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Board of Governors PACKET

AUGUST 8th, 2025



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EXECUTIVE SUMMARY APPENDIX

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corresponding material for each item.

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SUPPORTING MATERIALS APPENDIX

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CEO Update

Matthew Woodruff

To: Alameda Alliance for Health Board of Governors

From: Matthew Woodruff, Chief Executive Officer

Date: August 8th, 2025

Subject: CEO Report

- **Financials:**

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

	<u>June</u>	<u>YTD</u>
Medi-Cal	\$6.6M	(\$76.6M)
Group Care	(\$235K)	(\$273K)
Medicare	(\$1.4M)	(\$9.2M)
Total	\$4.9M	(\$86.1M)

- **Revenue was \$189.2 million in June 2025 and \$2.1 billion Year-to-Date (YTD).**
 - Medical expenses were \$175.2 million in June and \$2.1 billion for the fiscal year-to-date; the medical loss ratio is 92.6% for the month and 99.9% for the fiscal year-to-date.
 - Administrative expenses were \$11.4 million in June and \$115.8 million for the fiscal year-to-date; the administrative loss ratio is 6.0% of net revenue for the month and 5.4% of net revenue year-to-date.
- **Tangible Net Equity (TNE):** Financial reserves are 210% of the required DMHC minimum, representing \$88.6 million in excess TNE.
- **Total enrollment in June 2025 was 411,383**, decreased by 2002 Medi-Cal members compared to May 2025.
- **Key Performance Indicators:**
 - **Regulatory Metrics:**
 - The Claims team missed processing timelines. The team processed 82% of claims within 30 calendar days and the team processed 90% of claims within 45 calendar days. Both metrics should be at 95% to be considered compliant.
 - The team experienced a change in leadership in June and July, which caused a slowdown in overall processing.
 - **Non-Regulatory Metrics:**
 - All non-regulatory metrics were met for May.

- **Alliance Updates:**
 - **State And Federal Updates**
 - The Alliance is waiting on the updated California budget, and then we will begin strategic planning meetings.
 - The Alliance will hold a joint Executive and Finance Committee meeting on August 22nd, 2025, from 11:00 a.m. to 12:30 p.m.
- **Community Supports**
 - The State sent out updated guides with clarifications.
- **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 in 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, 74 of which are active, 32 requested, one (1) on hold, and one (1) complete.
 - Provider contracting is the highest priority for the D-SNP implementation, and AAH has engaged Chapman Consulting and ClearLink to assist the Plan in our efforts to convert the LOIs to Medicare Provider Amendments.
 - Prior authorization code list has been finalized. The Enrollment Form and Formulary were approved by CMS. Rebate allocation was approved by

SLT and is on track to be submitted to CMS on Wednesday, August 6th, 2025.

- On July 24th, 2025, AAH received confirmation from CMS that there were no deficiencies in our CY 2026 State Medicaid Agency Contract (SMAC) for H2035 D-SNP.
- All required materials have been drafted and submitted to the State and CMS for review:
 - Summary of Benefits (SOB): 7/14
 - ID Card: 7/14
 - Member Handbook/Evidence of Coverage (EOC): 7/27
 - Provider & Pharmacy Directory: 7/30
 - Formulary: 7/30
- PBM implementation is on track, and M3P implementation is starting.



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Demographics

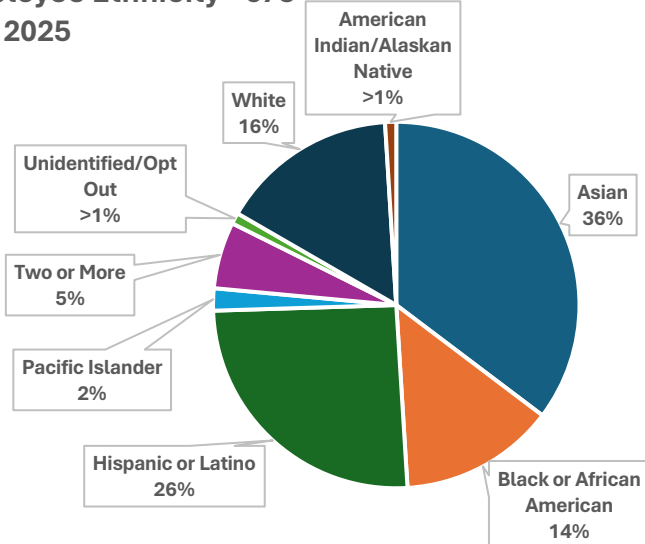
The purpose of this report is to conduct a comparative analysis of the demographic composition of Alameda Alliance for Health’s workforce and the population distribution of Alameda County. The primary focus of this comparison will be on key metrics, including race/ethnicity, gender, and age distribution.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

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

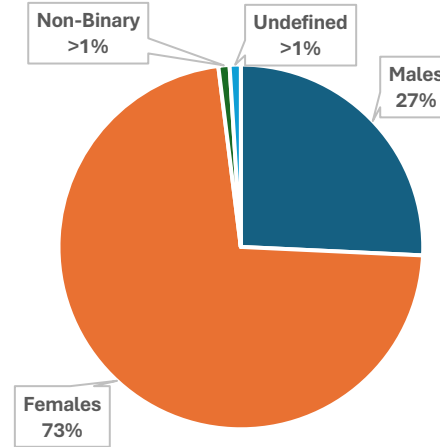
Category	Alameda Alliance for Health (Workforce information last updated July 2025)	Alameda County (Population Information last updated in May 2025)
Population/Total Employees	675	1,626,575
Race & Ethnicity		
Asian	36%	35.39%
Hispanic	26%	23.94%
White	16%	28.26%
Black/African American	14%	9.15%
Native Hawaiian/Pacific Islander	2%	0.82%
American Indian/Alaskan Native	>1%	1.18%
Two or More Races	5%	11.62%
Unidentified/Opt Out	>1%	-
Gender		
Male	27%	49.67%
Female	73%	50.33%
Non-Binary	>1%	-
Undefined	>1%	-
Age Distribution		
Under 25	>1%	8.33%
25-34	20%	13.92%
35-44	36%	16.13%
45-54	26%	13.59%
55-Older	17%	29.03%

AAH Employee Demographics Data Report July 2025

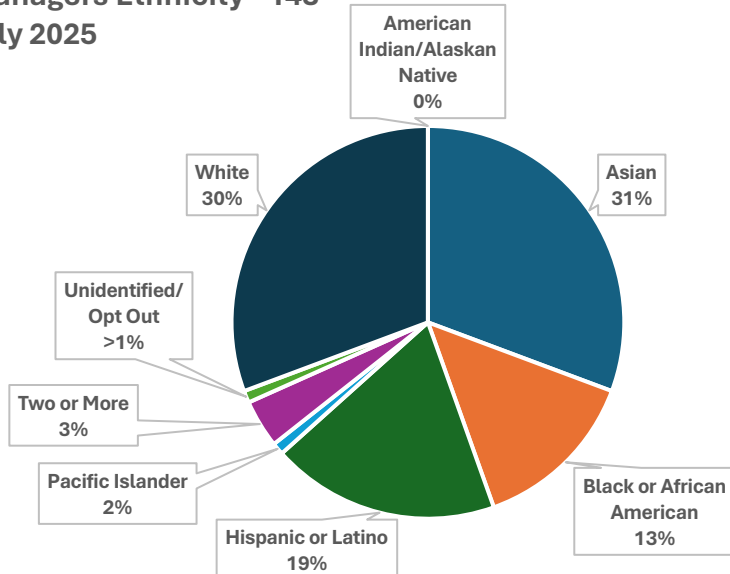
Employee Ethnicity - 675
July 2025



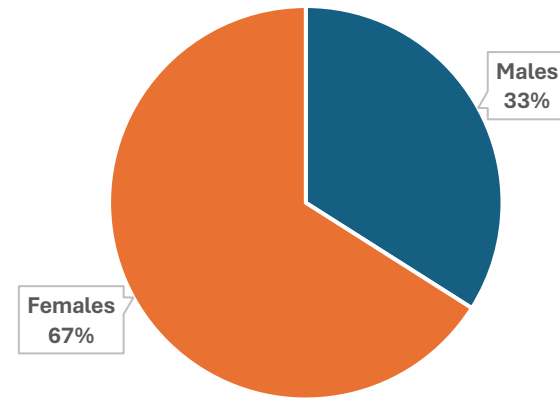
Employee Gender - 675
July 2025



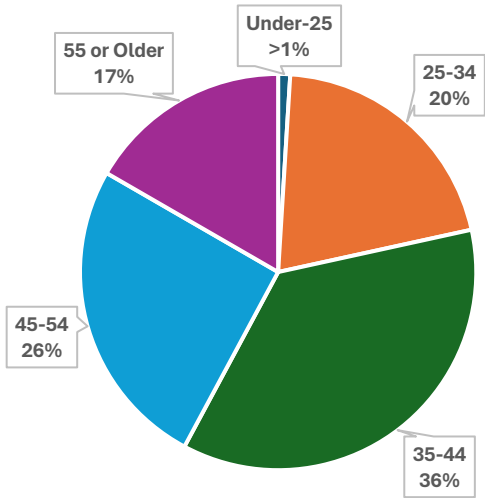
Managers Ethnicity - 143
July 2025



Managers Gender - 143
July 2025



Employee Age Demographics - 675
July 2025





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Legislative Tracking

2025 –2026 Legislative Tracking List

The state legislature is currently on summer recess through August 18th. While legislators are back in their districts, all committee hearings and floor sessions are stopped. Upon their return, legislators will work rapidly to move bills forward and fiscal committees will have until August 29th to hear and report on bills. Another big deadline is September 12th which is the last day for each house to pass bills.

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

[AB 4](#)

(Arambula D) Covered California expansion.

Current Text: Introduced: 12/2/2024 [html](#) [pdf](#)

Introduced: 12/2/2024

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

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

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

[AB 29](#)

(Arambula D) Medi-Cal: Adverse Childhood Experiences trauma screenings: providers.

Current Text: Amended: 3/19/2025 [html](#) [pdf](#)

Introduced: 12/2/2024

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

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

Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law requires that Medi-Cal provider

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

AB 37

(Elhawary D) Workforce development: mental health service providers: homelessness.

Current Text: Amended: 3/13/2025 [html](#) [pdf](#)

Introduced: 12/2/2024

Status: 5/1/2025-Failed Deadline pursuant to Rule 61(a)(2). (Last location was L. & E. on 3/13/2025)(May be acted upon Jan 2026)

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

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

AB 40

(Bonta D) Emergency services and care.

Current Text: Amended: 3/5/2025 [html](#) [pdf](#)

Introduced: 12/2/2024

Status: 7/7/2025-Ordered to inactive file at the request of Senator Menjivar.

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: 7/16/2025-From committee: Do pass and re-refer to Com. on APPR. (Ayes 11. Noes 1.) (July 15). 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 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: 7/17/2025 [html](#) [pdf](#)

Introduced: 12/2/2024

Status: 7/17/2025-From committee: Amend, and do pass as amended and re-refer to Com. on APPR. (Ayes 11. Noes 1.) (July 15). 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 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 immigration authority to enter a nonpublic area of a schoolsite for any purpose without being presented with a valid judicial warrant or a court order. The bill would require school

officials and employees of a local educational agency, to the extent practicable, to request valid identification of any immigration authority seeking to enter a nonpublic area of a schoolsite. The bill would also prohibit a local educational agency and its personnel from disclosing or providing, in writing, verbally, or in any other manner, the education records of or any information about a pupil, a pupil's family and household, a school employee, or a teacher to an immigration authority without a valid judicial warrant or judicial subpoena, or court order directing the local educational agency or its personnel to do so. By imposing additional duties on local educational agencies, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 50

(Bonta D) Pharmacists: furnishing contraceptives.

Current Text: Amended: 4/2/2025 [html](#) [pdf](#)

Introduced: 12/2/2024

Status: 6/24/2025-Read second time. Ordered to third reading.

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

Summary: Existing law, the Pharmacy Law, establishes in the Department of Consumer Affairs the California State Board of Pharmacy to license and regulate the practice of pharmacy. 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 follow-up 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 follow-up, 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: 7/16/2025-From committee: Do pass and re-refer to Com. on APPR. (Ayes 11. Noes 0.) (July 15). Re-referred to Com. on APPR.

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

Summary: Existing law sets forth 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: 7/8/2025 [html](#) [pdf](#)

Introduced: 1/8/2025

Status: 7/14/2025-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 establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law requires the department to establish a subacute care program in health facilities, as specified, to be available to patients in health facilities who meet subacute care criteria. Existing law requires that medical necessity for pediatric subacute care be substantiated by specified conditions. Existing regulations require a treatment authorization request for each admission to a subacute unit. This bill would require a provider seeking authorization for pediatric subacute or adult subacute care services pursuant to these provisions to submit with a treatment authorization request, including an electronic treatment authorization request, a specified form when requesting authorization for subacute care services. The bill would prohibit a Medi-Cal managed care plan from developing or using its own criteria to substantiate medical necessity for pediatric subacute or adult subacute care services with a condition or standard not enumerated in those forms. The bill would prohibit a Medi-Cal managed care plan from requiring a subsequent treatment authorization request upon a patient’s return from a bed hold for acute hospitalization. The bill would authorize the department to impose sanctions on Medi-Cal managed care plans for violations of these provisions, as specified.

AB 224

(Bonta D) Health care coverage: essential health benefits.

Current Text: Amended: 7/8/2025 [html](#) [pdf](#)

Introduced: 1/9/2025

Status: 7/17/2025-From committee: Do pass and re-refer to Com. on APPR. (Ayes 10. Noes 0.) (July 16). 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 Department of Insurance to regulate health insurers. Existing law requires an individual or small group health insurance policy issued, amended, or renewed on or after January 1, 2017, to include, at a minimum, coverage for essential health benefits pursuant to the federal Patient Protection and Affordable Care Act. Existing law requires a health insurance policy to cover the same health benefits that the benchmark plan, the Kaiser Foundation Health Plan Small Group HMO 30 plan, offered during the first quarter of 2014, as specified. This bill would express the intent of the Legislature to review California’s essential health benefits benchmark plan and establish a new benchmark plan for the 2027 plan year for health insurers. The bill would require, commencing January 1, 2027, if the United States Department of Health and Human Services approves a new essential health benefits benchmark plan for

the state, as specified, the benchmark plan for health insurers to include certain additional benefits, including coverage for specified fertility services and specified durable medical equipment.

AB 225

(Bonta D) State hospitals for persons with mental health disorders: patient funds.

Current Text: Introduced: 1/9/2025 [html](#) [pdf](#)

Introduced: 1/9/2025

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

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

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

AB 228

(Sanchez R) Pupil health: epinephrine delivery systems.

Current Text: Introduced: 1/13/2025 [html](#) [pdf](#)

Introduced: 1/13/2025

Status: 5/23/2025-In committee: Hearing postponed by committee.

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

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

AB 242

(Boerner D) Genetic disease screening.

Current Text: Introduced: 1/14/2025 [html](#) [pdf](#)

Introduced: 1/14/2025

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

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

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

AB 260

(Aguiar-Curry D) Sexual and reproductive health care.

Current Text: Amended: 6/18/2025 [html](#) [pdf](#)

Introduced: 1/16/2025

Status: 7/7/2025-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: 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: 7/15/2025 [html](#) [pdf](#)

Introduced: 1/21/2025

Status: 7/15/2025-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 and a health insurer that contracts with providers for alternative rates of payment to publish and maintain a provider directory or directories with information on contracting providers that deliver health care services enrollees or insureds, and requires a health care service plan and health insurer to regularly update its printed and online provider directory or directories, as specified. Existing law authorizes the departments to require a plan or insurer to provide coverage for all covered health care services provided to an enrollee or insured who reasonably relied on materially inaccurate, incomplete, or misleading information contained in a plan's or insurer's provider directory or directories. This bill would require a plan or insurer to annually verify and delete inaccurate listings from its provider directories, and would require a provider directory to be 60% accurate on July 1, 2026, with increasing required percentage accuracy benchmarks to be met each year until the directories are 95% accurate on or before July 1, 2029. The bill would subject a plan or insurer to administrative penalties for failure to meet the prescribed benchmarks. The bill would require a plan or insurer to provide coverage for all covered health care services provided to an enrollee or insured who reasonably relied on inaccurate, incomplete, or misleading information contained in a health plan or policy's provider directory or directories and to reimburse the provider the out-of-network amount for those services. The bill would prohibit a provider from collecting an additional amount from an enrollee or insured other than the applicable in-network cost sharing, which would count toward the in-network deductible and out-of-pocket maximum. The bill would require a plan or insurer to provide information about in-network providers to enrollees and insureds upon request, including whether the provider is accepting new patients at the time, and would limit the cost-sharing amounts an enrollee or insured is required to pay for services from those providers under specified circumstances. The bill would require the health care service plan or the insurer, as applicable, to ensure the accuracy of a request to add back a provider who was previously removed from a directory and approve the request within 10 business days of receipt, if accurate. The bill would authorize a health care service plan or insurer to include a specified statement in the provider listing before removing the provider from the directory if the provider does not respond within 5 calendar days of the plan or insurer's annual notification. Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

[AB 281](#)

(Gallagher R) Comprehensive sexual health education and human immunodeficiency virus (HIV) prevention education: outside consultants.

Current Text: Amended: 3/17/2025 [html](#) [pdf](#)

Introduced: 1/22/2025

Status: 6/12/2025-Ordered to inactive file at the request of Assembly Member Gallagher.

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

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

AB 290

(Bauer-Kahan D) California FAIR Plan Association: automatic payments.

Current Text: Amended: 7/3/2025 [html](#) [pdf](#)

Introduced: 1/22/2025

Status: 7/10/2025-From committee: Do pass and re-refer to Com. on APPR. with recommendation: To Consent Calendar. (Ayes 7. Noes 0.) (July 9). 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 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 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) Data brokers: elected officials and judges.

Current Text: Amended: 7/17/2025 [html](#) [pdf](#)

Introduced: 1/23/2025

Status: 7/17/2025-Read second time and amended. Re-referred to Com. on PUB. S. Withdrawn from committee. 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 Consumer Privacy Act of 2018 (CCPA) grants a consumer various rights with respect to personal information, as defined, that is collected or sold by a business, as defined, including the right to request that a business delete any personal information about the consumer that the business has collected from the consumer. The California Privacy Rights Act of 2020, approved by the voters as Proposition 24 at the November 3, 2020, statewide general election, amended, added to, and reenacted the CCPA and establishes the California Privacy Protection Agency (agency) and vests the agency with full administrative power, authority, and jurisdiction to enforce the CCPA. Existing law requires the agency to establish an accessible deletion mechanism that, among other things, allows a consumer to request the deletion of all personal information related to that consumer through a single deletion request. Existing law requires, beginning August 1, 2026, a data broker to access the accessible deletion mechanism at least once every 45 days and, within 45 days after receiving a request, process all deletion requests and delete all personal information related to the consumers making the requests, as prescribed. Existing law requires a data broker to delete all personal information of the consumer at least once every 45 days unless the consumer requests otherwise, as prescribed. Existing law defines “data broker” to mean a business, as defined, that knowingly collects and sells to third parties the personal information of a consumer with whom the business does not have a direct relationship, except as provided. This bill would require the agency to obtain a list of all state and local elected officials, would require the Judicial Council to provide the agency with a list of all California judges, and would require the agency to allow elected officials or a judges to remove their information from those lists, as prescribed. The bill would require the lists to be kept confidential, as specified. The bill would also require the agency to upload the lists to the accessible deletion mechanism described above and, beginning August 1, 2026, require an entity receiving a notification that a deletion is required to do so within 5 days. This bill would authorize an elected official or judge who is on a list described above, the Attorney General, a county counsel, or a city attorney to bring an action for a violation of the bill, as prescribed. This bill contains other related provisions and other existing laws.

AB 309

(Zbur D) Hypodermic needles and syringes.

Current Text: Introduced: 1/23/2025 [html](#) [pdf](#)

Introduced: 1/23/2025

Status: 7/14/2025-From committee: Do pass and re-refer to Com. on APPR. (Ayes 8. Noes 3.) (July 14). 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 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: 7/7/2025-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 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: 7/16/2025-From committee: Do pass and re-refer to Com. on APPR. (Ayes 11. Noes 2.) (July 15). 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 Consumer Privacy Act of 2018 (CCPA), grants a consumer various rights with respect to personal information, as defined, that is collected or sold by a business, as defined, including the right to direct a business that collects sensitive personal information about the consumer to limit its use, as prescribed. Existing law

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

AB 350

(Bonta D) Health care coverage: fluoride treatments.

Current Text: Amended: 7/7/2025 [html](#) [pdf](#)

Introduced: 1/29/2025

Status: 7/7/2025-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’s requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law sets forth specified coverage requirements for health care service plan contracts and health insurance policies. Existing law provides for the Medi-Cal program, administered by the State Department of Health Care Services and under which health care services are provided to low-income individuals. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law establishes a schedule of benefits under the Medi-Cal program and provides for various services, including certain dental services, that are rendered by Medi-Cal enrolled providers. Under existing law, silver diamine fluoride treatments are a covered benefit for eligible children 0 to 6 years of age, inclusive, as specified, and application of fluoride or other appropriate fluoride treatment is covered for children 17 years of age and under. This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2026, to provide coverage without cost sharing for the application of fluoride varnish in the primary care setting for children under 21 years of age. Because a willful violation of this provision by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill would make the application of fluoride or other appropriate fluoride treatment, including fluoride varnish, a covered benefit under the Medi-Cal program for children under 21 years of age. The bill would require the State Department of Health Care Services to establish and promulgate a policy governing billing and reimbursement for the application of fluoride varnish, as specified. This bill contains other related provisions and other existing laws.

AB 360

(Papan D) Menopause.

Current Text: Amended: 4/9/2025 [html](#) [pdf](#)

Introduced: 1/30/2025

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

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

Summary: Existing law establishes the Department of Health Care Access and Information to oversee and administer various health programs and to collect health data. Existing law establishes the Medical Board of California and the Osteopathic Medical Board of California for the licensure and regulation of physicians and surgeons and osteopathic physicians and surgeons. Existing law requires the boards to adopt and administer standards, including for the continuing education of those licensees. This bill would require the department to work with the Medical Board of California, the Osteopathic Medical Board of California, and state higher education entities to assess, among other things, physicians

and surgeons' education and training, as specified, relating to menopause diagnosis and treatment. The bill would require the department to prepare a report to the Legislature on or before January 1, 2027, that, among other things, identifies gaps in medical education and training related to menopause and in menopause diagnosis and management practices among physicians and surgeons.

AB 371

(Haney D) Dental coverage.

Current Text: Amended: 4/24/2025 [html](#) [pdf](#)

Introduced: 2/3/2025

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

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

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

AB 375

(Nguyen D) Medical Practice Act: health care providers: qualified autism service paraprofessionals.

Current Text: Introduced: 2/3/2025 [html](#) [pdf](#)

Introduced: 2/3/2025

Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. on 4/8/2025)(May be acted upon Jan 2026)

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

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

AB 384

(Connolly D) Health care coverage: mental health and substance use disorders: inpatient admissions.

Current Text: Amended: 3/17/2025 [html](#) [pdf](#)

Introduced: 2/3/2025

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

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

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

AB 403

(Ortega D) Medi-Cal: community health worker services.

Current Text: Amended: 3/17/2025 [html](#) [pdf](#)

Introduced: 2/4/2025

Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 4/9/2025)(May be acted upon Jan 2026)

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

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

AB 408

(Berman D) Physician Health and Wellness Program.

Current Text: Amended: 7/8/2025 [html](#) [pdf](#)

Introduced: 2/4/2025

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

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

Summary: Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons and licensed midwives by the Medical Board of California. A violation of the act is a crime. Existing law authorizes the board to establish a Physician and Surgeon Health and Wellness Program to support a physician and surgeon in their rehabilitation from substance abuse to ensure the physician and surgeon remains able to practice medicine in a manner that will not endanger the public health and safety and that will maintain the integrity of the medical profession. Existing law requires the board to contract with a third party for the program's administration in accordance with specified provisions of the Public Contract Code. Existing law provides that participation in the program shall not be a defense to any disciplinary action that may be taken by the board. Existing law requires the program to comply with the Uniform Standards Regarding Substance-Abusing Healing Arts Licensees adopted by the Substance Abuse Coordination Committee of the Department of Consumer Affairs. Existing law establishes the Physician and Surgeon Health and Wellness Program Account in the Contingent Fund of the Medical Board of California for the support of the program. This bill would revise and recast those provisions and would instead authorize the board to establish a Physician Health and Wellness Program to support, treat, monitor, and rehabilitate physicians and surgeons and other professionals licensed by the board with impairing physical and mental health conditions that may impact their ability to practice their profession in a reasonably safe, competent, and professional manner. The bill would require the administering entity to be a nonprofit entity and would require the contract with the administering entity to include procedures on specified topics. The bill would exempt the program from the Uniform Standards Regarding Substance-Abusing Healing Arts Licensees. The bill would exempt program records relating to current or former program participants from disclosure under the California Public Records Act, except as specified. The bill would authorize the board to establish advisory committees to assist in carrying out the duties of the administering entity, and would establish duties and responsibilities authorized to be performed by a committee. The bill would rename the Physician and Surgeon Health and Wellness Program Account as the Physician Health and Wellness Program Account, and would authorize the board to seek and use grant funds and gifts from public or private sources to pay any cost associated with the program. The bill would require the board to annually report to the Legislature and make available to the public the amount and source of funds. The bill would require a licensee to report a license to the administering entity or the board if they believe the licensee is impaired. By expanding the scope of a crime under the Medical Practice Act, the bill would impose a state-mandated local program. The bill would make a person who reports information or takes action in connection with the bill's provisions immune from civil liability for reporting information or taking the action, except as specified. The bill would make the program inapplicable to the Osteopathic Medical Board of California. This bill contains other related provisions and other existing laws.

AB 412

(Bauer-Kahan D) Generative artificial intelligence: training data: copyrighted materials.

Current Text: Amended: 5/7/2025 [html](#) [pdf](#)

Introduced: 2/4/2025

Status: 7/17/2025-Failed Deadline pursuant to Rule 61(a)(10). (Last location was JUD. on 5/21/2025)(May be acted upon Jan 2026)

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

Summary: Existing federal law, through copyright, provides authors of original works of authorship, as defined, with certain rights and protections. Existing federal law generally gives the owner of the copyright the right to reproduce the work in copies or phonorecords and the right to distribute copies or phonorecords of the work to the public. Existing federal law provides that sound recordings fixed before February 15, 1972, are not subject to copyright, but are subject to similar rights and protections under the Classics Protection and Access Act. Existing law requires, on or before January 1, 2026, and before each time thereafter that a generative artificial intelligence system or service, as defined, or a substantial modification to a generative artificial intelligence system or service, released on or after January 1, 2022, is made available to Californians for use, regardless of whether the terms of that use include compensation, a developer of the system or service to post on the developer's internet website documentation, as specified, regarding the data used to train the generative artificial intelligence system or service. This bill would require a developer of a generative artificial

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

AB 416

(Krell D) Involuntary commitment.

Current Text: Amended: 7/17/2025 [html](#) [pdf](#)

Introduced: 2/5/2025

Status: 7/17/2025-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 Lanterman-Petris-Short Act, authorizes the involuntary commitment and treatment of persons with specified mental disorders. Under the act, when a person, as a result of a mental health disorder, is a danger to self or others, or gravely disabled, the person may, upon probable cause, be taken into custody by specified individuals, including, among others, by a peace officer, a designated member of a mobile crisis team, or a professional person designated by the county, and placed in a facility designated by the county and approved by the State Department of Health Care Services for up to 72 hours for evaluation and treatment. Existing law authorizes county behavioral health director to develop procedures for the county's designation and training of professionals who will be designated to perform the above-described provisions. Existing law authorizes the procedures to include, among others, the license types, practice disciplines, and clinical experience of the professionals eligible to be designated by the county. Existing law exempts specified individuals, including a peace officer responsible for the detainment of a person under these provisions from criminal and civil liability for an action by a person who is released at or before the end of the period for which they were detained. This bill would require a county behavioral health director to include an emergency physician, as defined, as one of the practice disciplines eligible to be designated by the county when developing and implementing procedures for the designation and training of those professionals. The bill would also exempt an emergency physician who is responsible for the detainment of a person under those provisions from criminal and civil liability, as specified.

AB 423

(Davies R) Alcoholism or drug abuse recovery or treatment programs and facilities: disclosures.

Current Text: Amended: 4/2/2025 [html](#) [pdf](#)

Introduced: 2/5/2025

Status: 5/1/2025-Failed Deadline pursuant to Rule 61(a)(2). (Last location was HEALTH on 2/18/2025)(May be acted upon Jan 2026)

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

Summary: Existing law grants the sole authority in state government to the State Department of Health Care Services to certify alcohol or other drug programs and to license adult alcoholism or drug abuse recovery or treatment facilities. Existing law requires certified programs and licensed facilities to disclose to the department if any of its agents, partners, directors, officers, or owners own or have a financial interest in a recovery residence and whether it has contractual relationships with entities that provide recovery services to clients of certified programs or licensed facilities if the entity is not a part of a certified program or a licensed facility. Existing law defines "recovery residence" as a residential

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

AB 432

(Bauer-Kahan D) Menopause.

Current Text: Amended: 7/17/2025 [html](#) [pdf](#)

Introduced: 2/5/2025

Status: 7/17/2025-From committee: Amend, and do pass as amended and re-refer to Com. on APPR. (Ayes 10. Noes 0.) (July 16). 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 Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California and requires the board to adopt and administer standards for the continuing education of those licensees. Existing law requires the board, in determining its continuing education requirements, to consider including a course in menopausal mental or physical health. This bill would delete that requirement of the board. The bill would require, beginning July 1, 2026, a physician and surgeon who completes continuing medical education courses in perimenopause, menopause, and postmenopausal care to receive 2 hours of credit for each hour completed of that coursework, as specified. This bill contains other related provisions and other existing laws.

AB 489

(Bonta D) Health care professions: deceptive terms or letters: artificial intelligence.

Current Text: Amended: 7/8/2025 [html](#) [pdf](#)

Introduced: 2/10/2025

Status: 7/16/2025-From committee: Do pass and re-refer to Com. on APPR. (Ayes 13. Noes 0.) (July 15). 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 various healing arts boards within the Department of Consumer Affairs that license and regulate various healing arts licensees. Existing laws, including, among others, the Medical Practice Act and the Dental Practice Act, make it a crime for a person who is not licensed as a specified health care professional to use certain words, letters, and phrases or any other terms that imply that they are authorized to practice that profession. Existing law requires, with certain exemptions, a health facility, clinic, physician's office, or office of a group practice that uses generative artificial intelligence, as defined, to generate written or verbal patient communications pertaining to patient clinical information, as defined, to ensure that those communications include both (1) a disclaimer that indicates to the patient that a communication was generated by generative artificial intelligence, as specified, and (2) clear instructions describing how a patient may contact a human health care provider, employee, or other appropriate person. Existing law provides that a violation of these provisions by a physician shall be subject to the jurisdiction of the Medical Board of California or the Osteopathic Medical Board of California, as appropriate. This bill would make provisions of law that prohibit the use of specified terms, letters, or phrases to falsely indicate or imply possession of a license or certificate to practice a health care profession, as defined, enforceable against an entity who develops or deploys artificial intelligence (AI) or generative artificial intelligence (GenAI) technology that uses one or more of those terms, letters, or phrases in its advertising or functionality. The bill would prohibit the use by AI or GenAI technology of certain terms, letters, or phrases that indicate or imply that the advice, care, reports, or assessments being provided through AI or GenAI is being provided by a natural person with the appropriated health care license or certificate. This bill would make a violation of these provisions subject to the jurisdiction of the appropriate health care profession board, and would make each use of a prohibited term, letter, or phrase punishable as a separate violation. This bill contains other related provisions and other existing laws.

AB 510

(Addis D) Health care coverage: utilization review: peer-to-peer review.

Current Text: Amended: 4/28/2025 [html](#) [pdf](#)

Introduced: 2/10/2025

Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/7/2025)(May be acted upon Jan 2026)

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

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

AB 512

(Harabedian D) Health care coverage: prior authorization.

Current Text: Amended: 7/14/2025 [html](#) [pdf](#)

Introduced: 2/10/2025

Status: 7/14/2025-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 disability insurers by the Department of Insurance. Existing law generally authorizes a health care service plan or disability insurer to use utilization review, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. For a request prior to or concurrent with the provision of health care services, existing law requires utilization review decisions to be made within 5 business days from the plan's or insurer's receipt of the information reasonably necessary and requested by the plan or insurer to make the determination, or within 72 hours if the enrollee or insured faces an imminent and serious threat to their health or the normal timeframe would be detrimental to their life or health, as specified. This bill would change the timeline for prior or concurrent authorization requests to no more than 3 business days from the plan's or insurer's receipt via electronic submission, or 5 business days from receipt via submission that is not electronic, of the information reasonably necessary and requested by the plan or insurer to make the determination. The bill would require a utilization review decision to be made within 24 hours from receipt of a prior or concurrent authorization request via electronic submission, or 48 hours from receipt via submission that is not electronic, if the enrollee or insured faces an imminent and serious threat to their health or the normal timeframe would be detrimental to their life or health. Because a willful violation of this provision by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 517

(Krell D) Medi-Cal: complex rehabilitation technology: wheelchairs.

Current Text: Introduced: 2/10/2025 [html](#) [pdf](#)

Introduced: 2/10/2025

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

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

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

AB 534

(Schiavo D) Transitional housing placement providers.

Current Text: Amended: 5/23/2025 [html](#) [pdf](#)

Introduced: 2/11/2025

Status: 7/8/2025-From committee: Do pass and re-refer to Com. on APPR. with recommendation: To Consent Calendar. (Ayes 5. Noes 0.) (July 7). Re-referred to Com. on APPR.

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

Summary: Existing law, the California Community Care Facilities Act, requires the State Department of Social Services to license and regulate transitional housing placement providers as community care facilities. Existing law defines a “transitional housing placement provider” to mean an organization licensed by the department to provide transitional housing to foster children who are at least 16 years of age. A violation of the act is a misdemeanor. Existing law defines “Transitional Housing Program-Plus” to mean a provider certified by the applicable county to provide transitional housing services to former foster youth who have exited the foster care system on or after their 18th birthday. Existing law exempts Transitional Housing Program-Plus providers from licensure under the California Community Care Facilities Act if they are certified and have obtained a local fire clearance. This bill would require 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: 7/14/2025-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, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law generally requires a health care service plan contract or a health insurance policy issued, amended, or renewed on or after January 1, 2022, to provide coverage without cost sharing for a colorectal cancer screening test assigned either a grade of A or a grade of B by the United States Preventive Services Task Force and for a required colonoscopy for a positive result on a test with those grades. This bill would additionally require that coverage if the screening test is approved by the United States Food and Drug

Administration and either meets requirements for coverage established by the federal Centers for Medicare and Medicaid Services, as specified, or is included in the most recently published guidelines from the American Cancer Society.

AB 539

(Schiavo D) Health care coverage: prior authorizations.

Current Text: Amended: 4/28/2025 [html](#) [pdf](#)

Introduced: 2/11/2025

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

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

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

AB 543

(González, Mark D) Medi-Cal: street medicine.

Current Text: Amended: 6/23/2025 [html](#) [pdf](#)

Introduced: 2/11/2025

Status: 7/7/2025-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 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: 7/7/2025 [html](#) [pdf](#)

Introduced: 2/11/2025

Status: 7/7/2025-Read second time and amended. Re-referred to Com. on APPR.

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law sets forth specified coverage requirements for plan contracts and insurance policies, and limits the copayment, coinsurance, deductible, and other cost sharing that may be imposed for specified health care services. This bill would require a large group health care service plan contract or large group health insurance policy, except a specialized health care service plan contract or health insurance policy, that is issued, amended, or renewed on or after January 1, 2026, to include coverage for one portable high-efficiency particulate air (HEPA) purifier for an enrollee or insured who is pregnant or diagnosed with asthma or chronic obstructive pulmonary disease if the enrollee or insured is in a county where a local or state emergency has been declared due to wildfires and the HEPA purifier is prescribed by the enrollee's or insured's health care provider. The bill would prohibit the cost of the HEPA purifier from exceeding \$500, adjusted for inflation. Because a willful violation of these provisions by a health care service plan would be a crime, this bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 554

(González, Mark D) Health care coverage: antiretroviral drugs, drug devices, and drug products.

Current Text: Amended: 7/17/2025 [html](#) [pdf](#)

Introduced: 2/11/2025

Status: 7/17/2025-From committee: Amend, and do pass as amended and re-refer to Com. on APPR. (Ayes 9. Noes 0.) (July 16). Read second time and amended. Re-referred to Com. on APPR.

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

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

AB 575

(Arambula D) Obesity Prevention Treatment Parity Act.

Current Text: Amended: 3/12/2025 [html](#) [pdf](#)

Introduced: 2/12/2025

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

upon Jan 2026)

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

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

AB 577

(Wilson D) Health care coverage: antisteering.

Current Text: Amended: 5/1/2025 [html](#) [pdf](#)

Introduced: 2/12/2025

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

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

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

AB 582

(Pacheco D) Administrative Procedure Act.

Current Text: Introduced: 2/12/2025 [html](#) [pdf](#)

Introduced: 2/12/2025

Status: 5/8/2025-Failed Deadline pursuant to Rule 61(a)(3). (Last location was PRINT on 2/12/2025)(May be acted upon Jan 2026)

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

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

This bill would make a nonsubstantive change to those provisions.

AB 602

(Haney D) Public postsecondary education: student behavior: drug and alcohol use: rehabilitation programs.

Current Text: Amended: 6/16/2025 [html](#) [pdf](#)

Introduced: 2/13/2025

Status: 7/15/2025-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, 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: 7/7/2025-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 establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, through fee-for-service or managed care delivery systems. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing Medi-Cal provisions, behavioral health services, including specialty mental health services and substance use disorder treatment, are provided under the Medi-Cal Specialty Mental Health Services Program, the Drug Medi-Cal Treatment Program, and the Drug Medi-Cal organized delivery system (DMC-ODS) program, as specified. This bill would require each Medi-Cal managed care plan, county specialty mental health plan, Drug Medi-Cal certified program, and DMC-ODS program to electronically provide data for members of the respective entities to support member care. The bill would require the department to determine minimum data elements and the frequency and format of data sharing through a stakeholder process and guidance, with final guidance to be published by the department by January 1, 2027, in compliance with privacy laws.

AB 636

(Ortega D) Medi-Cal: diapers.

Current Text: Amended: 3/13/2025 [html](#) [pdf](#)

Introduced: 2/13/2025

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

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

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

AB 669

(Haney D) Substance use disorder coverage.

Current Text: Amended: 7/15/2025 [html](#) [pdf](#)

Introduced: 2/14/2025

Status: 7/15/2025-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 generally authorizes a health care service plan or health insurer to use prior authorization and other utilization management functions, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. Existing law requires health care service plan contracts and health insurance policies that provide hospital, medical, or surgical coverage and are issued, amended, or renewed on or after January 1, 2021, to provide coverage for medically necessary treatment of mental health and substance use disorders under the same terms and conditions applied to other medical conditions, as specified. On and after January 1, 2027, this bill would prohibit concurrent or retrospective review of medical necessity of in-network health care services and benefits (1) for the first 28 days of a treatment plan for inpatient or residential substance use disorder stay at a specified licensed facility during each plan or policy year or (2) for outpatient services provided by specified certified programs for substance use disorder visits, except as specified. The bill would authorize, after the 29th day, in-network health care services and benefits for inpatient or residential substance use disorder care to be subject to concurrent review. On and after January 1, 2027, the bill would prohibit retrospective review of medical necessity for the first 28 days of intensive outpatient or partial hospitalization services for substance use disorder, but would authorize concurrent or retrospective review for day 29 and days thereafter of that stay or service. With respect to health care service plans, the bill would specify that its provisions do not apply to Medi-Cal behavioral health delivery systems or Medi-Cal managed care plan contracts. Because a willful violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other existing laws.

AB 676

(Gonzalez, Jeff R) Medi-Cal: unrecovered payments: interest rate.

Current Text: Amended: 4/9/2025 [html](#) [pdf](#)

Introduced: 2/14/2025

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

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

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

AB 682

(Ortega D) Health care coverage reporting.

Current Text: Amended: 7/17/2025 [html](#) [pdf](#)

Introduced: 2/14/2025

Status: 7/17/2025-From committee: Amend, and do pass as amended and re-refer to Com. on APPR. (Ayes 9. Noes 0.) (July 16). 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 generally authorizes a health care service plan or health insurer to use prior authorization and other utilization review or utilization management functions, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. Existing law requires a health care service plan or health insurer to file various reports with the relevant regulating department. This bill would require a health care service plan or health insurer that imposes prior authorization to report specified prior authorization data from the previous calendar year on its internet website on or before February 1, 2026, and annually on or before February 1 thereafter. The bill would require a health care service plan or health insurer to annually report specified claims and prior authorization data to the relevant department by February 1 of each year, beginning February 1, 2027. The bill would require the departments to post this information, disaggregated by plan or insurer, on their internet websites by April 15 of each year, beginning April 15, 2027. The bill would authorize the Director of the Department of Managed Health Care to reject a report required pursuant to these provisions, and would authorize the commissioner to assess an administrative penalty against a health insurer for a failure to correct a deficiency in the report. The bill would authorize the director and commissioner to make rules and regulations specifying the form and content of the reports posted online and submitted to the relevant department, as specified. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

AB 787

(Papan D) Provider directory disclosures.

Current Text: Amended: 6/23/2025 [html](#) [pdf](#)

Introduced: 2/18/2025

Status: 7/7/2025-In committee: Referred to APPR. suspense file.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoe d	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: 7/8/2025 [html](#) [pdf](#)

Introduced: 2/18/2025

Status: 7/16/2025-Read second time. Ordered to third reading.

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

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

AB 798

(Calderon D) State Emergency Food Bank Reserve Program: diapers and wipes.

Current Text: Amended: 7/8/2025 [html](#) [pdf](#)

Introduced: 2/18/2025

Status: 7/14/2025-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 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: 7/17/2025-From committee: Do pass and re-refer to Com. on APPR. (Ayes 10. Noes 0.) (July 16). 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 Statewide Health Planning and Development to establish a program to contract with programs that train certified nurse-midwives and programs that train licensed midwives in accordance with the global standards for midwifery education and the international definition of "midwife" as established by the International Confederation of Midwives in order to increase the number of students receiving quality education and training as a certified nurse-midwife or as a licensed midwife. Existing law requires these provisions to be implemented only upon an appropriation by the Legislature for these purposes in the annual Budget Act or another act. This bill would require the Department of Health Care Access and Information, upon appropriation from the Legislature for this purpose, to administer funding for a statewide study on midwifery education. The bill would require the study to be conducted by an outside consultant familiar with the health care and midwifery landscapes and workforce in California that would, among other things, identify viable education programs that can serve both rural and urban geographic areas. The bill would require the department to submit a report from the study's findings to the Legislature, to post the report on the

department's internet website, and to notify all persons in the department's reproductive health and maternity care electronic mailing list, as specified. The bill would define "reproductive health care professionals" as, among others, medical doctors and licensed midwives.

AB 843

(Garcia D) Health care coverage: language access.

Current Text: Amended: 7/7/2025 [html](#) [pdf](#)

Introduced: 2/19/2025

Status: 7/8/2025-Withdrawn from committee. Re-referred to Com. on APPR.

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

Summary: (1)Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance, which is under the control of the Insurance Commissioner. Existing law requires the Department of Managed Health Care and the commissioner to develop and adopt regulations establishing standards and requirements to provide enrollees and insureds with appropriate access to language assistance in obtaining health care services and covered benefits. Existing law requires the Department of Managed Health Care and commissioner, in developing the regulations, to require health care service plans and health insurers to assess the linguistic needs of the enrollee and insured population, and to provide for translation and interpretation for medical services, as indicated. This bill would require a health care service plan or health insurer to take reasonable steps to provide meaningful access to each individual with limited English proficiency, including companions with limited English proficiency, eligible to receive services or likely to be directly affected by its programs and activities. The bill would require a health care service plan or health insurer to offer a qualified interpreter or to utilize a qualified translator when interpretation or translation services are required, as specified. The bill would prohibit a health care service plan or health insurer from requiring an individual with limited English proficiency to provide or pay for the costs of their own interpreter. The bill would require a health care service plan or health insurer to comply with specified requirements when providing remote interpreting services. The bill would make a health care service plan or health insurer that violates these provisions liable for administrative penalties, as specified. This bill contains other related provisions and other existing laws.

AB 877

(Dixon R) Health care coverage: substance use disorder: residential facilities.

Current Text: Amended: 4/21/2025 [html](#) [pdf](#)

Introduced: 2/19/2025

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

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

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

unlicensed residential facilities is almost exclusively nonmedical, with rare exceptions. The bill would authorize the Department of Managed Health Care, the Department of Insurance, and the State Department of Health Care Services to consult with each other, and would require those departments to consult with the State Department of Social Services, when preparing the contents of the letter. The bill would require the letters to be sent on or before October 1, 2026. The bill would repeal these provisions on January 1, 2027.

AB 910

(Bonta D) Pharmacy benefit management.

Current Text: Amended: 4/10/2025 [html](#) [pdf](#)

Introduced: 2/19/2025

Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/7/2025)(May be acted upon Jan 2026)

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

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

AB 951

(Ta R) Health care coverage: behavioral diagnoses.

Current Text: Chaptered: 7/30/2025 [html](#) [pdf](#)

Introduced: 2/20/2025

Status: 7/30/2025-Approved by the Governor. Chaptered by Secretary of State - Chapter 84, Statutes of 2025.

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

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

AB 960

(Garcia D) Patient visitation.

Current Text: Amended: 5/29/2025 [html](#) [pdf](#)

Introduced: 2/20/2025

Status: 7/15/2025-Read second time. Ordered to third reading.

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

Summary: Existing law provides for the licensure and regulation 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: 7/17/2025 [html](#) [pdf](#)

Introduced: 2/20/2025

Status: 7/17/2025-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: 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 decision making and materially impacts natural persons. This bill would require a developer of a covered ADS, as defined, to take certain actions, including conduct performance evaluations of the covered ADS and provide deployers to whom the developer transfers the covered ADS with certain information, including the results of those performance evaluations. This bill contains other related provisions and other existing laws.

AB 1032

(Harabedian D) Coverage for behavioral health visits.

Current Text: Amended: 7/15/2025 [html](#) [pdf](#)

Introduced: 2/20/2025

Status: 7/15/2025-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 issued, amended, or renewed on or after January 1, 2021, to provide coverage for medically necessary treatment of mental health and substance use disorders, as defined, under the same terms and conditions applied to other medical conditions. This bill would generally require a large group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2026, to reimburse an eligible enrollee or insured for up to 12 visits with a behavioral health provider if the enrollee or insured is in a county where a local or state emergency has been declared due to wildfires and the enrollee or insured has experienced a loss, trauma, or displacement because of the fire. The bill would prohibit these benefits from being subject to utilization review. The bill would require a health care service plan contract or health insurer to provide notice to all affected enrollees of these provisions, as specified. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

AB 1037

(Elhawary D) Public health: substance use disorder.

Current Text: Amended: 7/7/2025 [html](#) [pdf](#)

Introduced: 2/20/2025

Status: 7/16/2025-From committee: Do pass and re-refer to Com. on APPR. (Ayes 11. Noes 1.) (July 15). Re-referred to Com. on APPR.

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: 7/7/2025 [html](#) [pdf](#)

Introduced: 2/20/2025

Status: 7/7/2025-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'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, on or before January 1, 2028, to adopt regulations to establish minimum standards or policies and processes that can streamline and reduce redundancy and delay in provider credentialing, and to develop a standard 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 developed, whichever is later. The bill would require those departments to update the form 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: 7/17/2025 [html](#) [pdf](#)

Introduced: 2/20/2025

Status: 7/17/2025-Read second time and amended. Ordered to consent calendar.

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

Summary: Existing law states that it is the intent of the Legislature to maintain an ongoing program of birth defects monitoring statewide, and requires the State Public Health Officer to maintain a system for the collection of information related to birth defects, as specified. Existing law requires the officer to require general acute care hospitals and physician-owned or physician-operated clinics that regularly provide services for the diagnosis or treatment of birth defects, genetic counseling, or prenatal diagnostic services to make available to the department the medical records of children suspected or diagnosed as having birth defects, as specified. Existing law authorizes the department to enter into a contract for the establishment and implementation of the birth defects monitoring program. This bill would state that it is additionally the intent of the Legislature to enable and maintain an ongoing program to monitor conditions, as defined,

that occur during the 12-month period after an individual's birth statewide. The bill would authorize a local health officer to maintain a system for the collection of specified information within the local health jurisdiction related to birth defects and conditions. The bill would authorize a local health officer to require providers and laboratories, as specified, in addition to the facilities listed above, within the local health jurisdiction to either make available or to transmit to the local health department information related to birth defects and conditions, as specified. The bill would authorize a local health officer to enter into contracts for implementation of programs to collect information regarding, and to monitor, birth defects and conditions in their jurisdiction. This bill contains other related provisions and other existing laws.

AB 1137

(Krell D) Reporting mechanism: child sexual abuse material.

Current Text: Amended: 4/21/2025 [html](#) [pdf](#)

Introduced: 2/20/2025

Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/7/2025)(May be acted upon Jan 2026)

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

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

AB 1328

(Rodriguez, Michelle D) Medi-Cal reimbursements: nonemergency ambulance and other transportation.

Current Text: Amended: 7/17/2025 [html](#) [pdf](#)

Introduced: 2/21/2025

Status: 7/17/2025-From committee: Amend, and do pass as amended and re-refer to Com. on APPR. with recommendation: To Consent Calendar. (Ayes 10. Noes 0.) . 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, including emergency or nonemergency medical or nonmedical transportation services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under this bill, commencing on July 1, 2027, and subject to an appropriation, Medi-Cal fee-for-service reimbursement for nonemergency ambulance transportation services, as defined, would be in an amount equal to 80% of the amount set forth in the federal Medicare ambulance fee schedule for the corresponding level of service, adjusted by the Geographic Practice Cost Index, as specified. The bill would require the department to establish a Medi-Cal managed care directed payment program for nonemergency ambulance transportation services, with the reimbursement rates set in an amount equal to at least the amount set forth under fee-for-service reimbursement. The bill would require the department to maximize federal financial participation in implementing the above-described provisions to the extent allowable. To the extent that federal financial participation is unavailable, the bill would require the department to implement the provisions using state funds, as specified. This bill contains other related provisions and other existing laws.

AB 1405

(Bauer-Kahan D) Artificial intelligence: auditors: enrollment.

Current Text: Amended: 7/9/2025 [html](#) [pdf](#)

Introduced: 2/21/2025

Status: 7/9/2025-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 Department of Technology within the Government Operations Agency. Existing law requires the department to conduct, in coordination with other interagency bodies as it deems appropriate, a comprehensive inventory of all high-risk automated decision systems that have been proposed for use, development, or procurement by, or are being used, developed, or procured by, any state agency. Existing law defines “automated decision system” as a computational process derived from machine learning, statistical modeling, data analytics, or artificial intelligence that issues simplified output, including a score, classification, or recommendation, that is used to assist or replace human discretionary decision making and materially impacts natural persons. Existing law defines “artificial intelligence” as an engineered or machine-based system that varies in its level of autonomy and that can, for explicit or implicit objectives, infer from the input it receives how to generate outputs that can influence physical or virtual environments. This bill would require the Government Operations Agency, by January 1, 2027, to establish a mechanism on the agency’s internet website allowing AI auditors to enroll with the agency and allowing natural persons to report misconduct by an enrolled AI auditor. The bill would require the agency, commencing January 1, 2027, to publish information provided by an enrolled AI auditor on the agency’s internet website, retain specified reports for as long as the auditor remains enrolled, plus 10 years, and share reports submitted by persons reporting misconduct with other state agencies as necessary for enforcement purposes. This bill would, commencing January 1, 2027, require an AI auditor, prior to initially conducting a covered audit, as defined, to enroll with the agency. The bill would require an AI auditor that enrolls with the agency to pay an enrollment fee, to be fixed by the agency by January 1, 2027, and provide specified information. The bill would impose various requirements on an AI auditor that conducts a covered audit, including, among other things, providing the auditee with an audit report after the covered audit. This bill contains other related provisions and other existing laws.

AB 1415

(Bonta D) California Health Care Quality and Affordability Act.

Current Text: Amended: 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: 7/10/2025-From committee: Do pass and re-refer to Com. on APPR. (Ayes 11. Noes 0.) (July 9). 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 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: 7/9/2025 [html](#) [pdf](#)

Introduced: 12/2/2024

Status: 7/17/2025-From committee: Do pass and re-refer to Com. on APPR. (Ayes 9. Noes 4.) (July 16). 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 Department of Technology to conduct, in coordination with other interagency bodies as it deems appropriate, a comprehensive inventory of all high-risk automated decision systems (ADS) that have been proposed for use, development, or procurement by, or are being used, developed, or procured by, any state agency. Existing law establishes the Labor and Workforce Development Agency, which is composed of various departments responsible for protecting and promoting the rights and interests of workers in California, including the Division of Labor Standards Enforcement, led by the Labor Commissioner, within the Department of Industrial Relations. This bill would require an employer to provide a written notice that an ADS, for the purpose of making employment-related decisions, not including hiring, is in use at the workplace to all workers that will foreseeably be directly affected by the ADS, as specified. The bill would require the employer to maintain an updated list of all ADS currently in use. The bill would require an employer to notify, as provided, a job applicant that the employer utilizes an ADS in hiring decisions, if the employer will use the ADS in making decisions for that position. The bill would prohibit an employer from using an ADS that does certain functions and would limit the purposes and manner in which an ADS may be used to make decisions. The bill would require an employer to allow a worker to access their data collected or used by an ADS and to correct errors in 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: 7/17/2025 [html](#) [pdf](#)

Introduced: 12/2/2024

Status: 7/17/2025-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 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. make a prima facie determination without conducting a hearing. The bill, in the first hearing to determine competence to stand trial, would

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

SB 32

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

Current Text: Amended: 6/19/2025 [html](#) [pdf](#)

Introduced: 12/2/2024

Status: 7/16/2025-July 16 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 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: 7/17/2025 [html](#) [pdf](#)

Introduced: 12/3/2024

Status: 7/17/2025-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’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: 7/17/2025 [html](#) [pdf](#)

Introduced: 12/3/2024

Status: 7/17/2025-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 pharmacy benefit manager engaging in business with a health care service plan or health insurer to secure a license from the Department of Managed Health Care on or after January 1, 2027, or the date on which the department has established the licensure process, whichever is later. This bill would prohibit a pharmacy benefit manager from, among other things, unreasonably obstructing or interfering with a patient's right to timely access a prescription drug or device at a contract pharmacy, requiring use of only an affiliated pharmacy, as specified, and from imposing requirements, conditions, or exclusions that discriminate against a nonaffiliated pharmacy in connection with dispensing drugs. The bill would limit a pharmacy benefit manager's income to that derived from a pharmacy benefit management fee for pharmacy benefit management services provided, and would require a pharmacy benefit manager to use a passthrough pricing model. The bill would authorize the Attorney General to recover specified civil penalties and receive equitable relief for violations of the pharmacy benefit manager licensing provisions. Because a violation of these provisions would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

SB 53

(Wiener D) Artificial intelligence models: large developers.

Current Text: Amended: 7/17/2025 [html](#) [pdf](#)

Introduced: 1/7/2025

Status: 7/17/2025-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 generally regulates artificial intelligence, including by requiring, on or before January 1, 2026, and before each time thereafter, that a generative artificial intelligence system or service, or a substantial modification to a generative artificial intelligence system or service, released on or after January 1, 2022, is made publicly available to Californians for use, the developer of the system or service to post on the developer's internet website documentation regarding the data used by the developer to train the generative artificial intelligence system or service, as prescribed. This bill would enact the Transparency in Frontier Artificial Intelligence Act (TFAIA) that would, among other things related to ensuring the safety of a foundation model developed by a large developer, require a large developer to write, implement, and clearly and conspicuously publish on its internet website a safety and security protocol that describes in specific detail, among other things, the testing procedures that the large developer uses to assess catastrophic risks from its foundation models, as specified. The TFAIA would define "foundation model" to mean an artificial intelligence model that is trained on a broad data set, designed for generality of output, and adaptable to a wide range of distinctive tasks. The TFAIA would require the Attorney General to establish a mechanism to be used by a large developer or a member of the public to report, as prescribed, a critical safety incident, as defined, and would authorize the Attorney General to periodically update the definition of "foundation model," as specified. This bill contains other related provisions and other existing laws.

SB 62

(Menjivar D) Health care coverage: essential health benefits.

Current Text: Amended: 7/1/2025 [html](#) [pdf](#)

Introduced: 1/9/2025

Status: 7/16/2025-From committee: Do pass and re-refer to Com. on APPR. (Ayes 16. Noes 0.) (July 15). Re-referred to

Com. on APPR.

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

Summary: Existing law, 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: 7/17/2025 [html](#) [pdf](#)

Introduced: 1/17/2025

Status: 7/17/2025-From committee with author's amendments. Read second time and amended. Re-referred to Com. on APPR.

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

Summary: The Confidentiality of Medical Information Act (CMIA) prohibits a provider of health care, a health care service plan, a contractor, or a corporation and its subsidiaries and affiliates from intentionally sharing, selling, using for marketing, or otherwise using any medical information, as defined, for any purpose not necessary to provide health care services to a patient, except as provided. The CMIA prohibits a provider of health care, health care service plan, or contractor from disclosing medical information regarding a patient of the provider of health care or an enrollee or subscriber of a health care service plan without first obtaining authorization from the patient, except if the disclosure is compelled by, among other things, a search warrant lawfully issued to a governmental law enforcement agency or a court order. Existing law makes a violation of these provisions that results in economic loss or personal injury to a patient punishable as a misdemeanor. This bill would revise the definition of "medical information" to include immigration status, including current and prior immigration status, and place of birth, 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 shall disclose medical information regarding a patient of the provider of health care or an enrollee or subscriber or a health care service plan pursuant to a valid search warrant issued by a judicial officer, including a magistrate, to a governmental law enforcement agency, or pursuant to a court order issued by a court of this state. 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.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

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: 7/9/2025-From committee: Do pass and re-refer to Com. on APPR. with recommendation: To consent calendar. (Ayes 16. Noes 0.) (July 8). Re-referred to Com. on APPR.

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

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

SB 238

(Smallwood-Cuevas D) Workplace surveillance tools.

Current Text: Amended: 5/1/2025 [html](#) [pdf](#)

Introduced: 1/29/2025

Status: 7/17/2025-Failed Deadline pursuant to Rule 61(a)(10). (Last location was P. & C.P. on 6/26/2025)(May be acted upon Jan 2026)

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

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

SB 242

(Blakespear D) Medicare supplement coverage: open enrollment periods.

Current Text: Amended: 5/5/2025 [html](#) [pdf](#)

Introduced: 1/30/2025

Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/19/2025)(May be acted upon Jan 2026)

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

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

SB 246

(Grove R) Medi-Cal: graduate medical education payments.

Current Text: Introduced: 1/30/2025 [html](#) [pdf](#)

Introduced: 1/30/2025

Status: 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 non designated public hospitals, and to their affiliated government entities, in recognition of the Medi-Cal managed care share of GME costs. Under the bill, these payments would be made in a manner consistent with the methodology for GME payments to DPHs and their affiliated government entities and would consist of the above-described direct and indirect GME payment components. The bill would authorize the department to seek federal approval for other forms of GME payments to DMPHs and their affiliated government entities, as specified. This bill contains other related provisions and other existing laws.

SB 250

(Ochoa Bogh R) Medi-Cal: provider directory: skilled nursing facilities.

Current Text: Amended: 6/17/2025 [html](#) [pdf](#)

Introduced: 1/30/2025

Status: 7/3/2025-Read second time. Ordered to third reading.

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

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

SB 257

(Wahab D) Pregnancy As a Recognized Event for Nondiscriminatory Treatment (PARENT) Act.

Current Text: Amended: 7/17/2025 [html](#) [pdf](#)

Introduced: 2/3/2025

Status: 7/17/2025-Read second time and amended. Re-referred to Com. on APPR.

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

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

SB 278

(Cabaldon D) Health data: HIV test results.

Current Text: Amended: 7/17/2025 [html](#) [pdf](#)

Introduced: 2/4/2025

Status: 7/17/2025-Assembly Rule 63 suspended. From committee: Do pass as amended and re-refer to Com. on APPR. with recommendation: To consent calendar. (Ayes 15. Noes 0.) (July 16). Read second time and amended. Re-referred to Com. on APPR.

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

Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law generally imposes penalties on a person who negligently, willfully, or maliciously discloses the results of a human immunodeficiency virus (HIV) test to a third party in a manner that identifies or provides identifying characteristics of the person to whom the test results apply, as specified. Existing law, notwithstanding the above-described restrictions, authorizes the recording of the HIV test results by the physician who ordered the test in the test subject's medical record and authorizes other disclosure of the results without written authorization of the test subject, or the subject's representative, to the test subject's providers of health care, excluding a regulated health care service plan, for purposes of diagnosis, care, or treatment of the patient. This bill would authorize the disclosure of results of an HIV test that identifies or provides identifying characteristics of a Medi-Cal beneficiary without written authorization of the test subject, or the subject's representative, to the Medi-Cal managed care plan to which the beneficiary is assigned, if applicable, for the purpose of administering quality improvement programs, including, but not limited to, value-based payment programs and healthy behavior incentive programs, designed to improve HIV care for Medi-Cal beneficiaries. The bill would make an exception for Medi-Cal beneficiaries who have opted out through a mechanism that the department would be required to develop by December 31, 2026, as specified. Under the bill, HIV test results that do not identify or provide identifying characteristics of the test subjects would be authorized for disclosure without written authorization by the Medi-Cal managed care plan to departmental staff for the above-described purpose. This bill contains other existing laws.

SB 306

(Becker D) Health care coverage: prior authorizations.

Current Text: Amended: 7/17/2025 [html](#) [pdf](#)

Introduced: 2/10/2025

Status: 7/17/2025-Read second time and amended. Re-referred to Com. on APPR.

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law generally authorizes a health care service plan or health insurer to use prior authorization and other utilization review or utilization management functions, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. Existing law requires a health care service plan or health insurer, including those plans or insurers that delegate utilization review or utilization management functions to medical groups, independent practice associations, or to other contracting providers, to comply with specified requirements and limitations on their utilization review or utilization management functions. This bill would require the departments to issue instructions on or before July 1, 2026, to health care service plans and health insurers to report statistics regarding covered health care services subject to prior authorization and the percentage rate at which they are approved or modified, among other things. The bill would require a health care service plan or health insurer to report those statistics, including information from another entity to which the plan or insurer delegates responsibility for prior authorization decisions, to the appropriate department on or before December 31, 2026. The bill would require the departments to evaluate these reports, identify the health care services most frequently approved, and, on or before July 1, 2027, publish a list of the services identified. Beginning on the date specified by the relevant department, but no later than January 1, 2028, the bill would require a plan or insurer, or its delegated entities, to cease requiring prior authorization for the most frequently approved covered health care services. The bill would authorize a plan or insurer to reinstate prior authorization for a specific health care provider if it determines that the provider has engaged in fraudulent activity or clinically inappropriate care, as specified. No later than 4 years after the cessation of prior authorization requirements, the bill would require the departments to publish reports regarding the impact of that cessation using information reported by plans and insurers, including data on reinstatements of prior authorization for specific providers. The bill would repeal these provisions on January 1, 2034. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program. This bill contains other related provisions and other existing laws.

[SB 324](#)

(Menjivar D) Medi-Cal: enhanced care management and community supports.

Current Text: Amended: 7/3/2025 [html](#) [pdf](#)

Introduced: 2/11/2025

Status: 7/3/2025-Read second time and amended. Re-referred to Com. on APPR.

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

Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law, subject to implementation of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, requires the department to implement an enhanced care management (ECM) benefit designed to address the clinical and nonclinical needs on a whole-person-care basis for certain target populations of Medi-Cal beneficiaries enrolled in Medi-Cal managed care plans. Under existing law, target populations include, among others, high utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits, and individuals experiencing homelessness. Existing law, subject to CalAIM implementation, authorizes a Medi-Cal managed care plan to elect to cover community supports, as specified. Under existing law, community supports that the department is authorized to approve include, among others, housing transition navigation services and medically supportive food and nutrition services. This bill would require a Medi-Cal managed care plan, for purposes of covering the ECM benefit, or if it elects to cover a community support, to contract with community providers, as defined, that can demonstrate that they are capable of providing access and meeting quality requirements in accordance with Medi-Cal guidelines. In determining which community providers to contract with, the bill would authorize Medi-Cal managed care plans to take into consideration whether those providers are available in the respective county and have experience in providing the applicable ECM or community support. The bill would require the department, for purposes of enforcing these provisions, to require Medi-Cal managed care plans to set goals every other year for the level of contracting and utilization of community providers and local entities, as defined. The bill

would require these goals to be established in consultation with the department, as specified. This bill contains other related provisions and other existing laws.

SB 339

(Cabaldon D) Medi-Cal: laboratory rates.

Current Text: Amended: 4/9/2025 [html](#) [pdf](#)

Introduced: 2/12/2025

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

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

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

SB 363

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

Current Text: Amended: 7/17/2025 [html](#) [pdf](#)

Introduced: 2/13/2025

Status: 7/17/2025-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 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: 7/17/2025-Read second time. Ordered to third reading.

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law 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: 7/9/2025 [html](#) [pdf](#)

Introduced: 2/18/2025

Status: 7/9/2025-Read second time and amended. Re-referred to Com. on APPR.

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act’s requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law also provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services pursuant to a schedule of benefits. Existing law sets forth specified coverage requirements for health care service plan contracts and health insurance policies. Existing law generally authorizes a health care service plan or health insurer to use utilization controls to approve, modify, delay, or deny requests for health care services based on medical necessity. Existing law requires health care service plans and health insurers, as specified, within 6 months after the relevant department issues specified guidance, or no later than March 1, 2025, to require all of their staff who are in direct contact with enrollees or insureds in the delivery of care or enrollee or insured services to complete evidence-based cultural competency training for the purpose of providing trans-inclusive health care for individuals who identify as transgender, gender diverse, or intersex. This bill would require a health care service plan contract or health insurance policy issued, amended, renewed, or delivered on or after the bill’s operative date to cover up to a 12-month supply of a United States Food and Drug Administration (FDA)-approved prescription hormone therapy, and the necessary supplies for self-administration, that is prescribed by a network provider within their scope of practice and dispensed at one time, as specified. The bill would make the same prescription hormone therapy a covered benefit under the Medi-Cal program, as specified. The bill would prohibit a plan, an insurer, or the Medi-Cal program from imposing utilization controls or other forms of medical management limiting the supply of this hormone therapy to an amount that is less than a 12-month supply, but would not prohibit a contract, a policy, or the Medi-Cal program from limiting refills that may be obtained in the last quarter of the plan, policy, or coverage year if a 12-month supply of the prescription hormone therapy has already been dispensed during that year. The bill would repeal these provisions on January 1, 2035. This bill contains other related provisions and other existing laws.

SB 439

(Weber Pierson D) California Health Benefit Review Program: extension.

Current Text: Amended: 4/10/2025 [html](#) [pdf](#)

Introduced: 2/18/2025

Status: 7/2/2025-July 2 set for first hearing. Placed on suspense file.

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

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.	Enrolled	Vetoed	Chaptered
1st House				2nd House				Conc.			

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

SB 466

(Caballero D) Drinking water: primary standard for hexavalent chromium: exemption.

Current Text: Amended: 7/17/2025 [html](#) [pdf](#)

Introduced: 2/19/2025

Status: 7/17/2025-Read second time and amended. Re-referred to Com. on APPR.

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

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 determined, held, considered, or otherwise deemed in violation of the primary drinking water standard for hexavalent chromium while implementing a state board approved compliance plan or while state board action on the proposed and submitted compliance plan is pending, as provided.

SB 468

(Becker D) High-risk artificial intelligence systems: duty to protect personal information.

Current Text: Introduced: 2/19/2025 [html](#) [pdf](#)

Introduced: 2/19/2025

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

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

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

Summary: Existing law, the California Consumer Privacy Act of 2018 (CCPA), grants a consumer various rights with respect to personal information that is collected or sold by a business. The CCPA defines various terms for these purposes. The California Privacy Rights Act of 2020 (CPRA), approved by the voters as Proposition 24 at the November 3, 2020, statewide general election, amended, added to, and reenacted the CCPA and establishes the California Privacy Protection Agency (agency) and vests the agency with full administrative power, authority, and jurisdiction to enforce the CCPA. Existing law requires, on or before January 1, 2026, and before each time thereafter that a generative artificial intelligence system or service, as defined, or a substantial modification to a generative artificial intelligence system or service, released on or after January 1, 2022, is made available to Californians for use, regardless of whether the terms of that use include compensation, a developer of the system or service to post on the developer's internet website documentation, as specified, regarding the data used to train the generative artificial intelligence system or service. This bill would impose a duty on a covered deployer, defined as a business that deploys a high-risk artificial intelligence system that processes personal information, to protect personal information held by the covered deployer, subject to certain requirements. In this regard, the bill would require a covered deployer whose high-risk artificial intelligence systems process personal information to develop, implement, and maintain a comprehensive information security program, as specified, that contains administrative, technical, and physical safeguards that are appropriate for, among other things, the covered deployer's size, scope, and type of business. The bill would require the program described above to meet specified requirements, including, among other things, that the program incorporates safeguards that are consistent with the safeguards for the protection of personal information and information of a similar character under applicable state or federal laws and regulations. This bill contains other related provisions and other existing laws.

[SB 481](#)

(Alvarado-Gil R) In-home supportive services.

Current Text: Introduced: 2/19/2025 [html](#) [pdf](#)

Introduced: 2/19/2025

Status: 2/26/2025-Referred to Com. on RLS.

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

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

[SB 528](#)

(Weber Pierson D) Health care: maintenance and expansion.

Current Text: Amended: 5/5/2025 [html](#) [pdf](#)

Introduced: 2/20/2025

Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/19/2025)(May be acted upon Jan 2026)

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

Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law establishes, under the Medi-Cal program, the Family Planning, Access, Care, and Treatment (Family PACT) Program. If Family PACT becomes inoperative, existing law requires all persons who have received, or are eligible to receive, comprehensive clinical family planning services pursuant to Family PACT to receive family planning services under other specified provisions of the Medi-Cal program or under the State-Only Family Planning Program, which is also established within the department for purposes of family planning services. This bill would require the department, subject to an appropriation, to develop a

new program or to expand any existing state-only-funded health programs, in order to provide to Medi-Cal beneficiaries certain services or benefits that are otherwise covered under the Medi-Cal program but for any lack of, elimination of, reduction in, or limitation on, federal financial participation. This bill contains other related provisions and other existing laws.

SB 530

(Richardson D) Medi-Cal: time and distance standards.

Current Text: Amended: 7/9/2025 [html](#) [pdf](#)

Introduced: 2/20/2025

Status: 7/16/2025-From committee: Do pass and re-refer to Com. on APPR. (Ayes 15. Noes 0.) (July 15). 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, under fee-for-service or managed care delivery systems. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law establishes, until January 1, 2026, certain time and distance and appointment time standards for specified Medi-Cal managed care covered services, consistent with federal regulations relating to network adequacy standards, to ensure that those services are available and accessible to enrollees of Medi-Cal managed care plans in a timely manner, as specified. This bill would extend the operation of those standards to January 1, 2029. The bill would also require a managed care plan to ensure that each subcontractor network complies with certain appointment time standards unless already required to do so. The bill would set forth related reporting requirements with regard to subcontractor networks. This bill contains other related provisions and other existing laws.

SB 535

(Richardson D) Obesity Care Access Act.

Current Text: Amended: 7/17/2025 [html](#) [pdf](#)

Introduced: 2/20/2025

Status: 7/17/2025-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's requirements a crime. Existing law sets forth specified coverage requirements for plan contracts. This bill, the Obesity Care Access Act, would require an individual or group health care service plan contract or health insurance policy that provides coverage for outpatient prescription drug benefits and is issued, amended, or renewed on or after January 1, 2026, to include coverage for bariatric surgery and at least one anti obesity medication approved by the United States Food and Drug Administration. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

SB 579

(Padilla D) Mental health and artificial intelligence working group.

Current Text: Amended: 3/26/2025 [html](#) [pdf](#)

Introduced: 2/20/2025

Status: 5/23/2025-Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 4/21/2025)(May be acted upon Jan 2026)

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

Summary: Existing law establishes the Government Operations Agency, which consists of several state entities, including, among others, the State Personnel Board, the Department of General Services, and the Office of Administrative Law. Under existing law, the Government Operations Agency is under the direction of an executive officer known as the Secretary of Government Operations, who is appointed by, and holds office at the pleasure of, the Governor, subject to confirmation by the Senate. This bill would require the secretary, by July 1, 2026, to appoint a

mental health and artificial intelligence working group, as specified, that would evaluate certain issues to determine the role of artificial intelligence in mental health settings. The bill would require the working group to take input from various stakeholder groups, including health organizations and academic institutions, and conduct at least 3 public meetings. The bill would require the working group to produce a report of its findings to the Legislature by July 1, 2028, and issue a follow up report by January 1, 2030, as specified. The bill would repeal its provisions on July 1, 2031.

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

Current Text: Amended: 7/17/2025 [html](#) [pdf](#)

Introduced: 2/20/2025

Status: 7/17/2025-Read second time and amended. Re-referred to Com. on APPR.

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

Summary: Current law requires a licensed health care practitioner who provides prenatal, postpartum, or interpregnancy care for a patient to offer to screen or appropriately screen a mother for maternal mental health conditions. For purposes of that requirement, existing law defines “maternal mental health condition” to mean a mental health condition that occurs during pregnancy, the postpartum period, or interpregnancy, as specified. This bill would modify the term “maternal mental health condition” to “perinatal mental health condition” and additionally include in its definition a mental health condition that occurs during the perinatal period. The bill would authorize a licensed health care practitioner to satisfy the above-described requirement by referring the patient or client to another licensed health care practitioner who is authorized to screen, diagnose, and treat the patient or client for a perinatal mental health condition. The bill would require a licensed health care practitioner who provides perinatal care for a patient or client to diagnose and treat the patient or client for a perinatal mental health condition in accordance with the standards appropriate to the provider’s license, training, and scope of practice, as specified.

SB 660 **(Menjivar D) California Health and Human Services Data Exchange Framework.**

Current Text: Amended: 7/17/2025 [html](#) [pdf](#)

Introduced: 2/20/2025

Status: 7/17/2025-Assembly Rule 63 suspended. From committee: Do pass as amended and re-refer to Com. on APPR. (Ayes 12. Noes 0.) (July 16). Read second time and amended. Re-referred to Com. on APPR.

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

Summary: Existing law establishes the 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.

SB 812 **(Allen D) Qualified youth drop-in center health care coverage.**

Current Text: Amended: 7/17/2025 [html](#) [pdf](#)

Introduced: 2/21/2025

Status: 7/17/2025-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 issued, amended, renewed, or delivered on or after January 1, 2024, that provides coverage for medically necessary treatment of mental health and substance use disorders to cover the provision of those services to an individual 25 years of age or younger when delivered at a schoolsite. This bill would expand the definition of schoolsite to additionally require a contract or policy that provides coverage for medically necessary treatment of mental health and substance use disorders to cover the provision of those services to an individual 25 years of age or younger when delivered at a qualified youth drop-in center. Because a violation of this requirement relative to health care service plans would be a crime, the bill would create a state-mandated local program. This bill contains other related provisions and other existing laws.

[SB 833](#)

(McNerney D) Critical infrastructure: artificial intelligence systems: human oversight.

Current Text: Amended: 7/17/2025 [html](#) [pdf](#)

Introduced: 2/21/2025

Status: 7/17/2025-Assembly Rule 63 suspended. From committee: Do pass as amended and re-refer to Com. on APPR. (Ayes 15. Noes 0.) (July 16). 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 California Emergency Services Act, establishes the California Cybersecurity Integration Center within the Office of Emergency Services to serve as the central organizing hub of state government's cybersecurity activities and to coordinate information sharing with various entities. Existing law also requires the Technology Recovery Plan element of the State Administrative Manual to ensure the inclusion of cybersecurity strategy incident response standards for each state agency to secure its critical infrastructure controls and information, as prescribed. This bill would require, on or before July 1, 2026, an operator, defined as a state agency responsible for operating, managing, overseeing, or controlling access to critical infrastructure, that deploys a covered artificial intelligence (AI) system, as defined, to establish a human oversight mechanism that ensures a human monitors the system's operations in real time and reviews and approves any plan or action proposed by the covered AI system before execution, except as provided. The bill would require the Department of Technology to develop specialized training in AI safety protocols and risk management techniques to oversight personnel. The bill would require oversight personnel for an operator to conduct an annual assessment of its covered AI systems, as specified, and to submit a summary of the findings to the department. The bill would make findings and declarations related to its provisions. This bill contains other related provisions and other existing laws.

[SB 862](#)

(Committee on Health) Health.

Current Text: Amended: 7/17/2025 [html](#) [pdf](#)

Introduced: 3/17/2025

Status: 7/17/2025-Read second time and amended. Ordered to second reading.

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

Summary: Existing law, the 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.

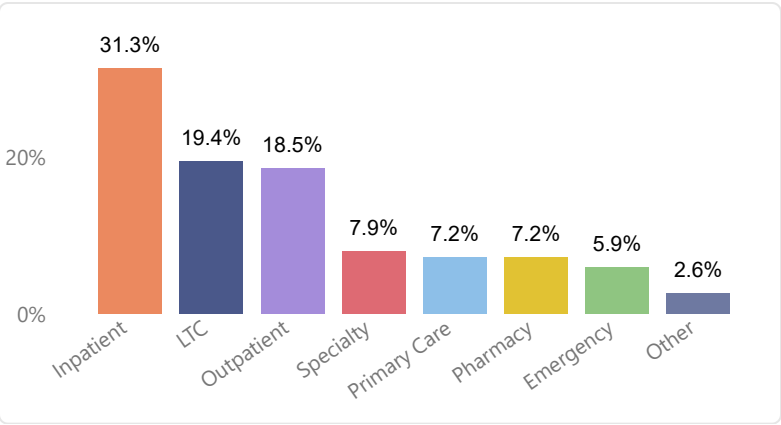
Executive Dashboard

Financials

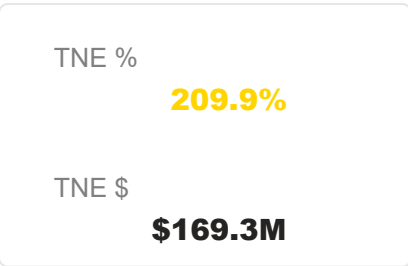
Income & Expenses

	JUNE 2025	FISCAL YTD
REVENUE	\$ 256.0 M	\$ 3.0 B
MEDICAL EXPENSE	\$ (175.2) M	\$ (2.1) B
ADMIN EXPENSE	\$ (11.4) M	\$ (115.8) M
OTHER/TAX	\$ (64.6) M	\$ (850.3) M
NET INCOME	\$ 4.9 M	\$ (86.1) M
Medical Loss % (Fiscal YTD)		
99.9%		

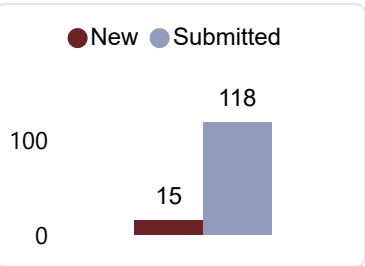
Medical Expenses



Liquid Reserves



Reinsurance Cases

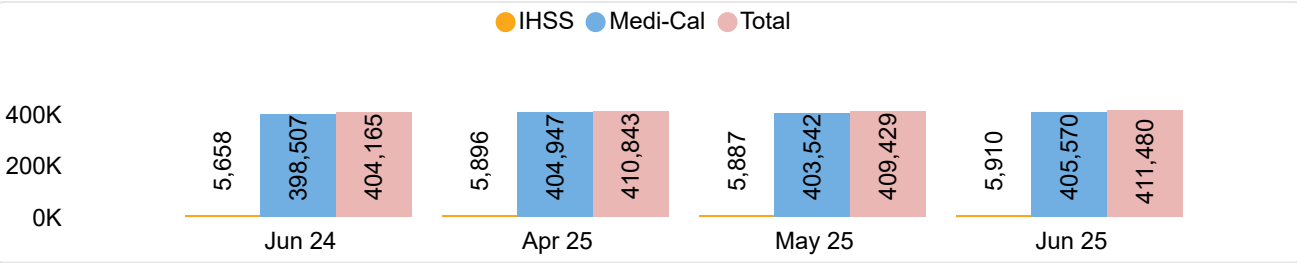


Balance Sheet

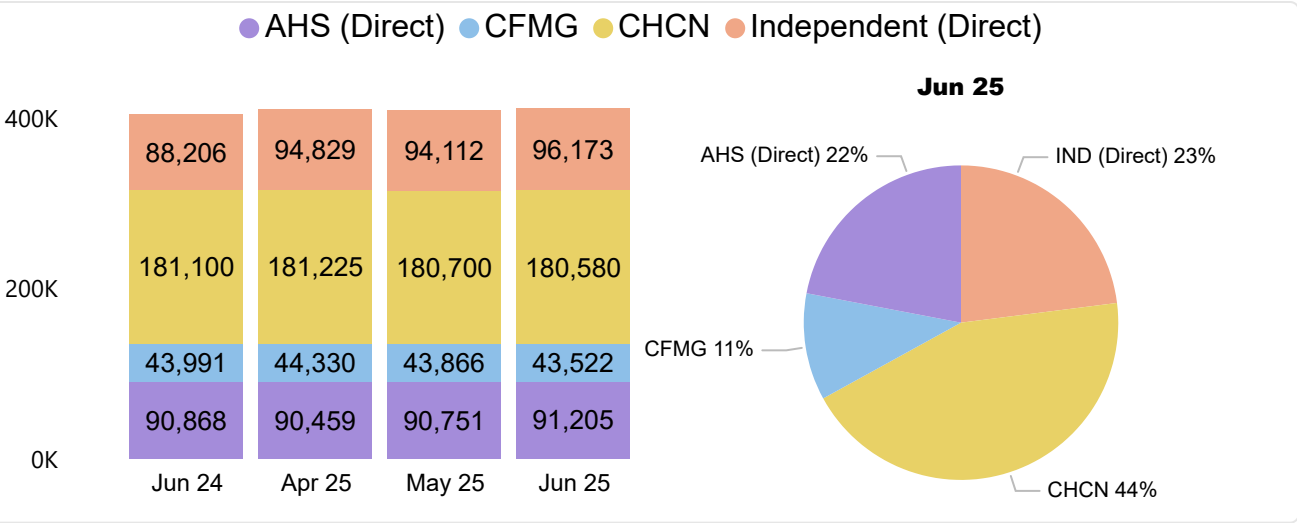
Cash Equivalents	\$533.0M	Current Ratio 1.12
Pass-Through Liabilities	\$152.4M	
Uncommitted Cash	\$380.6M	
Working Capital	\$115.4M	

Membership

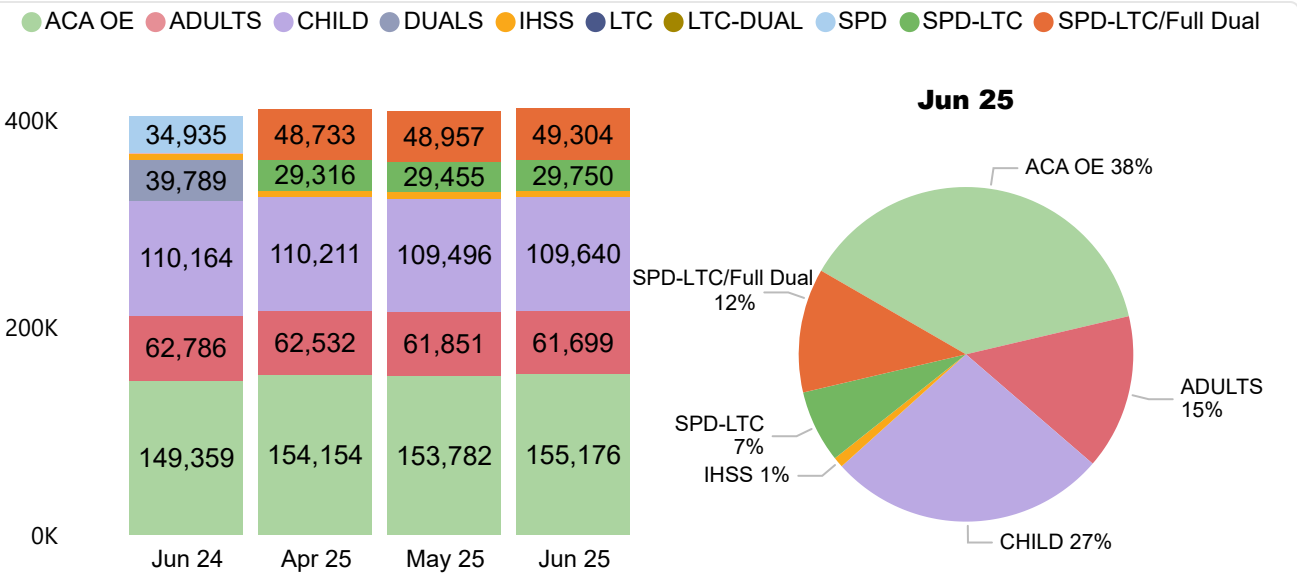
By Plan



By Network



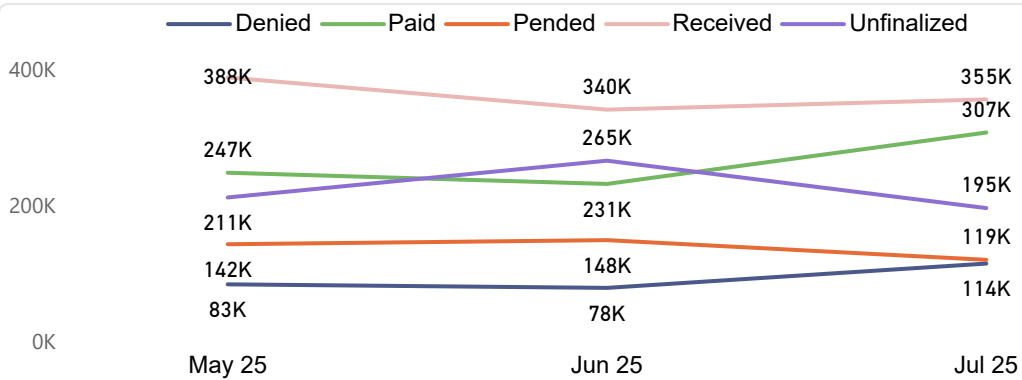
By Category



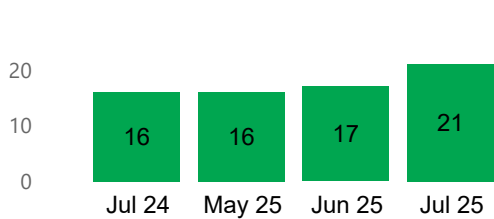
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Claims

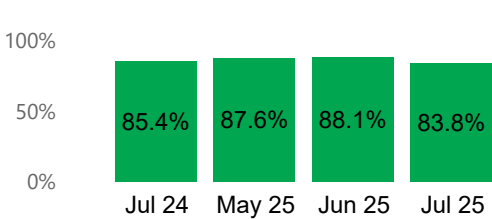
Claims Processing



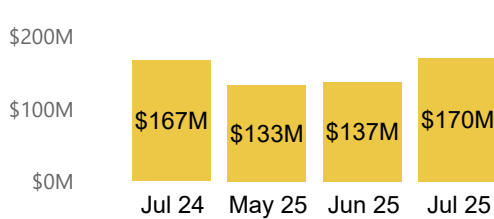
Average Payment TAT (Days)



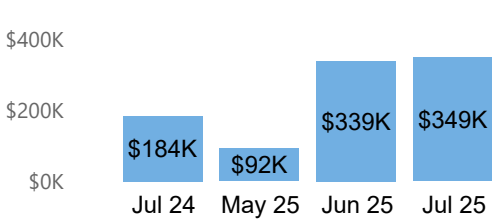
Auto Adjudication Rate (%)



Claims Paid (\$)

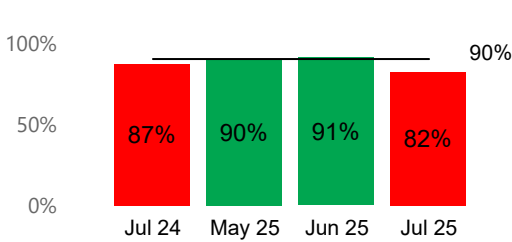


Interest Paid (\$)

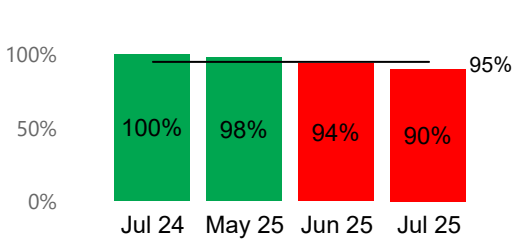


Claims Compliance

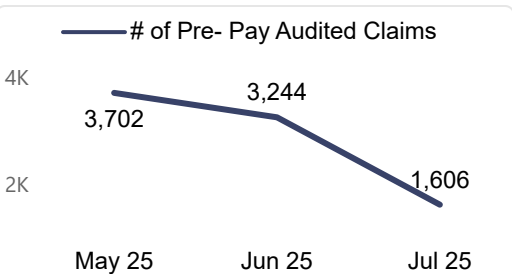
Processed 30 Cal Days (%)



Processed 45 Work Days (%)

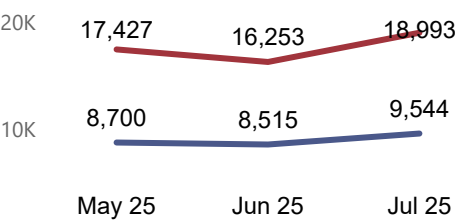


Claims Auditing

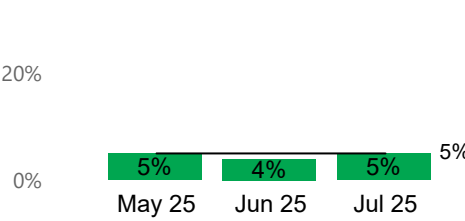


Member Services

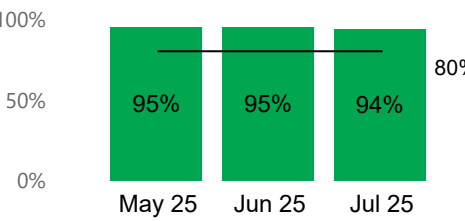
Inbound Calls Outbound Calls



Abandoned Call Rate (%)



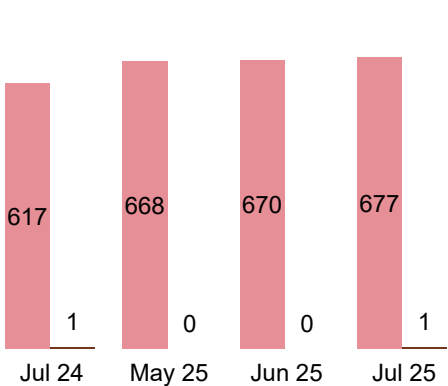
Calls Answered in 30 Seconds (%)



Average Call Times	May 25	Jun 25	Jul 25
Wait Time	00:11	00:11	00:13
Call Duration	07:33	07:50	07:39

Human Resources

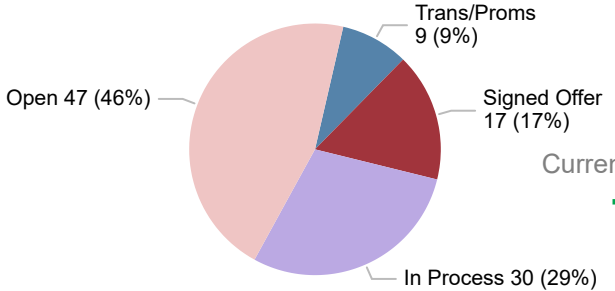
Full Time Part Time



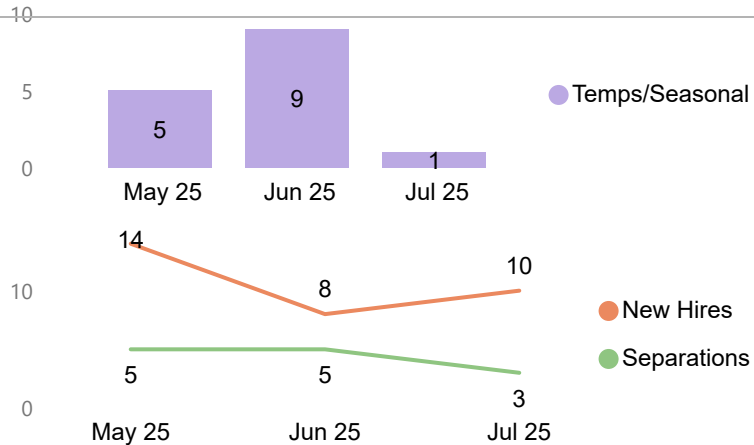
Recruiting Status

Jul 25

Trans/Proms Signed Offer In Process Open



Current Vacancy
7%



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Provider Services

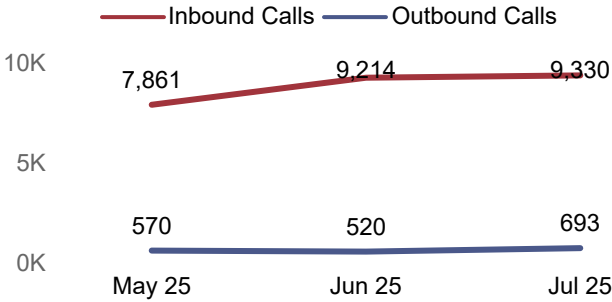
Provider Network

Hospital	17
Specialist	11,418
Primary Care Physician	768
Skilled Nursing Facility	107
Urgent Care	16
Health Centers (FQHCs and Non-FQHCs)	87
TOTAL	12,413

Provider Credentialing

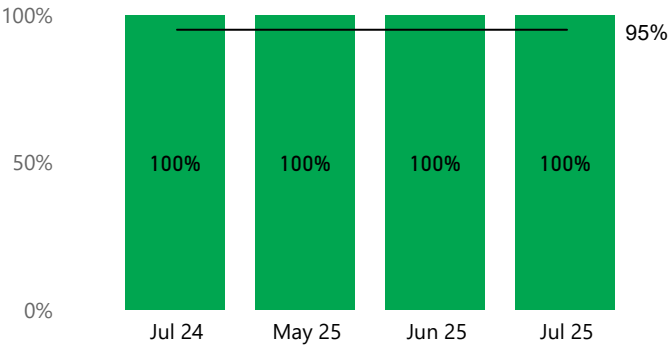
5,004

Provider Call Center



Provider Disputes & Resolutions

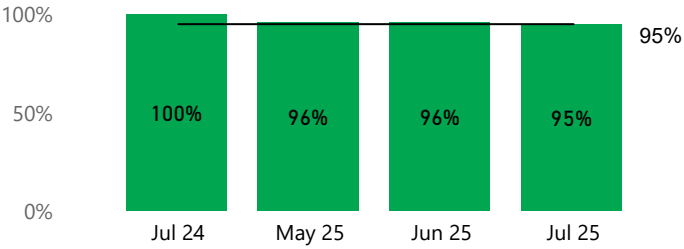
Turnaround Compliance (45 business days)



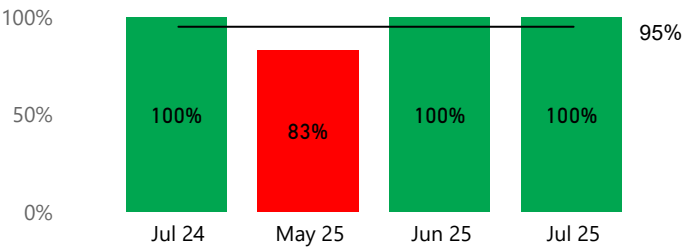
Compliance

Member Grievances

Standard (30 calendar days)

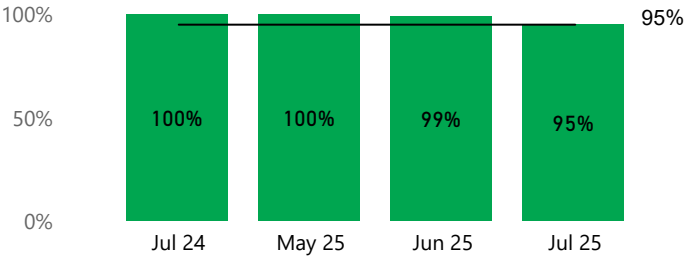


Expedited (3 calendar days)

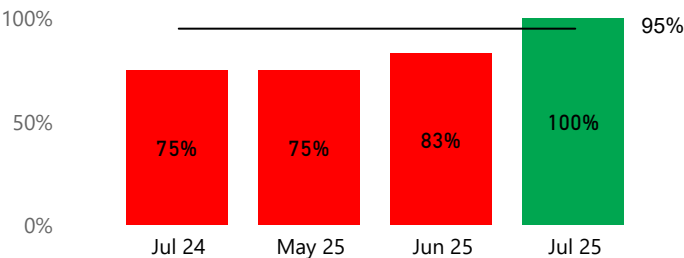


Member Appeals

Standard (30 calendar days)

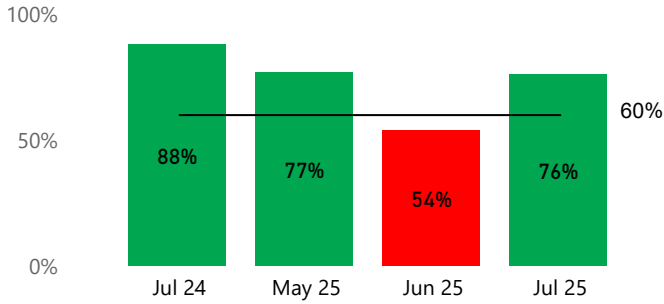


Expedited (3 calendar days)

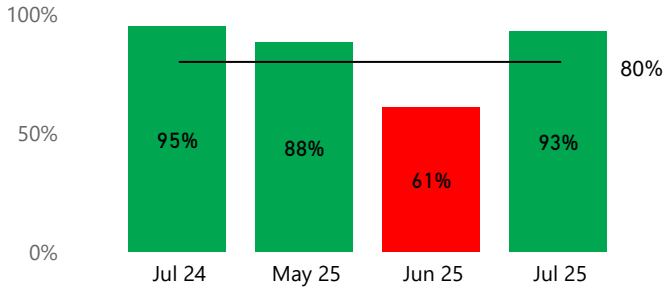


Encounter Data

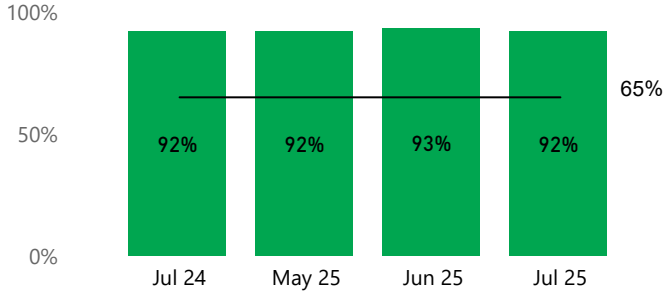
Institutional 0-90 days



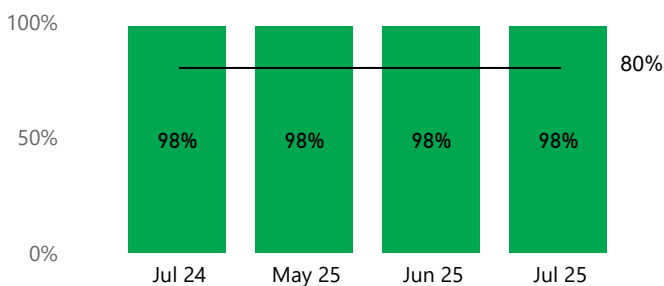
Institutional 0-180 days



Professional 0-90 days



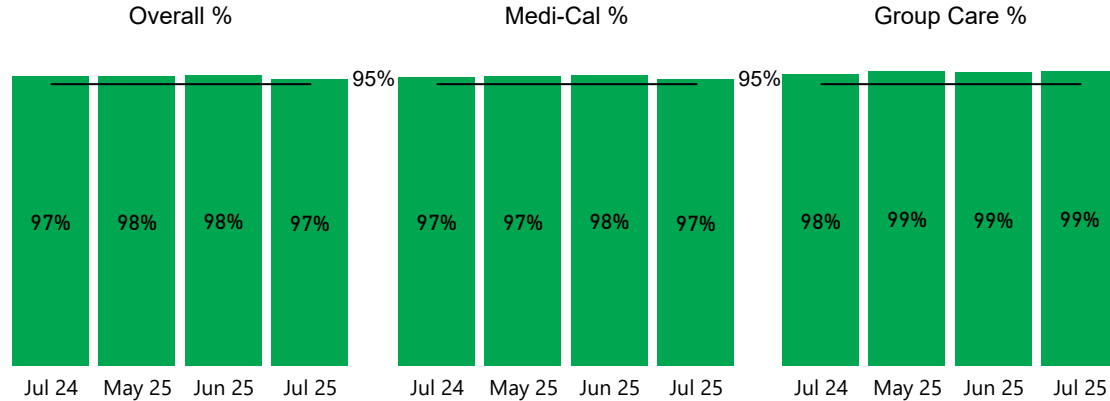
Professional 0-180 days



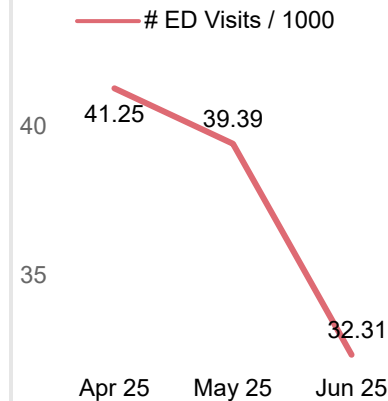
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Health Care Services

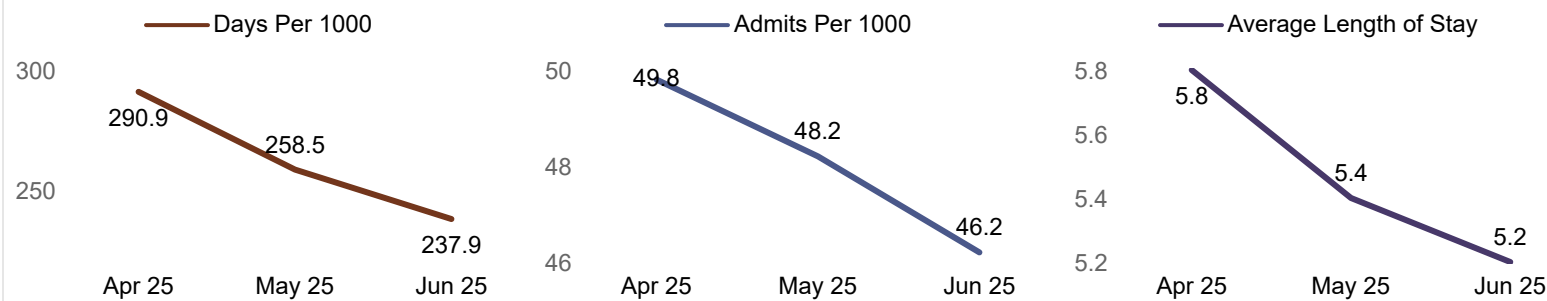
Authorization Turnaround



ED Utilization



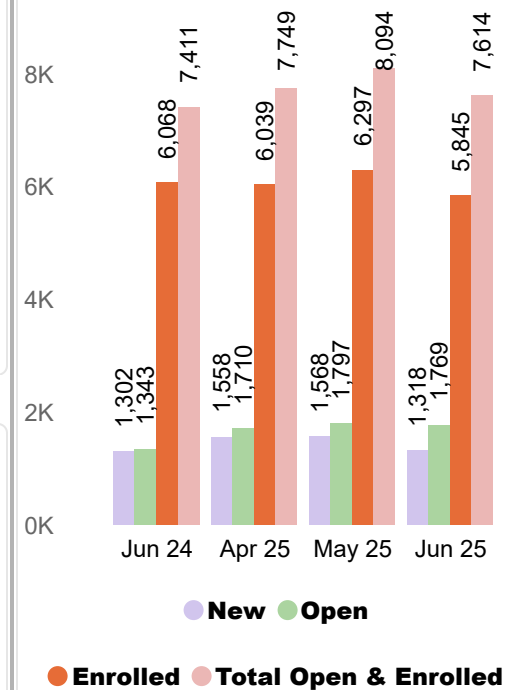
Inpatient Utilization



Case Management

Total Cases^

^ ECM Metrics since 2022

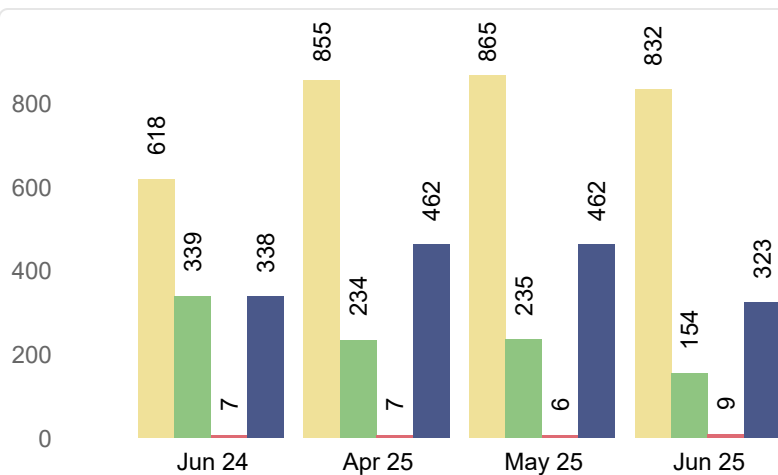


Case Management^

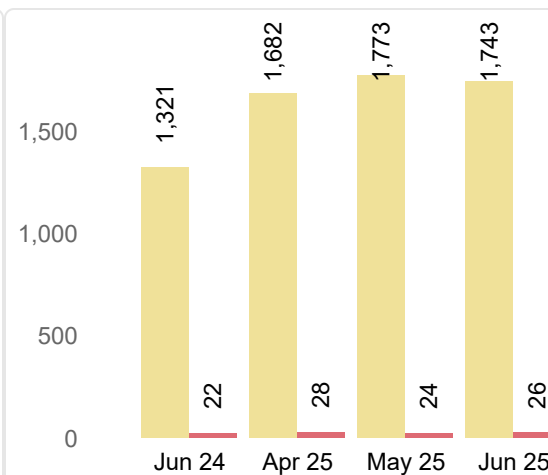
● Care Coordination ● Community Supports ● Complex Cases ● Enhanced Case Management

^ ECM Metrics since 2022

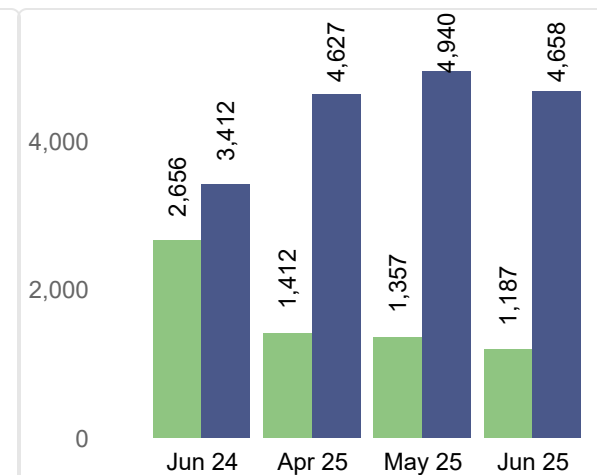
New Cases



Open Cases



Enrolled Cases



Technology (Business Availability)

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

Outpatient Authorization Denial Rates *

OP Authorization Denial Rates	Jul 24	May 25	Jun 25	Jul 25
Denial Rate Excluding Partial Denials (%)	3.3%	4.7%	4.7%	3.7%
Overall Denial Rate (%)	3.5%	5.1%	5.2%	4.1%
Partial Denial Rate (%)	0.2%	0.4%	0.5%	0.4%

* IHSS and Medi-Cal Line Of Business

Pharmacy Authorizations

Authorizations ▲	Jul 24	May 25	Jun 25	Jul 25
Approved Prior Authorizations	43	41	37	43
Closed Prior Authorizations	89	23	17	9
Denied Prior Authorizations	51	97	78	90
Total Prior Authorizations	183	161	132	142



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

Finance

Gil Riojas

To: Alameda Alliance for Health, Board of Governors

From: Gil Riojas, Chief Financial Officer

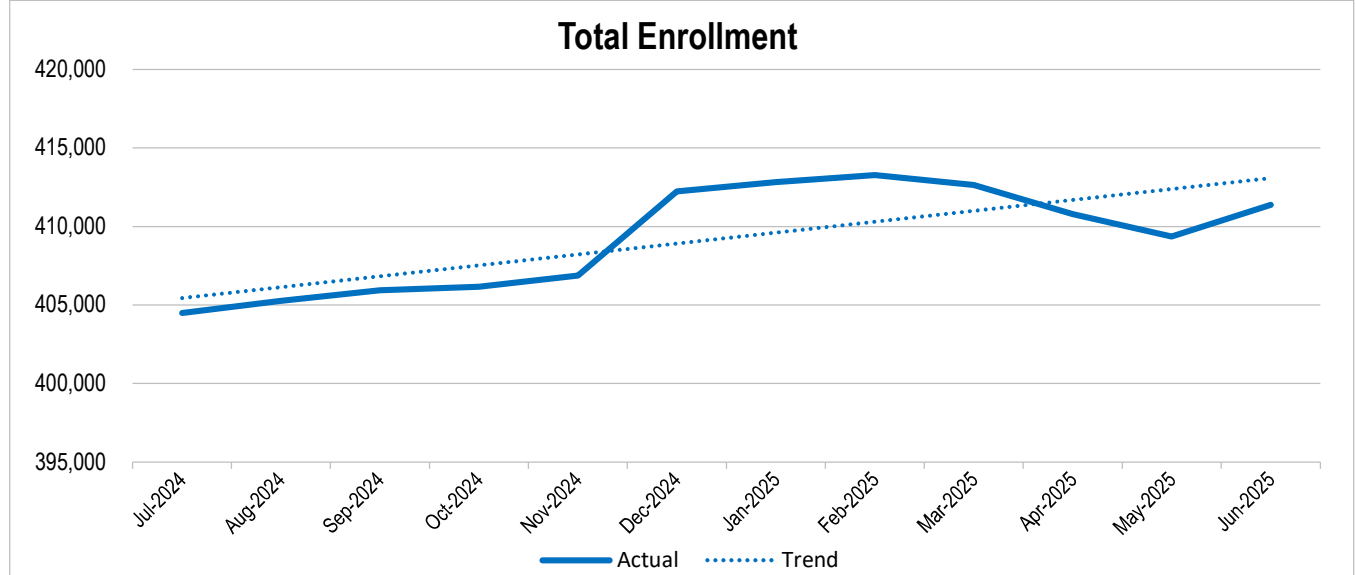
Date: August 8, 2025

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

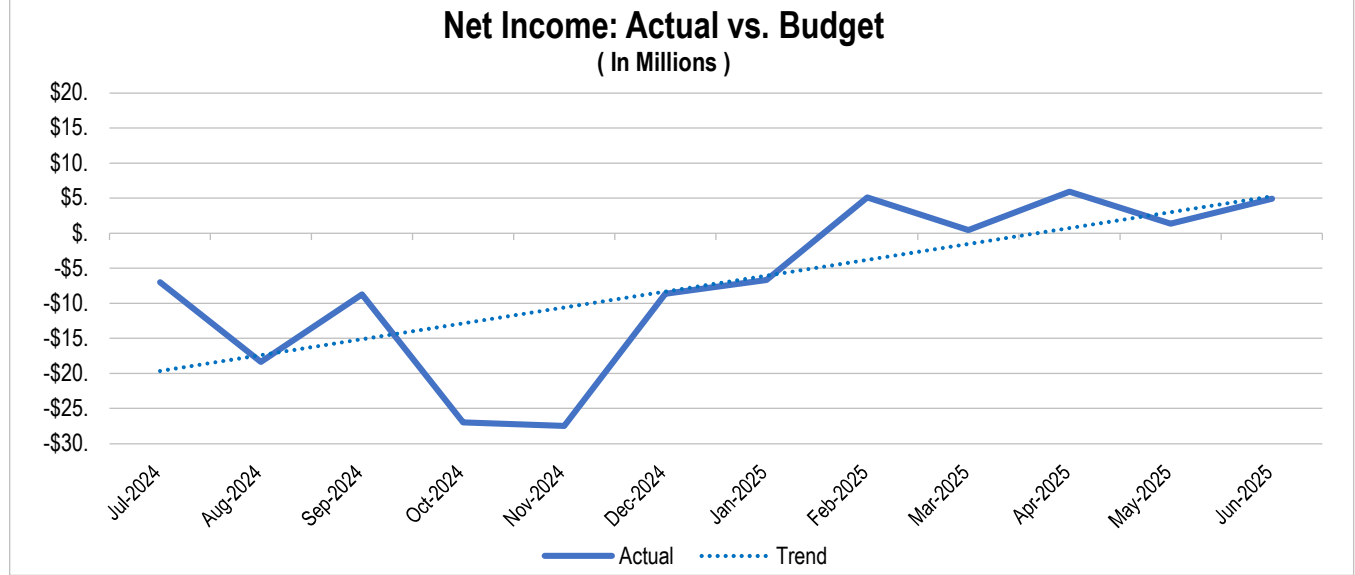
Executive Summary

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

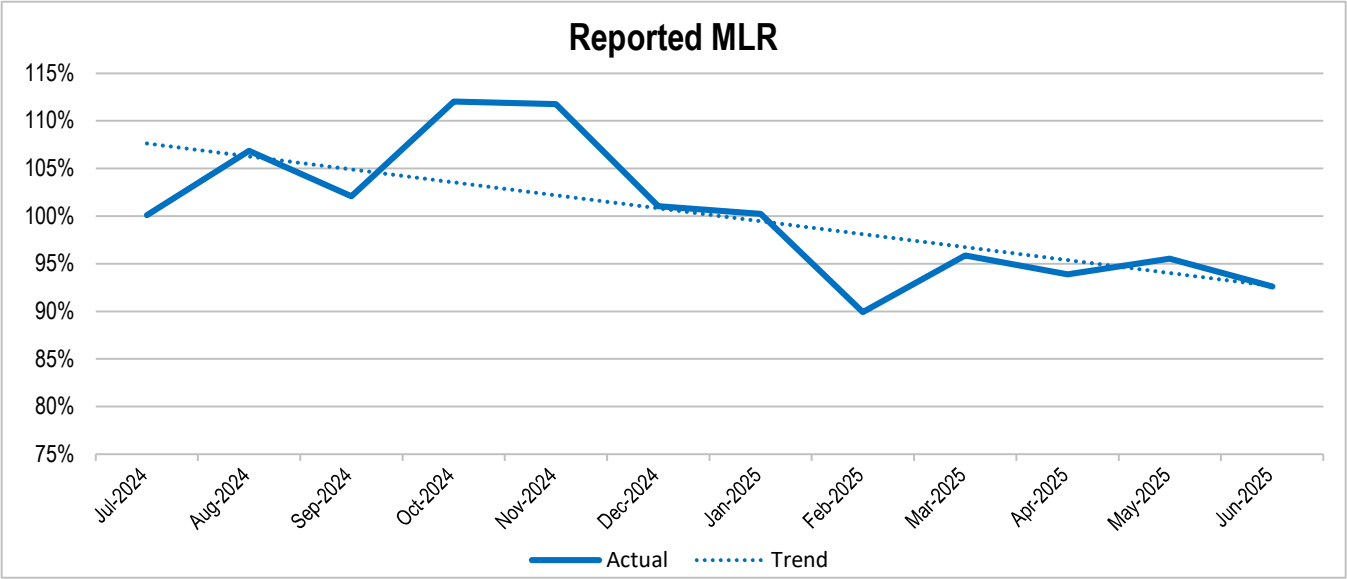
Enrollment – In June, Enrollment increased by 2,025 members.



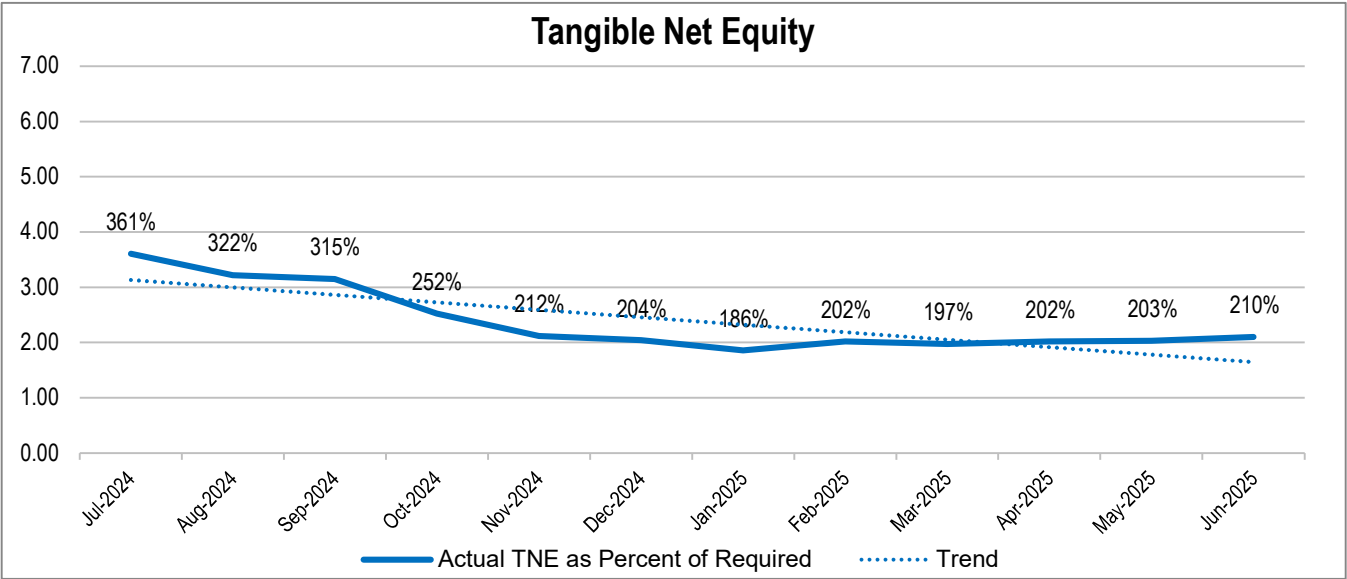
Net Income – For the month ended June, actual Net Income was \$4.9 million vs. budgeted Net Income of \$2.7 million. For the fiscal YTD, actual Net Loss was \$86.1 million vs. budgeted Net Loss of \$65.3 million. For the month, Premium Revenue was favorable to budget, actual Revenue was \$189.2 million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



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



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



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

To: Alameda Alliance for Health Board of Governors

From: Gil Riojas, Chief Financial Officer

Date: August 8th, 2025

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

Executive Summary

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

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

Net Income by Program: (in Thousands)		
	Month	YTD
Medi-Cal	\$6,556	(\$76,592)
Group Care	(235)	(273)
Medicare	(1,409)	(9,231)
	\$4,912	(\$86,096)

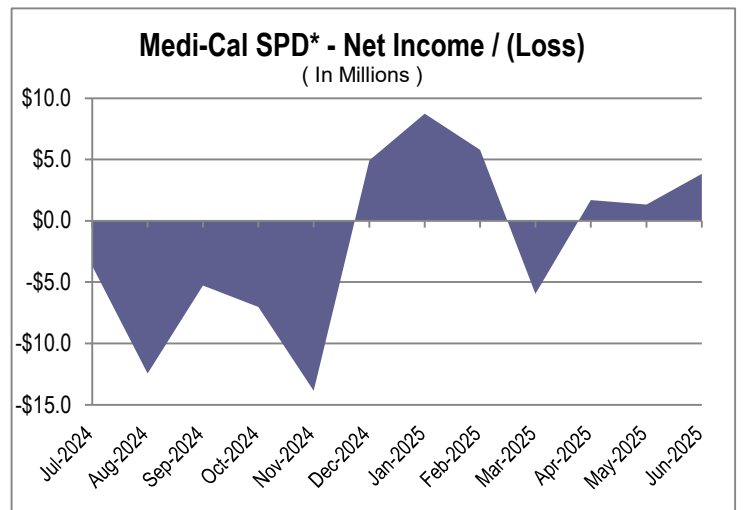
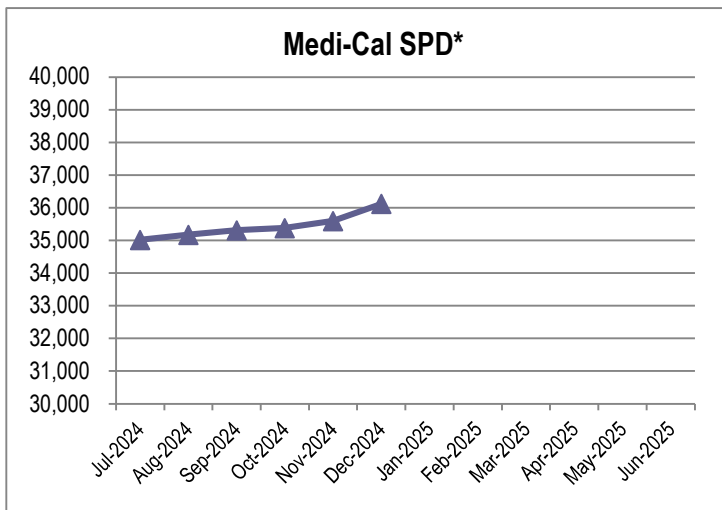
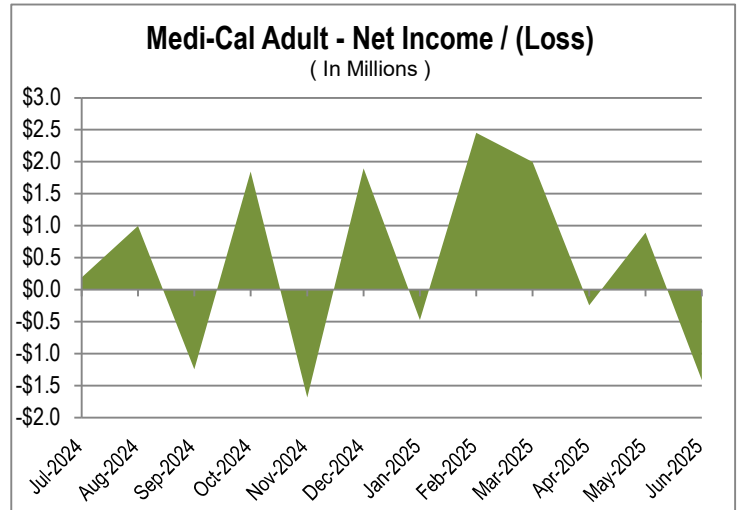
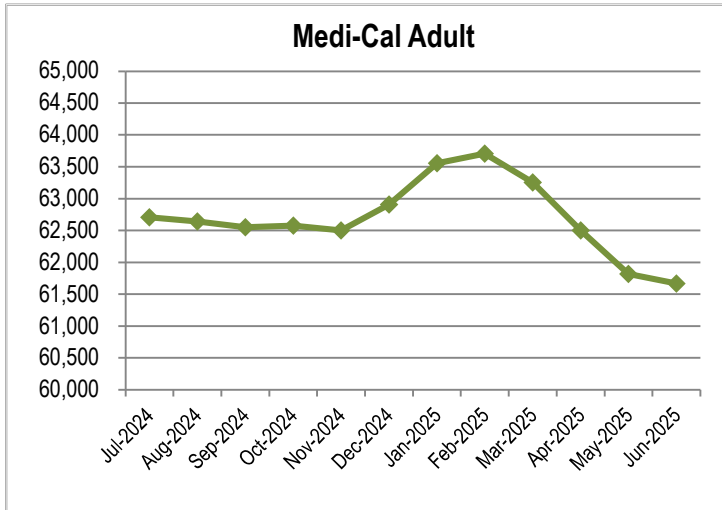
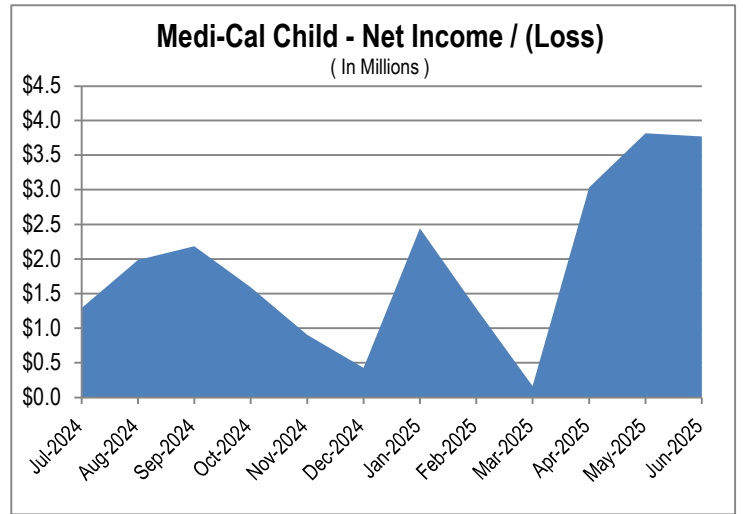
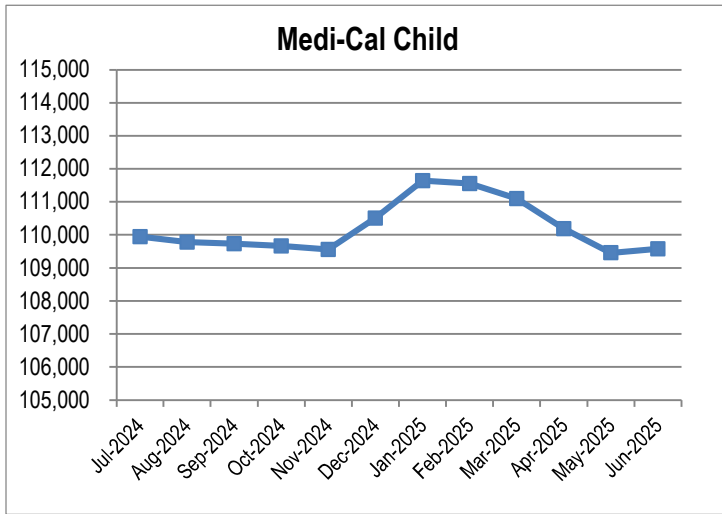
Enrollment

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

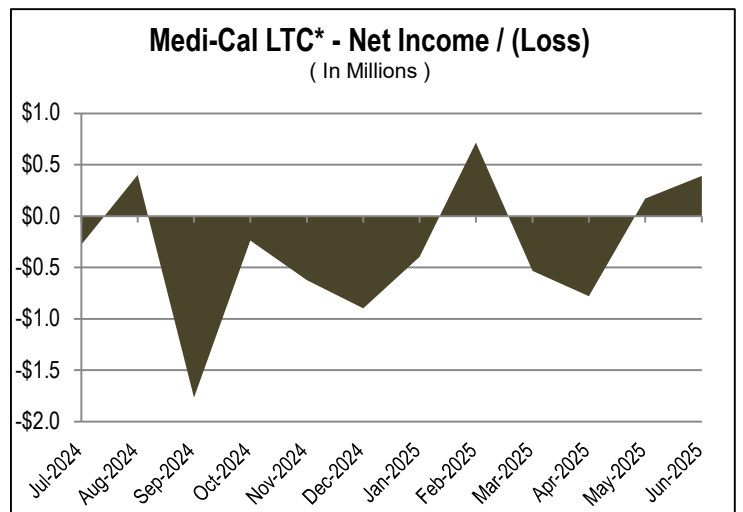
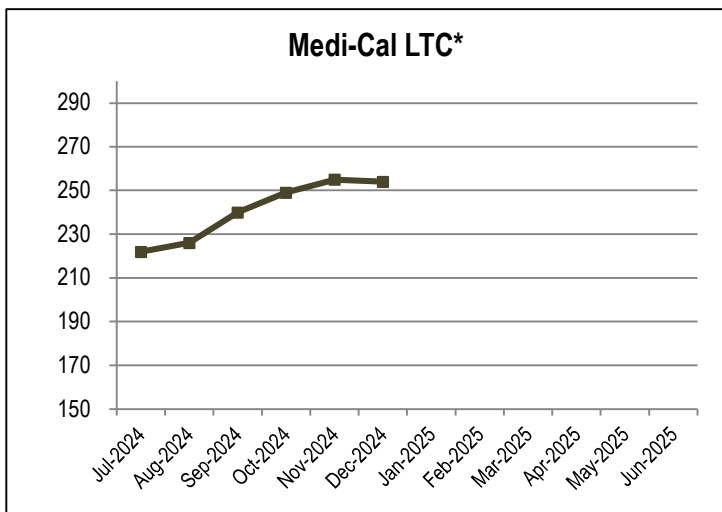
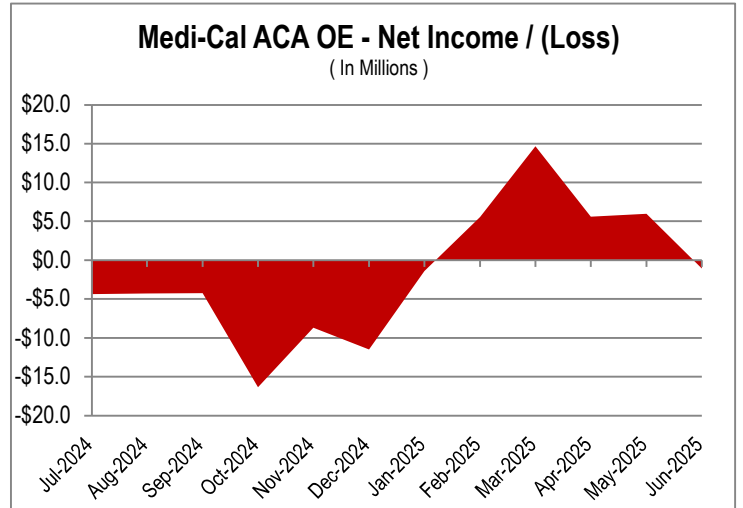
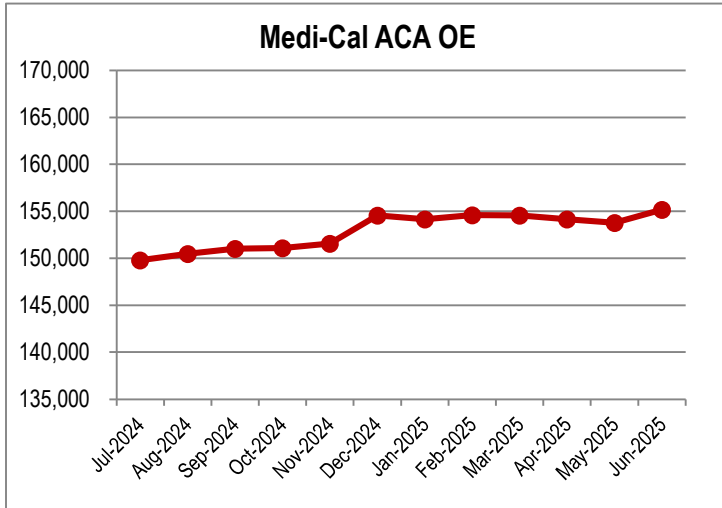
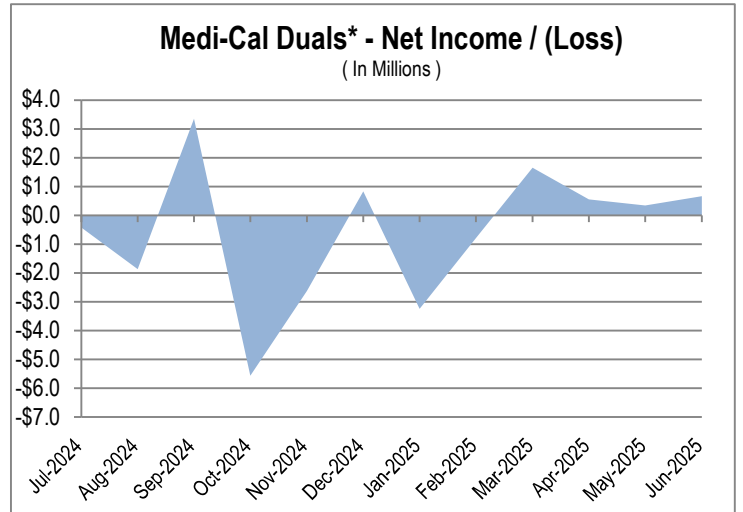
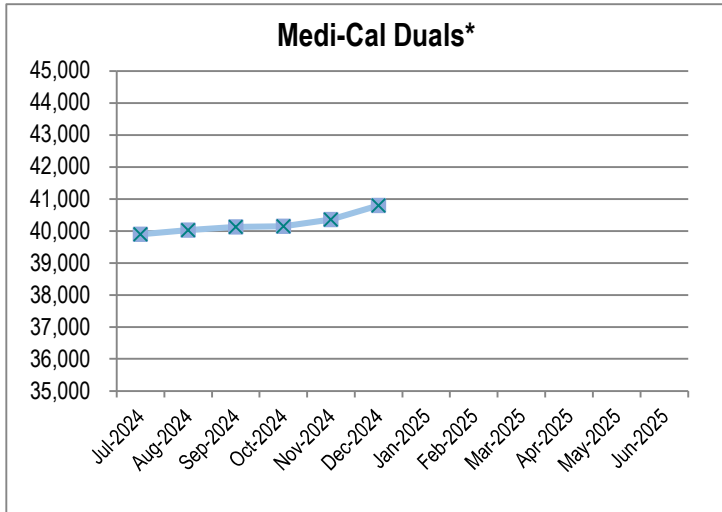
Monthly Membership and YTD Member Months								
Actual vs. Budget								
Enrollment				Medi-Cal:	Member Months			
Current Month					Year-to-Date			
Actual	Budget	Variance	Variance %		Actual	Budget	Variance	Variance %
109,574	110,653	(1,079)	(1.0%)		Child	1,322,714	1,321,045	1,669
61,669	63,082	(1,413)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

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

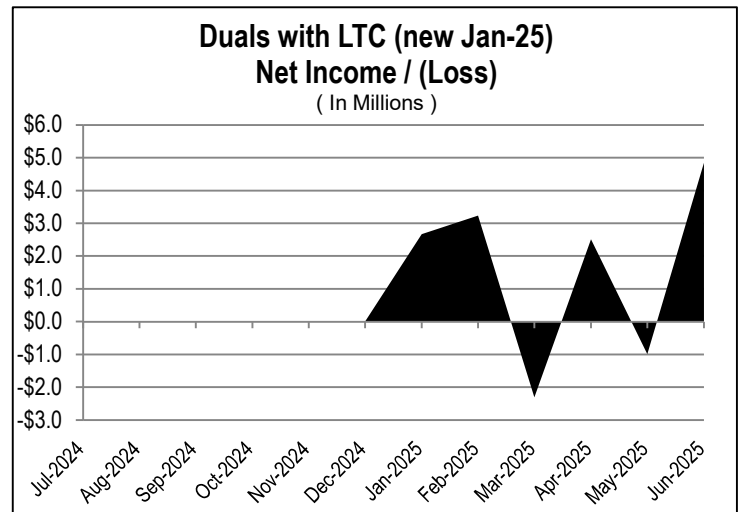
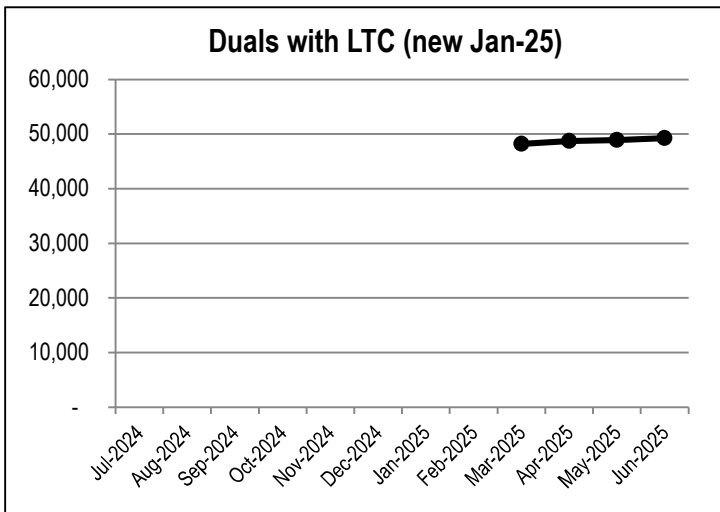
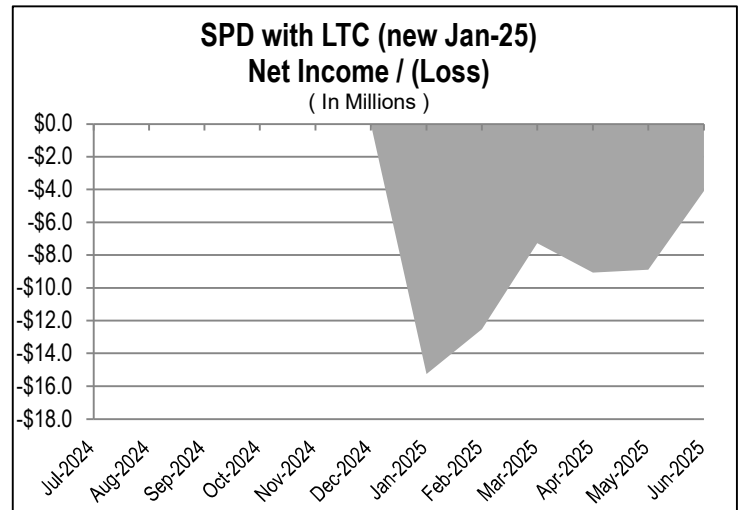
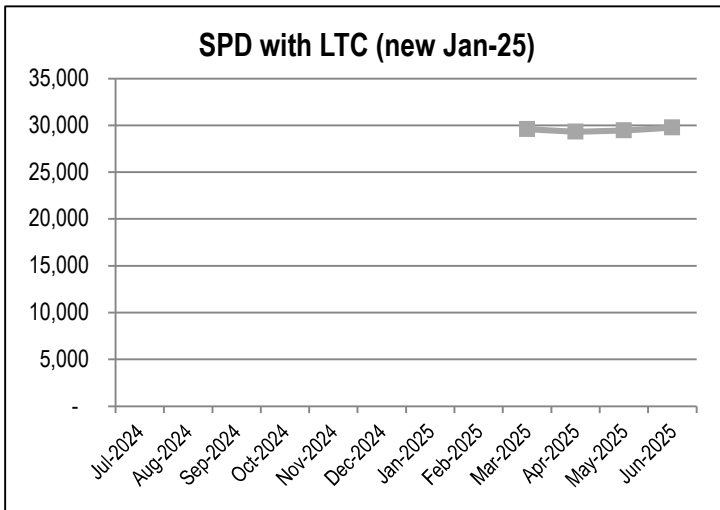
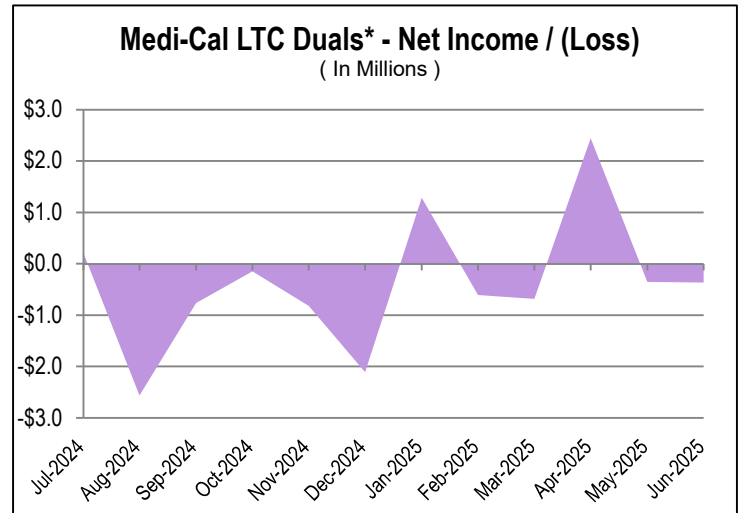
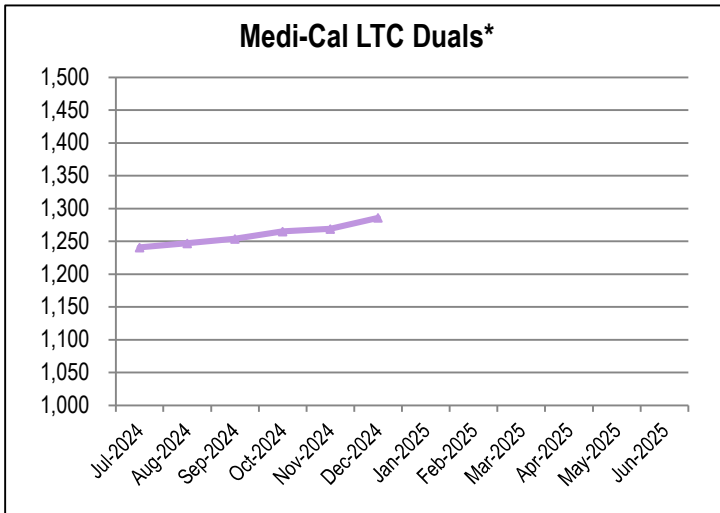
Enrollment and Profitability by Program and Category of Aid



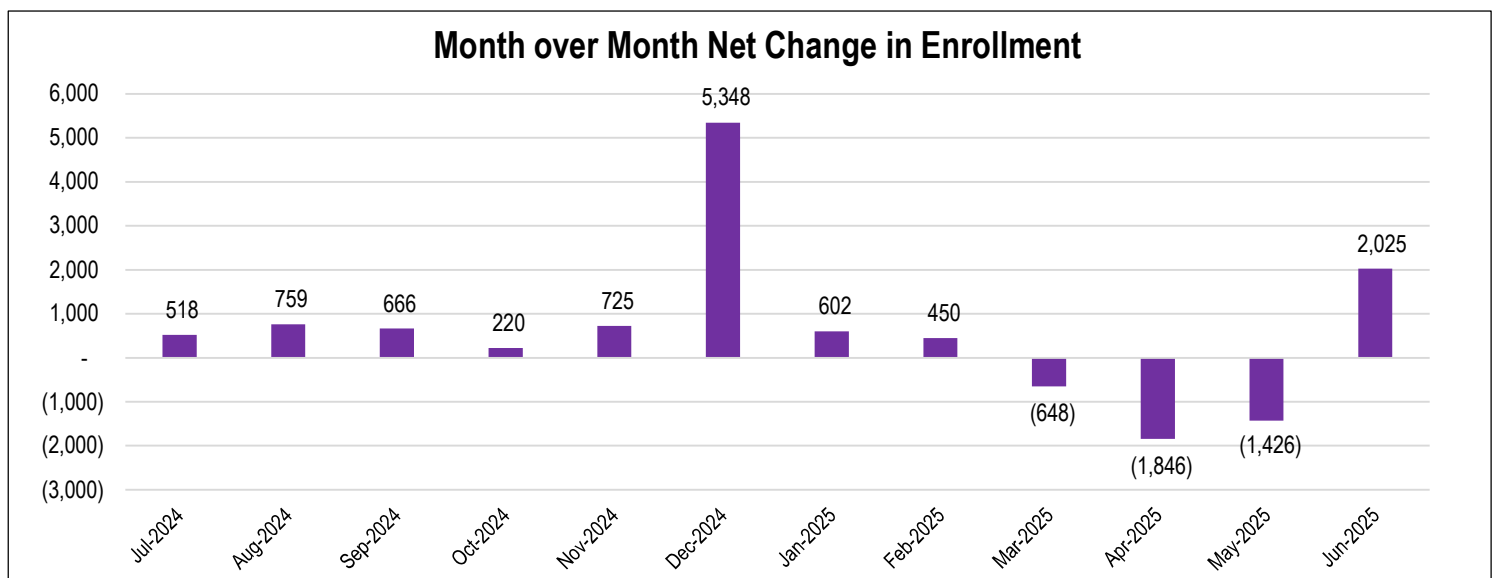
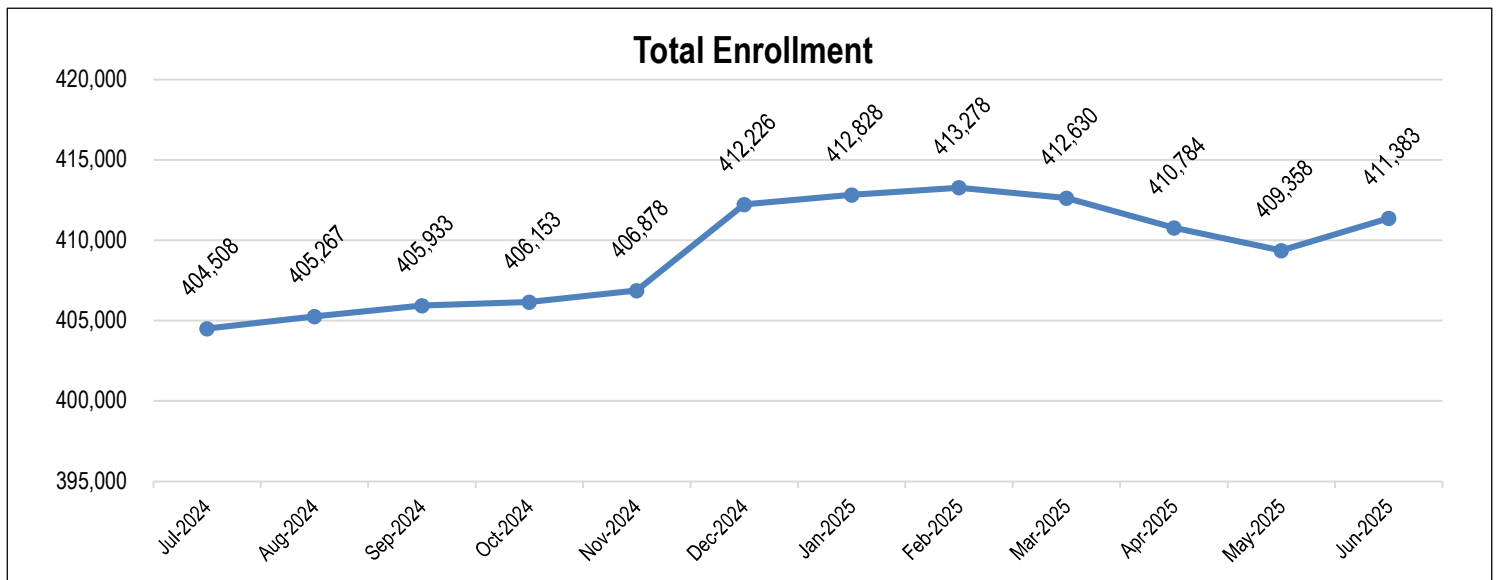
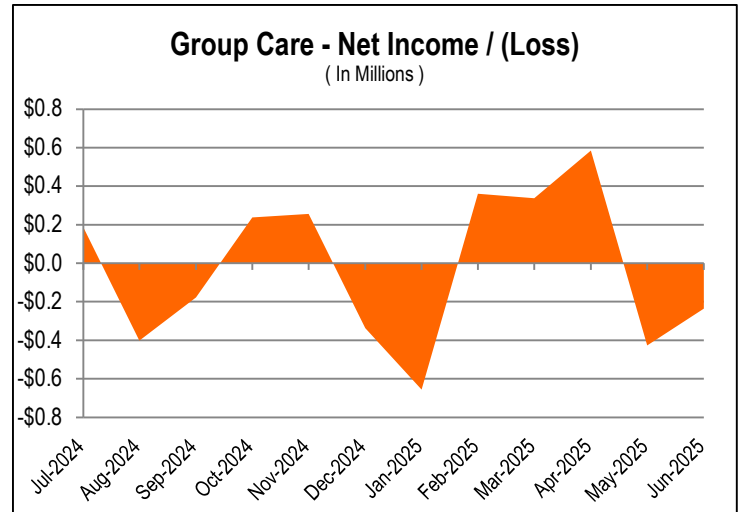
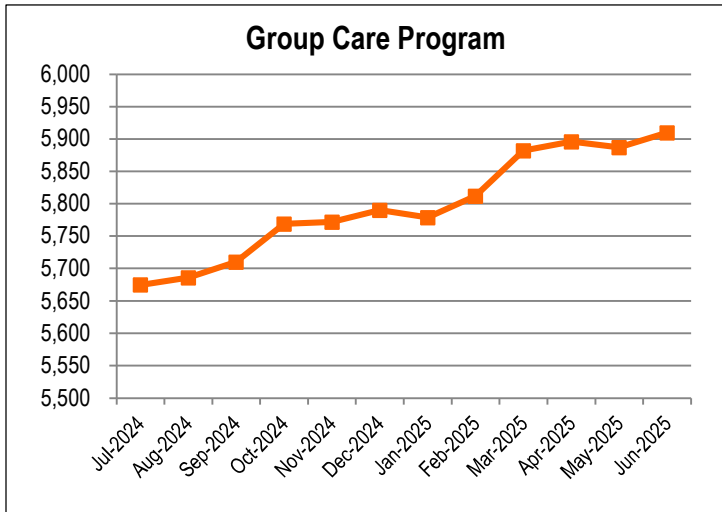
Enrollment and Profitability by Program and Category of Aid



Enrollment and Profitability by Program and Category of Aid

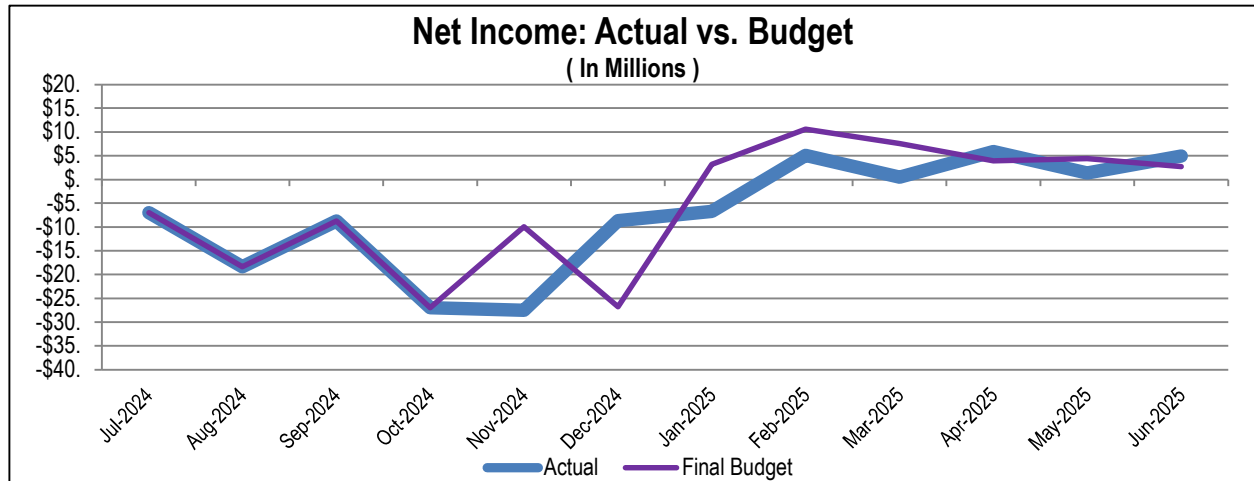


Enrollment and Profitability by Program and Category of Aid



Net Income

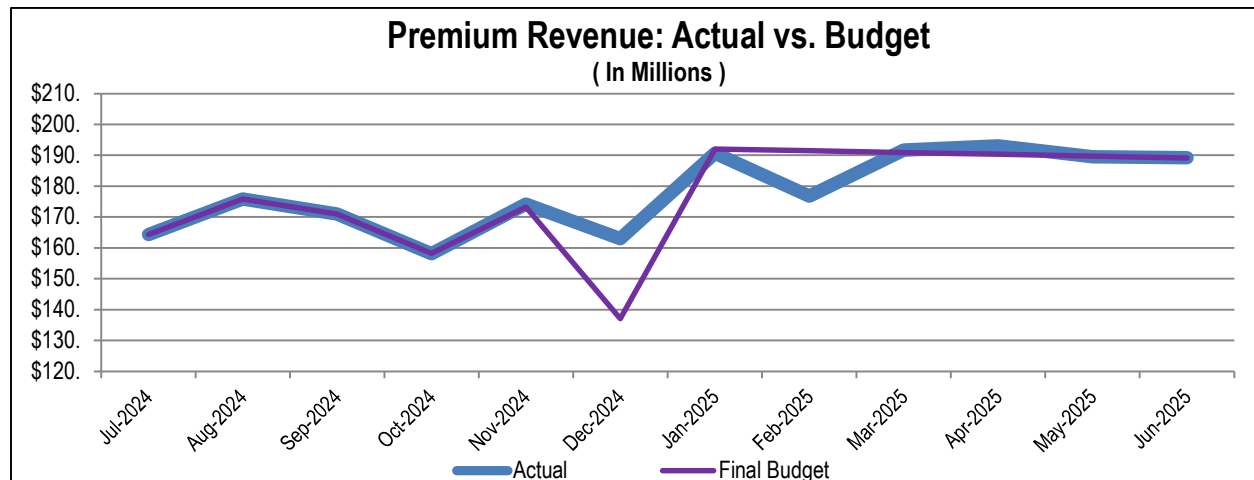
- For the month ended June 30th, 2025:
 - Actual Net Income: \$4.9 million.
 - Budgeted Net Income: \$2.7 million.
- For the fiscal YTD ended June 30th, 2025:
 - Actual Net Loss: \$86.1 million.
 - Budgeted Net Loss: \$65.3 million.



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

Premium Revenue

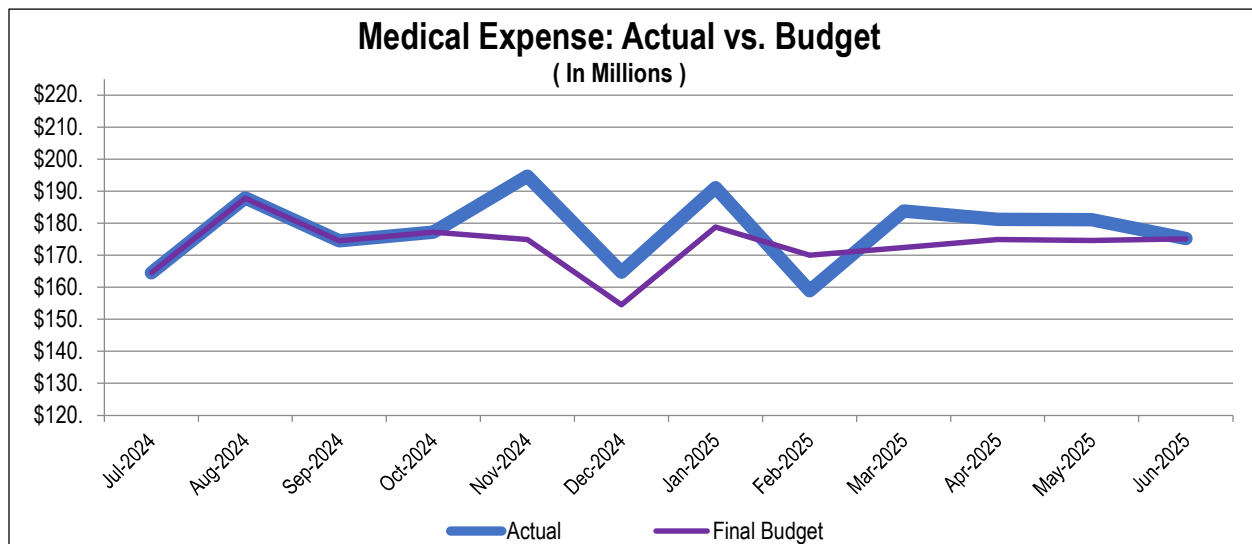
- For the month ended June 30th, 2025:
 - Actual Revenue: \$189.2 million.
 - Budgeted Revenue: \$189.1 million.
- For the fiscal YTD ended June 30th, 2025:
 - Actual Revenue: \$2.1 billion.
 - Budgeted Revenue: \$2.1 billion.



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

Medical Expense

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



- Reported financial results include medical expense, which contains estimates for Incurred-But-Not-Paid (IBNP) claims. Calculation of monthly IBNP is based on historical trends and claims payment. The Alliance's IBNP reserves are reviewed by actuarial consultants.
- For June, updates to Fee-For-Service (FFS) decreased the estimate for prior period unpaid Medical Expenses by \$5.2 million. Year to date, the estimate for prior years increased by \$12.2 million (per table below).

Medical Expense - Actual vs. Budget (In Dollars)						
Adjusted to Eliminate the Impact of Prior Period IBNP Estimates						
	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	<u>Adjusted</u>	<u>Change in IBNP</u>	<u>Reported</u>		<u>\$</u>	<u>%</u>
Capitated Medical Expense	\$213,141,247	\$0	\$213,141,247	\$200,581,538	(\$12,559,708)	(6.3%)
Primary Care FFS	\$34,822,717	\$164,799	\$34,987,516	\$45,652,180	\$10,829,462	23.7%
Specialty Care FFS	\$98,087,291	\$489,779	\$98,577,070	\$99,066,587	\$979,296	1.0%
Outpatient FFS	\$149,478,123	\$1,000,308	\$150,478,431	\$141,845,015	(\$7,633,108)	(5.4%)
Ancillary FFS	\$221,506,899	(\$293,764)	\$221,213,134	\$217,757,585	(\$3,749,314)	(1.7%)
Pharmacy FFS	\$152,536,943	\$345,527	\$152,882,471	\$152,893,100	\$356,157	0.2%
ER Services FFS	\$125,602,946	\$651,895	\$126,254,841	\$125,666,221	\$63,275	0.1%
Inpatient Hospital FFS	\$661,107,563	\$6,286,340	\$667,393,903	\$628,142,064	(\$32,965,499)	(5.2%)
Long Term Care & SNF FFS	\$411,005,870	\$3,548,288	\$414,554,158	\$401,279,568	(\$9,726,301)	(2.4%)
Other Benefits & Services	\$57,191,500	\$0	\$57,191,500	\$59,675,048	\$2,483,548	4.2%
Net Reinsurance	(\$1,885,647)	\$0	(\$1,885,647)	\$3,733,553	\$5,619,201	150.5%
	\$2,122,595,451	\$12,193,172	\$2,134,788,623	\$2,079,292,460	(\$43,302,990)	(2.1%)

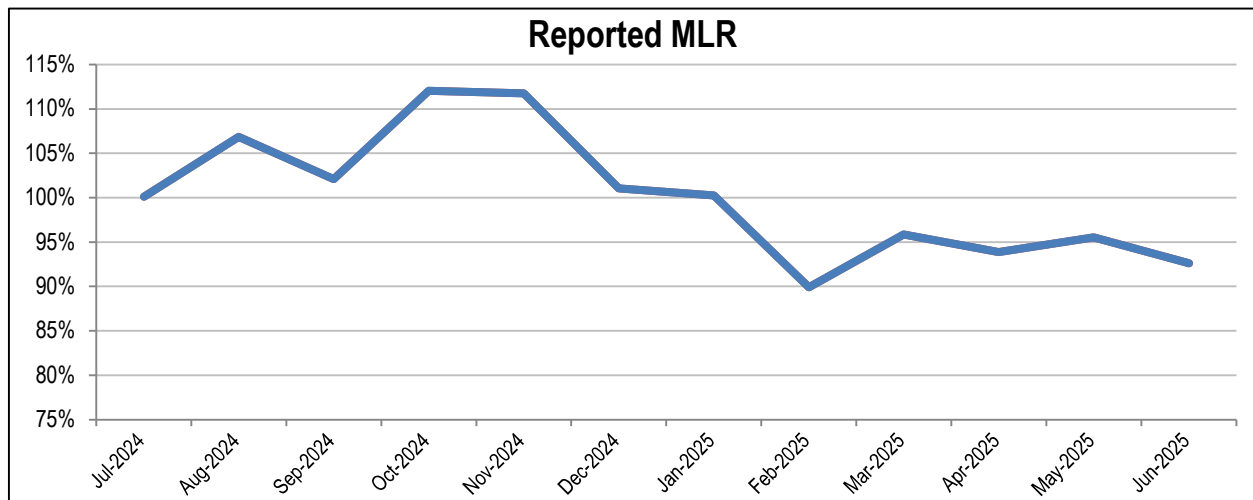
Medical Expense - Actual vs. Budget (Per Member Per Month)						
Adjusted to Eliminate the Impact of Prior Year IBNP Estimates						
	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	<u>Adjusted</u>	<u>Change in IBNP</u>	<u>Reported</u>		<u>\$</u>	<u>%</u>
Capitated Medical Expense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

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

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

Medical Loss Ratio (MLR)

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



Administrative Expense

- For the month ended June 30th, 2025:
 - Actual Administrative Expense: \$11.4 million.
 - Budgeted Administrative Expense: \$9.7 million.
- For the fiscal YTD ended June 30th, 2025:
 - Actual Administrative Expense: \$115.8 million.
 - Budgeted Administrative Expense: \$119.9 million.

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

The year-to-date variances include:

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

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

Other Income / (Expense)

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

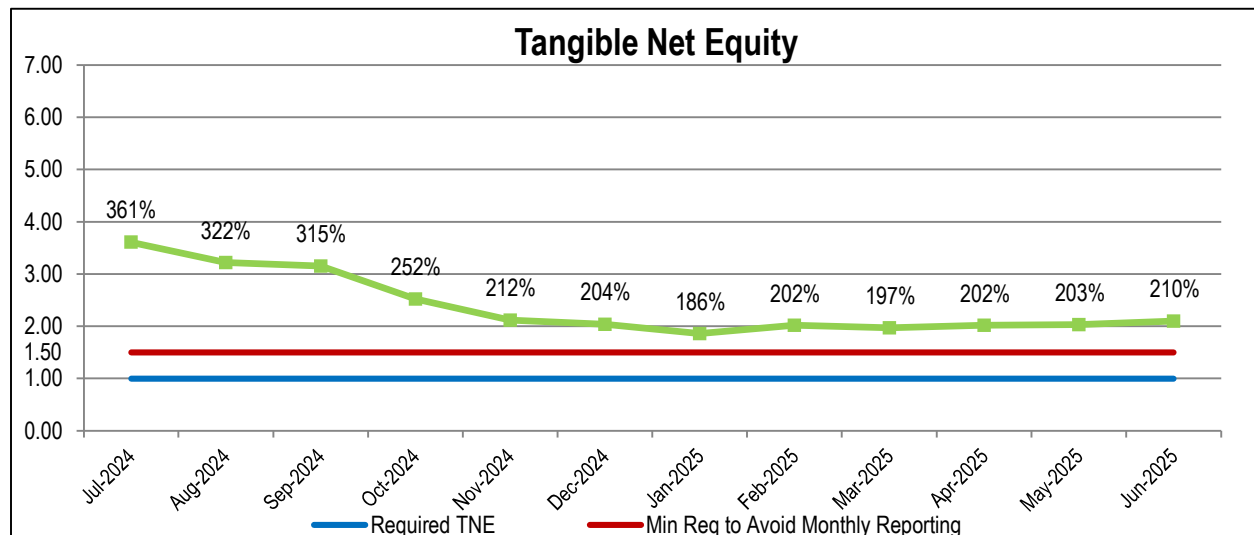
Managed Care Organization (MCO) Provider Tax

- Revenue:
 - For the month ended June 30th, 2025:
 - Actual: \$66.9 million.
 - Budgeted: \$64.0 million.
 - For the fiscal YTD ended June 30th, 2025:
 - Actual: \$877.5 million.
 - Budgeted: \$862.2 million.
- Expense:
 - For the month ended June 30th, 2025:
 - Actual: \$66.9 million.
 - Budgeted: \$67.0 million.
 - For the fiscal YTD ended June 30th, 2025:
 - Actual: \$882.5 million.
 - Budgeted: \$877.2 million.

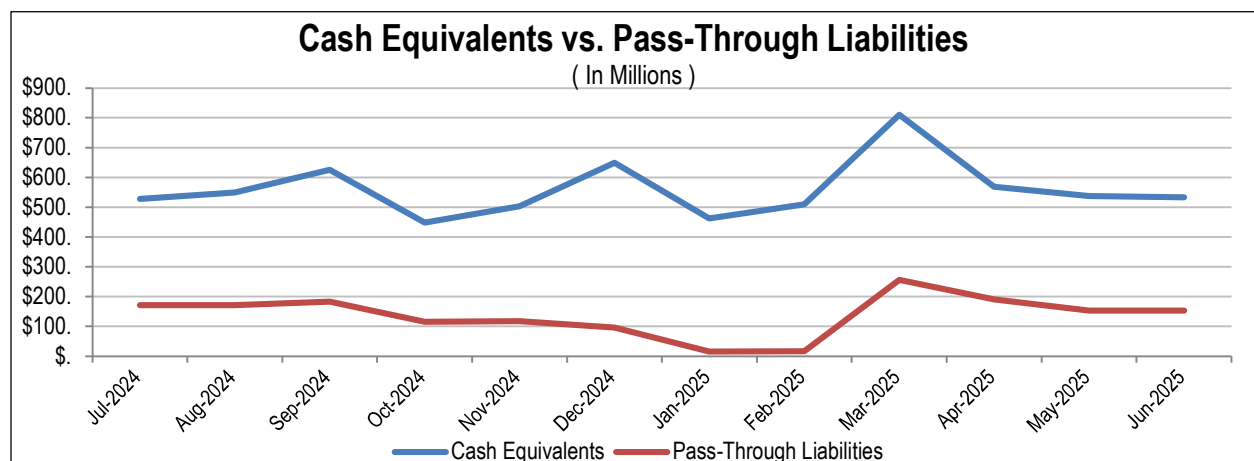
Tangible Net Equity (TNE)

- The Department of Managed Health Care (DMHC) monitors the financial stability of health plans to ensure that they can meet their financial obligations to providers. TNE is a calculation of a company's total tangible assets minus total liabilities divided by a percentage of fee-for-service medical expenses. The Alliance exceeds DMHC's required TNE.

- Required TNE \$80.7 million
- Actual TNE \$169.3 million
- Excess TNE \$88.6 million
- TNE % of Required TNE 210%



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



Capital Investment

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

Caveats to Financial Statements

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

Finance

Supporting Documents

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

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

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

	6/30/2025	5/31/2025	Difference	% Difference
CURRENT ASSETS				
Cash and Cash Equivalent				
Cash	\$23,866,602	\$34,937,836	(\$11,071,234)	(31.7%)
CNB Short-Term Investment	509,149,570	502,988,601	6,160,969	1.2%
Interest Receivable	3,586,958	2,735,862	851,096	31.1%
Premium Receivables	498,272,672	427,767,025	70,505,646	16.5%
Reinsurance Recovery Receivable	9,085,369	8,332,832	752,537	9.0%
Other Receivables	1,095,756	1,207,426	(111,670)	(9.2%)
Prepaid Expenses	717,811	752,970	(35,159)	(4.7%)
TOTAL CURRENT ASSETS	1,045,774,738	978,722,551	67,052,186	6.9%
OTHER ASSETS				
CNB Long-Term Investment	39,155,365	39,019,975	135,390	0.3%
CalPERS Net Pension Asset	(6,465,233)	(6,144,132)	(321,101)	5.2%
Deferred Outflow	15,271,214	14,319,532	951,681	6.6%
Restricted Asset-Bank Note	353,866	352,863	1,003	0.3%
GASB 87-Lease Assets (Net)	78,600	81,875	(3,275)	(4.0%)
GASB 96-SBITA Assets (Net)	3,531,090	3,803,493	(272,404)	(7.2%)
TOTAL OTHER ASSETS	51,924,901	51,433,607	491,294	1.0%
PROPERTY AND EQUIPMENT				
Land, Building & Improvements	9,842,648	9,842,648	0	0.0%
Furniture And Equipment	13,400,309	13,400,309	0	0.0%
Leasehold Improvement	902,447	902,447	0	0.0%
Internally Developed Software	14,824,002	14,824,002	0	0.0%
Fixed Assets at Cost	38,969,405	38,969,405	0	0.0%
Less: Accumulated Depreciation	(33,392,594)	(33,330,742)	(61,851)	0.2%
PROPERTY AND EQUIPMENT (NET)	5,576,811	5,638,663	(61,851)	(1.1%)
TOTAL ASSETS	1,103,276,450	1,035,794,821	67,481,629	6.5%
CURRENT LIABILITIES				
Trade Accounts Payable	11,516,923	10,566,156	950,767	9.0%
Incurred But Not Reported Claims	412,117,295	403,573,402	8,543,893	2.1%
Other Medical Liabilities	117,997,376	132,691,974	(14,694,598)	(11.1%)
Pass-Through Liabilities	152,405,332	152,356,058	49,274	0.0%
MCO Tax Liabilities	225,818,403	158,973,556	66,844,847	42.0%
GASB 87 and 96 ST Liabilities	1,147,713	1,326,682	(178,969)	(13.5%)
Payroll Liabilities	9,363,915	8,168,474	1,195,441	14.6%
TOTAL CURRENT LIABILITIES	930,366,958	867,656,302	62,710,656	7.2%
LONG TERM LIABILITIES				
GASB 87 and 96 LT Liabilities	389,826	443,848	(54,022)	(12.2%)
Deferred Inflow	3,240,306	3,327,530	(87,224)	(2.6%)
TOTAL LONG TERM LIABILITIES	3,630,132	3,771,378	(141,246)	(3.7%)
TOTAL LIABILITIES	933,997,089	871,427,679	62,569,410	7.2%
NET WORTH				
Contributed Capital	840,233	840,233	0	0.0%
Restricted & Unrestricted Funds	254,534,911	254,534,911	0	0.0%
Year-To-Date Net Surplus (Deficit)	(86,095,783)	(91,008,002)	4,912,219	(5.4%)
TOTAL NET WORTH	169,279,361	164,367,141	4,912,219	3.0%
TOTAL LIABILITIES AND NET WORTH	1,103,276,450	1,035,794,821	67,481,629	6.5%
Additional Information				
Cash Equivalents	533,016,172	537,926,437	(4,910,265)	(0.9%)
Pass-Through	152,405,332	152,356,058	49,274	0.0%
Uncommitted Cash	380,610,840	385,570,378	(4,959,539)	(1.3%)
Working Capital	115,407,780	111,066,250	4,341,530	3.9%
Current Ratio	112.4%	112.8%	(0.4%)	(0.4%)

**ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED**

June 30, 2025

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

**ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED**

June 30, 2025

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

**ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED**

June 30, 2025

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

**ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED**

June 30, 2025

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

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE MONTH OF JUNE 2025

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

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

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE FISCAL YEAR TO DATE JUNE 2025

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

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

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

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

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	\$ Variance (Unfavorable)	% Variance (Unfavorable)
3,839,584	4,291,666	452,082	10.5%	Salaries & Wages	45,532,965	46,668,247	1,135,282	2.4%
337,026	415,106	78,080	18.8%	Paid Time Off	4,246,619	4,778,745	532,126	11.1%
825	8,816	7,991	90.6%	Compensated Incentives	28,379	53,964	25,586	47.4%
0	0	0	0.0%	Severance	38,168	400,000	361,832	90.5%
68,662	63,124	(5,538)	(8.8%)	Payroll Taxes	879,657	1,058,876	179,219	16.9%
46,072	25,460	(20,612)	(81.0%)	Overtime	773,023	521,049	(251,974)	(48.4%)
242,898	334,967	92,069	27.5%	CalPERS ER Match	3,868,485	4,071,312	202,827	5.0%
1,094,689	743,171	(351,518)	(47.3%)	Employee Benefits	12,182,808	9,468,946	(2,713,862)	(28.7%)
(681)	0	681	0.0%	Personal Floating Holiday	192,862	202,966	10,104	5.0%
19,118	38,500	19,382	50.3%	Language Pay	253,850	406,009	152,160	37.5%
5,600	0	(5,600)	0.0%	Med Ins Opted Out Stipend	40,850	16,010	(24,840)	(155.2%)
0	0	0	0.0%	Holiday Bonus	(400,000)	0	400,000	1,333,333.4...
445,849	0	(445,849)	0.0%	Sick Leave	1,395,848	270,728	(1,125,119)	(415.6%)
273	30,692	30,418	99.1%	Compensated Employee Relations	9,111	278,139	269,028	96.7%
20,920	27,000	6,080	22.5%	Work from Home Stipend	242,030	289,270	47,240	16.3%
1,673	12,463	10,790	86.6%	Mileage, Parking & Local Travel	16,879	67,286	50,407	74.9%
8,125	22,832	14,707	64.4%	Travel & Lodging	49,632	231,949	182,317	78.6%
8,416	79,965	71,548	89.5%	Temporary Help Services	331,627	1,016,563	684,936	67.4%
17,777	31,555	13,779	43.7%	Staff Development/Training	210,201	515,410	305,209	59.2%
9,438	63,015	53,577	85.0%	Staff Recruitment/Advertisement	144,581	405,384	260,803	64.3%
6,166,263	6,188,330	22,067	0.4%	Personnel Expense	70,037,574	70,720,853	683,279	1.0%
26,127	22,018	(4,109)	(18.7%)	Pharmacy Administrative Fees	309,472	271,276	(38,195)	(14.1%)
53,270	53,191	(79)	(0.1%)	Telemedicine Admin. Fees	635,139	633,905	(1,234)	(0.2%)
79,397	75,209	(4,188)	(5.6%)	Benefits Administration Expense	944,610	905,182	(39,429)	(4.4%)
1,521,864	509,030	(1,012,834)	(199.0%)	Consultant Fees - Non Medical	7,392,691	7,738,269	345,578	4.5%
760,675	406,014	(354,661)	(87.4%)	Computer Support Services	5,643,835	6,257,889	614,053	9.8%
(43,099)	15,000	58,099	387.3%	Audit Fees	209,974	188,158	(21,816)	(11.6%)
(19,393)	8	19,401	232,630.7%	Consultant Fees - Medical	(11,708)	(15,272)	(3,564)	23.3%
589,877	215,081	(374,797)	(174.3%)	Other Purchased Services	3,279,493	3,002,336	(277,157)	(9.2%)
6,876	844	(6,032)	(714.7%)	Maint.&Repair-Office Equipment	15,581	10,128	(5,453)	(53.8%)
0	0	0	0.0%	Maint.&Repair-Computer Hardwar	2,018	0	(2,018)	0.0%
(53,772)	75,067	128,839	171.6%	Legal Fees	1,043,634	896,819	(146,815)	(16.4%)
0	0	0	0.0%	Member Health Education	312	320	8	2.6%
61,723	26,000	(35,723)	(137.4%)	Translation Services	356,990	295,064	(61,926)	(21.0%)
46,393	157,650	111,257	70.6%	Medical Refund Recovery Fees	2,292,835	2,415,871	123,036	5.1%
1,046,887	526,884	(520,002)	(98.7%)	Software - IT Licenses & Subsc	5,015,493	6,427,419	1,411,926	22.0%
64,664	88,584	23,920	27.0%	Hardware (Non-Capital)	364,666	808,960	444,295	54.9%
106,067	55,800	(50,267)	(90.1%)	Provider Credentialing	650,641	620,313	(30,327)	(4.9%)
4,088,763	2,075,962	(2,012,800)	(97.0%)	Purchased & Professional Services	26,256,454	28,646,273	2,389,819	8.3%
61,851	111,710	49,859	44.6%	Depreciation	729,921	1,048,301	318,380	30.4%
0	0	0	0.0%	Lease Building	762,017	783,998	21,982	2.8%
7,764	5,960	(1,804)	(30.3%)	Lease Rented Office Equipment	78,184	84,085	5,901	7.0%
6,715	18,073	11,358	62.8%	Utilities	154,523	249,342	94,819	38.0%
27,758	91,065	63,307	69.5%	Telephone	991,709	1,076,185	84,476	7.8%
60,332	63,584	3,252	5.1%	Building Maintenance	443,173	484,033	40,859	8.4%
272,405	249,136	(23,270)	(9.3%)	GASB96 SBITA Amort. Expense	3,088,990	2,916,865	(172,125)	(5.9%)

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

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

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

	Project ID	Prior YTD Acquisitions	Current Month Acquisitions	Fiscal YTD Acquisitions	Capital Budget Total	\$ Variance Fav/(Unf.)
1. Hardware:						
	Cisco UCS-X M6 or M7 Blades x 6	IT-FY24-04	\$ 265,100	\$ -	\$ 265,100	\$ 265,100 \$ 0
	Cisco Routers	IT-FY25-01	\$ -	\$ -	\$ -	\$ 120,000 \$ 120,000
	Cisco UCS Blades	IT-FY25-04	\$ 264,510	\$ -	\$ 264,510	\$ 873,000 \$ 608,490
	PURE Storage	IT-FY25-06	\$ 266,709	\$ -	\$ 266,709	\$ 150,000 \$ (116,709)
	Exagrid Immutable Storage	IT-FY25-07	\$ -	\$ -	\$ -	\$ 500,000 \$ 500,000
	Network Cabling	IT-FY25-09	\$ 62,598	\$ -	\$ 62,598	\$ 40,000 \$ (22,598)
	Hardware Subtotal		\$ 858,916	\$ -	\$ 858,916	\$ 1,948,100 \$ 1,089,184
2. Software:						
	Zerto renewal and Tier 2 add		\$ -	\$ -	\$ -	\$ -
	Software Subtotal		\$ -	\$ -	\$ -	\$ -
3. Building Improvement:						
	1240 Exterior lighting update	FA-FY25-03	\$ -	\$ -	\$ -	\$ 30,000 \$ 30,000
	Building Improvement Subtotal		\$ -	\$ -	\$ -	\$ 30,000 \$ 30,000
4. Furniture & Equipment:						
	Office desks, cabinets, shelvings (all building/suites: new or replacement)		\$ -	\$ -	\$ -	\$ -
	Replace, reconfigure, re-design workstations		\$ -	\$ -	\$ -	\$ -
	Furniture & Equipment Subtotal		\$ -	\$ -	\$ -	\$ -
5. Leasehold Improvement:						
	ExacqVision NVR Upgrade, Cameras/Video System upgrade		\$ -	\$ -	\$ -	\$ -
	Leasehold Improvement Subtotal		\$ -	\$ -	\$ -	\$ -
6. Contingency:						
			\$ -	\$ -	\$ -	\$ -
	Contingency Subtotal		\$ -	\$ -	\$ -	\$ -
	GRAND TOTAL		\$ 858,916	\$ -	\$ 858,916	\$ 1,978,100 \$ 1,119,184
6. Reconciliation to Balance Sheet:						
	Fixed Assets @ Cost - 6/30/25			\$ 38,969,405		
	Fixed Assets @ Cost - 6/30/24			\$ 38,110,489		
	Fixed Assets Acquired YTD			\$ 858,916		

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

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

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

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

Month Over Month Enrollment Change:

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

Enrollment Percentages:

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

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

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

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

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

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

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

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

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

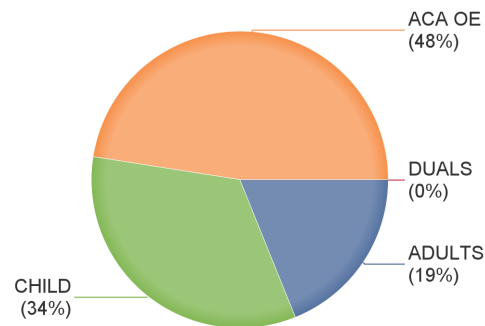
**ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED 30 JUNE, 2025**

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

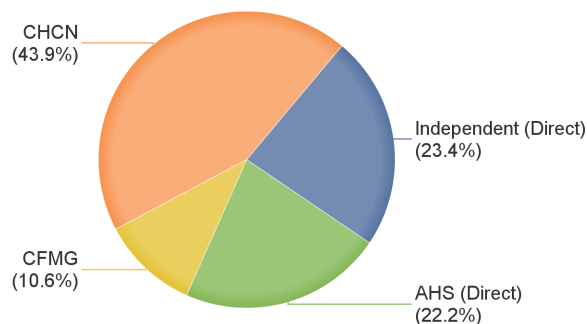
Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

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

Medi-Cal By Aid Category

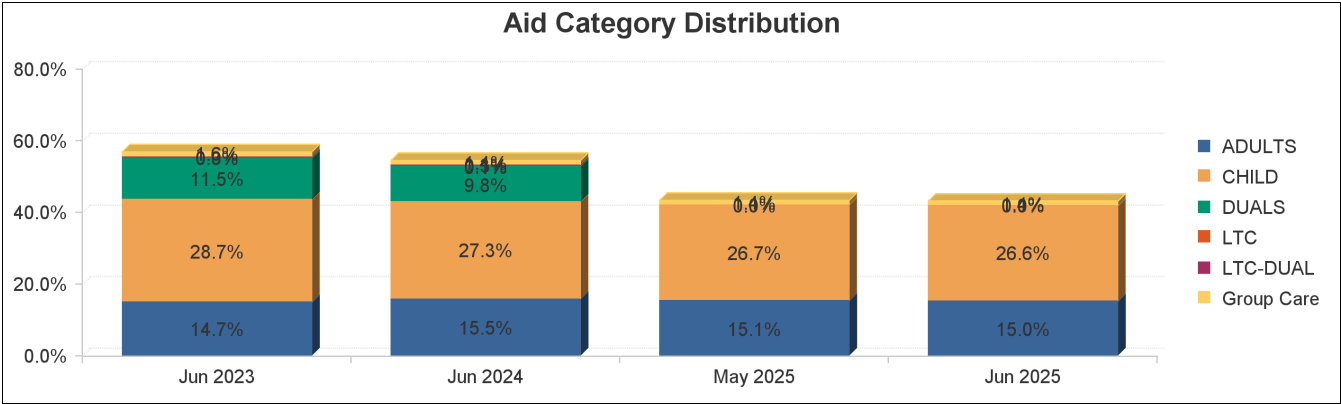


By Network

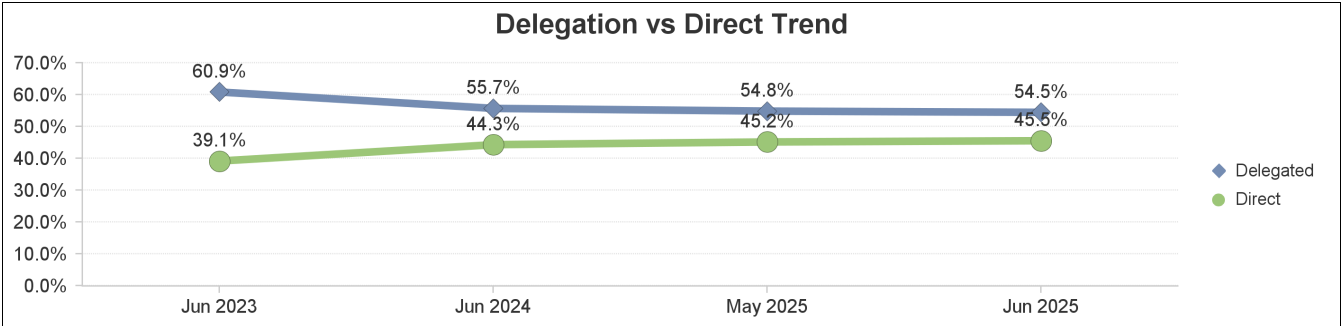


Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

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

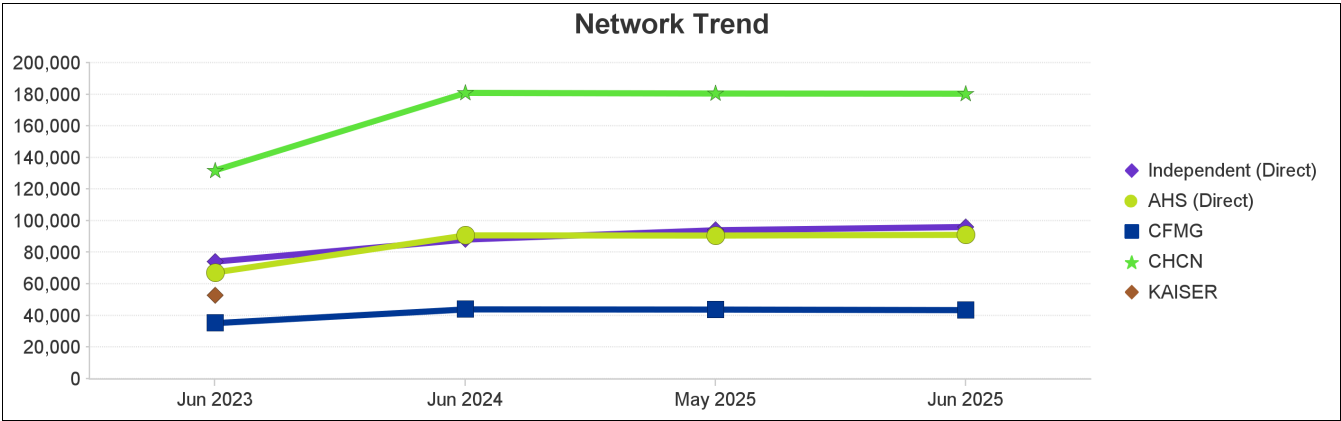


Delegation vs Direct Trend											
Members	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Jun 2023	Jun 2024	May 2025	Jun 2025	Jun 2023	Jun 2024	May 2025	Jun 2025	Jun 2023 to Jun 2024	Jun 2024 to Jun 2025	May 2025 to Jun 2025
Delegated	220,110	225,091	224,566	224,102	60.9%	55.7%	54.8%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



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

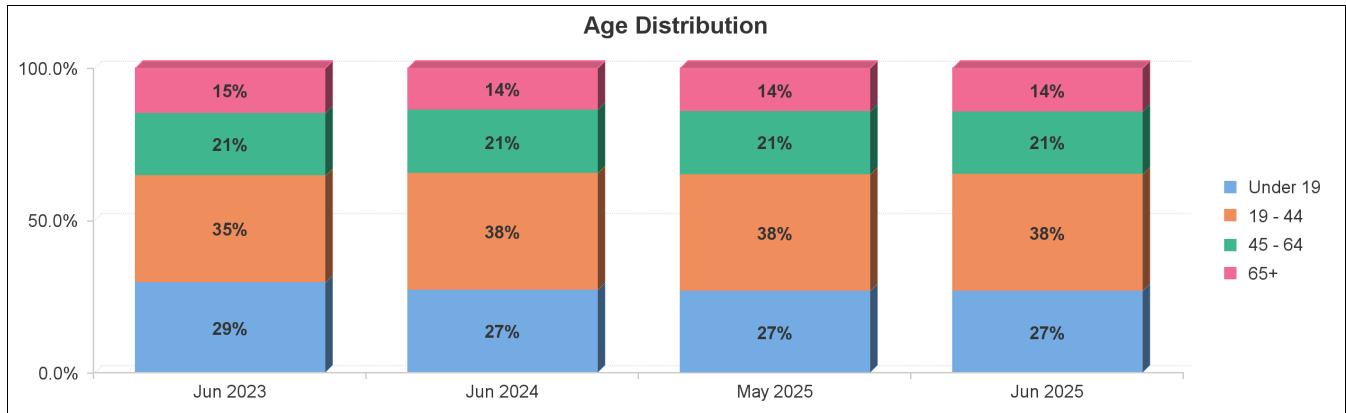
Network Trend											
Network	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Jun 2023	Jun 2024	May 2025	Jun 2025	Jun 2023	Jun 2024	May 2025	Jun 2025	Jun 2023 to Jun 2024	Jun 2024 to Jun 2025	May 2025 to Jun 2025
Independent (Direct)	74,242	88,206	94,112	96,173	20.5%	21.8%	23.0%	23.4%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



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

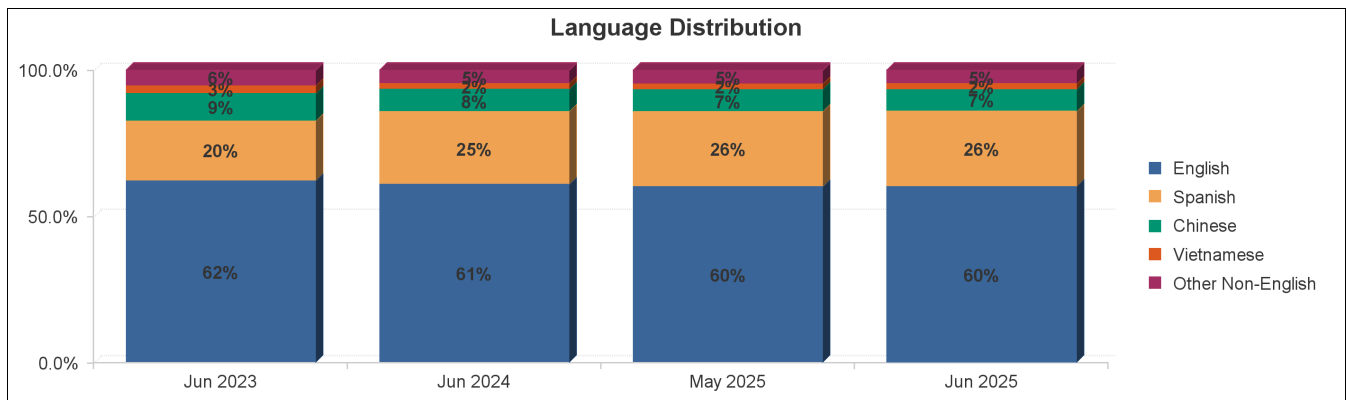
Age Category Trend

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



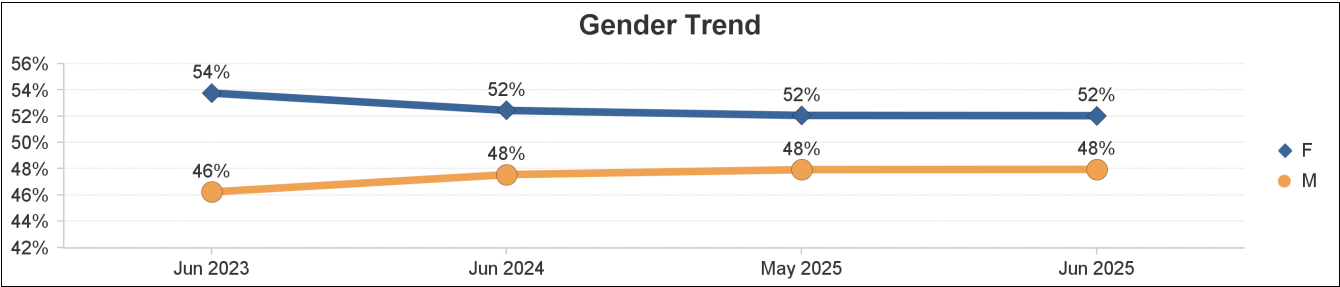
Language Trend

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

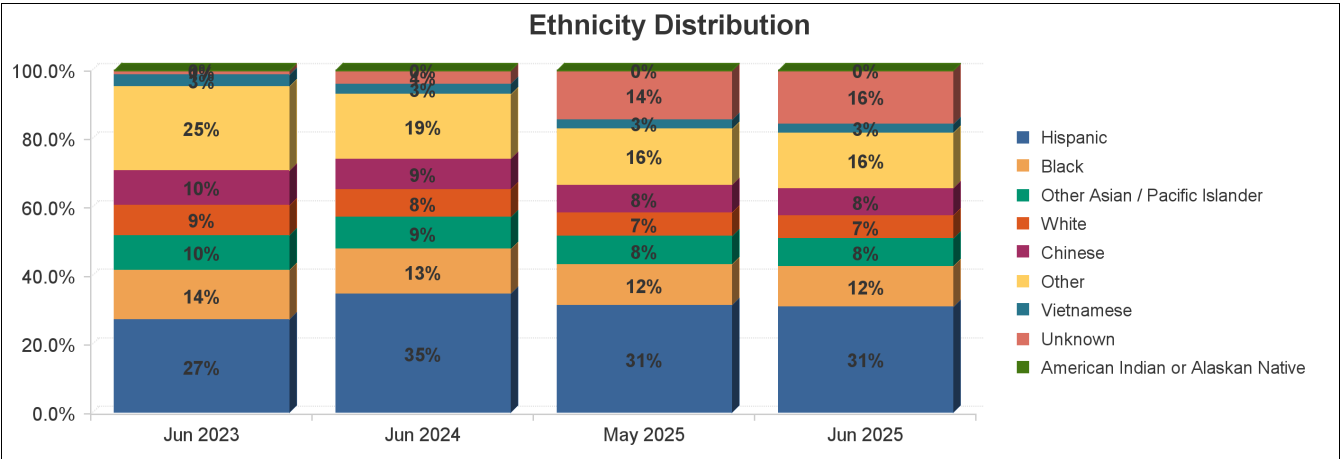


Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

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



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



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

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

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

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

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



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: August 8th, 2025

Subject: Operations Report

Member Services

- 12-Month Trend Blended Summary:
 - The Member Services Department received 18,993 calls in July 2025 compared to 18,546 in July 2024 and represents a 2% increase in calls.
 - The abandonment rate for July 2025 was 5% compared to 4% in July 2024.
 - The Department's service level was 94% in July 2025, compared to 94% in July 2024. The average speed to answer (ASA) was thirteen seconds (00:13) compared to fourteen seconds (00:14) in July 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 thirty-nine seconds (07:39) for July 2025 compared to six minutes and fifty-eight seconds (06:58) for July 2024.
 - 100% of calls were answered within 10 minutes for July 2025 and 100% of calls were answered within 10 minutes for July 2024.
 - Outbound calls totaled 9,544 in July 2025 compared to 7,613 in July 2024.
 - The top five call reasons for July 2025 were 1) Eligibility/Enrollment, 2) Change of PCP, 3) Grievances/Appeals, 4) Benefits, 5) ID Card Requests. The top five call reasons for July 2024 were: 1) Change of PCP, 2) Eligibility/Enrollment, 3) Benefits, 4) Provider Network, and 5) ID Card Requests.
 - July utilization for the member automated eligibility IVR system totaled 1,441 in July 2025 compared to 1,382 in July 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 1,332 web-based requests in July 2025 compared to 1,228 in July 2024. The top three web reason requests for July 2025 were: 1). Change of PCP, 2) ID Card Requests, and 3) Update Contact Information. 53 members were assisted in-person in July 2025 compared to 69 in 2024.

- Member Services Behavioral Health:
 - The Member Services Behavioral Health (MS BH) Unit received a total of 1,191 calls in July 2025 compared to 1,378 in July 2024.
 - The abandonment rate was 9% in July 2025 compared to 12% in 2024.
 - The service level was 75% in July 2025 and 75% in July 2024.
 - The average speed to answer (ASA) was one minute and four seconds (01:04) compared to one minute and nine seconds (01:09) in July 2024. Service levels were affected by several staff leaves. Two (2) representatives transferred internally, and vacancies are now filled.
 - Calls answered in 10 minutes were 100% in July 2025 compared to 99% in July 2024.
 - The Average Talk Time (ATT) was ten minutes and forty-two seconds (10:42) compared to eight minutes and fifty-eight seconds (07:58) in July 2024. The MS BH Team utilizes the DHCS age-appropriate screening tools for Medi-Cal Mental Health Services to determine the appropriate delivery system for members who are not currently receiving mental health services when they contact the plan.
 - 1,214 outbound calls were completed in July 2025 compared to 1,091 in July 2024.
 - 161 screenings were completed in July 2025 compared to 121 in July 2024.
 - 13 outreach campaigns were completed in July 2025 compared to 104 in July 2024.
 - 41 referrals were made to the County (ACCESS) in July 2025 compared to 40 in July 2024.
 - 15 members were referred to Center Point for SUD services in July 2025 compared to 20 in July 2024.

Claims

- 12-Month Trend Summary:
 - The Claims Department received 355,255 claims in July 2025 compared to 332,150 in July 2024.
 - The Auto Adjudication rate was 83.8% in July 2025 compared to 85.4% in July 2024.
 - Claims compliance for the 30-day turn-around time was 81.8% in July 2025 compared to 86.7% in July 2024. The 45-day turn-around time was 89.9% in July 2025 compared to 99.8% in July 2024.
- Monthly Analysis:
 - In July, we received a total of 355,255 claims in the HEALTHsuite system; this reflects a 4.4% increase from June 2025. It is also higher than the number of claims received in July 2024 by 23,105.
 - 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.
- 88% of claims were received via EDI and 12% of claims via paper during July.
- 89.9% of our claims were processed within 45 working days during the month.
- The Auto Adjudication rate was 83.8% for July.

Provider Dispute Resolution

- 12-Month Trend Summary:
 - In July 2025, the Provider Dispute Resolution (PDR) team received 4,426 PDRs compared to 2,375 PDRs received in July 2024. The number of PDRs received in July 2025 reflects a significant volume increase of 86.4% from June 2025 and is 16.7% higher than the number of PDRs received in July 2024, by 2,051. One provider is the driver for the significant increase.
- The PDR team resolved 2,819 cases in July 2025 compared to 1,976 cases in July 2024.
 - In July 2025, the PDR team upheld 72% of cases versus 75% in July 2024.
 - The PDR team resolved 99.8% of cases within the compliance standard of 95% within 45 working days in July 2025, compared to 99.8% in July 2024.
- Monthly Analysis
 - The Alliance received 4,426 PDRs in July 2025.
 - In the month of July, 2,819 PDRs were resolved, with 2,017 being upheld and 802 being overturned.
 - 2,816 out of 2,819 cases were resolved within 45 working days, resulting in a 99.8% compliance rate.
 - The average turnaround time for resolving PDRs in July was 37 days.
 - There were 6,165 PDRs pending resolution as of 07/31/2025, with no cases older than 45 working days.
 - The overturn rate for PDRs was 28%, which did not meet our goal of 25% or less.
- The primary reason that caused the Department to miss their goal of 25% or less was:
 - Member OHC corrections – 173 cases that were denied incorrectly.
 - Authorization issues – 163 cases that were denied incorrectly (claim denied in error; authorization was on file).
 - Incorrect Rate Configuration – 275 cases were denied incorrectly due to the contract not being loaded in the system correctly.
 - The full breakdown of all **802** overturned PDRs is:

Category	# of Cases	% of Cases	Comments
System Related Issues	75	9%	
General configuration issues	28	3%	Non-covered code, modifier, etc.
Financial responsibility	35	4%	MNF
Claims Editing System (CES)	12	2%	
Authorization Issues	163	20%	
Processor error	99	12%	Claim denied in error; authorization was on file
UM/retro auth review	38	5%	Retro medical necessity review
Auth System error	26	3%	
OHC Issues	173	22%	Inaccurate OHC Member TPL data
Incorrect Rates	321	40%	
Incorrect rate - System	275	34%	Contract not updated in system at the time of claim processing
Letter of Agreement (LOA)	15	2%	Underpaid; LOA on file
COB calculation	25	3%	Incorrectly calculated
Incorrect rate – Processor	6	1%	The processor did not calculate the rate correctly according to the contract or rate sheet.
Claim Processing Error	58	8%	
Duplicate claim	46	6%	The claim was a duplicate; the processor paid it in error
Incorrect Manual Denial	6	1%	The claim was manually denied incorrectly
Overpayment	6	1%	Provider request recoupment due to overpayment
Additional Documentation	12	1%	
Provider duplicate claim	2	0%	The documentation received confirmed claim was not a duplicate
Timely filing	4	0%	The documentation received confirmed that the claim was submitted on time
Provider billing	6	1%	Corrected claim due to provider error
PDR Overturn Totals	802	100%	

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 not resolved within the 95% of regulatory timeframes.

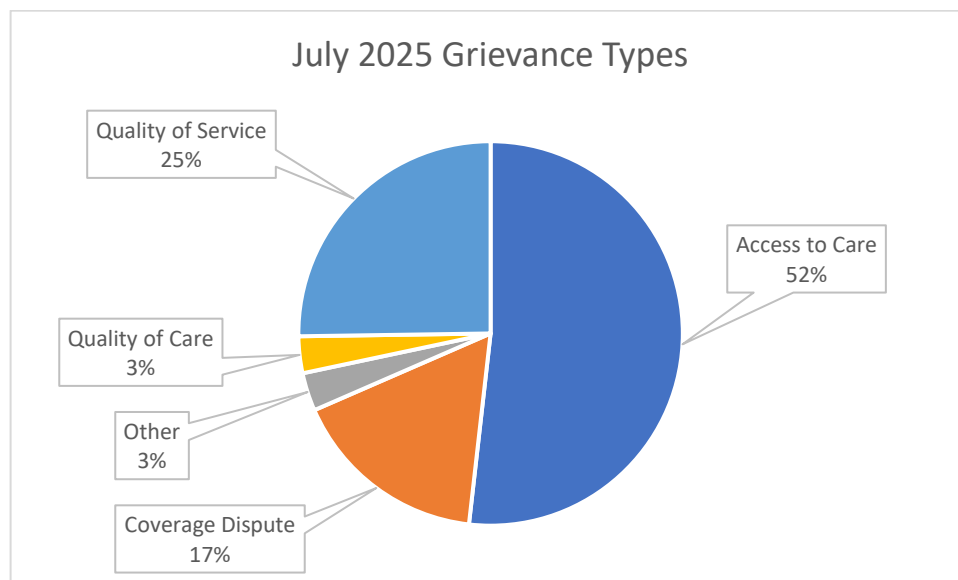
- Expedited Appeal cases were resolved within the 95% of regulatory timeframes.
- Total Unique grievances resolved in July were 8.54 complaints per 1,000 members.

July 2025 Cases	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate	Per 1,000 Members*
Standard Grievance	2,550	30 Calendar Days	95% compliance within standard	2,425	95.1%	4.87
Expedited Grievance	6	72 Hours	95% compliance within standard	6	100.0%	0.01
Exempt Grievance	1,725	Next Business Day	95% compliance within standard	1,725	100.0%	3.66
Standard Appeal	96	30 Calendar Days	95% compliance within standard	91	94.8%	0.23
Expedited Appeal	4	72 Hours	95% compliance within standard	4	100.0%	0.00
Total Cases:	4,381		95% compliance within standard	4,251	97.0%	8.54

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

Standard Grievances:

There were 2,014 unique grievance cases resolved during the reporting period, with a total of 2,556 grievances including 542 shadow cases.

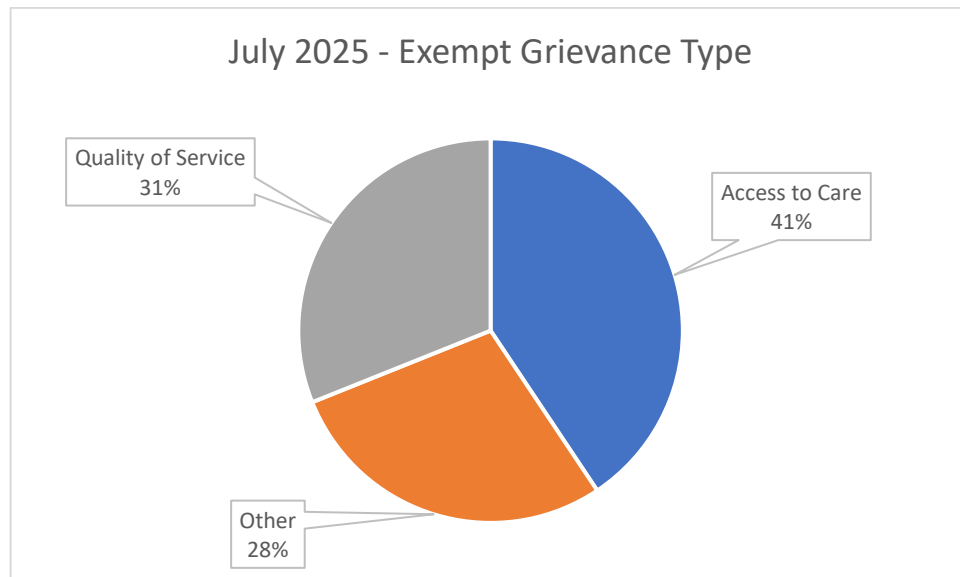


- **1,324** of 2,556 (52%) cases were related to Access to Care; the following are the top four (4) categories:
 - Timely Access – 319
 - Technology/Telephone – 310
 - Provider Availability – 289

- Authorization – 149
- **645** of 2,556 (25%) cases were related to Quality of Service; the following are the top three (3) categories:
 - Plan Customer Service – 139
 - Provider/Staff Attitude – 117
 - Authorization – 111
- **426** of 2,556 (17%) cases were related to Coverage Dispute; the following are the top two (2) categories:
 - Provider Direct Member Billing – 241
 - Provider Balance Billing – 113

Exempt Grievances:

There were 1,509 unique exempt grievance cases resolved during the reporting period, with a total of 1,725 exempt grievances including 216 shadow cases.

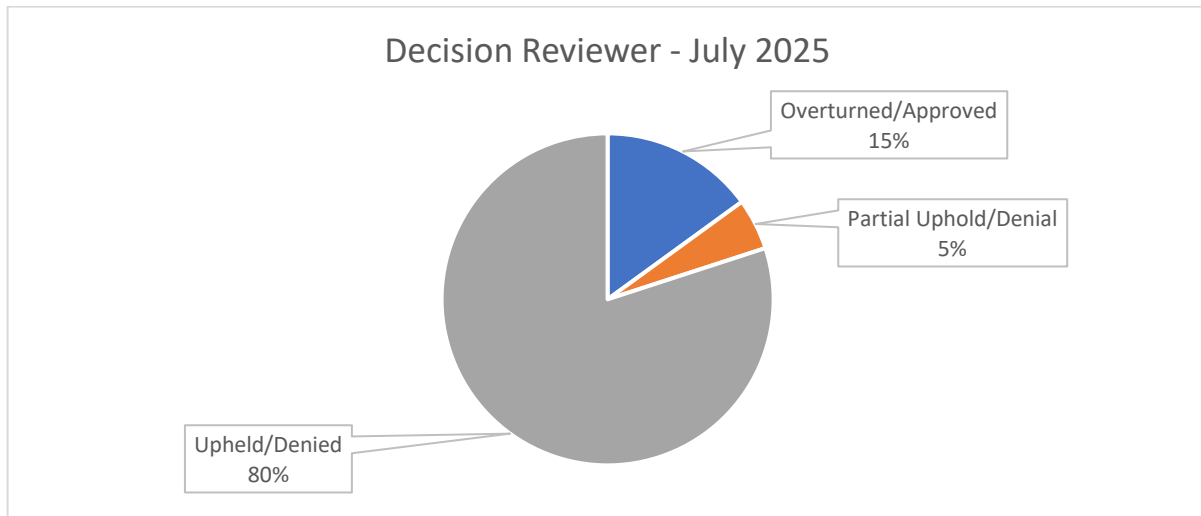


- **707** of 1,725 (41%) cases were related to Access to Care; the following are the top three (3) categories:
 - Telephone/Technology – 405
 - Provider Availability – 161
 - Geographic Access – 80
- **536** of 1,725 (31%) cases were related to Quality of Service; the following are the top two (2) categories:
 - Plan Customer Service – 302
 - Provider/Staff Attitude – 187
- **488** of 1,725 (28%) cases were related to Other; the following are the top two (2) categories:
 - Enrollment – 446

- Eligibility – 42

Appeals:

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



- **80** out of 100 (80%) cases were upheld/denied for the month of July 2025:
 - Disputes Involving Medical Necessity – 49
 - Out of Network – 30
 - Coverage Disputes – 1
- **15** out of 100 (15%) cases were overturned for the month of July 2025:
 - Disputes Involving Medical Necessity – 12
 - Out of Network – 3
- **5** out of 100 (5%) cases were partially upheld/denied for the month of July 2025:
 - Disputes Involving Medical Necessity – 4
 - Out of Network – 1

Provider Services

- 12-Month Trend Summary:
 - The Provider Services department's call volume in July 2025 was 9,330 calls compared to 8,593 calls in July 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 481 calls/visits during July 2025.

- The Provider Services department answered 7,785 calls for July 2025 and made 693 outbound calls.

Credentialing

- 12-Month Trend Summary:
 - At the Peer Review and Credentialing (PRCC) meeting held on July 15th, 2025, there were 105 initial network providers approved; 1 primary care provider, 18 specialists, 2 ancillary providers, 18 midlevel providers, and 66 behavioral health providers. Additionally, 37 providers were re-credentialed at this meeting; 7 primary care providers, 8 specialists, 3 ancillary providers, 3 midlevel providers and 16 behavioral health providers.
 - Please refer to the Credentialing charts and graphs located in the Operations supporting documentation for more information.

Community Relations and Outreach

- 12-Month Trend Summary:
 - In July 2025, the Alliance completed 1,153 member orientation outreach calls and 74 member orientations by phone.
 - The C&O Department reached 1,718 people (65% identified as Alliance members) during outreach activities, compared to 1,004 individuals (44% self-identified as Alliance members) in July 2024.
 - The C&O Department spent a total of \$0 in donations, fees, and/or sponsorships, compared to \$0 in July 2024.
 - The C&O Department reached members in 14 cities/unincorporated areas throughout Alameda County and the Bay Area, compared to 12 cities in July 2024.
- Monthly Analysis:
 - In July 2025, the C&O Department completed 1,153 member orientation outreach calls and 74 member orientations by phone, 58 Alliance website inquiries, six (6) service requests, and six (6) community events.
 - Among the 1,718 people reached, 65% identified as Alliance members.
 - In July 2025, the C&O Department reached members in 14 locations throughout Alameda County and the Bay Area.
 - Please see attached **Addendum A**.

Housing and Community Services Program Report

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

Incentives & Reporting Board Report – July 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
 - \$24.4M has been awarded to our HHIP partners to date
- A HHIP funding opportunity was released in June 2024 to SBHIP LEAs to address the challenges of students experiencing homelessness and associated behavioral health needs (i.e., anxiety, depression, etc.)
 - The Alliance received applications from 10 LEAs totaling \$1.3M in requests; all submitted applications were approved and work on the funded programs continued
- In a separate HHIP-funded initiative, the Alliance awarded \$11.2M in funding to 10 community partners through a program that supports the HHIP goals of reducing and preventing homelessness
 - Projects are underway with activities taking place through 2028 related to capacity building, innovation, diversity and health equity, and housing stability
- The Alliance continues to review partner project deliverables prior to payment and meet with partners to discuss program activities and barriers
 - One partner has withdrawn from the program as they could not reach an agreement with an external partner to complete the work; the unused funding will now be reviewed by the Alliance to determine potential areas of investment

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

- 2024-25 Program highlights:
 - Launched on June 1st, 2024

- 15 applications received totaling \$6M in funding requests
- \$2M in funding awarded to 13 provider partners for the following:
 - Nineteen providers in total, six (6) of which are bi-lingual
- \$219,976 has been awarded to our PRI partners to date
- Grants were provided to five (5) practices to support Community Health Worker (CHW) training certificate costs for 33 CHWs
- PRI deliverable trackers, to assist with program requirements, have been created and distributed to all awardees with signed MOUs
- 2025-26 Program status:
 - PRI program has been renewed for FY 2025-26 and launched July 1st, 2025
 - \$2M in funding is available for FY 2025-26 fiscal year
 - Reimbursement for Certified Medical Assistant training has been added to the program
 - Eight (8) organizations have expressed interest in the program to date
 - Three (3) informational sessions have been held
 - Program materials have been updated and were shared with interested organizations

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

- The original funding was \$700 million over five (5) years; however, due to state budget constraints, the funding was reduced to \$140 million over three (3) years
- Alameda Health System (AHS) was the only Alliance-associated applicant selected by DHCS to participate
 - AHS submitted their latest program deliverables that were due to DHCS on May 1st
 - The Alliance received \$302,463.84 from DHCS that AHS earned for their work and passed that payment on to AHS
- The Population Health Learning Center (PHLC) has requested MCPs sign a Data Sharing Agreement so they can work with a third-party vendor to help calculate Healthcare Effectiveness Data and Information Set (HEDIS) rates; the DSA is currently under review by the Alliance

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

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

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

Grant Program Updates

- The Incentives and Reporting (I&R) team implemented a grant management software system, Submittable, to support the various grant and incentive programs 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 Director, Health Equity will be participating in the equity focused learning network and leading project initiatives; I&R will provide program management support
 - The Alliance is receiving a small grant to cover the costs related to travel for participating in program activities
 - Participants are eligible to apply for a \$40k action project award to support implementation efforts for partners; the Alliance submitted its application in June
 - An application for a \$20,000 CIN Action Projects grant was released and is currently under review by the Health Equity team, applications are due Monday, August 11th
- 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
- The Alliance continues to work with internal and external stakeholders, such as First 5, regarding potential grant opportunities

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.



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Ruth Watson

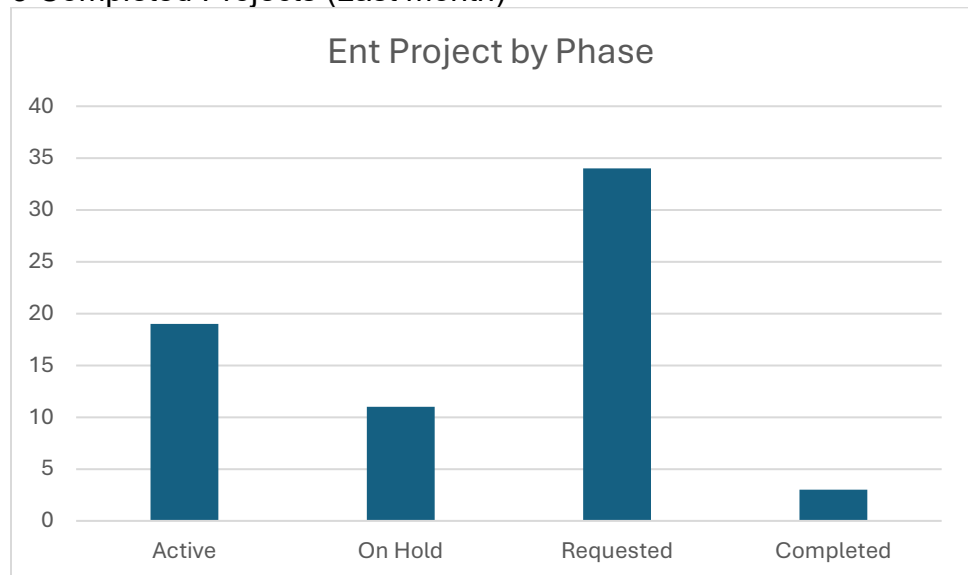
The Provider Recruitment Initiative (PRI) – program launched on June 1st, 2024, and is designed to provide grants to support the Alameda County Safety Net and community-based organizations to hire and retain healthcare professionals who serve the Alameda County Medi-Cal population. The PRI aims to grow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

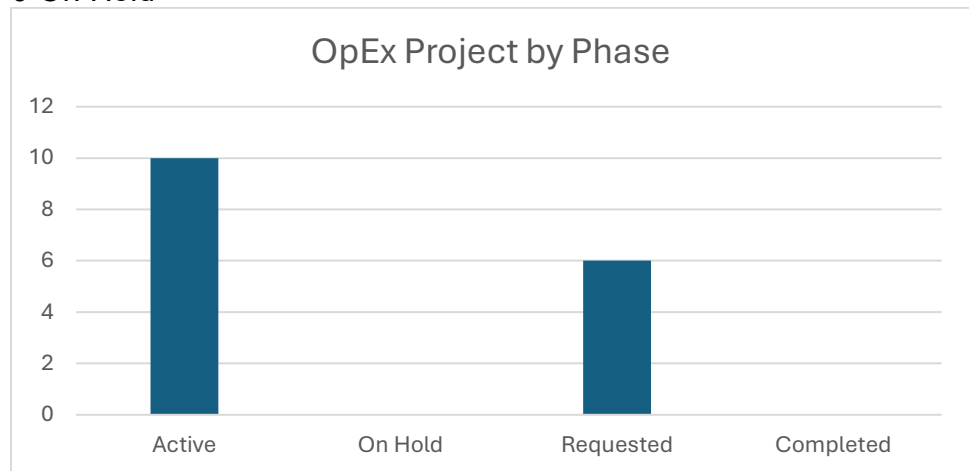
INTEGRATED PLANNING DIVISION BOARD REPORT – JULY 2025 ACTIVITIES

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



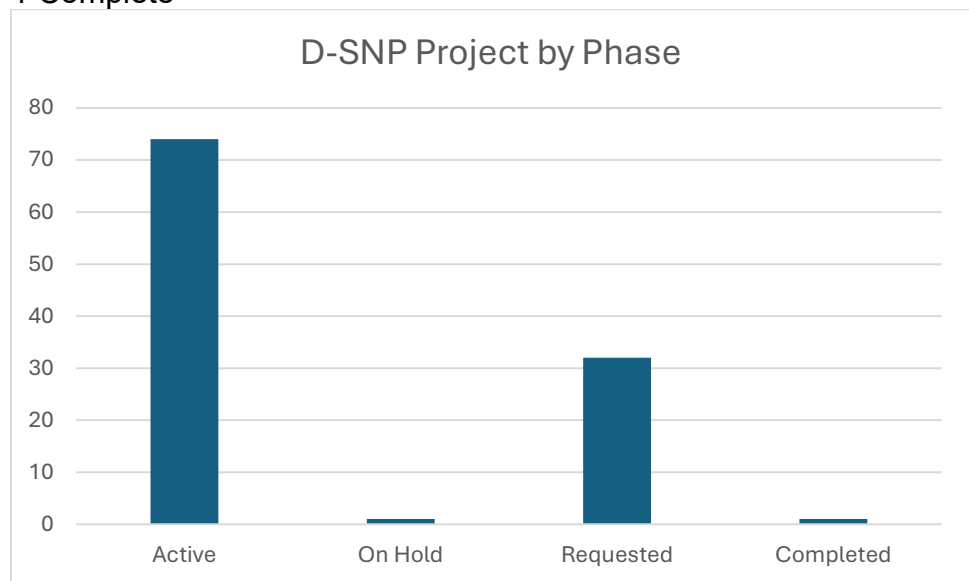
- Operational Excellence (OpEx) Portfolio
 - 16 projects currently on the Alameda Alliance for Health (AAH) OpEx portfolio
 - 10 Active projects (discovery, initiation, planning, execution, warranty)
 - 6 Requested Projects

- 0 On Hold



- D-SNP Portfolio

- 107 projects currently on the Alameda Alliance for Health (AAH) enterprise-wide portfolio
 - 74 Active projects (discovery, initiation, planning, execution, warranty)
 - 32 Requested Projects
 - 1 On Hold
 - 1 Complete



- D-SNP Key Initiatives and Dates:

- DMHC Material Modification Submission – MA Service Area Expansion – March 2024 - COMPLETE
- DMHC Material Modification Submission – D-SNP Product – August 2024
- CMS Notice of Intent to Apply – November 2024 - COMPLETE
- CMS Application Submission including MOC, Provider Network Adequacy & DMHC Approval – February 2025 - COMPLETE

- CMS Formulary & Bid Submission (Benefit Determination) – June 2nd, 2025 - COMPLETE
- Medication Therapy Management (MTM) program submission – June 4th, 2025 - COMPLETE
- CMS SMAC Submission – July 7th, 2025 - COMPLETE
- Rebate Allocation with CMS and Health Plan – July / August 2025 – In Process
- 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 – July 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 July 30th, 188 contracts are fully executed, which equates to 49% completion
 - Continued contract negotiations with Brown & Toland, Sutter, UCSF, Teladoc, and Quest
 - Engagement with ClearLink and Chapman for additional resource support
 - Submitted Provider Directory Front Matter to DHCS and CMS
 - 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
 - Reviews completed with CMO and final revision underway
 - MOC Internal Training – first draft complete
 - Quality Program
 - Quality Improvement Health Equity P&Ps continue to be updated/developed to align with D-SNP
 - 52 policies – 46 in progress, six (6) not started
 - Quality Workplan
 - Aligning QI Workplan and Stars Playbook

- Developing BRDs for reporting requirements related to QI Workplan
 - Establishing new committees for Utilization Management and Community Advisory Committee – 1st draft has been completed
 - Gathering Website and Provider Manual Requirements for Quality Committees
 - Charter redlines have been completed (Seven Quality Committees)
- 03 - Health Care Services (HCS) and 04 - Behavioral Health (BH):
 - Continuing policy development and revisions (130 policies)
 - UM Committee Charter draft complete to include D-SNP as an additional service line
 - Identifying and documenting reporting requirements for UM, CM, and BH
 - UM and CM letter inventory complete and under final review by C&O
 - Redlining UM and CM Program Descriptions for D-SNP elements
 - Prior authorization code list has been finalized
 - HRA Implementation Workgroup Kickoff with Vendor. Initial discussions on data feeds/elements and assessment administration
 - HRA draft was submitted to DHCS and has been 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 new net processes for California Integrated Care Management (CICM) to include new requirements outlined in the CY2026 Program Guide
 - D-SNP CM Assessment/HRA mapping to care plan for rules generation
 - Other assessments SRD to TruCare Team for configuration
 - Continuing to build out system rules documents for D-SNP TruCare to submit to IT for configuration – Finalizing Tru-Care Core Feeds SRD
 - D-SNP authorization workstream in building out requirements and work efforts for stand-up
 - Finalizing UM customer set up requirements for configuration
 - BH CM – D-SNP CM program structure 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
 - Continued development of the Finance Standard Operating Procedure (SOP)
 - Continued development of Finance Medicare Reporting and Board of Governor presentations
 - Continued requirements development and mapping of Finance related CMS data submission
- 06 – Product:
 - 6A – Bid and Benefit Design
 - CY2026 State Medicaid Agency Contract (SMAC)
 - On July 24th, AAH received confirmation from CMS there were no deficiencies in our CY 2026 State Medicaid Agency Contract (SMAC) for H2035 D-SNP
 - CY2026 CMS Formulary and Bid Submission (Benefit Determination)
 - On 7/28/2025, CMS released benchmarks regarding base beneficiary premium, national average bid amount, etc. CMS benchmarks were reviewed with Milliman, Matt Woodruff, and Ruth Watson. Due to minimal rebate allocation difference, the decision was made by AAH to leverage the bid rounding rules and no supplemental benefit changes. Milliman will submit new BPT by August 6th
 - 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
 - 6G – Organizational Training
 - Organization Training Workgroup kick-off meeting completed
 - Development of process for training content collections
 - Development of process to convert content provided by business areas into LMS.
 - Meetings with each business area for content discovery and gathering have kicked off
 - 6J – Liberty Dental
 - Operations kick-off meeting completed including business stakeholders
 - Workgroup meetings for Grievances and Appeals; Encounters and Eligibility (IT); Member Services scheduled
 - Submitted Enrollment Group Data Survey and review in progress
 - Confirmed Call Center Hours from Liberty Dental 8AM to 8PM Pacific Time (PT) – April 1st to September 30th (Monday to Friday); October 1st – March 31st (7 days a week)

- 07 – Compliance:
 - DMHC Material Modification – D-SNP Product (Filing #20244060)
 - Initial AAH responses submitted to DMHC on 9/9/2024
 - DMHC Comment Table received 6/5/2025; responses submitted on 7/3. No additional feedback from DMHC to date
 - D-SNP Compliance Policies
 - Policy Review at AOC – 7/16/2025
 - Three (3) policies approved
 - Five (5) policies reviewed with additional edits required
 - HPMS User Access Form (aka CARE Form)
 - Continued development of process flow supporting the completion, review, and approval of CARE form requests
- 08 - Operations (Claims / Member Services / Mailroom / IVR):
 - 8A – Claims
 - Continued development of a day in the life of a claim process flow
 - Completed review of claims denial codes
 - 8B – Member Services / Call Center / IVR
 - Continued Member Portal Master Document review to support D-SNP changes
 - Completed 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
 - 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
- Continued development of the phone tree (IVR) call flow between member services, providers, and sales
- Confirming lead load file formatting and frequency, ensuring all leads that are uploaded are qualified
- Revised SEP Attestation form; confirmed SEP codes are correct through Nations.
- Continue development of workflow with CHCN, roadshow dates confirmed
- “Call Monitoring/Recording” policy created, as well as “Guidelines for In-Person Events Policy”, these policies will be submitted for August review
- 9D – Medicare Marketing & Brand Strategy
 - 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 conditionally approved by CMS on 7/10/2025
 - D-SNP Website requirement gap analysis completed: all gaps in D-SNP website requirements have been identified and documented. Department working sessions underway; cross-functional teams are actively reviewing assigned requirements and collaborating to develop necessary website content. Target date to complete all content development is 8/15/2025, enabling the start of microsite framework construction
 - All required materials have been drafted and submitted to the State and CMS for review:
 - Member Handbook/EOC: 7/27/2025
 - Summary of Benefits: 7/14/2025
 - ID Card: 7/14/2025
 - Provider & Pharmacy Directory: 7/30/2025
 - Formulary: 7/30/2025
 - Awaiting feedback or approval from CMS and State reviewers. Preparing for potential revisions based on regulatory input to finalize materials for production and distribution upon approval
 - 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
- 10 – Pharmacy:
 - PBM Technical and Operational workgroup meetings are in progress
 - Formulary-Approved by CMS on 7/22/2025
 - 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 1/1/2026
- 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 complete
 - DME Benefit pre-delegation contracting complete
 - Health Risk Assessment (HRA) pre-delegation / contracting in process
 - Medicare Prescription Payment (M3P) Plan contracting in process
 - Pharmacy Consultant pre-delegation / contracting in process
 - Risk Adjustment pre-delegation / contracting in process
 - UM Guidelines (Clinical Policy Methodology) contracting in process
- 13 – Health Equity:
 - Completed 1st draft redline of policies to include Health Equity (HE) initiatives and requirements
 - Identified need for five (5) new policies to support HE
 - One (1) policy is in progress and four (4) have not been started
 - Beginning phase 2 of plan to develop monitoring process and procedures that HE team will oversee
 - Discovery and project plan development
 - Kick-off with HE Workgroup phase 2
 - Health Equity Workplan for quality improvement interventions 1st draft
 - Oversight policy and procedure 1st draft and workgroup review complete
- 15 - Grievance and Appeals:
 - D-SNP Policies and Procedures have been reviewed and revised by external D-SNP SMEs. 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 providers will be owned and managed by the Grievance and Appeals team
 - 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. HEALTHsuite confirmed as the system to trigger claims letters, EOBs, and RAs. Waiver of Liability Letters (Appeals): These letters will not require configuration in HEALTHsuite. AAH decided these letters will be managed by the AAH Grievance and Appeal team outside of HEALTHsuite. Provider Contract Conversion will be loaded by AAH via a SQL insert script in the staging region. The decision eliminates the need for AAH to build a conversion file
- 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.
- 16B - Enrollment Process
 - 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 to track Admission, Discharge, and Transfer Star measures
 - Pay-for-Performance and Pay-for-Reporting program – In process of finalizing the measure scope. Confirmed with CHCN that they will not have their own P4P Program
 - Data feeds – This is already in production and will be slightly modified to ensure support for D-SNP measures
 - Prospective Chart Review – This is already in production and will be slightly modified to ensure support for D-SNP measures Phase 1 of Star strategy
 - Stars Education – Internal and external training to provide a clear understanding of how Star measures impact quality ratings. Internal training has begun
- 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. Developing this in conjunction with the individual CHCN clinics to leverage their quality capabilities
 - ❖ Awareness Campaign – Beginning development of ad hoc awareness campaigns to deploy in 2026 (medication adherence and preventative services)
 - Welcome Postcard with checklist of preventative screenings
 - Member Birthday Cards
 - ❖ Preventive Physical Exam (IPPE) & Annual Wellness Visit (AWV) – Beginning development of IPPE & AWV program to engage providers and members for gap closure and accurate diagnosis capture Individual sessions with each clinic have been scheduled.
- **CalAIM Initiatives:**
 - Community Supports (CS)
 - Due to Budget Constraints, all CS enhancements and/or expansions are on hold
 - Justice-Involved (JI) Initiative:
 - CalAIM Re-entry: Project on hold pending direction from the State
 - Correctional facilities go-live date for pre-release services is determined based on DHCS readiness assessment and will go-live with pre-release services within a 24-month phase in period (10/1/2024 – 9/30/2026)
 - Santa Rita Jail is targeting to go-live on 7/1/2026 with pre-release services; Juvenile Justice Center's go-live is TBD
 - Managed Care Plans (MCPs) must be prepared to coordinate with correctional facilities as of October 1st, 2024, even if facilities in their county will go-live later

- JI project team is developing a contact list for the counties going live with pre-release to support coordination of referrals for any AAH members being released from these counties
 - DHCS has indicated they intend to release a revised JI Policy Guide; impacts to project scope and schedule will be assessed once this is released
 - DHCS JI Learning Collaboratives initiated in August 2024 and continues through January 2025. These collaborative sessions include correctional facilities, county behavioral health agencies, probation, managed care plans, and ECM providers
 - On 10/28/24, AAH SLT approved to place CalAIM JI Re-Entry project on hold until July 2025 to await final policy guide from DHCS and give Alameda County partners time to develop their internal processes and readiness
- CYBHI Fee Schedule: Project on hold pending direction from the State
 - Effective January 1st, 2024, the Alliance is partnering with Carelon (formerly known as Beacon) to implement the CYBHI Fee Schedule
 - Cohort 1 is intended to be a “learning” cohort
 - The Alliance was not selected to participate in the permanent ASO Model and will participate in an interim solution until further notice from Carelon and DHCS
- MOU
 - Interim Model MOU has been executed by AAH CEO 4/29/2025 and returned to Carelon
 - AAH Finance Team shall receive Invoice File from Carelon for billing purposes via secured file transfer process and process payments manually
 - This includes checking member eligibility internally to deliver payments when services have been rendered.
 - SFTP File Exchange template executed and resubmitted to Carelon 6/2/2025
 - Banking information with Carelon has been established and ready for invoice payments
 - Final stages of testing data with Carelon and DHCS
 - Test file from Carelon via SFTP picked up successfully
 - Project Close Activities
 - Upon completion of file transfer validation, the AAH business stakeholders propose closing this project
 - Anticipate project close in June 2025
 - Warranty period through end of July to monitor stabilization of potential incoming invoices
- **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

Supporting Documents Project Descriptions

- Key projects currently in-flight:
 - California Advancing and Innovating Medi-Cal (CalAIM) – program to provide targeted and coordinated care for vulnerable populations with complex health needs
 - Enhanced Care Management (ECM) – ECM will target eight (8) specific populations of vulnerable and high-risk children and adults.
 - Three (3) Populations of Focus (PoF) transitioned from HHP and/or WPC on January 1st, 2022
 - Two (2) additional PoF became effective on January 1st, 2023
 - One (1) PoF became effective on July 1st, 2023
 - Two (2) PoF became effective on January 1st, 2024
 - Restarting in July 2025 – Justice Involved Initiative – adults and children/youth transitioning from incarceration or juvenile facilities will be enrolled into Medi-Cal upon release
 - DHCS is finalizing policy and operational requirements for MCPs to implement the CalAIM Justice-Involved Initiative
 - MCPs must be prepared to go live with ECM for the Individuals Transitioning from Incarceration as of January 1st, 2024
 - MCPs must be prepared to coordinate with correctional facilities to support re-entry of members as the return to the community by October 1st, 2024
 - Correctional facilities will have two years from 10/1/2024-9/30/2026 to go live based on readiness
 - Dual Eligible Special Needs Plan (D-SNP) Implementation – All Medi-Cal MCPs will be required to operate Medicare Medi-Cal Plans (MMPs), the California-specific program name for Exclusively Aligned Enrollment Dual Eligible Special Needs Plans (EAE D-SNPs) by January 2026 to provide better coordination of care and improve care integration and person-centered care. Additionally, this transition will create both program and financial alignment, simplify administration and billing for providers and plans, and provide a more seamless experience for dual eligible beneficiaries by having one plan manage both sets of benefits for the beneficiary
 - CYBHI Statewide Fee Schedule – The Department of Health Care Services (DHCS), in collaboration with the Department of Managed Health Care (DMHC), has developed and a multi-payer, school-linked statewide fee schedule for outpatient mental health or substance use disorder services provided to a student 25 years of age or younger at or near a school site. CYBHI requires commercial health plans and the Medi-Cal delivery system, as applicable, to reimburse, at or above the published rates, these school-linked providers, regardless of network provider status, for services furnished to students pursuant to the fee schedule. Effective January 1st, 2024, the Alliance is partnering with the Alameda County Office of Education (ACOE)

and several Local Education Agencies (LEAs) who were selected to participate in the CYBHI Fee Schedule Cohort 1

Operations

Supporting Documents

Member Services

Blended Call Results

Blended Results	July 2025
Incoming Calls (R/V)	18,993
Abandoned Rate (R/V)	5%
Answered Calls (R/V)	17,973
Average Speed to Answer (ASA)	00:13
Calls Answered in 30 Seconds (R/V)	94%
Average Talk Time (ATT)	07:39
Calls Answered in 10 minutes	100%
Outbound Calls	9,544

Top 5 Call Reasons (Medi-Cal and Group Care) July 2025

Eligibility/Enrollment
Change of PCP
Grievances/Appeals
Benefits
ID Card Requests

Top 3 Web-Based Request Reasons (Medi-Cal and Group Care) July 2025

ID Card Requests
Change PCP
Update Contact Info

Member Services Behavioral Health	July 2025
Incoming Calls (R/V)	1,191
Abandoned Rate (R/V)	9%
Answered Calls (R/V)	1,089
Average Speed to Answer (ASA)	01:04
Calls Answered in 30 Seconds (R/V)	75%
Average Talk Time (ATT)	10:42
Calls Answered in 10 minutes	100%
Outbound Calls	1,214
Screenings Completed	161
ACBH Referrals	41
SUD referrals to Center Point	15

Claims Department
June 2025 Final and July 2025 Final

METRICS

Claims Compliance	Jun-25	Jul-25
90% of clean claims processed within 30 calendar days	91.3%	81.8%
95% of all claims processed within 45 working days	93.8%	89.9%
Claims Volume (Received)	Jun-25	Jul-25
Paper claims	38,862	42,409
EDI claims	301,362	312,846
Claim Volume Total	340,224	355,255
Percentage of Claims Volume by Submission Method	Jun-25	Jul-25
% Paper	11.42%	11.94%
% EDI	88.58%	88.06%
Claims Processed	Jun-25	Jul-25
HEALTHsuite Paid (original claims)	230,975	306,576
HEALTHsuite Denied (original claims)	78,113	113,868
HEALTHsuite Original Claims Sub-Total	309,088	420,444
HEALTHsuite Adjustments	40,654	23,715
HEALTHsuite Total	349,742	444,159
Claims Expense	Jun-25	Jul-25
Medical Claims Paid	\$136,772,399	\$169,869,293
Interest Paid	\$338,827	\$349,476
Auto Adjudication	Jun-25	Jul-25
Claims Auto Adjudicated	272,290	352,354
% Auto Adjudicated	88.1%	83.8%
Average Days from Receipt to Payment	Jun-25	Jul-25
HEALTHsuite	17	21
Pended Claim Age	Jun-25	Jul-25
0-30 calendar days	44,872	38,206
HEALTHsuite		
31-61 calendar days	37,936	33,385
HEALTHsuite		
Over 62 calendar days	65,511	47,767
HEALTHsuite		
*Pended claims over 31 days are high due to investigation of 3 providers for FWA		
Overall Denial Rate	Jun-25	Jul-25
Claims denied in HEALTHsuite	78,113	113,868
% Denied	22.3%	25.6%

Claims Department

June 2025 Final and July 2025 Final

Jul-25

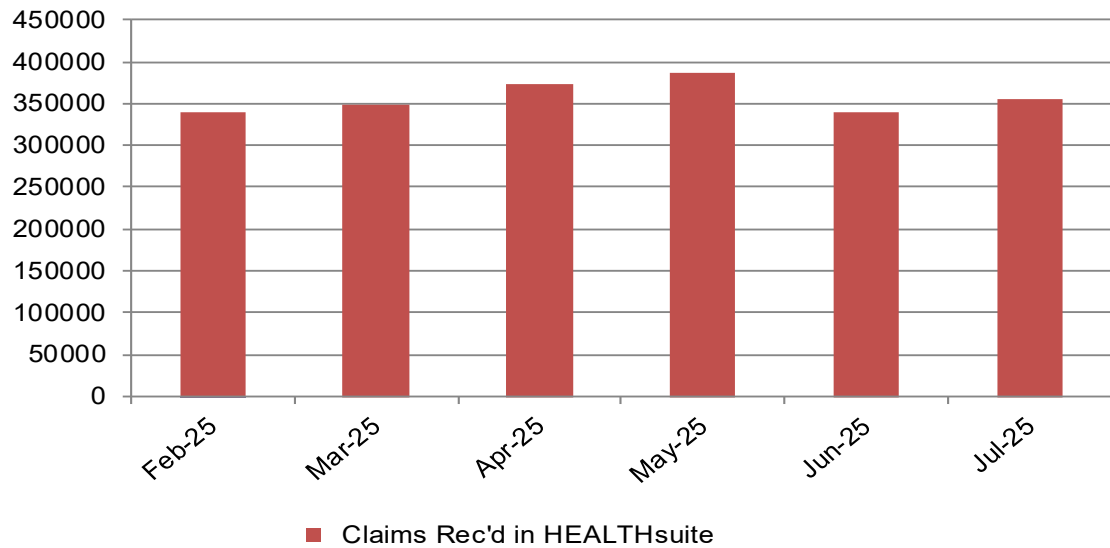
Top 5 HEALTHsuite Denial Reasons

% of all denials

Responsibility of Provider	21%
Must Submit Paper Claim With Copy of Primary Payor EOB	12%
No Benefits Found For Dates of Service	11%
Non-Covered Benefit For This Plan	10%
Duplicate Claim	9%
% Total of all denials	63%

Claims Received By Month

	3/1/2025	4/1/2025	5/1/2025	6/1/2025	7/1/2025	8/1/2025
Claims Received Through	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Claims Rec'd in HEALTHsuite	339,840	347,469	372,126	387,564	340,224	355,255



Claims Year Over Year Summary

Claims Compliance - comparing July 2025 to July 2024 as follows: 30 Days - 81.8% (2025) vs 86.7% (2024) 45 Days - 89.9% (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 355,255 claims in July 2025 vs 332,150 in July 2024	N/A	N/A
EDI - the volume of EDI submissions was 88.06% which exceeds our normal month to month range of ~77% - 87%	N/A	N/A
Original Claims Processed - AAH processed 420,444 in July 2025 (23 working days) vs 353,674 in July 2024 (23 working days)	N/A	N/A
Medical Claims Expense - the amount of paid claims in July 2025 was \$169,869,293 (5 check runs) vs \$166,789,642 in July 2024 (5 check runs)	N/A	N/A
Interest Expense - the amount of interest paid in July 2025 was \$349,476 vs \$183,683 in July 2024	N/A	.05% - .075% of the monthly medical expense
Auto Adjudication - the AAH rate in July 2025 was 83.8% vs 85.4% in July 2024	N/A	85% or higher
Average Days from Receipt to Payment - the average # of days from receipt to payment in July 2025 was 21 days vs 16 days in July 2024	N/A	<= 25 days
Pended Claim Age - comparing July 2025 to July 2024 as follows: 0-30 calendar days - 38,206 (2025) vs 36,877 (2024) 31-61 calendar days - 33,385 (2025) vs 21,302 (2024) Over 62 calendar days - 47,767 (2025) vs 14 (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 July 2025 to July 2024	N/A	N/A

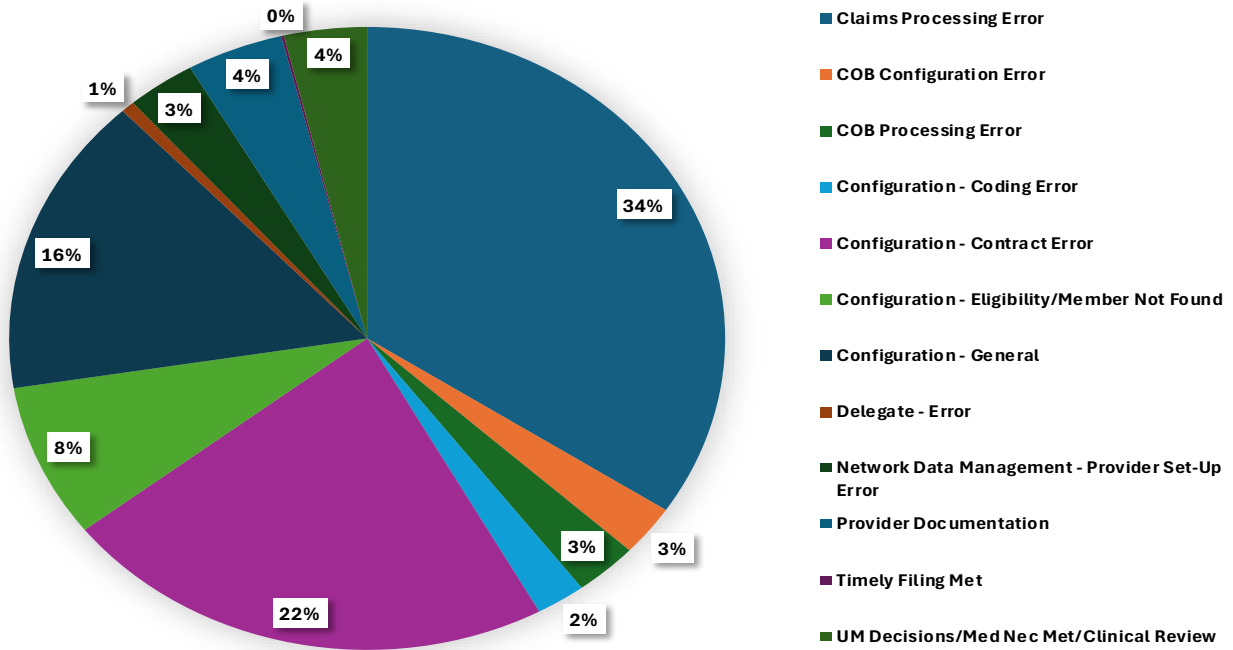
Provider Dispute Resolution		
June 2025 Final and July 2025 Final		
METRICS		
PDR Compliance	Jun-25	Jul-25
# of PDRs Resolved	2,634	2,819
# Resolved Within 45 Working Days	2,626	2,816
% of PDRs Resolved Within 45 Working Days	99.6%	99.8%
PDRs Received	Jun-25	Jul-25
# of PDRs Received	3,843	4,426
PDR Volume Total	3,843	4,426
PDRs Resolved	Jun-25	Jul-25
# of PDRs Upheld	2,183	2,017
% of PDRs Upheld	83%	72%
# of PDRs Overturned	451	802
% of PDRs Overturned	17%	28%
Total # of PDRs Resolved	2,634	2,819
Average Turnaround Time	Jun-25	Jul-25
Average # of Days to Resolve PDRs	38	37
Oldest Resolved PDR in Days	370	92
Unresolved PDR Age	Jun-25	Jul-25
0-45 Working Days	4,696	6,165
Over 45 Working Days	0	0
Total # of Unresolved PDRs	4,696	6,165

Provider Dispute Resolution

June 2025 Final and July 2025 Final

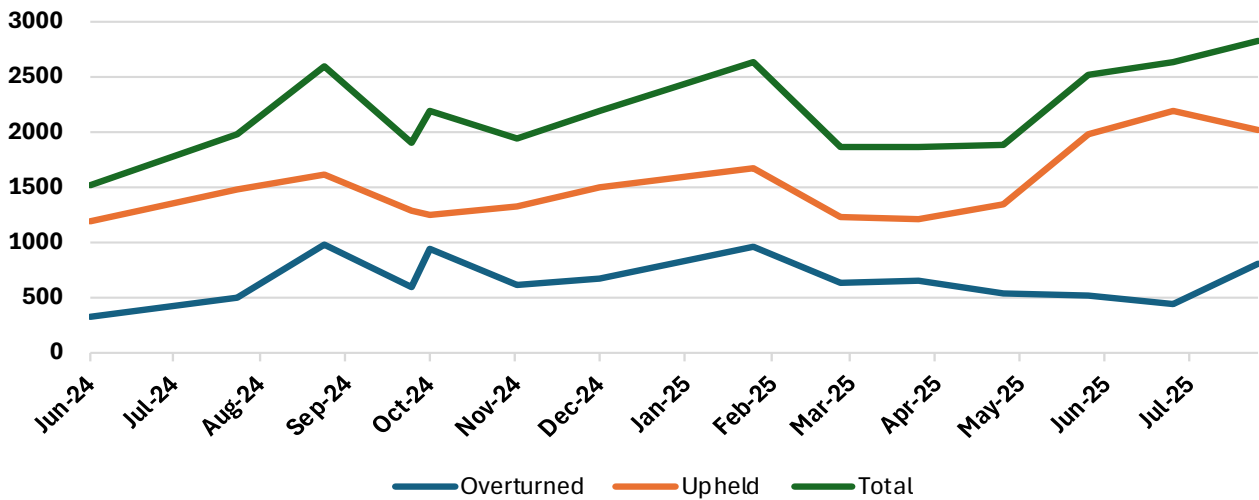
Jul-25

July 2025



Rolling 12-Month PDR Trend Line

July 2025



Provider Dispute Resolution Year Over Year Summary

Monthly Results	Regulatory Requirements	AAH Goal
# of PDRs Resolved - 2,819 in July 2025 vs 1,976 in July 2024	N/A	N/A
# of PDRs Received - 4,426 in July 2025 vs 2,375 in July 2024	N/A	N/A
# of PDRs Resolved within 45 working days - 2,816 in July 2025 vs 1,971 in July 2024	N/A	N/A
% of PDRs Resolved within 45 working days - 99.8% in July 2025 vs 99.8% in July 2024	95%	95%
Average # of Days to Resolve PDRs - 37 days in July 2025 vs 42 days in July 2024	N/A	30
Oldest Resolved PDR in Days - 92 days in July 2025 vs 62 days in July 2024	N/A	N/A
# of PDRs Upheld - 2,017 in July 2025 vs 1,127 in July 2024	N/A	N/A
% of PDRs Upheld - 72% in July 2025 vs 70% in July 2024	N/A	> 75%
# of PDRs Overturned - 802 in July 2025 vs 486 in July 2024	N/A	N/A
% of PDRs Overturned - 28% in July 2025 vs 30% in July 2024	N/A	< 25%
PDR Overturn Reasons: Claims processing errors - 34% (2025) vs 36% (2024) Configuration errors - 48% (2025) vs 35% (2024) COB - 6% (2025) vs 8% (2024) Clinical Review/UM Decisions/Medical Necessity Met - 12% (2025) vs 12% (2024)	N/A	N/A

Provider Relations Dashboard July 2025

Alliance Provider Relations Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Incoming Calls (PR)	10,977	8,885	8,303	8,709	7,861	9,214	9,330					
Abandoned Calls	3,600	1,133	1,434	1,685	1,254	2,245	1,545					
Answered Calls (PR)	7,377	7,752	6,869	7,024	6,607	6,969	7,785					
Recordings/Voicemails	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Incoming Calls (R/V)	2,910	2,140	13	15	12	6	14					
Abandoned Calls (R/V)												
Answered Calls (R/V)	2,910	2,140	13	15	12	6	14					
Outbound Calls	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Outbound Calls	868	1,162	434	602	570	520	693					
N/A												
Outbound Calls	868	1,162	434	602	570	520	693					
Totals	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Total Incoming, R/V, Outbound Calls	14,755	12,187	8,750	9,326	8,443	9,740	10,037					
Abandoned Calls	3,600	1,133	1,434	1,685	1,254	2,245	1,545					
Total Answered Incoming, R/V, Outbound Calls	11,155	11,054	7,316	7,641	7,189	7,495	8,492					

Provider Relations Dashboard July 2025

Call Reasons (Medi-Cal and Group Care)

Category	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Authorizations	5.1%	5.8%	5.4%	5.0%	5.2%	5.4%	5.7%					
Benefits	5.1%	3.7%	3.4%	3.9%	6.4%	3.4%	3.2%					
Claims Inquiry	39.4%	43.9%	43.7%	46.3%	47.7%	48.5%	46.8%					
Change of PCP	2.5%	2.7%	2.4%	2.9%	2.8%	2.0%	2.2%					
Check Tracer	0.7%	0.6%	1.0%	0.9%	0.7%	1.0%	0.6%					
Complaint/Grievance (includes PDR's)	5.8%	6.7%	6.8%	6.5%	7.6%	7.1%	8.6%					
Contracts/Credentialing	0.8%	0.8%	0.7%	0.8%	0.8%	0.8%	0.8%					
Demographic Change	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%					
Eligibility - Call from Provider	21.0%	17.4%	17.0%	17.9%	16.5%	17.2%	16.3%					
Exempt Grievance/ G&A	0.0%	0.1%	6.8%	0.0%	0.1%	0.0%	0.1%					
General Inquiry/Non member	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%					
Health Education	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%					
Intepreter Services Request	0.5%	0.5%	0.6%	0.4%	0.4%	0.4%	0.4%					
Provider Portal Assistance	3.4%	3.2%	3.9%	3.4%	3.4%	3.4%	3.6%					
Pharmacy	0.1%	0.2%	0.1%	0.0%	0.1%	0.1%	0.0%					
Prop 56	0.1%	0.0%	0.0%	0.1%	0.1%	0.1%	0.1%					
Provider Network Info	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%					
Transportation Services	0.0%	0.2%	0.2%	0.2%	0.3%	0.1%	0.1%					
Transferred Call	0.0%	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%	11.2%					
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%					

Field Visit Activity Details

Alliance Provider Relations Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Claims Issues	28	72	89	54	60	41	48					
Contracting/Credentialing	29	41	50	59	150	66	53					
Drop-ins	127	83	141	146	149	96	220					
JOM's	2	2	3	2	3	1	3					
New Provider Orientation	100	134	118	173	143	182						
Quarterly Visits	0	0	0	82	0	0	0					
UM Issues	0	0	3	1	1	5	3					
Total Field Visits	286	332	404	517	506	391	327	0	0	0	0	0

Alliance Network Summary, Currently Credentialed 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				Correction 601	Correction 367
Vendor Summary						
Credentialing Verification Organization, Symplyr CVO						
	Number		Average Calendar Days in Process	Goal - 25 Business Days*	Goal - 98% Accuracy	Compliant
Initial Files in Process	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)						
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			

COMMUNICATIONS & OUTREACH DEPARTMENT

ALLIANCE IN THE COMMUNITY

FY 2025-2026 | JULY 2025 OUTREACH REPORT

ALLIANCE IN THE COMMUNITY

FY 2025-2026 | JULY 2025 OUTREACH REPORT

In July 2025, the Alliance completed **1,153** member orientation outreach calls among net new and non-utilizer members and conducted **69** net new member orientations and **5** non-utilizer member orientations (**6.4%** member participation rate). In addition, in July 2025, the Outreach team completed **58** Alliance website inquiries, **6** service requests, **2** community events, **1** community meeting/presentation, and **3** member education events. The Alliance reached a total of **1,644** people and spent a total of \$0 on donations, fees, and/or sponsorships at the Fourth Annual “Backpacks for Kids, 2025 Family Resource Navigators (FRN) Family Empowerment Conference, Safe Kids Day – Health & Wellness Fair, Family Resource Fair, Homeless Resource & Job Fair, and Indigenous Red Market community events and activities.*

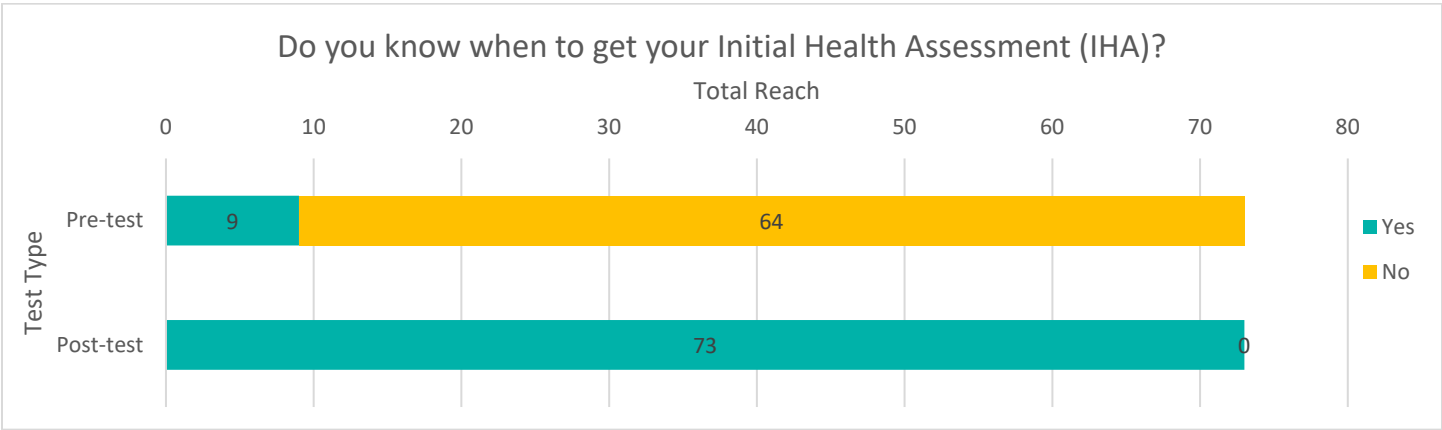
The Communications & Outreach Department began reporting the number of members reached during outreach activities in late February 2018. Since July 2018, **40,437** self-identified Alliance members have been reached during outreach activities.

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

On **Wednesday, March 18, 2020**, the Alliance began conducting member orientations by phone. As of July 31, 2025, the Outreach Team completed **51,427** member orientation outreach calls and conducted **9,939** member orientations (**19.3%** member participation rate).

The Alliance Member Orientation (MO) program has existed since August 2016. In 2019, the program was recognized as a promising practice to increase member knowledge and awareness about the Initial Health Appointment (IHA) by the Department of Health Care Services (DHCS), Managed Care Quality and Monitoring Division (MCQMD). We have steadily increased program participation. Our 2019 6-month average participation rate was **111** members per month. Between July 1, through July 31, 2025 (22 working days) – **74** members completed an MO by phone.

After completing the MO, **100%** of members who completed the post-test survey in July 2025 reported knowing when to get their IHA, compared to only **12.3%** of members knowing when to get their IHA in the pre-test survey.

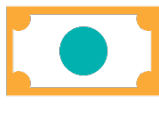


All report details can be reviewed at: **W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Outreach Reports\FY 25-26\Q1\July 2025**

ALLIANCE IN THE COMMUNITY

FY 2025-2026 | JULY 2025 OUTREACH REPORT

FY 2024-2025 JULY 2024 TOTALS

			
7 COMMUNITY EVENTS 0 MEMBER EDUCATION EVENTS 127 MEMBER ORIENTATIONS 0 MEETINGS/PRESENTATIONS/ 0 COMMUNITY TRAINING 11 TOTAL INITIATED/ INVITED EVENTS 134 TOTAL COMPLETED EVENTS	12 CITIES** Alameda Berkeley Castro Valley Dublin Fremont Hayward Newark Oakland <i>San Jose</i> San Leandro San Lorenzo Union City	1004 TOTAL REACHED AT COMMUNITY EVENTS 0 TOTAL REACHED AT MEMBER EDUCATION EVENTS 127 TOTAL REACHED AT MEMBER ORIENTATIONS 0 TOTAL REACHED AT MEETINGS/PRESENTATIONS 0 TOTAL REACHED AT COMMUNITY TRAINING 442 MEMBERS REACHED AT ALL EVENTS 1131 TOTAL REACHED AT ALL EVENTS	\$0.00 TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

FY 2025-2026 JULY 2025 TOTALS

			
2 COMMUNITY EVENTS 3 MEMBER EDUCATION EVENTS 74 MEMBER ORIENTATIONS 1 MEETINGS/PRESENTATIONS 0 COMMUNITY TRAINING 6 TOTAL INITIATED/ INVITED EVENTS 80 TOTAL COMPLETED EVENTS	14 CITIES** Alameda Ashland Berkeley Castro Valley Fremont Hayward Livermore Newark Oakland <i>San Jose</i> San Leandro San Lorenzo Union City <i>Winchester</i>	649 TOTAL REACHED AT COMMUNITY EVENTS 895 TOTAL REACHED AT MEMBER EDUCATION EVENTS 74 TOTAL REACHED AT MEMBER ORIENTATIONS 100 TOTAL REACHED AT MEETINGS/PRESENTATIONS 0 COMMUNITY TRAINING 1113 MEMBERS REACHED AT ALL EVENTS 1718 TOTAL REACHED AT ALL EVENTS	\$0.00 TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

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

COMMUNICATIONS & OUTREACH DEPARTMENT

SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2025-2026 | July 2025

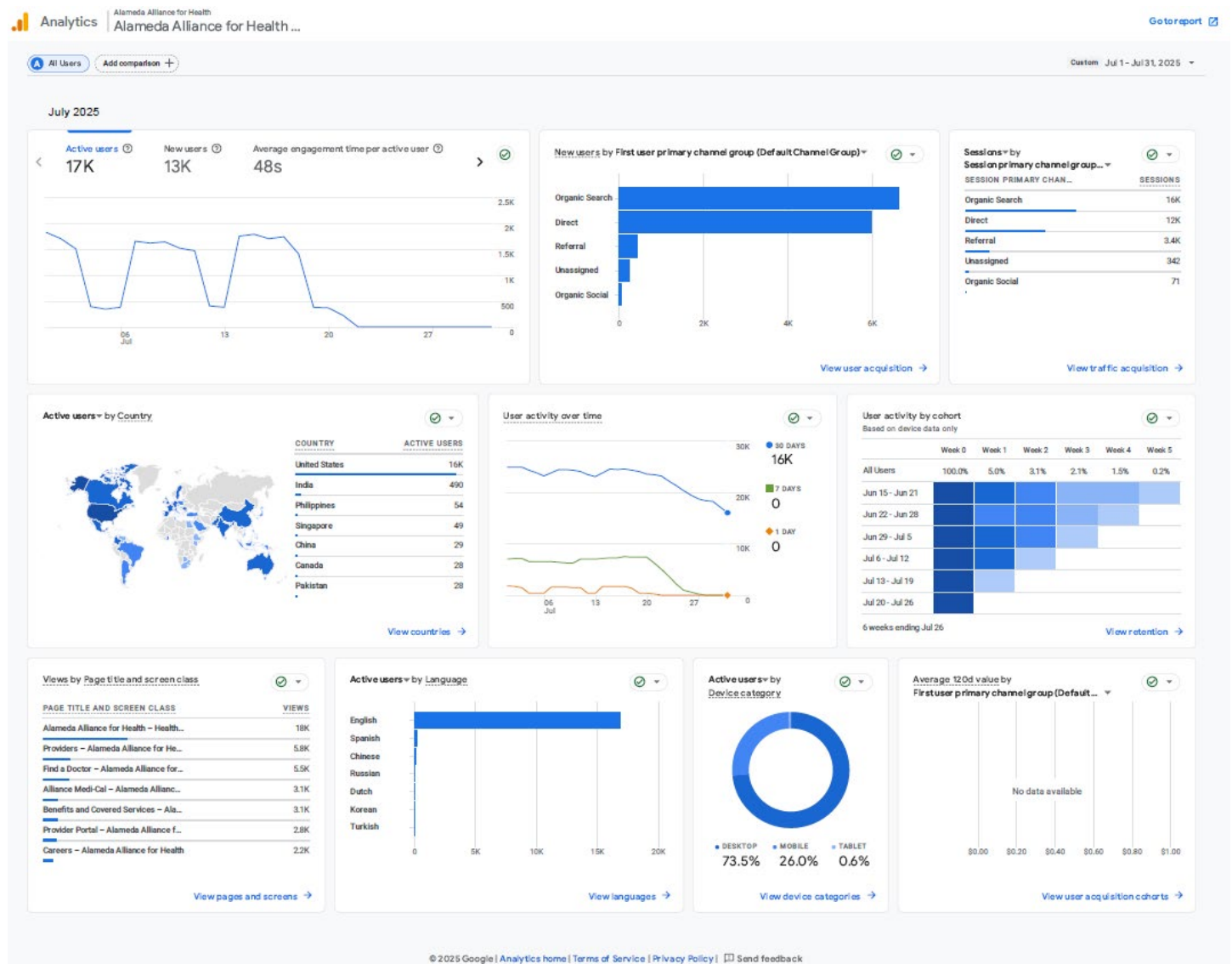
The Alliance Communications and Outreach (C&O) Department created the social media and website activity (SM&WA) Report to provide a high-level overview of stakeholder engagement through various digital media platforms. Between **July 1, 2025**, and **July 31, 2025**:

1. Alliance Website:
 - Received **17,000** unique visits
 - Received **13,000** new user visits
 - The top **10** website page visits were:
 - i. Homepage
 - ii. Provider Page
 - iii. Find a Doctor
 - iv. Members Medi-Cal
 - v. Benefits & Covered Services
 - vi. Provider Portal
 - vii. Careers
 - viii. Contact Us
 - ix. Members
 - x. Get a New ID Card
2. Facebook Page:
 - The number of fans remained at **635** throughout this period.
 - Did not receive any reviews in **July 2025**
3. Glassdoor Page:
 - Decreased from **3.5** to **3.1** out of a **5-star** overall rating
 - Did not receive any reviews in **July 2025**
4. Google Page:
 - **1,989** website clicks were made from the business profile
 - **1,503** calls made from the business profile
 - Did not receive any reviews in **July 2025**
5. Instagram Page:
 - Increased in followers from **636** to **648**
6. LinkedIn Page:
 - Increased followers from **6.7k** to **6.8k**
 - Received **318**-page clicks
7. X (previously Twitter) Page:
 - Increased in followers from **353** to **354**
8. Yelp Page:
 - Page visits **67**
 - Appeared in Yelp searches **155** times
 - Did not receive any reviews in **July 2025**

ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2025-2026 | July 2025

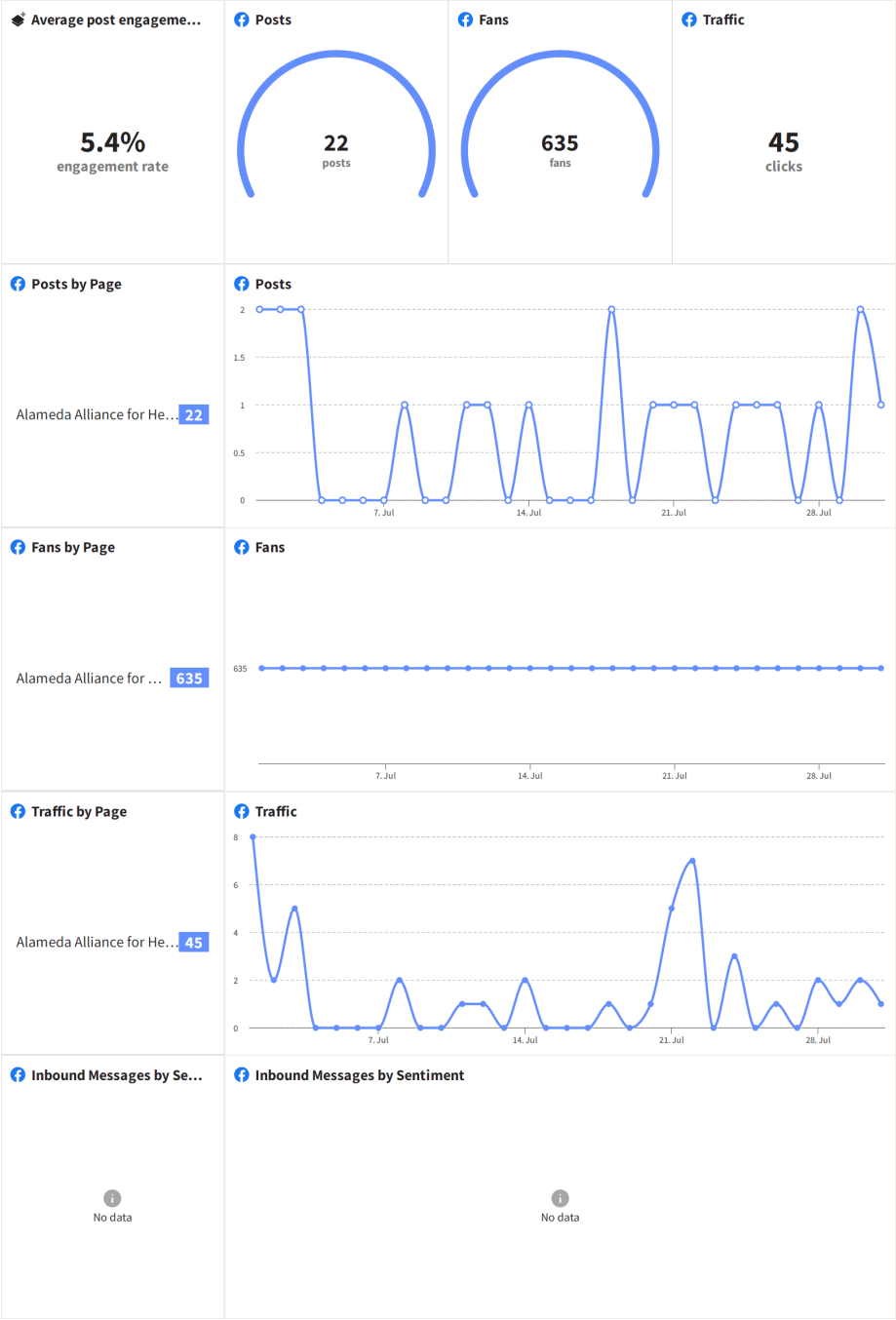
ALLIANCE WEBSITE OVERVIEW:



All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2025-2026\Q1\1. July 2025

ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT
FY 2025-2026 | July 2025

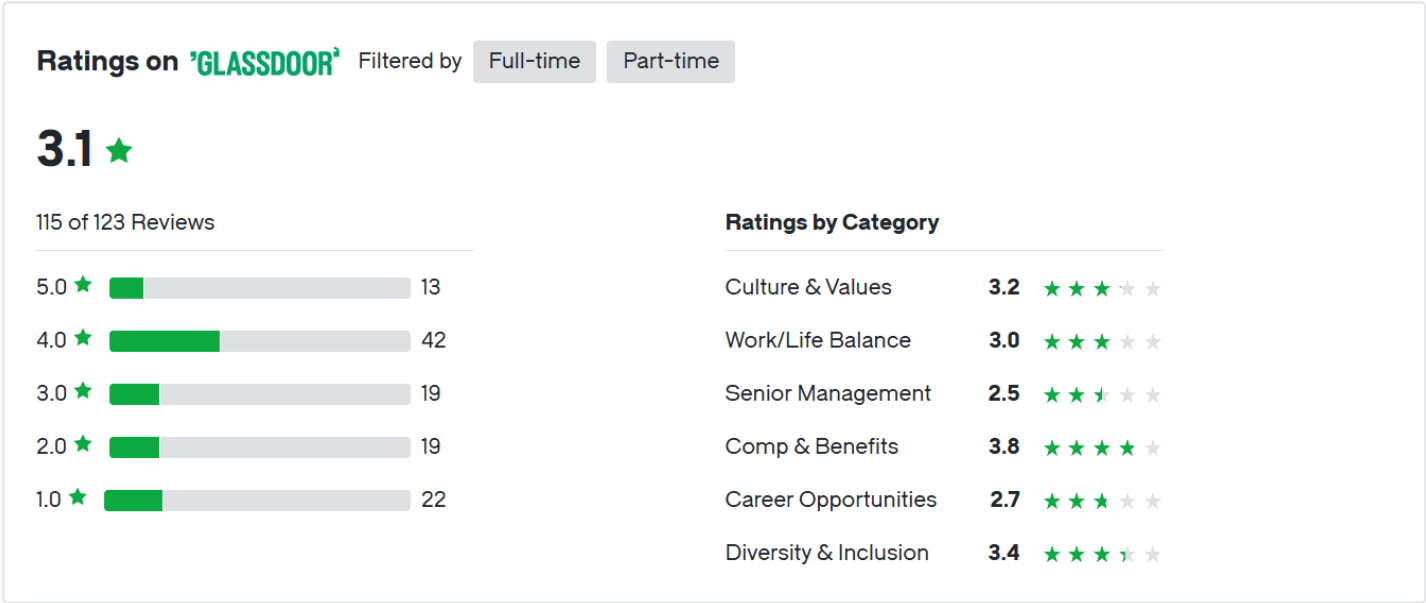
FACEBOOK OVERVIEW



All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2025-2026\Q1\1. July 2025

ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT
FY 2025-2026 | July 2025

GLASSDOOR OVERVIEW



Ratings by category

3.2	Culture & values
3.4	Diversity, Equity & Inclusion
3.0	Work/Life balance
2.5	Senior management
3.8	Compensation and benefits
2.7	Career opportunities

Ratings distribution

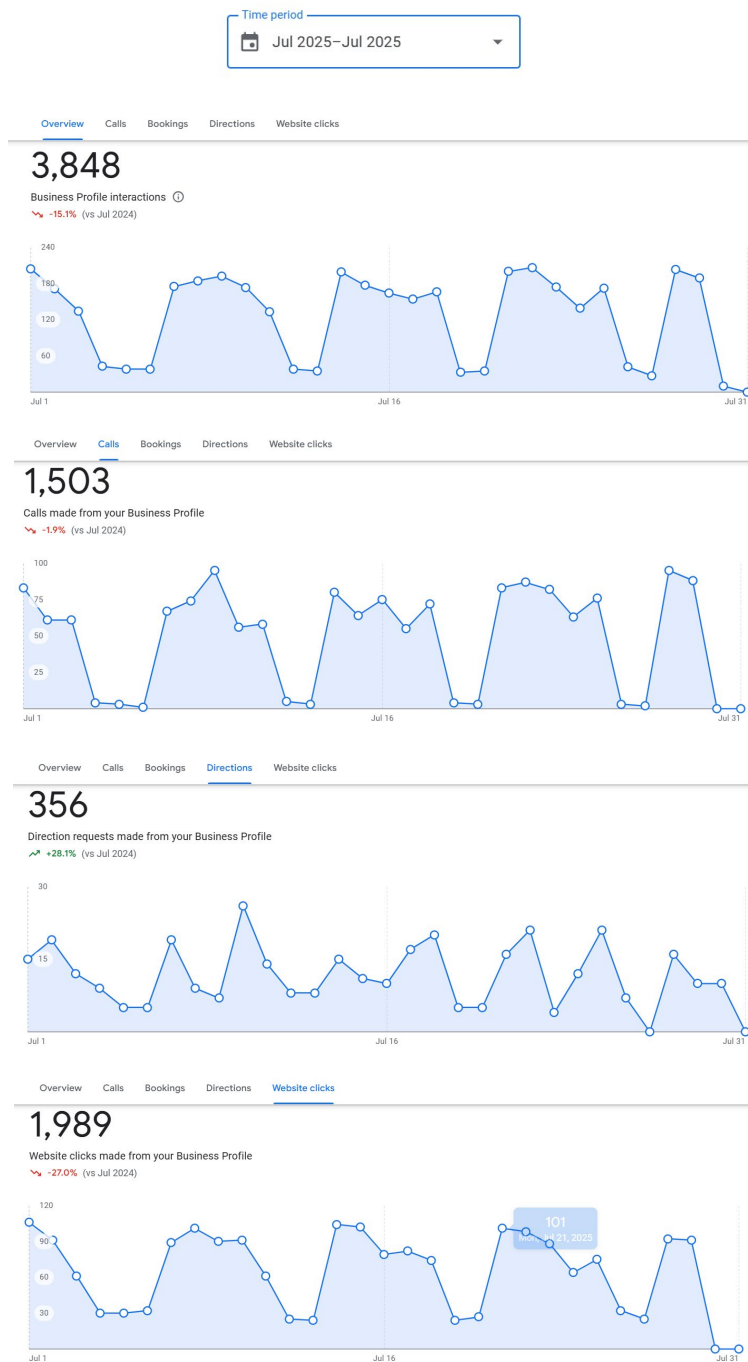
5 stars		11%
4 stars		37%
3 stars		17%
2 stars		17%
1 star		19%

All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2025-2026\Q1\1. July 2025

ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2025-2026 | July 2025

GOOGLE OVERVIEW:

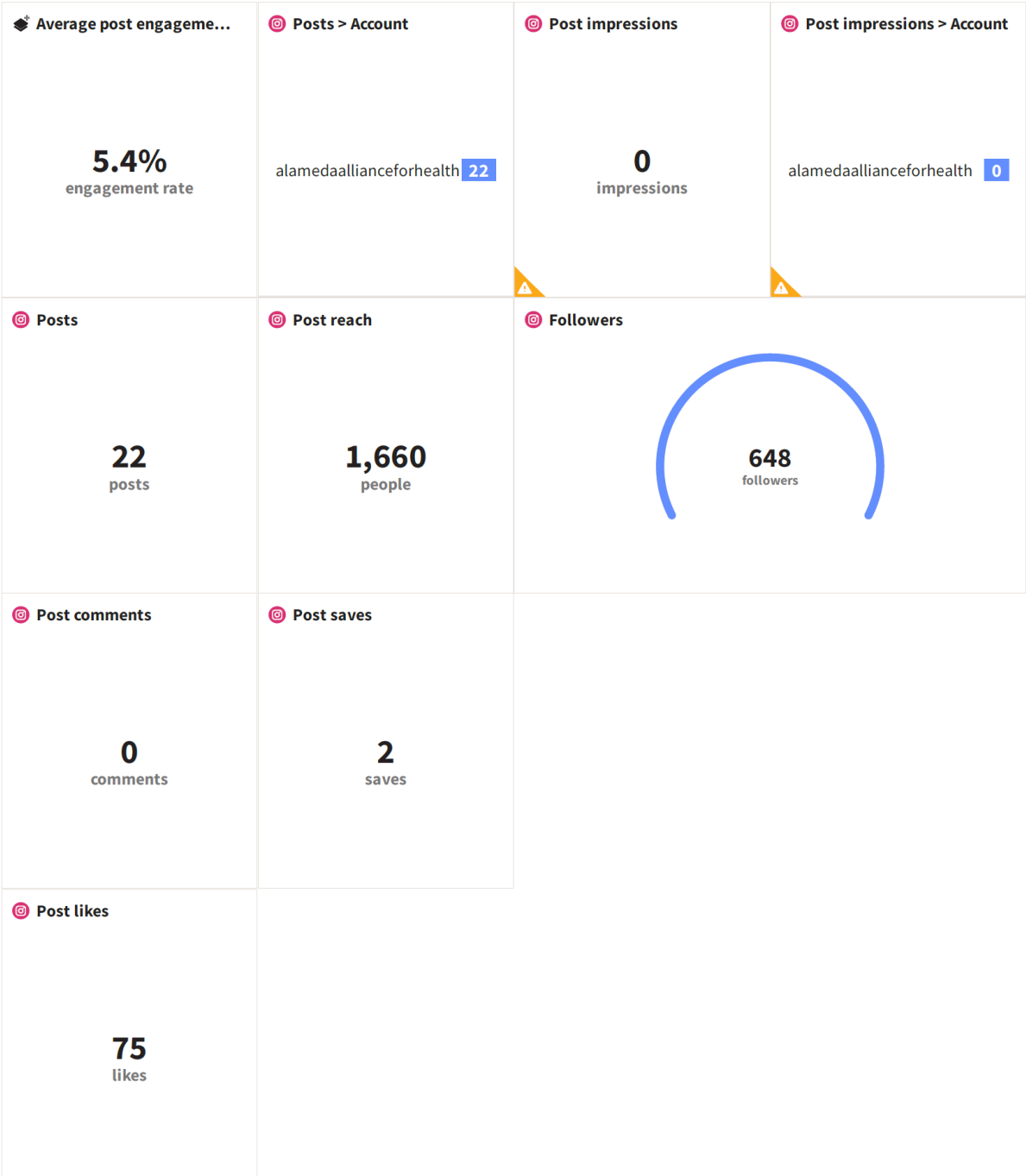


All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2025-2026\Q1\1. July 2025

ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2025-2026 | July 2025

INSTAGRAM OVERVIEW:

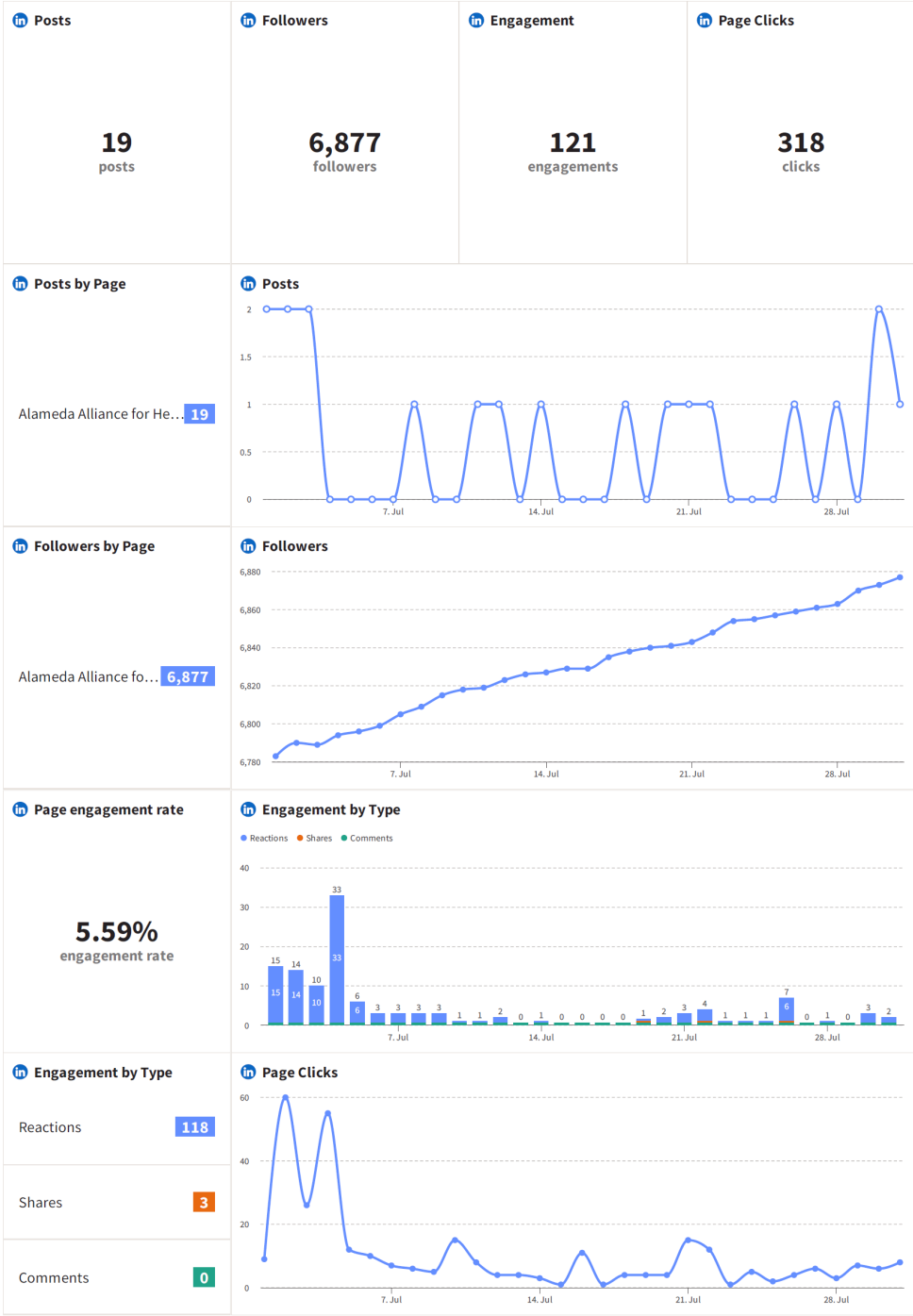


All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2025-2026\Q1\1. July 2025

ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2025-2026 | July 2025

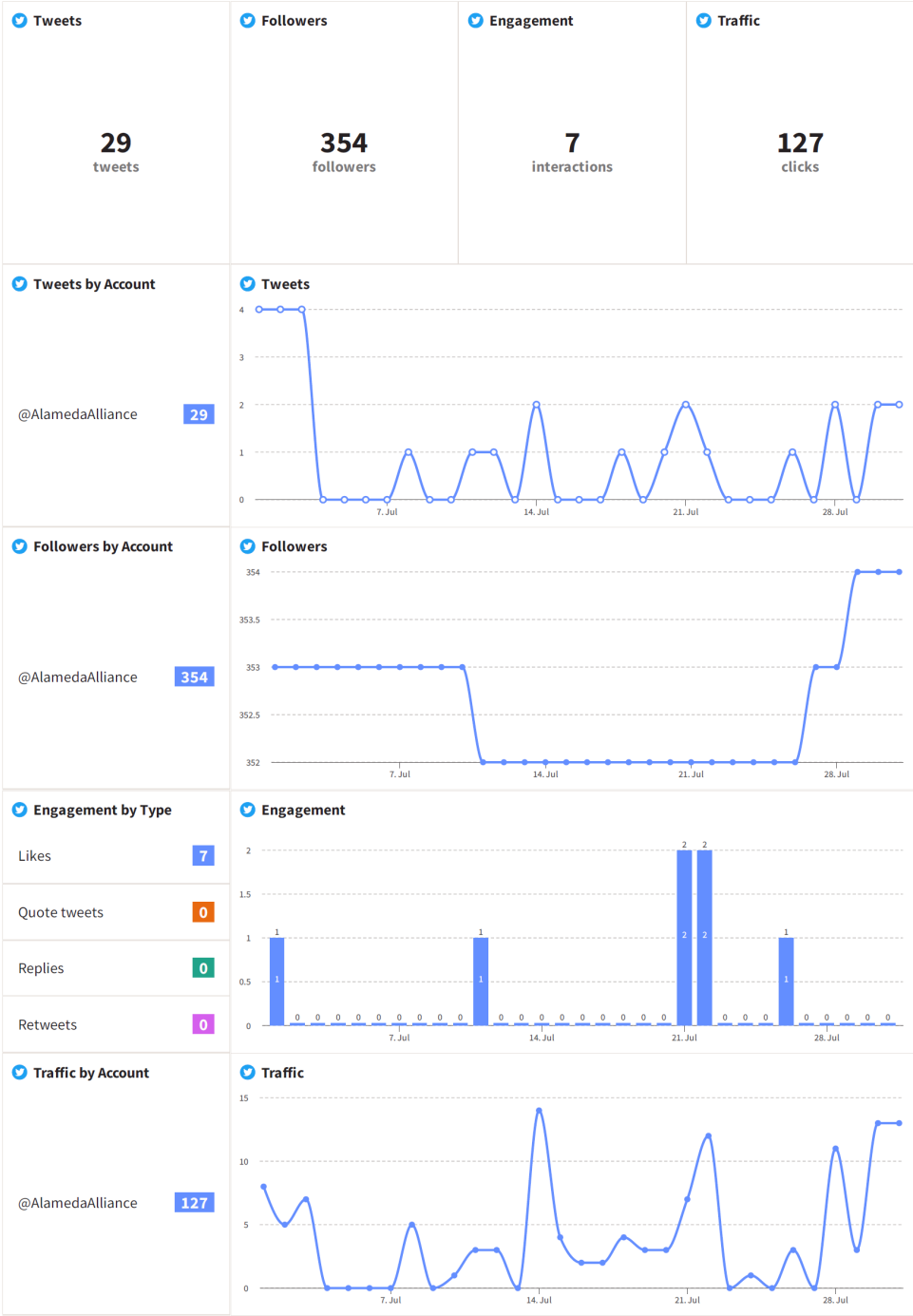
LINKEDIN OVERVIEW



All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2025-2026\Q1\1. July 2025

ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT
FY 2025-2026 | July 2025

X (previously TWITTER) OVERVIEW

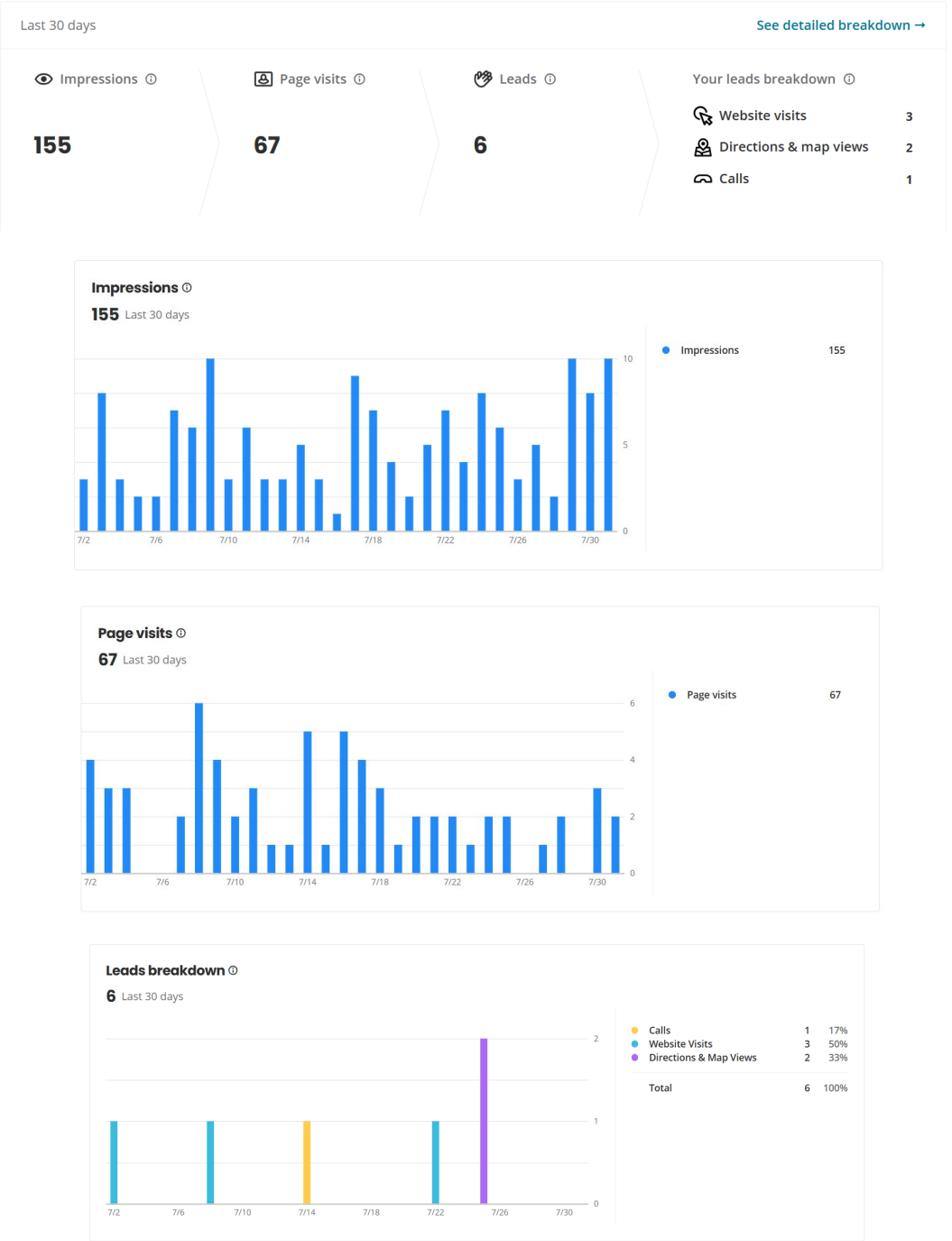


All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2025-2026\Q1\1. July 2025

ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2025-2026 | July 2025

YELP OVERVIEW



All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2025-2026\Q1\1. July 2025



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: August 8th, 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.
 - DHCS Final Report: On July 22nd, 2025, the Plan received the final report from the Department of Health Care Services (DHCS). Initially, the DHCS had cited one finding related to the lack of medical director review for post-stabilization authorization requests. The Plan disputed the finding during the CAP Remediation Process post-audit and provided supporting evidence by the required deadline of July 9th, 2025. Following its review, the DHCS withdrew the finding from the report.
 - DMHC Preliminary Report: As of the latest update, the Plan is still awaiting the DMHC's preliminary report.
- 2024 Department of Health Care Services (DHCS) Routine Full Medical Survey
 - The Department of Health Care Services (DHCS) conducted its Routine Full Medical Survey from June 17th to June 28th, 2024. The Plan received the Final Audit Report on November 18th, 2024, which identified a total of twenty (20) findings. The final CAP update was submitted timely on June 23rd, 2025. As of the latest update, sixteen (16) CAPs have been accepted, and four (4) CAPs remain under 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 Care Services and Transportation Services (NEMT & NMT). Nine (9) CAPs were identified. To date, six (6) CAPs have been accepted. There are three (3) CAPs that have been partially accepted; the data exchange between the Alliance and Alameda County Behavioral Health (ACBH) remains to have challenges with the Release

of Information (ROI) barriers and incomplete SmartCare system migration. ACBH anticipates full implementation in June 2026. In the interim, care coordination continues via bi-weekly case discussions and regular meetings with the Alliance and the county. DHCS confirmed receipt of the Plan's last update, submitted 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 routine examination of the Plan's fiscal and administrative affairs, to include an examination of the financial report for the quarter ending March 31st, 2025. The entrance conference will take place on August 4th, 2025. The DMHC expects to hold daily conference calls with the Plan through the month of August.
- 2025 Health Services Advisory Group, Inc. (HSAG) Network Adequacy Validation Audit (NAV)
 - Pre-audit materials were submitted timely to HSAG on July 17th, 2025. The Plan's virtual interviews are scheduled for August 11th, 2025.

Compliance Program Activity – All LOBs

- Bid and Formulary Submission
 - On June 2nd, 2025, the Alliance successfully submitted its CY2026 Medicare Bid and Formulary to CMS by the required deadline. The CMS Desk Review—a standard, post-submission process in which CMS analysts evaluate the bid for accuracy, completeness, and compliance with regulatory requirements has completed. The Alliance awaits approval of its Bid Pricing Tool, a spreadsheet-based tool used to calculate plan pricing, including premiums, cost-sharing, and subsidies that must be actuarially certified. In prior years CMS has completed this review by August 12th; however, CMS staffing reductions may delay this to late August.
- Department of Managed Health Care (DMHC) Medicare Filings
 - CY26 Medicare, 2024 EAE D-SNP Material Modification Filing (E-Filing No. 20244060). Per the DMHC EAE D-SNP Checklist, if Plans develop member facing notices, they must submit them as an amendment to its Material Modification filing. On August 1st, 2025, the Plan submitted several Case Management and Disease management letters for DMHC's review and will expect a response from DMHC within the next 30 days.

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 July 2nd, 2025, DMHC sent 17 comments. Compliance is in the process of responding to the comments with additional documents and will provide status updates on the legislation that is in progress. Compliance continues to collaborate with subject matter experts to successfully implement all legislation 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) that will delay the implementation to January 1st, 2026, has been approved by the legislature and has been signed by the Governor. Compliance is awaiting further guidance in a new APL to be issued by the DMHC.

- On April 1st, 2025, DMHC published APL 25-007 which provides guidance and outlines compliance requirements related to Assembly Bill 3275. The bill, effective January 1st, 2025, adjusts the claims reimbursement timeframe from 45 working days to 30 calendar days. Compliance has created several workstreams to identify implementation activities and to submit an e-Filing to DMHC by August 1st, 2025.
- Alameda Alliance Privacy Office Operational Updates&
 - In July 2025, the Alameda Alliance Privacy Office revised the current versions of the Notice of Privacy Practices (NPP) and Authorized Representative (AOR) forms to support compliance with Dual Eligible Special Needs Plan (D-SNP) regulatory requirements. These updates are intended to align with current federal and state guidelines and to ensure appropriate communication of members' privacy rights and delegation of authority. Approved NPP and AOR will be submitted to DHCS for File and Use.
 - In June 2025, the Privacy Office updated the HIPAA Incident Handling Policy and SOP as part of its ongoing efforts to strengthen organizational readiness for Dual Eligible Special Needs Plan (D-SNP) implementation. These updates were designed to ensure alignment with applicable federal and state privacy regulations, clarify internal reporting procedures, and enhance the Plan's ability to promptly identify, assess, and respond to potential privacy breaches in accordance with HIPAA requirements.
 - Q2 Executive Summary for HIPAA Incidents was submitted to the Chief Compliance and Privacy Officer; overview showed a decrease in overall number of incidents and an increase in timely reporting. The categories of verified incidents with the highest volume: unsecured emails with PHI, misdirected mail due to address updates required and expired AORs. No State or Federal reportable breaches occurred in Q2.
 - Q2 Executive Summary for Privacy Rounds conducted at the Alameda Alliance for Health office were submitted to the Chief Compliance and Privacy Officer. All work devices were appropriately locked and secured when not in

use. The number of identified PHI printouts unsecured in work areas were significantly reduced. Securing printed PHI continues to be a focal point of the audits and meetings with facilities and department leaders are underway.

- 2024 Board of Governors Training

As outlined in the Compliance Plan, the Plan has assigned HIPAA and FWA training to all new and standing members of the Board. Of the eighteen Board members, sixteen (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.
13	4/9/2025	DMHC	25-008	Provider Directory Annual Filing Requirements	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (the Department) issues this All Plan Letter (APL) to remind health care service plans (plans) of California Health and Safety Code section 1367.27, subdivision (m)'s requirement to annually submit provider directory policies and procedures to the Department. In addition, the Department reminds plans to submit the changes to their provider directory policies and procedures as instructed in APL 24-018 – Compliance with Senate Bill 923.

#	Date Released	Regulatory Agency	APL #	APL Title	LOB	APL Purpose Summary
14	4/15/2025	DMHC	25-009	2025 Health Plan Annual Assessments	GROUP CARE & MEDI-CAL	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) to provide information to health care service plans (health plans) pertaining to the DMHC's fiscal year (FY) 2025-26 annual assessment.
15	4/25/2025	DHCS	25-006	Timely Access Requirements	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with guidance regarding the ongoing requirement to meet timely access standards as outlined in Health and Safety Code (H&S) section 1367.03, as set forth by Senate Bill (SB) 221 (Chapter 724, Statutes of 2021) and SB 225 (Chapter 601, Statutes of 2022). MCPs are required to comply with these requirements pursuant to Welfare and Institutions Code (W&I) section 14197(d)(1)(a).1 Additionally, this APL outlines the required minimum performance levels (MPLs) as set by the Department of Health Care Services (DHCS) which go into effect Measurement Year (MY) 2025 for the Timely Access Survey.
16	4/25/2025	DHCS	25-007	Enforcement Actions: Corrective Action Plans, Administrative and Monetary Sanctions	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide clarification to Medi-Cal managed care plans (MCPs) of the Department of Health Care Services' (DHCS) policy regarding the imposition of enforcement actions, including corrective action plans, and administrative and monetary sanctions, which are among the enforcement actions DHCS may take to enforce compliance with MCP contractual provisions and applicable state and federal laws.
17	5/5/2025	DHCS	25-008	Hospice Services and Medi-Cal Managed Care	MEDI-CAL	The purpose of this All Plan Letter (APL) is to highlight contractual, regulatory, and statutory requirements applicable to Medi-Cal managed care plans (MCPs) with respect to their responsibilities to provide Medically Necessary hospice services to their MCP Members.
18	5/12/2025	DHCS	25-009	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 (Knox-Keene Act).
21	7/3/2025	DHCS	25-011	H.R.1 -- Federal Payments to Prohibited Entities	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care plans (MCPs) on handling of payments to Medi-Cal and Family Planning, Access, Care, and Treatment Program (Family PACT) Providers who may be impacted by H.R. 1 that was enacted on July 4, 2025 (Public Law No: 119-21). This APL also provides guidance pertaining to a recent Temporary Restraining Order (TRO) blocking immediate implementation of Section 71113 in H.R. 1, which will expire in 14 days of issuance, unless modified, extended, or stayed.

COMPLIANCE DASHBOARD SUMMARY

OVERALL FINDINGS	Resource	Type									TOTAL	% Completed	
			2018	2019	2020	2021	2022	2023	2024	2025			
	DHCS	Total State Audit Findings	38	28	7	33	15	24	20	TBD	165		
		Total Self-Identified Issues	12	0	0	2	0	2	6	3	25		
		Total Findings	50	28	7	35	15	26	26	3	190		
		Total In Progress	0	0	0	0	0	8	25	3	36		
		Total Completed	50	28	7	35	15	18	1	0	154		81%
		Total Findings	50	28	7	35	15	26	26	3	190		
	DMHC	Total State Audit Findings			5	6	8	3		TBD	22		
		Total Self-Identified Issues			3	0	0	0		TBD	3		
		Total Findings			8	6	8	3		TBD	25		
		Total In Progress			0	0	0	3		TBD	3		
		Total Completed			8	6	8	0		TBD	22		88%
		Total Findings	NA	NA	8	6	8	3	NA	TBD	25		
	DMHC Financial Services	Total State Audit Findings		5			4			TBD	9		
		Total Self-Identified Issues		0			0			TBD	0		
		Total Findings		5			4			TBD	9		
		Total In Progress		0			0			TBD	0		
		Total Completed		5			4			TBD	9		100%
		Total Findings	NA	5	NA	NA	4	NA	NA	TBD	9		
STATE AUDIT FINDINGS		In Progress	0	0	0	0	0	10	19	TBD	29	85%	
		Completed	38	33	12	39	27	17	1	0	167		
		Total Findings	38	33	12	39	27	27	20	0	196		
SELF-IDENTIFIED FINDINGS		In Progress	0	0	0	0	0	0	6	3	9	76%	
		Completed	12	0	3	2	0	2	0	0	19		
		Total Findings	12	0	3	2	0	2	6	0	25		
TOTAL OVERALL FINDINGS			50	33	15	41	27	29	26	3	224		

Compliance Dashboard Summary

COMPLIANCE DASHBOARD SUMMARY			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	196	89%
	Total Self-Identified Issues	25	11%
	Total Findings	221	
	Total In Progress	36	16%
	Total Completed	185	84%
	Total Findings	221	
STATE AUDIT FINDINGS	In Progress	29	15%
	Completed	167	85%
	Total Findings	196	
SELF-IDENTIFIED FINDINGS	In Progress	9	32%
	Completed	19	68%
	Total Findings	28	

2025 DHCS Audit Summary			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	0	0%
	Total Self-Identified Issues	3	100%
	Total Findings	3	
	Total In Progress	3	100%
	Total Completed	0	0%
	Total Findings	3	

Compliance Dashboard Summary

2024 DHCS Audit Summary			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	20	77%
	Total Self-Identified Issues	6	23%
	Total Findings	26	
	Total In Progress	25	96%
	Total Completed	1	4%
	Total Findings	26	

2023 DMHC Follow-Up Review			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	3	100%
	Total Self-Identified Issues	0	0%
	Total Findings	3	
	Total In Progress	3	100%
	Total Completed	0	0%
	Total Findings	3	

Compliance Dashboard Summary

2023 DHCS Focused Audit Summary			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	9	100%
	Total Self-Identified Issues	0	0%
	Total Findings	9	
	Total In Progress	8	89%
	Total Completed	1	11%
	Total Findings	9	

2023 DHCS Audit Summary			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	15	88%
	Total Self-Identified Issues	2	12%
	Total Findings	17	
	Total In Progress	0	0%
	Total Completed	17	100%
	Total Findings	17	

Compliance Dashboard Summary

2022 DMHC BHI Audit Summary			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	2	100%
	Total Self-Identified Issues	0	0%
	Total Findings	2	
	Total In Progress	0	0%
	Total Completed	2	100%
	Total Findings	2	

2022 DMHC RBO Audit: Delegate			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	3	100%
	Total Self-Identified Issues	0	0%
	Total Findings	3	
	Total In Progress	0	0%
	Total Completed	3	100%
	Total Findings	3	

Compliance Dashboard Summary

2022 DMHC RBO Audit: Delegate			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	3	100%
	Total Self-Identified Issues	0	0%
	Total Findings	3	
	Total In Progress	0	0%
	Total Completed	3	100%
	Total Findings	3	

2022 DMHC Financial Serviced Summary			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	4	100%
	Total Self-Identified Issues	0	0%
	Total Findings	4	
	Total In Progress	0	0%
	Total Completed	4	100%
	Total Findings	4	

Compliance Dashboard Summary

2022 DHCS Audit Summary			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	15	100%
	Total Self-Identified Issues	0	0%
	Total Findings	15	
	Total In Progress	0	0%
	Total Completed	15	100%
	Total Findings	15	

2021 DMHC Joint Audit Summary			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	6	100%
	Total Self-Identified Issues	0	0%
	Total Findings	6	
	Total In Progress	0	0%
	Total Completed	6	100%
	Total Findings	6	

Compliance Dashboard Summary

2021 DHCS Joint Audit Summary			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	33	94%
	Total Self-Identified Issues	2	6%
	Total Findings	35	
	Total In Progress	0	0%
	Total Completed	35	100%
	Total Findings	35	

2020 DHCS Focused Audit Summary			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	7	100%
	Total Self-Identified Issues	0	0%
	Total Findings	7	
	Total In Progress	0	0%
	Total Completed	7	100%
	Total Findings	7	

Compliance Dashboard Summary

2020 DMHC Medical Services Audit Summary			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	5	63%
	Total Self-Identified Issues	3	38%
	Total Findings	8	
	Total In Progress	0	0%
	Total Completed	8	100%
	Total Findings	8	

2019 DMHC Financial Services Audit Summary			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	5	100%
	Total Self-Identified Issues	0	0%
	Total Findings	5	
	Total In Progress	0	0%
	Total Completed	5	100%
	Total Findings	5	

Compliance Dashboard Summary

2019 DHCS Medical Services Audit Summary			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	28	100%
	Total Self-Identified Issues	0	0%
	Total Findings	28	
	Total In Progress	0	0%
	Total Completed	28	100%
	Total Findings	28	

2018 DHCS Medical Services Audit Summary			
OVERALL FINDINGS	Type	TOTAL	%
	Total State Audit Findings	38	76%
	Total Self-Identified Issues	12	24%
	Total Findings	50	
	Total In Progress	0	0%
	Total Completed	50	100%
	Total Findings	50	

**ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD**

KEY	
Yellow = Plan Observations	
White = State Finding in the final report that was not a Plan Observation	
<u>R</u> = Repeat Findings	

2025 DHCS Audit - Audit Review Period 6/1/2023 - 5/31/2024 Audit Onsite Dates - March 3, 2025 to March 7, 2025			
#	Category	DHCS Exit Conference March 20,2025	Department Responsible
1	UM	The Plan did not consistently secure timely authorization for medically necessary PSA or ensure contractors' compliance with APL 23-009.	UM
2	UM	The Plan did not adequately ensure the availability of a Medical Director or licensed physician 24/7 to coordinate care and respond to authorizations.	UM
3	UM	The Plan did not transfer out-of-network hospitalized members to in-network providers as required.	UM

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2024 DHCS Audit - Audit Review Period 6/1/2023 - 5/31/2024 Audit Onsite Dates - June 17, 2024 - June 28, 2024						
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible
1	UM	(1.2.1) Referral to Transplant Program Within 72 Hours The Plan did not directly refer an adult member to a transplant program for evaluation within 72 hours of the member's specialist identifying the member as a potential candidate for MOT.	1. The Plan's Standard Operating Procedures (SOP) were updated to reflect the 72 hours MOT TAT and all UM staff were re-trained on 6/20/2024. 2. The UM team instituted a formal internal review process to ensure all operating procedures align with Policy & Procedures. A Standard Operating Procedures (SOP) was developed and staff were trained on the internal review process. 3. Policy & Procedure Tracker developed to ensure at least annual and ad-hoc updates to P&Ps are monitored and aligned with regulatory guidance. The Plan monitors MOT turnaround times via daily operational reports.	1/15/2025	Completed	UM
2	UM	(1.2.2) Centers of Excellence (COE) for Major Organ Transplants The Plan did not ensure that all MOT procedures were performed in a Medi-Cal approved COE transplant program. The Plan did not confirm that its COEs were unable to perform a MOT surgery before arranging the MOT at a transplant program that is not a Medi-Cal approved COE.	1. On 6/27/2024 The Plans Medical Directors were notified that Bone Marrow Transplant (BMT) and other regulatory Major Organ Transplants (MOT) are only managed in-network unless Continuity Of Care (COC) or related to urgent/emergent hospitalization. In addition, The Plan took the following actions: On 6/27/2024 the MOT workflows were updated to include Chief Medical Officer (CMO) Denial oversight. On 8/14/2024 The Plan conducted Delegate training for the new CHCN Medical Director and CHCN Utilization Management Director. On 8/1/2024 a copy of the current DHCS Centers Of Excellence list was distributed to staff. The Plan updated policy UM-071 and submitted to Utilization Management Committee on 8/30/2024. 2. The Plan updated Standard Operating Procedures to include DHCS Center Of Excellence requirements. 3. The UM team instituted a formal internal review process to ensure all operating procedures align with Policy & Procedures. A Standard Operating Procedures was developed, and staff were trained on the internal review process. <u>Update 2/15/2025</u> : Operation Major Organ Transplant reported created and being used to monitor the appropriate use of Medi-Cal COEs.	In Progress	1. Completed 6/27/2024 2. Completed 6/27/2024 3. In Progress	UM
3	UM	(1.3.1) Written Member Consent The Plan did not obtain members' written consent when providers requested appeals on behalf of members.	1. The Plan updated G&A-008 Adverse Benefit Determination Appeal Process to meet the requirements of Member Written Consent in accordance with The Plan's DHCS contract. The workflow was updated and staff training completed on 11/6/2024 2. Internal audits for requirement of written member consent started in January 2024 and will continue.	In Progress	1. Completed 11/6/2024 2. In Progress	G&A
4	UM	(1.3.2) Appeals Letters: Nondiscrimination Notice (NDN) and Language Assistance Taglines (LAT) The Plan did not send NDN and LAT information that met the minimum requirements in APL 21-004 with member notifications for appeals.	1. CLS-003 Non-discrimination Language Assistance Services and Effective Communication for Individuals with Disabilities has been submitted to the MCO for approval. 2. The Your Rights Package was updated with the current Non-Discrimination Notice (NDN) and Language Assistance Tagline (LAT). The NDN and LAT were added to the Member Rights package and updated in the G&A system. 3. The G&A Department in conjunction with the Compliance Department will review all enclosures on an annual basis to ensure compliance. G&A is completing an Internal Audit SOP that outlines the self monitoring / internal audit process.	In Progress	1. In Progress 2. Completed 1/15/2025 3. In Progress	G&A

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2024 DHCS Audit - Audit Review Period 6/1/2023 - 5/31/2024 Audit Onsite Dates - June 17, 2024 - June 28, 2024						
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible
5	UM	(1.5.1) Overutilization of Subacute Level of Facility Care The Plan did not ensure that its delegate had mechanisms to detect overutilization of subacute level of facility care; the delegate inappropriately approved higher levels of subacute care for members who required lower levels of regular skilled nursing facility care.	1. The delegate reports over/under-utilization measures in their quarterly HICE report. The Plan has instituted a Standardized Operating Procedure that delineates roles and responsibilities for reviewing delegate reports, including a formal sign-off process, to be used in conjunction with P&P UM-060 Delegation Management and Oversight. 2. The Plan will request the delegate include post-acute cases in their annual UM audit universe and monthly internal UM audit reports. <u>Update 1/15/2025</u> : The Plan received the delegate's internal UM audit report submission on 12/27/2024 and completed a review of the delegate's audit results on 12/31/2024, and noted adequate strategies to address findings. 3. The Plan has requested the delegate include nursing facility utilization as part of their over/under utilization measures, reported in the Quarterly HICE report (auth volume by facility levels of care). The Q4 2024 HICE report is pending. 4. The Plan shares all newly issued DHCS APLs and guidance, including billing instructions related to revenue codes, and collects attestations from delegates	In Progress	1. Completed 10/1/2024 2. Completed 12/31/2024 3. In Progress 4. In Progress	UM
6	UM	(1.5.2) Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services The Plan did not ensure that its delegate provided medically necessary EPSDT services, care coordination, and appointment scheduling assistance to members under the age of 21.	1. The delegate created a new policy and procedure specific to EPSDT care coordination. This policy will be reviewed by the delegate's internal committee on 1/22/2025 and then the policy will be submitted to the Plan for review. 2. The Plan requested the delegate identify EPSDT cases in their monthly internal Case Management audit reports, as well as identifying EPSDT cases in their annual UM audit universe and monthly internal UM audit reports. The Plan will audit EPSDT cases to evaluate whether members are receiving appropriate EPSDT services, care coordination, and appointment scheduling as needed. <u>Updated 1/15/2025</u> : The Plan received confirmation that the delegate updated their internal audit tool to include the appropriate EPSDT elements. The Plan will review the delegate's next internal audit to verify use of the revised audit tool. <u>Update 2/15/2025</u> : The Plan received the delegate's internal audit tool and has confirmed it reflects the EPSDT elements were added appropriately. 3. The Plan will report the delegate's CM and UM audit outcomes at the UM Committee, upon receipt of reports.	In Progress	1. In Progress 2. In Progress 3. In Progress	UM
7	CM and CoC	(2.1.1) Provision of Blood Lead Screening The Plan did not ensure that blood lead screening tests were conducted for members up to six years of age.	1. The Plan updated Policy QI-125 to include a requirement for providers to follow up on lab orders. Policy QI-125 will be approved in Quality Committee by 2/30/2025 and the Administrative Oversight Committee by 4/16/2025. 2. Funding for point-of-care testing units was provided in January 2024 to the delegate. These units aim to eliminate the need for members to make an additional visit to the lab. The Plan conducted member outreach and member incentives; members were offered a gift card to complete their services at the lab. 3. The Plan continues to monitor the HEDIS lead screening rates. Monitoring includes tracking of the documentation of lead level results by providers for ordered blood lead tests and any necessary follow-up activities and services for members, which is done through IHA audits and facility site reviews. 4. The Plan has conducted provider education through webinars, 1:1 meetings, CLPP training 1) Healthcare Services All-Staff meeting, 2) Provider webinar (live) and video (posted on Alliance website) and Measure Highlight tools. 5. The Plan previously conducted annual IHA audits to review provider charts for completion of preventive screenings. The frequency of these audits has now increased to twice a year. Additionally, during Facility Site Reviews (FSRs), charts are monitored for lead screening compliance. An audit is conducted for Blood Lead Screening and charts are reviewed for evidence of diagnosis, orders, refusal and results. When evidence of	In Progress	1. In Progress 4/16/2025 2. Completed 1/2025 3. Completed 1/15/2025 4. Completed 12/21/2024 5. In Progress	QI

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2024 DHCS Audit - Audit Review Period 6/1/2023 - 5/31/2024 Audit Onsite Dates - June 17, 2024 - June 28, 2024						
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible
			screening, and charts are reviewed for evidence or discussion, orders/referrals and results. When evidence or lead screening is not found, the Plan sends education letters to providers indicating the discrepancy. <u>Update 2/15/2025:</u> The Plan conducted an IHA audit Q3 2024 for IHA period 10/1/2023-05/31/2024. 6. Lead screening rates and IHA results are reviewed at the Quality Improvement Health Equity Committee meetings.		6. Completed 12/21/2024	
9	CM and CoC	(2.3.1) Provision of Behavioral Health Therapy (BHT) Services The Plan did not ensure the provision of BHT services in accordance with approved BHT treatment plans for members under the age of 21.	1. The Plan's existing policies support BHT services in accordance with BHT plans for members under the age of 21. The Plan insourced BHT services on 4/1/23 with the goal of increasing member access to care. The Plan has a dedicated team of care coordinators and BCBA's to support access to care. The Plan continues to explore opportunities to improve access to BHT care. This includes interventions to enhance the network and incentivize agencies to prioritize AAH members for services. The Plan continues to authorize out-of-network services whenever possible. 2. The Plan authorizes care within the required timeframes as requests are received. To monitor this issue, The Plan has established a metric to track the number of authorized hours to bill services. This functions as an indicator of the need for additional provider resources. This is a continuous process that started 5/10/2024. The Plan has ongoing efforts to onboard and contract additional BHT/ABA providers as additional resources are necessary. A monitoring and reporting process has been put in place to show the monthly authorized services for each member receiving BHT/ABA Treatment and for each QASP. The plan compares the # of authorized hours of BHT/ABA to the # of hours delivered based on claims data to monitor, track and report the % of authorized hours that are delivered. The plan reports these findings to the UM committee and identifies the QASPs with the lowest delivered services for outreach and intervention. 3. The Plan has drafted parent advisement that is scripted and provided to each parent/guardian when BHT/ABA services are authorized that asks for parents/guardians to call the Alliance BHT/ABA case management team if they experience disruption or barriers in receiving the BHT/ABA services that have been authorized for their child.	In Progress	1. Completed 1/15/2025 2. In Progress 3. In Progress	Behavioral Health
8	CM and CoC	(2.3.2) Timely Access to Behavioral Health Therapy (BHT) Services The Plan did not arrange and coordinate BHT services for members under the age of 21 within 60 calendar days.	1. The Plan established an EPSDT Policy & Procedure QI-135. The Plan established care coordination guidelines for staff providing care coordination with expectations. The Plan has a dedicated team of care coordinators and BCBA's to support access to care. The Plan has increased staffing to better support member access to care. 2. BH Navigators are required to conduct monthly follow-up with parents or guardians to inform them of the status of Mental Health (MH), Behavioral Health Treatment (BHT), or Comprehensive Diagnostic Evaluation (CDE) referrals. This process ensures timely communication and continuity of care for families. 3. Mandatory training was provided to the BH Navigators with written standard work. 4. The Plan is developing a report that will be utilized in an ongoing manner to monitor compliance with current case management protocols and DHCS requirements. The implementation is scheduled for the end of the first quarter of 2025. <u>Update 2/15/2025:</u> Fields are undergoing validation to ensure accuracy with a goal to have a functional report ready by March 31, 2025 for monitoring and oversight. 5. BH will conduct biweekly reviews to confirm that follow-ups are performed consistently and on-schedule. Feedback loops will be established to address any barriers encountered during follow-ups and adjust the protocol accordingly. BH Navigators will undergo mandatory training to reinforce the importance of	In Progress	1. Completed 8/1/2024 2. Completed 8/1/2024 3. Completed 8/1/2024 4. In Progress 3/31/2025 5. In Progress	Behavioral Health

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2024 DHCS Audit - Audit Review Period 6/1/2023 - 5/31/2024 Audit Onsite Dates - June 17, 2024 - June 28, 2024						
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible
			consistent monthly follow-ups, effective communication with parents, and accurate documentation.			
10	CM and CoC	(2.4.1) Notice of Action (NOA) Letters for Continuity of Care (COC) Requests The Plan did not ensure that NOAs for COC requests that were sent to members contained a clear explanation of the reason for the denial decision.	1. Policy UM-054 Notice of Action supports the process to ensure NOAs contain clear explanations of denial reasons. SOPs were updated to reflect utilization of new CoC NOA in a single letter, Medical Directors were trained, and all impacted staff were notified on 8/14/2024. 2. The Plan will include CoC denial notices in the monthly operational NOA audits, reported quarterly at UMC.	In Progress	1. Completed 8/14/2024 2. In Progress	UM
11	Access and Availability	(3.1.1) Appointment Waitlist Timeliness The Plan did not ensure members were able to obtain medically necessary appointments within established timely access standards. One of the Plan's medical groups placed members on an appointment waitlist and had members waiting up to six months to make an appointment.	1. The Plan worked with the provider to close their panel in September, preventing additional wait listed members. (9/1/2024). The Plan met with the provider related to access in an On-going manner during Joint Operating Meetings (JOM) and Plan/provider Access Meetings. The provider actively outreached to members on the wait list. Progress reports were reviewed at Plan/provider Access meetings. In September 2024 the provider brought in two new providers to support with provider wait list. In review of grievances data, the number of grievances declined for timely access at this provider's location. The Plan has implemented QI initiatives to improve access to care, including pay for performance (P4P), extended office hours incentives and provider recruitment/retention incentives (AAH provider grant live as of 6/1/2024). 2. Provider access data shows outreach efforts have been effective in getting new members schedule for appointments and off the waitlist. The Plan is working on outreach reports from the provider to show continues self-monitoring as well as written procedures to support.	In Progress	1. Completed 10/21/2024 2. In Progress	QI
12	Access and Availability	(3.1.2) Monitoring In-Office Wait Times for Specialty and Behavioral Health Services The Plan did not monitor in-office wait time for specialists and behavioral health providers.	1. The Plan added in-office wait times measure to CG-CAHPS survey for BH providers on 5/6/2024. The finalized report was presented at the Access & Availability Committee in September. Specialist providers will be added to the CG-CAHPS survey starting on 1/21/2025. The final report is expected to be completed by Q2, 6/30/2025 QI-114 Monitoring of Access and Availability Standards was revised to include monitoring of in-office wait times for specialist and behavioral health providers.	In Progress	1. In Progress 6/30/2025	Behavioral Health
13	Access and Availability	(3.1.3) Monitoring Telephone Calls for Specialty and Behavioral Health Services The Plan did not monitor wait times for specialty and behavioral health providers to answer and return telephone calls.	1. The Plan added telephone wait times measure to CG-CAHPS survey for BH providers. The finalized report was presented at the Access & Availability Committee in September. Specialist providers will be added to the CG-CAHPS survey starting on 1/21/2025. The final report is expected to be completed by Q2, 6/30/2025. QI-114 Monitoring of Access and Availability Standards was revised to include monitoring of telephone wait times for specialist and behavioral health providers	In Progress	1. In Progress 6/30/2025	Behavioral Health

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2024 DHCS Audit - Audit Review Period 6/1/2023 - 5/31/2024 Audit Onsite Dates - June 17, 2024 - June 28, 2024						
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible
14	Member Rights	(4.1.1) Grievances Involving Clinical Issues The Plan did not ensure that a person with clinical expertise in treating a member's condition made the resolution decision for grievances involving clinical issues.	1. Policy G&A-003 Grievance and Appeals Receipt, Review, and Resolution was updated to require grievances with clinical issues, such as access or QOS grievances with clinical issues, to be resolved by the Medical Director. 2. The G&A Department will provide additional training to ensure that a person with clinical expertise in treating a member's condition made the resolution decision for grievances involving clinical issues. The Timeline will also need to be updated to include the contractual language. 3. The G&A Department will begin to conduct monthly internal audits in January 2025 to ensure that the requirement for grievances involving clinical issues is being met. 4. The G&A Department will provide an Internal Audit Standard Operating Procedure that outlines our self-monitoring/internal auditing processes.	In Progress	1. Completed 1/15/2025 2. In Progress 3. In Progress 4. In Progress	G&A
15	Member Rights	(4.1.2) Resolution of Grievances The Plan did not completely resolve the members' grievances.	1. The QA Grievance Audit Tool was reviewed to outline the future monitoring process to ensure that all grievances are resolved prior to being closed. 2. The G&A Department will begin to conduct monthly internal audits in January 2025 to ensure that the requirement for resolution of grievances is being met. 3. Staff training completed for the grievance timeline procedure.	TBD	1. Completed 1/15/2025 2. In Progress 3. Completed 2/15/2025	G&A
16	Member Rights	(4.1.3) Clear and Concise Resolution Letters The Plan's written resolution did not contain a clear and concise explanation of the Plan's decision.	1. The QA Grievance Audit Tool was reviewed to outline the future monitoring process to ensure that all grievances have clear and concise resolution letters prior to being closed. The G&A Department will provide additional training to ensure that the Plan's written resolution contains a clear and concise explanation. 2. The G&A Department will begin to conduct monthly internal audits in January 2025 to ensure that the requirement for Clear and Concise Resolution Letters is being met	TBD	1. In Progress 2. In Progress	G&A
17	Member Rights	(4.1.4) Grievance Letters: Non-Discrimination Notice (NDN) and Language Assistance Tagline (LAT) The Plan did not include updated NDN and LAT information with grievance acknowledgement and resolution letters.	1. Current LAT and NDN were added to the Member's Rights package and updated in the G&A system. 2. The G&A Department in conjunction with the Compliance Department will review all enclosures on an annual basis to ensure compliance	TBD	1. Completed 7/25/2024 2. In Progress	G&A
18	Member Rights	(4.2.1) Monitoring of Linguistic Performance The Plan did not assess the performance of its vendors' staff that provided linguistic services such as interpreter services.	1. The Plan has completed updates of Policy and Procedure (P&P) CLS-011-CLS Program Monitoring to include additional language on monitoring information collected and reporting. The Plan anticipates approval date of the updated draft by Alliance Administrative Oversight Committee (AOC) for 4/16/2025. 2. The Plan anticipates that updates to vendor contracts to include reporting requirements for vendor interpreter qualifications and cadence will be implemented by 3/31/2025. 3. The Plan anticipates the implementation of monthly vendor interpreter qualifications reporting by 1/31/2025. The Plan anticipates implementation of a monthly attestation of monthly vendor interpreter qualifications review by 1/31/2025. The Plan will review and address concerns with vendor interpreter qualifications at Quarterly Vendor Joint Operations Meeting (JOM) by 3/31/2025. The Plan will report and address concerns with vendor interpreter qualifications at Quarterly Cultural and Linguistic Services Subcommittee (CLSS) meeting by 4/30/2025.	TBD	1. In Progress 4/16/2025 2. In Progress 3/31/2025 3. In Progress 4/30/2025	Cultural and Linguistic Services

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#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible
19	Member Rights	(4.3.1) Notification to DHCS The Plan did not notify DHCS within 24 hours upon discovery of any suspected breach or security incident, unauthorized access, use or disclosure of PHI or PI.	1. The Plan updated CMP-013 "HIPAA Privacy Reporting" in September 2024 to include verbiage addressing the gap that contributed to the audit finding: "Referrals must be made immediately upon discovery, and no later than 24 hours after." Additional updates included a Corrective Action section to address late referrals: "Corrective actions will be taken for delayed referrals, including but not limited to education, training, and / or Corrective Action Plans (CAP)." CMP-013 also states, "The Alliance will investigate the incident and submit an Initial Privacy Incident Report (PIR) to DHCS within 24 hours of discovery of a breach, suspected breach or security incident." Verbiage of Privacy Incident Investigation and Reporting Procedure updated to formalize education and corrective action for late referrals. 2. Implement new monitoring process to address the gap in referrals from G&A and internally within Compliance that contributed to the audit finding: "The Privacy Office will monitor the Compliance inbox, Compliance hotline, Privacy Compliance Inbox, and HealthSuite system for referral of any HIPAA Privacy reporting incidents. Each will be checked daily at minimum." 3. The Privacy Office is conducting weekly audits of HealthSuite referrals to ensure privacy concerns reported by members are appropriately categorized by the Member Services Department. Appropriate categorization will enable timely reporting of privacy incidents. 4. The Plan will include review of the Internal Audit results at the Compliance Committee meetings.	In Progress	1. Completed 9/18/2024 2. Completed 12/13/2024 3. Completed 7/15/2024 4. In Progress	Compliance
			1. The Plan will review and update the following impacted P&Ps as needed: PRV-005 & CRE-002. <u>3/14/2025</u>: PRV-005 was reviewed and confirmed the information was present in the policy and no additional updates were identified. 2. The Plan will provide an advisory to delegates and/or providers that delegated for credentialing functions about timely reporting requirements. <u>3/14/2025</u>: The Plan notified providers delegated for Credentialing functions about timely adverse termination reporting requirements by email and provided a PowerPoint Reminder Notice and a Adverse Reporting Template. In addition, the information was also shared with Teladoc during the Q1 2025 Joint Operations Meeting (JOM) on 02/04/2025. 3. The Plan conducts monthly review of the exclusion and suspension lists and this is an ongoing process that will support ongoing monitoring and the identification and reporting of adverse provider termination. This is ongoing. There are no changes to the Plan's provider notice templates and member notice templates. 4. The Plan's provider manual will be updated in Q1 2025. 5. The Plan will develop a log that will track Provider terminations, provider notification, and member notification including date of reports received and submitted to DHCS and date members were notified		1. In Progress 2. In Progress 3. In Progress 4. In Progress 5. In Progress	

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#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible
20	Quality Management	(5.3.1) Notification of Provider Terminations The Plan did not meet DHCS reporting and member notification requirements for provider terminations.	6. The Plan will develop a reporting template/instruction for Providers/Delegate/Subcontractor for reporting adverse terminations to the Plan. <u>2/15/2025</u> : The Plan has developed a reporting template that includes instructions on how to complete for providers/delegates to use when reporting adverse terminations. The information was shared with providers delegated for Credentialing functions on 02/07/2025. 7. The Plan will review the quarterly HICE Credentialing report and confirm against the adverse termination log to determine if provider suspended/termed for quality of care has been reported during the month of termination. During this review, if providers are identified as having been suspended or terminated due to quality of care, the Plan will confirm submission of the 805 report to DHCS. 8. The Plan will include review of the reports/logs during Subcontractor Delegation Oversight Committee meetings. 9. The Plan will include review of the Internal Audit results at the Compliance Committee meetings.	In Progress	6. In Progress 7. In Progress 8. In Progress 9. In Progress	Operations

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#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsibility
1	BH	(2.1) Case Management and Care Coordination The Plan did not ensure the provision of coordination of care to deliver mental health care services to its members. Recommendation: Revise and implement policies and procedures to ensure the Plan coordinates care with the MHP.	1. On April 1, 2023 the Plan insourced behavioral health. The Plan met with the County to identify mechanisms for care coordination. A process was identified for data sharing for mental health, pending system implementation. To support care coordination, and MOU was executed on 4/2023. A manual process has been put in place to include by-weekly case discussions and TOC tools. 2. Policy BH-005 has been updated for written procedure for care coordinators role in care coordination and is going through the committee approval process. <u>Update 12/13/2024</u> : Policy BH-005 was approved at QIHEC on 11/15/2024, and will be presented for review and approval at the Administrative Oversight Committee (AOC) on 12/18/2024. <u>Update 3/14/2025</u> : Policy BH-005 approved at AOC on 12/18/2024	In Progress	1. In Progress 2. In Progress	Behavioral Health UM Provider Services
2	BH	(2.2) Information Exchange with the County Mental Health Plan (MHP) The Plan did not follow the written policies and procedures in its MOU for the timely sharing of medical information with the MHP. Recommendation: Implement policies and procedures to ensure the Plan follows agreed upon written policies and procedures in its MOU for the timely exchange of medical information with the MHP.	1. The Plan and the County collaborated to revise the agreed-upon MOU for multiple state and federal requirements, including information exchange between both systems for state mental health services with implementation date of 04/04/2023. 2. The Plan and the County established a plan for data exchange to support coordination of care and closed-loop referrals, which is currently in the final stages. We have continued to monitor the county's progress with data issues caused by its new electronic health management system. <u>Update 12/13/2024</u> : The Plan and the County continue to work together on the data sharing and electronic health systems. <u>Update 3/14/2025</u> : File exchange testing in process and bi-weekly case conferences continue.	In Progress	1. Completed 4/4/2023 2. In Progress TBD	Behavioral Health UM Privacy IT
3	BH	(2.3) Confirmation of Referred Treatments for Substance Use Disorder (SUD) The Plan did not make good faith efforts to confirm whether members received referred treatment for SUD and document when and where treatment was received, and any next steps following treatment. Recommendation: Revise and implement policies and procedures to ensure the Plan makes good faith efforts to confirm whether members received referred SUD treatment and document when and where treatment was received, and any next steps following treatment.	1. The Behavioral Health Department has developed and implemented a department-specific policy for the care of coordination for SUD on 3/19/2024. <u>Update 11/10/2024</u> : Care coordination policies for MH and SUD members have been combined into policy BH-005. <u>Update 12/13/2024</u> : Policy BH-005 has been approved by QIHEC, and is scheduled to go to AOC on 12/18/2024 for final review and approval. <u>Update 3/14/2025</u> : Policy approved at AOC on 12/18/2024. 2. The issue of 42 CFR posing a barrier to care coordination for individuals with SUD is a standing agenda item in leadership meetings with the Plan and the County. Issues with signed releases from members are preventing confirmation of SUD referrals, however a newly established MOU has a written policy to encourage Medi-Cal Managed Care beneficiaries for signed release for members starting or currently in treatment until this has been operationalized at the county. <u>Update 12/13/2024</u> : Discussions around universal release forms for SUD members are continuing. <u>Update 3/14/2025</u> : Continuing work to integrate operations to increase care coordination activities, with an estimated completion date of June 2026. 3. Update MOU to include an agreement that Medi-Cal managed care beneficiaries will be encouraged to complete the form. 4. Establish and implement process for regular exchange of information between the Plan and the County to ensure compliance with 42 CFR. <u>Update 3/14/2025</u> : Continuing work to integrate operations to increase care coordination activities, with an estimated completion date of June 2026.	In Progress	1. Completed 12/18/2024 2. In Progress 6/30/2026 3. Completed 11/10/2024 4. In Progress 6/30/2026	Behavioral Health UM Continuity of Care

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#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible
4	BH	(2.4) Follow Up for Referred Substance Use Disorder Treatments The Plan did not follow up with members who did not receive referred treatments to understand barriers and make subsequent adjustments to referrals. Recommendation: Revise and implement policies and procedures to ensure the Plan awareness of members who did not receive referred SUD treatments, to understand barriers and make subsequent adjustment to referrals, if warranted.	1. Develop form in coordination with county efforts for Enhanced Care Management for disclosure to support care coordination between the County, the MCP, and practitioners providing SUD and physical health services to the beneficiary. <u>Update 12/13/2024</u> : Discussion continues regarding universal release forms to accomplish care coordination for SUD members. <u>Update 3/14/2025</u> : Continuing work to integrate operations to increase care coordination activities, with an estimated completion date of June 2026. 2. Information regarding the Plan's PCP legal process for coordination of care for SUD members was included in P&P BH-006. <u>Update 12/13/2024</u> : Policy BH-005 and BH-006 were combined, and BH-005 was approved at QIHEC on 11/15/2024, and will be presented for review and approval at the Administrative Oversight Committee on 12/18/2024. <u>Update 3/14/2025</u> : Policy approved at AOC on 12/18/2024. 3. When the BH department identifies a member who needs to be referred for SUD treatment, a referral is completed and the receipt of the referral is confirmed and communicated during routine coordination meetings with the Plan and the County, as well as front line staff. There are reporting challenges with SUD treatment due to 42 CFR and the County and the Plan are working to address this. <u>Update 12/14/2024</u> : Ongoing Bi-weekly case discussions, TOC tools with the County regarding SUD members. <u>Update 3/14/2025</u> : Continuing work to integrate operations to increase care coordination activities, with an estimated completion date of June 2026.	In Progress	1. In Progress 6/30/2026 2. Completed 12/18/2024 3. In Progress 6/30/2026	Behavioral Health UM Case Management
5	NMT & NEMT	(3.1) Door-to-Door Assistance The Plan did not have a process in place to ensure that door-to-door assistance was provided for all members receiving NEMT services. Recommendation: Revise and implement policies and procedures to ensure door-to-door assistance is being provided for all members receiving NEMT services.	1. Remediating this involves an Alliance policy update and additional training of our transportation vendor. The Transportation Vendor has training and oversight in place in the form of repeat random audits of their transportation providers. Since the 2023 audit, this process was updated by the transportation provider. Additionally, AAH will participate in at least five (5) transportation trips per quarter with the broker to ensure door-to-door assistance is being provided when applicable. <u>Update 12/13/2024</u> : The Alliance participated in at least 5 transportation trips for Q4 2024, on November 4, 2024. The Alliance is planning 2025 Q1 field observation audits of trips. <u>Update 3/14/2025</u> : Q1 2025 field audit and training completed. No additional training was needed based on the observed field observations.	In Progress	1. In Progress TBD	Vendor Management
6	NMT & NEMT	(3.2) Monitoring of Door-to-Door Assistance The Plan did not conduct monitoring activities to verify NEMT providers were providing door-to-door assistance for members receiving NEMT services, per APL 22-008 Recommendation: Revise and implement policies and procedures to ensure the Plan conducts monitoring activities, to ensure providers provide door-to-door assistance, for all members receiving NEMT services.	1. This is a policy and process update. To ensure that the broker is appropriately spot checking NEMT and NMT transportation providers for the correct level of service, AAH will participate in at least five (5) transportation trips per quarter with the broker. <u>Update 12/13/2024</u> : The Alliance participated in at least 5 transportation trips for Q4 2024, on November 4, 2024. The Alliance is planning 2025 Q1 field observation audits of trips. <u>Update 3/14/2025</u> : Q1 2025 field audit and training completed. No additional training was needed based on the observed field observations.	In Progress	1. In Progress TBD	Vendor Management

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#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsibility
7	NMT & NEMT	(3.3) Transportation Liaison The Plan did not have a direct line to the transportation liaison that it provided to providers and members, and the transportation liaison did not process authorizations after business hours. Recommendation: Revise and implement policies and procedures to ensure there is a direct line to the transportation liaison and authorizations are processed after business hours.	To improve member access to transportation services and ensure that after-hours authorizations are being properly handled, the Plan will implement the following measures: Inclusion of Transportation Liaison Contact Information: The Plan will include the transportation liaison's phone number in the member handbook and on the Health Plan's website. This will ensure that members have easy access to contact information for transportation-related inquiries and support. Reporting of After-Hours Trip Reservations: The Plan will require subcontractors to report any trip reservations that could not be completed or authorized during after-hours periods. This reporting requirement will help the Plan track issues and address them effectively. Follow-Up with Members: The Transportation Liaison and the Case Management Team will follow up with members regarding any issues related to trip reservations that were not completed or authorized after hours. This proactive approach will ensure that members receive the support they need and that any problems are resolved in a timely manner. <u>Update 12/13/2024:</u> On track and awaiting publication of the new edition of member handbook with liaison contact number.	In Progress	In Progress TBD	CM
8	NMT & NEMT	(3.4) R Physician Certification Statement Forms The Plan did not ensure that members had the required PCS forms for NEMT services, nor did the Plan ensure that PCS forms contained all required components. Recommendation: Implement policies and procedures to ensure PCS forms are on file for all members receiving NEMT services and that the forms contain all the required components.	1. The PCS form intake was insourced beginning 3/1/2023, and AAH staff was hired to coordinate the PCS form effort and transportation.	3/1/2023	Completed	CM
9	NMT & NEMT	(3.5) Ambulatory Door-to-Door The Plan did not ensure its delegate, provided the appropriate level of service for members requiring ambulatory door-to-door service. Recommendation: Revise and implement policies and procedures to ensure its delegate provides the appropriate level of service for members requiring ambulatory door-to-door service.	. Remediating this involves an Alliance policy update and additional training of our transportation vendor. The Transportation Vendor has training and oversight in place in the form of repeat random audits of their transportation providers. Since the 2023 audit, this process was updated by the transportation provider. Additionally, the Plan will participate in at least five (5) transportation trips per quarter with the broker to ensure door-to-door assistance is being provided when applicable. <u>Update 12/13/2024:</u> The Alliance participated in at least 5 transportation trips for Q4 2024, on November 4, 2024. The Alliance is planning 2025 Q1 field observation audits of trips. <u>Update 3/14/2025:</u> Q1 2025 field audit and training completed. No additional training was needed based on the observed field observations.	In Progress	1. In Progress TBD	Vendor Manag

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2023 DMHC Follow-Up Review : Audit Review Period 11/1/2022 - 05/31/2023 Audit Onsite Dates - 10/23/2023 - 10/27/2023				INTERNAL AUDITS				
#	Category	Deficiency	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
1	Grievances & Appeals	When the Plan has notice of a case requiring expedited review, the Plan does not immediately inform complainants of their right to contact the Department.	G&A		State	DMHC	2023	
3	Grievances & Appeals	The Plan does not correctly display the statement required by Section 1368.02(b) in all required enrollee communications.	G&A Member Services UM Rx		State	DMHC	2023	
6	Prescription (Rx) Drug Coverage	The Plan does not display its formularies in a manner consistent with the Department's standard formulary template.	Rx		State	DMHC	2023	

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#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
1	UM	(1.5.1) Notice of Action (NOA) Letters The Plan did not ensure a delegate sent NOA letters to providers and members.	The Plan received the delegate's Root Cause Analysis (RCA) and CAP on 04/14/2023. After review and evaluation of the delegate's document the Plan issued a formal CAP on 05/31/2023 and received the delegate's CAP response on 06/27/2023. The initial corrective actions completed by the delegate includes updating their IT script and ensuring the identified missing NOA letters were sent out to the member and that outreach was completed to confirm that services approved or had denial modification authorizations were utilized by members. The delegate also developed workflows to detect and mitigate failures. The CAP includes the delegate's implementation of a remediation plan. The remediation plan includes updates in their workflow, training, and an internal monthly audit- with results submitted to The Alliance for review. The Plan reviewed and evaluated the delegate's CAP implementation and progress during the interim and provided guidance. The CAP was approved and closed on 09/25/2023. (Completed) The delegate is expected to continue its internal monthly audit for the NOA letters and fax confirmation. The Plan will continue to monitor the audit results for compliance. Please see document 1.5.1_AAH Response for full details. (On Track) Additionally, the Plan will review the UM delegates' P&P's to ensure that preventative, detective, and oversight measures are in place for internal NOA letter generation and fax confirmation and these will be evaluated annually at minimum. (On Track) 1a. Monitoring of the delegate's monthly internal audit is ongoing. (On Track) 2. Review the UM delegates' policies and procedures to ensure that preventative, detective, and oversight measures are in place for internal NOA letter generation and fax confirmation. (On Track) Update 3/8/2024 P&P review complete and P&P deemed adequate. Review of the delegate's P&P regarding NOAs is ongoing and The Alliance will continue to meet with the delegate to have P&P appropriately updated. <u>Update 4/5/2024</u> The delegates have submitted all requested policies for review. The policies have been reviewed and the delegates have made all necessary revisions.	3/31/2024	Completed	Compliance UM		State	DHCS	2023

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2	QI	(2.1.1) Provision of an Initial Health Assessment (IHA) The Plan did not ensure the provision of a complete IHA for new members.	1. Update IHA policy QI-124 (On Track) <u>Update 4/5/2024</u>: Policy updated and approved at Compliance Committee on 3/19/2024 1a. Update IHA policy 124 to include requirement regarding outreach attempts (On Track) <u>Update 4/5/2024</u>: Policy updated and approved at Compliance Committee on 3/19/2024 2. Provider education and feedback through Joint Operational Meetings (On going) <u>Update 4/5/2024</u>: Presented at JOMs with delegates in December 2023 2a. Deliver provider education webinars with information about IHA requirements (On Track) <u>Update 4/5/2024</u>: Webinars with delegates scheduled through May 2024 2b. Develop a "Measure Highlights" tool for providers. This tool will encompass outreach requirements, IHA elements, USPSTF screenings, and claim codes used to account for IHA completion 3. Expand code set to include additional codes for capturing IHA-related activities (On Track) <u>Update 3/8/2024</u>: Codes updated and included in policy QI-124. 3a. Communicate and provide code sets to providers (On Track) <u>Update 4/5/2024</u>: Codes updated and included in policy QI-124 4. Monitor IHA rates (Ongoing) <u>Update 4/5/2024</u>: Non-compliance providers and missing elements identified, CAPs issued. 5. Enhance the volume of medical records subjected to review for completeness, including review of USPSTF requirements. (On Track)	3/31/2024	Completed	Quality		State	DHCS	2023
3	BHT	(2.3.1) Behavioral Health Treatment (BHT) Plan Elements The Plan did not ensure members' BHT treatment plans contained all the required elements.	1. The Behavioral Health team developed the attached Treatment Plan Guidelines for our ABA Providers (please see attachment). This document outlines the treatment plan elements that are listed in APL 23-010. All treatment plans and prior authorization requests for ABA services are reviewed by Board Certified Behavior Analysts (BCBA). The guidelines were emailed to all providers and will also be available on-line for providers to access. In addition to the document, the ABA clinicians worked with the Provider communication team to send out updates/reminders to providers regarding the treatment plan guidelines. Our team is also available to meet with providers and educate them on how to apply the guidelines to their treatment plan templates. (Completed) 1a. Pending Project: We are currently developing an on-line treatment plan template/form that will be utilized by our ABA providers when completing the initial assessment and subsequent progress reports. This form includes the treatment plan elements required in APL 23-010 and providers will be required to complete this form when submitting the initial assessment/FBA and subsequent progress reports. This will ensure that all ABA providers use the same template and include the required elements in their reports/assessments. (On Track) In the interim while the project is pending, if information is missing from the Treatment Plan, the Plan will inform the provider and ask that they add the information and re-submit. <u>Update 4/5/2024</u>: Policy BH-004 is scheduled to be approved at April Compliance Committee. <u>Update 5/10/2024</u>: Policy BH-004 was approved at Compliance Committee on 4/10/2024. 1b. The Plan intends to conduct audits on our Treatment Review documentation to ensure that all required elements are covered in the review process in compliance with the requirements in the APL. The expected implementation date of this audit is Q1 of 2024. <u>Update 5/10/2024</u>: Q1 2024 treatment plan audits are in progress pending completion at end of March. The next audit period (Q2) will go through June. 1c. The Provider/PCP Manual is also pending updates that will include a FAQ for PCPs, provider education regarding the prior authorization process, and the referral process. This is currently under review-pending completion <u>Update 5/10/2024</u>: Provider Manual revised and submitted to DHCS Plan Communications Department, who is reviewing proposed revisions and once completed will be made available via the provider portal	5/10/2024	Completed	Behavioral Health		State	DHCS	2023

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4	Access and Availability	(3.1.1) First Prenatal Visit The Plan's policies and procedures for a first prenatal visit for a pregnant member is not compliant with the standard of two weeks upon request.	The Plan has edited Timely Access Standard table, policy QI-107 and QI-114 to reflect the first prenatal visit standard within 2 weeks of the request. (Completed)	Q4 2023	Completed	Quality		State	DHCS	2023
5	Family Planning and State Supported Services	(3.6.1) Non-contracted Provider Payments The Plan did not pay non-contracted providers at the appropriate Medi-Cal fee-for-service rate.	A Change Request was entered to change non-contract mid-level providers reimbursements to 100% of the Medi-Cal rate moving forward. (Completed)	11/16/2023	Completed	Claims		State	DHCS	2023
6	Family Planning and State Supported Services	(3.6.2) Proposition 56 Family Planning Payments The Plan did not distribute add-on payments for institutional family planning service claims as required by APL 22-011.	1. P&P has been revised to ensure that Family Planning services paid on institutional claims are paid As part of Prop 56 payments. 1a. The Plan's Analytics Team is in the midst of preparing the payment details for the retro payment on the FP institutional data and looking to complete by 11/30/2023 timeline. (On Track) 2. The Analytics dept has calculated the retroactive payments due to facilities as a result of finding 3.6.2, APL 22-011 and APL 23-008. (On Track) 2a. Payments will be distributed to providers prior to or latest by Nov 30, 2023. (On Track) 2b. Facility providers with qualifying Family Planning services as per APL 23-008 will be included as part of our monthly Prop 56 payment processing going forward starting Dec 2023. (On Track)	1/15/2024	Completed	Claims		State	DHCS	2023
7	NMT & NEMT	(3.8.1) R Physician Certificate Statement (PCS) Forms The Plan did not ensure PCS forms were on file for members receiving NEMT services.	1. The Plan made the decision to no longer allow courtesy NEMT trips for members without a PCS form on file and the decision to insource PCS form acquisition to the Plan's Case Management Department beginning 3/1/23. Working alongside the Plan's transportation subcontractor, the Plan created new workflows to ensure the transportation subcontractor was not scheduling NEMT trips for members unless there was a confirmed valid PCS form on file, or the Plan provided a verbal authorization due to a trip being of an urgent nature. The Plan hired two transportation coordinators to focus on PCS acquisition leveraging the Plan's preexisting relationships with the provider network and access to EHR's. Through the end of 2022 and beginning of 2023, the Plan's transportation subcontractor trained its call center agents on the new workflow. On 2/14/23, the Plan trained its transportation coordinators on PCS acquisition. On 2/21/23, the Plan trained its entire case management team, that participates in phone shifts for the Plan's case management phone line, on the parameters for verbal authorizations for NEMT trips of an urgent nature. The Plan continues to report on the success of the new workflows at the Plan's UM Committee. (On Track) 1a. The Plan is working with its analytics team to create a report using PCS data elements to match up against subcontractor's report of all NEMT trips taken each month. This report will assist in finding any gaps in PCS compliance. The Plan estimates this report to go live 12/1/2023. (On Track)	12/15/2023	Completed	Case Management		State	DHCS	2023
8	NMT & NEMT	(3.8.2) Transportation Providers' Medi-Cal Enrollment Status The Plan did not ensure all transportation providers were enrolled in the Medi-Cal program.	The Plan has updated the P&P VMG-005 from reviewing the Transportation Providers (TP) on a quarterly review to a monthly review. Attached for reference is the updated P&P. The Plan began reviewing the TP monthly for the utilization from April 2023 to current. (Completed and Ongoing)	4/1/2023	Completed	Vendor Management		State	DHCS	2023

ALAMEDA ALLIANCE FOR HEALTH
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2023 DHCS Audit - Audit Review Period 4/1/2022 - 3/31/2023 Audit Onsite Dates - April 17, 2023 - April 28, 2023							INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
9	Member Rights	(4.1.1) R Grievance Acknowledgement and Resolution Letter Timeframes The Plan did not send acknowledgement and resolution letters within the required timeframes.	A grievance processing timeline was created to outline the grievance 30 calendar day process, day by day. The timeline outlines that by day 5, acknowledgement letters will be sent out. We will continue to monitor the daily aging report to ensure that acknowledgement letters are sent in a timely manner. The timeline also outlines that on Day 20, "If response is not received, after at least two follow-up attempts, task to a Medical Director in Quality Suite." Complying with this process will ensure that the Medical Director has sufficient time to reach out to the provider or facility to assist in obtaining a response. The Grievance and Appeals staff were trained on the new timeline on 8/1/2023, copies of the timeline were distributed to the department. (Completed and Ongoing)	8/1/2023	Completed	G&A		State	DHCS	2023
10	Member Rights	(4.1.2) R Grievance Letters in Threshold Languages The Plan did not send acknowledgement, resolution delay, and resolution letters in threshold languages.	The Plan's Grievance and Appeals Department has created a reporting mechanism in our daily aging reports to monitor what cases are still pending translation and when was the request for translation sent out, this was implemented on 4/12/2023. We have then assigned one specific team member to be responsible for following up on translation letters to ensure that they are getting the attention that they need to be completed in a timely manner. The Grievance Processing Timeline will be updated to include when a request for translation needs to be sent out and the Grievance and Appeals staff will be provided with the updated timeline and a refresher training will be conducted on 10/10/2023. (Completed and ongoing)	10/10/2023	Completed	G&A		State	DHCS	2023
11	Member Rights	(4.1.3) R Written Notification of Grievance Resolution Delays The Plan did not notify members of resolution delays in writing for grievances not resolved within 30 calendar days and did not resolve grievances by the estimated resolution date in the delay letters.	The Plan's Grievance and Appeals Department will be updating our system, Quality Suite, to better capture data on if and/or when a delay letter is sent out. Once the system is updated, we will be able to create a reporting mechanism in our daily aging reports to monitor for when a case needs a delay letter and if the letter was sent out. The Grievance Processing Timeline will also be updated to include the process for sending out a delay letter and the Grievance and Appeals staff will be provided with the updated timeline and a refresher training will be conducted. (Completed and Ongoing)	12/1/2023	Completed	G&A		State	DHCS	2023
12	Member Rights	(4.1.4) Grievance Delay Timeframes The Plan inappropriately utilized a 14 calendar day delay timeframe for grievance resolutions.	In review of our current policy and procedures, and workflows; they were in line with the APL requirements. There was miscommunication in the staff training to use 14 calendar days instead of an estimated resolution date in the delay letters. There was a refresher training for the Grievance and Appeals staff held on 4/18/2023, the staff was provided the requirement and were reminded to provide an estimated resolution date in the delay letters if a resolution is not reached within 30 calendar days. (Completed)	4/18/2023	Completed	G&A		State	DHCS	2023
13	Member Rights	(4.1.5) Exempt Grievance Resolution The Plan did not resolve exempt grievances by close of the next business day.	In conjunction with the Grievance Department, the Member Services Grievance Guide was revised on 10/9/2023. (Completed) Training was provided to all Member Services staff on these revisions by 11/1/2023. (Completed)	11/1/2023	Completed	Member Services		State	DHCS	2023
14	Member Rights	(4.1.6) Grievance Identification The Plan did not process and resolve all member expressions of dissatisfaction as grievances.	Member Services has implemented a process to identify expressions of dissatisfaction that were not classified appropriately. (Completed) A Member Services Supervisor works with the agent to ensure the case is classified accurately and resolved in a timely manner. (Completed)	3/15/2023	Completed	Member Services		State	DHCS	2023
15	State Supported Services	(SSS.1) Minimum Proposition 56 Payments The Plan did not distribute minimum payments for a State Supported Services claim as described in APL 1013.	The claims system configuration team has corrected the fee schedule for the provider and adjusted the impacted claims to pay the correct rate. (Completed)	4/26/2023	Completed	Claims		State	DHCS	2023
16	CM	(2.2) PCP and members are not consistently notified of Case Management case closures	Configuration made in TruCare to ensure consistent notification	4/26/2023	Completed	Case Management		Self	DHCS	2023

ALAMEDA ALLIANCE FOR HEALTH
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2023 DHCS Audit - Audit Review Period 4/1/2022 - 3/31/2023 Audit Onsite Dates - April 17, 2023 - April 28, 2023							INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
17	Fraud and Abuse	(6.2) The Plan did not report preliminary investigations of all suspected cases of fraud and abuse to DHCS within 10 working days of the Plan receiving notification of the incident.	The Plan has created an interdepartmental team working in collaboration to develop a reporting process for timely submissions of possible HIPAA and FWA incidents to Compliance. Six points of entry for possible incidents have been identified. The team is utilizing technological improvements as well as developing staff training to be able to identify a possible incident for immediate reporting to compliance. At the initiation of the Reporting Process Enhancement, the FWA Specialist will conduct training designed for each department identified as a point of entry. The FWA Specialist will be responsible to track and monitor all privacy related referrals to the compliance department for timeliness Training provided to staff and new tools being used consistently	4/26/2023	Completed	Compliance		Self	DHCS	2023

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2022 DMHC Behavioral Health Investigation - Audit Review Period 4/1/2020 - 4/30/2022 Audit Onsite Dates - September 7, 2022 - September 8, 2022							INTERNAL AUDITS		
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency
1	UM	The Plan failed to timely implement the requirements of Sections 1374.72 and 1374.721 (SB 855)	The Alliance reviews and/or updates all policy and procedures at least annually, to ensure our policy and procedures content is reflective of current regulatory requirements. All UM policy and procedures including any updates and the UM Program Description, are reviewed in the Utilization Management Committee (UMC), subsequently reviewed, and approved at our Board Delegated Quality Improvement Health Equity Committee (QIHEC) which reports directly to the Alliance Board of Governors. In response and in compliance with SB 855, The Alliance has updated UM-063 - Gender Affirmation Surgery and Transgender Services and the Alliance UM Program Description. Both bodies of work are aligned with current WPATH Standards of Care. The Alliance is contracted with WPATH to provide training on WPATH Standards of Care - all UM decision makers (including RNs and physicians) are required to complete WPATH training to ensure the most current WPATH standards required by SB 855 are used for medical necessity decision-making. 100% of current UM reviewers will complete WPATH Training by Q2 2024 & 100% of newly hired UM reviewers will complete WPATH Training within 90-days of their start date <u>Update 3/14/2025</u>; WPATH trainings completed 9/23/2024. The Alliance also conducts annual Inter-Rater Reliability Studies (IRR) with all UM decision makers to ensure that documented criteria is being applied consistently and accurately by decision makers. Additional training and testing is conducted when a passing score is not met. Annual IRR: 100% of UM reviewers will complete the Annual IRR Studies by Q3 2024 <u>Update 3/14/2025</u>; IRR completed 9/24/2024. Passing rate 98% for UM reviewers.	9/27/2024	Completed	UM Behavioral Health		State	DMHC
2	Quality Assurance	The Plan does not ensure its delegate consistently documents quality of care provided is being reviewed, problems are being identified, effective action is taken to improve care where deficiencies are identified, and follow-up is planned where indicated.	As of 4/1/2023, The Alliance has terminated its contract with the delegate. Since termination, The Alliance has insourced all mental and behavioral health services and processes all quality of care issues identified. The Alliance follows its internal policy and procedures and workflows to ensure that all quality of care problems are identified, reviewed and further, that effective action is taken to improve care when deficiencies are identified, and that follow-up is planned where indicated.	4/1/2023	Completed	UM Quality Assurance Behavioral Health Compliance		State	DMHC
#	Category	Barriers to Care	Plan Response	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency
1	Pharmacy Services	The Plan has limited ability to provide Office Based Opioid Treatment (OBOT) and Opioid Treatment Program (OTP) therapy and lacks policies and procedures for these treatments.	Members access OBOT and OTP therapy through Medication Assisted Treatment (MAT) providers in primary care, inpatient hospitals, emergency departments, and other contracted medical settings per BH-005. PCPs, BH, and ED providers are responsible for identifying members with substance abuse disorder issues and arranging the MAT services; under the CA Bridge Program EDs can provide immediate access to MAT. If members contact the Alliance's MSD or BHD, it will provide appropriate referrals to MAT providers. MAT providers are providers that can prescribe opioid use disorder medications and have current Drug Enforcement Administration registration with Schedule III authority.	12/31/2024	Completed	UM Behavioral Health Pharmacy Provider Contracting	✓	State	DMHC
2	Cultural Competency and Health Equity	Neither the Plan nor its delegate conduct assessments pertaining to cultural competency and health equity specific to the Plan's enrollee population.	The Alliance conducts the following assessments for cultural competency and health equity: Annual NCLQA population assessment, member experience surveys (i.e. CG CAHPS, CAHPS, and TAR), provider satisfaction survey. Additionally, the Alliance utilizes various data sources to identify and determine intervention and quality activities to improve health needs and health disparities. Data sources include, but are not limited to, member demographic data, DHCS Alliance Specific health disparity data, claims, and encounter data. The Alliance monitors and addresses disparities, QIPs, and PIPs. These projects are driven by quantitative and qualitative data and are included in the OIHP Work Plan and Evaluation which is approved by the QIHEC. The QIHEC Work Plan identifies which activities and initiatives are	12/31/2024	Completed	Quality Assurance Behavioral Health	✓	State	DMHC
3	Enrollee Experience	Enrollees experience difficulties obtaining appointments.	The Alliance started insourcing behavioral health services on April 1, 2023, and no longer delegates behavioral health services. The Alliance does not require prior authorization for behavioral health services (except for psychological and neuropsychological testing), and members can directly contact Alliance behavioral health providers to schedule appointments.	4/1/2023	Completed	Quality Assurance Behavioral Health	✓	State	DMHC

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2022 DMHC RBO Audit: Delegate - Audit Review Period 1/1/2022 - 3/31/2022							INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
1	Claims Payment Accuracy	The Department's examination disclosed that the RBO failed to reimburse one paid claim correctly due to a systematic error. The claims system failed to classify the provider as a contracted provider. The claim was paid incorrectly at the non-contracted rate, which was less than the contracted rate. The RBO represented to the Department that this deficiency was due to a contract amendment, effective February 1, 2021, that was not updated in their claims system. This deficiency was noted in paid claims sample number P-18.	Delegate updated claims system to accurately reflect all providers listed on the provider roster as contracted with the effective date of 2/1/2021 to align with the contract amendment. A claims sweep was completed with a lookback to 2/1/2021. All claims previously paid noncontracted were reprocessed as contract and have been paid with any accrued interest and/or penalties associate with each claim reprocessed on 10/12/2022. Evidence of the complete claims audit sweep associated with members was sent to The Alliance on 1/19/2023 via secure email. Draft policy was created to ensure provider contracts and rosters are appropriately loaded within delegate's claims system. Draft policy will be presented to the delegate's Compliance Committee on 3/29/2023 for review and approval. <u>Update 4/14/2023</u>: The delegate's Compliance Committee rescheduled to 4/26/2023. The updated policy will be approved at that time. <u>Update 5/12/2023</u>: The delegate approved the policy at their Compliance Committee	5/12/2023	Completed	Claims Compliance		State	DMHC	2022
2	Claims Payment Accuracy	The Department's examination disclosed that the RBO failed to reimburse two high dollar claims correctly due to a systematic error. The contracted provider was not paid per contract for laboratory procedures. The RBO stated the laboratory procedures were based on an old boiler plate and should not have been included in the contract. The contract was amended on 9/1/2022. This deficiency was noted in high dollar claims sample numbers HD-18 and HD-24	There were no Alliance members impacted by this deficiency. Effective 10/12/2022 all claims were reprocessed and paid.	10/12/2022	Completed	Claims Compliance		State	DMHC	2022
3	Incorrect Claim Denials	The Department's examination disclosed that the RBO failed to reimburse one denied claim correctly due to a systematic error. The RBO incorrectly denied claims for podiatric and chiropractic services at federally qualified health centers and rural health clinics. The denial reason instructed the provider to bill "Medi-Cal EDS" when it should have been paid. This deficiency was noted in denied claims sample number D-29.	There were no Alliance members impacted by this deficiency. Effective 10/12/2022 all claims were reprocessed and paid.	10/12/2022	Completed	Claims Compliance		State	DMHC	2022

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2022 DMHC RBO Audit: Delegate - Audit Review Period 1/1/2022 - 3/31/2022							INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
1	Claims Payment Accuracy	The Department's examination disclosed that one of 30 high dollar claims were not reimbursed correctly. The claims billed with Current Procedural Terminology (CPT) codes 93005 were underpaid. This deficiency was noted in high dollar claim sample number 28.	The RBO is reprocessing all claims with code 93005 underpaid from January 2021 to present and will upload corrected explanations of benefits upon completion. Corrected explanations of benefits showing additional payment (plus interest and penalty where applicable) as well as the requested report and policies will be submitted to DMHC on or before 1/30/2023.	1/30/2023	Completed	Claims Compliance		State	DMHC	2022
2	Misdirected Claims	The Department's examination disclosed that five out of 40 denied claims were not forwarded. This deficiency was noted in the following denied claims sample numbers: 3, 6, 20, 34, and 37. This deficiency was also noted in the high dollar claim sample numbers: 3, 5, 9, 10, and 25.	There is a system limitation (i.e. mapping issue) where some of the claims (837i encounters) are not being forwarded through our claims processing system. Because of this issue, 837i claims are not being forwarded to health plans. 837i misdirected claims are denied as health plan responsibility and providers are notified via weekly explanations of benefits. The mapping issue was discovered Q1 2022 and tests began at that time with health plans and clearinghouses. 837P files continue to be submitted successfully. The delegate is working with IT to upgrade the server so that updates provided by our software vendors can be implemented for the mapping issue to be resolved. The expected compliance date will be on or before 2/28/2023. 1/26/2023: server updates completed, system updates happening this week. 1/27/2023: system consultant met with the software vendor and their development team to identify and resolve issues so that system updates can happen successfully. 1/30/2023: all system updates completed successfully on test environment	1/30/2023	Completed	Claims Compliance		State	DMHC	2022
3	Reimbursement of Claims Overpayments	The Department's examination disclosed that the RBO failed to send a written request for overpayment reimbursement to the provider. This deficiency was noted in the following late claim sample numbers: 16, 32, and 35.	Examiner error. When the claims examiner reprocessed these claims, the overpayment was reversed instead of a refund request letter being sent to the provider. Compliance met September 27, 2022 when the claims examiner was reminded in a verbal meeting of the above rule as well as the Delegate's internal policy on overpayments. Also, there is a report run prior to the weekly check run to ensure compliance. Because the overpayment was reversed in the adjusted claims, a refund request was not sent for the original claims.	1/30/2023	Completed	Claims Compliance		State	DMHC	2022

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2022 DMHC FINANCIAL SERVICES : Audit Review Period 1/1/2022 - 3/31/2022							INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
1	Provider Dispute Resolutions	The Department's examination disclosed that the Plan failed to timely acknowledge receipt of 12 out of 71 provider disputes reviewed.	1. Policies and procedures, including internal claims audit procedures, implemented to ensure provider disputes are acknowledged timely. <u>Update 2/13/2023</u> : Policy updated and will be approved at Committee 3/25/2023 2. Staff training completed January 2023 and created a audit workflow effective 01/01/2023. 3. Claims Operations Support Manager and PDR Supervisor. PDR Supervisor will monitor all incoming PDR mail. A daily audit will be conducted before the 15th due date to assure all cases are acknowledged timely.	2/24/2023	Completed	Claims		State	DMHC	2022
2	Claims	The Department's examination disclosed that, due to systemic issues, claims were not reimbursed accurately, including interest and penalties.	CORRECTIVE ACTION TAKEN DURING EXAMINATION The Plan submitted evidence on October 28, 2022, that the Plan reprocessed and paid claims previously paid incorrectly. This correction and remediation resulted in the additional payment of \$5,742.29, plus interest of \$7,675.43, on 742 claims. In addition, the Plan submitted evidence on October 28, 2022, that the Plan reprocessed and paid claims previously denied incorrectly. This correction and remediation resulted in the additional payment of \$64,718.77, plus interest of \$6,002.98, on 750 claims. The Plan corrected the deficiencies noted above and completed the required remediation during the course of the examination; therefore, no additional response is required.	10/28/2022	Completed	Claims		State	DMHC	2022
3	Changes in Plan Personnel	R The Department's examination disclosed that the Plan did not timely file changes in plan personnel.	1. The Plan revised its Desktop Procedure to define the Key Personnel as "Persons holding official positions that are responsible for the conduct of the Plan including but not limited to all Senior Leadership, all members of the BOG and other principal officers." The Desktop Procedure further clarifies the activities that will constitute an official personnel change event for Senior Leadership versus Board of Governors members. Finally, the Desktop Procedure was revised reflect that Key Personnel Change filings must be submitted within five (5) calendar days. 2. We have taken steps to improve the communication with the internal stakeholders to ensure personnel change events are routed to the Regulatory Affairs and Compliance team in a timely manner. The Board Clerk is responsible to immediately notify the Compliance Department of any Board Member changes. To ensure no updates are missed, each month the Compliance Specialist will email the Board Clerk and the Human Resources Department to confirm whether the BOG or SLT has experienced any personnel changes. The Compliance Specialist also maintains a log of Key Personnel Changes. Furthermore, once a personnel change event is anticipated, the Compliance Specialist immediately begins an electronic file and begins preparation of the necessary documents for submission.	1/13/2023	Completed	Compliance		State	DMHC	2022
4	Fidelity Bond	The Department's examination disclosed that the Plan's fidelity bond did not have a provision for 30 days' notice to the Department prior to cancellation.	Immediately after receiving the DMHC's audit request, The Alliance finance staff requested its insurance broker to work with the insurer in adding the requested provision. Before the DMHC's audit exit conference, such requested provision was provided to the DMHC auditor, and the auditor expressed that the supplied document was satisfactory. The Alliance has also created a new Policy & Procedure effective 1/11/2023.	1/11/2023	Completed	Finance		State	DMHC	2022

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2022 DHCS AUDIT FINDINGS: Audit Review Period 1/1/2021 - 3/31/2022							INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
1	G&A	(1.3.1) The Plan did not send acknowledgement letters for standard appeals within the required timeframe of five calendar days.	1. The Daily Clerk Report is received daily by Grievance & Appeals Clerks and Leadership. The report will be reviewed by the Grievance & Appeals Leadership team to ensure acknowledgment letters are mailed timely. 2. The Plan provided training to the Grievance & Appeals staff to review the regulatory requirements for mailing of acknowledgement letters.	10/1/2022	Completed	G&A		State	DHCS	2022
2	G&A	(1.3.2) The Plan did not comply with existing APLs to notify members receiving a NAR that upholds an adverse benefit determination that they have an additional 120 days in addition to the initial 120 days allowed to request a SFH.	1. Your Rights enclosure was updated to reflect enrollees have 240 days to request a State Fair Hearing 2. Policy & Procedure G&A-007 State Hearings has been updated to reflect the member has 240 calendar days to request a State Hearing. The policy will go to committee for review and approval in December. <u>Update 03/10/2022</u> : Plan submitted draft policy G&A-007 State Fair Hearings that reflects current timeframe to request a SFH (240 calendar days) per the PHE. Policy pending internal committee approval. Plan will need to monitor end of PHE in order to revise policy to reflect normal regulatory requirement of 120 calendar days. PHE was extended through 1/11/23. <u>Update 4/14/2023</u> : The updated policy was approved at Compliance Committee on 3/21/2023	3/21/2023	Completed	G&A		State	DHCS	2022
3	Provider Relations	R (1.5.1) The Plan did not ensure that its subcontractors submitted complete ownership and control disclosure information.	1. The Alliance has made updates to its Provider Services Standard Operating Procedure (SOP) – Ownership and Control Disclosure Reviews for Delegates. This includes an additional layer of review from the Alliance Compliance Department when ownership and control forms are received from delegates. The SOP and tracking sheet has been updated. 2. The findings specifically mentioned two (2) forms: • The delegate who provided the Alliance with the email confirming that the form they submitted to the Alliance is the same form that it files with DHCS. According to the delegate, DHCS confirmed acknowledgement of the form with no additional feedback. • Another delegate who does not have a sole owner and provided a list of their leadership team with the FEIN for each of the clinics. The Alliance will notify the impacted delegates of the findings to receive forms that meet requirements by DHCS. 3. The Alliance will collect the new forms starting Q1 2023. <u>Update 03/10/2023</u> : Delegate has submitted an updated form and delegate is currently working toward completion of the form for submission to the Plan. Provider Services and Compliance will review to validate all fields are complete once all forms are received. <u>Update 4/15/2023</u> : The other delegate's form received on 3/2/2023, and two levels of review completed 3/10/2023.	3/10/2023	Completed	Provider Relations		State	DHCS	2022

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2022 DHCS AUDIT FINDINGS: Audit Review Period 1/1/2021 - 3/31/2022

INTERNAL AUDITS

#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
4	QI	(2.1.1) The Plan did not document attempts to contact members and schedule the IHA.	1. The plan will continue to inform members of the IHA through the EOC, welcome letters to all new members, and videos. - In addition, all members are eligible for a new member orientation (including a financial incentive). - Information regarding the IHA will be included in the member newsletter. The Alliance will initiate a new phone campaign where all new members will receive a phone call encouraging the member to receive an IHA. This phone log will be appropriately documented. The Alliance will create a call script for new member phone calls. 2. The plan will create a report to identify new plan members <u>Update 5/12/2023</u>: Fulfillment Report created to track mailing of member Orientation reports that contain reminder to schedule IHA to new members. Member Orientation Service Request tracking report tracks outreach attempts to members to complete new member orientation, which includes communication about scheduling IHAs 3. The plan will create workflows for informing members of the IHA <u>Update 5/12/2023</u>: Clinical QI Program Coordinator will review IVR reports to determine all new members have received an outreach call. 4. The plan will update the IHA P&P to reflect the updated workflows <u>Update 3/10/2023</u>: Draft policy QI-124 completed, IVR outreach is pending DHCS approval of script. Upon DHCS approval we will continue to develop the process for IVR outreach and develop desktop procedures. <u>Update 4/15/2023</u>: The updated P&P was approved at Compliance Committee 3/21/2023 5. The plan will create a phone call campaign, create a script, and work with the state for approval <u>Update 3/10/2023</u>: Awaiting DHCS approval of script. <u>Update 6/9/2023</u>: Final documents submitted to DHCS for review. Awaiting DHCS response. The Plan will continue to ensure accurate documentation of IHA outreach attempts via providers, by reviewing documentation as part of FSRs.	9/8/2023	Completed	QI		State	DHCS	2022
5	CM	R(2.5.1) The Plan's MOU with the county MHP did not include the responsibility for the review of disputes between the Plan and the MHP.	1. The Alliance has made several updates to the MOU and incorporated APL 18-015, as well as APL 21-013 Dispute Resolution Process Between Mental Health Plans and Medi-Cal Managed Care Health Plans. The Alliance has had a series of meetings with the MHP to review redline changes to the MOU. The MHP is currently under review of the redline changes and will notify the Alliance when they can move forward with signing the MOU. The MHP MOU vetting process includes County Board of Supervisor (BOS) approval. Therefore, the Alliance is hoping to execute the MOU by the end of 2022.	12/31/2023	Completed	Provider Relations		State	DHCS	2022
6	Provider Relations	R(3.1.1) The Plan did not monitor the network providers' compliance with requirements for when appointments were extended.	1. The Provider Manual was edited to update the requirements, providers were advised in the Quarterly Provider Packet, and The Alliance Provider Representatives advised providers during PCP visits. Additionally, fax blasts were sent to providers regarding the updated requirements, and the Provider Education document was updated to reflect the requirements. 2. Edit P&P and Quality of Access Workflow to ensure all cases are reviewed by a QI Nurse. If a case is determined to be related to access, QI / A&A staff will review data for ED / Inpatient Stays as a result of delay in appointment. If the member does have an ED / IP Claim, the QI RN will then work the case up as a PQI / Quality of Care. This will be reviewed by the Medical Director and follow the PQI process. Finally, all QOA cases with available MRs will be reviewed to ensure the appropriate provider documentation. <u>Update 03/10/2023</u>: Policy QI-114 has been updated and is awaiting approval at committee <u>Update 4/14/2023</u>: P&P QI-114 was approved at Compliance Committee 3/21/2023	3/21/2023	Completed	Provider Relations QI		State	DHCS	2022

ALAMEDA ALLIANCE FOR HEALTH
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KEY

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2022 DHCS AUDIT FINDINGS: Audit Review Period 1/1/2021 - 3/31/2022							INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
7	Claims	(3.6.1) The Plan improperly denied emergency services claims.	1. Case #7 – The claim was paid on 8/11/2021. The vendor was notified of the finding on 5/19/2022 and asked to review their internal process to ensure that codes on claims are captured correctly. They acknowledged they reviewed their internal processes and stated that poor claim imaging may have caused the issue, but they will increase the resolution to help ensure better results in the future. 2. Case #20 – The vendor was notified of the issue on 5/19/2022 and asked to review their internal process to ensure that dates on claims are captured correctly. They acknowledged they reviewed their internal processes and stated that poor claim imaging may have caused the issue, but they will increase the resolution to help ensure better results in the future. In addition, an edit was enhanced to ensure that the date range order is correct. 3. The claim was paid on 1/5/2022 correctly. The Claims Processor was shown the claim finding for review along with the correct workflow document that shows the correct process to help ensure moving forward this does not occur again. This workflow was also reviewed by the Claim Processor team and training occurred.	10/11/2022	Completed	Claims		State	DHCS	2022
8	Access and Availability	R(3.8.1) The Plan did not use PCS forms for NEMT services.	1. The Plan will educate providers on PCS requirements. Update 3/10/2023: Provider Alert PCS Form Reminder and Form was sent out to Providers in a fax blast on Tuesday, 12/27/22. 2. Refine PCS workflows to meet all regulatory requirements. Update 3/10/2023: Workflow updated. 3. The Plan will conduct staff trainings on process workflow changes. Update 4/15/2023: Training completed 1/31/2023. 4. The Plan will ensure that the transportation subcontractor trains their staff on the PCS process workflow changes. The transportation subcontractor will provide training materials and sign in sheets. Update 4/15/2023: Training completed 1/31/2023. 5. The Plan will develop reports on PCS form outcomes using both transportation subcontractor information and the Plan's process to obtain PCS forms. Update 4/15/2023: Reports developed and presented at UM Committee Q4 2022. 6. The Plan will monitor process workflows from the transportation subcontractor and the Plan to obtain missing PCS forms. Update 4/15/2023: Reports developed and presented at UM Committee Q4 2022. 7. The Plan will analyze trends in provider practices and provide feedback to providers regarding PCS form requirements. Update 4/15/2023: Reports developed and presented at UM Committee Q4 2022, where trends analyzed. 8. The plan will evaluate whether to continue having the transportation subcontractor manage the PCS forms or take the direct management of PCS forms back into the Plan. Update 4/15/2023: Reports developed and presented at UM Committee Q4 2022. Will continue to analyze quarterly. 9. The Plan will provide a quarterly report to UM Committee. Update 4/15/2023: Reports developed and presented at UM Committee Q4 2022.	4/1/2023	Completed	UM		State	DHCS	2022
9	Member Rights	R(4.1.1) The Plan did not send acknowledgement and resolution letters within the required timeframes.	1. The G & A Department Leadership and Quality Assurance Specialist will reference the daily reports to ensure the acknowledgement and resolution letters are sent timely 2. The Plan provided training to the Grievance & Appeals staff to review the regulatory requirements for mailing of acknowledgement and resolution letters. 3. The Quality Assurance Specialist will audit 5 appeals cases and 5 grievances cases per Grievance & Appeals Coordinator per month.	10/1/2022	Completed	G&A		State	DHCS	2022

ALAMEDA ALLIANCE FOR HEALTH
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2022 DHCS AUDIT FINDINGS: Audit Review Period 1/1/2021 - 3/31/2022							INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
10	Member Rights	R(4.1.2) The Plan did not send acknowledgement and resolution letters in threshold languages.	1. Updated our system of record to capture the dates the resolution letter was submitted for translation and the date it was mailed to the member. 2. The Plan provided training to the Grievance & Appeals staff on the updates made to the system of record. 3. The Quality Assurance Specialist will audit 5 appeals cases and 5 grievances cases per Grievance & Appeals Coordinator per month.	9/20/2022	Completed	G&A		State	DHCS	2022
11	Member Rights	(4.1.3) The Plan was not compliant with grievance extension letter timeframes; in some cases, it did not send extension letters for grievances that were not resolved within 30 calendar days and in other cases it did not resolve grievances by the estimated completion date specified in the extension letter	1. The Plan provided training to the Grievance & Appeals staff on the system updates to capture extension letters. 2. The Quality Assurance Specialist will audit 5 appeals cases and 5 grievances cases per Grievance & Appeals Coordinator per month. 3. Updated Policy & Procedure G&A- 003: Grievance and Appeals, Receipt, Review and Resolution. The policy will be sent to Committee for approval. Update 03/10/2023: Draft policy updated and awaiting approval at committee. Update 4/15/2023: P&P G&A-003 was approved at Compliance Committee on 3/21/2023	3/21/2023	Completed	G&A		State	DHCS	2022
12	Member Rights	R(4.1.4) The Plan did not thoroughly investigate and resolve grievances prior to sending resolution letters	1. The Alliance will review resolution letters prior to mailing to the member. 2. The Alliance provided training to the Grievance & Appeals staff to ensure the resolution letter clearly addresses all of the member's concerns 3. The Quality Assurance Specialist will audit 5 appeals cases and 5 grievances cases per Grievance & Appeals Coordinator per month.	10/1/2022	Completed	G&A		State	DHCS	2022
13	Member Rights	R(4.3.1) The Plan did not report suspected security incidents or unauthorized disclosures of PHI to DHCS within the required timeframes.	The Plan has created an interdepartmental team in collaboration to develop a reporting process for timely submissions of possible HIPAA and FWA incidents to Compliance. Six points of entry for possible incidents have been identified. The team is utilizing technological improvements as well as developing staff training to be able to identify HIPAA and FWA incidents and the method for immediate reporting to compliance. Update 03/10/2023: Training created and provided to The Alliance staff; new referral tracking implemented and tool created.	3/10/2023	Completed	Compliance		State	DHCS	2022
14	Member Rights	(4.3.2) The Plan did not notify the DHCS Program Contract Manager and DHCS ISO of suspected security incidents or unauthorized disclosure of PHI or PI.	Due to human error, reporting to the three (3) entities at DHCS; DHCS Program Contract Manager, the DHCS Privacy Officer and the DHCS Information Security Officer was not completed for all possible HIPAA incidents. Reporting Policy CMP-013 has been updated to reflect the current reporting email address for possible HIPAA incidents to DHCS incidents@dhcs.ca.gov. This change was reviewed and approved by the Compliance Committee on 11/23/2021.	11/23/2021	Completed	Compliance		State	DHCS	2022
15	Fraud and Abuse	R(6.2.1) The Plan did not report preliminary investigations of all suspected cases of fraud and abuse to DHCS within 10 working days of the Plan receiving notification of the incident.	The Plan has created an interdepartmental team working in collaboration to develop a reporting process for timely submissions of possible HIPAA and FWA incidents to Compliance. Six points of entry for possible incidents have been identified. The team is utilizing technological improvements as well as developing staff training to be able to identify a possible incident for immediate reporting to compliance. At the initiation of the Reporting Process Enhancement, the FWA Specialist will conduct training designed for each department identified as a point of entry. The FWA Specialist will be responsible to track and monitor all privacy related referrals to the compliance department for timeliness. Update 03/10/2023: Training created and provided to The Alliance staff; new referral tracking implemented and tool created.	3/10/2023	Completed	Compliance		State	DHCS	2022

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2021 DMHC JOINT AUDIT FINDINGS : Audit Review Period 11/1/2018 - 10/31/2020							INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
1	Grievances & Appeals	When the Plan has notice of a case requiring expedited review, the Plan does not immediately inform complainants of their right to contact the Department.	The Plan updated the process to state when a call is received by the Member Services Department and it is categorized as a potential expedite, the call is transferred to the Grievance & Appeals Department queue and the Clerk will provide the member with their DMHC rights.	5/3/2022	Completed	G&A		State	DMHC	2021
2	Grievances & Appeals	The Plan's online grievance submission procedure is not accessible through a hyperlink clearly identified as "GRIEVANCE FORM," does not allow a member to preview and edit the form before submission, and does not include the required disclosure.	The Plan has worked with our internal Information Technology (IT) Department to have the updates made to the website to include the GRIEVANCE FORM hyperlink, the edit/preview functionality and to update the disclosure statement. Exhibit 2A_Preview_Edit_Disclosure shows the updates on the testing site. Regarding the disclosure statement, the Plan identified an outdated version of the statement. The Plan has updated the disclosure statement so that it is in alignment with the verbiage from Knox-Keene (see attached Exhibit 2B_Knox-Keene).	8/11/2022	Completed	G&A		State	DMHC	2021
3	Grievances & Appeals	The Plan does not correctly display the statement required by Section 1368.02(b) in all required enrollee communications.	The Plan identified an outdated version of the statement. The Plan has updated the disclosure statement so that it is in alignment with the verbiage from Knox-Keene (see attached Exhibit 3A_Knox-Keene). Exhibit 3F will apply to both the appeals and grievance letters. The Plan's UM materials were likewise updated to reflect compliance with the verbiage. Revised Your Rights attachments for NOAs and NARs were implemented in TruCare on 1/18/2022. The Plan's Pharmacy templates are being drafted and copies will be provided on 12/30/2022 for the following: •4A_GroupCare NOA template •5A_GroupCare NOA template •6A_Full Group Care Formulary/Template ~~12/30/2022~~ Template letters completed and submitted to DMHC	12/30/2022	Completed	G&A Member Services UM Rx		State	DMHC	2021
4	Prescription (Rx) Drug Coverage	The Plan's prescription drug denial and modification letters to enrollees do not include accurate information about their grievance rights.	The plan will update/ensure prescription drug denial and modification letters to the enrollees include accurate information about their grievance rights. Templates are being drafted and copies will be provided on December 30, 2022 ~~12/30/2022~~ Template letters completed and submitted to DMHC	12/30/2022	Completed	Rx		State	DMHC	2021
5	Prescription (Rx) Drug Coverage	The Plan does not inform enrollees of their right to seek an external exception request review in formulary exception request denial letters.	The plan will insert external exception request review in formulary exception request denial letters as seen below: "EXTERNAL REVIEWS You have the right to request an external review when the Alliance denies a prior authorization request for a drug that is not covered by the plan or for an investigational drug or therapy. A request for an external review will not prevent you from filing a Grievance or Independent Medical Review (IMR) with the California Department of Managed Health Care. You may request an external review through the Alliance contact information listed above." •Templates are being drafted and copies will be provided on December 30, 2022 ~~12/30/2022~~ Template letters completed and submitted to DMHC	12/30/2022	Completed	Rx		State	DMHC	2021
6	Prescription (Rx) Drug Coverage	The Plan does not display its formularies in a manner consistent with the Department's standard formulary template.	The Plan will update formularies in a manner consistent with the Department's standard formulary template. ~~12/30/2022~~ The formulary template has been updated.	12/30/2022	Completed	Rx		State	DMHC	2021

ALAMEDA ALLIANCE FOR HEALTH
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2021 DHCS JOINT AUDIT FINDINGS: Audit Review Period 6/1/2019 - 3/31/2021								INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Risk Category (High, Medium, Low)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
1	UM	(1.2.1) The Plan did not have appropriate processes to ensure that limitations on speech therapy services would not be imposed. In addition to using Medi-Cal guidelines, the Plan used MCG as its evidence-based criteria to make decisions. MCG criteria dictates the amount of visits that can be approved based on a diagnosis and therefore imposes limits.	1. The Plan developed workflow outlining standard review process for speech therapy Prior Authorization (PA) requests, ensuring that no limitations on speech therapy would be imposed on members under age 21. 2. The Plan will conduct a current staff training on standard process, and include it in new staff training. Update 10/8/2021: Training complete 9/29/2021 3. The Plan will revise 10748 Daily Auth Denial report to incorporate service type to capture PA requests for Speech Therapy. Update 11/12/2021: The report request has been submitted, estimated completion is 11/15/2021. Update 12/10/2021: Report has been created and is being completed weekly. 4. The Plan will monitor PA requests for Speech Therapy on a quarterly basis. Update 11/12/2021: The report request has been submitted, estimated completion is 11/15/2021. Update 12/10/2021: Requests for Speech Therapy are being monitored quarterly. 5. The Plan will report results quarterly to UMC. Update 12/10/2021: The first report will be given to the UMC in January 2022. Update 09/09/2022: Speech therapy is now being tracked on a quarterly basis and was reported out at the Q1 2022 UM Committee	Medium	Q1 2022	Completed	UM		State	DHCS	2021
2	UM	(1.2.2) The Plan did not ensure that a qualified health care professional reviewed dental anesthesia prior authorization requests which includes a review of clinical data. The Plan did not ensure the use of appropriate criteria/guidelines when reviewing dental anesthesia requests.	1. The Plan developed workflow outlining standard review process for dental anesthesia Prior Authorization (PA) requests. 2. The Plan will develop mitigation plan until auto auth programming is removed. Update 10/8/2021: Mitigation plan developed and put into place 9/29/2021 3. The Plan will conduct a staff training on the mitigation plan to identify and use standard UM review process for dental anesthesia (DA) and include it in new staff training. Update 10/8/2021 Training complete 9/29/2021 4. The Plan's UM and IT teams will collaborate to remove DA requests from Auto Authorization programming in TruCare (TC). Update 12/10/2021: DA requests have been removed from Auto Authorization programming in TruCare as of 10/1/2021 5. The Plan will develop a Tracking Report to capture and report on PA requests for Dental Anesthesia. Update 12/10/2021: The quarterly report (03127) Dental General Anesthesia Report will be utilized for monitoring 6. The Plan will monitor PA requests for Dental Anesthesia quarterly. Update 10/14/2022: PA requests for Dental Anesthesia are now being monitored quarterly 7. The Plan will report results quarterly to UMC. Update 10/14/2022: PA requests for Dental Anesthesia are now being tracked on a quarterly basis and was reported out at the Q1 2022 UM Committee	High	Q1 2022	Completed	UM		State	DHCS	2021
3	UM	(1.5.1) The Plan did not ensure the delegate met standards set forth by the Plan and DHCS. The Delegate inappropriately denied medical prior authorization requests.	1.The Plan will inform Delegate 1 of DHCS findings about inappropriately denied medical prior authorization requests. Update 11/12/2021: On 10/8/2021 a letter was sent to the delegate to advise of the audit findings. 2.The Plan will re-educate delegates on requirements for standard UM processes, including application of appropriate criteria guidelines. Update 11/12/2021: On 10/12/2021 a meeting was held with Delegate 1 leadership do educate on requirements for the standard UM process. 3.The Plan will audit Delegate 1's denied cases for appropriateness of denial elements using annual audit tool. Update 2/11/2022: The annual Delegate 1 delegation audit began 12/17/2021 and includes an audit of denied cases for appropriateness of denial elements. 4.The Plan will review denied cases at monthly Delegate 1 meeting for education. Update 2/11/2022: Denied cases are now being reviewed at the monthly Delegate 1 meeting for education. Update 5/13/2022: The Q1 2022 audit has commenced as of 5/5/2022. Update 08/09/2022: The Delegate 1 audit is in progress and is expected to be completed by 8/12/2022 Update 09/06/2022: The audit for Q2 2022 is in progress, preliminary findings have been submitted to Delegate 1. The audit for Q3 2022 is beginning. There will be four total quarters of reviews completed in order to close out this finding. 4/3/2023: Four quarters of the audit have been completed. Results under review. Update 6/9/2023: A Trend Report for 2022 Quarterly Focused Audit findings regarding medical necessity denials was issued to Delegate 1 along with the Final Report for their Annual Audit on 4/11/23. Delegate 1 CAP response due 6/16/2023. Update 9/8/2023: The 2022 CAP is ongoing. Delegate 1's CAP included updates to UM workflows, staff training, and internal audits. The CAP is in progress. Workflows, trainings, and internal audits have been completed and are under review by Alliance SMEs.	Medium	Q4 2023	Completed	UM		State	DHCS	2021

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2021 DHCS JOINT AUDIT FINDINGS: Audit Review Period 6/1/2019 - 3/31/2021								INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Risk Category (High, Medium, Low)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
4	UM	(1.5.2) The Plan did not ensure the delegate met standards set forth by the Plan and DHCS. The delegate did not ensure that requests to see out of network providers were reviewed and decisions were made by a qualified health care professional. It did not include the decision-maker's name in the NOA.	1.The Plan will inform Delegate of DHCS findings about qualified health care professional did not always make decisions to deny or only authorized an amount, duration, or scope that was less than requested, and the lack of name and contact information on the NOA of the decision-maker. <u>Update 11/12/2021</u> : On 10/8/2021 a letter was sent to delegate to advise of the audit findings. 2.The Plan will re-educate delegates on standard UM requirement that only qualified health care professionals make decisions to deny or authorize an amount, duration, or scope that is less than requested, including out of network requests, and on the requirement to have the decision-makers' name and contact information on the NOA. <u>Update 11/12/2021</u> : The Alliance met with the delegate on 10/28/2021 to provide re-education. 3.The Plan will audit delegate's cases during the annual audit to ensure that only qualified health care professionals make decisions on denials and authorizations of the amount, duration, and scope less than requested, and contact information for the decision maker. <u>Update 02/11/2022</u> : The annual delegation audit started on 12/20/2021 and is in progress. The audit is expected to be completed on 4/1/2022. <u>Update 09/09/2022</u> : The delegate audit is in progress. And is expected to be completed by 9/23/2022	Medium	12/20/2021	Completed	UM Compliance		State	DHCS	2021
5	UM	R (1.5.3) The Plan did not ensure complete ownership and control disclosure information were collected from its delegates.	1.The Plan has updated its documentation, Provider Services Standard Operating Procedure – Ownership and Control Disclosure Reviews for Delegates, to include collecting required disclosures from the managing employees, or board of directors and senior management team in cases where the entity is a non-profit with no majority ownership and/or owned by physician shareholders.	Low	9/14/2021	Completed	Provider Network Vendor Management		State	DHCS	2021
6	UM	(1.5.4) The Plan did not ensure the written agreements with its delegates included the requirement to allow specified departments, agencies, and officials to audit, inspect, and evaluate the Plan's facilities, records, and systems related to good and services provided to Medi-Cal members.	1.The Plan is adding the Comptroller General in the Behavioral Health contract, Amendment 7. <u>Update 11/12/2021</u> : The Comptroller General was added to the contract, Amendment 7, as of 10/13/2021 2.The Plan is currently working with its delegate on a new contract and delegation agreement which will include the provision and requirement to allow governmental and specified agencies and officials to audit records and systems. <u>Update 1/14/2022</u> : The draft agreement has been completed and is expected to be fully executed in January 2022. <u>Update 2/11/2022</u> : Full execution of the draft agreement is still in progress. <u>Update 09/09/2022</u> : Full execution of the draft agreement is expected by the end of September 2022 3.The Plan will conduct a review of all of its delegated agreements and update the agreements to ensure that all of the language requirements are included. <u>Update 1/14/2022</u> : The agreement has been reviewed and updated. <u>Update 2/11/2022</u> : The Plan conducts annual oversight of its Delegates via an Annual Delegation Audit, as described in CMP-019 – Delegation Oversight. The Plan has updated its Compliance Audit tool to ensure the audit includes a review of the Delegation Agreement to confirm it contains the required language.	Medium	12/31/2022	Completed	Provider Network Vendor Management Compliance		State	DHCS	2021
7	UM	(1.5.5) The Plan did not have policies and procedures for imposing financial sanctions on its delegate and delegated entities.	1.The Plan has created a new Policy, CMP-030 Sanction and Escalation. This Policy describes the standards by which the Plan may impose sanctions against Delegated Entities (DE), providers and vendors for non-compliance or failure to comply with Corrective Actions Plan (CAP) deficiencies, or for breach of any material term, covenant or condition of an agreement and/or for failure to comply with applicable federal or state statutes, regulations, and rules. <u>Update 12/10/2021</u> : Policy CMP-030 was approved at Compliance Committee on 11/23/2021	Low	12/1/2021	Completed	Compliance		State	DHCS	2021
8	Case Management	R (2.1.1) The Plan did not conduct HRAs within the required timeframes for newly enrolled SPD members in 2019 and 2020.	1. The Plan revised the HRA process to track all incoming HRAs via a Log, documenting date of receipt. 2. The Plan revised current process for HRAs received past due to be entered into the system of record TruCare (TC) during the month of receipt. 2.a. The Plan updated workflows. 3. The Plan re-trained staff on the HRA process. 4. The Plan will monitor the Log weekly to ensure adherence to the new process. <u>Update 10/8/2021</u> : The log has been created and is being monitored weekly 5. The Plan will report outcomes up to UMC quarterly. <u>Update 2/11/2022</u> : As of the December UM Committee meeting, outcomes are now being reported at the UMC.	Low	12/31/2021	Completed	Case Management		State	DHCS	2021

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2021 DHCS JOINT AUDIT FINDINGS: Audit Review Period 6/1/2019 - 3/31/2021								INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Risk Category (High, Medium, Low)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
9	Case Management	(2.1.2) The Plan did not ensure coordination of care in certain cases where EPSDT services were medically necessary.	1.The Plan will develop training on EPSDT PA requests to identify and refer members who need coordination of their care. <u>Update 11/12/2021</u>: Training developed 2.The Plan will provide training to UM and CM staff. <u>Update 11/12/2021</u>: Training completed for UM and CM staff 3.The Plan will create a reporting system to capture referrals to CM and the provision of care coordination. <u>Update 11/12/2021</u>: Reporting system to capture referrals has been created, change in reporting will be reflected mid-December 4.The Plan will report outcomes at UMC on a quarterly basis. <u>Update 5/13/2022</u>: Outcomes reported at January and March 2022 UMC Meetings.	Medium	5/13/2022	Completed	Case Management		State	DHCS	2021
10	Case Management	(2.2.1) The Plan did not ensure the completion of Individualized Care Plans for members enrolled in Complex Case Management.	1. The Plan revised its CCM ICP workflow and added the requirement that all staff complete ICPs for all members in CCM. 2. The Plan re-trained staff to complete ICPs for all members in CCM. 3. The Plan will revise its CM Aging Report to capture completion of ICPs for daily management and reporting outcomes. <u>Update 10/8/2021</u>: Aging report has been updated to capture completion of ICPs 4. The Plan will develop a monitoring workflow. <u>Update 10/8/2021</u>: The monitoring workflow has been completed 5. The Plan will routinely monitor completion of the ICPs. <u>Update 10/8/2021</u>: The log has been created and is being monitored weekly 6. The Plan will report outcomes at UMC quarterly. <u>Update 09/09/2022</u>: Monitoring of the ICPs is now being tracked and reported out quarterly at UM Committee.	Low	3/25/2022	Completed	Case Management		State	DHCS	2021
11	Case Management	(2.2.2) The Plan did not ensure development of care plans in collaboration with the PCP.	1. The Plan re-trained staff on policy regarding developing care plans in collaboration with PCP. 2. The Plan will revise its CM Aging Report to capture the date the letter regarding Care Plans was sent to the PCP <u>10/8/2021</u>: The CM Aging Report has been updated to capture the date the letter regarding Care Plans was sent to the PCP 3. The Plan will monitor, on an ongoing basis, the CM Aging Report to ensure CP letters are being sent to PCPs. <u>Update 10/8/2021</u>: Monitoring has begun, automation of this report is in progress 4. The Plan will report outcomes to UMC quarterly. <u>Update 09/09/2022</u>: Monitoring of the development of care plans with the PCP is now being tracked and reported out quarterly at UM Committee.	Low	3/25/2022	Completed	Case Management		State	DHCS	2021
12	Case Management	(2.2.3) The Plan did not conduct periodic evaluations to ensure the provision of complex case management based on the member's medical needs. The Plan did not implement procedures for monitoring time frame standards or maintaining monthly contact with members.	1. The Plan developed a workflow to maintain regular contact with members and ensure that the continuation of CCM is based on medical needs by using the Complex Criteria Checklist. 2. The Plan conducted staff training. 3. The Plan will revise its CM Aging Report to capture provision of CCM and maintaining monthly contact with member. <u>10/8/2021</u>: The CM Aging Report has been revised to capture the provision of CCM and maintaining monthly contact with member 4. The Plan will monitor, on an ongoing basis, the CM Aging Report. <u>10/8/2021</u>: Monitoring has begun, automation of this report is in progress 5. The Plan will report outcomes quarterly to UMC. <u>Update 09/09/2022</u>: Monitoring of the CM Aging Report is now being tracked and reported out quarterly at UM Committee.	Low	3/25/2022	Completed	Case Management		State	DHCS	2021

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2021 DHCS JOINT AUDIT FINDINGS: Audit Review Period 6/1/2019 - 3/31/2021								INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Risk Category (High, Medium, Low)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
13	Case Management	(2.2.4) The Plan did not ensure that interdisciplinary team assessments were included in the updating of members' care plans. The Plan did not ensure timely documentation of the interdisciplinary team meeting notes.	1. The Plan created an additional column in the Complex Case Log to monitor timely entry of IDT Round note into system of record. 2. The Plan will develop a workflow for staff to include the IDT note in the updated care plans. <u>Update 10/8/2021</u>: The workflow has been updated to include the IDT note in the updated care plans. 3. The Plan will develop a monitoring workflow. Monitoring will be done on a bi-weekly basis. <u>Update 9/9/2022</u>: Monitoring is now being completed on a bi-weekly basis 4. The Plan conducted a staff training on the process. 5. The Plan will use Complex Case Log to monitor adherence to procedure. <u>Update 11/12/2021</u>: The Plan is now using the Complex Case Log to monitor adherence 6. The Plan will report outcomes quarterly to UMC. <u>Update 09/09/2022</u>: Monitoring of the IDT assessments is now being tracked and reported out quarterly at UM Committee.	Low	3/25/2022	Completed	UM		State	DHCS	2021
14	Case Management	(2.5.1) The Plan's MOU with the County MHP did not meet all the requirements specified in APL 18-015.	1. The Plan will conduct annual meetings with the County to ensure that the MOU is being updated (when appropriate). <u>Update 1/14/2022</u>: Due to staffing availability, the meeting with the County to review the MOU was not able to take place in December, and will be scheduled for early 2022. <u>Update 2/11/2022</u>: The first meeting with the county took place on 1/31/2022. 1.a. The Plan will develop meeting minutes to demonstrate topic of discussions. The Plan will submit meeting minutes to DHCS. <u>Update 2/11/2022</u>: Meeting minutes completed for first meeting on 1/31/2022. 2. The Plan's internal departments will work together to ensure clinical and quality components that are not present be updated in the MOU to reflect the requirements in APL-018. <u>Update 2/11/2022</u>: MOU has been updated to ensure clinical and quality components reflected.	Low	1/31/2022	Completed	Case Management Provider Network		State	DHCS	2021
15	Case Management	(2.5.2) The Plan's MOU with the County MHP did not specify policies, procedures, and reports to address quality improvements requirements specified in APL 18-015. The Plan did not conduct semi-annual calendar year reviews of referral and care coordination processes, generate semi-annual reports, or develop performance measures and quality improvement initiatives during the audit period.	1. The Plan will establish a cross-functional workgroup to develop specific P&Ps and QI performance metrics, in addition to referral and care coordination reports. <u>Update 12/10/2021</u>: The cross-functional workgroup was established and held it's first meeting on 10/20/2021. County JOMs will begin January 2022.	High	12/10/2021	Completed	Case Management Provider Network		State	DHCS	2021
16	Access	(3.1.1) The Plan did not enforce and monitor providers' compliance with the requirement to document when timeframes for appointments were extended.	1. The Plan revised P&P QI-107 to include appointment extension language and will be submitted to committee for approval. <u>Update 11/12/2021</u>: The P&P has been revised and is awaiting approval at committee on 11/23/2021. <u>Update 12/10/2021</u>: The policy was approved at Compliance Committee on 11/23/2021. 2. The Plan revised Timely Access Standards Provider Communication Sheet and will be submitted to committee for approval. <u>Update 11/12/2021</u>: The Timely Access Standards Provider Communication Sheet has been revised and is awaiting approval at committee on 11/18/2021. <u>Update 12/10/2021</u>: The Timely Access Standards Provider Communication Sheet was approved at HCQC on 11/18/2021.	Low	11/23/2021	Completed	QI		State	DHCS	2021
17	Access	(3.1.2) The Plan did not continuously review, evaluate and improve access to and availability of the first prenatal appointment.	1. The Plan revised P&P QI-107 to indicate current Access Standards for First Prenatal Appointment from 2 weeks from date of request to 10 days for PCP OB/GYN and 15 days from request for OB/GYN Specialty Care. P&P will be submitted to committee for approval. <u>Update 11/12/2021</u>: Awaiting clarification and further guidance from DHCS Contract Manager. <u>Update 12/10/2021</u>: QI-107 was approved at the Compliance Committee on 11/23/2021. 2. The Plan revised Timely Access Standards Provider Communications Sheet. <u>Update 11/12/2021</u>: Awaiting clarification and further guidance from DHCS Contract Manager. <u>Update 12/10/2021</u>: The Timely Access Standards Provider Communication Sheet was approved at HCQC on 11/18/2021. 3. The Plan will be implementing a tracking and trending report of First Prenatal PQIs. <u>Update 11/12/2021</u>: Awaiting clarification and further guidance from DHCS Contract Manager. <u>Update 12/10/2021</u>: The Tracking and Trending report of First Prenatal PQIs has been implemented	Medium	11/23/2021	Completed	QI		State	DHCS	2021

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2021 DHCS JOINT AUDIT FINDINGS: Audit Review Period 6/1/2019 - 3/31/2021								INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Risk Category (High, Medium, Low)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
18	Access	(3.4.1) The Plan did not ensure standing referral determinations and processing were made within the required timeframes.	1. The Plan will develop a standing referral workflow. <u>11/12/2021</u>: Standing referral workflow has been developed 2. The Plan will update The Alliance system of record for UM and CM, TruCare (TC) to add user define field in order to identify standing referral status to ensure correct TAT, which would include a reportable field for monthly reporting. <u>Update 12/10/2021</u>: TruCare has been updated to add the user defined field. 3. The Plan will revise TruCare (TC) to capture timeframes for processing Standing Referrals. <u>Update 12/10/2021</u>: The reporting TAT has been scheduled to begin in December, with the first report, containing December data, due in January. 4. The Plan will revise Authorization Aging report for day to day management and to report on timeframes for Standing Referrals. <u>Update 01/14/2022</u>: Revision of aging report complete 5. The Plan will conduct staff training on standard work for Standing Referrals. <u>Update 01/14/2022</u>: Staff training on standing referrals completed 11/16/2021 6. The Plan will monitor Standing Referral timeframes with the daily Authorization Aging report. 7. The Plan will report results quarterly to UMC. <u>Update 09/09/2022</u>: Standing referrals are now being tracked and reported on during UM Committee quarterly	High	3/25/2022	Completed	UM Case Management	Completed	State	DHCS	2021
19	Access	(3.6.1) The Plan improperly denied emergency services claims and family planning claims.	1. The Plan updated its monitoring report criteria to include a denial code (code:0630) which would allow us to identify claims prior to finalizing adjudication.	Low	3/26/2021	Completed	Claims IT (Config)		State	DHCS	2021
20	Access	(3.6.2) The Plan did not pay interest for family planning claims not completely reimbursed within 45 working days of receipt.	1. The Plan reviewed the issue thru Claims Processor & Specialist training to ensure staff understands the issue that resulted in no interest. The trainings were completed in May 2021.	Low	5/1/2021	Completed	Claims		State	DHCS	2021
21	Access	(3.8.1) The Plan did not ensure its transportation broker's NEMT providers were enrolled in the Medi-Cal program.	1. The Plan notified its transportation broker that remaining unenrolled NEMT providers need to complete PAVE application by 12/01/2021. <u>Update 12/10/2021</u>: The notification letter was sent to the transportation broker on 12/1/2021, 2. The Plan will audit transportation broker providers to ensure drivers are enrolled in the Medi-Cal program. This was last completed August 27, 2021. Monitoring will be conducted on an annual basis.	Low	12/31/2022	Completed	Vendor Management		State	DHCS	2021
22	Access	(3.8.2) The Plan did not require PCS forms for NEMT services.	1. The Plan will require transportation broker to provide ongoing reports on rates of obtaining PCS forms from providers: <u>Update 11/12/2021</u>: UM Team working with Vendor Management and the transportation broker to obtain needed reports. <u>Update 12/10/2021</u>: The report was received from transportation broker on 10/28/2021. 2. The Plan will analyze trends in provider practices on a quarterly basis. <u>Update 12/10/2021</u>: The first report will be given at UMC in January 2022. <u>Update 2/11/2022</u>: Awaiting reports from the transportation broker 3. The Plan will educate providers on PCS requirements and provide data on their performance: <u>Update 2/11/2022</u>: Awaiting reports from the transportation broker 3.a. Provider newsletter. <u>Update 2/11/2022</u>: Awaiting reports from the transportation broker 3.b. Individual office contacts 4. The Plan will finalize process workflow to obtain missing PCS forms. <u>Update 11/12/2021</u>: UM Team working with Vendor Management and the transportation broker to obtain needed reports. <u>Update 12/10/2021</u>: The workflow has been finalized based on the reports received from the transportation broker 5. The Plan will conduct staff trainings on process workflow. <u>Update 12/10/2021</u>: Training was completed 11/8/2021. 6. The Plan will provide a quarterly report to UMC. <u>Update 01/14/2021</u>: Reporting will begin at UMC in Q1 2022. <u>Update 2/11/2022</u>: Awaiting reports from the transportation broker <u>Update 09/09/2022</u>: NEMT services are now being tracked and reported quarterly at the UM Committee.	Medium	12/31/2022	Completed	Vendor Management UM		State	DHCS	2021
23	Member Rights	(4.1.1) The Plan did not ensure that the medical director fully resolved QOC grievances prior to sending resolution letters.	1. The Plan updated G&A-003 Grievance and Appeals Receipt, Review and Resolution to include the process for the medical director's review and resolution of all levels of quality of care grievances prior to sending a resolution letter to members. The policy will be reviewed at the Health Care Quality Committee on November 18, 2021 and the Compliance Committee Meeting on November 23, 2021. <u>Update 12/10/2021</u>: G&A-003 was approved at the Compliance Committee meeting on 11/23/2021 2. The Plan will provide training to the medical directors to review G&A-003 Grievance and Appeals Receipt, Review and Resolution by November 30, 2021. <u>Update 3/11/2022</u>: Training was completed 1/12/2022	Medium	1/12/2022	Completed	G&A		State	DHCS	2021
24	Member Rights	(4.1.2) The Plan did not consistently implement its procedure for processing grievances. The Plan considered member's grievances resolved and classified as exempt without conducting investigation.	1. The Plan is updating its policy and procedures for processing Exempt Grievances to reflect its current process. The policy MBR-0024 will be reviewed at the Compliance Committee Meeting on November 23, 2021. <u>Update 12/10/2021</u>: MBR-024 was approved at Compliance Committee on 11/23/2021 2. The Plan will provide staff training by November 30, 2021. <u>Update 1/14/2022</u>: Training was completed 11/19/2021	Low	11/30/2021	Completed	Member Services		State	DHCS	2021

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2021 DHCS JOINT AUDIT FINDINGS: Audit Review Period 6/1/2019 - 3/31/2021								INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Risk Category (High, Medium, Low)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year
25	Member Rights	(4.1.3) The Plan did not send acknowledgement and resolution letters within the required timeframes. The Plan did not promptly notify the members that expedited grievances would not be resolved within the required timeframe.	1. The Plan provided training to the Grievance and Appeals staff to review G&A-003 Grievance and Appeals Receipt, Review and Resolution and G&A-005 Expedited Review of Urgent Grievances. The staff attested that they understood the requirements and will ensure that acknowledgement and resolution letters are sent within the required timeframes, and to also notify members when expedited grievances would not be resolved within the required timeframe.	Low	9/21/2021	Completed	G&A		State	DHCS	2021
26	Member Rights	(4.1.4) The Plan did not send acknowledgement and resolution letters in threshold languages.	1. The Plan provided training to the Grievance and Appeals staff to review G&A-001 Grievance and Appeals System Description and CLS-003 Language Assistance Services. The staff attested that they understood the requirements and will ensure that acknowledgement and resolution letters are sent to members in their threshold languages.	Low	9/21/2021	Completed	G&A		State	DHCS	2021
27	Member Rights	R (4.1.5) The Plan did not consistently resolve grievances prior to sending resolution letters.	1. The Plan provided training to the Grievance and Appeals staff to review G&A-001 Grievance and Appeals System Description. The staff attested that they understood the requirements and will ensure that grievances are fully resolved prior to sending resolution letters.	Low	9/21/2021	Completed	G&A		State	DHCS	2021
28	Member Rights	(4.3.1) The Plan did not report suspected security incidents or unauthorized disclosures of PHI to DHCS within 24 hours of discovery, did not provide an updated investigation report within 72 hours, and did not submit a complete report of the investigation within 10 working days.	1. To address staffing needs, the Plan has streamlined its Compliance Department and now has a dedicated staff member who focuses on Privacy. This FTE was hired on February 22, 2021. 2. The Plan reviewed and updated CMP-013 HIPAA Privacy Reporting to reflect the 24hr, 72hr and 10-day reporting requirements. This policy is scheduled to be reviewed and approved at the Compliance Committee on November 23, 2021. <u>Update 12/10/2021</u> : CMP-013 was approved at Compliance Committee on 11/23/2021	Low	11/30/2021	Completed	Compliance		State	DHCS	2021
29	Compliance	R (6.2.1) The Plan did not conduct and report preliminary investigations of all suspected cases of fraud and abuse to DHCS within ten working days.	1. The Plan has a dedicated staff member in the Special Investigations Unit (SIU) to focus on Fraud, Waste and Abuse FWA cases. This FTE was hired on 6/25/2021. 2. The plan updated CMP-002 to reflect reporting requirements. This policy is scheduled to be re-approved at the Compliance Committee on Nov 23, 2021. <u>Update 12/10/2021</u> : CMP-002 was approved at the 11/23/2021 Compliance Committee	Low	12/1/2021	Completed	Compliance		State	DHCS	2021
30	Compliance	(6.2.2) The Plan did not report recoveries of overpayments to DHCS annually.	After internal review, the Plan found that an update to CMP-002 was not necessary as the reporting of overpayments is addressed in CLM-008: Overpayment Recovery. The Plan has validated that reports were submitted appropriately to the Department.	Low	2/11/2022	Completed	Compliance		State	DHCS	2021
31	Claims	(SSS.1) The Plan did not distribute payments for state supported services claims within 90 calendar days as described in APL 19-013.	1. The Plan made changes to the claims system on 2/17/2021 and re-adjudicated all the previous claims paid incorrectly to pay the balance to the Prop 56 rate.	Low	2/17/2021	Completed	Claims		State	DHCS	2021
32	Claims	(SSS.2) The Plan did not pay interest for state supported services claims processed beyond the 90-calendar day timeframe specified in APL 19-013.	1. The Plan made changes to the claims system on 2/17/2021 and re-adjudicated all the previous claims paid incorrectly to pay the balance to the Prop 56 rate. The claim system was also updated to pay interest at the normal timeline of claims adjudicated after 45 work days from the received date.	Low	2/17/2021	Completed	Claims		State	DHCS	2021
33	Claims	(SSS.3) The Plan improperly denied state supported services claims.	1. As of 8/7/2020 the Plan reconfigured the system to no longer re-suspend the delegate's Non-Emergency Out of Area processed claims. In addition, the Claims workflow has been updated to accommodate the system change.	Low	8/7/2020	Completed	Claims		State	DHCS	2021
34	Compliance	The Plan should have a policy and workflow for tracking discrimination grievances	1. The Plan has created the Special Cases Incident Log for tracking discrimination grievances 2. The Plan will update the policy and create a workflow regarding tracking of discrimination grievances. <u>Update 12/1/2021</u> : The policy has been created and was approved at the Compliance Committee on 11/23/2021	Medium	12/1/2021	Completed	Compliance		Self Identified	AAH	2021
35	Quality Management	The Plan should ensure that PQIs are appropriately classified (as QOS / QOA / QOC)	1. Sr. Dir. Of Quality and the QI Supervisor conduct quarterly audits of QOA and QOS case files 2. QOC files are reviewed and leveled by Quality Medical Director weekly	Low	2/28/2021	Completed	QM		Self Identified	AAH	2021

**ALAMEDA ALLIANCE FOR HEALTH
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2020 DHCS STATE AUDIT FINDINGS - Audit Review Period: 10/01/2018 - 9/30/2020					INTERNAL AUDITS						
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
1	Claims	The Plan denied payment to a contracted hospital for continued treatment of Plan members with chronic medical conditions. The Plan did not provide for all medically necessary covered services for members	1. The Plan and the hospital renegotiated its hospital agreement with an effective date of February 1, 2021. The Alliance and the hospital agreed to a step down approach where The Alliance will authorize care at the appropriate level and work in conjunction with the hospital toward an appropriate discharge. The rate paid by Plan will be equal to the medical surgical rate. Please see Section 3.6 Utilization Management of The Alliance and hospital Contract Amendment. 2. The Plan and the hospital have a meeting set up for 4/6/2021 at 3:30 PM. The goal of this meeting is to finalize the cases in arbitration and any other outstanding claims. <u>Update 5/14/21</u> The legal team is continuing to review which claims to pay. <u>Update 6/11/21</u> The Alliance is working with the provider on evaluating and assessing the claims from the audit. Senior level discussions are in process between the hospital and the Alliance. <u>Update 10/8/2021</u> The Plan paid the hospital for all claims in Arbitration on the 7/22/2021 check run. The hospital had some additional claims they wanted reviewed and we met on 7/27/2021 to review them. The Plan agreed to pay these claims, as well, and they were paid out on the 8/25/2021 and 9/1/2021 check runs. <u>Update 5/13/2022</u> : DHCS advised The Alliance they consider the findings of this audit closed as of 4/19/2022	9/1/2021	Completed	UM / Claims		State	DHCS	2020	Completed
2	UM	The Plan did not apply written criteria for each concurrent review of continued long term acute care (LTAC) services throughout members' hospital stays	1. The Plan reviewed and revised the following P&P: a. UM-003 Concurrent Review and Discharge Planning Process to reflect frequency of reviews throughout the members' hospital stay, including after a NOA is sent, and the use of standard Utilization Review procedures. Policy and Procedure will be approved at the HCQC on 5/20/2021. b. The Plan's standard review procedures include applying written criteria for each review. The Plan's standard utilization review procedures are reflected in Plan's P&P UM-057 and in UM-054 Notice of Action. 2. The Plan will train its Utilization Management staff involved in the Concurrent Review process of the change. The training will be documented with training materials and attendance records. <u>Update 5/14/21</u> : Training was completed on 3/31/21 3. The Plan will audit the Concurrent review process after Q2 2021 to ensure that process are followed and implemented accordingly. <u>Update 5/14/21</u> : Manual audit in place, automated report in development. <u>Update 7/9/2021</u> : Manual tracking continues, nearing completion of automated report. <u>Update 10/8/2021</u> : Manual tracking continues, awaiting completion of automated report 4. The Plan will report the results of the Concurrent review process to the UM Committee on a quarterly basis, starting Q4 2021. <u>Update 10/8/2021</u> : First report to UMC on 8/24/2021. 100% compliance. <u>Update 12/10/2021</u> : The most recent audit concluded in November with a passing score for each factor reviewed. The results were reported at the UM Committee on 12/3/2021. <u>Update 04/08/2022</u> : The most recent audit encompassed NOA letters from January and February 2022 with a passing score for each factor reviewed. The results were reported at the UM Committee on 03/25/2022. <u>Update 5/13/2022</u> : DHCS advised The Alliance they consider the findings of this audit closed as of 4/19/2022	3/25/2022	Completed	UM		State	DHCS	2020	In Progress
3	UM	The Plan did not document that qualified physicians reviewed all denials of continued long term acute care (LTAC) services throughout members' hospital stays	1. The Plan reviewed and revised the following P&P: a. UM-003 Concurrent Review and Discharge Planning Process to reflect frequency of reviews throughout the members' hospital stay, including after a NOA is sent, and the use of standard Utilization Review procedures. Policy and Procedure will be approved at the HCQC on 5/20/2021. b. The Plan's standard review procedures include applying written criteria for each review. The Plan's standard utilization review procedures are reflected in Plan's P&P UM-057 and in UM-054 Notice of Action. 2. The Plan will train its Utilization Management staff involved in the Concurrent Review process of the change. The training will be documented with training materials and attendance records. <u>Update 5/14/21</u> : Training was completed on 3/31/21 3. The Plan will audit the Concurrent review process after Q2 2021 to ensure that process are followed and implemented accordingly. <u>Update 5/14/21</u> : Manual audit in place, automated report in development. <u>Update 7/9/2021</u> : Manual tracking continues, nearing completion of automated report. <u>Update 10/8/2021</u> : Manual tracking continues, awaiting completion of automated report 4. The Plan will report the results of the Concurrent review process to the UM Committee on a quarterly basis, starting Q4 2021. <u>Update 10/8/2021</u> : First report to UMC on 8/24/2021. 100% compliance. <u>Update 11/12/2021</u> : The results of the next quarterly audit will be presented at the November UM Committee. <u>Update 12/10/2021</u> : The results of the next quarterly audit will be reported at the December UM Committee. <u>Update 04/08/2022</u> : The most recent audit encompassed NOA letters from January and February 2022 with a passing score for each factor reviewed. The results were reported at the UM Committee on 03/25/2022. <u>Update 5/13/2022</u> : DHCS advised The Alliance they consider the findings of this audit closed as of 4/19/2022	3/25/2022	Completed	UM		State	DHCS	2020	In Progress

**ALAMEDA ALLIANCE FOR HEALTH
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2020 DHCS STATE AUDIT FINDINGS - Audit Review Period: 10/01/2018 - 9/30/2020					INTERNAL AUDITS						
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
4	UM	The Plan did not notify members and the hospital of continued denial of long term acute care (LTAC) services through NOA letters and "Your Rights" attachments for each concurrent review throughout the members' hospital stays	1. The Plan reviewed and revised the following P&P: a. UM-003 Concurrent Review and Discharge Planning Process to reflect frequency of reviews throughout the members' hospital stay, including after a NOA is sent, and the use of standard Utilization Review procedures. Policy and Procedure will be approved at the HCQC on 5/20/2021. b. The Plan's standard review procedures include applying written criteria for each review. The Plan's standard utilization review procedures are reflected in Plan's P&P UM-057 and in UM-054 Notice of Action. 2. The Plan will train its Utilization Management staff involved in the Concurrent Review process of the change. The training will be documented with training materials and attendance records. Update 5/14/21: Training was completed on 3/31/21 3. The Plan will audit the Concurrent review process after Q2 2021 to ensure that process are followed and implemented accordingly. Update 5/14/21: Manual audit in place, automated report in development. Update 7/9/2021: Manual tracking continues, nearing completion of automated report. <u>Update 10/8/2021</u> Manual tracking continues, awaiting completion of automated report 4. The Plan will report the results of the Concurrent review process to the UM Committee on a quarterly basis, starting Q4 2021. <u>Update 10/8/2021</u>: First report to UMC on 8/24/2021. 100% compliance. <u>Update 11/12/2021</u>: The results of the next quarterly audit will be presented at the November UM Committee. <u>Update 12/10/2021</u>: The most recent audit concluded in November with a passing score for each factor reviewed. The results were reported at the UM Committee on 12/3/2021. <u>Update 04/08/2022</u>: The most recent audit encompassed NOA letters from January and February 2022 with a passing score for each factor reviewed. The results were reported at the UM Committee on 03/25/2022. <u>Update 5/13/2022</u>: DHCS advised The Alliance they consider the findings of this audit closed as of 4/19/2022	3/25/2022	Completed	UM		State	DHCS	2020	In Progress
5	UM	The Plan provided unclear information about the Plan's decision for denial of long term acute care (LTAC) services in the only NOA letters that were issued to members and the Hospital. Letters contained inaccurate information about denied dates and requesting providers.	1. The automated section of the NOA letter generated by the Plan's system of record, TruCare, was incorrectly configured and displayed inaccurate information about the requesting LTAC provider and the dates of denial. The Plan's system of record, TruCare, was re-configured to display the correct dates and correct requesting provider in the automated portion of the NOA letters. 2. The Plan's In-Patient Utilization Management Leadership will continue to audit the NOA letters to ensure that they contain accurate information and meet the regulatory requirements. Update 5/15/2021: Identified deficiencies have been added to the audit tool and audits of inpatient NOA letters are currently taking place. 3. The Plan will report the results of NOA letter audit at Utilization Management Committee on a quarterly basis, starting Q3 2021. Update 7/9/2021: Manual tracking continues, report will be provided starting in Q3 2021 <u>Update 10/8/2021</u>: Manual tracking continues, awaiting completion of automated report. First report to UMC on 8/24/2021. 100% compliance. <u>Update 11/12/2021</u>: The results of the next quarterly audit will be presented at the November UM Committee. <u>Update 12/10/2021</u>: The most recent audit concluded in November with a passing score for each factor reviewed. The results were reported at the UM Committee on 12/3/2021. <u>Update 04/08/2022</u>: The most recent audit encompassed NOA letters from January and February 2022 with a passing score for each factor reviewed. The results were reported at the UM Committee on 03/25/2022. <u>Update 5/13/2022</u>: DHCS advised The Alliance they consider the findings of this audit closed as of 4/19/2022	3/25/2022	Completed	UM		State	DHCS	2020	In Progress

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COMPLIANCE DASHBOARD**

2020 DHCS STATE AUDIT FINDINGS - Audit Review Period: 10/01/2018 - 9/30/2020					INTERNAL AUDITS						
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
6	Delegation	The Plan did not ensure the Delegate met standards set forth by the Plan and DHCS. The Delegate did not ensure that concurrent review denials were reviewed and made by a qualified physician. It did not send NOA letters with "Your Rights" information for denial of services that occurred after initial denial. It did not include the decisions maker's name in the initial and only NOA sent to providers.	1. The Plan's revised policy UM-003 Concurrent Review and Discharge Planning Process and the revised process expectations were shared with Delegate on 3/26/2021. 2. The Plan will require the Delegate to do the following: a. Adopt the Plan's policies, to reflect that the concurrent review denials are reviewed and made by a qualified physician, that the clinical case is reviewed using the regulatory requirements on a regular cadence after the initial denial, that NOA letters with "Your Rights" information are sent after every subsequent review, and that the decision-maker's name is on each NOA. Update 6/11/2021 The Alliance's Health Care Services is working with the delegate to update the policies. b. Provide evidence of policy and procedure approval. Update 7/9/2021: Delegate has provided evidence that the revised policy was approved on 6/23/2021 c. Train its staff on the new Concurrent review process. Update 7/9/2021: Delegate states they are developing the training for their staff and are on track to provide the documents to The Alliance. <u>Update 9/10/2021</u>: Staff training completed, training documents provided. d. Provide evidence of the training, including the training materials and the attendance records. <u>Update 9/10/2021</u>: Delegate provided attestations to show training completed 6/23/2021 3. The Plan will audit the Delegate on a quarterly basis to ensure that the process is implemented, starting at the end of Q3 2021, and report the results of the audit at the Plan's UM Committee on a quarterly basis. <u>Update 10/8/2021</u>: Q3 2021 audit completed 9/29/2021, and initial audit results provided to the Delegate; final audit report will be issued to the Delegate by 10/13/2021. <u>Update 11/12/2021</u>: The next quarterly audit is scheduled for 12/17/2021. <u>Update 04/08/2022</u>: The next quarterly audit is scheduled to be completed in May 2022 4. At annual Delegate oversight audits, concurrent reviews and letters will be examined to ensure compliance. <u>Update 11/12/2021</u>: The next annual Delegation Oversight Audit is scheduled for February 2022. Concurrent reviews and letters will be reviewed at that time. <u>Update 04/08/2022</u>: The next quarterly audit is scheduled to be completed in May 2022. <u>Update 5/13/2022</u>: DHCS advised The Alliance they consider the findings of this audit closed as of 4/19/2022. <u>Update 5/13/2022</u>: The delegate does not have any cases that meet the criteria for audit for Q1 2022. DHCS advised The Alliance they consider the findings of this audit closed as of 4/19/2022. Update 07/08/2022: The Alliance is currently in the process of quarterly delegate audit. <u>Update 09/09/2022</u>: The quarterly delegate audit is in progress and is expected to be completed by October 2022. <u>Update 10/14/2022</u>: The quarterly delegate audit has been completed, there were no findings. This audit will be closed and the findings noted by DHCS will continue to be reviewed during the annual audit.	9/23/2022	Completed	UM		State	DHCS	2020	In Progress

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2020 DHCS STATE AUDIT FINDINGS - Audit Review Period: 10/01/2018 - 9/30/2020					INTERNAL AUDITS						
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
7	Delegation	The Plan did not ensure the Delegate met standards set forth by the Plan and DHCS. The Delegate denied medically necessary services.	1. The Plan's revised policy UM-003 Concurrent Review and Discharge Planning Process and the revised process expectations were shared with Delegate on 3/26/2021. 2. The Plan will require the Delegate to do the following: a. Adopt the Plan's policies, to reflect that the concurrent review denials are reviewed and made by a qualified physician, that the clinical case is reviewed using the regulatory requirements on a regular cadence after the initial denial, that NOA letters with "Your Rights" information are sent after every subsequent review, and that the decision-maker's name is on each NOA. Update 6/11/2021 The Alliance's Health Care Services is working with the delegate to update the policies. b. Provide evidence of policy and procedure approval. Update 7/9/2021: Delegate has provided evidence that the revised policy was approved on 6/23/2021 c. Train its staff on the new Concurrent review process. Update 7/9/2021: Delegate states they are developing the training for their staff and are on track to provide the documents to The Alliance. Update 9/10/2021: Staff training completed, training documents provided. d. Provide evidence of the training, including the training materials and the attendance records. Update 9/10/2021: Delegate provided attestations to show training completed 6/23/2021 3. The Plan will audit the Delegate on a quarterly basis to ensure that the process is implemented, starting at the end of Q3 2021, and report the results of the audit at the Plan's UM Committee on a quarterly basis. Update 10/8/2021: Q3 2021 audit completed 9/29/2021, and initial audit results provided to the Delegate; final audit report will be issued to the Delegate by 10/13/2021. Update 11/12/2021: The next quarterly audit is scheduled for 12/17/2021. Update 04/08/2022: The next quarterly audit is scheduled to be completed in May 2022 4. At annual Delegate oversight audits, concurrent reviews and letters will be examined to ensure compliance. Update 11/12/2021: The next annual Delegation Oversight Audit is scheduled for February 2022. Concurrent reviews and letters will be reviewed at that time. Update 04/08/2022: The next quarterly audit is scheduled to be completed in May 2022. Update 5/13/2022: The delegate does not have any cases that meet the criteria for audit for Q1 2022. DHCS advised The Alliance they consider the findings of this audit closed as of 4/19/2022. Update 07/08/2022: The Alliance is currently in the process of quarterly delegate audit. Update 09/09/2022: The quarterly delegate audit is in progress and is expected to be completed by October 2022. Update 10/14/2022: The quarterly delegate audit has been completed, there were no findings. This audit will be closed and the findings noted by DHCS will continue to be reviewed during the annual audit.	9/23/2022	Completed	UM		State	DHCS	2020	In Progress

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2020 DMHC STATE AUDIT FINDINGS - Audit Review Period: 1/01/2019 - 9/30/2019					INTERNAL AUDITS						
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
1	Grievances & Appeals	The Plan failed to accurately and consistently identify grievances received by telephone. Coverage Dispute issues were processed as an exempt grievance and not a standard grievance as required.	The G&A current procedures appropriately process coverage disputes as a standard grievance. Member Services will provide a refresher staff training of the procedures by 3/31/2020 to ensure coverage disputes are processed appropriately. <u>Update as of 4/10/2020</u> . Refresher training for benefits coverage disputes was completed on 3/12/2020.	3/12/2020	Completed	Member Services/ G&A	✓	State	DMHC	2020	Completed
2	Grievances & Appeals	The Plan does not consistently provide immediate notification to complainants of their right to contact the Department regarding expedited appeals.	G&A staff training was conducted to review regulations on 1/30/2020. G&A application was updated to include a new log type for expedited DMHC rights notification that was implemented on 2/6/2020.	2/6/2020	Completed	G&A	✓	State	DMHC	2020	Completed
3	UM	The Plan does not include the statement required by Section 1363.5(c) when disclosing medical necessity criteria for UM decisions.	Cover sheet being created in the TruCare system for all requests by providers for clinical criteria used to adjudicate requests. Creation of tracking log, workflow and training to be completed by 3/31/2020. <u>Update as of 4/10/2020</u> . Tracking log workflow and training completed as of 3/12/2020.	3/12/2020	Completed	UM	✓	State	DMHC	2020	Completed
4	Access to Emergency Services	The Plan does not provide all non-contracting hospitals in the state with Plan contact information needed to request authorization of post-stabilization care. DMHC expects the onus to be on the Plan to reach out to the hospitals and notices should be mailed at least annually.	The Plan is working with the Hospital Association to assist in sending out the notices to non-contracted hospitals. <u>Update as of 6/12/2020</u> . Notices were mailed to non-contracted hospital providers on May 26.	5/31/2020	Completed	Provider Relations	✓	State	DMHC	2020	Completed
5	Access & Availability	The Plan failed to adequately review and address access issues as part of its quality assurance (QA) program.	The QI Team and Member Services team perform an annual training to ensure that the appropriate process is followed. The Alliance is working on additional training to ensure the appropriate referral of PQIs. All access-related exempt grievances are compiled in a track and trend report and referred to Quality Improvement via the Access and Availability Sub-Committee	4/30/2020	Completed	Quality Management	✓	State	DMHC	2020	Completed
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Compliance Internal Audit	State/Self Identified	Agency	Year	Status
1	Quality Assurance	The Plan failed to ensure that all potential quality of care issues were identified and processed in accordance with its Quality Assurance (QA) Program. Cases were found to be misclassified and include documentation issues.	1. RN Staff In-Service on PQI definition, classification, review, processing and documentation conducted by Quality Sr. Director on 2/7/2020. 2. Deleted "Not a PQI" from classification drop down selections. 3. All new PQI submissions are reviewed and classified (as QOS/QOA/QOC) by Quality Director. 4. RN PQI Classification IRR conducted by Quality Director on 2/25/2020. 5. Department wide IRR Conducted by Medical Director on 2/27/2020 6. Quality Director to process all QOAs and QOSs 7. Medical Director is auditing random sample of QOA and QOS cases processed by nurse management staff as of 4/6/2020. 8. Quality Director to conduct weekly auditing of RN documentation of all QOCs as of 3/5/2020. 9. Medical Director continues to level and audit all QOC cases 10. Ongoing weekly team meeting continues to ensure case discussion and review <u>Update as of 4/30/2020</u> ; QI team has completed all steps listed above.	4/30/2020	Completed	Quality Improvement	✓	Self Identified	AAH	2020	Completed
2	UM	The Plan does not consistently provide enrollees with a clear and concise reason for denials based in whole or in part on medical necessity.	Quality checklist for review of NOA letters for all requirements prior to being sent out to be developed, then train staff, by 3/31. Quality checks of all NOAs by management before sending out continues. Weekly review by external consultants continue with MDs to improve decision notices. <u>Update as of 4/10/2020</u> . NOA checklist training and implementation done as of 4/2/2020. Weekly review by external consultants continues.	4/2/2020	Completed	UM	✓	Self Identified	AAH	2020	Completed
3	UM	In letters to providers denying or modifying requested services on the basis of medical necessity, the Plan does not include a direct telephone number or extension of the professional responsible for the decision. The peer to peer process to improve its oversight and tracking process.	Phone numbers in all UM template letters being checked for accuracy and corrected in TruCare as needed. Standardized tracking workflow of Peer to Peer communication is being developed, trained and implemented by 3/31/2020. <u>Update as of 4/10/2020</u> ; Training and tracking implemented as of 3/12/2020.	3/12/2020	Completed	UM	✓	Self Identified	AAH	2020	Completed

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2019 DMHC AUDIT FINDINGS - Audit Review Period: 10/1/2017-9/30/2019						INTERNAL AUDITS					
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
1	Payment Accuracy	Three out of 50 late paid claims (a compliance rate of 94 percent). This deficiency was caused by the Plan using the incorrect date to calculate interest on improperly denied and reprocessed claims. Three out of 30 high dollar claims. The deficiency was caused by the Plan not paying interest on a claim improperly denied for missing authorization when the independent practice association (IPA) authorized services but did not forward the authorization to the Plan, and underpaying claims due to processor error.	Late Claims – processing errors identified in this finding are attributable to human error by one specific individual. The incorrect handling was addressed verbally with the employee at the time of the audit. Refresher training on CLM-001 Claims Processing, CLM-003 Emergency Services Claims Processing and Claims Change Alert Clean Claim Interest Workflow was completed on March 13, 2020 to ensure that all staff who handles adjustments are using the appropriate received date for adjusted claims. <u>Update 5/1/2020</u>: At the Department's request, the Plan created a report to identify claims where the incorrect received date was used on an adjusted claim. The report was provided to the Department on 4/21/2020. The identified claims have been adjusted and the report has been updated to add the check date, check # and the amount of interest and penalties paid. Current policies and procedures do not require changes and meet compliance requirements. High Dollar Claims – processing errors identified in this finding are attributable to human error. Refresher training on CLM-001 Claims Processing and Claims Change Alert - Clean Claim Interest Workflow was completed on 3/13/2020 to ensure that all staff who handles adjustments are using the appropriate received date for adjusted claims.	4/29/2020	Completed	Claims	✓	State	DMHC	2019	Completed
2	Incorrect Claim Denials	Claims were improperly denied and should have been paid in three out of 50 denied claims (a compliance rate of 94 percent). The deficiency was caused by the Plan not re-processing retro enrollment, incorrectly denying a claim as duplicate and a system configuration issue that incorrectly denied claims as not the financial responsibility of the Plan.	Retro Eligibility Denial – The Plan's Claims management is working with its Information Technology/Analytics Department to create a retroactive eligibility report to identify claims that were denied correctly at the time of processing, but may be impacted due to the retroactive reinstatement of eligibility. Once the report is completed, the Plan will make sure to adjudicate any claims found to be improperly denied since 5/29/2018, and provide evidence that the claims were adjudicated appropriately. <u>Update 5/1/2020</u>: Report was put into production on 5/1/2020 and will be run weekly. Claims is working with IT to identify impacted claims from 5/29/2018-9/30/2019 and will adjust impacted claims and provide the final spreadsheet to the Department by 5/15/2020. Division Of Financial Responsibility (DOFR) Denial - this issue was identified as a configuration error for one specific service, and corrected in October 2019 prior to the audit. <u>Update 5/1/2020</u>: At the Department's request, the Plan created a report to identify claims where the service had been denied incorrectly. The report was provided to the Department on 4/21/2020. The identified claims are being adjusted and should be complete by 5/15/2020. The report will then be updated to add the check date, check # and the amount of interest paid. Duplicate Denial - duplicate claims refresher training on HS-004 Duplicate Claims was completed on 3/13/2020 for all staff that handles adjustments. Due to the unique cause of this non-system related error, a remediation report cannot be run.	4/15/2020 5/15/2020	Completed	Claims	✓	State	DMHC	2019	Completed
3	Clear & Accurate Denial Explanation	Plan provided an incorrect denial explanation in three out of 50 denied claims (a compliance rate of 94 percent).	The Plan reviewed the deficient cases and found that the three denial errors identified in the audit were related to Division of Financial Responsibility (DOFR) issues. The Plan will review the services where there are DOFR conflicts, come to agreement with the delegates, and make any required configuration changes to the system. <u>Update 5/1/2020</u>: System changes for the delegate were completed and put into production on 4/16/2020. The claims were originally denied correctly as the responsibility of another delegate but contained an additional incorrect message that they were forwarded to delegate. These claims do not need to be re-adjudicated and re-denied again. Due to the Coronavirus Pandemic, meetings with delegate have been put on hold. The Plan has updated the system to correct the configuration with out of area office visits that was identified during the audit. At the Department's request, the Plan created a report to identify claims where these services had been denied incorrectly. The report was provided to the Department on 4/21/2020. The identified claims are being adjusted and should be complete by 5/15/2020. The report will then be updated to add the check date, check # and the amount of interest paid.	6/30/2020 5/15/2020	Completed	Claims	✓	State	DMHC	2019	Completed

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2019 DMHC AUDIT FINDINGS - Audit Review Period: 10/1/2017-9/30/2019						INTERNAL AUDITS					
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
4	Change in Plan Personnel	Plan shall within five days, file an amendment when there are changes in personnel of the plan. Plan did not file the Board of Governors changes for three members.	The Plan has updated its internal procedures to ensure key personnel requirements are met. The Plan implemented a monthly quality check capturing any changes with the Plan's Board of Governor member seats. The Plan's Compliance team staff completed updated training for key personnel filing procedures on March 30, 2020. As of 3/31/2020, the Plan has also completed updates to the filings for three Board members as requested: Member 1: DMHC Filing #20201241 Member 2: DMHC Filing #20200184/#20201243 Member 3: DMHC Filing #20200644	4/1/2020	Completed	Compliance	✓	State	DMHC	2019	Completed
5	Control over Mailroom Claims Processing	Plan does not have sufficient control over its mailroom claims processing as the mailroom staff does not stamp the date of receipt on paper claims. In addition, the Plan's mailroom staff does not count the number of claims sent to vendors for further processing, impeding the Plan's ability to reconcile the number of claims received and processed.	The Plan has an established process for receiving claims in its onsite mailroom for capturing receipt dates. The Plan performs quality checks for reconciliations of claims count scanned and received to ensure all claims are captured for processing. The Plan has daily logs of professional and facility claims received and scanned. The logs have the original claim count, the claim count successfully scanned, the rejected claim count and the merged claim count. The Plan utilizes the daily log counts to perform reconciliation when the files are received and loaded. Included with the CAP response is the weekly reconciliation sample report and sample logs of claims as evidence of this quality internal control process for counting the number of claims.	4/1/2020	Completed	Support Services/ Claims	✓	State	DMHC	2019	Completed

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#	Category	Deficiency	Corrective Action Plan (CAP)	Repeat Finding (Yes/No)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status			
1	UM Delegation	The Plan did not ensure a delegate complied with all contractual and regulatory requirements. The delegate required PA for an initial visit with a mental health provider to determine if the member had mild-to-moderate mental health issues, which the contract does not allow.	The Alliance scheduled a meeting with the delegate to discuss the findings and will put a corrective action plan in place. <u>Update as of 12/5/2019:</u> The delegate has revised policy, and submitted to The Alliance for review. The Alliance will review and discuss changes with the delegate on the next Operations call. <u>Update as of 1/8/2020:</u> Plan reviewed documents and agree with the changes for member self-referral process. Discussing with DHCS prior to final CAP submission.	No	1/8/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed			
2	UM Delegation	The Plan did not ensure a delegate complied with all contractual and regulatory requirements. The delegate required a two-step prior authorization (PA) process for BHT services, which is allowed, but did not send written notification when it denied services at the first step. The delegate did not consistently apply criteria for approving BHT.	The Alliance scheduled a meeting with the delegate to discuss the findings and will put a corrective action plan in place. <u>Update as of 12/5/2019:</u> The delegate has revised policy, and submitted to The Alliance for review. The Alliance will review and discuss changes with the delegate on the next Operations call. <u>Update as of 1/8/2020:</u> Plan reviewed documents and still have open items not documented. Plan will be meeting with the delegate to discuss criteria and procedures for further documentation needed. <u>Update as of 2/7/2020:</u> Met with the delegate to review their criteria and approval process. Requested policy language changes to meet the regulatory requirements. Policy was approved by Committee on 1/27/20. Updated CAP response submitted to DHCS on 2/7/2020.	No	2/7/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed			
3	UM Delegation	(1.1.3) The Plan did not review ownership and control disclosure information for their Utilization Management (UM) delegates	The Plan will ensure that its delegated providers complete the Ownership and Control disclosure forms. The Plan will create a tracking log and document any follow up attempts made with the delegate to ensure accuracy. <u>Update as of 12/2/2019:</u> PR has created a tracking log and is working on a desktop procedure.	Yes	1/1/2020	Completed	Provider Services	✓	State	DHCS	2019	Completed			
4	UM Delegation	The Plan did not ensure receipt of all contractual and regulatory reports during the audit period.	The Plan will conduct staff retraining of delegation reporting procedures to ensure all are tracked and monitored for receipt and review. <u>Update as of 12/5/2019:</u> Staff training was conducted on 12/3/2019.	Yes	12/1/2019	Completed	Compliance	✓	State	DHCS	2019	Completed			
5	UM Delegation	The Plan's oversight of its delegate did not identify unclear NOA letters, and incorrect appeal and SFH information	The Alliance scheduled a meeting with the delegate to discuss the findings and will put a corrective action plan in place. <u>Update as of 12/5/2019:</u> The delegate has developed on a new process regarding NOA letters, appeal rights and SFH information. The Alliance will review and discuss changes with the delegate on the next Operations call. <u>Update as of 1/8/2020:</u> Plan reviewed documents and agreed with changes of procedure checklist and training materials.	No	1/15/2020	Completed	Utilization Management		State	DHCS	2019	Completed			
6	Referral Tracking process	The Plan did not track all approved PAs; the specialty referral tracking process did not include modified PAs and in-network approved services.	The UM Department is working with analytics to expand the routine referral tracking report to include all approved authorizations. <u>Update as of 12/5/19:</u> Clarity is being sought from DHCS on the scope of specialty referral tracking. <u>Update as of 1/8/20:</u> An updated referral tracking report is being developed to include all decision types and specialty services that require authorization. <u>Update as of 2/7/20:</u> Updated report sample generated and submitted to DHCS. Working with Analytics to create routine report that captures all needed data elements. <u>Update as of 3/5/2020:</u> UM met with Analytics to create the routine report capturing all needed elements. Report is in development. <u>Update as of 5/8/20:</u> Specialty Tracking Report has been created by Analytics, including all required elements, and will now be routinely reported quarterly through UMC and HCQC. Reported at HCQC on 5/21/20. <u>Update as of 6/12/20:</u> Report sent to HCQC on 5/21/20 and reviewed at UMC at 5/29/20.	Yes	5/21/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed			
7	Prior Authorizations	A review of PA data showed non-qualified Plan staff denied retrospective cases for administrative reasons other than non-eligibility for membership. The Plan denied retrospective service requests without review by a medical director if the provider submitted the request more than 30 days after the service delivery date, or if requests did not meet Plan-imposed conditions. The Plan's contract did not specify submission timeframes or other conditions that, if not met, allowed eliminating medical necessity review of retrospective requests for covered services.	Policy and procedure UM-001 Utilization Management will be updated to comply with the contractual requirements. Workflows will be updated to have all retrospective requests reviewed by a medical director. Workflows have been updated to have all retrospective requests reviewed by a medical director. <u>Update as of 12/5/2019:</u> Clarity is being sought from DHCS on allowing a time limit of 30 days. <u>Update as of 1/8/2020:</u> Plan received clarity from DHCS and is updating internal procedures. <u>Update as of 2/7/2020:</u> P&Ps updated to reflect that only an MD can deny retro PA requests. P&Ps approved at HCQC on 1/16/2020.	Yes	1/16/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed			
8	Prior Authorizations	(1.2.2) The Plan did not ensure it used appropriate processes to review and approve medically necessary covered services when it did not ensure that qualified medical personnel rendered medical decisions. Dependent practitioners reviewed, assessed and approved requests for continued hospital stays	The process for ensuring LVNs perform only within their scope of practice was updated and implemented on 10/2/2019. Additional changes to the UM systems to better track the change in process are being developed. <u>Update as of 12/5/2019:</u> Changes to the UM systems to better track the RN oversight role with the LVNs completed. Other Managed Medi-Cal plans have LVNs performing UM. Clarity is being sought from DHCS on the use of LVNs in UM. Policies and procedures and job descriptions are being reviewed to be aligned with the updated oversight process. <u>Update as of 1/8/2020:</u> Plan received clarity from DHCS and updated procedures for RN oversight.	No	1/8/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed			
9	Prior Authorizations (UM and Rx)	The Plan's notice of action (NOA) letters did not follow specifications in Health and Safety Code Section 1367.01. Provider letters in medical cases did not include the decision makers' direct phone number or contained the incorrect number. Letters did not explain the reasons for the denial. Pharmacy NOAs were not concise.	Accurate phone numbers for the decision makers are on the NOA, monitoring will be conducted through internal audits. UM NOA template letters were updated and implemented on 11/4/2019, internal auditing will be conducted monthly to ensure that the letters are clear and concise and explain the reasons for denial. Pharmacy NOA template letters were updated and implemented in April 2019, internal auditing will be conducted at least monthly to ensure that the letters are clear and concise and explain the reasons for denial. The pharmacy team also meets with the PBM on a weekly basis to optimize PA review process, NOA letter language and reasons for denial.	Yes	11/4/2019	Completed	Utilization Management /Pharmacy		State	DHCS	2019	Completed			

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10	Prior Authorizations	The Plan did not ensure that all contracting practitioners were aware of the procedures for orthotic items; the Plan provided inaccurate information about authorization requirements for orthotic items	The Alliance's Authorization Grid will be updated to include the accurate information about authorization requirements for orthotics. The updated grid will be uploaded on the website. <u>Update as of 12/5/2019</u> : A meeting will be scheduled the week of 12/9 to discuss changes. <u>Update as of 1/8/2020</u> : Meeting was conducted and PA grid will be updated to reflect corrections. <u>Update as of 2/7/2020</u> : PA grid is being updated for all services requiring PA, so that MDs do not receive repeat communication about changes to the PA grid. Orthotics will be included in the comprehensive update. <u>Update as of 3/5/2020</u> : Prior Auth requirement for Orthotics was added to the PA grid on the Provider Portal	No	3/2/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed
11	Appeals	The Plan's appeal notification letters did not comply with contractual regulations. NAR letters were not clear or concise, and contained inaccurate information	The G&A staff will attend additional training to review contractual regulations. Internal audits will be conducted monthly by the manager or director to monitor compliance. <u>Update as of 12/5/2019</u> : Training conducted on 11/14/2019.	No	11/22/2019	Completed	G&A		State	DHCS	2019	Completed
12	Case Management & Care Coordination - HRAs	The Plan did not follow the specified timeframes required for completion of the HRAs for newly enrolled SPD members. The Plan did not ensure that HRAs were completed within 45 calendar days of enrollment for those identified by the risk stratification mechanism as higher risk, and within 105 calendar days of enrollment for those identified as lower risk.	HRA tracking had been implemented in early 2019, and continues at present. HRAs are sent out within the required timeframes. Robo calls are made to low risk members to encourage them to complete and send in the HRA within the timeframe. Direct calls are made by CM staff on high risk members to encourage them to complete and send in the HRA within the timeframe. A tracking log is kept to ensure that the required timelines are met.	No	9/16/2019	Completed	Case Management		State	DHCS	2019	Completed
13	Case Management & Care Coordination - Initial Health Assessment (IHA)	The Plan did not ensure that all providers documented all required components of an IHA. Preventive services identified as USPSTF "A" and "B" recommended services were not provided, or status of these recommended services was not documented	The QI Department revised its provider medical record request letter to include: all categories that support IHA completion; a hyperlink and/or copy of the SHA/IHEBA form; and sample documentation of a compliant SHA/IHEBA. Providers were re-educated on the SHA/IHEBA requirements.	No	9/30/2019	Completed	Quality		State	DHCS	2019	Completed
14	Complex Case Management (CCM)	2.2.1 The Plan did not implement its monitoring of the CCM program to address member needs. The Plan did not close its CCM cases after 90 days, or present them at Case Rounds as stated in its policy	Existing aging reports are being utilized by the Case Management Department in CCM Rounds to ensure that members' cases are either reviewed and closed, or extended past 90 days.	Yes	10/14/2019	Completed	Case Management	✓	State	DHCS	2019	Completed
15	Access & Availability	3.1.1 The Plan did not maintain an accurate provider directory.	The Plan will continue to verify 10 providers per week and has added the following two processes to continuously maintain an accurate provider directory: 1. Provider Data Comparison to manually review provider data received from our delegates started September 2019 and 2. Provider Data Validation Yearly Project to review directly contracted providers who appear in the Provider Directory. In addition, the Provider Relations Department includes a Provider Demographic form in all provider quarterly packets and work with providers to obtain the completed forms during provider visits.	Yes	11/1/2019	Completed	Provider Services	✓	State	DHCS	2019	Completed
16	Emerg Family Planning Claims/SSS	The Plan paid non-contracted family planning services at less than the Medi-Cal Fee-For-Service rate. The Plan's claim system misclassified non-contracted family services as non-billable. The Plan is required to pay all covered family planning services regardless if these services are contracted with the Plan.	This finding is specific to one provider based on the list of services identified in the contract. No other provider was impacted by this issue. The claims system has been re-configured to reimburse services as follows: * services listed in the provider contract will be reimbursed at the contracted rate * covered Medi-Cal services not listed in the contract will be reimbursed at 100% of the prevailing Medi-Cal rate	No	9/5/2019	Completed	Claims	✓	State	DHCS	2019	Completed
17	Emerg Family Planning Claims	The Plan did not inform members of the correct minor consent provision for family planning services in its Evidence of Coverage (EOC).	The Plan has updated its 2020 EOC to include the appropriate minor consent provisions. The EOC was submitted to DHCS for review and approval on 10/7/2019.	No	10/7/2019	Completed	Compliance	✓	State	DHCS	2019	Completed
18	Access to Pharm Services	The Plan did not monitor the provision of drugs prescribed in emergency situations.	The Pharmacy Department is working with the PBM to create routine monitoring reports of drugs prescribed in emergency situations. <u>Update as of 1/8/20</u> : Internal meeting was conducted to ensure requirements are clear and next steps for updating policy and monitoring reports. <u>Update as of 2/11/2020</u> : Draft P&P and monitoring log have been created and are under review. <u>Update as of 4/10/2020</u> : The P&P and monitoring log were approved at the most recent P&T Committee meeting.	Yes	3/17/2020	Completed	Pharmacy	✓	State	DHCS	2019	Completed
19	Grievances	4.1.1 The Plan did not document review and final resolution of clinical grievances by a qualified health care professional	The G&A workflow for Quality of Care review was updated and implemented on 4/15/2019 to include the CMOs review and final resolution.	Yes	4/15/2019	Completed	G&A	✓	State	DHCS	2019	Completed
20	Grievances	4.1.2 The Plan's grievance system did not capture all complaints and expressions of dissatisfaction reported by members.	The G&A staff will attend additional training to review contractual regulations. Internal audits will be conducted monthly by the manager or director to monitor compliance. <u>Update as of 12/5/2019</u> : Training was conducted on 11/14/2019.	No	11/22/2019	Completed	G&A		State	DHCS	2019	Completed
21	Grievances	The Plan's grievance system did not capture all complaints and expressions of dissatisfaction filed through Plan providers.	The Plan provided training to its delegated entities of the Plan's grievance process to ensure the Plan's system receives and resolves all complaints of dissatisfaction. Clinics will be trained by the delegate to ensure that the Alliance is capturing all complaints. <u>Update as of 1/8/2020</u> : Medical group provided training sign in sheet. The delegate is working on next steps of educating providers. <u>Update as of 2/7/2020</u> : the delegate provided an attestation to complete its provider training by the end of Q1 2020. <u>Update as of 4/10/2020</u> : Meeting medical group week of 4/6 to discuss implementation. <u>Update as of 4/20/2020</u> : Process for forwarding complaints received by medical group has been implemented as of 4/20/2020.	Yes	4/24/2020 5/1/2020	Completed	G&A/Provider Services/ Compliance	✓	State	DHCS	2019	Completed
22	Grievances	4.1.4 The Plan sent member resolution letters without completely resolving all complaints.	The G&A staff will attend additional training to review contractual regulations. Internal audits will be conducted monthly by the manager or director to monitor compliance. <u>Update as of 12/5/2019</u> : Training was conducted on 11/14/2019.	Yes	11/22/2019	Completed	G&A		State	DHCS	2019	Completed

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2019 DHCS AUDIT FINDINGS - Audit Review Period: 6/1/2018-5/31/2019						INTERNAL AUDITS						
#	Category	Deficiency	Corrective Action Plan (CAP)	Repeat Finding (Yes/No)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
23	Quality Program	The QIPD did not list the individuals' qualifications, which was inconsistent with Plan policy.	The 2019 Annual Quality Improvement Program Description (QIPD) was revised to include the leadership positions and their qualifications (Licensure, Education, Work Exp) The program description was presented and approved in the July 18, 2019 Health Care Service oversight committee.	No	7/18/2019	Completed	Quality	✓	State	DHCS	2019	Completed
24	Provider Training	The Plan did not ensure provider training was conducted within 10 working days	During the last review period of June 2017 through May 2018, the Plan acknowledged deficiencies in the NPO process to be corrected by the end of December 2018. Since January 2019, the plan is meeting its goal of conducting training with the 10 day working timeframe 100% of the time.	Yes	1/1/2019	Completed	Provider Services	✓	State	DHCS	2019	Completed
25	Fraud, Waste, and Abuse (FWA)	The Plan did not conduct preliminary investigations of all suspected cases of fraud and abuse.	FWA reporting procedures will be revised to include the preliminary investigation details to DHCS within 10 working days. Staff training of the revised procedure will be completed by 12/01/2019. <u>Update as of 12/5/2019:</u> Staff training will be conducted on 12/11/2019 to review the updated procedure. <u>Update as of 1/8/2020:</u> Staff training was conducted on 12/11/2019	Yes	12/11/2019	Completed	Compliance		State	DHCS	2019	Completed
26	Fraud, Waste, and Abuse (FWA)	The Plan did not investigate all suspected fraud and abuse incidents promptly. The Plan did not conduct a preliminary or follow-up investigation of 4 of 12 suspected fraud and abuse cases until two to six months after it became aware of the incidents.	FWA reporting procedures will be revised to include the preliminary investigation details to DHCS within 10 working days. All cases will be resolved and closed within 90 days of receipt. Staff training of the revised procedure will be completed by 12/01/2019. <u>Update as of 12/5/2019:</u> Staff training will be conducted on 12/11/2019 to review the updated procedure. <u>Update as of 1/8/2020:</u> Staff training was conducted on 12/11/2019	Yes	12/11/2019	Completed	Compliance		State	DHCS	2019	Completed
27	Fraud, Waste, and Abuse (FWA)	The Plan's compliance officer did not develop and implement fraud, waste, and abuse policies and procedures	The Plan's designated compliance officer will develop and attest to all new and updated policies and procedures prior to committee review.	No	12/13/2019	Completed	Compliance	✓	State	DHCS	2019	Completed
28	State Supportive Services Claims	The Plan did not forward all misdirected claims within 10 working days.	The post-adjudication script that adds the forwarding action was corrected and deployed.	No	7/11/2019	Completed	IT/ Claims	✓	State	DHCS	2019	Completed

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2018 DHCS FINAL AUDIT REPORT FINDINGS - <i>Audit Review Period: 6/1/2017-5/31/2018</i>						INTERNAL AUDITS					
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
1	Utilization Management (UM) Program	1.1.1 The Plan did not continuously update and improve its UM program during the audit period.	The Plan's policy and procedure UM-001 includes the annual review process of the UM program. The 2018 UM program was approved by Committee timely this year on 3/20/2018. The Plan will continue to update its UM program annually and track for a timely approval by Committee.	3/31/2018	Completed	Utilization Management	✓	State	DHCS	2018	Completed
2	Prior Authorizations	1.2.1 The Plan did not conduct IRR testing to evaluate the consistency of UM criteria application during the audit period.	The Plan has implemented an IRR testing policy and procedure to ensure clinical staff is evaluated on an annual basis to ensure consistency in decision making and criteria application. - UM/Appeals IRR conducted on 5/25/2018 - Pharmacy IRR conducted on 12/17/2018 <u>Update as of 1/31/2019:</u> IRR testing for Health Care Services (Pharmacy & UM) has been completed as of 1/31/2019.	12/17/2018	Completed	Utilization Management/ Pharmacy	✓	State	DHCS	2018	Completed
3	Prior Authorizations	1.2.2 The Plan did not use appropriate processes to determine medical necessity for PA requests. The Plan's UM staff used outdated criteria and criteria that did not meet the case details.	The Plan has updated its policy and procedure to ensure the Plan's criteria is reviewed at least annually. IRR testing of clinical staff is completed annually to ensure consistency in decision making and criteria application. - UM/Appeals IRR conducted on 5/25/2018 - Pharmacy IRR conducted on 12/17/2018 <u>Update as of 1/31/2019:</u> IRR testing for Health Care Services (Pharmacy & UM) has been completed as of 1/31/2019.	12/17/2018	Completed	Utilization Management	✓	State	DHCS	2018	Completed
4	Prior Authorizations	1.2.3 The Plan denied retrospective service requests for medical services without documentation of a qualified health care professional's review for medical necessity.	The Plan updated its policy and procedure for the retrospective authorization request process to include details of the review process. The P&P and workflow will be reviewed and approved on 1/17/2019. Staff training will then be conducted on 1/22/2019. <u>Update as of 1/31/2019:</u> Updated P&P and workflow retro authorization request processes were approved at HCQC on 1/17/2019. Staff training was conducted on 1/29/2019.	1/22/2019	Completed	Utilization Management	✓	State	DHCS	2018	Completed
5	Prior Authorizations	1.2.4 The Plan did not respond to pharmacy requests within 24 hours or one business day.	The Plan monitors pharmacy authorization request timeframes by a daily aging report. Staff training of the turnaround timeframe requirements was provided on 10/02/2018. <u>Update as of 1/07/2019:</u> The Plan has determined that timeframe requirements were not consistently met due to a lack of coverage on weekends and holidays. The Plan has updated its Pharmacy Benefit Management contract to include coverage for weekends and holidays as of 12/1/2018. Staff training of the updated procedures will be completed by 1/22/2019. <u>Update as of 1/31/2019:</u> Staff training was completed on 1/23/2019.	1/22/2019	Completed	Pharmacy	✓	State	DHCS	2018	Completed
6	Prior Authorizations	1.2.5 The Plan's NOA letters were not clear and concise, or at sixth grade reading level.	<u>Update as of 3/5/2019:</u> Continuing internal audits revealed issues with how TruCare generates letters, leading to potentially confusing language for members. A team is working on a plan to mitigate the issues. Once the TruCare issues are resolved, staff will be retrained on the mitigation procedures. In the meantime, audits continue to ensure that the language is clear and concise and a process for final review before sending out is being developed. The updated timeline for completion is 4/30/2019. Update as of 4/10/2019: Denial rationale language has been updated. Staff training was completed on 3/29/2019.	4/30/2019	Completed	Utilization Management/ Pharmacy		State	DHCS	2018	Completed
7	Prior Authorizations	1.2.6 The Plan provided incorrect appeal, grievance, and state fair hearing information in translated pharmacy member notifications. The translated "Your Rights" attachments did not follow the required format.	The Plan will update its pharmacy member notifications to ensure the translated versions are in the required format with updated member rights information by 1/25/2019. <u>Update as of 2/4/2019:</u> Updated translated versions of the "Your Rights" attachments have been provided to the Pharmacy Benefits Manager. <u>Update as of 2/19/2019:</u> Updated translated versions of the "Your Rights" attachments have been placed into production by the Pharmacy Benefits Manager.	1/25/2019	Completed	Pharmacy	✓	State	DHCS	2018	Completed
8	Prior Authorizations	1.2.7 The Plan provided conflicting information to providers about podiatry benefits, which required PA; it therefore did not communicate to providers the services that required PA.	The Plan will be updating its Prior Authorization Grid and Provider Training Presentation to include clear communication of the prior authorization process including clarification of the podiatry benefit. <u>Update as of 1/07/2019:</u> The Plan will be updating its prior authorization grid and provider training materials by 1/25/2019. <u>Update as of 1/31/2019:</u> The PA Grid and Provider Training Presentation have been updated. The PA Grid and updated Provider Manual have been posted to the Plan website.	1/25/2019	Completed	Utilization Management	✓	State	DHCS	2018	Completed
9	Referral Tracking process	1.3.1 The Plan did not track authorized PAs to completion and inform providers of the referral tracking process.	The Plan has updated its referral tracking policy and procedure. Routine reporting has been developed to track authorization PAs to completion. The Plan's provider manual has been updated to include information on the Plan's referral tracking process for providers. <u>Update as of 1/07/2019:</u> The Plan will be uploading the provider manual to the website by 1/25/19. <u>Update as of 1/31/2019:</u> The updated Provider Manual has been posted to the Plan website.	1/25/2019	Completed	Utilization Management	✓	State	DHCS	2018	Completed
10	Appeal	1.4.1 The Plan did not ensure health care professionals with appropriate clinical expertise in treating the member's condition resolved pharmacy appeals. The Plan allowed the Pharmacy Director to resolve appeals for medication requests instead of requiring a clinical professional with expertise in treating the member's condition.	The Plan updated its appeal procedures to reflect MD review for final decision for pharmacy appeals on 09/26/2018 and conducted staff training on 10/30/2018.	10/30/2018	Completed	Health Care Services	✓	State	DHCS	2018	Completed

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#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
11	Appeal	1.4.2 The Plan did not translate acknowledgement and resolution appeal letters into the required threshold languages.	The Plan's appeal policies and procedures in place are compliant with the translation requirements. Staff training refresher of translation of letters was conducted on 10/30/2018.	10/30/2018	Completed	Grievance & Appeals	✓	State	DHCS	2018	Completed
12	Appeal	1.4.3 The Plan did not update its provider manual to include the new timeframes for filing a state fair hearing that became effective July 1, 2017.	The Plan updated its provider manual on 12/25/2018 to include the correct new SFH filing timeframes. <u>Update as of 1/07/2019:</u> The Manual is scheduled to be uploaded on our website on 1/25/2019. <u>Update as of 1/31/2019:</u> The updated Provider Manual has been posted to the Plan website.	1/25/2019	Completed	Grievance & Appeals/ Provider Relations	✓	State	DHCS	2018	Completed
13	Delegation Oversight	1.5.1 The Plan did not collect and review ownership and control disclosure information for their UM delegates.	The Plan's subcontractor policy & procedure addresses the ownership and control disclosure information requirements. <u>Update as of 1/07/2019:</u> The Plan has requested ownership and control disclosure information of its UM delegates as of 1/4/2019. <u>Update as of 1/30/2019:</u> All forms from the Plan's UM delegates have been received as of 1/31/2019 with the exception of the Plan Pharmacy Benefits Manager (PBM). <u>Update as of 3/6/2019:</u> All forms from the Plan's UM delegates have been received.	3/15/2019	Completed	Provider Relations	✓	State	DHCS	2018	Completed
14	Delegation Oversight	1.5.2 The Plan did not require corrective action for all identified deficiencies as a part of their annual oversight audits.	The Plan updated its corrective action plan policy and procedure on 11/8/2018 to ensure all identified deficiencies are a part of annual audits such as policy and procedure deficiencies. UM annual delegation audits conducted for 2018 reflect the policy and procedure deficiencies in the corrective action.	11/8/2018	Completed	Compliance	✓	State	DHCS	2018	Completed
15	Delegation Oversight	1.5.3 The Plan did not continuously monitor and evaluate the functions of its UM delegates. The Plan did not ensure receipt of all contractual and regulatory reports during the audit period.	The Plan has updated its monitoring of UM delegates to ensure all contractual and regulatory reports are being tracked for review. The Plan's delegation reporting tracking log has been updated to document all UM delegation reporting. <u>Update as of 1/7/2019:</u> The Plan will update the desktop procedure and conduct staff training on the monitoring process by 1/22/2019. <u>Update as of 1/31/2019:</u> The Plan completed staff training on 12/20/2018.	1/22/2019	Completed	Compliance	✓	State	DHCS	2018	Completed
16	Initial Health Assessment (IHA)	2.4.1 The Plan did not ensure that new members receive an IHA within 120 days from enrollment. The Plan's IHA completion records were inaccurate.	The Plan updated its procedures to monitor IHA completion and validate the procedure codes. Medical record auditing procedures will be conducted to monitor IHA completion and conduct validity testing. <u>Update as of 1/07/2019:</u> The Plan completed the audit and is completing the summary report for Committee by 1/17/2019.	1/17/2019	Completed	Quality Management	✓	State	DHCS	2018	Completed
17	Complex Case Management (CCM)	2.5.1 The Plan did not implement its policy and did not consistently monitor its CCM program.	The Plan monitors its daily aging report to ensure compliance with its CCM program.	12/1/2018	Completed	Health Services	✓	State	DHCS	2018	Completed
18	Complex Case Management (CCM)	2.5.2 The Plan did not ensure PCP participation in the provision of CCM services to each eligible member.	The Plan's updated CCM policy and procedure includes a process for PCP participation. The PCP Input Form was implemented for use on 5/31/2018.	5/31/2018	Completed	Health Services	✓	State	DHCS	2018	Completed
19	Access & Availability	3.1.1 The Plan did not initiate and implement steps to monitor wait times for providers to answer members' telephone calls.	The Plan will be updating its policy and procedure to include the telephone wait times standards for answering and returning calls. The Plan will monitor wait times for providers and answering member telephone calls through a quarterly survey. <u>Update as of 1/31/2019:</u> The Plan has updated its P&P to include all wait time standards. The Plan conducted a survey in January 2019 to assess and monitor wait times as required.	1/31/2019	Completed	Quality Management	✓	State	DHCS	2018	Completed
20	Access & Availability	3.1.2 The Plan did not maintain an accurate and complete provider directory.	The Plan implemented an audit process of the provider directory. The Plan expanded its annual audit for its Pharmacy Benefit Manager (PBM) to include monitoring its provider data included in the directory. <u>Update as of 1/30/2019:</u> Provider Directory Data P&P and desktop procedure for internal auditing have been updated.	2/28/2019	Completed	Provider Services/ Pharmacy	✓	State	DHCS	2018	Completed
21	Emergency & Family Planning Claims	3.5.1 The Plan denied emergency room (ER) service and family planning (FP) claims containing procedures that normally require prior authorization outside of an ER or FP setting.	The Plan updated its system configuration to ensure ER and FP claim procedure codes were updated and will not be denied for services not being authorized. Monitoring reports have been implemented to review any claims denied incorrectly that are adjusted the following week.	11/30/2018	Completed	Claims	✓	State	DHCS	2018	Completed
22	Emergency & Family Planning Claims	3.5.2 The Plan did not pay the greater of \$15 or 15 percent interest annually for emergency service claims not reimbursed within 45 working days of receipt.	The Plan updated its system to ensure interest is paid based on the greater of the \$15 or 15 percent interest annually for emergency services not reimbursed timely. <u>Update as of 1/07/2019:</u> The Plan will run a pre-payment monitoring report prior to each check run to ensure interest is paid based on the greater of the \$15 or 15% per annum for emergency services claims not adjudicated timely. <u>Update as of 1/31/2019:</u> The Plan's pre-payment monitoring report process is now in place prior to each check run to ensure interest is paid accurately for emergency services claims when interest is required. All claims identified on the weekly report are manually adjusted as needed prior to payment to providers.	1/25/2019	Completed	Claims	✓	State	DHCS	2018	Completed

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#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
23	Emergency & Family Planning Claims	3.5.3 The Plan improperly denied family planning claims for out of network, non-contracted providers. These claims were denied based on edits in the Plan's claims system and subsequent review by claims analysts.	The Plan provided staff training on 6/11/2018 to ensure FP claims edits for out of network claims are reviewed and not inappropriately denied. Monitoring reports have been implemented to review any claims denied incorrectly. Any claims identified as denied incorrectly are adjusted the following week manually.	12/31/2018	Completed	Claims	✓	State	DHCS	2018	Completed
24	Emergency & Family Planning Claims	3.5.4 The Plan did not disclose the specific rationale used in determining why claims are rejected.	<u>Update as of 3/6/2019:</u> The Plan will send via fax blast to the provider network training materials for reading remittance advice forms from Alliance claims by March 31. The training materials will also be included in all provider quarterly packets by May 31, 2019. <u>Update 4/8/2019:</u> The training guide created by the Claims director for providers has been sent to the entire Alliance network via fax as of 4/1/2019; the guide was also posted to the Alliance website as of 4/1/2019. The guide is currently also being hand-delivered by the Provider Relations team via the 2nd quarter provider packets.	4/1/2019	Completed	Claims	✓	State	DHCS	2018	Completed
25	Emergency Pharmacy Provisions	3.6.1 The Plan did not ensure the provision of sufficient amounts of drugs prescribed in emergency situations.	The Plan updated its policy and procedure to ensure emergency provisions of drugs are prescribed in emergency situations. The monitoring report was updated to include all supply claims to ensure members have access to medically necessary drugs.	12/11/2018	Completed	Pharmacy	✓	State	DHCS	2018	Completed
26	Grievances	4.1.1 The Plan's process omitted medical director review of QOC grievances prior to sending resolution letters.	The Plan updated its grievance procedures and letters to include MD review for quality of care grievances. <u>Update as of 1/7/2019:</u> Implementation will be completed by 3/31/2019 once RN staff are on board and trained on the updated process. <u>Update as of 3/5/2019:</u> Health Care Services has successfully recruited one nurse, and is in the process of filling the remaining vacancy. <u>Update as of 4/10/2019:</u> Training is to be completed by 4/11/2019. The checklist for standard and expedited grievances has been updated. <u>Update as of 5/8/2019:</u> The review process for QOC grievances was implemented on 4/15/2019.	4/15/2019	Completed	Health Care Services	✓	State	DHCS	2018	Completed
27	Grievances	4.1.2 The Plan sent member resolution letters without completely resolving all complaints.	The Plan updated its grievance procedure to include a process for resolving all complaints and resolutions resolved outside the 30 day timeframe. Staff training was conducted on 7/17/2018.	7/17/2018	Completed	Grievance & Appeals		State	DHCS	2018	Completed
28	Grievances	4.1.3 The Plan did not update its provider manual to include the new timeframes for filing grievances that became effective July 1, 2017.	The Plan updated its Provider Manual on 12/25/2018 to include the correct new grievance filing timeframes. <u>Update as of 1/07/19:</u> The Manual is scheduled to be uploaded on our website on 1/25/2019. <u>Update as of 1/25/2019:</u> The Plan has posted the updated Provider Manual to its website.	1/25/2019	Completed	Grievance & Appeals/ Provider Relations	✓	State	DHCS	2018	Completed
29	Grievances	4.1.4 The Plan's grievance system did not capture and process all complaints and expressions of dissatisfaction	The Plan provided training to its delegated entities of the Plan's grievance process to ensure the Plan's system receives and resolves all complaints of dissatisfaction. New provider orientation materials and the provider manual will include education materials of the Plan's grievance process for new and existing providers. <u>Update as of 1/7/2019:</u> The Plan will be uploading the provider manual to the website by 1/25/19. <u>Update as of 1/25/2019:</u> The Plan has posted the updated Provider Manual to its website.	1/25/2019	Completed	Grievance & Appeals/ Provider Relations	✓	State	DHCS	2018	Completed
30	HIPAA	4.3.1 The Plan did not report the discovery of PHI breaches to the DHCS Information Security Officer.	The Plan updated its procedures to ensure reporting of PHI incidents are reported to all DHCS contacts including the DHCS Information Security Officer. Staff training on updated procedures was conducted on 8/22/2018 and 10/3/2018.	10/3/2018	Completed	Compliance	✓	State	DHCS	2018	Completed
31	HIPAA	4.3.2 The Plan did not report all suspected security incidents or unauthorized disclosures of PHI to DHCS within 24 hours of discovery.	The Plan updated its procedures and tracking log to ensure monitoring of reporting to DHCS occurs timely. Staff training on updated procedures was conducted on 8/22/2018 and 10/3/2018.	10/3/2018	Completed	Compliance	✓	State	DHCS	2018	Completed
32	Provider Training	5.2.1 The Plan did not ensure provider training was conducted within 10 working days.	The Plan monitors its tracking log to ensure provider training is conducted within 10 working days. Staff training of the required timeframe was conducted on 12/17/2018.	12/31/2018	Completed	Provider Services	✓	State	DHCS	2018	Completed
33	Provider Training	5.2.2 The Plan did not specify in its written agreement provider training responsibilities for two delegated entities.	The Plan updated its contract with the two delegated entities to ensure provider training requirements. <u>Update 12/31/2018:</u> The Plan has updated its contract with one of the delegates to include delegation of provider training requirements. The other delegate's contract is in progress to be finalized. Estimated time for contract to be completed is 2/28/2019. <u>Update as of 3/4/2019:</u> The remaining delegate has agreed to the provider training responsibilities; the final contract will be signed once the delegate agrees to terms for non-related items. Update as of 8/5/2019: Both delegates involved in the finding delegation agreements were updated. Another delegate's contract still needs to be finalized.	6/30/2019	Completed	Provider Services	✓	State	DHCS	2018	Completed
34	Provider Training	5.2.3 The Plan did not ensure training materials provided by two delegated entities included information on Plan policies, procedures, services, and member rights and responsibilities.	The Plan's delegated entities have updated their training materials to include the required information. <u>Update 12/31/2018:</u> The Plan is currently working with the delegate to incorporate this information. Target date for materials to be updated is 1/31/19. <u>Update as of 1/30/2019:</u> Both delegates have revised their training materials to include member rights and responsibilities, grievances and services.	1/31/2019	Completed	Provider Services	✓	State	DHCS	2018	Completed

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#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
35	Fraud, Waste, and Abuse (FWA)	6.3.1 The Plan did not conduct and report preliminary investigations of all suspected cases of fraud and abuse to DHCS within 10-working days.	The Plan updated its fraud and abuse policy and procedure as of 7/17/2018 to ensure timely reporting of incidents to DHCS. Staff training on updated procedures was conducted on 7/17/2018. The Plan updated its monitoring tracking log to monitor the reporting timeframe requirement.	7/17/2018	Completed	Compliance	✓	State	DHCS	2018	Completed
36	Fraud, Waste, and Abuse (FWA)	6.3.2 The Plan did not conduct prompt and complete investigations of all suspected fraud and abuse incidents.	The Plan updated its fraud and abuse policy and procedure as of 7/17/2018 to investigate all suspected incidents and update DHCS until the case closure. Standardized investigation form for documentation was implemented as of 7/17/2018. Staff training on updated procedures was conducted on 7/17/2018.	7/17/2018	Completed	Compliance	✓	State	DHCS	2018	Completed
37	State Supportive Services	SSS.1 The Plan denied state supported services (SSS) claims containing procedures that normally require prior authorization outside of a SSS setting. These claims were denied based on edits in the Plan's claims system and review by claims analysts; the Plan's process did not include exceptions for FP or ER services.	The Plan updated its system configuration to ensure SSS claim procedure codes were updated and will not be denied for services not being authorized. Monitoring reports have been implemented to review any claims denied incorrectly that are adjusted the following week.	11/30/2018	Completed	Claims	✓	State	DHCS	2018	Completed
38	State Supportive Services	SSS.2 The Plan did not disclose the specific rationale used in determining why claims are rejected.	The Plan's Remittance Advice (RA) includes the specific rationale for claims denials. Denial codes can be applied at the Header level, line level or both. The Plan's claims processing system edits each claims and assigns all denial or informational codes that are applicable to the claim. <u>Update as of 1/31/2019:</u> The Plan will provide training to providers to ensure comprehension concerning the remittance advice set-up. <u>Update as of 3/6/19:</u> The Plan will send via fax blast to the provider network training materials for reading remittance advice forms from Alliance claims by March 31. The training materials will also be included in all provider quarterly packets by 5/31/2019. <u>Update 4/8/2019:</u> The training guide created by the Claims director for providers has been sent to the entire Alliance network via fax as of 4/1/2019; the guide was also posted to the Alliance website as of 4/1/2019. The guide is currently also being hand-delivered by the Provider Relations team via the 2nd quarter provider packets.	4/1/2019	Completed	Claims	✓	State	DHCS	2018	Completed
1	Prior Authorizations	Authorizations were auto-approved for hospital.	Effective 9/17/2018, the Plan started to review and impose standard UM authorization guidelines for hospital authorizations.	9/17/2018	Completed	Utilization Management	✓	Self Identified	AAH	2018	Completed
2	Appeal	The Plan's expedited appeals checklist does not include a reminder to call the member when the case is de-escalated from urgent to routine.	The expedited appeals checklist has been updated. Staff training will be conducted by 10/1/2018. Checklist includes requirements of De-expedited: Decision to de-expedite must be made within 24 hours. Send ack letter within 3 calendar days notifying of priority change and right to contact DMHC. Follow standard appeal process. If 24 hour TAT is not met, proceed with expedited appeal.	10/1/2018	Completed	Grievance & Appeals	✓	Self Identified	AAH	2018	Completed
3	Delegation Oversight	Some authorization cases included many errors with subcontractor's notices of actions. Plan oversight of authorizations and notices is in process.	Reestablished bi weekly meetings with subcontractors and conducted monthly focused file audit which included NOAs, conducted clinical case rounds for overturned appeals. The plan will continue to monitor during annual audit review process. The Plan will be terminating services subcontractor and consuming this function to review authorization effective 4/1/2019.	12/1/2018	Completed	Utilization Management	✓	Self Identified	AAH	2018	Completed
4	Care Coordination	The Plan did not annually review the County MOU for CCS services.	<u>Update 9/27/2019:</u> MOUs have transitioned to Provider Services. Provider Services is in discussion with the county on review MOUS, including CCS. <u>Update as of 12/2/2019:</u> The MOUs have been transitioned to the Provider Services team. The MOU was executed with an effective date of 8/1/2019	8/1/2019	Completed	Provider Services	✓	Self Identified	AAH	2018	Completed
5	Care Coordination	The Plan did not annually review the County MOU for Early intervention/development disabilities.	<u>Update 9/27/2019:</u> MOUs have been transitioned to Provider Services. Provider Services is in discussion with the county on review MOUS, including EI/DD services. <u>Update as of 12/2/2019:</u> The Plan is currently working on developing a full county MOU to include services for early intervention and development disabilities services <u>Update 7/10/2020:</u> The MOU was sent to the County for review on 6/16/2020. <u>Update 10/9/2020:</u> The County has accepted the Alliance's edits and the MOU is currently under review for final approval with the County. <u>Update 11/10/2020:</u> The County has cancelled the November 3rd meeting. This agenda item will be carried over to the December 15th docket. <u>Update 5/14/2021:</u> The MOU was approved by the county board on 4/6/2021.	~~2/28/20~~ TBD	Completed	Provider Services	✓	Self Identified	AAH	2018	Completed
6	Initial Health Assessment (IHA)	The Plan did not have a process for validating the procedure codes used for IHA completion.	P&P will be updated to include the detail of the process for annual validation and codes. The validated for this year will occur prior to 11/1/2018. <u>Update 11/6/2018:</u> Codes were validated and updated by QM department.	11/1/2018	Completed	Quality Management	✓	Self Identified	AAH	2018	Completed
7	Initial Health Assessment (IHA)	The Plan does not have a system in place for monitoring member's missed appointments.	Missed appointments are identified during the Medical Record Review that is part of a FSR. The criteria for missed primary care appointments and outreach efforts, which is part of DHCS's tool. The FSR review nurse evaluates this information and if a deficiency is identified the provider is educated on the importance of outreaching to the member and that documentation of the outreach attempts is required.	11/26/2019	Completed	Quality Management	✓	Self Identified	AAH	2018	Completed
8	Access & Availability	The Plan did not monitor appointment wait times.	Policy and procedure is in place for monitoring appointment wait time standards. Standardized process for monitoring and corrective action plan in place as of 9/20/2018.	9/20/2018	Completed	Quality Management	✓	Self Identified	AAH	2018	Completed
9	Grievances	Some exempt grievance cases were not resolved within the next business day timeframe (applied to 13 cases).	Policies and procedures in place are compliant with the exempt grievance resolution timeframe requirements. Staff training refresher of resolving all exempt grievances by close of next business day was conducted on 10/12/2018.	10/12/2018	Completed	Member Services	✓	Self Identified	AAH	2018	Completed

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

2018 DHCS FINAL AUDIT REPORT FINDINGS - Audit Review Period: 6/1/2017-5/31/2018						INTERNAL AUDITS					
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
10	Quality Improvement	Reporting of the HCQC was not consistently reported to the Board.	The Chief Medical Officer will provide HCQC summary updates to the Board starting in November. The meeting minutes will be included in the Board materials.	11/9/2018	Completed	Quality Management	✓	Self Identified	AAH	2018	Completed
11	Utilization Management	The Plan did not routinely review overturned UM denials for trends & to develop plans for intervention where needed.	The Plan will pull reporting of UM denial trends that will be presented at the UM committee. The first UM committee for presenting the overturn UM denial trends at UM committee will be on 9/28/2018. These findings will be presented to the HCQC and subsequently to the Board of Governors.	9/28/2018	Completed	Utilization Management	✓	Self Identified	AAH	2018	Completed
12	Utilization Management	The Plan did not have a clear process for peer-to-peer clinician discussions concerning denied services.	Steps Plan took or will take to correct deficiency: 1. Plan develop a desktop procedure on peer to peer discussion by 9/14/2018. 2. Plan to train physicians and pharmacists of desktop procedure and when and how to document peer-to-peer clinician discussions by 9/26/2018. 3. Plan has started a weekly meeting with physicians and pharmacist for peer to peer discussions as of 7/17/2018.	9/26/2018	Completed	Utilization Management	✓	Self Identified	AAH	2018	Completed

DASHBOARD KEY

Internal CAP Status Performance Measures

Indicator	Criteria
Green	CAP responses have been completed and fully address the findings

Notes

1) **Potential Self-Identified findings** are developed by the Alliance from regulatory agency feedback or self identification of a deficiency found. They are monitored internally by the Alliance.

2) **State Audit Findings** have been issued by the regulatory agencies in a audit report that requires a corrective action.

3) **Compliance Internal Audit** is conducted as the last step once the item has been fully resolved and all actions have been completed.



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: August 8th, 2025
Subject: Health Care Services (HCS) Report

Standing Committee Report

At the Peer Review and Credentialing (PRCC) meetings held on July 15, 2025, there were one hundred and five (105) initial network providers approved; One (1) primary care provider, eighteen (18) specialists, two (2) ancillary providers, eighteen (18) midlevel providers, and sixty-six (66) behavioral health providers.

Additionally, thirty-seven (37) providers were re-credentialed at this meeting; seven (7) primary care providers, eight (8) specialists, three (3) ancillary providers, three (3) midlevel providers, and sixteen (16) behavioral health providers.

Utilization Management (UM)

(Summary of 2024 UM Program Evaluation)

- Denial Rates
 - Overall, 2.31% *(0.04% decrease from 2023)*
- Authorization Turn-Around Times (goal = 95%)
 - Inpatient/outpatient: overall 99%, above goal
 - LTC: overall 96%, above goal
 - BH: overall 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 June to July 2025.

Total Authorization Volume (Medical Services)			
Authorization Type	May 2025	June 2025	July 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.
- Revision of prior authorization and benefits grid is in progress, to create a more provider-friendly reference document to delineate code-specific authorization rules. Development of an online searchable code database is also under development, with anticipated release in Q4 2025.
- OP processed a total of 4,035 for the month of July. We also processed 449 CCS referrals, of which 141 cases were submitted to our regional CCS office for review.

- OP Turnaround times continue to exceed the benchmark of 95%, with the average being 99.6% in the month of July.
- The top 5 categories remain unchanged Radiology, OP Rehab, TQ, Home Health and Outpatient facility. Radiology and Rehab representing 61% of this volume.
- Launched pilot authorization process for select Home Health codes, streamlining the submission process for home health agencies by allowing access to and guiding providers through clinical guidelines at the time of authorization submission. The pilot is being monitored, and if successful, will be expanded.

Total Outpatient Authorization Volume			
Authorization Status	May 2025	June 2025	July 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	May 2025	June 2025	July 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 (benchmark: 95%)			
Line of Business	May 2025	June 2025	July 2025
Overall	99.6%	99.6%	99.8%
Medi-Cal	99.6%	99.6%	99.8%
IHSS	100%	100%	99.4%

Source: #02569_AuthTAT_Summary

Utilization Management: Inpatient

- Total inpatient auth volume (including all IP authorization types processed by department: Acute, LTACH, Skilled SNF, and OP auths related to discharge) increased slightly from 3331 authorizations processed in June 2025 to 3,691 in July.

- Inpatient overall average LOS decreased from 5.8 in April to 5.4 in May, and 5.2 in June. Admits per thousand also trended down from 49.8 in April, to 48.2 in May, and 46.2 in June. Also trending down: Days per thousand at 290.9 in April, 258.5 in May, and 237.9 in June. The trend is consistent among Child, Adult, ACA and SPD categories.
- IP overall denial rate trended up from 0.7% in May, 1.7% in June, and 2.7% in July.
- 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 resulted in improved payment integrity.
- External hospital rounds are ongoing with UCSF, Stanford, Alameda Health System, Kindred LTACH, Kentfield LTACH, Washington, Eden, Alta Bates, and Summit, to review members' current active admissions discuss UM issues, address discharge barriers, offer other opportunities for supporting throughput and appropriate discharge.
- Kaiser interdisciplinary rounds began in January and continue monthly, with the goal of supporting AAH members at Kaiser facilities who have complex discharge needs and high ER utilization. Members delegated to CHCN are also reviewed in this forum.
- IP UM RN position has been filled for an onsite nurse at Washington Hospital. AAH Leadership met with Washington Care Management team this month, and will implement the onsite nurse program in the coming months.

Total Inpatient Authorization Volume			
Authorization Status	May 2025	June 2025	July 2025
Approvals	3284	3261	3607
Partial Approvals	0	0	1
Denials	79	70	83
Total	3363	3331	3691

Source: #02569_AuthTAT_Summary

Inpatient Med-Surg Utilization			
Total All Aid Categories			
Actuals (excludes Maternity)			
Metric	April 2025	May 2025	June 2025*
Authorized LOS	5.8	5.4	5.2
Admits/1,000	49.8	48.2	46.2
Days/1,000	290.9	258.5	237.9

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

Inpatient Authorization Denial Rates			
Denial Rate Type	May 2025	June 2025	July 2025
Overall	0.7%	1.7%	2.7%
Full Denials Rate	0.7%	1.7%	1.8%
Partial Denials	0%	0%	0.9%

Source: #01292_AllAuthDenialsRates

Inpatient Turn Around Time Compliance (benchmark: 95%)			
Line of Business	May 2025	June 2025	July 2025
Overall	97%	97%	95%
Medi-Cal	97%	97%	95%
IHSS	96%	100%	94%

Source: #02569_AuthTAT_Summary

Utilization Management: Long-Term Care

- LTC census during July 2025 was 2,402 members. This is an increase of 2.21% (52 members) from June 2025.
- Month to Month, the admissions, days and readmissions are decreasing. From April to June the admissions decreased by 64.38%, the days decreased by 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	April 2025	May2025	June 2025*
Admissions	146	105	52
Days	950	530	312
Readmissions	35	28	13

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

- LTC Staff continue to participate in SNF collaboratives around the county to ensure that our facility partners are updated with processes and program enhancements.
- Having virtual rounds with AHS, San Leandro, Kyakameena, Elmwood, Jones Convalescent and Eden LTC facilities to coordinate on complex cases

- LTC Team has met individually with multiple facilities to discuss collaboration with discharge planning and submitting proper documentation for requests.
- Quarterly rounds with Regional Center of Easy Bay to discuss any ICF/DD members.
- Continued internal Long Term Care rounds to discuss members coming into and leaving a long-term care setting.
- Social Workers continue visiting LTC facilities in person, on a monthly and quarterly basis depending on census, to assist with discharge planning and access to other resources. The team continues referrals to TCS and other internal/external programs to provide wraparound support to members preparing to discharge from an LTC custodial facility.
- LTSS Liaison is visiting and meeting with facilities to discuss any claims issues and educating on processes.
- Health Navigator and dedicated RN continue to assist with TCS for members coming back from an acute stay or transitioning from acute into long-term care. The current Health Navigator is transiting to another department and we are in the process of interviewing to fill that position.
- The team is working closely with the facilities to assist in getting all long-term member AID Codes updated to reflect their long-term care status.
- Authorization volume increased in July, compared to May and June.
- Authorization processing turn-around time (TAT) has remained between 98%- 99%, which is exceeding the threshold of 95%.

Total LTC Authorization Volume			
Authorization Status	May 2025	June 2025	July 2025
Approvals	753	708	888
Partial Approvals	0	0	0
Denials	33	45	52
Total	786	753	940

Source: #02569_AuthTAT_Summary

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

LTC Turn Around Time Compliance (benchmark: 95%)			
Line of Business	May 2025	June 2025	July 2025
Medi-Cal	99%	99%	99%

Source: #02569_AuthTAT_Summary

Behavioral Health

- In July, the Behavioral Health Department processed 756 authorizations, 448 Care Coordination referrals, and 231 mental health screenings and transition of care tools.

Total BH Authorization Volume			
	25-May	25-June	25-July
Approvals	650	642	726
Partial Approval	0	0	1
Denials	14	9	29
Total	664	651	756

Source: 14939_BH_AuthTAT

Mental Health Turnaround Times

MH TAT			
<i>*Goal ≥95%</i>	25-May	25-June	25-July
Determination TAT%	100%	96%	97%
Notification TAT%	96%	96%	98%

Behavioral Health Therapies (BHT/ABA) Turnaround Times

BHT TAT			
<i>*Goal ≥95%</i>	25-May	25-June	25-July
Determination TAT%	97%	95%	96%
Notification TAT%	100%	100%	100%

Behavioral Health Denial Rates

<i>*Goal ≤ 5%</i> BH Denial Rates		
25-May	25-June	25-July
1%	1%	<1%

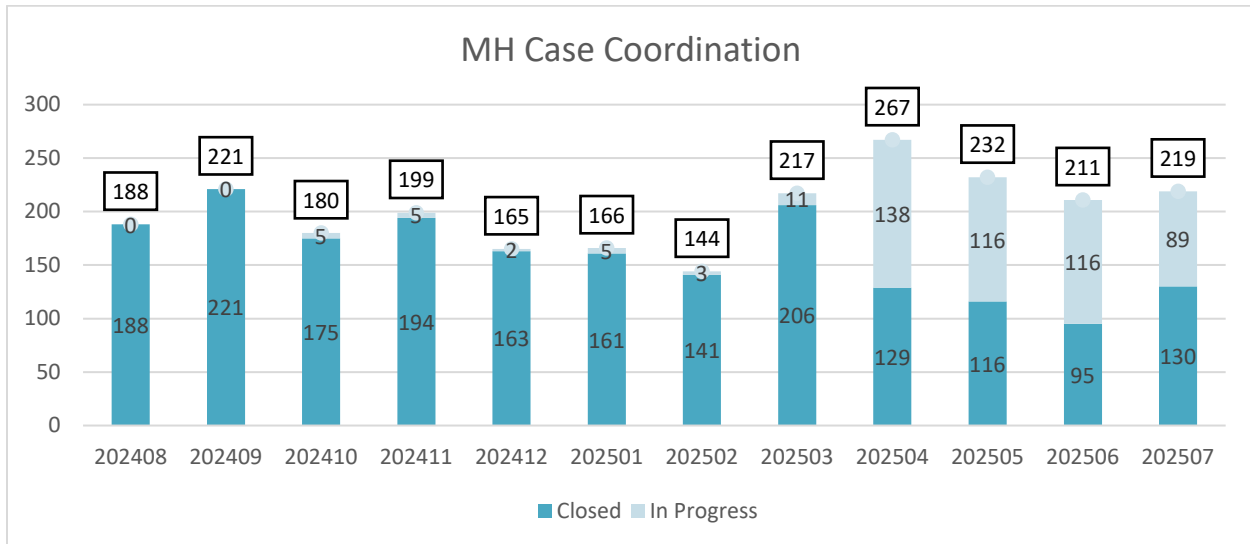
Source: 14939_BH_AuthTAT

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-May	25-June	25-July
Youth Screenings	91	59	75
Adults Screenings	135	131	153
Transition of Care Tools	1	2	3

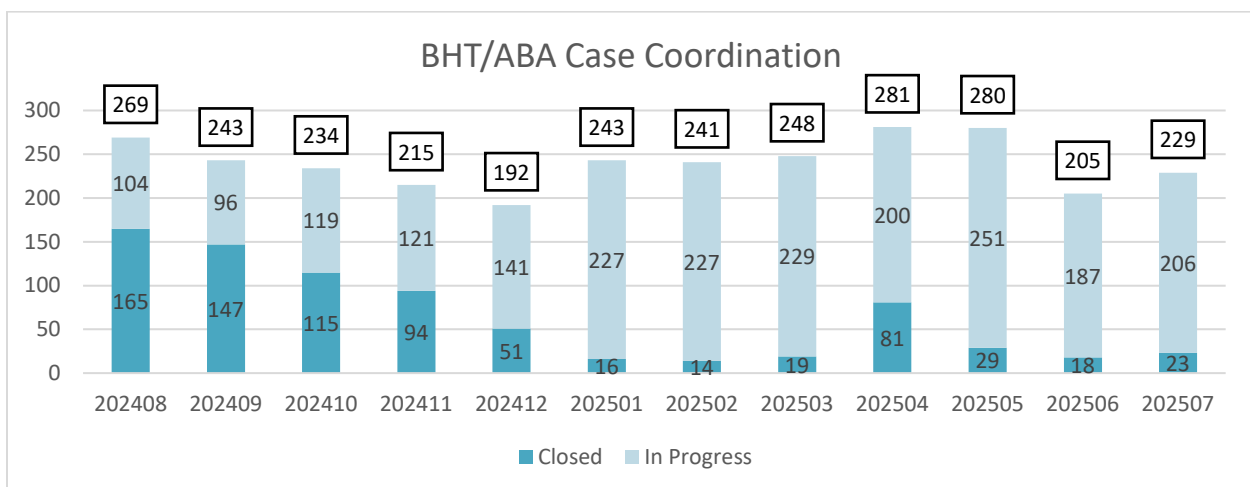
- Alliance licensed mental health clinicians, psychiatric nurses, and behavioral health navigators provide care coordination for members who need assistance accessing the mental health treatment services they need.



Source: 14665_BH_Cases

Behavioral Health Therapies (BHT/ABA)

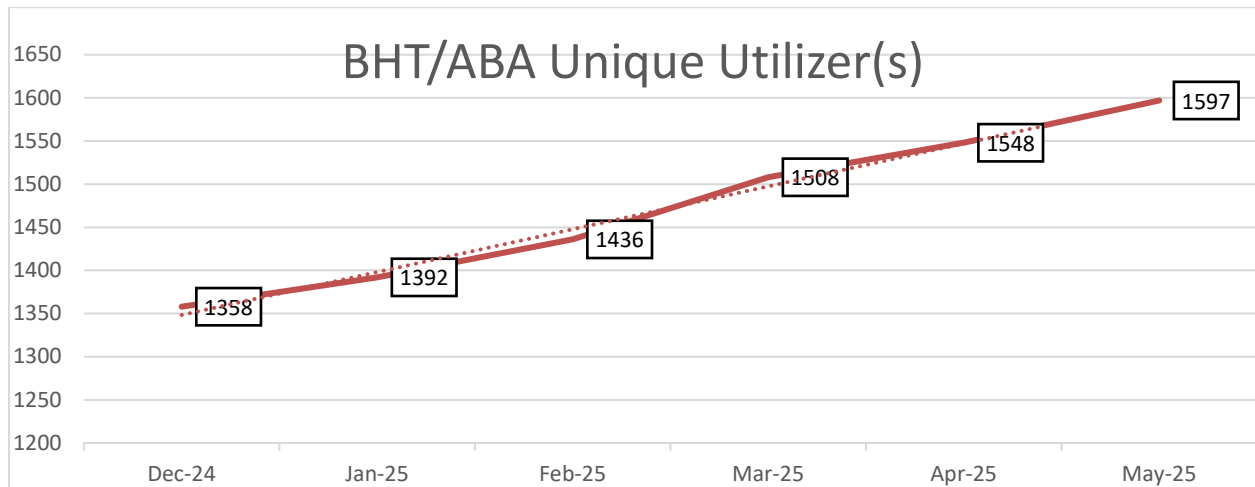
- Children and youth referred for BHT/ABA services, including Applied Behavioral Analysis (ABA) and Comprehensive Diagnostic Evaluations (CDE), require Care Coordination to access the services needed. The Alliance manages each child's unique needs and follows up with parents and caregivers to resolve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



Source: 14665_BH_Cases

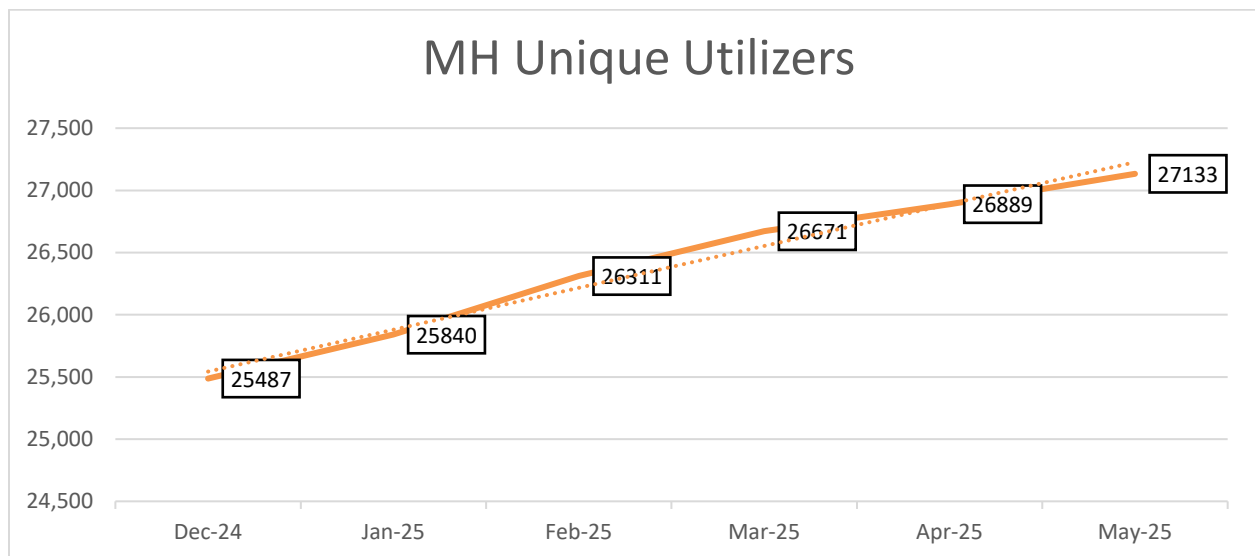
Behavioral Health Unique Utilizers

- Removing barriers to accessing BHT/ABA services remains a primary goal for the Alliance Behavioral Health team. One way to measure that is to monitor unique utilizers who are accessing care when interventions are implemented.
- We observed a continuing rise in unique utilizers of BHT/ABA services, reflecting a 3.1% increase compared to the previous month.



Source: PBI 14621 BHT Utilization Report

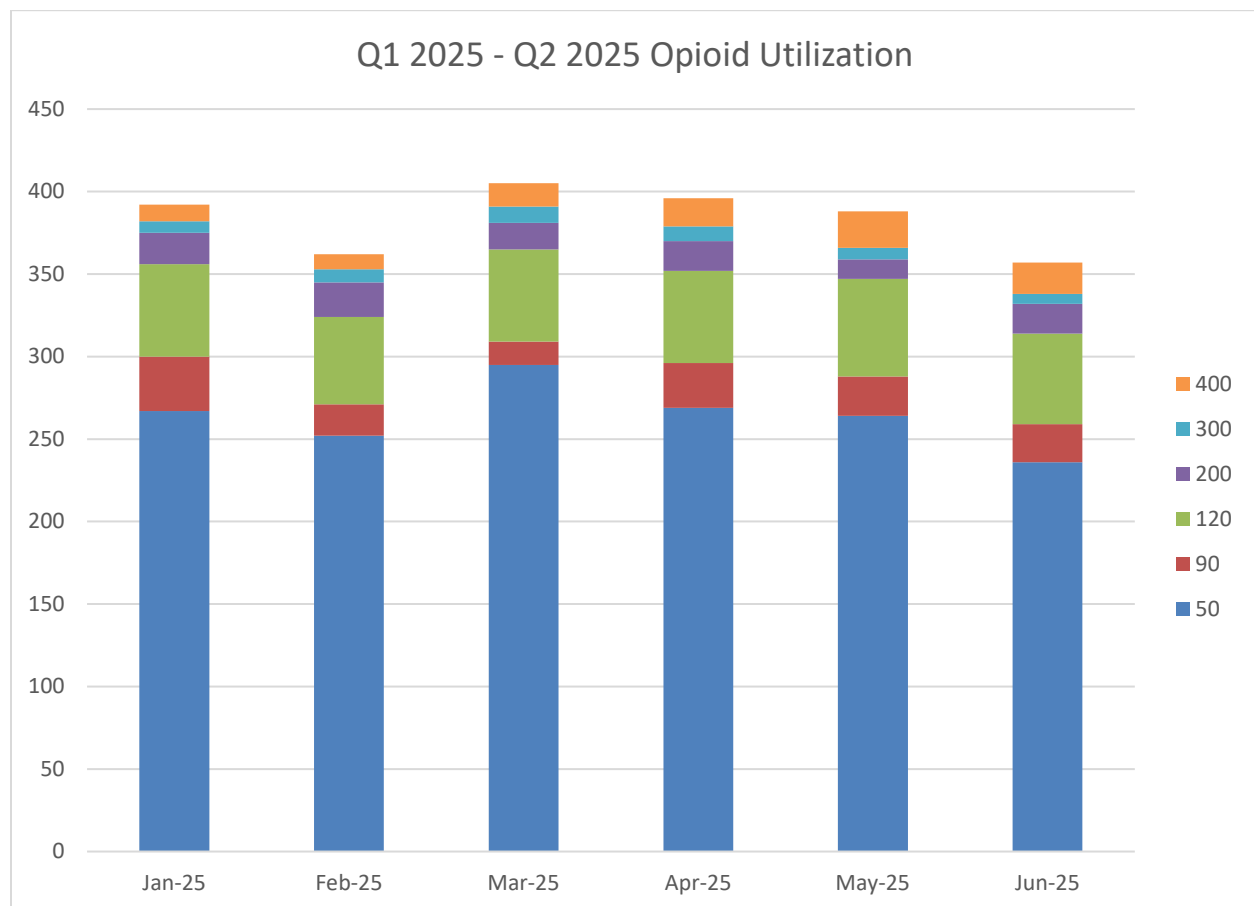
- The number of unique utilizers of mental health services has increased by 0.9% compared to the previous month.



Source: PBI 14637 BH12M Report

Pharmacy

- Pharmacy is collaborating with population health, QI, and disease management on creating clinical programs for HEDIS measures for high blood pressure, asthma, and diabetes.
- The Pharmacy Department continues to monitor members on use of opioids. We send bi-annual mailings to at risk members and their providers. Impacted members receive handouts on medication assisted treatment for opioid dependence, an opioid safety guide, and alternative pain management strategies. Their assigned PCPs receive guides to benzodiazepine and opioid tapering, formulary alternatives to opioids, and opioid dependence treatment approaches.
- We measure the use of opioid medications using Morphine Milligram Equivalents (MME). Utilization less than 400 MME decreased from April to June, while 400 MME or higher slightly increased (+2 members).

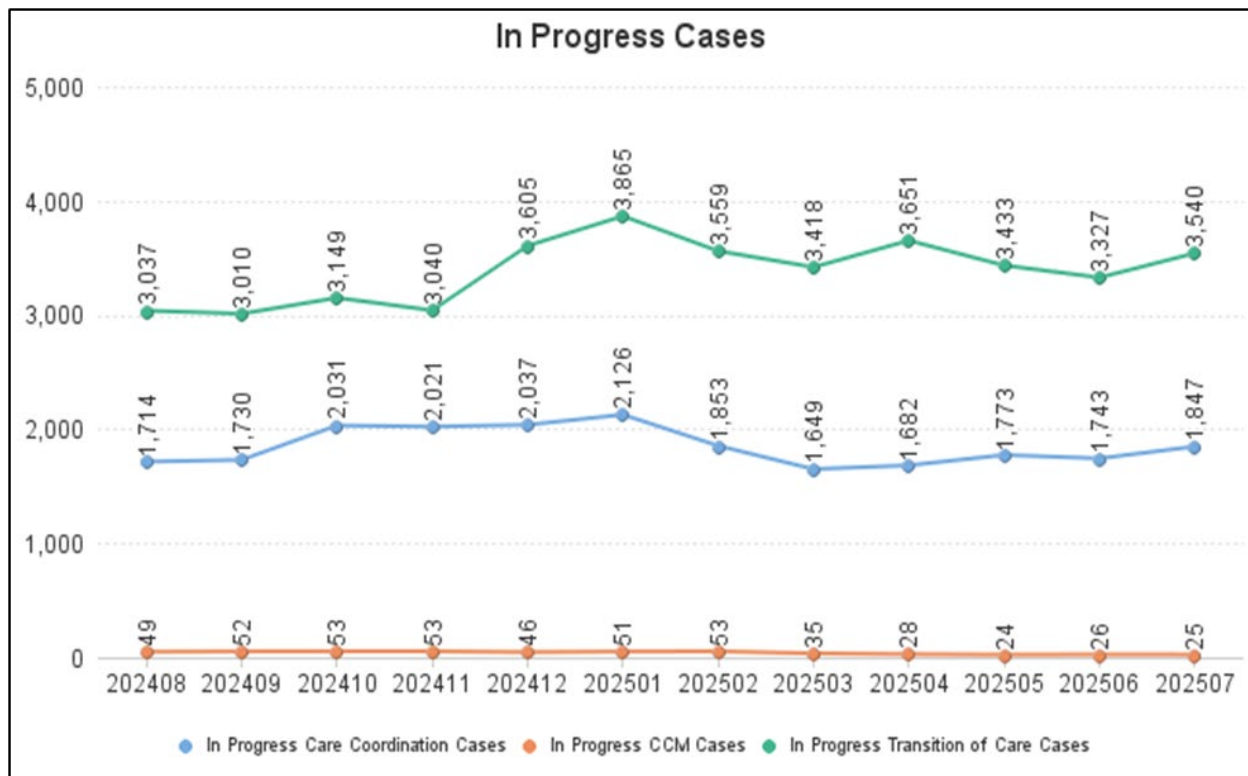


MME	IHSS	MCAL	Total
April			396
50	17	252	269
90	3	24	27
120	7	49	56
200		18	18
300		9	9
400		17	17
May			388
50	13	251	264
90		24	24
120	3	56	59
200		12	12
300		7	7
400		22	22
June			357
50	12	224	236
90	1	22	23
120	3	52	55
200	2	16	18
300		6	6
400		19	19

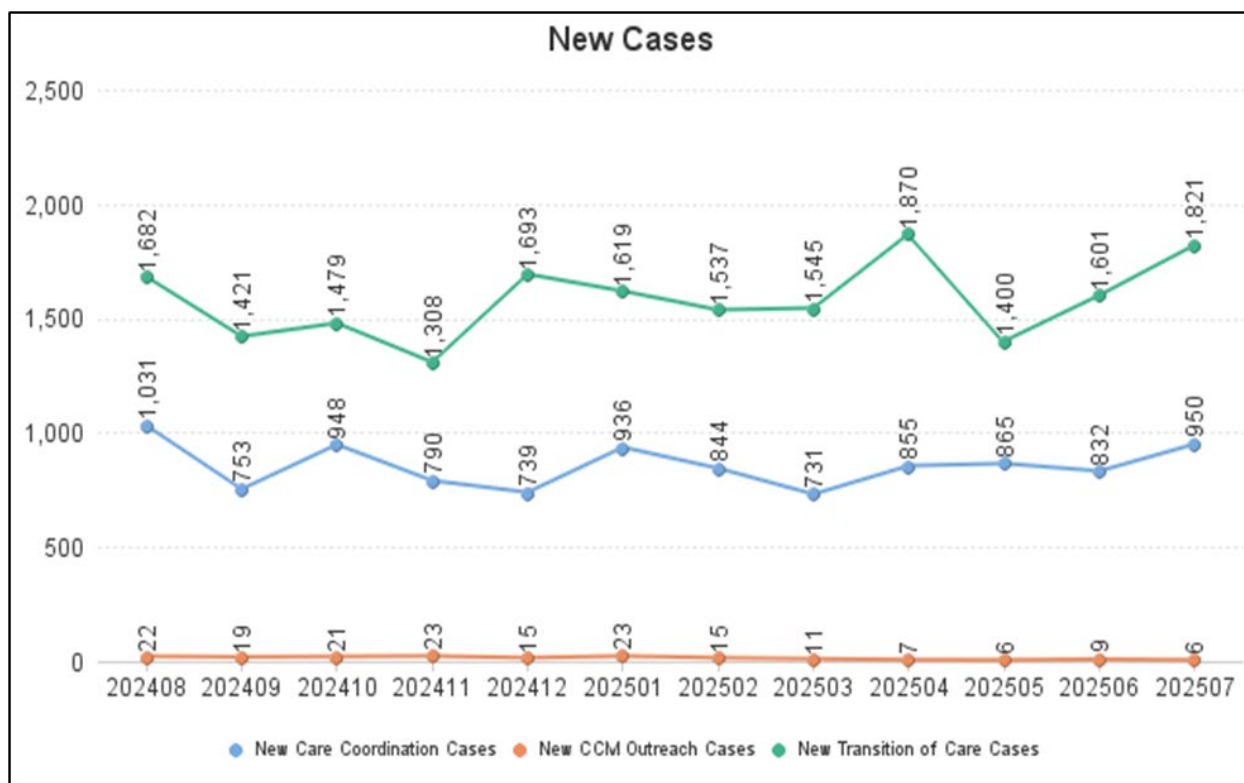
Case and Disease Management

- The CM team is working hard to assist the high volume of members needing Transitional Care Services (TCS) as they transition from one level of care to another. This includes outreaching to members who are still hospitalized and following up post-discharge to help meet the member's needs.
- The CM team continues to collaborate with clinic partners to ensure the TCS requirements are met, including but not limited to scheduling and ensuring follow-up appointments for members, informing members of CM services, notifying appropriate individuals of TCS services (hospital discharge planners, members, caregivers, support teams, etc.).
- CM is collaborating with UM and LTC to support members at hospitals with long-length stays and complex discharge barriers, including facilitating referrals to Community Supports, ECM and other community resources, as needed.

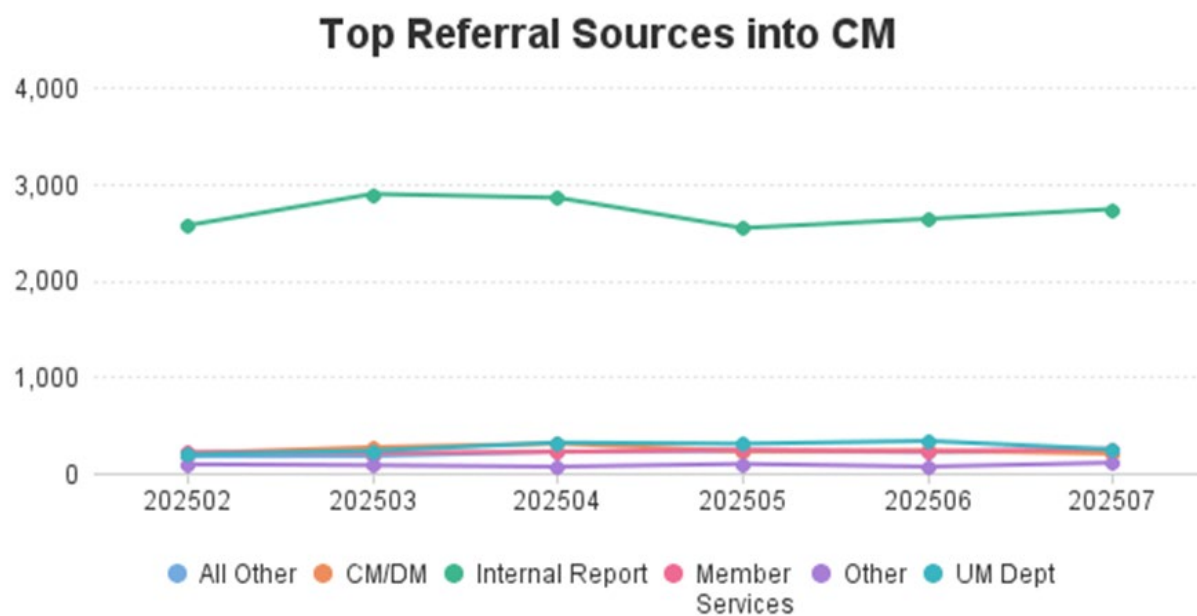
- CM is responsible for acquiring Physician Certification Statement (PCS) forms before Non-Emergency Medical Transportation (NEMT) trips to better align with DHCS requirements for members who need that higher level of transportation (former completed by Transportation broker, Modivcare). CM continues to educate the provider network, including hospital discharge planners, and dialysis centers about PCS form requirements. 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 May 2025

CalAIM

Enhanced Case Management

- All Populations of Focus have been live since January 1, 2024.
- The ECM team is working closely with IT and IPD to automate creation of authorizations and other areas of ECM. This will improve processing time of authorizations and free up the team to work on other areas of ECM (ie: graduating or assisting with stepping members down to a lower level of care).
- Efforts to expand the ECM provider network have begun. The screening panel reviews provider applications based on capacity to serve targeted Populations of Focus, demonstrated operational excellence in programming, and quality benchmarks.
- The Standardized ECM referral form and ECM eligibility information is now visible to providers on the provider portal. Network-wide provider trainings started in July. Some providers have been trained already on an ad-hoc basis.
- The ECM team continues to build rapport with the ECM providers, meeting at a minimum twice a month: once to discuss specific cases and once to discuss operational issues. This has led to more collaboration and community referrals to additional resources. Additional meetings are scheduled with ECM providers for case conferencing as needed.
- ECM and CS teams have begun a collaborative meeting to confirm communication is occurring between Community Supports providers and ECM lead care managers. The collaboration further enhances coordination of care, ensuring non-duplicative services and members receive appropriate services to meet their needs.
- As a result of the 2024 fall's audit of ECM providers, the ECM team developed training for the ECM providers to re-educate the ECM provider network on the core services DHCS is requiring for ECM. The ECM team scheduled monthly training sessions for all ECM providers' frontline staff to reinforce ECM requirements and expectations. The last training was held Friday, July 11, 2025.
- AAH continues to collaborate with Alameda County (AC) Health to discuss Street Medicine alignment. The ECM team works closely with the Street Team providers to make sure encounters are submitted and billed appropriately.
- Closed-Loop Referral (CLR) requirements went live on July 1, 2025. The closed-loop referral framework is designed to ensure that members, healthcare providers and ECM/CS providers are aware of the status of referrals from beginning to end.

	April 2025		May 2025		June 2025	
ECM Providers	Outreach	Enrolled	Outreach	Enrolled	Outreach	Enrolled
ACBH	-	14	-	14	-	14
Alameda Health System (AHS)	28	222	29	216	-28	219
Bay Area Community Services (BACS)	5	131	-	133	8	134
California Cardiovascular Consultants	-	155	-	155	-	153
California Children's Services (CCS)	4	30	6	32	5	35
CHCN	104	1,046	77	1,048	87	1,060
East Bay Innovations (EBI)	7	123	20	125	14	126
Full Circle	3	209	5	222	183	2224
Institute on Aging	234	258	121	257	36	227
La Familia	54	43	32	43	48	41
MedZed	14	621	16	660	40	711
Roots Community Health Center	2	632	1	690	-	708
Seneca Family Services	47	68	75	68	27	71
Pair Team	580	909	763	1,062	631	1,077
Titanium Health Care	549	895	508	968	584	1,011
Tiburcio Vasquez Health Center (Street Medicine)	-	132	-	129		130
BACH (Street Medicine)	-	78	-	78	-	77
Lifelong (Street Medicine)	2	284	1	276	-	291
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. Provider trainings have also started to review the new auditing and oversight requirements.
- DHCS Closed Loop Referral requirements became effective on 07/01/25.

Community Supports	Services Authorized in April 2025	Services Authorized in May2025	Services Authorized in June 2025
Housing Navigation	981	957	944
Housing Deposits	289	335	370
Housing Tenancy	733	783	845
Asthma Remediation	154	154	147
Meals	909	644	549
Medical Respite	79	66	58
Transition to Home	26	21	20
Nursing Facility	14	11	9
Home Modifications	3	3	3
Homemaker Services	41	37	22
Caregiver Respite	0	0	0
Total	3,229	3,011	2,961

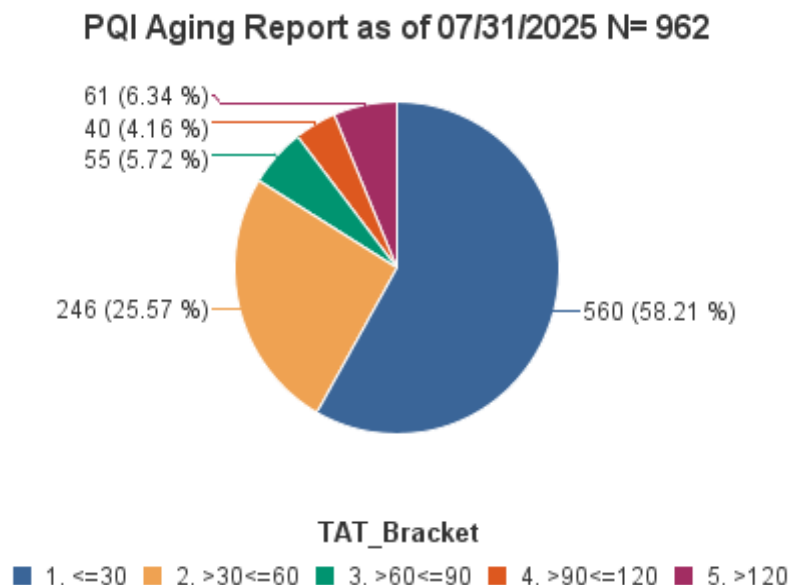
Source: #13581 Community Supports Auth Dashboard

Quality

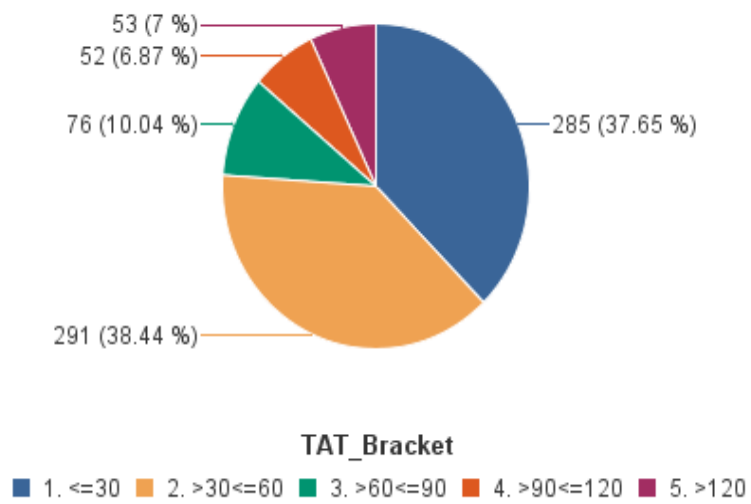
- The clinical team in QI is responsible for triaging all PQI types as they are received. This process involves assignment to an appropriate reviewer for assessment, planning, intervention and evaluation. Quality of Access issues are reviewed by the Access & Availability team and Quality of Language 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 current goal is to ensure 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. Corrective Action Plans are issued after the case is closed and where 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.

- However, 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 for July 2025 identified 61 QOC cases that were over the 120-day TAT. This represents a rate of 93.7% which falls below the 95% standard per PQI P&P QI-104. June 2025 was 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 allow for more timely review/closure of QOC cases. Additionally, the CMO has recommended increasing the PQI TAT standard to 150 days. This will be presented for committee approval this month.
- 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





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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: August 8th, 2025
Subject: Health Equity Report

Internal Collaboration

- **Ongoing 1x1 meetings and check-ins with Division Chiefs Update**
 - The CHEO meets with the Alliance division chiefs on a 1x1 basis monthly to update on Health Equity (HE) and Diversity, Equity, and Inclusion (DEI) activities.
- **Faith-Based Community Engagement Update**
 - The monthly meetings 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
 - Glad Tidings International Church of God
- **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.
- **Over/Under Utilization Workgroup**
 - The Health Equity team continues to engage in ongoing meetings with the Healthcare Service workgroup to discuss and share best practices on overcoming over- and underutilization.

External Collaboration

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

- **Monthly Meetings with DHCS' Chief Health Equity Officer (DHCS CHEO) Update**
 - The DHCS CHEO and MCPs CHEOs meet to collaborate on Health Equity and DEI initiatives.
 - The meeting included updates from DHCS and CHEO.
- **Local Initiatives DEI Training Monthly Collaborative Meeting**
 - Local MCPs continue to meet to update, share, and collaborate on the DEI Training Program. The monthly collaborative allows MCPs to ask questions, update each other on curriculum information, and assist with moving the DEI Training forward.

Alliance Health Equity Strategic Roadmap Update

- The Health Equity 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 the Community and Outreach to develop effective

	communications on all aspects of health equity activities to ensure that staff and members are fully informed.
5. Community Engagement	a) The Community Engagement workgroup was established in December 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 on July 6. f) Glad Tidings International Church of God: initiated conversation on July 24.
6. SDOH Mitigation Measures	a) Collaborate with CMO and HCS team to assess and analyze non-utilization data aimed at identifying health disparities.

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 subcontractors, downstream subcontractors, and network providers.
- **APL 24-018: TGI-SB 923 Update**
 - The Transgender, Gender Diverse, and Intersex (TGI) Cultural Competency Training was provided to all AAH staff
 - The next step is to train our member-facing vendors, followed by training our providers.
 - Timeline and completion rate:
 - Dec 2024: confirmation of vendor
 - Jan-Feb 2025: Implementation of training for all Alliance staff
 - Feb 14: 97% of 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 work group to develop plans to train member-facing vendors as part of the next step in this APL.
- Our overall goal is to achieve 90+% on both DEI and TGI training programs.

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

- **DEIB Committee Update**

- The DEIB Committee met on July 3rd and discussed the DEI Training launch. Updates on the TGI Training and the Health Equity Roadmap were also discussed.
- The committee was reminded of the upcoming July 10th Summer Social Event.

- **VIA Committee Update**

- At the July 8th VIA Committee meeting, the committee discussed DEI and TGI Training, which are currently on target.
- The Summer Social Event is set to take place on July 10th. The staff was surveyed regarding attendance, and we had a good response (approx. 251 people replied “yes” to attend).
- The committee recommended adding shout-outs back to 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 • In-person meetings 5 times in 2 years • Attended first in-person meeting in May 2025 • Received a one-time \$4500 “education” grant in March 2025 • Successfully identified a partner, e.g., Alameda Health System, to apply for a mini

			grant of \$20K for a Health Equity action project in August 2025 • Collaborator: QI
2	Oakland Catholic Workers	Provides transitional housing and resettlement resources to Central American refugees and immigrants.	• Collaboration began in March 2025 • Resource sharing • Collaborator: PHM
3	Black Women's Health Forum	Annual event to raise awareness about the resources available to Black women in the Bay Area.	• Table event April 8, 2025 • Collaborator: C&O
4	True Vine Ministries Church	Serves predominantly African Americans in the West Oakland area.	• RWJF Grant application of \$250K submitted in June 2025. • <i>Potential collaboration</i>, one-year grant-funded intervention to advance mental health healing through the arts. •
5	Native American Health Center	Native Americans and other PCP services, WIC, and dental.	• Collaboration began in December 2024 • Table at the annual Indigenous Red Market event on July 6, 2025 • Collaborators: QI team
6	Allen Temple Baptist Church	A predominantly African American church established since 1919. They serve approximately 3,000 members and the broader community.	• Collaboration began in June 2025 • <i>Potential collaboration</i>: Co-design community survey with the church to identify needs and SDOHs • Table event at their 45th annual Holistic Health Fair on August 9 • Collaborators: church, QI team
7	Oakland Unified School District (OUSD)	Largest school district in Alameda County, serving about 33,000 students in about 75 schools, K-12.	• Collaboration began in April 2025 • <i>Potential collaboration</i>: Co-design Parent Survey with OUSD to study food insecurity and SDOHs
8.	Glad tidings International Church of God	The church was established in 1978 and is well-known in the Hayward community	• Initiated meeting on July 24 • <i>Potential collaboration</i>: promoting resources in health education, e.g., Doula

			services, diabetes, and other chronic diseases.
9.	School-based Health Center in Madison Park Academy, Oakland	One of the eight school-based health centers operated by Native Americans.	• Visited the school clinic on July 8 • <i>Potential collaboration:</i> promote child health • Collaborator: QI



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Information Technology

Sasikumar Karaiyan

To: Alameda Alliance for Health Board of Governors

From: Sasi Karaiyan, Chief Information & Security Officer

Date: August 8th, 2025

Subject: Information Technology Report

Call Center System Availability

- In July 2025, AAH phone systems and call center applications maintained 100% availability even as they supported 97% of employees working remotely.
- Alliance is working on extending this system to include Spanish language support for speech to text. The project to enable the Spanish language pack for Calabrio is currently in progress, including the preparation of installation scripts. Selected Member Services staff will conduct translation reviews and phrase tuning, with this phase expected to commence by the end of September 2025.

Encounter Data

- In the month of July 2025, the Alliance submitted 146 encounter files to the Department of Health Care Services (DHCS) with a total of 428,140 encounters.

Enrollment

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

HEALTHsuite

- The Alliance received 355,255 claims in the month of July 2025.
- A total of 420,444 claims were finalized during the month out of which 352,354 claims auto adjudicated. This sets the auto-adjudication rate for this period to 83.8%.

TruCare

- A total of 21,891 authorizations were loaded and processed in the TruCare application.
- TruCare Application Uptime – 99.9%.

SQL Server Upgrade to version 2022

Objective:

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

Execution Plan:

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

Phase 1:

- The Infra team has recommended conducting OS upgrade testing on a cloned server for this cycle. The tentative upgrade dates are currently set for either August 24 or September 15.
- The team successfully performed the Windows OS upgrade on 07/13, following the completion of the normalization period for the database compatibility upgrade conducted on 06/20. The upgrade to Windows Server 2019 on AAH-ISR01-PROD has been fully completed and validated as of 07/13.
- Following the database compatibility upgrade to 2016 that was completed on 06/20, several SP has been optimized as well.

Phase 2:

- SQL server migration from 2016 to 2022 needs to be completed.
- This is being targeted for Q3 of 2025 and to be planned after phase 1 is completed.
- Post compatibility monitoring stabilization will take place until end of June.

Challenges:

- Following the OS upgrade of AAH-DBR1-PROD/AAH-SQLPROD to Windows Server 2019, we encountered unexpected issues related to RDP access and data storage and had to perform a rollback on 07/13 which lasted for two days due to infrastructure related issues on the disk size and the backup recovery.

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 now utilizes JIRA for project-based efforts and TrackIT ticket system for operational needs.
- OKTA and DUO tool true-up efforts are on-going.

- Vulnerability Management
 - Remediation efforts are now structured to be monthly with tracking in JIRA (Nessus). Nessus and SRA remediation and findings are an on-going effort while penetration test results are prioritized.
 - Technical debt reduction effort made progress for the month of July 2025 through system decommissions and EoL/EoS removal (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 July 2025”.
- See Table 1-2 “Summary of Primary Care Physician (PCP) Auto-assignment in the month of July 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 July 2025

Month	Total MC ¹	MC ¹ - Add/ Reinstatements	MC ¹ - Terminated	Total GC ²	GC ² - Add/ Reinstatements	GC ² - Terminated
June	411,626	6,401	6,966	5,958	156	109

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	2,937
Auto-assignments Expansion	3,595
Auto-assignments GC	69
PCP Changes (PCP Change Tool) Total	4,001

TruCare Application

- See Table 2-1 “Summary of TruCare Authorizations for the month of July 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 July 2025*

Transaction Type	Total Auths Received
Paper Fax to Scan (DocuStream)	3,733
Provider Portal Requests (Zipari)	5,289
EDI (CHCN)	6,000
Provider Portal to AAH Online (Long Term Care)	2
ADT	1,321
Behavioral Health COC Update - Online	35
Behavioral initial evaluation - Online	67
Manual Entry	3,333
OCR Face sheets	2,111
Total	21,891

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 June 2025

Group	Individual User Accounts	Individual User Accounts Accessed		Total Logins	New Users
Provider	8,524	6,251		424,132	765
MCAL	128,829	3,746		8,965	1,292
IHSS	4,083	75		703	24
Total	141,436	10,072		433,800	2,081

Table 3-2 Top Pages Viewed for the Month of July 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
February	11335	9026	869
March	11867	11151	709
April	15436	10925	1420
May	13306	10204	999
June	12594	9969	969
July	14228	10876	1389

Providers - Call Center Statistics			
Month	Calls Presented	Calls Handled	Calls Abandoned
February	10986	7586	1931
March	8303	6869	1434
April	11128	8864	1768
May	10018	8263	1328
June	11255	8140	2323
July	11601	9503	1629

- 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.

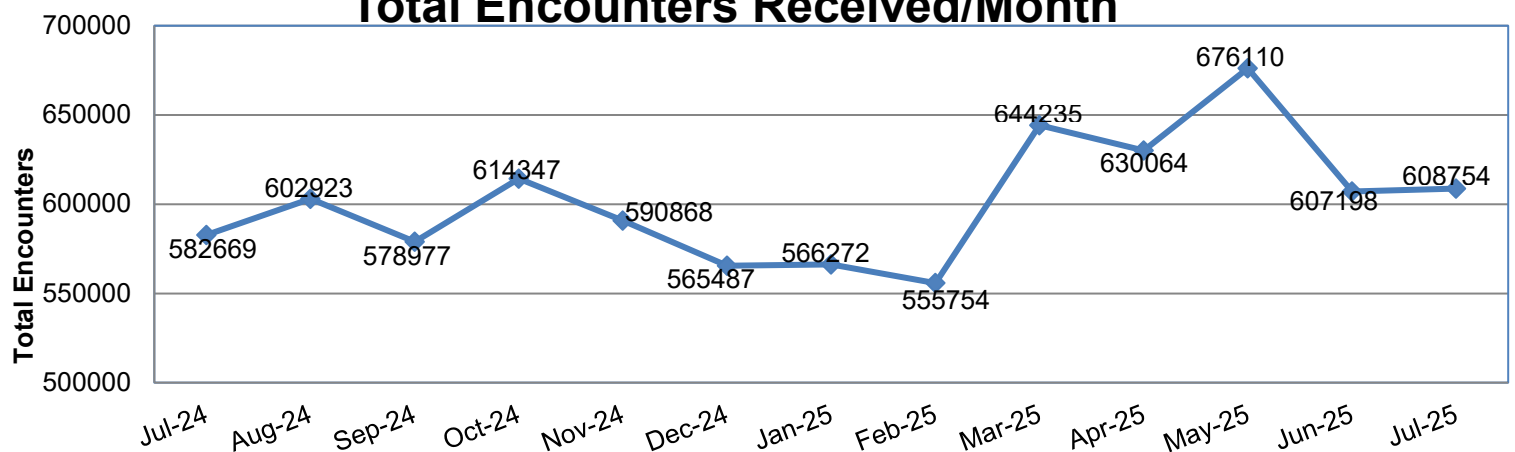
Encounter Data from Trading Partners 2025

- **AHS:** July weekly files (7,880 records) were received on time.
- **BACH:** July monthly files (172 records) were received on time.
- **BACS:** July monthly files (81 records) were received on time.
- **CHCN:** July weekly files (125,697 records) were received on time.
- **CHME:** July monthly files (8,115 records) were received on time.
- **CFMG:** July weekly files (13,266 records) were received on time.
- **Docustream:** July monthly files (1,216 records) were received on time.
- **EBI:** July monthly files (2,946 records) were received on time.
- **FULLCIR:** July monthly files (3,266 records) were received on time.
- **HCSA:** July monthly files (2,671 records) were received on time.
- **IOA:** July monthly files (1,851 records) were received on time.
- **Kaiser:** July bi-weekly files (0 records) were received on time.
- **LAFAM:** July monthly files (85 records) were received on time.
- **LIFE:** July monthly files (388 records) were received on time
- **LogistiCare:** July weekly files (38,834 records) were received on time.
- **March Vision:** July monthly files (6,914 records) were received on time.
- **MED:** July monthly files (2,722 records) were received on time.
- **OMATOCHI:** July monthly files (0 records) were received on time.
- **PAIRTEAM:** July monthly files (15,956 records) were received on time.
- **Quest Diagnostics:** July weekly files (18,000 records) were received on time.
- **SENECA:** July monthly files (76 records) were received on time.
- **SERENE:** July monthly files (581 records) were received on time.
- **TITANIUM:** July monthly files (2,782 records) were received on time.
- **TVHC:** July monthly files (0 records) were received on time.
- **Magellan:** July monthly files (486,802 records) were received on time.

Trading Partner Encounter Inbound Submission History

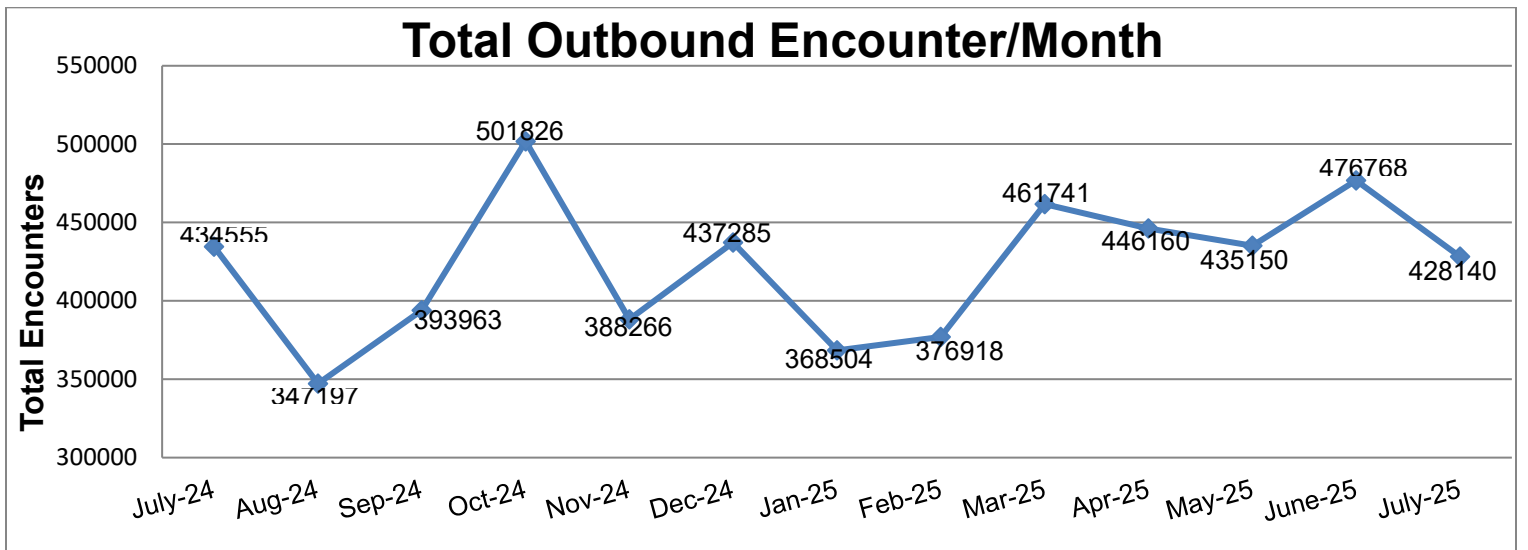
Trading Partners	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Health Suite	332150	368235	322196	367989	364130	332108	339760	339840	347469	372126	387564	340224	355255
AHS	7296	8859	7498	8309	10535	7261	9709	8654	9273	8211	15875	7712	7880
BACH					795		426		291	131		296	172
BACS	88	86	85	76	98	104	93	113	81	72	88	128	81
CHCN	135444	122293	155825	125042	127223	127327	117483	118972	181049	117350	151416	170810	125697
CHME	7242	6902	7680	7102	7589	7458	7781	7553	6794	8293	9045	8638	8115
CFMG	10776	22335	16421	16045	21352	16696	13536	17329	21767	15856	21443	15710	13266
Docustream	934	1102	1067	704	678	828	694	808	770	891	1068	1052	1216
EBI	1623	1825	3394	1640	1725	1476	1440	1597	1390	2926	1457	1381	2946
FULLCIR	1362	1798	3809	2523	2038	1085	806	1534	2099	2025	1479	1441	3266
HCSA	6841	3256	3386	2389	3423	2335	2432	2725	2118	2384	2628	2467	2671
IOA	847	752	4227	588	1064		3008	933	736		2068	3083	1851
Kaiser	2052	172	236	159									
LAFAM	70	88	63	89	76	83	112	96	85	93	101	81	85
LIFE		614	168	119	335	997	228	267	431	317	1274	412	388
LogistiCare	43038	29732	16139	49941	16183	34122	28671	32550	33754	55059	35875	15025	38834
March Vision	6404	7719	5769	5143	6016	6285	15146		6985	6704	7929	8100	6914
MED	615	608	610	645	656	619	758	1182	775		1581	958	2722
OMATOCHI		2											
PAIRTEAM	5763		9359	1108	2204	5816	3436		2055	16360	9244	7724	15956
Quest	18000	22502	18004	18002	22501	18003	18002	18001	22502	18003	22501	18000	18000
SENECA	109	129	101	105	117	131	1	69	129	108	109	160	76
SERENE						654	107		209				581
TITANIUM	2015	3914	2815	6192	1537	2099	2487	3531	2855	3039	2970	3792	2782
TVHC			125	437	593		156		618	116	395		
Total	582669	602923	578977	614347	590868	565487	566272	555754	644235	630064	676110	607198	608754

Total Encounters Received/Month



Outbound Encounter Submission

Trading Partners	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Health Suite	230706	183371	210971	276473	218194	263242	182192	205804	264948	210745	226401	284779	212832
AHS	6703	7101	8727	8201	10403	6850	7710	8135	7952	4510	9326	14010	7038
BACH					739	6	407		272	110		270	138
BACS	80	80	78	74	79	41	128	87	59	23	51	59	60
CHCN	94476	87485	87806	108806	88573	84649	85439	82973	95918	115571	106733	98329	106648
CHME	7095	6762	6994	6974	7474	7342	7426	7167	6682	8156	8914	8471	7991
CFMG	9994	4	24076	13152	13882	11342	9362	11960	15008	11394	12430	13853	9238
Docustream	725	806	715	545	482	239	634	559	478	551	540	385	381
EBI	1443	1727	3242	1559	1641	494	2208	1475	1308	1493	1346	1328	1885
FULLCIR	1084	674	1515	1767	1470	79	1298	1251	1823	1658	1155	1236	2889
HCSA	6757	3171	3310	2376	3394	2255	2497	2693	2103	2332	2603	2448	2637
IOA	749	680	1374	549	949		2783	781	626		48	1836	1732
Kaiser	1404	113	216	62		23							
LAFAM	66	81	58	86	62	3	178	89	80	84	90	67	80
LIFE		598	159	91	76	202	508	63	65	116	93	202	122
LogistiCare	43019	30006	16046	49705	15235	34035	28502	32441	33656	54971	35829	15010	38763
March Vision	3766	3482	4066	3543	3980	4156	9586	371	4354	3870	4591	4657	3888
MED	552	540	514	579	568	55	546	1083	731		595	553	2471
PAIRTEAM	3246		4617	782	1960	994	6334		1489	10873	4670	4549	9364
Quest	20898	16854	16937	21144	16909	21044	16828	16855	21048	16795	16853	21031	16774
SENECA	108	127	94	91	100	6	112	60	116	101	98	139	63
SERENE							82		20				569
TITANIUM	1684	3535	2332	5267	1278	228	3600	3071	2551	2764	2714	3556	2577
TVHC			116		818		144		454	43	70		
Total	434555	347197	393963	501826	388266	437285	368504	376918	461741	446160	435150	476768	428140

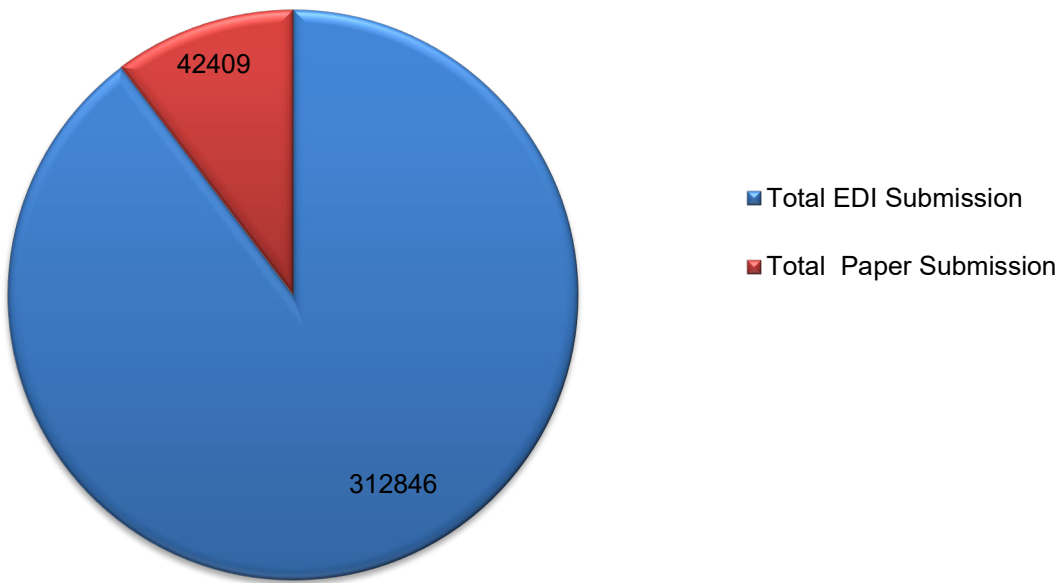


HealthSuite Paper vs EDI Claims Submission Breakdown

Period	Total EDI Submission	Total Paper Submission	Total claims
25-July	312846	42409	355255

Key: EDI – Electronic Data Interchange

EDI vs Paper Submission, July 2025

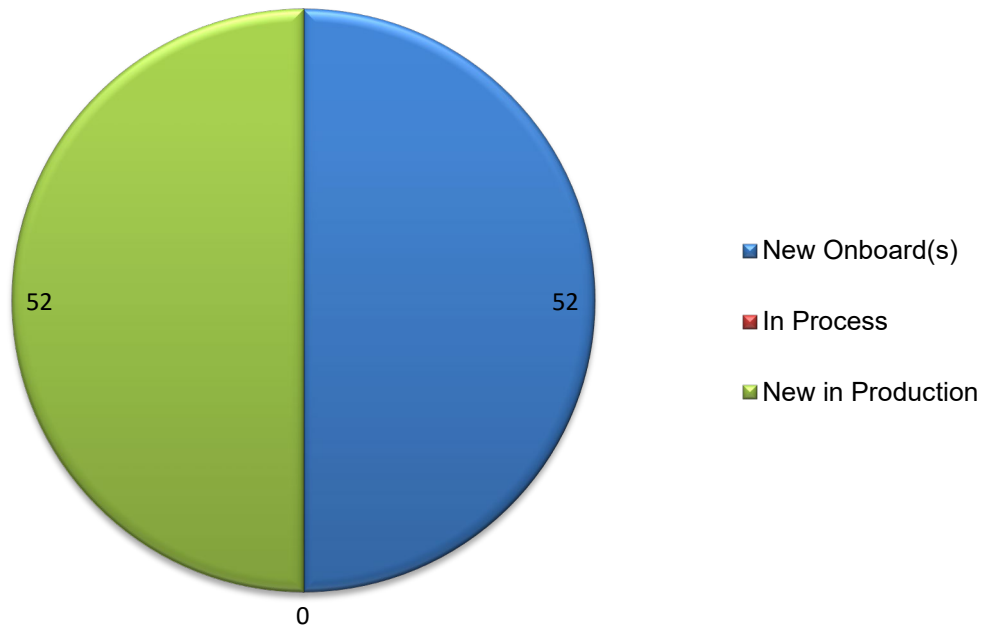


Onboarding EDI Providers – Updates

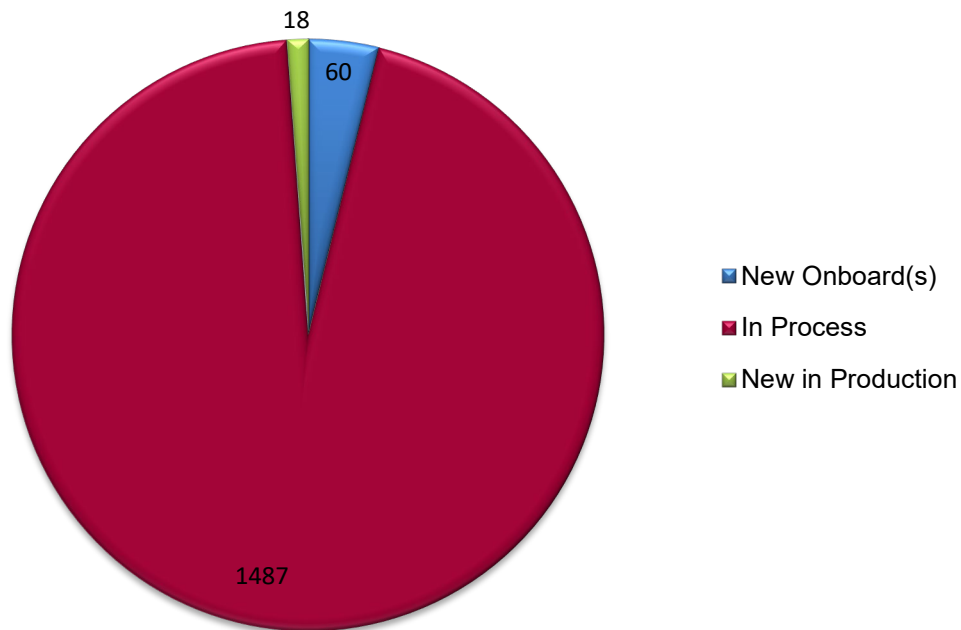
- July 2025 EDI Claims:
 - A total of 3104 new EDI submitters have been added since October 2015, with 52 added in July 2025.
 - The total number of EDI submitters is 3844 providers.
- July 2025 EDI Remittances (ERA):
 - A total of 1460 new ERA receivers have been added since October 2015, with 18 added in July 2025.
 - The total number of ERA receivers is 1447 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
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
Jul-25	52	0	52	3844	60	1487	18	1447

837 EDI Submitters - July 2025



835 EDI Receivers - July 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 **July** 2025.

File Type	Jul-25
837 I Files	30
837 P Files	116
Total Files	146

Lag-time Metrics/Key Performance Indicators (KPI)

AAH Encounters: Outbound 837	Jul-25	Target
Timeliness-% Within Lag Time - Institutional 0-90 days	76%	60%
Timeliness-% Within Lag Time - Institutional 0-180 days	93%	80%
Timeliness-% Within Lag Time - Professional 0-90 days	92%	65%
Timeliness-% Within Lag Time – Professional 0-180 days	98%	80%

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

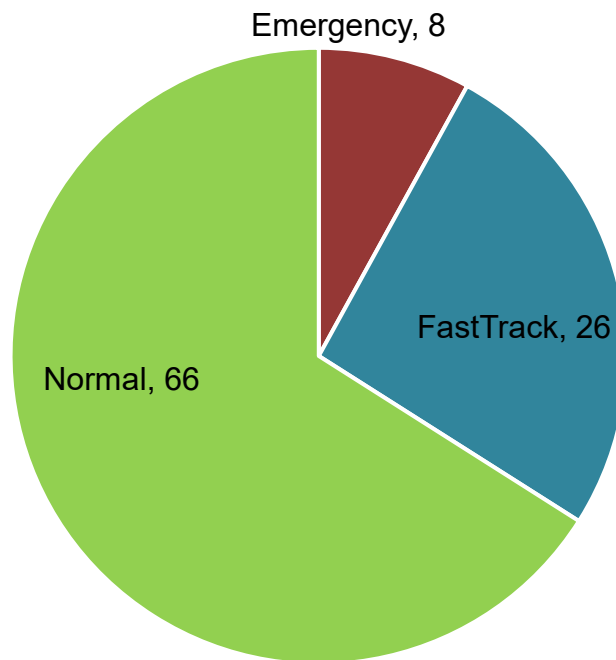
Encounter Data

- In the month of **July** 2025, the Alliance submitted **146** encounter files to the Department of Health Care Services (DHCS) with a total of **428,140** encounters

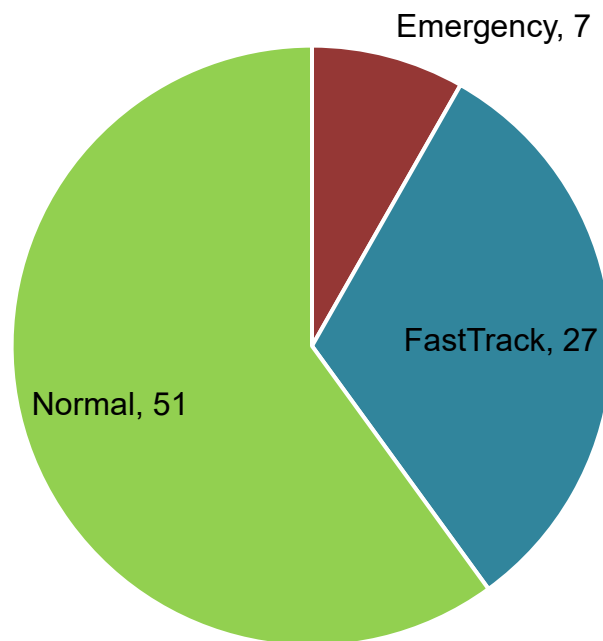
Change Management Key Performance Indicator (KPI)

- Change Request Overall Summary in the month of July 2025 KPI:
 - 100 Changes Submitted.
 - 85 Changes Completed and Closed.
 - 121 Active Change Requests in pipeline.
 - 6 Change Requests Cancelled or Rejected.

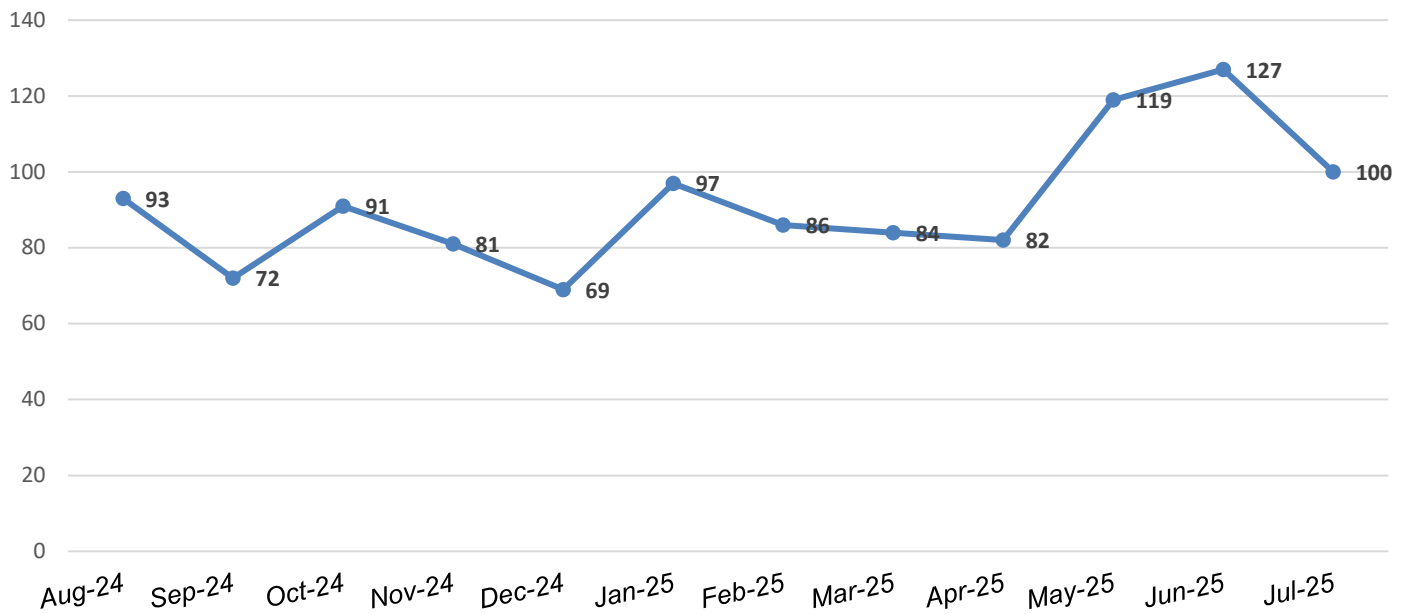
- 100 Change Requests Submitted/Logged in the month of July 2025



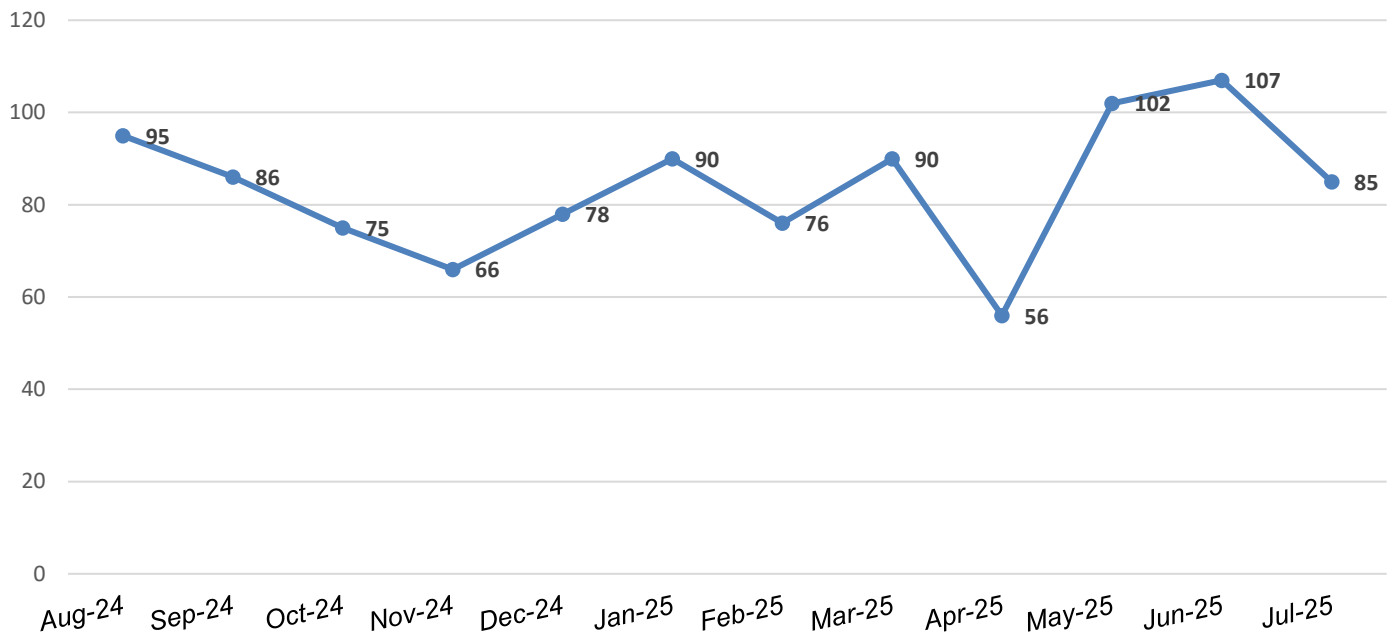
- 85 Change Requests Closed in the month of July 2025



Change Requests Submitted: Monthly Trend

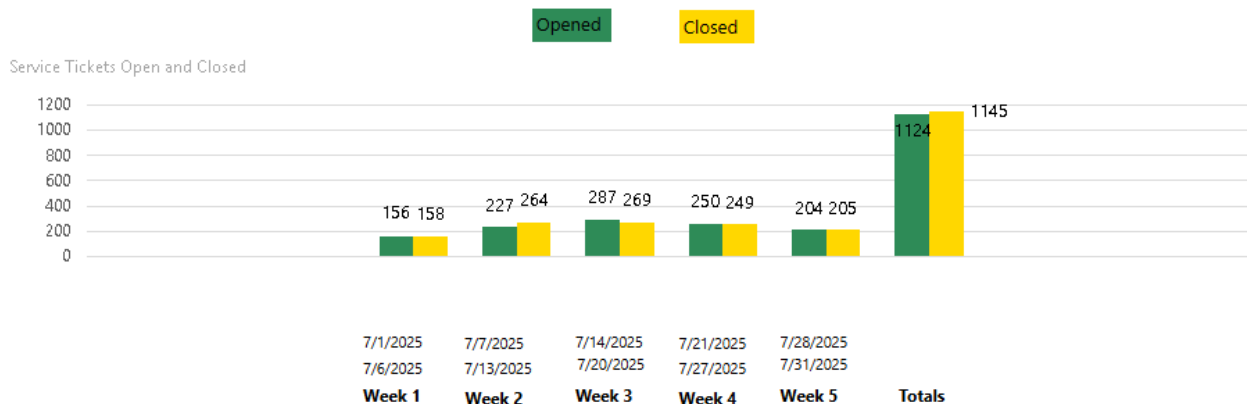


Change Requests Closed: Monthly Trend



IT Stats: Service Desk

IT Service Tickets Open and Closed



- 1124 Service Desk tickets were opened in the month of July 2025, which is 11.20% higher than the previous month (998) and 1.16% higher than the previous 3-month average of 1111.
- 1145 Service Desk tickets were closed in the month of July 2025, which is 13.27% higher than the previous month (993) and 4.98% higher than the previous 3-month average of 1088.

IT Stats: Security

Areas	Item Status
Ops.	• Completed ◦ Established remediation framework for Nessus (JIRA), penetration test, and SRA. ◦ Updated DNS for AAH's communication's webpage. ◦ IT-006 policy drafted completed by <u>ITSec</u>. ◦ Trued-up DUO license usage and renewal. • Upcoming/Underway ◦ Resume work on SRA findings ◦ Troubleshooting Bloodhound service account. ◦ Continued effort <u>EoL/EoS</u> software removal (3rd party). ◦ Arctic Wolf working on aligning security dashboard mockup.
Projects	• Network Segmentation (JIRA established) • PKI – prioritizing for Infra. (paused) • OKTA (SSO) and DUO (MFA) true-up.
GRC	• <u>TrackIT</u> for ops. and JIRA for project-based items • Continuation of policy revisions • Staging discussions with SLT regarding security reviews of new services/platforms.



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

Analytics

Tiffany Cheang

To: Alameda Alliance for Health Board of Governors
From: Tiffany Cheang, Chief Analytics Officer
Date: August 8th, 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: May 2024 – April 2025 dates of service

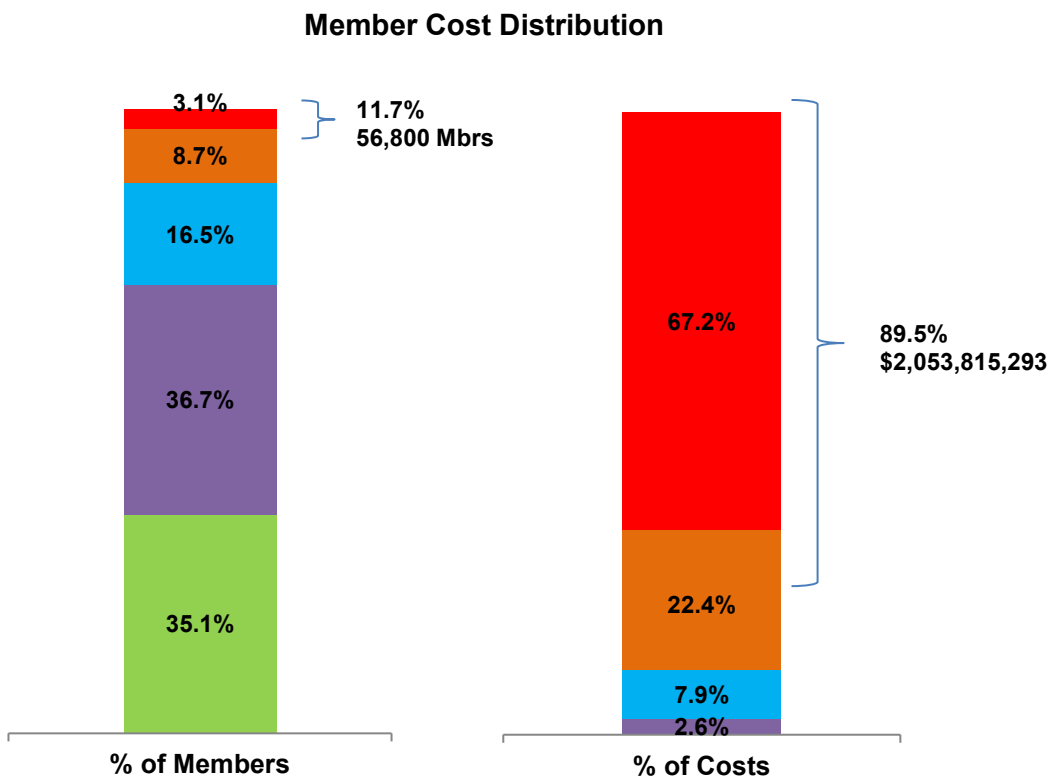
Prior reporting period: May 2023 – April 2024 dates of service

(Note: Data excludes Kaiser membership data.)

- For the Current reporting period, the top 11.7% of members account for 89.5% of total costs.
- In comparison, the Prior reporting period was lower at 8.5% of members accounting for 83.6% of total costs.
- Characteristics of the top utilizing population remained fairly consistent between the reporting periods:
 - The SPD/LTC (non duals) and ACA OE categories of aid decreased to account for 53.5% of the members, with SPD/LTCs accounting for 18.2% and ACA OE's at 35.3%.
 - The percent of members with costs >= \$30K increased from 2.3% to 3.1%.
 - Of those members with costs >= \$100K, the percentage of total members has increased to 1.0%.
 - For these members, non-trauma/pregnancy inpatient costs continue to comprise the majority of costs, decreasing to 30.8%.
 - Demographics for member city and gender for members with costs >= \$30K follow the same distribution as the overall Alliance population.
 - However, the age distribution of the top 11.7% is more concentrated in the 45-66 year old category (35.8%) compared to the overall population (20.6%).

Analytics

Supporting Documents



Cost Range	Members	% of Members	Costs	% of Costs
\$30K+	14,801	3.1%	\$ 1,540,866,055	67.2%
\$5K - \$30K	41,999	8.7%	\$ 512,949,238	22.4%
\$1K - \$5K	79,906	16.5%	\$ 180,190,530	7.9%
< \$1K	177,765	36.7%	\$ 59,519,852	2.6%
\$0	170,202	35.1%	\$ -	0.0%
Totals	484,673	100.0%	\$ 2,293,525,674	100.0%

Enrollment Status	Members	Total Costs
Still Enrolled as of Apr 2025	411,439	\$ 2,064,140,823
Dis-Enrolled During Year	73,234	\$ 229,384,851
Totals	484,673	\$ 2,293,525,674

Top 11.7% of Members = 89.5% of Costs

Cost Range	Members	% of Total Members	Costs	% of Total Costs
\$100K+	4,912	1.0%	\$ 1,008,256,459	44.0%
\$75K to \$100K	1,805	0.4%	\$ 157,302,675	6.9%
\$50K to \$75K	2,803	0.6%	\$ 171,036,309	7.5%
\$40K to \$50K	2,158	0.4%	\$ 96,268,021	4.2%
\$30K to \$40K	3,123	0.6%	\$ 108,002,590	4.7%
SubTotal	14,801	3.1%	\$ 1,540,866,055	67.2%
\$20K to \$30K	5,907	1.2%	\$ 142,975,311	6.2%
\$10K to \$20K	16,060	3.3%	\$ 227,109,055	9.9%
\$5K to \$10K	20,032	4.1%	\$ 142,864,872	6.2%
SubTotal	41,999	8.7%	\$ 512,949,238	22.4%
Total	56,800	11.7%	\$ 2,053,815,293	89.5%

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

11.7% of Members = 89.5% of Costs

Lines of Business: MCAL, IHSS; Excludes Kaiser Members

Dates of Service: May 2024 - Apr 2025

Note: Data incomplete due to claims lag

Run Date: 07/28/2025

11.7% of Members = 89.5% of Costs
18.2% of members are SPD/LTCs and account for 24.3% of costs.
35.3% of members are ACA OE and account for 32.6% of costs.
8.0% of members disenrolled as of Apr 2025 and account for 10.3% of costs.

Highest Cost Members: Cost Per Member >= \$100K
26.3% of members are SPD/LTCs and account for 28.3% of costs.
27.2% of members are ACA OE and account for 30.1% of costs.
8.8% of members disenrolled as of Apr 2025 and account for 11.1% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Members with Costs >=\$30K	Members with Costs \$5K-\$30K	Total Members	% of Members
IHSS	IHSS	203	975	1,178	2.1%
MCAL	MCAL - ADULT	1,289	7,905	9,194	16.2%
	MCAL - BCCTP	-	-	-	0.0%
	MCAL - CHILD	694	3,954	4,648	8.2%
	MCAL - ACA OE	4,806	15,266	20,072	35.3%
	MCAL - DUALS	-	-	-	0.0%
	MCAL - SPD-LTC	3,642	6,700	10,342	18.2%
	MCAL - SPD-LTC/Full Dual	2,660	4,174	6,834	12.0%
Not Eligible	Not Eligible	1,507	3,025	4,532	8.0%
Total		14,801	41,999	56,800	100.0%

Member Breakout by LOB

LOB	Eligibility Category	Total Members	% of Members
IHSS	IHSS	49	1.0%
MCAL	MCAL - ADULT	280	5.7%
	MCAL - BCCTP	-	0.0%
	MCAL - CHILD	98	2.0%
	MCAL - ACA OE	1,338	27.2%
	MCAL - DUALS	-	0.0%
	MCAL - SPD-LTC	1,292	26.3%
	MCAL - SPD-LTC/Full Dual	1,422	28.9%
Not Eligible	Not Eligible	433	8.8%
Total		4,912	100.0%

Cost Breakout by LOB

LOB	Eligibility Category	Members with Costs >=\$30K	Members with Costs \$5K-\$30K	Total Costs	% of Costs
IHSS	IHSS	\$ 16,803,239	\$ 11,339,510	\$ 28,142,749	1.4%
MCAL	MCAL - ADULT	\$ 124,295,422	\$ 95,771,637	\$ 220,067,058	10.7%
	MCAL - BCCTP	\$ -	\$ -	\$ -	0.0%
	MCAL - CHILD	\$ 53,196,517	\$ 44,434,823	\$ 97,631,340	4.8%
	MCAL - ACA OE	\$ 483,092,445	\$ 186,758,907	\$ 669,851,352	32.6%
	MCAL - DUALS	\$ -	\$ -	\$ -	0.0%
	MCAL - SPD-LTC	\$ 412,239,562	\$ 86,379,480	\$ 498,619,042	24.3%
	MCAL - SPD-LTC/Full Dual	\$ 277,964,941	\$ 50,412,619	\$ 328,377,559	16.0%
Not Eligible	Not Eligible	\$ 173,273,929	\$ 37,852,263	\$ 211,126,192	10.3%
Total		\$ 1,540,866,055	\$ 512,949,238	\$ 2,053,815,293	100.0%

Cost Breakout by LOB

LOB	Eligibility Category	Total Costs	% of Costs
IHSS	IHSS	\$ 8,926,829	0.9%
MCAL	MCAL - ADULT	\$ 73,617,648	7.3%
	MCAL - BCCTP	\$ -	0.0%
	MCAL - CHILD	\$ 24,131,525	2.4%
	MCAL - ACA OE	\$ 303,775,230	30.1%
	MCAL - DUALS	\$ -	0.0%
	MCAL - SPD-LTC	\$ 285,647,042	28.3%
	MCAL - SPD-LTC/Full Dual	\$ 199,850,485	19.8%
Not Eligible	Not Eligible	\$ 112,307,700	11.1%
Total		\$ 1,008,256,459	100.0%

% of Total Costs By Service Type

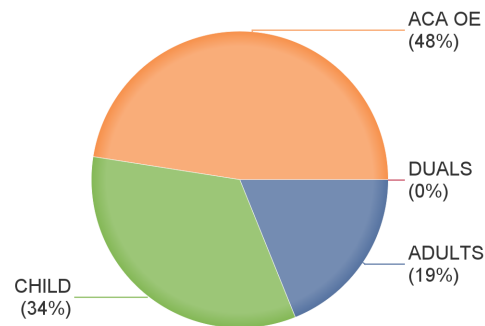
% of Total Costs By Service Type				Breakout by Service Type/Location						
Cost Range	Trauma Costs	Hep C Rx Costs	Pregnancy, Childbirth & Newborn Related Costs	Pharmacy Costs	Inpatient Costs (POS 21)	ER Costs (POS 23)	Outpatient Costs (POS 22)	Office Costs (POS 11)	Dialysis Costs (POS 65)	Other Costs (All Other POS)
\$100K+	4%	0%	1%	14%	36%	1%	11%	2%	2%	33%
\$75K to \$100K	4%	0%	1%	19%	26%	3%	6%	4%	5%	37%
\$50K to \$75K	5%	0%	2%	25%	29%	5%	6%	6%	4%	26%
\$40K to \$50K	6%	0%	2%	33%	27%	9%	5%	7%	1%	18%
\$30K to \$40K	10%	0%	3%	33%	23%	13%	6%	7%	1%	18%
\$20K to \$30K	2%	1%	6%	36%	23%	7%	8%	8%	1%	17%
\$10K to \$20K	0%	0%	11%	35%	24%	7%	9%	9%	1%	15%
\$5K to \$10K	0%	0%	5%	30%	11%	11%	13%	14%	0%	20%
Total	4%	0%	3%	22%	29%	4%	9%	5%	2%	27%

Notes:
- Report includes medical costs (HS & Diamond Claims, Beacon, Logisticare FFS, CHCN FFS Preventive Services, CHME) and pharmacy costs. IBNP factors are not applied.
- CFMG and CHCN encounter data has been priced out.
- Report excludes Capitation Expense

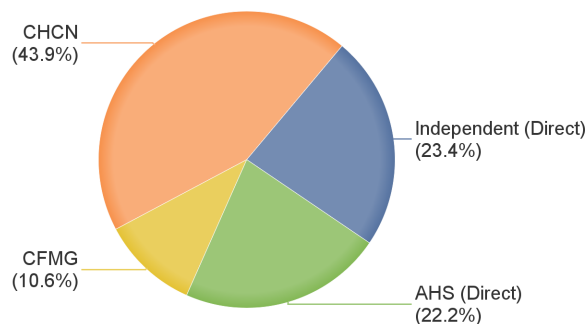
Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

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

Medi-Cal By Aid Category

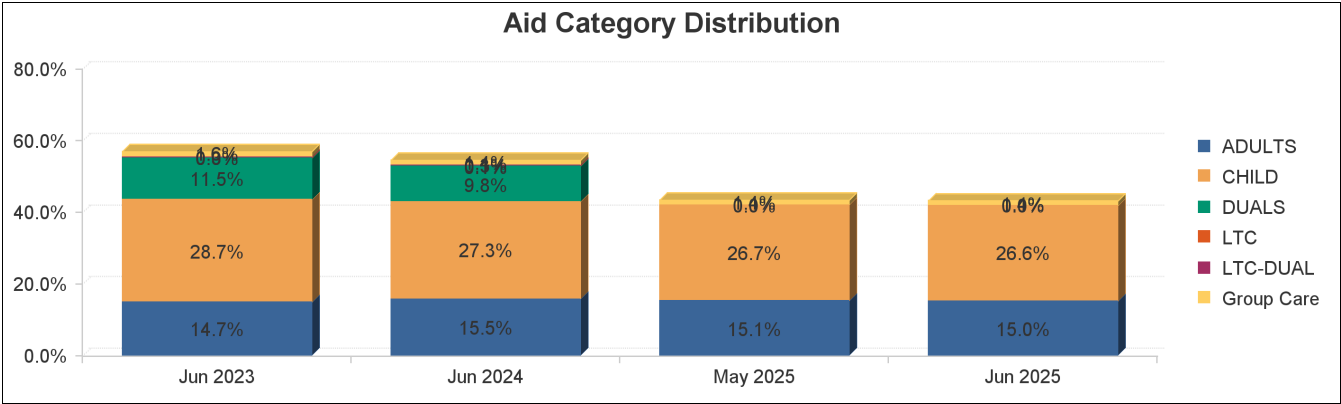


By Network

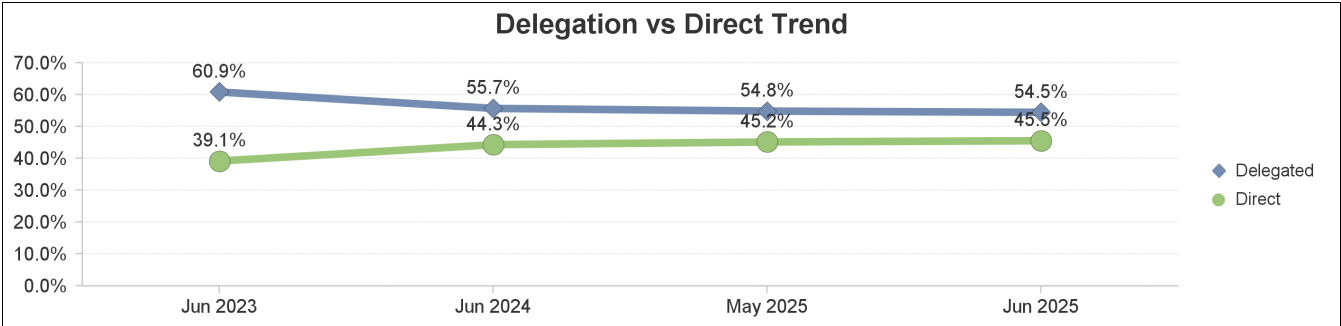


Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

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

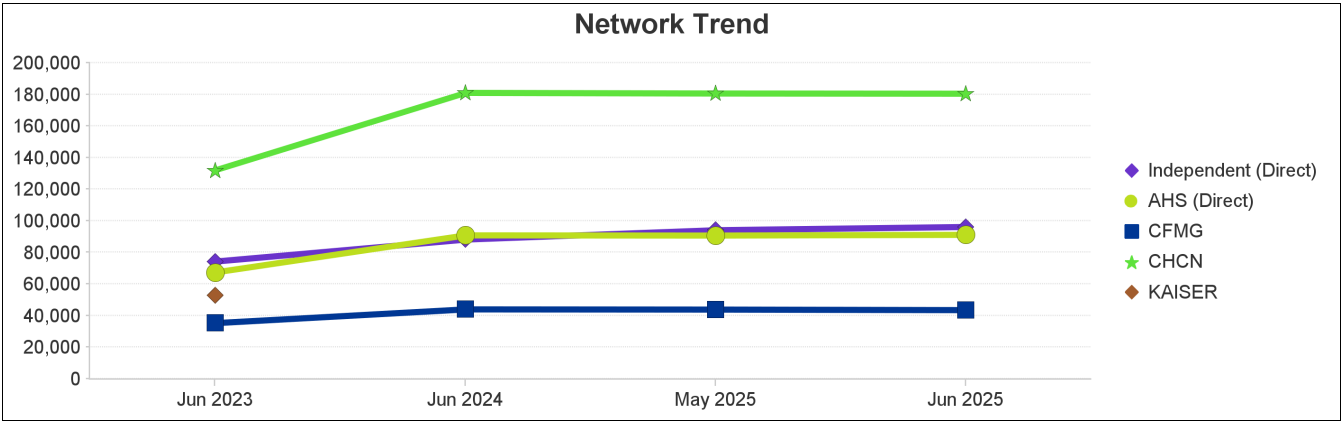


Delegation vs Direct Trend											
Members	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Jun 2023	Jun 2024	May 2025	Jun 2025	Jun 2023	Jun 2024	May 2025	Jun 2025	Jun 2023 to Jun 2024	Jun 2024 to Jun 2025	May 2025 to Jun 2025
Delegated	220,110	225,091	224,566	224,102	60.9%	55.7%	54.8%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



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

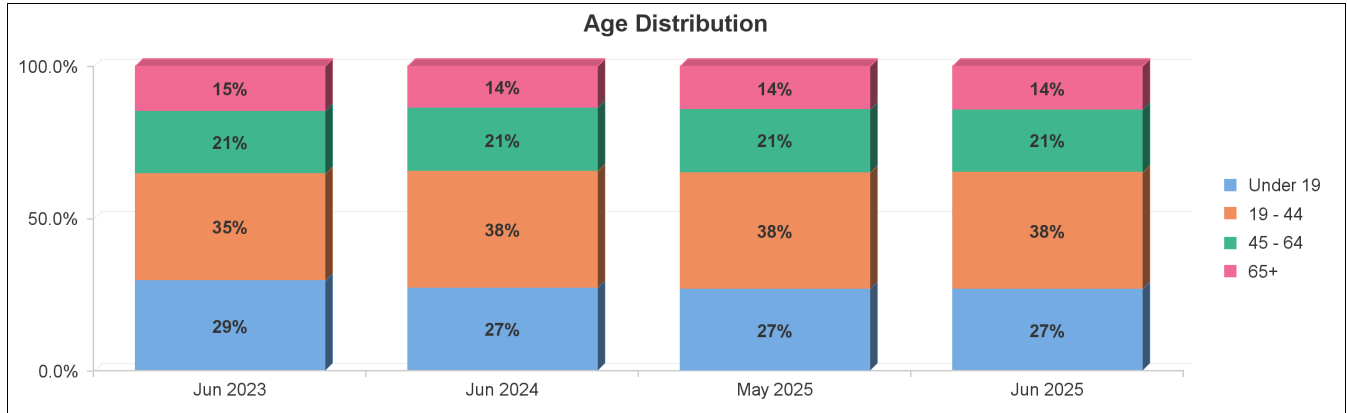
Network Trend											
Network	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Jun 2023	Jun 2024	May 2025	Jun 2025	Jun 2023	Jun 2024	May 2025	Jun 2025	Jun 2023 to Jun 2024	Jun 2024 to Jun 2025	May 2025 to Jun 2025
Independent (Direct)	74,242	88,206	94,112	96,173	20.5%	21.8%	23.0%	23.4%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



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

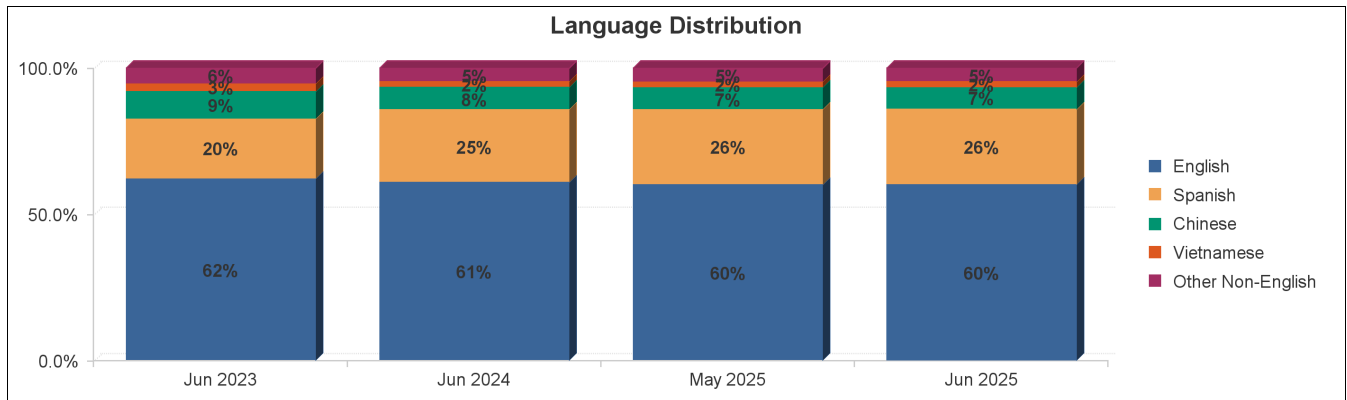
Age Category Trend

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



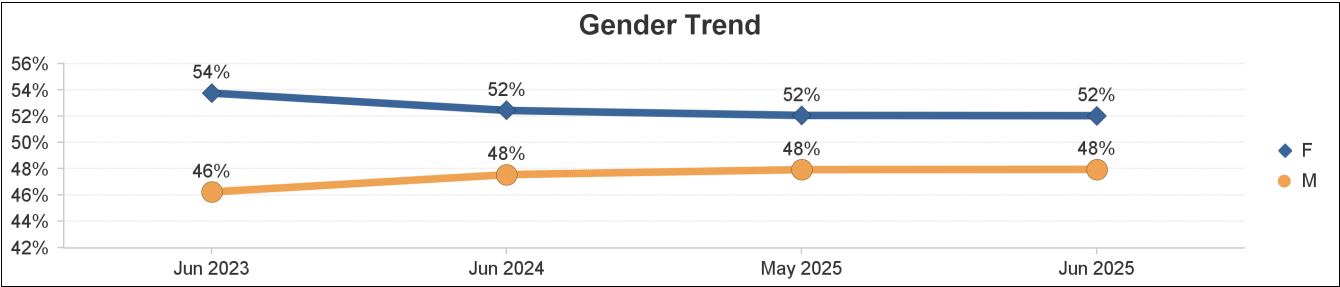
Language Trend

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

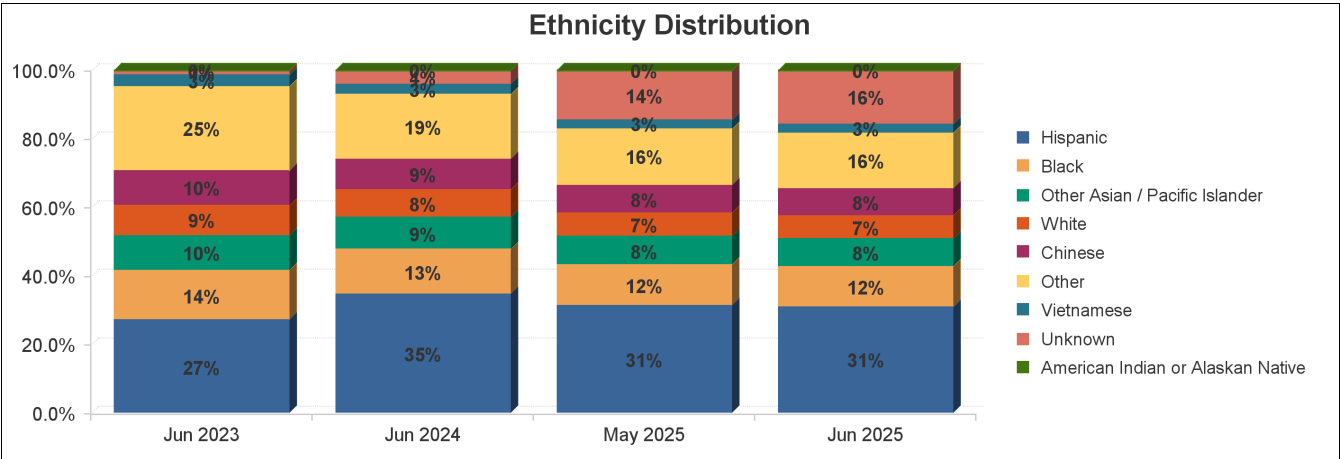


Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

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



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



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

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

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

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

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



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

Human Resources

Anastacia Swift

To: Alameda Alliance for Health Board of Governors

From: Anastacia Swift, Chief Human Resources Officer

Date: August 8th, 2025

Subject: Human Resources Report

Staffing

- As of August 1st, 2025, the Alliance had 677 full time employees and 1 part time employee.
- On August 1st, 2025, the Alliance had 47 open positions in which 17 signed offer acceptance letters have been received with start dates in the near future resulting in a total of 30 positions open to date. The Alliance is actively recruiting for the remaining 30 positions and several of these positions are in the interviewing or job offer stage.
- Summary of open positions by division:

Division	Open Position August 1 st	Signed Offers Accepted by Department	Remaining Recruitment Positions
Healthcare Services	15	7	8
Operations	23	9	14
Healthcare Analytics	1	0	1
Information Technology	3	0	3
Finance	1	1	0
Compliance	1	0	1
Human Resources	3	0	3
Health Equity	0	0	0
Executive	0	0	0
Total	47	17	30

- Our current recruitment rate is 7%.

Employee Recognition

- Employees reaching major milestones in their length of service at the Alliance in July 2025 included:
 - 5 years:
 - Daniel L (Healthcare Analytics)
 - Richard G (Compliance)
 - Andrew L (Claims)
 - 6 years:
 - Alan Z (Claims)
 - Adrian M (IT Data Exchange)
 - 7 years:
 - Trina C (Claims)
 - Nancy T (Member Services)
 - Cathy C (Grievance and Appeals)
 - 8 years:
 - Rubeen S (Member Services)
 - Jasmine C (Provider Services)
 - 9 years:
 - Cindy D (Credentialing)
 - Alex A (Marketing & Communications)
 - Roberta R (Privacy & SIU)
 - 10 years:
 - Matthew W (Executive)
 - 11 years:
 - Evelyn W (Long-Term Services and Support)
 - 12 years:
 - Julia K (Healthcare Analytics)
 - Jennifer R (Utilization Management)
 - 14 years:
 - Lorraine V (Claims)
 - 15 years:
 - Daniel M (IT Infrastructure)
 - 20 years:
 - Felicia A (Claims)