



Board of Governors

Regular Meeting

Friday, July 11th, 2025
12:00 p.m. – 2:00 p.m.

Video Conference Call and

1240 South Loop Road, Alameda, CA 94502

AGENDA

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

In-Person and Video Conference Call

1240 S. Loop Road
Alameda, CA 94502

and

7830 Macarthur Blvd
Oakland, CA 94605

PUBLIC COMMENTS: Public Comments can be submitted for any agenda item or for any item not listed on the agenda, by mailing your comment to: "Attn: Clerk of the Board," 1240 S. Loop Road, Alameda, CA 94502 or by emailing the Clerk of the Board at brmartinez@alamedaalliance.org. You may attend meetings in person or by computer by logging in to the following link: [Click here to join the meeting](#). You may also listen to the meeting by calling in to the following telephone number: [1-510-210-0967](tel:1-510-210-0967) conference id [407926431#](#). If you use the link and participate via computer, you may use the chat function and request an opportunity to speak on any agenda item, including general public comment. Your request to speak must be received before the item is called on the agenda. If you participate by telephone, please submit your comments to the Clerk of the Board at the email address listed above or by providing your comments during the meeting at the end of each agenda item. Oral comments to address the Board of Governors are limited to three (3) minutes per person. Whenever possible, the board would appreciate it if public comment communication was provided prior to the commencement of the meeting.

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

1. CALL TO ORDER

(A regular meeting of the Alameda Alliance for Health Board of Governors will be called to order on July 11th, 2025, at 12:00 p.m. in Alameda County, California, by Rebecca Gebhart, Presiding Officer. This meeting is to take place in person and by video conference call)

2. ROLL CALL

3. AGENDA APPROVAL

4. INTRODUCTIONS

5. CONSENT CALENDAR

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

- a) JUNE 10th, 2025, FINANCE COMMITTEE MEETING MINUTES
- b) JUNE 13th, 2025, COMPLIANCE ADVISORY COMMITTEE MEETING MINUTES
- c) JUNE 13th, 2025, BOARD OF GOVERNORS MEETING MINUTES
- d) REVIEW AND APPROVE RESOLUTION RE-APPOINTING DR. MARTY LYNCH TO DESIGNATED BOARD OF GOVERNORS SEAT (AT-LARGE SPD POPULATION)
- e) 2024 CASE MANAGEMENT & CARE COORDINATION, COMPLEX CASE MANAGEMENT & DISEASE MANAGEMENT PROGRAM EVALUATION
- f) 2025 CASE MANAGEMENT & CARE COORDINATION, COMPLEX CASE MANAGEMENT & DISEASE MANAGEMENT PROGRAM DESCRIPTION
- g) 2024 UTILIZATION MANAGEMENT PROGRAM EVALUATION
- h) 2025 UTILIZATION MANAGEMENT PROGRAM DESCRIPTION
- i) 2024 QUALITY IMPROVEMENT – PROGRAM EVALUATION
- j) 2025 QUALITY IMPROVEMENT – PROGRAM DESCRIPTION

6. BOARD MEMBER REPORTS

- a) CAC SELECTION COMMITTEE
- b) COMPLIANCE ADVISORY COMMITTEE
- c) FINANCE COMMITTEE

7. CEO UPDATE

8. BOARD BUSINESS

- a) REVIEW AND APPROVE MAY 2025 MONTHLY FINANCIAL STATEMENTS
- b) REVIEW AND APPROVE GRANT POLICY & PROCEDURE
- c) MEDICARE UPDATE

9. CLOSED SESSION

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

10. READ OUT FROM CLOSED SESSION & DISCUSSION

11. STAFF UPDATES

12. UNFINISHED BUSINESS

13. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS

14. PUBLIC COMMENT (NON-AGENDA ITEMS)

15. ADJOURNMENT

NOTICE TO THE PUBLIC

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

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

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

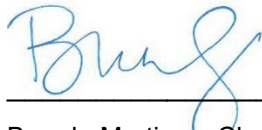
Additions and Deletions to the Agenda: Additions to the agenda are limited by California Government Code Section 54954.2 and confined to items that arise after the posting of the agenda and must be acted upon prior to the next Board meeting. For special meeting agendas, only those items listed on the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

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

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

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

I hereby certify that the agenda for the Board of Governors was posted on the Alameda Alliance for Health's web page at www.alamedaalliance.org by July 8th, 2025, by 12:00 p.m.



Brenda Martinez, Clerk of the Board



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EXECUTIVE SUMMARY APPENDIX

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

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PRESENTATIONS

APPENDIX

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

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SUPPORTING MATERIALS APPENDIX

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

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Consent Calendar



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Finance Committee Meeting Minutes

**ALAMEDA ALLIANCE FOR HEALTH
FINANCE COMMITTEE
REGULAR MEETING**

**June 10th, 2025
8:00 am – 9:00 am**

SUMMARY OF PROCEEDINGS

Meeting Conducted in-person and by Teleconference.

Committee Members in-person: Dr. Rollington Ferguson, Rebecca Gebhart, James Jackson, Yeon Park, Gil Riojas

Committee Members by Teleconference: None

Committee Members Excused: None

Board of Governor members in-person and on Conference Call:

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

CALL TO ORDER

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

ROLL CALL

Roll call was conducted and confirmed.

INTRODUCTIONS

There were no introductions.

CONSENT CALENDAR

Dr. Ferguson presented the Consent Calendar.

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

a) CEO UPDATE

Mr. Woodruff discussed the upcoming fiscal year, highlighting the numerous changes and uncertainties in the state and federal budgets.

- **Net Loss Projection:** There is a projection of an \$80 million net loss for the current fiscal year, which is better than initially expected, and a \$22 million net loss for the next fiscal year with variability due to pending state rates and budget enactments.
- **State Rate Impact:** Mr. Woodruff emphasized the impact of state rates on financial projections, noting that final rates will be available by the end of October.
- **Budget Enactment:** Mr. Woodruff discussed the importance of the state budget enactment process and its impact on the organization's financial projections.

b) REVIEW AND APPROVE APRIL 2025 MONTHLY FINANCIAL STATEMENTS

APRIL 2025 Financial Statement Summary

Enrollment:

Enrollment decreased by 1,846 members since March and an overall increase of 6,794 members since June 2024.

Net Income:

For the month ending April 30th, 2025, the Alliance reported a Net Income of \$5.9 million (versus budgeted Net Income of \$3.9 million). For the year-to-date, the Alliance recorded a Net Loss of \$92.4 million versus a budgeted Net Loss of \$72.4 million.

Premium Revenue:

For the month ending April 30th, 2025, actual Revenue was \$193.0 million vs. our budgeted amount of \$190.3 million.

Medical Expense:

Actual Medical Expenses for the month were \$181.2 million, vs. budgeted amount of \$174.9 million. For the year-to-date, actual Medical Expenses were \$1.8 billion vs. budgeted Medical Expense of \$1.7 billion.

Medical Loss Ratio:

Our MLR ratio for this month was reported as 93.9%. The year-to-date MLR was 101.1%.

Administrative Expense:

Actual YTD Administrative Expenses for the month ending April 30th, 2025, were \$95.5 million vs. our budgeted amount of \$101.1 million. Our Administrative Loss Ratio (ALR) is 4.5% of our Revenue for the month, and 5.4% of Net Revenue for year-to-date.

Other Income / (Expense):

As of April 30th, 2025, our YTD interest income from investments show a gain of \$28.1 million.

Managed Care Organization (MCO) Provider Tax:

For the month ending April 30th, 2025, we reported \$65.4 million MCO Tax Revenue vs. budgeted MCO Tax Revenue of \$63.9 million. Our MCO Tax Expense was \$65.4 million vs. budgeted MCO Tax Expense of \$66.9 million.

Tangible Net Equity (TNE):

For March, the DMHC requires that we have \$80.8 million in TNE, and we reported \$163.0 million, leaving an excess of \$82.2 million. As a percentage we are at 202%, which remains above the minimum required.

Cash and Cash Equivalents:

We reported \$811.1 million in cash; \$568.4 million is uncommitted. Our current ratio is above the minimum required at 1.13 compared to regulatory minimum of 1.0.

Capital Investments:

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

Question: Ms. Park inquired about the building occupancy costs.

Response: Mr. Riojas explained that building occupancy costs include expenses related to rent and building management. He clarified that the favorable situation in May was a result of terminating a lease, which saved approximately \$1 million annually.

Question: Mr. Jackson inquired about the implications of spending less on capital investments than what was budgeted.

Response: Mr. Karaiyan stated that the decrease in capital investments was primarily due to the decision to wait for newer versions of equipment and processors. The objective is to ensure that the systems remain up to date.

Motion: A motion was made by James Jackson, and seconded by Yeon Park, to accept and approve the April 2025 Financial Statements.

Motion Passed

No opposition or abstentions.

c) REVIEW AND APPROVE FY26 PRELIMINARY BUDGET

Revenue

- 98.1% of Revenue for Medi-Cal, 1.7% for Group Care, 0.2% for Medicare.
- Medi-Cal base rates are expected to rise by 4.3% per member, per month. However, uncertainty surrounding members with Unsatisfactory Immigration Status is anticipated to result in a \$92 million reduction in premium revenue.
- Per-member-per-month Group Care premium remains the same as FY2025.
- Medicare Revenue projected to be \$4.4 million.

Medical Expense:

- 97.8% of Expense for Medi-Cal, 1.9% for Group Care, 0.4% for Medicare.
- Medical loss ratio is 96.5%, a decrease of 2% over FY25.
- Lower Medi-Cal enrollment volume contributes to \$82 million reduction in Medical Expense.
- Community Supports expenditures are projected at \$17 million but may go up as DHCS criteria changes.

Hospital and Provider Rates:

- FY26 Hospital contracted rates increase by \$48.9 million over FY 2025.
- The most current information was used to capture changes in Hospital and Provider Rates. However, not all rate changes have been finalized.

Staffing:

- Staffing includes 655 full-time equivalent employees by June 30, 2026.
- The Alliance is in the process of implementing another soft hiring freeze to appropriately manage staffing as enrollment declines.

Enrollment:

- Medi-Cal enrollment is projected to decrease over FY2026.
- Group Care Enrollment is project to remain unchanged at 5,900 members.
- Projected Membership also reflects a reduction of members with Unsatisfactory Immigration Status (UIS) as Governor Newsom proposes freezing UIS enrollment effective January 2026.

Capital Expenditures:

- Preliminary budget is \$1.4 million for capitalized purchases.
- This is a decrease of \$0.6 million from FY25.
- Totals include \$1.2 million for IT hardware and \$0.1 million for building improvements.

Material Areas of Uncertainty:

- The Department of Health Care Services intends to adjust to Calendar Year 2025 rates in the Fall. We are anticipating a slight rate decrease.
- CY2026 Rates from DHCS are expected at the end of October.
- The State May Revision budget proposes to freeze new enrollment for full-scope state-only Medi-Cal coverage for undocumented individuals aged 19 and older who lack satisfactory immigration status.
- It is unknown how significant the impact from the Federal Budget will have on the Medi-Cal enrollment, but AAH is preparing for material impacts to membership in CY2026 and CY2027.
- Contract changes for hospitals and delegated providers in projections have not been finalized.
- Proposition 35 (TRI) impact for CY2025 rate is unknown and not budgeted.

Question: Mr. Jackson inquired whether the \$92 million reduction in premium revenue is a conservative number or a worst-case scenario.

Response: Mr. Riojas clarified that the number is conservative, balancing what is known and what is anticipated.

Question: Ms. Park inquired about reconciling the fiscal year budget with the state's calendar year rates.

Response: Mr. Riojas clarified that the budget is prepared on a fiscal year basis, while the state rates are received by the calendar year.

Question: Dr. Ferguson inquired about the measures taken to ensure adequate staffing for the Medicare program.

Response: Ms. Watson indicated that they are cross-training staff to absorb excess capacity and ensure adequate staffing for the Medicare program.

Question: Ms. Gebhart asked how much has been accrued for potential rate adjustments in FY25?

Response: Mr. Riojas mentioned that about \$20 million has been accrued for potential payback to the state.

Question: Dr. Ferguson asked if there is a separate accrual process for the death audits.

Response: Mr. Riojas confirmed that about \$700,000 has been accrued for the death audits, separate from the rate adjustment accrual.

Question: Dr. Ferguson inquired about the measures we are taking to manage the costs of group care.

Response: Mr. Riojas stated that the group care rates are on a two-year cycle, and the process of negotiating rates with the county will start in the fall.

Motion: A motion was made by James Jackson, and seconded by Yeon Park, to approve the FY2026 Preliminary Budget.

Motion Passed

No opposition or abstentions.

d) REVIEW AND APPROVE THE DRAFT GRANT POLICY AND PROCEDURE

The draft grant policy and procedure item was presented and includes the following key points:

- Board Approval Threshold: Any grants that are \$1.5 million or more will require review and approval by the board. This threshold aligns with the spending authority limits.
- Annual Reporting: The policy mandates annual reporting of all grants and sponsorships, both those distributed and those received. This reporting will be completed every June as part of the budget process.
- Visibility and Transparency: The policy aims to increase visibility and transparency of grant activities, ensuring that the board is informed about significant grants and sponsorships.

Motion: A motion was made by James Jackson, and seconded by Yeon Park, to approve the draft grant policy and procedure with the addition of the word “all” to ensure clarity in the annual reporting of all grants.

Motion Passed

No opposition or abstentions.

UNFINISHED BUSINESS

There was no unfinished business.

PUBLIC COMMENTS

There were no public comments.

ADJOURNMENT

Dr. Ferguson adjourned the meeting at 9:02 a.m.



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Compliance Advisory Committee Meeting Minutes

Compliance Advisory Committee
Regular Meeting Minutes
Friday, June 13th, 2025
10:30 a.m. – 11:30 a.m.

Video Conference Call or
1240 South Loop Road
Alameda, CA 94502

CALL TO ORDER

Committee Members Attendance: Byron Lopez, Richard Golfin III, Dr. Kelley Meade, Rebecca Gebhart.

Remote: None

Committee Members Excused: None

1. CALL TO ORDER

The regular Compliance Advisory Committee meeting was called to order by Dr. Kelley Meade at 10:31 am.

2. ROLL CALL

A roll call of Committee Members was taken, quorum was confirmed at 10:33 am.

3. AGENDA APPROVAL OR MODIFICATIONS

Agenda modifications include:

- 1.) Dr. Kelley Meade, the committee Chair, will leave at 11:05 a.m., at which point Byron Lopez will assume the role of Chair.*
- 2.) Addition of Medicaid and Medicare D-SNP program updates.*

Motion:

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

Vote:

*All voting members in attendance approved.
Motion passed.*

4. PUBLIC COMMENT (NON-AGENDA ITEMS)

None

5. CONSENT CALENDAR

a) March 14th, 2025, Compliance Advisory Committee Minutes

Motion:

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

Vote:

*All voting members in attendance approved.
Motion passed.*

6. COMPLIANCE MEMBER REPORTS

a) Compliance Activity Report

i. Plan Audits and State Regulatory Oversight

1. 2023 DHCS Focused Audit: Open CAPs

- The Compliance Audit Team met with DHCS in May to discuss 2023 focused audit findings.
- Both DHCS and the Plan acknowledged the presence of aged, open audit findings.
- There are 3 total findings that remain open, all related to the use of Universal Release of Information forms at the point of initial member contact.
- These forms are essential for improving care coordination with the Plan.
- Closure of the findings depends on actions from the county.
- DHCS noted similar feedback from other plans and requested that the Plan continue documenting interactions with the county.
- The next update is scheduled for June 16, 2025.

Question: Can we clarify which findings this pertains to with the dashboard?

Answer: all 3 findings are related to the fact that the county does not use the universal release of information form

2. 2024 DHCS Audit: CAP Updates

- At the beginning of June, only eight 8 out of 20 audit findings responses submitted by the Plan were accepted.
- As of this week, 16 of the 20 responses have been accepted, with the remaining 4 partially accepted.
- The 4 partially accepted findings relate to the Plan providing documentation of internal audits for the findings.
- Some of these internal audit activities have target completion dates later in the year.

- Full acceptance of all findings is anticipated by the summer.

3. 2025 DMHC Finance Audit: Gathering Pre-Audit Materials

- The Compliance Audit Team is currently gathering pre-audit documentation, which is approximately 90% complete.
- Documentation is due by Monday, June 16.
- The audit is scheduled to begin the week of August 4 and will be conducted virtually.
- No issues have been identified by Compliance in preparation for the audit.

4. 2025 HSAG NAV Audit: HSAG Kick-off on 6/5/2025

- The Network Validation Audit (NAV) will be conducted by DHCS's 3rd party vendor Health Services Advisory Group (HSAG).
- The first HSAG audit occurred last year, and this is expected to become an annual process.
- A kickoff meeting with the auditor took place on June 9, 2025. HSAG appears to be collaborative and partner-oriented.
- Compliance does not anticipate any issues with this audit.
- The audit will be virtual, with exact dates to be determined.
- The Plan has not yet received confirmed audit dates, however the virtual interviews will occur sometime between August 11 and September 5, 2025. The audit is expected to last 2–3 days.
- Office hours for the audit process have already begun.

Question: Does HSAG pertain to a government entity?

Answer: HSAG is a private contractor for DHCS.

5. 2024 Compliance Risk Assessment (Progress/Closure)

- The Board of Governors requested a Comprehensive Risk Assessment (CRA) to evaluate growth demand and leadership changes.
- The CRA was conducted by third-party consultant RGP from December 2022 to May 2023.
- The final report identified 22 findings across 14 areas of opportunity.
- Key areas include organizational structure, monitoring and testing, auditing, regulatory intake, and more.
- The Compliance division developed additional actions beyond RGP's recommendations to further address the findings.

Question: Why did the Compliance Division develop additional actions beyond the recommendations of RGP?

Answer: The Plan decided to take additional actions to account for the Plan's complex needs/structure. The Compliance Division utilized RGP recommendations as a base to expand and enhance the Compliance Program and related activities.

- One (1) outstanding recommendation pertains to the development of a P&P which will be ready for review by end of the month.

Question: How does the CRA and its subsequent remediations and improvements enhance operational readiness and compliance of the upcoming Medicare Line of Business (LOB)?

Answer: Because this CRA was conducted between December 2022 and May 2023, Medicare LOB was not a focus of the audit. However, because the recommendations and improvements holistically support the plans compliance structure, it provides the foundation of support for the Medicare LOB.

- Key highlights from recommendations and areas of opportunity:
 - Effective Compliance committee: The Plan established the Administrative Oversight Committee (AOC) to guide and approve administrative functions and processes. The AOC is responsible for reviewing and approving procedures, overseeing issue identification and remediation, and monitoring Key Performance Indicators (KPIs). Additionally, the Plan implemented a procedure to proactively identify, mitigate, and resolve potential issues.
 - Technology and P&P development: Policy Tech serves as the Plan's centralized repository for all Policies and Procedures (P&P). To promote consistency and standardization across the organization, the Plan has developed comprehensive resources within Policy Tech and conducted training sessions to ensure effective use and alignment with organizational standards.
 - Vendor Risk Management: The pre-delegation audit process is overseen by Vendor Management, and touches various business units across the Alliance. For Compliance, it includes a comprehensive review of key areas such as security protocols, business continuity planning, and Fraud, Waste, and Abuse (FWA) prevention. Vendor Management has also created a Vendor Management Playbook, which outlines essential contract requirements and considerations, including areas Compliance assisted with providing feedback on: Performance metrics, Indemnification clauses, Business Associate Agreements (BAAs), Data privacy addendums, and more.
 - Enterprise Risk Management: To support the development of a comprehensive Risk Assessment Program, the Plan engaged stakeholders across the Plan to gather insights and expertise on perceived risks. Compliance used this input to inform the design and direction of the program. RGP provided a detailed assessment and a roadmap for implementation for the program.

- Hotline Triage: The Plan created a confidential hotline for reporting questionable or unethical conduct. To ensure timely and appropriate handling of reports, triage protocols were developed to categorize and prioritize reported issues and direct concerns to the appropriate departments or personnel for resolution.

Question: Is there KPIs that will track the hotline assistance in meeting the Plan's regulatory reporting requirements?

Answer: Yes. Compliance maintains incident logs that are updated when leads are provided. Each incident will be tracked according to the source and category (FWA, Discrimination, Privacy).

ii. Compliance Dashboard

1. 2025 DMHC and DHCS Joint Audit Observations

- On March 20, DHCS held a preliminary exit conference and presented 3 initial observations to the Plan. These are subject to change pending final results, which will be shared at the formal exit conference (date not yet scheduled). The audit lookback period was from June 1, 2024, to February 28, 2025.
- While awaiting the formal exit conference, Compliance has been working with subject matter experts to address the concerns raised in March.
- DHCS Observation 1: The Plan does not consistently obtain timely authorization for medically necessary post-stabilization care and does not ensure contractor compliance with APL 23-009. In response, the Utilization Management (UM) team revised workflows to require that a note and authorization be entered into the clinical information system at the time a post-stabilization request is received.

Question: How does inputting a case note impact timing?

Answer: Current process requires clinical staff to provide documentation on a tracker that is outside of clinical information system. The change requires clinical staff to input notes into the clinical information system to meet timeliness requirements.

- DHCS Observation 2: The Plan did not ensure a Medical Director or licensed physician was available 24/7 to coordinate care and respond to authorization requests. In response, the UM team implemented continuous Medical Director coverage, including an after-hours on-call schedule, and provided the on-call calendar to auditors to address the finding.
- DHCS Observation 3: The Plan did not consistently transfer out-of-network members to in-network providers as required. In response, the UM team ensured that both contracted and non-contracted hospitals have 24-hour access to the UM department for authorization requests, with Medical Directors and RNs available to facilitate ER transfers to in-network providers as needed.
- The DMHC audit lookback period was from October 1, 2022, to September 30, 2024. DMHC does not conduct a preliminary exit conference. The

Compliance team developed internal observations based on questions asked during onsite interviews and follow-up document requests. The Plan collaborated with subject matter experts to assess the risk level of each observation and explore proactive mitigation strategies. Most observations were determined to be low risk due to existing processes, but they continue to be monitored and addressed internally to stay ahead of potential concerns.

- DMHC Observation 1 (self-identified): The Plan's CAP tracking, monitoring, and management was assessed as low risk due to recent improvements. The Plan enhanced the CAP form to streamline the review process and incorporated CAP discussions into meetings with delegates and subcontractors to ensure consistent follow-up. Compliance oversees annual and ad-hoc audit CAPs and reports to the Delegation and Subcontractor Oversight Committee (SDOC) for review and closure. Training is planned for subject matter experts on CAP verification and monitoring to ensure a timely, thorough, and standardized review process across the Plan.
- DMHC Observation 2 (self-identified): The Plan noted concerns regarding the communication process for decision and notification letters. This was assessed as low risk, as the UM departments have P&Ps in place to ensure notifications are issued within required timeframes. Oversight and monitoring mechanisms are also in place to support compliance.
- DMHC Observation 3 (self-identified): The Plan noted concerns regarding UM policies and procedures for 24/7 availability for urgent and emergent member requests. This was assessed as low risk, as both contracted and non-contracted hospitals have 24-hour access to the Plan's UM department through on-call nurses and Medical Directors for authorization requests.
- DMHC Observation 4 (self-identified): The Plan noted several questions focused on access to services for terminally ill members, particularly regarding the appeals process. The Plan already has a grievance and appeals policy in place that addresses terminally ill members, including provisions for accepting and resolving appeals through the expedited appeal process.
- DMHC Observation 5 (self-identified): The Plan noted several questions focused on the accuracy of provider network and directory information, which was assessed as low risk. The Provider Services team has processes in place to verify directory information with providers at regular intervals and to address inaccuracies reported by members or the Plan staff.
- DMHC Observation 6 (self-identified): The Plan noted several questions focused on concerns regarding monitoring of calls and member services for expressions of dissatisfaction. The observation was determined to be low risk as the Member Services department has well-defined processes to monitor calls and ensure all expressions of dissatisfaction are appropriately identified and addressed.

b) Medi-Cal Updates

i. D-SNP

- The Ops team met with the CMS Contract and Prescription Drug Benefits leader. The contract manager shared that CMS has undergone staff reductions, the San Francisco office has closed, and regional account management is now handled out of Dallas, with pharmacy operations based in New York. The CMS account manager's focus areas include network and marketing.
- Meetings with CMS are scheduled every two weeks for 30 minutes.
- Initial discussions covered expectations and what the Plan can anticipate from the contract management team, which is expected to operate similarly to DMHC and DHCS.
- CMS encourages self-reporting of issues; identifying and reporting problems proactively can influence the severity of CMS's response.
- The Plan is focused on KPIs and will be receiving a KPI list to support initial setup and alignment.

7. COMPLIANCE ADVISORY COMMITTEE BUSINESS

- a) None

8. STAFF UPDATES

- a) None

9. UNFINISHED BUSINESS

- a) None

10. STAFF ADVISORIES ON COMPLIANCE BUSINESS FOR FUTURE MEETINGS

- a) None

11. ADJOURNMENT

- Meeting adjourned at 11:20 am



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Board of Governors Meeting Minutes

BOARD OF GOVERNORS
Regular Meeting Minutes
Friday, June 13th, 2025
12:00 p.m. – 2:00 p.m.

Video Conference Call and
1240 S. Loop Road
Alameda, CA 94502

1. CALL TO ORDER

Board of Governors Present: Rebecca Gebhart (Chair), Dr. Noha Aboelata (Vice-Chair), Aarondeep Basrai, Tosan Boyo, Dr. Kathleen Clanon, Dr. Rollington Ferguson, Byron Lopez, Dr. Marty Lynch, Andie Martinez- Patterson, Dr. Kelley Meade, Wendy Peterson, Dr. Evan Seevak, Supervisor Lena Tam, Natalie Williams,

Board of Governors Remote (AB 2449 “Just Cause”): James Jackson, Jody Moore, Andrea Schwab-Galindo

Board of Governors Excused: Andrea Ford, Yeon Park

Alliance Staff Present: Matthew Woodruff, Dr. Donna Carey, Richard Golfin III, Gil Riojas, Anastacia Swift, Ruth Watson, Sasi Karaiyan, Tiffany Cheang, Michelle Lewis, Lao Paul Vang

Chair Gebhart called the regular Board of Governors meeting to order at 12:01 p.m.

2. ROLL CALL

Roll call was taken, and a quorum was established.

3. AGENDA APPROVAL

There were no modifications to the agenda.

4. INTRODUCTIONS

Tome Meyers introduced the members of the Medicare Operations team: Jaini Goradia, Hamid Noori, Kim Derpic, Kayla Williams, Dona Doran, MyLe Hillard, Stacey Steffire, and Crystal Villanueva.

5. CONSENT CALENDAR

a) MAY 6th, 2025, FINANCE COMMITTEE MEETING MINUTES

b) MAY 9th, 2025, BOARD OF GOVERNORS MEETING MINUTES

Motion: A motion was made by Dr. Rollington Ferguson and seconded by Dr. Marty Lynch to approve the Consent Calendar.

Vote: The motion was passed unanimously.

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

No opposition or abstentions.

6. BOARD MEMBER REPORTS

a) DHCS AND DMHC JUNE 2 MEETING UPDATE

Chair Gephart reported on the board's effort to address the financial situation, including a letter sent to state regulatory agencies and subsequent meetings with DHCS and DMHC to discuss the financial strategies and rate adjustments. The meeting with DHCS and DMHC was requested to provide an update on the financial situation and to facilitate more connection and face time with the state.

Highlights:

- The state acknowledged that the 2025 rates were designed to address the impact of the Anthem acuity adjustment and recoupment, implying that these rates involve some form of acuity adjustment for the Alliance, which means that we may not see a big adjustment in rates in October.
- The state responded positively to the board's commitment to community support programs, indicating that their data shows community supports are saving money, and they are supportive of maintaining these programs without reductions.
- The state welcomed the approach of deeper involvement in the community for medical management and transitions of care, indicating that denials are not the right approach and supporting the focus on transitions.

b) CAC SELECTION COMMITTEE UPDATE

Chair Gephart provided an update on the Consumer Advisory Committee and explained the new state guidance, which includes more specific inclusion criteria and allows meetings to be held in various formats. The Selection Committee will reconvene in late June to continue building the Consumer Advisory Committee.

Question: *Dr. Lynch inquired about the inclusion of a family member or an advocacy group on the consumer advisory committee.*

Answer: *Chair Gebhart indicated that the language includes a reasonably representative sample of the long-term services and supports population. This scope is quite broad and could potentially encompass family members or individuals with firsthand knowledge of these services and believe they intentionally kept it broad to allow for a strong argument for particular involvement.*

c) COMPLIANCE ADVISORY COMMITTEE

Dr. Meade reported on the Compliance Advisory Committee meeting, highlighting the resolution of issues from the focused audits conducted by the Department of Health Care Services (DHCS) for 2023 and 2024 and progress on the compliance risk assessment.

Several issues were resolved in the 2023 DHCS-focused audit, while sixteen items were fully resolved and four were partially resolved in the 2024 audit.

Regarding the compliance risk assessment, Dr. Meade emphasized the advancements made, which included guidance from an external entity and improvements to internal processes. Most of this work has been completed, indicating significant progress.

The committee also reviewed the compliance dashboard, which features a joint survey conducted by the Department of Managed Health Care (DMHC) and DHCS. Although the final report is not yet available, steps are already being taken to address observable issues that have been identified.

d) FINANCE COMMITTEE

Dr. Ferguson reported on the Finance Committee meeting held on June 10th, noting improvements in the financial situation, including a positive Tangible Net Equity (TNE) and Medical Loss Ratio (MLR). The committee also discussed the grant review and approval policy, which will be presented to the board for a vote in July.

7. CEO UPDATE

CEO Woodruff and Karina Rivera, Senior Manager, Public Affairs and Media Relations, provided an update on the ongoing changes at both the state and federal levels.

Highlights:

- **State and Federal Budget Updates:** Mr. Woodruff discussed the impact of federal budget changes on California, including a potential \$4.4 billion reduction due to the FMAP penalty and the implementation of work requirements starting in 2026.
- **Supplemental Payments:** Changes to state provider taxes and state-directed payments were highlighted, which could significantly impact hospitals.
- **Governor's Proposal:** The governor's budget proposal includes cuts to medical premiums, long-term care coverage, dental benefits, and reductions for FQHC partners.
- **Medical Loss Ratio:** The proposal to increase the medical loss ratio to 90% was defeated, keeping it at 85%.
- **Assembly and Senate Budget Plan:** The Assembly and Senate proposed modifications to the governor's budget, including delaying dental benefits cuts and restoring the medical asset limit.
- **Impact on Enrollment:** Enrollment is projected to decrease, impacting medical expenses and community supports.
- **Hospital Contracts:** Contract increases with hospital partners are budgeted at \$49 million for the next fiscal year.

- Staffing and Hiring Freeze: A soft hiring freeze is being considered due to declining enrollment.
- Material Areas of Uncertainty: Several areas of uncertainty were noted, including state and federal budget changes, undocumented member enrollment, and hospital contracts.

Question: Dr. Aboelata asked which agency would oversee the proposed work requirements for Medi-Cal.

Answer: Mr. Woodruff said the work requirements will go through the Social Services Agency.

Question: Ms. Williams inquired whether the work requirements will be assigned to staff or if clients need to provide additional information.

Answer: Mr. Woodruff stated that this process will require reaffirming the same information every six months, necessitating efforts from both the Medi-Cal members and the county staff.

Question: Dr. Lynch asked if there is an estimate of each of these cuts' impact on the Alliance.

Answer: Mr. Woodruff stated that the estimated impact includes a 5% disenrollment in the undocumented population and potentially 50-75% disenrollment once all changes take effect in 2027, which could result in a loss of approximately 80,000 members and \$500 million to the budget.

8. BOARD BUSINESS

a) COMMUNITY SUPPORTS DISCUSSION (May 9 public comment)

i. REVIEW AND APPROVE – COMMUNITY SUPPORTS

Chair Gebhart and Mr. Woodruff led a discussion on community supports, emphasizing the importance of these programs, the state's guidance, and the decision to refrain from reducing them.

Comment: Dr. Lynch emphasized the importance of prioritizing community supports that impact broader healthcare goals and requested analysis on the financial impact of community supports and ECM.

Comment: Dr. Clanon supported the question of why the board needed to vote on community supports and mentioned the need for detailed data on the financial impact of community supports and ECM.

Comment: Ms. Williams mentioned the impact of community supports on individuals and the importance of reconsidering the decision to eliminate the program.

Comment: Ms. Peterson supported rescinding the March vote, stating that having it off the record is clearer.

Comment: Dr. Ferguson expressed concern about funding community supports without knowing the payment source, highlighting the challenging financial situation.

Motion: A motion was made by Natalie Williams and seconded by Tosan Boyo to rescind the March vote to reduce Community Supports spending to the amount of the state payment. Instead, the staff was directed to look for ways to cover the subsidy (the difference between the cost and the state payment) and bring options to the Executive Committee for discussion and then to the board.

Vote: The motion passed.

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

Abstain: Dr. Rollington Ferguson

No opposition.

b) REVIEW AND APPROVE APRIL 2025 MONTHLY FINANCIAL STATEMENTS

April 2025 Financial Statement

Enrollment:

Enrollment decreased by 1,846 members since March and an overall increase of 6,794 members since June 2024.

Net Income:

For the month ending April 30th, 2025, the Alliance reported a Net Income of \$5.9 million (versus budgeted Net Income of \$3.9 million). For the year-to-date, the Alliance recorded a Net Loss of \$92.4 million versus a budgeted Net Loss of \$72.4 million.

Premium Revenue:

For the month ending April 30th, 2025, actual Revenue was \$193.0 million vs. our budgeted amount of \$190.3 million.

Medical Expense:

Actual Medical Expenses for the month were \$181.2 million, vs. budgeted amount of \$174.9 million. For the year-to-date, actual Medical Expenses were \$1.8 billion vs. budgeted Medical Expense of \$1.7 billion.

Medical Loss Ratio:

Our MLR ratio for this month was reported as 93.9%. The year-to-date MLR was 101.1%.

Administrative Expense:

Actual YTD Administrative Expenses for the month ending April 30th, 2025, were \$95.5 million vs. our budgeted amount of \$101.1 million. Our Administrative Loss Ratio (ALR) is 4.5% of our Revenue for the month, and 5.4% of Net Revenue for year-to-date.

Other Income / (Expense):

As of April 30th, 2025, our YTD interest income from investments show a gain of \$28.1 million.

Managed Care Organization (MCO) Provider Tax:

For the month ending April 30th, 2025, we reported \$65.4 million MCO Tax Revenue vs. budgeted MCO Tax Revenue of \$63.9 million. Our MCO Tax Expense was \$65.4 million vs. budgeted MCO Tax Expense of \$66.9 million.

Tangible Net Equity (TNE):

For March, the DMHC requires that we have \$80.8 million in TNE, and we reported \$163.0 million, leaving an excess of \$82.2 million. As a percentage we are at 202%, which remains above the minimum required.

Cash and Cash Equivalents:

We reported \$811.1 million in cash; \$568.4 million is uncommitted. Our current ratio is above the minimum required at 1.13 compared to regulatory minimum of 1.0.

Capital Investments:

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

Motion: A motion was made by Natalie Williams and seconded by Dr. Rollington Ferguson to approve the April 2025 monthly financial statements.

Vote: The motion was passed unanimously.

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

No opposition or abstentions.

c) REVIEW AND APPROVE FISCAL YEAR 2026 BUDGET**Highlights:**

- 2026 Projected Net Loss of \$22 million.
- Projected excess Tangible Net Equity at 6/30/26 of \$71 million is 186% of required TNE.
- Year-end enrollment is 30,000 lower than June 2025. Fiscal Year member months are 146,000 lower than prior year. Year-end projected enrollment is 378,000 in June 2026.
- Revenue is \$3.0 billion in FY 2026, a decrease of \$136 million (-4.5%) from FY 2025.
- Fee-for-Service and Capitated Medical Expense is \$2.1 billion in FY 2026, decrease of \$50 million (-2.4%) from FY 2025.
- Expenses for Long-Term Care are projected to be approximately \$33 million higher than FY2025 3Q Forecast.
- Administrative Department Expenses are \$5 million higher than FY 2025 3Q Forecast and represent 5.6% of revenue.

- Clinical Department Expenses are \$31 million lower than FY 2025 3Q Forecast and comprises 1.0% of revenue.
- DSNP Program is projected to start on January 2026.

Question: Chair Gebhart inquired about the potential risks to hospital payment increases due to changes in the MCO program or any state-related adjustments to provider taxes.

Response: Mr. Riojas explained that the changes to hospital contracts outlined in the budget are distinct from the discussions surrounding MCO taxes and direct payments. These are separate funding streams within the plan. However, he noted that MCO taxes and directed payments could be at risk starting in 2026 and continuing into 2027.

Question: Dr. Seevak mentioned that group care constitutes a small part of the overall discussion. Is there any effort underway to adjust those rates?

Response: Mr. Riojas confirmed that the group care rates are reviewed every two years in collaboration with the county. An analysis of these rates will be submitted to the county in October, with negotiations for adjustments expected to take place in the early part of the next calendar year.

Question: Dr. Lynch asked about the projected \$22 million deficit. Are there any ways we could potentially reduce this deficit or make necessary cuts?

Response: Mr. Riojas explained that the budget has already been adjusted based on discussions with the state. The projections are regarded as conservative, and further changes are anticipated by December.

Question: Dr. Ferguson inquired whether a balanced budget would affect our current contract negotiations with providers.

Response: Mr. Woodruff stated that contract negotiations have been challenging, and the hospitals have made concessions, indicating that negotiations are as close as they can be.

Motion: A motion was made by Dr. Kathleen Clanon and seconded by Tosan Boyo to approve the Fiscal Year 2026 Budget.

Vote: The motion was passed unanimously.

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

No opposition or abstentions.

9. UNFINISHED BUSINESS

None.

10. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS

None.

11. PUBLIC COMMENT (NON-AGENDA ITEMS)

There were no public comments for non-agenda items.

12. ADJOURNMENT

Chair Gebhart adjourned the meeting at 1:50 p.m.



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Dr. Marty Lynch Reappointment Resolution

RESOLUTION NO. 2025-

A RESOLUTION OF THE ALAMEDA ALLIANCE FOR HEALTH RECOMMENDING THAT THE ALAMEDA COUNTY BOARD OF SUPERVISORS REAPPOINT DR. MARTY LYNCH TO THE REGULAR #14 AT-LARGE SENIORS AND PERSONS WITH DISABILITIES EXPERT SEAT TO THE ALAMEDA ALLIANCE FOR HEALTH BOARD OF GOVERNORS

WHEREAS, Dr. Marty's Lynch current term as an Alameda Alliance for Health (Alliance) Board of Governors member, in the At-Large Seniors and Persons with Disabilities Expert Seat (Regular #14), expires September 18, 2025 and

WHEREAS, the Alliance Chief Executive Officer recommends that the Alliance Board of Governors nominate Dr. Marty Lynch for reappointment to the At-Large Seniors and Persons with Disabilities Expert Seat (Regular #14), pursuant to Section 3.D.8 of the Alliance *Bylaws*; and

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

WHEREAS, the Alliance Board of Governors desires to nominate Dr. Marty Lynch for reappointment to the Alliance Board of Governors (Regular #14); and

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

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

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

SECTION 1. That the Alliance Board of Governors approves the Chief Executive Officer's recommendation to nominate Dr. Marty Lynch for reappointment to the At-Large Seniors and Persons with Disabilities Expert Seat (Regular #14) pursuant to Section 3.D.8 of the Alliance *Bylaws*.

SECTION 2. The Alliance Board of Governors hereby recommends that the Alameda County Board of Supervisors, by majority vote, reappoint Dr. Marty Lynch to the At-Large Seniors and Persons with Disabilities Expert Seat (Regular #14), on the Alliance Board of Governors.

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

PASSED AND ADOPTED by the Board at a meeting held on the 11th day of July 2025.

CHAIR, BOARD OF GOVERNORS

ATTEST:

Secretary



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Trilogy Documents



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**Case Management/Care Coordination,
Complex Case Management & Disease Management
Program Evaluation**

2024

Case Management/Care Coordination,
Complex Case Management & Disease Management
2024 Program Evaluation

Signature Page

07/01/2025 | 1:20 PM PDT

Date

DocuSigned by:
Allison Lam
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Allison Lam, RN
Senior Director, Health Care Services

07/01/2025 | 3:59 PM PDT

Date

DocuSigned by:
Peter Currie
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Peter Currie, Ph.D.
Senior Director, Behavioral Health Services

07/02/2025 | 10:06 AM PDT

Date

DocuSigned by:
Lao "Paul" Vang
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Lao Paul Vang
Chief Health Equity Officer

07/02/2025 | 10:40 AM PDT

Date

DocuSigned by:
Donna Carey
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Donna Carey, MD, MS
Chief Medical Officer, Medical Management
Chair, Quality Improvement Health Equity Committee

07/02/2025 | 1:59 PM PDT

Date

DocuSigned by:
Matthew Woodruff
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Matthew Woodruff
Chief Executive Officer

07/02/2025 | 3:26 PM PDT

Date

Signed by:
Chair Rebecca Gebhart
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Rebecca Gebhart
Board Chair

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2024

Case Management Program Evaluation

Overview

Under the leadership and strategic direction established by Alameda Alliance for Health (The Alliance) Board of Directors, senior management and the Quality Improvement Health Equity Committee (QIHEC), the Health Care Services 2024 Case Management Program was successfully implemented. This report serves as the annual evaluation of the effectiveness of the Case Management (CM) program activities, which include care coordination, care management, complex case management and disease management.

The processes and data reported covers activities conducted from January 1, 2024 through December 31, 2024.

Membership and Provider Network

The Alliance products include:

- Medi-Cal Managed Care: serving beneficiaries eligible through one of several Medi-Cal programs, including Temporary Assistance for Need Families (TANF), Seniors and Persons with Disabilities (SPD), Medi-Cal Expansion and Dually Eligible Medi-Cal members who do not participate in California's Coordinated Care Initiative (CCI). For dually eligible beneficiaries, Medicare remains the primary insurance and Medi-Cal benefits are coordinated with the Medicare provider.
- Alliance Group Care (commercial product): an employer-sponsored plan providing low-cost comprehensive health care coverage to In-Home Supportive Services (IHSS) workers in Alameda County.

Covered services are provided to beneficiaries via Alliance's direct network or one of Alliance's contracted provider networks. In 2024, The Alliance's contracted provider networks included Alameda Health System (AHS), Children First Medical Group (CFMG), and Community Health

Center Network (CHCN). The below figures show membership trends throughout 2024.

Figure 1a. 2024 Membership - by Category of Aid

Category of Aid Trend						
Category of Aid	Dec 2024	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN
ADULTS	62,957	15%	13,651	14,118	6	35,182
CHILD	110,547	27%	10,501	13,443	41,092	45,511
SPD	36,127	9%	12,122	5,685	1,433	16,887
ACA OE	154,565	38%	29,490	53,129	1,574	70,372
DUALS	40,812	10%	26,881	2,910	6	11,015
LTC	255	0%	240	7	0	8
LTC-DUAL	1,285	0%	1,284	0	0	1
Medi-Cal	406,548		94,169	89,292	44,111	178,976
Group Care	5,790		2,144	946	0	2,700
Total	412,338	100%	96,313	90,238	44,111	181,676
Medi-Cal %	98.6%		97.8%	99.0%	100.0%	98.5%
Group Care %	1.4%		2.2%	1.0%	0.0%	1.5%
Network Distribution			23.4%	21.9%	10.7%	44.1%
			% Direct:	45%	% Delegated:	55%

Figure 1b. 2024 Membership - by Age Group

Age Category Trend								
Age Category	Members				% of Total (ie.Distribution)			
	Dec 2022	Dec 2023	Nov 2024	Dec 2024	Dec 2022	Dec 2023	Nov 2024	Dec 2024
Under 19	104,022	104,062	108,407	109,506	32%	30%	27%	27%
19 - 44	119,997	121,694	155,955	158,707	37%	35%	38%	38%
45 - 64	68,606	72,612	84,411	85,272	21%	21%	21%	21%
65+	35,170	53,641	58,152	58,853	11%	15%	14%	14%
Total	327,795	352,009	406,925	412,338	100%	100%	100%	100%

Figure 1c. 2024 Membership – by Provider Network

Network Trend								
Network	Members				% of Total (ie.Distribution)			
	Dec 2022	Dec 2023	Nov 2024	Dec 2024	Dec 2022	Dec 2023	Nov 2024	Dec 2024
Independent (Direct)	53,143	76,241	90,681	96,313	16.2%	21.7%	22.3%	23.4%
AHS (Direct)	65,771	63,548	90,459	90,238	20.1%	18.1%	22.2%	21.9%
CFMG	33,648	35,401	44,031	44,111	10.3%	10.1%	10.8%	10.7%
CHCN	126,009	128,342	181,754	181,676	38.4%	36.5%	44.7%	44.1%
KAISER	49,224	48,477	0	0	15.0%	13.8%	0.0%	0.0%
Total	327,795	352,009	406,925	412,338	100.0%	100.0%	100.0%	100.0%

Figure 1d. 2024 Membership – by Provider Network (Delegated vs. Direct Trend)

Delegation vs Direct Trend								
Members	Members				% of Total (ie.Distribution)			
	Dec 2022	Dec 2023	Nov 2024	Dec 2024	Dec 2022	Dec 2023	Nov 2024	Dec 2024
Delegated	208,881	212,220	225,785	225,787	63.7%	60.3%	55.5%	54.8%
Direct	118,914	139,789	181,140	186,551	36.3%	39.7%	44.5%	45.2%
Total	327,795	352,009	406,925	412,338	100.0%	100.0%	100.0%	100.0%

In 2024, the Alliance membership increased by 60,329 members by year-end. The largest membership increase was seen in the population age 19-44. The delegate, CHCN experienced the largest membership gains, with an increase of 53, 334 members by the end of 2024. This trend aligns with increases in Medi-Cal Enrollment overall, including members who transferred from Anthem in January 2024.

Case Management Program Scope and Structure

CM Program Scope

The Alliance provides person-centered case management services through multidisciplinary teams that address medical conditions, behavioral, functional, and psychosocial issues occurring throughout the continuum of care, including in between medical office visits. Case management activities are performed telephonically. The underlying premise of the program is that when an individual reaches the optimum level of wellness and functional capability, everyone benefits: the individuals being served, their support systems, and the overall health care delivery systems (including physicians, hospitals, and the various payer sources).

The case management program was established to provide case management processes and procedures that enable The Alliance to improve the health and health care of its membership. Members from both Alliance products (Managed Medi-Cal and Alliance Group Care) are eligible for participation in the program. The fundamental components of the Alliance case management

services encompass member identification and screening; member assessment; care plan development, care plan implementation and management; evaluation of the member care plan; and appropriate closure of the case. Case management interventions are organized to promote quality care, member satisfaction and cost-effectiveness using collaborative communications, evidence-based clinical guidelines and protocols, patient-centered care plans, and targeted goals and outcomes.

CM Program Structure

The structure of the CM Program is designed to promote organizational accountability and responsibility in the identification, evaluation, and appropriate use of the Alliance health care delivery network and community resources. Additionally, the structure is designed to enhance communication and collaboration on CM issues that affect all departments and disciplines within the organization. The CM Program is evaluated on an on-going basis for efficacy and appropriateness of content by the Alliance staff and oversight committees.

Responsibility, Authority and Accountability / Governing Committee

The Alameda County Board of Supervisors appoints the Board of Governors (BOG) of the Alliance, a 19-member body representing provider and community partner stakeholders. The BOG is the final decision-making authority for all aspects of The Alliance programs and is responsible for approving the Quality Improvement, Utilization Management and Case Management Programs. The Board of Governors delegates oversight of Quality and Utilization Management functions to The Alliance Chief Medical Officer (CMO) and the Quality Improvement Health Equity Committee (QIHEC) and provides the authority, direction, guidance, and resources to enable Alliance staff to carry out the Utilization Management and Case Management Programs. Utilization Management oversight is the responsibility of the QIHEC. Utilization Management and Case Management activities are the responsibility of The Alliance Health Care Services staff under the guidance of the Medical Director for Care Management, the Medical Director for Utilization Management, and the Senior Director, Health Care Services, in collaboration with The Alliance CMO.

Committee Structure

The Board of Governors appoints and oversees the QIHEC, the Peer Review and Credentialing Committees, and the Pharmacy and Therapeutics Committee (P&TC) which, in turn, provide the authority, direction, guidance, and resources to enable the Alliance staff to carry out the Quality Improvement, Utilization Management and Case Management Programs. Committee membership consists of provider representatives from the Alliance contracted networks and the community, including those who provide health care services to populations served by the Alliance (for example: Seniors and Persons with Disabilities, Dual-eligible members, and members with Chronic conditions).

The QIHEC provides oversight, direction, makes recommendations, and has final approval of the UM and CM Programs. Committee meeting minutes are maintained to summarize committee activities and decisions with appropriate signatories and dates.

QIHEC charters a sub-committee called the Utilization Management Committee (UMC), which meets at least once every 2 months. UMC serves as a forum for the Alliance to evaluate current CM activities, processes, and metrics, including case management/care coordination, complex case management, transitional care services, population health, integration of medical and behavioral health, regulatory compliance, and oversight for delegated CM activities. The UMC also evaluates the impact of CM programs on key stakeholders in other departments, including Compliance, Member Services, and Grievance and Appeals. Input from UMC members is included in continuous CM program monitoring, evaluation, and design of interventions.

In 2024, the UMC had 10 meetings. The 2023 CM Program Evaluation and 2024 CM Program Description and Workplan were presented for review and approval at the April 19, 2024 QIHEC meeting, and documented in the minutes for Board of Directors approval. The committee was chaired by the Chief Medical Officer with support from the Senior Director of Quality Management, external physicians, and key organizational staff.

Integration of Medical and Behavioral Health

The Alliance provides access to mental health services for the Medi-Cal and Commercial membership in several ways:

- Basic mental health care needs are provided by Primary Care Providers
- Medi-Cal members with “mild to moderate” impairments in mental, emotional, or behavioral functioning are referred to the Alliance’s network for behavioral health care.
- Medi-Cal members diagnosed with a severe mental health disorder and substance use disorders (SUD) are carved-out and managed by Alameda County Behavioral Health Care Services Department (ACBHCS).
- Commercial members accessed mental health/SUD benefits through the Alliance’s network for behavioral health care.

The Behavioral Health Program includes a care coordination program staffed by licensed clinicians and behavioral health navigators.

- The mental health team consists of 5 licensed clinicians and the ABA team consists of 4 board certified clinicians.
- The clinical teams are supported by 14 behavioral health navigators.
- A behavioral health manager and 2 supervisors oversee the daily operations of the behavioral health departments.
- The Alliance behavioral health program operates under the leadership of a Senior Director of Behavioral Health and Medical Director.

Involvement of senior-level physician and behavioral healthcare practitioners

The Board of Governors delegates oversight of Quality and Case Management functions to The Alliance Chief Medical Officer (CMO). The CMO provides the authority, direction,

guidance, and resources to enable Alliance staff to carry out the Case Management Program. The CMO delegates senior level physician involvement in appropriate committees to provide clinical expertise and guidance to program development. Dr. Peter Currie, Ph.D., Senior Director, Behavioral Health Services, provides leadership to behavioral health care at the Alliance, further supporting the integration of behavioral health care with medical care. Together, the senior-level physician and behavioral health practitioners are involved in the CM program by:

- Establishing CM policies (for medical and behavioral healthcare services)
- Reviewing and consulting on complex CM cases (for medical and behavioral healthcare services)
- Participating in various clinical and stakeholder committees (including UMC and QIHEC)
- Evaluating the overall effectiveness of the CM Program (for medical and behavioral healthcare services)

Case Management Resources

The Alliance CM Department is staffed with physicians, nurses, social workers, and non-clinical support staff, including clerical support and clinical support coordinators. A full description of staff roles and responsibilities is provided in the 2025 CM Program Description.

In 2024, the CM leadership structure was designed to meet the needs of the program and the staff, including Enhanced Care Management and Community Supports:

- 1.0 FTE Medical Director of Case Management
- 1.0 FTE Senior Director, Health Care Services
- 1.0 FTE Director, Social Determinants of Health
- 1.0 FTE Director, Long Term Services and Supports
- 1.0 FTE Manager, CM
- 2.0 FTE Supervisor of CM
- 2.0 FTE Non-Clinical Supervisor of CM
- 1.0 FTE Lead CM
- 1.0 FTE Clinical Manager, Enhanced Care Management (ECM)
- 1.0 FTE Manager of Community Supports
- 1.0 FTE Supervisor of Community Supports (CS)

The BH leadership to support Behavioral Health case management:

- 1.0 FTE Senior Director, Behavioral Health Services
- 1.0 FTE Manager, Behavioral Health
- 2.0 FTE Supervisors

The adequacy of case management resources is continuously evaluated to ensure appropriate staffing levels to manage programmatic changes and workload volumes, accounting for variations in members' health status and complexities of coordination of care needs. For example, in 2024, the Community Supports team transitioned to the Long-

Term Services and Supports Director, allowing for continued expansion and optimization of Community Supports services. Additionally, the BH team added 2 team supervisors to support the continued growth of behavioral health case management activity.

Delegated Case Management

The Alliance delegates case management (CM) activities to contracted health plan, provider groups, vendor networks and healthcare organizations that meet delegation agreement standards. The contractual agreements between the Alliance and delegated groups specify the responsibilities of both parties, including:

- the functions or activities that are delegated;
- the frequency of reporting on those functions and responsibilities;
- how performance is evaluated; and
- corrective action plan expectations, if applicable.

The Alliance conducts pre-contractual evaluations of delegated functions to ensure a delegates’ abilities to meet standards and requirements. The Alliance’s Compliance Department is responsible for the oversight of delegated activities. The Compliance Department works with the CM department, and other departments, to conduct the annual delegation oversight audits. When delegation occurs, The Alliance requires the delegated entity to comply with the NCQA standards and present quarterly reports of services provided to Alliance members. The Alliance’s Compliance Department completes an annual performance evaluation of delegated CM operations. Results of the annual evaluation, and any audit results, are reviewed by the Compliance and Delegation Oversight Committee, and shared with the delegates.

In 2024, the Alliance delegated CM activities to the following entities:

Figure 2. Delegated Entities (CM activities only)

Delegate Name	Provider Type	Delegated Activity-Care Coordination/Case Management
CHCN	Managed Care Organization (MCO)	Yes

Case Management Information Systems

The CM Department uses a clinical information system, TruCare®, as the case management platform. TruCare® is a member-centric application that automates the entire clinical, administrative, and technical components of case management into a single platform. The system supports case management with algorithmic clinical intelligence and best practices to guide case managers through assessments, development of care plans, and ongoing management of members. The system includes assessment templates to drive consistency in the program. Care plans are generated within the system and are individualized for each member and include short and long-term goals, interventions, and barriers to goals. The clinical information system includes automated features that provide accurate documentation for each entry; record actions or interactions with members, caregivers, and providers; and create automatic date, time, and user stamps. To facilitate care planning and management, the clinical information system includes features to set prompts and reminders for next steps or follow-up contact. Optimization of TruCare® continued into 2024, in preparation for the organization to take on the dual special needs population (DSNP). Thorough vetting processes are established between clinical and IT teams to ensure any enhancements and upgrades to the platform are amenable to all system users. System optimization and upgrades are ongoing as standard practices, including staff training to ensure competence in using the platform and alignment on best practice workflows.

Clinical Decision Support Tools

Evidence-based clinical guidelines are available to support the Case Managers in conducting assessments, developing care plans, and managing care. The clinical practice guidelines are based on current published literature, current practice standards, and expert opinion. Whenever possible, guidelines are derived from nationally recognized sources. If a nationally recognized guideline is not available, the Alliance will involve board certified specialists in the development of the appropriate guidelines, as well as medical and behavioral healthcare specialty societies and/or Alliance Clinical Practice Guidelines.

Case Management Process

Case Management Referral and Identification

The Alliance's Care Management program adopts a person-centered design, ensuring all care management activities align with members' needs, preferences, and goals. Members are identified as candidates for care management services through a variety of data sources and referrals. This includes, but is not limited to:

- Health Risk Assessment (HRA)
- Health Information Forms/Member Evaluation Tool (HIF/MET)
- Data sources such as Utilization reports and Admission, Transfer and Discharge (ADT) Feeds

- Population Health Reports - *In 2024, the Population Health initiatives at the Alliance continue to be strengthened and further integrated into ongoing Alliance care management identification activities. A stratification of member acuity remains in place, ranging from low-risk members who may need health promotion/education, to the highest risk, most vulnerable members needing full wraparound Enhanced Care Management services.*
- Self-referrals from members/authorized representatives
- Direct referrals from provider networks
- Internal referrals (including Utilization Management, Member Services, Appeals and Grievance, Leadership)
- Predictive modeling

The HRA and HIF/MET processes are essential components of the care management process, allowing members to self-report their health care needs and goals.

Health Risk Assessments (HRA)

The Alliance arranges for the assessment of every new Senior and Person with Disabilities (SPD) member through a process that stratifies all new members into an assigned risk category based on self-reported or available utilization data. Based on the results of the health risk stratification, the Alliance administers a Health Risk Assessment (HRA) survey to all newly enrolled SPD members within:

- 45 days of enrollment for members identified as high-risk.
- 105 days of enrollment for members identified as low-risk.

The Alliance outreaches to SPD members to administer the HRA and to develop a Care Plan. SPD members are re-assessed annually on the anniversary month of their enrollment. The responses from the HRA may result in the members being re-stratified as high risk or low risk (for some members, risk-level based on their HRA responses may be different from their earlier stratification based on the stratification tool/data). In addition, the HRA includes specific Long-Term Services and Supports (LTSS) referral questions. These questions are intended to assist in identifying members who may qualify for and benefit from LTSS services. These questions are for referral purposes only and are not meant to be used in stratifying members as high risk or low risk. After completion of the HRA, the Alliance develops Individualized Care Plans (ICPs) for members found to be high risk and coordinates referrals for identified LTSS, as needed.

CM staff are responsible for ensuring the Individualized Care Plan is completed, shared with the Member and PCP, and is accompanied by relevant community and health resources. For Members whose completed HRA results in a final stratification of Low Risk, CM staff review Member HRA responses to identify Member needs (i.e., resources for transportation, in-home support services (IHSS), durable medical equipment (DME), food resources). The CM staff generates the standardized low risk care plan, attaches the relevant resources, and prepares it for mailing. For Members whose completed HRA

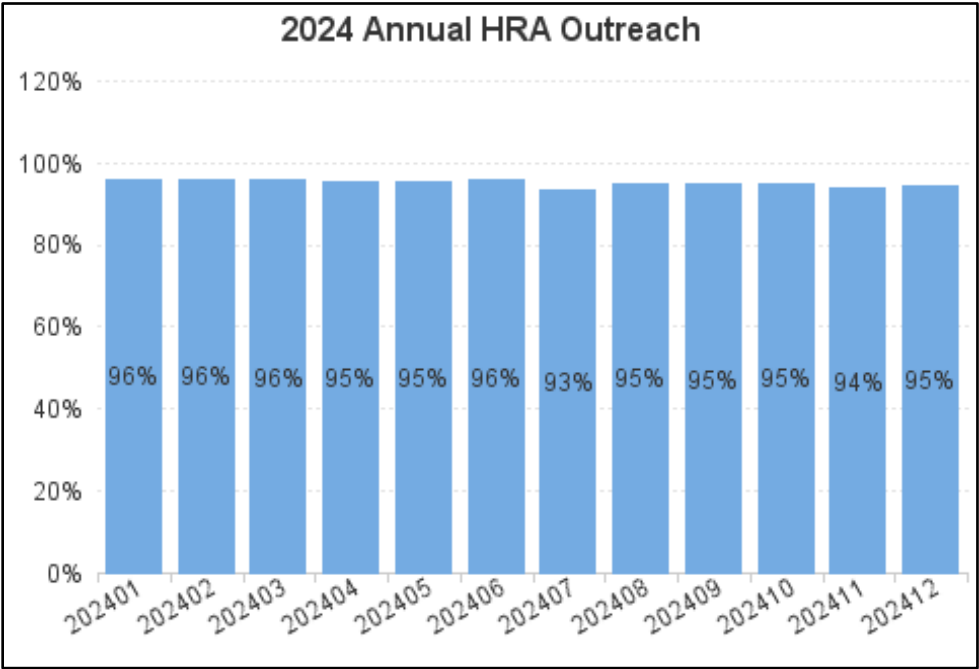
results in a final stratification of High Risk, clinical CM staff outreach to the Member and reviews Member HRA responses with the member to identify Member needs. The CM staff generate the standardized high-risk care plan and include additional health education resources and materials based on the conversation with the Member. If the member remains Unable to Contact (UTC), a standardized care plan is sent to the member. This is sent to members, even if they do not complete the HRA and return it to the plan.

Copies of the care plans, for both High Risk and Low Risk members, are mailed to the Member, the Primary Care Provider, and the Delegate Group if applicable.

The Alliance uses Interactive Voice Response (IVR) calls to remind and encourage Low Risk Members to complete an HRA. The Alliance’s internal IT team makes Interactive Voice Response (IVR) calls to members. These IVR calls are made to members so that the Alliance can give members every opportunity to complete the HRA and have the results acted upon by the CM department. High Risk Member receive calls from CM staff to remind and encourage completion of the HRA.

Below figures show 2024 HRA outreach and completion rates for the SPD population.

Figure 3. HRA Outreach for SPD Members



The average outreach rate for 2024 was 95%, reflecting the engagement of the Alliance IT team’s IVR to assist with the HRA process by reminding members to return HRAs in a timely manner.

Figure 4a. New HRA completion for SPD Members

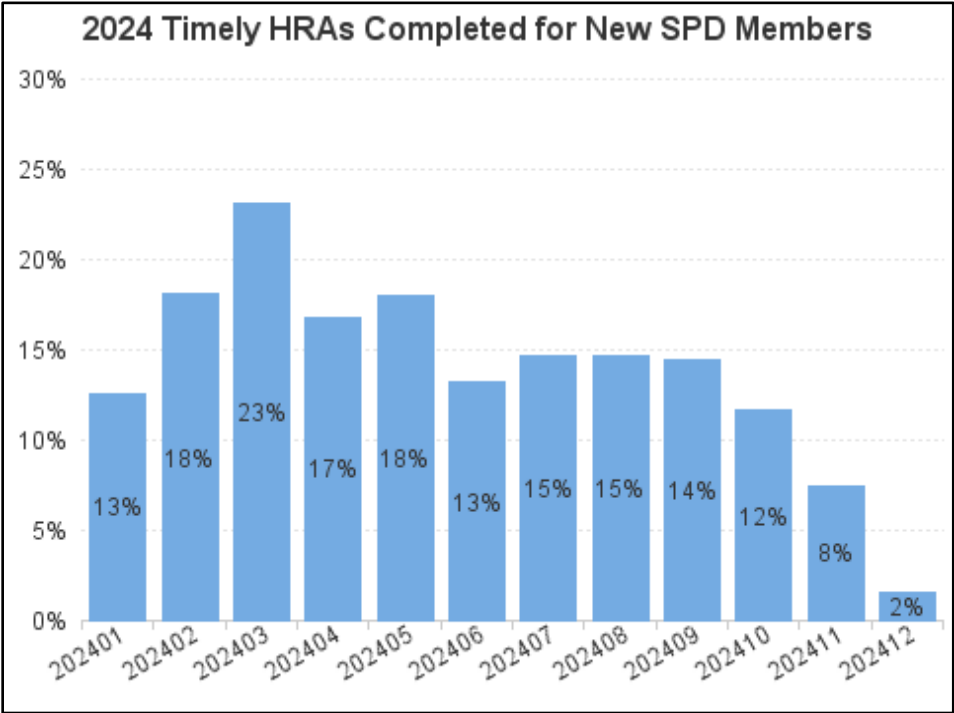
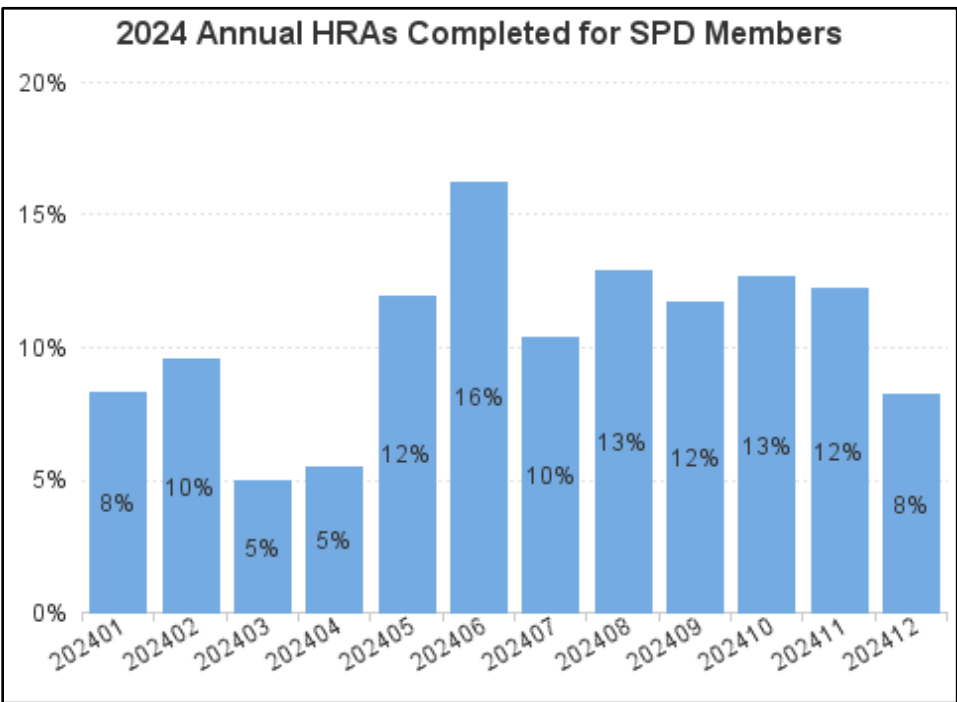


Figure 4b. Annual HRA completion for SPD Members



In 2024, the average combined completion rate for new and annual HRAs was 12%, representing no change in the completion rate in 2023. In 2024, the highest monthly completion rate was 23%.

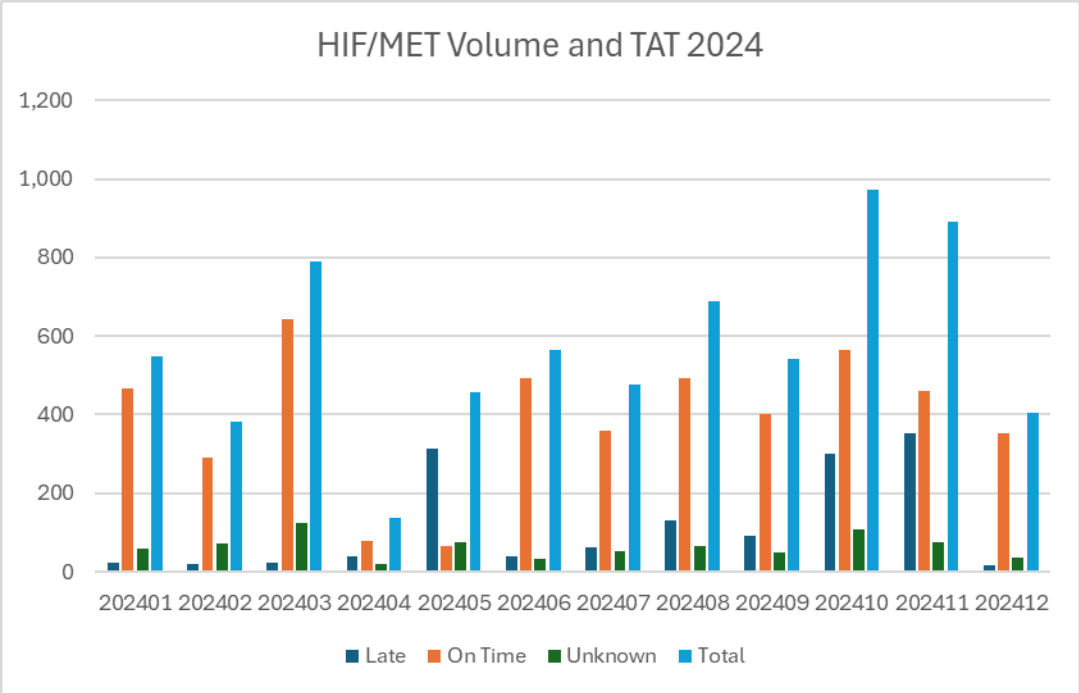
Health Information Forms/Member Evaluation Tools (HIF/MET)

The Alliance arranges for the assessment of every new member to the Alliance, and for members returning to the Alliance after a gap in coverage (with the Alliance) of 6 months or more. The HIF/MET is a brief federal initial screening requirement that is used to identify general member needs and to determine if a new member requires expedited care upon joining or returning to the Alliance.

HIFMETs are mailed in the new member packet for any member not stratified as a Senior and Persons with Disability (SPD). The responses from the HIF/METs are entered into the Case Management system of record (TruCare). Monthly reports are run to identify any positive responses to inform members’ assigned PCPs of the results. PCPs provide follow-up, as necessary.

The Alliance uses Interactive Voice Response (IVR) calls to encourage members to complete the HIF/METs. The Alliance’s internal IT team makes the IVR calls to members so that the Alliance can give every opportunity to complete the HIF/MET and have the results acted upon by the members’ assigned PCP.

Figure 5. 2024 Total Completed HIF/METs



In 2024, we saw a stable volume of HIF/METs received and processed on time with a decline in processing April 2024 which resulted in an increase in form processed late May 2024. This was due to Health Assessment Coordinators prioritizing influx of HRA’s received for newly transition Anthem members. The HIF/MET TAT was remedied by June 2024.

Referral Assignment

All CM referrals are reviewed by the CM Lead who makes daily assignments, considering referral data, pre-existing or historical CM cases, type of request, and acuity of request. The CM Lead verifies the appropriate CM staff to support the member (including Health Navigators, Social Workers, or Nurses) and assigns corresponding CM staff. Members are deemed ineligible if the member’s Alliance eligibility is inactive, the member has expired or is receiving duplicative services.

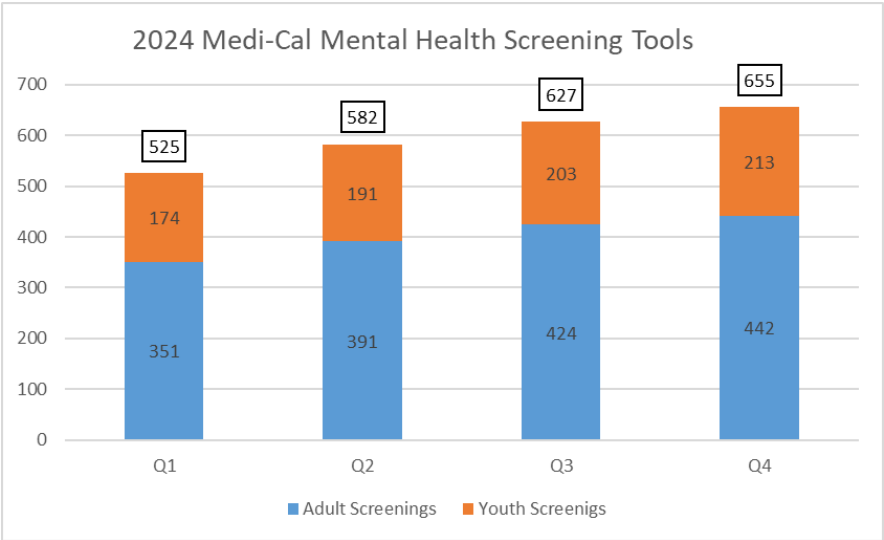
Behavioral Health CM Referrals

In 2024, to continue the integration of BH and medical services, the Alliance worked closely with ACBHCS to identify members who may benefit from co-management of medical and behavioral health services and/or specialty and non-specialty mental health services. The Behavioral Health (BH) Department maintained the relationship with ACBHCS to ensure eligible Medi-Cal members receive services through the ACBHCS linked mental health programs. The focus of the activities is to ensure contracted providers continue to identify and refer members with severe mental health/SUD conditions to the appropriate ACBHCS programs, as well as to facilitate coordination activities for co-existing medical and behavioral health disorders to assist with their treatment access and follow-up care.

In accordance with DHCS No Wrong Door policy, AAH and ACBHD continues to utilize the DHCS standardized screening tool between both entities to determine which system of care Medi-Cal members are referred into. The Alliance continued regular meetings with ACBHCS to facilitate coordination of care and identify potential duplication of services.

The graph below represents the number of adult and child DHCS MH screening tools that were completed by the Alliance 2024 for Medi-Cal.

Figure 6. 2024 Medi-Cal Mental Health Screening Tool



Care Coordination/Care Management Services and Supports

Upon identification and receipt of appropriate care management referrals, the Alliance provided the following Care Coordination and Care Management services and supports in 2024. Service categories are aligned with the DHCS Population Health Management (PHM) Policy Guide that governs the Alliance’s PHM Strategy.

- **Basic Population Health Management** (replaces DHCS’ “Basic Case Management” requirements, includes Care Coordination and Disease Management, also includes Basic Case Management delegated to CHCN)
- **Care Management Programs:**
 - Complex Care Management (CCM)
 - Enhanced Care Management (ECM)
 - Targeted Case Management (TCM)
- **Transitional Care Services**
- **Specialized Services:**
 - Continuity of Care (CoC)
 - Community Supports
 - Transportation

Also in 2024, the care management teams continued working on integration efforts between medical and behavioral health services, including:

- Enhancing CCM outreach to the chronically ill.
- Improve coordination of care by increasing clinical oversight and co-management with the medical management teams.
- Continued efforts toward improving communication between the primary care physician and behavioral health providers.
- Attendance by the Alliance’s behavioral health team at the Interdisciplinary Care (IDT) Team meetings to collaborate, advise, refer, and provide additional insight into medical CCM cases.

Below is a summary of care management cases managed in 2024, categorized by target diagnoses identified as part of the population health management strategy.

Figure 7. Volume of CM cases in Population Health Target Diagnoses in 2024

Diagnosis	Number of Members with Disease State in last 12 months	Enhanced Care Management (ECM) Enrolled	Care Coordination Enrolled	Transitional Care Services (TCS) Enrolled	Complex Case Management (CCM) Enrolled
Hypertension	75395	1993	314	1008	19
Hyperlipidemia	73345	1247	248	668	12
Obesity	47374	1260	186	354	11
Diabetes	41497	999	178	556	12

Anxiety, neuroses	32058	1256	204	290	9
Gingivitis	24872	395	45	57	4
Asthma	24176	994	103	239	5
Tobacco	20852	1173	97	357	9
Depression	18445	947	112	263	8
Substance Use Disorder	18003	1343	113	402	9
Major depression	16566	836	103	196	5
CAD	12949	558	81	353	5
Adjustment disorder	11491	519	55	112	3
Family and social problems	11190	707	49	76	2
Pregnancy (with and without complication)	10791	215	22	195	0
Psychologic signs and symptoms	9950	493	42	103	2
CHF	9292	635	79	357	4
Emphysema	8041	512	54	242	2
Schizophrenia	7382	369	35	139	2
Post traumatic stress disorder	6777	503	53	51	4
Attention deficit disorder	5068	196	26	8	0
Bipolar disorder	4280	264	29	65	0
Sleep disorders of nonorganic origin	3300	128	22	28	0
Psych-physiologic and somatoform disorders	2644	187	21	66	2
ESRD	2195	175	34	107	2
Breast Cancer	2012	29	24	18	0
Hepatitis C	1780	182	20	57	0
Psychological disorders of childhood	1514	73	7	7	0
Psychosexual	1467	33	8	4	0
Eating disorder	884	42	4	6	1
Colon Cancer	858	29	5	21	1
Impulse control	771	27	4	6	0
Lung Cancer	754	26	5	14	0
Burns-1st degree	716	38	2	9	1
Cervical Cancer	666	26	6	8	0
Personality disorders	632	42	6	9	0
Tuberculosis	313	8	3	4	1
Sickle Cell Disease	223	16	3	8	0
Other	306926	5459	723	1593	26

The highest volume of members with a Population Health target diagnoses are served by Enhanced Care Management (ECM), representing the most vulnerable members with complex physical, social, and emotional risk factors. The next highest volume are those members receiving Transitional Care Services. Transitional Care Services are provided to members

transitioning between settings of care, including those discharging from a hospital to a skilled nursing facility or to a home. Care Coordination represents the volume of work assisting members to navigate the health care system, including members who declined CCM and ECM, but will still receive case management services via a care coordination case. Complex CM (CCM), the lowest volume of enrolled members, is an opt-in telephonic program for members with multiple and/or complex health conditions, requiring member consent and participation in care planning and goal setting to appropriately self-manage their conditions. If a member declines Complex CM, the member is offered care coordination services. Members who qualify for both ECM and CCM may prefer the higher level ECM which has the option of in-person case management.

Each CM service category, and its impacts, are further evaluated below.

Basic Population Health Management

Basic Population Health Management (BPHM) is available to all Alliance members, regardless of risk tier, and includes ensuring access to primary care, care coordination, navigation and referrals across health and social services (including Community Supports), information sharing and referral support infrastructure, services provided by Community Health Workers (CHWs) under the new CHW benefit, wellness and preventions programs, chronic disease programs, programs focused on improving maternal health outcomes, and case management services for children.

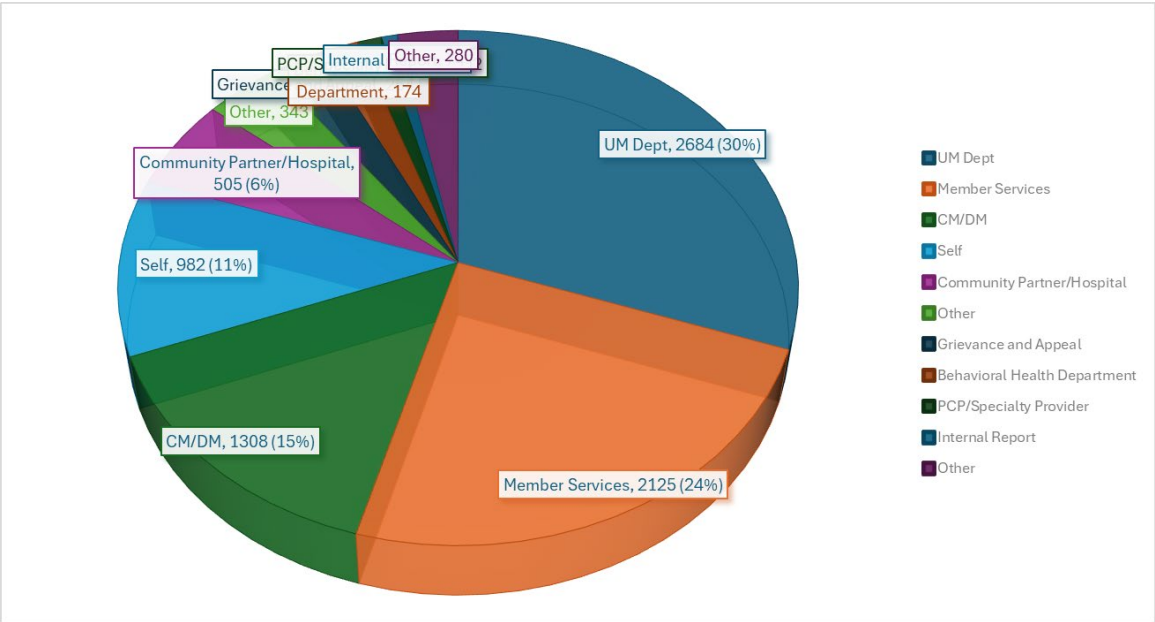
The Primary Care Provider (PCP) is responsible for Basic Population Health Management for his/her assigned members and is supported by the Provider Group CM team. The PCP is responsible for ensuring that members receive an initial screening and health assessment (IHA), which initiates Basic Medical Care Management. The PCP conducts an initial health assessment upon enrollment, and through periodic assessments provides age-appropriate periodic preventive health care according to established, evidence-based, preventive care guidelines. The PCP also makes referrals to specialists, ancillary services, and linked and community services as needed based on the member's Individual Care Plan (ICP). When additional care management assistance is needed, the PCP works with the Provider Group's CM department to facilitate coordination. For members enrolled in the Direct Network, the PCP works with the Alliance CM and UM teams to facilitate coordination.

Care Coordination – Medical Services

Care coordination is provided by the CM staff for members needing assistance in coordinating their health care services. Interventions may include referral coordination, focused disease management programs, and/or making arrangements for linked and carved-out services, programs, and agencies. The Alliance uses non-clinical staff called Health Navigators to support care coordination. Health Navigators have extensive training in facilitation and coordinating services both internally and with outside agencies (for example: Alameda County Public Health and other community resources). They are equipped to manage most care coordination cases, including those involving access to care and continuity of care.

Below figures show 2024 Care Coordination program outcomes by referral source, open/active volumes, and case closure reasons.

Figure 8. 2024 Care Coordination Program by Referral Source

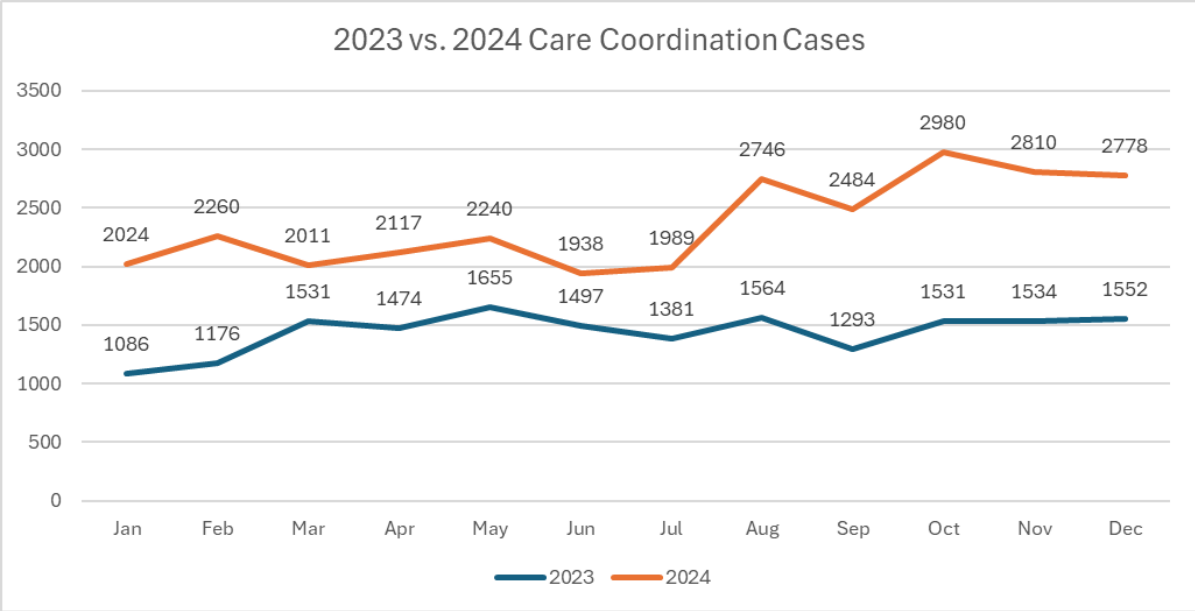


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In 2024, the top three referral sources for Care Coordination cases were the UM Department (2684 referrals), Member Services (2125 referrals), and the CM/DM department (1308 referrals)

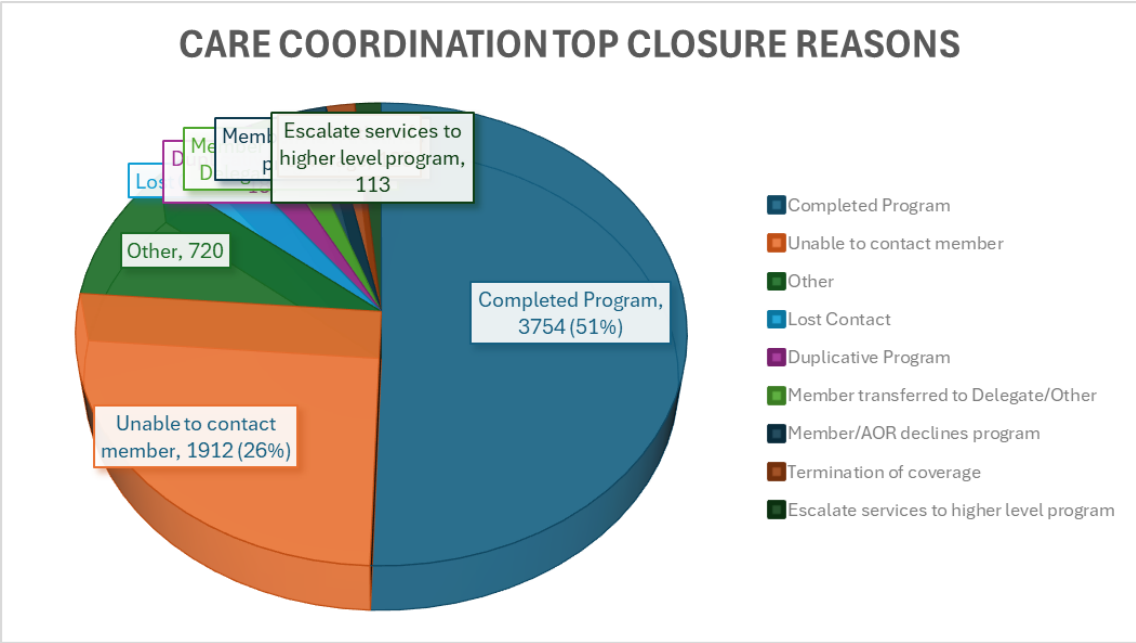
- The UM Department is a top referral source leading to care coordination cases showing the essential collaboration between UM and CM teams. Common referrals from UM include support with accessing and navigating care with in-network providers and facilitating continuity of care with out-of-network providers, when appropriate.
- The Member Services Department is a top referral source leading to care coordination cases because Member Services is the main entry point for members contacting the Alliance. Member Services also processes exempt same-day grievances, referring to CM for any care coordination needs related to grievances that cannot be resolved by a member services representative on the same day of the member’s call.
- CM/DM is a top referral source back into CM as these referrals are comprised of referrals for members being referred within the care management team (for example, a nurse may refer care coordination tasks to a health navigator, a health navigator may put in a referral for a nurse to assist with a case of increasing complexity), thus demonstrating the collaboration among the team and the resulting continuity of care management support to members.

Figure 9. 2023 vs. 2024 Care Coordination Program by New/In Progress Cases



In 2024, there was a monthly average of 2,338 in progress/new care coordination cases. This was a year-over-year average increase of 854 cases per month, compared to the monthly average of 1,484 in progress/new care coordination cases in 2023.

Figure 10. 2024 Care Coordination Program by Case Closure Reason



In 2024, the top three reasons for case closure were Completed Program (3,754 cases), Unable to Contact Member (1,912 cases), and Other (846 cases). Other top case closure reasons included: Lost Contact, Duplicative Program, Member Transferred to Delegate, Member /AOR Declines, and Termination of Coverage.

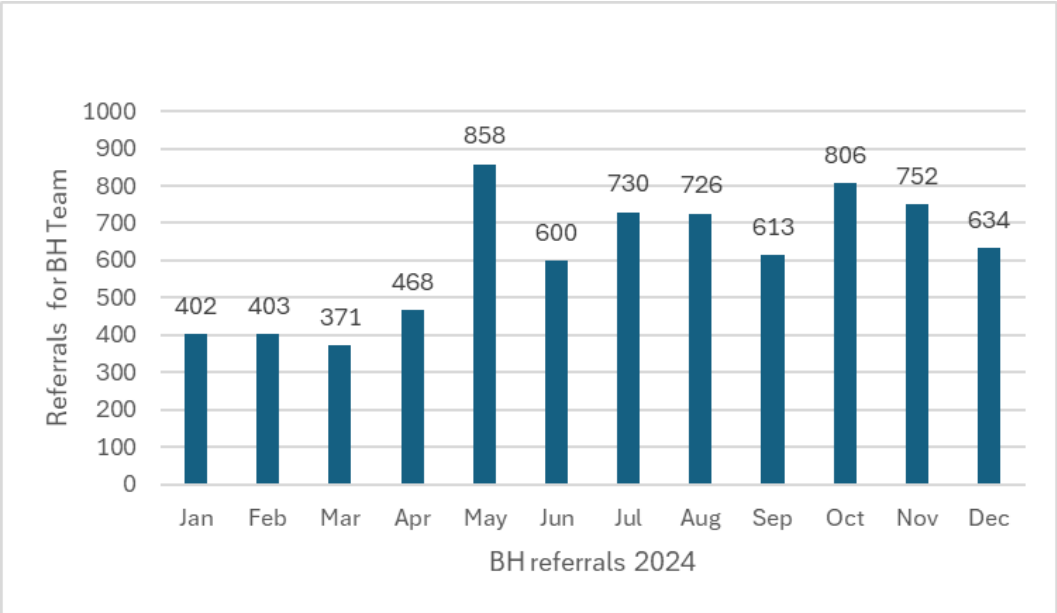
While nearly 26% of cases were closed due “unable to contact” member, it should be noted that when a referral is made from other departments or data sources besides

member “self-referral,” the member is not expecting a phone call from CM, and therefore, less likely to respond to contact attempts (including voicemails and letters) for assistance they have no yet consented to.

Care Coordination – Behavioral Health Services

The Alliance received a monthly average of 613 care coordination referrals. These are referrals from PCPs, mental health clinicians, interdepartmental referrals, and members themselves requesting assistance with coordination of behavioral health care. The graph below represents referrals for behavioral health services.

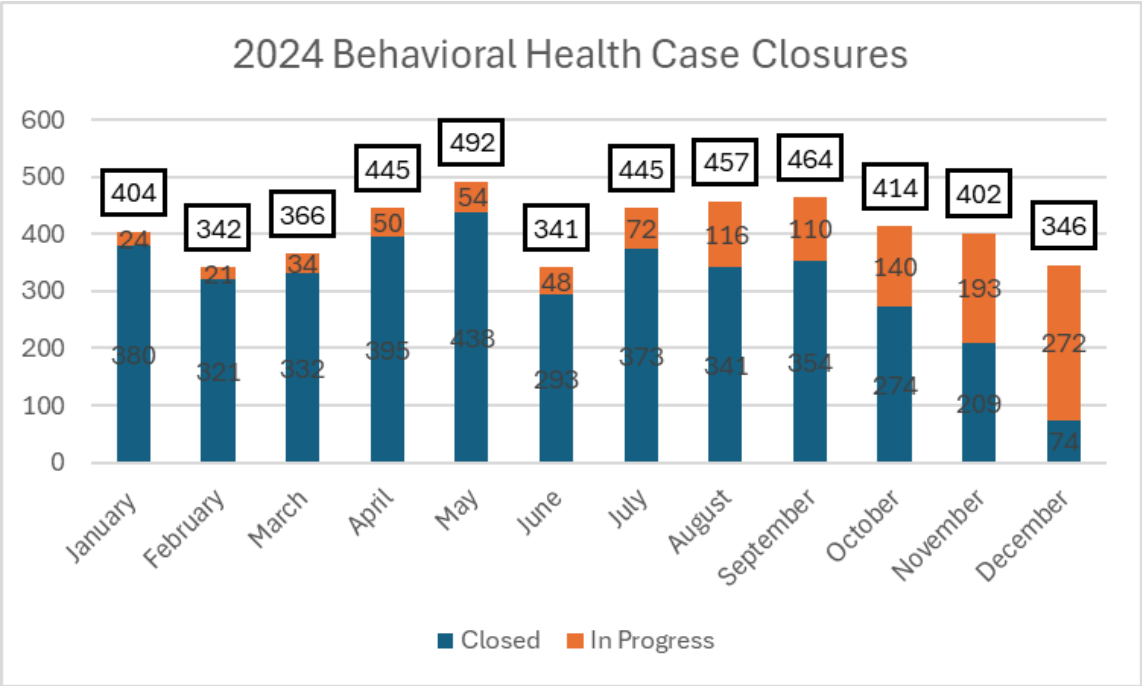
Figure 11. 2024 Total Behavioral Health Referrals



The Alliance’s focus is on reducing barriers to accessing mental health services. The Alliance behavioral health team is committed to facilitate coordination of care between mental health and primary care providers. To enable coordinated care, we deployed the Mental Health Initial Evaluation and the Mental Health Coordination of Care Update forms on our provider portal. These forms are designed to be an efficient and secure process whereby Mental Health providers log into the Alliance provider portal after evaluating a member to then enter the presenting problems, their findings and diagnosis.

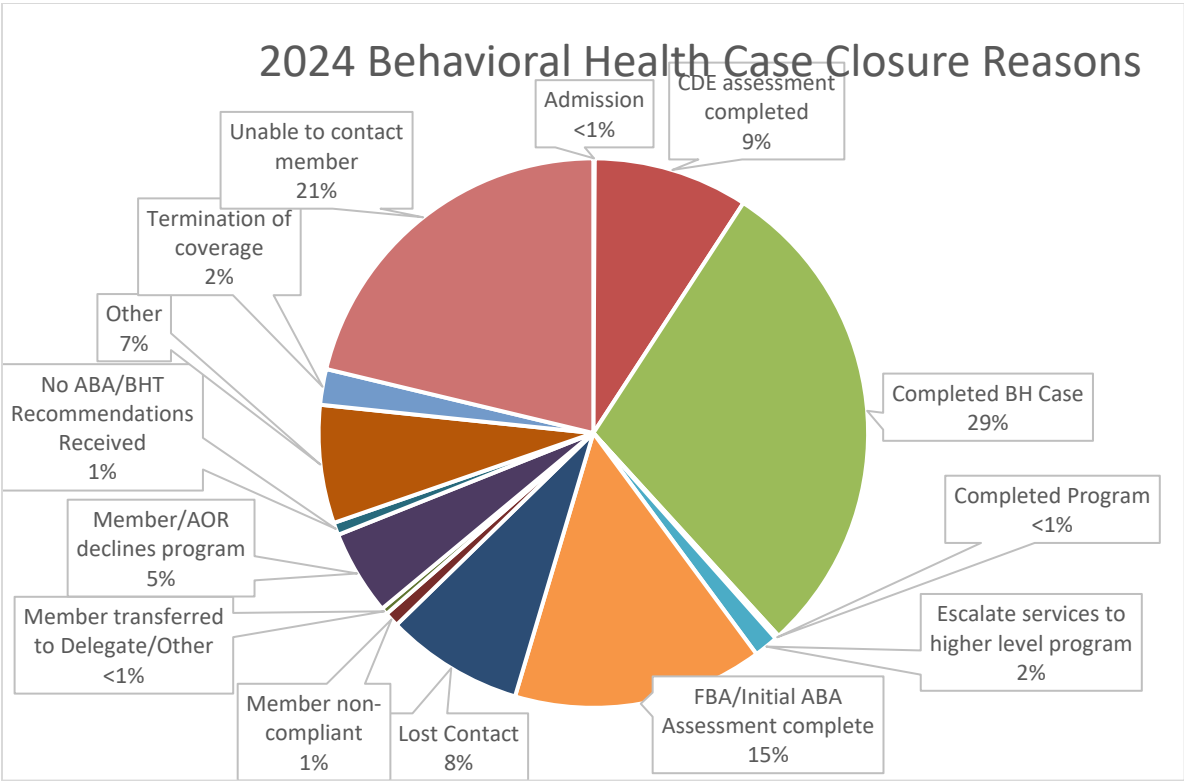
Locally and nationally, there has been a significant increase in the numbers of children identified and later diagnosed with developmental delays, mostly autism. The number of treatment providers has not grown at a comparable rate. This has resulted in longer than expected wait times for access to care. As a result, the Alliance has a high-touch care coordination program to support the members and their families in accessing care. In addition, the Alliance has taken action to increase network capacity. The care coordination program has also increased communication with primary care providers to keep them informed of the status of referrals.

Figure 12. 2024 BH Case Closures Volumes



Cases are primarily closed when the member has been successfully connected to care. The "In-Progress" cases refer to active cases that are still undergoing care coordination activities. It is important to note that a significant number of Behavioral Health Treatment (BHT) and Applied Behavior Analysis (ABA) ongoing case coordination is being conducted for these members due to various factors such as scheduling constraints, particularly related to school and after-school activities, language barriers, preferences for in-person treatment, requests for a new provider and provider network limitations, among others. The Behavioral Health Department is trained and committed to connecting members and their families to services that align with their preferences.

Figure 13: 2024 Behavioral Health Case Closure Reasons



As previously noted, Figure 13 illustrates that over 50% of case closures are attributed to completion-related reasons, including CDE assessments (9%), FBA assessments (15%), program completion (1%), and completed Behavioral Health (BH) cases (29%). Ongoing challenges persist regarding the inability to contact members for various reasons, such as unsuccessful contact member (21%), despite following department protocols and sending letters. Should the member initiate contact, a new case will be created to provide continued support with their request and/or treatment plan.

In Addition to the treatment plan with the mental health treatment modalities recommendations. The Mental Health provider also provided information about the member’s Primary Care Physician and the pharmacy information including all the medications the member has received from prescribers. The Mental Health provider is also able to include a message to the Primary Care Physician and make referrals to other mental health providers and to Alameda County Behavioral Health for specialty mental health services. This new mental health treatment report will help the Alliance connect mental health providers with co-treating providers and Primary Care Physicians to establish coordinated care that integrates behavioral and physical health care.

Disease Management

The Alliance Disease Management (DM) program is an Alliance Case Management and Health Education collaboration. Disease Management provides interventions for members with targeted chronic conditions. Interventions include case management for higher risk members and health coaching, care coordination and condition self-management education for lower risk members. The Alliance Population Health

Assessment identified asthma for children and adults, and diabetes, hypertension, and perinatal depression for adults as priority diagnoses affecting the Alliance membership at a disproportionate rate and/or with significant utilization. The Alliance Disease Management program collaborates with community partners, such as Alameda County Public Health's Asthma Start Program for children with asthma, and hospital-based Diabetes Self-Management Training (DSMT) programs to provide services for members with diabetes.

Figure 15a. Members Outreached to for Disease Management Services

Disease Management Program	Members Outreached
Asthma	6,662
Diabetes	5,595
Hypertension	2,196
Perinatal Depression	6,802

Figure 15b: Members Served for Disease Management Services

Disease Management Services	Members Served
Asthma Start - Child care-management, health education and asthma remediation	131
Health Coaching	58
Diabetes - Diabetes Self-Management Training (DSMT)	889

Basic Population Health Management (including Care Coordination for Medical and Behavioral Health Services and Disease Management) – Recommended Actions in 2025:

- Increase engagement in care coordination for medical services by continuing efforts to find alternative contact information for members through Electronic Health Records (EHR), PCP clinics, and Community Health Record (CHR)
- Work with Healthcare Analytics department to further enhance population analysis and program interventions to evaluate program efficacy
- Work with IT department to identify additional opportunities to automate processes administrative CM processes
- Identify populations experiencing disparities and conduct targeted outreach to increase disease management service utilization. Utilize community health workers (CHWs) to connect priority populations to disease management services
- Further solidification of case coordination processes for behavioral health services to increase efficiency and uniformity of practice
- Further collaboration with Alameda County Behavioral Health to ensure member's needs are met across systems of care
- Further collaboration with Alameda County Office of Education to coordinate school-based services
- Initiate bi-directional coordination of care between physical health and mental health

providers, including deployment of PCP referral to Mental Health Web Form, enabling PCPs to communicate more completely the needs of the members they refer for mental health services that can be passed on to the Mental Health Provider to enhance their evaluation

- Behavioral Health Treatment/Applied Behavioral Health Treatment plan deployed on the Alliance Provider Portal to enable Autism Service Providers to submit their assessments and treatment plans securely, that can then be shared with referring pediatricians and PCPS.
- Continued identification of data sharing pathways between PCPs and Behavioral Health Practitioners
- Increase member engagement into Alliance Disease Management programs through member mail and call campaigns and provider education

Care Management Programs: Complex Case Management (CCM)

Complex Case Management (CCM) is an opt-in program, provided to members who consent to participate. It is a collaborative process between the Primary and/or Specialty Care Providers, member, and Care Manager; and the Care Manager's role is to support the member with person-centered planning, coordinating, and monitoring options and services to meet the member's health care goals.

Members meeting criteria for CCM may have conditions in which the degree and complexity of illness or conditions is severe, the level of management necessary is intensive, and the number of resources required for member to regain optimal health or improved functionality is extensive. Eligibility criteria are subject to change, based on findings from the population needs assessment and/or community and stakeholder committees, but typically support Members with at least one of the following clinical features:

- Complex diagnoses such as End-Stage Renal Disease (ESRD), Chronic Heart Failure (CHF), and Chronic Obstructive Pulmonary Disease (COPD)
- High risk scores
- Multiple comorbidities
- Multiple Emergency Department (ED) visits in a year
- Multiple hospitalizations in a year

A clinician (CM nurse or social worker) may deem a member eligible for CCM if they feel a member could benefit from CCM services. The Alliance also employed proactive strategies to identify members meeting criteria for CCM.

Predictive Model Application

The Alliance uses a predictive model application, CareAnalyzer, to aggregate utilization data (including behavioral health and pharmacy data) to identify members who may be at risk and could benefit from CM interventions. CareAnalyzer's unique analytic approach stems from the integration of The Johns Hopkins University Adjusted Clinical Group (ACG) System, a comprehensive set of predictive modeling tools based on series of mutually exclusive, health status categories defined by morbidity, age, and sex. ACGs offer a person-

focused method of categorizing patients’ illnesses; over time, each person develops numerous conditions, and based on the pattern of these morbidities, the ACG approach assigns each individual to a single ACG category. The Johns Hopkins Resource Utilization Bands (RUBs) were added to the data sets to improve the sensitivity and specificity of the member data. In addition, the tool was enhanced to capture the Relative Risk Score (RRS) to apply predictability to the data. The enhancement identifies current and predictive changes based on utilization data.

Population Health Report

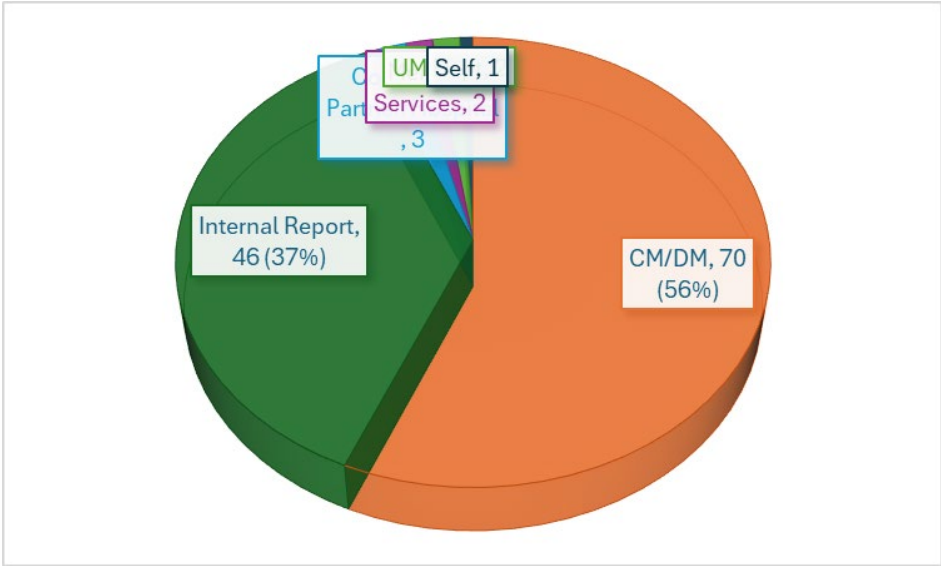
CM also worked with Healthcare Analytics to develop a Population Health Report based on claims, utilization data and the predictive modeling application, CareAnalyzer. Members identified on the report were contacted and offered CCM services.

Referral Sources, Case Volumes & Outcomes

The CM Department monitors CCM referral sources, case volumes and outcomes, and staff operational metrics to assess the effectiveness of the program, as well as, to identify patterns for potential program and process improvements.

The below chart shows members referred to Complex Case Management, categorized by referral source.

Figure 16. 2024 Complex Case Management – Referrals by Source

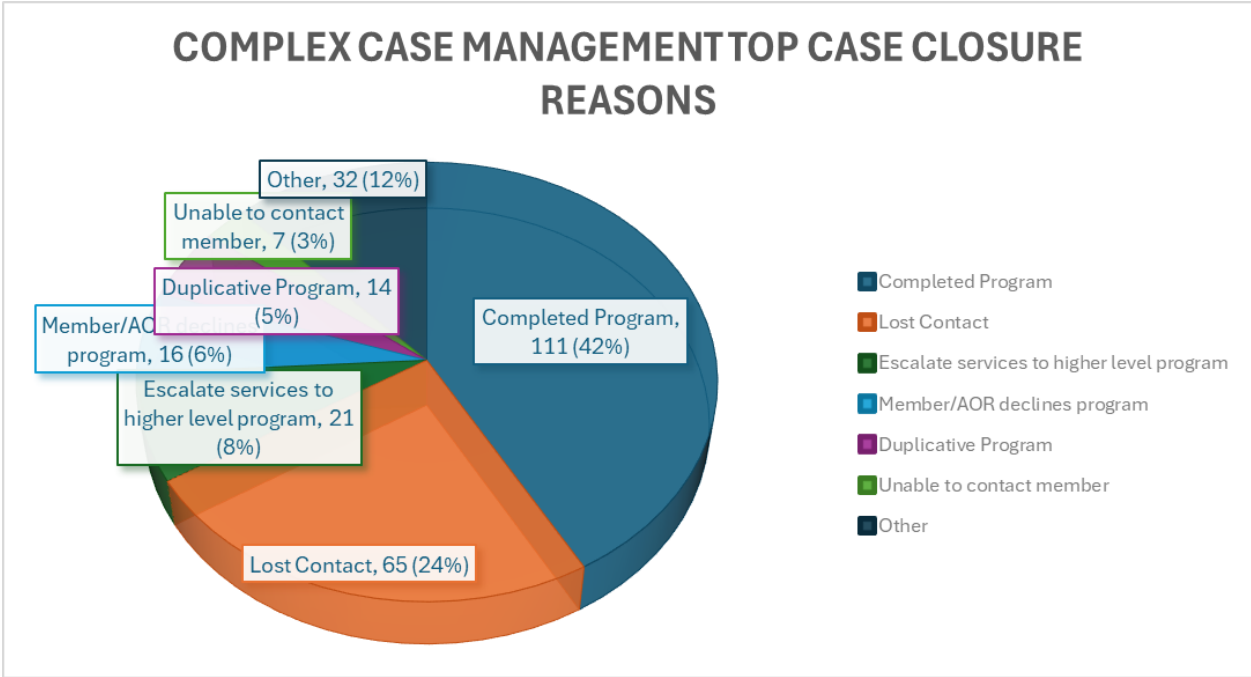


Referrals into CCM decreased from 352 referrals in 2023 to 216 referrals in 2024. This may be attributed to an increase in Transitional Care Services which became a new DHCS requirement for all members starting 1/1/24. For 2024, the top three referral sources were CM/DM (56%), Internal Report (37%), and Community Partner/Hospital (2%).

Some cases managed as care coordination may have indicators for CCM, but cannot be enrolled in CCM until the member consents. After member consent is received, a referral is made to enroll

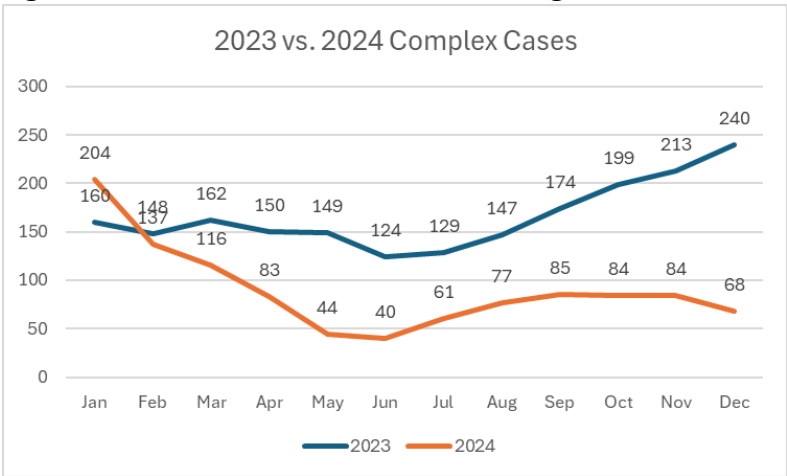
in Complex Case Management. In 2024, CM continued to monitor CCM productivity standard for CCM RNs, providing coaching sessions to practice motivational interviewing skills to increase consent from members to participate in CCM. Another factor may be members electing to go with higher level ECM program (if eligible) which offers in-person case management options.

Figure 17. Complex Case Management Program by Closure Reason



Of the total CCM referrals in 2024, 42% of members completed the program and 24% lost contact with staff. The other 34% of cases were closed for reasons including (but not limited to): escalating to a high level of care, the member was already enrolled in a more intensive case management program such as ECM, or the member/AOR declined the program.

Figure 18. 2023 vs. 2024 CCM New/In Progress Cases



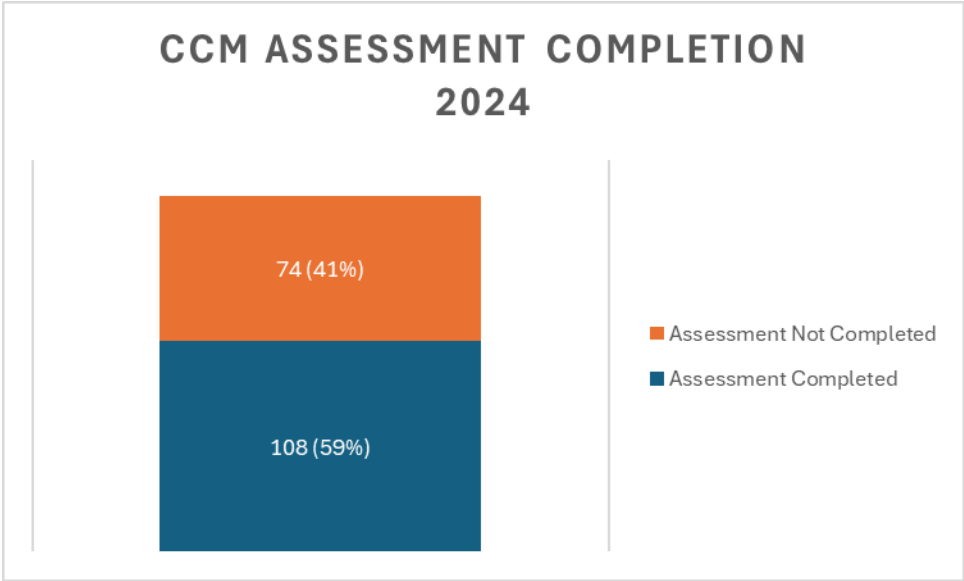
In 2024, there was a monthly average of 70 new/in progress CCM cases. This was a decrease of 59 cases per month, compared to the monthly average of 129 new/in progress CCM cases in

2023.

One potential factor for decrease in CCM cases in 2024 is the CM team has shifted resources to completing the increased volume of regulatory required TCS cases, limiting staff and resources available to dedicate to increase opt-in and engagement from members regarding CCM. Another factor is that eligible members may be opting for ECM which is a higher level care management program with in-person options.

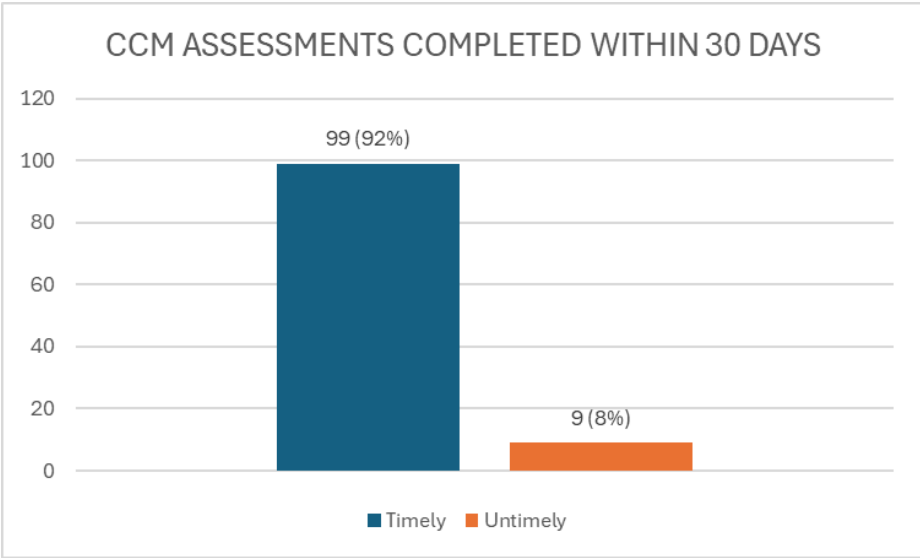
To evaluate the effectiveness and quality of CCM interventions, CCM assessment and Interdisciplinary Care Team presentations were evaluated for outcomes and completion timeliness. Case closures outcomes and staff operational metrics were also evaluated.

Figure 19a. 2024 Assessment Outcomes for Complex Cases



In 2024, 59% of CCM assessments were completed, compared to 70% in 2023. Reasons assessments might not be completed include losing contact with member before assessment completion or member transferring to a higher level of care (such as ECM).

Figure 19b. 2024 Assessment Completion Timeliness



In 2024, a total of 108 assessments were completed. This was a decrease from 272 total completed assessments in 2023. Out of the 108 completed assessments, 99 (or 92% total) were completed within 30 days, almost meeting the timeliness goal at 95.0%. Assessments that were not completed within 30 days were due to care coordination needs taking priority to the completion of the assessment, and/or difficulty re-engaging the member.

Complex Cases Open >90 days

An essential component of CCM is involvement of the Interdisciplinary Care Team (IDT). Members’ cases are presented to the IDT at IDT Rounds to elicit insight from multiple disciplines, ensuring comprehensive problem-solving to achieve the most optimal health outcomes. IDT Rounds are held bi-weekly and using the Daily Aging Report. So that staff meet the deadline to present a case at IDT Rounds by the 90th day the case is open, staff are notified of cases that are open at the 60-day mark, ensuring the case is ready to be presented before the 90th day deadline. The timeliness of case managers presenting cases during IDT Rounds was evaluated, pulling data from all cases that had been open for 90 days or more.

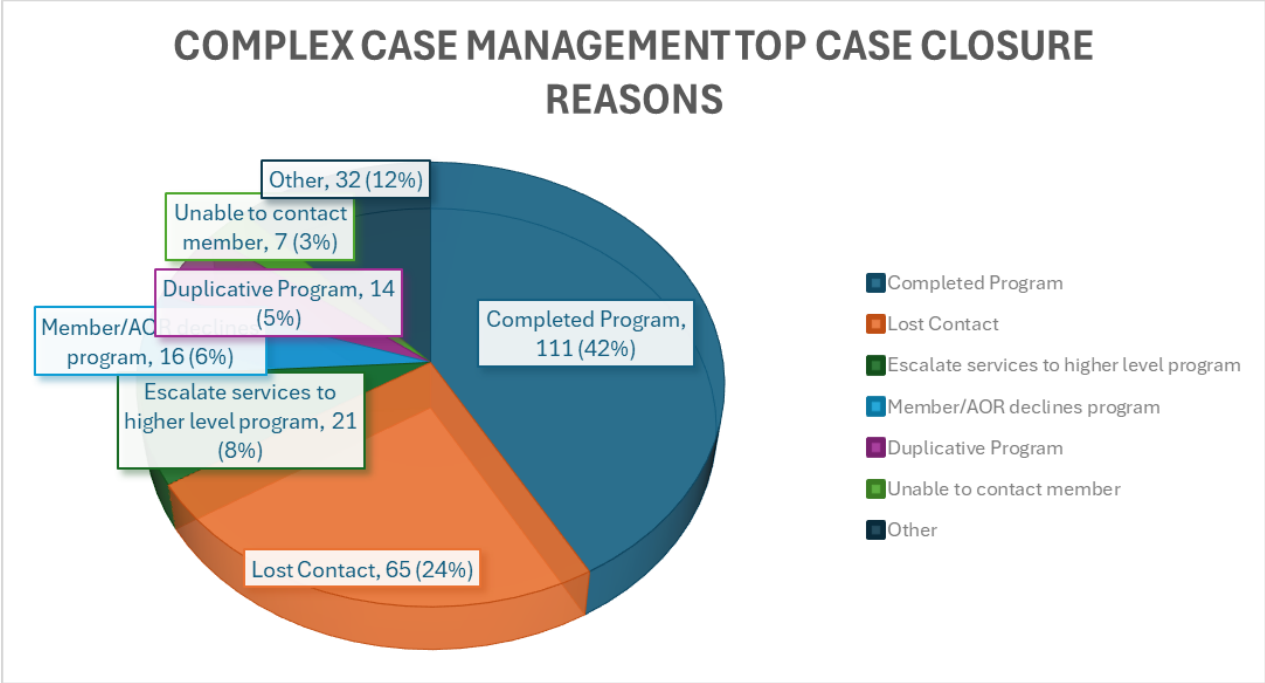
Figure 20: 2024 Results for IDT Rounds

Complex Cases ≥ 90days	Outcome of IDT	% of Timely IDT based on Report
0	No IDT	0%
6	Timely	100%
0	Untimely	0%

In 2024, 6 CCM cases were identified to be open for at least 90 days, and 100% of cases were presented at IDT meetings within 90 days of the case being opened.

Upon completion of care plan goals, including addressing all barriers, case closure is discussed with members to ensure they feel prepared to self-manage their health. The below figure shows CCM case closure reasons.

Figure 21. 2024 Complex Case Management Case Closures by Reason



In 2024, the top three reasons for case closure were Completed Program (111 cases), Lost Contact (65 cases), and Escalate services to a higher level program (21 cases). There was an increase in CCM cases with a case closure reason of “Completed Program”, 42% in 2024, up from 38% in 2023. Lost contact case closure reason continues to be addressed via multiple telephone attempts and sending member a “Lost Contact” Letter.

Performance Measures

The Alliance maintains operational performance measures for the complex case management program to maximize member health, wellness, safety, satisfaction, and cost efficiency while ensuring quality care. The Alliance selects measures that have significant and demonstrable bearing on the entire complex case management population or a defined subpopulation. The Alliance annually measures the effectiveness of its complex case management program based on the following performance goals and corresponding measures:

Figure 22. 2024 CM Performance Measures

	Goal	Measure	Measurement	Performance Goal	2024 Rate	Goal Met?
#1	Achieve and maintain high level of satisfaction with CM services.	Member Satisfaction Rates	High level of satisfaction with CM services. Score of 7 or higher on question 8 of CM Satisfaction Survey.	90%	95%	Yes

#2	Improve member outcomes	All-Cause readmission Rate	Readmission rates for all causes for members in CCM with admission within 6 months of enrollment in CCM	<i>Goal retired.</i>		N/A
#3	Improve member outcomes	Emergency Room Visit Rate	ER rates for members enrolled in CCM	<i>Goal retired.</i>		N/A
#4	Achieve optimal member functioning.	Health Status	% of members in CCM responding that their health status improved because of CCM. Score of 7 or higher on question 6 of CM Satisfaction Survey.	90%	85%	No

For 2024, CM continued to achieve the goal of achieving and maintaining high level of satisfaction with CM services at 95%. Also, 85% of members in CCM responded that their health status had improved because of CCM. This shows an opportunity to remind CCM nurses to ensure member has no outstanding health status questions before a CCM case is closed and to set realistic expectations on how much and how quickly a health status can improve through participation in complex case management.

In summary, for 2024, the following strategies resulted in an increased volume of members engaged in CCM and increased identification of members for the program:

- Continued review and revisions of the Population Health Report and the CM Daily Aging Report
- Department trainings to improve consistency in member outreach, improving the staff process to offer services to members and streamlining documentation in the electronic system of record.
- Continued collaborative efforts with hospital partners to identify eligible members, including implementing alternatives to member outreach
- Continued review of productivity standard with a goal of increasing outreach to members who may be eligible for CCM.
- Staff identifying members they are already working at a lower level of care for CCM through increased training for staff on proper identification
- Motivational interviewing of members to assist staff gaining more information that could qualify member for CCM and to assist in increasing member consent into CCM program

Complex Case Management - Recommended Actions for 2025:

- Continue to identify, implement, and evaluate different avenues to continue to increase member engagement.
- Continue SMART goal for:
 - Collaborative efforts with partnered hospitals
 - Productivity standard of Complex member outreach and engagement
 - Obtaining accurate member contact information.
 - Continue the use of the CHR and PCP for alternate phone numbers for member engagement

Care Management Programs: Enhanced Care Management (ECM)

ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of Members with the most complex medical and social needs. ECM provides systematic coordination of services and comprehensive care management that is community based, interdisciplinary, high touch and person centered. ECM coordinates all care for Members who receive it, including across the physical and behavioral health delivery systems. ECM offers comprehensive, whole person care management to high-need, high-cost Medi-Cal Managed Care Members, with the overarching goals of:

- Improving care coordination;
- Integrating services;
- Facilitating community resources;
- Addressing social determinants of health (SDOH);
- Improving health outcomes; and
- Decreasing inappropriate utilization and duplication of services.

The ECM program has evolved since its transition from the Health Homes Program (in 2021).

- In January 2022, The Alliance successfully launched ECM for homeless, high utilizer, and Serious Mental Health (SMI)/Substance Use Disorder (SUD) populations of focus.
- In September 1, 2022, Alameda County Behavioral Health (ACBH) became an ECM Provider.
- In January 2023, the Alliance launched programs to support two new ECM populations of focus (Adults Living in the Community at Risk for Institutionalization & Adult Nursing Facility Residents Transitioning to the Community).
- In July 2023, after DHCS re-structured ECM to further breakdown eligibility criteria for children and youth, The Alliance onboarded ECM providers to specifically support the children and youth populations.
- In January 2024, Justice Involved (post-release) and Birth Equity Populations of Focus went live.

Enrollment Data

As of 12/31/2024, the ECM program had served 3,383 members at the 39 ECM sites in Alameda County. The table below shows the number of members served in each Population of Focus.

Figure 23a. 2024 ECM Populations of Focus Enrollment

ECM Populations of Focus		Adults	Children & Youth
1	Individuals Experiencing Homelessness	700	491
2	Individuals At Risk for Avoidable Hospital or ED Utilization (Formerly “High Utilizers”)	795	322
3	Individuals with Serious Mental Health and/or SUD Needs	245	213
4	Adults Living in the Community and At Risk for LTC Institutionalization	380	
5	Adult Nursing Facility Residents Transitioning to the Community	12	
6	Children and Youth Enrolled in California Children’s Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition		86
7	Children and Youth Involved in Child Welfare		94
TOTAL		2132	1206
COMBINED TOTAL		3338	

Figure 23b. ECM Populations of Focus – Implementation Dates

ECM Populations of Focus		Adults	Children & Youth
1a	Individuals Experiencing Homelessness: Adults without Dependent Children/Youth Living with Them Experience Homelessness	✓	
1b	Individuals Experience Homelessness: Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness	✓	✓
2	Individuals At Risk for Avoidable Hospital or ED Utilization (Formerly “High Utilizers”)	✓	✓
3	Individuals with Serious Mental Health and/or SUD Needs	✓	✓
4	Individuals Transitioning from Incarceration	Go-Live January 1, 2024	
5	Adults Living in the Community and At Risk for LTC Institutionalization	✓	
6	Adult Nursing Facility Residents Transitioning to the Community	✓	
7	Children and Youth Enrolled in California Children’s Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition		✓
8	Children and Youth Involved in Child Welfare		✓
9	Birth Equity Population of Focus	Go-Live January 1, 2024	

In 2024, the Clinical Manager of ECM has leaned in to assist with process improvements, restructuring and engaging every ECM provider in regular meetings. With the current staff of five (5) Health Navigators, four (4) registered nurses and the CM Medical Director, the team is renewing collaboration and further developing relationships with the ECM providers to understand their capacity to support additional members. ECM program graduation will be a continued focus area in 2025, providing additional insight/education to providers on various programs (lower levels of case management services, Community Supports services, etc.) and working towards increasing enrollment (and graduation) of members enrolled in ECM.

Enhanced Care Management - Recommended Actions for 2025:

- Continue to develop, train, and maintain the ECM Provider network, in preparation for further expansion to support all ECM populations of focus.
- Provide consistent/routine monthly in-person and virtual provider audits and respective in-services to ensure ECM compliance and optimal use of ECM benefits.
- Work closely with ECM providers in monthly IDT meetings to provide guidance with the ECM graduation process.

Care Management Programs: Targeted Case Management (TCM)

Targeted Case Management is provided to members by Local Governmental Agencies (LGAs). The Alliance facilitates access to TCM for eligible members by ensuring referrals are appropriately made to the LGAs, so they can evaluate members for TCM services. Alliance staff follow preset guidelines and collaborate with primary care providers when necessary to identify members eligible for TCM services.

Members eligible for TCM services have generally been identified as moderate or high risk. Once a member is identified and referred to an LGA for potential TCM, they are assigned to an Alliance Case Manager, who ensures screening, referrals, care planning, and all other care coordination activities are coordinated between the member, their providers, the LGA, and The Alliance. Data exchange occurs between the Alliance and the various TCM LGAs, to ensure non-duplication of services. Collaboration with the LGA also ensures members who are no longer eligible for TCM are appropriately linked with alternate resources to support any ongoing health needs. In 2025, the Alliance will commence joint operational meetings (JOM) between the Plan and LGA's based contractual Memorandums of Understanding (MOU). These JOMs will include discussion on Targeted Case Management collaboration.

Transitional Care Services

The Alliance's Transitions of Care (TOC) Program has evolved since its inception in 2019. The TOC care model had always provided support to members at hospital discharge, using any individual or combination of the Case Management disciplines: Nurse Case Managers, Social Workers or non-clinical staff, Health Navigators. In 2022, the Alliance redesigned the TOC care model to align with DHCS' Transitional Care Services (TCS), as described in the Population Health Management Policy guide.

In January 2024, The Alliance implemented TCS for all members of all risk stratifications, transitioning from one setting or level of care to another. These transitions include, but are not limited to: discharges from hospitals, institutions, other acute care facilities, and skilled nursing facilities (SNFs) to home- or community-based settings, Community Supports placements (including Sobering Centers, Recuperative Care and Short-Term Post Hospitalization), post-acute care facilities, or long-term care (LTC) settings. The Alliance has established partnerships with hospitals and network providers, like Alameda Health Systems (AHS), to effectively implement TCS, ensuring members have access to supports across the continuum from admission to discharge.

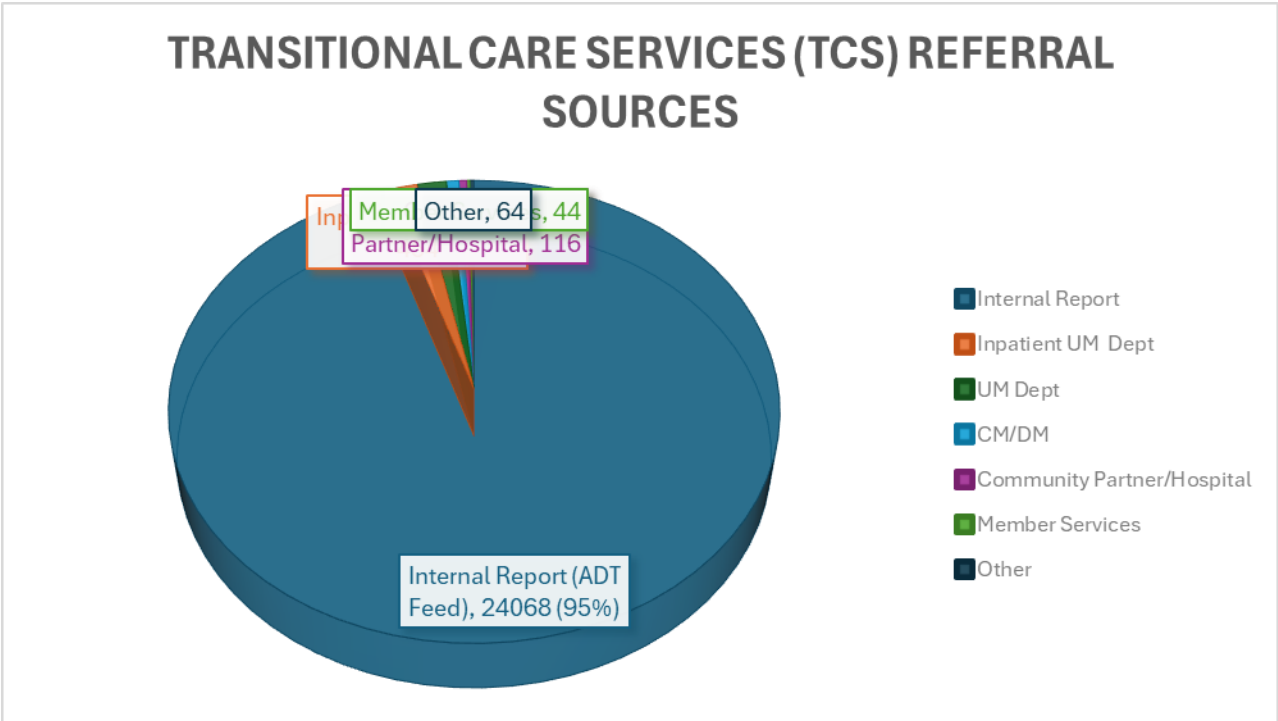
In January 2024, the Alliance expanded Transitional Care Services from high risk to all members, regardless of risk stratification.

The Alliance delegates TCS to CHCN for members assigned to the CHCN network – these members are supported via CHCN’s Care Transitions Registered Nurse (CTRN) program. The CM team provides oversight and monitoring of the delegated TCS activities to ensure compliance with all DHCS requirements.

Referral Sources, Case Volumes & Outcomes

The below data represents TCS outcomes in 2024, including referral sources, case volumes, and case closure reasons.

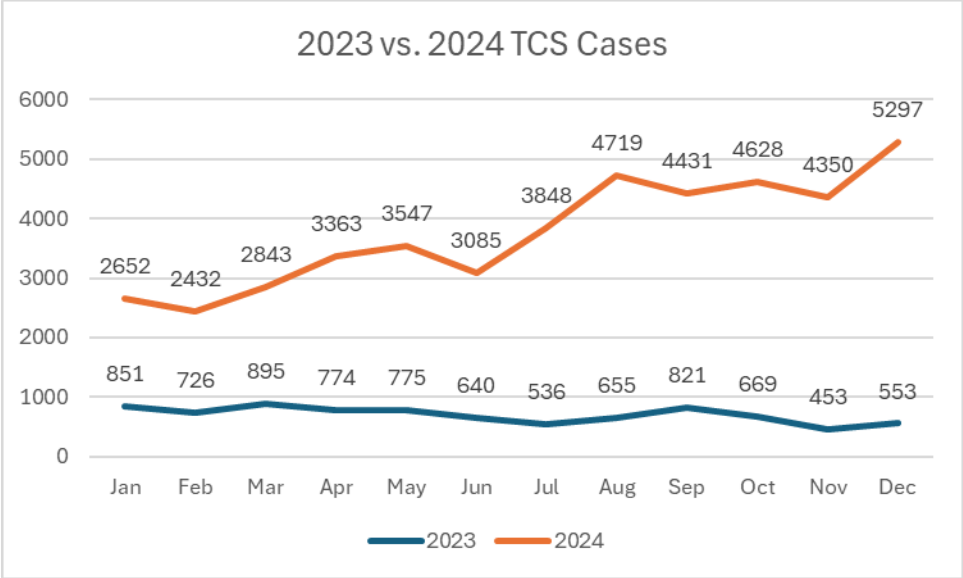
Figure 24. 2024 Transitional Care Services Referral Sources



In 2024, the top referral source into the TCS Case Management program was Internal Report, making up 95% of all referrals into TCS (24,068; up from 2,147 referrals in 2023).

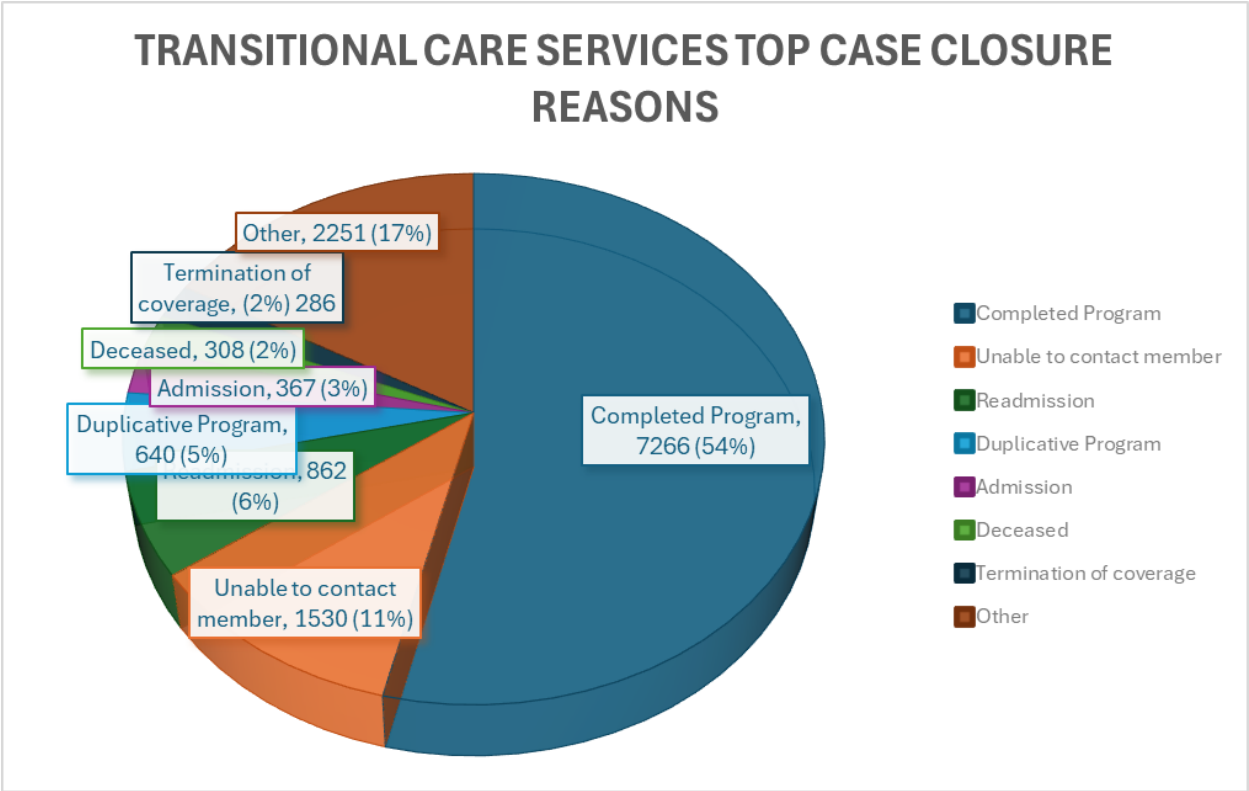
The Internal Report refer to the Admissions, Discharges, and Transfers (ADT) Feed, in which referrals are created automatically via ADT data received from hospitals and Skilled Nursinf Facilities who have agreed to provide ADT data. The significant increase in TCS referrals is due to implementation of the DHCS PHM requirement that all members received TCS case management.

Figure 25. 2023 vs. 2024 Transitional Care Services New/In Progress Cases



In 2024, there was a monthly average of 3,766 new/in progress TCS cases. This was a year-over-year increase of 3,070 cases per month, compared to the monthly average of 696 new/in progress TCS cases in 2023. The increase from 2023 to 2024 was due to new requirements from DHCS beginning in 2024, including that TCS in 2024 was required for all members of all risk stratification levels.

Figure 26. 2024 Transitional Care Services Case Closures By Reason



In 2024, the top) reasons for TCS Case Closure were Completed Program (7,266 cases),

Unable to Contact Member (1,530 cases), and other reasons such as readmission, duplicative program, or new admission.

The number of members who completed TCS increased year-over-year to 7,266 cases, compared to 923 cases in 2023.

Transitional Care Services - Recommended Actions for 2025:

- Continued efforts to improve member engagement rate will continue in 2025 via finding alternate phone numbers through CHR, and PCP office.
- Increased partnerships with hospital systems.
- Increased partnerships with PCP offices in collaborating on TCS, particularly postdischarge appointments.
- Increased focused on specific TCS populations such as OB and FFS Medicare Part A members.
- Explore leveraging Community Health Worker (CHW) benefit to collaborate on TCS work.
- Collaborate with Quality departments and other departments to address readmissions and ER utilization.

Specialized Services

Continuity of Care

The CM Department collaborates with the UM Department and Member Services on facilitating members' timely access to care and any appropriate continuity of care. CM is responsible assisting members who are redirected to In-Network Providers after their continuity of care period ends and assisting members whose initial request did not qualify for continuity of care. Continuity of Care referrals are sent to CM via direct referrals from UM and Member Services. The UM department also identifies and refers members to CM who have exhausted a benefit, who are aging out of a benefit (i.e., California Children Services), or have needs beyond those provided by partner agencies. CM supports these members with access to alternate resources.

In Q4 2024, the Alliance worked with DHCS and other managed care plans to prepare for the transition of about 2,700 members into The Alliance, due to the carve in for the Foster Care Youth population. The Alliance effectively executed the specialized Continuity of Care requirements for this transitioning population, proactively outreaching to providers and members, when appropriate.

Community Supports

Community Supports (CS) services were initiated as part of CalAIM and include a variety of

services not typically covered by managed care plans. These services were intended to provide additional cost-effective support to members in lieu of higher-level services. In 2024, the Alliance provided eleven (11) CS Services:

- Housing Navigation
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Recuperative Care (Medical Respite)
- Medically Tailored Meals/Medically Supportive Food
- Asthma Remediation (for children under 19 years of age)
- Environmental Accessibility Adaptations (Home Modifications)
- Nursing Facility Transition/Diversion to Assisted Living Facilities
- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care & Homemaker Services
- (Caregiver) Respite Services

The below table shows the number of members receiving Community Supports in 2024.

Figure 27. Number of Members Receiving Community Support Services

CS Service Type	CS Providers	Members Served	Number of Authorizations
Housing Deposits	Healthcare Service Agency (HCSA)	5571	574
	East Bay Innovation (EBI)	19	19
	Lesar Development Consultants	3	3
Housing Tenancy and Sustaining Services	Healthcare Service Agency (HCSA)	1941 972	1971950
	East Bay Innovation (EBI)	3	3
	MedZed Physician Services	5	5
Housing Transition/Navigation Services	Healthcare Service Agency (HCSA)	1715	1692
	East Bay Innovation	20	20
	MedZed Physician Services	23	23
Medically-Supportive	Project Open	1259	11242

Food/Medically Tailored Meals	Healthcare Service Agency (HCSA) - Recipe 4 Health	2174	2085
	Community Food Bank	56	57
Asthma Remediation	Health Care Service Agency (HCSA) - Asthma Start	179	180
	Roots Community Health Center	30	30
Community Transition Services/Nursing Facility Transition to a Home	East Bay Innovation (EBI)	24	24
Environmental Accessibility Adaptations	East Bay Innovation (EBI)	14	14
Nursing Facility Transition/Diversion to Assisted Living Facilities	East Bay Innovation (EBI)	4046	447
Personal Care/Homemaker Services	24 Hour Home Care	488	503
	Omatochi Corp	43	43
Recuperative Care/Medical Respite	Cardea Health	199	212
	Adeline Lifelong	74	776
	Bay Area Community Services (BACS)	40	40
Respite Services	24 Hour Home Care	18	18

The Alliance continued to work with the current providers of the current services.. The CS team meets regularly with all CS providers, discussing utilization, member support/cases and building rapport with the CS provider network. Oversight and monitoring continues with the providers who had been contracted with the Alliance for 12 months (or more).

Community Supports - Recommended Actions for 2025:

- Increase staff where appropriate to better meet needs of members and providers.
- Continue relationships with the providers to assist them where needed. Continue to work with

Analytics to further enhance the dashboard for CS services

- Continue development of accurate and reliable closed loop referral process with Community Supports providers, in alignment with the DHCS requirement by July 1, 2025; establish mechanism for CS providers to confirm members are being serviced after authorizations have been issued
- Implement the new guidance into existing criteria from the Community Supports Policy Guide from Feb 2025
- Provide training to all CS providers to promote best practices while working with our members and to continue to build rapport with CS providers

Transportation

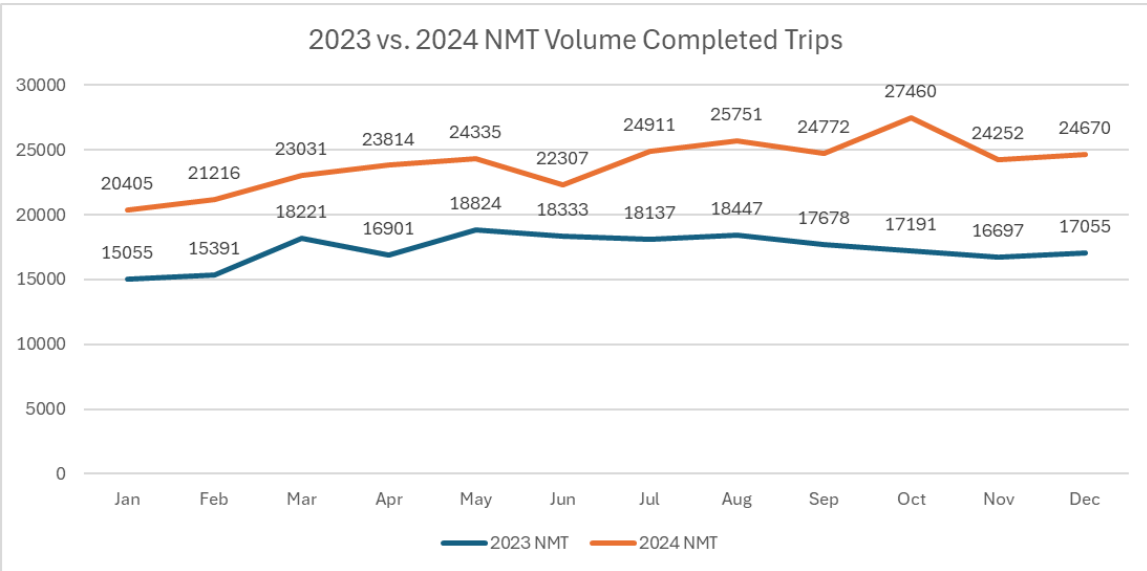
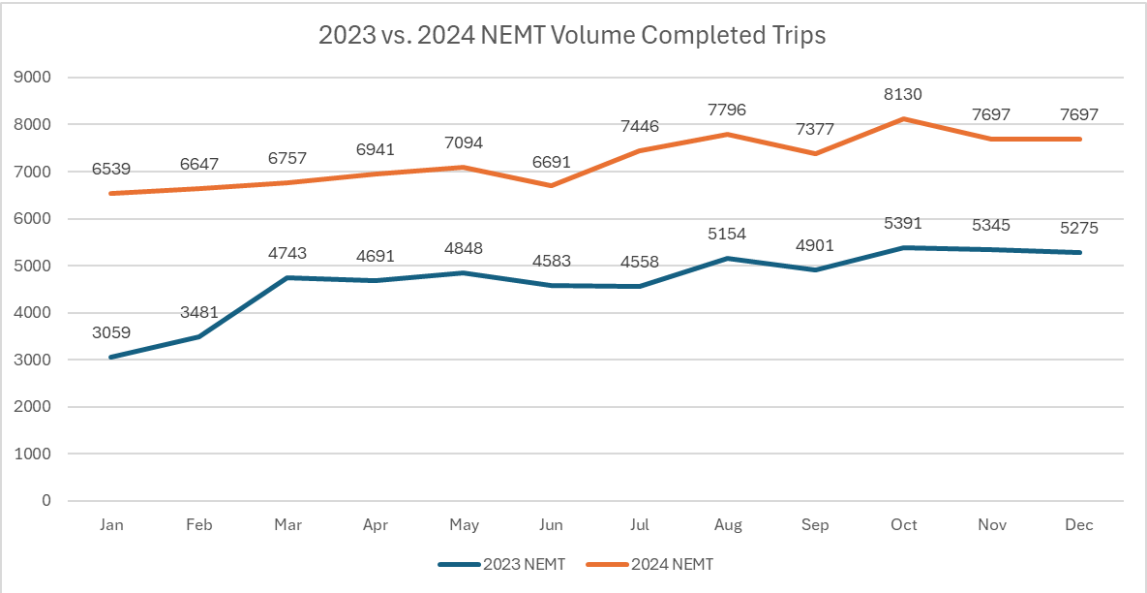
Ensuring access to adequate and timely transportation to medical appointments is an essential care management intervention to address this social determinant of health barrier. In 2024, the Alliance’s dedicated CM Transportation staff continued to provide oversight and management of the Transportation benefit. Transportation Coordinators continued to assume responsibility for obtaining completed Physician Certification Statement (PCS) forms prior to Non-Emergency Medical Transportation (NEMT) being scheduled. CM Leadership continued to collaborate with the vendor management department to ensure that Transportation processes aligned with the requirements of APL 22-008 for Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT).

Additionally, the Alliance continued to monitor the performance of its transportation subcontractor, ModivCare, in the provision of the Transportation benefit by conducting weekly joint operational meetings, quarterly joint operational meetings (JOM), weekly grievances meetings, weekly potential quality issue (PQI) meetings, and other ad-hoc meetings as needed. The below figures show ModivCare’s key performance indicators.

Figure 28. ModivCare Key Performance Indicators

	Description	1st QTR Total	1st QTR Average	% of Total	2nd QTR Total	2nd QTR Average	% of Total	3rd QTR Total	3rd QTR Average	% of Total	4th QTR Total	4th QTR Average	% of Total	YTD	YTD Totals
Members	Members Served		3,716		4,037			4,459			4,770			4,245	4,245
	Enrollment		399,794		402,418			403,287			402,874				
Utilization	Gross Reservations	132,349	44,116	100.0%	143,463	47,821	100.0%	147,580	49,193	100.0%	160,166	53,389	100.0%	583,558	583,558
	Cancellations	47,754	15,918	36.1%	52,281	17,427	36.4%	49,527	16,509	33.6%	60,260	20,087	37.6%	36.0%	209,822
	Completed Trips	84,595	28,198	63.9%	91,182	30,394	63.6%	98,053	32,684	66.4%	99,906	33,302	62.4%	373,736	373,736
	Utilization Rate		7.1%		7.6%			8.1%			8.3%			7.75%	
Trip Mode	Ambulatory (NMT)	63,367	21,122	74.9%	69,285	23,095	76.0%	74,237	24,746	75.7%	75,066	25,022	75.1%	75.4%	281,955
	Wheelchair (NEMT)	14,454	4,818	17.1%	15,252	5,084	16.7%	16,493	5,498	16.8%	16,652	5,551	16.7%	16.8%	62,851
	Advance Life Support (NEMT)	3	1	0.0%	10	3	0.0%	18	6	0.0%	22	7	0.0%	0.0%	53
	Stretcher (NEMT)	4,776	1,592	5.6%	4,762	1,587	5.2%	5,174	1,725	5.3%	5,741	1,914	5.7%	5.5%	20,453
	Basic Life Support (NEMT)	656	219	0.8%	656	219	0.7%	885	295	0.9%	1,057	352	1.1%	0.9%	3,254
	Specialty Care Transport (NEMT)	52	17	0.1%	46	15	0.1%	49	16	0.0%	52	17	0.1%	0.1%	199
	Fixed Wing (NEMT)	2	1	0.0%	-	-	0.0%	-	-	0.0%	-	-	0.0%	0.0%	-
	Mass Transit (NMT)	1,285	428	1.5%	1,171	390	1.3%	1,197	399	1.2%	1,316	439	1.3%	1.3%	4,969

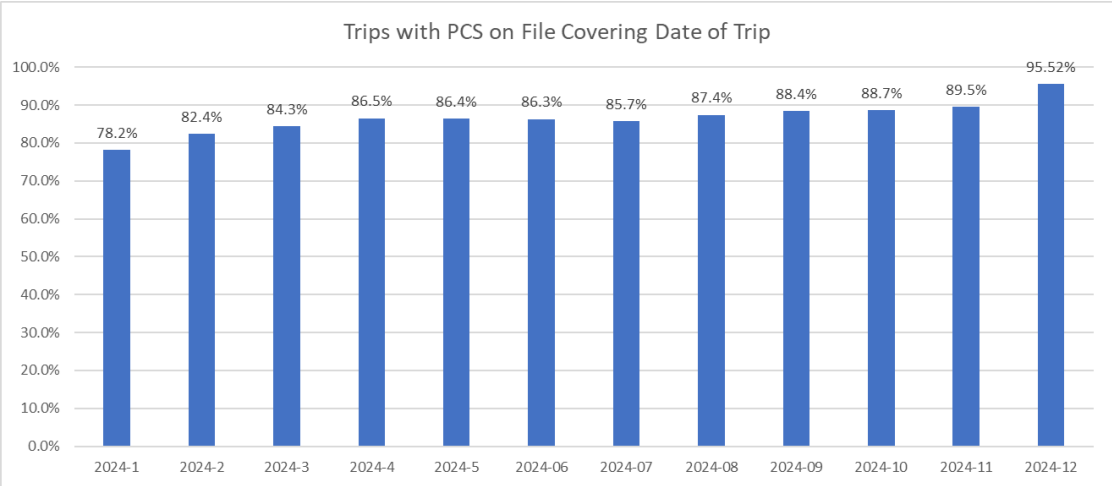
Figure 29. Total NMT vs. NEMT Completed Trip Volume



In 2024, ModivCare scheduled a monthly average of 7,234 NEMT trips and 23,910 NMT trips. Around 8% of Alliance members utilized the transportation benefit in 2024, compared to 6% of members in 2023. The top reason for transportation continuing to be transport to dialysis for members with End Stage Renal Disease.

The Case Management Leadership team and Case Management Transportation team continue to collaborate with the Vendor Management department and the subcontractor ModivCare to ensure increased oversight of transportation subcontractors and quality improvement for members. The Transportation Liaison is a role currently undertaken by the Manager, Case Manager. The Transportation liaison, along with vendor management staff, conduct quarterly onsite audits of subcontractor drivers in the field ensuring correct level of service is provided, including door to door assistance for ambulatory door-to-door trips and all NEMT trips.

Figure 30. NEMT trips with PCS on file



In 2024, the Alliance continued successful compliance rate of around 86% for the Physician Certification Statement (PCS) forms required for NEMT levels of transportation service. Transportation Coordinators leverage CM Department relationships with PCP offices, specialists, and dialysis centers to ensure timely completion of PCS forms. The Alliance ensures PCS data is shared with subcontractor for timely trip reservations.

Coordination with Compliance Department

The Alliance CM Department works closely with the Compliance Department to prepare for regulatory audits. In June 2024, the department participated in DHCS’ annual audit. There were no findings related to the care management program. Also in 2024, the CM Department continued working closely with the Vendor Management Department to resolve the 2023 DHCS Focused Audit Corrective Action Plan (CAP) regarding findings around the PCS Form, ensuring door to door assistance by transportation providers, and the role of the transportation liaison.

To maintain the integrity of The Alliance’s CM processes, ongoing auditing and monitoring of key operational functions will continue, ensuring compliance with all federal, state, regulatory, contractual and accreditation standards.

Member Satisfaction with the CM Process

Annually, CM evaluates member experience with the CCM Program by obtaining member feedback with the use of satisfaction surveys and continuous monitoring of member complaints. The information obtained assists The Alliance in measuring how well the complex case management program is meeting members’ expectations and identifying areas for improvement.

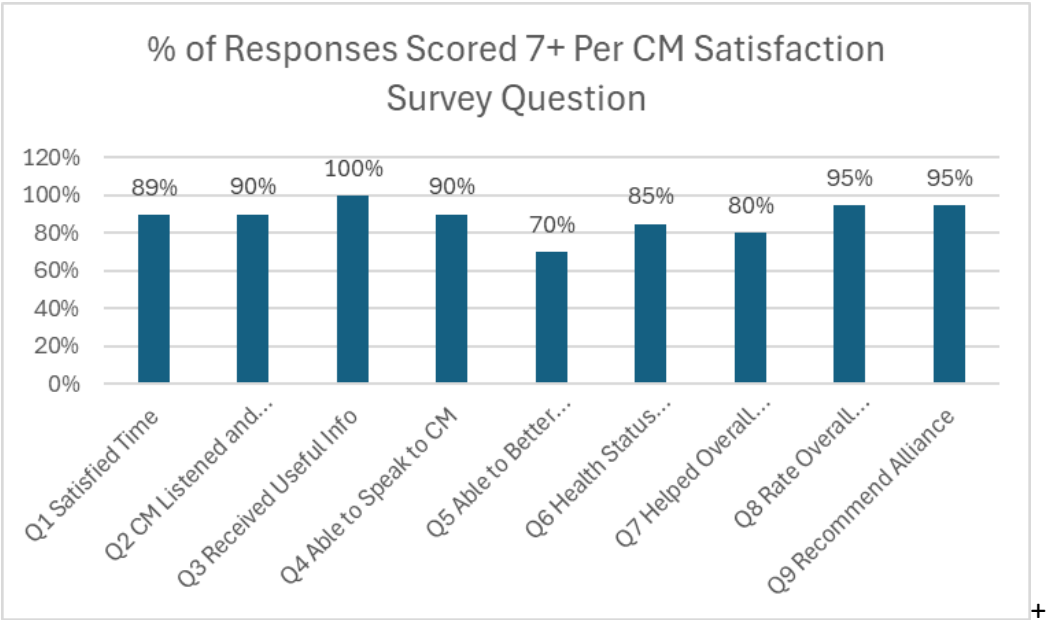
The Alliance’s goal is to obtain a 90% with every aspect of the CCM program. Satisfactory results are defined as a score of 7 or higher on each question.

Figure 31. 2024 CM Member Satisfaction Survey Questions

Member Satisfaction
I am satisfied with the amount of time I spent with my care manager throughout the program. (1 = Strongly Disagree, 10 = Strongly Agree)
My care manager listened to and understood my concerns. (1 = Strongly Disagree, 10 = Strongly Agree)
The information I received in managing my health was useful. (1 = Not What I Wanted, 10 = Very Useful)
Availability of CM to Communicate
When you called with questions about your health care needs, were you able to speak to your care manager? (1 = Never 10 = Always)
Overall Health Improvement
I am able to better manage my health condition since receiving care management services. (1 = Strongly Disagree, 10 = Strongly Agree)
My health status improved because I received care management services. (1 = Strongly Disagree, 10 = Strongly Agree)
The care management services helped my overall health and well-being. (1 = Strongly Disagree, 10 = Strongly Agree)
Member Experience
How would you rate your overall experience with the Alliance Program? (1 = Not What I Wanted, 10 = Very Useful)
How likely are you to recommend the the Alliance to your family and friends? (1= Not at all likely, 10= Very likely)

In 2024, CM Department received a total of 20 surveys related to CCM cases, up from 14 in 2023. Below are the results:

Figure 32. 2024 CM Member Satisfaction Survey Results



Out of 20 total returned satisfaction surveys for CCM cases, the goal of 90% of respondents giving a score of 7 or greater was met in the areas of members feeling listened to and understood, receiving useful information, ability to speak to their case manager, overall experience, and

recommending the Alliance to friends or family.

Opportunities for improvement based on this survey include satisfaction with the amount of time spent interacting with the case manager, ability to better self-manage health health conditions, improved health status, and improved overall health and well-being,

Member experience is also assessed by reviewing grievances filed against Case Management. Below are grievances filed in 2024:

Figure 33a. 2024 Complaints Filed Regarding CM Process – Non-Exempt (Standard) Grievances

Total Non-Exempt (Standard) Grievances Against CM	G&A Decision – In Favor of Member	G&A Decision – Neutral (or blank)	G&A Decision – In Favor of Plan
55	40	124	32

Figure 33b. 2024 Complaints Filed Regarding CM Process – Exempt Grievances

Total Exempt Grievances Against CM	G&A Decision – In Favor of Member	G&A Decision – Neutral (or blank)	G&A Decision – In Favor of Plan
21	21	0	0

The Alliance’s Grievances and Appeals (G&A) Department follows workflows when classifying and tracking grievances based on member’s reporting. Thus, some grievances classified as “against CMDM” may be related to member dissatisfaction with: PCP office, Long Term Care (LTC) Program, Access and Availability, Delegate CM Department, and other areas. CM Leadership is directly involved in all grievances related to specific CMDM staff to ensure appropriate resolution to the grievance and quality improvement opportunities for CMDM staff.

Member Satisfaction with CM - Recommended Actions for 2025:

- Increasing the return rate of satisfaction surveys.
 - Satisfaction surveys are attached to case closure letters, which are sent to all members who complete their CM case. CM will work on ensuring members are educated that they will receive a survey upon case closure to increase return rate.
 - In 2024, CM performed outreach calls to offer members the opportunity to complete satisfaction survey over the phone.
- Continue educating members on care management process, including establishing communication plans with member and establishing mutually-agreed upon scheduled calls
- Continue educating members on effective strategies for working with provider offices, including setting realistic expectations about provider treatment protocols

Evaluation of Delegated Case Management Activities

The Compliance Department is responsible for monitoring and tracking the overall performance

of delegates, including completion of annual audits. CM department staff review the CM components of the annual audit, which includes a review of delegates’ policies and procedures and member case files. The CM team also reviews the delegated entities’ annual work plans/evaluations, and semi-annual reporting. The Compliance Department is responsible for finalizing the audit findings. For entities that do not meet thresholds, a corrective action plan may be issued and tracked to ensure adequate resolution of the deficiency. All audit findings are reported to the Compliance Committee and the QIHEC.

In 2024, the Compliance Department conducted annual audits on 1 delegate with delegated CM responsibilities. The threshold for CM audit compliance was 90%. In 2024, delegate audit results for CM activities included:

- CHCN had findings and required corrective actions.

Figure 34. 2024 Delegate Annual Audit Results (CM components only)

Delegate Name	Provider Type	Delegated Activity- Care Coordination/Case Management	Delegated Activity- Complex Case Management	2024 Audit Results	Corrective Action Required
CHCN	Managed Care Organization (MCO)	Yes	No	1 finding File Review (91% score) <i>This is a preliminary finding</i>	Continue to address staffing to meet outreach turnaround times.

Delegated Case Management - Recommended Actions for 2025:

- Partner with the Compliance Department to evaluate audit tools and establish metrics that align with The Alliance’s key performance indicators.
- Provider regular training and share best practices with delegated entities, particularly around Enhanced Care Management, Community Supports, Transitional Care Services, and other activities impacting The Alliance’s Population Health Management strategy

Conclusion

Overall, the 2024 CM Program continued to develop into an effective program, maintaining compliance with regulatory and contractual requirements, monitoring of performance within the established benchmarks or goals, identifying opportunities for improvement and enhancing processes and outcomes. The CM program activities have met most of the established targets, including a reduction in regulatory findings. The Alliance leadership has played an active role in the CM Program structure by participating in various committee meetings, providing input and assistance in resolving barriers and developing effective approaches to achieve improvements.

To ensure that the Alliance used a comprehensive approach to designing the CM program structure, practicing physicians provided input through QIHEC. The CM program continues to analyze internal benchmarks to further enhance progress and provide quality service to the Alliance membership.

CM Program Recommendations for 2025

As a result of the 2024 program evaluation, opportunities for improvement have been identified and will be incorporated into the 2025 CM Program and Work Plan. A summary of process improvement opportunities is noted below:

Operational Efficiency and Compliance

Basic Population Health Management (including Care Coordination for Medical and Behavioral Health Services and Disease Management)

- Increase engagement in care coordination for medical services by continuing efforts to find alternative contact information for members through Electronic Health Records (EHR), PCP clinics, and Community Health Record (CHR)
- Work with Healthcare Analytics department to further enhance population analysis and program interventions to evaluate program efficacy
- Work with IT department to identify additional opportunities to automate processes administrative CM processes
- Identify populations experiencing disparities and conduct targeted outreach to increase disease management service utilization. Utilize community health workers (CHWs) to connect priority populations to disease management services
- Further solidification of case coordination processes for behavioral health services to increase efficiency and uniformity of practice
- Further collaboration with Alameda County Behavioral Health to ensure member's needs are met across systems of care
- Further collaboration with Alameda County Office of Education to coordinate school-based services
- Initiate bi-directional coordination of care between physical health and mental health providers, including deployment of PCP referral to Mental Health Web Form, enabling PCPs to communicate more completely the needs of the members they refer for mental health services that can be passed on to the Mental Health Provider to enhance their evaluation
- Behavioral Health Treatment/Applied Behavioral Health Treatment plan deployed on the Alliance Provider Portal to enable Autism Service Providers to submit their assessments and treatment plans securely, that can then be shared with referring pediatricians and PCPS.
- Continued identification of data sharing pathways between PCPs and Behavioral Health Practitioners
- Increase member engagement into Alliance Disease Management programs through member mail and call campaigns and provider education

Complex Case Management

- Continue to identify, implement, and evaluate different avenues to continue to increase member engagement.
- Continue SMART goal for:
 - Collaborative efforts with partnered hospitals
 - Productivity standard of Complex member outreach and engagement
 - Obtaining accurate member contact information.
 - Continue the use of the CHR and PCP for alternate phone numbers for member engagement

Enhanced Care Management

- Continue to develop, train, and maintain the ECM Provider network, in preparation for further expansion to support all ECM populations of focus.
- Provide consistent/routine monthly in-person and virtual provider audits and respective in-services to ensure ECM compliance and optimal use of ECM benefits.
- Work closely with ECM providers in monthly IDT meetings to provide guidance with the ECM graduation process.

Transitional Care Services

- Continued efforts to improve member engagement rate will continue in 2025 via finding alternate phone numbers through CHR, and PCP office.
- Increased partnerships with hospital systems.
- Increased partnerships with PCP offices in collaborating on TCS, particularly postdischarge appointments.
- Increased focused on specific TCS populations such as OB and FFS Medicare Part A members.
- Explore leveraging Community Health Worker (CHW) benefit to collaborate on TCS work.
- Collaborate with Quality departments and other departments to address readmissions and ER utilization.

Community Supports

- Increase staff where appropriate to better meet needs of members and providers.
- Continue relationships with the providers to assist them where needed. Continue to work with Analytics to further enhance the dashboard for CS services
- Continue development of accurate and reliable closed loop referral process with Community Supports providers, in alignment with the DHCS requirement by July 1, 2025; establish mechanism for CS providers to confirm members are being serviced after authorizations have been issued
- Implement the new guidance into existing criteria from the Community Supports Policy Guide from Feb 2025
- Provide training to all CS providers to promote best practices while working with our members and to continue to build rapport with CS providers

Quality Improvement

Member Satisfaction with CM

- Increasing the return rate of satisfaction surveys.
 - Satisfaction surveys are attached to case closure letters, which are sent to all members who complete their CM case. CM will work on ensuring members are educated that they will receive a survey upon case closure to increase return rate.
 - In 2024, CM performed outreach calls to offer members the opportunity to complete satisfaction survey over the phone.
- Continue educating members on care management process, including establishing communication plans with member and establishing mutually-agreed upon scheduled calls
- Continue educating members on effective strategies for working with provider offices, including setting realistic expectations about provider treatment protocols

Delegated Case Management

- Partner with the Compliance Department to evaluate audit tools and establish metrics that align with The Alliance's key performance indicators.
- Provider regular training and share best practices with delegated entities, particularly around Enhanced Care Management, Community Supports, Transitional Care Services, and other activities impacting The Alliance's Population Health Management strategy



Health care you can count on.
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**Case Management/Care Coordination,
Complex Case Management & Disease Management
Program Description**

2025

Case Management/Care Coordination,
Complex Case Management & Disease Management
2025 Program Description

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I. Background

Alameda Alliance for Health (the Alliance) is a public, not-for-profit managed care health plan committed to making high quality health care services accessible and affordable to citizens most in need in Alameda County. Established in January 1996, the Alliance was created by the Alameda County Board of Supervisors for Alameda County residents and reflects the cultural and linguistic diversity of the community. In addition, Alliance providers, employees, and Board of Governors live in areas that the health plan serves.

The Alliance provides health care coverage to over 400,000 children and adults in Alameda County through the Medi-Cal and Group Care programs. Through active partnerships with healthcare providers and community partnerships, the Alliance demonstrates that the managed care model can achieve the highest standard of care and successfully meet the individual needs of health plan Members.

The Alliance offers an array of care management services to support a collaborative patient and provider treatment process, and to improve the health of the Member population. The comprehensive case management program assists Members and providers in aligning effective healthcare services and appropriate community resources. The activities of the comprehensive case management program support Alliance Members and providers to attain the highest level of functioning available to the Member in relation to their overall health condition. The CM Program ensures parity between medical/surgical care and behavioral health care throughout all structures and functions. The Alliance oversees and maintains the following case management services in the comprehensive case management program:

- Health Risk Assessments
- Basic Population Health Management (inclusive of Care Coordination and Disease Management)
- Complex Case Management (CCM)
- Enhanced Care Management (ECM)
- Targeted Case Management (TCM)
- Transitional Care Services (TCS)
- Specialized Services (including Community Supports, Continuity of Care, California Children's Services, Major Organ Transplants, and Transportation)

This comprehensive case management program description includes a discussion of program scope, objectives, structure and resources, population assessment, clinical information systems, care coordination and case management services, and monitoring and oversight processes that ensure quality assurance of CM program interventions.

II. Program Purpose and Scope (including Goals and Objectives)

The purpose of the Alliance comprehensive case management program is to provide case management processes and structures to Members who may have complex health needs. Case management is defined by the Case Management Society of America (CMSA) as:

“a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual’s and family’s comprehensive health needs through communication and available resources to promote quality cost-effective outcomes.”

The Alliance provides person-centered case management services through multidisciplinary teams that address medical conditions, behavioral, functional, and psychosocial issues occurring throughout the continuum of care, including in between medical office visits. Case management activities are performed telephonically. The underlying premise of the program is that when an individual reaches the optimum level of wellness and functional capability, everyone benefits: the individuals being served, their support systems, and the overall health care delivery systems (including physicians, hospitals, and the various payer sources).

The case management program was established to provide case management processes and procedures that enable The Alliance to improve the health and health care of its membership. Members from both Alliance products (Managed Medi-Cal and Alliance Group Care) are eligible for participation in the program. The fundamental components of The Alliance case management services encompass member identification and screening; member assessment; care plan development, care plan implementation and management; evaluation of the member care plan; and appropriate closure of the case. Case management interventions are organized to promote quality care, member satisfaction and cost-effectiveness using collaborative communications, evidence-based clinical guidelines and protocols, patient-centered care plans, and targeted goals and outcomes.

Goals for the CM program include:

- Maximize the quality of life and promote a regular source of care for patients with chronic conditions
- Improve Member engagement as active participants in the care process
- Improve health, including behavioral health, outcomes
- Support the foundational role of the primary care physician and care team to achieve high-quality, accessible, and efficient health care
- Coordinate with community services to promote and provide Member access to available resources in the Alliance service area
- Provide person-centered support, education, and advocacy to Members in collaborative communications and interactions
- Engage the provider community as collaborative partners in the delivery of effective healthcare
- Develop and implement a program that meets all regulatory compliance and NCQA accreditation standards

Objectives of the CM program are stated to support concrete measurements that assess effectiveness and progress toward the overall program goal of making high quality health care services accessible and affordable to the Alliance Membership. The objectives of the program include:

- Promote appropriate utilization of services for Members enrolled in case management.
- Achieve and maintain Member's high levels of satisfaction with case management services as measured by Member satisfaction rates.
- Improve functional health status and sense of well-being of comprehensive case management Members as measured by Member self-reports of health condition.

III. Program Structure

The structure of the CM Program is designed to promote organizational accountability and responsibility in the identification, evaluation, and appropriate use of the Alliance health care delivery network and community resources. Additionally, the structure is designed to enhance communication and collaboration on CM issues that affect all departments and disciplines within the organization. The CM Program is evaluated on an on-going basis for efficacy and appropriateness of content by the Alliance staff and oversight committees.

A. Board of Governors

The Alameda County Board of Supervisors appoints the Board of Governors (BOG) of the Alliance, a 19-member body representing provider and community partner stakeholders. The BOG is the final decision-making authority for all aspects of the Alliance programs and is responsible for approving the Quality Improvement, Utilization Management and Case Management Programs. The Board of Governors delegates oversight of Quality and Utilization Management functions to The Alliance Chief Medical Officer (CMO) and the Quality Improvement Health Equity Committee (QIHEC) and provides the authority, direction, guidance, and resources to enable Alliance staff to carry out the Utilization Management and Case Management Programs. Utilization Management oversight is the responsibility of the QIHEC. Utilization Management and Case Management activities are the responsibility of the Alliance Health Care Services staff under the guidance of the Medical Director for Care Management, the Medical Director for Utilization Management, and the Senior Director, Health Care Services, in collaboration with The Alliance CMO.

The QIHEC and UMC are responsible for the review and assessment of the CM program performance against objectives during the annual program evaluation, and if appropriate, provide recommendations for improvement activities or changes to objectives.

B. Quality Improvement Health Equity Committee (QIHEC)

The QIHEC provides oversight, direction, makes recommendations, and has final approval of the CM Program. Committee meeting minutes are maintained to summarize committee activities and decisions with appropriate signatories and dates. A full description of the QIHEC Committee responsibilities can be found in the most recent Quality Improvement Program Description.

The QIHEC provides the external physician involvement to oversee The Alliance QI and UM Programs. The QIHEC includes a minimum of four (4) practicing physician representatives with active, unrestricted licenses to practice in the State of California. The composition includes the Senior Director of Behavioral Health and/or a Behavioral Health Practitioner to specifically address integration of behavioral and physical health, appropriate utilization of recognized

criteria, development of policies and procedures, and case review, as needed. The QIHEC functional responsibilities for the CM Program include:

- Annual review and approval of the CM Program Description
- Annual review and approval of CM Policies and Procedures
- Oversight and monitoring of the CM Program, including:
 - Define the strategies and direction for population health
 - Define the goals and measures to the target population
 - Integration of medical and behavioral health activities
 - Assist in identifying populations at high-risk for poor health outcomes, along with potential programs/services to be provided
 - Recommend policy decisions
 - Oversight of interventions to the provision of the programs and services
 - Recommend necessary actions

C. Utilization Management Committee (UMC)

The Utilization Management Committee (UMC) is a sub-committee of QIHEC. The UMC promotes the optimum utilization of health care services, while protecting and acknowledging Member rights and responsibilities, including their right to appeal denials of service. The sub-committee is multidisciplinary and provides a comprehensive approach to support the CM Program in the management of resource allocation through systematic monitoring of medical necessity and quality, while maximizing the cost effectiveness of the care and services provided to Members. UMC activities are reported to QIHEC, integrating CM activities into the Quality Improvement system.

UM Committee Membership

The UMC is chaired by the Chief Medical Officer, or their designee. Members of the UM Committee include:

- The Alliance Chief Analytics Officer
- The Alliance Medical Director, UM
- The Alliance Medical Director, CM
- The Alliance Medical Director, Quality Improvement
- The Alliance Senior Director, Quality Improvement
- The Alliance Senior Director, Pharmacy
- The Alliance Senior Director, Health Care Services
- The Alliance Senior Director, Behavioral Health
- The Alliance Senior Director, Healthcare Analytics
- The Alliance Director, Compliance and Special Investigations
- The Alliance Senior Director, Member Services
- The Alliance Director, Provider Relations and Provider Contracting
- The Alliance Director, Quality Assurance
- The Alliance Director, Social Determinants of Health
- The Alliance Director, Utilization Management
- The Alliance Director, Long-Term Supports and Services (LTSS)
- The Alliance Manager, Case Management

- The Alliance Clinical Manager, Enhanced Care Management
- The Alliance Senior Manager, Outpatient Utilization Management
- The Alliance Manager, Inpatient Utilization Management
- The Alliance Manager, Long-Term Care (LTC)
- The Alliance Senior Manager, Grievance & Appeals

UMC Voting Privileges

For the purposes of voting, only physician and Director-level members of the UMC may vote.

UMC Quorum

A quorum is established when fifty one percent (51%) of voting Members are present.

UMC Meetings

The UMC meets at least once every 2 months, but as frequently as necessary. The meeting dates are established and published each year.

UMC Minutes

All meetings of the UMC are formally documented in transcribed minutes which include discussion of each agenda topic, follow-up requirements, and recommendations to the QIHEC. All minutes are considered confidential. Draft minutes of prior meetings are reviewed and approved by the UMC with noted corrections. These minutes are then submitted to the QIHEC for review and approval.

UMC Functions

The UMC is a forum for facilitating clinical oversight and direction. Its purpose is to:

- Improve quality of care for the Alliance Members
- Evaluate and trend enrollment data for medical and behavioral health services provided to Alliance Members and benchmarks for care management program utilization.
- Provide a feedback mechanism to drive quality improvement efforts.
- Increase cross-functional collaboration and provide accountability across all departments in Health Care Services.
- Provide mechanism for oversight of delegated CM functions, including review and trend CM reports for delegated entities to identify improvement opportunities
- Identify behaviors, practices, patterns, and processes that may contribute to fraud, waste, and abuse with a goal to support the financial stability of providers and network
- Maintain the annual review and approval of the CM Program & Evaluations, CM Policies/Procedures, CM Criteria, and other pertinent CM documents such as the CM Delegation Oversight Plan.
- Review and analysis of utilization data for the identification of trends
- Assist in monitoring performance of CM activities and recommend appropriate actions when indicated.
- The UMC also evaluates the impact of CM programs on other key stakeholders within various departments and when needed, assesses, and plans for the implementation of any needed changes.

D. Staff Resources

The Alliance's Case Management Department (see Appendix A) is responsible for comprehensive case management programs and activities. The Behavioral Health Department (see Appendix B) is responsible for behavioral health case management activities, including triage, referral, and participation on the multi-disciplinary case management teams. The following are the primary staff with roles and responsibilities in the implementation of the comprehensive case management program:

Chief Medical Officer

The Chief Medical Officer (CMO) is the designated Board Certified in his/her specialty and California licensed physician with responsibility for development, oversight, and implementation of the comprehensive case management program. The CMO provides guidance for all clinical aspects of the program. The CMO serves as the chair of the QIHEC and makes periodic reports to the QIHEC regarding comprehensive case management program activities and the annual program evaluation. The CMO works collaboratively with the Alliance network physicians to continuously improve the services that the comprehensive management program provides Members and providers.

Medical Director

The Medical Director of CM, a licensed physician, provides clinical leadership and stewardship to the Case and Disease Management programs and staff. The Medical Director provides guidance to clinical program design and clinical consultation of Members enrolled in the case and disease management programs. The Medical Director works collaboratively with the Alliance network physicians to continuously improve the services that the case and disease management programs provide Members and providers.

Senior Director, Health Care Services

The Senior Director of Health Care Services, a Registered Nurse, provides operational leadership to the Case and Disease Management programs and staff. The Senior Director provides additional guidance to the programs' designs with a focus on analytics, operations, and regulatory adherence. The Senior Director also ensures the collaboration of the programs with other internal and external stakeholders. The Senior Director provides leadership for case management accreditation and regulatory activities, and works with the Director to evaluate and achieve program goals.

Senior Director, Behavioral Health Services

The Senior Director, Behavioral Health Services is a licensed Psychologist and is responsible for the overall Behavioral Health department operations, staff training, and coordination of services between departments. The Senior Director's management responsibilities include:

- Develop and maintain the Behavioral Health (BH) Program in collaboration with the Senior Medical Director of Quality and the CMO

- Coordinate BH activities with the Quality, UM, Case Management, Member Services Departments, as well as other Alliance units.
- Maintain compliance with the regulatory standards.
- Maintain professional collaboration with Alameda County Behavioral Health Care Services (ACBHCS) to coordinate care and care transitions across behavioral health care systems.
- Coordinate interventions with the CMO to address under and over utilization concerns when appropriate.
- Develop and monitor data and activities for clinical and utilization studies; and maintain professional relationships with colleagues from other Medi-Cal Managed Care Plans, sharing information about requirements and successful evaluation strategies.
- Monitor for consistent application of utilization criteria by BH staff, for each level and type of UM decision.
- Monitor for consistent application of Triage and Referral criteria by BH staff for each type of behavioral health service

Director, Social Determinants of Health

The Director of Social Determinants of Health provides operational leadership to the Case and Disease Management and Enhanced Care Management programs and staff. The Director provides guidance to the various programs with a focus on analytics, operations, and regulatory adherence. The Director assists with collaboration of the programs with other stakeholders. The Director develops the programs' goals and operationalizes processes needed to successfully commence and complete the desired goals.

Director, Long Term Services and Supports

The Director of Long-Term Services and Supports provides operational leadership to the Long-Term Services and Supports and Community Supports programs and staff. The Director provides guidance to the various programs with a focus on analytics, operations, and regulatory adherence. The Director assists with collaboration of the programs with other stakeholders. The Director develops the programs' goals and operationalizes processes needed to successfully commence and complete the desired goals.

Manager, Case Management and Disease Management

The Manager of Case and Disease Management provides daily oversight over the comprehensive case management program. Under the supervision of the Director of Social Determinants of Health, the scope of responsibilities of the Manager of Case and Disease Management includes supervision and management of department staff; development of the operational plan; allocation and management of program resources; and accountability for the quality of care and services. The Manager reviews and evaluates the performance of the comprehensive case management program activities and presents regular reports to the UMC and QIHEC.

Manager, Community Supports

The Manager of Community Supports provides daily oversight over the Community Supports program. Under the supervision of the Director of Long Term Services and

Supports, the scope of responsibilities of the Manager of Community Supports includes supervision and management of department staff; development of the operational plan; allocation and management of program resources; and accountability for the quality of care and services. The Manager reviews and evaluates the performance of the Community Supports services and team and presents regular reports to the UMC and QIHEC.

Manager, Behavioral Health

The Manager of Behavioral Health is responsible for the daily oversight of the care coordination program for behavioral health. This includes supervision and management of department staff; development of the operational plan; allocation and management of program resources; and accountability for the quality of care and services. The Manager reviews and evaluates the performance of the comprehensive case management program activities and presents regular reports to the UMC and QIHEC.

Clinical Manager of Enhanced Care Management

The Clinical Manager of Enhanced Care Management is responsible for the provision of daily oversight of components of the case management program, including programs between the Alliance and contracted Community Based Organizations (CBOs). Under the supervision of the Director of Social Determinants of Health, the scope of responsibilities of the Clinical Manager of Enhanced Care Management includes supervision and management of department staff; development of the operational plan; allocation and management of program resources; and accountability for the quality of care and services. The Manager reviews and evaluates the performance of the comprehensive case management program activities and presents regular reports to the UMC and QIHEC.

Supervisor of Case Management and Disease Management

The Supervisor of Case and Disease Management is a licensed California registered nurse who provides daily oversight over the comprehensive case management program. Under the supervision of the Manager of Case Management and Disease Management, the scope of responsibilities of the Supervisor of Case and Disease Management includes supervision of department clinical staff; allocation and management of program resources; and accountability for the quality of care and services.

Non-Clinical Supervisor of Case Management and Disease Management

The Non-Clinical Supervisor of Case and Disease Management provides daily oversight over the comprehensive case management program. Under the supervision of the Manager of Case Management and Disease Management, the scope of responsibilities of the Non-Clinical Supervisor of Case and Disease Management includes supervision of department non-clinical staff; allocation and management of program resources; and accountability for the quality of care and services.

Supervisor of Community Supports

The Supervisor of Community Supports provides daily oversight over the Community Supports services. Under the supervision of the Director of Long Term Services and

Supports, the scope of responsibilities of the Supervisor of Community Supports include supervision of department staff; allocation and management of program resources; and accountability for the quality of care and services.

Supervisor of Behavioral Health

The Behavioral Health Supervisor is responsible for the daily oversight of the care coordination program within behavioral health. This includes supervising and managing non-clinical and clinical department staff, developing and implementing operational plans, allocating and managing program resources, and ensuring the quality of care and services provided.

Lead Complex Case Manager, Nurse

The Lead Case Manager (CM) is a licensed California registered nurse, who acts as a daily resource to the case management, social work, and navigator staff. Under the supervision of the Supervisor of CM/DM, the scope of responsibilities of the Lead CM are to assist in identifying and resolving issues impeding the daily delivery of consistent CM services to meet regulatory and quality requirements, escalate issues unable to be resolved to upper leadership, carry a caseload of members, and assist in the coaching of staff in the standard work of the department.

Complex Case Manager, Nurse

The Alliance uses licensed California registered nurses in the role of the Complex Case Manager. The Complex Case Manager provides case management services, including transitional care services, for health plan Members with highly complex medical conditions where advocacy and coordination are necessary to help the Member reach the optimum functional level and autonomy within the constraints of the Member's disease conditions. Working within a multi-functional team, the Complex Case Manager coordinates with the Member, Member caregiver(s), community resources, and health plan partners to assess Member health status, identify care needs and ensure access to appropriate services to achieve positive health outcomes. The Alliance uses staffing guidelines to assign caseloads to each Complex Case Manager. Caseload assignments are made with the following considerations: current case load size; acuity level of case load; characteristics of Members, primary care provider, health plan product; and relevant case management responsibilities.

Enhanced Care Management, Nurse

The Alliance uses licensed California registered nurses in the role of the Enhanced Care Management, Nurse. The Enhanced Care Management nurse provides collaborative assistance for Enhanced Care Management (ECM) providers. The ECM nurse participates in regular interdisciplinary team rounds with each ECM provider clinic site and offers clinical support and recommendations to ECM providers to assist with members enrolled in ECM. The ECM nurse also assists with clinical review for ECM authorizations.

Community Supports, Nurse

The Alliance uses licensed California registered nurses in the role of the Community Supports, Nurse. The Community Supports nurse provides collaborative assistance for

Community Supports (CS) providers. The CS nurse participates in regular meetings with each CS provider and offers clinical support and recommendations to CS providers to assist with members receiving CS. The CS nurse assists with clinical review for all CS authorizations requiring a clinical review. If members need continued services past an expired authorization, the CS nurse reviews all requests and corresponding justification to determine whether services can be appropriately continued.

Social Worker

The Alliance employs Medical Social Workers to assist in the provision of services for Members enrolled in one of the comprehensive case management programs. Services the Medical Social Workers assist in accessing include but are not limited to housing, income programs, food resources, In-Home Support Services (IHSS), community supports, and other services as needed. The Medical Social Worker is also responsible for coordinating medical, social and or behavioral health care needs with Alliance CM teams. Under general supervision from the Supervisor, Case and Disease Management, the Medical Social Worker is responsible for meeting the day-to-day care coordination needs among assigned case management teams. Occasionally, the Social Worker may be required to support delegated Provider Group teams with care coordination and community resources.

Health Navigator

Under guidance from the Non-Clinical Supervisor, Case Management or the Clinical Manager, Enhanced Care Management, the Health Navigator supports clinical staff through the completion of components of case management, disease management, transitional care services, and wellness/health maintenance programs. The Health Navigator provides the Member with individualized, patient-centered support and education to assist and guide the Member across the continuum of the healthcare delivery system. The Health Navigator works with the Case Management team to perform follow-up case management activities and coordinate care and services for the Member with providers and community resources. The Health Navigator also coordinates care for Members not admitted to the complex case management program.

Community Supports Coordinator

Under guidance from the Supervisor of Community Supports, the Community Supports Coordinator works with Community Supports providers to process authorizations into AAH's information system of record. The Community Supports Coordinator works with the Medical Director and Supervisor to perform follow up management to meet specific turn-around times for authorizations. They also assist with coordination of weekly meetings with Community Supports providers and facilitate communication to meet appropriate authorization regulatory requirements.

Transportation Coordinator

Under guidance from the Non-Clinical Supervisor of Case Management, the Transportation Coordinator supports the case management department in ensuring members receive non-medical transportation (NMT) and Non-Emergency Medical

Transportation (NEMT) as needed to all covered services. The Transportation Coordinator is responsible for acquisition of the Physician Certification Statement for NEMT transportation. The Transportation Coordinator works with members, providers, the transportation subcontractor, and other stakeholders to coordinate transportation for members.

Case Management Coordinator

Under guidance from the Non-Clinical Supervisor of Case Management the Case Management Coordinator supports the case management department through assisting with administrative duties including intake of incoming phone calls and emails into the Case Management Department. The Case Management Coordinator provides the member and providers with individualized, patient-centered support and assistance to help guide the member across the continuum of the healthcare delivery system.

Health Assessment Coordinator

Under the guidance of the Manager of Case and Disease Management, the Health Assessment Coordinator is responsible for the non-clinical support of the Health Risk Assessments (HRAs) and Health Information Forms / Member Evaluation Tools (HIFs/METs). The Health Assessment Coordinator is responsible for the final processing of completed HRAs and providing the preventative health and community resources identified from the Member responses. Fulfillment also includes sending the HRA letter, care plan, and resources to the Members and the PCPs. The Health Assessment Coordinator is also responsible for the management of mailings and data entry of hardcopy documents received (HRAs and HIFs/METs) for entry into the clinical information system.

Behavioral Health Triage Specialist

Under guidance from the Senior Director of Behavioral Health, Behavioral Health Triage Specialists provide the behavioral health case management components for members to enable integration of physical and behavioral health to address the member's whole person health needs.

The Alliance uses California Licensed Clinical Social Workers, Licensed Marriage and Family Counselors and Licensed Psychologists in the role of the Behavioral Health Triage Specialist. The Behavioral Health Triage Specialist provides case management services for health plan Members with highly complex behavioral health conditions where advocacy and coordination are necessary to help the Member reach the optimum functional level and autonomy within the constraints of the Member's conditions. Working within a multi-functional team, the Behavioral Health Triage Specialist coordinates with the Member, Member caregiver(s), community resources, and health plan partners to assess Member health status, identify care needs and ensure access to appropriate services to achieve positive health outcomes.

Behavioral Health RN Case Manager

Under guidance from the Senior Director of Behavioral Health, Behavioral Health RN Case Managers provide the behavioral health case management components for members to enable integration of physical and behavioral health to address the member's whole person health needs. Additionally, the Behavioral Health RN Case Manager participates in the multi-disciplinary case management team when there are psychiatric conditions impacting the members health outcomes to ensure psychiatric conditions are addressed in coordination with physical health conditions.

The Alliance uses California Licensed registered nurses who have specialized in psychiatric/mental health nursing in the role of the Behavioral Health RN Case Manager. The Behavioral Health RN Case Manager provides case management services for health plan Members with highly complex behavioral health conditions where advocacy and coordination are necessary to help the Member reach the optimum functional level and autonomy within the constraints of the Member's conditions. Working within a multi-functional team, the Behavioral Health RN Case Manager coordinates with the Member, Member caregiver(s), community resources, and health plan partners to assess Member health status, identify care needs and ensure access to appropriate services to achieve positive health outcomes.

Applied Behavioral Analysis (ABA) Analyst

Under guidance from the Senior Director of Behavioral Health, the ABA Analyst provides the behavioral health therapy/Applied Behavioral Analysis (ABA) case management components for members to ensure member under the age of 21 who need ABA services for the treatment of Autism or other developmental conditions receive medically necessary services.

The Alliance uses Board Certified Behavioral Analysts (BCBA) in the role of the ABA Analyst. The ABA Analyst provides case management services for health plan Members with Autism or other developmental conditions where advocacy and coordination are necessary to help the Member reach the optimum functional level and autonomy within the constraints of the Member's conditions. Working within the behavioral health team the ABA Analyst coordinates with the Member, Member caregiver(s), community resources, and health plan partners to assess Member health status, identify care needs and ensure access to appropriate services to achieve positive health outcomes.

Behavioral Health Navigator

Under the guidance of the Senior Director of Behavioral Health, the Behavioral Health Navigator is responsible for the non-clinical support of the Alliance Behavioral Health Department. The Behavioral Health Navigator is responsible for the non-clinical support of members who need assistance in accessing the behavioral health services they need. The Behavioral Health Navigator supports the Behavioral Health Department's clinical staff in following through on referrals and services to ensure member health care needs are met. The Behavioral Health Navigator is also responsible for the management of

mailings and data entry of hardcopy documents received for entry into the clinical information system.

Liaisons

Liaisons are members of the care management team who have subject matter expertise with the population and/or entity they are assigned to. Liaison names and contact information are shared with DHCS, and their roles and responsibilities are as follows:

- California Children's Services (CCS) Liaison: serves as the primary point of contact responsible for the CCS members' care coordination. CCS liaisons must receive training on the full spectrum of rules and regulations pertaining to the CCS Program, including referral requirements and processes, annual medical review processes with counties, care management and authorization processes for CCS Children
- Foster Care Liaison: has expertise in Child welfare services, County Behavioral Health Services, and ensures appropriate ECM staff, including the ECM Lead Care Manager whenever possible, attend meetings of the Child and family teams, in accordance W&I section 16501(a)(4); Ensure Covered services are closely coordinated with other services, including social services and Specialty Mental Health Care Services; Act as a resource to ECM Providers providing services to Child welfare-involved Children and Youth, provide technical assistance to Contractor and ECM Provider staff as needed, and serve as a point of escalation for care managers if they face operational obstacles when working with County and community partners; Coordinate with foster care liaisons for other Medi-Cal managed care plans to notify them when Members cross county lines and/or change managed care plans; Serve as a family advocate.
- Justice-Involved (JI) Liaison: Support correctional facilities, pre-release care management providers, and/or ECM providers in the re-entry planning process.
- Regional Center Liaison: Coordinates with each Regional Center (RC) operating within Contractor's Service Area to assist Members with Developmental Disabilities (DD) in understanding and accessing services, and to act as a central point of contact for questions, access and care concerns, and problem resolution.
- Dental Liaison: Is available to Medi-Cal Dental Providers and Members to assist with referring the Member to other Covered Services, including but not limited to, laboratory services, and pre-admission physical examinations required for admission to an outpatient surgical service center, or an in-patient hospitalization required for a dental procedure (including facility fees and anesthesia services for both inpatient and outpatient services).
- In-Home Support Services (IHSS) Liaison: Day-to-day liaison with county IHSS agency; sufficiently trained on IHSS assessment and referral processes and providers, and how the Alliance and PCPs can support IHSS eligibility applications and coordinate care across IHSS, medical services, and long-term services and supports; includes training on IHSS referrals for Members in inpatient and SNF settings as a part of Transitional Care Services requirements, to support safe and stable transitions to home and community-based settings

IV. Population and Member Needs Assessment

The Alliance routinely assesses the characteristics and needs of the Member population, including relevant subpopulations. The Alliance analyzes available enrollment and census data, in combination with other data sources, including but not limited to:

- Product lines and eligibility categories
- Language and subpopulations
- Race and ethnicity
- Age
- Gender
- High volume diagnoses
- Results of Health Risk Assessments (HRA)
- Chronic and co-morbid medical conditions
- Laboratory Reports
- Internal department data sources
- Utilization history (including claims and authorizations for medical, behavioral, and pharmacy services)

To effectively address Member needs, after the collection of Member population data, the CM Medical Director, Senior Director of Health Care Services, Senior Director of Behavioral Health, Director of Social Determinants of Health, and Manager of Case Management and Disease Management analyze and review the data to determine any necessary updates to the processes and resources of the comprehensive case management program. The information gathered in this process is used to further define and revise the program's structure and resources, including the following types of factors:

- **Department staffing** – by analyzing the data the Alliance revises staffing ratios and roles, for example adding nurse Case Managers or Behavioral Health Triage Specialists versus unlicensed social workers when the level of higher risk Members increases in the program.
- **Evidence-based guidelines** – as the mix of condition types increases the Chief Medical Officer assists in identifying clinical guidelines to be used in creating care plans for Members.
- **Member materials** – Alliance uses data, Case Manager feedback, and patient satisfaction information to identify new types of materials or revise materials to support language and cultural needs.

V. Case Management Clinical Systems

A. Case Management Information Systems

The CM Department uses a clinical information system, TruCare®, as the case management platform. TruCare® is a member-centric application that automates the entire clinical, administrative, and technical components of case management into a single platform. The

system supports case management with algorithmic clinical intelligence and best practices to guide case managers through assessments, development of care plans, and ongoing management of members. The system includes assessment templates to drive consistency in the program. Care plans are generated within the system and are individualized for each member and include short and long-term goals, interventions, and barriers to goals. The clinical information system includes automated features that provide accurate documentation for each entry; record actions or interactions with members, caregivers, and providers; and create automatic date, time, and user stamps. To facilitate care planning and management, the clinical information system includes features to set prompts and reminders for next steps or follow-up contact. Optimization of TruCare® continued throughout 2024. Thorough vetting processes are established between clinical and IT teams to ensure any enhancements and upgrades to the platform are amenable to all system users. System optimization and upgrades are ongoing as standard practices, including staff training to ensure competence in using the platform and alignment on best practice workflows.

B. Clinical Decision Support Tools

Evidence-based clinical guidelines are available to support the Case Managers in conducting assessments, developing care plans, and managing care. The clinical practice guidelines are based on current published literature, current practice standards, and expert opinion. Whenever possible, guidelines are derived from nationally recognized sources. If a nationally recognized guideline is not available, the Alliance will involve board certified specialists in the development of the appropriate guidelines, as well as medical and behavioral healthcare specialty societies and/or Alliance Clinical Practice Guidelines (see Appendix C). Clinical guidelines are reviewed and approved by the UMC and QIHEC.

VI. Case Management Services

The Alliance maintains and oversees the delivery of the following case management services in the comprehensive case management program:

- Health Risk Assessments
- Basic Population Health Management (inclusive of Care Coordination and Disease Management)
- Complex Case Management (CCM)
- Enhanced Care Management (ECM)
- Targeted Case Management (TCM)
- Transitional Care Services (TCS)
- Specialized Services (including California Children's Services, Community Supports, Continuity of Care, Major Organ Transplants, and Transportation)

To effectively deliver case management services, the Alliance's Care Management program adopts a person-centered design, ensuring all care management activities align with members' needs, preferences, and goals. Members are identified as candidates for care management services through various data sources and referrals. This includes, but is not limited to:

- Health Risk Assessment (HRA)
- Health Information Forms/Member Evaluation Tool (HIF/MET)
- Data sources such as Utilization reports and Admission, Transfer and Discharge (ADT) Feeds
- Population Health Reports
- Self-referrals from members/authorized representatives
- Direct referrals from provider networks
- Internal referrals (including Utilization Management, Member Services, Appeals and Grievance, Leadership)
- Predictive modeling

After members are identified as candidates for care management, they are aligned to the appropriate case management service. Each service component is described in further detail below.

A. Health Risk Assessment (HRA)

The Alliance arranges for the assessment of every new Senior and Person with Disabilities (SPD) member through a process that stratifies all new members into an assigned risk category based on self-reported or available utilization data. Based on the results of the health risk stratification, the Alliance administers a Health Risk Assessment (HRA) survey to all newly enrolled SPD members within:

- 45 days of enrollment for members identified as high-risk
- 105 days of enrollment for members identified as lower-risk

The Alliance uses a standardized HRA questionnaire (see appendix F) to identify member care needs and provide early interventions for Members at higher risk for adverse outcomes. The questions are focused on medical care needs, community resource needs, the appropriate level of caregiver involvement, timely access to primary and specialty care needs, identification of communication of care needs across providers as well as identifying any activities or services to optimize a member's health status, including a mental health screener. In addition to the standardized HRA questions, the DHCS LTSS questionnaire (see appendix G) is completed to identify whether a member is experiencing risk factors that make them a candidate for LTSS services that will help keep them in their home and community.

For members stratified as lower risk, members receive the HRA questionnaire via mail, and also receive interactive voice calls encouraging them to return the questionnaire to complete the HRA process. For members stratified as high-risk, CM staff initiate outreach to the member to attempt completion of the HRA over the phone. The responses from the HRA may result in the reclassification of Members as higher or lower risk (for some members, risk-level based on their HRA responses may be different from their earlier stratification based on the stratification

tool/data). After completion of the HRA, the Alliance develops Individualized Care Plans (ICPs) for members found to be high risk and coordinates referrals for identified LTSS, as needed.

CM staff are responsible for ensuring the Individualized Care Plan is completed, shared with the Member and PCP, and is accompanied by relevant community and health resources.

For Members whose completed HRA results in a final stratification of Low Risk, CM staff review Member HRA responses to identify Member needs (i.e., resources for transportation, in home support services (IHSS), durable medical equipment (DME), food resources, etc.). The CM staff generate the standardized low risk care plan, attaches the relevant resources, and prepares it for mailing.

For Members whose completed HRA results in a final stratification of High Risk, clinical CM staff outreach to the Member and reviews Member HRA responses with the member to identify Member needs. The CM staff generate the standardized high-risk care plan and include additional health education resources and materials based on the conversation with the Member.

If the member remains Unable to Contact (UTC), a standardized care plan is sent to the member. This is sent to members, even if they do not complete the HRA and return it to the plan. Copies of the care plans, for both High Risk and Low Risk members, are mailed to the Member, the Primary Care Provider, and the Delegate Group if applicable.

SPD members are reassessed annually in the month of their enrollment. All HRAs are reviewed by a CM staff, whether a member is identified as Low-Risk or High-Risk, to determine needs or any changes in condition. For High-Risk Members, the assigned clinical staff is responsible for ensuring the HRA is reviewed, and the Care Plan updated accordingly. For Members identified as Low-Risk, the Alliance uses utilization data to re-stratify Members. Members that are re-stratified from Low to High-risk based on annual re-assessment activities are referred to a CM Nurse for further assessment and development of a Care Plan. If the member continues to be stratified as Low-Risk in the annual re-assessment, the member is provided with a standardized care plan and informed of the availability of case management services as needed.

B. Care Team Roles and Responsibilities

Case Management services are provided using a combination of care teams:

- The core care team is comprised of an RN Complex Case Manager, Health Navigator and Social Worker, working together to manage a group of Members with complex and care navigation needs.
- The extended care team supports specific needs of the core care team. The extended care team members work across functional areas to provide additional support and interventions, as needed. The extended care team may include Medical Directors, pharmacy, behavioral health, utilization management, long-term care, and health education.

Care teams are assigned specific roles to address the needs of Members. The CM Nurse will

serve as the medical lead for the team. The role of the CM Nurse is to ensure the CM assessments and follow-up are completed in a timely manner. The CM Nurse will communicate the outcomes of each assessment with the other team Members to ensure the team is knowledgeable on care needs and understands their role in the care plan.

The Behavioral Health Triage Specialist or the Behavioral Health RN Case Manager is engaged in the Care Team when behavioral health conditions are identified. The teams are directed by defined workflows and serve as sources to identify and refer Members to other programs, including Enhance Care Management (ECM), Community Supports (CS), and behavioral health services. Communication is key to the effectiveness of the program, with the care team meeting daily to discuss member needs and expectations.

Extended Care Team Members are consultants to the core care team. As needed, the CM Nurse will coordinate care team discussions to address identified care needs. This may include medication reconciliation or adherence issues, behavioral health concerns, social determinants of health best managed using community resources, or health literacy issues.

C. Basic Population Health Management Services

Basic Population Health Management (BPHM) is available to all Alliance members, regardless of risk tier, and includes ensuring access to primary care, care coordination, navigation and referrals across health and social services (including Community Supports), information sharing and referral support infrastructure, services provided by Community Health Workers (CHWs) under the CHW benefit, wellness and preventions programs, chronic disease programs, programs focused on improving maternal health outcomes, and case management services for children.

The Primary Care Provider (PCP) is responsible for Basic Population Health Management for his/her assigned members and is supported by the Provider Group CM team. The PCP is responsible for ensuring that members receive an initial screening and health assessment (IHA), which initiates Basic Medical Care Management. The PCP conducts an initial health assessment upon enrollment, and through periodic assessments provides age-appropriate periodic preventive health care according to established, evidence-based, preventive care guidelines. The PCP also makes referrals to specialists, ancillary services, and linked and community services as needed based on the member's Individual Care Plan (ICP). When additional care management assistance is needed, the PCP works with the Provider Group's CM department to facilitate coordination. For members enrolled in the Direct Network or without an internal Provider Group CM program, the PCP works with the Alliance CM and UM teams to facilitate coordination.

Basic Population Health Management services are provided by the primary care provider, in collaboration with the Alliance, and include the following elements:

- Initial Health Assessment (IHA) (including a history and physical evaluation sufficient to assess the acute, chronic, and preventive health needs of the Member)
- Identification of appropriate providers and facilities (such as medical rehabilitation, and support services) to meet Member needs.
- Direct communication between the provider and Member, family and/or caregiver.

- Member, caregiver and/or family education, including healthy lifestyle changes when warranted.
- Coordination of carved out and out of plan services, and referral to appropriate community resources and other agencies.

Care Coordination

Alliance Case Management staff maintains procedures to assist Members who are unable to secure and coordinate their own care because of functional, cognitive, or behavioral limitations, or the complexity of the community-based services. Members are assigned to a Case Manager, Social Worker, or Health Navigator to assist with short-term assistance with care coordination. Members, during program enrollment, will also be assessed for long-term care needs provided through Complex Case Management and Disease Management.

Members eligible for care coordination services have generally been identified as low or moderate risk, and meet the following criteria:

- Suffer from one or more acute or chronic conditions.
- Require case management services that are less intensive than services provided in CCM.
- Have medical, functional, and/or behavioral health conditions that require extra support but generally demand fewer resources to achieve or maintain stability than do Members enrolled in more intensive case management programs.
- Care requires moderate coordination with several providers involved.
- Member and/or caregiver education is needed to support self-management skills and strategies. Once available resources are accessed, successful self-management is achievable with moderate intensity of care coordination services.
- Issues may be acutely destabilized and time-limited OR chronic, ongoing but stable.

Once a member is identified and referred for care coordination, the Alliance Lead Case Manager or Case Management Supervisor screens for and assigns out referrals, for care planning, and all other care coordination activities. Members are matched to the Case Management staff that is specialized based on the prominence of needs. Though there is one assigned "primary" case manager for each case, the support and expertise of others may be harnessed to provide collaboration and comprehensive, multidisciplinary care. This approach is most important for those Members who are diagnosed with medical, functional, cognitive, and psychosocial conditions. Health Navigators, Social Workers or Case Managers are responsible for the following services:

- Screening and enrollment
- Comprehensive clinical assessment
- Development and implementation of a "service plan."
- All care coordination activities – including facilitating communication, referrals, treatment/service authorizations, etc.

- Maintenance of comprehensive, written records based upon assessment and care plan.
- Clear documentation of service delivery, provider communications, Member interactions, etc.
- Periodic review of cases
- Case closure and evaluation as appropriate

Disease Management

The Alliance has four disease management programs as a part of the overall Population Health Management strategy. Disease Management (DM) programs provide health education interventions, seek to close care gaps, and focus on improving equity and reducing health disparities. Disease Management programs aim to improve the health status of its participants through assessment, support with adherence to treatment plans, health coaching, and care coordination.

All program interventions are based on data-identified patient needs and are developed using evidence-based practice guidelines and care pathways. Members are identified for engagement by claims, pharmacy, and lab data and direct referrals from Alliance staff, physicians, and community partners. Current Alliance Disease Management programs address the following conditions:

- Diabetes
- Cardiovascular Disease
- Asthma
- Depression

The Alliance Disease Management (DM) Programs will:

- Provide disease management as an “opt-out” service meaning that all eligible members identified are enrolled unless they choose to decline participation.
- Ensure that all Alliance members are identified and stratified into appropriate levels for disease management services depending on risk.
- Provide DM services based on evidence-based guidelines and an individual assessment of gaps in care.
- Maintain documentation of program enrollment and provision of services using a Clinical Information System
- Promote DM to members and practitioners via written information about the program.

The Alliance delegates DM for a small proportion of its population. The delegates are required to follow NCQA standards.

Alliance Disease Management Programs

Disease state	Program name	Criteria	Key program offerings	Member outreach
Asthma	Asthma Remediation Services	Alliance Medi-Cal members ages 0-18 with poorly controlled asthma.	Asthma education, tools, and home modifications to improve asthma management.	Letter and telephonic outreach
Asthma	Happy Lungs	Members 18 years or younger with lower-risk asthma and their caregivers.	Opportunity to engage in pediatric asthma case management services.	Educational letter and an invitation to engage in pediatric asthma services.
Asthma	Living Your Best Life with Asthma	Members 19 years or older with lower risk asthma.	Opportunity to receive Alliance care management, health coaching, health education, care coordination or other services based on need.	Educational letter with an invitation to engage with the Alliance for additional resources.
Diabetes	Living Your Best Life with Diabetes	Members 19 years and older with diabetes.	Opportunity to receive Alliance care management, health coaching, health education, care coordination or other services based on need.	Members identified at lower risk will receive an educational letter and an invitation to engage with diabetes management programs. Members identified with diabetes at a higher risk of worsening outcomes will also receive an outreach call.

Hypertension	Living Your Best Life with a Healthy Heart	Members aged 18 years or older with high blood pressure.	Opportunity to receive Alliance care management, health coaching, health education, care coordination or other services based on need.	Educational letter and an invitation to engage with the Alliance for additional resources. Members identified with high blood pressure at a higher risk will also receive an outreach call.
Depression	Birthwise Wellbeing	Members between the ages 18-50 who are pregnant, or have been pregnant within the past year	Opportunity to receive assessment, care coordination to access behavioral health services, and perinatal health education services.	An educational flyer in the Alliance Baby Steps packet of educational materials for a healthy pregnancy. Members identified as higher risk for depression may also receive an outreach call.

Identification and Screening

Disease Management (DM) services at the Alliance are provided to all Alliance members with a diagnosis of diabetes, asthma, hypertension, or depression who meet the age criteria specified in the above table and are identified as eligible based on clinical, pharmacy and utilization data or direct referral.

Members are identified for program eligibility through one of the following:

- a. Monthly report from HealthCare Analytics department utilizing claims, encounter, and pharmacy data. The report is further risk stratified according to the program criteria (see below).
- b. Health Risk Assessment (HRA) for Medi-Cal Seniors and Persons with Disability (SPD). Members are identified as eligible with the appropriate age and diagnoses eligible for the DM program, and have a score calculated from HRA answers that may impact the member's health. The list of members meeting these criteria will be provided to the Intake Department for further processing.

Additional referral sources include, but are not limited to, self-referral, caregiver, Primary Care Providers or Specialists, laboratory results, discharge planners at medical facilities and internal department referrals such as Utilization Management (UM), Case and Disease Management and Member Services.

The Alliance informs practitioners about the DM programs and how to refer members through multiple methods, including, Provider Services educational material, Alliance webpage, and Provider bulletins. The communication methods describe how to use disease management services and how the Alliance works with their patients enrolled in DM. Targeted communications for key referral sources such as the CM department, UM department, Member Services, Hospital Discharge planners occur at least annually.

Information needed for a DM referral includes:

- a. Referral or data source (name, affiliation, and contact information).
- b. Date referral received by Intake. If secondary referral, document initial contact information and date.
- c. Member information
- d. Reason for referral
- e. Diagnosis (asthma, diabetes, hypertension, or depression)
- f. Level of urgency
- g. Additional information, as necessary.

DM Risk Stratification

1. The CM/DM designee stratifies all members directly referred to the Alliance DM services into the appropriate DM program.
2. Data reports provided to the Case & Disease Management Department monthly are already stratified into levels according to the following risk criteria:
 1. **High Risk Diabetes:** Eligible age members with diagnosis of diabetes and other comorbidities and potentially significant risk factors, such as history of hospital or ER admission.
 2. **Moderate Risk Diabetes:** Eligible age members with diabetes and identified gaps in care. Members with a diagnosis of diabetes will be initially classified as Moderate Risk and referred to the Health Navigator to determine appropriate risk stratification.
 3. **Low risk Diabetes:** Eligible age members with diagnosis of diabetes and who do not fall into the high or moderate risk category.
 4. **High Risk Asthma:** Eligible age members identified with pediatric asthma, ER and hospital utilization, and asthma medications. Members with a diagnosis of asthma will be classified as High Risk and referred for outreach and follow up.
 5. **Low Risk Asthma:** Eligible age members not in the high-risk category.
 6. **High Risk Hypertension:** Eligible age members with at least one hypertension medication in the last year or whose blood pressure was not adequately controlled as defined by HEDIS Controlling High Blood Pressure (CBP) measure

and frequent inpatient, emergency room visits or readmissions. Members with a diagnosis of hypertension will be classified as High Risk and referred to the Health Navigator for appropriate follow up and interventions.

7. **Low Risk hypertension:** Eligible age members with a diagnosis of hypertension and at least one hypertension medication in the last year or whose blood pressure was not adequately controlled as defined by HEDIS Controlling High Blood Pressure (CBP) measure.
8. **High Risk Perinatal Depression:** Eligible age members identified as pregnant or having given birth within the past year and who have a prescription for anti-depressants or anti-psychotic medications in the past year. Members with a diagnosis of depression will be classified as High Risk and referred for outreach and follow-up.
9. **At Risk Perinatal Depression:** Age-eligible members identified as pregnant or having given birth within the past year, not in the high-risk category.

DM referrals will be completed within the month of receipt of the request of the DM Identification and Stratification. If at any time, the CM/DM staff or the referral source believes that the case is of an urgent nature, priority will be given to the case to be completed as soon as possible.

Eligible members (or parents/guardians of minors) are sent letters about the availability of disease management program services. The letter will also inform them how to use the program, eligibility criteria and opt-in and opt out program aspects.

Upon receipt of the necessary information for a referral, the CM/DM designee documents the referral into Clinical Information System. Members assigned to a delegate entity that provides Disease Management will be referred to the delegate. If the member is no longer eligible for services, the case should be closed and the reason for case closure will be marked as transitioned to a lower level of care, or Other.

Enrollment

1. High-Risk and Moderate-Risk Programs. Referrals will be assigned to staff based on existing caseload and specialization.
 - a. Case Managers (CMs) and Health Navigator staff assigned to the case will outreach to members for further engagement regarding disease management program enrollment and/or update any existing Care Plan for the member with the new information.
 - b. Case Management will document one of the following programs the member is enrolled in, by opening an appropriately corresponding case:
 - i. DM – Asthma
 - ii. DM – Depression
 - iii. DM – Diabetes
 - iv. DM – Hypertension

2. Low Risk Programs: Members identified for the Low-Risk programs will be counted as enrolled by sending the appropriate DM low-risk Letter.

Assessment

1. Upon engagement from the member, staff will complete the appropriate intake assessment within the Clinical Information System.
2. Procedures for conducting assessments are addressed in *CM-001, CCM Identification, Screening, Assessment and Triage Policy*. Along with assessment questions regarding co-morbidities, cognitive deficits, psycho-social issues, depression, physical limitations and health behaviors, additional questions specific to the disease management condition have been added to the DM High Risk assessments.

DM Plan Development and Management

1. The steps in developing the Care Plan involve:
 - a. Development of case management goals, including prioritized goals
 - b. Identification of barriers to meet the goals and complying with the plans
 - c. Development of schedules for follow-up and communication with members
 - d. Development and communication of member self-management plans
 - e. Assessment of progress against CCM plans and goals, and modifications as needed
2. Condition monitoring (self-monitoring and medical testing) and adherence to the applicable chronic disease treatment plan will be an important component of the DM Plan of Care and goals should be set accordingly.
3. The Care Plan for the Diabetes DM Program is developed from evidence-based Standards of care for Diabetes Management. Goals will be set as short-term goals defined as achievable within 30 days. Goals can be extended by another 30 days, however, at the 60-day mark the member should be reviewed at Case Rounds. At any time, the member may be referred to CCM for ongoing case management needs.
4. Referrals for additional services and resources will be made as documented in the Plan of Care. Referrals will be made as necessary and timely (within 7 business days of identifying the need) and follow-up on these referrals will occur within 30 calendar days after the referral.

DM Case Evaluation and Closure

The DM program is structured where DM cases are closed either by meeting prescribed length in program criteria or by defined closure criteria.

High Risk Program enrollees will be evaluated for closure to DM services using *CM-003, Policy and Procedure, Complex Case Management Plan Evaluation and Closure Evaluation and Closure criteria*. Diabetes DM Program enrollees will also be evaluated for closure to DM services using CM-003 P&P criteria.

All closure actions will be documented in the Clinical Information System. At the time of case closure, a satisfaction survey, and a case closure letter if appropriate will be sent.

D. Complex Case Management (CCM)

Complex Case Management (CCM) is an opt-in program, provided for members who consent to participate. It is a collaborative process between the Primary and/or Specialty Care Providers, member, and Care Manager; and the Care Manager's role is to support the member with person-centered planning, coordinating, and monitoring options and services to meet the member's health care goals. Complex Case Management includes at a minimum the following elements:

- Case Management services
- Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team.
- Intense coordination of resources to ensure Member regains optimal health or improved functionality.
- With Member and PCP input, development of care plans specific to individual needs and updating at least annually.

The Alliance CCM process provides opportunities along the continuum of care to identify and address potential risks for medical errors and ensure patient safety. The CCM program includes the following activities to ensure and enhance Member safety:

- Completion of a comprehensive general assessment that supports proactive prevention or correction of patient safety risk factors.
- Active management of transitions of care to ensure that the Member's health condition will not be placed at risk for an unsafe situation that may result in a negative outcome.
- Care plan development that ensures individualized access to quality, safe, effective, and timely care.
- Monitoring of information exchanges across the provider continuum to ensure safety, prevent medical errors, and support effective continuity of care. Review of medication regimen to monitor drug utilization, interactions and side-effects that compromise patient health and safety
- Patient advocacy to ensure the care plan is followed by all providers. Annual evaluation of satisfaction with the complex case management program.

Identification of Eligible Members

Members meeting criteria for CCM may have conditions in which the degree and complexity of illness or conditions is severe, the level of management necessary is intensive, and the number of resources required for member to regain optimal health or improved functionality is extensive. Eligibility criteria (see Appendix D) are subject to change, based on findings from the population needs assessment and/or community and stakeholder committees. Criteria are developed under the guidance of the Chief Medical Officer, and routinely, but no less than annually, evaluated to ensure Members at high-risk of poor health outcomes receive the appropriate level of care management support. Typically, CCM supports Members with at least one of the following clinical features:

- Complex diagnoses such as End-Stage Renal Disease (ESRD), Chronic Heart Failure (CHF), and Chronic Obstructive Pulmonary Disease (COPD)
- High risk scores
- Multiple comorbidities
- Multiple Emergency Department (ED) visits in a year
- Multiple hospitalizations in a year
- Mental Health diagnosis
- Complex Psychosocial Needs (i.e., Homelessness)

Referral Process

Referrals to CCM can be made by members, caregivers, practitioners/providers (including PCPs and Specialists), hospitals or facilities, and internal departments (including UM, Member Services, Disease Management, Behavioral Health, and Grievance & Appeals). A CM clinician (nurse or social worker) may also deem a member eligible for CCM if they feel a member could benefit from CCM services.

The Alliance also employs proactive strategies to identify members meeting criteria for CCM, including but not limited to:

- Predictive Model Application – *the Alliance uses a predictive model application, CareAnalyzer, to aggregate utilization data (including behavioral health and pharmacy data) to identify members who may be at risk and could benefit from CM interventions*
- Inpatient census reports
- Hospital discharge reports
- Health Risk Assessments (HRA)
- Readmission Report
- Laboratory Results
- Claims and pharmacy data
- Admission, Transfer, Discharge (ADT) report

Program Interventions

Members referred to CCM are reviewed by CM triage nurses, taking into consideration the known information about the case from claims history, medical records that may be on file for UM purposes, and Member Services call history. The triage nurse verifies Member appropriateness for CM, and if determined as appropriate then a case is opened in the care management information system and assigned to a Case Manager. If the Member does not meet criteria for complex case management, the Member may be referred to other Alliance programs for coordination of care, assistance in managing risk-factors, referral to community services or assistance in identifying a primary care practitioner. Members are deemed ineligible if they do not have active Alliance eligibility or are receiving another duplicative CM service.

The Alliance considers a member enrolled in case management when they are given a

program overview and provides verbal or written consent to program enrollment. The encounter establishing eligibility is tracked in the Clinical Information System as a CCM Consent Note. The Member may opt out of CCM services at any time during the process. Members who make the decision to opt out of CCM are offered the opportunity to enroll again, into CCM upon request or by outreach from The Alliance upon a new triggering event.

Once a member is enrolled in CCM, the Case Manager is responsible for the following services:

A. Identification of Care Needs

The Case Manager (with collaboration with a Social Worker if applicable) conducts a Comprehensive Assessment of the Member health, behavioral, functional, and psychosocial status specific to identified health conditions and comorbidities. The assessment also includes:

- Screening for presence or absence of comorbidities and their status.
- Member's self-reported health status.
- Information on the event or diagnosis that led to the Member's identification for complex case management.
- Assessment of current medications, including schedules and dosages.

An initial assessment is performed as expeditiously as the Member's condition requires (and may be completed by multiple calls), but always within 30 calendar days of the Member becoming eligible. At the time of the assessment, the Case Manager obtains consent to participate in the complex case management program and information about the Member's primary care practitioner, identifies short-term and long-term needs and initiates the care plan. If the Member declines complex case management services, the Member may be referred to community services or assistance in identifying a primary care practitioner.

As part of the General Assessment, the Case Manager reviews and documents the member's clinical history, including disease onset; key events such as acute phases; inpatient stays; treatment history; and current and past medications, including schedules and dosages. All clinical documentation is collected and stored in a secure clinical information system and is organized in structured templates to facilitate efficient access and use of information. Assessment components are further detailed below, and information gathered in the assessment is used to identify care gaps and potential barriers to care.

- **Assessment of Activities of Daily Living** – evaluates Member functional status related to activities of daily living such as eating/feeding, bathing, dressing, going to the toilet, continence, transferring, and mobility.

- **Assessment of Behavioral Health Status Including Cognitive Functions** – evaluates mental health status, including psychosocial factors, cognitive functions, and depression; also includes evaluation of the member’s ability to communicate, understand instructions, and their ability to process information about their illness. Alcohol and drug use screening is also included in the assessment, and referrals are made to the behavioral health Triage Specialists or behavioral health RN Case Managers to collaborate with the Complex Case Management Team for members, as needed.
- **Assessment of Social Determinants of Health** – evaluates for social determinants of health barriers, which are economic and social conditions that affect a wide range of health, functioning and quality of life outcomes and risks that may affect a member’s ability to meet their health goals; assessment includes questions on:
 - Current living situation, such as homelessness
 - Issues related to obtaining or using medications.
 - Transportation issues in meeting healthcare needs
 - Overall financial concerns that impact member’s well-being
- **Assessment of Life-Planning Activities** – evaluates member preferences about healthcare and treatment decisions that may impact their care, including life planning activities (including wills, living wills or advance directives, health care powers of attorney and Medical or Physician Orders of Life Sustaining Treatment (MOLST or POLST forms); life planning materials can also be mailed, as appropriate (e.g., advance directive)
- **Evaluation of Cultural and Linguistic Needs, Care Preferences or Limitations** – determines communication methods best suited for the Member, cultural and linguistic needs, care preferences or limitations; also includes assessment of any personal, religious, cultural preferences or any cultural restrictions to consider in their care
- **Evaluation of Visual and Hearing Needs, Preferences or Limitations** – determines any visual and hearing needs, preferences or limitations, including details such as use of hearing aids and eyeglasses
- **Evaluation of Caregiver Resources and Involvement** – determines any family and/or caregiver involvement in decision-making about the member’s care
- **Evaluation of Health Plan Benefits and Community Resources** – determines access to resources that may impact care, including caregiver, community, transportation, and financial resources delivered by local, county, and state agencies as well as disease-specific organizations, ECM, CS, and community groups to provide services such as community mental health, transportation, wellness organizations, palliative care programs, and nutritional support. United Way, Meals on Wheels, local food banks, and the American Cancer Society are examples of programs with available assistance.

B. Care Plan Development

Following the initial assessment, the Case Manager develops an Individualized Care Plan (ICP), consisting of goals and interventions. Case Managers must develop an ICP within 30 calendar days of completing an initial assessment. The Case Management staff incorporate information from the initial assessment, as well as other assessments such as Health Risk Assessments, Pharmacy profile, specialized assessments, such as PHQ-9 or PHQ-2, that may be included in the Initial Assessment, HRA and Health Information Form/Member Evaluation Tool.

The Care Plan includes a personalized person-centered planning and treatment approach that is collaborative and responsive to meet Member specific health care needs. The ICP is a comprehensive, individualized, interdisciplinary action plan that includes varying types of goals such as clinical milestones, pain management, addressing care gaps, and member self-management. The person-centered approach involves the development of the care management plan with member input regarding preferences and choices in treatments, services, and abilities. Working with the member, the Case Manager or Social Worker establishes and documents a set of prioritized goals.

Case Managers establish care plan goals with the following characteristics:

- Goals are relevant to the Member's condition with identified goals driving optimally coordinated care.
- Goals take into consideration the Member's or primary caregiver's goals and preferences, and desired level of involvement. These goals must be:
 - **Specific** - usually defining a maximum of four behaviors or measurable outcomes.
 - **Measurable** - so that it is easily understood when the goal is achieved.
 - **Achievable** - it does no good for the patient or for the case manager to set unrealistic or unachievable goals. This is an invitation for frustration and disappointment for all parties involved.
 - **Relevant** - are the chosen goals the ones for which the greatest value can be achieved for the time, resources, energy expended?
 - **Time-dimensioned** - Is there a realistic timeframe in which the goal can be achieved?
- Goals are prioritized. A complex case may have many goals toward regaining optimal health or improved function; therefore, each goal is prioritized against other goals for dependencies. The Alliance designates goals on a scale of 1 to 10. 1 = High, 10 = Low.
- Goals have specific time frames for re-evaluation. Members with complex health concerns require ongoing assessment and management. When establishing a goal, the Case Management staff sets a specific date for follow-up on progress toward that goal. Upon re-evaluation the goal may be on track, may require revision, or may no longer be appropriate due to changes in conditions or circumstances. When a goal is retained as is or revised the Case Management staff establishes a next follow-up date in the case management system.

- Goals have identified resources to be utilized, including the appropriate level of care when applicable.
- Goals include documentation of any collaborative approaches to be used, including family participation, to achieve the goal. Goals have an assessment of barriers. Barriers may be assessed at the individual goal level (such as limited transportation to physical therapist) or at the case level (such as Member is in denial about prognosis).

The Case Manager or Social Worker facilitates the participation of the Member, and any family, friends, and professionals of their choosing, to participate in any discussion or decisions regarding treatments, services, support, and education. The Case Manager or Social Worker ensures that the Member receives all necessary information regarding treatment and services so that the Member can make informed choices and provide input regarding care management, prioritized goals as high, medium, or low, and interventions. The Case Manager or Social Worker includes the Member in appropriate and regular updates to the care management plan that occur at a minimum on an annual basis.

The Case Manager also provides the Member or Member caregiver(s) instructions and/or materials to assist the Member with self-management of his or her complex medical condition. The development and communication of a self-management plan includes Member monitoring of key symptoms, activities, behaviors, and vital statistics as appropriate (i.e., weight, blood pressure and glucose levels). The Case Manager documents oral or written communication of self-management activities provided to the Member or caregiver(s).

Care plans also assess the level of care settings, i.e., home health, custodial care, adult, or child day care. Case Managers or Social Workers determine the appropriate setting, education and training required, and community network resources required to achieve a desired level of functioning/independence. In some cases, a specialist, or multiple specialists, in lieu of the Member's PCP, are best positioned to provide the most appropriate care. In these situations, the care manager discusses this option with the Member's PCP and the specialist(s) and arranges for a standing referral to the specialist(s). The care manager notifies the Member that he/she will have direct access to the managing specialist for a specific period.

C. Identification of Barriers to Care

The case manager identifies and addresses the Member's beliefs and concerns about their condition and any perceived or real barriers to their treatment such as access, transportation, or financial barriers to obtaining treatment. The Care Plan identifies barriers to care and interventions to reduce or resolve Member specific healthcare barriers. Additionally, cultural, religious, and ethnic beliefs are assessed that may impact the condition being managed. Based on the assessment of these psychosocial issues, interventions may be modified. Examples of such issues include:

- Beliefs or concerns about the condition or treatment.

- Perceived barriers to meeting treatment requirements.
- Access, transportation, and financial barriers to obtaining treatment.

D. Communication with Member

The case manager communicates directly with the Member, connects Member with the PCP to meet Member specific health care needs, and includes family, caregivers, and other appropriate providers in the case management process. The case manager facilitates the participation of the Member, and any family, friends, and professionals of their choosing, to participate in any discussion or decisions regarding treatments, services, support, and education. The case manager, in collaboration with the PCP, ensures that the Member receives all necessary information regarding treatment and services so that the Member makes informed choices regarding case management, prioritized goals, and interventions.

The Case Manager arranges follow-up interactions with members to review progress towards their care plan goals, including but not limited to, counseling, referral to disease management, education, or self-management support. The Case Manager also evaluates whether previously identified barriers to goals are impeding progress and may work with members to adjust their care plan and goals, as needed.

E. Coordination of Services

The Care Plan includes care coordination and follow-up activities to reduce or eliminate barriers for obtaining needed health care services and for achieving goals. The Case Manager, in collaboration with the PCP facilitates linkages between Members and community organizations to enhance access to community resources and ensure Members can utilize these resources. Case Management staff coordinate access to community services, monitor service delivery, advocate for Member needs, and evaluate service outcomes. A directory of community resources is available to Case Managers and Social Workers as they work with Members, caregivers, and providers. Case Management and Health Education department staff regularly compile and document resources available in Alameda County and update the directory when necessary.

F. Monitoring of PCP Services

Alliance Case Management staff monitor the Member's condition, responses to case management interventions, and access to appropriate care. The Alliance ensures the PCP performs the necessary activities to achieve care plan goals, such as recommended periodic screenings, identification of appropriate healthcare services, and appropriate referrals to specialists or ancillary services.

G. Case Closure

The Case Manager in collaboration with the PCP terminate case management services for Members based on established case closure guidelines. For Members that do not meet the closure criteria with 90 calendar days of enrollment, the Case Management staff will present the case to the Inter-Disciplinary Care Team (ICT) to evaluate whether established

goals are appropriate, and if additional goals are needed or referrals to additional services are warranted. The criteria for case closure include:

- Goals met
- Interventions not successful/All resources exhausted
- Loss of eligibility
- Unable to establish or maintain contact with Member
- Member transferred to another setting and no longer requiresCCM
- Client refuses necessary psychosocial services and/or medical services
- Member declines CM
- Death of the Member
- Member not compliant with plan of care
- Determination by the Case Manager that the member is unable to appropriately and actively participate in the program

Inter-Disciplinary Care Teams

Complex Case Management staff cannot achieve maximum success for member without input from the formal and informal circle of care that surrounds the Member. The Case Management staff integrates CCM program activities with all Members of the Interdisciplinary Care Team (ICT). CCM care plans are made available to the Member or Member representative and the ICT which includes PCP. The Case Management staff collaborates with other licensed professionals on the care team, such as a social worker, clinical pharmacist, and health plan medical directors, and with external professionals in addition to the PCP such as specialty care practitioners. When indicated, the Case Management staff incorporates feedback for the care plan from specially trained Behavioral Health Case Manager, Carve-Out Service CM team, a CM from a Community Based Organization, (CBO) or a CM from an Organ Transplant Center of Excellence (COE). The Case Management staff continually plans for the Member's developing and future needs, which includes ongoing interaction with other Alliance programs such as Disease Management.

The ICT is a team of healthcare professionals from various professional and care management disciplines who work together to manage the physical, psychological, and social needs of the Members. Internal ICTs are held to review care plans and provide guidance to the CM team caring for the Member. For CM, the core ICT is comprised of the CM Medical Director, Manager of CMDM, the assigned CM. Ad-hoc Members of the team may be invited to attend based on the needs of the Member. This includes Pharmacy, Social Worker, or Behavioral Health Specialist. Ad-Hoc Case Conferences are held with invitations to the Member, Caregiver, and/or PCP, and Specialists as needed.

ICTs are held bi-weekly to discuss complex care planning, and to provide support and direction to the dedicated care teams.

E. Enhanced Care Management (ECM)

ECM offers comprehensive, whole person care management to high-need, high-cost Medi-Cal Managed Care Members, with the overarching goals of:

- Improving care coordination;
- Integrating services;
- Facilitating community resources;
- Addressing SDOH;
- Improving health outcomes; and
- Decreasing inappropriate utilization and duplication of services.

Types of Services

ECM service includes:

- Outreach & Engagement
- Comprehensive Assessment & Care Plan
- Enhanced Care Coordination
- Health Promotion
- Comprehensive Transitional Care Services
- Member & Family Supports
- Coordination of & Referral to Community & Support Services

Program activities focus on transitioning from a fragmented and siloed approach provided by various health delivery systems, county/community programs and health plans to an integrated county-wide program focused on accessible shared health information, effective linkages to county resources, and access to high quality community case management services. The Alliance maintains regular communication and coordination with contracted ECM providers to ensure optimal delivery of ECM services, providing clinical consultative and liaison support to navigate the managed care plan.

Team Composition and Roles

Contracted ECM providers are multi-disciplinary and may include (but are not limited to) the following:

- ECM Director
- Clinical Consultant
- Nurse Care Manager
- Behavioral Health Care Manager
- Care Coordinator
- Community Health Worker

The Alliance requests that ECM providers structure their ECM program to contain the following roles:

- Dedicated Lead Care Manager
 - Oversee the provision of ECM services and implementation of the Health Action Plan (HAP)

- Offers services where the ECM member lives, seeks care or finds most easily accessible
- Engage eligible ECM members
- Connect the ECM member to other social services and supports he/she/they may need
- Advocate on behalf of the member with health care professionals
- Use motivational interviewing and trauma-informed care practices
- Work with hospital staff on discharge plan, as appropriate
- Accompany ECM member to office visits as needed
- Monitor for treatment adherence (including medication)
- Provide health promotion and self-management training
- Call ECM member to facilitate ECM member visit with the ECM care coordinator
- Engaging with a multi-disciplinary care team to identify gaps in the member's care and ensure appropriate input is obtained to effectively coordinate all primary, behavioral, developmental, oral health, LTSS, Community Supports and other services that address SDOH.
- ECM Director
 - Overall responsibility for management and operations of the ECM team
 - Responsibility for quality measures and reporting for the ECM provider team
- Clinical Consultant
 - Review and inform HAP
 - Act as a clinical resource for care coordinator, as needed
 - Facilitate access to primary care and behavioral health providers, as needed
- Community Health Workers
 - Engage eligible ECM members
 - Accompany ECM member to office visits as needed
 - Health promotion and self-management training
 - Arrange transportation
 - Assist with linkage to social supports
 - Distribute health promotion materials
 - Call ECM member to facilitate ECM visit with care coordinator
 - Connect ECM member to other social services and supports he/she/they may need
 - Advocate on behalf of the member with health care providers
 - Use motivational interviewing and trauma-informed care practices
 - Monitor for treatment adherence (including medications)

The Alliance has contracted with community-based agencies to deliver Enhanced Care Management (ECM). The purpose of the program is to build community infrastructure to improve integration, reduce unnecessary utilization of health services and improve health outcomes. The ECM providers include both clinic-based CBOs and social agencies (see Appendix H), and serve the following Populations of Focus:

1. Adults, Families and Unaccompanied Children/Youth Experiencing Homelessness

2. Individuals At Risk for Avoidable Hospital or ED Utilization
3. Individuals with Serious Mental Health and/or SUD Needs
4. Individuals Transitioning from Incarceration
5. Adults Living in the Community and At Risk for LTC Institutionalization
6. Adult Nursing Facility Residents Transitioning to the Community
7. Children and Youth Enrolled in California Children's Services (CCS) with Additional Needs Beyond the CCS Condition
8. Children and Youth Involved in Child Welfare
9. Birth Equity Population of Focus

Eligibility criteria

1. Adults who are experiencing homelessness,

- a. defined as meeting one or more of the following conditions:
 - i. Lacking a fixed, regular, and adequate nighttime residence
 - ii. Having a primary residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground.
 - iii. Living in a supervised publicly or privately operated shelter, designed to provide temporary living arrangements (including hotels and motels paid for by federal, state, or local government programs for low-income individuals or by charitable organizations, congregate shelters, and transitional housing)
 - iv. Exiting an institution into homelessness (regardless of length of stay in the institution)
 - v. Will imminently lose housing in the next 30 days
 - vi. Fleeing domestic violence, dating violence, sexual assault, stalking, and other dangerous, traumatic, or life-threatening conditions relating to such violence

AND

- b. Have at least one complex physical, behavioral, or developmental need, with inability to successfully self-manage, for whom coordination of services would likely result in improved health outcomes and/or decreased utilization of high-cost services.

2. Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness

- a. Children, Youth, and Families with members under 21 years of age who:
 - i. Are experiencing homelessness, as defined above, OR
 - ii. Sharing the housing of other persons (i.e., couch surfing) due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; or abandoned in hospitals (in hospital without a safe place to be discharged to), as modified from the 45 CFR 11434a McKinney-Vento Homeless Assistance Act definition of "at risk of homelessness".

3. Adults at Risk for Avoidable Hospital or ED Utilization

- a. Adults who meet one or more of the following conditions:
 - i. Four (4) or more emergency rooms visits in a twelve-month period that could have been avoided with appropriate outpatient care or improved treatment adherence

- ii. Two (2) or more unplanned hospital and/or short-term skilled nursing facility (SNF) stays in a twelve-month period that could have been avoided with appropriate outpatient care or improved treatment adherence.

4. Children and Youth At Risk for Avoidable Hospital or ED Utilization

- a. Children and youth who meet one or more of the following conditions:
 - i. Three (3) or more emergency room visits in a twelve-month period that could have been avoided with appropriate outpatient care or improved treatment adherence
 - ii. Two (2) or more unplanned hospital and/or short-term SNF stays in a twelve-month period that could have been avoided with appropriate outpatient care or improved treatment adherence.

5. Adults with Serious Mental Health and/or SUD Needs

- a. Adults who:
 - i. Meeting the eligibility criteria for participation in, or obtaining services through:
 - 1. SMHS delivered by MHPs
 - 2. The Drug Medi-Cal Organization Delivery System (DMC-ODS) OR the Drug Medi-Cal (DMC) Program

AND
 - ii. Are experiencing at least one complex social factor influencing their health (e.g., lack of access to food, lack of access to stable housing, inability to work or engage in the community, high measure (four or more) of ACEs based on screening, former foster youth, history of recent contacts with law enforcement related to mental health and/or substance use symptoms

AND

 - iii. Meet one or more of the following criteria:
 - 1. Are at high risk of institutionalization, overdose and/or suicide
 - 2. Use crisis services, EDs, urgent care, or inpatient stays as the primary source of care
 - 3. Experienced two or more ED visits or two or more hospitalizations due to serious mental health or SUD in the past 12 months

6. Children and Youth with Serious Mental Health and/or SUD Needs

- a. Children and Youth who:
 - i. Meet the eligibility criteria for participation in, or obtaining services through one or more of the following:
 - 1. SMHS delivered by MHPs
 - 2. The DMC-ODS or the DMC program

7. Adults Transitioning from Incarceration

- a. Adults who:
 - i. Are transitioning from a correctional facility (e.g., prison, jail, or youth correctional facility) or transitioned from correctional facility within the past 12 months

AND

 - ii. Have at least one of the following conditions:
 - 1. Mental Illness

2. SUD
3. Chronic Condition/Significant Non-Chronic Clinical Condition
4. Intellectual or Developmental Disability (I/DD)
5. Traumatic Brain Injury (TBI)
6. HIV/AIDS
7. Pregnant or postpartum

8. Children and Youth Transitioning from a Youth Correctional Facility

- a. Children and youth under 21 or former foster youth between 18 and 26 who are transitioning from a youth correctional facility or adult jail/prison or transitioned from being in a youth correctional facility or adult jail/prison within the past 12 months.

9. Adults Living in the Community and At Risk for LTC Institutionalization

- a. Adults who:
 - i. Are living in the community who meet the SNF Level of Care (LOC) criteria, or who require lower-acuity skilled nursing, such as time-limited and/or intermittent medical and nursing services, support, and/or equipment for prevention, diagnosis, or treatment of acute illness or injury, AND
 - ii. Are actively experiencing at least one complex social or environmental factor influencing their health (including, but not limited to, needing assistance with activities of daily living (ADLs), communication difficulties, access to food, access to stable housing, living alone, the need for conservatorship or guided decision-making, poor or inadequate caregiving which may appear as a lack of safety monitoring, AND
 - iii. Are able to reside continuously in the community with wraparound supports (i.e., some individuals may not be eligible because they have high-acuity needs or conditions that are not suitable for home-based care due to safety or other concerns)

10. Adult Nursing Facility Residents Transitioning to the Community

- a. Adult nursing facility residents who:
 - i. Are interested in moving out of the institution, AND
 - ii. Are likely candidates to do so successfully, AND
 - iii. Are able to reside continuously in the community

11. Children and Youth Enrolled in CCS or CCS WCM with Additional Needs Beyond the CCS Condition

- a. Children and youth who:
 - i. Are enrolled in CCS or CCS WCM, AND
 - ii. Are experiencing at least one complex social actor influencing their health. Examples include (but are not limited to) lack of access to food, lack of access to stable housing, difficulty accessing transportation, high measure (four or more) of ACEs screening, history or recent contacts with law enforcement, or crisis intervention services related to mental health and/or substance use symptoms

12. Children and Youth Involved in Child Welfare

- a. Children and youth who meet one or more of the following conditions:
 - i. Are under age 21 and are currently receiving foster care in California
 - ii. Are under age 21 and previously received foster care in California or another

state within the last 12 months

- iii. Have aged out of foster care up to age 26 (having been in foster care on their 18th birthday or later) in California or another state
- iv. Are under age 18 and are eligible for and/or in California's Adoption Assistance Program
- v. Are under age 18 and are currently receiving or have received services from California's Family Maintenance program within the last 12 months

13. Birth Equity Population of Focus (Adults and Youth)

- a. Adults and youth who:
 - i. Are pregnant or are postpartum (through 12 months period, AND
 - ii. Are subject to racial and ethnic disparities as defined by California public health data on maternal morbidity and mortality

Referral Process and Case Finding for ECM

Referrals to ECM can be made by members, caregivers, practitioners/providers (including PCPs and Specialists), hospitals or facilities, and internal departments (including UM, Member Services, Disease Management, Behavioral Health, and Grievance & Appeals). A CM team member may also deem a member eligible for ECM if they feel a member could benefit from ECM services.

The Alliance also employs proactive strategies to identify members meeting criteria for ECM, including but not limited to:

- Predictive Model Application – *the Alliance uses a predictive model application, CareAnalyzer, to aggregate utilization data (including behavioral health and pharmacy data) to identify members who may be at risk and could benefit from CM/ECM interventions*
- Inpatient census reports
- Hospital discharge reports
- Health Risk Assessments (HRA)
- Readmission Report
- Laboratory Results
- Claims and pharmacy data
- Admission, Transfer, Discharge (ADT) report

There are two major avenues to refer a member into Enhanced Care Management:

1. Alameda Alliance Analytics Department uses the Predictive Modeling to run against the entire Alameda Alliance membership population to identify if members are eligible for ECM. Identification of eligible members occurs monthly, and each member is assigned out to the various ECM provider network based on (but not limited to) the following:
 - a. Member choice
 - b. Population of Focus served
 - c. Location

2. If a community partner or ECM provider identifies an individual who is eligible for ECM, the Alliance welcomes the referral, and the member will be assigned out accordingly.

Alameda Alliance has a 'no wrong door' approach and welcomes any and all referrals for ECM support.

F. Targeted Case Management (TCM)

Targeted Case Management is provided to members by Local Governmental Agencies (LGAs). The Alliance facilitates access to TCM for eligible members by ensuring referrals are appropriately made to the LGAs, so they can evaluate members for TCM services.

Identification of Eligible Members

Alliance staff follow preset guidelines and collaborate with primary care providers when necessary to identify members eligible for TCM services. The Alliance identifies Members that may be eligible for targeted case management services through admission review, concurrent review processes, provider referral, or at the request of the Member. Members eligible for TCM services have generally been identified as moderate or high risk, and meet the following criteria:

- Suffer from one or more acute or chronic conditions.
- Require case management services that are less intensive than services provided in CCM.
- Have medical, functional, and/or behavioral health conditions that require extra support but generally demand fewer resources to achieve or maintain stability than do Members enrolled in more intensive case management programs.
- Care requires moderate coordination with several providers involved.
- Member and/or caregiver education is needed to support self-management skills and strategies. Once available resources are accessed, successful self-management is achievable with moderate intensity of care coordination services.
- Issues may be acutely destabilized and time-limited OR chronic, ongoing but stable.

Referral Process

Once a member is identified and referred to an LGA for potential TCM, they are assigned to an Alliance Case Manager, who ensures screening, referrals, care planning, and all other care coordination activities are coordinated between the member, their providers, the LGA, and The Alliance. The LGA determines eligibility for TCM and assigns a Lead Case Manager to support the member once deemed eligible. For Members under the age of twenty-one (21) who are not accepted for TCM services, the Alliance ensures Member access to services comparable to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) TCM services as well as California Children Services (CCS) for case management for Members with a qualified CCS condition.

Program Interventions

When enrolled in TCM, the LGA Lead Case Manager is responsible for the following services:

- **Screening and enrollment:** determines eligibility and obtains member consent to services
- **Comprehensive clinical assessment:** assesses the Member's health and psychosocial status to identify the specific needs of the Member, including identification of barriers to care such as Member lack of understanding of condition, motivation, financial or insurance issues and transportation problems
- **Development and implementation of an Individualized Care Plan ("ICP") also referred to as a "service plan":** includes information from the Member assessment as well as Member input regarding preferences and choices in treatments, services, and abilities
- **Care coordination activities:** including facilitating communication, referrals, treatment/service authorizations, collaborating with Alliance Utilization and Case Management staff to assist Members with accessing services identified in the service plan
- **Crisis assistance:** collaborating with Alliance Case Management and Behavioral Health staff to coordinate and arrange crisis services or treatment for Members when immediate intervention is necessary or in situations that appear emergent in nature
- **Maintenance of comprehensive, written records:** including assessments, service plans and documentation of service delivery, provider communications, member interactions, etc.
- **Periodic review and evaluation of cases, including case closure, as appropriate**

Oversight

Alliance Case Management and Behavioral Health staff monitor the Member's condition, responses to case management interventions, and access to appropriate care. The Alliance ensures the TCM LGA performs the necessary activities of TCM services. Data exchange occurs between the Alliance and the various TCM LGAs, to ensure non-duplication of services. Collaboration with the LGA also ensures members who are no longer eligible for TCM are appropriately linked with alternate resources to support any ongoing health needs.

G. Transitional Care Services

Alliance Case Management staff maintains procedures to assist Members who transition from one setting or level of care to another. These transitions include, but are not limited to: discharges from hospitals, institutions, other acute care facilities, and skilled nursing facilities (SNFs) to home- or community-based settings, Community Supports placements (including Sobering Centers, Recuperative Care and Short-Term Post Hospitalization), post-acute care facilities, or long-term care (LTC) settings. The Alliance has established partnerships with hospitals and network providers, like Alameda Health Systems (AHS), to effectively implement TCS, ensuring members have access to support across the continuum from admission to discharge.

The Alliance delegates TCS to CHCN for members assigned to the CHCN network – these

members are supported via CHCN's Care Transitions Registered Nurse (CTRN) program. The CM team provides oversight and monitoring of the delegated TCS activities to ensure compliance with all DHCS requirements.

Regardless of risk level, members are assigned to a Case Manager, Social Worker, or Health Navigator to provide transitional care support throughout their hospitalization, and after they leave the hospital. Members are also assessed for ongoing care management needs provided through Complex Case Management, Enhanced Care Management, Disease Management, or other available resources.

The member's Lead Case Manager, whether Alliance-based or community-based, is responsible for the following services:

- Enrollment
- Ensuring completion of the discharge risk assessment by hospital staff or internally
- Ensuring completion of the discharge document (containing lead case manager's name and contact information) and sharing with appropriate parties
- Evaluation of post-discharge needs in association with the transition of care
- All care coordination activities – including facilitating communication, referrals, treatment/service authorizations, etc.
- Maintenance of comprehensive, written records based upon evaluation.
- Clear documentation of service(s) provided, provider communications, Member interactions, etc.
- Case closure and evaluation as appropriate

H. Specialized Services

The Alliance maintains several programs to assist Members with specific or targeted program needs. Those programs include:

- California Children Services (CCS)
- Community Supports
- Continuity of Care (CoC) with Out-of-Network providers
- Major Organ Transplants
- Transportation

California Children Services

The Alliance participates in the identification and referral of eligible children to the California Children Service Program. California Children's Services (CCS) is a statewide program that assists children and youth:

- With a chronic, disabling, or life-threatening CCS eligible medical condition
- In need of specialty medical care
- Meeting income requirements (See Eligibility, below)
- Age birth to 21

Referred children are screened for eligibility criteria and referred to a specialized

contracted CCS provider. As the program is limited to providing services to children under the age of 21 years, The Alliance has developed a program to identify and provide care coordination for the services not covered by the CCS program, as well as for the members nearing 21 years of age and aging out of pediatric health care services. As CCS children age out of the system, staff will assist with the transitions to appropriate adult specialists in a collaborative manner to protect the individual and ensure age-appropriate care is provided.

The CCS Program is coordinated through the UM department, including the CCS Outpatient Utilization Management RN who is employed internally by the Alliance. The Case Managers provide coordination of care in collaboration with the UM department as needed to ensure that all needs are met.

Community Supports Services

Community Supports (CS) services include a variety of services not typically covered by managed care plans. These services are intended to provide additional cost-effective support to members in lieu of higher-level services. In 2025, the Alliance is providing eleven (11) CS services:

- Housing Navigation
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Recuperative Care (Medical Respite)
- Medically Tailored/Medically Supportive Food
- 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

Each CS service has eligibility criteria following the DHCS requirements. The Alliance has contracted with Community Based Organizations (CBOs) to provide the CS services. The goal of the collaboration is to ensure targeted Members and providers can access intensive, community-based care management services from anywhere in the care continuum, providing the “right care-right place-right time”. The program outcomes focus on providing services that will:

- Improve physical and behavioral health outcomes.
- Improve Quality of Life
- Enhance PCP and Member experience with the Health Plan
- Enhance the efficiency and effectiveness of service delivery

The Alliance maintains regular communication and coordination with contracted CS

providers to ensure optimal delivery of CS services, providing clinical consultative and liaison support to navigate the managed care plan.

Continuity of Care (CoC) with Out-of-Network Providers

When the Alliance's network is unable to provide necessary services covered under the Plan to a particular Member, The Alliance must adequately and timely cover these services with out-of-network providers, until services are completed, or the Member can be safely transitioned back into The Alliance network of providers. Continuity of Care may be provided to members in one of the following situations:

- Mandatorily enrolled from Medi-Cal FFS or another managed care plan
- Members with terminated providers
- Medical Exceptions Requests for Newly Enrolled Medi-Cal Enrollees
- Newly enrolled with active course of treatment

The Alliance's UM Department is responsible for the initial care determinations related to CoC situations. Once the CoC is approved, the Member is referred to Case Management for the identification of any care coordination needs. The Case Management ensures the fulfillment of any CoC member is authorized for. Individual case management staff work closely with the Member, the physicians, contracting department, and any other associated healthcare delivery organization involved in the case, to provide timely, quality-based care meeting the needs of the individual member. The CM staff ensure the coordination of services with the Primary Care Providers and Specialists. A full description of the CoC process can be found in the relevant UM Policies.

Major Organ Transplants

In 2022, the Major Organ Transplants (MOT) benefit was carved-in to the Alliance, from Medi-Cal Fee-for Service. This uniquely vulnerable member population receives focused Case Management services throughout the care continuum, from pre-transplant to post-transplant. The CM program works closely with Transplant Centers of Excellence to ensure comprehensive, wraparound services to support members throughout their transplant care.

Transportation Services

Transportation services are a covered benefit, including:

- Emergency Ground Transportation
- Non-emergency medically necessary (NEMT)
- Non-medical transportation (NMT)

The Alliance contracts with a subcontractor, ModivCare (formerly called LogistiCare), to provide NEMT and NMT. The day-to-day operational monitoring and provision of NEMT and NMT utilization is performed by Case Management staff including the Manager of CMDM and Transportation Coordinators, in collaboration with ModivCare. Transportation Coordinators obtain in completed Physician Certification Statement (PCS)

forms prior to NEMT trips taking place.

Case Management collaborates with the Vendor Management Department to ensure that Transportation processes align with the requirements of APL 22-008 for Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT). A full description of the process is defined in the most recent policies on transportation services.

The Alliance is also responsible for the provision of NMT and NEMT to eligible children under the age of 21 to access Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, (now called Medi-Cal for Kids and Teens). The Alliance provides appointment scheduling assistance through its Member Services and Case Management staff and provides necessary transportation, including NEMT and NMT, to and from medical appointments for the medically necessary covered services through its subcontractor. AAH follows DHCS All Plan Letter 19-010 Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment of Services for Medi-Cal Members Under the Age of 21.

VII. Case Management Monitoring and Oversight

The Alliance utilizes several activities to monitor and oversight CM program activities and staff performance. Management staff and auditors monitor cases for timeliness of screening, triage, assessment, and care planning in compliance with CM/CCM policies and procedures. Triage nurses (Lead CM RN), Case Managers, and all internal IDT Members are provided with timely feedback (both positive and negative). Retraining and the disciplinary process are employed as indicated by monitoring.

Internal reports developed to monitor CM/CCM activities for case referrals by source, open active cases, cases open by number of days, timeliness of assessments, timeliness of Member contacts, timeliness of care plan development, PCP contact for care planning purpose, and case closure activities.

Monitoring and oversight activities are the responsibility of CM management. Monitoring occurs monthly, with reporting regarding CCM to the UMC and QIHEC on a quarterly basis.

Productivity and Quality monitoring for all Case Management staff is conducted on a monthly basis by CM Supervisors and Non-Clinical Supervisors. Feedback is given to staff and results are presented to the Director of Social Determinants of Health and Sr. Director of Health Care Services via a quality and productivity data tracker. Data is used to update productivity and quality goals and address any trends.

A. Program Effectiveness

The Alliance is committed to continuous program improvement. Care Management leadership seeks to improve the CCM program through several formal processes.

Complex Case Management Performance Measurement

The Alliance maintains performance measures (see Appendix E) for the complex case management program to maximize Member health, wellness, safety, and satisfaction while ensuring quality care. The Alliance selects measures that have significant and demonstrable bearing on the entire case management population or a defined subpopulation. The Alliance CM leadership staff annually evaluates the measures of the effectiveness of its complex case management program based on the following performance goals and corresponding measures (also see Appendix E):

1. Achieve and maintain high levels of satisfaction with CM services.

Measure One - Member Satisfaction Rates

2. Improve Member outcomes

Measure Two – Care Management for High-Risk Members after Discharge

Measure Three – Percentage of members enrolled in ECM

3. Achieve optimal Member functioning.

Measure Four – Health Status Rate

For each of the performance measures, the Alliance completes the following procedures to produce annual performance measurement reports:

1. Identifies a relevant process or outcome.
2. Uses valid methods that provide quantitative results.
3. Sets a performance goal.
4. Clearly identifies measure specifications.
5. Analyzes results.
6. Identifies opportunities for improvement, if applicable
7. Develops a plan for intervention and re-measurement.

Performance measurement involves the use of quantitative information derived from a valid methodology that considers the numerator and denominator, sampling methodology, sample size calculation, and measurement period. The measure is relevant to the target population so appropriate interventions result in a significant improvement to the care or health of the population.

With data analytic support from the Healthcare Analytics, the CM Medical Director, Senior Director of Health Services, Director of Social Determinants of Health and Manager of Case and Disease Management, in collaboration with the Chief Medical Officer, establish a quantifiable measures and performance goal for each measure that reflects the desired level of achievement or progress. The team will identify measure specifications to ensure that reliable and valid measures can be produced with available analytic capabilities and data resources. Annually the data is compiled, and results reviewed against performance goals. The team completes the evaluation using qualitative and quantitative analysis to identify opportunities to improve performance on the measures and improve the overall effectiveness of the CM program. When opportunities to improve a measure are

identified, the CM leadership team will develop an intervention action plan to improve measurement performance and subsequently re-measure performance to assess effectiveness of the intervention.

Member Experience with Case Management

An annual assessment of Member experience with the CM program is conducted. Member satisfaction is evaluated using a Member survey upon discharge from any CM program. Any Member complaints received regarding CM are also used, whether the complaint was made during the case or submitted after case closure. Formal quantitative and qualitative analyses are conducted using trended data over time, identification of opportunities, barrier analysis, development of interventions for implementation, and plans for re-measurement. The Experience with CM Process report is presented to the UM Committee for review and approval.

Annual CM Program Evaluation

The Chief Medical Officer, the Senior Director, Health Care Services, the Director of Social Determinants of Health, and the Manager of Case and Disease Management collaboratively conduct an annual evaluation of the Alliance complex case management program. This includes an analysis of performance measures, an evaluation of Member satisfaction, a review of policies and program description, analysis of population characteristics and an evaluation of the resources to meet the needs of the population. The results of the annual program evaluation are reported to the UMC and QIHEC for review and feedback. The UMC and QIHEC make recommendations for actions and/or interventions to improve program performance, as appropriate.

Annual CM Workplan

Each year, the Alliance establishes objectives and priorities based on findings from the Annual Program Evaluation and outlines a strategic workplan for the coming year. The workplan incorporates goals, measures, anticipated completion timeframes, and responsible parties, and is maintained throughout the year to monitor progress towards goals and adjust goals, as necessary. The CM workplan is reviewed and approved by the UMC and QIHEC annually.

Delegation of Case Management Activities

The Compliance Department is responsible for monitoring and tracking the overall performance of delegates, including completion of annual audits. CM department staff review the CM components of the annual audit, which includes a review of delegates' policies and procedures and member case files. The CM team also reviews the delegated entities' annual work plans/evaluations, and semi-annual reporting. The Compliance Department is responsible for finalizing the audit findings. For entities that do not meet thresholds, a corrective action plan may be issued and tracked to ensure adequate resolution of the deficiency. All audit findings are reported to the Compliance Committee and the QIHEC.

In 2025, the Alliance will continue to delegate Care Coordination to the following entity:

Delegate	Provider Type	HRA	Care Coordination	CCM	DM
CHCN	Managed Care Organization	No	X	No	No

The Alliance is responsible for ensuring delegated entities deliver quality, cost-effective services. In all delegated arrangements, oversight and evaluation are maintained through the following activities:

1. Evaluation of the delegate’s abilities to perform case management functions prior to delegation in accordance with all regulatory requirements and accreditation standards.
2. Review of required reports monthly, quarterly, semi-annually, and annually, or as defined by the delegate’s contract.
3. Annual delegation review

When a Provider Group is identified as interested in performing a delegated function, the Alliance performs a pre-delegation review to ensure the entities can perform the functions in compliance with the regulatory and accreditation standards. When delegation occurs, the CM team works with the Contracting department to create an appropriate delegation agreement which requires the delegated entity to comply with all regulatory and accreditation requirements. The oversight of a delegated activity includes regular reporting of CM services provided to Alliance Members (e.g., monthly, quarterly, semi-annually, or annually).

B. Summary of Recommendations for 2025

As a result of the 2024 program evaluation, opportunities for improvement have been identified and incorporated into the 2025 CM Program and Work Plan, as follows:

Operational Efficiency and Compliance

Basic Population Health Management (including Care Coordination for Medical and Behavioral Health Services and Disease Management)

- Increase engagement in care coordination for medical services by continuing efforts to find alternative contact information for members through Electronic Health Records (EHR), PCP clinics, and Community Health Record (CHR)
- Work with Healthcare Analytics department to further enhance population analysis and program interventions to evaluate program efficacy
- Work with IT department to identify additional opportunities to automate processes administrative CM processes
- Identify populations experiencing disparities and conduct targeted outreach to increase disease management service utilization. Utilize community health

- workers (CHWs) to connect priority populations to disease management services
- Further solidification of case coordination processes for behavioral health services to increase efficiency and uniformity of practice
- Further collaboration with Alameda County Behavioral Health to ensure member's needs are met across systems of care
- Further collaboration with Alameda County Office of Education to coordinate school-based services
- Initiate bi-directional coordination of care between physical health and mental health providers, including deployment of PCP referral to Mental Health Web Form, enabling PCPs to communicate more completely the needs of the members they refer for mental health services that can be passed on to the Mental Health Provider to enhance their evaluation
- Behavioral Health Treatment/Applied Behavioral Health Treatment plan deployed on the Alliance Provider Portal to enable Autism Service Providers to submit their assessments and treatment plans securely, that can then be shared with referring pediatricians and PCPS.
- Continued identification of data sharing pathways between PCPs and Behavioral Health Practitioners
- Increase member engagement into Alliance Disease Management programs through member mail and call campaigns and provider education

Complex Case Management

- Continue to identify, implement, and evaluate different avenues to continue to increase member engagement.
- Continue SMART goal for:
 - Collaborative efforts with partnered hospitals
 - Productivity standard of Complex member outreach and engagement
 - Obtaining accurate member contact information.
 - Continue the use of the CHR and PCP for alternate phone numbers for member engagement

Enhanced Care Management

- Continue to develop, train, and maintain the ECM Provider network, in preparation for further expansion to support all ECM populations of focus.
- Provide consistent/routine monthly in-person and virtual provider audits and respective in- services to ensure ECM compliance and optimal use of ECM benefits.
- Work closely with ECM providers in monthly IDT meetings to provide guidance with the ECM graduation process.

Transitional Care Services

- Continued efforts to improve member engagement rate will continue in 2025 via finding alternate phone numbers through CHR, and PCP office.
- Increased partnerships with hospital systems.

- Increased partnerships with PCP offices in collaborating on TCS, particularly post discharge appointments.
- Increased focused on specific TCS populations such as OB and FFS Medicare Part A members.
- Explore leveraging Community Health Worker (CHW) benefit to collaborate on TCS work.
- Collaborate with Quality departments and other departments to address readmissions and ER utilization.

Community Supports

- Increase staff where appropriate to better meet needs of members and providers.
- Continue relationships with the providers to assist them where needed. Continue to work with Analytics to further enhance the dashboard for CS services
- Continue development of accurate and reliable closed loop referral process with Community Supports providers, in alignment with the DHCS requirement by July 1, 2025; establish mechanism for CS providers to confirm members are being serviced after authorizations have been issued
- Implement the new guidance into existing criteria from the Community Supports Policy Guide from Feb 2025
- Provide training to all CS providers to promote best practices while working with our members and to continue to build rapport with CS providers

Quality Improvement

Member Satisfaction with CM

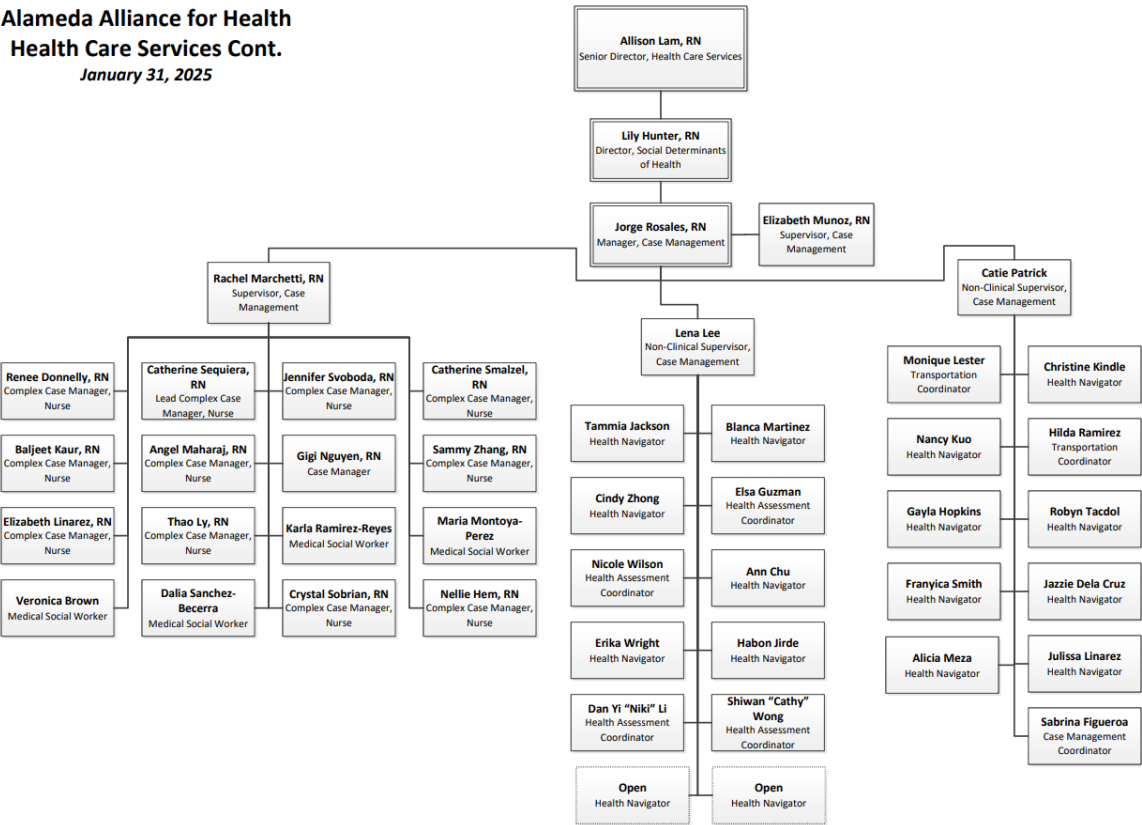
- Increasing the return rate of satisfaction surveys.
 - Satisfaction surveys are attached to case closure letters, which are sent to all members who complete their CM case. CM will work on ensuring members are educated that they will receive a survey upon case closure to increase return rate.
 - In 2024, CM performed outreach calls to offer members the opportunity to complete satisfaction survey over the phone.
- Continue educating members on care management process, including establishing communication plans with member and establishing mutually-agreed upon scheduled calls
- Continue educating members on effective strategies for working with provider offices, including setting realistic expectations about provider treatment protocols

Delegated Case Management

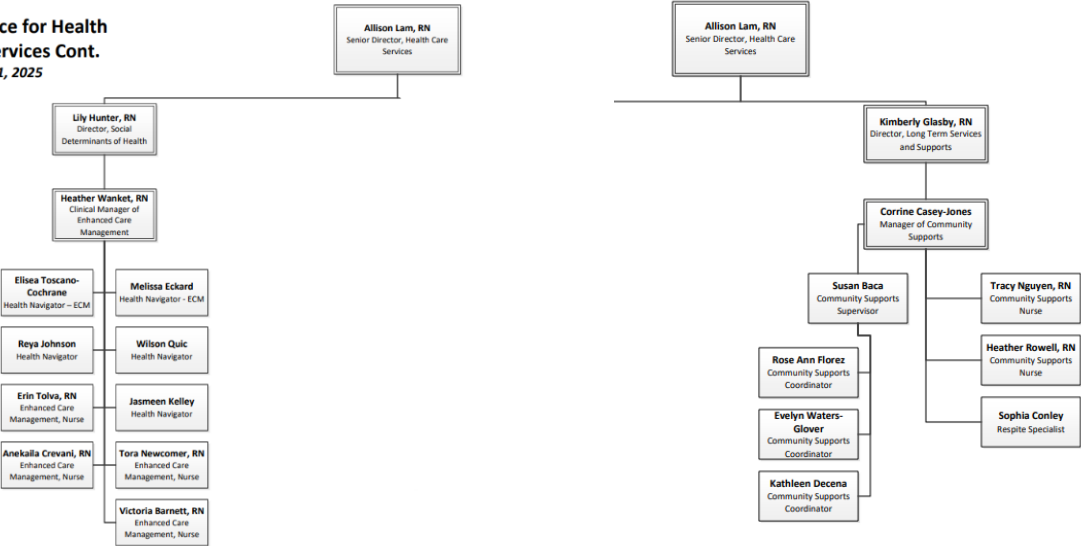
- Partner with the Compliance Department to evaluate audit tools and establish metrics that align with The Alliance's key performance indicators.
- Provider regular training and share best practices with delegated entities, particularly around Enhanced Care Management, Community Supports, Transitional Care Services, and other activities impacting The Alliance's Population Health Management strategy

Appendix A – Case Management Department Organization Chart

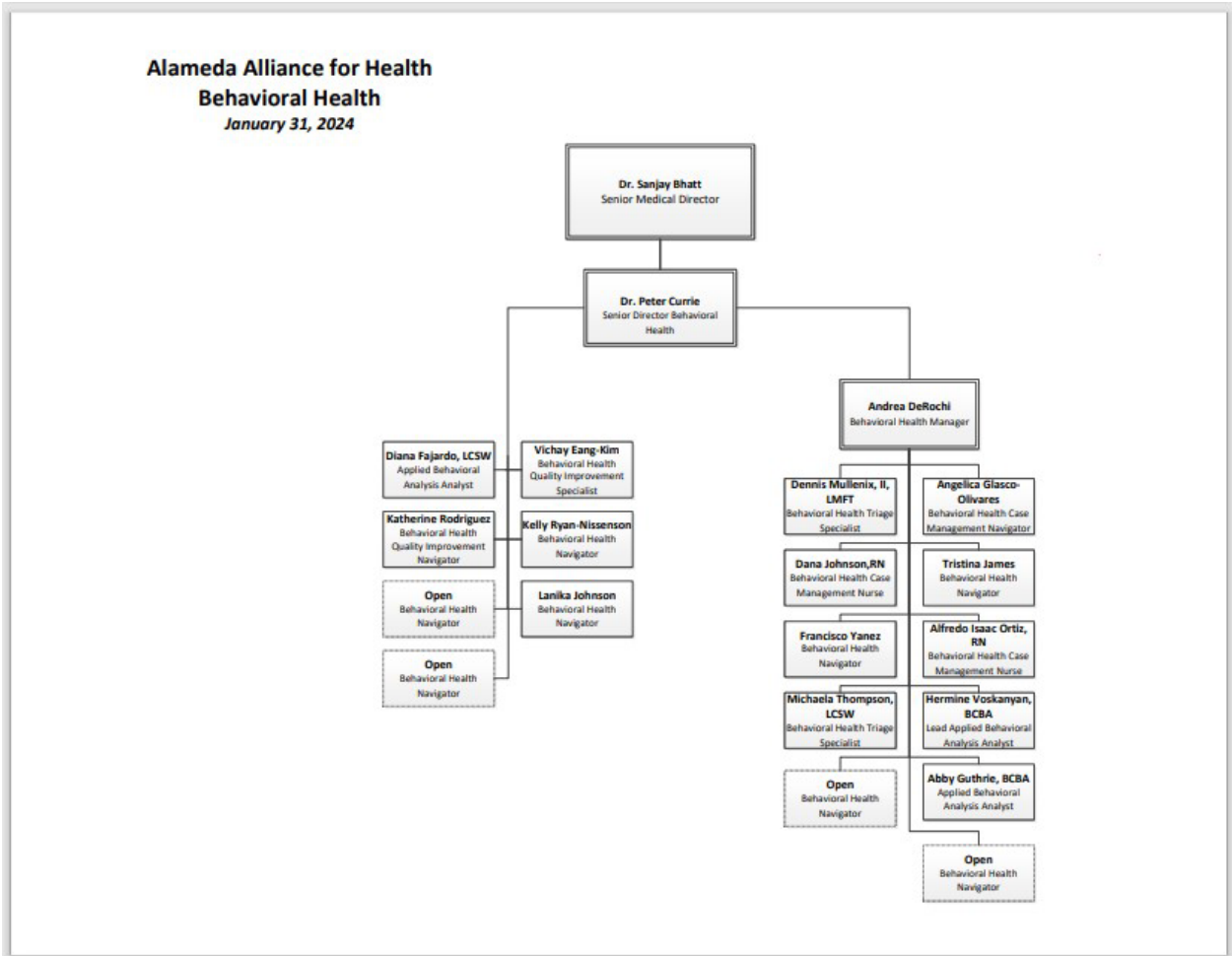
Alameda Alliance for Health
Health Care Services Cont.
January 31, 2025



Alameda Alliance for Health
Health Care Services Cont.
January 31, 2025



Appendix B – Behavioral Health Department Organization Chart



Appendix C – Clinical Practice Guidelines

The Alliance recommends its provider network follow the most current versions of [Clinical Practice Guidelines](#), as found on the Alliance Provider Website and detailed below:

Preventive Care Guidelines

Preventive Care

For Alliance members 21 years of age and under, the Alliance adheres to the most recent Bright Futures/American Academy of Pediatrics (AAP) Recommendations for Preventive Pediatric Health Care. This is a schedule of screenings and assessments recommended at each well-child visit from infancy through adolescence. The full periodicity schedule is found [here](#).

For asymptomatic healthy adults and pregnant women, the Alliance follows the current U.S. Preventive Services Task Force (USPSTF) A and B Recommendations for providing clinical preventive services. Current recommendations are found [here](#).

Immunizations

The Alliance covers immunizations according to the immunization schedules recommended by the Advisory Committee on Immunization Practices (ACIP) and approved by the Centers for Disease Control and Prevention (CDC) and other medical associations. The child and adult immunization schedules are found [here](#).

Perinatal Guidelines

The Alliance provides perinatal services for pregnant members according to the most current standards and guidelines of the American College of Obstetrics and Gynecology (ACOG). Current guidelines are found [here](#).

Mental and Behavioral Health Services

The Alliance uses the following externally validated criteria for provision and effective management of Behavioral and Mental Health services:

1. Milliman Clinical Guidelines. Current guidelines found [here](#).
2. Level of Care Utilization System (LOCUS). Current guidelines found at the [American Association for Community Psychiatry \(AACAP\)](#).
3. Child and Adolescent Level of Care Utilization System (CALOCUS). Current guidelines found at the [American Academy of Child and Adolescent Psychiatry \(AACAP\)](#).
4. Early Childhood Service Intensity Instrument (ECSII). Current guidelines found at the [American Academy of Child and Adolescent Psychiatry \(AACAP\)](#).
5. APA Board Guidelines for Autism Spectrum Disorders. Current guidelines found here [APA-Approved Standards and Guidelines](#).

Tobacco Cessation Guidelines

1. [Alameda Alliance for Health Tobacco Provider Guide](#)
2. U.S. Department of Health and Human Services – [Treating Tobacco Use and Dependence Guidelines](#): 2008 Update

Appendix D – Complex Case Management Criteria



Complex Case Management Criteria

(any 3 of ANY of the following)

High Utilization:

- ER visits: greater than 4 in the past 6 months
- Acute inpatient admissions: greater than 3 admissions in the past 6 months
- Readmissions: 2 or more readmissions in past 6 months

At Risk Diagnoses:

- Cancer
- CHF
- COPD
- CVA
- Diabetes
- End Stage Renal Disease (ESRD) with or without dialysis
- Hemophilia
- HIV/AIDS
- Multiple Sclerosis (MS)
- Transplant
- Neonates who are premature, have a congenital anomaly, or cancer (If selected, this will qualify member for Complex criteria alone)
- Schizophrenia
- schizoaffective
- anxiety
- depression
- bipolar
- PTSD
- Chemical dependency/substance use

Complex Medical/Psychosocial Needs:

- Three (3) or more dependencies for ADLs
- The member reports abuse, neglect, or threat of harm to self or others (Reminder, if select: file appropriate report with protective services)
- The member does not have permanent housing
- There is no caregiver present
- Per the member, the caregiver is unreliable
- Per the member, the caregiver is not enough

Appendix E – CCM Performance Measures (2025)

	Goal	Measure	Measurement	Performance Goal	2024 Outcome	Goal Met in 2024?
#1	Achieve and maintain high level of satisfaction with CM services	Member Satisfaction Rates	High level of satisfaction with CM services. Score of 7 or higher on question 8 of CM Satisfaction Survey.	90%	95%	Yes
#2	Improve Member Outcomes	Care Management for High-Risk Members after Discharge	The number and percentage of transitions for high-risk Medi-Cal members that had at least one interaction with their assigned care manager within 7 days post discharge	28%	25% (baseline measure)	
		Percentage of members enrolled in ECM	The number of members who are enrolled in ECM out of the total number of enrolled members in the Alliance	2%	1.6% (baseline measure)	
#3	Achieve optimal member functioning	Health Status	% of members in CCM responding that their health status improved because of CCM. Score of 7 or higher on question 6 of CM Satisfaction Survey.	90%	85%	No

Appendix F – Health Risk Assessment (HRA) Questionnaire



Health Survey

Member Name:

Alliance Member ID#:

Member Address:

Member Phone Number:

☐ Cell ☐ Home

1. What is your preferred language:

- ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese
☐ Other: _____

2. Where do you live:

- ☐ Own home ☐ Temporary housing
☐ Rent ☐ Homeless
☐ Staying with friends/family ☐ Group home
☐ Assisted living ☐ Other: _____

Please answer the questions on this form as best you can.

3. In general, how would you describe your health?

- ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Decline to answer

4. Do you know the name of your Primary Care Provider (PCP)? Your PCP is the main doctor you see for check-ups and when you have a medical problem. ☐ Yes ☐ No

5. Have you had a hard time trying to see your PCP or specialist? ☐ Yes ☐ No

6. Have you seen your PCP in the last three (3) months? ☐ Yes ☐ No

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7. Do you need to see a doctor in the next 60 days? ☐ Yes ☐ No
8. Are you under the care of any specialists? ☐ Yes ☐ No
9. Are you pregnant? ☐ Yes ☐ No
- a. If you are pregnant, are you currently seeing a doctor for this pregnancy? ☐ Yes ☐ No
10. Do you have a condition that limits your activities or what you can do? ☐ Yes ☐ No
11. Do you have chronic pain? ☐ Yes ☐ No
12. Have you been to the Emergency Room (ER) two (2) or more times in the last 12 months? ☐ Yes ☐ No
13. Have you been admitted to the hospital in the past 12 months? ☐ Yes ☐ No
14. Have you been in a Skilled Nursing Facility (SNF) in the past 12 months? ☐ Yes ☐ No
15. Do you see a doctor regularly for a chronic condition? ☐ Yes ☐ No
- If yes, check all that apply:
- | | | |
|--|---|--|
| ☐ Asthma | ☐ Cancer | ☐ Cystic Fibrosis |
| ☐ Diabetes | ☐ Heart Problems | ☐ Hepatitis |
| ☐ High Blood Pressure | ☐ HIV or AIDS | ☐ Kidney Disease |
| ☐ Seizures | ☐ Sickle Cell Anemia | ☐ Tuberculosis |
| ☐ Other: _____ | | |

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16. Do you take three (3) or more prescription medicines each day? ☐ Yes ☐ No

17. Please tell us the medications you are taking at this time (if any):

Name of Medication	Dose (How Much)	How Often Taken

18. Do you need help picking up your medication? ☐ Yes ☐ No

19. Do you need help taking your medicines? ☐ Yes ☐ No

20. Over the past month (30 days), how many days have you felt lonely?

- ☐ None – I never feel lonely
- ☐ Less than 5 days
- ☐ More than half the days (more than 15 days)
- ☐ Most days – I always feel lonely

21. Do you see a doctor regularly for a mental health condition such as depression, bipolar disorder, or schizophrenia? ☐ Yes ☐ No

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22.		Not at all	Several Days	More than half the days	Nearly everyday
	a. Over the last two (2) weeks, how often have you had little interest or pleasure in doing things?				
	b. Over the last two (2) weeks, how often have you felt down, depressed or hopeless?				

23. Have you had any changes in thinking, remembering, or making decisions? ☐ Yes ☐ No

24. Do you feel you have a problem with:

a. Alcohol use	☐ Yes	☐ No
b. Drug Use	☐ Yes	☐ No
c. Tobacco use	☐ Yes	☐ No

25. If you use tobacco or smoke, are you ready to try quitting within the next month? ☐ Yes ☐ No

26. Are you using medical equipment or supplies, such as a hospital bed, wheelchair, walker, oxygen, or ostomy bags? ☐ Yes ☐ No
Please list _____

27. Do you need assistive devices that you do not have? ☐ Yes ☐ No
Please list _____

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28. Do you need help with any of these actions?

a. Taking a bath or shower	☐ Yes	☐ No
b. Going up stairs	☐ Yes	☐ No
c. Eating	☐ Yes	☐ No
d. Getting dressed	☐ Yes	☐ No
e. Brushing your teeth or hair, or shaving	☐ Yes	☐ No
f. Making meals or cooking	☐ Yes	☐ No
g. Getting out of a bed or a chair	☐ Yes	☐ No
h. Shopping and getting food	☐ Yes	☐ No
i. Using the toilet	☐ Yes	☐ No
j. Walking	☐ Yes	☐ No
k. Washing dishes or clothes	☐ Yes	☐ No
l. Writing checks or keeping track of money	☐ Yes	☐ No
m. Getting a ride to the doctor or to see your friends	☐ Yes	☐ No
n. Doing house or yard work	☐ Yes	☐ No
o. Going out to visit family or friends	☐ Yes	☐ No
p. Using the phone	☐ Yes	☐ No
q. Keeping track of your appointments	☐ Yes	☐ No

If yes, are you getting all the help you need with these actions? ☐ Yes ☐ No

If you get help with any of the tasks listed above, who is your helper? ☐ Yes ☐ No

Name of your helper: _____

What is your relationship to the helper: _____

May we contact your helper? ☐ Yes ☐ No

Phone number of helper: _____

29. Do you ever think your caregiver has a hard time giving you all the help you need? ☐ Yes ☐ No

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30. Is there a family member or friend who helps you make your health care decisions or who is involved in your plan of care? ☐ Yes ☐ No

If yes, please provide the name and relationship to you.

Name: _____

Relationship: _____

31. As of today, do you receive any of these services from an agency?
- a. Home Health Nurse ☐ Yes ☐ No
 - b. Physical, Occupational, Speech Therapy at Home ☐ Yes ☐ No
 - c. Home Care Worker ☐ Yes ☐ No
 - d. Social Worker ☐ Yes ☐ No
 - e. Adult Day Care Center ☐ Yes ☐ No
 - f. Help with Transportation ☐ Yes ☐ No
- Other (please list): _____

32. Do you have family members or others willing and able to help you when you need it? ☐ Yes ☐ No

33. Do you need help with food? ☐ Yes ☐ No

34. Do you need help with housing? ☐ Yes ☐ No

35. Do you need help with transportation? ☐ Yes ☐ No

36. Do you need help with your heating or water bill? ☐ Yes ☐ No

37. Have you completed an Advance Directive (a form that directs your health care wishes)? ☐ Yes ☐ No

38. Can you live safely and move around easily in your home? ☐ Yes ☐ No

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39. If no, does the place where you live have:
- | | | |
|--|------------------------------|-----------------------------|
| a. Good lighting | ☐ Yes | ☐ No |
| b. Good heating | ☐ Yes | ☐ No |
| c. Good cooling | ☐ Yes | ☐ No |
| d. Rails for any stairs or ramps | ☐ Yes | ☐ No |
| e. Hot water | ☐ Yes | ☐ No |
| f. Indoor toilet | ☐ Yes | ☐ No |
| g. A door to the outside that locks | ☐ Yes | ☐ No |
| h. Stairs to get into your home or stairs inside your home | ☐ Yes | ☐ No |
| i. Elevator | ☐ Yes | ☐ No |
| j. Space to use a wheelchair | ☐ Yes | ☐ No |
| k. Clear ways to exit your home | ☐ Yes | ☐ No |
40. Have you fallen in the last month? ☐ Yes ☐ No
41. Are you afraid of falling? ☐ Yes ☐ No
42. Do you need help filling out health forms? ☐ Yes ☐ No
43. Do you need help answering questions during a doctor's visit? ☐ Yes ☐ No
44. Are you afraid of anyone or is anyone hurting you? ☐ Yes ☐ No
45. Is anyone using your money without your okay? ☐ Yes ☐ No
46. Do you sometimes run out of money to pay for food, rent, bills, and medicine? ☐ Yes ☐ No

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This Health Survey is complete. Thank you!

Please return to:

Alameda Alliance for Health
Case Management Department
1240 S. Loop Road
Alameda, CA 94501

If you have questions, please call:

Alliance Member Services Department
Monday – Friday, 8 am – 5 pm
Phone Number: **1.510.747.4567**
Toll-free at **1.877.932.4567**
People with hearing and speaking impairments (CRS/TTY):
711/1.800.735.2929

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Appendix G – Long-Term Services and Supports Referral Questions

Background: In 2016, the Department of Health Care Services (DHCS) announced several strategies designed to improve referrals to Long Term Services and Supports (LTSS), including creating and releasing standardized LTSS referral questions for all Medi-Cal managed care plans (MCPs) to administer during the Health Risk Assessment (HRA) process. DHCS convened a workgroup to develop recommendations to increase the effectiveness of the questions.

The workgroup identified four different categories of risk factors: social determinants, functional capacity, medical conditions, and behavioral health conditions. These risk factors address the spectrum of challenges a beneficiary may face, reflecting a whole person approach to understanding the need for LTSS. The workgroup developed standardized LTSS referral questions to address the most directly connected risk factors. Each of the questions seeks to identify whether a beneficiary is experiencing risk factors that make them a candidate for LTSS services that will help keep them in their home and community. The questions are organized in the following two tiers and MCPs must take a holistic view of questions in both tiers to identify beneficiaries in need of follow-up assessments:

- Tier 1 contains questions directly related to LTSS eligibility criteria and should trigger a follow-up assessment to determine if the beneficiary is eligible for LTSS services.
- Tier 2 contains questions that identify contributory risk factors, which would put a beneficiary at higher risk for needing LTSS services when combined with risk factors identified in Tier 1.

The headings in italics are not part of the questions but provide the intent of the questions.

Long-Term Services and Supports Referral Questions <i>Reference: DHCS Population Health Management Policy Guide</i>	
Tier 1 LTSS Questions	
Activities of Daily Living Functional Limitations / Instrumental Activities of Daily Living Limitations / Functional Supports (Functional Capacity Risk Factor)	
Question 1: Do you need help with any of these actions? (Yes/No to each individual action) a) Taking a bath or shower b) Going up stairs c) Eating d) Getting Dressed e) Brushing teeth, brushing hair, shaving f) Making meals or cooking g) Getting out of a bed or a chair h) Shopping and getting food i) Using the toilet j) Walking k) Washing dishes or clothes l) Writing checks or keeping track of money m) Getting a ride to the doctor or to see your friends n) Doing house or yard work o) Going out to visit family or friends p) Using the phone q) Keeping track of appointments If yes, are you getting all the help you need with these actions?	
Housing Environment / Functional Supports (Social Determinants Risk Factor)	
Question 2: Can you live safely and move easily around in your home? (Yes/No) If no, does the place where you live have: (Yes/No to each individual item) a) Good lighting b) Good heating c) Good cooling d) Rails for any stairs or ramps e) Hot water f) Indoor toilet g) A door to the outside that locks h) Stairs to get into your home or stairs inside your home i) Elevator j) Space to use a wheelchair k) Clear ways to exit your home	

Long-Term Services and Supports Referral Questions <i>Reference: DHCS Population Health Management Policy Guide</i>
Low Health Literacy (Social Determinants Risk Factor)
Question 3: “I would like to ask you about how you think you are managing your health conditions” a) Do you need help taking your medicines? (Yes/No) b) Do you need help filling out health forms? (Yes/No) c) Do you need help answering questions during a doctor’s visit? (Yes/No)
Caregiver Stress (Social Determinants Risk Factor)
Question 4: Do you have family Members or others willing and able to help you when you need it? (Yes/No) Question 5: Do you ever think your caregiver has a hard time giving you all the help you need? (Yes/No)
Abuse and Neglect (Social Determinants Risk Factor)
Question 6a: Are you afraid of anyone or is anyone hurting you? (Yes/No) Question 6b: Is anyone using your money without your ok? (Yes/No)
Cognitive Impairment (Functional Capacity, Medical Conditions, Behavioral Health Condition Risk Factor)
Question 7: Have you had any changes in thinking, remembering, or making decisions? (Yes/No)
Tier 2 LTSS Questions:
Fall Risk (Functional Capacity Risk Factor)
Question 8a: Have you fallen in the last month? (yes/No) Question 8b: Are you afraid of falling? (Yes/No)
Financial Insecurity or Poverty (Social Determinants Risk Factor)
Question 9: Do you sometimes run out of money to pay for food, rent, bills, and medicine? (Yes/No)
Isolation (Social Determinants Risk Factor)
Question 10: Over the past month (30 days), how many days have you felt lonely? (Check one) None – I never feel lonely Less than 5 days More than half the days (more than 15) Most days – I always feel lonely

Appendix H – ECM Providers

ECM Contracted Providers	ECM Sites
HCSA – Alameda County Behavioral Health	ACBH
Alameda Health Systems (AHS)	AHS Eastmont
AHS Highland	AHS Highland
AHS Hayward	AHS Hayward
Bay Area Community Services (BACS)	BACS
California Cardiovascular Consultants	California Cardiovascular Consultants
California Children’s Services (CCS)	CCS
CHCN	Asian Health Services
	BACH - Liberty
	BACH - Mowry
CHCN Axis Community Center	La Clinica – San Antonio
CHCN La Clinica De La Raza	La Clinica - Transit Village
CHCN LifeLong Medical Care	LifeLong – Downtown Oakland
	Lifelong – East Oakland
	Lifelong – Howard Daniel
	Lifelong – Trust Center
	Lifelong – West Berkeley
CHCN Native America Health Center	Native America Health Services
CHCN Tiburcio Vasquez Health Center	Tiburcio Vasquez Health Center
CHCN West Oakland Health Council	West Oakland Health Council
East Bay Innovations (EBI)	EBI
Full Circle	A Better Way
	Alameda Family Services
	Alternative Family Services
	East Bay Agency for Children
	Fred Finch Youth and Family Services
	Lincoln Family Services
	Stars. Inc
	West Coast Children’s Clinic
Institute on Aging (IOA)	IOA
La Familia	La Familia
MedZed	MedZed
Roots Community Health Center	Roots Community Health Center
Seneca Family Services	Seneca Family Services
Titanium Health Care	Titanium Health Care

2025 Case Management Work Plan

Performance Measures	2025 Goal	Supporting Document / Report	Responsible Staff	Timeframe for completion	Committee & Reporting Frequency
Program Scope and Structure					
Utilization Management Committee (UMC) schedule	UMC meets at least quarterly; 2026 UMC schedule/agenda prepared and distributed by November 2025	UMC Meeting Minutes	Sr. Director, HCS	meet at least Quarterly; 2026 UMC schedule completed by November 2025	N/A - operational
Review of Policies & Procedure	100% of P&Ps reviewed within annual timeframe, and as needed	P&Ps	Sr. Director, Health Care Services	As needed, and at least Annually	UMC - annually
2024 CM Program Evaluation	Complete 2024 CM Program Evaluation by Q1 2025	2024 CM Program Evaluation	Sr. Director, Health Care Services	Annually, by Q1 2025	UMC - annually
2025 CM Program Description	Complete 2025 CM Program Description by Q1 2025	2025 CM Program Description	Sr. Director, Health Care Services	Annually, by Q1 2025	UMC - annually
2025 CM Work Plan	Complete 2025 CM Work Plan by Q1 2025	2025 CM Workplan	Sr. Director, Health Care Services	Annually, by Q1 2025	UMC - annually
CM Program Effectiveness					
CM Measures					

ALLIANCE CASE MANAGEMENT DEPARTMENT
2023 WORK PLAN

Performance Measures	2025 Goal	Supporting Document / Report	Responsible Staff	Timeframe for completion	Committee & Reporting Frequency
Health Risk Assessment for SPDs (timely outreach & completion rate for newly enrolled and annual reviews)	≥ 90% timely outreach; ≥ 30% completion rate for newly enrolled; ≥ 30% completion rate for annual reviews	HRA Dashboard Report	Manager, CM	Quarterly	UMC - quarterly
HIF/MET (timely completion rate)	≥ 90% timely completion rate	HIF/MET Dashboard	Manager, CM	Quarterly	UMC - quarterly
Quality Audit Scores	≥ 90% audit score (CM, ECM, CS)	Internal File Review Audits (CM, ECM, CS)	Managers (CM, ECM, CS)	Monthly	UMC - quarterly
Percentage of Transitions for high-risk members that had at least 1 interaction with assigned CM within 7 days post-discharge	≥ 28% post-discharge engagement	PHM KPI report	Manager, CM	Quarterly	UMC - quarterly
Percentage of members enrolled in ECM	≥ 2% enrollment	PHM KPI report	Manager, ECM	Quarterly	UMC - quarterly
BH - increase case closures with reason "complete"	5% increase in completed BH CM cases	BH Case Closure Report	Manager, BH CM	Quarterly	UMC - quarterly
ECM Oversight (includes Grandfathered ECM members, network capacity expansion)	100% grandfathered ECM members re-evaluated for eligibility, expand ECM capacity	ECM Project Report	Manager, ECM	Quarterly	UMC - quarterly
CS Oversight	appropriate application of CS criteria	CS Dashboard Report Internal Quality Audits	Manager, CS	Quarterly	UMC - quarterly
Member Experience with CM					
Member Satisfaction Survey	≥ 90% of respondents will score a 7 or higher for overall satisfaction with the CM program	Member Survey Outcomes	Manager, CM	Annually	UMC - annually
Member complaints related to CCM program activities (NCQA)	< 3% of CCM cases will have a grievance filed with G&A related to CM process	G&A Reports	Manager, CM / Director, G&A	Quarterly	UMC - quarterly
Community Advisory Committee Insights	Present Quarterly report of Community Advisory Committee Insights	Community Advisory Committee Report	Director, Population Health	Quarterly	UMC - quarterly
Evaluation of Delegated Case Management					
Delegation Oversight - Audit & Corrective Action monitoring	100% timely review, analysis, and attestation completion for Delegate audits & corrective action plans	Delegation Oversight Auditing Templates	Delegation Oversight / CM Director	Quarterly	UMC - quarterly
Delegation Oversight - Standard CM monitoring	100% timely review, analysis, and attestation completion for Delegate CM reports (monthly, quarterly, annually)	Delegation Oversight Reporting Templates	Delegation Oversight / CM Director	Monthly, Quarterly, Annually (depending on report)	N/A - operational
Regulatory, Compliance, Accreditation Findings					
DHCS - Corrective Action Plans for CM Activities	100% timely participation and response to DHCS CM Findings and/or Corrective Action Plans and associated activities	DHCS Findings / CAP Report	Sr. Director, Health Care Services	as needed	UMC - as needed
DMHC - Corrective Action Plans for CM Activities	100% timely participation and response to DMHC CM Findings and/or Corrective Action Plans and associated activities	DMHC Findings / CAP Report	Sr. Director, Health Care Services	as needed	UMC - as needed
NCQA - Corrective Action Plans for CM Activities	100% timely participation and response to NCQA CM Findings and/or Corrective Action Plans and associated activities	NCQA Findings / CAP Report	Sr. Director, Health Care Services	as needed	UMC - as needed
CM Processes					

ALLIANCE CASE MANAGEMENT DEPARTMENT
2023 WORK PLAN

Performance Measures	2025 Goal	Supporting Document / Report	Responsible Staff	Timeframe for completion	Committee & Reporting Frequency
TCM - Identification and Referrals made to TCM LGAs	Benchmark -≤ 1%	Internal Tracking Log	Manager, CM	Quarterly	N/A - operational
Out of Plan Services - Referrals made for Developmental Disabled/Regional Center	Benchmark -≤ 1%	Regional Center Tracking Log	Manager, CM	Quarterly	N/A - operational
Out of Plan Services - Referrals made for Early Intervention Services/Regional Center	Benchmark -≤ 1%	Regional Center Tracking Log	Manager, CM	Quarterly	N/A - operational
CM Activity Reporting (AAH CM only) - engagement and UTC rate	≥ 60% engagement rate; ≤ 30% UTC rate	Case and Disease Management Dashboard	Manager, CM	Quarterly	N/A - operational
CCM Activity Report - referrals & outreach rate, UTC rate, aged-cases rate (CCM case open >90days); ICT completion rate	≥ 80% outreach rate to CCM-eligible members; ≤ 40% UTC rate; ≤ 1% of CCM cases open >90 days; ≥ 90% ICT completion (for CCM members open for >90 days)	Case and Disease Management Dashboard, Daily Aging Report and Complex Case Log	Manager, CM	Quarterly	N/A - operational
CCM Assessment Timeliness (per NCQA)	100% of CCM cases with initial assessment started within 30 calendar days of identifying a member for CCM; 100% of CCM cases with assessment completed within 60 days of identifying a member for CCM	CM Aging Report	Manager, CM	Quarterly	N/A - operational
Collaborate with Analytics to enhance predictive modeling to improve identification of appropriate members for CCM	100% active participation in Population Health Management Workgroups and Risk Stratification discussions	Population Health Report	Director, SDOH	Semi-annual	N/A - operational
Major Organ Transplant Reporting	100% timely review and submission of DHCS MOT Report	DHCS Quarterly MOT Reports	Manager, CM	Quarterly	N/A - operational
MCP Transition Post-Transitional Monitoring (PTM) Reporting	100% timely review and submission of DHCS MCP Transition PTM Reports	DHCS Quarterly MCP Transition Post-Transition Reports	Sr. Director, HCS	per DHCS schedule	N/A - operational
Continuity of Care (MER & OON requests) Reporting	100% timely review, analysis, and submission of COC and OON sections in DHCS Quarterly Monitoring Report	DHCS Quarterly Monitoring Reports	Sr. Director, HCS	Quarterly	N/A - operational
Accuracy of Published CM content	100% timely completion of platform audits	Member and Provider Portals (public and secure site), Platform Audit Results	Sr. Director, HCS	As needed, and at least Annually	N/A - operational
Accuracy of Member and Provider Communications related to CM, ECM, and CS Process	100% participation in creation or updates to member and/or provider-facing content for CM activities (including NOAs, EOC, Provider Manual, Website, Portals)	Member- and Provider-facing communications	Sr. Director, HCS	As needed, and at least Annually	N/A - operational
Administrative					
Annual Review of CM Staffing	Timely and accurate submission of staffing review, including applicable justifications	Staffing Worksheets	Sr. Director, HCS	Annually, by Q1 2025	N/A - operational
Clinical Information System Enhancements	100% participation in TruCare Steering Committee and System Optimization Efforts	Change Requests, Project Plans	Sr. Director, HCS	n/a	N/A - operational



Utilization Management Program Evaluation

2024

Utilization Management
2024 Program Evaluation

Signature Page

07/01/2025 | 1:19 PM PDT

Date

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Chair Rebecca Gebhart

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Rebecca Gebhart
Board Chair

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2024 Utilization Management Program Evaluation

Overview

Under the leadership and strategic direction established by Alameda Alliance for Health (The Alliance) Board of Directors, senior management and the Quality Improvement Health Equity Committee (QIHEC), the 2024 Utilization Management Programs were successfully implemented. This report serves as an annual evaluation of the effectiveness of the Utilization Management (UM) program activities, which include appropriate medical necessity evaluation and evidence-based clinical decision making.

The processes and data reported covers activities conducted from January 1, 2024 through December 31, 2024.

Membership and Provider Network

The Alliance products include:

- Medi-Cal Managed Care: serving beneficiaries eligible through one of several Medi-Cal programs, including Temporary Assistance for Needy Families (TANF), Seniors and Persons with Disabilities (SPD), Medi-Cal Expansion and Dually Eligible Medi-Cal members who do not participate in California's Coordinated Care Initiative (CCI). For dually eligible beneficiaries, Medicare remains the primary insurance and Medi-Cal benefits are coordinated with the Medicare provider.
- Alliance Group Care (commercial product): an employer-sponsored plan providing low-cost comprehensive health care coverage to In-Home Supportive Services (IHSS) workers in Alameda County.

Covered services are provided to beneficiaries via Alliance's direct network or one of Alliance's contracted provider networks. In 2024, The Alliance's contracted provider networks included Alameda Health System (AHS), Children First Medical Group (CFMG), and Community Health Center Network (CHCN). The figures below represent the Alliance's membership trends in 2024.

Figure 1a. 2024 Membership - by Category of Aid

Category of Aid Trend						
Category of Aid	Dec 2024	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN
ADULTS	62,957	15%	13,651	14,118	6	35,182
CHILD	110,547	27%	10,501	13,443	41,092	45,511
SPD	36,127	9%	12,122	5,685	1,433	16,887
ACA OE	154,565	38%	29,490	53,129	1,574	70,372
DUALS	40,812	10%	26,881	2,910	6	11,015
LTC	255	0%	240	7	0	8
LTC-DUAL	1,285	0%	1,284	0	0	1
Medi-Cal	406,548		94,169	89,292	44,111	178,976
Group Care	5,790		2,144	946	0	2,700
Total	412,338	100%	96,313	90,238	44,111	181,676
Medi-Cal %	98.6%		97.8%	99.0%	100.0%	98.5%
Group Care %	1.4%		2.2%	1.0%	0.0%	1.5%
<i>Network Distribution</i>			23.4%	21.9%	10.7%	44.1%
			% Direct:	45%	% Delegated:	55%

Figure 1b. 2024 Membership - by Age Group

Age Category Trend								
Age Category	Members				% of Total (ie.Distribution)			
	Dec 2022	Dec 2023	Nov 2024	Dec 2024	Dec 2022	Dec 2023	Nov 2024	Dec 2024
Under 19	104,022	104,062	108,407	109,506	32%	30%	27%	27%
19 - 44	119,997	121,694	155,955	158,707	37%	35%	38%	38%
45 - 64	68,606	72,612	84,411	85,272	21%	21%	21%	21%
65+	35,170	53,641	58,152	58,853	11%	15%	14%	14%
Total	327,795	352,009	406,925	412,338	100%	100%	100%	100%

Figure 1c. 2024 Membership – by Provider Network

Network Trend								
	Members				% of Total (ie.Distribution)			
Network	Dec 2022	Dec 2023	Nov 2024	Dec 2024	Dec 2022	Dec 2023	Nov 2024	Dec 2024
Independent (Direct)	53,143	76,241	90,681	96,313	16.2%	21.7%	22.3%	23.4%
AHS (Direct)	65,771	63,548	90,459	90,238	20.1%	18.1%	22.2%	21.9%
CFMG	33,648	35,401	44,031	44,111	10.3%	10.1%	10.8%	10.7%
CHCN	126,009	128,342	181,754	181,676	38.4%	36.5%	44.7%	44.1%
KAISER	49,224	48,477	0	0	15.0%	13.8%	0.0%	0.0%
Total	327,795	352,009	406,925	412,338	100.0%	100.0%	100.0%	100.0%

Figure 1d. 2024 Membership – by Provider Network (Delegated vs. Direct)

Delegation vs Direct Trend								
	Members				% of Total (ie.Distribution)			
Members	Dec 2022	Dec 2023	Nov 2024	Dec 2024	Dec 2022	Dec 2023	Nov 2024	Dec 2024
Delegated	208,881	212,220	225,785	225,787	63.7%	60.3%	55.5%	54.8%
Direct	118,914	139,789	181,140	186,551	36.3%	39.7%	44.5%	45.2%
Total	327,795	352,009	406,925	412,338	100.0%	100.0%	100.0%	100.0%

The Alliance membership increased by 60,329 members, comparing December 2023 to December 2024. The largest membership increase was seen in the population aged 19-44. The Alliance direct network experienced the largest membership gains, with an increase of 46,762 members by the end of 2024. This trend aligns with increases in Medi-Cal Enrollment overall, including dual-eligible members and Long-Term Care members receiving custodial level of care in Skilled Nursing Facilities in January 2023 and the integration of Anthem and Adult Expansion Members in January 2024.

Utilization Management Program Scope and Structure

UM Program Scope

The UM Program serves Alliance members by ensuring that appropriate processes are used to review and approve the provision of medically necessary covered services. The UM Program also ensures timely and appropriate access to care, including the provision of continuity of care and coordination of medical and behavioral services to improve member health outcomes. Additionally, the UM Program encompasses delegated utilization management functions, whereby the Alliance provides oversight and monitoring of delegated entities for compliance with all utilization management activities.

The Alliance offers a comprehensive list of covered services, including but not limited to:

- Ambulatory Care
- Behavioral health (mental health and substance use disorder services)
- Care Coordination, including arrangements for linked and carved-out services, programs, and agencies
- Community-Based Adult Services
- Community Supports
- Emergency services
- Hospital care
- Home Health care
- Hospice
- Managed Long-Term Services and Support (MLTSS)
- Long-Term Care in skilled nursing facilities
- Palliative Care
- Pharmacy
- Rehabilitation services
- Skilled nursing services - Acute
- Transplant Services
- Transportation

A full list of covered services is available to members in the Evidence of Coverage, published online and available in print, upon request. Covered services are provided through a contracted network of providers that include hospitals, nursing facilities, ancillary providers, and contracted vendors. The UM program, in coordination with the Contracting and Quality teams, monitors the adequacy of the Alliance's contracted network to ensure members have access to care within time and distance standards. As needed, contracting arrangements are made with providers outside of the network if Alliance's contracted network is not available to service the need.

UM Program activities promote utilization of covered services at the right time and at the most appropriate site and level of care. Activities include the following, but are not limited to:

- Admission and concurrent review
- Discharge planning: pre-admission, concurrent, and post-discharge follow-up with member/provider
- Coordination with Claims, including review of Provider Disputes
- Coordination with Compliance, to support monitoring and auditing activities for internal and delegated entities

- Coordination with Grievance and Appeals, including review of overturned decisions
- Continuity and coordination of care for members when a provider is terminated from the network
- Continuity and coordination of care for members newly eligible with The Alliance, receiving active care and treatment from a non-Alliance provider
- Discharge planning: pre-admission, concurrent, and post-discharge follow-up with member/provider
- Evaluate and refer members needing care coordination/case management (including children/youth under Medi-Cal for Kids & Teens, California Children's Services, Enhanced Care Management, Complex Case Management, Community Supports, Dental Health, Behavioral Health, or Long-Term Care)
- Integration of medical and behavioral health, including collaboration with Alameda County Behavioral Health Services (ACBHCS)
- Peer-to-peer discussions to support providers regarding clinical decision-making
- Prior authorization of services (including pre-admission education)
- Quality improvement projects, based on analysis of utilization trends
- Retrospective review

UM Program Structure

The structure of the UM Program is designed to promote organizational accountability and responsibility in the identification, evaluation, and appropriate use of the Alliance health care delivery network. Additionally, the structure is designed to enhance communication and collaboration on UM issues that affect entities and multiple disciplines within the organization. The UM Program is evaluated on an on-going basis for efficacy and appropriateness of content by The Alliance staff and oversight committees.

Responsibility, Authority and Accountability / Governing Committee

The Alameda County Board of Supervisors appoints the Board of Governors (BOG) of the Alliance, a 19-member body representing provider and community partner stakeholders. The BOG is the final decision-making authority for all aspects of the Alliance programs and is responsible for approving the Quality Improvement and Utilization Management Programs. The Board of Governors delegates oversight of Quality and Utilization Management functions to the Alliance Chief Medical Officer (CMO) and the Quality Improvement Health Equity Committee (QIHEC). The CMO and the QIHEC provide the authority, direction, guidance, and resources to enable Alliance staff to carry out the Utilization Management Program. Utilization Management activities are the responsibility of the Alliance Health Care Services staff under the guidance of the Medical Director for Utilization Management and the Senior Director of Health Care Services, in collaboration with the Alliance CMO.

Committee Structure

The Board of Governors appoints and oversees the QIHEC, the Peer Review and Credentialing Committees, and the Pharmacy and Therapeutics Committee (P&TC) which,

in turn, provide the authority, direction, guidance, and resources to enable the Alliance staff to carry out the Quality Improvement, Utilization Management and Case Management Programs. Committee membership consists of provider representatives from the Alliance contracted networks and the community, including those who provide health care services to populations served by The Alliance (for example: Seniors and Persons with Disabilities, Dual-eligible members, and members with Chronic conditions).

The P&T Committee is responsible for oversight and assurance of ensuring the promotion of clinically appropriate, safe, and cost-effective drug therapy by managing and approving the Alliance's drug formulary, monitoring drug utilization, and developing provider education programs on drug appropriateness. P&T Committee meeting minutes and pharmacy updates are shared with the BOG. The voting membership consists of:

- Alliance Chief Medical Officer (Chair) or designee
- Alliance Senior Director of Pharmacy Services (Co-Chair)
- Practicing physician(s) representing Internal Medicine
- Practicing physician(s) representing Family Practice
- Practicing physician(s) representing Pediatrics
- Practicing physician(s) representing common medical specialties
- Practicing psychiatric specialist (e.g., psychiatric pharmacist/physician)
- Practicing community pharmacists contracted with Alliance (not to exceed 1/3 of the voting membership of the committee or three pharmacists, whichever is greater).

The QIHEC provides oversight, direction, makes recommendations, and has final approval of the UM Program. Committee meeting minutes are maintained to summarize committee activities and decisions with appropriate signatories and dates.

QIHEC charters a sub-committee called the Utilization Management Committee (UMC), which meets at least once every 2 months. In 2024, the UMC had 10 meetings. UMC serves as a forum for The Alliance to evaluate current UM activities, processes, and metrics. The UMC also evaluates the impact of UM programs on key stakeholders in other departments, including Compliance, Member Services, Quality, and Grievance and Appeals. Input from UMC members is included in continuous UM program monitoring, evaluation, and design of interventions.

The 2023 UM Program Evaluation and 2024 UM Program Description and Workplan were presented for review and approval at the March 22, 2024 UMC meeting, and subsequently presented at the March 31, 2024 QIHEC meeting for final Board of Governors approval (documented in meetings minutes). The committee was chaired by the Chief Medical Officer with support from the Senior Director of Quality Management, external physicians, and key organizational staff.

Integration of Medical and Behavioral Health

The Alliance's utilization management activities for behavioral healthcare have been performed in partnership with Alameda County Behavioral Health Care Services (ACBHCS). The Alliance provides access to mental health services for the Medi-Cal and Group Care membership in several ways:

- Basic mental health care needs are provided by Primary Care Providers.
- The Alliance manages Medi-Cal and Group Care members with mild to moderate impairments in mental, emotional, and/or behavioral functioning. Medi-Cal members diagnosed with a severe persistent mental health disorder and substance use disorders (SUD) are carved-out and managed by Alameda County Behavioral Health Care Services Department (ACBHCS).
- The Alliance manages Group Care members diagnosed with severe persistent mental health disorders and substance use disorders (SUD). Increasing access to care and increasing utilization was a primary driver of the Alliance's decision to insource the management of behavioral health services. The Behavioral Health Program includes a care coordination program staffed by licensed clinicians and behavioral health navigators.
- The mental health team consists of 5 licensed clinicians and the Applied Behavior Analysis (ABA) team consists of 4 licensed clinicians.
- The clinical teams are supported by 5 behavioral health navigators.
- Two supervisors hired in Q4 2024 to further support the growth and visibility of the behavioral health program at the Alliance.
- The Alliance behavioral health program operates under the leadership of a Manager, Senior Director, and Medical Director.

Involvement of senior-level physician and behavioral healthcare practitioners

The Board of Governors delegates oversight of Quality and Utilization Management functions to The Alliance Chief Medical Officer (CMO). The CMO provides the authority, direction, guidance, and resources to enable Alliance staff to carry out the Utilization Management Program. The CMO delegates senior level physician involvement in appropriate committees to provide clinical expertise and guidance to program development. Dr. Peter Currie, Ph.D., Senior Director, Behavioral Health Services, provides leadership to behavioral health care at The Alliance, further supporting the integration of behavioral health care with medical care. Together, the senior-level physician and behavioral health practitioners are involved in the UM program by:

- Establishing UM policies (for medical and behavioral healthcare services)
- Reviewing UM cases for medical necessity determinations (for medical and behavioral healthcare services)
- Participating in various clinical and stakeholder committees (including UMC and QIHEC)
- Evaluating the overall effectiveness of the UM Program (for medical and behavioral healthcare services)

Utilization Management Resources

The Alliance UM Department is staffed with physicians, nurses, pharmacists, and non-clinical support staff including clerical support and clinical support coordinators. A full description of staff roles and responsibilities is provided in the 2024 UM Program Description.

In 2024, the UM leadership structure was designed to meet the needs of the program and the staff, including Pharmacy, LTSS, and Behavioral Health:

- 1.0 FTE Medical Director of Utilization Management
- 1.0 FTE Senior Director, Health Care Services
- 1.0 FTE Senior Director, Pharmacy
- 1.0 FTE Senior Director, Behavioral Health Services
- 1.0 FTE Director, Utilization Management
- 1.0 FTE Director, Long Term Services and Supports
- 1.0 FTE Senior Manager, Outpatient Utilization Management
- 1.0 FTE Manager, Inpatient Utilization Management
- 1.0 FTE Manager, Long-Term Care
- 1.0 FTE Manager, Behavioral Health
- 1.0 FTE Non-Clinical Supervisor, Outpatient Utilization Management
- 1.0 FTE Clinical Supervisor, Outpatient Utilization Management
- 1.0 FTE Clinical Supervisor, Utilization Management
- 1.0 FTE Clinical Supervisor, Long Term Care
- 1.0 FTE Pharmacy Supervisor
- 1.0 FTE Lead Clinical Pharmacist

The adequacy of utilization management resources is continuously evaluated to ensure appropriate staffing levels to manage programmatic changes and workload volumes, accounting for variations in members' health status, access and complexities of coordination of care needs. For example, in 2024, the Long-Term Services and Supports Director assumed oversight of the Community Supports team – this organizational shift will allow for continued expansion of Community Supports services, optimize utilization of Community Supports, and integrate supports for the highest risk members.

Delegated Utilization Management

The Alliance delegates UM activities to provider groups, networks and healthcare organizations that meet delegation standards. The contractual agreements between the Alliance and delegated groups specify the responsibilities of both parties, including:

- the functions or activities that are delegated;
- the frequency of reporting on those functions and responsibilities;
- how performance is evaluated; and
- corrective action plan expectations, if applicable.

The Alliance conducts a pre-contractual evaluation of delegated functions to ensure the delegates’ ability to meet regulatory and accreditation standards and requirements. The Alliance’s Compliance Department is responsible for the oversight of delegated activities. The Compliance Department works with the UM Department, and other departments, to conduct the annual delegation oversight audits. When delegation occurs, the Alliance requires the delegated entity to comply with regulatory, contractual and NCQA standards, as well as submit regular utilization reports (i.e., quarterly, semi-annual, and annual) to assess the delegate’s performance on services provided to Alliance members. The Alliance has adopted the Healthcare Industry Collaborative Efforts (HICE) UM Reporting Templates as an acceptable format of reporting results of the annual evaluation, and audit results are reviewed by the Compliance and Delegation Oversight Committee.

In 2024, the Alliance delegated UM activities to the following entities:

Figure 2. Delegated Entities (UM activities only)

Delegate Name	Provider Type	NCQA Accreditation or Certification	Delegated Activity- Utilization Management	Delegated Activity- Grievance and Appeals
CHCN	Managed Care Organization (MCO)	No	Yes	No
CFMG	Managed Care Organization (MCO)	No	Yes	No

Utilization Management Information Systems

The Alliance maintains a core clinical information system, TruCare®, that is utilized by all Utilization Management, Long-Term Care, Case Management and Pharmacy teams. TruCare® is a member-centric application that aligns necessary clinical and administrative information related to members' care into a single chart record and allows seamless multidisciplinary collaboration within a case. In 2024, clinical staff, in collaboration with the Information Technology (IT) team, continued to identify opportunities to enhance the functionality of the system and optimize the systems' performance. Thorough vetting processes are established between clinical and IT teams to ensure any enhancements and upgrades to the platform are amenable to all system users. System optimization and upgrades are ongoing as standard practices, including staff training to ensure competence in using the platform and alignment on best practice workflows.

Clinical Decision Support Tools

Utilization Management Clinical Decision-Making

Clinical decision-making tools and screening criteria are designed to assist UM staff, and UM-delegated entities, in assessing the appropriateness of care for medical and behavioral health services. Application of the criteria is based on the specific and individualized health care needs of the member (including social determinant of health needs), medical risk factors, and in accordance with the member's plan benefits and capacity of the health care delivery systems. A full description of the criteria used for UM clinical decision-making is available in the 2024 UM Program Description. All decision-making criteria are available to members and providers upon request. In 2024, there was 1 request from members, and no requests from providers for copies of the decision-making clinical criteria.

In 2024, the Alliance used Milliman's CareWebQI® interactive software tools, which integrate the MCG® criteria into the core clinical information system, TruCare®. The 28th Edition MCG® criteria was released in February 2024, staff were trained in October 2024, and TruCare® was updated in December 2024 to deploy the 28th Edition MCG® criteria for completing reviews. Prior to December 2024, reviews were completed using the 27th Edition MCG® criteria.

The Alliance also used evidence-based clinical decision support found in UpToDate®, a collection of well-referenced topics, guidelines, and updated research. UpToDate® makes updates three times a year, and new information goes through a multilevel peer-review process¹.

Upon review of member needs and the requirement to use alternative criteria as appropriate, there were no changes in 2024 to the clinical decision-making tools or hierarchy of applying the tools. Clinical criteria are applied in the following hierarchy:

1. Regulatory and contractual guidelines/regulations, including:
 - Department of Health Care Services (DHCS) Medi-Cal Provider Manuals and All-Plan Letters

¹ [Fam Pract Manag. 2003;10\(7\):49-52](#)

- Department of Managed Health Care (DMHC) All-Plan Letters
 - WPATH Standards of Care (SOC) for Gender-Affirming Care
 - LOCUS/CALOCUS, CASII/ECSII/ASAM for Mental Health and Substance Use Disorders
 - Code of Federal Regulations
 - California Health and Safety Code.
 - California Code of Regulations Title 22.
 - California Code of Regulations Title 28.
 - California Welfare and Institution Code
2. Evidence based guidelines, primarily MCG®, US Preventive Services Task Force, National Comprehensive Cancer Network, and if needed, UpToDate®
 3. Alliance guidelines, as approved through governing committees (including QIHEC and P&T)
 4. National medical association guidelines (including American Commission of Obstetrics and Gynecology (ACOG), American Association of Pediatrics (AAP), American Diabetes Association (ADA))
 5. Independent Medical Review for specialty consultation
 6. Medical necessity/medical judgment

Consistency in Application of Criteria: Inter-Rater Reliability

The Alliance evaluates inter-rater reliability (IRR) to monitor consistency with which physicians, non-physicians, pharmacists, and behavioral health practitioners apply clinical decision-making criteria. A full description of the IRR testing methodology is referenced in Alliance policy and procedure QI-133. Testers complete 5 modules and up to 3 attempts per module, if needed to achieve a score of 90% or higher to pass the annual IRR evaluation. Remediation activities, based on IRR outcomes, are noted in the below figure. We continue to evaluate the effectiveness of the IRR evaluation and remediation processes, and will adjust remediation activities, as needed, to ensure all clinical reviewers are adequately trained to apply the clinical criteria.

Figure 3. Inter-Rater Reliability Scoring and Remediation Activities

IRR Score	Action/Remediation Activities
High – 90%-100%	No action required
Medium – 71%-89%	Additional training with Supervisor / Manager / Director / Clinical Designee to re-perform the IRR cases / scenarios
Low – Below 70%	Additional training provided. • If staff twice fails the IRR evaluation, a Corrective Action Plan is required with report to the Respective Department Director and CMO. • If staff three times fails to pass the IRR evaluation, the case will be escalated to Human Resources which may result in further disciplinary action.

In 2024, IRR testing was performed in Q3 2024. Results are shown in the below table:

Figure 4. 2024 IRR Scores

Clinical Reviewers	Number of Testers	2024 IRR Overall Score
Non-physician (RN) – Outpatient	12	99%
Non-physician (RN) – Inpatient	15	97%
Non-physician (RN) – Grievance & Appeals	2	99%
Non-physician (RN) – Long-Term Care	6	100%
Pharmacist	4	100%
Behavioral Health	9	100%
Physician	6	98%

Overall behavioral health, pharmacist, and non-physician reviewers IRR evaluations scored 90% or higher. Physician reviewers had an overall score of 88.2% - 5 physician reviewers did not meet the 90% passing rate for at least 1 of the 5 assigned modules, and remediation activities were completed with the Utilization Management Medical Director. Inpatient non-physician (RN) reviewers had an overall score of 97% - 12 RNs did not meet the 90% passing rate for at least 1 of the 5 assigned modules, and remediation activities were completed with the Utilization Management Manager.

Utilization Management Processes

Utilization Review Procedures

The Alliance follows all regulatory, contractual, and NCQA requirements to effectively administer utilization review procedures, including decision turn-around times and member and provider notification standards. For services that require prior authorization, the UM process requires that qualified, licensed health professionals assess the clinical information used to support UM decisions. Only physicians, pharmacists, or doctoral level behavioral health specialists can make determinations to deny or modify care based on medical necessity.

Services Exempt from Prior Authorization

- For both Managed Medi-Cal and Group Care products, there are services exempt from prior authorization. Exemptions include, but are not limited to:
- Emergency Services
 - Urgent Care
 - Primary Care Visits
 - Preventative Services including immunizations
 - Mental Health Care and Substance Use treatment
 - Women’s health services – *a woman can go directly to any network provider for women’s health care such as breast or pelvic exams. This includes care provided by a Certified Nurse Midwife/ OB-GYN and Certified Nurse Practitioners.*
 - Basic prenatal care
 - Family planning services, including counseling, pregnancy tests, medications, and

- procedures for the termination of pregnancy (abortion)
- Treatment for Sexually Transmitted Diseases includes testing, counseling, treatment, and prevention
- HIV testing and counseling
- COVID-19 testing and therapies
- Second Opinions from In Network providers arranged by the assigned PCP
- Initial Mental Health Assessments
- Early and Periodic Screening, Diagnostic and Treatment
- Biomarker testing for members with advanced or metastatic cancer stage 3 or 4
- Annual Cognitive Assessment for Medi-Cal members over 65 without Medicare

Services Requiring Prior Authorization

The Alliance communicates to all contracted providers the procedures, treatments, and services that require prior authorization. Services that require prior authorization include, but are not limited to:

- Non-emergency/ elective out-of-area care
- Out-of-network care, for services not provided by contracted provider
- Inpatient Admissions if non-emergency/ elective
- Inpatient Admissions to Acute Skilled Nursing Facility or Nursing Home
- Outpatient hospital services/ surgery
- Outpatient facilities (non-hospital based), such as surgeries or sleep studies
- Outpatient diagnostic and radiology services, minimally invasive or invasive including CT Scans, MRIs, cardiac catheterization, PET
- Durable Medical Equipment, standard or customized; rental or purchased
- Infusion Services
- Medical Supplies
- Prosthetics and Orthotics
- Podiatry services
- Home Health Care, including skilled nursing, nursing aides, rehabilitation therapies, and social workers
- Transplant Services
- Tertiary/Quaternary office visits and consultations at academic centers
- Experimental or Investigational Services
- Cancer Clinical Trials
- Long-Term Care in Skilled Nursing Facilities, Subacute facilities, and ICF/DD
- Community Supports
- Community Based Adult Services (CBAS)
- Acupuncture, greater than 4 visits per month
- Chiropractic Services
- Second Opinions from out-of-Network providers
- Select behavioral health services

The Alliance routinely analyzes utilization patterns to determine whether it would be in

members’ best interests to add or remove any of the listed services from prior authorization requirements. All decisions to adjust prior authorization requirements are reviewed and approved by the appropriate committees (including UMC or P&TC, and QIHEC).

Review Types

Authorizations are processed based on the date the Alliance receives the request. Below are the types of utilization reviews:

- **Prospective (pre-service) Review** is the process in which utilization review determination for medical necessity or coverage under the health plan benefit is conducted prior to the delivery of a health care service or supply to a member. A prospective review decision is based on the collection of medical information available to the health care provider prior to the time the service or supply is provided.
- **Concurrent Review** is the process in which utilization review determination for medical necessity or coverage under the health plan benefit is conducted during a member’s ongoing stay in a facility or course of outpatient treatment. The frequency of review is based on the member’s medical condition with respect to applicable care guidelines.
- **Retrospective (post-service) Review** is the process in which utilization review determination for medical necessity or coverage under the health plan benefit is conducted after the health care service or supply is provided to a member. Retrospective requests received within 90 days from the date of service are reviewed for medical necessity. Retrospective requests received after 90 days from the date of service are administratively denied for not obtaining prior authorization (with limited exceptions, including member eligibility issues, if the services were emergent/urgent, or inpatient services where the facility is unable to confirm enrollment with the Alliance).

Timeliness Standards

The Alliance processes authorizations within the following turn-around times, following the strictest regulatory standard:

Figure 5. UM Decision Turnaround Times

Review Type	Managed Medi-Cal	Group Care
Pre-Service – Urgent	72 hours	72 hours
Pre-Service – Routine	5 business days	5 business days
Concurrent	72 hours	72 hours
Retrospective	30 calendar days	30 calendar days
Hospice	24 Hours	24 Hours

For routine pre-service decisions, notifications of the decision must be sent to providers within 24 hours of the decision and to members within 2 business days.

For urgent pre-service and concurrent decisions, notifications of the decision must be sent to members and providers within 72 hours of receiving all the information needed to make a decision.

For retrospective decisions, notifications of the decision must be sent to the provider and member within 30 calendar days of the request.

Notice of Action Requirements

For any adverse benefit determination (including denial, delay, modification, termination, suspension, reduction, or carve-out of a treatment or service), The Alliance provides members with a written Notice of Action (NOA). The Notice of Action includes all DHCS-required templates to inform members of their rights, and the content of the notification includes all the following:

- a. A statement of the action the Alliance intends to take.
- b. A clear and concise explanation of the reasons for the decision.
- c. A description of the criteria or guidelines used. This includes a reference to the specific regulation or authorization procedure(s) that supports the decision, as well as an explanation of the criteria or guideline.
- d. The clinical reasons for the decision. The Alliance must explicitly state how the member's condition does not meet the criteria or guidelines.
- e. For written notification to the provider, the name and direct telephone number or extension of the decision maker. Decisions must be communicated to the member in writing. In addition, except for decisions rendered retrospectively, decisions must be communicated to the provider initially by telephone or facsimile, and also in writing.

Utilization Review Measures

Inpatient and Outpatient Utilization

The Alliance monitors, measures, and evaluates all aspects of the above utilization review procedures as follows:

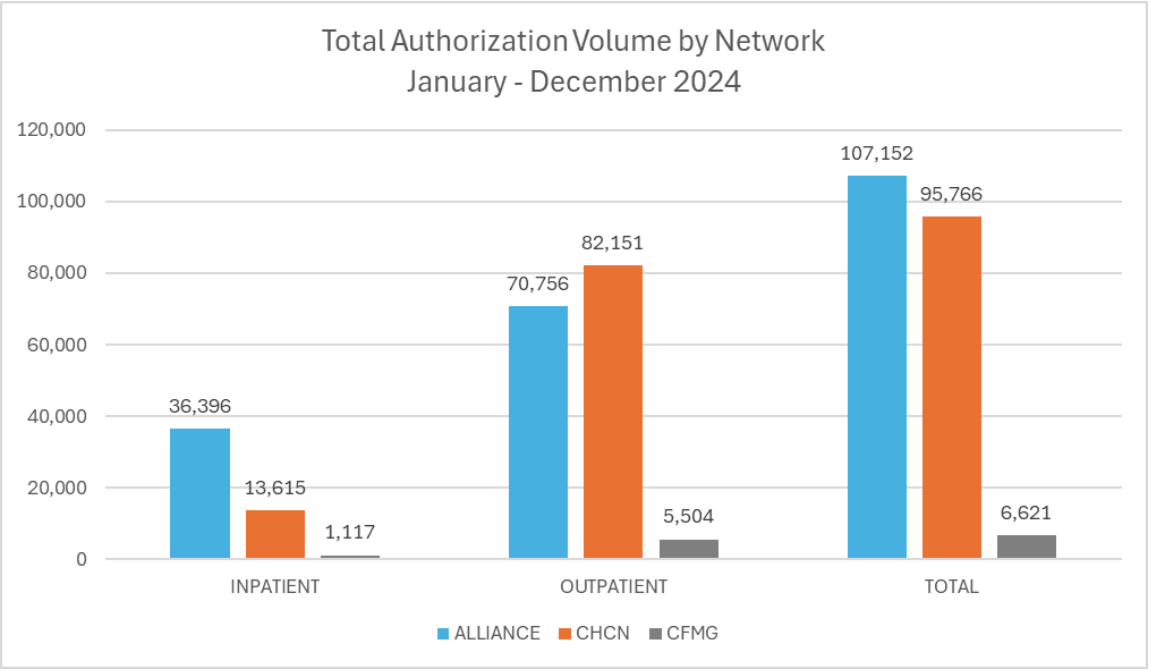
- Volume of authorization requests, reported by:
 - Total Number of requests
 - Total Number of requests approved, denied, and partially denied
- Denial Rate (the established threshold is 5% denial rate)
- Compliance with timeliness standards (the established threshold is 95% compliance)
- Compliance with NOA requirements, including appropriate content and enclosures

NOTE: The Group Care product represents 1.4% of the total Alliance membership. Therefore, the data for both product lines is aggregated for reporting. In key areas where the activities are specific to a network, the report will note the differences. Also, inpatient and outpatient data are represented for medical services only - LTSS, BH, and Pharmacy data is reported separately.

Authorization Volumes and Determinations

The below figure shows the total volume of inpatient and outpatient authorizations processed by the Alliance and its delegates in 2024. Total Authorization volume is measured by line items.

Figure 6. 2024 Total Authorization Volumes



The Alliance network’s inpatient authorization volume accounted for 71% of all Inpatient authorizations in 2024. The primary reason for higher Alliance network volume was

because CHCN and CFMG were not delegated to complete authorizations for the Long-Term Care services that were carved-in starting January 2023. The Alliance staff issued Long-Term Care authorizations while members remained delegated to their assigned network. CHCN completed more Outpatient authorizations than the Alliance in 2024, consistent with the historical delegated membership distribution and higher medical acuity.

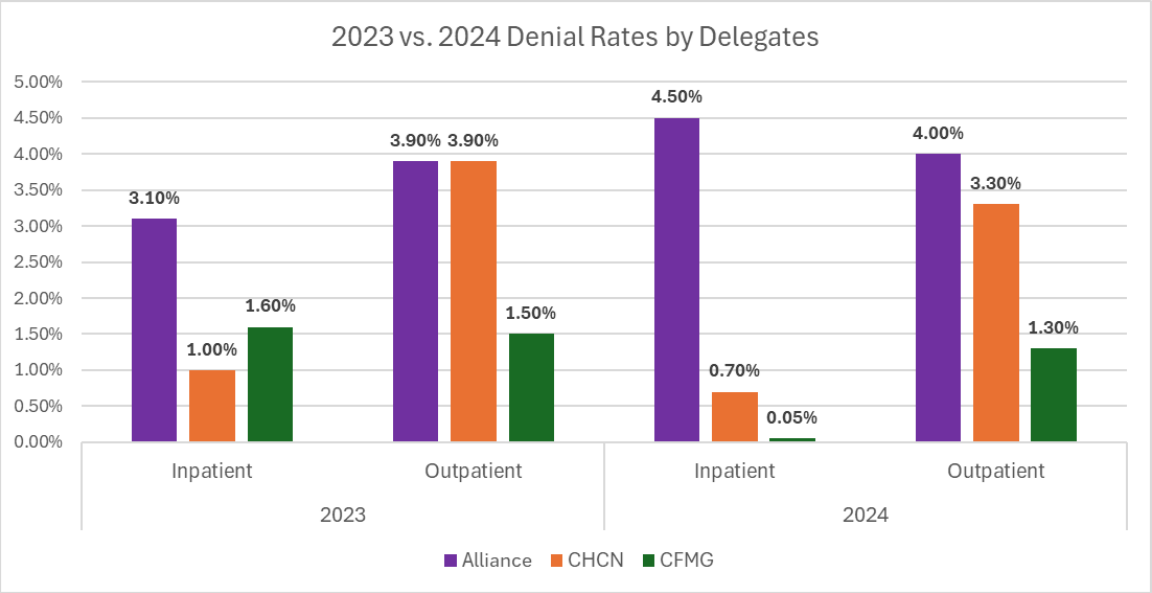
Outpatient service requests historically comprise the largest authorization volume for the health plan. Outpatient service requests experienced the largest authorization volume increases in the Alliance and CHCN networks. CFMG continues to have the lowest number of authorizations (only 3% of total auth volume is attributed to CFMG), related to the group’s lower overall membership comprised of primarily children and adolescents and lower overall utilization rates in this population.

Of note, there was a significant increase (+101,992) in total authorization volume in 2024 compared to volumes reported in 2023 – this was attributable to membership growth and higher observed utilization with the new Long-Term Care membership, in particular. Additionally, enhancements to Alliance’s system configuration to capture authorization volumes may have contributed to the increase – the system configuration will continue to be evaluated in 2025 to ensure accurate reporting of authorization volumes.

Denial Rates

Denial rates are evaluated to ensure appropriate service utilization, consistent evidence-based clinical decision-making, and to identify potential outlier trends that warrant further root cause analysis.

Figure 7. Denial Rates by Delegates from January – December 2024



Across all networks in 2024, the inpatient authorization denial rate was 1.75% and the

outpatient denial rate was 2.87%. Combined all denial rates, across all networks was 2.31% in 2024, representing a -0.04% year-over-year decrease compared to the prior year.

By network, The Alliance saw a increased inpatient denial rate (4.50%, +1.4) and an increased outpatient denial rate (2.87%, -1.08). Outpatient denial rates are attributable to the Tertiary Quaternary policy for academic care, and the continued practice of redirected services to in-network care that meet timely access when unrelated to continuity of care.

The CHCN delegated network saw an inpatient denial rate decrease (0.70%, -0.30) of unclear reason, and an outpatient denial rate decrease (3.30%, -0.6). Annual delegate audit and DHCS Audit case reviews with the UM Delegate team and provider education were attributable to these reduced denial rates.

The CFMG delegated network saw an inpatient denial increase (1.75%, +.15) due to ineligible members, and outpatient denials decreased (1.3%, -0.2%) in 2024. The overall decrease in outpatient denial rates across all networks, are attributable to education provided to UM reviewers on appropriate application of the Medi-Cal Provider Manual, evidenced based clinical guidelines, and UM policies, and improved standardization between reviewers, and with UM Delegate reviewers. Goals for 2025 continue to be to integrate the CHCN Authorization denial and approvals reasons into The Alliance analytical reports to better monitor decision making and network adequacy.

Authorization Turnaround Time

The Alliance monitors authorization turnaround time (TAT) to ensure members receive appropriate and timely access to care. The below figures show TAT compliance throughout 2024.

Figure 8a. 2024 Inpatient Authorization TAT

2024 Inpatient Authorization TAT						
	Q1	Q2	Q3	Q4	MY2024	Goal
Medi-Cal	98%	97%	98%	97%	98%	95%
Group Care	100%	99%	100%	98%	99%	95%
Overall	97%	97%	98%	97%	97%	95%

Figure 8b. 2024 Outpatient Authorization TAT

2024 Outpatient Authorization TAT						
	Q1	Q2	Q3	Q4	MY2024	Goal
Medi-Cal	100%	100%	100%	100%	100%	95%
Group Care	100%	100%	100%	100%	100%	95%
Overall	100%	100%	100%	100%	100%	95%

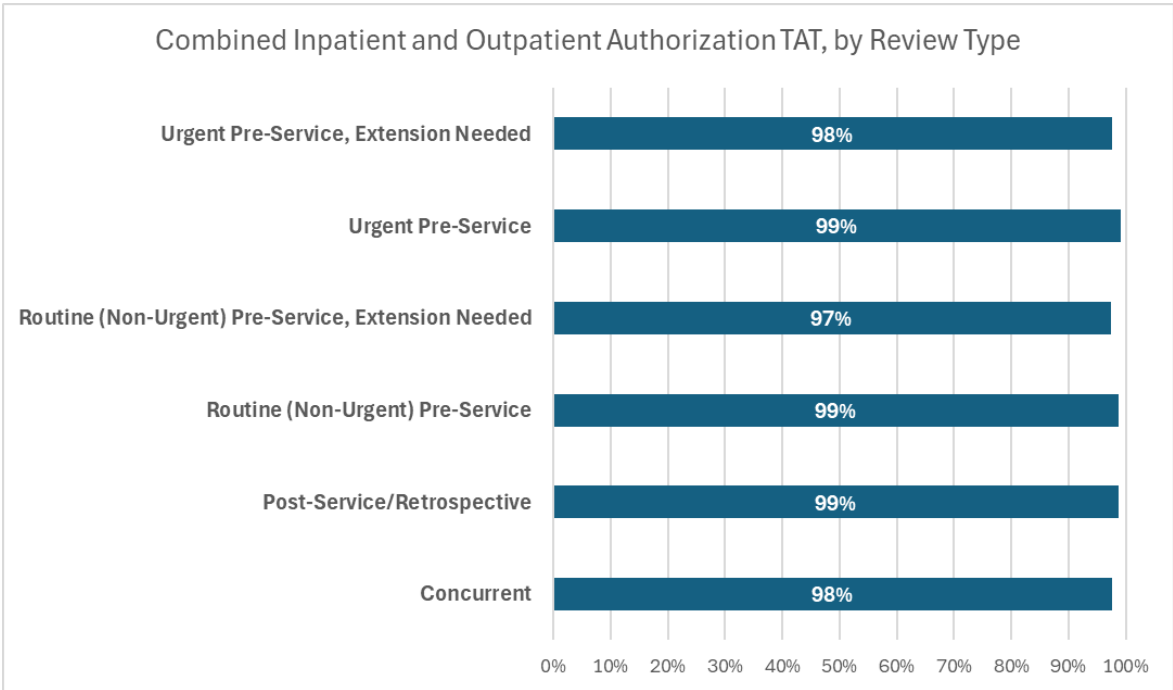
Figure 8c. 2024 Combine Inpatient & Outpatient Authorization TAT

2024 Combined Inpatient & Outpatient Authorization TAT						
	Q1	Q2	Q3	Q4	MY2024	Goal
Medi-Cal	99%	99%	99%	99%	99%	95%
Group Care	100%	100%	100%	99%	100%	95%
Overall	99%	99%	99%	99%	99%	95%

For 2024, both inpatient and outpatient TAT compliance were above threshold quarter-over-quarter, with an overall TAT compliance of 99% for Medi-Cal Line of Business and 100% for Group Care. This represents a consistent year-over-year trend, given the overall TAT compliance in 2024 was 98% across both product lines.

Attention will be placed on individual staff fall outs if there is a trend to direct education, improve production line processes or staffing, and support alignment with department goals. Additionally, efforts are planned for aligning UM Analytical report configuration with Regulatory TAT for Inpatient authorizations. Continued monitoring of TAT compliance will continue in 2025.

Figure 9. 2024 Overall Authorization TAT, by Review Type



Looking at the data categorized by Review Types, the Routine (Non-Urgent) Pre-Service, Extension Needed and the Concurrent Reviews had lower TAT compliance than other review types, however still exceeded the department’s benchmark of 95%. While both categories exceeded benchmarks, they will continue to be focus areas in 2025.

Notice of Action (NOA) Compliance

In 2024, the Alliance continued to perform quality assurance monitoring to ensure

compliance with NOA requirements for the Alliance UM team, and the UM-delegated entities. Annual NOA audits were performed to review for accurate application and reference of medical necessity guidelines, clear and concise letters, culturally and linguistically appropriate health literacy considerations, and TAT of provider/ member notifications. Continued monitoring is required for both the Alliance UM team and the UM-delegated entities to ensure all appropriate enclosures are sent with NOA letters, especially as DHCS and DMHC make periodic updates to their required templates.

Inpatient and Outpatient UM - Recommended Actions for 2025:

Upon evaluation of the above utilization review measures, potential program enhancements are:

- Continued monitoring and process improvements to meet NOA compliance
- End-to-end authorization system enhancements to streamline authorization processing and eliminate manual workarounds
- Continued evaluation of services that do not require prior authorization with goal to remove unnecessary reviews
- Continue the Tertiary Quaternary Policy
- Develop Authorization and claims stay level configuration for inpatient levels of care and facility types
- Validate different network contracting to ensure accurate out-of-network utilization is reflected in Plan analytical reports and aligned with Delegate utilization reporting.
- Increased alignment with case management, specifically related to transitional care services in alignment with DHCS population health management policy guide

Long-Term Services and Supports (LTSS)

The LTSS department was newly formed in 2023 as an extension of the Utilization Management team. The formation of the LTSS department was essential to accommodate the carve-in of the Long-Term Care (LTC) skilled nursing facility benefit in 1/1/2023, and the expansion that occurred 1/1/2024. The expansion included members in adult and pediatric subacute facilities and intermediate care facilities for developmentally disabled. The LTSS department is responsible for the provision of Long-Term Services and Supports, defined in the DHCS contract as:

“Services and supports designed to allow a member with functional limitations and/or chronic illnesses the ability to live or work in the setting of the Member’s choice, which may include the Member’s home, a worksite, a Provider-owned or controlled residential setting, a nursing facility, or other institutional setting. LTSS includes both Long-Term Care (LTC) and Home and Community-Based Services (HCBS) programs and includes carved-in and carved-out services”

The DHCS contract defines LTC as specialized rehabilitative services and care provided in a Skilled Nursing Facility (SNF), subacute facility, pediatric subacute facility, Intermediate Care Facility/ Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICF/DD-H), or ICF/DD-Nursing (ICF/DD-N) homes.

The DHCS contract defines HCBS programs as programs that include but are not limited to HCBS programs authorized under the Social Security Act (SSA) at 42 USC section 1396n(c), the California Medicaid State Plan option authorized under 42 USC section 1396n(k), California Medicaid State

Plan HCBS benefits authorized under 42 USC section 1396n(k), and other State and federally funded Medi-Cal HCBS programs.

The LTSS department consists of clinical and non-clinical staff who administer the program, providing oversight & monitoring to ensure adherence to all regulatory requirements and performance standards. Team members work collaboratively with other internal departments (including UM, Case Management, Pharmacy, and Behavioral Health), delegated entities, and safety net providers within the community to deliver timely, appropriate, cost-effective, and quality healthcare to members using LTSS benefits.

LTSS evaluation measures were developed to establish baseline thresholds and to identify opportunities for further refining of measures. These measures included authorization turnaround times, acute admissions, bed holds, emergency room visits, and facility network status.

Authorization Turnaround Times

LTC authorization requests are monitored to ensure compliance with contractually required turnaround times (TAT). Timeliness standards are aligned with those listed in the section titled, Utilization Review Procedures. The established threshold is 95% compliance.

Figure 10. 2024 LTC Authorization TAT

	Q1	Q2	Q3	Q4	MY2024
Authorizations Meeting TAT	2116	1804	2016	2209	8145
Total Authorizations	2210	1858	2091	2332	8491
% Compliant	96%	97%	96%	94%	96%
Goal	95%	95%	95%	95%	95%

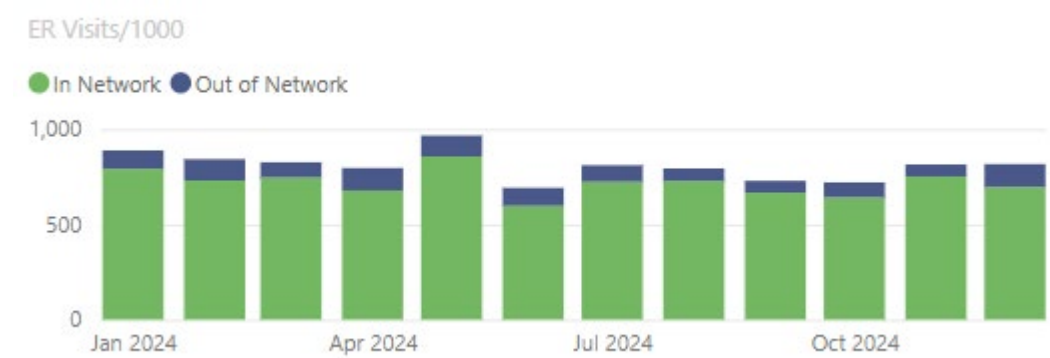
For 2024, TAT compliance was met for every quarter but Q4 due to a staffing shortage. The year concluded with an overall TAT compliance of 96% for the year.

Ongoing education and monitoring for TAT compliance will continue to be a high priority for the LTSS department in 2025.

Emergency Room Visits

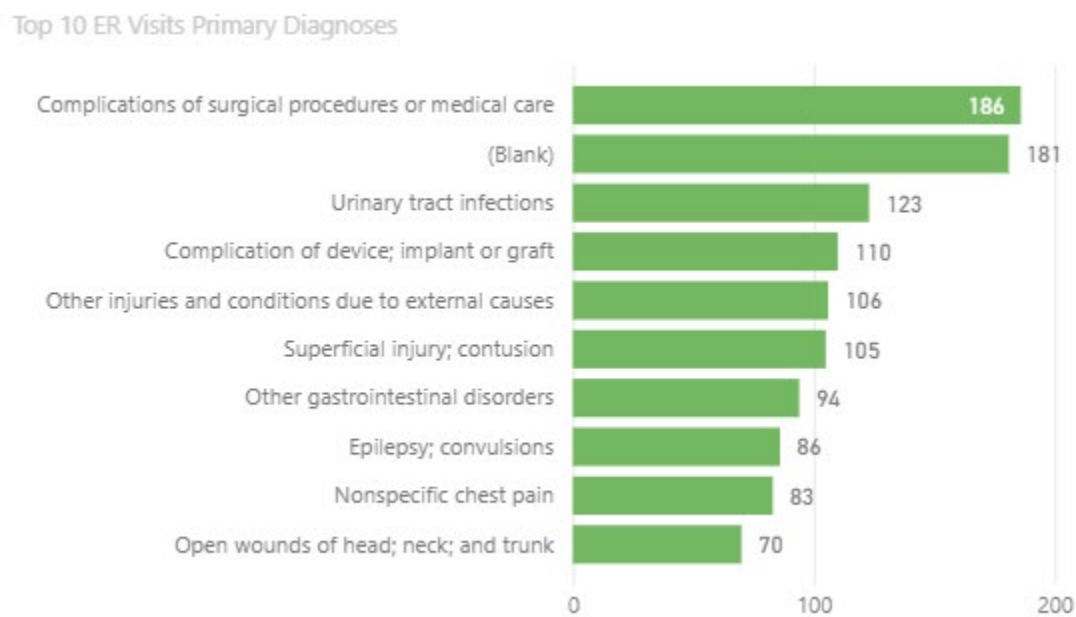
Monitoring for avoidable emergency room (ER) visits can identify potential member education and provider training opportunities. It can also support the Quality Management team’s review of potential LTC facility quality of care issues.

Figure 11a: 2024 ER Visits (LTC population)*



**Note: Data only available through October 2024 at the time of this report*

Figure 11b: 2024 ER Visits by Diagnosis (LTC population)



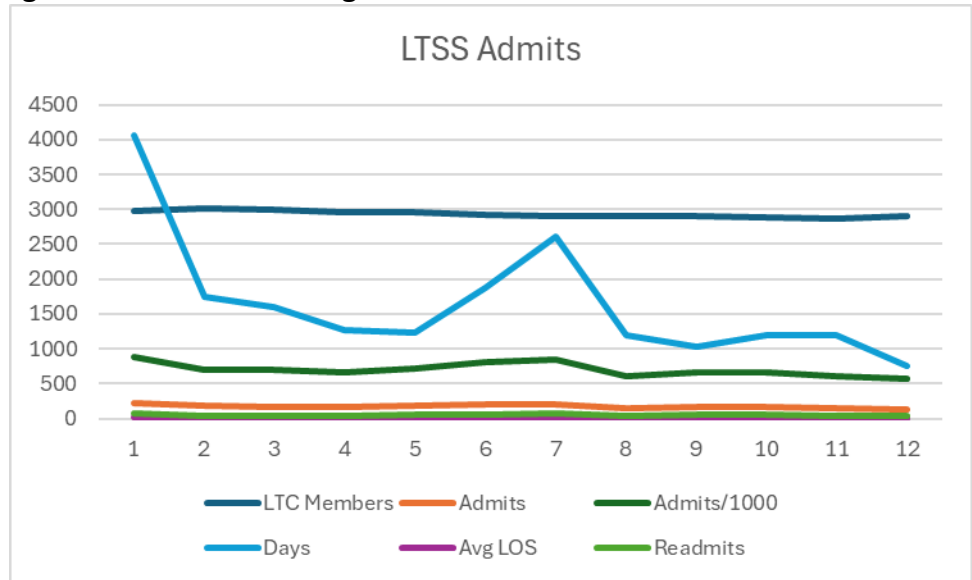
For 2024, there was a monthly average of 197 ER visits/month for the LTC population, with peaks in January, June, and November. The top 3 reasons for ER visits were surgical complications, urinary tract infections, and complications of a device, implant or graft.

In 2025, in collaboration with the Quality Management department, the LTSS department will continue to work on quality performance measures for LTC facilities, with the goal of preventing unnecessary/avoidable ER visits.

Acute Admissions

Monitoring of acute admissions can provide insight on the disease burden of the LTC population and allow evaluation and identification of additional resources that might support their needs. The below figure shows the monthly trend of acute admissions, average length of stay (ALOS), and readmission rate for the LTC population in 2024.

Figure 12. 2024 Acute Long-Term Care Admissions

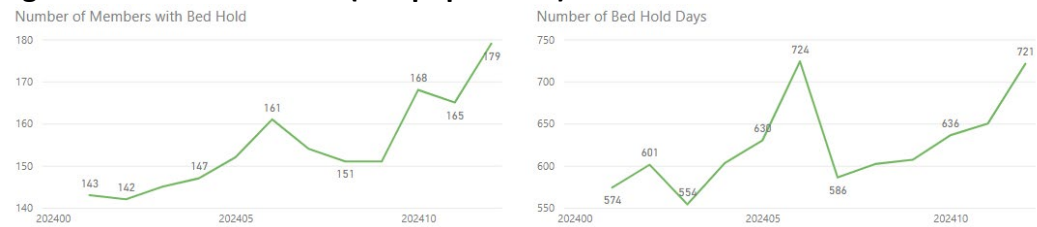


For 2024, the number of acute admissions for LTC members has been consistent, averaging 171 admits/month since the transition of the LTC benefit in January 2024. There was a peak in the summer months. The average length of stay (ALOS) for 2024 was 9.6 days, and the readmission rate was 28.9% for 2024.

Bed holds

For members who get admitted to an acute care hospital from a nursing facility, the nursing facility is allowed to request a bed hold authorization, in which they hold the bed vacant for a maximum of seven days per hospitalization. Monitoring the utilization of bed holds can provide insight on the disease burden of the LTC population, as the bed hold is correlated with the acute admission. The below figure shows the monthly trend of LTC members with approved bed holds and the total number of bed hold days authorized.

Figure 13: 2024 Bed holds (LTC population)



For 2024, there was an average of 97.6 members/month with approved bed holds, and an average of 624 bed hold days authorized/month. The inpatient days don't peculiarly

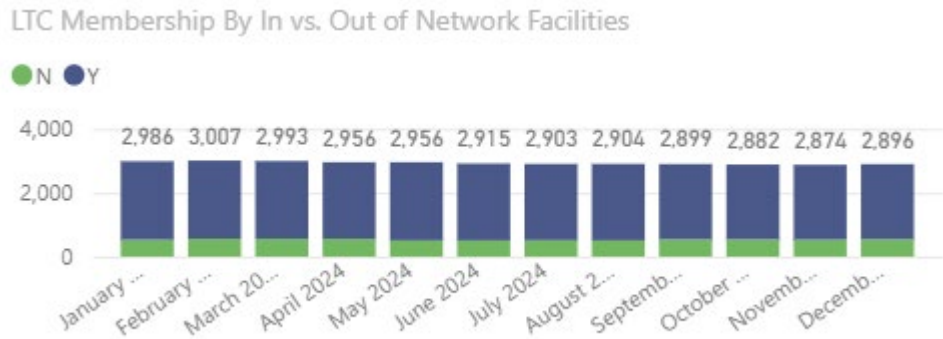
correlate with the inpatient statistics due to half of the long-term care members being dual and Medicare covering the inpatient stays.

The LTSS department has an LTC care management program to support high-risk LTC members, including those with high numbers of acute admissions, high numbers of bed holds, or those who may be at high-risk for re-admissions. Continuous monitoring of acute admissions, preventable re-admissions, and bed hold utilization in 2025 will be aimed at decreasing readmissions of the long-term care members.

Facility Network Status

For Members residing in LTC facilities after the January 1, 2024 transition, the Alliance ensured eligible Members had continued residency in the nursing facilities for 12 months, for continuity of care, with the coordinated contracting efforts by Provider Services.

Figure 14. In vs. Out of Network Facilities for LTC Memberships



In 2024, the majority of LTC members were in contracted facilities. In 2024, the Alliance had an average of 533 members residing at out-of-network facilities, while an average of 2,397 were at in- network facilities. A majority of the out-of-network is from the transition to the Alliance and the mandatory continuity of care requirements. The LTSS department continues to work with the Contracting team to identify network and access gaps to facilitate data-informed efforts to seek contracts with additional facilities.

LTSS - Recommended Actions for 2025:

- Upon evaluation of the above LTC measures, potential program enhancements are:
- Continue to work with facilities to notify the Alliance about changes to LTC member Transition of Care status, and timely Bed Hold and Admission LTC authorizations.
 - Continuing to collaborate with the LTSS liaison and provider services to establish relationships with facility partners, including our onsite facility visits from LTSS social workers
 - Increase the number of facilities that the long-term team has ongoing rounds with.
 - Ensure the Quality Management department develops quality performance measures for LTC facilities

Community-Based Adult Services (CBAS)

CBAS is a type of LTSS benefit, and CBAS centers offer services to eligible older adults and/or adults with disabilities to restore or maintain their optimal capacity for self-care and delay or prevent inappropriate or personally undesirable institutionalization. The Alliance is responsible for ensuring Members who are eligible to receive LTSS are identified and referred and dedicates an RN on the UM team to provide assessment, re-assessment, and re-authorization of CBAS services to members. The below figure shows the total number of members enrolled in CBAS in 2023.

Figure 15. 2024 CBAS Enrollment by Center, by Delegate

Number of Members					
Facility Name	Alliance	IHSS	CHCN	Kaiser	Total
Family Bridges Inc.	52	0	165	0	217
Golden Castle Adult Day Health Care Center	3	0	0	0	3
Grace Adult Day Healthcare	7	0	0	0	7
Silicon Valley Adult Day Health Care	1	0	0	0	1
Total	63	0	165	0	228

In 2024, there were a total of 228 members receiving services through one of five contracted CBAS centers. The center with the highest volume of members is Family Bridges. Alzheimer's of the East Bay closed its doors officially on 12/13/2024. At the time of the closure, the facility had 7 members all of which were transitioned to other CBAS centers within the service area.

In 2024, CBAS Centers continued to provide remote services and remain in telephonic communication with their members through CBAS Emergency Remote Services (ERS), per DHCS APL 22-020 requirements. The Alliance established processes to ensure that ERS requirements were met.

Behavioral Health Services

The Alliance provides access to behavioral health services for the Medi-Cal and Group Care membership in several ways:

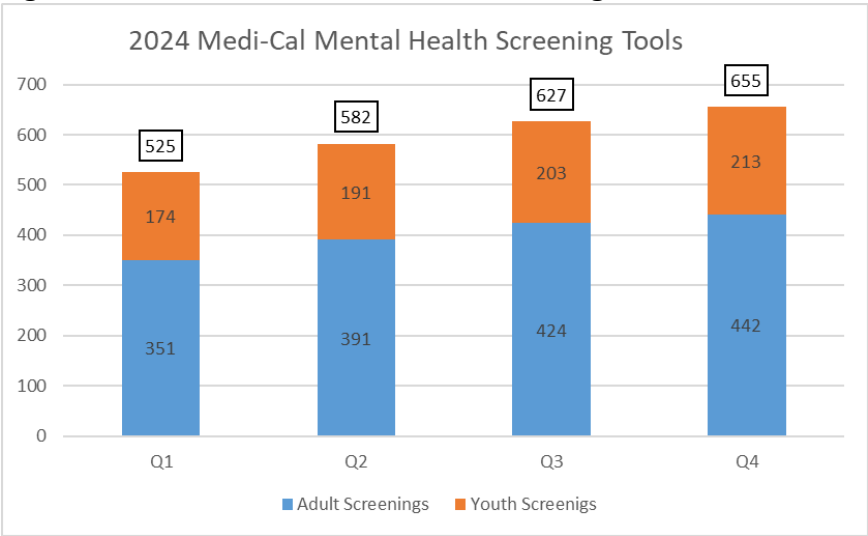
- Basic mental health care needs are provided by Primary Care Providers
- The Alliance manages Medi-Cal and Group Care members with mild- to moderate impairments in mental, emotional, and/or behavioral functioning
- Medi-Cal members diagnosed with a severe persistent mental health disorder and/or substance use disorders (SUD) are carved-out and managed by Alameda County Behavioral Health Care Services Department (ACBHCS).
The Alliance manages Group Care members diagnosed with severe persistent mental health disorder and/or substance use disorders (SUD).

The Alliance has collaborated closely with Alameda County Behavioral Health Care Services

(ACBHCS) to identify members who may benefit from the co-management of medical and behavioral health services. The Utilization Management (UM) and Behavioral Health (BH) Departments are responsible for maintaining ongoing relationships with ACBHCS to ensure that eligible Medi-Cal members receive services through both the Linked and Carved Out mental health programs. The primary focus of these activities is to ensure that contracted providers continue to identify and refer members with serious and persistent mental health and/or substance use disorder (SUD) conditions to the appropriate ACBHCS programs. Additionally, efforts are made to facilitate coordination for members with co-existing medical and behavioral health disorders, aiming to improve their access to treatment and ensure timely follow-up care.

The "No Wrong Door" collaboration efforts between the Alameda Alliance for Health (AAH) and the Alameda County Behavioral Health Care Services (ACBHCS) are ongoing. These efforts aim to enhance the coordination of care to ensure that members receive access to the appropriate behavioral health systems. Key components of this collaboration include the implementation of the Department of Health Care Services (DHCS) age-appropriate mental health screening tools, the establishment of a transition of care tool, and the assurance that services provided are not duplicative. The primary goal of these initiatives is to streamline service access, improve care continuity, and better support the behavioral health needs of the members served.

Figure 16: AAH 2024 Mental Health Screening and Referrals

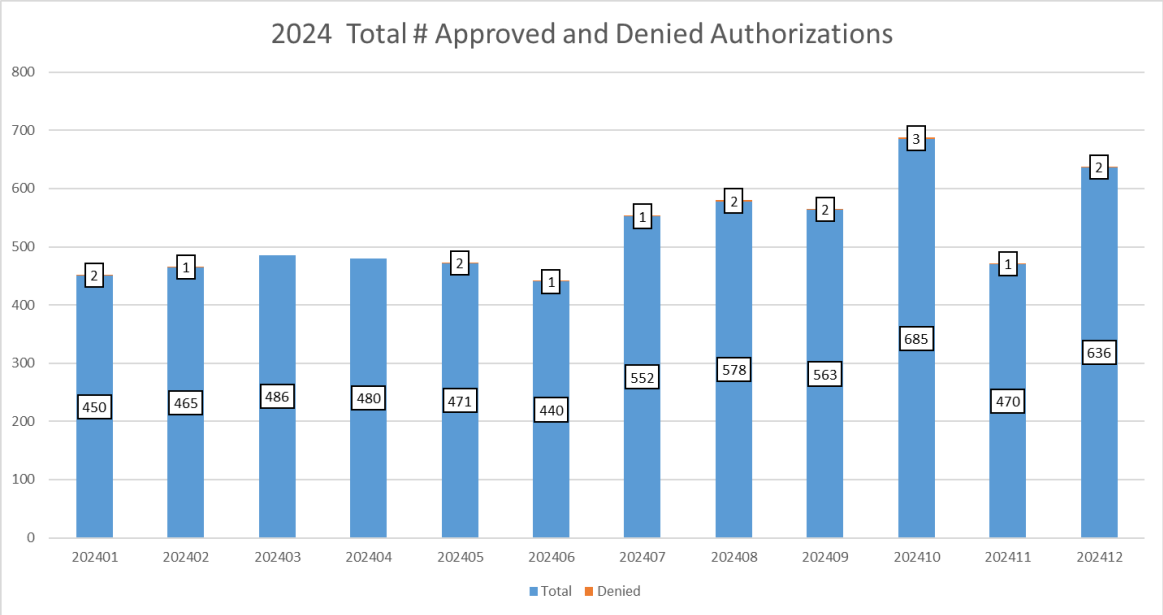


This graph represents the number of adult and child DHCS MH screening tools that were completed by the Alliance 2024 for Medi-Cal

Authorization Volumes, Determinations, and Denial Rates

The graph below represents the total number of authorizations processed after the insourcing of BH utilization review to The Alliance, and by approval and denial determinations.

Figure 17. 2024 Behavioral Health Authorization Determinations



There was a monthly average of 523 authorizations processed. Overall, the denial rate is low, which is representative of the commitment the Alliance has to members accessing appropriate mental health care.

Authorization Turnaround Times

The data below represents decisioning turnaround times for mental health and BHT/ABA authorizations.

Figure 18a. 2024 Combined Mental Health & BHT/ABA Decision TAT

Behavioral Health Turnaround Time					
	Q1	Q2	Q3	Q4	MY2024
Authorizations Meeting TAT	1253	1335	1646	1737	5971
Total Authorizations	1396	1371	1679	1794	6240
% Compliant	90%	90%	90%	90%	90%

Figure 18b. 2024 Mental Health Decision TAT

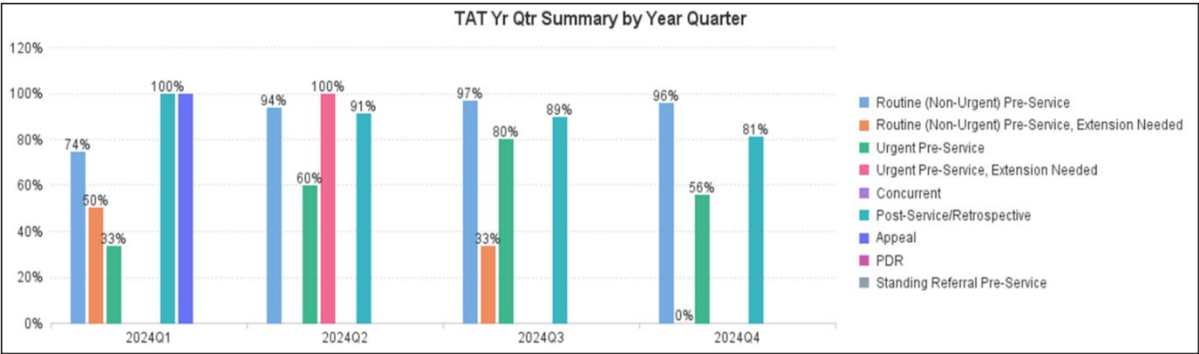
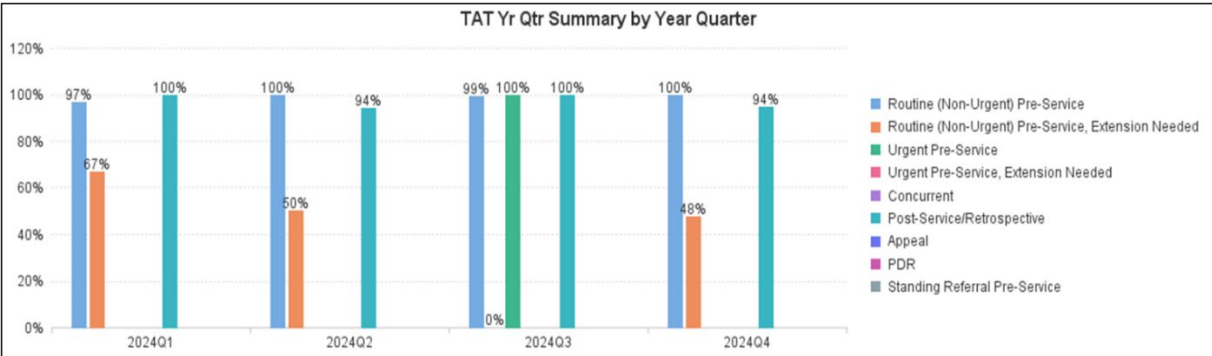


Figure 18c. 2024 BHT/ABA Decision TAT



Behavioral Health Services - Recommended Actions for 2025:

- Upon evaluation of the above BH measures, potential program enhancements are:
- Enhance process defects impacting TAT performance and implement interventions to meet
 - TAT goals in 2025.
 - Increase access as measured by an increase in unique utilizers of mental health and BHT/ABA services.
 - Ensure that Contracting continues to increase network capacity, particularly for ABA services.

Pharmacy

The management and monitoring of Pharmacy utilization activities is reported through the Pharmacy and Therapeutics Committee and BOG. A full review of Pharmacy Utilization activities can be found in the P&T Committee minutes; summary data is represented below.

Authorization Volumes and Turnaround Times

The data below represents the total Outpatient Pharmacy prior authorization volumes and TAT for Group Care members.

Figure 20. Outpatient Pharmacy Authorization Volume & TAT

	Q1 2024	Q2 2024	Q3 2024	Q4 2024
Number of Outpatient Pharmacy PAs Processed	499	519	545	543
TAT (%)	99%	100%	99.82%	100%

The data below represents the total Physician Administered Medications/Injections prior authorization volumes and TAT for both Medi-Cal and Group Care members.

Figure 21. Physician Administered Medications (PAD)/Injections Authorization Volume & TAT

		Q1 2024	Q2 2024	Q3 2024	Q4 2024
Number of Physician Administered Medications/Injections PAs Processed	Group Care	22	35	32	42
	Medi-Cal	1517	1260	1350	1361
Total Auth Volume		1539	1295	1382	1403
TAT (%)	Group Care	100%	100%	100%	100%
	Medi-Cal	99.16%	99.06%	99.72%	99.65%
TAT Average (%)		99.2%	99.1%	99.7%	99.7%

Pharmacy - Recommended Actions for 2025:

- Refining process for carveout drugs billed under the medical benefit with cross functional configuration and claims team.
- Implement a policy for medications that are self-administered and communicate it to the physician network. Ultimate goal: to review self-administered drugs billed under the medical benefit for medically necessity.
- Enhance external exception request review process to apply to denials of prior authorization and step therapy exception requests.
- Continued monitoring of unclassified drugs and unclassified biologics, in partnership with an external vendor, to enhance the claim adjudication process ensure appropriate billing and configuration

Clinical Appeals

Clinical Appeals are investigated to determine if the initial UM determination was appropriate. The final appeal is resolved with determinations of upheld, overturn, or partially overturned. Overturn appeal determinations are considered an opportunity to assess the UM process, and all overturned cases are reviewed monthly with Medical Directors for educational feedback, adherence to DHCS regulation, and review of UM process opportunities. The Alliance established a threshold of 25% for overturn determinations.

The grievance and appeals department reports appeal & overturn trends in UMC and QIHEC, allowing committee members to provide insights on notable trends. As the Alliance only

delegates the resolution of grievances and appeals to Knox-Keene licensed Health Plans, the data below is inclusive of determinations made by the Alliance and all delegated provider groups.

Appeal Volumes

The figures below show appeal volumes for Medi-Cal and Group Care lines of business.

Figure 22a. 2024 Medi-Cal Clinical Appeals

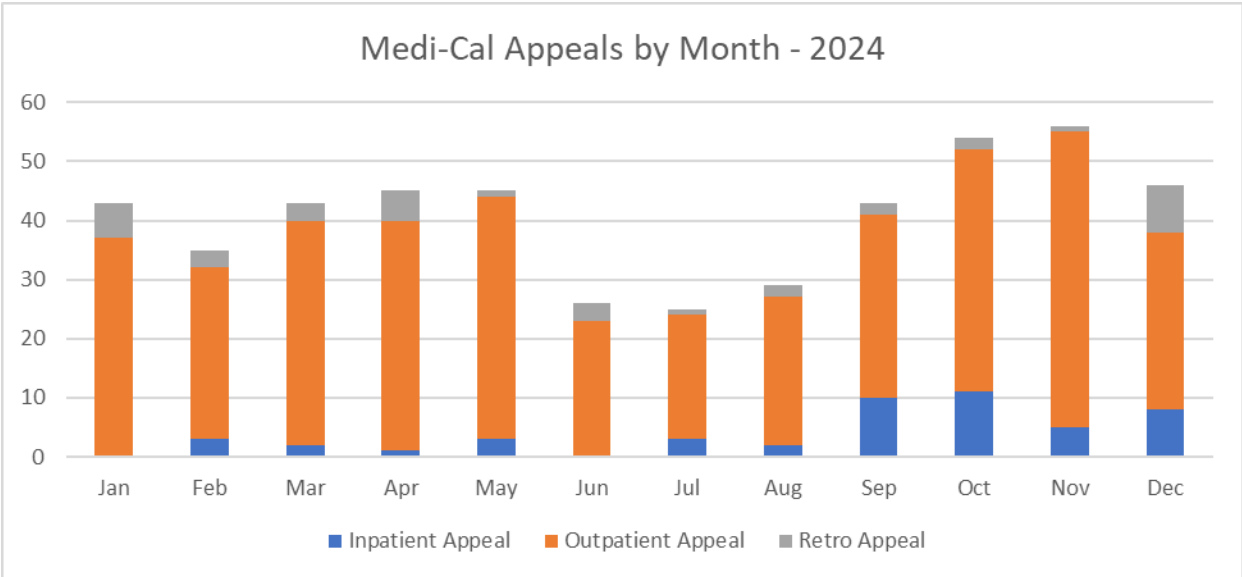
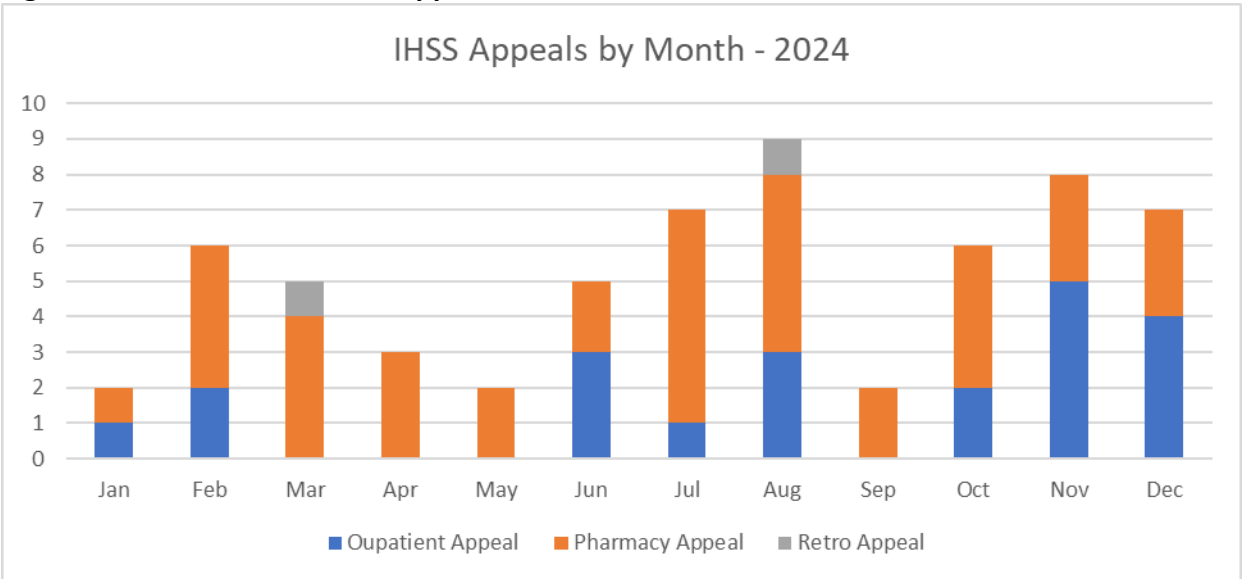


Figure 22b. 2024 IHSS Clinical Appeals



There was an increase in Medi-Cal outpatient appeals in 2024, with majority of appeals related to out-of-network services, followed by disputes involving medical necessity. There was also an increase in pharmacy appeals in 2024, for our commercial LOB, compared to 2023. Several pharmacy requests were denied due to members needing to try and/or fail other preferred medications first before they can be prescribed the requested medications.

Overturn Rates

The figures below show overturn rates for Medi-Cal and Group Care lines of business.

Figure 23a. 2024 Medi-Cal Overturn Rate by Decision Maker

Medi-Cal Overturn Rate by Decision Maker Q4 2023 – Q4 2024				
Decision Maker	Q4 2023	Q1 2024	Q2 2024	Q3 2024
CFMG	0.0%	100.0%	50.0%	0.0%
CHCN	9.10%	18.7%	17.6%	24.1%
Plan - Outpatient	23.4%	27.5%	19.1%	18.3%
Plan - Retro/Inpatient	0.0%	5.80%	16.6%	47.3%

- **CFMG:** There was a total of 3 appeals in 2024, and 2 of the 3 appeals were overturned due to services not available in-network, and guidelines were met after a different criterion was used.
- **CHCN:** We continue to meet our internal benchmark for all quarters in 2024. The Alliance continues to meet with CHCN decision makers monthly to review overturns, and this could possibly be attributed to the decrease of overturn rate.
- **The Plan - Outpatient:** We met our internal benchmark for all quarters in 2024, except Q1 2024. In Q1 2024, there were 24 out of 87 appeals that were overturned.
 - 11 - Additional information was obtained
 - 6 - Inappropriate denials
 - 4 - It was in the members' best interest to approve the services based on their health conditions
 - 1 - Continuity of Care was met
 - 1 - Not available in-network
- **The Plan - Retro/Inpatient:** We did not meet the internal benchmark of 25% and below for overturns in Q3 and Q4 2024. There was a total of 22 out of 81 Retro/Inpatient appeals that were overturned:
 - 15 - Additional information was obtained
 - 4 - Inappropriate denials
 - 1 - Not available within timely access standards
 - 1 - Not available in-network
 - 1 - Per facility, bed hold attempts were made on 3 earlier dates.

Figure 23b. 2024 IHSS Overturn Rate by Decision Maker

IHSS Overturn Rate by Decision Maker					
Q4 2023 – Q4 2024					
Decision Maker	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024
CHCN	0.0%	0.0%	0.0%	33.3%	40.0%
Plan – Pharmacy	28.6%	0.0%	42.8%	15.3%	30.0%
Plan – Outpatient	0.0%	0.0%	0.0%	0.0%	16.6%
Plan – Retro/Inpatient	0.0%	0.0%	0.0%	0.0%	0.0%

- **CHCN:** There was an increase in appeal cases during the Q3 and Q4 period, as 3 out of 8 appeals were overturned:
 - 1 - Inappropriate denial, as medical necessity was met
 - 1 - Additional information obtained during the appeal process
 - 1 - Timely access was not available in-network
- **The Plan - Pharmacy:** Although the Plan met the 25% and below internal benchmark for 2024, with a total of 20.5% overturn rate, there was still an increase in overturn rates in a few quarters with 8 out of 39 appeals overturned due to additional information obtained for all 8 cases during the appeal process and medical necessity was met.
- **The Plan - Outpatient:** No trends identified.
- **The Plan - Retro/Inpatient:** No trends identified.

Figure 24a – 2024 Medi-Cal Clinical Appeals by Resolution/Overturn – Threshold Compliance

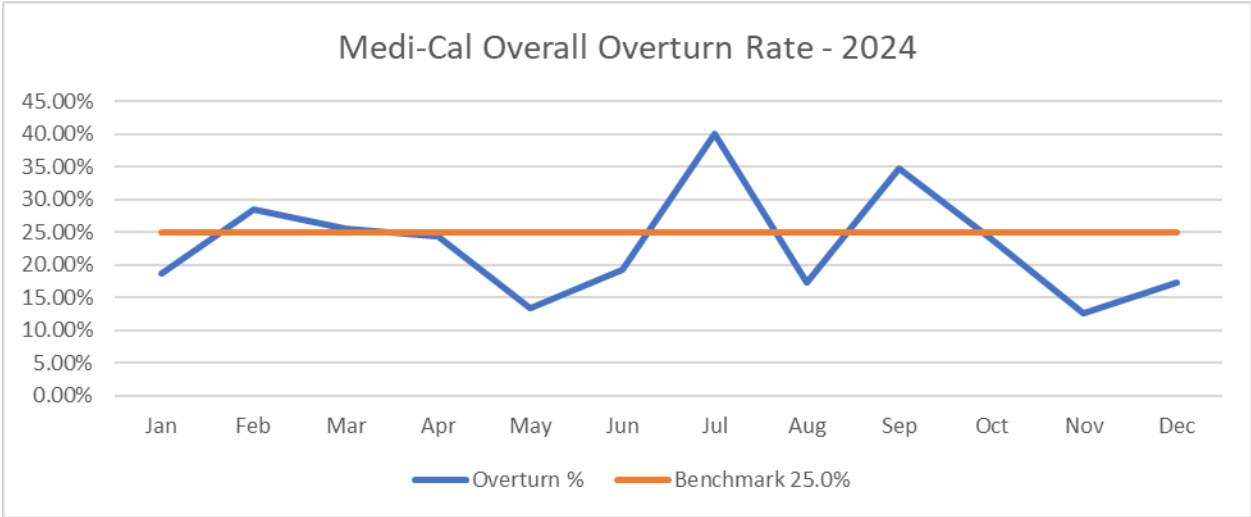
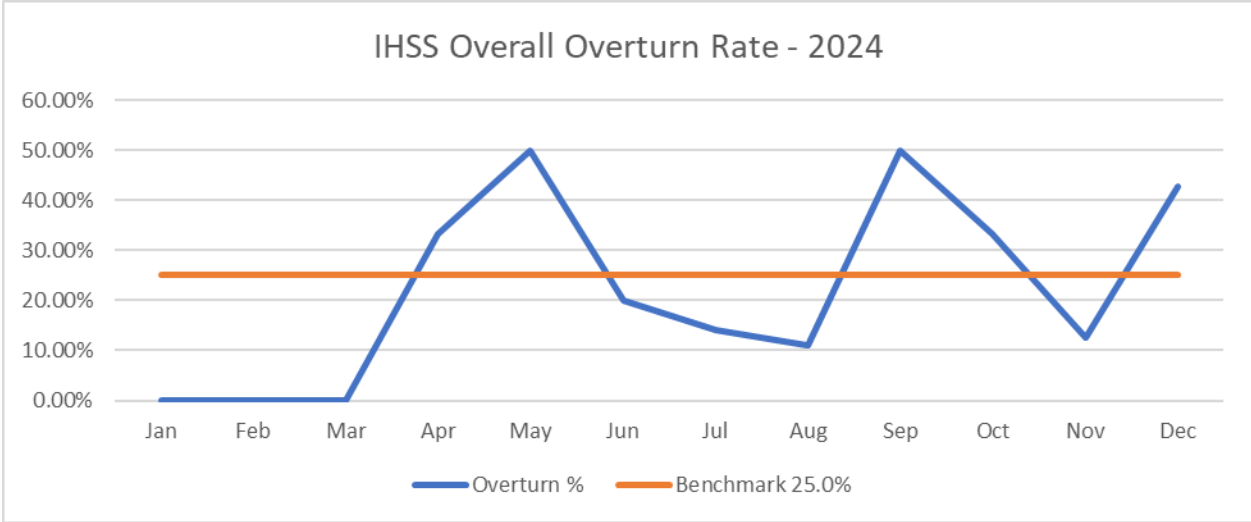


Figure 24b – 2024 IHSS Clinical Appeals by Resolution/Overturn – Threshold Compliance



The Alliance had an average overturn rate of 29.9% for MCAL appeals in 2024, which was slightly above our internal benchmark of 25%. The Alliance also had an average overturn rate of 33.9% in 2024 for IHSS appeals, which is also above our internal benchmark.

Clinical Appeals - Recommended Actions for 2025:

Upon evaluation of the above Appeal measures, potential program enhancements are:

- There were no trends identified.
- Continuing to monitor overturn rates for both lines of business.

Coordination with Compliance Department

The Alliance UM Department works closely with the Compliance Department to prepare for regulatory audits. In April 2024, the department participated in DHCS’ annual audit. There was one finding related to delegated utilization management activities, in which The Alliance did not ensure a UM-delegated entity had mechanisms to detect inappropriate utilization of subacute level of facility care; the delegate inappropriately approved levels of subacute care for members that were at a custodial level of care. This was remediated on 08/01/24. The UM department, in coordination with the Delegation Oversight Department, implemented DHCS’ recommendation to ensure policies and procedures to ensure UM-delegated entities monitor over and under-utilization of nursing facilities, including the utilization of appropriate levels of care.

To maintain the integrity of The Alliance’s UM processes, including those of delegated entities, ongoing auditing and monitoring of key operational functions will continue, ensuring compliance with all federal, state, regulatory, contractual and accreditation standards.

Evaluation of Delegated Utilization Management Activities

The Alliance provides covered services to members through a delegated network. For UM-delegated entities, the Alliance has shared-risk arrangements in which the delegated entity is responsible for inpatient and outpatient authorization reviews for certain services, while the Alliance UM Department is responsible for certain outpatient and inpatient authorization

reviews, based on contractual agreements noted in the Divisions of Responsibility.

The Compliance Department is responsible for monitoring and tracking the overall performance of delegates, including completion of annual audits. UM department staff review the UM components of the annual audit, which includes a review of delegates’ policies and procedures and member case files. The UM team also reviews the delegated entities annual work plans/evaluations, and other standing reporting activities, as required. The Compliance Department is responsible for finalizing the audit findings. For entities that do not meet thresholds, a corrective action plan may be issued and tracked to ensure adequate resolution of the deficiency. All audit findings are reported to the Compliance Committee and the QIHEC.

In 2024, the UM staff conducted annual audits on the three (2) delegates with delegated UM responsibilities. The threshold for UM audit compliance was 90%. In 2024, delegate audit results for UM activities included:

- CHCN did not pass the UM components of the annual delegation oversight audit and corrective actions were required
- CMFG did not pass the UM components of the annual delegation oversight audit and corrective actions were required

Figure 25. 2024 Delegate Annual Audit Results (UM components only)

Delegate Name	Provider Type	2024 Audit Results	Corrective Action Required
CHCN	Managed Care Organization (MCO)	21 findings File Review (24% score) <i>These are preliminary findings</i>	1. Provide Root Cause Analysis for cases with missed TAT, and corresponding mitigation plan to address identified issues. 2. Provide Root Cause Analysis for cases with missed TAT, and corresponding mitigation plan to address identified issues. 3. Provide corrective action plan related to timely member notification. 4. Provide corrective action plan related to timely member AND provider notification. 5. Staff/MD training of cases that missed Medical Necessity review, Stay Level Medical Necessity, IP Late Notifications, and Retro >90d MD reviews. Please provide trainee

			attendance and provide training content. Develop templates or checklist for staff/ MD workflows to ensure Medical Necessity is reviewed. Internal Audit of cases Quarterly to review specifically for these elements and case types. 6. Cases must include evidence of a service denial in addition to the CoC Denial. 7. Staff/MD training of cases for IP Late Notifications, Retro >90d MD reviews, Home Health, Genetic Counseling vs Specialty consultation, IP Stay levels, etc. Please provide trainee attendance and provide training content. Develop and share templates or checklist for staff/ MD workflows to ensure Late Notifications review for Retro Eligibility or John Doe/Insurance mix-ups, Notice of Non Medical Coverage. Ensure UM Policies reflect these exceptions. Develop and share templates or checklist for staff/ MD workflows to ensure Retros >90 days reviews screen for Retro Eligibility, Insurance mix-up, or Notice of Non Medical Coverage. Ensure UM Policies reflect these exceptions. Develop and share templates or checklist for staff/ MD workflows to review for appropriate stay level, or opportunity to de-escalate IP care. Internal Audit of cases Quarterly to review specifically for these elements and case types. 8. Staff/MD training of cases for COC (Knox-Keene conditions, COC

			duration, active course of treatment), and OON review with specific attention to Network Adequacy, Timely Access, and Tertiary Quaternary care, Clinical Trial access. Please provide trainee attendance and provide training content. Develop and share templates or checklist for staff/ MD workflows to ensure COC (Knox-Keene conditions, COC duration, active course of treatment), and OON review with specific attention to Network Adequacy, Timely Access, and Tertiary Quaternary care, Clinical Trial access Ensure UM Policies reflect regulation and member protections, as well as network adequacy/timely access standards. Internal Audit of cases Quarterly to review specifically for these elements and case types: COC, OON, TQ, Redirection of INN Care and CM assistance. 9. Provide P&P for NOA process, including reference to language that providers can discuss denial decisions with MD. Provide copy of NOA template that is sent to providers (including all enclosures). 10. Staff/MD training of cases for COC (Knox Keene conditions, COC duration, active course of treatment), and OON review with specific attention to Network Adequacy, Timely Access, and Tertiary Quaternary care, Clinical Trial access. Please provide trainee attendance and provide training content.

			11. Provide P&P for NOA process, including reference to language that providers can discuss denial decisions with MD. Provide copy of NOA template that is sent to providers (including all enclosures). 12. Same as 11. 13. Provide P&P for NOA process, including reference to all required enclosures. Provide checklist and/or workflow to ensure all appropriate enclosures are included with member notifications. 14. Provide P&P for NOA process, including reference to language that providers can discuss denial decisions with MD. Provide copy of NOA template that is sent to providers (including all enclosures). 15. Provide P&P for NOA process, including reference to all required enclosures. Provide checklist and/or workflow to ensure all appropriate enclosures are included with member notifications. 16. Provide P&P for NOA process, including reference to language that providers can discuss denial decisions with MD. Provide copy of NOA template that is sent to providers (including all enclosures). 17. Provide documentation that DMHC envelop was sent as a part of the Mailing Process (ie: sample file from mailing vendor, documentation from mailing vendor)

			18. Provide Root Cause Analysis for noncompliant cases, and corresponding mitigation plan to address identified issues. 19. Provide Root Cause Analysis for noncompliant cases, and corresponding mitigation plan to address identified issues. 20. Provide P&P and workflow process for referring members with CCS-eligible conditions to CCS, including reference to criteria used to refer to CCS. 21. Provide P&P and workflow process for referring members with CCS-eligible conditions to CCS, including reference to any member/provider notification processes.

Delegate Name	Provider Type	2024 Audit Results	Corrective Action Required
CFMG	Managed Care Organization (MCO)	8 findings File Review (68% score) <i>These are preliminary findings</i>	1. Present a workflow on how CFMG coordinates CCS cases. 2. Same as 1. 3. Same as 1. 4. Present a workflow on how CFMG documents the review. 5. Same as 4. 6. Submit copies of letter templates in threshold language with applicable attachments when completed Q1 2025. 7. Same as 1. 8. Same as 1.
		3 findings P&P Review (96% score) <i>These are preliminary</i>	1. P&P provided does not address "non-urgent preservice (Routine) decisions written decisions must be

		<i>findings</i>	communicated to the member within 15 calendar days of the request" requirement. The UM 001 Policy states that CFMG must notify the member within 2 working days of making the decision and not to exceed 28 days from the receipt of the service. Please update P&P to state the 28 days should state 15 days. 2. Please develop a process for discharge risk assessment oversight. 3. Please provide process developed for any potential care coordination/ handoffs that may occur between the Delegate and AAH.

For 2024, the CFMG UM delegates continued to meet the program’s required scope of activities, however the CHCN delegates continue to have repeated findings in certain areas. The UM team, in combination with the Delegation Oversight team, address ongoing compliance concerns regarding delegation requirements directly with the delegate to identify potential process improvement activities and monitor corrective action plans.

Delegated Utilization Management - Recommended Actions for 2025:

- The UM Department partnered with the Compliance Department to create a new audit tool that will go into effect for the next delegate audits.
- UM Continues to partner and establish metrics that align with The Alliance’s key performance indicators.
- Monitor and support Delegate CAP activities, in coordination with the Compliance Department
- Provide regular training and share best practices with delegated entities, particularly around Enhanced Care Management, Community Supports, Transitional Care Services, and other activities impacting The Alliance’s Population Health Management strategy

Over/Under Utilization

Assessment and monitoring of Over/Under Utilization is a collaborative effort between the Quality Management and UM Department. This evaluation will focus on those efforts specific to the UM department, in which over- and under-utilization is evaluated for selected services or treatments that may indicate barriers to accessibility for covered health care services. Over/Under Utilization reports are presented at UMC to elicit insights from committee members and identify opportunities for improvement, as necessary. The UM Department monitors over-

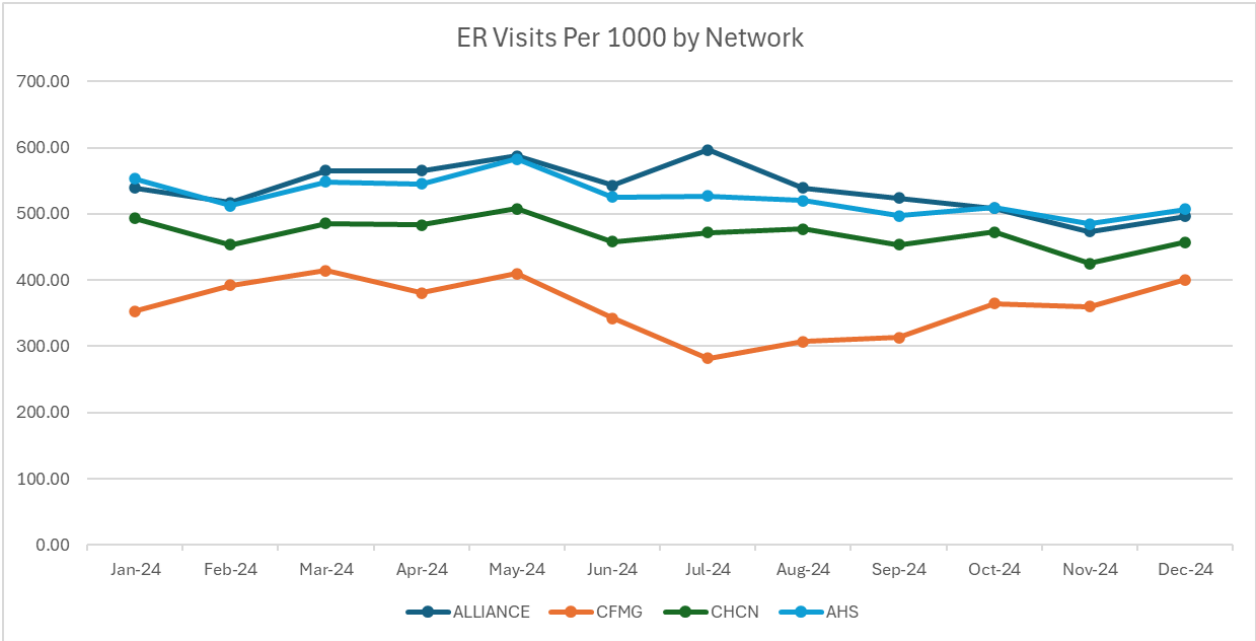
and under-utilization for:

- Emergency Room Visits
- Acute Inpatient Hospitalizations (including admits, average length of stay, bed days, and readmission rates)
- Specialty and Ancillary visits (including out-of-network activities)
- Unused Authorizations

Emergency Room Utilization

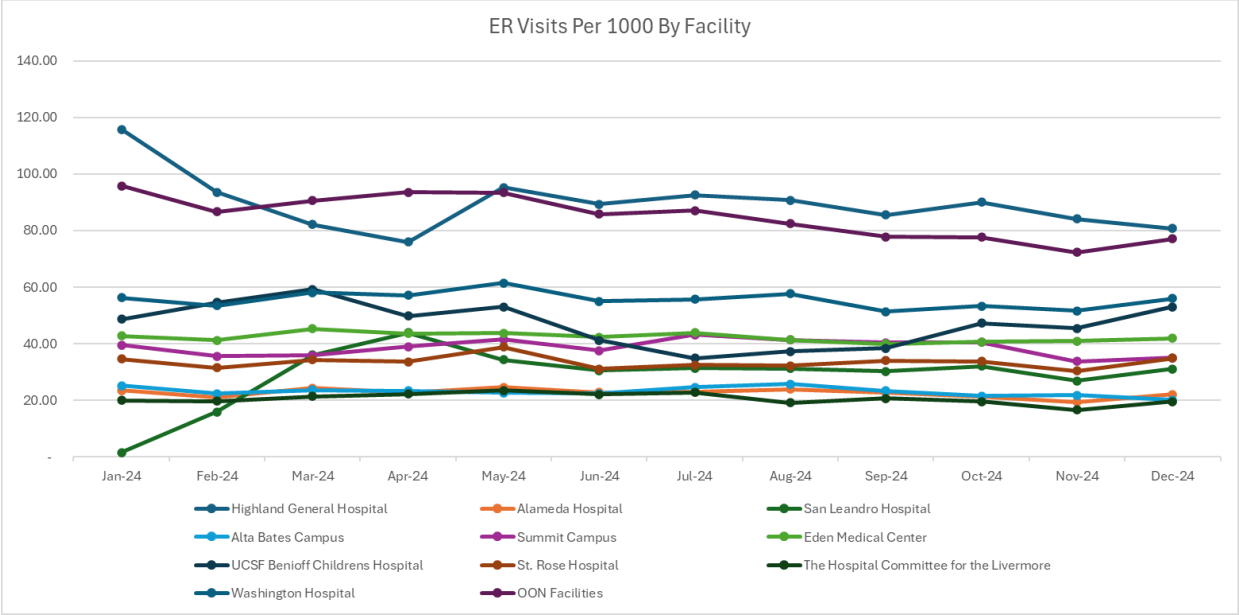
Monitoring for avoidable emergency room (ER) visits can identify potential member education, primary care access needs, and provider training opportunities.

Figure 26a. 2024 Overall ER utilization, by Network



In 2024, emergency utilization was 491.6/1000 members across all networks, which was an decrease in volume (-33.4/1000) compared to 2023. Members in the CFMG network continue to have the lowest ER utilization rate (362.3 visits/1000), while members in the Alliance network have the highest emergency room utilization rates (547.48 visits/1000) comprising the 3 top EDs visited are Highland, OON ERs and Washington.

Figure 26b. 2024 Overall ER Utilization, by Facility



In 2024, emergency room utilization is highest at Highland Hospital at 90.4 visits/1000 followed by out-of-network hospitals with 86.9 visits/1000 members and Washington Hospital at 56.1 visits/1000 members. The Out-of-Network hospitals consist primarily of Kaiser facilities, including Kaiser Richmond, Kaiser San Leandro, and Kaiser Hayward. This is related to the geographic hospital desert in the northern part of Alameda County, following the closure of the Doctors Medical Center in Richmond (2015). Both Highland Hospital, which is a Tier-1 trauma center for Alameda County, and Washington Hospital, which is the only major facility in the southern part of Alameda County, continue to be the two highest contracted hospitals for emergency room utilization.

In 2024, the Alliance implemented an Over/ Under Workgroup that meets monthly to discuss opportunities to drive down inappropriate over-utilization of services. The workgroup is attended by representatives from various departments in the organization including UM, Case Management (CM), Quality, Population Health Management (PHM), Health Equity, and Member Services. Specifically for ER utilization, the workgroup has focused on strategy to divert members who may be using the emergency department inappropriately to use other appropriate services such as their Primary Care Physician, Urgent Cares, Teledoc and the Nurse Advice Line.

Emergency Room Utilization - Recommended Actions for 2025:

- Continue collaboration with Case Management, QualityManagement and Population Health Management teams to ensure access to post-discharge care, particularly with primary care providers.
- Monitor diagnosis drivers for emergency room visits, especially for repeat utilizers and for facilities with high emergency room rates.
- Monitor PCP primary care homes for facilities with high ER rates and for repeat utilizers and facilities with high emergency room rates: Identify Teledoc opportunities and those diagnoses that could be managed in primary care offices.

- Track utilization that is associated with members who readmit to the hospital, for case escalation to the Case Management department and supports.
- Increase collaboration with Behavioral Health team and Alameda County Behavioral Health Services to support access to necessary BH/SUD treatment
- Explore opportunities with Community Health Workers and Bridge Programs embedded in the Emergency Departments throughout the county to decrease Emergency Department Utilization.

Acute Inpatient Hospital Utilization

Monitoring usage of acute inpatient hospitals can identify trends in disease burden among our membership, potential member education, primary care access needs, and provider training opportunities.

Inpatient Hospital Admissions

The Alliance UM department provides clinical oversight of the inpatient concurrent/continued stay review process when members are admitted to an acute care hospital. Reviews for acute admissions focus on:

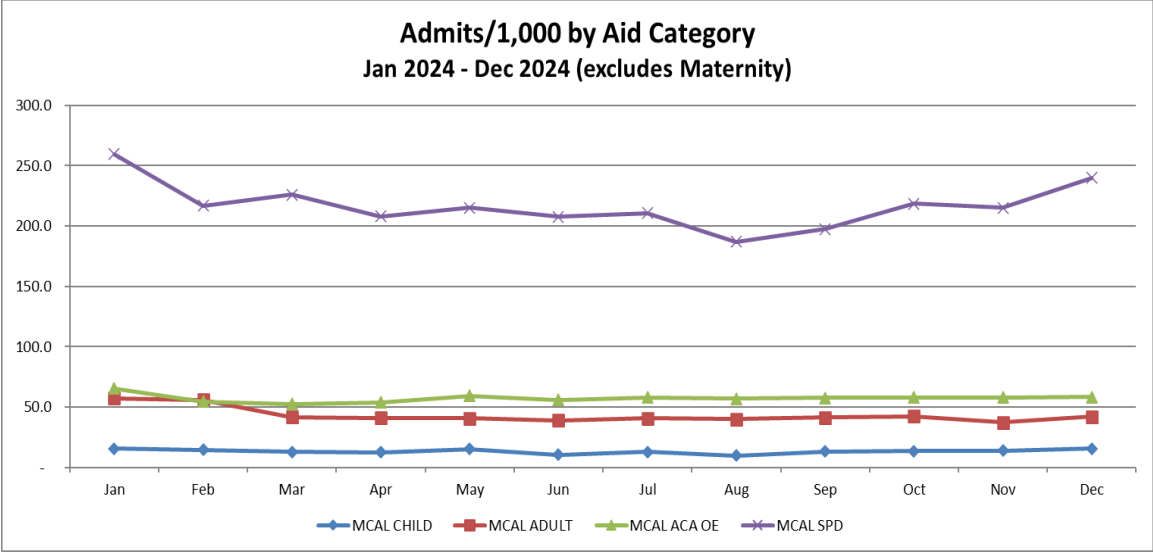
- Facilitating timely provision of services through evidence-based medical necessity review processes, including appropriate and timely notification of review decisions
- Promoting adherence to established UM and Discharge Planning standards of care with Transition of Care service integration.
- Identifying any Quality-of-Care issues, including Hospital Acquired Infections, delayed services rendered while hospitalized, preventable readmissions, and other Potential Quality Indicators
- Coordinating safe and timely transfer to the most appropriate level of care and care settings
- Identifying and coordinating ongoing follow-up and/or case management needs after discharge, including but not limited to:
- Communicating to the attending physicians, specialists, and members regarding covered services needed post-discharge, or upon transfer to a lower level of care
- Assisting with locating appropriate placement for members with complex medical or psychosocial barriers to discharge in collaboration with our LTSS, CM and BH departments
- Referring to the Alliance Case Management (CM) department, or other appropriate care management programs, including Enhanced Care Management, Community Supports, and Targeted Case Management

To evaluate trends in acute inpatient hospitalizations, the Alliance measures:

- Admissions per thousand
- Average length of stay (ALOS)
- Bed days per thousand

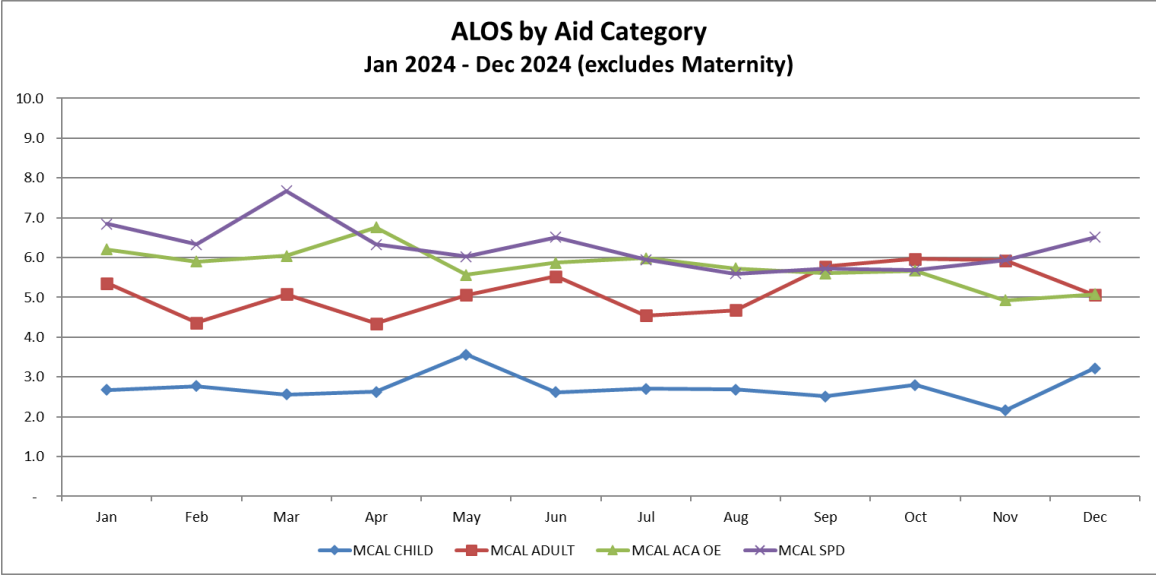
Admissions per Thousand

Figure 27. 2024 Hospital Admits per Thousand, by Aid Category



Claims data comprise the admits per thousand metric for all lines of business in inpatient utilization management. LTC Duals have the highest admits per 1000 members (674.5/1000) followed closely by LTC at 545.7/1000 while all other member aid categories remain significantly less. In decreasing order, the other aid categories were the Duals 215.8/1000, SPD 214.7, ACA OE 52.2/1000, Adult 61.9/1000 and Child 10.2/1000. The LTC Dual and LTC populations have more complex medical needs and more frequent utilization, and it is expected to have a higher than average admits per 1,000 as compared to the other aid category populations. When comparing these volumes to 2023, LTC Duals (+122.7), LTC (+35.6), Duals (+1.6), SPD (8.39) all increased. Decreases were noted in ACA OR (-10.8), Adult (-10.7) and Child (-0.2) For this population, focus remains on supporting them with care transitions between settings, particularly during and after a hospitalization, and connecting increased supports as necessary.

Average Length of Stay
Figure 28. 2024 Hospital Average Length of Stay (ALOS) per Thousand, by Aid Category

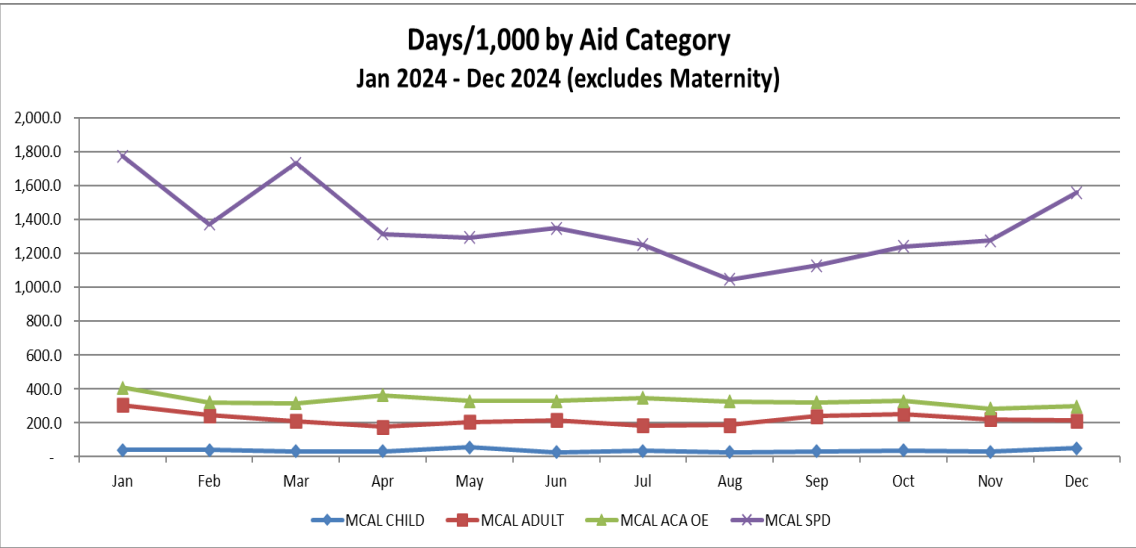


In 2024, there was an increase in the number of members admitted to the hospital with complex social determination of health barriers that led to barriers with discharge and placement at lower levels of care. These barriers contributed to the ALOS in 2024 decreasing (-0.3%) compared to 2023. Only the LTC population saw a slight increase in 2024, but the drops in all other Aid Categories show that the efforts being made by the Inpatient teams in alignment with the DHCS Transitional Care Services requirements have been effective in reducing overall Long Length of Stays. The most common discharge barriers related to placement difficulties included higher member age, the presence of complex behavioral health diagnoses requiring placement, conservatorship and placement needs, ventilator/ tracheostomy with hemodialysis needs, and members with multidrug-resistant organisms (MDRO) status.

The UM team and TCS teams work collaboratively to reduce ALOS related to inappropriate discharge delays by proactively collaborating with hospitals in discharge planning from the point of admission notification, coordinating joint rounds with hospitals, expanding searches for skilled nursing facilities and/or other lower level-of-care settings, and linking providers to care management resources, including Enhanced Care Management and Community Supports. The Alliance teams have enhanced our Internal Extended Length of Stay Rounds, which brings together representatives from IP UM, CM, Community Supports, Pharmacy, BH and others to discuss members with SDOH or highly complicated medical needs to help create and implement discharge planning and wrap around supports, which allow for members to discharge from the Acute Settings safely and more expeditiously.

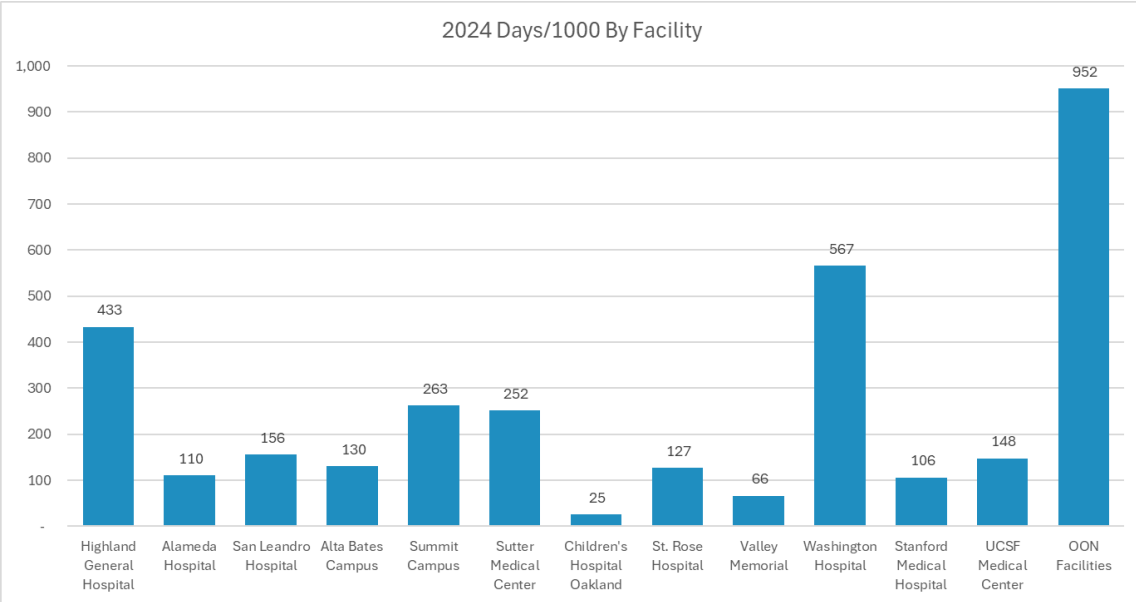
Bed Days per Thousand

Figure 29a. 2024 Hospital Bed Days per Thousand, by Aid category



For 2024, the Medi-Cal SPD population again had the highest bed days per 1000 members, while all other aid categories remain relatively flat, which is consistent with significantly higher SPD admits/1000 members and higher on average length of stay. However, the aid categories that experienced an increase in days/1000 members was Child with a (+0.4). The others experienced decreases as follows Medi- Cal Adults (-30.5), Medi-Cal Expansion (-9.5) and Medi-Cal SPD (-92).

Figure 29b. 2024 Hospital Bed Days per Thousand, by facility



For 2024, the average days/1000 at San Leandro (+1.7) Eden (+1.8) and Alta Bates (+1.3) increased. The following hospitals saw decreases in their average days/ 1,000; OON (-21.8), Highland (-6.1), Summit (-0.3), Washington (-0.8), and UCSF (-3.6).

The increase in out-of-network hospitalization days/1000 is related to continued trends of Kaiser hospitalizations at Hayward, San Leandro, and Richmond facilities and their respective ED utilization. Possible key driver for high out-of-network hospital authorization volume could be member choice and geographic location when seeking emergent care, because ultimately emergency room visits drive out-of-network inpatient admissions.

To support the appropriate management of acute hospitalizations, The Alliance continued joint rounds with contracted acute hospital partners in 2024. The joint discharge rounds have provided an opportunity to collectively share resources and brainstorm solutions to support members with complex medical and social health needs. The Alliance restarted weekly rounds with Alameda Hospital/ Highland Hospital , following partner staffing turnover that required a temporary suspension. The University of California San Francisco (UCSF) and Stanford Medical Center facilities were added to the joint weekly rounds to incorporate improved transplant, oncology care, and other complex tertiary quaternary care coordination and discharge planning. The inpatient discharge risk assessment form was updated to improve Transition of Care warm hand-off to Case Management. Notable increases in LTC acute SNF authorizations volume following acute hospital discharge were noted in 2023 due to the LTC membership expansion. The Alliance also contracted with additional Long-term Acute Care Hospitals (LTACs), Subacute facilities, and Medical Respite Beds to address LTC placement needs to the next level of care and ensure transition to appropriate care settings.

During Calendar Year 2024, only 36.3% of member in acute settings discharged to a home setting which included home, home with home health, Assisted Living Facility and Board and Care. Second largest discharge disposition from an Acute Hospital was into a Lower Level of Care such as Nursing Facility, Subacute, Acute Rehab Unit or LTACH. The Alliance IP team continues to collaborate with internal teams to ensure resources for placement to the least restrictive locations are available.

Readmission Rate

All-Cause Readmission rates, defined as an unplanned readmission to an acute hospital within 30 days of discharge, are monitored and evaluated to identify preventable readmissions and member centric care plans and identify potential gaps in post-discharge care, such as high-risk social determinants of health, increased skilled or caregiving needs, and Transitions of Care support needs.

Figure 30a. 2024 Overall Inpatient Hospital Readmission Rate

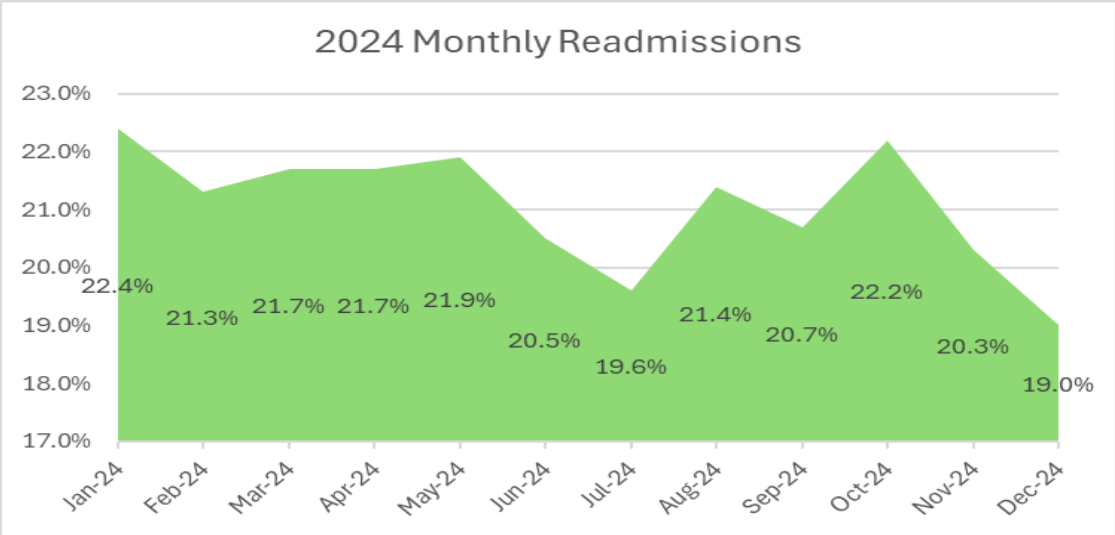
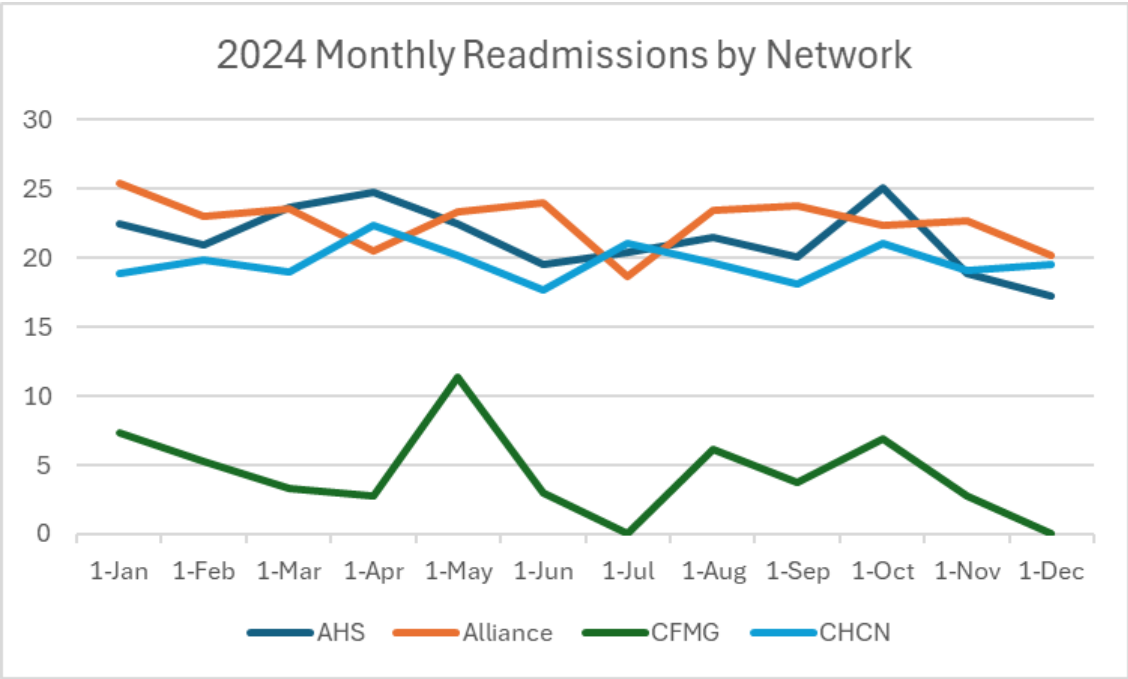


Figure 30b. 2024 Overall Inpatient Hospital Readmission Rate, by Network



The Alliance and CHCN networks saw relatively stable readmissions rates in 2024. The AHS network has medically complex members with higher social determinants of health needs, served by the 3 county hospitals in Oakland, Alameda, and San Leandro. This network saw an upward readmission trend and a unique August spike.

The AHS readmissions workgroup is focused on reducing readmissions for Black members with substance use disorders and behavioral health needs and are developing a risk stratification tool rather than disease-based strategies for reducing readmissions. The Alliance is also aware of access issues to see new AHS primary care physicians and establish follow-up visits after hospital discharge in the AHS network, with current strategies focusing on replacing medical staff FTE to increase access capacity in 2025. The CFMG network typically experiences few readmissions with low admissions and readmissions.

Figure 30c. 2024 Overall Hospital Readmission Rate, by Aid Category

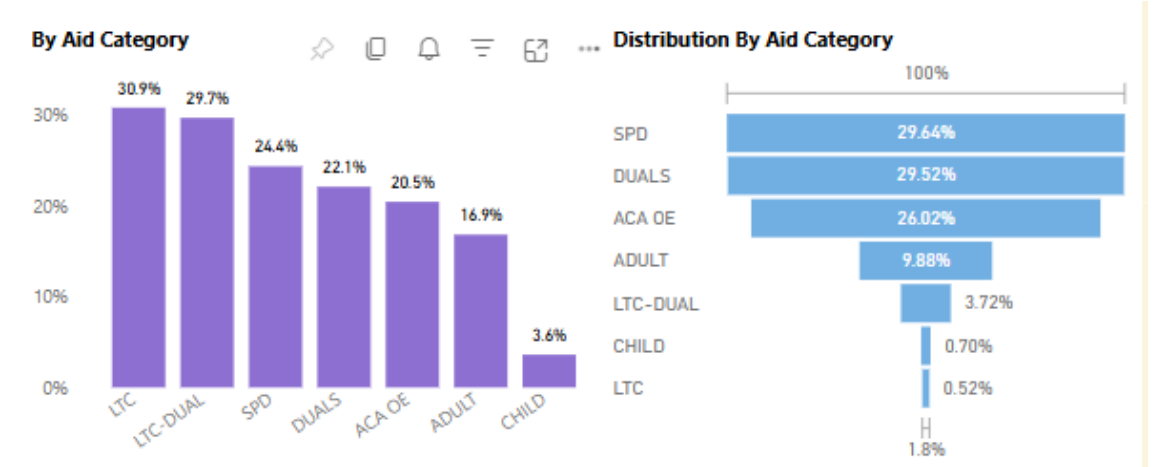
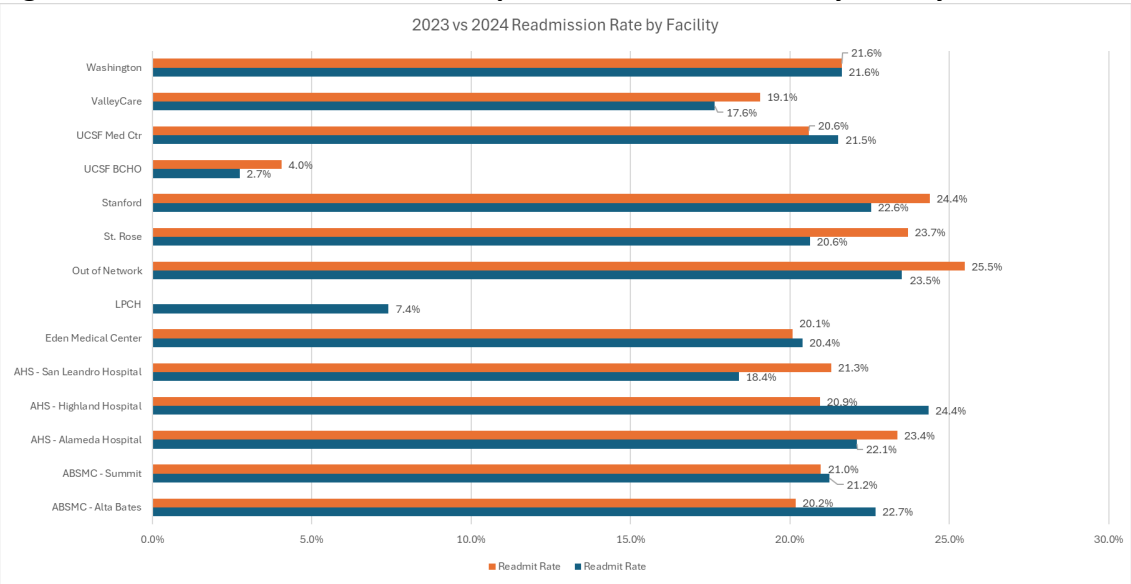


Figure 30d. 2023 vs. 2024 Overall Hospital Readmission Rate, by Facility



In 2024, the overall all-cause readmission rate across all networks increased to 21.1%, compared to 20.1% in 2023 and 19.6% from 2022. Out of Network Hospitals have the highest overall readmission rate (25.5%, +2.0) in 2024, replacing Highland (20.9%, -3.4%) as the highest readmitting facility in 2024. OON readmissions were comprised of Affordable Care Act (29.43%), SPD (24.84%), and Duals (25.26%).

ABSMC (-2.5%), Summit (-0.03%), Highland (-3.4%), Eden (-0.3%), LHPC (-7.4%) and UCSF (-0.9%) all saw a decrease in the year-to-year readmission rates, while Alameda Hospital (+1.3%), St. Rose (+3.1%), Stanford (+1.8%), UCSF BCHO (+1.3%), Valley Care (+1.4%) and Stanford (+1.8%) all saw increases.

The biggest change in readmissions compared to 2024 were linked to the LTC Duals which had an increase of 8.2%, LTC members with an increase of +5.9% and the SOD wgi saw an increase of 1%. The Alliance acknowledges that these aid categories with the highest readmission rate across all networks, demonstrating the anticipated higher utilization for this membership due to their higher morbidity and mortality risk factors and intensity of care needs.

In 2024, there was strengthened efforts to prevent inappropriate readmissions. The UM team, in alignment with DHCS' Transitional Care Services requirements, completed discharge risk assessments for high-risk members who are admitted to a facility, proactively identifying potential barriers to discharge, identifying high risk readmissions diagnoses, identifying changes in prior functioning at discharge, and determining any follow-up care needs while simultaneously referring admitted members to the appropriate Case Management programs like Community Supports or Enhanced Case Management team. Identifying follow-up care and discharge needs well before discharge allowed more adequate time for planning follow-up care when Care Managers became involved. As part of new regulatory Transitional Care Services guidance, case managers served as a single point of contact for members and providers to receive support throughout the hospital stay, and as members transitioned out of the hospital. Care Managers maintained contact with members after discharge, ensuring they received all necessary follow-up care and linking them to ongoing care management or community-based support, as needed.

Acute Hospital Utilization - Recommended Actions for 2025:

- Expand ADT feeds and comparable data sharing sources for acute hospitals that are not yet established (Stanford, UCSF, Childrens Hospital).
- Build staffing capacity to manage new membership and inpatient volume for new Long-Term Care higher utilization and 2024 Managed Care Plan to Managed Care Plan and Fee-For- Service Medi-Cal Transitions
- Improve identification members who are at-risk for readmission or who re-admitted, including revision of risk-stratification methodology, and use of additional data sources as available to DHCS or community-based partners
- Continue referral processes for Enhanced Case Management, Complex Case Management and

- Community Supports, with goal to link members to appropriate resources for next level of care
- Foster continued collaboration and relationship building with hospital and skilled nursing facility partners to support discharge management, and complex case rounds for members with long length of stay or complex discharge barriers.
 - Coordinate collaboration between the Alliance and its delegates around identifying Potential Quality Issues, Avoidable days variance, Provider Preventable Conditions, and preventable readmissions
 - Expand screening for appropriate Case Management referrals for palliative/hospice eligible members

Specialty Care Utilization

Certain specialty care utilization was monitored to detect patterns of over or under-utilization.

Figure 31. 2024 Specialty Care Utilization (select specialties and ancillary services only)



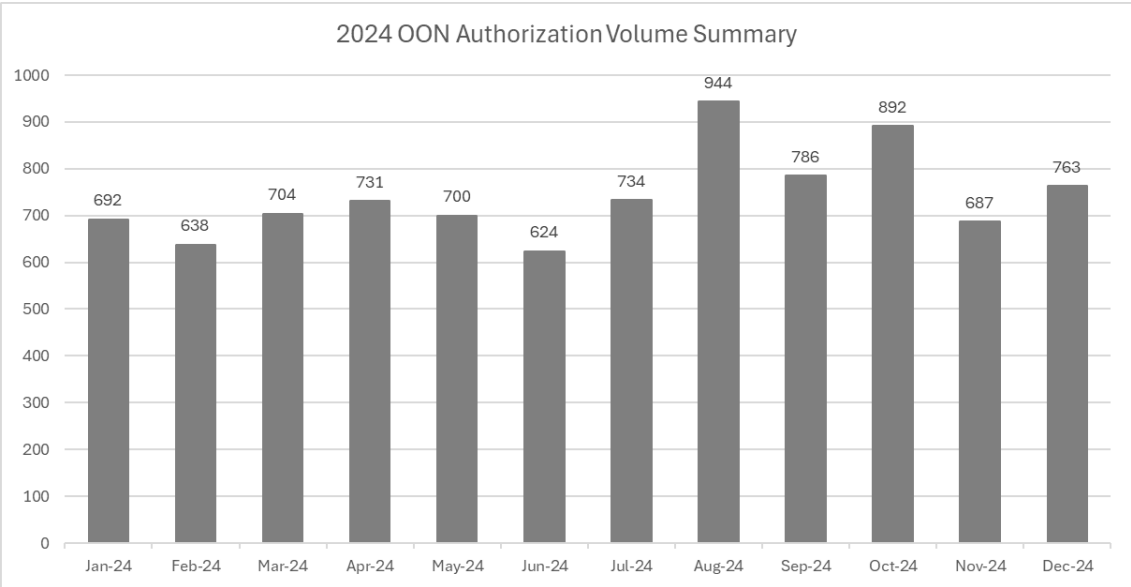
Podiatry is one of the few Specialty services that requires prior authorization for in-network and out-of-network care. In 2024, Podiatry observed a slight drop in utilization, an average 38/month, compared to 45 approved authorizations in 2023, however the reason is unclear. Chiropractic services saw relatively no change from 2023, and Transplant services increased by 28 cases per month. Palliative Care has risen by 1 cases per month. Since 2020, the Alliance has collaborated

with Alameda Health Systems (AHS) to enhance and extend the use of this benefit by seriously ill members. In December 2022, the Alliance expanded the eligible conditions to receive Palliative Care to include members with advanced dementia and Alzheimer’s disease, likely contributing to the increased utilization in 2023 and 2024. The Alliance continues efforts focusing on working with the Contracting team to expand the Palliative Care network.

Out-of-Network Services

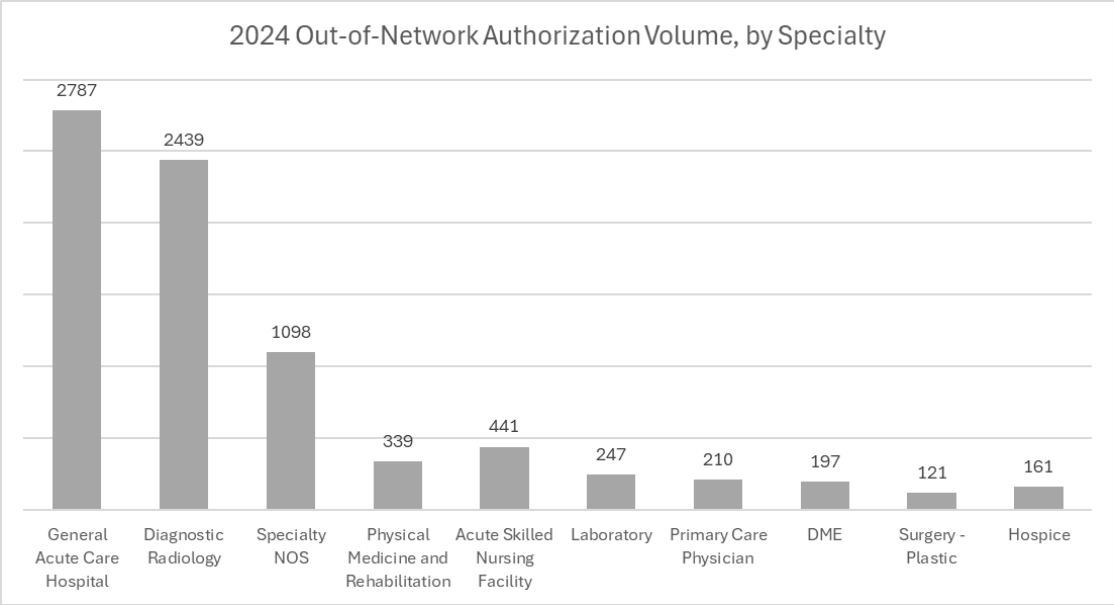
In addition to monitoring the utilization of certain specialty types, the Alliance also monitors the utilization of out-of-network vs. in-network services to evaluate network adequacy. Out-of-network (OON) services are those provided by non-participating providers or facilities. Members may access OON services either through an emergency room, or as a direct referral for specialty services that are not available in-network, or when they are available but do not meet timely access standards. OON services may also be accessed when new members meet continuity of care criteria, as outlined in DHCS APL 23-022.

Figure 32a. 2024 Out-of-Network Authorization Volume



In 2024, a monthly average of 741 (+293) out-of-network authorizations were approved, representing an increase from 2023 due to member growth.

Figure 32b. 2024 Out-of-Network Authorization Volume, by Specialty

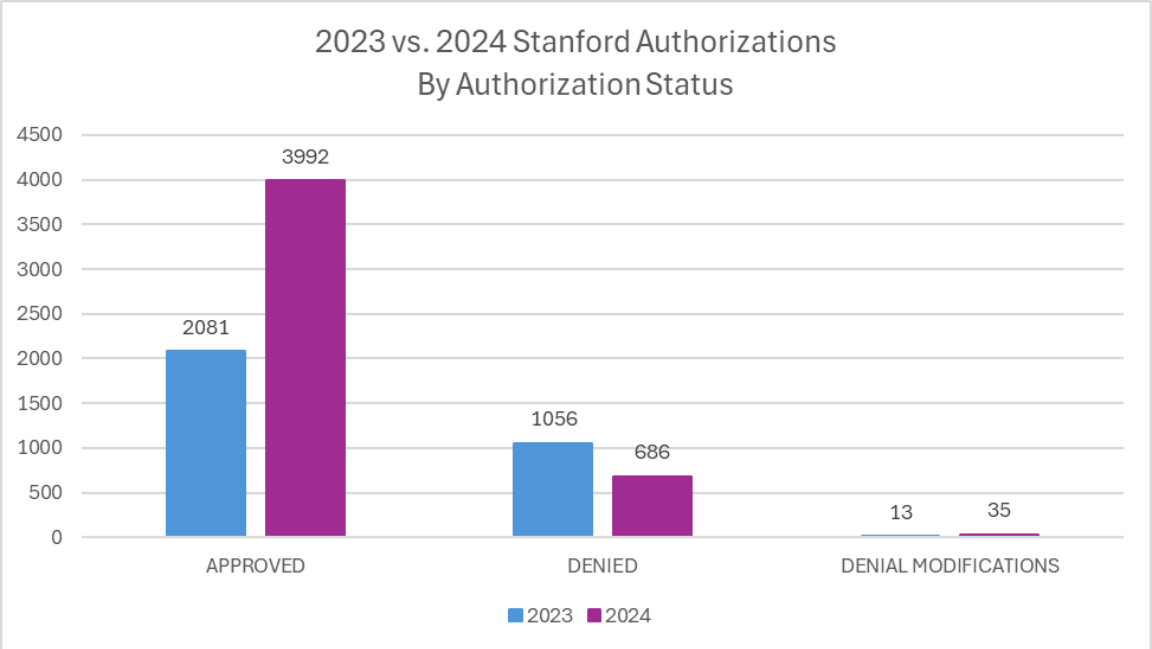


In 2024, the top 5 most accessed out-of-network services were General Acute Hospitalizations (2787), Diagnostic Radiology (2439), Specialty Care - not otherwise specified (1096), Physical Medicine and Rehabilitation (339) and Acute Skilled Nursing facilities (441). Of note, the data includes OON specialty types as reported by delegated entities (CHCN and CFMG), and the Alliance UM department is aware of potential differences in the outpatient network status between the AAH direct network and the Delegated networks. There is an ongoing effort to enhance system configurations to appropriately validate potential network status discrepancies and ensure accurate reporting of OON specialties.

Stanford Utilization

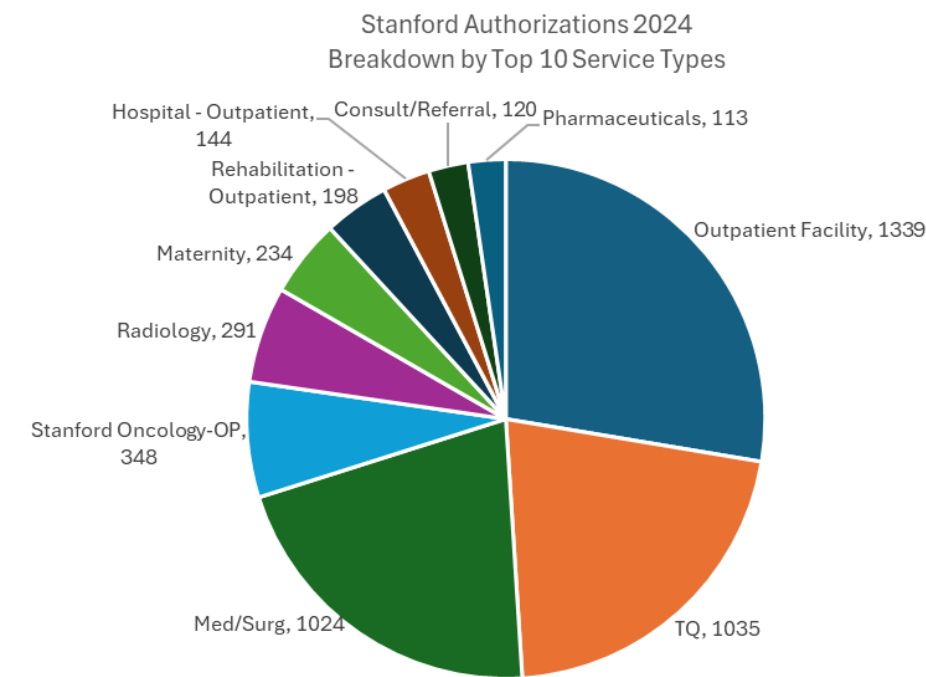
The Alliance contracts with Stanford for Transplant services, and both CHCN and AAH contract with Stanford for oncology care. For all other specialties, ancillary, and diagnostic testing at Stanford is considered out-of-network and requires close monitoring. AAH signed a Letter of Agreement for non-contracted Stanford services in Q4 2023 to ensure continuity of care for Dual and new members to the Plan, and to ensure academic Tertiary Quaternary access for Clinical trials and specialties not available in the in-network.

Figure 33a. 2024 Stanford Authorization Volume



Stanford continues to demonstrate a rise in total authorization volume in 2024 related to Oncology Program enrollment, Specialty referrals due to no timely access in-network, and related hospitalizations. Out-of-network Stanford approvals are also rising relative to Stanford denials due to continuity of care for Dual members increased in 2024, rising SHC Oncology program enrollment and related specialty services, and ED utilization.

Figure 34b. 2024 Stanford Authorization Volume, by Top 10 Service Types



In 2024, a total of 3992 (+1,911) authorizations were approved at Stanford compared to 2023. The top 3 services accessed at Stanford were Outpatient Facility (1339), Tertiary/Quaternary (1035) and Med/ Surg (1024). Stanford utilization change to note is a decrease in OP Oncology from 1158 in 2023 down to 348 in 2024. Part of this decrease is attributable to the Alliance differentiating Hematology/ Oncology and Benign Hematology.

Specialty Care Utilization - Recommended Actions for 2025:

- Monitoring elective hospitalizations, Inpatient hospitalizations through the emergency room, hospital transfers for higher level of care, and provider visits and ancillary services, related to established with the Oncology and Transplant Program enrollment.
- Continued partnership with Contracting team to provide insights on in-network needs, based on utilization patterns and identified access barriers, especially for tertiary and quaternary academic centers.

Unused Authorizations

The Alliance monitors the use and non-use of authorizations to ensure members are accessing approved services timely, and to identify potential barriers if findings indicate approved services aren't utilized.

An "Unused Authorization Report" is generated to identify authorizations that have no evidence of claims activity; letters are sent to members to remind them to access the services they have been approved to use. Trends from these reports are reviewed in UMC for committee input and further root cause analysis. In 2024, the most commonly unused authorized service types were Tertiary/Quaternary, Physician Office Visit and Office Procedures. There were 275 Unique members in 2024 with unused authorizations, and of those members 5 had greater than 10 unused authorizations.

Timely access and waiting lists at academic centers emphasize the importance of network adequacy evaluation, care coordination for in-network care, and tertiary quaternary medical necessity. Continued monitoring and root cause analysis is required to determine the reasons for members not using approved services – some potential reasons may be loss of eligibility, change in member health condition, timely access at the authorized service provider, delay in claims activity, or other access barriers including lack of transportation.

Unused Authorizations - Recommended Actions for 2025:

- Continued partnership with Contracting team to provide insights on network needs, based on utilization patterns and identified access barriers
- Continued monitoring and root-cause analysis of unused authorizations
- Collaboration with the Alliance Case Management Department for member specific outreach to address barriers to utilizing authorizations.
- Re-evaluation of unused authorization report to ensure appropriate analysis of authorization and claims activity

Integration with Quality Management

The UM department collaborates with Quality Management to ensure holistic analysis of utilization patterns that inform quality improvement activities, ultimately improving health outcomes of Alliance members. For examples, HEDIS reports are reviewed at UMC as part of the over/under-utilization trend monitoring. Also, the UM team identifies and reports Potential Quality Issues to the Quality Management department to ensure health and safety for Alliance members.

Satisfaction with UM Process

In addition to quantitative insight on the efficacy of the UM program, quality measures also include satisfaction surveys to assess the efficacy of the UM program from the perspective and experience of members and providers. Member and provider satisfaction surveys are administered annually by an external vendor.

Provider Satisfaction

Figure 35. Provider Satisfaction with Utilization Management

Question	MY2022	MY2023	MY2024	Benchmark
Access to UM Staff	49.4%	48.5%	54.7%	33.3%
Obtaining Pre-Auth Info	56.8%	49.0%	61.4%	35.4%
Timeliness of Pre-Auth Info	52.9%	49.0%	61.1%	36.4%
Facilitation of Care	51.8%	48.0%	43.0%	35.8%
Coverage of Prevention	54.9%	54.2%	47.4%	41.0%

For measurement year 2024, all scores were well above the established benchmark, however, two (2) of five (5) scores decreased: Facilitation of Care and Coverage of Prevention. A significant increase in percentage scores were seen for ‘Obtaining Pre-Auth Info’ and ‘Timeliness of Pre-Auth Info’.

Member Satisfaction

The figures below show results from the Consumer Assessment of Healthcare Providers and Hospital Systems (CAHPS), used to assess patient satisfaction across health plans, providers, and health care facilities. The 3 selected questions are used to assess member satisfaction with UM. *NOTE: Survey results are currently available through measurement year 2023 (CAHPS data for measurement year 2024 will be available in August 2025).*

Figure 36a. Member Satisfaction with Utilization Management – Medi-Cal (Adult)

CAHPS Question	MY2021	MY2022	MY2023
Getting Care Quickly	75.9%	72.9%	74.9%
Getting Needed Care	75.9%	75.2%	73.6%
Coordination of Care	79.0%	91.7%	78.3%

Figure 36b. Member Satisfaction with Utilization Management – Medi-Cal (Child)

CAHPS Question	MY2021	MY2022	MY2023
Getting Care Quickly	77.8%	73.0%	78.3%
Getting Needed Care	78.4%	79.2%	76.3%
Coordination of Care	89.1%	83.0%	84.3%

Figure 36c. Member Satisfaction with Utilization Management – Group Care (Adult)

CAHPS Question	MY2021	MY2022	MY2023
Getting Care Quickly	62.0%	56.0%	65.0%
Getting Needed Care	65.8%	72.0%	71.1%
Coordination of Care	74.4%	80.0%	78.2%

For measurement year 2023, there was an average 1.8% year-over-year decrease in satisfaction rates, across product lines, for Getting Needed Care. Improvement in rating was seen for Getting Care Quickly, especially for the commercial LOB at 9%.

Member and Provider Satisfaction with UM - Recommended Actions for 2025:

- Continue efforts to streamline and improve the accessibility of prior authorization information to providers, including increase visibility of authorization details on public portals and secure online platforms
- Ensure providers receive appropriate training to access the resources
- Participate in the review of satisfaction survey data for measurement year 2023, using those survey insights to further inform process improvement efforts

Conclusion

Overall, the 2024 UM Program was effective in maintaining compliance with regulatory and contractual requirements, monitoring performance within the established benchmarks or goals, identifying opportunities for improvement and enhancing processes and outcomes. The UM program activities have met most of the established targets, including a reduction in regulatory findings. The UM department successfully carved-in the remaining Long-Term Care Intermediate Care Facility for the Developmentally Disabled (ICFDD) and the Subacute benefits in January 2024. The Alliance leadership has played an active role in the UM Program structure by participating in committee meetings, providing input and assistance in resolving barriers and developing effective approaches to achieve improvements. To ensure that the Alliance used a comprehensive approach to designing the UM program structure, practicing physicians provided input through QIHEC. The UM program continues to analyze internal benchmarks to further enhance progress and provide timely, cost-effective, and quality service to the Alliance

membership.

Summary of UM Program Recommendations for 2025

As a result of the 2024 program evaluation, opportunities for improvement have been identified and will be incorporated into the 2025 UM Program and Work Plan. A summary of process improvement opportunities is noted below:

Operational Efficiency and Compliance:

Inpatient and Outpatient UM

- Continued monitoring and process improvements to meet NOA compliance
- End-to-end authorization system enhancements to streamline authorization processing and eliminate manual workarounds
- Continued evaluation of services that do not require prior authorization with goal to remove unnecessary reviews
- Continue the Tertiary Quaternary Policy
- Develop Authorization and claims stay level configuration for inpatient levels of care and facility types
- Validate different network contracting to ensure accurate out-of-network utilization is reflected in Plan analytical reports and aligned with Delegate utilization reporting.
- Increased alignment with case management, specifically related to transitional care services in alignment with DHCS population health management policy guide

LTSS

- Continue to work with facilities to notify the Alliance about changes to LTC member Transition of Care status, and timely Bed Hold and Admission LTC authorizations.
- Continuing to collaborate with the LTSS liaison and provider services to establish relationships with facility partners, including our onsite facility visits from LTSS social workers
- Increase the number of facilities that the long-term team has ongoing rounds with.
- Ensure the Quality Management department develops quality performance measures for LTC facilities

Pharmacy Services

- Refining process for carveout drugs billed under the medical benefit with cross functional configuration and claims team.
- Implement a policy for medications that are self-administered and communicate it to the physician network. Ultimate goal: to review self-administered drugs billed under the medical benefit for medical necessity.
- Enhance external exception request review process to apply to denials of prior authorization and step therapy exception requests.
- Continued monitoring of unclassified drugs and unclassified biologics, in partnership with an external vendor, to enhance the claim adjudication process ensure appropriate billing and configuration

Behavioral Health Services

- Enhance process defects impacting TAT performance and implement interventions to meet
- TAT goals in 2025.
- Increase access as measured by an increase in unique utilizers of mental health and BHT/ABA services.
- Ensure that Contracting continues to increase network capacity, particularly for ABA services.

Clinical Appeals

- Continuing to monitor overturn rates for both lines of business.

Delegated Utilization Management

- The UM Department partnered with the Compliance Department to create a new audit tool that will go into effect for the next delegate audits.
- UM Continues to partner and establish metrics that align with The Alliance's key performance indicators.
- Monitor and support Delegate CAP activities, in coordination with the Compliance Department
- Provide regular training and share best practices with delegated entities, particularly around Enhanced Care Management, Community Supports, Transitional Care Services, and other activities impacting The Alliance's Population Health Management strategy

Quality Improvement

Management of Emergency Room Utilization

- Continue collaboration with Case Management, Quality Management and Population Health Management teams to ensure access to post-discharge care, particularly with primary care providers.
- Monitor diagnosis drivers for emergency room visits, especially for repeat utilizers and for facilities with high emergency room rates.
- Monitor PCP primary care homes for facilities with high ER rates and for repeat utilizers and facilities with high emergency room rates: Identify Teledoc opportunities and those diagnoses that could be managed in primary care offices.
- Track utilization that is associated with members who readmit to the hospital, for case escalation to the Case Management department and supports.
- Increase collaboration with Behavioral Health team and Alameda County Behavioral Health Services to support access to necessary BH/SUD treatment
- Explore opportunities with Community Health Workers and Bridge Programs embedded in the Emergency Departments throughout the county to decrease Emergency Department Utilization.

Management of Acute Hospitalizations

- Expand ADT feeds and comparable data sharing sources for acute hospitals that are not yet established (Stanford, UCSF, Childrens Hospital).

- Build staffing capacity to manage new membership and inpatient volume for new Long-Term Care higher utilization and 2024 Managed Care Plan to Managed Care Plan and Fee-For-Service Medi-Cal Transitions
- Improve identification members who are at-risk for readmission or who re-admitted, including revision of risk-stratification methodology, and use of additional data sources as available to DHCS or community-based partners
- Continue referral processes for Enhanced Care Management, Complex Case Management and Community Supports, with goal to link members to appropriate resources for next level of care
- Foster continued collaboration and relationship building with hospital and skilled nursing facility partners to support discharge management, and complex case rounds for members with long length of stay or complex discharge barriers.
- Coordinate collaboration between the Alliance and its delegates around identifying Potential Quality Issues, Avoidable days variance, Provider Preventable Conditions, and preventable readmissions
- Expand screening for appropriate Case Management referrals for palliative/hospice eligible members

Management of Specialty Care Utilization

- Monitoring elective hospitalizations, Inpatient hospitalizations through the emergency room, hospital transfers for higher level of care, and provider visits and ancillary services, related to established with the Oncology and Transplant Program enrollment.
- Continued partnership with Contracting team to provide insights on in-network needs, based on utilization patterns and identified access barriers, especially for tertiary and quaternary academic centers.

Management of Unused Authorizations

- Continued partnership with Contracting team to provide insights on network needs, based on utilization patterns and identified access barriers
- Continued monitoring and root-cause analysis of unused authorizations
- Collaboration with the Alliance Case Management Department for member specific outreach to address barriers to utilizing authorizations.
- Re-evaluation of unused authorization report to ensure appropriate analysis of authorization and claims activity

Member and Provider Satisfaction with UM

- Continue efforts to streamline and improve the accessibility of prior authorization information to providers, including increase visibility of authorization details on public portals and secure online platforms
- Ensure providers receive appropriate training to access the resources
- Participate in the review of satisfaction survey data for measurement year 2024, using those survey insights to further inform process improvement efforts



Utilization Management Program Description

2025

Utilization Management
2025 Program Description

Signature Page

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Chair, Quality Improvement Health Equity Committee

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Chief Executive Officer

07/02/2025 | 3:23 PM PDT

Date

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Chair Rebecca Gebhart

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Rebecca Gebhart
Board Chair

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I. Background

Alameda Alliance for Health (the Alliance) is a public, not-for-profit managed care health plan committed to making high quality health care services accessible and affordable to citizens most in need in Alameda County. Established in January 1996, the Alliance was created by the Alameda County Board of Supervisors for Alameda County residents and reflects the cultural and linguistic diversity of the community. In addition, Alliance providers, employees, and Board of Governors live in areas that the health plan serves.

The Alliance provides health care coverage to over 400,000 children and adults in Alameda County through the Medi-Cal and Group Care programs. Through active partnerships with healthcare providers and community partnerships, the Alliance demonstrates that the managed care model can achieve the highest standard of care and successfully meet the individual needs of health plan Members.

The Alliance's Utilization Management (UM) Program was established to provide care management structures and key processes that enable the health plan to improve the health and health care of its members. The UM Program is a supportive and dynamic tool that the Alliance uses to achieve these objectives as well as respond to the needs and standards of consumers, the healthcare provider community, and regulatory and accrediting organizations. The UM Program ensures parity between medical/surgical care and behavioral health care throughout all structures and functions. The UM Program is compliant with Health and Safety Code Sections 1363.5, 1367.01, 1368.1, 1374.16, 1374.72, 1374.76, and Title 28, CCR, Sections 1300.1300.67.2, 1300.70(b)(2)(H) & (c).

II. Program Purpose and Scope

The purpose of the Alliance's UM Program is to objectively monitor and evaluate the appropriateness of utilization management services delivered to members of the Alliance. The UM Program serves Alliance members through the following objectives:

- Ensure that appropriate processes are used to review and approve the provision of medically necessary covered services.
- Provide continuity of care and coordination of medical and behavioral services.
- Improve health, including behavioral health, outcomes; and
- Assure the effectiveness and efficiency of healthcare services.

The Alliance adheres to the following operating principles for the UM Program, for both the medical/surgical services and behavioral health services:

- Appropriately licensed and qualified health care professionals with clinical care expertise make UM review determinations according to approved clinical review criteria.
- UM decisions are made on appropriateness of care and service, as well as existence of benefit coverage.
- Appropriate processes are used to review and approve provision of medically necessary

covered services.

- Prior authorization requirements are not applied to emergency, family planning, preventive, or basic prenatal care, and sexually transmitted disease or HIV testing services.
- The Alliance does not financially reward clinicians or other individuals for issuing denials of coverage, care, or service.
- The Alliance does not encourage UM decisions that result in under-utilization of care to members.
- Members have the right to:
 - Participate with providers in making decisions about their individual health care, including the right to refuse treatment.
 - Discuss candidly with providers the appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
 - Receive written notification of a decision to deny, defer, or modify requests for prior authorization.
 - Request a second opinion from a qualified health professional at no cost to the member.
 - Voice grievances or appeals, either verbally or in writing, about the organization of the care received.
 - Request a Medi-Cal state hearing, including information on the circumstances under which an expedited fair hearing is possible.
 - Have access to, and where legally appropriate, receive copies of, amend or correct their medical record; and
 - Receive information about how to access State resources for investigation and resolution of member complaints, including a description of the DHCS Medi-Cal Managed Care Ombudsman Program and its toll-free number, and the DMHC, Health Maintenance Organization (HMO) Consumer Service and its toll-free number

UM Program activities promote utilization of covered services at the right time and at the most appropriate site and level of care. Activities include, but are not limited to:

- Admission and concurrent review
- Discharge planning: pre-admission, concurrent, and post-discharge follow-up with member/provider
- Coordination with Claims, including review of Provider Disputes
- Coordination with Compliance, to support monitoring and auditing activities for internal and delegated entities
- Coordination with Grievance and Appeals, including review of overturned decisions
- Continuity and coordination of care for members when a provider is terminated from the network
- Continuity and coordination of care for members newly eligible with The Alliance, receiving active care and treatment from a non-Alliance provider
- County Behavioral Health Care Services (ACBHCS)
- Discharge planning: pre-admission, concurrent, and post-discharge follow-up with member/provider

- Evaluate and refer members needing care coordination/case management (including children/youth under Medi-Cal for Kids & Teens, California Children's Services, Enhanced Care Management, Complex Case Management, Community Supports, Dental Health, Behavioral Health, or Long-Term Care)
- Integration of medical and behavioral health, including collaboration with Alameda County Behavioral Health Services
- Peer-to-peer discussions to support providers regarding clinical decision-making
- Prior authorization of services (including pre-admission education)
- Quality improvement projects, based on analysis of utilization trends
- Retrospective review

III. Program Structure

The structure of the UM Program is designed to promote organizational accountability and responsibility in the identification, evaluation, and appropriate use of the Alliance health care delivery network. Additionally, the structure is designed to enhance communication and collaboration on UM issues that affect entities and multiple disciplines within the organization. The UM Program is evaluated on an on-going basis for efficacy and appropriateness of content by The Alliance staff and oversight committees.

A. Board of Governors

The Alameda County Board of Supervisors appoints the Board of Governors (BOG) of the Alliance, a 19-member body representing provider and community partner stakeholders. The BOG is the final decision-making authority for all aspects of the Alliance programs and is responsible for approving the Quality Improvement and Utilization Management Programs. The Board of Governors delegates oversight of Quality and Utilization Management functions to the Alliance Chief Medical Officer (CMO) and the Quality Improvement Health Equity Committee (QIHEC). The CMO and the QIHEC provide the authority, direction, guidance, and resources to enable Alliance staff to carry out the Utilization Management Program. Utilization Management activities are the responsibility of the Alliance Health Care Services staff under the guidance of the Medical Director for Utilization Management and the Senior Director of Health Care Services, in collaboration with the Alliance CMO.

The Board of Governors appoints and oversees the QIHEC, the Peer Review and Credentialing Committees, and the Pharmacy and Therapeutics Committee (P&TC) which, in turn, provide the authority, direction, guidance, and resources to enable the Alliance staff to carry out the Quality Improvement, Utilization Management and Case Management Programs. Committee membership consists of provider representatives from the Alliance contracted networks and the community, including those who provide health care services to populations served by The Alliance (for example: Seniors and Persons with Disabilities, Dual-eligible members, and members with Chronic conditions). Alliance committees meet on a regular basis and in accordance with Alliance Bylaws. Alliance Board meetings are open to the public, except for peer review activities, contracting issues, and other proprietary matters of business, which are held in closed session.

B. Quality Improvement Health Equity Committee (QIHEC)

The QIHEC provides oversight, direction, makes recommendations, and has final approval of the CM Program. Committee meeting minutes are maintained to summarize committee activities and decisions with appropriate signatories and dates. A full description of the QIHEC Committee responsibilities can be found in the most recent Quality Improvement Program Description.

The QIHEC provides the external physician involvement to oversee The Alliance QI and UM Programs. The QIHEC includes a minimum of four (4) practicing physician representatives with active, unrestricted licenses to practice in the State of California. The composition includes the Senior Director of Behavioral Health and/or a Behavioral Health Practitioner to specifically address integration of behavioral and physical health, appropriate utilization of recognized criteria, development of policies and procedures, and case review, as needed.

The QIHEC functional responsibilities for the UM Program include:

- Annual review and approval of the UM Program Description
- Annual review and approval of UM Policies and Procedures
- Oversight and monitoring of the UM Program, including:
 - Recommend policy decisions
 - Review and approve clinical criteria for UM decision-making
 - Oversight of interventions to address over and under-utilization of health services.
 - Oversight of the integration of medical and behavioral health activities
 - Guide studies and improvement activities.
 - Review results of improvement activities, HEDIS measures, other studies and profiles and the results of audits
 - Recommend necessary actions

C. Pharmacy & Therapeutics Committee (P&TC)

The P&T Committee is responsible for oversight and assurance of ensuring the promotion of clinically appropriate, safe, and cost-effective drug therapy by managing and approving the Alliance's drug formulary, monitoring drug utilization, and developing provider education programs on drug appropriateness. P&T Committee meeting minutes and pharmacy updates are shared with the BOG.

The voting membership consists of:

- Alliance Chief Medical Officer (Chair) or designee
- Alliance Senior Director of Pharmacy Services (Co-Chair)
- Practicing physician(s) representing Internal Medicine
- Practicing physician(s) representing Family Practice
- Practicing physician(s) representing Pediatrics
- Practicing physician(s) representing common medical specialties
- Practicing community pharmacists contracted with Alliance (not to exceed 1/3 of the voting membership of the committee or three pharmacists, whichever is greater).

D. Utilization Management Committee (UMC)

The Utilization Management Committee (UMC) is a sub-committee of QIHEC. The UMC promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The sub-committee is multidisciplinary and provides a comprehensive approach to support the UM Program in the management of resource allocation through systematic monitoring of medical necessity and quality, while maximizing the cost effectiveness of the care and services provided to members.

UMC activities reporting through the QIHEC integrates UM activities into the Quality Improvement system. While the QIHEC is responsible for the overall direction and development of strategies to manage the UM program, including but not limited to reviewing all recommendations and actions taken by the UM Committee, the QIHEC has delegated authority of the following functions to the UMC:

- Annual review and approval of the effectiveness of the UM/BH Program
- Annual review and approval of the UM/BH Program
- UM/BH Policies/Procedures,
- UM/BH Criteria, and
- Other pertinent UM documents such as the UM Delegation Oversight Plan, UM Notice of Action Templates, and
- Case/Care Management Program and Policies/ Procedures.

UM Committee Membership

The UMC is chaired by the Chief Medical Officer, or their designee. Members include:

- The Alliance Chief Analytics Officer
- The Alliance Medical Directors, UM
- The Alliance Medical Director, CM
- The Alliance Senior Medical Director, Quality Improvement
- The Alliance Senior Director, Quality Improvement
- The Alliance Senior Director, Pharmacy & Formulary
- The Alliance Senior Director, Health Care Services
- The Alliance Senior Director, Behavioral Health
- The Alliance Director, Compliance
- The Alliance Director, Member Services
- The Alliance Director of Provider Relations and Provider Contracting
- The Alliance Director, Quality Assurance
- The Alliance Director, Utilization Management
- The Alliance Director, Long Term Services and Supports
- The Alliance Director, Social Determinants of Health
- The Alliance Manager, Healthcare Analytics
- The Alliance Managers, Case Management
- The Alliance Managers, Utilization Management
- The Alliance Manager, Grievance & Appeals

UMC Voting Privileges

For the purposes of voting at the UM Committee, only physician and Director level members of the UM committee may vote.

UMC Quorum

A quorum is established when fifty one percent (51%) of voting members are present.

UMC Meetings

The UMC meets at least quarterly but as frequently as necessary. The meeting dates are established and published each year.

UMC Minutes

All meetings of the UM Committee are formally documented in transcribed minutes which include discussion of each agenda topic, follow-up requirements, and recommendations to the QIHEC. All minutes are considered confidential. Draft minutes of prior meetings are reviewed and approved by the UMC with noted corrections. These minutes are then submitted to the QIHEC for review and approval.

UMC Functions

The UM Committee is a forum for facilitating clinical oversight and direction. Its purpose is to:

- Improve quality of care for the Alliance members.
- Evaluate and trend utilization data for medical and behavioral health services provided to Alliance members and benchmark for over/under utilization. This includes in-network and out-of-network utilization data review to ensure services are accessible and available timely to members.
- Provide a feedback mechanism to drive quality improvement efforts in UM.
- Increase cross-functional collaboration and provide accountability across all departments in Health Care Services
- Provide mechanism for oversight of delegated UM functions, including review and trend authorization and utilization reports for delegated entities to identify improvement opportunities.
- Maintain the annual review and approval of the UM/BH Program, UM/BH Policies/Procedures, UM/BH Criteria, and other pertinent UM documents such as the UM Delegation Oversight Plan, UM/BH Notice of Action Templates, and UM/BH and Case/Care Management Program and Policies/ Procedures.
- Identify behaviors, practices patterns and processes that may contribute to fraud, waste, and abuse with a goal to support the financial stability of our providers and network.
- Recommend actions to the Quality Improvement Health Equity Committee when opportunities for improvement are identified from review of utilization data including, but not limited to, Ambulatory Visits, Emergency Visits, Hospital Utilization Rates, Hospital Admission Rates, Average Length of Stay Rates, Behavioral Health usage and outcomes, and Discharge Rates.

- Receive updates about New Medical Technologies from the Pharmacy & Therapeutics Committee, including new applications of existing technologies that have been approved by P&T committee

Based on the decision of the UM Committee and recommendations through the appropriate Quality Committees, the approval of a new technology or new application of an existing technology by the QIHEC shall be deemed to be the Alliance policy on coverage, and where the Alliance does not have the authority to modify the benefit package, the Chief Medical Officer shall notify, in writing, each payer for whom the Alliance manages benefits of its recommendation.

The UM committee also evaluates the impact of UM/BH programs on other key stakeholders within various departments and when needed, assesses, and plans for the implementation of any needed changes.

E. Staff Resources

The Alliance Health Care Services Department is responsible for the operational management and oversight of clinical programs, including the UM Program. The UM, Behavioral Health (BH), and Pharmacy Departments administer the UM Program, and the primary staff roles and responsibilities are as follows:

Chief Medical Officer

The Chief Medical Officer is a designated board-certified physician with responsibility for development, oversight, and implementation of the UM Program. The CMO holds a current unrestricted license to practice medicine in California. The CMO serves as the chair of the QIHEC and UMC, and makes periodic reports of committee activities, UM Program activities and the annual program evaluation to the BOG. The CMO works collaboratively with Alliance network physicians to continuously improve the services that the UM Program provides to members and providers.

Any changes in the status of the CMO shall be reported to the Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC) within the required timeframe.

Medical Directors

The Medical Directors are licensed physicians with authority and responsibility for providing professional judgment and decision-making regarding matters of UM. The Medical Directors hold current unrestricted license to practice medicine in California. Medical Directors responsibilities include but are not limited to the following:

- Ensure that medical decisions are rendered by and are not influenced by fiscal or administrative management considerations
- The decision to deny services based on medical necessity is made only by Medical Directors
- Ensure that the medical care provided meets the standards for acceptable medical care

- Ensure that medical protocols and rules of conduct for plan medical personnel are followed
- The initial reviewer must not review any appeal cases in which they were the decision maker for the authorization
- Develop and implement medical policy

The Alliance may also use external specialized physicians to provide specific expertise in conducting utilization reviews. These physicians are currently licensed, and many have board certification in specific areas of medical expertise. The CMO is responsible for managing access and use of specialized physicians.

Senior Director, Health Care Services

The Senior Director, Health Care Services is a Licensed Registered Nurse and is responsible for overall UM Department operations, staff training, and coordination of services between departments. The Senior Director's responsibilities include:

- Develop and maintain the UM Program in collaboration with the CMO
- Coordinate UM activities with the Quality Department and other Alliance units
- Maintain compliance with regulatory and accreditation standards.
- Monitor utilization data for over and under-utilization, and coordinate interventions with the CMO to address under and over utilization concerns, as appropriate
- Monitor utilization data and activities for clinical and utilization studies;
- Maintain professional relationships with colleagues from other Medi-Cal Managed Care Plans, sharing information about requirements and successful evaluation strategies
- Monitor for consistent application of UM criteria by UM staff, for each level and type of UM decision
- Monitor documentation for adequacy
- Available for UM staff on site or by telephone

Senior Director, Behavioral Health Services

The Senior Director, Behavioral Health Services is a licensed Psychologist and is responsible for the overall Behavioral Health department operations, staff training, and coordination of services between departments. The Senior Director's responsibilities include:

- Develop and maintain the Behavioral Health (BH) Program in collaboration with the Senior Medical Director of Quality and the CMO.
- Coordinate BH activities with the Quality, UM, Case Management, Member Services Departments, as well as other Alliance units.
- Maintain compliance with the regulatory standards.
- Maintain professional collaboration with Alameda County Behavioral Health Care Services (ACBHCS) to coordinate care and care transitions across behavioral health care systems.
- Coordinate interventions with the Senior Medical Director and the CMO to address under and over utilization concerns when appropriate.

- Develop and monitor data and activities for clinical and utilization studies; and maintain professional relationships with colleagues from other Medi-Cal Managed Care Plans, sharing information about requirements and successful evaluation strategies.
- Monitor for consistent application of utilization criteria by BH staff, for each level and type of UM decision.

Senior Director, Pharmacy Services

The Senior Director, Pharmacy Services is a licensed pharmacist (Pharm.D.) responsible for coordinating daily operations and reviewing and managing pharmacy utilization reports to identify trends and patterns. The Director provides clinical expertise relative to the Pharmacy, Quality and UM components of Alliance plan management including Member and Provider Services and Claims operations. The scope of responsibilities of the Pharmacy Services Director includes:

- Function as the authoritative source of relevant and current information on all pharmaceuticals' efficacy, safety, comparative efficacy, cost, and cost impact.
- Oversee all levels of pharmaceutical information and/or education, in a proactive and timely manner to internal staff, members and providers.
- Oversee policies and procedures, systems, and processes to assure compliance with all federal and state regulatory requirements pertaining to Formulary and benefit management.
- Co-chair the Pharmacy & Therapeutics (P&T)
- Oversee the pharmacy prior authorization, physician administered drugs pass thru pharmacy, and pharmacy appeal process to meet the regulatory and contractual requirements with federal and state government agencies, including CMS, NCQA, DMHC and DHCS.
- Monitor, research, recommend and contract with vendors and implement programs related to pharmaceuticals include but not limited to PBM, Specialty pharmacy, Identify trends and patterns in pharmaceuticals utilization.
- Develop provider and member programs to optimize medication prescribing patterns, ensure appropriate drug utilization, and increase patient compliance and adherence for improving quality measures.

Lead Clinical Pharmacist, Medical Drug Management

The Lead Clinical Pharmacist, Medical Drug Management is a licensed pharmacist (Pharm.D.) responsible for leading the planning and implementation of new physician administered drugs (PAD) operational and/or clinical initiatives. This position works closely with Pharmacy Supervisor, Lead Pharmacy Technician, and mentors clinical pharmacists and acts as a backup for pharmacy supervisor. The scope of responsibilities of the Lead Clinical Pharmacist includes:

- Guide the tasks performed by the pharmacy technicians and clinical pharmacists related to PAD.
- Review and make determinations for outpatient pharmacy prior authorization

(PA) requests, coverage determinations, exceptions requests, complaints, and appeals and ensure criteria and decisions are properly communicated and applied.

- Create, update PAD policies & procedures and support pharmacy related audits related to PAD in accordance with DHCS, DMHC, NCQA and CMS requirements and other regulatory and contractual requirements.
- Create and update PAD related contents of the plan communications such as letters/fax blast and websites and portals and for member and provider bulletin in accordance with NCQA, Medi-Cal and Medicare requirements.
- Develop and train educational services for internal staff, employers, providers, and other stakeholders related to PAD topics.
- Prepare and gather PAD related reporting for internal committees and/or external publication to assist the Senior Director of Pharmacy Services.

Clinical Pharmacists

The Clinical Pharmacists are licensed pharmacists and responsible for providing clinical expertise relative to the Alliance pharmacy drug benefit programs and participating in designing, developing, and implementing pharmacy clinical programs to promote a quality, cost-effective pharmacy benefit. This position reviews and makes determinations for outpatient pharmacy prior authorization (PA) requests and in office medical drug authorizations. The scope of responsibilities of the Clinical Pharmacists includes:

- Review pharmacy related coverage determinations, exceptions requests, complaints, and appeals and ensure criteria and decisions are properly communicated and applied.
- Make presentations to develop training, reports, and other communications for internal staff, employers, providers, and to other stakeholders related to clinical pharmacy issues.
- Provide pharmacotherapy expertise, review cases, and make formal recommendations at the request of Alameda Alliance clinical staff
- Analyze pharmacy and medical utilization data to identify trends and at-risk populations; recommend and develop appropriate interventions; monitor and act on results.

Pharmacy Supervisor

The Pharmacy Supervisor is a licensed pharmacist and responsible for ensuring efficient, compliant, and productive workflows in the operational and clinical areas of pharmacy services. The Pharmacy Supervisor leads the planning and implementation of new operational and/or clinical initiatives. The Pharmacy Supervisor is responsible for the direct supervision of lead technicians, and pharmacy technicians while mentoring clinical pharmacists for guidance and/or decision making. This position also develops, reviews and updates policies and procedures, medication guidelines for pharmacy prior authorization (PA) and pharmacy appeal per DHCS, DMHC, NCQA and CMS requirements. The scope of responsibilities of the Clinical Pharmacists includes:

- Supervise and lead the provision of timely, efficient, equitable, and effective

pharmacy services.

- Hold staff accountable to the standards of the department and Alameda Alliance for Health.
- Serve as the liaison to coordinate compliance and regulatory issues for areas of responsibility.
- Support clinical pharmacy workflows and practice expectations through operational planning.
- Create, update pharmacy policies & procedures and support pharmacy related audits related to formulary and benefit management and pharmacy performance in accordance with DHCS, DMHC, NCQA and CMS requirements and other regulatory and contractual requirements.
- Lead the Alliance's Pharmacy & Therapeutics (P & T) Committee presentation materials and implement the recommendations with a PBM and specialty pharmacy on formulary and PA guidelines including benefit coding and formulary updates on websites, PA guideline implementation, and follow up on other pharmacy related initiatives resulting from the Committee's decision(s).

Lead Pharmacy Technician

The Lead Pharmacy Technician is a licensed pharmacy technician. This position supports pharmacy prior authorization (PA), P & T, and DHCS, DMHC, CMS audits and NCQA survey preparation. The scope of responsibilities of the Lead Pharmacy Technician includes:

- Train and mentor pharmacy technicians.
- Train and mentor Pharmacy Technicians on how to draft the Pharmacy and Therapeutics (P & T) meeting materials included but not limited to the meeting minutes, the post P & T summary, and assist on other pharmacy related initiatives resulting from the P & T Committee's decision(s).
- Assist physician administered drugs prior authorization passing thru pharmacy and ensure criteria and decisions are properly communicated with PBM, specialty pharmacy (SP) and internal staff.
- Retrieve drug-specific technical data and information necessary for the completion of departmental and interdepartmental pharmacy-related functions and operations.
- Create and prepare ad hoc reports as well as recurring reports using pharmacy reporting tools for pharmacy clinical programs and quality initiatives, such as HEDIS, drug utilization review (DUR), medication reconciliation, medication therapy management (MTM), inter-rater reliability (IRR) reviews, audits, root-cause analyses, PDSA cycles, corrective action plans, and other related activities.
- Create, update desktop procedures, pharmacy policies & procedures and support pharmacy related audits related to Pharmacy Operations in accordance with DHCS, DMHC, NCQA and CMS requirements and other regulatory and contractual requirements.

Pharmacy Technicians

The Pharmacy Technicians are licensed pharmacy technicians. They utilize specialized pharmacy knowledge and expertise to assist participating pharmacies, members, and

providers to ensure the efficient, timely, and effective delivery of pharmaceutical products and services to Alliance members. This position is responsible for completing daily pharmacy service operations. This position also supports clinical staff through completion of the administrative and clinical coordinator functional components of Physician Administered (PAD) Disease medication management. The scope of responsibilities of the Pharmacy Technicians include:

- Process Pharmacy Authorizations (PA) and assist physician administered drugs prior authorization passing thru pharmacy and ensure criteria and decisions are effectively communicated with PBM, specialty pharmacy (SP) and internal staff in a timely manner according to the regulatory requirements.
- Support Pharmacy Transition of Care (TOC) and pharmacy referrals from CM (e.g., via email, outreach calls and TruCare).
- Coordinate employee RxNova via PerformRx and new internal DU access for FirstCI.
- Assist with drug recall, formulary change, channel management, population health, disease management, Alliance quarterly platform updates and/or product discontinuation support for impacted member and provider notifications (e.g., Cognito requests to C&O for mailing).
- Help coordinate with business ops/internal departments to ensure appropriate member eligibility/product overrides for access to medicinal treatment.
- Pharmacy Services phone queue and email triage/support.
- Perform ad-hoc audit of the pharmacy authorization letters and claims under the guidance of a pharmacist.
- Create and prepare ad hoc reports as well as recurring reports using pharmacy reporting tool.
- Retrieve drug-specific technical data and information necessary for the completion of departmental and interdepartmental pharmacy-related functions and operations.
- Process member reimbursement requests

Director, Utilization Management

The Director, Utilization Management has day-to-day responsibility for the operations of the UM Program under the direction of the Senior Director, HCS, and the Chief Medical Officer. The Director oversees health service compliance functions, internal and delegation oversight auditing and monitoring. The Director also reports to the QIHEC and serves a voting member in the UMC.

Director, Long-Term Services and Supports

The Director, Long-Term Services and Supports (LTSS) reports to the Senior Director, HCS and is responsible for the operational management and directional guidance of the LTSS Department and activities including institutional Long- Term Care (LTC), Community Supports (CS), and Community Based Adult Services (CBAS). The Director is knowledgeable of and responsible for compliance with regulatory requirements of Managed Medi-Cal and Medicare for LTSS, Nursing Facility (NF-B)/Sub-

Acute Facility (NF-A)/Distinct Part of Hospital (DP-H,) ICFs, CBAS, CS, long term care settings, continued stay requirements, as well as transitions of care to community settings.

Managers, Utilization Management

The Managers, Utilization Management are Registered Nurses with current, active and unrestricted California nursing licenses. They supervise all Alliance UM activities, including:

- Provide supervision of assigned UM staff
- Participate in staff training
- Monitor for consistent application of UM criteria by UM staff, for each level and type of UM decision
- Monitor documentation for adequacy
- Ensure staff are following policies, procedures, and all requirements
- Are available to UM staff on site or by telephone/computer
- Collaborate with other departments on interdepartmental initiatives that involve UM activities or functions
- Participate in delegate oversight activities, including annual and/or focused audits, meetings, and joint initiatives
- Participate in regulatory audits and enact regulatory changes or process changes as required

Manager, Long Term Care

Under the general direction of Director of Long-Term Services and Supports, the Manager, Long Term Care, is responsible for the oversight and operations of the Long-Term Care Department. The Manager is knowledgeable of and responsible for compliance with regulatory requirements of Nursing Facility (NF-B)/Sub-Acute Facility (NF-A)/Distinct Part of Hospital (DP-H) long term care admissions, ICF and ICF/DD admissions, continued stay requirements as well as transitions of care to community settings and case management activities for long term care. The Manager provides leadership and executes decision-making based on subject matter expertise and judgment. Additional responsibilities include:

- Monitor program performance to maintain compliance with federal and state regulatory agencies.
- Make decisions within department guidelines and policies, conduct staff training, and facilitate learning opportunities.
- Identify trends, patterns, and opportunities for improvement and communicate findings to appropriate Alliance committees; and
- Provide daily oversight of operations and staff.
- Develops and implements departmental policies and procedures.
- Develops, implements, and monitors performance standards.
- Facilitates inter-disciplinary meetings for LTC admissions.
- Lead any technological implementations for the unit.

- Provide training, development, and continuing education to staff.
- Conduct internal audits which include regular case audits
- Track turnaround time for decision-making and ensure cases are entered into the information system and updated in a timely manner.
- Serve as the primary liaison to resolve complex issues across departments.

Clinical and Nonclinical Supervisors, Utilization Management

Clinical Supervisors, Utilization Management are Registered Nurses and Nonclinical Supervisors are qualified staff with health care and utilization management experience. Supervisors are responsible for:

- Provide day-to-day oversight of the staff to ensure adherence to departmental processes, productivity, and departmental functions.
- Consult on or assume responsibility for challenging cases
- Provide staff training and coaching
- Assist in audit preparation

Clinical Supervisor, Long Term Care

Under general direction of the Manager of Long-Term Care and working in cooperation with other departments, such as Utilization Management, the Lead Long-Term Care (LTC) Nurse Specialist provides providing health plan administrative and clinical support to staff and to Members on the admissions and continued stay services in LTC Nursing Facilities/Intermediate Care Facilities/Distinct Part Hospitals. The lead role supports the day-to-day operations of the department by providing guidance and priority-setting for front line staff and communicating operational issues to the Manager of LTC. Additional Responsibilities include:

- Coordinate the identification, documentation, and resolution of LTC facility related issues in a timely manner.
- Identify opportunities for process improvements to facilitate department functions and ensure compliance within applicable governmental program guidelines.
- Audit staff documentation according to departmental standards.
- Work as part of a multidisciplinary care team to support members as well as meet Alameda Alliance, regulatory and accreditation requirements
- Participate in program development and quality improvement initiatives

Utilization Review Clinicians

Utilization Review Clinicians are Registered Nurses with current, active unrestricted California nursing licenses, Physician Assistants with active California Physician Assistant license, and/or licensed Behavioral Health clinicians responsible for the review and determinations of medical necessity coverage decisions. Clinicians may approve prospective, concurrent, and retrospective inpatient or outpatient medically necessary services using established guidelines and evidenced-based medical criteria, tools, and references within the scope of their clinical training and education. Licensed Vocational Nurses (LVNs) Nurse Reviewers are supervised by a Registered Nurse (RN) and do not

make clinical approval or denial decisions. Utilization Review Clinicians also work collaboratively with case managers and assist members with transitional care and discharge planning. For cases that do not satisfy medical necessity criteria, the UM Review Clinicians refer to a Medical Director/doctoral Behavioral Health Specialist for final determination. All clinical staff involved in the authorization review process must identify and refer any potential quality issues appropriately for further investigation.

UM Coordinators

UM Coordinators are non-clinical staff responsible for performing basic administrative and operational UM functions. Clinical staff provides oversight to the non-clinical staff. Their roles and responsibilities include:

- Outpatient UM Coordinators
 - Ensure appropriate UM referral entries into the information system.
 - Process UM referrals approvals for selected requests identified as Auto Authorizations or Authorization in their Scope of Work that do not require clinical interpretation
 - Complete intake functions with the use of established scripted guidelines
 - Manage and complete UM Member and Provider communications.
 - Complete administrative denials for non-eligibility
- Inpatient UM Coordinators:
 - Monitor and collect facility admissions census data
 - Complete data entry of initial case.
 - Maintain member and provider communications
 - Assist in requesting additional information as needed
 - Review of hospital referral to ensure appropriate case closure
- Ensuring efficient processing for the authorization process and maintain documentation in support of the on-site and telephonic UM nurse staff

Nurse Specialist, Long Term Care

Under general direction of the Manager of Long-Term Care and working in cooperation with other departments, such as Utilization Management, the Long-Term Care (LTC) Nurse Specialist is responsible for providing health plan administrative support and clinical support to Members on the admissions and continued stay services in LTC Nursing Facilities/Intermediate Care Facilities/Distinct Part Hospitals. The Nurse Specialist collaborates with LTC facilities to ensure appropriate physical and behavioral healthcare and social services are provided timely and efficiently for Alliance members, including performing clinical review of Skilled Nursing Facilities (NF-A/B), Distinct Part Hospitals and Intermediate Care Facility admissions and recertifications to validate the appropriate level of care. The LTC Nurse Specialist has knowledge of current upcoming programs and services that intersect with LTC services, including Enhanced Case Management, Community Support, Population Health Management, Regional Services, HCBS (Home and Community Based Services). Performs clinical review of Skilled Nursing Facilities (NF-A/B), Distinct Part Hospitals and Intermediate Care Facility admissions and recertifications to validate the appropriate level of care.

Long Term Care, Social Worker

Under general direction of the Manager of Long-Term Care (LTC), and working in cooperation with other departments, the LTC Social Worker is part of a multidisciplinary care team that includes the Social Worker, a Health Navigator, a Nurse Case Manager, Medical Director and Long-Term care/Skilled nursing facility partners. The LTC Social Worker serves as a resource for the care team on best practices for psychosocial assessment and mental health interventions. The Social Worker makes referrals to the community and manages internal and external relationships. The LTC Social worker also possesses knowledge of current upcoming programs and services that intersect with LTC services, including Enhanced Case Management, Community Support, Population Health Management, Regional Services, HCBS (Home and Community Based Services). Additional responsibilities include:

- Developing patient-centered plans based on clinical needs assessments and goals
- Organize and participate in clinical case conferences, multidisciplinary care team meetings and LTC/Skilled nursing ICT/IDT meetings consisting of other health professionals and collaborate to construct a treatment plan that addresses all the members' needs.
- Support complex, care coordination, continuity of care, end of life discussions, and transition of care throughout the continuum.

Long Term Care, Coordinator

The Long-Term Care Coordinator supports clinical staff through completion of the administrative and non-clinical coordination functions. The Long-Term Care Coordinator is responsible for continuous processing and monitoring of the review and authorization process and ensuring that corresponding documentation is received timely. The Long-Term Care Coordinator is responsible in ensuring the quality and accuracy of any corresponding documentation. Additional responsibilities include:

- Processing and issuing member and provider notifications (mail, fax, electronic media, telephone)
- Establish, facilitate, and maintain effective ongoing relationships with network hospitals, SNFs, delegated groups, vendors and providers; facilitate communication and care coordination between network entities
- Respond to provider, member, and staff inquiries at any given time in a professional and timely manner.

Long Term Care, Health Navigator

The LTC Health Navigator supports clinical staff of the Long-Term Care program. This role focuses on transitions of care and care coordination for members coming both in and out of Long-Term Care. The LTC Health Navigator provides assistance in locating accepting facilities and to members needing support in accessing medical, social or behavioral services or information from providers and community services. The LTC Health Navigator possesses knowledge of current upcoming programs and services that intersect with LTC services, Enhanced Case Management, Community Support, Population Health Management, Regional Services, HCBS (Home and Community Based Services).

Long-Term Services and Supports (LTSS) Liaison

The LTSS Liaison is trained on the rules and regulations pertaining to Medi-Cal covered LTC, including payment and coverage policies, prompt claims payment requirements, provider resolutions, policies and procedures, and care management, coordination and transition policies. They serve in both a provider representative and care coordination representative role, and support the facilitation of member care transitions, as needed, in collaboration with the LTC team.

Behavioral Health Navigators

The Behavioral Health Navigators are the non-clinical staff responsible for performing basic administrative and operational UM functions for behavioral health services. Behavioral Health Clinical staff provides oversight to the non-clinical staff. Their roles and responsibilities include:

- Ensure appropriate UM referral entries into the information system.
- Process UM referrals approvals for selected requests identified as Auto Authorizations or Authorization in their Scope of Work that do not require clinical interpretation.
- Complete intake functions with the use of established scripted guidelines
- Manage and complete UM Member and Provider communications.
- Complete administrative denials for non-eligibility
- Ensuring the efficient processing for the authorization process and maintain documentation in support of the on-site and telephonic Behavioral Health Clinical staff

F. Delegated Utilization Management

The Alliance delegates utilization management activities to provider groups, vendor networks and healthcare organizations that meet delegation agreement standards. The contractual agreements between the Alliance and delegated groups specify: the responsibilities of both parties; the functions or activities that are delegated; the frequency of reporting on those functions and responsibilities to the Alliance; how performance is evaluated; and corrective action plan expectations, if applicable. The Alliance conducts a pre-contractual evaluation of delegated functions to assure capacity to meet standards and requirements. The Alliance's Compliance Department is responsible for the oversight of delegated activities. The Compliance Department will work with other respective departments to conduct the annual delegation oversight audits. Delegate work plans, reports and evaluations are reviewed by the Alliance and the findings are summarized at QIHEC and Compliance Committee meetings, as appropriate. The Compliance Department in conjunction with each respective department monitors the delegated functions of each delegate through reports and annual oversight audits.

As part of delegation responsibilities, delegated providers must:

- Develop, enact, and monitor a UM Program description that addresses all State, Federal, health plan and accreditation requirements.
- Provide encounter information and access to medical records pertaining to

Alliance members.

- Submit at least quarterly reports, annual evaluations, and program descriptions and work plans; and
- Cooperate with annual audits and complete any corrective actions necessary by the Alliance.
- Participate in performance improvement activities.

IV. Benefits

Benefit coverage is verified by Utilization Management staff during the utilization review process. The Alliance administers health care benefits for members, as outlined by contracts established for each product line. Medi-Cal benefits are developed by the State of California, Department of Health Care Services (DHCS), and Group Care benefits are developed by the Public Authority of Alameda County. Covered services include but are not limited to:

- Ambulatory Care
- Behavioral health (mental health and substance use disorder services)
- Care Coordination, including for linked and carved-out services, programs, and agencies
- Emergency services
- Hospital care
- Home Health care
- Hospice
- Palliative Care
- Managed Long Term Services and Support (MLTSS)
 - Community-based Adult Services
 - Long-term Care in skilled nursing facilities
 - Intermediate care facility/developmentally disabled (ICF/DD)
 - Intermediate care facility/developmentally disabled-habilitative (ICF/DDH)
 - Intermediate care facility/developmentally disabled-nursing (ICF/DD-N)
- Pharmacy
- Rehabilitation services
- Skilled nursing services - Acute
- Transplant Services
- Transportation
- Pharmacy

A full list of covered services is available to members in the Evidence of Coverage, published online and available in print, upon request. Covered services are provided through a contracted network of providers that include hospitals, nursing facilities, ancillary providers, and contracted vendors. The UM program, in coordination with the Contracting and Quality teams, monitor the adequacy of the Alliance's contracted network to ensure members have access to care within time and distance standards. As needed, contracting arrangements are made with providers outside of the network if Alliance's contracted network is not available to service the need.

Benefit Exclusions

Based on the specific contract requirements and applicable laws, some services are explicitly excluded from coverage. Per contract requirements, specific services may not be covered benefits, unless clinical indicators support medical necessity as determined by clinical review, in which case the medically-needed services will be provided. Every attempt is made by the UM staff to identify additional community programs to provide wrap-around services to enhance the Alliance benefit package.

Transition to Other Care when Benefits End

The Alliance assists with, and/or ensures that practitioners assist with, a member's transition to other care, if necessary, when benefits end.

V. Utilization Management Information System

The Alliance maintains a core clinical information system, TruCare®, that is utilized by all Utilization Management, Long-Term Care, Case Management and Pharmacy teams. TruCare® is a member-centric application that aligns necessary clinical and administrative information related to members' care into a single chart record and allows seamless multidisciplinary collaboration within a case. The clinical information system tracks all authorized, denied, deferred, and modified service requests and includes timeliness records. Clinical staff, in collaboration with the Information Technology (IT) team, identify opportunities to enhance the functionality of the system and optimize the systems' performance. Thorough vetting processes are established between clinical and IT teams to ensure any enhancements and upgrades to the platform are amenable to all system users. System optimization and upgrades are ongoing as standard practices, including staff training to ensure competence in using the platform and alignment on best practice workflows.

The core clinical information system is designed to ensure the accuracy, confidentiality and security of paper and electronic data and information. The Alliance has comprehensive security controls and established monitoring processes to ensure secure data management, and to prevent inappropriate modification of UM denials, including any inappropriate modification to receipt and denial notification dates.

VI. Clinical Decision Support Tools**A. Utilization Management Clinical Decision Making**

Clinical decision-making tools and screening criteria are designed to assist UM staff, and UM-delegated entities, in assessing the appropriateness of care for medical and behavioral health services. Application of the criteria is based on the specific and individualized health care needs of the member (including social determinant of health needs), medical risk factors, and in accordance with the member's plan benefits and capacity of the health care delivery systems.

The appropriate use of criteria and guidelines require strong clinical assessment skills, sound professional medical judgment, and application of individual case information and local geographical practice patterns. Licensed UM, BH, and Pharmacy review staff apply professional

judgment during all phases of decision-making regarding the Alliance members. Decision Support Tools are intended for use as references, resources, screening criteria, and guidelines with respect to the decisions regarding medical necessity of health care services, and not as a substitute for professional clinical judgment.

All utilization review staff document the clinical review criteria used to support authorization decisions. All decision-making criteria are available to members and providers upon request.

B. Clinical Review Criteria and Hierarchy

Review Criteria

The Alliance adopts the following definition of medical necessity from the DHCS contract:

Medically Necessary or Medical Necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I section 14059.5(a) and 22 CCR section 51303(a). Medically Necessary services must include services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.

For Members less than 21 years of age, a service is Medically Necessary if it meets the EPSDT standard of Medical Necessity set forth in 42 USC section 1396d(r)(5), as required by W&I sections 14059.5(b) and 14132(v). Without limitation, Medically Necessary services for Members less than 21 years of age include all services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support, or maintain the Member's current health condition. Contractor must determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the Child.

Medical necessity determinations are made based on a consistently applied, systematic evaluation of clinical criteria. The following clinical criteria and hierarchy are applied by UM staff and Medical Directors:

1. Regulatory and contractual guidelines/regulations, including:
 - Department of Health Care Services (DHCS) Medi-Cal Provider Manuals and All-Plan Letters
 - Department of Managed Health Care (DMHC) All-Plan Letters
 - WPATH Standards of Care (SOC) for Gender-Affirming Care
 - LOCUS/CALOCUS, CASII/ECSII/ASAM for Mental Health and Substance Use Disorders
 - Code of Federal Regulations
 - California Health and Safety Code.
 - California Code of Regulations Title 22.
 - California Code of Regulations Title 28.
 - California Welfare and Institution Code

2. Evidence based guidelines, primarily MCG®, US Preventive Services Task Force, National Comprehensive Cancer Network, and if needed, UpToDate®¹
3. Alliance guidelines, as approved through governing committees (including QIHEC and P&T)
4. National medical association guidelines (including American Commission of Obstetrics and Gynecology (ACOG), American Association of Pediatrics (AAP), American Diabetes Association (ADA))
5. Independent Medical Review for specialty consultation
6. Medical necessity/medical judgment

The UMC and QIHEC review and approve clinical criteria and hierarchy for clinical decision-making at least annually, and more often as needed for changes and updates.

New Medical Technology Evaluation Assessment

The Alliance maintains a formal mechanism to evaluate and address new developments in technology and new applications of existing technology for inclusion in its coverage and review processes to keep pace with changes and to ensure that members have equitable access to safe and effective care. Evaluation of new technology is applied for medical and behavioral health procedures, pharmaceuticals, and devices. The UMC and Pharmacy and Therapeutics Committee are responsible for evaluating and recommending new technology to the QIHEC. Requests for evaluation of a new technology or a new application of an existing technology may come from a member, practitioner, organization, the Alliance's physician reviewers, or other staff. The following are evaluated when considering new technology:

- Organizational reviews from appropriate government regulatory bodies, such as FDA or CMS.
- Relevant scientific information from peer-review literature, professional societies, and/or specialists and professionals who have expertise in the technology.

After QIHEC approves utilization of a new technology or new application of an existing technology, the Alliance adopts the policy and follows all required processes to notify providers. When the Alliance does not have the authority to modify the benefit package, the Chief Medical Officer shall notify, in writing, each payer for whom the Alliance manages benefits of its recommendation.

¹ a collection of well-referenced topics, guidelines, and updated research. UpToDate® makes updates three times a year, and new information goes through a multilevel peer-review process ([Fam Pract Manag. 2003;10\(7\):49-52](#))

C. Consistency in Application of Criteria: Inter-Rater Reliability

The Alliance evaluates inter-rater reliability (IRR) to monitor consistency with which physicians, non-physicians, pharmacists, and behavioral health practitioners apply clinical decision-making criteria. It provides a score of how much homogeneity or consensus there is when using clinical criteria to make a medical necessity determination. A full description of the IRR testing methodology is referenced in Alliance policy and procedure QI-133, and the methodology is evaluated at least annually to ensure effectiveness of the IRR evaluation and remediation processes. IRR test results are collated and reviewed by department management and annually reviewed and approved by the UMC and QIHEC. The Alliance also reviews the IRR process and score reports for delegated entities engaged in utilization management activities.

VII. Utilization Management Processes

The UM Program consists of comprehensive and systematic functions, services, and processes that provide care management to members, including utilization review to determine the medical necessity of covered services. Utilization review procedures are further described below.

A. Communication to Members and Providers

Alliance members, providers, and the public can access information about the UM program in various ways.

Members and providers may contact the UM department to discuss any aspect of the UM program.

- Members may contact the Member Services Department and be warm transferred to UM management.
- Providers may contact the UM Department directly at 510-747-4540.

UM staff are available at least 8 hours per normal business day (excludes weekends and holidays). During scheduled business hours, the Alliance provides access to staff for members and practitioners seeking information about the UM process and the authorization of care. Calls coming in outside of the normal business hours that do not require clinical decision making are routed to the phone voicemail system and non-emergency calls are returned the following business day. After-hour calls requiring clinical decision-making are transferred to the Alliance on-call nurse. Staff identify themselves by name, title and as representatives of the Alliance when initiating or returning calls. HIPAA protocols are followed to ensure protection of privacy. Language assistance and TDD/TTY services are available as needed for members to communicate with the Alliance regarding the UM program.

The UM voicemail system is secured with password protections, accessible only by designated individuals in the UM department. The facsimile machines used for utilization review information are located within the Department to monitor and protect confidential health information.

The UM program description, and other core documents containing UM policies and procedures, can be found as follows:

- **Provider Manual:** available on the Alliance web site, and in print upon request, provides an overview of operational aspects of the relationship between the Alliance, providers, and members. Information about the Alliance's UM Program, referral and tracking procedures, processes, and timeframes necessary to obtain prior authorization are included in the manual. In addition, the Provider Manual describes how providers may obtain a copy of the clinical guidelines used to make medical determinations.
- **Provider Bulletins:** periodic newsletter distributed to all contracted provider sites and delegated groups on topics relevant to the provider community, including new or updated UM policies, procedures, and activities.
- **Member Alert:** a periodic newsletter distributed to all Alliance members; each issue covers different topics of interest to members about their health, and may include information about UM policies and procedures
- **Evidence of Coverage (EOC):** distributed to members, based on their product line, provides details on benefits and authorization processes, including description of members' right to submit a complaint or grievance about any Plan action. The Evidence of Coverage document directs members to call the Member Service phone number to initiate complaints or grievances involving UM issues and actions. Member complaints or grievances are documented in the data system and forwarded to the UM unit for follow-up response. The Alliance Grievance and Appeal unit coordinates with the UM unit on appropriate responses to member complaints or grievances.

The Alliance arranges for triage, screening, and referral services, available by telephone to members 24 hours per day, 7 days per week. The Alliance ensures that telephone triage services are provided in a timely manner appropriate for the requesting member's condition, including medical/surgical and behavioral health conditions.

The Alliance's contracted provider network also provides triage services to its members. Primary care providers and mental health care providers provide triage and screening services 24 hours a day, 7 days a week for medical and behavioral health care services. For cases when the providers are unable to meet the time-elapsed standards, the Alliance provides members the Alliance's nurse advice line and/or a behavioral health crisis service call line, as an alternative triage and screening service arrangement. Providers who are unable to provide triage and screening services are required to inform members about the Alliance's nurse advice line information.

Emergency health care services are available and accessible within the service area 24 hours a day, 7 days per week and do not require authorization. The Alliance provides access for members and providers to obtain timely authorization for medically necessary care, for circumstances where the member has received emergency services and care and is stabilized,

but the treating provider believes that the member may not be discharged safely. Inpatient UM Staff are available 24/7 to assist with post-stabilization and/or discharge authorization needs. If an after-hours call is received, but not answered within 30 minutes, the Alliance allows for automatic approval until the member is stable, and UM staff are available to coordinate the transfer of stabilized Members in an emergency department, if necessary.

Emergency health care services, including behavioral health care services are covered without prior approval:

- to screen and stabilize the member where a prudent layperson*, acting reasonably, would have believed an emergency medical condition existed.
- when there is an imminent and serious threat to health including, but not limited to, the potential loss of life, limb, or other major bodily function.
- when a delay in decision making would be detrimental to the member's life or health or could jeopardize the member's ability to regain maximum function.
- If an authorized representative, acting for the Alliance, has authorized the provision of emergency services.

*Prudent Layperson is defined as a person who is without medical training, and who draws on his/her practical experience when deciding whether emergency medical treatment is needed. A Prudent layperson is considered to have acted reasonably if other similarly situated laypersons would have believed that emergency medical treatment was necessary.

Other Alliance representatives who may direct members to emergency services include the Nurse Advice Line staff, and the Alliance nurse case manager or disease manager, an Alliance Member Services Representative or after-hours call answering service, or a contracted specialist. Additionally, the Alliance provides access to the Alameda County Crisis Services to respond to behavioral health calls after hours. The Alliance will honor health plan coverage for services when directed by any Alliance staff member or delegated representative.

B. Utilization Review Procedures

The Alliance follows all regulatory, contractual, and NCQA requirements to effectively administer utilization review procedures, including decision turn-around times and member and provider notification standards. For services that require prior authorization, the UM process requires that qualified, licensed health professionals assess the clinical information used to support UM decisions. Only physicians or doctoral level behavioral health specialists can make determinations to deny or modify care based on medical necessity.

Services Exempt from Prior Authorization

For both Managed Medi-Cal and Group Care products, there are services exempt from prior authorization. Exemptions include, but are not limited to:

- Emergency Services
- Urgent Care
- Primary Care Visits

- Preventative Services including immunizations
- Mental Health Care and Substance Use treatment
- Women's health services – *a woman can go directly to any network provider for women's health care such as breast or pelvic exams. This includes care provided by a Certified Nurse Midwife/ OB-GYN and Certified Nurse Practitioners.*
- Basic prenatal care
- Family planning services, including counseling, pregnancy tests, medications, and procedures for the termination of pregnancy (abortion)
- Treatment for Sexually Transmitted Diseases includes testing, counseling, treatment, and prevention
- HIV testing and counseling
- COVID-19 testing and therapies
- Second Opinions from In Network providers arranged by the assigned PCP
- Initial Mental Health Assessments
- Early and Periodic Screening, Diagnostic and Treatment
- Biomarker testing for members with advanced or metastatic cancer stage 3 or 4
- Annual Cognitive Assessment for Medi-Cal members over 65 without Medicare

Services Requiring Prior Authorization

The Alliance communicates to all contracted providers the procedures, treatments, and services that require prior authorization. Services that require prior authorization include, but are not limited to:

- Non-emergency/ elective out-of-area care
- Out-of-network care, for services not provided by contracted provider
- Inpatient Admissions if non-emergency/ elective
- Inpatient Admissions to Acute Skilled Nursing Facility or Nursing Home
- Outpatient hospital services/ surgery
- Outpatient facilities (non-hospital based), such as surgeries or sleep studies
- Outpatient diagnostic and radiology services, minimally invasive or invasive including CT Scans, MRIs, cardiac catheterization, PET
- Durable Medical Equipment, standard or customized; rental or purchased
- Infusion Services
- Medical Supplies
- Prosthetics and Orthotics
- Podiatry services
- Home Health Care, including skilled nursing, nursing aides, rehabilitation therapies, and social workers
- Transplant Services
- Tertiary/Quaternary office visits and consultations at academic centers
- Experimental or Investigational Services
- Cancer Clinical Trials
- Long-Term Care in Skilled Nursing Facilities, Subacute facilities, and ICF/DD
- Community Supports

- Community Based Adult Services (CBAS)
- Acupuncture, greater than 4 visits per month
- Chiropractic Services
- Second Opinions from out-of-Network providers
- Select behavioral health services

The Alliance also maintains an auto-authorization scope list that is reviewed and approved annually by the UMC and QIHEC, for services that do not require clinical review. The Alliance routinely analyzes utilization patterns to determine whether it would be in members' best interests to add or remove services from prior authorization requirements. All decisions to adjust prior authorization requirements are reviewed and approved by the appropriate committees (including UMC or P&TC, and QIHEC).

Review Types

Authorizations are processed based on the date the Alliance receives the request. Below are the types of utilization reviews:

- **Prospective (pre-service) Review** is the process in which utilization review determination for medical necessity or coverage under the health plan benefit is conducted prior to the delivery of a health care service or supply to a member. A prospective review decision is based on the collection of medical information available to the health care provider prior to the time the service or supply is provided.
- **Concurrent Review** is the process in which utilization review determination for medical necessity or coverage under the health plan benefit is conducted during a member's ongoing stay in a facility or course of outpatient treatment. The frequency of review is based on the member's medical condition with respect to applicable care guidelines.
- **Retrospective (post-service) Review** is the process in which utilization review determination for medical necessity or coverage under the health plan benefit is conducted after the health care service or supply is provided to a member. Retrospective requests received within 90 days from the date of service are reviewed for medical necessity. Retrospective received after 90 days from the date of service are denied for not obtaining prior authorization (with limited exceptions, including member eligibility issues, if the services were emergent/urgent, or inpatient services where the facility is unable to confirm enrollment with the Alliance).

Medical Necessity Review

Qualified health professionals supervise review decisions, including service reductions. UM decisions based on medical necessity to deny or authorize an amount, duration, or scope that is less than requested shall be made by qualified physicians/doctoral behavioral health specialists or appropriate health care professionals, who have appropriate clinical expertise in treating the condition and disease. Appropriate health care professionals at the Alliance are qualified physicians, qualified doctoral level behavioral health care professionals, and qualified pharmacists. Additionally, a qualified physician may approve, defer, modify, or deny prior

authorizations for pharmaceutical services, provided that such determinations are made under the auspices of and pursuant to criteria established by the Plan Medical Director in collaboration with the Plan Pharmacy and Therapeutics committee (P&T Committee) or its equivalent.

Board certified physician and doctoral level Behavioral Health Specialist advisors are available to the UM Program for consultation on clinical issues as well as consultation for potential denials. The UM Program maintains a list of board-certified physician specialists identified for consultation and documents their involvement in member authorization and appeal records when appropriate.

UM decisions are not based on the outcome of individual authorization decisions, or the number and type of non-authorization decisions rendered. UM staff involved in clinical and health plan benefit coverage determination processes are compensated solely based on overall performance and contracted salary and are not financially incentivized by the Alliance based on the outcome of clinical determinations.

In addition to guidelines and criterion, patient records and conversations with appropriate practitioners are used in the decision-making process. UM staff collects relevant clinical information from health care providers to complete prospective, concurrent, and retrospective utilization review for medical necessity and health plan benefit coverage determinations. The Alliance collects only the minimum amount of information necessary to conduct reviews. Clinical information is provided to the appropriate clinical reviewers to support the determination review process. Examples of relevant sources of patient clinical data and information used by clinical reviewers to make medical necessity and health plan benefit coverage determinations include the following:

- History and physical examinations.
- Clinical examinations.
- Treatment plans and progress notes.
- Diagnostic and laboratory testing results.
- Consultations and evaluations from other practitioners or providers.
- Office and hospital records.
- Physical therapy notes.
- On-site, telephonic and fax concurrent reviews from inpatient facilities.
- Information regarding benefits for services or procedures.
- Information regarding the local delivery system.
- Patient characteristics and information.
- Information from responsible family members; and
- Independent, unbiased, and evidenced based analyses of new, emerging, and controversial healthcare technologies.

Prospective (pre-service) Authorization Management

Alliance network physicians are the primary care managers for member healthcare services. Based on the member's assignment, authorizations may be managed by the Alliance or a delegated Provider Group.

Network Primary Care Physicians (PCPs) may process in-network specialist and facility referrals directly to members as "direct referrals" without administrative pre-authorization from the UM Program or the Provider Group. These referrals are primarily for routine outpatient and diagnostic services and are tracked by the UM Program using claim and encounter data. Tertiary/Quaternary evaluations require prior authorization. For services identified as requiring prior authorization, practitioners and providers must submit and coordinate prior authorization for services that require prior authorization, such as DME, home health and certain radiology services. All elective inpatient surgeries and non-contracted provider referrals require prior authorization.

Practitioners and providers send requests for prior authorization to the UM Department via the Alliance provider portal, mail, fax and/or telephone, based on the urgency of the requested service. Requests must include the following information for the requested service:

- Member demographic information (name, date of birth, etc.)
- Provider demographic information (Referring and Referred to)
- Requested service/procedure, including specific CPT/HCPCS Codes
- Member diagnosis (ICD-10 Code and description)
- Pertinent medical history and treatment
- Location where service(s) will be performed.
- Clinical indications necessitating service or referral

Authorization determinations related to Medi-Cal and Group Care are defined, as follows:

- Approval – the determination to provide a service
- Modification – the determination to either approve less than what was requested, or to approve something else in place of what was requested
- Denial – a determination to not provide the request service.
- Delay – when a determination cannot be made, and additional time is required to obtain relevant clinical information.
- Termination – to reduce or end a previously authorized service (e.g., PT visits, SNF days, etc.); NOTE: must give 10 calendar days' notice of terminations

If non-physician UM reviewers have questions about the medical necessity of services, or the appropriateness of the level of care for service based on clinical criteria and guidelines, the case is referred to the Medical Director/doctoral Behavioral Health Specialist for review. The Medical Director/doctoral BH Specialist, or physician designee, may contact the attending physician to discuss the case, if necessary.

If a Medical Director or physician designee/doctoral Behavior Health specialist determine that requested services are not medically necessary or indicated, a denial determination may be made by the Medical Director/doctoral Behavioral Health specialist. Denial

notification and communication to members and providers in accordance with current regulatory timeliness standards and denial notification requirements, as established by regulators, including the Department of Healthcare Services (DHCS) and Department of Managed Health Care (DMHC) and national accrediting organizations, such as NCQA.

Concurrent/Continued Stay Review (including Acute, Skilled, Rehabilitation)

Concurrent/Continued Stay Review is performed during the course of a member's inpatient stay, which may include acute hospital, skilled nursing, and acute rehabilitation, to assess the medical necessity and appropriateness of continuation of services at the requested level of care. Concurrent Review is performed for both contracted and non-contracted facilities. Telephonic, facsimile, or electronic medical record reviews are completed every 2 to 5 days at intervals based on a member's clinical status. If a scheduled review date falls on a weekend or holiday, UM staff attempt to coordinate a Concurrent Review on the workday prior to the scheduled review date, or not later than the first workday after the holiday or weekend.

Additional objectives of continued stay review are to:

- Ensure that services are provided in a timely and efficient manner.
- Ensure that established standards of quality care are met.
- Implement timely and efficient transfer to lower levels of care when clinically indicated and appropriate.
- Implement effective and safe discharge planning.
- Identify cases appropriate for Transitional Care Services and ongoing Case Management services.

Continued inpatient care that does not meet continued stay criteria are referred to the Medical Director/doctoral BH Specialist, or physician designee, to evaluate and consult with the attending physician, as appropriate. When the Medical Director decides that the case does not meet criteria for continued stay based on medical necessity or appropriateness, a Notice of Action (NOA) letter may be issued immediately by fax or via overnight Certified Mail to the attending physician/hospital, and the member. The NOA will contain information related to contacting Medical Director/doctoral BH Specialist, or physician designee for a Peer to Peer. If a Peer to Peer occurs, it does not necessarily mean that a decision will be overturned, however it will help the Alliance to obtain additional information that may be pertinent to coordination of an acceptable discharge plan.

Timeliness Standards

The timeliness of UM decisions shall be commensurate with the seriousness and urgency of the request, whether the request is routine or expedited, and made in a timely manner and not unduly delayed for medical conditions requiring time sensitive services. The Alliance maintains established timeliness standards for medical necessity determinations for routine and urgent Authorization Requests, in compliance with the strictest Regulatory Standards for each Product Line.

Review Type	Managed Medi-Cal	Group Care
Pre-Service – Urgent	72 hours	72 hours
Pre-Service – Routine	5 business days	5 business days
Concurrent	72 hours	72 hours
Retrospective	90 calendar days	90 calendar days
Hospice	24 hours	24 hours

For routine pre-service decisions, notifications of the decision must be sent to providers within 24 hours of the decision and to members within 2 business days.

For urgent pre-service and concurrent decisions, notifications of the decision must be sent to members and providers within 72 hours of receiving all the information needed to make a decision.

For retrospective decisions, notifications of the decision must be sent to the provider and member within 30 calendar days of the request.

Notice of Action Requirements

Decisions affecting care are communicated in writing to the provider and member in a timely manner, in accordance with regulatory guidelines for timeliness and translation, and are not unduly delayed for medical conditions that require time-sensitive services. Reasons for decisions are clearly documented in the member/provider correspondence in easily understandable language.

For any adverse benefit determination (including denial, delay, modification, termination, suspension, reduction, or carve-out of a treatment or service), the Alliance provides members and providers with a written Notice of Action (NOA). The Notice of Action includes all DHCS-required templates to inform members of their rights, and the content of the notification includes all the following:

- a. A statement of the action the Alliance intends to take.
- b. A clear and concise explanation of the reasons for the decision.
- c. A description of the criteria or guidelines used. This includes a reference to the specific regulation or authorization procedure(s) that supports the decision, as well as an explanation of the criteria or guideline.
- d. The clinical reasons for the decision. The Alliance must explicitly state how the member's condition does not meet the criteria or guidelines.
- e. For written notification to the provider, the name and direct telephone number or extension of the decision maker. Decisions must be communicated to the member in writing. In addition, except for decisions rendered retrospectively, decisions must be communicated to the provider initially by telephone or facsimile and also in writing.

The NOA includes a statement that members can obtain a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the denial decision was

based, upon request. Providers are informed how to contact and speak with the Medical Director/doctoral Behavioral Health Specialist who made the decision.

The NOA also includes appeal rights and procedures. Member notifications comply with appropriate contractual and regulatory guidance for each member's line of business. Member correspondence about authorization decisions includes a statement in each Alliance threshold language instructing the member how to obtain correspondence in their preferred language. Notice of Action Letters are sent in the Members' preferred language for those members whose preferred language is an identified threshold language, following the requirements of APL-21-004. Records, including Notice of Action letters, meet contractual retention requirements. Members are informed that they may request copies of their medical records at no cost.

Peer-to-Peer Review (Discussing a Denial with a Peer Reviewer)

All NOAs for adverse benefit determinations include a name and phone number for contacting the Peer Reviewer, allowing the Requesting Practitioner the opportunity to discuss issues or concerns regarding the decision. A practitioner can request a peer-to-peer by calling or writing, and the Peer Reviewer will make himself/herself available for discussion of the denial decision within one business day of the receipt of the provider's request. Upon completion of the peer-to-peer, the requesting practitioner can initiate an expedited or standard appeal, as appropriate.

Second Opinions

Alliance members may request a second opinion from any qualified primary care provider or specialist within the same medical group. If a qualified specialist is not available within the medical group, a referral is provided within the Alliance's network. If a qualified specialist is not available in the Alliance network, staff will assist the medical group to identify an out-of-network specialist. The second opinion from a qualified health professional will be provided at no cost to the member. The Alliance provides a second opinion from a qualified health care professional when a member or a practitioner requests it for reasons that include, but are not limited to, the following:

- The member questions the reasonableness or necessity of recommended surgical procedures.
- The member questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including but not limited to, a serious chronic condition.
- The clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition and requests consultation, or the member requests an additional diagnosis.
- The treatment plan in progress is not improving the medical condition of the member within an appropriate period given the diagnosis and plans of care, and the member requests a second opinion regarding the diagnosis or continuance of the treatment.
- The member has attempted to follow the practitioner's advice or consulted with the initial practitioner concerning serious concerns about the diagnosis or plan of care.

The Alliance educates its members and practitioners of the availability of second opinions in annual member publications. Policies regarding second opinions are available to the public upon request. Member rights related to second opinions include:

- To be provided with the names of two physicians who are qualified to give a second opinion.
- To obtain a second opinion within 30 calendar days, or if the medical need is emergent or urgent, to obtain an opinion within a timeframe that is appropriate to the member's condition and that does not exceed 72 hours
- To see the second opinion report.

Standing Referrals

The Alliance maintains processes to provide members a standing referral to a specialist. The procedure shall provide for a standing referral if the PCP, in consultation with the specialist and the Alliance Medical Director (or designee), determines that the enrollee has a condition or disease that requires continuing specialized medical care from the specialist or Specialty Care Center (SCC) that has expertise in treating the condition or disease. For Members with a condition or disease that requires specialized medical care over a prolonged period of time and is life-threatening, degenerative, or disabling, the Alliance has procedures to provide a standing referral to a specialist or SCC that has expertise in treating the condition or disease, for the purpose of having the specialist coordinate the Member's health care. Determinations for standing referrals are made within three (3) business days of receipt of the request.

The Alliance may require the PCP to submit a treatment plan during care or prior to the referral, as determined by the Medical Director. If a treatment plan is necessary during care and is approved by the Alliance, in consultation with the PCP, specialist, and member, a standing referral shall be made in accordance with the treatment plan. A treatment plan may be deemed unnecessary if the Alliance approves a current standing referral to a specialist. The treatment plan may limit the number of visits to the specialist, limit the period during which visits are authorized, or require that the specialist provide the PCP with regular reports on the care and treatment provided to the enrollee.

Standing referrals to a specialist or SCC are provided within the Alliance's network to participating providers unless there is no specialist or SCC within the Alliance's network that is appropriate to provide treatment.

Transitional Care Services and Discharge Planning

Transitional Care Services and Discharge Planning management are components of the UM process that assess necessary services and resources available to facilitate member discharge and/or transition to the appropriate level of care. Discharge Planning refers to activities related to planning the discharge of a member out of an inpatient medical/psychiatric/SUD facility.

Transitional Care Services (TCS) refers to activities related to transferring a member from one setting or level of care to another, including but are not limited to: discharges from hospitals,

institutions, other acute care facilities, and skilled nursing facilities (SNFs) to home- or community-based settings, Community Supports placements (including Sobering Centers, Recuperative Care and Short-Term Post Hospitalization), post-acute care facilities, or long-term care (LTC) settings.

Depending on a member's risk level (high or low), TCS involves the identification of a single point of contact and/or entity to support members through the inpatient stay to the post-discharge period. In collaboration with the discharging facility, TCS also involves completing a discharge risk assessment, facilitating completion, and sharing of the discharge document with the member and appropriate providers, and post-discharge follow-up (including medication reconciliation and appointment scheduling). The discharge document includes the following information:

1. Pre-admission status, including living arrangements, physical and mental function, SUD needs, social support, DME uses, and other services received prior to admission;
2. Pre-discharge factors, including the Member's medical condition, physical and mental function, financial resources, and social supports at the time of discharge;
3. The hospital, institution or facility to which the Member was admitted;
4. Specific agency or home recommended by the hospital, institution or facility after the Member's discharge based upon Member needs and preferences; specific services needed after the Member's discharge; specific description of the type of placement preferred by the Member, specific description of type of placement agreed to by the Member, specific description of agency or Member's return to home agreed to by the Member, and recommended pre-discharge counseling;
5. Summary of the nature and outcome of participation of Member, Member's parents, legal guardians, or ARs in the Discharge Planning process, anticipated problems in implementing post-discharge plans, and further action contemplated by the hospital, institution, or facility to be included in the Member's Medical Record; and
6. Information regarding available care, services, and support that are in the Member's community once the Member is discharged from a hospital, institution or facility, including the scheduled outpatient appointment or follow-up with the Member.

TCS begins at the point of admission to an inpatient facility, and is designed to identify and initiate cost effective, quality-driven treatment intervention for post-hospital care needs. It is a cooperative effort between the attending physicians, hospital discharge planner, UM/BH staff, assigned TCS Care Manager, health care delivery organizations, and community resources to coordinate care and services.

Additionally, for nursing facility transitions, the Alliance ensures timely transitions that do not delay or interrupt any Medically Necessary services. UM staff coordinate with facility discharge planners and assist members and their authorized representatives by evaluating all medical needs and care settings available including, but not limited to, discharge to a home or community setting, and referrals and coordination with IHSS, Community Supports, LTSS, and other Home and Community Based Services (HCBS). Once discharged from the hospital, UM staff verify with facilities or at-home settings that Members arrive safely at the agreed

upon care setting, and follow-up with members, as appropriate, to ensure their needs are met.

Objectives of the Discharge Planning Review are:

- Early identification during a member's hospitalization of high-risk medical/psycho-social issues with potential need for post-hospital intervention, including a discharge risk assessment.
- Development of an individual care plan involving an appropriate multi-disciplinary team and family members involved in the member's care.
- Communication with the attending physician and member, when appropriate, to suggest alternate health care resources.
- Communication to attending physician and member regarding covered benefits, to reduce the possibility of a financial discrepancy regarding non-covered services and denied days of hospitalization.
- Coordination of care between the member, PCP, attending physician, specialists, hospital UM/Discharge Planning staff, assigned TCS Care Manager, and UM staff.
- Referral to Transitional Care Services or Home Health Programs within or outside of AAH programs.

Continuity of Care

Continuity of Care (CoC) provisions ensure the lack of interruption in the care provided to members when circumstances dictate a change in the member's insurance coverage, geographic location, entity, or provider assignment. The Alliance provides Continuity of Care with an out-of-network provider according to all applicable laws, regulations, and state guidelines, if the below criteria are met:

- The Alliance can determine that the beneficiary has an existing relationship with the provider (self-attestation is not sufficient to provide proof of a relationship with a provider). An existing relationship means the member has seen an out-of-network primary care provider (PCP), behavioral health provider or specialist at least once during the 12 months prior to the date of his or her initial enrollment in the Alliance for a non-emergency visit, unless otherwise specified by regulation. CoC also extends to the following select ancillary providers: physical therapy, occupational therapy, speech therapy, respiratory therapy, and Behavioral Health Treatment (BHT) providers.
- The provider is willing to accept the higher of the Alliance's contract rates or Medi-Cal FFS rates.
- The provider meets the applicable professional standards and has no disqualifying quality of care issues (a quality-of-care issue means the Alliance can document its concerns with the provider's quality of care to the extent that the provider would not be eligible to provide services to any other Medi-Cal beneficiaries)
- The provider is a California State Plan approved provider; and
- The provider supplies the Alliance with all relevant treatment information, for the

purposes of determining medical necessity, as well as a current treatment plan, if it is allowable under federal and state privacy laws and regulations.

As outlined in DHCS APL 23-022, the Alliance also ensures CoC provisions for:

- Durable Medical Equipment (DME) Rentals and Medical Supplies
- Non-Emergency Medical Transportation (NEMT)
- Non-Medical Transportation (NMT)
- Mandatorily enrolled members with active course of treatment
- Newly enrolled members with acute or serious chronic conditions
- Pregnant and post-partum members
- Newborns between Birth through age 36 months
- Members with Terminal Illness
- Members with denied Medical Exemption Requests (MER)
- Members needing to complete a course of treatment with a terminated provider

The Alliance is not required to provide CoC for services not covered by Medi-Cal or those services managed directly by DHCS. In addition, CoC protections do not extend to additional ancillary services.

UM staff work with the member's current treating physician and/or PCP to assist the member in continuity of care. For members who are assigned to a Provider Group, if the current treating physician is not affiliated with the existing Provider Group's network, the UM staff works with the Provider Group to make arrangements with the physician to continue care of the member until the treatment is completed or the member can be safely transitioned to a physician within the Provider Group. As needed, members are referred to Case Management for additional support with coordination of care with in-network and out-of-network providers.

Required Reporting

As applicable, UM staff are required to report the following activities during the course of utilization review activities:

- Potentially fraudulent or abusive practices identified to the Compliance Department
- Potential under and over utilization to the UM Manager
- Coordination of care for results or facilitation to the UM Manager
- Opportunities for improvement to the UM Manager
- Breaches of adherence to confidentiality and HIPAA policies to the Alliance's designated Compliance staff member
- Potential quality issues identified through UM activities to the Quality Improvement Department
- Barriers to accessibility and availability of UM services to the UM Manager

C. Long-Term Services and Supports (LTSS)

The LTSS Department is an extension of the Utilization Management program, adhering to

utilization management procedures as described above. The LTSS department is responsible for the provision of Long-Term Services and Supports, defined in the DHCS contract as:

“Services and supports designed to allow a member with functional limitations and/or chronic illnesses the ability to live or work in the setting of the Member’s choice, which may include the Member’s home, a worksite, a Provider-owned or controlled residential setting, a nursing facility, or other institutional setting. LTSS includes both Long-Term Care (LTC) and Home and Community-Based Services (HCBS) programs and includes carved-in and carved-out services”

The LTSS department consists of clinical and non-clinical staff who administer the program, providing oversight & monitoring to ensure adherence to all regulatory requirements and performance standards. Team members work collaboratively with other internal departments (including UM, Case Management, Pharmacy, and Behavioral Health), delegated entities, and safety net providers within the community to deliver timely, appropriate, cost-effective, and quality healthcare to members using LTSS benefits.

Long Term Care (LTC)

DHCS defines LTC as specialized rehabilitative services and care provided in the following settings:

- Skilled Nursing Facility (SNF)
- Adult subacute facility
- Pediatric subacute facility
- Intermediate Care Facility/Developmentally Disabled (ICF/DD)
- ICF/DD-Habilitative (ICF/DD-H)
- ICF/DD-Nursing (ICF/DD-N)

The LTC Program provides a comprehensive framework for oversight and monitoring of the delivery of healthcare services to members in LTC settings. Its purpose is to:

- Ensure that members in LTC settings are receiving the care and services to meet their needs in the least restrictive environment.
- Comply with State and Federal laws and requirements to assure governmental payors and other regulatory agency guidelines, standards, and criteria are adhered to, as applicable.
- Educate staff, delegates, contracted network providers and facilities on the policies and procedures to ensure compliance with the goals and objectives of the Program.
- Identify institutionalized Members who may benefit from transitioning back to the community with support.
- Optimize the member’s health benefits by ensuring and supporting transitional care and coordination of services with the appropriate county/state sponsored programs.
- Monitor care through internal oversight auditing and monitoring activities.
- Provide Transitional Care Services
- Provide Basic and Intensive Care management, as needed

Community-Based Adult Services (CBAS)

DHCS defines HCBS programs as programs that include but are not limited to HCBS programs authorized under the Social Security Act (SSA) at 42 USC section 1396n(c), the California Medicaid State Plan option authorized under 42 USC section 1396n(k), California Medicaid State Plan HCBS benefits authorized under 42 USC section 1396n(k), and other State and federally funded Medi-Cal HCBS programs.

CBAS is a type of LTSS benefit under the HCBS umbrella of program. CBAS centers offer services to eligible older adults and/or adults with disabilities to restore or maintain their optimal capacity for self-care and delay or prevent inappropriate or personally undesirable institutionalization. The Alliance maintains procedures, processes, and mechanisms for administering assessments and re-assessments for CBAS services, including CBAS Emergency Remote Services (ERS), when appropriate.

The Alliance is responsible for ensuring Members who are eligible to receive LTSS, including CBAS, are identified and referred, and dedicates an RN on the UM team to provide assessment, re-assessment, and re-authorization of CBAS services to members.

D. Behavioral Health Services

Behavioral Health Services are integrated with the Utilization Management program, adhering to utilization management procedures as described above and ensuring parity between medical and behavioral health services. The scope of the program covers behavioral health treatment that may be beyond the customary scope of practice of a primary care physician. Care settings include home and office-based services, free-standing and hospital-based programs, residential treatment programs and facility based acute care treatment units. Medical necessity is determined by applying level of care criteria, while the clinical appropriateness of services is evaluated using criteria and guidelines developed by the nonprofit professional association for the relevant clinical specialty when conducting utilization review of treatment of mental health and substance use disorders.

The provision of behavioral health and substance use services are applied to Alliance members according to their benefit. Group Care members receive a comprehensive benefit for all behavioral health services. For Medi-Cal beneficiaries, Alameda County Behavioral Health Care Services (ACBHCS) provides Specialty Mental Health Services (SMHS) and Substance Use Disorder (SUD) services. The Alliance provides mild-to-moderate behavioral health and substance abuse screenings. The Alliance also provides Behavioral Health Therapy (BHT) or Applied Behavioral Analysis services for Medi-Cal members under the age of 21 for the treatment of Autism Spectrum Disorder and related conditions. other conditions where excessive and/or deficits of behaviors significantly interfere with home and community activities. The Alliance provides behavioral health utilization management activities and maintains the provider network for behavioral health and substance abuse services.

Alameda County Behavioral Health Care Services (ACBHCS)

Specialty behavioral health services for Medi-Cal members are excluded from the Alliance contract with DHCS. This is a carve-out arrangement for specialty behavioral

health management with the State of California directly overseeing and reimbursing the behavioral health services provided to Medi-Cal members. Care coordination for Alliance members receiving SMHS or SUD services are coordinated under a Memorandum of Understanding executed between the Alliance and ACBHCS.

The referral procedure for Alliance members includes:

- Alliance Primary Care Providers (PCPs) render outpatient behavioral health and substance abuse services within their scope of practice.
- PCPs refer the members to ACBHCS for evaluation and coordination of medically necessary specialty behavioral health services by the Access Team, including inpatient psychiatric care.
- Members may self-refer to ACBHCS' ACCESS Line

Behavioral Health Treatment Coverage

The Alliance is responsible for providing Early and Periodic Screening, Diagnosis, and Treatment (Medi-Cal for Kids and Teens,) services for beneficiaries ages 0 to 21. The services include medically necessary Behavioral Health Treatment (BHT) services such as Applied Behavioral Analysis and other evidence-based behavioral intervention services that develop or restore, to the maximum extent practicable, the functioning of children with any diagnosis including Autism Spectrum Disorder (ASD). In accordance with the requirements listed in the most recent DHCS All Plan Letter, the Alliance must provide continued access to out-of-network BHT providers (continuity of care) for up to 12 months.

Behavioral Health Integration

Members may contact the Alliance Behavioral Health Service department or be referred by the PCP and/or health care professional. The Alliance maintains procedures for providers to coordinate care and services for members in need of behavioral health services including, but not limited to, all medical necessary services across the behavioral health provider network.

The Alliance uses a variety of mechanisms that ensure behavioral health services and management processes are actively integrated into the UM Program and include:

- A behavioral healthcare practitioner, who is a behavioral healthcare physician or a doctoral-level behavioral health practitioner, is involved in quarterly QIHEC meetings to support, advise, and coordinate behavioral healthcare aspects into UM Program policies, procedures, and processes.
- The Senior Director of Behavioral Health Services directs all aspects of the BH program to ensure that the program meets all regulatory requirements and integrates with the UM Program, Case Management Program, Member Services, and other departments within the Alliance.
- There are regular care coordination rounds, in which the staff attending rounds evaluate topics such as access, availability, health management systems, practice guidelines, clinical and service quality improvement activities, member satisfaction,

continuity and coordination of care and member's rights and responsibilities.

- The Alliance routinely generates clinical reports reflecting metrics and outcomes of the Behavioral Health Services program, which are reviewed and acted upon as needed at appropriate AAH Committees and QIHEC.
- The Alliance participates in periodic operational meetings with ACBHCS to review and coordinate administrative, clinical, and operational activities.

E. Pharmacy Management

The pharmacy benefit for Medi-Cal members is carved-out and administered by the DHCS Medi-Cal Rx program. Non-capitated carved-out drugs, such as HIV/AIDS/Hepatitis B treatment drugs, alcohol and heroin detoxification and dependency treatment drugs, Blood Factors: Clotting Factor Disorder Treatment and psychiatric drugs are covered by Medi-Cal Fee-For-Service Intermediary.

For those pharmacy benefits that are not carved-out to Medi-Cal Rx and for Group Care members, the Alliance ensures the provision of pharmacy management to a pharmacy benefit manager (PBM). The PBM possesses service level guarantees that manages pharmacy services under the delegated arrangement and maintains clinical policies and procedures that are revised at least annually. The Alliance delegates some of its pharmacy utilization management activities to the pharmacy benefit management company. The PBM supports full prior authorization review services, including confirmation of denials for weekends/holidays/emergency. The PBM provides support to the Alliance's Pharmacy and Therapeutic Committee activities including formulary management, guideline development and trend reviews related to pharmacy services. The Pharmacy and Therapeutics Committee meets quarterly and provides oversight for evidence-based, clinically appropriate pharmacy guideline criteria. Guidelines are developed in conjunction with review of peer-reviewed literature and with consideration for such factors as safety, efficacy, and cost effectiveness, with the input and evaluation of external clinical specialists appropriate to the subject matter.

The PBM receives and processes medication prior authorization (PA) requests for medications filled through network retail and specialty pharmacies. The PBM's Prior Authorization Department is comprised of certified technicians and clinical pharmacists who conduct reviews and approve requests that meet prior authorization criteria. All requests that the PBM cannot approve per their protocol are forwarded to Alliance for the final determination. All pharmacy PA requests must be processed, and a decision rendered within regulatory requirements. Pharmacy UM decision monitoring is reported through the UMC.

F. Linked and Carved Out Services

Linked and carved-out services are those that are not covered by the Alliance but are still available to Alliance members through other Medi-Cal programs. The Alliance provides linkages with such programs to ensure that members with special health care needs, or high risk or complex medical and developmental conditions, receive wrap-around services that enhance their medical benefits. These linkages are established through specific program Memoranda of Understanding (MOU) with community agencies, such as the California Children's Services (CCS) and the Regional Center of the East Bay (RCEB).

UM staff and delegated entity practitioners identify members who may be eligible for services, and coordinate referral to appropriate agencies and specialist care when the benefit coverage of the member dictates. The UM Department coordinates activities with the Case Management Department to assist members in transitioning to other care, if necessary, when benefits end. This includes informing members about other sources to continue care.

VIII. Special Programs

A. Transplant Programs

The Alliance provides an appropriate level of care and services within the member's benefits for transplants according to product line requirements. All patients are monitored according to contractual requirements on an inpatient and outpatient basis, and the member, physician, and facilities are assisted to assure timely, efficient, and coordinated access.

Group Care Members are covered for all medically necessary organ transplants. This coverage is provided by Alliance-approved practitioners and facilities.

Medi-Cal Members are covered for medically necessary organ transplants, including related services such as organ procurement and living donor care. Coverage provisions are as follows:

- a) The Alliance covers the following Major Organ Transplants: bone marrow transplant (BMT), heart, heart/lung, kidney/pancreas, liver, liver/small bowel, lung, pancreas, and small bowel. The Alliance also covers kidney and corneal transplants.
- b) For members under 21 years of age, organ transplant coverage is provided by California Children Services (CCS). The Alliance refers members under 21 to CCS for evaluation of potential organ transplant. CCS will refer CCS-eligible members to the transplant Special Care Centers (SCC) for review and follow-up.
- c) For member 21 years of age and older, Major Organ Transplant evaluations are referred to a Medi-Cal approved Center of Excellence (CoE) on the most recent DHCS CoE list of facilities. The Alliance authorizes the request for a transplant after the transplant program confirms the member is a suitable transplant candidate.
- d) Kidney and corneal transplants are provided through Alliance-approved practitioners. Kidney transplants, along with related care such as dialysis, evaluation of potential donors, and nephrectomy from living or cadaver donors, continue to be covered benefits.

B. Palliative Care

Palliative Care Services are provided to members per the requirements of the latest All Plan Letter. Palliative care services may be delivered at the hospital, as part of the inpatient care treatment plan, or authorized and delivered in primary care, specialty care clinics, by home health teams, or by hospice entities. The Alliance offers a network of palliative care services to its members through various provider types.

The Alliance, as part of its palliative care network development, contracts with hospitals, long-term care facilities, clinics, hospice agencies, home health agencies, and other types of community-based providers that include licensed clinical staff with experience and /or training in palliative care. The Alliance may also contract with different types of providers depending on

local provider qualifications and the need to reflect the diversity of their membership. Community-Based Adult Services (CBAS) facilities may be considered as a palliative care partner for facilitating advance care planning or palliative care referrals. The Alliance utilizes qualified providers for palliative care based on the setting and needs of the members if the provider complies with the existing Medi-Cal requirements.

The Alliance ensures that palliative care provided in a member's home complies with existing Medi-Cal requirements for in-home providers, services, and authorizations.

Palliative care services follow the utilization review procedures as described above. Through the authorization review and decision process, the type of palliative care (including the location where palliative care services can be delivered) will be determined based on medical necessity. Referral and care coordination for palliative services will be provided to the member within the timely access standard requirements. Alliance's network providers receive instructions of the referral and authorization process for palliative care through the Alliance's provider educational materials and via the Alliance's website.

IX. UM Program Monitoring and Oversight

A. Evaluating Program Effectiveness

The effectiveness of the UM Program is monitored through quality assurance activities that support positive medical and behavioral health outcomes, and continuous quality improvement. The CMO guides these activities in collaboration with the Senior Director, Health Care Services, the Senior Director, Behavioral Health, the Senior Director, Quality, and the Director of Accreditation, with oversight by the QIHEC. Performance results are analyzed and reviewed, with opportunities for improvement identified for intervention and performance management. The following quality assurance activities are conducted:

- Monitoring Under and Over Utilization (used to inform activities related to timely access and network adequacy)
- Monitoring Utilization Review Measures
- Monitoring Internal Operational Quality Measures
- Monitoring Member Experience with the UM process
- Monitoring Grievances and Appeals (including Overturns)
- Monitoring Potential Quality Issue (PQIs), including Provider Preventable Condition identification and referral
- Operational Quality Audits
- Delegation oversight, including monitoring of Corrective Action Plans (as applicable)

Data sources used for quality assurance activities may include the following:

- Claims and encounter data
- Medical records
- Medical utilization data
- Behavioral Health utilization data

- Pharmacy utilization data
- Appeal, denial, and grievance information
- Internally developed data and reports
- Audit findings; and
- Other clinical or administrative data

Utilization Review Measures

The Alliance monitors, measures, and evaluates utilization review procedures as follows:

- Volume of authorization requests, including determination status
- Denial Rate (the established threshold is 5% denial rate)
- Compliance with timeliness standards (the established threshold is 95% compliance)
- Compliance with NOA requirements, including appropriate content and enclosures

Internal Operational Quality

The Alliance UM Department conducts ongoing auditing and monitoring of key operational functions to ensure compliance with all federal, state, regulatory, contractual and accreditation standards. The monitoring process allows for early identification of compliance risks and opportunities for retraining of staff. Internal quality monitoring consists of monthly, and as-needed, audits as follows:

- **UM File Review:** Files are assessed to ensure compliance using the regulatory and accreditation requirements as well as to identify opportunities for process improvement. Elements of the review include, but are not limited to, ensuring the appropriate medical information is obtained, use of criteria, application of clinical decision-making criteria, and appropriate referral to physician reviewers, as applicable. For cases that are denied or modified, the file is also assessed for the NOA requirements for communication to the member and provider.
- **Authorization Turn-Around-Time (TAT):** An authorization aging report is used to monitor TATs for authorizations. Any open authorization without a final determination will appear in this report. The UM Manager or designee monitors the report daily to ensure all authorization determinations are compliant with UM TATs.

Monitoring Over and Under Utilization

The Alliance monitors potential over and under-utilization of covered services (including medical and behavioral health services), based on population and member-specific analysis of service utilization trends. Assessment and monitoring of Over and Under Utilization is a collaborative effort between the Quality Management and UM Department. The UM Department monitors over- and under-utilization for:

- Emergency Room Visits
- Acute Inpatient Hospitalizations (including admits, average length of stay, bed

- days, and readmission rates)
- Specialty and Ancillary visits (including out-of-network activities)
- Unused Authorizations

In the absence of national or regional benchmarks, the Alliance monitors monthly, quarterly, and annual utilization data (including claims, encounters, and authorizations) for significant trends. Root cause analysis is conducted to determine potential drivers for trends, and recommendations are presented to the UMC and QIHEC, at least quarterly. Insights from committee members are used to identify opportunities for improvement, as necessary.

Grievances and Appeals

The Alliance maintains an effective member grievance and appeals (G&A) process that follows all regulatory, contractual and accreditation requirements. G&A is managed within Health Care Services, and complaints identified with clinical service needs are supported by UM staff and Medical Directors. Trending data for clinical appeals and fair hearings is reported to the UMC to identify opportunities to improve the UM experience for members and providers.

Potential Quality Issues

At any time during the utilization review process, staff may identify a condition or situation that appears to deviate from the professional standard of care. In such instances, a Potential Quality Issue (PQI), including Provider Preventable Conditions, is referred to the Quality Improvement Department to be evaluated per policy and procedure.

Member and Provider Experience with Utilization Management

Annually, Alliance members and providers are surveyed to assess their experience with the utilization management processes and services. Satisfaction surveys assess the efficacy of the UM program from the perspective and experience of members and providers.

- **Member Experience:** The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is administered by mail to Alliance Medi-Cal members. UM program efficacy is evaluated using the below composite measures:
 1. Getting Needed Care – member experience when attempting to get care, tests, or treatments
 2. Getting Care Quickly – member experience when receiving care; and
 3. Rating the Health Plan
- **Provider Experience:** A vendor employed by the plan contacts a sample of network providers by mail and/or internet. Among the survey questions, six (6) questions ask providers to rate the plan on:
 1. Access to knowledgeable UM staff.
 2. Procedures for obtaining prior authorization information.
 3. Timeliness for obtaining prior authorization information.

4. The Plan's facilitation/support of appropriate clinical care for patients.
5. Degree to which the Plan covers and encourages preventive care and wellness.

The Alliance conducts quantitative and qualitative analysis to identify areas for improvement. Survey outcomes, analysis, and recommendations are presented to the UMC and QIHEC to assist in identifying opportunities for improvement. The Alliance UM Department actively participates in ideation to improve the member and provider experience with the UM process.

Delegation of Utilization Management Activities

The Alliance provides covered services to members through a delegated network. For UM-delegated entities, the Alliance has shared-risk arrangements, meaning the delegated entity is typically responsible for outpatient authorization reviews, while the Alliance UM Department is typically responsible for certain outpatient and inpatient authorization reviews. UM-delegated entities perform utilization management activities based on their contract, which includes agreements on divisions of responsibility.

The Compliance Department is responsible for monitoring and tracking the overall performance of delegates, including completion of annual audits. UM department staff review the UM components of the annual audit, which includes a review of delegates' policies and procedures and member case files. The UM team also reviews the delegated entities annual work plans/evaluations, and other standing reporting activities, as required. The Compliance Department is responsible for finalizing the audit findings. For entities that do not meet thresholds, a corrective action plan may be issued and tracked to ensure adequate resolution of the deficiency. All audit findings are reported to the Compliance Committee and the QIHEC.

Annual UM Evaluation

The Chief Medical Officer, the Senior Director, Health Care Services, and the Directors of UM and LTSS collaboratively conduct an annual evaluation of the Alliance UM program. The evaluation includes, at a minimum:

- Review of changes in staffing, reorganization, structure, or scope of the program
- Resources allocated to support the program
- Review of completed and ongoing UM work plan activities
- Assessment of performance indicators
- Review of delegated arrangement activities
- Recommendations for program enhancements

The results of the annual program evaluation are reported to the UMC and QIHEC for review and feedback. The UMC and QIHEC make recommendations for actions and/or interventions to improve program performance, as appropriate.

Annual UM Workplan

Each year, the Alliance establishes objectives and priorities based on findings from the Annual Program Evaluation and outlines a strategic workplan for the coming year. The

workplan incorporates goals, measures, anticipated completion timeframes, and responsible parties, and is maintained throughout the year to monitor progress towards goals and adjust goals, as necessary. The CM workplan is reviewed and approved by the UMC and QIHEC annually.

B. Summary of UM Program Recommendations for 2025

As a result of the 2024 program evaluation, opportunities for improvement have been identified and are incorporated into the 2025 UM Program and Work Plan, as follows.

Operational Efficiency and Compliance:

Inpatient and Outpatient UM

- Continued monitoring and process improvements to meet NOA compliance
- End-to-end authorization system enhancements to streamline authorization processing and eliminate manual workarounds
- Continued evaluation of services that do not require prior authorization with goal to remove unnecessary reviews
- Continue the Tertiary Quaternary Policy
- Develop Authorization and claims stay level configuration for inpatient levels of care and facility types
- Validate different network contracting to ensure accurate out-of-network utilization is reflected in Plan analytical reports and aligned with Delegate utilization reporting.
- Increased alignment with case management, specifically related to transitional care services in alignment with DHCS population health management policy guide

LTSS

- Continue to work with facilities to notify the Alliance about changes to LTC member Transition of Care status, and timely Bed Hold and Admission LTC authorizations.
- Continuing to collaborate with the LTSS liaison and provider services to establish relationships with facility partners, including our onsite facility visits from LTSS social workers
- Increase the number of facilities that the long-term team has ongoing rounds with.
- Ensure the Quality Management department develops quality performance measures for LTC facilities

Pharmacy Services

- Refining process for carveout drugs billed under the medical benefit with cross functional configuration and claims team.
- Implement a policy for medications that are self-administered and communicate it to the physician network. Ultimate goal: to review self-administered drugs billed under the medical benefit for medical necessity.
- Enhance external exception request review process to apply to denials of prior authorization and step therapy exception requests.
- Continued monitoring of unclassified drugs and unclassified biologics, in partnership with an external vendor, to enhance the claim adjudication process ensure appropriate billing and configuration

Behavioral Health Services

- Enhance process defects impacting TAT performance and implement interventions to meet
- TAT goals in 2025.
- Increase access as measured by an increase in unique utilizers of mental health and BHT/ABA services.
- Ensure that Contracting continues to increase network capacity, particularly for ABA services.

Clinical Appeals

- Continuing to monitor overturn rates for both lines of business.

Delegated Utilization Management

- The UM Department partnered with the Compliance Department to create a new audit tool that will go into effect for the next delegate audits.
- UM Continues to partner and establish metrics that align with The Alliance's key performance indicators.
- Monitor and support Delegate CAP activities, in coordination with the Compliance Department
- Provide regular training and share best practices with delegated entities, particularly around Enhanced Care Management, Community Supports, Transitional Care Services, and other activities impacting The Alliance's Population Health Management strategy

Quality Improvement

Management of Emergency Room Utilization

- Continue collaboration with Case Management, QualityManagement and Population Health Management teams to ensure access to post-discharge care, particularly with primary care providers.
- Monitor diagnosis drivers for emergency room visits, especially for repeat utilizers and for facilities with high emergency room rates.
- Monitor PCP primary care homes for facilities with high ER rates and for repeat utilizers and facilities with high emergency room rates: Identify Teledoc opportunities and those diagnoses that could be managed in primary care offices.
- Track utilization that is associated with members who readmit to the hospital, for case escalation to the Case Management department and supports.
- Increase collaboration with Behavioral Health team and Alameda County Behavioral Health Services to support access to necessary BH/SUD treatment
- Explore opportunities with Community Health Workers and Bridge Programs embedded in the Emergency Departments throughout the county to decrease Emergency Department Utilization.

Management of Acute Hospitalizations

- Expand ADT feeds and comparable data sharing sources for acute hospitals that are not yet established (Stanford, UCSF, Childrens Hospital).

- Build staffing capacity to manage new membership and inpatient volume for new Long-Term Care higher utilization and 2024 Managed Care Plan to Managed Care Plan and Fee-For- Service Medi-Cal Transitions
- Improve identification members who are at-risk for readmission or who re-admitted, including revision of risk-stratification methodology, and use of additional data sources as available to DHCS or community-based partners
- Continue referral processes for Enhanced Care Management, Complex Case Management and Community Supports, with goal to link members to appropriate resources for next level of care
- Foster continued collaboration and relationship building with hospital and skilled nursing facility partners to support discharge management, and complex case rounds for members with long length of stay or complex discharge barriers.
- Coordinate collaboration between the Alliance and its delegates around identifying Potential Quality Issues, Avoidable days variance, Provider Preventable Conditions, and preventable readmissions
- Expand screening for appropriate Case Management referrals for palliative/hospice eligible members

Management of Specialty Care Utilization

- Monitoring elective hospitalizations, Inpatient hospitalizations through the emergency room, hospital transfers for higher level of care, and provider visits and ancillary services, related to established with the Oncology and Transplant Program enrollment.
- Continued partnership with Contracting team to provide insights on in-network needs, based on utilization patterns and identified access barriers, especially for tertiary and quaternary academic centers.

Management of Unused Authorizations

- Continued partnership with Contracting team to provide insights on network needs, based on utilization patterns and identified access barriers
- Continued monitoring and root-cause analysis of unused authorizations
- Collaboration with the Alliance Case Management Department for member specific outreach to address barriers to utilizing authorizations.
- Re-evaluation of unused authorization report to ensure appropriate analysis of authorization and claims activity

Member and Provider Satisfaction with UM

- Continue efforts to streamline and improve the accessibility of prior authorization information to providers, including increase visibility of authorization details on public portals and secure online platforms
- Ensure providers receive appropriate training to access the resources
- Participate in the review of satisfaction survey data for measurement year 2023, using those survey insights to further inform process improvement efforts

2025 Utilization Management Work Plan

Performance Measure	2025 Goal	Supporting Document / Report	Responsible Staff	Timeframe for completion	Committee & Reporting Frequency
Program Scope and Structure					
Utilization Management Committee (UMC) schedule	UMC meets at least quarterly 2026 UMC schedule/agenda prepared and distributed by November 2025	UMC Meeting Minutes	Sr. Director, HCS	meet at least Quarterly; 2026 UMC schedule completed by November 2025	N/A - operational
Review of Policies & Procedure	100% of P&Ps reviewed within annual timeframe, and as needed	P&Ps	Sr. Director, Health Care Services	As needed, and at least Annually	UMC - annually
2024 UM Program Evaluation	Complete 2024 UM Program Evaluation by Q1 2025	2024 UM Program Evaluation	Sr. Director, Health Care Services	Annually, by Q1 2025	UMC - annually
2025 UM Program Description	Complete 2025 UM Program Description by Q1 2025	2025 UM Program Description	Sr. Director, Health Care Services	Annually, by Q1 2025	UMC - annually
2025 UM Work Plan	Complete 2025 UM Work Plan by Q1 2025	2025 UM Workplan	Sr. Director, Health Care Services	Annually, by Q1 2025	UMC - annually
Clinical Decision Support Tools					
Review of Clinical Criteria & Hierarchy	Present Annual Review of Clinical Criteria and Hierarchy	Internal report: Clinical Criteria & Hierarchy	UM Medical Director / UM & LTSS Director	Annually	UMC - annually
Review of Code-Specific Prior Authorization Rules (including auto-authorization code list)	Present Annual Review & Recommendations for PA rules (including auto-authorization Code List)	PA grid, auto-authorization code list	UM Medical Director / UM Director	Annually	UMC - annually
Review of Board-Certified Consultants	Present Annual Review of Board-Certified Consultants	Internal report: Board-Certified Consultants; list of specialties from AMR	Sr. Director, HCS	Annually	UMC - annually
Inter-Rater Reliability	100% of eligible UM reviewers complete IRR by Q3 2025; ≥ 90% overall IRR score (UM, LTSS, Pharmacy, BH, Appeals, Physicians)	Internal IRR report	Quality Improvement / UM & LTSS Director	Annually	UMC - annually
Tracking Disclosures of UM Criteria/Policies	Present Annual Report on Volume of UM Criteria/Policies disclosed to members and providers	Member/Provider Request Log for UM criteria/policies	Managers (UM, LTSS, Pharmacy, BH)	Annually	UMC - annually
UM Program Effectiveness					
Utilization Review Measures					
Authorization Volume <i>MediCal & Group Care, separate data</i>	Present Quarterly Report of Authorization Volumes (UM, LTSS, Pharmacy, BH)	UM Reports (total auth volume and determination status)	Managers (UM, LTSS, Pharmacy, BH)	Quarterly	UMC - quarterly
UM Timeliness (Decision and Notification TAT) <i>MediCal & Group Care, separate data</i>	≥ 95% TAT compliance (UM, LTSS, Pharmacy, BH)	Analytics Report 02569_AuthTAT	Managers (UM, LTSS, Pharmacy, BH)	Quarterly	UMC - quarterly
Denial Rate <i>MediCal & Group Care, separate data</i>	≤ 5% denial rate (UM, LTSS, Pharmacy, BH)	Analytics Report 01292_AllAuthDenialRates	UM Medical Director	Quarterly	UMC - quarterly
NOA Compliance <i>MediCal & Group Care, separate data</i>	≥ 95% audit score (UM, LTSS, Pharmacy, BH)	Internal Audits for NOA Content & Enclosures (UM, LTSS, Pharmacy, BH)	Managers (UM, LTSS, Pharmacy, BH)	Monthly	UMC - quarterly
Quality Audit Scores	≥ 95% audit score (UM, LTSS, Pharmacy, BH)	Internal File Review Audits (UM, LTSS, Pharmacy, BH)	Managers (UM, LTSS, Pharmacy, BH)	Monthly	UMC - quarterly
CBAS Measures	Present Quarterly Report of CBAS Measures	CBAS reports	Manager, UM	Quarterly	UMC - quarterly
California Children's Services (CCS) Measures	Present Quarterly Report of CCS Measures	CCS reports	Manager, UM	Quarterly	UMC - quarterly
UM System Controls					

Performance Measure	2025 Goal	Supporting Document / Report	Responsible Staff	Timeframe for completion	Committee & Reporting Frequency
UM System Controls Audit Scores	100% completion of quarterly system controls audits; present Quarterly Report of UM Denial System Control audit results (including analysis of inappropriate modifications within audit sample)	Analytics Report, Internal Audits	UM & LTSS Director	Quarterly	UMC - quarterly
Over/Under Utilization					
Emergency Room Utilization & Group Care, separate data <i>MediCal</i>	3% decrease of avoidable ER visits	PBI Delegate Summary_UR_ALL ED Util tab	UM Medical Director / UM Director	Quarterly	UMC - quarterly
Acute Inpatient Hospitalizations (Admits/K, ALOS, Days/K) <i>MediCal & Group Care, separate data</i>	Present Quarterly Report of Acute Inpatient Hospitalizations	PBI 12412 Monthly Trend	UM Medical Director / UM Director	Quarterly	UMC - quarterly
Acute Inpatient Hospitalizations (Readmission Rate) <i>MediCal & Group Care separate reports</i>	1.5% decrease of all-cause readmission rate	Hospital reports for readmissions	UM Medical Director / UM Director	Quarterly	UMC - quarterly
Specialty and Ancillary Visits (including Out-Of-Network utilization)	Present Quarterly Report of Specialty & Ancillary Utilization, including OON analysis	PBI 12378 Network Tab	UM Medical Director / UM Director	Quarterly	UMC - quarterly
Unused Authorizations	Present Quarterly Report of Unused Authorizations	PBI 13521 Util vs NonUtil % tab	UM Medical Director / UM Director	Quarterly	UMC - quarterly
Bedhold Utilization (SNF - skilled, custodial)	Present Quarterly Report of Bedhold Authorizations	PBI LTC 14236	UM & LTSS Director	Quarterly	UMC - quarterly
Behavioral Health Underutilization of Services	<i>pending - establishing baselines</i>	Auth volumes report	UM BH Manager	Quarterly	UMC Quarterly
Grievance & Appeals					
Grievance & Appeals (volume and overturn rates)	Quarterly Report of Grievance & Appeals Analysis	Grievance and Appeal Report	Manager, G&A	Quarterly	UMC - quarterly
Potential Quality Issues (PQIs)					
Provider Preventable Condition Monitoring	100% of PPCs reported to QI team as PQIs	QI Report/Tracker (by referral sources) / Analytics report (with list of codes for PPCs crosswalked with logged PQI) - <i>in development</i>	Quality Improvement / UM & LTSS Director	Quarterly	Semi-annual
Member and Provider Experience with UM					
Member Satisfaction (CAHPS) <i>Medi-Cal Adult & Child, Group Care Adult</i>	Year-over-year improvement in the below categories: Getting Care Quickly Getting Needed Care Coordination of Care	CAHPS results (MY2024)	Sr. Director, HCS	Annually	UMC - annually
Provider Satisfaction (Provider Survey)	Year-over-year improvement in the below categories: Access to UM Staff Obtaining Pre-Auth Info Timeliness of Pre-Auth Info Facilitation of Care Coverage of Prevention	Provider Satisfaction Survey (MY2025)	Sr. Director, HCS	Annually	UMC - annually
Community Advisory Committee Insights	Present Quarterly report of Community Advisory Committee Insights	Community Advisory Committee Report	Director, Population Health	Quarterly	UMC - quarterly
Evaluation of Delegated Utilization Management					
Delegation Oversight - Audit & Corrective Action monitoring	100% timely review, analysis, and attestation completion for Delegate audits & corrective action plans	Delegation Oversight Auditing Templates	Delegation Oversight / UM Director	Quarterly	UMC - quarterly

Performance Measure	2025 Goal	Supporting Document / Report	Responsible Staff	Timeframe for completion	Committee & Reporting Frequency
Delegation Oversight - Standard UM monitoring	100% timely review, analysis, and attestation completion for Delegate UM reports (monthly, quarterly, annually)	Delegation Oversight Reporting Templates	Delegation Oversight / UM Director	Monthly, Quarterly, Annually (depending on report)	N/A - operational
Regulatory, Compliance, Accreditation Findings					
DHCS - Corrective Action Plans for UM Activities	100% timely participation and response to DHCS UM Findings and/or Corrective Action Plans and associated activities	DHCS Findings / CAP Report	Sr. Director, Health Care Services	as needed	UMC - as needed
DMHC - Corrective Action Plans for UM Activities	100% timely participation and response to DMHC UM Findings and/or Corrective Action Plans and associated activities	DMHC Findings / CAP Report	Sr. Director, Health Care Services	as needed	UMC - as needed
NCQA - Corrective Action Plans for UM Activities	100% timely participation and response to NCQA UM Findings and/or Corrective Action Plans and associated activities	NCQA Findings / CAP Report	Sr. Director, Health Care Services	as needed	UMC - as needed
UM Processes					
Accuracy of Published UM content	100% timely completion of platform audits	Member and Provider Portals (public and secure site), Platform Audit Results	Sr. Director, HCS	As needed, and at least Annually	N/A - operational
Accuracy of Member and Provider Communications related to UM Process	100% participation in creation or updates to member and/or provider-facing content for UM activities (including NOAs, EOC, Provider Manual, Website, Portals)	Member- and Provider-facing communications	Sr. Director, HCS	As needed, and at least Annually	N/A - operational
Transitional Care Services - Completion of Discharge Risk Assessment for High-Risk Members <i>(definition of high-risk per DHCS PHM Policy Guide)</i>	≥ 95% audit score	Internal File Review Audits (audit element: discharge risk assessment completed for "high-risk" member admitted to inpatient facility)	IP UM Manager	Monthly	N/A - operational
Continuity of Care (MER & OON requests) Reporting	100% timely review, analysis, and submission of COC and OON sections in DHCS Quarterly Monitoring Report	DHCS Quarterly Monitoring Reports	Sr. Director, HCS	Quarterly	N/A - operational
CBAS utilization (including ERS) Reporting	100% timely review and submission of DHCS CBAS Monitoring Report	DHCS Quarterly CBAS Reports	OP UM Manager	Quarterly	N/A - operational
Major Organ Transplant Reporting	100% timely review of operational MOT reports	Internal MOT Reports	OP UM Manager	Monthly	N/A - operational
MCP Transition Post-Transitional Monitoring (PTM) Reporting	100% timely review and submission of DHCS MCP Transition PTM Reports	DHCS Quarterly MCP Transition Post-Transition Reports	Sr. Director, HCS	per DHCS schedule	N/A - operational
LTSS Post-Transitional Monitoring (PTM) Reporting	100% timely review and submission of DHCS LTSS PTM Reports	DHCS Quarterly LTSS Post-Transition Reports	LTSS Director/Manager	per DHCS schedule	N/A - operational
Administrative					
Annual Review of UM Staffing	Timely and accurate submission of staffing review, including applicable justifications	Staffing Worksheets	Sr. Director, HCS	Annually, by Q1 2025	N/A - operational
Clinical Information System Enhancements	100% participation in TruCare Steering Committee and Authorization Enhancement Project Deliverables	Authorization Enhancement Project Work Plan	Sr. Director, HCS	Continuously	N/A - operational
MCG Auto-Authorization Implementation	100% participation in launching MCG Auto-Authorization, phase I	MCG Auto-Authorization SOW	Sr. Director, HCS	Continuously, through project lifecycle	N/A - operational

ALAMEDA ALLIANCE FOR HEALTH

QUALITY IMPROVEMENT HEALTH EQUITY PROGRAM EVALUATION 2024

2024 Quality Improvement Health Equity Program Evaluation Signature Page

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Introduction

Alameda Alliance for Health (Alliance) is a local, public, not-for-profit managed care health plan committed to making high-quality health care services accessible and affordable to County residents. The Alliance staff and provider network reflect the county's cultural and linguistic diversity. Established in January 1996, the Alliance was created by the Alameda County Board of Supervisors for county residents. The Alliance currently provides health care coverage to over 412,732 children and adults through its programs.

Under the leadership and strategic direction established by the Board of Governors (BOG), senior management and the Quality Improvement Health Equity Committee (QIHE), the 2024 Quality Improvement Health Equity (QIHE) Program was successfully implemented. This report serves as the annual evaluation of the effectiveness of the program activities.

The processes and data reported covers activities conducted from January 1, 2024, through December 31, 2024.

Mission, Vision, and Values

Mission

Improving the health and well-being of our members by collaborating with our provider and community partners to deliver high quality and accessible services.

Vision

All residents of Alameda County will achieve optimal health and well-being at every stage of life.

Values

Teamwork: We actively participate, support each other, develop local talent, and interact as one team.

Respect: We put people first, embracing diversity and equity, striving to create a positive work environment, excellent customer service, and value all people's health and well-being.

Accountability: We work to create and maintain efficient processes and systems that minimize barriers, maximize access, and sustain high quality.

Commitment & Compassion: We are empathic and care for the communities we serve including our members, providers, community partners and staff.

Knowledge & Innovation: We collaborate to find better ways to address the needs of our members and providers by proactively focusing innovative resources on population health and clinical quality.

Scope of the 2024 Quality Improvement Health Equity Program Evaluation

The Alliance's Quality Department is designed to monitor the quality of clinical care and health care service delivery to all Alliance members. The structure provides ongoing reviews of activities and identifies opportunities to improve the quality of care provided, fosters financial stewardship to the health plan, and collaborates with internal and external stakeholders to deliver high quality and accessible health care. Further, the department fosters consistency in quality assessment and improvement to the health care system while:

- Adopting and integrating community health priorities, standards, and goals that impact the health of Alliance's members.
- Identify and target improvement to improve access, care, and service.
- Identify overuse, misuse, and underuse of health care services.
- Identify opportunities to improve patient safety and care.
- Address quality issues, both potential and tangible.
- Monitor data trends that display variations in services or disparities in care.

The Quality Department set goals designed to improve quality and the effectiveness of clinical care served to our members:

- Primary goal: to objectively monitor and evaluate the quality, appropriateness, health equity, and outcome of care and services delivered to members of the Alliance.
- Overall goal: to ensure that members have access to quality health care services that are safe, effective, equitable, and meet their needs.

The Quality Department is structured to continuously pursue opportunities for improvement and problem resolution by:

- Monitoring services and care provided.
- Improving data and analytics to validate care outcomes.
- Peruse opportunities for improvement in areas that are important to Alliance members' care and health.
- Identify interventions when opportunities for improvement are identified.
- Improving member experience through provider access to care.

Quality Improvement Structure

QIHE Structure

The structure of the Alliance QIHE Program is designed to promote organizational accountability and responsibility in the identification, evaluation, and appropriate use of the Alliance health care delivery network for medical and mental health (MH) and behavioral health treatment (BHT) services. Also, the structure is designed to enhance communication and collaboration on QIHE program goals and objectives, activities, and initiatives that impact member care and safety both internal and external to the organization, including delegates. The QIHE Program is evaluated on an on-going basis for efficacy and appropriateness of content by Alliance staff and oversight committees.

Governing Committee

The Alameda County Board of Supervisors appoints the BOG of the Alliance, a 15-member body representing provider and community partner stakeholders. The BOG is the final decision-making authority for all aspects of the Alliance QIHE Programs and is responsible for approving the annual QIHE Program Description, Work Plan, and Program Evaluation. The BOG delegates oversight of Quality functions to the Alliance Chief Medical Officer (CMO) in collaboration with the Chief Health Equity Officer (CHEO), and the QIHEC, and provides the authority, direction, guidance, and resources to enable Alliance staff to carry out responsibilities, functions, and activities of the QIHE Program. QIHE oversight is the responsibility of the QIHEC.

The QIHEC develops and implements the QIHE program and oversees the QIHE functions within the Alliance.

The QIHEC:

- Recommends policies or revisions to policies for the operational effectiveness of the QIHE Program and the achievement of QI program objectives.
- Oversees the analysis, evaluation, and monitoring of the QI, Utilization Management (UM), Behavioral Health and Case Management (CM) programs and Work Plan activities and assesses the results.
- Ensures practitioner participation in the QIHE program activities through attendance and discussion in relevant QI committee or QI subcommittee meetings.
- Identifies needed actions, and ensures follow-up to improve quality, prioritizing actions based on their significance and provides guidance on which to choose and pursue as appropriate.
- The QIHEC meets a minimum of four times per year or as often as needed, to follow-up on findings and required actions.
- Oversees the actions of the Internal Quality Sub-Committee, Utilization Management Sub-Committee, Access, and Availability Sub-Committee, and the Cultural and Linguistics Sub-Committee.

Committee Structure

The BOG appoints and oversees the QIHEC which, in turn, provides the authority, direction, guidance, and resources to enable Alliance staff to carry out the QIHE Programs. The BOG also

oversees the Peer Review Committee (PRC) and Credentialing Committee (CC), which provides a peer review platform and a platform to review provider credentialing and re-credentialing. Committee membership is made up of provider representatives from the Alliance contracted networks and the Alliance community including, those who provide health care services to members with Mental Health and Behavioral Health Treatment, Seniors, and Persons with Disabilities (SPD) and chronic conditions.

The QIHEC provides oversight, direction, recommendations, and final approval of the QIHE Program documents. Committee meeting minutes are maintained summarizing committee activities and decisions and are signed and dated.

QIHEC charters a sub-committee, the Internal Quality Improvement Sub-Committee (IQIC) which serves as a forum for the Alliance to evaluate current QIHE activities, processes, and metrics. The IQIC also evaluates the impact of QIHE programs on other key stakeholders within various departments and when needed, assesses, and plans for the implementation of any needed changes. QIHEC assumes responsibility for oversight of the IQIC activities and monitoring its areas of accountability as needed. The structure of the committee meetings is designed to increase engagement from all participants.

The major committees that support the quality and utilization of care and service include:

- Quality Improvement Health Equity Committee (QIHEC)
- Peer Review Committee (PRC) and Credentialing Committee (CC)
- Community Advisory Committee (CAC)
- Pharmacy and Therapeutics (P&T) Sub-committee
- Utilization Management (UM) Sub-committee
- Access and Availability Sub-committee
- Internal Quality Improvement Sub-committee (IQIC)
- Cultural and Linguistic Services Sub-committee
- Additionally, Joint Operations Meetings (JOMs) support the quality improvement work of the Alliance. Each committee meets at least quarterly, some monthly, and all committees / sub- committees, except the PRCC, CAC, and P&T committees, report directly to the QIHEC. The PRC and CC, CAC, and P&T report directly to the BOG. Each committee continues to meet the goals outlined in their charters, as applicable. The QIHEC membership includes practitioners representing a broad range of specialties, as well as Alliance leadership and staff.

Evaluation of Senior-Level Physician and Behavioral Health Practitioners

The BOG delegates oversight of QI, CM and UM functions to the QIHEC which is chaired by the Alliance CMO in collaboration with the CHEO, and vice-chaired by the Medical Director of Quality. The CMO, CHEO, and Medical Director provide the authority, direction, guidance, and resources to enable Alliance staff to carry out the QIHE Program. The CMO delegates senior level physician involvement in appropriate committees to provide clinical expertise and guidance to program development.

The committee is comprised of multiple physician representatives and includes CMOs of partner delegate groups. A psychiatrist and CMO of Alameda County Behavioral Health Care (ACBH), actively participates in the QIHEC meetings and provides clinical input ensuring policies and reports considered behavioral health implications. The active involvement of senior-level physicians including the psychiatrist from Alameda County Behavioral Health (ACBH) has provided consistent input into the quality program. Their participation helped ensure that the Alliance is meeting accreditation and regulatory requirements. The Senior Director of Behavioral Health at Alameda Alliance for Health is also an active participant of the QIHE Program.

Program Structure and Operations

The Alliance QIHE Program encompasses quality of care across the Alliance enterprise and across the health care continuum.

2024 QIHE Program activities included, but were not limited to the following:

- Evaluation of the effectiveness of the QIHE program structure and oversight.
- Implementation and completion of ongoing QIHE activities that addressed quality and safety or clinical care and quality of service.
- Trending of measures to assess performance in the quality and safety of clinical care and quality of service.
- Analysis of QIHE initiatives and barriers to improvement.
- Monitoring, auditing, and evaluation of delegated entities QIHE activities for compliance with contractual requirements with the implementation of corrective action plans as appropriate.
- Internal monitoring and auditing of QIHE activities for regulatory compliance and assurance of quality and safety of clinical care and quality of service.
- Development and revision of department policies, procedures, and processes as applicable.
- Development and implementation of direct and delegate network corrective action plans because of non-compliance and identified opportunities for improvement, as applicable.

QI Resources

The Alliance QI Department key staff included licensed physicians and registered nurses, qualified non-clinical management staff, as well as non-clinical specialist staff and non-clinical administrative support coordinators. The assignment and performance of work within the team, whether working on site or remotely, for both clinical and non-clinical activities, is seamless to the Alliance operations processes. Established job description expectations with assigned tasks and responsibilities remain unchanged regardless of the geographical location of staff member.

The QIHE program moved forward in providing quality improvement guidance enterprise-wide meeting regulatory and accreditation standards and promoting positive health outcomes for the Alliance membership. New positions were hired in fiscal year 24/25: 1) QI Engagement Coordinators to conduct outreach to members to complete all preventive screenings and 2) QI Review Nurse to conduct facility site reviews and support Skilled Nursing Facility/Long Term

Care quality monitoring. QI, Health Care Services, and the Alliance continue to evaluate staff turnover and strive to provide a positive work environment while creating a stable work force.

Throughout 2024, vendor partnerships were a part of the QI resource strategy. The QI department continued to augment QI resources via consultants and analytic expertise for the Healthcare Effectiveness Data and Information Set (HEDIS) program.

Additionally, the Alliance maintained its strong relationship with healthcare services support and survey vendor, Press Ganey (PG) Analytics. Press Ganey supported the QI Department work with implementation, analysis, and reporting on the following surveys:

- Afterhours and Emergency Instruction Survey
- Member Satisfaction Survey (CAHPS 5.1H, CG CAHPS)
- Provider Satisfaction Survey
- To support Dual Special Needs Population (DSNP) implementation, the following surveys were initiated as new scope of work to launch in 2025:
 - Medicare CAHPS simulation
 - Health Outcomes Questionnaire

Membership and Provider Network

Membership

The Alliance product lines include Medi-Cal managed care and Group Care commercial insurance. Medi-Cal managed care beneficiaries, eligible through one of several Medi-Cal programs, e.g. Seniors and Persons with Disability (SPD), Medi-Cal Expansion, Long-Term Care and Dually Eligible Medi-Cal members. For dually eligible Medi-Cal and Medicare beneficiaries, Medicare remains the primary insurance and Medi-Cal benefits are coordinated with the Medicare provider.

Alliance Group Care is an employer-sponsored plan offered by the Alliance. The Group Care product line provides comprehensive health care coverage to In-Home Supportive Services (IHSS) workers in Alameda County.

Trended Enrollment by Network and Aid Category

Current Membership by Network by Category of Aid						
Category of Aid	Nov-24	% of Medi- Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN
Adults	62,582	15.57%	12,962	14,232	5	35,383
Child	109,832	27.33%	9,506	13,553	41,055	45,718
SPD	35,738	8.89%	11,711	5,682	1,450	16,895
ACA OE	151,520	37.71%	26,900	53,058	1,540	70,022
Duals	40,616	10.11%	26,562	2,929	5	11,120
LTC	1,269	0.32%	1,268			1
LTC-Dual	255	0.06%	239	7		9
Total Medi-Cal:	401,812	100%	89,148	89,461	44,055	179,148
Total: Group Care:	5,586		2,147	939	0	2,686
Total	407,398	100%	91,295	90,400	44,055	181,834
Medi-Cal %	98.63%		97.65%	98.96%	100.00%	98.52%
Group Care %	1.37%		2.35%	1.04%	0.00%	1.48%
			22.41%	22.19%	10.81%	44.63%
			% Direct:	45%	% Delegated:	55%

2024 Trended Categories of Aid, Distribution and Growth/Loss

Category of Aid Trend											
Category of Aid	Members				% of Total (ie. Distribution)				% Growth (Loss)		
	Nov-2022	Nov-2023	Oct-2024	Nov-2024	Nov-2022	Nov-2023	Oct-2024	Nov-2024	Nov 2022 to Nov 2023	Nov 2023 to Nov 2024	Oct 2024 to Nov 2024
Adults	50,124	52,215	62,638	62,582	15.37%	14.76%	15.40%	15.36%	4.2%	19.9%	-0.1%
Child	101,680	101,660	109,879	109,832	31.19%	28.74%	27.02%	26.96%	0.0%	8.0%	0.0%
SPD	28,505	31,018	35,535	35,738	8.74%	8.77%	8.74%	8.77%	8.8%	15.2%	0.6%
ACA OE	117,051	120,761	151,048	151,520	35.90%	34.14%	37.14%	37.19%	3.2%	25.5%	0.3%
Duals	22,889	41,381	40,488	40,616	7.02%	11.70%	9.96%	9.97%	80.8%	-1.8%	0.3%
LTC-Dual	0	986	1,263	1,269	0.00%	0.28%	0.31%	0.31%		28.7%	0.5%
LTC	0	139	250	255	0.00%	0.04%	0.06%	0.06%		83.5%	2.0%
Medi-Cal Total:	320,249	348,160	401,101	401,812	98.22%	98.42%	98.62%	98.63%	8.7%	15.4%	0.2%
Group Care Total:	5,791	5,586	5,607	5,586	1.78%	1.58%	1.38%	1.37%	-3.5%	0.0%	-0.4%
Total Membership:	326,040	353,746	406,708	407,398	100.00%	100.00%	100.00%	100.00%	8.5%	15.2%	0.2%

2024 Trend Enrollment by Age Category

Age Category	Members				% of Total (Distribution)				% Growth (Loss)		
	Nov-22	Nov-23	Oct-24	Nov-24	Nov-22	Nov-23	Oct-24	Nov-24	Nov-22	Nov-23	Oct-24
									to	to	to
									Nov 2023	Nov 2024	Nov 2024
Under 19	103,974	104,107	112,347	112,273	32%	29%	28%	28%	0%	8%	0%
19 - 44	119,089	122,783	152,338	152,599	37%	35%	37%	37%	3%	24%	0%
45 - 64	68,279	72,981	84,403	84,501	21%	21%	21%	21%	7%	16%	0%
65+	34,698	53,875	57,782	58,209	11%	15%	14%	14%	55%	7%	1%
Total	326,040	353,746	406,870	407,582	100%	100%	100%	100%	8%	15%	0%

In November of 2024, the Alliance annual membership increased by 15.0% from November 2023. The Alliance experienced membership growth in all age categories from 2023 to 2024 with 8.0% growth in the Under 19 category, 24.0% growth in the 19-44 age category, 16.0% growth for 45-64 age category and 7.0% growth for the 65+ age category.

The increase in membership was due to the transition of Anthem members into Alliance, under the single plan model arrangement. In addition, the delay in member disenrollments from health plans by the state also contributed to the growth in membership.

Provider Network

Medical services are provided to beneficiaries through contracted provider networks. Currently, the Alliance provider network includes:

2024 Provider Network by Type, Enrollment and Percentage

PROVIDER NETWORK	PROVIDER TYPE	Line of Business	MEMBERS (ENROLLMENT)	% OF ENROLLMENT IN NETWORK
Direct-Contracted Network	Independent	GroupCare	2,142	0.52%
Direct-Contracted Network	Independent	Medi-Cal	93,942	22.78%
Alameda Health System (AHS)	Managed Care Organization	GroupCare	946	0.23%
Alameda Health System (AHS)	Managed Care Organization	Medi-Cal	89,539	21.71%
Children First Medical Group (CFMG)	Medical Group	Medi-Cal	44,124	10.70%
Community Health Clinic Network (CHCN)	Medical Group	GroupCare	2,703	0.66%
Community Health Clinic Network (CHCN)	Medical Group	Medi-Cal	179,022	43.41%
TOTAL			412,418	100%

The Alliance offers a comprehensive health care delivery system, including the following scope of services:

- Ambulatory care
- Hospital care

- Emergency Services
- Mental Health
- Home Health Care
- Hospice
- Palliative Care
- Rehabilitation Services
- Skilled Nursing Services
- Long-Term Services and Support (LTSS)
- Community Based Adult Services
- Enhanced Care Management and Community Support
- Long Term Care (custodial, Subacute care, and Intermediate Care Facility for the Developmentally Disabled (ICF/DD) facilities)
- Transportation
- Pharmacy

Care coordination along the continuum of care includes arrangements for linked and carved out services, programs, and agencies. These services are provided through a network of contracted providers inclusive of hospitals, nursing facilities, ancillary providers, and service vendors. The providers/vendors are responsible for specifically identified services through contractual arrangements and delegation agreements.

The Alliance provider network includes:

Alliance Ancillary Network

Ancillary Type	Count
Behavioral Health Network	Individuals: 2,607
Durable Medical Equipment (DME) Vendor	1 Capitated, 12 Non-Capitated
Health Centers (FQHCs)	83
Hospitals	17
Pharmacies/Pharmacy Benefit Manager (PBM)	Over 200
Skilled Nursing and Long Term Care Facilities	106
Transportation Vendor	1 Individual Vendor with 380 Individual Transportation Providers

Alliance members may choose from a network of over 500 Primary Care Practitioners (PCPs), more than 9,000 specialists, 17 hospitals, 83 health centers, 106 skilled nursing and long term care facilities, and more than 200 pharmacies throughout Alameda County. The Alliance demonstrates that the managed care model can achieve the highest standard of care and successfully meet the individual needs of health plan members. Our members' optimal health is

always our priority.

The Alliance QIHE Program strives to ensure that members have access to quality health care services.

Health Plan Quality Performance

HEDIS Performance

The Alliance is committed to ensuring the level of care provided to all enrollees meets professionally recognized standards of care and is not withheld or delayed for any reason. The Alliance adopts, re-adopts, and evaluates recognized standards of care for preventive, chronic and behavioral health care conditions. The Alliance also approves the guidelines used by delegated entities. Guidelines are approved through QIHEC. Adherence to practice guidelines and clinical performance is evaluated primarily using standard Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS is a set of national standardized performance measures used to report on health plan performance in preventive health, chronic condition care, access, and utilization measures. The California Department of Health Care Services (DHCS) requires all Medicaid plans to report a subset of the HEDIS measures. Preliminary 2024 Medicaid administrative rates are noted below. Minimum Performance Level (MPL) and High-Performance Level are determined by the Medi-Cal Managed Care Division.

Medicaid Administrative HEDIS Rates

NCQA Acronym	Measure Description	2023 Admin Rates	2023 Hybrid Rates	2024 Admin Rates	MPL	Measure Type
Behavioral Health						
FUA1	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 30 Day	38.90%		42.37%	36.34%	Administrative
FUM1	Follow-Up After Emergency Department Visit for Mental Illness - 30 Day	54.69%		28.52%	54.87%	Administrative
Children's Domain						
CIS10	Childhood Immunization Status - Combo 10	41.24%	45.74%	37.07%	27.94%	Administrative / Hybrid
IMA	Immunizations for Adolescents - Combo 2	49.27%	47.69%	47.86%	34.30%	Administrative / Hybrid
LSC	Lead Screening in Children	60.78%	61.31%	66.72%	63.84%	Administrative / Hybrid
DEV	Developmental Screening in the First Three Years of Life	54.39%		63.61%	35.70%	Administrative / Hybrid
TFL	Topical fluoride for Children Rate 1 – dental or oral health	14.13%		14.68%	19.00%	Administrative / Hybrid

	services					
W30	Well-Child Visits in the First 15 Months of Life - 6 or More Visits	58.67%		64.74%	60.38%	Administrative
W30	Well-Child Visits for Age 15 Months to 30 Months - Two or More Visits	74.03%		77.65%	69.43%	Administrative
WCV	Child and Adolescent Well-Care Visits	56.30%		55.56%	51.81%	Administrative
Chronic Disease						
AMR	Asthma Medication Ratio	69.88%		68.55%	66.24%	Administrative / Hybrid
GSD 2	HbA1c Control (>9.0%)	32.06%		33.85%	33.33%	Administrative / Hybrid
CBP	Controlling High Blood Pressure	48.85%	65.21%	50.21%	64.48%	Administrative / Hybrid
Women's Health						
BCS	Breast Cancer Screening	59.59%		59.63%	52.68%	Administrative
CCS	Cervical Cancer Screening	58.33%	60.58%	49.77%	57.18%	Administrative / Hybrid
CHL	Chlamydia Screening in Women	67.14%		69.95%	55.95%	Administrative
PPC1	Timeliness of Prenatal Care	85.90%	90.87%	86.16%	84.55%	Administrative / Hybrid
PPC2	Timeliness of Postpartum Care	86.74%	89.95%	85.99%	80.23%	Administrative / Hybrid

Analysis of HEDIS Medicaid Managed Care Accountability Set (MCAS)

In Measurement Year (MY) 2024, the Alliance observed improvements in some HEDIS/MCAS rates, while a few measures declined compared to MY2023. The most significant barriers to measures falling below the Minimum Performance Level (MPL) include data discrepancies, the transition to a single-plan county, and the adult expansion in 2024.

Despite these challenges, the Alliance has achieved notable improvements in several HEDIS/MCAS measures from MY2023 to MY2024, including:

- **Follow-Up after Emergency Visit for Alcohol and Other Drug Dependencies (FUA)**
- **Lead Screening in Children (LSC)**
- **Well-Child Visits 0-15 months (W30)**
- **Well-Child Visits and 15-30 months (W30)**
- **Chlamydia Screening in Women (CHL)**

These gains result from provider education and support, member and provider incentive programs, and data mining efforts.

Preliminary MY2024 administrative rates indicate a few areas where the Alliance falls short of the MPL:

- **Follow-Up After Emergency Visit for Mental Health (FUM)**
- **Topical Fluoride for Children (TFL)**
- **HbA1c Control (>9.0) (GSD 2)**
- **Controlling High Blood Pressure (CBP)**
- **Cervical Cancer Screening (CCS)**

The primary factor affecting FUM and TFL rates is data integrity. While Alameda County provided some FUM data, system upgrades have led to missing information. The Alliance expects an increase in FUM rates once complete data is integrated. For TFL, key challenges include a shortage of dental providers in Alameda County and inconsistent coding for TFL services. Although the Alliance quality team has worked with FQHC medical providers on proper coding, many non-FQHC providers rely on the county's dental network, which the Alliance does not oversee. Additionally, providers report that members have barriers to accessing dental care in Alameda County. While the number of Primary Care Providers (PCPs) offering TFL services has increased, many are reluctant to provide the service for children over five since it is not reimbursed.

The Alliance remains committed to improving HEDIS/MCAS rates to meet or exceed the MPL. Our comprehensive quality strategy includes:

- Expanding access to care
- Strengthening provider engagement
- Enhancing member and community outreach
- Increasing educational efforts
- Focused QI projects through multidisciplinary workgroups

These initiatives will drive progress toward meeting the required 2025 milestones through internal and external collaboration.

Quality Improvement Health Equity Performance Initiatives and Projects

Overview

The Alliance's quality improvement efforts strive to impact the safety and quality of care and service provided to our members and providers. Review of the Alliance's 2024 QIHE activities as described herein demonstrates the Alliance's QI department ability (in collaboration with internal and external entities) to successfully assess, design, implement, and evaluate an effective QIHE Program including but not limited to, the following:

1. Improved focus on the importance of chronic condition management and accessing appropriate care through initiatives to educate and connect with members, direct and delegated providers, community-based organizations, state, and county entities and enhance our improvements in our internal operations.
2. Maintained a targeted focus on the analysis of key drivers, barriers, and best practices to improve access to care.
3. Expanded staff knowledge of health disparities and equity within the Alliance membership through population data collection, analysis, segmentation, and targeted quality improvement activities as part of the Population Health Management Program
4. Promoted the awareness and concepts of inter-departmental QI initiatives and activities, data-driven approaches, including Plan-Do-Study-Act (PDSA), and Inter-Rater Reliability (IRR), to:
 - a. Identify, investigate, and resolve Potential Quality Issues (PQIs).
 - b. Identify and address service over-and-underutilization.
 - c. Promote patient safety.
 - d. Remove barriers to access timely care and services.
5. Invested in quality measurement analysis expertise.
6. Monitored and demonstrated improvement in HEDIS measures.
7. Ensured timely Facility Site Review (FSR/Medical Record Review (MRR) audits and Physical Accessibility Review Surveys (PARS) in person and virtually.
8. Targeted QIHE initiatives to improve direct and delegate provider engagement in access to care efforts to improve rates of preventive care and services, screenings, and referrals for members.
9. Targeted partnerships with community-based county agencies and delegate providers to improve referral and resources triage and management through technology collaboration and support.
10. Improved engagement with interpreter services vendors and Alliance network providers to ensure quality interpreter services at all points of healthcare service contact.
11. Coordinated engagement with Behavioral Health and Care Management teams
12. Collaborated with First 5 of Alameda County and delegate provider networks to improve well-child visits (WCV) and Early Periodic Screening and Diagnostic Treatment (EPSDT)

service utilization for pediatric and adolescent members.

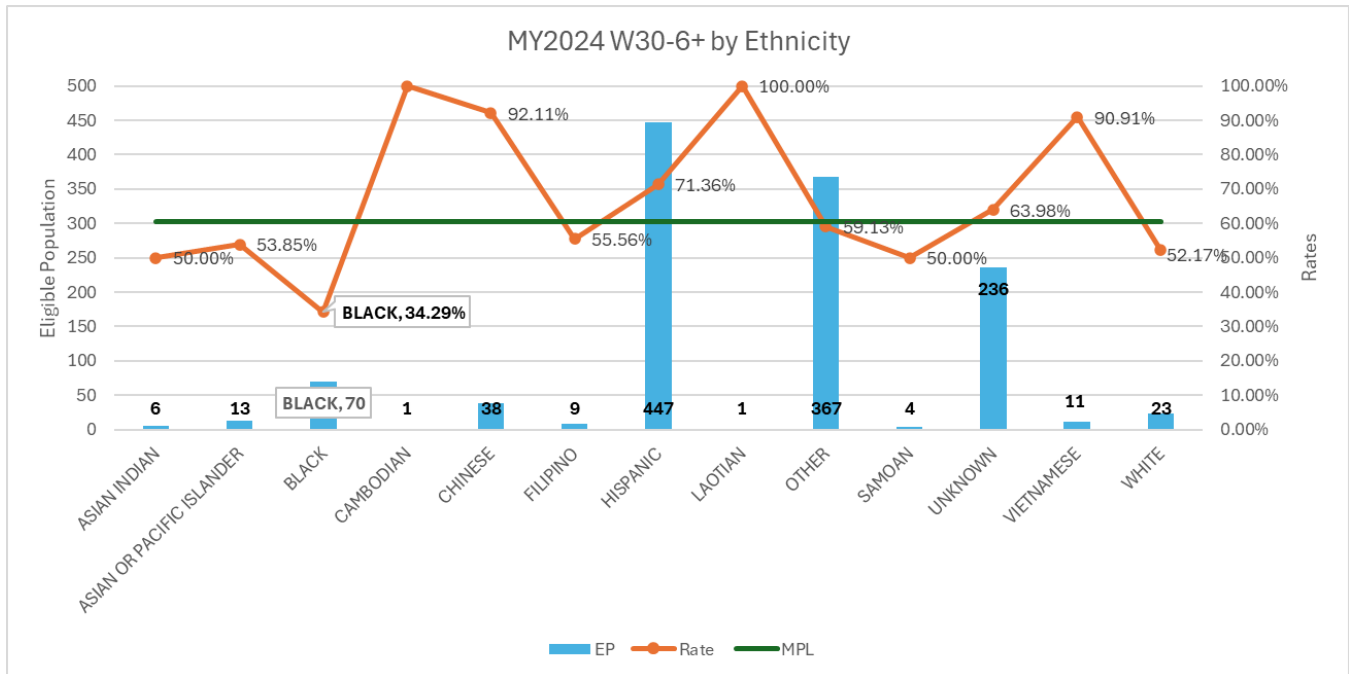
13. Provided webinars and technical assistance to providers to promote access, preventive care, chronic disease management, women's health, and behavioral health services.
14. Incorporated a health equity lens by analyzing health disparity data, member feedback on barriers and root causes, and alignment with the Population Health Strategy and Health Equity Department initiatives.

The Alliance is invested in a multi-year strategy to ensure that the organization adapts to health plan industry changes now and within 3 - 5 years. An effective QIHE program with commitment across all entities is essential to the Alliance's successful adaptation to expected changes and challenges.

Equity Performance Improvement Project (PIP) (2023 – 2026) – Well Child Visit in the First 15 Months of Life - (W30 6+)

The Department of Health Care Services (DHCS) has reported a concerning trend of lower rates of well-child visits for African American children aged 0-15 months. As a result, the Equity Performance Improvement Project (PIP) topic for MY2023-MY2026 is focused on enhancing well-visit rates for African American children in this age group. In MY2023, the Alliance submitted population size and baseline data for African American children aged 0-15 months residing in Alameda County and a member of the Alliance to DHCS, and the PIP topic was accepted as an equity project through 2026.

The chart below indicates that the Well Child Visits in the First 30 Months of Life (W30-6+) score for Black/African American children ages 0-15 falls below the Minimum Performance Level (MPL). When comparing the Black population with other demographic groups in the Alliance population, the rates for Black children are significantly lower. The Alliance recognizes an opportunity to improve the current scores for Black children to reach or exceed the MPL of 55.72%. As the first step in the PIP process the Alliance is conducting barrier analysis through member surveys to help inform the Alliance and providers on barriers members encounter to completing well visits. In partnership with First 5 Alameda County, the Alliance conducted member surveys targeting African American families to help understand barriers to completing appointments. The results of the survey revealed transportation was a barrier to completing well visits.

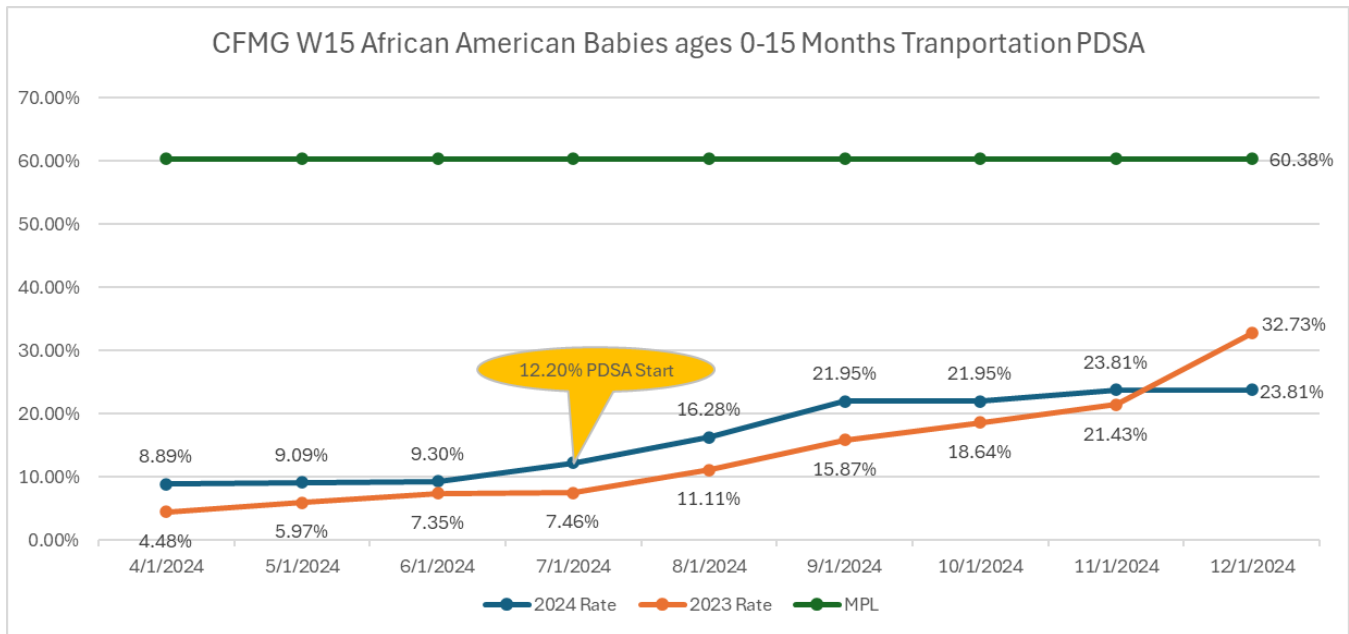


2024 Intervention

Alameda Alliance for Health, in partnership with First 5 Alameda County, implemented a Plan-Do-Study-Act (PDSA) cycle to improve well-child visit completion rates among Black/African American children aged 0-15 months. This outreach intervention specifically targeted families assigned to Children’s First Medical Group (CFMG), providing information on the Alliance transportation benefit and educating them on the importance of well-child visits. The PDSA cycle was conducted from July 15, 2024, to December 31, 2024, focusing on 41 African American children within the age group.

2024 Results

- Of the 41 members identified, 5 had invalid phone numbers, reducing the outreach population to 36 members.
- 10 members completed at least one well-child visit after the outreach.
- 7 members utilized the Alliance transportation benefit between July and November 2024.
- The chart below shows CFMG’s rates for African American members 0-15 months, a month-over-month improvement is display comparing MY2024 to MY2023.
- The preliminary well-child visit rate for CFMG African American children (0-15 months) is 23.81%. This data will be further analyzed once all MY2024 claims are submitted.
- The overall Alliance well-child visit rate for African American children (0-15 months) is 63.87%, reflecting a 5.2% improvement in MY2024 from MY2023.



Nonclinical Performance Improvement Project (PIP) (2023-2026) – Improve the Percentage of Provider Notifications for Members with SUD/SMH Diagnoses Following or Within 7 Days of Emergency Department (ED) Visit

When a member seeks care in the Emergency Department (ED) for either substance use disorder (SUD) or mental health conditions, it is typically because they are in crisis or in need of assistance not currently provided by their regular providers. During such crises or urgent situations, there's an opportunity for intervention if the member can relate to the appropriate services and receive timely follow-up care. Without such follow-up, members are more likely to return to the ED, and their SUD or mental health conditions often worsen when consistent treatment is not initiated. Therefore, the Department of Health Care Services (DHCS) has identified Follow-up After Emergency Department Visit for Substance Use or Mental Health as the nonclinical Performance Improvement Project (PIP) for 2023 – 2026.

For the nonclinical PIP, DHCS has allowed managed care plans to choose from three topics:

1. Improve the percentage of provider notifications for members with SUD/SMH diagnoses following or within 7 days of an emergency department (ED) visit.
2. Enhance the percentage of referrals to Community Support programs (such as Sobering Centers, Day Habilitation programs) within 7 days of visiting the ED for members with a SUD/SMH diagnosis and seen in the ED for the same diagnoses.
3. Increase the percentage of members enrolled in care management, complex care management (CCM), or enhanced care management (ECM) within 14 days of a provider visit where the member was diagnosed with SMH/SUD.

The Alliance has selected topic number one: to improve the percentage of provider notifications for members with SUD/SMH diagnoses following or within 7 days of an ED visit. This choice was made because a notification system to ensure providers are aware that their patients had an ED visit is crucial and represents the first step in following up with patients.

In the chart below, MY2022 rates for Follow-up After ED Visit for Substance Use or Mental Health (FUA/FUM) within 7 days are low. Therefore, the Alliance believes that by increasing provider notifications, the rates for FUA/FUM within 7 days will also increase.

Measure	Number of Events	Notified Provider within 7 Days	Rate
Follow-Up After Emergency Department Visit for Substance Use (FUA)	1,700	37	2.18%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	1,591	44	2.77%

2024 Intervention

There were two interventions tested for this PIP in 2023 - 2024:

- ADT report-based provider notification
- ED claims-based provider notification

ADT report-based provider notification

Primary care providers are usually not aware when their assigned members visit the emergency department due to the hospital and the PCP provider being in different health care systems. This lack of notification creates a barrier for the provider to follow up with the member within 30 days. Thus, from 01/01/2023 – 06/30/2023, the Alliance Analytics teams created a report based on hospital admit, discharge, and transfer (ADT) data to identify members who were seen for a condition that qualified them to be included in the FUA or FUM measure. Reports were then sent to providers via Secure File Transfer Protocol (SFTP) daily. Through this intervention the Alliance notified PCP providers when their assigned member visits the ED within 7 days to facilitate a timely follow up. After evaluating this intervention, the Alliance learned that the ADT data is not an effective source for notifying providers. In June 2023, the Alliance Analytics team analyzed the ADT feed and found that it identified less than 10% of visits eligible for follow-up. The Alliance decided to modify this intervention after June 2023, by switching from using ADT data to using ED claims data to notify providers.

ED claims-based provider notification

From 07/01/2023 - 12/31/2023, this intervention utilized ED claims data instead of ADT feeds to identify members who meet the criteria for FUA and FUM measures. Under this revised process, the Alliance Analytics team extracted ED claims data daily, identifying members who had a qualifying visit and met HEDIS measurement criteria. These reports were then sent to PCPs via SFTP to facilitate timely outreach and follow-up care within the required 7-day timeframe. After evaluating this intervention, the Alliance has discovered that ED Claims data provides a more comprehensive report to providers of the eligible population. The claims data captures all the members who are eligible for follow up for both the FUA & FUM measure. The Alliance has seen

an increase in the 7-day notification rate to providers since switching to using ED claims data. When the Alliance was using ADT data to notify PCPs of ED events that required follow up, the 7-day notification rate for both the FUA and FUM measure was 0%. Since using the ED claims data, the 7-day notification rate is 13.56% for FUA and 12.46% for FUM.

2024 Results

Between January 1, 2024, to December 31, 2024, there were 1784 ED visits in the eligible populations for FUA and 1675 ED visits in the eligible populations for the FUM measure. Among the 1784 ED visits eligible for follow up for FUA, there were 104 ED visits where the member's PCP received a notification within 7 days. Among the 1675 ED visits eligible for follow up for FUM, there were 88 ED visits where the member's PCP received a notification within 7 days. Thus, the Alliance's FUA 7-day provider notification rate 5.83% and FUM 7-day provider notification rate is 5.25%.

Measure	Number of Events	Notified Provider within 7 Days	Rate
Follow-Up After Emergency Department Visit for Substance Use (FUA)	1,784	104	5.83%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	1,675	88	5.25%

Initial Health Appointment (IHA) Rates & Audits

The Alliance continues to make outreach efforts to encourage members to schedule Initial Health Appointments (IHA). These efforts include Interactive Voice Recordings (IVR), reminders through New Member Letters and member orientation. Additionally, the Alliance provides IHA reports to help providers identify members who are newly enrolled or re-enrolled and regularly educates providers on IHA guidelines through provider meetings, webinars and newsletters.

The preliminary rates for 2024 indicate a slight decrease. The decline can be attributed to the departure of Kaiser members and addition of the Anthem and Adult Expansion members. Furthermore, due to claims lag and 120-day timeframe for completion, quarters 3 and 4 data is not finalized. The Alliance will continue to strategize opportunities for improving IHA rates.

Audit of Initial Health Appointments via FSR/MRR

IHAs include History and Physical (H&P). An IHA must be completed within 120 days of member plan enrollment or PCP effective date (whichever is more recent) or documented within the 12 months prior to plan enrollment/PCP effective date.

Alliance reviewed records of IHA for members eligible for IHA criteria. IHA was also reviewed for newly enrolled members who presented for well care visits at the provider's office. In 2024, medical records at 54 sites were reviewed for the presence of an IHA. During the MRR, there were at least 30% of records reviewed or members eligible for IHA. The Table below lists the results of these reviews. There was a total of 54 IHA charts audited and 67% (36) were compliant with the required elements. The 18 total non-compliant providers received CAPs and re-

education/training on IHA compliance.

2024 MRR Results

TYPE	Q1	Q2	Q3	Q4	TOTAL
Total IHAs Audited via FSR	6	20	15	13	54
# of MRRs with Compliant* IHAs	4 (66%)	14 (70%)	9 (60%)	9 (69%)	36 (67%)
# of MRRs with Non-Compliant IHAs (CAPS)	2	6	6	4	18 (33%)

**Compliant = Per DHCS CAP guidelines, no CAP issued if MRR score is 90% or greater and 80% or greater on Pediatric/Adult Preventive section.*

IHA Audit

The Alliance conducted 2 audits of the Initial Health Appointments (IHA). A random sample of member charts were selected, and medical records were requested to review the IHA elements, including:

- Comprehensive physical and mental exam
- Identification of risks
- Preventive care
- Health Education
- Diagnoses and plan of care

In 2024, 30 charts were requested, 30 received. The following were the results of the IHA audit:

- Adults – 15charts reviewed, 47% of elements completed.
- Children – 8 charts reviewed, 63% of elements completed.
- Adolescents – 5 charts reviewed, 78% of elements completed.

To improve IHA compliance rates, the Alliance worked to:

- Ensure member education – through mailings, member orientation and outreach.
- Improve provider education – through provider manual and newsletter/packets, Joint Operational Meetings (JOMS), QIHEC meeting, provider site visits to educate providers on timely access standards, and provider educational webinars.
- Improve data sharing – by sharing newly enrolled members in addition to gaps in care lists with delegates and providers.
- Developed an IHA Provider Guide with requirements, codes, and best practices which was shared with providers through various communication methods.
- Monitor medical records – through IHA audits, FSR/MRR site review, and monitoring of IHA rates.
- Provider webinars on IHA, preventive screenings, and chronic care management guidelines

- Ensure accountability – through corrective action plans and follow up.

Well Child Domain

The Well-Child Workgroup focused on improving performance on childhood domain measures held to the Minimum Performance Level (MPL) on the California DHCS Managed Care Accountability Set (MCAS) for MY24/RV25. The aim of the workgroup was as follows:

Alameda Alliance for Health (AAH) will improve on well-child measures in the Managed Care Accountability Set (MCAS) that are under the Minimum Performance Level (MPL), by conducting improvement projects to increase the rates from below the MPL to above the MPL and to maintain current rates, by December 31, 2024, as follows:

- Child and Adolescent Well-Care Visits (WCV), from 56.30% to 58.07%, by December 31, 2024.
- Lead Screening in Children (LSC), from 60.78% to 66.72%, by December 31, 2024.
- Well-Child Visits in the First 0-15 Months of Life (W30-6+), from 58.67% to 64.74%, by December 31, 2024.

To support these improvements, the Workgroup conducted various projects on member education, member outreach, provider education, provider collaboration, and addressing data gaps with the Analytics Department. Here are highlights of projects that helped drive improvements in the overall rates:

- HEDIS Sprint with Children First Medical Group (CFMG): The goal of this project was to meet or exceed CFMG's rates in W30-6+, W30-2+, and WCV measures by providing members, and their families, with a \$25 Target Gift Card upon completion of their well-visits. For MY24, 14 CFMG clinics collectively distributed 1,419 gift cards from June-December of 2024. As a result, CFMG exceeded the MPL in the W30-2+ and WCV measures. W30-6+ did not meet or exceed the MPL; however, CFMG had a 0.14% improvement in this rate from MY23, which may be attributed to the HEDIS Sprint project.
- Measure Highlight Tools: In MY2023 the Alliance's QI Team developed Measure Highlight Tools to help providers reference a guide on the various MCAS measure definitions, codes, best practices, and tips to meet the measures. In MY2024 these tools continued to support provider education.
- Supplemental Data for W30-6+: The QI Team partnered with the Quality Analytics Team to bridge the gap in data for the W30-6+ visits. The Alliance identified that there was a significant gap in administrative data for the first well-child visits given to newborns due to the babies' Medi-CAL Client Index Numbers (CINs) being tied to their Mother's Medi-Cal CIN. As a result, when reviewing claims or administrative data it is difficult to delineate if the visit should be attributed to the mother or the baby. To improve this data gap, the Quality Analytics Team worked with CFMG providers, who historically performed low in this measure, to collect medical records. After reviewing the medical records, the Quality Analytics Team would abstract information from encounters that met the NCQA W30 measure specifications.
- Lead Screening Point-of-Care (POC) Incentive: To improve lead screening rates, provider network groups moved towards the use of Point of Care (POC) units. Completing the

lead screening at a provider's office eliminates the need for an extra visit for members to labs and improves adherence. In MY2023 Children's First Medical Group (CFMG) supported their providers to obtain POC units. The Alliance also provided incentive payment to Community Health Center Network (CHCN) to obtain POC units. As a result both delegated entities improved lead screening rates in MY2024.

- CFMG: 10 clinics participated. CFMG's overall Lead Screening rate increased by 8.12% from MY2023.
- CHCN: 6 CHCN clinics participated. CHCN's overall Lead Screening rate increased by 3.69% from MY2023.
- Extended Office Hours (EOH) Incentive: The EOH incentive offers an incentive to providers who offer clinic hours outside of regular business hours. Regular business hours are defined as Monday-Friday, 8 a.m. – 5 p.m. If a clinic can achieve a 70% rate of Alliance members scheduled, with a 70% overall completion rate, they can be rewarded \$500 per hour. The number of hours each clinic can claim is approved by QI Leadership. This program addresses access barriers for members who cannot access care during regular business hours. Two clinics participated in the EOH Incentive, focusing on W15 and WCV, outcomes:
 - Patients scheduled: 62
 - Appointments completed: 55
 - Completion rate: 88.70%
 - **Disease Management Domain**

The Chronic Disease Workgroup focused on improving performance on measures held to the MPL on the MCAS. The aim of the workgroup was as follows:

Alameda Alliance for Health (AAH) will improve or maintain performance on chronic disease management measures in the Managed Care Accountability Set (MCAS) to meet the Minimum Performance Level (MPL), by conducting PDSA (Plan, Do, Study, Act) projects by December 31, 2024, as follows:

- Asthma Medication Ratio (AMR), maintain at least 10% performance above MPL, by December 31, 2024.
- Controlling High Blood Pressure (CBP), increase from 48.84% to 61.31%, by December 31, 2024.
- Hemoglobin A1c Control for Patients with Diabetes, decrease from 32.48% to 37.96%, by December 31, 2024.

The overall focus of projects in 2024 was on developing QI infrastructure and increasing provider knowledge of measures and best practices to meet the measure. In partnership with the Pharmacy and Analytics teams, the workgroup produced specialized gap in care reports that provided further detail on the health status of members to increase provider awareness of patient gaps. The CBP/GSD comorbidity report identified members who were diagnosed with either or both hypertension and diabetes, and included information such as the member's latest blood pressure or A1c levels, date of last primary care visit, whether the member has

received a blood pressure monitor as a covered benefit, whether the member is eligible for a Diabetes Prevention Program, and whether the member has a history of tobacco use. The AMR, GSD, and CBP medication reports respectively identified gaps in members either receiving or filling medications that help manage their conditions. These reports were sent to providers on a monthly basis to facilitate tailored interventions to improve performance rates.

One area of needed identified by network providers is staff capacity to conduct outreach. To help address this, the workgroup developed two PDSA projects and a mailing outreach campaign.

The first PDSA involved calling members who are diagnosed with hypertension, have a most recent blood pressure level above 140/90, and have not received a blood pressure monitor as a covered benefit. Contracted call center agents outreached to 105 members to inform them of their eligibility to receive a monitor and to facilitate having the monitor delivered to the member whenever possible. Of those 105 members, 21 out of the 26 members agents spoke to opted to receive a monitor, which resulted in a 24.8% successful contact rate and an 80.8% opt-in rate. Members were also offered the opportunity to receive health coaching on the use of the monitor once it was received; two members received health coaching calls. Throughout the PDSA several barriers were encountered: several members were told by their chosen pharmacy that the monitor was not covered, some never received a monitor, and some members had not been seen at the partnering provider and so were unable to have prescriptions written. In total, only 5 members received a monitor during the PDSA cycle. The workgroup will work to incorporate the lessons learned from the first round into the next PDSA cycle.

The second PDSA project involved conducting phone outreach by AAH engagement staff to members who were diagnosed with hypertension or diabetes, were missing an A1c or blood pressure reading, and were newly transitioned into the plan. A total of 2,488 members received an outreach call encouraging them to schedule an appointment with their provider and receive assistance with updating their assigned provider if needed. There were 1,868 successful contacts which included leaving a voicemail or speaking with the member to assist changing their PCP, transferring to their PCP to schedule an appointment, or receiving additional assistance from the Member Services Department. Staff members were also able to collect qualitative feedback from the members, which included learning that some members had recently seen their PCP, some members had difficulty with understanding recommendations for managing their condition or planning to see their PCP soon. Engagement staff also heard about several access issues include transportation, being on a waitlist, and not receiving a call back from their provider. These findings support the need for increased communication between the Alliance, providers, and members, as well as increased structural support and health education.

The final project related to assisting with member outreach included sending a flyer to members ages 45-49 who were due for colorectal cancer screening. Flyers were sent to 3,231 members informing them about the recommendations for screening including the recently expanded age range to begin screening and how to be connected to screening. Following the mailing campaign, 287 members received colorectal cancer screening. While our data do not

allow for determining whether a member was prompted to complete a screening due to the flyer, these results show there may be at least some benefit to multiple forms of screening reminders from multiple sources.

The other approach to supporting quality program infrastructure was through grants. The Community Health Center Network received funding to improve remote self-measured blood pressure (SMBP) programs and increase colorectal cancer screening. All eight (8) health centers participated in the SMBP grant, with the overall goal of improving the overall CBP rate by 10% above the 2023 rate (60.03% administrative), and the rate for African American members by 15% above the 2023 rate (49.0%). CHCN tracked several measures:

1. The percentage of patients with improved blood pressure readings (≥ 5 mmHg decrease in systolic blood pressure) in 2024: 53.6% (1810/3377).
2. CBP control stratified by race/ethnicity: African American 55%, all others 63%
3. Number of AAH patients with an SMBP cuff order: 3672
4. Number of AAH patients with an SBMP cuff order and subsequent BP reading: 3376 (92%)

Overall, CHCN has not achieved either aim of increasing the control rate for the overall population or African American patients specifically. However, there were several additional outcomes that show SMBP is a promising intervention: in addition to the number of patients whose systolic BP improved, 85% of members who responded to a satisfaction survey at one health center indicated they were satisfied with the program, and the percentage of members using the monitors increased (92% vs 83% in 2023). Health center staff members also reported increased familiarity with the devices and plan to continue targeted outreach and enrollment into SMBP programs.

CHCN also received funding to improve colorectal cancer screening rates, with the aim to increase the overall rate from 41% in 2023 to 48%. Health center efforts to increase screening included delivering provider education and access to technology, mitigating linguistic barriers, and improving patient responsiveness to outreach through member incentives. Increased access to education and technology was completed by integrating Cologuard ordering into the network's electronic health record (EHR) which allowed for easier ordering and more accessible screening results. Health center staff also received training from Exact Sciences (the manufacturer of Cologuard) covering the importance of colorectal cancer (CRC) screening, how to use Cologuard testing kits, patient engagement strategies, and CRC screening resources. Two health centers also used funds to continue contracts with text-based outreach programs allowing for easier and more frequent outreach attempts. CHCN in partnership with the American Cancer Society also provided colon cancer screening information in languages other than English and Spanish. Health centers purchased gift cards to provide to patients who successfully completed CRC, with a variable response: health centers with well-established outreach programs saw a higher response and patients were more likely to collect their gift card, whereas for those without a robust program the screening rate remained low. Some barriers to the effectiveness of a gift card incentive included patients not returning test kits, patients losing their test kits, and not scheduling a pickup within the specified time. Overall, CHCN's COL rate improved to 49.33% in MY2024, with strong evidence for the importance of electronic health record sharing and improved technological

infrastructure to increase access to colon cancer screening.

Women's Health Domain

The Women's Health Workgroup focused on improving measures that were performing below the minimum performance level in the Managed Care Accountability Set (MCAS), aiming to increase rates to meet or exceed the minimum performance level (MPL) and coordinate efforts to address population health disparities. These measures included:

- Cervical cancer screenings (CCS)
- Breast cancer screenings (BCS)
- Chlamydia screenings in women (CHL)
- Timeliness of prenatal care (PPC 1)
- Timeliness of postnatal care (PPC 2)

In 2024, the workgroup initiated several quality improvement projects to enhance measures in the women's health domain. These projects included mobile mammography, texting campaign in partnership with Alameda Health Systems, outreach efforts through birthday card reminders and outreach calls targeting newly added Anthem and Adult Expansion members.

Mobile Mammography: The Alliance aimed to improve access to BCS screenings for its members and streamline clinic workflows for breast cancer by offering mobile mammography services. In partnership with the provider network, the Alliance hosted 21 mobile mammography events, resulting in 185 completed screenings.

BCS Texting Campaign: In partnership with Alameda Health Systems and Lifelong Medical Health Center, members were eligible to receive a \$50.00 gift card for completing a mammogram. Automated text messages were sent to 2,485 members at Alameda Health Systems and those who completed a screening were mailed a gift card resulting in 136 completed screenings. At Lifelong Medical Health Center, out of 1,391 members, 83 members completed a mammogram and received a gift card.

CCS Birthday Card: Birthday cards targeting women who are non-compliant for cervical cancer screenings was mailed a birthday card reminder. Two versions of the birthday card were created: one with an incentive and one without. The incentive birthday card facilitated 267 screenings out of 15,283 eligible members from July 2023 to December 2024, while the non-incentive birthday card facilitated 63 screenings from June 2023 to December 2024 among 1,816 eligible members.

CCS Outreach Calls: Outreach calls were conducted targeting Anthem and Adult Expansion members to address the decline in cervical cancer screening rates following the departure of Kaiser members and the addition of the Adult Expansion members. In collaboration with the vendor Xaqt, these calls aimed to remind members of their due screenings, facilitate real time appointment scheduling with their PCPs, and offer a \$25.00 incentive to encourage participation. As a result, 15,914 members were identified as eligible, leading to 91 actual completed cervical cancer screenings.

Cervical Cancer Pap Drives: Multiple providers organized pap events to increase cervical

cancer screenings for women aged 24-64. The Alliance supported these events by conducting outreach calls to schedule appointments, reminding members of their upcoming appointments, and providing incentives and giveaways. These efforts led to 142 completed cervical cancer screenings through these events.

As a result of the improvement projects, preliminary MY2024 data indicates breast cancer screenings rates improved over MY2023 for both Medical and Group Care line of business, exceeding the 75th percentile. Additionally, breast cancer screening rates for African American women have increased significantly in MY2024 compared to MY2023. Preliminary administrative rates for Cervical Cancer Screening shows improvement in MY2024 rates for Group Care; however, Medi-Cal rates have declined over MY2023. This decline is a result of the Adult Expansion members who may have received services under other state coverage. Challenges with accessing this data have contributed to lower reported rates.

Behavioral Health

The Behavioral Health Workgroup focused on increasing performance rates of measures held to MPL on the MCAS: Follow-up after Emergency Department Visit for Mental Illness (FUM) and Follow-Up after Emergency Department Visit for Substance Use (FUA). The aim statement of the workgroup was as follows:

By December 31, 2024, Alameda Alliance for Health will improve behavioral health measures in the MCAS to meet MPL and to further increase rates to reach the 75th percentile.

To meet this goal the workgroup engaged in the following activities:

Learning Best Practices from Other Health Plans

The Behavioral Health Workgroup studied successful strategies from high-performing health plans to improve follow-up care for members after ED visits. Key learnings include:

- The importance of connecting with and following up with members before they leave the ED to improve follow-up rates.
- The role of CA Bridge Substance Use Navigators (SUN) in ensuring that members are linked to care before discharge.
- Collaborations with hospitals employing Community Health Workers (CHWs) in the ED to conduct follow-ups before discharge, which has shown positive results.

In 2024, the workgroup prioritized implementing these best practices within the Alliance. Through research, it was discovered that half of the EDs in the Alliance network were funded for SUNs via the CA Bridge program. To assess the impact, the workgroup analyzed data from Measurement Year 2023 to determine if members in the FUA and FUM categories were receiving follow-up care from SUNs. However, findings revealed that this was not the case—SUNs were not using the appropriate CPT or diagnosis codes to document these visits. To address this gap, the Alliance provided the correct coding information to Alameda Health System, which has the most frequently utilized ED in the network. There are administrative challenges that make it difficult for SUNs to use these codes and submit a claim. The Alliance is continuing to work with the hospital to come up with a way to accurately track and improve follow-up care for members in need.

Targeting High-Utilization Emergency Departments

Using data analysis, the workgroup identified the most frequently utilized EDs among members requiring follow-up care. Nearly 50% of members that fall in the FUA and FUM measures visited Highland Hospital, Sutter Alta Bates, Eden Medical Center, and Washington Hospital in measurement year 2023. This analysis allowed the team to focus intervention efforts on these high-utilization hospitals in 2024. As discussed above, the Alliance worked with Alameda Health Systems, which runs Highland Hospital, to provide data, education on the measures, and make sure follow up care by SUNs is being captured.

Member Incentives for Follow-Up Care

A PDSA cycle was conducted in partnership with Axis Community Health Center from 8/1/2024 - 12/31/2024 to test whether financial incentives could encourage members to complete follow-up visits after an ED visit for mental illness. Despite offering a \$25 gift card, most members were not interested in returning for follow-up care. Additionally, the provider noted that many of these ED visits involved individuals experiencing homelessness, making post-discharge outreach particularly challenging.

Expanding Community Health Worker (CHW) Partnerships

To strengthen follow-up efforts, the workgroup has been exploring collaborations with Journey Health, a medical group and CHW provider. In partnership with the Alliance Director of Housing & Community Services and Journey Health, two efforts were put forth in 2024:

- Placing CHWs in EDs to conduct follow-ups with members before discharge
- Utilizing CHWs to make outreach calls to recently discharged members to ensure they stay connected to care

Journey Health already has CHWs deployed at Sutter Hospitals and will conduct follow-ups before members leave those EDs. However, the project to make outreach calls to members who have already been discharged from the ED is on hold, because Journey Health has decided it no longer would like to utilize CHWs for that purpose.

As a result of the improvement efforts, preliminary MY2024 data suggests that the Alliance will be above MPL and in the 75th percentile for FUA. There has been an increase in the rate from MY 2023 by 3.47%, going from 38.90% to 42.97%. The Alliance is still waiting for data from Alameda County Behavioral Health to determine FUM rates.

First 5 Alameda Partnership

The Alliance continued to partner with First 5 Alameda in MY2024. The goal of the initiative was to engage, assess, and connect Medi-Cal enrolled children, ages 0-5 and their families to appropriate clinical and community-based services and support to improve their health and well-being through an integrated community-based care management program. First 5 Alameda served as a key care management entity for Alliance pediatric members, ages 0 to 5 and worked in partnership with the Alliance to:

- Conduct outreach and engagement to increase child access to well-child preventative care for select Alliance members, ages 0-5.

- Provide pediatric health education to families in a culturally appropriate and accessible manner.
- Bolster pediatric health provider capacity to deliver DHCS/Bright Futures mandated pediatric screenings, with an emphasis developmental screening, Adverse Childhood Experiences (ACEs) Screening, and social determinants of health.
- Coordinate family-centered access to well-child visits, as well as needed developmental/behavioral services, mental health services, community-based services and supports, and social support needs, to enhance and supplement practice-based care coordination services and comply with EPSDT requirements.

Through our partnership with First 5, 2,379 distinct Alliance members received an outreach call, 693 members completed a well visit or has a scheduled visit. First 5 facilitated 10 in-person or virtual provider training on EPSDT requirements and conducted 14 provider training to improve capacity to deliver ASQ and ACEs screenings. 457 Alliance members referred by First 5 to at least one community services or support.

Non-Utilization Outreach

The Alliance Board of Governors expressed ongoing concerns about the utilization of services by Alliance members. In addition, the Alliance gained an additional population of members through accepting Anthem transition and adult expansion members. As a result, non-utilization was included as a strategic organization-wide goal. The goal was to reach out to at least 20% of non-utilizers over the age of fifty and connect 2% to primary care services, as well as to outreach to 20% of non-utilizers ages six and under and connect 2% to primary care services by June 30, 2024.

In partnership with Xaqt, a vendor for member outreach, the Alliance conducted outreach calls from March to June 2024. The outreach campaign aimed to facilitate scheduling an appointment for members who had not utilized any services during the baseline period of October 2022 to September 2023, with a specific focus on adults 50 and older and children 6 and younger. The primary goal of the outreach was to update the members' assigned PCP and facilitate scheduling an appointment with their assigned PCP. The secondary goal was to identify members with HEDIS measure completion gaps to tailor calls to complete needed preventive services. One outreach attempt was made to 10,156 adults (9,527 Medi-Cal, 629 Group Care) and 2,179 children.

The results of the outreach campaign:

- 41.72% overall outreach success* rate – 39.90% of adults, 50.21% of children.
- 0.33% (34) adults and 4.96% (1087) children had a PCP visit following a successful contact based on claims filed.
- 36.52% of calls resulted in voicemail.
- 18.35% of members had a terminated account at the time of the outreach attempt.

- 29.04% of members could not be reached due to incorrect/disconnected phone number, no option to leave voicemail or no phone number on file.

*Note – successful defined as, changed PCP, Left Voicemail, Shared General Information, Spoke with Member, Parent or Guardian, Transferred to PCP.

Opioid/SUD Continuation

In 2020, the Alliance partnered with the network providers and other local leaders to develop a Substance Use Disorder Program. This program continued through 2024.

Alameda Alliance has continued to use multiple strategies involving *Member and Provider Educational Outreach and Pharmacy Safeguards*. The Alliance has accurate and comprehensive monthly reports that detail opioid overutilization, members grandfathered to high dose opioids, members excluded from the SUD Program (including those involved in hospice/palliative, cancer, and members with sickle cell disease), and monitoring the changes in Morphine Milligram Equivalence (MME).

The Alliance monitors a list of members who meet the definition of *chronic opioid users and potential chronic opioid users*. Chronic users are defined as members with prescriptions of greater than 120 MME consecutively for the last three months. Potential chronic opioid users are defined as members with prescriptions between 50 to 119 MME consecutively for the last three months.

The Alliance also has compiled a list of members who presented to the ED with opioid and benzodiazepine overdose and a separate list of members on concurrent use of opioids and benzodiazepines.

In 2024, the Alliance sent pertinent members and providers with educational mailings. Mailing includes:

1. Provider Facing:
 - a. Lists of identified members who are chronic users, high risk members on becoming chronic users, concurrent chronic opioid/benzodiazepine usage and members presenting to ED for opioid/benzodiazepine overdose.
 - b. Provider Opioid and Benzodiazepine Tapering Tools.
 - c. Treatment for opioid dependence.
2. Member Facing:
 - a. Opioid Safety guide for members and caregivers.
3. Provider and Member Facing:
 - a. Non-opioid formulary alternatives.
 - b. Mailer Timeline

Day	Member	Provider
1	Original mailing gets sent out	Original mailing gets sent out.
45	Repeat mailing. Refer to case management	Repeat mailing.

	if a member is on greater than 300 MME.	
90	Check if a member transition to buprenorphine or received appropriate pain treatment.	Receive letters from medical director. Submit a PQI.
120	N/A	Include operations and peer review committee to decide whether to keep in-network.

Note the above escalation process for members and providers with persistent chronic use of opioids. Cancer, hospice, and sickle cell anemia members are excluded from this. Pharmacy will work with QI to receive chart notes to check on this. Rising risk members will be tracked and looked at on a case-by-case basis. Handouts may include opioid safety, medication assisted therapy, non-opioid alternatives, opioid and benzodiazepines tapering tools and provider maps for non-opioid alternatives such as physical therapy, acupuncture, etc.

The table above outlines the actions to be taken after initially mailing to members and providers (day 1). Each respective row reflects a higher escalation process to be taken if members and providers continue to use opioid inappropriately or with no identified treatment plan.

Opioids Stewardship Report

June 2024 and January 2025: Mailings to 23 high-risk members with prescriptions of greater than 120MME consecutively for the last three months. These members received:

- High risk cover letter
- Health education: Safety guide for patients and caregivers
- Health education: Treating pain without opioids.
- Health education: Medicines for opioid dependence

June 2024 and January 2025: Mailings to 46 rising risk members with prescriptions between 50 to 119 MME consecutively for the last three months. These members received:

- Rising risk cover letter
- Health education: Safety guide for patients and caregivers
- Health education: Treating pain without opioids.

June 2024 and January 2025: Mailings of a total of 44 clinics in June 2024 and 39 clinics in January 2025 with members who were on any of the following lists:

- Opioid and Benzodiazepine Co-use list
- Rising risk list: 50-119 MME for 3 consecutive months
- High risk list: 120+ MME for 3 consecutive months
- Opioid and Benzodiazepine ER list
- Chronic use without Naloxone Mail list

The Alliance developed a Provider packet that included an Opioid and Benzodiazepine Tapering

Tool, Shared Data for providers / delegates / committees, Health Education materials, Local Maps that identify providers who may meet the member's needs, and member facing materials.

Goals for 2024

- Continue educating members and providers who are chronic and rising risk opioid users.
- Continue sharing data for providers/delegates/committees.
- Organize materials on Alliance website to be accessible to members and providers.

Opioid and Benzodiazepine ER Reporting

- Reports are based on claims data and reflected on each unique claim with opioids/benzodiazepine related ICD code.
- Reports are shared with assigned PCPs of members on an annual basis.
- There were several peaks between 2023 and 2024 with opioid/benzodiazepine related ER visits. After the highest peak in February 2024, there was a steady decline in opioid/benzodiazepine overdoses, ending with December 2024 having fewer overdoses

The Alliance will continue to improve our opioid stewardship program. Below are results of our interventions.

Figure 1: 2023 – 2024 Benzodiazepines and Opioid ED visits

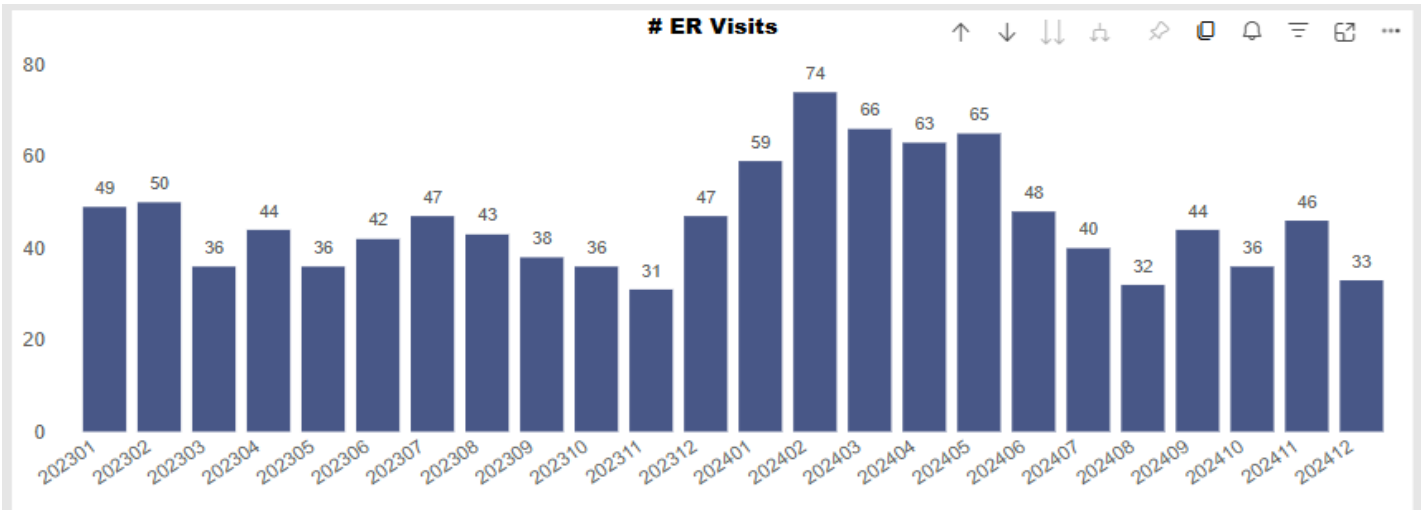
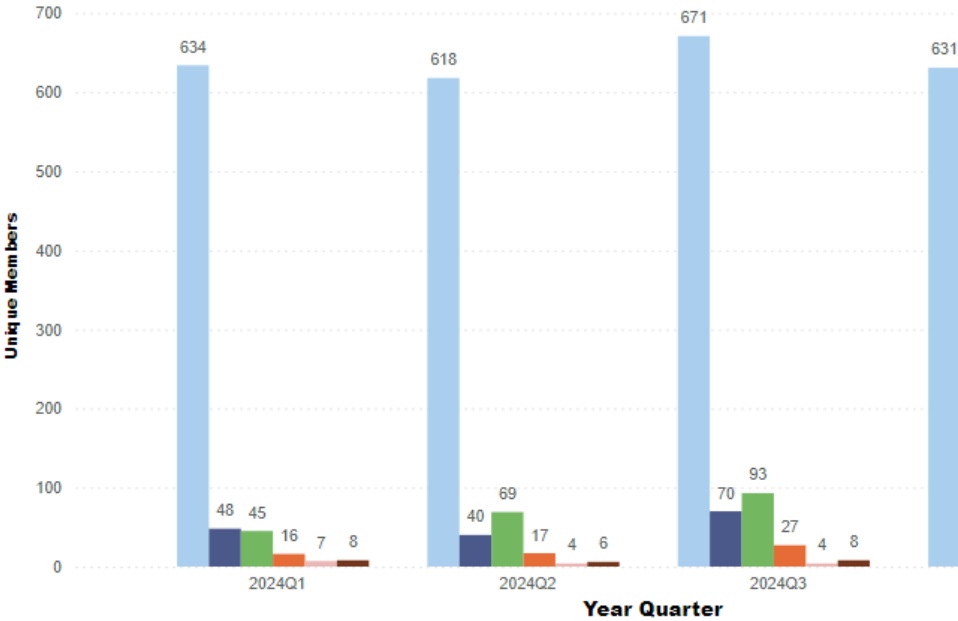


Table 2: Unique Members per Quarter on >50MME

MME (MORPHINE MILLIGRAM EQUIVALENTS)				
MME	2024Q1	2024Q2	2024Q3	2024Q4

50-89	634	618	671	631
90-119	48	40	70	68
120-199	45	69	93	86
200-299	16	17	27	31
300-399	7	4	4	10
>400	8	6	8	17

Figure 2: 2024 Active Opioid Members by Quarter



2023 Active Opioid Members by Quarter

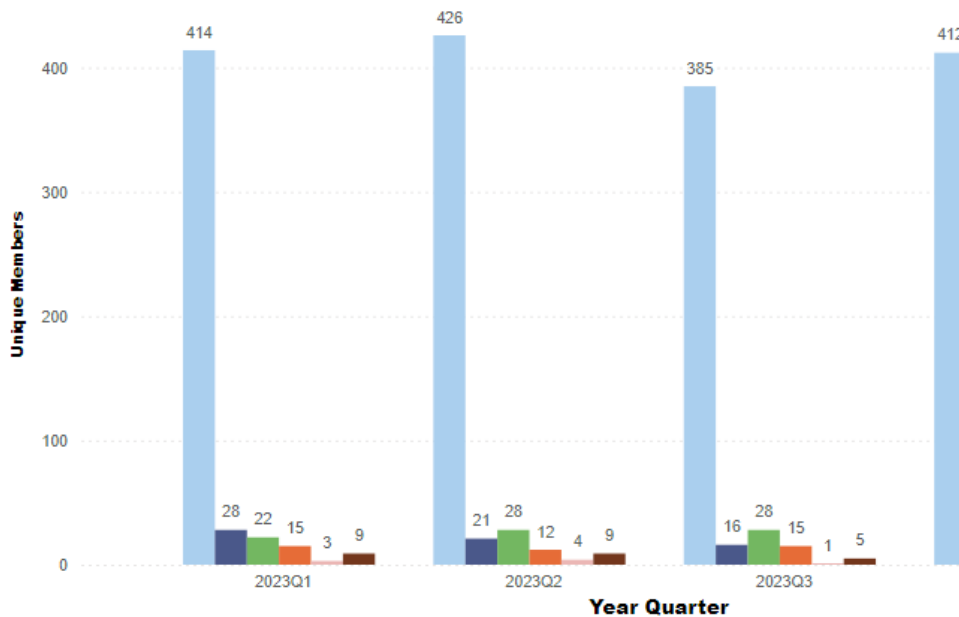


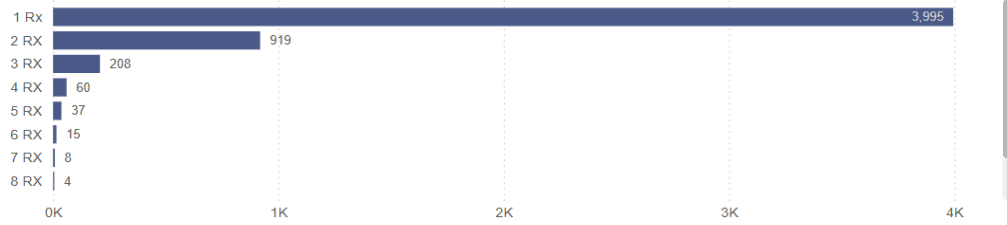
Figure 2 and Table 2 both show opioid utilization by MME. Table 2 shows a significant increase in Q1 2024 of the number of utilizers under 200 MME. We hypothesize this increase could be due to the influx of Adult Expansion and Anthem Transition members, many with chronic conditions. Utilization >300 MME remains stable until an increase in Q4 2024.

Below is a graph depicting how many unique providers prescribing opioids categorized by ascending MME. These graphs are looking at provider prescription claims. There is a general decrease in prescribing trend as the MME goes up. In 2024, 21 providers each wrote 1 prescription for 300-399 MME and 31 providers each wrote 1 prescription greater than 400 MME. In addition, 1 provider wrote at least 10 prescriptions. The top five providers who wrote more than 300 MME were oncology, internal medicine, and family practitioners. In comparison with 2023, there was an increase in utilization for all MME.

Figure 3: Frequency of Provider Opioid Prescription Count by MME for 2023 and 2024

2024

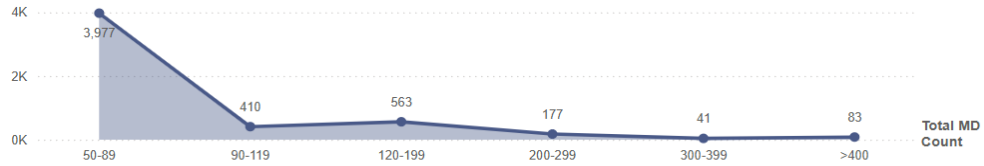
Rx Summary by Provider



Rx by # Provider

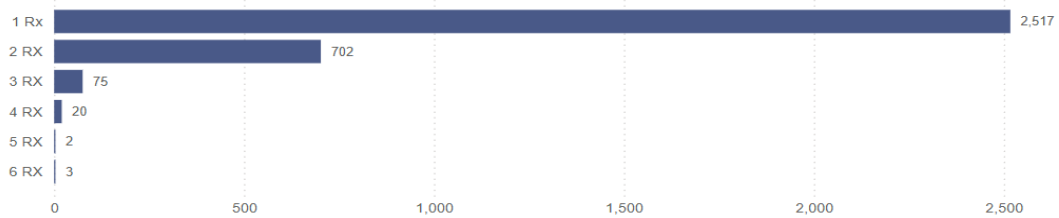
MME	1 Rx	2 RX	3 RX	4 RX	5 RX	6 RX	7 RX	8 RX	9 RX	10+ RX	Total
50-89	3,257	570	112	18	10	6	1	3			3,977
90-119	229	131	28	10	10	1	1				410
120-199	367	136	33	13	7	2	1	1	2	1	563
200-299	90	59	22	2	4						177
300-399	21	5	6	6	2		1				41
>400	31	18	7	11	4	6	4		2		83
Total	3,995	919	208	60	37	15	8	4	4	1	5,251

Provider Summary by MME



2023

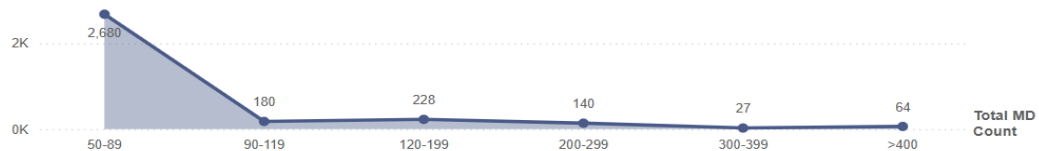
Rx Summary by Provider



Rx by # Provider

MME	1 Rx	2 RX	3 RX	4 RX	5 RX	6 RX	Total
50-89	2,170	443	49	13	2	3	2,680
90-119	99	77	3	1			180
120-199	151	67	7	3			228
200-299	47	78	14	1			140
300-399	19	8					27
>400	31	29	2	2			64
Total	2,517	702	75	20	2	3	3,319

Provider Summary by MME



Drug Recalls

The Pharmacy Department monitors all drug recalls for IHSS. In 2024, there were 102 recalls. Recalls were monitored for adversely affected members. The number of notifications where the PBM completed a claims data review was 3.

2024 Pharmacy Recalls

RECALL TYPE	QUANTITY
Total number of safety notices/recalls	102
Total number of withdrawals	0
The number of notifications where PBM completed a claims data review	3

Pay-for-Performance Programs

Overview

The Alliance Pay-for-Performance (P4P) program offers performance-based incentive payments for delivered services. Through this program, primary care providers (PCPs) and PCP Groups are rewarded for superior performance and yearly improvement. The P4P program focuses on preventative care, pediatrics, access, and chronic disease and includes clinical quality measures (HEDIS) and other measures. The evaluation of the P4P is for January 1, 2023, through December 31, 2023.

2023 Program Summary

The 2023 P4P program is tailored to each delegate and directly contracted PCP group category: AHS, CHCN, CFMG, and Directs. The measures for each are outlined below.

Category	Measure	AHS	CHCN	CFMG	Directs - Family Practice	Directs - Internal Medicine	Directs - Pediatrics
HEDIS	Childhood Immunizations: Combo 10 (CIS)			X			X
	Immunizations for Adolescents: Combo 2 (IMA)			X			X
	Lead Screening in Children (LSC)	X	X	X	X		X
	Well-Child Visits in the First 15 Months of Life: Six or More Visits (W30)	X	X	X			X
	Well-Child Visits 15- 30 Months of Life: Two or More Visits (W30)	X	X	X			X
	Child and Adolescent Well-Care Visits (WCV)	X	X	X	X		X
	Breast Cancer Screening (BCS)	X	X		X	X	

	Cervical Cancer Screening (CCS)	X	X		X	X	
	Hemoglobin A1c Poor Control (> 9%) For Diabetics (HBD)	X	X		X	X	
	Follow-up After ED Visit for Mental Illness (FUM) - 30 day	X	X				
Other	PCP Visits Per 1,000 Members	X	X	X	X	X	X
	ED Visits Per 1,000 Members	X	X	X	X	X	X
	Readmission Rate	X	X				
	Member Satisfaction Survey: Non-Urgent Appt Availability	X	X	X	X	X	X
	Member Satisfaction Survey: Urgent Appt Availability	X	X	X	X	X	X

Delegates and PCP groups earned points based on performance compared to the NCQA 50th percentile and/or improvement from the prior year. This applied to all measures except for the Member Satisfaction Survey questions. For the “Member Satisfaction Survey: Urgent Appointment Availability” full points were earned if 70% of the responses indicate a member was able to get an urgent appointment within two (2) business days. To earn full points for the “Member Satisfaction Survey: Non-Urgent Appointment Availability” 80% of the survey responses for a delegate or PCP group needed to indicate that the member was able to schedule a non-urgent appointment within 10 business days. Below is a breakout of percentage of pool dollars earned by delegate and directly contracted provider category.

Delegate/Directly Contracted Provider Category	% of Pool Dollars Earned in 2023
AHS	34.00%
CHCN	46.91%
CFMG	51.33%
Directs - Family Practice Providers	58.05%
Directs - Internal Medicine Providers	43.12%
Directs - Pediatric Providers	73.35%
TOTAL	44.67%

Delegates and directly contracted PCP groups earned 44.67% of the available pool dollars allocated to the 2023 P4P program. QI Improvement Academy

To establish a culture of quality and enhance knowledge HEDIS/MCAS measures both with internal staff and provider network, the QI Performance Team have established a training program under the umbrella of Improvement Academy. Through the Improvement Academy, the QI Performance Team offers a range of educational webinars throughout the year. The webinars include education on the improvement methodologies, transferring knowledge on the PDSA (Plan-Do-Study-Act) methodology. The training encompassed methods for enhancing quality, creating an aim statement, utilizing data for performance enhancement, tools for devising change ideas, and testing change ideas with the PDSA methodology. In 2024, the QI

Performance Team hosted two webinar series, each comprising of three one-hour sessions, attended by 188 Alliance and provider staff. Out of the 12 respondents who completed the survey, 100% gave the course an excellent/very good rating.

Annually, the Alliance conducts education sessions, to delegates and primary care direct providers, for the Pay-for-Performance (P4P) incentive program. The education session's objectives are for attendees to understand the P4P measures, goals, points, potential earnings, and review new or updated measure descriptions. Conducted in January 2024, the Alliance extended this opportunity to primary care direct providers for the first time, 22 provider staff attended.

Lastly, to support performance improvements on the DHCS Managed Care Accountability Set (MCAS), the QI Team offered a Measure Highlight Webinar Series which focused on the domain measures for cancer prevention, childhood, and chronic disease. The objectives for these webinars reviewed the measures specifications, shared tips on what counts to complete the measures successfully and allowed opportunity for high-performing providers to discuss and share bright spots on what made them successful in achieving the measures. This series spanned through February-May of 2024, with 70 attendees from various primary care clinics. Overall, 6 providers completed the survey, indicating they found this webinar beneficial particularly as it pertains to learning bright spots from their peers.

Patient Safety and Quality Compliance

Consistency in Application of Criteria

The Alliance QI Department assesses the consistency with which clinical reviewers, physicians, pharmacists, UM nurses, Retrospective Review nurses and non-physician reviewers apply criteria to evaluate Inter- Rater Reliability (IRR). A full description of the testing methodology is available in policy QI-133. The IRR passing threshold is noted below.

IRR Thresholds (UM)	
SCORE	ACTION
High – 90%-100%	IRR Pass Rate - No action required.
Medium – 61%-89%	Increased training and focus by supervisors/managers.
Low – Below 60%	• Additional training provided on clinical decision-making. • If staff fails the IRR test for the second time, a Corrective Action Plan is required with reports to the Senior Director of Health Services and the Chief Medical Officer. • If staff fails to pass the IRR test a third time, the case will be escalated to Human Resources which may result in possible further disciplinary action.

The IRR process for PQIs involves reviewing actual PQI cases. Results will be tallied as they complete the process and corrective actions implemented as needed. When there are opportunities for improving consistency in applying criteria, QI staff address corrective actions

through global, individualized training, or completing additional IRR case reviews.

For 2024, IRR testing was performed with QI clinical staff to evaluate consistency in classification, investigation and leveling of PQIs. All QI Review Nurses and Medical Director Reviewers passed the IRR testing with scores of 100%.

Facility Site Reviews

Facility Site Review (FSR) and Medical Record Review (MRR) audits are mandated for Medical Managed Care Plans to occur every three (3) years, per DHCS All Plan Letter 22-017. FSRs are another way the Alliance ensures member quality of care and safety within the provider office environment. Interim monitoring and focused reviews occur between each regularly scheduled full scope review. Corrective Action Plans (CAPs) for non-compliance are required depending on the site FSR and MRR scores and critical element failures.

The bi-annual DHCS report was submitted in August 2024 for FSRs conducted in January to June 2024) and FSRs conducted in July to December 2024 was submitted in February 2025 through DHCS Web Portal. The DHCS' Managed Care Quality and Monitoring Division (MCQMD) Site Review Portal (MSRP) is still in the process of bulk upload testing and production file submission. Alliance will continue to submit the report via Web Portal until further notice.

In 2024, there were 178 site reviews including PCP sites and urgent care centers. The total number and types of audits are detailed in the table below.

2024 Facility Site Reviews

TYPE	Q1	Q2	Q3	Q4	TOTAL
FSR					
Initial FSR	0	1	1	2	4
Periodic FSR	7	7	15	21	50
Annual FSR	2	1	0	0	3
Urgent Care FSR	1	0	0	0	1
MRR					
Initial MRR	0	3	1	0	4
Periodic MRR	3	8	14	13	38
Annual MRR	1	2	0	0	3
Focused MRR	1	5	3	0	9
Interim Monitoring	9	0	1	4	14
PARS	2	5	29	16	52
Total Reviews	26	32	64	56	178

DHCS regulation requires that Critical Element (CE) CAPs be received by the Alliance within 10

business days and FSR/MRR CAPs within 30-days of the FSR and/or MRR Report. A CE CAP is issued for deficiencies in any of the 14 critical elements in the FSR that identify the potential for adverse effects on patient health or safety. In 2024, there were 74 CAPs issued and all CAPs are closed.

Per DHCS regulation, failed periodic reviews are reported bi-annually. In 2024, the Alliance had two providers with non-passing scores of 79% and below for the full scope MRR. This is the first time these two providers were audited on the new DHCS tool effective July 2022. Alliance will continue to educate the providers on the new standards and conduct focused reviews. An annual full scope review will be conducted in 2025.

In July 2022, DHCS implemented the use of the revised FSR/MRR tools. Many providers are continuing to adjust to the new standards. Alliance anticipated the drop in scores on their subsequent periodic reviews. We conducted provider education and training leading to the changes. A corrective action plan was provided to DHCS. Failed reviews are escalated to the Medical Director to follow up with the provider. In addition, a new process implemented to facilitate CAP closure was placing new member assignments on hold for PCP sites that receive failing scores on FSR/MRR and/or providers who do not correct FSR/MRR deficiencies within established CAP timelines until the CAP is closed. In 2024, there were 6 providers with new member assignment holds.

PCP FSR/MRR CAPs Issued in 2024

TYPE	Q1	Q2	Q3	Q4	TOTAL
Total CAPs Issued	11	18	22	27	74
Open	0	0	0	1	1
<i>Open >120 days</i>	0	0	0	0	0
Closed	11	18	22	10	73

2024 Audits with Non-Passing Scores

QUARTER	Audit Date	FSR Score	MRR Score
Q1	N/A	N/A	N/A
Q2	Provider 1: 6/28/24	95.04%	79.19%
Q3	N/A	N/A	N/A
Q4	Provider 2: 11/14/24	88.72%	77.39%

On August 13, 2024, DHCS notified the Alliance of a DHCS random full-scope FSR and MRR from September 17 to 19, 2024. The DHCS' Site Review Unit's team of Nurse Evaluators (NE) conducted the FSRs and MRRs in 10 provider sites. DHCS conducts separate site reviews to validate the Alliance's FSR and MRR processes. The two Alliance site review nurses accompanied the NEs during the audits. DHCS notified the Alliance of the report findings on Critical Elements (CE) on September 24, 2004. Eight out of ten provider sites had CE CAPs. The Alliance nurses worked with the providers to be in compliance. On October 4, all CE

CAPs were submitted to DHCS. On October 22, 2024, DHCS notified the Alliance of the complete FSR and MRR report findings with CAP due within 30 calendar days of the report date. The Alliance issued the CAP to the providers and assisted them to be in compliance. On December 6, the Compliance Department submitted the CAP to DHCS. DHCS confirmed receipt on December 18, 2024. Additional documents were uploaded to the DHCS Web Portal on January 6, 2025. On February 10, 2025, DHCS notified the Alliance that the CAP addressed all findings in the report. All items of the CAP have been corrected, and the review is considered closed.

Long Term Care Quality Monitoring

With the transition of the Long Term Care (LTC) benefit and members to Medi-Cal Managed Care Plans, the Alliance is in the process of building out the LTC quality monitoring program. For Skilled Nursing Facilities (SNF), to comply with APL 23-004, a tracker was developed to collect quality assurance and improvement findings from California Department of Public Health (CDPH) survey deficiency findings, Medicare Stars, and PQIs. An attestation was developed for SNF providers to attest to compliance with the five key elements identified by the Centers for Medicare and Medicaid (CMS) Quality Assurance Performance Improvement (QAPI) program. In addition, Analytics programmed a report for the LTC measures within the MCAS of performance measures for each SNF, including emergency room visits, healthcare associated infections requiring hospitalization, and potentially preventable readmissions. For Subacute facilities, these facilities will emulate the SNF quality monitoring process. For Intermediate care facilities for individuals with developmental disabilities (ICF/DD), in addition to monitoring CDPH findings, quality monitoring includes service delivery findings from the Regional Centers. In 2024, efforts included adding a QI Review Nurse to conduct site visits as needed, interdisciplinary meetings the Regional Center, and performance measures monitoring and reporting. The clinical QI nursing team have on-going meetings bi-weekly LTC teams at the Alliance to ensure appropriate coordination, quality, and oversight of these facilities.

Peer Review Committee and Credentialing Committee

In 2024, 70 practitioners were reviewed for lack of board certification. If there were complaints about a practitioner’s office, facility site reviews were conducted, and the outcome was reviewed by the CC. There were no site reviews conducted based on complaints in 2024. All grievances, complaints, and PQIs that required investigation were forwarded to this committee for review. In 2024, 148 practitioner grievances, complaints, or PQIs were investigated by the committee. There were no practitioners that required reporting to the National Practitioner Data Bank (NPDB) by the Alliance.

In 2024, the CC granted a one-year reappointment for three (3) practitioner for grievances filed regarding quality of care and accessibility and one-year reappointment for one (1) practitioner for grievances filed regarding quality of care and accessibility. The table below shows evidence of practitioners reviewed by the CC for credentialing and re-credentialing decisions.

Count of Practitioners Reviewed for Quality Issues at PRC and CC in 2024

Count of Practitioners Reviewed for Quality Issues At Credentialing Committee in 2024												
PRCC Date	PRC	NPDB	Attestation	Malpractice	Felony/Misde meanor/Fraud	Facility Site Review	Grievance, Complaints, PQI	License Action	Board Certification	CAP	GAP	Total
January		4	2	1			14		2	4	6	33
February		4	1				16		4	1	2	28
March		11	1	1			11		3		8	35
April		4	2	1			17		5	3	14	46
May		9	7	2			13	1		2	24	58
June		2	4	3			7		2	1	11	30
July		3					11					14
August	No Credentialing Commiittee Meeting											
September		7	5				12		21	3	13	61
October	1		2				15		11	3	7	39
November		6	2	1			18		12	4	7	50
December		2	1				14		10	3	9	39
Total	1	52	27	9			148	1	70	24	101	433

Potential Quality Issues

Potential Quality Issues (PQIs) are defined as: An individual occurrence or occurrences with a potential or suspected deviation from accepted standards of care, including diagnostic or therapeutic actions or behaviors that are considered the most favorable in affecting the patient's health outcome, which cannot be affirmed without additional review and investigation to determine whether a quality issue exists. PQI cases are classified as Quality of Care (QOC), Quality of Service (QOS), Quality of Access (QOA) or Quality of Language (QOL). The Alliance QI Department investigates all PQIs referred to as outlined in Policy QI-104, Potential Quality Issues. PQIs may be submitted via a wide variety of sources including but not limited to members, practitioners, internal staff, and external sources. PQIs are referred to the QI Department through a secure electronic feed or entered manually into the PQI application, for evaluation, investigation, resolution, and tracking.

Quality Review Nurses investigate PQIs and summarize their findings. QOA cases are referred to the A&A Team for review and tracking while QOS cases that do not contain a clinical component are investigated and closed by the review nurse. QOL cases are reviewed and investigated by the Cultural and Linguistic Team. The Senior Director and/or the QI RN Supervisor oversees and audits a random sample of QOS cases. The QI Medical Director reviews all QOC cases, in addition to any QOA, QOL, or QOS cases where the Quality Review Nurse and/or RN manager/director requests Medical Director case review. The QI Medical Director will refer cases to the Peer Review Committee (RPC) and/or the Credentialing Committee (CC) for resolution, per clinical discretion

Quality of Care (QOC) Issue Severity Level

SEVERITY LEVEL	DESCRIPTION
C0	No QOC Issue
C1	Appropriate QOC May include medical / surgical complication in the <i>absence of negligence</i> . Examples: Medication or procedure side effect
C2	Borderline QOC With potential for adverse effect or outcome Examples: Delay in test with <i>potential</i> for adverse outcome
C3	Moderate QOC Actual adverse effect or outcome (non-life or limb threatening) Examples: Delay in / unnecessary test <i>resulting in</i> poor outcome
C4	Serious QOC With significant adverse effect or outcome (life or limb threatening) Examples: Life or limb threatening

The Alliance's QI Department received 10424 PQIs during MY2024, which is a 12% increase from 2023. The total volume of PQIs increased by 1148 which is largely reflected in the number of QOS and QOA issues identified during the measurement year. Of the 10424PQIs received in 2024, 6%, or 596of the PQIs were classified as a QOC. PQI monthly and quarterly totals are listed below:

2024 All PQI Type Monthly Totals

PQI Type	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	TOTAL	%
All Types of PQIs	991	1198	1027	1412	720	444	587	808	669	1051	607	912	10424	
QOA	301	430	316	451	210	153	197	248	182	293	163	262	3206	30%
QOC	54	64	50	47	49	38	60	47	36	56	57	38	596	6%
QOS	608	659	612	869	438	242	318	479	403	659	359	579	6225	60%
QOL*	28	45	49	45	23	11	12	34	48	43	28	33	399	4%

QI clinical management investigated, reviewed, and triaged all referrals both internal and external to the organization to ensure that access, clinical, language, service related PQIs were addressed through RN investigation and oversight support from Compliance and Vendor Management as applicable.

Prior to 2024, there was a PQI designation of "Other" that pertained to referrals related to Beacon or Kaiser. Since they are no longer delegated entities as of January 2024, this PQI designation is no longer being used.

As of February 2025, there are still 106 QOC cases open due to turnaround time of 120 days which may extend closure date to end of April for cases that were received at the end of

December 2024.

2024QOC PQI Quarterly Totals

INDICATOR	Q1	Q2	Q3	Q4
Indicator 1: QOC PQIs	Denominator: 3216 Numerator: 168 Rate: 5%	Denominator: 2576 Numerator: 134 Rate: 5%	Denominator: 2064 Numerator: 143 Rate: 7%	Denominator: 2570 Numerator: 151 Rate: 6%
Indicator 2: QOC PQIs leveled at severity C2-4	Denominator: 168 Numerator: 14 Rate 8%	Denominator: 134 Numerator: 9 Rate: 7%	Denominator: 143 Numerator: 19 Rate: 13% 1 case still open	Denominator: 150 Numerator: 6 Rate: 4% 105 cases still open

Exempt Grievance Audit

QI RN management continued to conduct Exempt Grievances case audits via random sampling, to ensure that clinical PQIs are not missed and forwarded to the Quality Department. QI Department clinical management provides oversight of exempt grievances via review of randomly selected exempt grievances. In 2024, 100 exempt grievance cases per quarter were reviewed by QI clinical management, with an overall performance rate of 100% which exceeds the established performance metric of 90%.

	Q42023	Q1 2024	Q22024	Q3 2024
Numerator	100	100	100	100
Denominator	100	100	100	100
Performance Rate	100%	100%	100%	100%
Gap to Goal	N/A	N/A	N/A	N/A
Universe	4448	7162	5383	5444

*
The Alliance IT department continues to provide support with workflow enhancements to the PQI application. An enhancement was made in Quality Suite with the ability to identify long term care (LTC) facilities when PQIs are opened. This will allow the QI clinical safety team to track and trend PQI cases in LTC facilities. The PQI application remains a robust and responsive system allowing for timely and accurate reporting, documentation, tracking, and adjudication of PQIs.

Quality in Member Experience

Overview

Analyses of member experience information helps managed care organizations identify aspects of performance that do not meet member and provider expectations and initiate actions to improve performance. The Alliance monitors multiple aspects of member and provider experience, including:

- Member Experience Survey
- Member Complaints (Grievances)
- Member Appeals

Standards and Provider Education

The Alliance has continued to educate providers on, monitor, and enforce the following standards:

Appointments Wait Times

APPOINTMENTS WAIT TIMES	
Appointment Type:	Appointment Within:
Urgent Appointment that <i>does not</i> requires Prior Authorization	48 Hours of Request
Urgent Appointment that <i>requires</i> Prior Authorization	96 Hours of Request
Non-Urgent Primary Care Appointments	10 Business Days of the Request
First Prenatal Visit	2 Weeks of the Request
Non-Urgent Appointment with a Specialist Physician	15 Business Days of the Request
Non-Urgent Appointment with a Behavioral Health Provider	10 Business Days of the Request
Non-Urgent Appointment for Ancillary Services for the diagnosis or treatment of injury, illness, or other health conditions	15 Business Days of the Request

All Provider Wait Time/Telephone/Language Practices

ALL PROVIDER WAIT TIME/TELEPHONE/LANGUAGE PRACTICES	
Standard:	Within:
In-Office Wait Time	60 Minutes

Call Return Time	1 Business Day
Time to Answer Call	10 Minutes
Telephone Access – Provide coverage 24 hours a day, 7 days a week.	
Telephone Triage and Screening – Wait time not to exceed 30 minutes.	
Emergency Instructions – Ensure proper emergency instructions.	
Language Services – Provide interpreter services 24 hours a day, 7 days a week.	

**Per DMHC and DHCS Regulations, and NCQA HP Standards and Guidelines*

**The DMHC Timely Access Standard is 15 Business days for Psychiatrist; however, to comply with NCQA accreditation standards of 10 business days, Alliance uses the more stringent standards.*

Urgent Care refers to services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (i.e., sore throats, fever, minor lacerations, and some broken bones).

Non-urgent Care refers to routine appointments for non-urgent conditions.

Triage or Screening refers to the assessment of a member's health concerns and symptoms via communication with a physician, registered nurse, or other qualified health professional acting within their scope of practice. This individual must be trained to screen or triage and determine the urgency of the member's need for care.

Shortening or Extending Appointment Timeframes: The applicable waiting time to obtain a particular appointment may be extended if the referring or treating licensed health care Practitioner, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the member's medical record that a longer waiting time will not have a detrimental impact on the health of the member.

Each of these standards are monitored as described in the table below. In 2023, the Alliance made changes to the CG-CAHPS instrument to ensure that the collected data was consistent with the Alliance standards which remained in place since MY2020.

Access Monitoring Surveys

Primary Care Physician (PCP) Appointment

PRIMARY CARE PHYSICIAN (PCP) APPOINTMENT	
Appointment Type:	Measured By:
Urgent Appointment that <i>requires</i> Prior Authorization	PAAS, CG-CAHPS, Confirmatory Survey
Urgent Appointment that <i>does not</i> require Prior Authorization	PAAS, CG-CAHPS, Confirmatory Survey
Non-Urgent Primary Care Appointment	PAAS, CG-CAHPS, Confirmatory Survey
First Prenatal Appointment	Non-PAAS, Confirmatory Survey

Non-Urgent Appointment with a Specialist Physician	PAAS, Confirmatory Survey
Non-Urgent Appointment with a Behavioral Health Provider	PAAS, CG- CAHPS, Confirmatory Survey
Non-Urgent Appointment for Ancillary Services for the diagnosis or treatment of injury, illness, or other health conditions	PAAS, Confirmatory Survey

All Provider Wait Time/Telephone/Language Practices

ALL PROVIDER WAIT TIME/TELEPHONE/LANGUAGE PRACTICES	
Standard:	Measured By:
In-Office Wait Time	CG-CAHPS, Confirmatory Survey
Call Return Time	CG-CAHPS, Confirmatory Survey
Time to Answer Call	CG-CAHPS, Confirmatory
Telephone Access – Provide coverage 24 hours a day, 7 days a week	After Hours: Emergency Instruction Survey, Confirmatory Survey
Telephone Triage and Screening – Wait time not to exceed 30 minutes	After Hours: Emergency Instruction Survey, Confirmatory Survey
Emergency Instructions – Ensure proper emergency instructions	After Hours: Emergency Instructions Survey, Confirmatory Survey
Language Services-Provide interpreter services 24 hours a day, 7 days a week	CG-CAHPS

The Alliance and the QI team adopted a PDSA approach to the access standards:

Plan: The standards were discussed and adopted, and surveys have been aligned with our adopted standards.

Do: The surveys were administered, per our policies and procedures (P&Ps); survey methodologies, vendors, and processes are outlined in P&Ps.

Study: Survey results along with QI recommendations were brought forward to the A&A Committee; the Committee formalizes recommendations which are forwarded to the QIHEC and Board of Governors

Act: Dependent on non-compliant providers and study / decision of the A&A Committee, actions may include, but are not limited to, provider education/re- education and outreach, focused discussions with providers and delegates, re-surveying providers to

assess/reassess provider compliance with timely access standard(s), issuing of corrective action plans (CAPs), and referral to the Peer Review Committee and/or the Credentialing Committee.

Provider Capacity

The Alliance reviews network capacity reports monthly to determine whether primary care providers are reaching network capacity standards of 1:2000. The Alliance Provider Services Department continues to monitor the threshold at 80% and above to ensure member assignment does not reach the 2,000-capacity standard. If a provider is close to the threshold, the plan will outreach to the provider to make them aware and see if they intend to recruit other providers. If not, the panel is closed to new assignment if they reach 2,000 capacity standards. During this time, the plan and the provider were in communication of such changes. In 2024, there were providers who reached 80% of the threshold and received outreach and were monitored throughout the year. No providers exceeded the 2,000-capacity standard.

Geo Access

The geographic access reports were reviewed quarterly to ensure that the plan meets the geographic access standards for provided services in Alameda County. For PCPs, the Alliance has adopted standards of one provider within 30 minutes / 10 miles. For specialists, the Alliance has adopted standards of one provider within 30 minutes / 15 miles. During 2024, the Alliance continued its cross functional quarterly meetings to review access issues and concerns.

In 2024, the Alliance continued to face geographic access issues for certain pediatric specialists in various parts of Alameda County, specifically in zip code 94550 in Livermore, CA.

In 2024, there were 32 alternative access standards (AAS) requested and approved by the Department of Health Care Services (DHCS) for pediatric specialties. The zip code of 94550 had the largest area of deficiency with 15 AAS requested and approved. The remaining 17 AAS were in zip codes spread throughout Alameda County and had less than 5 specialties per zip code that were outside of time and distance standards. For adults, there were 12 AAS requests that were submitted and approved and all for zip code 94550 in Livermore, CA. There were no deficiencies in time or distance for PCP services. For hospitals, there was one hospital AAS that was requested and approved by DHCS for zip code 94550.

In those instances, the Plan requested approval of alternative access standards from DHCS. When reviewing the geographic access maps and data, Livermore has unincorporated parts of Alameda County or where Adult and Pediatric Specialties may not be available, resulting in deficiencies. Even though the provider and member were in the same zip code, the time and distance standards were still compromised. The Plan requested alternative access standards in these instances.

Member Satisfaction Survey (CAHPS 5.1H)

The Medi-Cal and Commercial Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is administered by the National Committee for Quality Assurance (NCQA), a certified Health Effectives Data and Information Set (HEDIS) survey vendor. Press Ganey Analytics was selected by the Alliance to conduct the 2024 CAHPS 5.1H survey. The HEDIS

CAHPS survey included minor changes to some of the instructions and survey items to indicate the different ways in which patients may be receiving care: in person or via telehealth.

The survey method includes mail and phone responses. Members in each Alliance line of business (LOB) was surveyed separately. The table below shows the survey response rates. As of April 2024, the Alliance had a total of 405,340 members.

The breakdown of member enrollment by network are as follows:

- AHS: 22.41%
- Directs: 22.08%
- CHCN: 44.7%
- CFMG: 10.80%

• **Survey Response Rates by Line of Business**

	Medi-Cal Adult	Medi-Cal Child	Commercial Adult
2024	13.6%	15.8%	17.6%
2023	11.7%	12.3%	20.0%
2022	12.4%	12.3%	21.5%

The Medi-Cal Child, Adult Medi-Cal, and Adult Commercial Trended Survey Results in the tables below, contains trended survey results for the Medi-Cal Child, Medi-Cal Adult, and Commercial Adult populations across composites. Quality Compass All Plans (QCAP) benchmark noted within the tables is a collection of CAHPS 5.1H mean summary ratings for the Medicaid and Commercial samples that were submitted to NCQA in 2023.

In respect to benchmark scores, Red signifies that the current year 2024 score is significantly lower than the 2023 score. Green indicates that the current year 2024 score is significantly higher than the 2023 score.

Medi-Cal Child Trended Survey Results

Summary Rate Scores: Medi-Cal Child				
Composite	2024	Previous Year Comparison	2023	2022
Getting Needed Care	76.3%	↓	79.2%	78.4%
Getting Care Quickly	78.3%	↑	73.0%	77.8%
How Well Doctors Communicate	92.6%	↓	92.8%	91.3%
Customer Service	91.0%	↓	92.1%	85.5%

Rating of Health Care (8-10)	89.9%	↑	81.7%	89.5%
Rating of Personal Doctor (8-10)	93.4%	↑	90.7%	90.6%
Rating of Specialist (8-10)	87.7%	↓	95.2%	85.3%
Rating of Health Plan (8-10)	90.9%	↑	86.6%	86.0%
Coordination of Care	84.3%	↑	83.0%	89.1%

Medi-Cal Adult Trended Survey Results

Summary Rate Scores: Medi-Cal Adult				
Composite	2024	Previous Year Comparison	2023	2022
Getting Needed Care	73.6%	↓	75.2%	75.9%
Getting Care Quickly	74.9%	↑	72.9%	75.9%
How Well Doctors Communicate	93.9%	↑	87.5%	92.3%
Customer Service	87.3%	↓	88.7%	89.4%
Rating of Health Care (8-10)	81.6%	↑	61.1%	66.3%
Rating of Personal Doctor (8-10)	83.5%	↑	80.0%	82.9%
Rating of Specialist (8-10)	73.8%	↓	80.3%	78.6%
Rating of Health Plan (8-10)	76.4%	↑	70.9%	74.4%
Coordination of Care	78.3%	↓	91.7%	79.0%

Commercial Adult Trended Survey Results

Summary Rate Scores: Commercial Adult				
Composite	2024	Previous Year Comparison	2023	2022
Getting Needed Care	71.1%	↓	72.0%	65.8%
Getting Care Quickly	65.0%	↑	56.0%	62.0%
How Well Doctors Communicate	89.7%	↑	87.5%	83.2%
Customer Service	82.7%	↓	82.9%	78.5%
Rating of Health Care (8-10)	75.0%	↓	76.7%	61.0%

Rating of Personal Doctor (8-10)	83.4%	↑	82.4%	74.9%
Rating of Specialist (8-10)	76.3%	↓	80.6%	72.6%
Rating of Health Plan (8-10)	73.7%	↑	67.1%	65.9%
Coordination of Care	78.2%	↓	80.0%	74.4%

Tables below contain trended survey results for the three (3) member populations and their delegate network compared to the Alliance.

Medi-Cal Child Trended Survey Results – Delegates

MY2023 CAHPS 5.1H Child MediCal	2024 Plan Total	CHCN			CFMG			AHS			Alliance		
		2024	2023	YoYT	2024	2023	YoYT	2024	2023	YoYT	2024	2023	YoYT
Total Respondents	323	160	115		107	65		38	21		18	7	
Rating of Health Care (8-10)	89.9%	90.5%	78.6%	↑	94.7%	82.9%	↑	80.0%	92.9%	↓	71.4%	66.7%	↑
Rating of Personal Doctor (8-10)	93.4%	92.1%	87.5%	↑	93.5%	96.3%	↓	97.0%	87.5%	↑	93.8%	100.0%	↓
Rating of Specialist (8-10)	87.7%	83.9%	100.0%	↓	100.0%	91.7%	↑	66.7%	100.0%	↓	100.0%	100.0%	↔
Rating of Health Plan (8-10)	90.9%	90.7%	84.8%	↑	93.3%	90.2%	↑	89.2%	90.0%	↓	82.4%	80.0%	↑
Getting Needed Care	76.3%	71.5%	71.9%	↓	82.9%	87.1%	↓	77.9%	76.2%	↑	92.9%	83.3%	↑
Getting Care Quickly	78.3%	70.6%	70.9%	↓	87.1%	81.2%	↑	71.8%	77.8%	↓	90.0%	55.0%	↑
How Well Doctors Communicate	92.6%	89.6%	90.5%	↓	96.1%	98.5%	↓	92.4%	90.7%	↑	95.0%	93.8%	↑
Customer Service	91.0%	90.4%	88.8%	↑	91.7%	97.2%	↓	95.5%	100.0%	↓	83.3%	100.0%	↓
Coordination of Care	84.3%	77.5%	92.0%	↓	93.3%	90.0%	↑	90.9%	60.0%	↑	50.0%	100.0%	↓

YoYT = Year-Over-Year Trend

Medi-Cal Adult Trended Survey Results - Delegates

MY2023 CAHPS 5.1H Adult MediCal	2024 Plan Total	CHCN			AHS			Alliance		
		2024	2023	YoYT	2024	2023	YoYT	2024	2023	YoYT
Total Respondents	181	80	70		46	32		54	28	
Rating of Health Care (8-10)	81.6%	75.0%	58.5%	↑	95.7%	70.6%	↑	80.0%	57.1%	↑
Rating of Personal Doctor (8-10)	83.5%	80.4%	71.4%	↑	92.3%	92.0%	↑	81.4%	83.3%	↓
Rating of Specialist (8-10)	73.8%	64.3%	70.8%	↓	88.2%	81.8%	↑	73.7%	94.1%	↓
Rating of Health Plan (8-10)	76.4%	76.6%	67.1%	↑	81.0%	80.6%	↑	72.2%	69.2%	↑
Getting Needed Care	73.6%	73.1%	71.8%	↑	81.6%	78.7%	↑	67.9%	90.6%	↓
Getting Care Quickly	74.9%	67.8%	62.4%	↑	82.0%	80.3%	↑	79.2%	80.0%	↓
How Well Doctors Communicate	93.9%	91.4%	81.8%	↑	100.0%	90.9%	↑	93.0%	92.1%	↑
Customer Service	87.3%	86.7%	82.3%	↑	94.1%	95.5%	↓	82.6%	93.3%	↓
Coordination of Care	78.3%	70.8%	93.3%	↓	100.0%	90.9%	↑	76.9%	85.7%	↓

YoYT = Year-Over-Year Trend

Commercial Adult Trended Survey Results – Delegated Network

MY2023 CAHPS 5.1H Adult Commerical	2024 Plan Total	CHCN			Alliance			AHS		
		2024	2023	YoYT	2024	2023	YoYT	2024	2023	YoYT
Total Respondents	185	91	91		71	90		23	34	
Rating of Health Care (8-10)	75.0%	74.6%	73.7%	↑	85.0%	78.8%	↑	52.9%	80.0%	↓
Rating of Personal Doctor (8-10)	83.4%	82.1%	82.9%	↓	83.3%	79.2%	↑	88.9%	89.3%	↓
Rating of Specialist (8-10)	76.3%	77.8%	80.6%	↓	80.6%	78.0%	↑	50.0%	87.5%	↓
Rating of Health Plan (8-10)	73.7%	72.4%	68.2%	↑	79.7%	64.0%	↑	60.9%	72.7%	↓
Getting Needed Care	71.1%	70.6%	67.4%	↑	67.5%	72.0%	↓	82.7%	83.7%	↓
Getting Care Quickly	65.0%	64.2%	47.7%	↑	68.3%	60.6%	↑	58.3%	67.0%	↓
How Well Doctors Communicate	89.7%	91.8%	86.4%	↑	86.1%	87.6%	↓	94.6%	90.0%	↑
Customer Service	82.7%	81.4%	79.4%	↑	80.4%	83.9%	↓	94.4%	88.9%	↑
Coordination of Care	78.2%	83.3%	82.1%	↑	71.8%	75.8%	↓	83.3%	84.6%	↓

YoYT = Year-Over-Year Trend

The 2024 CAHPS survey results year-over-year trends show variation within the **Alliance** business lines. Across LOBs, the Medi-Cal Child population had the highest measure summary rate scores in 2024.

2023 – 2024 Alliance and Delegate Comparative Findings

Medi-Cal Child

- AHS: Four (4) of nine (9) scores increased based on the above table. A significant increase in percentage scores were seen for 'Rating of Personal Doctor' and 'Coordination of Care.' Significant decreases in percentage scores were seen for 'Rating of Specialist.'
- Direct: Five (5) of nine (9) scores increased based on the above table. With significant increase in percentage scores for 'Getting Care Quickly.' Significant decreases in percentage scores were seen for 'Customer Services' and 'Coordination of Care'.
- CFMG: Five (5) of the nine (9) scores increased based on the above table. Overall, there is no significant increase or decrease in scores for CFMG in 2024.
- CHCN: Four (4) of nine (9) scores increased based on the above table. A significant increase in percentage scores was seen for 'Rating of Healthcare.' Significant decreases in percentage scores were seen for 'Rating of Specialist' and 'Coordination of Care'.

Quantitative Trends:

- Overall, a consistent increase in percentage scores was seen throughout all delegate groups. 'Rating of Specialist' and 'Coordination of Care' are the largest decreased compared to previous year.

Medi-Cal Adult

- AHS: Eight (8) of nine (9) scores increase based on the above table. A significant increase was seen for 'Rating of Health Care,' 'How Well Doctors Communicate,' and 'Coordination of Care.'
- Direct: Three (3) of nine (9) scores increase based on the above table. With significant

increase in percentage scores for 'Rating of Health Care.' Significant decrease in percentage scores were seen for 'Rating of Specialist' and 'Getting Needed Care.'

- CHCN: Seven (7) of nine (9) scores increased based on the above table. With a significant increase for 'Rating of Health Care,' and 'How well Doctors Communicate.' Significant decrease in percentage score was seen for 'Coordination of Care.'

Quantitative Trends:

- All delegates showed significant increased percentage scores in 'Rating of Health Care.'

Commercial Adult

- AHS: Seven (7) of nine (9) scores decreased based on the above table. A significant decrease in percentage scores were seen for 'Rating of Health Care,' 'Rating of Specialist,' and 'Rating of Health Plan.'
- Direct: Five (5) of nine (9) scores increased based on the above table. A significant increase was seen for 'Rating of Health Plan.'
- CHCN: Seven (7) of nine (9) scores increase based on the above table. A significant increase was seen for 'Getting Care Quickly.'

Quantitative Trends:

- Small fluctuation of percentage scores was seen overall for most of the measures but 'How Well Doctors Communicate' received the accumulative highest rating compared to other measures.

Top and Bottom 3 Measures

Population	Top 3 Measures	Bottom 3 Measures
Medi-Cal Child	Rating of Health Plan (9or10)	How Well Doctors Communicate
	Customer Service	Getting Needed Care
	Rating of Personal Doctor (9 or10)	Getting Care Quickly
Medi-Cal Adult	Rating of Healthcare (9-10)	Getting Care Quickly
	How well Doctors Communicate	Getting Needed Care
	Rating of Health Plan (9 or 10)	Coordination of Care
Commercial Adult	Rating of Health Plan (9or10)	Rating of Specialist (9or10)
	Rating of Health Care (9or10)	How Well Doctors Communicate
	Rating of Personal Doctor (9 or 10)	Getting Care Quickly

'Getting Care Quickly' is identified in 2024 as the common bottom measure for all three Lines of Business. The low scoring measures provide opportunities for improvement via root cause analysis as part of the QIHE Work Plan for 2025.

Key Drivers of Rating of Health Plan

Population	Key Drivers
Medi-Cal Child	Rating of Health Care
	Rating of Personal Doctor
	Dr. Listened carefully
Medi-Cal Adult	Rating of Health Care
	Rating of Personal Doctor
	Getting Care, Test, or Treatment
Commercial Adult	Getting Routine Care
	Rating of Personal Doctor
	Dr. Spent enough time

The above table shows 'Rating of Personal Doctor' was found to be the common Key Driver in all three Lines of Business. With 'Rating of Health Care' being the second most common Key Drivers in at least two Lines of Business.

Next Steps

The Alliance will continue to collaborate interdepartmentally, focusing on maintaining power in top rated measures and improving member perception of care and services ranked at the bottom of composite scores. Additionally, the Alliance will continue to partner with providers on initiatives designed to improve the member experience and survey scores in 2024 using PDSA cycles to improve or maintain Member Satisfaction scores.

Review improvement strategies recommendations by Press Ganey (PG) for targeted improvement focus that include:

- Assess CAHPS data by direct and delegate provider/networks. Beginning Q2 2024 share results at Joint Operations Meetings (JOM) and Quality Improvement meetings with providers. Correlate with grievance data and access PQI complaint data to share with providers.
- Continue best practices for LOBs with increasing survey results.
- Educate providers and staff about Plan and regulatory appointment wait time requirements or standards (i.e., CAHPS, CMS, States, etc.). Identify opportunities for improvement.
- Virtual/onsite visits to providers not meeting Timely Access year over year.
- Encourage/support provider in approaches toward open access scheduling. Allow portion of each day to open the schedules urgent care and/or follow-up care.
- Support members and collaborate with providers to enhance routine and urgent access to care through proactive approaches with Member Services, Provider Relations, Utilization Management, Behavioral Health, and Case and Care Management.
- Ensure Member Services representatives are able to accurately advise members of available alternatives for care, such as Nurse advise line, Telehealth, Urgent Care, etc.

Provider Satisfaction Survey Overview

The Alliance contracted with its NCQA certified vendor, Press Ganey (PG), to conduct a Provider Satisfaction Survey for MY2024. Information obtained from these surveys allows plans to measure how well they are meeting their providers' expectations and needs. The Alliance provided PG with a database of Primary Care Physicians (PCPs), Specialists (SPCs) and Behavioral Health (BH) providers who were part of the Alliance network. Duplicate provider names or NPIs were removed from the database prior to submitting to survey vendor. From the database of unique providers, a sample of 915 records was sampled. A total of 137 surveys were completed between September - November 2024 (83 mail, 39 internet, 15 phone).

The table below contains the survey response rates, survey respondents, and role of survey respondents for 2024 compared to 2023.

Survey Response Rates for Mail/Internet and Phone: 2024 vs. 2023

	Mail/Internet	Phone
2024	13.3%	1.6%
2023	12.6%	1.7%

Survey Respondents for PCPs, BH Providers, SPCs: 2024 vs. 2023

	PCPs	BH Providers	SPCs
2024	10.4%	25.1%	15.5%
2023	9.7%	24.0%	14.6%

Year to Year Trend Comparisons

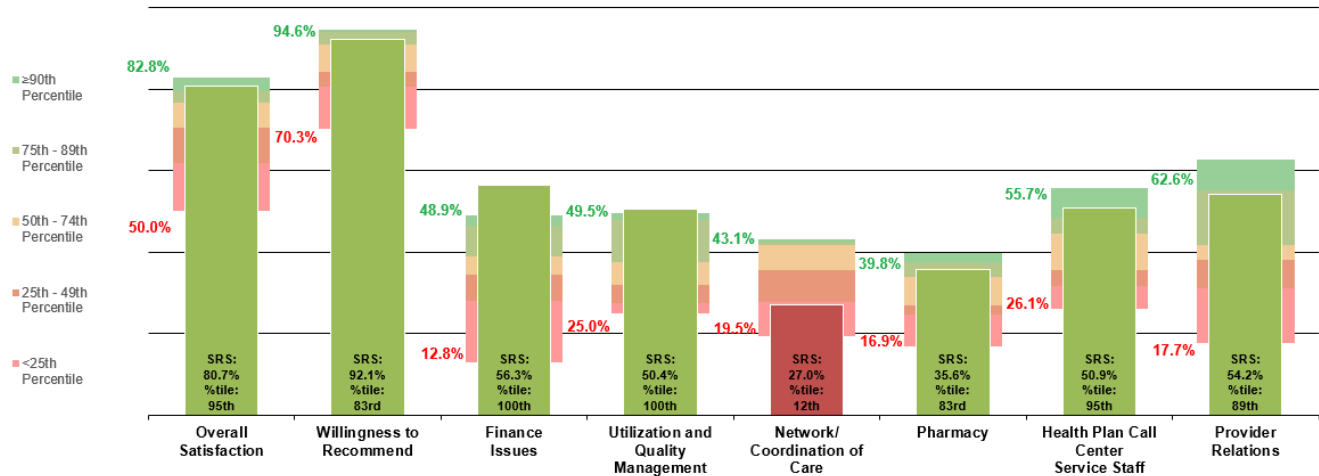
The table below contains the trended survey results across composites.

Trended Survey Results Across Composites

Summary Rate Scores				
Composite / Attribute	2024	Variance Compared to Previous Year	Variance Compared to PG Commercial Benchmark BoB	2023
Overall Satisfaction with the Alliance	80.7%	Higher	Significantly Higher	78.4%

All Other Plans (Comparative Rating)	64.1%	Higher	Significantly Higher	55.3%
Finance Issues	56.3%	Higher	Significantly Higher	49.0%
Utilization and Quality Management	50.4%	Higher	Significantly Higher	47.5%
Network Coordination of Care	27.0%	Lower	N/A	41.7%
Pharmacy	35.6%	Lower	N/A	38.1%
Health Plan Call Center Service Staff	50.9%	Higher	Significantly Higher	49.2%
Provider Relations	54.2%	Lower	Significantly Higher	62.7%

The Alliance identified higher composite scores in 5 of 8 measures compared to 2023 scores. One (1) of the 8 composites scored significantly lower compared to 2023. All six (6) composites scores significantly higher than the vendor commercial BoB benchmark.



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

Red bar = AA performing below the 25th percentile

Survey results indicated that the Alameda Alliance is performing above the 75th percentile in 7 of 8 measures compared to the distribution of scores in the 2023 PG Commercial Book of Business and performing below the median measure 'Network/Coordination of Care. PG Alliance POWER List:

Promote and Leverage Strengths (Top 5 Listed):

1. Timeliness of plan decisions on urgent prior authorization requests.
2. Timeliness of plan decisions on routine prior authorization requests.
3. Procedures for obtaining pre-certification/referral/authorization information.
4. Health Plan call center staff helpfulness in assisting with the referral process or referral network

5. Timeliness of obtaining pre-certification/referral/authorization information.

Best Practice

Below are the performance results for the past three years, for Overall Satisfaction with the Alliance, which has exceeded the PG Aggregate BoB value in all three years.

Overall Satisfaction with Alameda Alliance for Health	Numerator: % Completely of Somewhat Satisfied	Denominator: No. of question respondents	Rate	PG Aggregate Book of Business	Met PG Aggregate BoB? (Y/N)
2022	88	102	86.3%	70.2%	Y
2023	98	125	78.4%	70.1%	Y
2024	108	135	80.7%	69.8%	Y

Next Steps

- Survey results will be shared at the Access and Availability Sub-Committee and Quality Improvement Health Equity Committee.

CG-CAHPS Survey

The Alliance contracted with Press Ganey (PG) Analytics to conduct its quarterly Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) survey within 2024, which measures member perception of and experience with three timely access standards: In-Office Wait Time; Call Return Time; and Time to Answer Call. The CG-CAHPS survey was fielded in Q1, Q2, Q3, Q4 of 2024. PG followed a mixed methodology of mail and phone to administer the survey to a randomized selection of eligible members who had accessed care with their PCP and BH providers within the previous six months.

*BH providers were added to the survey starting Q2 2024.

The table below presents the compliance rates across the three metrics for the CG-CAHPS surveys conducted in 2024 within each quarter.

CG-CAHPS Survey Results 2024 - PCP

Metric	Compliance Goal	Q1 2024	Q2 2024	Q3 2024	Q4 2024
In-Office Wait Time (Within 60 minutes)	80%	91.8%	91.7%	93.9%	90.5%
Call Return Time (Within 1 Business Day)	70%	74.1%	72.0%	73.5%	85.9%

Time To Answer Call (Within 10 minutes)	70%	71.5%	76.1%	76.6%	80.0%

CG-CAHPS Survey Results 2024 - BH

Metric	Compliance Goal	Q1 2024	Q2 2024	Q3 2024	Q4 2024
In-Office Wait Time (Within 60 minutes)	80%	n/a	94.4%	90.5%	89.7%
Call Return Time (Within 1 Business Day)	70%	n/a	72.0%	61.9%	73.7%
Time To Answer Call (Within 10 minutes)	70%	n/a	80.0%	80.0%	81.8%

Providers and delegates have continued to face staffing and provider shortages in their offices.

Possible Barriers	6-month delay in survey fielding from date of encounter. Results are based on <i>a member's perception</i> of encounter experience.
Next Action Steps	- Track and Trend compliance rates. - Continue to follow escalation process for providers non-compliant with CG-CAHPS: 1Q: Track & trend 2Qs: Letter/JOM discussion 3Qs: CAP/Discussion with COO/CFO - Share results with Provider Services department, FSR staff, to incorporate as part of Member & Provider Satisfaction work group discussions and PDSA/Intervention planning as applicable. - Share results with delegate groups and discuss improvement strategies. - Schedule onsite or virtual meetings with providers who have trends for non-compliance

After Hours Care

The Alliance contracted with Press Ganey (PG) Analytics to conduct the annual Provider After-Hours Survey for MY2024, which measures providers' compliance with the after-hours emergency instructions standard. The MY2024 After-Hours Survey was conducted in September of 2024. PG followed a phone-only protocol to administer the survey to the eligible provider population during closed office hours. A total of 480 Alliance providers and/or their staff were surveyed, which consisted of 96 primary care physicians (PCPs), 261 specialists, and 123

behavioral health (BH) providers. Of the 480 providers 314 providers were eligible with 166 providers ineligible and have been excluded from the survey results. The survey assesses the presence of instructions for a caller in an emergency, either via a recording or auto-attendant, or a live person.

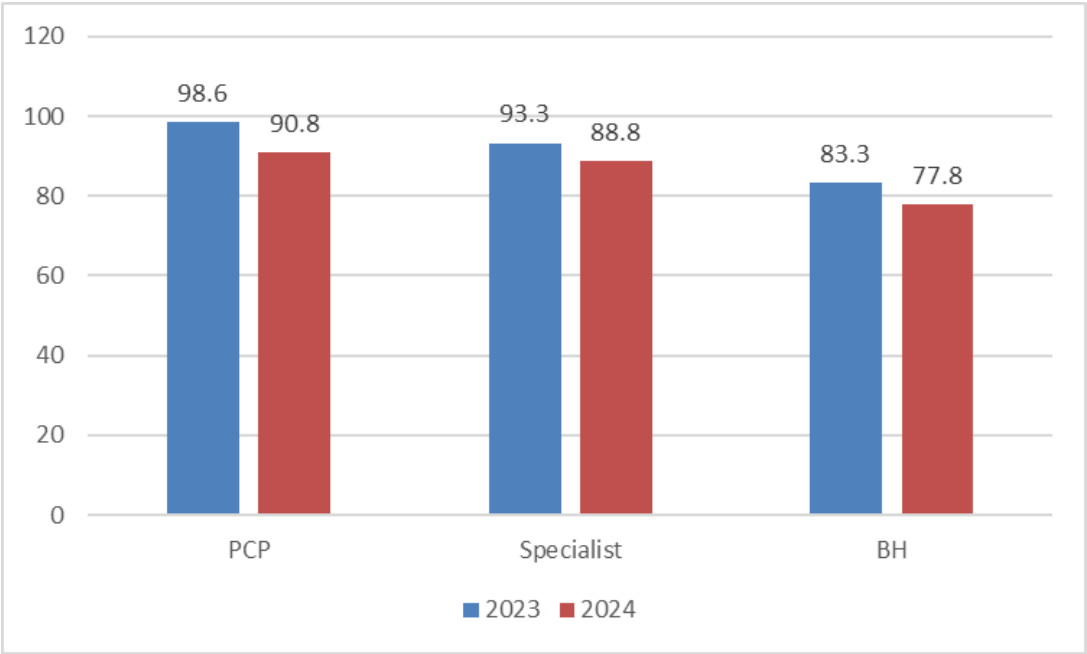
The table below presents the compliance rates for the providers surveyed in the After-Hours Survey:

Compliance Rates for After Hours Survey

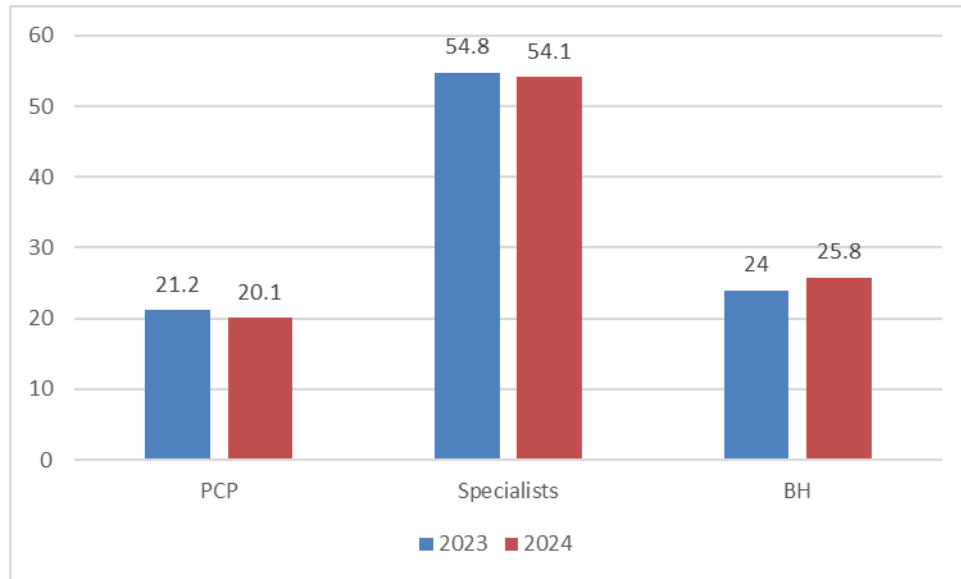
Provider Type	Emergency Instructions		
	Total Compliant	Total non-compliant	Compliance Rate
PCP	57	6	90.8%
Specialist	151	19	88.8%
BH	63	18	77.8%
Total	261	43	

A total of 43 providers (6 PCPs, 19 Specialists, 18 BH) were found to be non-compliant with the emergency instructions standard for the After-Hours Survey. Behavioral Health providers had the highest non-compliance rate in 2024.

**After Hours Emergency Instruction and Access to Physician
Compliance Rate Comparison (2023 v 2024)**



After Hours Emergency Instruction and Access to Provider Survey Response Rate Comparison (2023 v 2024)



- Number of survey respondents in 2023 = 325
- Number of survey respondents in 2024 = 314
- Year-over-year Specialist providers have had the highest response rate to the survey.
- BH providers showed a slight increase in response rate in 2024 from 2023
- Both PCP and Specialists providers had a slight decrease in response rate in 2024 from 2023

In 2024, PCPs and Specialists continue to perform above the 80% compliance rate goal. While BH providers decreased in compliance rate by 2.2% bringing them below the threshold goal in 2024. Results of survey were presented at Q1 2025 Access and Availability Committee with the following next steps for improvement:

- Share results with Delegate and Direct entities.
- Share results with Provider Services and FSR staff to incorporate as part of provider and office staff education for identification of barriers and improvement opportunities.
- CAPs to be sent to non-compliant providers.
- CAPs are issued at the delegate level.

- CAPs are issued at the direct provider level.

Initial Pre-Natal Visits

The Alliance conducted the annual First Prenatal Visit Survey for 2024, which measures providers' compliance with the first prenatal visit standard. The survey was conducted in November – December of 2024 and was administered to a random sample of eligible Alliance Obstetrics and Gynecology (OB/GYN) providers. The table below shows the results of the survey.

First Prenatal Visit Survey			
Appointment within 2 weeks of request	75% Target Goal Met	Percent of Ineligibles	Percent of Non- Responsive
49.2%	No	44%%	10%

Measurement Year 2024, the Alliance did not meet the threshold goal of 75% for First Prenatal Visit Survey. Corrective Action Plans (CAPs) will be issued to all non-responding and non-compliant providers within Q1 2025.

The Alliance's QI Department will continue:

1. Survey monitoring of First Prenatal Visit compliance via Quality of Access PQIs
2. Ongoing provider education and discussions at delegate JOMs and QI meetings regarding timely access standards.
3. CAPs for non-compliant and non-responsive providers.
4. Virtual/Onsite office visits to providers not meeting Timely Access year over year.
5. Collaboration with Analytics, Provider Services, and delegate networks to improve the accuracy of provider data, thus decreasing the number of ineligible providers.
6. Provider recruitment incentive focusing on improving access to care.

Provider Appointment Availability Survey

The Alliance's annual Provider Appointment Availability Survey (PAAS) for MY2024 was used to review appointment wait times for the following provider types:

- Primary Care Physicians (PCPs)
- Specialist Physicians (SPCs):
 - Cardiovascular Disease
 - Endocrinology
 - Gastroenterology

- Dermatology
- Neurology
- Ophthalmology
- ENT
- Pulmonology
- Urology
- Oncology
- Non-Physician Mental Health (NPMH) Providers (PhD-level and Masters-level)
- Ancillary Services Providers offering Mammogram and/or Physical Therapy
- Psychiatrists

The Alliance reviewed the results of its annual PAAS for MY2024 to identify areas of deficiency and areas for potential improvement. The Alliance defines deficiency as a provider group scoring less than a seventy-five percent (75%) compliance rate on any survey question related to appointment wait times.

The Alliance analyzed results for Alameda County, as most members live and receive care in Alameda County, the Alliance's service area. Additionally, per the MY2024 Department of Managed Health Care (DMHC) PAAS Methodology, the Alliance reported compliance rates for all counties in which its contracted providers were located, regardless of whether the providers were located outside the Alliance's service area. This included provider groups in the following counties – Contra Costa, San Joaquin, Sacramento, San Francisco, Santa Clara, San Jose, Solano, Marin, Madera, Monterey, San Mateo, Santa Cruz, San Luis Obispo, Santa Barbara, and Sonoma.

MY2024 Compliance Rates by Appointment/Type across All Provider Types

LOB	Urgent Appt	Routine Appt	
IHSS	Not applicable	72.7%	
MCL	Not applicable	72.7%	
PCPs			
LOB	Urgent Appt	Routine Appt	
IHSS	47.5%	71.9%	
MCL	60.7%	73.3%	
NPMH			
LOB	Urgent Appt	Routine Appt	Follow-up Appt
IHSS	81.9%	93.2%	91.4%
MCL	81.4%	90.8%	91.1%
Psychiatrists			
LOB	Urgent Appt	Routine Appt	
IHSS	80.4%	96.2%	

MCL	80.4%	96.2%	
Specialists			
LOB	Urgent Appt	Routine Appt	
IHSS	34.7%	51.2%	
MCL	48.4%	51.8%	

Across all provider types, there was greater compliance with the routine appointment standards than with the urgent appointment standard, and this was evidenced for both LOBs – MCL and IHSS. The Alliance will continue engaging in provider/delegate re-education around the timely access standards, to increase its efforts around compliance for urgent and non-urgent appointment standard, AAH performed through the following:

- Onsite/Virtual office visits to providers not meeting Timely Access year over year
- Ongoing provider education and delegate JOM discussions regarding Timely Access Standards
- Closed provider panel to prevent longer waiting time
- Encourage/support provider in approach toward open access scheduling. Allow a portion of each day open for urgent care and/or follow care
- Access and Availability collaborate with Analytics and Provider Services to reconsolidate provider data, and thus to decrease the number of ineligible providers
- QI initiatives to improve access such as pay for performance (P4P), extended office hours incentives, practice coaching, and provider recruitment/retention incentive
- CAP and Timely Access Standard sent out to non-compliant and non-responsive providers

Percentage of Ineligible Provider Types

MY	Psychiatrists	PCPs	Specialists	Ancillary	NPMH
2024	8.2%	13.8%	9.7%	25.0%	8.1%
2023	14.0%	23.0%	21.3%	10.0%	7.6%

In MY2024, across all provider types, Ancillary providers had the highest percentage of ineligible providers followed by PCP, Specialists, Psychiatrist, and NPMH. PCPs, Psychiatrists, and Specialist providers all showed improvement for MY2024. NPMH had a slight increase in ineligible providers compared to MY2023. Ancillary showed the highest increase in ineligible providers compared to MY2023. However, Ancillary providers have the smallest sample size compared to all other provider types. Due to the smaller sample size, a few ineligible providers can alter the percentage score in a more drastic way compared to other provider types. The Alliance will ensure continued collaboration with its Analytics and Provider Services Teams, as well as with its delegate networks to enhance accuracy of provider contact information, provider specialty, provider network status, and/or provider appointment availability, with the goal of decreasing the overall percentage of ineligible providers.

Percentage of Non-Responsive Provider Types

MY	Psychiatrists	PCPs	Specialists	Ancillary	NPMH
2024	20.5%	22.8%	62.5%	20.0%	38.1%
2023	17.5%	19.9%	51.9%	10.0%	36.2%

Across all provider types, Specialists had the highest percentage of non-responsive providers, followed by NPMH, PCPs and Psychiatrists, and with Ancillary having the lowest percentage of non-responsive providers in MY2024 (see table above). The Alliance will increase its level of provider/delegate education around survey completion and purpose, including a focus on the development of provider/delegate improvement plans, with the overall goal of lessening and/or removing barriers for non-responsiveness. These efforts will include a focus on Specialists, given they had the highest level of survey non-responsiveness across provider types year-on-year.

Year-Over-Year Analysis

For eligible providers who completed the survey in MY2024, most of the provider categories showed a decrease in percentage score. Psychiatrists were the only providers who show percentage increase in both appointment standards. NPMH providers also had a percentage increase for non-urgent and follow-up appointment standard for both LOBs. Both Psychiatrist and NPMH continue to meet the 75% compliance goal. Ancillary providers were the only provider category that received a 100% in MY2023. However, in MY2024 they dropped below the threshold goal. PCP providers continue to stay around the same scores as the previous year. Lastly, Specialist providers continue to score the lowest compared to other provider types.

Alameda Health Systems (AHS)

For the PCP provider type, AHS met the compliance goal of 75% for non-urgent appointment standard but did not meet the compliance rate threshold for urgent appointment standard for both LOBs. For the Specialists provider type, AHS scored 100% for non-urgent appointment standard for both LOBs for Cardiology and ENT. AHS did not meet the compliance rate threshold for both appointment standards for Endocrinology, Gastroenterology, Neurology, and Pulmonology.

Children's First Medical Group (CFMG)

For the PCP provider type, CFMG providers maintained a stable rate of compliance and met the compliance rate threshold of 75% for urgent and non-urgent appointments. For the Specialist provider type, CFMG providers met the compliance rate for both appointment standards for Cardiology, Hematology/Oncology, and Ophthalmology. The threshold goal was not met for both appointment standards for Endocrinology, Gastroenterology, ENT, Pulmonology and NPMH.

Community Health Center Network (CHCN)

For the PCP providers, CHCN met the compliance goal of 75% for non-urgent appointment

standard for both LOBs but failed to meet the compliance rate threshold for urgent appointment. For Ancillary providers, CHCN scored 100% compliance rate for Mammography, but did not meet the compliance rate threshold for Physical Therapy. For the NPMH providers, CHCN met the compliance rate threshold for both appointment standards for both LOBs. As for Hematology/Oncology and Ophthalmology, CHCN met the compliance rate threshold for both appointment standard for both LOBs. For Cardiology, CHCN met the compliance rate threshold for the Commercial LOB for non-urgent appointment but failed to meet the threshold goal for Medi-Cal. As for Endocrinology, Gastroenterology, Dermatology, Neurology, ENT, and Urology, CHCN did not meet the threshold goal for these provider type.

Individual Contracted Providers (ICP)

ICPs meet the threshold goal of 75% for both appointment standards and LOBs for PCP, Psychiatrists, and NPMH. For the Specialty providers, ICPs met the compliance threshold goal for Cardiology, Pulmonology, and Urology for both appointment standards and LOBs. Gastroenterology and ENT both met the non-urgent appointment standard but did not meet the urgent appointment standard. Endocrinology, Dermatology, Neurology, and Ophthalmology did not meet the appointment standard threshold goal for MY2024.

Provider-Focused Improvement Activities

As part of the QI strategy for 2025, the Alliance will continue its ongoing re-education of providers/delegates regarding timely access standards via various methods (e.g., quarterly provider packets, fax blasts, postings on the Alliance website, targeted outreach to providers/delegates, and in-office provider visits as appropriate), with the goal of increasing individual response and compliance rates to $\geq 75\%$. Additionally, the Alliance A&A unit will conduct focused scheduled and confirmatory surveys/audits that assess provider compliance with timely access standards. Time-sensitive corrective action plans (CAPs) will be issued to all non-responsive and non-compliant providers. Results and corrective actions needed for improvement will be discussed with delegate leadership staff during Joint Operations Meetings between the Alliance and its delegate. The Alliance will review other survey result indicators of access and availability to identify both best practice and opportunities for improvement throughout the year for performance improvement activities. In addition, AAH provides incentives for extending office hours, funding for provider retention and recruitment, focusing on improving access to care.

For PAAS MY2024 all non-compliant PCPs, Specialists, NPMH providers, Ancillary providers, and Psychiatrists receive notification of their survey results and the timely access standards in which they were deficient, along with time-sensitive CAPs. All non-responsive PCPs, Specialists, NPMH providers, Ancillary providers, and Psychiatrists receive notification of their non-responsiveness reminding them of the requirement to respond to timely access surveys, along with the timely access standards and time-sensitive CAPs.

The Alliance will share findings from the MY2024 PAAS at the Q2 2025 Access and Availability Sub-Committee for feedback and recommendations, as well as, in the August 2025 QIHEC, which is comprised of Chief Medical Officer leadership from delegated networks, offering additional opportunities for discussion of best practice and improvement opportunities.

Provider Outreach and Engagement

During 2024, the Provider Services department continued outreach to all PCP, Specialists and Ancillary provider offices. Outreach and engagement with providers were done in various ways including virtual meetings, email, telephone, fax blasts, and mail.

Topics covered in the outreach, engagement, and fax blasts included but, were not limited to: Provider Satisfaction updates, Provider Appointment Availability Survey (PAAS) updates, utilization management updates and reminders, Immunizations, provider network updates, Annual Healthcare Effectiveness Data and Information Set® (HEDIS) medical record data retrieval notice, Fraud, Waste and Abuse information, Timely Access Standards Reminders, coverage reminders for Tobacco Cessation Medications, Health Education information, information about how members may receive access to Doula services, Case and Disease Management program information, Pay-for-Performance program, Long-Term Care updates, behavioral health updates, Provider webinars, and Member Rights.

In addition to ongoing outreach, every newly credentialed provider received a new provider orientation within 30 business days of becoming effective with the Alliance. This orientation includes a very detailed summary which includes but not limited to:

- Plan review and summary of Alliance programs,
- Review of network and contract information,
- How to verify eligibility,
- Referrals and how to submit prior authorizations,
- Timely Access Standards,
- Member benefits and services that require PCP referral,
- Filing of complaints and the appeal process,
- Interpreter Services process,
- Transportation benefit information,
- Initial Health Appointment,
- Coordination of Care, California Children's Services, Regional Center, WIC program,
- Claims and billing information,
- Child Health and Disability Program,
- Members' Rights and Responsibilities,
- Member Grievances,
- PQIs,
- Provider Portal, and
- Health Education.

Overall, there were over 500 quarterly packets mailed to providers with updates as mentioned above. Additionally, over 3,500 outreach occurrences were conducted during the 2024 calendar

year. The Provider Services department plans to continue our robust provider outreach and engagement strategies in 2025.

Member Outreach and Member Services

The Alliance Member Services (MS) Department continues to have a strong focus on providing high-quality service. The Alliance mission is to help our members live a healthy life by providing access to high-quality care and services that they need. Providing excellent customer service is just one of the many ways that we serve our members, providers, and community.

The Alliance monitors access to its Member Services Department quarterly. The following internal standards and goals are used to evaluate access to the Member Services Department by telephone.

Member Services Department Telephone Access Standards	
Standards	Goal
% of calls answered by a live agent within 30 seconds	80%
Calls Abandoned before a live voice is reached	≤ 5 %

The Alliance also offers an orientation to help members better understand their benefits, the importance of the initial health assessment and who to call when they need help. The member orientation is available to all Alliance members.

Member Engagement and Feedback

Community Advisory Committee (CAC)

The purpose of the CAC is to provide a link between the Alliance and the community. The CAC reflects the Alliance’s member population and diversity. The CAC meets quarterly and advises the Alliance on the development and implementation of policies and procedures that affect cultural and linguistic access, quality, and health equity.

In 2024, the CAC provided input and feedback on various topics. A summary of the input and feedback provided by the CAC across various domains is outlined in the table below.

2024 CAC Input and Feedback

Topic	CAC Input and Feedback
Health Education	1. Promote Member Materials and Use of Alliance Benefits • Use clinics, staff, community partners (i.e., IHSS, Regional Center) and Alliance newsletters to promote materials, care books, and Alliance benefits. • Promote preventive care with member stories ▪ Promote benefit Awareness in newsletter and reduce benefit silos for members
Population Health	1. Promote screenings and well visits through focus on inequities, taking trust in doctors, disability access, and possible provider

	shortages into consideration. Conduct culturally concordant surveys to understand reasons for low visit rates. 2. Consider using telehealth for follow-ups or for those unable to visit in-person. 3. Importance of having trusted, compassionate relationships with doctors for new symptoms, medications or serious matters.
Alameda County Public Health Needs Assessment	1. Concern about multiple poor health outcomes for African Americans 2. Recommend assessing the needs of young adults, elders, children, and understand mental health needs. 3. Recommend easier access to public health services and to inform members about available services. 4. Concern about food quality and access to healthy food, housing and rent burden.
Non-Specialty Mental Health Services (NSMHS) Outreach and Education Plan	1. Interest in ease of access to talk to someone about mental health problems and having support with follow-up and understanding pre-authorizations. 2. A community organization's social media may be a good way to promote NSMHS 3. Suggested partnering with sports teams to reduce mental health condition stigma.
Alliance Services	1. Promote doula program with OB/GYN, PCP, and La Leche League. 2. ABA service concerns about high turnover of staff, minimal qualifications, and low pay. 3. Increase awareness off the transportation benefit by featuring why members like ModivCare, how to preschedule regular dialysis appointments, and share how easy it is to make a complaint to help with program improvement.
Communication	Diversify outreach strategies, such as using radio or television campaigns may work best for certain communities (i.e., newcomers or older Latinx population); members use email and text more than other modes of communication.

CAC input and feedback was shared at the Cultural and Linguistic Services Subcommittee, Quality Improvement Health Equity Committee, and Utilization Management Committee. This ensured that the feedback was reviewed and utilized to help address Alliance member needs and improve Alliance services.

QI Engagement Coordinator Data

In September of 2024, the Quality Improvement (QI) Performance Team launched a program to conduct outreach to Alliance Medi-Cal members to engage them in their care. Members were identified based on gaps in their services through measures on the Managed Care Accountability Set (MCAS). Outreach campaigns were conducted on Cervical Cancer Screening, Controlling Blood Pressures, and Glycemic Status Assessments for Patients with

Diabetes (>9.0%). Profoundly, members from all outcall campaigns shared their appreciation for these phone calls, as they have not received a call like this from their Health Plan before. Additionally:

- Cervical Cancer Screening: During December 2024, 254 calls were made to members needing a pap smear, resulting in 173 successful contacts, or 68.11%. The QI Performance Team learned:
 - Pap Smears have been completed for members who previously resided in other counties. However, their medical records were not transferred from their prior provider(s).
 - Most members agreed to schedule a pap smear, acknowledging the importance due to knowing someone close to them who previously had cervical cancer.
- Controlling High Blood Pressure and Glycemic Status Assessments for Patients with Diabetes (>9.0%): Over the course of four months, September-December 2024, 2,972 calls were made to patients identified not having received care in the last year, who had qualified diagnosis for each of these measures. The Outreach Coordinators successfully contacted 1,868 of these members, or 62.85%. From these calls, the QI Performance Team learned:
 - Many members are unfamiliar with what it means to have their blood pressure or diabetes controlled. However, many of these members also reported they felt like they were under control because they do not feel sick or unwell.
 - Home testing devices are readily available, but the data is not being shared with their Primary Care Physicians (PCPs). These devices do not have Wifi to help transfer this data easily.

Population Health and Equity

Population Health Management (PHM) Overview

In accordance with NCQA 2024 Population Health Program Standards and Guidelines and in alignment with the California Department of Health Care Services (DHCS) *CalAIM: Population Health Management Policy Guide*, the Alliance has developed a PHM Strategy for identifying and addressing member needs across the continuum of care with the aim of improving the health outcomes of the Alliance membership and supporting enhanced quality of life. This continuum includes members with the highest levels of needs, those with emerging risks, and wellness and prevention activities for all members. The Alliance conducts an annual analysis of the impact of its PHM strategy that includes quantitative and qualitative analysis for evidence of program effectiveness and opportunities for improvement.

PHM Strategy

Goal

Develop the Alliance 2024 PHM Strategy to address priority gaps in care and disparities in compliance with DHCS and NCQA requirements.

Results

This goal was achieved. The Alliance created the *2024 Alliance Population Health Management Strategy* and approved the strategy at the May 17, 2024, Quality Improvement and Health Equity Committee (QIHEC) meeting and submitted the strategy to DHCS in October 2024. The 2024 PHM Strategy is described in a separate document. The following table highlights objectives in key focus areas included in the 2024 Alliance PHM Strategy.

The 2024 Population Assessment included a disparity analysis by race/ethnicity of the Department of Managed Health Care (DMHC) Health Equity Quality Measures Set (DMHC HEQMS) and NCQA health equity HEDIS measures. The 2024 Alliance PHM Strategy includes goals and programs to address disparities identified for the following measures: W30 (Well-Child Visits in the First 30 Months), CIS-10 (Childhood Immunization Status), and BCS (Breast Cancer Screening).

Note: Line of Business (LOB) is noted by Medi-Cal (MC) or Group Care (GC).

Alameda Alliance for Health 2024 NCQA PHM Strategy Goals

2024 PHM Strategy Goals			
Domain	LOB	Program Name	Goal
Managing Multiple Chronic Illnesses			
Connect members in need to whole person care	MC & GC	Complex Case Management	At least 80% of members with at least 2 or more comorbidities that are enrolled in CCM between April 2024 and March 2025 will report a confidence level of at least 6 out of 10 in being able to better manage their health condition since receiving care management services on the case management satisfaction survey.
Support members managing health conditions	MC & GC	Multiple Chronic Disease Management	At least 80% of members with 2 or more chronic conditions who enrolled in Disease Management between April 2024 and March 2025 will have a confidence score in disease self-management knowledge and behaviors of at least 24 out of 30 after receiving 2 to 3 health coaching sessions as measured by post health coaching assessment.
Managing Members with Emerging Risk			
Support members managing health conditions	MC	Diabetes Prevention Program	20% of participants who have continued tracking their weight through 26 weeks between April 2024 and March 2025 will have reached and maintained at least 5% weight loss.

Connect members in need to whole person care	MC	BirthWise Wellbeing	By March 2025, at least 3% of (or approximately 75) Black (African American), Hispanic (Latino), or American Indian or Alaskan Native members who are or were pregnant in the last year will receive doula services.
Address primary care gaps and inequities	MC & GC	Black (African American) Breast Cancer Screening QI Project	Increase Breast Cancer Screening (BCS) rates for Black (African American) women ages 50-74 by 3% from MY2023 (as of April 2024) to MY2024.
Keeping Members Healthy			
Address primary care gaps and inequities	MC	Black (African American) Well-Child Visit QI Project	HEDIS well-child visit (W30) and immunization (CIS-10) rates will increase for Black (African American) members by 5% from MY2023 (as of April 2024) to MY2024.
Address primary care gaps and inequities	MC & GC	Non-Utilizer Outreach QI Project	Outreach to at least 20% of members ages 50 years and above who did not utilize services from October 2022 to September 2023 by June 2024 and connect 2% to primary care services.
Address primary care gaps and inequities	MC	Non-Utilizer Outreach QI Project	Outreach to at least 20% of members ages 6 years and under who did not utilize services from October 2022 to September 2023 by June 2024 and connect 2% to primary care services.
Patient Safety of Outcomes Across Settings			
Support members managing health conditions	MC	Follow-up after ED Visit for Mental Illness QI Project	Follow-up After ED Visits for Mental Illness (FUM) - 30 days HEDIS rate for Medi-Cal members will increase from 51.10% in MY2023 (as of April 2024) to 54.87% in MY2024.
Connect members in need to whole person care	MC & GC	Transitional Care Services	Increase the percentage of transitions for high-risk members that had at least one interaction with their assigned care manager within 7 days post-discharge from 20.7% for Medi-Cal and 21.3% for Group Care in August 2024 by 1 percentage point in March 2025.

Population Needs Assessment

Goal

Define meaningful participation in Alameda County and City of Berkeley Community Health Assessment (CHA) and Community Health Improvement Program (CHIP) processes in coordination with Kaiser by August 1, 2024.

Establish project plans with Alameda County and City of Berkeley by September 30, 2024.

Results

This goal was achieved. Alameda Alliance and Kaiser Permanente participated in monthly meetings with both the Alameda County Public Health Department (ACPHD) and City of Berkeley to align CHA/CHIP efforts, identify resource contributions, and support data sharing. The MCPs, Alameda County, and the City of Berkeley worked together on a worksheet provided by DHCS to define meaningful participation. Collaboration progress was reported to DHCS in October 2024 through the PHM deliverable. It continues to be a challenge to align DHCS deadlines for the collaboration with LHJ timelines.

PHM Monitoring

Goal

Expand PHM monitoring and evaluation processes to include further analysis for understanding PHM Key Performance Indicators (KPIs), Quality Measures, PHM Strategy goals, and identifying barriers and opportunities for action by the end of 2024.

Results

This goal was achieved. The Alliance conducted the 2024 comprehensive analysis of the impact of its 2023 Population Health Management (PHM) Strategy. The PHM Evaluation includes quantitative results for relevant clinical, utilization, and experience measures. Quantitative and qualitative analysis are conducted on the results for evidence of program effectiveness and continuous improvement. This analysis is conducted by the Health Care Services Department to support Alliance members and promote an effective PHM Strategy. The complete 2023 PHM Strategy is a separate document.

Although the submission of the DHCS PHM KPIs was put on hold in 2024, the PHM Workgroup continued to monitor the KPIs monthly and discuss semiannually. The PHM quality measures and NCQA health equity measures were also reviewed. The Alliance onboarded a consultant group in November 2024 to create a monitoring framework for KPIs, Quality Measures, and PHM Strategy goals.

Health Education Overview

Alliance promotes the appropriate use of plan health care services, risk reduction, healthy lifestyles, and self-management of health conditions through a Health Education Program available to all members. The Alliance Health Education Program is updated annually as needed with input from the PHM Population Needs Assessment. The Program develops culturally appropriate materials and programs that meet the diverse needs of the Alliance membership and participates in community collaborations to promote health and wellness in Alameda County. The 2024 Health Education objectives and results are as follows:

Member Wellness Handouts and Programs

Health Education continues to offer educational handouts and programs to members covering

a wide variety of prevention, healthy lifestyle, and condition self-management topics.

From January 2024 to December 2024, a total of 2,685 health education and community referral mailings were distributed. These mailings covered important health topics such as nutrition and exercise, heart health, tobacco cessation, and fall prevention. Additionally, they included healthcare tools like Advance Directives, medication lists, and healthcare visit checks.

Below is a breakdown of the distribution of health education materials and community referrals through member mailings:

- Health Education
 - 385 Mailings
 - 381 Unique Members
- Case Management
 - 2,300 mailings
 - 2,243 Unique Members

In addition to health materials, Health Education also conducted targeted outreach and referrals for members living with asthma, diabetes, and our birthing members in 2024. Below is a summary of this effort:

Health Topics	Effort
Asthma	• There were 799 Asthma Start pediatric asthma post emergency department visit and member referrals. • Asthma Start provided asthma education and remediation services to 62 members.
Diabetes	• Alliance providers offered Diabetes Self-Management Education and Support to 769 unique members at hospital and clinic locations.
Pregnancy, Baby Care, and Lactation	• Continued prenatal (5,227) and postpartum (3,395) mailing campaigns. • Referrals to Alameda County and Black Infant Health (637) for culturally responsive care.

Objective 1

Maintain a 95% fulfillment rate for health education material requests and referrals within 10 business days for threshold languages and within 15 business days for translated materials through the end of 2024.

Results 1

The fulfillment goal for health education requests was met in quarters two, three and four (98.3%, 100% and 100%, respectively), but it was not met in quarter one (89.7%). A challenge in quarter one was back filling a vacant staff position for the Health Education Coordinator whose responsibility is to fulfill member health education requests. The position was filled in April 2024.

Members request health education materials and program information through the Wellness

Request Form, referrals from Alliance staff, and provider referrals. The Wellness Request form is included in the Alliance biannual member newsletter (mailed out to all Alliance households) and Health Risk Assessment, Case Management and Health Education mailings.

Top 6 Requested Health Topics 2024

Topic	Member Requests
Diabetes	185
Hypertension	181
Nutrition	172
Back Care	134
Asthma	126
Safety	99

Objective 2.1

Implement the Health Education Intake form and enable reporting on Health Education activities by Q2 of 2024.

Results 2.1

This goal was met, but the timeline was extended to the end of December 2024. Additional time was needed for health education to have the form tested by multiple departments before finalizing a go-live date. The Health Education Request Form was finalized by December 2024 and is now fully operational. The form has been uploaded to our internal website and integrated with a Smartsheet for tracking and reporting.

Objective 2.2

Develop one new health education initiative by the end of 2024.

Result 2.2

This goal was met. The Alliance contracted with Our Roots. Our Roots virtually connects perinatal communities of color impacted by poverty with peer support coaches. The organization's goal is to prevent anxiety and depression and promote intergenerational healing. The Health Education team developed rationale and designed how it could connect members to perinatal peer supports. A community health worker (CHW) provider contract has been executed and onboarded. The organization is currently finalizing a Scope of Work (SOW) and referral workflows.

Disease Management (DM) Overview

Alliance Health Education and Case Management teams collaborate to launch programs and interventions that support members in disease self-management. From 2023 to 2024, the Alliance launched its full suite of disease management interventions in Asthma, Cardiovascular Disease, Diabetes, and Perinatal Depression.

Objective 1

Collaboratively develop a strategy to support DM populations with closing care gaps and addressing inequities by the end of 2024.

Results 1

This goal was met. The DM team reviewed disease management disparities data and built a health equity data index. A target population of members with gaps in care was identified. The DM team developed a diabetes and cardiovascular disease disparities analysis and developed a plan for tailored outreach to address disparities. The outreach intervention included health-related social needs screening, health coaching, a health coaching member incentive, and referrals to Alliance and community-based resources. The pilot ran for six months. Five members participated in health coaching, 7 members were connected to resources associated to their health-related social need, 10 members were provided care coordination, and 13 members were referred to Case Management, Health Education or Pharmacy services.

Objective 2

Develop a comprehensive DM dashboard that can track all applicable measures. Each DM program will utilize the dashboard to find and analyze 75% of the data they will require for reporting by the end of 2024.

Results 2

This goal was met. The DM team developed and refined the DM PowerBI Dashboard, which was launched in June 2024. Subsequent program goals like eligibility, outreach, and engagement measures were tracked and monitored in the dashboard. The DM team used 100% of the data in the dashboard to complete annual program evaluations.

Summary

The Alliance continues to achieve its goals and make strides across Population Health and Equity programs. The Alliance launched new collaborations with local health jurisdictions, Alameda County Public Health and the City of Berkeley, to define and begin meaningfully participating in community health assessment and improvement programs. Although the deliverables this year for the CHA/CHIP collaboration were met, it continues to be a challenge to align DHCS deadlines for the collaboration with LHJ timelines. A challenge for the PHM team was to continue to add to its capability to analyze and address disparities. The evolution of collaborative efforts internally and externally will lead to increased understanding of its member populations, strengthen capacities to identify inequities and help inform its overall population health strategy.

Health Education continued to fulfill wellness requests from members at 100% of the service level target after a brief ramp up period. It also launched and implemented a successful Diabetes Prevention Program with strong interest and engagement from members. It will continue to work toward the launch of new CHW efforts to connect members to health education and navigation. The DM team also saw various successes with the design and launch of additional analytical capabilities via the DM dashboard that will help inform future program improvements and additional tailored interventions for subpopulations experiencing disparities.

Cultural and Linguistic Services Program

Alameda Alliance for Health (Alliance) regularly evaluates its performance on planned culturally and linguistically appropriate services described in the Cultural and Linguistic Services (CLS) Program description and work plan. This includes:

- Analysis of results of activities, including barrier analysis.
- Trending of measures to assess performance.
- Review and evaluation of the results by community representatives.
- Evaluation of the overall effectiveness of the program.

Completed and Ongoing Activities:

a. Member Cultural and Linguistic Assessment.

Workplan goal: Assess the cultural and linguistic needs of plan enrollees.

Description: The Alliance conducts a quarterly assessment of trending data at multidisciplinary Cultural and Linguistic Services Subcommittee (CLSS Committee) meeting. The Alliance CLSS Committee reviews trends in the linguistic, racial and ethnic make of our member population each quarter comparing current trends to the previous year.

Results: This goal was met. The Alliance reviewed the Member Cultural and Linguistic Assessment at the quarterly Cultural and Linguistic Services Subcommittee meetings held on: January 24, 2024, April 24, 2024, August 8, 2024, and December 3, 2024. Overall, there was an increase in membership and significant increase in Spanish-speaking and Latinx members. This increase can be attributed to the transition of Anthem members and the Adult Expansion for Medi-Cal.

Completion dates: January 24, 2024, April 24, 2024, August 8, 2024, and December 3, 2024

b. Language Assistance Services Fulfillment

Workplan goal: Reach or exceed an average fulfillment rate of ninety-five percent (95%) or more for in-person, video, and telephonic interpreter services.

Description: The Alliance CLS team presents trending data for interpreter services provision and a 4-quarter comparison of interpreter services rates quarterly, and by vendor.

Results: This goal was met. The Alliance exceeded an average fulfillment rate of 95% or more for in-person, video, and telephonic interpreter services:

- Q1 2024: 97%
- Q2 2024: 98%
- Q3 2024: 98%
- Q4 2024: 98%

Completion date: December 31, 2024

c. Language Assistance Services for Behavioral Health

Workplan goal: Ensure tracking of interpreter services utilization for Behavioral Health (BH) services.

Description: The Alliance will work with our interpreter services vendors to develop systems needed to track the provision of interpreter services for behavioral health visits and develop tracking systems that will assist in comparing interpreter services offered for BH and other types of services

Results: This goal was not met. The Alliance worked with our interpreter services vendor to develop a process to identify behavioral health (BH) calls. However, the vendor is unable to identify a BH call without changing the telephone prompt to indicate that it is a BH call. We will continue to work with the vendor to explore solutions for BH interpreter services tracking.

Completion date: In-progress

d. Provider Language Capacity (Member Satisfaction)

Workplan goal: Based on the Member CG-CAHPS Survey 81% of adult members and 92% of child members who need interpreter services will report receiving a non-family qualified interpreter through their doctor's office or health plan.

Description: The Alliance distributes the CG-CAHPS post-visit survey quarterly to measure the members' experience with health care providers and staff, including language access for interpreter services.

Results: This goal was met or unmet in the following quarters:

- Q1 2024-Adult: 84% (Met); Child: 91.4% (Unmet)
- Q2 2024-Adult: 86.6% (Met); Child: 94% (Met)
- Q3 2024-Adult: 90% (Met); Child: 93% (Met)
- Q4 2024-Data not available

For the Adult and Child surveys, satisfaction results improved in both 2024 Q2 and Q3. Q4 2024 data will be available in Q1 2025. Overall, we will continue to monitor satisfaction results.

Completion date: In-progress

e. Language Assistance Services (Member Satisfaction)

Workplan goal: Based on the Timely Access Requirement (TAR) Survey results, develop and implement action steps, as needed, to address member's satisfaction with: a) scheduling appointments with an interpreter; b) availability of interpreters who speak member's preferred spoken language; c) knowledge, skill, and quality of interpreters

Description: The Alliance distributes an annual Timely Access Requirement (TAR) Survey in 15 foreign languages and English to evaluate the experience of limited English proficient (LEP) Alliance members in obtaining interpreter services for health care services from their doctor or health care providers.

Results: This goal was met. This was the first year of fielding the TAR Survey and the 2024 TAR Survey results were reviewed at the Cultural and Linguistic Services Subcommittee and Quality Improvement and Health Education Committee meetings with no concerns identified. Based on 2024 results, there were no actions needed.

Completion date: May 1, 2024

f. **Provider Language Capacity and Race and/or Ethnicity (Provider Network).**

Workplan Goal: Complete Analysis of Capacity of Alliance Provider Network to meet Cultural and Linguistic needs of members.

Description: The Alliance monitors the capacity of our Network providers, including primary care providers, specialists and behavioral health providers, to meet the cultural and linguistic needs of our members. This includes the language preferences, cultural attributes, and race/ethnicity of our providers as compared to our members.

Results: This goal was met. The Alliance wrote the 2024 Availability of Practitioners to Meet the Cultural Needs and Preferences of Members Report (also referred to as the Net 1A Report). The report includes enhancements to the “Meeting Member Cultural Needs” section to include information on the cultural traits for ethnic groups within Alameda County and the religious beliefs of adults.

The Net1A Report was presented and reviewed at the Cultural and Linguistic Services Subcommittee and Quality Improvement Health Equity Committee meetings with no concerns identified. However, feedback was provided to include additional information regarding the discrimination cases, distinguishing between substantial vs. non-substantial cases in the 2025 report.

Overall, this report has met all standards, and the Alliance provider network capacity was achieved a ratio of 1 provider per 2000 members by language.

Completion date: May 1, 2024

g. **Community Engagement: Community Advisory Committee (CAC)**

Workplan goal: Ensure implementation of DHCS 2024 Contract updates to CAC and community engagement.

Description: The Alliance convenes a Community Advisory Committee (CAC) made up of 51% members. The CAC meets four (4) times a year to provide feedback and input into the member-facing programs and policies of the Alliance, including the Alliance Cultural and Linguistic Services Program and CLAS activities.

Results: The Alliance continues to ensure the implementation of 2024 contractual requirements for the CAC. Under the 2024 contractual updates, the Alliance was able to:

- Establish a CAC Selection Committee that will now review/vote on CAC candidates.
- Hold two (2) CAC Selection Committee meetings.
- Present and receive approval by the CAC Selection committee to bring onboard a new CAC member.
- Complete the CAC Demographic Survey to assess and ensure the CAC representation is reflective of the Alliance membership.
- Identify gaps in the CAC representation based on the CAC Demographic Survey.
- Start CAC member recruitment to fill identified gaps and present information about the CAC to the following organizations: Father-Friendly Provider Network (FFPN), Healthy Relationships Learning Community (HRLC), Health and Human Resource

Education Center (HHREC), and Alameda County Public Health Fatherhood Initiative.

The Alliance will continue to work on ongoing CAC member recruitment to fill identified gaps with guidance from the CAC Selection Committee.

Completion date: Ongoing

h. Address Quality of Language Potential Quality Issues (QOL PQIs)

Workplan goal: Monitor, evaluate, and conduct appropriate interventions for PQI-QOLs with a closure rate of 95% or more within 60 (updated in Q3 of 2024) business days.

Description: QOL PQIs are assigned to the CLS Manager and Cultural and Linguistic Services team for review, action as needed to ensure appropriate language services, and tracking and trending. Patterns of concern are addressed with the plan departments, providers or vendors and when needed Corrective Action Plans are put into place.

Results: This goal was met or unmet in the following quarters:

- Q1 2024: 96% closure rate (Met)
- Q2 2024: 86% closure rate (Unmet)
- Q3 2024: 95% closure rate (Met)
- Q4 2024: 93% closure rate (Unmet)

An increase in volume of scheduling interpreter services requests and difficulty reaching provider offices to provide education regarding availability of the Alliance interpreter services presented as challenges to meeting the goal. The Alliance plans to hire an additional staff person to support interpreter services provision, PQI interventions, and make workflow enhancements to address situations when staff are unable to reach a provider office.

Although our internal goal of 95% or more within 60 days was not met, all QOL PQIs were closed within the required closing threshold within 120 days with no trends of concern identified that led to issuing of a provider corrective action plan (CAP).

Completion date: December 31, 2024

Successes: Under the Cultural and Linguistic Services Program, the Alliance:

- Maintained a 95% or above fulfillment rate for all interpreter services modalities despite an increase in membership.
- Received favorable responses related to accessing interpreter services through member satisfaction surveys.
- Met all standards for the Net 1A report and identified an enhancement opportunity to improve reporting regarding discrimination cases.
- Met contractual requirements for the CAC regarding the CAC Selection Committee, member recruitment, and the annual CAC Demographic Survey.

Challenges: While the Alliance identified several successes, the Cultural and Linguistic Services Program faced the following challenges:

- Increased volumes in scheduling interpreter services request and QOL-PQIs.

- Limitations with the interpreter service vendor regarding tracking and reporting systems for BH calls.
- Difficulty with outreach to provider offices to address QOL-PQIs due to lack of contact.

Action Steps: The Alliance plans to address the identified challenges and leverage opportunities for better outcomes through:

- Implementation of a bulk interpreter services scheduling system with one of our interpreter services vendor to assist with the increased scheduling volume.
- Hiring additional staff.
- Reviewing and streamlining workflows for QOL-PQIs.
- Continuing to explore solutions for BH interpreter services tracking.
- Including granular information and outcomes for discrimination cases in the Net 1A report.

Delegation Oversight

As a part of its compliance program and strategy, the Alliance deploys an array of auditing and monitoring exercises throughout the year. Annually, First-tier subcontracted entities, called delegates, undergo an annual delegation oversight audit. The audits are conducted in accordance with DHCS, DMHC, and the NCQA regulations.

Audit results are reported to the Subcontractor & Delegation Oversight Committee, which is a committee that reports to the Compliance Committee.

In 2024, the Alliance conducted annual delegation oversight audits for the functions and entities included in the Alameda Alliance Delegated Entities - 2024 noted in the table below. For Quality Improvement, the Alliance does not delegate this function to any entity.

To supplement its approach to Compliance, the Alliance holds monthly meetings and quarterly JOMs with delegates, as necessary. The monthly meetings allow a collaborative partnership with the delegates to discuss reporting, audits, CAPs, APLs and operational changes, In addition to JOMs, the Alliance holds regular Executive Team meetings with its strategic partners CHCN and AHS.

ALAMEDA ALLIANCE DELEGATED ENTITIES - 2024																			
Delegate's Name		Quality Improvement		Utilization Management X = NCQA Accredited		Credentialing X = NCQA Accredited		Grievances & Appeals		Claims		Call Center		Case Management		Cultural & Linguistic Services		Provider Training	
		Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care
1	Community Health Center Network (CHCN)			X	X					X	X			X	X			X	X
2	March Vision Care Group, Inc.					X				X									
3	Children's First Medical Group (CFMG)			X		X				X									
4	PerformRx (PBM)				X		X				X						X		
5	UCSF (Credentialing)					X	X												
6	Physical Therapy PN (Credentialing)					X	X												
7	Lucille Packard (Credentialing)					X	X												
8	Teladoc (Credentialing)					X	X												

Analysis of 2024 Quality Program Evaluation and Effectiveness

The Alliance has identified successes, challenges/barriers, and improvements throughout the 2024 QIHE Evaluation. Many of the QIHE Program goals were met or exceeded. The evaluation

included recommended activities and interventions to inform the 2025 QIHE Work Plan

Major accomplishments in which objectives were met for 2024 include but are not limited to:

- Adequate QI program resources to carry out roles, functions, and responsibilities.
- Health Equity activities in collaboration with the Chief Health Equity Officer and team members
- Provided QI investments to improve HEDIS/MCAS performance through the following strategies: provider engagement, member engagement, data collection/sharing, innovative funding/projects, and organizational alignment.
- Enhanced Pay-for-Performance program with a focus on quality measures below the minimum performance level and promotion of primary care visits
- Implemented the Population Health Management Program, including publication of a Population Health Strategy with on-going goals/objectives, and in collaboration with multiple departments and community partners, utilized a health equity lens to address health disparities.
- Successful administration of all timely access surveys within the expected timeframes, allowing for timely analysis and implementation of next steps with providers and within the Alliance.
- Maintenance of favorable Provider Satisfaction Survey scores.
- Consistent Senior Level Physician involvement despite Medical Director transitions
- Improved HEDIS performance rates for measures; above the MPL for most reported HEDIS metrics.
- Ongoing Pediatric Care Management Program to promote access to care and EPSDT service utilization in partnerships with direct, delegate, and CBOs.
- Improved turn-around times and root cause analysis of PQIs.
- Robust Health Education and Cultural and Linguistic Programs adding Quality of Language (QOL) PQIs segmentation for tracking and trending.
- Ongoing Community Advisory Committee and member input to ensure continued member input into programs and services.
- Launched the QI member engagement outreach program to address HEDIS opportunities
- Offered webinars, in-person trainings and site visits, and technical assistance for providers
- Coordinated efforts established to improve SNF/LTC quality monitoring through internal and external meetings and follow up
- Comprehensive monitoring of all practitioners during credentialing / re-credentialing to ensure high quality network.

Challenges and barriers to achieving objectives encountered within the 2024 program year included but are not limited to:

- Timely access to care continues to be strained as there are provider workforce shortages compounded by pent up demand for preventive care services.
- Transition of senior leadership, including a new Chief Medical Officer hired and QI Medical Director vacancy
- Increase in membership volume for members from Anthem Blue Cross and Adult Expansion resulted in increases in PQIs and interpreter services.
- Transition to a single plan model with Kaiser no longer a delegate (and increased membership) resulted in initial decreases in HEDIS results in the beginning of 2024
- Financial impacts were imposed for quality sanctions and withholds based on HEDIS/MCAS performance.

Conclusion

Overall, the Alliance's QIHE Program was effective in reviewing data, assessing trends, identifying issues, and developing improvement activities within the Health Plan related to access to care, member and provider experience, health equity, and quality of care.

During 2024, Alameda Alliance focused on meeting the QIHE Program goals and completing all initiatives as outlined in the 2024 QIHE Work Plan. Health equity was integrated into the quality program and continues to be a main driver for the work. Throughout 2024, multiple PDSA activities and innovative projects resulted in improvements in the Alliance's quality performance. These PDSA activities have created a culture focused on the Alliance's mission, member-centric care, and provider satisfaction. In addition, there continues to be extensive collaboration as part of the Population Health Management program, including alignment with the DHCS Bold Goals and with both internal and external partners. In 2024, the Alliance committed to QI investments and supported strategies in member engagement, provider engagement, data collection/sharing, project funding, and organizational alignment; all of which resulted in demonstrated HEDIS/MCAS improvements. The Alliance is dedicated to improving the quality of healthcare delivered to its members through proactive analysis of shared processes and integration of health initiatives that align with the industry and government quality standards; including a preventive health model of whole person care and preemptive interventions related to health outcomes.

ALAMEDA ALLIANCE FOR HEALTH

QUALITY IMPROVEMENT HEALTH EQUITY
PROGRAM DESCRIPTION
2025



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

2025 Quality Improvement Health Equity Program Description Signature Page

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Senior Director of Quality

Date

Vice Chair, Quality Improvement Health Equity
Committee (Vacant)

Date

Lao Paul Vang
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Committee

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Chief Executive Officer
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OVERVIEW

Alameda Alliance for Health is a public, not-for-profit managed care health plan committed to making

high quality health care services accessible and affordable to lower-income people of Alameda County. Established in January 1996, the Alliance was created by and for Alameda County residents. The Alliance currently provides health care coverage to approximately 412,732 children and adults through its programs.

Alameda Alliance for Health is licensed by the State of California and product lines include Medi-Cal managed care and Group Care commercial insurance. Medi-Cal managed care beneficiaries, eligible through one of several Medi-Cal programs, e.g. SPD, Medi-Cal Expansion. For dually eligible Medi-Cal and Medicare beneficiaries, Medicare remains the primary insurance and Medi-Cal benefits are coordinated with the Medicare provider.

Alliance Group Care is an employer-sponsored plan offered by the Alliance. The Group Care product line provides comprehensive health care coverage to In-Home Supportive Services (IHSS) workers in Alameda County.

Alameda Alliance for Health's (Alliance) Quality Improvement Health Equity (QIHE) Program applies to all product lines and strives to ensure that members have access to quality health care services that are safe, effective, equitable, and meet their needs. The QIHE program includes systematic and continuous activities to monitor, evaluate, and improve upon the health equity and health care delivered to Members in accordance with the standards set forth in applicable State and Federal regulations.

The QIHE Program Description is a comprehensive document with a set of interconnected documents that describes our quality program governance, structure and responsibilities, operations, scope, goals, and measurable objectives. Participation of all Alliance departments and staff in quality improvement activities is essential to the organization in achieving our QIHE goals and objectives.

The Alliance complies with applicable State and Federal civil rights laws and does not discriminate based on race, color, religion, ancestry, national origin, ethnic group, age, mental or physical disability, sex, gender, gender identity, or sexual orientation, medical condition, genetic condition, or marital status. The Alliance QIHE Program is committed to serving the healthcare needs of our culturally and linguistically diverse membership. The Alliance staff and provider network reflect the county's cultural and linguistic diversity.

MISSION AND VISION

Mission

Improving the health and well-being of our members by collaborating with our provider and community partners to deliver high quality and accessible services.

Vision

All residents of Alameda County will achieve optimal health and well-being at every stage of their life.

QIHE PROGRAM SCOPE AND GOALS

The purpose of the Alliance QIHE Program is to objectively monitor and evaluate the quality, safety, appropriateness, health equity, and outcome of care and services delivered to members of the Alliance. The overall goal of the QIHE Program is to ensure that members have access to quality health care services that are safe, effective, equitable, and meet their needs. The QIHE Program is structured to continuously pursue opportunities for improvement and problem resolution. The QIHE Program is organized to meet overall program objectives as described below and as directed each year by the QIHE and UM Work Plans. Improvement priorities are selected based on volume, opportunities for improvement, risk, and evidence of disparities.

Although not limited to, the goals of the QIHE Program are to:

1. Maintain the delivery of high quality, safe, and appropriate medical and behavioral health care that meets professionally recognized standards of practice that is delivered to all enrollees.
2. Utilize objective and systematic measurement, monitoring, and evaluation through qualitative and quantitative analysis of health care services and to implement QIHE activities based on the findings.
3. Conduct performance improvement activities that are designed, implemented, evaluated, and reassessed using industry recognized quality improvement models such as Plan-Do-Study-Act (PDSA).
4. Ensure physicians and other appropriate licensed professionals, including behavioral health, are an integral and consistent part of the QIHE Program.
5. Ensure medical and behavioral health care delivery is consistent with professionally recognized standards of practice.
6. Track and trend the delivery of healthcare services to ensure care and services are not withheld or delayed for any reason, such as potential financial gain or incentive to plan providers.
7. Design and maintain an ongoing organizational culture of quality to ensure continual HEDIS improvement and accreditation readiness.

The scope of the QIHE Program is comprehensive and encompasses the following:

1. Timely access and availability to quality and safe medical, behavioral, and specialty health care and services.
2. Care and Disease management services.
3. Cultural and linguistic services
4. Patient safety.
5. Member and provider experience
6. Continuity and coordination of care across settings, with the goal of establishing consistent provider-patient relationships.
7. Tracking of service utilization trends, including over-and under-utilization
8. Clinical practice guideline development, adoption, distribution, and monitoring.
9. Targeted focus on acute, chronic, and preventive care services for children and adults for

Member and provider education.

10. Prenatal, primary, specialty, emergency, inpatient, and ancillary care.

11. Case review, investigation, and corrective actions of potential quality issues

12. Credentialing and re-credentialing activities.

13. Delegation oversight and monitoring.

14. Delegate and direct providers performance improvement project collaborations.

15. Targeted support of special needs populations including Seniors and Persons with Disabilities and persons with chronic conditions.

16. Population Health Management Integration.

17. Health care diversity and equity.

ORGANIZATIONAL STRUCTURE AND SUPPORT COMMITTEES' RESPONSIBILITY

Overview

The Alliance Board of Governors (BOG) appoints and oversees the Quality Improvement Health Equity Committee (QIHEC), Pharmacy & Therapeutics (P&T) Committee, Peer Review Committee, Credentialing Committee, Community Advisory Committee, and Compliance Committee which in turn, provide the authority, direction, guidance, and resources to enable Alliance staff to carry out the QIHE Program.

The organizational chart in **Appendix A** displays the reporting relationships for key staff responsible for QIHE activities at the Alliance. **Appendix B** displays the committee reporting relationship and organizational bodies.

Board of Governors

The Alliance BOG is appointed by the Alameda County Board of Supervisors and consists of up to 15 members who represent members, provider, and community partner stakeholders. The BOG is the final decision-making authority for the Alliance QIHE Program. Its duties include:

- Reviewing annually, updating, and approving the QIHE Program description, defining the scope, objectives, activities, and structure of the program.
- Reviewing and approval of the annual QIHE report and evaluation of QIHE workplan, studies, activities, and data on utilization and quality of services.
- Assessing QIHE Program's effectiveness and direct modification of operations as indicated.
- Defining the roles and responsibilities of QIHEC.
- Designating a physician member of senior management with the authority and responsibility for the overall operation of the QIHE program, who serves on QIHEC.
- Appointing and approving the roles of the Chief Medical Officer (CMO), including the support of the Chief Health Equity Officer, and other management staff in the QIHE Program.
- Receiving a report from the CMO as Chair on the agenda and actions of QIHEC.

Quality Improvement Health Equity Committee (QIHEC)

The QIHEC is a standing committee of the BOG and meets a minimum of four times per year, and as often as needed, to follow-up on findings and required actions. The QIHEC is responsible for the implementation, oversight, and monitoring of the QIHE Program and Utilization Management (UM) Programs. The QIHEC recommends policy decisions, analyzes and evaluates the QIHE work plan activities, and assesses the overall effectiveness of the QIHE Program. The QIHEC reviews results and outcomes for all QIHE activities to ensure performance meets standards and makes recommendations to resolve barriers to quality improvement activities. Any quality issues related to the health plan that are identified through the CAHPS and Provider Satisfaction surveys and health plan service reports are also discussed and addressed at QIHEC meetings. The QIHEC oversees and reviews all QI delegation summary reports and evaluates delegate quality program descriptions, program evaluations, and work plan activities. The QIHEC presents to the Board the annual QIHE Program description, work plan and prior year evaluation. Signed and dated minutes that summarize committee activities and decisions are maintained. The Annual QIHE Program, Work Plan, and Evaluation from the QIHEC (or other related documents as requested) are submitted to the California Department of Health Care Services (DHCS).

Responsibilities include but are not limited to:

- Analyze and evaluate the results of QIHE activities including annual review of the results of performance measures, utilization data, satisfaction surveys (i.e. CAHPS), and findings and activities of the quality committees, such as the Community Advisory Committee.
- Approve, select, design, and schedule studies and improvement activities.
- Review other member and provider survey results and related improvement initiatives.
- On-going reporting to the BOG.
- Meeting at least quarterly and maintaining approved minutes of all committee meetings.
- Approve definitions of outliers and develop corrective action plans.
- Recommend and approve Medical Necessity Criteria, Clinical Practice Guidelines, as well as pediatric and adult Preventive Care Guidelines and review compliance monitoring.
- Review member grievance and appeals data.
- Oversee the Plan's process for monitoring delegated providers.
- Oversee the Plan's UM Program.
- Review advances in healthcare technology and recommend incorporation of new technology into delivery of services as appropriate.
- Institute actions to address performance deficiencies, including policy recommendations, and ensure follow-up of identified findings.
- Provide guidance to staff on quality improvement activities.
- Monitor progress in meeting QIHE goals.
- Evaluate annually the effectiveness of the QIHE and Population Health Management program.
- Oversee the Plan's complex case management and disease management programs.
- Ensure that its fully delegated subcontractors and downstream fully delegated subcontractors

maintain a QIHEC that meets the QIHE program requirements.

- Review and approve annual QIHE and UM Program Descriptions, Work Plans, and Evaluations.
- Recommends and approves resource allocation for the QI Department Program. The QIHEC is chaired by the CMO and vice-chaired by the Medical Director of QI. The members are representatives of the Alliance contracted provider network including those who provide health care services to members affected by health disparities, Limited English Proficiency (LEP) members, Children with Special Health Care Needs (CSHCN), Seniors and Persons with Disabilities (SPD) and persons with chronic conditions. The QIHEC Members are appointed for two-year terms. The voting membership includes:
 - Alliance CMO (Chair)
 - Medical Director of Quality (Vice-Chair)
 - Chief Executive Officer (ex officio)
 - Chief Health Equity Officer
 - Medical Director or designee from each delegated medical group (i.e., Community Health Center Network, Children First Medical Group)
 - Physician representative of Alameda County Medical Center
 - Physician representative of Alameda County Ambulatory Clinics
 - Alliance contracted physicians (3 positions)
 - Representative of County Public Health Department
 - A Behavioral Health practitioner
 - Alliance Medical Directors
 - Alliance Senior Director, Quality

A quorum is established when the majority of voting membership is present at the meeting. The Chief Executive Officer does not count in the determination of a quorum.

Pharmacy and Therapeutics Committee (P&T)

The P&T Committee assists the QIHEC in oversight and assurance of ensuring the promotion of clinically appropriate, safe, and cost-effective drug therapy by managing and approving the Alliance's drug formulary, monitoring drug utilization, and developing provider education programs on drug appropriateness. P&T Committee meeting summaries and changes in Pharmacy related policies are presented directly to the Board of Governors.

The voting membership consists of:

- Alliance Chief Medical Officer (Chair) or designee
- Alliance Senior Director of Pharmacy Services (Co-Chair)
- Practicing physician(s) representing Internal Medicine
- Practicing physician(s) representing Family Practice
- Practicing physician(s) representing Pediatrics
- Practicing physician(s) representing common medical specialties

- Practicing Behavioral Health specialist (e.g., psychologist, psychiatrist)
- Practicing community pharmacists contracted with Alliance (not to exceed three pharmacists)

Peer Review and Credentialing Committee (PRCC)

The PRCC is a standing committee of the BOG that meets a minimum of ten times per year. The Alliance separates the functions of PRCC into two distinct committees – the Peer Review Committee (PRC) and the Credentialing Committee (CC). The chair of both committees is the CMO.

CREDENTIALING COMMITTEE

Primary responsibilities include:

- Ensuring that all applicants are reviewed against minimum standards or criteria and are treated fairly.
- Determining whether there is adequate/sufficient information to evaluate and make a determination/recommendation.
- Implementation and ongoing review of Credentialing Policies and Procedures.
- Assuring that the credentialing process conforms to applicable accreditation standards and other regulatory requirements.
- Making recommendations or decisions related to participation, appointment, and privileges.

PEER REVIEW COMMITTEE

Primary responsibilities include:

- Investigating complaints regarding the quality of clinical care provided by the Alliance's contracted providers and making recommendations for corrective action.
- Reviewing conditions identified as having quality concerns.

The following Committee members have voting rights:

- Committee Chairperson
- Committee Vice Chairperson

Committee Member: Positions held by practitioners

Internal Quality Improvement Committee (IQIC)

The IQIC assists the QIHEC in oversight and assurance of the quality of clinical care, patient safety, and customer service provided throughout the AAH organization. Its primary roles are to maintain and improve clinical operational quality, review organization-wide performance against the Alliance quality goals, and report results to the QIHEC.

Committee Responsibilities include but are not limited to:

- Develop, approve, and monitor a dashboard of key performance and QIHE indicators compared to organizational goals and industry benchmarks.
- Oversee and evaluate the effectiveness of AAH's performance improvement and quality activities.
- Review reports from workgroups and, if acceptable, forward them for review at the next

scheduled QIHEC.

- Review plan and delegate corrective plans regarding negative variances and serious errors.
- Oversee compliance with NCQA accreditation standards.
- Make recommendations to the QIHEC on all matters related to:
 - Quality of Care, Patient Safety, and Member/Provider Experience.
 - Performance Measurement.
 - Preventive services including:
 - Seniors and Persons with Disability (SPD)
 - Members with chronic conditions
 - Medi-Cal Expansion (MCE) members.

The Committee shall be comprised of the following members:

- Alliance Chief Medical Officer (CMO)
- Alliance Medical Director(s)
- Sr. Director, Quality
- Quality Improvement Manager
- Access to Care Manager
- Population Health and Equity Director
- Members from Provider Relations, Member Services, Business Analytics, Compliance, and Grievance and Appeals.

Utilization Management Committee (UMC)

The UMC is a forum for facilitating clinical oversight and direction. Its responsibilities are to:

- Maintain the annual review and approval of the:
 - UM and CM Program Descriptions, UM and CM Policies/Procedures, and UM Criteria
 - Other pertinent UM documents such as the UM and CM Program Evaluations, UM and CM Workplan, and any trends or updates pertaining to the workplans.
 - Enhanced Care Management (ECM) and Community Supports Policies/Procedures
- Health Risk Assessment (HRA) and Health Information Form/Member Evaluation Tool (HIF/MET) Policies and Procedures
- Participate in the utilization management/continuing care programs aligned with the Program's quality agenda.
- Assist in monitoring for potential areas of over and under-utilization and recommend appropriate actions when indicated.
- Review and analyze utilization data for the identification of trends, including trends related to health disparities, social determinants of health, and behavioral health.
- Recommend actions to the QIHEC when opportunities for improvement are identified from

review of utilization data including, but not limited to Ambulatory Visits, Emergency Visits, Hospital Utilization Rates, Hospital Admission Rates, Average Length of Stay Rates, and Discharge Rates.

- Review information about New Medical Technologies from the Pharmacy & Therapeutics Committee including new applications of existing technologies for potential addition as a new medical benefit for Members.

Access and Availability Subcommittee (AASC)

The AASC reviews the Alliance's access and availability data to evaluate whether the Alliance is meeting regulatory standards and provides corrective actions and recommendations for improvement when needed. The committee identifies opportunities for improvement and provides recommendations to maintain compliance with access and availability regulatory requirements.

Membership is comprised of Alliance staff within departments that are involved with access and availability which include the following representation:

- Chief Medical Officer
- Medical Directors
- Senior Director, Quality
- Access to Care Manager
- Quality Improvement Manager
- Population Health & Equity
- Quality Assurance
- Grievance and Appeals Management
- Compliance
- Healthcare Analytics
- Utilization Management
- Member Services
- Provider Services

The following are the monitoring activities the subcommittee reviews to ensure compliance with access and availability and network adequacy requirements including but not limited to:

- Provider network capacity levels
- Facility Site Reviews
- Geographic accessibility
- Appointment availability surveys
- High volume and high impact specialists
- Access-related grievances and appeals. Access-related potential quality issues. Provider language capacity. Wait time and telephone practices related to access. Member and provider satisfaction survey

- After-hours care

Cultural and Linguistic Services Subcommittee (CLSS)

The Cultural and Linguistic Services Subcommittee's role is to ensure members receive culturally and linguistically appropriate health care services and to monitor the Alliance's Cultural and Linguistic Services Program. The CLSS reviews demographic changes in the Alliance membership, language services, grievances and potential quality issues related to language access and discrimination, alternative formats and translation services, and overall execution of the Alliance's Cultural and Linguistic Services Program. The CLSS makes recommendations for program improvements and corrective actions as needed. The CLSS reports results to the QIHEC.

Responsibilities include but are not limited to:

- Monitor the cultural and linguistic needs of members.
- Review reports related to provision of cultural and linguistic services.
- Ensure that language assistance services are provided at all points of contact.
- Maintain and update cultural and linguistic services policies and procedures to be compliant with ongoing regulatory and contractual requirements.
- Annually review and update Cultural and Linguistic Services (CLS)'s program description and workplan. Quarterly monitor the CLS Workplan.
- Review input from the Community Advisory Committee (CAC) on cultural and linguistic services and consider how it may inform Alliance's CLS programs, policies, and procedures.
- Identify issues related to access and provision of culturally and linguistically appropriate services and develop corrective actions to correct deficiencies found.
- Review plan and delegate corrective action plans related to CLS.

The CLSS is composed of the following members:

- Chief Medical Officer
- Chief Health Equity Officer
- Senior Director of Quality
- Director, Population Health, and Equity
- Manager, Cultural and Linguistic Services
- Manager, Population Health, and Equity
- 1 Representative from Compliance
- 1 Representative from Communications and Outreach
- 1 Representative from Grievance and Appeals
- 1 Representative from Population Health and Equity
- 1 Representative from Health Care Services
- 1 Representative from Member Services

- 1 Representative from Provider Services
- 1 Representative from Quality Improvement
- 1 Representative from Behavioral Health

Community Advisory Committee (CAC)

The CAC provides a link between Alameda Alliance for Health and the community. The CAC reflects the Alliance's member population and advise the Alliance on the development and implementation of policies and procedures that affect cultural and linguistic access, quality, and health equity. All CAC findings and/or activities are reported to the QIHEC.

The CAC carries out, but is not limited to, the following duties:

- Identify and advocate for preventive care practices to be used by the Alliance.
- Develop and update cultural and linguistic policy and procedures related to cultural competency issues, educational and operational issues affecting seniors, people who speak a primary language other than English, and people who have a disability.
- Advise on Alliance member and provider-targeted services, programs, and trainings.
- Provide and make recommendations about the cultural appropriateness of communications, partnerships, and services.
- Advise on how to use findings from the CHAs/CHIPs to influence Alliance strategies and workstreams related to the Department of Healthcare Services Bold Goals, wellness and prevention, health equity, health education, and cultural and linguistic needs.
- Provide input and advice, including, but not limited to, the following:
 - Culturally appropriate service or program design
 - The Alliance's diversity, equity, and inclusion strategy
 - Priorities for health education and outreach program
 - Member satisfaction survey results
 - PNA findings
 - Plan marketing materials and campaigns
 - Communication of needs for network development and assessment
 - Community resources and information
 - Population Health Management
 - Quality
 - Health delivery systems to improve health outcomes.
 - Carved out services
 - Coordination of care
 - Health Equity
 - Accessibility of services
 - Development of the provider manual and clarification of new and revised policies and

procedures in the manual

- Development of covered, Non-Specialty Mental Health Services (NSMHS) outreach and education plan.

The CAC membership and representation reflects the Medi-Cal and Group Care populations in Alameda County, and representation includes the following:

- General population of the Alliance members (including adolescents and/or parents and/or caregivers of children, including foster youth)
- Diverse and hard-to-reach populations (including populations that experience health disparities, such as those with diverse racial and ethnic backgrounds, genders, gender identity, and sexual orientation and physical disabilities)
- At least 51% of the committee shall be Alliance members (and/or the parents/guardians of Alliance members who are minors or dependents).

Joint Operations Committee/Delegation

The contractual agreements between the Alliance and delegated entities specify:

- The responsibilities of both parties.
- The functions or activities that are delegated.
- The frequency of reporting on those functions and responsibilities to the Alliance and how performance is evaluated.
- Corrective action plan expectations, if applicable.

The Alliance may delegate QI, Credentialing, UM, Case Management, Disease Management, Claims, Grievance and Appeals activities to Health Plans, County entities, and/or vendors that meet the requirements as defined in a written delegation agreement, delegation policies, accreditation standards, and regulatory standards.

To ensure delegated entities meet required performance standards, the Alliance:

- Provides oversight to ensure compliance with federal and state regulatory standards, and accreditation standards.
- Reviews and approves program documents, evaluations, and policies and procedures relevant to the delegated activities.
- Conducts required pre-delegation activities.
- Conducts annual oversight audits.
- Reviews reports from delegated entities.
- Collaborates with delegated entities to continuously improve health service quality.

As part of delegation responsibilities, delegated entities must:

- Develop, enact, and monitor quality plans that meet contractual requirements and Alliance standards.
- Provide encounter information and access to medical records pertaining to Alliance members as

required for HEDIS and regulatory agencies.

- Provide a representative to the Joint Operations Committee.
- Submit at least semi-annual reports or more frequently if required on delegated functions.
- Cooperate with state/federal regulatory audits as well as annual oversight audits.
- Complete any corrective action deemed necessary by the Alliance.

The Alliance collaborates with delegated entities to formulate and coordinate QIHE activities and includes these activities in the QIHE work plan and program evaluation. Delegated activities are a shared function. Delegate program descriptions, work plans, reports, policies and procedures, evaluations and audit results are reviewed by the Subcontractor & Delegation Oversight Committee and Joint Operations Committee and findings are summarized at QIHEC meetings, as appropriate. The Alliance does not delegate QI functions as noted in Table 1 below.

The Alliance currently delegates the following functions:

Table 1: Alameda Alliance Delegated Entities

ALAMEDA ALLIANCE DELEGATED ENTITIES - 2025																			
Delegate's Name		Quality Improvement		Utilization Management <i>X = NCQA Accredited</i>		Credentialing <i>X = NCQA Accredited</i>		Grievances & Appeals		Claims		Call Center		Case Management		Cultural & Linguistic Services		Provider Training	
		Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care	Medi-Cal	Group Care
1	Community Health Center Network (CHCN)			X	X					X	X			X	X			X	X
2	March Vision Care Group, Inc.					X				X									
3	Children's First Medical Group (CFMG)			X		X				X									
4	PerformRx (PBM)				X		X				X						X		
5	UCSF (Credentialing)					X	X												
6	Physical Therapy PN (Credentialing)					X	X												
7	Lucille Packard (Credentialing)					X	X												
8	Teladoc (Credentialing)					X	X												

QUALITY IMPROVEMENT HEALTH EQUITY PROGRAM RESOURCES

Responsibilities for QIHE Program activities are an integral part of all Alliance departments. Each department is responsible for setting and monitoring quality goals and activities.

The Alliance QI Department is part of the Health Care Services Department, and responsible for implementing QIHE activities and monitoring the QIHE Program. The QI Department participates in the accreditation process, manages the HEDIS and CAHPS data collection and improvement process, conducts facility site reviews (FSRs), processes Potential Quality Issues (PQIs), and oversees the quality activities in other departments and those performed by delegated groups.

Resource allocation for the QI Department is determined by recommendations from the QIHEC, CMO, CEO and BOG. The Alliance recruits, hires, and trains staff, and provides resources to support activities required to meet the goals and objectives of the QIHE Program.

The Alliance's commitment to the QIHE Program extends throughout the organization and focuses on QIHE activities linked to service, access, continuity and coordination of care, and member and provider experience. The Senior Director of Quality, with direction from the Medical Director of Quality and CMO, coordinates the QIHE Program. Titles, education and/or training for key positions within the Quality Department include:

Chief Medical Officer

The Alliance Chief Medical Officer (CMO) is responsible for and oversees the QIHE Program. The CMO has relevant experience and current knowledge in clinical program administration, including utilization and quality improvement management. The CMO provides leadership to the QIHE Program through oversight of QI study design, development, implementation, and chairs the QIHEC, PR & CC, and P&T committees. The CMO makes periodic reports of committee activities, QI study and activity results, and the annual program evaluation to the BOG. The CMO reports to the Alliance CEO.

Chief Health Equity Officer

The Chief Health Equity Officer (CHEO) reports directly to the Chief Executive Officer (CEO) and is matrixed to the Chief of Human Resources (CHR). The position partners with leaders across the organization to develop and drive forward the key strategies of the organization as they relate to Diversity, Equity, and Inclusion (DEI) for members, providers, and employees. The executive position implements policies that ensure health equity is prioritized and addressed and is responsible for setting and implementing an overarching vision of DEI for the organization, including programmatic and administrative outcomes. The position is responsible for the promotion of internal and external DEI for members, providers, and employees. With supervision by the Chief Medical Officer (or designee) of the QIHE program, the CHEO participates in QIHEC and collaborates on QIHE program activities.

Medical Director, QI

The Medical Director has relevant experience and current knowledge in clinical program administration, including utilization and quality improvement management. The Medical Director is part of the medical team and is responsible for strategic direction of the Quality Improvement Health Equity programs. The Medical Director also forms a dyad partner with the Sr. Director of Quality and serves as an internal expert, consultant, and resource in QI. They are responsible for clinical appropriateness, quality of care, pay for performance, access and availability, provider experience, member experience and cost-effective utilization of services delivered to Alliance members. The Medical Director has oversight over the Behavioral Health Program responsibilities including participating in the grievance and external

medical review procedure process, resolving medically related and potential quality related grievances, and issuing authorizations, appeals, decisions, and denials. The Medical Director reports to the CMO.

Senior Director of Quality

The Senior (Sr.) Director of Quality is responsible for the strategic direction of the Quality Improvement Health Equity Program. This position has direct oversight for the development, implementation, and evaluation of the QIHE Program. This position is responsible for all performance improvement activities, including improving access and availability of network services, developing and managing quality programs as identified by DHCS, DMHC, and NCQA. This includes PIPs, Improvement Programs i.e., HEDIS/MCAS measures, QI Standards as well as managing, tracking, analyzing, and reporting member experience/satisfaction (i.e. Consumer Assessment Health Plan Surveys (CAHPS) as requested. The Sr. Director is also responsible for the oversight of FSR and potential quality issues (PQIs) and will direct performance improvement and access and availability activities. The Sr. Director is also the senior nurse to the organization to augment clinical oversight. This position, along with the Director of Population Health & Equity, assists with setting the priorities of the Population Health Management program, and ensures Health Education and Cultural and Linguistic Services are incorporated into the QIHE program. The Sr. Director of Quality is a dyad partner with the QI Medical Director and reports to the CMO.

Senior Director of Behavioral Health

The Senior Director of Behavioral Health has relevant experience and current knowledge in clinical program administration, including behavioral health and autism spectrum disorder management. The Sr. BH Director is responsible for and oversees the BH program. Responsibilities include participating in the QI, UM, and CM processes as they pertain to behavioral health and autism spectrum disorder programs. The Senior Director of BH reports to the Chief Medical Officer.

Director of Population Health and Equity

The Director of Population Health and Equity (PHE) provides operational oversight and leadership for the Alliance's population health assessments, strategy and evaluation. The PHE Director is also responsible for state and federal regulatory and accreditation requirements concerning Population Health, Cultural and Linguistic Services and member Health Education. This position reports to the Senior Director of Quality Improvement and works closely with the Chief of Health Equity.

Manager of Population Health and Equity

The Population Health and Equity (PHE) Manager is responsible for the implementation of the Alliance's population health assessments, strategy and evaluation. In addition, the PHE Manager oversees the execution of the Alliance's population health and health education programs and related equity initiatives, supervises PHE staff, and ensures compliance with state and federal regulatory and accreditation requirements concerning population health management and health education.

Manager of Cultural and Linguistic Services

The Cultural and Linguistic Services (CLS) Manager is responsible for direct oversight of the Alliance Cultural and Linguistic Services Program. This includes activities such as ensuring members have access to language assistance services for interpreting services, review of provider capacity to meet the cultural and linguistic needs of members, and overall assessment of the cultural and linguistic needs of members. The CLS Manager is also responsible for compliance with state and federal

regulatory and accreditation requirements related to CLS. Furthermore, the CLS Manager leads the planning and implementation of internal and external committees, such as the Cultural and Linguistics Services Subcommittee and the Community Advisory Committee. The CLS manager reports directly to the Population Health and Equity Director.

Quality Improvement Manager

The Quality Improvement (QI) Manager, is responsible in advancing the goals of the Quality Improvement and Health Equity (QIHE) program. The QI Manager is responsible for the day-to-day management of the Performance Improvement Team, including but not limited to HEDIS/MCAS project improvement oversight, physician practice activities, and Quality and Performance Improvement Project oversight. The QI Manager also acts as liaison between the Alliance's physician leadership and community practitioners/providers of care across all specialties and delegates. The QI Manager works collaboratively throughout the organization to lead and establish appropriate performance management/quality improvement systems including PDSA (Plan-Do-Study-Act).

Access to Care Manager

The Access to Care Manager is responsible for day-to-day management of access to care activities throughout the organization and includes leading and establishing appropriate access to care systems. The Access to Care Manager ensures the access program complies with timely access standards as regulated by the Department of Managed Health Care (DMHC), the Department of Health Care Services (DHCS) and the National Committee for Quality Assurance (NCQA). The Access to Care Manager ensures planning and oversight of access to care surveys, ensures appropriate follow up when compliance monitoring identifies deficiencies. The Access to Care Manager reports to the Sr. Director of Quality.

Accreditation Manager

The Accreditation Manager is responsible for management of NCQA Health Plan Accreditation and Health Equity Accreditation. Role is responsible for internal monitoring of regulatory requirements and standards.

Quality Improvement Nurse Supervisor

The Quality Improvement Nurse Supervisor works collaboratively throughout the organization to ensure appropriate oversight of performance management and clinical quality improvement assignments. The Quality Improvement Supervisor is responsible for day-to-day supervision of the work assigned to the clinical staff in the Quality Department. The Supervisor also acts as liaison between the health plan's physician leadership and community practitioners/providers of care across all specialties and delegates. The Quality Improvement Supervisor is responsible for oversight of timely and accurate investigation and completion of Potential Quality Issues (PQI), Provider Preventable Conditions (PPC), and quality of care corrective action plans, and participation in HEDIS activities. The QI Nurse Supervisor reports to the Sr. Director of Quality.

Quality Review Nurse (3)

The Quality Review Nurse is a registered nurse responsible for timely and accurate investigation and completion of Potential Quality of Care Issues (PQIs), collecting quality related data and reviewing medical records for HEDIS abstraction and overreads as able, chart audits, regulatory compliance, quality improvement (QI) activities development, data tracking and trending, and outcomes reporting. The Quality Review Nurse keeps accurate records, manages, and analyzes data, as well as responds

appropriately and timely, both verbally and in writing to internal and external clinical issues of staff and regulatory agencies. The Quality Review Nurse identifies, investigates, and reports on Potential Quality Issues (PQIs) and Provider Preventable Conditions (PPCs) as appropriate. Cases involving quality-of-care issues are presented to the Medical for review and determination.

Clinical Review Nurse (2)

The Clinical Review Nurse is responsible for investigating and processing comprehensive and complex grievances and appeals requests from members and providers, coding justifications, and provider disputes. This role has oversight by the Medical Director and CMO, and matrixed to the Grievance and Appeals team within the Operational Division.

Senior Quality Improvement Nurse Specialist (1)

The Senior Quality Improvement Nurse Specialist is responsible for the training, certification and recertification of DHCS facility site reviews (FSR) and medical record reviews (MRR) for all Alliance Provider Network and Delegated Provider Oversight. The Sr. QI Nurse Specialist is also responsible for the oversight and monitoring of the qualitative and quantitative content of the medical record process and maintaining compliance with state and regulatory quality of care standards. The Sr, QI Nurse Specialist develops provider training and education materials to assist providers with meeting quality standards.

Quality Improvement Review Nurse (1)

The Quality Improvement Review Nurse conducts facility site reviews, chart audits, regulatory compliance, quality improvement (QI) activities, and provider training. The QI Review Nurse partners with the Sr. QI Nurse Specialist to certify and recertify the Alliance Provider Network and Delegated Provider Oversight.

Quality Performance Supervisor

The Supervisor, Quality Performance, plays a critical operational role in advancing the goals of the Quality Improvement and Health Equity (QIHE) program. Under the oversight of Quality Improvement Manager, this position is responsible for implementing high-impact quality initiatives, managing complex, cross-functional projects, and supervising a team to ensure the achievement of key performance indicators (KPIs) related to health outcomes, member engagement, and regulatory compliance.

Quality Improvement Project Specialist II (4)

The Quality Improvement Project Specialist II (QIPS II) is responsible for developing and implementing quality assessment and performance improvement activities that include quality monitoring, evaluation and facilitation of performance improvement projects. The QI Project Specialist II conducts assessment activities and facilitates compliance with Medicare/Medicaid regulations, state licensure laws, and applicable regulatory/accrediting body.

Quality Improvement Project Specialist I (5)

The Quality Improvement Project Specialist I (QIPS I) is responsible for developing and implementing quality assessment and performance improvement activities that include quality monitoring, evaluation, and facilitation of performance improvement projects. The QI Project Specialist I conducts assessment activities and facilitates compliance with Medicare/Medicaid regulations, state licensure laws, and applicable regulatory/accrediting body.

Accreditation and Regulatory Compliance Specialist (2)

The Accreditation and Regulatory Compliance Specialist is responsible for the preparation of NCQA Health Plan and Health Equity accreditation through coordination and follow-up of deliverables and requirements.

Facility Site Review QI Coordinator (1)

The Facility Site Review Coordinator (FSRC) is responsible for performing facility site review audits and quality improvement activities in conjunction with the Sr. QI Nurse Specialists. The position assists with access and availability reports, provider training, HEDIS data collection, disease specific outreach, and preparation for accreditation and compliance surveys by external agencies such as DHCS, DMHC and NCQA.

Quality Program Coordinator (2)

The Quality Program Coordinator (QPC) is responsible for helping to plan, organize, and implement Alliance quality programs as assigned. Responsibilities include coordination of quality projects including case tracking (i.e. PQI, corrective action plans), assistance in audits or surveys (i.e. CAHPS), data collection and follow-up, and coordination of internal and external meetings. Supports the successful implementation of projects within timelines for associated department assignments.

Quality Improvement Engagement Coordinator (2)

The Quality Improvement Engagement Coordinator (QIEC) responsibilities include coordinating quality improvement projects, member outreach by phone and mail, provider and community collaboration, and data tracking and reporting. The goal of this role is to increase care for Alliance members by helping to connect them to services available directly related to QI measures.

ANCILLARY SUPPORT SERVICES FOR THE QIHE PROGRAM

Population Health and Equity

The Population Health and Equity team consists of a Population Health and Equity Director, a Population and Health Equity Manager, a Cultural and Linguistics Services Manager and supporting staff. The Population Health and Equity team is a component of the QI Department. The Population Health and Equity staff ensure integration of QIHE initiatives into the Alliance Population Health Strategy and support the QI team in the development and implementation of member and provider educational interventions and community collaborations to address health care quality, health equity and access to care. The Population Health and Equity team also manages and monitors the Population Health Management, Health Education, and Cultural and Linguistic programs for the Alliance. The Health Education and Cultural and Linguistic Programs and the Population Health Management Strategy are outlined in separate documents.

Analytics

The Analytics Department is comprised of two departments: 1) Healthcare Analytics and 2) Quality Analytics. The department works in collaboration with the Quality Improvement Department on improvement activities and initiatives.

The Healthcare Analytics Department performs reporting and analyses across the organization on clinical, claims, provider, and member data. Quality activities include management of and production

of the HEDIS NCQA certified software, HEDIS data validation/collection and HEDIS rate reporting and trending. In addition, the department collaborates on Population Health Management (PHM) strategies and initiatives, such as Risk Stratification and Segmentation (RSS), and supporting access and availability regulatory requirements.

The Quality Analytics Department is responsible for management of HEDIS operational activities, the Pay-for-Performance program, and oversight of access and availability survey vendor. HEDIS operational activities include Roadmap and rate submissions, oversight of the annual HEDIS audits, medical record retrieval and training, monitoring, and performing overreads, and oversight of the abstraction vendor.

Quality Assurance

The Director, Quality Assurance is responsible for the operations management of the Grievance and Appeals Department under the direction of the Chief Medical Officer. The Director is responsible for ensuring the Health Care Service's overall regulatory compliance with the Department of Managed Health Care and the Department of Health Care Services (DHCS) contractual responsibilities for Health Care Service Departments. The role is also responsible for overseeing ongoing audit readiness activities for DHCS, DMHC and NCQA. The Director is also responsible in coordinating processes, activities, and regulatory compliance involving grievances and appeals for all lines of business. The position identifies, analyzes, and coordinates resolution of grievances and appeals.

Utilization Management (UM) Services

The UM and QI Departments are part of the Alliance Health Care Services Department. These departments work collaboratively to ensure that appropriate quality and safe health care is delivered to members in a timely and organized manner. QI ensures that QIHEC can identify improvement opportunities regarding concurrent reviews, tracking key utilization data, and the annual evaluation of UM activities.

The Alliance's Utilization Management (UM) activities are outlined in the UM Program Description which describes the UM program structure, and how UM decisions are made based on evidence-based guidelines, applied in a consistent manner. The Alliance's Case Management (CM) Program works in an integrated manner with the UM Program, in which care coordination and complex case management programs are designed to address the needs of members with complex physical, mental, or social determinant of health needs. Some high-risk populations include seniors and persons with disabilities (SPDs), members with multiple chronic conditions, or members with unmet social determinant of health needs (i.e.: housing or food insecurity). Core Case Management program interventions include outreach, assessment, and care coordination with members and their trusted supports, to ensure the improvement of member outcomes and overall member satisfaction. Care management staff also partner with the QI department in QIHE activities including conducting member outreach calls and mailings, as appropriate.

There are identified staff persons dedicated to working with "linked and carved out services" such as East Bay Regional Center, California Children Services (children with complex health care needs), and the Alameda County Behavioral Health Care Department. The UM and CM Program Descriptions are approved by the UMC and QIHEC. For additional information, refer to the UM and CM Program Descriptions.

Pharmacy Services

The Pharmacy Department and QI Department work collaboratively on various QIHE projects. The Pharmacy Department supports patient safety initiatives including working with the Pharmacy Benefit Manager (PerformRx) to inform members, providers, and network pharmacies of medication safety alerts. Responsibilities also include review and update of the formulary through P&T, oversight of the Pharmacy Benefit Manager, and collaboration with QIHEC.

Provider Services

The Provider Services Department is the primary point of contact for network providers. They assist the QI Department on various QIHE activities with network providers as appropriate as well as disseminating QI information to practitioners. The Department collaborates with the Access and Availability team to monitor provider capacity and assess provider satisfaction. In addition, they assist with sharing information to providers about Alliance processes and provide educational material on monitoring availability and accessibility standards at physician offices, including after-hours coverage. Provider Services staff also assist the QI Department with practitioners who do not comply with requests from QI.

Credentialing Services

The Credentialing staff support the credentialing and re-credentialing processes for practitioners and network providers. The Credentialing staff conducts ongoing monitoring and evaluation of network practitioners to ensure the safety and quality of services to members. The QI Department provides the Credentialing Department with Potential Quality Issue trends and Facility Site Review and Medical Record audit scores. The Credentialing staff is responsible for coordinating the PR and CC meetings.

Member Services and Member Outreach

The Member Services staff fields all member inquiries regarding eligibility, benefits, claims, programs, and access to care. The Communication and Outreach conducts New Member orientations to educate new members about the health plan benefits. Member Services staff also works with the QI Department on member complaints via the PQI referral process and appeals in accordance with established policies and procedures. To assist in improving HEDIS scores, the QI Department may conduct member outreach activities to get HEDIS services completed. Hold messages are used to remind members of plan benefits and services offered while waiting to speak to an agent.

Grievance and Appeals

Alameda Alliance for Health reviews and investigates all grievance and appeal information submitted to the plan to identify quality issues that affect member experience. The grievance and appeals intake process are broken down into two processes, complaints, and appeals. In both instances, the details of the member's complaints are collected, processed, and reviewed and actions are taken to resolve the issue and Potential Quality Issues are forwarded to QI for review and investigation as needed. QI will collaborate with G&A for assurance of accurate reporting exempt grievance data.

Methods and Processes for Quality Improvement

The QIHE Program employs a systematic approach to identify opportunities for improvement and evaluating the results of interventions. All program activities are documented in writing and all quality studies are performed on any product line for which it seems relevant. The program aligns with the performance improvement framework recommended by the Department of Health Care Services

(DHCS). This framework, adopted by the Alliance Quality Department, is based on the Institute for Healthcare Improvement (IHI) Model of Improvement. Key concepts for DHCS performance improvement projects (PIP) utilize the following framework:

PIP Initiation

SMART Aim Data Collection

Intervention Determination

Plan-Do-Study-Act

PIP Conclusion

Identification of Important Aspects of Care

The Alliance uses several methods to identify aspects of care that are the focus of QIHE activities. Some studies are initiated based on performance measured as part of contractual requirements (e.g., HEDIS). Other studies are initiated based on analyses of the demographic and epidemiologic characteristics of Alliance members, health disparities, or identified through surveys and dialogue with member and provider communities (e.g., CAC, CAHPS, provider satisfaction survey, Joint Operating Meetings (JOM), Quality/Provider QI meetings, site visits, etc.). Particular attention is paid to those areas in which members are high risk, high volume, high cost, or problem prone.

Data Sources and Systems

The Alliance utilizes various resources to develop clinical and quality reporting and analyses that provide meaningful and actionable insights. Resources to support the QIHE Program include, but are not limited to the following:

- ODS (Operational Data Store) and Datawarehouse: These are the main databases and the primary sources for all data including member, eligibility, encounter, provider, pharmacy data, lab data, vision, encounters, etc. and claims. The databases are used for storing data required for quality reporting.
- HealthSuite: Claims and eligibility processing system
- CareAnalyzer (DST): used to inform Population Health Management and Population Needs Assessment initiatives and provide QI/UM/CM access to risk-stratified, segmented data that can be effectively applied to target high-risk members for early intervention and improve the overall coordination of care.
- Cotiviti: AAH's NCQA-certified HEDIS software that produces HEDIS/MCAS measure data and outcomes. Data integrity is audited annually through the HEDIS reporting audit process.
- CAHPS 5.1H and CG-CAHPS: Member experience survey via SPH vendor support
- California Immunization Registry (CAIR): Immunization registry information.
- Laboratory results: Data files from Quest, Foundation, and AHS
- Cactus: credentialing database.
- Provider satisfaction and coordination of care surveys via Press Ganey vendor support
- Pre-service, concurrent, post-service and utilization review data (TruCare).
- Case management data (TruCare)
- Member and provider grievance and appeal data.

- Potential Quality of Care Issue Application database (Quality Suite) used for tracking/trending data.
- Internally developed reports (e.g., asthma and diabetes).
- Provider Appointment Availability Survey (PAAS), after-hours access and emergency instructions. Other clinical or administrative data.

Evaluation

The Analytics Department compiles various data sources to produce reporting and analyses. Quality performance staff analyzes the data to determine variances from established criteria, performance goals, and for clinical issues. Data is analyzed to determine priorities or achievement of a desired outcome. Data is also analyzed to identify disparities based on ethnicity and language. Subsets of our membership may be examined when they are deemed to be particularly vulnerable or at risk.

HEDIS related analyses include investigating trends in provider and member profiling, data preparation (developing business rules for file creation, file creation for HEDIS vendors, mapping proprietary data to vendor and NCQA specifications, data quality review and data clean-up). These activities involve data sets maintained by the Alliance and supplemental files submitted by various trading partners, such as delegated provider organizations and various external health registries and programs (e.g., Quest Diagnostics, and the California Immunization Registry).

Aggregated reports are forwarded to the QIHEC. Status and final reports are submitted to regulatory agencies as contractually required. Evaluation is documented in committee minutes, workplans, and attachments.

ACTIONS TAKEN AS A RESULT OF QIHE ACTIVITIES

Action plans are developed and implemented when opportunities for improvement are identified. Each performance improvement plan specifies who or what is expected to change, the person responsible for implementing the change, the appropriate action, and when the action is to take place. Actions will be prioritized according to possible impact on the member or provider in terms of urgency and severity.

Actions taken are documented in reports, minutes, attachments to minutes, workplans, and other similar documents.

An evaluation of the effectiveness of each QIHE activity is performed. A re-evaluation will take place after an appropriate interval between implementation of an intervention and remeasurement. The evaluation of effectiveness is described qualitatively and quantitatively, in most cases, compared to previous measurements, with an analysis of statistical significance when indicated.

Based on the HEDIS data presented, areas of focus for 2025 include but are not limited to the following:

- Childhood Immunizations: Combo 10
- Well-Child Visits in the First 15 months of Life
- Well-Child Visits in members 3-15 months of Life
- Well Child Visit 3-21 Years of Age
- Lead Screening
- Topical Fluoride for Children
- Breast Cancer Screening

- Cervical Cancer Screening
- HbA1c Testing for Diabetics
- Controlling Blood Pressure
- Follow-up after Emergency Department visit for Mental Health illness (FUM) or Substance Use (FUA)

Other non-HEDIS related measures of focus will include but not be limited to:

- Initial Health Appointment
- Emergency Department Visits
- Readmission Rate
- Timely Access and Member Satisfaction Survey: Non-Urgent Appointment Availability
- Screening for Depression
- EPSDT Service Utilization
- Under and Over Service Utilization
- Behavioral Health Care Coordination

TYPES OF QI MEASURES AND ACTIVITIES

Healthcare Effectiveness Data Information Set (HEDIS)

The Managed Care Accountability Set (MCAS) Performance Measures, a subset of HEDIS (Health Effectiveness Data Information Set) are calculated, audited, and reported annually as required by DHCS. Additional measures from HEDIS are also reviewed. A root cause analysis may be performed, and improvement activities are initiated for measures not meeting benchmarks.

Consumer Assessment of Health Plan Survey (CAHPS 5.1H and CG-CAHPS)

The Alliance evaluates member experience periodically. Third party vendors conduct the Consumer Assessment of Health Plan Survey (CAHPS). The Alliance assists in the administration of these surveys, receives, and analyzes the results, and follows up with prioritized improvement initiatives. Survey results are distributed to the A&A Subcommittee, followed by QIHEC, and made available to members and providers upon request. The CAHPS survey is conducted annually for the entire Medi-Cal population and the results from the CAHPS are reported in the annual QIHEC evaluation and used to identify opportunities to improve health care and service for our members.

State Quality Improvement Activities

DHCS requires Medi-Cal Managed Care plans to conduct at least two QI projects each year. Forms provided by DHCS are used for QI project milestones.

Annually, the Alliance submits its QIHE Program Description, along with an evaluation of the prior year's QIHE Work Plan. A current year Work Plan is developed and updated throughout the year as QIHE activities are designed, implemented, and reassessed.

The Alliance complies with the requirements described in the regulatory All Plan Letters.

Monitoring Satisfaction

The QIHE Program measures member and provider satisfaction using several sources of satisfaction, including the results of the CAHPS survey, the Population Needs Assessment (PNA), the annual DMHC Timely Access survey, plan member and provider satisfaction surveys, complaint and grievance data, disenrollment and retention data, ad hoc member feedback surveys, Community Advisory Committee (CAC), and other data as available. These data sets are presented to the QIHEC at quarterly and annual intervals. The plan may administer topic specific satisfaction surveys depending on findings of other QIHE studies and activities.

Health Education Activities

The Health Education Program at the Alliance operates as part of the Population and Health Equity Unit of the Quality Improvement Department. The primary goal of Health Education is to improve members' health and well-being through the lifespan through promotion of appropriate use of health care services, preventive health care guidelines: Bright Futures/American Academy of Pediatrics, U.S. Preventive Services Task Force, and clinical guidelines from professional associations, healthy lifestyles and condition self-care and management. The primary goal of Health Education is to provide the knowledge needed for Alameda Alliance members to maintain and support their health.

Health education programs are developed in alignment with needs identified by the population assessments and include individual, provider, and community-focused health education and disease management activities which address health concerns such as nutrition, injury prevention, maternal health, diabetes, pre-diabetes, asthma, hypertension, and mental health. The Alliance also collaborates on community projects to develop and distribute important health education messages for at risk populations.

Cultural and Linguistic Activities

The Alliance Cultural and Linguistic Services Program operates as a part of the Population and Health Equity Unit of the Quality Improvement Department. It reflects the Alliance's adherence and commitment to the U.S. Department of Health & Human Services *National Standards for Culturally and Linguistically Appropriate Services* (CLAS). The program offers services and conducts activities designed to ensure that all members have access to quality health care services that are culturally and linguistically appropriate. These activities encompass efforts within the organization, as well as with Alliance members, providers, and our community partners.

Objectives include:

- Comply with state and federal guidelines related to assessment of enrollees to offer our members culturally and linguistically appropriate services.
- Provide no-cost language assistance services at all points of contact for covered benefits.
- Identify, inform, and assist limited English proficient (LEP) members in accessing quality interpretation services and written information materials in threshold languages.
- Ensure that all staff, providers, and subcontractors are compliant with the cultural and linguistic services program through cultural sensitivity training.
- Integrate community and Alliance member input into the development and implementation of Alliance cultural and linguistic accessibility standards and procedures.
- Monitor and continuously improve Alliance activities and services aimed at achieving cultural

competence and reducing health care disparities.

The objectives for cultural and linguistic activities are addressed and monitored in the Cultural and Linguistic Services work plan, updated annually, and reviewed quarterly.

Disease Surveillance

The Alliance maintains procedures to ensure accurate, timely, and complete reporting of any disease or condition to public health authorities as required by State law. The Provider Manual describes requirements and lists the Public Health Department contact phone and fax numbers.

Patient Safety and Quality of Care

The Alliance QI process incorporates several mechanisms to review incidents that pose potential risk or safety concerns for members. The following activities are performed to demonstrate the Alliance's commitment to improve quality of care and safety of its members via monitoring, investigation, track, and trending of:

- Complaints and grievances and determining quality of care impact.
- Iatrogenic events such as hospital-acquired infections reported on claims and reviewing encounter submissions.
- Inpatient admissions to evaluate and monitor the medical necessity and appropriateness of ongoing care and services. Safety issues may be identified during this review.
- Identified potential quality of care issues.
- Auditing Alliance internal processes/systems and delegated providers.
- Credentialing and re-credentialing of malpractice, license suspension registries, loss of hospital privileges for providers.
- Site review of provider offices for compliance with safety, infection control, emergency, and access standards.
- Operations compliance with local regulatory practices.
- Reviewing hospital readmission reports.
- Improve continuity and coordination of care between practitioners.
- Quality of care issues related to Long Term Care

Quality issues are referred to the QI Department to evaluate the issue, develop an intervention and involve the CMO when necessary.

Facility Site Reviews

The Alliance conducts site reviews, including Facility Site Review (FSR), Medical Record Review (MRR), and Physical Accessibility Review (PARS), including assigning scores, monitors, and reports site reviews in accordance with all applicable state and federal guidelines. If findings are identified, corrective action plans (CAP) are issued and followed upon until appropriate documentation are addressed for all deficiencies to close the CAP. A summary of the site reviews conducted are reported to A&A Committee or IQIC (i.e. workplan summary) followed by QIHEC to monitor the clinical safety activities of the Alliance Provider Network.

Long-Term Care Quality Monitoring

The Alliance maintains a comprehensive Quality Assurance Performance Improvement (QAPI) monitoring program for Long Term Care (LTC) services which includes on-going review of the following:

- A table-top review of quality assurance and improvement findings from California Department of Public Health (CDPH) to include, but not be limited to, survey deficiency results, site visit findings, and complaint findings.
- Review of QAPI programs in LTC (i.e. SNFs and Subacute) based on an attestation of compliance by the facilities of the five key elements identified by CMS:
 - Element 1: Design and Scope
 - Element 2: Governance and Leadership
 - Element 3: Feedback, Data Systems and Monitoring
 - Element 4: Performance Improvement Projects (PIPs)
 - Element 5: Systematic Analysis and Systemic Action
- Review of CMS Quality Star ratings
- Monitoring of quality measures for LTC within the Managed Care Accountability Set (MCAS) of performance measures, such as emergency room visits, healthcare associated infections requiring hospitalization, and potentially preventable readmissions.
- Review and investigation of Potential Quality Issues (PQIs)
- In collaboration with the LTC team, the Alliance monitors the quality and appropriateness of care furnished to members using LTSS, including:
 - Assessment of care between care settings and a comparison of services and supports received with those set forth, and
 - Efforts supporting member community integration.When significant trends or non-compliance related to the QAPI program are noted, medical chart reviews or on-site visits will be conducted for LTC facilities as appropriate. Corrective action plans may be issued to address and resolve deficiencies in the quality of care of residents.

For Intermediate Care Facility for Developmentally Disabled (ICF/DD) Homes, quality monitoring includes the review of compliance findings and data from CDPH as well as service delivery findings from the Regional Centers established in the Memoranda of Understanding. Activities and monitoring are discussed at joint Alliance and Regional Center meetings on an on-going basis to ensure the quality and appropriateness of care, but not limited to:

- Any applicable performance measures (as mutually agreed upon)
- QI initiatives as well as reports that track cross-system referrals.
- Member engagement
- Service utilization and to prevent duplication of services rendered.

On-going monitoring reports are reported to the quality committees, including A&A Committee or IQIC and QIHEC on an as needed basis.

Health Equity Activities

The Alliance is committed to Health Equity by mitigating social determinants of health to prevent and reduce health disparities and health inequities that adversely affect vulnerable populations. Health Equity is integrated throughout the organization and is a collaborative effort across multiple departments. Additional data beyond the historical HEDIS or MCAS measures might be needed to better understand the systemic barriers or SDOHs faced by our members. As part of the QIHE Program, the Alliance monitors and addresses member access, experience, and clinical outcome disparities by analyzing data stratified by race, ethnicity, and language (REL). According to specific standards and/or strategies, the QIHE Program involves implementing systematic and continuous activities to monitor, evaluate, and improve upon the health equity and health care delivered to our members. There is alignment with the Alliance Population Health Strategy and related activities. The QIHEC is responsible for overseeing the QIHE Program, including activities to identify and close health disparity gaps, providing feedback to meet goals/benchmarks as set forth by governing agencies (i.e., DHCS, DMHC, or NCQA), and to recommend required actions.

ACCESS AND AVAILABILITY

The Alliance implements mechanisms to maintain an adequate network of primary care providers (PCP) and high volume and high impact specialty care providers. Alliance policy defines the types of practitioners who may serve as PCPs. Policies and procedures establish standards for the number and geographic distribution of PCPs and high-volume specialists. The Alliance monitors and assesses the cultural, ethnic, racial, and linguistic needs and preferences of members, and adjusts availability of network providers, if necessary.

The following services are also monitored for access and availability:

- Children's preventive periodic health assessments/EPSTD
- Adult preventative health screenings
- Initial health appointments

The QIHE Program collaborates with the Provider Services Department to monitor access and availability of care including member wait times and access to practitioners for routine, urgent, emergent, and preventive, specialty, and after-hours care. Access to medical care is ensured by monitoring compliance with timely access standards for practitioner office appointments, telephone practices, and appointment availability. The QIHEC also oversees appropriate access standards for appointment wait times. Alliance appointment access standards are no longer than DMHC and DHCS established standards. The Provider Manual, virtual/onsite visits, and periodic fax blasts are some of the mechanisms to educate providers on Timely Access Standards.

The QIHEC reviews the following data and makes recommendations for intervention and quality activities when network availability and access improvement is indicated:

- Member complaints about access.
- CAHPS 5.1H and CG-CAHPS results for wait times and telephone practices.
- HEDIS measures for well child and adolescent primary care visits.
- Immunizations.
- Emergency room utilization.

- Facility site review findings.
- The review of specialty care authorization denials and appeals.
- Additional studies and surveys may be designed to measure and monitor access.

BEHAVIORAL HEALTH QUALITY

The Alliance maintains procedures for monitoring the coordination and quality of behavioral healthcare provided to all members including, but not limited to, all medically necessary services across the health care network. The Alliance reports activities in behavioral healthcare at QIHEC meetings to monitor, support, and improve behavioral healthcare aspects of QI.

Per DHCS contract, the Alliance is responsible for the administration of the mild to moderate non-specialty mental health benefit. Specialty Behavioral Health for Medi-Cal members with severe mental health conditions are excluded from the Alliance contract with DHCS. The Specialty Behavioral Health Services are coordinated under a Memorandum of Understanding between the Alliance and Alameda County Behavioral Health (ACBH). Some primary care physicians may choose to treat mild mental health conditions. The Alliance insourced the management and oversight of the non-specialty mental health and autism behavioral health services. The Alliance includes the involvement of a Senior Director of Behavioral Health in program oversight and implementation. The Alliance reviews reports of behavioral health quality, utilization, and surveys (i.e. timely access via member experience surveys, provider satisfaction) in its standing sub-committee meetings (i.e. A&A and IQIC subcommittees) to ensure members obtain necessary and appropriate behavioral health services.

Please see the UM / CM Program Description for additional information.

COORDINATION, CONTINUITY OF CARE AND TRANSITIONS

Member care transitions present the greatest opportunity to improve quality of care and decrease safety risks by ensuring coordination and continuity of health care as members transfer between different locations or different levels of care within the same location and/or across the healthcare continuum.

The Alliance Health Care Services focuses on interventions that support planned and unplanned transitions and promote chronic disease self-management. Primary goals of the department are to reduce unplanned transitions, prevent avoidable transitions and maintain members in the least restrictive setting possible.

Comprehensive case management services are available to each member. It is the PCP's responsibility to act as the primary case manager to all assigned members. Members have access to these services regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability. All services are provided in a culturally and linguistically appropriate manner.

Members who may need or are receiving services from out-of-network providers are identified. Procedures ensure these members receive medically necessary coordinated services and joint case management, if indicated. Written policies and procedures direct the coordination of care for the following:

- Services for Children with Special Health Care Needs (CSHCN).
- California Children's Service (CCS) eligible children are identified and referred to the local CCS

program.

- Overall coordination and case management for members who obtain Child Health and Disability Prevention Program (CHDP) services through local school districts or sites.
- Early Start eligible children are identified and referred to the local program.
- Members with developmental difficulties are referred to the Regional Center of the East Bay for evaluation and access to developmental services.

All new Medi-Cal members are expected to receive an Initial Health Appointment (IHA) within 120 days of their enrollment or provider assignment with the plan. Members are informed of the importance of scheduling and receiving an IHA from their PCP. The Provider Manual informs the PCP about the IHA, the HRA (for SPDs), and recommended forms. All new Medi-Cal non-SPD members also receive a Health Information Form\Member Information Tool (HIF\MET) in the New Member Packet upon enrollment. The Alliance ensures coordination of care with primary care for all members who return the form with a condition that requires follow up.

The Alliance coordinates with PCPs to encourage members to schedule IHAs. The medical record audit of the site review process is used to monitor coordination, and whether baseline assessments, diagnosis/treatment, and medically necessary follow-up services and referrals are documented.

COMPLEX CASE MANAGEMENT PROCESS

All Alliance members are potentially eligible for participation in the complex case management program. The purpose of the complex case management program is to provide the case management process and structure to a member who has complex health issues and medical conditions. The components of the Alliance complex case management program encompass member identification and selection; member assessment; member-centered care plan development, implementation, and management; evaluation of the member care plan; and closure of the case. Program structure is designed to promote quality case management, client satisfaction and cost efficiency using collaborative communication, evidence-based clinical guidelines and protocols, patient-centered care plans, and targeted goals and outcomes.

The complex case management program's objectives are concrete measures that assess effectiveness and progress toward the overall program goal of making high-quality health care services accessible and affordable to Alliance membership. The Chief Medical Officer, Senior Director of Health Care Services, Director of Social Determinants of Health, and Manager of Case and Disease Management develop and monitor the objectives. The QIHEC reviews and assesses program performance against objectives during the annual program evaluation, and if appropriate, provides recommendations for improvement activities or changes to objectives. The objectives of the program include:

- Preventing and reducing hospital and facility readmissions as measured by admission and readmission rates.
- Preventing and reducing emergency room visits as measured by emergency room visit rates.
- Achieving and maintaining member's high levels of satisfaction with case management services as measured by member satisfaction rates.
- Improving functional health status of complex case management members as measured by member self-reports of health condition.

The complex case management program is a supportive and dynamic resource that the Alliance uses to achieve these objectives as well as respond to the needs and standards of consumers, the healthcare provider community, regulatory and accrediting organizations.

The Alliance annually measures the effectiveness of its complex case management program based on the following measures (detailed information can be found in the Case Management Program Description):

1. Satisfaction with case management services - members are mailed a survey after case closure and are asked to rate experiences and various aspects of the program's service.
2. All-cause readmission rates - the Alliance measures admission rates for all causes within six months of being enrolled in complex case management.
3. Emergency room visit rate - the Alliance measures emergency room visit rates among members enrolled in complex case management.
4. Health status rate - the Alliance measures the percentage of members who received complex case management services and responded that their health status improved because of complex case management services.

The Chief Medical Officer and the Senior Director of Health Care Services collaboratively conduct an annual evaluation of the Alliance complex case management program. This includes an analysis of

performance measures, an evaluation of member satisfaction, a review of policies and program description, analysis of population characteristics and an evaluation of the resources to meet the needs of the population. The results of the annual program evaluation are reported to the QIHEC for review and feedback. The QIHEC makes recommendations for improvement and interventions to improve program performance, as appropriate.

DISEASE MANAGEMENT PROGRAM

The Alliance offers its members a disease management program. The purpose of the disease management program is to provide coordinated health care interventions and communications to both pediatric and adult members with chronic asthma and adults with diabetes, cardiovascular disease, and depression to support disease self-management and promote healthy outcomes. This is accomplished through the provision of interventions based on member acuity level. The intervention activities range from case management for those members at high risk, offering health coaching, educational materials, and care coordination to those members who may have gaps in care. The components of the Alliance disease management program include member identification and risk stratification, identification of gaps in care and health inequities, member outreach, provision of case management and health coaching services, and condition-specific education.

Program structure is designed to follow the National Committee for Quality and Assurance (NCQA) Population Health Management (PHM) standards. The program promotes quality condition management, member satisfaction and cost efficiency using collaborative communications, evidence-based clinical guidelines and protocols, patient-centered care plans, and targeted goals and outcomes. In 2025, the Alliance Disease Management Program focuses on four conditions Asthma, Diabetes, Perinatal Depression and Cardiovascular Disease.

The objectives of the disease management program are concrete measures that assess effectiveness and progress toward the overall program goals of meeting the health care needs of members and actively supporting members and practitioners to manage chronic asthma and diabetes. The QIHEC reviews and assesses program performance against objectives during the annual program evaluation, and if appropriate, provides recommendations for improvement activities or changes to objectives. The objectives of the disease management program include:

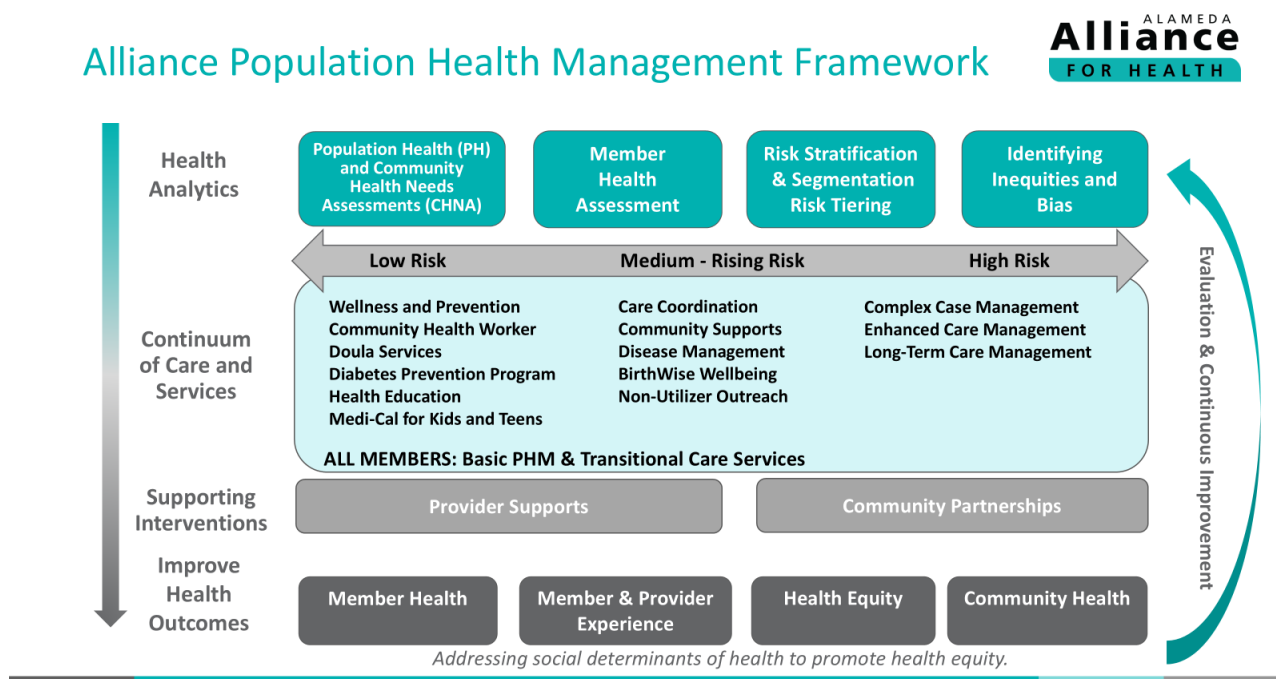
- Achieving and maintaining member's high levels of satisfaction with disease management services as measured by member satisfaction rates.
- Reducing gaps in care as measured by HEDIS clinical effectiveness measures specific to the management of asthma and diabetes.
- Addressing inequities related to chronic conditions.
- Increasing the rate of member engagement through targeted outreach activities regarding disease management services.
- Validating the efficacy of disease management health coaching as measured by post health coaching evaluations of member's knowledge and confidence.

POPULATION HEALTH MANAGEMENT (PHM) PROGRAM

Alameda Alliance for Health has a Population Health Management (PHM) Program that identifies member needs across the continuum of care and ensures access to a comprehensive set of services with the aim of improving health outcomes and supporting an enhanced quality of life. This continuum includes intensive case management and support for members with the highest levels of needs, programs and interventions for those with emerging risks, and basic population health management for all members. The Alliance PHM Program follows the NCQA 2025 Population Health Program Standards and Guidelines and aligns with the California Department of Health Care Services Population Health Management Policy Guide.

The PHM Program strives to target and close gaps in care and address upstream drivers of health disparities by addressing the social drivers of health (SDOH) that cause those disparities. The PHM Program is monitored via the Internal Quality Improvement Committee (IQIC), which is comprised of representatives from Quality Improvement, Utilization Management, Case Management, Behavioral Health, Pharmacy and Quality Assurance. In addition, overall outcomes, and findings from the Alliance population health assessments, population health strategy and evaluations are presented, reviewed, and approved by the QIHEC.

The Alliance PHM Framework illustrates how health analytics, a continuum of care and services, and supporting interventions, and evaluation lead to improved health outcomes. The Alliance's continuum of care and services aims to maintain or improve the physical and psychosocial well-being of individuals and address health disparities through best practice and culturally affirming member needs.



The Alliance conducts an annual Population Assessment

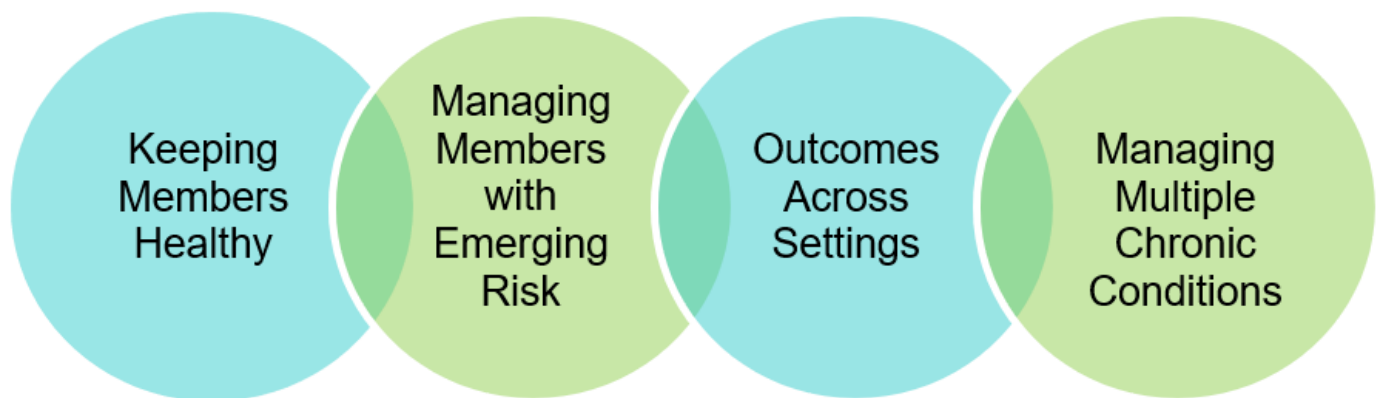
The Alliance annual PHM Assessment uses multiple data sources including member demographics, claims and encounters, HEDIS performance results, and social determinants of health to understand the health needs of our members. The HEDIS measures analyzed in the assessment include Department of Managed Health Care Health Equity Measure Set (DMHC HEQMS) and NCQA health equity measures, which are stratified by NCQA-defined race and ethnicity categories. The PHM team conducts a disparity analysis and leads cross-functional discussion of activities and resources needed to close disparities and improve measure performance. The Alliance prioritizes which programs and disparities to address in the development of the annual PHM Strategy.

The Alliance updates its PHM Strategy annually and uses it to:

- Improve case management programs including Complex Case Management (CCM), Enhanced Care Management (ECM), Community Supports (CS), and Transitional Care Services (TCS).
- Support development of basic population health activities to promote self-management of conditions and preventative care.
- Inform quality improvement projects.
- Guide development of health education materials and programs.
- Influence interventions that target member safety and outcomes across settings.
- Better understand utilization and identify high-risk members.
- Address identified health inequities.

The Alliance PHM strategy addresses four focus areas of population health that promote a whole-person approach to identify members at risk, and to provide strategies, programs, and services to mitigate or reduce that risk. The strategy has 4 areas of focus:

Four Areas of Focus



The Population Health Strategy includes:

- Population health assessment results
- Population risk stratification and segmentation
- PHM Strategy goals and programs

- Integration of Community Resources
- Delivery systems provider support structures
- Sharing data – provider measures and gaps in care
- Quality Dashboards – HEDIS measure-specific data
- Comparable Data – Peer performance, local averages, and national benchmarks
- Value-Based Payment Programs
- Ongoing Education/Support – Provider Newsletters & Education

The Alliance Population Health Management Assessment and Strategy can be found in separate documents. The Alliance Population Health Evaluation is included in the QIHE Evaluation.

SENIORS AND PERSONS WITH DISABILITY (SPD)

The Alliance categorizes all new SPD members as high risk. High risk members are contacted for an HRA within 45 calendar days and low risk members are contacted within 105 calendar days from their date of enrollment. Existing SPD members receive an annual HRA on their anniversary date. The objectives of an HRA are to assess the health status, estimate health risk, and address members' needs relating to medical, specialty, pharmacy, and community resources. Alliance staff uses the responses to the HRAs, along with any relevant clinical information, to generate care plans with interventions to decrease health risks and improve care management.

DHCS has established performance measures to evaluate the quality of care delivered to the SPD population using HEDIS measures and a hospital readmissions measure.

PROVIDER COMMUNICATION

The Alliance contracts with its providers to foster open communication and cooperation with QIHE activities:

- Provider cooperation with QIHE activities.
- Plan access to provider medical records to the extent permitted by state and federal law.
- Provider maintenance of medical record confidentiality.
- Open provider-patient communication about treatment alternatives for medically necessary and appropriate care.
- Provider regulatory requirements

Provider involvement in the QIHE Program occurs through membership in standing and ad-hoc committees, Joint Operating Committee meetings, and attendance at BOG and QIHEC meetings. Providers and members may request copies of the QIHE Program description, work plan, and annual evaluation. These documents are also posted on the Alliance website. Provider participation is essential to the success of QIHE studies including HEDIS and those that focus on improving aspects of member care. Additionally, providing feedback on surveys and questionnaires is encouraged as a means of continuously improving the QIHE Program.

Providers have an opportunity to review the findings of the QIHE Program through a variety of

mechanisms. The QIHEC reports findings from QIHE activities to the BOG through CMO reports (monthly), QIHE Trilogy documents (annually), and on an on-going basis. Findings include aggregate results, comparisons to benchmarks, deviation from threshold, drill-down results for provider group or type, race/ethnicity, and language, and other demographic or clinical factors. Findings are distributed directly to the provider when data is provider specific. Findings are included in an annual evaluation of the QIHE Program and made available to providers and members upon request. The Provider Bulletin contains a calendar of future BOG and standing committee dates and times.

EVALUATION OF QIHE PROGRAM (SEPARATE DOCUMENT)

The QIHEC reviews, makes recommendations, and approves a written evaluation of the overall effectiveness of the QIHE Program on an annual basis. The evaluation includes, at a minimum:

- Changes in staffing, reorganization, structure, or scope of the program during the year.
- Allocation of resources to support the program.
- Comparison of results with goals and targets.
- Tracking and trending of key indicators.
- Description of completed and ongoing QIHE activities.
- Analysis of the overall effectiveness of the program, including assessment of barriers or opportunities.
- Recommendations for goals, targets, activities, or priorities in subsequent QIHE Work Plan.

The review and revision of the program may be conducted more frequently as deemed appropriate by the QIHEC, CMO, CHEO, CEO, or BOG. The QIHEC's recommendations for revision are incorporated into the QIHE Program Description, as appropriate, which is reviewed by the BOG and submitted to DHCS on an annual basis.

ANNUAL QIHE WORK PLAN (SEPARATE DOCUMENT)

A QIHE Work Plan is received and approved annually by the QIHEC. The work plan describes the QIHE goals and objectives, planned projects, and activities for the year, including continued follow-up on previously identified quality issues, and a mechanism for adding new activities to the plan as needed. The QIHE work plan delineates the responsible party and the time frame in which planned activities will be implemented.

The work plan is included as a separate document and addresses the following:

- Quality of clinical care
- Quality of service
- Safety of clinical care
- Members' experience
- Health equity activities
- Yearly planned activities and objectives
- Time frame within which each activity is to be achieved.
- The staff member responsible for each activity
- Monitoring previously identified issues.
- Evaluation of the QIHE Program

Progress on completion of activities in the QIHE work plan is reported to the QIHEC quarterly. A summary of this progress will be reported by the CMO to the BOG.

SUPPORTING DOCUMENTS

In addition to this program description, the annual evaluation and work plan, the other additional documents important in communicating QI policies and procedures include and not limited to:

- "Provider Manual" provides an overview of operational aspects of the relationship between the Alliance, providers, and members. Information about the Alliance's QIHE Program is included in the provider manual. It is distributed to all contracted provider sites.
- "Provider Bulletin" is a newsletter distributed to all contracted provider sites on topics of relevance to the provider community, and can include QIHE policies, procedures, and activities.
- "Alliance Alert" is the member newsletter that also serves as a vehicle to inform members of QIHE policies and activities.

These documents, or summaries of the documents, are available upon request to providers, members, and community partners. In addition, the QIHE Program information is available on the Alliance website.

CONFIDENTIALITY AND CONFLICT OF INTEREST

All employees, contracted providers, delegated medical groups and sub-contractors of the Alliance maintain the confidentiality of personally identifiable health information, medical records, peer review, internal and external, and internal electronic transmissions, and quality improvement records. They will ensure that these records and information are not improperly disclosed, lost, altered, tampered with, destroyed, or misused in any manner. All information used in QIHE activities is maintained as confidential in compliance with applicable federal and state laws and regulations.

Access to member or provider-specific peer review and other QI information is restricted to individuals and/or committees responsible for these activities. Outside parties asking for information about QIHE activities must submit a written request to the CMO. Release of all information will be in accordance with state and federal laws.

All providers participating in the QIHEC or any of its subcommittees, or other QIHE Program activities involving review of member or provider records, will be required to sign and annually renew confidentiality and conflict of interest agreements. Guests or additional Alliance staff attending QIHEC meetings will sign a confidentiality agreement.

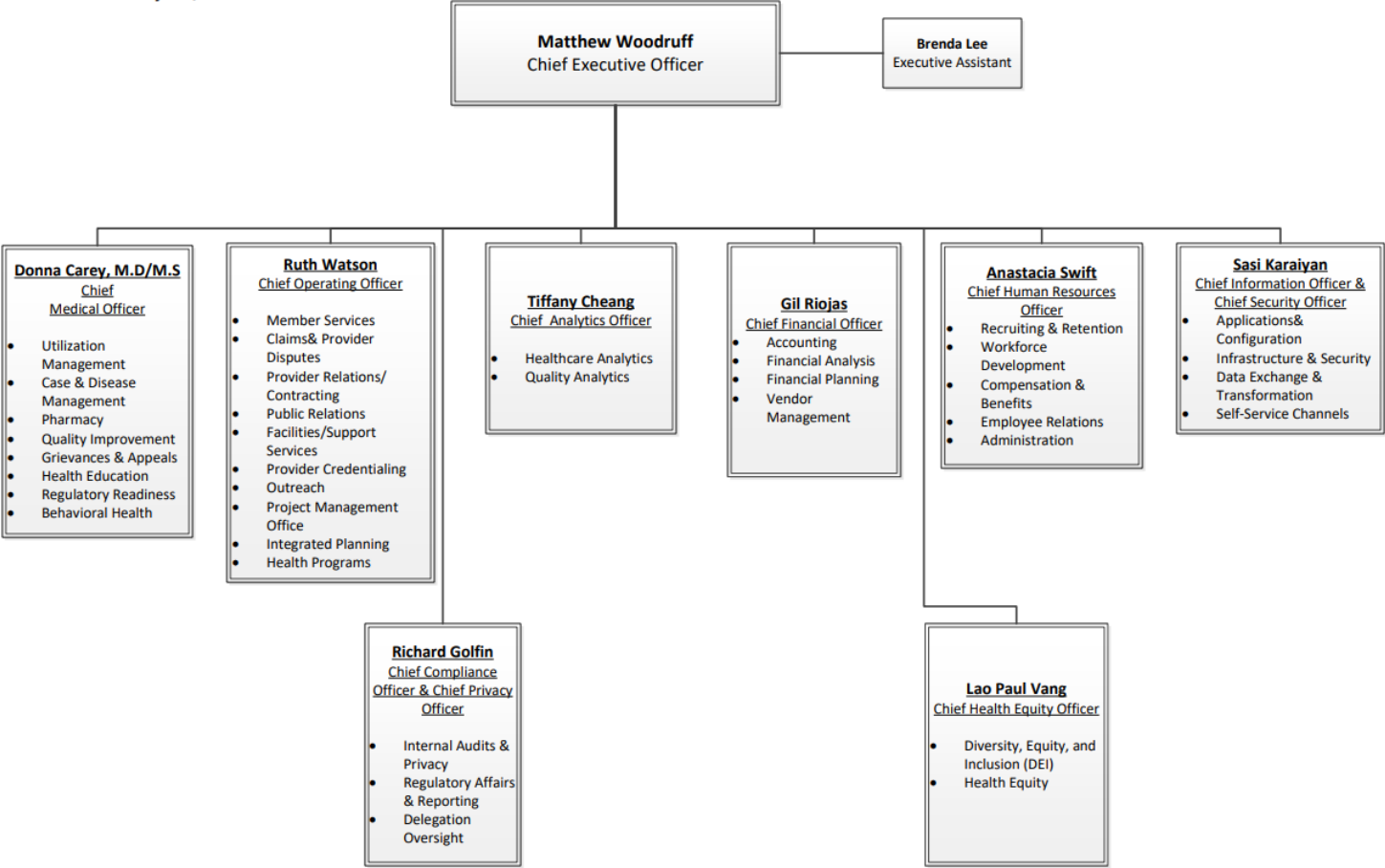
Committee members may not participate in the review of any case in which they have a direct professional, financial, or personal interest. It is each committee member's obligation to declare actual or potential conflicts of interest.

All QIHEC meeting materials and minutes are marked with the statement "Confidential". Copies of QIHE meeting documents and other QIHE data are maintained separately and secured to ensure strict confidentiality.

APPENDIX A: Organizational Charts

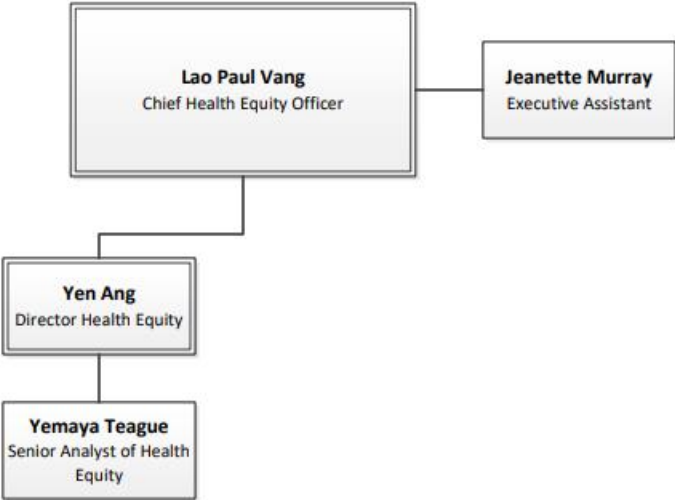
Senior Management

Alameda Alliance for Health
Senior Management
February 28, 2025



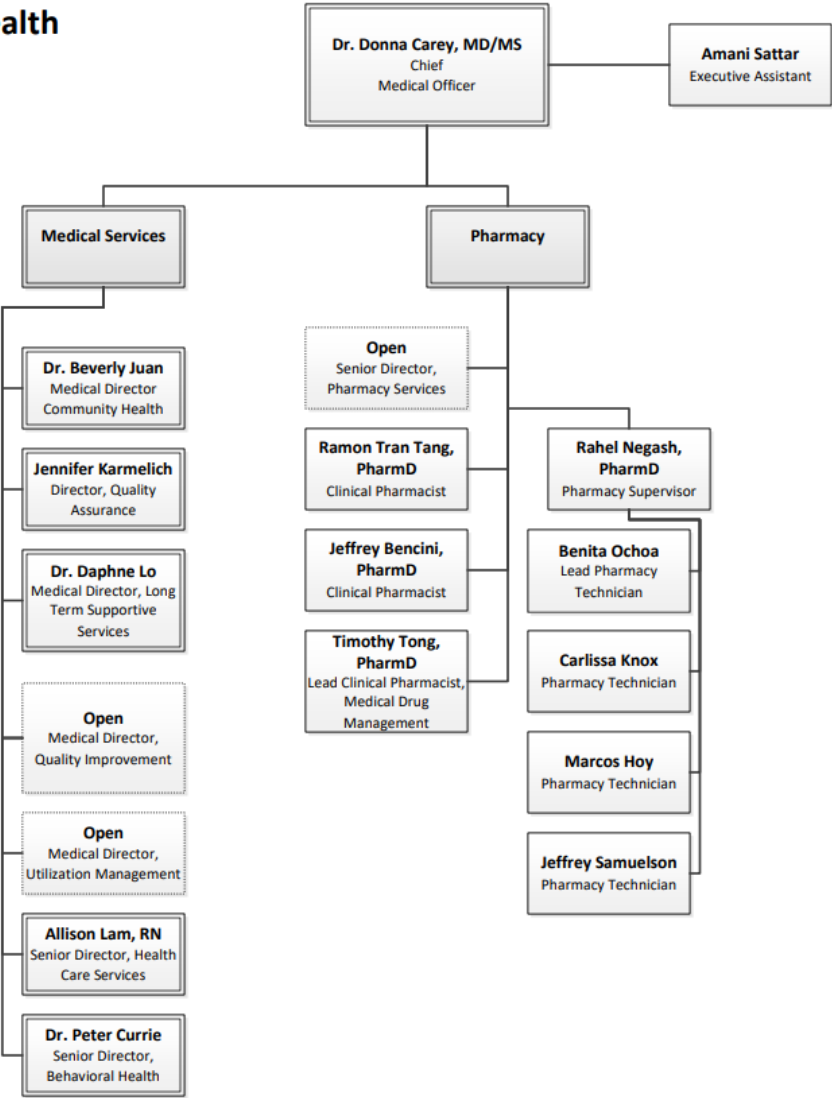
Health Equity

Alameda Alliance for Health
Health Equity
February 28, 2025



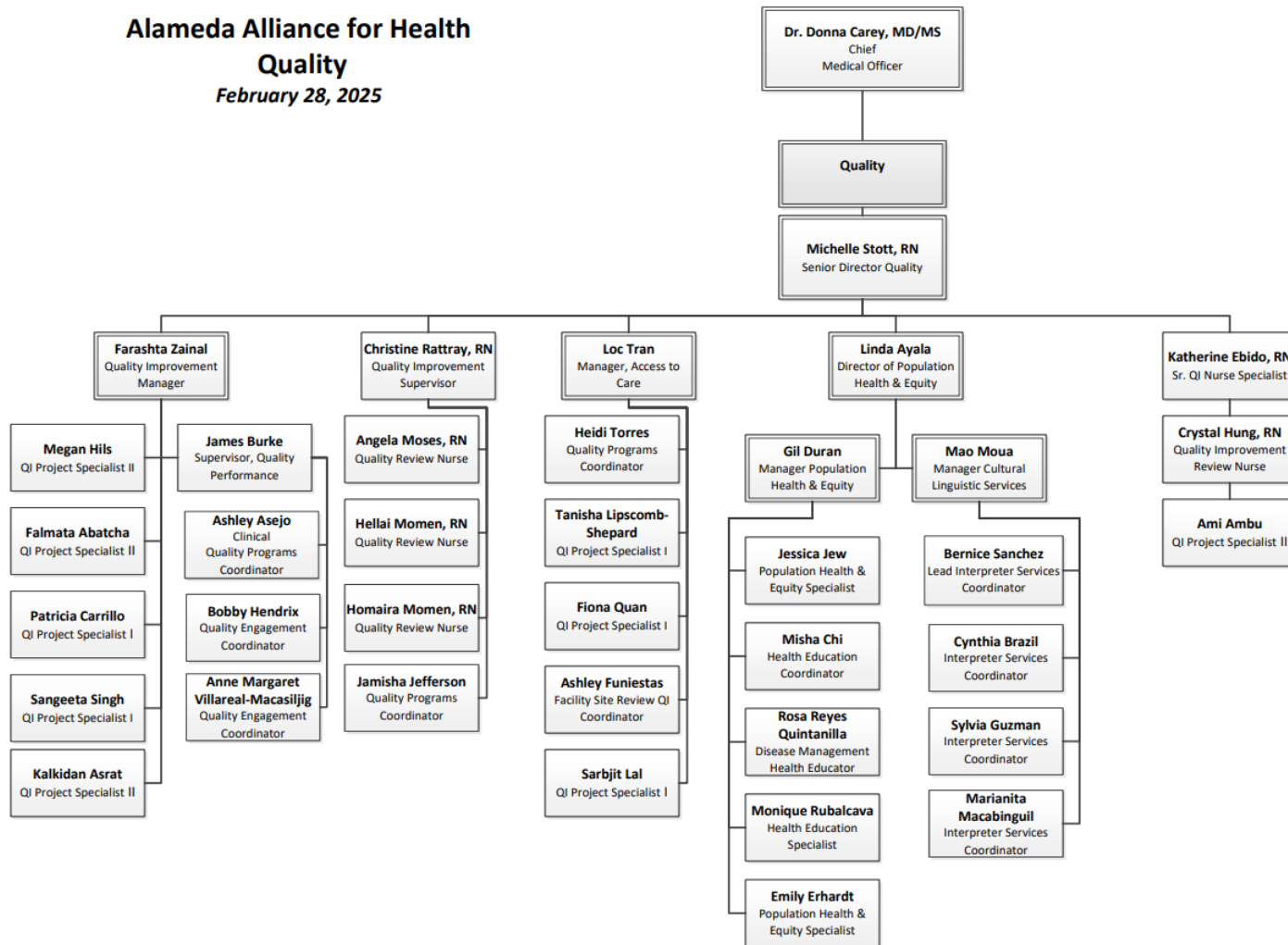
Medical Services and Pharmacy

Alameda Alliance for Health
Healthcare Services
February 28, 2025



Health Care Services – Quality

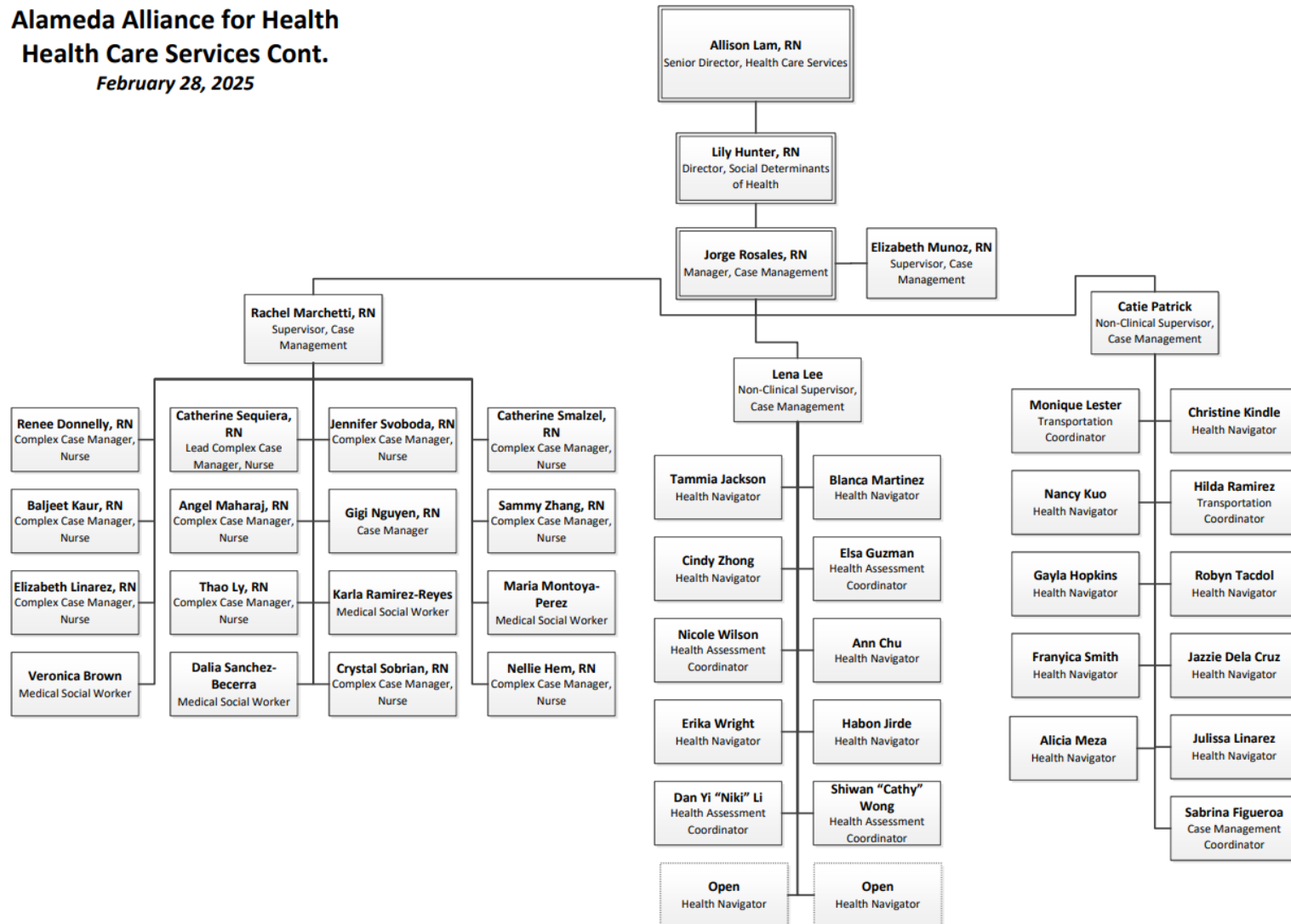
Alameda Alliance for Health Quality February 28, 2025



* Added Accreditation Manager, Accreditation & Regulatory Compliance Specialist (2), and Clinical Review Nurses (2) in April 2025

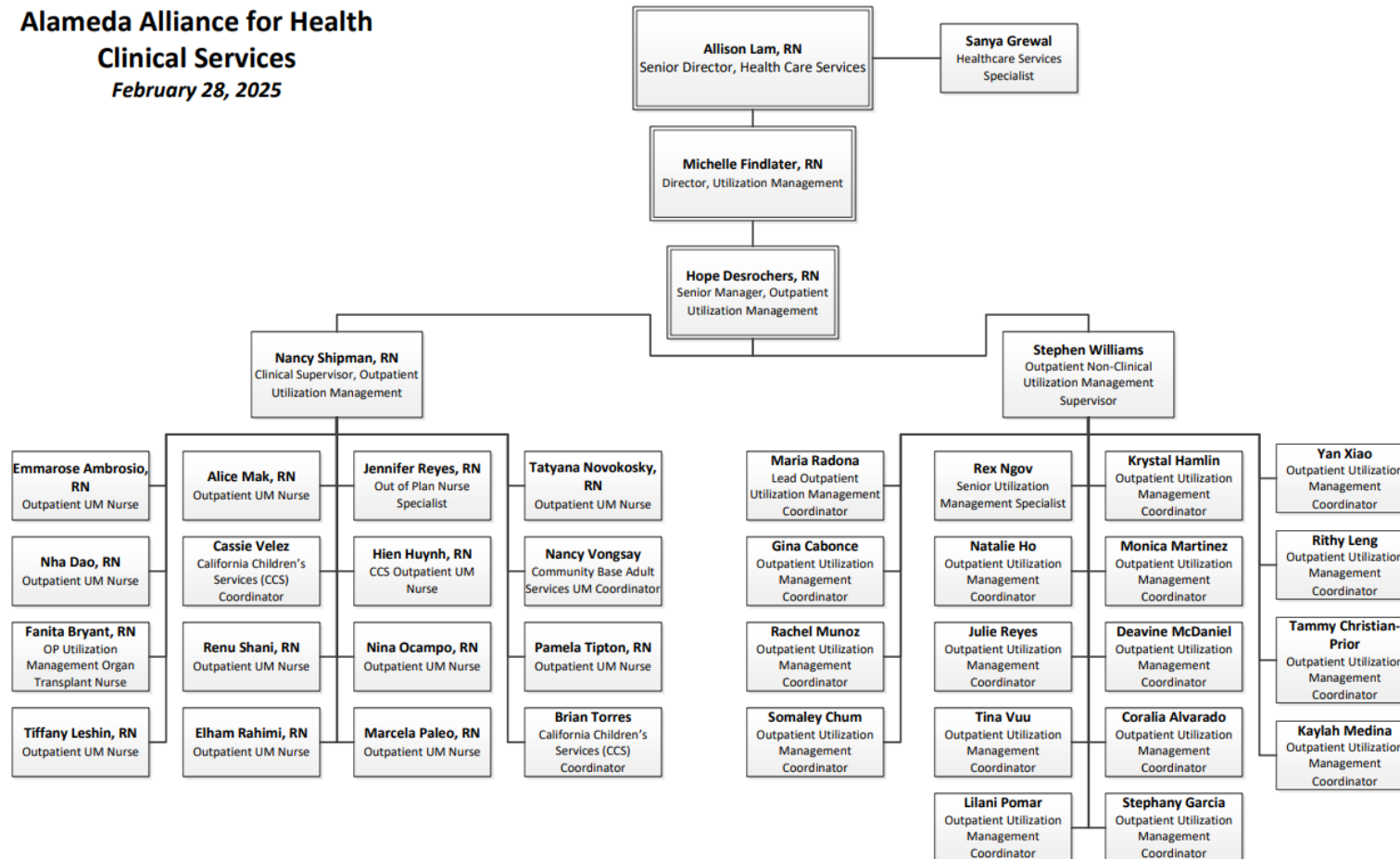
Case Management

Alameda Alliance for Health Health Care Services Cont. February 28, 2025



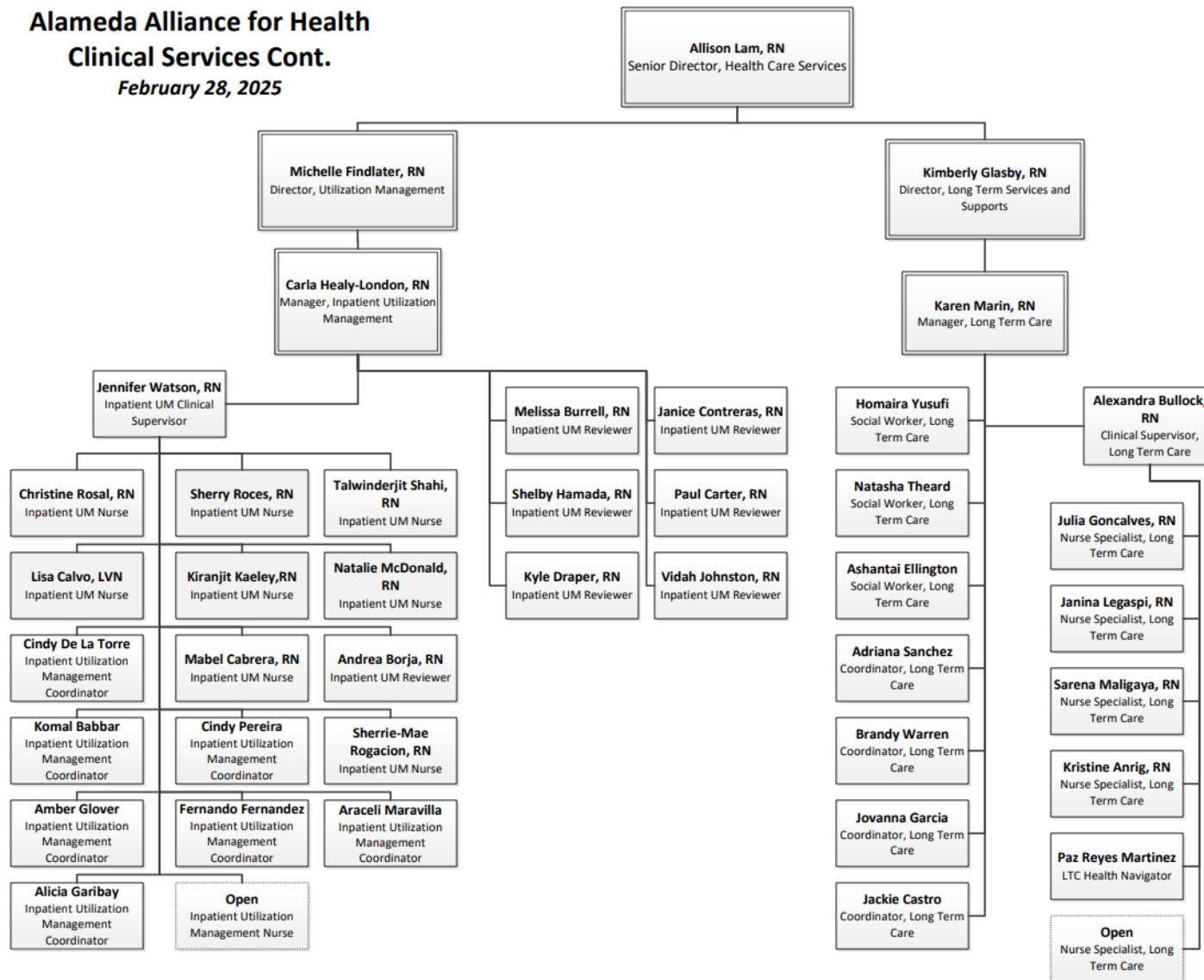
Utilization Management – Outpatient

Alameda Alliance for Health
Clinical Services
February 28, 2025



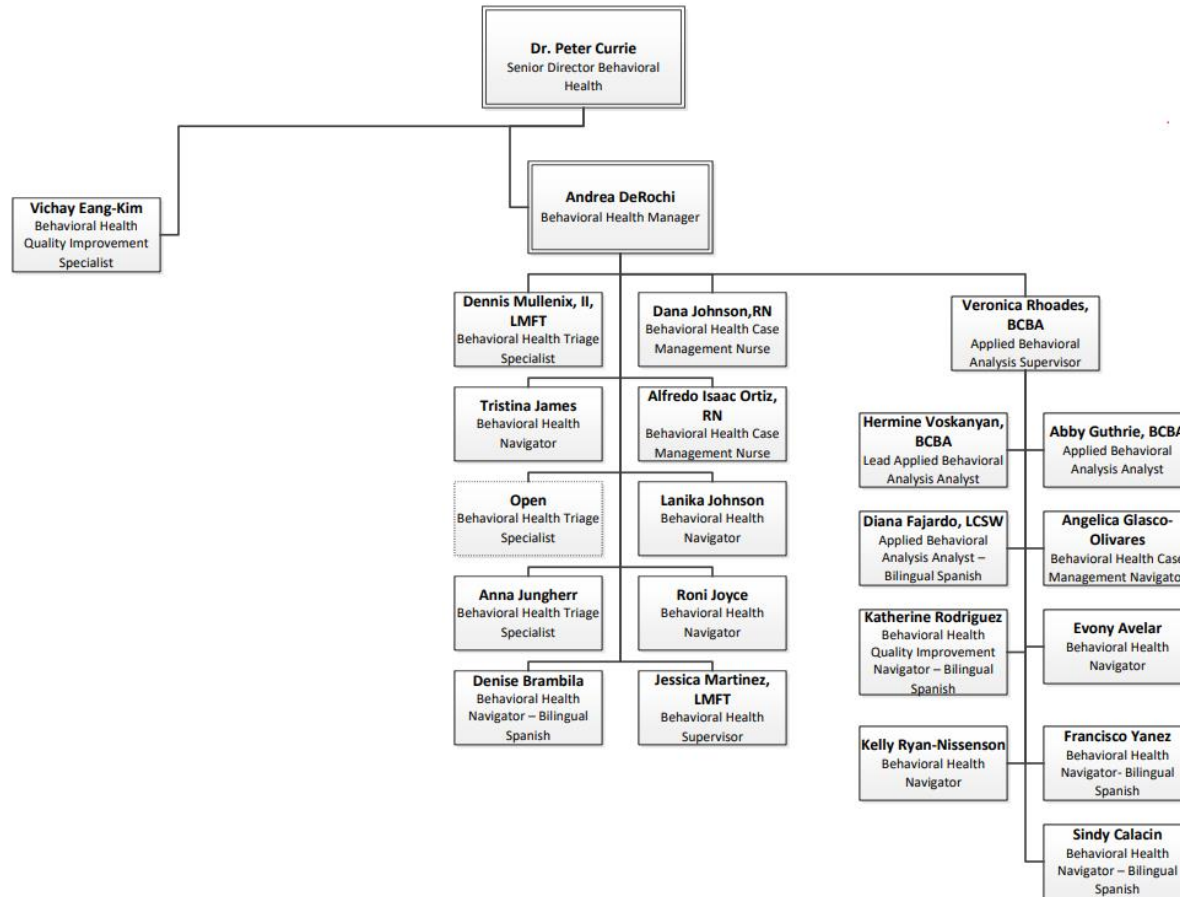
Utilization Management – Inpatient and Long Term Care

Alameda Alliance for Health
Clinical Services Cont.
February 28, 2025



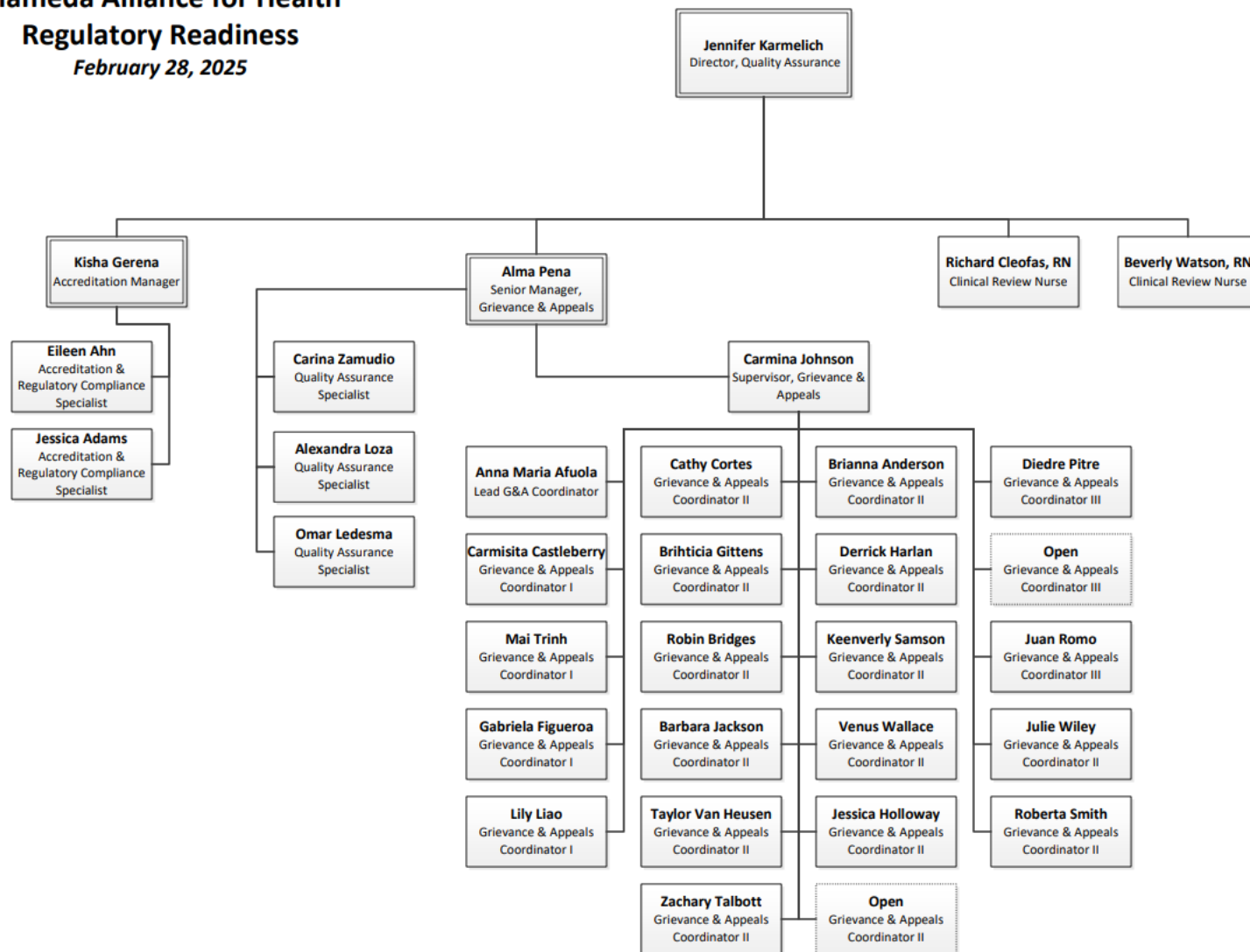
Behavioral Health

Alameda Alliance for Health
Behavioral Health
February 28, 2025



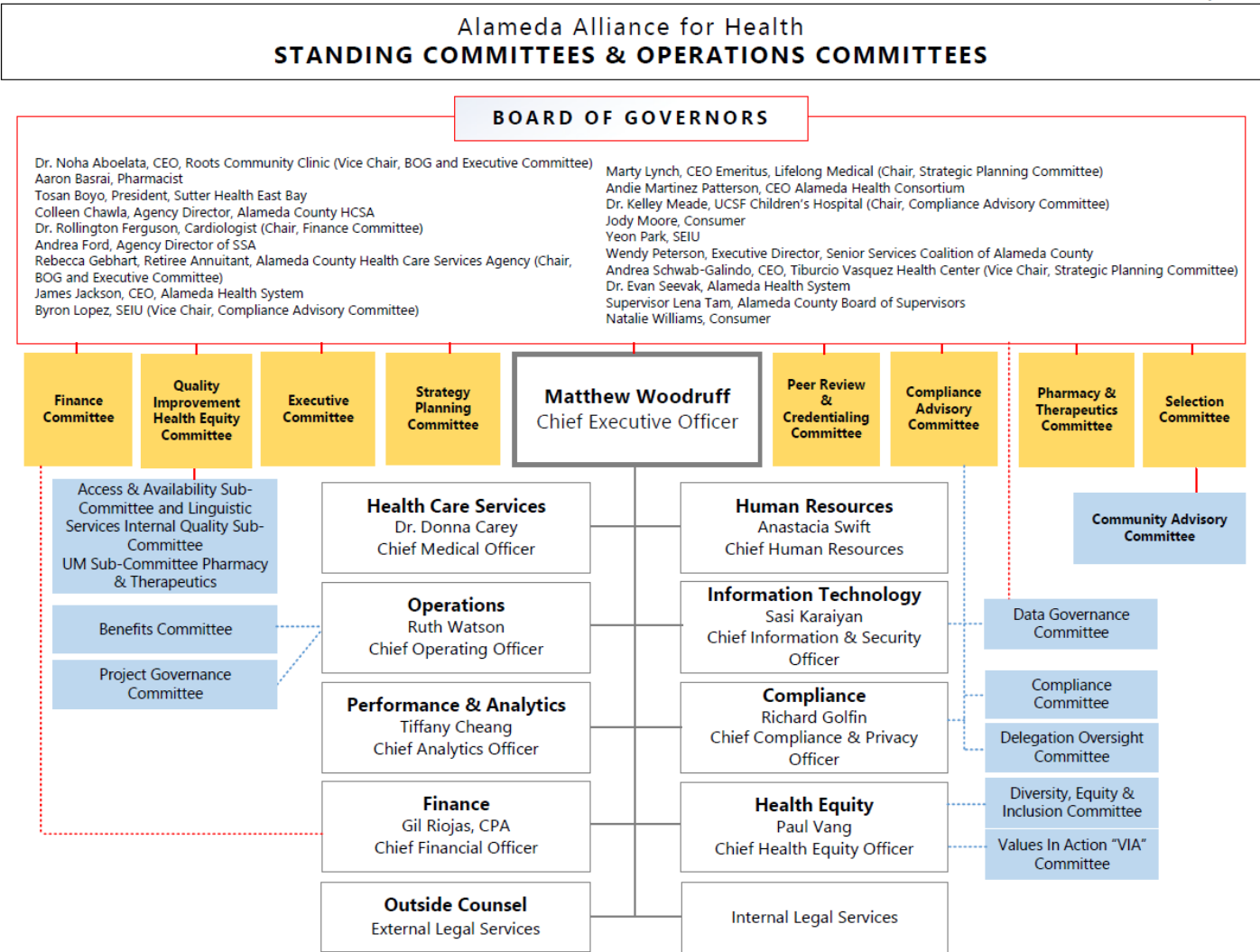
Regulatory Readiness

Alameda Alliance for Health
Regulatory Readiness
February 28, 2025



APPENDIX B: Alameda Alliance Committees

January 2025



2025 Quality Improvement & Health Equity (QIHE) Work Plan											
	Sponsor	Business Owner	QI Staff Lead	QI Activity/Initiative	Health Equity Focus (Y/N)	Continued or New?	Goal/Justification *Update this column		Subcommittee	Project Due Date	Monitoring of Previously Identified Issues (if applicable)
QIHE Evaluation	Title: Sr. QI Director Name: Michelle N. Stott	Title: Sr. QI Director Name: Michelle N. Stott	N/A	Annual QIHE Program Evaluation	Y	Continued	Conduct an annual written evaluation of the QIHE program that includes: 1. A description of completed and ongoing QIHE activities that address quality and safety of clinical care and quality of service 2. Trending of measures to assess performance in the quality and safety of clinical care and quality of service 3. Analysis and evaluation of the overall effectiveness of the QIHE program and of its progress toward influencing network wide safe clinical practices 4. Annual review of performance measures, utilization data, consumer satisfaction survey, and findings such as Community Advisory Committee		All Sub-Committees and QIHEC	12/31/25	Incorporated BH and SNF/LTC Quality Monitoring
Quality of Care	Title: Senior Director, Quality Name: Michelle Stott	Title: Manager, Quality Improvement Name: Farashtha Zainal	Title: Manager, Quality Improvement Name: Farashtha Zainal	HEDIS Rates MY 2025	N	Continued	Increase the HEDIS/MCAS measures below MPL in MY2025 to meet or exceed MPL by December 31, 2025		Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/25	Due to the pandemic AAH saw a decline in HEDIS measures with multiple years of service. Furthermore, state wide insufficient lead screening kits may be a factor in declining lead screening rates.
	Title: Senior Director, Quality Name: Michelle Stott	Title: Manager, Quality Improvement Name: Farashtha Zainal	Quality Performance Team	Pay For Performance (P4P) Program	N	Continued	By 12/31/2025, the Quality Performance Team will help clinics meet or exceed their established PAP goals (50th or 75th Percentile). This will be accomplished by providing performance updates to clinics, sharing best practices, and offering project support during their established Quality Meetings.		Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/25	The P4P program has been a successful tool used to support providers improve HEDIS rates.
	Title: Senior Director, Quality Name: Michelle Stott	Title: Manager, Quality Improvement Name: Farashtha Zainal	Title: Supervisor, Quality Performance Name: James Burke	Learning Academy	N	Continued	By December 31, 2025, the Quality Performance Team will: -OP POSA Cycle Trainings: Offer two QI POSA Cycle Training opportunities for providers to learn and apply the POSA (Plan-Do-Study-Act) methodology, with at least 70% of registered providers attending each session. -MCAS Trainings: Offer four learning opportunities to the provider network on MCAS measures. These sessions will cover measure specifications and best and promising practices. -Member Education: Will develop and deliver, in collaboration with Health Education and Health Equity, at least one member education session on the importance of preventive care. This session will be presented to a minimum of one Community-Based Organization (CBO) identified by the team.		Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/25	As quality improvement (QI) projects spread throughout the Health Care Service team, it is essential that all staff have an understanding of the POSA model for improvement. The model provides a vehicle to drive QI projects
	Title: Senior Director, Quality Name: Michelle Stott	Title: Manager, Quality Improvement Name: Farashtha Zainal	Title: QI Project Specialist II Name: Kalel Asrat	Priority PIP: Improve FUA/FUM - Improve 30 day follow-up rate	N	Continued	By December 31, 2025, Alameda Alliance will improve the 7-day provider notifications rate by 2% for members visiting the ED with SUD/SMH diagnoses.		Internal Quality Improvement Committee	12/31/25	This is a continued PIP topic that was assigned by the state based on low performance.
	Title: Senior Director, Quality Name: Michelle Stott	Title: Manager, Quality Improvement Name: Farashtha Zainal	Title: QI Project Specialist II Name: Faimata Abatcha	Equity PIP: Improve Well Child - W15 (6) for African American Children	Y	Continued	To address the disparity that exists with Well Child visits, by December 31, 2025, increase the percentage of well-child visits (W30-6) amongst African American children between the ages of 0-15 months from 30.54% to MPL.		Internal Quality Improvement Committee	12/31/25	This is a newly assigned PIP. PIP topic was assigned by the state based on low performance
	Title: Senior Director, Quality Name: Michelle Stott	Title: Manager, Quality Improvement Name: Farashtha Zainal	Title: QI Project Specialist I Name: Sangesta Singh	Workgroup: Reproductive Health and Cancer Prevention	Y	Continued	By December 31, 2025, the Alliance will improve on cancer prevention and reproductive health measures in the MCAS/P4P, by conducting improvement projects to increase the MY2025 rates by 3% over MY2024 rates. 1. Increase breast and cervical cancer screening rates for Alliance direct providers to 3 percent over prior years rate by end of 2025 2.As of 1/7/2025: -BCS-MY2024 53.03% to 56% 3.As of 1/7/2025: -CCCS-MY2024 40.37% to 42.37% 4. Continue to focus increasing BCS rates for African American women 5.As of 1/7/2025- MY2024 the rate is 52.36% below MPL at 52.68%. Aim to increase final rate by 3 percent. 6. Continue to focus increasing CCS rates for age band 24-30 7.As of 1/7/2025- MY2024 rate is 37.83%. Aim to increase the final rate by 3 percent. Cancer Prevention and Reproductive Health Measures: CCS, BCS, COL, PPC 1, PPC 2, and CHL.		Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/25	
	Title: Senior Director, Quality Name: Michelle Stott	Title: Manager, Quality Improvement Name: Farashtha Zainal	Title: QI Project Specialist II Name: Faimata Abatcha Title: QI Project Specialist I Name: Patty Camillo	Workgroup: Well Child	N	Continued	By December 31, 2025 the Alliance will improve on well-child measures in the MCAS, by: -Conducting improvement projects to increase the rates from below the MPL and to further increase rates to meet the 90th percentile: Well Child Measures: W15, W30, WCV, CIS10, IMA, DEV, TTL -By Dec 31, 2025, CFMG will increase the number of MPLs achieved from 3 to 5 by implementing targeted training, process optimizations, and performance monitoring, ensuring all teams have equitable access to the necessary resources and support. Progress will be reviewed quarterly to maintain momentum and adjust strategies as needed.		Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/25	This workgroup is committed to fostering collaboration among QI department teams to enhance performance on Well-Child measures.
	Title: Senior Director, Quality Name: Michelle Stott	Title: Manager, Quality Improvement Name: Farashtha Zainal	Title: QI Project Specialist II Name: Megan Hils	Workgroup: Chronic Disease Management	N	Continued	By December 31, 2025, Alameda Alliance for Health (AAH) will improve the administrative rates for chronic disease management hybrid measures as follows: CBP: 49% (MY2023) to 65% (MPL) GSD: 32% (MY2023 HED) to 29% (90th pctd) By December 31, 2025, Alameda Alliance for Health (AAH) will improve the rate for chronic disease management AMR as follows: AMR: 68% (MY2024) to 77% (90th pctd) By December 31, 2025, Alameda Alliance for Health (AAH) will improve data collection for CBP and GSD measures among direct providers from: CBP: 79% to 50% missing or incomplete GSD: 37% to 25% missing		Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/25	This workgroup supports the goal of creating a culture of quality improvement goals throughout the organization and increases alignment of quality improvement efforts across QI department teams. These goal were developed in the context of challenges collecting data for CBP and GSD measures, especially among direct providers, consistent administrative performance below hybrid rates, and steadily decreasing rates for AMR after several years of high performance.
	Title: Senior Director, Quality Name: Michelle Stott	Title: Manager, Quality Improvement Name: Farashtha Zainal	Title: QI Project Specialist II Name: Kalel Asrat	Workgroup: Behavioral Health	N	Continued	By December 31, 2025, Alameda Alliance for Health will sustain FUA HEDIS rates and improve FUM HEDIS rate by 2% from MY2024 to MY2025 to meet/exceed MPL. MY 2024 rates as of 5/1 FUA: 41.44% FUM:66.38 % Collaborate with BH Department in development of disease management for depression. Collaborate with ACBH to decriminalize resources to providers and encourage data sharing.		Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/25	This workgroup supports the goal of creating a culture of quality improvement goals throughout the organization and increases alignment of quality improvement efforts across QI department and the Behavioral Health Departments. These goals were developed in the context of challenges of data sharing with Alameda County for the FUA and FUM measures.
	Title: Senior Director, Quality Name: Michelle Stott	Title: Manager, Quality Improvement Name: Farashtha Zainal	Title: Supervisor, Quality Performance Name: James Burke	Member Engagement Program	N	Continued	By 12/31/2025, the Member Engagement Program will close care gaps in the DHCS MCAS measures by reaching or exceeding the MPLs. This will be achieved through the following actions: -Conducting at least 3,000 outreach quarterly to engage with members and identify care gaps. -Collaborate with at least one provider, quarterly, to implement member-focused campaigns. -Actively participate in at least four quality improvement projects, in the year, related to member engagement, contributing to measurable improvements.		Internal Quality Improvement Committee	12/31/25	

2025 Quality Improvement & Health Equity (QIHE) Work Plan										
	Sponsor	Business Owner	QI Staff Lead	QI Activity/Initiative	Health Equity Focus (Y/N)	Continued or New?	Goal/Justification *(Update this column)	Subcommittee	Project Due Date	Monitoring of Previously Identified Issues (if applicable)
QIHE Evaluation	Title: Sr. QI Director Name: Michelle N. Stott	Title: Sr. QI Director Name: Michelle N. Stott	N/A	Annual QIHE Program Evaluation	Y	Continued	Conduct an annual written evaluation of the QIHE program that includes: 1. A description of completed and ongoing QIHE activities that address quality and safety of clinical care and quality of service 2. Trending of measures to assess performance in the quality and safety of clinical care and quality of service 3. Analysis and evaluation of the overall effectiveness of the QIHE program and of its progress toward influencing network wide safe clinical practices 4. Annual review of performance measures, utilization data, consumer satisfaction survey, and findings such as Community Advisory Committee	All Sub-Committees and QIHEC	12/31/25	Incorporated BH and SNF/LTC Quality Monitoring
	Title: Senior Director, Quality Name: Michelle Stott	Title: Manager, Quality Improvement Name: Farashia Zainal	Title: Supervisor, Quality Performance Name: James Burke	IHI/DHCS Equity Learning Collaborative - Children's Health	Y	Continued	The focus of the Child Health Equity Collaborative is to improve the completion of well-child visits, ages 0-21. The Alliance will conduct Evidence-Based Interventions: -Equity & Transparent, Stratified, and Actionable Data (April-May 2024) -Understand Provider and Patient/Caregiver Experiences (June-July 2024) -Plan and Implement PSDAs with Provider Partners (August-October 2024) -Asset Mapping & Community Partnerships (November-December 2024) -Partnering for Effective Education & Communication (January-March 2025)	N/A	3/31/25	
Population Health Management	Title: Sr. QI Director Name: Michelle Stott	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	Population Needs Assessment	Y	New	Provide meaningful contributions to LHJ CHA/CHPs (including resources, in-kind staffing, and data sharing) by Q4 of 2025.	Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/2025	
	Title: Sr. QI Director Name: Michelle Stott	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	Population Health Management - PHM Monitoring	Y	Continued	Implement population-based PHM framework to inform monitoring processes and RSS guidance by the end of 2025.	Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/2025	
	Title: Sr. QI Director Name: Michelle Stott	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	Population Health Management - PHM Strategy	Y	Continued	Develop the Alliance 2025 PHM Strategy to address priority gaps in care and disparities in compliance with DHCS and NQQA requirements.	Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/2025	
Safety of Care	Title: Sr. Director, Pharmacy Services Name:	Title: Clinical Pharmacist Name: Ramon Tran Tang	N/A	QIP #5: Opioid / SUD - Continuation	N	Continued	Goal 1: By 12/31/25, educate chronic opioid users on health habits, management of chronic pain, and alternative therapy and care (>120 MME) daily). Goal 2: By 12/31/25, educate opioid users at risk of becoming chronic users (i.e., 50 to 119 MME/day)	Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/2025	Staff bandwidth and staffing transition
	Title: Sr. Director, Pharmacy Services Name:	Title: Clinical Pharmacist Name: Ramon Tran Tang	N/A	QIP #5: Opioid / SUD - Continuation	N	Continued	Goal 3: By 12/31/25, educate providers who are assigned members that utilize high dose opioids (>120MME) and who are presenting to the Emergency Department with opioid and / or benzodiazepine overdose.	Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/2025	Staff bandwidth and staffing transition
	Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name: Sanjay Bhatt	Title: Sr. Medical Director Name:	Title: QI Supervisor Name: Christine Ratray	Potential Quality Issues (PQIs) Continuation-Quarterly	N	Continued	Monitor, evaluate, and take effective action with >= 95% PQI closure within 120 days to address any needed improvements in the quality of care delivered by all providers rendering services on behalf of the Alliance in any setting along with internal data validation.	Internal Quality Improvement Committee Access to Care Sub-Committee Quality Improvement Health Equity Committee	12/31/2025	
	Title: Sr. QI Director Name: Michelle Stott	Title: Sr. Medical Director Name:	Title: QI Supervisor Name: Christine Ratray	PQI Corrective Action Plan Tracking & Trending	N	New	Monitor, evaluate and take effective action where appropriate on all Corrective Action Plans (CAPs) issued. Assess effectiveness of track and trend reports and refine if needed.	Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/2025	2024 CAP report presented at BOG and IQIC in March 2025
	Title: Sr. QI Director Name: Michelle Stott	Title: Sr. Medical Director Name:	Title: QI Supervisor Name: Christine Ratray	Exempt Grievances Auditing-Biannual	N	Continued	Ensure clinical monitoring of Exempt Grievances for Quality of Care, Service, Access and Language issues per P&P QI-104 through bi-annual review of 100 randomly selected Exempt Grievances.	Internal Quality Improvement Committee Access to Care Sub-Committee Quality Improvement Health Equity Committee	12/31/2025	
	Title: Sr. QI Director Name: Michelle Stott	Title: Sr. Medical Director Name:	Title: QI Supervisor Name: Christine Ratray	Potential Quality Issues (PQIs) Annual Training	N	Continued	Plan provides documented evidence of ongoing annual training on PQIs by clinical staff for both new and seasoned customer service staff who serve as the front-line entry for the intake of all potential quality of care grievances	Internal Quality Improvement Committee Access to Care Sub-Committee Quality Improvement Health Equity Committee	12/31/2025	
	Title: Sr. QI Director Name: Michelle Stott	Title: Sr. Medical Director Name:	Title: QI Supervisor Name: Christine Ratray	Provider Preventable Conditions (PPCs) workflow	N	New	Refine Provider Preventable Conditions (PPCs) workflow in collaboration with other departments.	Internal Quality Improvement Committee	12/31/2025	
	Title: Sr. QI Director Name: Michelle Stott	Title: Sr. Medical Director Name:	Title: QI Supervisor Name: Christine Ratray	PQI ModivCare Focus	N	New	On tracking and trending of PQI cases as well as a review of grievances, we note a substantial number of C1 / C2 cases and member complaints related to missed rides. Collaborate with Modivcare and Vendor Management to address any preventable system issues.	Internal Quality Improvement Committee Access to Care Sub-Committee Quality Improvement Health Equity Committee	12/31/2025	
	Title: Sr. QI Director Name: Michelle Stott	Title: Sr. Medical Director Name:	Title: QI Coordinator Name: Jamisha Jefferson	IHA Audit	N	New	Perform IHA audit bi-annually and distribute educational letters to providers. Determine if there are any provider trends for two consecutive audits and implement a follow up plan.	Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/2025	
	Title: Sr. QI Director Name: Michelle Stott	Title: Access to Care Manager Name: Loc Tran	Title: Sr. QI Nurse Specialist Name: Kathy Ebdio	Facility Site Review (FSR) Continuation	N	Continued	100% of corrective action plans for periodic (full-scope) site reviews (FSR/MRR) are received within 30 days and closed within 90 days of FSR/MRR Report. CAP closure do not exceed 120 days from FSR/MRR Report.	Access to Care Sub-Committee Quality Improvement Health Equity Committee	12/31/25	
Quality of Service	Title: Sr. QI Director Name: Michelle Stott	Title: Sr. Medical Director Name:	Title: QI Supervisor Name: Christine Ratray	Inter-rater Reliability (IRR) Continuation-Annual	N	Continued	IRR is performed annually to ensure >=90% IRR consistency and accuracy of review criteria applied by all clinical reviewers - physicians and non-physicians - who are responsible for conducting clinical reviews and to act on improvement opportunities identified through this monitoring.	Internal Quality Improvement Committee	12/31/2025	
	Title: Sr. QI Director Name: Michelle Stott	Title: Sr. QI Director Name:	Title: Sr. QI Nurse Name: Kathy Ebdio	Skilled Nursing Facility/Long Term Care (SNF/LTC) Quality Monitoring	N	Continued	Continue to monitor SNF/LTC quality monitoring tools to meet APL 23-004 SNF/LTC Benefit Standardization: 1) Obtain 60% of the SNF attestation by 12/31/25. 2) Draft standard operating procedures (SOP) as to actions taken for providers with quality of care trends 3) Monitor quality measures (i.e. HEDIS/NICAS) with the LTC team and develop interventions for trends.	Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/2025	
	Title: Sr. QI Director Name: Michelle Stott	Title: QI Manager Name: Farashia Zainal	Title: Manager of Quality Improvement Name: Farashia Zainal	QIP #4: Increase Initial Health Appointment rates	N	Continued	By 12/31/2025 improve IHA completion rates from MY2024 to MY2025 by 3%.	Internal Quality Improvement Committee Quality Improvement Health Equity Committee	12/31/2025	State issued CAP for IHA
	Title: Sr. QI Director Name: Michelle Stott	Title: Access to Care Manager Name: Loc Tran	Title: QI Specialist Name: Tanisha Shepard	CG-CAHPS Survey Continuation (Quarterly)	N	Continued	Ensure that quarterly survey questions align with DMHC timely access and language requirements to evaluate member clinical & group satisfaction/experience with Timely Access Standards - Office Wait Time, Call Return Time, Time to Answer Call. To ensure that the survey results are actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities. The compliance threshold goal for Call Return Time and Time to Answer Call remains 70% (with a stretch goal of 80%). In Office Wait Time goal remains 80% for 2025. Started Q2 2024, CG-CAHPS will include BH providers. Specialist providers will be added to CG-CAHPS survey starting Q1 2025.	Access to Care Sub-Committee Quality Improvement Health Equity Committee	12/31/2025	

2025 Quality Improvement & Health Equity (QIHE) Work Plan										
	Sponsor	Business Owner	QI Staff Lead	QI Activity/Initiative	Health Equity Focus (Y/N)	Continued or New?	Goal/Justification *(Update this column)	Subcommittee	Project Due Date	Monitoring of Previously Identified Issues (if applicable)
QIHE Evaluation	Title: Sr. QI Director Name: Michelle N. Stott	Title: Sr. QI Director Name: Michelle N. Stott	N/A	Annual QIHE Program Evaluation	Y	Continued	Conduct an annual written evaluation of the QIHE program that includes: 1. A description of completed and ongoing QIHE activities that address quality and safety of clinical care and quality of service 2. Trending of measures to assess performance in the quality and safety of clinical care and quality of service 3. Analysis and evaluation of the overall effectiveness of the QIHE program and of its progress toward influencing network wide safe clinical practices 4. Annual review of performance measures, utilization data, consumer satisfaction survey, and findings such as Community Advisory Committee	All Sub-Committees and QIHEC	12/31/25	Incorporated BH and SNF/ILTC Quality Monitoring
	Title: Sr. QI Director Name: Michelle Stott	Title: Access to Care Manager Name: Loc Tran	Title: QI Specialist Name: Tanisha Shepard	Provider Satisfaction Survey Continuation (Annual)	N	Continued	Annually, timely completion of measures for provider and staff satisfaction/experience with the health plan and department services. To ensure that the survey meets NOCA requirements and is effective, direct, and actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities. Fielding Sep - November 2025. Goal: 2% increase from previous year overall satisfaction rate.	Access to Care Sub-Committee Quality Improvement Health Equity Committee	12/31/2025	
Member Experience/Access & Availability	Title: Sr. QI Director Name: Michelle Stott	Title: Access to Care Manager Name: Loc Tran	Title: QI Specialist Name: Fiona Quan	CAHPS 5.1 (Member Satisfaction Survey) Continuation (Annual)	N	Continued	Measures member experience with health plan and affiliated providers. To ensure that the annual survey aligns with NOCA standards and is effective, direct, and actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities for member experience. Fielding: Feb. - May of 2025. Goal: 2% increase from previous year overall satisfaction rate.	Access to Care Sub-Committee Quality Improvement Health Equity Committee	12/31/2025	
	Title: Sr. QI Director Name: Michelle Stott	Title: Access to Care Manager Name: Loc Tran	Title: QI Specialist Name: Tanisha Shepard	After Hours Care Continuation (Annual)	N	Continued	Audits provide after-hours protocols (Emergency Instructions/Access to Provider) and availability according to DMHC/NOCA methodology/standards for PCP, Spec, and BH providers. To ensure that the survey is effective, direct, and actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities. Maintains 80% compliance rate for After Hour Survey. Fielding September 2025.	Access to Care Sub-Committee Quality Improvement Health Equity Committee	12/31/2025	
	Title: Sr. QI Director Name: Michelle Stott	Title: Access to Care Manager Name: Loc Tran	Title: QI Specialist Name: Fiona Quan	Initial Pre-Natal Visits Continuation (Annual)	N	Continued	To ensure that the survey aligns with DHCS requirements and is effective, direct, and actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities related to OB/GYN appointments offered according to Timely Access Standards. Reach or exceed 75% compliance rate for First Prenatal appointment. Fielding Sep - Oct. 2025 HEDIS Prenatal visits: 85.36 baseline to 85.40 admin (MPL) - increase by 3%	Access to Care Sub-Committee Quality Improvement Health Equity Committee	12/31/2025	
	Title: Sr. QI Director Name: Michelle Stott	Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name:	Title: QI Specialist Name: Fiona Quan	PAAS (Provider Appt Availability Survey) Continuation (Annual)	N	Continued	To ensure that the annual survey aligns with DMHC requirements to assess appointment availability is effective, direct, and actionable while maintaining the availability of benchmarking metrics for analysis and implementation of improvement opportunities. Maintains a 75% compliance rate for urgent and non-urgent appointment. Fielding Sep - Dec. 2025	Access to Care Sub-Committee Quality Improvement Health Equity Committee	12/31/2025	
	Title: Sr. QI Director Name: Michelle Stott	Title: Sr. QI Director Name: Michelle Stott Title: Sr. Medical Director Name:	Title: QI Specialist Name: Fiona Quan	Provider Visits and Training	N	Continued	Conduct at least 4 site visits per quarter to provider offices/clinics and provide training on timely access standards through the end of 2025.	Access to Care Sub-Committee Quality Improvement Health Equity Committee	12/31/2025	
	Title: Sr. QI Director Name: Michelle Stott	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gi Duran	Health Education Operations	N	Continued	1.1 - Maintain a 95% fulfillment rate for health education material requests and referrals within 10 business days for threshold languages and within 30 business days for translated materials through the end of 2025. 1.2 - Support coordination and logistics of Community Advisory Committee meetings, monthly and quarterly learn meetings through the end of 2025.	Internal Quality Improvement Committee/Quality Improvement and Health Equity Committee	12/31/2025	
Health Education	Title: Sr. QI Director Name: Michelle Stott	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gi Duran	Health Education Programs	N	New	2.0 - Develop at least one strategy to support senior (DSNP) populations with health education or wellness and prevention services by the end of 2025. 2.1 - Conduct annual health education program evaluations to drive process and program improvements by Q4 2025.	Internal Quality Improvement Committee/Quality Improvement and Health Equity Committee	12/31/2025	
	Title: Sr. QI Director Name: Michelle Stott	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gi Duran	Health Education Programs	Y	New	3.0 - Measure the impact of doula utilization on maternal and child health outcomes by the end of 2025.	Internal Quality Improvement Committee/Quality Improvement and Health Equity Committee	12/31/2025	
	Title: Sr. QI Director Name: Michelle Stott	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gi Duran	Disease Management	Y	New	4.0 - Implement at least one new strategy to engage members in a Disease Management program by the end of 2025.	Utilization Management/Quality Improvement and Health Equity Committee	12/31/2025	
	Title: Sr. QI Director Name: Michelle Stott	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gi Duran	Disease Management	N	New	5.0 - Develop tailored disease management outcomes measures for subpopulations by the end of 2025.	Utilization Management/Quality Improvement and Health Equity Committee	12/31/2025	
	Title: Sr. QI Director Name: Michelle Stott	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gi Duran	Disease Management	N	New	5.0 - Develop tailored disease management outcomes measures for subpopulations by the end of 2025.	Utilization Management/Quality Improvement and Health Equity Committee	12/31/2025	
vices	Title: QI Senior Director Name: Michelle Stott	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Mous	Member Cultural and Linguistic Assessment	Y	Continued	Assess the cultural and linguistic needs of plan enrollees and identify action items that may need addressed to ensure the cultural and linguistic needs of member are met.	Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	12/31/2025	
	Title: QI Senior Director Name: Michelle Stott Title: QI Medical Director Name:	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Mous	Language Assistance Services Fulfillment	Y	Continued	Reach or exceed an average fulfillment rate of ninety-five percent (95%) or more for in-person, video, and telephonic interpreter services.	Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	12/31/2025	
	Title: QI Senior Director Name: Michelle Stott Title: QI Medical Director Name:	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Mous	Language Assistance Services Fulfillment	Y	Continued	Increase monthly use of on-demand vs in-person services by 2 percentage through improvements to on-demand access.	Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	12/31/2025	

2025 Quality Improvement & Health Equity (QIHE) Work Plan										
	Sponsor	Business Owner	QI Staff Lead	QI Activity/Initiative	Health Equity Focus (Y/N)	Continued or New?	Goal/Justification *(Update this column)	Subcommittee	Project Due Date	Monitoring of Previously Identified Issues (if applicable)
Cultural and Linguistic Services QIHE Evaluation	Title: Sr. QI Director Name: Michelle N. Stott	Title: Sr. QI Director Name: Michelle N. Stott	N/A	Annual QIHE Program Evaluation	Y	Continued	Conduct an annual written evaluation of the QIHE program that includes: 1. A description of completed and ongoing QIHE activities that address quality and safety of clinical care and quality of service 2. Trending of measures to assess performance in the quality and safety of clinical care and quality of service 3. Analysis and evaluation of the overall effectiveness of the QIHE program and of its progress toward influencing network wide safe clinical practices 4. Annual review of performance measures, utilization data, consumer satisfaction survey, and findings such as Community Advisory Committee	All Sub-Committees and QIHEC	12/31/25	Incorporated BH and SNF/LTC Quality Monitoring
	Title: QI Senior Director Name: Michelle Stott	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Mousa	Language Assistance Services for Behavioral Health	Y	Continued	Ensure tracking, analysis and reporting of interpreter services utilization for behavioral health services.	Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	12/31/2025	
	Title: QI Senior Director Name: Michelle Stott	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Mousa	Provider Language Capacity (Member Satisfaction)	Y	Continued	Based on the Member CG-CAHPS Survey 81% of adult members and 92% of child members who need interpreter services will report receiving a non-family qualified interpreter through their doctor's office or health plan.	Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	12/31/2025	
	Title: QI Senior Director Name: Michelle Stott	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Mousa	Language Assistance Services (Member Satisfaction)	Y	New	Increase the Timely Access Requirement (TAR) Survey response rate by 2% for combined adult and child. (2024 Adult Baseline: 3.4%) (2024 Child Baseline: 5%)	Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	12/31/2025	
	Title: QI Senior Director Name: Michelle Stott	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Mousa	Provider Language Capacity and Race and/or Ethnicity (Provider Network)	Y	New	Conduct NQDA NET 1 A Report: Analysis of Capacity of Alliance Provider Network to meet Cultural and Linguistic and share findings with internal and external stakeholders by May 31, 2025	Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	12/31/2025	
	Title: QI Senior Director Name: Michelle Stott	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Mousa	Community Engagement: Community Advisory Committee (CAC)	Y	New	Recruit at least one (1) committee member in each of the three (3) identified areas of representation gaps: Men, individuals aged 19-44 and those who are Limited English Proficient (LEP)	Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	12/31/2025	
	Title: QI Senior Director Name: Michelle Stott	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Cultural and Linguistic Services Name: Mao Mousa	Potential Quality Issues: Quality of Language (PQI-QOL)	Y	Continued	Monitor, evaluate, and conduct appropriate interventions for PQI-QOLs with a closure rate of 95% or more within 60 business days.	Cultural and Linguistic Services Committee/Quality Improvement Health Equity Committee	12/31/2025	
Inter-department	Title: QI Senior Director Name: Michelle Stott	Title: Director of Population Health and Equity Name: Linda Ayala	Title: Manager of Population Health and Equity Name: Gil Duran	Emergency Visits alignment	Y	New	Outcome measure: Reduce preventable ED visit rates Goal: Collaborate with internal departments to align on an ED visit definition(s) and data sources, analyze for health disparities, and identify populations that might benefit from interventions/programs. Process measures: Completion of ED current state mapping/documentation.	Internal Quality Improvement Committee	12/31/2025	
	Title: QI Senior Director Name: Michelle Stott	Title: Manager, Quality Improvement Name: Parashita Zainal	Title: QI Specialist Name: Kalel Asrat	Follow up for Emergency Visits for SUD and Mental Health	Y	New	Outcome measure: Reduce preventable ED visit rates Goal: Develop a coordinated (non-duplicated) process to conduct member outreach utilizing AHS ED Navigators and SUNs at other hospital, and QI Engagement Coordinators to obtain ED follow up appointments for FUM/FUA. Leverage the extended office hours incentive. Outcome measure: Refer to BH above. By December 31, 2025, Alameda Alliance for Health will sustain FUA HEDIS rates and improve FUM HEDIS rate by 2% from MY2024 to MY2025 to meet/exceed MPL. Process measures: Refer to PIP above. By December 31, 2025, Alameda Alliance will improve the 7-day provider notifications rate by 2% for members exiting the ED with SUD/SMH diagnoses	Internal Quality Improvement Committee	12/31/2025	The Alliance discovered last year that many of the EDs in the Alliance network have Substance Use Navigators (SUNs) that are funded by the CA Bridge Program. In 2025, the Alliance will work to make sure that the work being performed by the SUNs at various hospitals is captured by appropriate coding/claims submission
	Title: QI Senior Director Name: Michelle Stott	Title: Manager, Access to Care Name: Loc Tran	Title: Manager, Access to Care Name: Loc Tran	Emergency Visits	Y	New	Outcome measure: Reduce preventable ED visit rates Goal: Develop alternative access document and a communication plan for members Outcome measure: Monitor access metrics (i.e. Follow up visits after an ED, CAHPS timely access to care, urgent care visits, NAL, Teladoc) Process measure: Monitor outreach methods from the communication plan	Access to Care Internal Quality Improvement Committee	12/31/25	



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

CEO Update

Matthew Woodruff

To: Alameda Alliance for Health Board of Governors
From: Matthew Woodruff, Chief Executive Officer
Date: July 11th, 2025
Subject: CEO Report

- **Financials:**

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

	<u>May</u>	<u>YTD</u>
Medi-Cal	\$2.3M	(\$83.1M)
Group Care	(\$426K)	(\$38K)
Medicare	(\$496K)	(\$7.8M)
Total	\$1.4M	(\$91.0M)

- **Revenue was \$189.5 million in May 2025 and \$1.9 billion Year-to-Date (YTD).**
 - Medical expenses were \$181.0 million in May and \$2.0 billion for the fiscal year-to-date; the medical loss ratio is 95.5% for the month and 100.6% for the fiscal year-to-date.
 - Administrative expenses were \$9.0 million in May and \$104.4 million for the fiscal year-to-date; the administrative loss ratio is 4.7% of net revenue for the month and 5.4% of net revenue year-to-date.
- **Tangible Net Equity (TNE):** Financial reserves are 203% of the required DMHC minimum, representing \$83.5 million in excess TNE.
- **Total enrollment in May 2025 was 409,358**, decreased by 1,417 Medi-Cal members compared to April 2025.
- **Key Performance Indicators:**
 - **Regulatory Metrics:**
 - The G&A team currently faces challenges in managing a high volume of cases along with staffing shortages. During the month of May, the team missed the expedited case criteria for grievances, 83% (5 out of 6 were compliant). The criteria are that these cases be resolved in 3 calendar days. The staffing shortages resulted in the team being noncompliant on these two metrics.
 - The IT team missed the encounter data reporting due to a change in State reimbursement. The State retroactively changed facility reimbursement back a year. When the Alliance updated our payments to the facilities, in turn, our encounter data appeared to be noncompliant since it older than regulatory required.

- **Non-Regulatory Metrics:**
 - All non-regulatory metrics were met for May.
- **Alliance Updates:**
 - **State And Federal Updates**
 - **HR1**
 - **Community Supports**
 - **Budget Implementation**
 - **Other**
- **COMMUNITY SUPPORTS**
 - Verbal Update
- **STRATEGIC PLANNING**
 - Five Pillars of the Foundation
 1. Financial Sustainability
 2. Quality, Access and Equity
 3. Line of Business and Service Reach
 4. Community Partnership
 5. Infrastructure and Workforce
- **Board Guiding Principles**
 - Prioritize core mission and business
 - Better leverage community and network partner strengths
 - Manage core business effectively, strategically implement CalAIM in alignment with quality and access goals
 - Balance 'compliance' with broader mission to improve community health
 - Use crisis as an opportunity for creativity and innovation
- **AUTOMATION AND AI**
 - There will be an update at a future Board meeting
- **Alliance in the Community**
 - This will be a new section focused on partnership work the community
- **Medicare Overview**
 - **D-SNP Readiness**
 - Alameda Alliance for Health (AAH) Medicare Advantage (MA) Duals Eligible Special Needs Plan (D-SNP) will begin serving members on January 1st, 2026. Currently, there are 17 different departmental workstreams and a total of 107 projects, 69 of which are active, 37 requested, and one (1) on hold.
 - Final QA of PY2026 CMS Formulary and Bid Submission (Benefit Determination) was completed on Friday, May 30th, 2025, and submission completed, as required, before June 2nd, 2025.

- Medication Therapy Management (MTM) program submission was completed on June 4th, 2025, and MTM attestation was completed on June 18th, 2025.
- SMAC was fully executed by AAH and DHCS on June 25th, 2025, with intentions to submit prior to the deadline on Monday, July 7th, 2025.
- Drafting integrated marketing materials (Evidence of Coverage (EOC), Summary of Benefits (SOB), ID Card, Provider & Pharmacy Directory) is underway.
- PBM implementation is on track. Core systems implementations are underway with EMR upgrades at 64% complete. Sprint sessions are in full swing.

- **Medi-Cal Incentive Programs**

- **Overview**

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

- **Description of the Incentive Programs**

- **Program – Provider Recruitment Initiative Program**

- Description & Purpose:

The Alliance Provider Recruitment Initiative (PRI) was launched in June 2024. The program is designed to provide grants to support the Alameda County Safety Net and community-based organizations to hire and retain healthcare professionals who serve the Alameda County Medi-

Cal population, as well as provide training scholarships for community health workers and housing grants for providers relocating to the area. The PRI aims to grow the Alliance provider network and support our community partners' ability to supply culturally and linguistically competent care to increase accessibility, and to reflect the diversity of Alliance members. Program goals include:

- Expanding the Alameda Alliance Provider network
 - Improving member access to Primary Care Providers, Specialists, and Behavioral Health professionals
 - Promoting diverse and culturally inclusive care reflective of Alliance members
- Program Years: **6/1/2024 - 6/30/2025 and 7/1/2025 - 6/30/2026**
 - Maximum available from Alameda Alliance: **\$4 million**
 - Payments issued: **\$218,000**
 - Current Status:

The program launched on June 1st, 2024. Two million (\$2M) in funding was available for the fiscal year 2024-2025; an additional \$2M will be available for fiscal year 2025-2026. \$2M in funding was awarded to 13 provider partners which included Mid-Level providers, Behavioral Health Clinicians, MDs/DOs, and OB/GYNs. Additionally, grants were provided to five (5) practices to support Community Health Worker (CHW) training certificate costs for 33 CHWs. The Alliance is preparing to launch Year Two of the program beginning July 1st and includes the addition of Certified Medical Assistant training support. All program materials are in the process of being updated.

Program - Doula Scholarship Program

- Description & Purpose:

The Alliance: Health Care Services department launched this program in December 2024 to grow the Doula provider network to increase access to these services for members. Scholarships of up to \$1,000 per person are available for Doulas, both intending to contract with the Alliance and Doulas already contracted with the Alliance. Scholarships are intended to offset costs related to Medi-Cal Provider Application and Validation for Enrollment (PAVE), contracting and credentialing with the Alliance, continued education, training, and administrative and operational support required to be a Doula.
- Program Years: **7/1/2024 - 6/30/2025**
- Maximum available from Alameda Alliance: **\$20,000**
- Payments issued: **\$14,000**
- Current Status:

20 scholarships were awarded totaling \$20K. Seven (7) awardees are currently contracted with the Alliance and 13 awardees intend to contract with the Alliance. One (1) awardee has withdrawn from the program and one (1) awardee has indicated they will not complete the funding deliverables required for the final payment of \$500. With these changes,

the Alliance expects to expend a total of \$18,500 for the Doula Scholarship program.

○ **Equity and Practice Transformation (EPT) Payments Program**

- The Department of Health Care Services (DHCS) implemented a one-time \$700M (reduced to \$140M) primary care provider practice transformation program called the Equity and Practice Transformation (EPT) Payments Program. The program is designed to advance health equity, reduce COVID-19-driven care disparities, and prepare practices to participate in alternative payment models.
- The EPT program 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 funding was to be allocated in three separate pathways throughout the phases of the program year(s):
 - Medi-Cal Managed Care Plan (MCP) Initial Provider Planning Incentive Payments
- \$25 million over one (1) year to incentivize MCPs to identify and work with small-to medium-sized independent practices using standardized assessment tools to support these practices as they develop practice transformation plans and applications to the larger EPT Provider Directed Payment Program. AAH supported practices in preparing to submit their applications to DHCS on October 23rd, 2023. Subsequently, AAH evaluated all submitted applications for the larger EPT program and submitted fourteen (14) participation recommendations to DHCS on November 21st, 2023, of which DHCS identified six small/medium sized practices that would count towards the outlined MCP milestones. AAH was notified on March 18th, 2024, that our submitted deliverables were reviewed and approved; the associated payment of \$442K was received April 22nd, 2024.
 - EPT Provider Directed Payment Program
- \$97 million (\$48.5 million General Fund) over three (3) years to support delivery system transformation, specifically targeting primary care practices that provide primary care pediatrics, family medicine, internal medicine, primary care OB/GYN services, or behavioral health services that are integrated in a primary care setting to Medi-Cal members. A total of 197 practices are participating in the program dedicated to preparing practices for value-based care. This includes implementing practice infrastructure, such as electronic health record systems, data collection, recording capabilities, improved data exchange, and implementation of care management systems.
- AAH will not receive incentive dollars for this program; however, the Plan will be expected to transmit payments from DHCS to participating providers that earn dollars. DHCS announced final selections on January 12th, 2024, and one practice, Alameda Health System (AHS), was selected by DHCS to participate in the program. The Alliance received \$302,463.48 from DHCS based on AHS' successful completion of their EPT deliverables. The Alliance passed that money through to AHS on June 15th. The Alliance continues to participate in EPT Healthcare Effectiveness Data and

Information Set (HEDIS) with the Population Health Learning Center, and at the MCP level.

- Population Health Learning Center
- \$18 million (\$9M General Fund) over three (3) years to support participants in the Provider Directed Payment Program in implementation of practice transformation activities, sharing and spread of best practices, practice coaching activities, and achievement of stated quality and equity goals. On January 3rd, 2024, DHCS announced they were partnering with the [Population Health Learning Center](#) to run the EPT Learning Collaborative. The Population Health Learning Center will serve as the program office for the Provider Directed Payment Program, working closely with DHCS, participating practices, and Medi-Cal managed care plans. All practices in the Provider Directed Payment Program must participate in Population Health Learning Center activities.
- **Providing Access and Transforming Health (PATH)**
 - **Providing Access and Transforming Health (PATH):** Comprising 5 initiatives, PATH funding supports Enhanced Care Management (ECM) and Community Support (CS) providers. \$1.85 billion will be available statewide. Initiatives include:
 - **WPC Services & Transition to Managed Care Mitigation Initiative:** Direct funding for WPC Pilot Lead Entities to sustain existing WPC Pilot services that “map to” ECM/Community Supports until an MCP covers the service. Services that will not continue under CalAIM—either because they are not included in CalAIM or will not be picked up by any MCP in the future—are not eligible for this funding.
 - **Technical Assistance Initiative:** Providers will have access to a statewide marketplace for ECM/Community Supports related technical assistance.
 - **Collaborative Planning & Implementation Initiative:** Support for regional collaborative planning and implementation efforts across entities essential to the success of CalAIM. BluePath Health was selected by DHCS as the facilitator for Alameda County and the initial kick-off meeting was held on January 27th, 2023. BluePath Health is conducting monthly meetings with all Collaborative participants. BluePath Health also conducted two informational meetings with AAH in January and February. Health Care Services continues to represent Alameda Alliance in the monthly collaborative meetings.
 - **Capacity & Infrastructure Transition, Expansion, and Development Initiative (CITED):** Funding for providers, community-based organizations, counties, Lead Entities, tribes and others for capacity and infrastructure development activities that support the implementation of ECM and Community Supports. Round 1A CITED recipients were announced by DHCS on January 31st, 2023, and Round 1B CITED recipients were announced on March 24th, 2023; a

total of \$207M was awarded to 139 recipients during Round 1. The CITED Round 2 application period closed on May 31st, 2023, and DHCS announced the recipients on October 30th, awarding \$144M to 145 providers across California. The CITED Round 3 application period closed on February 15th, 2024, and DHCS announced the recipients on August 30th, awarding \$146.6M to 133 providers across California. The CITED Round 4 application period opened on January 6th, 2025, and will close on May 2nd, 2025.

- **Justice-Involved Capacity Building:** Funding to maintain and build pre-release and post-release services to support implementation of the CalAIM justice-involved population, including capacity and infrastructure to support services, including EHR systems. Round 1 grants in the amount of \$4.55M were awarded statewide in November 2022. The application period for Round 2 closed on March 31st, 2023; grants in the amount of \$64.5M were awarded in January 2024. The application period for Round 3 opened on May 1st, 2023, and closed on July 31st, 2023; awards have yet to be announced.
- Alameda County Health Care Services Agency has applied for the PATH Mitigation funds to continue the following WPC services under CalAIM:
 - **Sobering Center services**
 - **Street Health Outreach**



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Legislative Tracking

2025 –2026 Legislative Tracking List

On June 27th, Governor Newsom and state leaders reached a deal on the 2025-26 California state budget. The budget containing a \$321.1 billion spending plan maintained the enrollment freeze on undocumented individuals 19 years and older that includes a 6-month re-enrollment period and \$30 monthly premiums. Other areas of note include the proposal to increase MLR which was not included, the elimination of dental benefits and maintaining LTC for the undocumented population, along with other provisions which will be highlighted in a separate summary included in the Board packet.

With the likely passage of the federal reconciliation bill, state legislators will hold a special budget session in the fall.

During the next couple weeks, state legislators will be busy with committee hearings as they approach the deadline for committees to wrap up their work on July 18th.

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

[AB 4](#)

([Arambula](#) D) Covered California expansion.

Current Text: Introduced: 12/2/2024 [html](#) [pdf](#)

Introduced: 12/2/2024

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

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

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

[AB 29](#)

([Arambula](#) D) Medi-Cal: Adverse Childhood Experiences trauma screenings: providers.

Current Text: Amended: 3/19/2025 [html](#) [pdf](#)

Introduced: 12/2/2024

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

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

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

[AB 37](#)

(Elhawary D) Workforce development: mental health service providers: homelessness.

Current Text: Amended: 3/13/2025 [html](#) [pdf](#)

Introduced: 12/2/2024

Status: 5/1/2025-Failed Deadline pursuant to Rule 61(a)(2). (Last location was L. & E. on 3/13/2025)(May be acted upon Jan 2026)

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

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

[AB 40](#)

(Bonta D) Emergency services and care.

Current Text: Amended: 3/5/2025 [html](#) [pdf](#)

Introduced: 12/2/2024

Status: 7/1/2025-Read second time. Ordered to third reading.

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

Summary: Existing law provides for the licensing and regulation of health facilities by the State Department of Public

Health and makes a violation of those provisions a crime. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law requires a health facility to provide emergency services and care upon request or when a person is in danger of loss of life or serious injury or illness, and requires a health care service plan to reimburse providers for emergency services and care. Existing law defines “emergency services and care” for these purposes to mean medical screening, examination, and evaluation by a physician and surgeon, or other appropriate licensed persons under the supervision of a physician and surgeon, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person’s license, necessary to relieve or eliminate the emergency medical condition, within the capability of the facility, among other things. This bill would additionally define “emergency services and care” for the above-described purposes to mean reproductive health services, including abortion. By expanding the applicability of a crime with respect to health facilities and health care service plans, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

[AB 45](#)

(Bauer-Kahan D) Privacy: health data: location and research.

Current Text: Amended: 4/9/2025 [html](#) [pdf](#)

Introduced: 12/2/2024

Status: 6/18/2025-Referred to Com. on JUD.

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

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

[AB 49](#)

(Muratsuchi D) Schoolsites: immigration enforcement.

Current Text: Amended: 6/23/2025 [html](#) [pdf](#)

Introduced: 12/2/2024

Status: 6/23/2025-From committee chair, with author's amendments: Amend, and re-refer to committee. Read second time, amended, and re-referred to Com. on ED.

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

Summary: (1)Existing law prohibits, except as required by state or federal law or as required to administer a state or federally supported educational program, school officials and employees of a school district, county office of education, or charter school from collecting information or documents regarding citizenship or immigration status of pupils or their family members. Existing law requires the superintendent of a school district, the superintendent of a county office of

education, and the principal of a charter school, as applicable, to report to the respective governing board or body of the local educational agency in a timely manner any requests for information or access to a schoolsite by an officer or employee of a law enforcement agency for the purpose of enforcing the immigration laws in a manner that ensures the confidentiality and privacy of any potentially identifying information. This bill would prohibit school officials and employees of a local educational agency from allowing an officer or employee of an agency conducting immigration enforcement to enter a schoolsite for any purpose without providing valid identification and a valid judicial warrant or a court order, unless exigent circumstances necessitate immediate action. The bill would require the local educational agency, if the officer or employee meets those requirements, to limit access to facilities where pupils are not present. By imposing additional duties on local educational agencies, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 50

(Bonta D) Pharmacists: furnishing contraceptives.

Current Text: Amended: 4/2/2025 [html](#) [pdf](#)

Introduced: 12/2/2024

Status: 6/24/2025-Read second time. Ordered to third reading.

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

Summary: Existing law, the Pharmacy Law, establishes in the Department of Consumer Affairs the California State Board of Pharmacy to license and regulate the practice of pharmacy. Existing law requires a pharmacist, when furnishing self-administered hormonal contraceptives, to follow specified standardized procedures or protocols developed and approved by both the board and the Medical Board of California in consultation with the American Congress of Obstetricians and Gynecologists, the California Pharmacists Association, and other appropriate entities. Existing law requires those standardized procedures or protocols to require that the patient use a self-screening tool that will identify related patient risk factors and that require the pharmacist to refer the patient for appropriate followup care, as specified. Existing law requires the pharmacist to provide the recipient of the drug with a standardized factsheet that includes the indications and contraindications for use of the drug, the appropriate method for using the drug, the need for medical followup, and other appropriate information. Existing law authorizes a pharmacist furnishing an FDA-approved, self-administered hormonal contraceptive pursuant to the above-described protocols to furnish, at the patient's request, up to a 12-month supply at one time. This bill would limit the application of those requirements to self-administered hormonal contraceptives that are prescription-only, and would authorize a pharmacist to furnish over-the-counter contraceptives without following those standardized procedures or protocols. The bill would additionally authorize a pharmacist to furnish up to a 12-month supply at one time of over-the-counter contraceptives at the patient's request. The bill would make related conforming changes. This bill contains other related provisions.

AB 54

(Krell D) Access to Safe Abortion Care Act.

Current Text: Amended: 7/1/2025 [html](#) [pdf](#)

Introduced: 12/2/2024

Status: 7/1/2025-Read second time and amended. Re-referred to Com. on JUD.

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

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

AB 55**(Bonta D) Alternative birth centers: licensing and Medi-Cal reimbursement.****Current Text:** Amended: 5/29/2025 [html](#) [pdf](#)**Introduced:** 12/2/2024**Status:** 6/30/2025-In committee: Referred to APPR. suspense file.

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

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

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

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

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

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

AB 73

(Jackson D) Mental Health: Black Mental Health Navigator Certification.

Current Text: Introduced: 12/12/2024 [html](#) [pdf](#)

Introduced: 12/12/2024

Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 4/9/2025)(May be acted upon Jan 2026)

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

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

AB 92

(Gallagher R) Patient visitation.

Current Text: Introduced: 1/6/2025 [html](#) [pdf](#)

Introduced: 1/6/2025

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

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

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

AB 96

(Jackson D) Community health workers.

Current Text: Amended: 2/11/2025 [html](#) [pdf](#)

Introduced: 1/7/2025

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

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

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

[AB 220](#)

(Jackson D) Medi-Cal: subacute care services.

Current Text: Amended: 6/16/2025 [html](#) [pdf](#)

Introduced: 1/8/2025

Status: 6/26/2025-From committee: Do pass and re-refer to Com. on APPR. (Ayes 11. Noes 0.) (June 25). Re-referred to Com. on APPR.

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

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

[AB 224](#)

(Bonta D) Health care coverage: essential health benefits.

Current Text: Amended: 4/23/2025 [html](#) [pdf](#)

Introduced: 1/9/2025

Status: 6/11/2025-Referred to Com. on HEALTH.

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, requires the Department of Managed Health Care to license and regulate health care service plans and makes a willful violation of the act a crime. Existing law requires the Department of Insurance to regulate health insurers. Existing law requires an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2017, to include, at a minimum, coverage for essential health benefits pursuant to the federal Patient Protection and Affordable Care Act. Existing law requires a health care service plan contract or health insurance policy to cover the same health

benefits that the benchmark plan, the Kaiser Foundation Health Plan Small Group HMO 30 plan, offered during the first quarter of 2014, as specified. This bill would express the intent of the Legislature to review California's essential health benefits benchmark plan and establish a new benchmark plan for the 2027 plan year. The bill would require, commencing January 1, 2027, if the United States Department of Health and Human Services approves a new essential health benefits benchmark plan for the state, as specified, the benchmark plan identified above to include certain additional benefits, including coverage for specified fertility services and specified durable medical equipment. Because a violation of the bill by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other existing laws.

[AB 225](#)

(Bonta D) State hospitals for persons with mental health disorders: patient funds.

Current Text: Introduced: 1/9/2025 [html](#) [pdf](#)

Introduced: 1/9/2025

Status: 5/7/2025-Referred to Com. on HEALTH.

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

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

[AB 228](#)

(Sanchez R) Pupil health: epinephrine delivery systems.

Current Text: Introduced: 1/13/2025 [html](#) [pdf](#)

Introduced: 1/13/2025

Status: 5/23/2025-In committee: Hearing postponed by committee.

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

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

[AB 242](#)

(Boerner D) Genetic disease screening.

Current Text: Introduced: 1/14/2025 [html](#) [pdf](#)

Introduced: 1/14/2025

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

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

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

[AB 260](#)

(Aguiar-Curry D) Sexual and reproductive health care.

Current Text: Amended: 6/18/2025 [html](#) [pdf](#)

Introduced: 1/16/2025

Status: 6/23/2025-From committee: Do pass and re-refer to Com. on APPR. (Ayes 8. Noes 2.) (June 23). Re-referred to Com. on APPR.

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

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

[AB 277](#)

(Alanis R) Behavioral health centers, facilities, and programs: background checks.

Current Text: Amended: 4/22/2025 [html](#) [pdf](#)

Introduced: 1/21/2025

Status: 5/1/2025-Failed Deadline pursuant to Rule 61(a)(2). (Last location was HUM. S. on 2/10/2025)(May be acted upon Jan 2026)

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

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

[AB 278](#)

(Ransom D) Health care affordability.

Current Text: Introduced: 1/21/2025 [html](#) [pdf](#)

Introduced: 1/21/2025

Status: 5/1/2025-Failed Deadline pursuant to Rule 61(a)(2). (Last location was HEALTH on 2/10/2025)(May be acted

upon Jan 2026)

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

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

[AB 280](#)

(Aguiar-Curry D) Health care coverage: provider directories.

Current Text: Amended: 6/30/2025 [html](#) [pdf](#)

Introduced: 1/21/2025

Status: 6/30/2025-From committee chair, with author's amendments: Amend, and re-refer to committee. Read second time, amended, and re-referred to Com. on HEALTH.

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan and a health insurer that contracts with providers for alternative rates of payment to publish and maintain a provider directory or directories with information on contracting providers that deliver health care services enrollees or insureds, and requires a health care service plan and health insurer to regularly update its printed and online provider directory or directories, as specified. Existing law authorizes the departments to require a plan or insurer to provide coverage for all covered health care services provided to an enrollee or insured who reasonably relied on materially inaccurate, incomplete, or misleading information contained in a plan's or insurer's provider directory or directories. This bill would require a plan or insurer to annually verify and delete inaccurate listings from its provider directories, and would require a provider directory to be 60% accurate on July 1, 2026, with increasing required percentage accuracy benchmarks to be met each year until the directories are 95% accurate on or before July 1, 2029. The bill would subject a plan or insurer to administrative penalties for failure to meet the prescribed benchmarks. The bill would require a plan or insurer to provide coverage for all covered health care services provided to an enrollee or insured who reasonably relied on inaccurate, incomplete, or misleading information contained in a health plan or policy's provider directory or directories and to reimburse the provider the out-of-network amount for those services. The bill would prohibit a provider from collecting an additional amount from an enrollee or insured other than the applicable in-network cost sharing, which would count toward the in-network deductible and out-of-pocket maximum. The bill would require a plan or insurer to provide information about in-network providers to enrollees and insureds upon request, and would limit the cost-sharing amounts an enrollee or insured is required to pay for services from those providers under specified circumstances. The bill would require the health care service plan or the insurer, as applicable, to ensure the accuracy of a request to add back a provider who was previously removed from a directory and approve the request within 10 business days of receipt, if accurate. Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

[AB 281](#)

(Gallagher R) Comprehensive sexual health education and human immunodeficiency virus (HIV) prevention education: outside consultants.

Current Text: Amended: 3/17/2025 [html](#) [pdf](#)

Introduced: 1/22/2025

Status: 6/12/2025-Ordered to inactive file at the request of Assembly Member Gallagher.

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

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

[AB 290](#)

(Bauer-Kahan D) California FAIR Plan Association: automatic payments.

Current Text: Amended: 6/17/2025 [html](#) [pdf](#)

Introduced: 1/22/2025

Status: 6/17/2025-From committee chair, with author's amendments: Amend, and re-refer to committee. Read second time, amended, and re-referred to Com. on INS.

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

Summary: Existing law establishes the California FAIR Plan Association, a joint reinsurance association in which all insurers licensed to write basic property insurance participate to administer a program for the equitable apportionment of basic property insurance for persons who are unable to obtain that coverage through normal channels. Existing law authorizes cancellation of an insurance policy for nonpayment of premium, and requires an insurer to notify a policyholder at least 10 business days before the policy will be canceled for nonpayment. This bill, on or before April 1, 2026, would require the California FAIR Plan Association to create an automatic payment system and accept automatic payments for premiums from policyholders. The bill would prohibit an automatic payment amount from being different than if the policyholder made a payment through another method. The bill would prohibit cancellation or nonrenewal of a FAIR Plan policy solely because the policyholder is not enrolled in automatic payments. The bill would provide a 10-day grace period for the policyholder to pay any outstanding installment premium.

[AB 298](#)

(Bonta D) Health care coverage cost sharing.

Current Text: Amended: 3/4/2025 [html](#) [pdf](#)

Introduced: 1/23/2025

Status: 5/1/2025-Failed Deadline pursuant to Rule 61(a)(2). (Last location was HEALTH on 2/10/2025)(May be acted upon Jan 2026)

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

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

specified. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

[AB 302](#)

(Bauer-Kahan D) Protected individuals.

Current Text: Amended: 6/27/2025 [html](#) [pdf](#)

Introduced: 1/23/2025

Status: 6/27/2025-From committee chair, with author's amendments: Amend, and re-refer to committee. Read second time, amended, and re-referred to Com. on JUD.

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

Summary: The California Consumer Privacy Act of 2018 (CCPA) grants a consumer various rights with respect to personal information, as defined, that is collected or sold by a business, as defined, including the right to request that a business delete any personal information about the consumer that the business has collected from the consumer. The California Privacy Rights Act of 2020, approved by the voters as Proposition 24 at the November 3, 2020, statewide general election, amended, added to, and reenacted the CCPA and establishes the California Privacy Protection Agency (agency) and vests the agency with full administrative power, authority, and jurisdiction to enforce the CCPA. The Information Practices Act of 1977 regulates the use of personal information by certain state agencies, including by requiring a state agency to maintain in its records only personal information which is relevant and necessary to accomplish a purpose of the agency required or authorized by the California Constitution or statute or mandated by the federal government. This bill would authorize a protected individual, or the agency on behalf of a protected individual, to request that a person or governmental entity refrain from publishing or selling the protected individual's personal information or remove the protected individual's personal information from any existing publication and would require a person or governmental entity to comply with that request, as specified. The bill would authorize certain public attorneys, including the Attorney General, to punish noncompliance with this provision with a certain civil action. This bill contains other related provisions and other existing laws.

[AB 309](#)

(Zbur D) Hypodermic needles and syringes.

Current Text: Introduced: 1/23/2025 [html](#) [pdf](#)

Introduced: 1/23/2025

Status: 6/19/2025-From committee: Do pass and re-refer to Com. on B. P. & E.D. (Ayes 8. Noes 1.) (June 18). Re-referred to Com. on B. P. & E.D.

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

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

[AB 315](#)

(Bonta D) Medi-Cal: Home and Community-Based Alternatives Waiver.

Current Text: Introduced: 1/23/2025 [html](#) [pdf](#)

Introduced: 1/23/2025

Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 4/9/2025)(May be acted upon Jan 2026)

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

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

[AB 316](#)

(Krell D) Artificial intelligence: defenses.

Current Text: Amended: 4/28/2025 [html](#) [pdf](#)

Introduced: 1/24/2025

Status: 6/25/2025-From committee: Do pass and re-refer to Com. on APPR. (Ayes 12. Noes 0.) (June 24). Re-referred to Com. on APPR.

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

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

[AB 322](#)

(Ward D) Precise geolocation information.

Current Text: Amended: 6/23/2025 [html](#) [pdf](#)

Introduced: 1/24/2025

Status: 6/25/2025-Re-referred to Com. on JUD.

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

Summary: Existing law, the California Consumer Privacy Act of 2018 (CCPA), grants a consumer various rights with respect to personal information, as defined, that is collected or sold by a business, as defined, including the right to direct a business that collects sensitive personal information about the consumer to limit its use, as prescribed. Existing law defines "sensitive personal information" to mean, among other things, personal information that reveals a consumer's precise geolocation. Existing law, the California Privacy Rights Act of 2020, approved by the voters as Proposition 24 at the November 3, 2020, statewide general election, amended, added to, and reenacted the CCPA. This bill would require a business that collects precise geolocation information to prominently display, when information is being collected, a notice to the consumer whose information is being collected that states certain information related to the collection of the information and its use by the business, including the goods or services requested by the consumer for which the business is collecting, processing, or disclosing the geolocation information and a description of how the business will

process the geolocation information to carry out those purposes. This bill would prohibit a business that collects precise geolocation information from, among other things, retaining the information longer than necessary to provide the goods or services requested by the consumer or longer than one year after the consumer's last intentional interaction with the business, whichever is earlier. This bill would declare that its provisions further the purposes and intent of the California Privacy Rights Act of 2020.

[AB 350](#)

(Bonta D) Health care coverage: fluoride treatments.

Current Text: Amended: 5/23/2025 [html](#) [pdf](#)

Introduced: 1/29/2025

Status: 7/2/2025-VOTE: Do pass as amended, but first amend, and re-refer to the Committee on [Appropriations] (PASS)

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

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

[AB 360](#)

(Papan D) Menopause.

Current Text: Amended: 4/9/2025 [html](#) [pdf](#)

Introduced: 1/30/2025

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

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

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

[AB 371](#)

(Haney D) Dental coverage.

Current Text: Amended: 4/24/2025 [html](#) [pdf](#)

Introduced: 2/3/2025

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

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

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

[AB 375](#)

(Nguyen D) Medical Practice Act: health care providers: qualified autism service paraprofessionals.

Current Text: Introduced: 2/3/2025 [html](#) [pdf](#)

Introduced: 2/3/2025

Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. on 4/8/2025)(May be acted upon Jan 2026)

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

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

[AB 384](#)

(Connolly D) Health care coverage: mental health and substance use disorders: inpatient admissions.

Current Text: Amended: 3/17/2025 [html](#) [pdf](#)

Introduced: 2/3/2025

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

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

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

[AB 403](#)

(Ortega D) Medi-Cal: community health worker services.

Current Text: Amended: 3/17/2025 [html](#) [pdf](#)

Introduced: 2/4/2025

Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 4/9/2025)(May be acted upon Jan 2026)

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

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

[AB 408](#)

(Berman D) Physician Health and Wellness Program.

Current Text: Amended: 4/21/2025 [html](#) [pdf](#)

Introduced: 2/4/2025

Status: 6/26/2025-In committee: Hearing postponed by committee.

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

Summary: Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons and licensed midwives by the Medical Board of California. A violation of the act is a crime. Existing law authorizes the board to establish a Physician and Surgeon Health and Wellness Program to support a physician and surgeon in their rehabilitation from substance abuse to ensure the physician and surgeon remains able to practice medicine in a manner that will not endanger the public health and safety and that will maintain the integrity of the medical profession. Existing law requires the board to contract with a third party for the program's administration in accordance with specified

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

[AB 412](#)

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

Current Text: Amended: 5/7/2025 [html](#) [pdf](#)

Introduced: 2/4/2025

Status: 5/21/2025-Referred to Coms. on JUD. and APPR.

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

Summary: Existing federal law, through copyright, provides authors of original works of authorship, as defined, with certain rights and protections. Existing federal law generally gives the owner of the copyright the right to reproduce the work in copies or phonorecords and the right to distribute copies or phonorecords of the work to the public. Existing federal law provides that sound recordings fixed before February 15, 1972, are not subject to copyright, but are subject to similar rights and protections under the Classics Protection and Access Act. Existing law requires, on or before January 1, 2026, and before each time thereafter that a generative artificial intelligence system or service, as defined, or a substantial modification to a generative artificial intelligence system or service, released on or after January 1, 2022, is made available to Californians for use, regardless of whether the terms of that use include compensation, a developer of the system or service to post on the developer's internet website documentation, as specified, regarding the data used to train the generative artificial intelligence system or service. This bill would require a developer of a generative artificial intelligence model to, among other things, document any covered materials that the developer knows were used by the developer to train the model. The bill would require the developer to make available a mechanism on the developer's internet website allowing a rights owner to submit a request for information about the developer's use of covered materials that would allow the rights owner to provide the developer with, among other things, registration, preregistration, or index numbers and fingerprints for one or more covered materials. The bill would, subject to specified exceptions, require a developer to, within 30 days of receiving that request from the rights owner, assess whether the covered material represented by a fingerprint provided by the rights owner is likely to be present in the developer's dataset and provide the rights owner with a list of their covered materials that were used to train the model and are likely to be present in the developer's dataset, as specified. The bill would provide that each day following the 30-day period that a developer fails to provide a rights owner with that information constitutes a discrete violation. The bill would authorize a rights owner who complies with specified requirements for submitting a request that is not provided with information according to these provisions to bring a civil action against the developer for specified relief. The bill would

provide that the bill's requirements do not apply to a model that meets certain criteria, including, among other things, being trained exclusively using data the developer makes publicly available at no cost, as specified. The bill would define various terms for these purposes. This bill contains other existing laws.

[AB 416](#)

(Krell D) Involuntary commitment.

Current Text: Amended: 5/7/2025 [html](#) [pdf](#)

Introduced: 2/5/2025

Status: 7/2/2025-VOTE: Do pass, but first be re-referred to the Committee on [Judiciary] (PASS)

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

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

[AB 423](#)

(Davies R) Alcoholism or drug abuse recovery or treatment programs and facilities: disclosures.

Current Text: Amended: 4/2/2025 [html](#) [pdf](#)

Introduced: 2/5/2025

Status: 5/1/2025-Failed Deadline pursuant to Rule 61(a)(2). (Last location was HEALTH on 2/18/2025)(May be acted upon Jan 2026)

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

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

[AB 432](#)

(Bauer-Kahan D) Menopause.

Current Text: Amended: 5/27/2025 [html](#) [pdf](#)

Introduced: 2/5/2025

Status: 6/18/2025-Referred to Coms. on B. P. & E.D. and HEALTH.

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

Summary: Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California and requires the board to adopt and administer standards for the continuing education of those licensees. Existing law requires the board, in determining its continuing education requirements, to consider including a course in menopausal mental or physical health. This bill would delete that requirement of the board and, instead, require specified physicians whose patient population is composed of 25% or more adult women under 65 years of age, for their first license renewal after July 1, 2026, and every 4 years thereafter, to complete at least 5 hours of mandatory continuing medical education in a course in perimenopause, menopause, and postmenopausal care. This bill contains other related provisions and other existing laws.

[AB 489](#)

(Bonta D) Health care professions: deceptive terms or letters: artificial intelligence.

Current Text: Amended: 6/16/2025 [html](#) [pdf](#)

Introduced: 2/10/2025

Status: 6/23/2025-From committee: Do pass and re-refer to Com. on JUD. (Ayes 10. Noes 0.) (June 23). Re-referred to Com. on JUD.

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

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

[AB 510](#)

(Addis D) Health care coverage: utilization review: peer-to-peer review.

Current Text: Amended: 4/28/2025 [html](#) [pdf](#)

Introduced: 2/10/2025

Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/7/2025)(May be acted upon Jan 2026)

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of disability insurers by the Department of Insurance. Existing law generally authorizes a health care service plan or disability insurer to use prior authorization and other utilization review

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

[AB 512](#)

(Harabedian D) Health care coverage: prior authorization.

Current Text: Amended: 4/28/2025 [html](#) [pdf](#)

Introduced: 2/10/2025

Status: 6/11/2025-Referred to Com. on HEALTH.

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

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

[AB 517](#)

(Krell D) Medi-Cal: complex rehabilitation technology: wheelchairs.

Current Text: Introduced: 2/10/2025 [html](#) [pdf](#)

Introduced: 2/10/2025

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

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

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

[AB 534](#)

(Schiavo D) Transitional housing placement providers.

Current Text: Amended: 5/23/2025 [html](#) [pdf](#)

Introduced: 2/11/2025

Status: 6/11/2025-Referred to Com. on HUMAN S.

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

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

[AB 536](#)

(Patterson R) Health care coverage: colorectal cancer screening.

Current Text: Amended: 3/24/2025 [html](#) [pdf](#)

Introduced: 2/11/2025

Status: 6/26/2025-From committee: Do pass and re-refer to Com. on APPR. (Ayes 8. Noes 1.) (June 25). Re-referred to Com. on APPR.

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

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

[AB 539](#)

(Schiavo D) Health care coverage: prior authorizations.

Current Text: Amended: 4/28/2025 [html](#) [pdf](#)

Introduced: 2/11/2025

Status: 6/23/2025-In committee: Set, second hearing. Hearing canceled at the request of author.

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

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

would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 543

(González, Mark D) Medi-Cal: street medicine.

Current Text: Amended: 6/23/2025 [html](#) [pdf](#)

Introduced: 2/11/2025

Status: 6/23/2025-Read second time and amended. Re-referred to Com. on APPR.

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

Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law sets forth various provisions for Medi-Cal coverage of community health worker services, enhanced care management, and community supports, subject to any necessary federal approvals. Under existing law, these benefits are designed to, respectively, provide a link between health and social services and the community; address the clinical and nonclinical needs on a whole-person-care basis for certain target populations of Medi-Cal beneficiaries, including individuals experiencing homelessness; and provide housing transition navigation services, among other supports. Existing law establishes mechanisms for Medi-Cal presumptive eligibility for certain target populations, including, among others, pregnant persons, children, and patients of qualified hospitals, for purposes of Medi-Cal coverage while other Medi-Cal eligibility determination procedures are pending, as specified. This bill would set forth provisions regarding street medicine, as defined, under the Medi-Cal program for persons experiencing homelessness, as defined. The bill would state the intent of the Legislature that the street medicine-related provisions coexist with, and not duplicate, other Medi-Cal provisions, including, but not limited to, those regarding community health worker services, enhanced care management, and community supports. The bill would require the department to implement a program of presumptive eligibility for persons experiencing homelessness who appear to be otherwise eligible for full-scope Medi-Cal coverage without a share of cost. The bill would authorize an enrolled Medi-Cal provider to make a presumptive eligibility determination for those persons. The bill would authorize a Medi-Cal managed care plan to elect to offer Medi-Cal covered services through a street medicine provider, as defined. Under the bill, a managed care plan that elects to do so would be required to allow a Medi-Cal beneficiary who is experiencing homelessness to receive those services directly from a contracted street medicine provider, regardless of the beneficiary's network assignment, as specified. The bill would also require the managed care plan to allow a contracted street medicine provider enrolled in Medi-Cal to directly refer the beneficiary for covered services within the appropriate network, as specified. This bill contains other related provisions and other existing laws.

AB 546

(Caloza D) Health care coverage: portable HEPA purifiers.

Current Text: Amended: 5/1/2025 [html](#) [pdf](#)

Introduced: 2/11/2025

Status: 7/2/2025-VOTE: Do pass as amended, but first amend, and re-refer to the Committee on [Appropriations] (PASS)

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law sets forth specified coverage requirements for plan contracts and insurance policies, and limits the copayment, coinsurance, deductible, and other cost sharing that may be imposed for specified health care services. This bill would require a large group health care service plan contract or group health insurance policy, except a specialized health care service plan contract or health insurance policy, that is issued, amended, or renewed on or after January 1, 2026, to include coverage for portable high-efficiency particulate air (HEPA) purifiers for enrollees or insureds who are pregnant or diagnosed with asthma or chronic obstructive pulmonary disease if the enrollee or insured is in a county where a local or state emergency has been declared due to wildfires. The bill would prohibit the cost of the HEPA purifier from exceeding \$500, adjusted for inflation. This bill contains other related provisions and other existing laws.

AB 554**(González, Mark D) Health care coverage: antiretroviral drugs, drug devices, and drug products.****Current Text:** Amended: 6/24/2025 [html](#) [pdf](#)**Introduced:** 2/11/2025**Status:** 6/24/2025-From committee chair, with author's amendments: Amend, and re-refer to committee. Read second time, amended, and re-referred to Com. on HEALTH.

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

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

AB 575**(Arambula D) Obesity Prevention Treatment Parity Act.****Current Text:** Amended: 3/12/2025 [html](#) [pdf](#)**Introduced:** 2/12/2025**Status:** 5/1/2025-Failed Deadline pursuant to Rule 61(a)(2). (Last location was HEALTH on 2/24/2025)(May be acted upon Jan 2026)

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

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

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

5/14/2025)(May be acted upon Jan 2026)

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

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

AB 582

(Pacheco D) Administrative Procedure Act.

Current Text: Introduced: 2/12/2025 [html](#) [pdf](#)

Introduced: 2/12/2025

Status: 5/8/2025-Failed Deadline pursuant to Rule 61(a)(3). (Last location was PRINT on 2/12/2025)(May be acted upon Jan 2026)

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

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

AB 602

(Haney D) Public postsecondary education: student behavior: drug and alcohol use: rehabilitation programs.

Current Text: Amended: 6/16/2025 [html](#) [pdf](#)

Introduced: 2/13/2025

Status: 7/2/2025-From committee: Do pass and re-refer to Com. on APPR. (Ayes 6. Noes 1.) (July 2). Re-referred to Com. on APPR.

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

Summary: Existing law, known as the Donahoe Higher Education Act, establishes the California Community Colleges, the California State University, and the University of California as the public segments of postsecondary education in the state. Existing law requires the Regents of the University of California, the Trustees of the California State University, and the governing board of every community college district to adopt or provide for the adoption of specific rules and regulations governing student behavior and to adopt procedures by which all students are informed of the rules and regulations, with applicable penalties, as provided. Provisions of the act apply to the University of California only to the extent that the Regents of the University of California, by appropriate resolution, act to make a provision applicable. Existing federal law requires, as a condition of receiving federal funds or other forms of financial assistance, institutions of higher education to annually distribute to each student and employee standards of conduct that clearly prohibit unlawful possession, use, or distribution of illicit drugs or alcohol, as provided, and a clear statement that the institution

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

[AB 618](#)

(Krell D) Medi-Cal: behavioral health: data sharing.

Current Text: Amended: 6/23/2025 [html](#) [pdf](#)

Introduced: 2/13/2025

Status: 6/23/2025-Read second time and amended. Re-referred to Com. on APPR.

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

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

[AB 636](#)

(Ortega D) Medi-Cal: diapers.

Current Text: Amended: 3/13/2025 [html](#) [pdf](#)

Introduced: 2/13/2025

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

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

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

AB 669**(Haney D) Substance use disorder coverage.****Current Text:** Amended: 6/30/2025 [html](#) [pdf](#)**Introduced:** 2/14/2025**Status:** 6/30/2025-From committee chair, with author's amendments: Amend, and re-refer to committee. Read second time, amended, and re-referred to Com. on HEALTH.

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law generally authorizes a health care service plan or health insurer to use prior authorization and other utilization management functions, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. Existing law requires health care service plan contracts and health insurance policies that provide hospital, medical, or surgical coverage and are issued, amended, or renewed on or after January 1, 2021, to provide coverage for medically necessary treatment of mental health and substance use disorders under the same terms and conditions applied to other medical conditions, as specified. On and after January 1, 2027, this bill would prohibit concurrent or retrospective review of medical necessity of in-network health care services and benefits (1) for the first 28 days of an inpatient or residential substance use disorder stay during each plan or policy year or (2) for outpatient substance use disorder visits, except as specified. The bill would authorize, after the 29th day, in-network health care services and benefits for inpatient or residential substance use disorder care to be subject to concurrent review. On and after January 1, 2027, the bill would prohibit retrospective review of medical necessity for the first 28 days of intensive outpatient or partial hospitalization services for substance use disorder, but would require specified review for day 29 and days thereafter of that stay or service. On and after January 1, 2027, the bill would prohibit the imposition of prior authorization or other prospective utilization management requirements for in-network coverage of outpatient prescription drugs to treat substance use disorder that are determined medically necessary by the enrollee's or insured's prescribing physician or psychiatrist. With respect to health care service plans, the bill would specify that its provisions do not apply to Medi-Cal behavioral health delivery systems or Medi-Cal managed care plan contracts. Because a willful violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other existing laws.

AB 676**(Gonzalez, Jeff R) Medi-Cal: unrecovered payments: interest rate.****Current Text:** Amended: 4/9/2025 [html](#) [pdf](#)**Introduced:** 2/14/2025**Status:** 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 4/30/2025)(May be acted upon Jan 2026)

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

Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law requires the Director of Health Care Services to establish administrative appeal processes to review grievances or complaints arising from the findings of an audit or examination. Under existing law, if recovery of a disallowed payment has been made by the department, a provider who prevails in an appeal of that payment is entitled to interest at the rate equal to the monthly average received on investments in the Surplus Money Investment Fund, or simple interest at the rate of 7% per annum, whichever is higher. Under existing law, with exceptions, interest at that same rate is assessed against any unrecovered overpayment due to the department. In the case of an assessment against any unrecovered overpayment due to the department, this bill would require the department to waive the interest, as part of a repayment agreement entered into with the provider, if the latest date of service for a retroactive payment adjustment or audit period end date for the unrecovered overpayment occurred 4 or more years before the issuance of the first statement of account status or demand for repayment, and the department determines that certain factors apply. Under the bill, those factors would include, among others, the impact of

the repayment amounts on the fiscal solvency of the provider, and whether the overpayment was caused by a policy change or departmental error that was not caused by the billing provider. The bill would preserve the rights of the department to seek all remedies available at law if a provider defaults on a repayment plan. This bill would authorize the department to implement, interpret, or make specific these provisions, in whole or in part, by means of information notices, all-county letters, or other similar instructions without taking regulatory action.

[AB 682](#)

(Ortega D) Health care coverage reporting.

Current Text: Amended: 6/23/2025 [html](#) [pdf](#)

Introduced: 2/14/2025

Status: 6/23/2025-From committee chair, with author's amendments: Amend, and re-refer to committee. Read second time, amended, and re-referred to Com. on HEALTH.

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law requires a plan to submit financial statements to the Director of Managed Health Care at specified times. Existing law authorizes the Director of Managed Health Care to reject a financial statement filed pursuant to this requirement by providing notice and the cause for rejection, and makes a failure to correct the deficiency a violation of the act. Existing law authorizes the director to make rules and regulations specifying the form and content of those reports and financial statements, as specified. Existing law provides for the regulation of health insurers by the Department of Insurance and requires a health insurer or multiple employer welfare arrangement (MEWA) to annually report specified information to the department. Existing law requires the Department of Insurance to publicly report the data provided by each health insurer and MEWA on the department's internet website. This bill would require the above-described reports to include specified information for each month, including, among others, the total number of claims processed, adjudicated, denied, or partially denied. Because a violation of this requirement by a health care service plan would be a crime, the bill would create a state-mandated local program. The bill would require each department to publish on its internet website monthly claims denial information for each plan or insurer, as specified. This bill would require a health insurer or MEWA to submit to the Department of Insurance the claims denial information by February 1 of each year, beginning February 1, 2027. The bill would authorize the Insurance Commissioner to reject a report required pursuant to these provisions by providing notice and the cause for rejection, and would authorize the commissioner to assess an administrative penalty against a health insurer or MEWA for a failure to correct a deficiency, as specified. The bill would authorize the commissioner to make rules and regulations specifying the form and content of the reports, as specified. This bill contains other related provisions and other existing laws.

[AB 787](#)

(Papan D) Provider directory disclosures.

Current Text: Amended: 6/23/2025 [html](#) [pdf](#)

Introduced: 2/18/2025

Status: 6/23/2025-Read second time and amended. Re-referred to Com. on APPR.

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires specified health care service plans and health insurers to publish and maintain a provider directory or directories with information on contracting providers that deliver health care services to enrollees or insureds, and requires a health care service plan or health insurer to regularly update its printed and online provider directory or directories, as specified. Existing law requires provider directories to include specified information and disclosures. This bill would require a full service health care service plan, specialized mental health or dental plan, health insurer, or specialized mental health or dental insurer to include in its provider directory or directories a statement advising an enrollee or insured to contact the plan or insurer for assistance finding an in-network provider and for an explanation of their rights regarding out-of-network coverage, and would specify the format of the statement. The bill would require the plan or insurer to acknowledge the request within one business day if contacted for that assistance, and to provide a list of in-network

providers confirmed to be accepting new patients within 2 business days for a request deemed urgent by the enrollee or insured and 5 business days for a request deemed nonurgent by an enrollee or insured. Because a violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

[AB 789](#)

(Bonta D) Political Reform Act of 1974: security expenses.

Current Text: Amended: 6/23/2025 [html](#) [pdf](#)

Introduced: 2/18/2025

Status: 6/25/2025-Re-referred to Com. on E. & C.A.

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

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

[AB 798](#)

(Calderon D) State Emergency Food Bank Reserve Program: diapers and wipes.

Current Text: Amended: 4/22/2025 [html](#) [pdf](#)

Introduced: 2/18/2025

Status: 7/1/2025-From committee: Do pass and re-refer to Com. on APPR. with recommendation: To Consent Calendar. (Ayes 5. Noes 0.) (June 30). Re-referred to Com. on APPR.

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

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

[AB 804](#)

(Wicks D) Medi-Cal: housing support services.

Current Text: Introduced: 2/18/2025 [html](#) [pdf](#)

Introduced: 2/18/2025

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

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

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

[AB 836](#)

([Stefani D](#)) Midwifery Workforce Training Act.

Current Text: Amended: 6/23/2025 [html](#) [pdf](#)

Introduced: 2/19/2025

Status: 6/23/2025-From committee chair, with author's amendments: Amend, and re-refer to committee. Read second time, amended, and re-referred to Com. on HEALTH.

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

Summary: Existing law requires the Office of Statewide Health Planning and Development to establish a program to contract with programs that train certified nurse-midwives and programs that train licensed midwives in accordance with the global standards for midwifery education and the international definition of "midwife" as established by the International Confederation of Midwives in order to increase the number of students receiving quality education and training as a certified nurse-midwife or as a licensed midwife. Existing law requires these provisions to be implemented only upon an appropriation by the Legislature for these purposes in the annual Budget Act or another act. This bill would require the Department of Health Care Access and Information, upon appropriation from the Legislature for this purpose, to administer funding for a statewide study on midwifery education. The bill would require the study to be conducted by an outside consultant familiar with the health care and midwifery landscapes and workforce in California that would, among other things, identify viable education programs that can serve both rural and urban geographic areas. The bill would require the department to submit a report from the study's findings to the Legislature, to post the report on the department's internet website, and to notify all persons in the department's reproductive health and maternity care electronic mailing list, as specified. The bill would define "reproductive health care professionals" as, among others, medical doctors and licensed midwives.

[AB 843](#)

([Garcia D](#)) Health care coverage: language access.

Current Text: Introduced: 2/19/2025 [html](#) [pdf](#)

Introduced: 2/19/2025

Status: 7/2/2025-VOTE: Do pass as amended, but first amend, and re-refer to the Committee on [Judiciary] (PASS)

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

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

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

[AB 877](#)

(Dixon R) Health care coverage: substance use disorder: residential facilities.

Current Text: Amended: 4/21/2025 [html](#) [pdf](#)

Introduced: 2/19/2025

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

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

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

[AB 910](#)

(Bonta D) Pharmacy benefit management.

Current Text: Amended: 4/10/2025 [html](#) [pdf](#)

Introduced: 2/19/2025

Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/7/2025)(May be acted upon Jan 2026)

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

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

[AB 951](#)

(Ta R) Health care coverage: behavioral diagnoses.

Current Text: Amended: 6/23/2025 [html](#) [pdf](#)

Introduced: 2/20/2025

Status: 6/23/2025-Read second time and amended. Re-referred to Com. on APPR.

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

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

[AB 960](#)

(Garcia D) Patient visitation.

Current Text: Amended: 5/29/2025 [html](#) [pdf](#)

Introduced: 2/20/2025

Status: 6/26/2025-From committee: Do pass and re-refer to Com. on APPR. with recommendation: To Consent Calendar. (Ayes 11. Noes 0.) (June 25). Re-referred to Com. on APPR.

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

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

a hospital that complies with its requirements. By expanding the scope of a crime, this bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 974

(Patterson R) Medi-Cal managed care plans: enrollees with other health care coverage.

Current Text: Amended: 3/24/2025 [html](#) [pdf](#)

Introduced: 2/20/2025

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

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

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

AB 979

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

Current Text: Amended: 4/23/2025 [html](#) [pdf](#)

Introduced: 2/20/2025

Status: 7/2/2025-From committee: Do pass and re-refer to Com. on APPR. with recommendation: To Consent Calendar. (Ayes 13. Noes 0.) (July 1). Re-referred to Com. on APPR.

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

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

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

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

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

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

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

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

AB 1018**(Bauer-Kahan D) Automated decision systems.****Current Text:** Amended: 5/1/2025 [html](#) [pdf](#)**Introduced:** 2/20/2025**Status:** 6/26/2025-In committee: Hearing postponed by committee.

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

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

[AB 1032](#)

(Harabedian D) Coverage for behavioral health visits.

Current Text: Amended: 5/5/2025 [html](#) [pdf](#)

Introduced: 2/20/2025

Status: 6/11/2025-Referred to Com. on HEALTH.

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

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

[AB 1037](#)

(Elhawary D) Public health: substance use disorder.

Current Text: Amended: 4/24/2025 [html](#) [pdf](#)

Introduced: 2/20/2025

Status: 7/2/2025-VOTE: Do pass as amended, but first amend, and re-refer to the Committee on [Judiciary] (PASS)

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

Summary: Under existing law, a licensed health care provider who is authorized by law to prescribe an opioid antagonist may issue standing orders for the distribution of an opioid antagonist to a person at risk of an opioid-related overdose or to a family member, friend, or other person in a position to assist a person at risk of an opioid-related

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

[AB 1041](#)

(Bennett D) Health care coverage: health care provider credentials.

Current Text: Amended: 6/24/2025 [html](#) [pdf](#)

Introduced: 2/20/2025

Status: 7/2/2025-VOTE: Do pass as amended, but first amend, and re-refer to the Committee on [Appropriations] (PASS)

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act's requirements a crime. Existing law provides for the regulation of disability and health insurers by the Department of Insurance. This bill would require those departments to adopt specified forms, accreditation standards and guidelines, and regulations to establish minimum standards or policies and processes that can streamline and reduce redundancy and delay in provider credentialing. The bill would also require those departments to adopt, on or before January 1, 2028, the Council for Affordable Quality Healthcare (CAQH) standardized credentialing form to be used by full service health care service plans and health insurers and their designees for credentialing and recredentialing purposes. The bill would require every full service health care service plan or health insurer or their designees to use the standardized credentialing form on and after January 1, 2028, or 6 months after the form is adopted, whichever is later. The bill would require those departments to update the form in accordance with the CAQH updates, or as necessary to comply with changes in laws and regulations, as specified. This bill contains other related provisions and other existing laws.

[AB 1090](#)

(Davies R) Alcoholism or drug abuse treatment facilities: County of Orange pilot program.

Current Text: Amended: 3/24/2025 [html](#) [pdf](#)

Introduced: 2/20/2025

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

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

Summary: Existing law provides that the State Department of Health Care Services has the sole authority in state government to license adult alcoholism or drug abuse recovery or treatment facilities, as defined. Existing law authorizes the department to conduct announced or unannounced site visits to licensed facilities to review compliance with all applicable statutes and regulations. This bill would require the State Department of Health Care Services to establish a pilot program to locate an investigator within a participating county to investigate complaints against licensed adult alcoholism or drug abuse recovery or treatment facilities within the county. The participating county would be the County of Orange if the Orange County Board of Supervisors elects to participate in the pilot program. The bill would require the department to implement the pilot program by executing a contract with the County of Orange providing that

the department will assign an investigator and the county will reimburse the department for the costs associated with the pilot program, including, but not limited to, the administrative costs and the investigator's compensation and benefits. The bill would require the pilot program to be completed no later than December 31, 2029, and would require the county to submit a report of the results of the pilot program, as specified, to the Legislature no later than December 31, 2030. The provisions of this bill would be repealed on December 31, 2034.

[AB 1113](#)

(González, Mark D) Federally qualified health centers: mission spend ratio.

Current Text: Amended: 5/5/2025 [html](#) [pdf](#)

Introduced: 2/20/2025

Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/21/2025)(May be acted upon Jan 2026)

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

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

[AB 1129](#)

(Rodriguez, Celeste D) Birth defects monitoring.

Current Text: Amended: 6/30/2025 [html](#) [pdf](#)

Introduced: 2/20/2025

Status: 6/30/2025-From committee chair, with author's amendments: Amend, and re-refer to committee. Read second time, amended, and re-referred to Com. on HEALTH.

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

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

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

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

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

[**AB 1328**](#)**(Rodriguez, Michelle D) Medi-Cal reimbursements: nonemergency ambulance transportation.****Current Text:** Amended: 5/23/2025 [html](#) [pdf](#)**Introduced:** 2/21/2025**Status:** 6/11/2025-Referred to Com. on HEALTH.

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

Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, including emergency or nonemergency medical or nonmedical transportation services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under this bill, commencing on January 1, 2026, and subject to an appropriation, Medi-Cal fee-for-service reimbursement for nonemergency ambulance transportation services, as defined, would be in an amount equal to 80% of the amount set forth in the federal Medicare ambulance fee schedule for the corresponding level of service, adjusted by the Geographic Practice Cost Index, as specified. The bill would require the department to establish a directed payment program for Medi-Cal managed care in order to follow a similar treatment to reimbursement rates for nonemergency ambulance transportation services. This bill contains other related provisions.

[**AB 1405**](#)**(Bauer-Kahan D) Artificial intelligence: auditors: enrollment.****Current Text:** Amended: 4/3/2025 [html](#) [pdf](#)**Introduced:** 2/21/2025**Status:** 7/2/2025-From committee: Do pass and re-refer to Com. on G.O. (Ayes 11. Noes 1.) (July 1). Re-referred to Com. on G.O.

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

Summary: Existing law establishes the Department of Technology within the Government Operations Agency. Existing law requires the department to conduct, in coordination with other interagency bodies as it deems appropriate, a comprehensive inventory of all high-risk automated decision systems that have been proposed for use, development, or procurement by, or are being used, developed, or procured by, any state agency. Existing law defines “automated decision system” as a computational process derived from machine learning, statistical modeling, data analytics, or

artificial intelligence that issues simplified output, including a score, classification, or recommendation, that is used to assist or replace human discretionary decisionmaking and materially impacts natural persons. Existing law defines “artificial intelligence” as an engineered or machine-based system that varies in its level of autonomy and that can, for explicit or implicit objectives, infer from the input it receives how to generate outputs that can influence physical or virtual environments. This bill would require the Government Operations Agency, by January 1, 2027, to establish a mechanism on the agency’s internet website allowing AI auditors to enroll with the agency and allowing natural persons to report misconduct by an enrolled AI auditor. The bill would require the agency, commencing January 1, 2027, to publish information provided by an enrolled AI auditor on the agency’s internet website, retain specified reports for as long as the auditor remains enrolled, plus 10 years, and share reports submitted by persons reporting misconduct with other state agencies as necessary for enforcement purposes. This bill contains other related provisions and other existing laws.

[AB 1415](#)

(Bonta D) California Health Care Quality and Affordability Act.

Current Text: Amended: 7/2/2025 [html](#) [pdf](#)

Introduced: 2/21/2025

Status: 7/2/2025-From committee chair, with author's amendments: Amend, and re-refer to committee. Read second time, amended, and re-referred to Com. on APPR.

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

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

[AB 1418](#)

(Schiavo D) Department of Health Care Access and Information.

Current Text: Amended: 7/2/2025 [html](#) [pdf](#)

Introduced: 2/21/2025

Status: 7/2/2025-From committee chair, with author's amendments: Amend, and re-refer to committee. Read second time, amended, and re-referred to Com. on HEALTH.

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

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

annual basis, commencing with reports filed after January 1, 2027, about whether health care workers employed at the facilities are subject to waiting periods. The bill would also require the department to integrate this reporting requirement with existing reports made to the department by the facilities, to the extent feasible.

SB 7

(McNerney D) Employment: automated decision systems.

Current Text: Amended: 6/19/2025 [html](#) [pdf](#)

Introduced: 12/2/2024

Status: 6/26/2025-From committee: Do pass and re-refer to Com. on P. & C.P. (Ayes 5. Noes 0.) (June 25). Re-referred to Com. on P. & C.P.

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

Summary: Existing law requires the Department of Technology to conduct, in coordination with other interagency bodies as it deems appropriate, a comprehensive inventory of all high-risk automated decision systems (ADS) that have been proposed for use, development, or procurement by, or are being used, developed, or procured by, any state agency. Existing law establishes the Labor and Workforce Development Agency, which is composed of various departments responsible for protecting and promoting the rights and interests of workers in California, including the Division of Labor Standards Enforcement, led by the Labor Commissioner, within the Department of Industrial Relations. This bill would require an employer to provide a written notice that an ADS, for the purpose of making employment-related decisions, not including hiring, is in use at the workplace to all workers that will be directly affected by the ADS, as specified. The bill would require the employer to maintain an updated list of all ADS currently in use and would require the notice to include the list. The bill would require an employer to notify, as provided, a job applicant that the employer utilizes an ADS in hiring decisions. The bill would prohibit an employer from using an ADS that does certain functions and would limit the purposes and manner in which an ADS may be used to make decisions. The bill would require an employer to allow a worker to access data collected or used by an ADS and to correct errors in data, as specified. This bill contains other related provisions and other existing laws.

SB 12

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

Current Text: Amended: 4/10/2025 [html](#) [pdf](#)

Introduced: 12/2/2024

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

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

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

status, position, and rights, except as specified. The bill would create the Immigrant and Refugee Inclusion Fund within the State Treasury, and would make the moneys in the fund available to the office upon appropriation by the Legislature. The bill would transfer to the office any unencumbered balance of any appropriation or other funds that were available for use in connection with any function transferred to the office. This bill contains other related provisions and other existing laws.

SB 27

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

Current Text: Amended: 6/17/2025 [html](#) [pdf](#)

Introduced: 12/2/2024

Status: 7/2/2025-From committee: Do pass and re-refer to Com. on HEALTH. (Ayes 11. Noes 0.) (July 1). Re-referred to Com. on HEALTH.

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

Summary: Existing law, the Community Assistance, Recovery, and Empowerment (CARE) Act, authorizes specified adult persons to petition a civil court to create a voluntary CARE agreement or a court-ordered CARE plan and implement services, to be provided by county behavioral health agencies, to provide behavioral health care, including stabilization medication, housing, and other enumerated services, to adults who are currently experiencing a severe mental illness and have a diagnosis identified in the disorder class schizophrenia and other psychotic disorders, and who meet other specified criteria. Existing law authorizes a specified individual to commence the CARE process, known as the original petitioner. Existing law authorizes the court to dismiss a case without prejudice when the court finds that a petitioner has not made a prima facie showing that they qualify for the CARE process. Existing law requires the court to take prescribed actions if it finds that a prima facie showing has been made, including, but not limited to, setting the matter for an initial appearance on the petition. Existing law requires the court, if it determines the parties have entered or are likely to enter into a CARE agreement, to either approve or modify the CARE agreement and continue the matter at a progress hearing in 60 days, or continue the matter for 14 days to allow the parties additional time to enter into an agreement. Existing law prohibits a person from being tried or adjudged to punishment while that person is mentally incompetent. Existing law requires the court to, for a person found mentally incompetent and not charged with certain offenses, among other things, determine whether restoring the person to mental competence is in the interests of justice. Existing law requires the court to, if restoring the person to mental competence is not in the interests of justice, conduct a hearing, as specified, and determine the person's eligibility for diversion. Under existing law, if the court determines, at the first hearing, that the person is ineligible for diversion, the court is required to hold a hearing to determine the person's other options, including the CARE program. Existing law authorizes a court to refer an individual from, among other things, assisted outpatient treatment or conservatorship proceedings, as specified, to CARE Act proceedings. Existing law provides that if the individual is referred from assisted outpatient treatment, the county behavioral health director or their designee shall be the petitioner, whereas if the referral is from conservatorship proceedings, the conservator or proposed conservator is the petitioner. This bill would allow the court to conduct the initial appearance on the petition at the same time as the prima facie determination if specified requirements are met. The bill, in the first hearing to determine competence to stand trial, would authorize the court to consider the petitioner's eligibility for both diversion and the CARE program. The bill would authorize the county behavioral health agency and jail medical providers to share confidential medical records and other relevant information with the court for the purpose of determining likelihood of eligibility for behavioral health services and programs. This bill contains other related provisions and other existing laws.

SB 32

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

Current Text: Amended: 6/19/2025 [html](#) [pdf](#)

Introduced: 12/2/2024

Status: 7/2/2025-From committee: Do pass and re-refer to Com. on APPR. (Ayes 15. Noes 0.) (July 1). Re-referred to Com. on APPR.

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

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

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

SB 40

(Wiener D) Health care coverage: insulin.

Current Text: Amended: 6/27/2025 [html](#) [pdf](#)

Introduced: 12/3/2024

Status: 6/27/2025-From committee with author's amendments. Read second time and amended. Re-referred to Com. on HEALTH.

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or disability insurance policy issued, amended, delivered, or renewed on or after January 1, 2000, that covers prescription benefits to include coverage for insulin if it is determined to be medically necessary. This bill would prohibit a large group health care service plan contract or health insurance policy issued, amended, delivered, or renewed on or after January 1, 2026, or an individual or small group health care service plan contract or health insurance policy on or after January 1, 2027, from imposing a copayment, coinsurance, deductible, or other cost sharing of more than \$35 for a 30-day supply of an insulin prescription drug, except as specified. On and after January 1, 2026, the bill would prohibit a health care service plan or health insurer from imposing step therapy as a prerequisite to authorizing coverage of insulin, and, for a large group health care service plan contract or health insurance policy, would require at least one insulin for a given drug type in all forms and concentrations to be on the prescription drug formulary. The bill would limit the \$35 cap for an individual or small group health care service plan contract or health insurance policy to only Tier 1 and Tier 2 insulin if the drug formulary is grouped into tiers, except as provided. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

SB 41

(Wiener D) Pharmacy benefits.

Current Text: Amended: 6/30/2025 [html](#) [pdf](#)

Introduced: 12/3/2024

Status: 6/30/2025-From committee with author's amendments. Read second time and amended. Re-referred to Com. on HEALTH.

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

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

business with a health care service plan or health insurer to secure a license from the Department of Managed Health Care on or after January 1, 2027, or the date on which the department has established the licensure process, whichever is later. The bill would establish application requirements, and would require a pharmacy benefit manager applying for licensure to reimburse the Director of the Department of Managed Health Care for the actual cost of processing the application, including overhead, up to an amount not to exceed \$25,000. The bill would require a pharmacy benefit manager to submit financial statements to the department at specified intervals, and would require those statements and other proprietary information to be kept confidential, as specified. The bill would authorize the director to suspend or revoke a pharmacy benefit manager license, but would provide that, once issued, a license remains in effect until revoked or suspended. The bill would authorize a pharmacy benefit manager whose license has been revoked, or suspended for more than one year to petition the director to reinstate the license, and would authorize the director to prescribe a fee, not to exceed \$500, for the actual cost of processing the petition. The bill would create the Pharmacy Benefit Manager Fund in the State Treasury, into which fees, fines, penalties, and reimbursements collected from pharmacy benefit managers would be deposited, except fines and administrative penalties for specified acts or omissions would be deposited into the newly created Pharmacy Benefit Manager Administrative Fines and Penalties Fund in the State Treasury. The bill would additionally authorize the Attorney General to recover specified civil penalties and receive equitable relief for violations of these provisions. Because a violation of these provisions would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

SB 53

(Wiener D) CalCompute: foundation models: whistleblowers.

Current Text: Amended: 5/23/2025 [html](#) [pdf](#)

Introduced: 1/7/2025

Status: 7/2/2025-From committee: Do pass and re-refer to Com. on P. & C.P. (Ayes 12. Noes 0.) (July 1). Re-referred to Com. on P. & C.P.

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

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

SB 62

(Menjivar D) Health care coverage: essential health benefits.

Current Text: Amended: 7/1/2025 [html](#) [pdf](#)

Introduced: 1/9/2025

Status: 7/1/2025-From committee with author's amendments. Read second time and amended. Re-referred to Com. on HEALTH.

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

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

bill would require, commencing January 1, 2027, if the United States Department of Health and Human Services approves a new essential health benefits benchmark plan for the state, as specified, the benchmark plan for health care service plans to include certain additional benefits, including coverage for specified fertility services and specified durable medical equipment. Because a violation of the bill by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

SB 81

(Arreguín D) Health and care facilities: information sharing.

Current Text: Amended: 6/27/2025 [html](#) [pdf](#)

Introduced: 1/17/2025

Status: 6/27/2025-From committee with author's amendments. Read second time and amended. Re-referred to Com. on P. & C.P.

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

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

SB 85

(Umberg D) Civil actions: service of summons.

Current Text: Amended: 6/25/2025 [html](#) [pdf](#)

Introduced: 1/21/2025

Status: 7/1/2025-In Senate. Concurrence in Assembly amendments pending.

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

Summary: Existing law prescribes specified methods for the service of a summons in a civil action. Under existing law, if no provision is made in statute for the service of summons, a court may direct a summons to be served in a manner that is reasonably calculated to give actual notice to the party to be served. This bill would also authorize a court to direct a summons to be served in a manner that is reasonably calculated to give actual notice to the party to be served if a plaintiff, exercising reasonable diligence, has been unable to serve the summons using methods prescribed by statute. The bill would authorize a court, upon motion, to direct service of the summons by electronic means, if such service is reasonably calculated to give actual notice. The bill would require a plaintiff seeking to establish reasonable diligence under this section to set forth facts that detail, as specified, the attempts to effect service pursuant to the methods prescribed by statute. The bill would also except actions against public entities or agents or employees of public entities from these provisions.

SB 228

(Cervantes D) Comprehensive Perinatal Services Program.

Current Text: Amended: 5/23/2025 [html](#) [pdf](#)

Introduced: 1/28/2025

Status: 6/16/2025-Referred to Com. on HEALTH.

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

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

SB 238

(Smallwood-Cuevas D) Workplace surveillance tools.

Current Text: Amended: 5/1/2025 [html](#) [pdf](#)

Introduced: 1/29/2025

Status: 6/26/2025-From committee: Do pass and re-refer to Com. on P. & C.P. (Ayes 5. Noes 1.) (June 25). Re-referred to Com. on P. & C.P.

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

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

SB 242

(Blakespear D) Medicare supplement coverage: open enrollment periods.

Current Text: Amended: 5/5/2025 [html](#) [pdf](#)

Introduced: 1/30/2025

Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/19/2025)(May be acted upon Jan 2026)

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

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

SB 246

(Grove R) Medi-Cal: graduate medical education payments.

Current Text: Introduced: 1/30/2025 [html](#) [pdf](#)

Introduced: 1/30/2025

Status: 6/17/2025-From committee: Do pass and re-refer to Com. on APPR. with recommendation: To consent calendar. (Ayes 15. Noes 0.) (June 17). Re-referred to Com. on APPR.

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

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

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

[SB 250](#)

(Ochoa Bogh R) Medi-Cal: provider directory: skilled nursing facilities.

Current Text: Amended: 6/17/2025 [html](#) [pdf](#)

Introduced: 1/30/2025

Status: 7/2/2025-From committee: Do pass. (Ayes 14. Noes 0.) (July 2).

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

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

[SB 257](#)

(Wahab D) Pregnancy As a Recognized Event for Nondiscriminatory Treatment (PARENT) Act.

Current Text: Introduced: 2/3/2025 [html](#) [pdf](#)

Introduced: 2/3/2025

Status: 6/9/2025-Referred to Com. on HEALTH.

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

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

other existing laws.

SB 278

(Cabaldon D) Health data: HIV test results.

Current Text: Amended: 6/19/2025 [html](#) [pdf](#)

Introduced: 2/4/2025

Status: 6/19/2025-From committee with author's amendments. Read second time and amended. Re-referred to Com. on P. & C.P.

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

Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, public health records relating to human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS), containing personally identifying information, that were developed or acquired by a state or local public health agency, or an agent of that agency, are generally confidential and are prohibited from being disclosed. Under existing law, in the form of exceptions, certain disclosures of the information are authorized for the purpose of facilitating appropriate HIV/AIDS medical care and treatment, including disclosures by state or local public health agency staff to agency staff, the designated health care provider, or the HIV-positive person who is the subject of the record, as specified. This bill would additionally authorize state public health agency HIV surveillance staff to disclose the information to State Department of Health Care Services staff, followed by authorized disclosures to the Medi-Cal managed care plan if applicable, the HIV-positive person who is the subject of the record, and the designated health care provider, for the purpose of proactively offering and coordinating care and treatment services to the person or for the purpose of administering quality improvement programs, as specified, designed to improve HIV care for Medi-Cal beneficiaries. This bill would require the State Department of Health Care Services, in consultation with the State Department of Public Health, to develop a mechanism by which a Medi-Cal beneficiary would be authorized to opt out of the disclosure of personally identifying information in public health records relating to HIV or AIDS to State Department of Health Care Services staff or the Medi-Cal managed care plan for the above-described purposes. The bill would require the mechanism to be implemented no later than December 31, 2026. This bill contains other related provisions and other existing laws.

SB 306

(Becker D) Health care coverage: prior authorizations.

Current Text: Amended: 4/28/2025 [html](#) [pdf](#)

Introduced: 2/10/2025

Status: 6/5/2025-Referred to Com. on HEALTH.

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

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

each calendar year. The bill would also clarify how to calculate a plan's or insurer's approval rate for purposes of determining whether a service may be exempted from prior authorization. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

[SB 324](#)

(Menjivar D) Medi-Cal: enhanced care management and community supports.

Current Text: Amended: 6/18/2025 [html](#) [pdf](#)

Introduced: 2/11/2025

Status: 7/2/2025-From committee: Do pass as amended and re-refer to Com. on APPR. (Ayes 15. Noes 0.) (July 1).

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

Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law, subject to implementation of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, requires the department to implement an enhanced care management (ECM) benefit designed to address the clinical and nonclinical needs on a whole-person-care basis for certain target populations of Medi-Cal beneficiaries enrolled in Medi-Cal managed care plans. Under existing law, target populations include, among others, high utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits, and individuals experiencing homelessness. Existing law, subject to CalAIM implementation, authorizes a Medi-Cal managed care plan to elect to cover community supports, as specified. Under existing law, community supports that the department is authorized to approve include, among others, housing transition navigation services and medically supportive food and nutrition services. This bill would require a Medi-Cal managed care plan, for purposes of covering the ECM benefit, or if it elects to cover a community support, to contract with community providers, as defined. In determining which community providers to contract with, the bill would authorize Medi-Cal managed care plans to take into consideration whether those providers are available in the respective county, have experience in providing the applicable ECM or community support, and can demonstrate that they are capable of providing access and meeting quality requirements in accordance with Medi-Cal guidelines. The bill would require the department, in enforcing these provisions, to require Medi-Cal managed care plans to set goals every other year to increase the contracting and utilization of community providers and local entities, as defined. The bill would require these goals to be set in consultation with the department, as specified. This bill contains other related provisions and other existing laws.

[SB 339](#)

(Cabaldon D) Medi-Cal: laboratory rates.

Current Text: Amended: 4/9/2025 [html](#) [pdf](#)

Introduced: 2/12/2025

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

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

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

SB 363**(Wiener D) Health care coverage: independent medical review.****Current Text:** Amended: 6/24/2025 [html](#) [pdf](#)**Introduced:** 2/13/2025**Status:** 6/24/2025-From committee with author's amendments. Read second time and amended. Re-referred to Com. on HEALTH.

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law establishes the Independent Medical Review System within each department, under which an enrollee or insured may seek review if a health care service has been denied, modified, or delayed by a health care service plan or health insurer and the enrollee or insured has previously filed a grievance that remains unresolved after 30 days. This bill would require a health care service plan or health insurer to annually report to the appropriate department the total number of claims processed by the health care service plan or health insurer for the prior year and its number of treatment denials or modifications, separated and disaggregated as specified, commencing on or before June 1, 2026. The bill would require the departments to compare the number of a health care service plan's or health insurer's treatment denials and modifications to (1) the number of successful independent medical review overturns of the plan's or insurer's treatment denials or modifications and (2) the number of treatment denials or modifications reversed by a plan or insurer after an independent medical review for the denial or modification is requested, filed, or applied for. For a health care service plan or health insurer with 10 or more independent medical reviews in a given year, the bill would make the health care service plan or health insurer liable for an administrative penalty, as specified, if more than 50% of the independent medical reviews filed with a health care service plan or health insurer result in an overturning or reversal of a treatment denial or modification in any one individual category of specified general types of care. The bill would make a health care service plan or health insurer liable for additional administrative penalties for each independent medical review resulting in an additional overturned or reversed denial or modification in excess of that threshold. The bill would require the departments to annually include data, analysis, and conclusions relating to these provisions in specified reports. This bill contains other related provisions and other existing laws.

SB 402**(Valladares R) Health care coverage: autism.****Current Text:** Introduced: 2/14/2025 [html](#) [pdf](#)**Introduced:** 2/14/2025**Status:** 7/1/2025-From committee: Do pass and re-refer to Com. on HEALTH. (Ayes 17. Noes 0.) (July 1). Re-referred to Com. on HEALTH.

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

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

SB 418**(Menjivar D) Health care coverage: prescription hormone therapy and nondiscrimination.****Current Text:** Amended: 6/23/2025 [html](#) [pdf](#)**Introduced:** 2/18/2025

Status: 7/2/2025-Coauthors revised. From committee: Do pass and re-refer to Com. on B. & P. (Ayes 12. Noes 2.) (July 1). Re-referred to Com. on B. & P.

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law also provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services through, among other things, managed care plans licensed under the act that contract with the State Department of Health Care Services. Existing law sets forth specified coverage requirements for health care service plan contracts and health insurance policies. Existing law generally authorizes a health care service plan or health insurer to use utilization controls to approve, modify, delay, or deny requests for health care services based on medical necessity. Existing law requires health care service plans and health insurers, as specified, within 6 months after the relevant department issues specified guidance, or no later than March 1, 2025, to require all of their staff who are in direct contact with enrollees or insureds in the delivery of care or enrollee or insured services to complete evidence-based cultural competency training for the purpose of providing trans-inclusive health care for individuals who identify as transgender, gender diverse, or intersex. This bill would require a health care service plan contract, including a Medi-Cal managed care plan contract, or health insurance policy issued, amended, renewed, or delivered on or after January 1, 2026, to cover up to a 12-month supply of a United States Food and Drug Administration (FDA)-approved prescription hormone therapy, and the necessary supplies for self-administration, that is prescribed by a network provider within their scope of practice and dispensed at one time, as specified. The bill would prohibit a plan or insurer from imposing utilization controls or other forms of medical management limiting the supply of this hormone therapy to an amount that is less than a 12-month supply, but would not prohibit a contract or policy from limiting refills that may be obtained in the last quarter of the plan or policy year if a 12-month supply of the prescription hormone therapy has already been dispensed during that year. The bill would require the State Department of Health Care Services to seek federal approval, if necessary, and to issue all-plan letters or similar instructions to implement these provisions for Medi-Cal managed care plans. This bill contains other related provisions and other existing laws.

[SB 439](#)

(Weber Pierson D) California Health Benefit Review Program: extension.

Current Text: Amended: 4/10/2025 [html](#) [pdf](#)

Introduced: 2/18/2025

Status: 7/2/2025-July 2 set for first hearing. Placed on suspense file.

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

Summary: Existing law establishes the Health Care Benefits Fund to support the University of California's implementation of the California Health Benefit Review Program. Under the program, the University of California assesses legislation proposing to repeal or mandate a benefit or service requirement on health care insurance plans or health insurers. Under the program, the University of California provides a written analysis that includes, among other data, financial impacts of legislation on publicly funded state health insurance programs, including the Medi-Cal program and the Healthy Families Program. Existing law imposes an annual charge on health care service plans and health insurers for the 2022–23 to 2026–27 fiscal years, inclusive, as specified, to be deposited into the fund. Existing law prohibits the total annual assessment on health care service plans and health insurers from exceeding \$2,200,000. Under existing law, the fund and the program become inoperative on July 1, 2027, and are repealed as of January 1, 2028. This bill would extend the operation of the California Health Benefit Review Program and the Health Care Benefits Fund through July 1, 2033, and would authorize the continued assessment of the annual charge on health care service plans and health insurers for that purpose for the 2026–27 to 2032–33 fiscal years, inclusive. The bill would increase the allowable total annual assessment on health care service plans and health insurers to \$3,200,000. The bill would remove the Healthy Families Program as an example of the publicly funded state health insurance programs within an analysis of financial impacts of legislation. This bill contains other related provisions.

[SB 449](#)

(Valladares R) Health care service plan requirements.

Current Text: Introduced: 2/18/2025 [html](#) [pdf](#)

Introduced: 2/18/2025

Status: 2/26/2025-Referred to Com. on RLS.

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

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

[SB 466](#)

(Caballero D) Drinking water: hexavalent chromium: civil liability: exemption.

Current Text: Amended: 6/24/2025 [html](#) [pdf](#)

Introduced: 2/19/2025

Status: 7/2/2025-From committee: Do pass and re-refer to Com. on JUD. (Ayes 7. Noes 0.) (July 1). Re-referred to Com. on JUD.

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

Summary: The California Safe Drinking Water Act provides for the operation of public water systems and imposes on the State Water Resources Control Board various duties and responsibilities for the regulation and control of drinking water in the State of California. The act requires the state board to adopt primary drinking water standards for contaminants in drinking water based upon specified criteria, and requires a primary drinking water standard to be established for hexavalent chromium. Existing law authorizes the state board to grant a variance from primary drinking water standards to a public water system. This bill would prohibit a public water system that meets the total chromium maximum containment level (MCL) enforceable standard for drinking water in California from being held liable in any civil action brought by an individual or entity that is not a governmental agency related to hexavalent chromium in drinking water while implementing and in compliance with a state board-approved hexavalent chromium MCL compliance plan, or during the period between when it has submitted a hexavalent chromium MCL compliance plan for approval to the state board and action on the proposed compliance plan by the state board is pending, except as specified.

[SB 468](#)

(Becker D) High-risk artificial intelligence systems: duty to protect personal information.

Current Text: Introduced: 2/19/2025 [html](#) [pdf](#)

Introduced: 2/19/2025

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

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

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

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

[SB 481](#)

(Alvarado-Gil R) In-home supportive services.

Current Text: Introduced: 2/19/2025 [html](#) [pdf](#)

Introduced: 2/19/2025

Status: 2/26/2025-Referred to Com. on RLS.

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

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

[SB 528](#)

(Weber Pierson D) Health care: maintenance and expansion.

Current Text: Amended: 5/5/2025 [html](#) [pdf](#)

Introduced: 2/20/2025

Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/19/2025)(May be acted upon Jan 2026)

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

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

[SB 530](#)

(Richardson D) Medi-Cal: time and distance standards.

Current Text: Amended: 5/23/2025 [html](#) [pdf](#)

Introduced: 2/20/2025

Status: 6/5/2025-Referred to Com. on HEALTH.

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

Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, under fee-for-service or managed care delivery systems. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. This bill would extend the operation of those standards indefinitely. The bill would also require a managed care plan to ensure that each subcontractor network complies with certain appointment time standards unless already required to do so. The bill would set forth related reporting requirements with regard to subcontractor networks.

SB 535**(Richardson D) Obesity Treatment Parity Act.****Current Text:** Introduced: 2/20/2025 [html](#) [pdf](#)**Introduced:** 2/20/2025**Status:** 6/5/2025-Referred to Com. on HEALTH.

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

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

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

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

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

SB 626**(Smallwood-Cuevas D) Perinatal health screenings and treatment.****Current Text:** Amended: 5/5/2025 [html](#) [pdf](#)**Introduced:** 2/20/2025**Status:** 7/1/2025-July 8 hearing postponed by committee.

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

Summary: Existing law requires a licensed health care practitioner who provides prenatal, postpartum, or interpregnancy care for a patient to offer to screen or appropriately screen a mother for maternal mental health conditions. For purposes of that requirement, existing law defines "maternal mental health condition" to mean a mental health condition that occurs during pregnancy, the postpartum period, or interpregnancy, as specified. This bill would modify the term "maternal mental health condition" to "perinatal mental health condition" and additionally include in its definition a mental health condition that occurs during the perinatal period. The bill would require a licensed health care practitioner who provides perinatal care for a patient to screen, diagnose, and treat the patient for a perinatal mental health condition in accordance with applicable clinical guidelines or standards appropriate to the provider's license,

training, and scope of practice, as specified. This bill contains other related provisions and other existing laws.

SB 660

(Menjivar D) California Health and Human Services Data Exchange Framework.

Current Text: Amended: 6/23/2025 [html](#) [pdf](#)

Introduced: 2/20/2025

Status: 7/2/2025-From committee: Do pass and re-refer to Com. on P. & C.P. (Ayes 14. Noes 0.) (July 1). Re-referred to Com. on P. & C.P.

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

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

SB 812

(Allen D) Qualified youth drop-in center health care coverage.

Current Text: Amended: 5/5/2025 [html](#) [pdf](#)

Introduced: 2/21/2025

Status: 6/16/2025-Referred to Com. on HEALTH.

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

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

SB 833

(McNerney D) Critical infrastructure: automated decision systems: human oversight.

Current Text: Amended: 3/26/2025 [html](#) [pdf](#)

Introduced: 2/21/2025

Status: 6/9/2025-Referred to Com. on P. & C.P.

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

1st House	2nd House	Conc.			

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

[SB 862](#)

(Committee on Health) Health.

Current Text: Amended: 6/26/2025 [html](#) [pdf](#)

Introduced: 3/17/2025

Status: 6/26/2025-Read second time and amended. Re-referred to Com. on APPR.

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

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

Total Measures: 123

Total Tracking Forms: 123



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

Executive Dashboard

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Financials

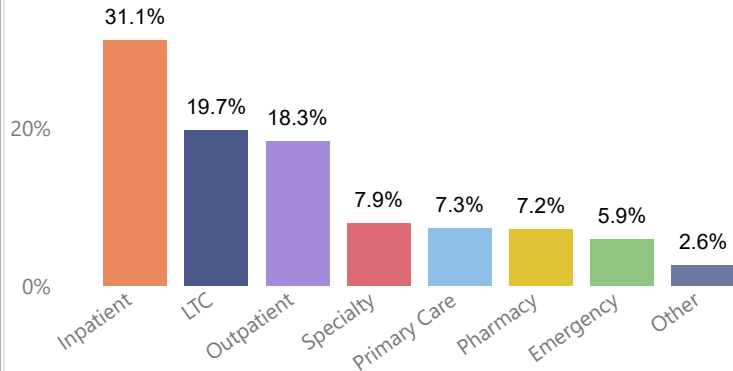
Income & Expenses

	MAY 2025	FISCAL YTD
REVENUE	\$ 254.7 M	\$ 2.8 B
MEDICAL EXPENSE	\$ (181.0) M	\$ (2.0) B
ADMIN EXPENSE	\$ (9.0) M	\$ (104.4) M
OTHER/TAX	\$ (63.4) M	\$ (785.7) M
NET INCOME	\$ 1.4 M	\$ (91.0) M

Medical Loss % (Fiscal YTD)

100.6%

Medical Expenses

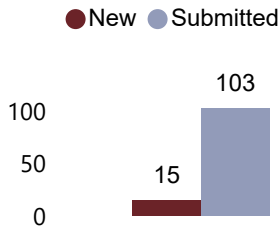


Liquid Reserves

TNE %
203.3%

TNE \$
\$164.4M

Reinsurance Cases

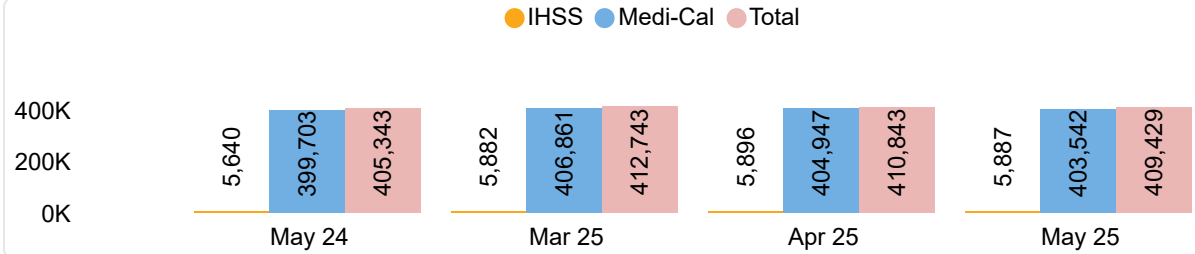


Balance Sheet

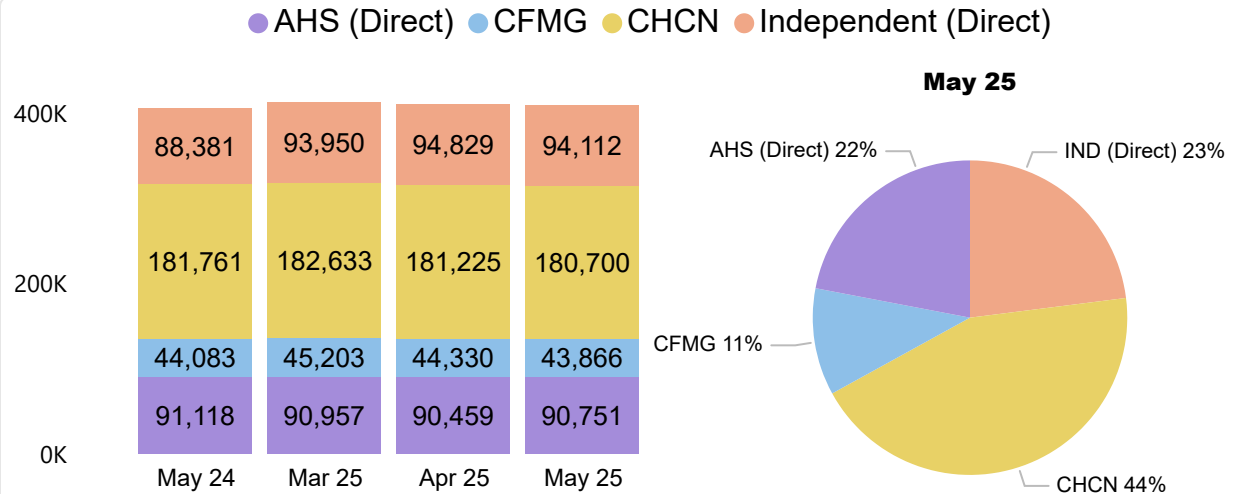
Cash Equivalents	\$537.9M	Current Ratio 1.13
Pass-Through Liabilities	\$152.4M	
Uncommitted Cash	\$385.6M	
Working Capital	\$111.1M	

Membership

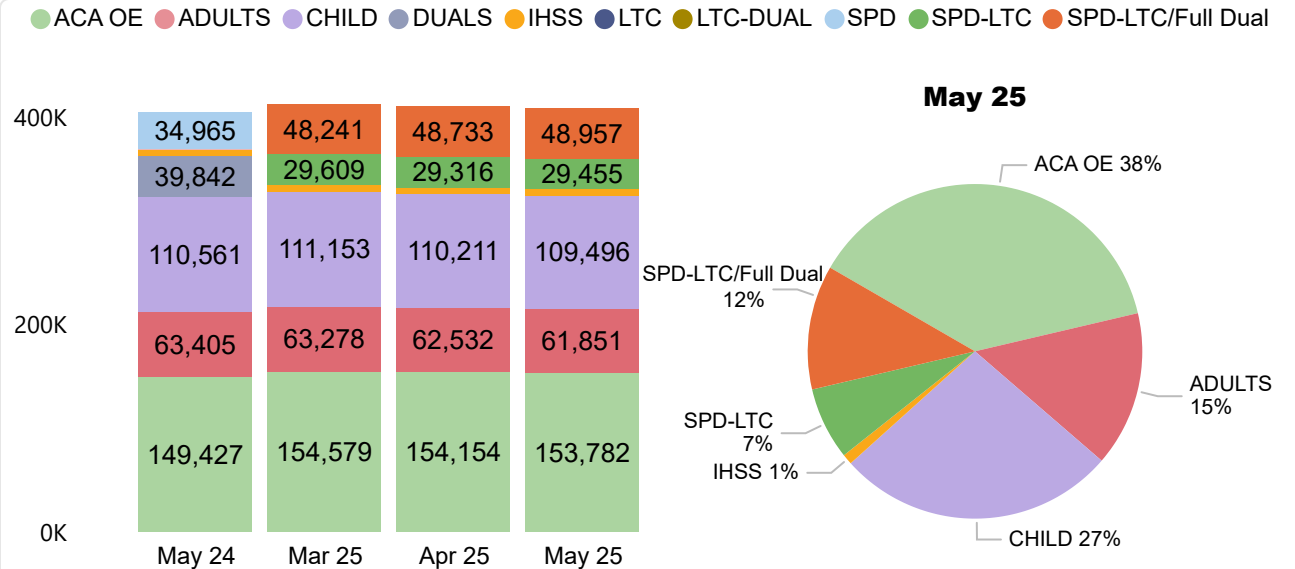
By Plan



By Network



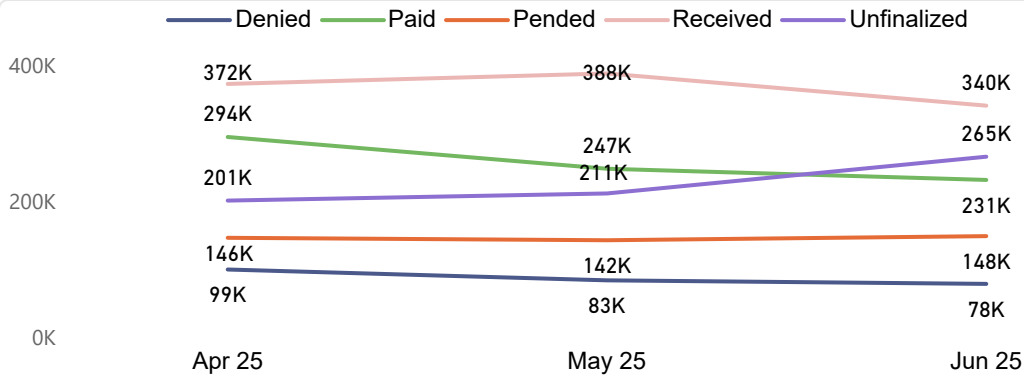
By Category



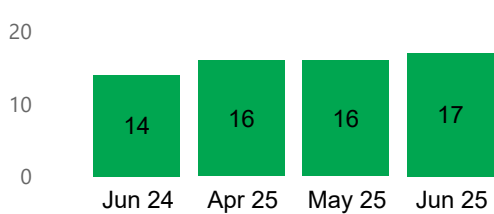
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Claims

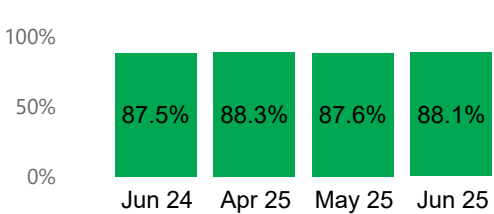
Claims Processing



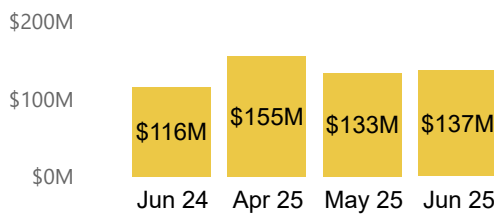
Average Payment TAT (Days)



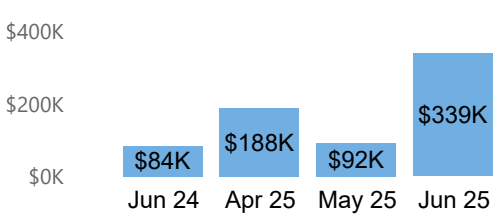
Auto Adjudication Rate (%)



Claims Paid (\$)

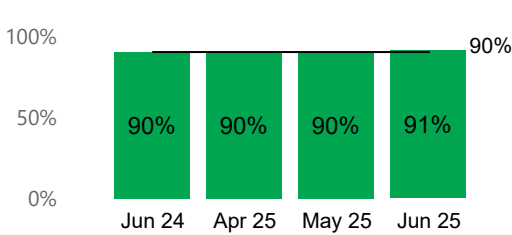


Interest Paid (\$)

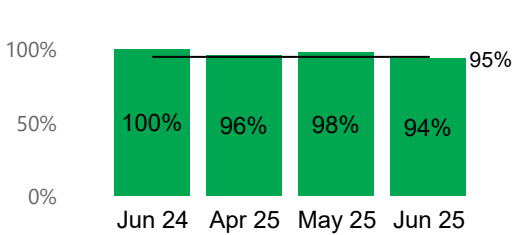


Claims Compliance

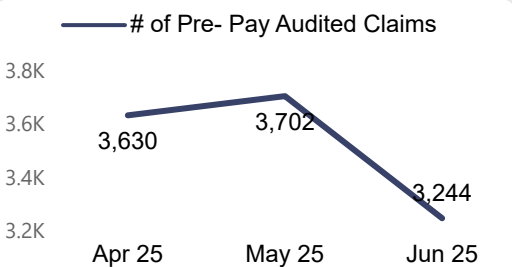
Processed 30 Cal Days (%)



Processed 45 Work Days (%)

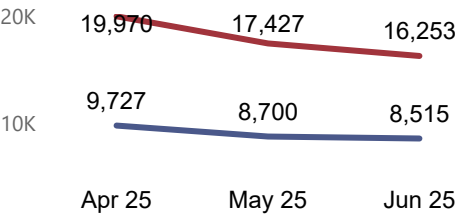


Claims Auditing

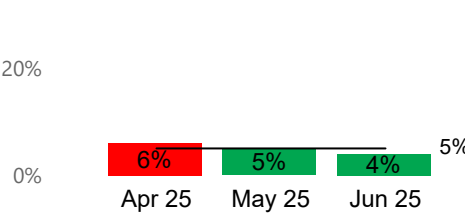


Member Services

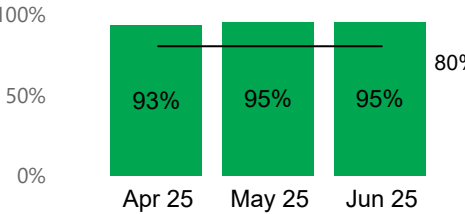
Inbound Calls Outbound Calls



Abandoned Call Rate (%)



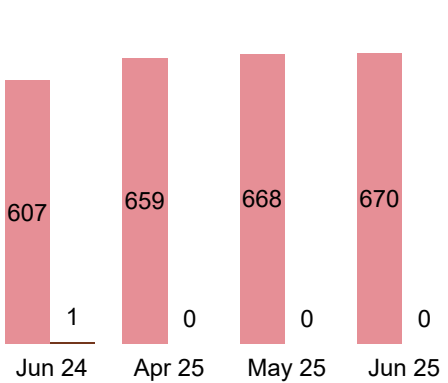
Calls Answered in 30 Seconds (%)



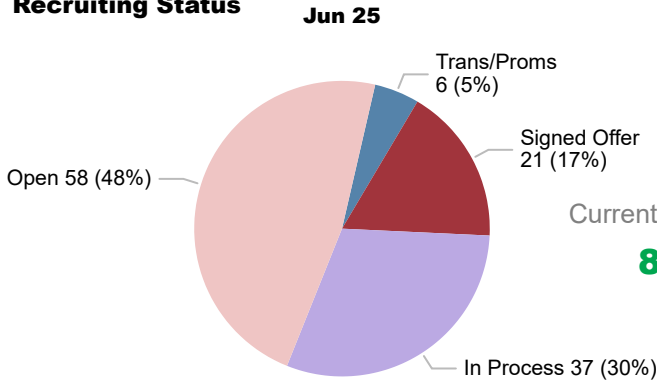
Average Call Times	Apr 25	May 25	Jun 25
Wait Time	00:15	00:11	00:11
Call Duration	07:25	07:33	07:50

Human Resources

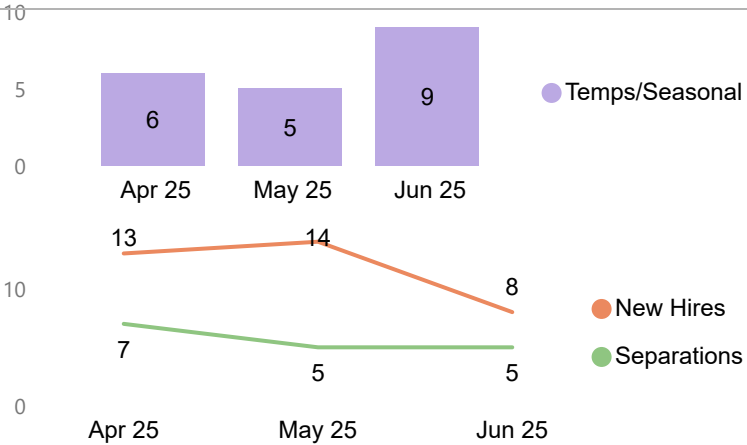
Full Time Part Time



Recruiting Status



Current Vacancy
8%



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Provider Services

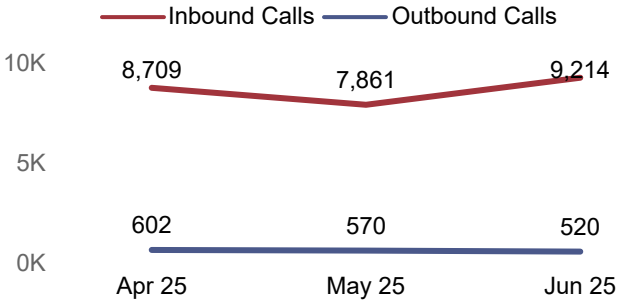
Provider Network

Hospital	17
Specialist	11,267
Primary Care Physician	787
Skilled Nursing Facility	107
Urgent Care	16
Health Centers (FQHCs and Non-FQHCs)	86
TOTAL	12,280

Provider Credentialing

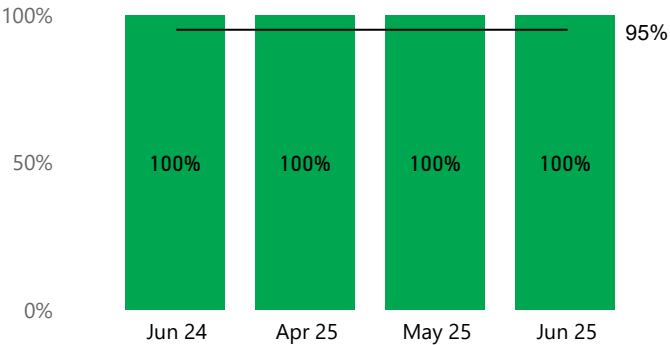
4,942

Provider Call Center



Provider Disputes & Resolutions

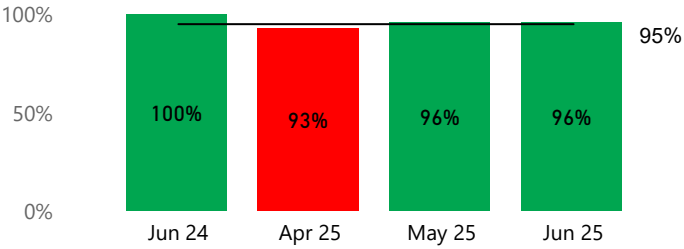
Turnaround Compliance (45 business days)



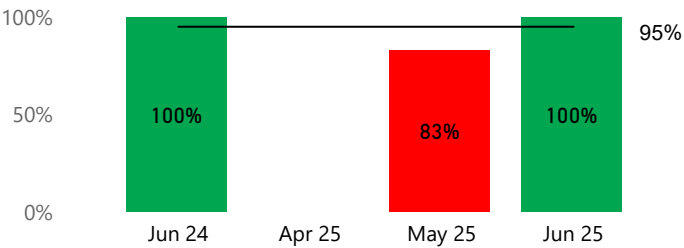
Compliance

Member Grievances

Standard (30 calendar days)

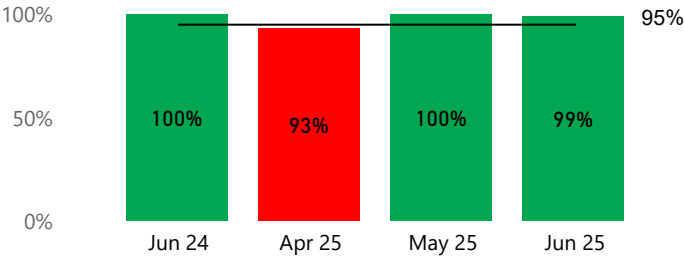


Expedited (3 calendar days)

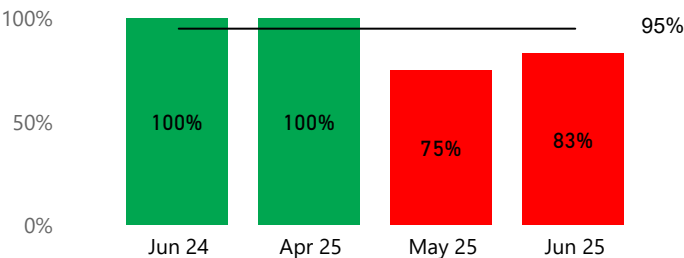


Member Appeals

Standard (30 calendar days)

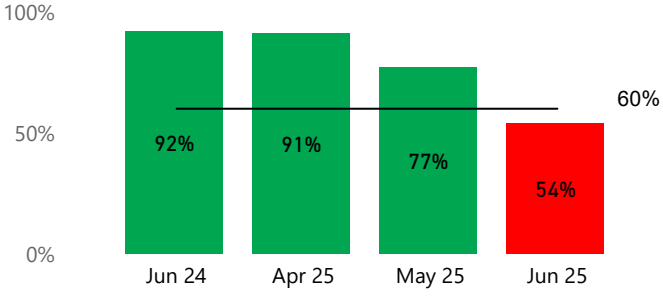


Expedited (3 calendar days)

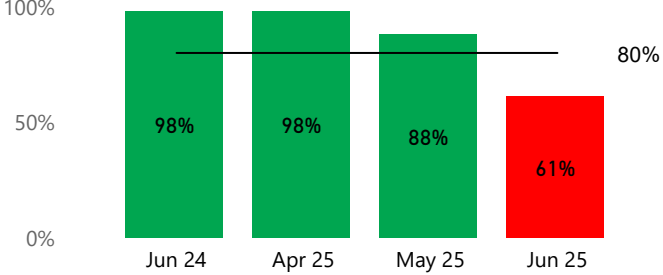


Encounter Data

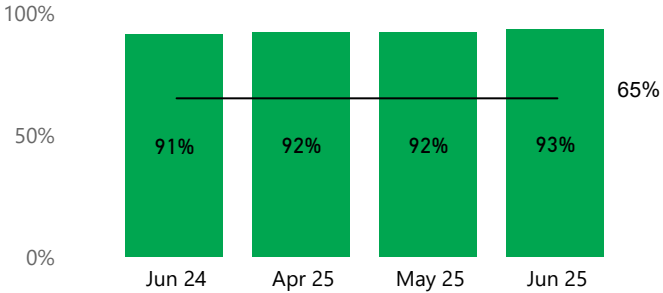
Institutional 0-90 days



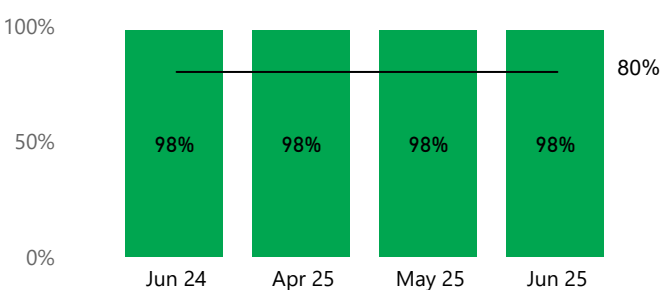
Institutional 0-180 days



Professional 0-90 days



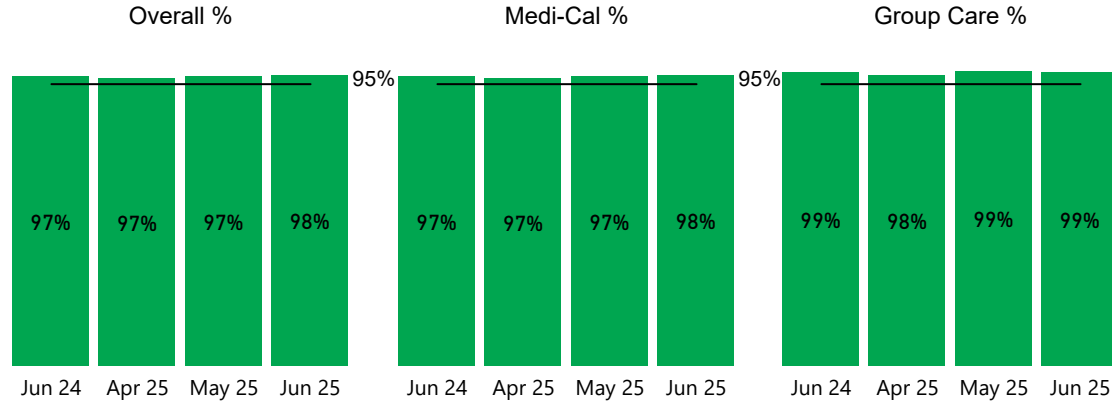
Professional 0-180 days



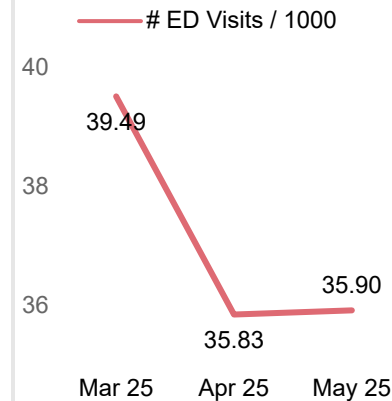
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Health Care Services

Authorization Turnaround



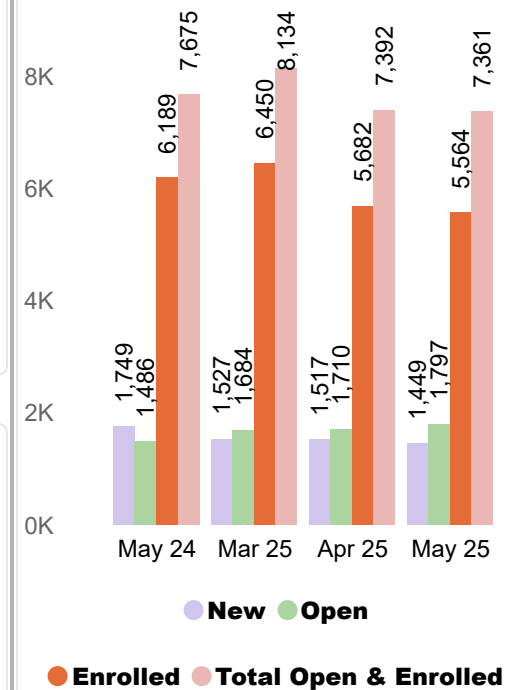
ED Utilization



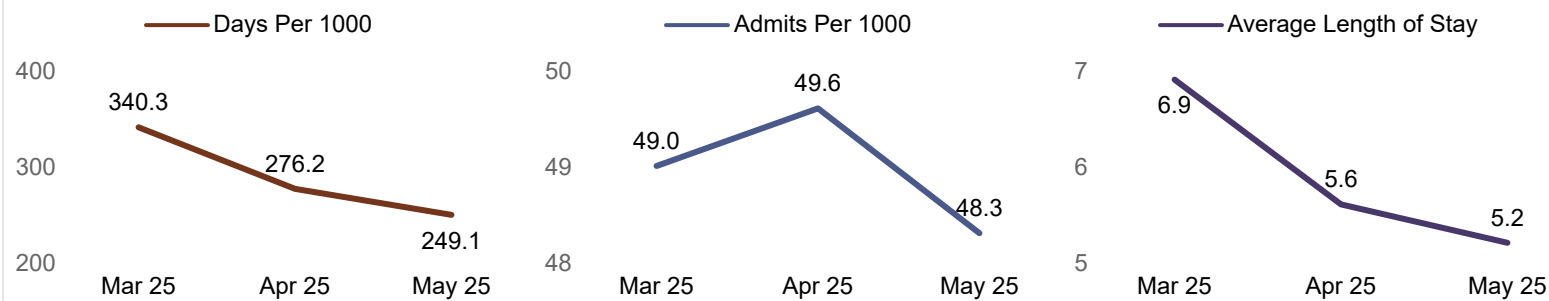
Case Management

Total Cases^

^ ECM Metrics since 2022



Inpatient Utilization

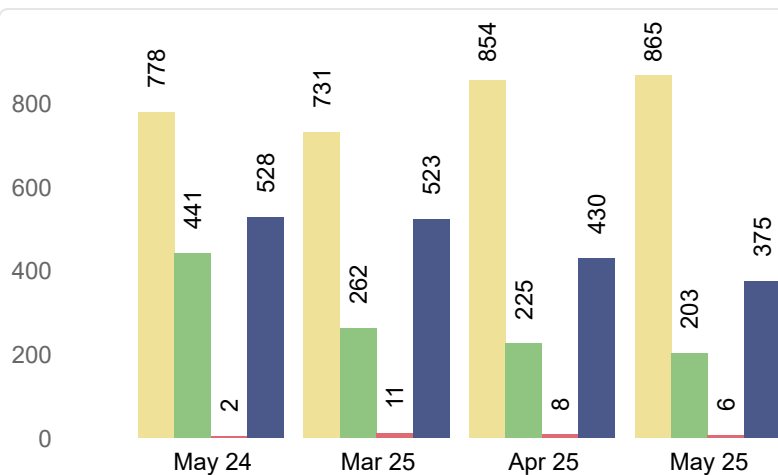


Case Management^

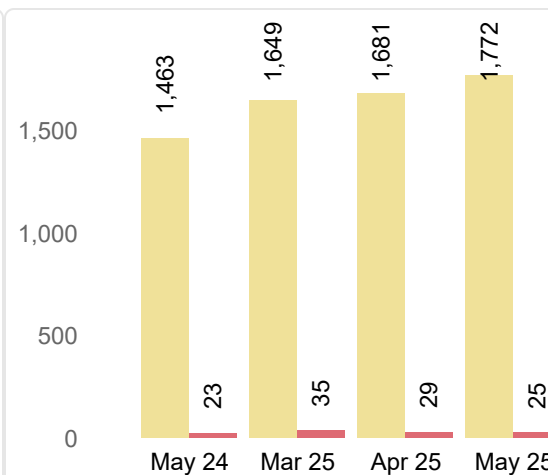
● Care Coordination ● Community Supports ● Complex Cases ● Enhanced Case Management

^ ECM Metrics since 2022

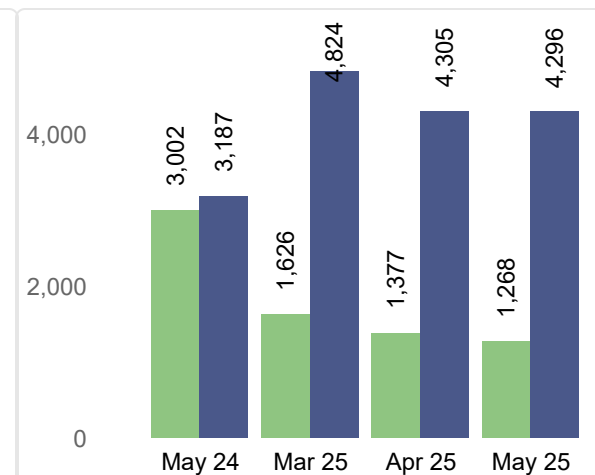
New Cases



Open Cases



Enrolled Cases



Technology (Business Availability)

Applications ▲	Jun 24	Apr 25	May 25	Jun 25
HEALTHsuite System	100.0%	99.5%	100.0%	99.9%
Other Applications	100.0%	99.5%	100.0%	99.6%
TruCare System	100.0%	100.0%	100.0%	100.0%

Outpatient Authorization Denial Rates *

OP Authorization Denial Rates	Jun 24	Apr 25	May 25	Jun 25
Denial Rate Excluding Partial Denials (%)	3.2%	4.9%	4.9%	4.3%
Overall Denial Rate (%)	3.5%	5.3%	5.2%	4.9%
Partial Denial Rate (%)	0.3%	0.4%	0.3%	0.6%

* IHSS and Medi-Cal Line Of Business

Pharmacy Authorizations

Authorizations ▲	Jun 24	Apr 25	May 25	Jun 25
Approved Prior Authorizations	36	37	41	37
Closed Prior Authorizations	95	26	23	17
Denied Prior Authorizations	55	92	97	78
Total Prior Authorizations	186	155	161	132



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Board Business



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Grant Policy & Procedure

POLICY AND PROCEDURE

Policy Number	FIN-XXX
Policy Name	Board Grant Review and Approval Policy
Department Name	Finance
Department Officer	Chief Financial Officer
Policy Owner	Chief Financial Officer
Line(s) of Business	All
Original Effective Date	
Compliance Committee Approval Date	

POLICY STATEMENT

This policy and procedure establishes the financial threshold at which grant proposals are subject to review and approval by the Board of Governors, as well as the review cycle during which the Board receives a summary of major grants awarded by Alameda Alliance for Health (Alameda Alliance).

PROCEDURE

This policy will govern the approval requirements for Alameda Alliance board reviewed grants. The following procedures will apply to new grants and renewal grants.

A. Board Approval

If the grant is for an amount equal to or less than \$1,500,000.00 per year for a single grantee, the grant may be awarded and entered into on behalf of Alameda Alliance by its CEO or their designee. Alameda Alliance shall award and enter any other grant greater than \$1,500,000.00 for a single grantee per year only by action of the Board.

B. Annual Board Review

Alameda Alliance will provide an annual update on the progress of all grants approved by the board, including what has been distributed, outcomes, and results. Annual reporting will be completed every June and will include review of all grants distributed, grants received and event sponsorships.

DEFINITIONS / ACRONYMS

Grant-A financial award provided by the Alliance to support a specific project, initiative, or purpose. Grants are awarded based on a detailed application process and are intended to fund activities that align with the grantor's objectives and mission. Unlike loans, grants do not require repayment.

AFFECTED DEPARTMENTS/PARTIES

All

RELATED POLICIES AND PROCEDURES

VMG-004: Procurement Policy

REVISIONS

RELATED WORKFLOW DOCUMENTS OR OTHER ATTACHMENTS

REFERENCES

MONITORING

The Chief Financial Officer and Controller will review the board grant review and approval policy annually.



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Medicare Update



Alameda Alliance for Health (Alliance) Board of Governors (BOG) Medicare Advantage (MA) Dual Eligible Special Needs Plan (D-SNP) Update

Ruth Watson, Chief Operating Officer (COO)

Tome Meyers, Executive Director, Medicare Programs

Jaini Goradia, Director, Stars Strategy & Program Management

Friday, July 11th, 2025

Agenda

- ▶ Executive Summary
- ▶ D-SNP Logo & Branding
- ▶ MA D-SNP Product Lifecycle
- ▶ Supplemental Benefits Update
- ▶ D-SNP Launch Approach
- ▶ What are Medicare Stars Ratings?
- ▶ Medicare Star Ratings Cycle & Domains
- ▶ Stars Strategy for D-SNP
- ▶ Medicare Risk Adjustment Overview
- ▶ Next Steps

Executive Summary

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

D-SNP Logo & Branding

▷ Plan Name: Alameda Alliance Wellness (HMO D-SNP)

▷ Main Logo:



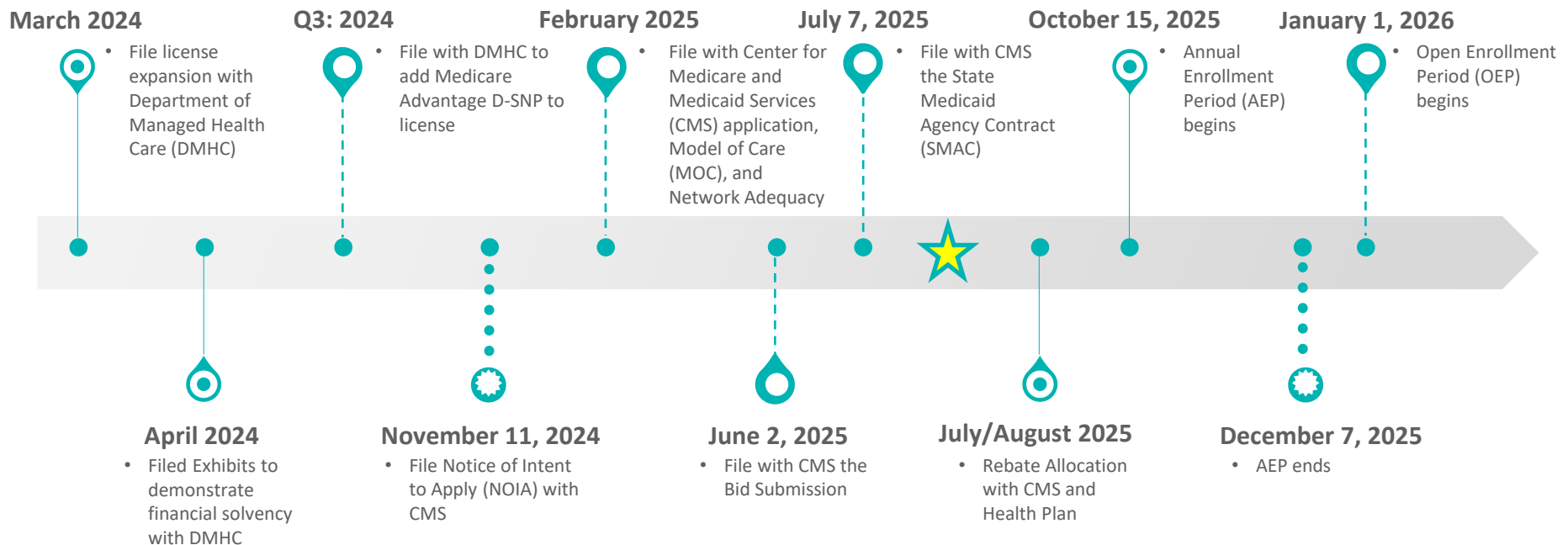
The warmth of gold and orange are balanced with the cool tone of blue and a darker teal symbolizing a connection to the natural world.



▷ Medicare Logo:



MA D-SNP Product Timeline



Supplemental Benefits Update

	Alameda County HMO D-SNPs PY2025					Public Plan HMO D-SNPs PY2025				
	CVS H4982-008 ★★1/2	Elevance H4471-007 Too new	Molina Healthcare H5649-024 ★★1/2	Imperial Health Plan H5496-011 ★★★1/2	Kaiser Permanente H8794-004 Too New	Health Plan San Mateo H6019-001 ★★★	LA Care H1224-001 ★★★	Santa Clara Family Health Plan H4045-001 ★★★	CalOptima H5433-001 ★★1/2	Community Health San Diego H6248-001 ★★★
	Aetna Medicare Preferred Plan	Anthem Dual Advantage	Central Health Dual Access Plan	Imperial Dual Plan	Kaiser Medicare Medi-Cal Plan North	CareAdvantage	L.A. Care Medicare Plus	DualConnect	OneCare a Medicare Medi-Cal Plan	CommuniCare Advantage
Vision	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dental	✓	✓	✗	✓	✗	✗	✓	✗	✓	✓
Hearing	✓	✓	✓	✓	✗	✗	✗	✓	✓	✗
Fitness	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Telehealth	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
In-Home Support Services	✗	✗	✓	✓	✗	✓	✓	✓	✓	✓
Health Education	✓	✗	✓	✗	✓	✓	✓	✓	✓	✓
Over-The-Counter Allowance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Personal Emergency Response System	✗	✓	✓	✓	✗	✓	✓	✓	✓	✓
Acupuncture	✓	✓	✓	✗	✓	✓	✓	✓	✓	✓
Chiropractic Services	✓	✓	✓	✓	✗	✗	✓	✗	✗	✗
Meals for Short Duration	✓	✓	✓	✓	✗	✓	✓	✓	✓	✓
Worldwide Emergency	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓
Massage Therapy	✗	✗	✗	✗	✗	✓	✓	✓	✓	✓
Alternative Therapies	✗	✗	✗	✗	✗	✓	✓	✓	✓	✓
Counseling Services	✗	✗	✗	✗	✗	✓	✓	✓	✓	✓
Support for Caregivers of Enrollees	✗	✗	✗	✗	✗	✓	✓	✓	✓	✓
Transportation: Any Health-Related Locations	✗	✗	✗	✗	✗	✓	✓	✓	✓	✓
Transportation: Plan-Approved Locations	✓	✓	✓	✓	✗	✓	✓	✓	✓	✓
Home and Bathroom Safety Devices	✓	✓	✗	✗	✗	✓	✓	✓	✓	✓
Annual Physical Exams	✓	✓	✓	✗	✓	✓	✓	✓	✓	✓

Note: This chart reflects Medicare-covered benefits only, as filed with CMS. Some services may also be covered under the Medi-Cal benefit.

Blue: Changes from PY2024 to PY2025

D-SNP Launch Approach

- ▶ Membership projection of 1,500 members by the end of 2026
 - ▶ Limited savings related to volume related departments
 - ▶ Fixed cost to stand up a D-SNP remain
- ▶ Focus on the basics
 - ▶ Small scale strategy
 - ▶ Limit brand awareness
 - ▶ No external brokers
- ▶ 107 project plans (69 active, 37 request, & 1 on hold)
- ▶ Core systems upgrades, implementations, & enhancements are in full swing

What are Medicare Star Ratings?



- ▶ Measures the quality of the health and drug services we provide to our D-SNP members
- ▶ Based on a scale of 1 to 5 stars (with 5 Stars being the highest rating)
- ▶ The Alliance will receive its first Medicare Star Ratings in “Star Year” (SY) 2028. Why 2028?

Medicare Star Rating Cycle & Domains



- ▶ The *Star Rating Cycle* has a two-year lag and consists of MY, Data Collection, and SY
 - ▶ Part C Domains
 - Staying Healthy: Screenings, Tests, & Vaccines
 - Managing Chronic (Long Term) Conditions
 - Member Experience with the Health Plan
 - Member Complaints & Changes in the Health Plan's Performance
 - Health Plan Customer Service
 - ▶ Part D Domains
 - Drug Plan Customer Service
 - Member Complaints and Changes in the Drug Plan's Performance
 - Member Experience with the Drug Plan
 - Drug Safety and Accuracy of Drug Pricing
- ▶ Two-years lag between performance period and rating period

Stars Strategy for D-SNP

- ▶ Leverage Existing Data Infrastructure
- ▶ Establish Annual Wellness Visit Readiness
- ▶ Launching Member Engagement Campaigns
- ▶ Developing Internal Operational Workflows for Outreach
- ▶ Integrate Stars Performance into Reporting

Medicare Risk Adjustment Overview

- ▶ Vendor selection complete
 - ▶ Contracting nearing completion
 - Episource: Data analytics, medical record reviews
 - Optum: Data submissions to CMS
- ▶ Project work underway to support implementation
 - ▶ System readiness
 - Claims ingestion & processing
 - Data delivery to vendors
 - ▶ Vendor implementation & integration
 - ▶ Policies & Procedures (P&Ps) to support compliance
 - ▶ Provider education planning
 - ▶ In-home assessment (IHA) planning
 - ▶ Alliance risk adjustment training

Thank You!

Questions?

APPENDIX

HEDIS Star Measures

Measure	Reported in Medi-Cal	Reported in D-SNP	Weight	1 star	2 star	3 star	4 star	5 star
Breast Cancer Screening	✓	✓	1	< 53%	>= 53% to < 67%	>= 67% to < 75%	>= 75% to < 82%	>= 82%
Diabetes Care – Blood Sugar Controlled	✓	✓	3	< 49%	>= 49% to < 72%	>= 72% to < 84%	>= 84% to < 90%	>= 90%
Controlling Blood Pressure	✓	✓	3	< 69%	>= 69% to < 74%	>= 74% to < 80%	>= 80% to < 85%	>= 85%
Colorectal Cancer Screening	✓	✓	1	< 53%	>= 53% to < 65%	>= 65% to < 75%	>= 75% to < 83%	>= 83%
Diabetes Care – Eye Exam	✓	✓	1	< 57%	>= 57% to < 70%	>= 70% to < 77%	>= 77% to < 83%	>= 83%
Kidney Health Evaluation for Patients with Diabetes	✓	✓	1	N/A	N/A	N/A	N/A	N/A
Statin Therapy for Patients with CVD	✓	✓	1	< 81%	>= 81% to < 85%	>= 85% to < 88%	>= 88% to < 92%	>= 92%
COA Functional Status*	✗	✓	1	N/A	N/A	N/A	N/A	N/A
COA Med Review	✗	✓	1	< 53%	>= 53% to < 80%	>= 80% to < 92%	>= 92% to < 98%	>= 98%
F/U after ED Visit – Multiple Chronic Conditions	✗	✓	1	< 39%	>= 39% to < 53%	>= 53% to < 60%	>= 60% to < 69%	>= 69%
Osteoporosis Mgt. in Women who had a Fracture	✗	✓	1	< 27%	>= 27% to < 39%	>= 39% to < 52%	>= 52% to < 71%	>= 71%
Plan All-Cause Readmissions	✗	✓	3	< 14%	>= 12% to < 14%	>= 10% to < 12%	>= 8% to < 10%	>= 8%
Transitions of Care	✗	✓	1	< 44%	>= 44% to < 52%	>= 52% to < 63%	>= 63% to < 77%	>= 77%

Note:

- *New measures without established cut points
- Table references Stars measure cut points from CMS 2025 technical notes on 10.03.2024
- CMS reserves the right to change measures and cut points

CAHPS & HOS Star Measures

Measure	Reported in Medi-Cal	Reported in D-SNP	Weight	1 star	2 star	3 star	4 star	5 star
Annual Flu Vaccine	✓	✓	1	< 61%	>= 61% to < 65%	>= 65% to < 71%	>= 71% to < 76%	>= 76%
Getting Needed Care	✓	✓	2	< 77%	>= 77% to < 79%	>= 79% to < 82%	>= 82% to < 83%	>= 83%
Getting Appointments and Care Quickly	✓	✓	2	< 80%	>= 80% to < 82%	>= 82% to < 84%	>= 84% to < 86%	>= 86%
Customer Service	✓	✓	2	< 88%	>= 88% to < 89%	>= 89% to < 91%	>= 91% to < 92%	>= 92%
Rating of Health Care Quality	✗	✓	2	< 84%	>= 84% to < 85%	>= 85% to < 87%	>= 87% to < 88%	>= 88%
Rating of Health Plan	✗	✓	2	< 84%	>= 84% to < 86%	>= 86% to < 88%	>= 88% to < 89%	>= 89%
Care Coordination	✓	✓	2	< 84%	>= 84% to < 85%	>= 85% to < 87%	>= 87% to < 88%	>= 88%
Monitoring Physical Activity	✗	✓	1	< 41%	>= 41% to < 47%	>= 47% to < 52%	>= 52% to < 60%	>= 60%
Reduce the Risk of Falling	✗	✓	1	< 50%	>= 50% to < 56%	>= 56% to < 63%	>= 63% to < 73%	>= 73%
Improving Bladder Control	✗	✓	1	< 39%	>= 39% to < 44%	>= 44% to < 48%	>= 48% to < 52%	>= 52%
Improving/Maintaining Physical Health*	✗	✓	3	N/A	N/A	N/A	N/A	N/A
Improving/Maintaining Mental Health*	✗	✓	3	N/A	N/A	N/A	N/A	N/A
Rating of Drug Plan	✗	✓	2	< 84%	>= 84% to < 86%	>= 86% to < 87%	>= 87% to < 89%	>= 89%
Getting Needed Prescription Drugs	✗	✓	2	< 87	>= 87 to < 88	>= 88 to < 90	>= 90 to < 91	>= 91

Note:

- *New measures without established cut points
- Table references Stars measure cut points from CMS 2025 technical notes on 10.03.2024
- CMS reserves the right to change measures and cut points

Part D Star Measures

Measure	Reported in Medi-Cal	Reported in D-SNP	Weight	1 star	2 star	3 star	4 star	5 star
Statin Use in Person with Diabetes	✗	✓	1	< 81%	>= 81% to < 86%	>= 86% to < 89%	>= 89% to < 93%	>= 93%
Med Adherence for Diabetes	✗	✓	3	< 80%	>= 80% to < 85	>= 85% to < 87	>= 87% to < 91%	>= 91%
Med Adherence for Hypertension (RAS antagonists)	✗	✓	3	< 83%	>= 83% to < 87%	>= 87% to < 90%	>= 90% to < 92%	>= 92%
Med Adherence for Cholesterol (Statins)	✗	✓	3	< 80%	>= 80% to < 85%	>= 85% to < 89%	>= 89% to < 93%	>= 93%
MPF Price Accuracy	✗	✓	1	< 97	>= 97 to < 98	>= 98 to < 99	>= 99 to < 100	100
MTM Program Completion Rate for CMR	✗	✓	1	< 57 %	>= 5 % to < 77%	>= 77% to < 89%	>= 89% to < 93%	>= 93%
Concurrent Use of Opioids and Benzodiazepines*	✗	✓	1	N/A	N/A	N/A	N/A	N/A
Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults*	✗	✓	1	N/A	N/A	N/A	N/A	N/A

Note:

- *New measures without established cut points
- Table references Stars measure cut points from CMS 2025 technical notes on 10.03.2024
- CMS reserves the right to change measures and cut points

Admin Ops Star Measures

Measure	Reported in Medi-Cal	Reported in D-SNP	Weight	1 star	2 star	3 star	4 star	5 star
Special Needs Care Management	❌	✅	1	< 46%	>= 46% to < 62%	>= 62% to < 76%	>= 76% to < 89%	>= 89%
Complaints about the Health Plan – Part C	❌	✅	2	>1.39	>.76 to <= 1.39	>.37 to <=.76	>.12 to <=.37	<= 12
Complaints about the Drug Plan – Part D	❌	✅	1	> 1.39	> 0.76 to <= 1.39	>.37 to <=.76	> 0.12 to <= 0.37	<= 0.12
Members Choosing to Leave the Plan – Part C	❌	✅	2	> 36%	>24% to <= 36%	> 17% to <=24%	>8% to <= 17%	<= 8%
Members Choosing to Leave the Plan – Part D	❌	✅	2	> 36%	>24% to <= 36%	> 17% to <=24%	>8% to <= 17%	<= 8%
Plan Makes Timely Decisions about Appeals	❌	✅	2	< 69%	>= 69% to < 85 %	>= 85% to < 95 %	>= 95% to < 99%	>= 99%
Review Appeals Decisions	❌	✅	2	< 78%	>= 78% to < 92%	>= 92% to < 96%	>= 96% to < 99%	>= 99%
Call Center – Foreign Language Interpreter and TTY Availability – Part C	❌	✅	1	< 46%	>= 46% to < 69%	>= 69% to < 93%	>= 93% to < 100%	100%
Call Center – Foreign Language Interpreter and TTY Availability – Part D	❌	✅	1	< 40 %	>= 40% to < 74%	>= 74% to < 90%	>= 90% to < 100%	100%
Health Plan Quality Improvement – Part C	❌	✅	5	< -0.179809	>= -0.179809 to < 0	>= 0 to < 0.174445	>= 0.174 to < 0.421	>= 0.421
Drug Plan Quality Improvement - Part D	❌	✅	5	< -0.218869	>= -0.218869 to < 0	>= 0 to < 0.242468	>= 0.242 to < 0.496	>= 0.496

Note:

- Table references Stars measure cut points from CMS 2025 technical notes on 10.03.2024
- CMS reserves the right to change measures and cut points



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Finance

Gil Riojas

To: Alameda Alliance for Health, Board of Governors

From: Gil Riojas, Chief Financial Officer

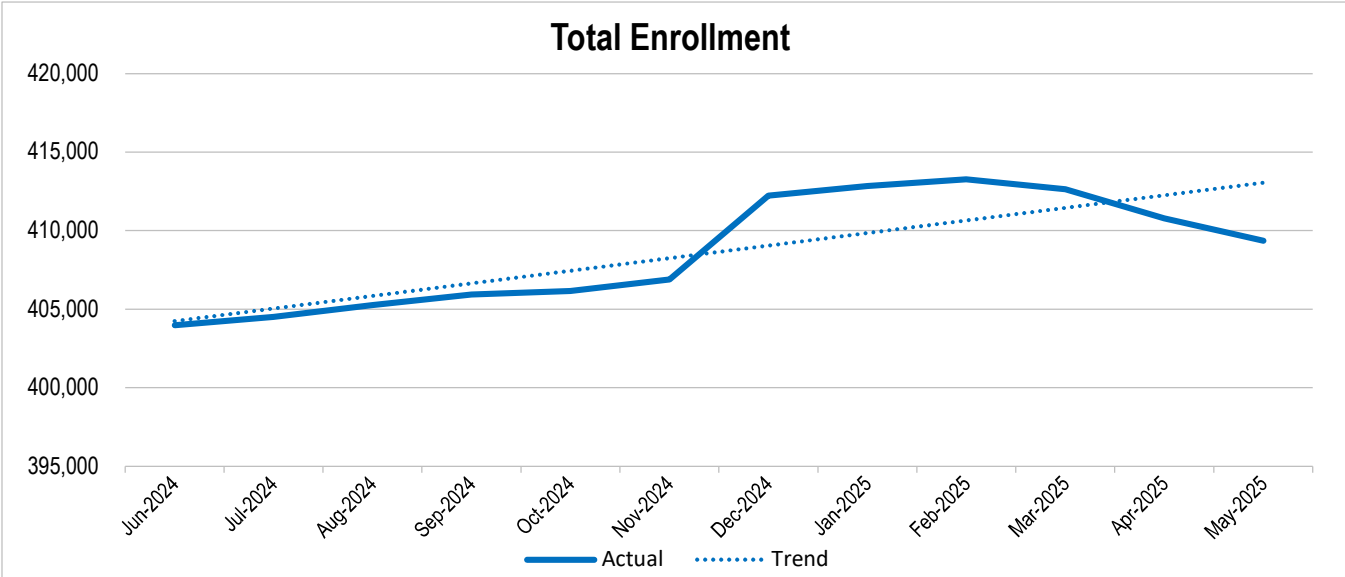
Date: July 11th, 2025

Subject: Finance Report – May 2025 Financials

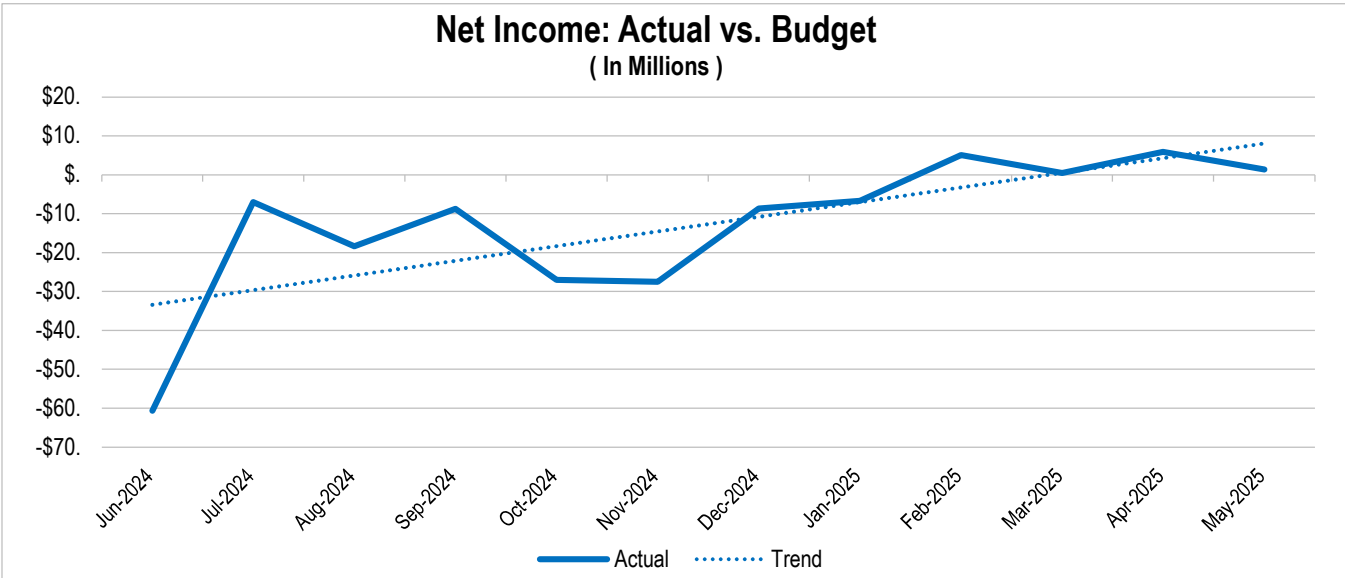
Executive Summary

For the month of May, the Alliance dipped slightly in enrollment, reaching 409,358 members. Net Income of \$1.4 million was reported, and the Plan's Medical Expenses represented 95.5% of Premium Revenue. Alliance reserves increased slightly to 203% of required and continue to remain above minimum requirements.

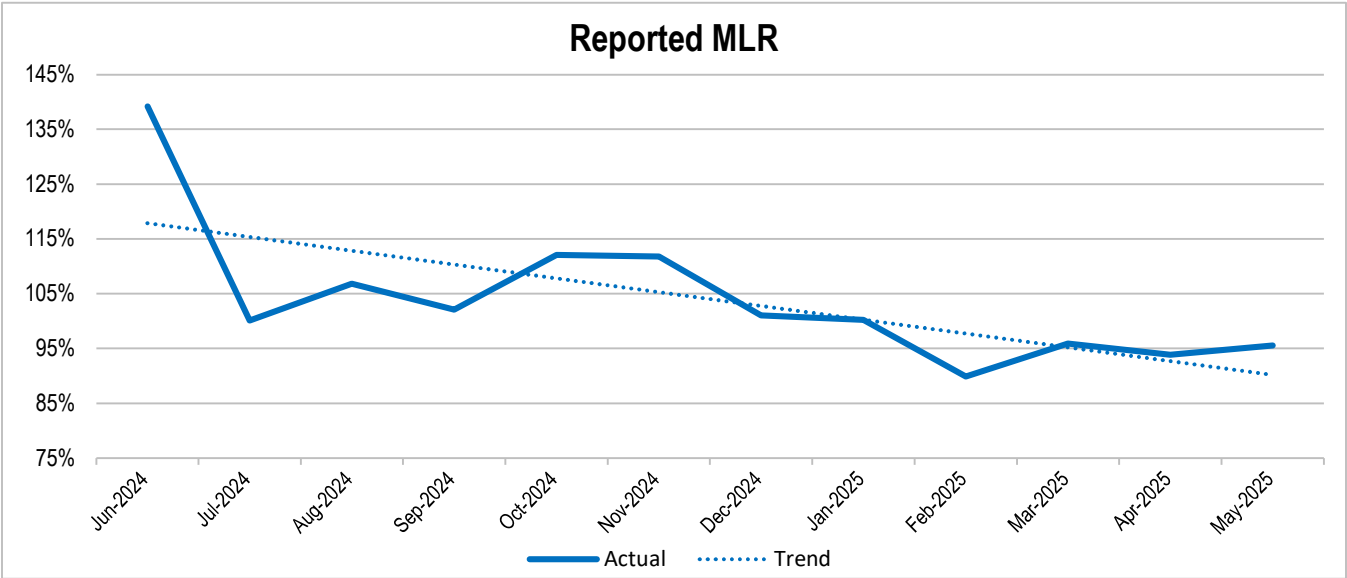
Enrollment – In May, Enrollment decreased by 1,426 members.



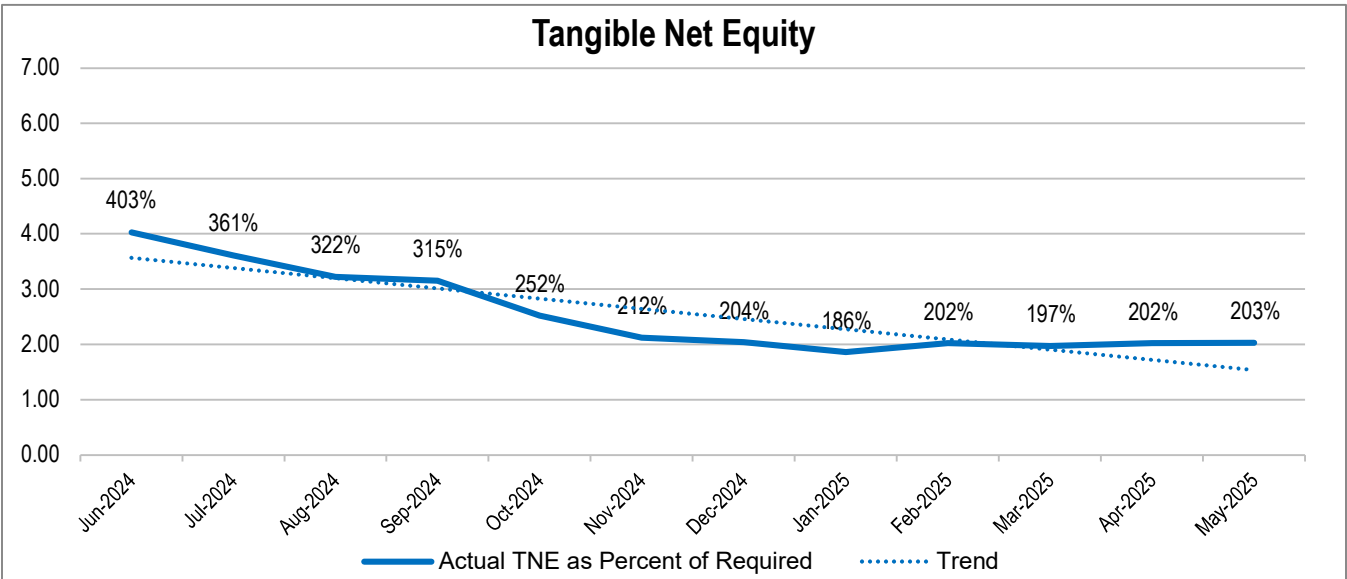
Net Income – For the month ended May, actual Net Income was \$1.4 million vs. budgeted Net Income of \$4.4 million. For the fiscal YTD, actual Net Loss was \$91.0 million vs. budgeted Net Loss of \$68.0 million. For the month, Premium Revenue was unfavorable to budget, actual Revenue was \$189.5 million vs. budgeted Revenue of \$189.7 million. Premium Revenue unfavorable variance of \$147,000 is primarily due to CY2025 Rate Acuity Reserve.



Medical Loss Ratio (MLR) – The Medical Loss Ratio was 95.5% for the month, and 100.6% for fiscal YTD. The major unfavorable variances include Inpatient Hospital FFS, Ancillary FFS Expense, and Long Term Care Expense. The major favorable variances include Outpatient Medical Expense, Primary Care Expense, and Reinsurance Expense.



Tangible Net Equity (TNE) - The Department of Managed Health Care (DMHC) required \$80.9 million in reserves, we reported \$164.4 million. Our overall TNE remains above DMHC requirements at 203%.



The Alliance continues to benefit from increased non-operating income. For Fiscal year-to-date investments show a gain of \$29.9 million. Capital assets acquired so far are \$859,000.

To: Alameda Alliance for Health Board of Governors

From: Gil Riojas, Chief Financial Officer

Date: July 11th, 2025

Subject: Finance Report – May 2025

Executive Summary

- For the month ended May 31st, 2025, the Alliance had enrollment of 409,358 members, a Net Income of \$1.4 million and 203% of required Tangible Net Equity (TNE).

Overall Results: (in Thousands)		
	Month	YTD
Revenue	\$254,712	\$2,758,738
Medical Expense	181,035	1,959,592
Admin. Expense	8,968	104,422
MCO Tax Expense	65,185	815,596
Other Inc. / (Exp.)	1,831	29,864
Net Income	\$1,356	(\$91,008)

Net Income by Program: (in Thousands)		
	Month	YTD
Medi-Cal	\$2,278	(\$83,148)
Group Care	(426)	(38)
Medicare	(496)	(7,822)
	\$5,939	(\$92,364)

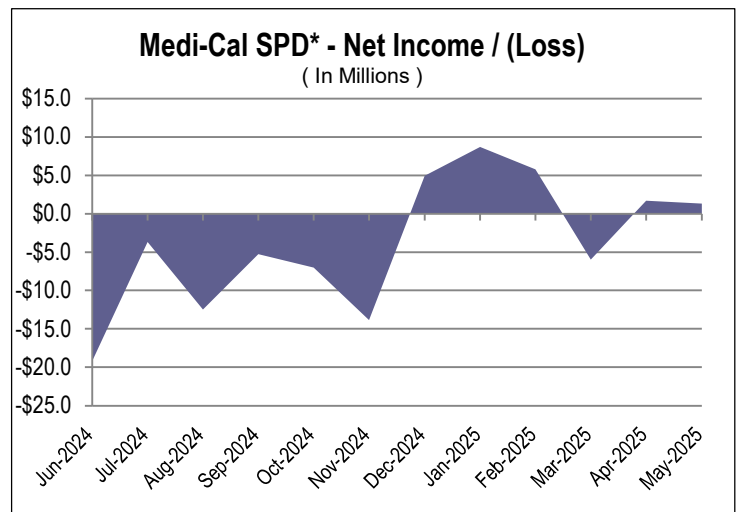
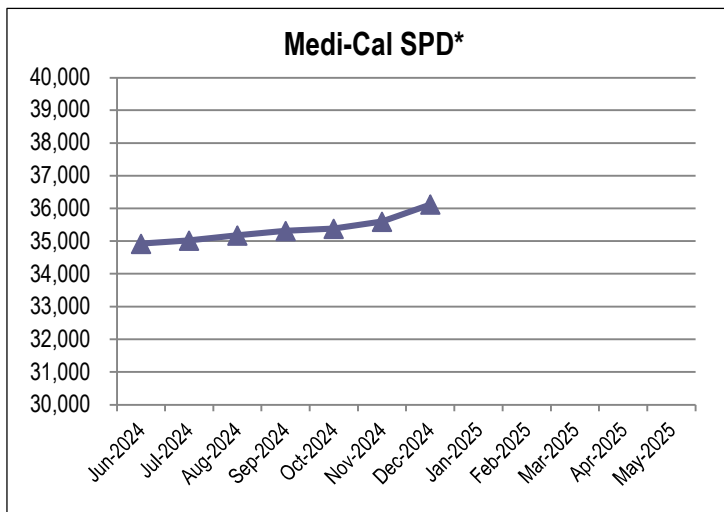
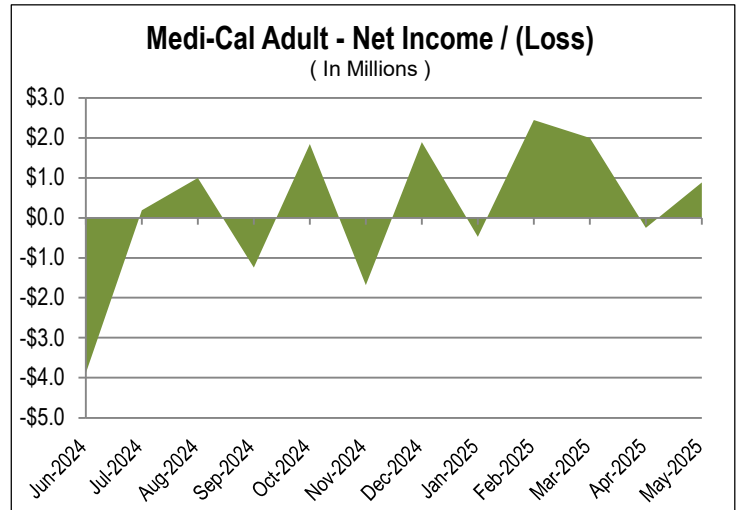
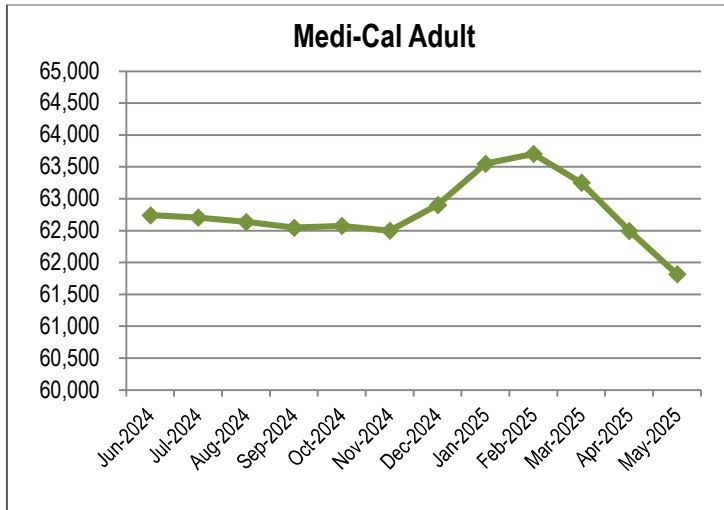
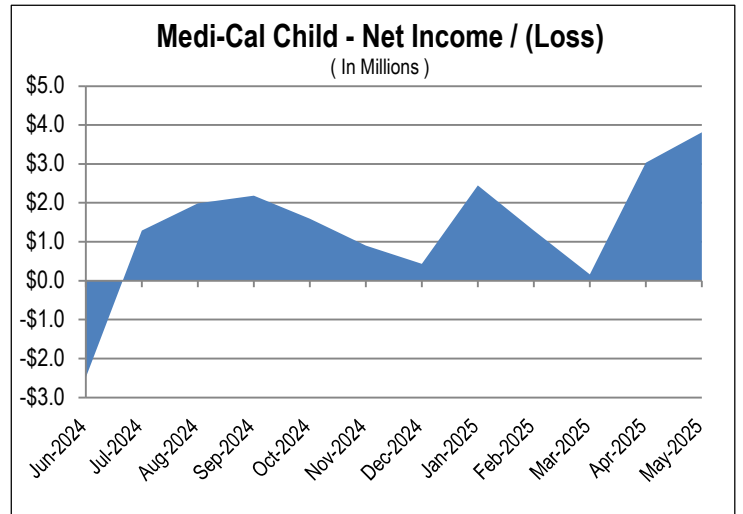
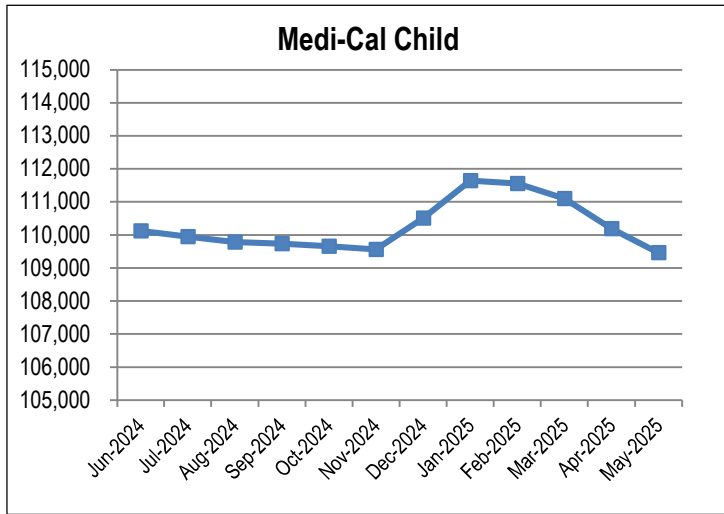
Enrollment

- Total enrollment decreased by 1,426 members since April 2025.
- Total enrollment increased by 5,368 members since June 2024.

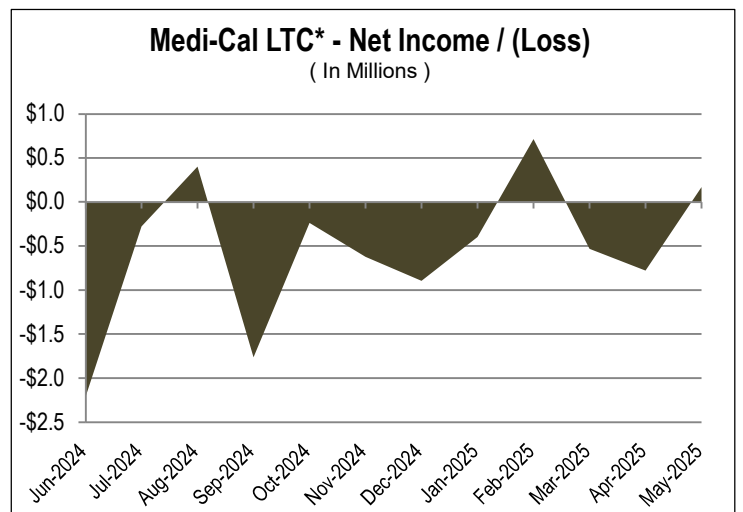
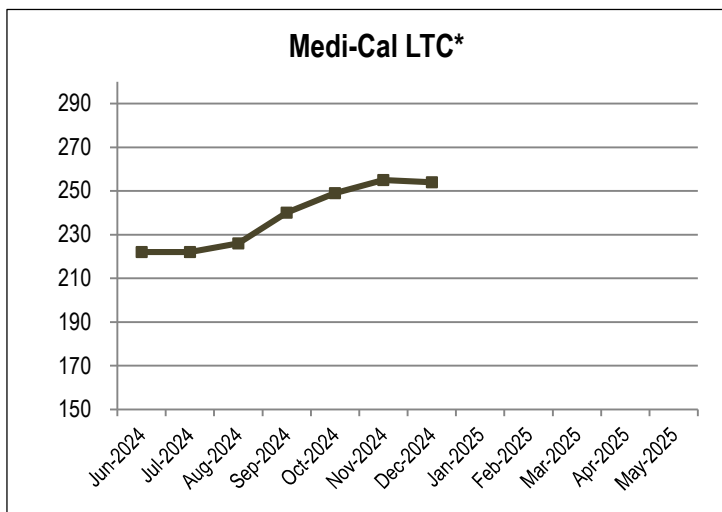
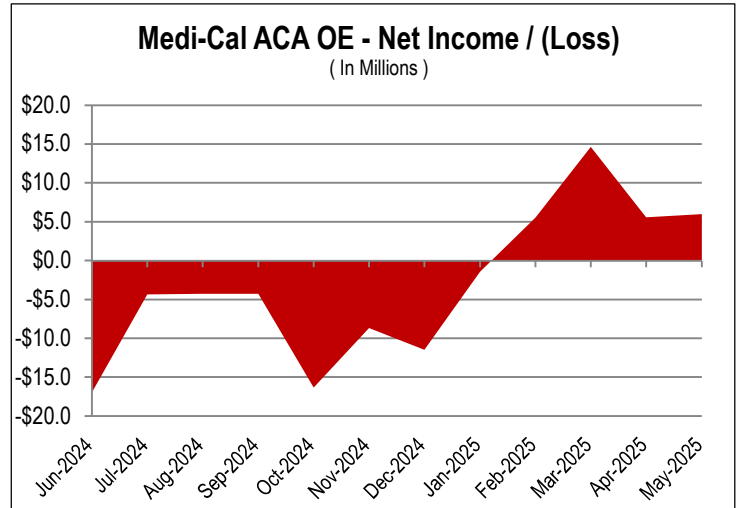
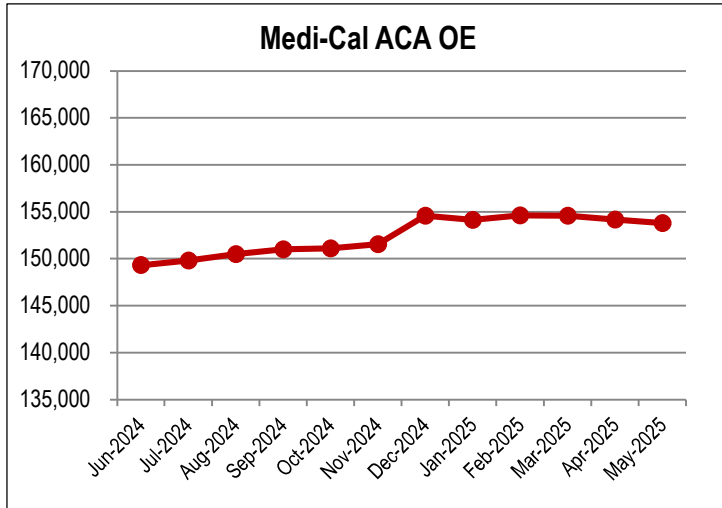
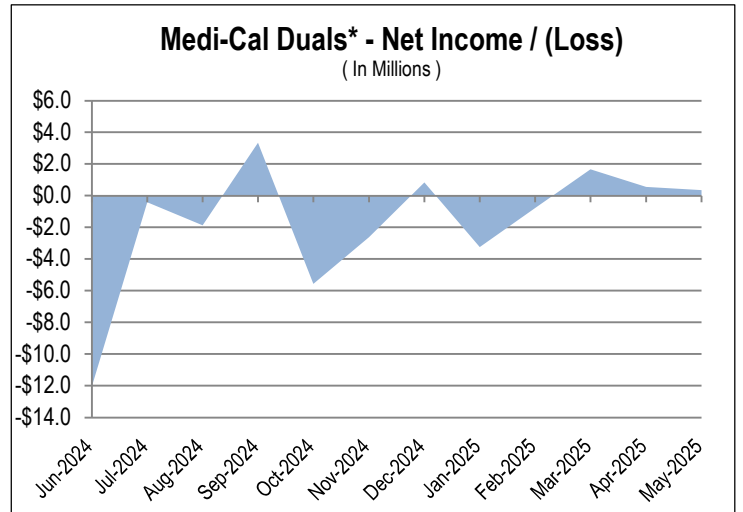
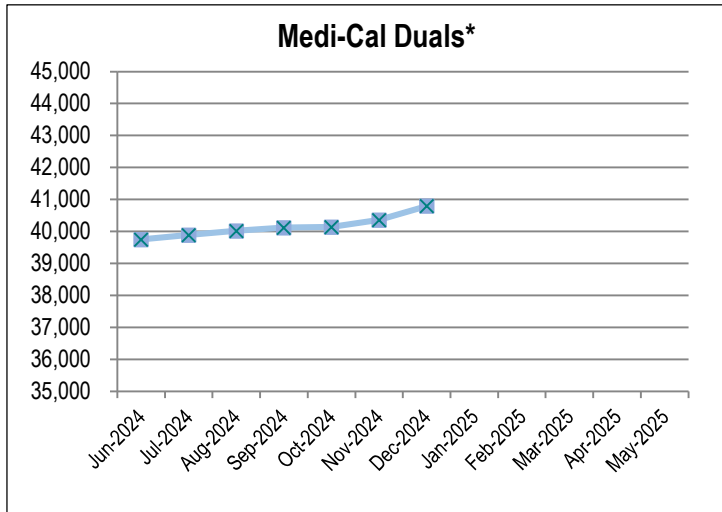
Monthly Membership and YTD Member Months								
Actual vs. Budget								
Enrollment				Medi-Cal:	Member Months			
Current Month					Year-to-Date			
Actual	Budget	Variance	Variance %		Actual	Budget	Variance	Variance %
109,459	110,542	(1,083)	(1.0%)		Child	1,213,140	1,210,392	2,748
61,818	63,019	(1,201)	(1.9%)	Adult	690,715	690,287	428	0.1%
0	0	0	100.0%	SPD*	212,632	211,783	849	0.4%
0	0	0	100.0%	Duals*	241,339	240,472	867	0.4%
153,782	152,159	1,623	1.1%	ACA OE	1,679,745	1,664,310	15,435	0.9%
0	0	0	100.0%	MCAL LTC*	1,446	1,442	4	0.3%
0	0	0	100.0%	MCAL LTC Duals*	7,562	7,540	22	0.3%
29,455	30,896	(1,441)	(4.7%)	SPD with LTC	147,437	164,120	(16,683)	(10.2%)
48,957	46,416	2,541	5.5%	Duals with LTC	242,169	222,070	20,099	9.1%
403,471	403,032	439	0.1%	Medi-Cal Total	4,436,185	4,412,416	23,769	0.5%
5,887	5,769	118	2.0%	Group Care	63,658	63,223	435	0.7%
409,358	408,801	557	0.1%	Total	4,499,843	4,475,639	24,204	0.5%

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

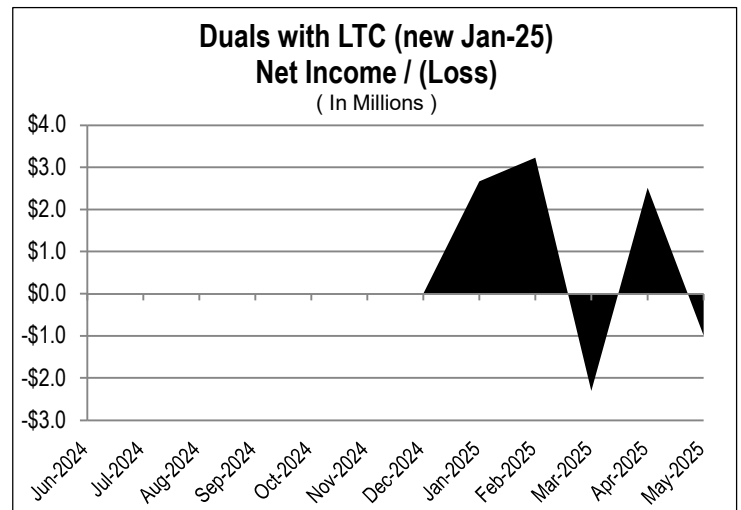
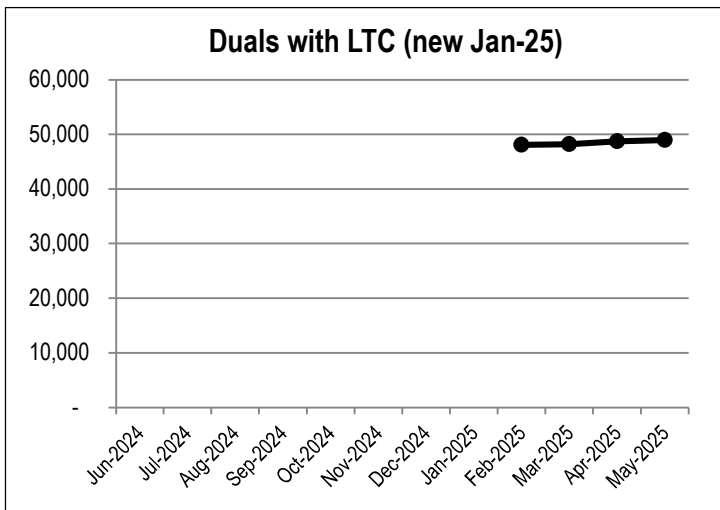
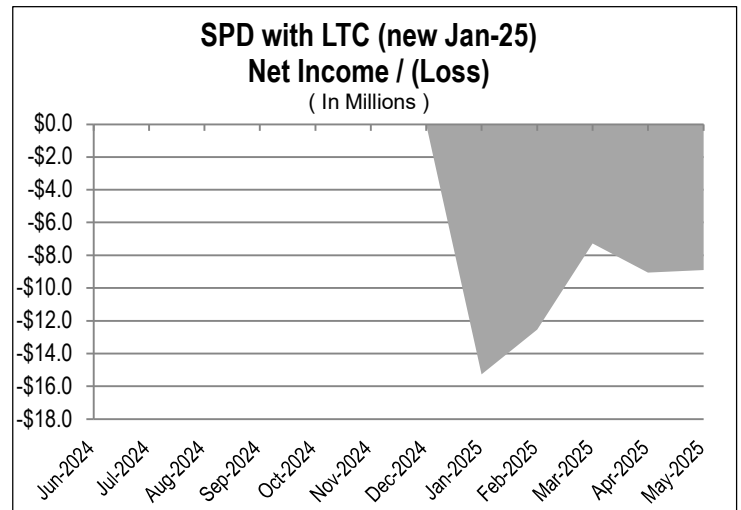
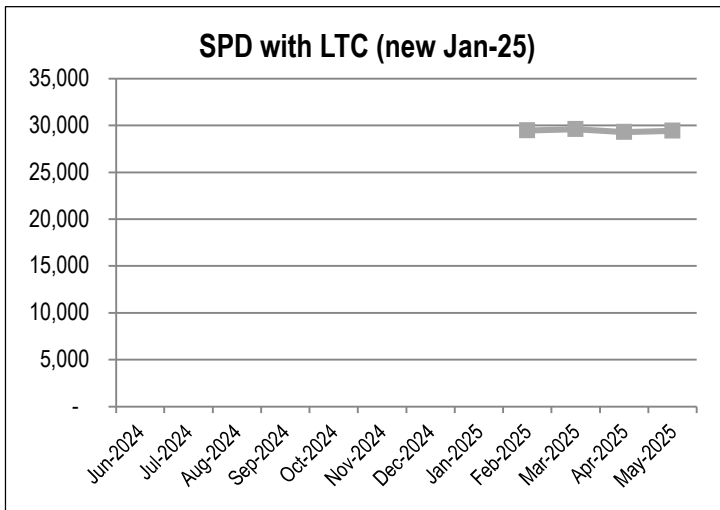
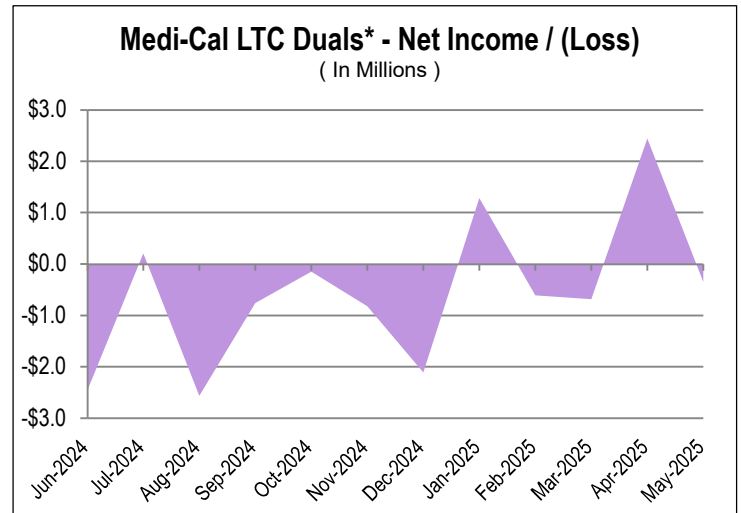
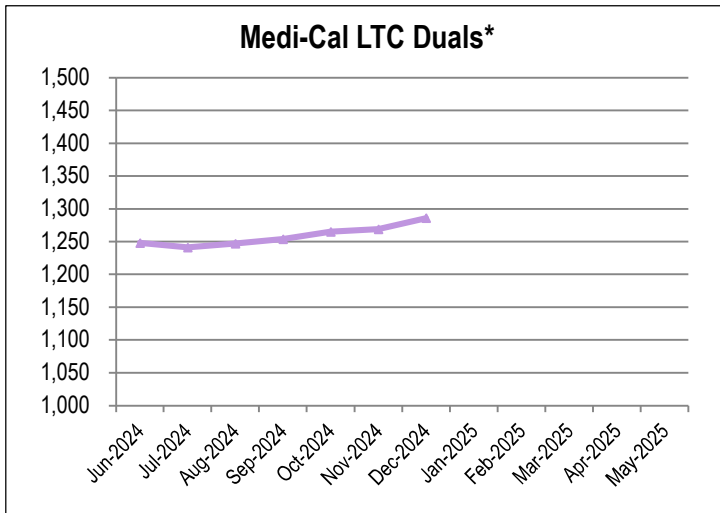
Enrollment and Profitability by Program and Category of Aid



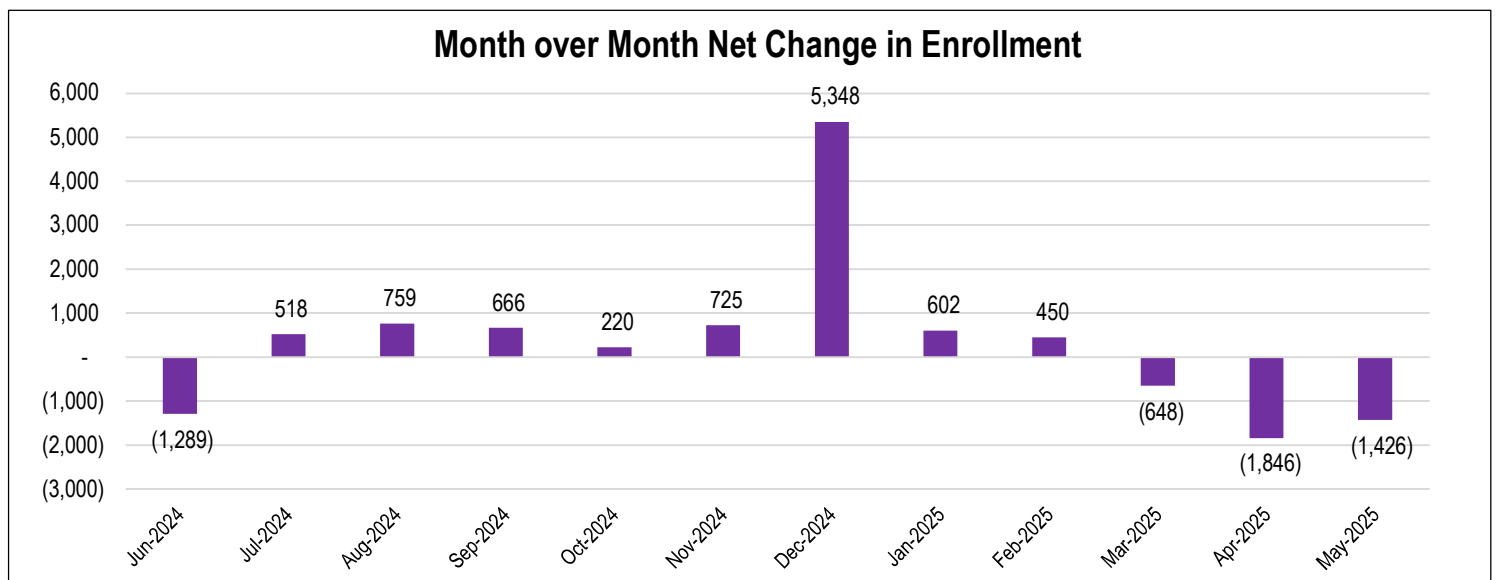
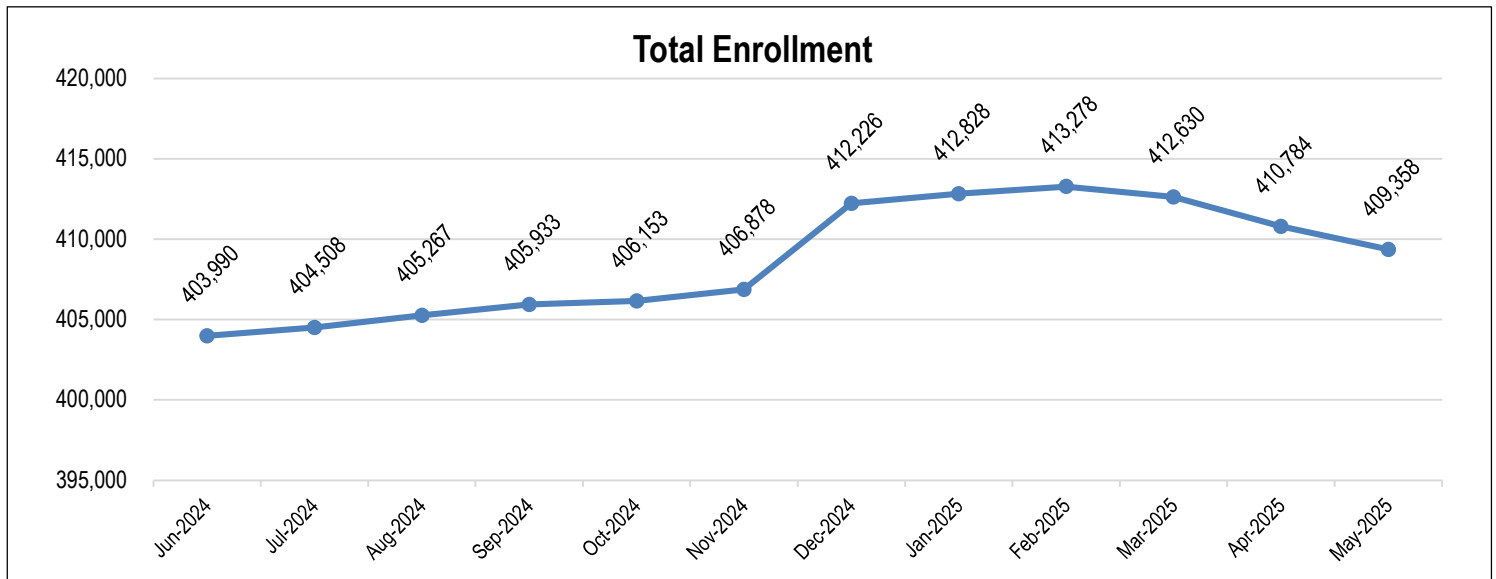
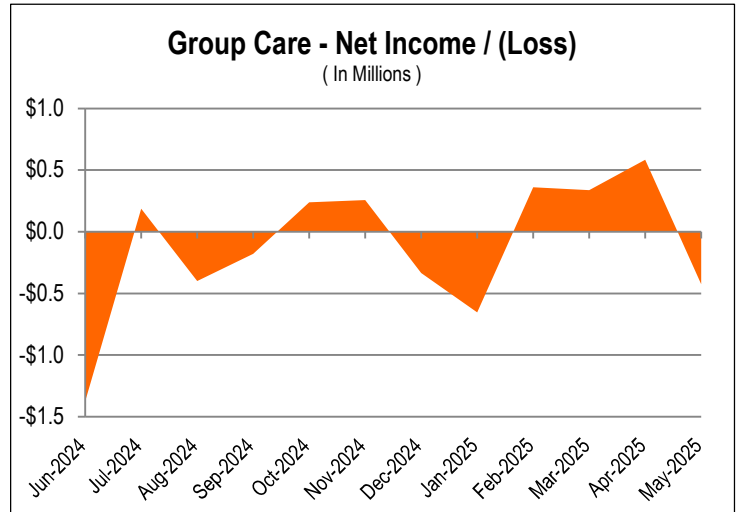
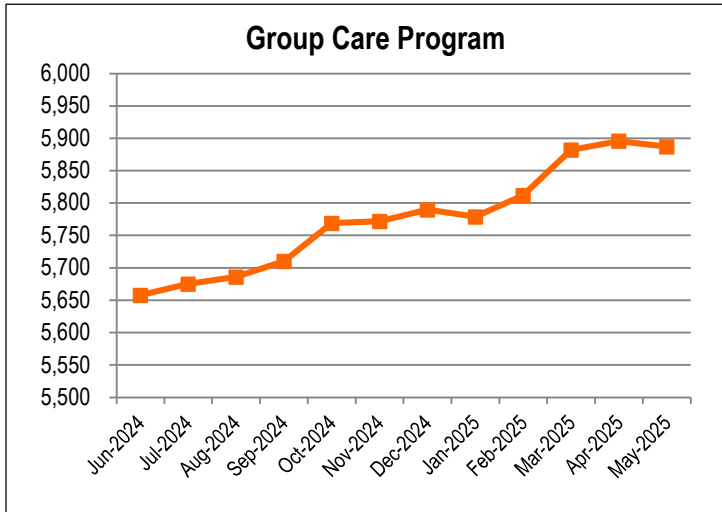
Enrollment and Profitability by Program and Category of Aid



Enrollment and Profitability by Program and Category of Aid

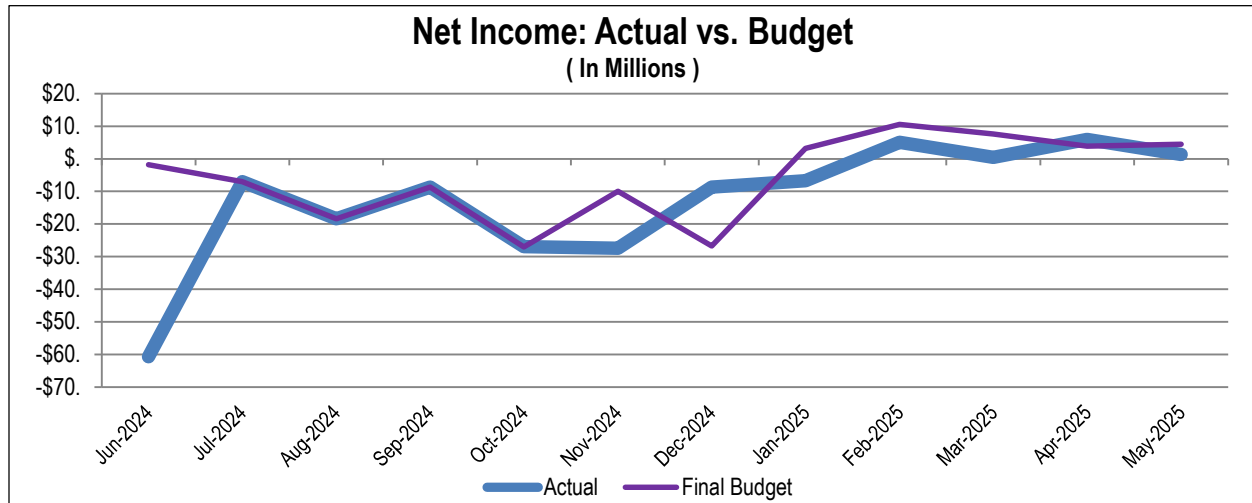


Enrollment and Profitability by Program and Category of Aid



Net Income

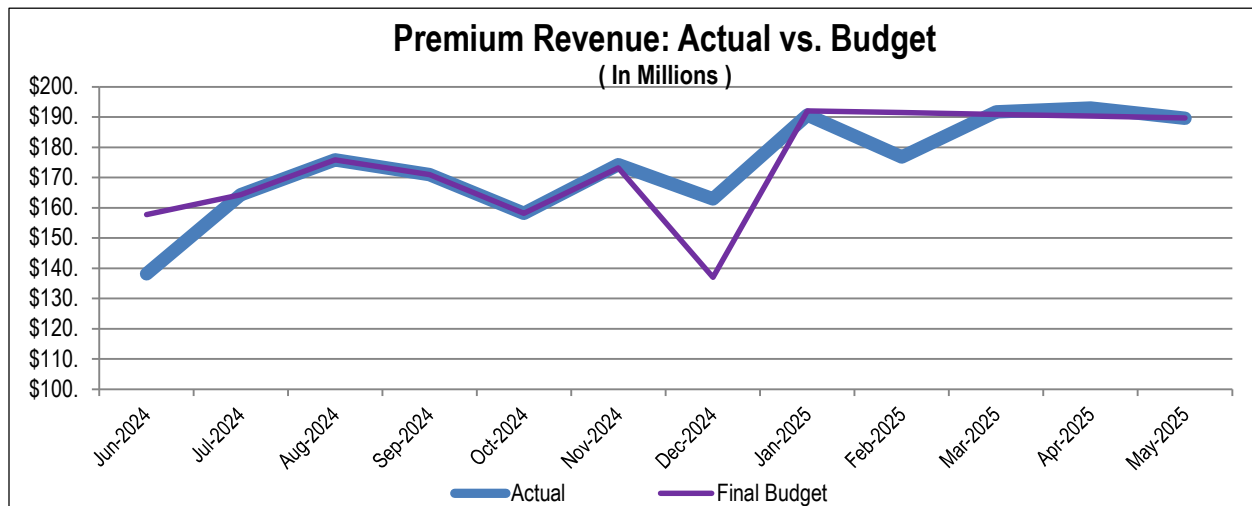
- For the month ended May 31st, 2025:
 - Actual Net Income: \$1.4 million.
 - Budgeted Net Income: \$4.4 million.
- For the fiscal YTD ended May 31st, 2025:
 - Actual Net Loss: \$91.0 million.
 - Budgeted Net Loss: \$68.0 million.



- The unfavorable variance of \$3.1 million in the current month is primarily due to:
 - Favorable \$1.8 million lower than anticipated MCO Tax Expense
 - Favorable \$1.2 million higher than anticipated MCO Tax Revenue.
 - Unfavorable \$6.5 million higher than anticipated Medical Expense.

Premium Revenue

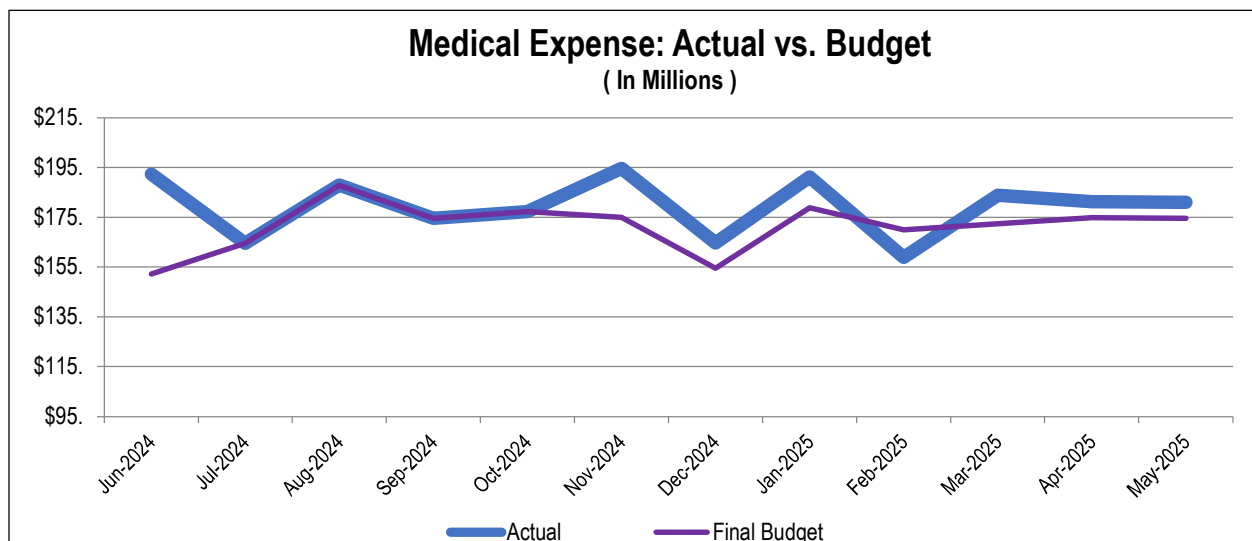
- For the month ended May 31st, 2025:
 - Actual Revenue: \$189.5 million.
 - Budgeted Revenue: \$189.7 million.
- For the fiscal YTD ended May 31st, 2025:
 - Actual Revenue: \$1.9 billion.
 - Budgeted Revenue: \$1.9 billion.



- For the month ended May 31st, 2025, the unfavorable Premium Revenue variance of \$147,000 is primarily due to the following:
 - Favorable Retroactive Medi-Cal Member Months.
 - Favorable Blended Medi-Cal Capitation Rate Variance.
 - Unfavorable CY2025 Rate Acuity Reserve.

Medical Expense

- For the month ended May 31st, 2025:
 - Actual Medical Expense: \$181.0 million.
 - Budgeted Medical Expense: \$174.6 million.
- For the fiscal YTD ended May 31st, 2025:
 - Actual Medical Expense: \$2.0 billion.
 - Budgeted Medical Expense: \$1.9 billion.



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

- For May, updates to Fee-For-Service (FFS) decreased the estimate for prior period unpaid Medical Expenses by \$3.1 million. Year to date, the estimate for prior years increased by \$12.6 million (per table below).

Medical Expense - Actual vs. Budget (In Dollars)						
Adjusted to Eliminate the Impact of Prior Period IBNP Estimates						
	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	<u>Adjusted</u>	<u>Change in IBNP</u>	<u>Reported</u>		\$	%
Capitated Medical Expense	\$196,640,091	\$0	\$196,640,091	\$183,573,762	(\$13,066,329)	(7.1%)
Primary Care FFS	\$31,552,266	\$160,187	\$31,712,453	\$41,075,907	\$9,523,641	23.2%
Specialty Care FFS	\$89,924,493	\$482,036	\$90,406,529	\$90,892,954	\$968,461	1.1%
Outpatient FFS	\$135,537,636	\$954,772	\$136,492,408	\$130,414,098	(\$5,123,538)	(3.9%)
Ancillary FFS	\$201,821,015	(\$344,655)	\$201,476,360	\$198,132,794	(\$3,688,221)	(1.9%)
Pharmacy FFS	\$141,052,451	\$330,717	\$141,383,168	\$141,175,681	\$123,230	0.1%
ER Services FFS	\$114,818,492	\$682,330	\$115,500,821	\$115,115,556	\$297,065	0.3%
Inpatient Hospital FFS	\$603,883,921	\$6,450,390	\$610,334,311	\$577,732,654	(\$26,151,268)	(4.5%)
Long Term Care & SNF FFS	\$381,609,743	\$3,870,000	\$385,479,742	\$367,523,307	(\$14,086,435)	(3.8%)
Other Benefits & Services	\$52,178,231	\$0	\$52,178,231	\$55,210,160	\$3,031,929	5.5%
Net Reinsurance	(\$2,011,685)	\$0	(\$2,011,685)	\$3,313,716	\$5,325,401	160.7%
	\$1,947,006,654	\$12,585,776	\$1,959,592,431	\$1,904,160,591	(\$42,846,063)	(2.3%)

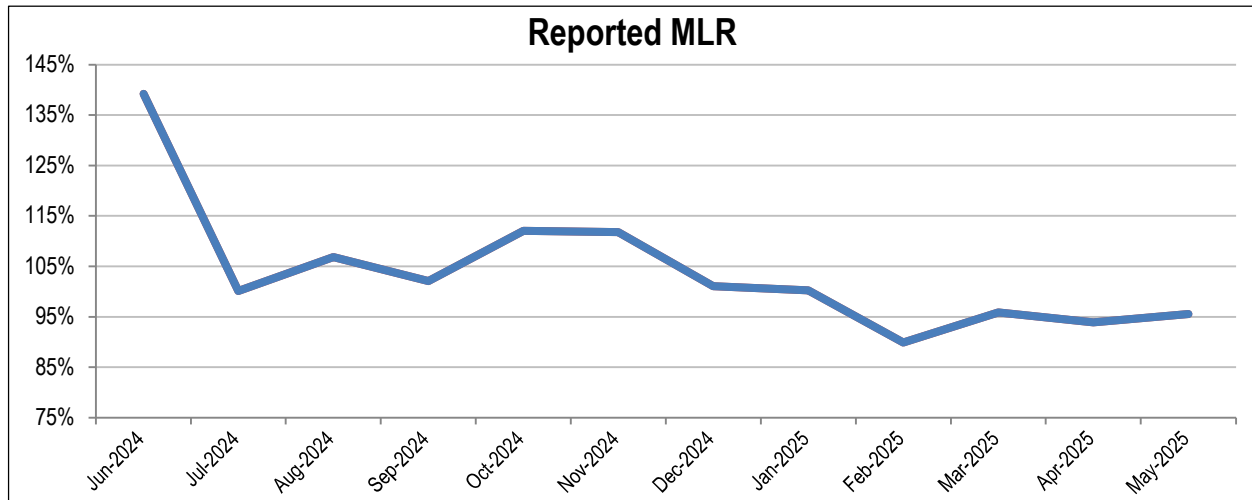
Medical Expense - Actual vs. Budget (Per Member Per Month)						
Adjusted to Eliminate the Impact of Prior Year IBNP Estimates						
	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	<u>Adjusted</u>	<u>Change in IBNP</u>	<u>Reported</u>		\$	%
Capitated Medical Expense	\$43.70	\$0.00	\$43.70	\$41.02	(\$2.68)	(6.5%)
Primary Care FFS	\$7.01	\$0.04	\$7.05	\$9.18	\$2.17	23.6%
Specialty Care FFS	\$19.98	\$0.11	\$20.09	\$20.31	\$0.32	1.6%
Outpatient FFS	\$30.12	\$0.21	\$30.33	\$29.14	(\$0.98)	(3.4%)
Ancillary FFS	\$44.85	(\$0.08)	\$44.77	\$44.27	(\$0.58)	(1.3%)
Pharmacy FFS	\$31.35	\$0.07	\$31.42	\$31.54	\$0.20	0.6%
ER Services FFS	\$25.52	\$0.15	\$25.67	\$25.72	\$0.20	0.8%
Inpatient Hospital & SNF FFS	\$134.20	\$1.43	\$135.63	\$129.08	(\$5.12)	(4.0%)
Long Term Care & SNF FFS	\$84.81	\$0.86	\$85.67	\$82.12	(\$2.69)	(3.3%)
Other Benefits & Services	\$11.60	\$0.00	\$11.60	\$12.34	\$0.74	6.0%
Net Reinsurance	(\$0.45)	\$0.00	(\$0.45)	\$0.74	\$1.19	160.4%
	\$432.68	\$2.80	\$435.48	\$425.45	(\$7.23)	(1.7%)

- Excluding the impact of prior year estimates for IBNP, year-to-date medical expense variance is \$42.8 million unfavorable to budget. On a PMPM basis, medical expense is 1.7% unfavorable to budget. For per-member-per-month expense:

- Capitated Expense is over budget due to inclusion of Targeted Rate Increases (TRI) in capitation payments.
- Primary Care Expense is under budget due to lower utilization in the ACA OE, Child, Adult and SPD aid code categories.
- Specialty Care Expense is slightly below budget, driven by lower SPD, Child and ACA OE unit cost and Adult utilization.
- Outpatient Expense is over budget mostly driven by lab and radiology unit cost and dialysis and facility other utilization in the SPD with LTC, ACA OE and Adult aid code categories and the Group Care population.
- Ancillary Expense is over budget due to higher Behavioral Health utilization in the Child aid code category.
- Pharmacy Expense is under budget due to lower Non-PBM utilization in the SPD and ACA OE categories of aid.
- Emergency Room Expense is slightly under budget driven by lower than expected unit cost across most populations.
- Inpatient Expense is over budget driven by higher utilization in the SPD with LTC, Duals with LTC, Adult, and ACA OE aid code categories.
- Long Term Care Expense is over budget due to higher unit cost in the Duals with LTC Duals aid code category.
- Other Benefits & Services is under budget, due to lower than expected employee, professional services and community relations expense.
- Net Reinsurance is under budget because more recoveries were received than expected.

Medical Loss Ratio (MLR)

The Medical Loss Ratio (total reported Medical Expense divided by Premium Revenue) was 95.5% for the month and 100.6% for the fiscal year-to-date.



Administrative Expense

- For the month ended May 31st, 2025:
 - Actual Administrative Expense: \$9.0 million.
 - Budgeted Administrative Expense: \$9.2 million.
- For the fiscal YTD ended May 31st, 2025:
 - Actual Administrative Expense: \$104.4 million.
 - Budgeted Administrative Expense: \$110.2 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 %	
\$6,388,914	\$5,942,439	(\$446,475)	(7.5%)		Personnel Expense	\$63,871,311	\$64,532,523	\$661,212	1.0%
78,996	75,162	(3,833)	(5.1%)		Medical Benefits Admin Expense	865,214	829,973	(35,241)	(4.2%)
1,634,858	1,832,558	197,700	10.8%		Purchased & Professional Services	22,167,691	26,570,311	4,402,620	16.6%
865,299	1,331,756	466,457	35.0%		Other Admin Expense	17,517,661	18,303,396	785,735	4.3%
\$8,968,066	\$9,181,916	\$213,849	2.3%		Total Administrative Expense	\$104,421,877	\$110,236,203	\$5,814,326	5.3%

The year-to-date variances include:

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

The Administrative Loss Ratio (ALR) is 4.7% of net revenue for the month and 5.4% of net revenue year-to-date. Fiscal year-to-date claims interest expense, due to delayed payment of certain claims, or recalculated interest on previously paid claims is \$1.5 million.

Other Income / (Expense)

Other Income & Expense is comprised primarily of investment income. Fiscal year-to-date net investments show a gain of \$29.9 million.

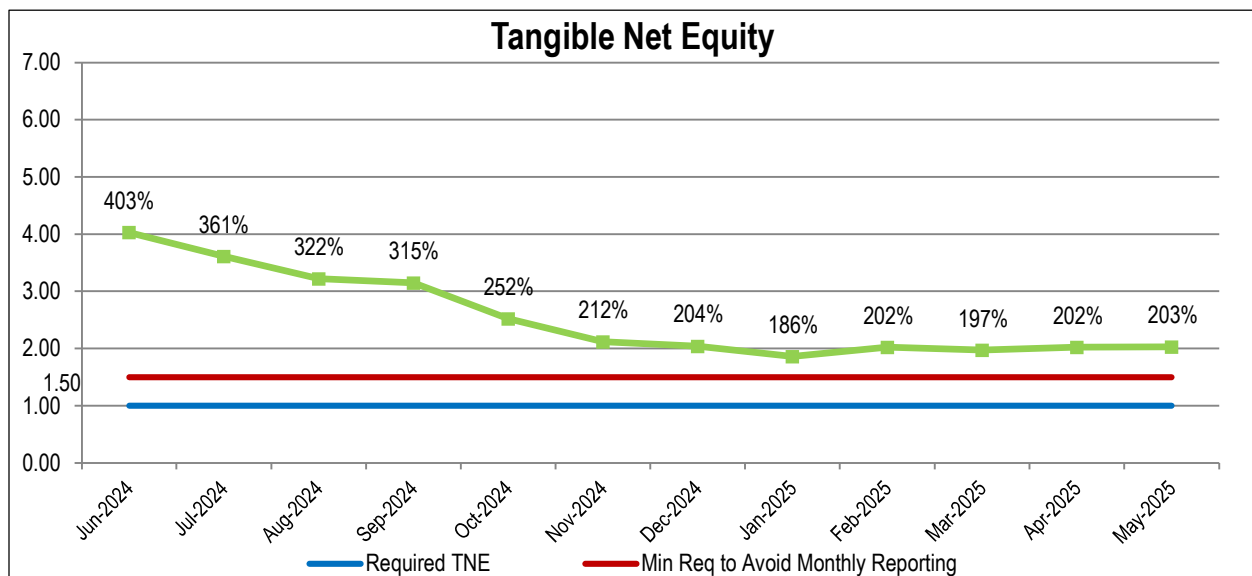
Managed Care Organization (MCO) Provider Tax

- Revenue:
 - For the month ended May 31st, 2025:
 - Actual: \$65.2 million.
 - Budgeted: \$64.0 million.

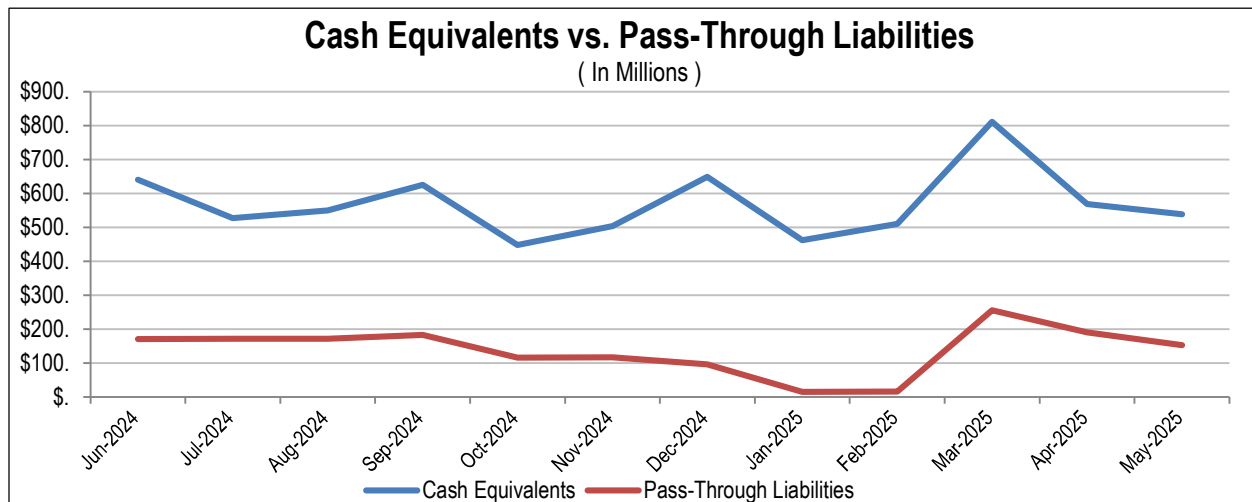
- For the fiscal YTD ended May 31st, 2025:
 - Actual: \$810.6 million.
 - Budgeted: \$798.2 million.
- Expense:
 - For the month ended May 31st, 2025:
 - Actual: \$65.2 million.
 - Budgeted: \$67.0 million.
 - For the fiscal YTD ended May 31st, 2025:
 - Actual: \$815.6 million.
 - Budgeted: \$810.2 million.

Tangible Net Equity (TNE)

- The Department of Managed Health Care (DMHC) monitors the financial stability of health plans to ensure that they can meet their financial obligations to providers. TNE is a calculation of a company's total tangible assets minus a percentage of fee-for-service medical expenses. The Alliance exceeds DMHC's required TNE.
 - Required TNE \$80.9 million
 - Actual TNE \$164.4 million
 - Excess TNE \$83.5 million
 - TNE % of Required TNE 203%



- To ensure appropriate liquidity and limit risk, the majority of Alliance financial assets are kept in short-term investments.
- Key Metrics
 - Cash & Cash Equivalents \$537.9 million
 - Pass-Through Liabilities \$152.4 million
 - Uncommitted Cash \$385.6 million
 - Working Capital \$111.1 million
 - Current Ratio 1.13 (regulatory minimum is 1.00)



Capital Investment

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

Caveats to Financial Statements

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

Finance

Supporting Documents

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

CURRENT MONTH				FISCAL YEAR TO DATE				
Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)
				MEMBERSHIP				
403,471	403,032	439	0.1%	1. Medi-Cal	4,436,185	4,412,416	23,769	0.5%
5,887	5,769	118	2.0%	2. GroupCare	63,658	63,223	435	0.7%
409,358	408,801	557	0.1%	3. TOTAL MEMBER MONTHS	4,499,843	4,475,639	24,204	0.5%
				REVENUE				
\$189,527,103	\$189,673,784	(\$146,681)	(0.1%)	4. Premium Revenue	\$1,948,141,870	\$1,933,917,657	\$14,224,213	0.7%
\$65,184,775	\$63,957,148	\$1,227,627	1.9%	5. MCO Tax Revenue AB119	\$810,596,474	\$798,210,061	\$12,386,413	1.6%
\$254,711,878	\$253,630,932	\$1,080,946	0.4%	6. TOTAL REVENUE	\$2,758,738,344	\$2,732,127,718	\$26,610,626	1.0%
				MEDICAL EXPENSES				
				Capitated Medical Expenses				
\$17,252,382	\$17,061,542	(\$190,839)	(1.1%)	7. Capitated Medical Expense	\$196,640,091	\$183,573,762	(\$13,066,329)	(7.1%)
				Fee for Service Medical Expenses				
\$55,799,885	\$51,402,507	(\$4,397,378)	(8.6%)	8. Inpatient Hospital Expense	\$610,334,311	\$577,732,654	(\$32,601,658)	(5.6%)
\$4,003,818	\$4,675,813	\$671,995	14.4%	9. Primary Care Physician Expense	\$31,712,453	\$41,075,907	\$9,363,455	22.8%
\$8,468,245	\$8,309,721	(\$158,525)	(1.9%)	10. Specialty Care Physician Expense	\$90,406,529	\$90,892,954	\$486,425	0.5%
\$22,153,233	\$19,866,517	(\$2,286,715)	(11.5%)	11. Ancillary Medical Expense	\$201,476,360	\$198,132,794	(\$3,343,566)	(1.7%)
\$10,224,993	\$11,627,035	\$1,402,041	12.1%	12. Outpatient Medical Expense	\$136,492,408	\$130,414,098	(\$6,078,310)	(4.7%)
\$10,771,248	\$10,658,867	(\$112,381)	(1.1%)	13. Emergency Expense	\$115,500,821	\$115,115,556	(\$385,265)	(0.3%)
\$11,862,536	\$11,976,319	\$113,783	1.0%	14. Pharmacy Expense	\$141,383,168	\$141,175,681	(\$207,487)	(0.1%)
\$35,181,079	\$34,071,095	(\$1,109,984)	(3.3%)	15. Long Term Care Expense	\$385,479,742	\$367,523,307	(\$17,956,435)	(4.9%)
\$158,465,037	\$152,587,874	(\$5,877,163)	(3.9%)	16. Total Fee for Service Expense	\$1,712,785,794	\$1,662,062,952	(\$50,722,841)	(3.1%)
\$5,249,062	\$4,494,978	(\$754,084)	(16.8%)	17. Other Benefits & Services	\$52,178,231	\$55,210,160	\$3,031,929	5.5%
\$68,229	\$423,167	\$354,938	83.9%	18. Reinsurance Expense	(\$2,011,685)	\$3,313,716	\$5,325,401	160.7%
\$181,034,710	\$174,567,561	(\$6,467,149)	(3.7%)	20. TOTAL MEDICAL EXPENSES	\$1,959,592,431	\$1,904,160,591	(\$55,431,840)	(2.9%)
\$73,677,168	\$79,063,371	(\$5,386,203)	(6.8%)	21. GROSS MARGIN	\$799,145,913	\$827,967,127	(\$28,821,214)	(3.5%)
				ADMINISTRATIVE EXPENSES				
\$6,388,914	\$5,942,439	(\$446,475)	(7.5%)	22. Personnel Expense	\$63,871,311	\$64,532,523	\$661,212	1.0%
\$78,996	\$75,162	(\$3,833)	(5.1%)	23. Benefits Administration Expense	\$865,214	\$829,973	(\$35,241)	(4.2%)
\$1,634,858	\$1,832,558	\$197,700	10.8%	24. Purchased & Professional Services	\$22,167,691	\$26,570,311	\$4,402,620	16.6%
\$865,299	\$1,331,756	\$466,457	35.0%	25. Other Administrative Expense	\$17,517,661	\$18,303,396	\$785,735	4.3%
\$8,968,066	\$9,181,916	\$213,849	2.3%	26. TOTAL ADMINISTRATIVE EXPENSES	\$104,421,877	\$110,236,203	\$5,814,326	5.3%
\$65,184,775	\$66,957,148	\$1,772,373	2.6%	27. MCO TAX EXPENSES	\$815,596,474	\$810,210,061	(\$5,386,413)	(0.7%)
(\$475,673)	\$2,924,307	(\$3,399,980)	(116.3%)	28. NET OPERATING INCOME / (LOSS)	(\$120,872,437)	(\$92,479,137)	(\$28,393,301)	(30.7%)
				OTHER INCOME / EXPENSES				
\$1,831,410	\$1,500,000	\$331,410	22.1%	29. TOTAL OTHER INCOME / (EXPENSES)	\$29,864,435	\$24,481,002	\$5,383,433	22.0%
\$1,355,737	\$4,424,307	(\$3,068,570)	(69.4%)	30. NET SURPLUS (DEFICIT)	(\$91,008,002)	(\$67,998,134)	(\$23,009,868)	(33.8%)
95.5%	92.0%	(3.5%)	(3.8%)	31. Medical Loss Ratio	100.6%	98.5%	(2.1%)	(2.1%)
4.7%	4.8%	0.1%	2.1%	32. Administrative Expense Ratio	5.4%	5.7%	0.3%	5.3%
0.5%	1.7%	(1.2%)	(70.6%)	33. Net Surplus (Deficit) Ratio	(3.3%)	(2.5%)	(0.8%)	(32.0%)

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

	5/31/2025	4/30/2025	Difference	% Difference
CURRENT ASSETS				
Cash and Cash Equivalent				
Cash	\$34,937,836	\$92,485,445	(\$57,547,610)	(62.2%)
CNB Short-Term Investment	502,988,601	475,954,357	27,034,243	5.7%
Interest Receivable	2,735,862	3,129,121	(393,259)	(12.6%)
Premium Receivables	427,767,025	365,046,255	62,720,770	17.2%
Reinsurance Recovery Receivable	8,332,832	8,135,264	197,568	2.4%
Other Receivables	1,207,426	1,249,398	(41,972)	(3.4%)
Prepaid Expenses	752,970	788,128	(35,159)	(4.5%)
TOTAL CURRENT ASSETS	978,722,551	946,787,969	31,934,582	3.4%
OTHER ASSETS				
CNB Long-Term Investment	39,019,975	44,018,618	(4,998,643)	(11.4%)
CalPERS Net Pension Asset	(6,144,132)	(6,144,132)	0	0.0%
Deferred Outflow	14,319,532	14,319,532	0	0.0%
Restricted Asset-Bank Note	352,863	351,895	968	0.3%
GASB 87-Lease Assets (Net)	81,875	147,788	(65,913)	(44.6%)
GASB 96-SBITA Assets (Net)	3,803,493	2,850,345	953,148	33.4%
TOTAL OTHER ASSETS	51,433,607	55,544,047	(4,110,440)	(7.4%)
PROPERTY AND EQUIPMENT				
Land, Building & Improvements	9,842,648	9,842,648	0	0.0%
Furniture And Equipment	13,400,309	13,400,309	0	0.0%
Leasehold Improvement	902,447	902,447	0	0.0%
Internally Developed Software	14,824,002	14,824,002	0	0.0%
Fixed Assets at Cost	38,969,405	38,969,405	0	0.0%
Less: Accumulated Depreciation	(33,330,742)	(33,268,891)	(61,851)	0.2%
PROPERTY AND EQUIPMENT (NET)	5,638,663	5,700,514	(61,851)	(1.1%)
TOTAL ASSETS	1,035,794,821	1,008,032,530	27,762,291	2.8%
CURRENT LIABILITIES				
Trade Accounts Payable	10,566,156	9,516,161	1,049,995	11.0%
Incurred But Not Reported Claims	403,573,402	386,593,973	16,979,429	4.4%
Other Medical Liabilities	132,691,974	150,958,997	(18,267,023)	(12.1%)
Pass-Through Liabilities	152,356,058	190,458,089	(38,102,030)	(20.0%)
MCO Tax Liabilities	158,973,556	93,788,781	65,184,775	69.5%
GASB 87 and 96 ST Liabilities	1,326,682	1,358,053	(31,371)	(2.3%)
Payroll Liabilities	8,168,474	8,772,625	(604,152)	(6.9%)
TOTAL CURRENT LIABILITIES	867,656,302	841,446,679	26,209,622	3.1%
LONG TERM LIABILITIES				
GASB 87 and 96 LT Liabilities	443,848	246,917	196,931	79.8%
Deferred Inflow	3,327,530	3,327,530	0	0.0%
TOTAL LONG TERM LIABILITIES	3,771,378	3,574,446	196,931	5.5%
TOTAL LIABILITIES	871,427,679	845,021,126	26,406,554	3.1%
NET WORTH				
Contributed Capital	840,233	840,233	0	0.0%
Restricted & Unrestricted Funds	254,534,911	254,534,911	0	0.0%
Year-To-Date Net Surplus (Deficit)	(91,008,002)	(92,363,740)	1,355,737	(1.5%)
TOTAL NET WORTH	164,367,141	163,011,404	1,355,737	0.8%
TOTAL LIABILITIES AND NET WORTH	1,035,794,821	1,008,032,530	27,762,291	2.8%
Cash Equivalents	537,926,437	568,439,803	(30,513,366)	(5.4%)
Pass-Through	152,356,058	190,458,089	(38,102,030)	(20.0%)
Uncommitted Cash	385,570,378	377,981,714	7,588,664	2.0%
Working Capital	111,066,250	105,341,290	5,724,960	5.4%
Current Ratio	112.8%	112.5%	0.3%	0.3%

**ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED**

May 31, 2025

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM OPERATING ACTIVITIES				
Commercial Premium Cash Flows				
Commercial Premium Revenue	\$3,217,329	\$9,648,708	\$19,153,635	\$34,802,117
GroupCare Receivable	3,215,455	6,873	6,217,235	650
Total	6,432,784	9,655,581	25,370,870	34,802,767
Medi-Cal Premium Cash Flows				
Medi-Cal Revenue	251,494,549	763,721,800	1,480,705,631	2,723,936,226
Premium Receivable	(65,936,225)	91,127,265	62,753,089	(60,824,155)
Total	185,558,324	854,849,065	1,543,458,720	2,663,112,071
Investment & Other Income Cash Flows				
Other Revenues	171,596	(487,592)	(58,512)	2,034,462
Interest Income	1,668,374	8,189,818	14,936,377	27,944,712
Interest Receivable	393,259	812,278	1,981,407	(819,798)
Total	2,233,229	8,514,504	16,859,272	29,159,376
Medical & Hospital Cash Flows				
Total Medical Expenses	(181,034,711)	(546,046,393)	(1,060,775,490)	(1,959,592,434)
Other Health Care Receivables	(155,912)	1,798,443	(1,140,878)	1,384,222
Capitation Payable	-	-	-	-
IBNP Payable	16,979,429	15,418,959	73,751,547	107,269,144
Other Medical Payable	(56,369,053)	140,740,966	51,678,814	(50,792,724)
Risk Share Payable	-	-	-	(2,680,192)
New Health Program Payable	-	-	-	-
Total	(220,580,247)	(388,088,025)	(936,486,007)	(1,904,411,984)
Administrative Cash Flows				
Total Administrative Expenses	(8,976,627)	(28,171,616)	(56,259,074)	(104,536,614)
Prepaid Expenses	35,159	(87,645)	(3,210)	(514,352)
Other Receivables	315	42,263	36,225	70,062
CalPERS Pension	-	-	-	-
Trade Accounts Payable	1,049,995	1,135,479	1,761,096	4,075,861
Payroll Liabilities	(604,151)	(552,602)	1,172,134	69,248
GASB Assets and Liabilities	(721,675)	(250,271)	(1,049,658)	(1,613,354)
Depreciation Expense	61,851	191,575	370,738	668,070
Total	(9,155,133)	(27,692,817)	(53,971,749)	(101,781,079)
MCO Tax AB119 Cash Flows				
MCO Tax Expense AB119	(65,184,775)	(199,102,182)	(400,192,554)	(815,596,474)
MCO Tax Liabilities	65,184,775	(240,897,818)	(165,276,196)	(809,959)
Total	0	(440,000,000)	(565,468,750)	(816,406,433)
Net Cash Flows from Operating Activities	(35,511,043)	17,238,308	29,762,356	(95,525,282)

**ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED**

May 31, 2025

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM INVESTING ACTIVITIES				
Investment Cash Flows				
Long Term Investments	4,998,644	11,008,583	5,142,097	(6,027,728)
Total	4,998,644	11,008,583	5,142,097	(6,027,728)
Restricted Cash & Other Asset Cash Flows				
Restricted Assets-Treasury Account	(968.00)	(2,863.00)	(2,863.00)	(2,863.00)
Total	(968.00)	(2,863.00)	(2,863.00)	(2,863.00)
Fixed Asset Cash Flows				
Fixed Asset Acquisitions	-	(266,709)	(329,306)	(858,916)
Purchases of Property and Equipment	-	(266,709)	(329,306)	(858,916)
Net Cash Flows from Investing Activities	4,997,676	10,739,011	4,809,928	(6,889,507)
Net Change in Cash	(30,513,367)	27,977,319	34,572,284	(102,414,789)
Rounding	-	-	-	-
Cash @ Beginning of Period	568,439,804	509,949,118	503,354,153	640,341,226
Cash @ End of Period	\$537,926,437	\$537,926,437	\$537,926,437	\$537,926,437
Variance	-	-	-	-

**ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED**

May 31, 2025

	MONTH	3 MONTHS	6 MONTHS	YTD
NET INCOME RECONCILIATION				
Net Income / (Loss)	\$1,355,735	\$7,752,543	(\$2,489,987)	(\$91,008,005)
Add back: Depreciation & Amortization	61,851	191,575	370,738	668,070
Receivables				
Premiums Receivable	(65,936,225)	91,127,265	62,753,089	(60,824,155)
Interest Receivable	393,259	812,278	1,981,407	(819,798)
Other Health Care Receivables	(155,912)	1,798,443	(1,140,878)	1,384,222
Other Receivables	315	42,263	36,225	70,062
GroupCare Receivable	3,215,455	6,873	6,217,235	650
Total	(62,483,108)	93,787,122	69,847,078	(60,189,019)
Prepaid Expenses	35,159	(87,645)	(3,210)	(514,352)
Trade Payables	1,049,995	1,135,479	1,761,096	4,075,861
Claims Payable and Shared Risk Pool				
IBNP Payable	16,979,429	15,418,959	73,751,547	107,269,144
Capitation Payable & Other Medical Payable	(56,369,053)	140,740,966	51,678,814	(50,792,724)
Risk Share Payable	-	-	0	(2,680,192)
Claims Payable				
Total	(39,389,624)	156,159,925	125,430,361	53,796,228
Other Liabilities				
CalPERS Pension	-	-	-	-
Payroll Liabilities	(604,151)	(552,602)	1,172,134	69,248
GASB Assets and Liabilities	(721,675)	(250,271)	(1,049,658)	(1,613,354)
New Health Program	-	-	-	-
MCO Tax Liabilities	65,184,775	(240,897,818)	(165,276,196)	(809,959)
Total	63,858,949	(241,700,691)	(165,153,720)	(2,354,065)
Rounding	-	-	-	-
Cash Flows from Operating Activities	(35,511,043)	17,238,308	29,762,356	(95,525,282)
Variance	-	-	-	-

**ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED**

May 31, 2025

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOW STATEMENT:				
Cash Flows from Operating Activities:				
Cash Received				
Capitation Received from State of CA	\$185,558,324	\$854,849,065	\$1,543,458,720	\$2,663,112,071
Medicare Revenue	\$0	\$0	\$0	\$0
GroupCare Premium Revenue	6,432,784	9,655,581	25,370,870	34,802,767
Other Income	171,596	(487,592)	(58,512)	2,034,462
Interest Income	2,061,633	9,002,096	16,917,784	27,124,914
Less Cash Paid				
Medical Expenses	(220,580,247)	(388,088,025)	(936,486,007)	(1,904,411,984)
Vendor & Employee Expenses	(9,155,133)	(27,692,817)	(53,971,749)	(101,781,079)
MCO Tax Expense AB119	0	(440,000,000)	(565,468,750)	(816,406,433)
Net Cash Flows from Operating Activities	(35,511,043)	17,238,308	29,762,356	(95,525,282)
Cash Flows from Investing Activities:				
Long Term Investments	4,998,644	11,008,583	5,142,097	(6,027,728)
Restricted Assets-Treasury Account	(968)	(2,863)	(2,863)	(2,863)
Purchases of Property and Equipment	0	(266,709)	(329,306)	(858,916)
Net Cash Flows from Investing Activities	4,997,676	10,739,011	4,809,928	(6,889,507)
Net Change in Cash	(30,513,367)	27,977,319	34,572,284	(102,414,789)
Rounding	-	-	-	-
Cash @ Beginning of Period	568,439,804	509,949,118	503,354,153	640,341,226
Cash @ End of Period	\$537,926,437	\$537,926,437	\$537,926,437	\$537,926,437
Variance	\$0	-	-	-
RECONCILIATION OF NET INCOME TO NET CASH FLOW FROM OPERATING ACTIVITIES:				
Net Income / (Loss)	\$1,355,735	\$7,752,544	(\$2,489,988)	(\$91,008,005)
Add Back: Depreciation	61,851	191,575	370,738	668,070
Net Change in Operating Assets & Liabilities				
Premium & Other Receivables	(62,483,108)	93,787,122	69,847,078	(60,189,019)
Prepaid Expenses	35,159	(87,646)	(3,209)	(514,352)
Trade Payables	1,049,995	1,135,479	1,761,096	4,075,861
Claims Payable, IBNP and Risk Sharing	(39,389,624)	156,159,925	125,430,361	53,796,228
Deferred Revenue	0	0	0	0
Other Liabilities	63,858,949	(241,700,691)	(165,153,720)	(2,354,065)
Total	(35,511,043)	17,238,308	29,762,356	(95,525,282)
Rounding	-	-	-	-
Cash Flows from Operating Activities	(\$35,511,043)	\$17,238,308	\$29,762,356	(\$95,525,282)
Variance	\$0	-	-	-

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE MONTH OF MAY 2025

	Medi-Cal Child	Medi-Cal Adult	Medi-Cal SPD*	Medi-Cal Duals*	Medi-Cal ACA OE	Medi-Cal LTC*	Medi-Cal LTC Duals*	Medi-Cal SPD with LTC	Medi-Cal Duals with LTC	Medi-Cal Total	Group Care	Medicare	Grand Total
Enrollments/Member Months	109,459	61,818	-	-	153,782	-	-	29,455	48,957	403,471	5,887	-	409,358
Revenue	\$36,035,302	\$33,254,519	(\$163,468)	\$165,104	\$92,049,001	\$6,970	\$32,039	\$47,695,253	\$42,419,827	\$251,494,548	\$3,217,330	\$0	\$254,711,878
Medical Expense	\$14,194,562	\$21,612,763	(\$1,520,439)	(\$189,412)	\$59,059,746	(\$162,275)	\$380,235	\$49,863,906	\$34,274,590	\$177,513,677	\$3,516,904	\$4,128	\$181,034,710
Gross Margin	\$21,840,740	\$11,641,756	\$1,356,971	\$354,516	\$32,989,255	\$169,245	(\$348,197)	(\$2,168,653)	\$8,145,237	\$73,980,871	(\$299,575)	(\$4,128)	\$73,677,168
Administrative Expense	\$426,686	\$977,297	\$33,691	\$8,253	\$2,773,350	\$153	\$2,930	\$2,530,635	\$1,569,431	\$8,322,424	\$153,838	\$491,803	\$8,968,066
MCO Tax Expense	\$17,684,196	\$9,987,316	\$0	\$0	\$24,845,020	\$0	\$0	\$4,758,750	\$7,909,493	\$65,184,775	\$0	\$0	\$65,184,775
Operating Income / (Expense)	\$3,729,858	\$677,143	\$1,323,280	\$346,263	\$5,370,885	\$169,092	(\$351,126)	(\$9,458,037)	(\$1,333,686)	\$473,672	(\$453,413)	(\$495,931)	(\$475,673)
Other Income / (Expense)	\$88,977	\$211,349	\$0	\$0	\$603,053	\$0	\$0	\$557,478	\$343,275	\$1,804,131	\$27,279	\$0	\$1,831,410
Net Income / (Loss)	\$3,818,835	\$888,492	\$1,323,280	\$346,263	\$5,973,938	\$169,092	(\$351,126)	(\$8,900,559)	(\$990,411)	\$2,277,803	(\$426,134)	(\$495,931)	\$1,355,737
PMPM Metrics:													
Revenue PMPM	\$329.21	\$537.94	\$0.00	\$0.00	\$598.57	\$0.00	\$0.00	\$1,619.26	\$866.47	\$623.33	\$546.51	\$0.00	\$622.22
Medical Expense PMPM	\$129.68	\$349.62	\$0.00	\$0.00	\$384.05	\$0.00	\$0.00	\$1,692.88	\$700.10	\$439.97	\$597.40	\$0.00	\$442.24
Gross Margin PMPM	\$199.53	\$188.32	\$0.00	\$0.00	\$214.52	\$0.00	\$0.00	(\$73.63)	\$166.38	\$183.36	(\$50.89)	\$0.00	\$179.98
Administrative Expense PMPM	\$3.90	\$15.81	\$0.00	\$0.00	\$18.03	\$0.00	\$0.00	\$85.92	\$32.06	\$20.63	\$26.13	\$0.00	\$21.91
MCO Tax Expense PMPM	\$161.56	\$161.56	\$0.00	\$0.00	\$161.56	\$0.00	\$0.00	\$161.56	\$161.56	\$161.56	\$0.00	\$0.00	\$159.24
Operating Income / (Expense) PMPM	\$34.08	\$10.95	\$0.00	\$0.00	\$34.93	\$0.00	\$0.00	(\$321.10)	(\$27.24)	\$1.17	(\$77.02)	\$0.00	(\$1.16)
Other Income / (Expense) PMPM	\$0.81	\$3.42	\$0.00	\$0.00	\$3.92	\$0.00	\$0.00	\$18.93	\$7.01	\$4.47	\$4.63	\$0.00	\$4.47
Net Income / (Loss) PMPM	\$34.89	\$14.37	\$0.00	\$0.00	\$38.85	\$0.00	\$0.00	(\$302.17)	(\$20.23)	\$5.65	(\$72.39)	\$0.00	\$3.31
Ratio:													
Medical Loss Ratio	77.3%	92.9%	930.1%	-114.7%	87.9%	-2328.1%	1186.8%	116.1%	99.3%	95.3%	109.3%	0.0%	95.5%
Administrative Expense Ratio	2.3%	4.2%	-20.6%	5.0%	4.1%	2.2%	9.1%	5.9%	4.5%	4.5%	4.8%	0.0%	4.7%
Net Income Ratio	10.6%	2.7%	-809.5%	209.7%	6.5%	2425.9%	-1095.9%	-18.7%	-2.3%	0.9%	-13.2%	0.0%	0.5%

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

**ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID**

**GAAP BASIS
FOR THE FISCAL YEAR TO DATE MAY 2025**

	Medi-Cal Child	Medi-Cal Adult	Medi-Cal SPD*	Medi-Cal Duals*	Medi-Cal ACA OE	Medi-Cal LTC*	Medi-Cal LTC Duals*	Medi-Cal SPD with LTC	Medi-Cal Duals with LTC	Medi-Cal Total	Group Care	Medicare	Grand Total
Enrollments/Member Months	1,213,140	690,715	212,632	241,339	1,679,745	1,446	7,562	147,437	242,169	4,436,185	63,658	-	4,499,843
Revenue	\$396,242,912	\$373,978,583	\$302,172,906	\$139,209,088	\$986,077,603	\$14,783,032	\$66,361,118	\$235,804,287	\$209,306,697	\$2,723,936,227	\$34,802,117	\$0	\$2,758,738,344
Medical Expense	\$149,985,178	\$232,161,108	\$275,070,413	\$94,383,838	\$675,132,414	\$18,055,456	\$65,782,956	\$255,855,060	\$159,404,431	\$1,925,830,855	\$33,471,605	\$289,971	\$1,959,592,431
Gross Margin	\$246,257,734	\$141,817,476	\$27,102,493	\$44,825,250	\$310,945,188	(\$3,272,424)	\$578,163	(\$20,050,773)	\$49,902,266	\$798,105,372	\$1,330,512	(\$289,971)	\$799,145,913
Administrative Expense	\$4,982,850	\$11,671,650	\$14,539,765	\$4,986,869	\$32,357,872	\$1,014,029	\$4,706,834	\$12,948,093	\$8,000,441	\$95,208,403	\$1,681,026	\$7,532,448	\$104,421,877
MCO Tax Expense	\$223,640,878	\$127,170,726	\$43,043,470	\$49,233,964	\$307,737,150	\$285,308	\$1,540,232	\$23,819,922	\$39,124,824	\$815,596,474	\$0	\$0	\$815,596,474
Operating Income / (Expense)	\$17,634,006	\$2,975,100	(\$30,480,742)	(\$9,395,583)	(\$29,149,833)	(\$4,571,761)	(\$5,668,904)	(\$56,818,788)	\$2,777,001	(\$112,699,505)	(\$350,514)	(\$7,822,419)	(\$120,872,437)
Other Income / (Expense)	\$1,490,983	\$3,632,990	\$4,709,375	\$1,609,737	\$10,087,597	\$338,837	\$1,557,352	\$3,790,565	\$2,334,092	\$29,551,529	\$312,907	\$0	\$29,864,435
Net Income / (Loss)	\$19,124,989	\$6,608,089	(\$25,771,368)	(\$7,785,846)	(\$19,062,236)	(\$4,232,924)	(\$4,111,551)	(\$53,028,222)	\$5,111,093	(\$83,147,976)	(\$37,607)	(\$7,822,419)	(\$91,008,002)
PMPM Metrics:													
Revenue PMPM	\$326.63	\$541.44	\$1,421.11	\$576.82	\$587.04	\$10,223.40	\$8,775.60	\$1,599.36	\$864.30	\$614.03	\$546.70	\$0.00	\$613.07
Medical Expense PMPM	\$123.63	\$336.12	\$1,293.65	\$391.08	\$401.93	\$12,486.48	\$8,699.15	\$1,735.35	\$658.24	\$434.12	\$525.80	\$0.00	\$435.48
Gross Margin PMPM	\$202.99	\$205.32	\$127.46	\$185.74	\$185.11	(\$2,263.09)	\$76.46	(\$136.00)	\$206.06	\$179.91	\$20.90	\$0.00	\$177.59
Administrative Expense PMPM	\$4.11	\$16.90	\$68.38	\$20.66	\$19.26	\$701.26	\$622.43	\$87.82	\$33.04	\$21.46	\$26.41	\$0.00	\$23.21
MCO Tax Expense PMPM	\$184.35	\$184.11	\$202.43	\$204.00	\$183.20	\$197.31	\$203.68	\$161.56	\$161.56	\$183.85	\$0.00	\$0.00	\$181.25
Operating Income / (Expense) PMPM	\$14.54	\$4.31	(\$143.35)	(\$38.93)	(\$17.35)	(\$3,161.66)	(\$749.66)	(\$385.38)	\$11.47	(\$25.40)	(\$5.51)	\$0.00	(\$26.86)
Other Income / (Expense) PMPM	\$1.23	\$5.26	\$22.15	\$6.67	\$6.01	\$234.33	\$205.94	\$25.71	\$9.64	\$6.66	\$4.92	\$0.00	\$6.64
Net Income / (Loss) PMPM	\$15.76	\$9.57	(\$121.20)	(\$32.26)	(\$11.35)	(\$2,927.33)	(\$543.71)	(\$359.67)	\$21.11	(\$18.74)	(\$0.59)	\$0.00	(\$20.22)
Ratio:													
Medical Loss Ratio	86.1%	93.8%	106.0%	104.0%	99.3%	124.5%	101.5%	120.7%	93.7%	100.7%	96.2%	0.0%	100.6%
Administrative Expense Ratio	2.9%	4.7%	5.6%	5.5%	4.8%	7.0%	7.3%	6.1%	4.7%	5.0%	4.8%	0.0%	5.4%
Net Income Ratio	4.8%	1.8%	-8.5%	-5.6%	-1.9%	-28.6%	-6.2%	-22.5%	2.4%	-3.1%	-0.1%	0.0%	-3.3%

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

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)
ADMINISTRATIVE EXPENSES SUMMARY (ADMIN. DEPT. ONLY)								
\$6,388,914	\$5,942,439	(\$446,475)	(7.5%)	Personnel Expenses	\$63,871,311	\$64,532,523	\$661,212	1.0%
\$78,996	\$75,162	(\$3,833)	(5.1%)	Benefits Administration Expense	\$865,214	\$829,973	(\$35,241)	(4.2%)
\$1,634,858	\$1,832,558	\$197,700	10.8%	Purchased & Professional Services	\$22,167,691	\$26,570,311	\$4,402,620	16.6%
\$592,281	\$583,187	(\$9,095)	(1.6%)	Occupancy	\$5,811,691	\$6,103,281	\$291,590	4.8%
\$397,228	\$389,457	(\$7,771)	(2.0%)	Printing Postage & Promotion	\$4,788,098	\$5,134,244	\$346,145	6.7%
(\$244,773)	\$176,996	\$421,769	238.3%	Licenses Insurance & Fees	\$4,080,302	\$5,015,297	\$934,995	18.6%
\$120,562	\$182,116	\$61,554	33.8%	Other Administrative Expense	\$2,837,570	\$2,050,575	(\$786,996)	(38.4%)
\$2,579,152	\$3,239,476	\$660,324	20.4%	Total Other Administrative Expenses (excludes Personnel Expenses)	\$40,550,566	\$45,703,680	\$5,153,114	11.3%
\$8,968,066	\$9,181,916	\$213,849	2.3%	Total Administrative Expenses	\$104,421,877	\$110,236,203	\$5,814,326	5.3%

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)
4,053,746	3,548,356	(505,390)	(14.2%)	Salaries & Wages	41,693,381	42,376,581	683,200	1.6%
393,210	608,320	215,111	35.4%	Paid Time Off	3,909,594	4,363,639	454,046	10.4%
4,994	3,780	(1,214)	(32.1%)	Compensated Incentives	27,554	45,149	17,595	39.0%
38,168	0	(38,168)	0.0%	Severance	38,168	400,000	361,832	90.5%
95,873	93,222	(2,651)	(2.8%)	Payroll Taxes	810,995	995,752	184,757	18.6%
95,257	26,210	(69,047)	(263.4%)	Overtime	726,951	495,589	(231,362)	(46.7%)
361,899	492,473	130,574	26.5%	CalPERS ER Match	3,625,587	3,736,345	110,758	3.0%
1,104,915	854,861	(250,055)	(29.3%)	Employee Benefits	11,088,119	8,725,776	(2,362,343)	(27.1%)
(291)	0	291	0.0%	Personal Floating Holiday	193,543	202,966	9,423	4.6%
24,620	57,750	33,130	57.4%	Language Pay	234,732	367,509	132,777	36.1%
(1,120)	0	1,120	0.0%	Med Ins Opted Out Stipend	35,250	16,010	(19,240)	(120.2%)
0	0	0	0.0%	Holiday Bonus	(400,000)	0	400,000	1,333,333.4...
123,116	0	(123,116)	0.0%	Sick Leave	949,998	270,728	(679,270)	(250.9%)
25	24,092	24,067	99.9%	Compensated Employee Relations	8,838	247,447	238,609	96.4%
20,250	26,850	6,600	24.6%	Work from Home Stipend	221,110	262,270	41,160	15.7%
1,269	5,543	4,274	77.1%	Mileage, Parking & Local Travel	15,206	54,823	39,616	72.3%
4,087	21,172	17,085	80.7%	Travel & Lodging	41,507	209,117	167,610	80.2%
20,197	96,085	75,888	79.0%	Temporary Help Services	323,211	936,598	613,388	65.5%
21,691	40,712	19,021	46.7%	Staff Development/Training	192,424	483,854	291,430	60.2%
27,008	43,015	16,006	37.2%	Staff Recruitment/Advertisement	135,143	342,369	207,226	60.5%
6,388,914	5,942,439	(446,475)	(7.5%)	Personnel Expense	63,871,311	64,532,523	661,212	1.0%
26,081	22,018	(4,063)	(18.5%)	Pharmacy Administrative Fees	283,345	249,258	(34,087)	(13.7%)
52,915	53,144	230	0.4%	Telemedicine Admin. Fees	581,868	580,714	(1,154)	(0.2%)
78,996	75,162	(3,833)	(5.1%)	Benefits Administration Expense	865,214	829,973	(35,241)	(4.2%)
764,523	467,530	(296,993)	(63.5%)	Consultant Fees - Non Medical	5,870,827	7,229,238	1,358,411	18.8%
171,424	322,620	151,197	46.9%	Computer Support Services	4,883,161	5,851,875	968,714	16.6%
56,915	15,000	(41,915)	(279.4%)	Audit Fees	253,073	173,158	(79,915)	(46.2%)
0	8	8	100.0%	Consultant Fees - Medical	7,685	(15,280)	(22,965)	150.3%
293,457	280,531	(12,927)	(4.6%)	Other Purchased Services	2,689,616	2,787,255	97,639	3.5%
0	844	844	100.0%	Maint.&Repair-Office Equipment	8,705	9,284	579	6.2%
0	0	0	0.0%	Maint.&Repair-Computer Hardwar	2,018	0	(2,018)	0.0%
258,254	70,067	(188,187)	(268.6%)	Legal Fees	1,097,406	821,752	(275,654)	(33.5%)
(8)	0	8	0.0%	Member Health Education	312	320	8	2.6%
34,954	26,000	(8,954)	(34.4%)	Translation Services	295,266	269,064	(26,203)	(9.7%)
89,166	157,650	68,484	43.4%	Medical Refund Recovery Fees	2,246,442	2,258,221	11,779	0.5%
(185,966)	352,924	538,890	152.7%	Software - IT Licenses & Subsc	3,968,606	5,900,534	1,931,928	32.7%
95,554	83,584	(11,970)	(14.3%)	Hardware (Non-Capital)	300,002	720,376	420,375	58.4%
56,585	55,800	(785)	(1.4%)	Provider Credentialing	544,573	564,513	19,940	3.5%
1,634,858	1,832,558	197,700	10.8%	Purchased & Professional Services	22,167,691	26,570,311	4,402,620	16.6%
61,851	111,043	49,192	44.3%	Depreciation	668,070	936,591	268,521	28.7%
62,638	76,371	13,733	18.0%	Lease Building	762,017	783,998	21,982	2.8%
9,569	5,960	(3,609)	(60.5%)	Lease Rented Office Equipment	70,420	78,125	7,705	9.9%
14,150	18,073	3,923	21.7%	Utilities	147,808	231,269	83,461	36.1%
91,877	91,065	(812)	(0.9%)	Telephone	963,951	985,120	21,169	2.1%
36,139	31,539	(4,599)	(14.6%)	Building Maintenance	382,841	420,449	37,607	8.9%
316,058	249,136	(66,922)	(26.9%)	GASB96 SBITA Amort. Expense	2,816,584	2,667,729	(148,855)	(5.6%)

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

CURRENT MONTH				FISCAL YEAR TO DATE				
Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)
592,281	583,187	(9,095)	(1.6%)	Occupancy	5,811,691	6,103,281	291,590	4.8%
43,459	37,718	(5,740)	(15.2%)	Postage	731,073	855,163	124,091	14.5%
4,675	5,300	625	11.8%	Design & Layout	53,670	88,280	34,610	39.2%
124,660	41,090	(83,570)	(203.4%)	Printing Services	1,442,210	1,157,030	(285,179)	(24.6%)
23,956	19,410	(4,546)	(23.4%)	Mailing Services	135,674	145,253	9,579	6.6%
7,305	15,373	8,068	52.5%	Courier/Delivery Service	63,472	115,337	51,866	45.0%
0	249	249	100.0%	Pre-Printed Materials & Public	589	3,581	2,991	83.5%
4,758	2,500	(2,258)	(90.3%)	Promotional Products	115,827	56,520	(59,307)	(104.9%)
0	150	150	100.0%	Promotional Services	0	1,350	1,350	100.0%
188,415	267,667	79,252	29.6%	Community Relations	2,245,584	2,711,729	466,145	17.2%
397,228	389,457	(7,771)	(2.0%)	Printing Postage & Promotion	4,788,098	5,134,244	346,145	6.7%
20,000	0	(20,000)	0.0%	Regulatory Penalties	315,000	485,000	170,000	35.1%
12,213	31,600	19,387	61.4%	Bank Fees	387,583	354,181	(33,402)	(9.4%)
0	0	0	0.0%	Insurance Premium	1,076,688	1,102,916	26,228	2.4%
(276,747)	105,026	381,773	363.5%	License, Permits, & Fee - NonIT	1,700,084	2,332,043	631,959	27.1%
(239)	40,370	40,609	100.6%	Subscriptions and Dues - NonIT	600,947	741,157	140,209	18.9%
(244,773)	176,996	421,769	238.3%	License Insurance & Fees	4,080,302	5,015,297	934,995	18.6%
6,001	11,108	5,107	46.0%	Office and Other Supplies	74,268	121,190	46,922	38.7%
0	1,000	1,000	100.0%	Furniture & Equipment	0	11,000	11,000	100.0%
11,577	26,483	14,906	56.3%	Ergonomic Supplies	255,597	323,431	67,834	21.0%
10,613	23,524	12,911	54.9%	Meals and Entertainment	129,153	181,895	52,743	29.0%
0	0	0	0.0%	Miscellaneous	898,625	5,300	(893,325)	(16,855.2%)
0	0	0	0.0%	Member Incentive	0	14,550	14,550	100.0%
92,371	120,000	27,629	23.0%	Provider Interest (All Depts)	1,479,927	1,393,208	(86,718)	(6.2%)
120,562	182,116	61,554	33.8%	Other Administrative Expense	2,837,570	2,050,575	(786,996)	(38.4%)
2,579,152	3,239,476	660,324	20.4%	Total Other Administrative ExpenseS (excludes Personnel Expenses)	40,550,566	45,703,680	5,153,114	11.3%
8,968,066	9,181,916	213,849	2.3%	TOTAL ADMINISTRATIVE EXPENSES	104,421,877	110,236,203	5,814,326	5.3%

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

	Project ID	Prior YTD Acquisitions	Current Month Acquisitions	Fiscal YTD Acquisitions	Capital Budget Total	\$ Variance Fav/(Unf.)
1. Hardware:						
	Cisco UCS-X M6 or M7 Blades x 6	IT-FY24-04	\$ 265,100	\$ -	\$ 265,100	\$ 265,100 \$ 0
	Cisco Routers	IT-FY25-01	\$ -	\$ -	\$ -	\$ 120,000 \$ 120,000
	Cisco UCS Blades	IT-FY25-04	\$ 264,510	\$ -	\$ 264,510	\$ 873,000 \$ 608,490
	PURE Storage	IT-FY25-06	\$ 266,709	\$ -	\$ 266,709	\$ 150,000 \$ (116,709)
	Exagrid Immutable Storage	IT-FY25-07	\$ -	\$ -	\$ -	\$ 500,000 \$ 500,000
	Network Cabling	IT-FY25-09	\$ 62,598	\$ -	\$ 62,598	\$ 40,000 \$ (22,598)
	Hardware Subtotal		\$ 858,916	\$ -	\$ 858,916	\$ 1,948,100 \$ 1,089,184
2. Software:						
	Zerto renewal and Tier 2 add		\$ -	\$ -	\$ -	\$ -
	Software Subtotal		\$ -	\$ -	\$ -	\$ -
3. Building Improvement:						
	1240 Exterior lighting update	FA-FY25-03	\$ -	\$ -	\$ -	\$ 30,000 \$ 30,000
	Building Improvement Subtotal		\$ -	\$ -	\$ -	\$ 30,000 \$ 30,000
4. Furniture & Equipment:						
	Office desks, cabinets, shelvings (all building/suites: new or replacement)		\$ -	\$ -	\$ -	\$ -
	Replace, reconfigure, re-design workstations		\$ -	\$ -	\$ -	\$ -
	Furniture & Equipment Subtotal		\$ -	\$ -	\$ -	\$ -
5. Leasehold Improvement:						
	ExacqVision NVR Upgrade, Cameras/Video System upgrade		\$ -	\$ -	\$ -	\$ -
	Leasehold Improvement Subtotal		\$ -	\$ -	\$ -	\$ -
6. Contingency:						
			\$ -	\$ -	\$ -	\$ -
	Contingency Subtotal		\$ -	\$ -	\$ -	\$ -
	GRAND TOTAL		\$ 858,916	\$ -	\$ 858,916	\$ 1,978,100 \$ 1,119,184
6. Reconciliation to Balance Sheet:						
	Fixed Assets @ Cost - 5/31/25			\$ 38,969,405		
	Fixed Assets @ Cost - 6/30/24			\$ 38,110,489		
	Fixed Assets Acquired YTD			\$ 858,916		

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

TANGIBLE NET EQUITY (TNE)	QRT. END Jun-24	Jul-24	Aug-24	QRT. END Sep-24	Oct-24	Nov-24	QRT. END Dec-24	Jan-25	Feb-25	QRT. END Mar-25	Apr-25	May-25
Current Month Net Income / (Loss)	\$ (60,612,285)	\$ (6,989,301)	\$ (18,354,880)	\$ (8,719,238)	\$ (26,984,341)	\$ (27,470,264)	\$ (8,643,229)	\$ (6,688,826)	\$ 5,089,524	\$ 457,935	\$ 5,938,872	\$ 1,355,735
YTD Net Income / (Loss)	\$ (68,581,898)	\$ (6,989,303)	\$ (25,344,182)	\$ (34,063,414)	\$ (61,047,753)	\$ (88,518,015)	\$ (97,161,241)	\$ (103,850,064)	\$ (98,760,546)	\$ (98,302,610)	\$ (92,363,740)	\$ (91,008,002)
Net Assets	\$ 255,375,143	\$ 248,385,840	\$ 230,030,961	\$ 221,311,729	\$ 194,327,390	\$ 166,857,128	\$ 158,213,902	\$ 151,525,079	\$ 156,614,597	\$ 157,072,533	\$ 163,011,403	\$ 164,367,141
Subordinated Debt & Interest	-	-	-	-	-	-	-	-	-	-	-	-
Total Actual TNE	\$ 255,375,143	\$ 248,385,840	\$ 230,030,961	\$ 221,311,729	\$ 194,327,390	\$ 166,857,128	\$ 158,213,902	\$ 151,525,079	\$ 156,614,597	\$ 157,072,533	\$ 163,011,403	\$ 164,367,141
Increase/(Decrease) in Actual TNE	\$ (60,612,285)	\$ (6,989,301)	\$ (18,354,880)	\$ (8,719,238)	\$ (26,984,341)	\$ (27,470,264)	\$ (8,643,229)	\$ (6,688,826)	\$ 5,089,524	\$ 457,935	\$ 5,938,872	\$ 1,355,735
Required TNE ⁽¹⁾	\$ 63,328,179	\$ 68,750,939	\$ 71,470,183	\$ 70,224,330	\$ 77,225,116	\$ 78,852,430	\$ 77,630,344	\$ 81,350,675	\$ 77,665,855	\$ 79,764,820	\$ 80,840,793	\$ 80,854,653
Min. Req'd to Avoid Monthly Reporting at 150% of Required TNE	\$ 94,992,268	\$ 103,126,409	\$ 107,205,275	\$ 105,336,495	\$ 115,837,673	\$ 118,278,645	\$ 116,445,516	\$ 122,026,012	\$ 116,498,783	\$ 119,647,230	\$ 121,261,190	\$ 121,281,980
TNE Excess / (Deficiency)	\$ 192,046,964	\$ 179,634,901	\$ 158,560,778	\$ 151,087,399	\$ 117,102,274	\$ 88,004,698	\$ 80,583,558	\$ 70,174,404	\$ 78,948,742	\$ 77,307,713	\$ 82,170,610	\$ 83,512,488
Actual TNE as a Multiple of Required	4.03	3.61	3.22	3.15	2.52	2.12	2.04	1.86	2.02	1.97	2.02	2.03
LIQUID TANGIBLE NET EQUITY												
Net Assets	\$ 255,375,143	\$ 248,385,840	\$ 230,030,961	\$ 221,311,729	\$ 194,327,390	\$ 166,857,128	\$ 158,213,902	\$ 151,525,079	\$ 156,614,597	\$ 157,072,533	\$ 163,011,403	\$ 164,367,141
Less: Fixed Assets at Net Book Value	(5,447,816)	(5,662,370)	(5,863,098)	(5,803,725)	(5,739,467)	(5,680,094)	(5,620,721)	(5,561,346)	(5,563,528)	(5,765,375)	(5,700,514)	(5,638,663)
Net Lease Assets	(501,485)	(319,957)	(496,877)	(1,004,186)	(1,303,630)	(1,065,182)	(2,704,898)	(2,504,545)	(1,864,566)	(1,666,263)	(1,393,164)	(2,114,839)
CD Pledged to DMHC	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,898)	(351,895)	352,863
Liquid TNE (Liquid Reserves)	\$ 249,075,842	\$ 242,053,513	\$ 223,320,986	\$ 214,153,818	\$ 186,934,293	\$ 159,761,852	\$ 149,538,283	\$ 143,109,188	\$ 148,836,503	\$ 149,289,997	\$ 155,565,830	\$ 156,966,502
Liquid TNE as Multiple of Required	3.93	3.52	3.12	3.05	2.42	2.03	1.93	1.76	1.92	1.87	1.92	1.94

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

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

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	109,662	109,561	110,506	111,643	111,554	111,103	110,186	109,459		1,213,140
Adult	62,708	62,641	62,550	62,578	62,502	62,905	63,553	63,706	63,255	62,499	61,818		690,715
SPD (retired Dec-24)*	35,018	35,177	35,319	35,388	35,603	36,127	0	0	0	0	0		212,632
Duals (retired Dec-24)*	39,892	40,024	40,124	40,144	40,357	40,798	0	0	0	0	0		241,339
ACA OE	149,801	150,482	151,005	151,098	151,559	154,560	154,136	154,609	154,559	154,154	153,782		1,679,745
LTC (retired Dec-24)*	222	226	240	249	255	254	0	0	0	0	0		1,446
LTC Duals (retired Dec-24)*	1,241	1,247	1,254	1,265	1,269	1,286	0	0	0	0	0		7,562
SPD with LTC (new Jan-25)	0	0	0	0	0	0	29,564	29,497	29,605	29,316	29,455		147,437
Duals with LTC (new Jan-25)	0	0	0	0	0	0	48,153	48,100	48,226	48,733	48,957		242,169
Medi-Cal Program	398,833	399,581	400,223	400,384	401,106	406,436	407,049	407,466	406,748	404,888	403,471		4,436,185
Group Care Program	5,675	5,686	5,710	5,769	5,772	5,790	5,779	5,812	5,882	5,896	5,887		63,658
Total	404,508	405,267	405,933	406,153	406,878	412,226	412,828	413,278	412,630	410,784	409,358		4,499,843

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

Month Over Month Enrollment Change:

Medi-Cal Monthly Change													
Child	(173)	(167)	(53)	(69)	(101)	945	1,137	(89)	(451)	(917)	(727)		(665)
Adult	(38)	(67)	(91)	28	(76)	403	648	153	(451)	(756)	(681)		(928)
SPD (retired Dec-24)	98	159	142	69	215	524	(36,127)	0	0	0	0		(34,920)
Duals (retired Dec-24)	144	132	100	20	213	441	(40,798)	0	0	0	0		(39,748)
ACA OE	477	681	523	93	461	3,001	(424)	473	(50)	(405)	(372)		4,458
LTC (retired Dec-24)	0	4	14	9	6	(1)	(254)	0	0	0	0		(222)
LTC Duals (retired Dec-24)	(7)	6	7	11	4	17	(1,286)	0	0	0	0		(1,248)
SPD with LTC (new Jan-25)	0	0	0	0	0	0	29,564	(67)	108	(289)	139		29,455
Duals with LTC (new Jan-25)	0	0	0	0	0	0	48,153	(53)	126	507	224		48,957
Medi-Cal Program	501	748	642	161	722	5,330	613	417	(718)	(1,860)	(1,417)		5,139
Group Care Program	17	11	24	59	3	18	(11)	33	70	14	(9)		229
Total	518	759	666	220	725	5,348	602	450	(648)	(1,846)	(1,426)		5,368

Enrollment Percentages:

Medi-Cal Program:													
Child % of Medi-Cal	27.6%	27.5%	27.4%	27.4%	27.3%	27.2%	27.4%	27.4%	27.3%	27.2%	27.1%		27.3%
Adult % of Medi-Cal	15.7%	15.7%	15.6%	15.6%	15.6%	15.5%	15.6%	15.6%	15.6%	15.4%	15.3%		15.6%
SPD % of Medi-Cal	8.8%	8.8%	8.8%	8.8%	8.9%	8.9%	0.0%	0.0%	0.0%	0.0%	0.0%		4.8%
Duals % of Medi-Cal	10.0%	10.0%	10.0%	10.0%	10.1%	10.0%	0.0%	0.0%	0.0%	0.0%	0.0%		5.4%
ACA OE % of Medi-Cal	37.6%	37.7%	37.7%	37.7%	37.8%	38.0%	37.9%	37.9%	38.0%	38.1%	38.1%		37.9%
LTC % of Medi-Cal	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%		0.0%
LTC Duals % of Medi-Cal	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%		0.2%
SPD with LTC % of Medi-Cal	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	7.3%	7.2%	7.3%	7.2%	7.3%		3.3%
Duals with LTC % of Medi-Cal	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	11.8%	11.8%	11.9%	12.0%	12.1%		5.5%
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%
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%
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%

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

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

	Actual Jul-24	Actual Aug-24	Actual Sep-24	Actual Oct-24	Actual Nov-24	Actual Dec-24	Actual Jan-25	Actual Feb-25	Actual Mar-25	Actual Apr-25	Actual May-25	Actual Jun-25	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted													
Directly Contracted (DCP)	87,980	88,518	89,634	89,724	90,655	96,247	94,389	94,869	93,866	94,804	94,078		1,014,764
Alameda Health System	91,091	91,170	91,024	90,756	90,451	90,222	91,158	90,932	90,950	90,450	90,739		998,943
Directly-Contracted Subtotal	179,071	179,688	180,658	180,480	181,106	186,469	185,547	185,801	184,816	185,254	184,817		2,013,707
Delegated:													
CFMG	44,087	43,956	43,837	43,910	44,029	44,099	44,982	45,072	45,190	44,318	43,854		487,334
CHCN	181,350	181,623	181,438	181,763	181,743	181,658	182,299	182,405	182,624	181,212	180,687		1,998,802
Delegated Subtotal	225,437	225,579	225,275	225,673	225,772	225,757	227,281	227,477	227,814	225,530	224,541		2,486,136
Total	404,508	405,267	405,933	406,153	406,878	412,226	412,828	413,278	412,630	410,784	409,358		4,499,843
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	167	617	970	(178)	626	5,363	(922)	254	(985)	438	(437)		5,913
Delegated:													
CFMG	96	(131)	(119)	73	119	70	883	90	118	(872)	(464)		(137)
CHCN	255	273	(185)	325	(20)	(85)	641	106	219	(1,412)	(525)		(408)
Delegated Subtotal	351	142	(304)	398	99	(15)	1,524	196	337	(2,284)	(989)		(545)
Total	518	759	666	220	725	5,348	602	450	(648)	(1,846)	(1,426)		5,368
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	44.3%	44.3%	44.5%	44.4%	44.5%	45.2%	44.9%	45.0%	44.8%	45.1%	45.1%		44.8%
Delegated:													
CFMG	10.9%	10.8%	10.8%	10.8%	10.8%	10.7%	10.9%	10.9%	11.0%	10.8%	10.7%		10.8%
CHCN	44.8%	44.8%	44.7%	44.8%	44.7%	44.1%	44.2%	44.1%	44.3%	44.1%	44.1%		44.4%
Delegated Subtotal	55.7%	55.7%	55.5%	55.6%	55.5%	54.8%	55.1%	55.0%	55.2%	54.9%	54.9%		55.2%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%

**ALAMEDA ALLIANCE FOR HEALTH
TRENDING ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2025**

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

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

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

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

	Variance Jul-24	Variance Aug-24	Variance Sep-24	Variance Oct-24	Variance Nov-24	Variance Dec-24	Variance Jan-25	Variance Feb-25	Variance Mar-25	Variance Apr-25	Variance May-25	Variance Jun-25	YTD Member Month Variance
Enrollment Variance by Plan & Aid Category - Favorable/(Unfavorable)													
Medi-Cal Program:													
Child	0	0	0	0	(211)	624	1,541	1,342	781	(246)	(1,083)		2,748
Adult	0	0	0	0	(139)	201	786	876	362	(457)	(1,201)		428
SPD (retired Dec-24)	0	0	0	0	180	669	0	0	0	0	0		849
Duals (retired Dec-24)	0	0	0	0	213	654	0	0	0	0	0		867
ACA OE	0	0	0	0	310	3,160	2,585	2,906	2,704	2,147	1,623		15,435
LTC (retired Dec-24)	0	0	0	0	4	0	0	0	0	0	0		4
LTC Duals (retired Dec-24)	0	0	0	0	3	19	0	0	0	0	0		22
SPD with LTC (new Jan-25)	0	0	0	0	0	0	(5,186)	(4,291)	(3,220)	(2,545)	(1,441)		(16,683)
Duals with LTC (new Jan-25)	0	0	0	0	0	0	5,741	4,687	3,812	3,318	2,541		20,099
Medi-Cal Program	0	0	0	0	360	5,327	5,467	5,520	4,439	2,217	439		23,769
Group Care Program	0	0	0	0	3	21	10	43	113	127	118		435
Total	0	0	0	0	363	5,348	5,477	5,563	4,552	2,344	557		24,204
Current Direct/Delegate Enrollment Variance - Favorable/(Unfavorable)													
Directly-Contracted													
Directly Contracted (DCP)	0	0	0	0	869	6,398	4,145	4,239	2,850	3,403	2,292		24,196
Alameda Health System	0	0	0	0	(392)	(708)	207	(28)	(18)	(526)	(245)		(1,710)
Directly-Contracted Subtotal	0	0	0	0	477	5,690	4,352	4,211	2,832	2,877	2,047		22,486
Delegated:													
CFMG	0	0	0	0	76	103	947	1,039	1,160	291	(170)		3,446
CHCN	0	0	0	0	(190)	(445)	178	313	560	(824)	(1,320)		(1,728)
Delegated Subtotal	0	0	0	0	(114)	(342)	1,125	1,352	1,720	(533)	(1,490)		1,718
Total	0	0	0	0	363	5,348	5,477	5,563	4,552	2,344	557		24,204

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

CURRENT MONTH				FISCAL YEAR TO DATE				
Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)
<u>CAPITATED MEDICAL EXPENSES</u>								
\$1,964,493	\$1,744,285	(\$220,208)	(12.6%)	PCP Capitation	\$43,783,903	\$26,837,994	(\$16,945,909)	(63.1%)
6,226,635	6,571,114	344,479	5.2%	PCP Capitation FQHC	67,857,713	70,734,749	2,877,036	4.1%
483,966	455,237	(28,728)	(6.3%)	Specialty Capitation	4,755,523	4,680,577	(74,946)	(1.6%)
5,493,258	5,951,361	458,102	7.7%	Specialty Capitation FQHC	59,654,292	63,547,997	3,893,705	6.1%
760,132	717,249	(42,883)	(6.0%)	Laboratory Capitation	8,347,583	8,001,900	(345,683)	(4.3%)
341,899	341,758	(140)	0.0%	Vision Capitation	3,762,987	3,743,167	(19,820)	(0.5%)
110,079	132,440	22,362	16.9%	CFMG Capitation	1,226,202	1,361,873	135,672	10.0%
840,319	290,094	(550,225)	(189.7%)	ANC IPA Admin Capitation FQHC	4,659,353	3,106,713	(1,552,640)	(50.0%)
0	0	0	0.0%	Kaiser Capitation	(8,639,235)	(8,639,177)	57	0.0%
0	0	0	0.0%	BHT Supplemental Expense	(65,356)	0	65,356	0.0%
0	0	0	0.0%	Maternity Supplemental Expense	37,270	27,953	(9,318)	(33.3%)
1,031,601	858,004	(173,597)	(20.2%)	DME Capitation	11,259,855	10,170,016	(1,089,839)	(10.7%)
17,252,382	17,061,542	(190,839)	(1.1%)	7. TOTAL CAPITATED EXPENSES	196,640,091	183,573,762	(13,066,329)	(7.1%)
<u>FEE FOR SERVICE MEDICAL EXPENSES</u>								
11,549,719	0	(11,549,719)	0.0%	IBNR Inpatient Services	46,799,113	(3,303,163)	(50,102,276)	1,516.8%
346,492	0	(346,492)	0.0%	IBNR Settlement (IP)	1,403,972	(99,094)	(1,503,066)	1,516.8%
923,977	0	(923,977)	0.0%	IBNR Claims Fluctuation (IP)	3,743,926	(264,254)	(4,008,180)	1,516.8%
38,200,605	51,402,507	13,201,902	25.7%	Inpatient Hospitalization FFS	503,085,574	562,017,958	58,932,384	10.5%
2,680,452	0	(2,680,452)	0.0%	IP OB - Mom & NB	34,609,951	12,540,164	(22,069,787)	(176.0%)
847,735	0	(847,735)	0.0%	IP Behavioral Health	6,473,136	1,070,307	(5,402,829)	(504.8%)
1,250,905	0	(1,250,905)	0.0%	Inpatient Facility Rehab FFS	14,218,640	5,770,736	(8,447,904)	(146.4%)
55,799,885	51,402,507	(4,397,378)	(8.6%)	8. Inpatient Hospital Expense	610,334,311	577,732,654	(32,601,658)	(5.6%)
269,598	0	(269,598)	0.0%	IBNR PCP	478,212	(293,439)	(771,651)	263.0%
8,087	0	(8,087)	0.0%	IBNR Settlement (PCP)	14,348	(8,801)	(23,149)	263.0%
21,568	0	(21,568)	0.0%	IBNR Claims Fluctuation (PCP)	106,519	44,791	(61,728)	(137.8%)
2,426,555	2,904,453	477,898	16.5%	PCP FFS	40,932,813	35,325,354	(5,607,459)	(15.9%)
439,974	855,163	415,189	48.6%	PCP FQHC FFS	4,351,964	7,516,484	3,164,520	42.1%
(6,000)	0	6,000	0.0%	Physician Extended Hrs. Incent	13,000	12,000	(1,000)	(8.3%)
0	916,197	916,197	100.0%	Prop 56 Physician Pmt	(12,256,206)	1,694,831	13,951,037	823.2%
16,242	0	(16,242)	0.0%	Prop 56 Hyde	230,393	64,923	(165,470)	(254.9%)
76,456	0	(76,456)	0.0%	Prop 56 Trauma Screening	336,306	110,133	(226,174)	(205.4%)
91,105	0	(91,105)	0.0%	Prop 56 Developmentl Screening	332,763	96,040	(236,723)	(246.5%)
660,233	0	(660,233)	0.0%	Prop 56 Family Planning	(421,565)	(767,666)	(346,102)	45.1%
0	0	0	0.0%	Prop 56 VBP	(2,406,095)	(2,718,741)	(312,647)	11.5%
4,003,818	4,675,813	671,995	14.4%	9. Primary Care Physician Expense	31,712,453	41,075,907	9,363,455	22.8%
511,019	0	(511,019)	0.0%	IBNR Specialist	1,516,420	(747,176)	(2,263,596)	303.0%
15,331	0	(15,331)	0.0%	IBNR Settlement (SCP)	45,497	(22,414)	(67,911)	303.0%
40,881	0	(40,881)	0.0%	IBNR Claims Fluctuation (SCP)	121,312	(59,775)	(181,087)	302.9%
502,901	0	(502,901)	0.0%	Psychiatrist FFS	4,742,961	1,559,071	(3,183,891)	(204.2%)
3,262,471	8,182,784	4,920,313	60.1%	Specialty Care FFS	38,706,788	72,085,702	33,378,914	46.3%
315,212	0	(315,212)	0.0%	Specialty Anesthesiology	2,640,008	1,061,004	(1,579,004)	(148.8%)
1,641,627	0	(1,641,627)	0.0%	Specialty Imaging FFS	18,266,672	6,843,037	(11,423,635)	(166.9%)
30,556	0	(30,556)	0.0%	Obstetrics FFS	397,373	181,208	(216,165)	(119.3%)
406,086	0	(406,086)	0.0%	Specialty IP Surgery FFS	4,489,752	1,679,499	(2,810,253)	(167.3%)
911,449	0	(911,449)	0.0%	Specialty OP Surgery FFS	10,654,170	4,353,452	(6,300,718)	(144.7%)
695,916	0	(695,916)	0.0%	Specialty IP Physician	7,423,689	2,543,833	(4,879,856)	(191.8%)
134,797	126,936	(7,861)	(6.2%)	Specialist FQHC FFS	1,401,888	1,415,513	13,625	1.0%
8,468,245	8,309,721	(158,525)	(1.9%)	10. Specialty Care Physician Expense	90,406,529	90,892,954	486,425	0.5%
1,335,470	0	(1,335,470)	0.0%	IBNR Ancillary (ANC)	4,521,327	904,191	(3,617,136)	(400.0%)

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

CURRENT MONTH				FISCAL YEAR TO DATE				
Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)
40,064	0	(40,064)	0.0%	IBNR Settlement (ANC)	222,701	114,188	(108,513)	(95.0%)
106,837	0	(106,837)	0.0%	IBNR Claims Fluctuation (ANC)	525,617	236,248	(289,369)	(122.5%)
432,756	0	(432,756)	0.0%	IBNR Transportation FFS	743,826	207,856	(535,970)	(257.9%)
2,796,079	0	(2,796,079)	0.0%	Behavioral Health Therapy FFS	25,051,787	8,190,565	(16,861,222)	(205.9%)
2,313,762	0	(2,313,762)	0.0%	Psychologist & Other MH Prof	22,197,528	7,234,250	(14,963,278)	(206.8%)
526,668	0	(526,668)	0.0%	Other Medical Professional	5,291,491	1,865,835	(3,425,656)	(183.6%)
131,557	0	(131,557)	0.0%	Hearing Devices	1,592,870	674,558	(918,312)	(136.1%)
23,896	0	(23,896)	0.0%	ANC Imaging	383,518	228,147	(155,371)	(68.1%)
85,857	0	(85,857)	0.0%	Vision FFS	827,328	280,298	(547,030)	(195.2%)
0	0	0	0.0%	Family Planning	56	10	(46)	(464.6%)
655,285	0	(655,285)	0.0%	Laboratory FFS	11,268,381	6,593,456	(4,674,926)	(70.9%)
127,276	0	(127,276)	0.0%	ANC Therapist	1,634,895	644,262	(990,632)	(153.8%)
1,929,172	0	(1,929,172)	0.0%	Transp/Ambulance FFS	18,376,378	5,962,027	(12,414,351)	(208.2%)
3,682,803	0	(3,682,803)	0.0%	Non-ER Transportation FFS	27,037,666	8,526,483	(18,511,183)	(217.1%)
1,394,370	0	(1,394,370)	0.0%	Hospice FFS	24,171,296	9,250,960	(14,920,336)	(161.3%)
1,418,818	0	(1,418,818)	0.0%	Home Health Services	19,557,119	7,088,754	(12,468,365)	(175.9%)
0	14,633,916	14,633,916	100.0%	Other Medical FFS	128	100,424,893	100,424,765	100.0%
38,689	0	(38,689)	0.0%	Medical Refunds through HMS	(1,478,125)	290,192	1,768,317	609.4%
0	0	0	0.0%	Medical Refunds	10,037	0	(10,037)	0.0%
20,691	0	(20,691)	0.0%	DME & Medical Supplies FFS	391,404	187,833	(203,570)	(108.4%)
2,610,340	2,292,025	(318,315)	(13.9%)	ECM Base/Outreach FFS ANC	7,852,374	6,365,049	(1,487,324)	(23.4%)
116,794	107,586	(9,208)	(8.6%)	CS Housing Deposits FFS ANC	1,221,244	1,196,346	(24,898)	(2.1%)
857,536	835,467	(22,069)	(2.6%)	CS Housing Tenancy FFS ANC	8,438,189	8,828,325	390,137	4.4%
491,198	460,782	(30,416)	(6.6%)	CS Housing Navi Servic FFS ANC	4,927,638	5,033,276	105,638	2.1%
291,752	738,285	446,533	60.5%	CS Medical Respite FFS ANC	6,008,693	7,522,394	1,513,701	20.1%
135,915	167,037	31,122	18.6%	CS Med. Tailored Meals FFS ANC	2,660,103	2,022,826	(637,277)	(31.5%)
44,187	25,378	(18,808)	(74.1%)	CS Asthma Remediation FFS ANC	156,960	194,631	37,671	19.4%
0	10,064	10,064	100.0%	MOT Wrap Around (Non Med MOT)	0	69,945	69,945	100.0%
0	10,014	10,014	100.0%	CS Home Modifications FFS ANC	24,053	94,050	69,997	74.4%
65,960	533,421	467,460	87.6%	CS P.Care & Hmker Svcs FFS ANC	2,441,912	5,219,941	2,778,029	53.2%
0	20,025	20,025	100.0%	CS Cgiver Respite Svcs FFS ANC	54,963	182,359	127,396	69.9%
680	0	(680)	0.0%	CS Housing Outreach	880	0	(880)	0.0%
457,143	0	(457,143)	0.0%	CommunityBased Adult Svc(CBAS)	5,154,131	2,203,374	(2,950,757)	(133.9%)
18,923	25,000	6,077	24.3%	CS LTC Diversion FFS ANC	200,238	242,778	42,540	17.5%
2,753	7,517	4,763	63.4%	CS LTC Transition FFS ANC	7,757	52,495	44,738	85.2%
22,153,233	19,866,517	(2,286,715)	(11.5%)	11. Ancillary Medical Expense	201,476,360	198,132,794	(3,343,566)	(1.7%)
(1,556,850)	0	1,556,850	0.0%	IBNR Outpatient	2,575,333	231,629	(2,343,704)	(1,011.8%)
(46,707)	0	46,707	0.0%	IBNR Settlement (OP)	77,263	6,949	(70,314)	(1,011.8%)
(124,549)	0	124,549	0.0%	IBNR Claims Fluctuation (OP)	206,020	18,527	(187,492)	(1,012.0%)
2,530,823	11,627,035	9,096,212	78.2%	Outpatient FFS	27,105,884	91,579,449	64,473,565	70.4%
2,354,967	0	(2,354,967)	0.0%	OP Ambul Surgery FFS	29,817,238	11,593,959	(18,223,279)	(157.2%)
2,920,555	0	(2,920,555)	0.0%	Imaging Services FFS	29,184,110	10,130,403	(19,053,708)	(188.1%)
127,442	0	(127,442)	0.0%	Behavioral Health FFS	664,767	97,460	(567,307)	(582.1%)
837,873	0	(837,873)	0.0%	Outpatient Facility Lab FFS	8,448,666	2,863,424	(5,585,242)	(195.1%)
241,370	0	(241,370)	0.0%	Outpatient Facility Cardio FFS	2,415,852	844,453	(1,571,399)	(186.1%)
115,669	0	(115,669)	0.0%	OP Facility PT/OT/ST FFS	1,106,719	400,408	(706,312)	(176.4%)
2,824,402	0	(2,824,402)	0.0%	OP Facility Dialysis Ctr FFS	34,890,556	12,647,437	(22,243,118)	(175.9%)
10,224,993	11,627,035	1,402,041	12.1%	12. Outpatient Medical Expense	136,492,408	130,414,098	(6,078,310)	(4.7%)
672,666	0	(672,666)	0.0%	IBNR Emergency	3,337,663	(165,803)	(3,503,466)	2,113.0%
20,179	0	(20,179)	0.0%	IBNR Settlement (ER)	100,130	(4,974)	(105,104)	2,112.9%
53,812	0	(53,812)	0.0%	IBNR Claims Fluctuation (ER)	267,008	(13,266)	(280,274)	2,112.7%
3,850	0	(3,850)	0.0%	ER Global	3,850	0	(3,850)	0.0%
8,897,856	10,658,867	1,761,012	16.5%	ER Facility	98,126,657	110,419,208	12,292,551	11.1%
1,122,885	0	(1,122,885)	0.0%	Specialty ER Physician FFS	13,665,514	4,880,392	(8,785,122)	(180.0%)
10,771,248	10,658,867	(112,381)	(1.1%)	13. Emergency Expense	115,500,821	115,115,556	(385,265)	(0.3%)

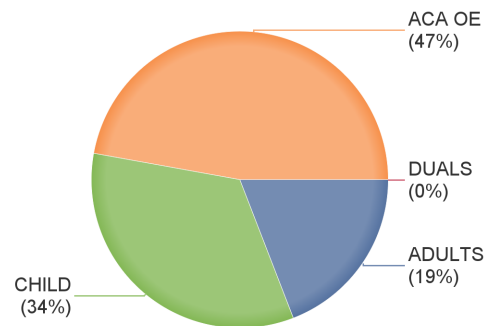
**ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 31 MAY, 2025**

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)
53,271	0	(53,271)	0.0%	IBNR Pharmacy (OP)	3,139,227	1,991,773	(1,147,454)	(57.6%)
1,598	0	(1,598)	0.0%	IBNR Settlement Rx (OP)	94,177	59,755	(34,422)	(57.6%)
4,261	0	(4,261)	0.0%	IBNR Claims Fluctuation Rx(OP)	251,140	159,342	(91,798)	(57.6%)
713,399	462,419	(250,980)	(54.3%)	Pharmacy FFS (OP)	7,706,604	6,256,102	(1,450,502)	(23.2%)
110,989	11,462,039	11,351,050	99.0%	Pharmacy Non PBM FFS Other-ANC	1,404,901	81,460,248	80,055,347	98.3%
8,141,003	0	(8,141,003)	0.0%	Pharmacy Non PBM FFS OP-FAC	99,295,818	39,326,556	(59,969,262)	(152.5%)
253,937	0	(253,937)	0.0%	Pharmacy Non PBM FFS PCP	2,710,209	985,563	(1,724,646)	(175.0%)
2,602,445	0	(2,602,445)	0.0%	Pharmacy Non PBM FFS SCP	27,181,246	10,617,727	(16,563,519)	(156.0%)
21,933	0	(21,933)	0.0%	Pharmacy Non PBM FFS FQHC	239,983	82,575	(157,408)	(190.6%)
9,700	0	(9,700)	0.0%	Pharmacy Non PBM FFS HH	162,445	91,629	(70,816)	(77.3%)
0	0	0	0.0%	RX Refunds HMS	(345)	(306)	39	(12.6%)
(50,000)	51,861	101,861	196.4%	Medical Expenses Pharm Rebate	(802,237)	144,719	946,956	654.3%
11,862,536	11,976,319	113,783	1.0%	14. Pharmacy Expense	141,383,168	141,175,681	(207,487)	(0.1%)
3,247,952	0	(3,247,952)	0.0%	IBNR LTC	22,630,552	(3,756,936)	(26,387,488)	702.4%
97,440	0	(97,440)	0.0%	IBNR Settlement (LTC)	678,916	(112,709)	(791,625)	702.4%
259,836	0	(259,836)	0.0%	IBNR Claims Fluctuation (LTC)	1,810,442	(300,555)	(2,110,997)	702.4%
1,930,506	0	(1,930,506)	0.0%	LTC - ICF/DD	17,949,879	6,755,726	(11,194,153)	(165.7%)
22,970,712	0	(22,970,712)	0.0%	LTC Custodial Care	259,185,347	99,683,289	(159,502,059)	(160.0%)
6,674,633	34,071,095	27,396,462	80.4%	LTC SNF	83,224,606	265,254,493	182,029,887	68.6%
35,181,079	34,071,095	(1,109,984)	(3.3%)	15. Long Term Care Expense	385,479,742	367,523,307	(17,956,435)	(4.9%)
158,465,037	152,587,874	(5,877,163)	(3.9%)	16. TOTAL FFS MEDICAL EXPENSES	1,712,785,794	1,662,062,952	(50,722,841)	(3.1%)
0	(1,310,108)	(1,310,108)	100.0%	Clinical Vacancy #102	0	(2,085,993)	(2,085,993)	100.0%
99,237	301,064	201,828	67.0%	Quality Analytics #123	2,095,216	2,549,412	454,196	17.8%
410,706	452,562	41,856	9.2%	Long Term Services and Support #139	3,179,847	3,312,411	132,564	4.0%
946,844	1,226,171	279,327	22.8%	Utilization Management #140	10,723,377	10,732,912	9,534	0.1%
756,951	913,848	156,897	17.2%	Case & Disease Management #185	7,847,702	7,831,424	(16,278)	(0.2%)
1,031,784	900,227	(131,557)	(14.6%)	Medical Management #230	9,946,520	11,992,050	2,045,530	17.1%
1,464,879	1,171,010	(293,869)	(25.1%)	Quality Improvement #235	12,604,857	13,498,956	894,100	6.6%
365,202	512,331	147,129	28.7%	HCS Behavioral Health #238	3,686,260	4,072,661	386,401	9.5%
167,152	242,858	75,706	31.2%	Pharmacy Services #245	1,475,023	2,539,252	1,064,229	41.9%
6,307	85,013	78,706	92.6%	Regulatory Readiness #268	619,430	767,075	147,645	19.2%
5,249,062	4,494,978	(754,084)	(16.8%)	17. Other Benefits & Services	52,178,231	55,210,160	3,031,929	5.5%
(1,611,625)	(1,269,500)	342,125	(26.9%)	Reinsurance Recoveries	(20,987,629)	(15,796,220)	5,191,409	(32.9%)
1,679,854	1,692,666	12,812	0.8%	Reinsurance Premium	18,975,944	19,109,936	133,992	0.7%
68,229	423,167	354,938	83.9%	18. Reinsurance Expense	(2,011,685)	3,313,716	5,325,401	160.7%
181,034,710	174,567,561	(6,467,149)	(3.7%)	20. TOTAL MEDICAL EXPENSES	1,959,592,431	1,904,160,591	(55,431,840)	(2.9%)

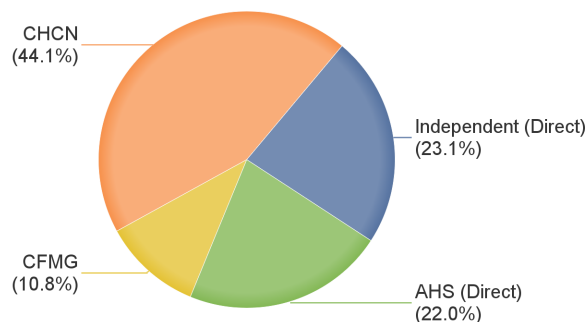
Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend						
Category of Aid	Apr 2025	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN
ADULTS	62,532	15%	13,585	14,080	0	34,867
CHILD	110,211	27%	10,486	13,429	41,303	44,993
SPD	0	0%	0	0	0	0
ACA OE	154,154	38%	28,361	53,370	1,545	70,878
DUALS	1	0%	1	0	0	0
LTC	0	0%	0	0	0	0
LTC-DUAL	0	0%	0	0	0	0
SPD-LTC	29,316	7%	8,653	5,074	1,479	14,110
SPD-LTC/Full Dual	48,733	12%	31,539	3,518	3	13,673
Medi-Cal	404,947		92,625	89,471	44,330	178,521
Group Care	5,896		2,204	988	0	2,704
Total	410,843	100%	94,829	90,459	44,330	181,225
Medi-Cal %	98.6%		97.7%	98.9%	100.0%	98.5%
Group Care %	1.4%		2.3%	1.1%	0.0%	1.5%
Network Distribution			23.1%	22.0%	10.8%	44.1%
			% Direct:	45%	% Delegated:	55%

Medi-Cal By Aid Category

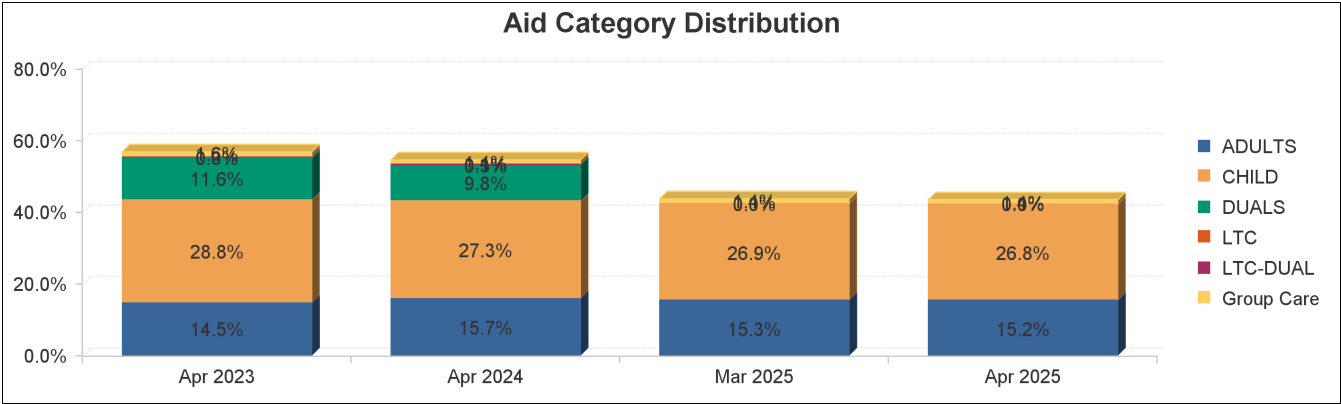


By Network

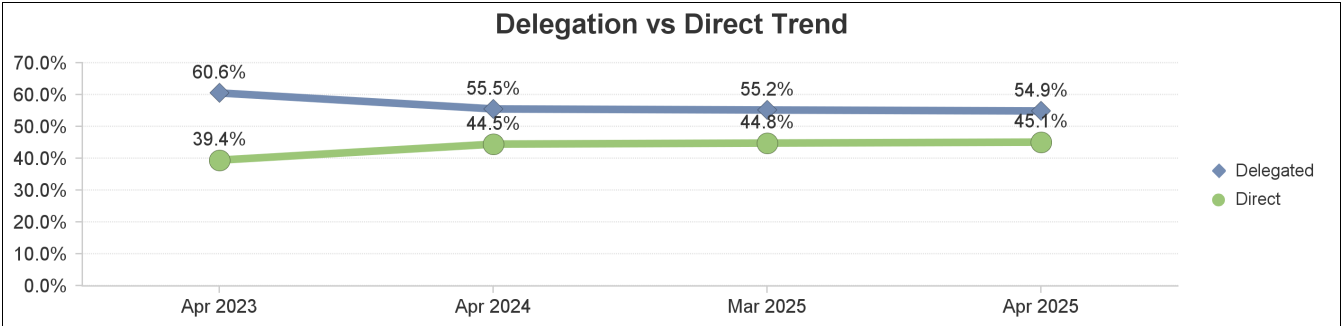


Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend											
Category of Aid	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Apr 2023	Apr 2024	Mar 2025	Apr 2025	Apr 2023	Apr 2024	Mar 2025	Apr 2025	Apr 2023 to Apr 2024	Apr 2024 to Apr 2025	Mar 2025 to Apr 2025
ADULTS	52,047	63,551	63,278	62,532	14.5%	15.7%	15.3%	15.2%	18.1%	-1.6%	-1.2%
CHILD	103,173	110,566	111,153	110,211	28.8%	27.3%	26.9%	26.8%	6.7%	-0.3%	-0.9%
SPD	31,130	34,887	0	0	8.7%	8.6%	0.0%	0.0%	10.8%	0.0%	0.0%
ACA OE	123,606	149,154	154,579	154,154	34.5%	36.8%	37.5%	37.5%	17.1%	3.2%	-0.3%
DUALS	41,473	39,912	1	1	11.6%	9.8%	0.0%	0.0%	-3.9%	#####	0.0%
LTC	145	223	0	0	0.0%	0.1%	0.0%	0.0%	35.0%	0.0%	0.0%
LTC-DUAL	983	1,291	0	0	0.3%	0.3%	0.0%	0.0%	23.9%	0.0%	0.0%
SPD-LTC	0	0	29,609	29,316	0.0%	0.0%	7.2%	7.1%	0.0%	100.0%	-1.0%
SPD-LTC/ Full Dual	0	0	48,241	48,733	0.0%	0.0%	11.7%	11.9%	0.0%	100.0%	1.0%
Medi-Cal	352,557	399,584	406,861	404,947	98.4%	98.6%	98.6%	98.6%	11.8%	1.3%	-0.5%
Group Care	5,669	5,643	5,882	5,896	1.6%	1.4%	1.4%	1.4%	-0.5%	4.3%	0.2%
Total	358,226	405,227	412,743	410,843	100.0%	100.0%	100.0%	100.0%	11.6%	1.4%	-0.5%

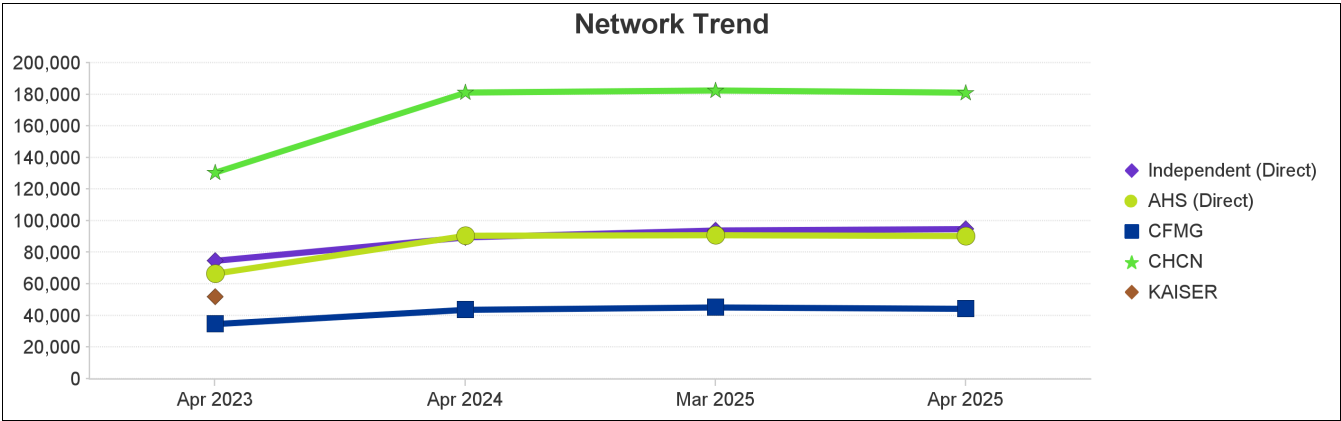


Delegation vs Direct Trend											
Members	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Apr 2023	Apr 2024	Mar 2025	Apr 2025	Apr 2023	Apr 2024	Mar 2025	Apr 2025	Apr 2023 to Apr 2024	Apr 2024 to Apr 2025	Mar 2025 to Apr 2025
Delegated	216,961	225,002	227,836	225,555	60.6%	55.5%	55.2%	54.9%	3.6%	0.2%	-1.0%
Direct	141,265	180,225	184,907	185,288	39.4%	44.5%	44.8%	45.1%	21.6%	2.7%	0.2%
Total	358,226	405,227	412,743	410,843	100.0%	100.0%	100.0%	100.0%	11.6%	1.4%	-0.5%

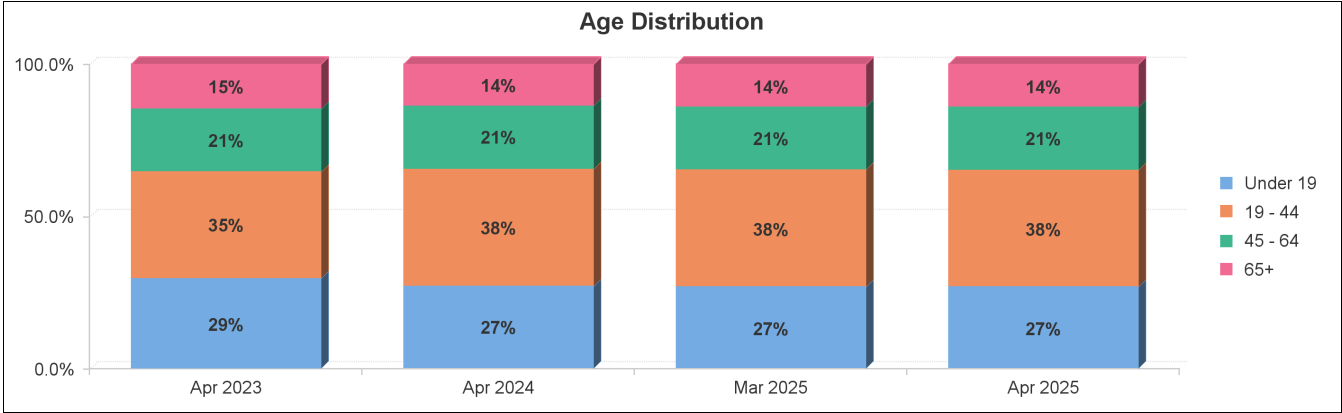


Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

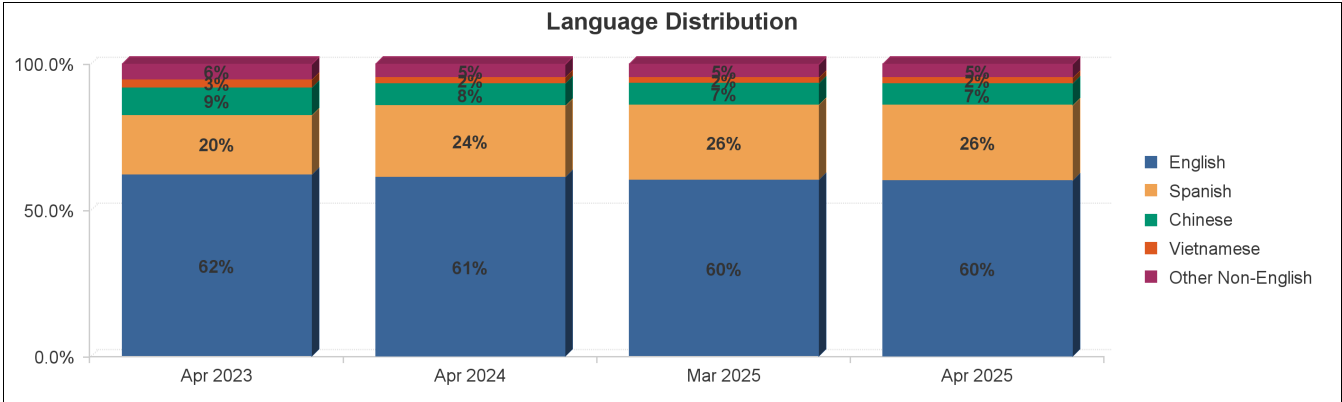
Network Trend											
Network	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Apr 2023	Apr 2024	Mar 2025	Apr 2025	Apr 2023	Apr 2024	Mar 2025	Apr 2025	Apr 2023 to Apr 2024	Apr 2024 to Apr 2025	Mar 2025 to Apr 2025
Independent (Direct)	74,713	89,595	93,950	94,829	20.9%	22.1%	22.8%	23.1%	16.6%	5.5%	0.9%
AHS (Direct)	66,552	90,630	90,957	90,459	18.6%	22.4%	22.0%	22.0%	26.6%	-0.2%	-0.6%
CFMG	34,644	43,702	45,203	44,330	9.7%	10.8%	11.0%	10.8%	20.7%	1.4%	-2.0%
CHCN	130,508	181,300	182,633	181,225	36.4%	44.7%	44.2%	44.1%	28.0%	0.0%	-0.8%
KAISER	51,809	0	0	0	14.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	358,226	405,227	412,743	410,843	100.0%	100.0%	100.0%	100.0%	11.6%	1.4%	-0.5%



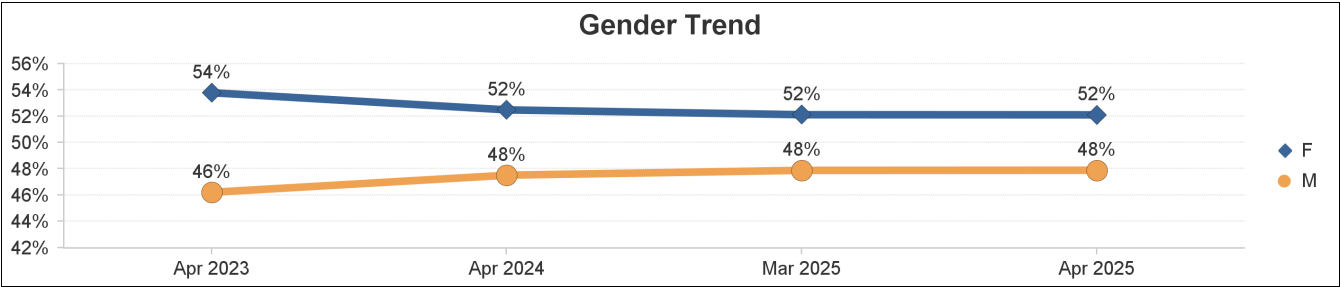
Age Category Trend											
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Apr 2023	Apr 2024	Mar 2025	Apr 2025	Apr 2023	Apr 2024	Mar 2025	Apr 2025	Apr 2023 to Apr 2024	Apr 2024 to Apr 2025	Mar 2025 to Apr 2025
Under 19	105,525	108,917	110,282	109,618	29%	27%	27%	27%	3%	1%	-1%
19 - 44	125,496	156,001	158,678	157,592	35%	38%	38%	38%	20%	1%	-1%
45 - 64	73,669	84,128	85,158	84,775	21%	21%	21%	21%	12%	1%	0%
65+	53,536	56,181	58,625	58,858	15%	14%	14%	14%	5%	5%	0%
Total	358,226	405,227	412,743	410,843	100%	100%	100%	100%	12%	1%	0%



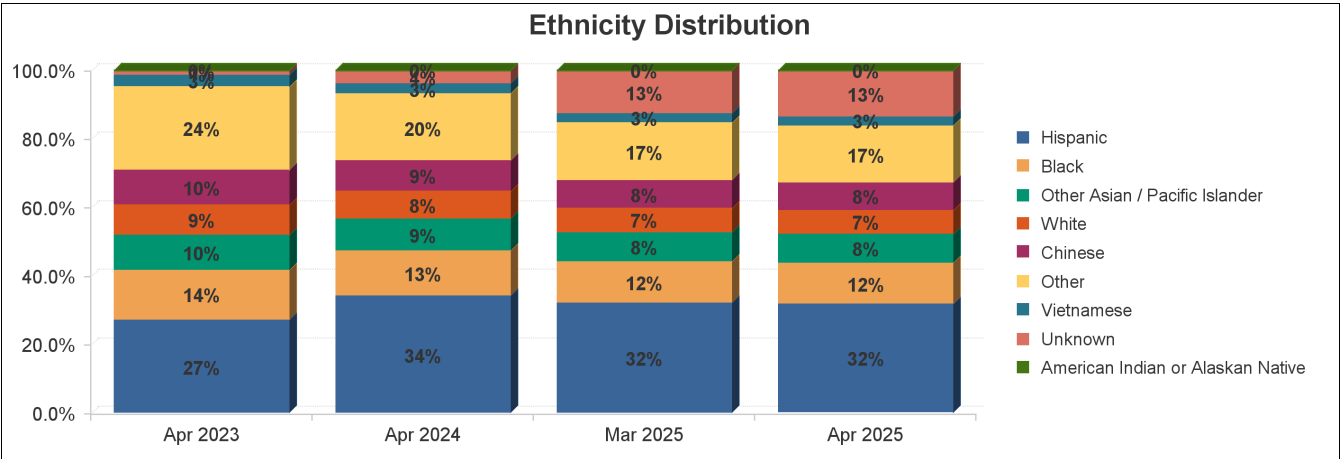
Language Trend											
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	Apr 2023	Apr 2024	Mar 2025	Apr 2025	pr 2023	pr 2024	Mar 2025	pr 2025	Apr 2023 to Apr 2024	Apr 2024 to Apr 2025	Mar 2025 to Apr 2025
English	221,974	247,927	248,349	246,716	62%	61%	60%	60%	10%	0%	-1%
Spanish	72,728	98,970	105,898	105,652	20%	24%	26%	26%	27%	6%	0%
Chinese	33,747	30,725	30,544	30,517	9%	8%	7%	7%	-10%	-1%	0%
Vietnamese	9,787	8,548	8,209	8,174	3%	2%	2%	2%	-14%	-5%	0%
Other Non-English	19,990	19,057	19,743	19,784	6%	5%	5%	5%	-5%	4%	0%
Total	358,226	405,227	412,743	410,843	100%	100%	100%	100%	12%	1%	0%



Gender Trend											
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Apr 2023	Apr 2024	Mar 2025	Apr 2025	Apr 2023	Apr 2024	Mar 2025	Apr 2025	Apr 2023 to Apr 2024	Apr 2024 to Apr 2025	Mar 2025 to Apr 2025
F	192,712	212,693	215,119	214,090	54%	52%	52%	52%	9%	1%	0%
M	165,514	192,534	197,624	196,753	46%	48%	48%	48%	14%	2%	0%
Total	358,226	405,227	412,743	410,843	100%	100%	100%	100%	12%	1%	0%



Ethnicity Trend											
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Apr 2023	Apr 2024	Mar 2025	Apr 2025	Apr 2023	Apr 2024	Mar 2025	Apr 2025	Apr 2023 to Apr 2024	Apr 2024 to Apr 2025	Mar 2025 to Apr 2025
Hispanic	96,968	138,080	132,032	130,033	27%	34%	32%	32%	30%	-6%	-2%
Black	51,913	53,580	49,884	49,313	14%	13%	12%	12%	3%	-9%	-1%
Other Asian / Pacific Islander	36,482	37,409	34,933	34,386	10%	9%	8%	8%	2%	-9%	-2%
White	31,763	32,949	29,347	28,815	9%	8%	7%	7%	4%	-14%	-2%
Chinese	36,306	35,847	33,490	33,056	10%	9%	8%	8%	-1%	-8%	-1%
Other	87,251	79,277	69,451	68,358	24%	20%	17%	17%	-10%	-16%	-2%
Vietnamese	12,333	12,050	10,972	10,834	3%	3%	3%	3%	-2%	-11%	-1%
Unknown	4,471	15,231	51,888	55,315	1%	4%	13%	13%	71%	72%	6%
American Indian or Alaskan Native	739	804	746	733	0%	0%	0%	0%	8%	-10%	-2%
Total	358,226	405,227	412,743	410,843	100%	100%	100%	100%	12%	1%	0%



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

Medi-Cal By City						
City	Apr 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	161,908	40%	25,161	42,075	17,344	77,328
HAYWARD	53,634	13%	12,227	15,133	5,878	20,396
FREMONT	38,585	10%	16,191	6,787	2,405	13,202
SAN LEANDRO	26,205	6%	7,124	4,360	3,239	11,482
UNION CITY	14,555	4%	5,809	2,617	847	5,282
ALAMEDA	13,812	3%	3,378	2,490	2,057	5,887
BERKELEY	15,792	4%	4,092	2,332	1,797	7,571
LIVERMORE	13,291	3%	2,027	525	2,244	8,495
NEWARK	9,386	2%	2,783	4,043	574	1,986
CASTRO VALLEY	11,119	3%	3,215	1,784	1,756	4,364
SAN LORENZO	6,276	2%	1,337	1,426	723	2,790
PLEASANTON	8,051	2%	2,063	384	843	4,761
DUBLIN	7,762	2%	2,257	390	911	4,204
EMERYVILLE	2,990	1%	653	629	493	1,215
ALBANY	2,565	1%	620	297	573	1,075
PIEDMONT	504	0%	114	180	85	125
SUNOL	82	0%	21	15	7	39
ANTIOCH	22	0%	7	10	4	1
Other	18,408	5%	3,546	3,994	2,550	8,318
Total	404,947	100%	92,625	89,471	44,330	178,521

Group Care By City						
City	Apr 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	1,834	31%	350	371	0	1,113
HAYWARD	667	11%	313	171	0	183
FREMONT	664	11%	441	79	0	144
SAN LEANDRO	623	11%	254	92	0	277
UNION CITY	294	5%	184	45	0	65
ALAMEDA	303	5%	86	25	0	192
BERKELEY	149	3%	48	13	0	88
LIVERMORE	101	2%	31	3	0	67
NEWARK	145	2%	83	36	0	26
CASTRO VALLEY	206	3%	87	33	0	86
SAN LORENZO	145	2%	44	30	0	71
PLEASANTON	71	1%	22	4	0	45
DUBLIN	123	2%	43	7	0	73
EMERYVILLE	42	1%	13	6	0	23
ALBANY	23	0%	12	1	0	10
PIEDMONT	7	0%	1	1	0	5
SUNOL	1	0%	1	0	0	0
ANTIOCH	24	0%	8	4	0	12
Other	474	8%	183	67	0	224
Total	5,896	100%	2,204	988	0	2,704

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

Total By City						
City	Apr 2025	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN
OAKLAND	163,742	40%	25,511	42,446	17,344	78,441
HAYWARD	54,301	13%	12,540	15,304	5,878	20,579
FREMONT	39,249	10%	16,632	6,866	2,405	13,346
SAN LEANDRO	26,828	7%	7,378	4,452	3,239	11,759
UNION CITY	14,849	4%	5,993	2,662	847	5,347
ALAMEDA	14,115	3%	3,464	2,515	2,057	6,079
BERKELEY	15,941	4%	4,140	2,345	1,797	7,659
LIVERMORE	13,392	3%	2,058	528	2,244	8,562
NEWARK	9,531	2%	2,866	4,079	574	2,012
CASTRO VALLEY	11,325	3%	3,302	1,817	1,756	4,450
SAN LORENZO	6,421	2%	1,381	1,456	723	2,861
PLEASANTON	8,122	2%	2,085	388	843	4,806
DUBLIN	7,885	2%	2,300	397	911	4,277
EMERYVILLE	3,032	1%	666	635	493	1,238
ALBANY	2,588	1%	632	298	573	1,085
PIEDMONT	511	0%	115	181	85	130
SUNOL	83	0%	22	15	7	39
ANTIOCH	46	0%	15	14	4	13
Other	18,882	5%	3,729	4,061	2,550	8,542
Total	410,843	100%	94,829	90,459	44,330	181,225



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: July 11th, 2025

Subject: Operations Report

Member Services

- 12-Month Trend Blended Summary:
 - The Member Services Department received 16,253 calls in June 2025 compared to 16,528 in June 2024 and represents a 2% decrease in calls.
 - The abandonment rate for June 2025 was 4% compared to 3% in June 2024.
 - The Department's service level was 95% in June 2025, compared to 94% in June 2024. The average speed to answer (ASA) was eleven seconds (00:11) compared to fifteen seconds (00:15) in June 2024. The Department continues to recruit to fill open positions. Customer Service support service vendor continues to provide overflow call center support.
 - The average talk time (ATT) was seven minutes and fifty seconds (07:50) for June 2025 compared to six minutes and fifty-five seconds (06:55) for June 2024.
 - 100% of calls were answered within 10 minutes for June 2025 and 100% of calls were answered within 10 minutes for June 2024.
 - Outbound calls totaled 8,515 in June 2025 compared to 7,219 in June 2024.
 - The top five call reasons for June 2025 were 1) Change of PCP, 2) Eligibility/Enrollment 3) Grievances/Appeals, 4) Benefits, 5) Provider Network. The top five call reasons for June 2024 were: 1) Change of PCP, 2) Eligibility/Enrollment, 3) Benefits, 4) Provider Network, 5) ID Card Requests.
 - June utilization for the member automated eligibility IVR system totaled 1,225 in June 2025 compared to 1,489 in June 2024.
 - The Department continues to service members via multiple communication channels (telephonic, email, online, web-based requests, and in-person) while honoring the organization's policies. The Department responded to 1,300 web-based requests in June 2025 compared to 1,228 in June 2024. The top three web reason requests for June 2025 were: 1) Change of PCP, 2) ID Card Requests, 3) Update Contact Information. 62 members were assisted in-person in June 2025 compared to 61 in 2024.

- Member Services Behavioral Health:
 - The Member Services Behavioral Health (BH) Unit received a total of 1,037 calls in June 2025 compared to 1,181 in June 2024.
 - The abandonment rate was 7% in June 2025 compared to 8% in 2024.
 - The service level was 81% in June 2025 and 83% in June 2024.
 - The average speed to answer (ASA) was forty seconds (00:40) compared to fifty-two seconds (00:52) in June 2024.
 - Calls answered in 10 minutes were 99% in June 2025 compared to 99% in June 2024.
 - The Average Talk Time (ATT) was nine minutes and eight seconds (09:08) compared to eight minutes and fifty-nine seconds (08:59) in June 2024. MS BH Team utilizes the DHCS age-appropriate screening tools for Medi-Cal Mental Health Services to determine the appropriate delivery system for members who are not currently receiving mental health services when they contact the plan.
 - 991 outbound calls were completed in June 2025 compared to 973 in June 2024.
 - 111 screenings were completed in June 2025 compared to 136 in June 2024.
 - 90 outreach campaigns were completed in June 2025 compared to 63 in June 2024.
 - 50 referrals were made to the County (ACCESS) in June 2025 compared to 34 in June 2024.
 - 19 members were referred to Center Point for SUD services in June 2025 compared to 33 in June 2024.

Claims

- 12-Month Trend Summary:
 - The Claims Department received 340,224 claims in June 2025 compared to 297,267 in June 2024.
 - The Auto Adjudication rate was 88.1% in June 2025 compared to 87.5% in June 2024.
 - Claims compliance for the 30-day turn-around time was 91.3% in June 2025 compared to 89.7% in June 2024. The 45-day turn-around time was 93.8% in June 2025 compared to 99.8% in June 2024.
- Monthly Analysis:
 - In June, we received a total of 340,224 claims in the HEALTHsuite system; this reflects a 12.21% decrease from May 2025. It is also higher than the number of claims received in June 2024 by 12,110.
 - Drivers of the higher volume of claims received includes:
 - Increased membership and corresponding utilization of services.
 - Certain provider types that bill more frequently, e.g., LTC facilities that bill weekly or bi-weekly.

- Providers with dual eligible members who are submitting paper and or EDI claims even though we receive the same claim in our COBA file.
- 89% of claims were received via EDI and 11% of claims via paper during June.
- 93.8% of our claims were processed within 45 working days during the month.
- The Auto Adjudication rate was 88.1% for June.

Provider Dispute Resolution

- 12-Month Trend Summary:
 - In June 2025, the Provider Dispute Resolution (PDR) team received 3,843 PDRs compared to 3,791 PDRs received in June 2024. The number of PDRs received in June 2025 reflects a significant volume increase of 56% from May 2025.
- The PDR team resolved 2,634 cases in June 2025 compared to 1,613 cases in June 2024.
 - In June 2025, the PDR team upheld 83% of cases versus 70% in June 2024.
 - The PDR team resolved 99.6% of cases within the compliance standard of 95% within 45 working days in June 2025, compared to 99.8% in June 2024.
- Monthly Analysis
 - The Alliance received 3,843 PDRs in June 2025.
 - In the month of June, 2,634 PDRs were resolved, with 2,183 being upheld and 451 being overturned.
 - 2,626 out of 2,634 cases were resolved within 45 working days, resulting in a 99.6% compliance rate.
 - The average turnaround time for resolving PDRs in June was 38 days.
 - There were 4,696 PDRs pending resolution as of 06/30/2025, with no cases older than 45 working days.
 - The overturn rate for PDRs was 17%, which met our goal of 25% or less.

Grievances & Appeals

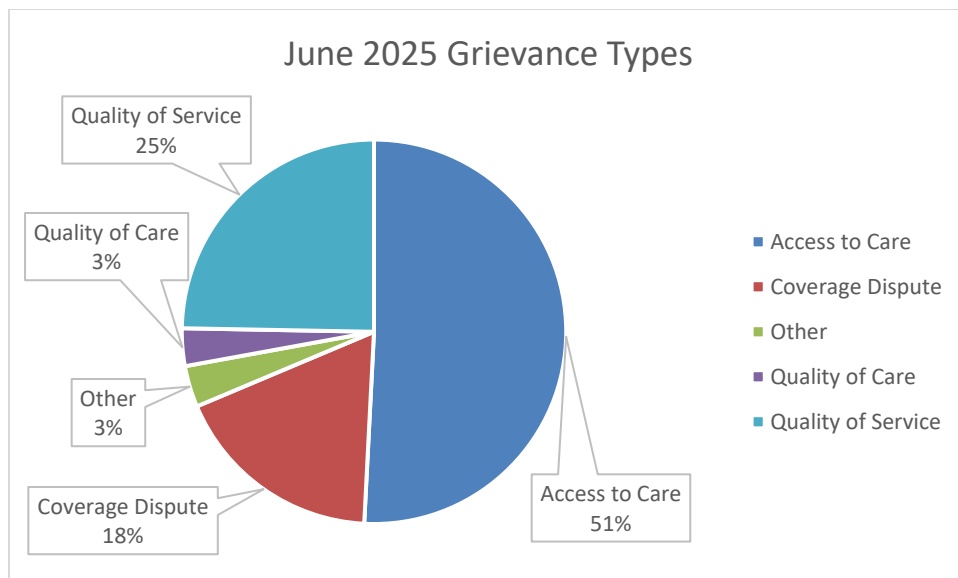
- Standard Grievance and Exempt Grievance cases were resolved within the goal of 95% of regulatory timeframes.
- Expedited Grievance cases were resolved within the goal of 95% of regulatory timeframes.
- Standard Appeal cases were resolved within the 95% of regulatory timeframes.
- Expedited Appeal cases were not resolved within the 95% of regulatory timeframes.
- Total Unique grievances resolved in June were 7.58 complaints per 1,000 members.

June 2025 Cases	Total Cases	TAT Standard	Benchmark	Total Compliance in	Compliance Rate	Per 1,000 Members*
Standard Grievance	2,212	30 Calendar Days	95% compliance within standard	2,117	95.7%	4.26
Expedited Grievance	2	72 Hours	95% compliance within standard	2	100.00%	0.004
Exempt Grievance	1,546	Next Business Day	95% compliance within standard	1,546	100.00%	3.87
Standard Appeal	73	30 Calendar Days	95% compliance within standard	72	98.6%	0.17
Expedited Appeal	6	72 Hours	95% compliance within standard	5	83.3%	0.01
Total Cases:	3,839		95% compliance within standard	3,742	97.5%	7.58

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

Standard Grievances:

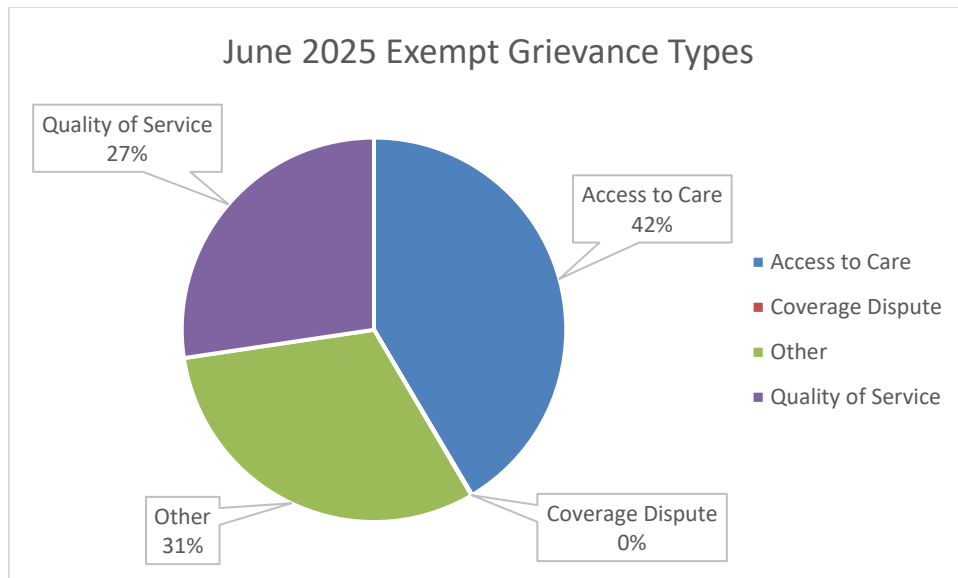
There were 1,757 unique grievance cases resolved during the reporting period, with a total of 2,214 grievances including 457 shadow cases.



- **1,125** of 2,214 (51%) cases were related to Access to Care; the following are the top four (4) categories:
 - Timely Access – 351
 - Technology/Telephone – 279
 - Provider Availability – 229
 - Authorization – 144
- **547** of 2,214 (25%) cases were related to Quality of Service; the following are the top three (3) categories:
 - Authorization – 105
 - Provider/Staff Attitude – 104
 - Plan Customer Service – 103
- **295** of 2,214 (13%) cases were related to Coverage Dispute; the following are the top two (2) categories:
 - Provider Direct Member Billing – 242
 - Provider Balance Billing – 86

Exempt Grievances:

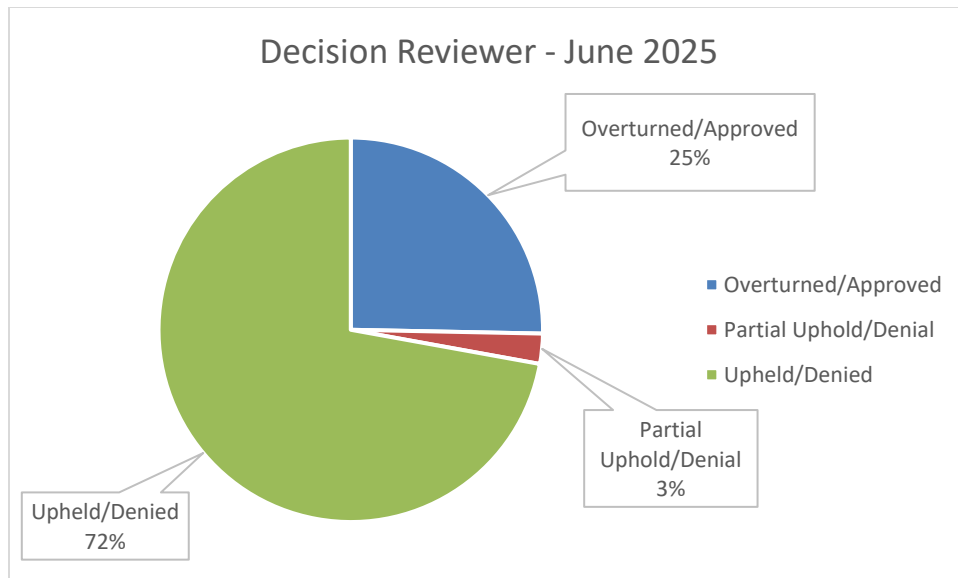
There were 1,361 unique exempt grievance cases resolved during the reporting period, with a total of 1,594 exempt grievances including 233 shadow cases.



- 661 of 1,594 (42%) cases were related to Access to Care; the following are the top three (3) categories:
 - Telephone/Technology – 351
 - Provider Availability – 173
 - Geographic Access – 87
- 496 of 1,594 (31%) cases were related to Other; the following are the top two (2) categories:
 - Enrollment – 455
 - Eligibility – 41
- 436 of 1,594 (27%) cases were related to Quality of Service; the following are the top two (2) categories:
 - Plan Customer Service – 250
 - Provider/Staff Attitude – 158

Appeals:

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



- **57** out of 79 (72%) cases were upheld/denied for the month of June 2025:
 - Disputes Involving Medical Necessity – 31
 - Out of Network – 21
 - Coverage Disputes – 5
- **20** out of 79 (25%) cases were overturned for the month of June 2025:
 - Disputes Involving Medical Necessity – 13
 - Out of Network – 5
 - Coverage Disputes – 2
- **2** out of 79 (3%) cases were partially upheld/denied for the month of June 2025:
 - Out of Network – 2

Provider Services

- 12-Month Trend Summary:
 - The Provider Services department's call volume in June 2025 was 9,214 calls compared to 6,825 calls in June 2024.
 - Provider Services continuously works to achieve first call resolution and reduction of the abandonment rates. Efforts to promote provider satisfaction is our first priority.
 - The Provider Services department completed 391 calls/visits during June 2025.
 - The Provider Services department answered 6,969 calls for June 2025 and made 520 outbound calls.

Credentialing

- 12-Month Trend Summary:
 - At the Peer Review and Credentialing (PRCC) meeting held on June 17th, 2025, there were 156 initial network providers approved; 4 primary care providers, 7 specialists, 20 ancillary providers, 8 midlevel providers, and 117 behavioral health providers. Additionally, 40 providers were re-credentialed at this meeting; 11 primary care providers, 16 specialists, 2 ancillary providers, and 11 midlevel providers.
 - Please refer to the Credentialing charts and graphs located in the Operations supporting documentation for more information.

Community Relations and Outreach

- 12-Month Trend Summary and Quarterly Analysis:
 - In Q4 2025, the Alliance completed 2,777 member orientation outreach calls and 274 member orientations by phone.
 - The C&O Department reached 2,282 people (56% identified as Alliance members) compared to approximately 1,426 individuals who identified as Alliance members in Q4 2024.
 - The C&O Department spent a total of \$520.00 on donations, fees, and/or sponsorships, compared to \$719.75 in Q4 2024.
 - The C&O Department reached members in 21 cities/unincorporated areas throughout Alameda County, the Bay Area, and the U.S., compared to 19 locations in Q4 2024.
- Monthly Analysis:
 - In June 2025, the C&O Department completed 761 member orientation outreach calls and 68 member orientations by phone, and 55 Alliance website inquiries.
 - Among the 1,371 people reached, 57% identified as Alliance members.
 - In June 2025, the C&O Department reached members in 13 locations throughout Alameda County, the Bay Area, and the U.S.
 - Please see attached **Addendum A**.

Housing and Community Services Program Report

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

Incentives & Reporting Board Report – June 2025 Activities

Current Incentive and Grant Programs

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

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

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

- The Alliance earned \$38M out of \$44M available under this program based on submission of deliverables and achievement of DHCS-defined metrics
 - \$23.7M has been awarded to our HHIP partners to date
- A HHIP funding opportunity was released in June 2024 to SBHIP LEA's to address the challenges of students experiencing homelessness and associated behavioral health needs (i.e., anxiety, depression, etc.)
 - The Alliance received applications from 10 LEAs totaling \$1.3M in requests; all submitted applications were approved and work on the funded programs continued
- In a separate HHIP-funded initiative, the Alliance awarded \$11.2M in funding to 10 community partners through a program that supports the HHIP goals of reducing and preventing homelessness
 - Projects are underway with activities taking place through 2028 related to capacity building, innovation, diversity and health equity, and housing stability
- The Alliance continues to review partner project deliverables prior to payment and meet with partners to discuss program activities and barriers
 - One partner has withdrawn from the program as they could not reach an agreement with an external partner to complete the work; the unused funding will now be reviewed by the Alliance to determine potential areas of investment
 - The Alliance is working with some partners to extend project timelines as they have experienced staffing challenges along with challenges executing necessary agreements to complete their scope of work

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

- 2024-25 Program highlights:
 - Launched on June 1st, 2024

- 15 applications received totaling \$6M in funding requests
- \$2M in funding awarded to 13 provider partners for the following:
 - Nineteen providers in total, six (6) of which are bilingual, including:
 - Six (6) Mid-Level Providers
 - Five (5) Behavioral Health Clinicians
 - Five (5) MD/DOs
 - Three (3) OB/GYNs
- \$218,000 has been awarded to our PRI partners to date
- Grants were provided to five (5) practices to support Community Health Worker (CHW) training certificate costs for 33 CHWs
- PRI deliverable trackers, to assist with program requirements, have been created and distributed to all awardees with signed MOUs
- 2025-26 Program status:
 - Program has been renewed for FY 2025-26 and will launch July 1st, 2025
 - Program materials are being updated, including the additional of Certified Medical Assistants to the program

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

- The original funding was \$700 million over five (5) years; however, due to state budget constraints, the funding was reduced to \$140 million over three (3) years
- Alameda Health System (AHS) was the only Alliance-associated applicant selected by DHCS to participate
 - AHS submitted their latest program deliverables that were due to DHCS on May 1st
 - The Alliance received \$302,463.84 from DHCS that AHS earned for their work and passed that payment on to AHS

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

- Scholarships are intended to offset costs related to the following:
 - Medi-Cal Provider Application and Validation for Enrollment (PAVE)
 - Contracting and credentialing with the Alliance
 - Continued education, training, and administrative and operational support required to be a Doula
- Scholarships of up to \$1,000 per person are available for Doulas both intending to contract with the Alliance and Doulas already contracted with the Alliance
- MOUs for the 20 scholarship awardees were signed, including seven (7) awards to support currently contracted Doulas and 13 awards for Doulas that intend to contract with the Alliance
 - To date, \$14,000 of the available \$20,000 in scholarships has been paid to program participants for completion of scholarship deliverables

- One (1) awardee has withdrawn from the program and one (1) awardee has indicated they will not complete the deliverables required for their final payment; with these changes, the Alliance expects to expend a total of \$18,500 instead of \$20,000

Grant Program Updates

- The Incentives and Reporting team implemented a grant management software system, Submittable, to support the various grant and incentive programs in which the Alliance participates
 - Submittable creates an online application process for community partners, an electronic evaluation process, reporting for fund management, and awardee deliverable tracking
 - The Doula Scholarship Program application was piloted within Submittable in December and continues to be used for partner communications and deliverable tracking
 - The Alliance is currently negotiating with Submittable on a Statement of Work to potentially create a dashboard to manage and track program related deliverables, including fund distribution
- California Improvement Network – the Alliance was selected, along with 24 other partners, to participate in an opportunity through the California Improvement Network (CIN), which is a learning and action community that advances equitable health care experiences and outcomes for Californians through cross-sector connections, spreading good ideas, and implementing improvements
 - CIN participation provides the Alliance with an opportunity to partner and connect with other organizations that are also working to improve health equity
 - The Alliance is receiving a small grant to cover the costs related to travel for participating in program activities
 - Participants are eligible to apply for a \$40k action project award to support implementation efforts for partners; the Alliance will be submitting its application in June
 - The Director, Health Equity will be participating in the equity focused learning network and leading project initiatives; Incentives & Reporting will provide program management support
 - The first in-person CIN Partner Meeting was held on May 8th; the Alliance was represented by Health Equity and Incentives & Reporting
- The California Wellness Foundation – a meeting with The California Wellness Foundation was held on January 23rd to discuss funding opportunities and eligibility criteria; however, the Foundation confirmed in February that MCPs are not eligible for funding
 - Future funding may be attainable by partnering with a Community Based Organization (CBO) as the lead applicant
- California Endowment - a Letter of Inquiry (LOI) was submitted to the California Endowment on January 31st to be considered for their grant opportunities; a response is still pending

- California Health Care Foundation – a LOI was submitted to the California Health Care Foundation on March 21st, in collaboration with support from Behavioral Health (BH) leads from Operations and Health Care Services, for two proposals focusing on the need for funding to support BH workforce needs, as well as infrastructure support for CBOs to bill for Medi-Cal covered services
- Robert Wood Johnson Foundation – In collaboration with True Vine Ministries, Health and Human Resource Center, and the Alliance Health Equity department, the application for a research grant was submitted to the Robert Wood Johnson Foundation on June 4th
 - Funding is for a new cohort of community-led pilot studies to produce new, actionable evidence about how to help medical, social, and public health systems work together to address forms of systemic racism
- Meetings continue with internal teams such as Health Equity, Health Care Services, and Behavioral Health (clinical and operational) leads to further develop and pursue grant-seeking strategies

Recruiting and Staffing

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

Incentive and Grant Program Descriptions

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

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

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

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

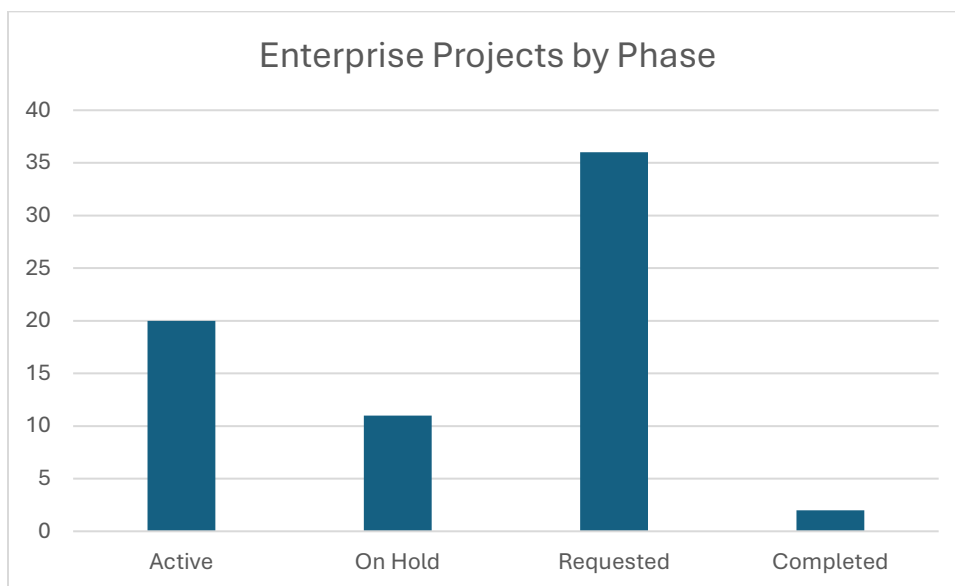
The Provider Recruitment Initiative (PRI) – program launched on June 1st, 2024, and is designed to provide grants to support the Alameda County Safety Net and community-based organizations to hire and retain healthcare professionals who serve the Alameda County Medi-Cal population. The PRI aims to grow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

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

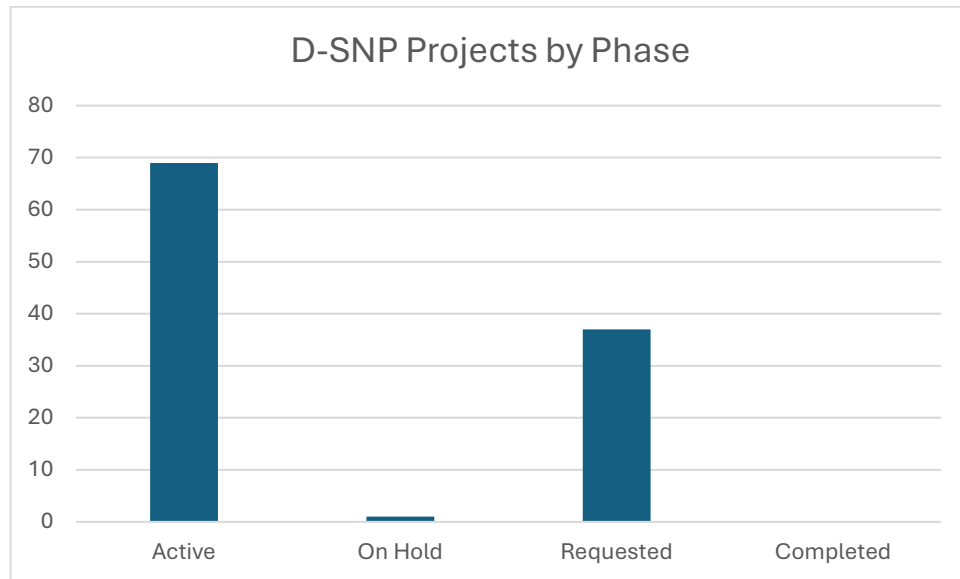
Doula Scholarship Program – program launched in December 2024 to grow the Doula provider network to increase access to these services for members.

INTEGRATED PLANNING DIVISION BOARD REPORT – JUNE 2025 ACTIVITIES

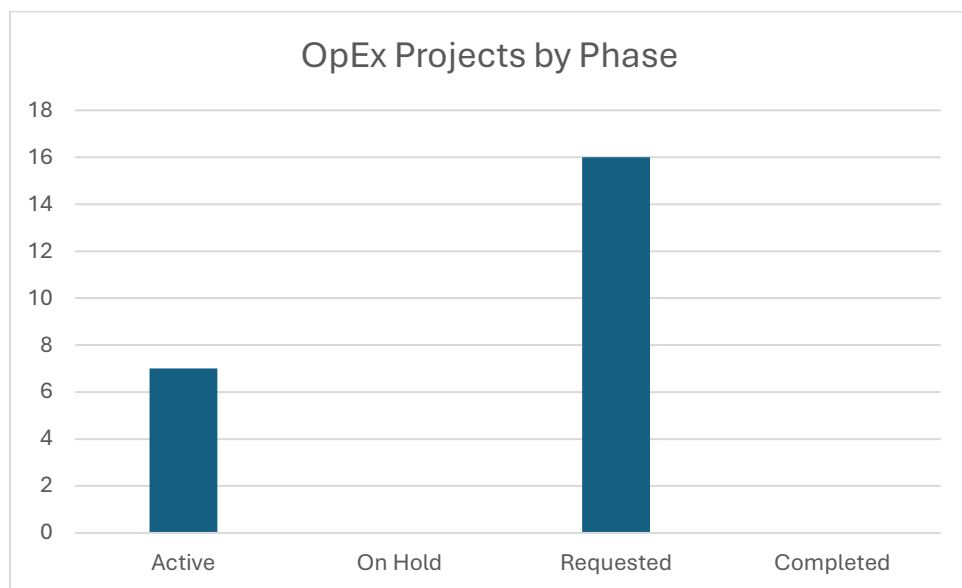
- Enterprise Portfolio
 - 67 projects currently on the Alameda Alliance for Health (AAH) enterprise-wide portfolio
 - 20 Active projects (discovery, initiation, planning, execution, warranty)
 - 11 On Hold projects
 - 36 Requested and Approved Projects
 - 2 Completed Projects (Last month)



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



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



- **D-SNP Key Initiatives and Dates:**
 - DMHC Material Modification Submission – MA Service Area Expansion – March 2024 - COMPLETE
 - DMHC Material Modification Submission – D-SNP Product – August 2024
 - CMS Notice of Intent to Apply – November 2024 - COMPLETE
 - CMS Application Submission including MOC, Provider Network Adequacy & DMHC Approval – February 2025 - COMPLETE
 - CMS Formulary & Bid Submission (Benefit Determination) – June 2nd, 2025 - COMPLETE
 - Medication Therapy Management (MTM) program submission – June 4th, 2025 - COMPLETE
 - CMS SMAC Submission – July 7th, 2025
 - Rebate Allocation with CMS and Health Plan – July / August 2025
 - Annual Enrollment Period (AEP) – October thru December 2025
 - IT System Readiness – December 15th, 2025
 - Open Enrollment Period (OEP) Begins – January 1st, 2026
- **D-SNP Activities – June 2025**
 - **01 – Provider Services & Contracting:**
 - Provider Contracting
 - Continued outreach to AAH provider network to complete the execution of the D-SNP Provider Amendment. As of June 25th, 103 contracts are fully executed, which equates to 25% completion
 - Continued contract negotiations with Brown & Toland, Sutter, UCSF, and Teladoc
 - Provider Services
 - Continued review and editing of the Provider Manual to support inclusion of D-SNP requirements
 - Initial requirements development for the online and printed D-SNP Provider Directory
 - Continued Provider Repository updates for the executed D-SNP Provider Amendments supporting D-SNP Provider Network Adequacy
 - Provider Rates and Reimbursement
 - Continued development of the Pay4Performance (P4P) program.
 - **02 – Quality:**
 - Model of Care
 - MOC has been approved by both DHCS and CMS
 - 96.25% earning three (3) year approval
 - MOC Provider Training – first draft deck completed
 - Quality Program
 - Quality Improvement Health Equity P&Ps continue to be updated/developed to align with D-SNP
 - 52 policies, 29 in progress, 11 not started
 - Quality Workplan
 - Aligning QI Workplan and Stars Playbook

- Developing BRDs for reporting requirements related to QI Workplan
 - Gathering Website and Provider Manual Requirements for Quality Committees
 - Charter redlines have been completed (Seven Quality Committees)
 - Establishing new committees for Utilization Management and Community Advisory Committee – 1st draft has been completed
- 03 - Health Care Services (HCS) and 04 - Behavioral Health (BH):
 - Continuing policy development and revisions (130 policies)
 - Redlining UM and CM Program Descriptions for D-SNP elements
 - Prior authorization code list has been finalized
 - HRA draft was submitted to DHCS and was approved
 - Final stages of future State D-SNP CM Global Workflow draft – outlining process flows for new D-SNP components to include Face-to-Face visit, Palliative Care Program, and Dementia Care Program
 - Continuing to define structure and net new processes for California Integrated Care Management (CICM) to include new requirements outlined in the CY2026 Program Guide
 - D-SNP CM Assessment/HRA mapping to care plan for rules generation
 - Other assessments SRD to TruCare Team for configuration
 - Continuing to build out system rules documents for D-SNP TruCare to submit to IT for configuration – Finalizing Tru-Care Core Feeds SRD
 - D-SNP authorization workstream in building out requirements and work efforts for stand-up
 - Finalizing UM customer set up requirements for configuration
 - BH CM – D-SNP CM program structure being finalized
 - Establishing framework to coordinate Medicare non-covered services with Alameda County Behavioral Health (ACBH)
 - BH programs policy and procedure development and revisions underway
 - Completing BH call flow and intersections with Member Services
 - Completed edits for D-SNP Member and Provider letters; additional letters created to support CMS and DHCS requirements
 - Risk Stratification model alignment with Medi-Cal model
 - Working to establish a framework for identification of populations of focus for CICM, Palliative Care, and Most Vulnerable Populations
 - BH UM – establishing additional levels of care for D-SNP population and documenting design requirements for TruCare
 - Initial stages of collaboration outline with ACBH for carve out BH services; first meeting with ACBH occurred on 03/26/2025 with additional follow-up meetings being scheduled
- 05 – Finance:
 - Continued Part D and Payment Reconciliation policy development
 - Discussion supporting the development of Finance Standard Operating Procedure (SOP)
 - Discussion supporting the development of Finance Medicare Reporting and Board of Governor presentations

- Continued requirements development and mapping of Finance related CMS data submission
- 06 – Product:
 - Final QA of 2026 CMS Formulary and Bid Submission (Benefit Determination) was completed on Friday, May 30th and submission completed, as required, before June 2nd, 2025
 - Continued development of the SMAC for CMS submission on July 7th
 - SMAC fully executed by AAH and DHCS on June 25th, 2025
 - Continued partnership with OTC and hearing aid vendor to prepare for 10/1 and 1/1 readiness; kickoff meetings with Vision and Dental vendors are upcoming
 - Continued development of Standard Operating Procedures (SOPs) and Policies and Procedures (P&Ps) to standardize departmental operations and ensure adherence to best practices annually
 - Creating a Product View Tool (PVT) that delineates between Medicare and Medi-Cal services that front line staff can use to improve member experience
- 07 – Compliance:
 - DMHC Material Modification – D-SNP Product (Filing #20244060)
 - Initial AAH responses submitted to DMHC on 9/9/24
 - DMHC Comment Table received 6/5/25; responses due 7/6 with target to submit on 7/3
 - D-SNP Compliance Policies
 - Continued review of 21 policies with projected review at the Administrative Oversight Committee (AOC) on August 5th
 - HPMS User Access Form (aka CARE Form)
 - Initial development of process flow supporting the completion, review, and approval of CARE form requests
- 08 - Operations (Claims / Member Services / Mailroom / IVR):
 - 8A – Claims
 - Completed review of the Provider Manual supporting clean claim, clean claim processing times and claims interest
 - Initial development of a day in the life of a claim process flow
 - Initial review of claims denial codes
 - Decision Confirmed: changes to current COBA file is out of scope; it will be reviewed in 2026 for potential changes in 2027
 - 8B – Member Services / Call Center / IVR
 - Approved Member Services IVR Phone Tree and Scripts
 - Initial Member Portal Master Document review to support D-SNP changes
 - IT demo of Call Center calendar
 - Initial review of phone book and not ready codes
 - 8H – Policies, SOPs, and KPIs
 - Continued development of policies to support Claims and Member Services
- 09 – Sales:
 - Continued implementation of the Sales System with Nations and on track

- Sales Script initial draft completed and submitted to Compliance for review and for approval to route to CMS
- Continued development of Policies and Standard Operating Procedures
- Developed initial draft of Incentive Plan for Medicare Sales agents and working with leadership on approval
- Job Description for licensed full-time agent created and submitted for approval
- Continued development of workstreams with CHCN sites, coordinate with Care Navigators and front-house staff to direct prospective members to AAH educational and marketing events
- Developing approved procedures for in-person appointments by CMS regulations at CHCN sites
- Creating Alameda Alliance Wellness D-SNP Plan Certification slides and implementing them into Cirrus. Must be submitted to CMS after Summary of Benefits (SOB) is finalized
- Received pricing for 2026 AHIP Certification for employees with or without an NPN number
- First Sales Department Policy (Sales Compliance) created and due for submission on July 1st
- Enrollment Form completed, developing SEP attachment sheet
- Business Case created for additional licensed staffing needs, submitted for review
- Finalizing Pre-Enrollment Kit materials and pricing (Nations vs KP); decision to be made in early July
- Scope of Appointment Form created for D-SNP product, due for submission in July
- Continued development of the phone tree (IVR) call flow between member services, providers, and sales
- 10 – Pharmacy:
 - PBM Technical and Operational workgroup meetings are in progress
 - MTM Operational meetings are in progress; MTM program submission was submitted on June 4th and MTM attestation was completed on June 18th
 - A one-tier Formulary from the Pharmacy Benefit Manager (PBM), PerformRx, will be implemented for AAH; PerformRx is partnering with AAH on submitting requested formulary revisions to CMS, per the CMS standard review process
 - M3P program in AAH will be managed by PerformRx
 - AAH will delegate Part D appeals to the PBM and AAH will own Part D grievances; contract will be amended to reflect this decision
 - D-SNP Policies and Procedures are all in review with internal pharmacy team or at various levels of committee approval; targeting to complete and approve all policies and procedures by 1/1/26
 - Standard operating procedures for D-SNP are in development
- 12 - Vendor Management:
 - Continued engagement with the following vendors:
 - Behavioral Health After Hours pre-delegation in process

- CES Pre-Payment (PPS) and Claims Editing System contracting in process
 - DME Benefit pre-delegation / contracting in process
 - Health Risk Assessment (HRA) pre-delegation / contracting in process
 - Medicare Prescription Payment (M3P) Plan contracting in process
 - Pharmacy Consultant pre-delegation / contracting in process
 - Risk Adjustment pre-delegation / contracting in process
 - UM Guidelines (Clinical Policy Methodology) contracting in process
 - Vision contracting complete
- 13 – Health Equity:
 - Completed 1st draft redline of policies to include Health Equity (HE) initiatives and requirements
 - Identified need for five (5) new policies to support HE
 - One (1) policy is in progress and four (4) have not been started
 - Beginning phase 2 of plan to develop monitoring process and procedures that HE team will oversee
- 15 - Grievance and Appeals:
 - D-SNP Policies and Procedures have been reviewed and revised by external D-SNP SMEs. Additional internal revisions are in progress. Policies and procedures will be added to the next QIHEC committee for approval in August 2025
 - Standard operating procedures for D-SNP are in development
 - G&A Letter inventory completed; new and revised letters are in review with C&O for approval and will be configured into QualitySuite once approved
 - Waiver of Liability (WOL) process for out of network provider will be owned and managed by the Grievance and Appeals team
 - Payment Reconsideration workgroup is active
 - CMS five (5) levels of appeal are currently being configured in QualitySuite
- 16 – IT:
 - TruCare: Project is 64% complete. Continue configuration of CM and UM letters and assessments. Continuing to work closely with Zyter and the business to complete the remaining system requirement documents. Workstream meetings in progress to continue documenting system requirements for the various TruCare UM, CM and Core functions. Finalizing mapping specifications for loading DM Care Opportunities data. Care Opportunities QA completed; BRD for TruCare Actions will be shared for approvals this week. BHP configuration is complete. Core feeds, mapping design and development are in progress for the provider, product/network, and member feeds.
 - HEALTHsuite: Enrollment Letters High and Medium priority configuration is completed in stage environment and QA testing is in progress by AAH Testing Team. Membership and Eligibility workflow configuration in progress. OEC+ File testing in progress with Nations and RAM. Training sessions in progress for AAH QA Testers and Operations on Letter

triggers. Confirmed decision AAH will automate PCP assignment using Medi-Cal enrollment logic.

- QualitySuite: D-SNP stage environment upgrade is complete. Grievance module development is underway. Complaint Tracking Module (CTM) user stories are ready for sprint planning and Appeals user stories are actively in the grooming process in partnership with the G&A business team and QS technical team. Provider Dispute Resolution (PDR) requirements have been finalized; User story grooming for PDR is in progress.
- 16A - Marketing
 - Marketing and Compliance reviews of Enrollment Letters have been completed and include material ID; letters are in QA testing with IT
 - Enrollment Form has been successfully drafted and reviewed by all relevant stakeholders. Submission to CMS for review has been delayed as a result of Nations and HEALTHSuite limitation for a dedicated field to capture member consent for the plan to contact members via phone number and email. Modifications to the content disclosure section of the form are currently in progress, with a submission to CMS planned for review during the week of June 30th.
 - Identified D-SNP website requirements and currently collaborating with the IPD team to conduct a gap analysis. This will help ensure alignment between current capabilities and the required functionality for the upcoming D-SNP website launch.
 - Drafting Integrated Marketing materials (EOC, SOB, ID Card, Provider & Pharmacy Directory)
 - CY2026 Integrated Marketing Material CMS models were released July 17th. We have pivoted to update drafts accordingly to ensure alignment with the latest CMS requirements; targeting submitting materials to regulators for review July 14th – July 30th.
 - Other marketing materials (prospect and on-boarding): Enrollment Kit, Welcome Kit, Member OTC Debit Card
 - Requirement sessions have officially begun to identify and develop necessary materials, budget, and timeline for prospect and member onboarding materials
- 16B - Enrollment Process
 - D-SNP Enrollment Form is pending approval
 - Initial letter testing with RAM (HEALTHsuite) and KP (AAH Print Vendor)
- 17 – Stars:
 - Phase 1 of Star strategy
 - Identified initiatives for the HEDIS measures supported in the Medi-Cal line of business and Operational measures that will impact Star ratings on Day 1

- Building out Stars playbook to align interventions to D-SNP for Day 1
- Aligning interventions to Quality Workplan
- Process flow documentation for the measures is underway with Quality, Health Care Services, and Analytics. We will plan to implement foundational initiatives to support Star gap closure.
 - TruCare Star gap integration in process
 - Pay-for-Performance and Pay-for-Reporting program – This is ongoing. Confirmed with CHCN that they will not have their own P4P Program
 - EMR Data feeds – This is already in production and will be slightly modified to ensure support for D-SNP measures
 - Prospective Chart Review – This is already in production and will be slightly modified to ensure support for D-SNP measures Phase 1 of Star strategy
 - Stars Education – Internal and external training to provide a clear understanding of how Star measures impact quality ratings
- We plan to implement operational initiatives to support Star gap closure.
 - New:
 - Concierge Care Gap Closure Program – Beginning development of a member/provider outreach program for members with 2+ care gaps
 - Awareness Campaign – Beginning development of ad hoc awareness campaigns to deploy in 2026 (medication adherence and preventative services)
 - Welcome Postcard with checklist of preventative screenings
 - Member Birthday Cards
 - Preventive Physical Exam (IPPE) & Annual Wellness Visit (AWV) – Beginning development of IPPE & AWV program to engage providers and members for gap closure and accurate diagnosis capture
- **CalAIM Initiatives:**
 - Community Supports (CS)
 - Due to Budget Constraints, all CS enhancement and expansion activities are on hold
 - Justice-Involved (JI) Initiative:
 - CalAIM Re-entry
 - Correctional facilities go-live date for pre-release services is determined based on DHCS readiness assessment and will go-live with pre-release services within a 24-month phase in period (10/1/2024 – 9/30/2026)

- Santa Rita Jail is targeting to go-live on 7/1/2026 with pre-release services; Juvenile Justice Center's go-live is TBD
- Managed Care Plans (MCPs) must be prepared to coordinate with correctional facilities as of October 1st, 2024, even if facilities in their county will go-live later
- JI project team is developing a contact list for the counties going live with pre-release to support coordination of referrals for any AAH members being released from these counties
- DHCS has indicated they intend to release a revised JI Policy Guide; impacts to project scope and schedule will be assessed once this is released
- DHCS JI Learning Collaboratives initiated in August 2024 and continued through January 2025. These collaborative sessions included correctional facilities, county behavioral health agencies, probation, MCPs, and ECM providers
- On 10/28/24, AAH SLT approved to place CalAIM JI Re-Entry project on hold until July 2025 to await final policy guide from DHCS and give Alameda County partners time to develop their internal processes and readiness
- CYBHI Fee Schedule
 - Effective January 1st, 2024, the Alliance began partnering with Carelon (formerly known as Beacon) to implement the CYBHI Fee Schedule
 - Cohort 1 is intended to be a "learning" cohort
 - The Alliance was not selected to participate in the permanent ASO Model and will participate in an interim solution until further notice from Carelon and DHCS
- MOU
 - Interim Model MOU was executed by AAH CEO on 4/29/25 and returned to Carelon
 - AAH Finance Team shall receive an Invoice File from Carelon for billing purposes via secured file transfer process and process payments manually
 - This includes checking member eligibility internally to deliver payments when services have been rendered
 - SFTP File Exchange template executed and resubmitted to Carelon 6/2/25
 - Banking information with Carelon has been established and ready for invoice payments
 - Final stages of testing data with Carelon and DHCS
 - Test file from Carelon via SFTP picked up successfully
 - Project Close Activities
 - Upon completion of file transfer validation, the AAH business stakeholders propose closing this project
 - Anticipate project close in June 2025
 - Warranty period through end of July to monitor stabilization of potential incoming invoices

- **Recruiting and Staffing**
 - Integrated Planning Open position(s):
 - Supervisor, Business Analyst - Started on June 16th, 2025
 - Backfill Business Analyst, Integrated Planning – Posting reactivated
 - Backfill Business Process Analyst, Integrated Planning – Candidate
Target Start: July 7th, 2025

IPD Project Descriptions

- Key projects currently in-flight:
 - California Advancing and Innovating Medi-Cal (CalAIM) – program to provide targeted and coordinated care for vulnerable populations with complex health needs.
 - Enhanced Care Management (ECM) – ECM will target eight (8) specific populations of vulnerable and high-risk children and adults
 - Three (3) Populations of Focus (PoF) transitioned from HHP and/or WPC on January 1st, 2022
 - Two (2) additional PoF became effective on January 1st, 2023
 - One (1) PoF became effective on July 1st, 2023
 - Two (2) PoF became effective on January 1st, 2024
 - Restarting in July 2025 - Justice Involved Initiative – adults and children/youth transitioning from incarceration or juvenile facilities will be enrolled into Medi-Cal upon release
 - DHCS is finalizing policy and operational requirements for MCPs to implement the CalAIM Justice-Involved Initiative
 - MCPs must be prepared to go live with ECM for the Individuals Transitioning from Incarceration as of January 1st, 2024
 - MCPs must be prepared to coordinate with correctional facilities to support reentry of members as the return to the community by October 1st, 2024
 - Correctional facilities will have two years from 10/1/2024-9/30/2026 to go live based on readiness
 - Dual Eligible Special Needs Plan (D-SNP) Implementation – All Medi-Cal MCPs will be required to operate Medicare Medi-Cal Plans (MMPs), the California-specific program name for Exclusively Aligned Enrollment Dual Eligible Special Needs Plans (EAE D-SNPs) by January 2026 to provide better coordination of care and improve care integration and person-centered care. Additionally, this transition will create both program and financial alignment, simplify administration and billing for providers and plans, and provide a more seamless experience for dual eligible beneficiaries by having one plan manage both sets of benefits for the beneficiary.
 - CYBHI Statewide Fee Schedule – The Department of Health Care Services (DHCS), in collaboration with the Department of Managed Health Care (DMHC), has developed a multi-payer, school-linked statewide fee schedule for outpatient mental health or substance use disorder services provided to a student 25 years of age or younger at or near a school site. CYBHI requires commercial health plans and the Medi-Cal delivery system, as applicable, to reimburse these school-linked providers at or above the published rates, 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	June 2025
Incoming Calls (R/V)	16,253
Abandoned Rate (R/V)	4%
Answered Calls (R/V)	15,534
Average Speed to Answer (ASA)	00:11
Calls Answered in 30 Seconds (R/V)	95%
Average Talk Time (ATT)	07:50
Calls Answered in 10 minutes	100%
Outbound Calls	8,515

Top 5 Call Reasons (Medi-Cal and Group Care) June 2025

Change of PCP
Eligibility/Enrollment
Grievances/Appeals
Benefits
Provider Network Info

Top 3 Web-Based Request Reasons (Medi-Cal and Group Care) June 2025

Change PCP
ID Card Requests
Update Contact Info

MSBH	June 2025
Incoming Calls (R/V)	1037
Abandoned Rate (R/V)	7%
Answered Calls (R/V)	962
Average Speed to Answer (ASA)	00:40
Calls Answered in 30 Seconds (R/V)	81%
Average Talk Time (ATT)	09:08
Calls Answered in 10 minutes	100%
Outbound Calls	991
Screenings Completed	111
ACBH Referrals	29
SUD referrals to Center Point	15

Claims Department
May 2025 Final and June 2025 Final

METRICS

Claims Compliance	May-25	Jun-25
90% of clean claims processed within 30 calendar days	90.4%	91.3%
95% of all claims processed within 45 working days	97.6%	93.8%
Claims Volume (Received)	May-25	Jun-25
Paper claims	35,937	38,862
EDI claims	351,627	301,362
Claim Volume Total	387,564	340,224
Percentage of Claims Volume by Submission Method	May-25	Jun-25
% Paper	9.27%	11.42%
% EDI	90.73%	88.58%
Claims Processed	May-25	Jun-25
HEALTHsuite Paid (original claims)	247,441	230,975
HEALTHsuite Denied (original claims)	83,314	78,113
HEALTHsuite Original Claims Sub-Total	330,755	309,088
HEALTHsuite Adjustments	3,333	40,654
HEALTHsuite Total	334,088	349,742
Claims Expense	May-25	Jun-25
Medical Claims Paid	\$133,062,018	\$136,772,399
Interest Paid	\$92,371	\$338,827
Auto Adjudication	May-25	Jun-25
Claims Auto Adjudicated	289,805	272,290
% Auto Adjudicated	87.6%	88.1%
Average Days from Receipt to Payment	May-25	Jun-25
HEALTHsuite	16	17
Pended Claim Age	May-25	Jun-25
0-30 calendar days	52,859	44,872
HEALTHsuite		
31-61 calendar days	31,491	37,936
HEALTHsuite		
Over 62 calendar days	57,931	65,511
HEALTHsuite		
*Pended claims over 31 days are high due to investigation of 3 providers for FWA		
Overall Denial Rate	May-25	Jun-25
Claims denied in HEALTHsuite	83,314	78,113
% Denied	24.9%	22.3%

Claims Department

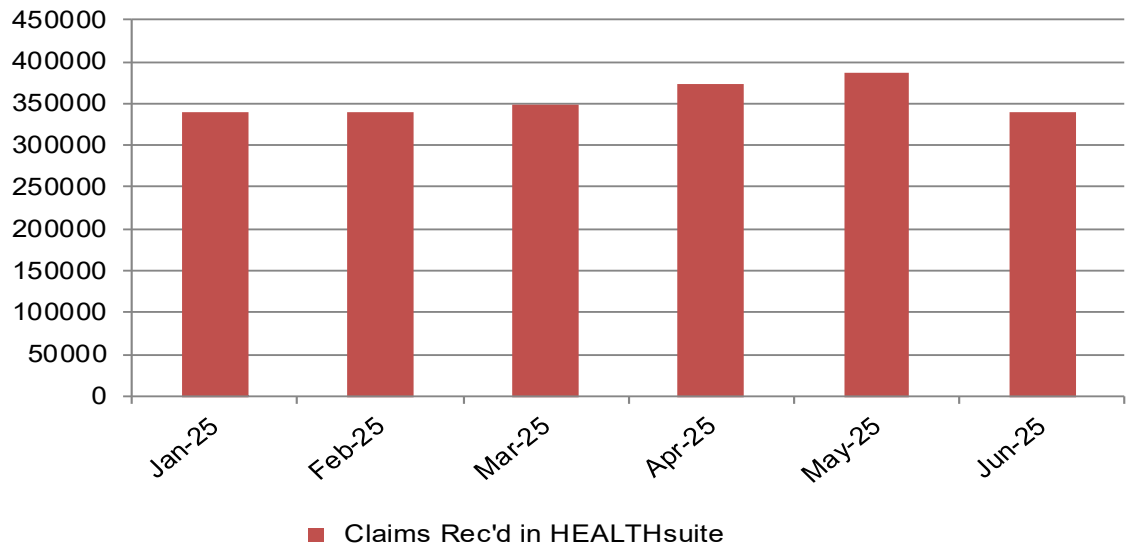
May 2025 Final and June 2025 Final

Jun-25

Top 5 HEALTHsuite Denial Reasons	% of all denials
Responsibility of Provider	26%
No Benefits Found For Dates of Service	13%
Duplicate Claim	9%
Non-Covered Benefit For This Plan	9%
Must Submit Paper Claim With Copy of Primary Payor EOB	9%
% Total of all denials	66%

Claims Received By Month

	2/1/2025	3/1/2025	4/1/2025	5/1/2025	6/1/2025	7/1/2025
Claims Received Through	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Claims Rec'd in HEALTHsuite	339,760	339,840	347,469	372,126	387,564	340,224



Claims Year Over Year Summary		
Monthly Results	Regulatory Requirement	AAH Goal
Claims Compliance - comparing June 2025 to June 2024 as follows: 30 Days - 91.3% (2025) vs 89.7% (2024) 45 Days - 93.8% (2025) vs 99.8% (2024) 90 Days - 99.9% (2025) vs 99.9% (2024)	90% of clean claims in 30 calendar days 95% of all claims in 45 working days 99% of all claims in 90 calendar days	90% of clean claims in 30 calendar days 95% of all claims in 45 working days 99% of all claims in 90 calendar days
Claims Received - AAH received 340,224 claims in June 2025 vs 297,267 in June 2024	N/A	N/A
EDI - the volume of EDI submissions was 88.58% which exceeds our normal month to month range of ~77% - 87%	N/A	N/A
Original Claims Processed - AAH processed 309,088 in June 2025 (20 working days) vs 286,554 in June 2024 (20 working days)	N/A	N/A
Medical Claims Expense - the amount of paid claims in June 2025 was \$136,772,939 (4 check runs) vs \$115,671,347 in June 2024 (4 check runs)	N/A	N/A
Interest Expense - the amount of interest paid in June 2025 was \$338,827 vs \$84,231 in June 2024	N/A	.05% - .075% of the monthly medical expense
Auto Adjudication - the AAH rate in June 2025 was 88.1% vs 87.5% in June 2024	N/A	85% or higher
Average Days from Receipt to Payment - the average # of days from receipt to payment in June 2025 was 17 days vs 14 days in June 2024	N/A	<= 25 days
Pended Claim Age - comparing June 2025 to June 2024 as follows: 0-30 calendar days - 44,872 (2025) vs 40,621 (2024) 31-61 calendar days - 37,936 (2025) vs 17,365 (2024) Over 62 calendar days - 65,511 (2025) vs 10 (2024) *Pended claims over 31 days are high due to the investigation of 3 providers for FWA	N/A	N/A
Top 5 Denial Reasons - the claim denial reasons remain consistent from month to month so there is no significant changes to report from June 2025 to June 2024	N/A	N/A

Provider Dispute Resolution

May 2025 and June 2025

METRICS

PDR Compliance	May-25	Jun-25
# of PDRs Resolved	2,517	2,634
# Resolved Within 45 Working Days	2,508	2,626
% of PDRs Resolved Within 45 Working Days	99.6%	99.6%
PDRs Received	May-25	Jun-25
# of PDRs Received	2,462	3,843
PDR Volume Total	2,462	3,843
PDRs Resolved	May-25	Jun-25
# of PDRs Upheld	1,988	2,183
% of PDRs Upheld	79%	83%
# of PDRs Overturned	529	451
% of PDRs Overturned	21%	17%
Total # of PDRs Resolved	2,517	2,634
Average Turnaround Time	May-25	Jun-25
Average # of Days to Resolve PDRs	40	38
Oldest Resolved PDR in Days	286	370
Unresolved PDR Age	May-25	Jun-25
0-45 Working Days	5,019	4,696
Over 45 Working Days	0	0
Total # of Unresolved PDRs	5,019	4,696

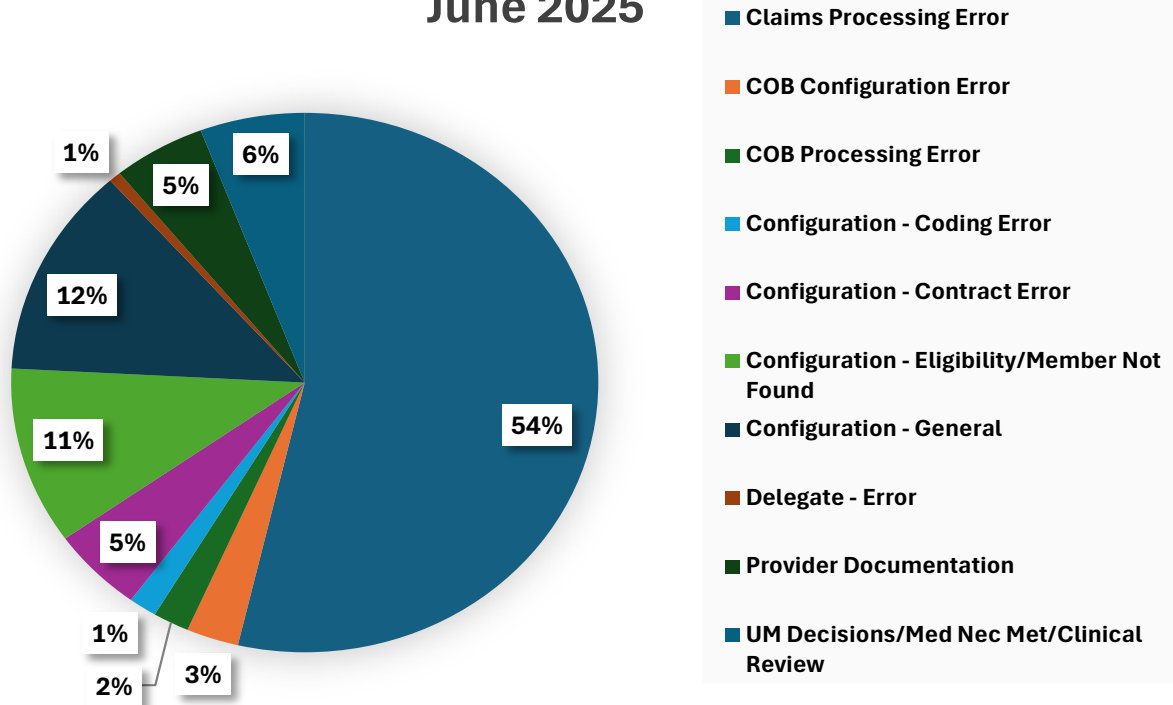
Provider Dispute Resolution

May 2025 and June 2025

May-25

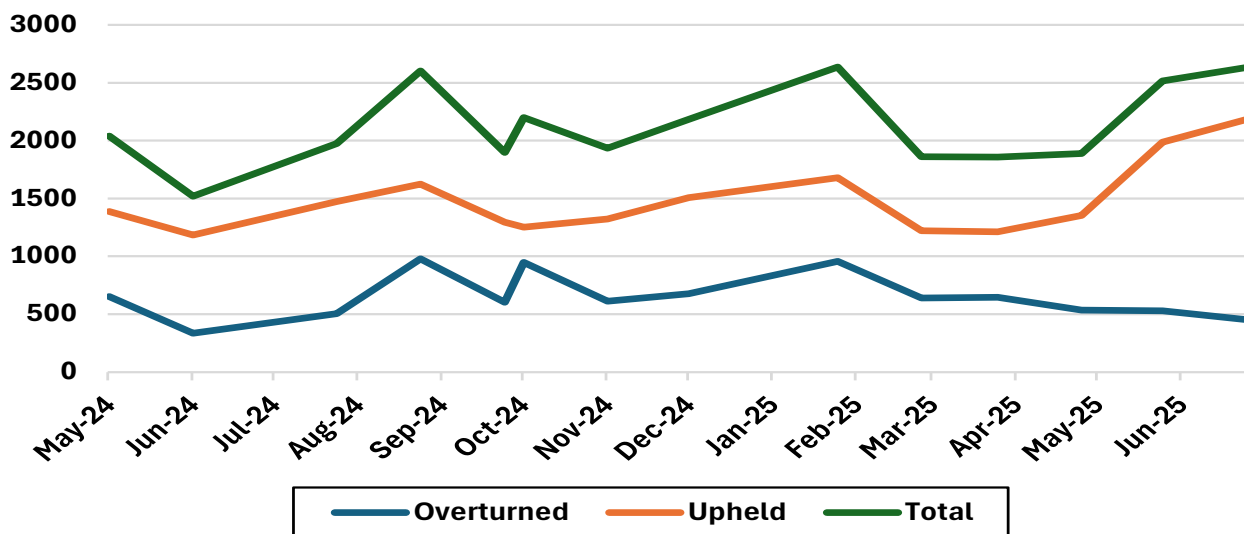
PDR Resolved Case Overturn Reasons

June 2025



Rolling 12-Month PDR Trend Line

June 2025



Provider Dispute Resolution Year Over Year Summary		
Monthly Results	Regulatory Requirements	AAH Goal
# of PDRs Resolved - 2,634 in June 2025 vs 1,613 in June 2024	N/A	N/A
# of PDRs Received - 3,843 in June 2025 vs 3,792 in June 2024	N/A	N/A
# of PDRs Resolved within 45 working days - 2,626 in June 2025 vs 1,609 in June 2024	N/A	N/A
% of PDRs Resolved within 45 working days - 99.6% in June 2025 vs 99.8% in June 2024	95%	95%
Average # of Days to Resolve PDRs - 38 days in June 2025 vs 42 days in June 2024	N/A	30
Oldest Resolved PDR in Days - 370 days in June 2025 vs 61 days in June 2024	N/A	N/A
# of PDRs Upheld - 2,183 in June 2025 vs 1,127 in June 2024	N/A	N/A
% of PDRs Upheld - 83% in June 2025 vs 70% in June 2024	N/A	> 75%
# of PDRs Overturned - 451 in June 2025 vs 486 in June 2024	N/A	N/A
% of PDRs Overturned - 17% in June 2025 vs 30% in June 2024	N/A	< 25%
PDR Overturn Reasons: Claims processing errors - 54% (2025) vs 16% (2024) Configuration errors - 30% (2025) vs 35% (2024) COB - 5% (2025) vs 16% (2024) Clinical Review/UM Decisions/Medical Necessity Met - 11% (2025) vs 16% (2024)	N/A	N/A

Provider Relations Dashboard June 2025

Alliance Provider Relations Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Incoming Calls (PR)	10977	8885	8303	8709	7861	9214						
Abandoned Calls	3600	1133	1434	1685	1254	2245						
Answered Calls (PR)	7377	7752	6869	7024	6607	6969						
Recordings/Voicemails	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Incoming Calls (R/V)	2910	2140	13	15	12	6						
Abandoned Calls (R/V)												
Answered Calls (R/V)	2910	2140	13	15	12	6						
Outbound Calls	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Outbound Calls	868	1162	434	602	570	520						
N/A												
Outbound Calls	868	1162	434	602	570	520						
Totals	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Total Incoming, R/V, Outbound Calls	14755	12187	8750	9326	8443	9740						
Abandoned Calls	3600	1133	1434	1685	1254	2245						
Total Answered Incoming, R/V, Outbound Calls	11155	11054	7316	7641	7189	7495						

Provider Relations Dashboard June 2025

Call Reasons (Medi-Cal and Group Care)

Category	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Authorizations	5.1%	5.8%	5.4%	5.0%	5.2%	5.4%						
Benefits	5.1%	3.7%	3.4%	3.9%	6.4%	3.4%						
Claims Inquiry	39.4%	43.9%	43.7%	46.3%	47.7%	48.5%						
Change of PCP	2.5%	2.7%	2.4%	2.9%	2.8%	2.0%						
Check Tracer	0.7%	0.6%	1.0%	0.9%	0.7%	1.0%						
Complaint/Grievance (includes PDR's)	5.8%	6.7%	6.8%	6.5%	7.6%	7.1%						
Contracts/Credentialing	0.8%	0.8%	0.7%	0.8%	0.8%	0.8%						
Demographic Change	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%						
Eligibility - Call from Provider	21.0%	17.4%	17.0%	17.9%	16.5%	17.2%						
Exempt Grievance/ G&A	0.0%	0.1%	6.8%	0.0%	0.1%	0.0%						
General Inquiry/Non member	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%						
Intrepreter Services Request	0.5%	0.5%	0.6%	0.4%	0.4%	0.4%						
Provider Portal Assistance	3.4%	3.2%	3.9%	3.4%	3.4%	3.4%						
Pharmacy	0.1%	0.2%	0.1%	0.0%	0.1%	0.1%						
Prop 56	0.1%	0.0%	0.0%	0.1%	0.1%	0.1%						
Provider Network Info	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%						
Transportation Services	0.0%	0.2%	0.2%	0.2%	0.3%	0.1%						
Transferred Call	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%						
All Other Calls	15.5%	14.4%	7.9%	11.4%	7.9%	10.4%						
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%						

Field Visit Activity Details

Alliance Provider Relations Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Claims Issues	28	72	89	54	60	41						
Contracting/Credentialing	29	41	50	59	150	66						
Drop-ins	127	83	141	146	149	96						
JOM's	2	2	3	2	3	1						
New Provider Orientation	100	134	118	173	143	182						
Quarterly Visits	0	0	0	82	0	0						
UM Issues	0	0	3	1	1	5						
Total Field Visits	286	332	404	517	506	391	0	0	0	0	0	0

ALLIANCE NETWORK SUMMARY, CURRENTLY CREDENTIALIAED PRACTITIONERS - June 2025						
Practitioners		PCP 390	SPEC 762	AHP 680	BH/ABA 3,098	PCP/SPEC 12
Direct Network vs Delegated Network Breakdown			AAH 3,676	AHS 298	CHCN 6,014	COMBINATION OF GROUPS 3,679
Facilities	443					
VENDOR SUMMARY						
Credentialing Verification Organization, Symplr CVO						
	Number	Average Calendar Days in Process	Goal - 25 Business Days*	Goal - 98% Accuracy	Compliant	
Initial Files in Process	113	2	Y	Y	Y	
Recred Files in Process	223	0	Y	Y	Y	
Expirables updated Insurance, License, DEA, Board Certifications					Y	
Files currently in process	336					
		* 25 business days = 35 calendar days				
June 2025 Peer Review and Credentialing Committee Approvals						
Initial Credentialing	Number					
PCP	4					
SPEC	7					
ANCILLARY	20					
MIDLEVEL/AHP	8					
BH/ABA	117					
Sub-total	156					
Recredentialing						
PCP	11					
SPEC	16					
ANCILLARY	2					
MIDLEVEL/AHP	11					
Sub-total	40					
TOTAL	196					
June 2025 Facility Approvals						
Initial Credentialing	1					
Recredentialing	9					
Sub-total	10					
Facility Files in Process	57					
June 2025 Employee Metrics (6 FTEs)		Goal	Met (Y/N)			
File Processing	Timely processing within 3 days of receipt		Y			
Credentialing Accuracy	<3% error rate		Y			
DHCS, DMHC, CMS, NCQA Compliant	98%		Y			
MBC Monitoring	Timely processing within 3 days of receipt		Y			

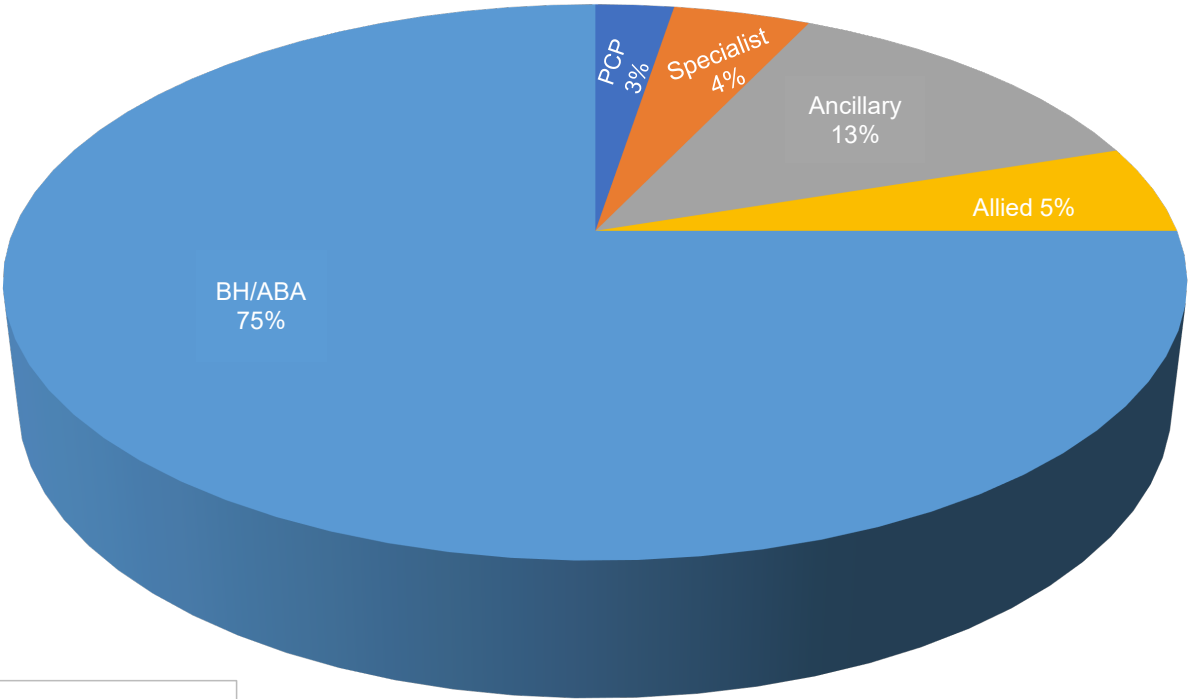
LAST NAME	FIRST NAME	CATEGORY	INITIAL / RE-CRED	CRED DATE
Alas Martinez	Imelda	BH	INTIAL	6/17/2025
Aleman	Llesenia	BH	INTIAL	6/17/2025
Alli	Moritha	BH-Telehealth	INTIAL	6/17/2025
Alvarado	Kaela	BH-Telehealth	INTIAL	6/17/2025
Arora	Ruchi	Primary Care Physician	INTIAL	6/17/2025
Arroyo Gomez	Yamile	ABA-Telehealth	INTIAL	6/17/2025
Barber	Ebonique	BH	INTIAL	6/17/2025
Bell	Robert	Allied Health	INTIAL	6/17/2025
Bendas	Eric	ABA-Telehealth	INTIAL	6/17/2025
Benson	Regina	Doula	INTIAL	6/17/2025
Bhamra	Jasmit	ABA	INTIAL	6/17/2025
Boggs	Audrey	BH-Telehealth	INTIAL	6/17/2025
Bombon	Marilyn	ABA-Telehealth	INTIAL	6/17/2025
Breuner	Lisa	Specialist	INTIAL	6/17/2025
Brewer	Monisha	BH	INTIAL	6/17/2025
Bueno	Joana Ruby	BH-Telehealth	INTIAL	6/17/2025
Buenrostro Contreras	Karen	ABA-Telehealth	INTIAL	6/17/2025
Burke	Addison	ABA-Telehealth	INTIAL	6/17/2025
Burns	Shana	BH-Telehealth	INTIAL	6/17/2025
Caballero	Rita	ABA-Telehealth	INTIAL	6/17/2025
Campos	Erica	BH-Telehealth	INTIAL	6/17/2025
Cho	Ann	ABA-Telehealth	INTIAL	6/17/2025
Coleman	Krystal	ABA-Telehealth	INTIAL	6/17/2025
Corral	Mercedes	BH-Telehealth	INTIAL	6/17/2025
Crenshaw	Kaelyn	Doula	INTIAL	6/17/2025
Crockett	Joel	Specialist	INTIAL	6/17/2025
Cruz	Ariana	Doula	INTIAL	6/17/2025
Cruz	Yohanna	BH	INTIAL	6/17/2025
Daher	Jamal-Eddin	BH-Telehealth	INTIAL	6/17/2025
De Vera	Rodelle Ann	Allied Health	INTIAL	6/17/2025
Denardo	Sophia	BH-Telehealth	INTIAL	6/17/2025
Dominguez	Antonio	ABA-Telehealth	INTIAL	6/17/2025
Dougherty	Desiree	Doula	INTIAL	6/17/2025
Dulai	Bobby	BH-Telehealth	INTIAL	6/17/2025
Duncan	Rebecca	Doula	INTIAL	6/17/2025
Earhart	Maria	BH-Telehealth	INTIAL	6/17/2025
Edwards	Ann	BH-Telehealth	INTIAL	6/17/2025
Farokhi	Stephanie	BH-Telehealth	INTIAL	6/17/2025
Fascio	Joanne	Allied Health	INTIAL	6/17/2025
Forte	Dianna	BH	INTIAL	6/17/2025
Frey	Kendall	Doula	INTIAL	6/17/2025
Fuhrmann-Knowles	Angela	ABA-Telehealth	INTIAL	6/17/2025
Fullerton	John	Specialist	INTIAL	6/17/2025
Gendron	Geralyn	BH	INTIAL	6/17/2025
Gill	Kanwaljit	Specialist	INTIAL	6/17/2025
Giro	Chloe	Doula	INTIAL	6/17/2025
Gomez	Valerie	ABA-Telehealth	INTIAL	6/17/2025
Gorman	Shaelyn	ABA-Telehealth	INTIAL	6/17/2025
Grajeda	Marilyn	ABA-Telehealth	INTIAL	6/17/2025
Griggs	Brittany	BH-Telehealth	INTIAL	6/17/2025
Harrell	Cayley	BH-Telehealth	INTIAL	6/17/2025
Hefner	Bruyere	ABA-Telehealth	INTIAL	6/17/2025
Henderson	Jessica	ABA-Telehealth	INTIAL	6/17/2025
Hendrik	Dwight	ABA-Telehealth	INTIAL	6/17/2025
Hernandez	Melissa	Doula	INTIAL	6/17/2025
Holman	Zakiya	ABA-Telehealth	INTIAL	6/17/2025
Howard	Adam	Specialist	INTIAL	6/17/2025
Iqbal	Bushra	Allied Health	INTIAL	6/17/2025
Issac	Aji	BH-Telehealth	INTIAL	6/17/2025
James	Melody	BH-Telehealth	INTIAL	6/17/2025

LAST NAME	FIRST NAME	CATEGORY	INITIAL / RE-CRED	CRED DATE
Jankowski	Matthew	ABA-Telehealth	INTIAL	6/17/2025
Johnson	Aliyah	ABA-Telehealth	INTIAL	6/17/2025
Johnson	Dino	ABA-Telehealth	INTIAL	6/17/2025
Johnson	Heather	BH-Telehealth	INTIAL	6/17/2025
Jones	Joscelyn	ABA	INTIAL	6/17/2025
Kaur	Simranjeet	BH	INTIAL	6/17/2025
Keylani	Judy	Doula	INTIAL	6/17/2025
Khatri	Pyar	BH-Telehealth	INTIAL	6/17/2025
Kimble	Dominique	Allied Health	INTIAL	6/17/2025
La Barbara	Allyson	BH-Telehealth	INTIAL	6/17/2025
Le	Kristie	Ancillary	INTIAL	6/17/2025
Lee	Helen	Ancillary	INTIAL	6/17/2025
Ley	Staci	ABA-Telehealth	INTIAL	6/17/2025
Lhoest	Elisabeth	BH	INTIAL	6/17/2025
Liu	Grace	BH	INTIAL	6/17/2025
Loera	Toni	BH-Telehealth	INTIAL	6/17/2025
Logie	Kevin	BH-Telehealth	INTIAL	6/17/2025
Logo	Dawneshia	Doula	INTIAL	6/17/2025
Martinez	Christina	BH	INTIAL	6/17/2025
Matthews	Cameron	ABA	INTIAL	6/17/2025
McClure	Dylan	BH-Telehealth	INTIAL	6/17/2025
McGowan	Kourtney	Doula	INTIAL	6/17/2025
McIrvin	Jennifer	Primary Care Physician	INTIAL	6/17/2025
Meastas	Rebecca	ABA-Telehealth	INTIAL	6/17/2025
Meyer	Curtis	ABA-Telehealth	INTIAL	6/17/2025
Miller	Sara	BH-Telehealth	INTIAL	6/17/2025
Montenegro	Alexandra	ABA-Telehealth	INTIAL	6/17/2025
Morales	Anachristina	BH-Telehealth	INTIAL	6/17/2025
Morgan	Heather	Doula	INTIAL	6/17/2025
Munoz-Sigala	Carmen	Doula	INTIAL	6/17/2025
Muro	Melissa	BH-Telehealth	INTIAL	6/17/2025
Ng	Fion	Allied Health	INTIAL	6/17/2025
Nguyen	Phi Oanh	ABA-Telehealth	INTIAL	6/17/2025
Nguyen	Tiffany	Allied Health	INTIAL	6/17/2025
Oda	Lindsay	Doula	INTIAL	6/17/2025
Olusanya	Abimbola	BH-Telehealth	INTIAL	6/17/2025
Osborne	Brooke	BH-Telehealth	INTIAL	6/17/2025
Pandya	Sima	Specialist	INTIAL	6/17/2025
Panikyan	Lusine	BH-Telehealth	INTIAL	6/17/2025
Perry	Barbara	BH	INTIAL	6/17/2025
Picard	Kristen	BH-Telehealth	INTIAL	6/17/2025
Pio	Marjorie Anne	ABA-Telehealth	INTIAL	6/17/2025
Pixley	Adrianne	BH-Telehealth	INTIAL	6/17/2025
Pope	Lezah	BH	INTIAL	6/17/2025
Porter	Kiana	ABA-Telehealth	INTIAL	6/17/2025
Quan	George	ABA-Telehealth	INTIAL	6/17/2025
Ragasa	Meleah	ABA	INTIAL	6/17/2025
Rajesh	Shikha	Allied Health	INTIAL	6/17/2025
Ramirez	Karina	ABA-Telehealth	INTIAL	6/17/2025
Reyes	German	BH-Telehealth	INTIAL	6/17/2025
Rezaie	Zhaleh	ABA-Telehealth	INTIAL	6/17/2025
Rierner	Dana	ABA-Telehealth	INTIAL	6/17/2025
Roberts	Bryan	ABA-Telehealth	INTIAL	6/17/2025
Rodriguez-Barba	Alejandra	ABA-Telehealth	INTIAL	6/17/2025
Roth	Jill	BH	INTIAL	6/17/2025
Roussel	Brittany	Doula	INTIAL	6/17/2025
Rowe-Lee	Gwendolyn	BH	INTIAL	6/17/2025
Saetern	Fam	ABA	INTIAL	6/17/2025
Safari	Regina	BH	INTIAL	6/17/2025
Saltz	Natasha	ABA-Telehealth	INTIAL	6/17/2025

LAST NAME	FIRST NAME	CATEGORY	INITIAL / RE-CRED	CRED DATE
Samsundar	Sarah	ABA-Telehealth	INTIAL	6/17/2025
Sarkarati	Minoo	Primary Care Physician	INTIAL	6/17/2025
Sarmienta	Dario	BH	INTIAL	6/17/2025
Sarsour	Zahiah	ABA-Telehealth	INTIAL	6/17/2025
Schulz	Olivia	BH-Telehealth	INTIAL	6/17/2025
Settle	Jillian	BH	INTIAL	6/17/2025
Sharbrough	Natalie	ABA-Telehealth	INTIAL	6/17/2025
Sheehan	Samantha	ABA-Telehealth	INTIAL	6/17/2025
Silva	Bertha	BH-Telehealth	INTIAL	6/17/2025
Sivard	David	ABA-Telehealth	INTIAL	6/17/2025
Snyder	Holly	BH-Telehealth	INTIAL	6/17/2025
Song	Linfei	ABA-Telehealth	INTIAL	6/17/2025
Spevak	Jennifer	BH	INTIAL	6/17/2025
Stabile	Heather	BH-Telehealth	INTIAL	6/17/2025
Stern	Leah	BH-Telehealth	INTIAL	6/17/2025
Story	Raquel	Doula	INTIAL	6/17/2025
Su	Caroline	ABA-Telehealth	INTIAL	6/17/2025
Tajon-Scott	Marie	BH	INTIAL	6/17/2025
Thallapaneni	Rambabu	Primary Care Physician	INTIAL	6/17/2025
Thom	Frances	BH-Telehealth	INTIAL	6/17/2025
Thomas	Clarence	BH	INTIAL	6/17/2025
Tomlinson	Mynoska	BH-Telehealth	INTIAL	6/17/2025
Torres	Christine	Doula	INTIAL	6/17/2025
Uriostegui	Amy	BH	INTIAL	6/17/2025
Verga	Meghan	ABA-Telehealth	INTIAL	6/17/2025
Wade	Mary-Catherine	BH	INTIAL	6/17/2025
Wang	Qian	BH	INTIAL	6/17/2025
Weiss	Samantha	BH	INTIAL	6/17/2025
White	Jeffrey	BH-Telehealth	INTIAL	6/17/2025
White Curtis	Felicia	Doula	INTIAL	6/17/2025
Williams	Diamond	ABA-Telehealth	INTIAL	6/17/2025
Wilson	Sydney	BH-Telehealth	INTIAL	6/17/2025
Ye	Xuemei	ABA	INTIAL	6/17/2025
Yu	Wei	ABA-Telehealth	INTIAL	6/17/2025
Zamora	Carissa	ABA-Telehealth	INTIAL	6/17/2025
Zhao	Xixi	Specialist	INTIAL	6/17/2025
Agarwal	Sanjay	Specialist	RE-CRED	6/17/2025
Bissonnette	Cris	Allied Health	RE-CRED	6/17/2025
Bohman	Corey	Allied Health	RE-CRED	6/17/2025
Bonner	Bryant	Specialist	RE-CRED	6/17/2025
Chan	Jennifer	Specialist	RE-CRED	6/17/2025
Chang	Gene-Yuan	Specialist	RE-CRED	6/17/2025
Cheng	Ernest	Specialist	RE-CRED	6/17/2025
Chu	Jason	Specialist	RE-CRED	6/17/2025
Clark	Alana	Allied Health	RE-CRED	6/17/2025
Coale	Megan	Allied Health	RE-CRED	6/17/2025
Cooper	Janice	Allied Health	RE-CRED	6/17/2025
Cortez	Michelle	Allied Health	RE-CRED	6/17/2025
DeGalan	Steven	Specialist	RE-CRED	6/17/2025
Dharan	Murali	Specialist	RE-CRED	6/17/2025
Duterte	Jason	Allied Health	RE-CRED	6/17/2025
Fischer	Gina	Allied Health	RE-CRED	6/17/2025
Francis	Damon	Primary Care Physician	RE-CRED	6/17/2025
Gong	Merry	Primary Care Physician	RE-CRED	6/17/2025
Hsu	Mark	Specialist	RE-CRED	6/17/2025
Hyder	Shakir	Specialist	RE-CRED	6/17/2025
Kane	Amy	Specialist	RE-CRED	6/17/2025
Kasozi Lubega	Samali	Primary Care Physician	RE-CRED	6/17/2025
Krosin	Michael	Specialist	RE-CRED	6/17/2025

LAST NAME	FIRST NAME	CATEGORY	INITIAL / RE-CRED	CRED DATE
Lunny	Peter	Specialist	RE-CRED	6/17/2025
Magana	Tomas	Primary Care Physician	RE-CRED	6/17/2025
Navarro	Maria Paz	Allied Health	RE-CRED	6/17/2025
Nemeth	Nicole	Specialist	RE-CRED	6/17/2025
Pant	Meenakshi	Specialist	RE-CRED	6/17/2025
Saifulrahman	Najibulrahman	Primary Care Physician	RE-CRED	6/17/2025
Sheth	Bansari	Primary Care Physician	RE-CRED	6/17/2025
Shigeura	Angelina	Primary Care Physician	RE-CRED	6/17/2025
Singer	Samuel	Primary Care Physician	RE-CRED	6/17/2025
Sy	Christian	Ancillary	RE-CRED	6/17/2025
Tse	Chung-Hing	Primary Care Physician	RE-CRED	6/17/2025
Watung	Michael	Allied Health	RE-CRED	6/17/2025
Yoo	Karam	Allied Health	RE-CRED	6/17/2025
Yumena	Lucia	Specialist	RE-CRED	6/17/2025
Zafer	Sadaf	Primary Care Physician	RE-CRED	6/17/2025
Zhang	Lan	Primary Care Physician	RE-CRED	6/17/2025
Zhu	Baibing	Ancillary	RE-CRED	6/17/2025

**JUNE PEER REVIEW AND CREDENTIALING
INITIAL APPROVALS BY SPECIALTY**



PCP	4
SPECIALIST	7
ANCILLARY	20
ALLIED	8
BH/ABA	117
TOTAL	156

Between April 2025 and June 2025, the Alliance completed **2,777** member orientation outreach calls among net new members and non-utilizers and conducted **247** net new member orientations and **27** non-utilizer member orientations (**9.9%** member participation rate). In addition, the Outreach team completed **159** Alliance website inquiries, **14** service requests, **5** community events, **14** member education events and **3** Community Meeting/Presentation events in Q4.

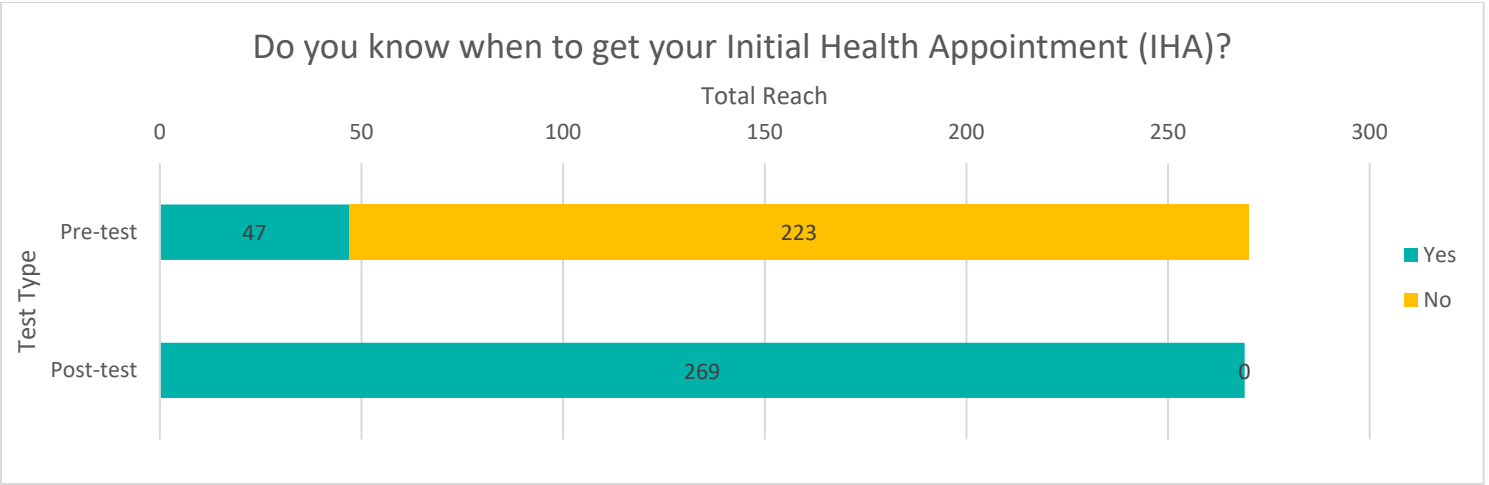
The Communications & Outreach Department began reporting the number of members reached during outreach activities in late February 2018. Since July 2018, approximately **39,324** self-identified Alliance members have been reached during outreach activities.

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

On **Wednesday, March 18, 2020**, the Alliance began conducting member orientations by phone. As of **Monday, June 30, 2025**, the Outreach Team has completed **50,274** member orientation outreach calls and conducted **9,865** orientations, achieving a **19.6%** participation rate.

The Alliance Member Orientation (MO) program has been in place since August 2016. In 2019, the program was recognized as a promising practice to increase member knowledge and awareness about the Initial Health Appointment, by the Department of Health Care Services (DHCS), Managed Care Quality and Monitoring Division (MCQMD). We have steadily increased program participation. Our 2019 6-month average participation rate was **111** members per month. Between March 18, 2020, through June 30, 2025, **9,865** members completed our MO program by phone.

After completing a MO, **100%** of members who completed the post-test survey in Q4 FY 24-25 reported knowing when to get their IHA, compared to only **17.4%** of members knowing when to get their IHA in the pre-test survey.



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

Q4 FY 2024-2025 TOTALS



5 COMMUNITY EVENTS



1040 TOTAL REACHED AT COMMUNITY EVENTS

14 MEMBER EDUCATION EVENTS

851 TOTAL REACHED AT MEMBER EDUCATION EVENTS

274 MEMBER ORIENTATIONS

274 TOTAL REACHED AT MEMBER ORIENTATIONS

3 MEETINGS/ PRESENTATIONS

120 TOTAL REACHED AT MEETINGS/PRESENTATIONS

38 TOTAL INITIATED/INVITED EVENTS

1285 TOTAL MEMBERS REACHED AT EVENTS

296 TOTAL EVENTS

2282 TOTAL REACHED AT ALL EVENTS



ALAMEDA
ASHLAND
BERKELEY

CASTRO
VALLEY
DUBLIN

FREMONT
HAYWARD
LIVERMORE

NEWARK
OAKLAND
PLEASANTON

SAN LEANDRO
SAN LORENZO
UNION CITY

TOTAL REACH 21 CITIES

Cities represent the mailing addresses for members who completed a Member Orientation by phone.. The following cities had <1% reach during Q4 2025: Brooklyn, Cherryland, Emeryville, Fairview, Moraga, Richmond, and Sunol. The C&O Department started including these cities in the Q3 FY21 Outreach Report.



\$520.00

TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

** Includes refundable deposit.*



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

Compliance

Richard Golfin III

To: Alameda Alliance for Health Board of Governors

From: Richard Golfin III, Chief Compliance & Privacy Officer

Date: July 11th, 2025

Subject: Compliance Division Report

Enterprise Audit Updates

- 2025 Department of Managed Health Care (DMHC) and Department of Health Care Services (DHCS) Routine Full Medical Survey
 - The DMHC lookback period spanned October 1st, 2022, through September 30th, 2024, while the DHCS lookback period covered June 1st, 2024, through February 28th, 2025. Both agencies conducted onsite interview sessions from March 3rd to March 7th, 2025.
 - During its formal exit conference on June 23rd, 2025, the Department of Health Care Services (DHCS) presented its preliminary report. The report included one finding: “The Plan failed to ensure that a medical director—or a licensed physician acting on the medical director’s behalf—reviewed post-stabilization authorization requests to determine the medical necessity of post-stabilization care services.” The Plan has 15 days to submit its response to the preliminary report. The Plan’s response is due to DHCS on July 9th, 2025.
 - The Plan is still awaiting receipt of the preliminary report from DMHC.
- 2024 Department of Health Care Services (DHCS) Routine Full Medical Survey
 - The DHCS conducted its 2024 Routine Full Medical Survey from June 17th, 2024, through June 28th, 2024. The Plan received its Final Audit Report on November 18th, 2024, citing twenty (20) final audit findings. Monthly CAP updates were submitted to the DHCS by the 15th of each month. To date, sixteen (16) CAPs have been accepted and four (4) have additional questions. The final CAP update was submitted timely on June 23rd, 2025. The Plan is awaiting DHCS’ review.
- 2023 Department of Health Care Services (DHCS) Focused Medical Survey
 - On September 4th, 2024, the DHCS issued the Final Medical Survey Audit Report and CAP Request for the 2023 DHCS Focused Medical Survey. The DHCS identified findings related to Behavioral Health Services and Transportation Services. Nine (9) CAPs were identified. To date, six (6) CAPs have been accepted, and three (3) CAPs were partially accepted. The DHCS acknowledged the Plan’s response to three (3) open CAP items and requested

updates for June. The Plan submitted the last update on June 16th, 2025. The Plan is awaiting DHCS' review and response.

- 2025 Department of Managed Health Care (DMHC) Financial Examination
 - On April 14th, 2025, the DMHC notified the Plan of its intent to conduct a routine examination of the Plan's fiscal and administrative affairs, including an examination of the financial report for the quarter ending March 31st, 2025. The pre-audit materials were submitted timely on June 16th, 2025. The examination will begin remotely on August 4th, 2025. The DMHC informed the Plan that guidance regarding the audit interview schedule will be forthcoming.
- 2025 Health Services Advisory Group, Inc. (HSAG) Network Adequacy Validation Audit (NAV)
 - On May 29th, 2025, the Plan received the document request packet, including the audit memo, from HSAG. The technical assistance webinar on June 5th, 2025, covered the audit activities and the document request packet. Pre-audit materials are due to HSAG by July 17th, 2025. The Plan's virtual interviews are scheduled for August 11th, 2025, and are expected to last approximately six to eight hours.

Compliance Program Activity – All LOBs

- Bid and Formulary Submission
 - On June 2nd, 2025, the Alliance successfully submitted its CY2026 Medicare Bid and Formulary to CMS by the required deadline. The submission is currently in CMS Desk Review—a standard, post-submission process in which CMS analysts evaluate the bid for accuracy, completeness, and compliance with regulatory requirements. CMS identified some deficiencies in desk review. The Alliance has addressed and responded to all issues raised to date and remains in good standing in the review process.
- State Medicaid Agency Contract (SMAC) Submission Update
 - On June 16th, 2025, the Alliance finalized and DHCS executed the State Medicaid Agency Contract (SMAC). The accompanying SMAC Matrix, which aligns CMS requirements with contract provisions, has also been completed. The Alliance submitted both the executed SMAC and Matrix to CMS on July 2, 2025—five days ahead of CMS's July 7th, 2025, deadline.
- Department of Managed Health Care (DMHC) Medicare Filings
 - CY26 Medicare, 2024 EAE D-SNP Material Modification Filing (E-Filing No. 20244060). On June 5th, DMHC requested confirmation of any outstanding CMS or DHCS requirements related to the Alliance's CY2026 EAE D-SNP expansion. The Alliance confirmed the State Medicaid Agency Contract

(SMAC) was executed with DHCS on June 16th, 2025. The executed SMAC and required Matrix were submitted to CMS on July 2nd, 2025, and the Medicare Bid, Formulary, and SMAC are now under CMS Desk Review. The Alliance now awaits DMHC's further comments or approval and closeout by August 1st, 2025.

- New Legislation

- On March 21st, 2025, Compliance submitted DMHC's 2024 Annual Newly Enacted Statutes All Plan Letter (APL 24-023) filing. This APL includes seventeen newly enacted laws that impact the Plan's Medi-Cal and/or Group Care lines of business. On April 17th, 2025, DMHC sent 24 comments. Compliance submitted a response to the Comment Table on May 23rd, 2025, and continues to collaborate with subject matter experts to successfully implement all legislations and demonstrate compliance. Notably, Senate Bill 729 (Health Care Coverage: Treatment for Infertility and Fertility Services) was intended to become effective on July 1st, 2025. However, a Trailer Bill Language (TBL) has been proposed to delay the implementation to January 1st, 2026. The TBL has been approved by the legislature and has been signed by the Governor. Compliance is awaiting further guidance in a new APL to be issued by the DMHC.
- On April 1st, 2025, DMHC published APL 25-007 which provides guidance and outlines compliance requirements related to Assembly Bill 3275. The bill, effective January 1st, 2025, adjusts the claims reimbursement timeframe from 45 working days to 30 calendar days. Compliance has created several workstreams to identify implementation activities and to submit an e-Filing to DMHC by August 1st, 2025.

- 2024 Board of Governors Training

- As outlined in the Compliance Plan, the Plan has assigned HIPAA and FWA training to all new and standing members of the Board. Of the eighteen Board members, sixteen (89%) have either completed their training or submitted sufficient proof of equivalent outside training, and two (11%) have not started. The Plan continues coordination efforts with the Board Clerk and the Board Chair to improve Board training rates of compliance and will be scheduling an in-person or virtual training opportunity for the two Board of Governors members still needing to complete the training.

Compliance

Supporting Documents

2025 APL IMPLEMENTATION TRACKING LIST						
#	Date Released	Regulatory Agency	APL #	APL Title	LOB	APL Purpose Summary
1	1/9/2025	DMHC	25-001	Southern California Fires and Enrollees' Continued Access to Health Care Services	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) 25-001, which provides information regarding Health and Safety Code section 1368.7.
2	1/17/2025	DHCS	25-001	2024-2025 Medi-Cal Managed Care Health Plan Meds/834 Cutoff and Processing Scheduling	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with the 2024-2025 Medi-Cal Eligibility Data System (MEDS)/834 cutoff and processing schedule.
3	1/13/2025	DHCS	25-002	Skilled Nursing Facility Workforce Quality Incentive Program	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with instructions on the payment and data sharing process required for the Skilled Nursing Facility (SNF) Workforce and Quality Incentive Program (WQIP) for Rating Periods between January 1, 2023, and December 31, 2026. The Calendar Year (CY) 2023 Rating Period is referred to as Program Year (PY) 1, CY 2024 Rating Period as PY 2, and so forth.
4	1/15/2025	DHCS	25-003	Establishing D-SNPs by 2026	DSNP	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with information regarding the Department of Health Care Services' (DHCS) enforcement of California Welfare and Institutions Code (W&I) section 14184.208, related to the requirement for MCPs to operate or be affiliated with a Dual Eligible Special Needs Plan (D-SNP) by 2026, to provide integrated care through affiliated MCPs and D-SNPs for dually eligible Medicare and Medi-Cal Members.
5	1/28/2025	DMHC	25-002	Plan Year 2026 QHP, QDP, and Off-Exchange Filing Requirements	N/A	The Department of Managed Health Care (Department) issues this All Plan Letter (APL) 25-002 to assist in the preparation of Plan Year 2026 regulatory submissions, in compliance with the Knox-Keene Act at California Health and Safety Code sections 1340 et seq. (Act) and regulations promulgated by the Department at California Code of Regulations, title 28 (Rules).
6	2/5/2025	DMHC	25-003	Large Group Renewal Notice Requirements	GROUP CARE	The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 25-003 to provide guidance to plans on the timing and content requirements for renewal notices to large group contractholders under HSC section 1374.21 and HSC section 1385.046.
7	2/7/2025	DHCS	25-004	Community Reinvestments Requirements	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with guidance regarding the MCP Contract's requirement that MCPs reinvest a minimum level of their net income into their local communities.
8	2/12/2025	DHCS	25-005	Standards For Determining Threshold Languages, Nondiscrimination Requirements, Language Assistance Services, And Alternative Formats	MEDI-CAL	This All Plan Letter (APL) serves to inform all Medi-Cal managed care plans (MCPs) of the dataset for threshold and concentration languages and clarifies the threshold and concentration standards specified in state and federal law and the MCP Contract. This dataset identifies the threshold and concentration languages in which, at a minimum, MCPs must provide written translated Member information. This APL also provides guidance on federal and state requirements regarding nondiscrimination, discrimination grievance procedures, language assistance, and communications with individuals with disabilities as set forth in the federal regulations implementing Section 1557 of the Patient Protection and Affordable Care Act (ACA), Title 42 of the Code of Federal Regulations (CFR) Part 438, Senate Bill (SB) 223 (Atkins, Chapter 771, Statutes of 2017), and SB 1423 (Hernandez, Chapter 568, Statutes of 2018)
9	3/12/2025	DMHC	25-004	AB 118: Part 1 - Compliance with Large Group Standardized Evidence of Coverage/Disclosure Form	GROUP CARE	Assembly Bill (AB) 118 (Ting, Chapter 42, Statutes of 2023) added Health and Safety Code section 1363.3 and revised Sections 1352.1, 1363, 1367.041, and 1367.24, effective January 1, 2025. These statutory changes apply to all commercial full-service health care service plans (plans), and require the Department of Managed Health Care (DMHC) to develop standardized templates for various documents describing health plan member benefits, such as the Evidence of Coverage (EOC), Disclosure Form (DF), Schedule of Benefits (SOB), Explanation of Benefits (EOB), and Cost-Share Summary (CSS). The DMHC's work to implement AB 118's requirement to develop standardized templates will be an iterative process. The first part of the standardized EOC/DF will be the following template components: (1) Exclusions and Limitations, (2) Members' Rights and Responsibilities, and (3) Definitions, for use in large group health care service plan contracts issued, amended, or renewed on or after January 1, 2026. This All Plan Letter (APL) and its accompanying attachments set out the filing requirements needed to demonstrate compliance with each template component.
10	3/19/2025	DMHC	25-005	Southern California Fires and Flexibilities to Impacted Providers	GROUP CARE & MEDI-CAL	On January 7, 2025, California Governor Gavin Newsom declared a State of Emergency in Los Angeles and Ventura Counties due to wildfires. The fires destroyed homes and businesses and displaced enrollees and health care providers. After the Governor declares a state of emergency, Health and Safety Code section 1368.7 allows the DMHC to take actions to help mitigate the impact to enrollees and providers.
11	3/21/2025	DMHC	25-006	Health Plan Coverage of Mobile Crisis Services	GROUP CARE	This APL provides guidance regarding the obligations of health plans related to behavioral health crisis services provided to an enrollee by a 988 center or mobile crisis team.
12	4/1/2025	DMHC	25-007	Assembly Bill 3275 Guidance (Claim Reimbursement)	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) under the Knox-Keene Health Care Service Plan Act of 1975, as amended, to provide guidance to health care service plans (plans) on requirements for the processing and reimbursement of claims for health care services with a date of receipt on or after January 1, 2026. Assembly Bill 3275 (Soria, 2024) amended Health and Safety Code sections 1371 and 1371.35 relating to reimbursement of claims for health care services, and enacted Health and Safety Code section 1371.34 enhancing consumer protections relating to grievances about claims for health care services.

#	Date Released	Regulatory Agency	APL #	APL Title	LOB	APL Purpose Summary
13	4/9/2025	DMHC	25-008	Provider Directory Annual Filing Requirements	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (the Department) issues this All Plan Letter (APL) to remind health care service plans (plans) of California Health and Safety Code section 1367.27, subdivision (m)'s requirement to annually submit provider directory policies and procedures to the Department. In addition, the Department reminds plans to submit the changes to their provider directory policies and procedures as instructed in APL 24-018 – Compliance with Senate Bill 923.
14	4/15/2025	DMHC	25-009	2025 Health Plan Annual Assessments	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) to provide information to health care service plans (health plans) pertaining to the DMHC's fiscal year (FY) 2025-26 annual assessment.
15	4/25/2025	DHCS	25-006	Timely Access Requirements	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with guidance regarding the ongoing requirement to meet timely access standards as outlined in Health and Safety Code (H&S) section 1367.03, as set forth by Senate Bill (SB) 221 (Chapter 724, Statutes of 2021) and SB 225 (Chapter 601, Statutes of 2022). MCPs are required to comply with these requirements pursuant to Welfare and Institutions Code (W&I) section 14197(d)(1)(a).1 Additionally, this APL outlines the required minimum performance levels (MPLs) as set by the Department of Health Care Services (DHCS) which go into effect Measurement Year (MY) 2025 for the Timely Access Survey.
16	4/25/2025	DHCS	25-007	Enforcement Actions: Corrective Action Plans, Administrative and Monetary Sanctions	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide clarification to Medi-Cal managed care plans (MCPs) of the Department of Health Care Services' (DHCS) policy regarding the imposition of enforcement actions, including corrective action plans, and administrative and monetary sanctions, which are among the enforcement actions DHCS may take to enforce compliance with MCP contractual provisions and applicable state and federal laws.
17	5/5/2025	DHCS	25-008	Hospice Services and Medi-Cal Managed Care	MEDI-CAL	The purpose of this All Plan Letter (APL) is to highlight contractual, regulatory, and statutory requirements applicable to Medi-Cal managed care plans (MCPs) with respect to their responsibilities to provide Medically Necessary hospice services to their MCP Members.
18	5/12/2025	DHCS	25-009	Community Advisory Committee	MEDI-CAL	The purpose of this All Plan Letter (APL) is to summarize the Community Advisory Committee (CAC) requirements and provide Medi-Cal managed care plans (MCP) with information and guidance regarding their responsibility to implement, maintain, and maximize Member, family, and community engagement through the CAC.
19	5/20/2025	DMHC	25-010	Sections 1357.503 and 1357.505 MEWA Registration and Annual Compliance Requirements	N/A	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) to inform health care service plans (Plans) and association of employers defined as multiple employer welfare arrangements (MEWAs) of the requirements of AB 2072 (Weber, Ch. 374, Stats. 2024) and AB 2434 (Grayson, Ch. 398, Stats. 2024). This APL discusses the requirements on Plans and MEWAs for the initial MEWA registration pursuant to Section 1357.505. This APL also discusses the ongoing compliance requirements for Plans and registered MEWAs pursuant to Section 1357.503. Plans are asked to disseminate this information to their contracted MEWAs.
20	5/23/2025	DMHC	25-011	Health Plan Coverage of HIV Preexposure Prophylaxis (PrEP)	GROUP CARE & MEDI-CAL	On July 8, 2020 and July 6, 2021, the Department of Managed Health Care (DMHC) issued All Plan Letter (APL) 20-026 and 21-018 regarding health plans' obligations to cover Human Immunodeficiency Virus (HIV) antiretroviral drugs and preexposure prophylaxis (PrEP). This APL supplements the two prior APLs and gives further guidance to ensure health plans meet their obligations to cover PrEP with no prior authorization or cost-sharing.
21	6/3/2025	DHCS	25-010	Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services	MEDI-CAL	This All Plan Letter (APL) provides guidance to Medi-Cal managed care plans (MCP) on standardized, statewide Adult and Youth Screening and Transition of Care Tools to guide referrals of adult and youth Members to the appropriate Medi-Cal mental health delivery system and guide timely care coordination for Members requiring transition between delivery systems.
22	6/9/2025	DMHC	25-012	Closure of Rite Aid Pharmacies	GROUP CARE	In May 2025, Rite Aid announced it would be closing numerous pharmacies across multiple states as it moves through bankruptcy proceedings. This APL reminds health plans that they have an ongoing obligation to ensure their enrollees have timely access to prescription drugs. The APL also requires health plans to file with the DMHC a description of how the plans will ensure on-going access to prescription drugs within the access standards required by the Knox-Keene Health Care Service Plan Act (KnoxKeene Act).



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: July 11th, 2025

Subject: Health Care Services (HCS) Report

Board Standing Committees

Quality Improvement Health Equity Committee (QIHEC) activities

- Background: The Alliance is contractually required to maintain a Quality and Health Equity (QIHE) Program to monitor, evaluate, and improve upon the Health Equity and health care delivered to all members. The Board is accountable for the QIHE Program and delegated the Quality Improvement Health Equity Committee (QIHEC) the authority to oversee the performance activities of the program.
- Summary: The following are QIHEC activities of findings, actions, and recommendations from the May 9, 2025 meeting:
- Update from the Chief Health Equity Officer: DEI and TGI training are progressing, with broader rollouts planned soon. A three-year roadmap is nearly finalized for launch next fiscal year.
- Policies & Procedures: a total of 6 Policies were reviewed.
 - Community Supports (CS): 3 Policies
 - Quality improvement (QI): 2 Policies
 - Member Services (MS): 1 Policy
- Approved Voting Items
 - Quality Improvement trilogy documents (Program Description, 2024 Evaluation, 2024 Workplan)
 - Population Health Assessment, Impact & Strategy
 - Network Cultural Linguistic Capacity

- Quality Improvement Health Equity (QIHE) Program Description, Evaluation & Work Plan:
 - Quality & Equity Initiatives: Emphasis on monitoring, evaluation, and timely action to improve care quality with a strong focus on health equity, clinical safety, and provider accountability.
 - Key Achievements & Member Support: Hired engagement coordinators, met benchmarks for 15 of 18 measures, improved data collection, promoted the doula benefit, and increased interpreter service use to support member experience and satisfaction.
 - 2025 Priorities: multidisciplinary collaboration, campaigns to reverse declining immunization rates, ED utilization, expand doula use, enhance disease management, improve access to translation services and on-demand use, strengthen clinical safety oversight, while continuing provider training and support.
 - Targeted Improvement Projects: Increase well-child visits among African American children, enhance SUD and mental health outreach, and improve blood pressure control through active provider engagement. Improved office wait times, strong oversight on corrective action plans, expansion of the doula program.
 - Recommendations: Recommend enhancing provider training on access and interpreter services, expanding outreach to minority communities, increasing immunization efforts, improving care coordination for mental health and substance use patients, strengthening performance tracking, and maintaining member satisfaction through cultural support and ongoing accessibility assessments.
- Population Health: Assessment, Impact & Strategy Documents
 - Data-Driven & Risk-Based Approach: Utilizes health analytics, member assessments, and risk stratification to guide targeted interventions like education, care coordination, and complex case management.
 - Health Equity & Community Engagement: Integrates social determinants of health into care planning and strengthens services through provider support and collaboration with community-based organizations.
 - Ongoing Evaluation & Identified Needs: Conducts annual strategy reviews to address gaps in preventive care, mental health services, follow-ups, and culturally responsive outreach.
 - 2024 Achievements & Future Focus: Achieved strong outreach in high-risk programs and breast cancer screening for Black members; aims to improve case management, increase survey responses, and enhance well-child visit outreach.

- Recommendations: Enhancing provider training on interpreter use and access, expanding equity-focused outreach for minority well-child visits, boosting immunization rates with targeted campaigns, improving care coordination for SUD and mental health patients, refining performance tracking, and sustaining member satisfaction through cultural and linguistic support and ongoing accessibility monitoring.
- Network Cultural Linguistic Capacity
 - Language Access & Network Evaluation: The provider network is assessed for its ability to meet members' cultural and linguistic needs, supporting NCQA accreditation standards.
 - Shifting Member Language Trends: Spanish-speaking membership grew over 6%, while English speakers declined; Chinese-speaking group care members also slightly increased.
 - Provider Gaps & Language Capacity: Gaps remain in Latinx, Black, and Pacific Islander provider representation; Spanish member-to-PCP ratios exceeded benchmarks, though some improvement was seen in specialist and behavioral health access.
 - Interpreter Services & Challenges: Interpreter use rose 70% in 2024, especially for Spanish, Mandarin, and Hmong, but some members still rely on family for interpretation, particularly Chinese-speaking adults.
 - Grievances & Equity Efforts: Language-related grievances rose 75%, mainly tied to scheduling and provider changes; discrimination cases declined. Continued focus will be on language support, provider training, and equity initiatives.
 - Recommendations: Focus on increasing provider diversity by improving recruitment efforts, expanding interpreter services and member education, enhancing provider training on language access, monitoring language assistance programs to address issues, strengthening community partnerships for multilingual outreach, and improving data collection on provider race and ethnicity to support equity strategies.
- 2024 DHCS Audit Findings
 - Blood Lead Screening Compliance – The state accepted actions taken to ensure lead screening in initial health appointments, including chart reviews, as of February 15th.
 - Appointment Wait List Management – A delegate faced challenges with appointment wait times, leading to a temporary panel closure. The state accepted corrective actions as of April 15th, but monitoring continues.
 - Office Wait Time Monitoring – Measures were implemented to track specialist and behavioral health provider wait times through the CG CAP survey. The state approved this as of March 15th.

- Cultural & Linguistic Services (CLS) Compliance – Actions were partially accepted, pending verification of vendor interpreter qualifications. The final deliverable is expected in May to fully close out the issue.
- Recommendations: Enhancing provider compliance monitoring by continuously tracking appointment wait lists and office wait times to avoid access issues, strengthening lead screening procedures during initial visits to ensure compliance, improving oversight of language services through timely interpreter qualification verification and expanded education on CLS standards, and sustaining ongoing provider engagement with regular monitoring and meetings to evaluate corrective actions and prevent recurring problems.
- Access & Availability Update
 - Survey Participation & Compliance Trends – In 2024, response rates stayed about the same as before, with specialists responding the most. Compliance dropped a bit, especially among behavioral health providers added in Q2.
 - Provider Access Issues – Some behavioral health providers used personal phones without emergency instructions, contributing to lower compliance. Specialists also had incorrect phone listings, affecting accessibility.
 - New Behavioral Health Providers – Many newly onboarded BH providers were unfamiliar with after-hours service standards, necessitating additional education and support.
 - Timely Access Challenges – Updates to provider repositories and outreach efforts aim to improve accessibility for members needing after-hours services.
 - Recommendations: Expand training for new behavioral health providers on after-hours and timely access requirements, improving the accuracy of provider contact information, increasing compliance monitoring to ensure emergency instructions are available, and enhancing outreach through virtual and onsite visits to reinforce timely access policies and provider education.

Peer Review and Credentialing Committee (PRCC):

- At the Peer Review and Credentialing (PRCC) meetings held on June 17, 2025, there were one hundred and fifty-six (156) initial network providers approved; Four (4) primary care providers, seven (7) specialists, twenty (20) ancillary providers, eight (8) midlevel providers, and one hundred and seventeen (117) behavioral health providers.
- Additionally, forty (40) providers were re-credentialed at this meeting; eleven (11) primary care providers, sixteen (16) specialists, two (2) ancillary providers, and eleven (11) midlevel providers.

Alameda Alliance for Health Pharmacy & Therapeutics (P&T) Committee

- The P&T Committee reviewed the efficacy, safety, cost, and utilization profiles of the following therapeutic categories and drug monographs at the 6/17/2025 meeting:

Therapeutic/Monograph Class Reviews	
• Anticonvulsants Class Review • Contraceptives, Foams, and Devices Class Review • Parkinson's Disease Agents Class Review • Potassium Removing Agents Class Review • Potassium Supplements Class Review	• Alzheimer's Disease Agents Class Review • Stelara biosimilars review • Luxturna Monograph • Provenge Monograph • Ridaura Monograph • Sucraid Monograph

Pharmacy Benefit Group Care Policy & Procedure Updates
• RX-001 Pharmaceutical Operating Processes Summary • RX-003 Exception Review Process • RX-004 Exception Review Process

DSNP Policy & Procedures (7 NEW)
• RX-D-012 Medicare Part D Fraud, Waste and Abuse (FWA) • RX-D-013 Explanation of Benefits (EOB) Oversight and Monitoring • RX-D-019 Medicare Prescription Payment Plan (M3P) Process, Monitoring and Oversight • RX-D-020 Part D Delegation Oversight Auditing (PBM) • RX-D-021 Medicare Part D Best Available Evidence (BAE) • RX-D-022 Medicare Part D Complaint Tracking Module (CTM) • RX-D-025 Appointment of Representative (AOR)

New Business (New Group Care and PAD Guidelines)
Group Care • Tryngolza • Crenessity • H. Pylori Treatment Medications • MEK Inhibitors for Neurofibromatosis Type 1 (NF1) PAD • Kebilidi • Agents for graft versus host disease • Fertility Agents • Tryngolza

- The P&T Committee approved the following modifications to the formulary for the Alliance's Group Care programs.

Generic//Biosimilar Name & Strength/Dosage Form	Brand Name	Committee Actions
amoxicill-rifabutin- omeprazole Oral Capsule Delayed Release 250-12.5-10 MG	Talicia Oral Capsule Delayed Release 250-12.5-10 MG	Add to formulary with Prior Authorization (PA)
amoxicillin & vonoprazan Oral Therapy Pack 500 & 20 MG	Voquezna Dual Pak Oral Therapy Pack 500-20 MG	Add to formulary with PA
amoxicill-clarithro- vonoprazan Oral Therapy Pack 500 & 500 & 20 MG	Voquezna Triple Pak Oral Therapy Pack 500-500-20 MG	Add to formulary with PA
vortioxetine HBr Oral Tablet 5 MG	Trintellix Oral Tablet 5 MG	Add to formulary with PA
vortioxetine HBr Oral Tablet 10 MG	Trintellix Oral Tablet 10 MG	Add to formulary with PA
vortioxetine HBr Oral Tablet 20 MG	Trintellix Oral Tablet 20 MG	Add to formulary with PA
armodafinil Oral Tablet 200 MG	Nuvigil Oral Tablet 200 MG	Add to formulary with PA
sodium oxybate Oral Solution 500 MG/ML	Xyrem Oral Solution 500 MG/ML	Add to formulary with PA
ustekinumab-kfce Subcutaneous Solution Prefilled Syringe 45 MG/0.5ML	Yesintek Subcutaneous Solution Prefilled Syringe 45 MG/0.5ML	Add to formulary with PA
ustekinumab-kfce Subcutaneous Solution 45 MG/0.5ML	Yesintek Subcutaneous Solution 45 MG/0.5ML	Add to formulary with PA
ustekinumab-kfce Subcutaneous Solution Prefilled Syringe 90 MG/ML	Yesintek Subcutaneous Solution Prefilled Syringe 90 MG/ML	Add to formulary with PA
ustekinumab-aaaz Subcutaneous Solution Prefilled Syringe 45 MG/0.5ML	Otulfi Subcutaneous Solution Prefilled Syringe 45 MG/0.5ML	Add to formulary with PA
ustekinumab-aaaz Subcutaneous Solution Prefilled Syringe 90 MG/ML	Otulfi Subcutaneous Solution Prefilled Syringe 90 MG/ML	Add to formulary with PA

PRIOR AUTHORIZATION GUIDELINE UPDATES	
Filsuvez	Eohilia
Sedative Hypnotics	Spravato
Cholinesterase Inhibitors	Hemlibra (emicizumab-kxwh)
Specialty Biologic Agents	Anti-Obesity Medications
Calcitonin Gene-Related Peptide (CGRP) Antagonists for Headache Prevention	Erectile Dysfunction Medications
Hepatitis B Drugs	Vaginal Progesterone
Injectable Atypical Antipsychotic Medications	Fertility Agents
Opioid Use Disorder (OUD) Agents	Complement Inhibitors for the Treatment of Paroxysmal Nocturnal Hemoglobinuria (PNH)
Sleep Disorder Therapy	Complement Inhibitors for the Treatment of Myasthenia Gravis
Transthyretin-mediated Amyloidosis Agents	

PRIOR AUTHORIZATION GUIDELINES REVIEWED (NO UPDATES)	
Formulary, step therapy required *For drugs without specific criteria	Adenosine Triphosphate-Citrate Lyase (ACL) inhibitors
Non-formulary and prior authorization required oral liquid formulations	Gonadotropin Releasing Hormone Antagonists
Medications for Attention Deficit Hyperactivity Disorder (ADHD) and Narcolepsy	Hereditary Angioedema (HAE)
Roflumilast (Daliresp)	Pregabalin (Lyrica and Lyrica CR)
Wegovy	Rezdiffra
Vyjuvek	Acute Migraine Treatments
Joenia	Skyclarys (omaveloxolone)
Daybue (trofinetide)	Filspari
Lupkynis	Radicava
Levalbuterol (Xopenex/Xopenex HFA)	Hepatitis C Medications
Lidocaine Patch	Phosphate Binders
Fenofibrates	Xolair (omalizumab) for Asthma, Urticaria, and IgE-Mediated Food Allergy
Nutritional formulas, infant formulas	Short acting opioid containing products
Lipotropics	Alprazolam (Xanax)
Long-acting opioids	Diuretics
Serotonin Receptor Agonists (Tryptans)	Rectiv (nitroglycerin) ointment
Febuxostat (Uloric)	

- The P&T Committee approved the following modifications for Physician Administered Drugs.

GUIDELINE UPDATES	
Anti-CD19 CAR-T Immunotherapies	Myasthenia Gravis Agents
Calcitonin Gene-Related Peptide (CGRP) Antagonists for Headache Prevention	Bleeding Disorder Products
Complement Inhibitors	

GUIDELINES REVIEWED (NO UPDATES)	
SMN2 Splicing Modifiers for the Treatment of Spinal Muscular Atrophy (SMA)	Vyjuvek
Naglazyme	Generalized Pustular Psoriasis (GPP) Agents
Leqembi	Amtagvi
Radicava (edaravone)	Lenmeldy

Program: Community Health Strategy (CHS) – June Updates

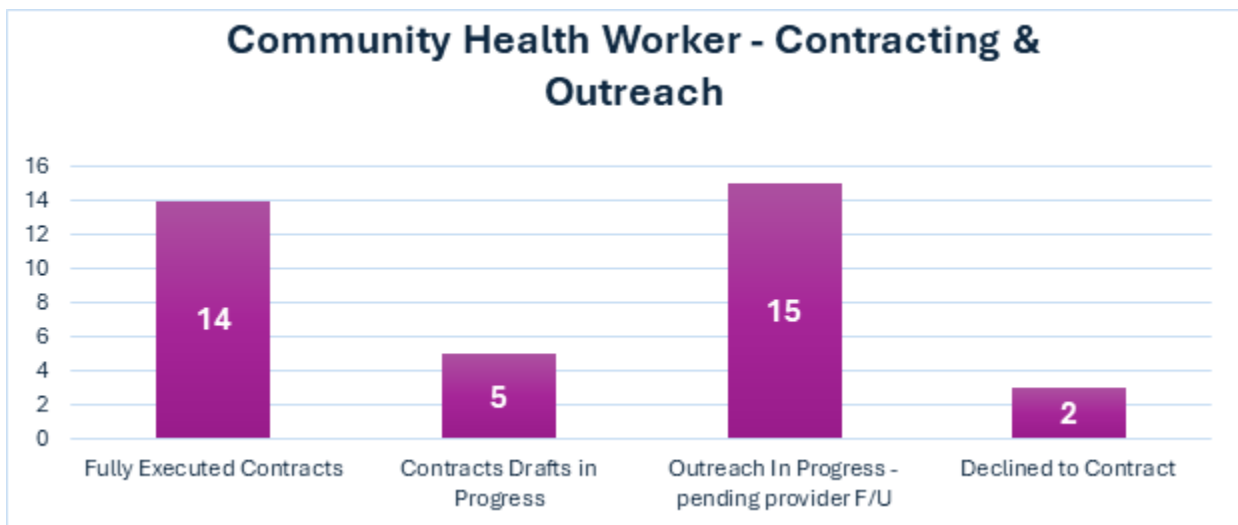
- Community Health Worker Program – The Community Health Worker (CHW) Benefit aims to mitigate health disparities and improve health outcomes of Alliance members by bridging the gap between health and housing systems of care to support members' overall health and wellness through the deployment of preventative services that create positive outcomes on a member's social determinants of health.
- Staffing Updates:
 - Manager, Community Health Worker Program – Pending position re-posting
- Community Program June Summary:
 - In June, the Community Health Worker (CHW) Program at Alameda Alliance for Health advanced its strategic refinement and operational buildout. This month's efforts focused on strengthening the program's infrastructure, enhancing provider onboarding tools, and moving from planning to execution through data-informed decision-making. Key areas of transformation, including billing optimization, program alignment, pre-screening protocols, and integrated cross-departmental workflows, are essential to establishing a scalable and sustainable CHW delivery system. An example of these highlights can be found in both the project status updates below and descriptions.

Project Status Updates:

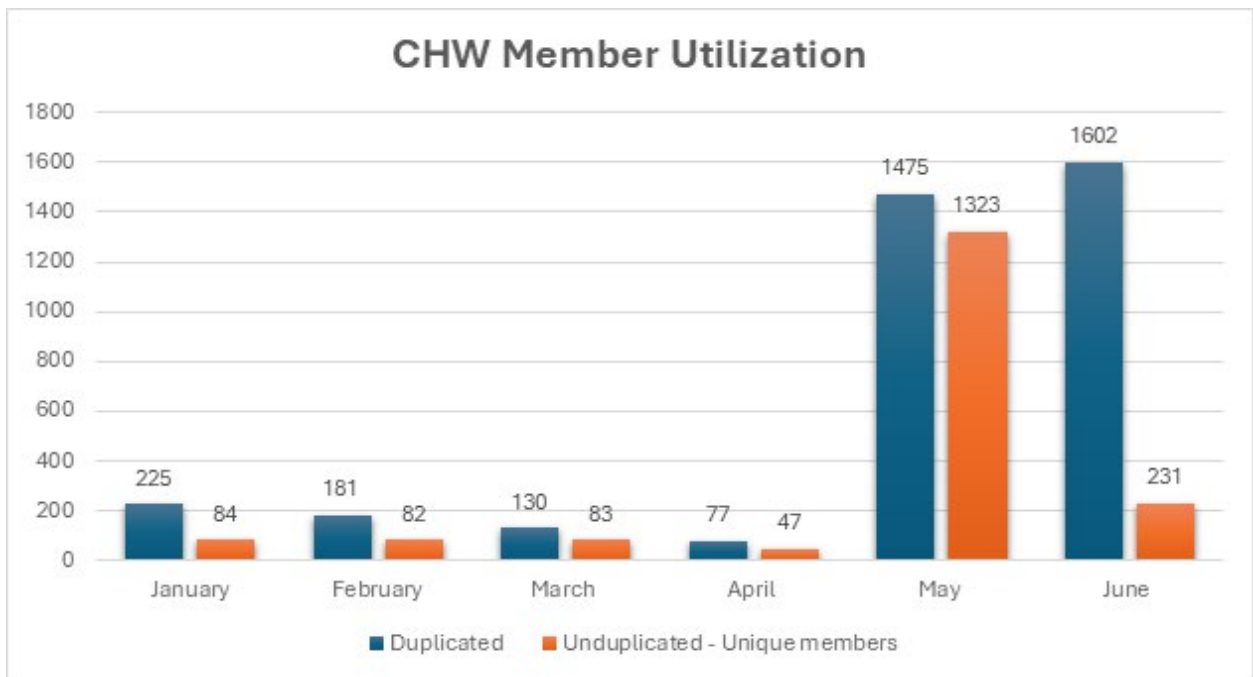
CHW Integration Strategy	 In Progress
CHW 12+ Unit SR Module Development Project	 In Progress
CHW Program Integration Strategy – Revisions	 In Progress
CHW G-Codes Billing & Configuration Project (partnership w/ Claims dept)	 Completed
CHW Contracting Language Updates – Partnership w/ Contracting	 Completed
CHW Certification Learning Module Development	 In Progress
CHW Billing Mitigation Reports	 Ongoing
CHW Training Cohort	 Postponed

- Key Accomplishments & Operational Milestones
 - CHW Integration Strategy
 - CHW Integration strategy is a core strategy designed to deliver preventive, person-centered, and equity-driven care. The primary goal is to improve health outcomes, build trust, and reduce disparities among Alliance members. This integration strategy provides a clear and actional roadmap for CHW program design and implementation, supporting alignment across internal teams and driving progress toward next-phase deliverables.
 - Claims and Billing System Improvements
CHS began targeted strategies to address legacy billing errors, including operationalizing new G-codes and developing a 12+ Unit Service Request (SR) module to support accurate claims processing and record keeping in our TruCare/Health suite systems.
 - Provider Engagement and Prescreening Tools
June preparation for launch of new enhanced tools, including Smartsheet-linked prescreening forms, instructional guides, decision templates, and gap-closure action plans, to streamline provider readiness and accelerate contracting.
 - Contract Infrastructure
Partnered with Provider Services to complete updated CHW contract language, aligning with program scope, new billing codes, and regulatory requirements.
 - CHW Workforce Development
Mapping re-design of CHW Certification Learning Modules to standardize onboarding and expand scalable recruitment. The CHW training cohort remains postponed until the new CHW Manager is hired to ensure adequate capacity and stakeholder continuity.
 - Policy and SOP Development (In Progress)
Entered the Drafting phase of new CHW policy guidance, workflows, and standard operating procedures to codify benefit requirements and support internal alignment.

- ROI Modeling (In Progress)
 - Launched efforts to develop a ROI framework for CHW services, integrating cost-avoidance analysis, PHM impact projections, and value-based performance metrics.
- CHW Program – Recruitment Efforts:
 - As of this reporting period, Alameda Alliance for Health has 14 fully executed CHW contracts, with five (5) additional contracts in development and 15 providers currently in the outreach phase. Two (2) provider organizations either declined to contract, did not meet Alliance readiness criteria, or did not respond during the reporting window. While the CHW program continues to make steady progress in expanding provider engagement, deeper recruitment efforts remain a system-level opportunity. Strengthening cross-departmental alignment, particularly with Provider Services, will be critical to accelerating network growth and ensuring equitable access to CHW support across Alameda County. Regionally, CHW utilization remains low across health plans.



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



- Between May and June, the CHW Program sustained high levels of member engagement, with duplicated encounters increasing from 1,475 in May to 1,602 in June. However, unduplicated (unique) members served declined from 1,323 to 231 during the same period. While the graph shows strong growth, it does not yet reflect the full scope of CHW activity. At least three CHW providers have missed or delayed claims submissions for June due to internal billing barriers. This points to a potential system bottleneck in encounter data capture, which Alameda Alliance for Health is actively investigating with providers to ensure timely, complete reporting and reimbursement.
- This decline was significant across provider types.
- When analyzing the member level nuances, (3) three critical assumptions emerge:
 - Is repeat engagement a possible indicator of trust building and caseload maturity?
 - Providers with higher encounter volume often showed recurring engagement with the same members suggesting that CHWs are building trusted relationships and managing informal caseloads. This trust-building dynamic reinforces the program's role in providing consistent, upstream support to members facing barriers to social connection, chronic health conditions, or ongoing referral and resource needs.
 - Community Health Strategy is required to identify streamlined pathways to engage in warm-handoff opportunities within Alameda Alliance Health Care Services teams.

- The consistency of member engagement highlights an opportunity to integrate CHWs more intentionally with case management, care coordination, and clinical teams. Members with repeat CHW touchpoints may benefit from warm handoffs to additional resources, especially when elevated acuity is identified.
- Community Health Strategy should be systemically integrated across the healthcare continuum.
 - The concentration of encounters among repeat members suggests, that there is a need to develop integrated care pathways that allow members to seamlessly step up into higher-acuity services or step down into lower-intensity supports, such as Community Health Worker (CHW) services, while maintaining consistent connection to social and community-based resources. By strengthening the community resource infrastructure and building a robust, accessible repository of CHW and SDOH referral options, both members and providers will be better equipped to coordinate across levels of care. This integrated approach supports whole-person care, facilitates timely referrals, and ensures members receive the right level of support based on evolving needs—internally and externally.
 - The Community Health Strategy Team will enter July with continued momentum and focus. As we advance our efforts to build a fully integrated community health strategy across the care continuum, we will conduct deeper member-level analyses to assess service intensity patterns, identify members who may benefit from escalated care or wraparound support, and refine strategies to braid CHW services with other CalAIM benefits. These efforts are designed to close population health and equity gaps through targeted CHW interventions, ensuring members receive timely, appropriate, and coordinated support. By aligning CHW services with the broader delivery system, we aim to strengthen the Alliance’s capacity to provide sustained, equitable, and person-centered care—particularly for those most at risk of falling through systemic gaps.

Utilization Management (UM)

(Summary of 2024 UM Program Evaluation)

- Denial Rates
 - Overall, 2.31% *(0.04% decrease from 2023)*
- Authorization Turn-Around Times (goal = 95%)
 - Inpatient/outpatient: overall 99%, above goal
 - LTC: overall 96%, above goal
 - BH: overall 90%, below goal
- Pharmacy:
 - Outpatient RX: overall 99.8%, above goal
 - Physician Administered Medications/Injections: overall 99.4%, above goal
- Over/Under Utilization Measures
 - ER visits: average 491.6 visits/K *(-33.4 visits/K compared to 2023)*
 - Acute Inpatient Hospitalization Readmission Rate: 21.1% *(+1.1% compared to 2023)*
- Opportunities incorporated into 2025 Program/Workplan:
 - Explore Community Health Workers and Bridge Programs embedded in Emergency Departments to decrease Emergency Department Utilization
 - Continue referral processes for Enhanced Care Management, Complex Case Management and Community Supports to link members to appropriate resources for next level of care
 - Streamline and improve accessibility of prior authorization information to providers, including increase visibility of authorization details online
 - Provide regular training and share best practices with delegated entities, particularly around Enhanced Care Management, Community Supports, Transitional Care Services

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

- Total authorization volume decreased month-over-month from May to June 2025.

Total Authorization Volume (Medical Services)			
Authorization Type	April 2025	May 2025	June 2025
Inpatient	2,742	2,563	2,609
Outpatient	4,262	4,208	4,035
Long-Term Care	804	786	753
Total	7,808	7,557	7,397

Source: #02569_AuthTAT_Summary

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

Utilization Management: Outpatient

- Foster care CoC cases continue to average 3-5/day. We are reviewing pended claims each week to identify CoC services and ensure there are no delays in the care for this population. With each case, we are reviewing for any potential care coordination or case management needs and referring to CM as needed.
- We continue to partner with our Medical Directors to review current prior authorization rules and evaluate which services should continue to require prior authorization, and which services should have prior authorization requirements removed (to decrease provider administrative burden).
- OP processed a total of 4,035 out of a total volume of 7,361 submitted authorization in the month of June. The delta represents duplicates, no PA required etc.
- OP Turnaround times continue to exceed the benchmark of 95% with the average being 99.8% in the month of June.
- The top 5 categories remain unchanged Radiology, OP Rehab, TQ, Home Health and Outpatient facility. Radiology and Rehab representing 61% of this volume.

Total Outpatient Authorization Volume			
Authorization Status	April 2025	May 2025	June 2025
Approvals	4,182	4,055	3,864
Partial Approvals	14	14	25
Denials	66	139	146
Total	4,262	4,208	4,035

Source: #02569_AuthTAT_Summary

Outpatient Authorization Denial Rates			
Denial Rate Type	April 2025	May 2025	June 2025
Overall Denial Rate	5.3%	5.2%	4.9%
Denial Rate Excluding Partial Denials	4.9%	4.9%	4.3%
Partial Denial Rate	0.4%	0.3%	0.6%

Source: #03690_Executive_Dashboard

Outpatient Turn Around Time Compliance			
Line of Business	April 2025	May 2025	June 2025
Overall	99.6%	99.6%	99.8%
Medi-Cal	99.6%	99.6%	99.8%
IHSS	100%	100%	99.4%
<i>Benchmark</i>	95%	95%	95%

Source: #02569_AuthTAT_Summary

Utilization Management: Inpatient

- Total inpatient auth volume decreased slightly from 4,055 authorizations processed in May 2025 to 3,864 in the month of June.
- Inpatient overall average LOS continued to decreased from 6.9 in March to 5.6 in April and 5.2 May. Admits per thousand increased from 49.6 in April to 48.3 in June. Days per thousand 340.3 in March and decreased to 276.2 in April, and then falling further to 249.1 in May. The trend is consistent among Child, Adult, ACA and SPD categories.
- IP overall denial rate was 4.5% in May and dropped to 3.5% in June.
- IP Auth TAT compliance continues to meet or surpass 95% benchmark, with overall TAT of 95% in April, 97% in May and 97% in June.
- IP Concurrent clinical review standard process of validating appropriate acute level of care being provided to members in: including ICU, Telemetry/Intermediate/ICU step-down, Med/Surg and Administrative stay levels in Acute care and Long Term Acute Care hospitals. Recent implementation of process change involved matching appropriate authorized level of care in Auth system TruCare with Claims system HealthSuite. This change led to accurate matching of authorizations to claim/billing that resulted in significant savings.
- External hospital rounds are ongoing with UCSF, Stanford, Alameda Health System, Kindred LTACH, Kentfield LTACH, Washington, Eden, Alta Bates, and Summit, to review members' current active admissions discuss UM issues, address discharge barriers, offer other opportunities for supporting throughput and appropriate discharge.
- Kaiser interdisciplinary rounds began in January and continue monthly, with the goal of supporting AAH members at Kaiser facilities who have complex discharge needs and high ER utilization. Members delegated to CHCN are also reviewed in this forum.

Total Inpatient Authorization Volume			
Authorization Status	April 2025	May 2025	June 2025
Approvals	2,721	2,513	2,553
Partial Approvals	0	0	0
Denials	21	50	56
Total	2,742	2,563	2,609

Source: #02569_AuthTAT_Summary

Inpatient Med-Surg Utilization			
Total All Aid Categories			
Actuals (excludes Maternity)			
Metric	March 2025	April 2025	May 2025
Authorized LOS	6.9	5.6	5.2
Admits/1,000	49.0	49.6	48.3
Days/1,000	340.3	276.2	249.1

Source: #01034_AuthUtilizationStatistics – *data only available through April 202

Inpatient Authorization Denial Rates			
Denial Rate Type	April 2025	May 2025	June 2025
Full Denials Rate	1.3%	1.3%	1.4%
Partial Denials	3.3%	3.2%	2.2%
All Types of Denials Rate	4.5%	4.5%	3.5%

Source: #01292_AllAuthDenialsRates

Inpatient Turn Around Time Compliance			
Line of Business	April 2025	May 2025	June 2025
Overall	95%	97%	97%
Medi-Cal	95%	97%	97%
IHSS	93%	96%	100%
<i>Benchmark</i>	<i>95%</i>	<i>95%</i>	<i>95%</i>

Source: #02569_AuthTAT_Summary

Utilization Management: Long-Term Care

- LTC census during June 2025 was 2,350 members. This is an increase of 1.64% (30 members) from May 2025.
- Month to Month, the admissions, days and readmissions are decreasing. From March to May the admissions decreased by 64.38%, the days decreased by -67.16% and the readmissions also decreased by 62.86%. Some of this could be due to a lag in claims data being available, but we are seeing a decrease overall.

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

**Source: #14236_LTC_Dashboard – data only available through April*

- LTC Staff continue to participate in SNF collaboratives around the county to ensure that our facility partners are updated with the processes and program enhancements.
- Having virtual rounds with AHS, San Leandro, Kyakameena, Elmwood, Jones Convalescent and Eden LTC facilities to coordinate on complex cases
- Quarterly rounds with Regional Center of Easy Bay to discuss any ICF/DD members.
- Continued internal Long Term Care rounds to discuss members coming into and leaving a long-term care setting.
- Social Workers continue visiting LTC facilities in person, on a monthly and quarterly basis depending on census, to assist with discharge planning and access to other resources. The team continues referrals to TCS and other internal/external programs to provide wraparound support to members preparing to discharge from an LTC custodial facility.
- LTSS Liaison is visiting and meeting with facilities to discuss any claims issues and educating on processes.
- Health Navigator and dedicated RN continue to assist with TCS for members coming back from an acute stay or transitioning from acute into long-term care.
- The 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 June, compared to April and May.
- Authorization processing turn-around time (TAT) has remained between 98%- 99%, which is exceeding the threshold of 95%.

Total LTC Authorization Volume			
Authorization Status	April 2025	May 2025	June 2025
Approvals	774	753	708
Partial Approvals	0	0	0
Denials	30	33	45
Total	804	786	753

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	April 2025	May 2025	June 2025
Medi-Cal	99%	99%	99%
<i>Benchmark</i>	95%	95%	95%

Source: #02569_AuthTAT_Summary

Behavioral Health

- In June, the Behavioral Health Department processed 651 authorizations, 416 Care Coordination referrals, and 192 mental health screenings and transition of care tools.

Total BH Authorization Volume			
	25-Apr	25-May	25-June
Approvals	741	650	642
Partial Approval	0	0	0
Denials	8	14	9
Total	749	664	651

Source: 14939_BH_AuthTAT

Mental Health Turnaround Times

MH TAT			
	25-Apr	25-May	25-June
Determination TAT%	97%	100%	96%
Notification TAT%	99%	96%	96%

Behavioral Health Therapies (BHT/ABA) Turnaround Times

BHT TAT			
<i>*Goal ≥95%</i>	25-Apr	25-May	25-June
Determination TAT%	100%	97%	95%
Notification TAT%	100%	100%	100%

Behavioral Health Denial Rates

BH Denial Rates		
25-Apr	25-May	25-June
1%	1%	1%

Source: 14939_BH_AuthTAT

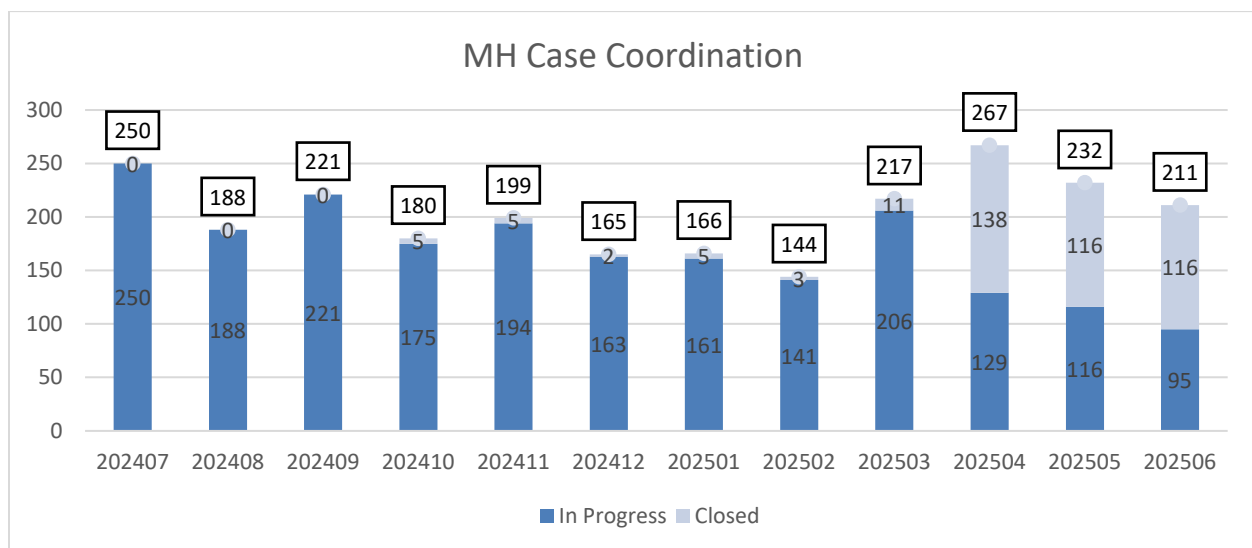
Mental Health Care Coordination

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

Total # Medi-Cal Screenings & TOC			
	25-Apr	25-May	25-June
Youth Screenings	90	91	59
Adults Screenings	164	135	131
Transition of Care Tools	1	1	2

Source: 16015_MH_Assessments

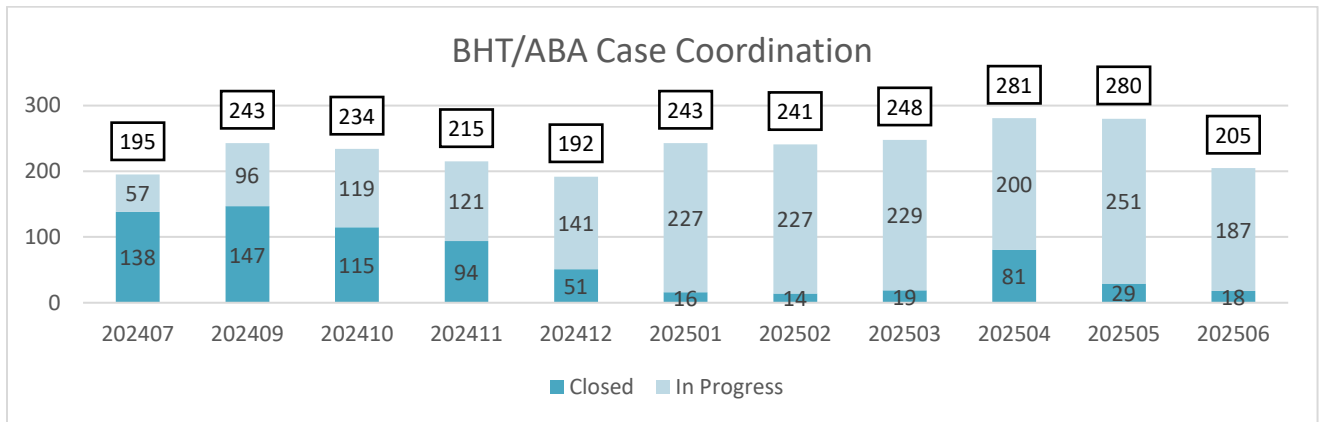
- Alliance licensed mental health clinicians, psychiatric nurses, and behavioral health navigators provide care coordination for members who need assistance accessing the mental health treatment services they need.



Source: 14665_BH_Cases

Behavioral Health Therapies (BHT/ABA)

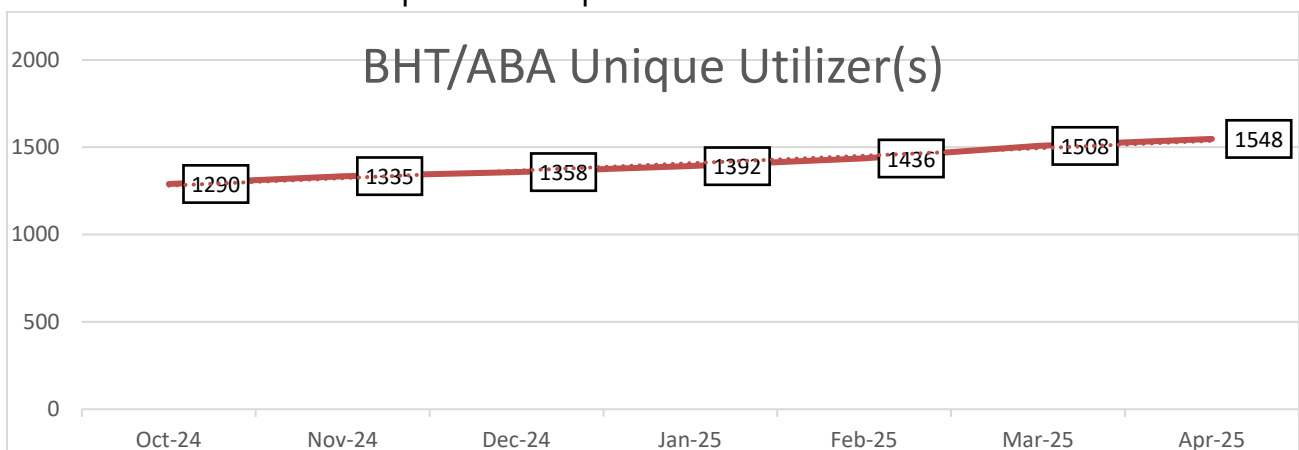
- Children and youth referred for BHT/ABA services, including Applied Behavioral Analysis (ABA) and Comprehensive Diagnostic Evaluations (CDE), require Care Coordination to access the services needed. The Alliance manages each child's unique needs and follows up with parents and caregivers to resolve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



Source: 14665_BH_Cases

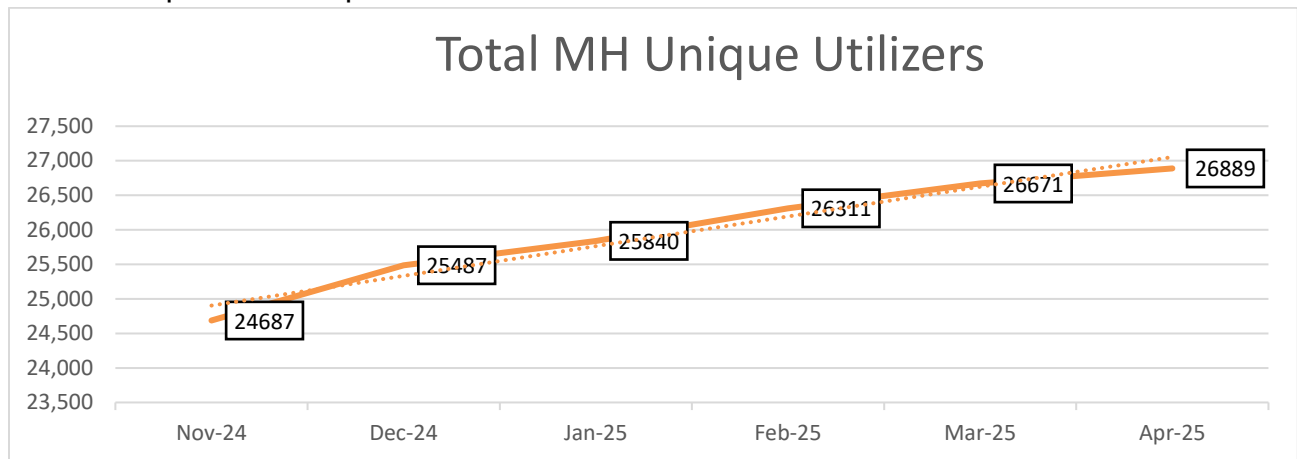
Behavioral Health Unique Utilizers

- Removing barriers to accessing BHT/ABA services remains a primary goal for the Alliance Behavioral Health team. One way to measure that is to monitor unique utilizers who are accessing care when interventions are implemented.
- We observed a continuing rise in unique utilizers of BHT/ABA services, reflecting a 2.7% increase compared to the previous month.



Source: PBI 14621 BHT Utilization Report

- The number of unique utilizers of mental health services has increased by 0.8% compared to the previous month.



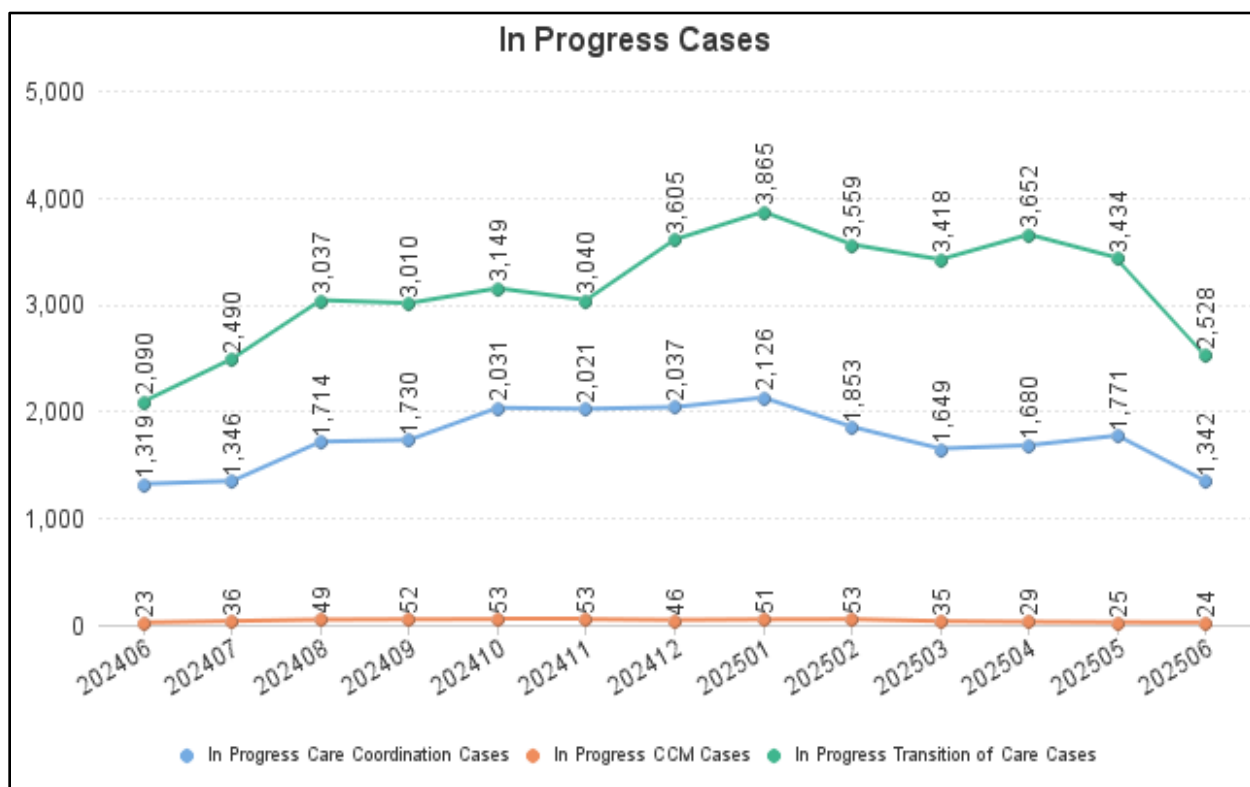
Source: PBI 14637 BH12M Report

Pharmacy

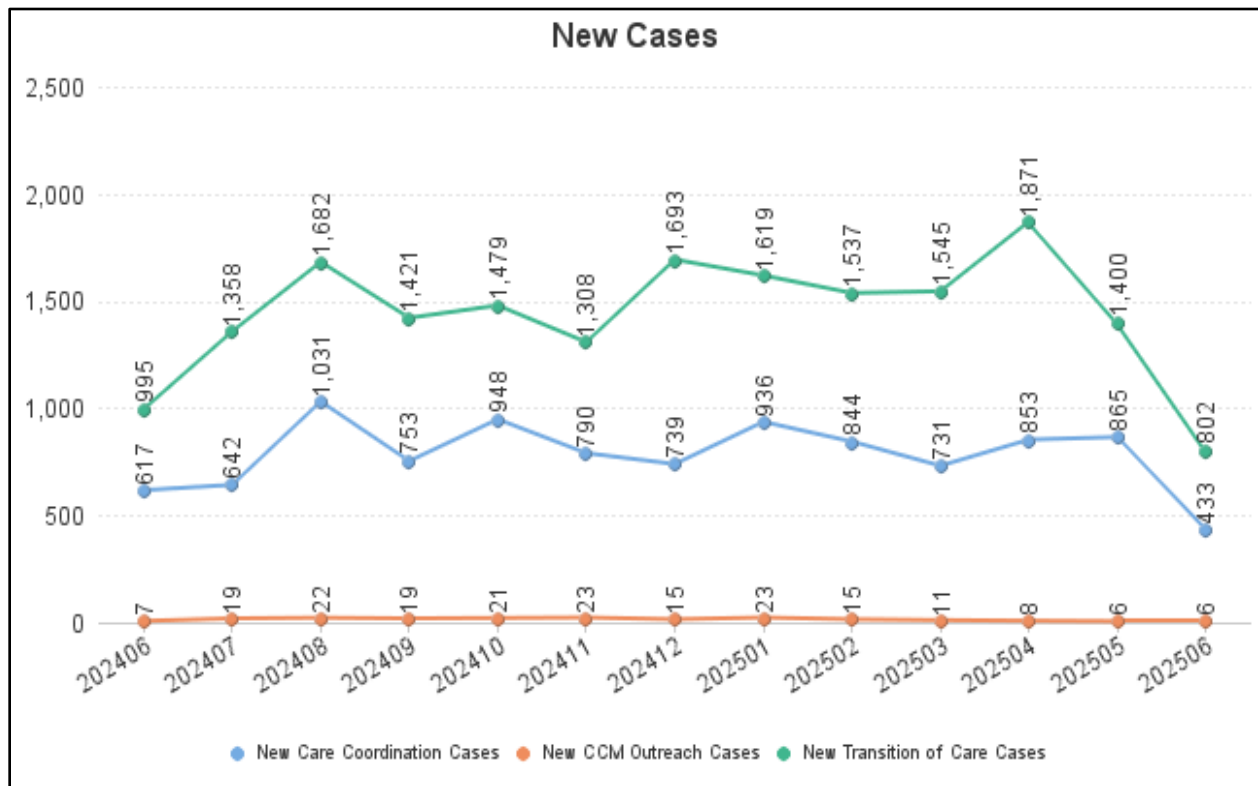
- The Pharmacy Transitional Care Services (TCS) program continues to prioritize outreach to members recently discharged from the hospital, aiming to reduce readmissions stemming from medication related issues. Our current efforts remain concentrated on assisting members who have either diagnoses of heart failure or sepsis; emphasizing cases that, while fewer in number, are higher-risk and may benefit from pharmacy intervention. Collaborations with Case Management have notably boosted direct referrals, resulting in increased effectiveness and helped streamline communication across departments as related to TCS.
- Direct referrals have gone up 33% in the last 6 months (8 direct referral cases) compared to the previous 6 months (6 direct referral cases). Note: these are different than the ADT feed screening cases as they are sent to us by other departments.
- A TCS Case involving a potential quality issue (PQI) was brought to our attention by one of the medical directors regarding medication access for one of our members at a pharmacy. This is the 1st PQI we submitted as related to pharmacy TCS and is now added to our TCS workflow for future cases as appropriate.
- We were able to successfully gain Stanford EMR access for our pharmacy TCS technician, and now Stanford is officially added to the pharmacy TCS workflow. We are now monitoring the ADT feed for a total of four hospitals (Stanford, Washington, AHS, and Sutter).

Case and Disease Management

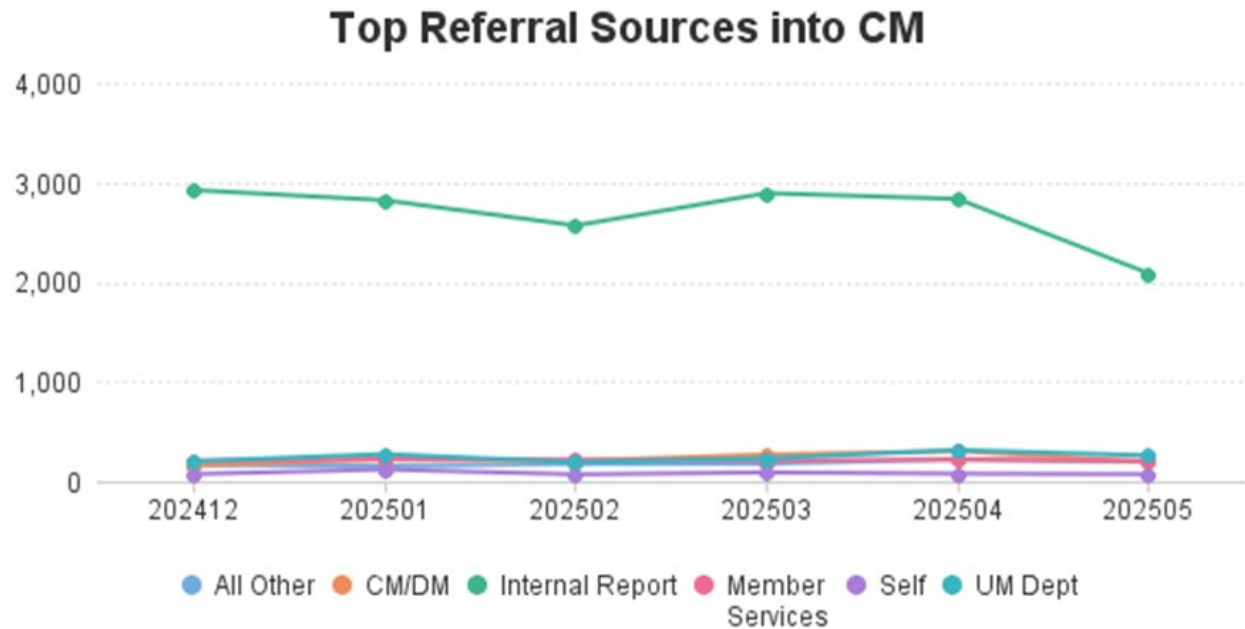
- The CM team continues to assist the high volume of members needing Transitional Care Services (TCS) as they transition from one level of care to another. This includes member transitions where the Alliance is not the primary payor (such as members with Medicare primary insurance).
- The CM team continues to collaborate with clinic partners to ensure the TCS requirements are met, including but not limited to scheduling and ensuring follow-up appointments for members, informing members of CM services, notifying appropriate individuals of TCS services (hospital discharge planners, members, caregivers, support teams, etc.).
- CM is collaborating with UM and LTC to support members at hospitals with long-length stays and complex discharge barriers, including facilitating referrals to Community Supports, ECM and other community resources, as needed.
- CM is responsible for acquiring Physician Certification Statement (PCS) forms before Non-Emergency Medical Transportation (NEMT) trips to better align with DHCS requirements for members who need that higher level of transportation (former completed by Transportation broker, Modivcare). CM continues to educate the provider network, including hospital discharge planners, and dialysis centers about PCS form requirements. Transportation liaison has also increased oversight of ModivCare's facility transportation services, including making onsite visits with hospitals to address transportation concerns.



Source: #03342 TruCare Caseload



Source: #03342 TruCare Caseload



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

Source: #03881 Case and Disease Management Dashboard - *data only available through May2025

CalAIM

Enhanced Case Management

- All Populations of Focus have been live since January 1, 2024.
- The ECM team is working closely with IT and IPD to automate creation of authorizations and potential other areas of ECM. This will improve processing time of authorizations and free up the team to work on other areas of ECM like graduating or stepping members down into a lower level of care.
- Efforts to expand the ECM provider network have begun. The screening panel is reviewing provider applications based on capacity to serve targeted Populations of Focus, demonstrated operational excellence in programming, and quality benchmarks.
- The Standardized ECM referral form and ECM eligibility information is now visible to providers on the provider portal. Network-wide provider training and communications are forthcoming. Some providers have been trained already on an ad-hoc basis.
- The ECM team continues to build rapport with the ECM providers, meeting at a minimum twice a month: once to discuss specific cases and once to discuss operational issues. This is leading to more collaboration and community referrals to additional resources. Additional meetings are scheduled with ECM providers for case conferencing as needed.
- ECM and CS teams have begun a collaborative meeting to confirm communication is occurring between Community Supports providers and ECM lead care managers. The collaboration further enhances coordination of care, ensuring non-duplicative services and members are receiving appropriate services to meet their needs.
- As a result of this fall's audit of ECM providers, the ECM team has developed training for the ECM providers to re-educate the ECM provider network on the core services DHCS is requiring for ECM. The ECM team has scheduled monthly training sessions for all ECM providers' frontline staff to reinforce ECM requirements and expectations. The last training is scheduled to occur Friday, July 11, 2025.
- AAH continues to collaborate with Alameda County (AC) Health to discuss Street Medicine alignment. The ECM team works closely with the Street Team providers to make sure encounters are submitted and billed appropriately.

- ECM staff, including the Foster Care/Child Welfare Liaison continue to participate in DHCS Foster Care Youth Transition Stakeholder meetings and work with county foster youth programs. This has led to the initial training of the Foster Care Youth Liaisons, which occurred in early February.
- Closed-Loop Referral (CLR) requirements went live on July 1, 2025. The closed-loop referral framework is designed to ensure that referrals between healthcare providers are completed efficiently and effectively. The ECM team is partnering with IPD to make sure Alameda Alliance can meet the regulatory requirements.

	March 2025		April 2025		May 2025	
ECM Providers	Outreach	Enrolled	Outreach	Enrolled	Outreach	Enrolled
ACBH	-	14	-	14	-	14
Alameda Health System (AHS)	27	217	27	224	28	216
Bay Area Community Services (BACS)	-	129	5	131	-	133
California Cardiovascular Consultants	-	156	-	155	-	155
California Children's Services (CCS)	7	27	4	31	6	32
CHCN	90	1,029	108	1,036	77	1,035
East Bay Innovations (EBI)	8	119	7	124	20	126
Full Circle	1	184	3	208	2	212
Institute on Aging	113	253	13	258	121	256
La Familia	57	35	54	43	31	43
MedZed	5	572	2	620	3	657
Roots Community Health Center	15	302	-	296	-	303
Seneca Family Services	38	65	46	68	75	68
Pair Team	799	858	582	859	720	863
Titanium Health Care	932	865	549	895	508	963
Tiburcio Vasquez Health Center (Street Medicine)	-	131	-	132		129
BACH (Street Medicine)	-	80	-	78	-	78
Lifelong (Street Medicine)	11	338	2	349	1	348
Roots Community Health Center (Street Medicine)	Combined with Roots 'traditional' ECM program					

Source: #13360 ECM Dashboard

Community Supports (CS)

- DHCS released new policy guides for all Community Supports on 04/30/25. The Alliance's Community Supports guidance was sent to providers, with an effective date of 07/01/25 for all non-housing Community Supports. Guidance for the Housing-related Community Supports guidance will be shared in Fall 2025, with an effective date of 01/01/26, per DHCS regulations.
- CS services are focused on offering services or settings that are medically appropriate and cost-effective alternatives. The Alliance offers the following community supports:
 - Housing Navigation
 - Housing Deposits
 - Tenancy Sustaining Services
 - Medical Respite
 - Medically Tailored/Supportive Meals
 - Asthma Remediation
 - (Caregiver) Respite Services
 - Personal Care & Homemaker Services
 - Environmental Accessibility Adaptations (Home Modifications)
 - Assisted Living Facility Transition
 - Community or Home Transition Services
- The Alliance is working to identify gaps in current service capacity and member access to Community Supports; this will inform future targeted efforts for CS network expansion.
- AAH CS staff continue to meet with CS providers to work through logistical issues as they arise, including referral management, claims payment and member throughput.
- DHCS Closed Loop Referral requirements became effective on 07/01/25.

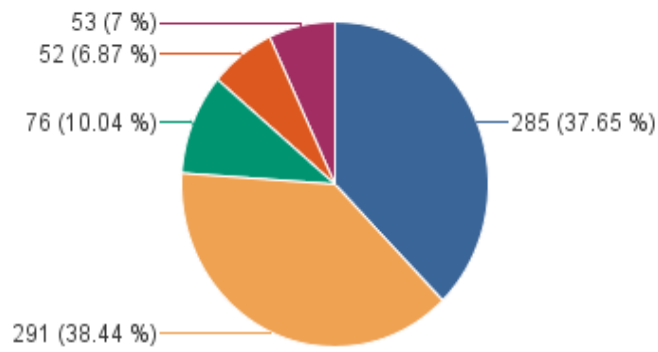
Community Supports	Services Authorized in March 2025	Services Authorized in April 2025	Services Authorized in May 2025
Housing Navigation	967	971	941
Housing Deposits	248	288	330
Housing Tenancy	804	733	780
Asthma Remediation	141	153	152
Meals	1,160	908	639
Medical Respite	74	78	63
Transition to Home	24	26	21
Nursing Facility	16	14	11
Home Modifications	0	0	0
Homemaker Services	50	41	38
Caregiver Respite	0	0	0
Total	3,484	3,212	2,975

Source: #13581 Community Supports Auth Dashboard

Quality

- The clinical team in QI is responsible for triaging all PQI types as they are received. This process involves assignment to an appropriate reviewer for assessment, planning, intervention and evaluation. Quality of Access issues are reviewed by the Access & Availability team and Quality of Language issues by the Cultural & Linguistics Services team. Quality of Care and Service issues are reviewed by the QI RN Reviewers. Final leveling for Quality-of-Care cases is determined by the Medical Director of Quality or alternate MD after RN review is completed.
- Quality Improvement continues to track and trend PQI Turn-Around-Time (TAT) compliance. Our goal is case closure of all PQI cases within 120 days from receipt to resolution. QOC cases involve nurse investigation and procurement of medical records and/or provider responses followed by final MD review when applicable.
- When cases are open for >120 days, the reason is typically due to delay in receipt of medical records and/or provider responses. As part of the escalation process of obtaining medical records and/or responses, efforts are made to identify barriers with specific providers to find ways to better collaborate to achieve resolution.
- Since November 2024, there has been a slower rate of MD case closure of Quality of Care (QOC) cases due to the vacancy of the QI Medical Director role. The Plan has been actively seeking a replacement since that time.
- The current PQI Aging Report identified 81 QOC cases completed by the RN case owner and awaiting MD review. Of these, 31 are over the standard 120-day TAT. This represents a rate of 93% which falls below the 95% standard per PQI P&P QI-104. June 2025 is the first month in many years that this standard was not met. A new PQI MD queue has been created to allow available MDs to easily identify QOC cases ready for review and will hopefully help to bring QOC TATs back into compliance.
- Upon initial assessment, the RN case owner makes necessary referrals to CMDM and/or alerts QI leadership concerning issues or trends that need to be addressed prior to MD review to prevent delays in necessary interventions and/or prevent future similar incidents.
- As always, the PQI process aims to support best practices in providing the highest level of care to Alliance members.

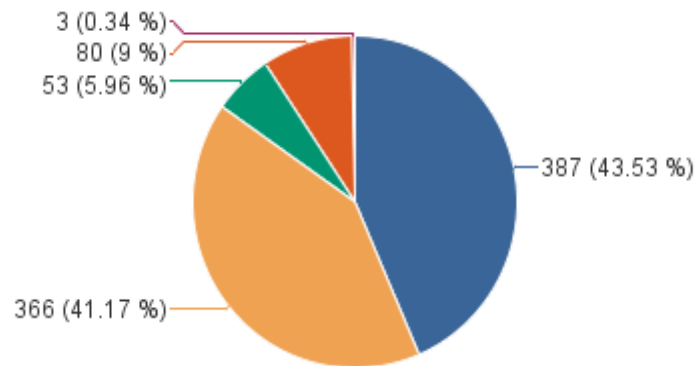
PQI Aging Report as of 06/30/2025 N= 757



TAT_Bracket

■ 1. <=30 ■ 2. >30<=60 ■ 3. >60<=90 ■ 4. >90<=120 ■ 5. >120

PQI Aging Report as of 05/31/2025 N= 889



TAT_Bracket

■ 1. <=30 ■ 2. >30<=60 ■ 3. >60<=90 ■ 4. >90<=120 ■ 5. >120

Quality Improvement: Population Health Management (PHM)

- The Alliance Population Health Management program follows the DHCS PHM Policy Guide and National Committee for Quality Assurance (NCQA) standards with the aim of improved health outcomes for all members through assessment of member needs and equitable access to necessary wellness and prevention services, care coordination and care management.
- Completed annual update of the Alliance population health assessment, evaluation of 2024 PHM Strategy, and NCQA compliant 2025 PHM Strategy in May 2025. QIHEC approved the documents on May 9, 2025.
 - In the 2024 PHM Strategy, goals were reached for non-utilizer outreach, Transitional Care Services, follow-up after ED visits for mental illness, Diabetes Prevention Program, one of three well-child visit measures, Medical Complex Case Management, and Group Care Multiple Chronic Disease Management.
 - To improve program and primary care engagement, the Alliance will increase outreach and follow-up efforts, improve staff training and internal coordination of referrals, continue to develop and expand partnerships, and strategically use member incentives.
 - The 2025 PHM Strategy includes the core programs listed in the table below. The programs address disparities and gaps in services identified in the population health assessment.

Strategic Pillars	2025 Programs
 Address primary care gaps and inequities	• Cancer Prevention • Under 30 Months Well-Visits – Equity
 Support members managing health conditions	• BirthWise Wellbeing – Equity • Blood Pressure Monitoring • Diabetes Prevention Program (DPP) • Disease Management Health Education
 Connect members in need to whole person care	• Doula Services • Multiple Chronic Case Management • Post ED Visit for Mental Illness • Transitional Care Services (TCS)

- Completed engagement with PHM consultant ideas42. From November 2024 to May 2025, ideas42 worked on deliverables for the following objectives:
 - Develop a measurement framework for population health management, including key performance indicators and dashboards.
 - Develop a risk stratification and segmentation methodology and guidance for using the RSS to connect members to programs.

- Continued meetings with Alameda County Public Health Department, City of Berkeley, and Kaiser to discuss Community Health Assessment and Improvement Plan (CHA/CHIP) collaborations.
 - Alameda Alliance executed agreements to contribute resources to the CHA/CHIP process. Alameda County will receive \$80,000 and City of Berkeley \$20,000 to support CHIP community engagement and strategy implementation.
 - Alliance staff participated in Alameda County CHIP focus area workgroups (access to care, economic security, and peaceful communities), which held four meetings each from June 2024 to April 2025.
 - Alameda Alliance continues to communicate with the Alameda County Public Health Doula Program and Perinatal Equity Initiative Steering Committee about efforts to facilitate new doula Medi-Cal enrollment and contracting with the Alliance.



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Health Equity

Lao Paul Vang

To: Alameda Alliance for Health Board of Governors
From: Lao Paul Vang, Chief Health Equity Officer
Date: July 11th, 2025
Subject: Health Equity Report

Internal Collaboration

- **On-going 1x1 meetings and check-ins with Division Chiefs Update**
 - The CHEO meets with the Alliance division chiefs on a 1x1 basis monthly to update on Health Equity (HE) and Diversity, Equity, and Inclusion (DEI) activities.
- **Faith-Based Community Engagement Update**
 - The monthly meetings have fostered collaboration and partnership across various functional groups within AAH. As a result of the workgroup, several partnership projects are in the pipeline:
 - True Vine Ministries Church.
 - Allen Temple Baptist Church
- **NCQA Health Equity Related Issues**
 - Continued collaboration with the NCQA Health Equity Accreditation Working Group, including the new DSNP Consultant who was hired to manage DSNP-related health equity issues as they pertain to NCQA health equity standards.
 - The NCQA Health Equity Accreditation application is tentatively scheduled to be submitted in July 2025.
- **PHM Workgroup**
 - The Health Equity team continues to collaborate with the PHM team and participates in the weekly PHM workgroup, including reviewing new PHM strategies for the upcoming year.
- **Food-is-Medicine Workgroup**
 - The Health Equity director presented a workshop “basics and challenges of Food-is-Medicine” to the workgroup on April 29.
- **Over/Under Utilization Workgroup**
 - The Health Equity team continues to engage in ongoing meetings with the Healthcare Service workgroup to discuss and share best practices relating to ways to overcome over- and underutilization.
- **Alliance Publication Workgroup**
 - As part of the Health Equity Roadmap milestone #4 Communication, the Health Equity team joined the Alliance Publication workgroup,

organized by Communication & Outreach, to help create content for social media postings and articles.

- The aim is to position the Alliance as the champion of health equity for our members.

External Collaboration

- **Bi-weekly meetings with Local Health Plans' Chief Health Equity Officers (CHEOs) Update**
 - Ongoing discussions regarding health equity-related issues and DEI training curriculum.
- **Monthly Meetings with DHCS' Chief Health Equity Officer (DHCS CHEO) Update**
 - The DHCS CHEO and MCPs CHEOs meet to collaborate on Health Equity and DEI initiatives.
 - The meeting included updates from DHCS and CHEO.
- **Local Initiatives DEI Training Monthly Collaborative Meeting**
 - Local MCPs continue to meet to update, share, and collaborate on the DEI Training Program. The monthly collaborative allows MCPs to ask questions, update each other on curriculum information, and assist with moving the DEI Training forward.

Alliance Health Equity Strategic Roadmap Update

- The Health Equity Department is pleased to resubmit the Alliance Health Equity Roadmap, which was presented to the BOG in December 2024:

Milestone	Goals
1. Organization Transformation	a) CHEO collaborates with SLT to facilitate a system-wide organizational transformation that supports the long-term vision of health equity for the Alliance.
2. Data-Driven	a) Collaboration with UM, PHM, QI, and Analytics. b) Utilize grant-funded health equity projects to gather data that will augment the Alliance's claim data depository to formulate a comprehensive understanding of the SDOHs that perpetuate the health disparities faced by our Medicaid members.
3. Education	a) Lead in the development of DEI Training APL 23-025 and APL 24-018 TGI-SB 923 training.

	b) Collaboration with Culture and Linguistic, PHM, QI, and other stakeholders to ensure all our policies, services, and programs are rooted in the core foundation of health equity. c) Participation in various Functional Area Delegate (FAD) workgroups to ensure the Alliance work supports the health equity vision and mission.
4. Communication	a) Collaboration with Alliance Publication Workgroup to develop effective communications on all aspects of health equity activities to ensure that staff and members are fully informed.
5. Community Engagement	a) Faith-Based Community Engagement (FBCE) workgroup since Dec 2024. b) CIN membership (2025-2027). c) Allen Temple Baptist church: joint community survey to identify community needs and uncover potential SDOHs. d) Oakland Unified School district: joint parents survey to identify SDOHs for food insecurity and healthcare access. e) Native American Health Center: supported the annual Indigenous Red Market event.
6. SDOH Mitigation Measures	a) Collaborate with CMO and HCS team to assess and analyze non-utilization data aimed at identifying health disparities.

Recommendations

The Health Equity Team would like to recommend the following BOG actions:

1. BOG review and provide feedback regarding the above milestones and goals.
2. BOG can add additional milestones and goals or revise the current milestones and goals.
3. Upon receiving BOG's feedback, the final milestones and goals will be established, and the HE Team will begin the implementation process of the Alliance Health Equity Roadmap.
4. Implementation of the Roadmap milestones will begin on July 1, 2025, and will be completed by June 30, 2028 (3 years).

DHCS-DMCS APL Update

- **DEI Training APL 23-025 Update**
 - We received approval from DHCS regarding the DEI training curriculum.
 - Updated Timeline:
 - May 2025: DEI Provider's Pilot will launch. California Cardiovascular Consultants (CCC) has been selected to participate in a pilot training program.
 - May – June 2025: pilot training completed.
 - July to Dec 2025: training given to downstream network providers and vendors.
- **APL 24-018: TGI-SB 923 Update**
 - The Transgender, Gender Diverse, and Intersex (TGI) Cultural Competency Training was provided to AAH staff who work directly with and communicate with our members.
 - The next step is to train our vendors, and then the last step is to train our providers.
 - Timeline and completion rate:
 - Dec 2024: confirmation of vendor
 - Jan-Feb 2025: Implementation of training for all Alliance staff
 - Feb 14: 97% of AAH staff completed the mandatory training. The 3% of non-completion represents staff who were on vacation or medical leave. Upon returning to the office, they will have up to 30 days to complete the training.
 - Feb 14, 2025: submission of documents per APL to the State, including evidence-based TGI training curriculum, updated online Providers Directory for gender-confirming services, G&A, and Policy and Procedures.
 - Feb 28, 2025: Attestation was submitted to DHCS.
 - HE Team is working with the TGI working group to develop plans to train member-facing vendors as part of the next step in this APL.
 - Our overall goal is to achieve 90+% on both DEI and TGI training programs.

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

- **DEIB Committee Update**
 - The DEIB Committee met on June 6th and discussed the successful launch of the DEI training pilot program, the TGI Training, and the Health Equity Roadmap.
 - The group has requested that HR add a second staff dental plan option (Delta Dental).
 - The committee was updated on the upcoming July 10th Summer

Social Event.

- **VIA Committee Update**

- At the June 10th VIA Committee meeting, the committee discussed the arrangements for the upcoming Summer Social Event.
- The Alliance staff's dental insurance was revisited, and the committee is awaiting a report from Megan Clinton.
- The committee requested the reintroduction of "Shout-Outs" at the All Staff Meeting.

Calendar of Community Engagements

CBO /FBO		Services	Status
1	California Improvement Network	A learning and action community that advances equitable health care experiences and outcomes for Californians through cross-sector connections, spreading good ideas, and implementing improvements.	• AAH became one of the 25 lead agency partners to CIN in the grant cycle 2025-2027 • Attended first in-person meeting in May 2025 • One-time \$4500 "education" grant • Opportunity to apply for a mini-grant \$40K for a Health Equity action project • In-person meetings 5 times in 2 years
2	Oakland Catholic Workers	Provides transitional housing and resettlement resources to Central American refugees and immigrants.	• Collaboration began in March 2025 • Resource sharing • Collaborator: PHM
3	Black Women's Health Forum	Annual event to raise awareness about the resources available to Black women in the Bay Area.	• Table event April 8, 2025 • Collaborator: C&O
4	True Vine Ministries Church	Serves predominantly African Americans in the West Oakland area.	• RWJF Grant application of \$250K submitted in June 2025 • Potential one-year health equity intervention, if grant approved
5	Native American Health Center	Native Americans and other PCP services, WIC, and dental.	• Collaboration began in December 2024

			• Table at the annual Indigenous Red Market event on July 6 • Collaborators: QI team
6	Allen Temple Baptist Church	A predominantly African American church since 1919. Serves about 3000 members and the community at large.	• Collaboration began in June 2025 • Table event at their 45th annual Holistic Health Fair on August 9 • Co-design community survey with the church to identify needs and SDOHs • Collaborators: church, QI team
7	Oakland Unified School District (OUSD)	Largest school district in Alameda County, serving about 33,000 students in about 75 schools, K-12.	• Collaboration began in April 2025 • Invited to join Back-to-School events in August • Co-design Parent Survey with OUSD to study food insecurity and SDOHs



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Information Technology

Sasikumar Karaiyan

To: Alameda Alliance for Health Board of Governors

From: Sasi Karaiyan, Chief Information & Security Officer

Date: July 11th, 2025

Subject: Information Technology Report

Call Center System Availability

- In June 2024, AAH phone systems and call center applications maintained 100% availability even as they supported 97% of employees working remotely.
- Alliance is working on extending this system to include Spanish language support for speech to text. The project to enable the Spanish language pack for Calabrio is currently in progress, including the preparation of installation scripts. Selected Member Services staff will conduct translation reviews and phrase tuning, with this phase expected to commence by the end of September 2025.

Encounter Data

- In the month of June 2025, the Alliance submitted 159 encounter files to the Department of Health Care Services (DHCS) with a total of 476,768 encounters.
- Institutional lag time increased due to reprocessing over 33,000 Long Term Care (LTC) claims after a one-time correction in June 2025. This update reflected AB1629 rates for 2024 and 2025, released by DHCS in April and May of 2025. The configuration team adjusted claims with service dates from 01/01/2024 to 12/31/2024 for retroactive pricing. As a result, approximately 33,000 paid claims were processed in June 2025.
- The Alliance submitted eight duplicate files to DHCS containing 9,951 encounters, which DHCS rejected. This happened due to an error that prevented files from being archived, causing them to be resubmitted. We have since adjusted the process to ensure files are archived and uploads are confirmed using the XML response file.

Enrollment

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

HEALTHsuite

- The Alliance received 340,224 claims in the month of June 2025.
- A total of 309,088 claims were finalized during the month out of which 272,290 claims auto adjudicated. This sets the auto-adjudication rate for this period to 88.1%.

TruCare

- A total of 18,715 authorizations were loaded and processed in the TruCare application.
- TruCare Application Uptime – 99.9%.

SQL Server Upgrade to version 2022

- Alliance is performing SQL server upgrade from 2016 to 2022 for SQLPROD /DBR1PROD by end of September 2026.
- The upgrade is divided into two phases as Phase 1 and Phase 2
Phase 1:
 - Windows upgrade to 2019 has been completed in SQLTEST and ISR01-TEST.Phase 2:
 - SQL server migration from 2016 to 2022 is targeted to be completed before first quarter of FY2026.
 - Post compatibility monitoring stabilization will take place until end of July.

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.
- IT Security begins heavy use of TrackIT ticket system for operational streamlining.
- In partnership with Privacy, Incident Management, and Service Desk teams – major process and language modernization improvements are being made to policy IT-006 (Mobile Device Policy).

- Vulnerability Management - technical debt reduction of End-of-Life/Service software removal exercise completed for Microsoft Silverlight. Staging removal for Oracle Java SE.

Information Technology

Supporting Documents

Enrollment

- See Table 1-1 “Summary of Medi-Cal and Group Care member enrolment in the month of June 2025”.
- See Table 1-2 “Summary of Primary Care Physician (PCP) Auto-assignment in the month of June 2025”.
- The following tables 1-1 and 1-2 are supporting documents from the enrollment summary section.

Table 1-1 Summary of Medi-Cal and Group Care Member enrollment in the month of June 2025

Month	Total MC ¹	MC ¹ - Add/ Reinstatements	MC ¹ - Terminated	Total GC ²	GC ² - Add/ Reinstatements	GC ² - Terminated
June	411,318	9,517	8,383	5,911	161	136

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 June 2025

Auto-Assignments	Member Count
Auto-assignments MC	2,231
Auto-assignments Expansion	2,519
Auto-assignments GC	65
PCP Changes (PCP Change Tool) Total	4,815

TruCare Application

- See Table 2-1 “Summary of TruCare Authorizations for the month of June 2025”.
- There were 18,715 authorizations processed within the TruCare application.
- TruCare Application Uptime – 99.9%.
- The following table 2-1 is a supporting document from the TruCare summary section.

Table 2-1 Summary of TruCare Authorizations for the Month of June 2025*

Transaction Type	Total Auths Received
Paper Fax to Scan (DocuStream)	2,287
Provider Portal Requests (Zipari)	5,506
EDI (CHCN)	5,225
Provider Portal to AAH Online (Long Term Care)	5
ADT	1,266
Behavioral Health COC Update - Online	40
Behavioral initial evaluation - Online	45
Manual Entry	2,609
OCR Face sheets	1,732
Total	18,715

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 May 2025

Group	Individual User Accounts	Individual User Accounts Accessed	Total Logins	New Users
Provider	8,409	6,199	435,289	827
MCAL	127,536	3,615	8,387	1,142
IHSS	4,059	79	683	27
Total	140,004	9,893	444,359	1,996

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

Category	Page Name	Page Views
Provider - eligibility/claim	Member Eligibility	1,563,290
Provider - Claims	Claim Status	286,429
Directory Config	Provider Directory	10,925
Provider - authorizations	Auth Search	8,164
Provider - authorizations	Auth Submit	7,318
Provider - Claims	Submit professional claims	5,417
Member My Care	Member Eligibility	4,777
Member Config	Provider Directory	4,384
Member Help Resources	Find a Doctor or Hospital	3,508
Provider - eligibility/claim	Member Roster	2,365
Member Help Resources	ID Card	2,262
Member Help Resources	Select or Change Your PCP	1,824
Member Home	MC ID Card	1,484
Member My Care	My Claims Services	1,441
Provider - Home	Behavior Health Forms SSO	1,127
Provider - Provider Directory	Provider Directory 2019	942
Member My Care	Authorization	790
Provider - Home	Forms	627
Provider - reports	Reports	573
Member My Care	My Pharmacy Medication Benefits	471
Provider - eligibility/claim	Claim Status	454
Provider - Home	Long Term Care Forms SSO	342
Member My Care	Member Benefits Materials	339
Provider - Provider Directory	Manual	291
Member Help Resources	Forms Resources	282

Call Center – Call Volume Overview:

Members - Call Center Statistics			
Month	Calls Presented	Calls Handled	Calls Abandoned
January	14,078	10,705	1,483
February	11,335	9,026	869
March	11,867	11,151	709
April	15,436	10,925	1,420
May	13,306	10,204	999
June	12,594	9,969	969

Providers - Call Center Statistics			
Month	Calls Presented	Calls Handled	Calls Abandoned
January	13,400	8682	3822
February	10,986	7586	1931
March	8303	6869	1434
April	11,128	8864	1768
May	10,018	8263	1328
June	11,255	8140	2323

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

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

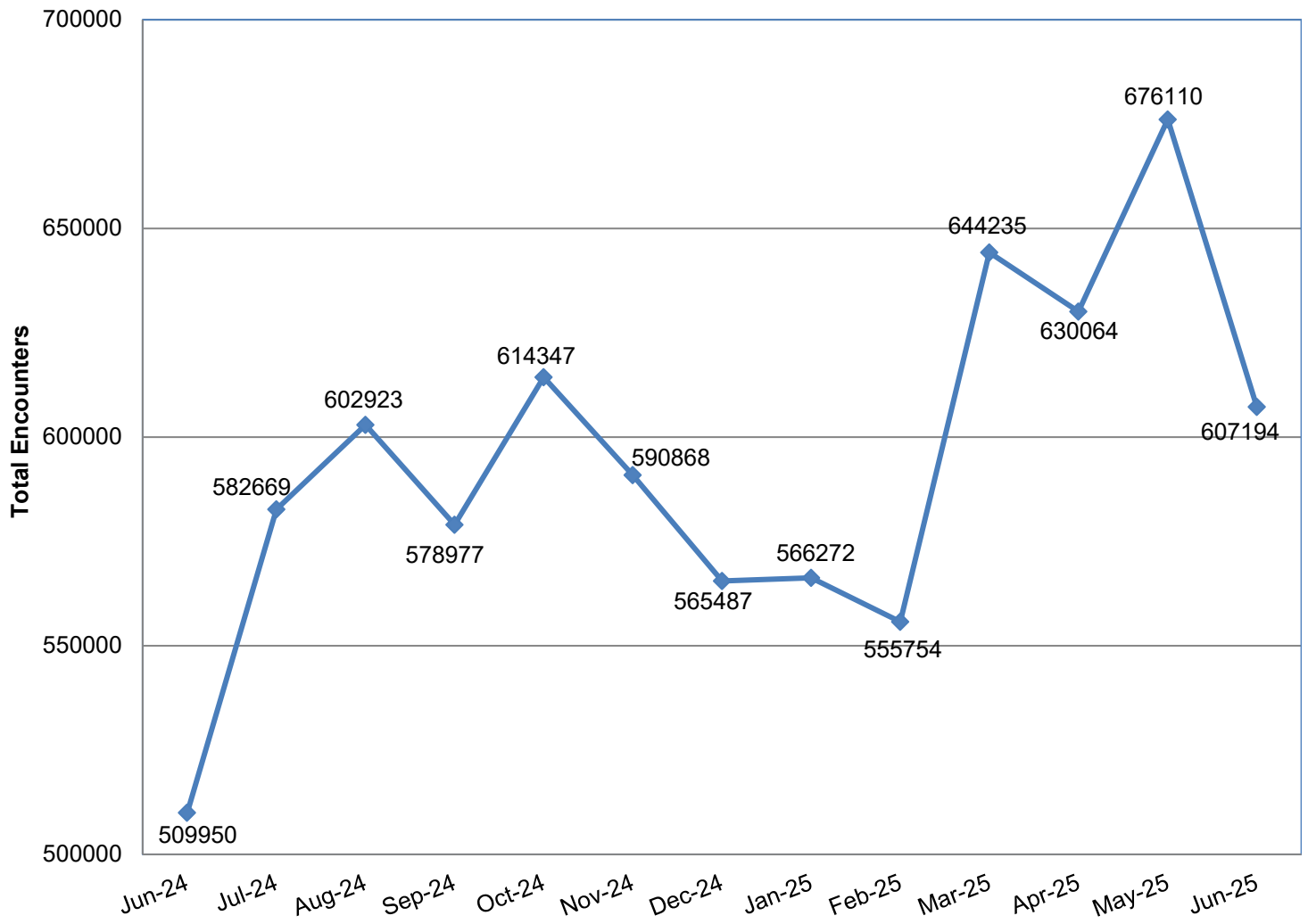
Encounter Data from Trading Partners 2025

- **AHS:** June weekly files (7,712 records) were received on time.
- **BACH:** June monthly files (296 records) were received on time.
- **BACS:** June monthly files (128 records) were received on time.
- **CHCN:** June weekly files (170,810 records) were received on time.
- **CHME:** June monthly files (8,638 records) were received on time.
- **CFMG:** June weekly files (15,710 records) were received on time.
- **Docustream:** June monthly files (1,052 records) were received on time.
- **EBI:** June monthly files (1,381 records) were received on time.
- **FULLCIR:** June monthly files (1,441 records) were received on time.
- **HCSA:** June monthly files (2,467 records) were received on time.
- **IOA:** June monthly files (3,083 records) were received on time.
- **Kaiser:** June bi-weekly files (0 records) were received on time.
- **LAFAM:** June monthly files (81 records) were received on time.
- **LIFE:** June monthly files (412 records) were received on time.
- **LogistiCare:** June weekly files (15,025 records) were received on time.
- **March Vision:** June monthly files (8,100 records) were received on time.
- **MED:** June monthly files (958 records) were received on time.
- **OMATOCHI:** June monthly files (0 records) were received on time.
- **PAIRTEAM:** June monthly files (7,724 records) were received on time.
- **Quest Diagnostics:** June weekly files (18,000 records) were received on time.
- **SENECA:** June monthly files (160 records) were received on time.
- **SERENE:** June monthly files (0 records) were received on time.
- **TITANIUM:** June monthly files (3,792 records) were received on time.
- **TVHC:** June monthly files (0 records) were received on time.
- **Magellan:** June monthly files (456,871 records) were received on time.

Trading Partner Encounter Inbound Submission History

Trading Partners	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Health Suite	297267	332150	368235	322196	367989	364130	332108	339760	339840	347469	372126	387564	340224
AHS	13316	7296	8859	7498	8309	10535	7261	9709	8654	9273	8211	15875	7712
BACH						795		426		291	131		296
BACS	77	88	86	85	76	98	104	93	113	81	72	88	128
CHCN	110650	135444	122293	155825	125042	127223	127327	117483	118972	181049	117350	151416	170810
CHME	7449	7242	6902	7680	7102	7589	7458	7781	7553	6794	8293	9045	8638
CFMG	21143	10776	22335	16421	16045	21352	16696	13536	17329	21767	15856	21443	15710
Docustream	749	934	1102	1067	704	678	828	694	808	770	891	1068	1052
EBI	2043	1623	1825	3394	1640	1725	1476	1440	1597	1390	2926	1457	1381
FULLCIR	2842	1362	1798	3809	2523	2038	1085	806	1534	2099	2025	1479	1441
HCSA	3663	6841	3256	3386	2389	3423	2335	2432	2725	2118	2384	2628	2467
IOA	1280	847	752	4227	588	1064		3008	933	736		2068	3083
Kaiser	1079	2052	172	236	159								
LAFAM	86	70	88	63	89	76	83	112	96	85	93	101	81
LIFE	1694		614	168	119	335	997	228	267	431	317	1274	412
LogistiCare	16205	43038	29732	16139	49941	16183	34122	28671	32550	33754	55059	35875	15025
March Vision	7092	6404	7719	5769	5143	6016	6285	15146		6985	6704	7929	8100
MED	744	615	608	610	645	656	619	758	1182	775		1581	958
OMATOCHI			2										
PAIRTEAM		5763		9359	1108	2204	5816	3436		2055	16360	9244	7724
Quest	22500	18000	22502	18004	18002	22501	18003	18002	18001	22502	18003	22501	18000
SENECA	71	109	129	101	105	117	131	1	69	129	108	109	160
SERENE							654	107		209			
TITANIUM		2015	3914	2815	6192	1537	2099	2487	3531	2855	3039	2970	3792
TVHC				125	437	593		156		618	116	395	
Total	509950	582669	602923	578977	614347	590868	565487	566272	555754	644235	630064	676110	607194

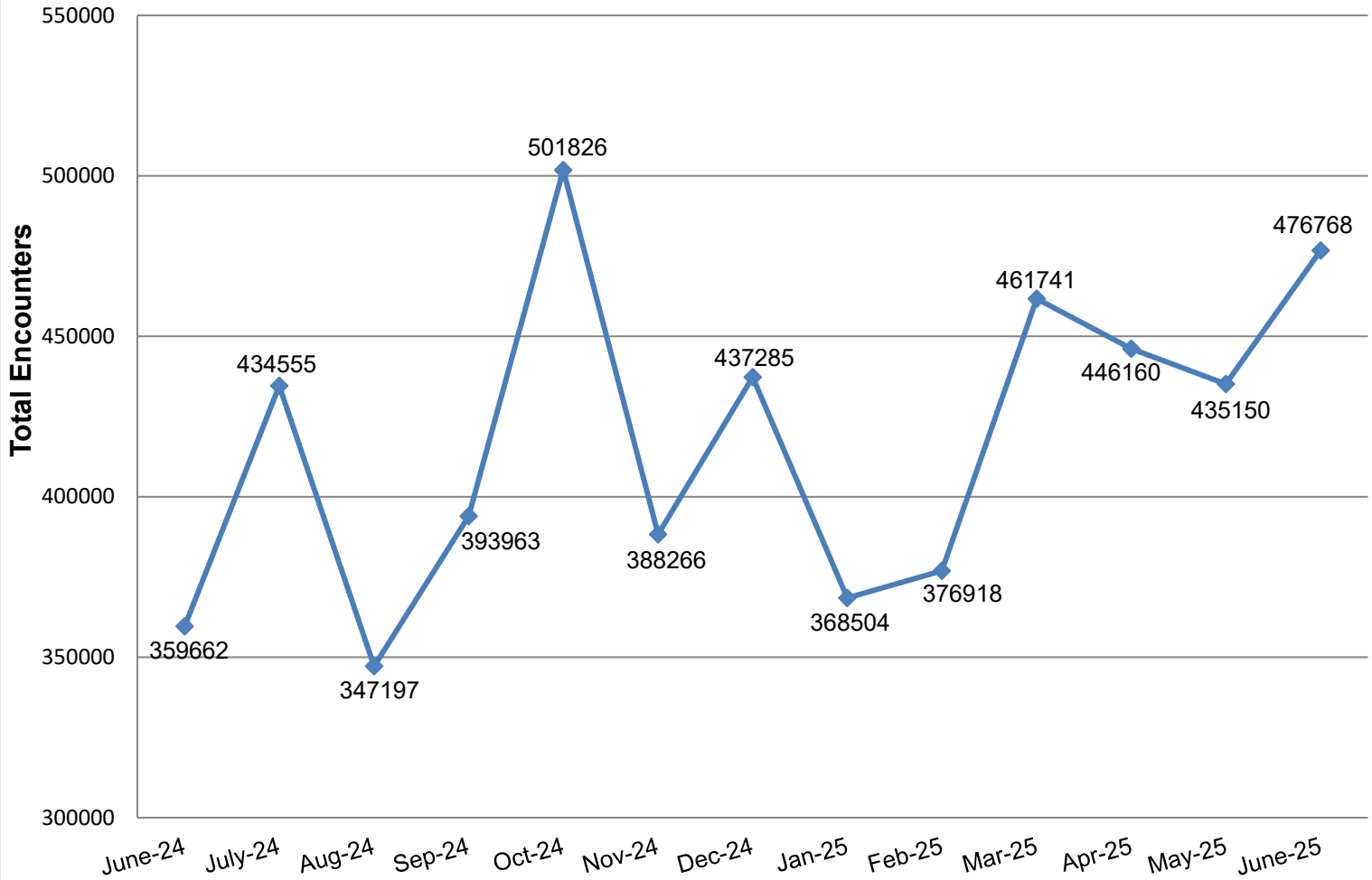
Total Encounters Received/Month



Outbound Encounter Submission

Trading Partners	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Health Suite	204068	230706	183371	210971	276473	218194	263242	182192	205804	264948	210745	226401	284779
AHS	10684	6703	7101	8727	8201	10403	6850	7710	8135	7952	4510	9326	14010
BACH						739	6	407		272	110		270
BACS	72	80	80	78	74	79	41	128	87	59	23	51	59
CHCN	77200	94476	87485	87806	108806	88573	84649	85439	82973	95918	115571	106733	98329
CHME	7310	7095	6762	6994	6974	7474	7342	7426	7167	6682	8156	8914	8471
CFMG	11506	9994	4	24076	13152	13882	11342	9362	11960	15008	11394	12430	13853
Docustream	570	725	806	715	545	482	239	634	559	478	551	540	385
EBI	1835	1443	1727	3242	1559	1641	494	2208	1475	1308	1493	1346	1328
FULLCIR	2410	1084	674	1515	1767	1470	79	1298	1251	1823	1658	1155	1236
HCSA	3493	6757	3171	3310	2376	3394	2255	2497	2693	2103	2332	2603	2448
IOA	1221	749	680	1374	549	949		2783	781	626		48	1836
Kaiser	812	1404	113	216	62		23						
LAFAM	58	66	81	58	86	62	3	178	89	80	84	90	67
LIFE	28		598	159	91	76	202	508	63	65	116	93	202
LogistiCare	16221	43019	30006	16046	49705	15235	34035	28502	32441	33656	54971	35829	15010
March Vision	4553	3766	3482	4066	3543	3980	4156	9586	371	4354	3870	4591	4657
MED	654	552	540	514	579	568	55	546	1083	731		595	553
PAIRTEAM		3246		4617	782	1960	994	6334		1489	10873	4670	4549
Quest	16898	20898	16854	16937	21144	16909	21044	16828	16855	21048	16795	16853	21031
SENECA	69	108	127	94	91	100	6	112	60	116	101	98	139
SERENE								82		20			
TITANIUM		1684	3535	2332	5267	1278	228	3600	3071	2551	2764	2714	3556
TVHC				116		818		144		454	43	70	
Total	359662	434555	347197	393963	501826	388266	437285	368504	376918	461741	446160	435150	476768

Total Outbound Encounter/Month

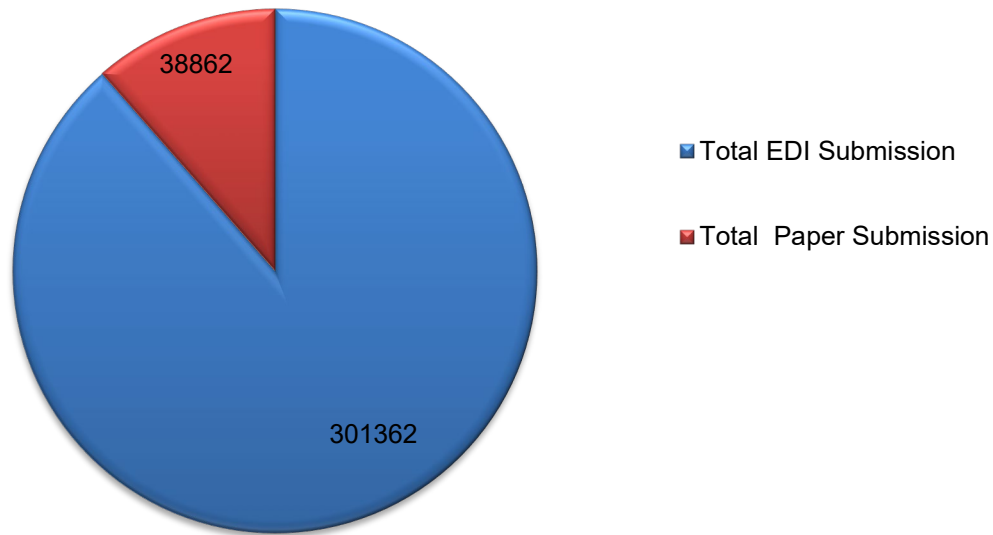


HealthSuite Paper vs EDI Claims Submission Breakdown

Period	Total EDI Submission	Total Paper Submission	Total claims
25-June	301,362	38,862	340,224

Key: EDI – Electronic Data Interchange

EDI vs Paper Submission, June 2025

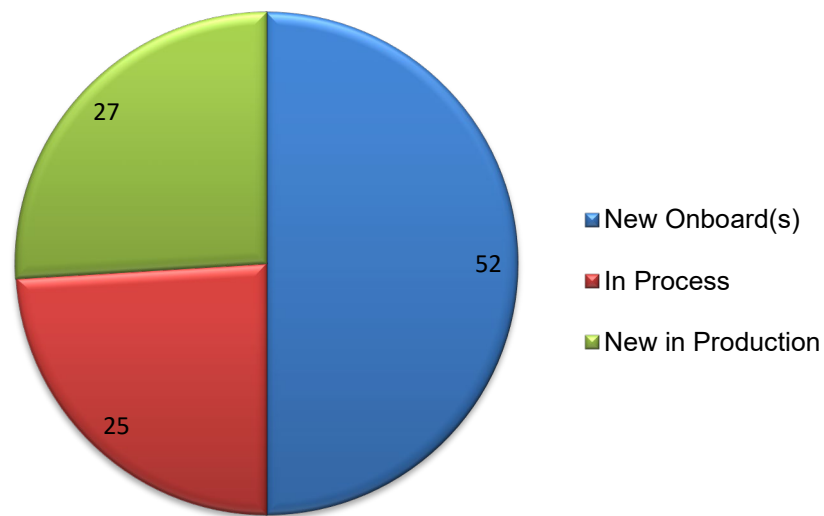


Onboarding EDI Providers – Updates

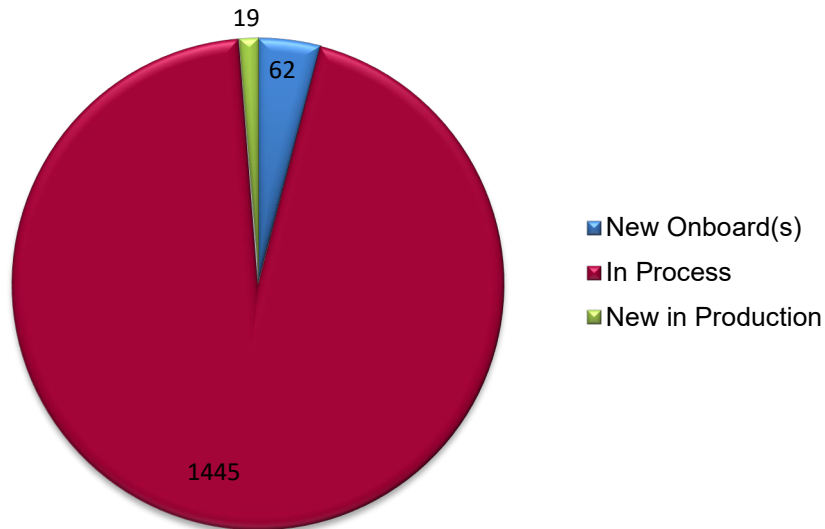
- June 2025 EDI Claims:
 - A total of 3052 new EDI submitters have been added since October 2015, with 27 added in June 2025.
 - The total number of EDI submitters is 3792 providers.
- June 2025 EDI Remittances (ERA):
 - A total of 1442 new ERA receivers have been added since October 2015, with 19 added in June 2025.
 - The total number of ERA receivers is 1429 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
Jul-24	86	3	83	3203	54	937	25	1093
Aug-24	181	2	179	3382	62	982	17	1110
Sep-24	46	5	41	3423	73	1027	28	1138
Oct-24	60	4	56	3479	80	1071	36	1174
Nov-24	61	20	41	3520	89	1131	29	1203
Dec-24	61	22	39	3559	97	1177	51	1254
Jan-25	61	8	53	3612	79	1234	22	1276
Feb-25	58	16	42	3654	83	1286	31	1307
Mar-25	46	3	43	3697	74	1328	32	1339
Apr-25	38	14	24	3721	63	1370	26	1365
May-25	47	3	44	3765	77	1402	45	1410
Jun-25	52	25	27	3792	62	1445	19	1429

837 EDI Submitters - Jun 2025



835 EDI Receivers - Jun 2025



Encounter Data Submission Reconciliation Form (EDSRF) and File Reconciliations

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

File Type	Jun-25
837 I Files	40
837 P Files	119
Total Files	159

Lag-time Metrics/Key Performance Indicators (KPI)

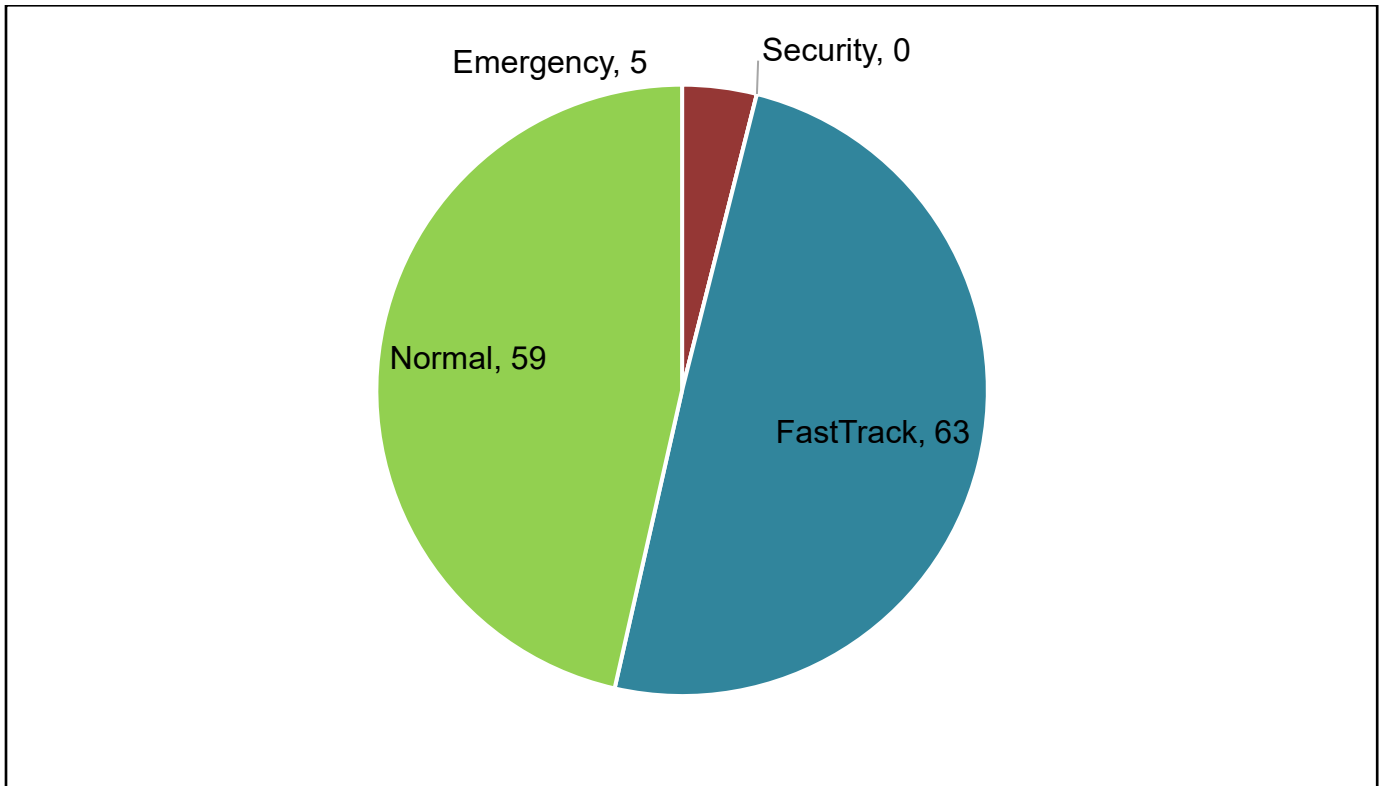
AAH Encounters: Outbound 837	Jun-25	Target
Timeliness-% Within Lag Time - Institutional 0-90 days	54%	60%
Timeliness-% Within Lag Time - Institutional 0-180 days	61%	80%
Timeliness-% Within Lag Time - Professional 0-90 days	93%	65%
Timeliness-% Within Lag Time – Professional 0-180 days	98%	80%

- Institutional lag time increased due to reprocessing over 33,000 Long Term Care (LTC) claims after a one-time correction in June 2025. This update reflected AB1629 rates for 2024 and 2025, released by DHCS earlier that year. The configuration team adjusted claims with service dates from 01/01/2024 to 12/31/2024 for retroactive pricing. As a result, approximately 33,000 paid claims were processed in June 2025.

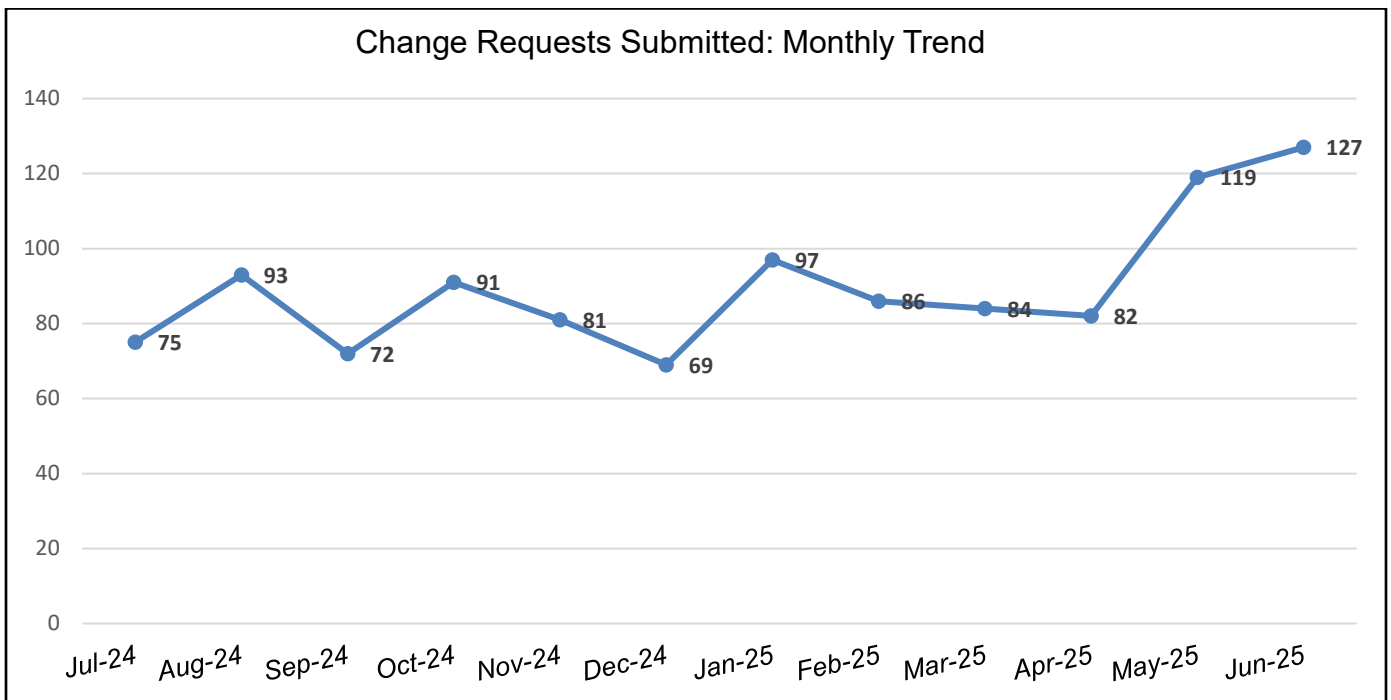
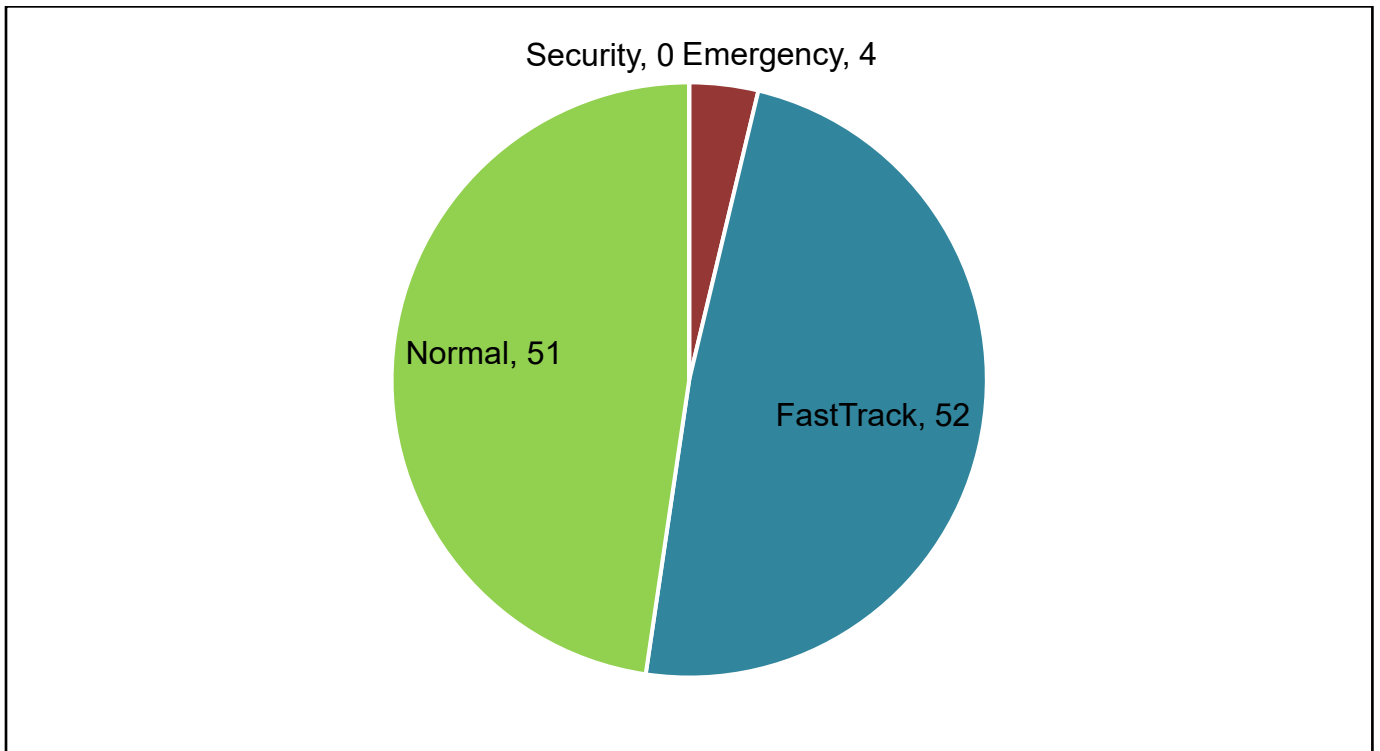
- The Alliance submitted eight duplicate files to DHCS containing 9,951 encounters, which DHCS rejected. This happened due to an error that prevented files from being archived, causing them to be resubmitted. We have since adjusted the process to ensure files are archived and uploads are confirmed using the XML response file.

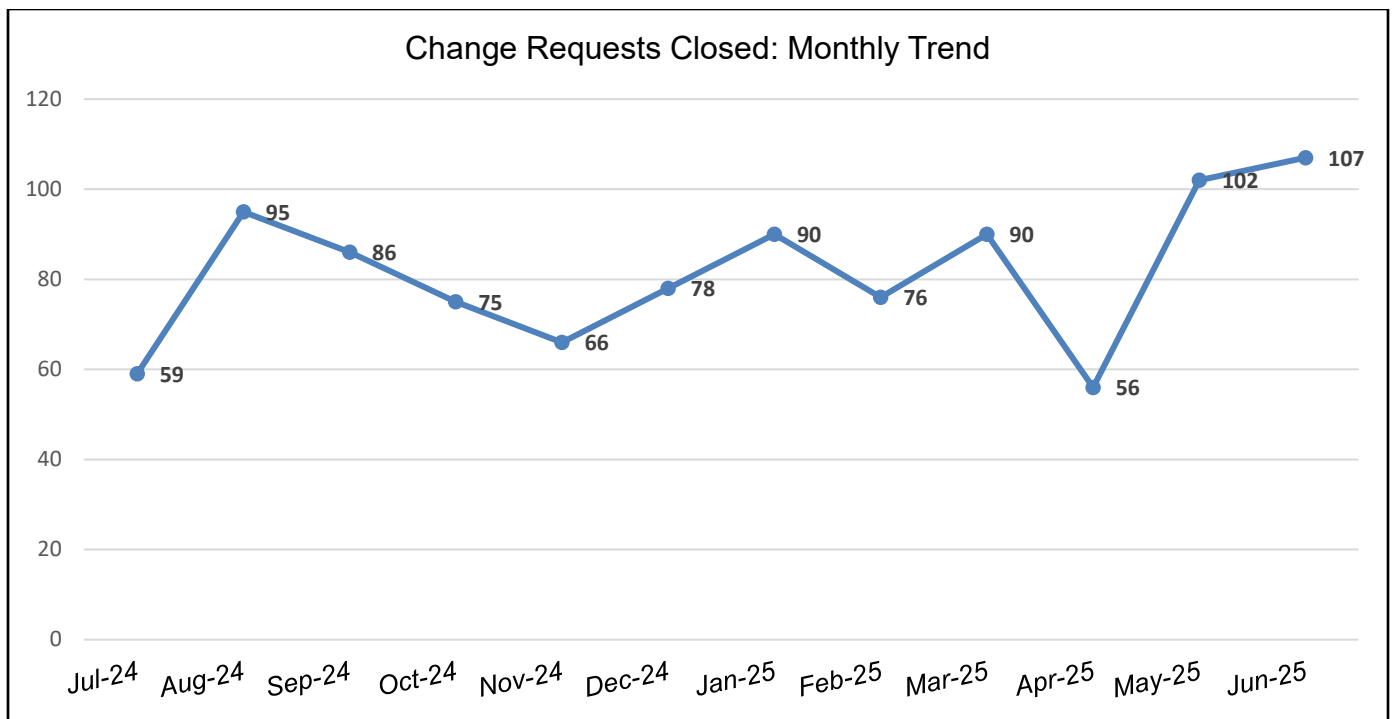
Change Management Key Performance Indicator (KPI)

- Change Request Overall Summary in the month of June 2025 KPI:
 - 127 Changes Submitted.
 - 107 Changes Completed and Closed.
 - 122 Active Change Requests in pipeline.
 - 10 Change Requests Cancelled or Rejected.
- 127 Change Requests Submitted/Logged in the month of June 2025



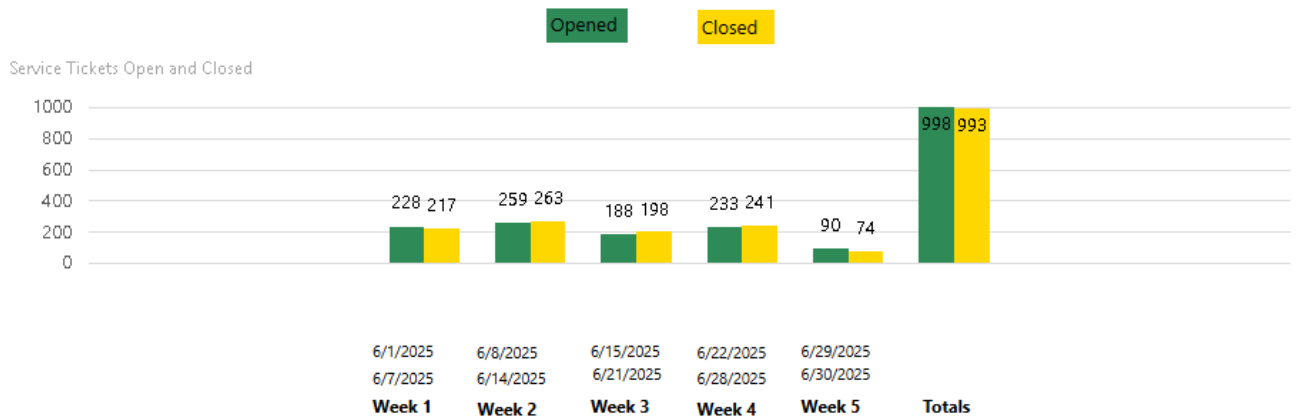
- 107 Change Requests Closed in the month of June 2025





IT Stats: Service Desk

IT Service Tickets Open and Closed



- 998 Service Desk tickets were opened in the month of June 2025, which is 10.00% lower than the previous month (1109) and 11.28% lower than the previous 3-month average of 1125.
- 993 Service Desk tickets were closed in the month of June 2025, which is 7.19% lower than the previous month (1070) and 10.38% lower than the previous 3-month average of 1108.

IT Stats: Security

Security + Network Updates

Areas	Item Status
Ops.	• Completed ○ Red Sift contract renewal (DMARC) ○ Performance reviews ○ Zipari/HealthX and QS cert renewal • Upcoming/Underway ○ OKTA (SSO) and DUO (MFA) true-up ○ Troubleshooting Nessus service account ○ Continued effort EoL/EoS software removal (up next – Oracle Java SE) ○ Review of Atlassian JIRA security controls ○ Lost/Stolen device policy ○ Security dashboard mockup complete. Feasibility exercise with Arctic Wolf is upcoming.
Projects	• Network Segmentation (parked due to personnel circumstances) • PKI – prioritizing for Infra.
GRC	• Use of TrackIT as source of truth (app. needs modernizing) • Continuing policy revisions • Staging discussions with IT Directors/Managers regarding Security Reviews of new services/platforms.



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Service you can trust.

Analytics

Tiffany Cheang

To: Alameda Alliance for Health Board of Governors

From: Tiffany Cheang, Chief Analytics Officer

Date: July 11th, 2025

Subject: Performance & Analytics Report

Member Cost Analysis

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

Current reporting period: Apr 2024 – March 2025 dates of service

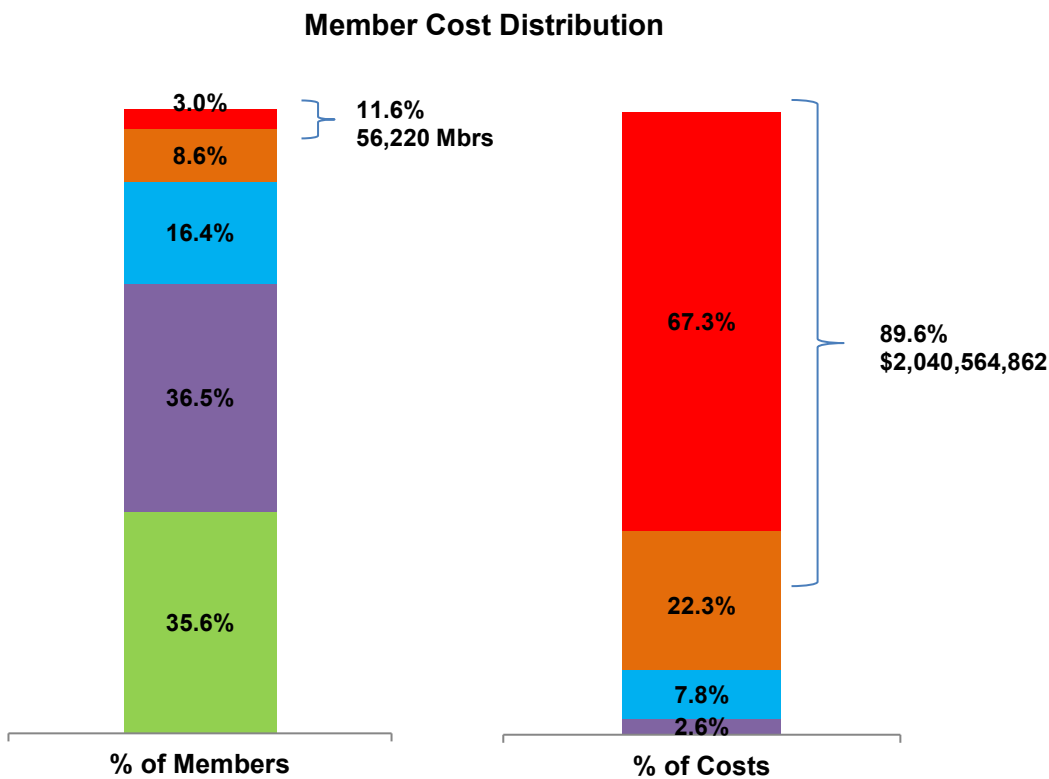
Prior reporting period: Apr 2023 – March 2024 dates of service

(Note: Data excludes Kaiser membership data.)

- For the Current reporting period, the top 11.6% of members account for 89.6% of total costs.
- In comparison, the Prior reporting period was lower at 8.3% of members accounting for 83.6% of total costs.
- Characteristics of the top utilizing population remained fairly consistent between the reporting periods:
 - The SPD/LTC (non duals) and ACA OE categories of aid slightly decreased to account for 53.9% of the members, with SPD/LTCs accounting for 18.5% and ACA OE's at 35.4%.
 - The percent of members with costs >= \$30K increased from 2.2% to 3.0%.
 - Of those members with costs >= \$100K, the percentage of total members has increased to 1.0%.
 - For these members, non-trauma/pregnancy inpatient costs continue to comprise the majority of costs, decreasing to 30.5%.
 - Demographics for member city and gender for members with costs >= \$30K follow the same distribution as the overall Alliance population.
 - However, the age distribution of the top 11.6% is more concentrated in the 45-66 year old category (35.8%) compared to the overall population (20.7%).

Analytics

Supporting Documents



Cost Range	Members	% of Members	Costs	% of Costs
\$30K+	14,707	3.0%	\$ 1,533,110,593	67.3%
\$5K - \$30K	41,513	8.6%	\$ 507,454,268	22.3%
\$1K - \$5K	79,346	16.4%	\$ 178,765,195	7.8%
< \$1K	176,810	36.5%	\$ 59,238,489	2.6%
\$0	172,515	35.6%	\$ -	0.0%
Totals	484,891	100.0%	\$ 2,278,568,545	100.0%

Enrollment Status	Members	Total Costs
Still Enrolled as of Mar 2025	413,191	\$ 2,058,322,057
Dis-Enrolled During Year	71,700	\$ 220,246,489
Totals	484,891	\$ 2,278,568,545

Top 11.6% of Members = 89.6% of Costs

Cost Range	Members	% of Total Members	Costs	% of Total Costs
\$100K+	4,864	1.0%	\$ 1,001,616,919	44.0%
\$75K to \$100K	1,838	0.4%	\$ 159,845,844	7.0%
\$50K to \$75K	2,793	0.6%	\$ 169,769,550	7.5%
\$40K to \$50K	2,143	0.4%	\$ 95,680,744	4.2%
\$30K to \$40K	3,069	0.6%	\$ 106,197,537	4.7%
SubTotal	14,707	3.0%	\$ 1,533,110,593	67.3%
\$20K to \$30K	5,838	1.2%	\$ 141,490,186	6.2%
\$10K to \$20K	15,898	3.3%	\$ 224,871,703	9.9%
\$5K to \$10K	19,777	4.1%	\$ 141,092,379	6.2%
SubTotal	41,513	8.6%	\$ 507,454,268	22.3%
Total	56,220	11.6%	\$ 2,040,564,862	89.6%

Notes:

- Report includes medical costs (HS & Diamond Claims, Beacon, Logisticare FFS, CHCN FFS Preventive Services, CHME) and pharmacy costs. IBNP factors are not applied.
- CFMG and CHCN encounter data has been priced out.

Alameda Alliance for Health - Analytics Supporting Documentation: Member - Cost Analysis

11.6% of Members = 89.6% of Costs
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Apr 2024 - Mar 2025

Note: Data incomplete due to claims lag
Run Date: 07/01/2025

11.6% of Members = 89.6% of Costs
18.5% of members are SPD/LTCs and account for 24.8% of costs.
35.4% of members are ACA OE and account for 32.5% of costs.
7.7% of members disenrolled as of Mar 2025 and account for 9.9% of costs.

Highest Cost Members: Cost Per Member >= \$100K
26.9% of members are SPD/LTCs and account for 29.1% of costs.
26.7% of members are ACA OE and account for 29.6% of costs.
8.7% of members disenrolled as of Mar 2025 and account for 10.7% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Members with Costs >=\$30K	Members with Costs \$5K-\$30K	Total Members	% of Members
IHSS	IHSS	197	950	1,147	2.0%
MCAL	MCAL - ADULT	1,273	7,930	9,203	16.4%
	MCAL - BCCTP	-	-	-	0.0%
	MCAL - CHILD	672	3,903	4,575	8.1%
	MCAL - ACA OE	4,792	15,122	19,914	35.4%
	MCAL - DUALS	-	-	-	0.0%
	MCAL - SPD-LTC	3,669	6,720	10,389	18.5%
	MCAL - SPD-LTC/Full Dual	2,637	4,018	6,655	11.8%
Not Eligible	Not Eligible	1,467	2,870	4,337	7.7%
Total		14,707	41,513	56,220	100.0%

Member Breakout by LOB

LOB	Eligibility Category	Total Members	% of Members
IHSS	IHSS	47	1.0%
MCAL	MCAL - ADULT	286	5.9%
	MCAL - BCCTP	-	0.0%
	MCAL - CHILD	95	2.0%
	MCAL - ACA OE	1,297	26.7%
	MCAL - DUALS	-	0.0%
	MCAL - SPD-LTC	1,310	26.9%
	MCAL - SPD-LTC/Full Dual	1,406	28.9%
Not Eligible	Not Eligible	423	8.7%
Total		4,864	100.0%

Cost Breakout by LOB

LOB	Eligibility Category	Members with Costs >=\$30K	Members with Costs \$5K-\$30K	Total Costs	% of Costs
IHSS	IHSS	\$ 16,339,957	\$ 11,002,527	\$ 27,342,484	1.3%
MCAL	MCAL - ADULT	\$ 125,974,775	\$ 96,057,766	\$ 222,032,541	10.9%
	MCAL - BCCTP	\$ -	\$ -	\$ -	0.0%
	MCAL - CHILD	\$ 51,723,803	\$ 43,814,759	\$ 95,538,562	4.7%
	MCAL - ACA OE	\$ 477,711,851	\$ 185,284,637	\$ 662,996,488	32.5%
	MCAL - DUALS	\$ -	\$ -	\$ -	0.0%
	MCAL - SPD-LTC	\$ 418,519,120	\$ 86,701,865	\$ 505,220,985	24.8%
	MCAL - SPD-LTC/Full Dual	\$ 276,033,335	\$ 48,713,706	\$ 324,747,042	15.9%
Not Eligible	Not Eligible	\$ 166,807,754	\$ 35,879,007	\$ 202,686,761	9.9%
Total		\$ 1,533,110,593	\$ 507,454,268	\$ 2,040,564,862	100.0%

Cost Breakout by LOB

LOB	Eligibility Category	Total Costs	% of Costs
IHSS	IHSS	\$ 8,518,450	0.9%
MCAL	MCAL - ADULT	\$ 76,269,921	7.6%
	MCAL - BCCTP	\$ -	0.0%
	MCAL - CHILD	\$ 23,551,687	2.4%
	MCAL - ACA OE	\$ 296,020,773	29.6%
	MCAL - DUALS	\$ -	0.0%
	MCAL - SPD-LTC	\$ 291,614,452	29.1%
	MCAL - SPD-LTC/Full Dual	\$ 198,845,779	19.9%
Not Eligible	Not Eligible	\$ 106,795,858	10.7%
Total		\$ 1,001,616,919	100.0%

% of Total Costs By Service Type

% of Total Costs By Service Type				Breakout by Service Type/Location						
Cost Range	Trauma Costs	Hep C Rx Costs	Pregnancy, Childbirth & Newborn Related Costs	Pharmacy Costs	Inpatient Costs (POS 21)	ER Costs (POS 23)	Outpatient Costs (POS 22)	Office Costs (POS 11)	Dialysis Costs (POS 65)	Other Costs (All Other POS)
\$100K+	5%	0%	1%	14%	36%	1%	11%	2%	2%	33%
\$75K to \$100K	4%	0%	1%	19%	26%	3%	5%	4%	5%	39%
\$50K to \$75K	5%	0%	2%	26%	29%	5%	6%	6%	4%	25%
\$40K to \$50K	6%	0%	2%	33%	28%	8%	5%	7%	1%	19%
\$30K to \$40K	10%	0%	3%	34%	23%	13%	5%	7%	1%	17%
\$20K to \$30K	2%	1%	6%	36%	23%	7%	8%	8%	1%	17%
\$10K to \$20K	0%	0%	11%	36%	24%	7%	9%	9%	1%	15%
\$5K to \$10K	0%	0%	5%	31%	12%	11%	13%	14%	0%	19%
Total	4%	0%	3%	22%	30%	4%	9%	5%	2%	27%

Notes:
- Report includes medical costs (HS & Diamond Claims, Beacon, Logisticare FFS, CHCN FFS Preventive Services, CHME) and pharmacy costs. IBNP factors are not applied.
- CFMG and CHCN encounter data has been priced out.
- Report excludes Capitation Expense



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Human Resources

Anastacia Swift

To: Alameda Alliance for Health Board of Governors

From: Anastacia Swift, Chief Human Resources Officer

Date: July 11th, 2025

Subject: Human Resources Report

Staffing

- As of July 1st, 2025, the Alliance had 670 full time employees and 0 part time employee.
- On July 1st, 2025, the Alliance had 58 open positions in which 21 signed offer acceptance letters have been received with start dates in the near future resulting in a total of 37 positions open to date. The Alliance is actively recruiting for the remaining 37 positions and several of these positions are in the interviewing or job offer stage.
- Summary of open positions by division:

Division	Open Position July 1 st	Signed Offers Accepted by Department	Remaining Recruitment Positions
Healthcare Services	12	3	9
Operations	28	9	19
Healthcare Analytics	2	1	1
Information Technology	10	7	3
Finance	2	1	1
Compliance	1	0	1
Human Resources	3	0	3
Health Equity	0	0	0
Executive	0	0	0
Total	58	21	37

- Our current recruitment rate is 8%.

Employee Recognition

- Employees reaching major milestones in their length of service at the Alliance in June 2025 included:

5 years:

- Ruth W (Operations)

6 years:

- Lily H (Case/Disease Management)
- Harinath P (Apps Management, IT Quality & Process Improvement)
- Rosa S (Provider Services)
- Katherine G (Privacy & SIU)

8 years:

- Judith F (Member Services)
- Brittany N (Healthcare Analytics)

9 years:

- Sherry R (Utilization Management)

10 years:

- Tiana R (Provider Services)
- Latrice A (Claims)
- Jeanette M (Health Equity)

13 years:

- Marcie S (Claims)
- Thuan L (Claims)

14 years:

- Eileen A (Quality Management)
- Elisea T (Case/Disease Management)

28 years:

- Monina R (Claims)

29 years:

- Angie V (Member Services)