42,653	72,795	30,142	41.4%
0	0	0	0.0%	Pre-Printed Materials & Public	589	2,583	1,994	77.2%
65,903	10,902	(55,000)	(504.5%)	Promotional Products	111,069	54,020	(57,049)	(105.6%)
0	150	150	100.0%	Promotional Services	0	900	900	100.0%
203,447	170,667	(32,780)	(19.2%)	Community Relations	1,654,660	1,908,728	254,068	13.3%
731,236	**301,843**	**(429,393)**	**(142.3%)**	**Printing Postage & Promotion**	**3,282,247**	**3,653,083**	**370,836**	**10.2%**
0	50,000	50,000	100.0%	Regulatory Penalties	295,000	385,000	90,000	23.4%
82,161	31,600	(50,561)	(160.0%)	Bank Fees	329,254	259,381	(69,873)	(26.9%)
0	0	0	0.0%	Insurance Premium	976,728	982,916	6,188	0.6%
479,951	14,273	(465,678)	(3,262.7%)	License,Permits, & Fee - NonIT	1,428,306	2,090,917	662,611	31.7%
97,968	63,868	(34,100)	(53.4%)	Subscriptions and Dues - NonIT	567,564	621,801	54,237	8.7%
660,080	**159,740**	**(500,340)**	**(313.2%)**	**License Insurance & Fees**	**3,596,852**	**4,340,015**	**743,163**	**17.1%**
6,509	11,608	5,099	43.9%	Office and Other Supplies	58,530	88,016	29,486	33.5%
0	2,000	2,000	100.0%	Furniture & Equipment	0	8,000	8,000	100.0%
7,004	29,692	22,688	76.4%	Ergonomic Supplies	207,849	243,981	36,133	14.8%
7,797	18,566	10,769	58.0%	Meals and Entertainment	85,112	133,106	47,994	36.1%
0	0	0	0.0%	Miscellaneous	3,459	5,300	1,841	34.7%
0	0	0	0.0%	Member Incentive	0	9,700	9,700	100.0%
178,642	120,000	(58,642)	(48.9%)	Provider Interest (All Depts)	1,051,633	1,033,208	(18,425)	(1.8%)
199,952	**181,866**	**(18,086)**	**(9.9%)**	**Other Administrative Expense**	**1,406,583**	**1,521,311**	**114,728**	**7.5%**
3,869,982	**4,081,857**	**211,875**	**5.2%**	**Total Other Administrative ExpenseS (excludes Personnel Expenses)**	**30,458,427**	**35,020,035**	**4,561,608**	**13.0%**
9,755,329	**9,392,128**	**(363,201)**	**(3.9%)**	**TOTAL ADMINISTRATIVE EXPENSES**	**76,268,579**	**81,616,001**	**5,347,422**	**6.6%**

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

		Project ID	Prior YTD Acquisitions	Current Month Acquisitions	Fiscal YTD Acquisitions	Capital Budget Total	$ Variance Fav/(Unf.)
1. Hardware:							
	Cisco UCS-X M6 or M7 Blades x 6	IT-FY24-04	$ 265,100	$ -	**$ 265,100**	$ 265,100	$ 0
	Cisco Routers	IT-FY25-01	$ -	$ -	**$ -**	$ 120,000	$ 120,000
	Cisco UCS Blades	IT-FY25-04	$ 264,510	$ -	**$ 264,510**	$ 873,000	$ 608,490
	PURE Storage	IT-FY25-06	$ -	$ -	**$ -**	$ 150,000	$ 150,000
	Exagrid Immutable Storage	IT-FY25-07	$ -	$ -	**$ -**	$ 500,000	$ 500,000
	Network Cabling	IT-FY25-09	$ -	$ 62,598	**$ 62,598**	$ 40,000	$ (22,598)
Hardware Subtotal			**$ 529,610**	**$ 62,598**	**$ 592,208**	**$ 1,948,100**	**$ 1,355,892**
2. Software:							
	Zerto renewal and Tier 2 add		$ -	$ -	**$ -**	$ -	$ -
Software Subtotal			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
3. Building Improvement:							
	1240 Exterior lighting update	FA-FY25-03	**$ -**	$ -	**$ -**	$ 30,000	$ 30,000
Building Improvement Subtotal			**$ -**	**$ -**	**$ -**	**$ 30,000**	**$ 30,000**
4. Furniture & Equipment:							
	Office desks, cabinets, shelvings (all building/suites: new or replacement)		$ -	$ -	**$ -**	$ -	$ -
	Replace, reconfigure, re-design workstations		$ -	$ -	**$ -**	$ -	$ -
Furniture & Equipment Subtotal			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
5. Leasehold Improvement:							
	ExacqVision NVR Upgrade, Cameras/Video System upgrade		$ -		**$ -**	$ -	$ -
Leasehold Improvement Subtotal			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
6. Contingency:							
			$ -		**$ -**	$ -	$ -
Contingency Subtotal			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
GRAND TOTAL			**$ 529,610**	**$ 62,598**	**$ 592,208**	**$ 1,978,100**	**$ 1,385,892**

6. Reconciliation to Balance Sheet:

Fixed Assets @ Cost - 2/28/25	**$ 38,702,696**
Fixed Assets @ Cost - 6/30/24	**$ 38,110,489**
Fixed Assets Acquired YTD	**$ 592,208**

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

TANGIBLE NET EQUITY (TNE)	**QRT. END Jun-24**	**Jul-24**	**Aug-24**	**QRT. END Sep-24**	**Oct-24**	**Nov-24**	**QRT. END Dec-24**	**Jan-25**	**Feb-25**
Current Month Net Income / (Loss)	$(60,614,034)	$ (6,989,301)	$(18,354,880)	$ (8,719,238)	$(26,984,341)	$ (27,470,264)	$ (8,643,229)	$ (6,688,826)	$ 5,089,524
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)
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
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**
Increase/(Decrease) in Actual TNE	$(60,614,034)	$ (6,989,301)	$(18,354,880)	$ (8,719,238)	$(26,984,341)	$ (27,470,264)	$ (8,643,229)	$ (6,688,826)	$ 5,089,524
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**
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
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
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**
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
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)
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)
CD Pledged to DMHC	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)
Liquid TNE (Liquid Reserves)	**$249,075,842**	**$242,053,513**	**$223,320,986**	**$214,153,818**	**$186,934,293**	**$ 159,761,852**	**$ 149,538,283**	**$ 143,109,188**	**$ 148,836,503**
Liquid TNE as Multiple of Required	**3.93**	**3.52**	**3.12**	**3.05**	**2.42**	**2.03**	**1.93**	**1.76**	**1.92**

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

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

	Actual Jul-24	Actual Aug-24	Actual Sep-24	Actual Oct-24	Actual Nov-24	Actual Dec-24	Actual Jan-25	Actual Feb-25	Actual Mar-25	Actual Apr-25	Actual May-25	Actual Jun-25	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program:													
Child	109,951	109,784	109,731	109,662	109,561	110,506	111,643	111,554					882,392
Adult	62,708	62,641	62,550	62,578	62,502	62,905	63,553	63,706					503,143
SPD (retired Dec-24)*	35,018	35,177	35,319	35,388	35,603	36,127	0	0					212,632
Duals (retired Dec-24)*	39,892	40,024	40,124	40,144	40,357	40,798	0	0					241,339
ACA OE	149,801	150,482	151,005	151,098	151,559	154,560	154,136	154,609					1,217,250
LTC (retired Dec-24)*	222	226	240	249	255	254	0	0					1,446
LTC Duals (retired Dec-24)*	1,241	1,247	1,254	1,265	1,269	1,286	0	0					7,562
SPD with LTC (new Jan-25)	0	0	0	0	0	0	29,564	29,497					59,061
Duals with LTC (new Jan-25)	0	0	0	0	0	0	48,153	48,100					96,253
Medi-Cal Program	398,833	399,581	400,223	400,384	401,106	406,436	407,049	407,466					3,221,078
Group Care Program	5,675	5,686	5,710	5,769	5,772	5,790	5,779	5,812					45,993
Total	**404,508**	**405,267**	**405,933**	**406,153**	**406,878**	**412,226**	**412,828**	**413,278**					**3,267,071**

*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)					1,430
Adult	(38)	(67)	(91)	28	(76)	403	648	153					960
SPD (retired Dec-24)	98	159	142	69	215	524	(36,127)	0					(34,920)
Duals (retired Dec-24)	144	132	100	20	213	441	(40,798)	0					(39,748)
ACA OE	477	681	523	93	461	3,001	(424)	473					5,285
LTC (retired Dec-24)	0	4	14	9	6	(1)	(254)	0					(222)
LTC Duals (retired Dec-24)	(7)	6	7	11	4	17	(1,286)	0					(1,248)
SPD with LTC (new Jan-25)	0	0	0	0	0	0	29,564	(67)					29,497
Duals with LTC (new Jan-25)	0	0	0	0	0	0	48,153	(53)					48,100
Medi-Cal Program	501	748	642	161	722	5,330	613	417					9,134
Group Care Program	17	11	24	59	3	18	(11)	33					154
Total	**518**	**759**	**666**	**220**	**725**	**5,348**	**602**	**450**					**9,288**

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%					27.4%
Adult % of Medi-Cal	15.7%	15.7%	15.6%	15.6%	15.6%	15.5%	15.6%	15.6%					15.6%
SPD % of Medi-Cal	8.8%	8.8%	8.8%	8.8%	8.9%	8.9%	0.0%	0.0%					6.6%
Duals % of Medi-Cal	10.0%	10.0%	10.0%	10.0%	10.1%	10.0%	0.0%	0.0%					7.5%
ACA OE % of Medi-Cal	37.6%	37.7%	37.7%	37.7%	37.8%	38.0%	37.9%	37.9%					37.8%
LTC % of Medi-Cal	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	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%					0.2%
SPD with LTC % of Medi-Cal	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.3%	7.2%					1.8%
Duals with LTC % of Medi-Cal	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	11.8%	11.8%					3.0%
Medi-Cal Program % of Total	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%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**					**100.0%**

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

	Actual Jul-24	Actual Aug-24	Actual Sep-24	Actual Oct-24	Actual Nov-24	Actual Dec-24	Actual Jan-25	Actual Feb-25	Actual Mar-25	Actual Apr-25	Actual May-25	Actual Jun-25	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted													
Directly Contracted (DCP)	87,980	88,518	89,634	89,724	90,655	96,247	94,389	94,869					732,016
Alameda Health System	91,091	91,170	91,024	90,756	90,451	90,222	91,158	90,932					726,804
Directly-Contracted Subtotal	179,071	179,688	180,658	180,480	181,106	186,469	185,547	185,801					1,458,820
Delegated:													
CFMG	44,087	43,956	43,837	43,910	44,029	44,099	44,982	45,072					353,972
CHCN	181,350	181,623	181,438	181,763	181,743	181,658	182,299	182,405					1,454,279
Delegated Subtotal	225,437	225,579	225,275	225,673	225,772	225,757	227,281	227,477					1,808,251
Total	**404,508**	**405,267**	**405,933**	**406,153**	**406,878**	**412,226**	**412,828**	**413,278**					**3,267,071**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	167	617	970	(178)	626	5,363	(922)	254					6,897
Delegated:													
CFMG	96	(131)	(119)	73	119	70	883	90					1,081
CHCN	255	273	(185)	325	(20)	(85)	641	106					1,310
Delegated Subtotal	351	142	(304)	398	99	(15)	1,524	196					2,391
Total	**518**	**759**	**666**	**220**	**725**	**5,348**	**602**	**450**					**9,288**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	44.3%	44.3%	44.5%	44.4%	44.5%	45.2%	44.9%	45.0%					44.7%
Delegated:													
CFMG	10.9%	10.8%	10.8%	10.8%	10.8%	10.7%	10.9%	10.9%					10.8%
CHCN	44.8%	44.8%	44.7%	44.8%	44.7%	44.1%	44.2%	44.1%					44.5%
Delegated Subtotal	55.7%	55.7%	55.5%	55.6%	55.5%	54.8%	55.1%	55.0%					55.3%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**					**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING

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

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING

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

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

	Variance Jul-24	Variance Aug-24	Variance Sep-24	Variance Oct-24	Variance Nov-24	Variance Dec-24	Variance Jan-25	Variance Feb-25	Variance Mar-25	Variance Apr-25	Variance May-25	Variance Jun-25	YTD Member Month Variance
Enrollment Variance by Plan & Aid Category - Favorable/(Unfavorable)													
Medi-Cal Program:													
Child	0	0	0	0	(211)	624	1,541	1,342					3,296
Adult	0	0	0	0	(139)	201	786	876					1,724
SPD (retired Dec-24)	0	0	0	0	180	669	0	0					849
Duals (retired Dec-24)	0	0	0	0	213	654	0	0					867
ACA OE	0	0	0	0	310	3,160	2,585	2,906					8,961
LTC (retired Dec-24)	0	0	0	0	4	0	0	0					4
LTC Duals (retired Dec-24)	0	0	0	0	3	19	0	0					22
SPD with LTC (new Jan-25)	0	0	0	0	0	0	(5,186)	(4,291)					(9,477)
Duals with LTC (new Jan-25)	0	0	0	0	0	0	5,741	4,687					10,428
Medi-Cal Program	0	0	0	0	360	5,327	5,467	5,520					5,687
Group Care Program	0	0	0	0	3	21	10	43					24
Total	**0**	**0**	**0**	**0**	**363**	**5,348**	**5,477**	**5,563**					**16,751**
Current Direct/Delegate Enrollment Variance - Favorable/(Unfavorable)													
Directly-Contracted													
Directly Contracted (DCP)	0	0	0	0	869	6,398	4,145	4,239					15,651
Alameda Health System	0	0	0	0	(392)	(708)	207	(28)					(921)
Directly-Contracted Subtotal	0	0	0	0	477	5,690	4,352	4,211					14,730
Delegated:													
CFMG	0	0	0	0	76	103	947	1,039					2,165
CHCN	0	0	0	0	(190)	(445)	178	313					(144)
Delegated Subtotal	0	0	0	0	(114)	(342)	1,125	1,352					2,021
Total	**0**	**0**	**0**	**0**	**363**	**5,348**	**5,477**	**5,563**					**16,751**

ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 28 FEBRUARY, 2025

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				CAPITATED MEDICAL EXPENSES				
$5,660,810	$1,748,014	($3,912,795)	(223.8%)	PCP Capitation	$35,250,706	$21,601,411	($13,649,296)	(63.2%)
6,088,478	6,629,677	541,199	8.2%	PCP Capitation FQHC	49,090,090	50,962,784	1,872,694	3.7%
500,885	456,228	(44,657)	(9.8%)	Specialty Capitation	3,277,068	3,313,874	36,806	1.1%
5,329,636	6,031,097	701,461	11.6%	Specialty Capitation FQHC	43,085,071	45,614,096	2,529,025	5.5%
779,953	714,840	(65,113)	(9.1%)	Laboratory Capitation	6,055,707	5,852,558	(203,149)	(3.5%)
454,790	340,941	(113,848)	(33.4%)	Vision Capitation	2,732,563	2,718,708	(13,856)	(0.5%)
113,926	132,733	18,807	14.2%	CFMG Capitation	889,927	964,260	74,334	7.7%
147,812	293,477	145,664	49.6%	ANC IPA Admin Capitation FQHC	2,124,667	2,233,044	108,377	4.9%
(57)	0	57	0.0%	Kaiser Capitation	(8,639,235)	(8,639,177)	57	0.0%
0	0	0	0.0%	BHT Supplemental Expense	(65,356)	0	65,356	0.0%
0	0	0	0.0%	Maternity Supplemental Expense	37,270	27,953	(9,318)	(33.3%)
1,036,386	875,124	(161,262)	(18.4%)	DME Capitation	8,165,587	7,578,861	(586,726)	(7.7%)
20,112,619	**17,222,131**	**(2,890,488)**	**(16.8%)**	**7. TOTAL CAPITATED EXPENSES**	**142,004,065**	**132,228,372**	**(9,775,693)**	**(7.4%)**
				FEE FOR SERVICE MEDICAL EXPENSES				
2,300,950	0	(2,300,950)	0.0%	IBNR Inpatient Services	25,726,533	(3,303,163)	(29,029,696)	878.8%
69,028	0	(69,028)	0.0%	IBNR Settlement (IP)	771,796	(99,094)	(870,890)	878.9%
184,076	0	(184,076)	0.0%	IBNR Claims Fluctuation (IP)	2,058,121	(264,254)	(2,322,375)	878.8%
45,385,018	50,412,587	5,027,569	10.0%	Inpatient Hospitalization FFS	374,917,217	408,048,603	33,131,386	8.1%
2,307,142	0	(2,307,142)	0.0%	IP OB - Mom & NB	23,902,205	12,540,164	(11,362,041)	(90.6%)
276,632	0	(276,632)	0.0%	IP Behavioral Health	5,012,422	1,070,307	(3,942,115)	(368.3%)
892,969	0	(892,969)	0.0%	Inpatient Facility Rehab FFS	10,295,097	5,770,736	(4,524,361)	(78.4%)
51,415,815	**50,412,587**	**(1,003,228)**	**(2.0%)**	**8. Inpatient Hospital Expense**	**442,683,391**	**423,763,299**	**(18,920,092)**	**(4.5%)**
89,193	0	(89,193)	0.0%	IBNR PCP	1,248,585	(293,439)	(1,542,024)	525.5%
2,675	0	(2,675)	0.0%	IBNR Settlement (PCP)	37,459	(8,801)	(46,260)	525.6%
7,134	0	(7,134)	0.0%	IBNR Claims Fluctuation (PCP)	168,149	44,791	(123,358)	(275.4%)
4,346,739	2,830,754	(1,515,985)	(53.6%)	PCP FFS	31,739,594	26,643,385	(5,096,208)	(19.1%)
360,525	833,815	473,290	56.8%	PCP FQHC FFS	3,061,576	4,962,052	1,900,477	38.3%
0	0	0	0.0%	Physician Extended Hrs. Incent	19,000	12,000	(7,000)	(58.3%)
(8,789,064)	845,857	9,634,920	1,139.1%	Prop 56 Physician Pmt	(12,256,206)	(1,016,644)	11,239,562	(1,105.6%)
16,504	0	(16,504)	0.0%	Prop 56 Hyde	181,285	64,923	(116,362)	(179.2%)
(229,560)	0	229,560	0.0%	Prop 56 Trauma Screening	99,401	110,133	10,732	9.7%
(275,337)	0	275,337	0.0%	Prop 56 Developmentl Screening	65,401	96,040	30,639	31.9%
(3,684,191)	0	3,684,191	0.0%	Prop 56 Family Planning	(2,432,462)	(767,666)	1,664,796	(216.9%)
0	0	0	0.0%	Prop 56 VBP	(2,406,095)	(2,718,741)	(312,647)	11.5%
(8,155,381)	**4,510,426**	**12,665,807**	**280.8%**	**9. Primary Care Physician Expense**	**19,525,686**	**27,128,033**	**7,602,346**	**28.0%**
146,457	0	(146,457)	0.0%	IBNR Specialist	3,048,260	(747,176)	(3,795,436)	508.0%
4,395	0	(4,395)	0.0%	IBNR Settlement (SCP)	91,452	(22,414)	(113,866)	508.0%
11,717	0	(11,717)	0.0%	IBNR Claims Fluctuation (SCP)	243,860	(59,775)	(303,635)	508.0%
423,570	0	(423,570)	0.0%	Psychiatrist FFS	3,175,931	1,559,071	(1,616,860)	(103.7%)
3,229,759	7,964,224	4,734,465	59.4%	Specialty Care FFS	27,892,256	47,640,773	19,748,517	41.5%
151,782	0	(151,782)	0.0%	Specialty Anesthesiology	1,925,365	1,061,004	(864,360)	(81.5%)
1,538,546	0	(1,538,546)	0.0%	Specialty Imaging FFS	12,935,021	6,843,037	(6,091,984)	(89.0%)
30,620	0	(30,620)	0.0%	Obstetrics FFS	306,314	181,208	(125,106)	(69.0%)
329,472	0	(329,472)	0.0%	Specialty IP Surgery FFS	3,123,278	1,679,499	(1,443,779)	(86.0%)
867,272	0	(867,272)	0.0%	Specialty OP Surgery FFS	7,930,858	4,353,452	(3,577,406)	(82.2%)
695,750	0	(695,750)	0.0%	Speciality IP Physician	5,039,605	2,543,833	(2,495,772)	(98.1%)
106,731	123,358	16,627	13.5%	Specialist FQHC FFS	989,657	1,036,456	46,799	4.5%
7,536,072	**8,087,581**	**551,509**	**6.8%**	**10. Specialty Care Physician Expense**	**66,701,856**	**66,068,968**	**(632,889)**	**(1.0%)**
(704,133)	0	704,133	0.0%	IBNR Ancillary (ANC)	4,256,969	904,191	(3,352,778)	(370.8%)

ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 28 FEBRUARY, 2025

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
(21,125)	0	21,125	0.0%	IBNR Settlement (ANC)	214,772	114,188	(100,584)	(88.1%)
(56,327)	0	56,327	0.0%	IBNR Claims Fluctuation (ANC)	504,471	236,248	(268,223)	(113.5%)
(357,844)	0	357,844	0.0%	IBNR Transportation FFS	(52,591)	207,856	260,447	125.3%
2,058,341	0	(2,058,341)	0.0%	Behavioral Health Therapy FFS	16,935,302	8,190,565	(8,744,737)	(106.8%)
2,001,246	0	(2,001,246)	0.0%	Psychologist & Other MH Prof	14,718,883	7,234,250	(7,484,633)	(103.5%)
438,823	0	(438,823)	0.0%	Other Medical Professional	3,633,308	1,865,835	(1,767,473)	(94.7%)
152,334	0	(152,334)	0.0%	Hearing Devices	1,209,470	674,558	(534,912)	(79.3%)
24,276	0	(24,276)	0.0%	ANC Imaging	317,109	228,147	(88,961)	(39.0%)
80,533	0	(80,533)	0.0%	Vision FFS	590,739	280,298	(310,441)	(110.8%)
10	0	(10)	0.0%	Family Planning	56	10	(46)	(464.6%)
512,232	0	(512,232)	0.0%	Laboratory FFS	9,257,243	6,593,456	(2,663,787)	(40.4%)
134,410	0	(134,410)	0.0%	ANC Therapist	1,190,315	644,262	(546,053)	(84.8%)
1,566,213	0	(1,566,213)	0.0%	Transp/Ambulance FFS	11,814,458	5,962,027	(5,852,431)	(98.2%)
2,384,534	0	(2,384,534)	0.0%	Non-ER Transportation FFS	18,316,483	8,526,483	(9,790,000)	(114.8%)
2,282,328	0	(2,282,328)	0.0%	Hospice FFS	18,910,969	9,250,960	(9,660,008)	(104.4%)
1,847,846	0	(1,847,846)	0.0%	Home Health Services	14,181,396	7,088,754	(7,092,643)	(100.1%)
0	14,147,930	14,147,930	100.0%	Other Medical FFS	128	56,811,277	56,811,149	100.0%
19,588	0	(19,588)	0.0%	Medical Refunds through HMS	608,770	290,192	(318,578)	(109.8%)
0	0	0	0.0%	Medical Refunds	10,037	0	(10,037)	0.0%
28,039	0	(28,039)	0.0%	DME & Medical Supplies FFS	306,820	187,833	(118,987)	(63.3%)
2,639,076	2,258,702	(380,374)	(16.8%)	ECM Base/Outreach FFS ANC	(191,304)	(505,218)	(313,913)	62.1%
70,423	98,698	28,275	28.6%	CS Housing Deposits FFS ANC	856,923	881,417	24,495	2.8%
805,030	784,216	(20,814)	(2.7%)	CS Housing Tenancy FFS ANC	5,840,074	6,362,963	522,889	8.2%
383,297	437,049	53,752	12.3%	CS Housing Navi Servic FFS ANC	3,473,132	3,669,235	196,104	5.3%
437,552	702,372	264,820	37.7%	CS Medical Respite FFS ANC	4,905,598	5,336,736	431,138	8.1%
475,917	159,244	(316,673)	(198.9%)	CS Med. Tailored Meals FFS ANC	1,941,961	1,526,974	(414,987)	(27.2%)
13,118	25,032	11,914	47.6%	CS Asthma Remediation FFS ANC	75,911	118,679	42,768	36.0%
0	9,689	9,689	100.0%	MOT Wrap Around (Non Med MOT)	0	39,949	39,949	100.0%
0	9,939	9,939	100.0%	CS Home Modifications FFS ANC	24,053	64,047	39,994	62.4%
100,115	522,703	422,588	80.8%	CS P.Care & Hmker Svcs FFS ANC	2,194,387	3,625,293	1,430,906	39.5%
2,793	19,909	17,116	86.0%	CS Cgiver Respite Svcs FFS ANC	48,949	122,347	73,398	60.0%
22,624	0	(22,624)	0.0%	CommunityBased Adult Svc(CBAS)	3,500,773	2,203,374	(1,297,400)	(58.9%)
19,687	25,000	5,313	21.3%	CS LTC Diversion FFS ANC	144,999	167,778	22,779	13.6%
0	7,427	7,427	100.0%	CS LTC Transition FFS ANC	5,003	29,992	24,989	83.3%
17,360,959	**19,207,910**	**1,846,951**	**9.6%**	**11. Ancillary Medical Expense**	**139,745,566**	**138,934,955**	**(810,611)**	**(0.6%)**
(621,260)	0	621,260	0.0%	IBNR Outpatient	5,385,652	231,629	(5,154,023)	(2,225.1%)
(18,636)	0	18,636	0.0%	IBNR Settlement (OP)	161,573	6,949	(154,624)	(2,225.1%)
(49,701)	0	49,701	0.0%	IBNR Claims Fluctuation (OP)	430,848	18,527	(412,320)	(2,225.4%)
2,181,842	11,310,404	9,128,561	80.7%	Outpatient FFS	19,706,918	56,846,245	37,139,327	65.3%
2,354,211	0	(2,354,211)	0.0%	OP Ambul Surgery FFS	21,843,741	11,593,959	(10,249,782)	(88.4%)
3,009,317	0	(3,009,317)	0.0%	Imaging Services FFS	20,641,372	10,130,403	(10,510,969)	(103.8%)
121,545	0	(121,545)	0.0%	Behavioral Health FFS	287,339	97,460	(189,879)	(194.8%)
811,679	0	(811,679)	0.0%	Outpatient Facility Lab FFS	5,889,201	2,863,424	(3,025,777)	(105.7%)
218,454	0	(218,454)	0.0%	Outpatient Facility Cardio FFS	1,659,496	844,453	(815,043)	(96.5%)
100,613	0	(100,613)	0.0%	OP Facility PT/OT/ST FFS	801,878	400,408	(401,470)	(100.3%)
2,971,782	0	(2,971,782)	0.0%	OP Facility Dialysis Ctr FFS	25,085,959	12,647,437	(12,438,522)	(98.3%)
11,079,847	**11,310,404**	**230,557**	**2.0%**	**12. Outpatient Medical Expense**	**101,893,975**	**95,680,894**	**(6,213,081)**	**(6.5%)**
222,486	0	(222,486)	0.0%	IBNR Emergency	2,187,530	(165,803)	(2,353,333)	1,419.4%
6,676	0	(6,676)	0.0%	IBNR Settlement (ER)	65,626	(4,974)	(70,600)	1,419.3%
17,798	0	(17,798)	0.0%	IBNR Claims Fluctuation (ER)	174,999	(13,266)	(188,265)	1,419.1%
8,388,169	10,220,655	1,832,486	17.9%	ER Facility	71,145,665	78,739,999	7,594,334	9.6%
1,259,187	0	(1,259,187)	0.0%	Specialty ER Physician FFS	9,744,821	4,880,392	(4,864,429)	(99.7%)
9,894,316	**10,220,655**	**326,339**	**3.2%**	**13. Emergency Expense**	**83,318,641**	**83,436,348**	**117,707**	**0.1%**
(893,046)	0	893,046	0.0%	IBNR Pharmacy (OP)	2,069,377	1,991,773	(77,604)	(3.9%)

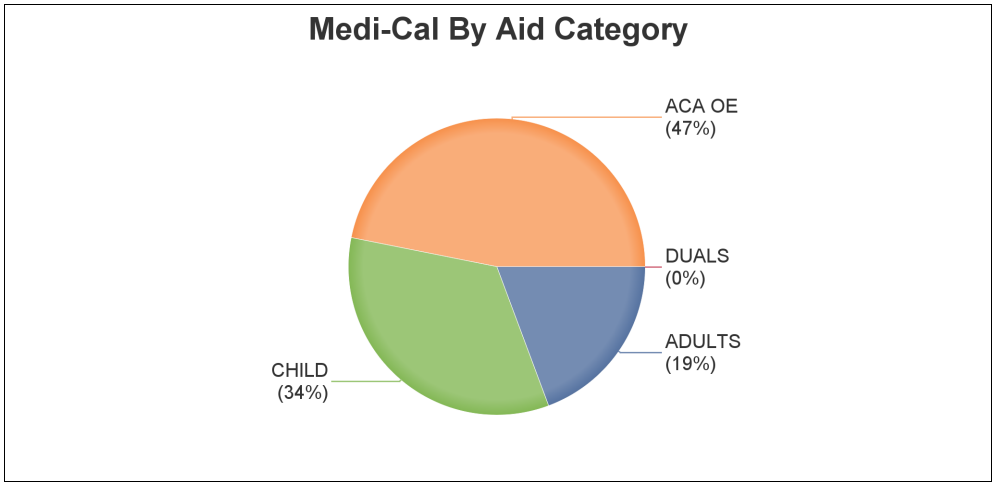
ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 28 FEBRUARY, 2025

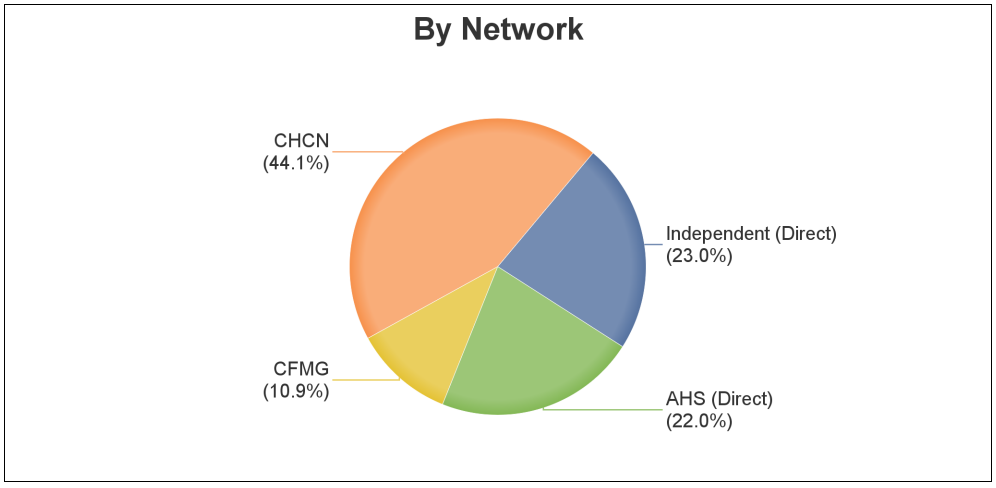
CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
(26,792)	0	26,792	0.0%	IBNR Settlement Rx (OP)	62,082	59,755	(2,327)	(3.9%)
(71,444)	0	71,444	0.0%	IBNR Claims Fluctuation Rx(OP)	165,552	159,342	(6,210)	(3.9%)
624,047	447,170	(176,877)	(39.6%)	Pharmacy FFS (OP)	5,702,318	4,876,893	(825,425)	(16.9%)
73,735	11,273,395	11,199,660	99.3%	Pharmacy Non PBM FFS Other-ANC	921,927	47,087,893	46,165,965	98.0%
7,985,512	0	(7,985,512)	0.0%	Pharmacy Non PBM FFS OP-FAC	74,616,378	39,326,556	(35,289,821)	(89.7%)
269,845	0	(269,845)	0.0%	Pharmacy Non PBM FFS PCP	1,809,444	985,563	(823,881)	(83.6%)
2,487,079	0	(2,487,079)	0.0%	Pharmacy Non PBM FFS SCP	19,348,407	10,617,727	(8,730,680)	(82.2%)
12,003	0	(12,003)	0.0%	Pharmacy Non PBM FFS FQHC	167,066	82,575	(84,491)	(102.3%)
15,258	0	(15,258)	0.0%	Pharmacy Non PBM FFS HH	154,706	91,629	(63,077)	(68.8%)
0	0	0	0.0%	RX Refunds HMS	(306)	(306)	0	0.0%
(196,014)	50,165	246,179	490.7%	Medical Expenses Pharm Rebate	(264,571)	(9,970)	254,601	(2,553.7%)
10,280,183	**11,770,730**	**1,490,547**	**12.7%**	**14. Pharmacy Expense**	**104,752,378**	**105,269,428**	**517,049**	**0.5%**
15,887,621	0	(15,887,621)	0.0%	IBNR LTC	18,107,569	(3,756,936)	(21,864,505)	582.0%
476,628	0	(476,628)	0.0%	IBNR Settlement (LTC)	543,226	(112,709)	(655,935)	582.0%
1,271,010	0	(1,271,010)	0.0%	IBNR Claims Fluctuation (LTC)	1,448,604	(300,555)	(1,749,159)	582.0%
846,049	0	(846,049)	0.0%	LTC - ICF/DD	12,523,051	6,755,726	(5,767,326)	(85.4%)
11,343,545	0	(11,343,545)	0.0%	LTC Custodial Care	185,014,806	99,683,289	(85,331,517)	(85.6%)
7,869,989	32,544,857	24,674,868	75.8%	LTC SNF	60,838,530	164,119,132	103,280,602	62.9%
37,694,842	**32,544,857**	**(5,149,985)**	**(15.8%)**	**15. Long Term Care Expense**	**278,475,786**	**266,387,946**	**(12,087,840)**	**(4.5%)**
137,106,653	**148,065,149**	**10,958,497**	**7.4%**	**16. TOTAL FFS MEDICAL EXPENSES**	**1,237,097,281**	**1,206,669,870**	**(30,427,411)**	**(2.5%)**
0	(229,865)	(229,865)	100.0%	Clinical Vacancy #102	0	(1,008,236)	(1,008,236)	100.0%
101,452	137,688	36,236	26.3%	Quality Analytics #123	1,676,931	1,738,689	61,758	3.6%
268,352	326,641	58,289	17.8%	LongTerm Services and Support #139	2,054,200	2,206,321	152,120	6.9%
872,126	846,466	(25,659)	(3.0%)	Utilization Management #140	7,752,631	7,785,220	32,589	0.4%
695,699	643,838	(51,860)	(8.1%)	Case & Disease Management #185	5,622,304	5,628,665	6,361	0.1%
262,253	798,880	536,628	67.2%	Medical Management #230	8,357,840	9,511,692	1,153,853	12.1%
1,001,866	961,703	(40,163)	(4.2%)	Quality Improvement #235	8,321,662	10,289,443	1,967,781	19.1%
328,472	368,062	39,590	10.8%	HCS Behavioral Health #238	2,604,886	2,832,945	228,060	8.1%
122,774	330,550	207,777	62.9%	Pharmacy Services #245	997,672	1,865,807	868,135	46.5%
63,703	60,586	(3,117)	(5.1%)	Regulatory Readiness #268	514,066	560,196	46,130	8.2%
3,716,696	**4,244,551**	**527,855**	**12.4%**	**17. Other Benefits & Services**	**37,902,192**	**41,410,743**	**3,508,552**	**8.5%**
(3,664,104)	(1,299,396)	2,364,708	(182.0%)	Reinsurance Recoveries	(17,382,658)	(11,957,800)	5,424,857	(45.4%)
1,688,716	1,732,528	43,812	2.5%	Reinsurance Premium	13,925,158	13,992,044	66,886	0.5%
(1,975,388)	**433,132**	**2,408,520**	**556.1%**	**18. Reinsurance Expense**	**(3,457,500)**	**2,034,243**	**5,491,743**	**270.0%**
158,960,579	**169,964,963**	**11,004,383**	**6.5%**	**20. TOTAL MEDICAL EXPENSES**	**1,413,546,038**	**1,382,343,229**	**(31,202,809)**	**(2.3%)**

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend

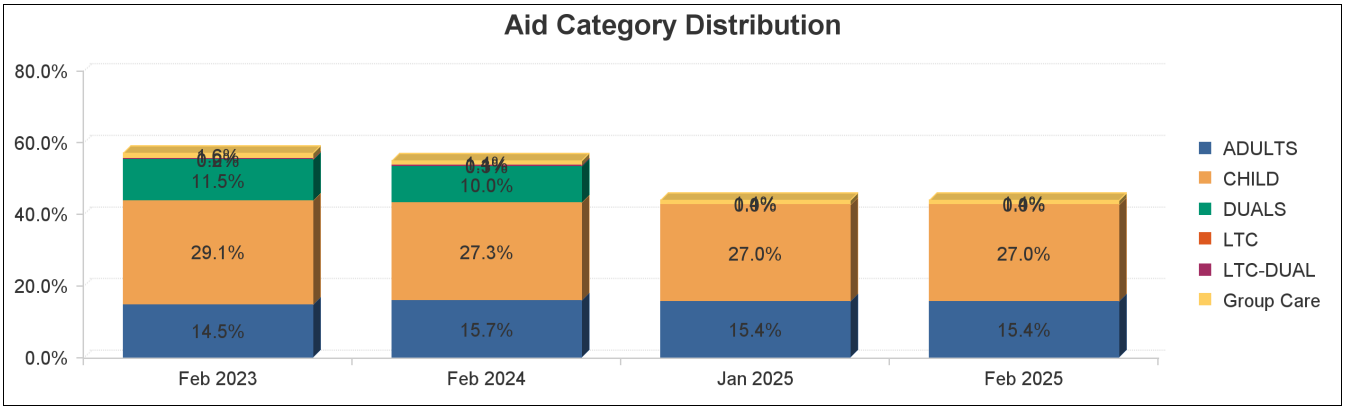
Category of Aid	Feb 2025	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN
ADULTS	63,758	16%	14,202	14,161	7	35,388
CHILD	111,576	27%	10,560	13,481	42,081	45,454
SPD	0	0%	0	0	0	0
ACA OE	154,609	38%	28,185	53,799	1,532	71,093
DUALS	2	0%	2	0	0	0
LTC	0	0%	0	0	0	0
LTC-DUAL	0	0%	0	0	0	0
SPD-LTC	29,497	7%	8,785	5,028	1,453	14,231
SPD-LTC/Full Dual	48,100	12%	30,994	3,532	6	13,568
Medi-Cal	407,542		92,728	90,001	45,079	179,734
Group Care	5,812		2,171	950	0	2,691
Total	**413,354**	**100%**	**94,899**	**90,951**	**45,079**	**182,425**
Medi-Cal %	98.6%		97.7%	99.0%	100.0%	98.5%
Group Care %	1.4%		2.3%	1.0%	0.0%	1.5%
	Network Distribution		**23.0%**	**22.0%**	**10.9%**	**44.1%**
			% Direct:	**45%**	**% Delegated:**	**55%**





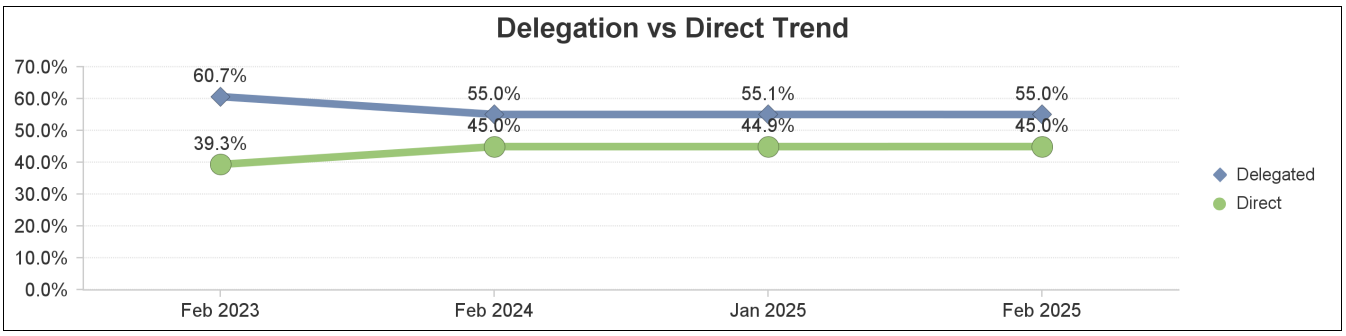
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Feb 2023	Feb 2024	Jan 2025	Feb 2025	Feb 2023	Feb 2024	Jan 2025	Feb 2025	Feb 2023 to Feb 2024	Feb 2024 to Feb 2025	Jan 2025 to Feb 2025
ADULTS	51,154	63,130	63,593	**63,758**	14.5%	15.7%	15.4%	15.4%	19.0%	1.0%	0.3%
CHILD	102,305	109,957	111,656	**111,576**	29.1%	27.3%	27.0%	27.0%	7.0%	1.5%	-0.1%
SPD	30,922	34,876	0	**0**	8.8%	8.7%	0.0%	0.0%	11.3%	0.0%	0.0%
ACA OE	120,657	146,758	154,136	**154,609**	34.3%	36.5%	37.3%	37.4%	17.8%	5.1%	0.3%
DUALS	40,334	40,403	1	**2**	11.5%	10.0%	0.0%	0.0%	0.2%	##########	50.0%
LTC	129	217	0	**0**	0.0%	0.1%	0.0%	0.0%	40.6%	0.0%	0.0%
LTC-DUAL	849	1,329	0	**0**	0.2%	0.3%	0.0%	0.0%	36.1%	0.0%	0.0%
SPD-LTC	0	0	29,566	**29,497**	0.0%	0.0%	7.2%	7.1%	0.0%	100.0%	-0.2%
SPD-LTC/ Full Dual	0	0	48,153	**48,100**	0.0%	0.0%	11.7%	11.6%	0.0%	100.0%	-0.1%
Medi-Cal	346,350	396,670	407,105	**407,542**	98.4%	98.6%	98.6%	98.6%	12.7%	2.7%	0.1%
Group Care	5,746	5,608	5,779	**5,812**	1.6%	1.4%	1.4%	1.4%	-2.5%	3.5%	0.6%
Total	**352,096**	**402,278**	**412,884**	**413,354**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**12.5%**	**2.7%**	**0.1%**



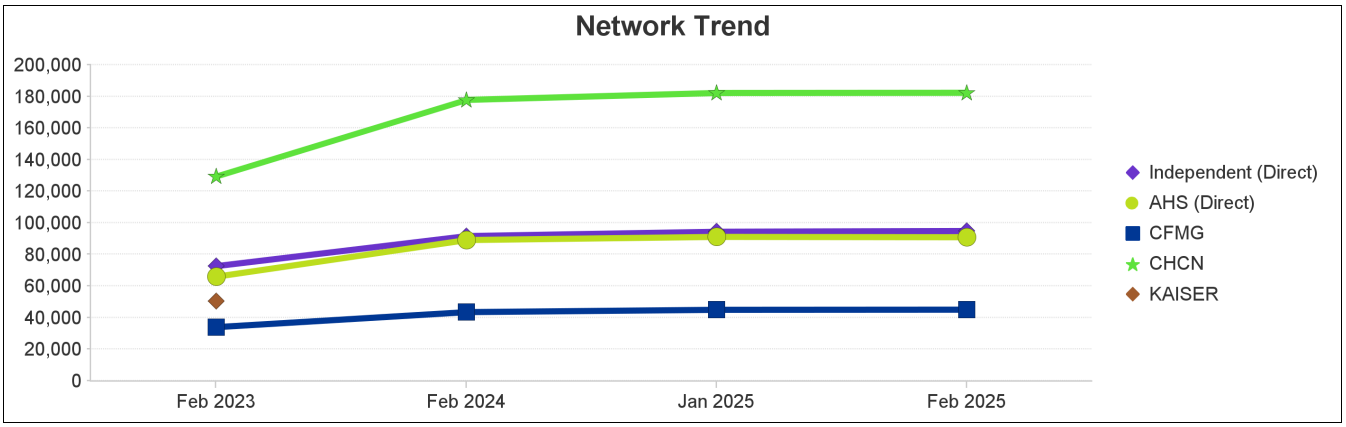
Delegation vs Direct Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	Feb 2023	Feb 2024	Jan 2025	Feb 2025	Feb 2023	Feb 2024	Jan 2025	Feb 2025	Feb 2023 to Feb 2024	Feb 2024 to Feb 2025	Jan 2025 to Feb 2025
Delegated	213,591	221,438	227,300	**227,504**	60.7%	55.0%	55.1%	55.0%	3.5%	2.7%	0.1%
Direct	138,505	180,840	185,584	**185,850**	39.3%	45.0%	44.9%	45.0%	23.4%	2.7%	0.1%
Total	**352,096**	**402,278**	**412,884**	**413,354**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**12.5%**	**2.7%**	**0.1%**



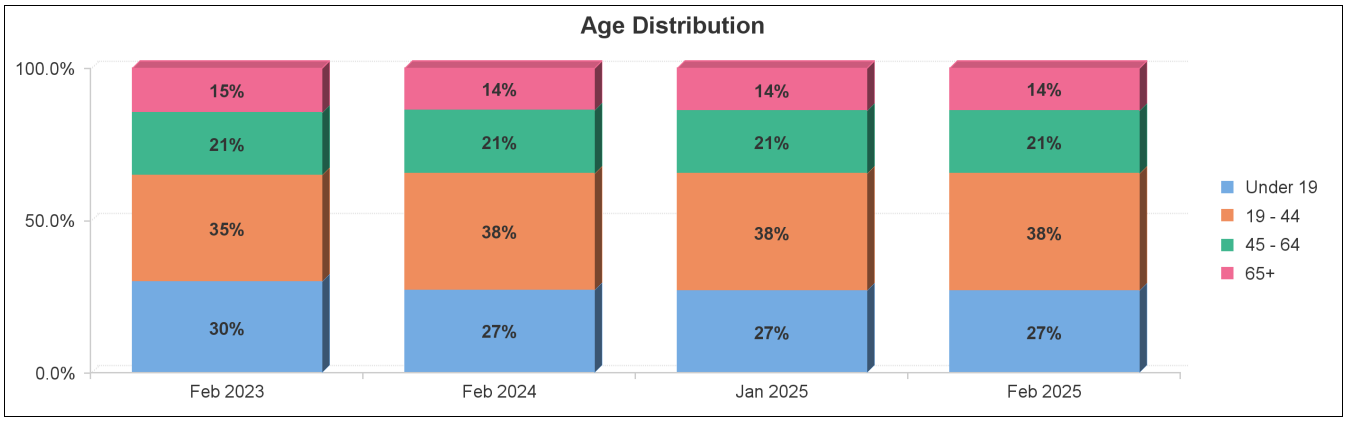
Network Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Feb 2023	Feb 2024	Jan 2025	Feb 2025	Feb 2023	Feb 2024	Jan 2025	Feb 2025	Feb 2023 to Feb 2024	Feb 2024 to Feb 2025	Jan 2025 to Feb 2025
Independent (Direct)	72,607	91,671	94,414	**94,899**	20.6%	22.8%	22.9%	23.0%	20.8%	3.4%	0.5%
AHS (Direct)	65,898	89,169	91,170	**90,951**	18.7%	22.2%	22.1%	22.0%	26.1%	2.0%	-0.2%
CFMG	33,983	43,528	44,988	**45,079**	9.7%	10.8%	10.9%	10.9%	21.9%	3.4%	0.2%
CHCN	129,269	177,910	182,312	**182,425**	36.7%	44.2%	44.2%	44.1%	27.3%	2.5%	0.1%
KAISER	50,339	0	0	**0**	14.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	**352,096**	**402,278**	**412,884**	**413,354**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**12.5%**	**2.7%**	**0.1%**



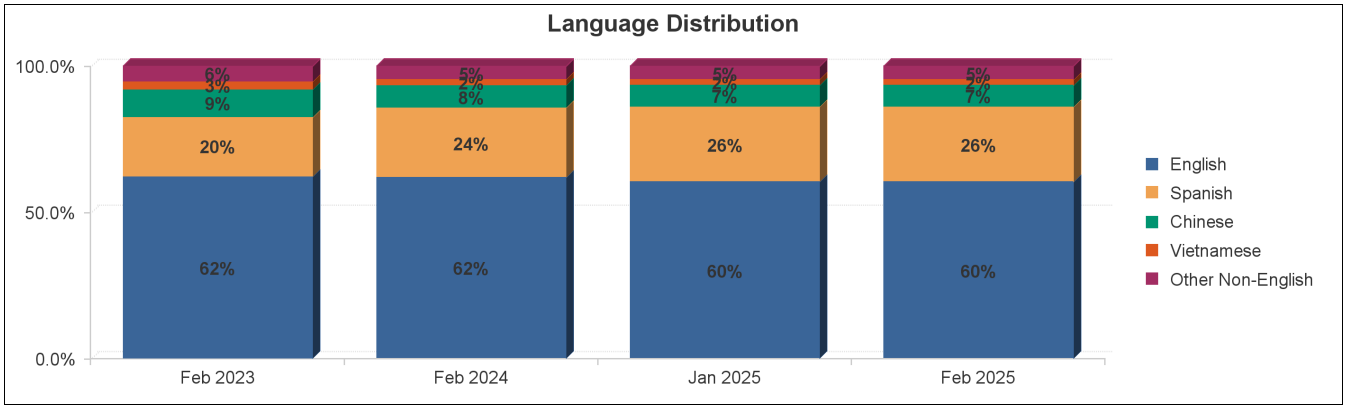
Age Category Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Feb 2023	Feb 2024	Jan 2025	Feb 2025	Feb 2023	Feb 2024	Jan 2025	Feb 2025	Feb 2023 to Feb 2024	Feb 2024 to Feb 2025	Jan 2025 to Feb 2025
Under 19	104,659	108,207	110,492	**110,599**	30%	27%	27%	27%	3%	2%	0%
19 - 44	122,990	154,277	158,893	**159,068**	35%	38%	38%	38%	20%	3%	0%
45 - 64	72,480	83,582	85,072	**85,271**	21%	21%	21%	21%	13%	2%	0%
65+	51,967	56,212	58,427	**58,416**	15%	14%	14%	14%	8%	4%	0%
Total	**352,096**	**402,278**	**412,884**	**413,354**	**100%**	**100%**	**100%**	**100%**	**12%**	**3%**	**0%**



Language Trend

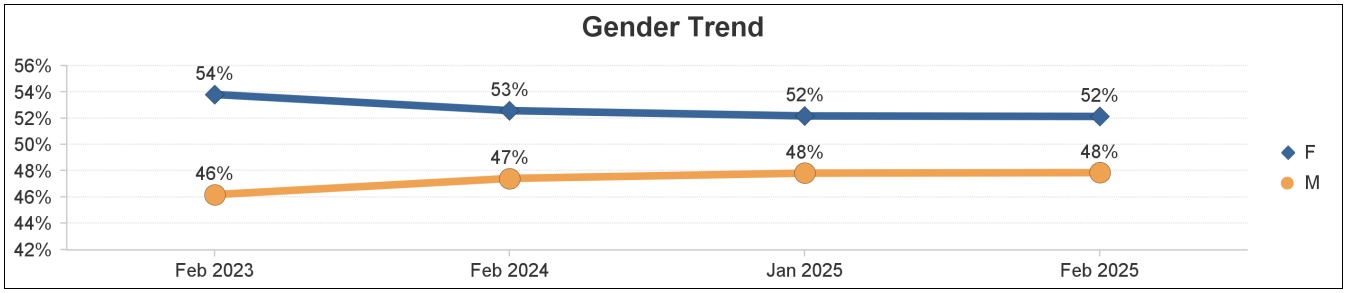
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	Feb 2023	Feb 2024	Jan 2025	Feb 2025	eb 2023	eb 2024	Jan 2025	eb 2025	Feb 2023 to Feb 2024	Feb 2024 to Feb 2025	Jan 2025 to Feb 2025
English	218,360	248,268	248,847	**248,996**	62%	62%	60%	60%	12%	0%	0%
Spanish	71,247	95,947	105,452	**105,721**	20%	24%	26%	26%	26%	9%	0%
Chinese	33,248	30,706	30,623	**30,594**	9%	8%	7%	7%	-8%	0%	0%
Vietnamese	9,714	8,516	8,263	**8,238**	3%	2%	2%	2%	-14%	-3%	0%
Other Non-English	19,527	18,841	19,699	**19,805**	6%	5%	5%	5%	-4%	5%	1%
Total	**352,096**	**402,278**	**412,884**	**413,354**	**100%**	**100%**	**100%**	**100%**	**12%**	**3%**	**0%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

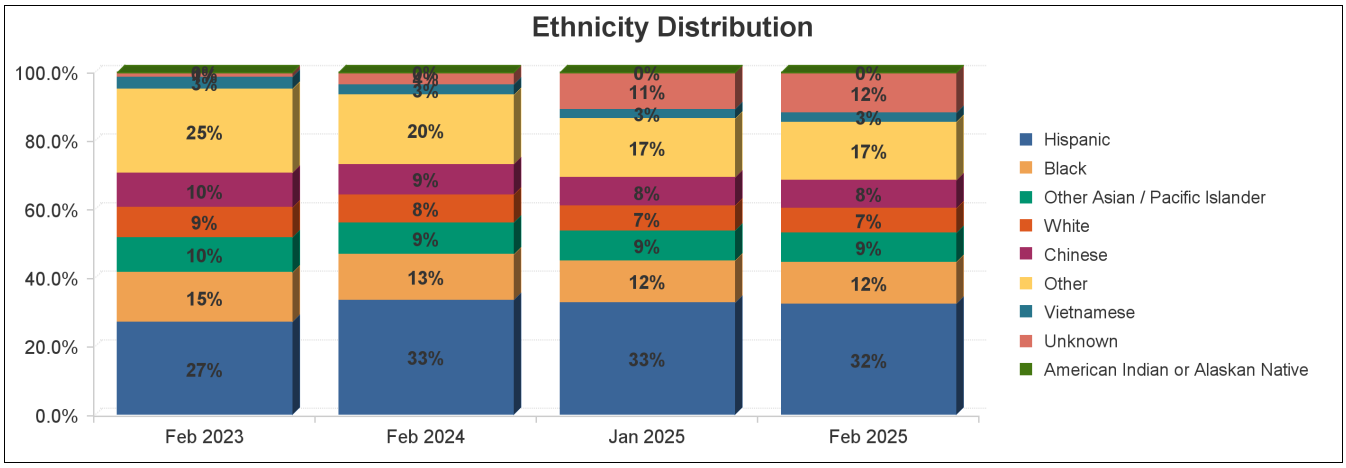
Gender Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Feb 2023	Feb 2024	Jan 2025	Feb 2025	Feb 2023	Feb 2024	Jan 2025	Feb 2025	Feb 2023 to Feb 2024	Feb 2024 to Feb 2025	Jan 2025 to Feb 2025
F	189,484	211,525	215,437	**215,525**	54%	53%	52%	52%	10%	2%	0%
M	162,612	190,753	197,447	**197,829**	46%	47%	48%	48%	15%	4%	0%
Total	**352,096**	**402,278**	**412,884**	**413,354**	**100%**	**100%**	**100%**	**100%**	**12%**	**3%**	**0%**



Ethnicity Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Feb 2023	Feb 2024	Jan 2025	Feb 2025	Feb 2023	Feb 2024	Jan 2025	Feb 2025	Feb 2023 to Feb 2024	Feb 2024 to Feb 2025	Jan 2025 to Feb 2025
Hispanic	95,061	134,527	134,750	**133,402**	27%	33%	33%	32%	29%	-1%	-1%
Black	51,086	53,620	50,793	**50,373**	15%	13%	12%	12%	5%	-6%	-1%
Other Asian / Pacific Islander	35,706	37,048	35,742	**35,321**	10%	9%	9%	9%	4%	-5%	-1%
White	31,044	32,781	30,308	**29,853**	9%	8%	7%	7%	5%	-10%	-2%
Chinese	35,508	35,685	34,193	**33,774**	10%	9%	8%	8%	0%	-6%	-1%
Other	86,361	81,682	70,977	**70,242**	25%	20%	17%	17%	-6%	-16%	-1%
Vietnamese	12,164	12,017	11,227	**11,084**	3%	3%	3%	3%	-1%	-8%	-1%
Unknown	4,437	14,108	44,135	**48,550**	1%	4%	11%	12%	69%	71%	9%
American Indian or Alaskan Native	729	810	759	**755**	0%	0%	0%	0%	10%	-7%	-1%
Total	**352,096**	**402,278**	**412,884**	**413,354**	**100%**	**100%**	**100%**	**100%**	**12%**	**3%**	**0%**



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

Medi-Cal By City

City	Feb 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	162,679	40%	25,103	42,234	17,611	77,731
HAYWARD	65,340	16%	13,942	17,940	7,687	25,771
FREMONT	38,668	9%	16,251	6,730	2,381	13,306
SAN LEANDRO	33,350	8%	8,610	5,582	4,320	14,838
UNION CITY	14,818	4%	5,805	2,649	878	5,486
ALAMEDA	13,939	3%	3,433	2,479	2,095	5,932
BERKELEY	15,764	4%	4,301	2,369	1,819	7,275
LIVERMORE	13,312	3%	1,976	568	2,273	8,495
NEWARK	9,525	2%	2,821	4,102	587	2,015
CASTRO VALLEY	9,693	2%	2,839	1,529	1,501	3,824
SAN LORENZO	7,385	2%	1,508	1,670	895	3,312
PLEASANTON	8,011	2%	2,033	397	848	4,733
DUBLIN	7,748	2%	2,207	386	921	4,234
EMERYVILLE	2,951	1%	688	611	480	1,172
ALBANY	2,590	1%	675	303	588	1,024
PIEDMONT	500	0%	129	176	79	116
SUNOL	82	0%	23	14	7	38
ANTIOCH	20	0%	5	6	2	7
Other	1,167	0%	379	256	107	425
Total	407,542	100%	**92,728**	**90,001**	**45,079**	**179,734**

Group Care By City

City	Feb 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	1,823	31%	341	364	0	1,118
HAYWARD	681	12%	320	170	0	191
FREMONT	666	11%	440	81	0	145
SAN LEANDRO	609	10%	250	88	0	271
UNION CITY	287	5%	179	42	0	66
ALAMEDA	309	5%	88	25	0	196
BERKELEY	144	2%	47	10	0	87
LIVERMORE	98	2%	29	3	0	66
NEWARK	138	2%	81	33	0	24
CASTRO VALLEY	192	3%	86	28	0	78
SAN LORENZO	142	2%	45	27	0	70
PLEASANTON	71	1%	25	3	0	43
DUBLIN	125	2%	44	5	0	76
EMERYVILLE	34	1%	12	5	0	17
ALBANY	21	0%	11	1	0	9
PIEDMONT	9	0%	1	1	0	7
SUNOL	1	0%	1	0	0	0
ANTIOCH	26	0%	7	6	0	13
Other	436	8%	164	58	0	214
Total	**5,812**	**100%**	**2,171**	**950**	**0**	**2,691**

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

Total By City

City	Feb 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	164,502	40%	25,444	42,598	17,611	78,849
HAYWARD	66,021	16%	14,262	18,110	7,687	25,962
FREMONT	39,334	10%	16,691	6,811	2,381	13,451
SAN LEANDRO	33,959	8%	8,860	5,670	4,320	15,109
UNION CITY	15,105	4%	5,984	2,691	878	5,552
ALAMEDA	14,248	3%	3,521	2,504	2,095	6,128
BERKELEY	15,908	4%	4,348	2,379	1,819	7,362
LIVERMORE	13,410	3%	2,005	571	2,273	8,561
NEWARK	9,663	2%	2,902	4,135	587	2,039
CASTRO VALLEY	9,885	2%	2,925	1,557	1,501	3,902
SAN LORENZO	7,527	2%	1,553	1,697	895	3,382
PLEASANTON	8,082	2%	2,058	400	848	4,776
DUBLIN	7,873	2%	2,251	391	921	4,310
EMERYVILLE	2,985	1%	700	616	480	1,189
ALBANY	2,611	1%	686	304	588	1,033
PIEDMONT	509	0%	130	177	79	123
SUNOL	83	0%	24	14	7	38
ANTIOCH	46	0%	12	12	2	20
Other	1,603	0%	543	314	107	639
Total	413,354	100%	**94,899**	**90,951**	**45,079**	**182,425**

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: **April 11th, 2025**

Subject: **Operations Report**

Member Services

- 12-Month Trend Blended Summary:
    - The Member Services Department received a twenty-three percent (23%) decrease in calls in March 2025, totaling seventeen thousand, two hundred fifty-six (17,256) compared to twenty-two thousand five hundred and one (22,501) in March 2024.
    - The abandonment rate for March 2025 was four percent (4%), compared to eight percent (8%) in March 2024.
    - The Department's service level was ninety-five percent (95%) in March 2025, compared to eighty three percent (83%) in March 2024. The average speed to answer (ASA) was eleven seconds (00:11) compared to forty-nine seconds (00:49) in March 2024. The Department continues to recruit to fill open positions. Customer Service support service vendor continues to provide overflow call center support.
    - The average talk time (ATT) was seven minutes and twenty-nine seconds (07:29) for March 2025 compared to seven minutes and two seconds (07:02) for March 2024.
    - One hundred percent (100%) of calls were answered within 10 minutes for March 2025 and ninety-eight percent (98%) of calls were answered within 10 minutes for March 2024.
    - Outbound calls totaled ninety-one hundred and sixty-three (9,163) in March 2025 compared to ninety-seven hundred and thirteen (9,713) in March 2024.
    - The top five call reasons for March 2025 were: 1). Change of PCP, 2). Eligibility/Enrollment, 3). Grievances/Appeals, 4). Benefits, 5). Provider Network. The top five call reasons for March 2024 were: 1). Change of PCP, 2). Eligibility/Enrollment 3). Benefits, 4). Provider Network., 5). Grievances/Appeals.
    - March utilization for the member automated eligibility IVR system totaled twelve hundred seven (1207) in March 2025 compared to sixteen hundred forty-eight (1648) in March 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 eleven hundred and eighty-six (1186) web-based requests in March 2025 compared to fourteen hundred and ninety-five (1495) in March 2024. The top three web reason requests for March 2025 were: 1). Change of PCP, 2). ID Card Requests, 3). Update Contact Information. Forty-seven (47) members were assisted in-person in March 2025 compared to thirty-two (32) in 2024.

- Member Services Behavioral Health:

  - The Member Services Behavioral Health Unit received a total of twelve hundred and fifty-five (1,255) calls in March 2025 compared to sixteen hundred and sixty-one (1,661) in March 2024.
  - The abandonment rate was five percent (5%) in March 2025 compared to twenty-six percent (26%) in 2024.
  - The service level was eighty-six percent (86%) in March 2025 and fifty-two percent (52%) in March 2024.
  - The average speed to answer (ASA) was thirty-three seconds (00:33) compared to three minutes and thirty-three seconds (03:33) in March 2024.
  - Calls answered in 10 minutes were one hundred percent (100%) in March 2025 compared to eighty-nine percent (89%) in March 2024.
  - The Average Talk Time (ATT) was eight minutes and twenty-nine seconds (08:29) compared to eighty minutes and fifty seconds (08:50) in March 2024. MS BH Team utilizes the DHCS age-appropriate screening tools for Medi-Cal Mental Health Services to determine the appropriate delivery system for members who are not currently receiving mental health services when they contact the plan.
  - Eleven hundred and forty-two (1,142) outbound calls were completed in March 2025 compared to thirteen hundred and eighty-one (1,381) in March 2024.
  - One hundred and thirty-six (136) screenings were completed in March 2025 compared to two hundred and ninety-two (192) in March 2024.

Claims

- 12-Month Trend Summary:

  - The Claims Department received 347,469 claims in March 2025 compared to 308,453 in March 2024.
  - The Auto Adjudication rate was 85.8% in March 2025 compared to 81.0% in March 2024.
  - Claims compliance for the 30-day turn-around time was 90.5% in March 2025 compared to 95.6% in March 2024. The 45-day turn-around time was 96.9% in March 2025 compared to 100% in March 2024.

- Monthly Analysis:

    - In the month of March, we received a total of 347,469 claims in the HEALTHsuite system. This represents a minimal increase from February 2025 but is 2.24% higher than the number of claims received in March 2024 by 39,016.
    - Drivers of the higher volume of claims received includes:
        - Increased membership since March 2024 (Anthem member transition; Unsatisfactory Immigration Status member transition).
        - Certain provider types that bill more frequently, e.g., LTC facilities that bill weekly or bi-weekly.
        - Providers with dual eligible members who are submitting paper claims even though we receive the same claim in our COBA file.
    - We received 89% of claims via EDI and 11% of claims via paper.
    - During the month of March, 96.9% of our claims were processed within 45 working days.
    - The Auto Adjudication rate was 85.8% for the month of March.

Provider Services

- 12-Month Trend Summary:

    - The Provider Services department's call volume in March 2025 was 8,303 calls compared to 9,033 calls in March 2024.
    - Provider Services continuously works to achieve first-call resolution and reduction of the abandonment rates. Efforts to promote provider satisfaction are our first priority.
    - The Provider Services department completed 404 calls/visits during March 2025.
    - The Provider Services department answered 6,869 calls for March 2025 and made 434 outbound calls.

Credentialing

- 12-Month Trend Summary:

    - At the Peer Review and Credentialing (PRCC) meeting held on March 18th, 2025, there were one hundred and seventy-seven (177) initial network providers approved; Five (5) primary care providers, four (4) specialists, thirteen (13) ancillary providers, three (3) midlevel providers, and one hundred and fifty-two (152) behavioral health providers. Additionally, forty-three (43) providers were re-credentialed at this meeting; fourteen (14) primary care providers, nineteen (19) specialists, two (2) ancillary providers, and eight (8) midlevel providers.

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

Provider Dispute Resolution

- 12-Month Trend Summary:
    - In March 2025, the Provider Dispute Resolution (PDR) team received 4,707 PDRs versus 1,475 in March 2024. This represents an increase of 84.5% from February 2025 and is 219% higher than the number of PDRs received in March 2024 by 3,232.
    - The PDR team resolved 1,857 cases in March 2025 compared to 1,701 cases in March 2024.
    - In March 2025, the PDR team upheld 65% of cases versus 62% in March 2024.
    - The PDR team resolved 99.5% of cases within the compliance standard of 95% within 45 working days in March 2025, compared to 99.4% in March 2024.

- Monthly Analysis:
    - The Alliance received 4,707 PDRs in March 2025.
    - In the month of March, 1,857 PDRs were resolved. Out of the 1,857 PDRs, 1,212 were upheld, and 645 were overturned.
    - 1,854 out of 1,857 cases were resolved within 45 working days, resulting in a 99.5% compliance rate.
    - The average turnaround time for resolving PDRs in March was 37 days.
    - There were 4,162 PDRs pending resolution as of 03/31/2025, with no cases older than 45 working days.
    - The overturn rate for PDRs was 35%, which did not meet our goal of 25% or less.
- The primary reason which caused the Department to miss their goal of 25% or less was:
    - Member OHC corrections – 158 cases that were denied incorrectly.
    - Authorization issues – 155 cases that were denied incorrectly (claim denied in error; authorization was on file)
    - The full breakdown of all **645** overturned PDRs is:

Category	# of Cases	% of Cases	Comments
System Related Issues	**65**	**9%**	
General configuration issues	30	4%	Non-covered code, modifier, etc.
Financial responsibility	9	1%	MNF
Claims Editing System (CES)	26	4%	
OHC Issues	**158**	**25%**	Inaccurate OHC Member TPL data
Authorization Issues	**155**	**24%**	
Processor error	100	16%	Claim denied in error; authorization was on file
UM/retro auth review	42	6%	Retro medical necessity review
Auth System error	13	2%	

Incorrect Rates	**167**	**27%**	
Incorrect rate - System	75	13%	AB1629 rate change, contract update
Letter of Agreement (LOA)	4	0%	Underpaid; LOA on file
COB calculation	19	3%	Incorrectly calculated
Incorrect rate – Processor	69	11%	The processor did not calculate the rate correctly according to the contract or rate sheet
Claim Processing Error	**63**	**10%**	
Duplicate claim	20	3%	The claim was a duplicate; the processor paid it in error
Incorrect Manual Denial	33	5%	Claim manually denied incorrectly
Overpayment	10	2%	Provider request recoupment due to overpayment
Additional Documentation	**37**	**5%**	
Provider duplicate claim	26	4%	The documentation received confirmed claim was not a duplicate
Timely filing	7	1%	The documentation received confirmed claim was submitted on time
Provider billing	4	0%	Corrected claim due to provider error
PDR Overturn Totals	**646**	**100%**	

Community Relations and Outreach

- 12-Month Trend Summary:
    - In Q3 2025, the Alliance completed 2,430 member orientation outreach calls and 312 member orientations by phone.
    - The C&O Department reached 3,628 people (61% identified as Alliance members) during outreach activities, compared to 3,777 individuals (59% identified as Alliance members) in Q3 2024.
    - The C&O Department spent $750.00 on donations, fees, and/or sponsorships, compared to $1007.10 in Q3 2024.
    - The C&O Department reached members in 20 cities/unincorporated areas throughout Alameda County, the Bay Area, and the U.S., compared to 20 cities in Q3 2024.

- Quarterly Analysis:
    - In March 2025, the C&O Department completed 732 member orientation outreach calls, 123 member orientations by phone, 44 Alliance website inquiries, 4 community events, 5 member education events, and 1 community meeting/presentation.
    - Among the 1,420 people reached, 38% identified as Alliance members.
    - The C&O Department reached members in 19 locations throughout Alameda County, the Bay Area, and the U.S.

- Monthly Analysis:
    - In March 2025, the C&O Department completed 732 member orientation outreach calls, 123 member orientations by phone, 44 Alliance website inquiries, 4 community events, 5 member education events, and 1 community meeting/presentation.
    - Among the 1,420 people reached, 38% identified as Alliance members.
    - The C&O Department reached members in 19 locations throughout Alameda County, the Bay Area, and the U.S.
    - Please see attached **Addendum A**.

Housing and Community Services Program Report – March Activities

Overview

The Housing and Community Services Program (HCSP) leads, develops, and implements a comprehensive housing and homelessness strategy for Alameda Alliance for Health (Alliance). HCSP will evaluate the current processes for members' access to the healthcare system, identify the barriers to achieving housing outcomes for members, and create a strategic plan to establish partnerships with various community stakeholders.

Project Status Updates:

- Denial Process Workflow in TruCare – in progress
- Developing Strengths, Weaknesses, Opportunities and Threats (SWOT) Analysis for the housing bundle – ongoing
- Developed Standard Operating Procedures (SOPs) for housing-related Community Supports (CS) – pending senior leadership approval
- Housing CS automation for referral eligibility – in progress
- ROI project for housing-related CS – pending review
- Developed operating definitions for reasonable and necessary criteria – pending senior leadership approval
- Housing Intranet Project – in progress
- Housing CS Authorization Guidelines – in progress
- Transitional Rent Implementation – in progress

Interdepartmental Collaborations:

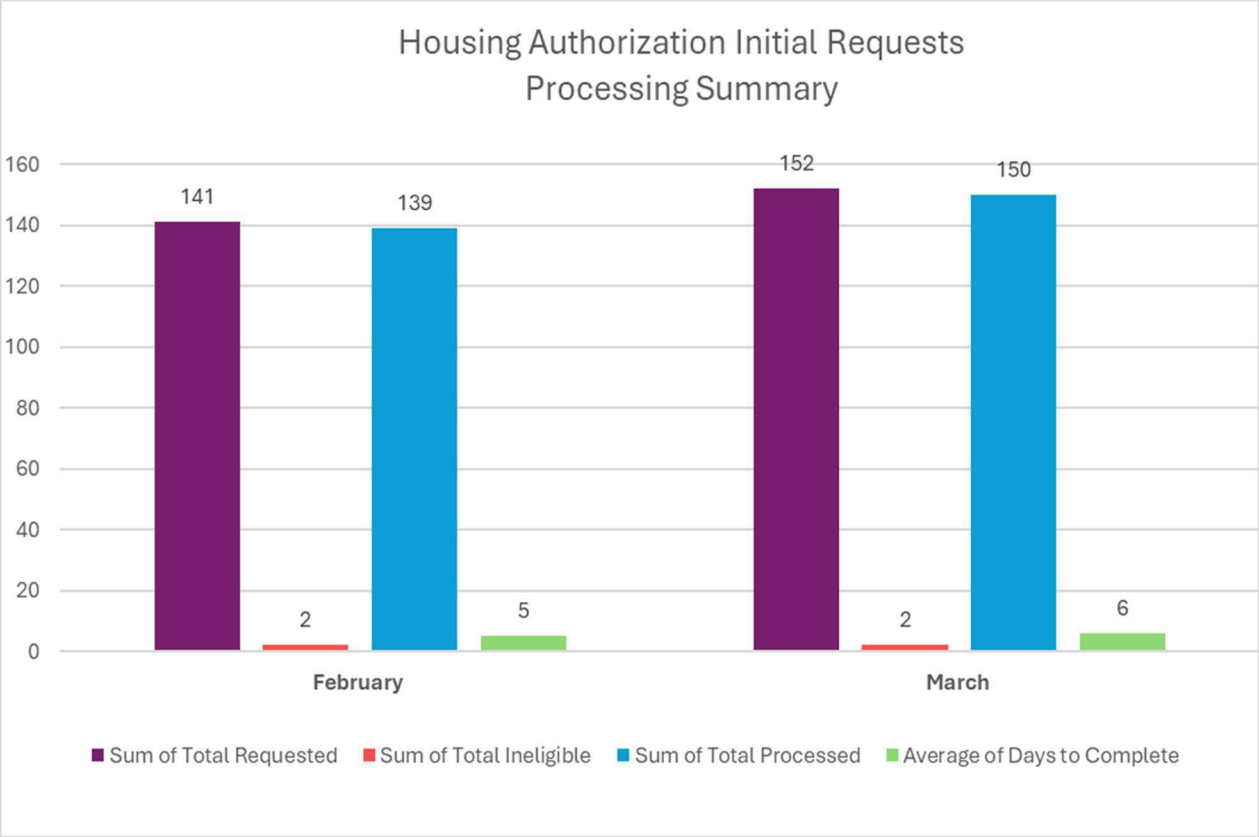
- Health Care Services and Housing Operations
    - ECM/CS Operational Efficiency Workgroup – ongoing
    - Closed Loop Referral Implementation Workgroup – in progress
    - CalAIM PATH collaborative planning – ongoing
- TruCare Steering Committee Workgroup – ongoing
- CalAIM CS Hot Topics Workgroup – ongoing
- Alameda CalAIM PATH Collaborative – ongoing
- Data Analytics Housing & Homelessness Project – completed
- Transitional Rent Implementation workgroup – in progress
- Community Advisory Committee (CAC) Housing CS presentation – completed

Community Networks and Partnership Development:

- Continued participation with various committees within Alameda County Continuum of Care (CoC), including, Racial Equity Committee, Homeless Management Information System (HMIS) Committee, and Housing Community Supports Implementation Learning Collaborative.
    - Shared projects with Alameda County CoC – Racial Equity Analysis Project for Home together plan

- Corporation for Supportive Housing Advisory Council – Transitional Rent; next meeting scheduled for 4/15/2025
- DHCS Transitional Rent Workgroup; next meeting scheduled for 04/02/2025
- National Association of Housing & Redevelopment Officials Monthly Board Meeting – ongoing
- Sacramento Briefing: CalAIM Housing Community Support Mtg – 03/12/2025

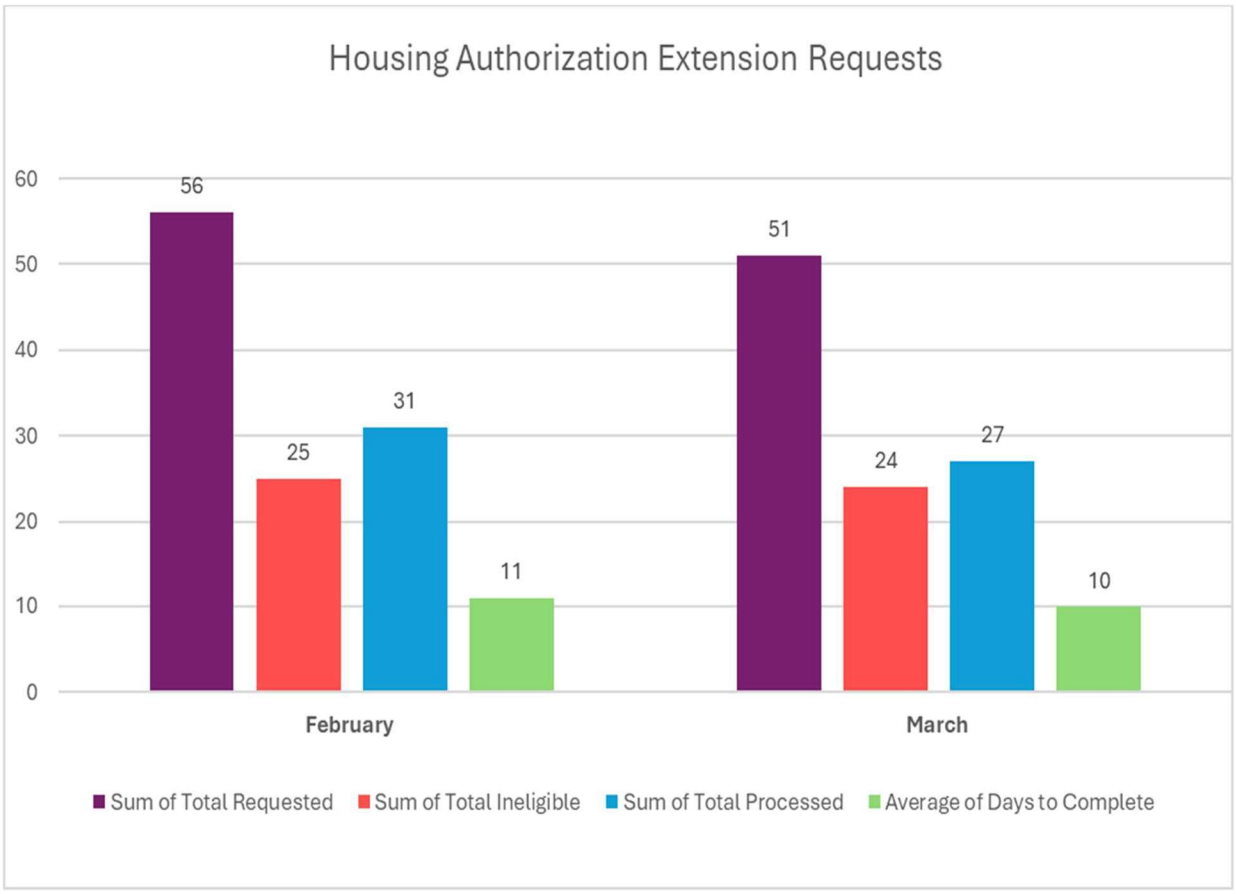
Initial Housing Authorization Requests Report:



The Initial Housing Authorization Request Report is a point-in-time report focusing on Initial Authorization completion for the Housing & Community Supports Department. The following provides an overview of Initial Authorization requests for February 2025 and March 2025:

- February 2025:
  - HCSD received four (4) batches of initial housing authorizations requests which included 141 individual requests
    - Two (2) authorizations were determined to be ineligible due to members not meeting the criteria for the service
  - The team completed 139 authorizations, with an average completion time of five (5) days per batch
- March 2025:
  - HCSD received four (4) batches of initial housing authorizations requests which included 152 individual requests
    - Two (2) authorizations were determined to be ineligible due to members not meeting the criteria for the service

- The team completed 150 authorizations with an average completion time of six (6) days per batch



- February 2025:
    - HCSD received four (4) batches of extension authorization requests which included 56 individual requests
        - 25 requests were determined to be ineligible due to members not meeting the criteria for the service
        - The team completed 31 authorization extensions, with an average completion time of 11 days
- March 2025:
    - HCSD received six (6) batches of extension authorization requests which included 179 individual requests
        - 24 requests were determined to be ineligible due to members not meeting the criteria for the service
        - The team completed 27 authorization extensions, with an average completion time of 10 days per batch
            - Please note that the March data for “total ineligible”, “total processed”, and “average days to complete” excludes a total 128 extensions submitted after March 28th. HCSD is currently on target with processing these and will report on the completion of March extensions during the next board report.

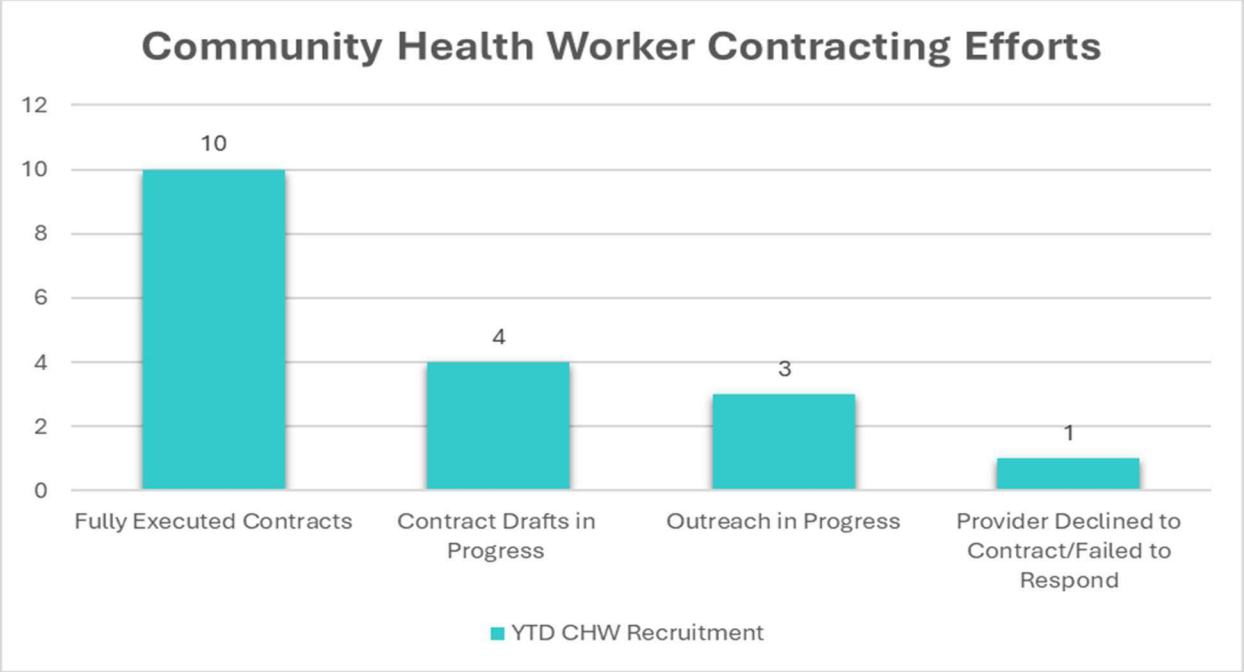
Community Health Worker Program – The Community Health Worker (CHW) Benefit aims to mitigate health disparities and improve health outcomes of Alliance members by bridging the gap between health and housing systems of care to support members' overall health and wellness through the deployment of preventative services that create positive outcomes on a member’s social determinants of health.

Project Status Updates:

- CHW Training Cohort – designed to engage public health professionals, community-based organizations, hospital partners, and other local health jurisdictions in the CHW work; go-live has been postponed
- CHW Service Request Module development – postponed
- Revise CHW strategy – in process
- CHW Billing Reports – ongoing
- DHCS CHW Emergency Department Policy updates – completed
- CHW Integration and PHM Policy updates Project – completed

CHW Program Recruitment & Outreach:

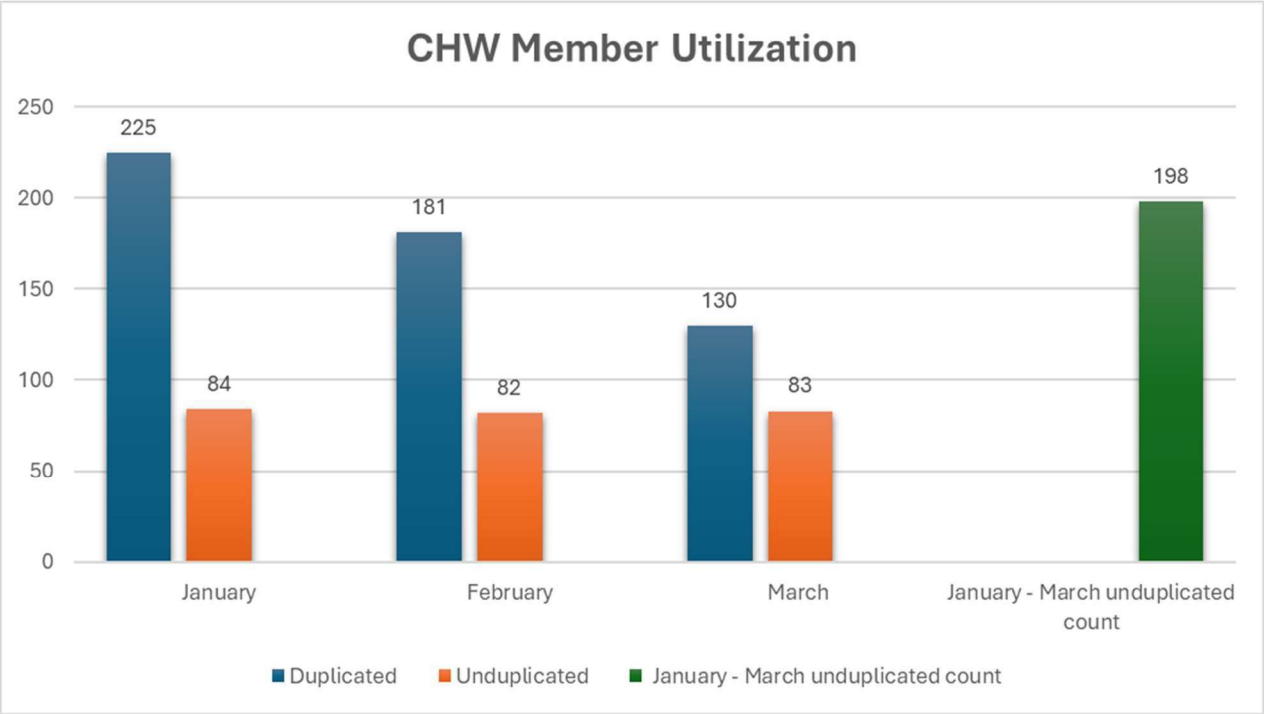
March has been a month focused on strengthening community relationships, though progress on signed Community Health Worker (CHW) contract amendments has been slower. Many community partners have expressed uncertainty regarding the evolving political landscape and are facing administrative challenges in adopting CHW billing. Currently, Alameda Alliance for Health has 10 fully executed CHW contracts, with four (4) contract drafts in progress and three (3) providers still in the outreach phase. Additionally, one (1) provider organization either declined to contract with Alameda Alliance or did not respond by the end of the reporting period.



CHW Member Utilization Snapshot

Working Definitions:

- **Duplicated:** Refers to instances where a member received CHW services more than once within the reporting period.
- **Unduplicated:** Represents the count of unique individuals who accessed CHW services, ensuring each member is counted only once, regardless of the number of visits.



The data presented reflects CHW member utilization trends from January through March 2025. A consistent decline in duplicated utilizations, i.e., instances where members received services more than once within a month, was observed over the reporting period:

- January: 225 duplicated encounters
- February: 181 duplicated encounters
- March: 130 duplicated encounters

The Alliance CHW program is actively analyzing this downward trend to explore potential correlations with reduced visit frequency per member, improved health outcomes leading to decreased service needs, or other external factors influencing utilization patterns.

At this time, there is no conclusive evidence suggesting that high duplicated service utilization should be viewed negatively. On the contrary, as Alameda Alliance introduces additional scopes of work, we anticipate being able to draw stronger connections between CHW service usage and cost-saving outcomes, such as reductions in emergency department (ED) utilization.

In contrast, unduplicated utilization reflects the number of unique individuals receiving services, which remained relatively stable throughout the three months:

- January: 84 unique members
- February: 82 unique members
- March: 83 unique members

These minimal fluctuations suggest that CHW services among the contracted provider cohort are consistently reaching members in the community. Notably, the total

unduplicated count for the quarter was 198, indicating both repeat engagement and a continuous influx of new participants accessing CHW support.

Alameda Alliance remains committed to expanding its CHW programming and increasing member engagement. Doing so will allow for a more robust dataset to assess utilization trends and better align CHW interventions with improvements in member outcomes. The Alliance CHW program has begun intentional development of a revised CHW logic model supporting a broader, integrated approach inviting deeper cross collaboration with Population Health, Health Equity, Housing, Quality, and Disease Management initiatives to use CHW services as a targeted intervention strategy to support member wellness and access to care.

Incentives & Reporting Board Report – February 2025 Activities

Current Incentive and Grant Programs

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

- The Alliance worked with Local Education Agencies (LEAs) and program partners on the Project Outcome Report (POR), which was submitted to DHCS on December 19th
    - The POR was the final SBHIP report for the entire program measurement period of January 1st, 2022, to December 31st, 2024; the Alliance is awaiting approval from DHCS, and payment is anticipated by April 2025
        - DHCS requested clarification on three (3) of the five (5) PORs on February 10th; the Alliance worked with the LEAs and Kaiser to update the PORs and responded to DHCS on February 14th
- To date, $8.9M has been awarded to the Alliance by DHCS for completed deliverables, and a total of $7.9M has been paid to LEA and SBHIP partners

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

- Total eligible dollars available to the Alliance under this program was $44M
- The Alliance earned a total of $38M based on submission of deliverables and achievement of DHCS-defined metrics
    - $22.7M has been awarded to our HHIP partners to date
- A HHIP funding opportunity was released in June 2024 to SBHIP LEAs to address the challenges of students experiencing homelessness and associated behavioral health needs (i.e., anxiety, depression, etc.)
    - The Alliance received applications from 10 LEAs totaling $1.3M in requests; all submitted applications were approved and work on the funded programs continues
- In a separate HHIP-funded initiative, the Alliance awarded $11.2M in funding to 10 community partners through a program that supports the HHIP goals of reducing and preventing homelessness
    - Projects are underway with activities taking place through 2028 related to capacity building, innovation, diversity and health equity, and housing stability

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

- Program highlights:
    - Launched on June 1st, 2024
    - 15 applications received totaling $6M in funding requests
    - $2M in funding awarded to 13 provider partners for the following:
        - Nineteen providers in total, six (6) of which are bi-lingual, including:
- Six (6) Mid-Level Providers
- Five (5) Behavioral Health Clinicians
- Five (5) MD/DOs
- Three (3) OB/GYNs

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

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

- The original funding was $700 million over five (5) years; however, due to state budget constraints, the funding was reduced to $140 million over three (3) years
- Alameda Health System was the only Alliance-associated applicant selected by DHCS to participate
- The Alliance submitted EPT MCP Practice numerators, denominators, and rates for Alameda Health System, the contracted EPT practices, for the Healthcare Effectiveness Data and Information Set (HEDIS) like key performance indicators (28 measures total) for MY 2023.

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

- Scholarships are intended to offset costs related to the following:
  - Medi-Cal Provider Application and Validation for Enrollment (PAVE)
  - Contracting and credentialing with the Alliance
  - Continued education, training, and administrative and operational support required to be a Doula
- Scholarships of up to $1,000 per person are available for Doulas both intending to contract with the Alliance and Doulas already contracted with the Alliance
- MOUs for the 20 scholarship awardees have been signed, including seven (7) awards to support currently contracted Doulas and 13 awards for Doulas that intend to contract with the Alliance
  - To-date, $8,500 of the available $20,000 in scholarships has been paid to program participants for completion of scholarship deliverables
  - The Alliance continues to receive interest in the scholarship program, although all scholarship funds have been expended
- Training materials were created and distributed to all Doulas that completed their MOUs to provide assistance with deliverable submission via the new grant software system, Submittable
  - Additional coordination is being done among internal teams to help the Doulas who intend to contract understand internal processes

Grant Program Updates

- The Incentives and Reporting team selected a grant management software system, Submittable, to support the various grant and incentive programs the Alliance participates in
  - Submittable creates an online application process for community partners, an electronic evaluation process, reporting for fund management, and awardee deliverable tracking

    - The Doula Scholarship Program application was piloted within Submittable in December and continues to be used for partner communications and deliverable tracking
- California Improvement Network (CIN) - the Alliance submitted an application on January 14th to participate in an opportunity through the California Improvement Network (CIN), which is a learning and action community that advances equitable health care experiences and outcomes for Californians through cross-sector connections, spreading good ideas, and implementing improvements
    - On March 6th, the Alliance was selected, along with 24 other partners, to participate in this two-year program
    - The Director of Health Equity will be participating in the equity focused learning network and leading project initiatives
    - There is no funding available for the initial CIN opportunity; however, it is an opportunity to partner and connect with other organizations that are also working to improve health equity
        - Those selected to participate in the above activities will be eligible to apply for a $40k action project award to support implementation efforts for partners
- The California Wellness Foundation – a meeting with The California Wellness Foundation was held on January 23rd to discuss funding opportunities and eligibility criteria; however, the Foundation confirmed in February that MCPs are not eligible for funding
    - Future funding may be attainable by partnering with a Community Based Organization (CBO) as the lead applicant
- California Endowment - a Letter of Inquiry (LOI) was submitted to the California Endowment on January 31st to be considered for their grant opportunities; a response is pending
- California Health Care Foundation – a LOI was submitted to the California Health Care Foundation on March 21st, in collaboration with support from Behavioral Health (BH) leads from Operations and Health Care Services, for two proposals focusing on the need for funding to support BH workforce needs, as well as infrastructure support for CBOs to bill for Medi-Cal
- Robert Wood Johnson – planning is underway, in collaboration with a community partner and the Alliance Health Equity and Health Care Services departments, for an application to a Robert Wood Johnson research grant
    - Funding is for a new cohort of community-led pilot studies to produce new, actionable evidence about how to help medical, social, and public health systems work together to address forms of systemic racism
- The I&R team met with First 5 Alameda County to discuss areas of need for grant funding and collaboration
- Meetings continue with internal teams such as Health Equity, Health Care Services, and Behavioral Health (clinical and operational) leads to further develop and pursue grant seeking strategies

Incentive and Grant Program Descriptions

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

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

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

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

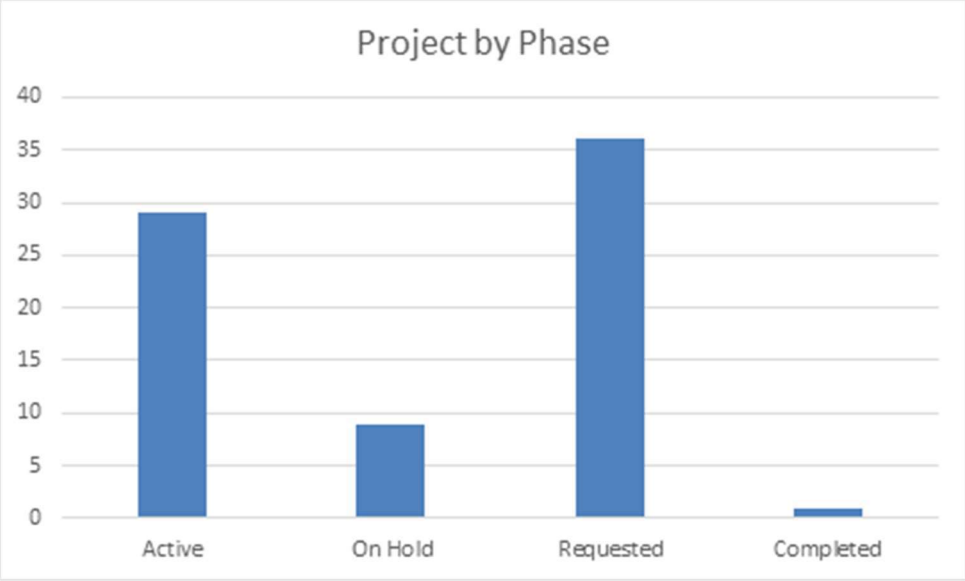
The Provider Recruitment Initiative (PRI) – program launched on June 1st, 2024, and is designed to provide grants to support the Alameda County Safety Net and community-based organizations to hire and retain healthcare professionals who serve the Alameda County Medi-Cal population. The PRI aims to grow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

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

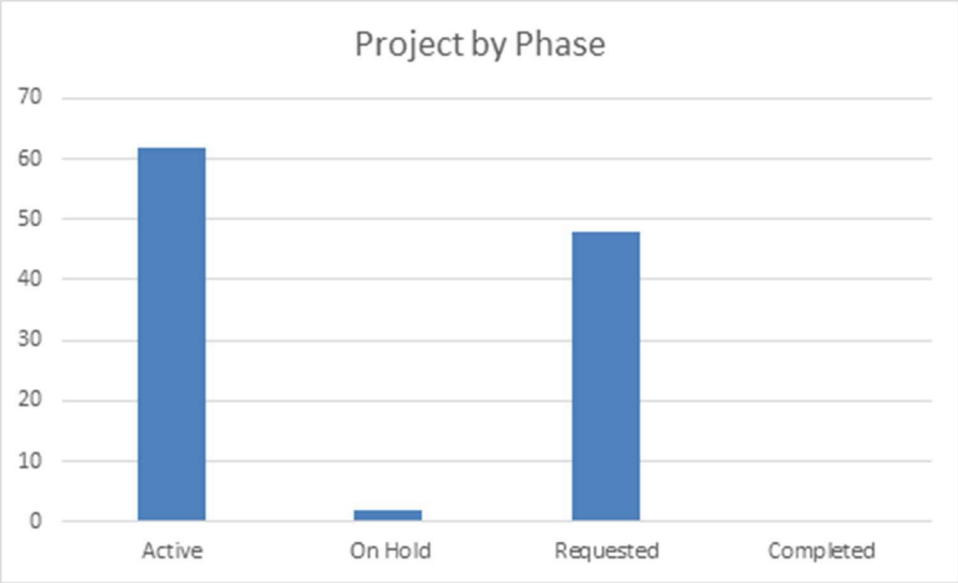
Doula Scholarship Program – program launched in December 2024 to grow the Doula provider network to increase access to these services for members.

INTEGRATED PLANNING DIVISION BOARD REPORT – FEBRUARY 2025 ACTIVITIES

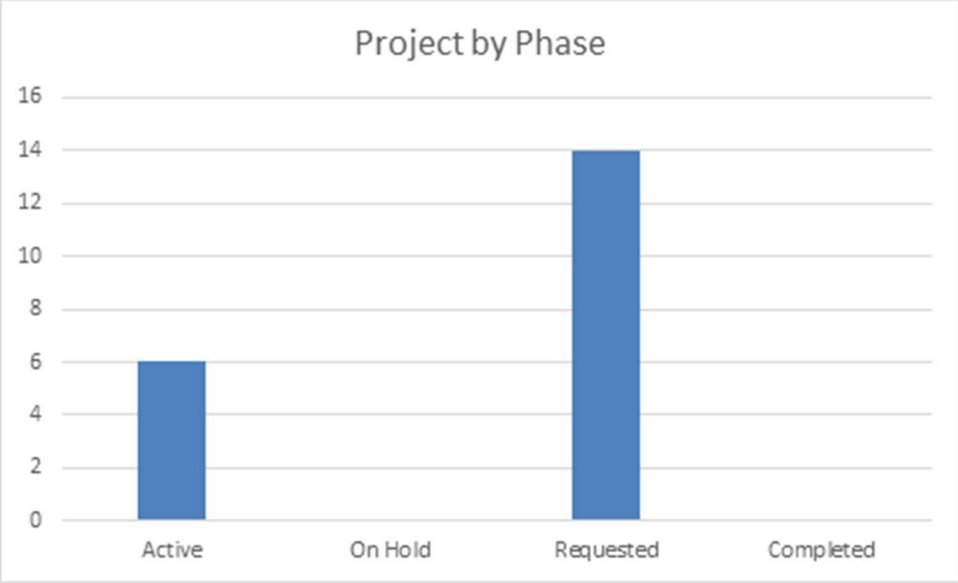
- Enterprise Portfolio
  - 74 projects currently on the Alameda Alliance for Health (AAH) enterprise-wide portfolio
    - 29 Active projects (discovery, initiation, planning, execution, warranty)
    - 9 On Hold projects
    - 36 Requested and Approved Projects
    - 1 Completed Projects (Last month)



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



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



  - D-SNP Key Initiatives and Dates
    - DMHC Material Modification Submission – MA Service Area Expansion – March 2024
    - DMHC Material Modification Submission – DSNP Product – August 2024
    - CMS Notice of Intent to Apply – November 2024

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

- D-SNP Activities – March 2025
  - Provider Services & Contracting
    - Provider Contracting
      - LOI Conversion Project
        - 19 LOIs converted to D-SNP Amendments
      - AAH passed on the 8 specialties below in the CMS application with the 10% application credit. Therefore, AAH is working on adding more providers to meet CMS network adequacy go-live w/o the 10% application credit by July 15th, 2025:
        - Gastroenterology
        - Urology
        - Acute Inpatient Hospitals
        - Critical Care Services- ICUs
        - Surgical Services (Outpatient or ASC)
        - Physical Therapy
        - Occupational Therapy
        - Speech Therapy
      - AAH is working on adding more for Inpatient Psychiatric Facility Services
        - Valley Care (Standford) signed an LOI, which will meet CMS Network Adequacy.
    - Continued Onsite D-SNP Townhall Planning for April 23, 2025
    - Provider Rates and Reimbursement
      - Work continued with Milliman on the development of Capitation Rates and Rates Analysis
  - Product
    - 5 new staff members have accepted and going through background checks
    - Completed 4 hour onsite with CHCN on March 24th.
    - Completed 1st pass with Milliman on the Bid Design
    - CMS Application submitted February 12, 2025
      - First Cure Notice received, and responses submitted on March 24, 2025.
    - CMS Bid Submission
      - Continued benefit structure design discussions with Milliman with focused review on First Pass Financial Model.
    - Continued integrated member materials requirements development for Evidence of Coverage (EOC), Summary of Benefits (SOB), and Member Letters.

- Sales
  - Continued Sales System, Hearing, and Flex Card implementation planning with Nations CRM
  - Finalized Enrollment Data file (OEC+) requirements with HEALTHsuite vendor (RAM)
  - Confirmed October 1, 2025, go live
- Vendor Management
  - Continued engagement with the following vendors to support Supplemental Benefit Offering(s)
    - Dental – in Pre-Del / Contracting
    - Vision – in Pre-Del / Contracting
    - Hearing – in Pre-Del / Contracting / Project Kickoff

- Planning – Position targeted to start April 1, 2025
  - Flex Card – in Pre-Del / Contracting / Project Kickoff
  - MTM – Contracted / Project Kickoff
  - HRA – in Pre-Del / Contracting
- Quality
  - Model of Care
    - MOC document and Matrixes submitted on February 12, 2025, with application to CMS and DHCS.
      - 4/14/25 Scoring results are uploaded by CMS to HPMS
      - 4/17/25 Cure Technical Assistance Call (CMS)
      - DHCS is currently reviewing MOC submissions. No feedback or requests for additional information received.
  - Quality Program
    - Quality Improvement Health Equity P&Ps being updated/created per business need/requirement.
    - D-SNP functions and roles being incorporated into current organization structure
    - Quality Suite and Portals (Provider and Member) requirements gathering to establish BRDs.
    - Quality Workplan review and finalization (Goals, Metrics, KPIs, and Monitoring Included)
- Health Care Services (HCS) and Behavioral Health (BH)
  - Continuing policy development and revisions (130 policies)
  - Redlining UM and CM Program Descriptions for DSNP elements
  - HRA draft was submitted to DHCS with application.
  - Continuing to finalize future State DSNP CM Global Workflow draft – Outlining process flows for new DSNP components to include Face-to-Face visit, Palliative Care Program, and Dementia Care Program

        - Continuing to define structure for California Integrated Care Management (CICM) to include new requirements outlined in the CY2026 Program Guide
        - Working with Provider Network to establish network of CBO's for CICM
        - Review and edits of existing CM and UM artifacts including assessments and notes to identify needs BH UM Future State (D-SNP) Business Process Documentation in progress – Defining program model and IT needs as this will be a new process for DSNP
        - BH CM – Proposed DSNP CM program structure.
        - Continued discussions of CBO integrations for BH CM Programs.
        - BH programs policy and procedure development and revisions underway.
        - Continuing to edit D-SNP Member and Provider letters for D-SNP additional letters created to support CMS and DHCS requirements.
        - BH UM – establishing additional levels of care for DSNP population and documenting design requirements for TruCare
        - Initial stages of collaboration outline with ACBH for carve out BH services – first meeting with ACBH occurred on 03/26/2025 with additional follow-up meetings being scheduled.

- Finance

    - Continued Finance policy review for approval at the AOC on April 16, 2025
    - Completed the following Finance training
        - Revenue and Medical Expense
        - Admin Expense / Regulatory / Budgeting and Forecasting

- Compliance
    - DMHC Material Modification – D-SNP Product (Filing #20244060)
        - Initial AAH responses submitted to DMHC on 9/9/24
        - DMHC Comment Table received 1/7/25; responses submitted 2/6/25; no further comments received from DMHC
    - Continued Compliance policy review for approval at AOC in August 2025
    - Supported development, review, and submission of D-SNP Cure Notice responses.

- Enrollment and Eligibility

- D-SNP Enrollment Form is pending approval
- Continued discussions with RAM (HEALTHsuite) and KP (AAH Print Vendor) documenting process flow and requirements

- Pharmacy
  - PBM and MTM workgroup meeting have commenced
  - PBM standard network will be adopted for AAH Part D Pharmacy benefit
  - Part D benefit design package in progress and is being led by the Operations workgroup
  - Call Center functionalities for member calls and technical calls are in progress
  - 7 Policies and Procedures were presented to AOC. There are 6 remaining Policies and Procedures to be completed/
  - Members who enroll in Part C D-SNP Plan will automatically be enrolled in Part D
  - AAH will delegate Part D appeals to PerformRx (PBM) and AAH will own Part D grievances
- Integrated Grievance and Appeals
  - Program description completed
  - Business requirements for Appeals and Grievance completed
  - CTM business requirements completed
  - 1 Policy and Procedure is in draft. Discovery for additional Policies and Procedures in process
  - Waiver of Liability process for out of network provider will be owned and managed by the Grievance and Appeals team
  - CMS 5 levels of appeal are currently being configured in Quality Suite
- Operations (Claims / Member Services / Mailroom / IVR)
  - Continue development of Claims, Member Services, Mailroom, and IVR business process and requirements
- IT
  - TruCare: Workstream meetings in progress to continue documenting system requirements for the various TruCare UM, CM and Core functions. Finalizing mapping specifications to loading DM Care Opportunities data.
  - HEALTHsuite: Workstream sessions are in progress. RAM provided with 4 options for Plan Structure. IT confirmed Plan Structure decision, Senior Leadership approval pending. Enrollment Letters configuration is in progress. Enrollment Testing strategy reviewed with RAM team.
  - QualitySuite: Upgrade moved to April 4 as UAT is still in progress. Grievances and Appeals (G&A) – requirements complete. Appeals requirements out for approval. Appeals reporting requirements in progress.
- Stars

- Phase 1 of Star strategy is 50% complete
  - Phase 1 is defined as HEDIS measures already supported under the Medi-Cal line of business and Operational measures that will impact Star ratings on day 1.
  - Review of initiatives for the HEDIS measures supported in the Medi-Cal line of business and Operational measures that will impact Star ratings on day 1 has been completed.
  - Process flow documentation for the measures is underway with Quality, Healthcare Services, and Analytics.
- We will plan to implement foundational initiatives to support Star gap closure.
  - TruCare Star gap integration – This is ongoing.
  - Pay-for-Performance and Pay-for-Reporting program – This is ongoing. Confirmed with CHCN that they will not have their own P4P Program.
  - EMR Data feeds – This is already in production and will be slightly modified to ensure support for D-SNP measures.
  - Prospective Chart Review – This is already in production and will be slightly modified to ensure support for D-SNP measures.

CalAIM Initiatives:

- Community Supports (CS):
  - Due to Budget Constraints, all CS enhancement and expansion are on hold.
- Justice-Involved (JI) Initiative:
  - CalAIM Re-entry
    - Correctional facilities go-live date for pre-release services is determined based on DHCS readiness assessment and will go-live with pre-release services within a 24-month phase in period. (10/1/2024 – 9/30/2026)
      - Santa Rita Jail is targeting to go-live on 7/1/2026 with pre-release services; Juvenile Justice Center's go-live is TBD.
      - Managed Care Plans (MCPs) must be prepared to coordinate with correctional facilities as of October 1st, 2024, even if facilities in their county will go-live later.
      - JI project team is developing a contact list for the counties going live with pre-release to support coordination of referrals for any AAH members being released from these counties.
    - DHCS has indicated they intend to release a revised JI Policy Guide; impacts to project scope and schedule will be assessed once this is released.

        - DHCS JI Learning Collaboratives initiated in August and continues through January 2025. These collaborative sessions include correctional facilities, county behavioral health agencies, probation, managed care plans, and ECM providers.
        - On 10/28, AAH SLT approved to place CalAIM JI Re-Entry project on hold until July 2025 to await final policy guide from DHCS and give Alameda County partners time to develop their internal processes and readiness.
- AAH/Roots JI Pilot Project:
    - Project closeout processes are in progress and expected to close the project on 12/6.

- CYBHI Fee Schedule – Effective January 1st, 2024, the Alliance is partnering with Carelon (formerly known as Beacon) to implement the CYBHI Fee Schedule.
    - Cohort 1 is intended to be a "learning" cohort
    - DHCS continues holding a series of meetings with Cohort participants; these include Onboarding Sessions for the LEAs as well as Technical Office Hours each Thursday of the month
        - The meetings held have been heavily focused on the LEA process
    - The Alliance will utilize Carelon as the Third-Party Administrator (TPA)
    - The Claims submission date has been extended from April 1, 2024, to July 1, 2024
        - It may not be true that all MCPs or LEAs have systems set up however, LEAs may submit claims for up to 180 days from the date of service.
        - Claims may be submitted retroactively back to July 1st, 2024, as long as it is submitted by end of the year
    - MCP/DHCS/Carelon weekly workgroup meetings cancelled 3/7 & 3/14 due to DHCS resource constraints
- MOU
    - Interim Model document reviewed by AAH Stakeholders.
    - Awaiting final Interim Model MOU as it has been in review with CDI and DMHC for review and feedback.
        - No further feedback or edits will be accepted after this version is published
        - ASO Model MOU is expected to be published shortly after
    - Policy Guide/APL must be reviewed by CDI and DMHC before submitting to stakeholders for review, feedback and finalization. Date not provided

Recruiting and Staffing

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

Integrated Planning

Ruth Watson

Integrated Planning

Supporting Documents Project Descriptions

Key projects currently in-flight:

- California Advancing and Innovating Medi-Cal (CalAIM) – program to provide targeted and coordinated care for vulnerable populations with complex health needs.
    - Enhanced Care Management (ECM) – ECM will target eight (8) specific populations of vulnerable and high-risk children and adults
        - Three (3) Populations of Focus (PoF) transitioned from HHP and/or WPC on January 1st, 2022
        - Two (2) additional PoF became effective on January 1st, 2023
        - One (1) PoF became effective on July 1st, 2023
        - Two (2) PoF became effective on January 1st, 2024
    - *Restarting in July 2025* - Justice Involved Initiative – adults and children/youth transitioning from incarceration or juvenile facilities will be enrolled into Medi-Cal upon release
        - DHCS is finalizing policy and operational requirements for MCPs to implement the CalAIM Justice-Involved Initiative
            - MCPs must be prepared to go live with ECM for the Individuals Transitioning from Incarceration as of January 1st, 2024
            - MCPs must be prepared to coordinate with correctional facilities to support reentry of members as the return to the community by October 1st, 2024
            - Correctional facilities will have two years from 10/1/2024-9/30/2026 to go live based on readiness
    - Dual Eligible Special Needs Plan (D-SNP) Implementation – All Medi-Cal MCPs will be required to operate Medicare Medi-Cal Plans (MMPs), the California-specific program name for Exclusively Aligned Enrollment Dual Eligible Special Needs Plans (EAE D-SNPs) by January 2026 to provide better coordination of care and improve care integration and person-centered care. Additionally, this transition will create both program and financial alignment, simplify administration and billing for providers and plans, and provide a more seamless experience for dual eligible beneficiaries by having one plan manage both sets of benefits for the beneficiary.

- CYBHI Statewide Fee Schedule – The Department of Health Care Services (DHCS), in collaboration with the Department of Managed Health Care (DMHC), has developed and a multi-payer, school-linked statewide fee schedule for outpatient mental health or substance use disorder services provided to a student 25 years of age or younger at or near a school site. CYBHI requires commercial health plans and the Medi-Cal delivery system, as applicable, to reimburse, at or above the published rates, these school-linked providers, regardless of network provider status, for services furnished to students pursuant to the fee schedule. Effective January 1st, 2024, the Alliance is partnering with the Alameda County Office of Education (ACOE) and several Local Education Agencies (LEAs) who were selected to participate in the CYBHI Fee Schedule Cohort 1.

Operations

Supporting Documents

Member Services

Blended Call Results

Blended Results	March 2025
Incoming Calls (R/V)	17,256
Abandoned Rate (R/V)	4%
Answered Calls (R/V)	16,497
Average Speed to Answer (ASA)	00:11
Calls Answered in 30 Seconds (R/V)	95%
Average Talk Time (ATT)	07:29
Calls Answered in 10 minutes	100%
Outbound Calls	9,163

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

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

MSBH	March 2025
Incoming Calls (R/V)	1255
Abandoned Rate (R/V)	5%
Answered Calls (R/V)	1190
Average Speed to Answer (ASA)	00:38
Calls Answered in 30 Seconds (R/V)	86%
Average Talk Time (ATT)	08:29
Calls Answered in 10 minutes	100%
Outbound Calls	1142
Screenings Completed	136
ACBH Referrals	36
SUD referrals to Center Point	12

Claims Department
February 2025 Final and March 2025 Final

METRICS

Claims Compliance	Feb-25	Mar-25
90% of clean claims processed within 30 calendar days	91.7%	90.5%
95% of all claims processed within 45 working days	94.9%	96.9%
Claims Volume (Received)	**Feb-25**	**Mar-25**
Paper claims	34,889	37,076
EDI claims	304,951	310,393
Claim Volume Total	**339,840**	**347,469**
Percentage of Claims Volume by Submission Method	**Feb-25**	**Mar-25**
% Paper	10.27%	10.67%
% EDI	89.73%	89.33%
Claims Processed	**Feb-25**	**Mar-25**
HEALTHsuite Paid (original claims)	223,831	243,052
HEALTHsuite Denied (original claims)	75,164	84,743
HEALTHsuite Original Claims Sub-Total	**298,995**	**327,795**
HEALTHsuite Adjustments	4,835	7,839
HEALTHsuite Total	**303,830**	**335,634**
Claims Expense	**Feb-25**	**Mar-25**
Medical Claims Paid	$124,917,616	$143,774,747
Interest Paid	$178,657	$148,561
Auto Adjudication	**Feb-25**	**Mar-25**
Claims Auto Adjudicated	256,648	281,086
% Auto Adjudicated	85.8%	85.8%
Average Days from Receipt to Payment	**Feb-25**	**Mar-25**
HEALTHsuite	16	17
Pended Claim Age	**Feb-25**	**Mar-25**
0-30 calendar days	46,504	44,970
HEALTHsuite		
31-61 calendar days	37,124	22,786
HEALTHsuite		
Over 62 calendar days	32,723	49,196
HEALTHsuite		

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

Overall Denial Rate	Feb-25	Mar-25
Claims denied in HEALTHsuite	75,164	84,743
% Denied	24.7%	25.2%

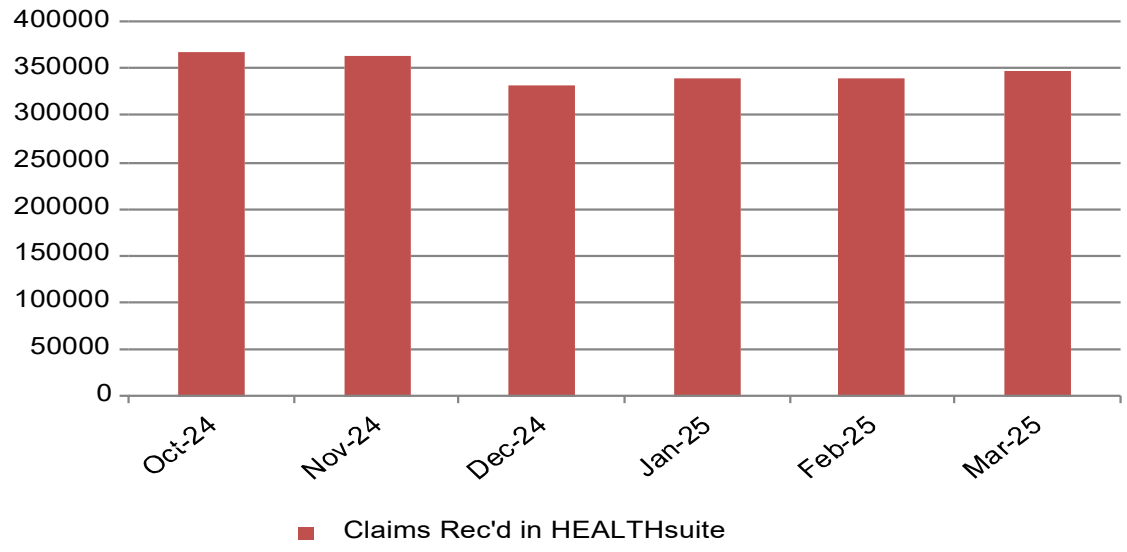
Claims Department
February 2025 Final and March 2025 Final

Mar-25

Top 5 HEALTHsuite Denial Reasons	% of all denials
Responsibility of Provider	23%
No Benefits Found For Dates of Service	13%
Must Submit Paper Claim With Copy of Primary Payor EOB	12%
Non-Covered Benefit For This Plan	12%
Duplicate Claims	7%
%Total of all denials	**67%**

Claims Received By Month

Run Date	11/1/2024	12/1/2024	1/1/2025	2/1/2025	3/1/2025	4/1/2025
Claims Received Through	**Oct-24**	**Nov-24**	**Dec-24**	**Jan-25**	**Feb-25**	**Mar-25**
aims Rec'd in HEALTHsuite	367,989	364,130	332,108	339,760	339,840	347,469



Claims Year Over Year Summary		
Monthly Results	**Regulatory Requirement**	**AAH Goal**
Claims Compliance - comparing March 2025 to March 2024 as follows: 30 Days - 90.5% (2025) vs 95.6% (2024) 45 Days - 96.9% (2025) vs 100% (2024) 90 Days - 99.9% (2025) vs 99.9% (2024)	90% of clean claims in 30 calendar days 95% of all claims in 45 working days 99% of all claims in 90 calendar days	90% of clean claims in 30 calendar days 95% of all claims in 45 working days 99% of all claims in 90 calendar days
Claims Received - AAH received 347,469 claims in March 2025 vs 308,453 in March 2024	N/A	N/A
EDI - the volume of EDI submissions was 85.8% which falls within ~~exceeded~~ our normal month to month range of ~77% - 87%	N/A	N/A
Original Claims Processed - AAH processed 327,795 in March 2025 (21 working days) vs 228,860 in March 2024 (21 working days)	N/A	N/A
Medical Claims Expense - the amount of paid claims in March 2025 was $143,774,747 (4 check runs) vs $110,283,537 in March 2024 (4 check runs)	N/A	N/A
Interest Expense - the amount of interest paid in March 2025 was $148,561 vs $62,198 in March 2024	N/A	.05% - .075% of the monthly medical expense
Auto Adjudication - the AAH rate in March 2025 was 85.8% vs 81.0% in March 2024	N/A	85% or higher
Average Days from Receipt to Payment - the average # of days from receipt to payment in March 2025 was 16 days vs 14 days in March 2024	N/A	<= 25 days
Pended Claim Age - comparing March 2025 to March 2024 as follows: 0-30 calendar days - 44,970 (2025) vs 32,840 (2024) 31-61 calendar days - 22,786 (2025) vs 1,122 (2024) Over 62 calendar days - 49,196 (2025) vs 24 (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 March 2025 to March 2024	N/A	N/A

Provider Relations Dashboard March 2025

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

Provider Relations Dashboard March 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%									
Benefits	5.1%	3.7%	3.4%									
Claims Inquiry	39.4%	43.9%	43.7%									
Change of PCP	2.5%	2.7%	2.4%									
Check Tracer	0.7%	0.6%	1.0%									
Complaint/Grievance (includes PDR's)	5.8%	6.7%	6.8%									
Contracts/Credentialing	0.8%	0.8%	0.7%									
Demographic Change	0.0%	0.0%	0.0%									
Eligibility - Call from Provider	21.0%	17.4%	17.0%									
Exempt Grievance/ G&A	0.0%	0.1%	6.8%									
General Inquiry/Non member	0.0%	0.0%	0.0%									
Health Education	0.0%	0.0%	0.0%									
Intrepreter Services Request	0.5%	0.5%	0.6%									
Provider Portal Assistance	3.4%	3.2%	3.9%									
Pharmacy	0.1%	0.2%	0.1%									
Prop 56	0.1%	0.0%	0.0%									
Provider Network Info	0.0%	0.0%	0.0%									
Transportation Services	0.0%	0.2%	0.2%									
Transferred Call	0.0%	0.0%	0.0%									
All Other Calls	15.5%	14.4%	7.9%									
TOTAL	100.0%	100.0%	100.0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Field Visit Activity Details

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

ALLIANCE NETWORK SUMMARY, CURRENTLY CREDENTIALED PRACTITIONERS - March 2025						
Practitioners		PCP 395	SPEC 759	AHP 654	BH/ABA 2,774	PCP/SPEC 12
Direct Network vs Delegated Network Breakdown			AAH 3,351	AHS 296	CHCN 610	COMBINATION OF GROUPS 337
Facilities	436					

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	122	2	Y	Y	Y
Recred Files in Process	15	0	Y	Y	Y
Expirables updated **Insurance, License, DEA, Board Certifications**					Y
Files currently in process	**137**				
		*** 25 business days = 35 calendar days**			

March 2025 Peer Review and Credentialing Committee Approvals	
Initial Credentialing	**Number**
PCP	5
SPEC	4
ANCILLARY	13
MIDLEVEL/AHP	3
BH/ABA	152
Sub-total	**177**
Recredentialing	
PCP	14
SPEC	19
ANCILLARY	2
MIDLEVEL/AHP	8
Sub-total	**43**
TOTAL	**220**

March 2025 Facility Approvals	
Initial Credentialing	5
Recredentialing	12
Sub-total	**17**
Facility Files in Process	**42**

March 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
Afsari	Peter	BH-Telehealth	INITIAL	3/18/2025
Ali	Ziad	BH-Telehealth	INITIAL	3/18/2025
Ali Leger	Sabrina	BH-Telehealth	INITIAL	3/18/2025
Alinejad	Behrod	BH-Telehealth	INITIAL	3/18/2025
Aljayeh	Mohsen	Specialist	INITIAL	3/18/2025
Aniol	Ania	BH-Telehealth	INITIAL	3/18/2025
Ayala	Lindsey	BH-Telehealth	INITIAL	3/18/2025
Barman	Rajdip	BH	INITIAL	3/18/2025
Bautista	Cynthia	BH	INITIAL	3/18/2025
Belmonte Aguilar	Jesus	ABA-Telehealth	INITIAL	3/18/2025
Bencito	Nicole	BH-Telehealth	INITIAL	3/18/2025
Bryant	Tiffany	Allied Health	INITIAL	3/18/2025
Bustos	Erica	ABA-Telehealth	INITIAL	3/18/2025
Cai	Sheila	BH-Telehealth	INITIAL	3/18/2025
Carroll	Revital	Doula	INITIAL	3/18/2025
Chaudhry	Natasha	ABA-Telehealth	INITIAL	3/18/2025
Chen	Peter	ABA	INITIAL	3/18/2025
Chiaji	Kairis	Doula	INITIAL	3/18/2025
Chiriac	Irinel	BH-Telehealth	INITIAL	3/18/2025
Choudry	Sabah	BH-Telehealth	INITIAL	3/18/2025
Chung	Rose Mae	BH-Telehealth	INITIAL	3/18/2025
Churchill	Cynthia	BH-Telehealth	INITIAL	3/18/2025
Clark	Carolyn	BH-Telehealth	INITIAL	3/18/2025
Cohen	Samantha	BH	INITIAL	3/18/2025
Cohen	Scott	BH	INITIAL	3/18/2025
Cologne	Scott	BH-Telehealth	INITIAL	3/18/2025
Colon	Aryana	ABA-Telehealth	INITIAL	3/18/2025
Cotter	Meaghan	BH-Telehealth	INITIAL	3/18/2025
Cox	Paul	BH-Telehealth	INITIAL	3/18/2025
Crawford	Dana	ABA	INITIAL	3/18/2025
Dearring	F'tyna	Allied Health	INITIAL	3/18/2025
Dietrich	Eloisa	BH-Telehealth	INITIAL	3/18/2025
DiManno	Natalie	BH-Telehealth	INITIAL	3/18/2025
Din	Angela	BH-Telehealth	INITIAL	3/18/2025
Donaldson-Fletch	Katherine	Allied Health	INITIAL	3/18/2025
Dougherty	Heather	BH-Telehealth	INITIAL	3/18/2025
Dougherty	Joshua	BH-Telehealth	INITIAL	3/18/2025
Dubin	Jorge	BH-Telehealth	INITIAL	3/18/2025
Duchock	Diedra	BH-Telehealth	INITIAL	3/18/2025
Duprey	Amy	Doula	INITIAL	3/18/2025
Edmonds	Jadea	Doula	INITIAL	3/18/2025
Favela	Sagrario	ABA-Telehealth	INITIAL	3/18/2025
Fayyaz	Farzook	BH-Telehealth	INITIAL	3/18/2025
Ferguson	Traci	BH-Telehealth	INITIAL	3/18/2025
Flowers	Lynessa	Doula	INITIAL	3/18/2025
Freeman	Nia	ABA-Telehealth	INITIAL	3/18/2025
Garcia	Erika	BH-Telehealth	INITIAL	3/18/2025
Gardner	Lakeyla	BH	INITIAL	3/18/2025
Gardner	Shalesse	BH-Telehealth	INITIAL	3/18/2025
Garnelo	Daisy	ABA-Telehealth	INITIAL	3/18/2025
Gill	Amanjot	BH-Telehealth	INITIAL	3/18/2025
Gonzalez	Stephen	BH-Telehealth	INITIAL	3/18/2025
Haider	Syeda Razia	BH-Telehealth	INITIAL	3/18/2025
Hakami	Mustafa	BH-Telehealth	INITIAL	3/18/2025
Herrera Ramirez	Josefina	BH-Telehealth	INITIAL	3/18/2025

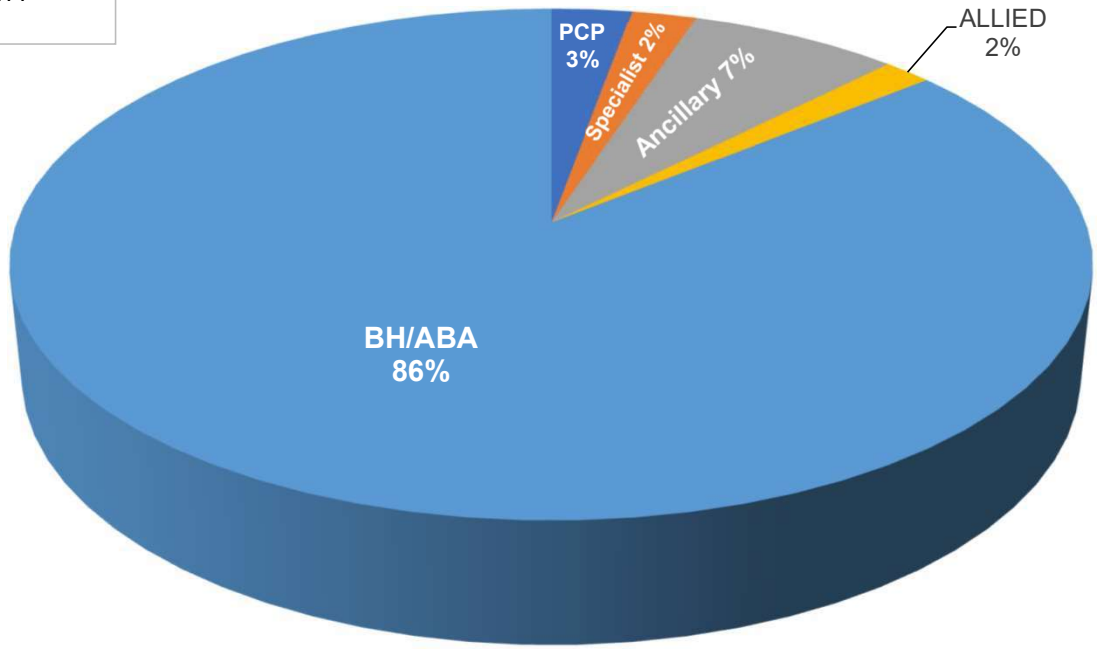
LAST_NAME	FIRST_NAME	CATEGORY	INITIAL/RE-CRED	CRED_DATE
Hicks	Elena	BH	INITIAL	3/18/2025
Hiranandani	Nitisha	Primary Care Physician	INITIAL	3/18/2025
Hla	Ni-Ni	BH-Telehealth	INITIAL	3/18/2025
Holloway	Kimberly	BH-Telehealth	INITIAL	3/18/2025
Hopkins	Lauren	BH-Telehealth	INITIAL	3/18/2025
Horrocks	Amanda	BH-Telehealth	INITIAL	3/18/2025
Hoye	Mary	BH-Telehealth	INITIAL	3/18/2025
Huffman	Heidi	BH-Telehealth	INITIAL	3/18/2025
Hutchinson	April	BH-Telehealth	INITIAL	3/18/2025
Huthsteiner	Conny	BH-Telehealth	INITIAL	3/18/2025
Island	Rosendo	BH-Telehealth	INITIAL	3/18/2025
Jacuinde	Victoria	ABA-Telehealth	INITIAL	3/18/2025
Jordan	Denee	BH-Telehealth	INITIAL	3/18/2025
Jordan	Joshua	Primary Care Physician	INITIAL	3/18/2025
Juckem	Kora	BH-Telehealth	INITIAL	3/18/2025
Kallas	Michael	BH-Telehealth	INITIAL	3/18/2025
Karay	Samantha	BH-Telehealth	INITIAL	3/18/2025
Karve	Shweta	BH-Telehealth	INITIAL	3/18/2025
Kaur	Harpreet	BH-Telehealth	INITIAL	3/18/2025
Keeler	Brittney	ABA-Telehealth	INITIAL	3/18/2025
Kehoe	Ellen	ABA-Telehealth	INITIAL	3/18/2025
Khatchatrian	Karine	BH-Telehealth	INITIAL	3/18/2025
Kim	Edward	BH-Telehealth	INITIAL	3/18/2025
Kleiner	Michelle	BH-Telehealth	INITIAL	3/18/2025
Kubai	John	BH-Telehealth	INITIAL	3/18/2025
Kwiatkowski	Fernando	BH-Telehealth	INITIAL	3/18/2025
LaFreniere	Julie	BH-Telehealth	INITIAL	3/18/2025
Lee	Susan	BH	INITIAL	3/18/2025
Lee Young	Damien	BH-Telehealth	INITIAL	3/18/2025
Lespinasse	Strachella	BH-Telehealth	INITIAL	3/18/2025
Le-Tran	Vivian	Specialist	INITIAL	3/18/2025
Li	Kevin	Primary Care Physician	INITIAL	3/18/2025
Lindahl	Tara	BH-Telehealth	INITIAL	3/18/2025
Liss	Sarah	BH	INITIAL	3/18/2025
Litsch	Simone	BH-Telehealth	INITIAL	3/18/2025
Lowry	John	BH-Telehealth	INITIAL	3/18/2025
MacDonald	Cheryl	BH-Telehealth	INITIAL	3/18/2025
Machado	Darcy	ABA-Telehealth	INITIAL	3/18/2025
Maddalone	Antoinette	Doula	INITIAL	3/18/2025
Maradia	Jaykumar	BH-Telehealth	INITIAL	3/18/2025
Marella	Hemnishil	Specialist	INITIAL	3/18/2025
Markis	Matthew	BH-Telehealth	INITIAL	3/18/2025
Martinez	Micah	BH-Telehealth	INITIAL	3/18/2025
Mashadi	Najma	BH-Telehealth	INITIAL	3/18/2025
Maxwell	Michele	BH-Telehealth	INITIAL	3/18/2025
McCarter	Michele	BH-Telehealth	INITIAL	3/18/2025
McCartney	Christina	ABA	INITIAL	3/18/2025
McKinney	Carole	BH-Telehealth	INITIAL	3/18/2025
McManus	Michael	BH-Telehealth	INITIAL	3/18/2025
Meiselman	Mary	BH-Telehealth	INITIAL	3/18/2025
Mendoza-Beardsl	Agueda	BH-Telehealth	INITIAL	3/18/2025
Michels	Luke	BH-Telehealth	INITIAL	3/18/2025
Miller	Clara	Doula	INITIAL	3/18/2025
Miller	Lindsey	BH-Telehealth	INITIAL	3/18/2025
Mora	Stephanie	BH-Telehealth	INITIAL	3/18/2025
Morache	Christopher	BH-Telehealth	INITIAL	3/18/2025
Murphy	Tiffany	Doula	INITIAL	3/18/2025

LAST_NAME	FIRST_NAME	CATEGORY	INITIAL/RE-CRED	CRED_DATE
Newmark	Noreen	BH-Telehealth	INITIAL	3/18/2025
Nishan	Patricia	ABA-Telehealth	INITIAL	3/18/2025
Olvera	Alexandria	ABA-Telehealth	INITIAL	3/18/2025
Paintal	Nita	BH-Telehealth	INITIAL	3/18/2025
Pannell	Breanna	Doula	INITIAL	3/18/2025
Patel	Anil	BH-Telehealth	INITIAL	3/18/2025
Patel	Mandakini	Primary Care Physician	INITIAL	3/18/2025
Pellizzon	Julianne	ABA-Telehealth	INITIAL	3/18/2025
Pena	Brian	ABA-Telehealth	INITIAL	3/18/2025
Perlov	Jack	BH-Telehealth	INITIAL	3/18/2025
Perryman	Alexis	Doula	INITIAL	3/18/2025
Pham	Phuong	BH-Telehealth	INITIAL	3/18/2025
Prettapapop	Paul	BH-Telehealth	INITIAL	3/18/2025
Puyau	Megan	BH-Telehealth	INITIAL	3/18/2025
Raygoza	Joanna	BH-Telehealth	INITIAL	3/18/2025
Rehman	Naima	Primary Care Physician	INITIAL	3/18/2025
Reinert	Megan	Ancillary	INITIAL	3/18/2025
Rewick	Kristen	BH	INITIAL	3/18/2025
Rivera	Kelly	LCSW SP_CHW	INITIAL	3/18/2025
Rodriguez	Angelika	BH-Telehealth	INITIAL	3/18/2025
Rodriguez	Tracy	ABA-Telehealth	INITIAL	3/18/2025
Romano	Lorraine	ABA-Telehealth	INITIAL	3/18/2025
Rosengarten	Arthur	BH-Telehealth	INITIAL	3/18/2025
Saeturn	Genevieve	BH-Telehealth	INITIAL	3/18/2025
Saeturn	Nai	BH-Telehealth	INITIAL	3/18/2025
Salas	Dimarrah	ABA-Telehealth	INITIAL	3/18/2025
Salway	Milton	BH-Telehealth	INITIAL	3/18/2025
San Antonio	Arielle	ABA	INITIAL	3/18/2025
Sanchez	Bianca	BH-Telehealth	INITIAL	3/18/2025
Sandhu	Manjot	ABA-Telehealth	INITIAL	3/18/2025
Sekhon	Amret	BH-Telehealth	INITIAL	3/18/2025
Shapiro	Allie	BH	INITIAL	3/18/2025
Sharif	Hamdia	Doula	INITIAL	3/18/2025
Shin	Anne	BH-Telehealth	INITIAL	3/18/2025
Simon	Leanne	ABA-Telehealth	INITIAL	3/18/2025
Simpson	Jennine	ABA-Telehealth	INITIAL	3/18/2025
Singh	Ajay	BH-Telehealth	INITIAL	3/18/2025
Skaff	Richard	BH-Telehealth	INITIAL	3/18/2025
Smerik	Elisa	BH-Telehealth	INITIAL	3/18/2025
Smith	Jahthaime	BH-Telehealth	INITIAL	3/18/2025
Smith	Kristin	BH-Telehealth	INITIAL	3/18/2025
Smith Gishizky	Tiffany	BH-Telehealth	INITIAL	3/18/2025
Steenburgh	Sean	Specialist	INITIAL	3/18/2025
Sterling	Carli	BH-Telehealth	INITIAL	3/18/2025
Tellez	Rebecca	ABA-Telehealth	INITIAL	3/18/2025
Thara	Saad	BH-Telehealth	INITIAL	3/18/2025
Thornton	Billy	BH-Telehealth	INITIAL	3/18/2025
Torres	Liezl	ABA	INITIAL	3/18/2025
Torres	Sasha	ABA-Telehealth	INITIAL	3/18/2025
Trimmer	Robert	BH-Telehealth	INITIAL	3/18/2025
Tsai	Jaesun	BH-Telehealth	INITIAL	3/18/2025
Tucker	Ryan	BH-Telehealth	INITIAL	3/18/2025
Ullal	Monish	BH	INITIAL	3/18/2025
Vazquez	Maria	ABA-Telehealth	INITIAL	3/18/2025
Velasco	Irene	BH-Telehealth	INITIAL	3/18/2025
Vizon	Melanie	BH-Telehealth	INITIAL	3/18/2025

LAST_NAME	FIRST_NAME	CATEGORY	INITIAL/RE-CRED	CRED_DATE
Wanchek	Gabrielle	BH-Telehealth	INITIAL	3/18/2025
Watts	Hatira	BH-Telehealth	INITIAL	3/18/2025
Wells	Nikkia	BH-Telehealth	INITIAL	3/18/2025
Winston	Robert	BH-Telehealth	INITIAL	3/18/2025
Woods	Kristen	BH	INITIAL	3/18/2025
Wu	Alfred	BH-Telehealth	INITIAL	3/18/2025
Wurbel	Joseph	BH-Telehealth	INITIAL	3/18/2025
Yun	Yujin	BH-Telehealth	INITIAL	3/18/2025
Zarek	Elizabeth	BH-Telehealth	INITIAL	3/18/2025
Basu	Sanjay	Primary Care Physician	RE-CRED	3/18/2025
Bunker-Alberts	Michele	Allied Health	RE-CRED	3/18/2025
Burack	Jeffrey	Primary Care Physician	RE-CRED	3/18/2025
Carper	John	Primary Care Physician	RE-CRED	3/18/2025
Chan	Vanessa	Specialist	RE-CRED	3/18/2025
Chichili	Sudhathi	Specialist	RE-CRED	3/18/2025
Concepcion	Noel	Specialist	RE-CRED	3/18/2025
Do	Tri	Primary Care Physician	RE-CRED	3/18/2025
Dugoni	William	Specialist	RE-CRED	3/18/2025
Farahmand	Guity	Specialist	RE-CRED	3/18/2025
Georgis	Martha	Allied Health	RE-CRED	3/18/2025
Golden	Donald	Primary Care Physician	RE-CRED	3/18/2025
Hart	Britton	Allied Health	RE-CRED	3/18/2025
Hopson	Christina	Specialist	RE-CRED	3/18/2025
Ito	Timothy	Specialist	RE-CRED	3/18/2025
Jacka	Ciaran	Specialist	RE-CRED	3/18/2025
Jain	Aditya	imary Care Physician and Special	RE-CRED	3/18/2025
Jothi	Sumana	Specialist	RE-CRED	3/18/2025
Khan	Tanveer	Specialist	RE-CRED	3/18/2025
Kim	Jin	imary Care Physician and Special	RE-CRED	3/18/2025
Lam	Felicia	Primary Care Physician	RE-CRED	3/18/2025
Law	Abraham	Primary Care Physician	RE-CRED	3/18/2025
Lenoir	Michael	imary Care Physician and Special	RE-CRED	3/18/2025
Leung	Man	Specialist	RE-CRED	3/18/2025
Levesque	Lindsay	Allied Health	RE-CRED	3/18/2025
Lomeli-Loibl	Cadelba	Allied Health	RE-CRED	3/18/2025
McClaughry	Corinne	Primary Care Physician	RE-CRED	3/18/2025
Pacheco Torres	Monica	Allied Health	RE-CRED	3/18/2025
Paxton	Lamont	Specialist	RE-CRED	3/18/2025
Peterson	Michael	Specialist	RE-CRED	3/18/2025
Prado	Madeline	Allied Health	RE-CRED	3/18/2025
Pyle	Lorna	Allied Health	RE-CRED	3/18/2025
Ramachandra	Srinivas	Specialist	RE-CRED	3/18/2025
Reynolds	Kerisimasi	Specialist	RE-CRED	3/18/2025
Richmond	Stephen	Primary Care Physician	RE-CRED	3/18/2025
Riordan	Nolli	Specialist	RE-CRED	3/18/2025
Roitshteyn	Misha	Primary Care Physician	RE-CRED	3/18/2025
Siani	Elena	Specialist	RE-CRED	3/18/2025
Slome	Sally	Primary Care Physician	RE-CRED	3/18/2025
Van Tassel	Jason	Specialist	RE-CRED	3/18/2025
Vargas	Berenise	Ancillary	RE-CRED	3/18/2025
Wei	Wei Jane	Ancillary	RE-CRED	3/18/2025
Xu	Weiwei	Specialist	RE-CRED	3/18/2025

MARCH PEER REVIEW AND CREDENTIALING
INITIAL APPROVALS BY SPECIALTY

PCP	5
SPECIALIST	4
ANCILLARY	13
ALLIED	3
BH/ABA	152
TOTAL	177



Provider Dispute Resolution
February 2025 and March 2025

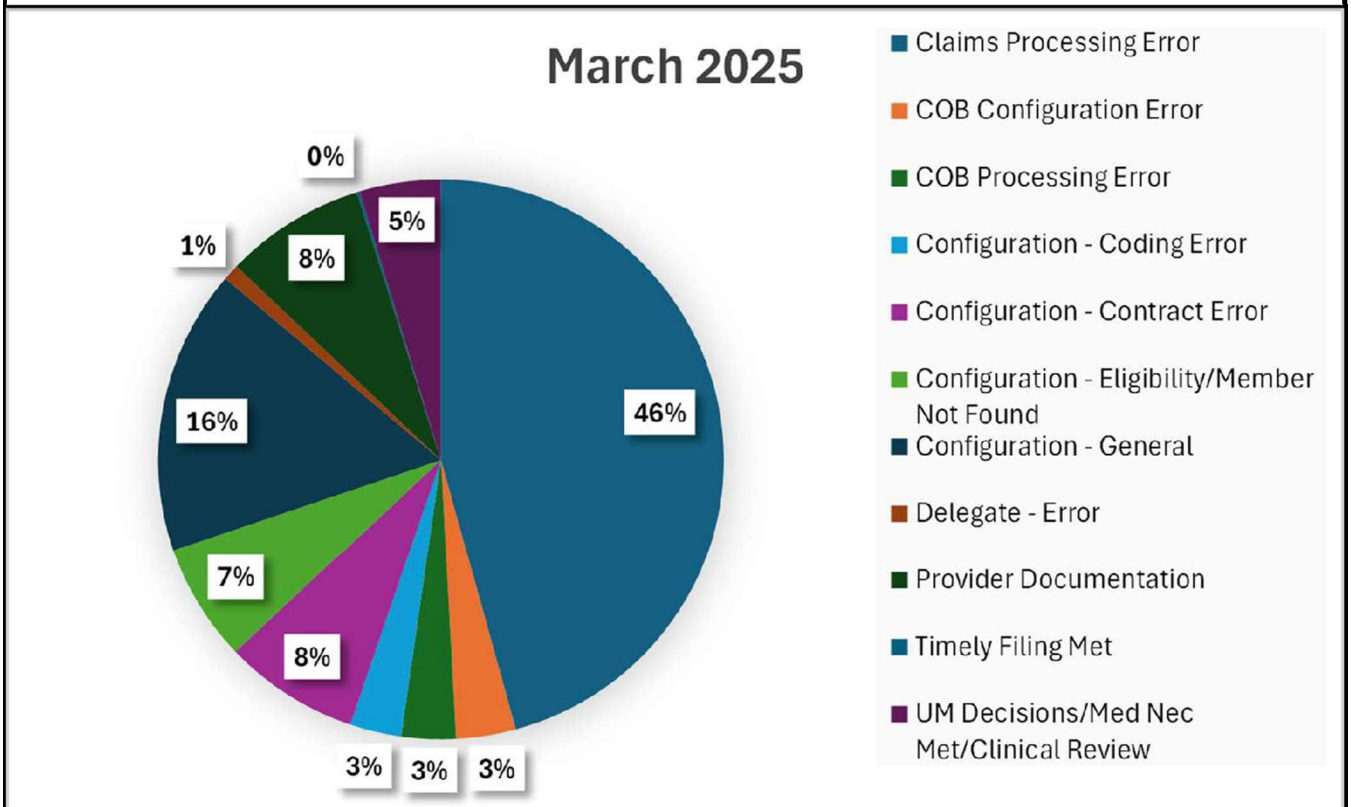
METRICS

PDR Compliance	Feb-25	Mar-25
# of PDRs Resolved	1,861	1,857
# Resolved Within 45 Working Days	1,854	1,849
% of PDRs Resolved Within 45 Working Days	99.6%	99.5%
PDRs Received	**Feb-25**	**Mar-25**
# of PDRs Received	2,551	4,707
PDR Volume Total	**2,551**	**4,707**
PDRs Resolved	**Feb-25**	**Mar-25**
# of PDRs Upheld	1,222	1,212
% of PDRs Upheld	66%	65%
# of PDRs Overturned	639	645
% of PDRs Overturned	34%	35%
Total # of PDRs Resolved	**1,861**	**1,857**
Average Turnaround Time	**Feb-25**	**Mar-25**
Average # of Days to Resolve PDRs	34	37
Oldest Resolved PDR in Days	286	124
Unresolved PDR Age	**Feb-25**	**Mar-25**
0-45 Working Days	3,466	4,162
Over 45 Working Days	0	0
Total # of Unresolved PDRs	**3,466**	**4,162**

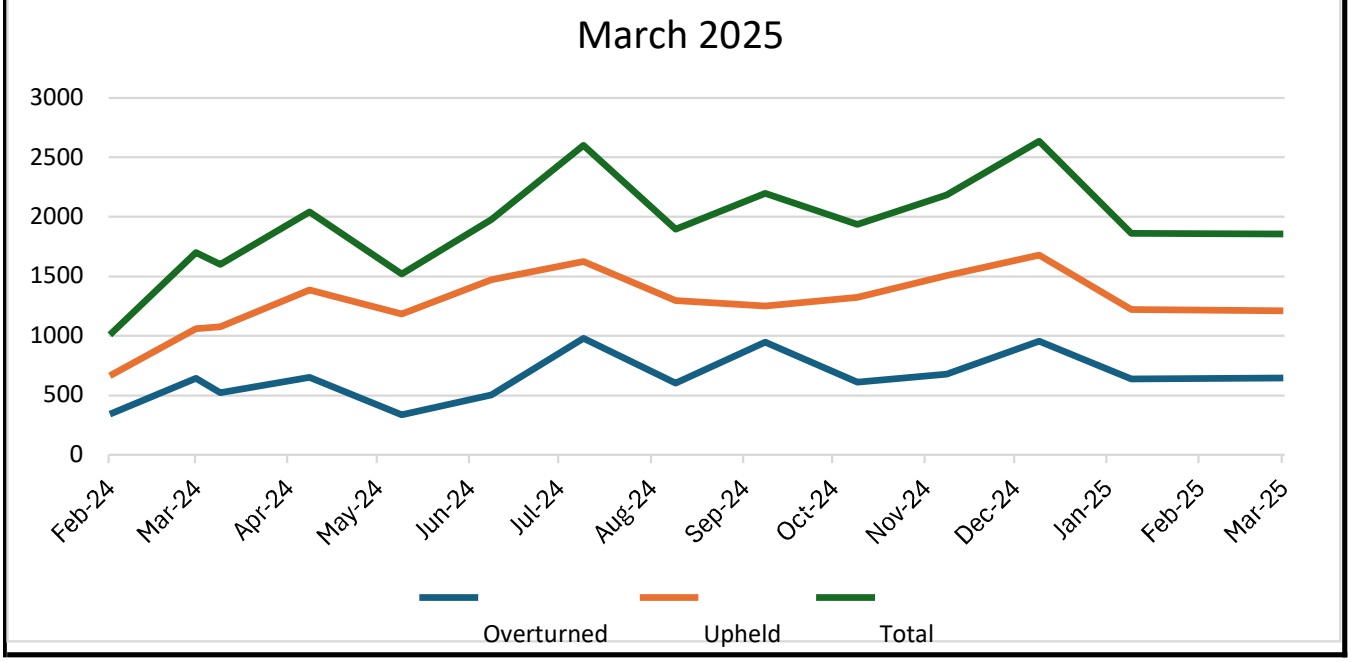
Provider Dispute Resolution
February 2025 and March 2025

Feb-25

PDR Resolved Case Overturn Reasons



Rolling 12-Month PDR Trend Line



Provider Dispute Resolution Year Over Year Summary		
Monthly Results	**Regulatory Requirements**	**AAH Goal**
# of PDRs Resolved - 1,857 in March 2025 vs 1,701 in March 2024	N/A	N/A
# of PDRs Received - 4,707 in March 2025 vs 1,475 in March 2024	N/A	N/A
# of PDRs Resolved within 45 working days - 1,854 in March 2025 vs 1,007 in March 2024	N/A	N/A
% of PDRs Resolved within 45 working days - 99.5% in March 2025 vs 99.4% in March 2024	95%	95%
Average # of Days to Resolve PDRs - 37 days in March 2025 vs 43 days in March 2024	N/A	30
Oldest Resolved PDR in Days - 124 days in March 2025 vs 70 days March 2024	N/A	N/A
# of PDRs Upheld - 1,212 in March 2025 vs 1,059 in March 2024	N/A	N/A
% of PDRs Upheld - 65% in March 2025 vs 62% in March 2024	N/A	> 75%
# of PDRs Overturned - 645 in March 2025 vs 642 in March 2024	N/A	N/A
% of PDRs Overturned - 35% in March 2025 vs 38% in March 2024	N/A	< 25%
PDR Overturn Reasons: Claims processing errors - 46% (2025) vs 49% (2024) Configuration errors - 34% (2025) vs 24% (2024) COB - 7% (2025) vs 12% (2024) Clinical Review/UM Decisions/Medical Necessity Met - 13% (2025) vs 15% (2024)	N/A	N/A

COMMUNICATIONS & OUTREACH DEPARTMENT

ALLIANCE IN THE COMMUNITY

FY 2024 - 2025 | **3RD QUARTER (Q3) OUTREACH REPORT**

ALLIANCE IN THE COMMUNITY

FY 2024 - 2025 | 3RD QUARTER (Q3) OUTREACH REPORT

Between January 2025 and March 2025, the Alliance completed **2,430** member orientation outreach calls among net new members and non-utilizers and conducted **312** member orientations (**12.8%** member participation rate). In addition, the Outreach team completed **153** Alliance website inquiries, **14** service requests, **7** community events, **12** member education events and **2** Community Meeting/Presentation events in Q3.

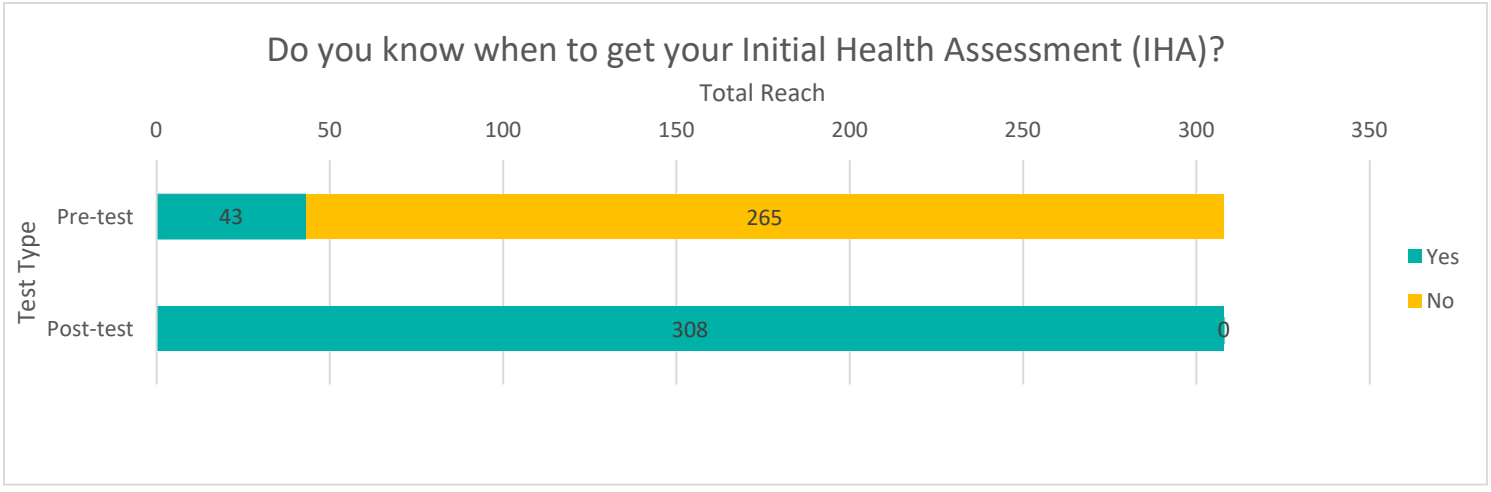
The Communications & Outreach Department began reporting the number of members reached during outreach activities in late February 2018. Since July 2018, **38,033** self-identified Alliance members have been reached during outreach activities.

On **Monday, March 16, 2020**, the Alliance began assisting members by telephone only, following the statewide Shelter-in-Place (SIP) guidance to protect the general public from the Coronavirus Disease (COVID-19). As a result, the Alliance proactively postponed all face-to-face member orientations and community events until further notice.

On **Wednesday, March 18, 2020,** the Alliance began conducting member orientations by phone. As of **Monday, March 31, 2025**, the Outreach Team completed **47,497** member orientation outreach calls and conducted **9,591** orientations, achieving a **20.2%** participation rate.

The Alliance Member Orientation (MO) program has been in place since August 2016. In 2019, the program was recognized as a promising practice to increase member knowledge and awareness about the Initial Health Assessment, by the Department of Health Care Services (DHCS), Managed Care Quality and Monitoring Division (MCQMD). We have steadily increased program participation. Our 2019 6-month average participation rate was **111** members per month. Between March 18, 2020, through March 31, 2025 – **9,591** members completed our MO and Non-utilizer program by phone.

After completing a MO **100%** of members who completed the post-test survey in Q3 FY 24-25 reported knowing when to get their IHA, compared to only **16.2%** of members knowing when to get their IHA in the pre-test survey.



All report details can be reviewed at: **W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Outreach Reports\FY 24-25\Q3\3. March 2025**

ALLIANCE IN THE COMMUNITY

FY 2024 - 2025 | 3RD QUARTER (Q3) OUTREACH REPORT

Q3 FY 2024-2025 TOTALS

7 COMMUNITY EVENTS

12 MEMBER EDUCATION EVENTS

312 MEMBER ORIENTATIONS

2 MEETINGS/ PRESENTATIONS

23 TOTAL INITIATED/INVITED EVENTS

333 TOTAL EVENTS

1875 TOTAL REACHED AT VIRTUAL COMMUNITY EVENTS

1194 TOTAL REACHED AT MEMBER EDUCATION EVENTS

312 TOTAL REACHED AT MEMBER ORIENTATIONS

247 TOTAL REACHED AT MEETINGS/PRESENTATIONS

2210 TOTAL MEMBERS REACHED AT EVENTS

3628 TOTAL REACHED AT ALL EVENTS

ALAMEDA
ASHLAND
BERKELEY
CASTRO VALLEY
DUBLIN
FREMONT
HAYWARD
LIVERMORE
NEWARK
OAKLAND
PLEASANTON
SAN LEANDRO
SAN LORENZO
UNION CITY

TOTAL REACH 20 CITIES

Cities represent the mailing addresses for members who completed a Member Orientation by phone. The italicized cities are outside of Alameda County. The following cities had <1% reach during Q3 2025: Albany, Brentwood, Cherryland, Emeryville, Fairfield, and Los Angeles. The C&O Department started including these cities in the Q3 FY21 Outreach Report.

$750.00

TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

** Includes refundable deposit.*

Compliance

Richard Golfin III

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

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

Date: **April 11th, 2025**

Subject: **Compliance Division Report**

Compliance Audit Updates

- 2025 Department of Managed Health Care (DMHC) and Department of Health Care Services (DHCS) Routine Full Medical Survey (Joint Audit)
    - The DMHC lookback period is from October 1st, 2022, through September 30th, 2024. The DHCS lookback period is from June 1st, 2024, through February 28th, 2025. From March 3rd to March 7th, 2025, both agencies conducted onsite interview sessions. Following the visit, DMHC and DHCS submitted requests for additional documentation, totaling 149 and 28 requests, respectively. All responses have been submitted.
    - The DHCS conducted an exit conference on March 20th, 2025, during which the department raised three concerns regarding Post-Stabilization Authorization (PSA):
        - The Plan did not consistently secure timely authorization for medically necessary PSA or ensure contractors' compliance with APL 23-009.
        - The Plan did not adequately ensure the availability of a Medical Director or licensed physician 24/7 to coordinate care and respond to authorizations.
        - The Plan did not transfer out-of-network hospitalized members to in-network providers as required.
    - The department informed the Plan that these observations are preliminary and may be revised upon further review. Additional documentation was requested on March 24th, 2025, and promptly submitted by the Plan on March 25th, 2025.
    - The Plan is awaiting the formal preliminary report. Once the report is received the Plan has 15 calendar days to respond to DHCS.
- 2024 Department of Health Care Services (DHCS) Routine Full Medical Survey
    - The DHCS conducted its 2024 Routine Full Medical Survey from June 17th, 2024, through June 28th, 2024. The Plan received its Final Audit Report on November 18th, 2024, citing twenty (20) final audit findings. Monthly CAP updates are due to the DHCS on the 15th of each month. To date five (5) CAPs

have been accepted, ten (10) CAPs have been partially accepted, one (1) CAP has not been accepted, and four (4) CAPs are pending deliverables. The last CAP update was submitted timely on March 14th, 2025. The April CAP update is due on April 15th, 2025.

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

    - On September 4th, 2024, the DHCS issued the Final Medical Survey Audit Report and CAP Request for the 2023 DHCS Focused Medical Survey. The DHCS identified findings related to Behavioral Health Services and Transportation Services. Nine (9) CAPs were identified. To date six (6) CAPs have been accepted and three (3) CAPs have been partially accepted. The Plan submitted the last update on March 14th, 2025. The Plan's next update is due on April 18th, 2025.

Compliance Activity Updates

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

    - Representatives from Compliance Division, Integrated Planning Division, and the Medicare Operations Division successfully submitted the CMS Medicare Advantage Dual Eligible Special Needs Plan application via CMS' Health Plan Management System (HPMS) on February 12th, 2025. On March 13th, the Plan received its first Cure Notice with 31 deficiencies noted. All deficiencies were resolved or addressed and resubmitted on March 24th. The Plan is expecting CMS' response the first week of April.

- Department of Health Care Services (DHCS)
    - The Compliance Division is expecting DHCS feedback on the State Specific Model of Care (MOC) Matrix and Health Risk Assessment (HRA) to DHCS by late April or early May. The State Specific MOC and HRA were submitted on February 12th, 2025.
- Department of Managed Health Care (DMHC) Medicare Filings – CY26 Medicare, 2024 EAE D-SNP Material Modification Filing (E-Filing *No. 20244060*)

    - The Plan expects that DMHC will complete its review of its March 14th, 2025, comment responses and approve and close this filing by April 13th, 2025.

- New Legislation
    - DMHC's 2024 annual Newly Enacted Statutes All Plan Letter (APL 24-023) includes Seventeen newly enacted laws that impact the Plan's Medi-Cal and/or Group Care lines of business. DMHC E-Filing was completed March 21st. Compliance anticipates DMHC comments to begin by April 20th.
- 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, fourteen (78%) have either completed their training or submitted sufficient proof of equivalent outside training. One member (6%) has training in progress and three (16%) have not started. The Plan continues coordination with the Board Clerk and the Board Chair to improve Board training rates of compliance.

Confidentiality Agreements

- As required by the Code of Conduct and Compliance Plan, all Board Members must sign Confidentiality Agreements. All eighteen have signed.

Compliance

Supporting Documents

Q4 2024 - PRESENT APL IMPLEMENTATION TRACKING LIST						
#	Date Released	Regulatory Agency	APL #	APL Title	LOB	APL Purpose Summary
Q4 2024						
35	10/30/2024	DMHC	24-019	Amendments to Rule 1300.67.2.2 and the Incorporated Annual Network Submission Instruction Manual and Annual Network Report Forms for Reporting Year 2025	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC) issues this All-Plan Letter (APL) to inform health care service plans (health plans) of new amendments to 28 CCR § 1300.67.2.2 and the incorporated Annual Network Submission Instruction Manual and Annual Network Report Forms for the reporting year (RY) 2025 Annual Network Report submission.
36	10/31/2024	DHCS	18-022	Access Requirements for Freestanding Birth Centers and the Provision of Midwife Services (TECHNICAL CHANGE)	MEDI-CAL	The purpose of this All Plan Letter (APL) is to clarify the requirements for Medi-Cal managed care health plans (MCPs) regarding their responsibilities to provide members with access to freestanding birth centers (FBCs) as well as to services provided by Certified Nurse Midwives (CNMs) and Licensed Midwives (LMs).
37	11/3/2024	DHCS	23-024	Doula Services (TECHNICAL CHANGE)	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with guidance regarding the qualifications for providing doula services, effective for dates of service on or after January 1, 2023.
38	11/13/2024	DMHC	24-020	RY 2026/MY 2025 Provider Availability Survey Manual and Report Form Amendments	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) to provide notice to health care service plans (health plans) of amendments to Rule 1300.67.2.2 and the following reporting year (RY) 2026/measurement year (MY) 2025 Timely Access Compliance Report documents: Provider Appointment Availability Survey (PAAS) Manual, PAAS Report Forms and the Timely Access Submission Instruction Manual (TA Instruction Manual).
39	12/5/2024	DHCS	24-016	Diversity, Equity, and Inclusion Training Program Requirements	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with guidance regarding the Diversity, Equity, and Inclusion (DEI) training program requirements.
40	12/5/2024	DHCS	24-017	Transgender, Gender Diverse or Intersex Cultural Competency Training Program and Provider Directory Requirements	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with guidance regarding the transgender, gender diverse, intersex (TGI) cultural competency training program and Provider Directory changes required by Senate Bill (SB) 923 (Chapter 822, Statutes of 2022) for the purpose of providing trans-inclusive health care to MCP Members.
41	12/12/2024	DMHC	24-021	Notice of Amendments to Rules 1300.67.2.1, 1300.67.2 and Incorporated Documents – Network Adequacy Standards and Methodology for RY 2025	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) to notice amendments to 28 CCR § 1300.67.2.1, 28 CCR § 1300.67.2, and documents incorporated by reference. References to "Rule" refer to the California Code of Regulations (CCR), title 28. The amendments are noticed pursuant to Senate Bill (SB) 225 (Wiener, Chapter 601, Statutes of 2022).
42	12/13/2024	DHCS	24-018	Medical Loss Ratio Requirements For Subcontractors And Downstream Subcontractors	MEDI-CAL	The purpose of this All-Plan Letter (APL) is to provide guidance to Medi-Cal managed care plans (MCPs) on the Medical Loss Ratio (MLR) requirements set forth by the federal Centers for Medicare & Medicaid Services (CMS) in the California Advancing & Innovating Medi-Cal (CalAIM) Section 1915(b) waiver's Special Terms and Conditions (STCs) and pursuant to the MCPs' contractual requirements in Exhibit A, Attachment III, Provision 3.1.5(B)(31).
43	12/13/2024	DMHC	24-022	Children and Youth Behavioral Health Initiative, Certified Wellness Coaches	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC), together with the Department of Health Care Access and Information (HCAI), issues this All-Plan Letter (APL) 24-022 - Children and Youth Behavioral Health Initiative, Certified Wellness Coaches to provide health care service plans with information regarding the establishment of the state Wellness Coach certification program and encourage health plans to provide access to Wellness Coach services as a means of increasing behavioral health resources to health plan members.
44	12/20/2024	DMHC	24-023	Newly Enacted Statutes Impacting Health Plans (2024 Legislative Session)	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC) issues this All-Plan Letter (APL) 24-023, which outlines the newly enacted statutory requirements for health care service plans (plans) regulated by the Department of Managed Health Care (DMHC).
45	12/31/2024	DHCS	24-019	Minor Consent to Outpatient Mental Health Treatment or Counseling	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care plans (MCPs) regarding the provision of non-specialty mental health outpatient treatment or counseling services to minors as a result of Assembly Bill (AB) 665 (Chapter 338, Statutes of 2023)1 which amended Family Code (Fam. Code) section 6924.
Q1 2025						
1	1/9/2025	DMHC	25-001	Southern California Fires and Enrollees' Continued Access to Health Care Services	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) 25-001, which provides information regarding Health and Safety Code section 1368.7.
2	1/17/2025	DHCS	25-001	2024-2025 Medi-Cal Managed Care Health Plan Meds/834 Cutoff and Processing Scheduling	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with the 2024-2025 Medi-Cal Eligibility Data System (MEDS)/834 cutoff and processing schedule.
3	1/13/2025	DHCS	25-002	Skilled Nursing Facility Workforce Quality Incentive Program	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with instructions on the payment and data sharing process required for the Skilled Nursing Facility (SNF) Workforce and Quality Incentive Program (WQIP) for Rating Periods between January 1, 2023, and December 31, 2026. The Calendar Year (CY) 2023 Rating Period is referred to as Program Year (PY) 1, CY 2024 Rating Period as PY 2, and so forth.
4	1/15/2025	DHCS	25-003	Establishing D-SNPs by 2026	DSNP	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with information regarding the Department of Health Care Services' (DHCS) enforcement of California Welfare and Institutions Code (W&I) section 14184.208, related to the requirement for MCPs to operate or be affiliated with a Dual Eligible Special Needs Plan (D-SNP) by 2026, to provide integrated care through affiliated MCPs and D-SNPs for dually eligible Medicare and Medi-Cal Members.
5	1/28/2025	DMHC	25-002	Plan Year 2026 QHP, QDP, and Off-Exchange Filing Requirements	N/A	The Department of Managed Health Care (Department) issues this All Plan Letter (APL) 25-002 to assist in the preparation of Plan Year 2026 regulatory submissions, in compliance with the Knox- Keene Act at California Health and Safety Code sections 1340 et seq. (Act) and regulations promulgated by the Department at California Code of Regulations, title 28 (Rules).
6	2/5/2025	DMHC	25-003	Large Group Renewal Notice Requirements	GROUP CARE	The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 25-003 to provide guidance to plans on the timing and content requirements for renewal notices to large group contractholders under HSC section 1374.21 and HSC section 1385.046.

#	Date Released	Regulatory Agency	APL #	APL Title	LOB	APL Purpose Summary
7	2/7/2025	DHCS	25-004	Community Reinvestments Requirements	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with guidance regarding the MCP Contract's requirement that MCPs reinvest a minimum level of their net income into their local communities.
8	3/12/2025	DMHC	24-004	AB 118: Part 1 - Compliance with Large Group Standardized Evidence of Coverage/Disclosure Form	GROUP CARE	Assembly Bill (AB) 118 (Ting, Chapter 42, Statutes of 2023) added Health and Safety Code section 1363.3 and revised Sections 1352.1, 1363, 1367.041, and 1367.24, effective January 1, 2025. These statutory changes apply to all commercial full-service health care service plans (plans), and require the Department of Managed Health Care (DMHC) to develop standardized templates for various documents describing health plan member benefits, such as the Evidence of Coverage (EOC), Disclosure Form (DF), Schedule of Benefits (SOB), Explanation of Benefits (EOB), and Cost-Share Summary (CSS). The DMHC's work to implement AB 118's requirement to develop standardized templates will be an iterative process. The first part of the standardized EOC/DF will be the following template components: (1) Exclusions and Limitations, (2) Members' Rights and Responsibilities, and (3) Definitions, for use in large group health care service plan contracts issued, amended, or renewed on or after January 1, 2026. This All Plan Letter (APL) and its accompanying attachments set out the filing requirements needed to demonstrate compliance with each template component.
9	3/19/2025	DMHC	25-005	Southern California Fires and Flexibilities to Impacted Providers	GROUP CARE & MEDI-CAL	On January 7, 2025, California Governor Gavin Newsom declared a State of Emergency in Los Angeles and Ventura Counties due to wildfires. The fires destroyed homes and businesses and displaced enrollees and health care providers. After the Governor declares a state of emergency, Health and Safety Code section 1368.7 allows the DMHC to take actions to help mitigate the impact to enrollees and providers.
10	3/21/2025	DMHC	25-006	Health Plan Coverage of Mobile Crisis Services	GROUP CARE	This APL provides guidance regarding the obligations of health plans related to behavioral health crisis services provided to an enrollee by a 988 center or mobile crisis team.
11	4/1/2025	DMHC	25-007	Assembly Bill 3275 Guidance (Claim Reimbursement)	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) under the Knox-Keene Health Care Service Plan Act of 1975, as amended, to provide guidance to health care service plans (plans) on requirements for the processing and reimbursement of claims for health care services with a date of receipt on or after January 1, 2026. Assembly Bill 3275 (Soria, 2024) amended Health and Safety Code sections 1371 and 1371.35 relating to reimbursement of claims for health care services, and enacted Health and Safety Code section 1371.34 enhancing consumer protections relating to grievances about claims for health care services.

ALAMEDA Alliance FOR HEALTH

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

Health Care Services

Donna Carey, MD

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

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

Date: **April 11th, 2025**

Subject: **Health Care Services Report**

CMO Committee Meeting Report

Peer Review and Credentialing (PRCC)

- Committee meeting March 18, 2025.
    - At the PRCC meetings held on March 18, 2025, there were one hundred and seventy-seven (177) initial network providers approved; Five (5) primary care providers, four (4) specialists, thirteen (13) ancillary providers, three (3) midlevel providers, and one hundred and fifty-two (152) behavioral health providers.
    - Additionally, forty-three (43) providers were re-credentialed at this meeting; fourteen (14) primary care providers, nineteen (19) specialists, two (2) ancillary providers, and eight (8) midlevel providers.

P&T Committee- Q1

- Committee meeting March 18, 2025
    - Reviewed 9 Therapeutic categories and drug monographs
    - 33 formulary modifications
        - Updated 4 drugs to non-formulary status
        - Added 5 medications to our formulary
        - Added 2 medications to formulary w/PA (prior authorization) requirement
        - Added 11 medications to formulary w/ST (Step Therapy) requirement
        - Added 9 medications to formulary w/PA (prior authorization) and SP (Specialty Medication) requirements
        - Added 2 medications to formulary w/PA (prior authorization) and SP (Specialty Medication) requirements
    - Updated 19 PA guidelines
    - Reviewed 30 PA guidelines with no updates

No QIHEC meeting in March

Utilization Management (UM)

- Denial Rates
    - Overall, 2.5% (0.7% decrease from 2022)

- Authorization Turn-Around Times (goal = 95%)
    - Inpatient/outpatient: overall 98%, above goal
    - LTC: overall 99%, above goal
    - BH: overall 82%, below goal

- Pharmacy:
    - Outpatient RX: overall 100%, above goal
    - Physician Administered Medications/Injections: overall 99%, above goal

- Over/Under Utilization Measures
    - ER visits: average 525 visits/K
    - Acute Inpatient Hospitalization Readmission Rate: 20.1%

- Opportunities incorporated into 2024 Program/Workplan:
    - Stabilizing team infrastructure
    - Enhanced coordination across internal departments to support Population Health Management and Quality Improvement activities
    - Increased collaboration with external partners to improve over/under utilization

Overall Authorization Volumes *(inpatient, outpatient, and long-term care):*

- Total authorization volume increased month-over-month from February to March 2025.

Total Authorization Volume (Medical Services)			
Authorization Type	**January 2025**	**February 2025**	**March 2025**
Inpatient	3,436	3,107	2,963
Outpatient	4,310	3,660	4,008
Long-Term Care	917	935	1,124
Total	**8,663**	**7,702**	**8,095**

***Source**: #02569_AuthTAT_Summary*

- The following sections provide additional detail on utilization management trends in each department.

Utilization Management: Outpatient

- Anthem-transition authorization activity 1 yr. Post CoC is running between 7-10% of active authorizations daily.

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

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

- OP processed a total of 4,008 authorizations in the month of March.

- OP Turnaround times continue to exceed the benchmark of 95% with the average being 98% in the month of March.

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

Total Outpatient Authorization Volume			
Authorization Status	**January 2025**	**February 2025**	**March 2025**
Approvals	4,351	3,530	3,728
Partial Approvals	18	20	79
Denials	182	110	201
Total	**4,532**	**3,660**	**4,008**

***Source**: #02569_AuthTAT_Summary*

Outpatient Authorization Denial Rates			
Denial Rate Type	**January 2025**		**February 2025**
Overall Denial Rate	**3.5%**	**3.0%**	**3.5%**
Denial Rate Excluding Partial Denials	**3.1%**	**2.7%**	**3.3%**
Partial Denial Rate	**0.2%**	**0.2%**	**0.1%**

***Source**: #03690_Executive_Dashboard*

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

***Source**: #02569_AuthTAT_Summary*

Utilization Management: Inpatient

- Total inpatient auth volume decreased from 3,107 authorizations processed in February 2025 to 2,963 in the month of March.

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

- IP overall denial rate was 3.4% in January, 4.4% in February, and 3.0% in March.

- IP Auth TAT compliance continues to meet or surpass 95% benchmark, with overall TAT of 97% in December, 96% in January and February.

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

- External hospital rounds are ongoing with UCSF, Stanford, Alameda Health System, Kindred LTACH, Kentfield LTACH, Washington, Eden, Alta Bates, and Summit, to review members' current active admissions discuss UM issues, address discharge barriers, offer other opportunities for supporting throughput and appropriate discharge.

- Kaiser interdisciplinary rounds began in January, with the goal of supporting AAH members at Kaiser facilities who have complex discharge needs and high ER utilization.

Total Inpatient Authorization Volume			
Authorization Status	**January 2025**	**February 2025**	**March 2025**
Approvals	3412	3032	2902
Partial Approvals	0	0	0
Denials	24	75	61
Total	**3436**	**3,107**	**2,963**

Source: #02569_AuthTAT_Summary

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

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

Inpatient Authorization Denial Rates			
Denial Rate Type	**January 2025**	**February 2025**	**March 2025**
Full Denials Rate	1.4%	1.6%	1.0 %
Partial Denials	1.9%	2.8%	2.0%
All Types of Denials Rate	3.4%	4.4%	3.0%

Source: #01292_AllAuthDenialsRates

Inpatient Turn Around Time Compliance			
Line of Business	**January 2025**	**February 2025**	**March 2025**
Overall	96%	96%	97%
Medi-Cal	95%	95%	97%
IHSS	100%	100%	94%
Benchmark	*95%*	*95%*	*95%*

Source: #02569_AuthTAT_Summary

Utilization Management: Long-Term Care

- LTC census during March 2025 was 2,295 members. This is an increase of 9.07% from February 2025.

- Month to Month, the admissions, days and readmissions are decreasing. From December to February the admissions decreased by 50.97%, the days decreased by 51.22% and the readmissions also decreased by 44.74%. Some of this could be due to a lag in claims data being available, but we are seeing a decrease overall.

Totals	December 2024	January 2025	February 2025*
Admissions	155	144	76
Days	1,023	1,047	499
Readmissions	38	33	21

Source: #14236_LTC_Dashboard – data only available through February

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

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

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

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

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

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

- Health Navigator continues to assist with TCS for members coming back from an acute stay or transitioning from acute into long-term care.

- The team is working closely with the facilities to assist in getting all long-term member AID Codes updated to reflect their long-term care status.

- Authorization volume increased in March, compared to January and February.

- Authorization processing turn-around time (TAT) has remained at 99%, which is exceeding the threshold of 95%. We just backfilled an open LTC Nurse position and no longer have a Temp Nurse in place.

Total LTC Authorization Volume			
Authorization Status	**January 2025**	**February 2025**	**March 2025**
Approvals	881	905	1079
Partial Approvals	0	0	0
Denials	36	30	45
Total	**917**	**935**	**1124**

Source: #02569_AuthTAT_Summary

****Numbers change month over month based on the void and copy process to adjust authorizations for bed holds***

LTC Turn Around Time Compliance			
Line of Business	**January 2025**	**February 2025**	**March 2025**
Medi-Cal	**99%**	**99.6%**	**99%**
Benchmark	*95%*	*95%*	*95%*

Source: #02569_AuthTAT_Summary

Behavioral Health

- In March, the Behavioral Health Department processed 689 authorizations, 392 Care Coordination referrals, and 213 mental health screenings and transition of care tools.

Total BH Authorization Volume			
	25-Jan	**25-Feb**	**25-Mar**
Approvals	685	646	680
Partial Approval	0	0	0
Denials	6	2	9
Total	691	648	689

Source: 14939_BH_AuthTAT

Mental Health Turnaround Times

MH TAT			
	25-Jan	**25-Feb**	**25-Mar**
Determination TAT%	75%	97%	99%
Notification TAT%	99%	92%	96%

Behavioral Health Therapies (BHT/ABA) Turnaround Times

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

Behavioral Health Denial Rates

**Goal ≤ 5%*	BH Denial Rates	
25-Jan	**25-Feb**	**25-Mar**
0.01%	0.01%	1%

Source: 14939_BH_AuthTAT

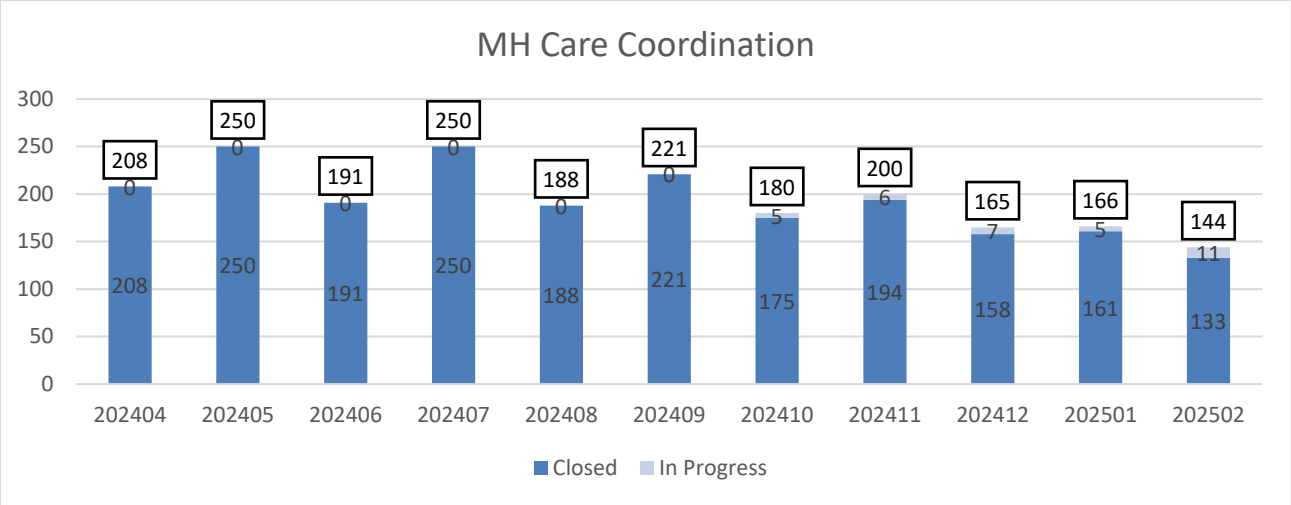
Mental Health Care Coordination

- 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-Jan	25-Feb	25-Mar
Youth Screenings	77	88	81
Adults Screenings	157	146	130
Transition of Care Tools	4	2	2

Source: PBI_14460 – MLS BH TruCare Assessments

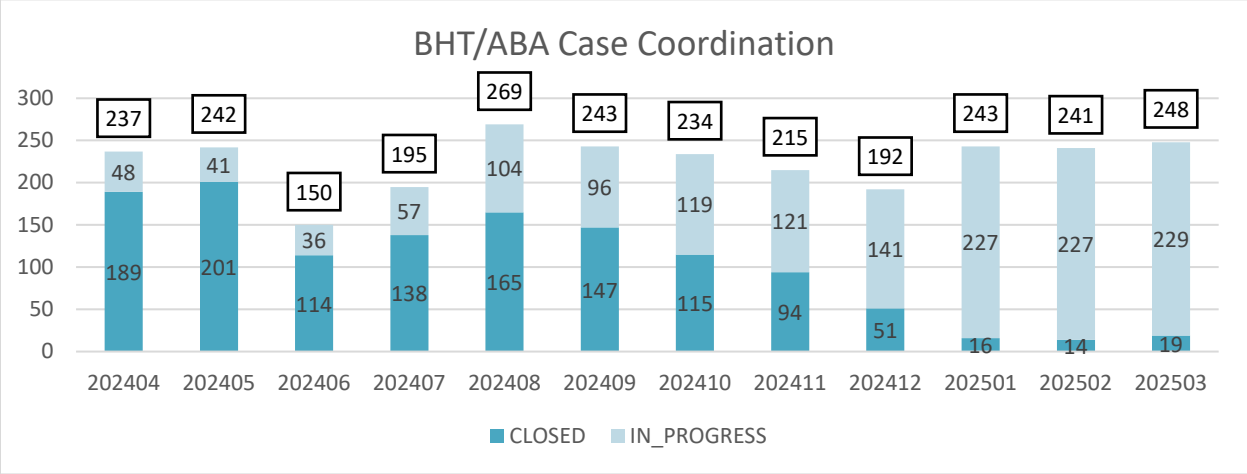
- Alliance licensed mental health clinicians, psychiatric nurses, and behavioral health navigators provide care coordination for members who need assistance accessing the mental health treatment services they need.



Source: 14665_BH_Cases

Behavioral Health Therapies (BHT/ABA)

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

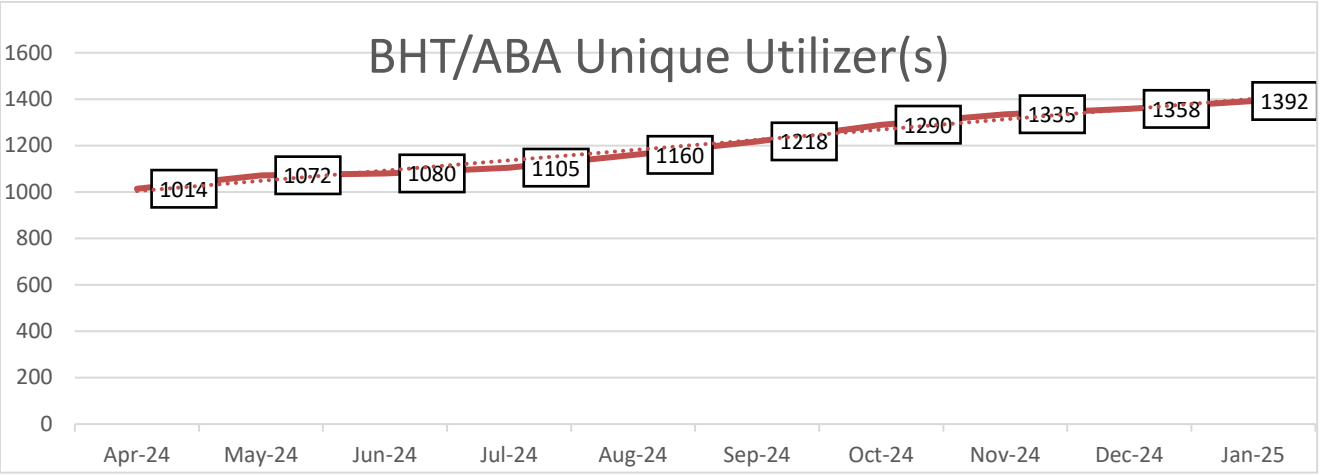


Source: 14665_BH_Cases

Behavioral Health Unique Utilizers

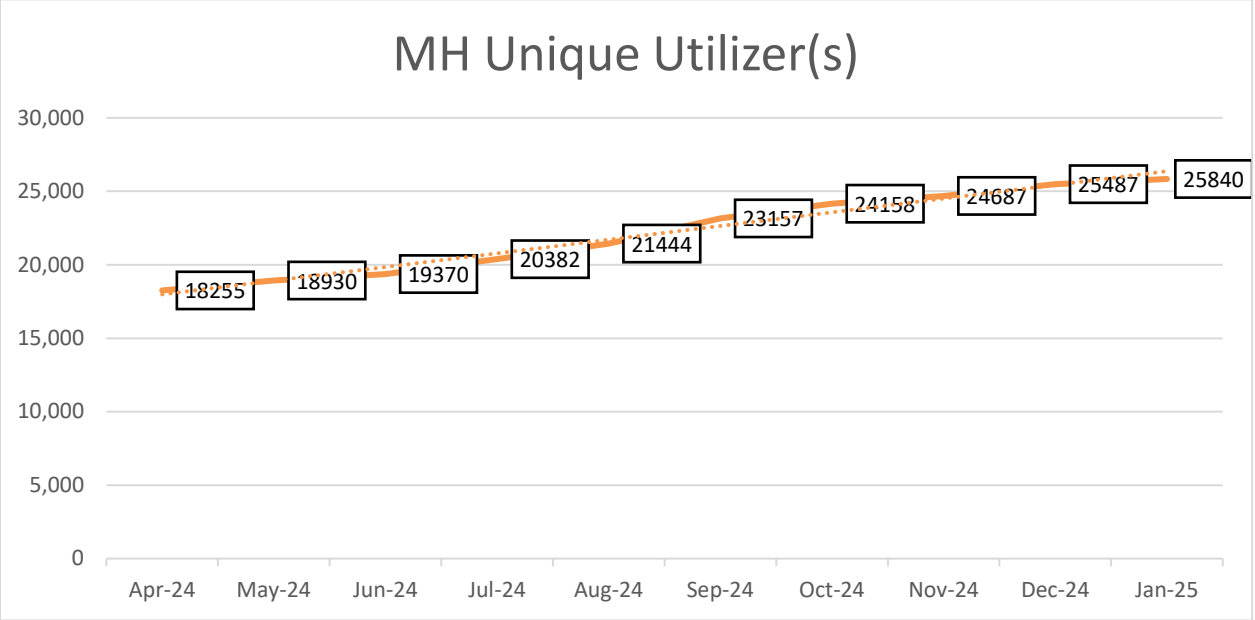
- Removing barriers to accessing BHT/ABA services remains a primary goal for the Alliance Behavioral Health team. One way to measure that is to monitor unique utilizers who are accessing care when interventions are implemented.

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



Source: PBI 14621 BHT Utilization Report

- The number of unique utilizers of mental health services has increased by 1% compared to the previous month.



Source: PBI 14637 BH12M Report

Pharmacy

- Pharmacy is collaborating with Case Management on the Pharmacy Transitional Care Services (TCS) program with a focus on congestive heart failure and sepsis with plans of adding additional diagnoses in the near future. Alliance pharmacists work with some of these members after hospital discharge to help decrease hospital readmission through education to the members as well as filling potential gaps between providers and their patients. AAH Pharmacy is focusing on helping lower volume but higher risk members that may benefit from pharmacy outreach. Pharmacy has also decreased the program requirements to meet criteria to help increase volume for the TCS program.

- In collaboration with IT, Pharmacy was able to successfully add Washington Hospital to the TCS program.

Case and Disease Management

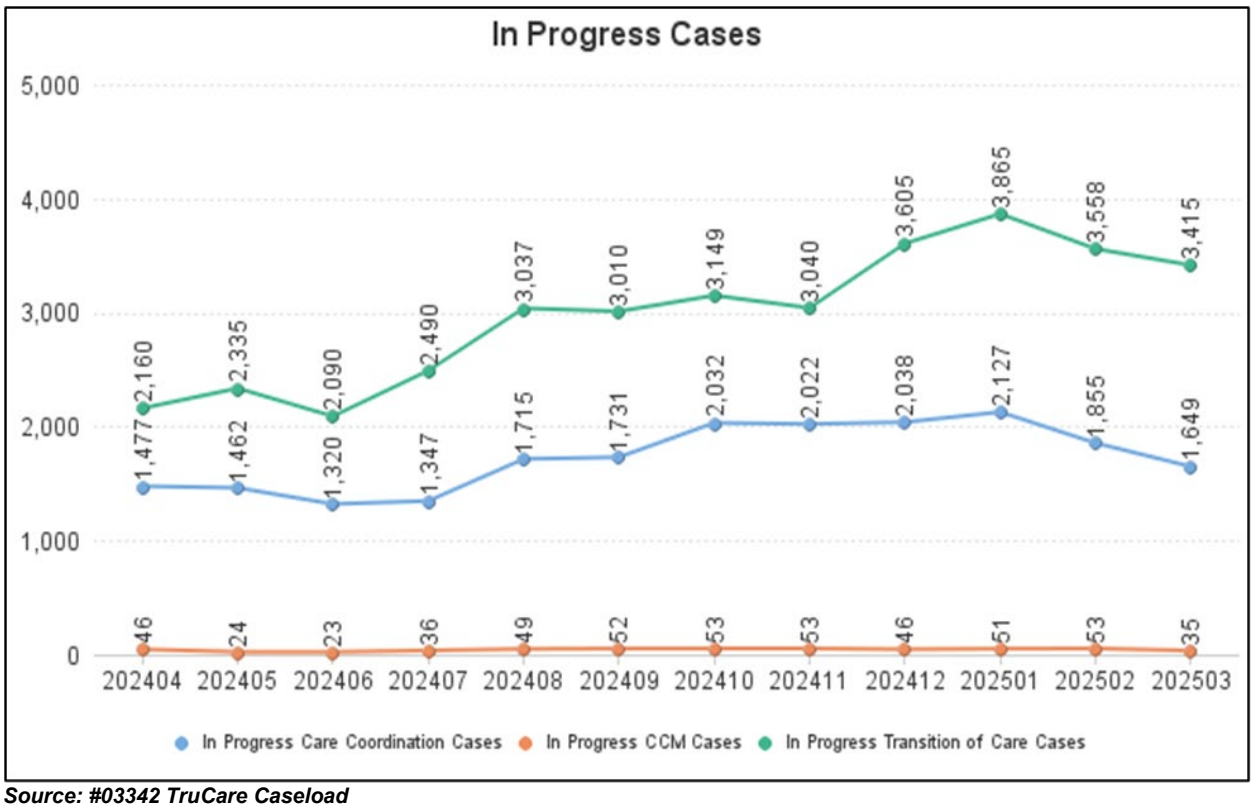
- The CM Team is assisting with coordination of continuity of care for the incoming foster youth population.

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

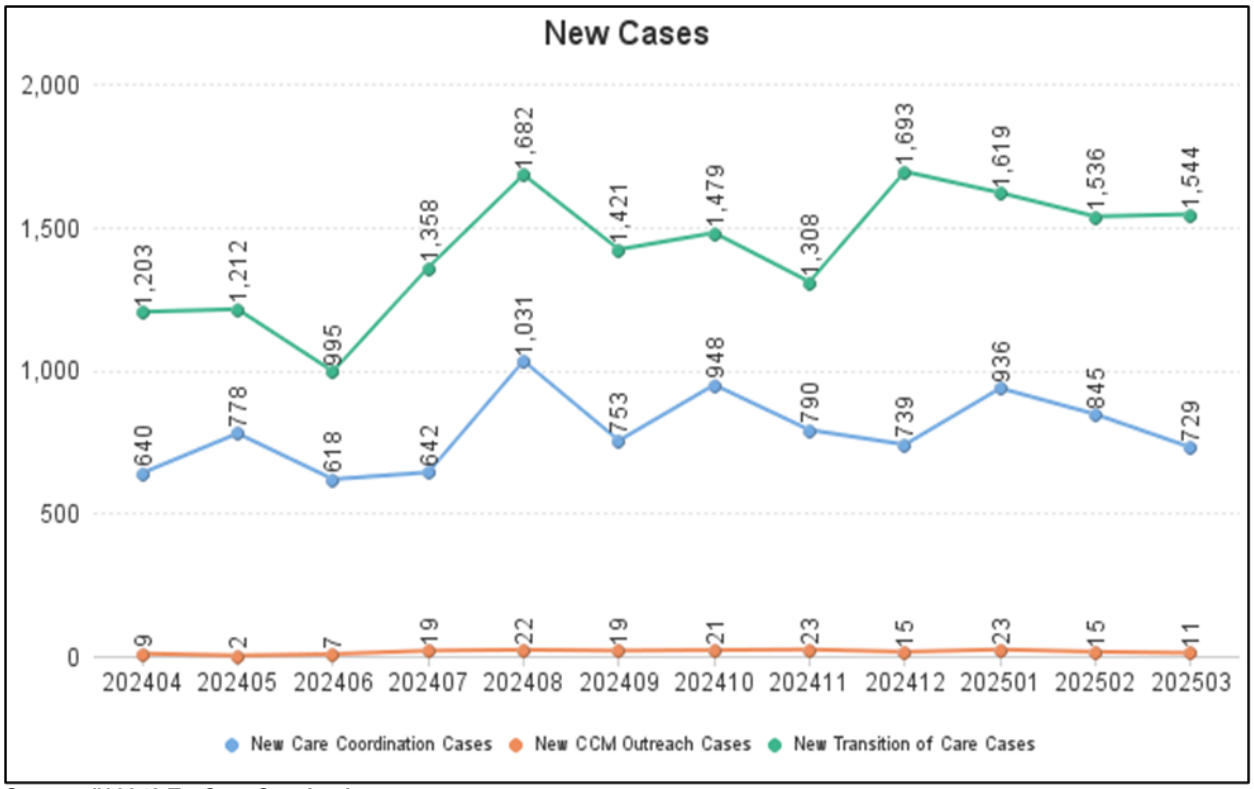
- The CM team continues to collaborate with clinic partners to ensure the TCS requirements are met, including but not limited to scheduling and ensuring follow-up appointments for members, informing members of CM services, notifying appropriate individuals of TCS services (hospital discharge planners,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

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

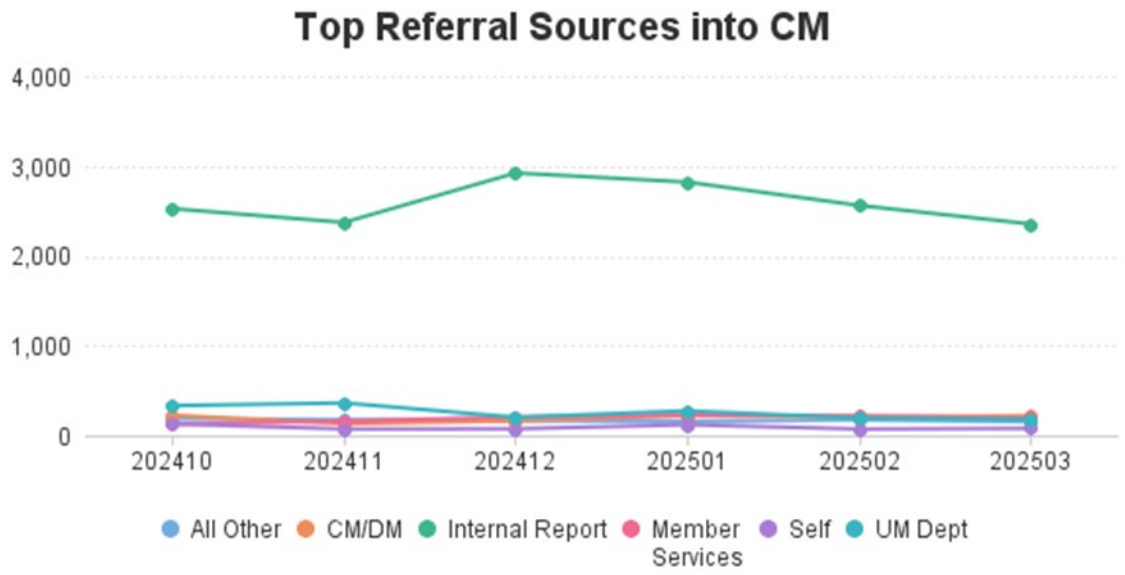
- CM is responsible for acquiring Physician Certification Statement (PCS) forms before Non-Emergency Medical Transportation (NEMT) trips to better align with DHCS requirements for members who need that higher level of transportation (former completed by Transportation broker, Modivcare). CM continues to educate the provider network, including hospital discharge planners, and dialysis centers about PCS form requirements. 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 only available through September 2024**

CalAIM

Enhanced Case Management

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

- The ECM team is working closely with IT and IPD to automate creation of authorizations and potential other areas of ECM. This will improve processing time of authorizations.

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

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

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

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

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

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

	December 2024		**January 2024**		**February 2025**	
ECM Providers	**Outreach**	**Enrolled**	**Outreach**	**Enrolled**	**Outreach**	**Enrolled**
ACBH	-	14	-	14	-	14
Alameda Health System (AHS)	16	208	22	203	-	186
Bay Area Community Services (BACS)	-	125	-	125	-	125
California Cardiovascular Consultants	-	160	-	160	-	161
California Children's Services (CCS)	8	22	7	24	-	22
CHCN	77	988	111	1,037	-	993
East Bay Innovations (EBI)	3	118	3	116	-	114
Full Circle	26	192	-	184	-	164
Institute on Aging	549	241	24	245	-	254
La Familia	76	39	55	36	-	33
MedZed	35	519	24	514	-	413
Roots Community Health Center	3	246	5	246	-	242
Seneca Family Services	-	61	10	61	-	58
Pair Team	816	718	396	744	-	723
Titanium Health Care	186	603	965	696	-	697
Tiburcio Vasquez Health Center (Street Medicine)	-	98	-	98	-	98
BACH (Street Medicine)	-	78	-	77	-	76
Lifelong (Street Medicine)	1	234	10	239	-	227
Roots Community Health Center (Street Medicine)	Combined with Roots 'traditional' ECM program					

Community Supports (CS)

- The team implemented new authorization criteria and Utilization Management processes effective 12/1/2024. The changes were needed to ensure full compliance with regulatory and contractual expectations. We continue to meet with CS providers to address questions about the new processes and support this change. Additional criteria revisions will be coming soon based on the new policy guide released February 2025 and the BOG decision to cap spending in the March meeting.

- CS services are focused on offering services or settings that are medically appropriate and cost-effective alternatives. The Alliance offers the following community supports:
    - Housing Navigation
    - Housing Deposits
    - Tenancy Sustaining Services
    - Medical Respite
    - Medically Tailored/Supportive Meals
    - Asthma Remediation
    - (Caregiver) Respite Services
    - Personal Care & Homemaker Services
    - Environmental Accessibility Adaptations (Home Modifications)
    - Nursing Facility Transition/Diversion to Assisted Living Facilities
    - Community Transition Services/Nursing Facility Transition to a Home

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

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

- DHCS outlined new closed loop referral requirements and moved the closed loop referral target date to 07/01/25. AAH is working on requirements to comply with the new DHCS requirements.

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

Community Supports	Services Authorized in December 2024	Services Authorized in January 2025	Services Authorized in February 2025
Housing Navigation	922	861	899
Housing Deposits	230	240	238
Housing Tenancy	1,006	935	774
Asthma Remediation	103	112	121
Meals	1,446	1,399	1,335
Medical Respite	92	86	78
Transition to Home	23	24	24
Nursing Facility	26	22	20
Home Modifications	0	0	
Homemaker Services	79	52	53
Caregiver Respite	5	4	3
Total	**3,932**	**3,735**	**3,545**

Grievances & Appeals

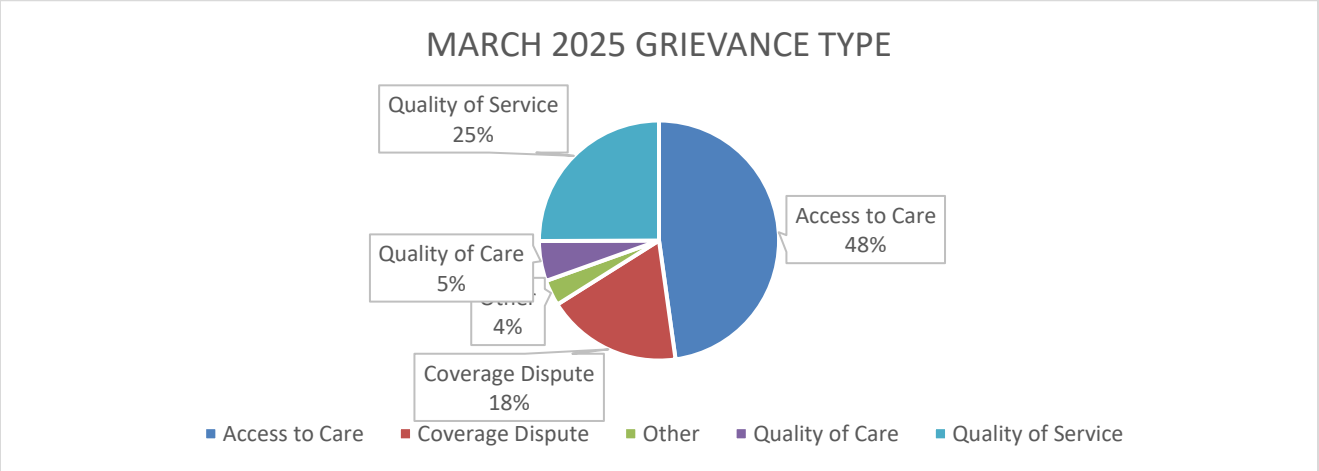
- Standard Grievance cases were not resolved within the goal of 95% of regulatory timeframes.
- Appeal cases were not resolved within the 95% of regulatory timeframes.
- Total Unique grievances resolved in March were 7.66 complaints per 1,000 members.

March 2025 Cases	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate	Per 1,000 Members*
Standard Grievance	1,927	30 Calendar Days	95% compliance within standard	1,777	92.2%	3.81
Expedited Grievance	0	72 Hours	95% compliance within standard	0	N/A	N/A
Exempt Grievance	1,869	Next Business Day	95% compliance within standard	1,854	99.1%	3.85
Standard Appeal	45	30 Calendar Days	95% compliance within standard	34	75.5%	1.05
Expedited Appeal	3	72 Hours	95% compliance within standard	2	66.6%	0.00
Total Cases:	3,844		95% compliance within standard	3,667	95.3 %	7.66

*Calculation: the sum of all unique grievances for the month divided by the sum of all enrollment for the month multiplied by 1000.

Standard Grievances:

- There were 1,573 unique grievance cases resolved during the reporting period, with a total of 1,927 grievances including all 354 shadow cases.



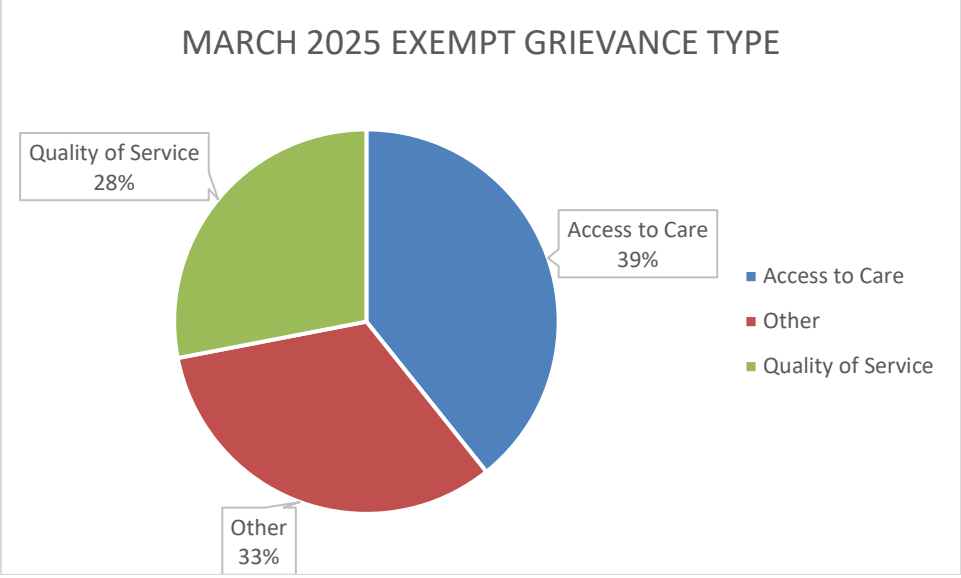
- **921** of 1,927 (48%) cases were related to Access to Care, the top 4 grievance categories are:
  - (286) Timely Access
  - (250) Technology/Telephone
  - (183) Provider Availability
  - (130) Authorization

- **483** of 1,927 (25%) cases were related to Quality of Service, the top 3 categories are:
  - (115) Plan Customer Service
  - (97) Provider/Staff Attitude
  - (76) Transportation

- **352** of 1,927 (18%) cases were related to Coverage Dispute, the top 3 grievance categories are:
  - (199) Provider Direct Member Billing
  - (86) Provider Balance Billing
  - (41) Reimbursement

Exempt Grievances:

- There were 1,590 unique exempt grievance cases resolved during the reporting period, with a total of 1,869 exempt grievances including all 279 shadow cases.



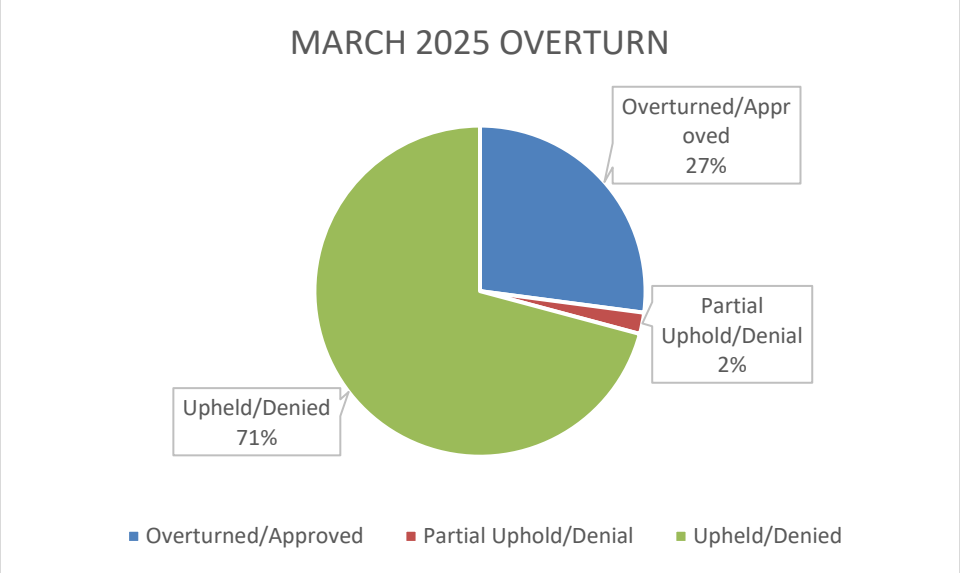
- 734 of 1,869 (39%) cases were related to Access to Care, the top 3 categories were:
  - (362) Telephone/Technology
  - (181) Provider Availability
  - (120) Geographic Access

- 611 of 1,869 (33%) cases were related to Other, the top 2 categories were:
  - (568) Enrollment
  - (43) Eligibility

- 524 of 1,869 (28%) cases were related to Quality of Service, the 2 categories were:
  - (258) Plan Customer Service
  - (227) Provider/Staff Attitude.

Appeals:

- The Alliance's goal is to have an overturn rate of less than 25%, for the reporting period of February 2025, we did not meet our goal with a 27% overturn rate



- **13** out of 48 (27%) cases were overturned for the month of March 2025:
  - (9) Disputes Involving Medical Necessity
  - (3) Out of Network
  - (1) Coverage Dispute

- **1** out of 48 (2%) cases were partially overturned for the month of March 2025:
  - (1) Disputes Involving Medical Necessity

- **34** out of 48 (71%) cases were upheld/denied for the month of March 2025:
  - (16) Disputes Involving Medical Necessity
  - (16) Out of Network
  - (2) Coverage Disputes

Quality

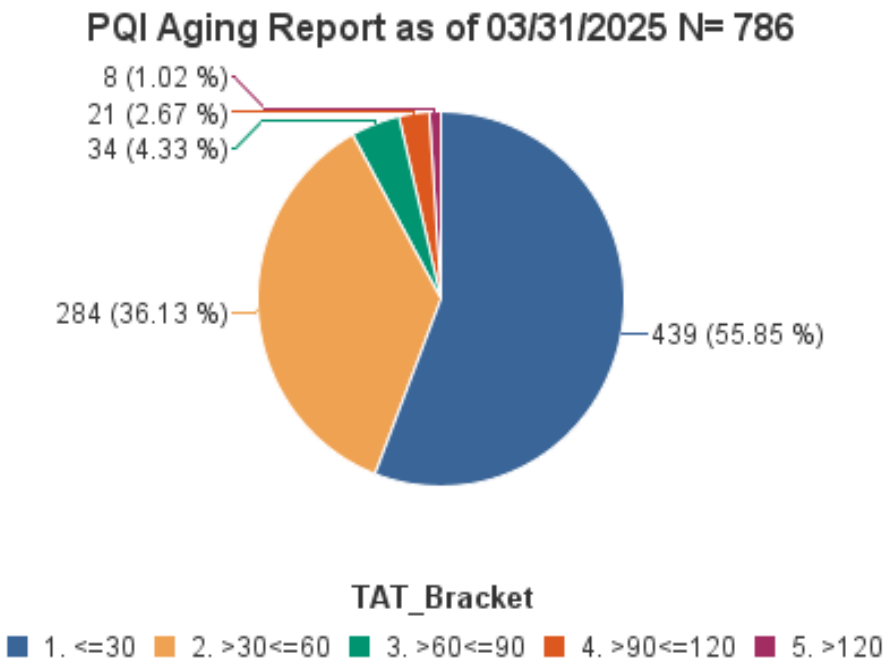
- Quality Improvement continues to track and trend PQI Turn-Around-Time (TAT) compliance. Our goal is closure of PQI cases within 120 days from receipt to resolution via nurse investigation and procurement of medical records and/or provider responses followed by final MD review when applicable.

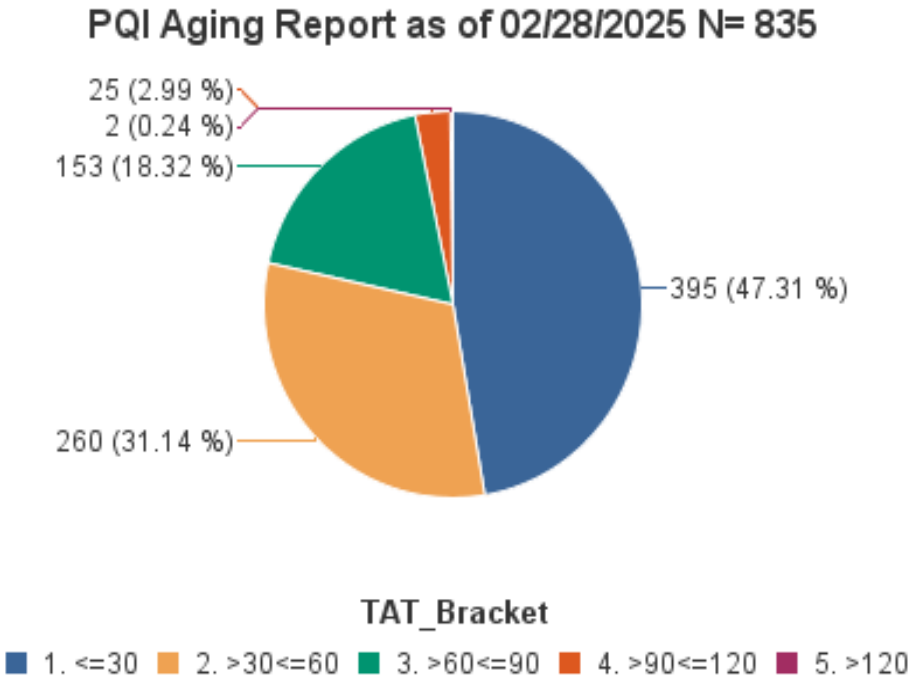
- Quality of Access issues are reviewed by the Access & Availability team and Quality of Language issues by the Cultural & Linguistics Services team after they are triaged by the QI Clinical team. Quality of Care and Service issues are reviewed by the QI RN Reviewers. Final leveling for Quality-of-Care cases is determined by the Sr Medical Director of Quality after RN review is completed. Weekly meetings are scheduled for the purpose of Quality-of-Care case review with the Sr Medical Director.

- 100% of cases in February 2025 and 98.98% of cases in March 2025 were closed within the 120-day TAT. Therefore, turnaround times for case review and closure remain well within the benchmark of 95% per PQI P&P QI-104 for this lookback period.

- When cases are open for >120 days, the reason continues to be primarily due to delay in receipt of medical records and/or provider responses. As part of the escalation process of obtaining medical records and/or responses, efforts are made to identify barriers with specific providers to find ways to better collaborate to achieve resolution.

- The total number of PQIs including all categories decreased by 49 referrals from February to March 2025. TATs are closely monitored on a weekly basis to ensure timely closure of cases within the standard 95%.


PQI Aging Report as of 03/31/2025 N= 786
8 (1.02 %)
21 (2.67 %)
34 (4.33 %)
284 (36.13 %)
439 (55.85 %)
TAT_Bracket
1. <=30
2. >30<=60
3. >60<=90
4. >90<=120
5. >120


PQI Aging Report as of 02/28/2025 N= 835
25 (2.99 %)
2 (0.24 %)
153 (18.32 %)
395 (47.31 %)
260 (31.14 %)
TAT_Bracket
1. <=30
2. >30<=60
3. >60<=90
4. >90<=120
5. >120

Quality Improvement Health Equity Committee (QIHEC) activities

- Background: The Alliance is contractually required to maintain a Quality and Health Equity (QIHE) Program to monitor, evaluate, and improve upon the Health Equity and health care delivered to all members. The Board is accountable for the QIHE Program and delegated the Quality Improvement Health Equity Committee (QIHEC) the authority to oversee the performance activities of the program.

- Summary: The following are QIHEC activities of findings, actions, and recommendations from the February 14, 2025 meeting:

- Health Equity Roadmap:
    - The roadmap is being rolled out, focusing on community engagement, particularly around cancer screenings, and staff training on DEI and transgender care. The focus will be on community engagement and staff training to effectively roll out the health equity roadmap

- DHCS Audit 2024 Findings:
    - Blood Lead Screening: The Plan did not ensure that blood lead screening tests were conducted for members up to six years of age.
    - Actions: Updated Policy QI-125 Blood Lead Screening to include a requirement for providers to follow up on lab orders; approved by QIHEC. Funded point-of-care testing units in January 2024 to the CHCN network. Conducted member outreach, member incentives, and provider education. HEDIS lead screening rates are now above the minimum performance level.
    - Appointment waitlist: The Plan did not ensure members were able to obtain medically necessary appointments within established timely access standards. One of the Plan's medical groups placed members on an appointment waitlist and had members waiting up to six months to make an appointment.
    - Actions: Closed provider panel in September, preventing additional wait listed members on 9/1/2024. There are on-going meetings: Joint Operating Meetings (JOM) and AAH/Provider Access Meetings, active outreach to members on the wait list, and progress reports were reviewed at AAH/Provider Access meetings. In September, two new providers were hired to support the wait list. In review of grievances data, the number of grievances declined for timely access. QI initiatives to improve access to care includes pay for performance (P4P), extended office hours incentives and provider recruitment/retention incentives. Monitoring will continue at the Access & Availability (A&A) Committee.
    - Monitoring In-Office Wait Times for Specialty and Behavioral Health Services:

- Actions: The Plan added in-office wait times measure to CG-CAHPS survey for BH providers on 5/6/2024. The finalized report was presented at the A&A Committee in September. Specialist providers will be added to the CG-CAHPS survey starting on 1/21/2025, anticipated final report June 2025. QI-114 Monitoring of Access and Availability Standards was revised to include monitoring of in-office wait times for specialist and behavioral health providers.

- Cultural and Linguistic Services: The Plan did not monitor the linguistic performance of vendors that provide interpreter services.
  - Actions: Updated P&P CLS-011: CLS Program Monitoring to include additional language on monitoring information collected and reporting. Updated vendor contracts to include reporting requirements for vendor interpreter qualifications and cadence. Implemented a process for monthly vendor interpreter qualifications reporting and monthly attestation of monthly vendor interpreter qualifications review. Concerns will be reviewed with vendor interpreter qualifications at the Quarterly Vendor Joint Operations Meeting (JOM). On-going reporting and monitoring with vendor interpreter qualifications are discussed at Quarterly Cultural and Linguistic Services Subcommittee (CLSS) meeting.
  - Recommendations: Continue to monitor and address any issues related to the 2024 DHCS audit findings

- **UM Workplan Updates**: Key metrics for 2023 and 2024 were shared, including average length of stay, inpatient admissions, readmission, and denial rates. Readmission rates were significantly higher than the 18% goal, with SPD having the highest rate at 23.9%. Six out of 13 hospitals saw a decrease in readmissions in 2024. The focus will be on getting readmission rates down at the facilities that have had increases, such as San Leandro, St. Rose, and Stanford. Denial rates showed a decrease in full denials, an increase in partial denials, particularly in the outpatient setting. A deeper dive will be conducted into why members are accessing care outside of Alameda County

- **Case Management Workplan Updates**: Updates on transportation and case management were provided, including a transition from Lyft ride share recovery pilot to a standard network option. Case management saw a 10% increase in Transition of Care Services (TCS) cases and a 2% increase in complex cases. The internal complex case management audit showed 100% assessment and 98% care plan adherence. Increase in Transition of Care cases from January to December 2024, with more cases kept open longer due to high caseloads. Staff performance improvements and retraining to help manage caseloads and prioritize tasks. Referrals increased from Q2 to Q3 2024, with ADT being the majority of referrals related to TCS. Enhanced Care Management (ECM) authorizations increased, and impact analysis showed a 47.9% decrease in admissions and a 51.2% decrease in bed days post-ECM enrollment.

- **Alameda County Public Health CHNA/CHIP**: Carolina Guzman from Alameda County Public Health discussed the Community Health Needs Assessment (CHNA). Key issues identified in the 2022-2024 CHNA include access to care, language interpretation, mental health, income, employment, and community safety.

- **PQI Update:** For Q1-Q4 2024, 9,855 PQIs were closed, with most related to quality of service and access issues. PQI chart audits were conducted for oversight: 1) Exempt grievances: 100 randomly selected exempt grievances, and achieved over 90% accuracy in identifying PQIs, 2) Clinical Quality of Service: audited 59 cases in Q2 and 48 in Q3, focusing on quality of care, service, access, and language issues, achieved goal of >90%.

- **Community Advisory Committee (CAC) Insights**: The 2024 CAC feedback was shared with highlights relating to health education, population health, Alliance services, communications and outreach methods, grievance and appeals process, and non-specialty mental health outreach and education plan. Follow up is underway for the recommended feedback from CAC

- **Behavioral Health Update**: The presentation covered the rise in mental health and ADA/DHT utilization since January 2024, with a 95% turnaround time target met in Q4 2024. A 6% rate for non-specialty mental health services was achieved, up from 4% in 2023. Implement and evaluate the non-specialty mental health outreach and education plan over the next year. Analysis revealed opportunities for outreach to older adults, Chinese, Vietnamese, and Spanish speakers, and those in long-term care. The new Senate Bill 1019 requires outreach and education on non-specialty mental health services, aligned with cultural and linguistic standards. Plans include mailings, website posts, and social media outreach for members and providers

Health Equity

Lao Paul Vang

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

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

Date: **April 11th, 2025**

Subject: **Health Equity Report**

Internal Collaboration

- **Meetings and check-ins with Division Chiefs Update**
  - The CHEO meets with the Alliance division chiefs on a 1x1 basis monthly to update on Health Equity (HE) and Diversity, Equity, and Inclusion (DEI) activities.

- **Faith-Based Community Engagement Update**
  - A cross-functional stakeholder workgroup, Faith-Based Community Engagement (FBCE), was created in December 2024 as part of the broader strategic effort to fulfill our milestone # 5 in our Health Equity Roadmap.
  - Monthly Meetings are scheduled to foster collaboration among internal stakeholders and develop strategies that will lead to partnerships with faith-based organizations.
  - We rely on three (3) critical factors to identify priority FBOs and guide our work: 1) members' relationships with the faith-based organization, 2) the health disparity gap, and 3) available funding and resources.
  - Subgroups have been formed to address specific aspects of the FBO's partnership, specifically collaborating with PHM and QI teams to develop culturally appropriate education with specific ethnic minority FBOs.
  - Health Equity is collaborating with QI and PHM to develop an education seminar that addresses the three high disparity areas that impact the BIPOC community:
    - Women's health preventive screenings, such as Breast cancer and Cervical cancer screenings
    - Child well-visits
    - Doula Services
  - In collaboration with C&O, the HE team participated in the Black Women's Health Forum (BWHF) on April 8th in downtown Oakland. Health education/promotional materials were provided to attendees.

- **SOGI Data Workgroup**
  - Given the new federal executive order, the SOGI data committee decided to temporarily suspend our work until April, pending further guidance or possibly a new advisory from NCQA regarding potential changes in this area.

- **NCQA-Health Equity Accreditation**
  - The HE Team will continue to participate in the NCQA working group to address health equity-related standards relating to AAH's application for NCQA Accreditation by January 2026.

- **PHM Workgroup**
  - The HE Team continues to collaborate with PHM and participates in their weekly work group, including reviewing the new PHM strategies for the coming year.

- **Over/Under Utilization Workgroup**
  - HE Team continues to engage in ongoing meetings with the Healthcare Service unit in their working group to discuss and share best practices relating to ways to overcome over- and underutilization.

- **Alliance Publication Workgroup**
  - As part of the Health Equity Roadmap milestone # 4 Communication, the HE Team joined the Alliance Publication workgroup organized by Communication & Outreach to help create content for social media postings and articles with an aim to position AAH as the champion for health equity advancement for our members.

External Collaboration

- **Bi-weekly meetings with Local Health Plans' Chief Health Equity Officers (CHEOs) Update**
  - Ongoing discussions regarding health equity-related issues and DEI training curriculum.

- **Monthly Meetings with DHCS' Chief Health Equity Officer (DHCS CHEO) Update**
  - DHCS CHEOs and MCPs CHEOs met to collaborate on Health Equity and DEI initiatives.
  - The meeting consisted of DHCS and CHEO Updates.

- **Local Initiatives DEI training, Monthly Collaborative Meeting**
  - Local MCPs continue to meet to update, share, and collaborate on the DEI Training Program. The monthly collaborative allows MCPs to ask questions, update each other on curriculum information, and assist with moving the DEI Training forward**.**

- **CIN (California Improvement Network)**
  - HE Team participated in a competitive membership application to California Improvement Network (CIN) and was successfully selected to be a partner as of March 6, 2025.
  - The CIN consists of 25 leaders from major healthcare, managed care, and public health organizations across California. The term of service

is 2 years, from 2025 to 2027.
    - As a CIN partner, our Alliance is now part of a diverse learning and action network focused on advancing equitable healthcare experiences and outcomes in California.
    - Additionally, Alliance would have an opportunity to apply for a grant to advance specific health equity among our Medicaid members.

- **First-5**
    - HE participated in an exploration discussion with First-5, along with the CEO and CMO, on January 8, 2025. Future discussions on a possible partnership are ongoing.

- **American Heart Association**
    - The HE Team initiated a discussion with the American Heart Association (AHA) on February 26 to explore a potential collaboration to close health disparity gaps in the incidence of cardiovascular diseases among the BIPOC (Black, Indigenous, and People of Color).

Alliance Health Equity Strategic Roadmap Update

- The Alliance Health Equity Roadmap was presented in December 2024:

Milestones	Goals
1. Organization Transformation	a) CHEO works collaboratively with SLT to facilitate system-wide organization transformation that supports the long-term vision of health equity for the Alliance.
2. Data-Driven	a) Collaboration with UM, PHM, QI, and Analytics. b) Utilize grant-funded health equity projects to gather data that will augment the Alliance's claim data depository to formulate a comprehensive understanding of the SDOHs that perpetuate the health disparities faced by our Medicaid members.
3. Education	a) Lead in the development of DEI Training APL 23-025 and APL 24-018 TGI-SB 923 training. b) Collaboration with C&L (Culture and Linguistics), PHM, QI, and other stakeholders to ensure all our policies, services, and programs are rooted in the core foundation of health equity.

	c) Participation in various Functional Area Delegate (FAD) workgroups to ensure the Alliance work supports the health equity vision and mission
4. Communications	a) Collaboration with Alliance Publication Workgroup to develop effective communications on all aspects of health equity activities to ensure that staff and members are fully informed.
5. Community Engagement	a) Faith-Based Community Engagement (FBCE) workgroup b) CIN membership c) Other CBOs, and national or local organizations such as AHA, First-5.
6. SDOH Mitigated Measures	a) Collaborate with CMO and HCS team to assess and analyze non-utilization data aimed at identifying health disparities.

Recommendations:

1. BOG should review and provide feedback regarding the above milestones and goals.
2. BOG can add additional milestones and goals and or revise the current milestones and goals.
3. Upon receiving BOG's feedback, the final milestones and goals will be established, and the HE Team will begin the implementation process of the Alliance Health Equity Roadmap.

DHCS-DMCS APL Update

- **DEI Training APL 23-025 Update**
  - The HE Team received approval from DHCS regarding the DEI training curriculum.
  - Updated Timeline:
    - April 2025: DEI Provider's Pilot will launch. California Cardiovascular Consultants (CCC) has been selected to receive the pilot training.
    - April – June 2025: Pilot training completed.
    - July – December 2025: Training given to downstream network providers and vendors.

- **APL 24-018: TGI-SB 923 Update**
  - The TGI (Transgender, Gender Diverse, intersex) Cultural Sensitive Training was provided to AAH staff who are directly working and dealing with our members.

- Timeline:
  - December 2024: Confirmation of vendor
  - January - February 2025: Implementation of training for all Alliance staff.
  - February 14, 2025: 97% of AAH staff completed the mandatory training. The 3% of non-completion represents staff who were on vacation or medical leave. Upon returning to the office, they will have up to 30 days to complete the training.
  - February 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.
  - February 28, 2025: Attestation was submitted to DHCS.
  - The HE Team is working with the TGI working group to develop plans to train member-facing vendors as part of the next step in this APL.

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

- **DEIB Committee Update**
  - The DEIB Committee met on March 21st and discussed Health Equity and DEI Activities and the Spring Social Update.

- **VIA Committee Update**
  - At the March 28th VIA meeting, the committee discussed the national and cultural events in March and April 2025.
  - The Spring Social Event is confirmed to be on April 22nd. This will be one of the three social events for the Alliance Staff in 2025. There will be four vendors with a mixture of cultural foods.

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: **April 11th, 2025**

Subject: **Information Technology Report**

Call Center System Availability

- In March 2024, AAH phone systems and call center applications maintained 100% availability even as they supported 97% of employees working remotely.

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

Encounter Data

- In the month of March 2025, the Alliance submitted 168 encounter files to the Department of Health Care Services (DHCS) with a total of 461,741 encounters.

Enrollment

- The Medi-Cal Enrollment file for the month of March 2025 was received and loaded to HEALTHsuite.

HEALTHsuite

- The Alliance received 347,469 claims in the month of March 2025.

- A total of 327,795 claims were finalized during the month out of which 281,086 claims auto adjudicated. This sets the auto-adjudication rate for this period to 85.8%.

TruCare

- A total of 19,546 authorizations were loaded and processed in the TruCare application.

- TruCare Application Uptime – 99.9%.

IT Security Program

- The IT Security 3.0 initiative ranks among the Alliance's foremost objectives for fiscal year 2025. Our aim is to consistently enhance and advance our security measures, secure our network perimeter against threats and vulnerabilities, and bolster our security policies and procedures.

- Prioritized vulnerability remediation efforts around the most mission critical findings in Nessus and annual security risk assessment report. KPI tracked on a weekly basis.

- For completeness, IT Security is expanding the vulnerability scanning footprint to databases, VMware environment, and unused IP spaces to rule out shadow IT.

- *User Acceptance Policy* drafted, going through internal review.

Microsoft InTune roll-out

- To enhance workstation security, Alliance is deploying Microsoft Intune on our workstations and mobile devices. This cloud-based service specializes in mobile device and application management, allowing the Alliance to secure and manage access to corporate data on mobile devices while protecting information. Intune enables device and app management, data protection, and policy compliance.

    - The engineering team has finished the core technical setups and is currently supporting the IT Service Desk on user migrations. Emails have been dispatched to all staff members as part of the campaign and rollout plan.

    - 667 migrations were completed, covering 8 departments, bringing project completion to 99%. Migrations are nearly completed.

    - Manual pre-check tasks have been automated for efficiency.

Information Technology

Supporting Documents

Enrollment

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

Month	Total MC[1]	MC[1] - Add/ Reinstatements	MC[1] - Terminated	Total GC[2]	GC[2] - Add/ Reinstatements	GC[2]- Terminated
March	412,651	6,432	7,970	5,883	188	117

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 March 2025

Auto-Assignments	Member Count
Auto-assignments MC	2,926
Auto-assignments Expansion	2,624
Auto-assignments GC	59
PCP Changes (PCP Change Tool) Total	5,609

TruCare Application

- See Table 2-1 “Summary of TruCare Authorizations for the month of March 2025”.
- There were 19,546 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 March 2025*

Transaction Type	Total Auths Received
Paper Fax to Scan (DocuStream)	2,660
Provider Portal Requests (Zipari)	5,531
EDI (CHCN)	6,322
Provider Portal to AAH Online (Long Term Care)	14
ADT	1257
Behavioral Health COC Update - Online	54
Behavioral initial evaluation - Online	33
Manual Entry (all other not automated or faxed vs portal use)	2,608
OCR Face sheets	1,067
Total	19,546

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 February 2025

Group	Individual User Accounts	Individual User Accounts Accessed	Total Logins	New Users
Provider	8,064	5,835	502,048	753
MCAL	123,831	3,772	8,760	1,195
IHSS	3,968	80	481	32
Total	135,863	9,687	511,289	1,980

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

Category	Page Name	Page Views
Provider - eligibility/claim	Member Eligibility	1,402,716
Provider - Claims	Claim Status	224,257
Provider - eligibility/claim	Claim Status	26,339
Provider - authorizations	Auth Submit	15,475
Provider - authorizations	Auth Search	7,840
Member Config	Provider Directory	7,739
Directory Config	Provider Directory	4,531
Provider - Claims	Submit professional claims	4,526
Member My Care	Member Eligibility	4,266
Member Help Resources	Find a doctor or Hospital	3,204
Member Help Resources	ID Card	2,452
Provider - eligibility/claim	Member Roster	2,094
Member Help Resources	Select or Change Your PCP	1,956
Member Home	MC ID Card	1,443
Member My Care	My Claims Services	1,235
Provider - Provider Directory	Provider Directory 2019	1,039
Provider - reports	Reports	851
Member My Care	Authorization	610
Member My Care	My Pharmacy Medication Benefits	431
Provider - Home	Behavior Health Forms SSO	422
Provider - Home	Forms	401
Member Help Resources	FAQs	387
Member My Care	Member Benefits Materials	343
Provider - Provider Directory	Instruction Guide	315
Member Help Resources	Forms Resources	309

Call Center – Call Volume Overview:

Members - Call Center Statistics			
Month	Calls Presented	Calls Handled	Calls Abandoned
October	8437	7798	269
November	7427	6186	390
December	8438	6912	414
January	14078	10705	1483
February	11335	9026	869
March	11867	11151	709

Providers - Call Center Statistics			
Month	Calls Presented	Calls Handled	Calls Abandoned
October	10863	8972	1751
November	8931	6786	2007
December	9598	7285	2152
January	13400	8682	3822
February	10986	7586	1931
March	8303	6869	1434

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

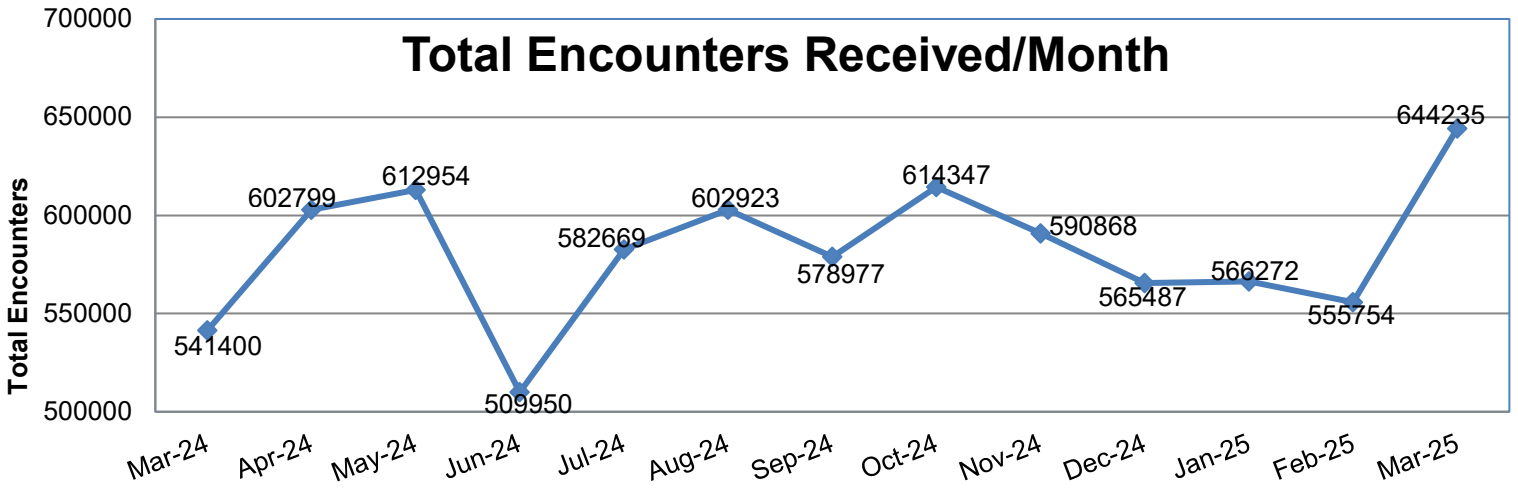
Note: It is important to note that there is a slight discrepancy between the number of calls presented, handled, and abandoned. This discrepancy is due to calls being rerouted to the XAQT vendor, which are not included in the calls handled or abandoned statistics. This rerouting can account for some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

Encounter Data from Trading Partners March 2025

- **AHS**: March weekly files (9,273 records) were received on time.
- **BACH**: March monthly files (291 records) were received on time.
- **BACS**: March monthly files (81 records) were received on time.
- **CHCN**: March weekly files (181,049 records) were received on time.
- **CHME**: March monthly files (6,794 records) were received on time.
- **CFMG**: March weekly files (21,767 records) were received on time.
- **Docustream**: March monthly files (770 records) were received on time.
- **EBI**: March monthly files (1,390 records) were received on time.
- **FULLCIR**: March monthly files (2,099 records) were received on time.
- **HCSA**: March monthly files (2,118 records) were received on time.
- **IOA**: March monthly files (736 records) were received on time.
- **Kaiser**: March bi-weekly files (0 records) were received on time.
- **LAFAM**: March monthly files (85 records) were received on time.
- **LIFE**: March monthly files (431 records) were received on time
- **LogistiCare**: March weekly files (33,754 records) were received on time.
- **March Vision**: March monthly files (6,985 records) were received on time.
- **MED**: March monthly files (775 records) were received on time.
- **OMATOCHI**: March monthly files (0 records) were received on time.
- **PAIRTEAM**: March monthly files (2,055 records) were received on time.
- **Quest Diagnostics**: March weekly files (22,502 records) were received on time.
- **SENECA**: March monthly files (129 records) were received on time.
- **SERENE**: March monthly files (209 records) were received on time.
- **TITANIUM**: March monthly files (2,855 records) were received on time.
- **TVHC**: March monthly files (618 records) were received on time.
- **Magellan**: March monthly files (479,718 records) were received on time.

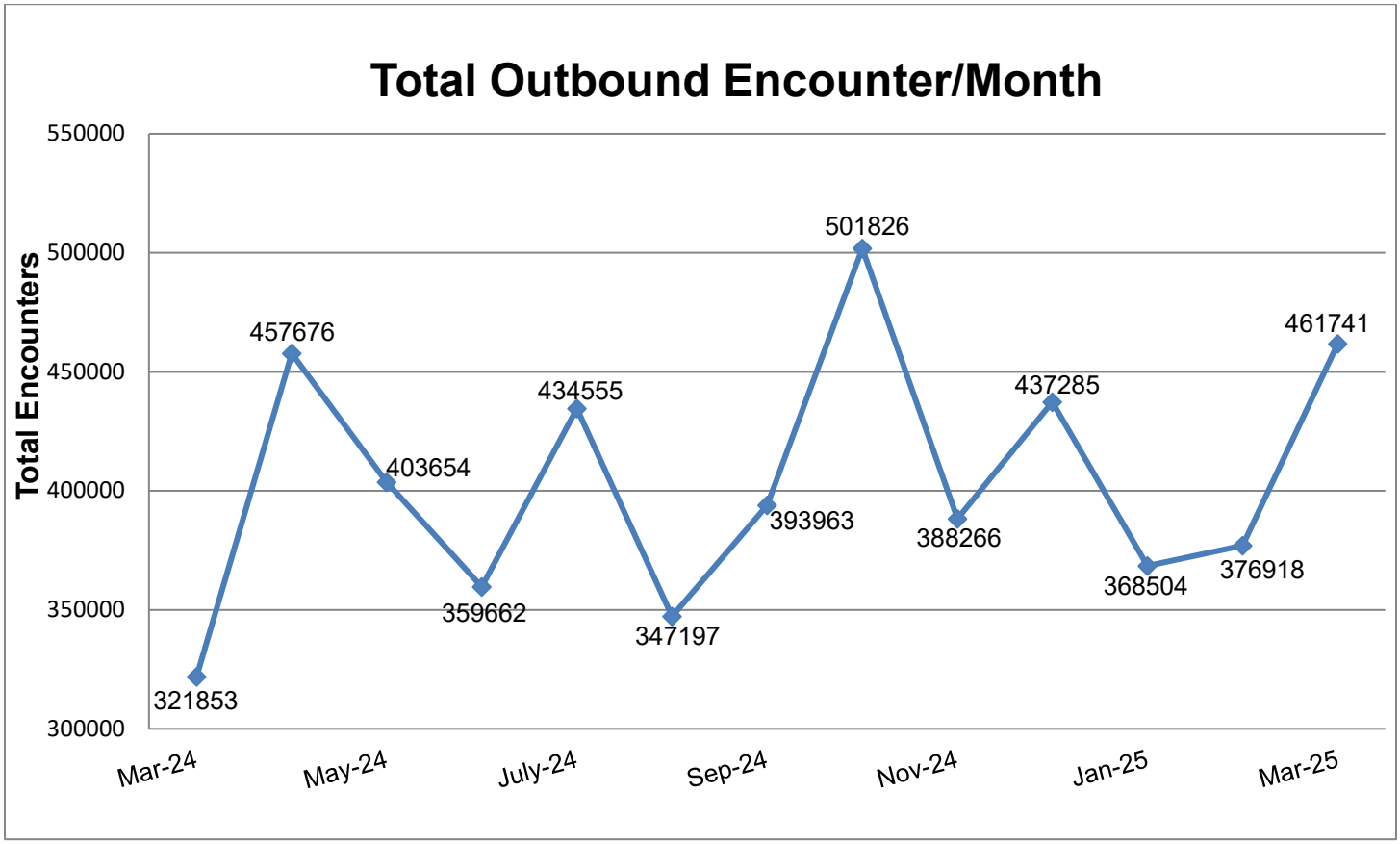
Trading Partner Encounter Inbound Submission History

Trading Partners	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Health Suite	308453	322786	375454	297267	332150	368235	322196	367989	364130	332108	339760	339840	347469
AHS	7005	6573	8412	13316	7296	8859	7498	8309	10535	7261	9709	8654	9273
BACH									795		426		291
BACS	55	64	70	77	88	86	85	76	98	104	93	113	81
CHCN	122217	170653	122445	110650	135444	122293	155825	125042	127223	127327	117483	118972	181049
CHME	6022	7969	7107	7449	7242	6902	7680	7102	7589	7458	7781	7553	6794
CFMG	12651	16394	15934	21143	10776	22335	16421	16045	21352	16696	13536	17329	21767
Docustream	698	302	1589	749	934	1102	1067	704	678	828	694	808	770
EBI	1625	1700	184	2043	1623	1825	3394	1640	1725	1476	1440	1597	1390
FULLCIR	213	2261	8478	2842	1362	1798	3809	2523	2038	1085	806	1534	2099
HCSA	2822	7118	5535	3663	6841	3256	3386	2389	3423	2335	2432	2725	2118
IOA	1054	1925	1163	1280	847	752	4227	588	1064		3008	933	736
Kaiser	9966	2286	886	1079	2052	172	236	159					
LAFAM	39	105	116	86	70	88	63	89	76	83	112	96	85
LIFE				1694		614	168	119	335	997	228	267	431
LogistiCare	35600	32632	27531	16205	43038	29732	16139	49941	16183	34122	28671	32550	33754
March Vision	6183	3633	8546	7092	6404	7719	5769	5143	6016	6285	15146		6985
MED	683	633	722	744	615	608	610	645	656	619	758	1182	775
OMATOCHI		29				2							
PAIRTEAM		5344	7582		5763		9359	1108	2204	5816	3436		2055
Quest	22306	18000	18001	22500	18000	22502	18004	18002	22501	18003	18002	18001	22502
SENECA	112	159	113	71	109	129	101	105	117	131	1	69	129
SERENE										654	107		209
TITANIUM	3696	2233	3086		2015	3914	2815	6192	1537	2099	2487	3531	2855
TVHC							125	437	593		156		618
Total	541400	602799	612954	509950	582669	602923	578977	614347	590868	565487	566272	555754	644235



Outbound Encounter Submission

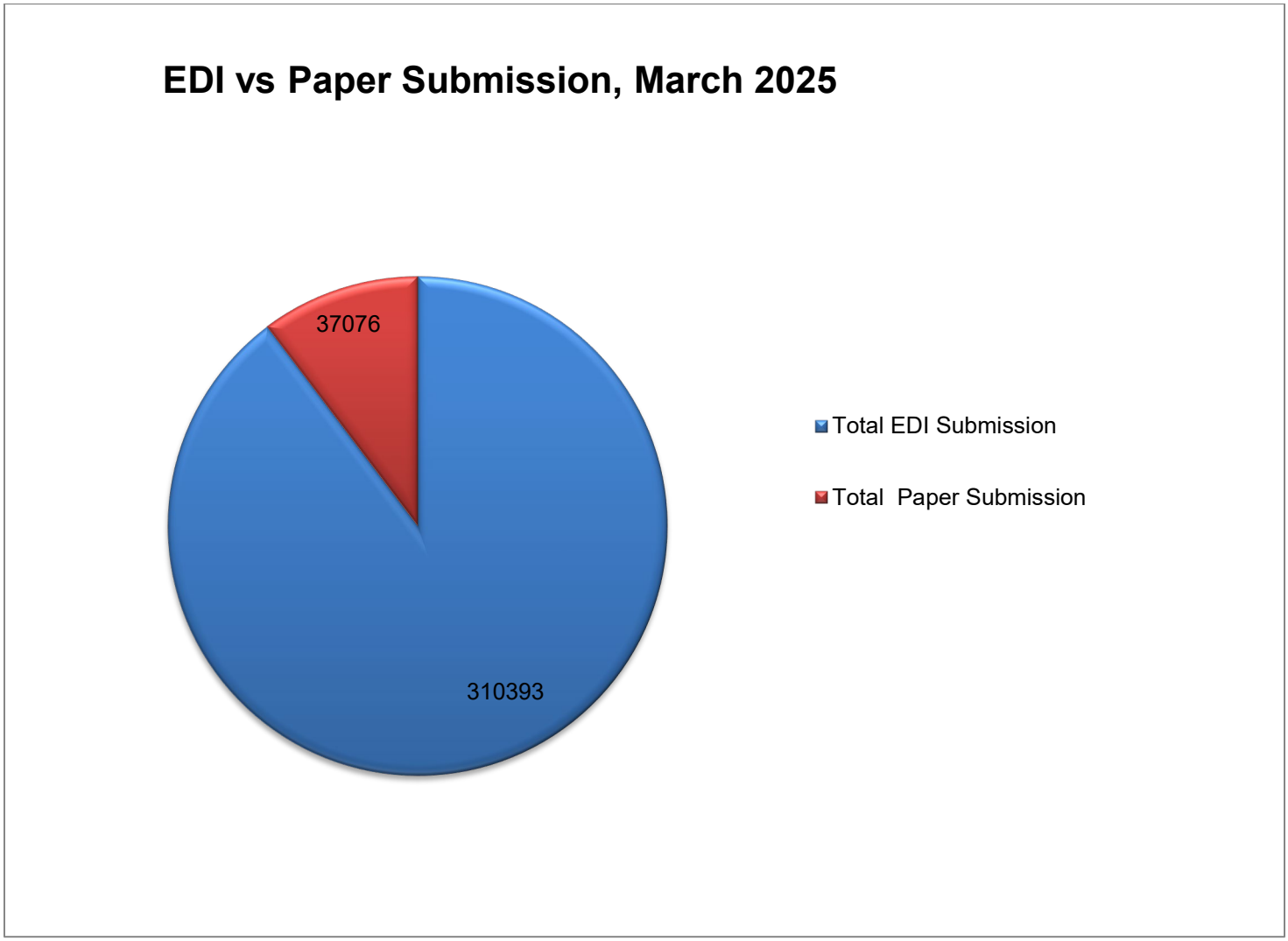
Trading Partners	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Health Suite	147776	250835	198595	204068	230706	183371	210971	276473	218194	263242	182192	205804	264948
AHS	6968	6524	7002	10684	6703	7101	8727	8201	10403	6850	7710	8135	7952
BACH									739	6	407		272
BACS	47	59	66	72	80	80	78	74	79	41	128	87	59
CHCN	80498	104625	107577	77200	94476	87485	87806	108806	88573	84649	85439	82973	95918
CHME	5889	7558	6749	7310	7095	6762	6994	6974	7474	7342	7426	7167	6682
CFMG	6757	13467	11561	11506	9994	4	24076	13152	13882	11342	9362	11960	15008
Docustream	377	267	839	570	725	806	715	545	482	239	634	559	478
EBI	1002	1589	60	1835	1443	1727	3242	1559	1641	494	2208	1475	1308
FULLCIR	116	1636	5401	2410	1084	674	1515	1767	1470	79	1298	1251	1823
HCSA	2769	4710	5363	3493	6757	3171	3310	2376	3394	2255	2497	2693	2103
IOA	1000	1868	1029	1221	749	680	1374	549	949		2783	781	626
Kaiser	9650	1905	1292	812	1404	113	216	62		23			
LAFAM	16	92	103	58	66	81	58	86	62	3	178	89	80
LIFE				28		598	159	91	76	202	508	63	65
LogistiCare	34931	32247	27487	16221	43019	30006	16046	49705	15235	34035	28502	32441	33656
March Vision	3736	2407	5719	4553	3766	3482	4066	3543	3980	4156	9586	371	4354
MED	528	518	579	654	552	540	514	579	568	55	546	1083	731
OMATOCHI		56											
PAIRTEAM		4279	4422		3246		4617	782	1960	994	6334		1489
Quest	16333	20983	16912	16898	20898	16854	16937	21144	16909	21044	16828	16855	21048
SENECA	199	140	109	69	108	127	94	91	100	6	112	60	116
SERENE											82		20
TITANIUM	3261	1911	2789		1684	3535	2332	5267	1278	228	3600	3071	2551
TVHC							116		818		144		454
Total	321853	457676	403654	359662	434555	347197	393963	501826	388266	437285	368504	376918	461741


Total Outbound Encounter/Month
Total Encounters
550000
500000
450000
400000
350000
300000
321853
457676
403654
359662
434555
347197
393963
501826
388266
437285
368504
376918
461741
Mar-24
May-24
July-24
Sep-24
Nov-24
Jan-25
Mar-25

HealthSuite Paper vs EDI Claims Submission Breakdown

Period	Total EDI Submission	Total Paper Submission	Total claims
25-Mar	310393	37076	347469

Key: EDI – Electronic Data Interchange

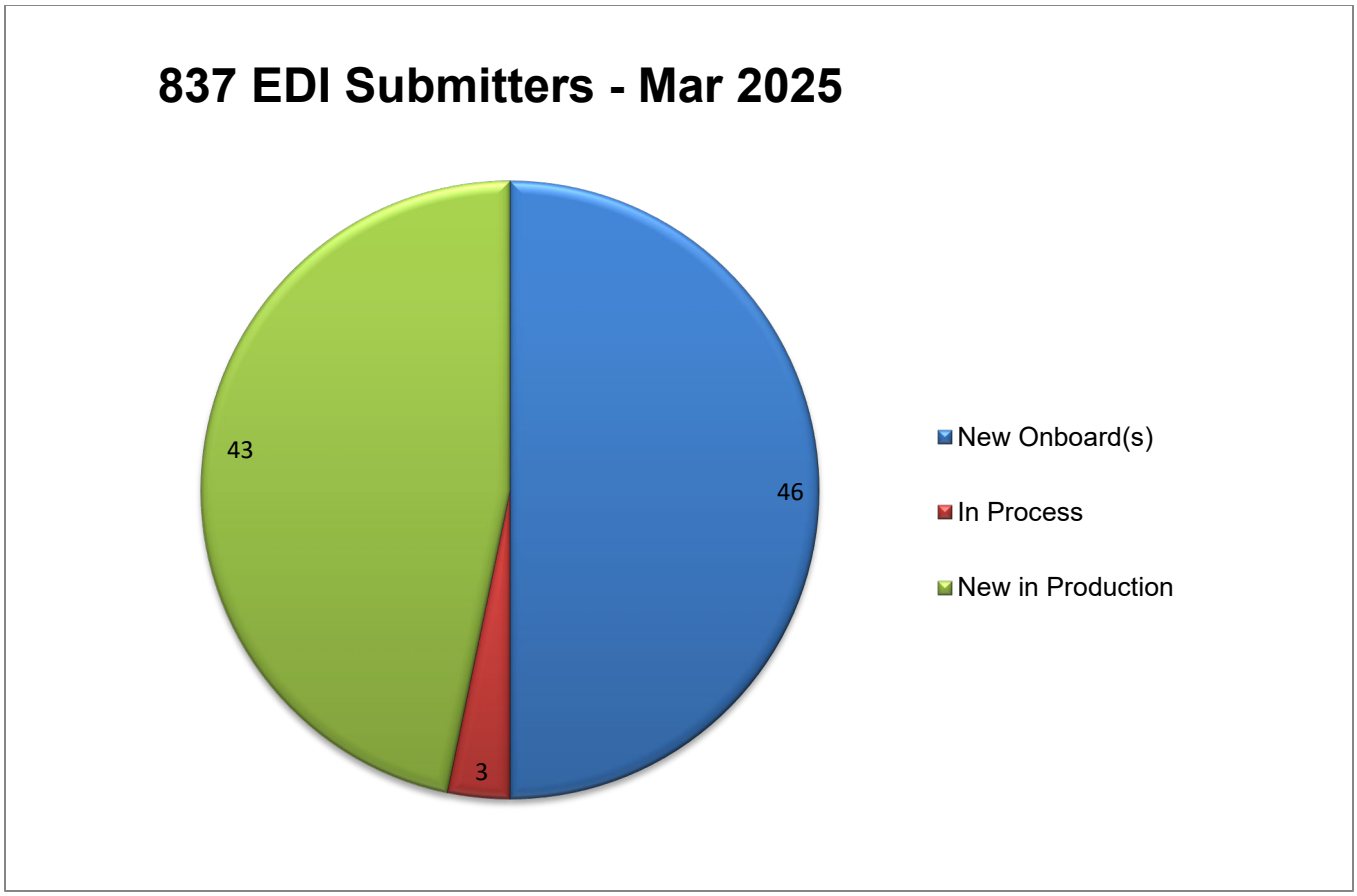


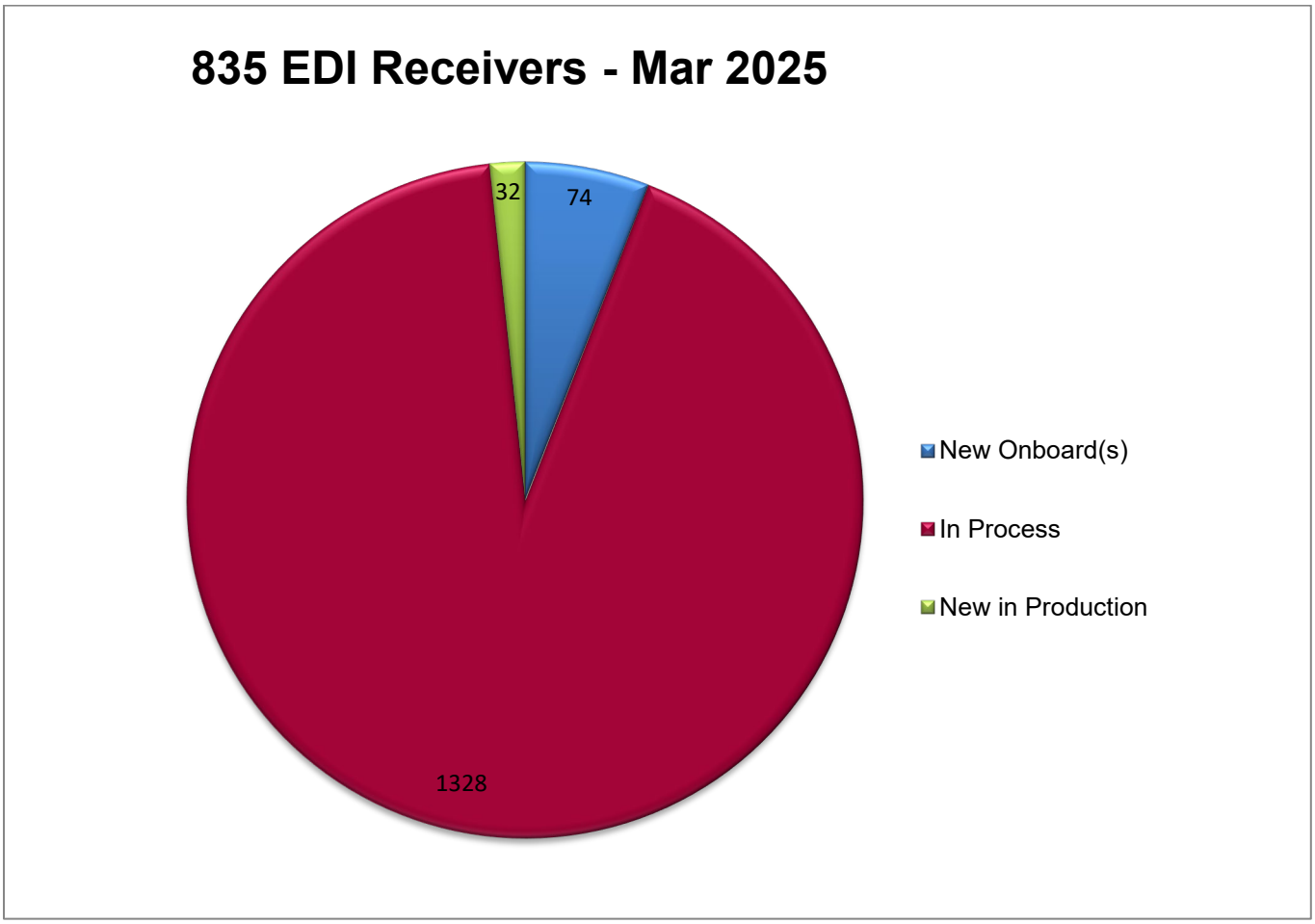
Onboarding EDI Providers – Updates

- Mar 2025 EDI Claims:
  - A total of 2957 new EDI submitters have been added since October 2015, with 43 added in March 2025.
  - The total number of EDI submitters is 3697 providers.

- Mar 2025 EDI Remittances (ERA):
  - A total of 1352 new ERA receivers have been added since October 2015, with 32 added in March 2025.
  - The total number of ERA receivers is 1339 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
Apr-24	120	3	117	3017	83	851	54	1012
May-24	81	13	68	3085	63	874	40	1052
Jun-24	39	4	35	3120	50	908	16	1068
Jul-24	86	3	83	3203	54	937	25	1093
Aug-24	181	2	179	3382	62	982	17	1110
Sep-24	46	5	41	3423	73	1027	28	1138
Oct-24	60	4	56	3479	80	1071	36	1174
Nov-24	61	20	41	3520	89	1131	29	1203
Dec-24	61	22	39	3559	97	1177	51	1254
Jan-25	61	8	53	3612	79	1234	22	1276
Feb-25	58	16	42	3654	83	1286	31	1307
Mar-25	46	3	43	3697	74	1328	32	1339


837 EDI Submitters - Mar 2025
43
46
3
New Onboard(s)
In Process
New in Production


835 EDI Receivers - Mar 2025
32
74
1328
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 **March** 2025.

File Type	Mar-25
837 I Files	36
837 P Files	132
Total Files	168

Lag-time Metrics/Key Performance Indicators (KPI)

AAH Encounters: Outbound 837	Mar-25	Target
Timeliness-% Within Lag Time - Institutional 0-90 days	91%	60%
Timeliness-% Within Lag Time - Institutional 0-180 days	98%	80%
Timeliness-% Within Lag Time - Professional 0-90 days	92%	65%
Timeliness-% Within Lag Time – Professional 0-180 days	97%	80%

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

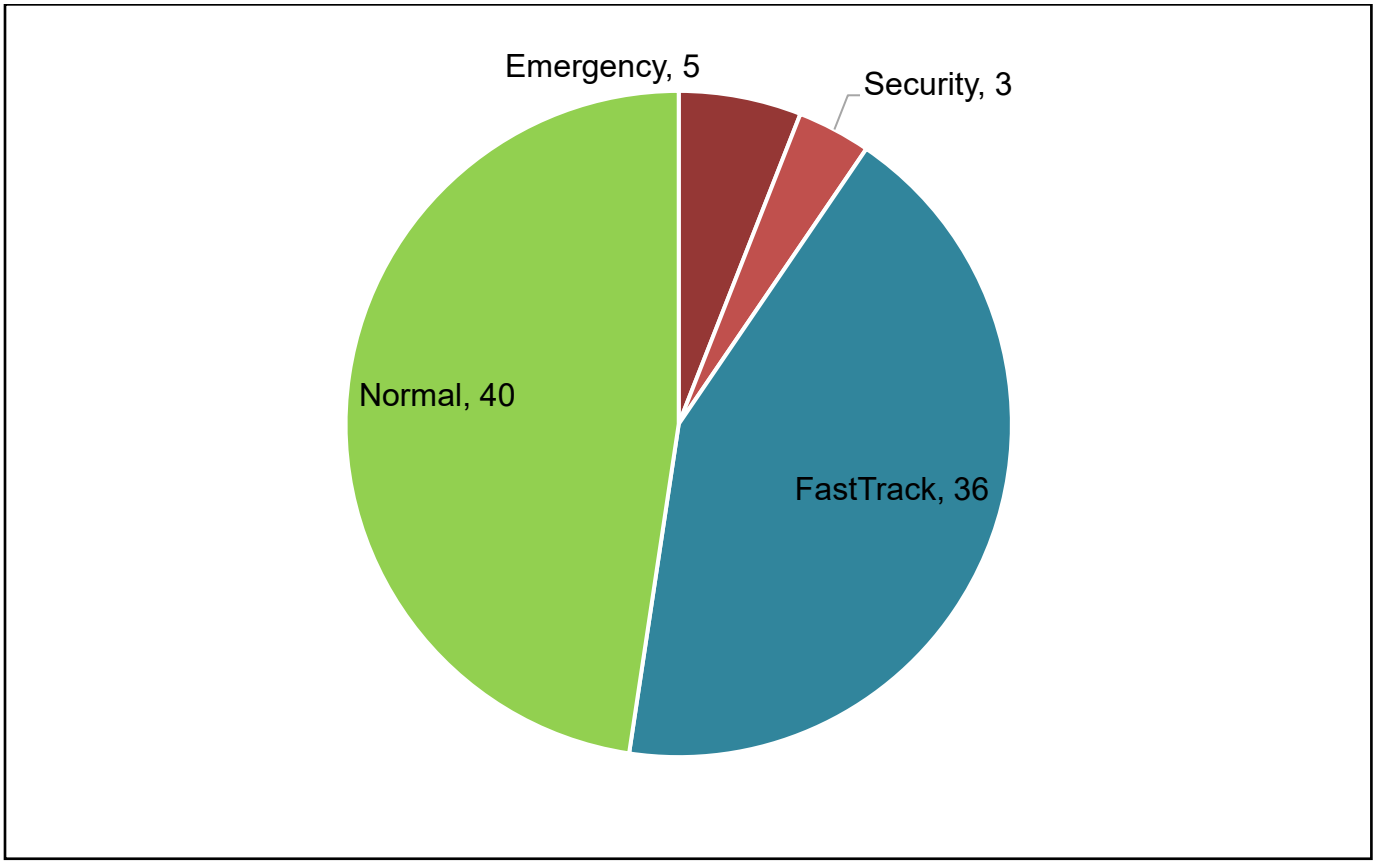
Encounter Data

In the month of **March** 2025, the Alliance submitted **168** encounter files to the Department of Health Care Services (DHCS) with a total of **461,741** encounters.

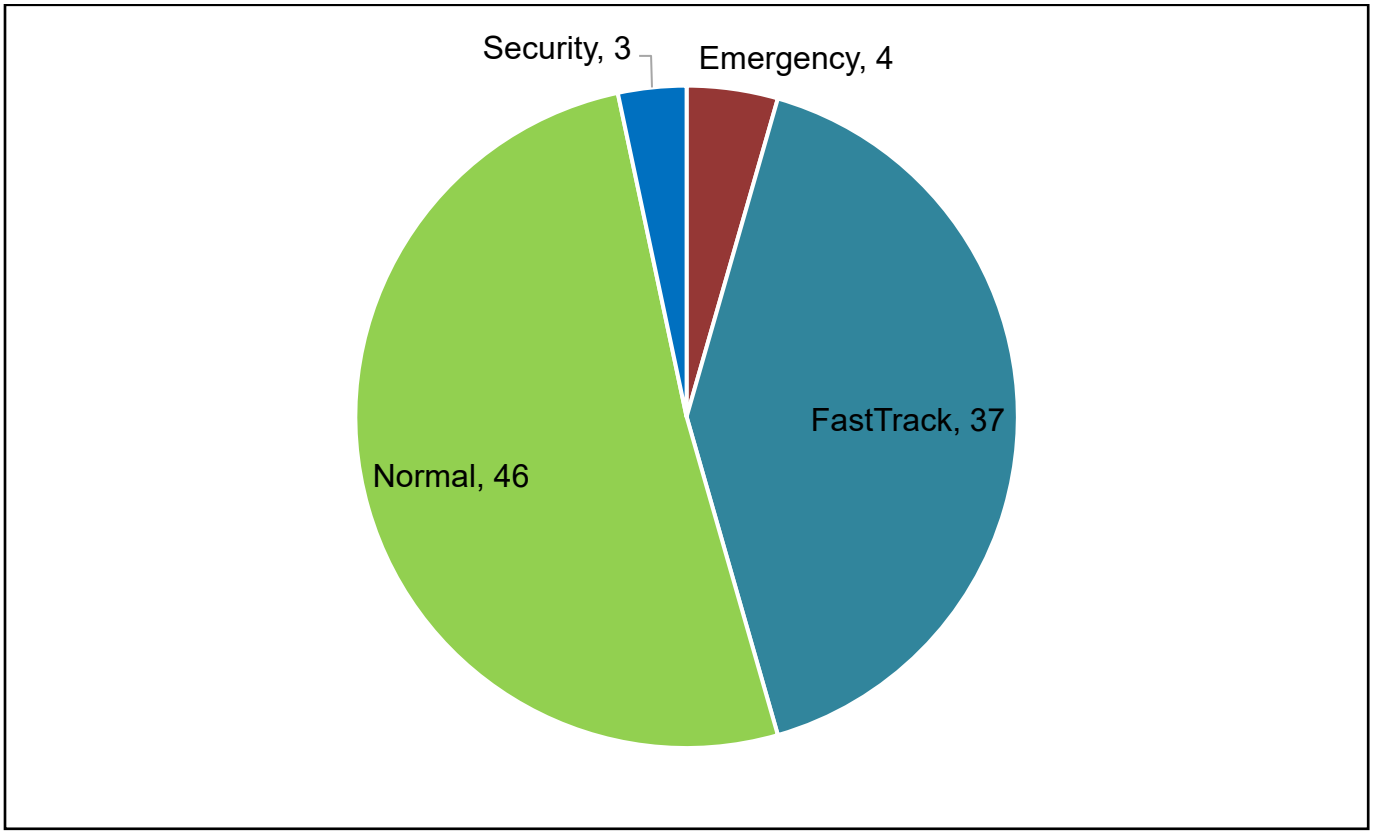
Change Management Key Performance Indicator (KPI)

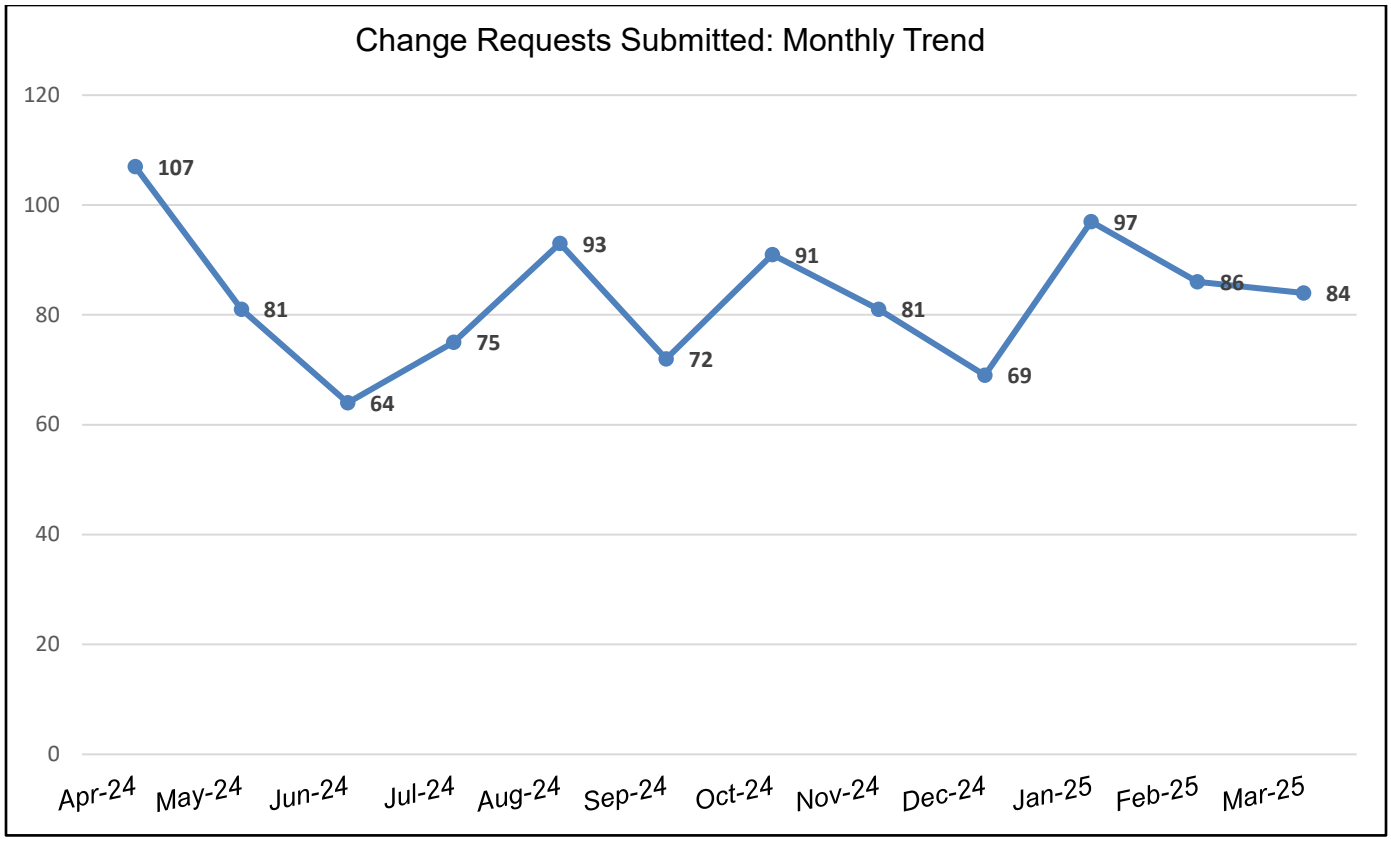
- Change Request Overall Summary in the month of March 2025 KPI:
  - 84 Changes Submitted.
  - 90 Changes Completed and Closed.
  - 93 Active Change Requests in pipeline.
  - 5 Change Requests Cancelled or Rejected.

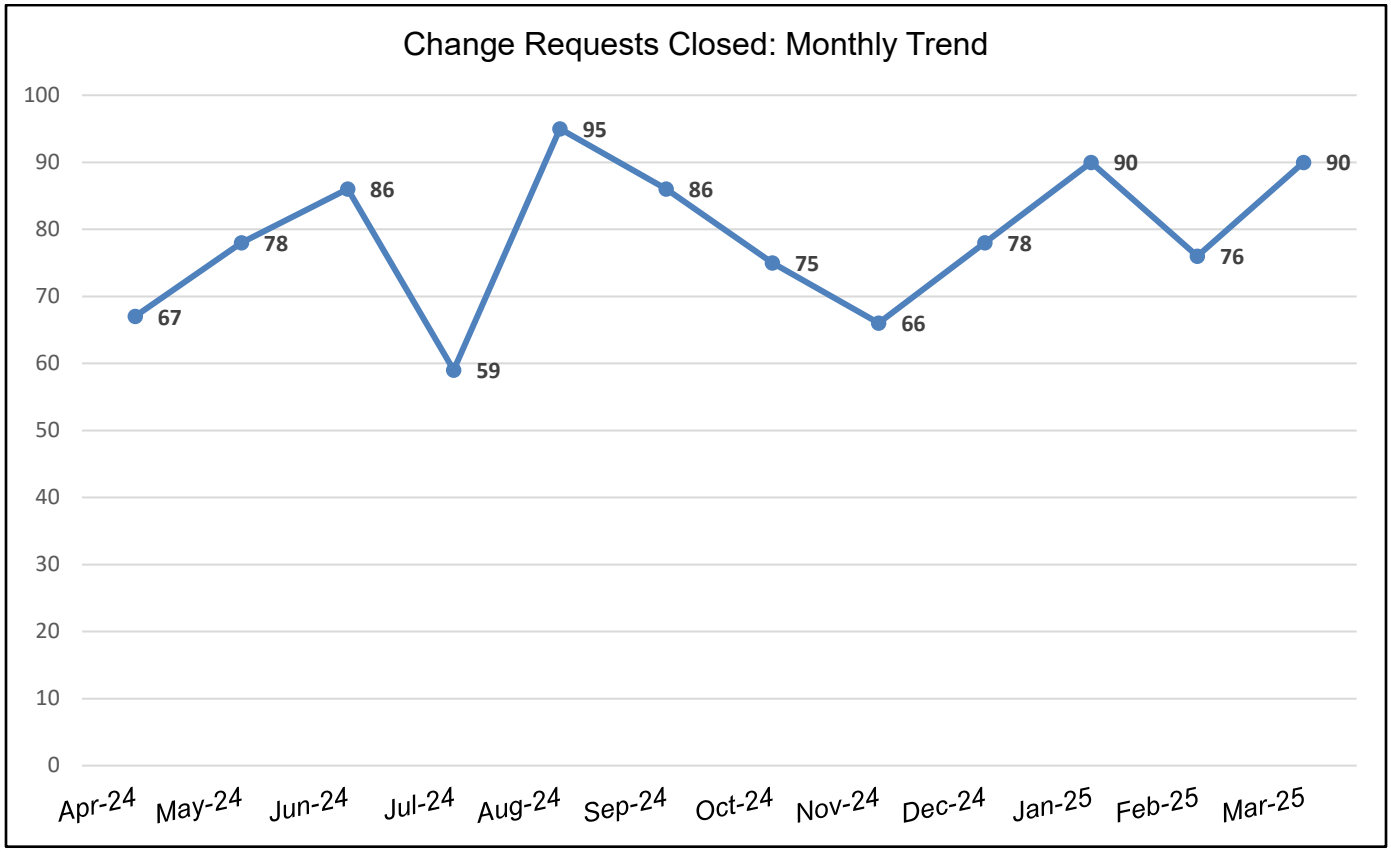
- 84 Change Requests Submitted/Logged in the month of March 2025



- 90 Change Requests Closed in the month of March 2025




Change Requests Submitted: Monthly Trend
120
100
80
60
40
20
0
107
81
64
75
93
72
91
81
69
97
86
84
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25


Change Requests Closed: Monthly Trend
100
90
80
70
60
50
40
30
20
10
0
67
78
86
59
95
86
75
66
78
90
76
90
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25

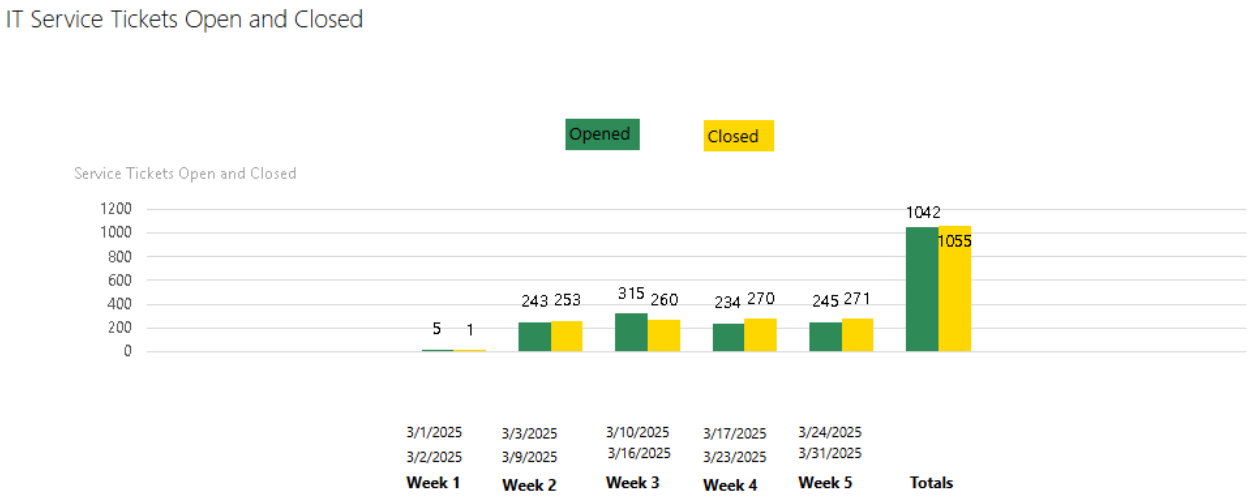
IT Stats: Infrastructure

Application Server Uptimes - March 2025

Data View	HEALTHsuite Claims and Membership System	TruCare Care Management System	All Other Applications and Systems	Timeliness of file submitted by Due Date
MTD	100.00%	100%	100.00%	100.00%
GOAL	99.50%	99.50%	99.50%	99.50%
PERCENTAGE	0	0	0	0

- All mission critical applications are monitored and managed thoroughly.
- There were no outages experienced in the month of March.

IT Stats: Service Desk



- 1042 Service Desk tickets were opened in the month of March 2025, which is 14.29% higher than the previous month (893) and 6.90% higher than the previous 3-month average of 970.
- 1055 Service Desk tickets were closed in the month of March 2025, which is 14.02% higher than the previous month (907) and 5.30% higher than the previous 3-month average of 999.

IT Stats: Security

Security + Network Updates

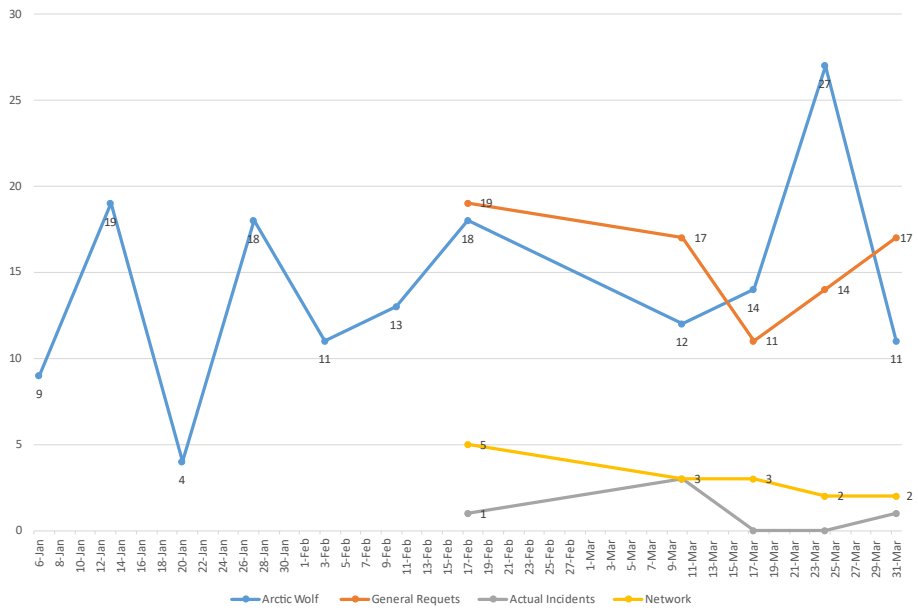
Areas	Item Status	Next Up

Ops.	• Troubleshooting Bloodhound service account
	• Network
	  • Access for Jim (April 9th)
	  • Docs, diagram, etc (April 16th)
	  • Topology presentation (April 23rd)
	• Cisco Umbrella – determine top 5 upload cloud apps and block where available
	• Entra ID – geofence test is successful
	• DUO upgrade – protect mobile devices	

Projects	• **Vuln. Mgmt.**
	  ○ Completed auth scans on all on-premise devices over 36k ports
	• **Cert. Collection**
	  • Collection is 100% and closing mini -project mid-April
	  • Processing into IT Glue to close in May
		• Look into Local Administrator Password Service (LAPS) with SD
		• **Nessus (Vuln. Mgmt.)**
		  ○ Scanning entire RFC 1918 IP space to rule out shadow IT
		  ○ Vuln. Remediation strategy (dependency owner) NEW

GRC	• User Acceptance Policy – drafted for review NEW • Backup Policy – under revision • Role assignment to Azure (IT Sec + Network) - WIP	• **PnP/Policy** • SRA network-related "high" value findings (2x)

Security + Network Activity



- Arctic Wolf
  - Numerous false-positives around out-of-country users
- General Requests
  - False-positive PII/PHI
  - Phishing
- Actual Incidents
  - DHCS password alert
- Network
  - Operational changes
  - Circuit upgrade

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: **April 11th, 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: Jan 2024 – Dec 2024 dates of service
Prior reporting period: Jan 2023 – Dec 2023 dates of service
(Note: Data excludes Kaiser membership data.)

- For the Current reporting period, the top 11.3% of members account for 89.6% of total costs.
- In comparison, the Prior reporting period was lower at 9.8% of members accounting for 83.6% of total costs.
- Characteristics of the top utilizing population remained fairly consistent between the reporting periods:
    - The SPD (non duals) and ACA OE categories of aid slightly decreased to account for 55.7% of the members, with SPDs accounting for 20.7% and ACA OE's at 35.0%.
    - The percent of members with costs >= $30K slightly increased from 2.7% to 3.0%.
    - Of those members with costs >= $100K, the percentage of total members has slightly increased to 1.0%.
        - For these members, non-trauma/pregnancy inpatient costs continue to comprise the majority of costs, decreasing to 31.5%.
    - 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 11.3% is more concentrated in the 45-66 year old category (35.9%) compared to the overall population (20.6%).

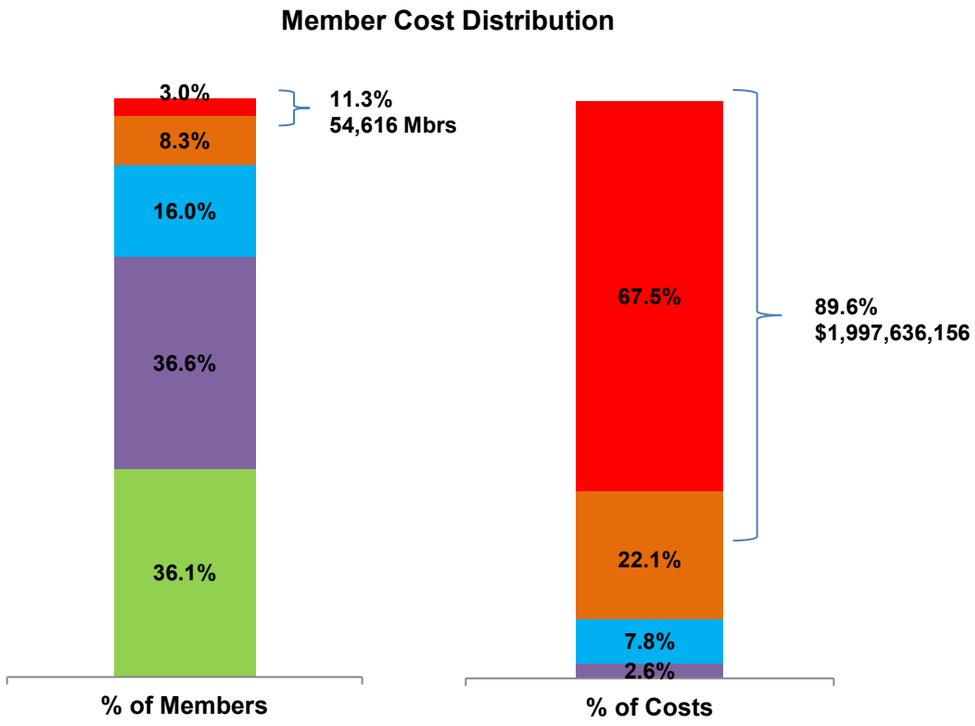
Analytics

Supporting Documents

Alameda Alliance for Health - Analytics Supporting Documentation: Member - Cost Analysis
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Jan 2024 - Dec 2024

Note: Data incomplete due to claims lag

Run Date: 03/28/2025



Cost Range	Members	% of Members	Costs	% of Costs
$30K+	14,420	3.0%	$ 1,505,481,237	67.5%
$5K - $30K	40,196	8.3%	$ 492,154,919	22.1%
$1K - $5K	76,862	16.0%	$ 172,820,150	7.8%
< $1K	176,416	36.6%	$ 58,776,617	2.6%
$0	173,667	36.1%	$ -	0.0%
Totals	**481,561**	**100.0%**	**$ 2,229,232,923**	**100.0%**

Top 11.3% of Members = 89.6% of Costs

Cost Range	Members	% of Total Members	Costs	% of Total Costs
$100K+	4,757	1.0%	$ 982,749,195	44.1%
$75K to $100K	1,801	0.4%	$ 157,016,688	7.0%
$50K to $75K	2,723	0.6%	$ 166,180,149	7.5%
$40K to $50K	2,139	0.4%	$ 95,781,825	4.3%
$30K to $40K	3,000	0.6%	$ 103,753,380	4.7%
SubTotal	***14,420***	***3.0%***	***$ 1,505,481,237***	***67.5%***
$20K to $30K	5,673	1.2%	$ 137,908,981	6.2%
$10K to $20K	15,444	3.2%	$ 218,021,032	9.8%
$5K to $10K	19,079	4.0%	$ 136,224,907	6.1%
SubTotal	***40,196***	***8.3%***	***$ 492,154,919***	***22.1%***
Total	**54,616**	***11.3%***	**$ 1,997,636,156**	***89.6%***

Enrollment Status	Members	Total Costs
Still Enrolled as of Dec 2024	412,737	$ 2,025,108,800
Dis-Enrolled During Year	68,824	$ 204,124,123
Totals	**481,561**	**$ 2,229,232,923**

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
11.3% of Members = 89.6% of Costs
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Jan 2024 - Dec 2024
Note: Data incomplete due to claims lag
Run Date: 03/28/2025

11.3% of Members = 89.6% of Costs
20.7% of members are SPDs and account for 27.0% of costs.
35.0% of members are ACA OE and account for 32.5% of costs.
7.7% of members disenrolled as of Dec 2024 and account for 9.4% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Members	% of Members
IHSS	IHSS	186	921	1,107	2.0%
MCAL	MCAL - ADULT	1,266	7,582	8,848	16.2%
	MCAL - BCCTP	-	-	-	0.0%
	MCAL - CHILD	636	3,836	4,472	8.2%
	MCAL - ACA OE	4,606	14,484	19,090	35.0%
	MCAL - SPD	3,984	7,326	11,310	20.7%
	MCAL - DUALS	1,060	3,164	4,224	7.7%
	MCAL - LTC	210	17	227	0.4%
	MCAL - LTC-DUAL	1,037	87	1,124	2.1%
Not Eligible	Not Eligible	1,435	2,779	4,214	7.7%
Total		**14,420**	**40,196**	**54,616**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Costs	% of Costs
IHSS	IHSS	$ 15,867,273	$ 10,597,707	$ 26,464,981	1.3%
MCAL	MCAL - ADULT	$ 123,375,158	$ 92,235,151	$ 215,610,309	10.8%
	MCAL - BCCTP	$ -	$ -	$ -	0.0%
	MCAL - CHILD	$ 49,587,547	$ 43,097,480	$ 92,685,026	4.6%
	MCAL - ACA OE	$ 472,665,896	$ 176,728,010	$ 649,393,906	32.5%
	MCAL - SPD	$ 442,945,835	$ 95,533,503	$ 538,479,338	27.0%
	MCAL - DUALS	$ 100,679,126	$ 37,689,504	$ 138,368,629	6.9%
	MCAL - LTC	$ 34,079,910	$ 273,044	$ 34,352,954	1.7%
	MCAL - LTC-DUAL	$ 113,707,516	$ 1,390,421	$ 115,097,937	5.8%
Not Eligible	Not Eligible	$ 152,572,977	$ 34,610,100	$ 187,183,076	9.4%
Total		**$ 1,505,481,237**	**$ 492,154,919**	**$ 1,997,636,156**	**100.0%**

% of Total Costs By Service Type

Cost Range	Trauma Costs	Hep C Rx Costs	Pregnancy, Childbirth & Newborn Related Costs
$100K+	5%	0%	1%
$75K to $100K	4%	0%	1%
$50K to $75K	5%	0%	2%
$40K to $50K	7%	0%	2%
$30K to $40K	10%	0%	3%
$20K to $30K	2%	1%	6%
$10K to $20K	0%	0%	11%
$5K to $10K	0%	0%	6%
Total	**4%**	**0%**	**3%**

Breakout by Service Type/Location

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)
14%	37%	1%	11%	2%	2%	33%
18%	26%	3%	5%	4%	5%	39%
25%	29%	5%	6%	5%	4%	26%
33%	28%	8%	6%	7%	1%	18%
33%	23%	13%	5%	7%	1%	18%
36%	24%	7%	8%	7%	1%	17%
35%	24%	6%	9%	9%	1%	15%
30%	13%	11%	13%	14%	1%	19%
22%	**30%**	**4%**	**9%**	**5%**	**2%**	**27%**

Notes:
- Report includes medical costs (HS & Diamond Claims, Beacon, Logisticare FFS, CHCN FFS Preventive Services, CHME) and pharmacy costs. IBNP factors are not applied.
- CFMG and CHCN encounter data has been priced out.
- Report excludes Capitation Expense

Highest Cost Members; Cost Per Member >= $100K
29.6% of members are SPDs and account for 31.0% of costs.
26.1% of members are ACA OE and account for 30.4% of costs.
8.5% of members disenrolled as of Dec 2024 and account for 9.7% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Total Members	% of Members
IHSS	IHSS	43	0.9%
MCAL	MCAL - ADULT	290	6.1%
	MCAL - BCCTP	-	0.0%
	MCAL - CHILD	92	1.9%
	MCAL - ACA OE	1,243	26.1%
	MCAL - SPD	1,406	29.6%
	MCAL - DUALS	487	10.2%
	MCAL - LTC	175	3.7%
	MCAL - LTC-DUAL	618	13.0%
Not Eligible	Not Eligible	403	8.5%
Total		**4,757**	**100.0%**

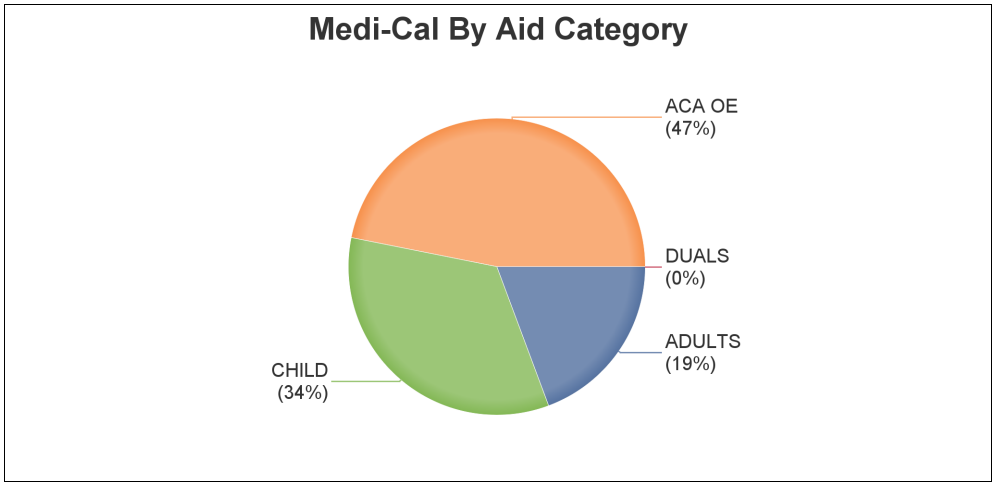
Cost Breakout by LOB

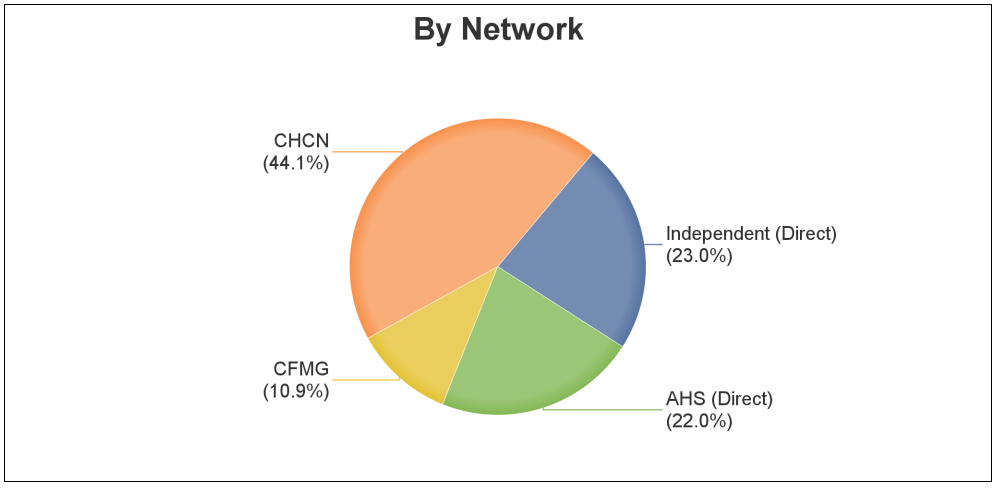
LOB	Eligibility Category	Total Costs	% of Costs
IHSS	IHSS	$ 8,490,739	0.9%
MCAL	MCAL - ADULT	$ 73,454,769	7.5%
	MCAL - BCCTP	$ -	0.0%
	MCAL - CHILD	$ 22,989,148	2.3%
	MCAL - ACA OE	$ 298,528,715	30.4%
	MCAL - SPD	$ 304,998,960	31.0%
	MCAL - DUALS	$ 66,607,253	6.8%
	MCAL - LTC	$ 31,848,221	3.2%
	MCAL - LTC-DUAL	$ 80,881,791	8.2%
Not Eligible	Not Eligible	$ 94,949,599	9.7%
Total		**$ 982,749,195**	**100.0%**

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend

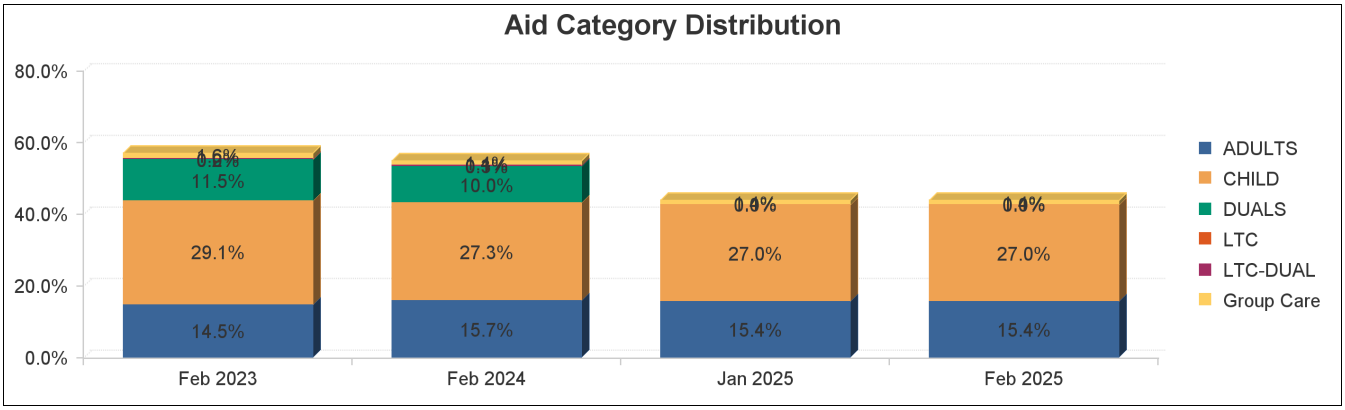
Category of Aid	Feb 2025	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN
ADULTS	63,758	16%	14,202	14,161	7	35,388
CHILD	111,576	27%	10,560	13,481	42,081	45,454
SPD	0	0%	0	0	0	0
ACA OE	154,609	38%	28,185	53,799	1,532	71,093
DUALS	2	0%	2	0	0	0
LTC	0	0%	0	0	0	0
LTC-DUAL	0	0%	0	0	0	0
SPD-LTC	29,497	7%	8,785	5,028	1,453	14,231
SPD-LTC/Full Dual	48,100	12%	30,994	3,532	6	13,568
Medi-Cal	407,542		92,728	90,001	45,079	179,734
Group Care	5,812		2,171	950	0	2,691
Total	**413,354**	**100%**	**94,899**	**90,951**	**45,079**	**182,425**
Medi-Cal %	98.6%		97.7%	99.0%	100.0%	98.5%
Group Care %	1.4%		2.3%	1.0%	0.0%	1.5%
	Network Distribution		**23.0%**	**22.0%**	**10.9%**	**44.1%**
			% Direct:	**45%**	**% Delegated:**	**55%**





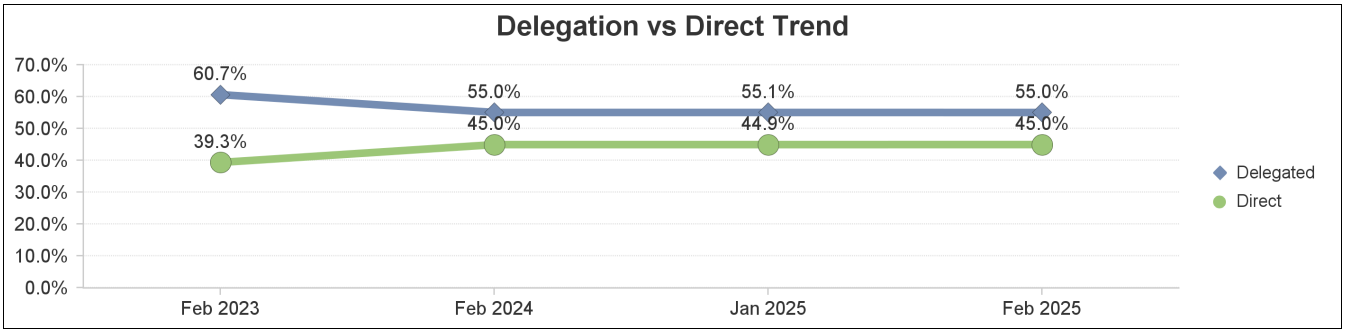
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Feb 2023	Feb 2024	Jan 2025	Feb 2025	Feb 2023	Feb 2024	Jan 2025	Feb 2025	Feb 2023 to Feb 2024	Feb 2024 to Feb 2025	Jan 2025 to Feb 2025
ADULTS	51,154	63,130	63,593	**63,758**	14.5%	15.7%	15.4%	15.4%	19.0%	1.0%	0.3%
CHILD	102,305	109,957	111,656	**111,576**	29.1%	27.3%	27.0%	27.0%	7.0%	1.5%	-0.1%
SPD	30,922	34,876	0	**0**	8.8%	8.7%	0.0%	0.0%	11.3%	0.0%	0.0%
ACA OE	120,657	146,758	154,136	**154,609**	34.3%	36.5%	37.3%	37.4%	17.8%	5.1%	0.3%
DUALS	40,334	40,403	1	**2**	11.5%	10.0%	0.0%	0.0%	0.2%	##########	50.0%
LTC	129	217	0	**0**	0.0%	0.1%	0.0%	0.0%	40.6%	0.0%	0.0%
LTC-DUAL	849	1,329	0	**0**	0.2%	0.3%	0.0%	0.0%	36.1%	0.0%	0.0%
SPD-LTC	0	0	29,566	**29,497**	0.0%	0.0%	7.2%	7.1%	0.0%	100.0%	-0.2%
SPD-LTC/ Full Dual	0	0	48,153	**48,100**	0.0%	0.0%	11.7%	11.6%	0.0%	100.0%	-0.1%
Medi-Cal	346,350	396,670	407,105	**407,542**	98.4%	98.6%	98.6%	98.6%	12.7%	2.7%	0.1%
Group Care	5,746	5,608	5,779	**5,812**	1.6%	1.4%	1.4%	1.4%	-2.5%	3.5%	0.6%
Total	**352,096**	**402,278**	**412,884**	**413,354**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**12.5%**	**2.7%**	**0.1%**



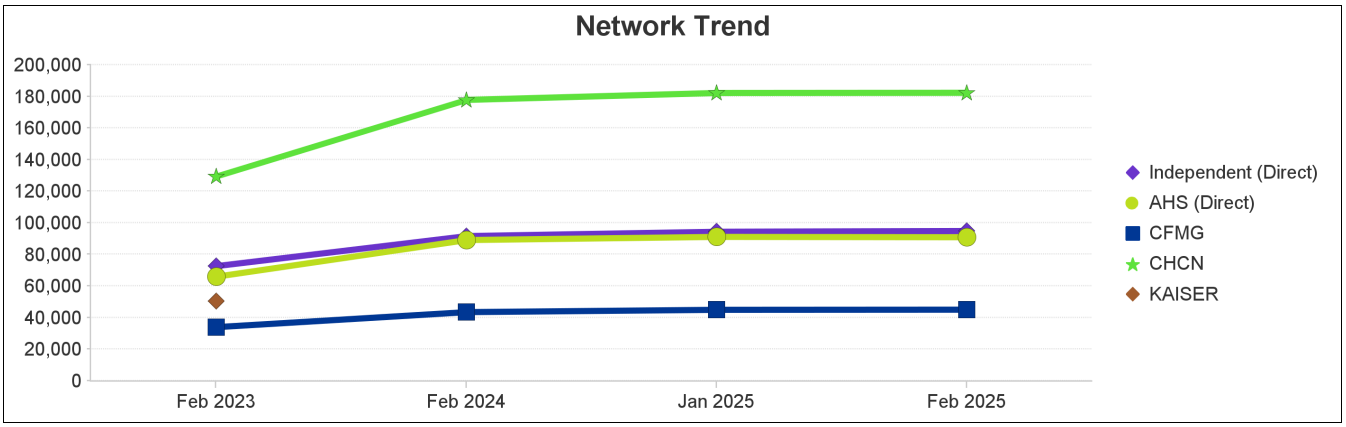
Delegation vs Direct Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	Feb 2023	Feb 2024	Jan 2025	Feb 2025	Feb 2023	Feb 2024	Jan 2025	Feb 2025	Feb 2023 to Feb 2024	Feb 2024 to Feb 2025	Jan 2025 to Feb 2025
Delegated	213,591	221,438	227,300	**227,504**	60.7%	55.0%	55.1%	55.0%	3.5%	2.7%	0.1%
Direct	138,505	180,840	185,584	**185,850**	39.3%	45.0%	44.9%	45.0%	23.4%	2.7%	0.1%
Total	**352,096**	**402,278**	**412,884**	**413,354**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**12.5%**	**2.7%**	**0.1%**



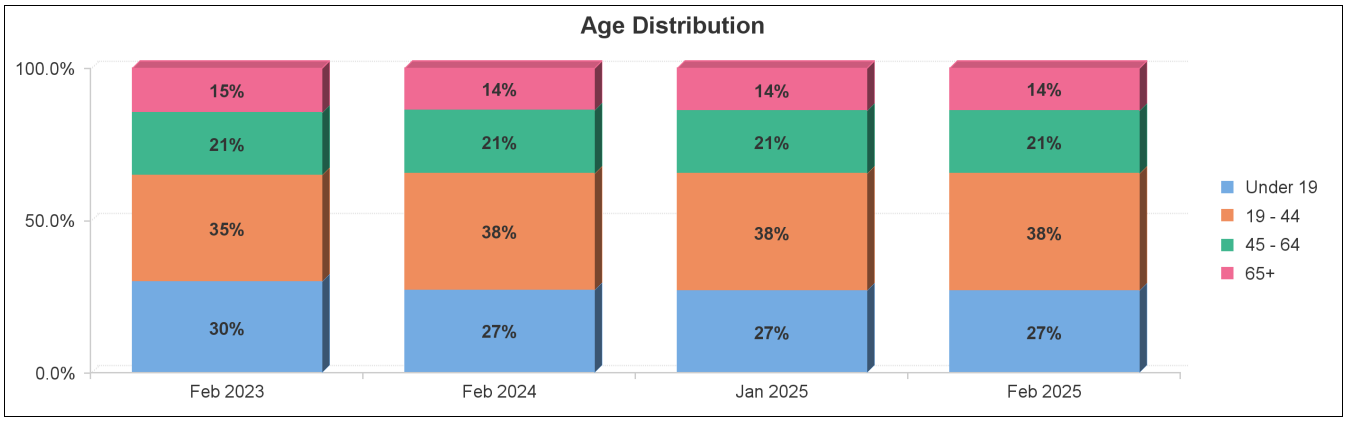
Network Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Feb 2023	Feb 2024	Jan 2025	Feb 2025	Feb 2023	Feb 2024	Jan 2025	Feb 2025	Feb 2023 to Feb 2024	Feb 2024 to Feb 2025	Jan 2025 to Feb 2025
Independent (Direct)	72,607	91,671	94,414	**94,899**	20.6%	22.8%	22.9%	23.0%	20.8%	3.4%	0.5%
AHS (Direct)	65,898	89,169	91,170	**90,951**	18.7%	22.2%	22.1%	22.0%	26.1%	2.0%	-0.2%
CFMG	33,983	43,528	44,988	**45,079**	9.7%	10.8%	10.9%	10.9%	21.9%	3.4%	0.2%
CHCN	129,269	177,910	182,312	**182,425**	36.7%	44.2%	44.2%	44.1%	27.3%	2.5%	0.1%
KAISER	50,339	0	0	**0**	14.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	**352,096**	**402,278**	**412,884**	**413,354**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**12.5%**	**2.7%**	**0.1%**



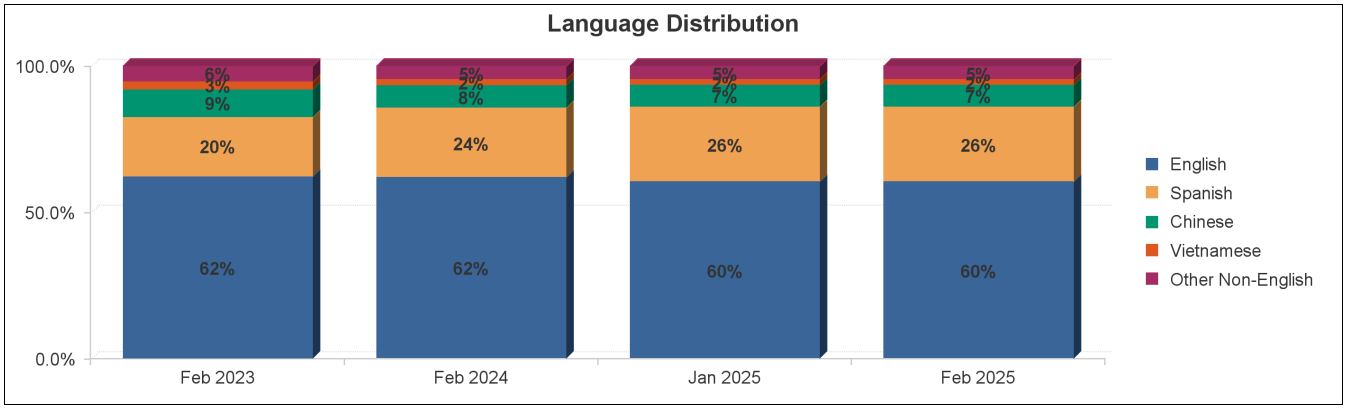
Age Category Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Feb 2023	Feb 2024	Jan 2025	Feb 2025	Feb 2023	Feb 2024	Jan 2025	Feb 2025	Feb 2023 to Feb 2024	Feb 2024 to Feb 2025	Jan 2025 to Feb 2025
Under 19	104,659	108,207	110,492	**110,599**	30%	27%	27%	27%	3%	2%	0%
19 - 44	122,990	154,277	158,893	**159,068**	35%	38%	38%	38%	20%	3%	0%
45 - 64	72,480	83,582	85,072	**85,271**	21%	21%	21%	21%	13%	2%	0%
65+	51,967	56,212	58,427	**58,416**	15%	14%	14%	14%	8%	4%	0%
Total	**352,096**	**402,278**	**412,884**	**413,354**	**100%**	**100%**	**100%**	**100%**	**12%**	**3%**	**0%**



Language Trend

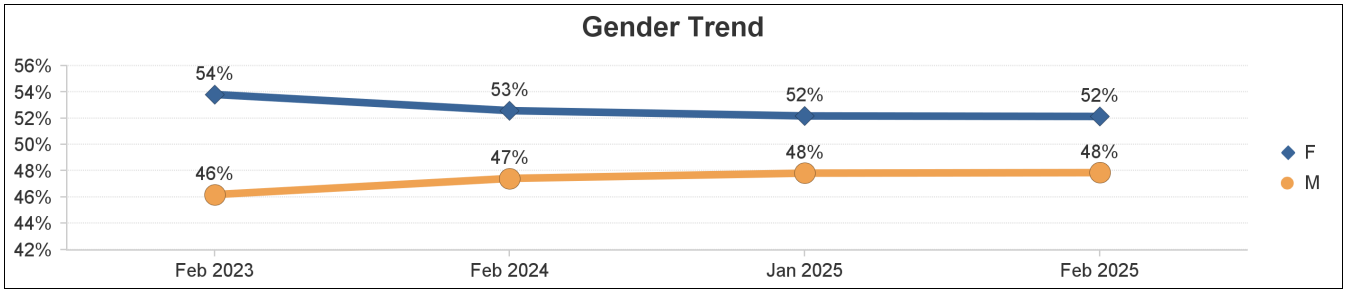
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	Feb 2023	Feb 2024	Jan 2025	Feb 2025	eb 2023	eb 2024	Jan 2025	eb 2025	Feb 2023 to Feb 2024	Feb 2024 to Feb 2025	Jan 2025 to Feb 2025
English	218,360	248,268	248,847	**248,996**	62%	62%	60%	60%	12%	0%	0%
Spanish	71,247	95,947	105,452	**105,721**	20%	24%	26%	26%	26%	9%	0%
Chinese	33,248	30,706	30,623	**30,594**	9%	8%	7%	7%	-8%	0%	0%
Vietnamese	9,714	8,516	8,263	**8,238**	3%	2%	2%	2%	-14%	-3%	0%
Other Non-English	19,527	18,841	19,699	**19,805**	6%	5%	5%	5%	-4%	5%	1%
Total	**352,096**	**402,278**	**412,884**	**413,354**	**100%**	**100%**	**100%**	**100%**	**12%**	**3%**	**0%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

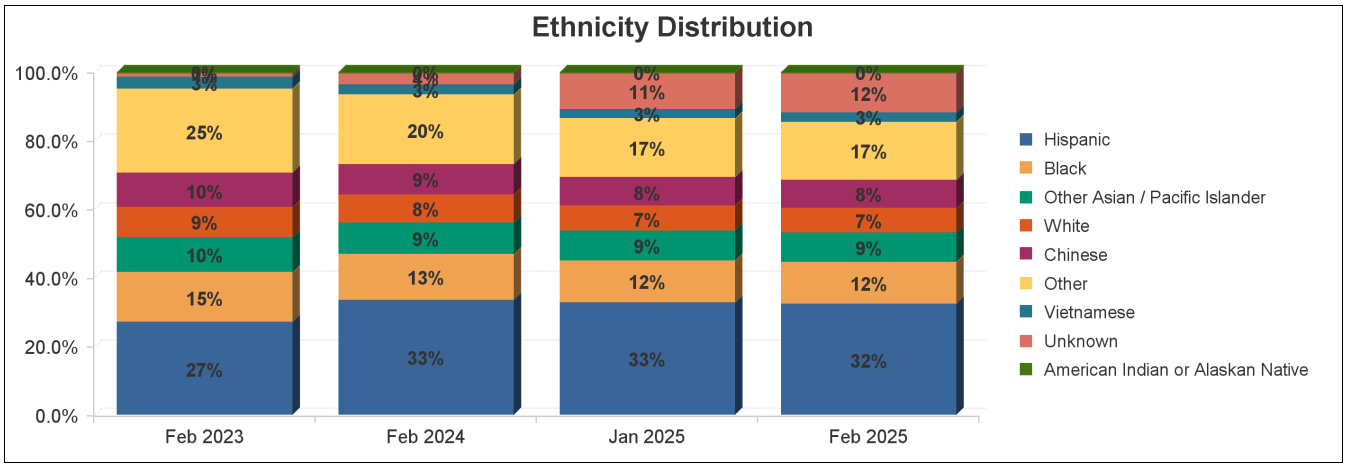
Gender Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Feb 2023	Feb 2024	Jan 2025	Feb 2025	Feb 2023	Feb 2024	Jan 2025	Feb 2025	Feb 2023 to Feb 2024	Feb 2024 to Feb 2025	Jan 2025 to Feb 2025
F	189,484	211,525	215,437	**215,525**	54%	53%	52%	52%	10%	2%	0%
M	162,612	190,753	197,447	**197,829**	46%	47%	48%	48%	15%	4%	0%
Total	**352,096**	**402,278**	**412,884**	**413,354**	**100%**	**100%**	**100%**	**100%**	**12%**	**3%**	**0%**



Ethnicity Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Feb 2023	Feb 2024	Jan 2025	Feb 2025	Feb 2023	Feb 2024	Jan 2025	Feb 2025	Feb 2023 to Feb 2024	Feb 2024 to Feb 2025	Jan 2025 to Feb 2025
Hispanic	95,061	134,527	134,750	**133,402**	27%	33%	33%	32%	29%	-1%	-1%
Black	51,086	53,620	50,793	**50,373**	15%	13%	12%	12%	5%	-6%	-1%
Other Asian / Pacific Islander	35,706	37,048	35,742	**35,321**	10%	9%	9%	9%	4%	-5%	-1%
White	31,044	32,781	30,308	**29,853**	9%	8%	7%	7%	5%	-10%	-2%
Chinese	35,508	35,685	34,193	**33,774**	10%	9%	8%	8%	0%	-6%	-1%
Other	86,361	81,682	70,977	**70,242**	25%	20%	17%	17%	-6%	-16%	-1%
Vietnamese	12,164	12,017	11,227	**11,084**	3%	3%	3%	3%	-1%	-8%	-1%
Unknown	4,437	14,108	44,135	**48,550**	1%	4%	11%	12%	69%	71%	9%
American Indian or Alaskan Native	729	810	759	**755**	0%	0%	0%	0%	10%	-7%	-1%
Total	**352,096**	**402,278**	**412,884**	**413,354**	**100%**	**100%**	**100%**	**100%**	**12%**	**3%**	**0%**



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

Medi-Cal By City

City	Feb 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	162,679	40%	25,103	42,234	17,611	77,731
HAYWARD	65,340	16%	13,942	17,940	7,687	25,771
FREMONT	38,668	9%	16,251	6,730	2,381	13,306
SAN LEANDRO	33,350	8%	8,610	5,582	4,320	14,838
UNION CITY	14,818	4%	5,805	2,649	878	5,486
ALAMEDA	13,939	3%	3,433	2,479	2,095	5,932
BERKELEY	15,764	4%	4,301	2,369	1,819	7,275
LIVERMORE	13,312	3%	1,976	568	2,273	8,495
NEWARK	9,525	2%	2,821	4,102	587	2,015
CASTRO VALLEY	9,693	2%	2,839	1,529	1,501	3,824
SAN LORENZO	7,385	2%	1,508	1,670	895	3,312
PLEASANTON	8,011	2%	2,033	397	848	4,733
DUBLIN	7,748	2%	2,207	386	921	4,234
EMERYVILLE	2,951	1%	688	611	480	1,172
ALBANY	2,590	1%	675	303	588	1,024
PIEDMONT	500	0%	129	176	79	116
SUNOL	82	0%	23	14	7	38
ANTIOCH	20	0%	5	6	2	7
Other	1,167	0%	379	256	107	425
Total	407,542	100%	**92,728**	**90,001**	**45,079**	**179,734**

Group Care By City

City	Feb 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	1,823	31%	341	364	0	1,118
HAYWARD	681	12%	320	170	0	191
FREMONT	666	11%	440	81	0	145
SAN LEANDRO	609	10%	250	88	0	271
UNION CITY	287	5%	179	42	0	66
ALAMEDA	309	5%	88	25	0	196
BERKELEY	144	2%	47	10	0	87
LIVERMORE	98	2%	29	3	0	66
NEWARK	138	2%	81	33	0	24
CASTRO VALLEY	192	3%	86	28	0	78
SAN LORENZO	142	2%	45	27	0	70
PLEASANTON	71	1%	25	3	0	43
DUBLIN	125	2%	44	5	0	76
EMERYVILLE	34	1%	12	5	0	17
ALBANY	21	0%	11	1	0	9
PIEDMONT	9	0%	1	1	0	7
SUNOL	1	0%	1	0	0	0
ANTIOCH	26	0%	7	6	0	13
Other	436	8%	164	58	0	214
Total	**5,812**	**100%**	**2,171**	**950**	**0**	**2,691**

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

Total By City

City	Feb 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	164,502	40%	25,444	42,598	17,611	78,849
HAYWARD	66,021	16%	14,262	18,110	7,687	25,962
FREMONT	39,334	10%	16,691	6,811	2,381	13,451
SAN LEANDRO	33,959	8%	8,860	5,670	4,320	15,109
UNION CITY	15,105	4%	5,984	2,691	878	5,552
ALAMEDA	14,248	3%	3,521	2,504	2,095	6,128
BERKELEY	15,908	4%	4,348	2,379	1,819	7,362
LIVERMORE	13,410	3%	2,005	571	2,273	8,561
NEWARK	9,663	2%	2,902	4,135	587	2,039
CASTRO VALLEY	9,885	2%	2,925	1,557	1,501	3,902
SAN LORENZO	7,527	2%	1,553	1,697	895	3,382
PLEASANTON	8,082	2%	2,058	400	848	4,776
DUBLIN	7,873	2%	2,251	391	921	4,310
EMERYVILLE	2,985	1%	700	616	480	1,189
ALBANY	2,611	1%	686	304	588	1,033
PIEDMONT	509	0%	130	177	79	123
SUNOL	83	0%	24	14	7	38
ANTIOCH	46	0%	12	12	2	20
Other	1,603	0%	543	314	107	639
Total	413,354	100%	**94,899**	**90,951**	**45,079**	**182,425**

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: **April 11th, 2025**

Subject: **Human Resources Report**

Staffing

- As of April 1st, 2025, the Alliance had 654 full-time employees and 0 part-time employees.

- On April 1st, 2025, the Alliance had 69 open positions in which 18 signed offer acceptance letters have been received with start dates in the near future resulting in a total of 51 positions open to date. The Alliance is actively recruiting for the remaining 51 positions and several of these positions are in the interviewing or job offer stage.

- Summary of open positions by division:

Division	Open Position April 1st	Signed Offers Accepted by Department	Remaining Recruitment Positions
Healthcare Services	7	1	6
Operations	40	14	26
Healthcare Analytics	2	0	2
Information Technology	10	1	9
Finance	3	1	2
Compliance	4	1	3
Human Resources	3	0	3
Health Equity	0	0	0
Executive	0	0	0
Total	69	18	51

- Our current recruitment rate is 10%.

Employee Recognition

- Employees reaching major milestones in their length of service at the Alliance in March 2025 included:

  5 years:
  - Amani S (Health Plan Operations)
  - Rosa C (Quality Management)
  - Gabriela P (Marketing & Communications)

  6 years:
  - Susan B (Long Term Services & Support)
  - Timothy T (Pharmacy Services)
  - Catherine S (Case & Disease Management)
  - Stephen W (Utilization Management)
  - Tatyana N (Utilization Management)
  - Gurjit S (IT – Apps Management, IT Quality & Process Improvement)

  7 years:
  - Jayme M (Claims)
  - Anthony P (IT Infrastructure)
  - Carlos L (Member Services)
  - Simin L (Finance)
  - Homaira Y (Long Term Services & Support)

  8 years:
  - Angelica G (Behavioral Health)
  - Sivilay S (Provider Services)

  9 years:
  - Darryl C (Provider Services)
  - Jamisha J (Quality Management)

  10 years:
  - Shiuwen F (IT Development)
  - Ed F (IT Development)
  - Dan P (IT Development)

  11 years:
  - Lisa C (Utilization Management)

  13 years:
  - Jeffrey M (IT Development)

  20 years:
  - Crista T (IT – Apps Management, IT Quality & Process Improvement)

  24 years:
  - Anet Q (Claims)

  29 years:
  - Donna C (Credentialing)