ALAMEDA Alliance FOR HEALTH

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Board of Governors

PACKET

APRIL 12th, 2024

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EXECUTIVE SUMMARY APPENDIX

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

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SUPPORTING MATERIALS APPENDIX

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

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CEO Update

Matthew Woodruff

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

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

Date: **April 12th, 2024**

Subject: **CEO Report**

- **Financials:**
  - **March 2024:** Net Operating Performance by Line of Business for the month of February 2023 and Year-To-Date (YTD):

	February	YTD
Medi-Cal	$3.2M	$29.8M
Group Care	$2.2M	$3.0M
Total	$5.4M	$32.8M

  - **Revenue was $165.9 million in February 2024 and $1.2 billion Year-to-Date (YTD)**.
    - Medical expenses were $152.7 million in February and $1.1 billion for the fiscal year-to-date; the medical loss ratio is 92.0% for the month and 93.4% for the fiscal year-to-date.
    - Administrative expenses were $6.4 million in February and $59.4 million year-to-date; the administrative loss ratio is 3.8% of net revenue for the month and 5.1% of net revenue year-to-date.
  - **Tangible Net Equity (TNE)**: Financial reserves are 645% of the required DMHC minimum, representing $304.1 million in excess TNE.
  - **Total enrollment in February 2024 was 402,259**, an increase of 1,741 Medi-Cal members compared to January.
- **Key Performance Indicators:**
  - **Regulatory Metrics:**
    - All Regulatory Metrics were met.
  - **Non-Regulatory Metrics:**
    - The member services team did not meet one internal metric for service. The team's abandonment rate was at 8%, compared to the internal metric of 5%.

- **Program Implementations:**
  - **Single Plan Model**
    - Good news. The Alliance enrollment as of January 25th, 2024, is 402,259.
    - Member Services had their third largest call volume in its history, almost surpassing 23,000 calls, compared to nearly 24,000 calls in February.
    - The Health Care Services Department had its second largest volume of authorizations ever in March 2024. The team received 7,807 authorization requests in March, compared to 7,761 in February 2024. These numbers encompass authorizations for all categories (including inpatient, outpatient, and long-term care).

  - **Pay Equity Salary Survey**
    - We will continue to include updates as the Alliance works through the entire process.

- **Medicare Overview**
  - **<u>D-SNP Readiness</u>**
    - Alameda Alliance for Health (AAH) Medicare Advantage Duals Special Needs Plan (D-SNP) will begin serving members on January 1st, 2026.
    - During the first two weeks of April, departments have been brought onsite for specific departments discussions and planning.
    - The team has created 3 project management plans (Operational Readiness, IT, and Quality/STARs) and during the onsite meetings, the operational readiness project management plan was discussed, so each department had a chance to understand Medicare tasks/sub-tasks and evaluate the changes and differences from Medi-Cal.
    - The operational readiness project management plan is broken up into 13 different phases with workstream leads/executives assigned and various deliverables under each workstream. AAH is using a Portfolio Project Management (PPM) tool called TeamDynamix (TDX) for resource allocation management, timeline roadmaps, and understanding competing priorities.

- **Alliance/DHCS Incentive Programs Update**
  - **Program #1 – CalAIM Incentive Payment Program**
    - Description & Purpose:
      - CalAIM's Enhanced Care Management (ECM) and Community Supports (CS) programs began launching on January 1st, 2022.
      - The purpose of this incentive program is to expand ECM and Community Supports by building capacity, investing in delivery

system infrastructure, addressing disparities and equity, adding community supports, and improving quality.

  - Any provider or community-based organization is invited to apply for incentive funding. In order to qualify for funding, the participating organizations are required to join the Alliance's ECM and Community Supports program, and to meet specified outcomes and performance measures.

- Program Years: **1/1/2022 – 6/30/2024**
- Maximum allocation to Alameda Alliance: **$14.8 million (year 1); $15.1 million (year 2)**
- Earned incentive dollars: **$14.8 million**
- Payments Issues to IPP Providers and Organizations: **$8.3M million**
- State Guidance: DHCS APL 21-016
- Current Status:
  - For Program Year 1 (1/1/2022-12/31/2022), AAH earned $14.8M, which was 100% of eligible funds. Funds were distributed to ten (10) providers and organizations to support the ECM and CS programs.
  - For Program Year 2 (1/1/2023-12/31/2023), funds have been distributed to twelve (12) providers and organizations to support the ECM and CS programs. AAH received notification from DHCS in November that we had earned 60% of the eligible points allocated to Submission 3. Funding for Submission 3 was estimated to be released by December 29th, 2023, but has not been received.
  - The Submission 4 report was submitted to DHCS on March 1st, 2024.

- **Program #2 – Student Behavioral Health Incentive Program**
  - Description & Purpose:
    - Statewide $389 million is designated over a three-year period (January 1, 2022-December 31, 2024) for incentive payments to Medi-Cal managed care plans that meet predefined goals and metrics. The goals and metrics are associated with targeted interventions that increase access to preventive, early intervention, and behavioral health services by school-affiliated behavioral health providers for TK-12 children in public schools. Public charter schools are also included.
    - The purpose of this incentive program is to invest in three priority areas of school-based behavioral health services: planning and coordination, infrastructure, prevention and early intervention.

- Program Years: **1/1/2022 - 12/31/2024**
- Maximum allocation to Alameda Alliance: **$9.7 million**
- Earned incentive dollars: **$6.3 million.**
- Payments issued to SBHIP Partners: **$5.5 million**
- State Guidance: DHCS APL 23-035
- Current Status:
  - The Bi-Quarterly Report (BQR) for the second measurement period (July 1st, 2023-December 31st, 2023) was submitted to DHCS on December 21st, 2023. On March 13th, AAH received notification from DHCS the BQR for the second measurement period was fully approved by DHCS; the associated payment of $1.1M (100% of eligible funds) is expected to be paid in April 2024.
  - A Memorandum of Understanding (MOU) was executed on August 30th, 2023, with ACOE to support LEAs in developing the infrastructure to sustain program activities post-SBHIP. As of January 2024, ACOE has completed deliverables to develop an initial sequence and description of all Learning Exchange session topics, as well as hosting regularly scheduled Learning Exchanges and Office Hour sessions. The MOU with CHSC was fully executed in November 2023 and outlines activities that will provide additional support to LEAs for SBHIP program activities related to expanding behavioral health and wellness resources, expanding behavioral health work force, and support for culturally appropriate and targeted populations. CHSC has completed deliverables related to resource development (i.e., crisis support) and hosting Professional Learning Communities to support SBHIP activities.

- **Program #3 – Housing and Homelessness Incentive Program**
  - Description & Purpose:
    - This incentive program is built upon the DHCS' quality strategy and the Home- and Community Based Spending Plan. The spending plan focuses on addressing homelessness and unhoused people and encompasses the community-based residential continuum pilots for older, frail adults and disabled populations. The plan includes the assisted living waiver waitlist, community care expansion program, and other services.
    - Address homelessness and housing insecurity as social determinants of health. Developing a local homelessness plan will be jointly created with Alameda County Health Care Services Agency (HCSA) and Alameda Alliance and submitted to the DHCS. The existing partnership that originated during the Whole Person Care and Health Home Pilots (2017 – 2021) would be extended to build more capacity to support more referrals for housing services, and to better coordinate housing needs.

- This incentive program enables further investing in the expansion of street medicine, data management systems, and staffing to attain three measurement areas: 1) local partnerships to address disparities and equity, 2) infrastructure to support housing navigation, and 3) service delivery and member engagement.

- Program Years: **1/1/2022 - 3/31/2024**
- Maximum allocation to Alameda Alliance: **$44.3 million**
- Earned incentive dollars: **$20.4 million**
- Payments issued: **$17.6 million**
- State Guidance: DHCS APL 22-007
- Current Status:
  - The Alliance has issued $12.8M in HHIP payments to Alameda County Health (formerly HCSA) for the completion of deliverables related to a Housing Financial Supports Progress Report, Street Medicine data, analytics, the 2023 Q1 and Q2 Housing Community Supports (HCS) Capacity Building progress report, a HCS Legal Services pilot that went live July 2023, and funding to support the 2024 Point-in-Time (PIT) count. The Alliance has extended its agreement with Alameda County Health (AC Health) to provide additional time for the HCS Capacity Building work as hiring challenges were identified by HCS providers; this work has been extended through June 2024. On February 6th, the Alliance announced a new opportunity available to SBHIP LEAs to address the challenge of students experiencing homelessness and associated behavioral health needs (i.e., anxiety, depression, etc.). Informational listening sessions were held on March 19th and 21st. The Alliance is in the process of developing a program to reinvest earned HHIP dollars and increase partnerships within the community to support HHIP program goals; funds available to applicants will be dependent on dollars earned from the S2 report.
  - The Alliance is eligible to earn up to $44.3M over the course of HHIP. $6.6 million was allocated and earned for the calendar year 2022, and $15.5 million was allocated for the calendar year 2023, of which $13.7 has been earned; to date, AAH has earned 92% of allocated funds. $22.1 million is allocated for the calendar year 2024. Payments were issued in October 2022, December 2022, and June 2023. The final payment is tied to Submission 2 (S2) Report, which reflects the measurement period of 1/1/2023-10/31/2023. AAH received notification from DHCS on March 6th that AAH had earned $17.6M (79% of eligible funds) for the S2 Report, and payment is expected in April 2024. AAH is awaiting further details from DHCS regarding the scoring of the S2 report.

- **Providing Access and Transforming Health (PATH):** Comprising 5 initiatives, PATH funding supports Enhanced Care Management (ECM) and Community Support (CS) providers. $1.85 billion will be available statewide. Initiatives include:
- **WPC Services & Transition to Managed Care Mitigation Initiative**: Direct funding for WPC Pilot Lead Entities to sustain existing WPC Pilot services that "map to" ECM/Community Supports until an MCP covers the service. Services that will not continue under CalAIM—either because they are not included in CalAIM or will not be picked up by any MCP in the future—are not eligible for this funding.
- **Technical Assistance Initiative**: Providers will have access to a statewide marketplace for ECM/Community Supports related technical assistance.
- **Collaborative Planning & Implementation Initiative**: Support for regional collaborative planning and implementation efforts across entities essential to the success of CalAIM. BluePath Health was selected by DHCS as the facilitator for Alameda County and the initial kick-off meeting was held on January 27th, 2023. BluePath Health is conducting monthly meetings with all Collaborative participants. BluePath Health also conducted two informational meetings with AAH in January and February. Health Care Services continues to represent Alameda Alliance in the monthly collaborative meetings.
- **Capacity & Infrastructure Transition, Expansion, and Development Initiative (CITED)**: Funding for providers, community-based organizations, counties, Lead Entities, tribes, and others for capacity and infrastructure development activities that support the implementation of ECM and Community Supports. Round 1A CITED recipients were announced by DHCS on January 31st, 2023, and Round 1B CITED recipients were announced on March 24th, 2023; a total of $207M was awarded to 139 recipients during Round 1. The CITED Round 2 application period closed on May 31st, 2023, and DHCS announced the recipients on October 30th, awarding $144M to 145 providers across California. The CITED Round 3 application period opened on January 15th, 2024, and closed on February 15th, 2024.
- **Justice-Involved Capacity Building**: Funding to maintain and build pre-release and post-release services to support implementation of the CalAIM justice-involved population, including capacity and infrastructure to support services, including EHR systems. Round 1 grants in the amount of $4.55M were awarded statewide in November 2022. The application period for Round 2 closed on March 31st, 2023; grants in the amount of $64.5M were awarded in January 2024. The application period for Round 3 opened on May 1st, 2023, and closed on July 31st, 2023; awards have not been announced.

- **Alliance Sponsored Programs**

  - **Program 1 - Community Reinvestment Fund**

    - An Alliance Community Reinvestment program is currently in development. The program is designed to strengthen existing and new partnerships with community-based organizations and help build capacity to best serve Alliance Medi-Cal members. The Alliance has allocated funding over the next two (2) years to support new and innovative approaches focused on vulnerable populations and addressing health disparities. Priority initiatives include:
      - HEDIS
      - Access to care
      - Social determinants of health
      - Complex case management, including populations of focus
      - Behavioral health

    - The Alliance is currently working to develop program materials, including provider-facing program overview documents, application materials, evaluation criteria, governance structure, and policy and procedures. A Board designee(s) will provide final approval of applications selected for funding; the program is anticipated to launch on July 1st, 2024.

  - **Program 2 - Provider Recruitment Initiative**

    - An Alliance Provider Recruitment Initiative (PRI) is currently in development. The program is designed to provide grants to support the Alameda County Safety Net and community-based organizations to recruit, 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 reflect the diversity of Alliance members. Program goals include:
      - Expanding the Alameda Alliance Provider network by approximately 10 to 15 providers a year
      - Improving member access to Primary Care Providers, Specialists, and Behavioral Health professionals
      - Promoting diverse and culturally inclusive care reflective of Alliance members

    - The Alliance is currently working to develop program materials, including provider-facing program overview documents, application materials, evaluation criteria, governance structure, and policy and procedures. A Board designee(s) will provide final approval of applications selected for funding; the program is anticipated to launch on July 1st, 2024.

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Executive Dashboard

OPERATIONS DASHBOARD

APRIL 2024

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Financials

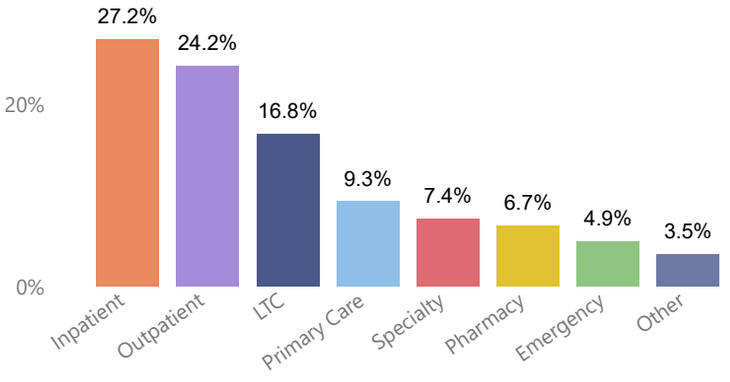
Income & Expenses

	FEBRUARY 2024	FISCAL YTD
REVENUE	$ 325.8 M	$ 1.3 B
MEDICAL EXPENSE	$ (152.7) M	$ (1.1) B
ADMIN EXPENSE	$ (6.4) M	$ (59.4) M
OTHER/TAX	$ (161.3) M	$ (142.6) M
NET INCOME	$ 5.4 M	$ 32.8 M

Medical Loss % (Fiscal YTD)

93.5%

Medical Expenses



Liquid Reserves

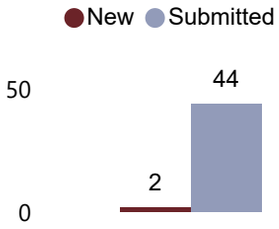
TNE %

644.5%

TNE $

$356.7M

Reinsurance Cases



Balance Sheet

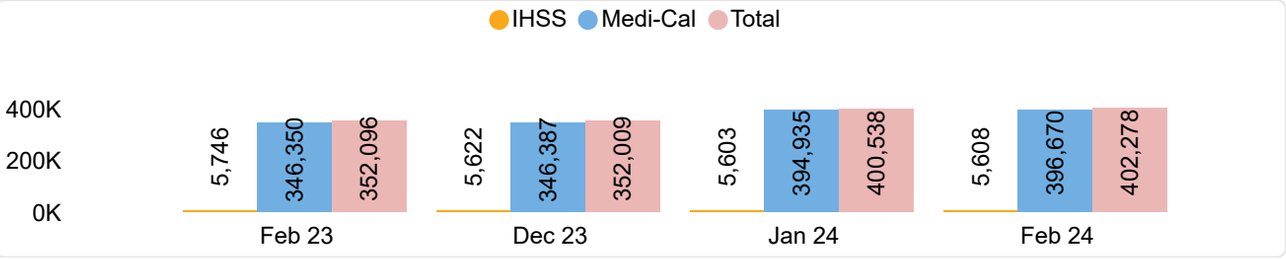
Cash Equivalents	$530.5M
Pass-Through Liabilities	$305.4M
Uncommitted Cash	$225.1M
Working Capital	$343.8M

Current Ratio

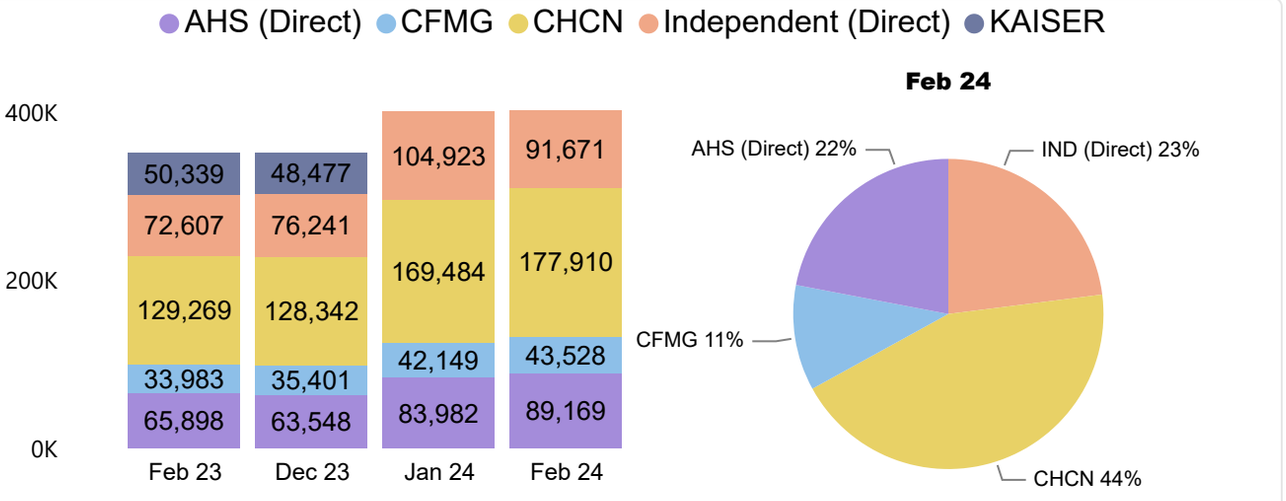
1.56

Membership

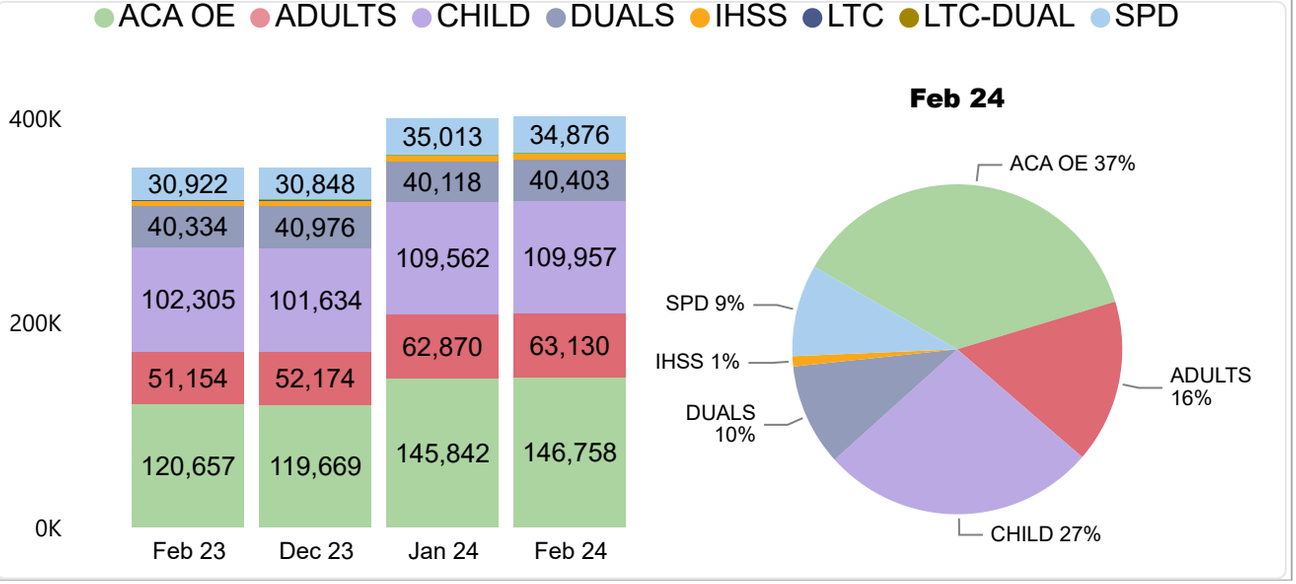
By Plan



By Network

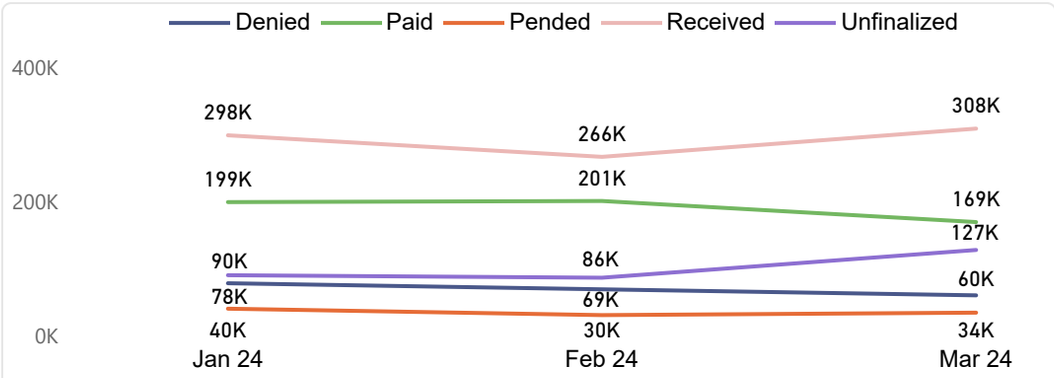


By Category

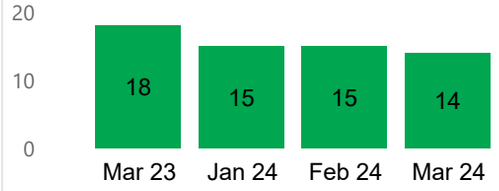


Claims

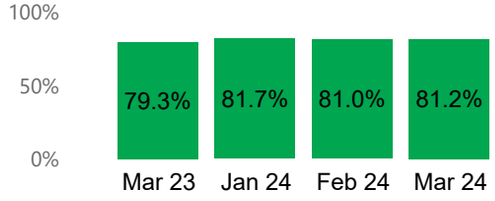
Claims Processing



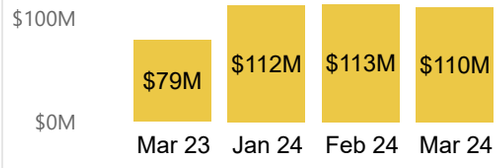
Average Payment TAT (Days)



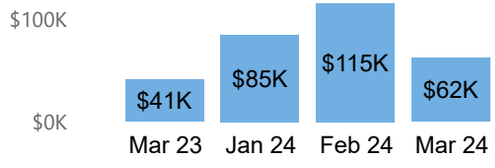
Auto Adjudication Rate (%)



Claims Paid ($)

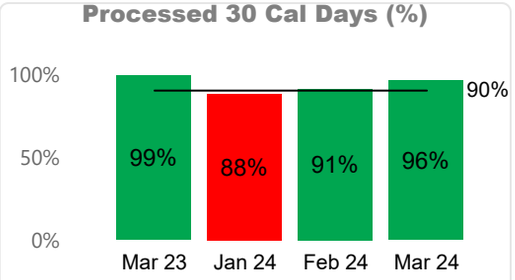


Interest Paid ($)

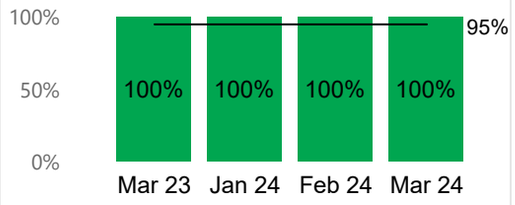


Claims Compliance

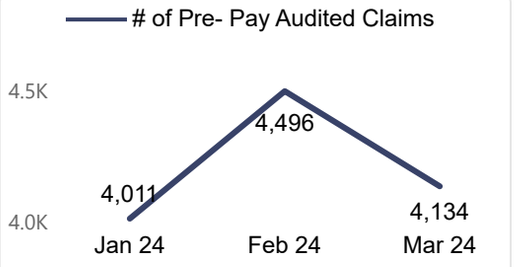
Processed 30 Cal Days (%)



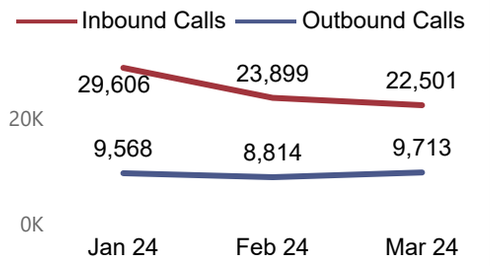
Processed 45 Work Days (%)



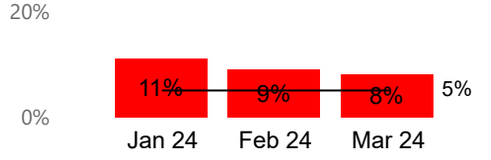
Claims Auditing



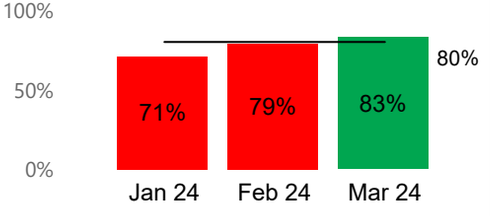
Member Services



Abandoned Call Rate (%)

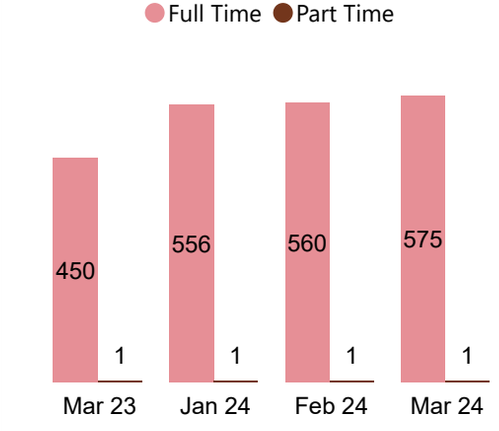


Calls Answered in 30 Seconds (%)

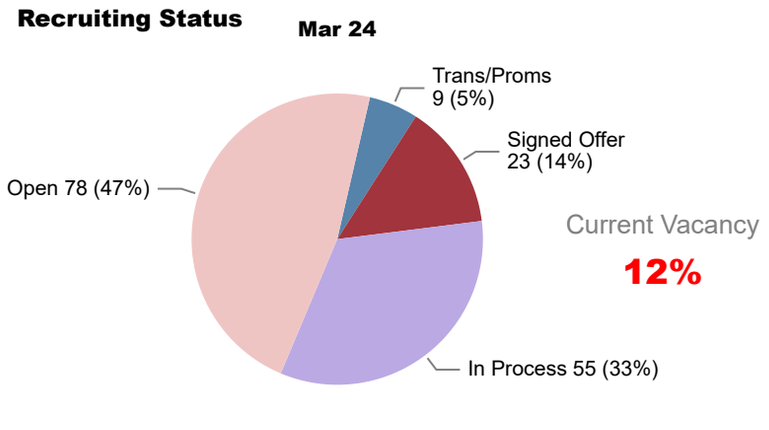


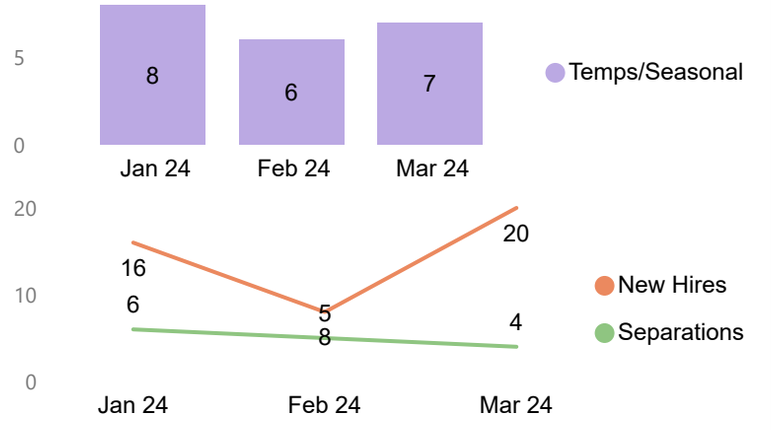
Average Call Times	Jan 24	Feb 24	Mar 24
Wait Time	01:26	00:58	00:49
Call Duration	06:58	06:49	07:02

Human Resources



Recruiting Status





Provider Services

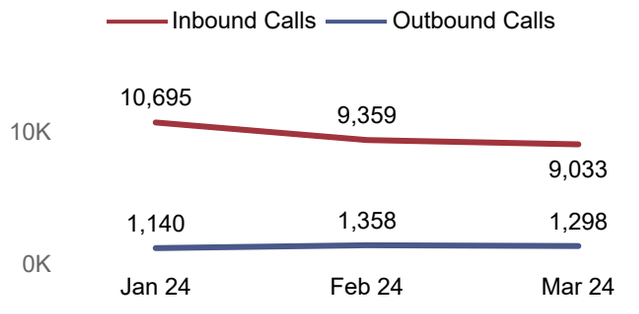
Provider Network

Hospital	17
Specialist	9,899
Primary Care Physician	800
Skilled Nursing Facility	104
Urgent Care	7
Health Centers (FQHCs and Non-FQHCs)	68
TOTAL	**10,895**

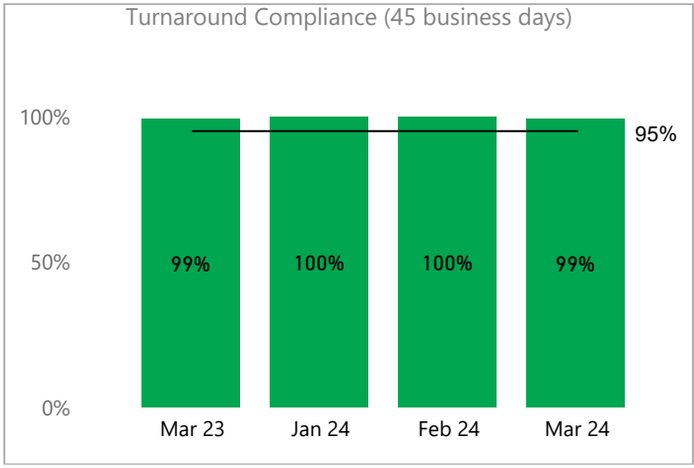
Provider Credentialing

3,305

Provider Call Center

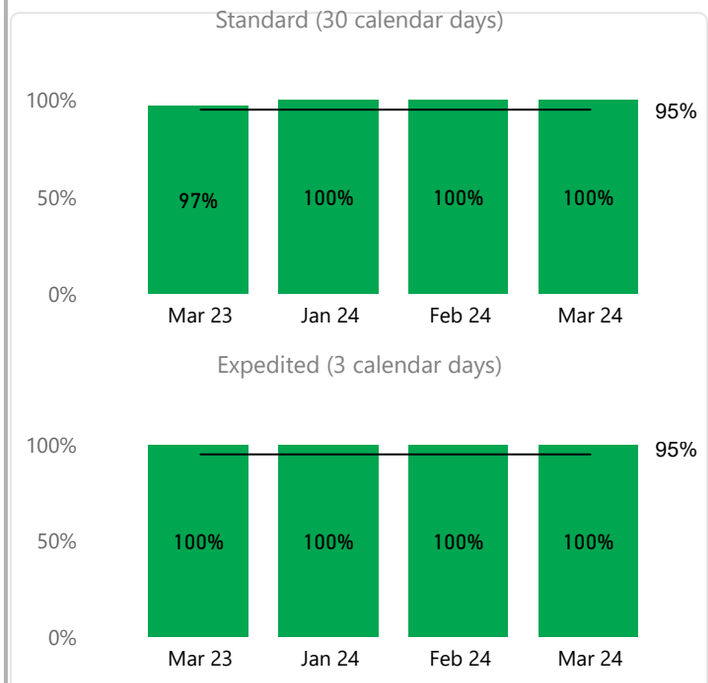


Provider Disputes & Resolutions

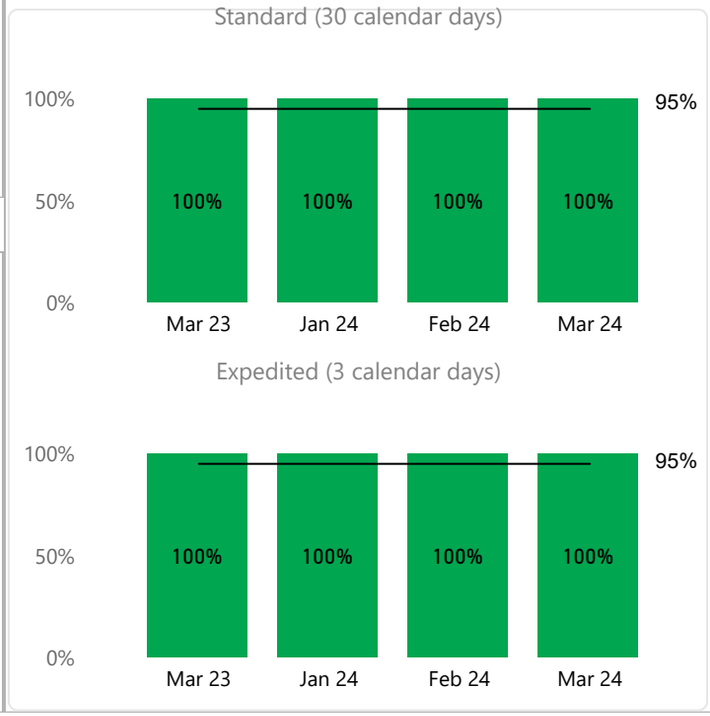


Compliance

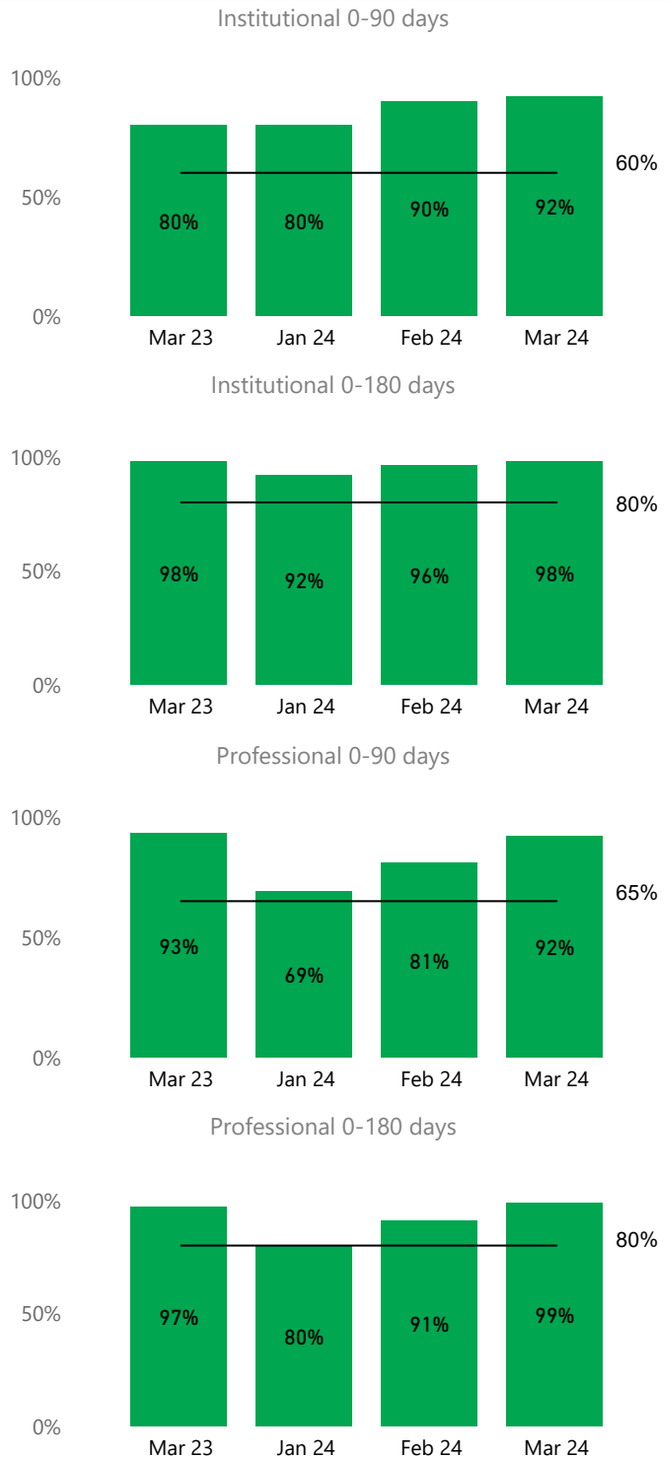
Member Grievances



Member Appeals

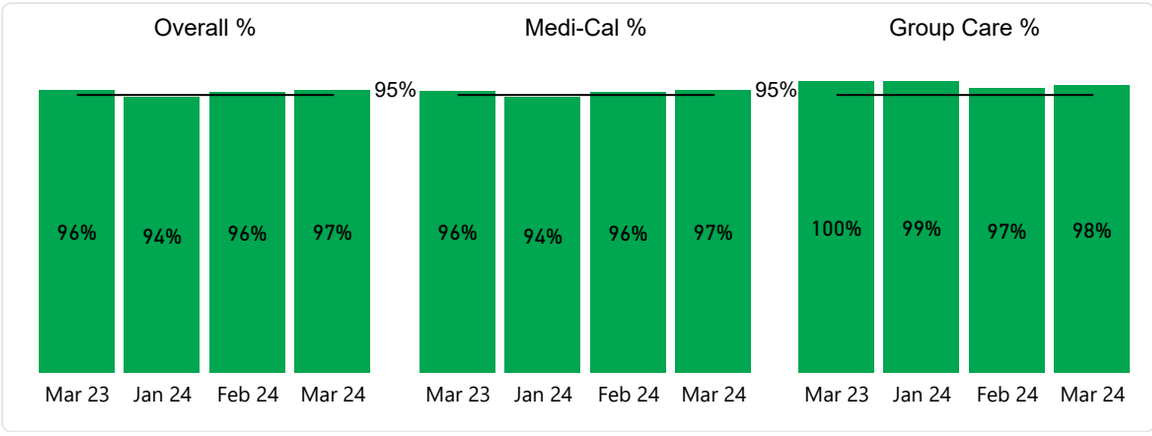


Encounter Data

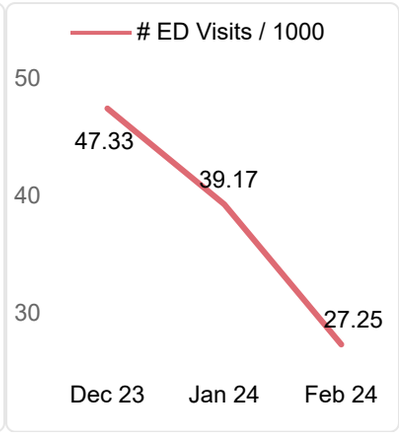


Health Care Services

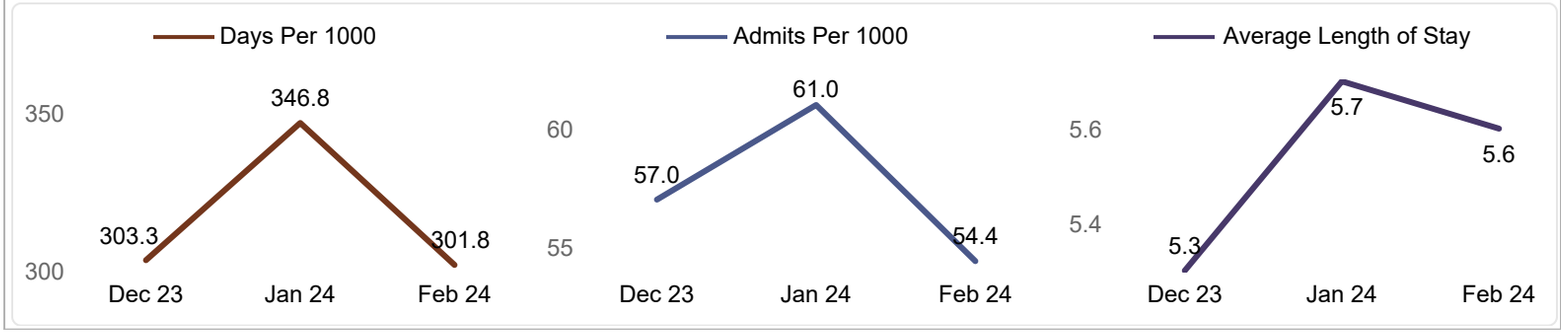
Authorization Turnaround



ED Utilization

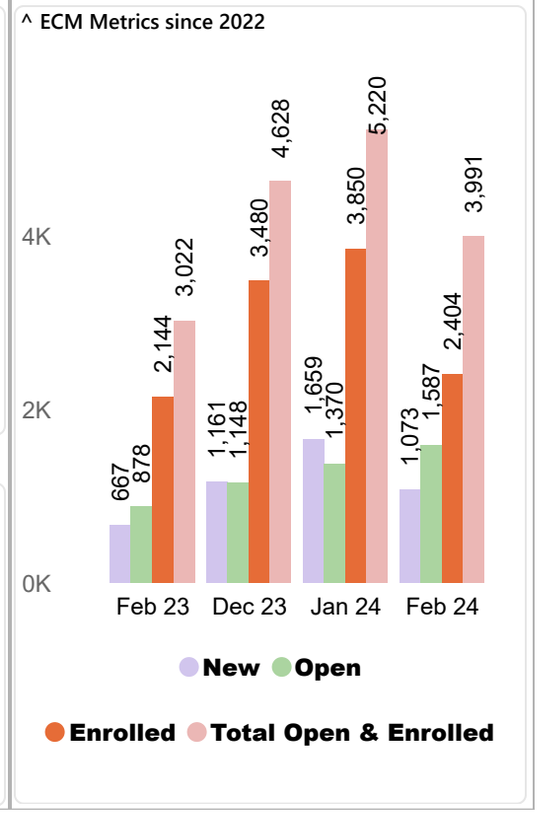


Inpatient Utilization

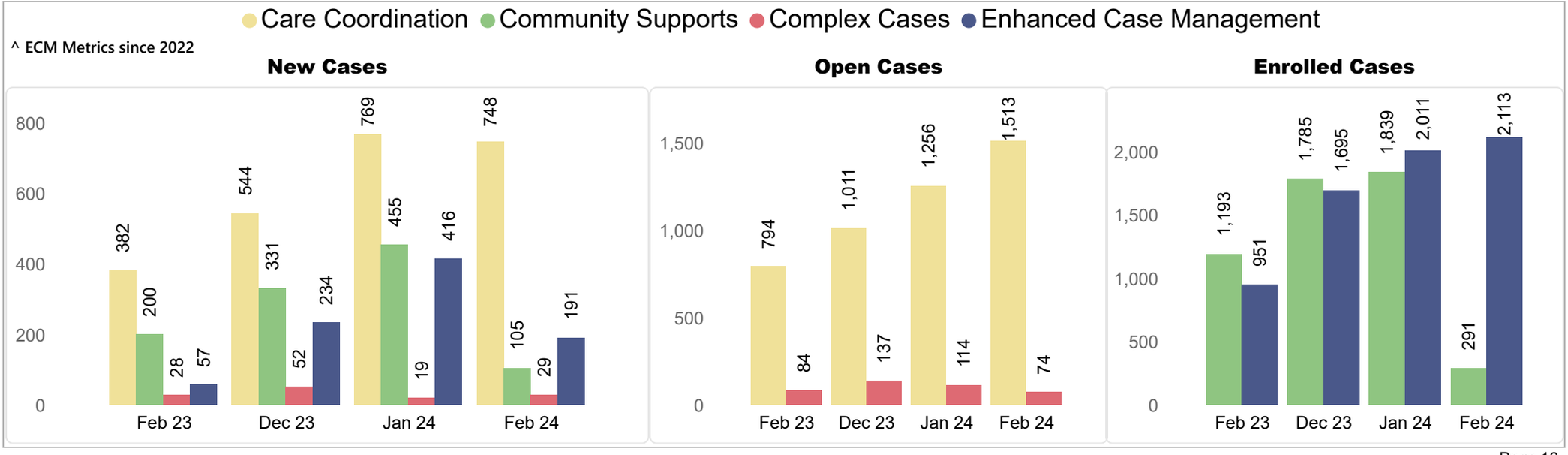


Case Management

Total Cases^



Case Management^



Technology (Business Availability)

Applications	Mar 23	Jan 24	Feb 24	Mar 24
HEALTHsuite System	100.0%	100.0%	100.0%	100.0%
Other Applications	100.0%	100.0%	100.0%	100.0%
TruCare System	100.0%	100.0%	100.0%	100.0%

Outpatient Authorization Denial Rates *

OP Authorization Denial Rates	Mar 23	Jan 24	Feb 24	Mar 24
Denial Rate Excluding Partial Denials (%)	3.5%	3.0%	4.0%	3.4%
Overall Denial Rate (%)	4.0%	3.3%	4.2%	3.8%
Partial Denial Rate (%)	0.5%	0.3%	0.3%	0.4%

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

Pharmacy Authorizations

Authorizations	Mar 23	Jan 24	Feb 24	Mar 24
Approved Prior Authorizations	32	30	35	34
Closed Prior Authorizations	99	107	91	109
Denied Prior Authorizations	37	43	36	80
Total Prior Authorizations	168	180	162	223

ALAMEDA Alliance FOR HEALTH

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

Finance

Gil Riojas

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

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

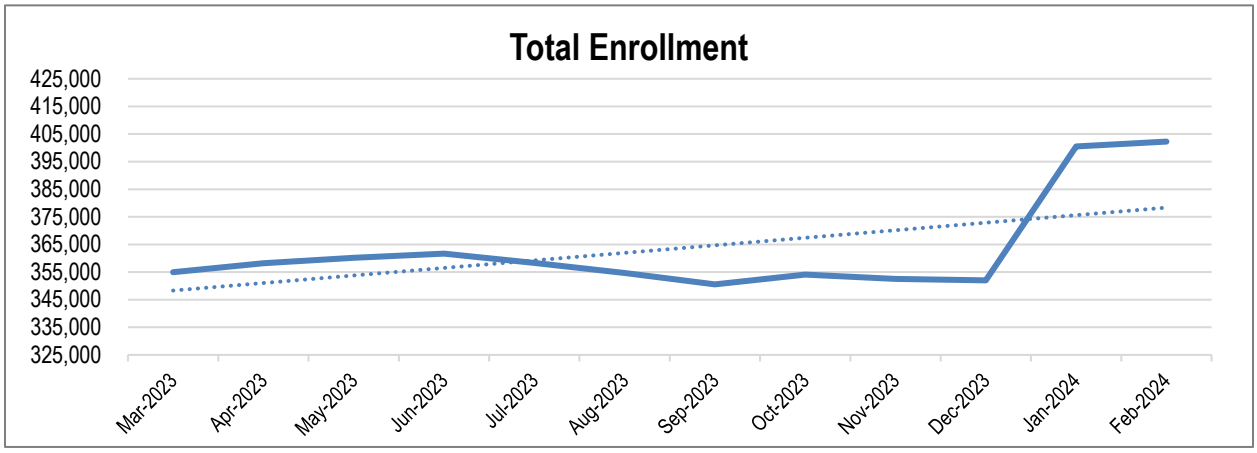
Date: **April 12th, 2024**

Subject: **Finance Report – February 2024 Financials**

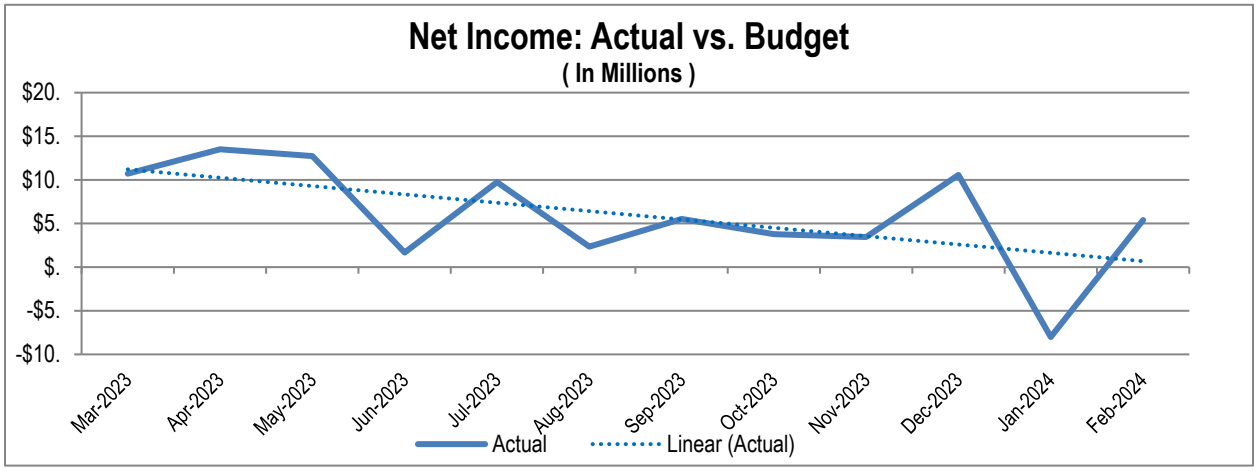
Executive Summary

For the month ended February 29th, 2024, the Alliance continued to experience increases in enrollment, bringing total enrollment to 402K members. Net Income of $3.4 million was reported in February. The Plan's February medical expenses represented 92.0% of revenue. Alliance reserves increased to 645% of required and remain well above minimum requirements.

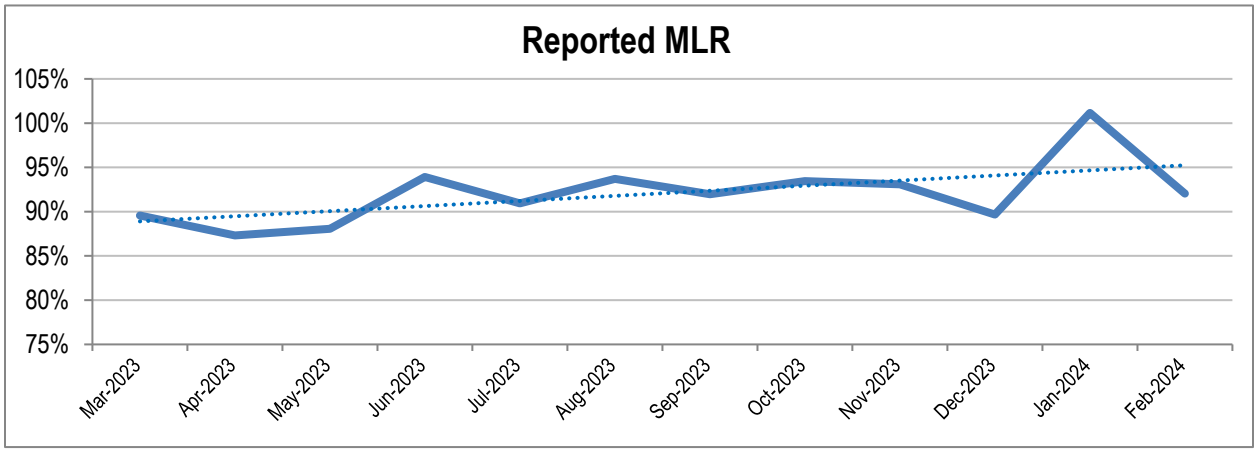
Enrollment – In February, Enrollment increased by 1,741 members.



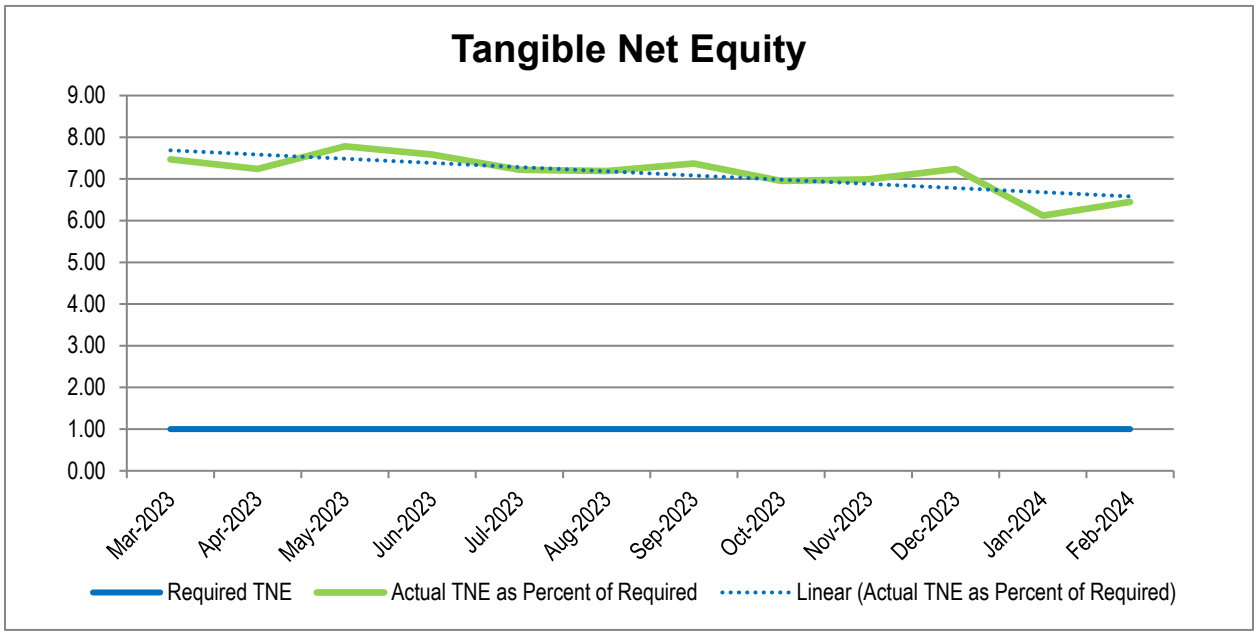
Net Income – For the month ended February 29th, 2024, actual Net Income was $5.4 million vs. budgeted Net Income of $3.4 million. Fiscal year-to-date actual Net Income was $32.8 million vs. Budgeted Net Income of $20.0 million. For the month, Premium revenue was 2.7% favorable to Budget.



Medical Loss Ratio (MLR) – The Medical Loss Ratio was 92.0% for the month and 93.4% for the fiscal year-to-date. MLR percentages above 95% may result in net losses for the plan.



Tangible Net Equity (TNE) - The Department of Managed Health Care (DMHC) required $55.3M in reserves, we reported $356.7M. Our overall TNE remains healthy at 645%.



The Alliance continues to benefit from increased non-operating income. For February we reported returns of $1.3M, and year-to-date $20.4M, in the investment portfolio.

Finance

Supporting Documents

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

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

Date: **April 12th, 2024**

Subject: **Finance Report – February 2024**

Executive Summary

- For the month ended February 29th, 2024, the Alliance had enrollment of 402,259 members, a Net Income of $5.4 million and 645% of required Tangible Net Equity (TNE).

Overall Results: (in Thousands)

	Month	YTD
Revenue	$325,775	$1,315,536
Medical Expense	152,709	1,080,763
Admin. Expense	6,351	59,382
MCO Tax Expense	162,537	162,537
Other Inc. / (Exp.)	1,214	19,915
Net Income	**$5,392**	**$32,769**

Net Income by Program: (in Thousands)

	Month	YTD
Medi-Cal*	$3,191	$29,817
Group Care	2,201	2,952
	$5,392	**$32,769**

*Includes consulting cost for Medicare implementation.

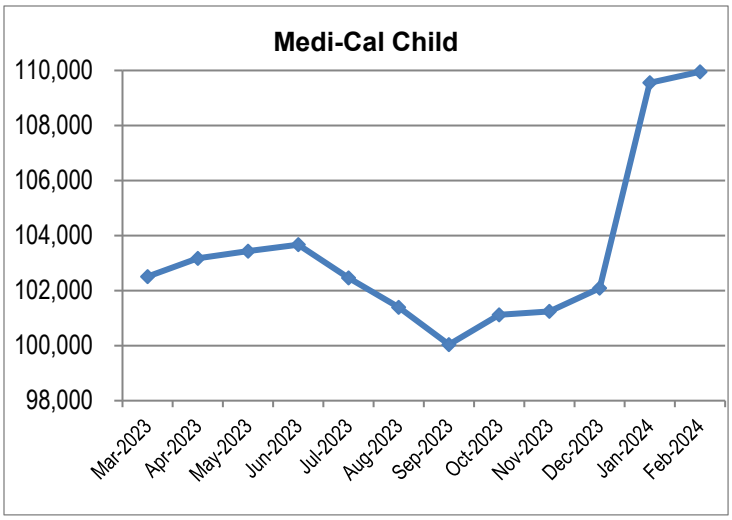
Enrollment

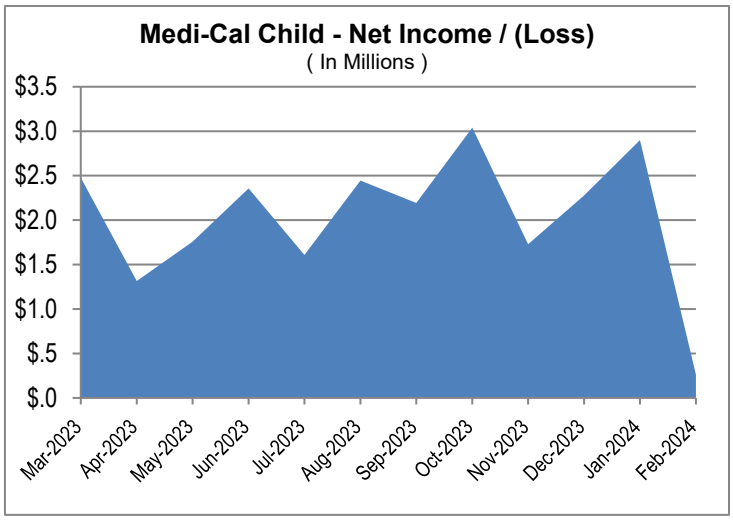
- Total enrollment increased by 1,741 members since January 2024.
- Total enrollment increased by 40,574 members since June 2023.

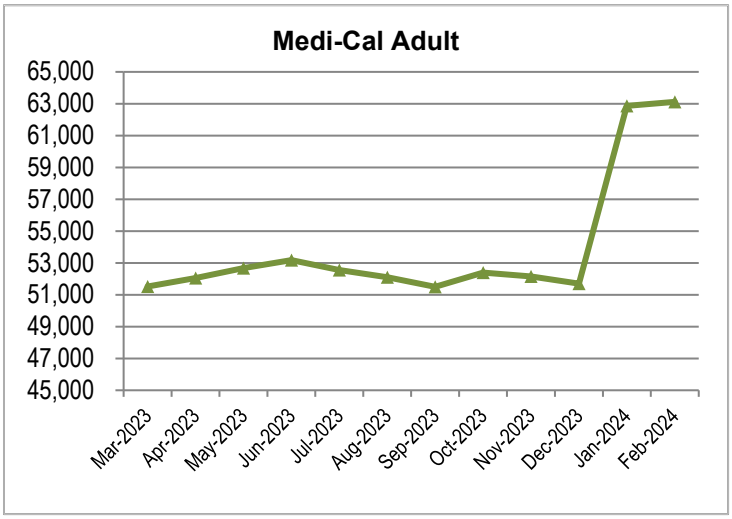
Monthly Membership and YTD Member Months
Actual vs. Budget
For the Month and Fiscal Year-to-Date

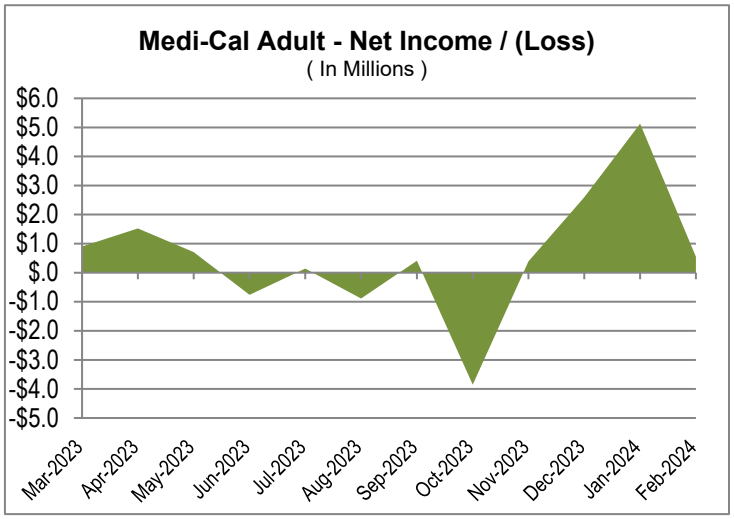
Enrollment					Member Months			
Current Month					Year-to-Date			
Actual	Budget	Variance	Variance %		Actual	Budget	Variance	Variance %
				Medi-Cal:				
63,117	56,788	6,329	11.1%	Adult	438,371	425,986	12,385	2.9%
109,953	100,933	9,020	8.9%	Child	827,851	807,223	20,628	2.6%
34,875	42,133	(7,258)	-17.2%	SPD	254,974	269,203	(14,229)	-5.3%
40,403	45,694	(5,291)	-11.6%	Duals	329,019	340,744	(11,725)	-3.4%
146,757	147,556	(799)	-0.5%	ACA OE	1,019,812	1,024,510	(4,698)	-0.5%
217	173	44	25.4%	LTC	1,261	1,171	90	7.7%
1,329	1,176	153	13.0%	LTC Duals	8,619	8,379	240	2.9%
396,651	**394,453**	**2,198**	**0.6%**	**Medi-Cal Total**	**2,879,907**	**2,877,216**	**2,691**	**0.1%**
5,608	5,549	59	1.1%	Group Care	44,968	44,830	138	0.3%
402,259	**400,002**	**2,257**	**0.6%**	**Total**	**2,924,875**	**2,922,046**	**2,829**	**0.1%**

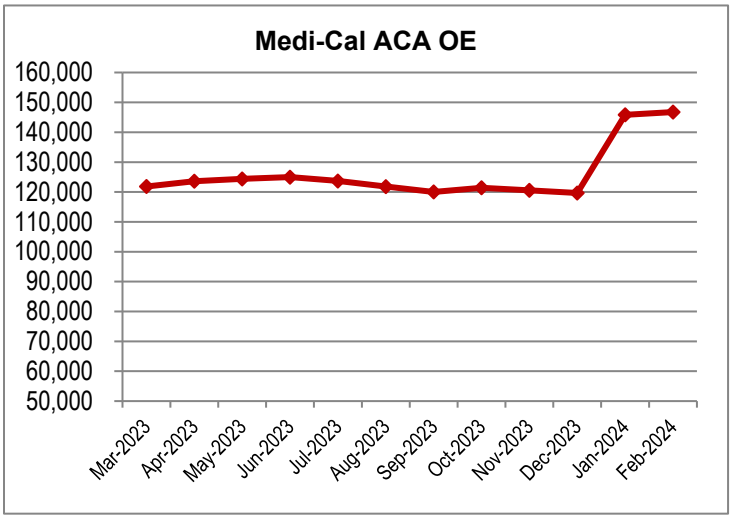
Enrollment and Profitability by Program and Category of Aid

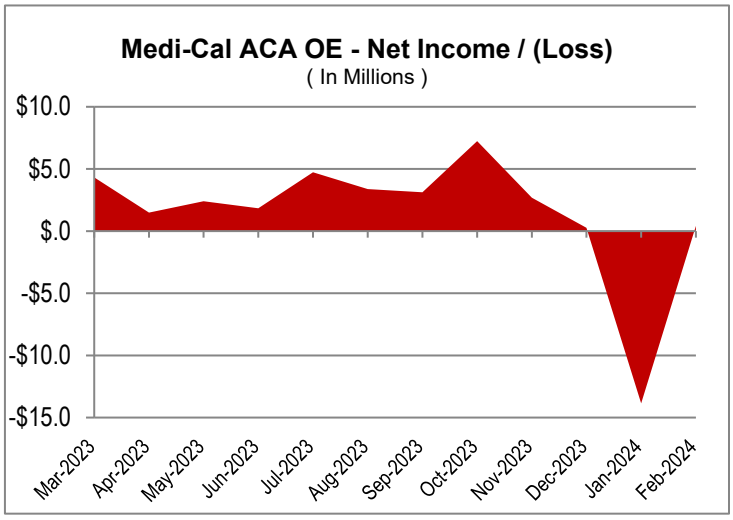




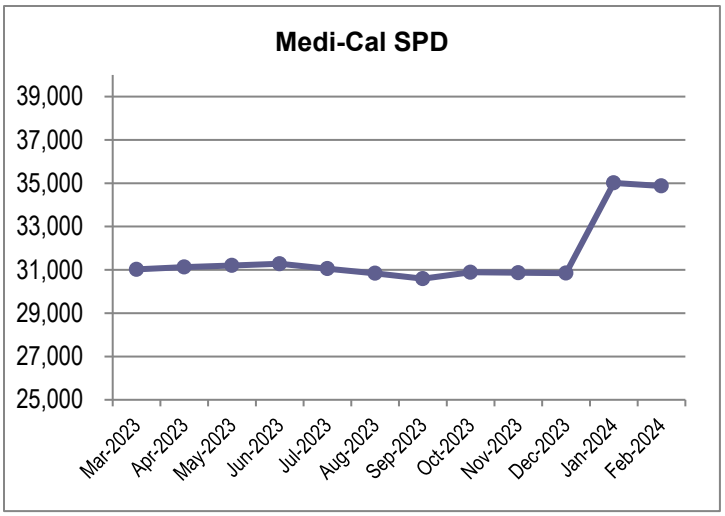


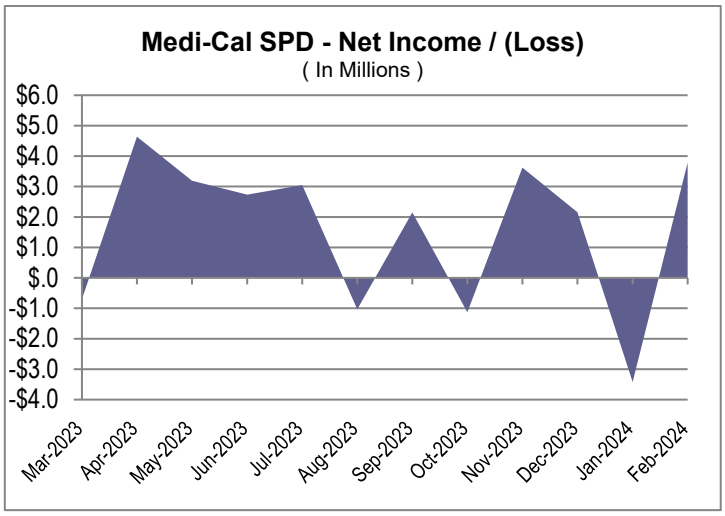


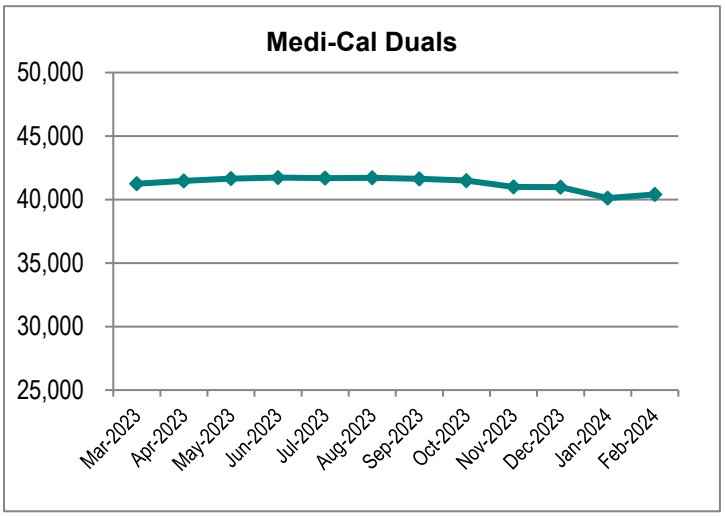


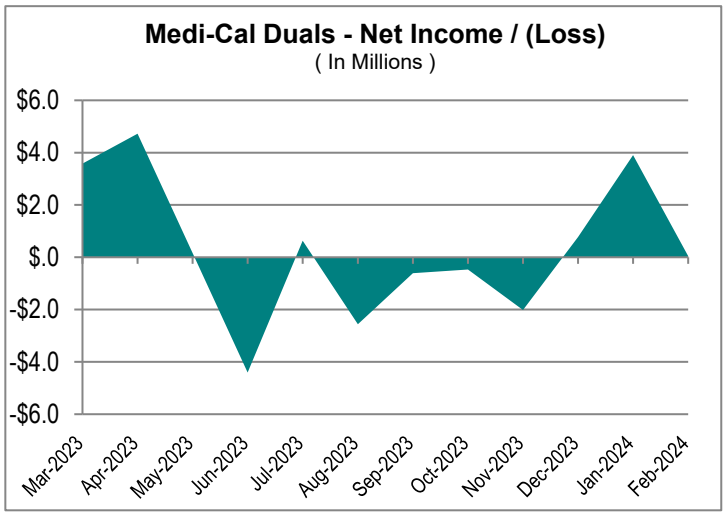


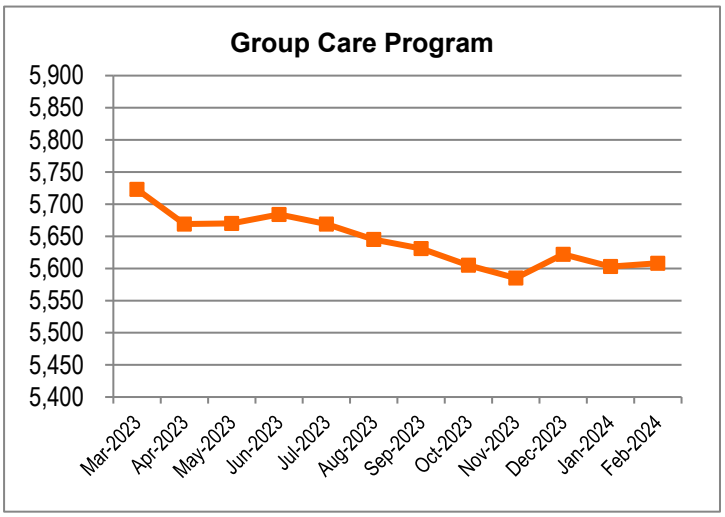
Enrollment and Profitability by Program and Category of Aid

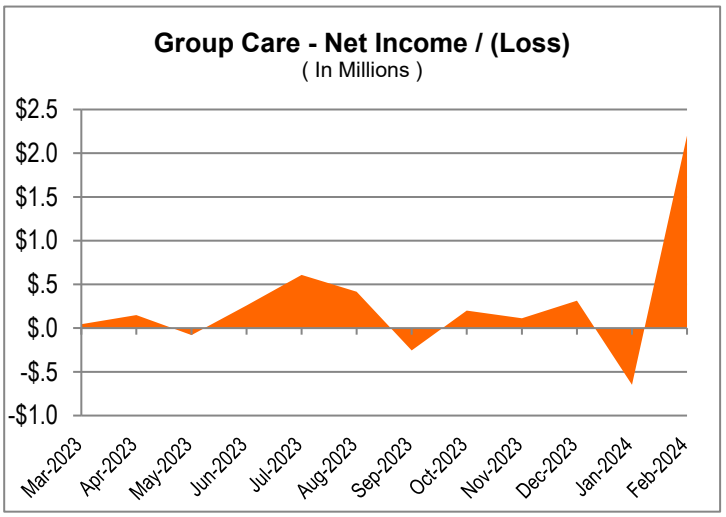




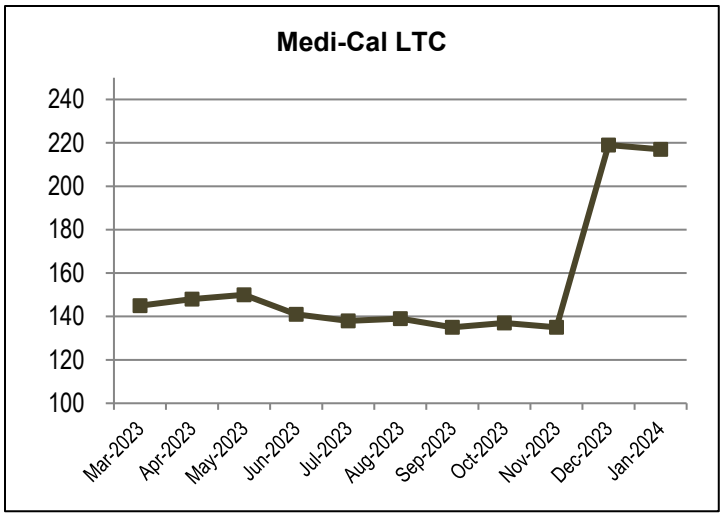


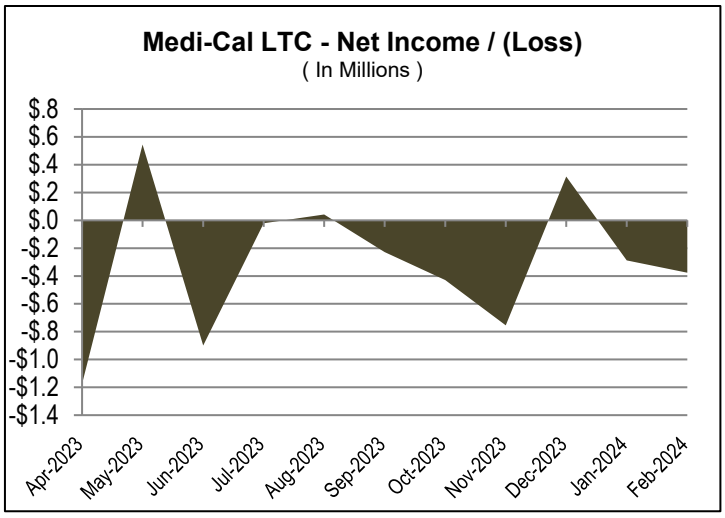


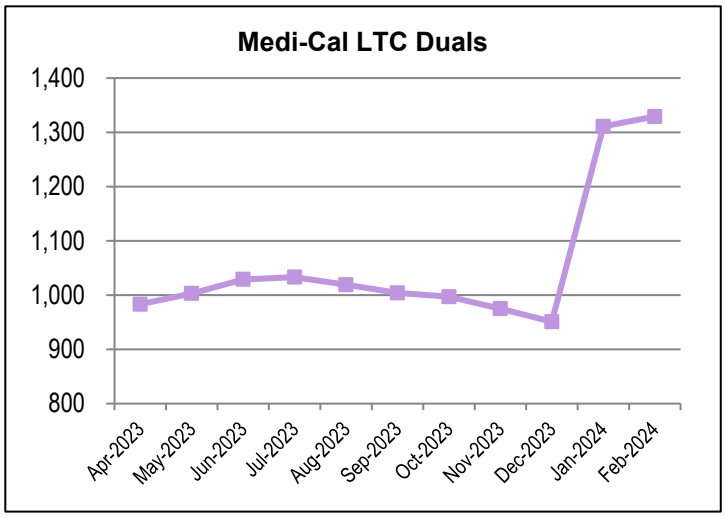


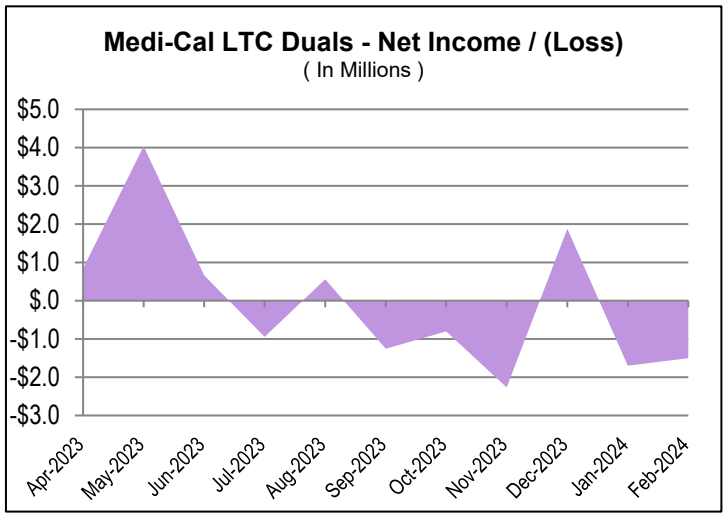


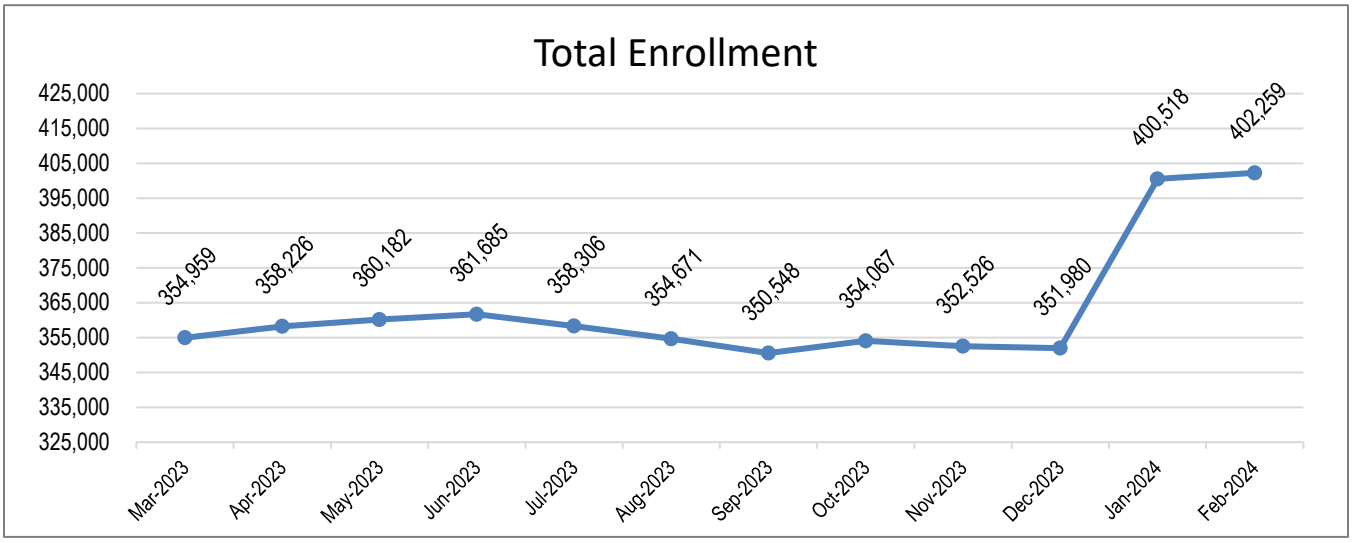
Enrollment and Profitability by Program and Category of Aid

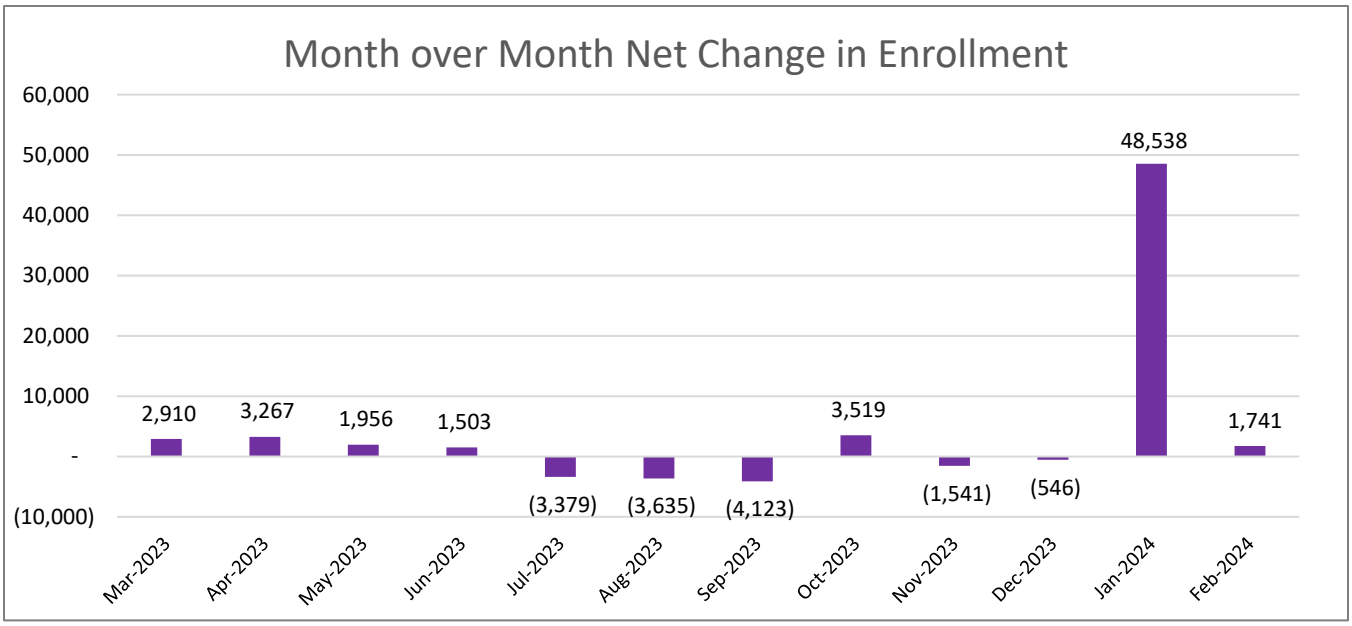










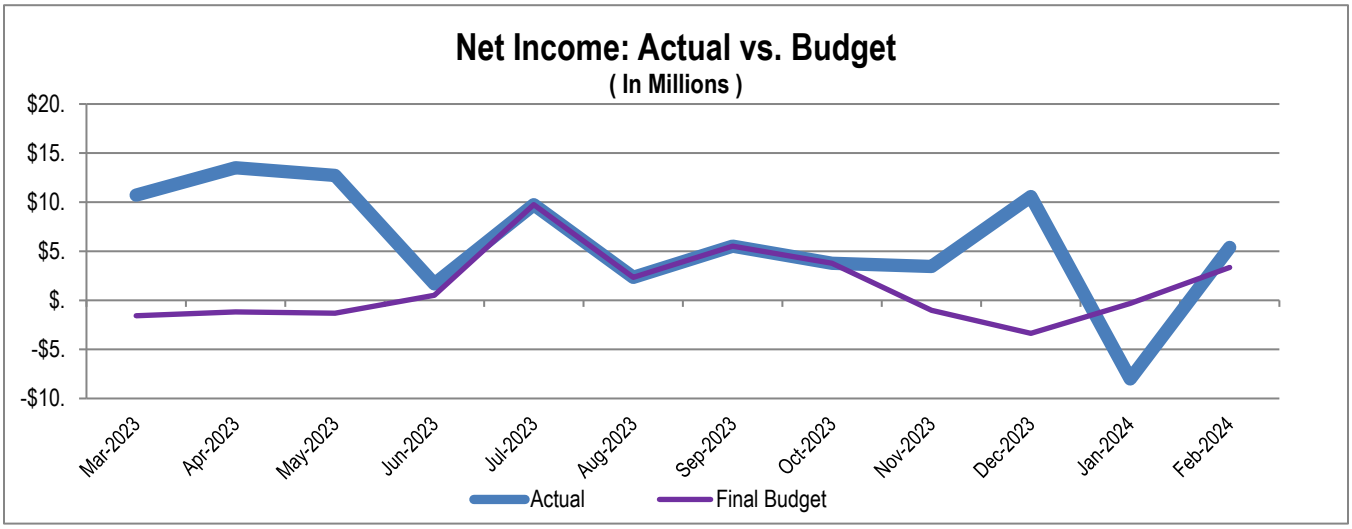


- The Public Health Emergency (PHE) ended May 2023. Disenrollments related to redetermination started July 2023 and will continue through May 2024. In preparation for the Single Plan Model, effective October 2023 DHCS no longer assigned members to Anthem, and instead new members were assigned to the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

Net Income

- For the month ended February 29th, 2024:
  - Actual Net Income $5.4 million.
  - Budgeted Net Income $3.4 million.

- For the fiscal YTD ended February 29th, 2024:
  - Actual Net Income $32.8 million.
  - Budgeted Net Income $20.0 million.

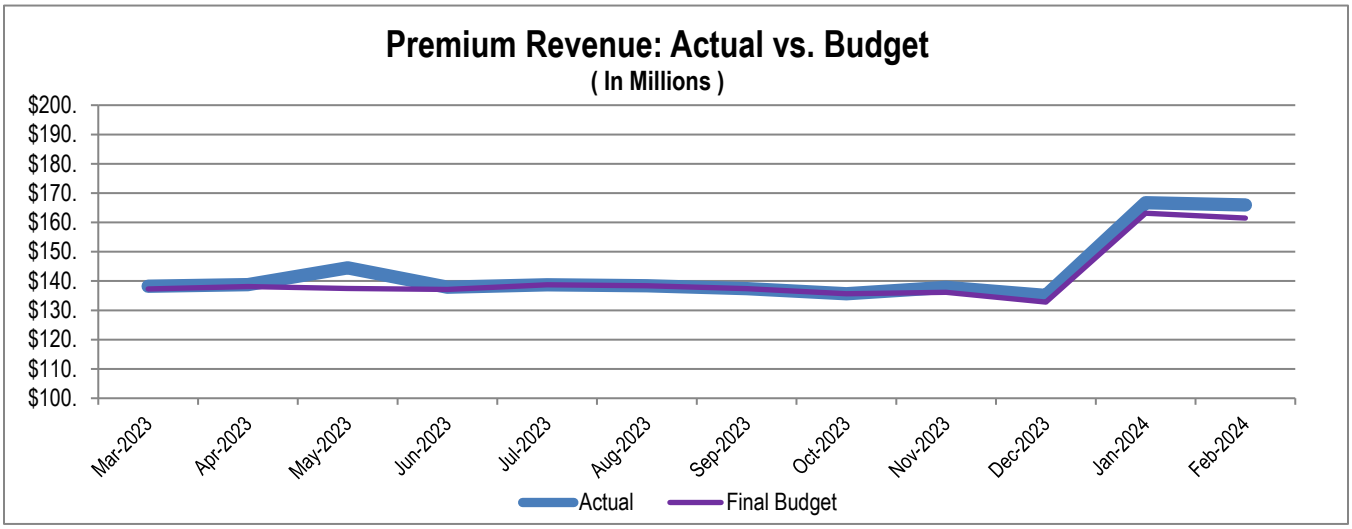


- The favorable variance of $2.0 million in the current month is primarily due to:
  - Favorable $4.4 million higher than anticipated Premium Revenue.
  - Unfavorable $500,000 higher than anticipated Medical Expense.
  - Favorable $2.1 million lower than anticipated Administrative Expense.
  - Unfavorable $1.2 million higher than anticipated Other Income/Expense.
  - Unfavorable $2.7 million higher than anticipated net MCO Tax.

Premium Revenue

- For the month ended February 29th, 2024:
  - Actual Revenue: $165.9 million.
  - Budgeted Revenue: $161.5 million.

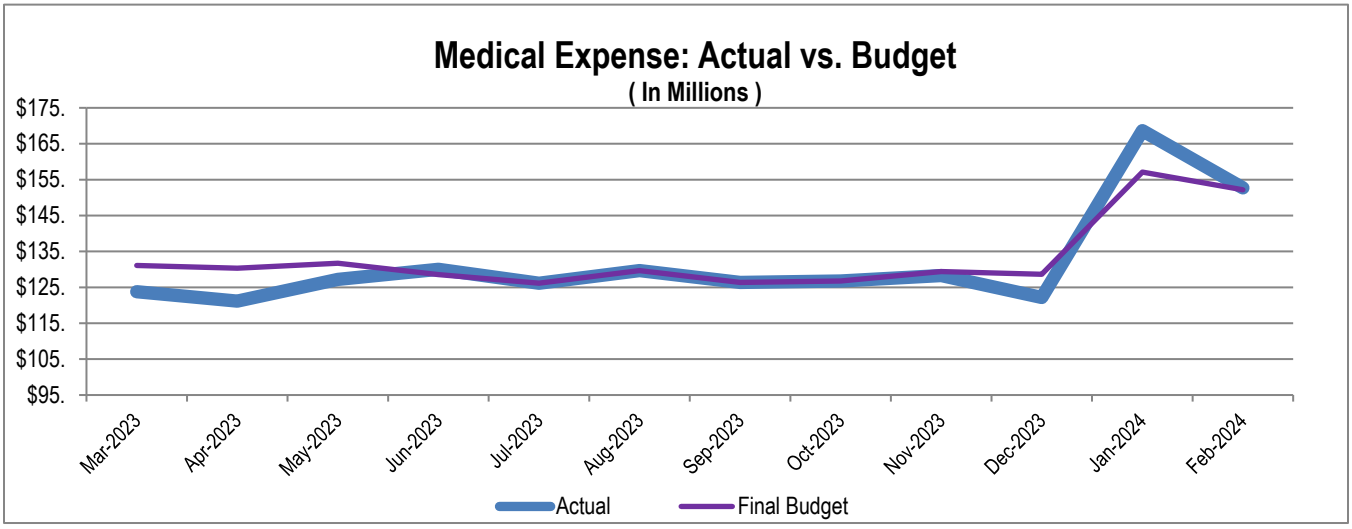
- For the fiscal YTD ended February 29th, 2024:
  - Actual Revenue: $1.2 billion.
  - Budgeted Revenue: $1.1 billion.



- For the month ended February 29th, 2024, the favorable Premium Revenue variance of $4.4 million is primarily due to the following:
    - Favorable Capitation Rate variance. Rates were not available at time of budget and the magnitude of new Targeted Rate Increase (TRI) revenue and expense was unknown and therefore not budgeted.
    - Unfavorable Medi-Cal enrollment volume variance for February 2024.
    - The 2022 Acuity Adjustment reserve was released, making an unfavorable impact on capitation revenue.

Medical Expense

- For the month ended February 29th, 2024:
    - Actual Medical Expense: $152.7 million.
    - Budgeted Medical Expense: $152.2 million.
- For the fiscal YTD ended February 29th, 2024:
    - Actual Medical Expense: $1.1 billion.
    - Budgeted Medical Expense: $1.1 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 our actuarial consultants.

- For February, updates to Fee-For-Service (FFS) decreased the estimate for prior period unpaid Medical Expenses by $1.5 million. Year to date, the estimate for prior years increased by $7.4 million (per table below).

Medical Expense - Actual vs. Budget (In Dollars)

Adjusted to Eliminate the Impact of Prior Period IBNP Estimates

	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$192,290,515	$0	$192,290,515	$187,788,967	($4,501,548)	-2.4%
Primary Care FFS	$45,392,574	$7,377	$45,399,951	$46,831,601	$1,439,027	3.1%
Specialty Care FFS	$44,444,363	$39,849	$44,484,212	$46,374,828	$1,930,465	4.2%
Outpatient FFS	$67,657,659	$304,806	$67,962,465	$72,780,085	$5,122,426	7.0%
Ancillary FFS	$91,863,440	$702,037	$92,565,477	$93,445,104	$1,581,664	1.7%
Pharmacy FFS	$71,581,543	$411,310	$71,992,854	$76,294,466	$4,712,923	6.2%
ER Services FFS	$53,084,011	$657	$53,084,668	$49,611,799	($3,472,212)	-7.0%
Inpatient Hospital & SNF FFS	$289,023,929	$4,637,257	$293,661,186	$295,684,153	$6,660,224	2.3%
Long Term Care FFS	$179,907,428	$1,256,538	$181,163,966	$162,963,361	($16,944,067)	-10.4%
Other Benefits & Services	$35,798,913	$0	$35,798,913	$39,860,036	$4,061,123	10.2%
Net Reinsurance	($641,212)	$0	($641,212)	$1,602,307	$2,243,519	140.0%
Provider Incentive	$3,000,000	$0	$3,000,000	$3,000,000	$0	0.0%
	$1,073,403,162	**$7,359,830**	**$1,080,762,992**	**$1,076,236,707**	**$2,833,545**	**0.3%**

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

Adjusted to Eliminate the Impact of Prior Year IBNP Estimates

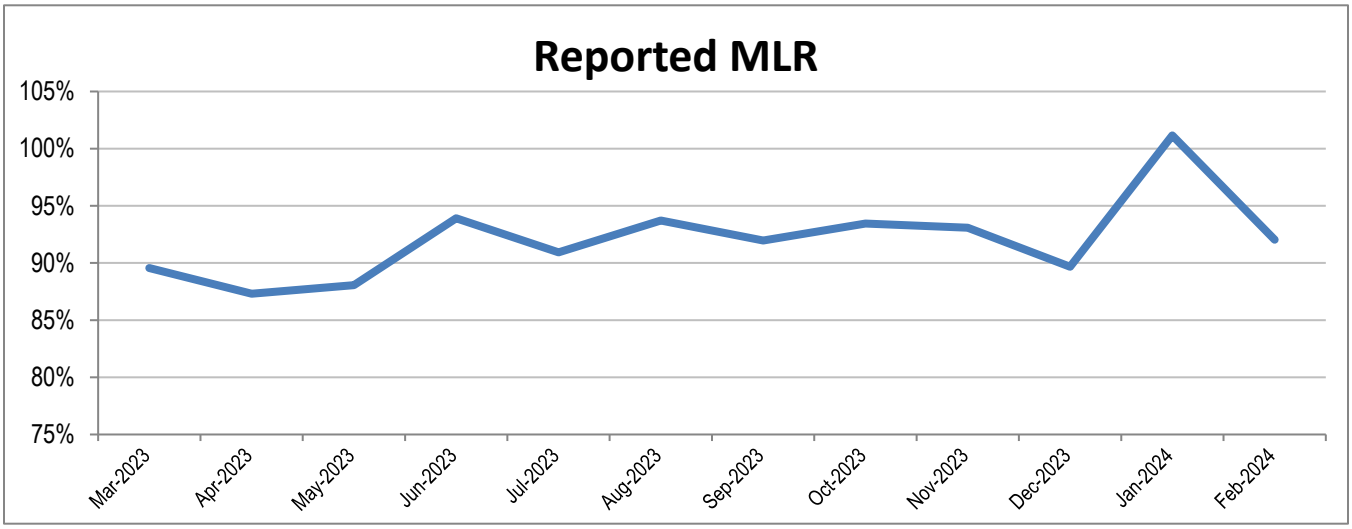
	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$65.74	$0.00	$65.74	$64.27	($1.48)	-2.3%
Primary Care FFS	$15.52	$0.00	$15.52	$16.03	$0.51	3.2%
Specialty Care FFS	$15.20	$0.01	$15.21	$15.87	$0.68	4.3%
Outpatient FFS	$23.13	$0.10	$23.24	$24.91	$1.78	7.1%
Ancillary FFS	$31.41	$0.24	$31.65	$31.98	$0.57	1.8%
Pharmacy FFS	$24.47	$0.14	$24.61	$26.11	$1.64	6.3%
ER Services FFS	$18.15	$0.00	$18.15	$16.98	($1.17)	-6.9%
Inpatient Hospital & SNF FFS	$98.82	$1.59	$100.40	$101.19	$2.37	2.3%
Long Term Care FFS	$61.51	$0.43	$61.94	$55.77	($5.74)	-10.3%
Other Benefits & Services	$12.24	$0.00	$12.24	$13.64	$1.40	10.3%
Net Reinsurance	($0.22)	$0.00	($0.22)	$0.55	$0.77	140.0%
Provider Incentive	$1.03	$0.00	$1.03	$1.03	$0.00	0.1%
	$366.99	**$2.52**	**$369.51**	**$368.32**	**$1.33**	**0.4%**

- Excluding the impact of prior year estimates for IBNP, year-to-date medical expense variance is $2.8 million favorable to budget. On a PMPM basis, medical expense is 0.4% favorable to budget. For per-member-per-month expense:
    - Capitated Expense is slightly over budget, largely driven by unfavorable PCP Capitation expense due to accruals for the implementation of the Provider Targeted Rate Increases (TRI), partially offset by favorable FQHC expense.

- Primary Care Expense is slightly under budget driven mostly by the lower ACA OE utilization.
- Specialty Care Expense is below budget, driven mostly by lower SPD utilization.
- Outpatient Expense is under budget due to lower facility other and dialysis utilization across most populations.
- Ancillary Expense is under budget mostly due to lower utilization in the Child Category of Aid (COA).
- Pharmacy Expense is under budget mostly due to lower Non-PBM expense driven by lower utilization in the SPD and ACA OE COAs.
- Emergency Room Expense is over budget driven mostly by higher utilization in the ACA OE, Adult and Child COAs.
- Inpatient Expense is under budget mostly driven by lower utilization and unit cost in the SPD and Adult populations.
- Long Term Care Expense is over budget mostly due to higher utilization and unit cost in the SPD, ACA OE and Duals COAs.
- Other Benefits & Services is under budget, due to favorable community relations, other purchased, professional and interpreter services.
- Net Reinsurance year-to-date is under budget because more recoveries were received than expected.

Medical Loss Ratio (MLR)

The Medical Loss Ratio (total reported medical expense divided by Premium revenue) was 92.0% for the month and 93.4% for the fiscal year-to-date.



Administrative Expense

- For the month ended February 29th, 2024:
  - Actual Administrative Expense: $6.4 million.
  - Budgeted Administrative Expense: $8.4 million.

- For the fiscal YTD ended February 29th, 2024:
  - Actual Administrative Expense: $59.4 million.
  - Budgeted Administrative Expense: $67.3 million.

Summary of Administrative Expense (In Dollars) **For the Month and Fiscal Year-to-Date** **Favorable/(Unfavorable)**								
Current Month					**Year-to-Date**			
Actual	**Budget**	**Variance $**	**Variance %**		**Actual**	**Budget**	**Variance $**	**Variance %**
$5,151,309	$5,296,152	$144,843	2.7%	Employee Expense	$39,372,380	$42,702,412	$3,330,032	7.8%
61,464	73,556	12,092	16.4%	Medical Benefits Admin Expense	1,315,191	1,323,637	8,446	0.6%
671,787	778,327	106,540	13.7%	Purchased & Professional Services	7,679,800	8,821,203	1,141,403	12.9%
466,194	2,286,977	1,820,783	79.6%	Other Admin Expense	11,014,205	14,420,483	3,406,279	23.6%
$6,350,754	$8,435,012	$2,084,259	24.7%	Total Administrative Expense	$59,381,576	$67,267,736	$7,886,160	11.7%

The year-to-date variances include:

- Favorable impact of delayed timing of start dates for Consulting for new projects and Computer Support Services.
- Favorable Employee and Temporary Services variances and delayed Training, Travel, Recruitment, and other employee-related expenses.

The Administrative Loss Ratio (ALR) is 3.8% of net revenue for the month and 5.1% of net revenue year-to-date.

Other Income / (Expense)

Other Income & Expense is comprised of investment income and claims interest.

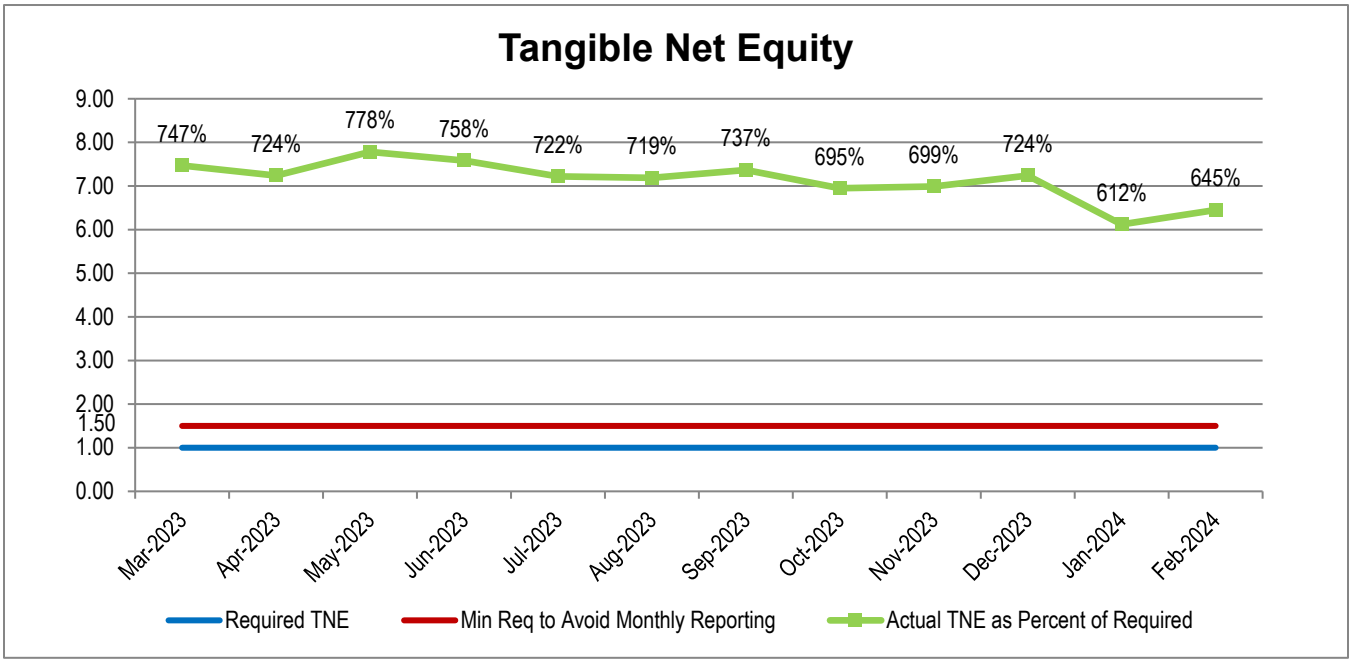
- Fiscal year-to-date net investments show a gain of $20.4 million.
- Fiscal year-to-date claims interest expense, due to delayed payment of certain claims, or recalculated interest on previously paid claims is $493,000.

Managed Care Organization (MCO) Provider Tax

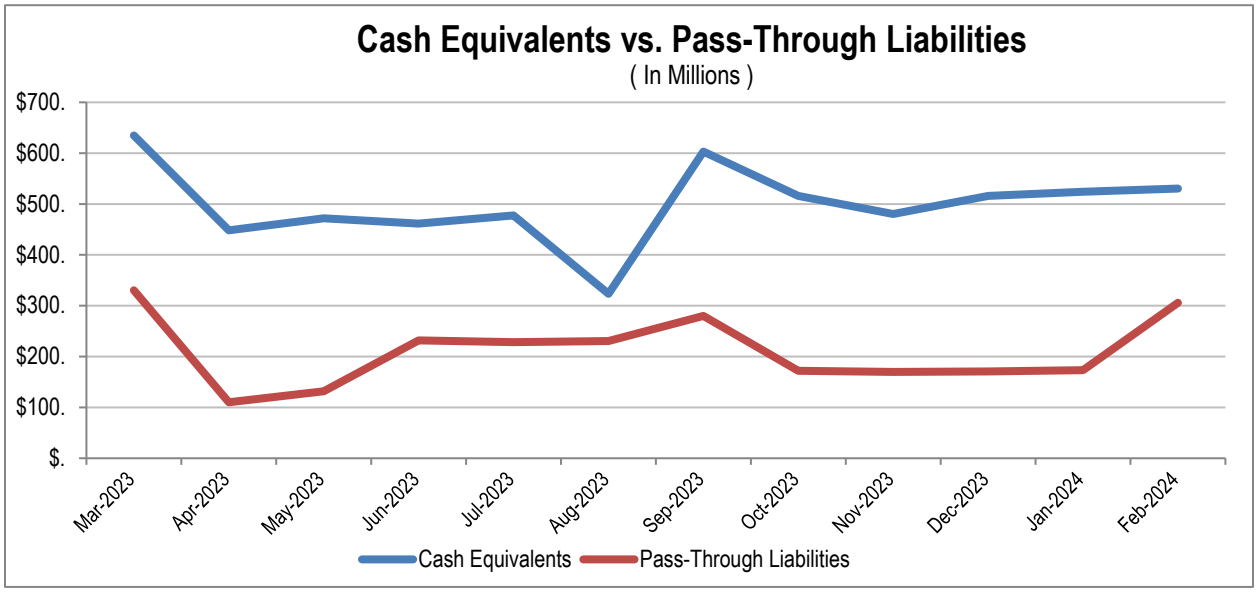
- For the month ended February 29th, 2024:
  - $159.8 million unbudgeted MCO Tax Revenue.
  - $162.5 million unbudgeted MCO Tax Expense.

Tangible Net Equity (TNE)

- The Department of Managed Health Care (DMHC) monitors the financial stability of health plans to ensure that they can meet their financial obligations to providers. TNE is a calculation of a company's total tangible assets minus a percentage of fee-for-service medical expenses. The Alliance exceeds DMHC's required TNE.
    - Required TNE $55.3 million
    - Actual TNE $356.7 million
    - Excess TNE $301.4 million
    - TNE % of Required TNE 645%



- To ensure appropriate liquidity and limit risk, the majority of Alliance financial assets are kept in short-term investments.
- Key Metrics
    - Cash & Cash Equivalents $530.5 million
    - Pass-Through Liabilities $305.4 million
    - Uncommitted Cash $225.1 million
    - Working Capital $343.8 million
    - Current Ratio 1.56 (regulatory minimum is 1.00)



Capital Investment

- Fiscal year-to-date capital assets acquired: $1.2 million.
- Annual capital budget: $1.6 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.

ALAMEDA ALLIANCE FOR HEALTH
STATEMENT OF REVENUE & EXPENSES
ACTUAL VS. BUDGET
COMBINED BASIS (RESTRICTED & UNRESTRICTED FUNDS)
FOR THE MONTH AND FISCAL YTD ENDED FEBRUARY 29, 2024

CURRENT MONTH					FISCAL YEAR TO DATE			
		$ Variance	% Variance				$ Variance	% Variance
Actual	Budget	(Unfavorable)	(Unfavorable)	Account Description	Actual	Budget	(Unfavorable)	(Unfavorable)
				MEMBERSHIP				
396,651	394,453	2,198	0.6%	1. Medi-Cal	2,879,907	2,877,216	2,691	0.1%
5,608	5,549	59	1.1%	2. GroupCare	44,968	44,830	138	0.3%
402,259	**400,002**	**2,257**	**0.6%**	**3. TOTAL MEMBER MONTHS**	**2,924,875**	**2,922,046**	**2,829**	**0.1%**
				REVENUE				
165,930,573	161,497,794	4,432,779	2.7%	4. Premium Revenue	1,155,690,969	1,143,742,754	11,948,215	1.0%
159,844,656	0	159,844,656	0.0%	5. MCO Tax Revenue AB119	159,844,656	0	159,844,656	0.0%
$325,775,228	**$161,497,794**	**$164,277,434**	**101.7%**	**6. TOTAL REVENUE**	**$1,315,535,625**	**$1,143,742,754**	**$171,792,871**	**15.0%**
				MEDICAL EXPENSES				
				Capitated Medical Expenses:				
$19,372,805	$16,217,251	($3,155,554)	(19.5%)	7. Capitated Medical Expense	$192,290,515	$187,788,967	($4,501,548)	(2.4%)
				Fee for Service Medical Expenses:				
$44,890,142	$47,546,027	$2,655,884	5.6%	8. Inpatient Hospital Expense	$293,661,186	$295,684,153	$2,022,967	0.7%
$5,403,501	$6,663,993	$1,260,492	18.9%	9. Primary Care Physician Expense	$45,399,951	$46,831,601	$1,431,650	3.1%
$6,553,051	$7,526,161	$973,110	12.9%	10. Specialty Care Physician Expense	$44,484,212	$46,374,828	$1,890,616	4.1%
$14,205,948	$13,969,187	($236,761)	(1.7%)	11. Ancillary Medical Expense	$92,565,477	$93,445,104	$879,628	0.9%
$8,777,527	$12,074,755	$3,297,228	27.3%	12. Outpatient Medical Expense	$67,962,465	$72,780,085	$4,817,621	6.6%
$10,350,184	$7,555,585	($2,794,599)	(37.0%)	13. Emergency Expense	$53,084,668	$49,611,799	($3,472,869)	(7.0%)
$10,371,169	$12,130,467	$1,759,298	14.5%	14. Pharmacy Expense	$71,992,854	$76,294,466	$4,301,613	5.6%
$28,735,481	$23,533,464	($5,202,018)	(22.1%)	15. Long Term Care Expense	$181,163,966	$162,963,361	($18,200,605)	(11.2%)
$129,287,004	$130,999,639	$1,712,635	1.3%	16. Total Fee for Service Expense	$850,314,777	$843,985,397	($6,329,380)	(0.7%)
$4,025,667	$4,580,566	$554,899	12.1%	17. Other Benefits & Services	$35,798,913	$39,860,036	$4,061,124	10.2%
$23,762	$364,736	$340,974	93.5%	18. Reinsurance Expense	($641,212)	$1,602,307	$2,243,519	140.0%
$0	$0	$0	0.0%	19. Risk Pool Distribution	$3,000,000	$3,000,000	$0	(0.0%)
$152,709,238	**$152,162,192**	**($547,046)**	**(0.4%)**	**20. TOTAL MEDICAL EXPENSES**	**$1,080,762,992**	**$1,076,236,707**	**($4,526,285)**	**(0.4%)**
$173,065,990	**$9,335,602**	**$163,730,388**	**1,753.8%**	**21. GROSS MARGIN**	**$234,772,632**	**$67,506,047**	**$167,266,586**	**247.8%**
				ADMINISTRATIVE EXPENSES				
$5,151,309	$5,296,152	$144,843	2.7%	22. Personnel Expense	$39,372,380	$42,702,414	$3,330,034	7.8%
$61,464	$73,556	$12,092	16.4%	23. Benefits Administration Expense	$1,315,191	$1,323,637	$8,446	0.6%
$671,787	$778,327	$106,540	13.7%	24. Purchased & Professional Services	$7,679,800	$8,821,203	$1,141,403	12.9%
$466,194	$2,286,977	$1,820,783	79.6%	25. Other Administrative Expense	$11,014,205	$14,420,483	$3,406,279	23.6%
$6,350,754	**$8,435,012**	**$2,084,259**	**24.7%**	**26. TOTAL ADMINISTRATIVE EXPENSES**	**$59,381,576**	**$67,267,738**	**$7,886,162**	**11.7%**
$162,536,656	**$0**	**($162,536,656)**	**0.0%**	**27. MCO TAX EXPENSES**	**$162,536,656**	**$0**	**($162,536,656)**	**0.0%**
$4,178,581	**$900,590**	**$3,277,991**	**364.0%**	**28. NET OPERATING INCOME / (LOSS)**	**$12,854,401**	**$238,309**	**$12,616,092**	**5,294.0%**
				OTHER INCOME / EXPENSES				
$1,213,540	**$2,450,000**	**($1,236,460)**	**(50.5%)**	**29. TOTAL OTHER INCOME / (EXPENSES)**	**$19,914,566**	**$19,788,842**	**$125,723**	**0.6%**
$5,392,121	**$3,350,590**	**$2,041,531**	**60.9%**	**30. NET SURPLUS (DEFICIT)**	**$32,768,967**	**$20,027,151**	**$12,741,816**	**63.6%**
92.0%	94.2%	2.2%	2.3%	**31.** Medical Loss Ratio	93.5%	94.1%	0.6%	0.6%
3.8%	5.2%	1.4%	26.9%	**32.** Administrative Expense Ratio	5.1%	5.9%	0.8%	13.6%
1.7%	2.1%	0.4%	19.0%	**33.** Net Surplus (Deficit) Ratio	2.5%	1.8%	0.7%	38.9%

ALAMEDA ALLIANCE FOR HEALTH
BALANCE SHEETS
CURRENT MONTH VS. PRIOR MONTH
FOR THE MONTH AND FISCAL YTD ENDED FEBRUARY 29, 2024

	2/28/2024	1/31/2024	Difference	% Difference
CURRENT ASSETS:				
Cash & Equivalents				
Cash	$163,524,058	$71,248,415	$92,275,643	129.51%
Short-Term Investments	366,969,217	452,825,898	(85,856,681)	-18.96%
Interest Receivable	2,571,146	3,372,472	(801,326)	-23.76%
Premium Receivables	403,732,995	264,648,167	139,084,828	52.55%
Reinsurance Receivables	6,023,597	5,192,459	831,138	16.01%
Other Receivables	781,572	699,148	82,424	11.79%
Prepaid Expenses	2,503,896	2,505,779	(1,883)	-0.08%
CalPERS Net Pension Assets	(5,286,448)	(5,286,448)	0	0.00%
Deferred Outflow	14,099,056	14,099,056	0	0.00%
TOTAL CURRENT ASSETS	**$954,919,089**	**$809,304,945**	**$145,614,144**	**17.99%**
OTHER ASSETS:				
Long-Term Investments	2,327,040	4,748,952	(2,421,912)	-51.00%
Restricted Assets	350,000	350,000	0	0.00%
GASB 87-Lease Assets (Net)	1,070,577	1,136,490	(65,913)	-5.80%
GASB 96-SBITA Assets (Net)	4,623,846	4,412,698	211,148	4.79%
TOTAL OTHER ASSETS	**$8,371,463**	**$10,648,141**	**($2,276,677)**	**-21.38%**
PROPERTY AND EQUIPMENT:				
Land, Building & Improvements	10,167,264	10,167,264	0	0.00%
Furniture And Equipment	12,962,138	12,962,138	0	0.00%
Leasehold Improvement	902,447	902,447	0	0.00%
Internally Developed Software	14,824,002	14,824,002	0	0.00%
Fixed Assets at Cost	$38,855,851	$38,855,851	$0	0.00%
Less: Accumulated Depreciation	($32,964,648)	($32,906,443)	($58,205)	0.18%
NET PROPERTY AND EQUIPMENT	**$5,891,203**	**$5,949,408**	**($58,205)**	**-0.98%**
TOTAL ASSETS	**$969,181,755**	**$825,902,494**	**$143,279,261**	**17.35%**
CURRENT LIABILITIES:				
Accounts Payable	3,796,710	4,105,836	(309,126)	-7.53%
Other Accrued Liabilities	29,660,135	17,577,983	12,082,152	68.73%
GASB 87 ST Lease Liabilities	913,444	831,119	82,326	9.91%
GASB 96 ST SBITA Liabilities	2,445,307	2,226,765	218,542	9.81%
Claims Payable	34,919,508	54,961,645	(20,042,137)	-36.47%
IBNP Reserves	214,216,150	200,914,934	13,301,216	6.62%
Pass-Through Liabilities	305,400,471	173,306,815	132,093,656	76.22%
Risk Sharing - Providers	6,629,337	6,629,337	0	0.00%
Payroll Liabilities	8,167,535	7,711,460	456,075	5.91%
Deferred Inflow	5,004,985	5,004,985	0	0.00%
TOTAL CURRENT LIABILITIES	**$611,153,582**	**$473,270,877**	**$137,882,705**	**29.13%**
LONG TERM LIABILITIES:				
GASB 87 LT Lease Liabilities	318,596	396,771	(78,175)	-19.70%
GASB 96 LT SBITA Liabilities	983,568	900,958	82,610	9.17%
TOTAL LONG TERM LIABILITIES	**$1,302,165**	**$1,297,729**	**$4,436**	**0.34%**
TOTAL LIABILITIES	**$612,455,747**	**$474,568,606**	**$137,887,140**	**29.06%**
NET WORTH:				
Contributed Capital	840,233	840,233	0	0.00%
Restricted & Unrestricted Funds	323,116,808	323,116,808	0	0.00%
Year-to Date Net Income / (Loss)	32,768,967	27,376,846	5,392,121	19.70%
TOTAL NET WORTH	**$356,726,008**	**$351,333,888**	**$5,392,121**	**1.53%**
TOTAL LIABILITIES AND NET WORTH	**$969,181,755**	**$825,902,494**	**$143,279,261**	**17.35%**
Cash Equivalents	$530,493,275	$524,074,312	$6,418,962	1.22%
Pass-Through	$305,400,471	$173,306,815	$132,093,656	76.22%
Uncommitted Cash	$225,092,804	$350,767,498	($125,674,694)	-35.83%
Working Capital	$343,765,507	$336,034,068	$7,731,439	2.30%
Current Ratio	156.2%	171.0%	-14.8%	-8.7%

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 2/29/2024

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM OPERATING ACTIVITIES				
Commercial Premium Cash Flows				
Commercial Premium Revenue	$2,563,231	$7,698,382	$15,387,161	$20,560,261
GroupCare Receivable	(3,658)	48,009	38,404	(2,540,830)
Total	2,559,573	7,746,391	15,425,565	18,019,431
Medi-Cal Premium Cash Flows				
Medi-Cal Revenue	323,211,997	619,865,482	1,023,053,778	1,294,975,366
Premium Receivable	(139,081,170)	(157,482,343)	24,278,792	(104,829,744)
Total	184,130,827	462,383,139	1,047,332,570	1,190,145,622
Investment & Other Income Cash Flows				
Other Revenues	(502,768)	444,638	1,523,034	1,978,770
Interest Income	1,849,239	8,038,500	13,936,468	18,582,860
Interest Receivable	801,326	(1,629,762)	(2,025,472)	(1,856,570)
Total	2,147,797	6,853,376	13,434,030	18,705,060
Medical & Hospital Cash Flows				
Total Medical Expenses	(152,709,239)	(443,525,155)	(824,948,621)	(1,080,762,986)
Other Health Care Receivables	(912,972)	(2,868,185)	(3,284,151)	(2,967,054)
Capitation Payable	-	-	-	(7,387,555)
IBNP Payable	13,301,217	50,743,728	62,876,304	49,711,748
Other Medical Payable	75,389,842	112,099,339	53,854,038	54,936,560
Risk Share Payable	-	-	3,001,000	1,022,154
New Health Program Payable	-	-	11,640	-
Total	(64,931,152)	(283,550,273)	(708,489,790)	(985,447,133)
Administrative Cash Flows				
Total Administrative Expenses	(6,483,683)	(22,038,361)	(45,736,591)	(60,028,637)
Prepaid Expenses	(3,878)	1,594,879	2,720,625	2,372,771
Other Receivables	5,171	8,194	94,569	45,001
CalPERS Pension	-	-	-	-
Trade Accounts Payable	(1,546,319)	(3,800,095)	(723,098)	(794,496)
Payroll Liabilities	456,075	(388,203)	1,129,888	2,237,648
GASB Assets and Liabilities	160,067	(371,045)	(558,472)	(528,572)
Depreciation Expense	58,205	198,385	375,327	487,523
Total	(7,354,362)	(24,796,246)	(42,697,752)	(56,208,762)
MCO Tax AB119 Cash Flows				
MCO Tax Expense AB119	(162,536,656)	(162,536,656)	(162,536,656)	(162,536,656)
MCO Tax Liabilities	49,981,021	39,135,492	38,357,569	38,357,569
Total	(112,555,635)	(123,401,164)	(124,179,087)	(124,179,087)
Net Cash Flows from Operating Activities	**3,997,048**	**45,235,223**	**200,825,536**	**61,035,131**

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 2/29/2024

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM INVESTING ACTIVITIES				
Investment Cash Flows				
Long Term Investments	2,421,912	4,770,967	6,992,225	9,233,497
Total	2,421,912	4,770,967	6,992,225	9,233,497
Restricted Cash & Other Asset Cash Flows				
Restricted Assets-Treasury Account	-	-	-	-
Total	-	-	-	-
Fixed Asset Cash Flows				
Fixed Asset Acquisitions	-	(10,578)	(727,265)	(1,160,755)
Purchases of Property and Equipment	-	(10,578)	(727,265)	(1,160,755)
Net Cash Flows from Investing Activities	**2,421,912**	**4,760,389**	**6,264,960**	**8,072,742**
Net Change in Cash	**6,418,960**	**49,995,612**	**207,090,496**	**69,107,873**
Rounding	2	(1)	-	(12)
Cash @ Beginning of Period	524,074,314	480,497,665	323,402,780	461,385,415
Cash @ End of Period	**$530,493,276**	**$530,493,276**	**$530,493,276**	**$530,493,276**
Variance	-	-	-	-

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 2/29/2024

	MONTH	3 MONTHS	6 MONTHS	YTD
NET INCOME RECONCILIATION				
Net Income / (Loss)	$5,392,121	$7,946,829	$20,678,573	$32,768,978
Add back: Depreciation & Amortization	58,205	198,385	375,327	487,523
Receivables				
Premiums Receivable	(139,081,170)	(157,482,343)	24,278,792	(104,829,744)
Interest Receivable	801,326	(1,629,762)	(2,025,472)	(1,856,570)
Other Health Care Receivables	(912,972)	(2,868,185)	(3,284,151)	(2,967,054)
Other Receivables	5,171	8,194	94,569	45,001
GroupCare Receivable	(3,658)	48,009	38,404	(2,540,830)
Total	(139,191,303)	(161,924,087)	19,102,142	(112,149,197)
Prepaid Expenses	(3,878)	1,594,879	2,720,625	2,372,771
Trade Payables	(1,546,319)	(3,800,095)	(723,098)	(794,496)
Claims Payable and Shared Risk Pool				
IBNP Payable	13,301,217	50,743,728	62,876,304	49,711,748
Capitation Payable & Other Medical Payable	75,389,842	112,099,339	53,854,038	47,549,005
Risk Share Payable	-	-	3,001,000	1,022,154
Claims Payable				
Total	88,691,059	162,843,067	119,731,342	98,282,907
Other Liabilities				
CalPERS Pension	-	-	-	-
Payroll Liabilities	456,075	(388,203)	1,129,888	2,237,648
GASB Assets and Liabilities	160,067	(371,045)	(558,472)	(528,572)
New Health Program	-	-	11,640	-
MCO Tax Liabilities	49,981,021	39,135,492	38,357,569	38,357,569
Total	50,597,163	38,376,244	38,940,625	40,066,645
Rounding	-	1.00	-	-
Cash Flows from Operating Activities	**3,997,048**	**45,235,223**	**200,825,536**	**61,035,131**
Variance	-	-	-	-

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED 2/29/2024

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOW STATEMENT:				
Cash Flows from Operating Activities:				
Cash Received				
Capitation Received from State of CA	$184,130,827	$462,383,139	$1,047,332,570	$1,190,145,622
Medicare Revenue	$0	$0	$0	$0
GroupCare Premium Revenue	2,559,573	7,746,391	15,425,565	18,019,431
Other Income	(502,768)	444,638	1,523,034	1,978,770
Interest Income	2,650,565	6,408,738	11,910,996	16,726,290
Less Cash Paid				
Medical Expenses	(64,931,152)	(283,550,273)	(708,489,790)	(985,447,133)
Vendor & Employee Expenses	(7,354,362)	(24,796,246)	(42,697,752)	(56,208,762)
MCO Tax Expense AB119	(112,555,635)	(123,401,164)	(124,179,087)	(124,179,087)
Net Cash Flows from Operating Activities	**3,997,048**	**45,235,223**	**200,825,536**	**61,035,131**
Cash Flows from Investing Activities:				
Long Term Investments	2,421,912	4,770,967	6,992,225	9,233,497
Restricted Assets-Treasury Account	0	0	0	0
Purchases of Property and Equipment	0	(10,578)	(727,265)	(1,160,755)
Net Cash Flows from Investing Activities	**2,421,912**	**4,760,389**	**6,264,960**	**8,072,742**
Net Change in Cash	**6,418,960**	**49,995,612**	**207,090,496**	**69,107,873**
Rounding	2	(1)	-	(12)
Cash @ Beginning of Period	524,074,314	480,497,665	323,402,780	461,385,415
Cash @ End of Period	**$530,493,276**	**$530,493,276**	**$530,493,276**	**$530,493,276**
Variance	$0	-	-	-
RECONCILIATION OF NET INCOME TO NET CASH FLOW FROM OPERATING ACTIVITIES:				
Net Income / (Loss)	$5,392,121	$7,946,829	$20,678,573	$32,768,978
Add Back: Depreciation	58,205	198,385	375,327	487,523
Net Change in Operating Assets & Liabilities				
Premium & Other Receivables	(139,191,303)	(161,924,087)	19,102,142	(112,149,197)
Prepaid Expenses	(3,878)	1,594,879	2,720,625	2,372,771
Trade Payables	(1,546,319)	(3,800,095)	(723,098)	(794,496)
Claims Payable, IBNP and Risk Sharing	88,691,059	162,843,067	119,731,342	98,282,907
Deferred Revenue	0	0	0	0
Other Liabilities	50,597,163	38,376,244	38,940,625	40,066,645
Total	3,997,048	45,235,222	200,825,536	61,035,131
Rounding	-	1	-	-
Cash Flows from Operating Activities	**$3,997,048**	**$45,235,223**	**$200,825,536**	**$61,035,131**
Variance	$0	-	-	-

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE MONTH OF FEBRUARY 2024

	Medi-Cal Child	Medi-Cal Adult	Medi-Cal SPD	Medi-Cal ACA OE	Medi-Cal Duals	Medi-Cal LTC	Medi-Cal LTC Duals	Medi-Cal Total	Group Care	Medicare	Grand Total
Enrollments/Member Months	109,953	63,117	34,875	146,757	40,403	217	1,329	396,651	5,608	-	402,259
Revenue	$59,913,327	$48,872,320	$56,216,933	$112,550,932	$30,912,655	$2,382,789	$12,363,040	$323,211,997	$2,563,231	$0	$325,775,228
Medical Expense	13,330,247	22,561,284	36,441,855	51,771,146	12,741,066	2,604,508	12,987,333	152,437,438	271,800	-	$152,709,238
Gross Margin	$46,583,080	$26,311,036	$19,775,078	$60,779,786	$18,171,589	($221,719)	($624,293)	$170,774,559	$2,291,432	$0	$173,065,990
Administrative Expense	$324,882	$727,244	$2,031,073	$2,078,199	$534,644	$94,940	$452,651	$6,243,633	$107,121	$0	$6,350,754
MCO Tax Expense	$46,057,074	$25,179,453	$14,360,023	$58,656,197	$17,695,984	$79,302	$508,622	$162,536,656	$0	$0	$162,536,656
Operating Income / (Expense)	$201,124	$404,340	$3,383,982	$45,390	($59,039)	($395,960)	($1,585,566)	$1,994,270	$2,184,311	$0	$4,178,581
Other Income / (Expense)	$60,557	$142,852	$403,062	$379,687	$105,775	$19,604	$85,425	$1,196,962	$16,577	$0	$1,213,540
Net Income / (Loss)	$261,681	$547,191	$3,787,044	$425,077	$46,736	($376,356)	($1,500,140)	$3,191,232	$2,200,888	$0	$5,392,121
PMPM Metrics:											
Revenue PMPM	$544.90	$774.31	$1,611.96	$766.92	$765.11	$10,980.60	$9,302.51	$814.85	$457.07	$0.00	$809.86
Medical Expense PMPM	$121.24	$357.45	$1,044.93	$352.77	$315.35	$12,002.34	$9,772.26	$384.31	$48.47	$0.00	$379.63
Gross Margin PMPM	$423.66	$416.86	$567.03	$414.15	$449.76	($1,021.74)	($469.75)	$430.54	$408.60	$0.00	$430.24
Administrative Expense PMPM	$2.95	$11.52	$58.24	$14.16	$13.23	$437.51	$340.59	$15.74	$19.10	$0.00	$15.79
MCO Tax Expense PMPM	$418.88	$398.93	$411.76	$399.68	$437.99	$365.45	$382.71	$409.77	$0.00	$0.00	$404.06
Operating Income / (Expense) PMPM	$1.83	$6.41	$97.03	$0.31	($1.46)	($1,824.70)	($1,193.05)	$5.03	$389.50	$0.00	$10.39
Other Income / (Expense) PMPM	$0.55	$2.26	$11.56	$2.59	$2.62	$90.34	$64.28	$3.02	$2.96	$0.00	$3.02
Net Income / (Loss) PMPM	$2.38	$8.67	$108.59	$2.90	$1.16	($1,734.36)	($1,128.77)	$8.05	$392.46	$0.00	$13.40
Ratio:											
Medical Loss Ratio	91.1%	93.6%	86.6%	94.4%	94.1%	113.0%	109.5%	93.3%	10.6%	0.0%	92.0%
Administrative Expense Ratio	2.2%	3.0%	4.8%	3.8%	3.9%	4.1%	3.8%	3.8%	4.2%	0.0%	3.8%
Net Income Ratio	0.4%	1.1%	6.7%	0.4%	0.2%	-15.8%	-12.1%	1.0%	85.9%	0.0%	1.7%

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE FISCAL YEAR TO DATE FEBRUARY 2024

	Medi-Cal Child	Medi-Cal Adult	Medi-Cal SPD	Medi-Cal ACA OE	Medi-Cal Duals	Medi-Cal LTC	Medi-Cal LTC Duals	Medi-Cal Total	Group Care	Medicare	Grand Total
Enrollments/Member Months	827,851	438,371	254,974	1,019,812	329,019	1,261	8,619	2,879,907	44,968	-	2,924,875
Revenue	$155,808,065	$173,419,000	$309,617,004	$446,457,693	$123,249,356	$13,352,490	$73,071,756	$1,294,975,364	$20,560,261	$0	$1,315,535,625
Medical Expense	90,767,598	139,521,047	273,748,093	367,311,695	102,157,768	14,477,747	76,027,822	1,064,011,769	16,751,223	-	$1,080,762,992
Gross Margin	$65,040,467	$33,897,952	$35,868,911	$79,145,998	$21,091,588	($1,125,257)	($2,956,066)	$230,963,595	$3,809,038	$0	$234,772,632
Administrative Expense	$3,662,553	$6,352,834	$18,809,255	$18,796,227	$5,570,678	$828,123	$3,942,097	$57,961,768	$1,197,758	$222,050	$59,381,576
MCO Tax Expense	$46,057,074	$25,179,453	$14,360,023	$58,656,197	$17,695,984	$79,302	$508,622	$162,536,656	$0	$0	$162,536,656
Operating Income / (Expense)	$15,320,840	$2,365,665	$2,699,633	$1,693,574	($2,175,074)	($2,032,682)	($7,406,786)	$10,465,171	$2,611,280	($222,050)	$12,854,401
Other Income / (Expense)	$1,133,895	$2,106,987	$6,478,230	$6,306,132	$1,882,334	$291,347	$1,375,371	$19,574,296	$340,269	$0	$19,914,566
Net Income / (Loss)	$16,454,735	$4,472,653	$9,177,863	$7,999,706	($292,740)	($1,741,334)	($6,031,414)	$30,039,467	$2,951,549	($222,050)	$32,768,967
PMPM Metrics:											
Revenue PMPM	$188.21	$395.60	$1,214.31	$437.78	$374.60	$10,588.81	$8,477.99	$449.66	$457.22	$0.00	$449.77
Medical Expense PMPM	$109.64	$318.27	$1,073.63	$360.18	$310.49	$11,481.16	$8,820.96	$369.46	$372.51	$0.00	$369.51
Gross Margin PMPM	$78.57	$77.33	$140.68	$77.61	$64.10	($892.35)	($342.97)	$80.20	$84.71	$0.00	$80.27
Administrative Expense PMPM	$4.42	$14.49	$73.77	$18.43	$16.93	$656.72	$457.37	$20.13	$26.64	$0.00	$20.30
MCO Tax Expense PMPM	$55.63	$57.44	$56.32	$57.52	$53.78	$62.89	$59.01	$56.44	$0.00	$0.00	$55.57
Operating Income / (Expense) PMPM	$18.51	$5.40	$10.59	$1.66	($6.61)	($1,611.96)	($859.36)	$3.63	$58.07	$0.00	$4.39
Other Income / (Expense) PMPM	$1.37	$4.81	$25.41	$6.18	$5.72	$231.04	$159.57	$6.80	$7.57	$0.00	$6.81
Net Income / (Loss) PMPM	$19.88	$10.20	$36.00	$7.84	($0.89)	($1,380.92)	($699.78)	$10.43	$65.64	$0.00	$11.20
Ratio:											
Medical Loss Ratio	82.1%	93.9%	92.6%	94.5%	96.5%	109.1%	104.8%	93.7%	81.5%	0.0%	93.5%
Administrative Expense Ratio	3.3%	4.3%	6.4%	4.8%	5.3%	6.2%	5.4%	5.1%	5.8%	0.0%	5.1%
Net Income Ratio	10.6%	2.6%	3.0%	1.8%	-0.2%	-13.0%	-8.3%	2.3%	14.4%	0.0%	2.5%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED FEBRUARY 29, 2024

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				ADMINISTRATIVE EXPENSE SUMMARY				
$5,151,309	$5,296,152	$144,843	2.7%	Personnel Expenses	$39,372,380	$42,702,414	$3,330,034	7.8%
61,464	73,556	12,092	16.4%	Benefits Administration Expense	1,315,191	1,323,637	8,446	0.6%
671,787	778,327	106,540	13.7%	Purchased & Professional Services	7,679,800	8,821,203	1,141,403	12.9%
367,168	501,017	133,849	26.7%	Occupancy	3,593,775	4,006,231	412,456	10.3%
(293,888)	1,019,328	1,313,216	128.8%	Printing Postage & Promotion	3,133,165	4,308,251	1,175,086	27.3%
384,489	752,740	368,252	48.9%	Licenses Insurance & Fees	4,104,729	5,906,051	1,801,322	30.5%
8,425	13,892	5,466	39.3%	Supplies & Other Expenses	182,535	199,950	17,415	8.7%
$1,199,445	$3,138,861	$1,939,416	61.8%	Total Other Administrative Expense	$20,009,196	$24,565,323	$4,556,128	18.5%
$6,350,754	$8,435,012	$2,084,259	24.7%	Total Administrative Expenses	$59,381,576	$67,267,738	$7,886,162	11.7%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED FEBRUARY 29, 2024

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				Personnel Expenses				
3,450,741	3,108,238	(342,502)	(11.0%)	Salaries & Wages	25,599,224	25,588,734	(10,490)	0.0%
336,029	338,310	2,281	0.7%	Paid Time Off	2,610,643	2,728,853	118,210	4.3%
905	4,600	3,695	80.3%	Compensated Incentives	14,918	1,929,797	1,914,879	99.2%
0	200,000	200,000	100.0%	Severance Pay	6,160	842,000	835,840	99.3%
48,494	62,739	14,245	22.7%	Payroll Taxes	513,613	522,167	8,554	1.6%
78,891	24,517	(54,375)	(221.8%)	Overtime	269,331	212,861	(56,470)	(26.5%)
303,187	263,086	(40,101)	(15.2%)	CalPERS ER Match	2,185,548	2,179,584	(5,964)	(0.3%)
854,827	977,089	122,262	12.5%	Employee Benefits	5,871,931	6,184,414	312,483	5.1%
9,218	0	(9,218)	0.0%	Personal Floating Holiday	180,094	169,701	(10,393)	(6.1%)
17,374	20,500	3,126	15.2%	Premium Bi/Multilingual Pay	96,442	86,000	(10,442)	(12.1%)
77	0	(77)	0.0%	Prizes	128	0	(128)	0.0%
3,470	0	(3,470)	0.0%	Med Ins Opted Out Stipend	7,250	0	(7,250)	0.0%
0	0	0	0.0%	Holiday Bonus	1,141,961	0	(1,141,961)	0.0%
24,670	0	(24,670)	0.0%	Sick Leave	27,081	0	(27,081)	0.0%
(6,556)	22,120	28,676	129.6%	Compensated Employee Relations	46,447	221,564	175,117	79.0%
17,680	22,600	4,920	21.8%	Work from Home Stipend	130,790	147,445	16,655	11.3%
1,391	4,927	3,536	71.8%	Mileage, Parking & LocalTravel	6,913	21,423	14,510	67.7%
1,294	16,782	15,488	92.3%	Travel & Lodging	79,621	161,617	81,996	50.7%
(10,660)	198,930	209,589	105.4%	Temporary Help Services	354,401	1,185,685	831,284	70.1%
14,267	30,683	16,416	53.5%	Staff Development/Training	149,128	332,639	183,511	55.2%
6,010	1,031	(4,979)	(482.8%)	Staff Recruitment/Advertising	80,757	187,930	107,172	57.0%
$5,151,309	**$5,296,152**	**$144,843**	**2.7%**	**Total Employee Expenses**	**$39,372,380**	**$42,702,414**	**$3,330,034**	**7.8%**
				Benefit Administration Expense				
9,303	21,556	12,253	56.8%	RX Administration Expense	159,243	167,580	8,337	5.0%
0	0	0	0.0%	Behavioral Hlth Administration Fees	817,710	817,710	0	0.0%
52,161	52,000	(161)	(0.3%)	Telemedicine Admin Fees	338,238	338,347	109	0.0%
$61,464	**$73,556**	**$12,092**	**16.4%**	**Total Benefit Administration Expenses**	**$1,315,191**	**$1,323,637**	**$8,446**	**0.6%**
				Purchased & Professional Services				
165,686	186,911	21,225	11.4%	Consultant Fees - Non Medical	1,897,939	2,828,199	930,261	32.9%
169,070	311,478	142,408	45.7%	Computer Support Services	2,714,995	2,892,080	177,085	6.1%
11,875	12,500	625	5.0%	Audit Fees	95,000	97,500	2,500	2.6%
0	33	33	100.0%	Consultant Fees - Medical	0	133	133	100.0%
151,552	(16,836)	(168,388)	1,000.2%	Other Purchased Services	1,230,990	719,123	(511,868)	(71.2%)
0	1,574	1,574	100.0%	Maint.& Repair-Office Equipment	10,176	8,952	(1,224)	(13.7%)
0	0	0	0.0%	Maint.&Repair-Computer Hardware	1,180	1,180	0	0.0%
80,000	119,086	39,086	32.8%	Medical Refund Recovery Fees	676,529	886,231	209,702	23.7%
49,662	0	(49,662)	0.0%	Software - IT Licenses & Subsc	186,880	0	(186,880)	0.0%
18,518	66,667	48,149	72.2%	Hardware (Non-Capital)	484,024	752,781	268,756	35.7%
2,604	44,565	41,961	94.2%	Provider Relations-Credentialing	212,315	292,759	80,444	27.5%
0	52,350	52,350	100.0%	Legal Fees	146,953	342,266	195,313	57.1%
22,819	0	(22,819)	0.0%	Interpretive Services	22,819	0	(22,819)	0.0%
$671,787	**$778,327**	**$106,540**	**13.7%**	**Total Purchased & Professional Services**	**$7,679,800**	**$8,821,203**	**$1,141,403**	**12.9%**
				Occupancy				
58,205	53,815	(4,391)	(8.2%)	Depreciation	487,523	446,653	(40,870)	(9.2%)
62,638	62,639	1	0.0%	Building Lease	501,108	498,950	(2,158)	(0.4%)

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED FEBRUARY 29, 2024

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
(4,707)	5,870	10,577	180.2%	Leased and Rented Office Equipment	18,219	55,899	37,680	67.4%
2,303	18,432	16,129	87.5%	Utilities	146,897	158,166	11,270	7.1%
3,135	86,510	83,375	96.4%	Telephone	553,850	658,461	104,611	15.9%
3,632	24,616	20,984	85.2%	Building Maintenance	200,934	251,295	50,361	20.0%
241,961	249,136	7,175	2.9%	SBITA Amortization Expense-GASB 96	1,685,243	1,936,806	251,563	13.0%
$367,168	**$501,017**	**$133,849**	**26.7%**	**Total Occupancy**	**$3,593,775**	**$4,006,231**	**$412,456**	**10.3%**
				Printing Postage & Promotion				
88,314	120,576	32,262	26.8%	Postage	386,448	657,388	270,941	41.2%
0	5,300	5,300	100.0%	Design & Layout	26,759	38,116	11,357	29.8%
139,825	152,312	12,486	8.2%	Printing Services	829,234	979,616	150,382	15.4%
0	6,910	6,910	100.0%	Mailing Services	71,807	77,861	6,054	7.8%
7,023	9,247	2,224	24.0%	Courier/Delivery Service	75,471	75,383	(88)	(0.1%)
0	0	0	0.0%	Pre-Printed Materials and Publications	1,038	500	(538)	(107.6%)
1,595	0	(1,595)	0.0%	Promotional Products	7,541	22,871	15,331	67.0%
(2,900)	150	3,050	2,033.3%	Promotional Services	(1,253)	5,050	6,303	124.8%
(947,911)	701,500	1,649,411	235.1%	Community Relations	1,143,342	2,240,139	1,096,797	49.0%
3,166	23,333	20,168	86.4%	Translation - Non-Clinical	175,779	211,326	35,547	16.8%
417,000	0	(417,000)	0.0%	Community Reinvestment Expense	417,000	0	(417,000)	0.0%
($293,888)	**$1,019,328**	**$1,313,216**	**128.8%**	**Total Printing Postage & Promotion**	**$3,133,165**	**$4,308,251**	**$1,175,086**	**27.3%**
				Licenses Insurance & Fees				
0	0	0	0.0%	Regulatory Penalties	80,000	500,000	420,000	84.0%
10,691	29,000	18,309	63.1%	Bank Fees	242,098	221,587	(20,511)	(9.3%)
83,393	89,100	5,707	6.4%	Insurance Premium	648,872	667,222	18,349	2.8%
258,357	471,423	213,066	45.2%	Licenses, Permits and Fees	2,096,816	3,062,118	965,301	31.5%
32,048	163,218	131,170	80.4%	Subscriptions and Dues - NonIT	1,036,943	1,455,125	418,182	28.7%
$384,489	**$752,740**	**$368,252**	**48.9%**	**Total Licenses Insurance & Postage**	**$4,104,729**	**$5,906,051**	**$1,801,322**	**30.5%**
				Supplies & Other Expenses				
3,643	4,559	916	20.1%	Office and Other Supplies	66,978	58,726	(8,253)	(14.1%)
0	2,000	2,000	100.0%	Furniture and Equipment	12,364	26,153	13,789	52.7%
948	1,200	252	21.0%	Ergonomic Supplies	38,001	18,525	(19,476)	(105.1%)
3,834	5,666	1,832	32.3%	Meals and Entertainment	37,841	56,782	18,940	33.4%
0	0	0	0.0%	Miscellaneous Expense	22,499	27,948	5,448	19.5%
0	0	0	0.0%	Member Incentive Expense	4,850	9,700	4,850	50.0%
0	100	100	100.0%	Covid-19 IT Expenses	0	400	400	100.0%
0	367	367	100.0%	Covid-19 Non IT Expenses	0	1,717	1,717	100.0%
$8,425	**$13,892**	**$5,466**	**39.3%**	**Total Supplies & Other Expense**	**$182,535**	**$199,950**	**$17,415**	**8.7%**
$6,350,754	**$8,435,012**	**$2,084,259**	**24.7%**	**TOTAL ADMINISTRATIVE EXPENSE**	**$59,381,576**	**$67,267,738**	**$7,886,162**	**11.7%**

ALAMEDA ALLIANCE FOR HEALTH
CAPITAL SPENDING INCLUDING CONSTRUCTION-IN-PROCESS
ACTUAL VS. BUDGET
FOR THE FISCAL YEAR-TO-DATE ENDED JUNE 30, 2024

		Project ID	Prior YTD Acquisitions	Current Month Acquisitions	Fiscal YTD Acquisitions	Capital Budget Total	$ Variance Fav/(Unf.)
1. Hardware:							
	Cisco Catalyst 9300 - Catalyst Switches	IT-FY24-01	$ -	$ -	**$ -**	$ 50,000	$ 50,000
	Cisco Catalyst 8500 - Routers	IT-FY24-02	$ -	$ -	**$ -**	$ 60,000	$ 60,000
	Cisco AP-9166 - Access Point	IT-FY24-03	$ -	$ -	**$ -**	$ 10,000	$ 10,000
	Cisco UCS-X M6 or M7 Blades x 6	IT-FY24-04	$ 426,471	$ -	**$ 426,471**	$ 426,371	$ (100)
	PURE Storage array	IT-FY24-05	$ -	$ -	**$ -**	$ 300,000	$ 300,000
	PKI management	IT-FY24-06	$ -	$ -	**$ -**	$ 20,000	$ 20,000
	IBM Power Hardware Upgrade	IT-FY24-07	$ 560,652	$ -	**$ 560,652**	$ 288,629	$ (272,023)
	Misc Hardware	IT-FY24-08	$ 7,119	$ -	**$ 7,119**	$ 15,000	$ 7,881
	Network / AV Cabling	IT-FY24-09	$ 107,600	$ -	**$ 107,600**	$ 30,000	$ (77,600)
	Training Room Projector	IT-FY24-10	$ 1,359	$ -	**$ 1,359**	$ 13,000	$ 11,641
	Conference room upgrades	IT-FY24-11	$ -	$ -	**$ -**	$ 107,701	$ 107,701
Hardware Subtotal			**$ 1,103,201**	**$ -**	**$ 1,103,201**	**$ 1,320,701**	**$ 217,500**
2. Software:							
	Zerto renewal and Tier 2 add	AC-FY24-01	$ -	$ -	**$ -**	$ 126,000	$ 126,000
Software Subtotal			**$ -**	**$ -**	**$ -**	**$ 126,000**	**$ 126,000**
3. Building Improvement:							
	Appliances over 1k new/replacement (all buildings/suites)	FA-FY24-01	**$ -**	$ -	**$ -**	$ -	$ -
	ACME Security: Readers, HID boxes, Cameras, Doors (planned/unplanned	FA-FY24-02	$ -	$ -	**$ -**	$ 20,000	$ 20,000
	HVAC: Replace VAV boxes, duct work, replace old equipment	FA-FY24-03	$ 18,295	$ -	**$ 18,295**	$ 20,000	$ 1,705
	Electrical work for projects, workstations requirement	FA-FY24-04	$ -	$ -	**$ -**	$ 10,000	$ 10,000
	1240 Interior blinds replacement	FA-FY24-05	**$ -**	$ -	**$ -**	$ 25,000	$ 25,000
	EV Charging stations, if not completed in FY23 and carried over to FY24	FA-FY24-06	**$ 35,399**	$ -	**$ 35,399**	$ 50,000	$ 14,601
Building Improvement Subtotal			**$ 53,694**	**$ -**	**$ 53,694**	**$ 125,000**	**$ 71,306**
4. Furniture & Equipment:							
	Office desks, cabinets, shelvings (all building/suites: new or replacement)	FA-FY24-17	$ 3,860	$ -	**$ 3,860**	$ 10,000	$ 6,140
	Replace, reconfigure, re-design workstations	FA-FY24-18	$ -	$ -	**$ -**	$ 20,000.00	$ 20,000
Furniture & Equipment Subtotal			**$ 3,860**	**$ -**	**$ 3,860**	**$ 30,000**	**$ 26,140**
GRAND TOTAL			**$ 1,160,755**	**$ -**	**$ 1,160,755**	**$ 1,601,701**	**$ 440,946**

5. Reconciliation to Balance Sheet:

Fixed Assets @ Cost - 2/29/24	**$ 38,855,851**
Fixed Assets @ Cost - 6/30/23	**$ 37,695,096**
Fixed Assets Acquired YTD	**$ 1,160,755**

ALAMEDA ALLIANCE FOR HEALTH
TANGIBLE NET EQUITY (TNE) AND LIQUID TNE ANALYSIS
SUMMARY - FISCAL YEAR 2024

TANGIBLE NET EQUITY (TNE)

	Jul-23	Aug-23	QTR. END Sep-23	Oct-23	Nov-23	QTR. END Dec-23	Jan-24	Feb-24
Current Month Net Income / (Loss)	$9,746,933	$2,343,460	$5,514,335	$3,776,499	$3,440,910	$10,563,766	($8,009,058)	$5,392,121
YTD Net Income / (Loss)	$9,746,933	$12,090,393	$17,604,728	$21,381,227	$24,822,137	$35,385,903	$27,376,845	$32,768,966
Actual TNE								
Net Assets	$333,703,974	$336,047,435	$341,561,770	$345,338,268	$348,779,178	$359,342,945	$351,333,888	$356,726,008
Subordinated Debt & Interest	$0	$0	$0	$0	$0	$0	$0	$0
Total Actual TNE	**$333,703,974**	**$336,047,435**	**$341,561,770**	**$345,338,268**	**$348,779,178**	**$359,342,945**	**$351,333,888**	**$356,726,008**
Increase/(Decrease) in Actual TNE	$9,746,933	$2,343,460	$5,514,335	$3,776,499	$3,440,910	$10,563,766	($8,009,058)	$5,392,121
Required TNE[(1)]	**$46,228,233**	**$46,744,204**	**$46,352,062**	**$49,676,617**	**$49,894,371**	**$49,622,261**	**$57,429,796**	**$55,347,714**
Min. Req'd to Avoid Monthly Reporting (Increased from 130% to 150% of Required TNE effective July-2022)	$69,342,350	$70,116,307	$69,528,093	$74,514,926	$74,841,557	$74,433,391	$86,144,695	$83,021,571
TNE Excess / (Deficiency)	$287,475,741	$289,303,231	$295,209,708	$295,661,651	$298,884,807	$309,720,684	$293,904,092	$301,378,294
Actual TNE as a Multiple of Required	**7.22**	**7.19**	**7.37**	**6.95**	**6.99**	**7.24**	**6.12**	**6.45**

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

LIQUID TANGIBLE NET EQUITY

Net Assets	$333,703,974	$336,047,435	$341,561,770	$345,338,268	$348,779,178	$359,342,945	$351,333,888	$356,726,008
Fixed Assets at Net Book Value	(5,169,098)	(5,539,264)	(5,608,622)	(5,653,388)	(6,079,010)	(5,997,733)	(7,085,899)	(6,961,780)
Net Lease Assets/Liabilities/Interest	(711,429)	(475,037)	(1,115,074)	(727,353)	(662,463)	(1,135,481)	(1,193,576)	(1,033,509)
CD Pledged to DMHC	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)
Liquid TNE (Liquid Reserves)	**$328,184,876**	**$330,158,171**	**$335,603,148**	**$339,334,880**	**$342,350,168**	**$352,995,212**	**$343,897,989**	**$349,414,228**
Liquid TNE as Multiple of Required	**7.10**	**7.06**	**7.24**	**6.83**	**6.86**	**7.11**	**5.99**	**6.31**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2024

	Actual Jul-23	Actual Aug-23	Actual Sep-23	Actual Oct-23	Actual Nov-23	Actual Dec-23	Actual Jan-24	Actual Feb-24	Actual Mar-24	Actual Apr-24	Actual May-24	Actual Jun-24	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program:													
Child	102,463	101,393	100,038	101,120	101,243	102,088	109,553	109,953					827,851
Adult	52,550	52,102	51,499	52,396	52,151	51,696	62,860	63,117					438,371
SPD	31,055	30,840	30,592	30,888	30,865	30,846	35,013	34,875					254,974
ACA OE	123,707	121,819	120,016	121,430	120,573	119,668	145,842	146,757					1,019,812
Duals	41,688	41,715	41,629	41,496	40,997	40,974	40,117	40,403					329,019
MCAL LTC	141	138	139	135	137	135	219	217					1,261
MCAL LTC Duals	1,033	1,019	1,004	997	975	951	1,311	1,329					8,619
Medi-Cal Program	352,637	349,026	344,917	348,462	346,941	346,358	394,915	396,651					2,879,907
Group Care Program	5,669	5,645	5,631	5,605	5,585	5,622	5,603	5,608					44,968
Total	**358,306**	**354,671**	**350,548**	**354,067**	**352,526**	**351,980**	**400,518**	**402,259**					**2,924,875**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	(1,207)	(1,070)	(1,355)	1,082	123	845	7,465	400					6,283
Adult	(624)	(448)	(603)	897	(245)	(455)	11,164	257					9,943
SPD	(225)	(215)	(248)	296	(23)	(19)	4,167	(138)					3,595
ACA OE	(1,260)	(1,888)	(1,803)	1,414	(857)	(905)	26,174	915					21,790
Duals	(43)	27	(86)	(133)	(499)	(23)	(857)	286					(1,328)
MCAL LTC	(9)	(3)	1	(4)	2	(2)	84	(2)					67
MCAL LTC Duals	4	(14)	(15)	(7)	(22)	(24)	360	18					300
Medi-Cal Program	(3,364)	(3,611)	(4,109)	3,545	(1,521)	(583)	48,557	1,736					40,650
Group Care Program	(15)	(24)	(14)	(26)	(20)	37	(19)	5					(76)
Total	**(3,379)**	**(3,635)**	**(4,123)**	**3,519**	**(1,541)**	**(546)**	**48,538**	**1,741**					**40,574**
Enrollment Percentages:													
Medi-Cal Program:													
Child % of Medi-Cal	29.1%	29.1%	29.0%	29.0%	29.2%	29.5%	27.7%	27.7%					28.7%
Adult % of Medi-Cal	14.9%	14.9%	14.9%	15.0%	15.0%	14.9%	15.9%	15.9%					15.2%
SPD % of Medi-Cal	8.8%	8.8%	8.9%	8.9%	8.9%	8.9%	8.9%	8.8%					8.9%
ACA OE % of Medi-Cal	35.1%	34.9%	34.8%	34.8%	34.8%	34.6%	36.9%	37.0%					35.4%
Duals % of Medi-Cal	11.8%	12.0%	12.1%	11.9%	11.8%	11.8%	10.2%	10.2%					11.4%
Medi-Cal Program % of Total	98.4%	98.4%	98.4%	98.4%	98.4%	98.4%	98.6%	98.6%					98.5%
Group Care Program % of Total	1.6%	1.6%	1.6%	1.6%	1.6%	1.6%	1.4%	1.4%					1.5%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**					**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING
FOR THE FISCAL YEAR 2024

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

	Actual Jul-23	Actual Aug-23	Actual Sep-23	Actual Oct-23	Actual Nov-23	Actual Dec-23	Actual Jan-24	Actual Feb-24	Actual Mar-24	Actual Apr-24	Actual May-24	Actual Jun-24	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted													
Directly Contracted (DCP)	74,547	73,027	72,504	78,530	75,141	76,228	104,906	91,656					646,539
Alameda Health System	66,089	65,344	64,133	63,271	63,903	63,545	83,981	89,168					559,434
	140,636	138,371	136,637	141,801	139,044	139,773	188,887	180,824					1,205,973
Delegated:													
CFMG	34,810	34,649	34,144	34,035	35,105	35,399	42,148	43,527					293,817
CHCN	130,230	129,183	127,430	126,705	127,641	128,331	169,483	177,908					1,116,911
Kaiser	52,630	52,468	52,337	51,526	50,736	48,477	0	0					308,174
Delegated Subtotal	217,670	216,300	213,911	212,266	213,482	212,207	211,631	221,435					1,718,902
Total	**358,306**	**354,671**	**350,548**	**354,067**	**352,526**	**351,980**	**400,518**	**402,259**					**2,924,875**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	(939)	(2,265)	(1,734)	5,164	(2,757)	729	49,114	(8,063)					39,249
Delegated:													
CFMG	(441)	(161)	(505)	(109)	1,070	294	6,749	1,379					8,276
CHCN	(1,721)	(1,047)	(1,753)	(725)	936	690	41,152	8,425					45,957
Kaiser	(278)	(162)	(131)	(811)	(790)	(2,259)	(48,477)	0					(52,908)
Delegated Subtotal	(2,440)	(1,370)	(2,389)	(1,645)	1,216	(1,275)	(576)	9,804					1,325
Total	**(3,379)**	**(3,635)**	**(4,123)**	**3,519**	**(1,541)**	**(546)**	**48,538**	**1,741**					**40,574**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	39.3%	39.0%	39.0%	40.0%	39.4%	39.7%	47.2%	45.0%					41.2%
Delegated:													
CFMG	9.7%	9.8%	9.7%	9.6%	10.0%	10.1%	10.5%	10.8%					10.0%
CHCN	36.3%	36.4%	36.4%	35.8%	36.2%	36.5%	42.3%	44.2%					38.2%
Kaiser	14.7%	14.8%	14.9%	14.6%	14.4%	13.8%	0.0%	0.0%					10.5%
Delegated Subtotal	60.7%	61.0%	61.0%	60.0%	60.6%	60.3%	52.8%	55.0%					58.8%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**					**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING

FOR THE FISCAL YEAR 2024	FINAL BUDGET												
	Budget Jul-23	Budget Aug-23	Budget Sep-23	Budget Oct-23	Budget Nov-23	Budget Dec-23	Budget Jan-24	Budget Feb-24	Budget Mar-24	Budget Apr-24	Budget May-24	Budget Jun-24	YTD Member Months
Enrollment by Plan & Aid Category:													
Medi-Cal Program by Category of Aid:													
Child	102,463	101,393	100,038	101,120	100,109	99,008	102,159	100,933	99,823	98,725	97,639	96,565	1,199,975
Adult	52,550	52,102	51,499	52,396	51,872	51,301	57,478	56,788	56,107	55,434	54,769	54,112	646,408
SPD	31,055	30,840	30,592	30,888	30,734	30,488	42,473	42,133	41,796	41,462	41,130	40,801	434,392
ACA OE	123,707	121,819	120,016	121,430	121,180	119,605	149,197	147,556	145,933	144,328	142,740	141,170	1,598,681
Duals	41,688	41,715	41,629	41,496	41,410	41,325	45,787	45,694	45,600	45,506	45,412	45,318	522,580
MCAL LTC	141	138	139	135	136	137	172	173	174	175	176	177	1,873
MCAL LTC Duals	1,033	1,019	1,004	997	985	971	1,194	1,176	1,159	1,142	1,125	1,108	12,913
Medi-Cal Program	352,637	349,026	344,917	348,462	346,426	342,835	398,460	394,453	390,592	386,772	382,991	379,251	4,416,822
Group Care Program	5,669	5,645	5,631	5,605	5,591	5,577	5,563	5,549	5,535	5,521	5,507	5,493	66,886
Total	**358,306**	**354,671**	**350,548**	**354,067**	**352,017**	**348,412**	**404,023**	**400,002**	**396,127**	**392,293**	**388,498**	**384,744**	**4,483,708**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	(1,207)	(1,070)	(1,355)	1,082	(1,011)	(1,101)	3,151	(1,226)	(1,110)	(1,098)	(1,086)	(1,074)	(7,105)
Adult	(624)	(448)	(603)	897	(524)	(571)	6,177	(690)	(681)	(673)	(665)	(657)	938
SPD	(225)	(215)	(248)	296	(154)	(246)	11,985	(340)	(337)	(334)	(332)	(329)	9,521
ACA OE	(1,260)	(1,888)	(1,803)	1,414	(250)	(1,575)	29,592	(1,641)	(1,623)	(1,605)	(1,588)	(1,570)	16,203
Duals	(43)	27	(86)	(133)	(86)	(85)	4,462	(93)	(94)	(94)	(94)	(94)	3,587
MCAL LTC	(9)	(3)	1	(4)	1	1	35	1	1	1	1	1	27
MCAL LTC Duals	4	(14)	(15)	(7)	(12)	(14)	223	(18)	(17)	(17)	(17)	(17)	79
Medi-Cal Program	(3,364)	(3,611)	(4,109)	3,545	(2,036)	(3,591)	55,625	(4,007)	(3,861)	(3,820)	(3,781)	(3,740)	23,250
Group Care Program	(15)	(24)	(14)	(26)	(14)	(14)	(14)	(14)	(14)	(14)	(14)	(14)	(191)
Total	**(3,379)**	**(3,635)**	**(4,123)**	**3,519**	**(2,050)**	**(3,605)**	**55,611**	**(4,021)**	**(3,875)**	**(3,834)**	**(3,795)**	**(3,754)**	**23,059**
Enrollment Percentages:													
Medi-Cal Program:													
Child % (Medi-Cal)	29.1%	29.1%	29.0%	29.0%	28.9%	28.9%	25.6%	25.6%	25.6%	25.5%	25.5%	25.5%	27.2%
Adult % (Medi-Cal)	14.9%	14.9%	14.9%	15.0%	15.0%	15.0%	14.4%	14.4%	14.4%	14.3%	14.3%	14.3%	14.6%
SPD % (Medi-Cal)	8.8%	8.8%	8.9%	8.9%	8.9%	8.9%	10.7%	10.7%	10.7%	10.7%	10.7%	10.8%	9.8%
ACA OE % (Medi-Cal)	35.1%	34.9%	34.8%	34.8%	35.0%	34.9%	37.4%	37.4%	37.4%	37.3%	37.3%	37.2%	36.2%
Duals % (Medi-Cal)	11.8%	12.0%	12.1%	11.9%	12.0%	12.1%	11.5%	11.6%	11.7%	11.8%	11.9%	11.9%	11.8%
MCAL LTC % (Medi-Cal)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
MCAL LTC Duals % (Medi-Cal)	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%
Medi-Cal Program % of Total	98.4%	98.4%	98.4%	98.4%	98.4%	98.4%	98.6%	98.6%	98.6%	98.6%	98.6%	98.6%	98.5%
Group Care Program % of Total	1.6%	1.6%	1.6%	1.6%	1.6%	1.6%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.5%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING

FOR THE FISCAL YEAR 2024	FINAL BUDGET												
	Budget Jul-23	Budget Aug-23	Budget Sep-23	Budget Oct-23	Budget Nov-23	Budget Dec-23	Budget Jan-24	Budget Feb-24	Budget Mar-24	Budget Apr-24	Budget May-24	Budget Jun-24	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted													
Directly Contracted (DCP)	74,547	73,027	72,504	78,530	78,174	77,543	103,987	103,154	102,341	101,536	100,739	99,949	1,066,031
Alameda Health System	66,089	65,344	64,133	63,271	62,977	62,254	86,850	85,925	85,022	84,129	83,245	82,371	891,610
	140,636	138,371	136,637	141,801	141,151	139,797	190,837	189,079	187,363	185,665	183,984	182,320	1,957,641
Delegated:													
CFMG	34,810	34,649	34,144	34,035	33,709	33,339	43,104	42,595	42,131	41,671	41,217	40,767	456,171
CHCN	130,230	129,183	127,430	126,705	125,969	124,637	170,082	168,328	166,633	164,957	163,297	161,657	1,759,108
Kaiser	52,630	52,468	52,337	51,526	51,188	50,639	0	0	0	0	0	0	310,788
Delegated Subtotal	217,670	216,300	213,911	212,266	210,866	208,615	213,186	210,923	208,764	206,628	204,514	202,424	2,526,067
Total	**358,306**	**354,671**	**350,548**	**354,067**	**352,017**	**348,412**	**404,023**	**400,002**	**396,127**	**392,293**	**388,498**	**384,744**	**4,483,708**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted													
Directly Contracted (DCP)	305	(1,520)	(523)	6,026	(356)	(631)	26,444	(833)	(813)	(805)	(797)	(790)	25,707
Alameda Health System	(1,244)	(745)	(1,211)	(862)	(294)	(723)	24,596	(925)	(903)	(893)	(884)	(874)	15,038
	(939)	(2,265)	(1,734)	5,164	(650)	(1,354)	51,040	(1,758)	(1,716)	(1,698)	(1,681)	(1,664)	40,745
Delegated:													
CFMG	(441)	(161)	(505)	(109)	(326)	(370)	9,765	(509)	(464)	(460)	(454)	(450)	5,516
CHCN	(1,721)	(1,047)	(1,753)	(725)	(736)	(1,332)	45,445	(1,754)	(1,695)	(1,676)	(1,660)	(1,640)	29,706
Kaiser	(278)	(162)	(131)	(811)	(338)	(549)	(50,639)	0	0	0	0	0	(52,908)
Delegated Subtotal	(2,440)	(1,370)	(2,389)	(1,645)	(1,400)	(2,251)	4,571	(2,263)	(2,159)	(2,136)	(2,114)	(2,090)	(17,686)
Total	**(3,379)**	**(3,635)**	**(4,123)**	**3,519**	**(2,050)**	**(3,605)**	**55,611**	**(4,021)**	**(3,875)**	**(3,834)**	**(3,795)**	**(3,754)**	**23,059**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted													
Directly Contracted (DCP)	20.8%	20.6%	20.7%	22.2%	22.2%	22.3%	25.7%	25.8%	25.8%	25.9%	25.9%	26.0%	23.8%
Alameda Health System	18.4%	18.4%	18.3%	17.9%	17.9%	17.9%	21.5%	21.5%	21.5%	21.4%	21.4%	21.4%	19.9%
	39.3%	39.0%	39.0%	40.0%	40.1%	40.1%	47.2%	47.3%	47.3%	47.3%	47.4%	47.4%	43.7%
Delegated:													
CFMG	9.7%	9.8%	9.7%	9.6%	9.6%	9.6%	10.7%	10.6%	10.6%	10.6%	10.6%	10.6%	10.2%
CHCN	36.3%	36.4%	36.4%	35.8%	35.8%	35.8%	42.1%	42.1%	42.1%	42.0%	42.0%	42.0%	39.2%
Kaiser	14.7%	14.8%	14.9%	14.6%	14.5%	14.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.9%
Delegated Subtotal	60.7%	61.0%	61.0%	60.0%	59.9%	59.9%	52.8%	52.7%	52.7%	52.7%	52.6%	52.6%	56.3%
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 2024

	Variance Jul-23	Variance Aug-23	Variance Sep-23	Variance Oct-23	Variance Nov-23	Variance Dec-23	Variance Jan-24	Variance Feb-24	Variance Mar-24	Variance Apr-24	Variance May-24	Variance Jun-24	YTD Member Month Variance
Enrollment Variance by Plan & Aid Category - Favorable/(Unfavorable)													
Medi-Cal Program:													
Child	0	0	0	0	1,134	3,080	7,394	9,020					20,628
Adult	0	0	0	0	279	395	5,382	6,329					12,385
SPD	0	0	0	0	131	358	(7,460)	(7,258)					(14,229)
ACA OE	0	0	0	0	(607)	63	(3,355)	(799)					(4,698)
Duals	0	0	0	0	(413)	(351)	(5,670)	(5,291)					(11,725)
MCAL LTC	0	0	0	0	1	(2)	47	44					90
MCAL LTC Duals	0	0	0	0	(10)	(20)	117	153					240
Medi-Cal Program	0	0	0	0	515	3,523	(3,545)	2,198					2,691
Group Care Program	0	0	0	0	(6)	45	40	59					138
Total	**0**	**0**	**0**	**0**	**509**	**3,568**	**(3,505)**	**2,257**					**2,829**
Current Direct/Delegate Enrollment Variance - Favorable/(Unfavorable)													
Directly-Contracted													
Directly Contracted (DCP)	0	0	0	0	(3,033)	(1,315)	919	(11,498)					(14,927)
Alameda Health System	0	0	0	0	926	1,291	(2,869)	3,243					2,591
	0	0	0	0	(2,107)	(24)	(1,950)	(8,255)					(12,336)
Delegated:													
CFMG	0	0	0	0	1,396	2,060	(956)	932					3,432
CHCN	0	0	0	0	1,672	3,694	(599)	9,580					14,347
Kaiser	0	0	0	0	(452)	(2,162)	0	0					(2,614)
Delegated Subtotal	0	0	0	0	2,616	3,592	(1,555)	10,512					15,165
Total	**0**	**0**	**0**	**0**	**509**	**3,568**	**(3,505)**	**2,257**					**2,829**

ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED FEBRUARY 29, 2024

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				CAPITATED MEDICAL EXPENSES:				
$5,144,379	$1,423,768	($3,720,611)	(261.3%)	PCP Capitation	$17,232,365	$9,754,947	($7,477,418)	(76.7%)
6,077,487	6,292,927	215,439	3.4%	PCP Capitation FQHC	38,083,264	39,134,795	1,051,531	2.7%
375,962	369,842	(6,119)	(1.7%)	Specialty-Capitation	2,549,409	2,519,565	(29,844)	(1.2%)
5,281,277	5,651,876	370,599	6.6%	Specialty-Capitation FQHC	33,141,957	34,473,078	1,331,120	3.9%
708,530	718,953	10,423	1.4%	Laboratory Capitation	4,434,927	4,503,832	68,905	1.5%
338,079	333,219	(4,861)	(1.5%)	Vision Cap	2,195,583	2,183,647	(11,936)	(0.5%)
109,326	107,720	(1,606)	(1.5%)	CFMG Capitation	741,601	733,556	(8,045)	(1.1%)
261,470	276,148	14,678	5.3%	Anc IPA Admin Capitation FQHC	1,642,277	1,700,017	57,739	3.4%
0	0	0	0.0%	Kaiser Capitation	83,773,193	84,015,590	242,397	0.3%
0	0	0	0.0%	BHT Supplemental Expense	4,672	0	(4,672)	0.0%
195,670	0	(195,670)	0.0%	Maternity Supplemental Expense	2,442,419	2,311,103	(131,317)	(5.7%)
880,625	1,042,799	162,174	15.6%	DME Cap	6,048,846	6,458,838	409,992	6.3%
$19,372,805	**$16,217,251**	**($3,155,554)**	**(19.5%)**	**5 - TOTAL CAPITATED EXPENSES**	**$192,290,515**	**$187,788,967**	**($4,501,548)**	**(2.4%)**
				FEE FOR SERVICE MEDICAL EXPENSES:				
2,798,653	0	(2,798,653)	0.0%	IBNR Inpatient Services	8,501,532	(2,306,298)	(10,807,830)	468.6%
83,959	0	(83,959)	0.0%	IBNR Settlement (IP)	255,046	(69,188)	(324,234)	468.6%
223,893	0	(223,893)	0.0%	IBNR Claims Fluctuation (IP)	680,124	(184,504)	(864,628)	468.6%
38,649,372	47,546,027	8,896,655	18.7%	Inpatient Hospitalization FFS	258,233,540	285,174,385	26,940,844	9.4%
2,507,477	0	(2,507,477)	0.0%	IP OB - Mom & NB	16,520,154	7,462,632	(9,057,522)	(121.4%)
77,951	0	(77,951)	0.0%	IP Behavioral Health	1,241,130	895,483	(345,647)	(38.6%)
548,837	0	(548,837)	0.0%	IP Facility Rehab FFS	8,229,658	4,711,642	(3,518,016)	(74.7%)
$44,890,142	**$47,546,027**	**$2,655,884**	**5.6%**	**6 - Inpatient Hospital & SNF Expense**	**$293,661,186**	**$295,684,153**	**$2,022,967**	**0.7%**
(252,095)	0	252,095	0.0%	IBNR PCP	337,613	46,983	(290,630)	(618.6%)
(7,564)	0	7,564	0.0%	IBNR Settlement (PCP)	10,128	1,409	(8,719)	(618.8%)
(20,167)	0	20,167	0.0%	IBNR Claims Fluctuation (PCP)	27,012	3,759	(23,253)	(618.6%)
4,299,873	2,638,583	(1,661,290)	(63.0%)	Primary Care Non-Contracted FF	20,079,598	16,887,212	(3,192,387)	(18.9%)
423,932	313,294	(110,638)	(35.3%)	PCP FQHC FFS	3,610,198	3,164,510	(445,689)	(14.1%)
0	0	0	0.0%	Phys Extended Hours Incentive	3,500	6,000	2,500	41.7%
14,659	3,712,116	3,697,457	99.6%	Prop 56 Physician	13,885,687	23,049,640	9,163,953	39.8%
16,105	0	(16,105)	0.0%	Prop 56 Hyde	208,849	58,257	(150,592)	(258.5%)
73,278	0	(73,278)	0.0%	Prop 56 Trauma Screening	624,638	316,945	(307,693)	(97.1%)
77,980	0	(77,980)	0.0%	Prop 56 Develop. Screening	720,970	383,782	(337,188)	(87.9%)
777,501	0	(777,501)	0.0%	Prop 56 Family Planning	5,891,184	2,905,675	(2,985,509)	(102.7%)
0	0	0	0.0%	Prop 56 VBP	573	7,428	6,856	92.3%
$5,403,501	**$6,663,993**	**$1,260,492**	**18.9%**	**7 - Primary Care Physician Expense**	**$45,399,951**	**$46,831,601**	**$1,431,650**	**3.1%**
237,280	0	(237,280)	0.0%	IBNR Specialist	516,593	(704,271)	(1,220,864)	173.4%
353,456	0	(353,456)	0.0%	Psychiatrist FFS	2,182,282	927,497	(1,254,784)	(135.3%)
2,760,215	7,425,060	4,664,845	62.8%	Specialty Care FFS	19,345,475	35,152,044	15,806,569	45.0%
201,186	0	(201,186)	0.0%	Specialty Anesthesiology	1,413,644	733,088	(680,556)	(92.8%)
1,294,152	0	(1,294,152)	0.0%	Specialty Imaging FFS	9,043,486	4,332,553	(4,710,933)	(108.7%)
24,599	0	(24,599)	0.0%	Obstetrics FFS	150,706	71,825	(78,882)	(109.8%)
242,747	0	(242,747)	0.0%	Specialty IP Surgery FFS	2,260,992	1,146,377	(1,114,615)	(97.2%)
679,217	0	(679,217)	0.0%	Specialty OP Surgery FFS	5,006,915	2,380,160	(2,626,755)	(110.4%)
611,171	0	(611,171)	0.0%	Spec IP Physician	3,866,711	1,804,945	(2,061,766)	(114.2%)
122,927	101,101	(21,826)	(21.6%)	SCP FQHC FFS	640,582	608,079	(32,504)	(5.3%)
7,119	0	(7,119)	0.0%	IBNR Settlement (SCP)	15,500	(21,127)	(36,627)	173.4%
18,982	0	(18,982)	0.0%	IBNR Claims Fluctuation (SCP)	41,325	(56,342)	(97,667)	173.3%
$6,553,051	**$7,526,161**	**$973,110**	**12.9%**	**8 - Specialty Care Physician Expense**	**$44,484,212**	**$46,374,828**	**$1,890,616**	**4.1%**
512,450	0	(512,450)	0.0%	IBNR Ancillary	3,717,906	2,122,555	(1,595,351)	(75.2%)
15,375	0	(15,375)	0.0%	IBNR Settlement (ANC)	111,540	63,677	(47,863)	(75.2%)
40,994	0	(40,994)	0.0%	IBNR Claims Fluctuation (ANC)	297,432	169,805	(127,627)	(75.2%)
156,718	0	(156,718)	0.0%	IBNR Transportation FFS	166,623	45,720	(120,903)	(264.4%)
1,339,519	0	(1,339,519)	0.0%	Behavioral Health Therapy FFS	10,099,606	4,951,126	(5,148,480)	(104.0%)
1,355,665	0	(1,355,665)	0.0%	Psychologist & Other MH Prof.	8,901,855	4,215,464	(4,686,391)	(111.2%)
339,238	0	(339,238)	0.0%	Acupuncture/Biofeedback	2,260,634	1,075,338	(1,185,296)	(110.2%)
205,321	0	(205,321)	0.0%	Hearing Devices	937,154	381,525	(555,628)	(145.6%)
88,372	0	(88,372)	0.0%	Imaging/MRI/CT Global	306,769	141,544	(165,225)	(116.7%)
83,173	0	(83,173)	0.0%	Vision FFS	410,399	164,593	(245,805)	(149.3%)
0	0	0	0.0%	Family Planning	59	30	(30)	(100.0%)
463,721	0	(463,721)	0.0%	Laboratory-FFS	4,003,373	1,917,612	(2,085,761)	(108.8%)
143,063	0	(143,063)	0.0%	ANC Therapist	764,692	395,200	(369,492)	(93.5%)
1,466,238	0	(1,466,238)	0.0%	Transportation (Ambulance)-FFS	8,645,208	3,746,485	(4,898,722)	(130.8%)
2,140,257	0	(2,140,257)	0.0%	Transportation (Other)-FFS	12,448,164	5,929,067	(6,519,097)	(110.0%)
1,191,679	0	(1,191,679)	0.0%	Hospice	11,266,871	5,779,983	(5,486,888)	(94.9%)

ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED FEBRUARY 29, 2024

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
1,310,631	0	(1,310,631)	0.0%	Home Health Services	9,962,058	4,994,036	(4,968,022)	(99.5%)
0	12,095,754	12,095,754	100.0%	Other Medical-FFS	10,871	42,975,347	42,964,476	100.0%
636,245	0	(636,245)	0.0%	Medical Refunds through HMS	45,000	(309,963)	(354,963)	114.5%
(1,791)	0	1,791	0.0%	Medical Refunds	(583,412)	(565,083)	18,329	(3.2%)
21,553	0	(21,553)	0.0%	DME & Medical Supplies	199,509	116,689	(82,819)	(71.0%)
0	0	0	0.0%	GEMT FFS	(373,988)	(373,988)	0	0.0%
1,788,650	1,863,432	74,783	4.0%	ECM Base/Outreach FFS Anc.	12,158,109	11,748,267	(409,841)	(3.5%)
44,260	0	(44,260)	0.0%	CS Housing Deposits FFS Ancillary	205,701	135,985	(69,716)	(51.3%)
437,034	0	(437,034)	0.0%	CS Housing Tenancy FFS Ancillary	2,023,965	1,183,089	(840,876)	(71.1%)
118,104	0	(118,104)	0.0%	CS Housing Navigation Services FFS Ancillary	502,523	257,647	(244,876)	(95.0%)
47,282	0	(47,282)	0.0%	CS Medical Respite FFS Ancillary	633,164	377,892	(255,272)	(67.6%)
76,383	0	(76,383)	0.0%	CS Medically Tailored Meals FFS Ancillary	301,388	128,446	(172,942)	(134.6%)
9,510	0	(9,510)	0.0%	CS Asthma Remediation FFS Ancillary	32,487	11,648	(20,839)	(178.9%)
0	10,000	10,000	100.0%	MOT Wrap Around (Non Medical MOT Cost)	0	40,000	40,000	100.0%
170,952	0	(170,952)	0.0%	Community Based Adult Services (CBAS)	3,072,354	1,425,263	(1,647,091)	(115.6%)
0	0	0	0.0%	CS Pilot LTC Diversion Expense	0	15,291	15,291	100.0%
5,352	0	(5,352)	0.0%	CS Pilot LTC Transition Expense	37,463	23,701	(13,762)	(58.1%)
0	0	0	0.0%	Justice Involved Pilot	0	161,111	161,111	100.0%
$14,205,948	**$13,969,187**	**($236,761)**	**(1.7%)**	**9 - Ancillary Medical Expense**	**$92,565,477**	**$93,445,104**	**$879,628**	**0.9%**
(61,869)	0	61,869	0.0%	IBNR Outpatient	2,946,290	422,626	(2,523,664)	(597.1%)
(1,856)	0	1,856	0.0%	IBNR Settlement (OP)	88,386	12,677	(75,709)	(597.2%)
(4,951)	0	4,951	0.0%	IBNR Claims Fluctuation (OP)	235,702	33,811	(201,891)	(597.1%)
1,777,212	12,074,755	10,297,543	85.3%	Out Patient FFS	13,139,072	47,385,232	34,246,160	72.3%
1,697,640	0	(1,697,640)	0.0%	OP Ambul Surgery FFS	13,610,040	6,937,396	(6,672,644)	(96.2%)
1,947,418	0	(1,947,418)	0.0%	OP Fac Imaging Services FFS	13,615,542	6,670,623	(6,944,919)	(104.1%)
25,731	0	(25,731)	0.0%	Behav Health FFS	80,814	(21,966)	(102,780)	467.9%
674,567	0	(674,567)	0.0%	OP Facility Lab FFS	4,431,037	2,081,864	(2,349,173)	(112.8%)
184,473	0	(184,473)	0.0%	OP Facility Cardio FFS	1,217,059	608,098	(608,961)	(100.1%)
224,720	0	(224,720)	0.0%	OP Facility PT/OT/ST FFS	1,230,003	270,230	(959,773)	(355.2%)
2,314,441	0	(2,314,441)	0.0%	OP Facility Dialysis FFS	17,368,520	8,379,495	(8,989,025)	(107.3%)
$8,777,527	**$12,074,755**	**$3,297,228**	**27.3%**	**10 - Outpatient Medical Expense Medical Expense**	**$67,962,465**	**$72,780,085**	**$4,817,621**	**6.6%**
278,480	0	(278,480)	0.0%	IBNR Emergency	799,669	30,260	(769,409)	(2,542.7%)
8,354	0	(8,354)	0.0%	IBNR Settlement (ER)	23,991	910	(23,081)	(2,536.4%)
22,279	0	(22,279)	0.0%	IBNR Claims Fluctuation (ER)	63,979	2,423	(61,556)	(2,540.5%)
1,104,788	0	(1,104,788)	0.0%	Special ER Physician FFS	6,836,660	3,056,795	(3,779,865)	(123.7%)
8,936,283	7,555,585	(1,380,699)	(18.3%)	ER Facility	45,360,368	46,521,411	1,161,042	2.5%
$10,350,184	**$7,555,585**	**($2,794,599)**	**(37.0%)**	**11 - Emergency Expense**	**$53,084,668**	**$49,611,799**	**($3,472,869)**	**(7.0%)**
(440,739)	0	440,739	0.0%	IBNR Pharmacy OP	2,866,268	(204,308)	(3,070,576)	1,502.9%
(13,223)	0	13,223	0.0%	IBNR Settlement (RX) OP	85,984	(6,133)	(92,117)	1,502.0%
(35,259)	0	35,259	0.0%	IBNR Claims Fluctuation (RX) OP	229,302	(16,345)	(245,647)	1,502.9%
480,978	361,016	(119,962)	(33.2%)	Pharmacy FFS	3,921,870	3,416,558	(505,312)	(14.8%)
120,133	11,738,380	11,618,247	99.0%	Pharmacy Non-PBM FFS-Other Anc	1,019,089	41,669,903	40,650,814	97.6%
7,448,424	0	(7,448,424)	0.0%	Pharmacy Non-PBM FFS-OP FAC	44,711,475	21,975,503	(22,735,972)	(103.5%)
293,431	0	(293,431)	0.0%	Pharmacy Non-PBM FFS-PCP	1,740,562	615,362	(1,125,200)	(182.9%)
2,513,778	0	(2,513,778)	0.0%	Pharmacy Non-PBM FFS-SCP	17,563,307	8,807,902	(8,755,406)	(99.4%)
24,436	0	(24,436)	0.0%	Pharmacy Non-PBM FFS-FQHC	94,438	41,158	(53,280)	(129.5%)
14,210	0	(14,210)	0.0%	Pharmacy Non-PBM FFS-HH	60,620	27,987	(32,633)	(116.6%)
0	0	0	0.0%	RX Refunds HMS	(63)	(63)	0	0.0%
(35,000)	31,071	66,071	212.6%	Pharmacy Rebate	(300,000)	(33,059)	266,941	(807.5%)
$10,371,169	**$12,130,467**	**$1,759,298**	**14.5%**	**12 - Pharmacy Expense**	**$71,992,854**	**$76,294,466**	**$4,301,613**	**5.6%**
4,234,029	0	(4,234,029)	0.0%	IBNR LTC	15,351,062	4,802,539	(10,548,523)	(219.6%)
127,020	0	(127,020)	0.0%	IBNR Settlement (LTC)	460,534	144,077	(316,457)	(219.6%)
338,721	0	(338,721)	0.0%	IBNR Claims Fluctuation (LTC)	1,228,083	384,202	(843,881)	(219.6%)
789,866	0	(789,866)	0.0%	LTC - ICF/DD	809,196	0	(809,196)	0.0%
19,264,060	0	(19,264,060)	0.0%	LTC Custodial Care	138,066,388	63,392,176	(74,674,212)	(117.8%)
3,981,786	23,533,464	19,551,678	83.1%	LTC SNF	25,248,703	94,240,367	68,991,664	73.2%
$28,735,481	**$23,533,464**	**($5,202,018)**	**(22.1%)**	**13 - Long Term Care Expense**	**$181,163,966**	**$162,963,361**	**($18,200,605)**	**(11.2%)**
$129,287,004	**$130,999,639**	**$1,712,635**	**1.3%**	**14 - TOTAL FFS MEDICAL EXPENSES**	**$850,314,777**	**$843,985,397**	**($6,329,380)**	**(0.7%)**
0	(401,463)	(401,463)	100.0%	Clinical Vacancy	0	(1,225,677)	(1,225,677)	100.0%
49,804	94,641	44,837	47.4%	Quality Analytics	646,899	1,170,033	523,134	44.7%
888,424	1,102,230	213,806	19.4%	Health Plan Services Department Total	6,599,955	7,451,259	851,304	11.4%
629,917	684,779	54,862	8.0%	Case & Disease Management Department Total	4,767,220	4,959,979	192,759	3.9%
1,081,491	1,534,108	452,617	29.5%	Medical Services Department Total	13,946,924	14,968,473	1,021,549	6.8%

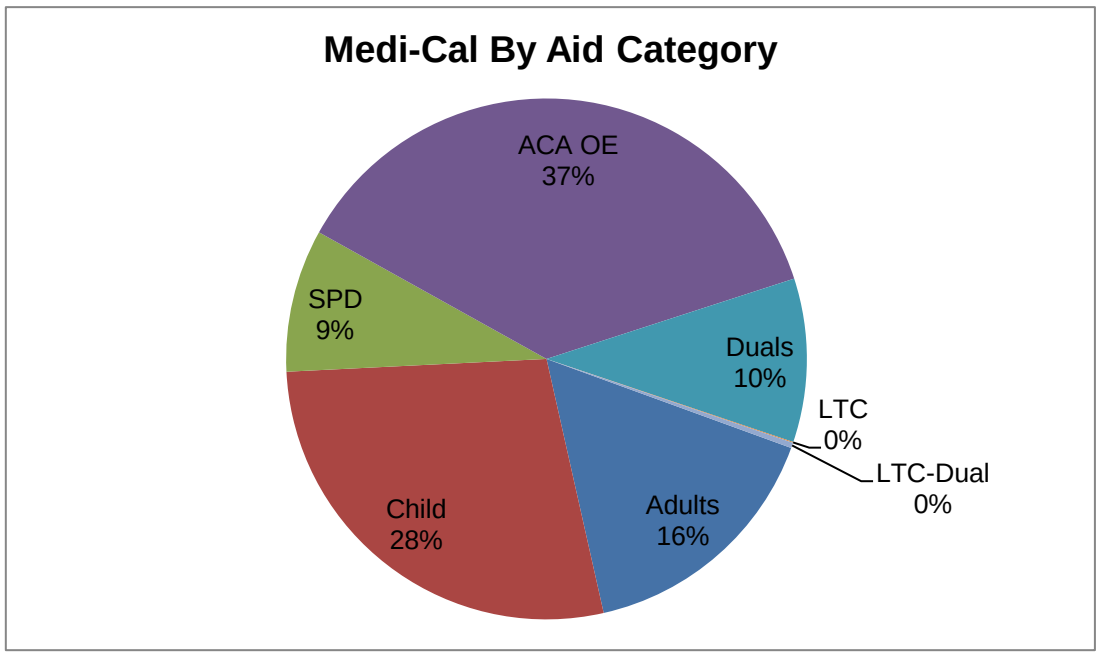
ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED FEBRUARY 29, 2024

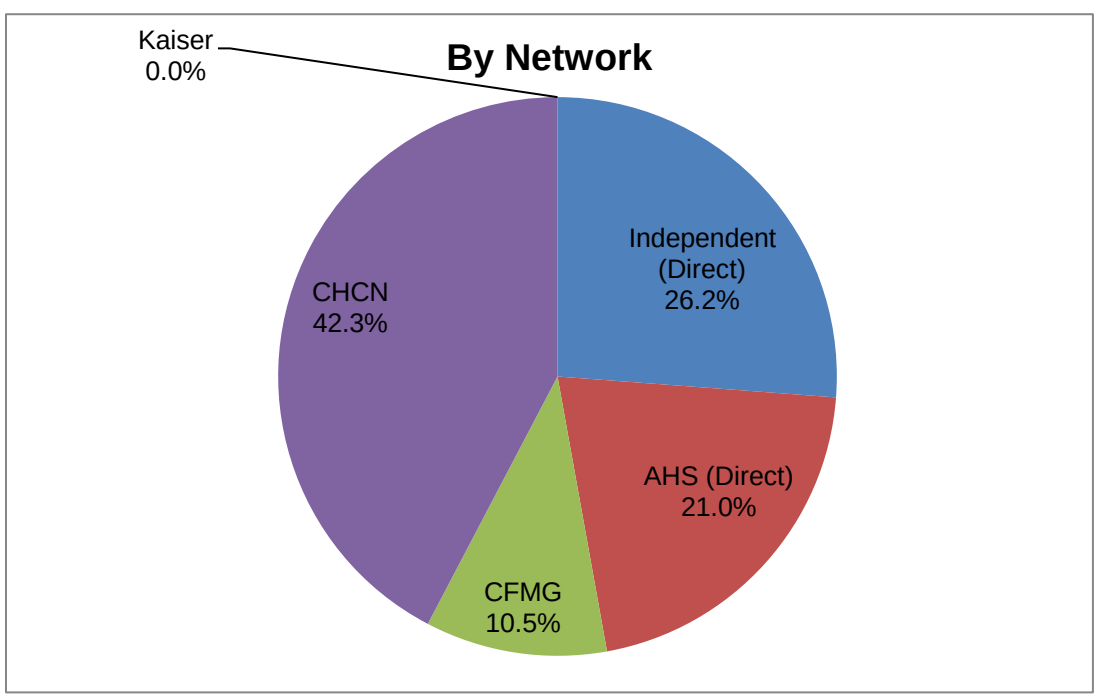
CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
776,061	1,037,266	261,205	25.2%	Quality Management Department Total	6,034,539	8,521,770	2,487,231	29.2%
406,234	324,731	(81,503)	(25.1%)	HCS Behavioral Health Department Total	2,178,653	2,312,627	133,974	5.8%
138,023	142,298	4,275	3.0%	Pharmacy Services Department Total	1,129,305	1,169,059	39,755	3.4%
55,714	61,976	6,262	10.1%	Regulatory Readiness Total	495,418	532,512	37,094	7.0%
$4,025,667	**$4,580,566**	**$554,899**	**12.1%**	**15 - Other Benefits & Services**	**$35,798,913**	**$39,860,036**	**$4,061,124**	**10.2%**
(1,365,756)	(1,094,208)	271,548	(24.8%)	Reinsurance Recoveries	(9,791,311)	(7,464,257)	2,327,055	(31.2%)
1,389,518	1,458,944	69,426	4.8%	Reinsurance Premium	9,150,099	9,066,564	(83,535)	(0.9%)
$23,762	**$364,736**	**$340,974**	**93.5%**	**16- Reinsurance Expense**	**($641,212)**	**$1,602,307**	**$2,243,519**	**140.0%**
0	0	0	0.0%	P4P Risk Pool Provider Incenti	3,000,000	3,000,000	0	0.0%
$0	**$0**	**$0**	**0.0%**	**17 - Risk Pool Distribution**	**$3,000,000**	**$3,000,000**	**$0**	**0.0%**
$152,709,238	**$152,162,192**	**($547,046)**	**(0.4%)**	**18 - TOTAL MEDICAL EXPENSES**	**$1,080,762,992**	**$1,076,236,707**	**($4,526,285)**	**(0.4%)**

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend

Category of Aid	Jan 2024	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Adults	62,870	16%	20,321	12,823	31	29,695	-
Child	109,562	28%	10,345	13,290	39,072	46,855	-
SPD	35,013	9%	12,066	5,359	1,416	16,172	-
ACA OE	145,842	37%	29,644	49,468	1,629	65,101	-
Duals	40,118	10%	28,908	2,169	1	9,040	-
LTC	219	0%	195	9	-	15	-
LTC-Dual	1,311	0%	1,310	-	-	1	-
Medi-Cal	394,935		102,789	83,118	42,149	166,879	-
Group Care	5,603		2,134	864	-	2,605	-
Total	**400,538**	**100%**	**104,923**	**83,982**	**42,149**	**169,484**	**-**
Medi-Cal %	98.6%		98.0%	99.0%	100.0%	98.5%	0%
Group Care %	1.4%		2.0%	1.0%	0.0%	1.5%	0.0%
	Network Distribution		*26.2%*	*21.0%*	*10.5%*	*42.3%*	*0.0%*
			% Direct:	**47%**		**% Delegated:**	**53%**

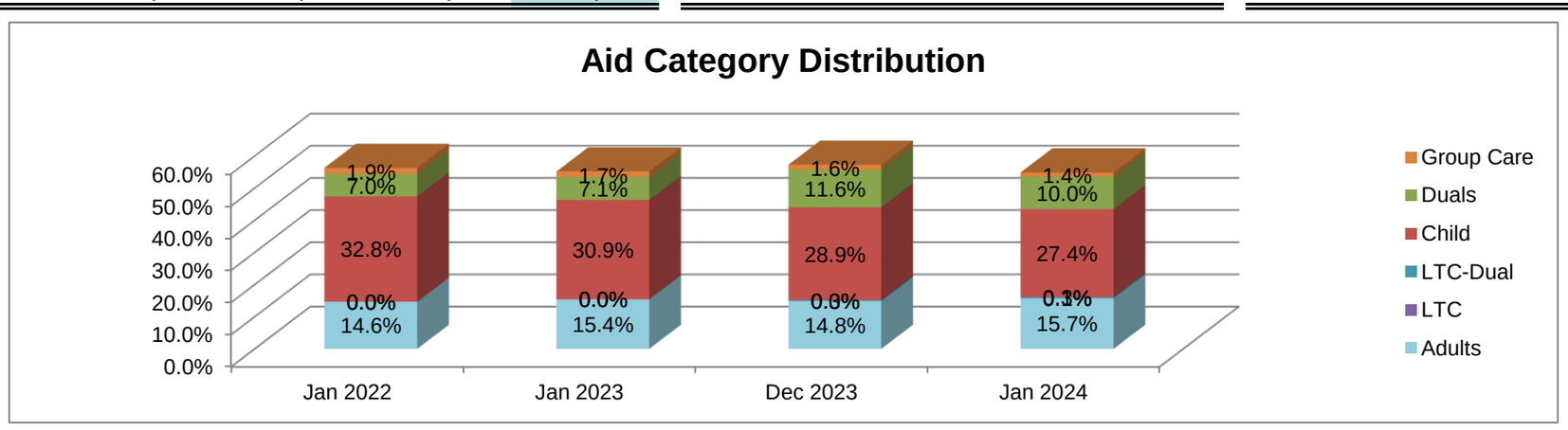




Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

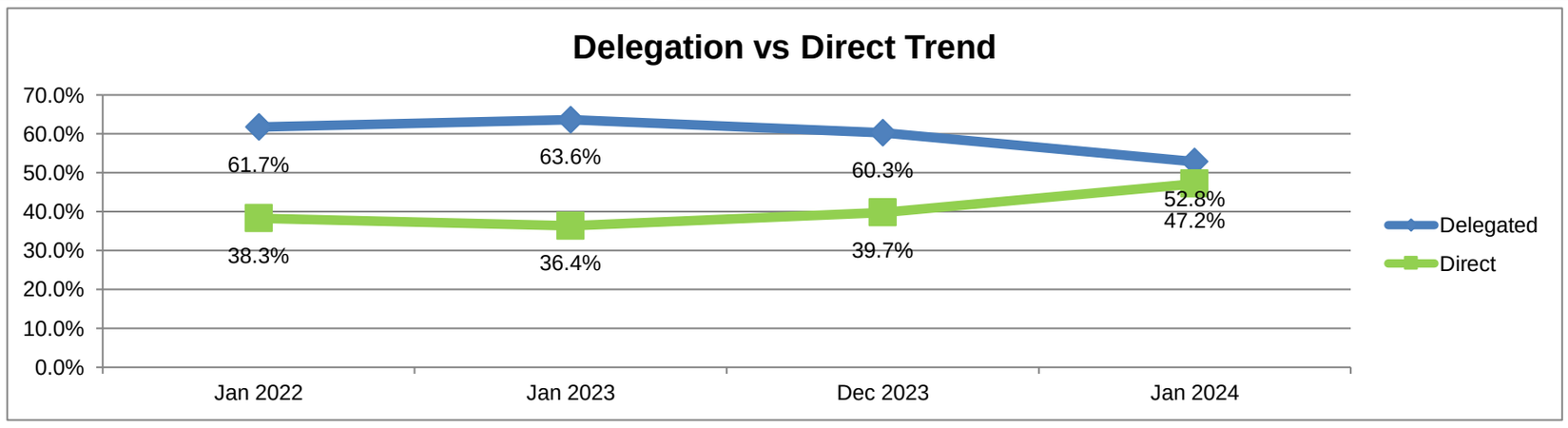
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Jan 2022	Jan 2023	Dec 2023	Jan 2024	Jan 2022	Jan 2023	Dec 2023	Jan 2024	Jan 2022 to Jan 2023	Jan 2023 to Jan 2024	Dec 2023 to Jan 2024
Adults	44,340	50,687	52,174	62,870	14.6%	15.4%	14.8%	15.7%	14.3%	24.0%	20.5%
Child	99,337	101,914	101,634	109,562	32.8%	30.9%	28.9%	27.4%	2.6%	7.5%	7.8%
SPD	26,633	28,685	30,848	35,013	8.8%	8.7%	8.8%	8.7%	7.7%	22.1%	13.5%
ACA OE	105,897	119,302	119,669	145,842	34.9%	36.2%	34.0%	36.4%	12.7%	22.2%	21.9%
Duals	21,135	23,444	40,976	40,118	7.0%	7.1%	11.6%	10.0%	10.9%	71.1%	-2.1%
LTC	-	6	135	219	0.0%	0.0%	0.0%	0.1%	0.0%	3550.0%	62.2%
LTC-Dual	-	15	951	1,311	0.0%	0.0%	0.3%	0.3%	0.0%	8640.0%	37.9%
Medi-Cal Total	297,342	324,053	346,387	394,935	98.1%	98.3%	98.4%	98.6%	9.0%	21.9%	14.0%
Group Care	5,831	5,761	5,622	5,603	1.9%	1.7%	1.6%	1.4%	-1.2%	-2.7%	-0.3%
Total	**303,173**	**329,814**	**352,009**	**400,538**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**8.8%**	**21.4%**	**13.8%**



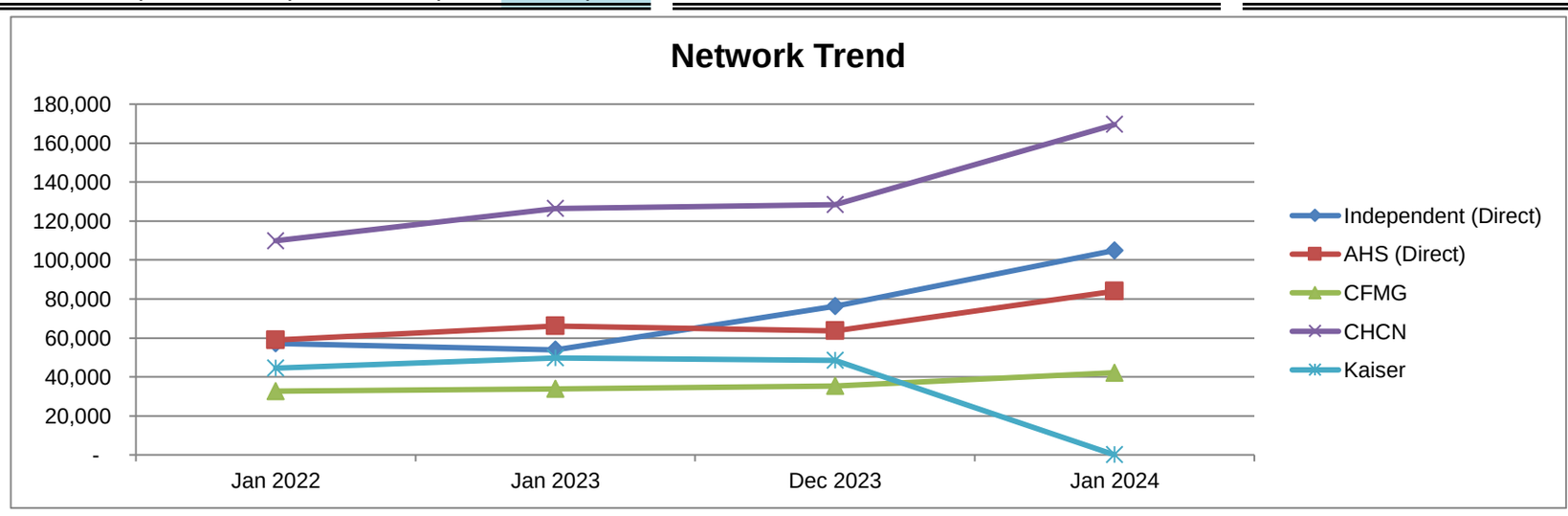
Delegation vs Direct Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	Jan 2022	Jan 2023	Dec 2023	Jan 2024	Jan 2022	Jan 2023	Dec 2023	Jan 2024	Jan 2022 to Jan 2023	Jan 2023 to Jan 2024	Dec 2023 to Jan 2024
Delegated	187,200	209,892	212,220	211,633	61.7%	63.6%	60.3%	52.8%	12.1%	0.8%	-0.3%
Direct	115,973	119,922	139,789	188,905	38.3%	36.4%	39.7%	47.2%	3.4%	57.5%	35.1%
Total	**303,173**	**329,814**	**352,009**	**400,538**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**8.8%**	**21.4%**	**13.8%**



Network Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Jan 2022	Jan 2023	Dec 2023	Jan 2024	Jan 2022	Jan 2023	Dec 2023	Jan 2024	Jan 2022 to Jan 2023	Jan 2023 to Jan 2024	Dec 2023 to Jan 2024
Independent (Direct)	57,046	53,870	76,241	104,923	18.8%	16.3%	21.7%	26.2%	-5.6%	94.8%	37.6%
AHS (Direct)	58,927	66,052	63,548	83,982	19.4%	20.0%	18.1%	21.0%	12.1%	27.1%	32.2%
CFMG	32,689	33,741	35,401	42,149	10.8%	10.2%	10.1%	10.5%	3.2%	24.9%	19.1%
CHCN	109,878	126,433	128,342	169,484	36.2%	38.3%	36.5%	42.3%	15.1%	34.1%	32.1%
Kaiser	44,633	49,718	48,477	-	14.7%	15.1%	13.8%	0.0%	11.4%	-100.0%	-100.0%
Total	**303,173**	**329,814**	**352,009**	**400,538**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**8.8%**	**21.4%**	**13.8%**



ALAMEDA Alliance FOR HEALTH

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

Operations

Ruth Watson

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

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

Date: **April 12th, 2024**

Subject: **Operations Report**

Member Services

- 12-Month Trend Blended Summary:
    - The Member Services Department received a twenty-five percent (9%) increase in calls in March 2024, totaling 22,501 compared to 20,378 in March 2023.
    - The abandonment rate for March 2024 was eight percent (8%), compared to nineteen percent (19%) in March 2023.
    - The Department's service level was eighty-three percent (83%) in March 2024, compared to forty-six percent (46%) in March 2023. The average speed to answer (ASA) was forty-nine seconds (00:49) compared to four minutes and sixteen seconds (04:16) in March 2023. The Department continues to recruit to fill open positions. Customer Service support service vendor continues to provide overflow call center support.
    - The average talk time (ATT) was seven minutes and two seconds (07:02) for March 2024 compared to six minutes and fifty-two seconds (06:52) for March 2023.
    - Ninety-eight percent (98%) of calls were answered within 10 minutes for March 2024 compared to eighty percent (80%) in March 2023.
    - Outbound calls totaled eighty-four hundred and four (8404) in March 2024 compared to seventy-nine hundred and seventy-three (7973) in March 2023.
    - The top five call reasons for March 2024 were: 1). Change of PCP, 2). Eligibility/Enrollment, 3). Benefits, 4). Provider Network, 5). Grievances/Appeals. The top five call reasons for March 2023 were: 1). Change of PCP, 2). Eligibility/Enrollment, 3). Benefits, 4). Kaiser, 5). ID Card Requests.
    - March utilization for the member automated eligibility IVR system totaled sixteen hundred forty-eighty (1648) March 2024 compared to one thousand seventy-two (1072) in March 2023.
    - The Department continues to service members via multiple communication channels (telephonic, email, online, web-based requests and in-person) while honoring the organization's policies. The Department responded to fourteen-hundred ninety-five (1495) web-based requests in March 2024 compared to eleven hundred thirty-four (1134) in March 2023. The top three web reason requests for March 2024 were: 1). Change of PCP, 2). ID Card Requests, 3). Update Contact Information. Sixty-three (63) members were assisted in-person in March 2024.

- Member Services Behavioral Health:

    - The Member Services Behavioral Health Unit received a total of sixteen hundred sixty-one (1661) calls in March 2024.
    - The abandonment rate was twenty-six percent (26%).
    - The service level was fifty-two percent (52%).
    - The average speed to answer (ASA) was three minutes thirty-three seconds. (3:33).
    - Calls answered in 10 minutes were eighty-nine percent (89%).
    - The Average Talk Time (ATT) was eight minutes and fifty seconds (08:50). ATT are impacted by the DHCS requirements to complete a screening for all members initiating MH services for the first time.
    - Thirteen hundred eighty-one (1381) outbound calls were completed in March 2024.
    - Two hundred twenty-nine (229) outreach campaigns were completed in March 2024. Includes twenty-one (21) BH/ABA screenings.
    - One hundred forty (140) screenings were completed in March 2024.
    - Thirty (30) referrals were made to the County (ACCESS) in March 2024.
    - Fourteen (14) members were referred to Center Point for SUD services in March 2024.

Claims

- 12-Month Trend Summary:

    - The Claims Department received 308,453 claims in March 2024 compared to 238,283 in March 2023.
    - The Auto Adjudication was 81.2% in March 2024 compared to 79.3% in March 2023.
    - Claims compliance for the 30-day turn-around time was 95.6% in March 2024 compared to 99.3% in March 2023. The 45-day turn-around time was 100% in March 2024 compared to 99.9% in March 2023.

- Monthly Analysis:

    - In the month of March, we received a total of 308,453 claims in the HEALTHsuite system. This represents an increase of 15.8% from February and is higher, by 70,170 claims, than the number of claims received in March 2023; the higher volume of received claims remains attributed to an increased membership.
    - We received 88.30% of claims via EDI and 11.70% of claims via paper.
    - During the month of March, 100% of our claims were processed within 45 working days.
    - The Auto Adjudication rate was 81.2% for the month of March.

Provider Services

- 12-Month Trend Summary:

    - The Provider Services department's call volume in March 2024 was 9,033 calls compared to 6,283 calls in March 2023.
    - Provider Services continuously works to achieve first call resolution and reduction of the abandonment rates. Efforts to promote provider satisfaction is our first priority.
    - The Provider Services department completed 259 calls/visits during March 2024.
    - The Provider Services department answered 5,761 calls for March 2024 and made 1,970 outbound calls.

Credentialing

- 12-Month Trend Summary:

    - At the Peer Review and Credentialing (PRCC) meeting held on March 19, 2024, there were one hundred and six (106) initial network providers approved; nine (9) primary care providers, fifteen (15) specialists, one (1) ancillary provider, fifteen (15) midlevel providers, and sixty-six (66) behavioral health providers. Additionally, twenty-nine (29) providers were re-credentialed at this meeting; six (6) primary care providers, fifteen (15) specialists, zero (0) ancillary providers, and eight (8) midlevel providers.

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

Provider Dispute Resolution

- 12-Month Trend Summary:

    - In March 2024, the Provider Dispute Resolution (PDR) team received 2,274 PDRs versus 1,475 in March 2023.
    - The PDR team resolved 1,701 cases in March 2024 compared to 1,111 cases in March 2023.
    - In March 2024, the PDR team upheld 62% of cases versus 75% in March 2023.
    - The PDR team resolved 99.4% of cases within the compliance standard of 95% within 45 working days in March 2024 compared to 99.3% in March 2023.

- Monthly Analysis:

    - AAH received 2,274 PDRs in March 2024.
    - In the month of March 1,701 PDRs were resolved. Out of the 1,701 PDRs, 1,059 were upheld and 642 were overturned.
    - The overturn rate for PDRs was 38%, which did not meet our goal of 25% or less.
    - Below is a breakdown of the various causes for the 642 overturned PDRs. Please note that there was one primary area that caused the Department to miss their goal of 25% or less. There were two larger than normal volumes of overturn cases. The first was due to Member Other Health Coverage (OHC) corrections, with 94 cases that had been denied incorrectly. The second was due to 148 physical therapy claims denied incorrectly for no authorization. The combined volumes of these two primary overturn reasons this month prevented us from achieving the goal of 25% or less overturned PDRs.

        - System Related Issues 16% (99 cases):
            - 75 cases: General configuration issues, i.e., Not Covered, Modifier, Eligibility. (12%)
            - 7 cases: LTC SOC Recoupment (1%)
            - 17 cases: CES (3%)

        - OHC Related Issues 15% (94 cases)
            - 94 cases: OHC Member TPL data, incorrect primary EOB not matching, incorrect manual entry. (15%)

        - Authorization Related Issues 46% (294 cases):
            - 59 cases: Processor errors when authorization was on file. (9%)
            - 13 cases: System (2%)
            - 148 cases: PTPN (physical therapy) (24%)
            - 16 cases: CFMG (2%)
            - 58 cases: UM/retro review (9%)

        - Additional Documentation Provided 3% (22 cases):
            - 16 cases: Duplicate claim documentation that allows for claims to be adjusted. (2%)
            - 6 cases: Timely Filing (1%)

        - Incorrect Rates 9% (59 cases)
            - 50 cases: System (8%)
            - 9 cases: LOA (1%)

        - Claim Processing Errors 11% (74 cases)
            - 33 cases: Duplicate (5%)
            - 41 cases: Various Processor errors. (6%)

- 1,691 out of 1,701 cases were resolved within 45 working days resulting in a 99.4% compliance rate.
- The average turnaround time for resolving PDRs in March was 43 days.
- There were 3,531 PDRs pending resolution as of 03/31/2024; with no cases older than 45 working days.

Community Relations and Outreach

- 12-Month Trend Summary:
  - In Q3 2024, the Alliance completed 2,235 member orientation outreach calls and 433 member orientations by phone.
  - The C&O Department reached 3,777 people (59% identified as Alliance members) during outreach activities, compared to 1,618 individuals (39% identified as Alliance members) in Q3 2023.
  - The C&O Department spent $1017.10 in donations, fees, and/or sponsorships, compared to $800.00 in Q3 2023.
  - The C&O Department reached members in 20 cities/unincorporated areas throughout Alameda County, the Bay Area, and the U.S., compared to 17 cities in Q3 2023.

- Quarterly Analysis:
  - In Q3 2024, the C&O Department completed 2,235 member orientation outreach calls and 433 member orientations by phone.
  - Among the 3,777 people reached, 59% identified as Alliance members.
  - The C&O Department reached members in 20 locations throughout Alameda County, the Bay Area, and the U.S.

- Monthly Analysis:
  - In March 2024, the C&O Department completed 920 member orientation outreach calls, 159 member orientations by phone, 2 community events, 1 member education event, and 249 Alliance website inquiries.
  - Among the 899 people reached, 25% identified as Alliance members.
  - In March 2024, the C&O Department reached members in 17 locations throughout Alameda County, the Bay Area, and the U.S.
  - Please see attached **Addendum A**.

Operations

Supporting Documents

Member Services

Blended Call Results

Blended Results	March 2024
Incoming Calls (R/V)	22,501
Abandoned Rate (R/V)	8%
Answered Calls (R/V)	20,805
Average Speed to Answer (ASA)	00:49
Calls Answered in 30 Seconds (R/V)	83%
Average Talk Time (ATT)	07:02
Calls Answered in 10 minutes	98%
Outbound Calls	8,332

Top 5 Call Reasons (Medi-Cal and Group Care) March 2024
Change of PCP
Eligibility/Enrollment
Benefits
Provider Network Info
Grievances

Top 3 Web-Based Request Reasons (Medi-Cal and Group Care) March 2024
Change PCP
ID Card Requests
Update Contact Info

MSBH	March 2024
Incoming Calls (R/V)	1661
Abandoned Rate (R/V)	26%
Answered Calls (R/V)	1230
Average Speed to Answer (ASA)	03:33
Calls Answered in 30 Seconds (R/V)	52%
Average Talk Time (ATT)	08:50
Calls Answered in 10 minutes	89%
Outbound Calls	1381
Screenings Completed	140
ACBH Referrals	30
SUD referrals to Center Point	14

Claims Department
February 2024 Final and March 2024 Final

METRICS

Claims Compliance	Feb-24	Mar-24
90% of clean claims processed within 30 calendar days	91.4%	95.6%
95% of all claims processed within 45 working days	99.9%	100.0%
Claims Volume (Received)	**Feb-24**	**Mar-24**
Paper claims	30,550	36,087
EDI claims	235,789	272,366
Claim Volume Total	**266,339**	**308,453**
Percentage of Claims Volume by Submission Method	**Feb-24**	**Mar-24**
% Paper	11.47%	11.70%
% EDI	88.53%	88.30%
Claims Processed	**Feb-24**	**Mar-24**
HEALTHsuite Paid (original claims)	200,503	169,061
HEALTHsuite Denied (original claims)	68,775	59,799
HEALTHsuite Original Claims Sub-Total	**269,278**	**228,860**
HEALTHsuite Adjustments	7,599	3,000
HEALTHsuite Total	**276,877**	**231,860**
Claims Expense	**Feb-24**	**Mar-24**
Medical Claims Paid	$113,271,742	$110,283,537
Interest Paid	$115,387	$62,198
Auto Adjudication	**Feb-24**	**Mar-24**
Claims Auto Adjudicated	218,137	185,783
% Auto Adjudicated	81.0%	81.2%
Average Days from Receipt to Payment	**Feb-24**	**Mar-24**
HEALTHsuite	15	14
Pended Claim Age	**Feb-24**	**Mar-24**
0-29 calendar days	30,078	32,840
HEALTHsuite		
30-59 calendar days	208	1,122
HEALTHsuite		
Over 60 calendar days	27	24
HEALTHsuite		

Claims Department
February 2024 Final and March 2024 Final

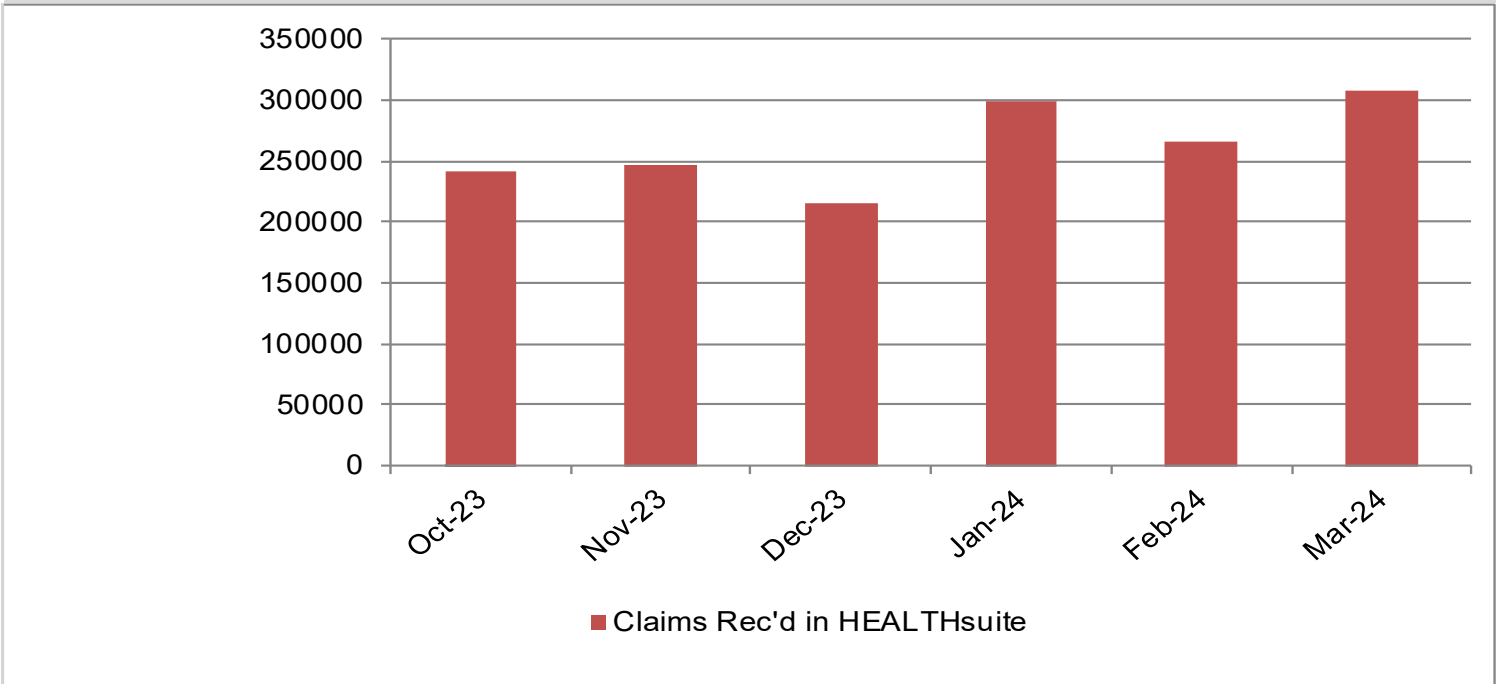
Overall Denial Rate	Feb-24	Mar-24
Claims denied in HEALTHsuite	68,775	59,799
% Denied	24.8%	25.8%

Mar-24

Top 5 HEALTHsuite Denial Reasons	% of all denials
Responsibility of Provider	24%
No Benefits Found For Dates of Service	13%
Non-Covered Benefit For This Plan	11%
Duplicate Claims	10%
Must Submit Paper Claim With Copy of Primary Payor EOB	9%
% Total of all denials	**67%**

Claims Received By Month

Run Date	11/1/2023	12/1/2023	1/1/2024	2/1/2024	3/1/2024	4/1/2024
Claims Received Through	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**
Claims Rec'd in HEALTHsuite	241,298	247,537	215,246	298,465	266,339	308,453



Claims Year Over Year Summary

Monthly Results	Regulatory Requirement	AAH Goal
Claims Compliance - comparing March 2024 to March 2023 as follows: 30 Days - 95.6% (2024) vs 99.3% (2023) 45 Days - 100% (2024) vs 99.9% (2023) 90 Days - 99.9% (2024) vs 99.9% (2023)	90% of clean claims in 30 calendar days 95% of all claims in 45 working days 99% of all claims in 90 calendar days	90% of clean claims in 30 calendar days 95% of all claims in 45 working days 99% of all claims in 90 calendar days
Claims Received - AAH received 308,453 claims in March 2024 vs 238,283 in March 2023.	N/A	N/A
EDI - the volume of EDI submissions remains consistent from month to month at ~77% - 87%.	N/A	N/A
Original Claims Processed - AAH processed 228,860 in March 2024 (21 working days) vs 207,347 in March 2023 (23 working days).	N/A	N/A
Medical Claims Expense - the amount of paid claims in March 2024 was $110,283,537 (4 check runs) vs $78,512,420 in March 2023 (5 check runs).	N/A	N/A
Interest Expense - the amount of interest paid in March 2024 was $62,198 vs $41,054 in March 2023.	N/A	< $496,000 per fiscal year or $30,000 per month
Auto Adjudication - the AAH rate in March 2024 was 81.2% vs 79.3% in March 2023.	N/A	70% or higher
Average Days from Receipt to Payment - the average # of days from receipt to payment in March 2024 was 14 days vs 18 days in March 2023.	N/A	<= 25 days

Claims Year Over Year Summary

Pended Claim Age - comparing March 2024 to March 2023 as follows: 0-30 calendar days - 32,840 (2024) vs 19,753 (2023) 30-59 calendar days - 1,122 (2024) vs 741 (2023) Over 60 calendar days - 24 (2024) vs 8 (2023)	N/A	N/A
Top 5 Denial Reasons - the claim denial reasons remain consistent from month to month so there is no significant changes to report from March 2024 to March 2023.	N/A	N/A

Provider Relations Dashboard March 2024

Alliance Provider Relations Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Incoming Calls (PR)	10695	9359	9033									
Abandoned Calls	4806	4325	3272									
Answered Calls (PR)	5889	5034	5761									
Recordings/Voicemails	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Incoming Calls (R/V)	413	2551	1970									
Abandoned Calls (R/V)												
Answered Calls (R/V)	413	2551	1970									
Outbound Calls	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Outbound Calls	1140	1358	1298									
N/A												
Outbound Calls	1140	1358	1298									
Totals	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Total Incoming, R/V, Outbound Calls	11835	13268	12301									
Abandoned Calls	4806	4325	3272									
Total Answered Incoming, R/V, Outbound Calls	7442	8993	9029									

Provider Relations Dashboard March 2024

Call Reasons (Medi-Cal and Group Care)

Category	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Authorizations	5.5%	5.6%	5.5%									
Benefits	4.3%	3.6%	2.4%									
Claims Inquiry	38.5%	41.7%	45.4%									
Change of PCP	3.3%	3.9%	2.6%									
Check Tracer	1.1%	1.1%	1.2%									
Complaint/Grievance (includes PDR's)	4.4%	4.3%	6.1%									
Contracts/Credentialing	1.1%	1.0%	1.5%									
Demographic Change	0.0%	0.0%	0.0%									
Eligibility - Call from Provider	23.0%	20.5%	17.5%									
Exempt Grievance/ G&A	0.6%	0.1%	0.1%									
General Inquiry/Non member	0.0%	0.0%	0.0%									
Health Education	0.0%	0.0%	0.0%									
Intrepreter Services Request	0.5%	0.6%	0.7%									
Provider Portal Assistance	3.7%	3.8%	3.2%									
Pharmacy	0.1%	0.1%	0.1%									
Prop 56	0.2%	0.4%	0.3%									
Provider Network Info	0.0%	0.0%	0.1%									
Transportation Services	0.2%	0.2%	0.1%									
Transferred Call	0.0%	0.0%	0.0%									
All Other Calls	13.4%	13.1%	13.1%									
TOTAL	100.0%	100.0%	100.0%									

Field Visit Activity Details

Alliance Provider Relations Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Claims Issues	13	56	38									
Contracting/Credentialing	9	21	50									
Drop-ins	27	49	29									
JOM's	3	2	2									
New Provider Orientation	104	103	140									
Quarterly Visits	0	0	0									
UM Issues	0	0	0									
Total Field Visits	156	231	259	0	0	0	0	0	0	0	0	0

Provider Dispute Resolution
February 2024 and March 2024

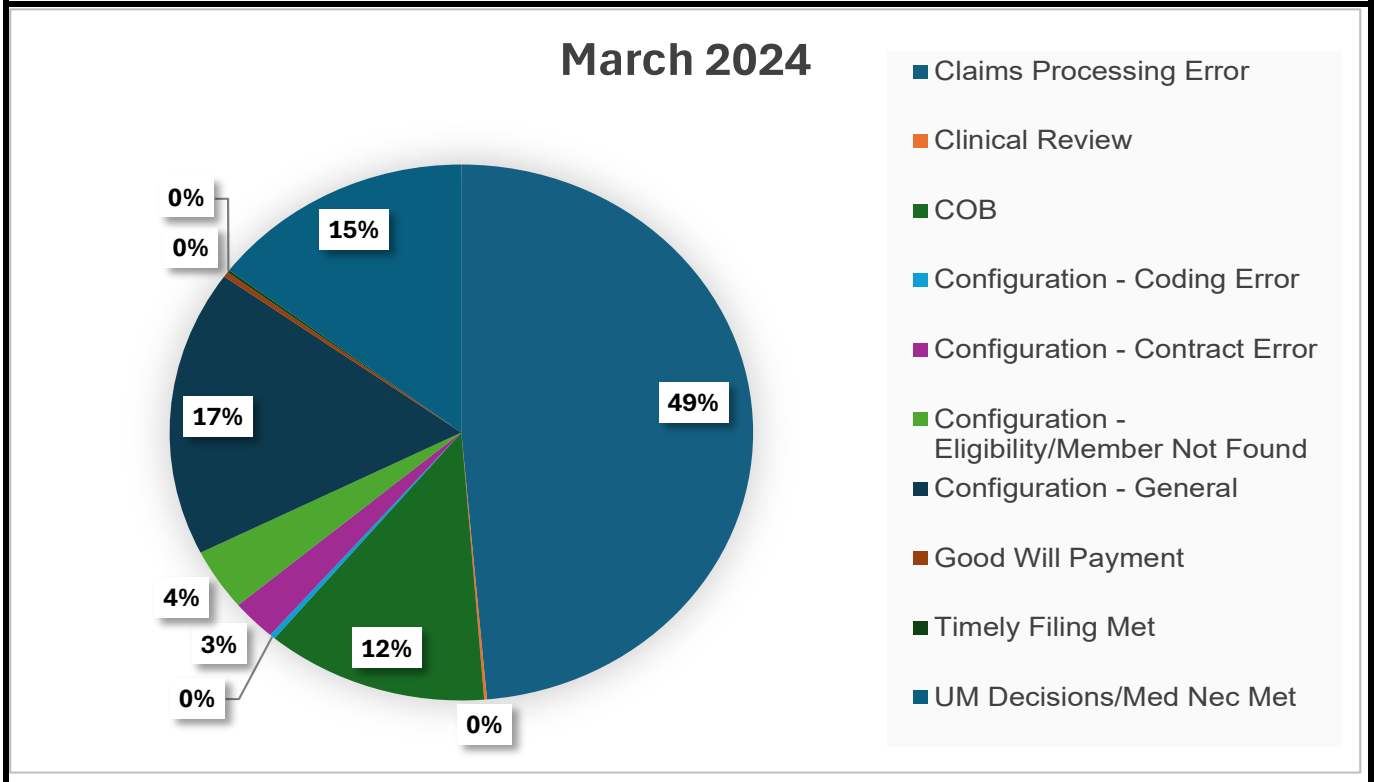
METRICS

PDR Compliance	Feb-24	Mar-24
# of PDRs Resolved	1,007	1,701
# Resolved Within 45 Working Days	1,007	1,691
% of PDRs Resolved Within 45 Working Days	100.0%	99.4%
PDRs Received	**Feb-24**	**Mar-24**
# of PDRs Received	2,064	2,274
PDR Volume Total	**2,064**	**2,274**
PDRs Resolved	**Feb-24**	**Mar-24**
# of PDRs Upheld	666	1,059
% of PDRs Upheld	66%	62%
# of PDRs Overturned	341	642
% of PDRs Overturned	34%	38%
Total # of PDRs Resolved	**1,007**	**1,701**
Average Turnaround Time	**Feb-24**	**Mar-24**
Average # of Days to Resolve PDRs	41	43
Oldest Resolved PDR in Days	44	70
Unresolved PDR Age	**Feb-24**	**Mar-24**
0-45 Working Days	3,442	3,531
Over 45 Working Days	0	0
Total # of Unresolved PDRs	**3,442**	**3,531**

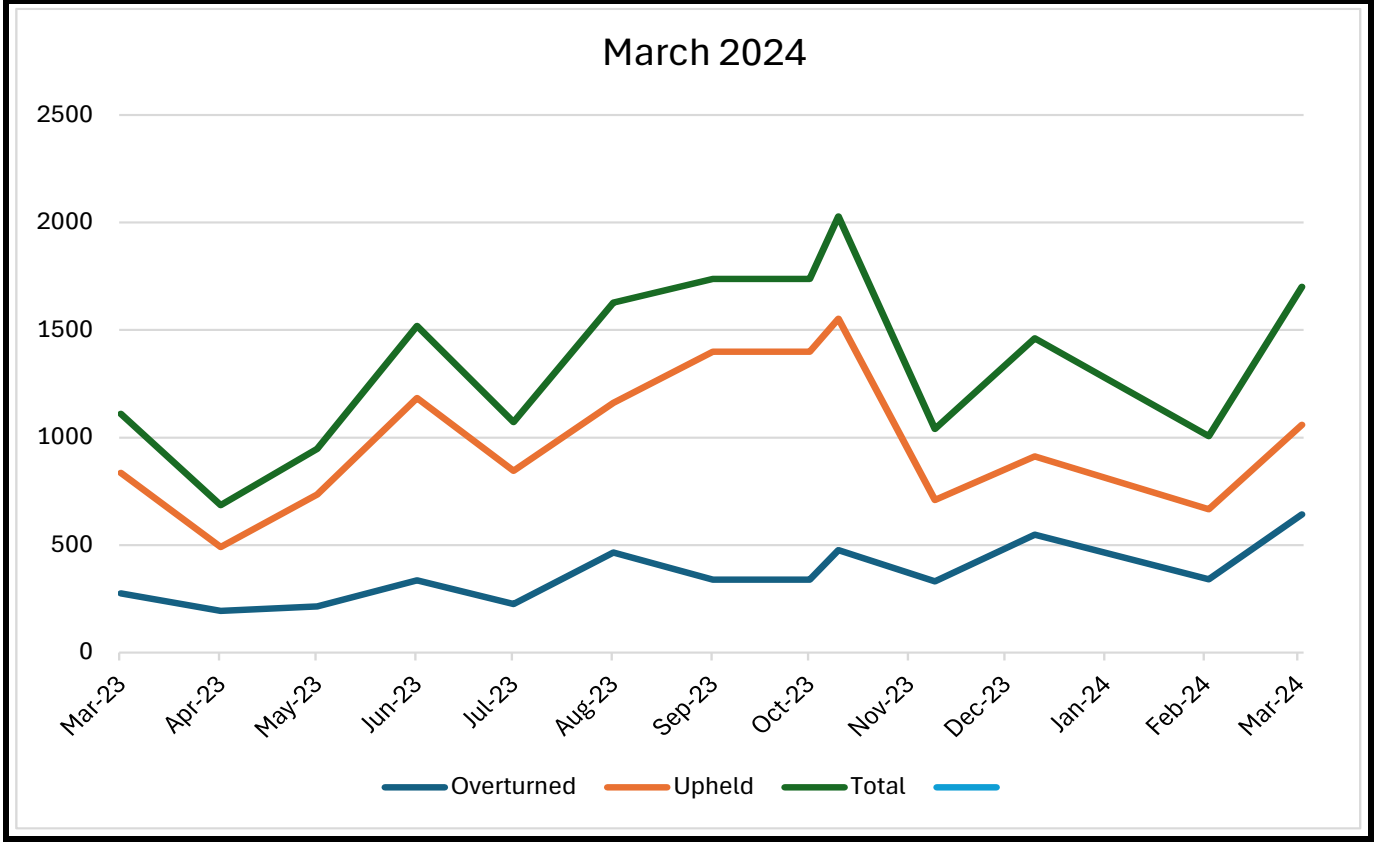
Provider Dispute Resolution
February 2024 and March 2024

Mar-24

PDR Resolved Case Overturn Reasons



Rolling 12-Month PDR Trend Line



Provider Dispute Resolution Year Over Year Summary

Monthly Results	Regulatory Requirements	AAH Goal
# of PDRs Received - 2,274 in March 2024 vs 1,475 in March 2023	N/A	N/A
# of PDRs Resolved - 1,701 in March 2024 vs 1,111 in March 2023	N/A	N/A
# of PDRs Resolved within 45 working days - 1,691 in March 2024 vs 1,103in March 2023	N/A	N/A
% of PDRs Resolved within 45 working days - 99.4% in March 2024 vs 99.3% in March 2023	95%	95%
Average # of Days to Resolve PDRs - 43 days in March 2024 vs 29 days in March 2023	N/A	30
Oldest Resolved PDR in Days - 70 days in March 2024 vs 39 days March 2023	N/A	N/A
# of PDRs Upheld - 1,059 in March 2024 vs 836 in March 2023	N/A	N/A
% of PDRs Upheld - 62% in March 2024 vs 75% in March 2023	N/A	> 75%
# of PDRs Overturned - 642 in March 2024 vs 275 in March 2023	N/A	N/A

Provider Dispute Resolution Year Over Year Summary		
% of PDRs Overturned - 38% in March 2024 vs 25% in March 2023	N/A	< 25%
PDR Overturn Reasons: Claims processing errors - 49% (2024) vs 43% (2023) Configuration errors - 24% (2024) vs 33% (2023) COB -12% (2024) vs 6% (2023) Clinical Review/UM Decisions/Medical Necessity Met - 15% (2024) vs 14% (2023)	N/A	N/A

ALLIANCE NETWORK SUMMARY, CURRENTLY CREDENTIALED PRACTITIONERS						
Practitioners		BH/ABA 1,656	AHP 547	PCP 381	SPEC 708	PCP/SPEC 13
AAH/AHS/CHCN Breakdown			AAH 2,099	AHS 271	CHCN 577	COMBINATION OF GROUPS 358
Facilities	**417**					

VENDOR SUMMARY Credentialing Verification Organization, Symplyr CVO	Number	Average Calendar Days in Process	Goal - Business Days	Goal - 98% Accuracy	Compliant
Initial Files in Process	318	3	25	Y	Y
Recred Files in Process	119	33	25	Y	Y
Expirables updated Insurance, License, DEA, Board Certifications					Y
Files currently in process	**437**				

March 2024 Peer Review and Credentialing Committee Approvals	
Initial Credentialing	**Number**
PCP	9
SPEC	15
ANCILLARY	1
MIDLEVEL/AHP	15
BH/ABA	66
	106
Recredentialing	
PCP	6
SPEC	15
ANCILLARY	0
MIDLEVEL/AHP	8
	29
TOTAL	**135**
March 2024 Facility Approvals	
Initial Credentialing	**2**
Recredentialing	**11**
	13
Facility Files in Process	**29**

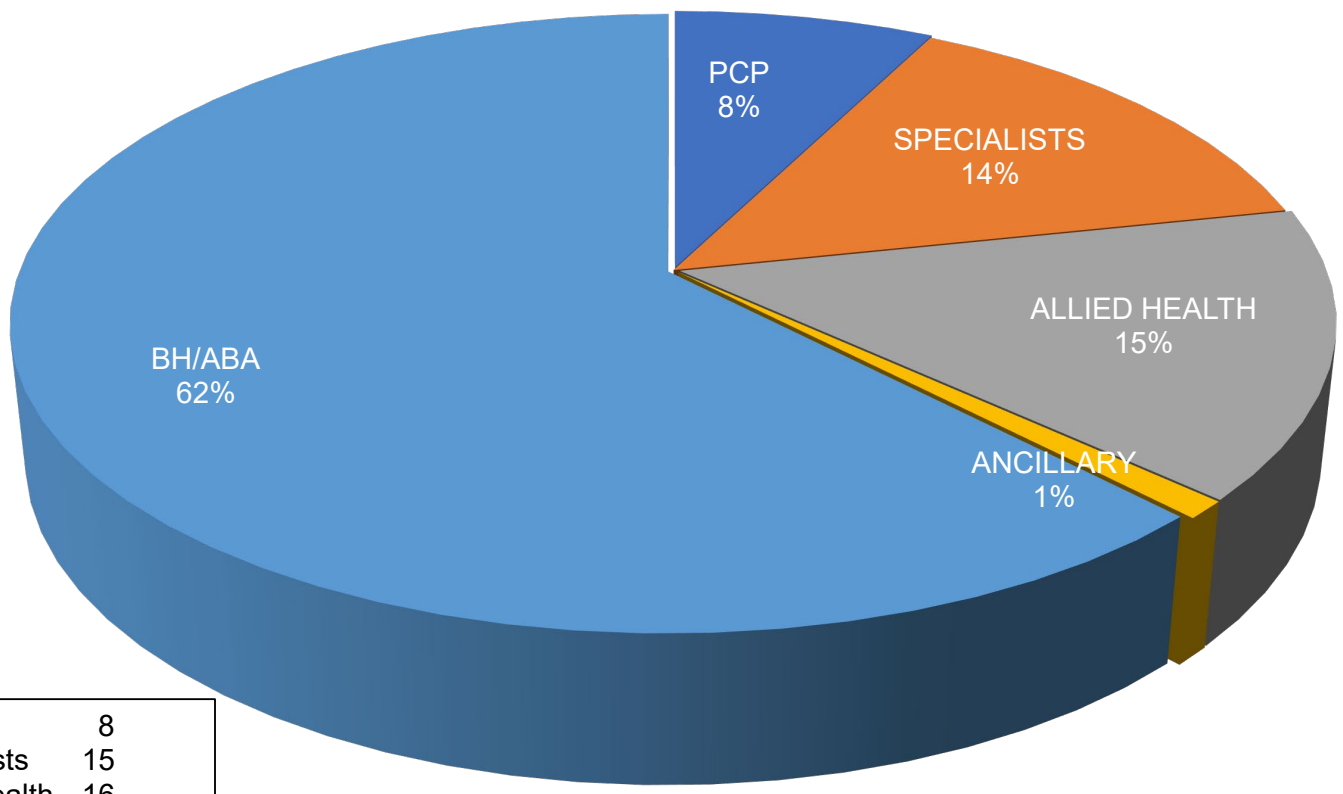
March 2024 Employee Metrics (5 FTEs)	Goal		Met (Y/N)
File Processing	Timely processing within 3 days of receipt		Y
Credentialing Accuracy	<3% error rate		Y
DHCS, DMHC, CMS, NCQA Compliant	98%		Y
MBC Monitoring	Timely processing within 3 days of receipt		Y

LAST NAME	FIRST NAME	CATEGORY	INITIAL/RE-CRED	CRED DATE
Abhadhan	Tasfia	BH-Telehealth	INITIAL	3/19/2024
Amin	Faisal	Specialist	INITIAL	3/19/2024
Amos	Jennifer	BH	INITIAL	3/19/2024
Anderson	Patricia	BH-Telehealth	INITIAL	3/19/2024
Andrade	Angelica	BH	INITIAL	3/19/2024
Arango	Adrian	BH-Telehealth	INITIAL	3/19/2024
Baker	Carolynn	ABA	INITIAL	3/19/2024
Barbic	Elizabeth	BH-Telehealth	INITIAL	3/19/2024
Bifano	Alyson	BH	INITIAL	3/19/2024
Bores	Nicole	Primary Care Physician	INITIAL	3/19/2024
Brown	Dariah	BH	INITIAL	3/19/2024
Brown	Patricia	BH-Telehealth	INITIAL	3/19/2024
Bryson	Angela	ABA	INITIAL	3/19/2024
Bugarin	Adriana	BH	INITIAL	3/19/2024
Cereda	Julia	Allied Health	INITIAL	3/19/2024
Chiapuzio	Brandon	BH	INITIAL	3/19/2024
Chiu	Stephanie	Allied Health	INITIAL	3/19/2024
Cobleigh	Zoey	ABA-Telehealth	INITIAL	3/19/2024
Cruz	Alison	ABA-Telehealth	INITIAL	3/19/2024
Delzer	Haley	BH	INITIAL	3/19/2024
Doolan	Janine	BH-Telehealth	INITIAL	3/19/2024
Dosanjh	Amrita	Specialist	INITIAL	3/19/2024
Dougherty	Sean	Specialist	INITIAL	3/19/2024
Eggers	Kristie	ABA-Telehealth	INITIAL	3/19/2024
Evnin-Bingham	Aimee	BH-Telehealth	INITIAL	3/19/2024
Fein	Rachel	BH-Telehealth	INITIAL	3/19/2024
Galaviz	Nikkie	BH-Telehealth	INITIAL	3/19/2024
Geddins	Regina	BH-Telehealth	INITIAL	3/19/2024
Gilbertson	Cybil	BH-Telehealth	INITIAL	3/19/2024
Godber	Bailey	BH-Telehealth	INITIAL	3/19/2024
Gonzalez	Celene	BH-Telehealth	INITIAL	3/19/2024
Graves	Gretchen	Primary Care Physician	INITIAL	3/19/2024
Gray	Ashley	BH-Telehealth	INITIAL	3/19/2024
Hanif	Mohammad	Primary Care Physician	INITIAL	3/19/2024
Harik	Danielle	Specialist	INITIAL	3/19/2024
Hassanein	Mohamed	Specialist	INITIAL	3/19/2024
Hernandez-Sutton	Oscar	BH	INITIAL	3/19/2024
Holmes	Lola	BH	INITIAL	3/19/2024
Huseni	Shehlanoor	Specialist	INITIAL	3/19/2024
Jackson	Jennifer	BH	INITIAL	3/19/2024
Johnson	Sara	Specialist	INITIAL	3/19/2024
Kan	David	BH	INITIAL	3/19/2024
Khan	Aleena	Allied Health	INITIAL	3/19/2024
Kormi	Touraj	Specialist	INITIAL	3/19/2024
Kubala	Meghan	Specialist	INITIAL	3/19/2024
Ling	Irving	Primary Care Physician	INITIAL	3/19/2024
Liu	Lian	BH-Telehealth	INITIAL	3/19/2024
Lumboy	Charles Vincent	Allied Health	INITIAL	3/19/2024
MacVittie	Rinnah	Allied Health	INITIAL	3/19/2024
Major	Valerie	Allied Health	INITIAL	3/19/2024
Manus	Yuriyah	BH-Telehealth	INITIAL	3/19/2024
Mesa	Juan	ABA	INITIAL	3/19/2024
Moore	Verretta	BH-Telehealth	INITIAL	3/19/2024
Moszkowicz	Aaron	ABA-Telehealth	INITIAL	3/19/2024
Muse	Emily	BH	INITIAL	3/19/2024
Mutaboyerwa	Tamara	ABA-Telehealth	INITIAL	3/19/2024
Ni	Christina	BH-Telehealth	INITIAL	3/19/2024

LAST NAME	FIRST NAME	CATEGORY	INITIAL/RE-CRED	CRED DATE
Permenter	Lauren	BH-Telehealth	INITIAL	3/19/2024
Pierre	Judith	Allied Health	INITIAL	3/19/2024
Piya	Anjuli	Primary Care Physician	INITIAL	3/19/2024
Pritchett	Cynthia	BH-Telehealth	INITIAL	3/19/2024
Propersi	Taryn	BH	INITIAL	3/19/2024
Puryear	Debra	BH	INITIAL	3/19/2024
Rawls	Allison	BH-Telehealth	INITIAL	3/19/2024
Reed	LaTesha	Allied Health	INITIAL	3/19/2024
Rhodes	Sarah	BH-Telehealth	INITIAL	3/19/2024
Robbins	Mark	BH-Telehealth	INITIAL	3/19/2024
Rodriguez	Angee	Doula	INITIAL	3/19/2024
Rogala	Carol	BH-Telehealth	INITIAL	3/19/2024
Ruffin	Chantilay	Allied Health	INITIAL	3/19/2024
Rydell	Stacey	BH-Telehealth	INITIAL	3/19/2024
Sadatmousavi	Afsaneh	ABA-Telehealth	INITIAL	3/19/2024
Sapasap	Pamee	ABA-Telehealth	INITIAL	3/19/2024
Setiawan	Eugenie	Allied Health	INITIAL	3/19/2024
Shain	Philip	BH	INITIAL	3/19/2024
Sharma	Gauri	Specialist	INITIAL	3/19/2024
Sherman	Michael	Specialist	INITIAL	3/19/2024
Sieu	Katherine	Allied Health	INITIAL	3/19/2024
Soeur	Chan Mary	BH	INITIAL	3/19/2024
St Marie	Annette	BH-Telehealth	INITIAL	3/19/2024
Stambor	Kaela	BH-Telehealth	INITIAL	3/19/2024
Superfin	Diana	Specialist	INITIAL	3/19/2024
Sutton-Innocencio	Elliot	BH	INITIAL	3/19/2024
Swanier	Kiara	Allied Health	INITIAL	3/19/2024
Tak	Bernice	BH-Telehealth	INITIAL	3/19/2024
Taylor	Alexis	BH-Telehealth	INITIAL	3/19/2024
Theimer	Svetlana	BH	INITIAL	3/19/2024
Tio	Andrew-Justin	Allied Health	INITIAL	3/19/2024
Titov	Vladimir	Primary Care Physician	INITIAL	3/19/2024
To	Amanda	ABA-Telehealth	INITIAL	3/19/2024
Tsui	Mo Ying	ABA-Telehealth	INITIAL	3/19/2024
Tumber	Navdeep	Primary Care Physician	INITIAL	3/19/2024
Valadez	Andrew	Allied Health	INITIAL	3/19/2024
Vono	Michelle	BH-Telehealth	INITIAL	3/19/2024
Wachtarz	Amber	Allied Health	INITIAL	3/19/2024
Ward	Ashley	ABA-Telehealth	INITIAL	3/19/2024
Wardzinska	Jane	Primary Care Physician	INITIAL	3/19/2024
Watson	Tracie	Specialist	INITIAL	3/19/2024
Wilson	Alexis	BH-Telehealth	INITIAL	3/19/2024
Wilson	Jennifer	BH-Telehealth	INITIAL	3/19/2024
Windon	Charles	BH	INITIAL	3/19/2024
Wolff	Courtney	ABA-Telehealth	INITIAL	3/19/2024
Ya	Jason	Specialist	INITIAL	3/19/2024
Yamamoto	Hannah	Allied Health	INITIAL	3/19/2024
Yang	Ying	BH	INITIAL	3/19/2024
Zaw	Andrea	Specialist	INITIAL	3/19/2024
Bernstein	Laurel	Allied Health	RE-CRED	3/19/2024
Bloom	Ernest	Specialist	RE-CRED	3/19/2024
Brown	Blair	Primary Care Physician	RE-CRED	3/19/2024
Burroughs	Sweena	Allied Health	RE-CRED	3/19/2024
Eliasieh	Kasra	Specialist	RE-CRED	3/19/2024
Johnson	Wanda	Allied Health	RE-CRED	3/19/2024
Knopf	Kevin	Specialist	RE-CRED	3/19/2024
Kopelnik	Alexander	Specialist	RE-CRED	3/19/2024
Lennox	John	Specialist	RE-CRED	3/19/2024

LAST NAME	FIRST NAME	CATEGORY	INITIAL/RE-CRED	CRED DATE
Liu	Rock	Specialist	RE-CRED	3/19/2024
Lo	Susan	Primary Care Physician	RE-CRED	3/19/2024
Lovato	Esteban	Primary Care Physician	RE-CRED	3/19/2024
Massella Hernandez	Maria	Allied Health	RE-CRED	3/19/2024
Molina	Ricardo	Specialist	RE-CRED	3/19/2024
Morrar	Maisa	Allied Health	RE-CRED	3/19/2024
Nord	Russell	Specialist	RE-CRED	3/19/2024
Quon	Tina	Allied Health	RE-CRED	3/19/2024
Renik	Margaret	Primary Care Physician	RE-CRED	3/19/2024
Sehgal	Rohit	Specialist	RE-CRED	3/19/2024
Shah	Saurin	Specialist	RE-CRED	3/19/2024
Simons	Pamela	Specialist	RE-CRED	3/19/2024
Siopack	Jorge	Specialist	RE-CRED	3/19/2024
Spence	Rebecca	Allied Health	RE-CRED	3/19/2024
Stancescu-Popescu	Roxana	Primary Care Physician	RE-CRED	3/19/2024
Sweeney	Michael	Allied Health	RE-CRED	3/19/2024
Traynor	Jeffrey	Specialist	RE-CRED	3/19/2024
Velkuru	Vani	Specialist	RE-CRED	3/19/2024
Won	Rosa	Specialist	RE-CRED	3/19/2024
Woolf	Sara	Primary Care Physician	RE-CRED	3/19/2024

MARCH PEER REVIEW AND CREDENTIALING
INITIAL APPROVALS BY SPECIALTY



PCP	8
Specialists	15
Allied Health	16
Ancillary	1
BH/ABA	66
Total	106

COMMUNICATIONS & OUTREACH DEPARTMENT

ALLIANCE IN THE COMMUNITY

FY 2023 - 2024 | **3RD QUARTER (Q3) OUTREACH REPORT**

ALLIANCE IN THE COMMUNITY

FY 2023 - 2024 | 3rd QUARTER (Q3) OUTREACH REPORT

Between January 2024 and March 2024, the Alliance completed **2,235** member orientation outreach calls among net new members and non-utilizers and conducted **433** member orientations (**19.4%** member participation rate). In addition, the Outreach team completed **249** Alliance website inquiries, **36** service requests, **5** social media inquiries, **7** community events, and **5** member education events in Q3.

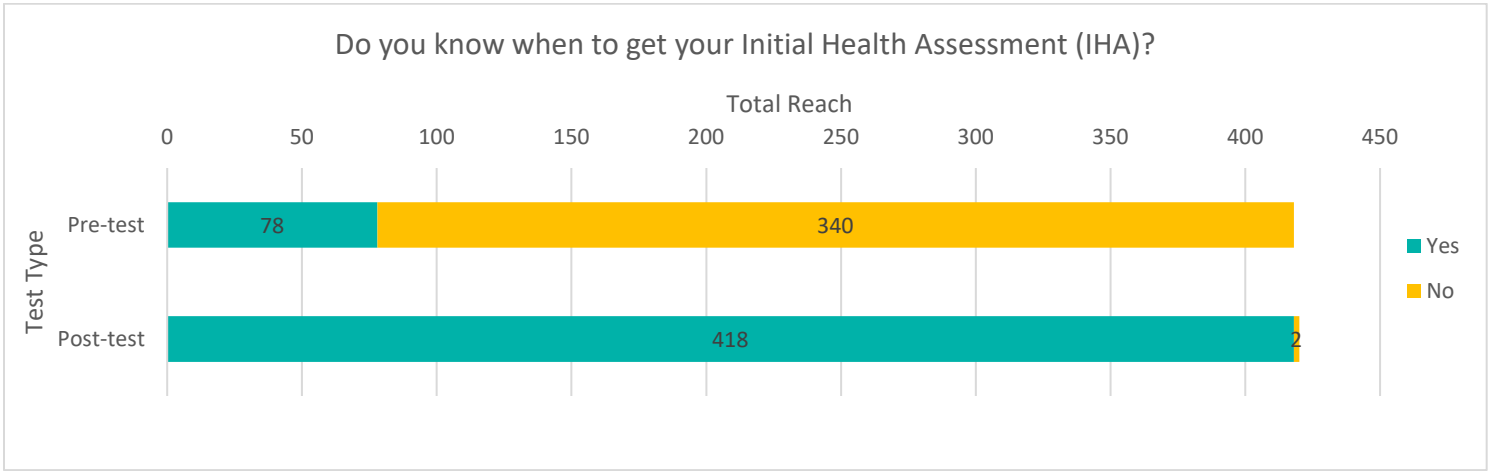
The Communications & Outreach Department began reporting the number of members reached during outreach activities in late February 2018. Since July 2018, **31,717** self-identified Alliance members have been reached during outreach activities.

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

On **Wednesday, March 18, 2020,** the Alliance began conducting member orientations by phone. As of **Sunday, March 31, 2024**, the Outreach Team completed **34,506** member orientation outreach calls and conducted **8,230** member orientations (23.9%-member participation rate).

The Alliance Member Orientation (MO) program has been in place since August 2016. In 2019, the program was recognized as a promising practice to increase member knowledge and awareness about the Initial Health Assessment, by the Department of Health Care Services (DHCS), Managed Care Quality and Monitoring Division (MCQMD). We have steadily increased program participation. Our 2019 6-month average participation rate was **111** members per month. Between March 18, 2020, through March 31, 2024 – **8,230** members completed our MO and Non-utilizer program by phone.

After completing a MO **99.22%** of members who completed the post-test survey in Q3 FY 23-24 reported knowing when to get their IHA, compared to only **18.7%** 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 23-24\Q3\3. March 2024**

ALLIANCE IN THE COMMUNITY

FY 2023 - 2024 | 3RD QUARTER (Q3) OUTREACH REPORT

Q3 FY 2023-2024 TOTALS

7	COMMUNITY EVENTS	**3344**	TOTAL REACHED AT VIRTUAL COMMUNITY EVENTS
5	MEMBER EDUCATION EVENTS	**1787**	TOTAL REACHED AT MEMBER EDUCATION EVENTS
433	MEMBER ORIENTATIONS	**433**	TOTAL REACHED AT MEMBER ORIENTATIONS
0	MEETINGS/ PRESENTATIONS	**0**	TOTAL REACHED AT MEETINGS/PRESENTATIONS
18	TOTAL INITIATED/INVITED EVENTS	**2220**	TOTAL MEMBERS REACHED AT EVENTS
451	TOTAL EVENTS	**3777**	TOTAL REACHED AT ALL EVENTS

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

TOTAL REACH 20 CITIES

Cities represent the mailing addresses for members who completed a Member Orientation by phone. The italicized cities are outside of Alameda County. The following cities had <1% reach during Q3 2024: Antioch, Pittsburg, Stockton, and Vallejo. The C&O Department started including these cities in the Q3 FY21 Outreach Report.

$1,007.10

TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

** Includes refundable deposit.*

COMMUNICATIONS & OUTREACH DEPARTMENT

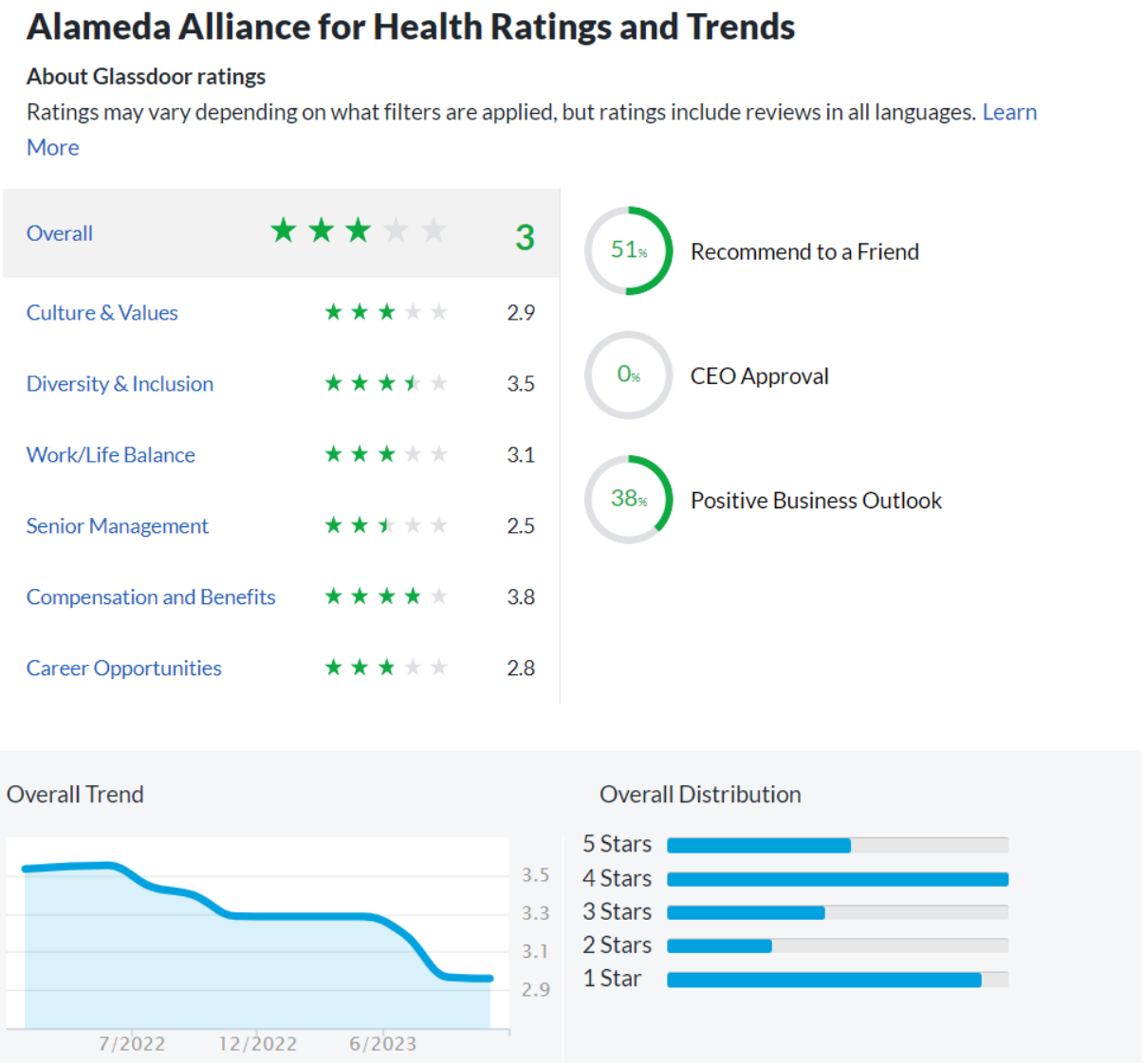
SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2023-2024 | March 2024

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

1. Alliance Website:
    - Received **25,000** unique visits
    - Received **22,000** new user visits
    - The top **10** website page visits were:
        i. Homepage
        ii. Provider Page
        iii. Find a Doctor
        iv. Contact Us
        v. Medi-Cal Benefits and Services
        vi. Careers
        vii. Contact Us
        viii. Medi-Cal Members
        ix. Get a New ID Card
        x. About Us
2. Facebook Page:
    - Maintained Fans at **631**
    - Did not receive any reviews in **March 2024**
3. Glassdoor Page:
    - **3** out of a **5-star** overall rating
    - Received 1 review in **March 2024**
4. Instagram Page:
    - Page debuted **June 10, 2021**
    - Increase in followers from **498** to **509**
5. Twitter Page:
    - Slight decrease in followers from **358 to 357**
6. LinkedIn Page:
    - Increased followers from **5.1k to 5.2k**
    - Received **271-**page clicks
7. Yelp Page:
    - Page visits **53**
    - Appeared in Yelp searches **127** times
    - Did not receive any reviews in **March 2024**
8. Google Page:
    - **4,985** website clicks made from the business profile
    - **1,521** calls made from the business profile
    - Received **2** reviews in **March 2024**
    - Received **12** chat messages in **March 2024**

GLASSDOOR OVERVIEW

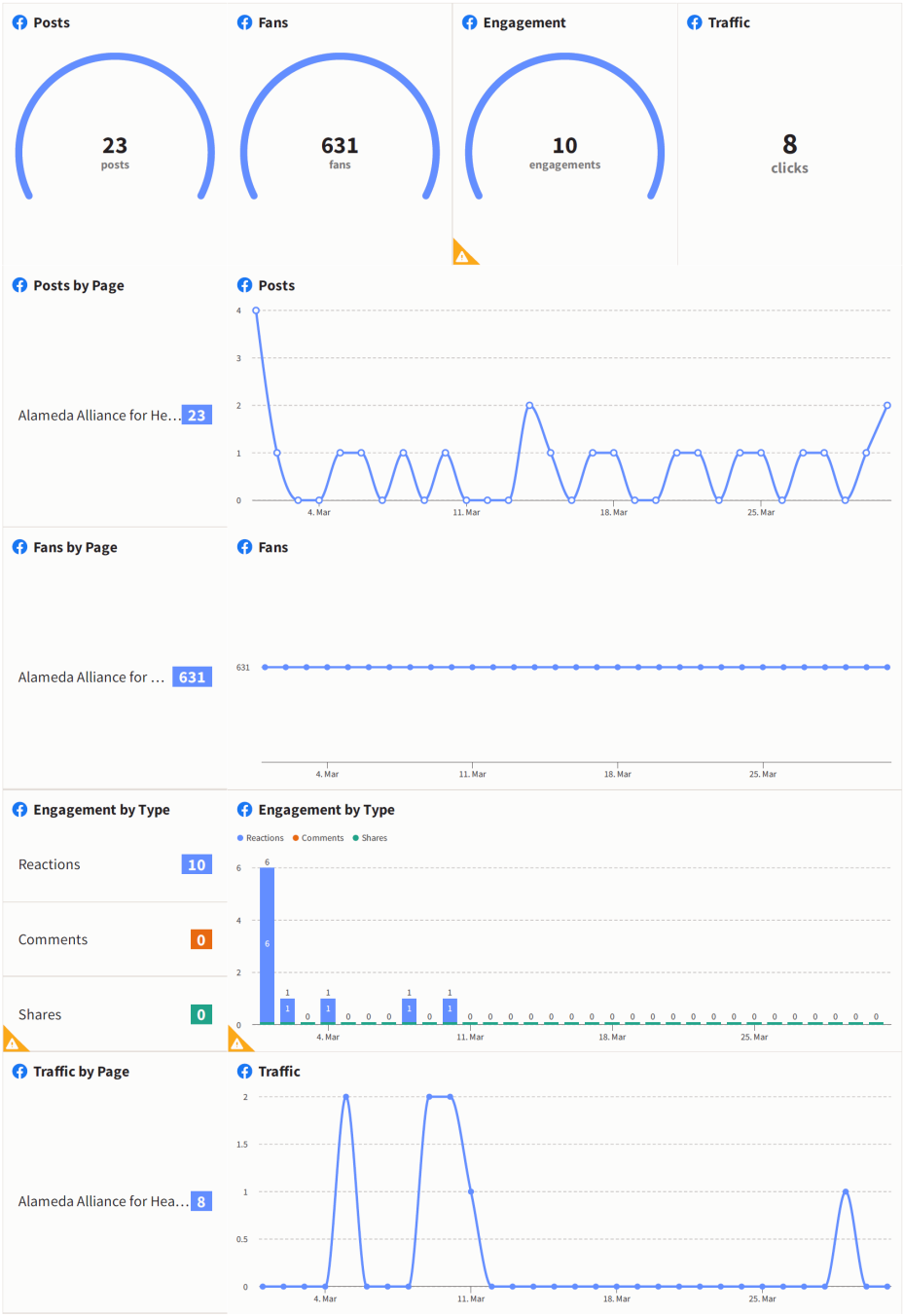


All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2023-2024\Q3\3. March 2024

ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2023-2024 | March 2024

FACEBOOK OVERVIEW



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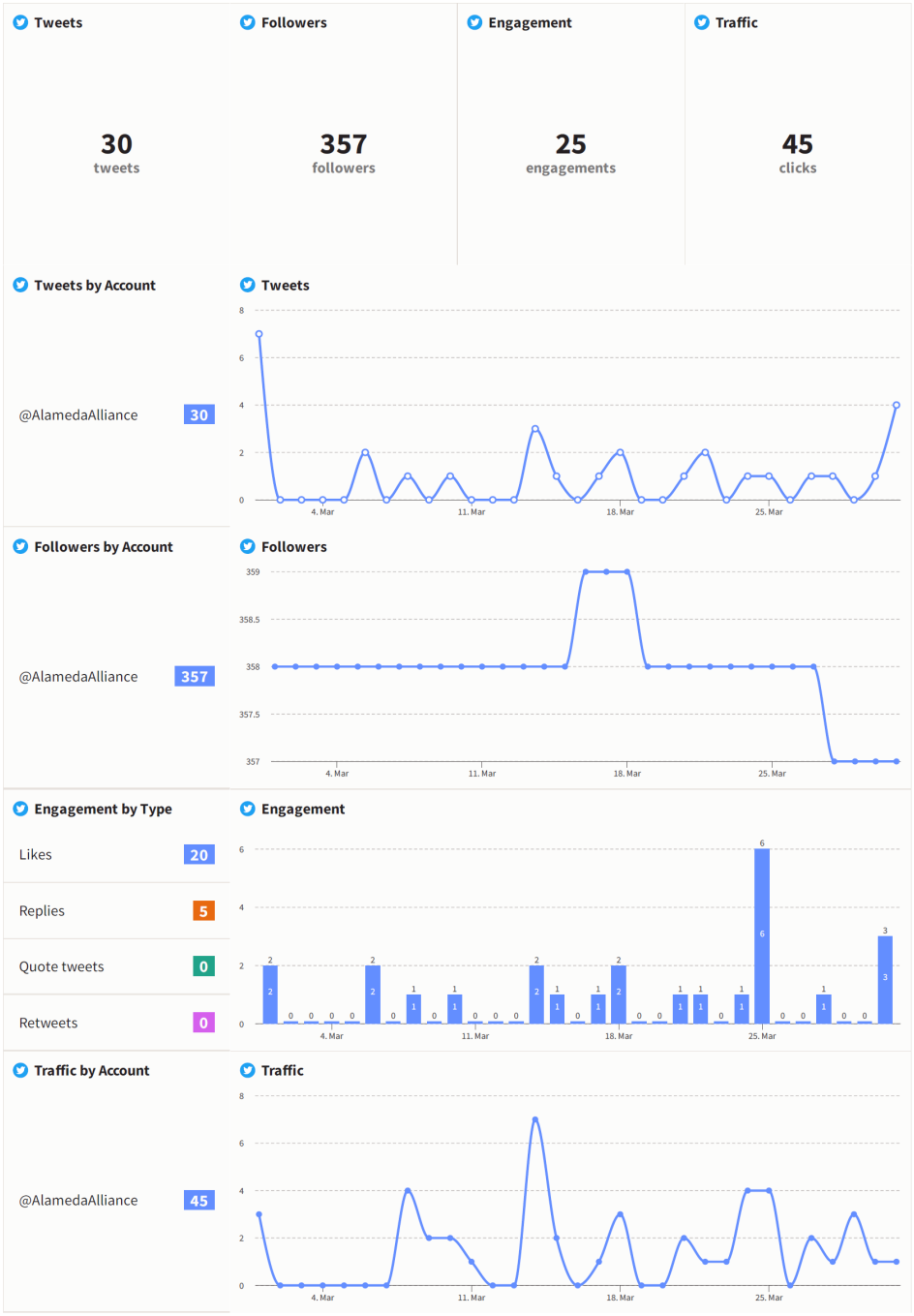
ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2023-2024 | March 2024

TWITTER OVERVIEW



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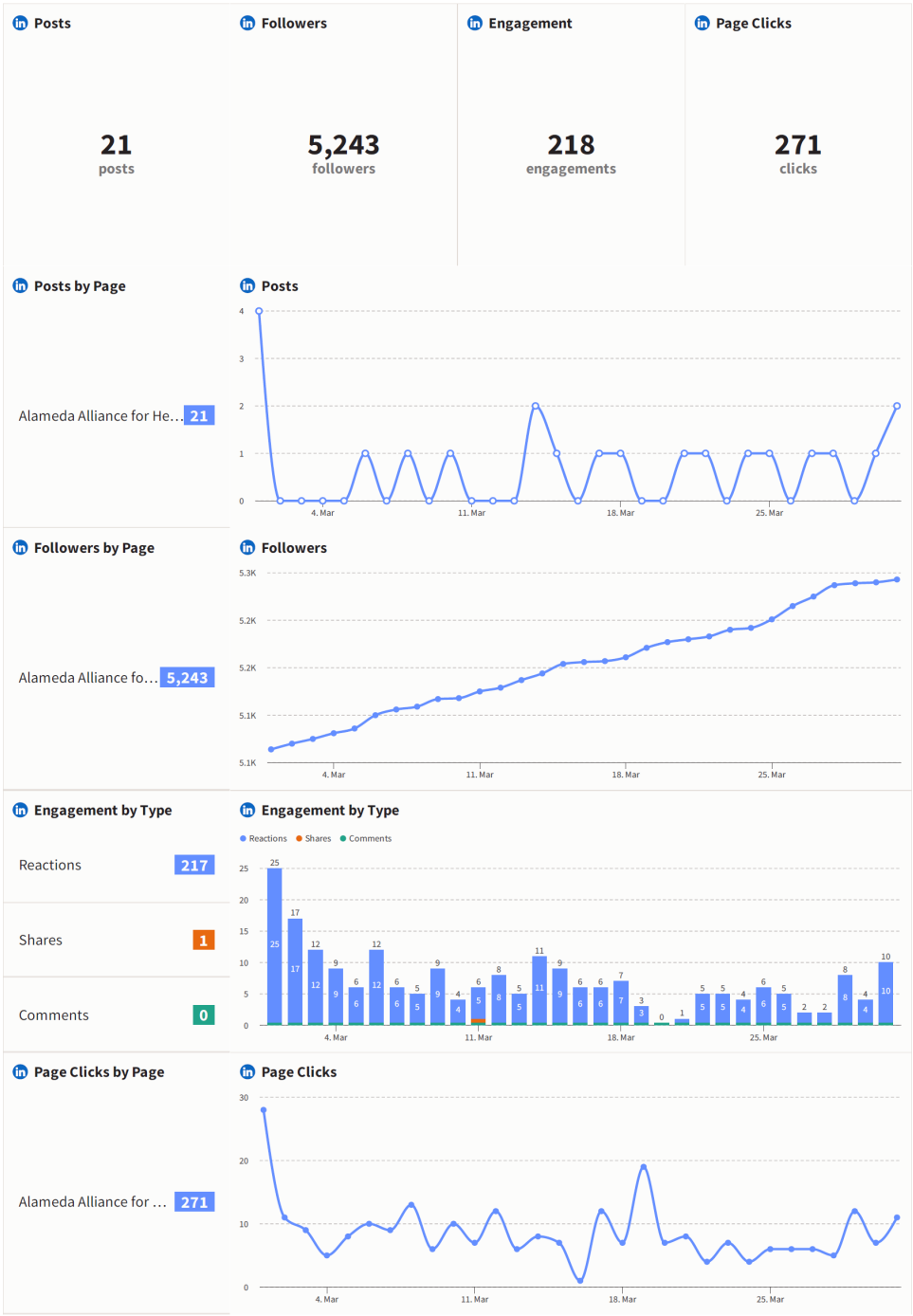
ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2023-2024 | March 2024

LINKEDIN OVERVIEW



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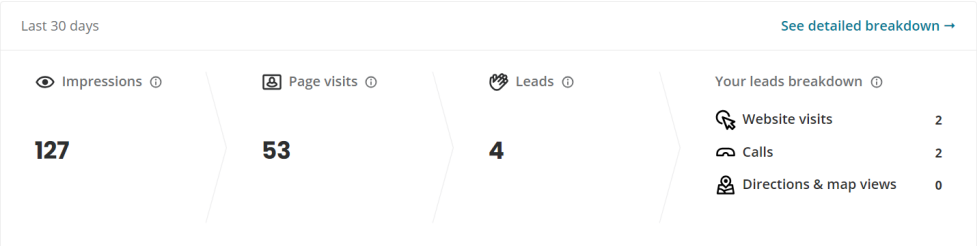
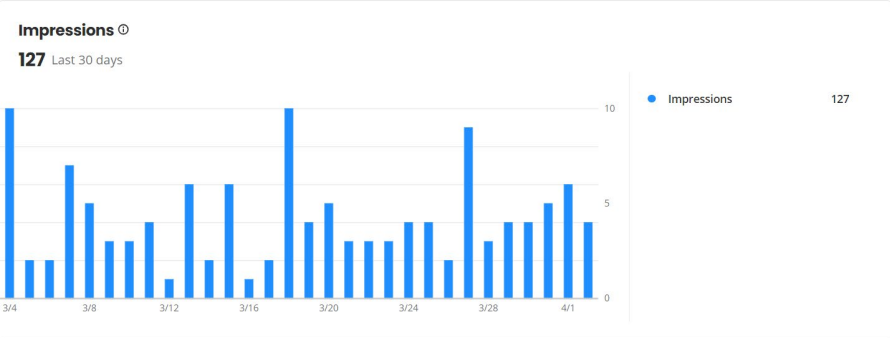
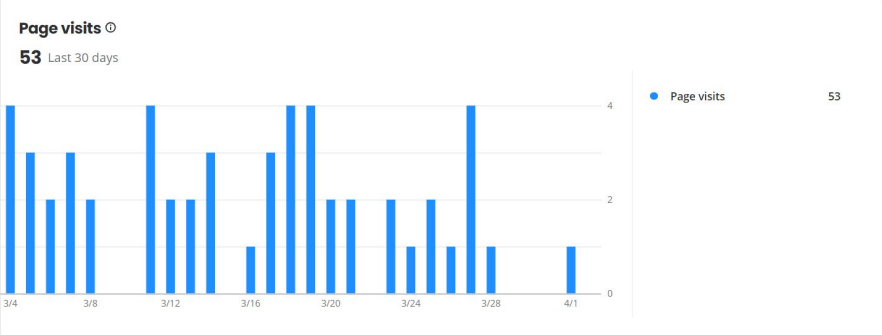
ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

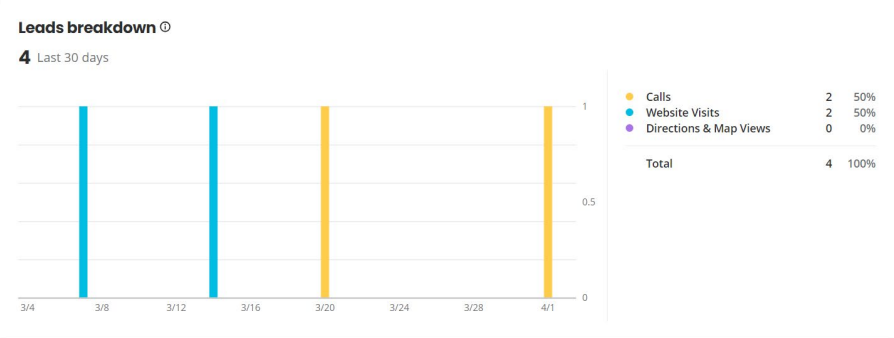
FY 2023-2024 | March 2024

YELP OVERVIEW









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ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2023-2024 | March 2024

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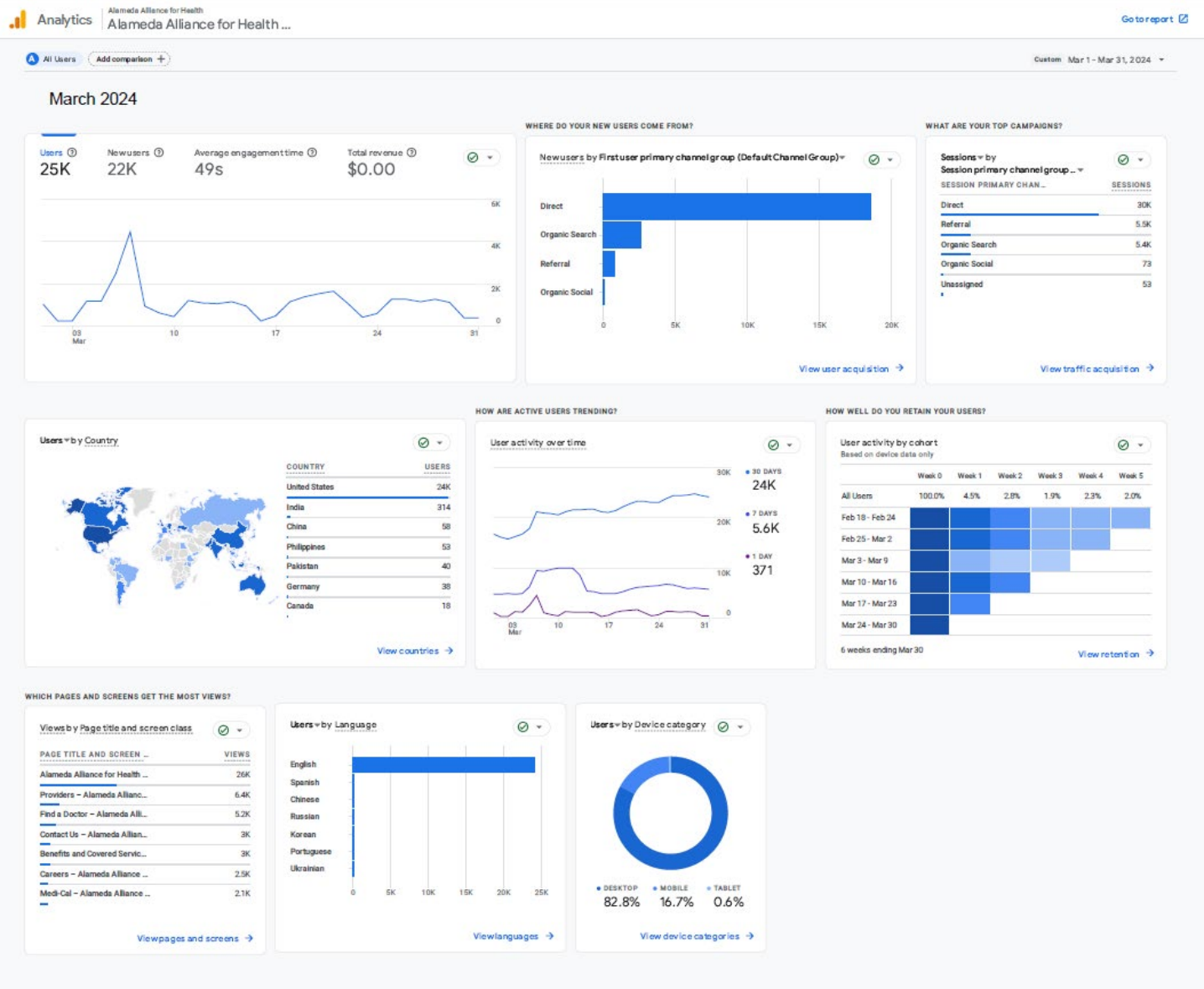

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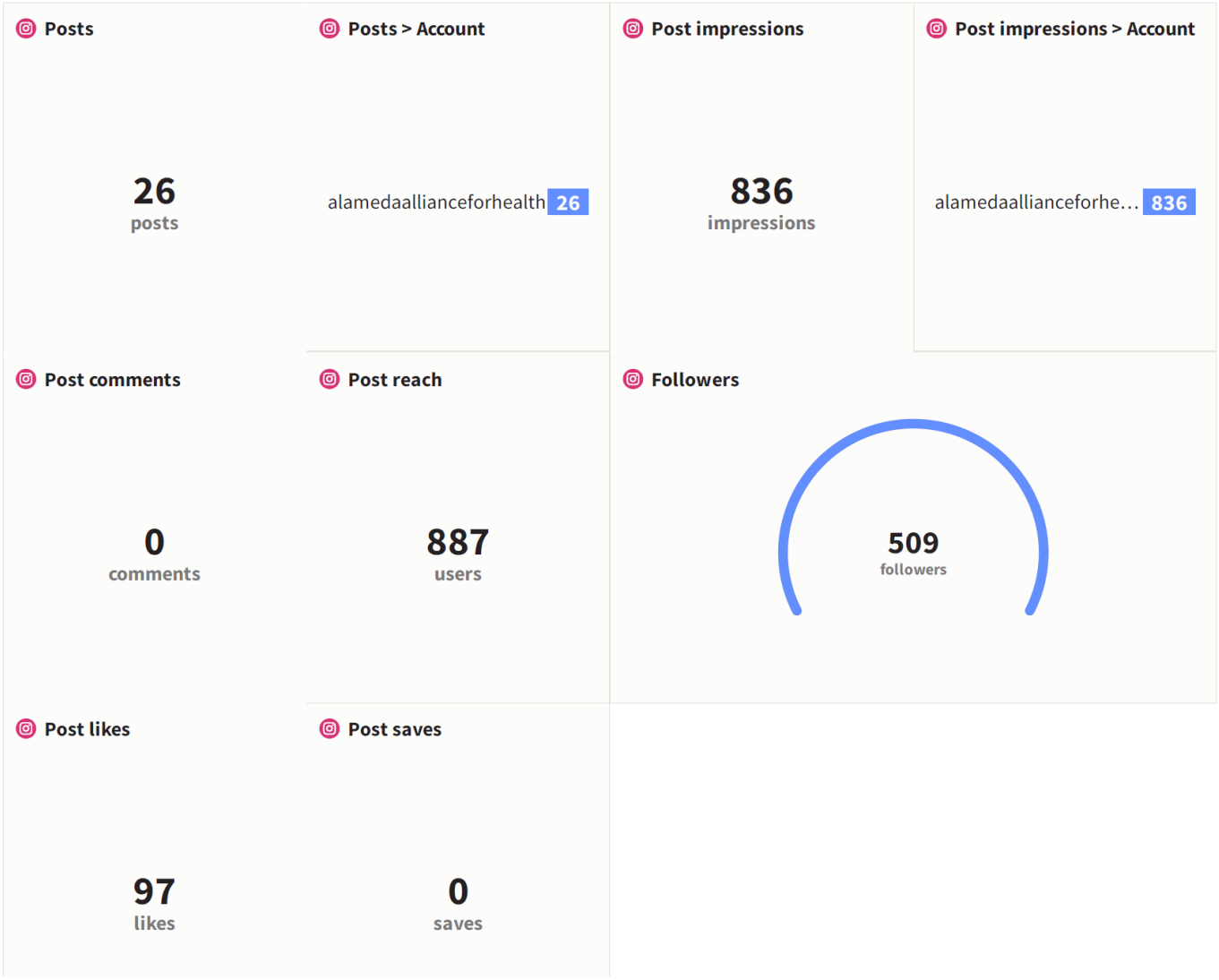
ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2023-2024 | March 2024

Instagram OVERVIEW:



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ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

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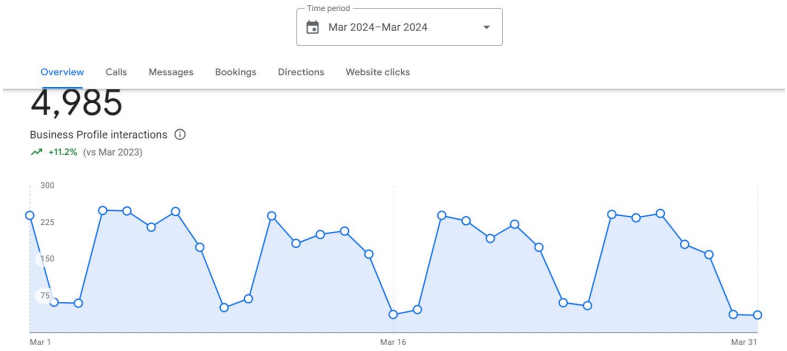

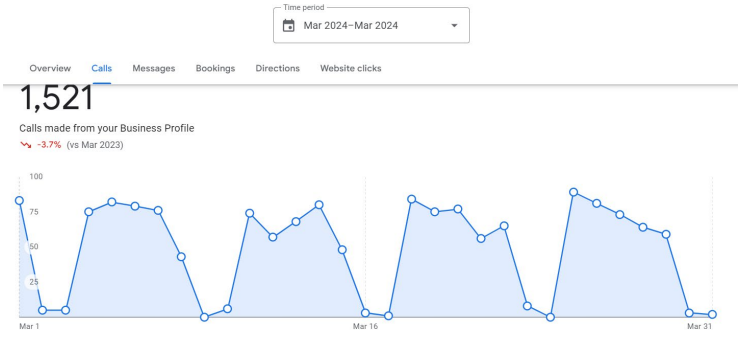

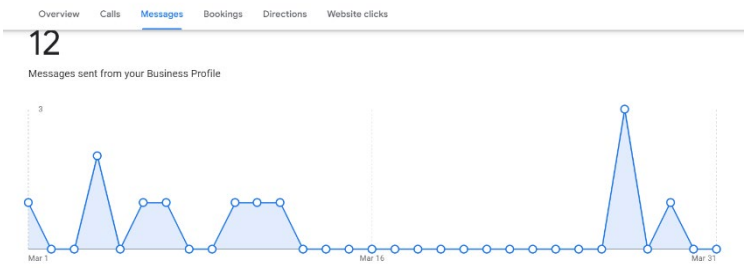

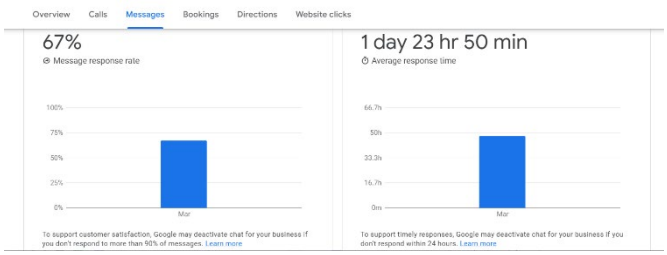

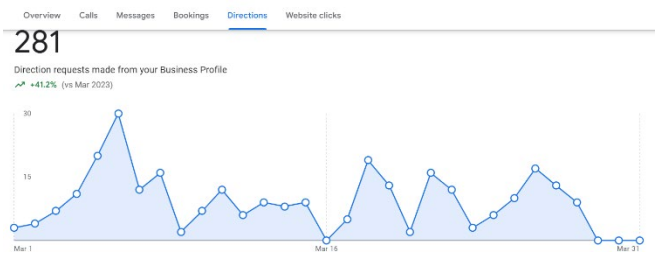

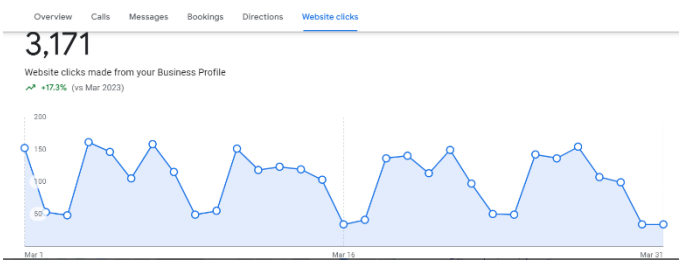

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Integrated Planning

Ruth Watson

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

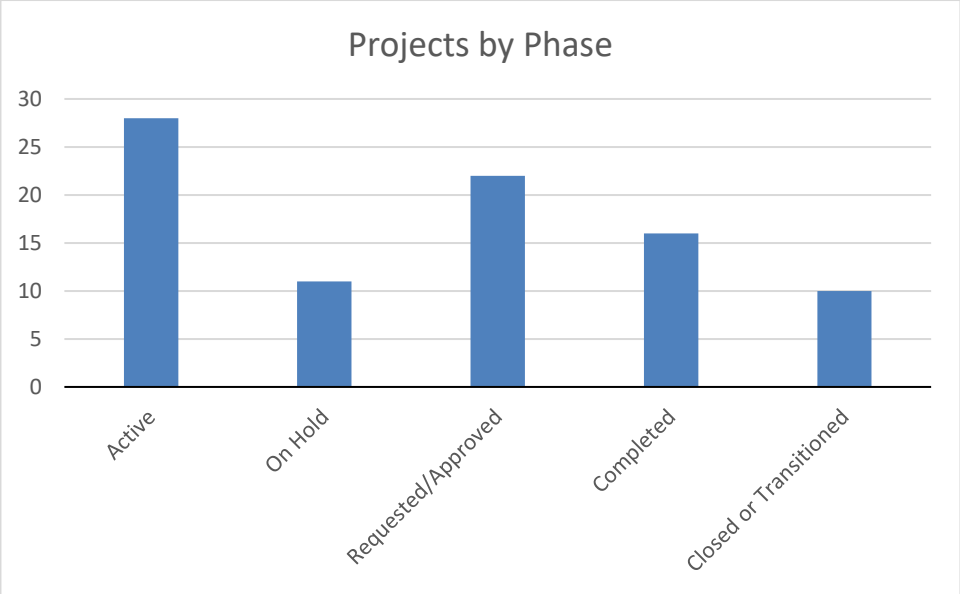
From: **Ruth Watson, Chief Operating Officer**

Date: **April 12th, 2024**

Subject: **Integrated Planning Division Report – March 2024 Activities**

Project Management Office

- 87 projects currently on the Alameda Alliance for Health (AAH) enterprise-wide portfolio
    - 28 Active projects (discovery, initiation, planning, execution, warranty)
    - 11 On Hold projects
    - 22 Requested and Approved Projects
    - 16 Complete projects
    - 10 Closed/Transitioned to Department or IT Led



Integrated Planning

- **Medicare Overview**
  <u>D-SNP Readiness</u>
  Alameda Alliance for Health (AAH) Medicare Advantage Duals Special Needs Plan (DNSP) will begin serving members on January 1st, 2026

  Key milestones and dates the Alliance is working toward for January 1st, 2026, include the following:
  - D-SNP Feasibility Study (ProForma) – January 2024 - completed

- Core System (Claims, Medical Management, Grievance & Appeals) Review – January 2024 – completed
- DHCS & DMHC Material Modification Submission 1 – March 1st, 2024 - completed
- DHCS & DMHC Material Modification Submission 2 (Financials) – April 15th, 2024
- Provider Network Development and Recruitment – February 2024 thru February 2025
- CMS Notice of Intent to Apply – November 2024
- CMS Application (Model of Care (MOC), Provider Network, & DMHC Approval) – February 2025
- CMS Formulary and Bid Submission (Benefit Determination) – June 2025
- Operational Readiness Assessment, Training, and Audit – June through December 2025
- Annual Enrollment Period – October thru December 2025

2024 Q2 (April thru June)

- AAH and Rebellis completed the kickoff and initial review and development for the following:
    - Review of current Policy & Procedures (all business areas)
    - Model of Care. The Model of Care includes four parts, MOC 1 Description of the SNP Population, MOC 2 Care Coordination, MOC 3 Provider Network, MOC 4 Quality Measurement & Performance Measurement. The initial focus is on MOC part 1
        - Clinical services for Utilization Management, Quality, Stars, and HEDIS
        - Sales and Marketing Planning
        - Product Management with a focus on Benefit Pre-Planning
        - Member Experience with a focus on Member Call Center Planning

- **<u>CalAIM Initiatives:</u>**
    - Community Supports (CS):
        - MOC for January 2024 CS elections submitted to DHCS on July 5th, 2023, and approved by DHCS on December 26th
            - AAH added two (2) additional CS services effective January 1st, 2024
                - Nursing Facility Transition/Diversion to Assisted Living Facilities
                - Community Transition Services/Nursing Facility to a Home
                - Sobering Centers has been delayed to July 1st, 2024
        - AAH received interest from various providers to contract for the provision of these new CS services
        - DHCS required all MCPs to submit an updated CS MOC for July 2024 by January 1st, 2024
            - Updated CS MOC was submitted to DHCS on December 29th

- Justice-Involved (JI) Initiative:
    - CalAIM Re-entry
        - Go-live date for the CalAIM Re-Entry initiative is October 1st, 2024, for all MCPs

        - Correctional facilities will have the ability to select their go-live date within a 24-month phase-in period (10/1/2024 – 9/30/2026)
            - Santa Rita Jail is targeting to go-live on 7/1/2026 with pre-release services; Juvenile Justice Center's go-live is TBD
        - Managed Care Plans (MCPs) must be prepared to coordinate with correctional facilities as of October 1st, 2024, even if facilities in their county will go-live at a later date
    - Bi-weekly workgroup meetings with Alameda County Sheriff's Office, Probation, Alameda County Behavioral Health, Social Security Administration, Kaiser Permanente and AAH continue to support collaboration on the strategy for this initiative
        - Workgroup is developing workflows and strategies to support behavioral health linkages, care plans, and the pre-release warm hand-off
    - Additional meetings will be held internally to further define the data requirements for AAH to share with external agencies in support of the JI initiatives
    - AAH met with representatives from the Alameda County Office of Education's Division of Student Programs and Services (ACOE SPaS) to learn about their programs serving justice involved youth and youth at risk of incarceration
        - A follow-up meeting will be scheduled in April
    - AAH met with Wellpath (clinical provider within Santa Rita Jail) to continue discussions about data sharing and also to learn about discharge planning
        - Monthly meetings have been scheduled through Q1 in support of ongoing collaboration with Wellpath
    - AAH JI project team will meet with Alameda County Collaborative Courts on April 12 to discuss progress on JI re-entry, in partnership with Kaiser Permanente
    - AAH JI project team will be attending a tour of the Juvenile Justice Center and Camp Sweeny led by the Probation department on April 26

- Justice Involved ECM Population of Focus:
    - Justice-Involved (JI) ECM Population of Focus (PoF) went live on January 1st, 2024
    - DHCS reviewed all materials submitted by AAH in the initial MOC process and requests for additional information and has given us a "pre-CAP" letter
        - DHCS has indicated our submission was inadequate in the following areas: A) At least one (1) experienced JI ECM Provider in each county of operation and B) Network sufficiency to meet the estimated ECM capacity needs
        - AAH revised our MOC submissions based on the outcomes of the TA calls with DHCS and consultation with our ECM provider network
        - AAH's response to the pre-CAP letter was submitted to DHCS on March 22nd

- AAH/Roots JI Pilot Project:
    - AAH's pilot for post-release services began in July 2023 in preparation for the 2024 programs related to this population

- The team has started analyzing the data we received from Roots to support the development of our strategy for the re-entry initiative that commences in 2024
- Initial data analysis has shown a disparity between the number of males vs. females seeking help upon release (roughly 10% of males vs. near 100% females)
- Housing assistance is also a top need for this population
- Monthly check-ins with Roots will continue through the remainder of the pilot term, ending in July 2024

- Population Health Management (PHM) Program – effective January 1st, 2023:
  - The IPD supported project is ending in April, 2024
  - PHM Disease Management Deliverables
    - DHCS-approved letters sent out to notify members of the availability of Asthma, Diabetes and Cardiovascular Disease programs
    - Depression member letter has been approved by DHCS; team is finalizing workflows with Member Services and Behavioral Health; goal is to include Depression Perinatal Program – Birthwise Wellbeing information in member prenatal and postpartum health education mail campaign in April
  - 2023 DHCS PHM Strategy Deliverable
    - Held multiple meetings with Alameda County Health Care Services Agency (HCSA), City of Berkeley, Health Housing and Community Services, and Kaiser Permanente regarding Alliance collaboration with the Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHIP)
    - City Of Berkeley, Kaiser Permanente and Alameda Alliance have agreed on the following goal with City of Berkeley:
      - Goal: Improve mental health and well-being for at-risk populations by addressing gaps in mental health screening and referrals to follow-up treatment and supportive services
      - SMART Objective: By September 2024, the City of Berkeley and Alameda Alliance for Health will develop and complete a landscape analysis to identify available services and gaps in mental health screenings and referrals in Berkeley. The assessment will inform the development of a targeted strategy to improve mental health care and supports for at-risk populations by March 2025.
    - The Team is working with Alameda County Public Health “Signature” programs that promote birth equity and immunizations to define a shared goal that aligns with the County’s Community Health Improvement Plan, the Alliance PHM Strategy and the DHCS Clinical Quality Strategy Bold Goals
  - 2023 DHCS PHM Monitoring Requirements
    - Work continued to establish internal monitoring processes for PHM Key Performance Indicators (KPIs) and Quality metrics, including stratification by race, ethnicity, language, and age
    - DHCS has put a hold on quarterly KPI reporting as they relook at the metric specifications
    - Reviewing KPI performance and identifying areas for improvement

- Community Health Worker (CHW) Benefit – Medi-Cal benefit effective July 1st, 2022, designed to promote the MCP's contractual obligations to meet DHCS broader Population Health Management standards as an adjunctive service as part of the interventions to positively impact health outcomes

  Provider Recruitment Activities:
  - Journey Health:
    - Will begin receiving new referrals in April 2024 as our first contracted CHW provider
    - Will also initiate referrals for members they are already seeing
    - CHW group works in partnership with internal PHM teams to understand their 2024 priority population disease management goals and receive a referral list for our partners
  - Pair Team:
    - Provider is fully credentialed and a fully executed contract is expected by mid-April
  - Family Resource Navigators:
    - Currently in pre-contract phase with AAH to become a CHW provider
    - AAH is awaiting a sustainability plan from the provider for infrastructure development funds
    - Provider will be subcontracting with Full Circle to meet CHW billing requirements
  - Youth Alive:
    - Pending organization's response to AAH contract proposal
    - Meeting scheduled with Youth Alive CEO next month for further contract discussions
  - Save DV:
    - Organization supports individuals who are fleeing domestic violence/intimate partner violence and provides other crisis intervention services
    - Informational meeting schedule for April

  CHW Workgroup Activities:
  - Developed a Proposal for a $100K grant to support CHW network providers with infrastructure development; pending Executive Sponsor review
  - Reviewing potential claims issue to prevent non-contracted providers from billing CHW services
    - Working with Health Care Services regarding ideas for CHWs to support low-risk Transitional Care Services (TCS) members

- Dual Eligible Special Needs Plan (D-SNP) Implementation - All Medi-Cal MCPs will be required to implement a Medicare Medi-Cal Plan (MMP) as of January 1st, 2026:
  - Rebellis provided their Final Draft System Review; AAH internal review is in process
  - A decision on whether to continue to use the existing Claims (HEALTHsuite) and Medical Management (TruCare) platforms or move to new systems to support the addition of the D-SNP line of business is pending
  - Development of the project schedule and project status reporting continues

Other Initiatives

- Business Continuity Plan - required as part of our 2024 Operational Readiness:
  - Disaster Recovery Plan
    - Included in the overall Business Continuity Plan (BCP)
    - Development of the Disaster Recovery Plan is complete
  - Engagement with BCP Consultant – Quest
  - Quest is working with AAH business areas on the completion of the BCP Questionnaire
  - Extension of Quest SOW through June 30, 2024.
  - Go Live date was extended from March 31st, 2024 to June 1, 2024.
- Memorandums of Understanding (MOUs) with Third Parties - required as part of our 2024 Operational Readiness (OR):
  - MOUs associated with OR requirements were submitted to DHCS on December 29th
  - DHCS has published seven (7) final DHCS MOU templates; one (1) MOU template for Women, Infant, and Children (WIC) is pending from DHCS
  - Two (2) MOUs have been moved from 12/29/2023 to 7/1/2024
    - Drug Medi-Cal/DMC-ODS MOU – Alcohol and Substance Use Disorder (SUD) treatment.
    - LGA MOU – Targeted Case Management (TCM)
  - MOU Quarterly Report
    - Next submission is due April 30, 2024, for reporting period Q1 January 2024 thru March 31, 2024

- CYBHI Fee Schedule – Effective January 1st, 2024, the Alliance is partnering with Carelon (formerly known as Beacon) to implement the CYBHI Fee Schedule.
  - Cohort 1 is intended to be a "learning" cohort
  - DHCS continues holding a series of meetings with Cohort participants; these include Onboarding Sessions for the LEAs as well as Technical Office Hours each Thursday of the month
  - The Alliance will utilize Carelon as the Third-Party Administrator (TPA)
  - The Claims submission date has been extended from April 1, 2024 to July 1, 2024

Recruiting and Staffing

Integrated Planning Open position(s):

- Recruitment for new positions effective February 2024 – pending
- Backfill for Business Analyst – Integrated Planning

Integrated Planning

Supporting Documents

Integrated Planning

Supporting Documents Project Descriptions

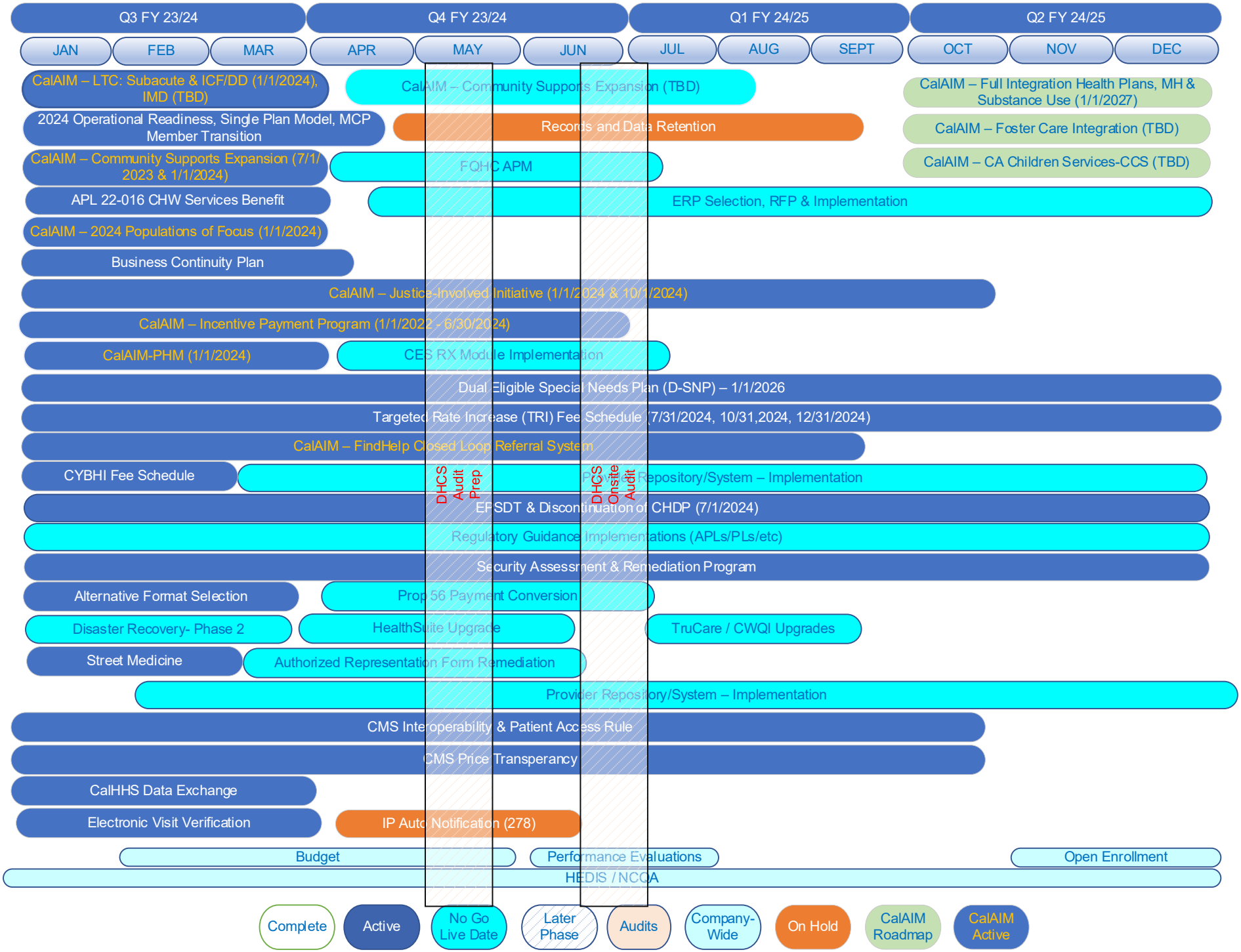
Key projects currently in-flight:

- California Advancing and Innovating Medi-Cal (CalAIM) – program to provide targeted and coordinated care for vulnerable populations with complex health needs
  - Enhanced Care Management (ECM) – ECM will target eight (8) specific populations of vulnerable and high-risk children and adults
    - Three (3) Populations of Focus (PoF) transitioned from HHP and/or WPC on January 1st, 2022
    - Two (2) additional PoF became effective on January 1st, 2023
    - One (1) PoF became effective on July 1st, 2023
    - Two (2) PoF will become effective on January 1st, 2024
  - Community Supports (CS) effective January 1st, 2022 – menu of optional services, including housing-related and flexible wraparound services, to avoid costlier alternatives to hospitalization, skilled nursing facility admission and/or discharge delays
    - As of January 1st, 2024, AAH will offer twelve (12) of the fourteen (14) DHCS-designated CS services
      - January 1st, 2022 – Six (6) Community Supports were implemented
      - July 1st, 2023 – Three (3) additional CS services went live
      - January 1st, 2024
        - Two (2) CS services that support the LTC PoFs that were effective January 2023 are being piloted in 7/1 - 12/31/2023 and will go live in January
        - One (1) additional CS service is also targeted for implementation in July 2024
  - Long Term Care - benefit was carved into all MCPs effective January 1st, 2023, with the exception of Subacute and ICF-DD facilities which are scheduled for implementation January 1st, 2024; IMD facilities implementation date TBD
  - Justice Involved Initiative – adults and children/youth transitioning from incarceration or juvenile facilities will be enrolled into Medi-Cal upon release
    - DHCS is finalizing policy and operational requirements for MCPs to implement the CalAIM Justice-Involved Initiative
      - MCPs must be prepared to go live with ECM for the Individuals Transitioning from Incarceration as of January 1st, 2024
      - MCPs must be prepared to coordinate with correctional facilities to support reentry of members as the return to the community by October 1st, 2024
      - Correctional facilities will have two years from 10/1/2024 - 9/30/2026 to go live based on readiness

- Population Health Management (PHM) – all Medi-Cal managed care plans were required to develop and maintain a whole system, person-centered population health management strategy effective January 1st, 2023. PHM is a comprehensive, accountable plan of action for addressing Member needs and preferences, and building on their strengths and resiliencies across the continuum of care that:
    - Builds trust and meaningfully engages with Members;
    - Gathers, shares, and assesses timely and accurate data on Member preferences and needs to identify efficient and effective opportunities for intervention through processes such as data-driven risk stratification, predictive analytics, identification of gaps in care, and standardized assessment processes;
    - Addresses upstream factors that link to public health and social services;
    - Supports all Members staying healthy;
    - Provides care management for Members at higher risk of poor outcomes;
    - Provides transitional care services for Members transferring from one setting or level of care to another; and
    - Identifies and mitigates social drivers of health to reduce disparities
- Dual Eligible Special Needs Plan (D-SNP) Implementation – All Medi-Cal MCPs will be required to operate Medicare Medi-Cal Plans (MMPs), the California-specific program name for Exclusively Aligned Enrollment Dual Eligible Special Needs Plans (EAE D-SNPs) by January 2026 in order to provide better coordination of care and improve care integration and person-centered care. Additionally, this transition will create both program and financial alignment, simplify administration and billing for providers and plans, and provide a more seamless experience for dual eligible beneficiaries by having one plan manage both sets of benefits for the beneficiary.

- Community Health Worker Services Benefit – Community Health Worker (CHW) services became a billable Medi-Cal benefit effective July 1st, 2022. CHW services are covered as preventive services on the written recommendation of a physician or other licensed practitioner of the healing arts within their scope of practice under state law for individuals who need such services to prevent disease, disability, and other health conditions or their progression; prolong life; and promote physical and mental health and well-being.
- 2024 Single Plan Model
    - 2024 Managed Care Plan Contract Operational Readiness – new MCP contract developed as part of Procurement RFP; all MCPs must adhere to new contract effective January 1st, 2024
        - Business Continuity Plan required as part of Operational Readiness
        - MOUs with third parties required as part of Operational Readiness
    - MCP Member Transition
        - Anthem members will transition to AAH effective January 1st, 2024
        - Members currently delegated to Kaiser will transition to Kaiser as part of their direct contract with DHCS effective January 1st, 2024
- CYBHI Statewide Fee Schedule – The Department of Health Care Services (DHCS), in collaboration with the Department of Managed Health Care (DMHC), has developed and a multi-payer, school-linked statewide fee schedule for outpatient mental health or substance use disorder services provided to a student 25 years of age or younger at or near a school site. CYBHI requires commercial health plans and the Medi-Cal delivery system, as applicable, to reimburse, at or above the published rates, these school-

linked providers, regardless of network provider status, for services furnished to students pursuant to the fee schedule. Effective January 1st, 2024, the Alliance is partnering with the Alameda County Office of Education (ACOE) and several Local Education Agencies (LEAs) who were selected to participate in the CYBHI Fee Schedule Cohort 1.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JAN
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CalAIM – LTC: Subacute & ICF/DD (1/1/2024), IMD (TBD)
CalAIM – Community Supports Expansion (TBD)
CalAIM – Full Integration Health Plans, MH & Substance Use (1/1/2027)
2024 Operational Readiness, Single Plan Model, MCP Member Transition
Records and Data Retention
CalAIM – Foster Care Integration (TBD)
CalAIM – Community Supports Expansion (7/1/2023 & 1/1/2024)
FQHC APM
CalAIM – CA Children Services-CCS (TBD)
APL 22-016 CHW Services Benefit
ERP Selection, RFP & Implementation
CalAIM – 2024 Populations of Focus (1/1/2024)
Business Continuity Plan
CalAIM – Justice-Involved Initiative (1/1/2024 & 10/1/2024)
CalAIM – Incentive Payment Program (1/1/2022 - 6/30/2024)
CalAIM-PHM (1/1/2024)
CES RX Module Implementation
Dual Eligible Special Needs Plan (D-SNP) – 1/1/2026
Targeted Rate Increase (TRI) Fee Schedule (7/31/2024, 10/31,2024, 12/31/2024)
CalAIM – FindHelp Closed Loop Referral System
CYBHI Fee Schedule
DHCS Audit Prep
DHCS Onsite Audit
Repository/System – Implementation
EPSDT & Discontinuation of CHDP (7/1/2024)
Regulatory Guidance Implementations (APLs/PLs/etc)
Security Assessment & Remediation Program
Alternative Format Selection
Prop 56 Payment Conversion
Disaster Recovery- Phase 2
HealthSuite Upgrade
TruCare / CWQI Upgrades
Street Medicine
Authorized Representation Form Remediation
Provider Repository/System – Implementation
CMS Interoperability & Patient Access Rule
CMS Price Transperancy
CalHHS Data Exchange
Electronic Visit Verification
IP Auto Notification (278)
Budget
Performance Evaluations
Open Enrollment
HEDIS / NCQA
Complete
Active
No Go Live Date
Later Phase
Audits
Company-Wide
On Hold
CalAIM Roadmap
CalAIM Active

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

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

Date: **April 12th, 2024**

Subject: **Incentives & Reporting Board Report – March 2024 Activities**

Current Incentive Programs

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

- For Program Year 1 (1/1/2022 - 12/31/2022):
  - AAH was allocated $14.8M and earned 100% of the allocated funds
  - AAH distributed funding to ten (10) providers and organizations to support the ECM and CS programs
- For Program Year 2 (1/1/2023 - 12/31/2023):
  - AAH was allocated $15.1M for potential earnable dollars
  - AAH was notified by DHCS in November that it earned 60% of earnable dollars based on the Submission 3 report
  - AAH is still awaiting the release of Payment 3
  - AAH has distributed funding to twelve (12) providers and organizations to support the ECM and CS programs
- The Submission 4 report, reflecting the lookback period of 7/1/2023 - 12/31/2023, was submitted to DHCS on March 1st, 2024
- AAH completed the review of the Wave 4 IPP Provider Applications

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

- The second Bi-Quarterly Report (BQR) for the measurement period of July – December 2023, was submitted to DHCS on December 21st, 2023. On March 13th, DHCS notified AAH that the report was approved and payment in the amount of $1.1M (100% of eligible funds) is expected in April 2024
- Partner meetings continued with Local Education Agencies (LEAs) regarding project plan activities for successful completion of the milestones
- The Alameda County SBHIP Steering Group became a part of an Alameda County Office of Education (ACOE) and Alameda County Center for Healthy Schools and Communities (CHSC) led School Health Steering Committee, which includes the Alliance, Kaiser, and Alameda County Behavioral Health
- CHSC is partnering with the Alliance through SBHIP to support LEAs through monthly Professional Learning Communities, through the development and coordination of resources (i.e., Coordination of Services Team (COST) toolkit, School-Based Behavioral Health framework, culturally appropriate resources, and Crisis Protocols), and through analysis of current behavioral based workforce

- ACOE is partnering with the Alliance through SBHIP to build infrastructure to sustain program activities post-SBHIP through regularly scheduled Learning Exchanges and Office Hour sessions
- To-date, $6.3M has been awarded to the Alliance by DHCS for completed deliverables, and a total of $5.5M has paid to LEA and SBHIP partners

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

- The Submission 2 (S2) Report for the final reporting period of January – October 2023 was submitted to DHCS on December 27th; DHCS notified AAH on March 6th that the Plan had earned $17.6M (79% of eligible funds) for the S2 report and payment is expected in April 2024
- To date (not including the upcoming payment), $20.4M has been awarded to the Alliance by DHCS and a total of $17.6M has been paid to HHIP partners
- Alameda County Health (formerly HCSA) continues to complete deliverables and milestones outlined in the December 2022 MOU:
    - To date, Alameda County Health (AC Health) has completed deliverables related to:
        - HHIP data reporting
        - Housing Financial Supports Progress Report
        - Street Medicine Data and Program Model as well as Contracting recommendations
        - 2023 Q1 and Q2 Housing Community Supports Capacity Building progress reports
        - Housing Community Supports Legal Services Pilot grant agreement execution with a legal services provider, hiring of 1.0 FTE staff attorney, and completion of progress report(s)
        - An executed contract with a Data Reporting firm and Project Manager for the 2024 Point-in-Time (PIT) Count
    - As of March 31st, $12.8M in total payments has been paid to AC Health for HHIP milestone completion
- Internal and external workgroup meetings continue to plan for and implement initiatives related to HHIP program goals, which includes:
    - A new opportunity available to SBHIP LEAs to address the challenge of students experiencing homelessness and associated behavioral health needs (i.e., anxiety, depression, etc.); two informational listening sessions were held on March 19th and 21st to share funding information and better understand the needs of SBHIP LEAs to support these students
    - Development of an application process to increase partnerships within the community to support HHIP program goals of reducing and preventing homelessness; funds available to applicants will be dependent on dollars earned from the S2 report

Equity and Practice Transformation (EPT) Payments Program – DHCS is implementing a one-time $700M primary care provider practice transformation program called the Equity and Practice Transformation (EPT) Payments Program. The five-year program is designed to advance health equity, reduce COVID-19-driven care disparities, and prepare practices to participate in alternative payment models.

- Of the 14 practices that submitted program applications, Alameda Health System was the only applicant selected by DHCS for this initial cohort
- The MCP Initial Planning Incentive Payment Program milestone submission, specific to activities associated with small/medium sized practices, was due to DHCS on January 19th, 2024, and was submitted ahead of schedule on January 4th, 2024. DHCS notified AAH on March 18th that our submitted deliverables were reviewed and approved; the associated payment of $442K is anticipated to be received in April 2024

New Programs in Development

The Community Reinvestment Program is designed to strengthen existing and new partnerships with community-based organizations and help build capacity to best serve Alliance Medi-Cal members. The Alliance has allocated funding over the next two (2) years to support new and innovative approaches focused on vulnerable populations and addressing health disparities. Priority initiatives include:

- HEDIS
- Access to care
- Social determinants of health
- Complex case management, including populations of focus
- Behavioral health

The Alliance is currently working to develop program materials, including provider-facing program overview documents, application materials, evaluation criteria, governance structure, and policy and procedures. A Board designee(s) will provide final approval of applications selected for funding; the program is anticipated to launch by July 1st, 2024.

The Provider Recruitment Initiative (PRI) is designed to provide grants to support the Alameda County Safety Net and community-based organizations to recruit, 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 by approximately 10 to 15 providers a year
- Improving member access to Primary Care Providers, Specialists, and Behavioral Health professionals
- Promoting diverse and culturally inclusive care reflective of Alliance members

The Alliance is currently working to develop program materials, including provider-facing program overview documents, application materials, evaluation criteria, governance structure, and policy and procedures. A Board designee(s) will provide final approval of applications selected for funding; the program is anticipated to launch by July 1st, 2024.

Recruiting and Staffing

Incentives & Reporting Open position(s):

- There are no open positions at this time

Incentive Program Descriptions

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

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

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

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

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

Equity and Practice Transformation (EPT) Payments Program – new program released by DHCS in August 2023 and is a one-time $700M 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 0B/GYN, and/or Behavioral Health in an integrated primary care setting
- Medi-Cal Managed Care Plan (MCP) Initial Provider Planning Incentive Payments
    - $25 million over one (1) year to incentivize MCPs to identify and work with small-to medium-sized independent practices as they develop practice transformation plans and applications to the larger EPT Provider Directed Payment Program

- EPT Provider Directed Payment Program
    - $650 million over five (5) years to support delivery system transformation, specifically targeting primary care practices that provide primary care pediatrics, family medicine, internal medicine, primary care OB/GYN services, or behavioral health services that are integrated in a primary care setting to Medi-Cal members; $200 million of the $650 million will be dedicated to preparing practices for value-based care
    - The Statewide Learning Collaborative

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

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

Date: **April 12th, 2024**

Subject: **Housing & Community Services Program Report – Fiscal Year 2023-2024 Status**

Housing & Community Services Department Overview: The Housing and Community Services Program (HCSP) is responsible for leading, developing, and implementing a comprehensive housing & homelessness strategy for Alameda Alliance for Health (Alliance). HCSP will evaluate the current processes for members' access to the healthcare system, identify the barriers to achieving housing outcomes for members, and create a strategic plan to establish partnerships with various community stakeholders. HCSP aims to mitigate health disparities and improve health outcomes of Alliance members by bridging the gap between health and housing systems of care to support member's overall health, wellness, and positive outcomes on a member's social determinants of health.

Program Year 1 Update

Infrastructure Development

Foundational:

- Conducted landscape analysis of Housing & Homelessness in Alameda County to align strategies with key stakeholders
- Created Alameda County Homeless Strategy Literature Review Crosswalk to align local, regional, and national framework ideas with the Alliance Bridge the Gap Model
- Developed Housing & Homelessness strategy – Phase 1
- Developed Housing & Community Services Workplan
- Created a Housing & Community Services Logic Model

Staffing:

- Developed a proposed Housing & Community Services organizational chart/staffing model
- Developed standardized Housing & Community Services hiring/onboarding tools

Metrics Development:

- Developed Organizational Goals for Housing
- Created Housing & Community Services Metrics which align to other programs or requirements such as the Housing & Homelessness Incentive Program (HHIP), NCQA standards, and the values of cultural humility
- Attended NCQA 2024 Conference on Health Equity to align strategies

Community Networks & Partnerships Development:

- Participation in the following Continuum of Care (CoC) committees:
    - Leadership Board – Voting Member
    - Homeless Management Information System Committee – Co-Chair

    - Racial Equity Committee – Voting member
    - Systems Impact Committee – Attendee
- Also attended HMIS Conference 2023 with Alameda County HMIS leads to access opportunities to advance or invest in system performance, etc.
- Participation in the following Community Networks:
    - National Association of Housing & Redevelopment Officials – Chapter VP
    - Corporation for Supportive Housing (CSH), Housing-related Community Supports Standardization Advisory Council – members Housing & Community Services Projects & Collaboration

Interdepartmental Collaboration:

- Health Equity Department – Both departments collaboratively led the Alliance Point-In-Time (PIT) Count Volunteer program, where we supported recorded training sessions for Alameda County partners and conducted the PIT
- HHIP – Housing & Community Services Program continues to provide content and collaboration on the following projects:
    - HCSA Legal Aid Pilot
    - Student Behavioral Health Incentive Program (SBHIP) – Collaborative work with Incentives & Reporting to address challenges of students experiencing homelessness
    - Development of HHIP & Housing Application process content to reflect the Housing Bridge the Gap model and support HHIP program goals of reducing and preventing homelessness
- Health Care Services Department:
    - Management of the Community Health Worker program has transitioned to Housing & Community Services

Compliance

Richard Golfin III

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

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

Date: **April 12th, 2024**

Subject: **Compliance Division Report**

Compliance Audit Updates

- 2024 Plan Mock Audits
    - The Compliance Division will hold Mock Audit Interviews with Subject Matter Experts in preparation for the 2024 DHCS (Department of Health Care Services) Routine Medical Survey. The Mock Audits are scheduled from April 22nd, 2024, through May 3rd, 2024, and will cover all sections of the 2024 DHCS Routine Medical Survey. The Mock Audits will also include sessions with delegated partner entities ModivCare and CHCN (Community Health Center Network). These sessions will prepare both for success in their interviews.

- 2024 DHCS Routine Medical Survey
    - The Department of Health Care Services (DHCS) has confirmed this year's audit is scheduled for June 2024. The virtual interview sessions are scheduled to be conducted from June 17th, 2024, through June 28th, 2024. The Plan received formal audit notification on March 13th, 2024. The lookback period for the 2024 audit is from June 1st, 2023, through May 31st, 2024, and includes the following areas:

        Routine Survey:
        - Utilization Management.
        - Case Management & Care Coordination.
        - Access & Availability;
        - Member's Rights & Responsibilities;
        - Quality Improvement System;
        - Organization and Administration
        - Transportation, and;
        - Behavioral Health

    - Pre-audit materials are due to the Compliance Department on April 10th, 2024, and then to the DHCS on April 24th, 2024. Internal Kick-off meetings were held from March 26th, 2024. The Compliance Department has scheduled seven (7) internal "DHCS Office Hours" sessions in efforts to assist Subject Matter Experts in navigating the pre-audit submissions and deliverables.

- 2023 DHCS Routine Medical Survey
    - The 2023 DHCS Routine Medical Survey onsite virtual interview took place from April 17th, 2023, through April 28th, 2023. There were 15 findings and 4 repeat findings. The Plan submitted its Corrective Action Plan to the Department on November 22nd, 2023. In the months since the audit, the DHCS has established a process that includes a monthly update of the CAP progress. This process has been conferred to each Plan and provides the department with frequent updates on Plan oversight and CAP progression. The DHCS has provided additional questions for 6 out of the 15 findings. The Plan's final CAP update is due to DHCS on April 22, 2024.

Compliance Activity Updates

- DMHC Material Modification – 2024 RFP Readiness Submission
    - On March 5th, 2024, the Department of Managed Health Care (DMHC) provided additional comments to Filing #20234323 to which the Plan provided responses on April 2nd, 2024. Thus far, the Agency has not provided comments related to the Financial Exhibits shared in previous filings.

- 42 CFR Part 2 – Confidentiality of Substance Use Disorder (SUD) Patient Records
    - On Friday, February 16, 2024, the Department of Health and Human Services (DHHS) announced changes to 42 CFR Part 2, to bring the Regulation into alignment with the Health Insurance and Portability Accountability Act (HIPAA). Changes are effective on April 16th, 2024, with a Compliance date of February 16, 2026. The Privacy Office is watching these changes closely and will advise internal key stakeholders, as necessary.

- DHCS Annual Network Certification (ANC)
    - The Plan is required to submit documentation annually to the Department of Health Care Services (DHCS) which demonstrates network adequacy for the Reporting Year. The Plan submitted Phase 1 deliverables on February 1st, 2024. Phase 1 deliverables include a reporting of mandatory provider types, hospitals, and cancer treatment centers. The Plan also provided specific network related policies and procedures. For Phase 2, DHCS provided ArcGIS analysis results that highlighted network deficiencies. In response to the DHCS findings, the Plan submitted Alternative Access Requests on March 25th, 2024.

- DMHC Timely Access Report/Annual Network Review (TAR/ANR)
    - The Plan is required to annually submit a Timely Access Compliance Report (TAR) that includes information related to monitoring the Plans' network compliance with timely access standards, including network rates of compliance with the appointment wait time standards during the previous year. The Plan is also required to annually submit information confirming the status

of each network and its enrollment, including a complete list of the plan's contracted providers, hospitals, and enrollees within each network. These materials are due by May 1st, 2024.

- Behavioral Health Insourcing
  - On March 29, 2023, the Department of Managed Health Care (DMHC) conditionally approved the Alliance's Notice of Material Modification to insource behavioral health services. The DMHC's approval was subject to and conditioned upon the Alliance's full performance of eight (8) Undertakings. As of April 2024, there remains one (1) outstanding Undertaking to be addressed by the Plan.

Undertaking Compliance Chart			
Undertaking #	**Deliverable**	**Next Milestone**	**Progress**
No. 6	Submit electronically an Amendment filing to demonstrate compliance with the federal Mental Health Parity and Addiction Equity Act ("MHPAEA") (42 USC § 300 gg-26) and its regulations (45 CFR § 146.136) and Section 1374.76 of the Act.	April 19th, 2024	The Plan received extensive comments (E-filing No. 20233231) to which the Plan responded on January 30th, 2024. On March 7th, 2024, the Department provided an additional 152 comments. A response is due to the Department within 30 days. The Plan has partnered with outside counsel to assist with the completion of this Undertaking. To provide outside counsel enough time to complete the project, the Plan requested and was granted an extension.

Compliance

Supporting Documents

COMPLIANCE DASHBOARD SUMMARY										
	Resource	Type							TOTAL	% Completed
			2018	2019	2020	2021	2022	2023		
OVERALL FINDINGS	DHCS	Total State Audit Findings	38	28	7	33	15	15	136	
		Total Self-Identified Issues	12	0	0	2	0	2	16	
		Total Findings	**50**	**28**	**7**	**35**	**15**	**17**	**152**	
		Total In Progress	0	0	0	0	0	1	1	
		Total Completed	50	28	7	35	15	16	151	**99%**
		Total Findings	**50**	**28**	**7**	**35**	**15**	**17**	**152**	
	DMHC	Total State Audit Findings			5	6	8		19	
		Total Self-Identified Issues			3	0	0		3	
		Total Findings			**8**	**6**	**8**		**22**	
		Total In Progress			0	0	1		1	
		Total Completed			8	6	7		21	**95%**
		Total Findings	**NA**	**NA**	**8**	**6**	**8**	**NA**	**22**	
	DMHC Financial Services	Total State Audit Findings		5			4		9	
		Total Self-Identified Issues		0			0		0	
		Total Findings		**5**			**4**		**9**	
		Total In Progress		0			0		0	
		Total Completed		5			4		9	**100%**
		Total Findings	**NA**	**5**	**NA**	**NA**	**4**	**NA**	**9**	
STATE AUDIT FINDINGS		In Progress	0	0	0	0	1	1	2	
		Completed	38	33	12	39	26	14	162	**99%**
		Total Findings	**38**	**33**	**12**	**39**	**27**	**15**	**164**	
SELF-IDENTIFIED FINDINGS		In Progress	0	0	0	0	0	0	0	
		Completed	12	0	3	2	0	2	19	**100%**
		Total Findings	**12**	**0**	**3**	**2**	**0**	**2**	**19**	
TOTAL OVERALL FINDINGS			**50**	**33**	**15**	**41**	**27**	**17**	**183**	

COMPLIANCE DASHBOARD SUMMARY			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	Total State Audit Findings	164	90%
	Total Self-Identified Issues	19	10%
	Total Findings	**183**	
	Total In Progress	2	1%
	Total Completed	181	99%
	Total Findings	**183**	
STATE AUDIT FINDINGS	In Progress	2	1%
	Completed	162	99%
	Total Findings	**164**	
SELF-IDENTIFIED FINDINGS	In Progress	0	0%
	Completed	19	100%
	Total Findings	**19**	

2023 DHCS Audit Summary			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	Total State Audit Findings	15	88%
	Total Self-Identified Issues	2	12%
	Total Findings	**17**	
	Total In Progress	1	6%
	Total Completed	16	94%
	Total Findings	**17**	

2022 DMHC BHI Audit Summary			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	Total State Audit Findings	2	100%
	Total Self-Identified Issues	0	0%
	Total Findings	**2**	
	Total In Progress	1	50%
	Total Completed	1	50%
	Total Findings	**2**	

2022 DMHC RBO Audit: Delegate			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	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 RBO Audit: Delegate			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	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 Serviceds Summary			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	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**	

2022 DHCS Audit Summary			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	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			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	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**	

2021 DHCS Joint Audit Summary			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	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			
	Type	TOTAL	%
OVERALL FINDINGS	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**	

2020 DMHC Medical Services Audit Summary			
	Type	TOTAL	%
OVERALL FINDINGS	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			
	Type	TOTAL	%
OVERALL FINDINGS	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**	

2019 DHCS Medical Services Audit Summary			
	Type	TOTAL	%
OVERALL FINDINGS	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			
	Type	TOTAL	%
OVERALL FINDINGS	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 (Included in the Preliminary Report)
Orange = Plan Observations (Not Included in the Preliminary Report)
R = Repeat Findings

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	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 members 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. **Update 4/5/2024** 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

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

KEY
Yellow = Plan Observations (Included in the Preliminary Report)
Orange = Plan Observations (Not Included in the Preliminary Report)
R = Repeat Findings

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	State/Self Identified	Agency	Year
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) **Update 4/5/2024:** Policy updated and approved at Compliance Committee on 3/19/2024 1a. Update IHA policy 124 to include requirement regarding outreach attempts (On Track) **Update 4/5/2024**: Policy updated and approved at Compliance Committee on 3/19/2024 2. Provider education and feedback through Joint Operational Meetings (On going) Update 4/5/2024: Presented at JOMs with delegates in December 2023 2a. Deliver provider education webinars with information about IHA requirements (On Track) **Update 4/5/2024**: 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) Update 3/8/2024: Codes updated and included in policy QI-124. 3a. Communicate and provide code sets to providers (On Track) **Update 4/5/2024:** Codes updated and included in policy QI-124 4. Monitor IHA rates (Ongoing) **Update 4/5/2024**: 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

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

KEY
Yellow = Plan Observations (Included in the Preliminary Report)
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R = Repeat Findings

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	State/Self Identified	Agency	Year
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 Heath 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. **Update 4/5/2024**: Policy BH-004 is scheduled to be approved at April Compliance Committee 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. (On Track) 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. (On Track)	In Progress	4/1/2023 Q1 2024 Audit Q1 2024 Q1 2024 Q1 2024	Behavioral Health	State	DHCS	2023
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

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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
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

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#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	State/Self Identified	Agency	Year
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 19-013.	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
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**	**State/Self Identified**	**Agen**
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 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	In Progress	Closed 9/27/2022 Q2 2024 Q3 2024	UM Behavioral Health	State	DMH
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 whe deficiencies are identified, and that follow-up is planned where indicated.	4/1/2023	Completed	UM Quality Assurance Behavioral Health Compliance	State	DMH
#	**Category**	**Barriers to Care**	**Plan Response**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**State/Self Identified**	**Agen**
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.	We will continue to take action to ensure that our members are not experiencing any barriers to behavioral health services.	TBD	TBD	UM Behavioral Health Pharmacy Provider Contracting	State	DMH
2	Cultural Competency and Health Equity	Neither the Plan nor its delegate conduct assessments pertaining to cultural competency and health equit specific to the Plan's enrollee population.	We will continue to take action to ensure that our members are not experiencing any barriers to behavioral health services.	TBD	TBD	Quality Assurance Behavioral Health	State	DMH
3	Enrollee Experience	Enrollees experience difficulties obtaining appointments.	We will continue to take action to ensure that our members are not experiencing any barriers to behavioral health services.	TBD	TBD	Quality Assurance Behavioral Health	State	DMH

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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. Update 4/14/2023: The delegate's Compliance Committee rescheduled to 4/26/2023. The updated policy will be approved at that time. Update 5/12/2023: 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. Update 2/13/2023: 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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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. Update 03/10/2022: 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. Update 4/14/2023: 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 Update 03/10/2023: 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. Update 4/15/2023: 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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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. Update 5/12/2023: 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. Update 5/12/2023: 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. Update 3/10/2023: 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. Update 4/15/2023: 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. Update 3/10/2023: Awaiting DHCS approval of script. Update 6/9/2023: 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. Update 03/10/2023: Policy QI-114 has been updated and is awaiting approval at committee Update 4/14/2023: P&P Q1-114 was approved at Compliance Committee 3/21/2023	3/21/2023	Completed	Provider Relations QI		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
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 cause the issue, but they will increase the resolution to help ensure better results in the future. 2. Case #20 –The vender was notified of the issue on 5/19/2022 and asked to review their internal process to ensure that dates on clams are captured correctly. They acknowledged they reviewed their internal processes and stated that poor claim imaging may have cause 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 acknowledgment 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.	10/1/20222	Completed	G&A		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
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 to work 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:T**emplate 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

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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	Yea
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	202
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	202
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	202

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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. Update 5/14/21 The legal team is continuing to review which claims to pay. Update 6/11/21 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. Update 10/8/2021 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. Update 5/13/2022: 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. 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. Update 10/8/2021: 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. Update 10/8/2021: First report to UMC on 8/24/2021. 100% compliance. Update 12/10/2021: 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. Update 04/08/2022: 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. Update 5/13/2022: 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. 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. Update 10/8/2021: 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. Update 10/8/2021: First report to UMC on 8/24/2021. 100% compliance. Update 11/12/2021: The results of the next quarterly audit will be presented at the November UM Committee. Update 12/10/2021: The results of the next quarterly audit will be reported at the December UM Committee. Update 04/08/2022: 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. Update 5/13/2022: 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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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. Update 10/8/2021 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. Update 10/8/2021: First report to UMC on 8/24/2021. 100% compliance. Update 11/12/2021: The results of the next quarterly audit will be presented at the November UM Committee. Update 12/10/2021: 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. Update 04/08/2022: 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. Update 5/13/2022: 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 Update 10/8/2021: Manual tracking continues, awaiting completion of automated report. First report to UMC on 8/24/2021. 100% compliance. Update 11/12/2021: The results of the next quarterly audit will be presented at the November UM Committee. Update 12/10/2021: 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. Update 04/08/2022: 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. Update 5/13/2022: 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. 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: DHCS advised The Alliance they consider the findings of this audit closed as of 4/19/2022. 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

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
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. Update as of 4/10/2020 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. Update as of 4/10/2020: 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. Update as of 6/12/2020: 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 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 Update as of 4/30/2020: 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. Update as of 4/10/2020: 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. Update as of 4/10/2020: 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. Update 5/1/2020: 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. Update 5/1/2020: 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. Update 5/1/2020: 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. Update 5/1/2020: 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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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
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. Update as of 12/5/2019: 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. Update as of 1/8/2020: 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. Update as of 12/5/2019: 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. Update as of 1/8/2020: 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. Update as of 2/7/2020: 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. Update as of 12/2/2019: 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. Update as of 12/5/2019: 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. Update as of 12/5/2019: 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. Update as of 1/8/2020: 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. Update as of 12/5/19: Clarity is being sought from DHCS on the scope of specialty referral tracking. Update as of 1/8/20: An updated referral tracking report is being developed to include all decision types and specialty services that require authorization. Update as of 2/7/20. Updated report sample generated and submitted to DHCS. Working with Analytics to create routine report that captures all needed data elements. Update as of 3/5/2020 UM met with Analytics to create the routine report capturing all needed elements. Report is in development. Update as of 5/8/20 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. Update as of 6/12/20: 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. Update as of 12/5/2019: Clarity is being sought from DHCS on allowing a time limit of 30 days. Update as of 1/8/2020: Plan received clarity from DHCS and is updating internal procedures. Update as of 2/7/2020: 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. Update as of 12/5/2019: 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. Update as of 1/8/2020: 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. Update as of 12/5/2019: A meeting will be scheduled the week of 12/9 to discuss changes. Update as of 1/8/2020: Meeting was conducted and PA grid will be updated to reflect corrections. Update as of 2/7/2020. 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. Update as of 3/5/2020 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. Update as of 12/5/2019: 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	Emerge 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. Update as of 1/8/20: Internal meeting was conducted to ensure requirements are clear and next steps for updating policy and monitoring reports. Update as of 2/11/2020: Draft P&P and monitoring log have been created and are under review. Update as of 4/10/2020: 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. Update as of 12/5/2019: 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. Update as of 1/8/2020: Medical group provided training sign in sheet. The delegate is working on next steps of educating providers. Update as of 2/7/2020: the delegate provided an attestation to complete its provider training by the end of Q1 2020. Update as of 4/10/2020: Meeting medical group week of 4/6 to discuss implementation. Update as of 4/20/2020: Process for forwarding complaints received by medical group has been implemented as of 4/20/2020.	Yes	~~3/31/2020~~ 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. Update as of 12/5/2019: 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. Update as of 12/5/2019: Staff training will be conducted on 12/11/2019 to review the updated procedure. Update as of 1/8/2020: 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. Update as of 12/5/2019: Staff training will be conducted on 12/11/2019 to review the updated procedure. Update as of 1/8/2020: 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 - *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**
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 Update as of 1/31/2019: 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 Update as of 1/31/2019: 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. Update as of 1/31/2019: 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. Update as of 1/07/2019: 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. Update as of 1/31/2019: 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.	Update as of 3/5/2019: 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. Update as of 2/4/2019: Updated translated versions of the "Your Rights" attachments have been provided to the Pharmacy Benefits Manager. Update as of 2/19/2019: 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.Update as of 1/07/2019: The Plan will be updating its prior authorization grid and provider training materials by 1/25/2019. Update as of 1/31/2019: 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. Update as of 1/07/2019: The Plan will be uploading the provider manual to the website by 1/25/19. Update as of 1/31/2019: 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. Update as of 1/07/2019: The Manual is scheduled to be uploaded on our website on 1/25/2019. Update as of 1/31/2019: 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. Update as of 1/07/2019: The Plan has requested ownership and control disclosure information of its UM delegates as of 1/4/2019. Update as of 1/30/2019: 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). Update as of 3/6/2019: 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.Update as of 1/7/2019: The Plan will update the desktop procedure and conduct staff training on the monitoring process by 1/22/2019. Update as of 1/31/2019: 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.Update as of 1/07/2019: 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. Update as of 1/31/2019: 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.Update as of 1/30/2019: 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. Update as of 1/07/2019: 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. Update as of 1/31/2019: 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.	Update as of 3/6/2019: 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. Update 4/8/2019: 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.Update as of 1/7/2019: Implementation will be completed by 3/31/2019 once RN staff are on board and trained on the updated process. Update as of 3/5/2019: Health Care Services has successfully recruited one nurse, and is in the process of filling the remaining vacancy. Update as of 4/10/2019: Training is to be completed by 4/11/2019. The checklist for standard and expedited grievances has been updated. Update as of 5/8/2019: 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. Update as of 1/07/19: The Manual is scheduled to be uploaded on our website on 1/25/2019. Update as of 1/25/2019: 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. Update as of 1/7/2019: The Plan will be uploading the provider manual to the website by 1/25/19. Update as of 1/25/2019: 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.Update 12/31/2018: 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.Update as of 3/4/2019: 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. Update 12/31/2018: The Plan is currently working with the delegate to incorporate this information. Target date for materials to be updated is 1/31/19. Update as of 1/30/2019: 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. Update as of 1/31/2019: The Plan will provide training to providers to ensure comprehension concerning the remittance advice set-up. Update as of 3/6/19: 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. Update 4/8/2019: 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.	Update 9/27/2019: MOUs have transitioned to Provider Services. Provider Services is in discussion with the county on review MOUS, including CCS. Update as of 12/2/2019: 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.	Update 9/27/2019: MOUs have been transitioned to Provider Services. Provider Services is in discussion with the county on review MOUS, including EI/DD services. Update as of 12/2/2019: The Plan is currently working on developing a full county MOU to include services for early intervention and development disabilities services Update 7/10/2020: The MOU was sent to the County for review on6/16/2020. Update 10/9/2020: The County has accepted the Alliance's edits and the MOU is currently under review for final approval with the County.Update 11/10/2020: The County has cancelled the November 3rd meeting. This agenda item will be carried over to the December 15th docket.**Update 5/14/2021**: 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. Update 11/6/2018: 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 1 3 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

ALAMEDA Alliance FOR HEALTH

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

Health Care Services

Donna Carey, MD

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

From: **Dr. Donna Carey, Chief Medical Officer (Interim)**

Date: **April 12th, 2024**

Subject: **Health Care Services Report**

Utilization Management: Outpatient

- CoC volume is currently running at 10-12% of all incoming authorizations at any given time.

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

- We have developed an internal flag within our eligibility database to identify Anthem transition and adult expansion members.

- Reporting requirements for DHCS began November 22nd and will continue through 12/31/2024 as part of the DHCS monitoring and oversight process.

- We have begun to analyze claims data for claims submitted without prior authorization on file. We are identifying members who appear to be in active care and may require ongoing services as well as members that we have an auth on file, for the same category of service, but not the same services that may require ongoing care for those services as well.

- OP processed a total of 4234 authorizations in the month of March. The top 5 categories remain radiology, OP Rehab, TQ, Home Health and Outpatient facility.

Total Outpatient Authorization Volume			
Authorization Status	**January 2024**	**February 2024**	**March 2024**
Approvals	4244	3779	3994
Partial Approvals	22	17	26
Denials	208	222	214
Total	**4474**	**4018**	**4234**

***Source**: #02569_AuthTAT_Summary*

Outpatient Authorization Denial Rates			
Denial Rate Type	**January 2024**	**February 2024**	**March 2024**
Overall Denial Rate	**3.3%**	**4.2%**	**3.8%**
Denial Rate Excluding Partial Denials	**3.0%**	**4.0%**	**3.4%**
Partial Denial Rate	**0.3%**	**0.3%**	**0.4%**

***Source**: #03690_Executive_Dashboard*

Turn Around Time Compliance			
Line of Business	**January 2024**	**February 2024**	**March 2024**
Overall	**100%**	**99%**	**100%**
Medi-Cal	**100%**	**99%**	**100%**
IHSS	**100%**	**100%**	**100%**
Benchmark	***95%***	***95%***	***95%***

***Source**: #02569_AuthTAT_Summary*

Utilization Management: Inpatient

- The Inpatient UM team processed a total of 2608 reviews in the month of March. This is a slight increase from the volume reported in February 2024, markedly higher than December 2023 before the integration of the Anthem and Adult Expansion members in addition to the seasonal influx in acute admissions during the typical Winter Flu Season Months. The volumes of reviews were as follows: Acute Hospitalizations (2090), Skilled NF (443), Short Term Custodial NF (218) Skilled Bedholds (58), Acute Rehab39, LTAC (). . We continue to see an increase in the SNF Admissions related to 2023 volume increases from both the Long-Term Care carve-in and the dually eligible (MediCare and Medi-Cal) population throughout Q4 and into Q1 of this year. These new populations have a higher hospitalization rate, which contributed to increases in acute inpatient admissions.

- IP UM completed authorizations for Inpatient Admissions for the members transitioning from Anthem, the Adult Expansion Population and the LTC Phase 2 Carve in Populations.

- Auth TAT compliance was 97% for the months of January and February, and 99% in March. Despite the increase in auth volume, IP UM Team still exceeded the benchmark TAT of 95% for both our Medical and Commercial Lines of Business.

- IP UM is receiving ADT feed for Authorization automation from Alameda Health Sytem's, Alta Bates Summit Medical Center, Eden Hospital, Washington Hospital, and St Rose. IP UM team has, in working with IT, automated the auth request process for these hospitals. This has reduced the administrative burden on the hospital provider side while facilitating real time communication on member admissions.

- As part of the Transitional Care Services (TCS) requirement for Population Health Management, the IP UM team continues to identify high-risk members admitted to a hospital, conducts inpatient discharge risk assessment, provides the name of Care Manager for inclusion in the discharge summary, and refers to Case Management department for follow up. Starting in 2024, TCS also includes simplified requirements for low-risk members, and the IP team has operationalized the enhanced TCS requirements.

- IP UM continues weekly hospital rounds with tertiary care centers UCSF and Stanford, as well as contracted hospital providers; Alameda Health System, Sutter, Kindred LTACH, Kentfield LTACH, and Washington, to discuss UM issues, address discharge barriers, and improve throughput and real time communication.

Total Inpatient Authorization Volume			
Authorization Status	**January 2024**	**February 2024**	**March 2024**
Approvals	2820	2488	2533
Partial Approvals	0	0	0
Denials	61	69	75
Total	**2881**	**2557**	**2608**

***Source**: #02569_AuthTAT_Summary*

Inpatient Med-Surg Utilization			
Total All Aid Categories			
Actuals (excludes Maternity)			
Metric	**December 2023**	**January 2024**	**February 2024**
Authorized LOS	**5.3**	**5.7**	**5.6**
Admits/1,000	**57.0**	**61.0**	**54.4**
Days/1,000	**303.3**	**346.8**	**301.8**

***Source**: #01034_AuthUtilizationStatistics*

Inpatient Authorization Denial Rates			
Denial Rate Type	**December 2023**	**January 2024**	**February 2024**
Full Denials Rate	**1.8%**	**0.9%**	**0.7%**
Partial Denials	**1.5%**	**1.4%**	**1.7%**
All Types of Denials Rate	**3.2%**	**2.3%**	**2.4%**

***Source**: #01292_AllAuthDenialsRates*

Turn Around Time Compliance			
Line of Business	**January 2024**	**February 2024**	**March 2024**
Overall	**98%**	**97%**	**99%**
Medi-Cal	**97%**	**97%**	**99%**
IHSS	**100%**	**100%**	**94%**
Benchmark	***95%***	***95%***	***95%***

***Source**: #02569_AuthTAT_Summary*

Utilization Management: Long Term Care

- LTC census during March 2024 was 2,498 members. This is a decrease of 3.25% from January 2024. This most likely represents the cases closed from the census cleanup project.

- During Q1 2024, LTC members had a total of 188 admissions with an average LOS of 4.9 days, which is down from the 6.4 days reported last quarter.

Totals	Q3 2023	Q4 2023	Q1 2024
Admissions	227	289	188
Days	1,401	1,850	914
Readmissions	62	66	36

***Source**: #14236_LTC_Dashboard*

- LTC Deliverables all submitted, awaiting DHCS approval.

- Continuing to meet with Regional Center of East Bay, monthly meetings have been scheduled to have a “rounds” discussion to touch base on the members and their possible needs while in the ICF/DD facilities.

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

- LTC Director attended the DHCS PHM Transitional Care Summit in Los Angeles on 03/06/24, to align the transitional care process for the Long-Term Care members.

- Continue to reconcile census and authorizations, as well as generate referrals to TCS and other internal/external programs to provide wraparound supports to members preparing to discharge from an LTC custodial facility.

- We currently have 132 members in ICF/DD and 69 in subacute.

- Authorization volume has decreased by 18.63% inMarch 2024 compared to February 2024.

Total LTC Authorization Volume			
Authorization Status	**January 2024**	**February 2024**	**March 2024**
Approvals	1226	1167	955
Partial Approvals	0	0	0
Denials	23	19	10
Total	**1249**	**1186**	**965**

***Source**: #02569_AuthTAT_Summary*

Turn Around Time Compliance			
Line of Business	**January 2024**	**February 2024**	**March 2024**
Medi-Cal	95%	96%	96%
Benchmark	**95%**	**95%**	**95%**

***Source**: #02569_AuthTAT_Summary*

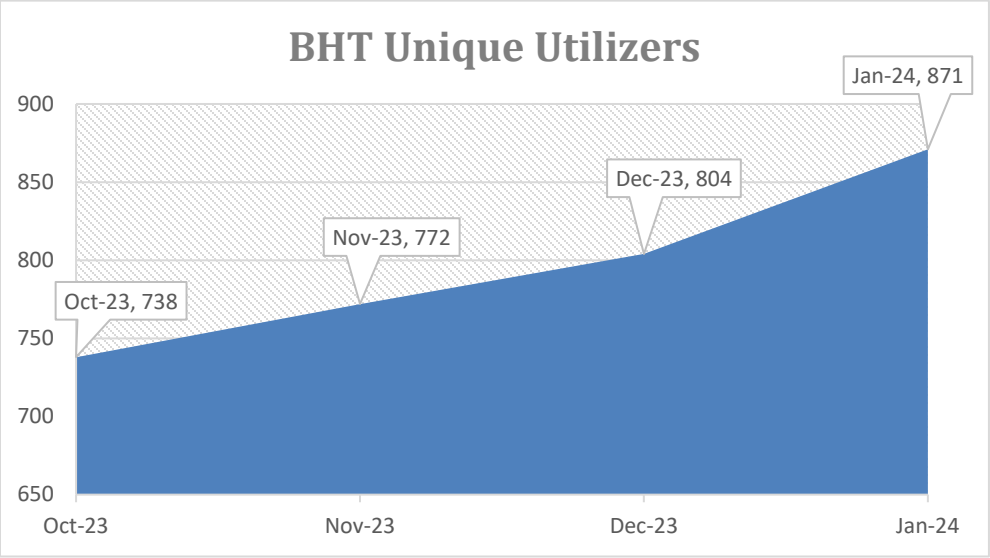
- Authorization processing turn-around time (TAT) **meets** benchmark:
- LTC team continues the following activities to manage increased production volumes and maintain TAT compliance:
    - Hiring additional staff to assist with the increase in volume
    - Continue staff education so that TAT is calculated correctly
    - Working with analytics to help capture line level TAT correctly

Behavioral Health

BH UM Outpatient

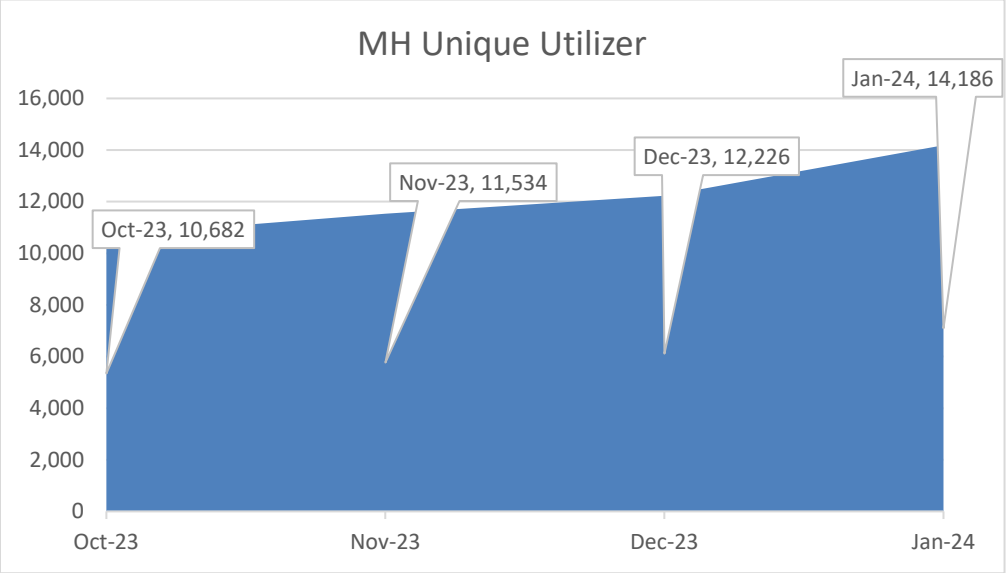
- Since insourcing management of these benefits in April, the Behavioral Health Department has prioritized increasing the utilization of mental health and BHT/ABA services. To track and measure our progress, we track and trend the Unique utilizers for BHT Services.

(Figure 1) BHT Unique Utilizer



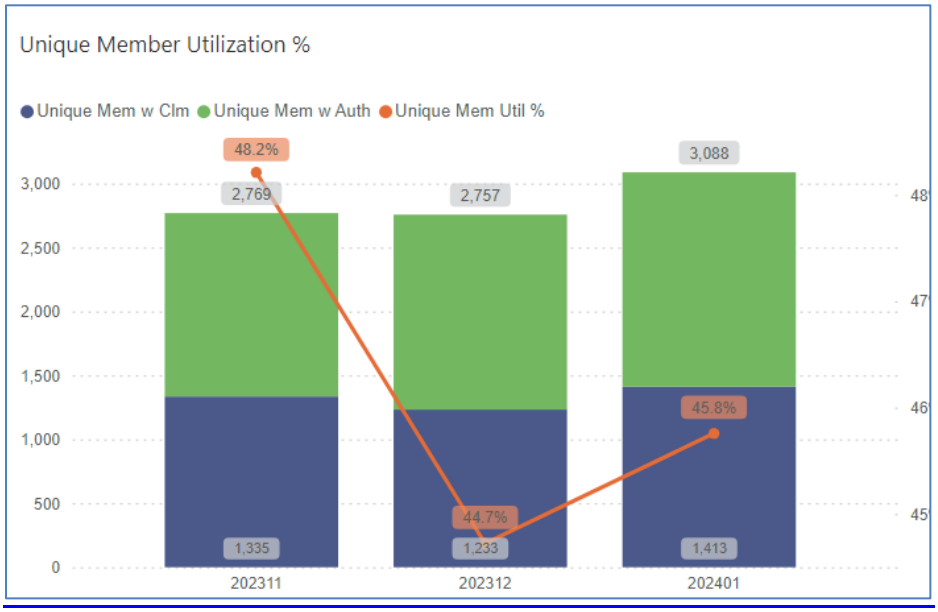
- We are seeing a steady increase in unique utilizers of BHT/ABA services from the baseline of 550 (the Average number of children receiving ABA services in the four months before April 1, 2023).

Figure (2) Mental Health Unique Utilizer



- The utilization of mental health services has steadily increased, notably with a 16% rise observed during the Anthem transition. The baseline, established at 4,077 on April 1, 2023, reflects this trend.

(Figure 3) BHT unique member utilization rate per authorization



- From November 2023 through January 2024, 46.2% of members utilized BHT services per authorization.

Behavioral Health Turnaround Times (TAT)

(Figure 4) Mental Health Turnaround Times

MH TAT			
Goal ≥95%	**24-Jan**	**24-Feb**	**24-Mar**
Determination TAT%	97%	99%	99%
Notification TAT%	73%	81%	75%

- The 5% decrease is mainly caused by automatic approvals through the provider portal, while letters are currently not automated. We are collaborating with IT to address this system challenge.

(Figure 5) Behavioral Health Treatment Turnaround Times

BHT TAT			
Goal ≥95%	**24-Jan**	**24-Feb**	**24-Mar**
Determination TAT%	94%	97%	99%
Notification TAT%	100%	100%	100%

(Figure 6) Behavioral Health Denial Rates

Goal ≤ 5%	BH Denial Rates	
24-Jan	**24-Feb**	**24-Mar**
0.01%	0.01%	0

BH Case Management

- AAH completes mental health screening tools per DHCS requirements. This is a shared responsibility between member services and the behavioral health team.

(Figure 7) Medi-Cal Screening Tools

Total # Medi-Cal Screening Tools			
	Jan-24	Feb-24	Mar-24
Youth Screenings	65	63	44
Adults Screenings	140	111	97

- AAH completes mental health screening tools per DHCS requirements. This is a shared responsibility between member services and the behavioral health team. AAH completes mental health screening tools per DHCS requirements. This is a shared responsibility between member services and the behavioral health team.

(Figure 8) Case Coordination

MH Case Coordination			
	202401	202402	202403
In Progress	50	90	85
Closed	148	76	91
Total	198	166	176

BHT Case Coordination			
	202401	202402	202403
In Progress	141	159	170
Closed	58	2	5
Total	199	161	175

Community Relationships and Collaboration

- The Behavioral Health Team in collaboration with Operations continues to Meet with high volume mental health and BHT/ABA providers. These meeting have yielded a deeper understanding of the barriers and has posed new consideration under review of management:
    - Payment for treatment reports and Transition of Care forms that are required by DHCS.
    - Incentives to stabilize the BHT/ABA workforce where turnover is resulting in disruption in services.

- The Behavioral Health Team meets bi-monthly with the ACBH ACCESS Team to coordinate care for our members receiving specialty mental health services.
    - No Wrong Door collaborative meeting activities are ongoing addressing closed-loop referrals and tracking for duplication of services and coordination of care.
    - Data exchange efforts are currently underway. ACBH plans to roll out a new system (SmartCare) in mid-April, with the resumption of behavioral health and mental health data exchange development activities with AAH scheduled for mid-May.
    - Currently, the BH Team is meeting with ACBH clinical leadership to collaborate on several areas for improvement, including the implementation of screening tools, Transition of care tools, and crisis services.

Additional Initiatives

- AAH BH Department will begin sending the coordination of care treatment report received from the Mental Health Provider and sent to PCP/pediatrician in April. This initiative aims to bridge the gap where PCPs/Pediatricians were not receiving feedback from mental health providers.

- DHCS Audit CAP Finding 2.3.1: The CAP deliverables and responses have been progressing satisfactorily, with no official concerns raised by DHCS. The next submission update to DHCS is scheduled for April 8, 2024.

- The Behavioral Health Department has participated in the CYBHI initiatives that began with the SBHIP program. The SBHIP program has been successful meeting all the requirements established by DHCS, and in our participation, AAH has forged collaborative relationships with the Alameda County Office of Education (ACOE) as well as many school districts (LEAs) in Alameda County in anticipation of the expansion of our responsibilities to provide mental health and BHT/ABA services in and near schools. AAH is participating in the first cohort of MCPs, and LEAs selected to implement the new school-based mental health services for which school-based providers will begin billing AAH for services. Currently, the Alameda County Office of Education and AAH are evaluating the pros and cons of a direct contract versus utilizing the statewide TPA established by DHCS.

Pharmacy

- Pharmacy Services process outpatient pharmacy claims, and pharmacy prior authorization (PA) has met turn-around time compliance for GroupCare line of business (LOB) for Q1, 2024:

LOB	Quarterly Number of Outpatient PAs Processed	Quarterly Turn Around Rate Compliance (%)
GroupCare	499	99%

Decisions	Number of PAs Processed in March
Approved	34
Denied	80
Closed	109
Total	**223**

- Medications for weight management, diabetes, dry eye syndrome, and acne are in the top ten categories for denials.

March Ranking	Drug Name	Common Use	Common Denial Reason
1	WEGOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.25 MG/0.5ML	Weight Management	Criteria for approval not met
2	OZEMPIC (0.25 or 0.5 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/3ML	Diabetes	Criteria for approval not met
3	XIIDRA OPHTHALMIC SOLUTION 5%	Dry Eyes	Criteria for approval not met
4	LIDOCAINE EXTERNAL PATCH 5%	Nerve Pain	Criteria for approval not met
5	WEGOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.5ML	Weight Management	Criteria for approval not met
6	TRETINOIN EXTERNAL CREAM 0.025%	Acne	Criteria for approval not met
7	WEGOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1.7 MG/0.75ML	Weight Management	Criteria for approval not met
8	ZEPBOUND SUBCUTANEOUS SOLUTION AUTO-INJECTOR 2.5 MG/0.5ML	Weight Management	Criteria for approval not met
9	CONTRAVE ORAL TABLET EXTENDED RELEASE 12 Hour 8-90 MG	Weight Management	Criteria for approval not met
10	WEGOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 2.4 MG/0.75ML	Weight Management	Criteria for approval not met

- The AAH Pharmacy Department has re-launched its Transition of Care pilot program as of 4/1/2024, with a focus on members with Congestive Heart Failure. Alliance pharmacists work with some of these members after hospital discharge to help decrease hospital readmission through education to the members as well as filling potential gaps between providers and their patients. The Alliance Pharmacy Department will be collaborating with AAH IT to help streamline some of these processes in the coming months. Additional high-risk diagnoses with potential for greatest member outcomes will be added later this year.

Case and Disease Management

- CM has extended Transitional Care Services (TCS) to all members, starting January 1, 2024. CM continues to collaborate with hospital and clinic partners to ensure TCS requirements, such as post discharge follow up appointments, are met.

- CM continues to work with UM on Continuity of Care requests for former Anthem members that transitioned over to the Alliance on January 1, 2024. CM is also working closely with the IPD team and Anthem to ensure effective transition for members formerly with Anthem regarding case management and transportation services.

- Major Organ Transplant (MOT) CM Bundle continues to be offered to members needing evaluation and transplantation of major organs and bone marrow. The volume continues to increase, (currently 561 members). Case management nurses support members throughout the MOT process, and coordinate services with the AAH UM department and the Centers of Excellence staff.

- CM is working to include high utilizers in its population health telephone outreach, where complex case management eligible members are invited to engage in complex case management.

- 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.

- As of January 1, 2024, Disease Management programming is offered for Asthma, Diabetes, Cardiovascular Disease and Depression diseases in accordance with the Population Health Management Policy Guide.

As of January 1, 2024,

Case Type	Cases Opened in February 2024	Total Open Cases as of February 2024	Cases Opened in March 2024	Total Open Cases as of March 2024
Care Coordination	748	1513	563	1453
Complex Case Management	16	74	12	62
Transitions of Care (TCS)	879	1545	1100	1728

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

CalAIM

Enhanced Case Management

- January 1, 2024, was the launch of the final Populations of Focus (Justice Involved & Birth Equity).

- The ECM team received Continuity of Care authorization requests for members formerly assigned to Anthem. The team is working closely with each provider to confirm all appropriate Continuity of Care authorizations are on file with the Alliance.

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

- AAH continues to collaborate with Health Care Services Agency (HCSA) to discuss Street Medicine alignment. 2 of the 4 Street Medicine teams have finalized their contracts for ECM. The ECM team has started to receive referrals and have processed 62 authorizations to date.

ECM Outreach in December 2023	Total Open Cases as of December 2023	ECM Outreach in January 2024	Total Open Cases as of January 2024	ECM Outreach in February 2024	Total Open Cases as of February 2024
354	1854	370	2170	243	2071

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

Community Supports (CS)

- Community Supports continues to receive authorization requests for Continuity of Care for members previously assigned to Anthem. The CS team continues to work closely with each provider to confirm all authorizations are on file with the Alliance.

- AAH CS team is working on notifying members that are receiving services from non-contracted providers, that they need to start transitioning to in-network providers as the 6-month continuity of care timeline is ending.

- CS services are focused on offering services or settings that are medically appropriate and cost-effective alternatives. The Alliance offers the following community supports:
    - Housing Navigation
    - Housing Deposits
    - Tenancy Sustaining Services
    - Medical Respite
    - Medically Tailored/Supportive Meals
    - Asthma Remediation
    - (Caregiver) Respite Services
    - Personal Care & Homemaker Services
    - Environmental Accessibility Adaptations (Home Modifications)
    - Nursing Facility Transition/Diversion to Assisted Living Facilities
    - Community Transition Services/Nursing Facility Transition to a Home
    - Sobering Centers (Coming July 2024)
    - Short term Post Hospitalization Housing (coming Jan 2025)
    - Day Habilitation (coming Jan 2025)

- AAH CS staff team continues to meet regularly with each CS provider to work through logistical issues as they arise, including referral management, claims payment and member throughput.

- To meet the regulatory requirements of a closed loop referral process, AAH continues to work with FindHelp as the support platform. AAH continues with onboarding Community Supports providers and the CS team is working closely with each CS provider to bring them onto the platform.

Community Supports	Services Authorized in December 2023	Services Authorized in January 2024	Services Authorized in February 2024
Housing Navigation	716	1033	968
Housing Deposits	115	104	104
Housing Tenancy	823	1104	1075
Asthma Remediation	64	62	65
Meals	1124	1012	1034
Medical Respite	78	89	85
Transition to Home	4	5	6
Nursing Facility Diversion	15	21	23
Home Modifications	5	4	4
Homemaker Services	130	181	232
Caregiver Respite	2	3	6

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

Grievances & Appeals

- All cases were resolved within the goal of 95% of regulatory timeframes.
- Total grievances resolved in February were 8.12 complaints per 1,000 members.
- The Alliance's goal is to have an overturn rate of less than 25%, for the reporting period of February 2024; we met our goal at 24.3% overturn rate.

February 2024 Cases	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate	Per 1,000 Members*
Standard Grievance	1,376	30 Calendar Days	95% compliance within standard	1,376	100.0%	3.08
Expedited Grievance	2	72 Hours	95% compliance within standard	2	100.0%	0.00
Exempt Grievance	2,306	Next Business Day	95% compliance within standard	2,305	99.9%	5.03
Standard Appeal	41	30 Calendar Days	95% compliance within standard	41	100.0%	0.10
Expedited Appeal	0	72 Hours	95% compliance within standard	N/A	N/A	0.00
Total Cases:	3,725		95% compliance within standard	3,724	99.9%	8.12

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

Grievances

- 496 of 1,378 (36%) cases were related to Access to Care, the top 3 grievance categories are:
  - (209) Timely Access
  - (124) Provider Availability
  - (38) Authorization

- 397 of 1,378 (29%) cases were related to Coverage Dispute, the top 3 grievance categories are:
  - (179) Provider Balance Billing
  - (155) Provider Direct Member Billing
  - (28) Benefit

- 321 of 1,378 (23%) cases were related to Quality of Service, the top 3 categories are:
  - (111) Plan Customer Service
  - (43) Transportation
  - (41) Case Management/Care Coordination

Appeals:

- 10 out of 41 (24.3%) cases were overturned for the month of February 2024:
  - (5) Out of Network
  - (3) Disputes Involving Medical Necessity
  - (2) Coverage Disputes

Quality

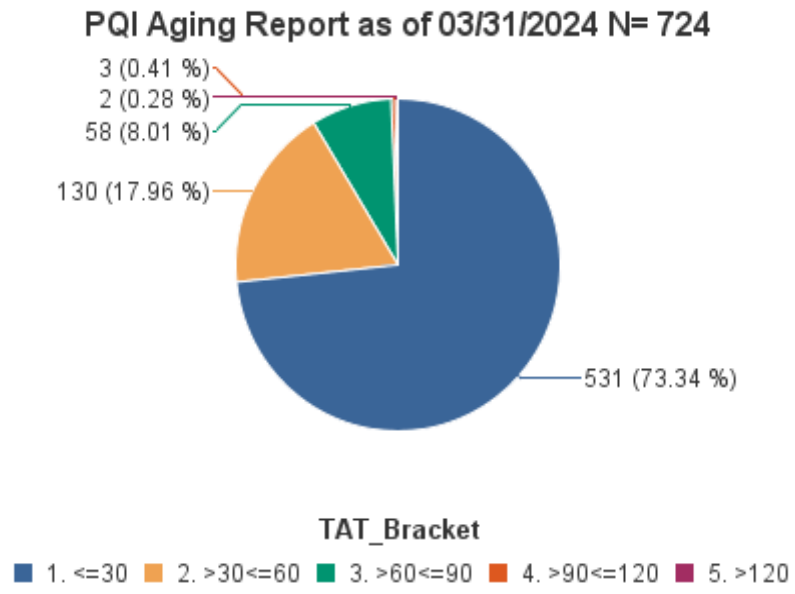
- Quality Improvement continues to track and trend PQI Turn-Around-Time (TAT) compliance. Our goal is closure of PQIs cases within 120 days from receipt to resolution via nurse investigation and procurement of medical records and/or provider responses followed by final MD review when applicable.

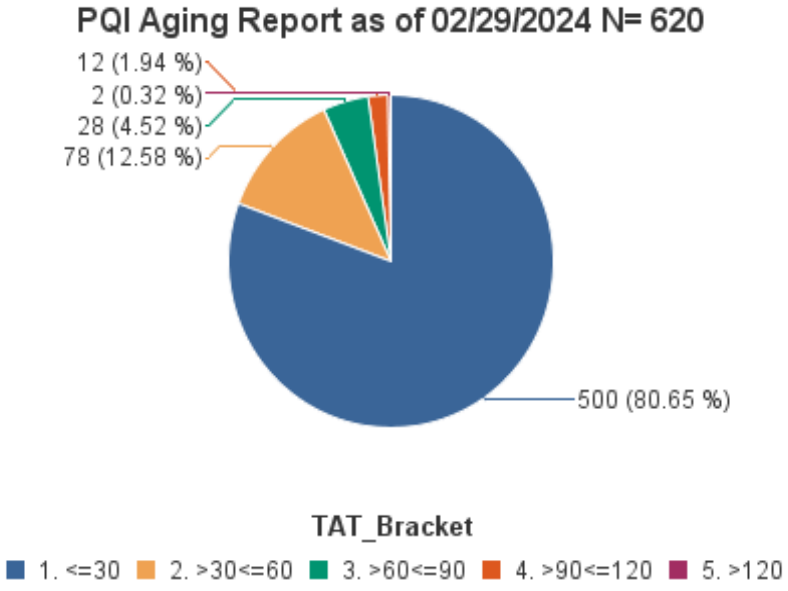
- As part of an effort to streamline the PQI review process, Quality of Access issues are reviewed by the Access & Availability team and Quality of Language issues by the Cultural & Linguistics team after they are triaged by the QI Clinical team. Quality of Care and Service issues continue to be reviewed by the QI Clinical staff.

- 0.32% of cases in February and 0.28% of cases in March were still open past the 120-day TAT. Therefore, turnaround times for case review and closure remain well within the benchmark of 95% per PQI P&P QI-104 for this lookback period.

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

- As membership has increased since the beginning of the year, QI continues to see an increase in PQIs, the majority of which are Quality of Service and Access issues. TATs are closely monitored to ensure timely closure of cases within the standard 95%.





Potential Quality Issues

- Potential Quality Issues (PQIs) are defined as: An individual occurrence or occurrences with a potential or suspected deviation from accepted standards of care, including diagnostic or therapeutic actions or behaviors that are considered the most favorable in affecting the patient's health outcome, which cannot be affirmed without additional review and investigation to determine whether a quality issue exists. PQI cases are classified as Quality of Care (QOC), Quality of Service (QOS), Quality of Access (QOA) or Quality of Language (QOL). The Alliance QI Department investigates all PQIs referred to as outlined in policy QI-104, Potential Quality Issues. PQIs may be submitted via a wide variety of sources including but not limited to members, practitioners, internal staff, and external sources. PQIs are referred to the Quality Improvement (QI) Department through a secure electronic feed or entered manually into the PQI application, for evaluation, investigation, resolution, and tracking.

- Quality Review Nurses investigate PQIs and summarize their findings. QOS cases that do not contain a clinical component are investigated and closed by the review nurse. QOA cases are referred to the Access and Availability Team while QOL cases referred to the Cultural and Linguistic Team for review and investigation. The Senior Director and/or the QI RN Supervisor oversees and audits a random sample of all QOS cases. The QI Medical Director reviews all QOC cases, in addition to any QOS cases where the Quality Review Nurse and RN Supervisor/Director requests Medical Director case review. The QI Medical Director will refer cases to the Peer Review and Credentialing Committee (PRC) for resolution on clinical discretion or if a case is found to be a significant Quality of Care Issue (Clinical Severity 3, 4)

Quality of Care Issue (QOC) Severity Levels

SEVERITY LEVEL	DESCRIPTION
C0	No QOC Issue
C1	Appropriate QOC May include medical / surgical complication in the *absence of negligence* Examples: Medication or procedure side effect
C2	Borderline QOC With potential for adverse effect or outcome Examples: Delay in test with *potential* for adverse outcome
C3	Moderate QOC Actual adverse effect or outcome (non-life or limb threatening) Examples: Delay in / unnecessary test *resulting in* poor outcome
C4	Serious QOC With significant adverse effect or outcome (life or limb threatening) Examples: Life or limb threatening

2023 Potential Quality Issues Analysis for Medi-Cal and IHSS Line of Business

- Alameda Alliance for Health's Quality Department received 9276 Potential Quality Issues (PQIs) during measurement year 2023, which is a 43.84% increase from 2022. The total volume of PQIs increased by 2818 which is largely reflected in the number of QOS and QOA issues identified during this measurement year. Of the 9276 PQIs received in 2023, 7% or 644, of the PQIs were classified as a QOC issue. PQI monthly and quarterly totals are listed below:

2023 All PQI Type Monthly Totals

PQI Type	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	TOTAL	%
All Types of PQIs	650	643	875	707	764	846	857	945	858	930	716	465	**9276**	
QOA	198	183	254	216	229	240	265	314	273	250	223	140	**2785**	**30%**
QOC	56	62	90	39	45	61	53	52	46	56	42	42	**644**	**7%**
QOS	371	371	488	417	456	514	500	554	492	585	427	281	**5456**	**59%**
QOL	12	14	32	27	27	25	32	19	35	31	17	16	**287**	**3%**
Other*	13	13	11	8	7	6	7	6	12	8	7	6	**104**	**1%**

- QI clinical management investigated, reviewed, and triaged all referrals both internal and external to the organization to ensure that clinical, service, access, and language related PQIs were addressed through RN investigation and oversight support from Compliance and Vendor Management as applicable.

2023 QOC PQI Quarterly Totals

INDICATOR	Q1	Q2	Q3	Q4
Indicator 1: QOC PQIs	Denominator: **2168** Numerator: **208** Rate: **10%**	Denominator: **2317** Numerator: 145 Rate: **6%**	Denominator: **2660** Numerator: **151** Rate: **6%**	Denominator: **2131** Numerator: 140 Rate: **7%**
Indicator 2: QOC PQIs leveled at severity C2-4	Denominator: **208** Numerator: **38** Rate **18.3%**	Denominator: **145** Numerator: **34** Rate: **23%**	Denominator: **151** Numerator: **18** Rate: **12%** **2 cases still open**	Denominator: **140** Numerator: **3** Rate: **2%** **67 cases still open** *

*Q4 2023 data available at the end of April 2024 due to 120-day TAT for closure

QI Audit of Exempt Grievances

- QI RN management continues to conduct Exempt Grievances case audits via random sampling to ensure that clinical PQIs are not missed and are forwarded to the Quality Department for investigation. QI Department clinical management provides oversight of exempt grievances via review of randomly selected exempt grievances. In 2023, 100 exempt grievance case file reviews were performed per quarter with an overall performance rate of 99.5 which exceeds the established performance metric of 90%.

	Q4 2022	Q1 2023	Q2 2023	Q3 2023
Numerator	98	100	100	100
Denominator	100	100	100	100
Performance Rate	98	100	100	100
Gap to Goal	N/A	N/A	N/A	N/A
Universe	3126	5096	5352	5604

- The Alliance IT department continues to provide support with workflow enhancements to the PQI application as needed. facilities when PQIs are opened. This will allow the QI clinical safety team to track and trend PQI cases in LTC facilities. The PQI application remains a robust and responsive system allowing for timely and accurate reporting, documentation, tracking and adjudication of PQIs.

****A full description of the PQI process is documented in policy QI-104*

Consistency in Application of Criteria for Inter-rater Reliability (IRR)

- The Alliance QI Department assesses the consistency with which physicians, pharmacists, Quality Review nurses, UM nurses, Retrospective Review nurses and non-physician reviewers apply criteria to evaluate inter-rater reliability (IRR). A full description of the testing methodology is available in policy QI-133. The QI Department has set the IRR passing threshold as noted.

Inter-rater Reliability (IRR) Thresholds

SCORE	ACTION
High – 90%-100%	IRR Pass Rate/No action required.
Medium – 61%-89%	Increased training and focus by supervisors/managers.
Low – Below 60%	• Additional training provided on clinical decision-making. • If staff fails the IRR test for the second time, a Corrective Action Plan is required with reports to the Director of Health Services and the Chief Medical Officer. • If staff fails to pass the IRR test a third time, the case will be escalated to Human Resources which may result in possible further disciplinary action.

- The IRR process for PQIs uses actual PQI cases. IRRs include a combination of acute and/or behavioral health IRRs. Results will be tallied as they complete the process and corrective actions implemented as needed. When opportunities for improving the consistency in applying criteria, QI staff addresses corrective actions through requirement of global or individualized training or completing additional IRR case reviews.

- For the 2023 measurement year, IRR testing was performed with QI clinical staff to evaluate consistency in classification, investigation and leveling of PQIs. All QI Review Nurse and Medical Director Reviewers passed the IRR testing with scores of 100%.

ALAMEDA Alliance FOR HEALTH

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

Health Equity

Lao Paul Vang

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

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

Date: **April 12th, 2024**

Subject: **Health Equity Report**

Internal Collaboration:

- **Meetings and check-ins with Division Chiefs Update** –
    - Conducted on-going 1:1 meetings with division chiefs to provide updates on Health Equity and DEI activities, as well as seeking opportunities to collaborate and support each other.

- **Population Health Management (PHM), Quality Improvement (QI), and Utilization Management (UM) Update** –
    - Further discussions surrounding data governance ownership.
    - Discussions about future collaboration with PHM re: their PHM strategy and how it will be embedded in AAH's DEI strategic framework.

- **Vendor Management (VM) Update –**
    - **Supplier Diversity Project:**
        - Continued work with the vendor management team, which includes supplier diversity program strategy and implementation.
        - Provided feedback on supplier diversity copy for the website and provided internal communication touchpoints for client review.

External Collaboration

- **Bi-weekly meetings with Local Health Plans' Chief Health Equity Officers (CHEOs) Update** – The following items were discussed at the March meeting –
    - Continued conversation and work surrounding SOGI data collection challenges and lessons learned.
    - Open discussions for questions or concerns regarding the building and implementation of the DEI Training Program.

- **Monthly Meetings with DHCS' Chief Health Equity Officer (DHCS CHEO) Update** –

    - Attended monthly meeting with DHCS CHEO and MCPs CHEOs to discuss on-going collaboration on health equity and DEI initiatives; particularly on DEI training as required by APL 23-025.

<u>Advancing Health Equity Initiative (AHEI)</u>

- **Assessments**
    - AHEI assessments are complete.

- **Key Findings Report –**

    - The Findings Report has been presented to the Chief Executive Officer and the Senior Leadership Team.
    - The Findings Report will be presented to the Board of Governors in the near future.

- **Leadership Enrichment Sessions**

    - Two sessions for the Senior Leadership have been scheduled, the first for April and the second for May, to provide SLT with the necessary information regarding their roles and responsibilities for supporting Health Equity and DEI initiatives for the Alliance.

- **Alliance Strategic Roadmap Update**

    - Currently scheduling the Strategic Roadmap Committee Meetings, targeting the first meeting in May. Once this committee has met and completed all necessary sessions and discussions, a tentative date will be announced regarding the first draft of the roadmap.

- **The Data Review Update**

    - Final Data Review meeting and wrap–up were conducted with key personnel; it was determined that all deliverables listed in the scope of work have been completed.
    - Additional support is available upon request.

- **DEI Training Curriculum (APL 23–025) Updates**

    <u>Alliance Staff DEI Training</u>

    - Internal Contact: Chief Human Resources Officer
    - Efforts being made with CHRO to review employee training elements to meet APL requirements compared to the current internal educational offering (CST-Cultural Sensitivity Training).

- Slated to gain access/review of staff training materials in the first part of April (Per HR, tentatively 4/18).

Downstream Vendors DEI Training

- Internal Contact: Director of Vendor Management
- Collaborating with Vendor Management to review and inventory existing vendor training efforts on DEI to see if such training meets APL 23-025 or not.

Providers DEI Training

- Internal Contact: Interim Chief Medical Officer
- Collaborated with interim Chief Medical Officer and gained insight into past efforts and feedback for the current development of DEI training curriculum.

Additional Related Meetings

- Compliance: Scheduled to meet with the compliance contact during the first week of April.
- Community: In the process of scheduling a meeting with A. Martinez for community insights.

Training Delivery System

- Conducting exploratory work to identify and recommend the most expeditious training delivery vehicles, such as the Learning Management System (LMS) for providers and downstream vendors.

DEI Training Curriculum Submission To DHCS

- The second week of September has been identified as a tentative submission date to DHCS for the DEI training curriculum; for approval by December, to go live with the pilot training by January 2025.

- **Communications Update –**

  - The HE Department has developed an intranet page for the staff that will go live in April.

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

- **DEIB Committee Update –**
    - In March, the DEIB Committee discussed a DEIB luncheon for the Committee to take place after June.

- **VIA Committee Update** –
    - Matt Woodruff, CEO, attended the March VIA Committee and discussed upcoming changes in the committee.
    - Yemaya presented Spring Social Event updates. The Committee discussed the caterers for the event.
    - Lao asked the Committee to send Jeanette any ideas for the All-Staff Meeting.

ALAMEDA Alliance FOR HEALTH

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Service you can trust.

Information Technology

Sasikumar Karaiyan

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

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

Date: **April 12th, 2024**

Subject: **Information Technology Report**

Call Center System Availability

- AAH phone systems and call center applications performed at 100% availability during the month of March 2024 despite supporting 97% of staff working remotely.

- As part of the call center processes of efficiency and effectiveness, IT is implementing Calabrio Analytics and Speech to Text features which will accurately and cost-effectively analyze customer interactions and agent activity along with its multichannel artificial intelligence and deep learning, all-in-one solution that captures and transforms data, turning raw interactions into usable data for reporting.

    - Completed Analytics training on March 26, 2024.
    - Provider Services is now live on Calabrio Analytics starting March 28, 2024.
    - Member Services will receive a Non-English (Spanish) language pack by April 15, 2024.

IT Security Program

- IT Security 3.0 initiative is one of the Alliance's top priorities for fiscal year 2024. Our goal is to continue to elevate and further improve our security posture, ensure that our network perimeter is secure from threats and vulnerabilities, and to improve and strengthen our security policies and procedures.

    - **Key initiatives include:**

        - Implement actionable items from the Azure Governance best-practices and recommendations document.
        - Remediating issues from security assessments. (e.g., Cyber, Microsoft Office 365, & Azure Cloud).
        - Continue to create, update, and implement policies and procedures to operationalize and maintain security level after remediation.

- The Annual Security Penetration testing was conducted successfully in the month of March 2024. This includes simulated attacks on the network (Internal and External), phishing tests, privilege escalation and lateral movements across the network.

IT Disaster Recovery (Phase 2)

- One of the Alliance primary objectives for fiscal year 2024 is to complete the second phase of the implementation of an enterprise IT Disaster Recovery program that will focus on tier 2/3 applications and systems. This is to ensure that our core business areas have the ability to restore and continue operations when there is a disaster.

- IT Disaster Recovery involves a set of policies, tools, and procedures to enable the recovery or continuation of vital technology infrastructure and systems following a natural or human-induced disaster. IT Disaster Recovery focuses on technology systems supporting critical business functions, which involve keeping all essential aspects of the business functioning, despite significant disruptive events.

- Application owners are now gathering artifacts, procedures, diagrams and inventory of their respective systems listed under tier 2/3 systems and applications.

Encounter Data

- In the month of March 2024, the Alliance submitted 156 encounter files to the Department of Health Care Services (DHCS) with a total of 321,853 encounters.

Enrollment

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

HealthSuite

- The Alliance received $308,453 claims in the month of March 2024.

- A total of 228,860 claims were finalized during the month out of which 185,783 claims auto adjudicated. This sets the auto-adjudication rate for this period to 81.2%.

- The TruCare application continues to operate with an uptime of 99.99%.

TruCare

- A total of 15,858 authorizations were loaded and processed in the TruCare application.

- The TruCare application continues to operate with an uptime of 99.99%.

Information Technology

Supporting Documents

Enrollment

- See Table 1-1 “Summary of Medi-Cal and Group Care member enrollment in the month of March 2024”.
- See Table 1-2 “Summary of Primary Care Physician (PCP) Auto-assignment in the month of March 2024”.
- The following tables 1-1 and 1-2 are supporting documents from the enrollment summary section.

Table 1-1 Summary of Medi-Cal and Group Care Member enrollment in the month of March 2024

Month	Total MC[1]	MC[1] - Add/ Reinstatements	MC[1] - Terminated	Total GC[2]	GC[2] - Add/ Reinstatements	GC[2]- Terminated
March	398,200	8,641	7,932	5,621	138	125

1. MC – Medi-Cal Member 2. GC – Group Care Member

Table 1-2 Summary of Primary Care Physician (PCP) Auto-Assignment For the Month of March 2024

Auto-Assignments	Member Count
Auto-assignments MC	2,708
Auto-assignments Expansion	2,437
Auto-assignments GC	56
PCP Changes (PCP Change Tool) Total	5,630

TruCare Application

- See Table 2-1 “Summary of TruCare Authorizations for the month of March 2024”.
- There were 14,458 authorizations processed within the TruCare application.
- TruCare Application Uptime – 99.99%.
- The following table 2-1 is a supporting document from the TruCare summary section.

Table 2-1 Summary of TruCare Authorizations for the Month of March 2024*

Transaction Type	Inbound automated Auths	Errored	Total Auths Loaded in TruCare
Paper Fax to Scan (DocuStream)	2,770	2,277	1,555
Provider Portal Requests (Zipari)	5,546	1,458	5,430
EDI (CHCN)	5,491	1,606	5,316
Provider Portal to AAH Online (Long Term Care)	30	18	26
ADT	1,201	632	714
Anthem	15	8	11
Behavioral Health COC Update - Online	50	31	44
Behavioral initial evaluation - Online	57	39	45
Manual Entry (all other not automated or faxed vs portal use)	N/A	N/A	2,717
Total			15,858

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 always one month behind current month)

Table 3-1 Web Portal Usage for the Month of February 2024

Group	Individual User Accounts	Individual User Accounts Accessed	Total Logins	New Users
Provider	6,818	5,022	402,504	748
MCAL	107,972	4,926	13,144	2,245
IHSS	3,624	117	99	27
Total	118,414	10,065	415,747	3,020

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

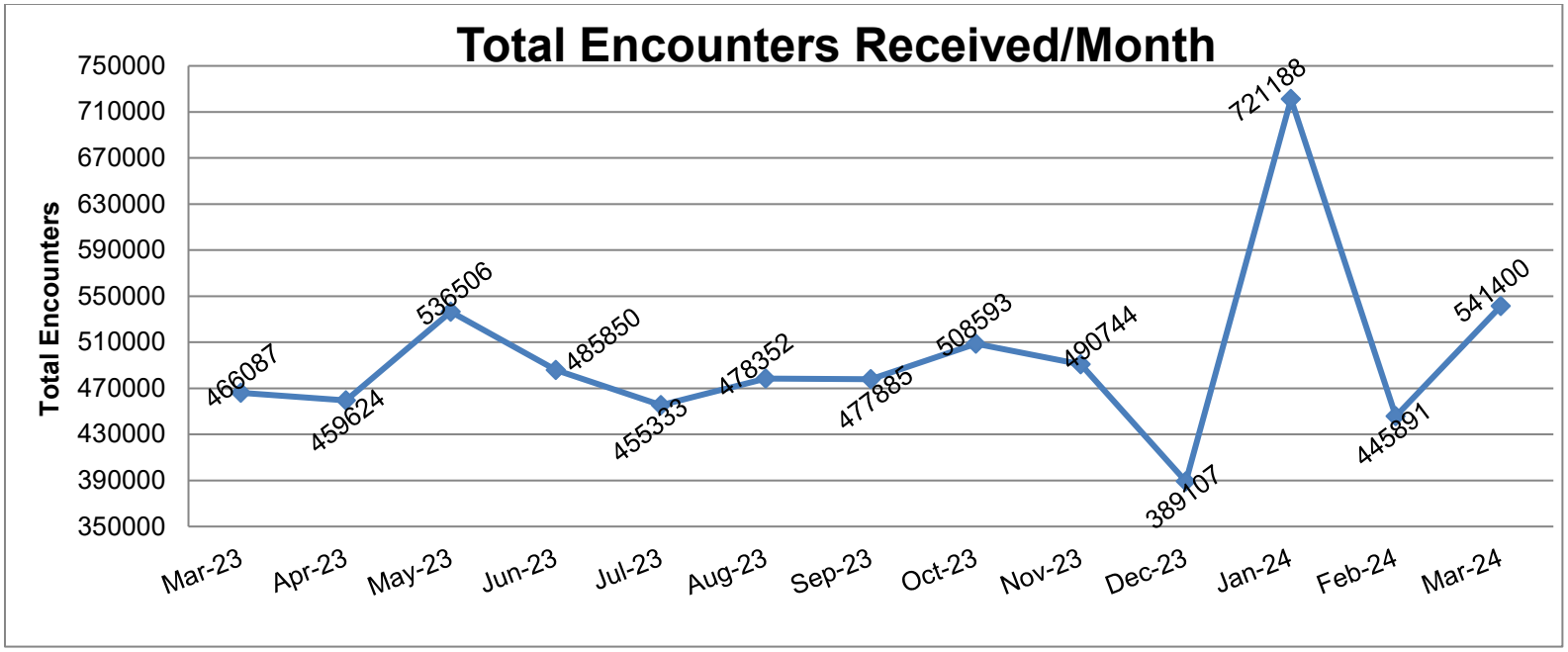
Category	Page Name	Page Views
Provider - eligibility/claim	Member Eligibility	1,395,348
Provider - Claims	Claim Status	289,011
Provider - eligibility/claim	Claim Status	32,233
Provider - authorizations	Auth Submit	15,976
Provider - authorizations	Auth Search	8,691
Member Config	Provider Directory	8,483
Member My Care	Member Eligibility	7,052
Member Help Resources	ID Card	6,621
Member Help Resources	Find a doctor or Hospital	4,479
Provider - Claims	Submit professional claims	4,434
Provider - eligibility/claim	Member Roster	4,022
Member Help Resources	Select or Change Your PCP	3,047
Member Home	MC ID Card	1,710
Member My Care	My Claims Services	1,678
Provider - Provider Directory	Provider Directory 2019	1,073
Member My Care	Authorization	1,031
Provider - reports	Reports	860
Provider - Home	Forms	569
Provider - Home	Behavior Health Forms SSO	530
Member Help Resources	Forms Resources	512
Member My Care	Member Benefits Materials	507
Member Help Resources	FAQs	487
Member Help Resources	Authorizations Referrals	427
Member Help Resources	Contact Us	363
Provider - Provider Directory	Manual	343
Provider - Provider Directory	Instruction Guide	335
Provider - Home	Long Term Care Forms SSO	226
Provider - eligibility/claim	Member Eligibility	1,395,348
Provider - Claims	Claim Status	289,011

Encounter Data From Trading Partners 2024

- **ACBH**: March monthly files (0 records)
    - No longer receiving encounter files but through HCSA.
- **AHS**: March weekly files (7,005 records) were received on time.
- **BAC**: March monthly files (55 records) were received on time.
- **Beacon**: March weekly files (0 records)
    - No longer receiving encounter files.
- **CHCN**: March weekly files (122,217 records) were received on time.
- **CHME**: March monthly files (6,022 records) were received on time.
- **CFMG**: March weekly files (12,651 records) were received on time.
- **Docustream**: March monthly files (698 records) were received on time.
- **EBI**: March monthly files (1,625 records) were received on time.
- **FULLCIR**: March monthly files (213 records) were received on time.
- **HCSA**: March monthly files (2,822 records) were received on time.
- **IOA**: March monthly files (1,054 records) were received on time.
- **Kaiser**: March bi-weekly files (9,966 records) were received on time.
- **LAFAM**: March monthly files (39 records) were received on time.
- **LogistiCare**: March weekly files (35,600 records) were received on time.
- **March Vision**: March monthly files (6,183 records) were received on time.
- **MED**: March monthly files (683 records) were received on time.
- **Quest Diagnostics**: March weekly files (22,306 records) were received on time.
- **SENECA**: March monthly files (112 records) were received on time.
- **TITANIUM**: March monthly files (3,696 records) were received on time.
- **Magellan**: March monthly files (430,202 records) were received on time.

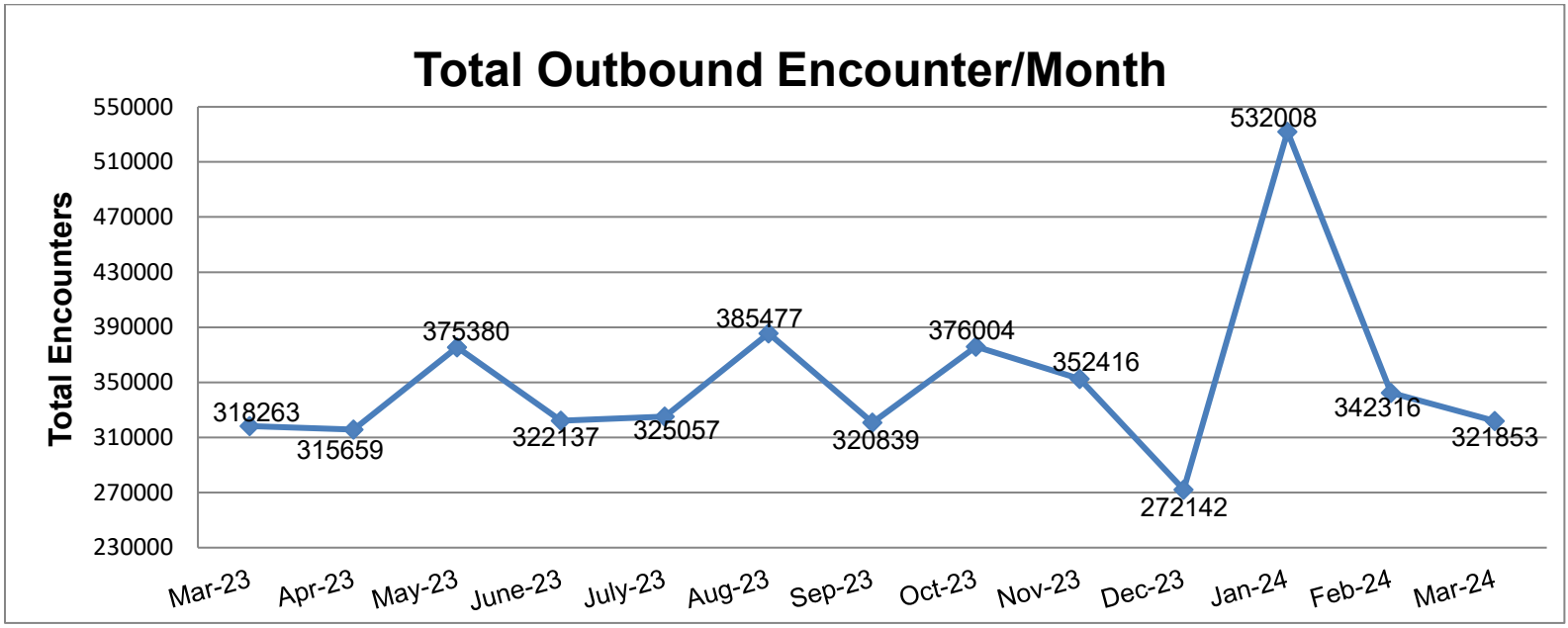
Trading Partner Encounter Inbound Submission History

Trading Partners	Mar-23	Apr-23	May-23	Jun-23	July-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Health Suite	238283	218296	251858	267437	224540	244907	247423	241298	247537	215246	298465	266339	308453
ACBH	95												
AHS	5088	6353	5380	6250	4363	4380	5479	5371	5243	6284	4570	7736	7005
BAC	32	38	40	37	39	38	38	57	73	55	59	57	55
Beacon	12159	15799	5822	4559	620								
CHCN	82394	84654	117764	90418	102081	85836	77060	111275	87839	58566	96124	103674	122217
CHME	4729	5277	4987	5692	5706	5704	6212	7609	6445	5694	5843	5560	6022
Claimsnet	8851	16155	12526	9986	12379	8946	12302	12167	11670	18995	12043	10557	12651
Docustream	1361	865	575	607	567	744	562	400	705	476	930	814	698
EBI		976	15	910	1664	814	867	718	823	811	1047	2903	1625
FULLCIR								888	598	177	828	1586	213
HCSA	590	78	72	5573	3824	3466	2490	1913	2403	2087	2223	2097	2822
IOA	156	201	325	974	424	673	1086	967	1073	1250	1453	1233	1054
Kaiser	73095	68883	91196	53820	56673	76278	79751	81985	87005	26208	77407	3725	9966
LAFAM								24				60	39
Logisticare	21647	20558	28628	20859	22235	27129	22456	25509	20781	32181	182822	20774	35600
March Vision	3281	4275	3647	5101	4468	4563	4933	4427	4428	4562	9693		6183
MED					9	11	144	194	523	532	535	742	683
Quest	14326	17216	13671	13627	15741	14859	17008	13712	13077	15834	27022	17658	22306
SENECA						4	74	79	56	52	124	222	112
TITANIUM									465	97		154	3696
Total	466087	459624	536506	485850	455333	478352	477885	508593	490744	389107	721188	445891	541400



Outbound Encounter Submission

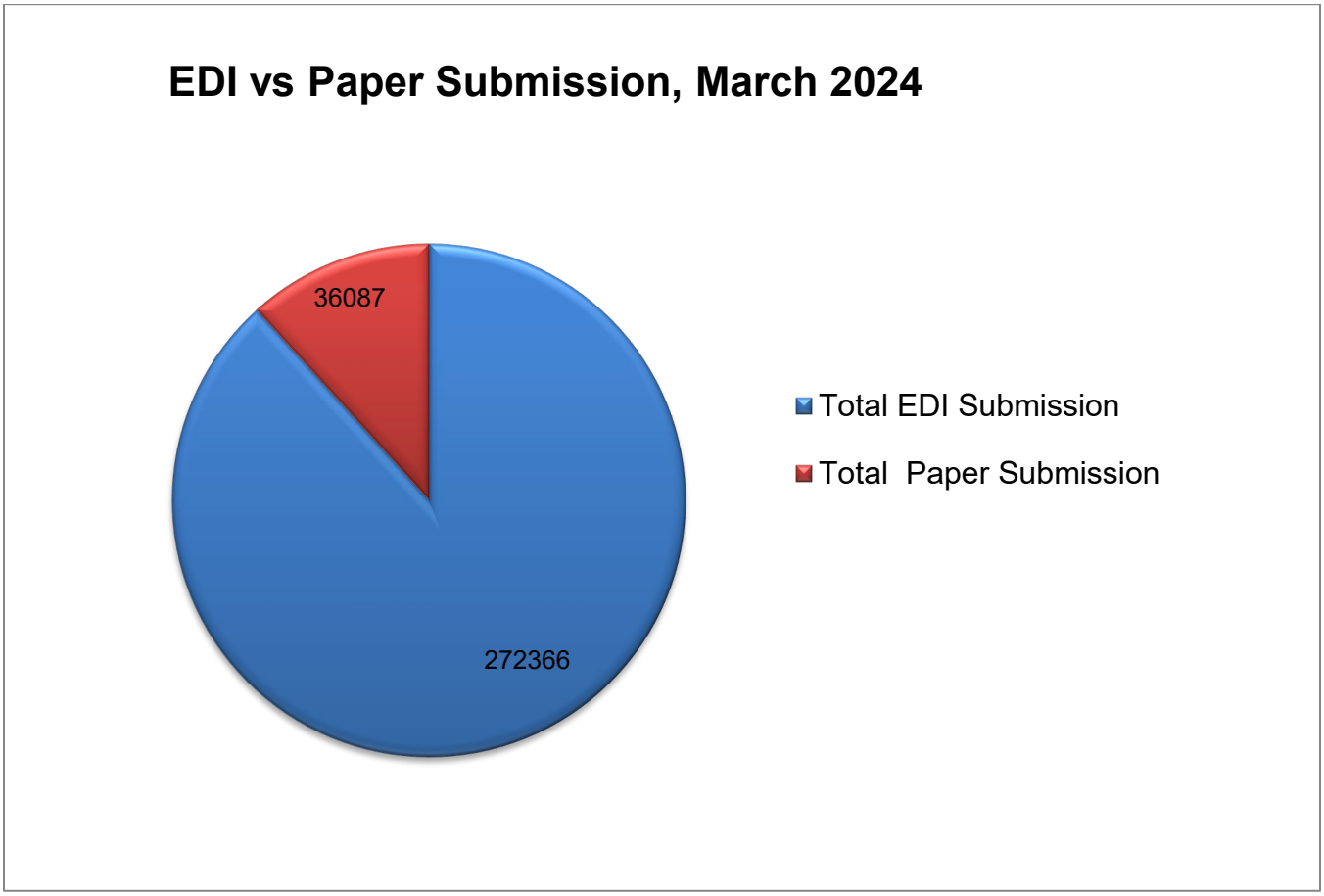
Trading Partners	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Health Suite	117672	117823	151866	126674	147199	170751	127465	163149	134823	136233	172386	177658	147776
ACBH	73												
AHS	3845	7300	5236	5070	5318	4251	4253	6355	5147	4936	5667	7497	6968
BAC	32	38	40	37	39	37	38	52	67	53	55	55	47
Beacon	9674	11927	2879	2233	318								
CHCN	59074	60373	79256	65595	56593	74313	55365	62962	73866	39846	67063	74336	80498
CHME	4606	5159	4864	5577	5595	5546	6063	7475	6321	5588	5703	5470	5889
Claimsnet	6361	9834	10891	7445	8849	6386	7075	7452	8031	11581	10145	7730	6757
Docustream	1232	481	411	378	347	529	441	270	573	404	387	600	377
EBI		906	15	872	1574	804	855	710	794	802	987	1347	1002
FULLCIR								806	516	124	653	540	116
HCSA	287	52	55	1781	3778	3405	2349	1876	2342	1991	2142	2013	2769
IOA	152	45	276	751	410	654	984	65	934	1228	1378	1156	1000
Kaiser	72409	65652	72893	68887	55988	75591	78162	81165	85807	26113	76335	3542	9650
LAFAM								2					16
LogistiCare	27071	20411	28455	20787	21686	26670	22142	24497	25951	31546	157548	40529	34931
March Vision	2400	3006	2366	3408	2720	2737	2992	2863	2661	2752	2700	2616	3736
MED					9	11	126	145	438	428	446	624	528
Quest	13375	12652	15877	12642	14634	13788	12456	16082	3655	8394	28299	16589	16333
SENECA						4	73	78	52	48	114	14	199
TITANIUM									438	75			3261
Total	318263	315659	375380	322137	325057	385477	320839	376004	352416	272142	532008	342316	321853



HealthSuite Paper vs EDI Claims Submission Breakdown

Period	Total EDI Submission	Total Paper Submission	Total claims
24-Mar	272366	36087	308453

Key: EDI – Electronic Data Interchange

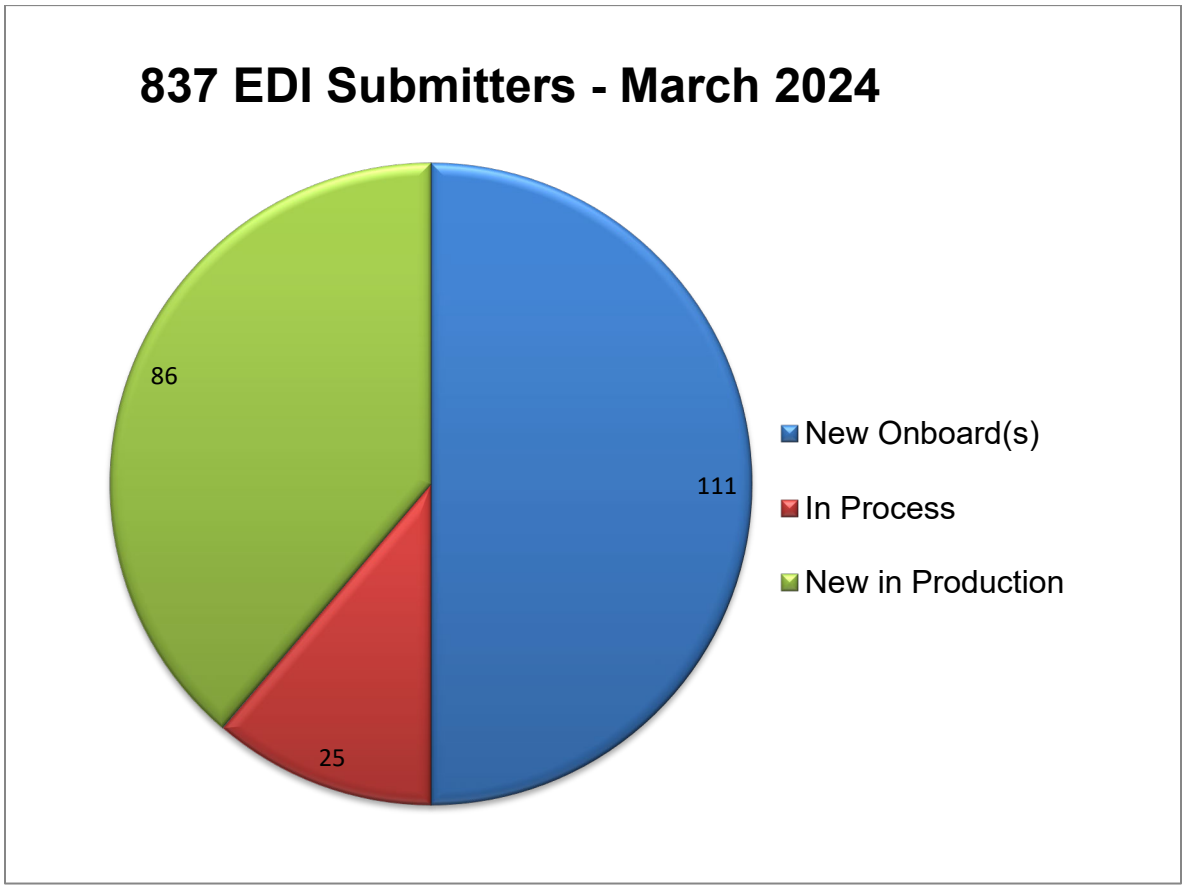


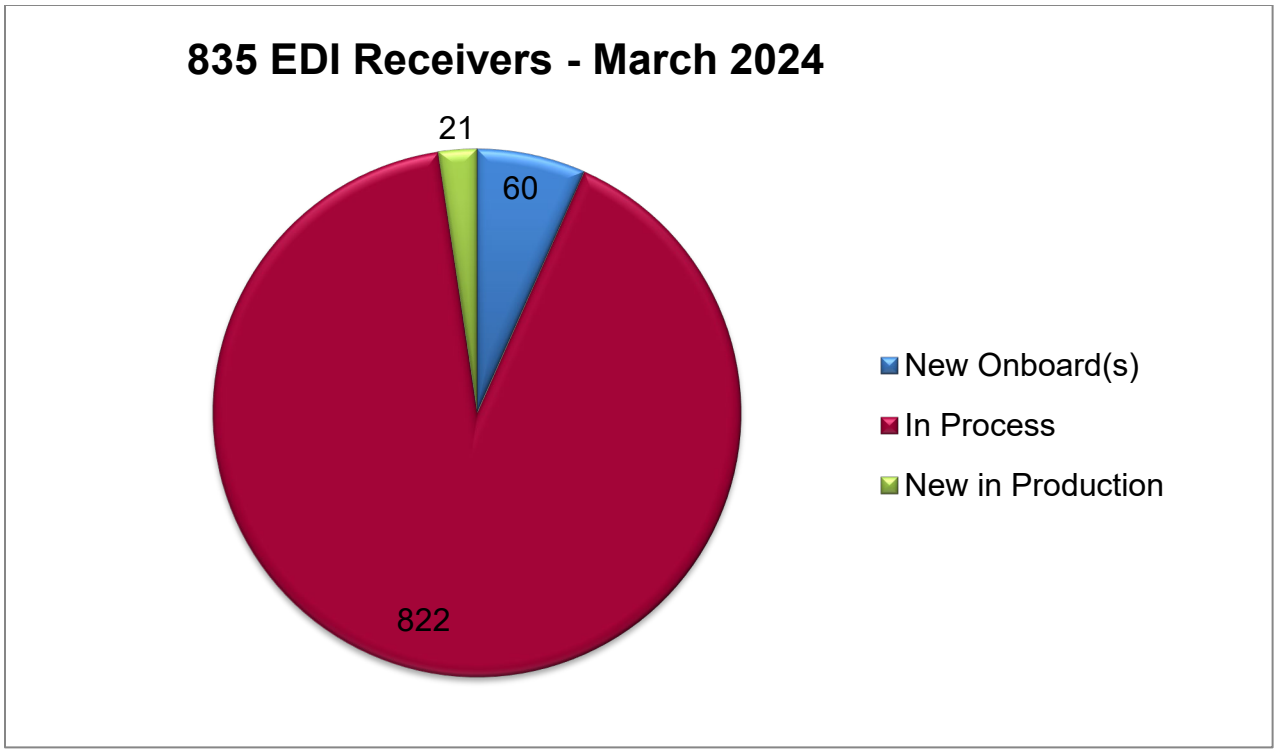
Onboarding EDI Providers – Updates

- March 2024 EDI Claims:
  - A total of 2160 new EDI submitters have been added since October 2015, with 86 added in March 2024.
  - The total number of EDI submitters is 2925 providers.

- March 2024 EDI Remittances (ERA):
  - A total of 942 new ERA receivers have been added since October 2015, with 21 added in March 2024.
  - The total number of ERA receivers is 958 providers.

	837				835			
	New on Boards	In Process	New In Production	Total in Production	New on Boards	In Process	New In Production	Total in Production
Apr-23	50	3	47	2370	24	491	5	714
May-23	35	5	30	2400	44	527	8	722
Jun-23	79	7	72	2472	58	544	41	763
Jul-23	48	2	46	2518	62	583	23	786
Aug-23	44	1	43	2561	41	602	22	808
Sep-23	70	0	70	2631	46	621	27	835
Oct-23	36	2	34	2665	21	640	2	837
Nov-23	47	2	45	2710	45	679	6	843
Dec-23	25	2	23	2733	63	716	26	869
Jan-24	63	2	61	2794	76	751	41	910
Feb-24	37	17	20	2814	59	783	27	937
Mar-24	111	25	86	2900	60	822	21	958





Encounter Data Submission Reconciliation Form (EDSRF) and File Reconciliations

- EDSRF Submission: Below is the total number of encounter files that AAH submitted in the month of **March** 2024.

File Type	MAR-24
837 I Files	28
837 P Files	128
Total Files	156

Lag-time Metrics/Key Performance Indicators (KPI)

AAH Encounters: Outbound 837	Mar-24	Target
Timeliness-% Within Lag Time - Institutional 0-90 days	92%	60%
Timeliness-% Within Lag Time - Institutional 0-180 days	98%	80%
Timeliness-% Within Lag Time - Professional 0-90 days	92%	65%
Timeliness-% Within Lag Time – Professional 0-180 days	99%	80%

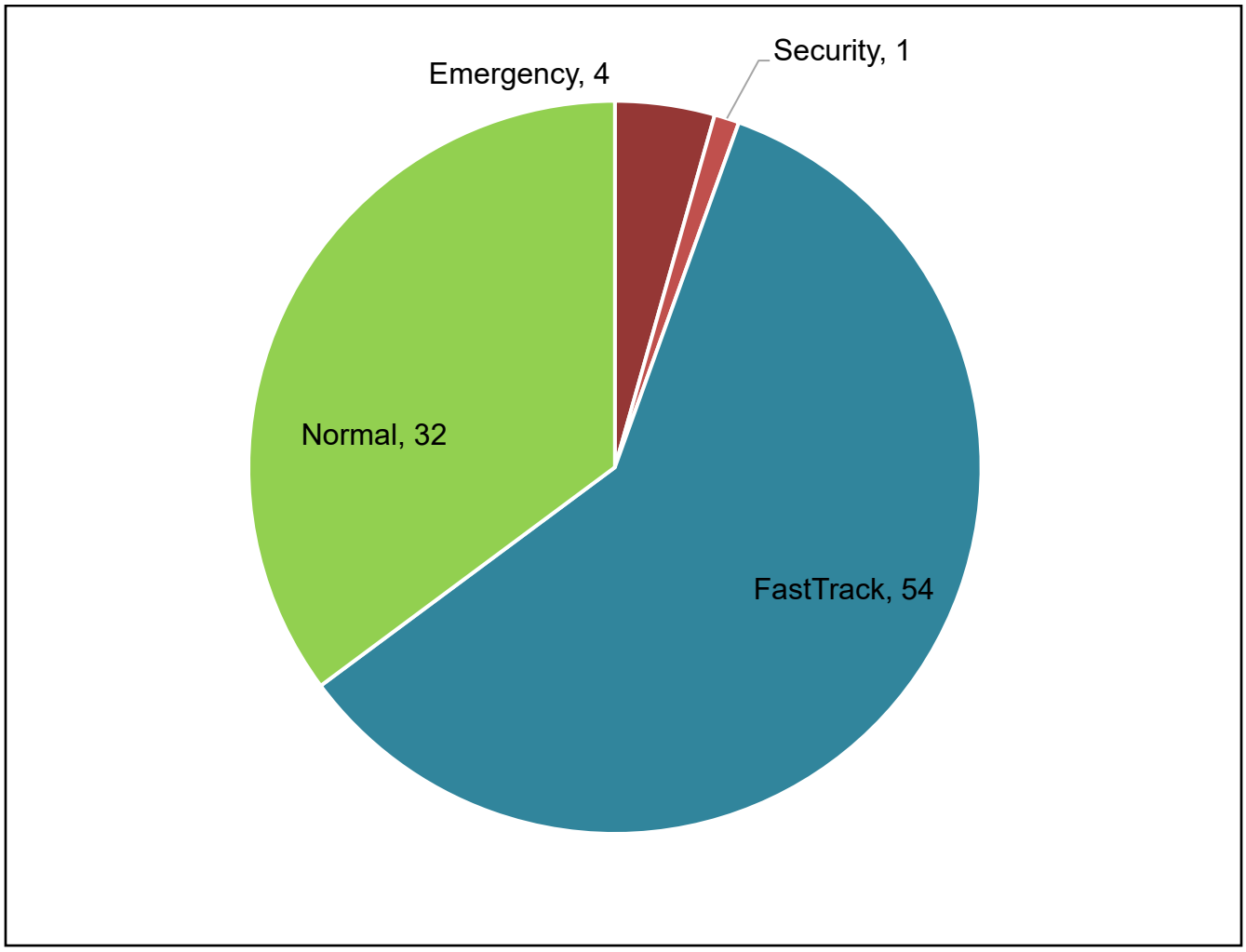
*Note, the Number of Encounters comes from: Total at bottom of this chart: **Outbound**

Encounter Submission

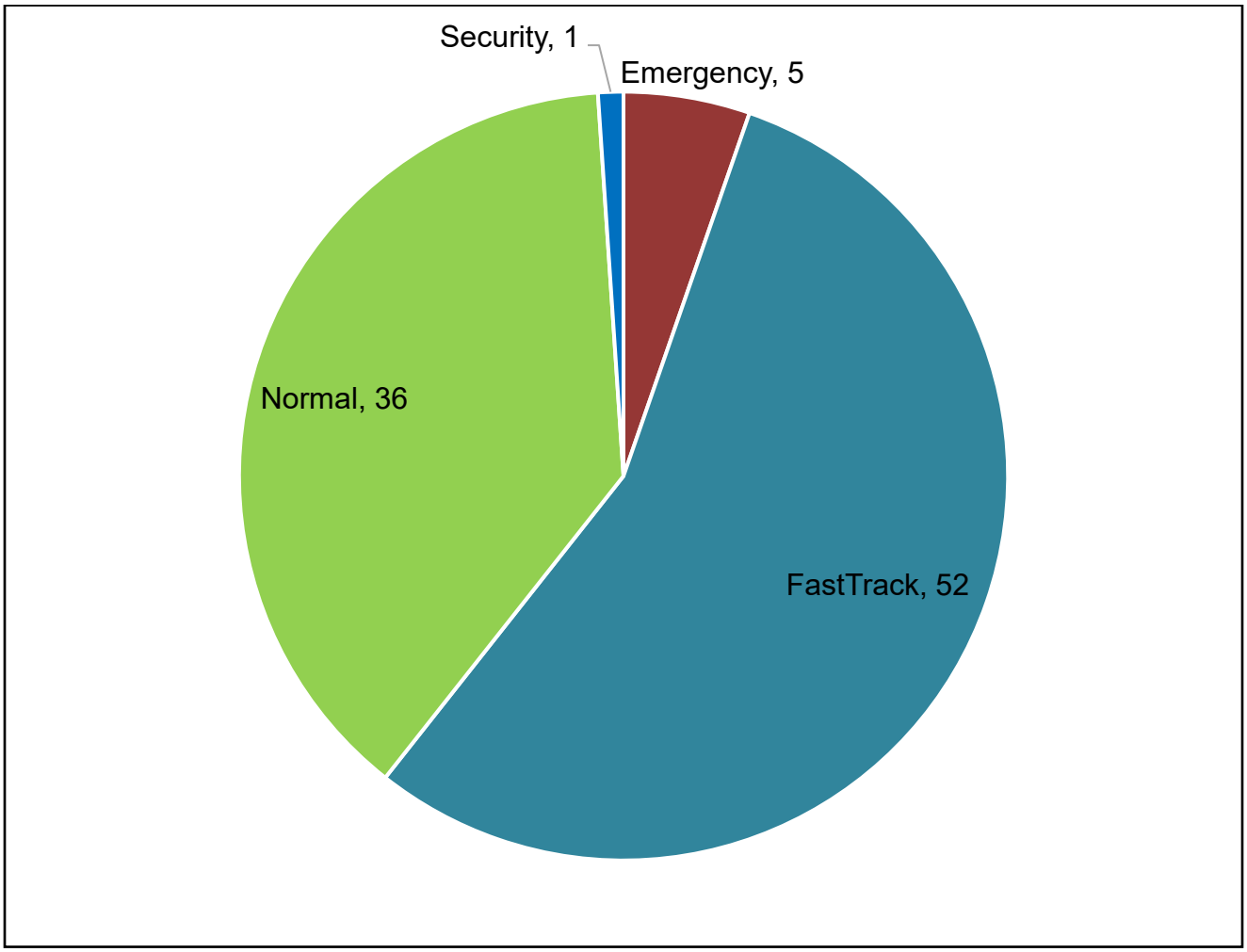
Change Management Key Performance Indicator (KPI)

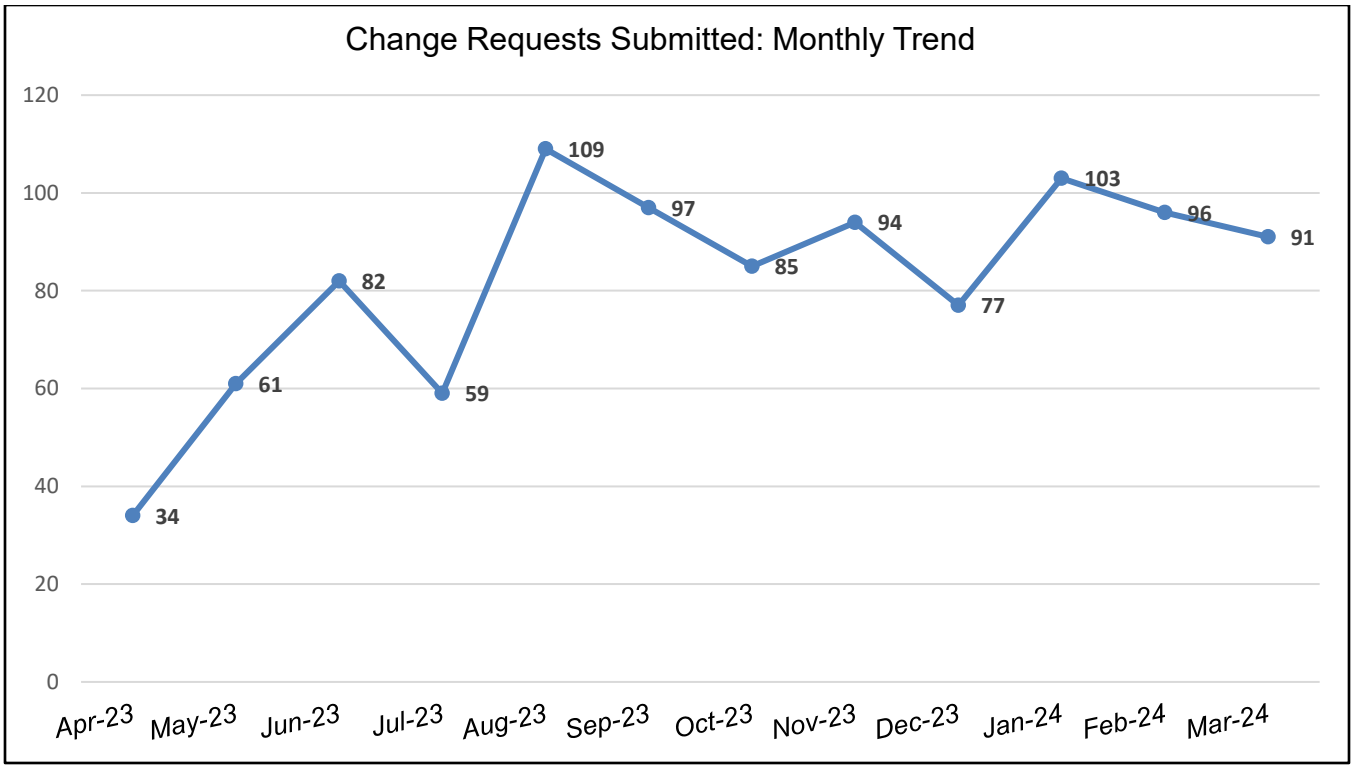
- Change Request Overall Summary in the month of March 2024 KPI:
  - 91 Changes Submitted.
  - 94 Changes Completed and Closed.
  - 168 Active Change Requests in pipeline.
  - 7 Change Requests Cancelled or Rejected.

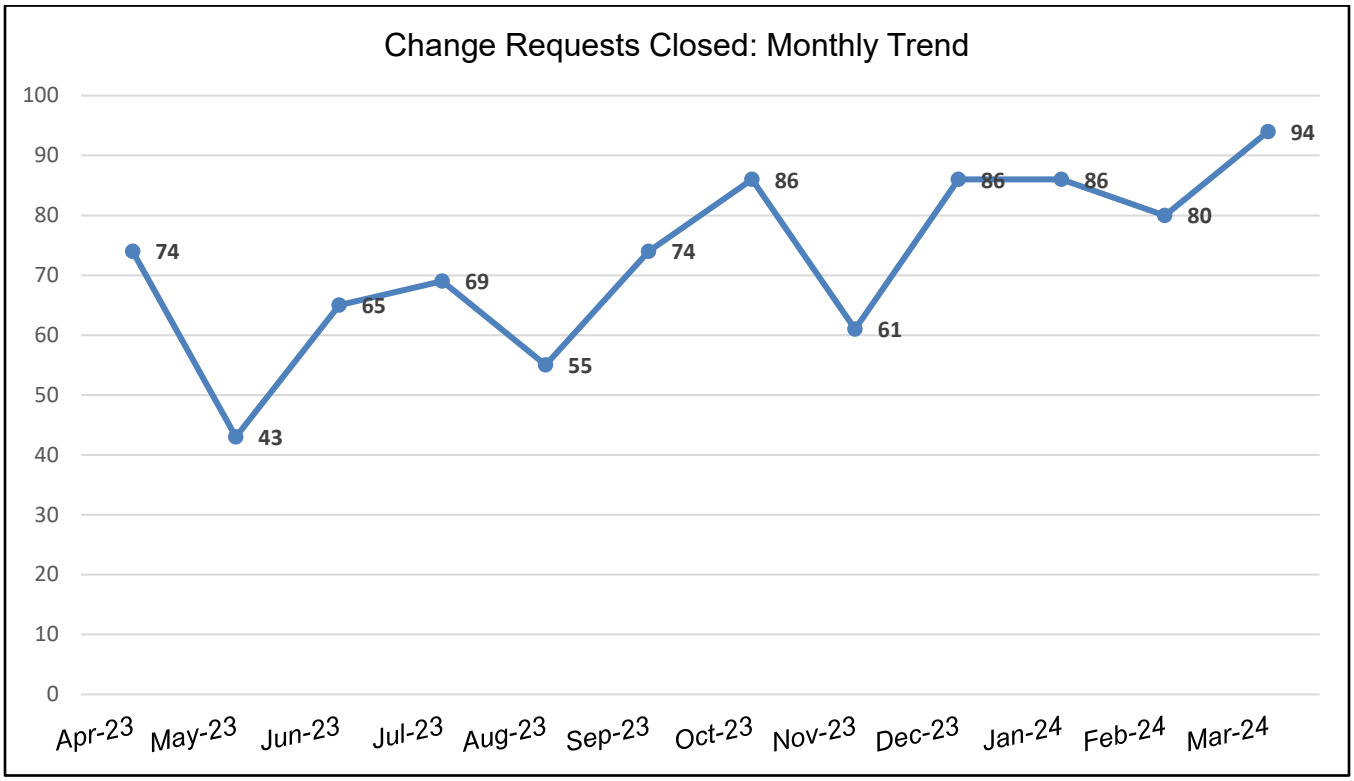
- 91 Change Requests Submitted/Logged in the month of March 2024



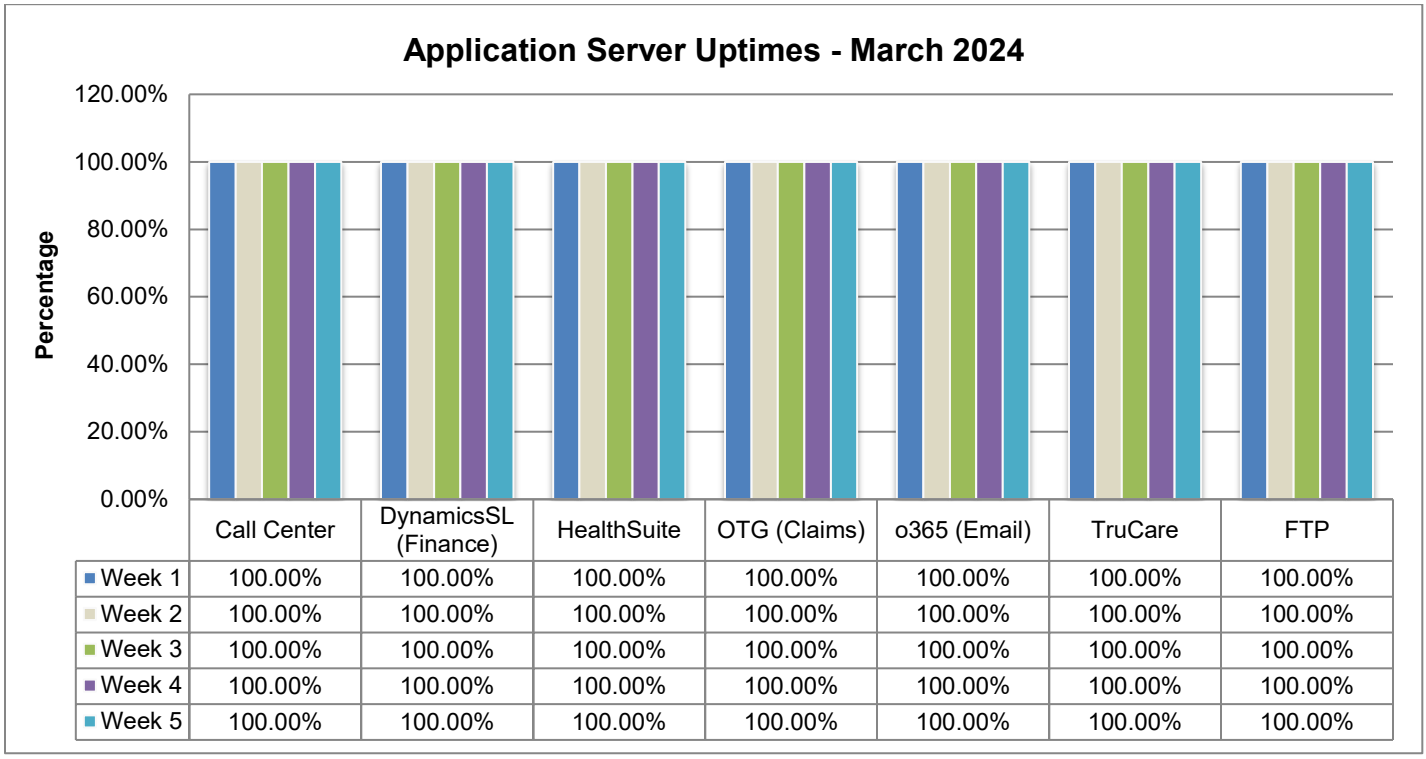
- 94 Change Requests Closed in the month of March 2024




Change Requests Submitted: Monthly Trend
120
100
80
60
40
20
0
34
61
82
59
109
97
85
94
77
103
96
91
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24


Change Requests Closed: Monthly Trend
100
90
80
70
60
50
40
30
20
10
0
74
43
65
69
55
74
86
61
86
86
80
94
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24

IT Stats: Infrastructure



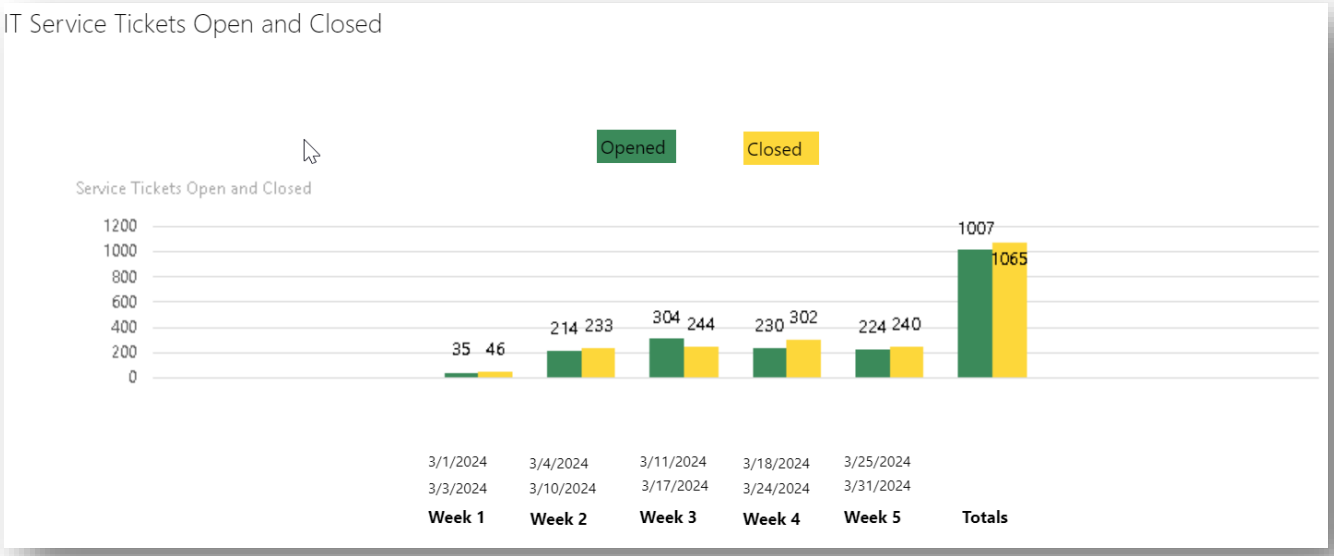
	Call Center	DynamicsSL (Finance)	HealthSuite	OTG (Claims)	o365 (Email)	TruCare	FTP
Week 1	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Week 2	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Week 3	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Week 4	100.00%	100.00%	100.00%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

- All mission critical applications are monitored and managed thoroughly.

- On Thursday, March 14th, 2024, at 12:28pm 2Ring Call Center application experienced a license utilization issue. Incoming/outgoing calls were not impacted by this issue.
  - The issue was resolved on Friday, March 15th, 2024, at 8:00am.

- On Friday, March 15th, 2024, at 9:00am TruCare application experienced a brief outage that affected “Auth submissions”.
  - The issue was resolved on Friday, March 15th, 2024, at 9:33am.

- On Monday, March 18th, 2024, at 10:43am Virtual Private Network (VPN) experienced major slowness that primarily affected Call Center staff.
  - The issue was identified to be caused by the planned annual IT Security Penetration testing.
  - The issue was resolved and coordinated with security vendor to perform testing after-hours.



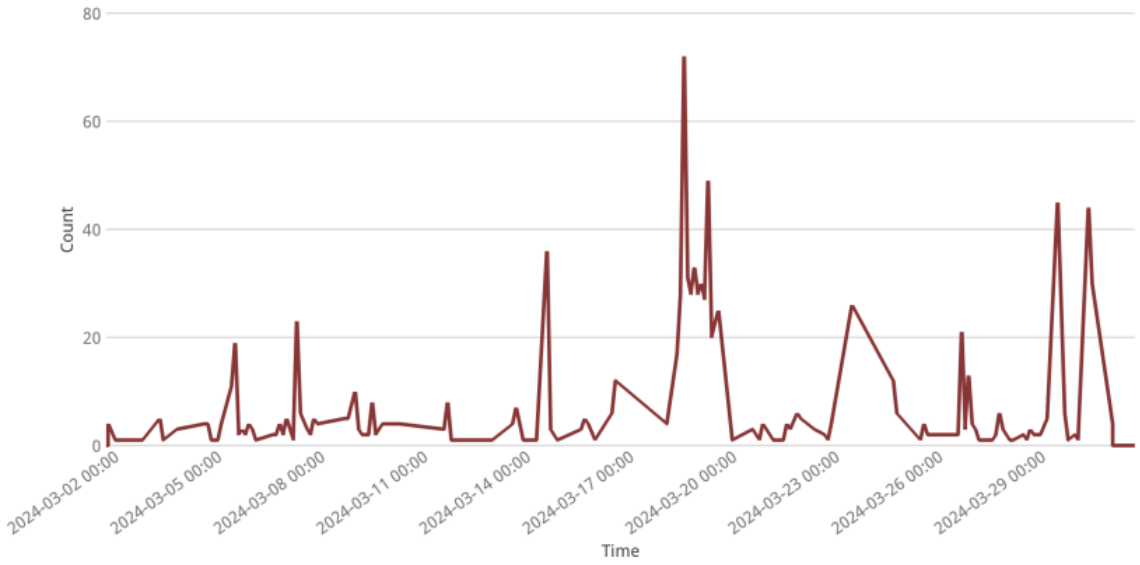
- 1007 Service Desk tickets were opened in the month of March 2024, which is 14.35% higher than the previous month (860) and 18.82% higher than the previous 3-month average of 834.

- 1065 Service Desk tickets were closed in the month of March 2024, which is 23.75% higher than the previous month (812) and 22.25% higher than the previous 3-month average of 828.

March 2024

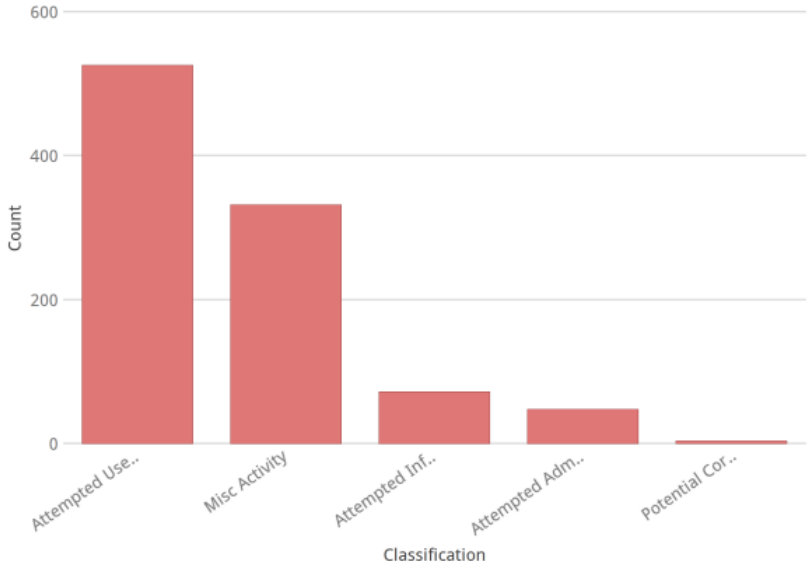
All Intrusion Events

Time Window: *2024-03-01 09:29:00 - 2024-03-31 09:29:00*



Dropped Intrusion Events

Time Window: *2024-03-01 09:30:00 - 2024-03-31 09:30:00*
Constraints: *Inline Result = !Alert,!Would **



Classification	Count
Attempted User Privilege Gain	526
Misc Activity	332
Attempted Information Leak	72
Attempted Administrator Privilege Gain	48
Potential Corporate Policy Violation	4

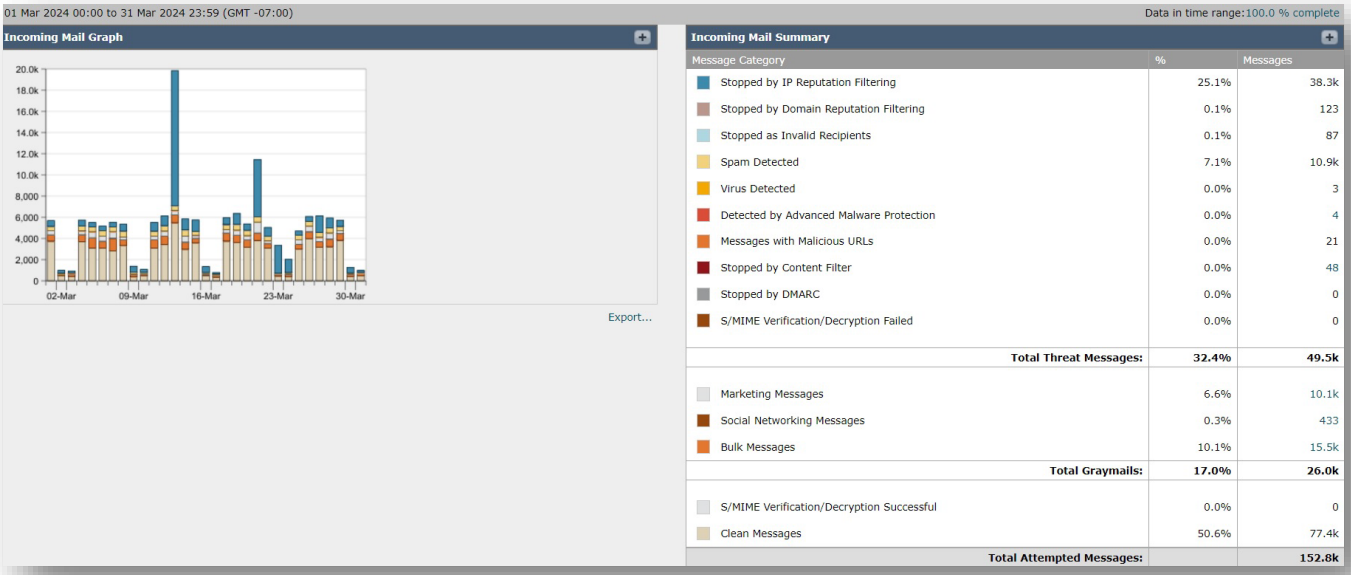
IronPort Email Security Gateways

Email Filters

March 2024

MX4

Inbound Mail



01 Mar 2024 00:00 to 31 Mar 2024 23:59 (GMT -07:00) — Data in time range: 100.0 % complete

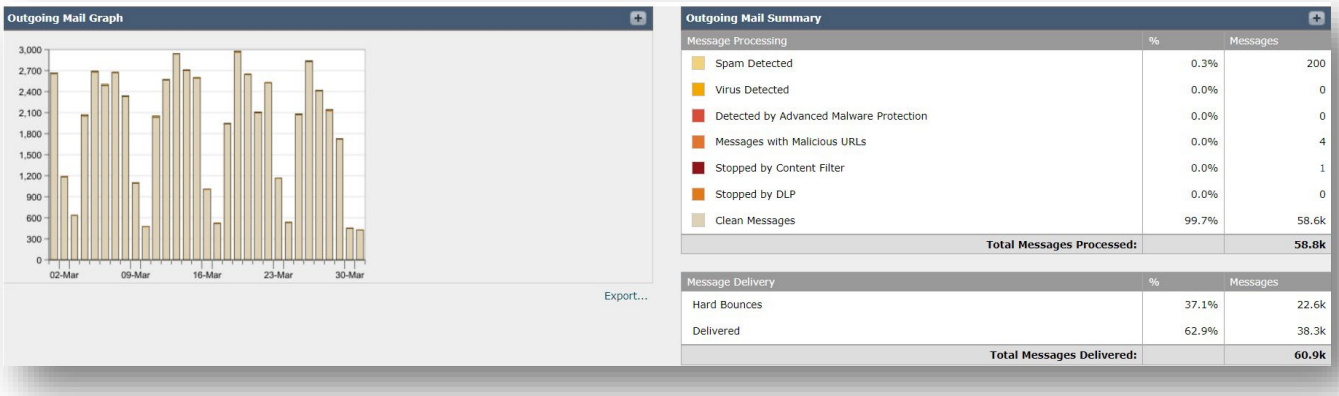
Incoming Mail Graph

Export...

Incoming Mail Summary

Message Category	%	Messages
Stopped by IP Reputation Filtering	25.1%	38.3k
Stopped by Domain Reputation Filtering	0.1%	123
Stopped as Invalid Recipients	0.1%	87
Spam Detected	7.1%	10.9k
Virus Detected	0.0%	3
Detected by Advanced Malware Protection	0.0%	4
Messages with Malicious URLs	0.0%	21
Stopped by Content Filter	0.0%	48
Stopped by DMARC	0.0%	0
S/MIME Verification/Decryption Failed	0.0%	0
Total Threat Messages:	**32.4%**	**49.5k**
Marketing Messages	6.6%	10.1k
Social Networking Messages	0.3%	433
Bulk Messages	10.1%	15.5k
Total Graymails:	**17.0%**	**26.0k**
S/MIME Verification/Decryption Successful	0.0%	0
Clean Messages	50.6%	77.4k
Total Attempted Messages:		**152.8k**

Outbound Mail



Outgoing Mail Graph

Export...

Outgoing Mail Summary

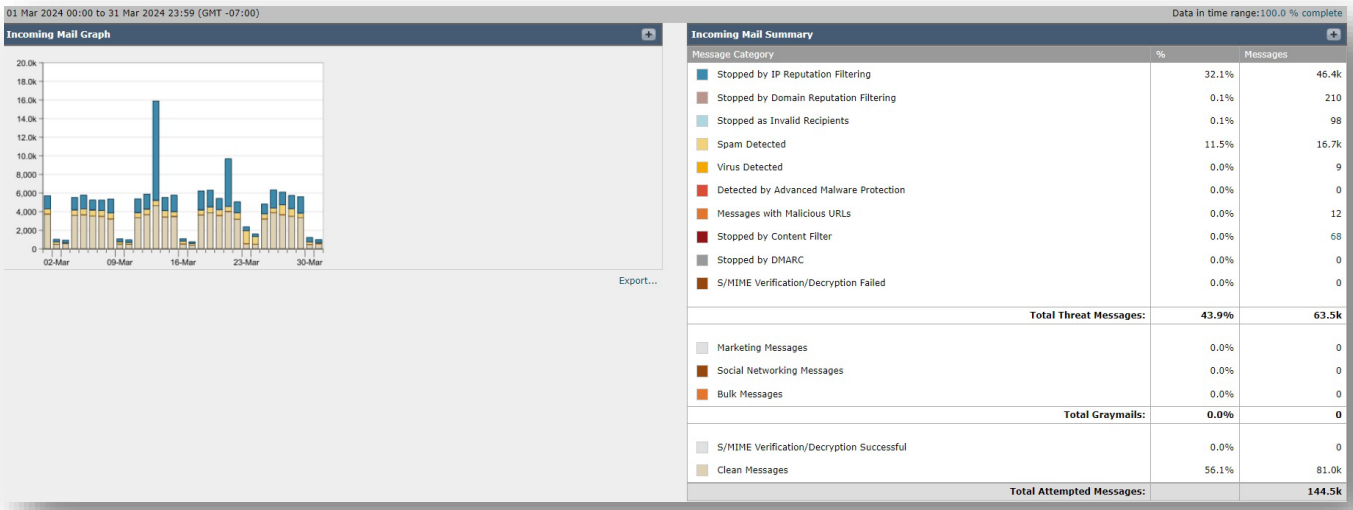
Message Processing	%	Messages
Spam Detected	0.3%	200
Virus Detected	0.0%	0
Detected by Advanced Malware Protection	0.0%	0
Messages with Malicious URLs	0.0%	4
Stopped by Content Filter	0.0%	1
Stopped by DLP	0.0%	0
Clean Messages	99.7%	58.6k
Total Messages Processed:		**58.8k**

Message Delivery	%	Messages
Hard Bounces	37.1%	22.6k
Delivered	62.9%	38.3k
Total Messages Delivered:		**60.9k**

March 2024

MX9

Inbound Mail



01 Mar 2024 00:00 to 31 Mar 2024 23:59 (GMT -07:00) — Data in time range: 100.0 % complete

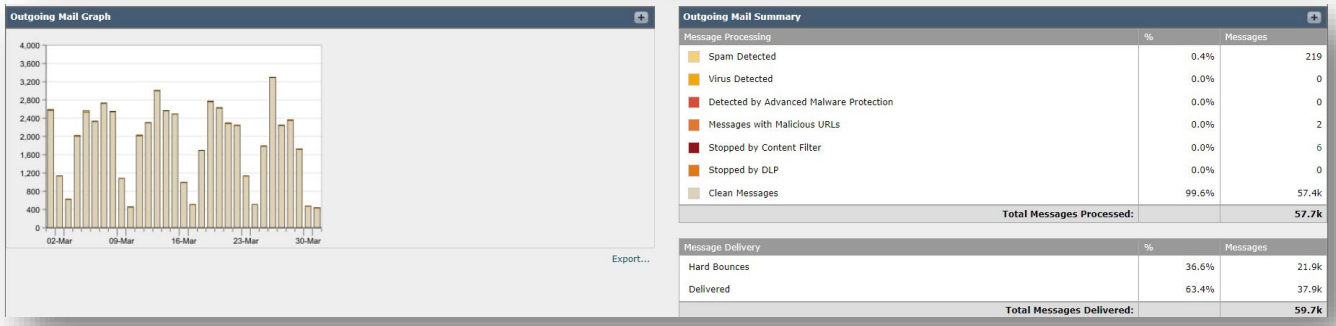
Incoming Mail Graph

Export...

Incoming Mail Summary

Message Category	%	Messages
Stopped by IP Reputation Filtering	32.1%	46.4k
Stopped by Domain Reputation Filtering	0.1%	210
Stopped as Invalid Recipients	0.1%	98
Spam Detected	11.5%	16.7k
Virus Detected	0.0%	9
Detected by Advanced Malware Protection	0.0%	0
Messages with Malicious URLs	0.0%	12
Stopped by Content Filter	0.0%	68
Stopped by DMARC	0.0%	0
S/MIME Verification/Decryption Failed	0.0%	0
Total Threat Messages:	**43.9%**	**63.5k**
Marketing Messages	0.0%	0
Social Networking Messages	0.0%	0
Bulk Messages	0.0%	0
Total Graymails:	**0.0%**	**0**
S/MIME Verification/Decryption Successful	0.0%	0
Clean Messages	56.1%	81.0k
Total Attempted Messages:		**144.5k**

Outbound Mail



Outgoing Mail Graph

Export...

Outgoing Mail Summary

Message Processing	%	Messages
Spam Detected	0.4%	219
Virus Detected	0.0%	0
Detected by Advanced Malware Protection	0.0%	0
Messages with Malicious URLs	0.0%	2
Stopped by Content Filter	0.0%	6
Stopped by DLP	0.0%	0
Clean Messages	99.6%	57.4k
Total Messages Processed:		**57.7k**

Message Delivery	%	Messages
Hard Bounces	36.6%	21.9k
Delivered	63.4%	37.9k
Total Messages Delivered:		**59.7k**

Item / Date	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	*Sep-23*	Oct-23	Nov-23	Dec-23	Jan-24	*Feb-24*	***Mar-24***
Stopped By Reputation	60.9k	31.7k	33.2k	27.1k	30.4k	59.1k	*99.7k*	74k	74.1k	58k	91.9k	51k	***84.7k***
Invalid Recipients	75	97	113	92	82	79	*98*	86	88	73	81	87	***185***
Spam Detected	15.4k	14.5k	13.7k	14.1k	12.5k	27.9k	*33.1*	28.7k	25.8k	20.6k	26.9k	22.6k	***27.6k***
Virus Detected	0	2	9	1	5	3	*22*	10	29	6	11	9	***12***
Advanced Malware	0	0	3	1	0	1	*55*	37	78	24	29	8	***4***
Malicious URLs	27	6	478	233	170	6	*50*	97	11	57	57	43	***33***
Content Filter	40	115	127	162	56	39	*110*	114	333	66	108	376	***116***
Marketing Messages	15.5k	15.5k	18.5k	16.1k	15.7k	16.2k	*8.4k*	9.5k	8.9k	8.1k	9.4k	10.1k	***10.1k***
Attempted Admin Privilege Gain	115	170	4	50	173	51	*250*	6	0	1	7	4	***48***
Attempted User Privilege Gain	87	428	42	66	162	47	*329*	146	48	48	69	330	***526***
Attempted Information Leak	12.5k	24.4k	5	1	18	53	*118*	71	51	50	65	51	***72***
Potential Corp Policy Violation	0	0	4	2	0	0	*0*	0	0	0	0	3	***4***
Network Scans Detected	0	0	0	0	0	0	*0*	0	0	0	0	0	***0***
Web Application Attack	2	2	7	1	8	0	*15*	7	4	4	1	0	***0***
Attempted Denial of Service	2.9k	109	0	0	1	0	*4*	0	0	0	0	0	***0***
Misc. Attack	2	521	2	3	1,862	151	*2,901*	1,023	347	2,146	1	424	***332***

- All security activity data is based on the current month's metrics as a percentage. This is compared to the previous three month's average, except as noted.
- Email based metrics currently monitored have remained with a return to a reputation-based block for a total of 84.7k.
- Attempted information leaks detected and blocked at the firewall is at 72 for the month of **March 2024.**
- Network scans returned a value of 0, which is in line with previous month's data.
- Attempted User Privilege Gain increased at 526 from a previous six-month average of 194.5.

ALAMEDA Alliance FOR HEALTH

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

Analytics

Tiffany Cheang

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

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

Date: **April 12th, 2024**

Subject: **Performance & Analytics Report**

Member Cost Analysis

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

- Current reporting period: Jan 2023 – Dec 2023 dates of service
- Prior reporting period: Jan 2022 – Dec 2022 dates of service
- (Note: Data excludes Kaiser membership data.)

- For the Current reporting period, the top 9.8% of members account for 88.8% of total costs.

- In comparison, the Prior reporting period was slightly lower at 9.6% of members accounting for 83.6% of total costs.

- Characteristics of the top utilizing population remained fairly consistent between the reporting periods:

    - The SPD (non duals) and ACA OE categories of aid decreased to account for 55.8% of the members, with SPDs accounting for 23.6% and ACA OE's at 32.2%.
    - The percent of members with costs >= $30K increased from 2.2% to 2.7%.
    - Of those members with costs >= $100K, the percentage of total members has slightly increased to 0.7%.
        - For these members, non-trauma/pregnancy inpatient costs continue to comprise the majority of costs, decreasing to 35.6%.
    - Demographics for member city and gender for members with costs >= $30K follow the same distribution as the overall Alliance population.
    - However, the age distribution of the top 9.8% is more concentrated in the 45-66 year old category (38.2%) compared to the overall population (20.8%).

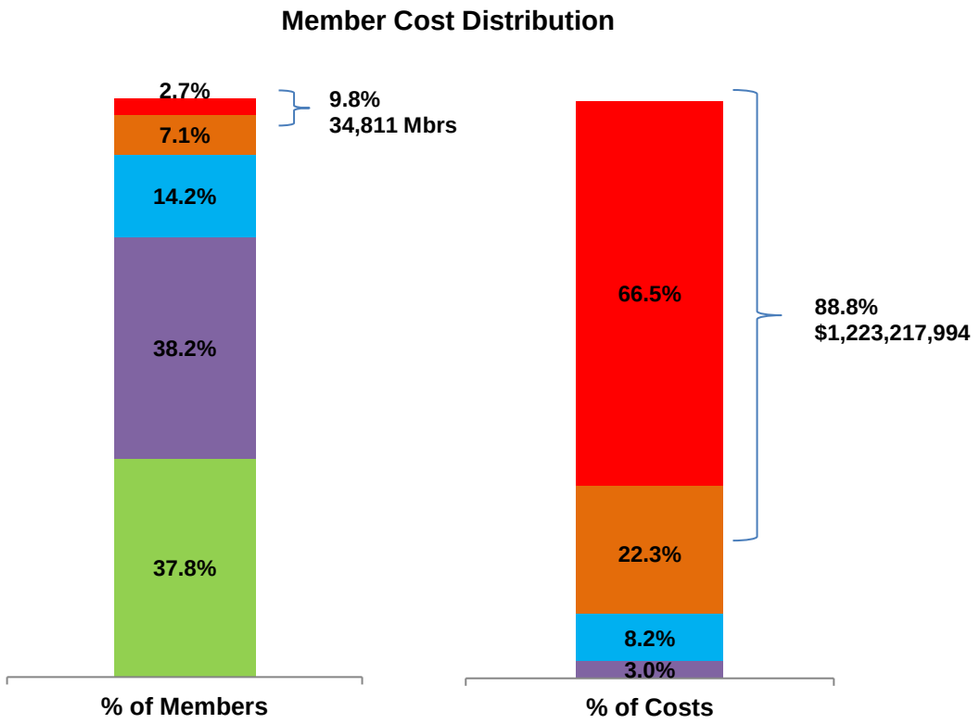
Analytics

Supporting Documents

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

Note: Data incomplete due to claims lag

Run Date: 03/28/2024



Cost Range	Members	% of Members	Costs	% of Costs
$30K+	9,634	2.7%	$ 916,193,611	66.5%
$5K - $30K	25,177	7.1%	$ 307,024,382	22.3%
$1K - $5K	50,518	14.2%	$ 112,881,104	8.2%
< $1K	136,144	38.2%	$ 40,802,905	3.0%
$0	134,503	37.8%	$ -	0.0%
Totals	**355,976**	**100.0%**	**$ 1,376,902,003**	**100.0%**

Top 9.8% of Members = 88.8% of Costs

Cost Range	Members	% of Total Members	Costs	% of Total Costs
$100K+	2,542	0.7%	$ 525,467,756	38.2%
$75K to $100K	1,502	0.4%	$ 130,463,218	9.5%
$50K to $75K	1,991	0.6%	$ 121,777,341	8.8%
$40K to $50K	1,406	0.4%	$ 62,611,621	4.5%
$30K to $40K	2,193	0.6%	$ 75,873,675	5.5%
SubTotal	***9,634***	***2.7%***	***$ 916,193,611***	***66.5%***
$20K to $30K	3,558	1.0%	$ 86,870,714	6.3%
$10K to $20K	9,555	2.7%	$ 134,057,549	9.7%
$5K to $10K	12,064	3.4%	$ 86,096,119	6.3%
SubTotal	***25,177***	***7.1%***	***$ 307,024,382***	***22.3%***
Total	**34,811**	***9.8%***	**$ 1,223,217,994**	***88.8%***

Enrollment Status	Members	Total Costs
Still Enrolled as of Dec 2023	302,734	$ 1,234,516,608
Dis-Enrolled During Year	53,242	$ 142,385,395
Totals	**355,976**	**$ 1,376,902,003**

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
9.8% of Members = 88.8% of Costs
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Jan 2023 - Dec 2023
Note: Data incomplete due to claims lag
Run Date: 03/28/2024

9.8% of Members = 88.8% of Costs
23.6% of members are SPDs and account for 28.2% of costs.
32.2% of members are ACA OE and account for 31.4% of costs.
9.0% of members disenrolled as of Dec 2023 and account for 10.6% of costs.

Highest Cost Members; Cost Per Member >= $100K
31.0% of members are SPDs and account for 31.6% of costs.
28.6% of members are ACA OE and account for 33.3% of costs.
10.2% of members disenrolled as of Dec 2023 and account for 11.2% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Members	% of Members
IHSS	IHSS	147	614	761	2.2%
MCAL	MCAL - ADULT	851	4,497	5,348	15.4%
	MCAL - BCCTP	-	-	-	0.0%
	MCAL - CHILD	370	1,931	2,301	6.6%
	MCAL - ACA OE	2,769	8,429	11,198	32.2%
	MCAL - SPD	2,873	5,339	8,212	23.6%
	MCAL - DUALS	668	2,239	2,907	8.4%
	MCAL - LTC	111	6	117	0.3%
	MCAL - LTC-DUAL	770	68	838	2.4%
Not Eligible	Not Eligible	1,075	2,054	3,129	9.0%
Total		**9,634**	**25,177**	**34,811**	**100.0%**

Member Breakout by LOB

LOB	Eligibility Category	Total Members	% of Members
IHSS	IHSS	32	1.3%
MCAL	MCAL - ADULT	182	7.2%
	MCAL - BCCTP	-	0.0%
	MCAL - CHILD	38	1.5%
	MCAL - ACA OE	726	28.6%
	MCAL - SPD	787	31.0%
	MCAL - DUALS	187	7.4%
	MCAL - LTC	82	3.2%
	MCAL - LTC-DUAL	248	9.8%
Not Eligible	Not Eligible	260	10.2%
Total		**2,542**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Costs	% of Costs
IHSS	IHSS	$ 11,250,050	$ 7,072,340	$ 18,322,390	1.5%
MCAL	MCAL - ADULT	$ 75,986,833	$ 52,070,151	$ 128,056,983	10.5%
	MCAL - BCCTP	$ -	$ -	$ -	0.0%
	MCAL - CHILD	$ 25,388,743	$ 22,332,365	$ 47,721,109	3.9%
	MCAL - ACA OE	$ 281,139,678	$ 103,039,327	$ 384,179,005	31.4%
	MCAL - SPD	$ 276,112,236	$ 69,096,927	$ 345,209,162	28.2%
	MCAL - DUALS	$ 55,397,419	$ 26,497,129	$ 81,894,548	6.7%
	MCAL - LTC	$ 15,337,106	$ 88,958	$ 15,426,065	1.3%
	MCAL - LTC-DUAL	$ 70,948,539	$ 1,238,144	$ 72,186,683	5.9%
Not Eligible	Not Eligible	$ 104,633,008	$ 25,589,042	$ 130,222,050	10.6%
Total		**$ 916,193,611**	**$ 307,024,382**	**$ 1,223,217,994**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Total Costs	% of Costs
IHSS	IHSS	$ 5,180,839	1.0%
MCAL	MCAL - ADULT	$ 42,372,849	8.1%
	MCAL - BCCTP	$ -	0.0%
	MCAL - CHILD	$ 9,690,129	1.8%
	MCAL - ACA OE	$ 174,769,430	33.3%
	MCAL - SPD	$ 165,987,243	31.6%
	MCAL - DUALS	$ 25,089,606	4.8%
	MCAL - LTC	$ 13,118,391	2.5%
	MCAL - LTC-DUAL	$ 30,285,482	5.8%
Not Eligible	Not Eligible	$ 58,973,786	11.2%
Total		**$ 525,467,756**	**100.0%**

% of Total Costs By Service Type

Cost Range	Trauma Costs	Hep C Rx Costs	Pregnancy, Childbirth & Newborn Related Costs
$100K+	8%	0%	1%
$75K to $100K	3%	0%	0%
$50K to $75K	4%	0%	2%
$40K to $50K	5%	0%	2%
$30K to $40K	10%	0%	2%
$20K to $30K	3%	1%	4%
$10K to $20K	0%	0%	9%
$5K to $10K	0%	0%	13%
Total	**5%**	**0%**	**2%**

Breakout by Service Type/Location

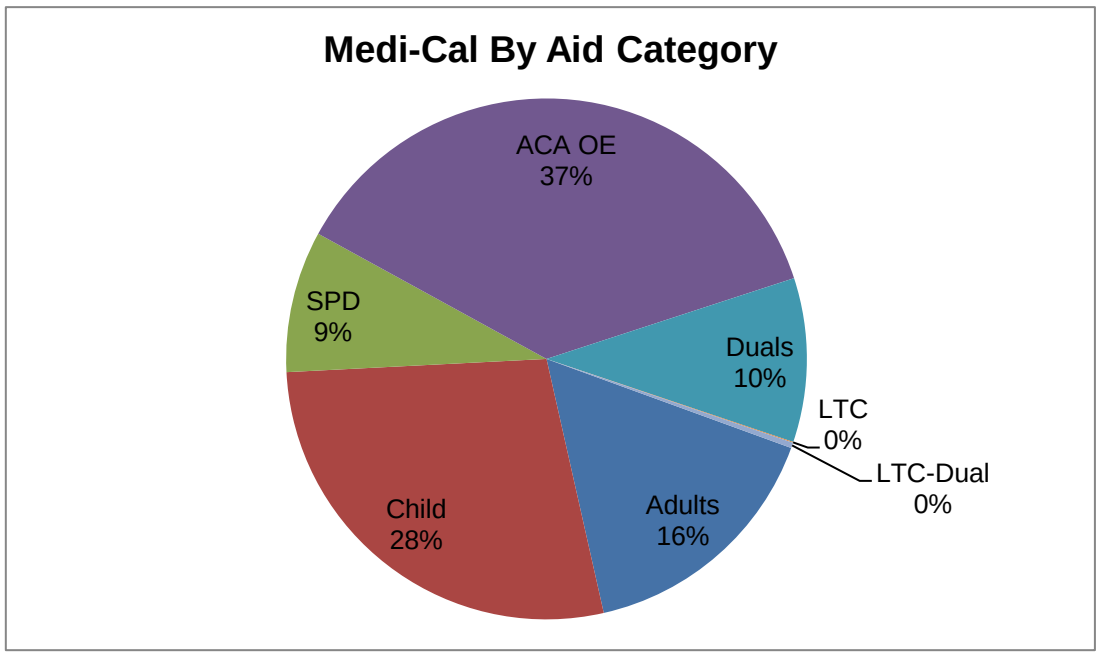
Pharmacy Costs	Inpatient Costs (POS 21)	ER Costs (POS 23)	Outpatient Costs (POS 22)	Office Costs (POS 11)	Dialysis Costs (POS 65)	Other Costs (All Other POS)
0%	44%	1%	12%	4%	1%	22%
0%	21%	2%	5%	2%	4%	50%
0%	29%	3%	6%	5%	5%	30%
1%	30%	5%	5%	6%	2%	21%
0%	25%	12%	6%	6%	1%	19%
0%	23%	6%	7%	6%	1%	18%
1%	25%	5%	9%	7%	3%	14%
1%	23%	7%	10%	10%	1%	16%
0%	**34%**	**3%**	**9%**	**5%**	**2%**	**24%**

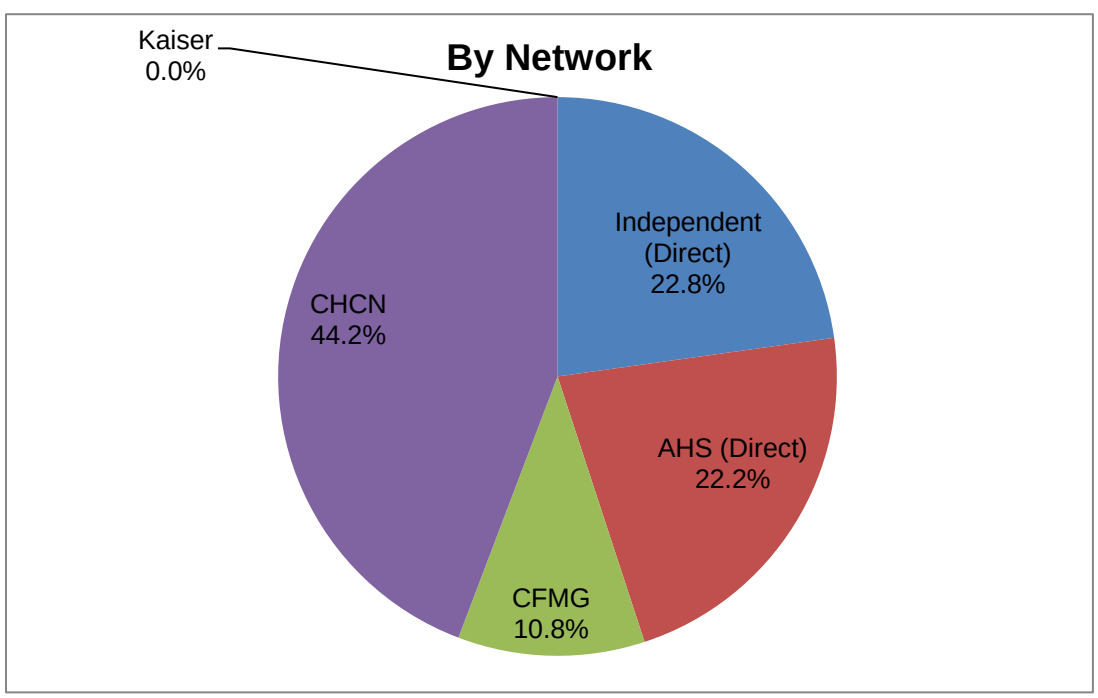
Notes:
- Report includes medical costs (HS & Diamond Claims, Beacon, Logisticare FFS, CHCN FFS Preventive Services, CHME) and pharmacy costs. IBNP factors are not applied.
- CFMG and CHCN encounter data has been priced out.
- Report excludes Capitation Expense

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend

Category of Aid	Feb 2024	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Adults	63,130	16%	13,332	14,231	41	35,526	-
Child	109,957	28%	9,476	13,358	40,340	46,783	-
SPD	34,876	9%	11,866	5,333	1,451	16,226	-
ACA OE	146,758	37%	24,345	53,154	1,695	67,564	-
Duals	40,403	10%	28,972	2,224	1	9,206	-
LTC	217	0%	200	8	-	9	-
LTC-Dual	1,329	0%	1,328	1	-	-	-
Medi-Cal	396,670		89,519	88,309	43,528	175,314	-
Group Care	5,608		2,152	860	-	2,596	-
Total	**402,278**	**100%**	**91,671**	**89,169**	**43,528**	**177,910**	**-**
Medi-Cal %	98.6%		97.7%	99.0%	100.0%	98.5%	0%
Group Care %	1.4%		2.3%	1.0%	0.0%	1.5%	0.0%
	Network Distribution		*22.8%*	*22.2%*	*10.8%*	*44.2%*	*0.0%*
			% Direct:	**45%**		**% Delegated:**	**55%**

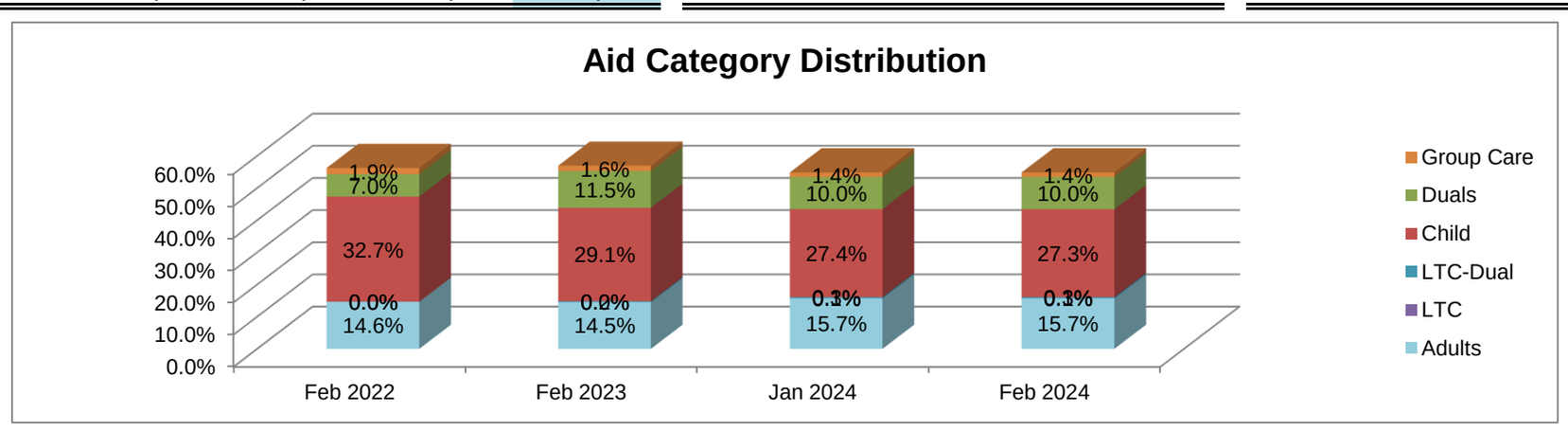




Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

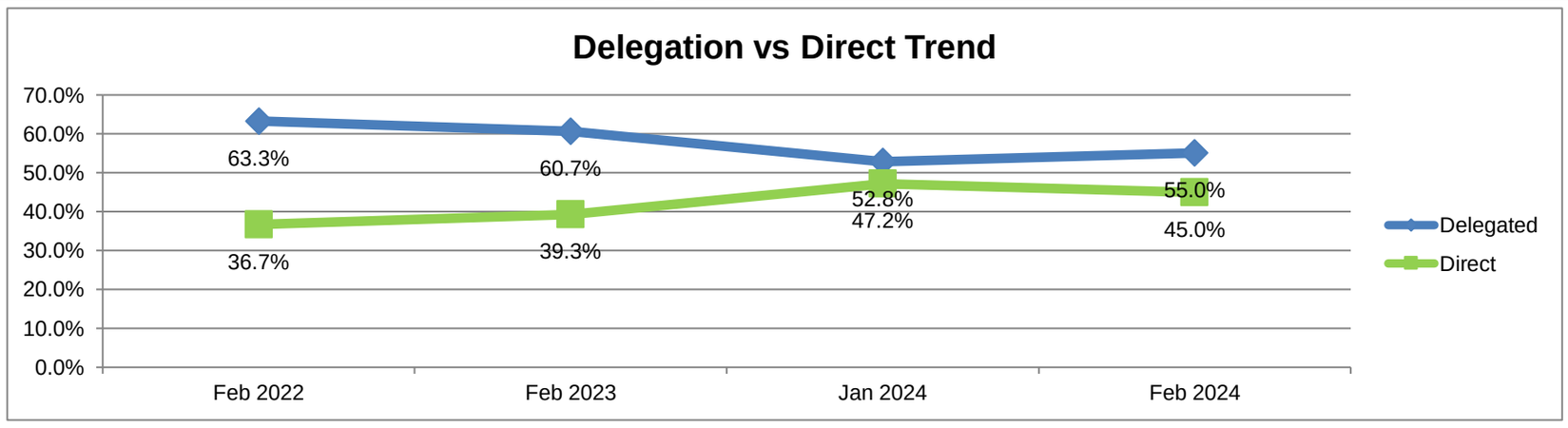
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Feb 2022	Feb 2023	Jan 2024	Feb 2024	Feb 2022	Feb 2023	Jan 2024	Feb 2024	Feb 2022 to Feb 2023	Feb 2023 to Feb 2024	Jan 2024 to Feb 2024
Adults	44,588	51,154	62,870	63,130	14.6%	14.5%	15.7%	15.7%	14.7%	23.4%	0.4%
Child	99,573	102,305	109,562	109,957	32.7%	29.1%	27.4%	27.3%	2.7%	7.5%	0.4%
SPD	26,675	30,922	35,013	34,876	8.8%	8.8%	8.7%	8.7%	15.9%	12.8%	-0.4%
ACA OE	106,553	120,657	145,842	146,758	35.0%	34.3%	36.4%	36.5%	13.2%	21.6%	0.6%
Duals	21,239	40,334	40,118	40,403	7.0%	11.5%	10.0%	10.0%	89.9%	0.2%	0.7%
LTC	-	129	219	217	0.0%	0.0%	0.1%	0.1%	0.0%	68.2%	-0.9%
LTC-Dual	-	849	1,311	1,329	0.0%	0.2%	0.3%	0.3%	0.0%	56.5%	1.4%
Medi-Cal Total	298,628	346,350	394,935	396,670	98.1%	98.4%	98.6%	98.6%	16.0%	14.5%	0.4%
Group Care	5,824	5,746	5,603	5,608	1.9%	1.6%	1.4%	1.4%	-1.3%	-2.4%	0.1%
Total	**304,452**	**352,096**	**400,538**	**402,278**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**15.6%**	**14.3%**	**0.4%**



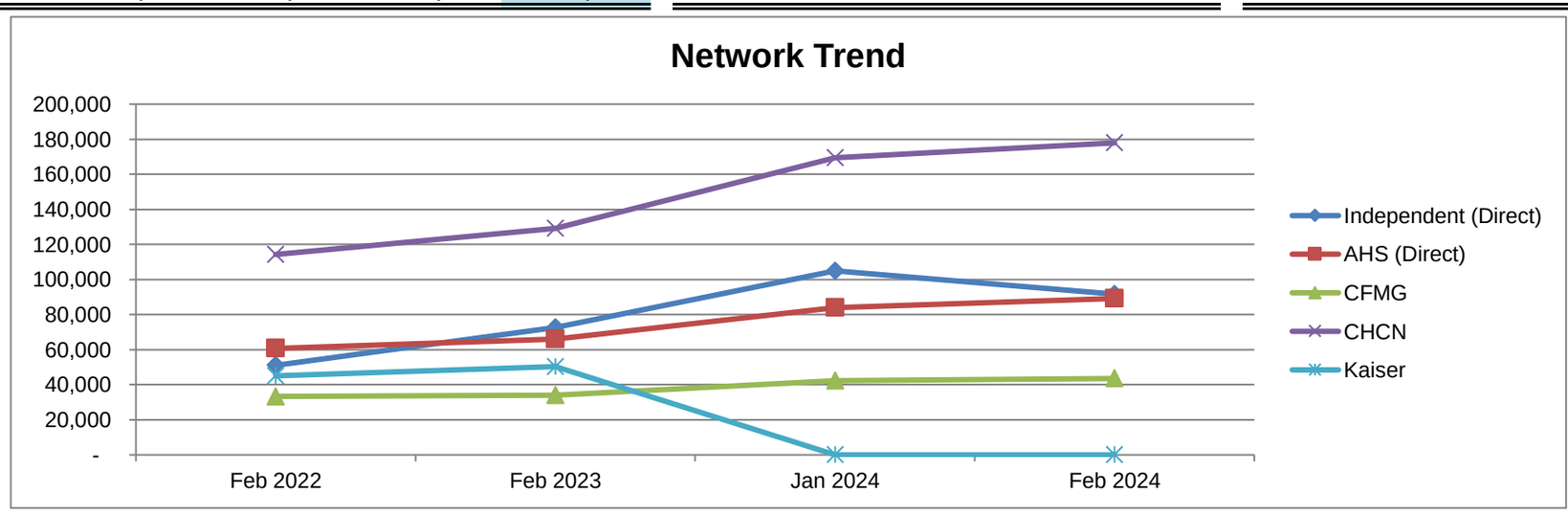
Delegation vs Direct Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	Feb 2022	Feb 2023	Jan 2024	Feb 2024	Feb 2022	Feb 2023	Jan 2024	Feb 2024	Feb 2022 to Feb 2023	Feb 2023 to Feb 2024	Jan 2024 to Feb 2024
Delegated	192,700	213,591	211,633	221,438	63.3%	60.7%	52.8%	55.0%	10.8%	3.7%	4.6%
Direct	111,752	138,505	188,905	180,840	36.7%	39.3%	47.2%	45.0%	23.9%	30.6%	-4.3%
Total	**304,452**	**352,096**	**400,538**	**402,278**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**15.6%**	**14.3%**	**0.4%**



Network Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Feb 2022	Feb 2023	Jan 2024	Feb 2024	Feb 2022	Feb 2023	Jan 2024	Feb 2024	Feb 2022 to Feb 2023	Feb 2023 to Feb 2024	Jan 2024 to Feb 2024
Independent (Direct)	51,053	72,607	104,923	91,671	16.8%	20.6%	26.2%	22.8%	42.2%	26.3%	-12.6%
AHS (Direct)	60,699	65,898	83,982	89,169	19.9%	18.7%	21.0%	22.2%	8.6%	35.3%	6.2%
CFMG	33,319	33,983	42,149	43,528	10.9%	9.7%	10.5%	10.8%	2.0%	28.1%	3.3%
CHCN	114,264	129,269	169,484	177,910	37.5%	36.7%	42.3%	44.2%	13.1%	37.6%	5.0%
Kaiser	45,117	50,339	-	-	14.8%	14.3%	0.0%	0.0%	11.6%	-100.0%	0.0%
Total	**304,452**	**352,096**	**400,538**	**402,278**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**15.6%**	**14.3%**	**0.4%**



ALAMEDA Alliance FOR HEALTH

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

Human Resources

Anastacia Swift

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

From: **Anastacia Swift, Chief Human Resources Officer**

Date: **April 12th, 2024**

Subject: **Human Resources Report**

Staffing

- As of April 1st, 2024, the Alliance had 575 full time employees and 1-part time employee.

- On April 1st, 2024, the Alliance had 78 open positions in which 23 signed offer acceptance letters have been received with start dates in the near future resulting in a total of 55 positions open to date. The Alliance is actively recruiting for the remaining 55 positions and several of these positions are in the interviewing or job offer stage.

- Summary of open positions by department:

Department	Open Position April 1st	Signed Offers Accepted by Department	Remaining Recruitment Positions
Healthcare Services	18	10	8
Operations	39	8	31
Healthcare Analytics	2	1	1
Information Technology	9	1	8
Finance	2	1	1
Compliance & Legal	4	0	4
Human Resources	3	2	1
Health Equity	1	0	1
Executive	0	0	0
Total	78	23	55

- Our current recruitment rate is 12%.

Employee Recognition

- Employees reaching major milestones in their length of service at the Alliance in March 2024 included:

- 5 years:
  - Susan Baca (Case/ Disease Mgmt)
  - Tatyana Novokovsky (Utilization Management)
  - Catherine Sequeira (Case/ Disease Mgmt)
  - Gurjit Singh (Apps Management, IT Quality & Process Improvement)
  - Timothy Tong (Pharmacy Services)
  - Stephen Williams (Utilization Management)
- 6 years:
  - Simin Li (Finance)
  - Carlos Lopez (Member Services)
  - Jayme Miles (Claims)
  - Anthony Pascua (IT Infrastructure)
  - Homaira Yusufi (Utilization Management)
- 7 years:
  - Angelica Glasco Olivares (HCS Behavioral Health)
  - Sivilay Sisombat (Provider Services)
- 8 years:
  - Darryl Crowder (Provider Services)
  - Jamisha Jefferson (Quality Management)
  - Sylvia Marquez (Member Services)
- 9 years:
  - Shiuwen Fu (IT Development)
  - Edward Fugaban (IT Development)
  - Daniel Primus (IT Development)
- 10 years:
  - Lisa Calvo (Utilization Management)
- 12 years:
  - Jeffrey McKenzie (IT Development)
- 19 years:
  - Crista Tran (Apps Management, IT Quality & Process Improvement)
- 23 years:
  - Anet Quiambao (Claims)
- 28 years:
  - Donna Ceccanti (Credentialing)

ALAMEDA Alliance FOR HEALTH

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

Legislative Tracking

2024 Legislative Tracking List

The 2024 California State Legislative Session returned to Sacramento at the beginning of April after taking a week off for their Spring recess. Lawmakers continue to discuss hundreds of bills at policy committee hearings, and they have until April 26th to hear bills with fiscal impacts. The following is a list of state bills tracked by the Public Affairs and Compliance Departments. These bills are of interest to and could have a direct impact on Alameda Alliance for Health and its membership.

AB 4 **(Arambula D) Covered California: expansion.**

Current Text: Amended: 7/13/2023 html pdf

Status: 9/1/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. on 7/13/2023)(May be acted upon Jan 2024)

Location: 9/1/2023-S. 2 YEAR

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

Summary: Current federal law, the Patient Protection and Affordable Care Act (PPACA), requires each state to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. Current state law creates the California Health Benefit Exchange, also known as Covered California, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA. Current law requires the Exchange to apply for a federal waiver to allow persons otherwise not able to obtain coverage through the Exchange because of their immigration status to obtain coverage from the Exchange. This bill would delete that requirement and would instead require the Exchange 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 given existing federal law and rules.

AB 47 **(Boerner D) Pelvic floor physical therapy coverage.**

Current Text: Introduced: 12/5/2022 html pdf

Status: 2/1/2024-From committee: Filed with the Chief Clerk pursuant to Joint Rule 56.

Location: 1/12/2024-A. DEAD

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

Summary: Would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2024, to provide coverage for pelvic floor physical therapy after pregnancy. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

AB 55 **(Rodriguez D) Medi-Cal: workforce adjustment for ground ambulance transports.**

Current Text: Amended: 4/27/2023 html pdf

Status: 2/1/2024-From committee: Filed with the Chief Clerk pursuant to Joint Rule 56.

Location: 1/18/2024-A. DEAD

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

Summary: Current law requires, with exceptions, that Medi-Cal reimbursement to providers of emergency medical transports be increased by application of an add-on to the associated Medi-Cal fee-for-service payment schedule. Under

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

AB 236 **(Holden D) Health care coverage: provider directories.**

Current Text: Amended: 1/22/2024 html pdf

Status: 1/30/2024-Read third time. Passed. Ordered to the Senate. (Ayes 59. Noes 9.) In Senate. Read first time. To Com. on RLS. for assignment.

Location: 1/30/2024-S. RLS.

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

Summary: Current law provides for the regulation of health insurers by the Department of Insurance. Current law requires a health care service plan and a health insurer that contracts with providers for alternative rates of payment to publish and maintain a provider directory or directories with information on contracting providers that deliver health care services enrollees or insureds, and requires a health care service plan and health insurer to regularly update its printed and online provider directory or directories, as specified. Current law authorizes the departments to require a plan or insurer to provide coverage for all covered health care services provided to an enrollee or insured who reasonably relied on materially inaccurate, incomplete, or misleading information contained in a health plan's provider directory or directories. This bill would require a plan or insurer to annually verify and delete inaccurate listings from its provider directories, and would require a provider directory to be 60% accurate on July 1, 2025, with increasing required percentage accuracy benchmarks to be met each year until the directories are 95% accurate on or before July 1, 2028. The bill would subject a plan or insurer to administrative penalties for failure to meet the prescribed benchmarks. If a plan or insurer has not financially compensated a provider in the prior year, the bill would require the plan or insurer to delete the provider from its directory beginning July 1, 2025, unless specified criteria applies. The bill would require a plan or insurer to arrange care and provide coverage for all covered health care services provided to an enrollee or insured who reasonably relied on inaccurate, incomplete, or misleading information contained in a health plan or policy's provider directory or directories and to reimburse the provider the contracted amount for those services.

AB 365 **(Aguiar-Curry D) Medi-Cal: diabetes management.**

Current Text: Amended: 9/8/2023 html pdf

Status: 9/14/2023-Failed Deadline pursuant to Rule 61(a)(14). (Last location was INACTIVE FILE on 9/12/2023)(May be acted upon Jan 2024)

Location: 9/14/2023-S. 2 YEAR

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

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

AB 412 **(Soria D) Distressed Hospital Loan Program.**

Current Text: Amended: 4/24/2023 html pdf
Status: 6/14/2023-Referred to Com. on HEALTH.
Location: 6/14/2023-S. HEALTH

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

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

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

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

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

AB 564 **(Villapudua D) Medi-Cal: claim or remittance forms: signature.**
Current Text: Amended: 4/5/2023 html pdf
Status: 7/14/2023-Failed Deadline pursuant to Rule 61(a)(10). (Last location was HEALTH on 6/14/2023)(May be acted upon Jan 2024)
Location: 7/14/2023-S. 2 YEAR

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

Summary: Current law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. Current law requires the Director of Health Care Services to develop and implement standards for the timely processing and payment of each claim type. Current law requires that the standards be sufficient to meet minimal federal requirements for the timely processing of claims. Current law states the intent of the Legislature that claim forms for use by physicians and hospitals be the same as claim forms in general use by other payors, as specified. This bill would require the department to allow a

provider to submit an electronic signature for a claim or remittance form under the Medi-Cal program, to the extent not in conflict with federal law.

AB 586 **(Calderon D) Medi-Cal: community supports: climate change or environmental remediation devices.**

Current Text: Amended: 3/30/2023 html pdf

Status: 2/1/2024-From committee: Filed with the Chief Clerk pursuant to Joint Rule 56.

Location: 1/18/2024-A. DEAD

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

Summary: Current law, subject to implementation of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, authorizes a Medi-Cal managed care plan to elect to cover community supports approved by the department as cost effective and medically appropriate in a comprehensive risk contract that are in lieu of applicable Medi-Cal state plan services. Under existing law, community supports that the State Department of Health Care Services is authorized to approve include, among other things, housing deposits, environmental accessibility adaptations or home modifications, and asthma remediation. This bill would add climate change or environmental remediation devices to the above-described list of community supports. For purposes of these provisions, the bill would define "climate change or environmental remediation devices" as coverage of devices and installation of those devices, as necessary, to address health-related complications, barriers, or other factors linked to extreme weather, poor air quality, or climate events, including air conditioners, electric heaters, air filters, or backup power sources, among other specified devices for certain purposes.

AB 815 **(Wood D) Health care coverage: provider credentials.**

Current Text: Amended: 4/20/2023 html pdf

Status: 7/14/2023-Failed Deadline pursuant to Rule 61(a)(10). (Last location was HEALTH on 6/7/2023)(May be acted upon Jan 2024)

Location: 7/14/2023-S. 2 YEAR

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

Summary: Would require the California Health and Human Services Agency to create and maintain a provider credentialing board, with specified membership, to certify private and public entities for purposes of credentialing physicians and surgeons in lieu of a health care service plan's or health insurer's credentialing process. The bill would require the board to convene by July 1, 2024, develop criteria for the certification of public and private credentialing entities by January 1, 2025, and develop an application process for certification by July 1, 2025.

AB 1022 **(Mathis R) Medi-Cal: Program of All-Inclusive Care for the Elderly.**

Current Text: Introduced: 2/15/2023 html pdf

Status: 2/1/2024-From committee: Filed with the Chief Clerk pursuant to Joint Rule 56.

Location: 1/12/2024-A. DEAD

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

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

for eligibility for enrollment in the PACE program. This bill, among other things relating to the PACE program, would require those capitation rates to also reflect the frailty level and risk associated with those populations. The bill would also expand an approved PACE organization's authority to use video telehealth to conduct all assessments, as specified.

AB 1091 **(Wood D) Health Care Consolidation and Contracting Fairness Act of 2023.**

Current Text: Introduced: 2/15/2023 html pdf

Status: 2/1/2024-From committee: Filed with the Chief Clerk pursuant to Joint Rule 56.

Location: 1/12/2024-A. DEAD

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

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

AB 1092 **(Wood D) Health care service plans: consolidation.**

Current Text: Amended: 6/28/2023 html pdf

Status: 9/1/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/14/2023)(May be acted upon Jan 2024)

Location: 9/1/2023-S. 2 YEAR

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

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

AB 1110 **(Arambula D) Public health: adverse childhood experiences.**

Current Text: Amended: 7/10/2023 html pdf

Status: 9/1/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/14/2023)(May be acted upon Jan 2024)

Location: 9/1/2023-S. 2 YEAR

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

Summary: Would, subject to an appropriation and until January 1, 2027, require the office and the State Department of Health Care Services, while administering the ACEs Aware initiative and in collaboration with subject matter experts, to

review available literature on ACEs, as defined, and ancestry or ethnicity-based data disaggregation practices in ACEs screenings, develop guidance for culturally and linguistically competent ACEs screenings through improved data collection methods, post the guidance on the department's internet website and the ACEs Aware internet website, and make the guidance accessible, as specified.

AB 1157 **(Ortega D) Rehabilitative and habilitative services: durable medical equipment and services.**

Current Text: Amended: 7/13/2023 html pdf

Status: 9/1/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/14/2023)(May be acted upon Jan 2024)

Location: 9/1/2023-S. 2 YEAR

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

Summary: Current law requires an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2017, to include, at a minimum, coverage for essential health benefits pursuant to the federal Patient Protection and Affordable Care Act. Under existing law, essential health benefits includes, among other things, rehabilitative and habilitative services. Current law requires habilitative services and devices to be covered under the same terms and conditions applied to rehabilitative services and devices under the plan contract or policy, and defines habilitative services to mean health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. This bill would specify that coverage of rehabilitative and habilitative services and devices under a health care service plan or health insurance policy includes durable medical equipment, services, and repairs, if the equipment, services, or repairs are prescribed or ordered by a physician, surgeon, or other health professional acting within the scope of their license. The bill would define "durable medical equipment" to mean devices, including replacement devices, that are designed for repeated use, and that are used for the treatment or monitoring of a medical condition or injury in order to help a person to partially or fully acquire, improve, keep, or learn, or minimize the loss of, skills and functioning of daily living. The bill would prohibit coverage of durable medical equipment and services from being subject to financial or treatment limitations, as specified.

AB 1282 **(Lowenthal D) Mental health: impacts of social media.**

Current Text: Amended: 9/1/2023 html pdf

Status: 9/14/2023-Failed Deadline pursuant to Rule 61(a)(14). (Last location was INACTIVE FILE on 9/11/2023)(May be acted upon Jan 2024)

Location: 9/14/2023-S. 2 YEAR

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

Summary: Would require the Mental Health Services Oversight and Accountability Commission to report to specified policy committees of the Legislature, on or before July 1, 2025, a statewide strategy to understand, communicate, and mitigate mental health risks associated with the use of social media by children and youth. The bill would require the report to include, among other things, (1) the degree to which individuals negatively impacted by social media are accessing and receiving mental health services and (2) recommendations to strengthen children and youth resiliency strategies and California's use of mental health services to reduce the negative outcomes that may result from untreated mental illness, as specified. The bill would require the commission to explore, among other things, the persons and populations that use social media and the negative mental health risks associated with social media and artificial intelligence, as defined.

AB 1313 **(Ortega D) Older individuals: case management services.**

Current Text: Amended: 4/27/2023 html pdf

Status: 9/1/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 7/3/2023)(May be acted upon Jan 2024)

Location: 9/1/2023-S. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	Policy	2	Floor	Conf.	Enrolled	Vetoed	Chaptered

						year		Conc.			
1st House				2nd House							

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

AB 1338 **(Petrie-Norris D) Medi-Cal: community supports.**

Current Text: Amended: 4/20/2023 html pdf

Status: 2/1/2024-From committee: Filed with the Chief Clerk pursuant to Joint Rule 56.

Location: 1/18/2024-A. DEAD

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

Summary: Current law, subject to implementation of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, authorizes a Medi-Cal managed care plan to elect to cover community supports approved by the department as cost effective and medically appropriate in a comprehensive risk contract that are in lieu of applicable Medi-Cal state plan services. Under current law, community supports that the department is authorized to approve include, among other things, housing transition navigation services, recuperative care, respite, day habilitation programs, and medically supportive food and nutrition services.

AB 1359 **(Schiavo D) Paid sick days: health care employees.**

Current Text: Amended: 6/26/2023 html pdf

Status: 9/14/2023-Failed Deadline pursuant to Rule 61(a)(14). (Last location was INACTIVE FILE on 9/11/2023)(May be acted upon Jan 2024)

Location: 9/14/2023-S. 2 YEAR

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

Summary: The Healthy Workplaces, Healthy Families Act of 2014 entitles employees who satisfy specified requirements to sick leave. The act generally entitles an employee who, on or after July 1, 2015, works in California for the same employer for 30 or more days within a year to paid sick leave, subject to various use and accrual limits. The act also authorizes an employer to limit an employee's use of accrued paid sick days to 24 hours or 3 days in each year of employment, calendar year, or 12-month period. This bill would grant an employee of a covered health care facility health care worker sick leave, as those terms are defined. The bill would permit accrued leave, and would prescribe for the use and carryover of that leave, including permitting health care worker sick leave to carry over to the following year of employment for those employees, subject to certain conditions. The bill would prohibit a covered health care facility from limiting an employee's use of health care worker sick leave.

AB 1450 **(Jackson D) Behavioral health: behavioral health and wellness screenings: notice.**

Current Text: Amended: 1/3/2024 html pdf

Status: 2/1/2024-From committee: Filed with the Chief Clerk pursuant to Joint Rule 56.

Location: 1/12/2024-A. DEAD

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

1st House	2nd House				

Summary: Current law requires the Medical Board of California, in determining its continuing education requirements, to consider including a course in integrating mental and physical health care in primary care settings, especially as it pertains to early identification of mental health issues and exposure to trauma in children and young adults and their appropriate care and treatment. Current law requires a physician and surgeon to provide notice to patients at an initial office visit regarding a specified database. Current law requires the State Department of Public Health to license and regulate health facilities, including general acute care hospitals. Current law requires a general acute care hospital to establish and adopt written policies and procedures to screen patients who are 12 years of age and older for purposes of detecting a risk for suicidal ideation and behavior. The Knox-Keene Health Care Service Plan Act of 1975 provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Current law provides for the regulation of health insurers by the Department of Insurance. This bill would require a physician and surgeon, a general acute care hospital, a health care service plan, and a health insurer to provide to each legal guardian of a patient, enrollee, or insured, 10 to 18 years of age, a written or electronic notice regarding the benefits of a behavioral health and wellness screening. The bill would require the providers to provide the notice at least once every 2 years in the preferred method of the legal guardian.

AB 1608 **(Patterson, Joe R) Medi-Cal: managed care plans.**

Current Text: Amended: 1/3/2024 html pdf

Status: 2/1/2024-From committee: Filed with the Chief Clerk pursuant to Joint Rule 56.

Location: 1/12/2024-A. DEAD

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

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

AB 1644 **(Bonta D) Medi-Cal: medically supportive food and nutrition services.**

Current Text: Amended: 4/27/2023 html pdf

Status: 2/1/2024-From committee: Filed with the Chief Clerk pursuant to Joint Rule 56.

Location: 1/18/2024-A. DEAD

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

Summary: Would make medically supportive food and nutrition interventions, as defined, a covered benefit under the Medi-Cal program, upon issuance of final guidance by the State Department of Health Care Services. The bill would require medically supportive food and nutrition interventions to be covered when determined to be medically necessary by a health care provider or health care plan, as specified. In order to qualify for coverage under the Medi-Cal program, the bill would require a patient to be offered at least 3 of 6 specified medically supportive food and nutrition

interventions and for the interventions to be provided for a minimum duration of 12 weeks, as specified. The bill would only provide coverage for nutrition support interventions when paired with the provision of food through one of the 3 offered interventions. The bill would require a health care provider to match the acuity of a patient's condition to the intensity and duration of the medically supportive food and nutrition intervention and include culturally appropriate foods whenever possible.

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

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

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

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

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

Summary: Current law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. This bill would make specified findings and would express the intent of the Legislature to enact future legislation relating to Medi-Cal.

AB 1783 **(Essayli R) Health care: immigration.**
Current Text: Introduced: 1/3/2024 html pdf
Status: 1/4/2024-From printer. May be heard in committee February 3.
Location: 1/3/2024-A. PRINT

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

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

AB 1842 **(Reyes D) Health care coverage: Medication-assisted treatment.**
Current Text: Introduced: 1/16/2024 html pdf
Status: 3/19/2024-From committee: Do pass and re-refer to Com. on APPR. (Ayes 13. Noes 0.) (March 19). Re-referred to Com. on APPR.
Location: 3/19/2024-A. APPR.

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

Summary: Current law authorizes health care service plans and health insurers that cover prescription drugs to utilize reasonable medical management practices, including prior authorization and step therapy, consistent with applicable law. This bill would prohibit a medical service plan and a health insurer from subjecting a naloxone product or another opioid antagonist approved by the United States Food and Drug Administration, or a buprenorphine product or long-acting injectable naltrexone for detoxification or maintenance treatment of a substance use disorder, to prior authorization or

step therapy. Because a willful violation of these provisions by a health care service plan would be a crime, this bill would impose a state-mandated local program.

AB 1895 **(Weber D) Public health: maternity ward closures.**
Current Text: Amended: 3/18/2024 html pdf
Status: 3/19/2024-Re-referred to Com. on HEALTH.
Location: 3/18/2024-A. HEALTH

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

Summary: Under current law, a general acute care hospital is required to provide certain basic services, including medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services. Current law authorizes a general acute care hospital to provide various special or supplemental services if certain conditions are met. Current regulations define a supplemental service as an organized inpatient or outpatient service that is not required to be provided by law or regulation. Current law requires a health facility to provide 90 days of public notice, with specified requirements, of the proposed closure or elimination of a supplemental service, such as maternity services. This bill would require an acute care hospital that offers maternity services, when those services are at risk of closure, as defined, in the next 12 months to provide specified information to the Department of Health Care Access and Information as well as the State Department of Public Health, including, but not limited to, the number of medical staff and employees working in the maternity ward and the hospital's prior and projected performance on financial metrics. The bill would require this information be kept confidential to the extent permitted by law. The bill would require, within 6 months of receiving this notice from the hospital, the Department of Health Care Access and Information, in conjunction with the State Department of Public Health, to conduct a community impact assessment to determine the 3 closest hospitals offering maternity services in the geographic area and their distance from the at-risk facility. The bill would require the hospital to provide public notice of the potential closure, including the results of the community impact assessment, and other specified information on the hospital's internet website 90 days in advance of the proposed closure.

AB 1926 **(Connolly D) Health care coverage: regional enteritis.**
Current Text: Amended: 3/19/2024 html pdf
Status: 4/3/2024-From committee: Do pass and re-refer to Com. on APPR. (Ayes 15. Noes 0.) (April 2). Re-referred to Com. on APPR.
Location: 4/2/2024-A. APPR.

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

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

AB 1943 **(Weber D) Medi-Cal: telehealth.**
Current Text: Amended: 4/4/2024 html pdf
Status: 4/8/2024-Re-referred to Com. on P. & C.P.
Location: 4/2/2024-A. P. & C.P.

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

Summary: Under current law, in-person, face-to-face contact is not required under the Medi-Cal program when covered

health care services are provided by video synchronous interaction, audio-only synchronous interaction, remote patient monitoring, or other permissible virtual communication modalities, when those services and settings meet certain criteria. This bill would require the department to produce a public report on telehealth in the Medi-Cal program that includes analyses of, among other things, (1) telehealth access and utilization, (2) the effect of telehealth on timeliness of, access to, and quality of care, and (3) the effect of telehealth on clinical outcomes, as specified. The bill would authorize the department, in collaboration with the California Health and Human Services Agency, to issue policy recommendations based on the report's findings.

AB 1970 **(Jackson D) Mental Health: Black Mental Health Navigator Certification.**
Current Text: Amended: 4/1/2024 html pdf
Status: 4/2/2024-Re-referred to Com. on HEALTH.
Location: 2/12/2024-A. HEALTH

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

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

AB 1975 **(Bonta D) Medi-Cal: medically supportive food and nutrition interventions.**
Current Text: Introduced: 1/30/2024 html pdf
Status: 3/15/2024-In committee: Set, first hearing. Hearing canceled at the request of author.
Location: 2/12/2024-A. HEALTH

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

Summary: Current law, subject to implementation of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, authorizes a Medi-Cal managed care plan to elect to cover community supports approved by the department as cost effective and medically appropriate in a comprehensive risk contract that are in lieu of applicable Medi-Cal state plan services. Under existing law, community supports that the State Department of Health Care Services is authorized to approve include, among other things, medically supportive food and nutrition services, including medically tailored meals. This bill would make medically supportive food and nutrition interventions, as defined, a covered benefit under the Medi-Cal program, through both the fee-for-service and managed care delivery systems, effective July 1, 2026, subject to federal approval and the issuance of final guidance by the department. The bill would require those interventions to be covered if determined to be medically necessary by a health care provider or health care plan, as specified. The bill would require the provision of interventions for 12 weeks, or longer if deemed medically necessary. The bill would require a Medi-Cal managed care plan to offer at least 3 of 6 listed interventions, with certain conditions for a 7th intervention.

AB 1977 **(Ta R) Health care coverage: behavioral diagnoses.**
Current Text: Amended: 4/1/2024 html pdf
Status: 4/2/2024-Re-referred to Com. on HEALTH.
Location: 2/12/2024-A. HEALTH

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

Summary: Would prohibit a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, from requiring an enrollee or insured previously diagnosed with pervasive developmental

disorder or autism to be reevaluated or receive a new behavioral diagnosis to maintain coverage for behavioral health treatment for their condition. 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. Th

AB 2028 **(Ortega D) Medical loss ratios.**

Current Text: Introduced: 2/1/2024 html pdf

Status: 2/12/2024-Referred to Com. on HEALTH.

Location: 2/12/2024-A. HEALTH

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

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

AB 2043 **(Boerner D) Medi-Cal: nonmedical and nonemergency medical transportation.**

Current Text: Amended: 4/1/2024 html pdf

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

Location: 2/12/2024-A. HEALTH

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

Summary: Current law covers emergency or nonemergency medical transportation, and nonmedical transportation, under the Medi-Cal program, as specified. This bill would require the State Department of Health Care Services to ensure that the fiscal burden of nonemergency medical transportation or nonmedical transportation is not unfairly placed on public paratransit service operators and would authorize the department to direct Medi-Cal managed care plans to reimburse public paratransit service operators who are enrolled as Medi-Cal providers at the fee-for-service rates for conducting that transportation, as described. The bill would require the department to engage with public paratransit service operators to understand the challenges as public operators of nonemergency medical transportation or nonmedical transportation services and would require the department to issue new guidance to ensure the fiscal burden is not unfairly placed on public operators on or before June 1, 2026.

AB 2105 **(Lowenthal D) Coverage for PANDAS and PANS.**

Current Text: Introduced: 2/5/2024 html pdf

Status: 3/25/2024-In committee: Set, first hearing. Hearing canceled at the request of author.

Location: 2/20/2024-A. HEALTH

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

Summary: Would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, to provide coverage for the prophylaxis, diagnosis, and treatment of Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS) that is prescribed or ordered by the treating physician and surgeon. The bill would prohibit coverage for PANDAS and PANS from being subject to a copayment, coinsurance, deductible, or other cost sharing that is greater than that applied to other benefits. The bill would prohibit a plan or insurer from denying or delaying coverage for PANDAS or PANS therapies because the enrollee or insured previously received treatment for PANDAS or PANS or was diagnosed with or received treatment for the condition under a different diagnostic name.

Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

AB 2110 **(Arambula D) Medi-Cal: Adverse Childhood Experiences trauma screenings: providers.**
Current Text: Introduced: 2/5/2024 html pdf
Status: 2/20/2024-Referred to Com. on HEALTH.
Location: 2/20/2024-A. HEALTH

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

Summary: Current law requires that Medi-Cal provider payments and payments for specified non-Medi-Cal programs be reduced by 10% for dates of service on and after June 1, 2011, and conditions implementation of those payment reductions on receipt of any necessary federal approvals. Current law, for dates of service on and after July 1, 2022, authorizes the maintenance of the reimbursement rates or payments for specified services, including, among others, Adverse Childhood Experiences (ACEs) trauma screenings and specified providers, using General Fund or other state funds appropriated to the State Department of Health Care Services as the state share, at the payment levels in effect on December 31, 2021, as specified, under the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 that were implemented with funds from the Healthcare Treatment Fund, as specified. Current law requires the department to develop the eligibility criteria, methodologies, and parameters for the payments and rate increases maintained, and would authorize revisions, as specified. This bill would require the department, as part of its above-described duties, to include (1)community-based organizations and local health jurisdictions that provide health services through community health workers and (2)doulas, that are enrolled Medi-Cal providers, as providers qualified to provide, and eligible to receive payments for, ACEs trauma screenings pursuant to the provisions described above. The bill would require the department to file a state plan amendment and seek any federal approvals it deems necessary to implement these provisions and condition implementation on receipt of any necessary federal approvals and the availability of federal financial participation.

AB 2115 **(Haney D) Controlled substances: clinics.**
Current Text: Amended: 4/1/2024 html pdf
Status: 4/2/2024-Re-referred to Com. on B. & P. In committee: Hearing postponed by committee.
Location: 2/26/2024-A. B.&P.

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

Summary: Under current law, specified clinics, including surgical clinics, may purchase drugs at wholesale for administration or dispensing to the clinic's patients. Current law requires these clinics to maintain certain records and to obtain a license from the board. Current law prohibits specified substances from being dispensed by a nonprofit or free clinic, as defined. This bill would authorize a nonprofit or free clinic to dispense a narcotic drug for the purpose of relieving acute withdrawal symptoms while arrangements are being made for referral for treatment, as described, and would require the clinic dispensing the narcotic to be subject to specified labeling and recordkeeping requirements. Because the bill would specify additional requirements under the Pharmacy Law, a violation of which would be a crime, it would impose a state-mandated local program.

AB 2129 **(Petrie-Norris D) Immediate postpartum contraception.**
Current Text: Introduced: 2/6/2024 html pdf
Status: 2/20/2024-Referred to Com. on HEALTH.
Location: 2/20/2024-A. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law generally regulates contractual provisions between health care service plans and health insurers and their contracting health care providers. This bill would require a contract between a health care service plan or health insurer and a health care provider issued, amended, or renewed on or after January 1, 2025, to authorize a provider to separately bill for devices, implants, or professional services, or a combination thereof, associated with immediate

postpartum contraception if the birth takes place in a licensed hospital or birthing center. The bill would prohibit that provider contract from considering those devices, implants, or services to be part of a payment for a general obstetric procedure. Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.

AB 2132 **(Low D) Health care services.**

Current Text: Amended: 2/27/2024 html pdf

Status: 3/19/2024-Coauthors revised. From committee: Do pass and re-refer to Com. on APPR. (Ayes 13. Noes 1.) (March 19). Re-referred to Com. on APPR.

Location: 3/19/2024-A. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law requires an adult patient receiving primary care services in certain health care settings to be offered a screening test for hepatitis B and hepatitis C, as specified. This bill would require an adult patient receiving primary care services in a facility, clinic, unlicensed clinic, center, office, or other setting, as specified, to be offered a tuberculosis (TB) risk assessment and TB screening test, if TB risk factors are identified, to the extent these services are covered under the patient's health insurance, unless the health care provider reasonably believes certain conditions apply. The bill would also require the health care provider to offer the patient followup health care or refer the patient to a health care provider who can provide followup health care if a screening test is positive, as specified. The bill would prohibit a health care provider who fails to comply with these provisions from being subject to any disciplinary action related to their licensure or certification, or to any civil or criminal liability for that failure.

AB 2169 **(Bauer-Kahan D) Prescription drug coverage: dose adjustments.**

Current Text: Amended: 3/21/2024 html pdf

Status: 4/1/2024-Re-referred to Com. on HEALTH.

Location: 2/20/2024-A. HEALTH

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

AB 2198 **(Flora R) Health information.**

Current Text: Introduced: 2/7/2024 html pdf

Status: 3/25/2024-In committee: Hearing postponed by committee.

Location: 2/26/2024-A. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law requires health care service plans and health insurers to establish and maintain specified application programming interfaces (API), including patient access API, for the benefit of enrollees, insureds, and contracted providers. This bill would exclude dental or vision benefits from the above-described API requirements.

AB 2200 **(Kalra D) Guaranteed Health Care for All.**
Current Text: Introduced: 2/7/2024 html pdf
Status: 3/21/2024-Referred to Com. on HEALTH.
Location: 3/21/2024-A. HEALTH

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

AB 2237 **(Aguiar-Curry D) Children and youth: transfer of specialty mental health services.**
Current Text: Amended: 3/18/2024 html pdf
Status: 3/19/2024-Re-referred to Com. on HEALTH.
Location: 3/18/2024-A. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Under current law, specialty mental health services include federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services provided to eligible Medi-Cal beneficiaries under 21 years of age. This bill would require, when a child or youth 18 years of age or younger changes residence from one county to another, the receiving county to provide specialty mental health services while the receiving county conducts its investigation and casework transfer process, if specified conditions are met, including, but not limited to, that the child or youth has been identified by the county of original residence as high risk or coming from a vulnerable population. The bill also would require the State Department of Health Care Services and the State Department of Social Services to collaborate to create a system of standardized communication between counties that respects the procedures of the receiving county and the needs of the child that is without mental health services and require the State Department of Social Services to establish care teams to help counties coordinate and expedite the transfer between counties.

AB 2246 **(Ramos D) Medical Practice Act: health care providers: qualified autism service paraprofessionals.**
Current Text: Amended: 3/18/2024 html pdf
Status: 3/19/2024-Re-referred to Com. on B. & P.
Location: 3/18/2024-A. B.&P.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law establishes requirements for the delivery of medical services, including via telehealth by specified health care providers. A violation of the Medical Practice Act is a crime. Under existing law, a "health care provider," for purpose of the act, includes a qualified autism service provider or a qualified autism service professional that is certified by a national entity, as specified. This bill would expand that definition of "health care provider" to also include a qualified autism service paraprofessional. By expanding the scope of a crime under the act, the bill would impose a state-mandated local program.

AB 2250 **(Weber D) Social determinants of health: screening and outreach.**
Current Text: Introduced: 2/8/2024 html pdf
Status: 4/3/2024-Coauthors revised. From committee: Do pass and re-refer to Com. on APPR. (Ayes 15. Noes 0.) (April

2). Re-referred to Com. on APPR.
Location: 2/8/2024-A. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law requires health care service plans and health insurers to include coverage for screening for various conditions and circumstances, including adverse childhood experiences. Current 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. This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2027, to include coverage for screenings for social determinants of health, as defined. The bill would require providers to use specified tools or protocols when documenting patient responses to questions asked in these screenings. The bill would require a health care service plan or health insurer to provide physicians who provide primary care services with adequate access to peer support specialists, lay health workers, social workers, or community health workers in counties where the plan or insurer has enrollees or insureds, as specified. The bill would authorize the respective departments to adopt guidance to implement its provisions.

AB 2258 **(Zbur D) Health care coverage: cost sharing.**
Current Text: Amended: 4/1/2024 html pdf
Status: 4/2/2024-Re-referred to Com. on HEALTH.
Location: 2/26/2024-A. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law provides for the regulation of health insurers by the Department of Insurance. Current law requires a group or individual nongrandfathered health care service plan contract or health insurance policy to provide coverage for, and prohibits a contract or policy from imposing cost-sharing requirements for, specified preventive care services and screenings. This bill would prohibit a group or individual nongrandfathered health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, from imposing a cost-sharing requirement for items or services that are integral to the provision of the above-described preventive care services and screenings. The bill would require those contracts and policies to cover items and services for those preventive care services and screenings, including home test kits for sexually transmitted diseases and specified cancer screenings.

AB 2271 **(Ortega D) Coverage for naloxone hydrochloride.**
Current Text: Introduced: 2/8/2024 html pdf
Status: 2/26/2024-Referred to Com. on HEALTH.
Location: 2/26/2024-A. HEALTH

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

Summary: Under current law, the pharmacist service of furnishing naloxone hydrochloride is a covered Medi-Cal benefit. The Medi-Cal program also covers certain medications to treat opioid use disorders as part of narcotic treatment program services, or as part of medication-assisted treatment services within the Drug Medi-Cal Treatment Program, as specified. Under this bill, prescription or nonprescription naloxone hydrochloride or another drug approved by the FDA for the complete or partial reversal of an opioid overdose would be a covered benefit under the Medi-Cal program. The bill would require a health care service plan contract or health insurance policy, as specified, to include coverage for the same medications under the same conditions. The bill would prohibit a health care service plan contract or health insurance policy from imposing any cost-sharing requirements for that coverage exceeding $10 per package of medication, and would prohibit a high deductible health plan from imposing cost sharing, as specified.

AB 2303 **(Carrillo, Juan D) Health and care facilities: prospective payment system rate increase.**
Current Text: Amended: 4/2/2024 html pdf
Status: 4/5/2024-In committee: Set, first hearing. Hearing canceled at the request of author.
Location: 2/26/2024-A. HEALTH

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

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

Current Text: Amended: 3/21/2024 html pdf

Status: 4/3/2024-From committee: Do pass and re-refer to Com. on APPR. (Ayes 12. Noes 2.) (April 2). Re-referred to Com. on APPR.

Location: 4/2/2024-A. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law requires the State Department of Public Health to maintain a program of maternal and child health, which may include, among other things, facilitating services directed toward reducing infant mortality and improving the health of mothers and children. Current law requires the Office of Health Equity within the department to serve as a resource for ensuring that programs collect and keep data and information regarding ethnic and racial health statistics, and strategies and programs that address multicultural health issues, including, but not limited to, infant and maternal mortality. Current law makes legislative findings relating to implicit bias and racial disparities in maternal mortality rates. Current law requires a hospital that provides perinatal care, and an alternative birth center or a primary clinic that provides services as an alternative birth center, to implement an evidence-based implicit bias program, as specified, for all health care providers involved in perinatal care of patients within those facilities. Current law requires the health care provider to complete initial basic training through the program and a refresher course every 2 years thereafter, or on a more frequent basis if deemed necessary by the facility. Existing law requires the facility to provide a certificate of training completion upon request, to accept certificates of completion from other facilities, and to offer training to physicians not directly employed by the facility. Current law requires the department to track and publish data on pregnancy-related death and severe maternal morbidity, as specified. This bill would make a legislative finding that the Legislature recognizes all birthing people, including nonbinary persons and persons of transgender experience. The bill would extend the evidence-based implicit bias training requirements to also include hospitals that provide perinatal care, as defined. The bill would require an implicit bias program to include recognition of intersecting identities and the potential associated biases. The bill would require initial basic training for the implicit bias program to be completed by June 1, 2025, for current health care providers, and within 6 months of their start date for new health care providers, unless exempted.

AB 2332 **(Connolly D) Corrections: health care.**

Current Text: Amended: 3/21/2024 html pdf

Status: 4/1/2024-Re-referred to Com. on PUB. S.

Location: 3/21/2024-A. PUB. S.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law establishes the Division of Health Care Operations and the Division of Health Care Policy and Administration within the Department of Corrections and Rehabilitation (CDCR) under the supervision of the

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

AB 2339 **(Aguiar-Curry D) Medi-Cal: telehealth.**

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

Status: 4/3/2024-From committee: Do pass and re-refer to Com. on APPR. (Ayes 15. Noes 0.) (April 2). Re-referred to Com. on APPR.

Location: 4/2/2024-A. APPR.

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

AB 2340 **(Bonta D) Medi-Cal: EPSDT services: informational materials.**

Current Text: Amended: 4/4/2024 html pdf

Status: 4/8/2024-Re-referred to Com. on HEALTH.

Location: 2/26/2024-A. HEALTH

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

AB 2342 **(Lowenthal D) Medi-Cal: critical access hospitals: islands.**

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

Status: 2/26/2024-Referred to Com. on HEALTH.

Location: 2/26/2024-A. HEALTH

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

AB 2352 **(Irwin D) Behavioral health and psychiatric advance directives.**
Current Text: Amended: 3/21/2024 html pdf
Status: 4/1/2024-Re-referred to Com. on JUD.
Location: 3/21/2024-A. JUD.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law establishes the requirements for executing a written advance health care directive that is legally sufficient to direct health care decisions. Current law provides a form that an individual may use or modify to create an advance health care directive. Under existing law, a written advance health care directive is legally sufficient if specified requirements are satisfied, may be revoked by a patient having capacity at any time, and is revoked to the extent of a conflict with a later executed directive. Current law requires a supervising health care provider who knows of the existence of an advance health care directive or its revocation to record that fact in the patient's health record. Existing law sets forth requirements of witnesses to a written advance health care directive. A written advance health care directive or similar instrument executed in another jurisdiction is valid and enforceable in this state under existing law. A person who intentionally falsifies, forges, conceals, defaces, or obliterates an individual's advance health care directive or its revocation without the individual's consent is subject to liability of up to $10,000 or actual damages, whichever is greater, plus reasonable attorney's fees. Current law authorizes an appeal of specified orders relating to an advance health care directive. Current law generally prohibits involuntary civil placement of a ward, conservatee, or person with capacity in a mental health treatment facility, subject to a valid and effective advance health care directive. Current law prohibits specified entities, including a provider, health care service plan, or insurer, from requiring or prohibiting the execution or revocation of an advance health care directive as a condition for providing health care, admission to a facility, or furnishing insurance. Current law requires the Secretary of State to establish a registry system for written advance health care directives, but failure to register does not affect the directive's validity and registration does not affect a registrant's ability to revoke the directive. This bill would extend the above-described advance health care directive provisions to psychiatric advance directives and would make conforming changes. The bill would specify that a psychiatric advance directive is a self-directed instruction with a chosen health care advocate, to be accessed during a behavioral health crisis or time when a person may or may not have capacity. The bill would require a psychiatric advance directive to be in written or digital form.

AB 2356 **(Wallis R) Medi-Cal: monthly maintenance amount: personal and incidental needs.**
Current Text: Introduced: 2/12/2024 html pdf
Status: 2/26/2024-Referred to Com. on HEALTH.
Location: 2/26/2024-A. HEALTH

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

Summary: Qualified individuals under the Medi-Cal program include medically needy persons and medically needy family persons who meet the required eligibility criteria, including applicable income requirements. Current law requires the department to establish income levels for maintenance need at the lowest levels that reasonably permit a medically

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

AB 2376 **(Bains D) Chemical dependency recovery hospitals.**
Current Text: Amended: 3/21/2024 html pdf
Status: 4/1/2024-Re-referred to Com. on HEALTH.
Location: 3/21/2024-A. HEALTH

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

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

AB 2446 **(Ortega D) Medi-Cal: diapers.**
Current Text: Amended: 4/4/2024 html pdf
Status: 4/8/2024-Re-referred to Com. on APPR.
Location: 4/2/2024-A. APPR.

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

Summary: Would add to the schedule of Medi-Cal benefits diapers for infants or toddlers with certain conditions, such as a urinary tract infection and colic, among others. The bill would establish diapers as a covered benefit for a child greater than 3 years of age who has been diagnosed with a condition that contributes to incontinence and would establish diapers as a covered benefit for individuals under 21 years of age, if necessary to correct or ameliorate a condition pursuant to specified standards. The bill would require the department to seek any necessary federal approval to implement this section.

AB 2449 **(Ta R) Health care coverage: qualified autism service providers.**
Current Text: Introduced: 2/13/2024 html pdf
Status: 3/15/2024-In committee: Set, first hearing. Hearing canceled at the request of author.
Location: 2/26/2024-A. HEALTH

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

Summary: Current law requires a health care service plan contract or health insurance policy to provide coverage for behavioral health treatment provided for pervasive developmental disorder or autism and requires a plan or policy to maintain an adequate network of qualified autism service providers. Under current law, a "qualified autism service provider" means, among other things, a person who is certified by a national entity, such as the Behavior Analyst Certification Board, with a certification that is accredited by the National Commission for Certifying Agencies. This bill would clarify that the Qualified Applied Behavior Analysis Credentialing Board is also a national entity that may certify a qualified autism service provider, and would authorize the certification to be accredited by the American National Standards Institute.

AB 2466 **(Carrillo, Wendy D) Medi-Cal managed care: network adequacy standards.**
Current Text: Amended: 3/18/2024 html pdf
Status: 3/19/2024-Re-referred to Com. on HEALTH.
Location: 3/18/2024-A. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law authorizes the Director of Health Care Services to terminate a contract or impose sanctions if the director finds that a Medi-Cal managed care plan fails to comply with contract requirements, state or federal law or regulations, or the state plan or approved waivers, or for other good cause. Current law establishes, until January 1, 2026, certain time and distance and appointment time standards for specified Medi-Cal managed care covered services, consistent with federal regulations relating to network adequacy standards, to ensure that those services are available and accessible to enrollees of Medi-Cal managed care plans in a timely manner, as specified. Under this bill, a Medi-Cal managed care plan would be deemed to be not in compliance with the appointment time standards if either (1) fewer than 85% of the network providers had an appointment available within the standards or (2) the department receives information establishing that the plan was unable to deliver timely, available, or accessible health care services to enrollees, as specified. Under the bill, failure to comply with the appointment time standard may result in contract termination or the issuance of sanctions as described above.

AB 2556 **(Jackson D) Behavioral health and wellness screenings: notice.**
Current Text: Amended: 4/4/2024 html pdf
Status: 4/8/2024-Re-referred to Com. on APPR.
Location: 4/2/2024-A. APPR.

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

Summary: The Knox-Keene Health Care Service Plan Act of 1975 provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Current law provides for the regulation of health insurers by the Department of Insurance. This bill would require a health care service plan or insurer to provide to each legal guardian of a patient, enrollee, or insured, 10 to 18 years of age, a written or electronic notice regarding the benefits of a behavioral health and wellness screening, as defined. The bill would require a health care service plan or insurer to provide the notice on an annual basis.

AB 2668 **(Berman D) Coverage for cranial prostheses.**
Current Text: Introduced: 2/14/2024 html pdf
Status: 3/4/2024-Referred to Com. on HEALTH.
Location: 3/4/2024-A. HEALTH

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

Summary: Would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, to cover cranial prostheses, as defined, for individuals experiencing permanent or temporary medical hair loss. The bill would require a licensed provider to prescribe the cranial prosthesis for an individual's course of treatment for a diagnosed health condition, chronic illness, or injury, as specified. The bill would limit coverage to once every 12 months and $750 for each instance of coverage. The bill would not apply these provisions to a specialized

health care service plan or specialized health insurance policy. Because a violation of these requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.

AB 2699 **(Carrillo, Wendy D) Hazardous materials: reporting: civil liability.**

Current Text: Amended: 4/1/2024 html pdf
Status: 4/2/2024-Re-referred to Com. on E.S. & T.M.
Location: 3/21/2024-A. E.S. & T.M.

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

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

AB 2701 **(Villapudua D) Medi-Cal: dental cleanings and examinations.**

Current Text: Introduced: 2/14/2024 html pdf
Status: 3/4/2024-Referred to Com. on HEALTH.
Location: 3/4/2024-A. HEALTH

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

Summary: Under current law, one dental prophylaxis cleaning per year and one initial dental examination by a dentist are covered Medi-Cal benefits for beneficiaries 21 years of age or older. Under current law, 2 dental prophylaxis cleanings per year and 2 periodic dental examinations per year are covered Medi-Cal benefits for beneficiaries under 21 years of age. Current law conditions implementation of those provisions on receipt of any necessary federal approvals and the availability of federal financial participation and funding in the annual Budget Act. This bill would restructure those provisions so that 2 cleanings and 2 examinations per year, as specified, would be covered Medi-Cal benefits for all beneficiaries, regardless of age.

AB 2703 **(Aguiar-Curry D) Federally qualified health centers and rural health clinics: psychological associates.**

Current Text: Introduced: 2/14/2024 html pdf
Status: 4/3/2024-From committee: Do pass and re-refer to Com. on APPR. with recommendation: To Consent Calendar. (Ayes 15. Noes 0.) (April 2). Re-referred to Com. on APPR.
Location: 4/2/2024-A. APPR.

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

Summary: Current law requires the State Department of Health Care Services to seek any necessary federal approvals and issue appropriate guidance to allow a federally qualified health center (FQHC) or a rural health clinic (RHC) to bill, under a supervising licensed behavioral health practitioner, for an encounter between an FQHC or RHC patient and an associate clinical social worker or associate marriage and family therapist when certain conditions are met, including, among others, that the FQHC or RHC is otherwise authorized to bill for services provided by the supervising practitioner as a separate visit. This bill would add a psychological associate to those provisions, requiring the department to seek

any necessary federal approvals and issue appropriate guidance to allow an FQHC or RHC to bill for an encounter between a patient and a psychological associate under those conditions. The bill would make conforming changes with regard to supervision by a licensed psychologist as required by the Board of Psychology.

AB 2726 **(Flora R) Specialty care network: telehealth and other virtual services.**

Current Text: Amended: 3/18/2024 html pdf

Status: 3/19/2024-Re-referred to Com. on HEALTH.

Location: 3/18/2024-A. HEALTH

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

Summary: Current law establishes, under the Medi-Cal program, certain time and distance standards for specified Medi-Cal managed care covered services, consistent with federal regulations relating to network adequacy standards, to ensure that those services, including certain specialty care, are available and accessible to enrollees of Medi-Cal managed care plans in a timely manner. Current law sets forth other timely access requirements for health care service plans and health insurers, including with regard to referrals to a specialist. Current law establishes various health professions development programs, within the Department of Health Care Access and Information, for the promotion of education, training, and recruitment of health professionals to address workforce shortage and distribution needs. Current law sets forth various provisions for the authorized use of telehealth in the delivery of health care services. This bill would, subject to an appropriation, require the California Health and Human Services Agency, in collaboration with the Department of Health Care Access and Information and the State Department of Health Care Services, to establish a demonstration project for a telehealth and other virtual services specialty care network that is designed to serve patients of safety-net providers consisting of qualifying providers, defined to include, among others, rural health clinics and community health centers. The bill would authorize the focus of the project to include increasing access to behavioral and maternal health services and additional specialties prioritized by the agency.

AB 2753 **(Ortega D) Rehabilitative and habilitative services: durable medical equipment and services.**

Current Text: Introduced: 2/15/2024 html pdf

Status: 4/3/2024-From committee: Do pass and re-refer to Com. on APPR. (Ayes 12. Noes 0.) (April 2). Re-referred to Com. on APPR.

Location: 4/2/2024-A. APPR.

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

Summary: Current law requires an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2017, to include, at a minimum, coverage for essential health benefits pursuant to the federal Patient Protection and Affordable Care Act. Under current law, essential health benefits include, among other things, rehabilitative and habilitative services. Current law requires habilitative services and devices to be covered under the same terms and conditions applied to rehabilitative services and devices under the plan contract or policy, and defines habilitative services to mean health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. This bill would specify that coverage of rehabilitative and habilitative services and devices under a health care service plan or health insurance policy includes durable medical equipment, services, and repairs, if the equipment, services, or repairs are prescribed or ordered by a physician, surgeon, or other health professional acting within the scope of their license. The bill would define “durable medical equipment” to mean devices, including replacement devices, that are designed for repeated use, and that are used for the treatment or monitoring of a medical condition or injury in order to help a person to partially or fully acquire, improve, keep, or learn, or minimize the loss of, skills and functioning of daily living. The bill would prohibit coverage of durable medical equipment and services from being subject to financial or treatment limitations, as specified.

AB 2843 **(Petrie-Norris D) Health care coverage: rape and sexual assault.**

Current Text: Introduced: 2/15/2024 html pdf

Status: 3/4/2024-Referred to Com. on HEALTH.

Location: 3/4/2024-A. HEALTH

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

1st House	2nd House	Conc.		d	

Summary: Would require a health care service plan or health insurance policy that is issued, amended, renewed, or delivered on or after January 1, 2025, to provide coverage without cost sharing for emergency room medical care and follow-up health care treatment for an enrollee or insured who is treated following a rape or sexual assault. The bill would prohibit a health care service plan or health insurer from requiring, as a condition of providing coverage, (1) an enrollee or insured to file a police report, (2) charges to be brought against an assailant, (3) or an assailant to be convicted of rape or sexual assault. Because a violation of the bill by a health care service plan would be a crime, the bill would impose a state-mandated local program.

AB 2956 **(Boerner D) Medi-Cal eligibility: redetermination.**

Current Text: Amended: 3/13/2024 html pdf

Status: 3/14/2024-Re-referred to Com. on HEALTH.

Location: 3/11/2024-A. HEALTH

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

Summary: Current law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Current law generally requires a county to redetermine a Medi-Cal beneficiary's eligibility to receive Medi-Cal benefits every 12 months and whenever the county receives information about changes in a beneficiary's circumstances that may affect their Medi-Cal eligibility. Current law conditions implementation of the redetermination provisions on the availability of federal financial participation and receipt of any necessary federal approvals. Under current law, if a county has facts clearly demonstrating that a Medi-Cal beneficiary cannot be eligible for Medi-Cal due to an event, such as death or change of state residency, Medi-Cal benefits are terminated without a redetermination. Current law requires the department, subject to federal funding, to extend continuous eligibility to children 19 years of age or younger for a 12-month period, as specified. Under current law, operative on January 1, 2025, or the date that the department certifies that certain conditions have been met, a child is continuously eligible for Medi-Cal up to 5 years of age. Under those provisions, a redetermination is prohibited during this time, unless certain circumstances apply, including, voluntary disenrollment, death, or change of state residency. This bill would require the department to seek federal approval to extend continuous eligibility to individuals over 19 years of age. Under the bill, subject to federal funding, and except as described above with regard to death, change of state residency, or other events, an individual would remain eligible from the date of a Medi-Cal eligibility determination until the end of a 12-month period, as specified. The bill would make various changes to the above-described redetermination procedures.

AB 2976 **(Jackson D) Mental health care.**

Current Text: Introduced: 2/16/2024 html pdf

Status: 2/17/2024-From printer. May be heard in committee March 18.

Location: 2/16/2024-A. PRINT

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

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

AB 3030 **(Calderon D) Health care services: artificial intelligence.**

Current Text: Amended: 3/21/2024 html pdf

Status: 4/1/2024-Re-referred to Com. on HEALTH.

Location: 3/21/2024-A. HEALTH

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

1st House	2nd House	Conc.		d	

Summary: Would require an entity, including a health facility, clinic, physician's office, or office of a group practice that uses a generative artificial intelligence tool to generate responses for health care providers to communicate with patients to ensure that those communications include both (1) a disclaimer that indicates to the patient that a communication was generated by artificial intelligence and (2) clear instructions for the patient to access direct communications with a health care provider, as specified. The bill would prohibit an entity or health care provider who fails to comply with these provisions from being subject to any disciplinary action related to licensure or certification, or to any civil or criminal liability for that failure.

AB 3129 **(Wood D) Health care system consolidation.**

Current Text: Introduced: 2/16/2024 html pdf

Status: 3/11/2024-Referred to Coms. on HEALTH and JUD.

Location: 3/11/2024-A. HEALTH

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

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

AB 3149 **(Garcia D) Promotores Advisory and Oversight Workgroup.**

Current Text: Amended: 3/18/2024 html pdf

Status: 3/19/2024-Re-referred to Com. on HEALTH.

Location: 3/18/2024-A. HEALTH

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

Summary: Current law includes in the definition of community health worker Promotores, Promotores de Salud, Community Health Representatives, navigators, and other nonlicensed health workers with specified qualifications.This bill would require the department to, by no later than January 1, 2026, and until December 31, 2026, convene the Promotores Advisory and Oversight Workgroup to examine the implementation of the community health worker benefit under the Medi-Cal program. The bill would require the director to appoint no fewer than 9 individuals to the workgroup who have at least ten years experience working in California as, or with, Promotores. The bill would require the workgroup to be comprised of no less than 51% Promotores, as specified, and require the appointees to be from geographically diverse areas of the state. The bill would require the workgroup to advise the department to ensure that community health worker services are available to all eligible Medi-Cal beneficiaries who want those services, to ensure that community health worker training and outreach materials are culturally and linguistically appropriate, to make recommendations on outreach efforts, as specified, and to provide input on issues that should be informed by community representatives who have lived experience with using and navigating Promotores services and the Medi-Cal program.

AB 3156 **(Patterson, Joe R) Medi-Cal managed care plans: exemption from mandatory enrollment.**

Current Text: Amended: 3/21/2024 html pdf

Status: 4/1/2024-Re-referred to Com. on HEALTH.

Location: 3/21/2024-A. HEALTH

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

Summary: The Lanterman Developmental Disabilities Services Act requires the State Department of Developmental Services to contract with regional centers to provide community services and supports for persons with developmental disabilities and their families. The act generally requires a regional center to identify and pursue all possible sources of funding, including the Medi-Cal program, for consumers receiving regional center services. Current law establishes the California Advancing and Innovating Medi-Cal (CalAIM) initiative, subject to receipt of any necessary federal approvals and the availability of federal financial participation, in order to, among other things, improve quality outcomes, reduce health disparities, and increase flexibility. Current law authorizes the department to standardize those populations that are subject to mandatory enrollment in a Medi-Cal managed care plan across all aid code groups and Medi-Cal managed care models statewide, as specified, in accordance with the CalAIM Terms and Conditions. Current law, if the department standardizes those populations subject to mandatory enrollment, exempts certain dual eligible and non-dual-eligible beneficiary groups from that mandatory enrollment. Under current law, a dual eligible beneficiary is an individual 21 years of age or older who is enrolled for benefits under the federal Medicare Program and is eligible for medical assistance under the Medi-Cal program. This bill would exempt, from mandatory enrollment in a Medi-Cal managed care plan, dual eligible and non-dual-eligible beneficiaries who receive services from a regional center and use a Medi-Cal fee-for-service delivery system as a secondary form of health coverage.

AB 3215 **(Soria D) Medi-Cal: mental health services for children.**
Current Text: Introduced: 2/16/2024 html pdf
Status: 2/17/2024-From printer. May be heard in committee March 18.
Location: 2/16/2024-A. PRINT

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

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

AB 3221 **(Pellerin D) Department of Managed Health Care: review of records.**
Current Text: Amended: 4/1/2024 html pdf
Status: 4/2/2024-Re-referred to Com. on HEALTH.
Location: 3/11/2024-A. HEALTH

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (hereafter the act), 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 the records, books, and papers of a health care service plan and other specified entities to be open to inspection by the director of the department during normal business hours.This bill would instead require the records, books, and papers of a health care service plan and other specified entities to be open to inspection by the director, including through electronic means. The bill would require a plan and other specified entities to furnish in electronic media records, books, and papers that are possessed in electronic media and to conduct a diligent review of records, books, and papers and make every effort to furnish those responsive to the director's request. The bill would require records, books, and papers to be furnished in a format that is digitally searchable, to the greatest extent feasible. The bill would require records, books, and papers to be preserved until furnished, if requested by the department. The bill would authorize the director to inspect and copy these records, books, and papers, and to seek relief in an administrative law proceeding if, in the director's determination, a plan or other specified entity fails to fully or timely respond to a duly authorized request for production of records, books, and papers. Because a willful violation of these requirements would be a crime, the bill would impose a state-mandated local program.

AB 3245 **(Patterson, Joe R) Coverage for colorectal cancer screening.**
Current Text: Introduced: 2/16/2024 html pdf
Status: 3/11/2024-Referred to Com. on HEALTH.

Location: 3/11/2024-A. HEALTH

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

Summary: Current law generally requires a health care service plan contract or a health insurance policy issued, amended, or renewed on or after January 1, 2022, to provide coverage without cost sharing for a colorectal cancer screening test, and for a colorectal cancer screening examination in specified circumstances, assigned either a grade of A or a grade of B by the United States Preventive Services Task Force. This bill would additionally require that coverage if the test or screening examination is assigned either a grade of A or a grade of B by another accredited or certified guideline agency.

AB 3260 **(Pellerin D) Health care coverage: reviews and grievances.**

Current Text: Amended: 4/1/2024 html pdf
Status: 4/2/2024-Re-referred to Com. on HEALTH.
Location: 3/11/2024-A. HEALTH

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

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

AB 3275 **(Soria D) Health care coverage: claim reimbursement.**

Current Text: Amended: 4/1/2024 html pdf
Status: 4/2/2024-Re-referred to Com. on HEALTH.
Location: 3/11/2024-A. HEALTH

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

Summary: Current law requires a health insurer or health care service plan, including a specialized health care service plan, to reimburse a claim or portion of a claim no later than 30 working days after receipt of the claim, unless the plan contests or denies the claim, in which case the plan is required to notify the claimant within 30 working days that the claim is contested or denied. Under current law, if a claim or portion thereof is contested on the basis that a health insurer or health care service plan has not received all information necessary to determine payer liability for the claim or portion thereof and notice has been provided, the health insurer or health care service plan has 30 working days after receipt of the additional information to complete reconsideration of the claim. Existing law extends these timelines to 45 working days for a health care service plan that is a health maintenance organization. Under existing law, if a claim is not reimbursed, contested, or denied pursuant to these timelines, as specified, interest accrues at a rate of 15% per annum for a health care service plan and 10% per annum for a health insurer. This bill would increase that interest accrual rate

for a health insurer to 15% per annum. The bill, notwithstanding the above-described timelines, would require a health care service plan or health insurer to reimburse a claim for a small and rural provider, critical access provider, or distressed provider within 10 business days after receipt of the claim, or, if the health care service plan or health insurer contests or denies the claim, to notify the claimant within 5 business days that the claim is contested or denied. Under the bill, if a claim for reimbursement to a small and rural provider, critical access provider, or distressed provider is contested on the basis that the health care service plan or health insurer has not received all information necessary to determine payer liability for the claim and notice has been provided, the health care service plan or health insurer would have 15 business days after receipt of the additional information to complete reconsideration of the claim. Under the bill, if a claim is not reimbursed, contested, or denied pursuant to these timelines, as specified, interest would accrue at a rate of 15% per annum for health care service plans and health insurers.

SB 70 **(Wiener D) Prescription drug coverage.**

Current Text: Amended: 6/29/2023 html pdf

Status: 9/1/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/16/2023)(May be acted upon Jan 2024)

Location: 9/1/2023-A. 2 YEAR

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

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

SB 136 **(Committee on Budget and Fiscal Review) Medi-Cal: managed care organization provider tax.**

Current Text: Chaptered: 3/25/2024 html pdf

Status: 3/25/2024-Approved by the Governor. Chaptered by Secretary of State. Chapter 6, Statutes of 2024.

Location: 3/25/2024-S. CHAPTERED

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

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

SB 238 **(Wiener D) Health care coverage: independent medical review.**

Current Text: Amended: 6/19/2023 html pdf
Status: 9/1/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/23/2023)(May be acted upon Jan 2024)
Location: 9/1/2023-A. 2 YEAR

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

Summary: Current law provides for the regulation of disability insurers by the Department of Insurance. Current law establishes the Independent Medical Review System within each department, under which an enrollee or insured may seek review if a health care service has been denied, modified, or delayed by a health care service plan or disability insurer and the enrollee or insured has previously filed a grievance that remains unresolved after 30 days. This bill, commencing July 1, 2024, would require a health care service plan or a disability insurer that modifies, delays, or denies a health care service, based in whole or in part on medical necessity, to automatically submit within 24 hours a decision regarding a disputed health care service to the Independent Medical Review System, as well as the information that informed its decision, without requiring an enrollee or insured to submit a grievance, if the decision is to deny, modify, or delay specified services relating to mental health or substance use disorder conditions for an enrollee or insured up to 26 years of age. The bill would require a health care service plan or disability insurer, within 24 hours after submitting its decision to the Independent Medical Review System to provide notice to the appropriate department, the enrollee or insured or their representative, if any, and the enrollee's or insured's provider. The bill would require the notice to include notification to the enrollee or insured that they or their representative may cancel the independent medical review at any time before a determination, as specified. The bill would apply specified existing provisions relating to mental health and substance use disorders for purposes of its provisions, and would be subject to relevant provisions relating to the Independent Medical Review System that do not otherwise conflict with the express requirements of the bill. With respect to health care service plans, the bill would specify that its provisions do not apply to Medi-Cal managed care plan contracts.

SB 282 **(Eggman D) Medi-Cal: federally qualified health centers and rural health clinics.**
Current Text: Amended: 3/13/2023 html pdf
Status: 9/1/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/16/2023)(May be acted upon Jan 2024)
Location: 9/1/2023-A. 2 YEAR

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

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

SB 294 **(Wiener D) Health care coverage: independent medical review.**
Current Text: Amended: 1/11/2024 html pdf
Status: 1/29/2024-Read third time. Passed. (Ayes 31. Noes 7.) Ordered to the Assembly. In Assembly. Read first time. Held at Desk.
Location: 1/29/2024-A. DESK

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

Summary: Would, commencing July 1, 2025, require a health care service plan or a disability insurer that upholds its decision to modify, delay, or deny a health care service in response to a grievance or has a grievance that is otherwise pending or unresolved upon expiration of the relevant timeframe to automatically submit within 24 hours a decision regarding a disputed health care service to the Independent Medical Review System, as well as the information that informed its decision, if the decision is to deny, modify, or delay specified services relating to mental health or substance use disorder conditions for an enrollee or insured up to 26 years of age. The bill would require a health care service plan or disability insurer, within 24 hours after submitting its decision to the Independent Medical Review System to provide notice to the appropriate department, the enrollee or insured or their representative, if any, and the enrollee's or insured's provider. The bill would require the notice to include notification to the enrollee or insured that they or their representative may cancel the independent medical review at any time before a determination, as specified.

SB 339 **(Wiener D) HIV preexposure prophylaxis and postexposure prophylaxis.**

Current Text: Chaptered: 2/6/2024 html pdf

Status: 2/6/2024-Chaptered by Secretary of State - Chapter 1, Statutes of 2024

Location: 2/6/2024-S. CHAPTERED

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

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

SB 363 **(Eggman D) Facilities for inpatient and residential mental health and substance use disorder: database.**

Current Text: Amended: 5/18/2023 html pdf

Status: 9/1/2023-September 1 hearing: Held in committee and under submission.

Location: 8/23/2023-A. APPR. SUSPENSE FILE

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

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

SB 424 **(Durazo D) Medi-Cal: Whole Child Model program.**

Current Text: Amended: 5/25/2023 html pdf

Status: 7/14/2023-Failed Deadline pursuant to Rule 61(a)(10). (Last location was HEALTH on 6/8/2023)(May be acted upon Jan 2024)

Location: 7/14/2023-A. 2 YEAR

Desk	Policy	Fiscal	Floor	Desk	2 year	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered

1st House	2nd House				

Summary: Current law establishes the California Children's Services (CCS) Program, administered by the State Department of Health Care Services and a designated agency of each county, to provide medically necessary services for persons under 21 years of age who have any of specified medical conditions and who meet certain financial eligibility requirements. Current law establishes the Medi-Cal program, which is administered by the department and under which qualified low-income individuals receive health care services. Current law requires the department to establish a statewide Whole Child Model program stakeholder advisory group that includes specified persons, including CCS case managers, and to consult with that advisory group on prescribed matters. Current law terminates the advisory group on December 31, 2023. This bill would extend the operation of the advisory group until December 31, 2026.

SB 427 **(Portantino D) Health care coverage: antiretroviral drugs, drug devices, and drug products.**

Current Text: Amended: 4/4/2024 html pdf

Status: 4/4/2024-Read third time and amended. Ordered to third reading.

Location: 2/26/2024-A. THIRD READING

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

Summary: Current law generally prohibits a health care service plan, excluding a Medi-Cal managed care plan, or health insurer from subjecting antiretroviral drugs that are medically necessary for the prevention of HIV/AIDS, including preexposure prophylaxis or postexposure prophylaxis, to prior authorization or step therapy. Under current law, a health care service plan or health insurer is not required to cover all the therapeutically equivalent versions of those drugs without prior authorization or step therapy if at least one is covered without prior authorization or step therapy. This bill would prohibit a health care service plan, excluding a Medi-Cal managed care plan, or health insurer from subjecting antiretroviral drugs, drug devices, or drug products that are either approved by the United States Food and Drug Administration (FDA) or recommended by the federal Centers for Disease Control and Prevention (CDC) for the prevention of HIV/AIDS, to prior authorization or step therapy, but would authorize prior authorization or step therapy if at least one therapeutically equivalent version is covered without prior authorization or step therapy and the plan or insurer provides coverage for a noncovered therapeutic equivalent antiretroviral drug, drug device, or drug product without cost sharing pursuant to an exception request. The bill would require a plan or insurer to provide coverage under the outpatient prescription drug benefit for those drugs, drug devices, or drug products, including by supplying participating providers directly with a drug, drug device, or drug product, as specified.

SB 516 **(Skinner D) Health care coverage: prior authorization.**

Current Text: Amended: 9/13/2023 html pdf

Status: 9/14/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. on 9/14/2023)(May be acted upon Jan 2024)

Location: 9/14/2023-A. 2 YEAR

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

Summary: Would, on or after January 1, 2026, prohibit a health care service plan or health insurer from requiring a contracted health professional to complete or obtain a prior authorization for any covered health care services if the plan or insurer approved or would have approved not less than 90% of the prior authorization requests they submitted in the most recent completed one-year contracted period. The bill would set standards for this exemption and its denial, rescission, and appeal. The bill would authorize a plan or insurer to evaluate the continuation of an exemption not more than once every 12 months, and would authorize a plan or insurer to rescind an exemption only at the end of the 12-month period and only if specified criteria are met. The bill would require a plan or insurer to provide an electronic prior authorization process. The bill would also require a plan or insurer to have a process for annually monitoring prior authorization approval, modification, appeal, and denial rates to identify services, items, and supplies that are regularly approved, and to discontinue prior authorization on those services, items, and supplies that are approved 95% of the time. 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.

SB 551 **(Portantino D) Beverage containers: recycling.**

Current Text: Amended: 3/21/2024 html pdf

Status: 3/21/2024-Read second time and amended. Re-referred to Com. on APPR.

Location: 3/19/2024-A. APPR.

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

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

SB 729 **(Menjivar D) Health care coverage: treatment for infertility and fertility services.**

Current Text: Amended: 8/14/2023 html pdf

Status: 9/1/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/23/2023)(May be acted upon Jan 2024)

Location: 9/1/2023-A. 2 YEAR

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

Summary: Would require large and small group health care service plan contracts and disability insurance policies issued, amended, or renewed on or after January 1, 2024, to provide coverage for the diagnosis and treatment of infertility and fertility services. With respect to large group health care service plan contracts and disability insurance policies, the bill would require coverage for a maximum of 3 completed oocyte retrievals, as specified. The bill would revise the definition of infertility, and would remove the exclusion of in vitro fertilization from coverage. The bill would also delete a requirement that a health care service plan contract and disability insurance policy provide infertility treatment under agreed-upon terms that are communicated to all group contractholders and policyholders. The bill would prohibit a health care service plan or disability insurer from placing different conditions or coverage limitations on fertility medications or services, or the diagnosis and treatment of infertility and fertility services, than would apply to other conditions, as specified. The bill would make these requirements inapplicable to a religious employer, as defined, and specified contracts and policies.

SB 966 **(Wiener D) Pharmacy benefits.**

Current Text: Introduced: 1/24/2024 html pdf

Status: 4/5/2024-Set for hearing April 15.

Location: 2/14/2024-S. B., P. & E.D.

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

Summary: The Pharmacy Law establishes the California State Board of Pharmacy in the Department of Consumer Affairs to license and regulate the practice of pharmacy. The Knox-Keene Health Care Service Plan Act of 1975 (the Knox-Keene Act), a violation of which is a crime, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. The Knox-Keene Act requires a pharmacy benefit manager under contract with a health care service plan to, among other things, register with the Department of Managed Health Care. Current law provides for the regulation of health insurers by the Department of Insurance. Current law imposes requirements on audits of pharmacy services provided to beneficiaries of a health benefit plan, as specified, and prohibits those audit provisions from being construed to suggest or imply that the Department of Consumer Affairs or the California State

Board of Pharmacy has any jurisdiction or authority over those audit provisions. This bill would delete the latter provision relating to the construction and jurisdiction over those provisions by the department and the board. This bill would require a pharmacy benefit manager, as defined by the bill, to apply for and obtain a license from the California State Board of Pharmacy to operate as a pharmacy benefit manager. The bill would establish application qualifications and requirements and would establish an unspecified fee for initial licensure and renewal.

SB 980 **(Wahab D) Medi-Cal: dental crowns and implants.**
Current Text: Amended: 3/21/2024 html pdf
Status: 4/8/2024-April 8 hearing: Placed on APPR suspense file.
Location: 4/8/2024-S. APPR. SUSPENSE FILE

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

Summary: Under current law, early and periodic screening, diagnostic, and treatment (EPSDT) services are covered under Medi-Cal for an individual under 21 years of age in accordance with certain federal provisions. Under existing law, for persons 21 years of age or older, laboratory-processed crowns on posterior teeth are a covered benefit when medically necessary to restore a posterior tooth back to normal function based on the criteria specified in the Medi-Cal Dental Manual of Criteria. This bill, for purposes of the above-described Medi-Cal coverage for laboratory-processed crowns, would remove the condition that the tooth be posterior and would apply the coverage to persons 13 years of age or older. Under the bill, this provision would not be construed to exclude Medi-Cal coverage for laboratory-processed crowns on teeth if otherwise required under EPSDT services.

SB 999 **(Cortese D) Health coverage: mental health and substance use disorders.**
Current Text: Amended: 4/8/2024 html pdf
Status: 4/8/2024-From committee with author's amendments. Read second time and amended. Re-referred to Com. on HEALTH.
Location: 2/14/2024-S. HEALTH

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

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

SB 1008 **(Bradford D) Obesity Treatment Parity Act.**
Current Text: Amended: 3/14/2024 html pdf
Status: 4/5/2024-Set for hearing April 24.
Location: 2/14/2024-S. HEALTH

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

Summary: Would require an individual or group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, to include comprehensive coverage for the treatment of obesity, including coverage for intensive behavioral therapy, bariatric surgery, and at least one FDA-approved antiobesity medication.

SB 1017 **(Eggman D) Available facilities for inpatient and residential mental health or substance use disorder treatment.**
Current Text: Introduced: 2/5/2024 html pdf
Status: 4/5/2024-Set for hearing April 15.
Location: 4/3/2024-S. APPR.

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

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

SB 1112 **(Menjivar D) Medi-Cal: families with subsidized childcare.**
Current Text: Amended: 3/21/2024 html pdf
Status: 4/4/2024-Set for hearing April 15.
Location: 3/21/2024-S. HUM. S.

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

Summary: This bill, subject to any necessary federal approvals and the availability of federal funding, would require the State Department of Health Care Services and the State Department of Social Services to develop a model memorandum of understanding (MOU), and would require the department to require Medi-Cal managed care plans and alternative payment agencies to enter an MOU that includes, at a minimum, the provisions included in the model.

SB 1120 **(Becker D) Health care coverage: utilization review.**
Current Text: Amended: 4/1/2024 html pdf
Status: 4/1/2024-From committee with author's amendments. Read second time and amended. Re-referred to Com. on HEALTH.
Location: 2/21/2024-S. HEALTH

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law generally authorizes a health care service plan or health insurer to use prior authorization and other utilization review or utilization management functions, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. Existing law requires a health care service plan or health insurer, including those plans or insurers that delegate utilization review or utilization management functions to medical groups, independent practice associations, or to other contracting providers, to comply with specified requirements and limitations on their utilization review or utilization management functions. Existing law authorizes the Director of the Department of Managed Health Care or the Insurance Commissioner to assess an administrative penalty to a health care service plan or health insurer, as applicable, for failure to comply with those requirements. This bill would require a health care service plan or health insurer to ensure that a licensed physician supervises the use of artificial intelligence decision making tools when those tools are used to inform decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees or insureds. The bill would require algorithms, artificial intelligence, and other software tools used for utilization review or utilization management decisions to comply with specified requirements, including that they be fairly and equitably applied. 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.

SB 1131 **(Gonzalez D) Medi-Cal providers.**

Current Text: Amended: 4/8/2024 html pdf

Status: 4/8/2024-Read second time and amended. Re-referred to Com. on APPR.

Location: 4/3/2024-S. APPR.

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

Summary: The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under current law, services provided by a certified nurse practitioner are covered under the Medi-Cal program to the extent authorized by federal law, and current law requires the department to permit a certified nurse practitioner to bill Medi-Cal independently for their services. This bill would similarly make services provided by a licensed physician assistant covered under the Medi-Cal program and would require the department to permit a certified nurse practitioner to bill Medi-Cal independently for their services.

SB 1180 **(Ashby D) Health care coverage: emergency medical services.**

Current Text: Introduced: 2/14/2024 html pdf

Status: 4/5/2024-Set for hearing April 24.

Location: 2/21/2024-S. HEALTH

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

Summary: Would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, to include coverage for services provided by a community paramedicine program, a triage to alternate destination program, and a mobile integrated health program. The bill would require those plans and policies to require an enrollee or insured who receives covered services from a noncontracting program to pay no more than the same cost-sharing amount they would pay for the same covered services received from a contracting program. The bill would specify the reimbursement process and amount for a noncontracting program. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. The bill would also make services provided by these programs covered benefits under the Medi-Cal program. This bill contains other related provisions and other existing laws.

SB 1213 **(Atkins D) Health care programs: cancer.**

Current Text: Amended: 4/8/2024 html pdf

Status: 4/8/2024-From committee with author's amendments. Read second time and amended. Re-referred to Com. on APPR.

Location: 4/3/2024-S. APPR.

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

Summary: Current law requires the State Department of Health Care Services to perform various health functions, including providing breast and cervical cancer screening and treatment for low-income individuals. Current law provides that an individual is eligible to receive treatment services if, among other things, the individual has a family income at or below 200% of the federal poverty level as determined by the provider performing the screening and diagnosis. This bill would provide that an individual is eligible to receive treatment services if the individual has a family income at or below 300% of the federal poverty level as determined by the provider performing the screening and diagnosis.

SB 1236 **(Blakespear D) Medicare supplement coverage: open enrollment periods.**

Current Text: Introduced: 2/15/2024 html pdf

Status: 4/5/2024-Set for hearing April 24.

Location: 2/29/2024-S. HEALTH

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

Summary: Current federal law provides for the issuance of Medicare supplement policies or certificates, also known as

Medigap coverage, which are advertised, marketed, or designed primarily as a supplement to reimbursements under the Medicare Program for the hospital, medical, or surgical expenses of persons eligible for the Medicare Program, including coverage of Medicare deductible, copayment, or coinsurance amounts, as specified. Current law, among other provisions, requires supplement benefit plans to be uniform in structure, language, designation, and format with the standard benefit plans, as prescribed. Current law prohibits an issuer from denying or conditioning the offering or effectiveness of any Medicare supplement contract, policy, or certificate available for sale in this state, or discriminating in the pricing of a contract, policy, or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application that is submitted prior to or during the 6-month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. This bill, on and after January 1, 2025, would prohibit an issuer of Medicare supplement coverage in this state from denying or conditioning the issuance or effectiveness of any Medicare supplement coverage available for sale in the state, or discriminate in the pricing of that coverage because of the health status, claims experience, receipt of health care, medical condition, or age of an applicant, if an application for coverage is submitted during an open enrollment period, as specified in the bill. 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.

SB 1258 **(Dahle R) Medi-Cal: unrecovered payments: interest rate.**

Current Text: Amended: 4/8/2024 html pdf

Status: 4/8/2024-Read second time and amended. Re-referred to Com. on APPR.

Location: 4/3/2024-S. APPR.

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

Summary: The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Current law requires the Director of Health Care Services to establish administrative appeal processes to review grievances or complaints arising from the findings of an audit or examination. Under current law, if recovery of a disallowed payment has been made by the department, a provider who prevails in an appeal of that payment is entitled to interest at the rate equal to the monthly average received on investments in the Surplus Money Investment Fund, or simple interest at the rate of 7% per annum, whichever is higher. Under current law, with exceptions, interest at that same rate is assessed against any unrecovered overpayment due to the department. In the case of an assessment against any unrecovered overpayment due to the department, this bill would authorize the department to waive the interest, as part of a repayment agreement entered into with the provider, if the unrecovered overpayment occurred 4 or more years before the issuance of the first statement of account status or demand for repayment, after taking into account specified factors, including the impact of the repayment amounts on the fiscal solvency of the provider, and whether the overpayment was caused by a policy change or departmental error that was not the fault of the billing provider.

SB 1268 **(Nguyen R) Medi-Cal managed care plans: contracts with safety net providers.**

Current Text: Amended: 3/20/2024 html pdf

Status: 4/5/2024-Set for hearing April 24.

Location: 4/3/2024-S. HEALTH

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

Summary: The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under current law, one of the methods by which Medi-Cal services are provided is pursuant to contracts between the State Department of Health Care Services and various types of managed care plans and between those plans and providers of those services. In the case of a contract between a Medi-Cal managed care plan and a safety net provider, as defined, that furnishes Medi-Cal services, the bill would, to the extent not in conflict with federal law, prohibit the plan and the provider from terminating the contract during the contract period without first declaring the cause of termination. The bill would prohibit the declared cause of termination from being a material fact or condition that existed at the time that the contract was entered into by those parties, and of which both parties had knowledge at that time.

SB 1269 **(Padilla D) Safety net hospitals.**

Current Text: Introduced: 2/15/2024 html pdf

Status: 4/3/2024-Set for hearing April 24.

Location: 2/29/2024-S. HEALTH

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

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

SB 1290 **(Roth D) Health care coverage: essential health benefits.**

Current Text: Introduced: 2/15/2024 html pdf

Status: 4/1/2024-Set for hearing April 10.

Location: 3/21/2024-S. HEALTH

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

Summary: Would express the intent of the Legislature to review California's essential health benefits benchmark plan and establish a new benchmark plan for the 2027 plan year. The bill would limit the applicability of the current benchmark plan benefits to plan years on or before the 2027 plan year. This bill contains other related provisions and other existing laws.

SB 1300 **(Cortese D) Health facility closure: public notice: inpatient psychiatric and maternity services.**

Current Text: Amended: 4/8/2024 html pdf

Status: 4/8/2024-Read second time and amended. Re-referred to Com. on APPR.

Location: 4/3/2024-S. APPR.

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

Summary: Current law requires the State Department of Public Health to license, regulate, and inspect health facilities, as specified, including general acute care hospitals. Under current law, a general acute care hospital is required to provide certain basic services, including medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services. Current law authorizes a general acute care hospital to provide various special or supplemental services if certain conditions are met. Current regulations define a supplemental service as an organized inpatient or outpatient service that is not required to be provided by law or regulation. Current law requires a health facility to provide 90 days of public notice of the proposed closure or elimination of a supplemental service, and 120 days of public notice of the proposed closure or elimination of an acute psychiatric hospital. This bill would change the notice period required before proposed closure or elimination of the supplemental service of inpatient psychiatric service or maternity service from 90 days to 120 days. By changing the definition of a crime, this bill would impose a state-mandated local program.

SB 1339 **(Allen D) Supportive community residences.**

Current Text: Amended: 3/20/2024 html pdf

Status: 4/5/2024-Set for hearing April 24.

Location: 4/3/2024-S. HEALTH

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

Summary: Current law generally requires the State Department of Public Health to license, inspect, and regulate health facilities, defined to include, among other types of health facilities, an acute psychiatric hospital. Current law requires the State Department of Health Care Services to license and establish regulations for psychiatric residential treatment facilities. Current law requires the State Department of Health Care Services to license and regulate facilities that provide

residential nonmedical services to adults who are recovering from problems related to alcohol, drug, or alcohol and drug misuse or abuse, and who need alcohol, drug, or alcohol and drug recovery treatment or detoxification services. Current law also requires the department to implement a voluntary certification program for alcohol and other drug treatment recovery services. The California Community Care Facilities Act generally provides for the licensing and regulation of community care facilities by the State Department of Social Services, to provide 24-hour nonmedical care of persons in need of personal services, supervision, or assistance. Existing regulation includes an adult residential facility as a community care facility for those purposes. This bill would require the State Department of Health Care Services (department), by January 1, 2027, and in consultation with relevant public agencies and stakeholders, to establish, and provide for the administration of, a voluntary certification program for supportive community residences. The bill would define a "supportive community residence" as a residential facility serving adults with a substance use disorder or mental health diagnosis that does not provide medical care or a level of support for activities of daily living that require state licensing.

SB 1354 **(Wahab D) Health facilities: payment source.**

Current Text: Introduced: 2/16/2024 html pdf

Status: 4/3/2024-Set for hearing April 24.

Location: 2/29/2024-S. HEALTH

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

Summary: Would require a long-term health care that participates as a provider under the Medi-Cal program to provide aid, care, service, or other benefits available under Medi-Cal to Medi-Cal beneficiaries in the same manner, by the same methods, and at the same scope, level, and quality as provided to the general public, regardless of payment source.

SB 1355 **(Wahab D) Medi-Cal: in-home supportive services: redetermination.**

Current Text: Amended: 4/3/2024 html pdf

Status: 4/3/2024-Set for hearing April 10. From committee with author's amendments. Read second time and amended. Re-referred to Com. on HEALTH.

Location: 3/13/2024-S. HEALTH

1st House				2nd House				Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law generally requires a county to redetermine a Medi-Cal beneficiary's eligibility to receive Medi-Cal benefits every 12 months and whenever the county receives information about changes in a beneficiary's circumstances that may affect their eligibility for Medi-Cal benefits. Current law provides for the In-Home Supportive Services (IHSS) program, administered by the State Department of Social Services and counties, under which qualified aged, blind, and disabled persons are provided with supportive services in order to permit them to remain in their own homes. Current law authorizes certain Medi-Cal beneficiaries to receive IHSS as a covered Medi-Cal benefit. This bill would, to the extent that any necessary federal approvals are obtained, and federal financial participation is available and not otherwise jeopardized, require an IHSS recipient to be continuously eligible for Medi-Cal for 3 years, if they have a fixed income, and would prohibit a redetermination of Medi-Cal eligibility before 3 years, except as specified. The bill would make the implementation of its provisions contingent upon the department obtaining all necessary federal approvals, the department determining that systems have been programmed to implement these provisions, and the Legislature has appropriated funding to implement these provisions after a determination that ongoing General Fund resources are available to support the ongoing implementation of these provisions.

SB 1397 **(Eggman D) Behavioral health services coverage.**

Current Text: Amended: 3/20/2024 html pdf

Status: 3/20/2024-Set for hearing April 10. From committee with author's amendments. Read second time and amended. Re-referred to Com. on HEALTH.

Location: 2/29/2024-S. HEALTH

1st House				2nd House				Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law provides for the regulation of health and disability insurers by the Department of Insurance. Current 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. This bill would require a health care service plan contract or health insurance policy issued, amended, renewed, or delivered on or after July 1, 2025, that covers medically necessary mental health and substance use disorder services to comply with rate and timely reimbursement requirements for services delivered by a county behavioral health agency, as specified. Unless an enrollee or insured is referred or authorized by the plan or insurer, the bill would require a county behavioral health agency to contact a plan or insurer before initiating services. The bill would authorize a plan or insurer to conduct a postclaim review to determine appropriate payment of a claim, and would authorize the use of prior authorization as permitted by the regulating department. The bill would require the Department of Managed Health Care and Department of Insurance to issue guidance to plans and insurers regarding compliance with these provisions no later than April 1, 2025.

SB 1423 **(Dahle R) Medi-Cal: critical access hospitals.**

Current Text: Amended: 4/8/2024 html pdf

Status: 4/8/2024-From committee with author's amendments. Read second time and amended. Re-referred to Com. on HEALTH.

Location: 2/29/2024-S. HEALTH

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Under current law, each hospital designated by the State Department of Health Care Services as a critical access hospital, and certified as such by the Secretary of the United States Department of Health and Human Services under the federal Medicare rural hospital flexibility program, is eligible for supplemental payments for Medi-Cal covered outpatient services rendered to Medi-Cal eligible persons. Current law conditions those payments on receipt of federal financial participation and an appropriation in the annual Budget Act for the nonfederal share of those payments, with supplemental payments being apportioned among critical access hospitals based on their number of Medi-Cal outpatient visits. This bill would require that each critical access hospital that elects to participate be reimbursed at 100% of the hospital's projected reasonable and allowable costs for covered Medi-Cal services, as defined, furnished in the Medi-Cal fee-for-service and managed care delivery systems for each subject calendar year, effective for dates of service on or after January 1, 2026. The bill would require the department to develop and maintain one or more reimbursement methodologies, or revise one or more existing reimbursement methodologies applicable to participating critical access hospitals, or both, to implement the minimum cost-based payment levels. The bill would set forth a timeline and a procedure for the department to notify each critical access hospital of the ability to elect to participate in those methodologies, and for a critical access hospital to inform the department of its election to participate, its discontinuance, or its later participation.

SB 1428 **(Atkins D) Health care coverage: triggering events.**

Current Text: Amended: 3/18/2024 html pdf

Status: 4/5/2024-Set for hearing April 15.

Location: 4/3/2024-S. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law provides for the regulation of health insurers by the Department of Insurance. Current law requires a health care service plan or a health insurer to allow an individual to enroll in or change individual health benefit plans as a result of specified triggering events, including a loss of minimum essential coverage, as defined, gaining a dependent or becoming a dependent, or being mandated to be covered as a dependent pursuant to a valid state or federal court order. Current law allows an individual 60 days from the date of a triggering event to apply for subsequent coverage. This bill would allow an individual 60 days before or and after the date of a triggering event to apply for subsequent coverage. coverage, to the extent no conflicts with the availability and length of specified special enrollment periods exist. 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 1492 **(Menjivar D) Medi-Cal reimbursement rates: private duty nursing.**

Current Text: Introduced: 2/16/2024 html pdf
Status: 4/3/2024-Set for hearing April 24.
Location: 2/29/2024-S. HEALTH

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

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