ALAMEDA Alliance FOR HEALTH

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Board of Governors

PACKET

NOVEMBER 8th, 2024

ALAMEDA Alliance FOR HEALTH

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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: **November 8th, 2024**

Subject: **CEO Report**

- **Financials:**
  - **September 2024:** Net Operating Performance by Line of Business for the month of September 2024 and Year-To-Date (YTD):

	September	**YTD**
Medi-Cal	($7.8M)	($32.6M)
Group Care	($178K)	($394K)
Medicare	($775K)	($1.0M)
Total	($8.7M)	($34.1M)

  - **Revenue was $170.9 million in September 2024 and $511.1 Year-to-Date (YTD)**.
    - Medical expenses were $174.5 million in September and $526.9 million for the fiscal year-to-date; the medical loss ratio is 102.1% for the month and 103.1% for the fiscal year-to-date.
    - Administrative expenses were $8.9 million in September and $29.2 million for the fiscal year-to-date; the administrative loss ratio is 5.2% of net revenue for the month and 5.7% of net revenue year-to-date.
  - **Tangible Net Equity (TNE)**: Financial reserves are 315% of the required DMHC minimum, representing $151.1 million in excess TNE.
  - **Total enrollment in September 2024 was 405,933**, an increase of 666 Medi-Cal members compared to August.

- **Key Performance Indicators:**
  - **Regulatory Metrics:**
    - Nothing to report
  - **Non-Regulatory Metrics:**
    - Nothing to report

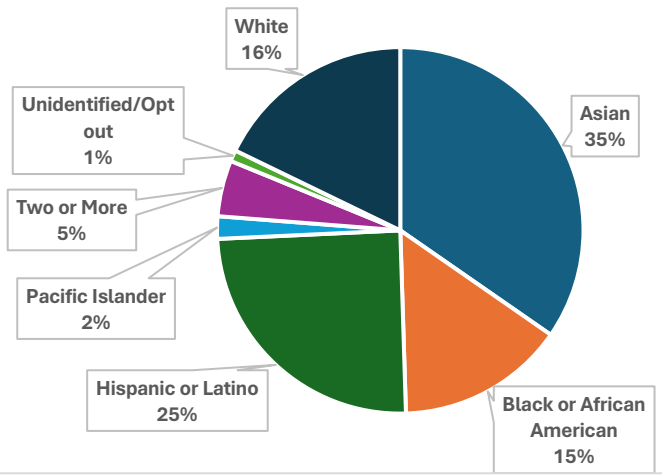
- **Alliance Updates:**
  - **Demographics**
    - Please see attached power point describing the demographics of the Alliance employees.

- **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.
        - Supplemental benefit vendors: finalizing contract for Dental, 2 finalists for Vision, and 2 finalists for Hearing.
        - Provider engagement webinars - “Understanding what matters the most. Creating a vision for the future” were held October 24th, 31st, and November 1st.
        - Pharmacy Benefit Manager (PBM) pre-delegation audit is nearing completion. Additional documentation was requested from PerformRx and expected to receive by 11/1.
            - Exit conference is scheduled for 11/6.
        - Continuing the D-SNP Branding Project and completed change order to SOW for Alameda Alliance master brand refresh.
        - Continuing to collaborate with IT in updating Core Claims / Medical Management Systems.

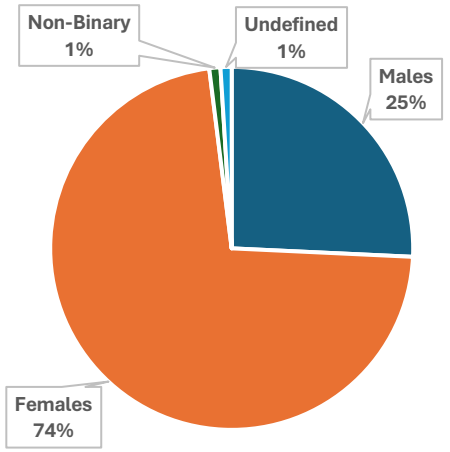
- **Financial Review**
        - FY25 net increase in rates of 3.9%
        - This increase for CY25 is about 50% of what we need
        - Gil and I met with DHCS on November 8, 2024, to advocate for increased rates

AAH Employee Demographics Data Report October 2024

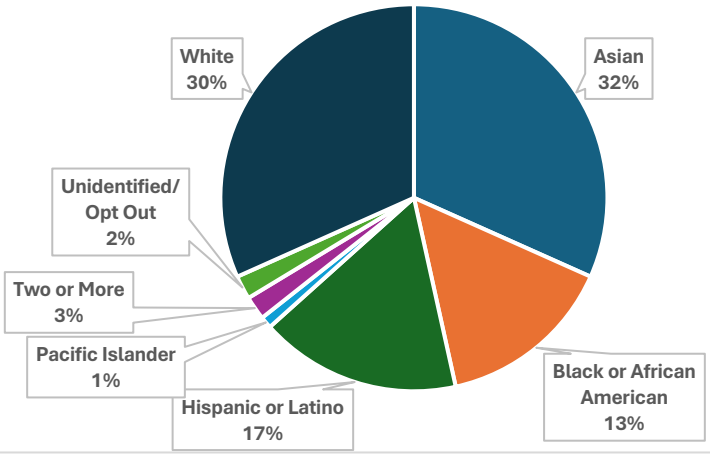
Employee Ethnicity - 644
October 2024



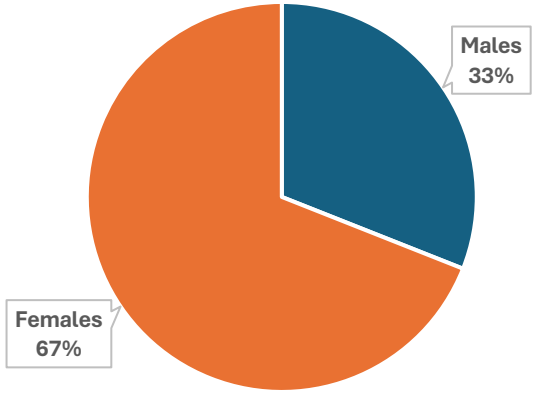
Employee Gender - 644
October 2024

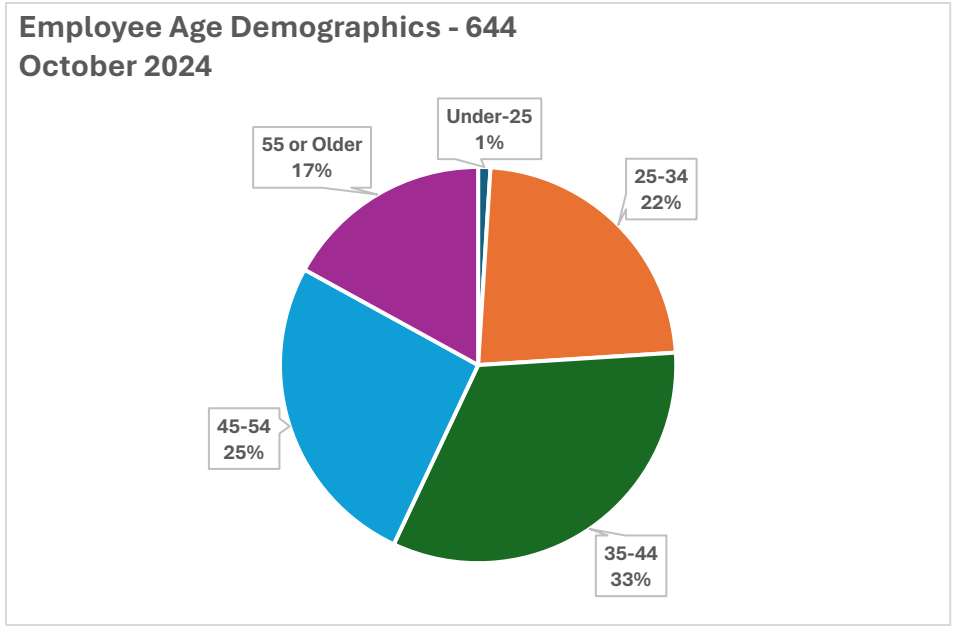


Managers Ethnicity - 129
October 2024



Managers Gender - 129
October 2024




Employee Age Demographics - 644
October 2024
Under-25
1%
25-34
22%
35-44
33%
45-54
25%
55 or Older
17%

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Legislative Tracking

2024 Legislative Tracking List

Since the 2023-2024 California legislative session wrapped up on September 30th, state legislators have been spending time in their home districts – some of them campaigning for reelection while others are finishing out their final terms. It is anticipated that the state legislature will see more turnover during this election than at any point in the last decade. However, it is very likely that Democrats will maintain their supermajority.

Looking ahead to the next two-year session, we will keep an eye out on State priority issues such as housing, behavioral health and continued CalAIM efforts. We will also see changes to significant committees, including a new Chair of the Senate Health committee.

The following is a list of state bills tracked by the Public Affairs and Compliance Departments. This list of 131 bills includes 37 bills that were signed by the Governor, 7 that were vetoed and the remainder which died along the legislative session. These bills are of interest to and could have a direct impact on Alameda Alliance for Health and its membership.

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

AB 4 **(Arambula D) Covered California: expansion.**
Current Text: Amended: 8/6/2024 html pdf
Status: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 8/12/2024)
Location: 8/15/2024-S. DEAD

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

Summary: Current 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. Current 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. Current 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, 2026, 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, 2027.

AB 47 **(Boerner D) Pelvic floor physical therapy coverage.**
Current Text: Introduced: 12/5/2022 html pdf
Status: 2/1/2024-From committee: Filed with the Chief Clerk pursuant to Joint Rule 56.
Location: 1/12/2024-A. DEAD

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

Summary: Would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2024, to provide coverage for pelvic floor physical therapy after pregnancy. 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.

AB 55 **(Rodriguez D) Medi-Cal: workforce adjustment for ground ambulance transports.**
Current Text: Amended: 4/27/2023 html pdf
Status: 2/1/2024-From committee: Filed with the Chief Clerk pursuant to Joint Rule 56.
Location: 1/18/2024-A. DEAD

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

Summary: Current law requires, with exceptions, that Medi-Cal reimbursement to providers of emergency medical transports be increased by application of an add-on to the associated Medi-Cal fee-for-service payment schedule. Under current law, those increased payments are funded solely from a quality assurance fee (QAF), which emergency medical transport providers are required to pay based on a specified formula, and from federal reimbursement and any other related federal funds. Current law sets forth separate provisions for increased Medi-Cal reimbursement to providers of ground emergency medical transportation services that are owned or operated by certain types of public entities. This bill would establish, for dates of service on or after July 1, 2024, a workforce adjustment, serving as an additional payment, for each ground ambulance transport performed by a provider of medical transportation services, excluding the above-described public entity providers. The bill would vary the rate of adjustment depending on the point of pickup and whether the service was for an emergency or nonemergency, with the workforce adjustment being equal to 80% of the lowest maximum allowance established by the federal Medicare Program reduced by the fee-for-service payment schedule amount, as specified.

AB 236 **(Holden D) Health care coverage: provider directories.**
Current Text: Amended: 6/27/2024 html pdf
Status: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 8/5/2024)
Location: 8/15/2024-S. DEAD

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

Summary: Current 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. Current 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 health plan'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, 2025, with increasing required percentage accuracy benchmarks to be met each year until the directories are 95% accurate on or before July 1, 2028. 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 arrange care and 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 contracted 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.

AB 365 **(Aguiar-Curry D) Medi-Cal: diabetes management.**
Current Text: Amended: 9/8/2023 html pdf
Status: 8/31/2024-Failed Deadline pursuant to Rule 61(b)(17). (Last location was INACTIVE FILE on 8/30/2024)
Location: 8/31/2024-S. DEAD

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

1st House	2nd House	Conc.			

Summary: Would add continuous glucose monitors and related supplies required for use with those monitors as a covered benefit under the Medi-Cal program for the treatment of diabetes when medically necessary, subject to utilization controls. The bill would require the State Department of Health Care Services, by July 1, 2024, to review, and update as appropriate, coverage policies for continuous glucose monitors, as specified. The bill would authorize the department to require a manufacturer of a continuous glucose monitor to enter into a rebate agreement with the department. The bill would limit its implementation to the extent that any necessary federal approvals are obtained and federal financial participation is available.

AB 412 **(Soria D) Distressed Hospital Loan Program.**
Current Text: Amended: 4/24/2023 html pdf
Status: 8/31/2024-Failed Deadline pursuant to Rule 61(b)(17). (Last location was HEALTH on 6/14/2023)
Location: 8/31/2024-S. DEAD

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

Summary: The California Health Facilities Financing Authority Act authorizes the California Health Facilities Financing Authority to, among other things, make loans from the continuously appropriated California Health Facilities Financing Authority Fund to participating health institutions, as defined, for financing or refinancing the acquisition, construction, or remodeling of health facilities. This bill would create the Distressed Hospital Loan Program, until January 1, 2032, for the purpose of providing loans to not-for-profit hospitals and public hospitals, as defined, in significant financial distress, or to governmental entities representing a closed hospital to prevent the closure or facilitate the reopening of a closed hospital. The bill would require, subject to an appropriation by the Legislature, the Department of Health Care Access and Information to administer the program and would require the department to enter into an interagency agreement with the authority to implement the program. The bill would require the department, in collaboration with the State Department of Health Care Services, the Department of Managed Health Care, and the State Department of Public Health, to develop a methodology to evaluate an at-risk hospital's potential eligibility for state assistance from the program, as specified.

AB 488 **(Nguyen, Stephanie D) Medi-Cal: skilled nursing facilities: vision loss.**
Current Text: Introduced: 2/7/2023 html pdf
Status: 2/1/2024-From committee: Filed with the Chief Clerk pursuant to Joint Rule 56.
Location: 1/12/2024-A. DEAD

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

Summary: Current law requires the State Department of Health Care Services, subject to any necessary federal approvals, for managed care rating periods that begin between January 1, 2023, and December 31, 2026, inclusive, to establish and implement the Workforce and Quality Incentive Program under which a network provider furnishing skilled nursing facility services to a Medi-Cal managed care enrollee may earn performance-based directed payments from the Medi-Cal managed care plan with which they contract, as specified. Current law, subject to an appropriation, requires the department to set the amounts of those directed payments under a specified formula. Current law requires the department to establish the methodology or methodologies, parameters, and eligibility criteria for the directed payments, including the milestones and metrics that network providers of skilled nursing facility services must meet in order to receive a directed payment from a Medi-Cal managed care plan, with at least 2 of these milestones and metrics tied to workforce measures. This bill would require that the measures and milestones include program access, staff training, and capital improvement measures aimed at addressing the needs of skilled nursing facility residents with vision loss.

AB 551 **(Bennett D) Public Utilities Commission.**
Current Text: Chaptered: 9/20/2024 html pdf
Status: 9/20/2024-Chaptered by Secretary of State - Chapter 299, Statutes of 2024
Location: 9/20/2024-A. CHAPTERED

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

Summary: Current law requires the Public Utilities Commission to submit amendments, revisions, or modifications of its Rules of Practice and Procedure to the Office of Administrative Law for prior review, but exempts from that requirement general orders, resolutions, or other substantive regulations. This bill would clarify that regulations and guidelines related to the California Environmental Quality Act are also exempt from that requirement.

AB 564 **(Villapudua D) Medi-Cal: claim or remittance forms: signature.**
Current Text: Amended: 4/5/2023 html pdf
Status: 7/2/2024-Failed Deadline pursuant to Rule 61(b)(13). (Last location was HEALTH on 6/14/2023)
Location: 7/2/2024-S. DEAD

Desk	Policy	Fiscal	Floor	Desk	Dead	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. Current law requires the Director of Health Care Services to develop and implement standards for the timely processing and payment of each claim type. Current law requires that the standards be sufficient to meet minimal federal requirements for the timely processing of claims. Current law states the intent of the Legislature that claim forms for use by physicians and hospitals be the same as claim forms in general use by other payors, as specified. This bill would require the department to allow a provider to submit an electronic signature for a claim or remittance form under the Medi-Cal program, to the extent not in conflict with federal law.

AB 586 **(Calderon D) Medi-Cal: community supports: climate change or environmental remediation devices.**
Current Text: Amended: 3/30/2023 html pdf
Status: 2/1/2024-From committee: Filed with the Chief Clerk pursuant to Joint Rule 56.
Location: 1/18/2024-A. DEAD

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

Summary: Current 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 State Department of Health Care Services is authorized to approve include, among other things, housing deposits, environmental accessibility adaptations or home modifications, and asthma remediation. This bill would add climate change or environmental remediation devices to the above-described list of community supports. For purposes of these provisions, the bill would define “climate change or environmental remediation devices” as coverage of devices and installation of those devices, as necessary, to address health-related complications, barriers, or other factors linked to extreme weather, poor air quality, or climate events, including air conditioners, electric heaters, air filters, or backup power sources, among other specified devices for certain purposes.

AB 815 **(Wood D) Health care coverage: physician and provider credentials.**
Current Text: Amended: 7/3/2024 html pdf
Status: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 8/5/2024)
Location: 8/15/2024-S. DEAD

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

Summary: Current law establishes the California Health and Human Services Agency, which includes departments charged with the administration of health, social, and other human services. Current law provides for the licensure and regulation of health care service plans by the Department of Managed Health Care under the Knox-Keene Health Care

Service Plan Act of 1975, and the regulation of health insurers by the Department of Insurance. Current law sets forth requirements for provider credentialing by a health care service plan or health insurer. This bill would require the California Health and Human Services Agency to create and maintain a physician credentialing board, with specified membership, and would require the board, on or before July 1, 2027, to develop a standardized credentialing form to be used by all health care service plans and health insurers. The bill would require every health care service plan or health insurer to use the standardized credentialing form, as specified. The bill would not apply the standardized form requirements to specified Medi-Cal managed care contracts with the State Department of Health Care Services.

AB 1022 **(Mathis R) Medi-Cal: Program of All-Inclusive Care for the Elderly.**
Current Text: Introduced: 2/15/2023 html pdf
Status: 2/1/2024-From committee: Filed with the Chief Clerk pursuant to Joint Rule 56.
Location: 1/12/2024-A. DEAD

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

Summary: Current federal law establishes the Program of All-Inclusive Care for the Elderly (PACE), which provides specified services for older individuals at a PACE center so that they may continue living in the community. Federal law authorizes states to implement PACE as a Medicaid state option. Current state law establishes the California Program of All-Inclusive Care for the Elderly (PACE program) to provide community-based, risk-based, and capitated long-term care services as optional services under the state's Medi-Cal state plan. Current law requires the department to develop and pay capitation rates to entities contracted through the PACE program using actuarial methods and that reflect the level of care associated with the specific populations served pursuant to the contract. Current law authorizes a PACE organization approved by the department to use video telehealth to conduct initial assessments and annual reassessments for eligibility for enrollment in the PACE program. This bill, among other things relating to the PACE program, would require those capitation rates to also reflect the frailty level and risk associated with those populations. The bill would also expand an approved PACE organization's authority to use video telehealth to conduct all assessments, as specified.

AB 1091 **(Wood D) Health Care Consolidation and Contracting Fairness Act of 2023.**
Current Text: Introduced: 2/15/2023 html pdf
Status: 2/1/2024-From committee: Filed with the Chief Clerk pursuant to Joint Rule 56.
Location: 1/12/2024-A. DEAD

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

Summary: This bill, the Health Care Consolidation and Contracting Fairness Act of 2023, would prohibit a contract issued, amended, or renewed on or after January 1, 2024, between a health care service plan or health insurer and a health care provider or health facility from containing terms that, among other things, restrict the plan or insurer from steering an enrollee or insured to another provider or facility or require the plan or insurer to contract with other affiliated providers or facilities. The bill would authorize the appropriate regulating department to refer a plan's or insurer's contract to the Attorney General, and would authorize the Attorney General or state entity charged with reviewing health care market competition to review a health care practitioner's or health facility's entrance into a contract that contains specified terms. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

AB 1092 **(Wood D) Health care service plans: consolidation.**
Current Text: Amended: 6/28/2023 html pdf
Status: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 8/14/2023)
Location: 8/15/2024-S. DEAD

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

Summary: Current law requires a health care service plan that intends to merge with, consolidate with, or enter into an agreement resulting in its purchase, acquisition, or control by, an entity, to give notice to, and secure prior approval from,

the Director of the Department of Managed Health Care. Current law authorizes the director to disapprove the transaction or agreement if the director finds it would substantially lessen competition in health care service plan products or create a monopoly in this state. Current law authorizes the director to conditionally approve the transaction or agreement, contingent upon the health care service plan's agreement to fulfill one or more conditions to benefit subscribers and enrollees of the health care service plan, provide for a stable health care delivery system, and impose other conditions specific to the transaction or agreement, as specified. This bill would additionally require a health care service plan that intends to acquire or obtain control of an entity, as specified, to give notice to, and secure prior approval from, the director. Because a willful violation of this provision would be a crime, the bill would impose a state-mandated local program.

AB 1110 **(Arambula D) Public health: adverse childhood experiences.**
Current Text: Amended: 7/10/2023 html pdf
Status: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 8/14/2023)
Location: 8/15/2024-S. DEAD

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

Summary: Would, subject to an appropriation and until January 1, 2027, require the office and the State Department of Health Care Services, while administering the ACEs Aware initiative and in collaboration with subject matter experts, to review available literature on ACEs, as defined, and ancestry or ethnicity-based data disaggregation practices in ACEs screenings, develop guidance for culturally and linguistically competent ACEs screenings through improved data collection methods, post the guidance on the department's internet website and the ACEs Aware internet website, and make the guidance accessible, as specified.

AB 1122 **(Bains D) Commercial harbor craft: equipment.**
Current Text: Vetoed: 9/29/2024 html pdf
Status: 9/29/2024-Vetoed by Governor.
Location: 9/29/2024-A. VETOED

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

Summary: Current law generally regulates the operation of vessels and associated equipment used, to be used, or carried in vessels used on waters subject to the jurisdiction of the state. Current regulations require the installation of a new engine or the retrofit of an existing engine in certain harbor craft to reduce emissions of air pollutants, as specified. This bill would require a diesel particulate filter that is retrofitted onto the engine of certain commercial harbor craft to include an override or bypass safety system that ensures that the commercial harbor craft can maintain a safe level of propulsion in the event of an emergency situation, as specified. The bill would require the manufacturer of an override or bypass safety system to design, install, and provide certain documentation regarding the override or bypass safety system, as specified. The bill would require the owner or operator of a commercial harbor craft that uses an override or bypass safety system to report the use and retain records regarding the use, as specified.

AB 1157 **(Ortega D) Rehabilitative and habilitative services: durable medical equipment and services.**
Current Text: Amended: 7/13/2023 html pdf
Status: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 8/14/2023)
Location: 8/15/2024-S. DEAD

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

Summary: Current 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. Under existing law, essential health benefits includes, among other things, rehabilitative and habilitative services. Current law requires habilitative services and devices to be

covered under the same terms and conditions applied to rehabilitative services and devices under the plan contract or policy, and defines habilitative services to mean health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. This bill would specify that coverage of rehabilitative and habilitative services and devices under a health care service plan or health insurance policy includes durable medical equipment, services, and repairs, if the equipment, services, or repairs are prescribed or ordered by a physician, surgeon, or other health professional acting within the scope of their license. The bill would define "durable medical equipment" to mean devices, including replacement devices, that are designed for repeated use, and that are used for the treatment or monitoring of a medical condition or injury in order to help a person to partially or fully acquire, improve, keep, or learn, or minimize the loss of, skills and functioning of daily living. The bill would prohibit coverage of durable medical equipment and services from being subject to financial or treatment limitations, as specified.

AB 1282 **(Lowenthal D) Mental health: impacts of social media.**
Current Text: Chaptered: 9/28/2024 html pdf
Status: 9/28/2024-Approved by the Governor. Chaptered by Secretary of State - Chapter 807, Statutes of 2024.
Location: 9/28/2024-A. CHAPTERED

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

Summary: The Mental Health Services Act, an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, establishes the Mental Health Services Oversight and Accountability Commission, and authorizes the commission to take specified actions, including advising the Governor or the Legislature regarding actions the state may take to improve care and services for people with mental illness. Current law authorizes the State Department of Public Health to, among other things, enforce its regulations and protect and preserve the public health. This bill would require the department, in consultation with the commission, to report to specified policy committees of the Legislature, on or before December 31, 2026, a statewide strategy to understand, communicate, and mitigate mental health risks associated with the use of social media by children and youth. The bill would require the report to include, among other things, (1) the degree to which the mental health of children and youth is positively, negatively, or neutrally impacted by use of social media and (2) recommendations to strengthen children and youth resiliency strategies and California's use of mental health services related to social media use.

AB 1313 **(Ortega D) Older individuals: case management services.**
Current Text: Amended: 4/27/2023 html pdf
Status: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 7/3/2023)
Location: 8/15/2024-S. DEAD

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

Summary: The Mello-Granlund Older Californians Act requires the California Department of Aging to designate various private nonprofit or public agencies as area agencies on aging to work within a planning and service area and provide a broad array of social and nutritional services. Under the act, the department's mission is to provide leadership to those agencies in developing systems of home- and community-based services that maintain individuals in their own homes or least restrictive homelike environments. This bill would, until January 1, 2030, and subject to an appropriation, require the department to establish a case management services pilot program. Under the bill, the purpose of the program would be to expand statewide the local capacity of supportive services programs by providing case management services to older individuals who need assistance to maintain health and economic stability. The bill would require the Counties of Alameda, Marin, and Sonoma to participate in the pilot program.

AB 1316 **(Irwin D) Emergency services: psychiatric emergency medical conditions.**
Current Text: Chaptered: 9/27/2024 html pdf
Status: 9/27/2024-Approved by the Governor. Chaptered by Secretary of State - Chapter 632, Statutes of 2024.
Location: 9/27/2024-A. CHAPTERED

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

1st House	2nd House	Conc.			

Summary: The Lanterman-Petris-Short Act provides for the involuntary commitment and treatment of a person who is a danger to themselves or others or who is gravely disabled, as defined. Pursuant to a schedule of covered benefits, current law requires Medi-Cal coverage for inpatient hospital services, subject to utilization controls, and with respect to fee-for service beneficiaries, coverage for emergency services and care necessary for the treatment of an emergency medical condition and medical care directly related to the emergency medical condition, as specified. Current 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. Current law defines "psychiatric emergency medical condition," for purposes of providing treatment for emergency conditions, as a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either an immediate danger to the patient or to others, or immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder. Current law includes various circumstances under which a patient is required to be treated by, or may be transferred to, specified health facilities for treatment that is solely necessary to relieve or eliminate a psychiatric emergency medical condition. This bill would revise the definition of "psychiatric emergency medical condition" to make that definition applicable regardless of whether the patient is voluntary, or is involuntarily detained for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment, under prescribed circumstances. The bill would make conforming and clarifying changes to provisions requiring facilities to provide that treatment.

AB 1338 **(Petrie-Norris D) Medi-Cal: community supports.**
Current Text: Amended: 4/20/2023 html pdf
Status: 2/1/2024-From committee: Filed with the Chief Clerk pursuant to Joint Rule 56.
Location: 1/18/2024-A. DEAD

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

Summary: Current 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 current law, community supports that the department is authorized to approve include, among other things, housing transition navigation services, recuperative care, respite, day habilitation programs, and medically supportive food and nutrition services.

AB 1359 **(Papan D) California Environmental Quality Act: geothermal exploratory projects: lead agency.**
Current Text: Chaptered: 9/27/2024 html pdf
Status: 9/27/2024-Approved by the Governor. Chaptered by Secretary of State - Chapter 678, Statutes of 2024.
Location: 9/27/2024-A. CHAPTERED

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

Summary: The California Environmental Quality Act (CEQA requires a lead agency to prepare a mitigated negative declaration for a project that may have a significant effect on the environment if revisions in the project would avoid or mitigate that effect and there is no substantial evidence that the project, as revised, would have a significant effect on the environment. Current law establishes the Geologic Energy Management Division in the Department of Conservation, under the direction of the State Oil and Gas Supervisor, who is required to supervise the drilling, operation, maintenance, and abandonment of wells so as to permit the owners or operators of those wells to utilize all methods and practices known to the industry for the purpose of increasing the ultimate recovery of geothermal resources, as provided. Current law requires the division to be the lead agency for all geothermal exploratory projects for purposes of CEQA, as specified. specified, and authorizes the division to delegate its lead agency responsibility for geothermal exploratory projects to a county that has adopted a geothermal element for its general plan. Current law requires the delegation to provide that the county complete its lead agency responsibility within 135 days of the receipt of the application for the project. This bill would delete the requirement of the delegation to provide that the county complete its lead agency responsibility within 135 days. The bill would specify, upon the request of an applicant of a geothermal exploratory project, that the county in which the project is located is to assume the responsibilities of a lead agency regardless of whether the county has adopted a geothermal element for its general plan. The bill would require the applicant to make

the request to the county and the division. If a county assumes lead agency responsibility for a geothermal exploratory project, the bill would require the county and the division to confer regarding necessary information that should be included in the environmental review for the project to facilitate the division's exercise of its authority as a responsible agency.

AB 1450 **(Jackson D) Behavioral health: behavioral health and wellness screenings: notice.**
Current Text: Amended: 1/3/2024 html pdf
Status: 2/1/2024-From committee: Filed with the Chief Clerk pursuant to Joint Rule 56.
Location: 1/12/2024-A. DEAD

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

Summary: Current law requires the Medical Board of California, in determining its continuing education requirements, to consider including a course in integrating mental and physical health care in primary care settings, especially as it pertains to early identification of mental health issues and exposure to trauma in children and young adults and their appropriate care and treatment. Current law requires a physician and surgeon to provide notice to patients at an initial office visit regarding a specified database. Current law requires the State Department of Public Health to license and regulate health facilities, including general acute care hospitals. Current law requires a general acute care hospital to establish and adopt written policies and procedures to screen patients who are 12 years of age and older for purposes of detecting a risk for suicidal ideation and behavior. 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. Current law provides for the regulation of health insurers by the Department of Insurance. This bill would require a physician and surgeon, a general acute care hospital, a health care service plan, and a health insurer to provide to each legal guardian of a patient, enrollee, or insured, 10 to 18 years of age, a written or electronic notice regarding the benefits of a behavioral health and wellness screening. The bill would require the providers to provide the notice at least once every 2 years in the preferred method of the legal guardian.

AB 1608 **(Patterson, Joe R) Medi-Cal: managed care plans.**
Current Text: Amended: 1/3/2024 html pdf
Status: 2/1/2024-From committee: Filed with the Chief Clerk pursuant to Joint Rule 56.
Location: 1/12/2024-A. DEAD

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

Summary: The Lanterman Developmental Disabilities Services Act makes the State Department of Developmental Services responsible for providing various services and supports to individuals with developmental disabilities, and for ensuring the appropriateness and quality of those services and supports. 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. Current law establishes the California Advancing and Innovating Medi-Cal (CalAIM) initiative, subject to receipt of any necessary federal approvals and the availability of federal financial participation, in order to, among other things, improve quality outcomes, reduce health disparities, and increase flexibility. Current law authorizes the department to standardize those populations that are subject to mandatory enrollment in a Medi-Cal managed care plan across all aid code groups and Medi-Cal managed care models statewide, subject to a Medi-Cal managed care plan readiness, continuity of care transition plan, and disenrollment process developed in consultation with stakeholders, in accordance with specified requirements and the CalAIM Terms and Conditions. Existing law, if the department standardizes those populations subject to mandatory enrollment, exempts certain dual and non-dual beneficiary groups, as defined, from that mandatory enrollment. This bill would additionally exempt dual and non-dual-eligible beneficiaries who receive services from a regional center and use a Medi-Cal fee-for-service delivery system as a secondary form of health coverage.

AB 1644 **(Bonta D) Medi-Cal: medically supportive food and nutrition services.**
Current Text: Amended: 4/27/2023 html pdf
Status: 2/1/2024-From committee: Filed with the Chief Clerk pursuant to Joint Rule 56.

Location: 1/18/2024-A. DEAD

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

Summary: Would make medically supportive food and nutrition interventions, as defined, a covered benefit under the Medi-Cal program, upon issuance of final guidance by the State Department of Health Care Services. The bill would require medically supportive food and nutrition interventions to be covered when determined to be medically necessary by a health care provider or health care plan, as specified. In order to qualify for coverage under the Medi-Cal program, the bill would require a patient to be offered at least 3 of 6 specified medically supportive food and nutrition interventions and for the interventions to be provided for a minimum duration of 12 weeks, as specified. The bill would only provide coverage for nutrition support interventions when paired with the provision of food through one of the 3 offered interventions. The bill would require a health care provider to match the acuity of a patient's condition to the intensity and duration of the medically supportive food and nutrition intervention and include culturally appropriate foods whenever possible.

AB 1690 **(Kalra D) Universal health care coverage.**
Current Text: Introduced: 2/17/2023 html pdf
Status: 2/1/2024-Died at Desk.
Location: 1/18/2024-A. DEAD

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

Summary: Would state the intent of the Legislature to guarantee accessible, affordable, equitable, and high-quality health care for all Californians through a comprehensive universal single-payer health care program that benefits every resident of the state.

AB 1698 **(Wood D) Medi-Cal.**
Current Text: Introduced: 2/17/2023 html pdf
Status: 2/1/2024-Died at Desk.
Location: 1/18/2024-A. DEAD

Dead	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, 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 make specified findings and would express the intent of the Legislature to enact future legislation relating to Medi-Cal.

AB 1783 **(Essayli R) Health care: immigration.**
Current Text: Introduced: 1/3/2024 html pdf
Status: 5/2/2024-Failed Deadline pursuant to Rule 61(b)(6). (Last location was PRINT on 1/3/2024)
Location: 5/2/2024-A. DEAD

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

Summary: Would state the intent of the Legislature to enact legislation to remove all taxpayer funding for health care for illegal immigrants from the California State Budget.

AB 1842 **(Reyes D) Health care coverage: Medication-assisted treatment.**
Current Text: Chaptered: 9/27/2024 html pdf
Status: 9/27/2024-Approved by the Governor. Chaptered by Secretary of State - Chapter 633, Statutes of 2024.
Location: 9/27/2024-A. CHAPTERED

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

Summary: Current law authorizes health care service plans and health insurers that cover prescription drugs to utilize reasonable medical management practices, including prior authorization and step therapy, consistent with applicable law. This bill would require a group or individual health care service plan or health insurer offering an outpatient prescription drug benefit to provide coverage without prior authorization, step therapy, or utilization review for at least one medication approved by the United States Food and Drug Administration in each of 4 designated categories, including medication for the reversal of opioid overdose, including a naloxone product or another opioid antagonist. 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 1895 **(Weber D) Public health: maternity ward closures.**
Current Text: Vetoed: 9/29/2024 html pdf
Status: 9/29/2024-Vetoed by Governor.
Location: 9/29/2024-A. VETOED

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

Summary: Would require an acute care hospital that operates a perinatal unit and expects challenges in the next 6 months that may result in a reduction or loss of perinatal services, to report specified information to the Department of Health Care Access and Information, including, but not limited to, the number of medical staff and employees working in the perinatal unit and the hospital's prior performance on financial metrics. The bill would require the Department of Health Care Access and Information to forward the provided information to the State Department of Health Care Services and the State Department of Public Health. The bill would require this information be kept confidential to the extent permitted by law. The bill would require, within 3 months of receiving this notice from the hospital, the Department of Health Care Access and Information, in conjunction with the State Department of Public Health and the State Department of Health Care Services, to conduct a community impact assessment to identify the 3 closest hospitals operating a perinatal unit, their distance from the challenged facility, and whether those hospitals have any restrictions on their reproductive health services. The bill would require the Department of Health Care Access and Information to provide the community impact assessment to specified entities and would require these entities to keep the community impact assessment confidential. If the hospital plans to close its perinatal unit, the bill would require the hospital to provide public notice of the proposed closure, including the results of the community impact assessment, and other specified information on the hospital's internet website 90 days in advance of the closure. The bill would require the public to be permitted to comment on the closure for 60 days after the notice is given, and would require one noticed public hearing be conducted by the hospital. The bill would also require the hospital to accept written public comment. By creating a new crime, this bill would impose a state-mandated local program.

AB 1926 **(Connolly D) Health care coverage: regional enteritis.**
Current Text: Amended: 3/19/2024 html pdf
Status: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 6/24/2024)
Location: 8/15/2024-S. DEAD

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

Summary: Current law requires a health care service plan contract and disability insurance policy that provides coverage for hospital, medical, or surgical expenses and is issued, amended, delivered, or renewed on and after July 1, 2000, to provide coverage for the testing and treatment of phenylketonuria, including coverage for the formulas and special food products that are part of a prescribed diet, as specified. This bill would require a health care service plan contract or disability insurance policy that provides coverage for hospital, medical, or surgical expenses and is issued, amended, delivered, or renewed on and after July 1, 2025, to provide coverage for dietary enteral formulas, as defined, for the treatment of regional enteritis, as specified. The bill would specify that these provisions do not apply to Medi-Cal managed care plans to the extent that the services are excluded from coverage under the contract between the Medi-Cal managed care plan and the State Department of Health Care Services. 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.

AB 1943 **(Weber D) Medi-Cal: telehealth.**
Current Text: Amended: 6/6/2024 html pdf
Status: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 6/17/2024)
Location: 8/15/2024-S. DEAD

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

Summary: Under current law, in-person, face-to-face contact is not required under the Medi-Cal program when covered health care services are provided by video synchronous interaction, audio-only synchronous interaction, remote patient monitoring, or other permissible virtual communication modalities, when those services and settings meet certain criteria. This bill would require the State Department of Health Care Services to, by October 1, 2025, produce a public report on telehealth in the Medi-Cal program that includes analyses of, among other things, (1) telehealth access and utilization, (2) the effect of telehealth on timeliness of, access to, and quality of care, and (3) the effect of telehealth on clinical outcomes, as specified. The bill would authorize the department, in collaboration with the California Health and Human Services Agency, to issue policy recommendations based on the report's findings.

AB 1970 **(Jackson D) Mental Health: Black Mental Health Navigator Certification.**
Current Text: Amended: 6/18/2024 html pdf
Status: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 6/24/2024)
Location: 8/15/2024-S. DEAD

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

Summary: Current law requires the Department of Health Care Access and Information to develop and approve statewide requirements for community health worker certificate programs. Current 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 1975 **(Bonta D) Medi-Cal: medically supportive food and nutrition interventions.**
Current Text: Vetoed: 9/25/2024 html pdf
Status: 9/25/2024-Vetoed by the Governor
Location: 9/25/2024-A. VETOED

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

Summary: Current law requires the State Department of Health Care Services to establish the Medically Tailored Meals Pilot Program and the Short-Term Medically Tailored Meals Intervention Services Program, to operate in specified counties and during limited periods for the purpose of providing medically tailored meal intervention services to eligible Medi-Cal beneficiaries with certain health conditions, including congestive heart failure, cancer, diabetes, chronic obstructive pulmonary disease, or renal disease. Current 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 current law, community supports that the department is

authorized to approve include, among other things, medically supportive food and nutrition services, including medically tailored meals. This bill would make medically supportive food and nutrition interventions a covered benefit under the Medi-Cal program, through both the fee-for-service and managed care delivery systems, no sooner than July 1, 2026, upon appropriation and subject to federal approval and the issuance of final guidance by the department. The bill would require those interventions to be covered if determined to be medically necessary by a health care provider or health care plan, as specified. The bill would require the provision of interventions for 12 weeks, or longer if deemed medically necessary.

AB 1977 **(Ta R) Health care coverage: behavioral diagnoses.**
Current Text: Vetoed: 9/22/2024 html pdf
Status: 9/22/2024-Vetoed by the Governor
Location: 9/22/2024-A. VETOED

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

Summary: Would prohibit a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, from requiring an enrollee or insured previously diagnosed with pervasive developmental disorder or autism to be reevaluated or receive a new behavioral diagnosis to maintain coverage for behavioral health treatment for their condition. The bill would require a treatment plan to be made available to the plan or insurer upon request. Because a willful violation of this provision by a health care service plan would be a crime, the bill would impose a state-mandated local program.

AB 2028 **(Ortega D) Medical loss ratios.**
Current Text: Introduced: 2/1/2024 html pdf
Status: 4/25/2024-Failed Deadline pursuant to Rule 61(b)(5). (Last location was HEALTH on 2/12/2024)
Location: 4/25/2024-A. DEAD

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

Summary: The federal Patient Protection and Affordable Care Act requires a health insurance issuer to comply with minimum medical loss ratios (MLRs) and to provide an annual rebate to each insured if the MLR of the amount of the revenue expended by the issuer on costs to the total amount of premium revenue is less than a certain percentage, as specified. Current law requires health care service plans and health insurers that issue, sell, renew, or offer a contract or policy, excluding specialized dental and vision contracts and policies, to comply with a minimum MLR of 85% and provide specified rebates. Current law requires a health care service plan or health insurer that issues, sells, renews, or offers a contract or policy covering dental services to annually report MLR information to the appropriate department. This bill would require a health care service plan or health insurer that issues, sells, renews, or offers a specialized dental health care service plan contract or specialized dental health insurance policy to comply with a minimum MLR of 85% and to provide a specified rebate to an enrollee or insured.

AB 2043 **(Boerner D) Medi-Cal: nonmedical and nonemergency medical transportation.**
Current Text: Amended: 4/1/2024 html pdf
Status: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 6/24/2024)
Location: 8/15/2024-S. DEAD

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

Summary: Current law covers emergency or nonemergency medical transportation, and nonmedical transportation, under the Medi-Cal program, as specified. This bill would require the State Department of Health Care Services to ensure that the fiscal burden of nonemergency medical transportation or nonmedical transportation is not unfairly placed on public paratransit service operators and would authorize the department to direct Medi-Cal managed care plans to reimburse public paratransit service operators who are enrolled as Medi-Cal providers at the fee-for-service rates for conducting that transportation, as described. The bill would require the department to engage with public paratransit

service operators to understand the challenges as public operators of nonemergency medical transportation or nonmedical transportation services and would require the department to issue new guidance to ensure the fiscal burden is not unfairly placed on public operators on or before June 1, 2026.

AB 2063 **(Maienschein D) Health care coverage.**
Current Text: Chaptered: 9/28/2024 html pdf
Status: 9/28/2024-Approved by the Governor. Chaptered by Secretary of State - Chapter 818, Statutes of 2024.
Location: 9/28/2024-A. CHAPTERED

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

Summary: Current law exempts a health care service plan from the requirements of the Knox-Keene Health Care Service Plan Act of 1975 if the plan is operated by a city, county, city and county, public entity, political subdivision, or public joint labor management trust that satisfies certain criteria, including that the plan requires providers to be reimbursed solely on a fee-for-service basis. Current law authorizes the Director of the Department of Managed Health Care, no later than May 1, 2021, to authorize 2 pilot programs, one in northern California and one in southern California, under which providers approved by the department may undertake risk-bearing arrangements with a voluntary employees' beneficiary association (VEBA) with enrollment of more than 100,000 lives, notwithstanding the fee-for-service requirement described above, or a trust fund that is a welfare plan and a multiemployer plan with enrollment of more than 25,000 lives, for independent periods of time beginning no earlier than January 1, 2022, to December 31, 2025, inclusive, if certain criteria are met. Current law requires the association or trust fund and each health care provider participating in each pilot program to report to the department information regarding cost savings and clinical patient outcomes compared to a fee-for-service payment model and requires the department to report those findings to the Legislature no later than January 1, 2027. Current law repeals these provisions on January 1, 2028. This bill would instead authorize the director to authorize one pilot program in southern California, under which providers approved by the department may undertake risk-bearing arrangements with a VEBA, as specified above, if certain criteria are met. The bill would extend that repeal date to January 1, 2030. The bill would extend the period of time authorized for the pilot program to operate from December 31, 2025, to December 31, 2027.

AB 2105 **(Lowenthal D) Coverage for PANDAS and PANS.**
Current Text: Chaptered: 9/28/2024 html pdf
Status: 9/28/2024-Approved by the Governor. Chaptered by Secretary of State - Chapter 822, Statutes of 2024.
Location: 9/28/2024-A. CHAPTERED

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

Summary: Current law sets forth specified coverage requirements for health care service plan contracts and health 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, 2025, to provide coverage for the prophylaxis, diagnosis, and treatment of Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS) that is prescribed or ordered by the treating physician and surgeon and is medically necessary, as specified. The bill would prohibit coverage for PANDAS and PANS from being subject to a copayment, coinsurance, deductible, or other cost sharing that is greater than that applied to other benefits. The bill would prohibit a plan or insurer from denying or delaying coverage for PANDAS or PANS therapies because the enrollee or insured previously received treatment for PANDAS or PANS or was diagnosed with or received treatment for the condition under a different diagnostic name. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

AB 2110 **(Arambula D) Medi-Cal: Adverse Childhood Experiences trauma screenings: providers.**
Current Text: Introduced: 2/5/2024 html pdf
Status: 5/16/2024-Failed Deadline pursuant to Rule 61(b)(8). (Last location was APPR. SUSPENSE FILE on 5/1/2024)
Location: 5/16/2024-A. DEAD

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

Summary: Current 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. Current 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. Current law requires the department to develop the eligibility criteria, methodologies, and parameters for the payments and rate increases maintained, and would authorize revisions, as specified. This bill would require the department, as part of its above-described duties, to include (1)community-based organizations and local health jurisdictions that provide health services through community health workers and (2)doulas, that are enrolled Medi-Cal providers, as providers qualified to provide, and eligible to receive payments for, ACEs trauma screenings pursuant to the provisions described above. The bill would require the department to file a state plan amendment and seek any federal approvals it deems necessary to implement these provisions and condition implementation on receipt of any necessary federal approvals and the availability of federal financial participation.

AB 2115 **(Haney D) Controlled substances: clinics.**
Current Text: Chaptered: 9/27/2024 html pdf
Status: 9/27/2024-Approved by the Governor. Chaptered by Secretary of State - Chapter 634, Statutes of 2024.
Location: 9/27/2024-A. CHAPTERED

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

Summary: Would authorize a practitioner authorized to prescribe a narcotic drug at a nonprofit or free clinic, as specified, to dispense the narcotic drug from clinic supply for the purpose of relieving acute withdrawal symptoms while arrangements are being made for referral for treatment, as described, and would require the clinic dispensing the narcotic to be subject to specified reporting, labeling, and recordkeeping requirements. The bill would require clinics with a supply of narcotic drugs being dispensed pursuant to these provisions to establish policies or procedures for dispensing the narcotics, as specified. Because the bill would specify additional requirements under the Pharmacy Law, a violation of which would be a crime, it would impose a state-mandated local program.

AB 2129 **(Petrie-Norris D) Immediate postpartum contraception.**
Current Text: Chaptered: 9/29/2024 html pdf
Status: 9/29/2024-Approved by the Governor. Chaptered by Secretary of State - Chapter 950, Statutes of 2024.
Location: 9/29/2024-A. CHAPTERED

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

Summary: Current law generally regulates contractual provisions between health care service plans and health insurers and their contracting health care providers. This bill would require a contract between a health care service plan or health insurer and a health care provider issued, amended, or renewed on or after January 1, 2025, to authorize a provider to separately bill for devices, implants, or professional services, or a combination thereof, associated with immediate postpartum contraception if the birth takes place in a general acute care hospital or licensed birth center. The bill would prohibit that provider contract from considering those devices, implants, or services to be part of a payment for a general obstetric procedure. 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.

AB 2132 **(Low D) Health care services: tuberculosis.**
Current Text: Chaptered: 9/29/2024 html pdf
Status: 9/29/2024-Approved by the Governor. Chaptered by Secretary of State - Chapter 951, Statutes of 2024.

Location: 9/29/2024-A. CHAPTERED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law requires an adult patient receiving primary care services in certain health care settings to be offered a screening test for hepatitis B and hepatitis C, as specified. This bill would require a patient who is 18 years of age or older receiving health care services in a facility, clinic, center, office, or other setting, where primary care services are provided, to be offered tuberculosis screening, if tuberculosis risk factors are identified, to the extent these services are covered under the patient's health care coverage, except as specified. The bill would also require the health care provider to offer the patient follow-up health care or refer the patient to a health care provider who can provide follow-up health care if a screening test is positive. The bill would prohibit a health care provider that fails to comply with these provisions from being subject to any disciplinary action related to their licensure or certification, or to any civil or criminal liability, for that failure.

AB 2169 **(Bauer-Kahan D) Prescription drug coverage: dose adjustments.**
Current Text: Amended: 3/21/2024 html pdf
Status: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 8/5/2024)
Location: 8/15/2024-S. DEAD

Desk	Policy	Fiscal	Floor	Desk	Policy	Dead	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law generally authorizes a health care service plan or health 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. Current law also prohibits a health care service plan that covers prescription drug benefits from limiting or excluding coverage for a drug that was previously approved for coverage if an enrollee continues to be prescribed that drug, as specified. The bill would authorize a licensed health care professional to request, and would require that they be granted, the authority to adjust the dose or frequency of a drug to meet the specific medical needs of the enrollee or insured without prior authorization if specified conditions are met. Under the bill, if the enrollee or insured has been continuously using a prescription drug selected by their prescribing provider for the medical condition under consideration while covered by their current or previous health coverage, the health care service plan or health insurance policy would be prohibited from limiting or excluding coverage of that prescription. With respect to health care service plans, the bill would specify that its provisions do not apply to Medi-Cal managed care plan contracts.

AB 2180 **(Weber D) Health care coverage: cost sharing.**
Current Text: Amended: 4/30/2024 html pdf
Status: 5/16/2024-Failed Deadline pursuant to Rule 61(b)(8). (Last location was APPR. SUSPENSE FILE on 5/15/2024)
Location: 5/16/2024-A. DEAD

Desk	Policy	Dead	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law generally prohibits a person who manufactures a prescription drug from offering in California any discount, repayment, product voucher, or other reduction in an individual's out-of-pocket expenses associated with the individual's health insurance, health care service plan, or other health coverage, including, but not limited to, a copayment, coinsurance, or deductible, for any prescription drug if a lower cost generic drug is covered under the individual's health insurance, health care service plan, or other health coverage on a lower cost-sharing tier that is designated as therapeutically equivalent to the prescription drug manufactured by that person or if the active ingredients of the drug are contained in products regulated by the federal Food and Drug Administration, are available without prescription at a lower cost, and are not otherwise contraindicated for the condition for which the prescription drug is approved. This bill would require a health care service plan, health insurance policy, or pharmacy benefit manager that administers pharmacy benefits for a health care service plan or health insurer to apply any amounts paid by the enrollee, insured, or a third-party patient assistance program for prescription drugs toward the enrollee's or insured's cost-sharing requirement, and would only apply those requirements with respect to enrollees or insureds who have a chronic disease

or terminal illness. The bill would limit the application of the section to health care service plans and health insurance policies issued, amended, delivered, or renewed on or after January 1, 2025. The bill would repeal those provisions on January 1, 2035.

AB 2198 **(Flora R) Health information.**
Current Text: Chaptered: 9/22/2024 html pdf
Status: 9/22/2024-Chaptered by Secretary of State - Chapter 386, Statutes of 2024
Location: 9/22/2024-A. CHAPTERED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law provides for the regulation of health insurers by the Department of Insurance. Current law requires health care service plans and health insurers, commencing January 1, 2024, to establish and maintain specified application programming interfaces (API), including patient access API, for the benefit of enrollees, insureds, and contracted providers. Current law authorizes the departments to require health care service plans or health insurers, as applicable, to establish and maintain provider access API and prior authorization support API if and when final federal rules are published. This bill would instead require the departments, commencing January 1, 2027, or when final federal rules are implemented, whichever occurs later, to require health care service plans and health insurers to establish and maintain patient access API, provider access API, payer-to-payer API, and prior authorization API. The bill, until January 1, 2027, would authorize the departments to issue guidance relating to these provisions not subject to the Administrative Procedure Act, as specified. Because a violation of these requirements by a health care service plan would be a crime, this bill would impose a state-mandated local program.

AB 2200 **(Kalra D) Guaranteed Health Care for All.**
Current Text: Amended: 4/30/2024 html pdf
Status: 5/16/2024-Failed Deadline pursuant to Rule 61(b)(8). (Last location was APPR. SUSPENSE FILE on 5/15/2024)
Location: 5/16/2024-A. DEAD

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

Summary: Current law provides for the regulation of health insurers by the Department of Insurance. Current 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. This bill, the California Guaranteed Health Care for All Act, would create the California Guaranteed Health Care for All program, or CalCare, to provide comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of all residents of the state. Under the bill, CalCare would be a health care service plan subject to Knox-Keene. The bill, among other things, would provide that CalCare cover a wide range of medical benefits and other services and would incorporate the health care benefits and standards of other existing federal and state provisions, including the federal Children's Health Insurance Program, Medi-Cal, ancillary health care or social services covered by regional centers for persons with developmental disabilities, Knox-Keene, and the federal Medicare Program. The bill would make specified persons eligible to enroll as CalCare members during the implementation period and would provide for automatic enrollment. The bill would require the board to seek all necessary waivers, approvals, and agreements to allow various existing federal health care payments to be paid to CalCare, which would then assume responsibility for all benefits and services previously paid for with those funds.

AB 2237 **(Aguiar-Curry D) Children and youth: transfer of specialty mental health services.**
Current Text: Vetoed: 9/27/2024 html pdf
Status: 9/27/2024-Vetoed by Governor.
Location: 9/27/2024-A. VETOED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under current law, specialty mental health services include federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services provided to eligible Medi-Cal beneficiaries under 21 years of age. This bill would require, when a child or youth 21 years of age or younger who is receiving Medi-Cal specialty mental health services changes residence from one county to another, the receiving county to provide specialty mental health services to the child or youth, if the transfer of those services from one county to another is not otherwise governed by a process established in statute. The bill also would require the State Department of Health Care Services to collect specified data related to the receipt of specialty mental health services by children and youth who move outside of the county where they originally received specialty mental health services, and to include the data in the department's Medi-Cal specialty mental health services performance dashboard. The bill would require the department to issue guidance, as specified, to define the requirements placed on a receiving county for the continued provision of specialty mental health services, to coordinate and expedite the transfer of services from one county to another, and reduce the burden on children and youth and their caregivers to reestablish services in the receiving county. The bill would authorize the department to implement, interpret, or make specific its provisions by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, until regulations are adopted, as specified.

AB 2246 **(Ramos D) Medical Practice Act: health care providers: qualified autism service paraprofessionals.**
Current Text: Amended: 3/18/2024 html pdf
Status: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 8/5/2024)
Location: 8/15/2024-S. DEAD

Desk	Policy	Fiscal	Floor	Desk	Policy	Dead	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law establishes requirements for the delivery of medical services, including via telehealth by specified health care providers. A violation of the Medical Practice 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.

AB 2250 **(Weber D) Social determinants of health: screening and outreach.**
Current Text: Vetoed: 9/22/2024 html pdf
Status: 9/22/2024-Vetoed by Governor.
Location: 9/22/2024-A. VETOED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2027, to include coverage for screenings for social determinants of health, as defined. The bill would require providers to use standardized codes when documenting patient responses to questions asked in these screenings and would require providers to use existing tools or protocols to conduct the screenings. The bill would require a health care service plan or health insurer to provide physicians who provide primary care services with adequate access to peer support specialists, lay health workers, social workers, or community health workers in counties where the plan or insurer has enrollees or insureds, as specified. The bill would authorize the respective departments to adopt guidance to implement its provisions until regulations are adopted and would require the departments to coordinate in the development of guidance and regulations. 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.

AB 2258 **(Zbur D) Health care coverage: cost sharing.**
Current Text: Chaptered: 9/27/2024 html pdf
Status: 9/27/2024-Approved by the Governor. Chaptered by Secretary of State - Chapter 708, Statutes of 2024.
Location: 9/27/2024-A. CHAPTERED

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

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Summary: Current law requires a group or individual nongrandfathered health care service plan contract or health insurance policy to provide coverage for and prohibits a contract or policy from imposing cost-sharing requirements for, specified preventive care services and screenings. This bill would prohibit a group or individual nongrandfathered health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, from imposing a cost-sharing requirement for items or services that are integral to the provision of the above-described preventive care services and screenings. The bill would require those contracts and policies to cover items and services for those preventive care services and screenings, including home test kits for sexually transmitted diseases and specified cancer screenings. 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. The bill would authorize the Insurance Commissioner to impose a civil penalty of not more than $5,000 against an insurer for each violation of these provisions, or not more than $10,000 per violation if the violation was willful.

AB 2271 **(Ortega D) St. Rose Hospital.**
Current Text: Vetoed: 9/22/2024 html pdf
Status: 9/22/2024-Vetoed by Governor.
Location: 9/22/2024-A. VETOED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law creates the Distressed Hospital Loan Program, until January 1, 2032, for the purpose of providing loans to not-for-profit hospitals and public hospitals, as defined, in significant financial distress or to governmental entities representing a closed hospital to prevent the closure or facilitate the reopening of a closed hospital. Current law authorizes the Board of Supervisors of the County of Alameda to establish the Alameda Health System Hospital Authority for the management, administration, and control of the medical center in that county. Current law authorizes the hospital authority to acquire and possess real or personal property and to dispose of real or personal property other than that owned by the county, as may be necessary for the performance of its functions. This bill would require HCAI, subject to review and approval by the Department of Finance, as specified, to approve the forgiveness of any loans under the Distressed Hospital Loan Program for the St. Rose Hospital in the City of Hayward if the hospital is acquired by the Alameda Health System Hospital Authority. The bill would require HCAI to forgive the full amounts of the principal, interests, fees, and any other outstanding balances of the loan.

AB 2303 **(Carrillo, Juan D) Health and care facilities: prospective payment system rate increase.**
Current Text: Amended: 4/2/2024 html pdf
Status: 4/25/2024-Failed Deadline pursuant to Rule 61(b)(5). (Last location was HEALTH on 2/26/2024)
Location: 4/25/2024-A. DEAD

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

Summary: Current law provides that federally qualified health center services and rural health clinic services, as defined, are covered benefits under the Medi-Cal program, to be reimbursed, to the extent that federal financial participation is obtained, to providers on a per-visit basis and at a per-visit prospective payment system rate, as defined. Current law establishes 5 separate minimum wage schedules for covered health care employees, as defined, depending on the nature of the employer and includes increases beginning on June 1, 2024. Current law generally requires the State Department of Public Health to license, regulate, and inspect health and care facilities. This bill would, upon appropriation, require the State Department of Health Care Services to develop a minimum wage add-on as an alternative payment methodology to increase rates of payment for specified health care facilities to account for the costs of complying with the minimum wage schedules described above. The bill would require that the alternative methodology be applied retroactively to January 1, 2025, until those costs are included in the prospective payment system rate. The bill would require the department to seek all necessary federal approvals or amendments to the state Medi-Cal plan to implement these provisions and would require the department to make any state plan amendments or waiver requests public 45 days prior to submitting them to the federal Centers for Medicare and Medicaid Services.

AB 2319 **(Wilson D) California Dignity in Pregnancy and Childbirth Act.**

Current Text: Chaptered: 9/26/2024 html pdf
Status: 9/26/2024-Approved by the Governor. Chaptered by Secretary of State - Chapter 621, Statutes of 2024.
Location: 9/26/2024-A. CHAPTERED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law makes legislative findings relating to implicit bias and racial disparities in maternal mortality rates. Current law requires a hospital that provides perinatal care, and an alternative birth center or a primary clinic that provides services as an alternative birth center, to implement an evidence-based implicit bias program, as specified, for all health care providers involved in perinatal care of patients within those facilities. Current law requires the health care provider to complete initial basic training through the program and a refresher course every 2 years thereafter, or on a more frequent basis if deemed necessary by the facility. Current law requires the facility to provide a certificate of training completion upon request, to accept certificates of completion from other facilities, and to offer training to physicians not directly employed by the facility. Current law requires the State Department of Public Health to track and publish data on pregnancy-related death and severe maternal morbidity, as specified. This bill would make a legislative finding that the Legislature recognizes all birthing people, including nonbinary persons and persons of transgender experience. The bill would extend the evidence-based implicit bias training requirements to specified health care providers at hospitals that provide perinatal care, alternative birth centers, or primary care clinics, as specified. The bill would require an implicit bias program to include recognition of intersecting identities and the potential associated biases. The bill would require initial basic training for the implicit bias program to be completed by June 1, 2025, for current health care providers, and within 6 months of their start date for new health care providers, unless exempted. The bill would require specified facilities to, by February 1 of each year, commencing in 2026, provide the Attorney General with proof of compliance with these provisions, as specified. The bill would authorize the Attorney General to pursue civil penalties for violations of these provisions, as specified. The bill would require that Attorney General be awarded all attorney's fees and costs in any civil action in which a court imposes any of those civil penalties. The bill would authorize the Attorney General to post on its internet website a list of facilities that did not timely submit proof of compliance or were assessed penalties under these provisions, as specified. The bill would authorize the Attorney General to post any other compliance data they deem necessary and would authorize the Attorney General to biennially publish a report outlining compliance data related to these provisions.

AB 2332 **(Connolly D) Corrections: health care.**
Current Text: Amended: 3/21/2024 html pdf
Status: 5/16/2024-Failed Deadline pursuant to Rule 61(b)(8). (Last location was APPR. SUSPENSE FILE on 5/1/2024)
Location: 5/16/2024-A. DEAD

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

Summary: Current law establishes the Division of Health Care Operations and the Division of Health Care Policy and Administration within the Department of Corrections and Rehabilitation (CDCR) under the supervision of the Undersecretary of Health Care Services. Current law requires the department to expand substance abuse treatment services in prisons to accommodate at least 4,000 additional inmates who have histories of substance abuse. Current law requires the department to establish a 3-year pilot program to provide a medically assisted substance use disorder treatment model for the treatment of inmates, as specified. This bill would require the CDCR to take specific actions in the provision of substance use treatment, such as ensuring uniform application of the California Correctional Health Care Services Care Guide and retaining at least one full-time addiction medicine physician and surgeon at each facility to be assigned medication-assisted treatment patients exclusively. The bill would require the CDCR to provide physicians and surgeons clear guidance on interpretation of certain toxicology tests, the misuse, abuse, and illegal distribution of substances, and access to alternative medication. The bill would require the CDCR to provide physicians and surgeons training consisting of at least 8 hours of integrated substance use disorder treatment didactic training, 3 days of shadowing an integrated substance use disorder treatment practice, and an annual training of at least 8 hours covering specified topics.

AB 2339 **(Aguiar-Curry D) Medi-Cal: telehealth.**
Current Text: Vetoed: 9/22/2024 html pdf
Status: 9/20/2024-Vetoed by Governor.

Location: 9/20/2024-A. VETOED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
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Summary: Under current law, subject to federal approval, in-person, face-to-face contact is not required under Medi-Cal when covered health care services are provided by video synchronous interaction, asynchronous store and forward, audio-only synchronous interaction, remote patient monitoring, or other permissible virtual communication modalities, when those services and settings meet certain criteria. Current law defines "asynchronous store and forward" as the transmission of a patient's medical information from an originating site to the health care provider at a distant site. This bill would expand that definition, for purposes of the above-described Medi-Cal provisions, to include asynchronous electronic transmission initiated directly by patients, including through mobile telephone applications.

AB 2340 **(Bonta D) Medi-Cal: EPSDT services: informational materials.**
Current Text: Chaptered: 9/25/2024 html pdf
Status: 9/25/2024-Chaptered by Secretary of State - Chapter 564, Statutes of 2024
Location: 9/25/2024-A. CHAPTERED

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

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 medically necessary 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 current law, early and periodic screening, diagnostic, and treatment (EPSDT) services are covered under Medi-Cal for an individual under 21 years of age in accordance with certain federal provisions. Current federal regulations require the state to provide for a combination of written and oral methods designed to inform individuals eligible for EPSDT services, or their families, about the EPSDT program, within 60 days of the individual's initial Medicaid eligibility determination and, in the case of families that have not utilized EPSDT services, annually thereafter, as specified. Under those regulations, required information includes, among other components, the benefits of preventive health care and the services available under the EPSDT program and where and how to obtain those services. This bill would require the department to prepare written informational materials that effectively explain and clarify the scope and nature of EPSDT services, as defined, that are available under the Medi-Cal program. Under the bill, the materials would include, but would not be limited to, the information required in the above-described federal regulations or their successor. Under the bill, the informational materials would also include content designed for youth, for purposes of delivery of that content to a beneficiary who is 12 years of age or older but under 21 years of age.

AB 2342 **(Lowenthal D) Medi-Cal: critical access hospitals: islands.**
Current Text: Introduced: 2/12/2024 html pdf
Status: 4/25/2024-Failed Deadline pursuant to Rule 61(b)(5). (Last location was HEALTH on 2/26/2024)
Location: 4/25/2024-A. DEAD

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

Summary: Under current law, a hospital designated by the State Department of Health Care Services as a critical access hospital, and certified as such by the Secretary of the United States Department of Health and Human Services under the federal Medicare rural hospital flexibility program, is eligible for supplemental payments for Medi-Cal covered outpatient services rendered to Medi-Cal eligible persons. Current law conditions those payments on receipt of federal financial participation and an appropriation in the annual Budget Act for the nonfederal share of those payments, with supplemental payments being apportioned among critical access hospitals based on their number of Medi-Cal outpatient visits. This bill, subject to appropriation and the availability of federal funding, would require the department to provide an annual supplemental payment, for services covered under Medi-Cal, to each critical access hospital that operates on an island that is located more than 10 miles offshore of the mainland coast of the state but is still within the jurisdiction of the state. The bill would specify the formula of the payment amount, which would be in addition to any supplemental payment described above.

AB 2352 **(Irwin D) Mental health and psychiatric advance directives.**
Current Text: Amended: 4/25/2024 html pdf
Status: 7/2/2024-Failed Deadline pursuant to Rule 61(b)(13). (Last location was JUD. on 5/29/2024)
Location: 7/2/2024-S. DEAD

Desk	Policy	Fiscal	Floor	Desk	Dead	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law establishes the requirements for executing a written advance health care directive that is legally sufficient to direct health care decisions. Current law provides a form that an individual may use or modify to create an advance health care directive. Under existing law, a written advance health care directive is legally sufficient if specified requirements are satisfied, may be revoked by a patient having capacity at any time, and is revoked to the extent of a conflict with a later executed directive. Current law requires a supervising health care provider who knows of the existence of an advance health care directive or its revocation to record that fact in the patient's health record. Existing law sets forth requirements of witnesses to a written advance health care directive. A written advance health care directive or similar instrument executed in another jurisdiction is valid and enforceable in this state under existing law. A person who intentionally falsifies, forges, conceals, defaces, or obliterates an individual's advance health care directive or its revocation without the individual's consent is subject to liability of up to $10,000 or actual damages, whichever is greater, plus reasonable attorney's fees. Current law authorizes an appeal of specified orders relating to an advance health care directive. Current law generally prohibits involuntary civil placement of a ward, conservatee, or person with capacity in a mental health treatment facility, subject to a valid and effective advance health care directive. Under current law, an advance psychiatric directive is a legal document, executed on a voluntary basis by a person who has the capacity to make medical decisions and in accordance with the requirements for an advance health care directive, that allows a person with mental illness to protect their autonomy and ability to direct their own care by documenting their preferences for treatment in advance of a mental health crisis. An individual may execute both an advance health care directive and a voluntary standalone psychiatric advance directive. This bill would extend the above-described advance health care directive provisions to psychiatric advance directives and would make conforming changes. The bill would specify that a psychiatric advance directive is a legal written or digital document, executed as specified, that allows a person with behavioral health illness to document their preferences for treatment and identify a health care advocate in advance of a behavioral health crisis.

AB 2356 **(Wallis R) Medi-Cal: monthly maintenance amount: personal and incidental needs.**
Current Text: Introduced: 2/12/2024 html pdf
Status: 5/16/2024-Failed Deadline pursuant to Rule 61(b)(8). (Last location was APPR. SUSPENSE FILE on 5/8/2024)
Location: 5/16/2024-A. DEAD

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

Summary: Qualified individuals under the Medi-Cal program include medically needy persons and medically needy family persons who meet the required eligibility criteria, including applicable income requirements. Current law requires the department to establish income levels for maintenance need at the lowest levels that reasonably permit a medically needy person to meet their basic needs for food, clothing, and shelter, and for which federal financial participation will still be provided under applicable federal law. In calculating the income of a medically needy person in a medical institution or nursing facility, or a person receiving institutional or noninstitutional services from a Program of All-Inclusive Care for the Elderly organization, the required monthly maintenance amount includes an amount providing for personal and incidental needs in the amount of not less than $35 per month while a patient. Current law authorizes the department to increase, by regulation, this amount as necessitated by increasing costs of personal and incidental needs. This bill would increase the monthly maintenance amount for personal and incidental needs from $35 to $50, and would require that the amount be increased annually, as specified. The bill would make these changes subject to receipt of necessary federal approvals.

AB 2376 **(Bains D) Chemical dependency recovery hospitals.**
Current Text: Chaptered: 9/27/2024 html pdf
Status: 9/27/2024-Approved by the Governor. Chaptered by Secretary of State - Chapter 637, Statutes of 2024.
Location: 9/27/2024-A. CHAPTERED

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

Summary: Current law provides for the licensure and regulation by the State Department of Public Health of certain health facilities, including a chemical dependency recovery hospital, which is defined to mean a health facility that provides 24-hour inpatient care for persons who have a dependency on alcohol or other drugs, or both alcohol and other drugs. Current law requires all beds in a chemical dependency recovery hospital to be designated for chemical dependency recovery services, as specified. Current law authorizes chemical dependency recovery services to be provided in a freestanding facility, within a hospital building that only provides chemical recovery services, or within a distinct part of a hospital, as defined. Current law also authorizes chemical dependency recovery services to be provided within a hospital building that has been removed from general acute care use. Existing law requires chemical dependency recovery services to comply with specified regulatory requirements for basic services, and optional services if the facility is approved by the department to provide them. Current law only authorizes the colocation of chemical dependency recovery services as a distinct part with other services or distinct parts of its parent hospital, as specified. Current law requires a separately licensed chemical dependency recovery hospital that is not a distinct part of a general acute care hospital to have agreements with one or more general acute care hospitals to provide specified additional services. This bill would expand the definition of "chemical dependency recovery services" to include medications for addiction treatment and medically supervised voluntary inpatient detoxification but would specify that it does not include certain treatment of severe, potentially life threatening, intoxication and withdrawal syndromes. The bill would delete the requirement for chemical dependency recovery as a supplemental service to be provided in a distinct part of a general acute care hospital or acute psychiatric hospital, and instead would authorize those facilities to provide chemical dependency recovery services as a supplemental service within the same building or in a separate building on campus that meets specified structural requirements of a freestanding chemical dependency recovery hospital.

AB 2446 **(Ortega D) Medi-Cal: diapers.**
Current Text: Vetoed: 9/27/2024 html pdf
Status: 9/27/2024-Vetoed by Governor.
Location: 9/27/2024-A. VETOED

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

Summary: Would establish diapers as a covered Medi-Cal benefit for a child greater than 3 years of age who has been diagnosed with a condition, as specified, that contributes to incontinence, and for an individual under 21 years of age if necessary to correct or ameliorate a condition pursuant to certain federal standards. The bill would limit the provided diapers to an appropriate supply based on the diagnosed condition and the age of the Medi-Cal beneficiary. The bill would require the department to seek any necessary federal approvals to implement these provisions. The bill would condition implementation of these provisions on receipt of any necessary federal approvals, the availability of federal financial participation, and an appropriation by the Legislature.

AB 2449 **(Ta R) Health care coverage: qualified autism service providers.**
Current Text: Amended: 6/3/2024 html pdf
Status: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 6/17/2024)
Location: 8/15/2024-S. DEAD

Desk	Policy	Fiscal	Floor	Desk	Policy	Dead	Floor	Conf.	Enrolled	Vetoed	Chaptered
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Summary: Current law requires a health care service plan contract or health insurance policy to provide coverage for behavioral health treatment provided for pervasive developmental disorder or autism and requires a plan or policy to maintain an adequate network of qualified autism service providers. Under current law, a "qualified autism service provider" means, among other things, a person who is certified by a national entity, such as the Behavior Analyst Certification Board, with a certification that is accredited by the National Commission for Certifying Agencies. This bill would clarify that the Qualified Applied Behavior Analysis Credentialing Board is also a national entity that may certify a qualified autism service provider and would authorize the certification to be accredited by another national accrediting entity approved by the Secretary of California Health and Human Services.

AB 2466 **(Carrillo, Wendy D) Medi-Cal managed care: network adequacy standards.**
Current Text: Amended: 4/18/2024 html pdf
Status: 5/16/2024-Failed Deadline pursuant to Rule 61(b)(8). (Last location was APPR. SUSPENSE FILE on 5/15/2024)
Location: 5/16/2024-A. DEAD

Desk	Policy	Dead	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law authorizes the Director of Health Care Services to terminate a contract or impose sanctions if the director finds that a Medi-Cal managed care plan fails to comply with contract requirements, state or federal law or regulations, or the state plan or approved waivers, or for other good cause. Current 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. Under this bill, a Medi-Cal managed care plan would be deemed to be not in compliance with the appointment time standards if either (1) fewer than 85% of the network providers had an appointment available within the standards or (2) the department receives information establishing that the plan was unable to deliver timely, available, or accessible health care services to enrollees, as specified. Under the bill, failure to comply with the appointment time standard may result in contract termination or the issuance of sanctions as described above.

AB 2467 **(Bauer-Kahan D) Health care coverage for menopause.**
Current Text: Vetoed: 9/28/2024 html pdf
Status: 9/28/2024-Vetoed by Governor.
Location: 9/28/2024-A. VETOED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law provides for the regulation of health insurers by the Department of Insurance. Current law sets forth specified coverage requirements for health care service plan contracts and health insurance policies. This bill would require a health care service plan contract or health insurance policy, except as specified, to include coverage for evaluation and treatment options for perimenopause and menopause. The bill would require a health care service plan or health insurer to annually provide clinical care recommendations, as specified, for hormone therapy to all contracted primary care providers who treat individuals with perimenopause and menopause. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

AB 2556 **(Jackson D) Behavioral health and wellness screenings: notice.**
Current Text: Chaptered: 8/26/2024 html pdf
Status: 8/26/2024-Chaptered by Secretary of State - Chapter 200, Statutes of 2024
Location: 8/26/2024-A. CHAPTERED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: 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. Current law provides for the regulation of health insurers by the Department of Insurance. This bill would require a health care service plan, except as specified, or health insurer to provide to enrollees and insureds a written or electronic notice regarding the benefits of a behavioral health and wellness screening, as defined, for children and adolescents 8 to 18 years of age. The bill would require a health care service plan or insurer to provide the notice annually.

AB 2630 **(Bonta D) Pupil health: oral health assessment.**
Current Text: Chaptered: 9/28/2024 html pdf

Status: 9/28/2024-Approved by the Governor. Chaptered by Secretary of State - Chapter 838, Statutes of 2024.
Location: 9/28/2024-A. CHAPTERED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Existing law requires a pupil, while enrolled in kindergarten in a public school, or while enrolled in first grade in a public school if the pupil was not previously enrolled in kindergarten in a public school, to present proof of having received an oral health assessment by a licensed dentist, or other licensed or registered dental health professional operating within the professional's scope of practice, that was performed no earlier than 12 months before the date of the initial enrollment of the pupil, as provided. This bill would define "kindergarten" for these purposes as including both transitional kindergarten and kindergarten and would require the above-described proof only once during a 2-year kindergarten program. To the extent the bill would impose additional duties on public schools, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 2668 **(Berman D) Coverage for cranial prostheses.**
Current Text: Introduced: 2/14/2024 html pdf
Status: 5/16/2024-Failed Deadline pursuant to Rule 61(b)(8). (Last location was APPR. SUSPENSE FILE on 5/8/2024)
Location: 5/16/2024-A. DEAD

Desk	Policy	Dead	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, to cover cranial prostheses, as defined, for individuals experiencing permanent or temporary medical hair loss. The bill would require a licensed provider to prescribe the cranial prosthesis for an individual's course of treatment for a diagnosed health condition, chronic illness, or injury, as specified. The bill would limit coverage to once every 12 months and $750 for each instance of coverage. The bill would not apply these provisions to a specialized health care service plan or specialized health insurance policy. Because a violation of these requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.

AB 2685 **(Ortega D) Older individuals: case management services.**
Current Text: Amended: 4/8/2024 html pdf
Status: 5/16/2024-Failed Deadline pursuant to Rule 61(b)(8). (Last location was APPR. SUSPENSE FILE on 5/1/2024)
Location: 5/16/2024-A. DEAD

Desk	Policy	Dead	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: The Mello-Granlund Older Californians Act requires the California Department of Aging to designate various private nonprofit or public agencies as area agencies on aging to work within a planning and service area and provide a broad array of social and nutritional services. Under the act, the department's mission is to provide leadership to those agencies in developing systems of home- and community-based services that maintain individuals in their own homes or least restrictive homelike environments. This bill would, until January 1, 2031, and subject to an appropriation, require the department to establish a case management services demonstration project in up to 4 counties located in varying regions of the state, based on a process of selection by the department and voluntary participation by the selected counties. Under the bill, the purpose of the project would be to expand statewide the local capacity of supportive services programs by providing case management services to older individuals who need assistance to maintain health and economic stability.

AB 2699 **(Carrillo, Wendy D) Hazardous materials: reporting: civil liability.**
Current Text: Amended: 4/1/2024 html pdf
Status: 5/16/2024-Failed Deadline pursuant to Rule 61(b)(8). (Last location was APPR. SUSPENSE FILE on 5/15/2024)
Location: 5/16/2024-A. DEAD

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Summary: (1)Existing law requires the Secretary for Environmental Protection to implement a unified hazardous waste and hazardous materials management regulatory program, known as the unified program. Existing law requires every county to apply to the secretary to be certified to implement the unified program and authorizes a city or local agency that meets specified requirements to apply to the secretary to be certified to implement the unified program, as a certified unified program agency. Existing law authorizes a state or local agency that has a written agreement with a certified unified program agency, and is approved by the secretary, to implement or enforce one or more of the unified program elements as a participating agency. Existing law defines "unified program agency" to mean a certified unified program agency or its participating agencies, as provided. This bill would require this reporting to be made to the California Environmental Protection Agency instead of the Office of Emergency Services. The bill would delete the requirement on the Office of Emergency Services to adopt regulations and would instead require the California Environmental Protection Agency to be responsible for the adoption and revision of the regulations and for the oversight of the enforcement of the regulations. The bill would require the California Environmental Protection Agency, on or before January 1, 2028, to review and revise the regulations that implement the reporting requirements. This bill contains other related provisions and other existing laws.

AB 2701 **(Villapudua D) Medi-Cal: dental cleanings and examinations.**
Current Text: Amended: 6/17/2024 html pdf
Status: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 6/24/2024)
Location: 8/15/2024-S. DEAD

Desk	Policy	Fiscal	Floor	Desk	Policy	Dead	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Under current law, one dental prophylaxis cleaning per year and one initial dental examination by a dentist are covered Medi-Cal benefits for beneficiaries 21 years of age or older. Under existing law, 2 dental prophylaxis cleanings per year and 2 periodic dental examinations per year are covered Medi-Cal benefits for beneficiaries under 21 years of age. Current law conditions implementation of those provisions on receipt of any necessary federal approvals, the availability of federal financial participation, and, for beneficiaries 21 years of age or older, funding in the annual Budget Act. This bill would expand the above-described dental benefits, for beneficiaries 21 years of age or older, to at least 2 cleanings and at least 2 examinations per year when medically necessary, as specified in the Medi-Cal Dental Manual of Criteria. The bill would, for purposes of these provisions, include an individual's inability to maintain daily oral hygiene habits, susceptibility to oral health disease or decay, preoperative dental care, or as required by other specified provisions of law, in the definition of "medically necessary," and require the department to update the Medi-Cal Dental Manual of Criteria to conform with this inclusion.

AB 2703 **(Aguiar-Curry D) Federally qualified health centers and rural health clinics: psychological associates.**
Current Text: Chaptered: 9/27/2024 html pdf
Status: 9/27/2024-Approved by the Governor. Chaptered by Secretary of State - Chapter 638, Statutes of 2024.
Location: 9/27/2024-A. CHAPTERED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, and under which qualified low-income individuals receive health care services, including federally qualified health center (FQHC) services and rural health clinic (RHC) services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. This bill would add to that list of practitioners a licensed professional clinical counselor. This bill contains other related provisions and other existing laws.

AB 2726 **(Flora R) Specialty care networks: telehealth and other virtual services.**
Current Text: Amended: 4/25/2024 html pdf
Status: 5/16/2024-Failed Deadline pursuant to Rule 61(b)(8). (Last location was APPR. SUSPENSE FILE on 5/15/2024)
Location: 5/16/2024-A. DEAD

Desk	Policy	Dead	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Would, subject to an appropriation, require the California Health and Human Services Agency, in collaboration with the Department of Health Care Access and Information and the State Department of Health Care Services, to establish a demonstration project for a grant program. Under the bill, the grant program would be aimed at facilitating a telehealth and other virtual services specialty care network or networks that are designed to serve patients of safety-net providers consisting of qualifying providers, as defined.

AB 2753 **(Ortega D) Rehabilitative and habilitative services: durable medical equipment and services.**
Current Text: Introduced: 2/15/2024 html pdf
Status: 5/16/2024-Failed Deadline pursuant to Rule 61(b)(8). (Last location was APPR. SUSPENSE FILE on 4/17/2024)
Location: 5/16/2024-A. DEAD

Desk	Policy	Dead	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current 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. Under current law, essential health benefits include, among other things, rehabilitative and habilitative services. Current law requires habilitative services and devices to be covered under the same terms and conditions applied to rehabilitative services and devices under the plan contract or policy and defines habilitative services to mean health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. This bill would specify that coverage of rehabilitative and habilitative services and devices under a health care service plan or health insurance policy includes durable medical equipment, services, and repairs, if the equipment, services, or repairs are prescribed or ordered by a physician, surgeon, or other health professional acting within the scope of their license. The bill would define “durable medical equipment” to mean devices, including replacement devices, that are designed for repeated use, and that are used for the treatment or monitoring of a medical condition or injury in order to help a person to partially or fully acquire, improve, keep, or learn, or minimize the loss of, skills and functioning of daily living. The bill would prohibit coverage of durable medical equipment and services from being subject to financial or treatment limitations, as specified.

AB 2843 **(Petrie-Norris D) Health care coverage: rape and sexual assault.**
Current Text: Chaptered: 9/29/2024 html pdf
Status: 9/29/2024-Approved by the Governor. Chaptered by Secretary of State - Chapter 971, Statutes of 2024.
Location: 9/29/2024-A. CHAPTERED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law requires a victim of sexual assault who seeks a medical evidentiary examination to be provided with one, as specified. Current law prohibits costs incurred by a qualified health care professional, hospital, clinic, sexual assault forensic examination team, or other emergency medical facility for the medical evidentiary examination portion of the examination of the victim of a sexual assault, as described in a specified protocol, when the examination is performed as specified, from being charged directly or indirectly to the victim of the assault. The bill would prohibit a health care service plan or health insurer from requiring, as a condition of providing coverage, (1) an enrollee or insured to file a police report, (2) charges to be brought against an assailant, (3) or an assailant to be convicted of rape or sexual assault. 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.

AB 2914 **(Bonta D) Health care coverage: essential health benefits.**
Current Text: Amended: 4/10/2024 html pdf
Status: 8/31/2024-Failed Deadline pursuant to Rule 61(b)(17). (Last location was INACTIVE FILE on 8/28/2024)
Location: 8/31/2024-S. DEAD

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

1st House	2nd House	Conc.			

Summary: Current law requires the Department of Insurance to regulate health insurers. Current 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. Current 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 2930 **(Bauer-Kahan D) Automated decision systems.**
Current Text: Amended: 8/28/2024 html pdf
Status: 8/31/2024-Failed Deadline pursuant to Rule 61(b)(17). (Last location was INACTIVE FILE on 8/31/2024)
Location: 8/31/2024-S. DEAD

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Dead	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: The Unruh Civil Rights Act provides that all persons within the jurisdiction of this state are free and equal and, regardless of their sex, race, color, religion, ancestry, national origin, disability, medical condition, genetic information, marital status, sexual orientation, citizenship, primary language, or immigration status, are entitled to the full and equal accommodations, advantages, facilities, privileges, or services in all business establishments of every kind whatsoever. 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. This bill would, among other things, require, as prescribed, a deployer, as defined, and a developer of an automated decision system, as defined, to perform an impact assessment on any automated decision system before the system is first deployed and annually thereafter that includes, among other things, a statement of the purpose of the automated decision system and its intended benefits, uses, and deployment contexts. The bill would require a deployer or a developer to provide any impact assessment that it performed to the Civil Rights Department and would exempt an impact assessment provided to the department from the California Public Records Act, as prescribed. This bill would require a deployer to, prior to an automated decision system making a consequential decision, as defined, or being a substantial factor, as defined, in making a consequential decision, notify any natural person that is subject to the consequential decision that an automated decision system is being used and to provide that person with specified information. The bill would require a deployer that has deployed an automated decision system to make, or be a substantial factor in making, a consequential decision concerning a natural person, to provide to the natural person, among other things, an opportunity to correct any incorrect personal data.

AB 2956 **(Boerner D) Medi-Cal eligibility: redetermination.**
Current Text: Amended: 4/18/2024 html pdf
Status: 5/16/2024-Failed Deadline pursuant to Rule 61(b)(8). (Last location was APPR. SUSPENSE FILE on 5/15/2024)
Location: 5/16/2024-A. DEAD

Desk	Policy	Dead	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law generally requires a county to redetermine a Medi-Cal beneficiary's eligibility to receive Medi-Cal benefits every 12 months and whenever the county receives information about changes in a beneficiary's circumstances that may affect their Medi-Cal eligibility. Current law conditions implementation of the redetermination provisions on the availability of federal financial participation and receipt of any necessary federal approvals. Under current law, if a county has facts clearly demonstrating that a Medi-Cal beneficiary cannot be eligible for Medi-Cal due to an event, such as death or change of state residency, Medi-Cal benefits are terminated without a redetermination. Current law requires the department, subject to federal funding, to extend continuous eligibility to children 19 years of age or younger for a 12-month period, as specified. Under current law, operative on January 1, 2025, or the date that the State Department of Health Care Services certifies that certain conditions have been met, a child is continuously eligible for Medi-Cal up to 5 years of age. Under those provisions, a redetermination is prohibited during this time, unless certain

circumstances apply, including, voluntary disenrollment, death, or change of state residency. This bill would require the department to seek federal approval to extend continuous eligibility to individuals over 19 years of age. Under the bill, subject to federal funding, and except as described above with regard to death, change of state residency, or other events, an individual would remain eligible from the date of a Medi-Cal eligibility determination until the end of a 12-month period, as specified.

AB 2976 **(Jackson D) Mental health care.**
Current Text: Introduced: 2/16/2024 html pdf
Status: 5/2/2024-Failed Deadline pursuant to Rule 61(b)(6). (Last location was PRINT on 2/16/2024)
Location: 5/2/2024-A. DEAD

Dead	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law establishes various state and local programs for the provision of mental health services within the jurisdiction of the State Department of Health Care Services, the State Department of Public Health, the California Behavioral Health Planning Council, the Department of Health Care Access and Information, and county public health or behavioral health departments, among other entities. This bill would state the intent of the Legislature to enact legislation relating to access to mental health care.

AB 3030 **(Calderon D) Health care services: artificial intelligence.**
Current Text: Chaptered: 9/28/2024 html pdf
Status: 9/28/2024-Approved by the Governor. Chaptered by Secretary of State - Chapter 848, Statutes of 2024.
Location: 9/28/2024-A. CHAPTERED

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

Summary: Would require a health facility, clinic, physician's office, or office of a group practice that uses generative artificial intelligence 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, as specified. The bill would exempt from this requirement a communication read and reviewed by a human licensed or certified health care provider. Under the bill, a violation of these provisions by a physician would be subject to the jurisdiction of the Medical Board of California or Osteopathic Medical Board of California, as appropriate.

AB 3059 **(Weber D) Human milk.**
Current Text: Chaptered: 9/29/2024 html pdf
Status: 9/29/2024-Approved by the Governor. Chaptered by Secretary of State - Chapter 975, Statutes of 2024.
Location: 9/29/2024-A. CHAPTERED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Would specify that a general acute care hospital is not required to have a license to operate a tissue bank to store or distribute pasteurized donor human milk that was obtained from a tissue bank licensed by the State Department of Public Health. The bill would exempt from licensing requirements a hospital storing or distributing human milk obtained from a licensed tissue bank. The bill would require hospitals that collect, process, store, or distribute human milk in any other circumstance to obtain a tissue bank license. To the extent that the bill would expand the class of hospitals subject to tissue bank licensing requirements, thereby expanding a crime, the bill would impose a state-mandated local program.

AB 3129 **(Wood D) Health care system consolidation.**
Current Text: Vetoed: 9/28/2024 html pdf
Status: 9/28/2024-Vetoed by Governor.
Location: 9/28/2024-A. VETOED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law requires a nonprofit corporation that operates or controls a health facility or other facility that provides similar health care to provide written notice to, and to obtain the written consent of, the Attorney General prior to entering into any agreement or transaction to sell, transfer, lease, exchange, option, convey, or otherwise dispose of the asset, or to transfer control, responsibility, or governance of the asset or operation, to a for-profit corporation or entity, to a mutual benefit corporation or entity, or to a nonprofit corporation, as specified. This bill would require a private equity group or a hedge fund, as defined, to provide written notice to, and obtain the written consent of, the Attorney General before a transaction between the private equity group or hedge fund and a health care facility, provider, or provider group, as those terms are defined, and any of those entities that directly or indirectly control, are controlled by, are under common control of, or are otherwise affiliated with a payor, except as specified. The bill would require the notice to be submitted at the same time that any other state or federal agency is notified pursuant to state or federal law, and otherwise at least 90 days before the transaction. The bill would authorize the Attorney General to extend that 90-day period under certain circumstances. The bill would additionally require a private equity group or hedge fund to provide advance written notice to the Attorney General before a transaction between a private equity group or hedge fund and a nonphysician provider or a provider, with specified gross annual revenue.

AB 3149 **(Garcia D) Promotores and Promotoras Advisory and Oversight Workgroup.**
Current Text: Amended: 4/18/2024 html pdf
Status: 5/16/2024-Failed Deadline pursuant to Rule 61(b)(8). (Last location was APPR. SUSPENSE FILE on 5/8/2024)
Location: 5/16/2024-A. DEAD

Desk	Policy	Dead	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law defines “community health worker” 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 and who is a frontline health worker either trusted by, or who has a close understanding of, the community served. Current law includes in the definition of community health worker Promotores, Promotores de Salud, Community Health Representatives, navigators, and other nonlicensed health workers with specified qualifications. This bill would require the State Department of Health Care Services, by no later than January 1, 2025, and until December 31, 2026, to convene the Promotores and Promotoras Advisory and Oversight Workgroup to provide perspective and guidance to changes in the health and human services delivery system, including, but not limited to, the Medi-Cal program. The bill would require the secretary to appoint no fewer than 9 individuals to the workgroup who have at least ten years experience working in California as, or with, Promotores or Promotoras. The bill would require the workgroup to be comprised of no less than 51% Promotores or Promotoras, as specified, and require the appointees to be from geographically diverse areas of the state. The bill would require the workgroup to advise the departments under the agency to ensure that services provided by Promotores or Promotoras are available and accessible to all eligible populations. The bill would also require the workgroup to advise the agency to ensure that Promotores and Promotoras training and outreach materials are culturally and linguistically appropriate, to make recommendations on outreach efforts, as specified, and to provide input on issues that should be informed by community representatives who have lived experience with using and navigating Promotores or Promotoras services and the Medi-Cal program.

AB 3156 **(Patterson, Joe R) Medi-Cal managed care plans: enrollees with other health care coverage.**
Current Text: Vetoed: 9/22/2024 html pdf
Status: 9/20/2024-Vetoed by Governor.
Location: 9/20/2024-A. VETOED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Under current 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.

AB 3215 **(Soria D) Medi-Cal: mental health services for children.**
Current Text: Introduced: 2/16/2024 html pdf
Status: 5/2/2024-Failed Deadline pursuant to Rule 61(b)(6). (Last location was PRINT on 2/16/2024)
Location: 5/2/2024-A. DEAD

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

Summary: Would express the intent of the Legislature to enact legislation to expand access to behavioral mental health services to children receiving Medi-Cal benefits.

AB 3221 **(Pellerin D) Department of Managed Health Care: review of records.**
Current Text: Chaptered: 9/27/2024 html pdf
Status: 9/27/2024-Approved by the Governor. Chaptered by Secretary of State - Chapter 760, Statutes of 2024.
Location: 9/27/2024-A. CHAPTERED

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

Summary: 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. Current law requires the records, books, and papers of a health care service plan and other specified entities to be open to inspection by the director of the department during normal business hours. This bill would instead require the records, books, and papers of a health care service plan and other specified entities to be open to inspection by the director, including through electronic means. The bill would require a plan and other specified entities to furnish in electronic media records, books, and papers that are possessed in electronic media and to conduct a diligent review of records, books, and papers and make every effort to furnish those responsive to the director's request. The bill would require records, books, and papers to be furnished in a format that is digitally searchable, to the greatest extent feasible. The bill would require records, books, and papers to be preserved until furnished, if requested by the department.

AB 3245 **(Patterson, Joe R) Coverage for colorectal cancer screening.**
Current Text: Vetoed: 9/29/2024 html pdf
Status: 9/29/2024-Vetoed by Governor.
Location: 9/29/2024-A. VETOED

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

Summary: Current law provides for the regulation of health insurers by the Department of Insurance. Current 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, and for a colorectal cancer screening examination in specified circumstances, assigned either a grade of A or a grade of B by the United States Preventive Services Task Force. This bill would additionally require that coverage if the test or screening examination is assigned either a grade of A or a grade of B, or equivalent, in accordance with the most current recommendations established by another accredited or certified guideline agency approved by the California Health and Human Services Agency.

AB 3260 **(Pellerin D) Health care coverage: reviews and grievances.**
Current Text: Amended: 6/27/2024 html pdf
Status: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 8/5/2024)
Location: 8/15/2024-S. DEAD

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

Summary: Current 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. Current law requires these decisions to be made within 30 days, or less than 72 hours when the enrollee faces an imminent and serious threat to their health. Current law requires a health care service plan to establish a grievance system to resolve grievances within 30 day but limits that timeframe to 3 days when the enrollee faces an imminent and serious threat to their health. Existing law requires a plan to provide a written explanation for its grievance decisions, as specified. This bill would require that utilization review decisions be made within 72 hours from the health care service plan's receipt of the clinical information reasonably necessary to make the determination when the enrollee's condition is urgent. If the plan lacks the information reasonably necessary to make a decision regarding an urgent request, the bill would require the plan to notify the enrollee and provider about the information necessary to complete the request within 24 hours of receiving the request. The bill would require the plan to notify the enrollee and the provider of the decision within a reasonable amount of time, but not later than 48 hours after specified circumstances occur. If a health care service plan fails to make a utilization review decision, or provide notice of a decision, within the specified timelines, the bill would require the health care service plan to treat the request for authorization as a grievance and provide notice with specified information to the enrollee that a grievance has commenced, if the plan has received the information necessary to make a decision.

AB 3275 **(Soria D) Health care coverage: claim reimbursement.**
Current Text: Chaptered: 9/27/2024 html pdf
Status: 9/27/2024-Approved by the Governor. Chaptered by Secretary of State - Chapter 763, Statutes of 2024.
Location: 9/27/2024-A. CHAPTERED

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

Summary: Current law requires a health insurer or health care service plan, including a specialized health care service plan, to reimburse a claim or portion of a claim no later than 30 working days after receipt of the claim, unless the plan contests or denies the claim, in which case the plan is required to notify the claimant within 30 working days that the claim is contested or denied. Under current law, if a claim or portion thereof is contested on the basis that a health insurer or health care service plan has not received all information necessary to determine payer liability for the claim or portion thereof and notice has been provided, the health insurer or health care service plan has 30 working days after receipt of the additional information to complete reconsideration of the claim. Current law extends these timelines to 45 working days for a health care service plan that is a health maintenance organization. Under current law, if a claim is not reimbursed, contested, or denied pursuant to these timelines, as specified, interest accrues at a rate of 15% per annum for a health care service plan and 10% per annum for a health insurer. Commencing January 1, 2026, this bill instead would require a health care service plan, including a Medi-Cal managed care plan, or health insurer to reimburse a complete claim or a portion thereof within 30 calendar days after receipt of the claim, or, if a claim or portion thereof does not meet the criteria for a complete claim or portion thereof, to notify the claimant as soon as practicable, but no later than 30 calendar days that the claim or portion thereof is contested or denied. The bill would authorize the departments to issue guidance and regulations related to these provisions. The bill would exempt the guidance and amendments from the Administrative Procedure Act until December 31, 2027.

SB 70 **(Wiener D) Prescription drug coverage.**
Current Text: Amended: 6/29/2023 html pdf
Status: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 8/16/2023)
Location: 8/15/2024-A. DEAD

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

Summary: Current law generally authorizes a health care service plan or health 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. Current law prohibits a health care service plan contract that covers prescription drug benefits or a specified health insurance policy from limiting or excluding coverage for a drug on the basis that the drug is prescribed for a use that is different from the use for which it was approved by the federal Food and Drug Administration if specified conditions are met. Current law also prohibits a health care service plan that covers prescription drug benefits from limiting or excluding coverage for a drug that was previously approved for coverage if an enrollee continues to be prescribed that drug, as specified. This bill would additionally prohibit limiting or excluding coverage of a drug, dose of a drug, or dosage form of a drug that is prescribed for off-label use if the drug has been previously covered for a chronic condition or cancer, as specified, regardless of whether or not the drug, dose, or dosage form is on the plan's or insurer's formulary. The bill would prohibit a health care service plan contract or health insurance policy from requiring additional cost sharing not already imposed for a drug that was previously approved for coverage.

SB 101 **(Skinner D) Budget Act of 2023.**
Current Text: Chaptered: 6/27/2023 html pdf
Status: 6/27/2023-Approved by the Governor. Chaptered by Secretary of State. Chapter 12, Statutes of 2023.
Location: 6/27/2023-S. CHAPTERED

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

Summary: This bill would make appropriations for the support of state government for the 2023–24 fiscal year. This bill contains other related provisions.

SB 136 **(Committee on Budget and Fiscal Review) Medi-Cal: managed care organization provider tax.**
Current Text: Chaptered: 3/25/2024 html pdf
Status: 3/25/2024-Chaptered by Secretary of State - Chapter 6, Statutes of 2024
Location: 3/25/2024-S. CHAPTERED

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

Summary: The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under current law, one of the methods by which Medi-Cal services are provided is pursuant to contracts with various types of managed care plans. Current law imposes a managed care organization (MCO) provider tax, administered and assessed by the department, on licensed health care service plans and managed care plans contracted with the department. Under current law, all revenues, less refunds, derived from the taxes are deposited into the Managed Care Enrollment Fund, to be available to the department, upon appropriation, for the purpose of funding specified subcomponents to support the Medi-Cal program. Current law sets forth certain taxing tiers and tax amounts for purposes of the tax periods of April 1, 2023, to December 31, 2023, inclusive, and the 2024, 2025, and 2026 calendar years. Under current law, the Medi-Cal per enrollee tax amount for Medi-Cal taxing tier II, as defined, is $182.50 for the 2024 calendar year, $187.50 for the 2025 calendar year, and $192.50 for the 2026 calendar year. This bill would raise that tax amount for that tier to $205 for all 3 of those calendar years.

SB 238 **(Wiener D) Health care coverage: independent medical review.**
Current Text: Amended: 6/19/2023 html pdf
Status: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 8/23/2023)
Location: 8/15/2024-A. DEAD

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

Summary: Current law provides for the regulation of disability insurers by the Department of Insurance. Current 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 disability insurer and the enrollee or insured has previously filed a grievance that remains unresolved after 30 days. This bill, commencing July 1, 2024, would require a health care service plan or a disability insurer that modifies, delays, or denies

a health care service, based in whole or in part on medical necessity, to automatically submit within 24 hours a decision regarding a disputed health care service to the Independent Medical Review System, as well as the information that informed its decision, without requiring an enrollee or insured to submit a grievance, if the decision is to deny, modify, or delay specified services relating to mental health or substance use disorder conditions for an enrollee or insured up to 26 years of age. The bill would require a health care service plan or disability insurer, within 24 hours after submitting its decision to the Independent Medical Review System to provide notice to the appropriate department, the enrollee or insured or their representative, if any, and the enrollee's or insured's provider. The bill would require the notice to include notification to the enrollee or insured that they or their representative may cancel the independent medical review at any time before a determination, as specified. The bill would apply specified existing provisions relating to mental health and substance use disorders for purposes of its provisions and would be subject to relevant provisions relating to the Independent Medical Review System that do not otherwise conflict with the express requirements of the bill. With respect to health care service plans, the bill would specify that its provisions do not apply to Medi-Cal managed care plan contracts.

SB 282 **(Eggman D) Medi-Cal: federally qualified health centers and rural health clinics.**

Current Text: Amended: 3/13/2023 html pdf

Status: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 8/16/2023)

Location: 8/15/2024-A. DEAD

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

Summary: Under current law of the Medi-Cal program, to the extent that federal financial participation is available, federally qualified health center (FQHC) and rural health clinic (RHC) services are reimbursed on a per-visit basis, as specified. "Visit" is defined as a face-to-face encounter between a patient of an FQHC or RHC and a physician or other specified health care professionals. Under existing law, "visit" also includes an encounter using video or audio-only synchronous interaction or an asynchronous store and forward modality, as specified. This bill would authorize reimbursement for a maximum of 2 visits that take place on the same day at a single site, whether through a face-to-face or telehealth-based encounter, if after the first visit the patient suffers illness or injury that requires additional diagnosis or treatment, or if the patient has a medical visit and either a mental health visit or a dental visit, as defined. The bill would require the department, by July 1, 2024, to submit a state plan amendment to the federal Centers for Medicare and Medicaid Services reflecting those provisions. The bill would include a licensed acupuncturist within those health care professionals covered under the definition of a "visit." The bill would also make a change to the provision relating to physicians and would make other technical changes.

SB 294 **(Wiener D) Health care coverage: independent medical review.**

Current Text: Amended: 5/24/2024 html pdf

Status: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 7/2/2024)

Location: 8/15/2024-A. DEAD

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

Summary: 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. Current law provides for the regulation of disability insurers by the Department of Insurance. Current 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 disability insurer and the enrollee or insured has previously filed a grievance that remains unresolved after 30 days. This bill, commencing January 1, 2026, would require a health care service plan or a disability insurer that upholds its decision to modify, delay, or deny a health care service in response to a grievance or has a grievance that is otherwise pending or unresolved upon expiration of the relevant timeframe to automatically submit within 24 hours a decision regarding a disputed health care service to the Independent Medical Review System, as well as the information that informed its decision, if the decision is to deny, modify, or delay specified services relating to mental health or substance use disorder conditions for an enrollee or insured up to 26 years of age. The bill would require a health care service plan or disability insurer, within 24

hours after submitting its decision to the Independent Medical Review System to provide notice to the appropriate department, the enrollee or insured or their representative, if any, and the enrollee's or insured's provider.

SB 299 **(Limón D) Voter registration: California New Motor Voter Program.**
Current Text: Vetoed: 9/29/2024 html pdf
Status: 9/29/2024-Vetoed by the Governor. In Senate. Consideration of Governor's veto pending.
Location: 9/29/2024-S. VETOED

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

Summary: Would require the Secretary of State and the Department of Motor Vehicles to develop a process for the department to use information from the statewide voter registration database to determine whether a person who submits a driver's license application is already registered or preregistered to vote in the state. The bill would require the department, based upon this determination, to transmit specified information provided by the person during their transaction with the department to the Secretary of State for the purpose of registering or preregistering that person to vote or to update their registration information. The bill would prohibit the department from providing a person the opportunity to attest to meeting voter eligibility requirements when they submit a driver's license application, if the person provides a document to the department during the transaction demonstrating that the person is not a United States citizen. The bill would permit the Secretary of State, upon a determination that sufficient technology infrastructure exists, to promulgate regulations concerning the establishment of a list of individuals who are eligible to be preapproved for voter registration, as specified.

SB 339 **(Wiener D) HIV preexposure prophylaxis and postexposure prophylaxis.**
Current Text: Chaptered: 2/6/2024 html pdf
Status: 2/6/2024-Chaptered by Secretary of State - Chapter 1, Statutes of 2024
Location: 2/6/2024-S. CHAPTERED

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

Summary: The Pharmacy Law provides for the licensure and regulation of pharmacists by the California State Board of Pharmacy. Current law authorizes a pharmacist to furnish at least a 30-day supply of HIV preexposure prophylaxis, and up to a 60-day supply of those drugs if certain conditions are met. Current law also authorizes a pharmacist to furnish postexposure prophylaxis to a patient if certain conditions are met. This bill would authorize a pharmacist to furnish up to a 90-day course of preexposure prophylaxis, or preexposure prophylaxis beyond a 90-day course, if specified conditions are met. The bill would require the California State Board of Pharmacy to adopt emergency regulations to implement these provisions by October 31, 2024.

SB 363 **(Eggman D) Facilities for inpatient and residential mental health and substance use disorder: database.**
Current Text: Amended: 5/18/2023 html pdf
Status: 8/31/2024-Failed Deadline pursuant to Rule 61(b)(17). (Last location was APPR. SUSPENSE FILE on 8/23/2023)
Location: 8/31/2024-A. DEAD

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

Summary: Would require, by January 1, 2026, the State Department of Health Care Services, in consultation with the State Department of Public Health and the State Department of Social Services, and by conferring with specified stakeholders, to develop a real-time, internet-based database to collect, aggregate, and display information about beds in specified types of facilities, such as chemical dependency recovery hospitals, acute psychiatric hospitals, and mental health rehabilitation centers, among others, to identify the availability of inpatient and residential mental health or substance use disorder treatment. The bill would require the database to include a minimum of specific information, including the contact information for a facility's designated employee, the types of diagnoses or treatments for which the bed is appropriate, and the target populations served at the facility, and have the capacity to, among other things, enable searches to identify beds that are appropriate for individuals in need of inpatient or residential mental health or substance

use disorder treatment.

SB 424 **(Durazo D) The Broadband Infrastructure Grant Account and Federal Funding Account.**
Current Text: Amended: 7/2/2024 html pdf
Status: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 8/7/2024)
Location: 8/15/2024-A. DEAD

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

Summary: Current law vests the Public Utilities Commission with regulatory authority over public utilities, including telephone corporations. Current law requires the commission to develop, implement, and administer the California Advanced Services Fund to encourage deployment of high-quality advanced communications services to all Californians that will promote economic growth, job creation, and the substantial social benefits of advanced information and communications technologies, as specified. Current law establishes the Broadband Infrastructure Grant Account in the fund to approve funding for infrastructure projects that will provide broadband access to no less than 98% of California households in each consortia region and establishes the Federal Funding Account in the fund to expeditiously connect unserved and underserved communities, as specified. The Get Connected California Act of 2024 would require the commission to ensure all deployment grant awardees, defined as all internet service providers that receive funding from the Broadband Infrastructure Grant Account and the Federal Funding Account within the California Advanced Services Fund, offer internet service that costs no more than $30 per month and meets certain minimum speed requirements, as specified. The bill would require a deployment grant awardee to allow any household in a project area, as defined, to switch to the above-described low-cost broadband service option in the billing cycle immediately following the household's enrollment in the low-cost broadband service option. The bill would not apply these requirements to applications submitted to the commission before January 1, 2025. The bill would make the above-described provisions severable.

SB 427 **(Portantino D) Health care coverage: antiretroviral drugs, drug devices, and drug products.**
Current Text: Amended: 4/4/2024 html pdf
Status: 8/31/2024-Failed Deadline pursuant to Rule 61(b)(17). (Last location was DESK on 5/13/2024)
Location: 8/31/2024-A. DEAD

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

Summary: Current 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 current 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 would 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 or step therapy, but would authorize prior authorization or step therapy if at least one therapeutically equivalent version is covered without prior authorization or step therapy 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 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.

SB 516 **(Skinner D) Health care coverage: prior authorization.**
Current Text: Amended: 8/22/2024 html pdf
Status: 8/31/2024-Failed Deadline pursuant to Rule 61(b)(17). (Last location was HEALTH on 8/22/2024)
Location: 8/31/2024-A. DEAD

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

1st House	2nd House	Conc.			

Summary: Current law provides for the regulation of health insurers by the Department of Insurance. Current 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. Current 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. Current 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 require the Department of Managed Health Care and the Department of Insurance, by July 1, 2025, to issue instructions to health care service plans and health insurers to report specified information relating to prior authorization, as defined, including designated health care services (services), items, and supplies subject to prior authorization and the percentage rate at which health care service plans, health insurers, or their delegated entities, approve or modify those services, items, and supplies. The bill would require health care service plans and health insurers to report that information to the relevant department by December 31, 2025, or as otherwise specified. The bill would require the relevant department to evaluate the reports received from the health care service plans and health insurers, and identify the services, items, and supplies most frequently approved by the plans or insurers or their delegated entities, as specified. The bill would require each department, after evaluating the reports received from health care service plans and health insurers, to identify, and by December 31, 2026, to publish a list of, the most frequently approved or modified services, items, and supplies, based on a prescribed threshold percentage rate.

SB 537

(Becker D) City or County of Los Angeles: memorial to forcibly deported Mexican Americans and Mexican immigrants.

Current Text: Chaptered: 9/28/2024 html pdf

Status: 9/28/2024-Approved by the Governor. Chaptered by Secretary of State. Chapter 859, Statutes of 2024.

Location: 9/28/2024-S. CHAPTERED

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

Summary: Current law provides for various memorials and monuments on the grounds of the State Capitol. Current law requires the Department of General Services to maintain state buildings and grounds. Existing law, the Apology Act for the 1930s Mexican Repatriation Program, makes findings and declarations regarding the unconstitutional removal and coerced emigration of United States citizens and legal residents of Mexican descent, between the years 1929 and 1944, to Mexico from the United States during the 1930s “Mexican Repatriation” Program. Current law expresses the apology of the State of California to those individuals who were illegally deported and coerced into emigrating to Mexico and requires that a plaque to commemorate those individuals be installed and maintained by the Department of Parks and Recreation in an appropriate public place in the City or County of Los Angeles. This bill would authorize a nonprofit organization representing Mexican Americans or Mexican immigrants to enter into negotiations to plan, construct, and maintain a memorial to Mexican Americans and Mexican immigrants who were forcibly deported from the United States during the Great Depression, as provided. The bill would require the memorial to be located at an appropriate public place in the City or County of Los Angeles. The bill would require the nonprofit organization to enter into negotiations with the Department of General Services and the state agency with jurisdiction over the state property where the memorial is proposed, where applicable, if the nonprofit organization proposes to locate the memorial on state property.

SB 551

(Portantino D) Beverage containers: recycling.

Current Text: Chaptered: 9/29/2024 html pdf

Status: 9/29/2024-Approved by the Governor. Chaptered by Secretary of State. Chapter 983, Statutes of 2024.

Location: 9/29/2024-S. CHAPTERED

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

Summary: The California Beverage Container Recycling and Litter Reduction Act requires plastic beverage containers sold by a beverage manufacturer, as specified, to contain a specified average percentage of postconsumer recycled plastic

per year. The act requires the manufacturer of a beverage sold in a plastic beverage container subject to the California Redemption Value to report to the Department of Resources Recycling and Recovery certain information about the amounts of virgin plastic and postconsumer recycled plastic used for plastic beverage containers subject to the California Redemption Value for sale in the state in the previous calendar year. Current law provides that a violation of the act or a regulation adopted pursuant to the act is a crime. This bill would authorize certain beverage manufacturers to submit with other beverage manufacturers a consolidated report, in lieu of individual reports, that identifies the postconsumer recycled plastic content for beverage containers and the amounts of virgin plastic and postconsumer recycled plastic used in beverage containers, as specified. The bill would require the consolidated report to be submitted under penalty of perjury and pursuant to standardized forms prescribed by the department.

SB 729 **(Menjivar D) Health care coverage: treatment for infertility and fertility services.**
Current Text: Chaptered: 9/29/2024 html pdf
Status: 9/29/2024-Approved by the Governor. Chaptered by Secretary of State. Chapter 930, Statutes of 2024.
Location: 9/29/2024-S. CHAPTERED

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

Summary: Current law imposes various requirements and restrictions on health care service plans and disability insurers, including, among other things, a requirement that every group health care service plan contract or disability insurance policy that is issued, amended, or renewed on or after January 1, 1990, offer coverage for the treatment of infertility, except in vitro fertilization. This bill would require large and small group health care service plan contracts and disability insurance policies issued, amended, or renewed on or after July 1, 2025, to provide coverage for the diagnosis and treatment of infertility and fertility services. With respect to large group health care service plan contracts and disability insurance policies, the bill would require coverage for a maximum of 3 completed oocyte retrievals, as specified. The bill would revise the definition of infertility and would remove the exclusion of in vitro fertilization from coverage. The bill would also delete a requirement that a health care service plan contract and disability insurance policy provide infertility treatment under agreed-upon terms that are communicated to all group contractholders and policyholders. The bill would prohibit a health care service plan or disability insurer from placing different conditions or coverage limitations on fertility medications or services, or the diagnosis and treatment of infertility and fertility services, than would apply to other conditions, as specified. The bill would make these requirements inapplicable to a religious employer, as defined, and specified contracts and policies.

SB 819 **(Eggman D) Medi-Cal: certification.**
Current Text: Chaptered: 9/22/2024 html pdf
Status: 9/22/2024-Chaptered by Secretary of State - Chapter 448, Statutes of 2024
Location: 9/22/2024-S. CHAPTERED

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

Summary: Current law requires the State Department of Public Health to license and regulate clinics. Current law exempts from those licensing provisions certain clinics that are directly conducted, maintained, or operated by federal, state, or local governmental entities, as specified. Current law also exempts from those licensing provisions a clinic that is operated by a primary care community or free clinic, that is operated on separate premises from the licensed clinic, and that is only open for limited services of no more than 40 hours per week. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Current law sets forth various procedures, including the submission of an application package, for providers to enroll in the Medi-Cal program. Under current law, an applicant or provider that is a government-run license-exempt clinic as described above is required to comply with those Medi-Cal enrollment procedures. Under current law, an applicant or provider that is operated on separate premises and is license exempt, including an intermittent site or mobile health care unit that is operated by a licensed primary care clinic that provides all staffing, protocols, equipment, supplies, and billing services, is not required to enroll in the Medi-Cal program as a separate provider or comply with the above-described enrollment procedures, if the licensed primary care clinic has notified the department of its separate locations, premises, intermittent sites, or mobile health care units. This bill would additionally exempt from the Medi-Cal enrollment procedures an intermittent site or mobile health care unit that is operated by the above-described government-run license-exempt clinic if that clinic has notified the department of its separate locations, premises, sites, or units.

SB 966 **(Wiener D) Pharmacy benefits.**
Current Text: Vetoed: 9/28/2024 html pdf
Status: 9/28/2024-Vetoed by the Governor. In Senate. Consideration of Governor's veto pending.
Location: 9/28/2024-S. VETOED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: The Knox-Keene Act 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. Current law provides for the regulation of health insurers by the Department of Insurance. This bill would additionally require a pharmacy benefit manager, as defined, 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.

SB 980 **(Wahab D) The Smile Act.**
Current Text: Amended: 6/10/2024 html pdf
Status: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 8/7/2024)
Location: 8/15/2024-A. DEAD

Desk	Policy	Fiscal	Floor	Desk	Policy	Dead	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Under current law, early and periodic screening, diagnostic, and treatment (EPSDT) services are covered under Medi-Cal for an individual under 21 years of age in accordance with certain federal provisions. Under current law, for persons 21 years of age or older, laboratory-processed crowns on posterior teeth are a covered benefit when medically necessary to restore a posterior tooth back to normal function based on the criteria specified in the Medi-Cal Dental Manual of Criteria. This bill, The Smile Act, for purposes of the above-described Medi-Cal coverage for laboratory-processed crowns, would remove the condition that the tooth be posterior and would apply the coverage to persons 13 years of age or older. The bill would also add, as a covered Medi-Cal benefit for persons of any age, subject to prior authorization, a dental implant if tooth extraction or removal is medically necessary or if the corresponding tooth is missing. The bill would condition this coverage on there being no other covered functional alternatives for prosthetic replacement to correct the person's dental condition, as specified, on the person being without medical conditions for which dental implant surgery would be contraindicated, on receipt of any necessary federal approvals, and on the availability of federal financial participation.

SB 999 **(Cortese D) Health coverage: mental health and substance use disorders.**
Current Text: Amended: 4/8/2024 html pdf
Status: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 8/7/2024)
Location: 8/15/2024-A. DEAD

Desk	Policy	Fiscal	Floor	Desk	Policy	Dead	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Would require a health care service plan and a disability insurer, and an entity acting on a plan's or insurer's behalf, to ensure compliance with specific requirements for utilization review, including maintaining telephone access and other direct communication access during California business hours for a health care provider to request authorization for mental health and substance use disorder care and conducting peer-to-peer discussions regarding specific patient issues related to treatment. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

SB 1008 **(Bradford D) Obesity Treatment Parity Act.**
Current Text: Amended: 4/29/2024 html pdf
Status: 5/16/2024-Failed Deadline pursuant to Rule 61(b)(8). (Last location was APPR. SUSPENSE FILE on 5/6/2024)
Location: 5/16/2024-S. DEAD

Desk	Policy	Dead	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Would require an individual or group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, to include specified coverage for the treatment of obesity, including coverage for at least one FDA-approved antiobesity medication.

SB 1017 **(Eggman D) Available facilities for inpatient and residential mental health or substance use disorder treatment.**
Current Text: Introduced: 2/5/2024 html pdf
Status: 8/31/2024-Failed Deadline pursuant to Rule 61(b)(17). (Last location was APPR. SUSPENSE FILE on 4/15/2024)
Location: 8/31/2024-S. DEAD

Desk	Policy	Dead	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law requires the State Department of Health Care Services to license and regulate facilities that provide residential nonmedical services to adults who are recovering from problems related to alcohol, drug, or alcohol and drug misuse or abuse, and who need alcohol, drug, or alcohol and drug recovery treatment or detoxification services. This bill would require the State Department of Health Care Services, in consultation with the State Department of Public Health and the State Department of Social Services, and by conferring with specified stakeholders, to develop a solution to collect, aggregate, and display information about beds in specified types of facilities, including licensed community care facilities and licensed residential alcoholism or drug abuse recovery or treatment facilities, to identify the availability of inpatient and residential mental health or substance use disorder treatment. The bill would require the solution to be operational by January 1, 2026, or the date the State Department of Health Care Services communicates to the Department of Finance in writing that the solution has been implemented to meet these provisions, whichever date is later.

SB 1112 **(Menjivar D) Childcare: alternative payment programs.**
Current Text: Chaptered: 9/30/2024 html pdf
Status: 9/30/2024-Approved by the Governor. Chaptered by Secretary of State. Chapter 1016, Statutes of 2024.
Location: 9/30/2024-S. CHAPTERED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current federal law establishes the Child Care and Development Fund authorized under the Child Care and Development Block Grant Act of 2014 and administered by states to provide assistance to low-income families who need childcare due to specified reasons. Current federal law requires a portion of those funds to be used to disseminate information on existing resources for developmental screenings and descriptions of how a family may utilize those resources to obtain developmental screenings. Current law authorizes, upon departmental approval, the use of appropriated funds for alternative payment programs to allow for maximum parental choice. Current law authorizes the reimbursement to those programs for the cost of child care paid to child care providers and the administrative and support services costs of the alternative program. This bill would state that the costs allowable for administration shall include, but not be limited to, costs associated with disseminating the above-described information.

SB 1120 **(Becker D) Health care coverage: utilization review.**
Current Text: Chaptered: 9/28/2024 html pdf
Status: 9/28/2024-Approved by the Governor. Chaptered by Secretary of State. Chapter 879, Statutes of 2024.
Location: 9/28/2024-S. CHAPTERED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
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Summary: Would require a health care service plan or disability insurer, including a specialized health care service plan or specialized health insurer, that uses an artificial intelligence, algorithm, or other software tool for the purpose of utilization review or utilization management functions, or that contracts with or otherwise works through an entity that uses that type of tool, to ensure compliance with specified requirements, including that the artificial intelligence, algorithm, or other software tool bases its determination on specified information and is fairly and equitably applied, as specified. Because a willful violation of these provisions by a health care service plan would be a crime, this bill would impose a state-mandated local program.

SB 1131 **(Gonzalez D) Medi-Cal providers: family planning.**
Current Text: Chaptered: 9/28/2024 html pdf
Status: 9/28/2024-Approved by the Governor. Chaptered by Secretary of State. Chapter 880, Statutes of 2024.
Location: 9/28/2024-S. CHAPTERED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf.	Enrolled	Vetoed	Chaptered
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Summary: Current law establishes, under the Medi-Cal program, the Family Planning, Access, Care, and Treatment (Family PACT) Program, administered by the Office of Family Planning within the department. Under Family PACT, comprehensive clinical family planning services are provided to a person who has a family income at or below 200% of the federal poverty level and who meets other eligibility criteria to receive those services. Current law makes the Family PACT Program inoperative if the program is determined to no longer be cost effective, as specified. If the program 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. Current law requires enrolled providers in the Family PACT Program or the State-Only Family Planning Program to attend a specific orientation approved by the department and requires providers who conduct certain services to have prior training in those services. This bill would, for the Family PACT Program, require a site certifier of a primary care clinic or affiliate primary care clinic, as those terms are defined, to be a clinician who oversees the provision of Family PACT services and would authorize certain clinic corporations to enroll multiple, but no more than 10, service addresses under one site certifier. The bill would require any orientation or training that the department requires of a site certifier to comply with specified requirements, including, among others, being offered through a virtual platform and being offered at least once every other month.

SB 1180 **(Ashby D) Health care coverage: emergency medical services.**
Current Text: Chaptered: 9/28/2024 html pdf
Status: 9/28/2024-Approved by the Governor. Chaptered by Secretary of State. Chapter 884, Statutes of 2024.
Location: 9/28/2024-S. CHAPTERED

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

Summary: Current law, until January 1, 2031, authorizes a local emergency medical services (EMS) agency to develop a community paramedicine or triage to alternate destination program that, among other things, provides case management services to frequent EMS users or triage paramedic assessments, respectively. This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after July 1, 2025, to establish a process to reimburse for services provided by a community paramedicine program, a triage to alternate destination program, and a mobile integrated health program, as defined.

SB 1213 **(Atkins D) Health care programs: cancer.**
Current Text: Vetoed: 9/27/2024 html pdf
Status: 9/27/2024-Vetoed by the Governor. In Senate. Consideration of Governor's veto pending.
Location: 9/27/2024-S. VETOED

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

1st House	2nd House	Conc.			

Summary: Current law requires the State Department of Health Care Services to perform various health functions, including providing breast and cervical cancer screening and treatment for low-income individuals. Current law provides that an individual is eligible to receive treatment services if, among other things, the individual has a family income at or below 200% of the federal poverty level as determined by the provider performing the screening and diagnosis. This bill would provide that, commencing no later than July 1, 2026, an individual is eligible to receive treatment services if the individual has a family income at or below 250% of the federal poverty level as determined by the provider performing the screening and diagnosis.

SB 1220 **(Limón D) Public benefits contracts: phone operator jobs.**
Current Text: Vetoed: 9/23/2024 html pdf
Status: 9/22/2024-Vetoed by the Governor. In Senate. Consideration of Governor's veto pending.
Location: 9/22/2024-S. VETOED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law prohibits, with specified exceptions, a state agency authorized to enter into contracts relating to public benefit programs from contracting for services provided by a call center that directly serves applicants for, recipients of, or enrollees in, those public benefit programs with a contractor or subcontractor unless that contractor or subcontractor certifies in its bid for the contract that the contract, and any subcontract performed under that contract, will be performed solely with workers employed in California. Current law provides an exception for contracts between a state agency and a health care service plan or a specialized health care service plan regulated by the Department of Managed Health Care and for contracts between a state agency and a disability insurer or specialized health insurer regulated by the Department of Insurance. Current law also authorizes the state to terminate a contract relating to services provided by a call center if the contractor or subcontractor performs services with workers not employed in California. This bill would, until July 1, 2030, instead require any state agency authorized to provide or enter into contracts relating to public benefit programs, or any local government agency authorized to provide or enter into contracts relating to public benefit programs funded by state funds, as specified, to provide services through, or contract for services provided by, a call center that directly serves callers with services performed solely with and by workers employed in California. The bill would also prohibit a state agency or specified local agency from using, or contracting with a call center that uses, artificial intelligence (AI) or automated decision systems (ADS) that would eliminate or automate core job functions of a worker, as specified. The bill would require an agency that utilizes AI or ADS that impact core job functions of workers to notify the workers, their collective bargaining representatives, and the public within a specified timeframe about prescribed information, including a general description of the AI or ADS system. The bill would require a contractor to certify in its bid that any services provided by the contractor, or its subcontractors, are to be performed with and by workers employed in California. The bill would also extend these contracting requirements to local government agencies.

SB 1236 **(Blakespear D) Medicare supplement coverage: open enrollment periods.**
Current Text: Amended: 4/29/2024 html pdf
Status: 5/16/2024-Failed Deadline pursuant to Rule 61(b)(8). (Last location was APPR. SUSPENSE FILE on 5/13/2024)
Location: 5/16/2024-S. DEAD

Desk	Policy	Dead	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current 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. 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. Current 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. Current law, among other provisions, requires supplement benefit plans to be uniform in structure, language, designation, and format with the standard benefit plans, as prescribed. Current 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. Current 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, 2025, 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.

SB 1258 **(Dahle R) Medi-Cal: unrecovered payments: interest rate.**
Current Text: Amended: 4/8/2024 html pdf
Status: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 8/7/2024)
Location: 8/15/2024-A. DEAD

Desk	Policy	Fiscal	Floor	Desk	Policy	Dead	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Current 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 current 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 current 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, including 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.

SB 1268 **(Nguyen R) Medi-Cal managed care plans: contracts with safety net providers.**
Current Text: Amended: 4/15/2024 html pdf
Status: 4/25/2024-Failed Deadline pursuant to Rule 61(b)(5). (Last location was HEALTH on 4/3/2024)
Location: 4/25/2024-S. DEAD

Desk	Dead	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Would require a Medi-Cal managed care plan to offer a network provider contract to, and maintain a network provider contract with, each safety net provider, as defined, operating within the plan's contracted geographic service areas if the safety net provider agrees to provide its applicable scope of services in accordance with the same terms and conditions that the Medi-Cal managed care plan requires of other similar providers. The bill would set forth exceptions to that requirement in the case of a safety net provider no longer being willing to accept those terms and conditions, its license being revoked or suspended, or the department determining that the health or welfare of a Medi-Cal enrollee is threatened by the provider. The bill would require the plan to follow certain notification procedures if it terminates the network provider contract. The bill would condition implementation of these provisions on receipt of any necessary federal approvals and the availability of federal financial participation.

SB 1269 **(Padilla D) Safety net hospitals.**
Current Text: Introduced: 2/15/2024 html pdf
Status: 5/2/2024-Failed Deadline pursuant to Rule 61(b)(6). (Last location was HEALTH on 2/29/2024)
Location: 5/2/2024-S. DEAD

Desk	Dead	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Would establish a definition for "safety net hospital" and would state the intent of the Legislature that this definition serve as a recommended definition for policymakers to elect to utilize when crafting policy aimed at focusing on or supporting those hospitals. Under the bill, the definition would not be construed as affecting existing or new references to safety net hospitals, unless future legislation or other action expressly makes reference to this definition, as specified.

SB 1290 **(Roth D) Health care coverage: essential health benefits.**
Current Text: Introduced: 2/15/2024 html pdf
Status: 8/31/2024-Failed Deadline pursuant to Rule 61(b)(17). (Last location was INACTIVE FILE on 8/28/2024)
Location: 8/31/2024-A. DEAD

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Dead	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: 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. This bill contains other related provisions and other existing laws.

SB 1300 **(Cortese D) Health facility closure: public notice: inpatient psychiatric and perinatal services.**
Current Text: Chaptered: 9/28/2024 html pdf
Status: 9/28/2024-Approved by the Governor. Chaptered by Secretary of State. Chapter 894, Statutes of 2024.
Location: 9/28/2024-S. CHAPTERED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Under current law, a general acute care hospital is required to provide certain basic services, including medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services. Current law authorizes a general acute care hospital to provide various special or supplemental services if certain conditions are met. Current regulations define a supplemental service as an organized inpatient or outpatient service that is not required to be provided by law or regulation. Current law requires a health facility to provide 90 days of public notice of the proposed closure or elimination of a supplemental service, and 120 days of public notice of the proposed closure or elimination of an acute psychiatric hospital. This bill would change the notice period required before proposed closure or elimination of the supplemental service of inpatient psychiatric unit or a perinatal unit from 90 days to 120 days. By changing the definition of a crime, this bill would impose a state-mandated local program. The bill would require the health facility to provide public notice of the proposed elimination of the supplemental service of either inpatient psychiatric unit or perinatal unit, as specified. The bill would require the health facility to conduct at least one noticed public hearing within 60 days of providing public notice of the proposed elimination of the inpatient psychiatric unit or perinatal unit and would require the health facility to accept public comment. The bill would require the health facility to post the public hearing notice and the agenda along with the public notice.

SB 1308 **(Gonzalez D) Ozone: indoor air cleaning devices.**
Current Text: Amended: 6/11/2024 html pdf
Status: 7/2/2024-Failed Deadline pursuant to Rule 61(b)(13). (Last location was NAT. RES. on 5/28/2024)
Location: 7/2/2024-A. DEAD

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

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Summary: Current law requires the State Air Resources Board to develop and adopt regulations, consistent with federal law, to protect the public health from ozone emitted by indoor air cleaning devices, including medical and nonmedical devices used in occupied spaces. Current law requires those regulations to include, among other things, an emission concentration standard for ozone emissions that is equivalent to the federal ozone emissions limit for air cleaning devices. Current law generally sets forth crimes and penalties for violations of air pollution laws and any rule, regulation, permit, or order of the state board. This bill would instead require the state board, by July 1, 2026, or as soon as feasible, as provided, to include in these regulations an emission concentration standard for ozone emissions not greater than 0.005 parts per million, to the extent consistent with federal law, thereby imposing a more protective standard. The bill would require the regulations to include a ban on the sale or the offering for sale of devices that exceed that emissions limit, even if previously certified, after a date determined by the state board, unless the state board determines an exemption applies.

SB 1320 **(Wahab D) Mental health and substance use disorder treatment.**
Current Text: Chaptered: 7/15/2024 html pdf
Status: 7/15/2024-Chaptered by Secretary of State - Chapter 135, Statutes of 2024
Location: 7/15/2024-S. CHAPTERED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law provides for the regulation of disability insurers by the Department of Insurance. Current law requires a health care service plan contract or disability 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 require a plan or insurer subject to the above-described coverage requirement, and its delegates, to establish a process to reimburse providers for mental health and substance use disorder treatment services that are integrated with primary care services and provided under a contract or policy issued, amended, or renewed on or after July 1, 2025. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

SB 1339 **(Allen D) Step-down care.**
Current Text: Amended: 6/17/2024 html pdf
Status: 7/2/2024-Failed Deadline pursuant to Rule 61(b)(13). (Last location was HEALTH on 6/3/2024)
Location: 7/2/2024-A. DEAD

Desk	Policy	Fiscal	Floor	Desk	Dead	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law requires the State Department of Health Care Services to license and regulate facilities that provide residential nonmedical services to adults who are recovering from problems related to alcohol, drug, or alcohol and drug misuse or abuse, and who need alcohol, drug, or alcohol and drug recovery treatment or detoxification services. Current law also requires the department to implement a voluntary certification program for alcohol and other drug treatment recovery services. The California Community Care Facilities Act generally provides for the licensing and regulation of community care facilities by the State Department of Social Services, to provide 24-hour nonmedical care of persons in need of personal services, supervision, or assistance. Current regulation includes an adult residential facility as a community care facility for those purposes. This bill would require the State Department of Health Care Services (department), by January 1, 2027, and in consultation with relevant public agencies and stakeholders, to establish, and provide for the administration of, a voluntary certification program for supportive community residences. The bill would define a “supportive community residence” as specified residential dwellings providing housing for adults with a substance use disorder, mental health diagnosis, or dual diagnosis seeking a cooperative living arrangement as a transitional or long-term residence during the process of recovery. The bill would require the certification program to include standards and procedures for operation, such as types of certifications needed and services navigation, and procedures and penalties for enforcing laws and regulations governing supportive community residences. The bill also would require the department to create and maintain a searchable online database of certified facilities, which would include specified contact and complaint information for those residences and would require the database to be updated on a monthly basis.

SB 1354 **(Wahab D) Long-term health care facilities: payment source and resident census.**
Current Text: Chaptered: 9/21/2024 html pdf
Status: 9/21/2024-Approved by the Governor. Chaptered by Secretary of State. Chapter 339, Statutes of 2024.
Location: 9/21/2024-S. CHAPTERED

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law provides for the licensing and regulation of long-term health care facilities, including, among others, skilled nursing facilities and intermediate care facilities, by the State Department of Public Health. A violation of those provisions is generally a crime. 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 require the facility to provide aid, care, service, and other benefits available under Medi-Cal to Medi-Cal beneficiaries in the same manner, by the same methods, and at the same scope, level, and quality as provided to the general public, regardless of payment source. The bill would find and declare that this requirement is declaratory of existing law and thus not reimbursable under Medi-Cal Long-Term Care Reimbursement Act or any other Medi-Cal ratesetting provisions, as specified. The bill would specify that if reimbursement is found to be required by state or federal law or regulation, as specified, the above requirement shall only become operative upon appropriation by the Legislature. The bill would also provide that this requirement and the above-described prohibition against discrimination on the basis of payment source be implemented only to the extent that these provisions do not conflict with federal law, that any necessary federal approvals are obtained, and that federal financial participation for the Medi-Cal program is available and is not otherwise jeopardized.

SB 1355 **(Wahab D) Medi-Cal: in-home supportive services: redetermination.**
Current Text: Amended: 4/25/2024 html pdf
Status: 5/16/2024-Failed Deadline pursuant to Rule 61(b)(8). (Last location was APPR. SUSPENSE FILE on 5/6/2024)
Location: 5/16/2024-S. DEAD

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

Summary: Current law generally requires a county to redetermine a Medi-Cal beneficiary's eligibility to receive Medi-Cal benefits every 12 months and whenever the county receives information about changes in a beneficiary's circumstances that may affect their eligibility for Medi-Cal benefits. Current 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. Current law authorizes certain Medi-Cal beneficiaries to receive IHSS as a covered Medi-Cal benefit. This bill would, to the extent that any necessary federal approvals are obtained, and federal financial participation is available and not otherwise jeopardized, require an IHSS recipient to be continuously eligible for Medi-Cal for 3 years, if they have a fixed income, and would prohibit a redetermination of Medi-Cal eligibility before 3 years, except as specified. The bill would make the implementation of its provisions contingent upon the department obtaining all necessary federal approvals, the department determining that systems have been programmed to implement these provisions, and the Legislature has appropriated funding to implement these provisions after a determination that ongoing General Fund resources are available to support the ongoing implementation of these provisions.

SB 1397 **(Eggman D) Behavioral health services coverage.**
Current Text: Amended: 4/15/2024 html pdf
Status: 8/15/2024-Failed Deadline pursuant to Rule 61(b)(14). (Last location was APPR. SUSPENSE FILE on 8/7/2024)
Location: 8/15/2024-A. DEAD

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

Summary: Would require a health care service plan contract or health insurance policy issued, amended, renewed, or

delivered on or after July 1, 2025, that covers medically necessary mental health and substance use disorder services to comply with rate and timely reimbursement requirements for services delivered by a county behavioral health agency, as specified. The bill would require in-network cost sharing, capped at the in-network deductible and in-network out-of-pocket maximum, to apply to these services. Unless an enrollee or insured is referred or authorized by the plan or insurer, the bill would require a county behavioral health agency to contact a plan or insurer before initiating services. The bill would authorize a plan or insurer to conduct a postclaim review to determine appropriate payment of a claim, and would authorize the use of prior authorization as permitted by the regulating department. The bill would require the departments to issue guidance to plans and insurers regarding compliance with these provisions no later than April 1, 2025. Because a willful violation of these provisions by a health care service plan would be a crime, and the bill would impose a higher level of service on a county behavioral health agency, this bill would impose a state-mandated local program.

SB 1423 **(Dahle R) Medi-Cal: Rural Hospital Technical Advisory Group.**
Current Text: Vetoed: 9/23/2024 html pdf
Status: 9/22/2024-Vetoed by the Governor. In Senate. Consideration of Governor's veto pending.
Location: 9/22/2024-S. VETOED

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

Summary: The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under current law, each hospital designated by the State Department of Health Care Services as a critical access hospital, and certified as such by the Secretary of the United States Department of Health and Human Services under the federal Medicare rural hospital flexibility program, Rural Hospital Flexibility Program, is eligible for supplemental payments for Medi-Cal covered outpatient services rendered to Medi-Cal eligible persons. Current law sets forth various other provisions regarding Medi-Cal reimbursement in consideration of small and rural hospitals. This bill would require the department to convene a Rural Hospital Technical Advisory Group, with a certain composition of stakeholders, at least bimonthly during the 2025 calendar year. The bill would set forth the purposes of the advisory group, including, among other things, analyzing the continued ability of small, rural, or critical access hospitals, as defined, to remain financially viable under existing Medi-Cal reimbursement methodologies, to provide related recommendations, and to identify key contributors to the financial challenges of those hospitals, as specified.

SB 1428 **(Atkins D) Reproductive health: mifepristone and other medication.**
Current Text: Amended: 6/17/2024 html pdf
Status: 7/2/2024-Failed Deadline pursuant to Rule 61(b)(13). (Last location was HEALTH on 6/13/2024)
Location: 7/2/2024-A. DEAD

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

Summary: Under the California Constitution, the state is prohibited from denying or interfering with an individual's reproductive freedom in their most intimate decisions, including their fundamental right to choose to have an abortion. 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. Under the act, a person is not subject to liability or penalty based on their actions or omissions with respect to their pregnancy or pregnancy outcome. Under the act, a person who aids or assists a pregnant person in exercising their rights under the act is not subject to liability or penalty based solely on their aid- or assistance-related actions, as specified. Under the bill, a person, in exercising their individual rights under the above-described constitutional provision and the Reproductive Privacy Act, would not be subject to civil or criminal liability or penalty, or otherwise deprived of their rights, for using, receiving, possessing, or storing brand or generic mifepristone or any drug used for medication abortion.

SB 1492 **(Menjivar D) Medi-Cal reimbursement rates: private duty nursing.**
Current Text: Amended: 4/15/2024 html pdf
Status: 5/16/2024-Failed Deadline pursuant to Rule 61(b)(8). (Last location was APPR. SUSPENSE FILE on 5/6/2024)
Location: 5/16/2024-S. DEAD

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

Summary: The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, one of the methods by which Medi-Cal services are provided is pursuant to contracts with various types of managed care plans. Current law sets forth requirements for private duty nursing and home health care under the Medi-Cal program. Current law imposes a managed care organization (MCO) provider tax, administered and assessed by the department, on licensed health care service plans and managed care plans contracted with the department to provide full-scope Medi-Cal services. Under existing law, proceeds from the MCO provider tax may be used, upon appropriation by the Legislature, for the increased costs incurred as a result of reimbursement requirements, among other things. This bill would provide that private duty nursing services provided to a child under 21 years of age by a home health agency are included as an eligible category for Medi-Cal reimbursement through the above-described scheme.

Total Measures: 131

Total Tracking Forms: 131

ALAMEDA Alliance FOR HEALTH

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Executive Dashboard

OPERATIONS DASHBOARD

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Financials

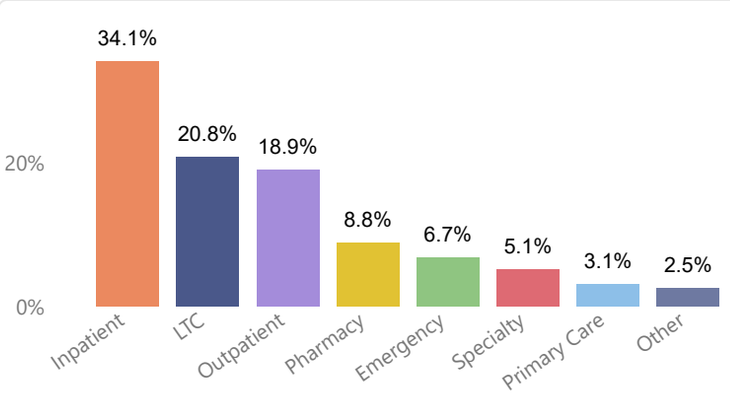
Income & Expenses

	SEPTEMBER 2024	FISCAL YTD
REVENUE	$ 365.2 M	$ 799.3 M
MEDICAL EXPENSE	$ (174.5) M	$ (526.9) M
ADMIN EXPENSE	$ (8.9) M	$ (29.2) M
OTHER/TAX	$ (190.5) M	$ (277.3) M
NET INCOME	$ (8.7) M	$ (34.1) M

Medical Loss % (Fiscal YTD)

103.1%

Medical Expenses



Liquid Reserves

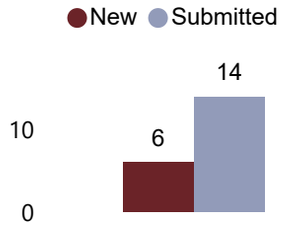
TNE %

315.2%

TNE $

$221.3M

Reinsurance Cases



Balance Sheet

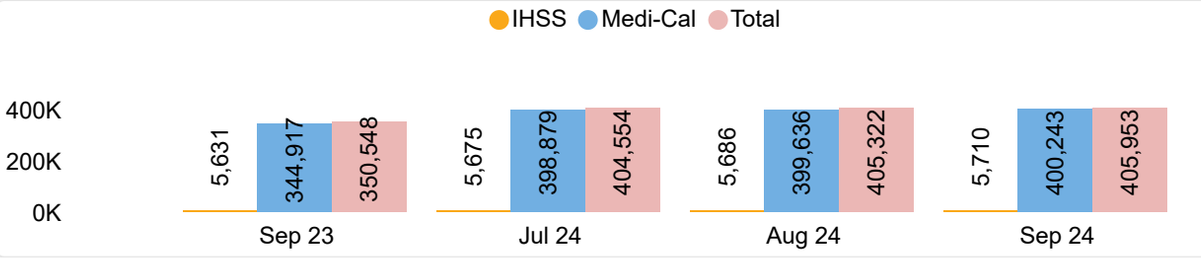
Cash Equivalents	$625.4M
Pass-Through Liabilities	$183.1M
Uncommitted Cash	$442.3M
Working Capital	$159.1M

Current Ratio

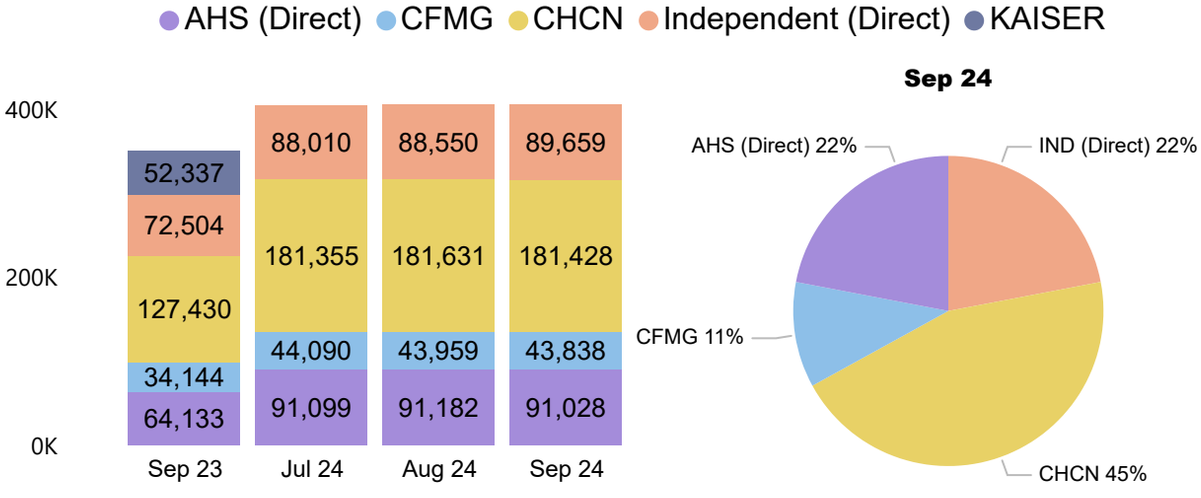
1.17

Membership

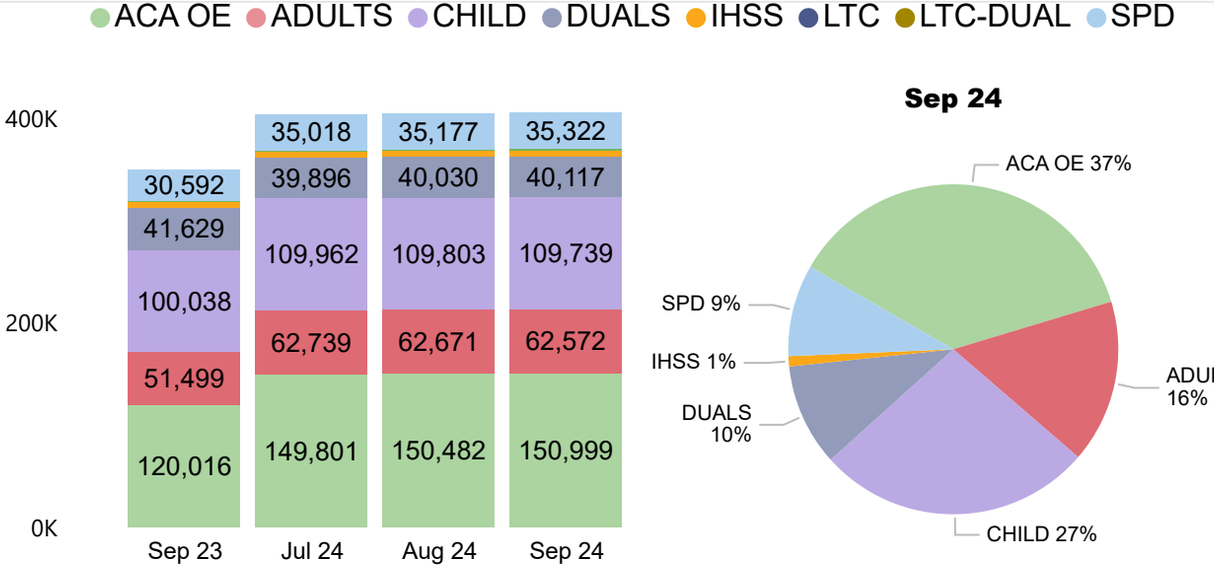
By Plan



By Network



By Category



OPERATIONS DASHBOARD

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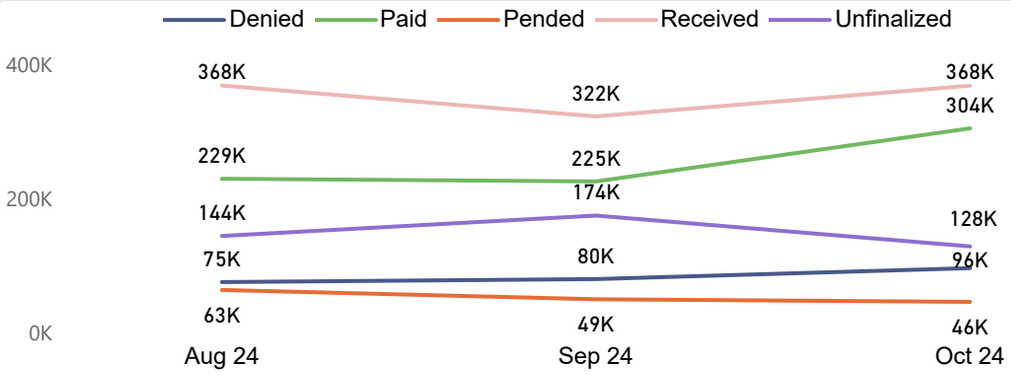
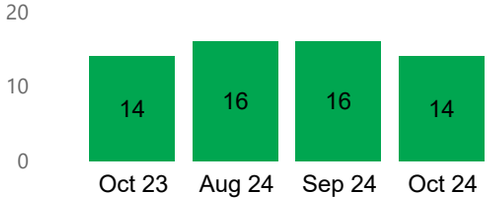
Claims

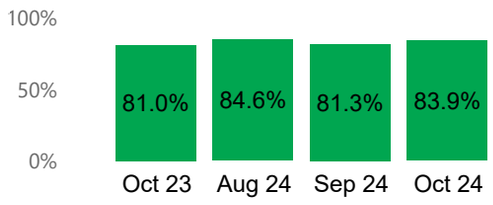
Claims Processing



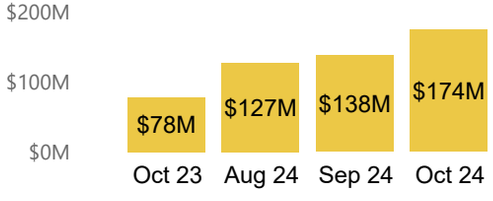
Average Payment TAT (Days)



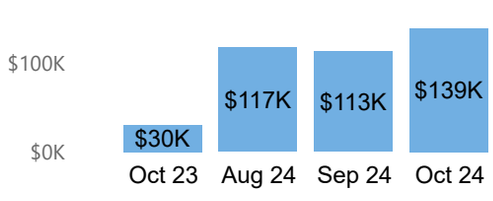
Auto Adjudication Rate (%)



Claims Paid ($)

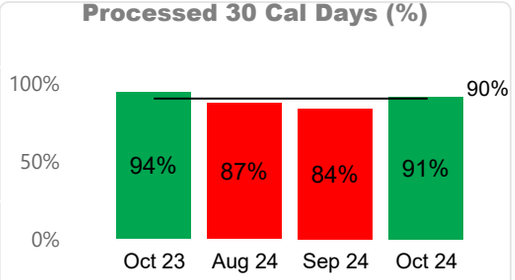


Interest Paid ($)

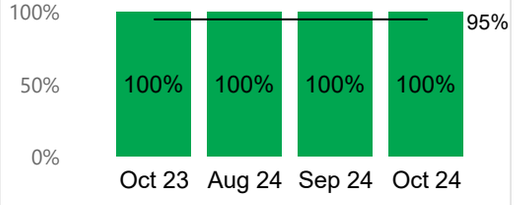


Claims Compliance

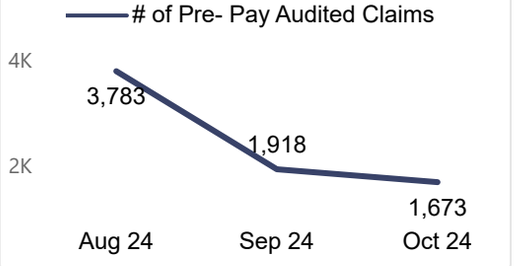
Processed 30 Cal Days (%)



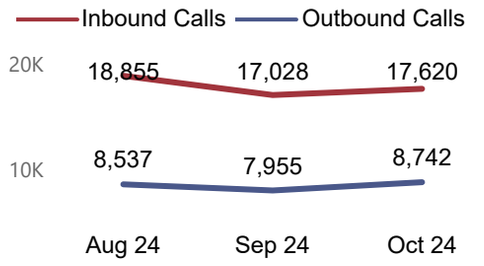
Processed 45 Work Days (%)



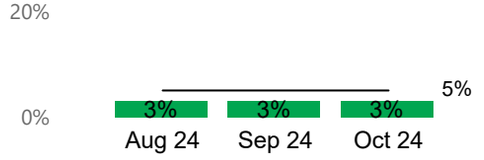
Claims Auditing



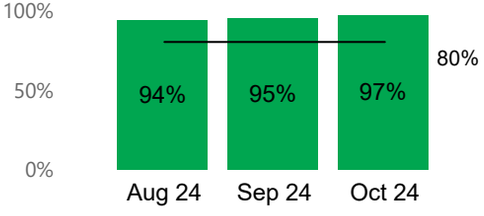
Member Services



Abandoned Call Rate (%)

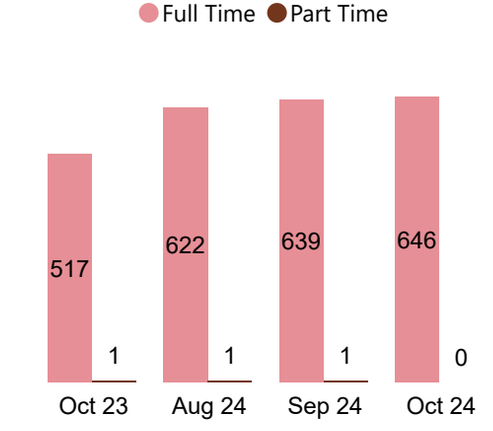


Calls Answered in 30 Seconds (%)

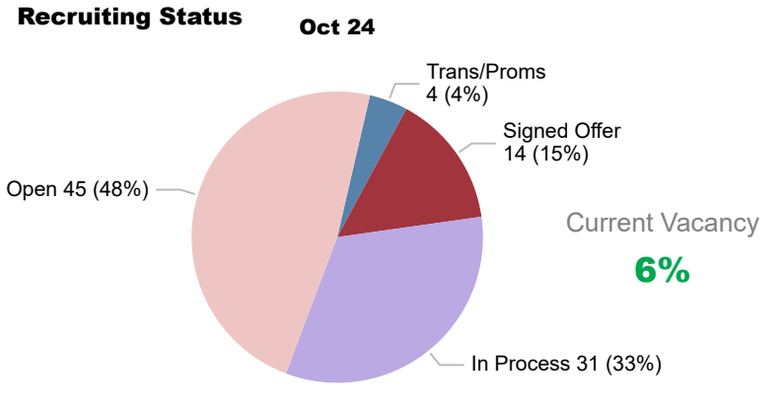


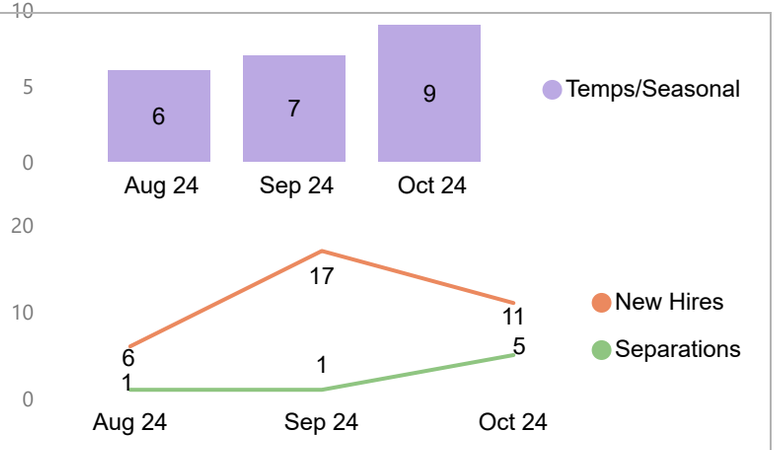
Average Call Times	Aug 24	Sep 24	Oct 24
Wait Time	00:13	00:14	00:9
Call Duration	07:10	07:11	07:08

Human Resources



Recruiting Status Oct 24





OPERATIONS DASHBOARD

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Provider Services

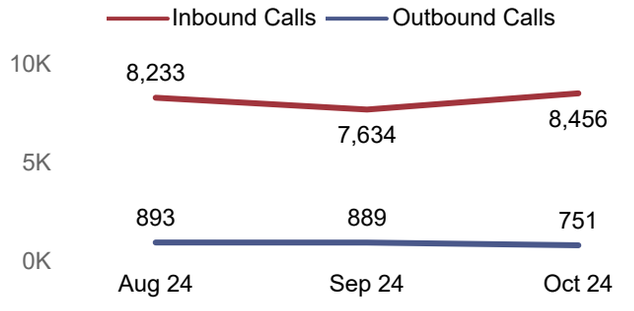
Provider Network

Hospital	17
Specialist	11,216
Primary Care Physician	772
Skilled Nursing Facility	105
Urgent Care	15
Health Centers (FQHCs and Non-FQHCs)	83
TOTAL	**12,208**

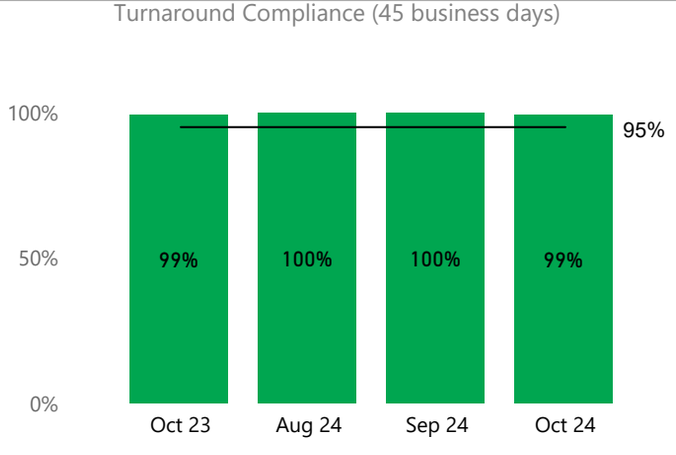
Provider Credentialing

4,056

Provider Call Center

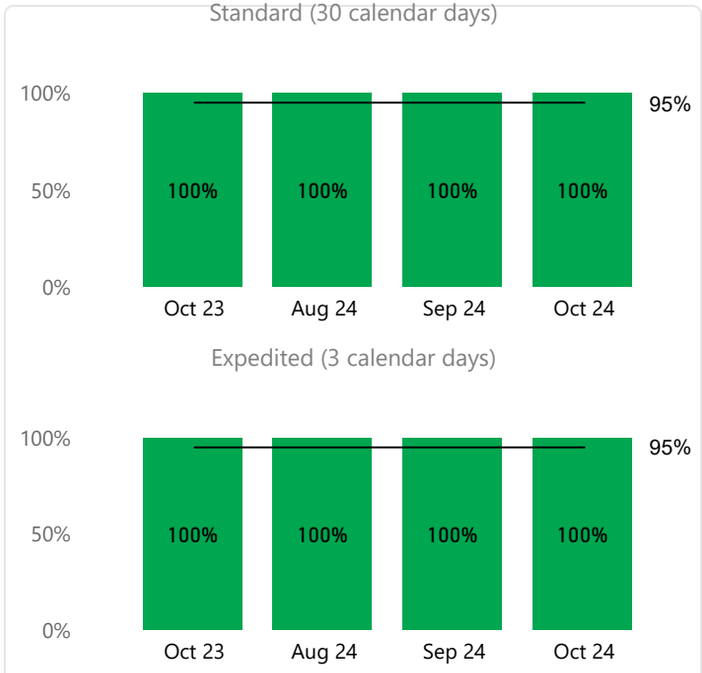


Provider Disputes & Resolutions

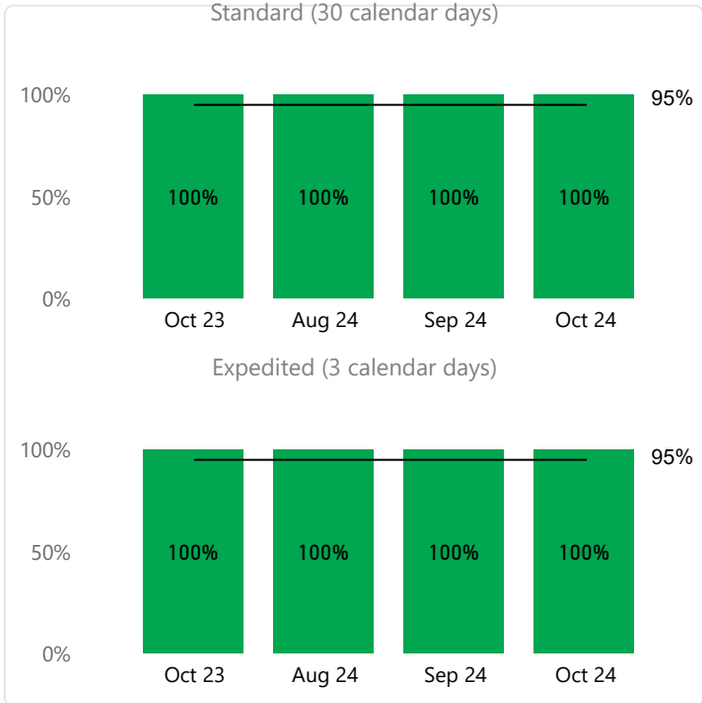


Compliance

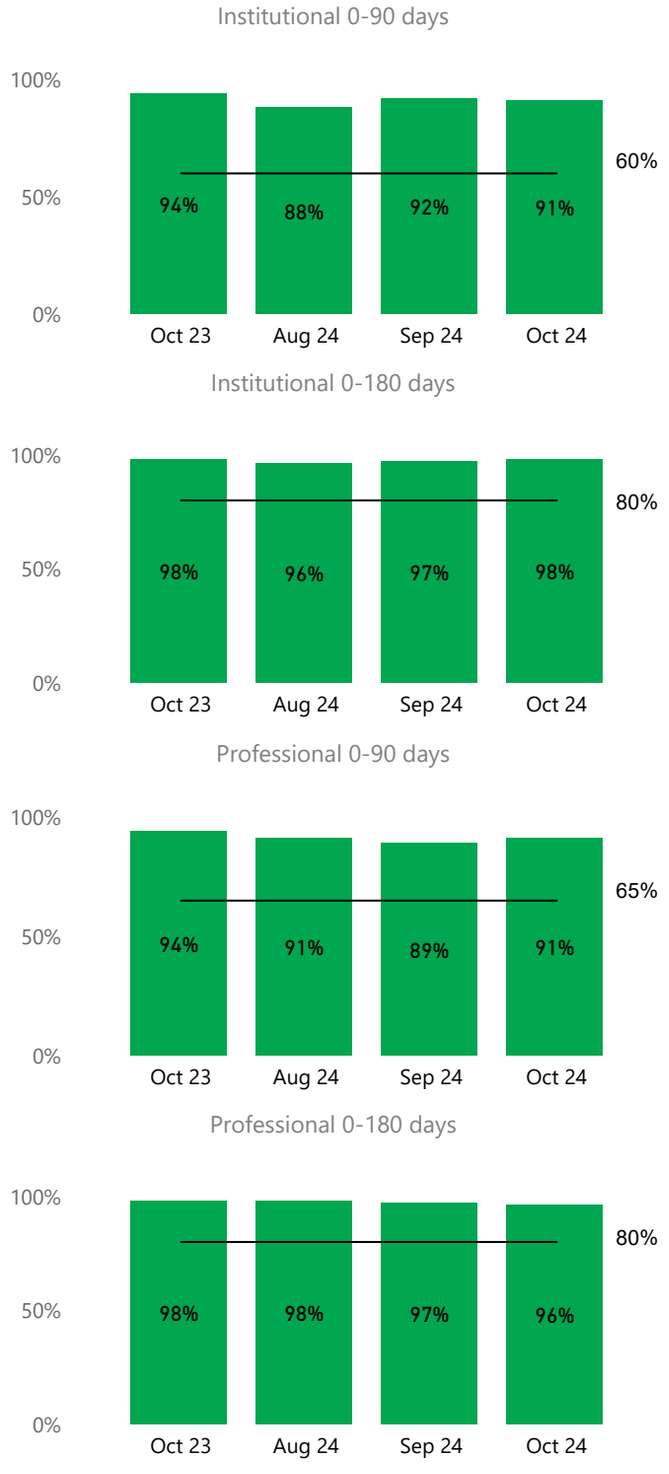
Member Grievances



Member Appeals



Encounter Data



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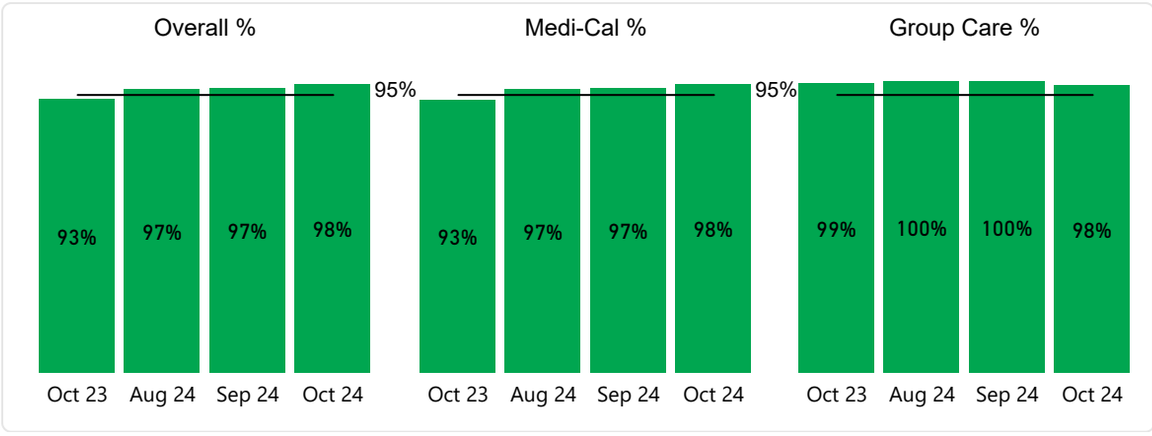
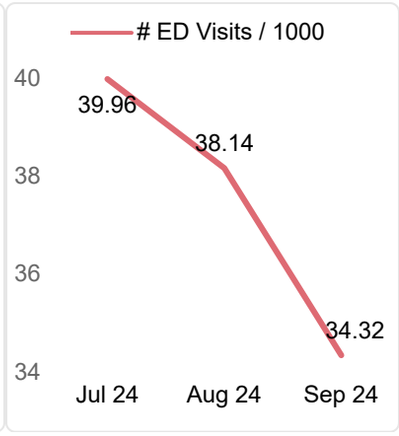
Health Care Services

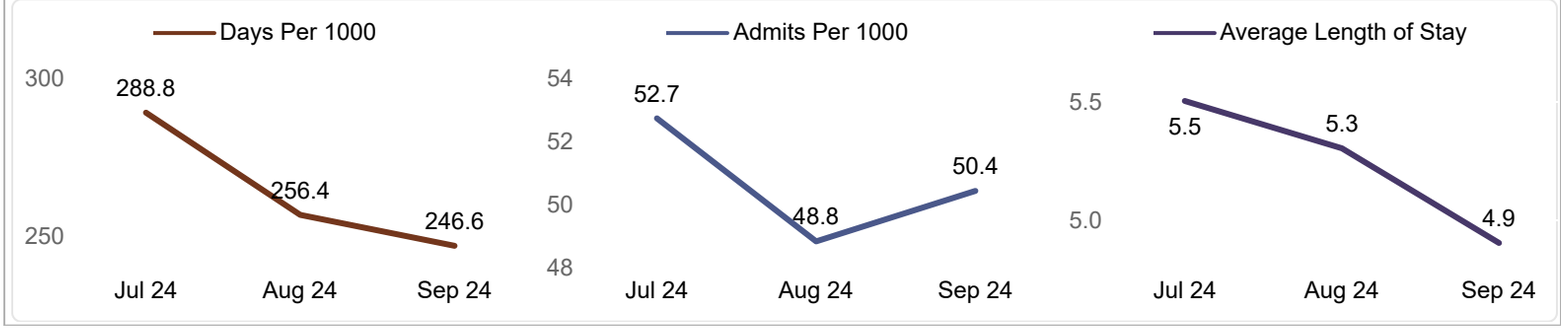
Authorization Turnaround



ED Utilization

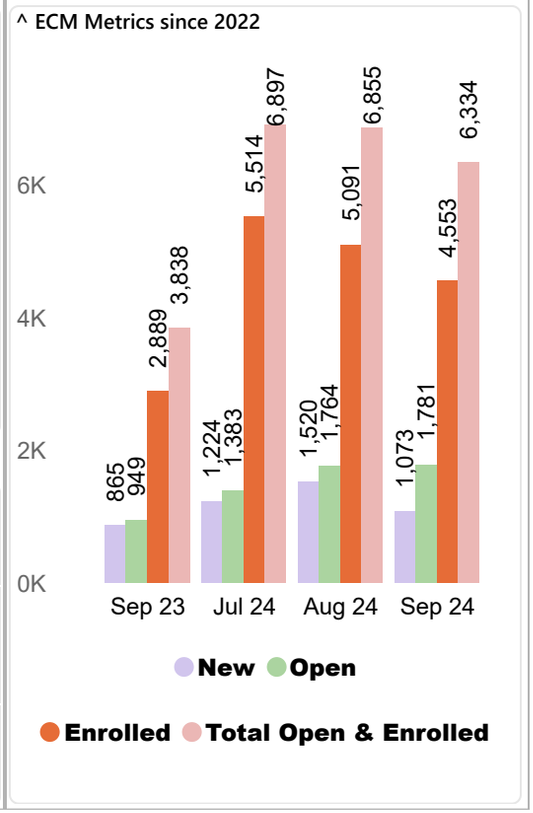


Inpatient Utilization

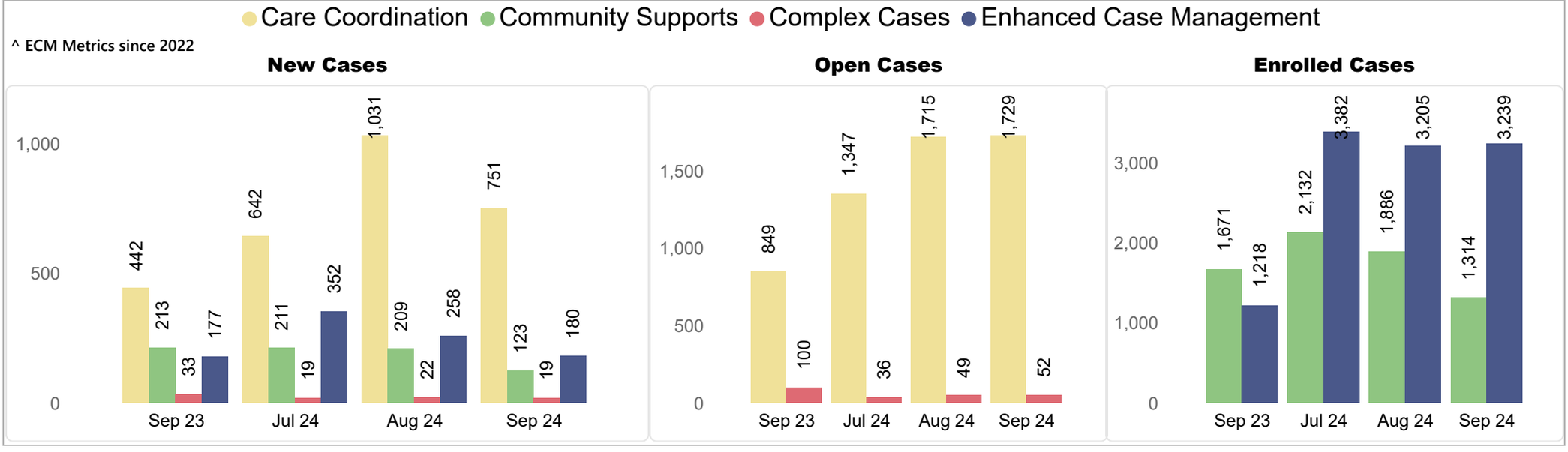


Case Management

Total Cases^



Case Management^



OPERATIONS DASHBOARD

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Technology (Business Availability)

Applications	Oct 23	Aug 24	Sep 24	Oct 24
HEALTHsuite System	100.0%	99.9%	100.0%	99.9%
Other Applications	100.0%	100.0%	100.0%	100.0%
TruCare System	100.0%	100.0%	100.0%	100.0%

Outpatient Authorization Denial Rates *

OP Authorization Denial Rates	Oct 23	Aug 24	Sep 24	Oct 24
Denial Rate Excluding Partial Denials (%)	4.9%	2.8%	2.8%	2.6%
Overall Denial Rate (%)	5.1%	3.0%	3.0%	2.8%
Partial Denial Rate (%)	0.3%	0.2%	0.1%	0.2%

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

Pharmacy Authorizations

Authorizations	Oct 23	Aug 24	Sep 24	Oct 24
Approved Prior Authorizations	37	46	39	55
Closed Prior Authorizations	98	97	74	115
Denied Prior Authorizations	29	51	57	50
Total Prior Authorizations	164	194	170	220

Finance

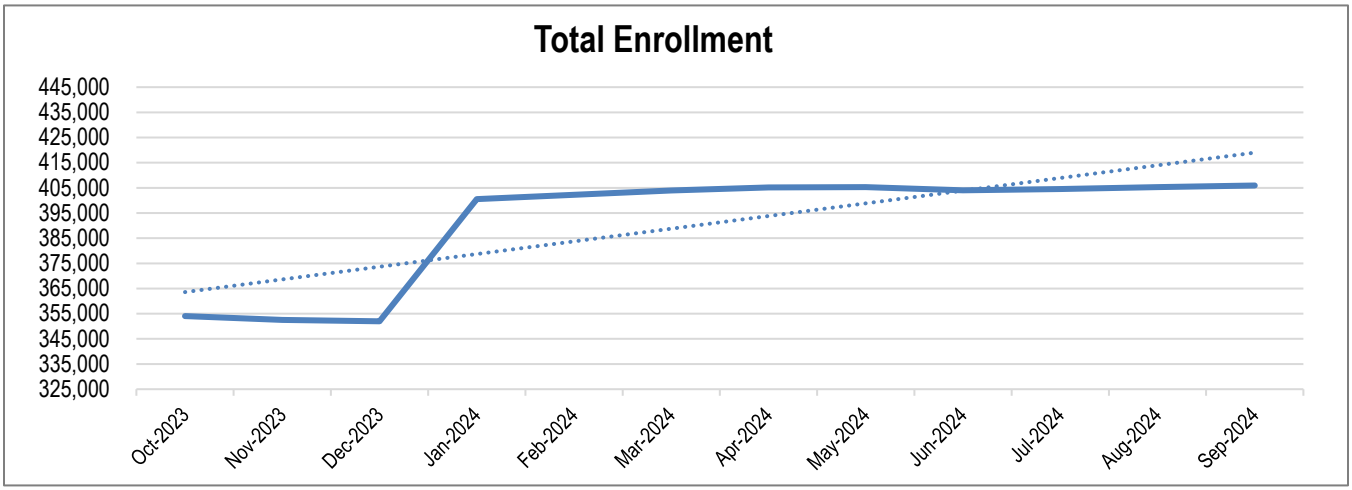
Gil Riojas

To: **Alameda Alliance for Health, Board of Governors**
From: **Gil Riojas, Chief Financial Officer**
Date: **November 12th, 2024**
Subject: **Finance Report – September 2024 Financials**

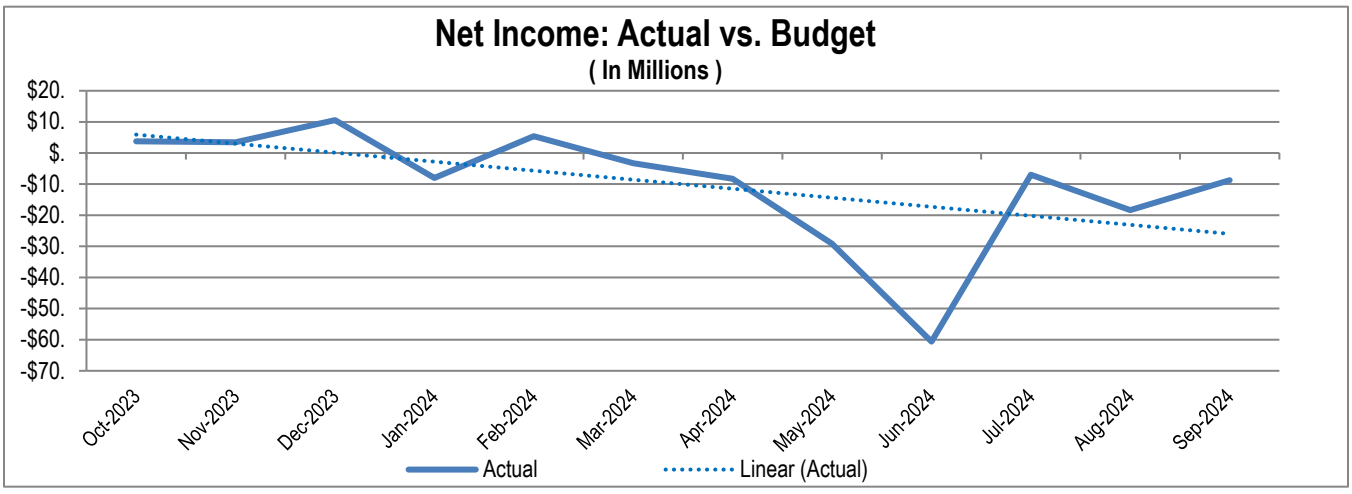
Executive Summary

For the month of September, the Alliance continued to see slight increases in enrollment, reaching 405,933 members. A Net Loss of $8.7 million was reported, and the Plan's Medical Expenses represented 102.1% of revenue. Alliance reserves decreased to 315% of required but continue to remain above minimum requirements.

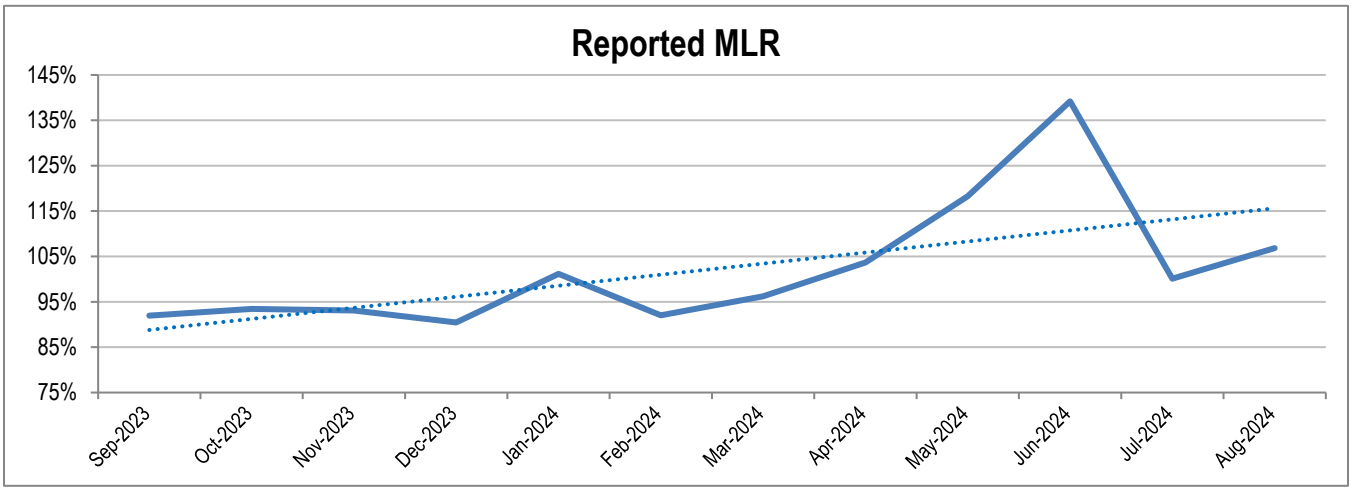
Enrollment – In September, Enrollment increased by 666 members.



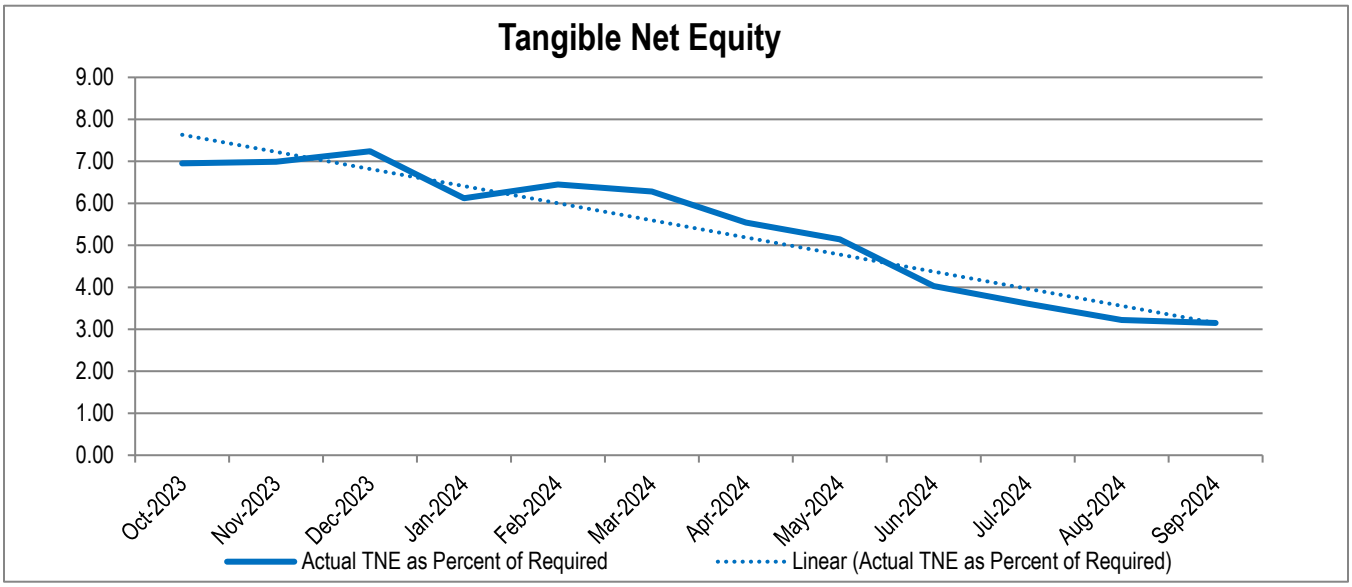
Net Income – For the month ended September 30th, 2024, actual Net Loss was $8.7 million vs. budgeted Net Loss of $215,000. For the fiscal YTD, actual Net Loss was $34.1 million vs. budgeted Net Loss of $5.4 million. For the month, Premium Revenue was favorable to budget, actual Revenue was $170.9 million vs. budgeted Revenue of $166.2 million.



Medical Loss Ratio (MLR) – The Medical Loss Ratio was 102.1% for the month, and 103.1% for fiscal YTD. The major variances include unfavorable Emergency Expense, Inpatient/SNF, Pharmacy, and Long-Term Care expenses.



Tangible Net Equity (TNE) - The Department of Managed Health Care (DMHC) required $70.2M in reserves, we reported $221.3M. Our overall TNE remains above DMHC requirements at 315%.



The Alliance continues to benefit from increased non-operating income. For Fiscal year-to-date, we reported returns of $10.9M, in the investment portfolio. Capital assets acquired FYTD is $530k.

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

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

Date: **November 12th, 2024**

Subject: **Finance Report – September 2024**

Executive Summary

- For the month ended September 30th, 2024, the Alliance had enrollment of 405,933 members, a Net Loss of $8.7 million and 315% of required Tangible Net Equity (TNE).

Overall Results: (in Thousands)

	Month	YTD
Revenue	$365,222	$799,308
Medical Expense	174,523	526,890
Admin. Expense	8,882	29,192
MCO Tax Expense	194,274	288,215
Other Inc. / (Exp.)	3,738	10,925
Net Income	**($8,719)**	**($34,063)**

Net Income by Program: (in Thousands)

	Month	YTD
Medi-Cal*	($7,766)	($32,627)
Group Care	(178)	(394)
Medicare	(775)	(1,043)
	($8,719)	**($34,063)**

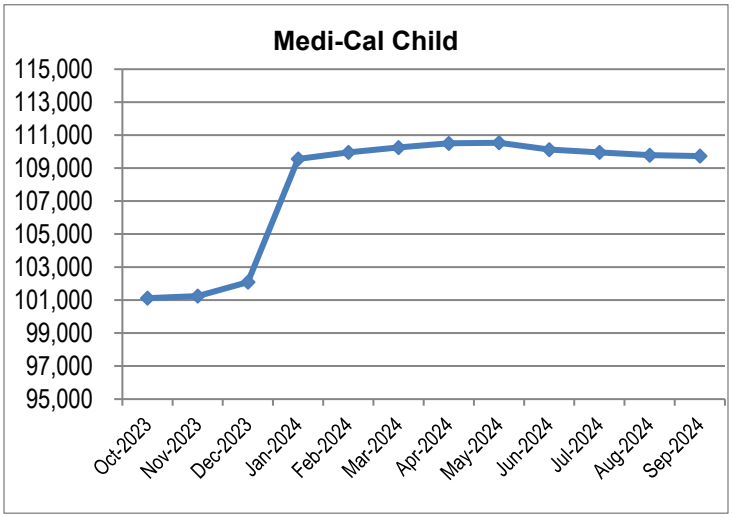
Enrollment

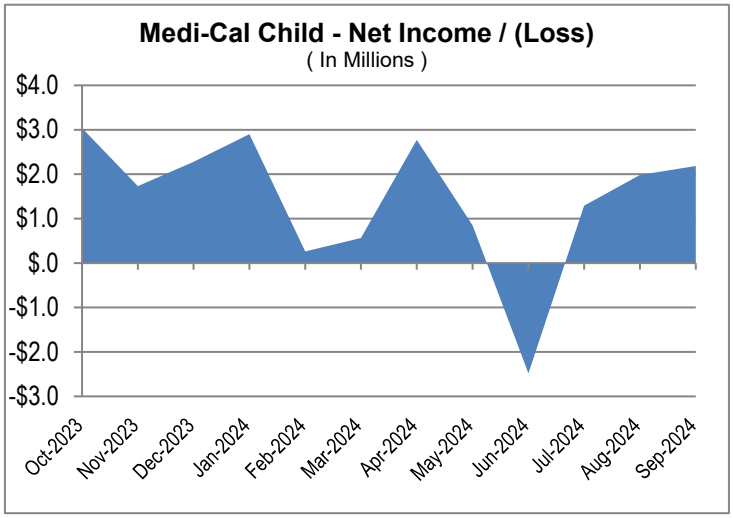
- Total enrollment increased by 666 members since August 2024.
- Total enrollment increased by 1,943 members since June 2025.

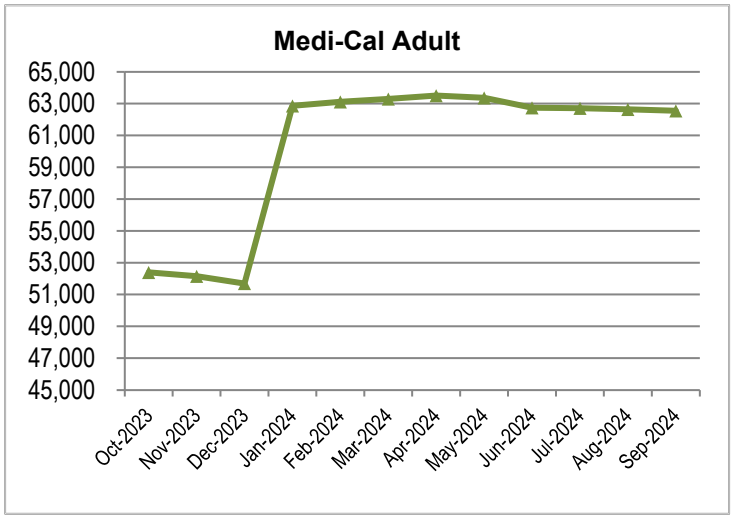
Monthly Membership and YTD Member Months
Actual vs. Budget
For the Month and Fiscal Year-to-Date

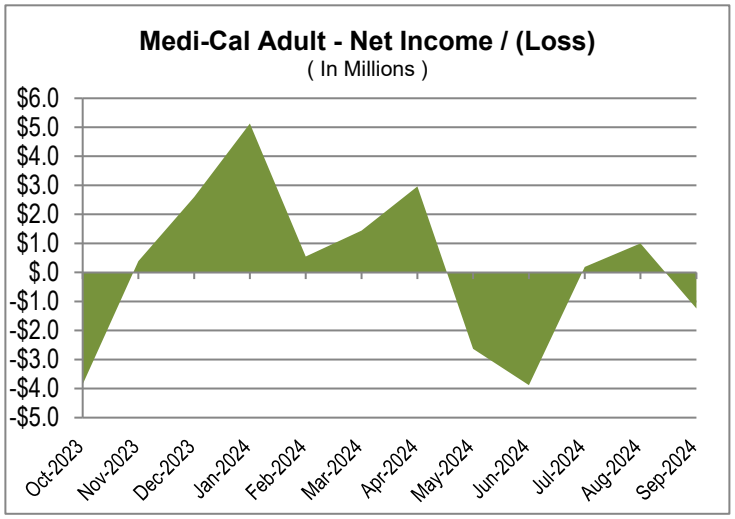
Enrollment					Member Months			
Current Month					Year-to-Date			
Actual	Budget	Variance	Variance %		Actual	Budget	Variance	Variance %
				Medi-Cal:				
62,550	63,699	(1,149)	-1.8%	Adult	187,899	190,905	(3,006)	-1.6%
109,731	111,166	(1,435)	-1.3%	Child	329,466	332,833	(3,367)	-1.0%
35,319	34,848	471	1.4%	SPD	105,514	104,544	970	0.9%
40,124	39,791	333	0.8%	Duals	120,040	119,373	667	0.6%
151,005	149,615	1,390	0.9%	ACA OE	451,288	448,398	2,890	0.6%
240	224	16	7.1%	LTC	688	672	16	2.4%
1,254	1,285	(31)	-2.4%	LTC Duals	3,742	3,855	(113)	-2.9%
400,223	**400,628**	**(405)**	**-0.1%**	**Medi-Cal Total**	**1,198,637**	**1,200,580**	**(1,943)**	**-0.2%**
5,710	5,643	67	1.2%	Group Care	17,071	16,929	142	0.8%
405,933	**406,271**	**(338)**	**-0.1%**	**Total**	**1,215,708**	**1,217,509**	**(1,801)**	**-0.1%**

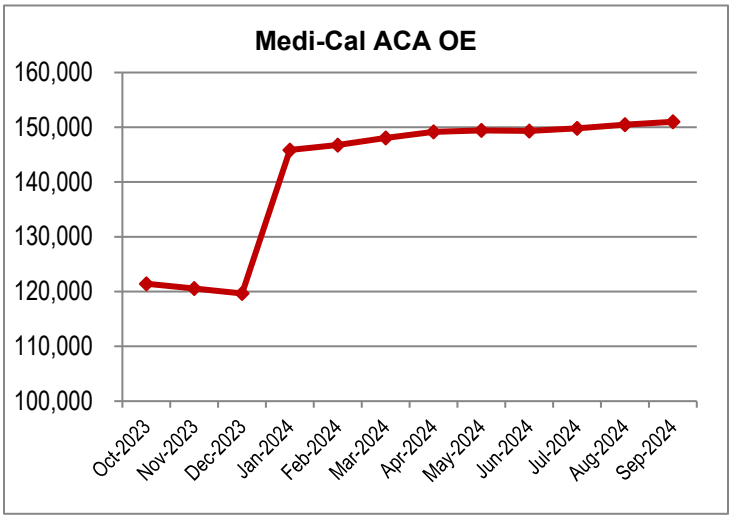
Enrollment and Profitability by Program and Category of Aid

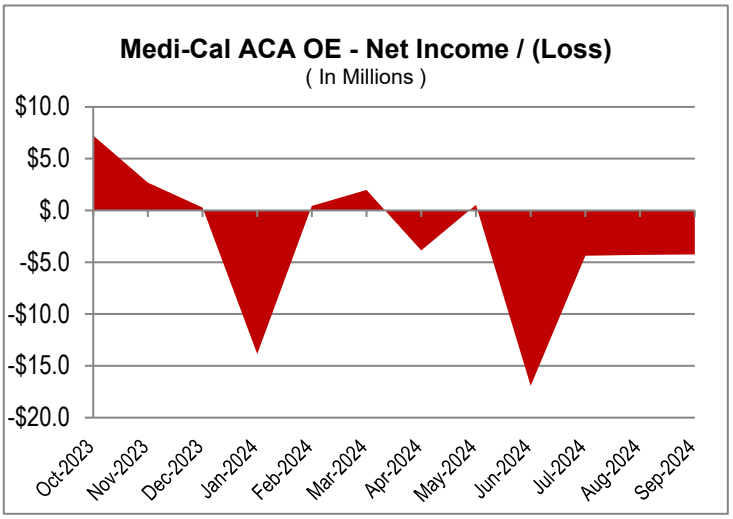




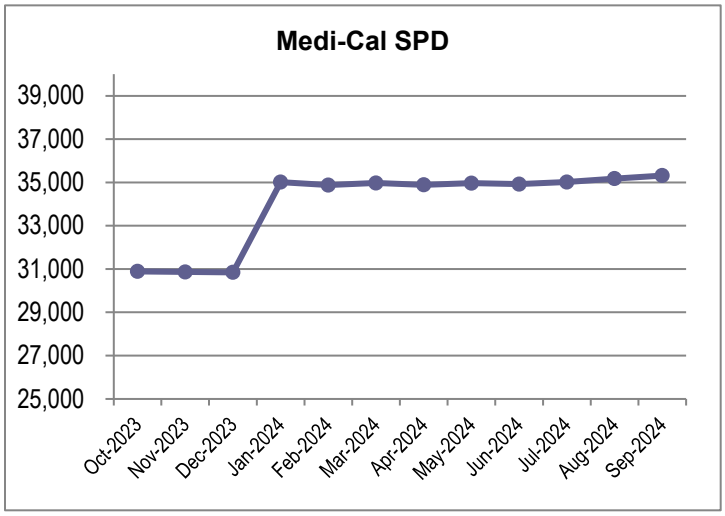


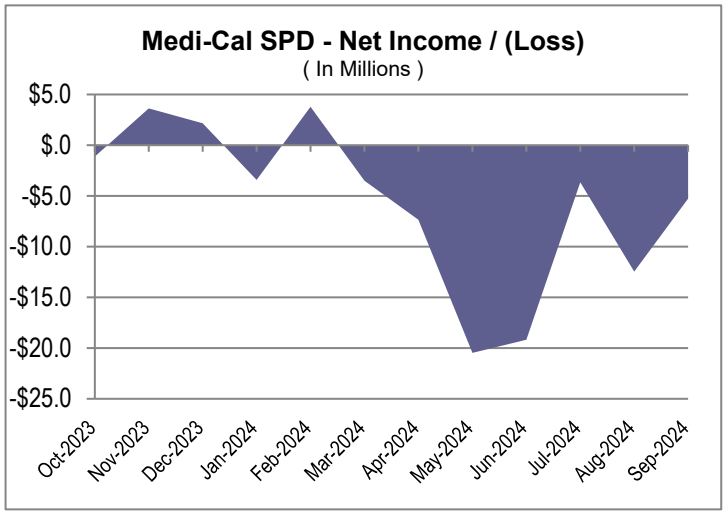


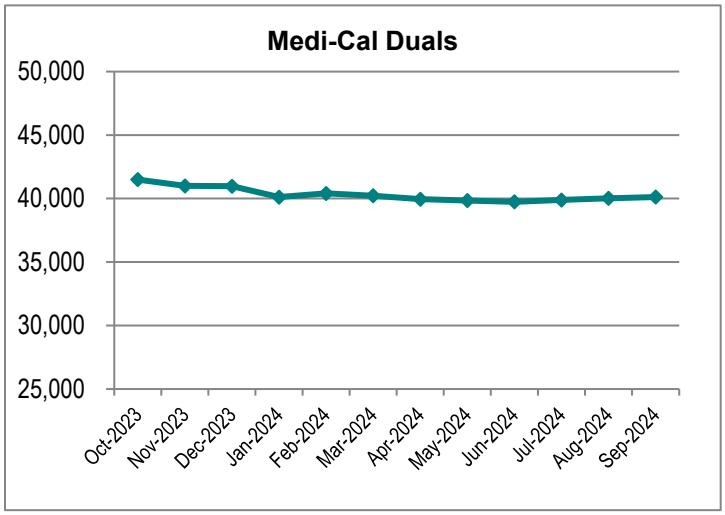


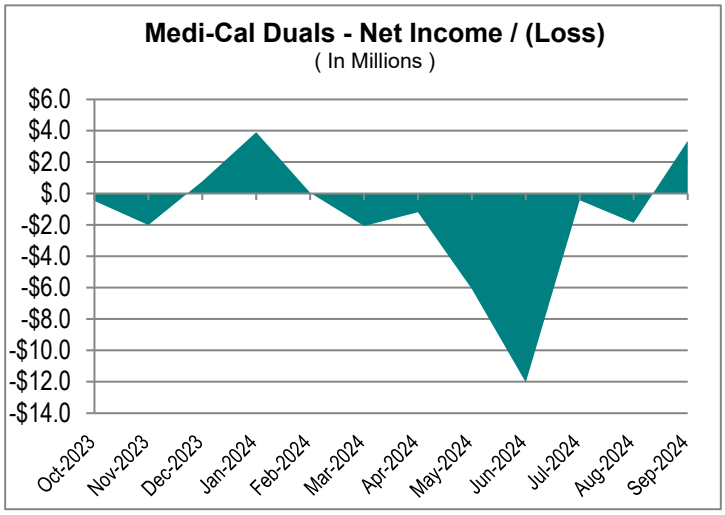


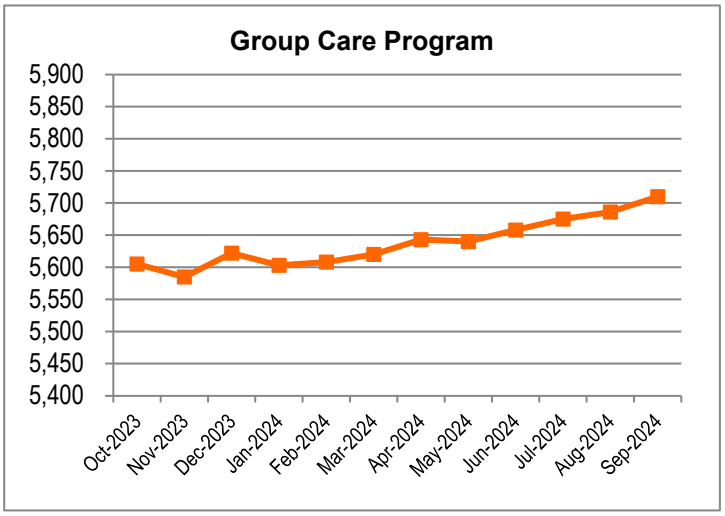
Enrollment and Profitability by Program and Category of Aid

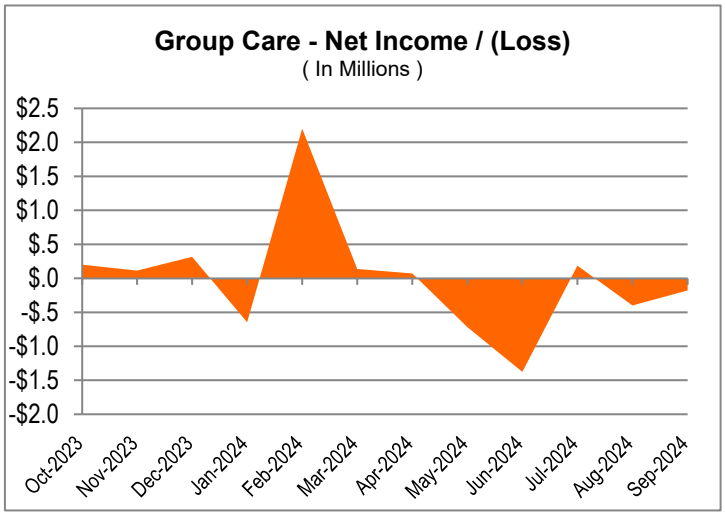




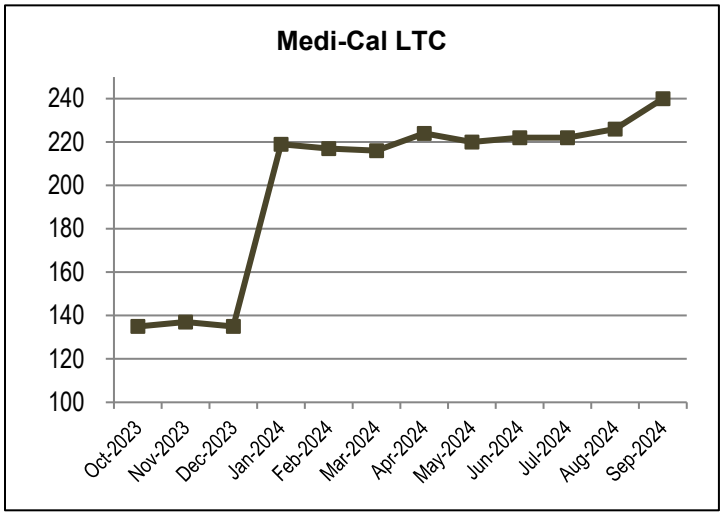


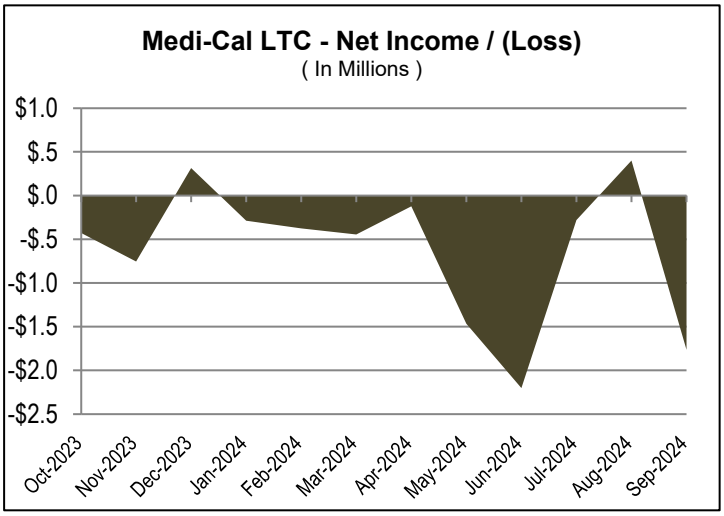


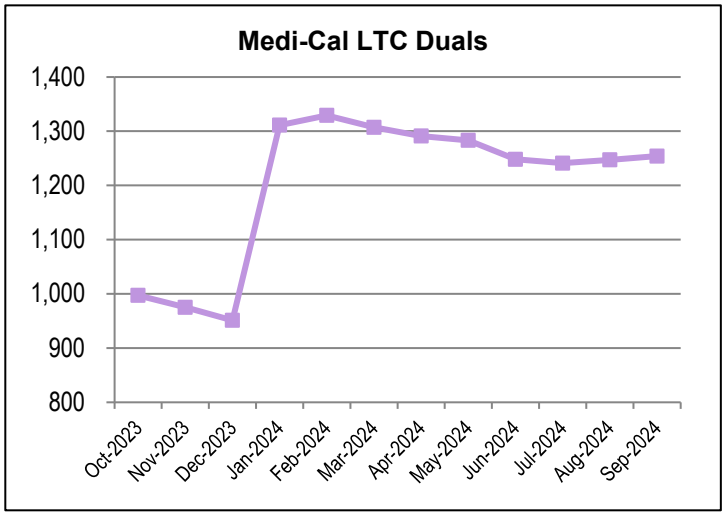


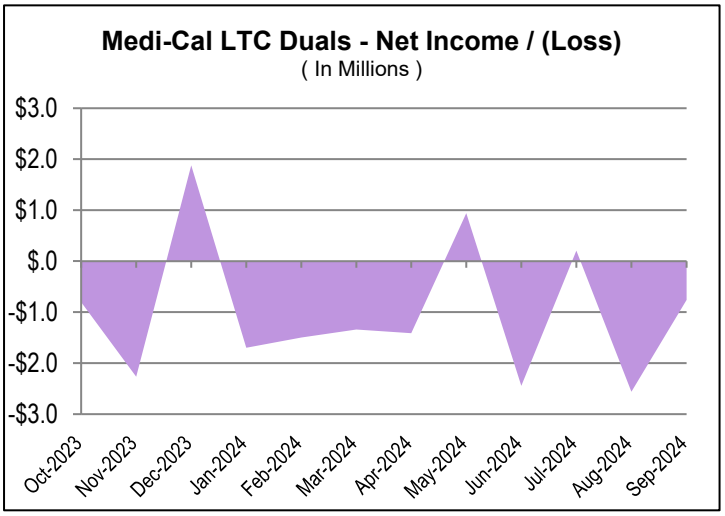


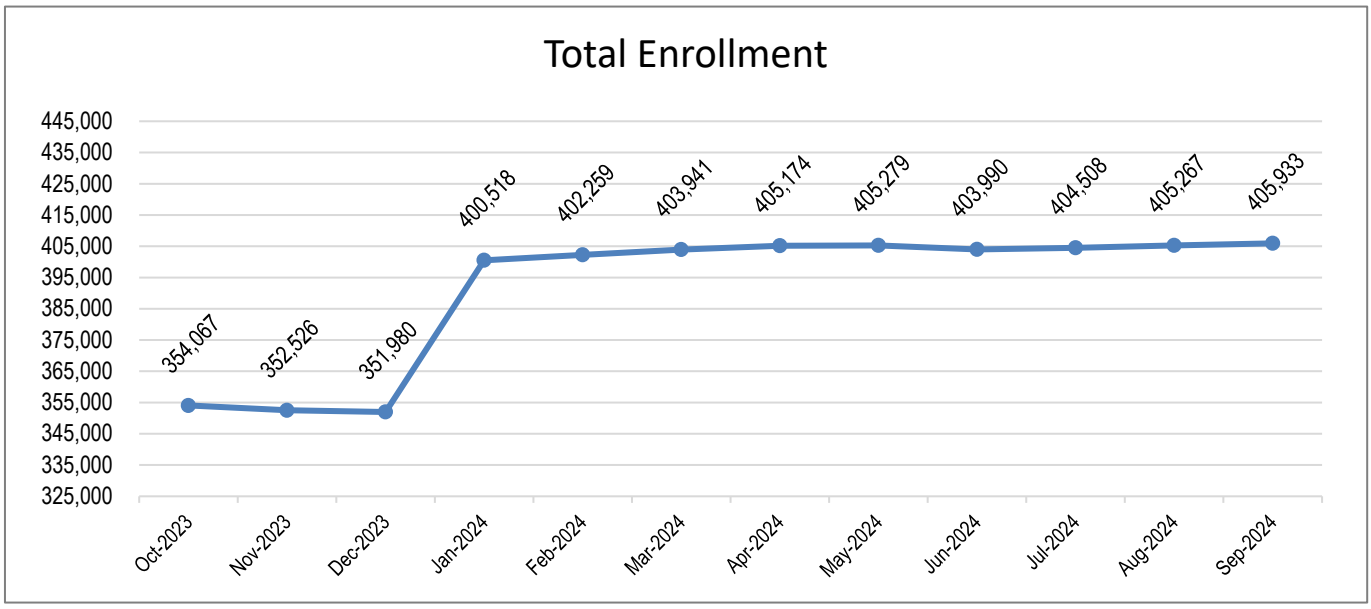
Enrollment and Profitability by Program and Category of Aid

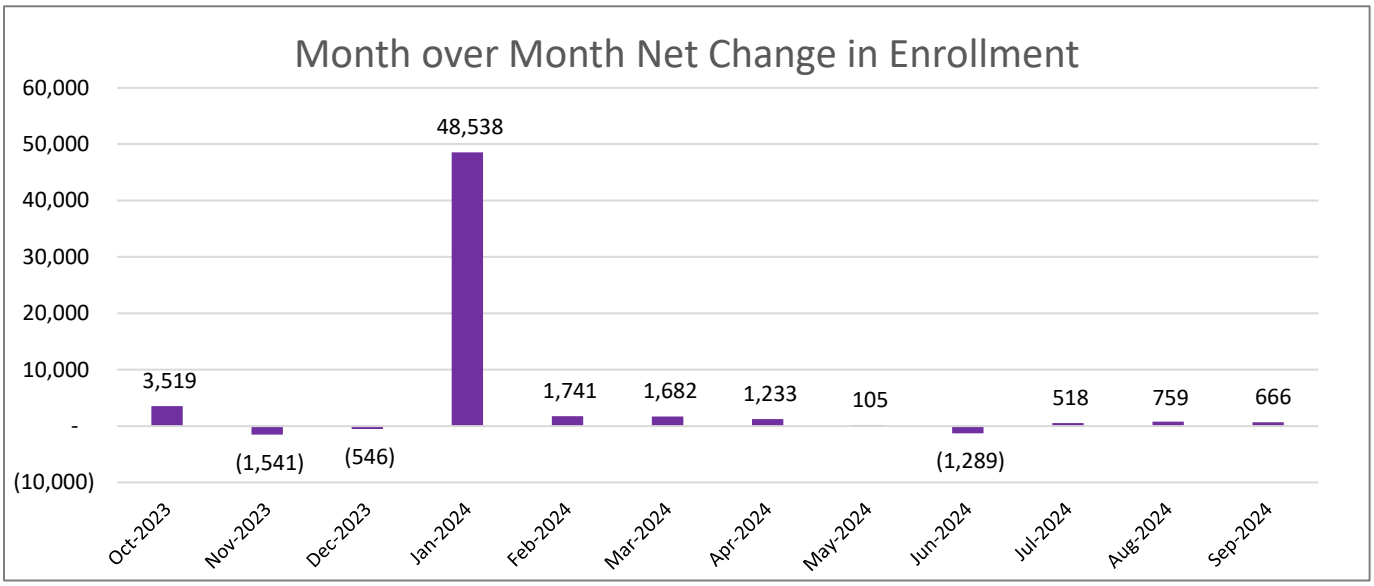








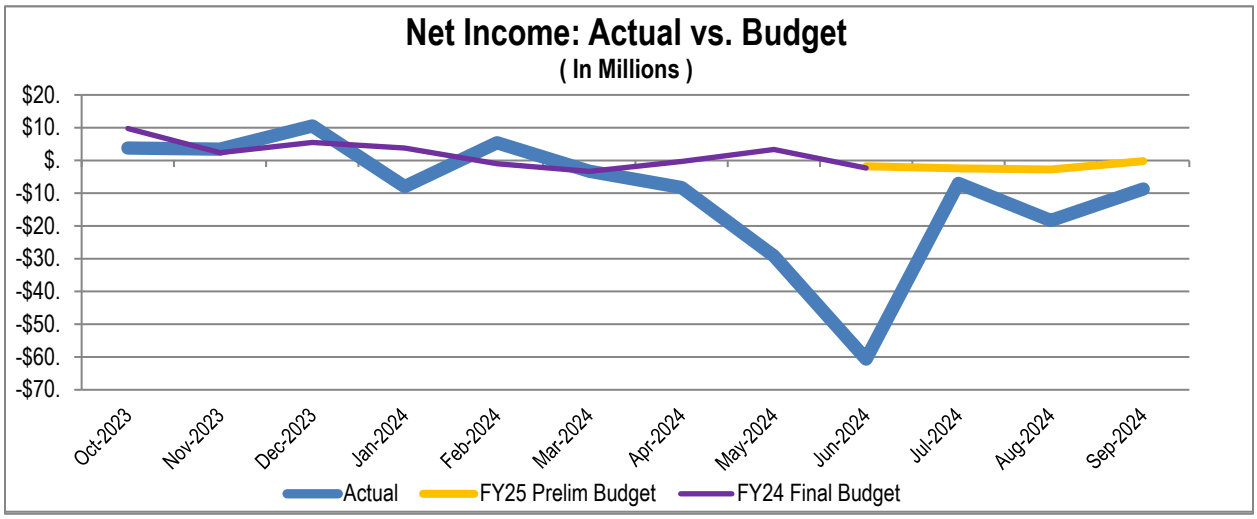




- The Public Health Emergency (PHE) ended May 2023. Disenrollments related to redetermination started July 2023 and ended May 2024. In preparation for the Single Plan Model, effective October 2023 DHCS no longer assigned members to Anthem, and instead new members were assigned to the Alliance.
- In January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

Net Income

- For the month ended September 30th, 2024:
  - Actual Net Loss $8.7 million.
  - Budgeted Net Loss $215,000.
- For the fiscal YTD ended September 30th, 2024:
  - Actual Net Loss $34.1 million.
  - Budgeted Net Loss $5.4 million.

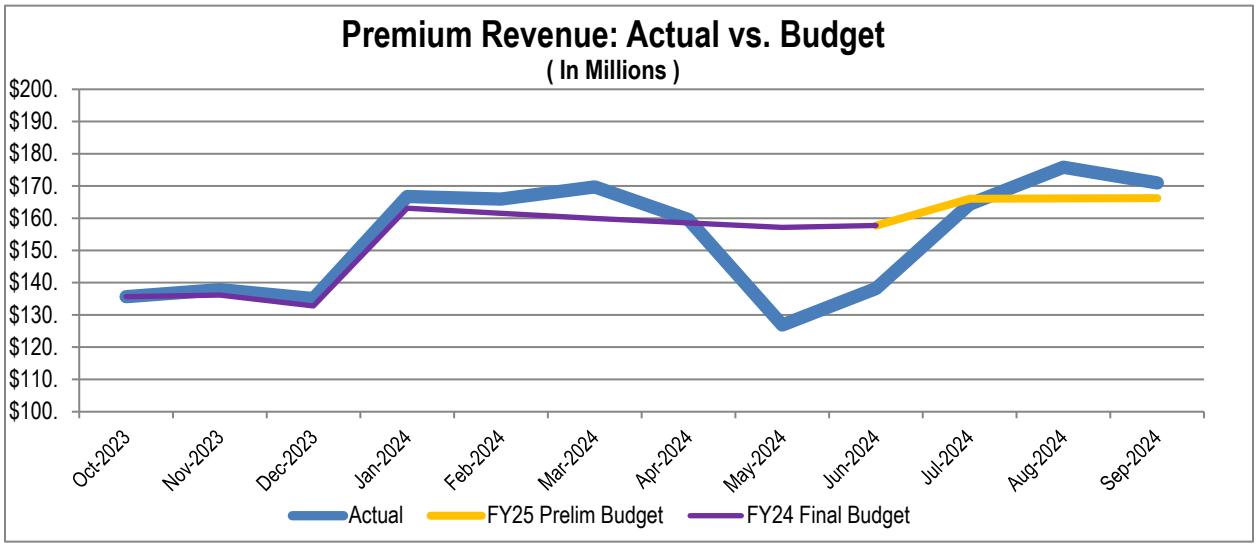


- The unfavorable variance of $8.5 million in the current month is primarily due to:
    - Unfavorable $15.5 million higher than anticipated Medical Expense.
    - Partially offset by favorable $4.7 million Premium Revenue.

Premium Revenue

- For the month ended September 30th, 2024:
    - Actual Revenue: $170.9 million.
    - Budgeted Revenue: $166.2 million.

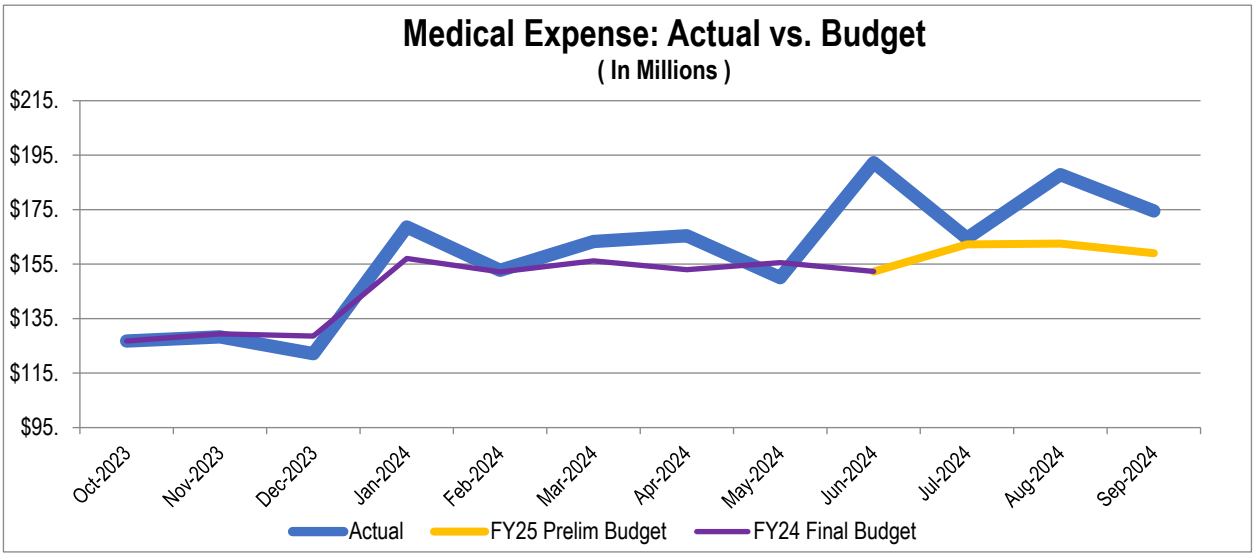
- For the fiscal YTD ended September 30th, 2024:
    - Actual Revenue: $511.1 million
    - Budgeted Revenue: $498.4 million.



- For the month ended September 30th, 2024, the favorable Premium Revenue variance of $4.7 million is primarily due to the following:
    - Favorable $1.5 million in rate changes for CY2024.
    - Favorable retroactive Medi-Cal member months for August 2023 through July 2024.

Medical Expense

- For the month ended September 30th, 2024:
    - Actual Medical Expense: $174.5 million.
    - Budgeted Medical Expense: $159.0 million.
- For the fiscal YTD ended September 30th, 2024:
    - Actual Medical Expense: $526.9 million.
    - Budgeted Medical Expense: $483.8 million.



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

- For September, updates to Fee-For-Service (FFS) increased the estimate for prior period unpaid Medical Expenses by $6.6 million. Year to date, the estimate for prior years increased by $17.8 million (per table below).

Medical Expense - Actual vs. Budget (In Dollars)

Adjusted to Eliminate the Impact of Prior Period IBNP Estimates

	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$53,289,958	$0	$53,289,958	$59,476,745	$6,186,786	10.4%
Primary Care FFS	$14,788,058	$7,436	$14,795,494	$18,218,116	$3,430,058	18.8%
Specialty Care FFS	$23,170,005	$979,860	$24,149,864	$23,828,752	$658,747	2.8%
Outpatient FFS	$36,159,429	$674,002	$36,833,430	$34,068,471	($2,090,958)	-6.1%
Ancillary FFS	$50,418,367	$2,361,883	$52,780,250	$50,471,083	$52,715	0.1%
Pharmacy FFS	$40,457,477	$1,180,202	$41,637,679	$35,979,285	($4,478,192)	-12.4%
ER Services FFS	$31,158,188	$664,136	$31,822,324	$26,021,405	($5,136,782)	-19.7%
Inpatient Hospital & SNF FFS	$153,011,371	$8,430,231	$161,441,603	$135,235,933	($17,775,438)	-13.1%
Long Term Care FFS	$94,804,097	$3,483,151	$98,287,248	$86,771,740	($8,032,357)	-9.3%
Other Benefits & Services	$11,284,486	$0	$11,284,486	$12,601,656	$1,317,170	10.5%
Net Reinsurance	$567,621	$0	$567,621	$1,157,239	$589,618	51.0%
Provider Incentive	$0	$0	$0	$0	$0	-
	$509,109,057	**$17,780,901**	**$526,889,958**	**$483,830,424**	**($25,278,633)**	**-5.2%**

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

Adjusted to Eliminate the Impact of Prior Year IBNP Estimates

	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$43.83	$0.00	$43.83	$48.85	$5.02	10.3%
Primary Care FFS	$12.16	$0.01	$12.17	$14.96	$2.80	18.7%
Specialty Care FFS	$19.06	$0.81	$19.86	$19.57	$0.51	2.6%
Outpatient FFS	$29.74	$0.55	$30.30	$27.98	($1.76)	-6.3%
Ancillary FFS	$41.47	$1.94	$43.42	$41.45	($0.02)	0.0%
Pharmacy FFS	$33.28	$0.97	$34.25	$29.55	($3.73)	-12.6%
ER Services FFS	$25.63	$0.55	$26.18	$21.37	($4.26)	-19.9%
Inpatient Hospital & SNF FFS	$125.86	$6.93	$132.80	$111.08	($14.79)	-13.3%
Long Term Care FFS	$77.98	$2.87	$80.85	$71.27	($6.71)	-9.4%
Other Benefits & Services	$9.28	$0.00	$9.28	$10.35	$1.07	10.3%
Net Reinsurance	$0.47	$0.00	$0.47	$0.95	$0.48	50.9%
Provider Incentive	$0.00	$0.00	$0.00	$0.00	$0.00	-
	$418.78	**$14.63**	**$433.40**	**$397.39**	**($21.38)**	**-5.4%**

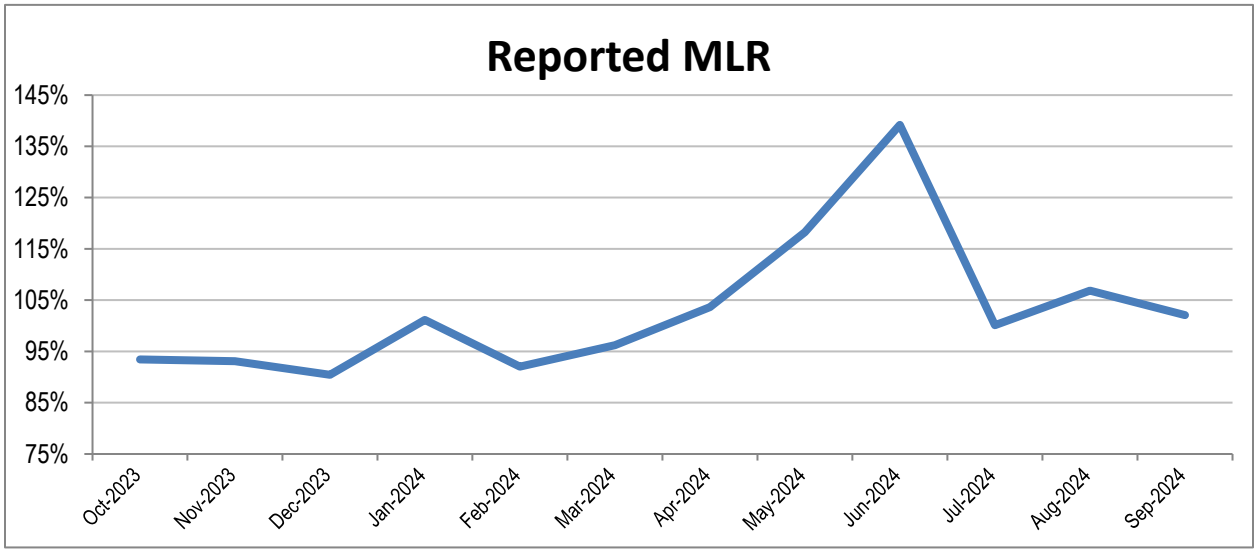
- Excluding the impact of prior year estimates for IBNP, year-to-date medical expense variance is $25.3 million unfavorable to budget. On a PMPM basis, medical expense is 5.4% unfavorable to budget. For per-member-per-month expense:
    - Capitated Expense is slightly under budget, largely driven by favorable PCP Capitation FQHC expense, partially offset by unfavorable PCP

Capitation expense due to inception of Provider Targeted Rate Increases (TRI).

- Primary Care Expense is under budget driven by the low utilization in the ACA OE, Child, Adult and Duals aid code categories.
- Specialty Care Expense is below budget, driven mostly by less than expected ACA OE, Adult and Duals aid code category utilization.
- Outpatient Expense is over budget mostly driven by utilization in the SPD, ACA OE and LTC Duals aid code categories.
- Ancillary Expense is under budget mostly due to lower than expected ACA OE utilization offset by higher utilization in the Child, Dual and Group Care populations.
- Pharmacy Expense is above budget due to Non-PBM expense driven by high utilization and unit cost in the ACA OE and SPD aid code categories.
- Emergency Room Expense is over budget driven by high utilization and unit cost in the SPD, ACA OE and Adult aid code categories.
- Inpatient Expense is over budget driven by higher utilization and unit cost due to increased catastrophic case and contract change expense in the ACA OE, SPD, Adult and Child aid code categories.
- Long Term Care Expense is over budget due to high utilization in the SPD, ACA OE, Child and Duals aid code categories.
- Other Benefits & Services is under budget, due to lower than planned community relations and grant expense.
- Net Reinsurance year-to-date 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 102.1% for the month and 103.1% for the fiscal year-to-date.



Administrative Expense

- For the month ended September 30th, 2024:
  - Actual Administrative Expense: $8.9 million.
  - Budgeted Administrative Expense: $10.0 million.

- For the fiscal YTD ended September 30th, 2024:
  - Actual Administrative Expense: $29.2 million.
  - Budgeted Administrative Expense: $27.4 million.

Summary of Administrative Expense (In Dollars) **For the Month and Fiscal Year-to-Date** **Favorable/(Unfavorable)**								
Current Month					**Year-to-Date**			
Actual	**Budget**	**Variance $**	**Variance %**		**Actual**	**Budget**	**Variance $**	**Variance %**
$6,158,741	$5,930,951	($227,789)	-3.8%	Employee Expense	$17,059,564	$17,067,893	$8,329	0.0%
78,173	74,569	(3,604)	-4.8%	Medical Benefits Admin Expense	227,213	223,536	(3,677)	-1.6%
1,368,656	1,916,111	547,455	28.6%	Purchased & Professional Services	6,373,258	5,053,041	(1,320,217)	-26.1%
1,276,071	2,029,916	753,845	37.1%	Other Admin Expense	5,531,784	5,082,309	(449,475)	-8.8%
$8,881,640	$9,951,547	$1,069,907	10.8%	Total Administrative Expense	$29,191,820	$27,426,780	($1,765,040)	-6.4%

The year-to-date variances include:

- Unfavorable in Purchased & Professional Services, primarily for the timing for Consulting Services, Other Purchased Services, Legal Fees, and HMS Recovery Fees.
- Unfavorable in Licenses, Insurance & Fees - for IT-related Licenses and Subscriptions as well as increases in Bank Fees and the timing of Insurance Premiums (early payments for the remainder of CY24).
- Unfavorable in Supplies & Other Expenses.
- Favorable Employee and Temporary Services and delayed training, travel, and other employee-related expenses.
- Favorable Building Occupancy costs.
- Favorable Printing/Postage/Promotion and Supplies & Other Expenses.

The Administrative Loss Ratio (ALR) is 5.2% of net revenue for the month and 5.7% of net revenue year-to-date. Fiscal year-to-date claims interest expense, due to delayed payment of certain claims, or recalculated interest on previously paid claims is $414,000.

Other Income / (Expense)

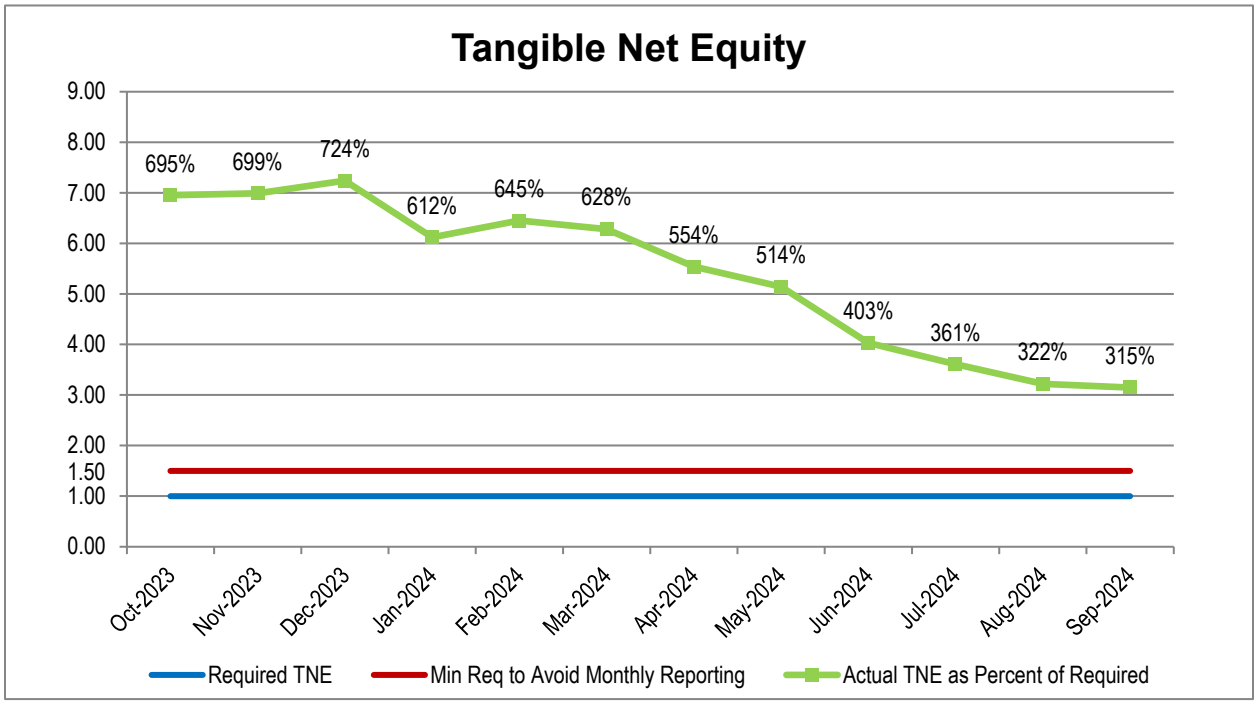
Other Income & Expense is comprised of investment income and claims interest. Fiscal year-to-date net investments show a gain of $10.9 million.

Managed Care Organization (MCO) Provider Tax

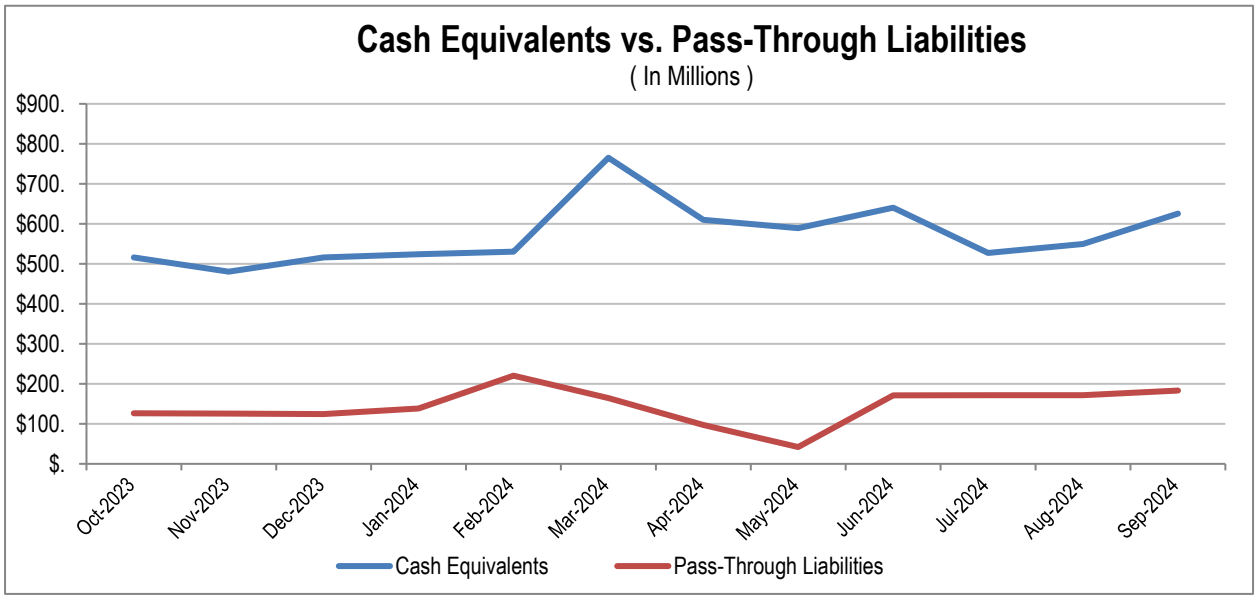
- Revenue:
  - For the month ended September 30th, 2024:
    - Actual: $194.3 million.
    - Budgeted: $47.1 million.
  - For the fiscal YTD ended September 30th, 2024:
    - Actual: $288.2 million.
    - Budgeted: $141.3 million.
- Expense:
  - For the month ended September 30th, 2024:
    - Actual: $194.3 million.
    - Budgeted: $47.1 million.
  - For the fiscal YTD ended September 30th, 2024:
    - Actual: $288.2 million.
    - Budgeted: $141.3 million.

Tangible Net Equity (TNE)

- The Department of Managed Health Care (DMHC) monitors the financial stability of health plans to ensure that they can meet their financial obligations to providers. TNE is a calculation of a company's total tangible assets minus a percentage of fee-for-service medical expenses. The Alliance exceeds DMHC's required TNE.
  - Required TNE $70.2 million
  - Actual TNE $221.3 million
  - Excess TNE $151.1 million
  - TNE % of Required TNE 315%



- To ensure appropriate liquidity and limit risk, the majority of Alliance financial assets are kept in short-term investments.
- Key Metrics
    - Cash & Cash Equivalents $625.4 million
    - Pass-Through Liabilities $183.1 million
    - Uncommitted Cash $442.3 million
    - Working Capital $159.1 million
    - Current Ratio 1.17 (regulatory minimum is 1.00)



Capital Investment

- Fiscal year-to-date capital assets acquired: $530,000.
- Annual capital budget: $1.7 million.
- A summary of year-to-date capital asset acquisitions is included in this monthly financial statement package.

Caveats to Financial Statements

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

Finance

Supporting Documents

ALAMEDA ALLIANCE FOR HEALTH
STATEMENT OF REVENUE & EXPENSES
ACTUAL VS. BUDGET
COMBINED BASIS (RESTRICTED & UNRESTRICTED FUNDS)
FOR THE MONTH AND FISCAL YTD ENDED SEPTEMBER 30, 2024

CURRENT MONTH					FISCAL YEAR TO DATE			
		$ Variance	% Variance				$ Variance	% Variance
Actual	Budget	(Unfavorable)	(Unfavorable)	Account Description	Actual	Budget	(Unfavorable)	(Unfavorable)
				MEMBERSHIP				
400,223	400,628	(405)	(0.1%)	1. Medi-Cal	1,198,637	1,200,580	(1,943)	(0.2%)
5,710	5,643	67	1.2%	2. GroupCare	17,071	16,929	142	0.8%
405,933	**406,271**	**(338)**	**(0.1%)**	**3. TOTAL MEMBER MONTHS**	**1,215,708**	**1,217,509**	**(1,801)**	**(0.1%)**
				REVENUE				
$170,947,560	$166,234,116	$4,713,443	2.8%	4. Premium Revenue	$511,092,971	$498,376,659	$12,716,312	2.6%
$194,274,080	$47,137,890	$147,136,189	312.1%	5. MCO Tax Revenue AB119	$288,215,471	$141,260,243	$146,955,228	104.0%
$365,221,640	**$213,372,007**	**$151,849,633**	**71.2%**	**6. TOTAL REVENUE**	**$799,308,442**	**$639,636,902**	**$159,671,540**	**25.0%**
				MEDICAL EXPENSES				
				Capitated Medical Expenses				
$14,174,687	$19,847,112	$5,672,425	28.6%	7. Capitated Medical Expense	$53,289,958	$59,476,745	$6,186,787	10.4%
				Fee for Service Medical Expenses				
$55,176,143	$44,079,182	($11,096,960)	(25.2%)	8. Inpatient Hospital Expense	$161,441,603	$135,235,933	($26,205,670)	(19.4%)
$2,608,833	$5,972,343	$3,363,509	56.3%	9. Primary Care Physician Expense	$14,795,494	$18,218,116	$3,422,622	18.8%
$7,897,040	$7,787,809	($109,231)	(1.4%)	10. Specialty Care Physician Expense	$24,149,864	$23,828,752	($321,112)	(1.3%)
$21,004,958	$16,603,808	($4,401,150)	(26.5%)	11. Ancillary Medical Expense	$52,780,250	$50,471,082	($2,309,168)	(4.6%)
$12,354,058	$11,131,245	($1,222,813)	(11.0%)	12. Outpatient Medical Expense	$36,833,430	$34,068,471	($2,764,960)	(8.1%)
$9,129,136	$8,522,652	($606,484)	(7.1%)	13. Emergency Expense	$31,822,324	$26,021,405	($5,800,918)	(22.3%)
$14,674,368	$11,741,636	($2,932,732)	(25.0%)	14. Pharmacy Expense	$41,637,679	$35,979,285	($5,658,394)	(15.7%)
$32,967,578	$28,383,488	($4,584,090)	(16.2%)	15. Long Term Care Expense	$98,287,248	$86,771,740	($11,515,508)	(13.3%)
$155,812,113	$134,222,163	($21,589,951)	(16.1%)	16. Total Fee for Service Expense	$461,747,892	$410,594,784	($51,153,108)	(12.5%)
$4,185,938	$4,542,108	$356,170	7.8%	17. Other Benefits & Services	$11,284,486	$12,601,657	$1,317,170	10.5%
$350,350	$385,992	$35,642	9.2%	18. Reinsurance Expense	$567,621	$1,157,239	$589,618	51.0%
$174,523,088	**$158,997,375**	**($15,525,713)**	**(9.8%)**	**20. TOTAL MEDICAL EXPENSES**	**$526,889,958**	**$483,830,425**	**($43,059,533)**	**(8.9%)**
$190,698,552	**$54,374,632**	**$136,323,920**	**250.7%**	**21. GROSS MARGIN**	**$272,418,484**	**$155,806,477**	**$116,612,007**	**74.8%**
				ADMINISTRATIVE EXPENSES				
$6,158,741	$5,930,952	($227,789)	(3.8%)	22. Personnel Expense	$17,059,564	$17,067,895	$8,330	0.0%
$78,173	$74,569	($3,604)	(4.8%)	23. Benefits Administration Expense	$227,213	$223,536	($3,677)	(1.6%)
$1,368,656	$1,916,111	$547,455	28.6%	24. Purchased & Professional Services	$6,373,258	$5,053,042	($1,320,217)	(26.1%)
$1,276,071	$2,029,916	$753,845	37.1%	25. Other Administrative Expense	$5,531,784	$5,082,310	($449,474)	(8.8%)
$8,881,640	**$9,951,548**	**$1,069,908**	**10.8%**	**26. TOTAL ADMINISTRATIVE EXPENSES**	**$29,191,820**	**$27,426,783**	**($1,765,037)**	**(6.4%)**
$194,274,080	**$47,137,890**	**($147,136,189)**	**(312.1%)**	**27. MCO TAX EXPENSES**	**$288,215,471**	**$141,260,243**	**($146,955,228)**	**(104.0%)**
($12,457,168)	**($2,714,807)**	**($9,742,362)**	**(358.9%)**	**28. NET OPERATING INCOME / (LOSS)**	**($44,988,807)**	**($12,880,549)**	**($32,108,258)**	**(249.3%)**
				OTHER INCOME / EXPENSES				
$3,737,936	**$2,500,000**	**$1,237,936**	**49.5%**	**29. TOTAL OTHER INCOME / (EXPENSES)**	**$10,925,393**	**$7,500,000**	**$3,425,393**	**45.7%**
($8,719,232)	**($214,807)**	**($8,504,425)**	**(3,959.1%)**	**30. NET SURPLUS (DEFICIT)**	**($34,063,414)**	**($5,380,549)**	**($28,682,865)**	**(533.1%)**
102.1%	95.6%	-6.5%	-6.8%	31. Medical Loss Ratio	103.1%	97.1%	-6.0%	-6.2%
5.2%	6.0%	0.8%	13.3%	32. Administrative Expense Ratio	5.7%	5.5%	-0.2%	-3.6%
-2.4%	-0.1%	-2.3%	-2,300.0%	33. Net Surplus (Deficit) Ratio	-4.3%	-0.8%	-3.5%	-437.5%

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

	9/30/2024	8/31/2024	Difference	% Difference
CURRENT ASSETS				
Cash and Cash Equivalent				
Cash	$367,885	$41,187,550	($40,819,665)	-99.11%
CNB Short-Term Investment	625,052,479	508,214,755	116,837,724	22.99%
Interest Receivable	5,107,654	4,360,743	746,911	17.13%
Premium Receivables	464,364,872	373,395,728	90,969,144	24.36%
Reinsurance Recovery Receivable	7,223,012	5,820,012	1,403,000	24.11%
Other Receivables	4,922,657	4,489,020	433,638	9.66%
Prepaid Expenses	797,015	256,172	540,844	211.13%
TOTAL CURRENT ASSETS	**1,107,835,574**	**937,723,979**	**170,111,595**	**18.14%**
OTHER ASSETS				
CNB Long-Term Investment	47,159,283	56,176,155	(9,016,872)	-16.05%
CalPERS Net Pension Asset	(6,144,132)	(6,144,132)	0	0.00%
Deferred Outflow	14,319,532	14,319,532	0	0.00%
Restricted Asset-Bank Note	350,000	350,000	0	0.00%
GASB 87-Lease Assets (Net)	609,183	675,096	(65,913)	-9.76%
GASB 96-SBITA Assets (Net)	3,792,137	3,980,524	(188,386)	-4.73%
TOTAL OTHER ASSETS	**60,086,003**	**69,357,175**	**(9,271,172)**	**-13.37%**
PROPERTY AND EQUIPMENT				
Land, Building & Improvements	9,842,648	9,842,648	0	0.00%
Furniture And Equipment	13,071,003	13,071,003	0	0.00%
Leasehold Improvement	902,447	902,447	0	0.00%
Internally Developed Software	14,824,002	14,824,002	0	0.00%
Fixed Assets at Cost	38,640,099	38,640,099	0	0.00%
Less: Accumulated Depreciation	(32,836,374)	(32,777,000)	(59,373)	0.18%
PROPERTY AND EQUIPMENT (NET)	**5,803,725**	**5,863,098**	**(59,373)**	**-1.01%**
TOTAL ASSETS	**1,173,725,302**	**1,012,944,252**	**160,781,050**	**15.87%**
CURRENT LIABILITIES				
Trade Accounts Payable	5,257,431	5,953,575	(696,144)	-11.69%
Incurred But Not Reported Claims	315,432,746	307,356,497	8,076,249	2.63%
Other Medical Liabilities	108,836,933	153,929,749	(45,092,817)	-29.29%
Pass-Through Liabilities	183,131,713	171,565,662	11,566,051	6.74%
MCO Tax Liabilities	322,530,053	128,255,973	194,274,080	151.47%
GASB 87 and 96 ST Liabilities	3,016,225	3,768,460	(752,235)	-19.96%
Payroll Liabilities	10,500,034	8,365,561	2,134,473	25.51%
TOTAL CURRENT LIABILITIES	**948,705,135**	**779,195,478**	**169,509,657**	**21.75%**
LONG TERM LIABILITIES				
GASB 87 and 96 LT Liabilities	380,908	390,283	(9,375)	-2.40%
Deferred Inflow	3,327,530	3,327,530	0	0.00%
TOTAL LONG TERM LIABILITIES	**3,708,438**	**3,717,813**	**(9,375)**	**-0.25%**
TOTAL LIABILITIES	**952,413,573**	**782,913,291**	**169,500,282**	**21.65%**
NET WORTH				
Contributed Capital	840,233	840,233	0	0.00%
Restricted & Unrestricted Funds	254,534,911	254,534,911	0	0.00%
Year-To-Date Net Surplus (Deficit)	(34,063,414)	(25,344,182)	(8,719,232)	34.40%
TOTAL NET WORTH	**221,311,730**	**230,030,961**	**(8,719,232)**	**-3.79%**
TOTAL LIABILITIES AND NET WORTH	**1,173,725,302**	**1,012,944,252**	**160,781,050**	**15.87%**
Cash Equivalents	625,420,363	549,402,305	76,018,059	13.84%
Pass-Through	183,131,713	171,565,662	11,566,051	6.74%
Uncommitted Cash	442,288,650	377,836,642	64,452,008	17.06%
Working Capital	159,130,439	158,528,501	601,939	0.38%
Current Ratio	116.8%	120.3%	-3.5%	-2.9%

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

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM OPERATING ACTIVITIES				
Commercial Premium Cash Flows				
Commercial Premium Revenue	$3,127,770	$9,339,564	$17,084,126	$9,339,564
GroupCare Receivable	(15,039)	(3,109,292)	(564,807)	(3,109,292)
Total	3,112,731	6,230,272	16,519,319	6,230,272
Medi-Cal Premium Cash Flows				
Medi-Cal Revenue	362,093,868	789,968,878	1,549,041,941	789,968,877
Premium Receivable	(90,954,104)	(94,312,060)	(323,353,516)	(94,312,060)
Total	271,139,764	695,656,818	1,225,688,425	695,656,817
Investment & Other Income Cash Flows				
Other Revenues	1,281,889	2,539,082	2,165,819	2,539,082
Interest Income	2,470,112	8,423,219	17,256,502	8,423,219
Interest Receivable	(746,911)	(3,191,590)	(2,604,196)	(3,191,590)
Total	3,005,090	7,770,711	16,818,125	7,770,711
Medical & Hospital Cash Flows				
Total Medical Expenses	(174,523,089)	(526,889,958)	(1,034,625,358)	(526,889,960)
Other Health Care Receivables	(1,842,849)	(1,184,019)	(3,717,413)	(1,184,019)
Capitation Payable	-	-	-	-
IBNP Payable	8,076,249	19,128,487	78,384,431	19,128,487
Other Medical Payable	(30,847,574)	(43,873,111)	25,985,883	(43,873,111)
Risk Share Payable	(2,679,192)	(2,679,192)	(2,679,192)	(2,679,192)
New Health Program Payable	-	-	-	-
Total	(201,816,455)	(555,497,793)	(936,651,649)	(555,497,795)
Administrative Cash Flows				
Total Administrative Expenses	(8,895,706)	(29,228,728)	(58,013,195)	(29,228,728)
Prepaid Expenses	(540,843)	(558,398)	(501,897)	(558,398)
Other Receivables	6,212	32,891	(22,755)	32,891
CalPERS Pension	-	-	637,208	-
Trade Accounts Payable	(696,144)	(1,232,865)	(262,069)	(1,232,865)
Payroll Liabilities	2,134,474	2,400,808	219,919	2,400,808
GASB Assets and Liabilities	(507,311)	(502,701)	(124,690)	(502,701)
Depreciation Expense	59,373	173,701	(191,946)	173,701
Total	(8,439,945)	(28,915,292)	(58,259,425)	(28,915,292)
MCO Tax AB119 Cash Flows				
MCO Tax Expense AB119	(194,274,080)	(288,215,471)	(625,010,393)	(288,215,471)
MCO Tax Liabilities	194,274,080	162,746,539	262,692,504	162,746,539
Total	0	(125,468,932)	(362,317,889)	(125,468,932)
Net Cash Flows from Operating Activities	**67,001,185**	**(224,216)**	**(98,203,094)**	**(224,219)**

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

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM INVESTING ACTIVITIES				
Investment Cash Flows				
Long Term Investments	9,016,873	(14,167,038)	(41,967,559)	(14,167,035)
Total	9,016,873	(14,167,038)	(41,967,559)	(14,167,035)
Restricted Cash & Other Asset Cash Flows				
Restricted Assets-Treasury Account	-	-	-	-
Total	-	-	-	-
Fixed Asset Cash Flows				
Fixed Asset Acquisitions	-	(529,610)	214,393	(529,610)
Purchases of Property and Equipment	-	(529,610)	214,393	(529,610)
Net Cash Flows from Investing Activities	**9,016,873**	**(14,696,648)**	**(41,753,166)**	**(14,696,645)**
Net Change in Cash	**76,018,058**	**(14,920,864)**	**(139,956,260)**	**(14,920,864)**
Rounding	3.00	2.00	2.00	2.00
Cash @ Beginning of Period	549,402,303	640,341,226	765,376,622	640,341,226
Cash @ End of Period	**$625,420,364**	**$625,420,364**	**$625,420,364**	**$625,420,364**
Variance	-	-	-	-

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

	MONTH	3 MONTHS	6 MONTHS	YTD
NET INCOME RECONCILIATION				
Net Income / (Loss)	($8,719,236)	($34,063,414)	($132,100,558)	($34,063,417)
Add back: Depreciation & Amortization	59,373	173,701	(191,946)	173,701
Receivables				
Premiums Receivable	(90,954,104)	(94,312,060)	(323,353,516)	(94,312,060)
Interest Receivable	(746,911)	(3,191,590)	(2,604,196)	(3,191,590)
Other Health Care Receivables	(1,842,849)	(1,184,019)	(3,717,413)	(1,184,019)
Other Receivables	6,212	32,891	(22,755)	32,891
GroupCare Receivable	(15,039)	(3,109,292)	(564,807)	(3,109,292)
Total	(93,552,691)	(101,764,070)	(330,262,687)	(101,764,070)
Prepaid Expenses	(540,843)	(558,398)	(501,897)	(558,398)
Trade Payables	(696,144)	(1,232,865)	(262,069)	(1,232,865)
Claims Payable and Shared Risk Pool				
IBNP Payable	8,076,249	19,128,487	78,384,431	19,128,487
Capitation Payable & Other Medical Payable	(30,847,574)	(43,873,111)	25,985,883	(43,873,111)
Risk Share Payable	(2,679,192.00)	(2,679,192.00)	(2,679,192)	(2,679,192)
Claims Payable				
Total	(25,450,517)	(27,423,816)	101,691,122	(27,423,816)
Other Liabilities				
CalPERS Pension	-	-	637,208.00	-
Payroll Liabilities	2,134,474	2,400,809	219,919	2,400,808
GASB Assets and Liabilities	(507,311)	(502,701)	(124,690)	(502,701)
New Health Program	-	-	-	-
MCO Tax Liabilities	194,274,080	162,746,539	262,692,504	162,746,539
Total	195,901,243	164,644,647	263,424,941	164,644,646
Rounding	-	(1.00)	-	-
Cash Flows from Operating Activities	**67,001,185**	**(224,216)**	**(98,203,094)**	**(224,219)**
Variance	-	-	-	-

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

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOW STATEMENT:				
Cash Flows from Operating Activities:				
Cash Received				
Capitation Received from State of CA	$271,139,764	$695,656,818	$1,225,688,425	$695,656,817
Medicare Revenue	$0	$0	$0	$0
GroupCare Premium Revenue	3,112,731	6,230,272	16,519,319	6,230,272
Other Income	1,281,889	2,539,082	2,165,819	2,539,082
Interest Income	1,723,201	5,231,629	14,652,306	5,231,629
Less Cash Paid				
Medical Expenses	(201,816,455)	(555,497,793)	(936,651,649)	(555,497,795)
Vendor & Employee Expenses	(8,439,945)	(28,915,292)	(58,259,425)	(28,915,292)
MCO Tax Expense AB119	0	(125,468,932)	(362,317,889)	(125,468,932)
Net Cash Flows from Operating Activities	**67,001,185**	**(224,216)**	**(98,203,094)**	**(224,219)**
Cash Flows from Investing Activities:				
Long Term Investments	9,016,873	(14,167,038)	(41,967,559)	(14,167,035)
Restricted Assets-Treasury Account	0	0	0	0
Purchases of Property and Equipment	0	(529,610)	214,393	(529,610)
Net Cash Flows from Investing Activities	**9,016,873**	**(14,696,648)**	**(41,753,166)**	**(14,696,645)**
Net Change in Cash	**76,018,058**	**(14,920,864)**	**(139,956,260)**	**(14,920,864)**
Rounding	3.00	2.00	2.00	2.00
Cash @ Beginning of Period	549,402,303	640,341,226	765,376,622	640,341,226
Cash @ End of Period	**$625,420,364**	**$625,420,364**	**$625,420,364**	**$625,420,364**
Variance	$0	-	-	-
RECONCILIATION OF NET INCOME TO NET CASH FLOW FROM OPERATING ACTIVITIES:				
Net Income / (Loss)	($8,719,236)	($34,063,413)	($132,100,559)	($34,063,417)
Add Back: Depreciation	59,373	173,701	(191,946)	173,701
Net Change in Operating Assets & Liabilities				
Premium & Other Receivables	(93,552,691)	(101,764,070)	(330,262,687)	(101,764,070)
Prepaid Expenses	(540,843)	(558,399)	(501,896)	(558,398)
Trade Payables	(696,144)	(1,232,865)	(262,069)	(1,232,865)
Claims Payable, IBNP and Risk Sharing	(25,450,517)	(27,423,816)	101,691,122	(27,423,816)
Deferred Revenue	0	0	0	0
Other Liabilities	195,901,243	164,644,647	263,424,941	164,644,646
Total	67,001,185	(224,215)	(98,203,094)	(224,219)
Rounding	-	(1)	-	-
Cash Flows from Operating Activities	**$67,001,185**	**($224,216)**	**($98,203,094)**	**($224,219)**
Variance	$0	-	-	-

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE MONTH OF SEPTEMBER 2024

	Medi-Cal Child	Medi-Cal Adult	Medi-Cal SPD	Medi-Cal ACA OE	Medi-Cal Duals	Medi-Cal LTC	Medi-Cal LTC Duals	Medi-Cal Total	Group Care	Medicare	Grand Total
Enrollments/Member Months	109,731	62,550	35,319	151,005	40,124	240	1,254	400,223	5,710	-	405,933
Revenue	$69,164,506	$49,903,853	$62,360,585	$129,561,778	$39,213,086	$2,255,399	$9,634,661	$362,093,870	$3,127,770	$0	$365,221,640
Medical Expense	13,179,964	19,960,674	49,396,116	59,589,474	15,949,486	3,828,921	9,401,743	171,306,378	3,216,710	-	$174,523,088
Gross Margin	$55,984,542	$29,943,180	$12,964,470	$69,972,304	$23,263,601	($1,573,522)	$232,918	$190,787,492	($88,940)	$0	$190,698,552
Administrative Expense	$427,678	$1,010,590	$2,162,818	$2,767,463	$739,493	$153,681	$705,464	$7,967,187	$139,310	$775,143	$8,881,640
MCO Tax Expense	$53,562,037	$30,646,127	$17,084,802	$72,735,509	$19,513,372	$110,627	$621,606	$194,274,080	$0	$0	$194,274,080
Operating Income / (Expense)	$1,994,826	($1,713,538)	($6,283,150)	($5,530,667)	$3,010,736	($1,837,830)	($1,094,152)	($11,453,775)	($228,250)	($775,143)	($12,457,168)
Other Income / (Expense)	$189,025	$468,216	$1,004,745	$1,278,022	$343,437	$72,291	$332,261	$3,687,998	$49,938	$0	$3,737,936
Net Income / (Loss)	$2,183,852	($1,245,322)	($5,278,405)	($4,252,645)	$3,354,173	($1,765,539)	($761,891)	($7,765,777)	($178,311)	($775,143)	($8,719,232)
PMPM Metrics:											
Revenue PMPM	$630.31	$797.82	$1,765.64	$858.00	$977.30	$9,397.50	$7,683.14	$904.73	$547.77	$0.00	$899.71
Medical Expense PMPM	$120.11	$319.12	$1,398.57	$394.62	$397.50	$15,953.84	$7,497.40	$428.03	$563.35	$0.00	$429.93
Gross Margin PMPM	$510.20	$478.71	$367.07	$463.38	$579.79	($6,556.34)	$185.74	$476.70	($15.58)	$0.00	$469.78
Administrative Expense PMPM	$3.90	$16.16	$61.24	$18.33	$18.43	$640.34	$562.57	$19.91	$24.40	$0.00	$21.88
MCO Tax Expense PMPM	$488.12	$489.95	$483.73	$481.68	$486.33	$460.94	$495.70	$485.41	$0.00	$0.00	$478.59
Operating Income / (Expense) PMPM	$18.18	($27.39)	($177.90)	($36.63)	$75.04	($7,657.63)	($872.53)	($28.62)	($39.97)	$0.00	($30.69)
Other Income / (Expense) PMPM	$1.72	$7.49	$28.45	$8.46	$8.56	$301.21	$264.96	$9.21	$8.75	$0.00	$9.21
Net Income / (Loss) PMPM	$19.90	($19.91)	($149.45)	($28.16)	$83.60	($7,356.41)	($607.57)	($19.40)	($31.23)	$0.00	($21.48)
Ratio:											
Medical Loss Ratio	84.5%	103.7%	109.1%	104.9%	81.0%	178.5%	104.3%	102.1%	102.8%	0.0%	102.1%
Administrative Expense Ratio	2.7%	5.2%	4.8%	4.9%	3.8%	7.2%	7.8%	4.7%	4.5%	0.0%	5.2%
Net Income Ratio	3.2%	-2.5%	-8.5%	-3.3%	8.6%	-78.3%	-7.9%	-2.1%	-5.7%	0.0%	-2.4%

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE FISCAL YEAR TO DATE SEPTEMBER 2024

	Medi-Cal Child	Medi-Cal Adult	Medi-Cal SPD	Medi-Cal ACA OE	Medi-Cal Duals	Medi-Cal LTC	Medi-Cal LTC Duals	Medi-Cal Total	Group Care	Medicare	Grand Total
Enrollments/Member Months	329,466	187,899	105,514	451,288	120,040	688	3,742	1,198,637	17,071	-	1,215,708
Revenue	$127,103,753	$110,972,145	$153,821,557	$283,836,672	$75,069,799	$7,338,822	$31,826,129	$789,968,878	$9,339,564	$0	$799,308,442
Medical Expense	41,326,106	63,505,466	145,310,138	182,853,805	43,475,280	8,495,223	32,498,516	517,464,533	9,427,425	(2,000)	$526,889,958
Gross Margin	$85,777,647	$47,466,679	$8,511,420	$100,982,867	$31,594,519	($1,156,402)	($672,386)	$272,504,344	($87,860)	$2,000	$272,418,484
Administrative Expense	$1,456,120	$3,498,487	$7,514,032	$9,561,348	$2,623,849	$536,785	$2,504,197	$27,694,817	$452,335	$1,044,668	$29,191,820
MCO Tax Expense	$79,416,058	$45,394,691	$25,343,946	$108,066,806	$28,916,288	$163,338	$914,344	$288,215,471	$0	$0	$288,215,471
Operating Income / (Expense)	$4,905,470	($1,426,498)	($24,346,558)	($16,645,287)	$54,382	($1,856,525)	($4,090,928)	($43,405,944)	($540,195)	($1,042,668)	($44,988,807)
Other Income / (Expense)	$552,490	$1,368,524	$2,936,709	$3,735,455	$1,003,813	$211,294	$971,146	$10,779,431	$145,961	$0	$10,925,393
Net Income / (Loss)	$5,457,960	($57,975)	($21,409,848)	($12,909,832)	$1,058,195	($1,645,230)	($3,119,782)	($32,626,512)	($394,234)	($1,042,668)	($34,063,414)
PMPM Metrics:											
Revenue PMPM	$385.79	$590.59	$1,457.83	$628.95	$625.37	$10,666.89	$8,505.11	$659.06	$547.10	$0.00	$657.48
Medical Expense PMPM	$125.43	$337.98	$1,377.16	$405.18	$362.17	$12,347.71	$8,684.80	$431.71	$552.25	$0.00	$433.40
Gross Margin PMPM	$260.35	$252.62	$80.67	$223.77	$263.20	($1,680.82)	($179.69)	$227.35	($5.15)	$0.00	$224.08
Administrative Expense PMPM	$4.42	$18.62	$71.21	$21.19	$21.86	$780.21	$669.21	$23.11	$26.50	$0.00	$24.01
MCO Tax Expense PMPM	$241.04	$241.59	$240.20	$239.46	$240.89	$237.41	$244.35	$240.45	$0.00	$0.00	$237.08
Operating Income / (Expense) PMPM	$14.89	($7.59)	($230.74)	($36.88)	$0.45	($2,698.44)	($1,093.25)	($36.21)	($31.64)	$0.00	($37.01)
Other Income / (Expense) PMPM	$1.68	$7.28	$27.83	$8.28	$8.36	$307.11	$259.53	$8.99	$8.55	$0.00	$8.99
Net Income / (Loss) PMPM	$16.57	($0.31)	($202.91)	($28.61)	$8.82	($2,391.32)	($833.72)	($27.22)	($23.09)	$0.00	($28.02)
Ratio:											
Medical Loss Ratio	86.7%	96.8%	113.1%	104.0%	94.2%	118.4%	105.1%	103.1%	100.9%	0.0%	103.1%
Administrative Expense Ratio	3.1%	5.3%	5.8%	5.4%	5.7%	7.5%	8.1%	5.5%	4.8%	0.0%	5.7%
Net Income Ratio	4.3%	-0.1%	-13.9%	-4.5%	1.4%	-22.4%	-9.8%	-4.1%	-4.2%	0.0%	-4.3%

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				ADMINISTRATIVE EXPENSES SUMMARY (ADMIN. DEPT. ONLY)				
$6,158,741	$5,930,952	($227,789)	(3.8%)	Personnel Expenses	$17,059,564	$17,067,895	$8,330	0.0%
$78,173	$74,569	($3,604)	(4.8%)	Benefits Administration Expense	$227,213	$223,536	($3,677)	(1.6%)
$1,368,656	$1,916,111	$547,455	28.6%	Purchased & Professional Services	$6,373,258	$5,053,042	($1,320,217)	(26.1%)
$480,341	$576,903	$96,562	16.7%	Occupancy	$1,460,312	$1,713,195	$252,882	14.8%
$318,728	$996,025	$677,297	68.0%	Printing Postage & Promotion	$1,076,541	$1,654,229	$577,689	34.9%
$326,577	$327,699	$1,122	0.3%	Licenses Insurance & Fees	$2,414,524	$1,317,544	($1,096,980)	(83.3%)
$150,424	$129,289	($21,135)	(16.3%)	Other Administrative Expense	$580,407	$397,342	($183,065)	(46.1%)
$2,722,900	$4,020,596	$1,297,696	32.3%	Total Other Administrative Expenses (excludes Personnel Expenses)	$12,132,255	$10,358,888	($1,773,367)	(17.1%)
$8,881,640	$9,951,548	$1,069,908	10.8%	Total Administrative Expenses	$29,191,820	$27,426,783	($1,765,037)	(6.4%)

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
3,836,603	3,759,858	(76,745)	(2.0%)	Salaries & Wages	11,096,321	11,495,950	399,629	3.5%
407,007	365,538	(41,469)	(11.3%)	Paid Time Off	955,667	1,035,722	80,055	7.7%
1,025	6,755	5,730	84.8%	Compensated Incentives	3,556	13,955	10,399	74.5%
0	400,000	400,000	100.0%	Severence	0	400,000	400,000	100.0%
63,427	61,047	(2,381)	(3.9%)	Payroll Taxes	183,496	177,343	(6,153)	(3.5%)
53,148	24,960	(28,188)	(112.9%)	Overtime	212,028	74,880	(137,148)	(183.2%)
332,553	286,808	(45,745)	(15.9%)	CalPERS ER Match	969,682	831,948	(137,734)	(16.6%)
1,071,076	665,439	(405,637)	(61.0%)	Employee Benefits	2,893,335	1,898,884	(994,451)	(52.4%)
3,116	0	(3,116)	0.0%	Personal Floating Holiday	4,872	0	(4,872)	0.0%
18,179	32,000	13,821	43.2%	Language Pay	60,785	83,500	22,715	27.2%
4,040	0	(4,040)	0.0%	Med Ins Opted Out Stipend	11,590	0	(11,590)	0.0%
248,810	0	(248,810)	0.0%	Holiday Bonus	248,810	0	(248,810)	0.0%
57,075	0	(57,075)	0.0%	Sick Leave	186,227	0	(186,227)	0.0%
0	21,017	21,017	100.0%	Compensated Employee Relations	25	55,075	55,050	100.0%
19,830	25,000	5,170	20.7%	Work from Home Stipend	58,740	71,250	12,510	17.6%
891	7,484	6,592	88.1%	Mileage, Parking & LocalTravel	3,569	19,276	15,707	81.5%
934	45,597	44,663	98.0%	Travel & Lodging	8,760	110,184	101,424	92.0%
25,829	146,730	120,900	82.4%	Temporary Help Services	69,252	585,869	516,617	88.2%
4,315	56,515	52,200	92.4%	Staff Development/Training	34,399	145,182	110,783	76.3%
10,883	26,206	15,323	58.5%	Staff Recruitment/Advertisement	58,450	68,875	10,425	15.1%
6,158,741	**5,930,952**	**(227,789)**	**(3.8%)**	**Personnel Expense**	**17,059,564**	**17,067,895**	**8,330**	**0.0%**
25,690	21,753	(3,936)	(18.1%)	Pharmacy Administrative Fees	69,976	65,260	(4,716)	(7.2%)
52,483	52,815	332	0.6%	Telemedicine Admin. Fees	157,237	158,276	1,039	0.7%
78,173	**74,569**	**(3,604)**	**(4.8%)**	**Benefits Administration Expense**	**227,213**	**223,536**	**(3,677)**	**(1.6%)**
612,872	189,038	(423,834)	(224.2%)	Consultant Fees - Non Medical	2,008,427	619,504	(1,388,923)	(224.2%)
729,336	519,809	(209,527)	(40.3%)	Computer Support Services	1,565,778	1,404,199	(161,580)	(11.5%)
12,500	15,000	2,500	16.7%	Audit Fees	41,535	45,000	3,465	7.7%
0	8	8	100.0%	Consultant Fees - Medical	(15,355)	25	15,380	61,544.6%
251,553	235,375	(16,177)	(6.9%)	Other Purchased Services	801,288	546,866	(254,422)	(46.5%)
0	2,454	2,454	100.0%	Maint.&Repair-Office Equipment	0	7,362	7,362	100.0%
47,728	45,067	(2,661)	(5.9%)	Legal Fees	200,437	135,200	(65,237)	(48.3%)
(8)	0	8	0.0%	Member Health Education	320	0	(320)	0.0%
19,032	28,133	9,101	32.4%	Translation Services	63,350	84,400	21,050	24.9%
2,000	161,698	159,698	98.8%	Medical Refund Recovery Fees	814,681	485,094	(329,587)	(67.9%)
(406,676)	615,644	1,022,320	166.1%	Software - IT Licenses & Subsc	682,135	1,427,740	745,604	52.2%
64,823	53,584	(11,239)	(21.0%)	Hardware (Non-Capital)	120,583	146,752	26,169	17.8%
35,497	50,300	14,803	29.4%	Provider Credentialing	90,078	150,900	60,822	40.3%
1,368,656	**1,916,111**	**547,455**	**28.6%**	**Purchased & Professional Services**	**6,373,258**	**5,053,042**	**(1,320,217)**	**(26.1%)**
59,373	104,004	44,630	42.9%	Depreciation	173,701	298,146	124,445	41.7%
62,638	76,371	13,733	18.0%	Lease Building	186,763	229,113	42,350	18.5%
3,275	5,960	2,685	45.1%	Lease Rented Office Equipment	12,204	17,880	5,676	31.7%
4,282	17,343	13,061	75.3%	Utilities	36,659	52,029	15,370	29.5%
73,381	91,065	17,684	19.4%	Telephone	242,198	273,195	30,997	11.3%
42,125	33,025	(9,100)	(27.6%)	Building Maintenance	113,583	95,425	(18,158)	(19.0%)
235,268	249,136	13,868	5.6%	GASB96 SBITA Amort. Expense	695,204	747,407	52,203	7.0%
480,341	**576,903**	**96,562**	**16.7%**	**Occupancy**	**1,460,312**	**1,713,195**	**252,882**	**14.8%**

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
43,973	92,151	48,178	52.3%	Postage	188,736	172,199	(16,537)	(9.6%)
11,127	5,300	(5,827)	(109.9%)	Design & Layout	21,412	15,900	(5,512)	(34.7%)
48,057	126,777	78,720	62.1%	Printing Services	277,324	215,831	(61,493)	(28.5%)
21,429	6,910	(14,519)	(210.1%)	Mailing Services	30,459	20,730	(9,729)	(46.9%)
5,788	11,550	5,761	49.9%	Courier/Delivery Service	17,923	34,578	16,655	48.2%
0	520	520	100.0%	Pre-Printed Materials & Public	0	540	540	100.0%
0	0	0	0.0%	Promotional Products	36,545	0	(36,545)	0.0%
0	150	150	100.0%	Promotional Services	0	450	450	100.0%
188,354	752,667	564,313	75.0%	Community Relations	504,143	1,194,001	689,858	57.8%
318,728	**996,025**	**677,297**	**68.0%**	**Printing Postage & Promotion**	**1,076,541**	**1,654,229**	**577,689**	**34.9%**
85,000	0	(85,000)	0.0%	Regulatory Penalties	85,000	100,000	15,000	15.0%
(15,307)	36,000	51,307	142.5%	Bank Fees	96,294	108,000	11,706	10.8%
0	95,133	95,133	100.0%	Insurance Premium	976,663	290,637	(686,026)	(236.0%)
12,303	140,436	128,132	91.2%	License,Permits, & Fee - NonIT	942,822	665,387	(277,435)	(41.7%)
244,581	56,130	(188,451)	(335.7%)	Subscriptions and Dues - NonIT	313,745	153,520	(160,225)	(104.4%)
326,577	**327,699**	**1,122**	**0.3%**	**License Insurance & Fees**	**2,414,524**	**1,317,544**	**(1,096,980)**	**(83.3%)**
4,262	10,688	6,426	60.1%	Office and Other Supplies	25,566	38,314	12,748	33.3%
0	1,050	1,050	100.0%	Furniture & Equipment	0	3,150	3,150	100.0%
19,260	26,483	7,223	27.3%	Ergonomic Supplies	103,777	79,450	(24,327)	(30.6%)
12,855	16,218	3,363	20.7%	Meals and Entertainment	36,065	61,578	25,513	41.4%
1,000	0	(1,000)	0.0%	Miscellaneous	1,000	0	(1,000)	0.0%
0	4,850	4,850	100.0%	Member Incentive	0	4,850	4,850	100.0%
113,048	70,000	(43,048)	(61.5%)	Provider Interest (All Depts)	413,999	210,000	(203,999)	(97.1%)
150,424	**129,289**	**(21,135)**	**(16.3%)**	**Other Administrative Expense**	**580,407**	**397,342**	**(183,065)**	**(46.1%)**
2,722,900	**4,020,596**	**1,297,696**	**32.3%**	**Total Other Administrative ExpenseS (excludes Personnel Expenses)**	**12,132,255**	**10,358,888**	**(1,773,367)**	**(17.1%)**
8,881,640	**9,951,548**	**1,069,908**	**10.8%**	**TOTAL ADMINISTRATIVE EXPENSES**	**29,191,820**	**27,426,783**	**(1,765,037)**	**(6.4%)**

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

		Project ID	Prior YTD Acquisitions	Current Month Acquisitions	Fiscal YTD Acquisitions	Capital Budget Total	$ Variance Fav/(Unf.)
1. Hardware:							
	Cisco UCS-X M6 or M7 Blades x 6	IT-FY24-04	$ 265,100	$ -	**$ 265,100**	$ -	$ (265,100)
	Cisco Routers	IT-FY25-01	$ -	$ -	**$ -**	$ 120,000	$ 120,000
	Cisco UCS Blades	IT-FY25-04	$ 264,510	$ -	**$ 264,510**	$ 873,000	$ 608,490
	PURE Storage	IT-FY25-06	$ -	$ -	**$ -**	$ 150,000	$ 150,000
	Exagrid Immutable Storage	IT-FY25-07	$ -	$ -	**$ -**	$ 500,000	$ 500,000
	Network Cabling	IT-FY25-09	$ -	$ -	**$ -**	$ 40,000	$ 40,000
Hardware Subtotal			**$ 529,610**	**$ -**	**$ 529,610**	**$ 1,683,000**	**$ 1,418,490**
2. Software:							
	Zerto renewal and Tier 2 add		$ -	$ -	**$ -**	$ -	$ -
Software Subtotal			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
3. Building Improvement:							
	1240 Exterior lighting update	FA-FY25-03	**$ -**	$ -	**$ -**	$ 30,000	$ 30,000
Building Improvement Subtotal			**$ -**	**$ -**	**$ -**	**$ 30,000**	**$ 30,000**
4. Furniture & Equipment:							
	Office desks, cabinets, shelvings (all building/suites: new or replacement)		$ -	$ -	**$ -**	$ -	$ -
	Replace, reconfigure, re-design workstations		$ -	$ -	**$ -**	$ -	$ -
Furniture & Equipment Subtotal			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
5. Leasehold Improvement:							
	ExacqVision NVR Upgrade, Cameras/Video System upgrade		$ -		**$ -**	$ -	$ -
Leasehold Improvement Subtotal			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
6. Contingency:							
			$ -		**$ -**	$ -	$ -
Contingency Subtotal			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
GRAND TOTAL			**$ 529,610**	**$ -**	**$ 529,610**	**$ 1,713,000**	**$ 1,448,490**

6. Reconciliation to Balance Sheet:

Fixed Assets @ Cost - 9/30/24	**$ 38,640,099**
Fixed Assets @ Cost - 6/30/24	**$ 38,110,489**
Fixed Assets Acquired YTD	**$ 529,610**

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

TANGIBLE NET EQUITY (TNE)	**QTR. END Jun-24**	**Jul-24**	**Aug-24**	**QTR. END Sep-24**
Current Month Net Income / (Loss)	($60,614,028)	($6,989,303)	($18,354,879)	($8,719,232)
YTD Net Income / (Loss)	($68,581,898)	($6,989,303)	($25,344,182)	($34,063,414)
Actual TNE				
Net Assets	$255,375,144	$248,385,841	$230,030,961	$221,311,730
Subordinated Debt & Interest	$0	$0	$0	$0
Total Actual TNE	**$255,375,144**	**$248,385,841**	**$230,030,961**	**$221,311,730**
Increase/(Decrease) in Actual TNE	($60,614,028)	($6,989,303)	($18,354,879)	($8,719,232)
Required TNE[(1)]	**$63,328,179**	**$68,750,939**	**$71,470,183**	**$70,224,330**
Min. Req'd to Avoid Monthly Reporting (Increased from 130% to 150% of Required TNE effective July-2022)	$94,992,268	$103,126,409	$107,205,274	$105,336,495
TNE Excess / (Deficiency)	$192,046,965	$179,634,902	$158,560,778	$151,087,400
Actual TNE as a Multiple of Required	**4.03**	**3.61**	**3.22**	**3.15**

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

LIQUID TANGIBLE NET EQUITY				
Net Assets	$255,375,144	$248,385,841	$230,030,961	$221,311,730
Fixed Assets at Net Book Value	(5,447,816)	(5,662,370)	(5,863,098)	(5,803,725)
Net Lease Assets/Liabilities/Interest	(501,485)	(319,957)	(496,877)	(1,004,186)
CD Pledged to DMHC	(350,000)	(350,000)	(350,000)	(350,000)
Liquid TNE (Liquid Reserves)	**$249,577,328**	**$242,373,471**	**$223,817,863**	**$215,158,005**
Liquid TNE as Multiple of Required	**3.94**	**3.53**	**3.13**	**3.06**

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

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

	Actual Jul-24	Actual Aug-24	Actual Sep-24	Actual Oct-24	Actual Nov-24	Actual Dec-24	Actual Jan-25	Actual Feb-25	Actual Mar-25	Actual Apr-25	Actual May-25	Actual Jun-25	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program:													
Child	109,951	109,784	109,731										329,466
Adult	62,708	62,641	62,550										187,899
SPD	35,018	35,177	35,319										105,514
ACA OE	149,801	150,482	151,005										451,288
Duals	39,892	40,024	40,124										120,040
MCAL LTC	222	226	240										688
MCAL LTC Duals	1,241	1,247	1,254										3,742
Medi-Cal Program	398,833	399,581	400,223										1,198,637
Group Care Program	5,675	5,686	5,710										17,071
Total	**404,508**	**405,267**	**405,933**										**1,215,708**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	(173)	(167)	(53)										(393)
Adult	(38)	(67)	(91)										(196)
SPD	98	159	142										399
ACA OE	477	681	523										1,681
Duals	144	132	100										376
MCAL LTC	0	4	14										18
MCAL LTC Duals	(7)	6	7										6
Medi-Cal Program	501	748	642										1,891
Group Care Program	17	11	24										52
Total	**518**	**759**	**666**										**1,943**
Enrollment Percentages:													
Medi-Cal Program:													
Child % of Medi-Cal	27.6%	27.5%	27.4%										27.5%
Adult % of Medi-Cal	15.7%	15.7%	15.6%										15.7%
SPD % of Medi-Cal	8.8%	8.8%	8.8%										8.8%
ACA OE % of Medi-Cal	37.6%	37.7%	37.7%										37.7%
Duals % of Medi-Cal	10.0%	10.0%	10.0%										10.0%
Medi-Cal Program % of Total	98.6%	98.6%	98.6%										98.6%
Group Care Program % of Total	1.4%	1.4%	1.4%										1.4%
Total	**100.0%**	**100.0%**	**100.0%**										**100.0%**

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

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

	Actual Jul-24	Actual Aug-24	Actual Sep-24	Actual Oct-24	Actual Nov-24	Actual Dec-24	Actual Jan-25	Actual Feb-25	Actual Mar-25	Actual Apr-25	Actual May-25	Actual Jun-25	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted													
Directly Contracted (DCP)	87,980	88,518	89,634										266,132
Alameda Health System	91,091	91,170	91,024										273,285
	179,071	179,688	180,658										539,417
Delegated:													
CFMG	44,087	43,956	43,837										131,880
CHCN	181,350	181,623	181,438										544,411
Kaiser	0	0	0										0
Delegated Subtotal	225,437	225,579	225,275										676,291
Total	**404,508**	**405,267**	**405,933**										**1,215,708**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	167	617	970										1,754
Delegated:													
CFMG	96	(131)	(119)										(154)
CHCN	255	273	(185)										343
Kaiser	0	0	0										0
Delegated Subtotal	351	142	(304)										189
Total	**518**	**759**	**666**										**1,943**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	44.3%	44.3%	44.5%										44.4%
Delegated:													
CFMG	10.9%	10.8%	10.8%										10.8%
CHCN	44.8%	44.8%	44.7%										44.8%
Kaiser	0.0%	0.0%	0.0%										0.0%
Delegated Subtotal	55.7%	55.7%	55.5%										55.6%
Total	**100.0%**	**100.0%**	**100.0%**										**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING

FOR THE FISCAL YEAR 2025								**PRELIMINARY BUDGET**					
	Budget Jul-24	**Budget Aug-24**	**Budget Sep-24**	**Budget Oct-24**	**Budget Nov-24**	**Budget Dec-24**	**Budget Jan-25**	**Budget Feb-25**	**Budget Mar-25**	**Budget Apr-25**	**Budget May-25**	**Budget Jun-25**	**YTD Member Months**
Enrollment by Plan & Aid Category:													
Medi-Cal Program by Category of Aid:													
Child	110,723	110,944	111,166	111,388	111,611	111,834	112,058	112,282	112,507	112,732	112,957	113,183	1,343,385
Adult	63,571	63,635	63,699	63,763	63,827	63,891	63,955	64,019	64,083	64,147	64,211	64,275	767,076
SPD	34,848	34,848	34,848	34,848	34,848	34,848	34,848	34,848	34,848	34,848	34,848	34,848	418,176
ACA OE	149,317	149,466	149,615	149,765	149,915	150,065	150,215	150,365	150,515	150,666	150,817	150,968	1,801,689
Duals	39,791	39,791	39,791	39,791	39,791	39,791	39,791	39,791	39,791	39,791	39,791	39,791	477,492
MCAL LTC	224	224	224	224	224	224	224	224	224	224	224	224	2,688
MCAL LTC Duals	1,285	1,285	1,285	1,285	1,285	1,285	1,285	1,285	1,285	1,285	1,285	1,285	15,420
Medi-Cal Program	399,759	400,193	400,628	401,064	401,501	401,938	402,376	402,814	403,253	403,693	404,133	404,574	4,825,926
Group Care Program	5,643	5,643	5,643	5,643	5,643	5,643	5,643	5,643	5,643	5,643	5,643	5,643	67,716
Total	**405,402**	**405,836**	**406,271**	**406,707**	**407,144**	**407,581**	**408,019**	**408,457**	**408,896**	**409,336**	**409,776**	**410,217**	**4,893,642**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	(1,207)	221	222	222	223	223	224	224	225	225	225	226	1,253
Adult	(624)	64	64	64	64	64	64	64	64	64	64	64	80
SPD	(225)	0	0	0	0	0	0	0	0	0	0	0	(225)
ACA OE	(1,260)	149	149	150	150	150	150	150	150	151	151	151	391
Duals	(43)	0	0	0	0	0	0	0	0	0	0	0	(43)
MCAL LTC	(9)	0	0	0	0	0	0	0	0	0	0	0	(9)
MCAL LTC Duals	4	0	0	0	0	0	0	0	0	0	0	0	4
Medi-Cal Program	(3,364)	434	435	436	437	437	438	438	439	440	440	441	1,451
Group Care Program	(15)	0	0	0	0	0	0	0	0	0	0	0	(15)
Total	**(3,379)**	**434**	**435**	**436**	**437**	**437**	**438**	**438**	**439**	**440**	**440**	**441**	**1,436**
Enrollment Percentages:													
Medi-Cal Program:													
Child % (Medi-Cal)	27.7%	27.7%	27.7%	27.8%	27.8%	27.8%	27.8%	27.9%	27.9%	27.9%	28.0%	28.0%	27.8%
Adult % (Medi-Cal)	15.9%	15.9%	15.9%	15.9%	15.9%	15.9%	15.9%	15.9%	15.9%	15.9%	15.9%	15.9%	15.9%
SPD % (Medi-Cal)	8.7%	8.7%	8.7%	8.7%	8.7%	8.7%	8.7%	8.7%	8.6%	8.6%	8.6%	8.6%	8.7%
ACA OE % (Medi-Cal)	37.4%	37.3%	37.3%	37.3%	37.3%	37.3%	37.3%	37.3%	37.3%	37.3%	37.3%	37.3%	37.3%
Duals % (Medi-Cal)	10.0%	9.9%	9.9%	9.9%	9.9%	9.9%	9.9%	9.9%	9.9%	9.9%	9.8%	9.8%	9.9%
MCAL LTC % (Medi-Cal)	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
MCAL LTC Duals % (Medi-Cal)	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%
Medi-Cal Program % of Total	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%
Group Care Program % of Total	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING

FOR THE FISCAL YEAR 2025	PRELIMINARY 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)	89,482	89,539	89,596	89,654	89,712	89,770	89,828	89,886	89,944	90,002	90,060	90,119	1,077,592
Alameda Health System	90,708	90,803	90,898	90,994	91,090	91,186	91,282	91,378	91,475	91,572	91,669	91,766	1,094,821
	180,190	180,342	180,494	180,648	180,802	180,956	181,110	181,264	181,419	181,574	181,729	181,885	2,172,413
Delegated:													
CFMG	43,781	43,864	43,948	44,032	44,116	44,200	44,284	44,368	44,453	44,538	44,623	44,708	530,915
CHCN	181,431	181,630	181,829	182,027	182,226	182,425	182,625	182,825	183,024	183,224	183,424	183,624	2,190,314
Kaiser	0	0	0	0	0	0	0	0	0	0	0	0	0
Delegated Subtotal	225,212	225,494	225,777	226,059	226,342	226,625	226,909	227,193	227,477	227,762	228,047	228,332	2,721,229
Total	**405,402**	**405,836**	**406,271**	**406,707**	**407,144**	**407,581**	**408,019**	**408,457**	**408,896**	**409,336**	**409,776**	**410,217**	**4,893,642**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted													
Directly Contracted (DCP)	305	57	57	58	58	58	58	58	58	58	58	59	942
Alameda Health System	(1,244)	95	95	96	96	96	96	96	97	97	97	97	(186)
	(939)	152	152	154	154	154	154	154	155	155	155	156	756
Delegated:													
CFMG	(441)	83	84	84	84	84	84	84	85	85	85	85	486
CHCN	(1,721)	199	199	198	199	199	200	200	199	200	200	200	472
Kaiser	(278)	0	0	0	0	0	0	0	0	0	0	0	(278)
Delegated Subtotal	(2,440)	282	283	282	283	283	284	284	284	285	285	285	680
Total	**(3,379)**	**434**	**435**	**436**	**437**	**437**	**438**	**438**	**439**	**440**	**440**	**441**	**1,436**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted													
Directly Contracted (DCP)	22.1%	22.1%	22.1%	22.0%	22.0%	22.0%	22.0%	22.0%	22.0%	22.0%	22.0%	22.0%	22.0%
Alameda Health System	22.4%	22.4%	22.4%	22.4%	22.4%	22.4%	22.4%	22.4%	22.4%	22.4%	22.4%	22.4%	22.4%
	44.4%	44.4%	44.4%	44.4%	44.4%	44.4%	44.4%	44.4%	44.4%	44.4%	44.3%	44.3%	44.4%
Delegated:													
CFMG	10.8%	10.8%	10.8%	10.8%	10.8%	10.8%	10.9%	10.9%	10.9%	10.9%	10.9%	10.9%	10.8%
CHCN	44.8%	44.8%	44.8%	44.8%	44.8%	44.8%	44.8%	44.8%	44.8%	44.8%	44.8%	44.8%	44.8%
Kaiser	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Delegated Subtotal	55.6%	55.6%	55.6%	55.6%	55.6%	55.6%	55.6%	55.6%	55.6%	55.6%	55.7%	55.7%	55.6%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

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

	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	(772)	(1,160)	(1,435)										(3,367)
Adult	(863)	(994)	(1,149)										(3,006)
SPD	170	329	471										970
ACA OE	484	1,016	1,390										2,890
Duals	101	233	333										667
MCAL LTC	(2)	2	16										16
MCAL LTC Duals	(44)	(38)	(31)										(113)
Medi-Cal Program	(926)	(612)	(405)										(1,943)
Group Care Program	32	43	67										142
Total	**(894)**	**(569)**	**(338)**										**(1,801)**
Current Direct/Delegate Enrollment Variance - Favorable/(Unfavorable)													
Directly-Contracted													
Directly Contracted (DCP)	(1,502)	(1,021)	38										(2,485)
Alameda Health System	383	367	126										876
	(1,119)	(654)	164										(1,609)
Delegated:													
CFMG	306	92	(111)										287
CHCN	(81)	(7)	(391)										(479)
Kaiser	0	0	0										0
Delegated Subtotal	225	85	(502)										(192)
Total	**(894)**	**(569)**	**(338)**										**(1,801)**

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				CAPITATED MEDICAL EXPENSES				
($238,596)	$1,982,566	$2,221,162	112.0%	PCP Capitation	$10,060,337	$5,936,634	($4,123,703)	(69.5%)
6,163,310	9,525,323	3,362,013	35.3%	PCP Capitation FQHC	18,471,230	28,545,067	10,073,837	35.3%
372,281	381,006	8,725	2.3%	Specialty Capitation	1,120,365	1,140,840	20,475	1.8%
5,400,197	5,574,819	174,622	3.1%	Specialty Capitation FQHC	16,187,615	16,709,888	522,273	3.1%
749,317	709,021	(40,296)	(5.7%)	Laboratory Capitation	2,245,765	2,124,773	(120,992)	(5.7%)
339,438	341,603	2,165	0.6%	Vision Capitation	1,017,487	1,023,564	6,077	0.6%
108,360	110,770	2,410	2.2%	CFMG Capitation	326,053	331,677	5,623	1.7%
266,193	276,123	9,930	3.6%	ANC IPA Admin Capitation FQHC	798,604	827,560	28,955	3.5%
(995)	0	995	0.0%	Kaiser Capitation	(995)	0	995	0.0%
0	0	0	0.0%	Maternity Supplemental Expense	27,953	0	(27,953)	0.0%
1,015,182	945,881	(69,301)	(7.3%)	DME Capitation	3,035,544	2,836,743	(198,801)	(7.0%)
14,174,687	**19,847,112**	**5,672,425**	**28.6%**	**7. TOTAL CAPITATED EXPENSES**	**53,289,958**	**59,476,745**	**6,186,787**	**10.4%**
				FEE FOR SERVICE MEDICAL EXPENSES				
7,844,397	0	(7,844,397)	0.0%	IBNR Inpatient Services	5,413,638	0	(5,413,638)	0.0%
235,331	0	(235,331)	0.0%	IBNR Settlement (IP)	162,409	0	(162,409)	0.0%
627,552	0	(627,552)	0.0%	IBNR Claims Fluctuation (IP)	433,091	0	(433,091)	0.0%
42,246,427	44,079,182	1,832,755	4.2%	Inpatient Hospitalization FFS	141,422,695	135,235,933	(6,186,762)	(4.6%)
2,849,148	0	(2,849,148)	0.0%	IP OB - Mom & NB	9,333,532	0	(9,333,532)	0.0%
201,447	0	(201,447)	0.0%	IP Behavioral Health	845,091	0	(845,091)	0.0%
1,171,841	0	(1,171,841)	0.0%	Inpatient Facility Rehab FFS	3,831,146	0	(3,831,146)	0.0%
55,176,143	**44,079,182**	**(11,096,960)**	**(25.2%)**	**8. Inpatient Hospital Expense**	**161,441,603**	**135,235,933**	**(26,205,670)**	**(19.4%)**
(52,456)	0	52,456	0.0%	IBNR PCP	300,406	0	(300,406)	0.0%
(1,572)	0	1,572	0.0%	IBNR Settlement (PCP)	9,014	0	(9,014)	0.0%
(4,197)	0	4,197	0.0%	IBNR Claims Fluctuation (PCP)	92,300	0	(92,300)	0.0%
1,377,635	3,623,140	2,245,505	62.0%	PCP FFS	10,387,447	11,087,695	700,247	6.3%
352,128	1,394,451	1,042,323	74.7%	PCP FQHC FFS	1,185,848	4,269,550	3,083,702	72.2%
0	0	0	0.0%	Physician Extended Hrs. Incent	12,000	0	(12,000)	0.0%
282	954,752	954,470	100.0%	Prop 56 Physician Pmt	961	2,860,872	2,859,911	100.0%
16,310	0	(16,310)	0.0%	Prop 56 Hyde	48,659	0	(48,659)	0.0%
68,677	0	(68,677)	0.0%	Prop 56 Trauma Screening	217,353	0	(217,353)	0.0%
90,210	0	(90,210)	0.0%	Prop 56 Developmentl Screening	248,779	0	(248,779)	0.0%
761,816	0	(761,816)	0.0%	Prop 56 Family Planning	2,292,727	0	(2,292,727)	0.0%
2,608,833	**5,972,343**	**3,363,509**	**56.3%**	**9. Primary Care Physician Expense**	**14,795,494**	**18,218,116**	**3,422,622**	**18.8%**
406,071	0	(406,071)	0.0%	IBNR Specialist	(26,713)	0	26,713	0.0%
12,182	0	(12,182)	0.0%	IBNR Settlement (SCP)	(801)	0	801	0.0%
32,486	0	(32,486)	0.0%	IBNR Claims Fluctuation (SCP)	(2,138)	0	2,138	0.0%
408,686	0	(408,686)	0.0%	Psychiatrist FFS	1,051,381	0	(1,051,381)	0.0%
3,152,473	7,689,278	4,536,806	59.0%	Specialty Care FFS	10,799,290	23,527,222	12,727,932	54.1%
191,412	0	(191,412)	0.0%	Specialty Anesthesiology	678,408	0	(678,408)	0.0%
1,485,041	0	(1,485,041)	0.0%	Specialty Imaging FFS	4,976,723	0	(4,976,723)	0.0%
44,659	0	(44,659)	0.0%	Obstetrics FFS	107,718	0	(107,718)	0.0%
278,437	0	(278,437)	0.0%	Specialty IP Surgery FFS	1,262,227	0	(1,262,227)	0.0%
1,146,009	0	(1,146,009)	0.0%	Specialty OP Surgery FFS	3,108,133	0	(3,108,133)	0.0%
632,754	0	(632,754)	0.0%	Speciality IP Physician	1,826,642	0	(1,826,642)	0.0%
106,829	98,531	(8,298)	(8.4%)	Specialist FQHC FFS	368,995	301,530	(67,465)	(22.4%)
7,897,040	**7,787,809**	**(109,231)**	**(1.4%)**	**10. Specialty Care Physician Expense**	**24,149,864**	**23,828,752**	**(321,112)**	**(1.3%)**

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
1,829,044	0	(1,829,044)	0.0%	IBNR Ancillary (ANC)	1,191,308	0	(1,191,308)	0.0%
54,871	0	(54,871)	0.0%	IBNR Settlement (ANC)	122,804	0	(122,804)	0.0%
146,325	0	(146,325)	0.0%	IBNR Claims Fluctuation (ANC)	259,217	0	(259,217)	0.0%
56,806	0	(56,806)	0.0%	IBNR Transportation FFS	161,729	0	(161,729)	0.0%
1,786,424	0	(1,786,424)	0.0%	Behavioral Health Therapy FFS	5,744,001	0	(5,744,001)	0.0%
1,629,925	0	(1,629,925)	0.0%	Psychologist & Other MH Prof	4,994,756	0	(4,994,756)	0.0%
466,178	0	(466,178)	0.0%	Other Medical Professional	1,354,155	0	(1,354,155)	0.0%
142,455	0	(142,455)	0.0%	Hearing Devices	482,131	0	(482,131)	0.0%
20,970	0	(20,970)	0.0%	ANC Imaging	199,318	0	(199,318)	0.0%
68,440	0	(68,440)	0.0%	Vision FFS	209,893	0	(209,893)	0.0%
1,279,524	0	(1,279,524)	0.0%	Laboratory FFS	4,014,902	0	(4,014,902)	0.0%
147,657	0	(147,657)	0.0%	ANC Therapist	425,621	0	(425,621)	0.0%
1,658,245	0	(1,658,245)	0.0%	Transp/Ambulance FFS	4,818,016	0	(4,818,016)	0.0%
2,436,183	0	(2,436,183)	0.0%	Non-ER Transportation FFS	6,974,893	0	(6,974,893)	0.0%
2,037,533	0	(2,037,533)	0.0%	Hospice FFS	6,812,701	0	(6,812,701)	0.0%
1,674,437	0	(1,674,437)	0.0%	Home Health Services	4,964,636	0	(4,964,636)	0.0%
0	12,108,846	12,108,846	100.0%	Other Medical FFS	128	37,036,063	37,035,935	100.0%
249,529	0	(249,529)	0.0%	Medical Refunds through HMS	249,836	0	(249,836)	0.0%
32,921	0	(32,921)	0.0%	DME & Medical Supplies FFS	142,934	0	(142,934)	0.0%
2,184,852	1,780,950	(403,902)	(22.7%)	ECM Base/Outreach FFS ANC	1,382,631	5,339,141	3,956,510	74.1%
46,458	45,484	(974)	(2.1%)	CS Housing Deposits FFS ANC	310,591	135,106	(175,485)	(129.9%)
1,058,808	640,963	(417,844)	(65.2%)	CS Housing Tenancy FFS ANC	1,867,069	1,900,120	33,051	1.7%
593,774	470,929	(122,846)	(26.1%)	CS Housing Navi Servic FFS ANC	1,076,054	1,404,878	328,825	23.4%
684,609	529,628	(154,980)	(29.3%)	CS Medical Respite FFS ANC	1,865,453	1,629,749	(235,703)	(14.5%)
184,284	210,452	26,168	12.4%	CS Med. Tailored Meals FFS ANC	332,088	620,555	288,467	46.5%
5,067	38,241	33,174	86.7%	CS Asthma Remediation FFS ANC	15,077	101,457	86,380	85.1%
0	10,000	10,000	100.0%	MOT Wrap Around (Non Med MOT)	0	30,000	30,000	100.0%
3,809	15,000	11,191	74.6%	CS Home Modifications FFS ANC	24,053	45,000	20,947	46.5%
276,337	495,075	218,737	44.2%	CS P.Care & Hmker Svcs FFS ANC	1,193,065	1,474,279	281,214	19.1%
7,035	89,376	82,341	92.1%	CS Cgiver Respite Svcs FFS ANC	33,721	242,592	208,871	86.1%
0	132,751	132,751	100.0%	CS Sobering Center FFS ANC	0	407,103	407,103	100.0%
226,288	0	(226,288)	0.0%	CommunityBased Adult Svc(CBAS)	1,523,908	0	(1,523,908)	0.0%
16,170	22,364	6,193	27.7%	CS LTC Diversion FFS ANC	33,564	65,663	32,099	48.9%
0	13,750	13,750	100.0%	CS LTC Transition FFS ANC	0	39,375	39,375	100.0%
21,004,958	**16,603,808**	**(4,401,150)**	**(26.5%)**	**11. Ancillary Medical Expense**	**52,780,250**	**50,471,082**	**(2,309,168)**	**(4.6%)**
229,772	0	(229,772)	0.0%	IBNR Outpatient	1,445,894	0	(1,445,894)	0.0%
6,893	0	(6,893)	0.0%	IBNR Settlement (OP)	43,376	0	(43,376)	0.0%
18,381	0	(18,381)	0.0%	IBNR Claims Fluctuation (OP)	115,670	0	(115,670)	0.0%
2,547,802	11,131,245	8,583,443	77.1%	Outpatient FFS	7,494,813	34,068,471	26,573,657	78.0%
3,026,021	0	(3,026,021)	0.0%	OP Ambul Surgery FFS	8,495,381	0	(8,495,381)	0.0%
2,221,028	0	(2,221,028)	0.0%	Imaging Services FFS	7,106,941	0	(7,106,941)	0.0%
17,164	0	(17,164)	0.0%	Behavioral Health FFS	71,226	0	(71,226)	0.0%
657,722	0	(657,722)	0.0%	Outpatient Facility Lab FFS	2,025,590	0	(2,025,590)	0.0%
160,624	0	(160,624)	0.0%	Outpatient Facility Cardio FFS	562,872	0	(562,872)	0.0%
98,327	0	(98,327)	0.0%	OP Facility PT/OT/ST FFS	286,413	0	(286,413)	0.0%
3,370,324	0	(3,370,324)	0.0%	OP Facility Dialysis Ctr FFS	9,185,253	0	(9,185,253)	0.0%
12,354,058	**11,131,245**	**(1,222,813)**	**(11.0%)**	**12. Outpatient Medical Expense**	**36,833,430**	**34,068,471**	**(2,764,960)**	**(8.1%)**
197,158	0	(197,158)	0.0%	IBNR Emergency	2,181,401	0	(2,181,401)	0.0%
5,915	0	(5,915)	0.0%	IBNR Settlement (ER)	65,442	0	(65,442)	0.0%
15,772	0	(15,772)	0.0%	IBNR Claims Fluctuation (ER)	174,511	0	(174,511)	0.0%
7,863,407	8,522,652	659,245	7.7%	ER Facility	25,892,583	26,021,405	128,823	0.5%
1,046,885	0	(1,046,885)	0.0%	Specialty ER Physician FFS	3,508,387	0	(3,508,387)	0.0%

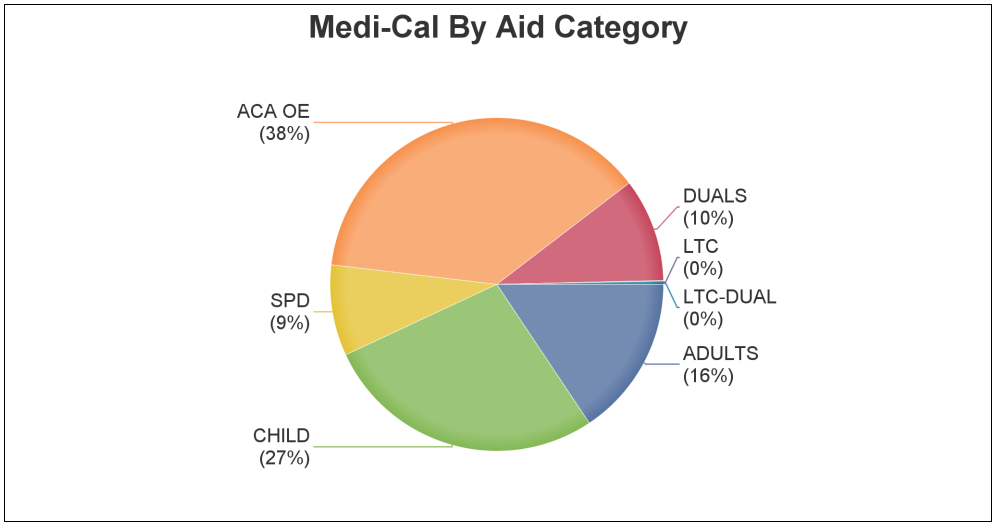
ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED SEPTEMBER 30, 2024

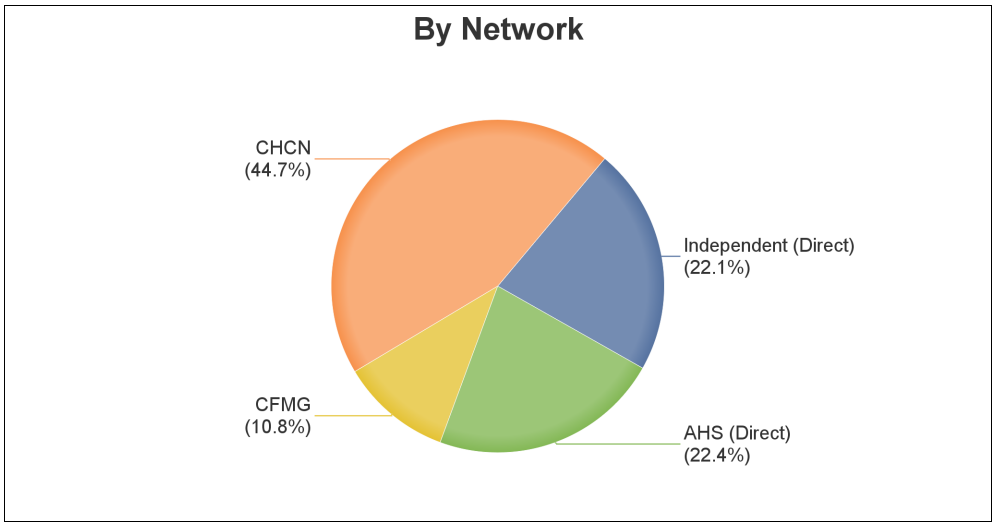
CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
9,129,136	**8,522,652**	**(606,484)**	**(7.1%)**	**13. Emergency Expense**	**31,822,324**	**26,021,405**	**(5,800,918)**	**(22.3%)**
1,034,867	0	(1,034,867)	0.0%	IBNR Pharmacy (OP)	1,440,918	0	(1,440,918)	0.0%
31,047	0	(31,047)	0.0%	IBNR Settlement Rx (OP)	43,230	0	(43,230)	0.0%
82,790	0	(82,790)	0.0%	IBNR Claims Fluctuation Rx(OP)	115,274	0	(115,274)	0.0%
725,785	377,967	(347,819)	(92.0%)	Pharmacy FFS (OP)	2,230,204	1,159,912	(1,070,292)	(92.3%)
135,560	11,315,546	11,179,986	98.8%	Pharmacy Non PBM FFS Other-ANC	439,973	34,671,804	34,231,830	98.7%
10,129,939	0	(10,129,939)	0.0%	Pharmacy Non PBM FFS OP-FAC	28,718,688	0	(28,718,688)	0.0%
230,698	0	(230,698)	0.0%	Pharmacy Non PBM FFS PCP	730,684	0	(730,684)	0.0%
2,322,867	0	(2,322,867)	0.0%	Pharmacy Non PBM FFS SCP	7,947,889	0	(7,947,889)	0.0%
24,518	0	(24,518)	0.0%	Pharmacy Non PBM FFS FQHC	58,810	0	(58,810)	0.0%
10,297	0	(10,297)	0.0%	Pharmacy Non PBM FFS HH	74,314	0	(74,314)	0.0%
0	0	0	0.0%	RX Refunds HMS	(306)	0	306	0.0%
(54,000)	48,123	102,123	212.2%	Medical Expenses Pharm Rebate	(162,000)	147,569	309,569	209.8%
14,674,368	**11,741,636**	**(2,932,732)**	**(25.0%)**	**14. Pharmacy Expense**	**41,637,679**	**35,979,285**	**(5,658,394)**	**(15.7%)**
(459,244)	0	459,244	0.0%	IBNR LTC	(1,673,344)	0	1,673,344	0.0%
(13,778)	0	13,778	0.0%	IBNR Settlement (LTC)	(50,201)	0	50,201	0.0%
(36,740)	0	36,740	0.0%	IBNR Claims Fluctuation (LTC)	(133,868)	0	133,868	0.0%
1,441,591	0	(1,441,591)	0.0%	LTC - ICF/DD	5,119,822	0	(5,119,822)	0.0%
23,424,973	0	(23,424,973)	0.0%	LTC Custodial Care	71,967,085	0	(71,967,085)	0.0%
8,610,776	28,383,488	19,772,712	69.7%	LTC SNF	23,057,754	86,771,740	63,713,986	73.4%
32,967,578	**28,383,488**	**(4,584,090)**	**(16.2%)**	**15. Long Term Care Expense**	**98,287,248**	**86,771,740**	**(11,515,508)**	**(13.3%)**
155,812,113	**134,222,163**	**(21,589,951)**	**(16.1%)**	**16. TOTAL FFS MEDICAL EXPENSES**	**461,747,892**	**410,594,784**	**(51,153,108)**	**(12.5%)**
0	0	0	0.0%	Medical Exp. OthClinicalGrants	(809,521)	0	809,521	0.0%
0	(66,674)	(66,674)	100.0%	Clinical Vacancy #102	0	363,420	363,420	100.0%
126,153	247,944	121,790	49.1%	Quality Analytics #123	407,184	555,523	148,339	26.7%
372,681	332,888	(39,793)	(12.0%)	LongTerm Services and Support #139	516,501	970,669	454,168	46.8%
945,635	857,051	(88,584)	(10.3%)	Utilization Management #140	3,087,654	2,510,633	(577,021)	(23.0%)
683,273	610,352	(72,921)	(11.9%)	Case & Disease Management #185	2,046,802	1,698,661	(348,141)	(20.5%)
401,003	524,703	123,701	23.6%	Medical Management #230	1,160,747	1,479,448	318,701	21.5%
1,078,708	1,380,230	301,522	21.8%	Quality Improvement #235	3,312,085	3,065,155	(246,929)	(8.1%)
352,571	353,079	508	0.1%	HCS Behavioral Health #238	974,672	1,059,798	85,126	8.0%
130,667	241,094	110,427	45.8%	Pharmacy Services #245	347,928	718,421	370,493	51.6%
95,247	61,441	(33,806)	(55.0%)	Regulatory Readiness #268	240,436	179,928	(60,508)	(33.6%)
4,185,938	**4,542,108**	**356,170**	**7.8%**	**17. Other Benefits & Services**	**11,284,486**	**12,601,657**	**1,317,170**	**10.5%**
(1,403,000)	(1,157,976)	245,024	(21.2%)	Reinsurance Recoveries	(4,674,497)	(3,471,718)	1,202,779	(34.6%)
1,753,350	1,543,968	(209,382)	(13.6%)	Reinsurance Premium	5,242,118	4,628,957	(613,161)	(13.2%)
350,350	**385,992**	**35,642**	**9.2%**	**18. Reinsurance Expense**	**567,621**	**1,157,239**	**589,618**	**51.0%**
174,523,088	**158,997,375**	**(15,525,713)**	**(9.8%)**	**20. TOTAL MEDICAL EXPENSES**	**526,889,958**	**483,830,425**	**(43,059,533)**	**(8.9%)**

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend

Category of Aid	Sep 2024	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN
ADULTS	62,572	16%	12,834	14,380	6	35,352
CHILD	109,739	27%	9,212	13,623	40,898	46,006
SPD	35,322	9%	11,525	5,610	1,427	16,760
ACA OE	150,999	38%	26,114	53,666	1,501	69,718
DUALS	40,117	10%	26,349	2,845	6	10,917
LTC	240	0%	224	8	0	8
LTC-DUAL	1,254	0%	1,252	0	0	2
Medi-Cal	400,243		87,510	90,132	43,838	178,763
Group Care	5,710		2,149	896	0	2,665
Total	**405,953**	**100%**	**89,659**	**91,028**	**43,838**	**181,428**
Medi-Cal %	98.6%		97.6%	99.0%	100.0%	98.5%
Group Care %	1.4%		2.4%	1.0%	0.0%	1.5%
	Network Distribution		**22.1%**	**22.4%**	**10.8%**	**44.7%**
			% Direct:	**45%**	**% Delegated:**	**55%**

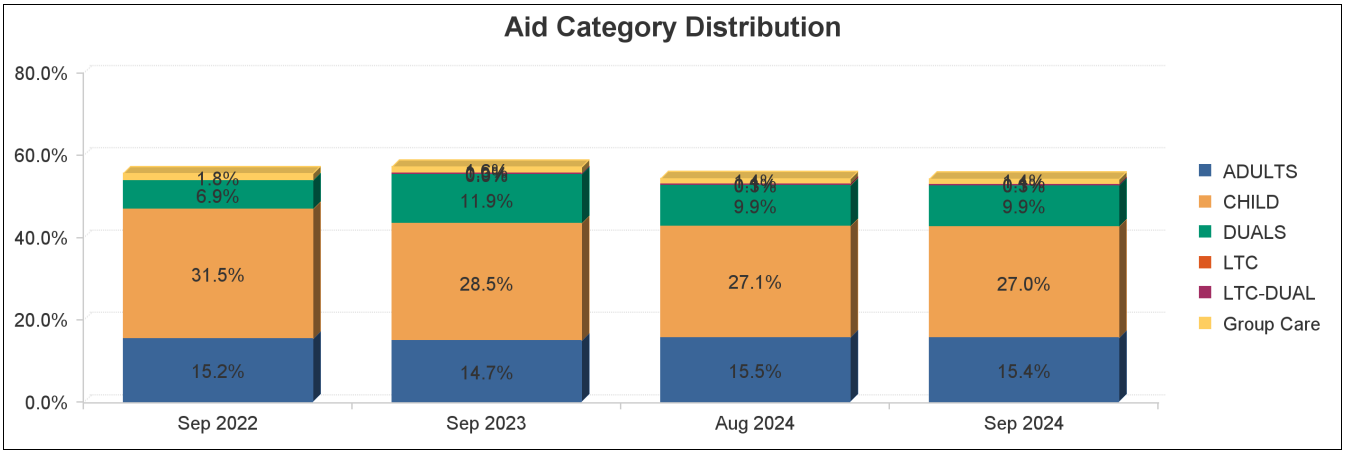




Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

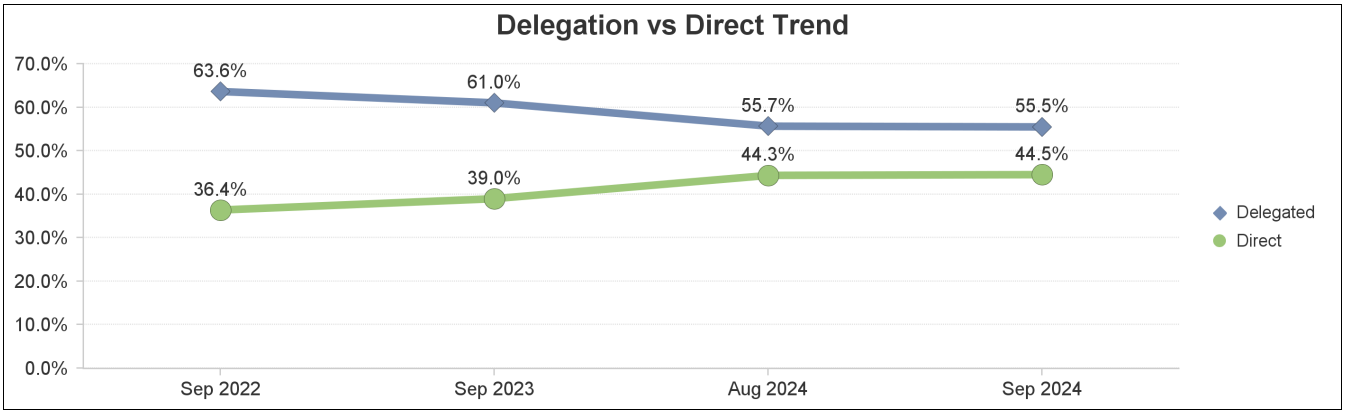
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Sep 2022	Sep 2023	Aug 2024	Sep 2024	Sep 2022	Sep 2023	Aug 2024	Sep 2024	Sep 2022 to Sep 2023	Sep 2023 to Sep 2024	Aug 2024 to Sep 2024
ADULTS	48,711	51,499	62,671	**62,572**	15.2%	14.7%	15.5%	15.4%	5.7%	21.5%	-0.2%
CHILD	101,276	100,038	109,803	**109,739**	31.5%	28.5%	27.1%	27.0%	-1.2%	9.7%	-0.1%
SPD	28,200	30,592	35,177	**35,322**	8.8%	8.7%	8.7%	8.7%	8.5%	15.5%	0.4%
ACA OE	115,018	120,016	150,482	**150,999**	35.8%	34.2%	37.1%	37.2%	4.3%	25.8%	0.3%
DUALS	22,319	41,629	40,030	**40,117**	6.9%	11.9%	9.9%	9.9%	86.5%	-3.6%	0.2%
LTC	0	139	226	**240**	0.0%	0.0%	0.1%	0.1%	0.0%	72.7%	6.2%
LTC-DUAL	0	1,004	1,247	**1,254**	0.0%	0.3%	0.3%	0.3%	0.0%	24.9%	0.6%
Medi-Cal	315,524	344,917	399,636	**400,243**	98.2%	98.4%	98.6%	98.6%	9.3%	16.0%	0.2%
Group Care	5,809	5,631	5,686	**5,710**	1.8%	1.6%	1.4%	1.4%	-3.1%	1.4%	0.4%
Total	**321,333**	**350,548**	**405,322**	**405,953**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**9.1%**	**15.8%**	**0.2%**



Delegation vs Direct Trend

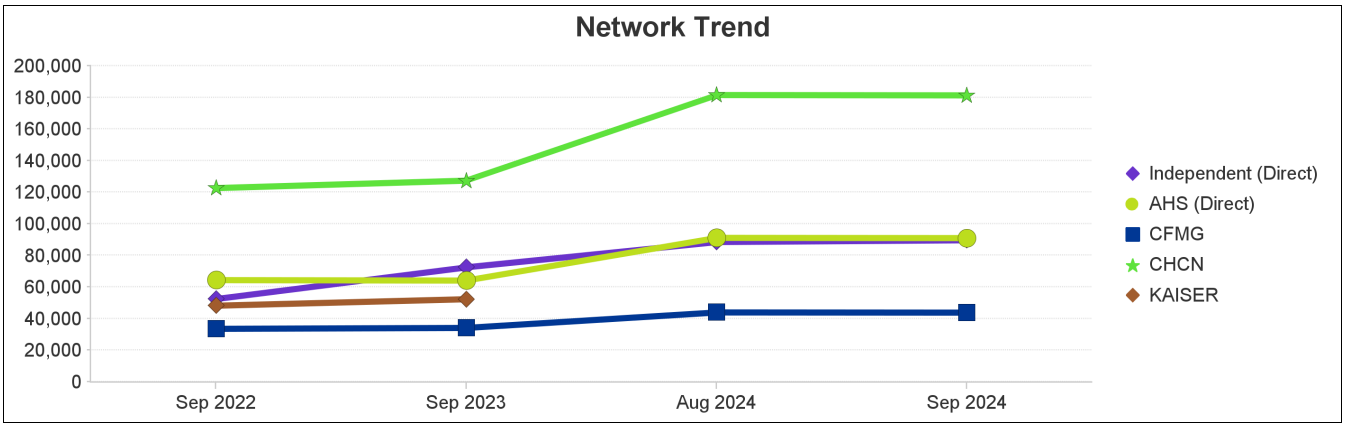
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	Sep 2022	Sep 2023	Aug 2024	Sep 2024	Sep 2022	Sep 2023	Aug 2024	Sep 2024	Sep 2022 to Sep 2023	Sep 2023 to Sep 2024	Aug 2024 to Sep 2024
Delegated	204,491	213,911	225,590	**225,266**	63.6%	61.0%	55.7%	55.5%	4.6%	5.3%	-0.1%
Direct	116,842	136,637	179,732	**180,687**	36.4%	39.0%	44.3%	44.5%	16.9%	32.2%	0.5%
Total	**321,333**	**350,548**	**405,322**	**405,953**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**9.1%**	**15.8%**	**0.2%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Network Trend

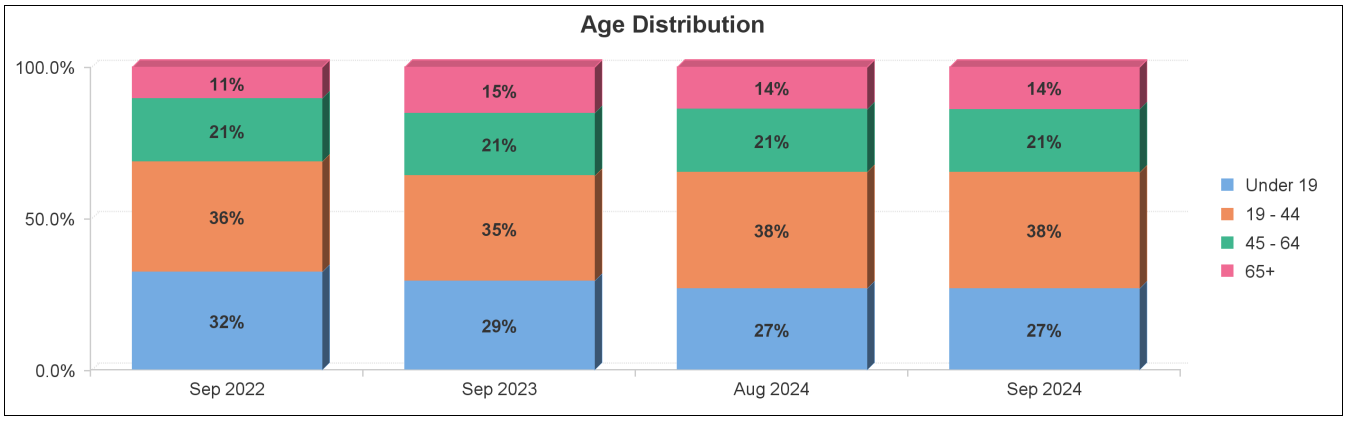
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Sep 2022	Sep 2023	Aug 2024	Sep 2024	Sep 2022	Sep 2023	Aug 2024	Sep 2024	Sep 2022 to Sep 2023	Sep 2023 to Sep 2024	Aug 2024 to Sep 2024
Independent (Direct)	52,418	72,504	88,550	**89,659**	16.3%	20.7%	21.8%	22.1%	38.3%	23.7%	1.3%
AHS (Direct)	64,424	64,133	91,182	**91,028**	20.0%	18.3%	22.5%	22.4%	-0.5%	41.9%	-0.2%
CFMG	33,577	34,144	43,959	**43,838**	10.4%	9.7%	10.8%	10.8%	1.7%	28.4%	-0.3%
CHCN	122,696	127,430	181,631	**181,428**	38.2%	36.4%	44.8%	44.7%	3.9%	42.4%	-0.1%
KAISER	48,218	52,337	0	**0**	15.0%	14.9%	0.0%	0.0%	8.5%	-100.0%	0.0%
Total	**321,333**	**350,548**	**405,322**	**405,953**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**9.1%**	**15.8%**	**0.2%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

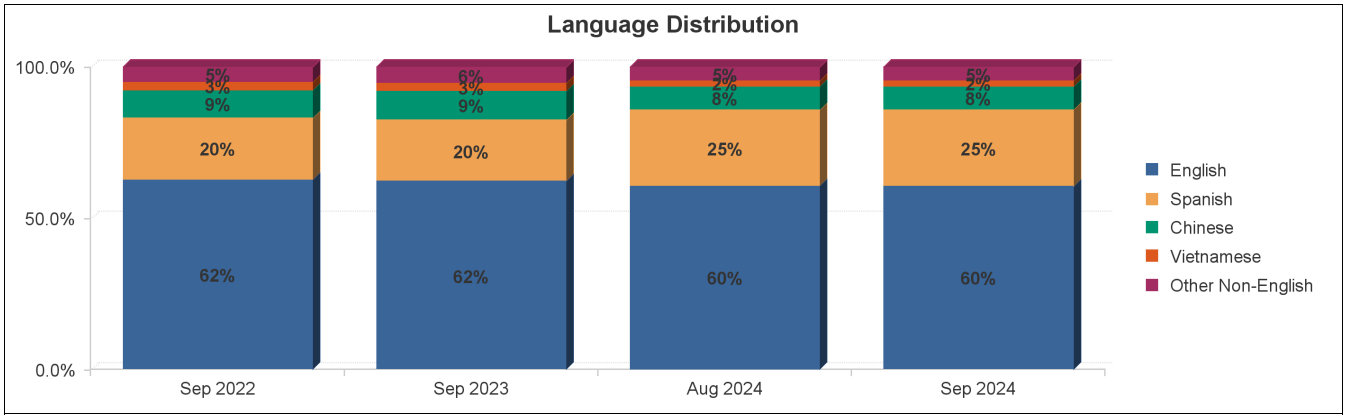
Age Category Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Sep 2022	Sep 2023	Aug 2024	Sep 2024	Sep 2022	Sep 2023	Aug 2024	Sep 2024	Sep 2022 to Sep 2023	Sep 2023 to Sep 2024	Aug 2024 to Sep 2024
Under 19	103,516	102,388	108,349	**108,338**	32%	29%	27%	27%	-1%	6%	0%
19 - 44	116,874	121,851	155,686	**155,780**	36%	35%	38%	38%	4%	28%	0%
45 - 64	66,989	72,445	84,199	**84,362**	21%	21%	21%	21%	8%	16%	0%
65+	33,954	53,864	57,088	**57,473**	11%	15%	14%	14%	59%	7%	1%
Total	**321,333**	**350,548**	**405,322**	**405,953**	**100%**	**100%**	**100%**	**100%**	**9%**	**16%**	**0%**



Language Trend

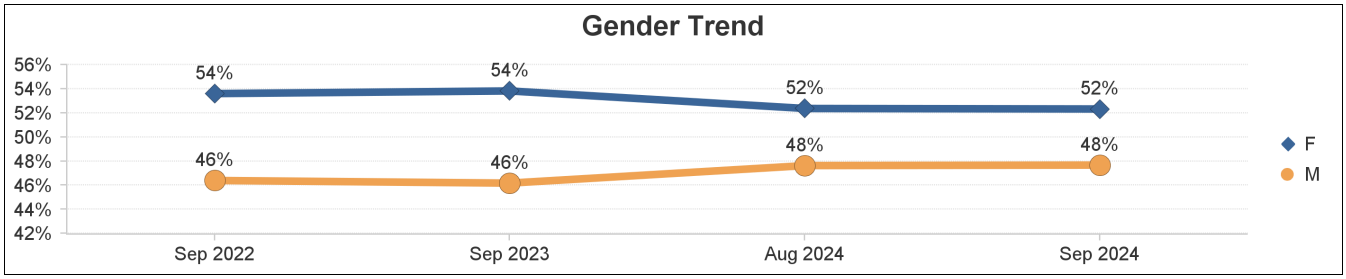
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	Sep 2022	Sep 2023	Aug 2024	Sep 2024	ep 2022	ep 2023	Aug 2024	ep 2024	Sep 2022 to Sep 2023	Sep 2023 to Sep 2024	Aug 2024 to Sep 2024
English	200,696	217,655	245,150	**245,070**	62%	62%	60%	60%	8%	13%	0%
Spanish	65,837	70,947	102,034	**102,701**	20%	20%	25%	25%	8%	45%	1%
Chinese	29,053	33,023	30,695	**30,727**	9%	9%	8%	8%	14%	-7%	0%
Vietnamese	8,928	9,522	8,310	**8,280**	3%	3%	2%	2%	7%	-13%	0%
Other Non-English	16,819	19,401	19,133	**19,175**	5%	6%	5%	5%	15%	-1%	0%
Total	**321,333**	**350,548**	**405,322**	**405,953**	**100%**	**100%**	**100%**	**100%**	**9%**	**16%**	**0%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

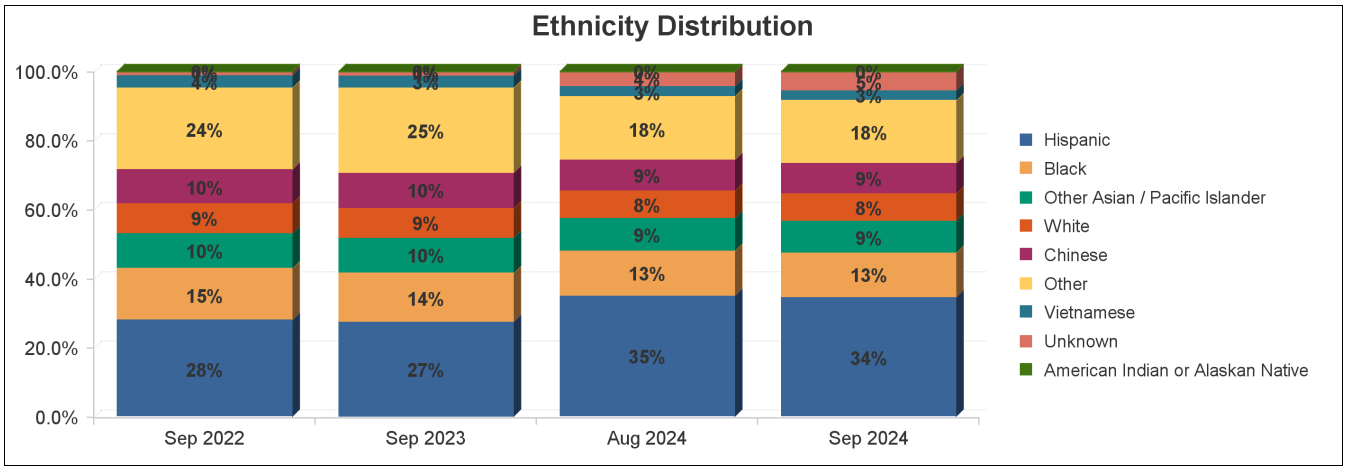
Gender Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Sep 2022	Sep 2023	Aug 2024	Sep 2024	Sep 2022	Sep 2023	Aug 2024	Sep 2024	Sep 2022 to Sep 2023	Sep 2023 to Sep 2024	Aug 2024 to Sep 2024
F	172,247	188,681	212,258	**212,422**	54%	54%	52%	52%	10%	13%	0%
M	149,086	161,867	193,064	**193,531**	46%	46%	48%	48%	9%	20%	0%
Total	**321,333**	**350,548**	**405,322**	**405,953**	**100%**	**100%**	**100%**	**100%**	**9%**	**16%**	**0%**



Ethnicity Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Sep 2022	Sep 2023	Aug 2024	Sep 2024	Sep 2022	Sep 2023	Aug 2024	Sep 2024	Sep 2022 to Sep 2023	Sep 2023 to Sep 2024	Aug 2024 to Sep 2024
Hispanic	89,573	95,595	141,075	**139,641**	28%	27%	35%	34%	7%	46%	-1%
Black	48,141	49,809	52,860	**52,255**	15%	14%	13%	13%	3%	5%	-1%
Other Asian / Pacific Islander	32,208	35,405	38,062	**37,604**	10%	10%	9%	9%	10%	6%	-1%
White	27,911	30,367	32,586	**32,080**	9%	9%	8%	8%	9%	6%	-2%
Chinese	31,599	35,649	35,869	**35,544**	10%	10%	9%	9%	13%	0%	-1%
Other	76,226	86,602	74,954	**74,071**	24%	25%	18%	18%	14%	-14%	-1%
Vietnamese	11,448	12,022	11,804	**11,649**	4%	3%	3%	3%	5%	-3%	-1%
Unknown	3,533	4,380	17,310	**22,311**	1%	1%	4%	5%	24%	409%	29%
American Indian or Alaskan Native	694	719	802	**798**	0%	0%	0%	0%	4%	11%	0%
Total	**321,333**	**350,548**	**405,322**	**405,953**	**100%**	**100%**	**100%**	**100%**	**9%**	**16%**	**0%**



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

Medi-Cal By City

City	Sep 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	160,428	40%	23,670	42,625	17,260	76,873
HAYWARD	64,274	16%	13,065	17,399	7,485	26,325
FREMONT	37,448	9%	15,485	6,635	2,174	13,154
SAN LEANDRO	33,124	8%	8,215	5,707	4,250	14,952
UNION CITY	14,672	4%	5,569	2,642	863	5,598
ALAMEDA	13,839	3%	3,317	2,511	2,075	5,936
BERKELEY	14,954	4%	4,042	2,286	1,766	6,860
LIVERMORE	12,950	3%	1,859	618	2,231	8,242
NEWARK	9,387	2%	2,740	4,119	516	2,012
CASTRO VALLEY	9,463	2%	2,579	1,625	1,392	3,867
SAN LORENZO	7,327	2%	1,464	1,672	847	3,344
PLEASANTON	7,544	2%	1,717	409	829	4,589
DUBLIN	7,495	2%	1,981	431	897	4,186
EMERYVILLE	2,825	1%	629	619	456	1,121
ALBANY	2,521	1%	654	296	565	1,006
PIEDMONT	471	0%	107	196	50	118
SUNOL	82	0%	25	13	6	38
ANTIOCH	27	0%	9	8	1	9
Other	1,412	0%	383	321	175	533
Total	400,243	100%	**87,510**	**90,132**	**43,838**	**178,763**

Group Care By City

City	Sep 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	1,805	32%	359	333	0	1,113
HAYWARD	646	11%	310	147	0	189
FREMONT	641	11%	426	71	0	144
SAN LEANDRO	607	11%	242	93	0	272
UNION CITY	301	5%	188	48	0	65
ALAMEDA	296	5%	87	26	0	183
BERKELEY	152	3%	49	12	0	91
LIVERMORE	98	2%	29	4	0	65
NEWARK	138	2%	84	28	0	26
CASTRO VALLEY	190	3%	80	30	0	80
SAN LORENZO	135	2%	43	23	0	69
PLEASANTON	69	1%	25	2	0	42
DUBLIN	119	2%	41	5	0	73
EMERYVILLE	33	1%	13	4	0	16
ALBANY	21	0%	12	1	0	8
PIEDMONT	9	0%	2	0	0	7
SUNOL	2	0%	2	0	0	0
ANTIOCH	26	0%	7	5	0	14
Other	422	7%	150	64	0	208
Total	**5,710**	**100%**	**2,149**	**896**	**0**	**2,665**

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

Total By City

City	Sep 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	162,233	40%	24,029	42,958	17,260	77,986
HAYWARD	64,920	16%	13,375	17,546	7,485	26,514
FREMONT	38,089	9%	15,911	6,706	2,174	13,298
SAN LEANDRO	33,731	8%	8,457	5,800	4,250	15,224
UNION CITY	14,973	4%	5,757	2,690	863	5,663
ALAMEDA	14,135	3%	3,404	2,537	2,075	6,119
BERKELEY	15,106	4%	4,091	2,298	1,766	6,951
LIVERMORE	13,048	3%	1,888	622	2,231	8,307
NEWARK	9,525	2%	2,824	4,147	516	2,038
CASTRO VALLEY	9,653	2%	2,659	1,655	1,392	3,947
SAN LORENZO	7,462	2%	1,507	1,695	847	3,413
PLEASANTON	7,613	2%	1,742	411	829	4,631
DUBLIN	7,614	2%	2,022	436	897	4,259
EMERYVILLE	2,858	1%	642	623	456	1,137
ALBANY	2,542	1%	666	297	565	1,014
PIEDMONT	480	0%	109	196	50	125
SUNOL	84	0%	27	13	6	38
ANTIOCH	53	0%	16	13	1	23
Other	1,834	0%	533	385	175	741
Total	405,953	100%	**89,659**	**91,028**	**43,838**	**181,428**

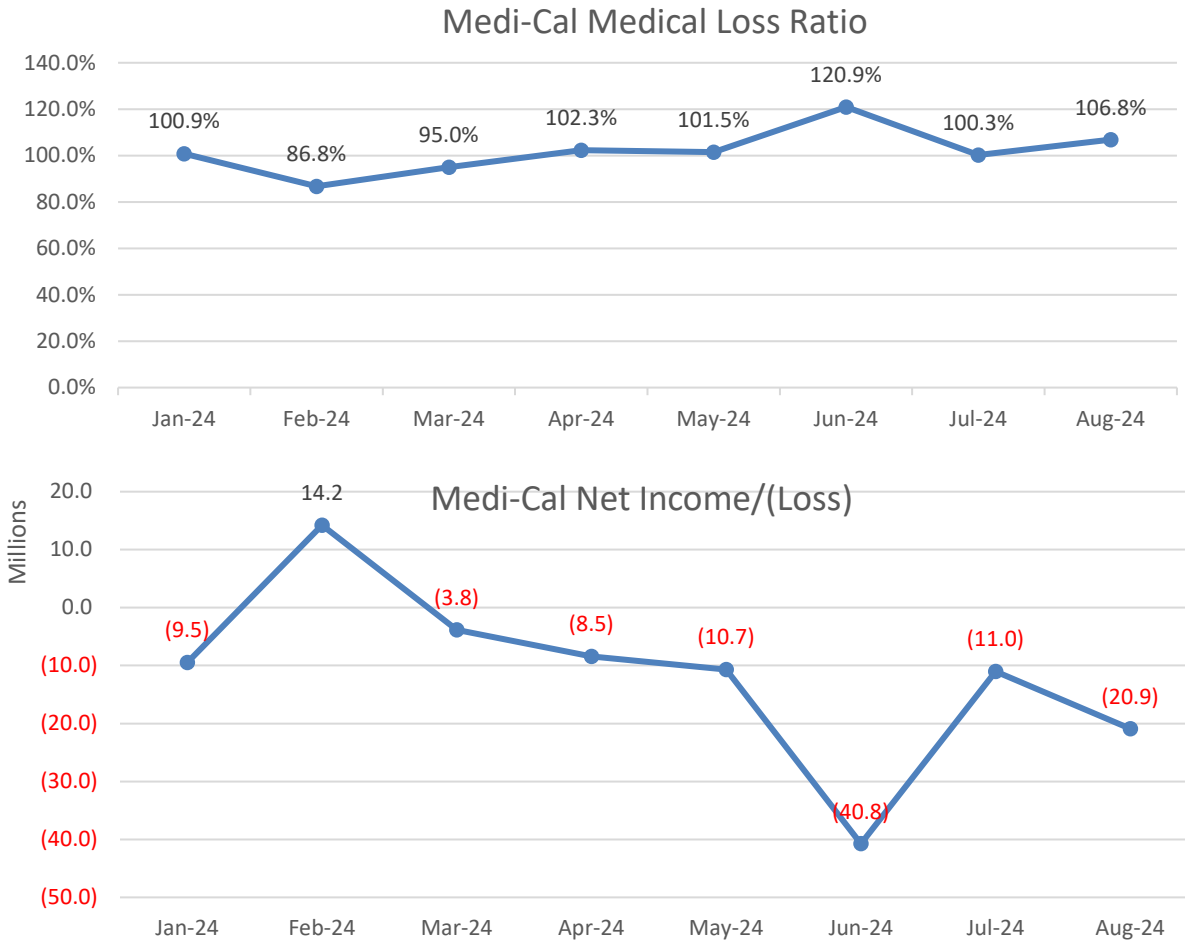
Alameda Alliance October Financial Update

ALAMEDA Alliance FOR HEALTH

Updated Year to Date Numbers

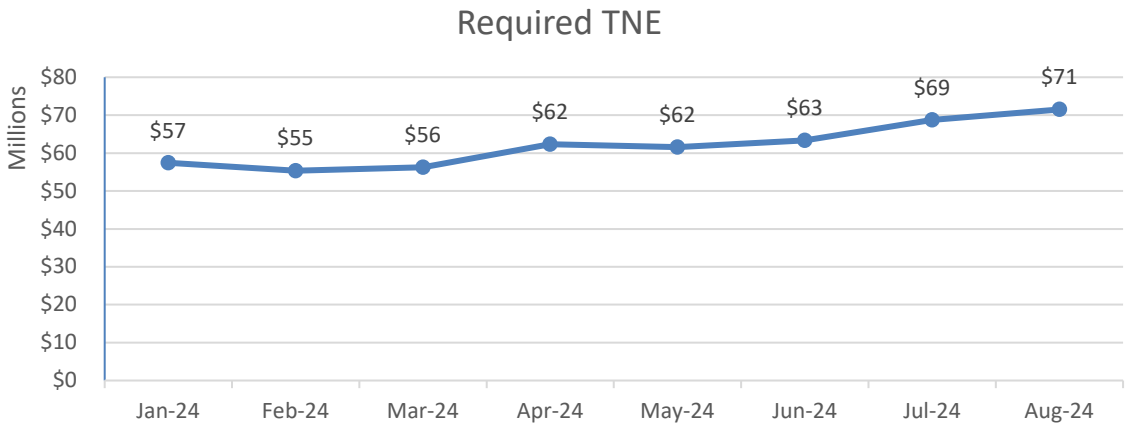
- Removed prior period revenue adjustment related to CY23 acuity and any gains from investment income.
- Medical Loss Ratio above 100% from April through August and beyond.
- Year to date MLR at 102%.
- Total Net Loss of $91M.
- Tangible Net Equity near 200%.
- Community support costs estimated to be $33.6M for the fiscal year, representing at 54% increase from fiscal year 2024.
- There was a significant negative variance in Community Supports revenue($7.3M) compared to expenses for FY24 ($21.8M) and this negative variance is expected to increase for FY25.
- Draft CY25 rates represent only a 3.9% increase from CY24.

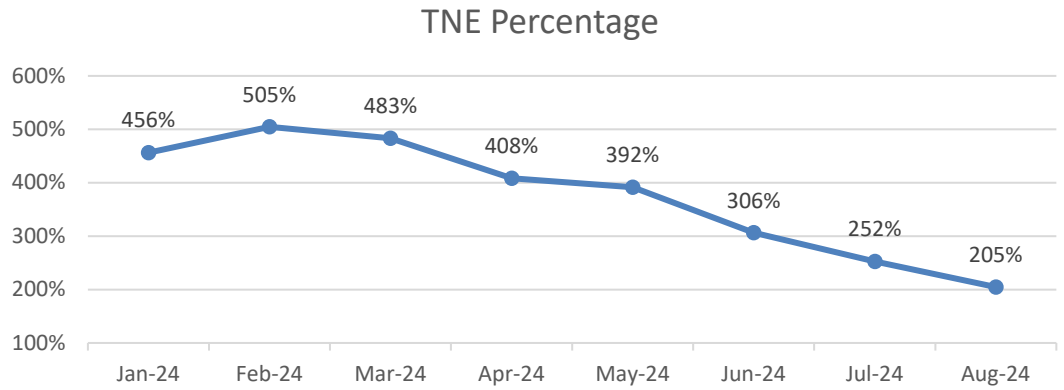
CY24 Financial Trends
Removed Prior Period Adjustment for CY23 and Investment Income



- Medical Loss Ratio above 100% from April through August.
- Material Net Loss continues even with the removal of prior period revenue adjustments.

CY24 Financial Trends
Percentage of Excess TNE Drops Significantly





Tangible Net Equity drops precipitously with the removal of investment income from the Other Income and Expense category.

CY24 Year to Date Medi-Cal only Financial Results Excluding Prior Period Revenue Adjustment and Investment Income

Alameda Alliance for Health
Medi-Cal Profit & Loss
January - August 2024
Excludes CY23 Medi-Cal Rate Reduction and Other Income/Expense

	Medi-Cal							
	Child	Adults	SPD	ACA OE	Duals	LTC	LTC Duals	Total
Premium Revenue	115,608,927	173,396,402	312,156,004	426,841,568	109,778,101	17,941,366	88,541,440	1,244,263,807
Add-back: CY23 Rate Reduction	2,385,406	5,748,290	15,722,186	16,889,008	15,339,980	347,962	2,578,435	59,011,268
MCO Tax Revenue	201,611,918	108,941,281	63,742,170	256,221,726	77,723,214	330,595	2,176,652	**710,747,557**
Total Revenue	**319,606,252**	**288,085,973**	**391,620,360**	**699,952,302**	**202,841,296**	**18,619,923**	**93,296,526**	**2,014,022,631**
Medical Expense								
Total Medical Expense	**104,702,538**	**162,844,292**	**363,951,322**	**450,494,891**	**125,076,907**	**21,920,423**	**94,490,431**	**1,323,480,804**
Gross Margin Excluding MCO Tax	**10,906,389**	**10,552,109**	**(51,795,318)**	**(23,653,323)**	**(15,298,806)**	**(3,979,057)**	**(5,948,991)**	**(79,216,997)**
Administrative Expense	3,883,649	8,532,726	22,320,133	24,106,179	6,373,997	1,169,671	5,589,624	**71,975,979**
MCO Tax Expense	201,602,816	108,837,978	62,660,008	256,213,881	77,717,854	330,334	2,177,546	**709,540,417**
Net Income	**9,417,248**	**7,870,977**	**(57,311,103)**	**(30,862,649)**	**(6,327,463)**	**(4,800,505)**	**(8,961,074)**	**(90,974,569)**
MLR excluding MCO Tax	**89%**	**91%**	**111%**	**102%**	**100%**	**120%**	**104%**	**102%**
ALR	**3.4%**	**4.9%**	**7.2%**	**5.6%**	**5.8%**	**6.5%**	**6.3%**	**5.8%**

- Total MLR of 102% for the period.
- SPD MLR 111%, LTC MLR 120%.
- Total Net Loss of $91M reported from January to August 2024.
- Medi-Cal ALR less than 6%.

Community Support Costs Exceed Projected Revenue

Community Supports Service	FY25
FY25 (July 2024-June 2025) Estimated Expense	
CS Housing Deposit FFS Ancillary	$ 1,174,668
CS Housing Tenancy FFS Ancillary	$ 9,381,815
CS Housing Navigation Services FFS Ancillary	$ 5,287,386
CS Medical Respite FFS Ancillary	$ 8,442,793
CS Medically Tailored Meals FFS Ancillary	$ 1,946,767
CS Asthma Remediation FFS Ancillary	$ 255,000
CS Home Modification FFS Ancillary	$ 120,000
CS Personal Care & Homemaker Services FFS Ancillary	$ 6,371,243
CS Caregiver Respite Services FFS Ancillary	$ 240,000
Sobering Center	-
LTC Diversion FFS Ancillary	$ 300,000
LTC Transition FFS Ancillary	$ 82,500
Day Habilitation	-
Short Term Post Hospitalization	-
	$ 33,602,171

- Community Supports expense projected to exceed $33M for fiscal year 2025. This is an increase of 54% from fiscal year 2024.
- Housing bundle represents 47% of total CS expense.
- Revenue projections fell well short of expected expenses for FY24 and are expected to fall short of FY25.
- Refreshing return on investment analysis but fiscal year 2024 analysis did not show savings from community supports investments.

DHCS Rate Support Needed

- Material rate increases for CY25 across most COAs are needed to support increasing volume and expense trends.
- Core business impacted by Community Supports costs.
- DSNP line of business ramp up includes significant expense outlay (labor, consulting, vendor) without supporting revenue.
- Positive returns from investment income will diminish as interest rates are lowered.
- Safety net system impacts will be experienced with our County partnership and safety net hospitals (AHS/St. Rose).
- Network adequacy concerns (provider groups closing to our members).

Thank You

Questions?

You can contact me at:

GRiojas@alamedaalliance.org

ALAMEDA Alliance FOR HEALTH

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

Operations

Ruth Watson

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

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

Date: **November 8th, 2024**

Subject: **Operations Report**

Member Services

- 12-Month Trend Blended Summary:

    - The Member Services Department received a five percent (5%) increase in calls in October 2024, totaling seventeen thousand six hundred twenty (17,620) compared to sixteen thousand seven hundred fifty-two (16,752) in October 2023.
    - The abandonment rate for October 2024 was three percent (3%), compared to six percent (6%) in October 2023.
    - The Department's service level was ninety-seven percent (97%) in October 2024, compared to eighty-five percent (85%) in October 2023. The average speed to answer (ASA) was nine seconds (00:09) compared to thirty-two seconds (00:32) in October 2023. 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 eight seconds (07:08) for October 2024 compared to six minutes and forty seconds (06:40) for October 2023.
    - One hundred percent (100%) of calls were answered within 10 minutes for October 2024 and ninety-nine percent (99%) of calls were answered within 10 minutes for October 2023.
    - Outbound calls totaled seven thousand seven hundred sixty-seven (7,767) in October 2024 compared to seven thousand-two hundred ninety-eight (7,298) in October 2023.
    - The top five call reasons for October 2024 were: 1). Change of PCP, 2). Eligibility/Enrollment, 3). Provider Network, 4). Benefits, 5). Grievances/Appeals. The top five call reasons for October 2023 were: 1). Change of PCP, 2). Eligibility/Enrollment 3). Benefits, 4). Grievance and Appeals, 5). ID Card requests.
    - October utilization for the member automated eligibility IVR system totaled one thousand one hundred eighty-eight (1,188) in October 2024 compared to one thousand two hundred twenty-three (1,223) in October 2023.
    - 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 one thousand forty (1,040) web-based requests in October 2024 compared to nine hundred ninety-nine (999) in October 2023. The top three web reason requests for October 2024 were: 1). Change of PCP, 2). ID Card

Requests, 3). Update Contact Information. Sixty-four (64) members were assisted in-person in October 2024 compared to eighteen (18) in 2023.

- Member Services Behavioral Health:

    - The Member Services Behavioral Health Unit received a total of one thousand two hundred sixty-two (1,262) calls in October 2024 compared to one thousand one hundred sixty-five (1,165) in October 2023.
    - The abandonment rate was seven percent (7%) in October 2024 compared to eight percent (8%) in 2023.
    - The service level was eighty percent (80%) in October 2024 and eighty-seven percent (87%) in October 2023.
    - The average speed to answer (ASA) was forty-five seconds (00:45) compared to forty seconds (00:44) in October 2023.
    - Calls answered in ten (10) minutes were ninety-eight percent (98%) in October 2024 compared to ninety-nine percent (99%) in October 2023.
    - The Average Talk Time (ATT) was nine minutes and twenty-one seconds (09:21) compared to ten minutes and eighteen seconds (10:18) in October 2023. 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.
    - One hundred seventy-eight (178) screenings were completed in October 2024 compared to two hundred forty-one (241) in October 2023.
    - Forty-five (45) referrals were made to the County (ACCESS) in October 2024 compared to sixty-seven (67) in October 2023.
    - Nine hundred seventy-five (975) outbound calls were completed in October 2024 compared to one thousand five hundred six (1,506) in October 2023.
    - Ninety-seven (97) outreach campaigns were completed in October 2024 compared to two hundred and fifty (250) in October 2023.
    - Thirty-two (32) members were referred to Center Point for SUD services in October 2024 compared to thirty-one (31) in October 2023.

Claims

- 12-Month Trend Summary:

    - The Claims Department received 367,989 claims in October 2024 compared to 241,298 in October 2023.
    - The Auto Adjudication was 83.9% in October 2024 compared to 81.0% in October 2023.
    - Claims compliance for the 30-day turn-around time was 90.8% in October 2024 compared to 94.0% in October 2023. The 45-day turn-around time was 99.8% in October 2024 compared to 99.9% in October 2023.

- Monthly Analysis:

    - In the month of October, we received a total of 367,989 claims in the HEALTHsuite system. This represents an increase of 14.22% from September and is higher, by 126,691 claims, than the number of claims received in October 2023.
    - Drivers of the higher volume of received claims includes:
        - The increased membership since January 2024.
        - Members who delayed care during the pandemic are now catching up and utilizing services.
        - Certain provider types that bill more frequently, e.g., LTC facilities that bill weekly or bi-weekly.
        - Providers with dual eligible members who are submitting paper claims even though we receive the same claim in our COBA file.
    - We received 90.6% of claims via EDI and 9.4% of claims via paper.
    - During the month of October, 99.8% of our claims were processed within 45 working days.
    - The Auto Adjudication rate was 83.9% for the month of October.

Provider Services

- 12-Month Trend Summary:

    - The Provider Services department's call volume in October 2024 was eight thousand four hundred fifty-six (8,456) calls compared to seven thousand one hundred ninety-nine (7,199) calls in October 2023.
    - Provider Services continuously works to achieve first call resolution and reduction of the abandonment rates. Efforts to promote provider satisfaction is our first priority.
    - The Provider Services department completed six hundred twenty (620) calls/visits during October 2024.
    - The Provider Services department answered six thousand nine hundred two (6,902) calls for October 2024 and made seven hundred fifty-one (751) outbound calls.

Credentialing

- 12-Month Trend Summary:

    - At the Peer Review and Credentialing (PRCC) meeting held on October 15th, 2024, there were one hundred six (106) initial network providers approved; four (4) primary care providers, seventeen (17) specialists, eight (8) ancillary providers, six (6) midlevel providers, and seventy-one (71) behavioral health providers. Additionally, twenty-nine (29) providers were

re-credentialed at this meeting; six (6) primary care providers, seventeen (17) specialists, one (1) ancillary providers, and five (5) 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 October 2024, the Provider Dispute Resolution (PDR) team received 2,708 PDRs versus 1,560 in October 2023.
  - The PDR team resolved 2,200 cases in October 2024 compared to 1,786 cases in October 2023.
  - In October 2024, the PDR team upheld 57% of cases versus 77% in October 2023.
  - The PDR team resolved 99.1% of cases in October 2024 compared to 99% in October 2023; the compliance standard is 95% within 45 working days.

- Monthly Analysis:
  - AAH received 2,708 PDRs in October 2024.
  - In the month of October, 2,200 PDRs were resolved. Out of the 2,200 PDRs, 1,253 were upheld and 947 were overturned.
  - 2,181 out of 2,200 cases were resolved within 45 working days resulting in a 99.1% compliance rate.
  - The average turnaround time for resolving PDRs in October was 41 days.
  - There were 4,609 PDRs pending resolution as of 10/31/2024, with no cases older than 45 working days.
  - The overturn rate for PDRs was 43%, which did not meet our goal of 25% or less.
    - The two primary reasons that caused the Department to miss their goal of 25% or less are:
      - Member OHC corrections – 218 cases that were denied incorrectly.
      - Incorrect denials for Mental Health – 113 cases denied to the delegate in error.
      - The combined volumes of the two primary reasons for the overturned PDRs this month alone prevented us from achieving the goal of 25% or less.
  - The full breakdown of all 947 overturned PDRs is as follows:

Category	**# of Cases**	**% of Cases**	**Comments**
System Related Issues	**242**	**26%**	
General configuration issues	15	2%	Non-covered code, modifier, etc

Retro eligibility changes	7	1%	Member not eligible at time claim was denied
Financial responsibility	179	19%	Mental Health denied to delegate, CHME services were authorized.
Claims Editing System (CES)	41	4%	33 Cased due to 59025 incorrectly denied for invalid modifier. System has been corrected.
OHC Issues	**218**	**23%**	OHC Member TPL data, incorrect primary EOB not matching, incorrect manual entry
Authorization Issues	**173**	**18%**	
Processor error	60	6%	Claim denied in error; authorization was on file
Delegate Auth	14	1%	Delegate NOA attached to PDR
UM/retro auth review	99	11%	Auth updated after claim was processed and sent for medical review.
Additional Documentation	**39**	**4%**	
Duplicate claim	30	3%	Documentation received confirmed claim was not a duplicate
Timely filing	9	1%	Documentation received confirmed claim was submitted on time
Incorrect Rates	**149**	**15%**	
System	62	7%	Incorrect rates in system 24 cases PTPN
Letter of Agreement (LOA)	13	1%	Underpaid; LOA on file
LTC/Retro Rates	30	3%	Rates updated after claim was paid
COB calculation	40	4%	Incorrectly calculated
Share of Cost (SOC)	4	0%	Underpaid; SOC already met
Processor Errors	**126**	**14%**	
Duplicate claim	34	4%	Claim was a duplicate; processor paid it in error
Incorrect rate	9	1%	Claim manually priced incorrectly
Incorrect Manual Denial	63	7%	
Misc errors	20	2%	
PDR Overturn Totals	**602**	**100%**	

Community Relations and Outreach

- 12-Month Trend Summary:
    - In October 2024, the Alliance completed 1,704 member orientation outreach calls and 146 member orientations by phone.
    - The C&O Department reached 1,169 people (333 identified as Alliance members) during outreach activities, compared to 460 individuals (53% self-identified as Alliance members) in October 2023.

- The Alliance spent a total of $100.00 in donations, fees, and/or sponsorships, compared to $5,250.00 in October 2023.
- The C&O Department reached members in 13 cities/unincorporated areas throughout Alameda County, and Bay Area, and the U.S., compared to 12 locations in October 2023.

- Monthly Analysis:

  - In October 2024, the C&O Department completed 1,704 member orientation outreach calls, 146 member orientations by phone, 53 Alliance website inquiries 8 service requests, 2 community events, and 9 member education events.
  - Among the 1,169 people reached, 28% identified as Alliance members.
  - In October 2024, the C&O Department reached members in 13 locations throughout Alameda County and the Bay Area.
  - Please see attached **Addendum A**.

Housing and Community Services Program Report – October Activities

Housing & Community Services Department 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:

- Community Supports (CS) housing bundle transitioned to Housing & Community Services on 10/1/2024
- ROI project for housing-related CS is ongoing
- Development of Standard Operating Procedures (SOPs) for housing-related CS
- Revamped Housing Service Plan with Alameda County Health Housing & Homelessness (AC Health H&H)
- Cross organization training planning with AC Health H&H
- Developing SWOT Analysis for the housing bundle

Interdepartmental Collaborations:

- Health Care Services & Housing Operations – Operational Efficiency Workgroup established

Community Networks and Partnership Development:

- Continued participation with various stakeholders throughout Alameda County, including the Continuum of Care (CoC), Racial Equity Committee, Outreach Access & Coordination Committee, Healthcare for the Homeless Oakland Regional Housing

Meeting, Homeless Management Information System (HMIS) Committee, and Corporation for Supportive Housing Advisory Council.

- Racial Equity Committee – Co-Development of Racial Equity presentation for CoC Fall 2024 Home Together Symposium
- HMIS Committee – working to implement the CoC Racial Equity Framework to support persons with lived experience (PWLE) in HMIS evaluation
- Corporation for Supportive Housing Advisory Council – developing standardization documentation for Housing Community Supports across the state of California CalAIM participating providers
- National Association of Housing & Redevelopment Officials – designing introduction to CalAIM presentation

Staffing:

- Housing and Community Services Housing Program Coordinators – two (2) new staff started October 7th, 2024

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 – CHW Learning Cohort, designed to engage public health professionals, community-based organizations, hospital partners, and other local health jurisdictions in the CHW work; go-live targeted for March 2025

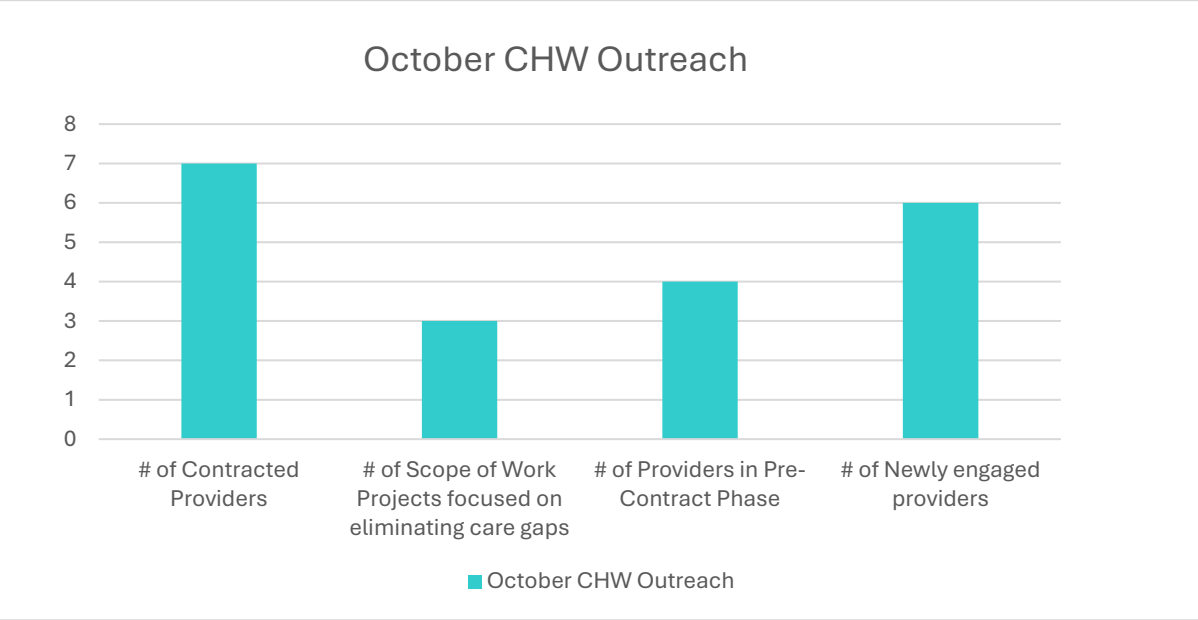
Interdepartmental Collaboration:

- Health Equity Department – cross-collaboration on the Social Determinants of Health (SDOH) project and CHW Logic Model
- Quality Team – CHW utilization projects
  - CHW utilization to support member follow-up for Mental Health (FUM) measures
  - CHW integration to improve A1C for Alameda Alliance members
- Population Health Management – integration of CHW services for Perinatal Depression

Community Networks & Partnership Development:

- Seven (7) organizations are fully contracted to provide CHW services
- Three (3) active scope of work projects focused on eliminating care gaps
- Four (4) providers in the pre-contract phase
- Six (6) providers newly engaged

- CHWs services expanded to provide Violence Prevention and Intervention by bringing on Youth Alive through Journey Health



Incentives & Reporting Board Report – October 2024 Activities

Current Incentive and Grant Programs

CalAIM Incentive Payment Program (IPP) – three-year DHCS program to provide funding for the support of ECM and Community Supports (CS) in 1) Delivery System Infrastructure, 2) ECM Provider Capacity Building, 3) CS Provider Capacity Building and CS Take-Up, and 4) Quality and Emerging CalAIM Priorities:

- For Program Year 1 (1/1/2022 - 12/31/2022):
  - Alameda Alliance was allocated $14.8M and earned 100% of the allocated funds; the Plan distributed funding to ten (10) providers and organizations to support ECM and CS programs
- For Program Year 2 (1/1/2023 - 12/31/2023):
  - Alameda Alliance was allocated $15.1M and earned 60% of the allocated funds based on the Submission 3 report which equaled $4.56M; the Plan distributed funding to 12 providers and organizations to support ECM and CS programs
  - The Submission 4 report, reflecting the lookback period of 7/1/2023 - 12/31/2023, was submitted to DHCS on March 1st, 2024; the Alliance is still awaiting feedback from DHCS
- For Program Year 3 (1/1/2024 - 6/30/2024):
  - The Alliance completed the review of Wave 4 IPP Provider Applications and awarded funding to two (2) entities to support CS programs
  - The Submission 5 report, reflecting the lookback period of 1/1/2024 - 06/30/2024, was submitted to DHCS on September 9th, 2024; the Alliance is still awaiting feedback from DHCS

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

- Partner meetings continued with the Local Education Agencies (LEAs) regarding project plan activities and to prepare for the last SBHIP submission, the Project Outcome Report, which is due to DHCS December 31st
- The Alliance submitted the Bi-Quarterly Report (BQR) for the reporting period of January – June 2024 on June 27th, 2024
    - DHCS notified the Alliance on September 18th, 2024, that we had earned 100% of eligible funds tied to the reporting period ($1.1M)
    - Funds were received on October 28th, 2024, and the Alliance will begin to distribute payments to the LEAs in early November
- To date, $8.6M has been awarded to the Alliance by DHCS for completed deliverables, and a total of $6.6M 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
    - $18.7M has been awarded to our HHIP partners to date
- A HHIP funding opportunity was released earlier this year 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 ten (10) LEAs totaling $1.3M in requests; all submitted applications were approved and work on the funded programs has begun
- Decisions for the HHIP funding opportunity that was released to the community to support HHIP goals of reducing and preventing homelessness utilizing funds earned from the S2 report were announced in September 2024
    - Ten (10) applications were received totaling $19.9M in funding requests related to capacity building, innovation, diversity and health equity, and housing stability
    - The Alliance awarded $11.2M in funding to the ten (10) organizations and MOUs are being developed with partners

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.

- Of the fourteen (14) practices that submitted program applications, Alameda Health System was the only Alliance-associated applicant selected by DHCS to participate

- The original funding was $700 million over five (5) years; however, due to state budget constraints, the funding has been reduced to $140 million over three (3) years
    - One impact related to the funding reduction is that DHCS has delayed the initial program payment for practices to March 2025

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

- Program launched on June 1st, 2024
- Eleven (11) informational sessions were conducted to share program details with interested practices
- The application period closed on September 6th; and the Alliance received a total of fifteen (15) applications totaling $6M in funding requests
- A multi-disciplinary team evaluated the applications and made funding recommendations to a group of senior leaders (CEO, COO, CFO, CMO); funding decisions were approved on October 25th, 2024, and partners were notified
- $2M in funding will be awarded to thirteen (13) provider partners, pending finalization of MOUs and related program deliverables for the following:
    - Eighteen (18) providers total, nine (9) of which are bi-lingual
        - Six (6) Nurse Practitioners (NPs), including behavioral health NPs
        - Five (5) Primary Care Medical Doctors
        - Four (4) Licensed Clinical Social Workers (LCSW) and Licensed Marriage and Family Therapists (LMFT)
        - Three (3) Obstetrics and Gynecology Medical Doctors
        - Thirty-three (33) scholarships for Community Health Worker (CHW) certification training

Recruiting and Staffing

Incentives & Reporting Open position(s):

- The Business Analyst, Incentives & Reporting started October 14th

Incentive and Grant Program Descriptions

CalAIM Incentive Payment Program (IPP) – The CalAIM ECM and CS programs will require significant new investments in care management capabilities, ECM and CS infrastructure, information technology (IT) and data exchange, and workforce capacity across MCPs, city and county agencies, providers, and other community-based organizations. CalAIM incentive payments are intended to:

- Build appropriate and sustainable ECM and Community Supports capacity
- Drive MCP investment in necessary delivery system infrastructure
- Incentivize MCP take-up of Community Supports
- Bridge current silos across physical and behavioral health care service delivery
- Reduce health disparities and promote health equity
- Achieve improvements in quality performance

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.

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

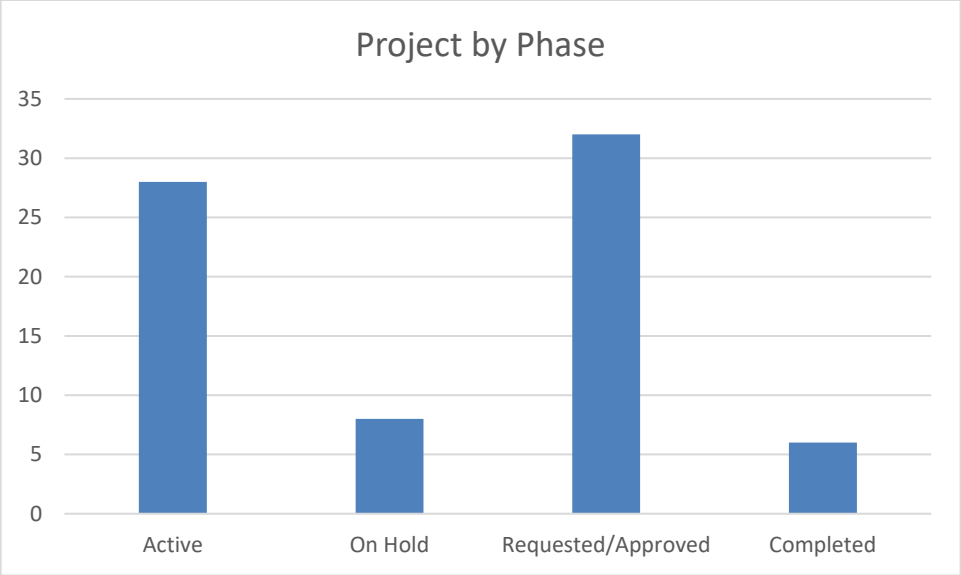
Equity and Practice Transformation (EPT) Payments Program – new program released by DHCS in August 2023 as a one-time primary care provider practice transformation program designed to advance health equity, reduce COVID-19-driven care disparities, and prepare practices to participate in alternative payment 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 has been 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:

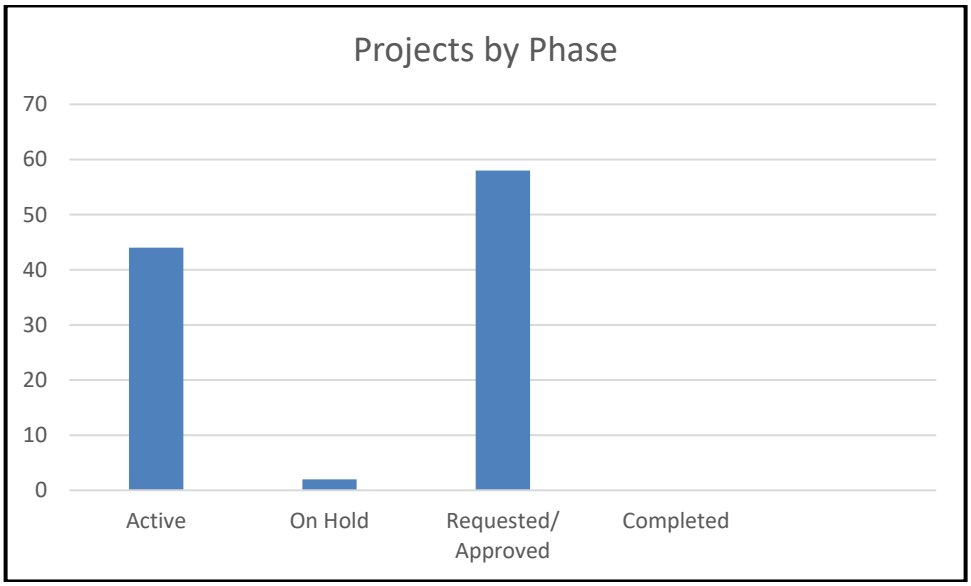
- Expanding the Alameda Alliance Provider network
- Improving member access to Primary Care Providers, Specialists, and Behavioral Health professionals
- Promoting diverse and culturally inclusive care reflective of Alliance members

INTEGRATED PLANNING DIVISION BOARD REPORT – OCTOBER 2024 ACTIVITIES

- Enterprise Portfolio
    - 75 projects currently on the Alameda Alliance for Health (AAH) enterprise-wide portfolio
        - 28 Active projects (discovery, initiation, planning, execution, warranty)
        - 8 On Hold projects
        - 32 Requested and Approved Projects
        - 6 Completed Projects (Last month)



- D-SNP Portfolio
  - 113 projects currently on the Alameda Alliance for Health (AAH) enterprise-wide portfolio
    - 51 Active projects (discovery, initiation, planning, execution, warranty)
    - 56 Requested Projects
    - 6 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 – October 2024
  - Provider Services & Contracting
    - Provider contracting started July 22, 2024. To date, 142 providers have returned signed contracts for AAH execution.
    - Three D-SNP Consideration Campaign 2 theme "*Understanding what matters the most. Creating a vision for the future*" webinars were held October 24th, 31st and November 1st.
    - Continued development of business process future state workflows and requirements development for the Provider Portal and Provider Repository

  - Product
    - Continuing the D-SNP Branding Project and completed change order to SOW for Alameda Alliance master brand refresh.
    - Continuing the D-SNP Medicare Organizational Structure Exercise and 17 documents reviewed / approved out of 28 total number of departments.
    - Completed MA D-SNP presentation within the quarterly CalAIM discussion.
    - Continued development of business requirements for Enrollment, Disenrollment and Eligibility with request for final review and approval
    - Engagement with the following vendors to support Supplemental Benefit Offering(s)
      - Dental –Initial benefit discussion in process
      - Vision – scoring in process
      - Hearing – scoring in process
      - Flex Card – scoring in process
      - MTM – scoring in process
      - HRA – scoring in process

  - Quality
    - 73 Narratives completed along with 3 additional narratives required by DHCS.
    - MOC 2 all narratives have been reviewed by the business and edits have been completed. Currently being reviewed by ED of Medicare Programs
    - MOC 3 all narratives have been reviewed by the business and edits have been completed. Next step is review by ED of Medicare Programs
    - MOC 4 narratives are currently being reviewed by the business.

- MOC 1 all narratives are complete and currently being reviewed by the business.
- Defining specific goals and objectives for QIP and CCIP initial stages.

MOC Element	Total Factors	# Draft Complete	# In Progress	# Not Started
MOC 1	8	8	0	0
MOC 2	32	32	0	0
MOC 3	12	12	0	0
MOC 4	21	21	0	0
Totals	73	73	0	0
		100%	0%	0%

- Health Care Services / Behavioral Health
  - UM clinical guidelines demo completed with MCG on 10/15
  - Redlining UM and CM Program Descriptions for DSNP elements
  - Developing Prior Authorization Form
  - Updating existing HRA with DSNP Requirements
  - Future State (DSNP) Inpatient and OP UM Business BRD – System Requirements Documentation started in collaboration with vendor.
  - Future State DSNP CM Global Workflow in draft – Outlining process flows for new DSNP components to include Face-to-Face visit, Palliative Care Program, and Dementia Care Program
  - Completing inventory of existing CM and UM artifacts including assessments and notes to identify needs
  - BH UM Future State (DSNP) Business Process Documentation in progress – Defining program model and IT needs as this will be a new process for DSNP
  - BH CM – Continuing to document DSNP CM program structure

- Finance
  - Completed a MA D-SNP finance accounting evaluation exercise for Q3 2024.
  - Business Requirements Document (BRD) Approval received for each of the following:
    - 5A – Finance Planning & Decisions
    - 5B – Medicare Finance Program
    - 5C – Financial Reconciliation and Reporting
  - Initiated development of policies and business processes to support the approved requirements

- Compliance
  - NOIA internal exercise complete and ready to submit NOIA on 11/8
  - DMHC Material Modification – D-SNP Product (Filing #20244060)
    - Initial AAH responses submitted to DMHC on 9/9/24
    - DMHC Comment Table received 10/4/24
    - AAH responses to comment table submitted 10/29/24

- Pharmacy
  - Pre-delegation audit is nearing completion. Additional documentation was requested from PerformRx; expected to be received by 11/1. Exit conference is scheduled for 11/6
  - MTM vendor scoring and selection is underway. Additional questions posed to 3 potential vendors and scoring is almost complete
  - 15 P&Ps in development with Rebellis: 1 not started, 5 in review, 9 ready for committee review

- Operations (Claims / Member Services / Mailroom / IVR)/
  - Kicked off Medicare Claim Edit Modules with Optum
  - Completed initial workgroup kickoff meetings with business stakeholders from Claims, IVR, Mailroom and Member Services
  - Review of current state process and gap analysis are in process for Claims, IVR, Mailroom, and Member Services

- IT
  - TruCare: Requirements clarification sessions and Business Hierarchy Profile (BHP) demo for single and multiple eligibilities in progress
  - HEALTHsuite: Completed RAM discovery sessions. Workstream Leads identified and working sessions are in progress. Letters capability demonstration completed
  - QualitySuite: Requirement development supporting G&A, PDR, PQI & Part D are in process

- P&Ps / SOPs / KPIs
  - Completed SOP Oversight and Policy Tech process flow development.
  - Introduced Standard Operating Procedure (SOP) development process at Medicare State of the Union on September 3rd
  - Completed development of the Key Performance Indicators (KPI) Strategy and initiated development of KPI measures by business area

- Program Decisions Reviewed
  - Supplemental Benefits

- Transportation and Chiropractic services will be covered under the Medi-Cal benefit.

- Grievance & Appeals
  - Current state of Sending Acknowledgement Letter will not be changed even with D-SNP implementation and the increased volume.

- Quality
  - Existing Program Descriptions will be used, and D-SNP program requirements added

- Utilization Management
  - One (1) integrated PA list will be used for Medi-Cal, Medicare, and Group Care.
  - Behavioral Health UM functions will be managed within the Behavioral Health department

- Enrollment and Eligibility
  - AAH will receive online applications from medicare.gov – Online Enrollment Center (OEC).
  - DHCS 834 file will be the single source of truth to validate Medi-Cal eligibility for AAH Medi-Cal dual-eligible members who elect AAH D-SNP plan. For new-to-AAH members, Medi-Cal eligibility must be verified using the State AEVS portal.

- **<u>CalAIM Initiatives:</u>**
  - Community Supports (CS):
    - Due to Budget Constraints, all CS enhancement and expansion are on hold.

  - Justice-Involved (JI) Initiative:
    - CalAIM Re-entry
      - Go-live date for the Behavioral Health Linkages is October 1st, 2024, for all MCPs.
        - At a high level, the expectation of DHCS for MCPs for this BH Linkages go-live is to ensure the pathways for correctional facilities and county agencies to submit referrals to the health plans for behavioral health services
        - Project team is developing a custom referral form for JI referrals that includes specific CMDM/BH/ECM required information
        - Project team is developing a list of contacts at counties to support coordination of referrals for any AAH members being released from outside county CFs back into Alameda County

- Met with Santa Clara Family Health Plan to facilitate intros and hear about their readiness preparations

- 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 at a later date
  - 3 counties going live with pre-release services on 10/1/24: Yuba, Inyo, and Santa Clara
  - 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

- DHCS has announced that MCPs will be notified of individuals who are eligible for pre-release services and therefore eligible for ECM through the daily/monthly 834 file with the JI indicator starting in September 2024
  - Internal working sessions to document use cases for this JI indicator have been initiated with IT, Analytics, ECM, and other impacted departments

- Collaborative workgroup meetings with Alameda County Sheriff's Office, Probation, Alameda County Behavioral Health, Social Security Administration, Kaiser Permanente and AAH will continue on a quarterly basis
  - The first quarterly meeting is set for 11/13. Additional meetings will be held internally to further define the data requirements for AAH to share with external agencies in support of the JI initiatives

- AAH/Roots JI Pilot Project:
    - AAH's pilot for post-release services began in July 2023 in preparation for the 2024 programs related to this population
        - The analysis of the data from July 2023 through June 2024 is complete. On 10/29, the final analysis was presented to AAH Senior Leadership
        - Project will initiate closeout processes and close in early November

- Community Health Worker (CHW) Benefit – Medi-Cal benefit effective July 1st, 2022, designed to promote the MCP's contractual obligations to meet DHCS broader Population Health Management standards and as adjunctive services as part of the interventions to positively impact health outcomes
    - CHW Workgroup Activities:
        - Project closeout is underway and will close out by 11/8

- CYBHI Fee Schedule – Effective January 1st, 2024, the Alliance is partnering with Carelon (formerly known as Beacon) to implement the CYBHI Fee Schedule.
    - Cohort 1 is intended to be a "learning" cohort

    - DHCS continues holding a series of meetings with Cohort participants; these include Onboarding Sessions for the LEAs as well as Technical Office Hours each Thursday of the month
        - The meetings held have been heavily focused on the LEA process

    - The Alliance will utilize Carelon as the Third Party Administrator (TPA)

    - The Claims submission date has been extended from April 1st, 2024 to July 1st, 2024
        - It may not be true that all MCPs or LEAs have systems set up, however, LEAs may submit claims for up to 180 days from the date of service
        - Claims may be submitted retroactively back to July 1st, 2024 as long as it is submitted by end of the year

    - MCPs have expressed concern over the initial TPA model and DHCS is considering two options, requesting MCP feedback

    - DHCS Health Plan Work Group (HPWG were to meet every week, Fridays between August and September 10-11am, however, most meetings have been cancelled in the month of October
        - An email was to be shared each Monday with recaps and agendas for subsequent meetings, however, this has not been taking place

    - High Level Timeline provided by Carelon for Claims Processing without solid Go Live Date
        - Interim ASO Model proposed

- MOU & BAAs between Plans and Carelon not yet finalized, as well as clearinghouses
    - Third MOU draft republished for MCPs to review and provide feedback. Due back to LHPC on 10/7
    - MOU still pending finalization
- Program Design and Documentation not yet finalized
- Invoice Template introduced
- Establish electronic fund transfer with Carelon
- Testing invoice and claims reconciliation

Recruiting and Staffing

- Integrated Planning Open position(s):
    - Business Process Change Analyst – 1 Job Offer Accepted: in Background Check
    - Business Analyst – Integrated Planning – Position pending
    - Backfill Business Analyst – Integrated Planning – Position pending

ALAMEDA Alliance FOR HEALTH

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Service you can trust.

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

    - Community Supports (CS) effective January 1st, 2022 – menu of optional services, including housing-related and flexible wraparound services, to avoid costlier alternatives to hospitalization, skilled nursing facility admission and/or discharge delays
        - As of January 1st, 2024, AAH will offer twelve (12) of the fourteen (14) DHCS-designated CS services
            - January 1st, 2022 – Six (6) Community Supports were implemented
            - July 1st, 2023 – Three (3) additional CS services went live
            - January 1st, 2024
                - Two (2) CS services that support the LTC PoFs that were effective January 2023 are being piloted in 7/1-12/31/2023 and went ;ove in January
                - One (1) additional CS service is also targeted for implementation in July 2024

    - 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 in order 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.

- Community Health Worker Services Benefit – Community Health Worker (CHW) services became a billable Medi-Cal benefit effective July 1st, 2022. CHW services are covered as preventive services on the written recommendation of a physician or other licensed practitioner of the healing arts within their scope of practice under state law for individuals who need such services to prevent disease, disability, and other health conditions or their progression; prolong life; and promote physical and mental health and well-being.

- 2024 Single Plan Model
  - 2024 Managed Care Plan Contract Operational Readiness – new MCP contract developed as part of Procurement RFP; all MCPs must adhere to new contract effective January 1st, 2024
    - Business Continuity Plan required as part of Operational Readiness
    - MOUs with third parties required as part of Operational Readiness
  - MCP Member Transition
    - Anthem members will transition to AAH effective January 1st, 2024
    - Members currently delegated to Kaiser will transition to Kaiser as part of their direct contract with DHCS effective January 1st, 2024

- 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	October2024
Incoming Calls (R/V)	17,620
Abandoned Rate (R/V)	3%
Answered Calls (R/V)	17,179
Average Speed to Answer (ASA)	00:09
Calls Answered in 30 Seconds (R/V)	97%
Average Talk Time (ATT)	07:08
Calls Answered in 10 minutes	100%
Outbound Calls	8,742

Top 5 Call Reasons (Medi-Cal and Group Care) October2024
Change of PCP
Eligibility/Enrollment
Provider Network Info
Benefits
Grievances/Appeals

Top 3 Web-Based Request Reasons (Medi-Cal and Group Care) October2024
Change PCP
ID Card Requests
Update Contact Info

MSBH	OCTOBER 2024
Incoming Calls (R/V)	1,262
Abandoned Rate (R/V)	7%
Answered Calls (R/V)	1,175
Average Speed to Answer (ASA)	00:45
Calls Answered in 30 Seconds (R/V)	80%
Average Talk Time (ATT)	09:21
Calls Answered in 10 minutes	100%
Outbound Calls	975
Screenings Completed	178
ACBH Referrals	45
SUD referrals to Center Point	32

Claims Department
September 2024 Final and October 2024 Final

METRICS

Claims Compliance	Sep-24	Oct-24
90% of clean claims processed within 30 calendar days	83.5%	90.8%
95% of all claims processed within 45 working days	99.9%	99.8%
Claims Volume (Received)	**Sep-24**	**Oct-24**
Paper claims	31,470	34,606
EDI claims	290,726	333,383
Claim Volume Total	**322,196**	**367,989**
Percentage of Claims Volume by Submission Method	**Sep-24**	**Oct-24**
% Paper	9.77%	9.40%
% EDI	90.23%	90.60%
Claims Processed	**Sep-24**	**Oct-24**
HEALTHsuite Paid (original claims)	225,229	304,352
HEALTHsuite Denied (original claims)	79,577	95,910
HEALTHsuite Original Claims Sub-Total	**304,806**	**400,262**
HEALTHsuite Adjustments	18,762	9,287
HEALTHsuite Total	**323,568**	**409,549**
Claims Expense	**Sep-24**	**Oct-24**
Medical Claims Paid	$137,769,061	$174,220,848
Interest Paid	$113,063	$139,209
Auto Adjudication	**Sep-24**	**Oct-24**
Claims Auto Adjudicated	247,723	335,624
% Auto Adjudicated	81.3%	83.9%
Average Days from Receipt to Payment	**Sep-24**	**Oct-24**
HEALTHsuite	16	14
Pended Claim Age	**Sep-24**	**Oct-24**
0-30 calendar days	42,285	44,707
HEALTHsuite		
31-61 calendar days	7,187	885
HEALTHsuite		
Over 62 calendar days	4	3
HEALTHsuite		

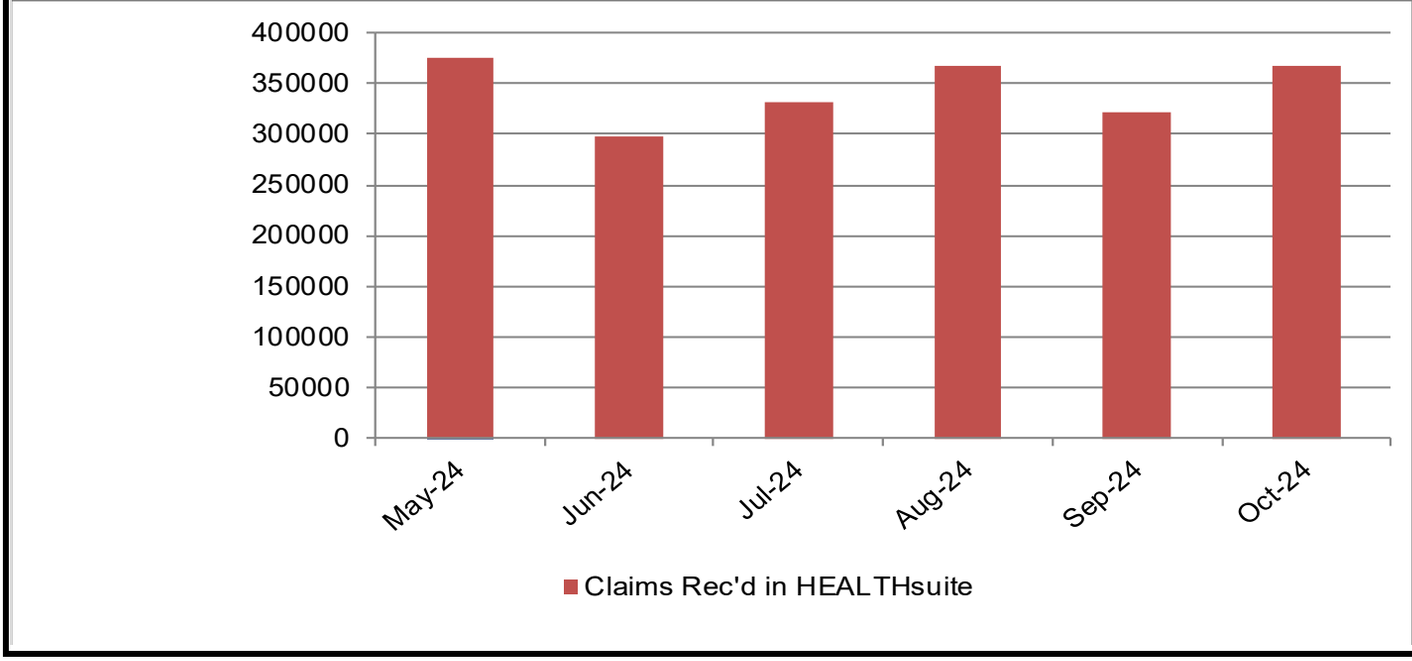
Overall Denial Rate	Sep-24	Oct-24
Claims denied in HEALTHsuite	79,577	95,910
% Denied	24.6%	23.4%

Claims Department
September 2024 Final and October 2024 Final

Top 5 HEALTHsuite Denial Reasons	Oct-24 % of all denials
Responsibility of Provider	24%
No Benefits Found For Dates of Service	12%
Non-Covered Benefit For This Plan	11%
Duplicate Claims	10%
Must Submit Paper Claim With Copy of Primary Payor EOB	9%
% Total of all denials	**66%**

Claims Received By Month

Run Date	6/1/2024	7/1/2024	8/1/2024	9/1/2024	10/1/2024	11/1/2024
Claims Received Through	**May-24**	**Jun-24**	**Jul-24**	**Aug-24**	**Sep-24**	**Oct-24**
Claims Rec'd in HEALTHsuite	375,454	297,267	332,150	368,235	322,196	367,989



Claims Year Over Year Summary

Monthly Results	Regulatory Requirement	AAH Goal
Claims Compliance - comparing October 2024 to October 2023 as follows: 30 Days - 90.8% (2024) vs 94.0% (2023) 45 Days - 99.8% (2024) vs 99.9% (2023) 90 Days - 99.9% (2024) vs 99.9% (2023)	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 367,989 claims in October 2024 vs 241,298 in October 2023	N/A	N/A
EDI - the volume of EDI submissions was 90.60% which exceeded our normal month to month range of ~77% - 87%	N/A	N/A
Original Claims Processed - AAH processed 400,262 in October 2024 (23 working days) vs 211,450 in October 2023 (22 working days)	N/A	N/A
Medical Claims Expense - the amount of paid claims in October 2024 was $174,220,848 (5 check runs) vs $77,888,843 in October 2023 (4 check runs)	N/A	N/A
Interest Expense - the amount of interest paid in October 2024 was $139,209 vs $30,031 in October 2023	N/A	< $496,000 per fiscal year or $30,000 per month
Auto Adjudication - the AAH rate in October 2024 was 81.3% vs 83.9% in October 2023	N/A	85% or higher
Average Days from Receipt to Payment - the average # of days from receipt to payment in October 2024 was 14 days vs 14 days in October 2023	N/A	<= 25 days
Pended Claim Age - comparing October 2024 to October 2023 as follows: 0-30 calendar days - 44,707 (2024) vs 30,274 (2023) 31-61 calendar days - 885 (2024) vs 2,095 (2023) Over 62 calendar days - 3 (2024) vs 3 (2023)	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 October 2024 to October 2023	N/A	N/A

Provider Relations Dashboard October 2024

Alliance Provider Relations Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Incoming Calls (PR)	10695	9359	9033	8064	7469	6825	8593	8233	7634	8456		
Abandoned Calls	4806	4325	3272	2275	1519	1207	1787	1663	1529	1554		
Answered Calls (PR)	5889	5034	5761	5789	5950	5618	6806	6570	6105	6902		
Recordings/Voicemails	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Incoming Calls (R/V)	413	2551	1970	1595	1093	896	1247	1211	985	1055		
Abandoned Calls (R/V)												
Answered Calls (R/V)	413	2551	1970	1595	1093	896	1247	1211	985	1055		
Outbound Calls	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Outbound Calls	1140	1358	1298	831	1018	829	1066	893	889	751		
N/A												
Outbound Calls	1140	1358	1298	831	1018	829	1066	893	889	751		
Totals	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Total Incoming, R/V, Outbound Calls	11835	13268	12301	10490	9580	8550	10906	10337	9508	10262		
Abandoned Calls	4806	4325	3272	2275	1519	1207	1787	1663	1529	1554		
Total Answered Incoming, R/V, Outbound Calls	7442	8993	9029	8215	8061	7343	9119	8674	7979	8708		

Provider Relations Dashboard October 2024

Call Reasons (Medi-Cal and Group Care)

Category	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Authorizations	5.5%	5.6%	5.5%	6.1%	6.4%	6.4%	6.0%	6.0%	6.4%	5.8%		
Benefits	4.3%	3.6%	2.4%	3.0%	2.5%	2.8%	2.8%	2.9%	2.9%	2.9%		
Claims Inquiry	38.5%	41.7%	45.4%	40.1%	43.3%	42.1%	43.8%	44.0%	44.9%	45.6%		
Change of PCP	3.3%	3.9%	2.6%	3.6%	2.6%	2.9%	2.9%	2.9%	2.9%	3.1%		
Check Tracer	1.1%	1.1%	1.2%	1.0%	1.3%	1.2%	0.9%	0.9%	1.0%	1.0%		
Complaint/Grievance (includes PDR's)	4.4%	4.3%	6.1%	5.8%	7.9%	7.5%	7.6%	8.0%	7.5%	7.1%		
Contracts/Credentialing	1.1%	1.0%	1.5%	1.4%	0.7%	0.7%	0.6%	0.9%	1.0%	0.7%		
Demographic Change	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		
Eligibility - Call from Provider	23.0%	20.5%	17.5%	20.9%	18.2%	17.7%	17.8%	18.1%	17.8%	15.4%		
Exempt Grievance/ G&A	0.6%	0.1%	0.1%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.1%		
General Inquiry/Non member	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		
Health Education	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		
Intrepreter Services Request	0.5%	0.6%	0.7%	1.1%	0.6%	0.7%	0.4%	0.4%	0.7%	0.6%		
Provider Portal Assistance	3.7%	3.8%	3.2%	3.2%	3.6%	3.6%	3.5%	3.2%	2.9%	4.5%		
Pharmacy	0.1%	0.1%	0.1%	0.2%	0.1%	0.1%	0.1%	0.1%	0.2%	0.1%		
Prop 56	0.2%	0.4%	0.3%	0.3%	0.4%	0.4%	0.2%	0.2%	0.4%	0.5%		
Provider Network Info	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%		
Transportation Services	0.2%	0.2%	0.1%	0.1%	0.2%	0.2%	0.1%	0.1%	0.1%	0.2%		
Transferred Call	0.0%	0.0%	0.0%	0.1%	0.1%	0.0%	0.1%	0.0%	0.0%	0.1%		
All Other Calls	13.4%	13.1%	13.1%	13.1%	12.3%	13.5%	12.9%	12.4%	11.4%	12.2%		
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		

Field Visit Activity Details

Alliance Provider Relations Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Claims Issues	13	56	38	40	28	60	66	65	77	70		
Contracting/Credentialing	9	21	50	26	19	49	63	99	53	44		
Drop-ins	27	49	29	30	54	73	77	174	119	168		
JOM's	3	2	2	2	2	1	2	3	2	1		
New Provider Orientation	104	103	140	101	113	219	82	125	N/A	334		
Quarterly Visits	0	0	0	0	82	89	125	94	65	1		
UM Issues	0	0	0	0	0	1	7	7	4	2		
Total Field Visits	156	231	259	199	298	492	422	567	320	620	0	0

ALLIANCE NETWORK SUMMARY, CURRENTLY CREDENTIALED PRACTITIONERS - OCTOBER 2024						
Practitioners		BH/ABA 2,341	AHP 583	PCP 376	SPEC 743	PCP/SPEC 13
AAH/AHS/CHCN Breakdown			AAH 2,854	AHS 291	CHCN 566	COMBINATION OF GROUPS 345
Facilities	**429**					

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	208	25	Y	Y	Y
Recred Files in Process	103	0	Y	Y	Y
Expirables updated **Insurance, License, DEA, Board Certifications**					Y
Files currently in process	**311**				
		*** 25 business days = 35 calendar days**			

October 2024 Peer Review and Credentialing Committee Approvals	
Initial Credentialing	**Number**
PCP	4
SPEC	17
ANCILLARY	8
MIDLEVEL/AHP	6
BH/ABA	71
Sub-total	**106**
Recredentialing	
PCP	6
SPEC	17
ANCILLARY	1
MIDLEVEL/AHP	5
Sub-total	**29**
TOTAL	**135**

October 2024 Facility Approvals	
Initial Credentialing	**3**
Recredentialing	**5**
Sub-total	**8**
Facility Files in Process	**51**

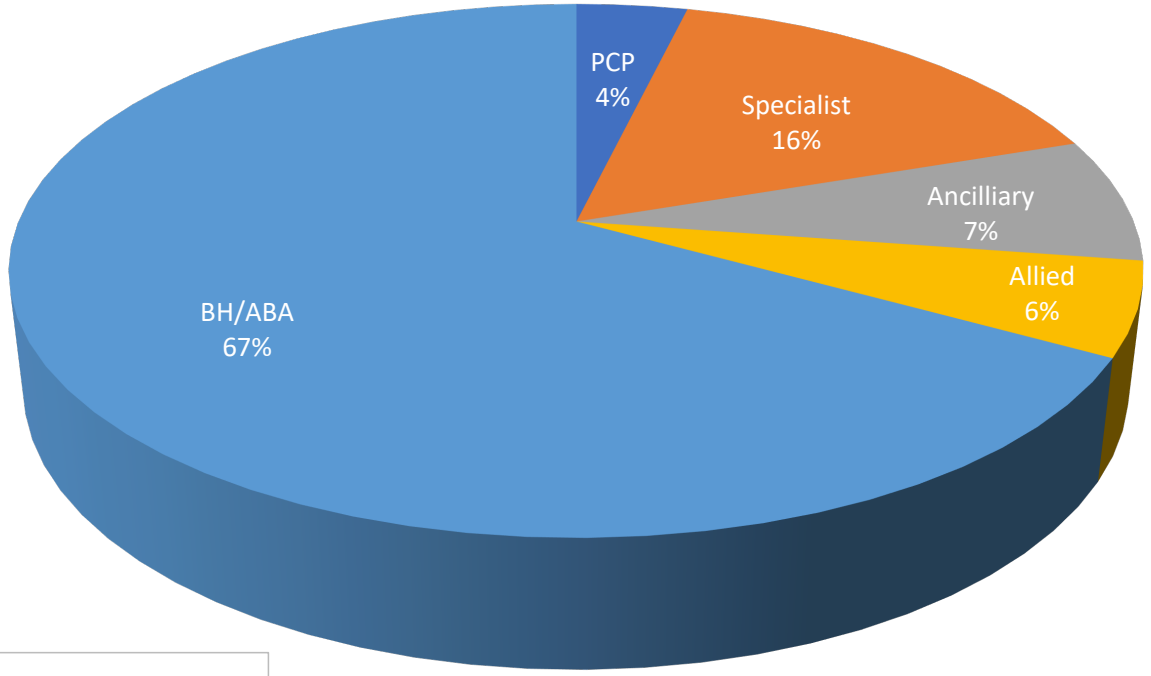
October 2024 Employee Metrics (5 FTEs)	**Goal**		**Met (Y/N)**
File Processing	Timely processing within 3 days of receipt		Y
Credentialing Accuracy	<3% error rate		Y
DHCS, DMHC, CMS, NCQA Compliant	98%		Y
MBC Monitoring	Timely processing within 3 days of receipt		Y

LAST NAME	FIRST NAME	CATEGORY	INITIAL RE-CRED	CRED_DATE
Alberding	Anthony	ABA	INITIAL	10/15/2024
Aldaz	Edward	BH-Telehealth	INITIAL	10/15/2024
Anthony	Katherine	ABA-Telehealth	INITIAL	10/15/2024
Ayres	Ellen	BH	INITIAL	10/15/2024
Azizuddin	Yumna	Ancillary	INITIAL	10/15/2024
Bui	Hoai	BH	INITIAL	10/15/2024
Burky	Christopher	BH-Telehealth	INITIAL	10/15/2024
Carson	Evelyn	Allied Health	INITIAL	10/15/2024
Casey	Ashley	AHP SP_CHW	INITIAL	10/15/2024
Chen	Katherine	Specialist	INITIAL	10/15/2024
Chiu	Stephan	Specialist	INITIAL	10/15/2024
Cooper	Cicily	Allied Health	INITIAL	10/15/2024
Derrough	Joseph	Specialist	INITIAL	10/15/2024
De'Santiago	Adrianna	BH	INITIAL	10/15/2024
Dua	Elizabeth	Ancillary	INITIAL	10/15/2024
Dudley	Chanell	BH-Telehealth	INITIAL	10/15/2024
Dvorsky	Katherine	BH	INITIAL	10/15/2024
Elm	Zella	ABA-Telehealth	INITIAL	10/15/2024
Esguerra	Chris	BH-Telehealth	INITIAL	10/15/2024
Espinosa	Raquel	BH-Telehealth	INITIAL	10/15/2024
Esters	Latavia	BH-Telehealth	INITIAL	10/15/2024
Evans	Shahana	ABA-Telehealth	INITIAL	10/15/2024
Figueroa	Vivian	BH-Telehealth	INITIAL	10/15/2024
Folauo'o	Patsy	BH-Telehealth	INITIAL	10/15/2024
Gaehring	Jazzy	BH-Telehealth	INITIAL	10/15/2024
Gallegos	Lizette	ABA-Telehealth	INITIAL	10/15/2024
Giangreco	LouAnne	Specialist	INITIAL	10/15/2024
Gonzalez	Karina	BH	INITIAL	10/15/2024
Gould	Raegan	ABA-Telehealth	INITIAL	10/15/2024
Gray	Tacorra	ABA-Telehealth	INITIAL	10/15/2024
Grimes	Andrew	Specialist	INITIAL	10/15/2024
Guptill	Briana	Ancillary	INITIAL	10/15/2024
Hadfield	Brooke	ABA	INITIAL	10/15/2024
Harwood	Dylan	BH	INITIAL	10/15/2024
Hasserjian	Lauren	ABA	INITIAL	10/15/2024
Hedmann	Monique	Primary Care Physician	INITIAL	10/15/2024
Heinl	Brielle	ABA	INITIAL	10/15/2024
Henley	Robert	BH-Telehealth	INITIAL	10/15/2024
Herman	Britney	Allied Health	INITIAL	10/15/2024
Hernandez	David	ABA-Telehealth	INITIAL	10/15/2024
Hernandez	Griselda	BH-Telehealth	INITIAL	10/15/2024
Ji	Ok	BH-Telehealth	INITIAL	10/15/2024
Johnson	Christina	ABA-Telehealth	INITIAL	10/15/2024
Jones	Auriana	BH	INITIAL	10/15/2024
Jones	Evan	BH-Telehealth	INITIAL	10/15/2024
Kane	Kevin	Specialist	INITIAL	10/15/2024
Lacap	Marjorie	ABA	INITIAL	10/15/2024
Lavigna	Richard	Specialist	INITIAL	10/15/2024
Lee	Chi	Specialist	INITIAL	10/15/2024
Lee	Tiffany	ABA-Telehealth	INITIAL	10/15/2024
Leon	Patricia	BH-Telehealth	INITIAL	10/15/2024
Lewallen	Shevaun	Allied Health	INITIAL	10/15/2024
Lin	Andrew	Specialist	INITIAL	10/15/2024
Lotlikar	Siddhesh	Specialist	INITIAL	10/15/2024
Majid	Abid	Specialist	INITIAL	10/15/2024

LAST NAME	FIRST NAME	CATEGORY	INITIAL RE-CRED	CRED_DATE
Matityahu	Amir	Specialist	INITIAL	10/15/2024
Maxie	Andre	BH-Telehealth	INITIAL	10/15/2024
McClellan	Adrian	BH-Telehealth	INITIAL	10/15/2024
McGee	Brandi	ABA-Telehealth	INITIAL	10/15/2024
Mettler	Morgan	Doula	INITIAL	10/15/2024
Mirza	Claudia	ABA-Telehealth	INITIAL	10/15/2024
Morton	Trinity	BH	INITIAL	10/15/2024
Moyer	Kaili	BH-Telehealth	INITIAL	10/15/2024
Murphy	Timothy	BH-Telehealth	INITIAL	10/15/2024
Naidoff	Emilie	Ancillary	INITIAL	10/15/2024
Nguyen	Josie	ABA-Telehealth	INITIAL	10/15/2024
Nolan	Kara	BH-Telehealth	INITIAL	10/15/2024
Oberlin	Daniel	Specialist	INITIAL	10/15/2024
Oelberger	Richard	BH	INITIAL	10/15/2024
Ombach	Sadie	ABA-Telehealth	INITIAL	10/15/2024
Orantes	Xiomara	ABA-Telehealth	INITIAL	10/15/2024
Ornellas	Sarah	BH	INITIAL	10/15/2024
Parks	Jessica	ABA-Telehealth	INITIAL	10/15/2024
Pehoski	Emily	ABA	INITIAL	10/15/2024
Pienkny	Andrew	Specialist	INITIAL	10/15/2024
Quach	Tiffany Thanh	BH-Telehealth	INITIAL	10/15/2024
Raees	Muhammad	Specialist	INITIAL	10/15/2024
Ragasa	Juli Anne	BH-Telehealth	INITIAL	10/15/2024
Rimlinger	Anna	BH	INITIAL	10/15/2024
Rios	Susana	AHP SP_CHW	INITIAL	10/15/2024
Rivera	Obianuju	BH-Telehealth	INITIAL	10/15/2024
Rodrigues	Annamarie	ABA	INITIAL	10/15/2024
Rodrigues	Appallonia	BH	INITIAL	10/15/2024
Rodriguez	Wesley	ABA-Telehealth	INITIAL	10/15/2024
Roslewicz	Lisa	ABA-Telehealth	INITIAL	10/15/2024
Ruddy	John	Specialist	INITIAL	10/15/2024
Safaee	Sam	BH-Telehealth	INITIAL	10/15/2024
Sahi	Jot Preet	Primary Care Physician	INITIAL	10/15/2024
Samlan	David	BH	INITIAL	10/15/2024
Sharlip	Ira	Specialist	INITIAL	10/15/2024
Shmerling	Alison	PCP SP_CHW	INITIAL	10/15/2024
Simon	Andrea	BH-Telehealth	INITIAL	10/15/2024
Smith	Antijuanne	ABA-Telehealth	INITIAL	10/15/2024
Stine	Nicholas	BH	INITIAL	10/15/2024
Swetland	Kayleigh	BH-Telehealth	INITIAL	10/15/2024
Taylor	Tracy	Allied Health	INITIAL	10/15/2024
Thibedeau	Mark	BH-Telehealth	INITIAL	10/15/2024
Thompson	Jantina	BH-Telehealth	INITIAL	10/15/2024
Tsacoumangos	Alexis	BH-Telehealth	INITIAL	10/15/2024
Tumaneng	Nickha	BH	INITIAL	10/15/2024
Vennam	Vamsi Krishna	BH-Telehealth	INITIAL	10/15/2024
Verma	Kristy	BH-Telehealth	INITIAL	10/15/2024
Virdi	Sukhjinder	Allied Health	INITIAL	10/15/2024
Williams	Kena	AHP SP_CHW	INITIAL	10/15/2024
Wu	Angela	ABA	INITIAL	10/15/2024
Yang	Ronald	Primary Care Physician	INITIAL	10/15/2024
Araj	Aileen	Allied Health	RE-CRED	10/15/2024
Attawia	Mariam	Allied Health	RE-CRED	10/15/2024
Blankenship	LeAnn	Specialist	RE-CRED	10/15/2024
Byrne	Nicholas	Specialist	RE-CRED	10/15/2024
Choudhary	Abhishek	Specialist	RE-CRED	10/15/2024
De Niro	Jennifer	Specialist	RE-CRED	10/15/2024

LAST NAME	FIRST NAME	CATEGORY	INITIAL RE-CRED	CRED_DATE
Doughty	Susan	Allied Health	RE-CRED	10/15/2024
Eichbaum	Eldan	Specialist	RE-CRED	10/15/2024
Gellman	Richard	Specialist	RE-CRED	10/15/2024
Harbour	Leia	Specialist	RE-CRED	10/15/2024
Hwang	Dennis	Specialist	RE-CRED	10/15/2024
Liptak	Alayna	Allied Health	RE-CRED	10/15/2024
McDonald	Henry	Specialist	RE-CRED	10/15/2024
Mirmira	Vijay	Primary Care Physician	RE-CRED	10/15/2024
Njenga	Kera	Allied Health	RE-CRED	10/15/2024
Ochalek	Daniel	Specialist	RE-CRED	10/15/2024
Puranam	Srilekha	Primary Care Physician	RE-CRED	10/15/2024
Ramdall	Risha	Specialist	RE-CRED	10/15/2024
Rodriguez	Geoffrey	Specialist	RE-CRED	10/15/2024
Rose	Melissa	Primary Care Physician	RE-CRED	10/15/2024
Savio	Robert	Primary Care Physician	RE-CRED	10/15/2024
Siddiq	Simin	Primary Care Physician	RE-CRED	10/15/2024
Simms-Edwards	Erin	Specialist	RE-CRED	10/15/2024
Singh	Charan	Specialist	RE-CRED	10/15/2024
Singh	Richa	Specialist	RE-CRED	10/15/2024
Smeester	Daniel	Specialist	RE-CRED	10/15/2024
Tesfalul	Martha	Specialist	RE-CRED	10/15/2024
Wuu	Rrobert-Jim	Ancillary	RE-CRED	10/15/2024
Zheng	Hui	Primary Care Physician	RE-CRED	10/15/2024

OCTOBER PEER REVIEW AND CREDENTIALING
INITIAL APPROVALS BY SPECIALTY



PCP	4
SPECIALIST	17
ANCILLARY	8
ALLIED	6
BH/ABA	71
TOTAL	106

Provider Dispute Resolution
September 2024 and October 2024

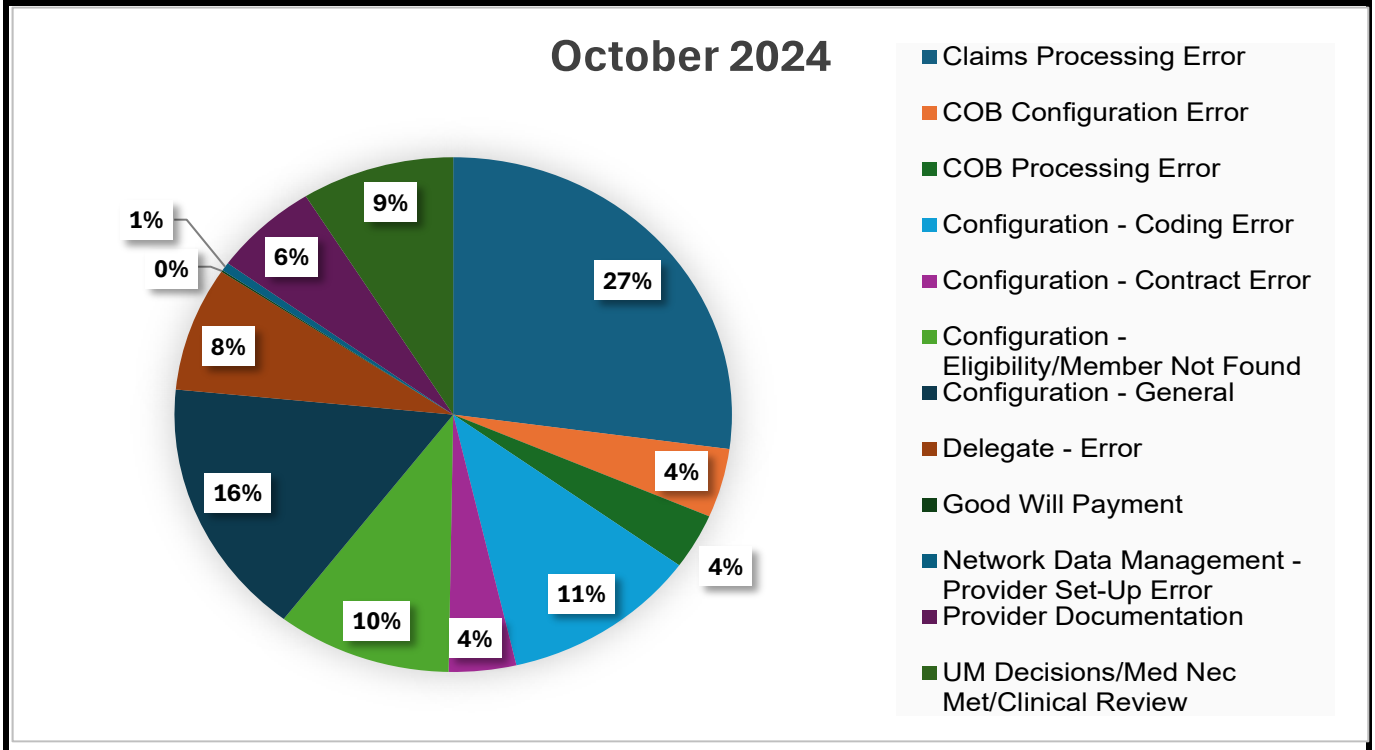
METRICS

PDR Compliance	Sep-24	Oct-24
# of PDRs Resolved	1,897	2,200
# Resolved Within 45 Working Days	1,889	2,181
% of PDRs Resolved Within 45 Working Days	99.6%	99.1%
PDRs Received	**Sep-24**	**Oct-24**
# of PDRs Received	2,340	2,708
PDR Volume Total	**2,340**	**2,708**
PDRs Resolved	**Sep-24**	**Oct-24**
# of PDRs Upheld	1,295	1,253
% of PDRs Upheld	68%	57%
# of PDRs Overturned	602	947
% of PDRs Overturned	32%	43%
Total # of PDRs Resolved	**1,897**	**1,897**
Average Turnaround Time	**Sep-24**	**Oct-24**
Average # of Days to Resolve PDRs	40	41
Oldest Resolved PDR in Days	112	139
Unresolved PDR Age	**Sep-24**	**Oct-24**
0-45 Working Days	4,159	4,609
Over 45 Working Days	0	0
Total # of Unresolved PDRs	**4,159**	**4,609**

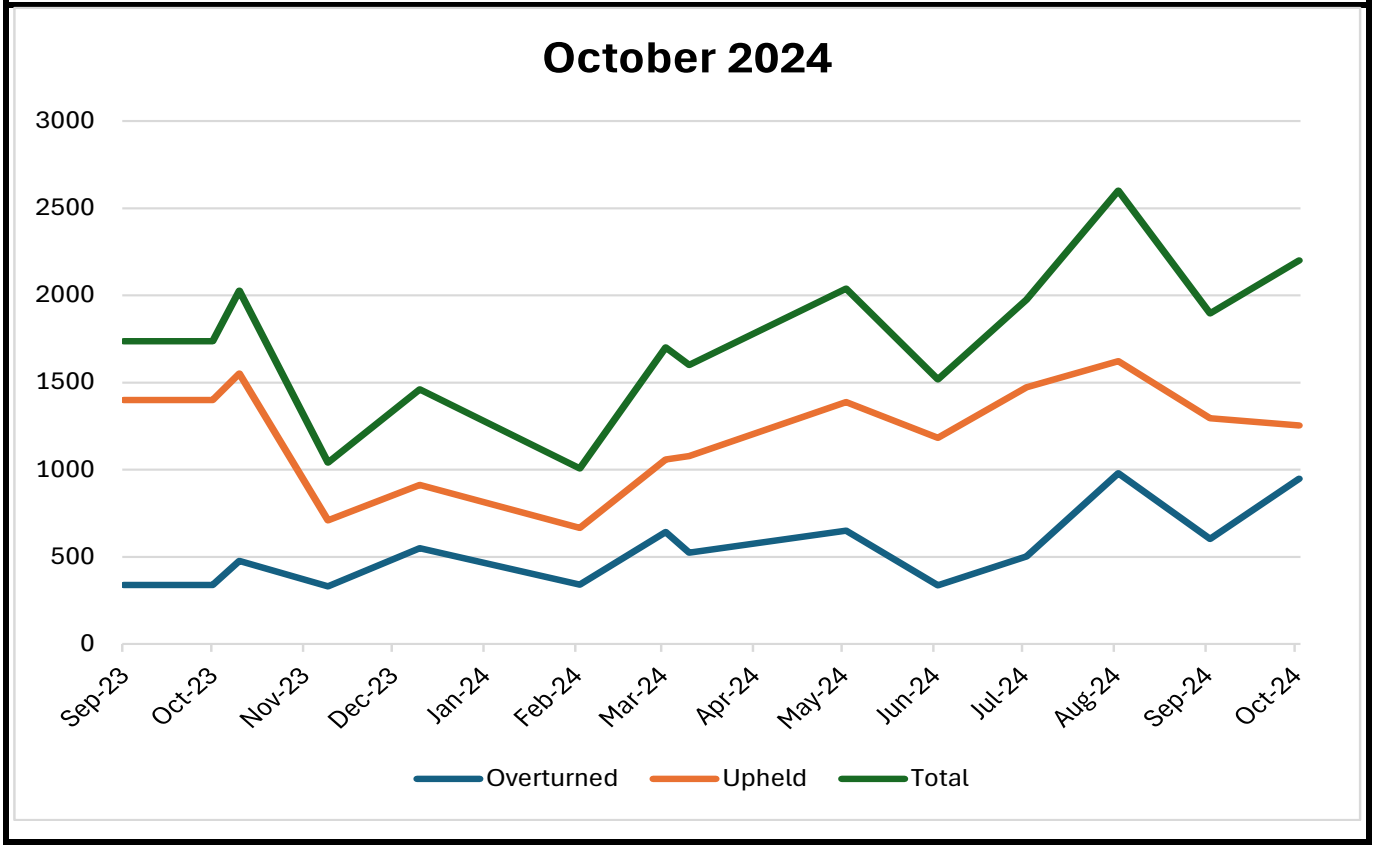
Provider Dispute Resolution
September 2024 and October 2024

Oct-24

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 - 2,200 in October 2024 vs ,1,786 in October 2023	N/A	N/A
# of PDRs Received - 2,708 in October 2024 vs 1,560 in October 2023	N/A	N/A
# of PDRs Resolved within 45 working days - 2,181 in October 2024 vs 1,781 in October 2023	N/A	N/A
% of PDRs Resolved within 45 working days - 99.1% in October 2024 vs 99% in October 2023	95%	95%
Average # of Days to Resolve PDRs - 41 days in October 2024 vs 41 days in October 2023	N/A	30
Oldest Resolved PDR in Days - 139 days in October 2024 vs 72 days October 2023	N/A	N/A
# of PDRs Upheld - 1,253 in October 2024 vs 1,374 in October 2023	N/A	N/A
% of PDRs Upheld - 57% in October 2024 vs 77% in October 2023	N/A	> 75%
# of PDRs Overturned - 947 in October 2024 vs 412 in October 2023	N/A	N/A
% of PDRs Overturned - 43% in October 2024 vs 23% in October 2023	N/A	< 25%
PDR Overturn Reasons: Claims processing errors - 27% (2024) vs 28% (2023) Configuration errors -42% (2024) vs 51% (2023) COB 7% (2024) vs 7% (2023) Clinical Review/UM Decisions/Medical Necessity Met -9% (2024) vs 7% (2023)	N/A	N/A

COMMUNICATIONS & OUTREACH DEPARTMENT

ALLIANCE IN THE COMMUNITY

FY 2024-2025 | **OCTOBER 2024 OUTREACH REPORT**

ALLIANCE IN THE COMMUNITY

FY 2024-2025 | OCTOBER 2024 OUTREACH REPORT

In October 2024, the Alliance completed **1,704** member orientation outreach calls among net new members and non-utilizers and conducted **146** member orientations (**9%** member participation rate). In addition, in October 2024, the Outreach team completed **53** Alliance website inquiries, **8** service requests, **2** community events, and **9** member education events. The Alliance reached a total of **1,023** people and spent a total of $100 on donations, fees, and/or sponsorships in October.*

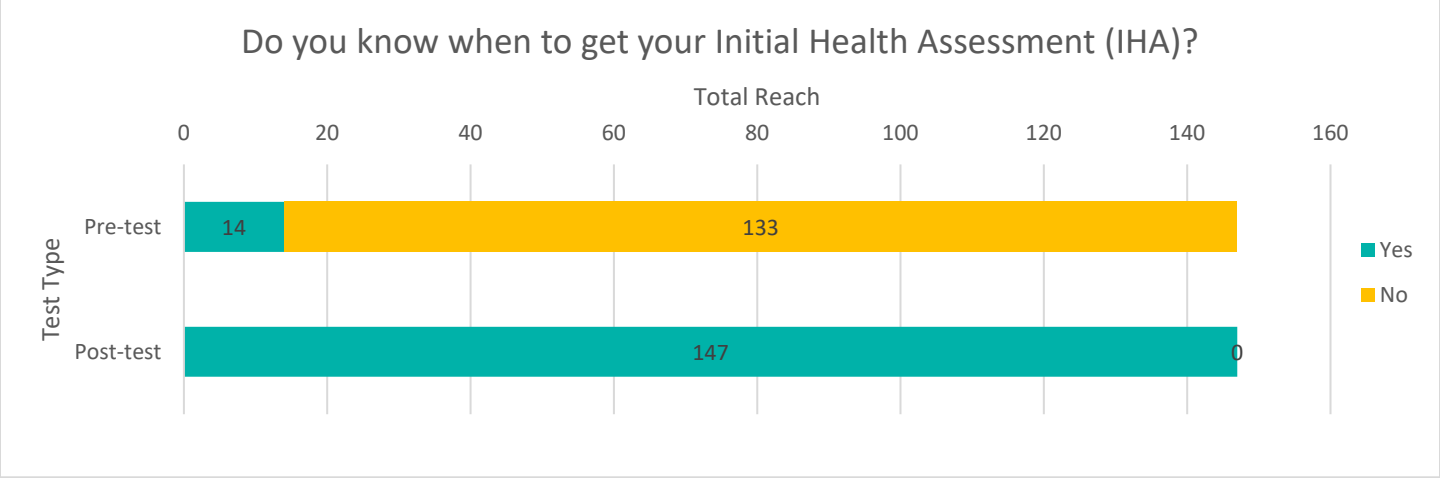
The Communications & Outreach Department began reporting the number of members reached during outreach activities in late February 2018. Since July 2018, **35,544** self-identified Alliance members have been reached during outreach activities.

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

On **Wednesday, March 18, 2020,** the Alliance began conducting member orientations by phone. As of October 31, 2024, the Outreach Team completed **43,309** member orientation outreach calls and conducted **9,090** member orientations (**20.99%** member participation rate).

The Alliance Member Orientation (MO) program has been in place since August 2016. In 2019, the program was recognized as a promising practice to increase member knowledge and awareness about the Initial Health Appointment (IHA) by the Department of Health Care Services (DHCS), Managed Care Quality and Monitoring Division (MCQMD). We have steadily increased program participation. Our 2019 6-month average participation rate was **111** members per month. Between October 1, and October 31, 2024 (23 working days) – **146** members completed an MO by phone.

After completing a MO **100%** of members who completed the post-test survey in October 2024 reported knowing when to get their IHA, compared to only **9.5%** 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\Q2\1. October 2024**

ALLIANCE IN THE COMMUNITY

FY 2024-2025 | OCTOBER 2024 OUTREACH REPORT

FY 2023-2024 OCTOBER 2023 TOTALS

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

12 CITIES

Alameda
Castro Valley
Fremont
Hayward
Livermore
Newark
Oakland
Pleasanton
San Leandro
San Lorenzo
Tracy
Union City

- 467 TOTAL REACHED AT COMMUNITY EVENTS
- 257 TOTAL REACHED AT MEMBER EDUCATION EVENTS
- 146 TOTAL REACHED AT MEMBER ORIENTATIONS
- 0 TOTAL REACHED AT MEETINGS/PRESENTATIONS
- 0 TOTAL REACHED AT COMMUNITY TRAINING
- 460 MEMBERS REACHED AT ALL EVENTS
- **870 TOTAL REACHED AT ALL EVENTS**

$5,250.00
TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

FY 2024-2025 OCTOBER 2024 TOTALS

- 2 COMMUNITY EVENTS
- 9 MEMBER EDUCATION EVENTS
- 146 MEMBER ORIENTATIONS
- 0 MEETINGS/ PRESENTATIONS
- 0 COMMUNITY TRAINING
- 12 TOTAL INITIATED/ INVITED EVENTS
- **157 TOTAL COMPLETED EVENTS**

13 CITIES**

Alameda
Castro Valley
Dublin
Emeryville
Fremont
Hayward
Livermore
Newark
Oakland
San Leandro
San Lorenzo
San Pablo
Union City

- 186 TOTAL REACHED AT COMMUNITY EVENTS
- 837 TOTAL REACHED AT MEMBER EDUCATION EVENTS
- 146 TOTAL REACHED AT MEMBER ORIENTATIONS
- 0 TOTAL REACHED AT MEETINGS/PRESENTATIONS
- 0 COMMUNITY TRAINING
- 333 MEMBERS REACHED AT ALL EVENTS
- **1,169 TOTAL REACHED AT ALL EVENTS**

$100.00
TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

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

COMMUNICATIONS & OUTREACH DEPARTMENT

SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2024-2025 | **October 2024**

The Alliance Communications and Outreach (C&O) Department created the social media and website activity (SM&WA) Report to provide a high-level overview of stakeholder engagement through various digital media platforms. Between **October 1, 2024**, and **October 31, 2024**:

1. Alliance Website:
    - Received **25,000** unique visits
    - Received **21,000** new user visits
    - The top **10** website page visits were:
        i. Homepage
        ii. Provider Page
        iii. Find a Doctor
        iv. Medi-Cal Benefits and Services
        v. Members Medi-Cal
        vi. Check-in for Checkups
        vii. Contact Us
        viii. Careers
        ix. Members
        x. Get a New ID Card
2. Facebook Page:
    - Maintained Fans at **633**
    - Did not receive any reviews in **October 2024**
3. Glassdoor Page:
    - **3** out of a **5-star** overall rating
    - Did not receive any reviews in **October 2024**
4. Instagram Page:
    - Page debuted **June 10, 2021**
    - Increased in followers from **576** to **584**
5. X (previously Twitter) Page:
    - Slight Increase in followers from **365** to **366**
6. LinkedIn Page:
    - Maintained followers at **5.9k**
    - Received **224-**page clicks
7. Yelp Page:
    - Page visits **43**
    - Appeared in Yelp searches **112** times
    - Did not receive any reviews in **October 2024**
8. Google Page:
    - **2,205** website clicks made from the business profile
    - **1,301** calls made from the business profile
    - Received **2** (two) reviews in **October 2024**

ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2024-2025 | **October 2024**

GLASSDOOR OVERVIEW

Alameda Alliance for Health Ratings and Trends

About Glassdoor ratings

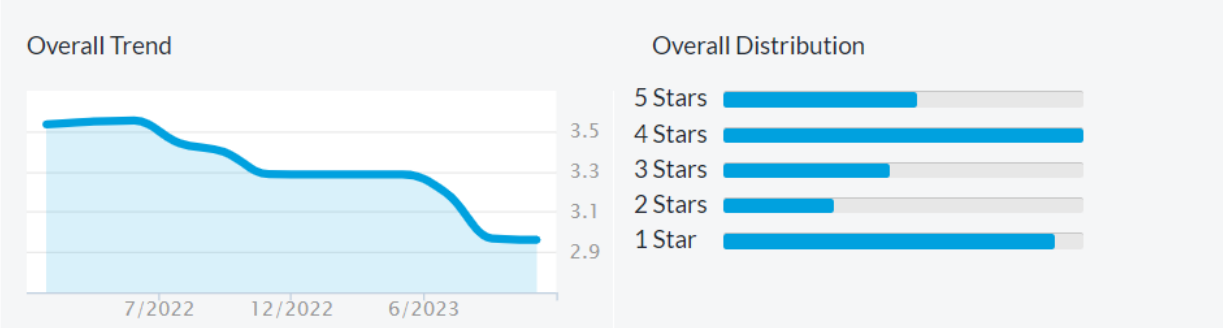
Ratings may vary depending on what filters are applied, but ratings include reviews in all languages. Learn More

Overall	3
Culture & Values	2.9
Diversity & Inclusion	3.5
Work/Life Balance	3.1
Senior Management	2.5
Compensation and Benefits	3.8
Career Opportunities	2.8

51% Recommend to a Friend

0% CEO Approval

38% Positive Business Outlook

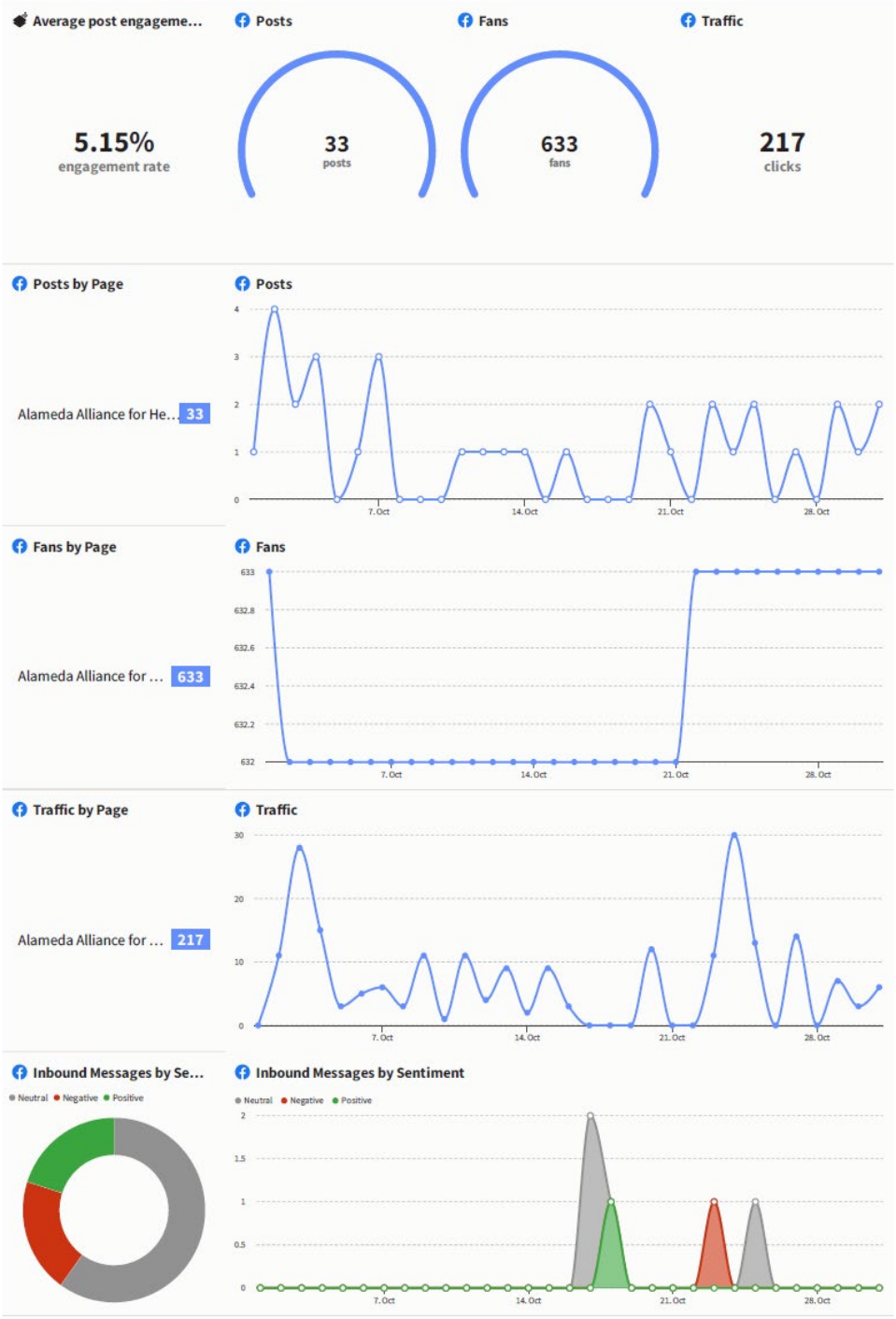


All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2024-2025\Q2\1. October 2024

ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2024-2025 | **October 2024**

FACEBOOK OVERVIEW



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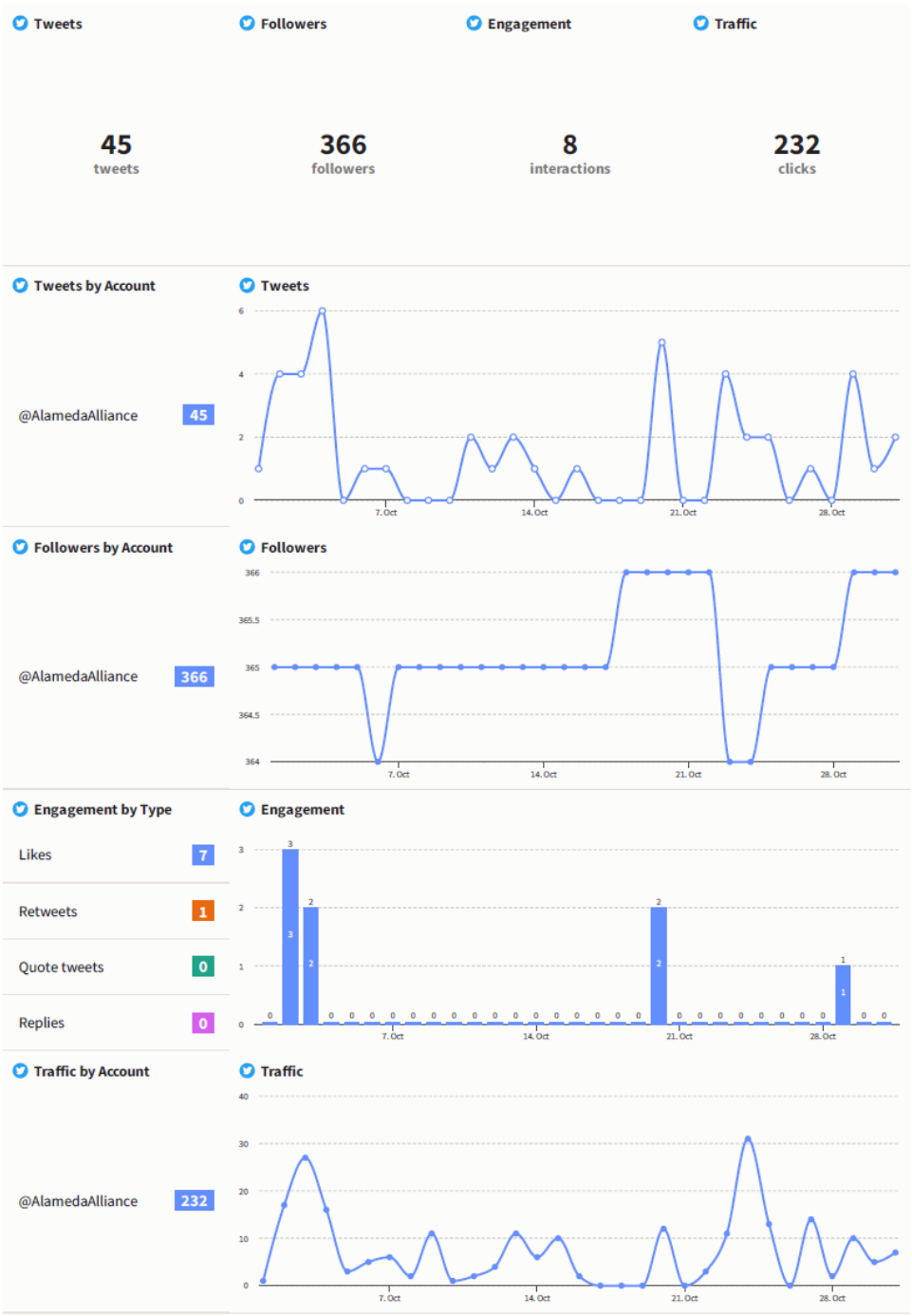
ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2024-2025 | October 2024

X (previously TWITTER) OVERVIEW



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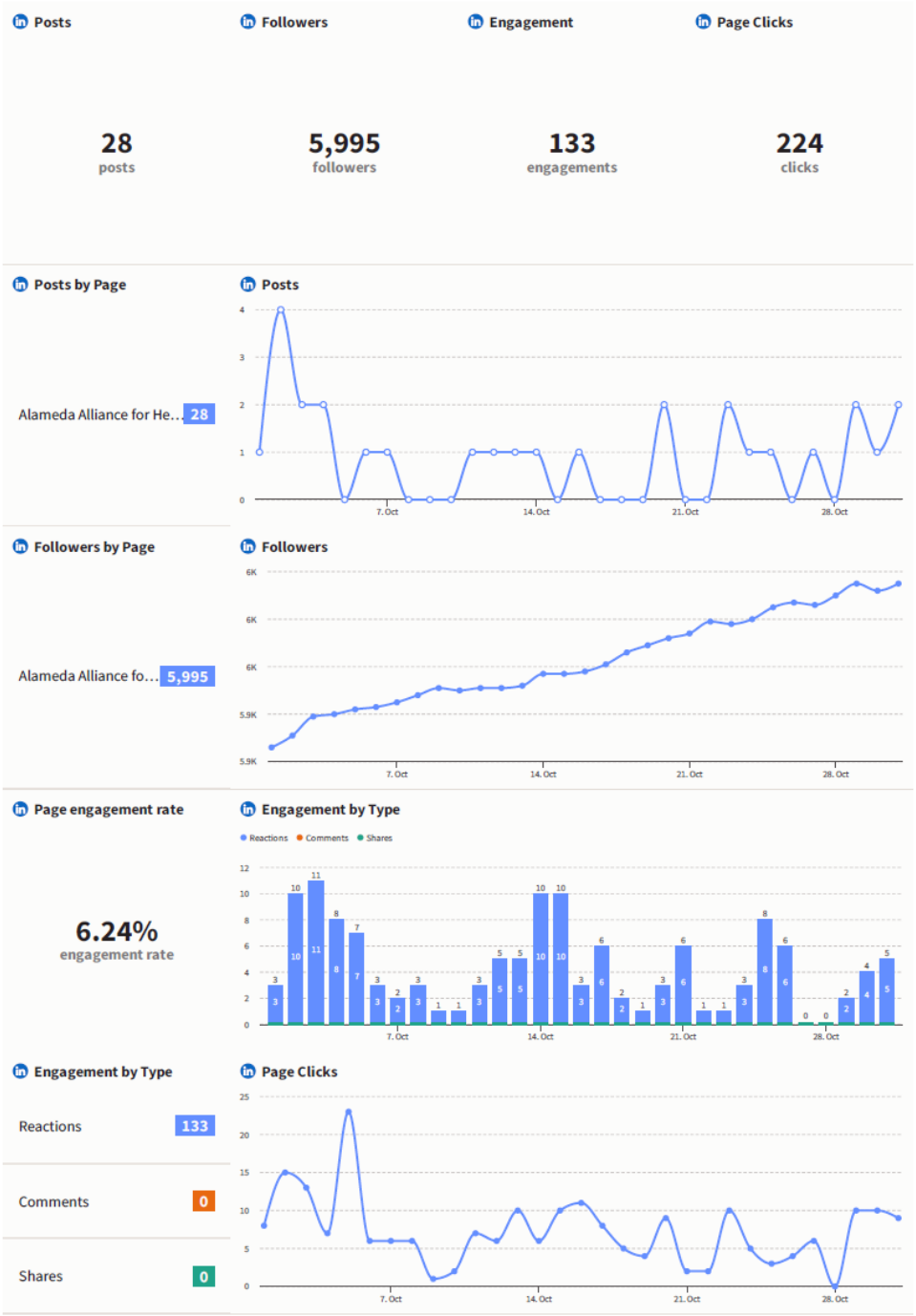
ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2024-2025 | **October 2024**

LINKEDIN OVERVIEW

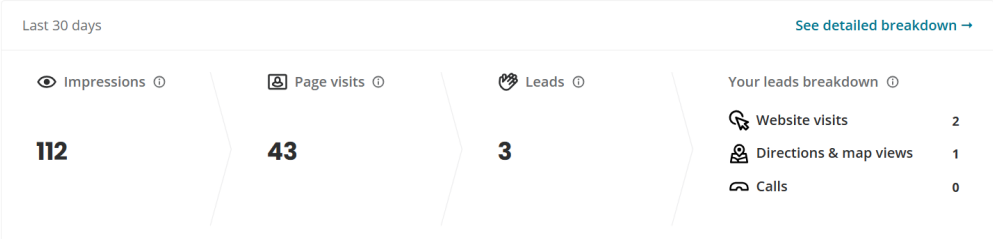


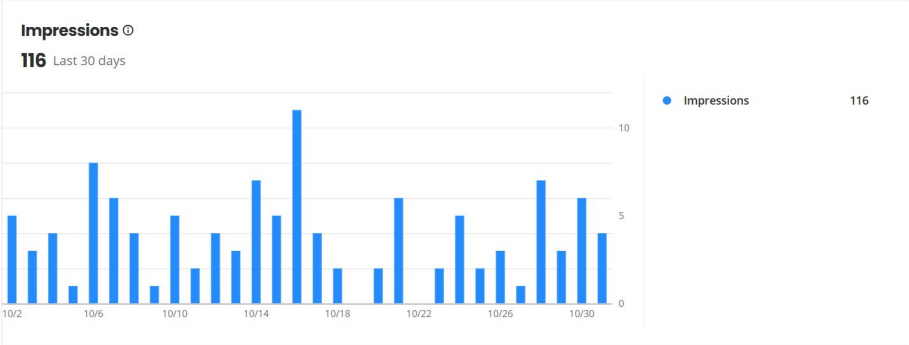
All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2024-2025\Q2\1. October 2024

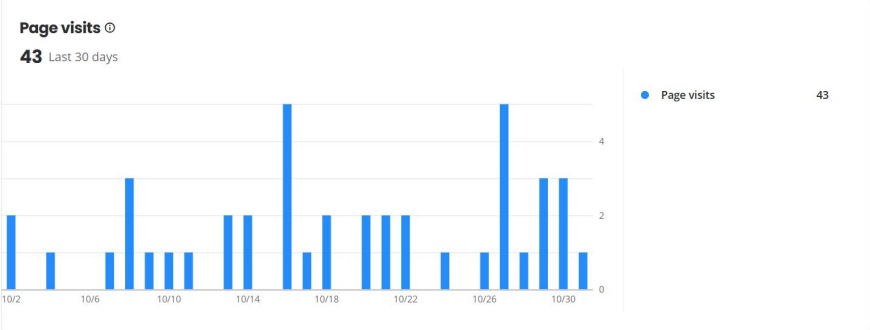
ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

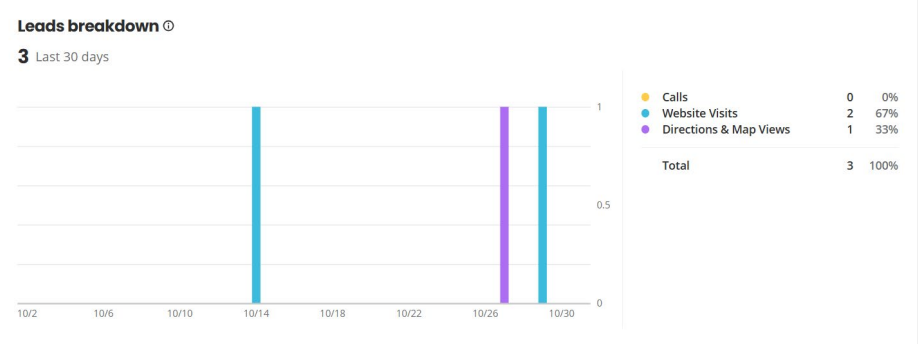
FY 2024-2025 | October 2024

YELP OVERVIEW









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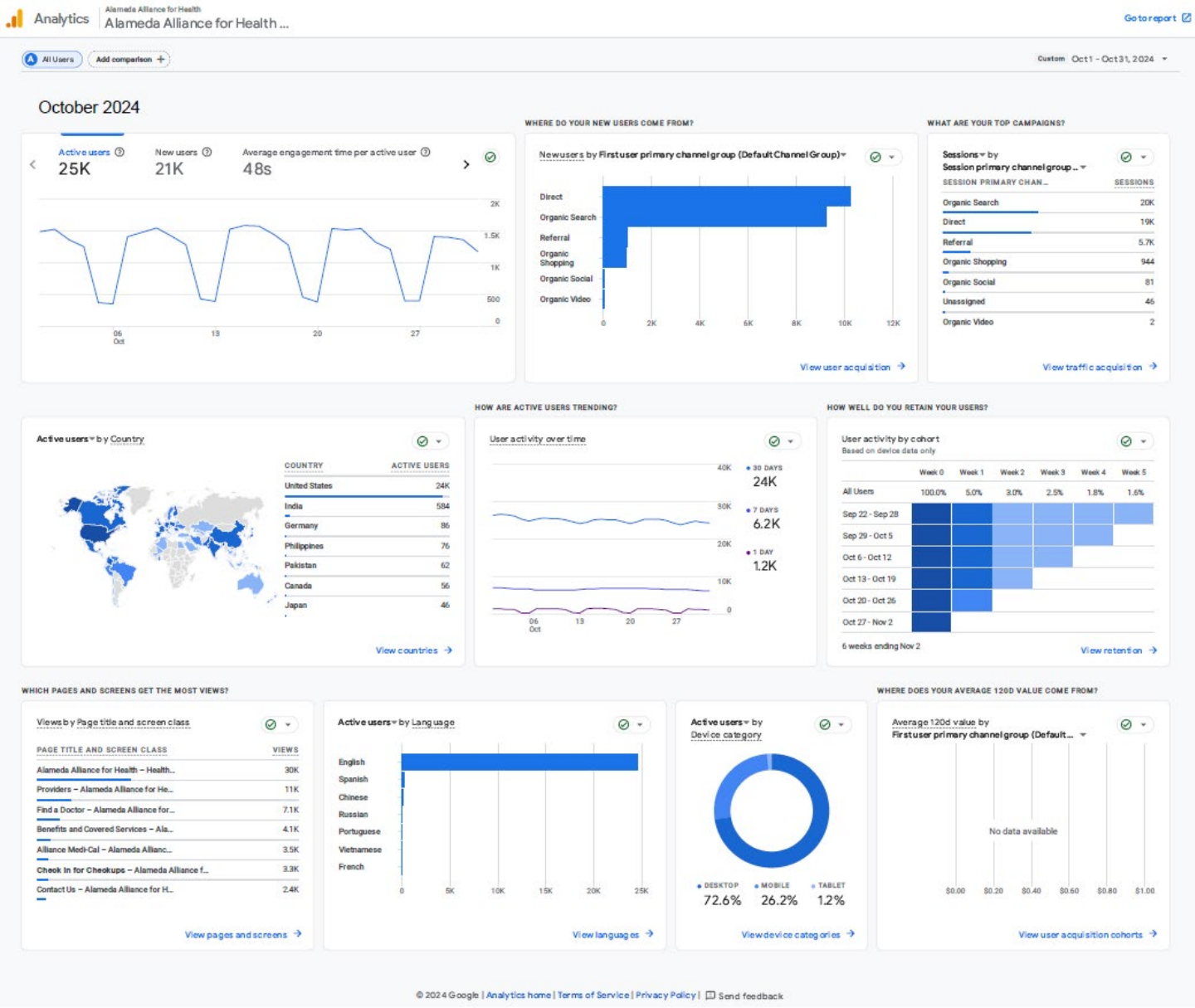
ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2024-2025 | **October 2024**

ALLIANCE WEBSITE OVERVIEW:



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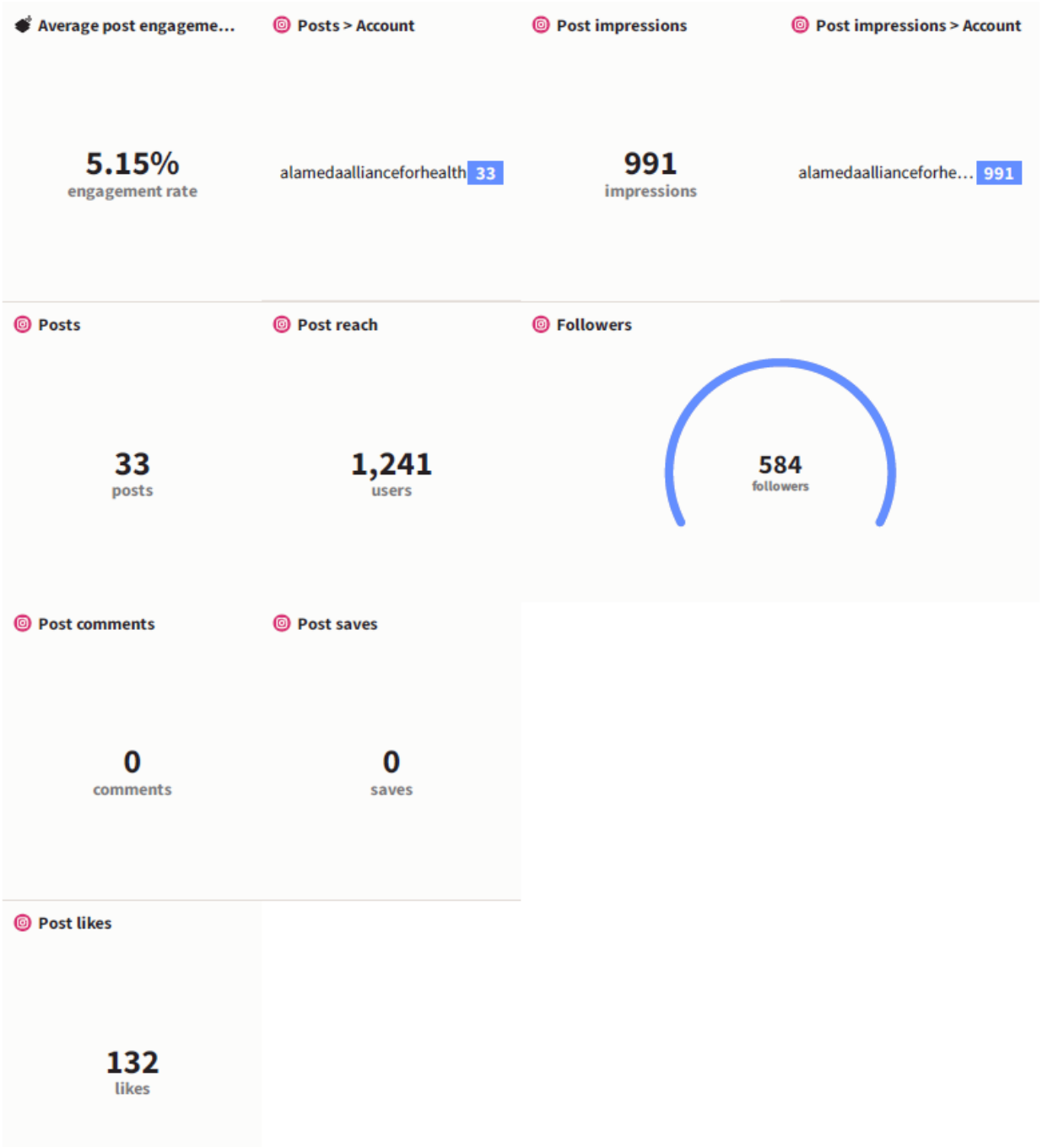
ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2024-2025 | **October 2024**

Instagram OVERVIEW:



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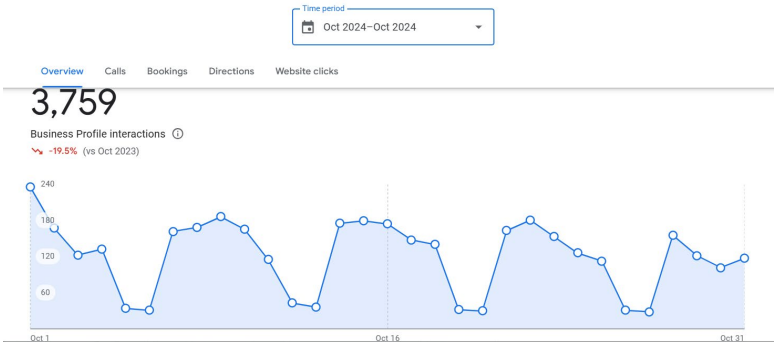
ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2024-2025 | **October 2024**

Google OVERVIEW:



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Projects and Programs

Supporting Documents

Compliance

Richard Golfin III

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

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

Date: **November 8th, 2024**

Subject: **Compliance Division Report**

Compliance Audit Updates

- 2025 Department of Managed Health Care (DMHC) Routine Full Medical Survey
    - On October 3rd, 2024, the Plan received notification from DMHC stating it will conduct a joint routine survey with the Department of Health Care Services (DHCS) starting March 3rd, 2025. The look back period is from October 1st, 2022, to September 30th, 2024. The Plan began submitting pre-onsite documents to DMHC on October 31st, 2024.

- 2024 Department of Health Care Services (DHCS) Routine Full Medical Survey
    - DHCS conducted its 2024 Routine Full Medical Survey from June 17th, 2024 - June 28th, 2024. The Department held its Exit Conference with the Plan on October 16th, 2024. DHCS issued the Preliminary Report on October 11th, 2024, identifying 23 total findings. The Plan must submit its response to DHCS by October 31st, 2024. DHCS will issue the final report in early November, and the Plan must submit its CAP response within thirty (30) days after receiving the DHCS CAP request.

- 2023 Department of Health Care Services (DHCS) Focused Medical Survey
    - DHCS issued the Medical Survey Audit Report and CAP Request Letter for the 2023 DHCS Focused Medical Survey to the Plan on September 4th, 2024. DHCS identified findings related to Behavioral Health Services and Transportation Services. Compliance hosted eight (8) office hour sessions to help SMEs address their questions, clarifications, or concerns about documenting CAP responses. The Plan submitted the CAP response to DHCS on October 4th, 2024. The Plan will provide monthly updates to DHCS starting in November.

- 2024 Department of Health Care Services (DHCS) Facility Site Review (FSR) and Medical Record Review (MRR)
    - DHCS conducted its required random full-scope FSR and MRR consistent with APL 22-017 on September 17th, 2024, through September 19th, 2024, for Alameda County. DHCS selected ten (10) PCPs from the Plan. The Plan's FSR Team guided the selected PCPs in preparation for the audit. A Plan nurse reviewer attended the onsite reviews through completion. DHCS issued the

Critical Elements findings report to the Plan on September 24th, 2024, identifying eight (8) providers with findings. The providers submitted a CAP and evidence of corrections to the Plan's FSR Team. The Plan submitted the CAPs to DHCS on October 4th, 2024. DHCS issued its Primary Care Provider FSR and MRR report to the Plan on October 22nd, 2024. The report requires all ten (10) providers to submit CAPs. The Plan must submit CAPs and respond to all audit report deficiencies within thirty (30) calendar days.

Compliance Activity Updates

- Centers for Medicare & Medicaid Services (CMS) Notice of Intent to Apply (NOIA)
  - On November 8th, 2024, the Plan will submit a NOIA that informs the Centers for Medicare and Medicaid Services (CMS) of its intent to participate in Medicare Advantage by establishing an Exclusively Aligned Enrollment Dual-Eligible Special Needs Plan (EAE D-SNP) product for Calendar Year 2026.
- Department of Managed Health Care (DMHC) Medicare Filings – 2026 Medicare Launch
  - 2024 EAE D-SNP Material Modification Filing (E-Filing *No. 20244060*): The Plan submitted its response to DMHC's comments on October 29th. DMHC will provide any follow-up comments by November 28th.
- 2024 Corporate Compliance Annual Training
  - The Plan launched its Annual Corporate Compliance Trainings on Monday, September 9th, 2024. These trainings cover HIPAA, FWA, and Cultural Sensitivity. Staff must complete assigned trainings by December 9th, 2024. Currently, forty-eight percent (48%) of staff have completed their assigned training.

- 2022 Behavioral Health Insourcing: Material Modification:

Undertaking No. 6		
Undertaking Deliverable	**Progress**	**Next Milestone**
"Submit an Amendment filing to demonstrate compliance with the Federal Mental Health Parity and Addiction Equity Act ("MHPAEA") (42 USC § 300 gg-26) and its regulations (45 CFR § 146.136) and Section 1374.76 of the Act."	The Plan must demonstrate it does not impose financial requirements and/or treatment limitations on mental health/substance use disorder (MH/SUD) benefits are on par with or are no more restrictive than the financial requirements and treatment limitations (TL) that it applies to medical/surgical (Med/Surg) benefits in the same classification.	The Plan submitted NQTL table revisions and substantive responses to DMHC's comments. DMHC will provide any follow-up questions by November 11th. The Plan expects to close this filing in December 2024.

Compliance

Supporting Documents

Q1 2024 - PRESENT APL IMPLEMENTATION TRACKING LIST						
#	Regulatory Agency	APL #	Date Released	APL/PL Title	LOB	APL Purpose Summary
1	DHCS	24-001	1/12/2024	Street Medicine Provider: Definitions and Participation in Managed Care	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care plans (MCPs) on opportunities to utilize street Medicine providers to address clinical and non-clinical needs of their Medi-Cal Members experiencing unsheltered homelessness.
2	DMHC	24-001	1/12/2024	Amendment to Rule 1300.71.31 regarding calculation of the “Average Contracted Rate” for AB 72 (2016) purposes	MEDI-CAL & GROUP CARE	The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 24-001 to provide guidance to plans on the Amendment to section 1300.71.31 of title 28 of the California Code of Regulations (Rule 1300.71.31).
3	DMHC	24-002	1/22/2024	Large Group Renewal Notice Requirements	GROUP CARE	The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 24-002 to provide guidance to plans on the timing and content requirements for renewal notices to large group contract holders under HSC section 1374.21 and HSC section 1385.046.
4	DMHC	24-003	1/29/2024	Plan Year 2025 QHP, QDP, and Off-Exchange Filing Requirements	N/A	The Department of Managed Health Care (Department) issues this All Plan Letter (APL) 24-003 to assist in the preparation of Plan Year 2025 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).
5	DHCS	24-002	2/8/2024	Medi-Cal Managed Care Plan Responsibilities for Indian Health Care Providers and American Indian Members	MEDI-CAL	The purpose of this All Plan Letter (APL) is to summarize and clarify existing federal and state protections and alternative health coverage options for American Indian Members enrolled in Medi-Cal managed care plans (MCPs). Additionally, this APL consolidates various MCP requirements pertaining to protections for Indian Health Care Providers (IHCPs), including requirements related to contracting with IHCPs and reimbursing claims from IHCPs in a timely and expeditious manner. This APL also provides guidance regarding MCP tribal liaison requirements and expectations in relation to their role and responsibilities.
6	DMHC	24-004	2/22/2024	Coverage of Over-the Counter FDA Approved Contraceptives	GROUP CARE	The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 24-004 to remind health plans, effective January 1, 2024, the rules changed regarding health plan coverage of over-the-counter (OTC) contraceptive drugs, devices, and products approved by the federal Food and Drug Administration (FDA).
7	DMHC	24-005	3/11/2024	Change Healthcare Cyberattack	MEDI-CAL & GROUP CARE	The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 24-005 to encourage health plans to be flexible to ensure stability of the health care system following the cyberattack of Change Healthcare
8	DMHC	24-006	3/20/2024	Provider Directory Annual Filing Requirements	MEDI-CAL & GROUP CARE	This All Plan Letter (APL) reminds health care service plans of California Health and Safety Code section 1367.27, subdivision (m)’s requirement to annually submit provider directory policies and procedures to the Department of Managed Health Care (Department).
9	DHCS	24-003	3/28/2024	Abortion Services	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCP) with information regarding their responsibility to provide Members with timely access to abortion services.
10	DMHC	24-007	4/3/2024	Implementation of Senate Bill 855 Regulation, Mental Health and Substance Use Disorder Coverage	GROUP CARE	The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 24-007 to provide guidance regarding implementation of the regulation as well as filing and compliance requirements for commercial full-service health plans and specialized health care service plans (plan or plans) offering behavioral health services.
11	DHCS	24-004	4/8/2024	Quality Improvement and Health Equity Transformation Requirements	MEDI-CAL	The purpose of this All Plan Letter (APL) is to notify Medi-Cal managed care plans (MCPs), including MCPs delivering services to Members with specialized health care needs under the Population-Specific Health Plan (PSP) model, of requirements for quality and health equity improvement. Unless otherwise noted, all MCP requirements set forth in this APL apply to PSPs.
12	DMHC	24-008	4/15/2024	2024 Health Plan Annual Assessments	GROUP CARE	The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 24-008 to provide information to health care service plans (health plans) pertaining to the DMHC’s fiscal year (FY) 2024-25 annual assessments.
13	DHCS	24-005	4/29/2024	California Housing and Homelessness Incentive Program	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCP) with guidance on the incentive payments linked to the Housing and Homelessness Incentive Program (HHIP) implemented by the California Department of Health Care Services (DHCS) in accordance with the Medi-Cal Home and Community-Based Services (HCBS) Spending Plan.
14	DMHC	24-008	4/15/2024	2024 Health Plan Annual Assessments	GROUP CARE	The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 24-008 to provide information to health care service plans (health plans) pertaining to the DMHC’s fiscal year (FY) 2024-25 annual assessments.

#	Regulatory Agency	APL #	Date Released	APL/PL Title	LOB	APL Purpose Summary
15	DMHC	24-009	5/6/2024	Change Healthcare Cyberattack Response Filing	MEDI-CAL & GROUP CARE	The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 24-009 to request information from plans regarding their response and outreach to enrollees potentially impacted by the Change Healthcare cyberattack.
16	DHCS	24-006	5/13/2024	Community Health Worker Services Benefit	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 becoming a Community Health Worker (CHW), the definitions of eligible populations for CHW services, and descriptions of applicable conditions for the CHW benefit.
17	DMHC	24-010	6/13/2024	Coverage of Ground Ambulance Services Provided by a Noncontracted Provider	GROUP CARE	The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 24-010 to provide additional guidance regarding Assembly Bill 716.
18	DMHC	24-011	6/17/2024	Request for Health Plan Information and Addendum Revisions	MEDI-CAL & GROUP CARE	The Department of Managed Health Care (Department) issues this All Plan Letter (APL) 24-011 to notify health care service plans the Department has revised the attached, Request for Health Plan Information (RHPI) and RHPI Addendum forms.
19	DHCS	24-007	6/20/2024	Targeted Provider Rate Increases	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with guidance on Network Provider payment requirements applicable to Medi-Cal Targeted Rate Increases (TRI), as defined herein, effective for dates of service on or after January 1, 2024.
20	DHCS	24-008	6/21/2024	Immunization Requirements	MEDI-CAL	The purpose of this All Plan Letter (APL) is to clarify requirements related to the provision of immunization services.
21	DHCS	20-016	6/24/2024	Blood Lead Screening of Young Children (TECHNICAL CHANGE)	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide requirements for blood lead screening tests and associated monitoring and reporting for Medi-Cal managed care plans (MCPs).
22	DMHC	24-012	6/25/2024	Single Point of Contact for Hospitals to Request Authorization for Poststabilization Care	MEDI-CAL & GROUP CARE	This All Plan Letter (APL) reminds plans they may not require a hospital to make more than one telephone call to request authorization to provide poststabilization care to plan enrollees.
23	DMHC	24-013	6/28/2024	Health Equity and Quality Program Policies and Requirements	MEDI-CAL & GROUP CARE	The Department of Managed Health Care (Department) issues this All Plan Letter (APL) 24-013 to inform all health care service plans (health plans) of the DMHC Health Equity and Quality (HEQ) program policies and requirements. The instructions provided herein supersede those previously published in APL 22-028 and REVISED APL 23-029.
24	DMHC	24-014	7/8/2024	Guidance Regarding Dental Rate Review Reporting Requirements	N/A	Assembly Bill 1048 (Wicks, 2023) added section 1385.14 to the California Health and Safety Code. Section 1385.14 requires health plans offering a specialized health care service plan contract covering dental services to file premium rate information and information regarding the methodology, factors, and assumptions used to determine rates with the Department of Managed Health Care (DMHC) annually and at least 120 days before implementing any change in the methodology, factors, or assumptions that would affect rates. This All Plan Letter (APL) provides guidance on dental rate review filing requirements.
25	DMHC	24-015	7/22/2024	High Deductible Health Plan Products and Coverage of COVID-19 Testing	N/A	The Department of Managed Health Care (Department) issues this All Plan Letter (APL) 24-015 which addresses coverage of COVID-19 tests delivered to enrollees in high deductible health plan (HDHP) products.
26	DMHC	24-016	7/25/2024	Request for Health Plan Contact Information	MEDI-CAL & GROUP CARE	The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 24-016 to request that all health care service plans (health plans) provide the Department with updated health plan contact information.
27	DMHC	24-017	7/31/2024	RY 2025 MY 2024 Provider Appointment Availability Survey NPMH Provider Follow-Up Appointment Rate of Compliance	MEDI-CAL & GROUP CARE	The Department of Managed Health Care (DMHC) hereby issues APL 24-017 (OPM) – RY 2025/MY 2024 Provider Appointment Availability Survey NPMH Provider Follow-Up Appointment Rate of Compliance.
28	DMHC	24-018	8/15/2024	Compliance with Senate Bill 923	MEDI-CAL & GROUP CARE	The Department of Managed Health Care (DMHC) hereby issues All Plan Letter (APL) 24-018 – Compliance with Senate Bill 923 to provide guidance regarding the implementation of SB 923, including filing and compliance requirements for all full-service and certain specialized health care service plans (plan or plans).
29	DHCS	24-009	9/16/2024	Skilled Nursing Facilities - Long Term Care Benefit Standardization and Transition of Members to Managed Care	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide requirements to all Medi-Cal managed care plans (MCPs) on the Skilled Nursing Facility (SNF) Long Term Care (LTC) benefit standardization provisions of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, including the mandatory transition of Medi-Cal members to managed care.

#	Regulatory Agency	APL #	Date Released	APL/PL Title	LOB	APL Purpose Summary
30	DHCS	24-010	9/16/2024	Subacute Care Facilities - Long Term Care Benefit Stnadardization and Transition of Members to Managed Care	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide requirements to all Medi-Cal managed care plans (MCPs) on the Subacute Care Facility Long Term Care (LTC) benefit standardization provisions of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, including the mandatory transition of Medi-Cal members to managed care.
31	DHCS	24-011	9/16/2024	Intermediate Care Facilities for Individuals with Developmental Disabilities - Long Term Care Benefit Standardization and Transition of Members to Managed Care	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide requirements to all Medi-Cal managed care plans (MCPs) for the Long-Term Care (LTC) Intermediate Care Facility/Home for Individuals with Developmental Disabilities services provisions of the California Advancing and Innovating Medi-Cal (CalAIM) benefit standardization initiative. This APL contains requirements related to Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) Homes, Intermediate Care Facilities for the Developmentally Disabled-Habilitative (ICF/DD-H) Homes, and Intermediate Care Facilities for the Developmentally Disabled-Nursing (ICF/DD-N) Homes.
32	DHCS	24-012	9/17/2024	Non-Specialty Mental Health Services: Member Outreach, Education, and Experience Requirements	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care plans (MCPs) regarding requirements for Member outreach, education, and assessing Member experience for Non-Specialty Mental Health Services (NSMHS), as required by Senate Bill (SB) 1019 (Gonzalez, Chapter 879, Statutes of 2022).
33	DHCS	24-013	9/18/2024	Managed Care Plan Child Welfare Liaison	MEDI-CAL	The purpose of this All Plan Letter (APL) is to clarify the intent and objectives of the Medi-Cal managed care plan (MCP) Child Welfare Liaison, formerly referred to as the Foster Care Liaison, as outlined and required by the 2024 MCP Contract (MCP Contract) with the Department of Health Care Services (DHCS). Additionally, this APL provides guidance regarding the requirements and expectations in relation to the role and responsibilities of the MCP Child Welfare Liaison.
34	DHCS	24-014	9/27/2024	Continuity of Care for Medi-Cal Members who are Foster Youth and Former Foster Youth in Single Plan Counties	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) in Single Plan counties with guidance on enhanced continuity of care protections for Foster Youth and Former Foster Youth Medi-Cal members who live in a Single Plan county and are mandatorily transitioning from Medi-Cal Fee-For-Service (FFS) to enroll as Members in Medi-Cal managed care.
35	DMHC	24-019	10/30/2024	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.

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: **November 8th, 2024**

Subject: **Health Care Services Report**

2023 Trilogy Document Summary

Case Management (CM)

- Types of CM: Enhanced Case Management (ECM), Complex Case Management (CCM), Basic Case Management (BCM), Care Coordination, Transitional Care Services (TCS)

- Trilogy documents also include CM teams of Behavioral Health and Long-term Support Services

- Health Risk Assessment (HRA) & HIF/MET Screener
    - Overall 12% HRA completion rate (2% decrease compared to 2022)
    - Increase in HIF/MET screening return rate in Q4 2023

- Case Volumes (open/active)
    - PH Care Coordination: average 434 cases/month
    - BH Care Coordination: average 147 cases/month
    - Disease Management – Asthma: 128 members served
    - Disease Management – Diabetes: 514 members served
    - Complex Case Management: average 34 cases/month
    - Enhanced Case Management: 972 adults & 369 children/youth served
    - Transitional Care Services: average 253 cases/month

- Opportunities incorporated into 2024 Program/Workplan:
    - Incorporate DHCS PHM Key Performance Indicators to workplan:
        - Increase % members enrolled in CCM & ECM
        - Care manager engagement for high-risk members within 7 days post-discharge
    - Expand ECM network providers (to increase access to ECM services)
    - Expand CS services and network providers (to increase access to and availability of CS services)

Utilization Management (UM)

- Authorization Volumes
    - Significant increase in total auth volume (+99,578 compared to 2022)
        - Membership growth, increased utilization with LTC membership
        - System and reporting configuration updates leading to more accurate data capture

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

- Authorization Turn-Around Times (goal = 95%)
    - Inpatient/outpatient: overall 98%, above goal
    - LTC: overall 97%, 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):*

- There was a month-over-month increase in total authorization volume from September to October 2024.

Total Authorization Volume (Medical Services)			
Authorization Type	**August 2024**	**September 2024**	**October 2024**
Inpatient	2,729	3,778	3,179
Outpatient	4,816	4,468	5,317
Long-Term Care	649	835	819
Total	**8,194**	**9,081**	**9,315**

***Source**: #02569_AuthTAT_Summary*

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

Utilization Management: Outpatient

- Anthem CoC volume has reduced to 5-10% of all incoming authorizations at any given time.

- We have successfully transitioned 90% of Anthem DME under CoC to our in-network provider CHME. Final transition will occur at the end of the year when our specific Anthem CoC DME contracts expire.

- Reporting is being analyzed to identify members who DHCS has categorized as special populations to ensure enhanced CoC benefits are managed properly for our new members. Provider relations contracting team continuing to engage in contract negotiations with identified OON providers to bring them into AAH.

- The OP team is also preparing for the transition of the Foster Youth Population to ensure CoC; currently, pending utilization data from DHCS.

- OP processed a total of 5,317 authorizations in the month of October.

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

Total Outpatient Authorization Volume			
Authorization Status	**August 2024**	**September 2024**	**October 2024**
Approvals	4,621	4,306	5,095
Partial Approvals	14	13	29
Denials	181	149	193
Total	**4,816**	**4,468**	**5,317**

***Source**: #02569_AuthTAT_Summary*

Outpatient Authorization Denial Rates			
Denial Rate Type	**August 2024**	**September 2024**	**October 2024**
Overall Denial Rate	**3.0%**	**3.0%**	**2.8%**
Denial Rate Excluding Partial Denials	**2.8%**	**2.8%**	**2.6%**
Partial Denial Rate	**0.2%**	**0.1%**	**0.2%**

***Source**: #03690_Executive_Dashboard*

Outpatient Turn Around Time Compliance			
Line of Business	**August 2024**	**September 2024**	**October 2024**
Overall	**99%**	**100%**	**100%**
Medi-Cal	**99%**	**99%**	**100%**
IHSS	**100%**	**100%**	**100%**
Benchmark	*95%*	*95%*	*95%*

***Source**: #02569_AuthTAT_Summary*

Utilization Management: Inpatient

- Total inpatient auth volume decreased from 3,739 in September to 3179 authorizations processed in October.

- Inpatient overall average LOS continues to decrease from 5.3 in August to 4.9 in September with an increase in admits per thousand from 48.8 in August to 50.4 in September, and decrease in days per thousand, 256.4 in August to 246.6 in September. The trend is consistent among Child, Adult, ACA and SPD categories.

- IP overall denial rate was 2.2% in both September and October.

- IP Auth TAT compliance continues to surpass benchmark, with overall TAT of 98% in September and October.

- IP UM receives ADT feed for automation of Authorization creation from Alameda Health System's, Alta Bates Summit Medical Center, Eden Hospital, Washington Hospital, and St Rose. Authorizations are tasked to clinical reviewers for concurrent review and care coordination needs for discharge to post acute levels of care.IP UM team has, in working with IT, automated the auth request process for these hospitals. This has reduced the administrative burden on the hospital provider side while facilitating real time communication on member admissions. The team continues to pursue ADT feeds at Stanford and UCSF, and is working with IT to increase SNF ADT feeds.

- IP UM team continues to identify members eligible for care management services who are currently admitted to a hospital, conducts inpatient discharge risk assessment, provides the name of Care Manager for inclusion in the discharge summary, and refers to Case Management department for follow up. The TCS process continues to be refined to ensure all members with care transitions receive the correct level of support.

- IP UM continues weekly hospital rounds with tertiary care centers UCSF and Stanford, as well as contracted hospital providers; Alameda Health System, Sutter, Kindred LTACH, Kentfield LTACH, and Washington, to review members' current active admissions discuss UM issues, address discharge barriers, and refer to Case Management programs including Complex, offer support in terms of ECM, Community Supports services, and other opportunities for supporting throughput and appropriate discharge.

Total Inpatient Authorization Volume			
Authorization Status	**August 2024**	**September 2024**	**October 2024**
Approvals	2,687	3,739	3,131
Partial Approvals	0	0	0
Denials	42	39	48
Total	**2,729**	**3,778**	**3,179**

Source: #02569_AuthTAT_Summary

Inpatient Med-Surg Utilization			
Total All Aid Categories			
Actuals (excludes Maternity)			
Metric	**July 2024**	**August 2024**	**September 2024***
Authorized LOS	**5.5**	**5.3**	**4.9**
Admits/1,000	**52.7**	**48.8**	**50.4**
Days/1,000	**288.8**	**256.4**	**246.6**

Source: #01034_AuthUtilizationStatistics – *data only available through August 2024

Inpatient Authorization Denial Rates			
Denial Rate Type	**August 2024**	**September 2024**	**October 2024**
Full Denials Rate	**1.1%**	**0.7%**	**0.7%**
Partial Denials	**1.0%**	**1.4%**	**1.5%**
All Types of Denials Rate	**2.0%**	**2.2%**	**2.2%**

Source: #01292_AllAuthDenialsRates

Inpatient Turn Around Time Compliance			
Line of Business	**August 2024**	**September 2024**	**October 2024**
Overall	**98%**	**98%**	**99%**
Medi-Cal	**98%**	**98%**	**99%**
IHSS	**100%**	**100%**	**100%**
Benchmark	*95%*	*95%*	*95%*

Source: #02569_AuthTAT_Summary

Utilization Management: Long-Term Care

- LTC census during October 2024 was 2,446 members. This is a decrease of 2.16% from September 2024.

- Month to Month, the admissions, days and readmissions are decreasing. From July to September the admissions decreased by 64.97%, the days decreased by 82.27% and the readmissions also decreased by 64.71%. Some of this could be due to a lag in claims data being available, but we are seeing a decrease, overall.

Totals	July 2024	August 2024	September 2024*
Admissions	157	96	55
Days	1,354	608	240
Readmissions	51	23	18

Source: #14236_LTC_Dashboard - *data only available through September 2024

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

- Having virtual rounds with AHS and Eden LTC facilities to coordinate on complex cases

- 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 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 supports to members preparing to discharge from an LTC custodial facility.

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

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

- Authorization volume decreased in October by 1.92%, compared to September 2024.

- Authorization processing turn-around time (TAT) continues to meet benchmark.

Total LTC Authorization Volume			
Authorization Status	**August 2024**	**September 2024**	**October 2024**
Approvals	619	787	777
Partial Approvals	0	0	0
Denials	30	48	42
Total	**649**	**835**	**819**

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	**August 2024**	**September 2024**	**October 2024**
Medi-Cal	**96%**	**97%**	**97%**
Benchmark	*95%*	*95%*	*95%*

Source: #02569_AuthTAT_Summary

Behavioral Health

- In October, Behavioral Health processed 591 authorizations, 414 Care Coordination referrals, and 265 Medi-Cal Mental Health Screenings.

Total BH Authorization Volume			
	24-Aug	**24-Sep**	**24-Oct**
Approvals	576	561	589
Partial Approval	0	0	0
Denials	2	2	2
Total	578	563	591

Source: 14939_BH_AuthTAT

Mental Health Turnaround Times

MH TAT			
**Goal ≥95%*	**24-Aug**	**24-Sep**	**24-Oct**
Determination TAT%	99%	96%	99%
Notification TAT%	97%	98%	94%

Source: 14939_BH_AuthTAT

Behavioral Health Therapies (BHT/ABA) Turnaround Times

BHT TAT			
**Goal ≥95%*	**24-Aug**	**24-Sep**	**24-Oct**
Determination TAT%	99%	99%	97%
Notification TAT%	100%	100%	99%

Source: 14939_BH_AuthTAT

Behavioral Health Denial Rates

*Goal ≤ 5%	BH Denial Rates	
24-Aug	24-Sep	24-Oct
0.01%	0.01%	0.01%

Source: 14939_BH_AuthTAT

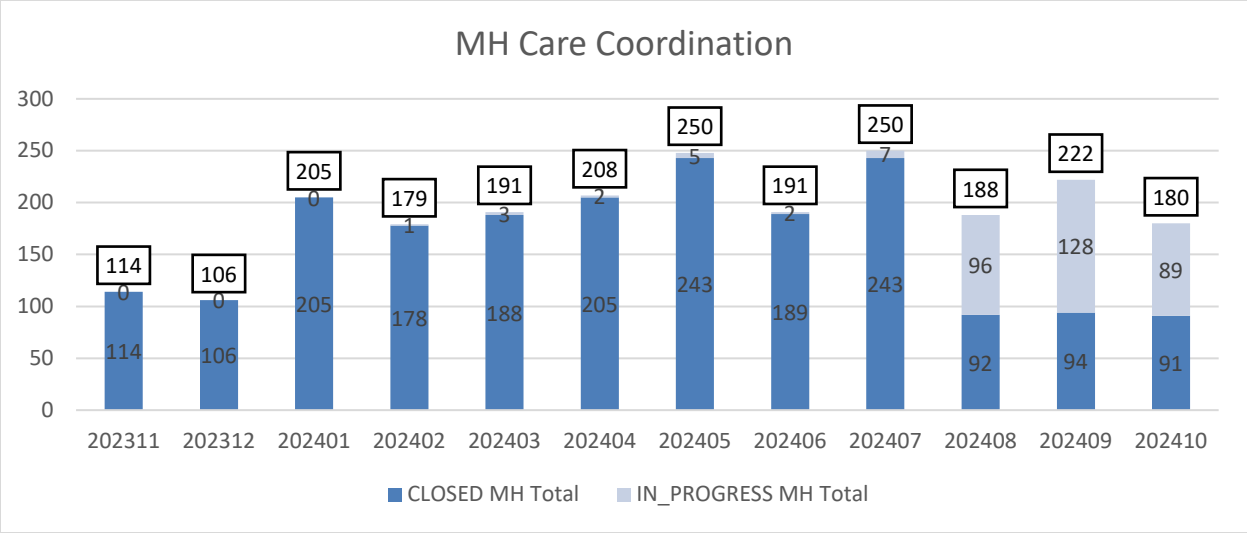
Mental Health Care Coordination

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

Total # Medi-Cal Screening Tools			
	24-Aug	24-Sep	24-Oct
Youth Screenings	59	78	84
Adults Screenings	141	123	181

Source: PBI_14460 – MLS BH TruCare Assessments

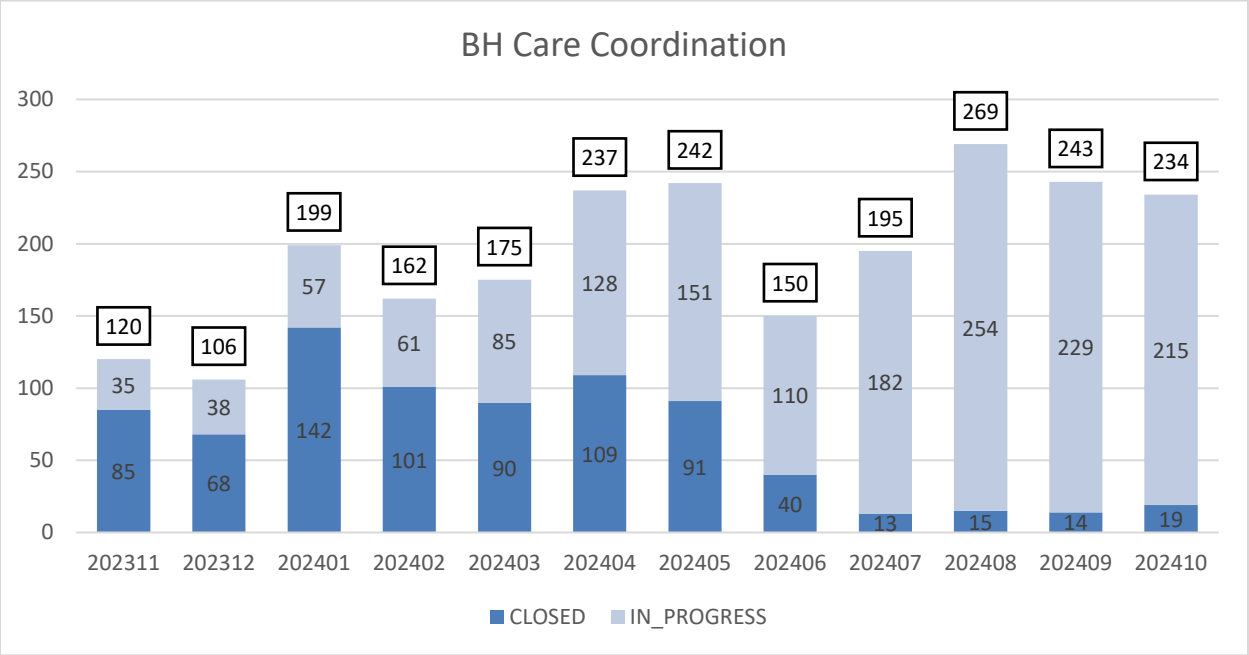
- Alliance licensed mental health clinicians, psychiatric nurses, and behavioral health navigators provide care coordination for members who need assistance accessing the mental health treatment services they need.



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 they need. The Alliance manages each child's unique needs and follows up with parents and caregivers to resolve barriers to care.

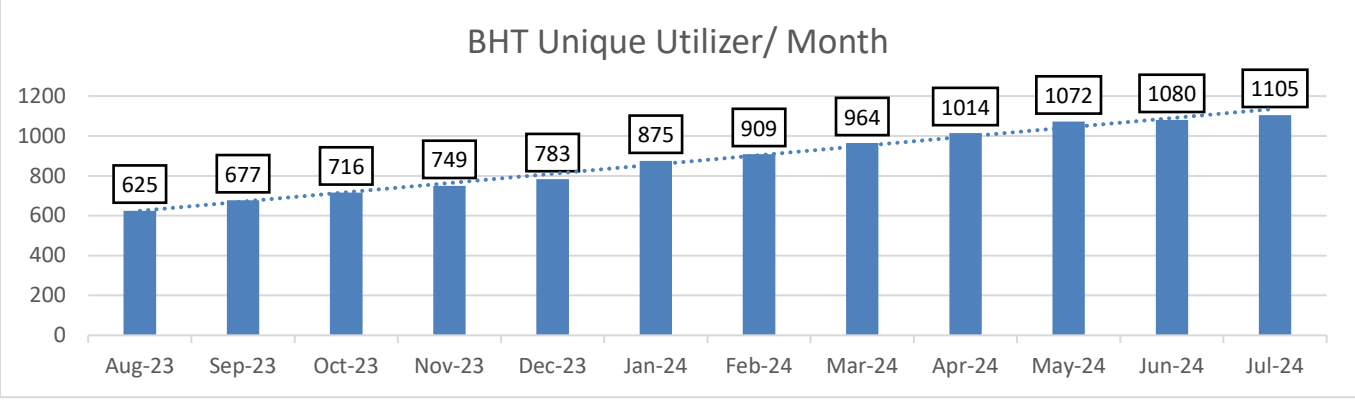


Source: 14665_BH_Cases

Behavioral Health Therapies (BHT/ABA) Utilization

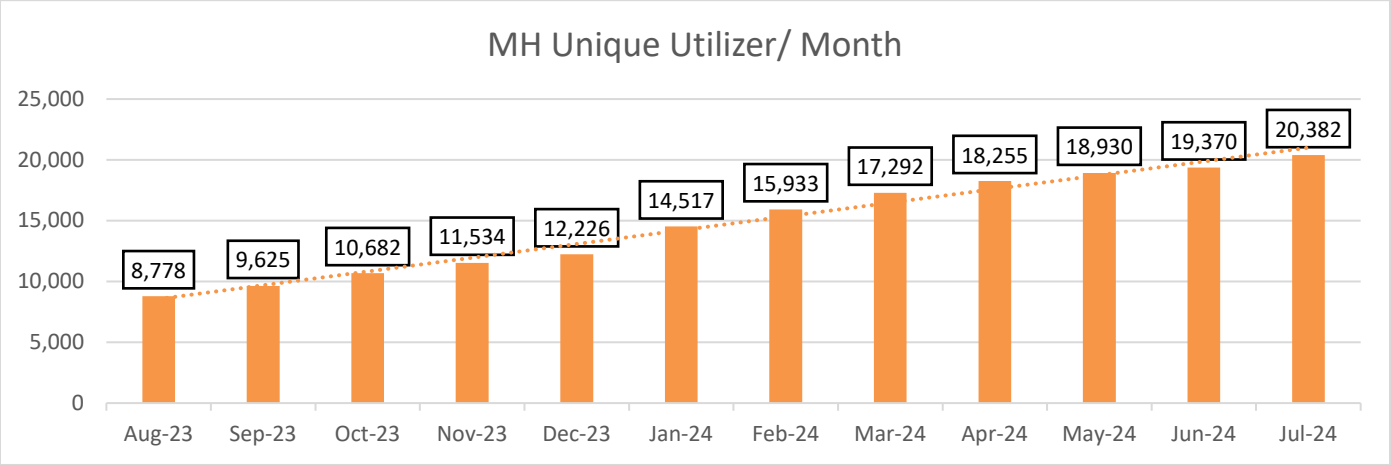
- Removing barriers to accessing BHT/ABA services remains a primary goal for the Alliance Behavioral Health team.

- We observed a consistent rise in unique utilizers of BHT/ABA services, with a 2% increase from the prior month.



Source: PBI 14621 BHT Utilization Report

- Rise in MH UU, showing a 5% increase from the prior month.



Source: PBI 14637 BH12M Report

Pharmacy

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

- Pharmacy continues to monitor members on use of opioids.

MME	IHSS	MCAL	Total
July			**376**
50	16	260	276
90	9	31	40
120	7	40	47
200		13	13
300			0
400			0
August			**423**
50	14	300	314
90	7	29	36
120	7	45	52
200		15	15
300	1		1
400		5	5
September			**440**
50	21	310	331
90	4	25	29
120	5	45	50
200	1	19	20
300	1	2	3
400		7	7

- 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.

Case and Disease Management

- 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 payor of the transition (such as Medi-Medi members).

- 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 work on members with long lengths of hospital stays in hopes of successful and safe discharges and referrals as appropriate. (Referrals include 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.

Case Type	Cases Opened in September 2024	Total Open Cases as of September 2024	Cases Opened in October 2024	Total Open Cases as of October 2024
Care Coordination	755	1,733	425	1,509
Complex Case Management	8	51	4	38
Transitions of Care (TCS)	1,418	3,005	745	2,409

***Source**: #03342 TruCare Caseload*

CalAIM

Enhanced Case Management

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

- The Alliance continues to meet with Roots regarding the Justice Involved (JI) Pilot. The Alliance is gaining a better understanding of how previously incarcerated members are assisted post-release, including member interest in any level of case management service.

- Behavioral Health linkages went live 10/1/24. In partnership with other county entities (Probation, JCC, Santa Rita, ACBH), the Alliance worked closely with the internal Behavioral Health (BH) team to prepare for members transitioning out of incarceration.
- The Alliance is continuing to collaborate with county entities in preparation of go-live for pre-release services in 2026.

- 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.

- 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 are participating in DHCS Foster Care Youth Transition Stakeholder meetings, to prepare for the mandatory transition of Foster Care Youth on 1/1/2025. DHCS released draft guidance for Continuity of Care for the Foster Care Youth Transition, and the team is reviewing to provide feedback.

- Further ECM network expansion is paused; potential providers have been notified.

ECM Outreach in July 2024	Total Open Cases as of July 2024	ECM Outreach in August 2024	Total Open Cases as of August 2024	ECM Outreach in September 2024	Total Open Cases as of September 2024
1,966	3,797	1,853	3,887	521	3,849

***Source**: #13360 ECM Dashboard*

Community Supports (CS)

- The team is currently developing new authorization criteria and collaborating with providers to implement them.

- 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.

- New Community Supports Nurse started 10/28/24

- 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 as FindHelp will not be able to accomplish that.

- Housing related community supports has transitioned to the operations team effective 10/01/24.

Community Supports	Services Authorized in July 2024	Services Authorized in August 2024	Services Authorized in September 2024
Housing Navigation	1,176	1,120	1,073
Housing Deposits	294	300	264
Housing Tenancy	1,300	1,231	1,092
Asthma Remediation	79	85	81
Meals	1,288	1,441	1,386
Medical Respite	127	129	137
Transition to Home	16	19	21
Nursing Facility Diversion	31	31	28
Home Modifications	7	6	3
Homemaker Services	164	139	113
Caregiver Respite	11	11	7
Total	**4,493**	**4,512**	**4,205**

***Source**: #13581 Community Support Auths Dashboard*

Grievances & Appeals

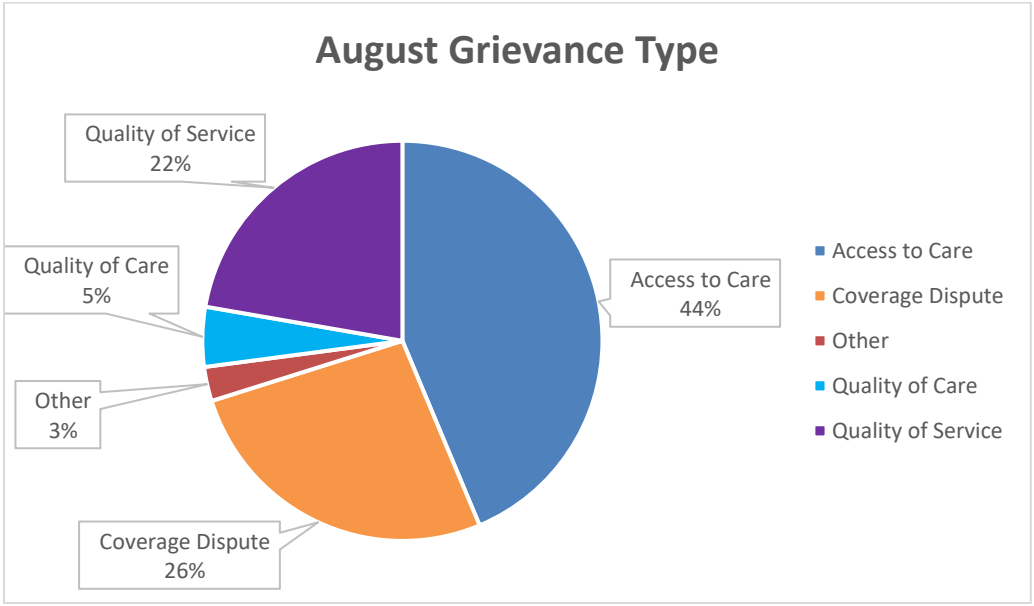
- All cases were resolved within the goal of 95% of regulatory timeframes.

- Total Unique grievances resolved in September were 7.71 complaints per 1,000 members.

September 2024 Cases	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate	Per 1,000 Members*
Standard Grievance	1,550	30 Calendar Days	95% compliance within standard	1,548	99.87%	3.31
Expedited Grievance	4	72 Hours	95% compliance within standard	4	100.00%	0.009
Exempt Grievance	1,532	Next Business Day	95% compliance within standard	1,532	100.00%	3.27
Standard Appeal	41	30 Calendar Days	95% compliance within standard	41	100.00%	0.1
Expedited Appeal	3	72 Hours	95% compliance within standard	3	100.00%	0.007
Total Cases:	3,130		95% compliance within standard	3,128	99.93%	6.59

*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:

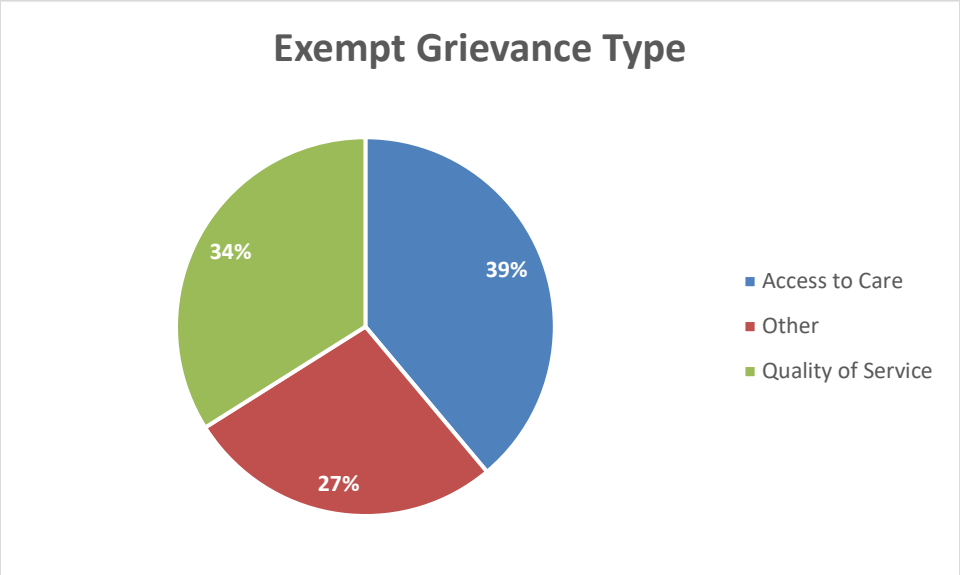


- 679 of 1,554 (44%) cases were related to Access to Care, the top 3 grievance categories are:
  - (251) Timely Access
  - (174) Technology/Telephone
  - (109) Authorization

- 411 of 1,554 (26%) cases were related to Coverage Dispute, the top 2 grievance categories are:
  - (217) Provider Direct Member Billing
  - (124) Provider Balance Billing

- 346 of 1,554 (22%) cases were related to Quality of Service, the top 3 categories are:
  - (93) Plan Customer Service
  - (71) Transportation
  - (52) Provider/Staff Attitude

Exempt Grievances:



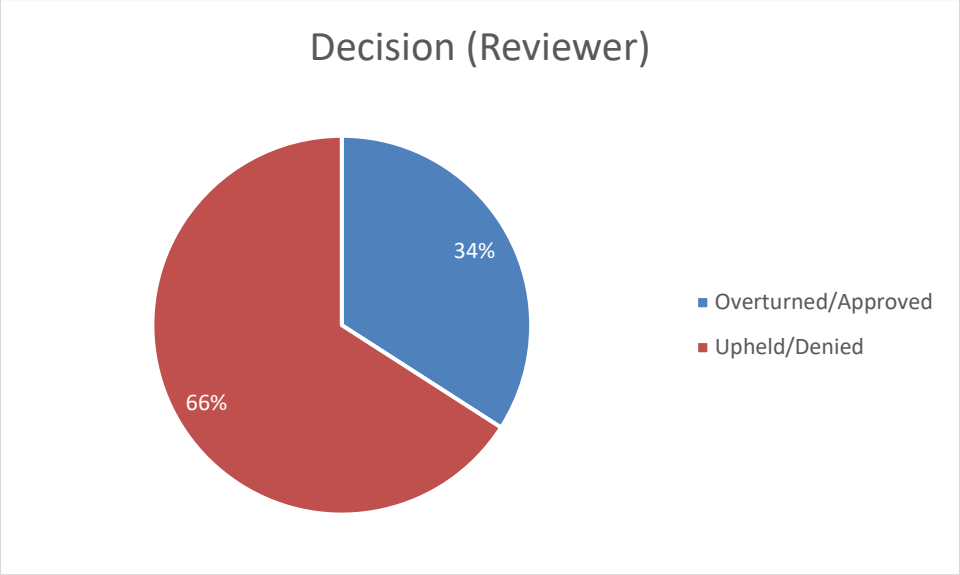
- 596 of 1,532 (39%) cases were related to Access to Care, the top 3 categories were:
  - (453) Telephone/Technology
  - (148) Provider Availability
  - (70) Geographic Access

- 520 of 1,532 (34%) cases were related to Quality of Service, the top 3 categories were:
  - (254) Plan Customer Service
  - (243) Provider/Staff Attitude
  - (14) Transportation

- 416 of 1,532 (27%) cases were related to Other, the top 2 categories were:
  - (393) Enrollment
  - (23) Eligibility

Appeals:

- The Alliance's goal is to have an overturn rate of less than 25%, for the reporting period of September 2024, we did not meet our goal at a 34% overturn rate.



- 15 out of 44 (34%) cases were overturned for the month of August 2024:
  - (7) Disputes Involving Medical Necessity
  - (5) Out of Network
  - (3) Coverage Disputes

Quality

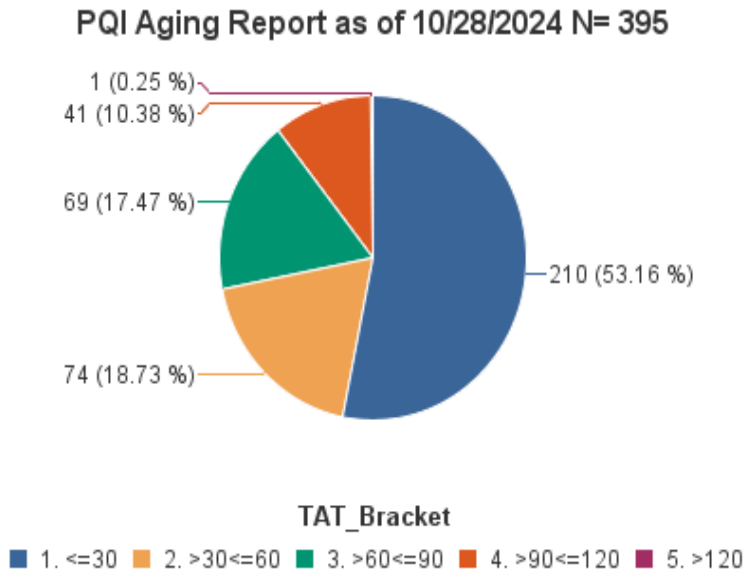
- Quality Improvement continues to track and trend PQI Turn-Around-Time (TAT) compliance. Our goal is closure of PQI cases within 120 days from receipt to resolution via nurse investigation and procurement of medical records and/or provider responses followed by final MD review when applicable.

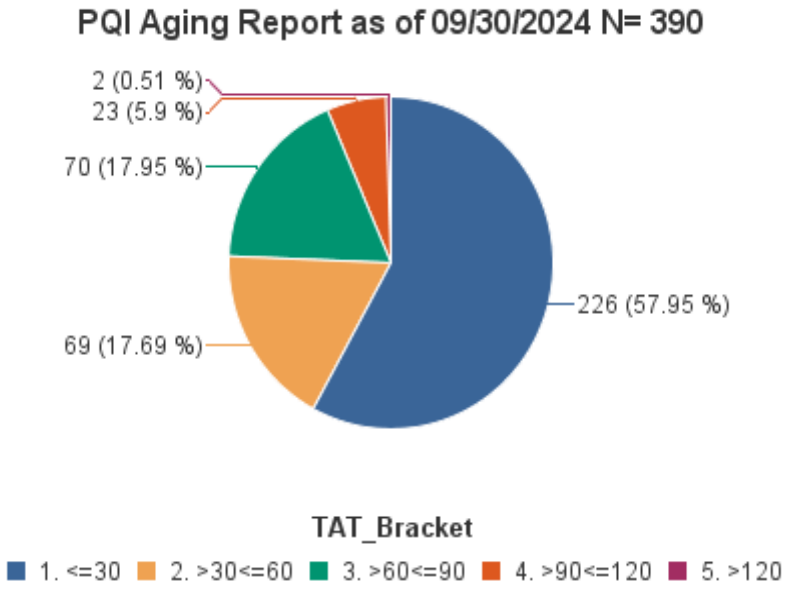
- Quality of Access issues are reviewed by the Access & Availability team and Quality of Language issues by the Cultural & Linguistics Services team after they are triaged by the QI Clinical team. Quality of Care and Service issues are reviewed by the QI RN Reviewers. Final leveling for Quality-of-Care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

- 0.51% cases in September and 0.25% cases in October were still open past the 120-day TAT. Therefore, turnaround times for case review and closure remain well within the benchmark of 95% per PQI P&P QI-104 for this lookback period.

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

- The total number of PQIs including all categories increased by 5 referrals from September to October. TATs are closely monitored on a weekly basis to ensure timely closure of cases within the standard 95%.

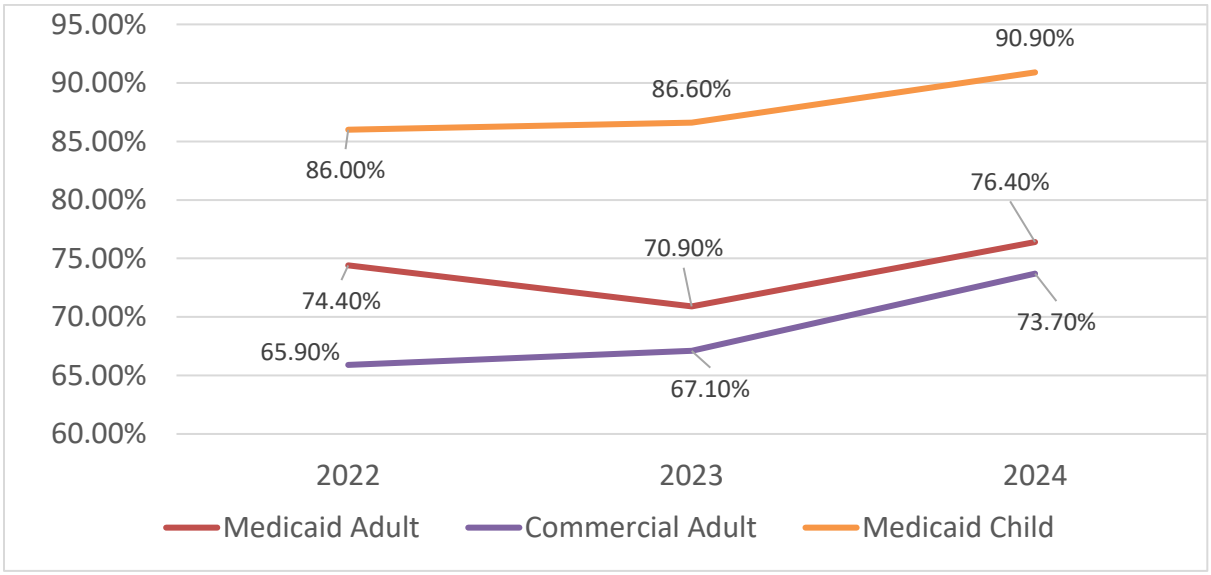




CAHPS 5.1H Survey

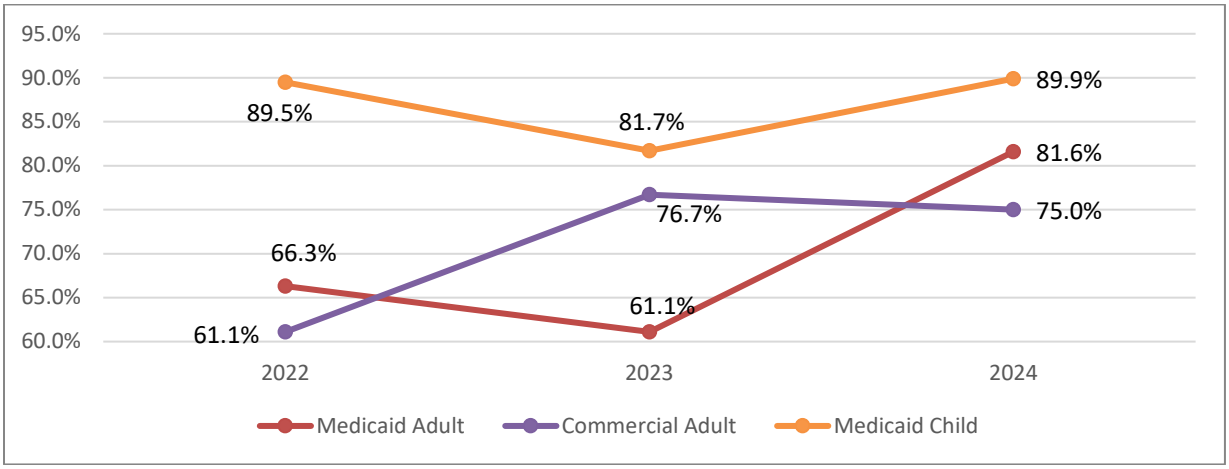
- Survey Objective: The overall objective of the CAHPS study is to capture accurate and complete information about consumer reported experiences with health care. Specifically, the survey aims to measure how well plans are meeting their members' expectations and goals; to determine which areas of services have the greatest effect on members' overall satisfaction; and to identify areas of opportunity for improvement, which can aid plans in increasing the quality of provided care. AAH vendor PG analytics collected valid surveys from each eligible member population from February to May of each year.

Rating of Health Plan 8, 9 or 10



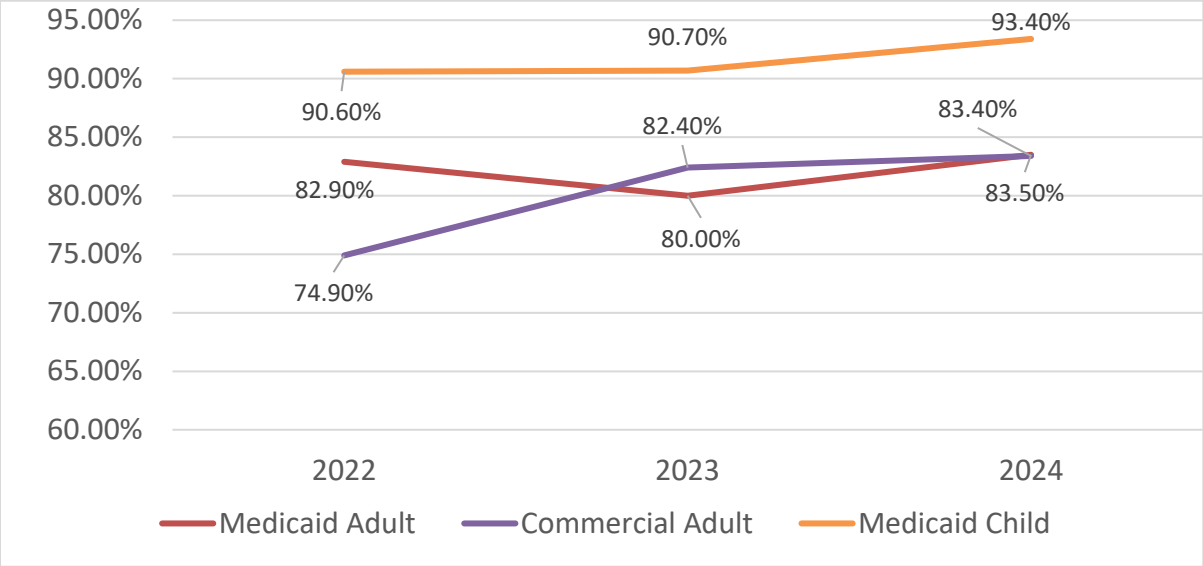
- Rates change from 2023 to 2024:
  - Medicaid Adult rate in 2024 increased from 2023 by 5.5%.
  - Medicaid Child rate in 2024 increased from 2023 by 4.3%.
  - Commercial Adult rate in 2024 increased from 2023 by 6.6%.

Rating of Health Care 8, 9 or 10



- Rates change from 2023 to 2024:
    - Medicaid Adult rate in 2024 increased from 2023 by 20.5%.
    - Medicaid Child rate in 2024 increased from 2023 by 8.2%.
    - Commercial Adult rate in 2024 decreased from 2023 by 1.7%.

Rating of Personal Doctor 8, 9 or 10



- Rates change from 2023 to 2024:
    - Medicaid Adult rate in 2024 increased from 2023 by 3.5%.
    - Medicaid Child rate in 2024 increased from 2023 by 2.7%.
    - Commercial Adult rate in 2024 increased from 2023 by 1.0%.

- Next Step: In the next two quarters, Access and Availability will continue to collaborate interdepartmentally to identify best practices and opportunities for improvement and develop improvement action plan for implementation, including provider education, joint meetings, and office visits.

Provider Satisfaction Survey

- Survey Objective: The Provider Satisfaction Survey targets providers to measure their satisfaction with Alameda Alliance for Health. Information obtained from these surveys allows plans to measure how well they are meeting their providers' expectations and needs. The Provider Satisfaction Survey typically fielding from September to November of each year.

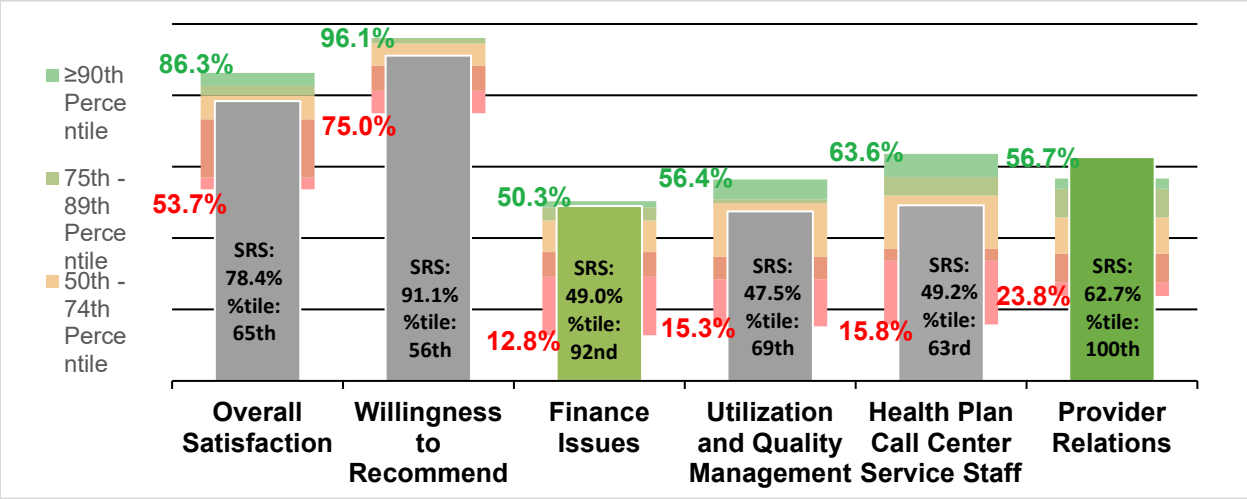
Provider Satisfaction Composite Scores

Composite	MY 2023 Result	Variance Compared to Previous Year	Variance Compared to SPH Commercial Benchmark BoB	MY 2022 Result	MY 2021 Result
Overall Satisfaction	**78.4%**	Lower	Significantly Higher	86.3%	77.3%
All Other Plans (Comparative Rating)	**55.3%**	Higher	Significantly Higher	53.5%	50.0%
Finance Issues (Claims)	**49.0%**	Higher	Significantly Higher	44.3%	44.5%
Utilization and Quality Management	**47.5%**	Lower	Significantly Higher	50.6%	45.3%
Network/Coordination of Care	**41.7%**	Higher	N/A	31.2%	37.6%
Pharmacy	**38.1%**	Higher	N/A	31.6%	35.1%
Health Plan Call Center Service Staff	**49.2%**	Lower	Significantly Higher	51.3%	54.0%
Provider Relations	**62.7%**	Higher	Significantly Higher	56.7%	63.5%

- The Alliance identified higher composite scores in 5 of 8 measures compared to MY 2022 scores.

- Six (6) of the 8 composites scores are significantly higher than the vendor commercial BoB scores

Comparison Relative to SPH Book of Business



Green bar = AA performing at or above the 75th percentile
Red bar = AA performing below the 25th percentile

- Survey results indicate that the Alliance is performing above the 75th percentile for Finance Issues and Provider Relation compared to the distribution of scores in the 2022 PG Commercial Book of Business. On the remaining measure, the plan is performing above the median.

Key Drivers of the Overall Rating of Health Plan

- Power: Promote and leverage Strengths (Top 5 Listed)
  - Timeliness of plan decisions on routine prior authorization requests
  - Procedures for obtaining pre-certification/referral/authorization information
  - Timeliness of obtaining pre-certification/referral/authorization information
  - Timeliness of plan decisions on urgent prior authorization requests
  - The health plan's facilitation/support of appropriate clinical care for patients

- Opportunities: Focus resources on improving processes that underline these items
  - Ability to speak with plan medical director about prior authorization decisions, including Did You Know campaign outlining AAH activities focusing on improving providers expectations and needs.

ALAMEDA Alliance FOR HEALTH

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

Health Equity

Lao Paul Vang

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

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

Date: **November 8th, 2024**

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.

- **Transgender, Gender Diverse, Intersex (TGI) APL 24-018 Collaborative Update –**
  - A Business Case initiation meeting was convened between IPD and the Health Equity Division (HED) on September 18th to identify the scope of work and stakeholders.
  - As the executive project leader of the APL, HED collaborates with IPD to launch a multi-stakeholder workgroup as of October 4th, 2024, with weekly check-in to implement the comprehensive plan according to the APL in compliance with SB923. The module consists of 4 components: a) TGI cultural competency training; b) Provider Directory; c) Policy and Procedures; d) Grievance and Appeals.

- **Non-Specific Mental Health Services (NSMHS) Work Group (APL 24–012) –**
  - Attended a newly established multi-stakeholder group on October 31st, 2024, to implement NSMHS according to APL 24-012.
  - Ensure health equity principles are embedded throughout the APL.

- **Foster Youth and Child Welfare Workgroup** (**APL 24–013 and APL 24–014) –**
  - Attended the new multi-state holder's group to implement the APL as of October 11th, 2024.

- **Strategic Collaboration with Internal Stakeholders to Advance Health Equity –**
  - Formulation of value-add partnerships with sections/units with the shared mission of health equity:

- ✓ PHM, QI, specifically Women's Health, and Chronic Disease workgroups where health disparity was observed among selected ethnic minorities. Specific data analysis has been mapped out for potential collaboration to address targeted health disparity.
- ✓ Communications and Outreach: Internal alignment regarding community events and identification of potential collaboration for future outreach events in 2025.
- ✓ Housing and Community Services Program team: exploratory discussions to streamline and consolidate resources to promote health equity.
- ✓ ECM and CS team: to discover partnership opportunities to advance health equity among the enrollees of these CalAIM benefits.
- ✓ Medical Services: HCS, Community Health, UM, and LTSS initiated discussions with several medical directors on innovative ideas of embedding health equity into existing services.
- ✓ HCS Newsletter: actively involved in the creation of the newsletter.

External Collaboration

- **Bi-weekly meetings with Local Health Plans' Chief Health Equity Officers (CHEOs) Update –**
  - ➢ Ongoing discussions regarding health equity-related issues and DEI training curriculum.
- **Monthly Meetings with DHCS' Chief Health Equity Officer (DHCS CHEO) Update** –
  - ➢ DHCS CHEO and MCPs CHEOs met to collaborate on Health Equity and DEI initiatives.
  - ➢ The meeting consisted of DHCS and CHEO Updates.
- **Local Initiatives DEI Training Monthly Collaborative Meeting –**
  - ➢ Health plan Updates on DEI Training curriculum progress.
  - ➢ Discussed tracking outside entities like CBO's attestations and training implementations, as well as collaboration and tracking of attestation with other MCPs in our counties.

Advancing Health Equity Initiative (AHEI) Update –

- **DEI Training APL 23-025 Update –**
  - ➢ Finalized the development of the DEI training curriculum with three (3) submodules: Health Equity, Cultural Competency, and DEIB (Diversity,

Equity, Inclusion, and Belonging) as per the APL, in collaboration with PHM, HR, Compliance, and our vendor.

- Timeline:
  - ✓ The training curriculum was submitted to DHCS in the first week of November 2024.
  - ✓ DEI Provider's Pilot will launch in January 2025. California Cardiovascular Consultants was selected for the provider pilot training.
  - ✓ April – June: pilot training will be completed, and the training will be launched to all providers and downstream networks.

- **Alliance Health Equity Strategic Roadmap –**

  - The HE Roadmap framework developed by the multi-stakeholders committee continues to be validated and adjusted based on prevailing health equity best practices and subject matter expertise of the Health Equity Division.
  - A total of six milestones have been identified:

    1) Organization
    2) Data-Driven
    3) Education
    4) Communication
    5) Community Engagement and
    6) SDOH Mitigation Measures

- **Community Engagement Update –**

  - Formation of a new Faith-based Community Outreach workgroup: first meeting on November 22nd, 2024.
  - Visited the Oakland LBGTQ Center on October 9th to discuss further collaborative opportunities that will add value to our members.
  - A one-year Calendar of Events has been developed for 2025 with the three high-value CBOs, including faith-based organizations we could partner with in community outreach events.
  - Strategic partnership meetings with local food banks.
  - Exploratory discussion with Alameda County Public Health on community needs assessment.

- **Communications Update**

  - Completed a short video introducing the DEI Training Curriculum.

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

- **DEIB Committee Update –**

- The DEIB Committee met on September 30th, and our special guest was Matt Woodruff.
- The committee discussed and asked Matt about combining the VIA and DEIB Committees and updating the charter.

- **VIA Committee Update** –

  - The October 10th Fall Fest was the last employee engagement gathering of the year. We had an excellent employee turnout and received positive emails and verbal feedback regarding the food being delicious and the event being enjoyable.
  - The VIA Committee met on October 21st and decided to support the *Building Futures Annual Holiday Gift Drive.*

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Service you can trust.

Information Technology

Sasikumar Karaiyan

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

From: **Sasi Karaiyan, Chief Information & Security Officer**

Date: **November 8th, 2024**

Subject: **Information Technology Report**

Call Center System Availability

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

- Call center applications now support English speech to text. The Alliance is aiming to extend the system to include Spanish and efforts to execute the contract is being finalized.

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.

- 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 concentrating on user testing and documentation. Emails have been dispatched to all staff members, initiating the campaign and rollout plan.

- 210 migrations have been successfully completed and will continue to ramp up in the coming weeks.

Data Retention Project (Phase 1)

- One of the Alliance major goals for fiscal year 2025 is to complete the first phase of the implementation of an enterprise Data Retention program that will focus on structured data.

- This program will guarantee the practice of storing and managing data and records for a designated period, to ensure that data is discoverable, cataloged, classified and easily accessible.

- The scanning of the Windows file share (SFTP) is completed with 8.79 million files. Data retention policies are being evaluated. Data retention policies are defined, and the maximum file type is .txt which contributes approximately 80% of the overall findings. A meeting with stakeholders is planned to review the findings.

- The scanning of all eight domains, including Finance, Pharmacy, and Medical Encounter within data warehouse has been completed with 12 million records. Major findings are in two: the Medical Encounter Domain with twelve key tables having many over-retained records, and the Member Domain with four key tables, one staging table accounting for 98% of the findings. The Provider and Claims Domains have minimal findings.

- Data Retention Policies have been set up and configured for both Windows file share (SFTP) and Data Warehouse which completes the first phase of the project.

- The data warehouse scanning focused on master and transactional data, excluding reference data. Over 11.9 million records, older than 10 years, were flagged.

Encounter Data

- In the month of October 2024, the Alliance submitted 215 encounter files to the Department of Health Care Services (DHCS) with a total of 501,826 encounters.

Enrollment

- The Medi-Cal Enrollment file for the month of October 2024 was received and loaded to HEALTHsuite.

HEALTHsuite

- The Alliance received 367,989 claims in the month of October 2024.

- A total of 400,262 claims were finalized during the month out of which 335,624 claims auto adjudicated. This sets the auto-adjudication rate for this period to 83.9%.

- HEATLHsuite application encountered a partial outage on October 10th, 2024, which lasted 40mins. This sets the up time to 99.85% for the application.

TruCare

- A total of 19,914 authorizations were loaded and processed in the TruCare application.

- TruCare Application Uptime – 99.99%.

Information Technology

Supporting Documents

Enrollment

- See Table 1-1 “Summary of Medi-Cal and Group Care member enrolment in the month of October 2024”.
- See Table 1-2 “Summary of Primary Care Physician (PCP) Auto-assignment in the month of October 2024”.
- 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 October 2024

Month	Total MC[1]	MC[1] - Add/ Reinstatements	MC[1] - Terminated	Total GC[2]	GC[2] - Add/ Reinstatements	GC[2]- Terminated
October	406,158	6,108	6,573	5,771	162	102

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 October 2024

Auto-Assignments	Member Count
Auto-assignments MC	2,520
Auto-assignments Expansion	1,988
Auto-assignments GC	67
PCP Changes (PCP Change Tool) Total	4,575

TruCare Application

- See Table 2-1 “Summary of TruCare Authorizations for the month of October 2024”.
- There were 19,914 authorizations processed within the TruCare application.
- TruCare Application Uptime – 99.99%.
- 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 October 2024*

Transaction Type	Total Auths Received
Paper Fax to Scan (DocuStream)	2,697
Provider Portal Requests (Zipari)	6.294
EDI (CHCN)	6,132
Provider Portal to AAH Online (Long Term Care)	11
ADT	1238
Behavioral Health COC Update - Online	77
Behavioral initial evaluation - Online	60
Manual Entry (all other not automated or faxed vs portal use)	3,405
Total	19914

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 September 2024

Group	Individual User Accounts	Individual User Accounts Accessed	Total Logins	New Users
Provider	7,629	5,545	422,695	704
MCAL	117.727	3.653	8.505	1,219
IHSS	3,831	83	238	22
Total	129,187	9,281	431,438	1,945

Table 3-2 Top Pages Viewed for the Month of September 2024

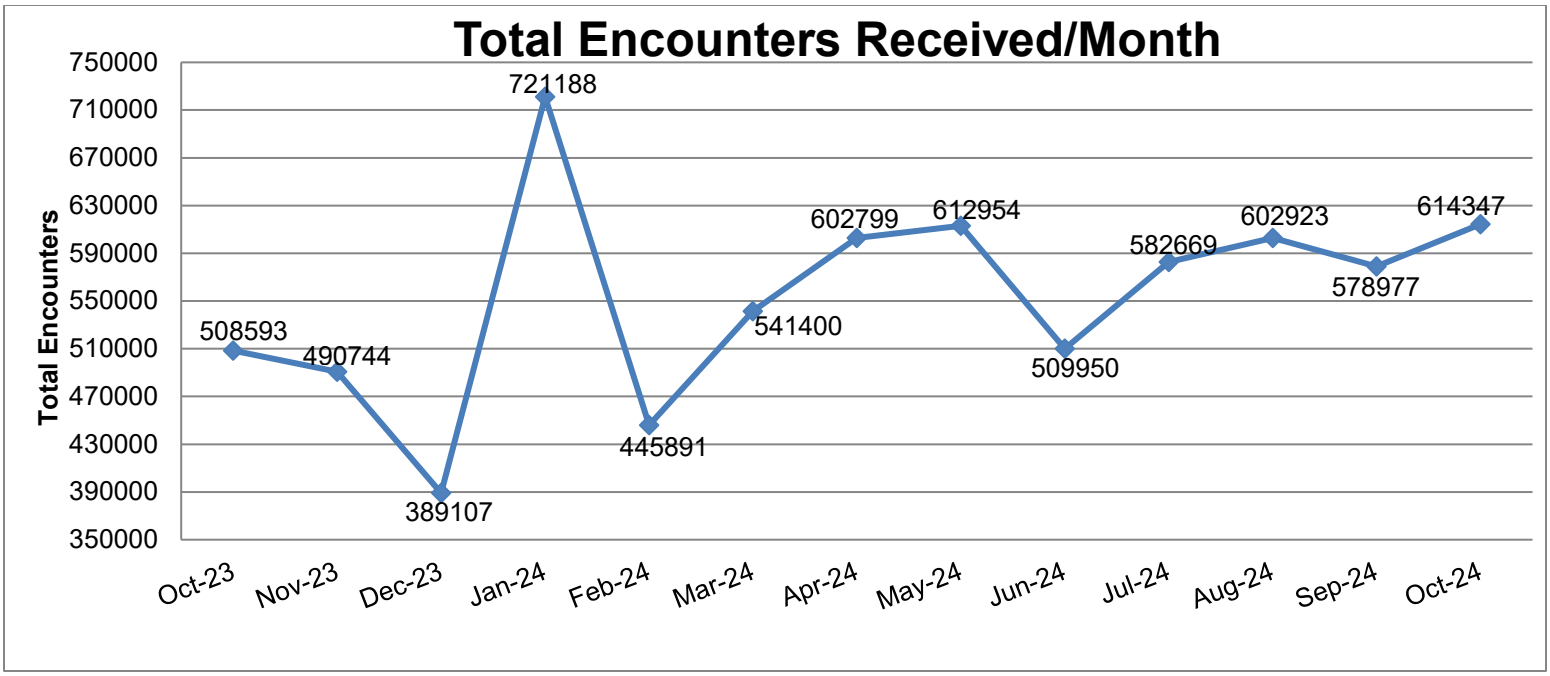
Category	Page Name	Page Views
Provider - eligibility/claim	Member Eligibility	1482205
Provider - Claims	Claim Status	245665
Provider - eligibility/claim	Claim Status	26282
Provider - authorizations	Auth Submit	17100
Provider - authorizations	Auth Search	7372
Member Config	Provider Directory	6015
Member My Care	Member Eligibility	4386
Provider - Claims	Submit professional claims	4151
Member Help Resources	Find a Doctor or Hospital	3290
Member Help Resources	ID Card	2448
Member Help Resources	Select or Change Your PCP	1950
Provider - eligibility/claim	Member Roster	1664
Member Home	MC ID Card	1491
Member My Care	My Claims Services	1056
Provider - reports	Reports	937
Provider - Provider Directory	Provider Directory 2019	910
Provider - eligibility	Member Eligibility	761
Member My Care	Authorization	640
Provider - Home	Behavior Health Forms SSO	615
Provider - Home	Forms	498
Member My Care	My Pharmacy Medication Benefits	418
Member Help Resources	FAQs	370
Member My Care	Member Benefits Materials	345
Member Help Resources	Forms Resources	332
Provider - Provider Directory	Manual	316
Provider - Provider Directory	Instruction Guide	299
Member Help Resources	Authorizations Referrals	268
Member Help Resources	Contact Us	237
Member Help Resources	Update My Contact Info	133

Encounter Data From Trading Partners 2024

- **AHS**: October weekly files (8,309 records) were received on time.
- **BAC**: October monthly files (76 records) were received on time.
- **CHCN**: October weekly files (125,042 records) were received on time.
- **CHME**: October monthly files (7,102 records) were received on time.
- **CFMG**: October monthly files (16,045 records) were received on time.
- **Docustream**: October monthly files (704 records) were received on time.
- **EBI**: October monthly files (1,640 records) were received on time.
- **FULLCIR**: October monthly files (2,523 records) were received on time.
- **HCSA**: October monthly files (2,389 records) were received on time.
- **IOA**: October monthly files (588 records) were received on time.
- **Kaiser**: October bi-weekly files (159 records) were received on time.
- **LAFAM**: October monthly files (89 records) were received on time.
- **LIFE**: October monthly files (119 records) were received on time
- **LogistiCare**: October weekly files (49,941 records) were received on time.
- **March Vision**: October monthly files (5,143 records) were received on time.
- **MED**: October monthly files (645 records) were received on time.
- **OMATOCHI**: October monthly files (0 records) were received on time.
- **PAIRTEAM**: October monthly files (1,108 records) were received on time.
- **Quest Diagnostics**: October weekly files (18,002 records) were received on time.
- **SENECA**: October monthly files (105 records) were received on time.
- **TITANIUM**: October monthly files (6,192 records) were received on time.
- **TVHC**: October monthly files (437 records) were received on time.
- **Magellan**: October monthly files (459,743 records) were received on time.

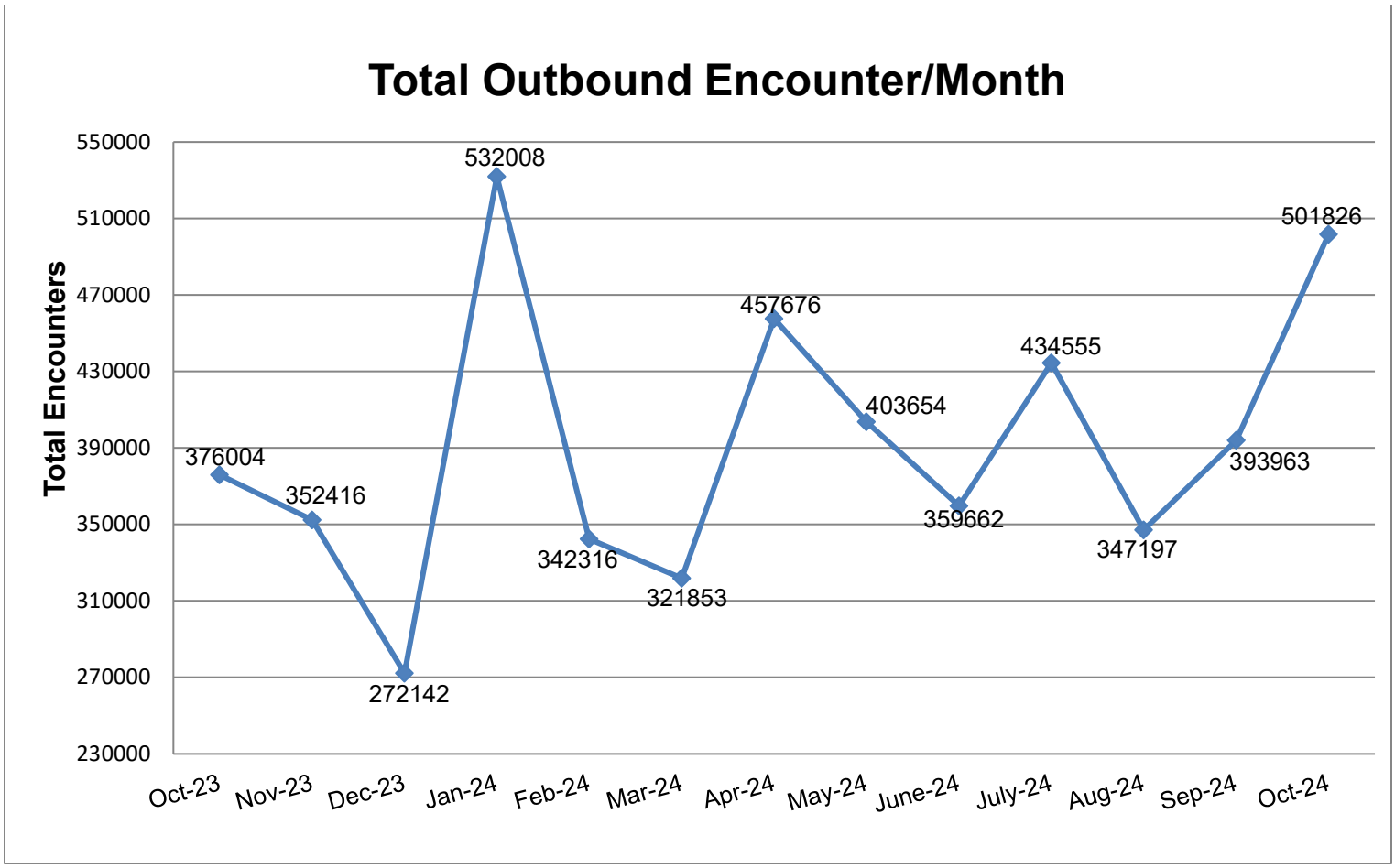
Trading Partner Encounter Inbound Submission History

Trading Partners	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
Health Suite	241298	247537	215246	298465	266339	308453	322786	375454	297267	332150	368235	322196	367989
AHS	5371	5243	6284	4570	7736	7005	6573	8412	13316	7296	8859	7498	8309
BAC	57	73	55	59	57	55	64	70	77	88	86	85	76
CHCN	111275	87839	58566	96124	103674	122217	170653	122445	110650	135444	122293	155825	125042
CHME	7609	6445	5694	5843	5560	6022	7969	7107	7449	7242	6902	7680	7102
Claimsnet	12167	11670	18995	12043	10557	12651	16394	15934	21143	10776	22335	16421	16045
Docustream	400	705	476	930	814	698	302	1589	749	934	1102	1067	704
EBI	718	823	811	1047	2903	1625	1700	184	2043	1623	1825	3394	1640
FULLCIR	888	598	177	828	1586	213	2261	8478	2842	1362	1798	3809	2523
HCSA	1913	2403	2087	2223	2097	2822	7118	5535	3663	6841	3256	3386	2389
IOA	967	1073	1250	1453	1233	1054	1925	1163	1280	847	752	4227	588
Kaiser	81985	87005	26208	77407	3725	9966	2286	886	1079	2052	172	236	159
LAFAM	24				60	39	105	116	86	70	88	63	89
LIFE									1694		614	168	119
LogistiCare	25509	20781	32181	182822	20774	35600	32632	27531	16205	43038	29732	16139	49941
March Vision	4427	4428	4562	9693		6183	3633	8546	7092	6404	7719	5769	5143
MED	194	523	532	535	742	683	633	722	744	615	608	610	645
OMATOCHI							29				2		
PAIRTEAM							5344	7582		5763		9359	1108
Quest	13712	13077	15834	27022	17658	22306	18000	18001	22500	18000	22502	18004	18002
SENECA	79	56	52	124	222	112	159	113	71	109	129	101	105
TITANIUM		465	97		154	3696	2233	3086		2015	3914	2815	6192
TVHC												125	437
Total	508593	490744	389107	721188	445891	541400	602799	612954	509950	582669	602923	578,977	614347



Outbound Encounter Submission

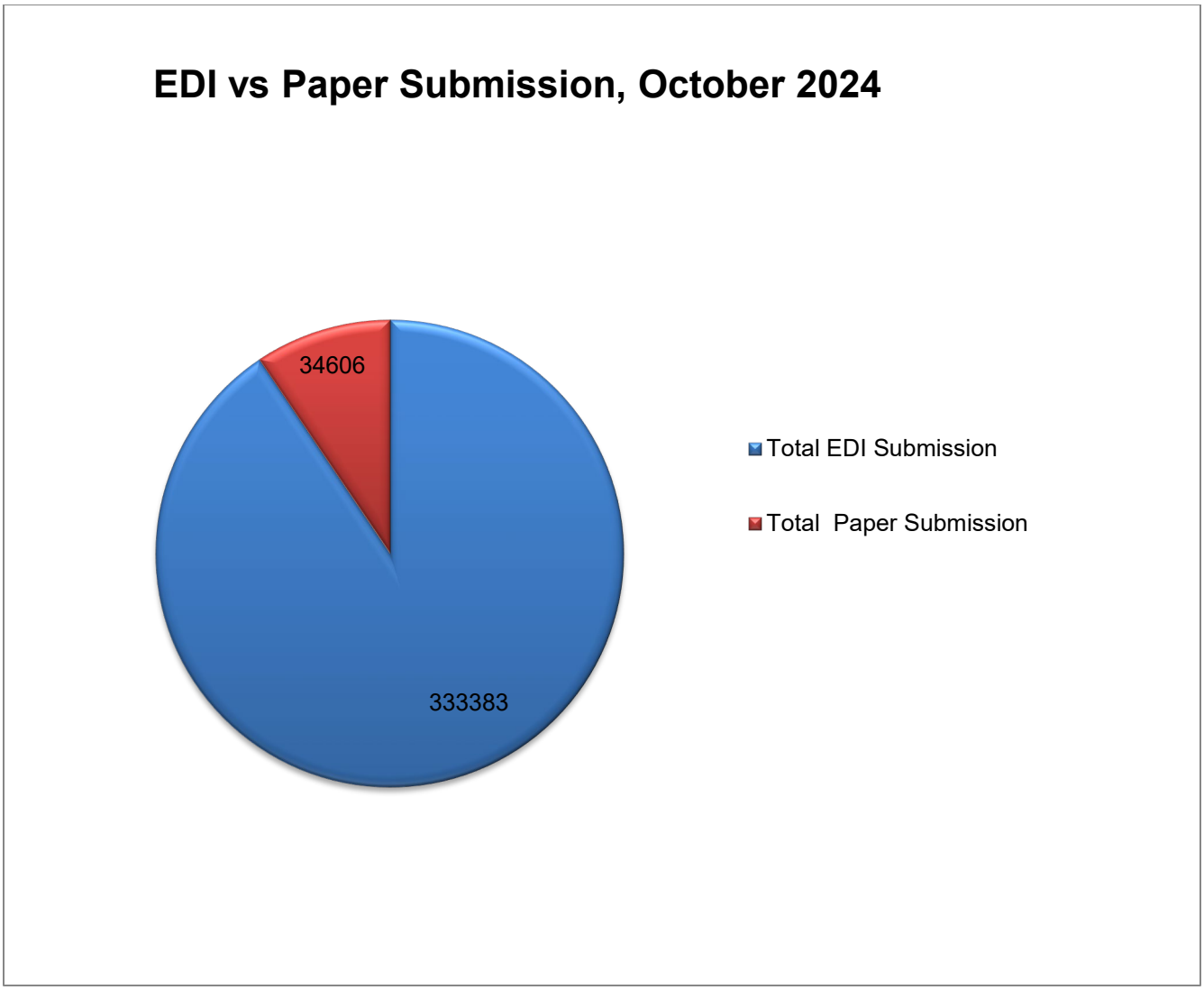
Trading Partners	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
Health Suite	163149	134823	136233	172386	177658	147776	250835	198595	204068	230706	183371	210971	276473
AHS	6355	5147	4936	5667	7497	6968	6524	7002	10684	6703	7101	8727	8201
BAC	52	67	53	55	55	47	59	66	72	80	80	78	74
CHCN	62962	73866	39846	67063	74336	80498	104625	107577	77200	94476	87485	87806	108806
CHME	7475	6321	5588	5703	5470	5889	7558	6749	7310	7095	6762	6994	6974
Claimsnet	7452	8031	11581	10145	7730	6757	13467	11561	11506	9994	4	24076	13152
Docustream	270	573	404	387	600	377	267	839	570	725	806	715	545
EBI	710	794	802	987	1347	1002	1589	60	1835	1443	1727	3242	1559
FULLCIR	806	516	124	653	540	116	1636	5401	2410	1084	674	1515	1767
HCSA	1876	2342	1991	2142	2013	2769	4710	5363	3493	6757	3171	3310	2376
IOA	65	934	1228	1378	1156	1000	1868	1029	1221	749	680	1374	549
Kaiser	81165	85807	26113	76335	3542	9650	1905	1292	812	1404	113	216	62
LAFAM	2					16	92	103	58	66	81	58	86
LIFE									28		598	159	91
LogistiCare	24497	25951	31546	157548	40529	34931	32247	27487	16221	43019	30006	16046	49705
March Vision	2863	2661	2752	2700	2616	3736	2407	5719	4553	3766	3482	4066	3543
MED	145	438	428	446	624	528	518	579	654	552	540	514	579
OMATOCHI							56						
PAIRTEAM							4279	4422		3246		4617	782
Quest	16082	3655	8394	28299	16589	16333	20983	16912	16898	20898	16854	16937	21144
SENECA	78	52	48	114	14	199	140	109	69	108	127	94	91
TITANIUM		438	75			3261	1911	2789		1684	3535	2332	5267
TVHC												116	
Total	376004	352416	272142	532008	342316	321853	457676	403654	359662	434555	347197	393963	501826


Total Outbound Encounter/Month
Total Encounters
550000
510000
470000
430000
390000
350000
310000
270000
230000
376004
352416
272142
532008
342316
321853
457676
403654
359662
434555
347197
393963
501826
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
June-24
July-24
Aug-24
Sep-24
Oct-24

HEALTHsuite Paper vs EDI Claims Submission Breakdown

Period	Total EDI Submission	Total Paper Submission	Total claims
24-Oct	333383	34606	367989

Key: EDI – Electronic Data Interchange



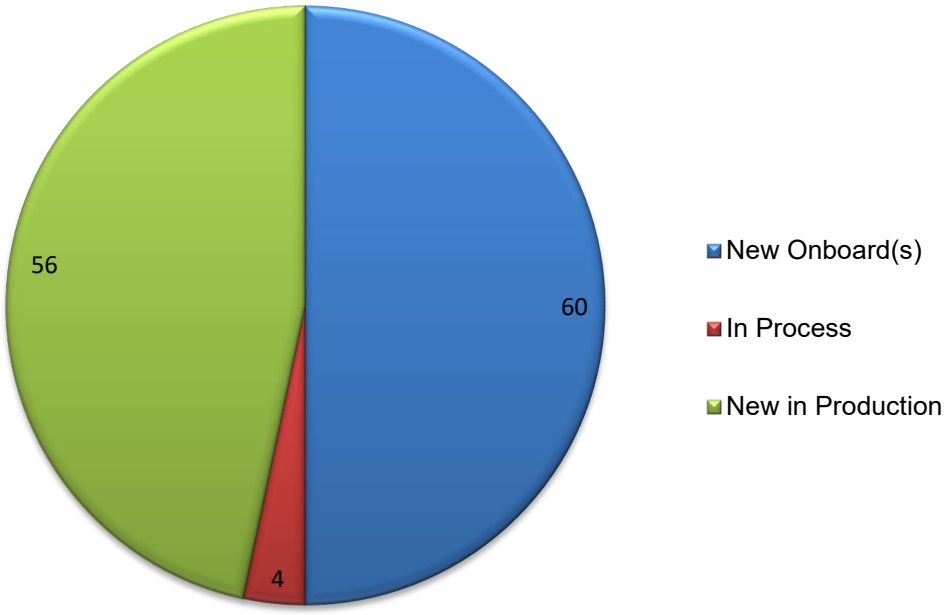
Onboarding EDI Providers – Updates

- OCT 2024 EDI Claims:
  - A total of 2739 new EDI submitters have been added since October 2015, with 56 added in October 2024.
  - The total number of EDI submitters is 3479 providers.

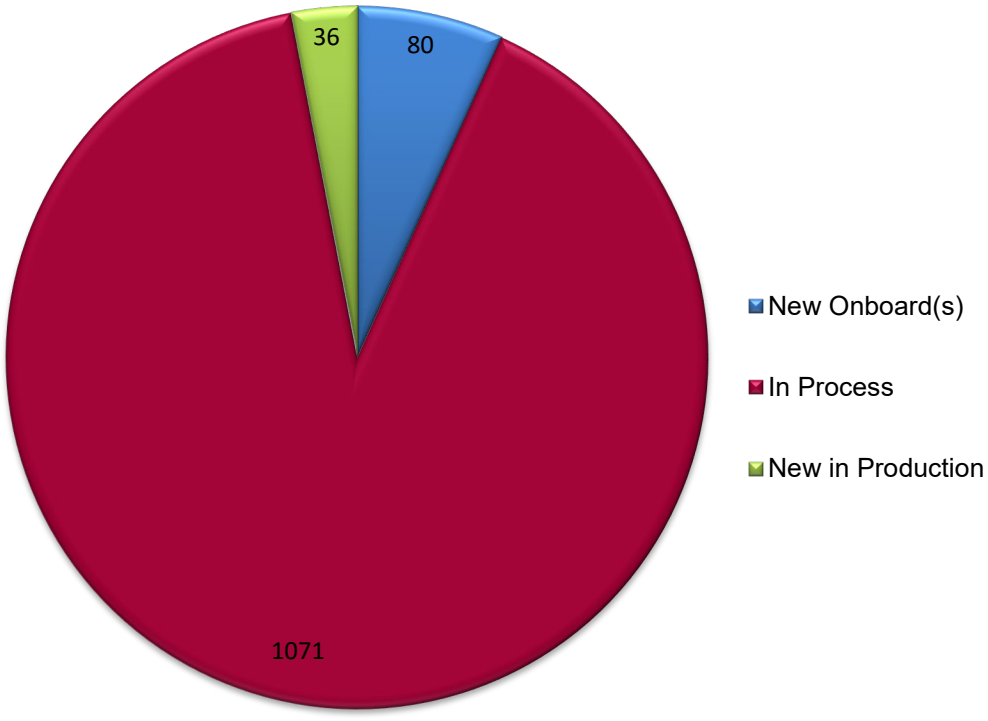
- OCT 2024 EDI Remittances (ERA):
  - A total of 1158 new ERA receivers have been added since October 2015, with 36 added in October 2024.
  - The total number of ERA receivers is 1174 providers.

	837				835			
	New on Boards	In Process	New In Production	Total in Production	New on Boards	In Process	New In Production	Total in Production
Nov-23	47	2	45	2710	45	679	6	843
Dec-23	25	2	23	2733	63	716	26	869
Jan-24	63	2	61	2794	76	751	41	910
Feb-24	37	17	20	2814	59	783	27	937
Mar-24	111	25	86	2900	60	822	21	958
Apr-24	120	3	117	3017	83	851	54	1012
May-24	81	13	68	3085	63	874	40	1052
Jun-24	39	4	35	3120	50	908	16	1068
Jul-24	86	3	83	3203	54	937	25	1093
Aug-24	181	2	179	3382	62	982	17	1110
Sep-24	46	5	41	3423	73	1027	28	1138
Oct-24	60	4	56	3479	80	1071	36	1174

837 EDI Submitters - OCT 2024



835 EDI Receivers - OCT 2024



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 **October** 2024.

File Type	Oct-24
837 I Files	46
837 P Files	169
Total Files	215

Lag-time Metrics/Key Performance Indicators (KPI)

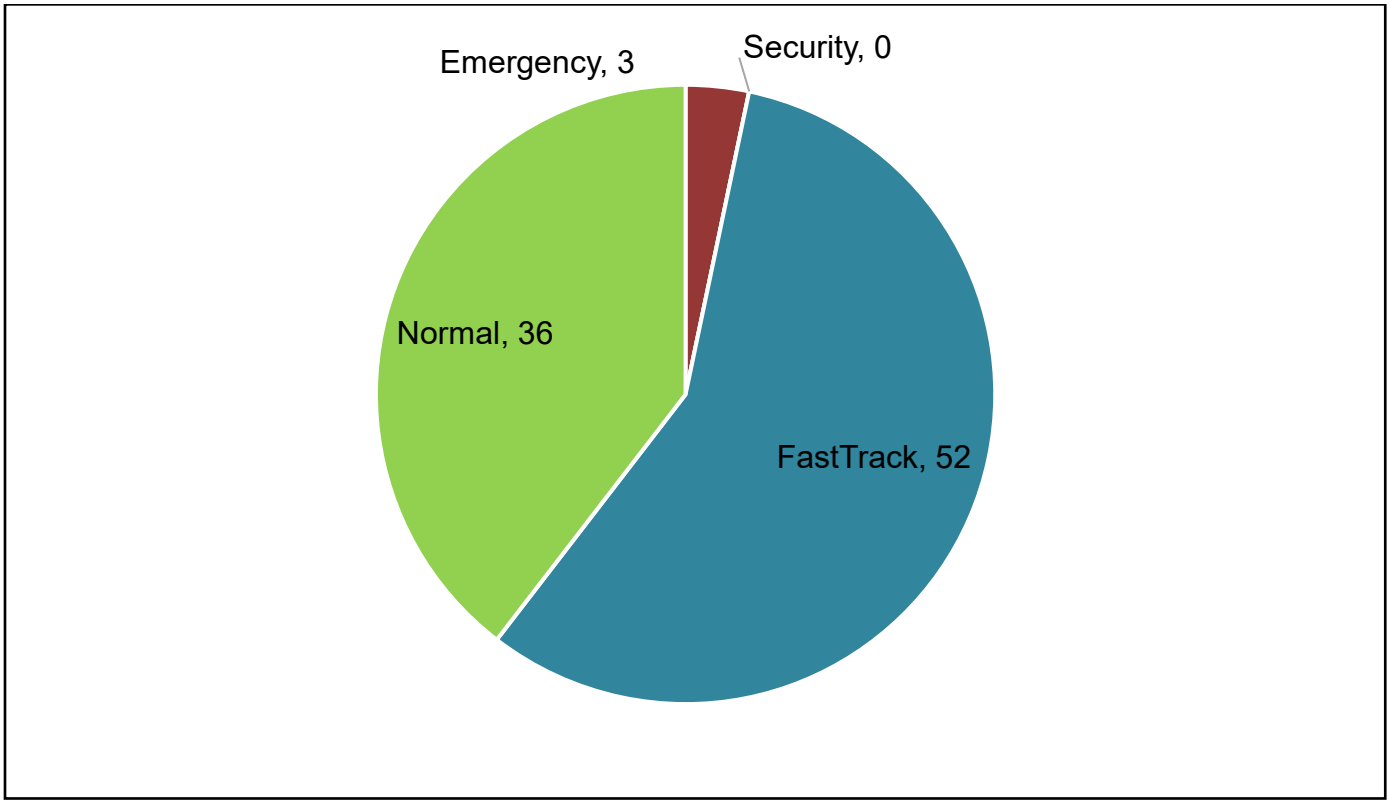
AAH Encounters: Outbound 837	Oct-24	Target
Timeliness-% Within Lag Time - Institutional 0-90 days	91%	60%
Timeliness-% Within Lag Time - Institutional 0-180 days	98%	80%
Timeliness-% Within Lag Time - Professional 0-90 days	91%	65%
Timeliness-% Within Lag Time – Professional 0-180 days	96%	80%

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

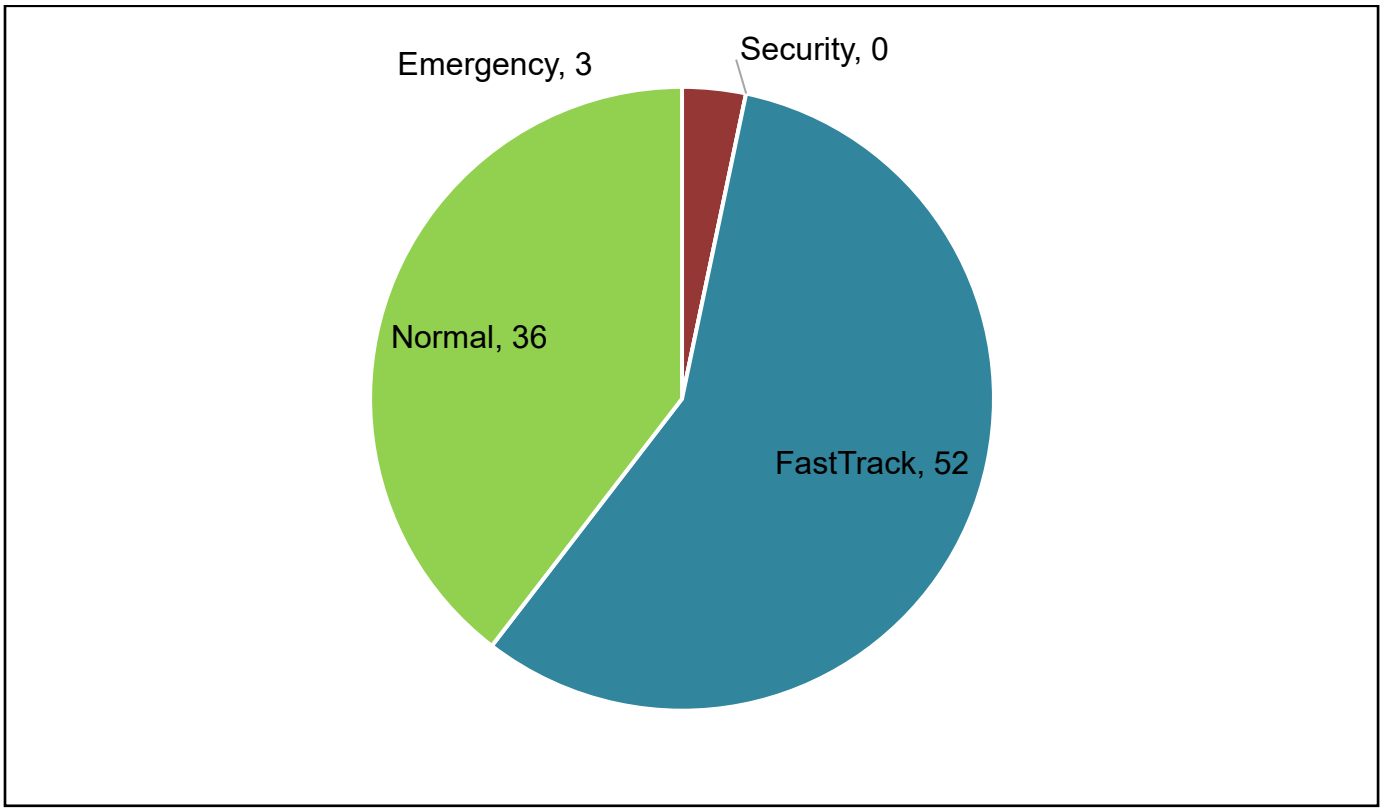
Change Management Key Performance Indicator (KPI)

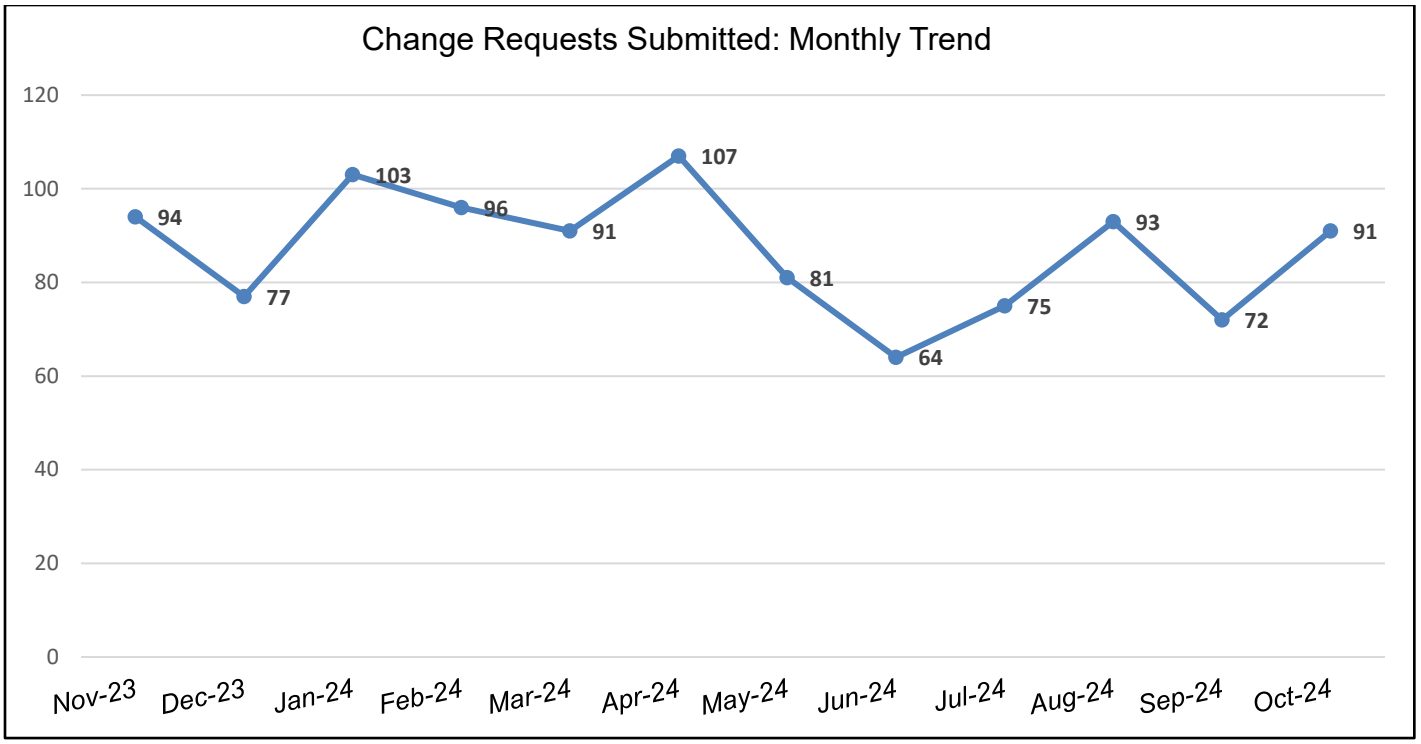
- Change Request Overall Summary in the month of October 2024 KPI:
  - 91 Changes Submitted.
  - 75 Changes Completed and Closed.
  - 114 Active Change Requests in pipeline.
  - 2 Change Requests Cancelled or Rejected.

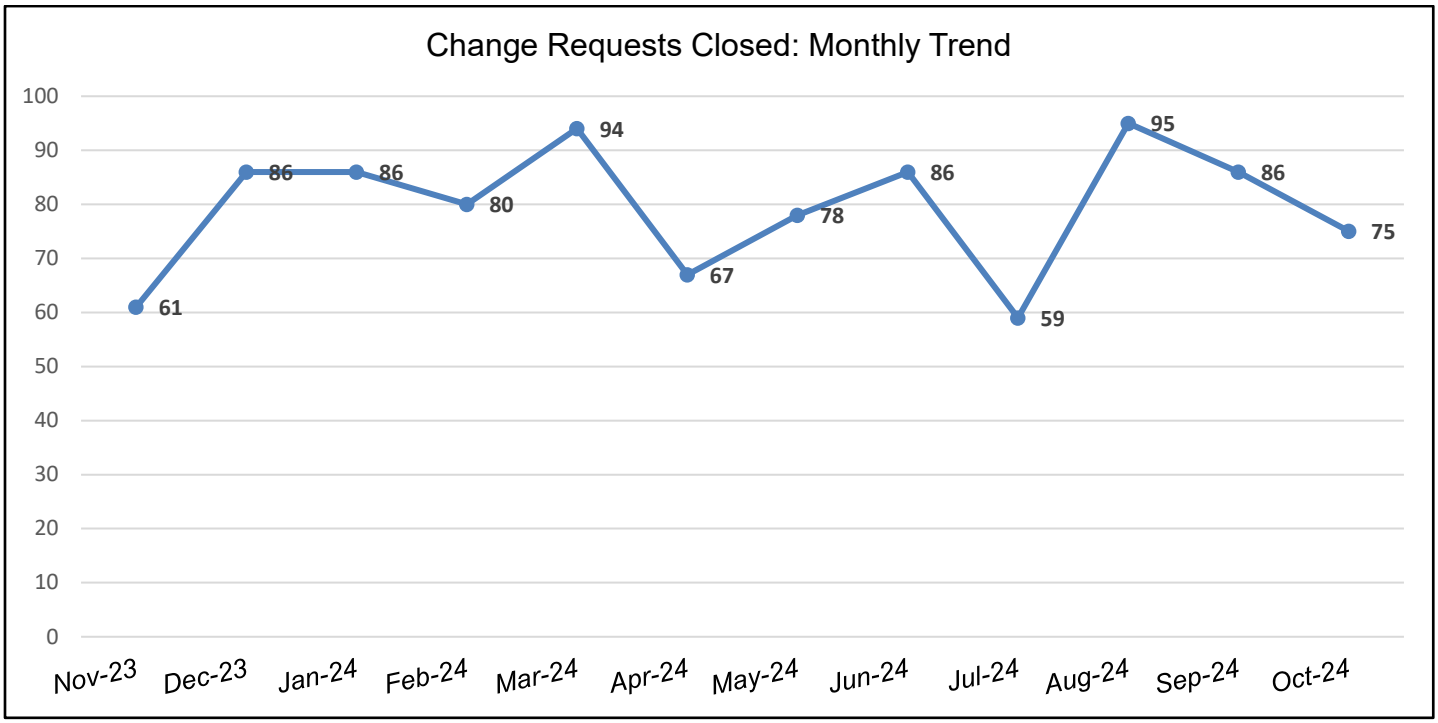
- 91 Change Requests Submitted/Logged in the month of October 2024



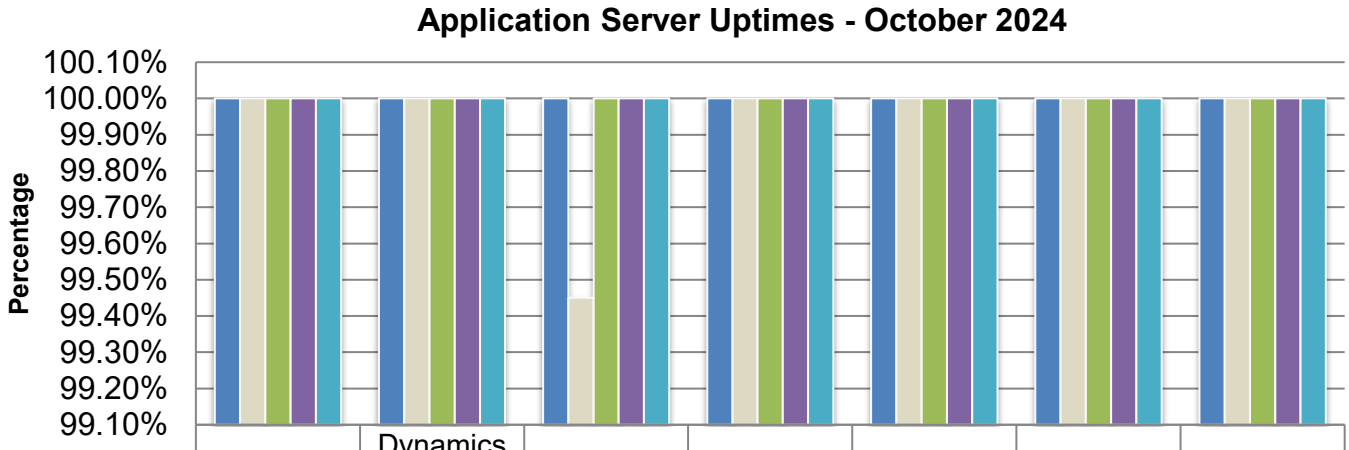
- 75 Change Requests Closed in the month of October 2024




Change Requests Submitted: Monthly Trend
120
100
80
60
40
20
0
94
77
103
96
91
107
81
64
75
93
72
91
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24


Change Requests Closed: Monthly Trend
100
90
80
70
60
50
40
30
20
10
0
61
86
86
80
94
67
78
86
59
95
86
75
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24

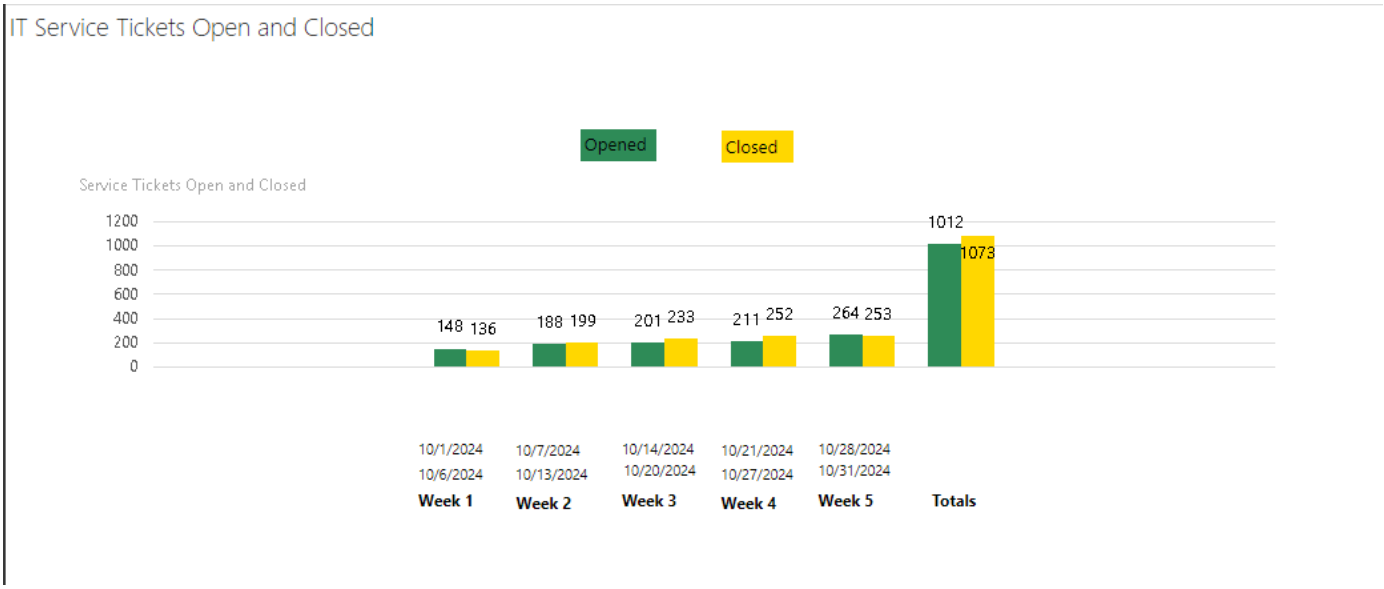
IT Stats: Infrastructure



	Call Center	Dynamics SL (Finance)	HealthSuite	OTG (Claims)	o365 (Email)	TruCare	FTP
Week 1	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Week 2	100.00%	100.00%	99.45%	100.00%	100.00%	100.00%	100.00%
Week 3	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Week 4	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Week 5	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

- All mission critical applications are monitored and managed thoroughly.
- On Thursday, October 10, 2024, HEALTHsuite application experienced a partial outage that lasted for 40 mins.

IT Stats: Service Desk



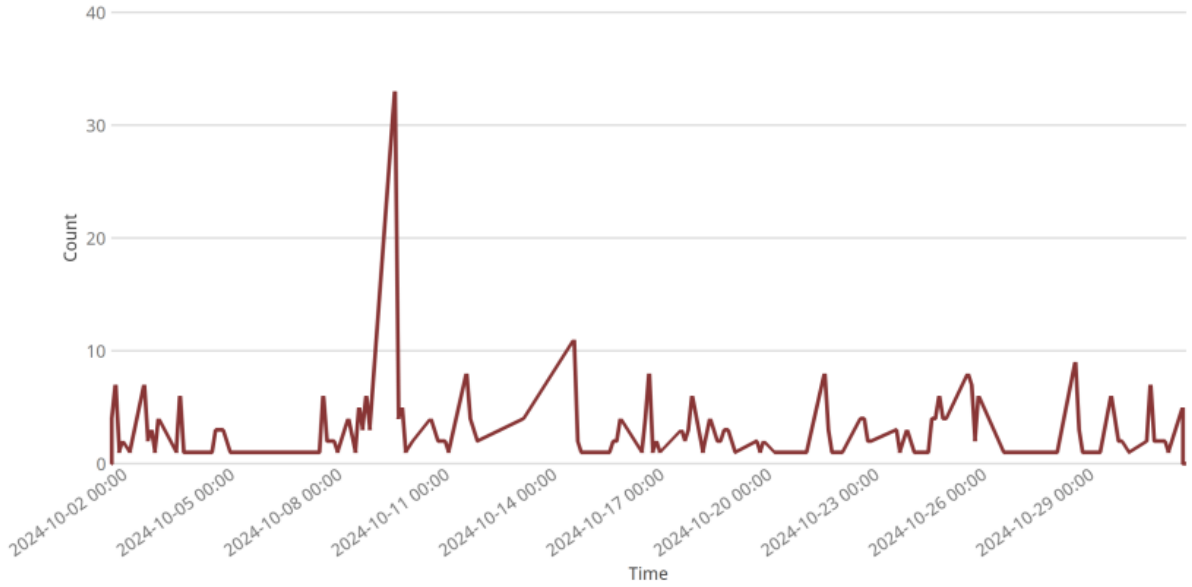
- 1012 Service Desk tickets were opened in the month of October 2024, which is 16.99% higher than the previous month (840) and 5.77% lower than the previous 3-month average of 1,074.

- 1073 Service Desk tickets were closed in the month of October 2024, which is 20.13% higher than the previous month (857) and 1.86% higher than the previous 3-month average of 1,053.

IT Stats: Network

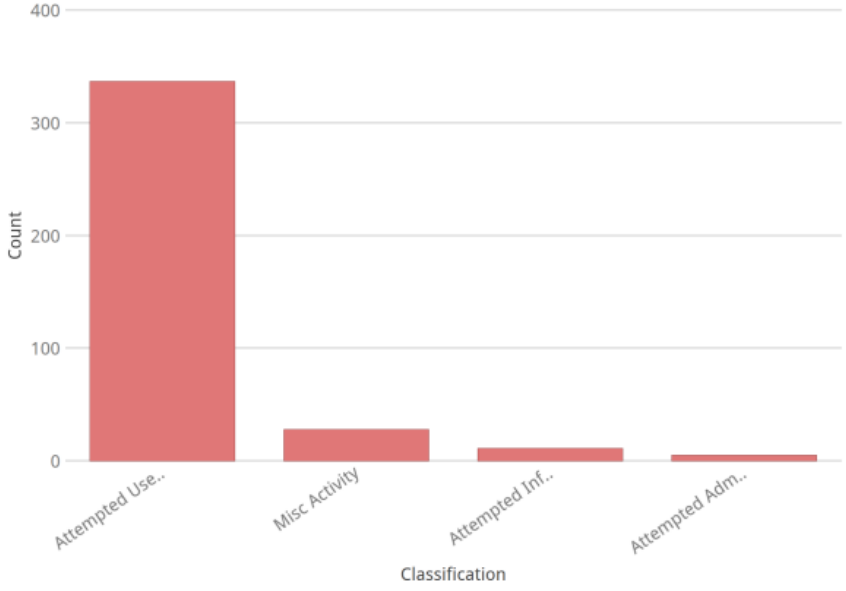
All Intrusion Events

Time Window: *2024-10-01 09:29:00 - 2024-10-31 09:29:00*



Dropped Intrusion Events

Time Window: *2024-10-01 09:30:00 - 2024-10-31 09:30:00*
Constraints: *Inline Result = !Alert,!Would **



Classification	Count
Attempted User Privilege Gain	337
Misc Activity	28
Attempted Information Leak	11
Attempted Administrator Privilege Gain	5

Item / Date	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	*May-24*	Jun-24	Jul-24	Aug-24	Sep-24	*Oct-24*
Attempted Admin Privilege Gain	6	0	1	7	4	48	3	1	4	1	3	250	***5***
Attempted User Privilege Gain	146	48	48	69	330	526	569	554	474	17	8	329	***337***
Attempted Information Leak	71	51	50	65	51	72	57	46	66	0	46	118	***11***
Potential Corp Policy Violation	0	0	0	0	3	4	0	0	0	0	0	0	***0***
Network Scans Detected	0	0	0	0	0	0	0	0	0	0	0	0	***0***
Web Application Attack	7	4	4	1	0	0	5	3	4	0	0	15	***0***
Attempted Denial of Service	0	0	0	0	0	0	0	1	0	1	0	4	***0***
Misc. Attack	1,023	347	2,146	1	424	332	795	145	64	29	124	72	***28***

- All security activity data is based on the current month’s metrics as a percentage. This is compared to the previous three month’s average, except as noted.
- Attempted information leaks detected and blocked at the firewall is at 11 for the month of October 2024.
- Network scans returned a value of 0, which is in line with previous month’s data.
- Attempted User Privilege Gain is at 337 from a previous six-month average of 286.

Analytics

Tiffany Cheang

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

From: **Tiffany Cheang, Chief Analytics Officer**

Date: **November 8th, 2024**

Subject: **Performance & Analytics Report**

Member Cost Analysis

The Member Cost Analysis below is based on the following 12 month rolling periods:

Current reporting period: August 2023 – July 2024 dates of service
Prior reporting period: August 2022 – July 2023 dates of service
(Note: Data excludes Kaiser membership data.)

- For the Current reporting period, the top 6.4% of members account for 87.0% of total costs.
- In comparison, the Prior reporting period was higher at 9.9% of members accounting for 83.6% of total costs.
- Characteristics of the top utilizing population remained fairly consistent between the reporting periods:
    - The SPD (non duals) and ACA OE categories of aid decreased to account for 49.8% of the members, with SPDs accounting for 20.6% and ACA OE's at 29.3%.
    - The percent of members with costs >= $30K decreased from 2.6% to 1.9%.
    - Of those members with costs >= $100K, the percentage of total members remained consistent at 0.6%.
        - For these members, non-trauma/pregnancy inpatient costs continue to comprise the majority of costs, decreasing to 39.8%.
    - 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 9.9% is more concentrated in the 45-66 year old category (38.2%) compared to the overall population (20.7%).

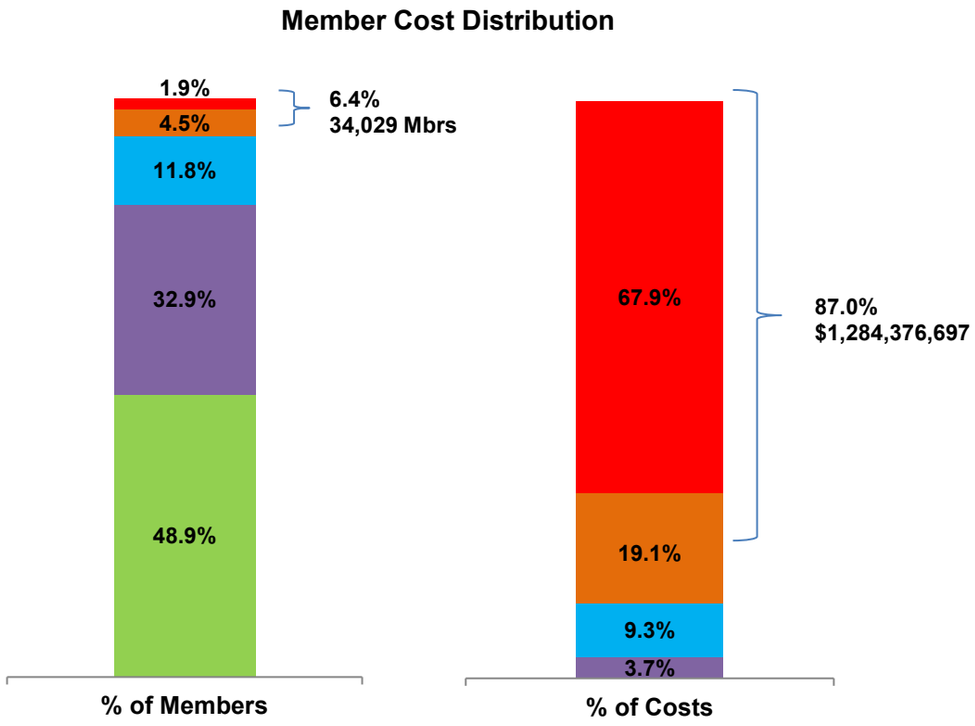
Analytics

Supporting Documents

Alameda Alliance for Health - Analytics Supporting Documentation: Member - Cost Analysis
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Aug 2023 - Jul 2024

Note: Data incomplete due to claims lag

Run Date: 10/28/2024



Cost Range	Members	% of Members	Costs	% of Costs
$30K+	9,969	1.9%	$ 1,002,773,534	67.9%
$5K - $30K	24,060	4.5%	$ 281,603,162	19.1%
$1K - $5K	62,730	11.8%	$ 136,778,287	9.3%
< $1K	174,564	32.9%	$ 55,015,095	3.7%
$0	259,605	48.9%	$ -	0.0%
Totals	**530,928**	**100.0%**	**$ 1,476,170,078**	**100.0%**

Top 6.4% of Members = 87.0% of Costs

Cost Range	Members	% of Total Members	Costs	% of Total Costs
$100K+	3,059	0.6%	$ 613,925,992	41.6%
$75K to $100K	1,401	0.3%	$ 121,188,688	8.2%
$50K to $75K	2,314	0.4%	$ 142,999,219	9.7%
$40K to $50K	1,367	0.3%	$ 61,305,563	4.2%
$30K to $40K	1,828	0.3%	$ 63,354,073	4.3%
SubTotal	***9,969***	***1.9%***	***$ 1,002,773,534***	***67.9%***
$20K to $30K	3,040	0.6%	$ 74,192,463	5.0%
$10K to $20K	8,631	1.6%	$ 120,144,246	8.1%
$5K to $10K	12,389	2.3%	$ 87,266,453	5.9%
SubTotal	***24,060***	***4.5%***	***$ 281,603,162***	***19.1%***
Total	**34,029**	***6.4%***	**$ 1,284,376,697**	***87.0%***

Enrollment Status	Members	Total Costs
Still Enrolled as of Jul 2024	404,748	$ 1,327,002,036
Dis-Enrolled During Year	126,180	$ 149,168,042
Totals	**530,928**	**$ 1,476,170,078**

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
6.4% of Members = 87.0% of Costs
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Aug 2023 - Jul 2024
Note: Data incomplete due to claims lag
Run Date: 10/28/2024

6.4% of Members = 87.0% of Costs
20.6% of members are SPDs and account for 27.2% of costs.
29.3% of members are ACA OE and account for 29.6% of costs.
9.2% of members disenrolled as of Jul 2024 and account for 10.6% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Members	% of Members
IHSS	IHSS	113	515	628	1.8%
MCAL	MCAL - ADULT	797	4,716	5,513	16.2%
	MCAL - BCCTP	-	-	-	0.0%
	MCAL - CHILD	322	2,678	3,000	8.8%
	MCAL - ACA OE	2,687	7,273	9,960	29.3%
	MCAL - SPD	2,624	4,369	6,993	20.6%
	MCAL - DUALS	916	2,585	3,501	10.3%
	MCAL - LTC	185	8	193	0.6%
	MCAL - LTC-DUAL	1,033	69	1,102	3.2%
Not Eligible	Not Eligible	1,292	1,847	3,139	9.2%
Total		**9,969**	**24,060**	**34,029**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Costs	% of Costs
IHSS	IHSS	$ 9,043,678	$ 5,701,600	$ 14,745,278	1.1%
MCAL	MCAL - ADULT	$ 77,910,950	$ 54,793,261	$ 132,704,211	10.3%
	MCAL - BCCTP	$ -	$ -	$ -	0.0%
	MCAL - CHILD	$ 17,283,242	$ 28,603,353	$ 45,886,595	3.6%
	MCAL - ACA OE	$ 298,243,652	$ 81,575,646	$ 379,819,298	29.6%
	MCAL - SPD	$ 295,056,177	$ 54,932,062	$ 349,988,239	27.2%
	MCAL - DUALS	$ 75,154,078	$ 30,708,416	$ 105,862,494	8.2%
	MCAL - LTC	$ 23,822,309	$ 128,298	$ 23,950,607	1.9%
	MCAL - LTC-DUAL	$ 93,837,145	$ 983,892	$ 94,821,037	7.4%
Not Eligible	Not Eligible	$ 112,422,303	$ 24,176,635	$ 136,598,938	10.6%
Total		**$ 1,002,773,534**	**$ 281,603,162**	**$ 1,284,376,697**	**100.0%**

Highest Cost Members; Cost Per Member >= $100K
30.4% of members are SPDs and account for 32.3% of costs.
27.8% of members are ACA OE and account for 32.7% of costs.
9.2% of members disenrolled as of Jul 2024 and account for 9.4% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Total Members	% of Members
IHSS	IHSS	26	0.8%
MCAL	MCAL - ADULT	181	5.9%
	MCAL - BCCTP	-	0.0%
	MCAL - CHILD	16	0.5%
	MCAL - ACA OE	851	27.8%
	MCAL - SPD	930	30.4%
	MCAL - DUALS	292	9.5%
	MCAL - LTC	110	3.6%
	MCAL - LTC-DUAL	372	12.2%
Not Eligible	Not Eligible	281	9.2%
Total		**3,059**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Total Costs	% of Costs
IHSS	IHSS	$ 4,628,837	0.8%
MCAL	MCAL - ADULT	$ 46,768,837	7.6%
	MCAL - BCCTP	$ -	0.0%
	MCAL - CHILD	$ 3,075,138	0.5%
	MCAL - ACA OE	$ 201,037,123	32.7%
	MCAL - SPD	$ 197,991,585	32.3%
	MCAL - DUALS	$ 37,653,449	6.1%
	MCAL - LTC	$ 18,551,849	3.0%
	MCAL - LTC-DUAL	$ 46,767,793	7.6%
Not Eligible	Not Eligible	$ 57,451,382	9.4%
Total		**$ 613,925,992**	**100.0%**

% of Total Costs By Service Type

Cost Range	Trauma Costs	Hep C Rx Costs	Pregnancy, Childbirth & Newborn Related Costs
$100K+	7%	0%	1%
$75K to $100K	5%	0%	1%
$50K to $75K	5%	0%	2%
$40K to $50K	7%	0%	2%
$30K to $40K	17%	0%	3%
$20K to $30K	5%	0%	7%
$10K to $20K	1%	0%	17%
$5K to $10K	0%	0%	7%
Total	**5%**	**0%**	**4%**

Breakout by Service Type/Location

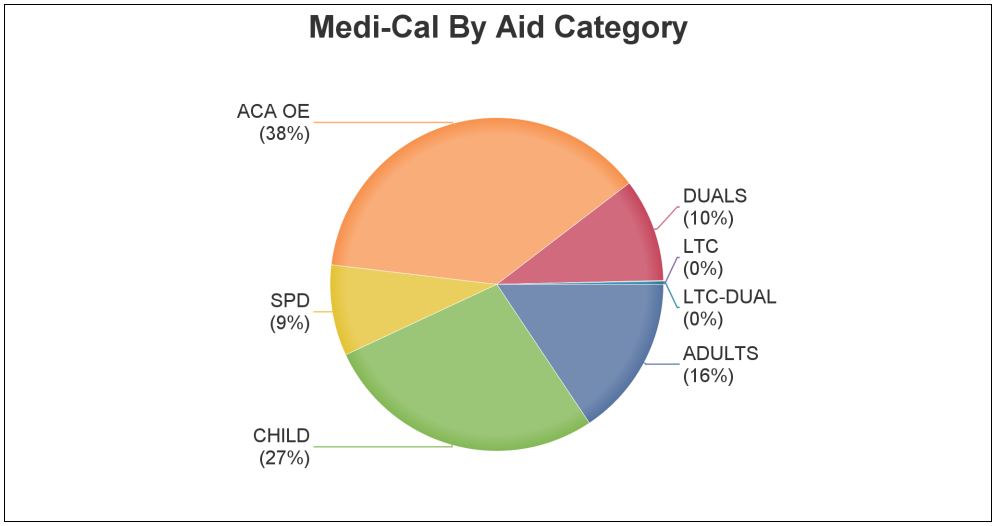
Cost Range	Pharmacy Costs	Inpatient Costs (POS 21)	ER Costs (POS 23)	Outpatient Costs (POS 22)	Office Costs (POS 11)	Dialysis Costs (POS 65)	Other Costs (All Other POS)
$100K+	0%	48%	1%	13%	3%	2%	33%
$75K to $100K	0%	30%	2%	5%	3%	5%	55%
$50K to $75K	0%	31%	3%	7%	5%	6%	49%
$40K to $50K	0%	42%	8%	6%	9%	2%	32%
$30K to $40K	0%	33%	20%	8%	8%	3%	28%
$20K to $30K	0%	41%	11%	11%	9%	2%	28%
$10K to $20K	0%	42%	9%	13%	12%	3%	22%
$5K to $10K	16%	16%	12%	16%	16%	1%	23%
Total	**2%**	**38%**	**5%**	**11%**	**7%**	**2%**	**34%**

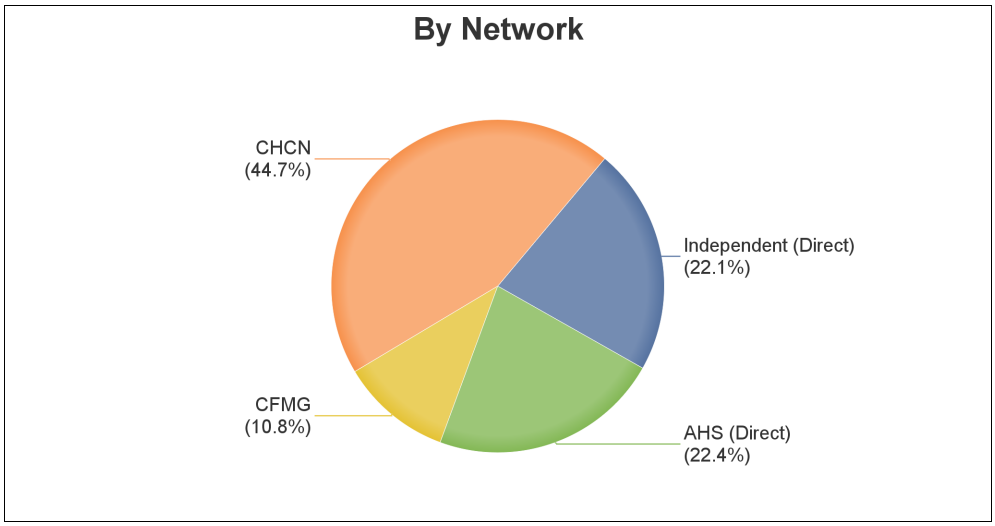
Notes:
- Report includes medical costs (HS & Diamond Claims, Beacon, Logisticare FFS, CHCN FFS Preventive Services, CHME) and pharmacy costs. IBNP factors are not applied.
- CFMG and CHCN encounter data has been priced out.
- Report excludes Capitation Expense

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend

Category of Aid	Sep 2024	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN
ADULTS	62,572	16%	12,834	14,380	6	35,352
CHILD	109,739	27%	9,212	13,623	40,898	46,006
SPD	35,322	9%	11,525	5,610	1,427	16,760
ACA OE	150,999	38%	26,114	53,666	1,501	69,718
DUALS	40,117	10%	26,349	2,845	6	10,917
LTC	240	0%	224	8	0	8
LTC-DUAL	1,254	0%	1,252	0	0	2
Medi-Cal	400,243		87,510	90,132	43,838	178,763
Group Care	5,710		2,149	896	0	2,665
Total	**405,953**	**100%**	**89,659**	**91,028**	**43,838**	**181,428**
Medi-Cal %	98.6%		97.6%	99.0%	100.0%	98.5%
Group Care %	1.4%		2.4%	1.0%	0.0%	1.5%
	Network Distribution		**22.1%**	**22.4%**	**10.8%**	**44.7%**
			% Direct:	**45%**	**% Delegated:**	**55%**

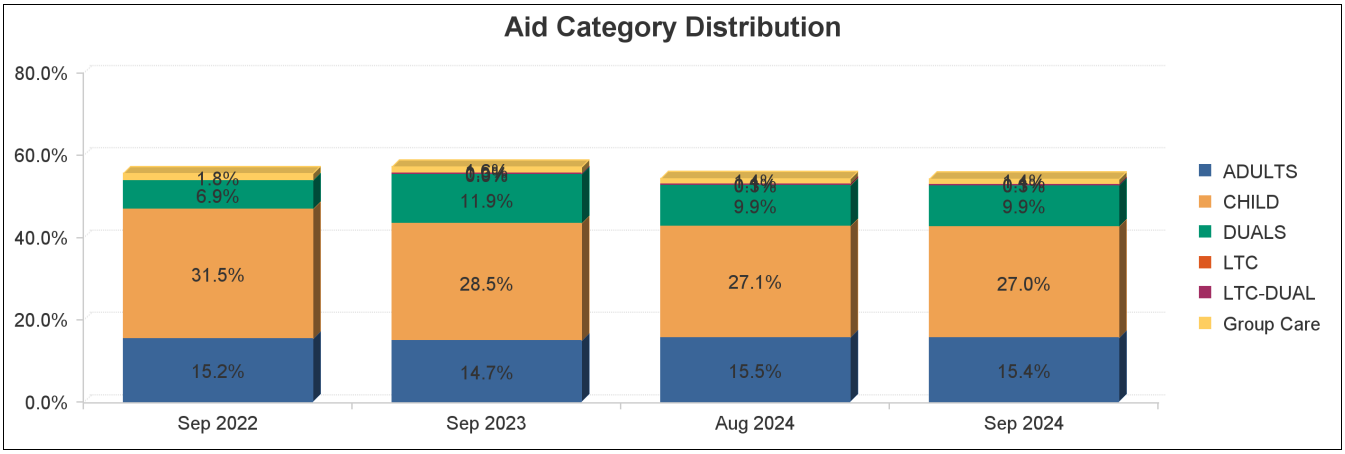




Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

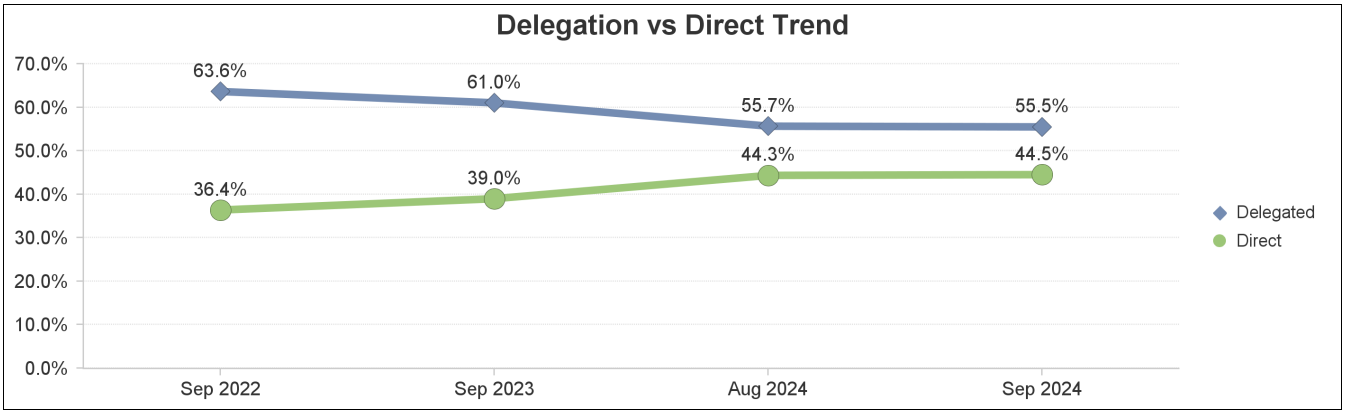
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Sep 2022	Sep 2023	Aug 2024	Sep 2024	Sep 2022	Sep 2023	Aug 2024	Sep 2024	Sep 2022 to Sep 2023	Sep 2023 to Sep 2024	Aug 2024 to Sep 2024
ADULTS	48,711	51,499	62,671	**62,572**	15.2%	14.7%	15.5%	15.4%	5.7%	21.5%	-0.2%
CHILD	101,276	100,038	109,803	**109,739**	31.5%	28.5%	27.1%	27.0%	-1.2%	9.7%	-0.1%
SPD	28,200	30,592	35,177	**35,322**	8.8%	8.7%	8.7%	8.7%	8.5%	15.5%	0.4%
ACA OE	115,018	120,016	150,482	**150,999**	35.8%	34.2%	37.1%	37.2%	4.3%	25.8%	0.3%
DUALS	22,319	41,629	40,030	**40,117**	6.9%	11.9%	9.9%	9.9%	86.5%	-3.6%	0.2%
LTC	0	139	226	**240**	0.0%	0.0%	0.1%	0.1%	0.0%	72.7%	6.2%
LTC-DUAL	0	1,004	1,247	**1,254**	0.0%	0.3%	0.3%	0.3%	0.0%	24.9%	0.6%
Medi-Cal	315,524	344,917	399,636	**400,243**	98.2%	98.4%	98.6%	98.6%	9.3%	16.0%	0.2%
Group Care	5,809	5,631	5,686	**5,710**	1.8%	1.6%	1.4%	1.4%	-3.1%	1.4%	0.4%
Total	**321,333**	**350,548**	**405,322**	**405,953**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**9.1%**	**15.8%**	**0.2%**



Delegation vs Direct Trend

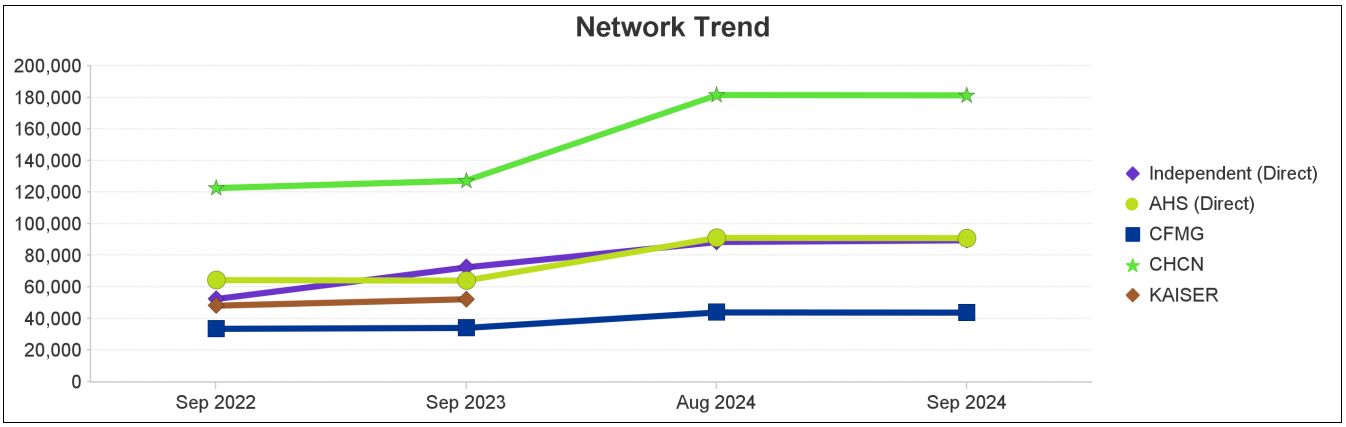
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	Sep 2022	Sep 2023	Aug 2024	Sep 2024	Sep 2022	Sep 2023	Aug 2024	Sep 2024	Sep 2022 to Sep 2023	Sep 2023 to Sep 2024	Aug 2024 to Sep 2024
Delegated	204,491	213,911	225,590	**225,266**	63.6%	61.0%	55.7%	55.5%	4.6%	5.3%	-0.1%
Direct	116,842	136,637	179,732	**180,687**	36.4%	39.0%	44.3%	44.5%	16.9%	32.2%	0.5%
Total	**321,333**	**350,548**	**405,322**	**405,953**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**9.1%**	**15.8%**	**0.2%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Network Trend

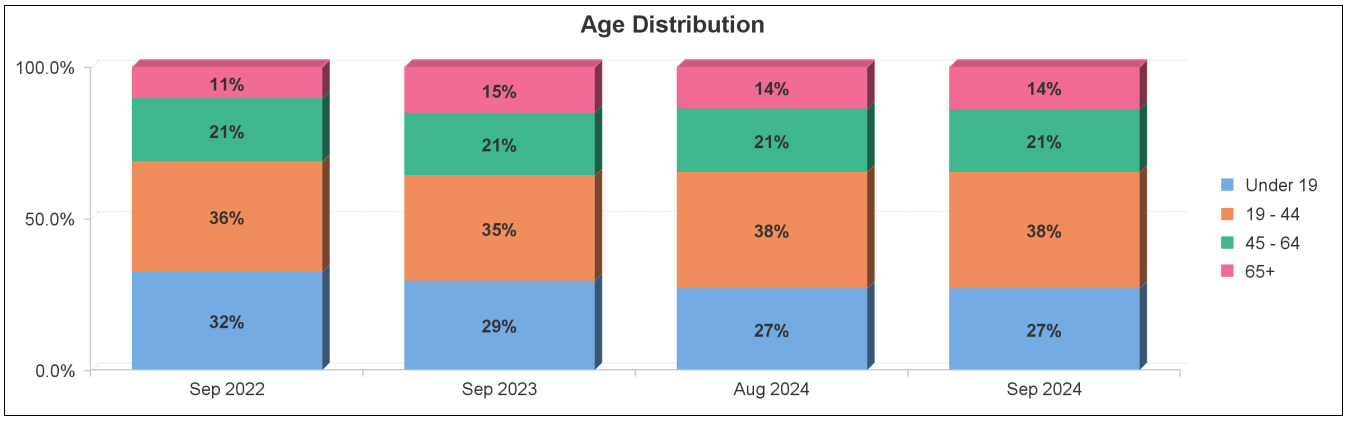
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Sep 2022	Sep 2023	Aug 2024	Sep 2024	Sep 2022	Sep 2023	Aug 2024	Sep 2024	Sep 2022 to Sep 2023	Sep 2023 to Sep 2024	Aug 2024 to Sep 2024
Independent (Direct)	52,418	72,504	88,550	**89,659**	16.3%	20.7%	21.8%	22.1%	38.3%	23.7%	1.3%
AHS (Direct)	64,424	64,133	91,182	**91,028**	20.0%	18.3%	22.5%	22.4%	-0.5%	41.9%	-0.2%
CFMG	33,577	34,144	43,959	**43,838**	10.4%	9.7%	10.8%	10.8%	1.7%	28.4%	-0.3%
CHCN	122,696	127,430	181,631	**181,428**	38.2%	36.4%	44.8%	44.7%	3.9%	42.4%	-0.1%
KAISER	48,218	52,337	0	**0**	15.0%	14.9%	0.0%	0.0%	8.5%	-100.0%	0.0%
Total	**321,333**	**350,548**	**405,322**	**405,953**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**9.1%**	**15.8%**	**0.2%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

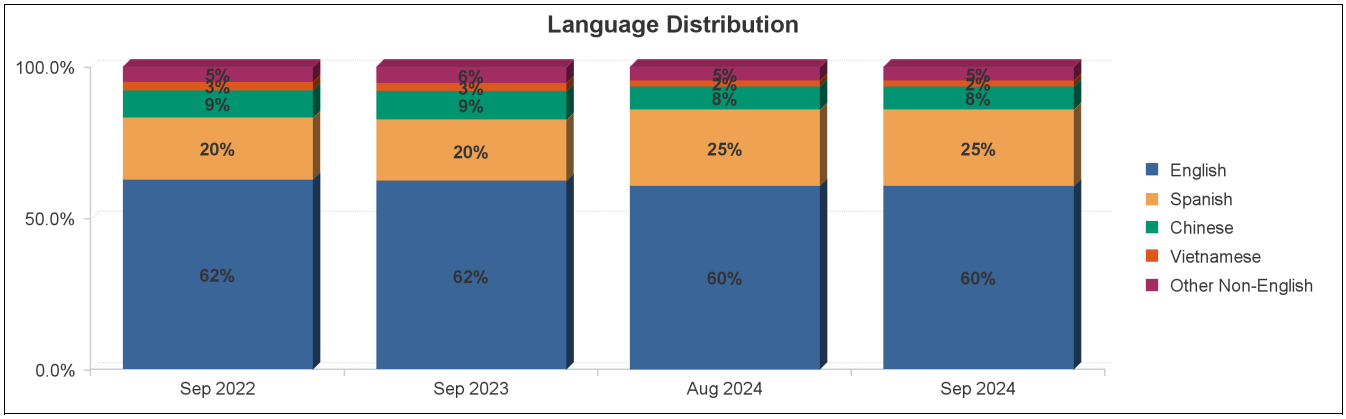
Age Category Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Sep 2022	Sep 2023	Aug 2024	Sep 2024	Sep 2022	Sep 2023	Aug 2024	Sep 2024	Sep 2022 to Sep 2023	Sep 2023 to Sep 2024	Aug 2024 to Sep 2024
Under 19	103,516	102,388	108,349	**108,338**	32%	29%	27%	27%	-1%	6%	0%
19 - 44	116,874	121,851	155,686	**155,780**	36%	35%	38%	38%	4%	28%	0%
45 - 64	66,989	72,445	84,199	**84,362**	21%	21%	21%	21%	8%	16%	0%
65+	33,954	53,864	57,088	**57,473**	11%	15%	14%	14%	59%	7%	1%
Total	**321,333**	**350,548**	**405,322**	**405,953**	**100%**	**100%**	**100%**	**100%**	**9%**	**16%**	**0%**



Language Trend

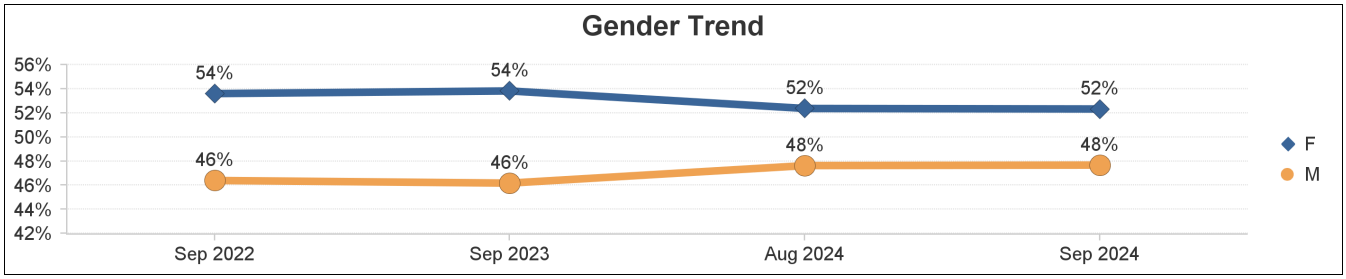
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	Sep 2022	Sep 2023	Aug 2024	Sep 2024	ep 2022	ep 2023	Aug 2024	ep 2024	Sep 2022 to Sep 2023	Sep 2023 to Sep 2024	Aug 2024 to Sep 2024
English	200,696	217,655	245,150	**245,070**	62%	62%	60%	60%	8%	13%	0%
Spanish	65,837	70,947	102,034	**102,701**	20%	20%	25%	25%	8%	45%	1%
Chinese	29,053	33,023	30,695	**30,727**	9%	9%	8%	8%	14%	-7%	0%
Vietnamese	8,928	9,522	8,310	**8,280**	3%	3%	2%	2%	7%	-13%	0%
Other Non-English	16,819	19,401	19,133	**19,175**	5%	6%	5%	5%	15%	-1%	0%
Total	**321,333**	**350,548**	**405,322**	**405,953**	**100%**	**100%**	**100%**	**100%**	**9%**	**16%**	**0%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

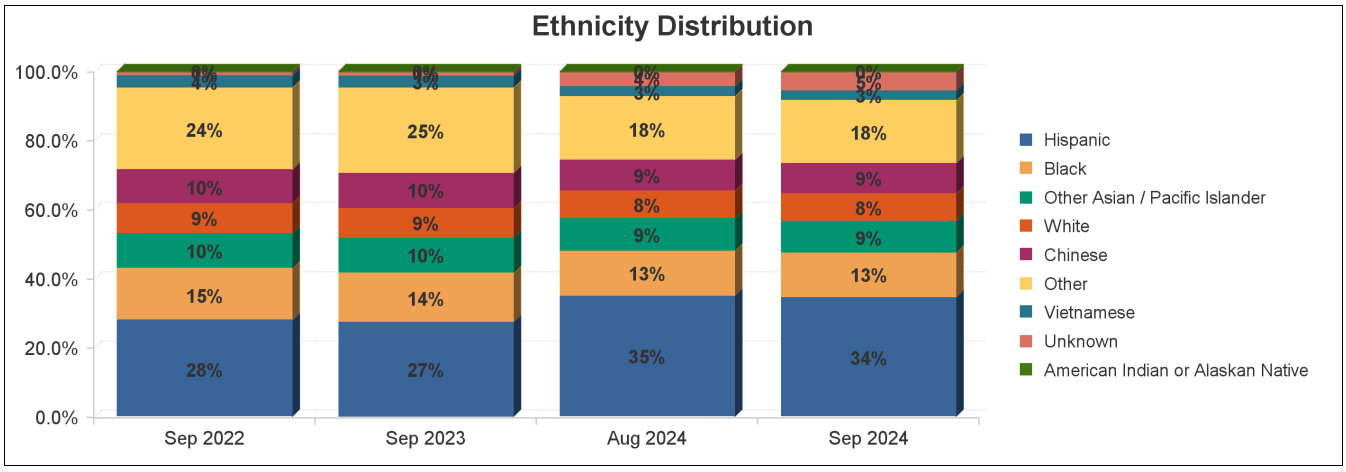
Gender Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Sep 2022	Sep 2023	Aug 2024	Sep 2024	Sep 2022	Sep 2023	Aug 2024	Sep 2024	Sep 2022 to Sep 2023	Sep 2023 to Sep 2024	Aug 2024 to Sep 2024
F	172,247	188,681	212,258	**212,422**	54%	54%	52%	52%	10%	13%	0%
M	149,086	161,867	193,064	**193,531**	46%	46%	48%	48%	9%	20%	0%
Total	**321,333**	**350,548**	**405,322**	**405,953**	**100%**	**100%**	**100%**	**100%**	**9%**	**16%**	**0%**



Ethnicity Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Sep 2022	Sep 2023	Aug 2024	Sep 2024	Sep 2022	Sep 2023	Aug 2024	Sep 2024	Sep 2022 to Sep 2023	Sep 2023 to Sep 2024	Aug 2024 to Sep 2024
Hispanic	89,573	95,595	141,075	**139,641**	28%	27%	35%	34%	7%	46%	-1%
Black	48,141	49,809	52,860	**52,255**	15%	14%	13%	13%	3%	5%	-1%
Other Asian / Pacific Islander	32,208	35,405	38,062	**37,604**	10%	10%	9%	9%	10%	6%	-1%
White	27,911	30,367	32,586	**32,080**	9%	9%	8%	8%	9%	6%	-2%
Chinese	31,599	35,649	35,869	**35,544**	10%	10%	9%	9%	13%	0%	-1%
Other	76,226	86,602	74,954	**74,071**	24%	25%	18%	18%	14%	-14%	-1%
Vietnamese	11,448	12,022	11,804	**11,649**	4%	3%	3%	3%	5%	-3%	-1%
Unknown	3,533	4,380	17,310	**22,311**	1%	1%	4%	5%	24%	409%	29%
American Indian or Alaskan Native	694	719	802	**798**	0%	0%	0%	0%	4%	11%	0%
Total	**321,333**	**350,548**	**405,322**	**405,953**	**100%**	**100%**	**100%**	**100%**	**9%**	**16%**	**0%**



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

Medi-Cal By City

City	Sep 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	160,428	40%	23,670	42,625	17,260	76,873
HAYWARD	64,274	16%	13,065	17,399	7,485	26,325
FREMONT	37,448	9%	15,485	6,635	2,174	13,154
SAN LEANDRO	33,124	8%	8,215	5,707	4,250	14,952
UNION CITY	14,672	4%	5,569	2,642	863	5,598
ALAMEDA	13,839	3%	3,317	2,511	2,075	5,936
BERKELEY	14,954	4%	4,042	2,286	1,766	6,860
LIVERMORE	12,950	3%	1,859	618	2,231	8,242
NEWARK	9,387	2%	2,740	4,119	516	2,012
CASTRO VALLEY	9,463	2%	2,579	1,625	1,392	3,867
SAN LORENZO	7,327	2%	1,464	1,672	847	3,344
PLEASANTON	7,544	2%	1,717	409	829	4,589
DUBLIN	7,495	2%	1,981	431	897	4,186
EMERYVILLE	2,825	1%	629	619	456	1,121
ALBANY	2,521	1%	654	296	565	1,006
PIEDMONT	471	0%	107	196	50	118
SUNOL	82	0%	25	13	6	38
ANTIOCH	27	0%	9	8	1	9
Other	1,412	0%	383	321	175	533
Total	400,243	100%	**87,510**	**90,132**	**43,838**	**178,763**

Group Care By City

City	Sep 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	1,805	32%	359	333	0	1,113
HAYWARD	646	11%	310	147	0	189
FREMONT	641	11%	426	71	0	144
SAN LEANDRO	607	11%	242	93	0	272
UNION CITY	301	5%	188	48	0	65
ALAMEDA	296	5%	87	26	0	183
BERKELEY	152	3%	49	12	0	91
LIVERMORE	98	2%	29	4	0	65
NEWARK	138	2%	84	28	0	26
CASTRO VALLEY	190	3%	80	30	0	80
SAN LORENZO	135	2%	43	23	0	69
PLEASANTON	69	1%	25	2	0	42
DUBLIN	119	2%	41	5	0	73
EMERYVILLE	33	1%	13	4	0	16
ALBANY	21	0%	12	1	0	8
PIEDMONT	9	0%	2	0	0	7
SUNOL	2	0%	2	0	0	0
ANTIOCH	26	0%	7	5	0	14
Other	422	7%	150	64	0	208
Total	**5,710**	**100%**	**2,149**	**896**	**0**	**2,665**

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

Total By City

City	Sep 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	162,233	40%	24,029	42,958	17,260	77,986
HAYWARD	64,920	16%	13,375	17,546	7,485	26,514
FREMONT	38,089	9%	15,911	6,706	2,174	13,298
SAN LEANDRO	33,731	8%	8,457	5,800	4,250	15,224
UNION CITY	14,973	4%	5,757	2,690	863	5,663
ALAMEDA	14,135	3%	3,404	2,537	2,075	6,119
BERKELEY	15,106	4%	4,091	2,298	1,766	6,951
LIVERMORE	13,048	3%	1,888	622	2,231	8,307
NEWARK	9,525	2%	2,824	4,147	516	2,038
CASTRO VALLEY	9,653	2%	2,659	1,655	1,392	3,947
SAN LORENZO	7,462	2%	1,507	1,695	847	3,413
PLEASANTON	7,613	2%	1,742	411	829	4,631
DUBLIN	7,614	2%	2,022	436	897	4,259
EMERYVILLE	2,858	1%	642	623	456	1,137
ALBANY	2,542	1%	666	297	565	1,014
PIEDMONT	480	0%	109	196	50	125
SUNOL	84	0%	27	13	6	38
ANTIOCH	53	0%	16	13	1	23
Other	1,834	0%	533	385	175	741
Total	405,953	100%	**89,659**	**91,028**	**43,838**	**181,428**

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: **November 8th, 2024**

Subject: **Human Resources Report**

Staffing

- As of November 1st, 2024, the Alliance had 646 full time employees and 0-part time employee.

- On November 1st, 2024, the Alliance had 45 open positions in which 14 signed offer acceptance letters have been received with start dates in the near future resulting in a total of 31 positions open to date. The Alliance is actively recruiting for the remaining 31 positions and several of these positions are in the interviewing or job offer stage.

- Summary of open positions by division:

Division	Open Position November 1st	Signed Offers Accepted by Department	Remaining Recruitment Positions
Healthcare Services	5	4	1
Operations	23	5	18
Healthcare Analytics	1	1	0
Information Technology	9	2	7
Finance	3	2	1
Compliance	2	0	2
Human Resources	2	0	2
Health Equity	0	0	0
Executive	0	0	0
Total	45	14	31

- Our current recruitment rate is 6%.

Employee Recognition

- Employees reaching major milestones in their length of service at the Alliance in October 2024 included:

  5 years:
  - Isaac Liang (Marketing & Communications)
  - Cynthia Alba (Provider Services)

  6 years:
  - Karen Valadez Tierrablanca (Credentialing)
  - Tigist Tesfaye (Claims)
  - Francisco Aguilar (Information Technology)
  - Brenda Lee (Executive)
  - Van Truong (Claims)
  - Aric Yu (Claims)

  8 years:
  - Tina Vuu (Utilization Management)
  - Fernando Izaguirre (Claims)
  - Jasdeep Joga (Apps Management, IT Quality & Process Improvement)
  - Elizabeth Olson Lennon (Vendor Management)

  9 years:
  - Katrina Madriz (Credentialing)

  10 years:
  - Cynthia Ngo (Claims)

  12 years:
  - Soniya Gupta (Apps Management, IT Quality & Process Improvement)

  16 years:
  - Gia DeGrano (Member Services)