ALAMEDA Alliance FOR HEALTH

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

Board of Governors

PACKET

AUGUST 9th, 2024

ALAMEDA Alliance FOR HEALTH

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EXECUTIVE SUMMARY APPENDIX

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

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SUPPORTING MATERIALS APPENDIX

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

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CEO Update

Matthew Woodruff

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

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

Date: **August 9th, 2024**

Subject: **CEO Report**

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

	June	YTD
Medi-Cal	($36.3M)	($46.7 M)
Group Care	($470K)	$2.0M
Total	($36.8M)	($44.7M)

  - **Revenue was $138.2 million in June 2024 and $1.8 billion Year-to-Date (YTD)**.
    - Medical expenses were $168.5 million in June and $1.7 billion for the fiscal year-to-date; the medical loss ratio is 121.9% for the month and 98.7% for the fiscal year-to-date.
    - Administrative expenses were $9.5 million in May and $97.7 million year-to-date; the administrative loss ratio is 6.9% of net revenue for the month and 5.6% of net revenue year-to-date.
  - **Tangible Net Equity (TNE)**: Financial reserves are 448% of the required DMHC minimum, representing $216.8 million in excess TNE.
  - **Total enrollment in June 2024 was 403,990**, a decrease of 1,289 Medi-Cal members compared to May.
- **Key Performance Indicators:**
  - **Regulatory Metrics:**
    - The Alliance missed our claims timeliness of payment. The State metric is 90% and we scored 87%.
    - The Alliance missed our expedited grievance timeliness. We received 4 expedited grievances, and one was not processed timely within the required 3 days.
  - **Non-Regulatory Metrics:**
    - The Alliance missed an internal metric on system availability. Our goal is 100% and we averaged 99.6%

- **Alliance Updates:**
    - **Demographics**
        - Please see attached power point describing the demographics of the Alliance employees.
    - **DMHC and DHCS Audit 2025**
        - The DMHC and DHCS have scheduled a joint audit of the Alliance for March 2025.
    - NCQA
        - NCQA has scheduled our next audit for June 2025.

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Executive Dashboard

OPERATIONS DASHBOARD

AUGUST 2024

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Financials

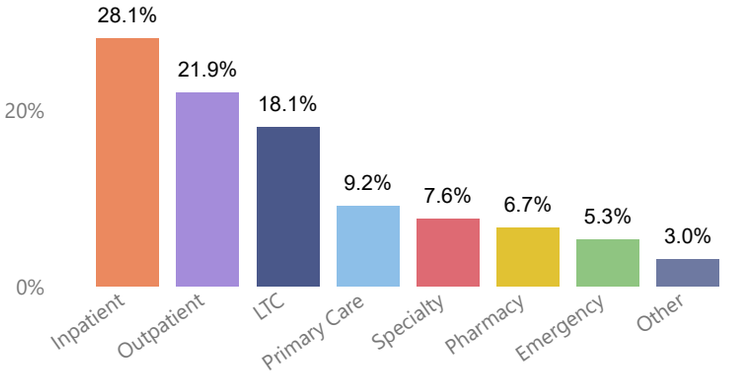
Income & Expenses

	JUNE 2024	FISCAL YTD
REVENUE	$ 252.9 M	$ 2.4 B
MEDICAL EXPENSE	$ (168.5) M	$ (1.7) B
ADMIN EXPENSE	$ (9.5) M	$ (97.7) M
OTHER/TAX	$ (111.7) M	$ (584.8) M
NET INCOME	$ (36.7) M	$ (44.7) M

Medical Loss % (Fiscal YTD)

98.7%

Medical Expenses



Liquid Reserves

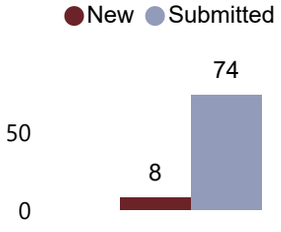
TNE %

447.5%

TNE $

$279.2M

Reinsurance Cases



Balance Sheet

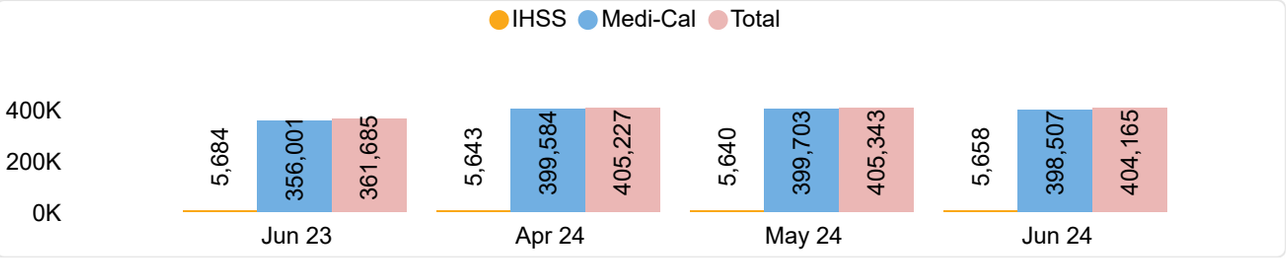
Cash Equivalents	$640.3M
Pass-Through Liabilities	$357.5M
Uncommitted Cash	$282.9M
Working Capital	$236.5M

Current Ratio

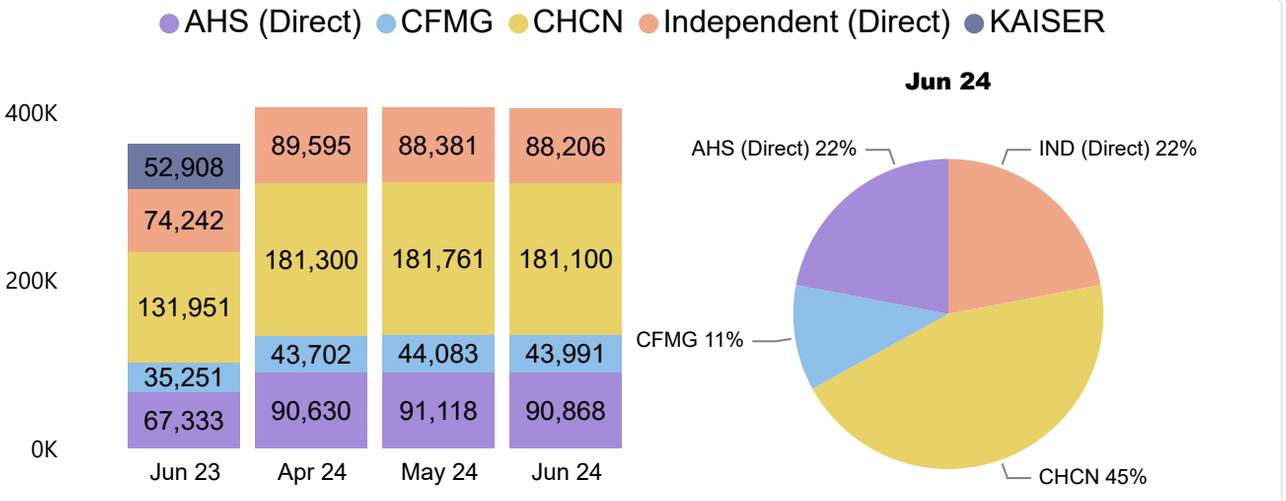
1.30

Membership

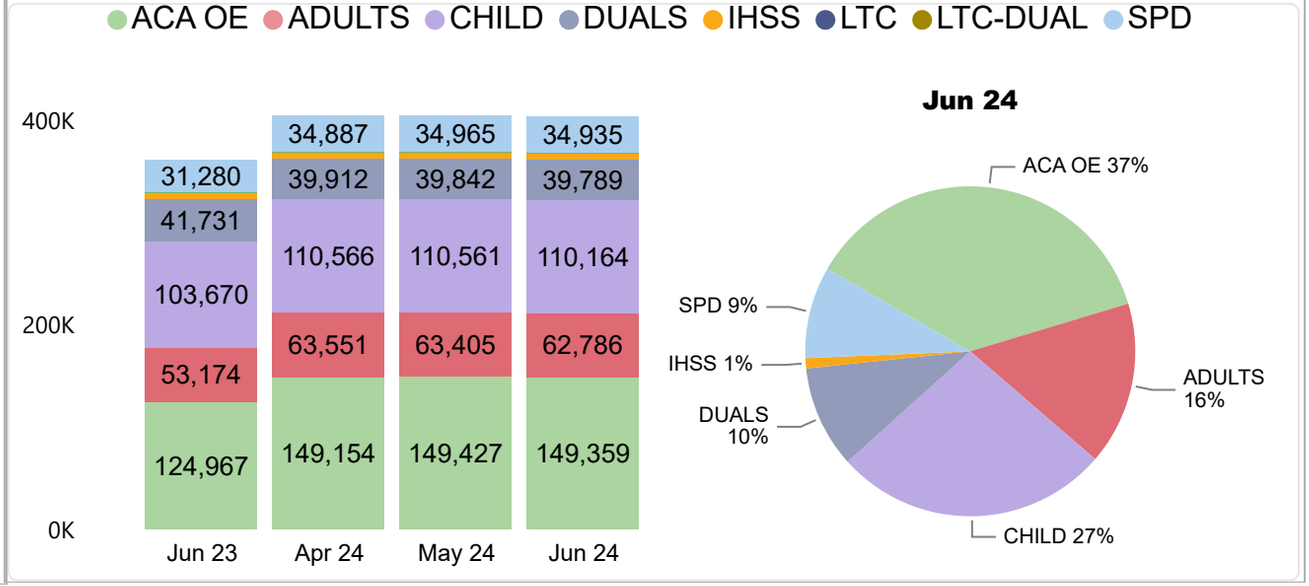
By Plan



By Network



By Category



OPERATIONS DASHBOARD

AUGUST 2024

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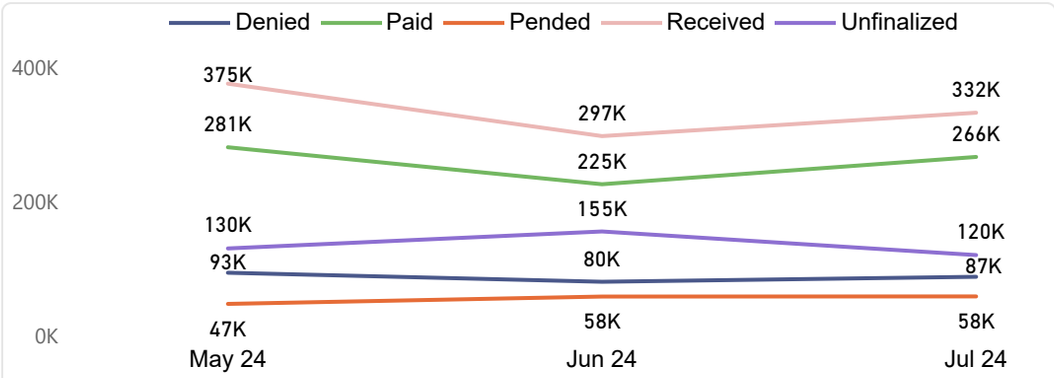
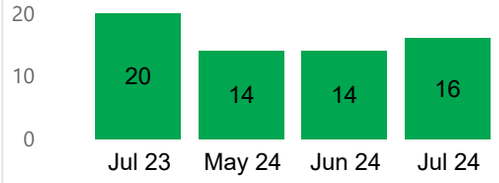
Claims

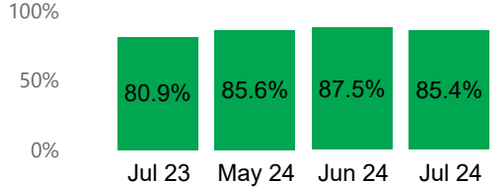
Claims Processing



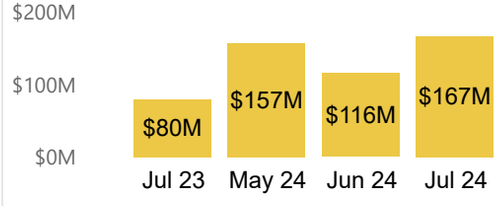
Average Payment TAT (Days)



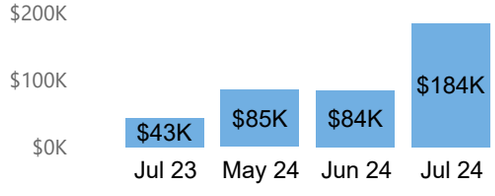
Auto Adjudication Rate (%)



Claims Paid ($)

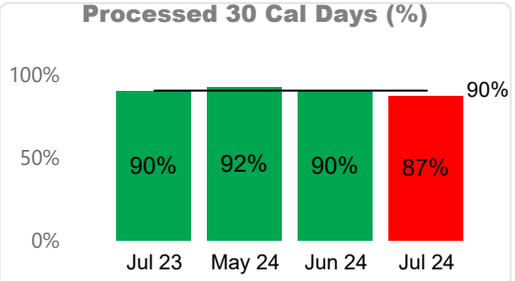


Interest Paid ($)

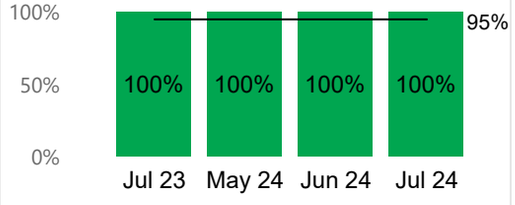


Claims Compliance

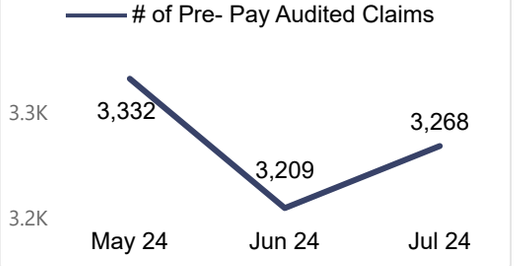
Processed 30 Cal Days (%)



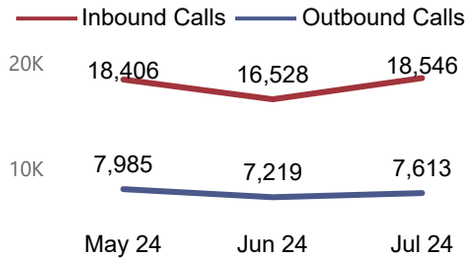
Processed 45 Work Days (%)



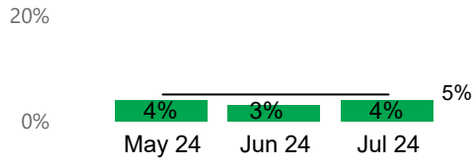
Claims Auditing



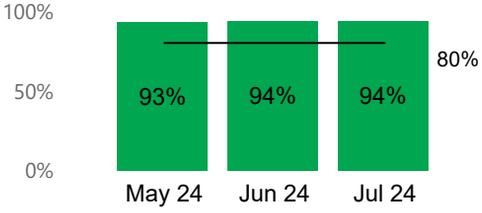
Member Services



Abandoned Call Rate (%)

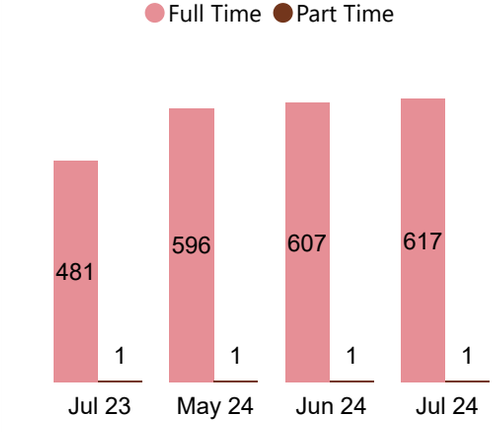


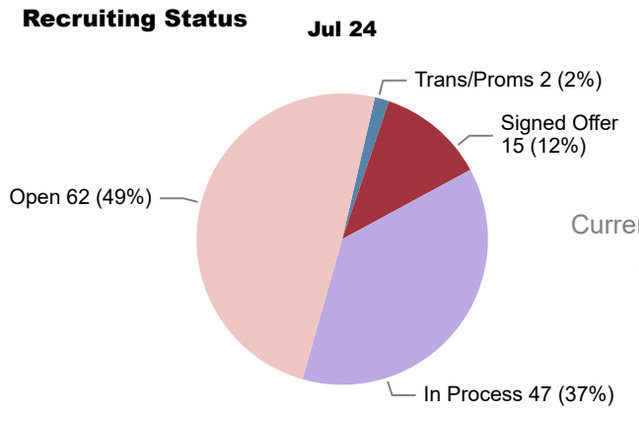
Calls Answered in 30 Seconds (%)



Average Call Times	May 24	Jun 24	Jul 24
Wait Time	00:19	00:15	00:14
Call Duration	06:48	06:55	06:58

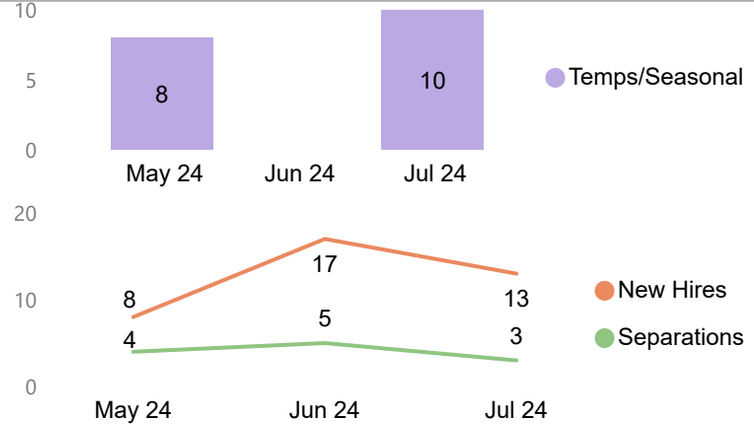
Human Resources





Current Vacancy

9%



Provider Services

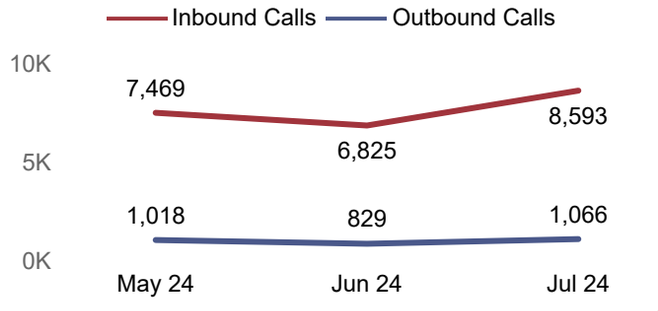
Provider Network

Hospital	17
Specialist	10,104
Primary Care Physician	762
Skilled Nursing Facility	106
Urgent Care	15
Health Centers (FQHCs and Non-FQHCs)	69
TOTAL	**11,073**

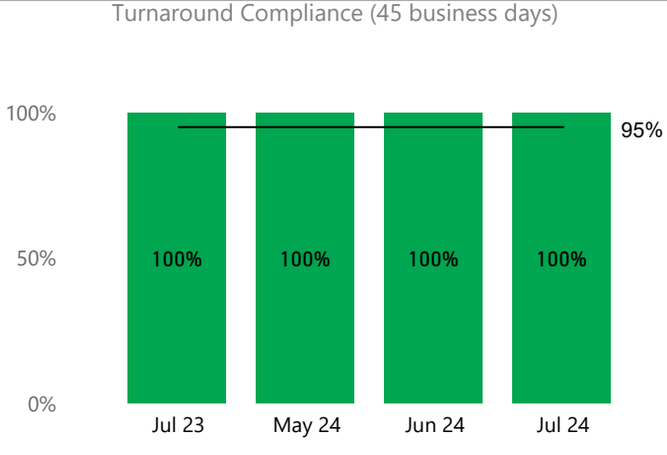
Provider Credentialing

3,699

Provider Call Center

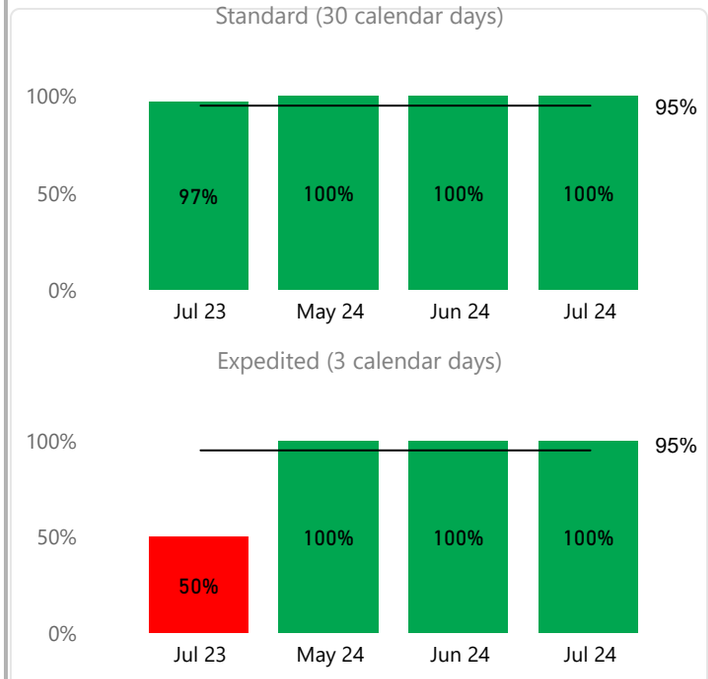


Provider Disputes & Resolutions

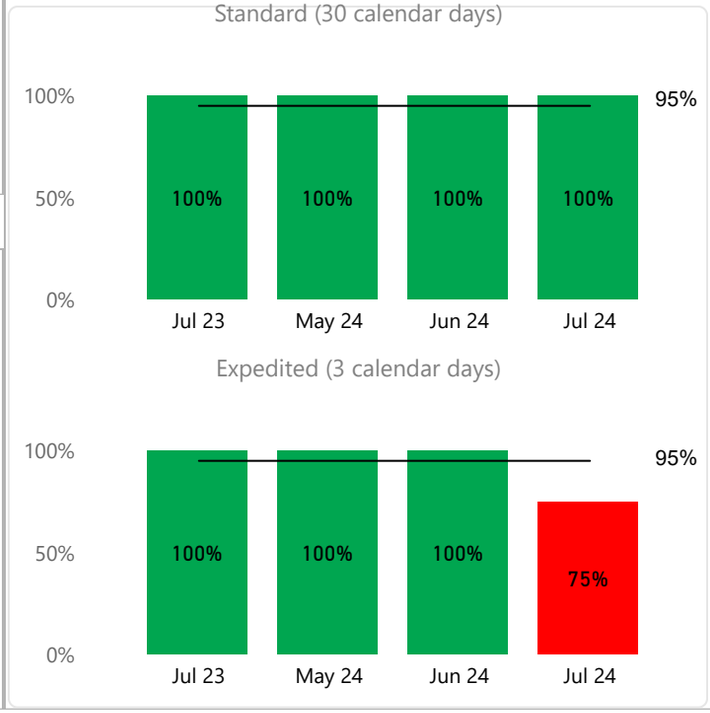


Compliance

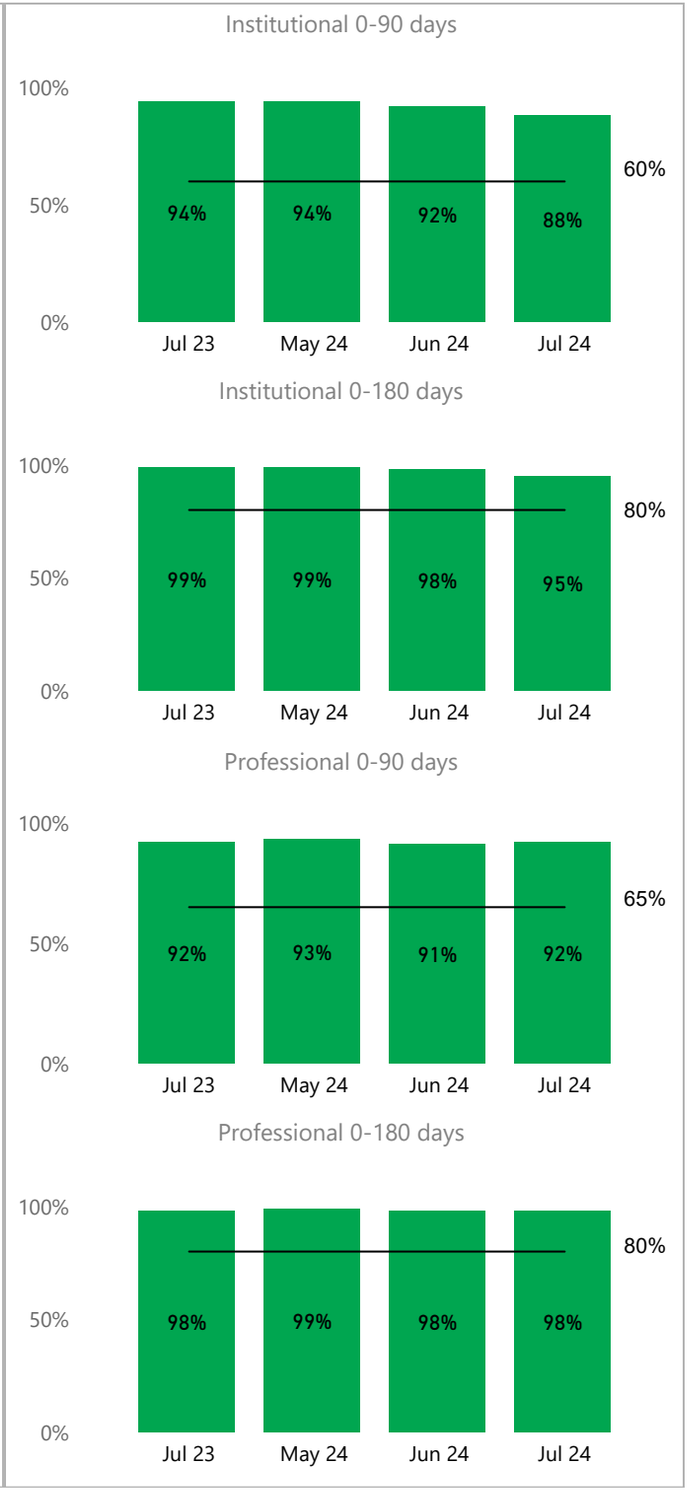
Member Grievances



Member Appeals



Encounter Data



OPERATIONS DASHBOARD

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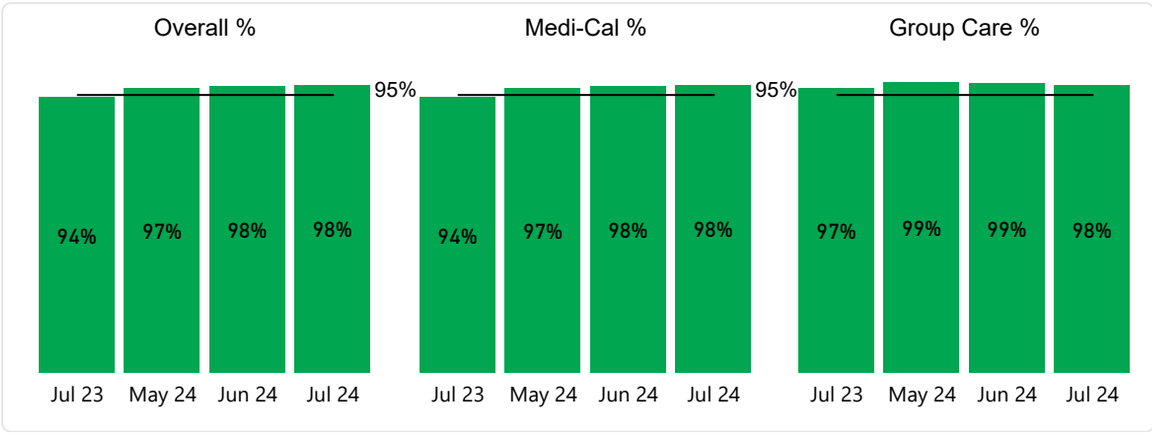
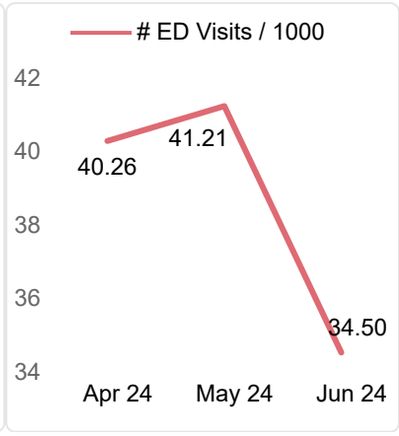
Health Care Services

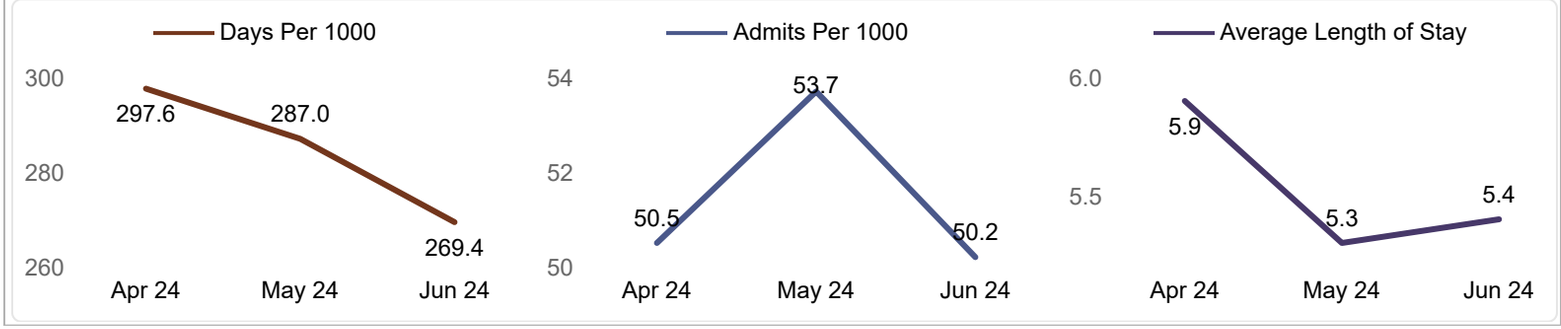
Authorization Turnaround



ED Utilization

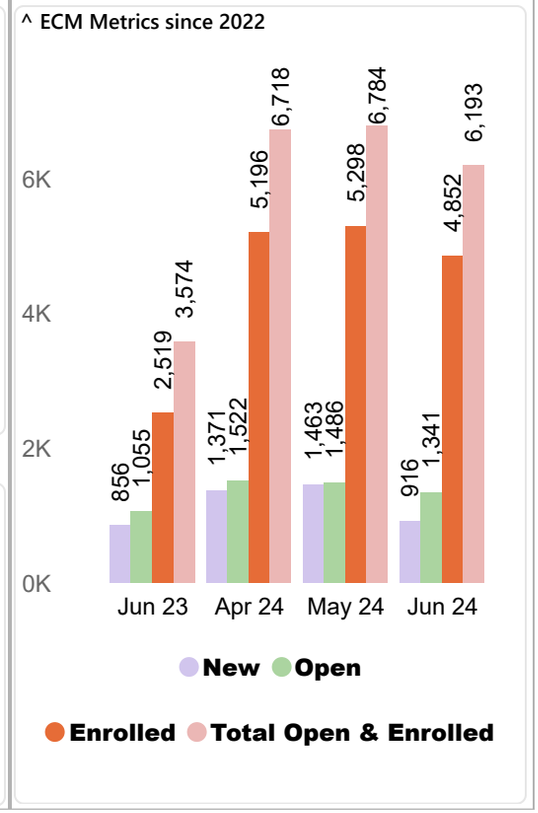


Inpatient Utilization

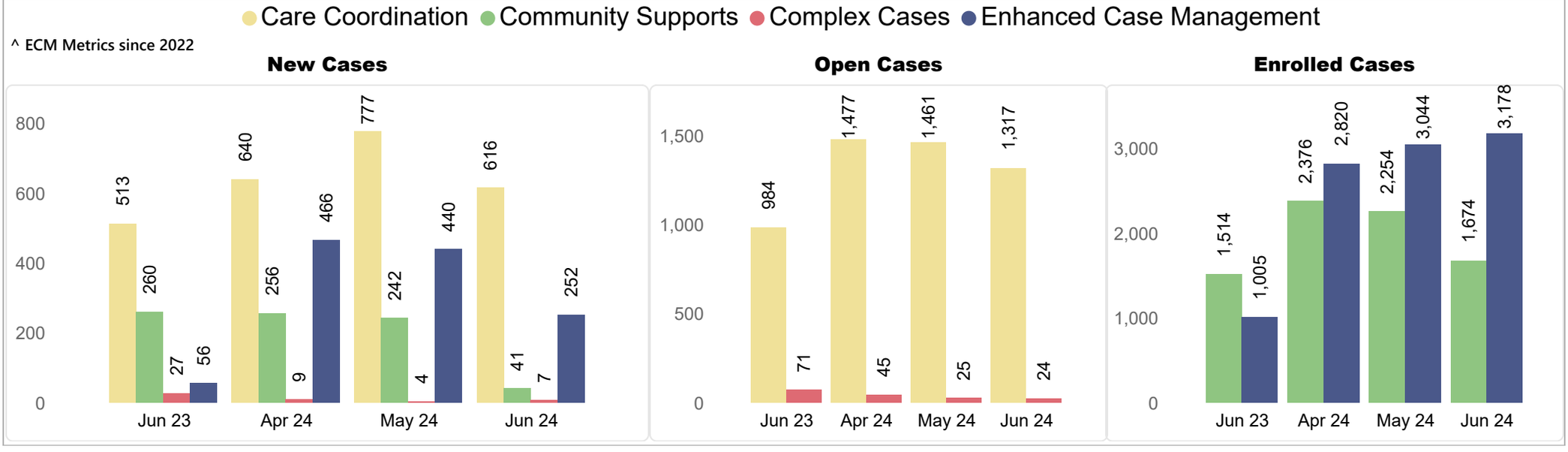


Case Management

Total Cases^



Case Management^



Technology (Business Availability)

Applications	Jul 23	May 24	Jun 24	Jul 24
HEALTHsuite System	98.0%	100.0%	100.0%	99.6%
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	Jul 23	May 24	Jun 24	Jul 24
Denial Rate Excluding Partial Denials (%)	3.6%	2.9%	2.3%	2.1%
Overall Denial Rate (%)	3.9%	3.1%	2.6%	2.2%
Partial Denial Rate (%)	0.3%	0.2%	0.2%	0.1%

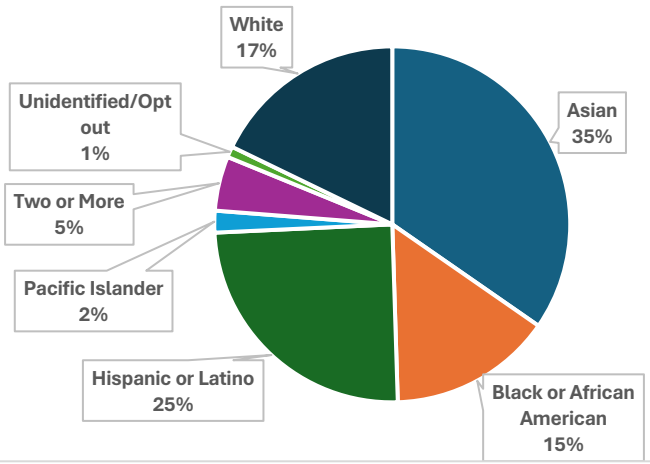
*** IHSS and Medi-Cal Line Of Business**

Pharmacy Authorizations

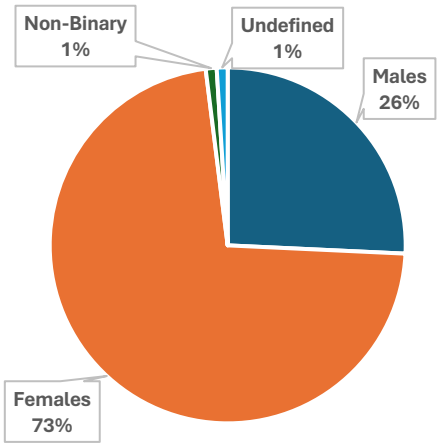
Authorizations	Jul 23	May 24	Jun 24	Jul 24
Approved Prior Authorizations	22	39	36	43
Closed Prior Authorizations	100	92	95	89
Denied Prior Authorizations	25	48	55	51
Total Prior Authorizations	147	179	186	183

AAH Employee Demographics Data Report June 2024

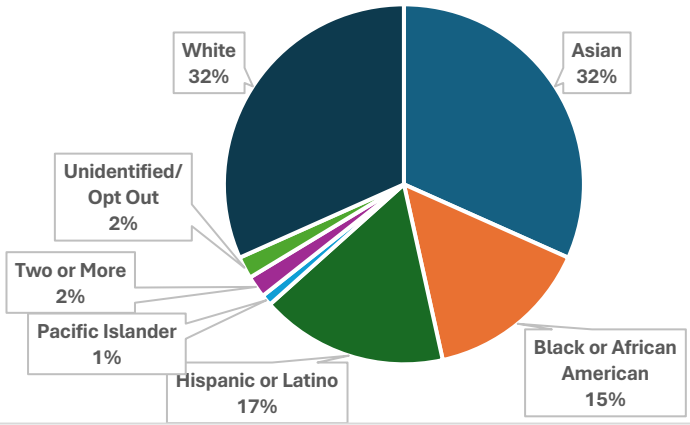
Employee Ethnicity - 608
June 2024



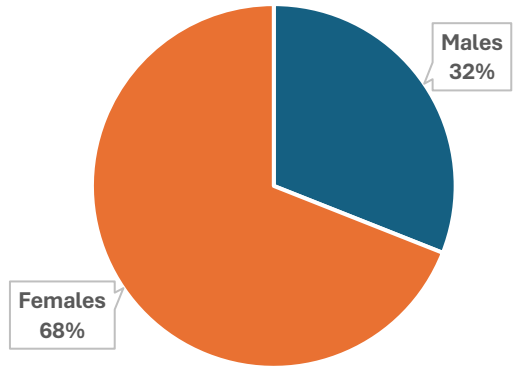
Employee Gender - 608
June 2024

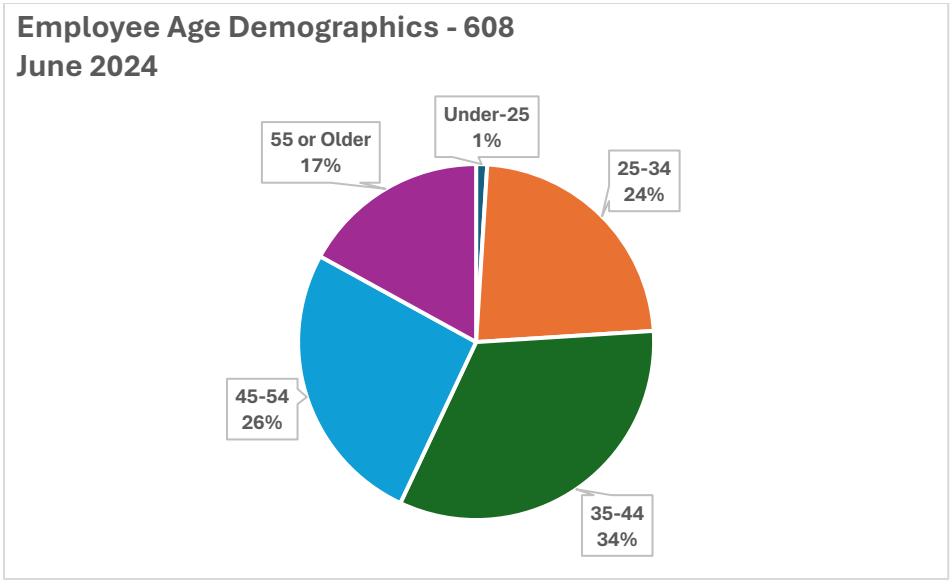


Managers Ethnicity - 121
June 2024



Managers Gender - 121
June 2024




Employee Age Demographics - 608
June 2024
Under-25
1%
25-34
24%
35-44
34%
45-54
26%
55 or Older
17%

Finance

Gil Riojas

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

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

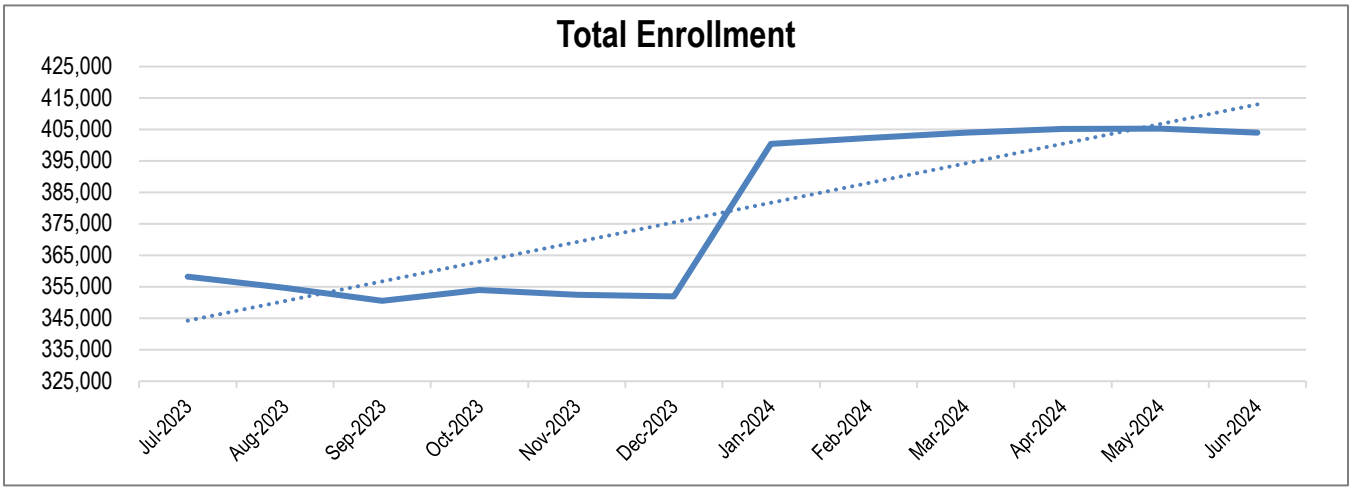
Date: **August 9th, 2024**

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

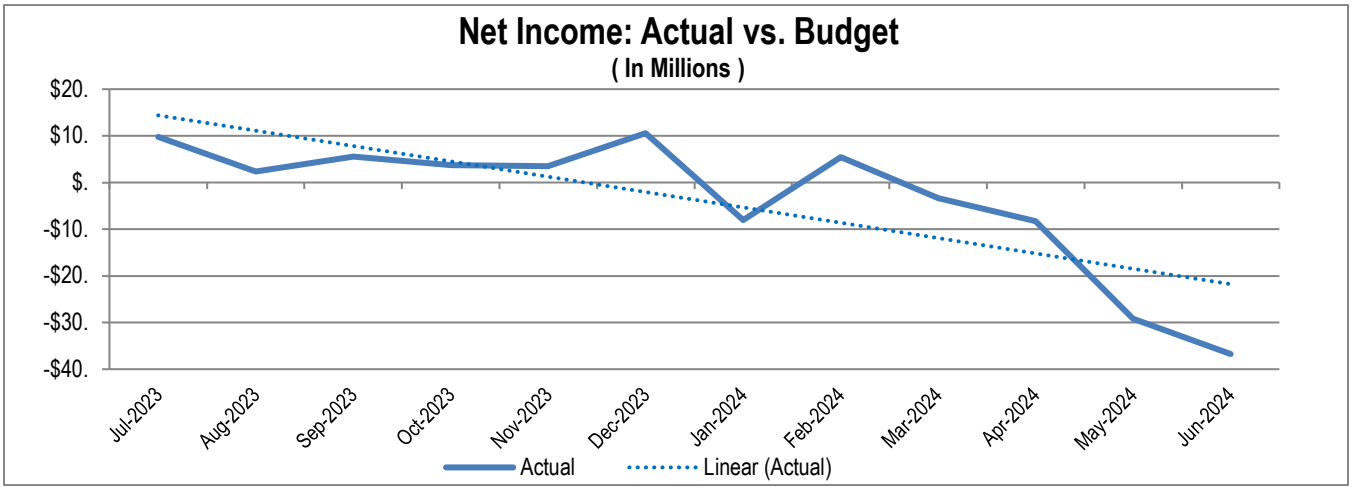
Executive Summary

For the month ended June 30th, 2024, the Alliance experienced a decrease in enrollment, ending our fiscal year at 404K members. A Net Loss of $36.7 million was reported in June. The Plan's Medical Expenses represented 121.9% of revenue. Alliance reserves decreased to 448% of required but remain above minimum requirements.

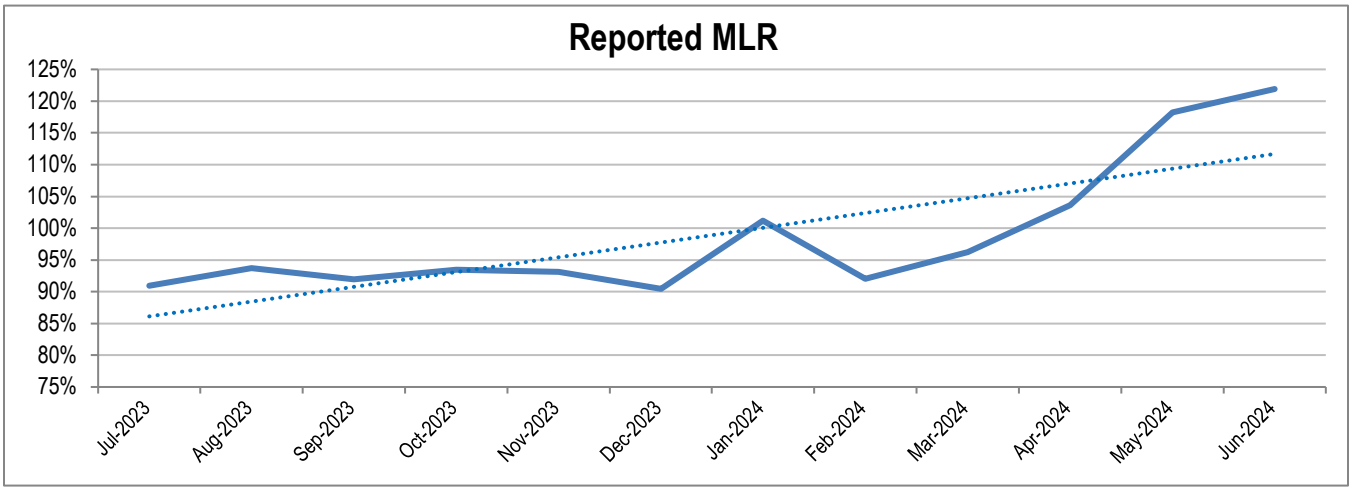
Enrollment – In June, Enrollment decreased by 1,289 members. In all, our enrollment increased by 42,305 during the 2023-2024 Fiscal Year.



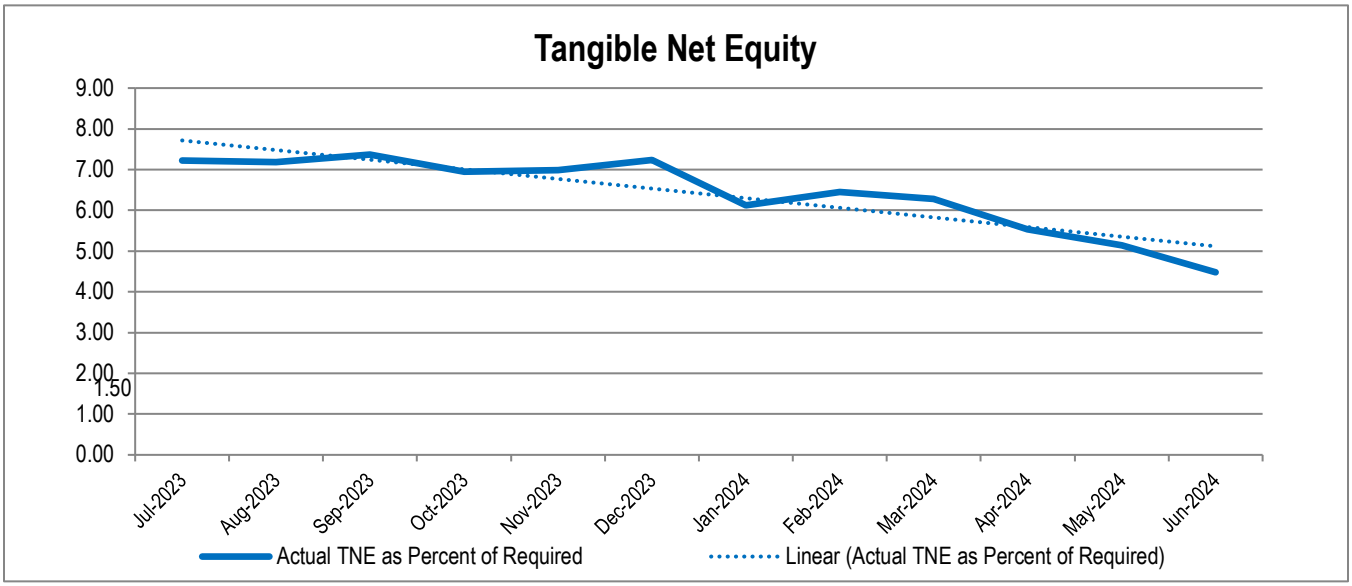
Net Income – For the month ended June 30th, 2024, actual Net Loss was $36.7 million vs. budgeted Net Loss of $1.8 million. Fiscal year-to-date actual Net Loss was $44.7 million vs. Budgeted Net Income of $9.3 million. For the month, Premium Revenue was unfavorable to budget, actual Revenue was $138.2 million vs. budgeted Revenue of $157.2 million. For our Fiscal Year, the plan was on budget at $1.8 billion in Revenue.



Medical Loss Ratio (MLR) – The Medical Loss Ratio was 121.9% for the month and 98.7% for the fiscal year-to-date. Revenue reductions related to the CY23 acuity adjustment significantly impacted revenue and consequently the MLR, which compares revenue to medical expenses.



Tangible Net Equity (TNE) - The Department of Managed Health Care (DMHC) required $62.4M in reserves, we reported $279.2M. Our overall TNE remains healthy at 448%.



The Alliance continues to benefit from increased non-operating income. For Fiscal year-to-date, we reported returns of $31.7M, in the investment portfolio, and paid $865,000 in claims interest expense.

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

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

Date: **August 9th, 2024**

Subject: **Finance Report – June 2024 (Pre-Audit)**

Executive Summary

- For the month ended June 30th, 2024, the Alliance had enrollment of 403,990 members, a Net Loss of $36.7 million and 448% of required Tangible Net Equity (TNE).

Overall Results: (in Thousands)

	Month	YTD
Revenue	$252,933	$2,365,626
Medical Expense	168,453	1,727,918
Admin. Expense	9,500	97,655
MCO Tax Expense	114,755	615,599
Other Inc. / (Exp.)	3,025	30,828
Net Income	**($36,750)**	**($44,718)**

Net Income by Program: (in Thousands)

	Month	YTD
Medi-Cal*	($36,280)	($46,690)
Group Care	(470)	1,972
	($36,750)	**($44,718)**

*Includes costs for Medicare implementation.

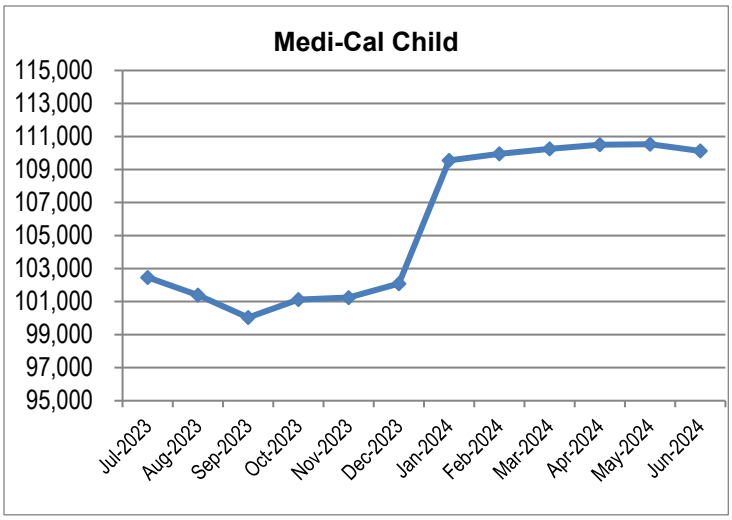
Enrollment

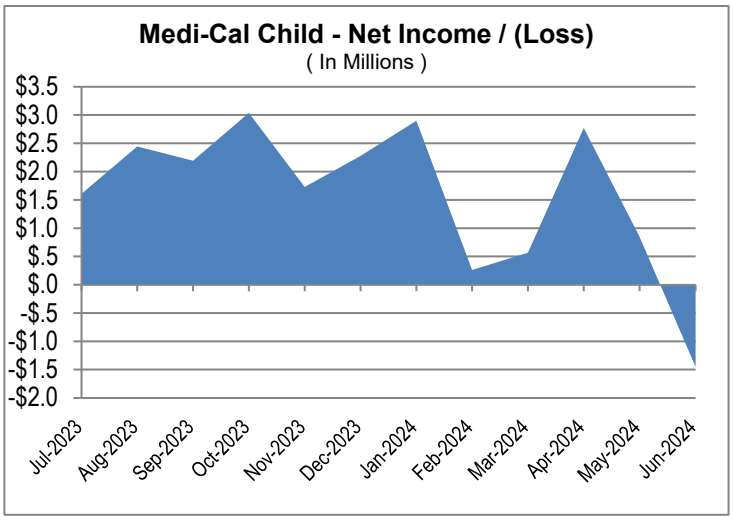
- Total enrollment decreased by 1,289 members since May 2024.
- Total enrollment increased by 42,305 members since June 2023.

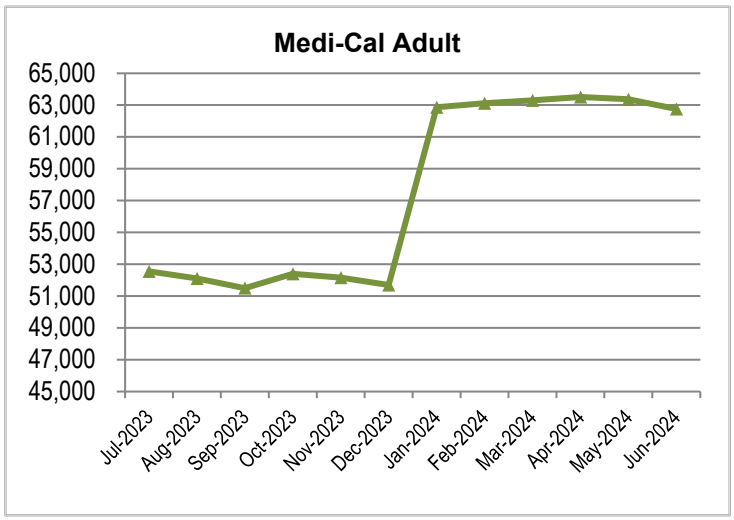
Monthly Membership and YTD Member Months
Actual vs. Budget
For the Month and Fiscal Year-to-Date

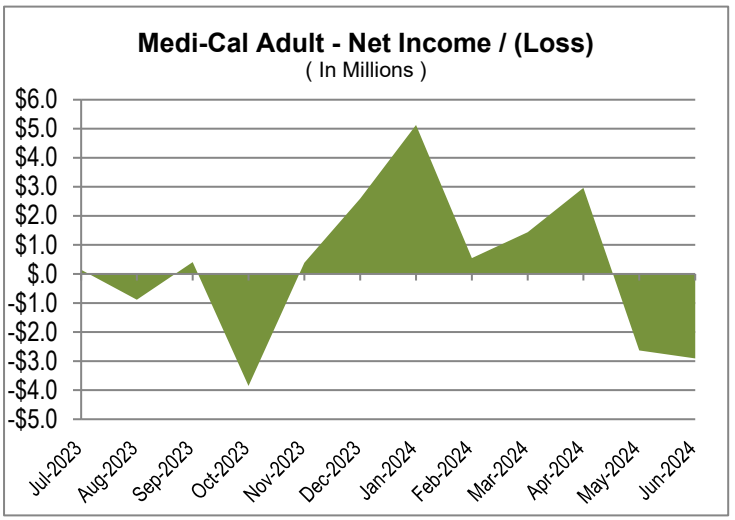
Enrollment					Member Months			
Current Month					Year-to-Date			
Actual	Budget	Variance	Variance %		Actual	Budget	Variance	Variance %
				Medi-Cal:				
62,746	54,112	8,634	16.0%	Adult	691,282	646,408	44,874	6.9%
110,124	96,565	13,559	14.0%	Child	1,269,266	1,199,975	69,291	5.8%
34,920	40,801	(5,881)	-14.4%	SPD	394,719	434,392	(39,673)	-9.1%
39,748	45,318	(5,570)	-12.3%	Duals	488,782	522,580	(33,798)	-6.5%
149,324	141,170	8,154	5.8%	ACA OE	1,615,790	1,598,681	17,109	1.1%
222	177	45	25.4%	LTC	2,143	1,873	270	14.4%
1,248	1,108	140	12.6%	LTC Duals	13,748	12,913	835	6.5%
398,332	**379,251**	**19,081**	**5.0%**	**Medi-Cal Total**	**4,475,730**	**4,416,822**	**58,908**	**1.3%**
5,658	5,493	165	3.0%	Group Care	67,529	66,886	643	1.0%
403,990	**384,744**	**19,246**	**5.0%**	**Total**	**4,543,259**	**4,483,708**	**59,551**	**1.3%**

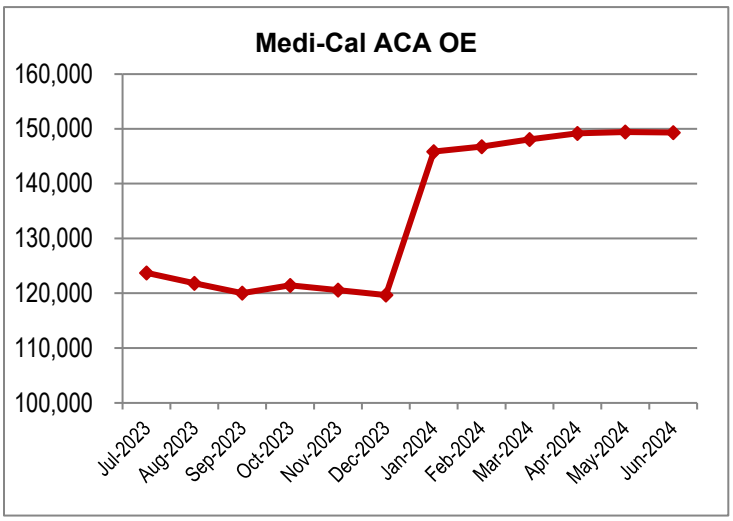
Enrollment and Profitability by Program and Category of Aid

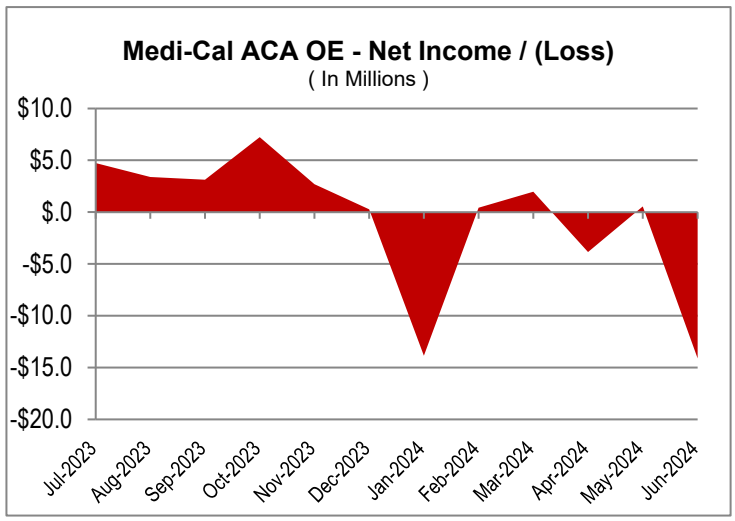




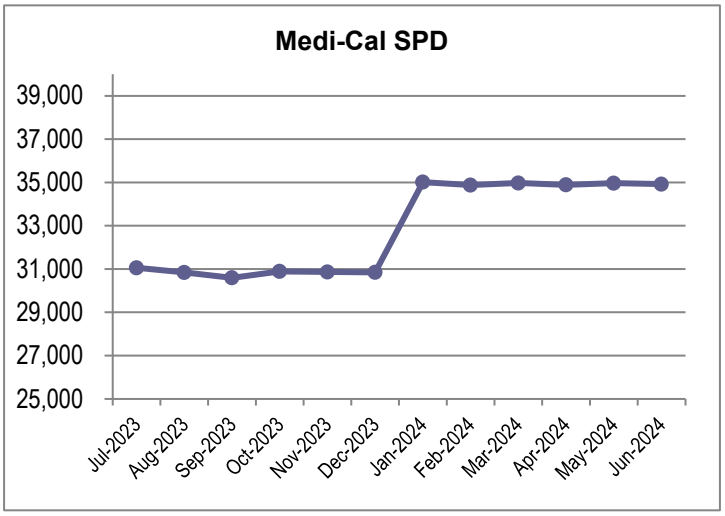


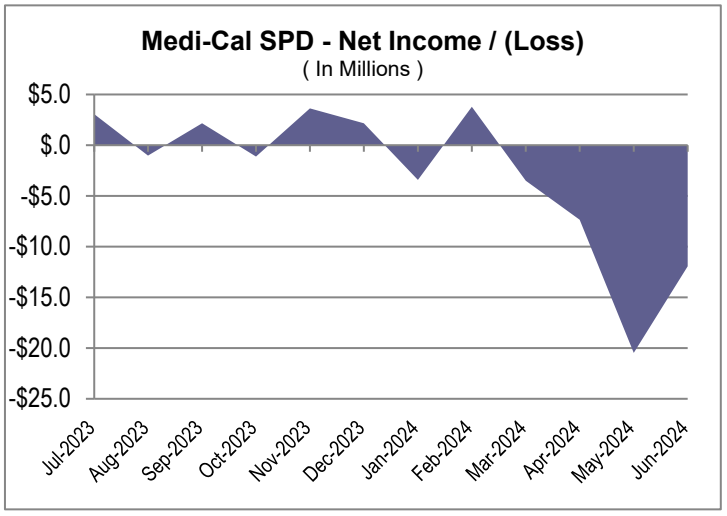


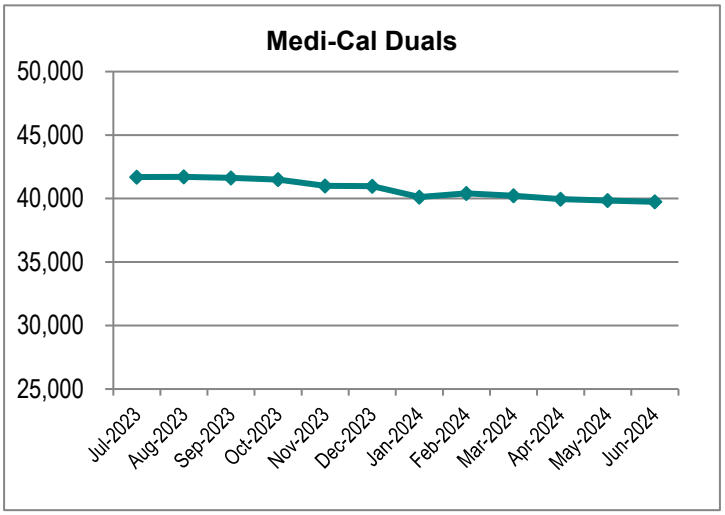


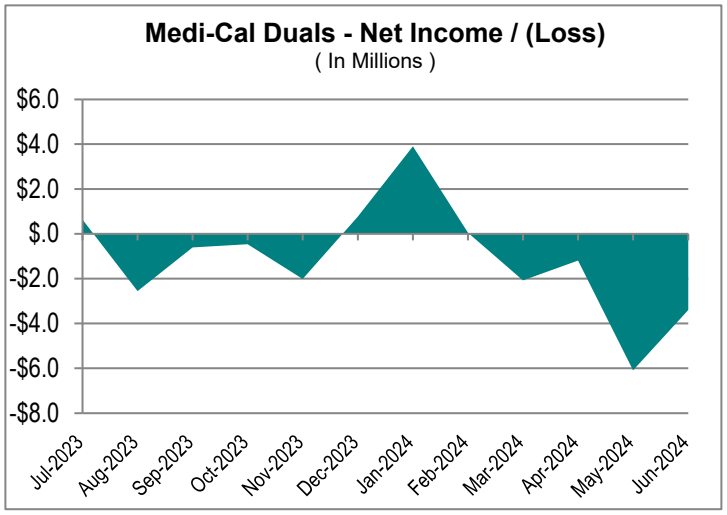


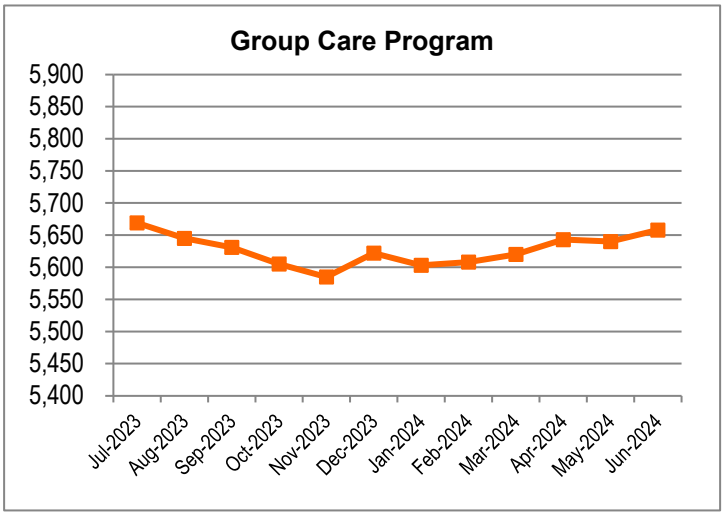
Enrollment and Profitability by Program and Category of Aid

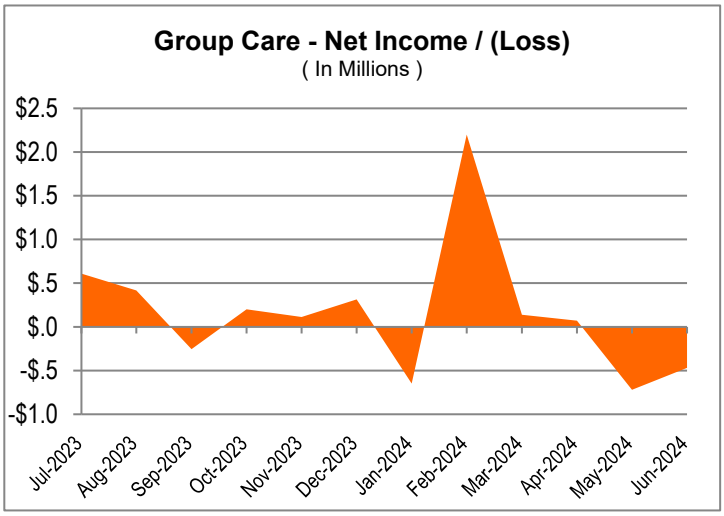




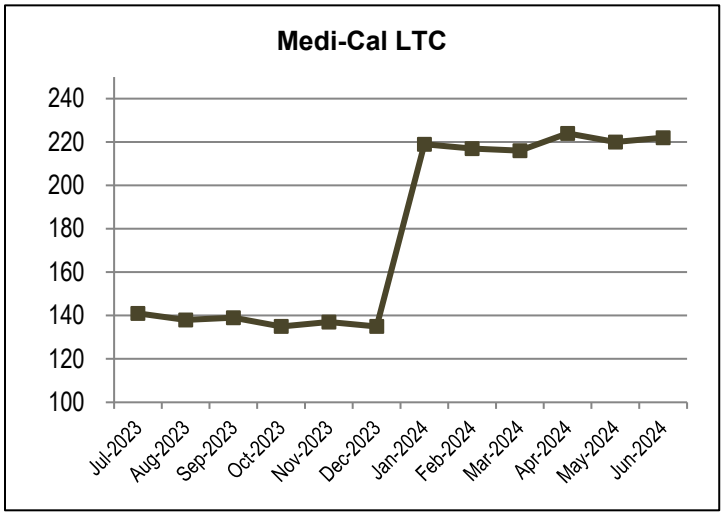


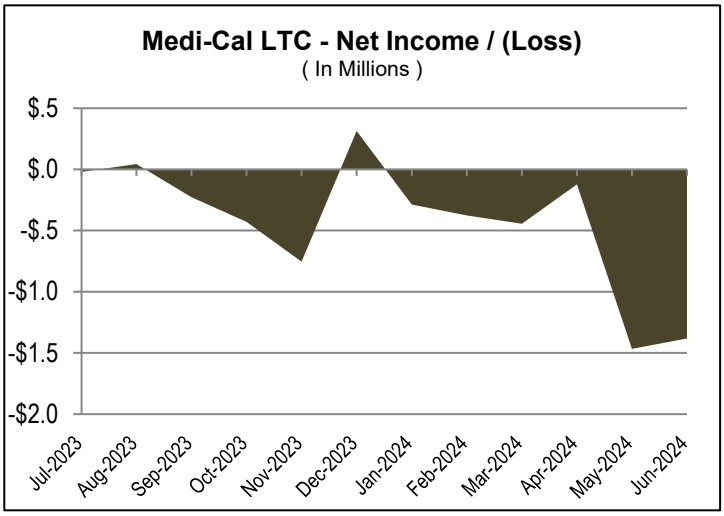


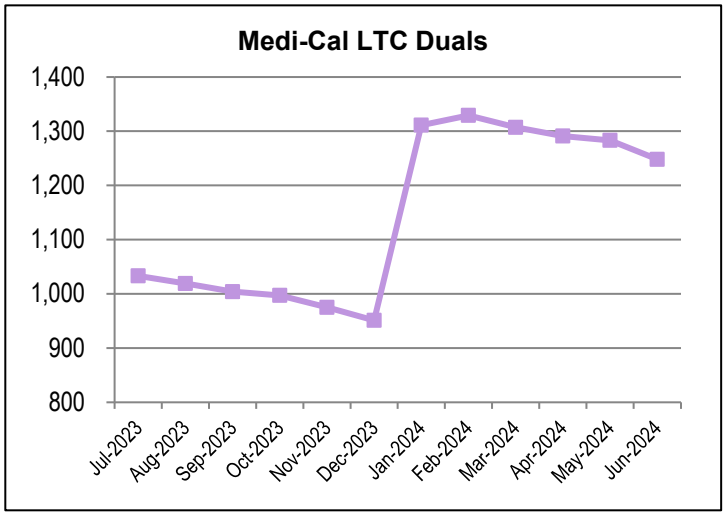


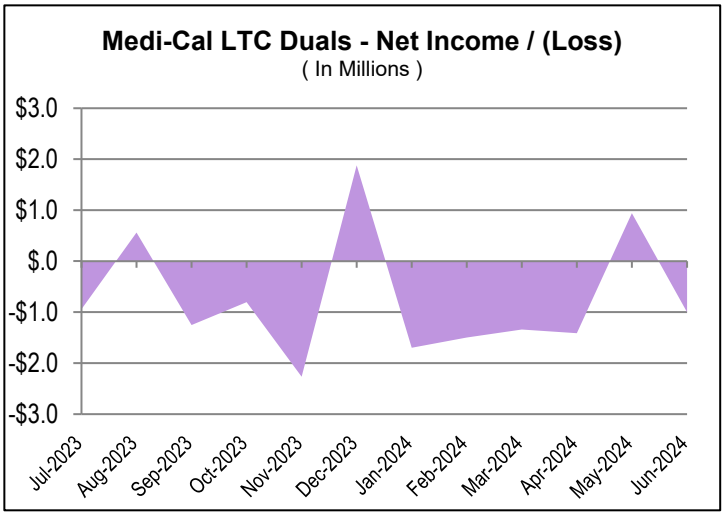


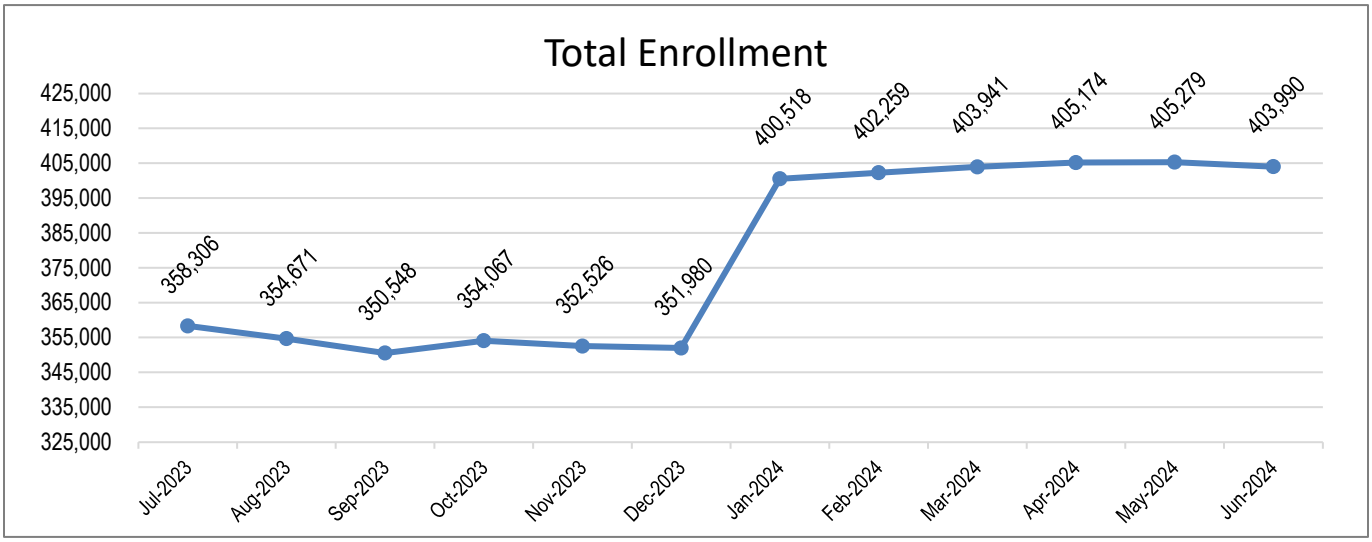
Enrollment and Profitability by Program and Category of Aid

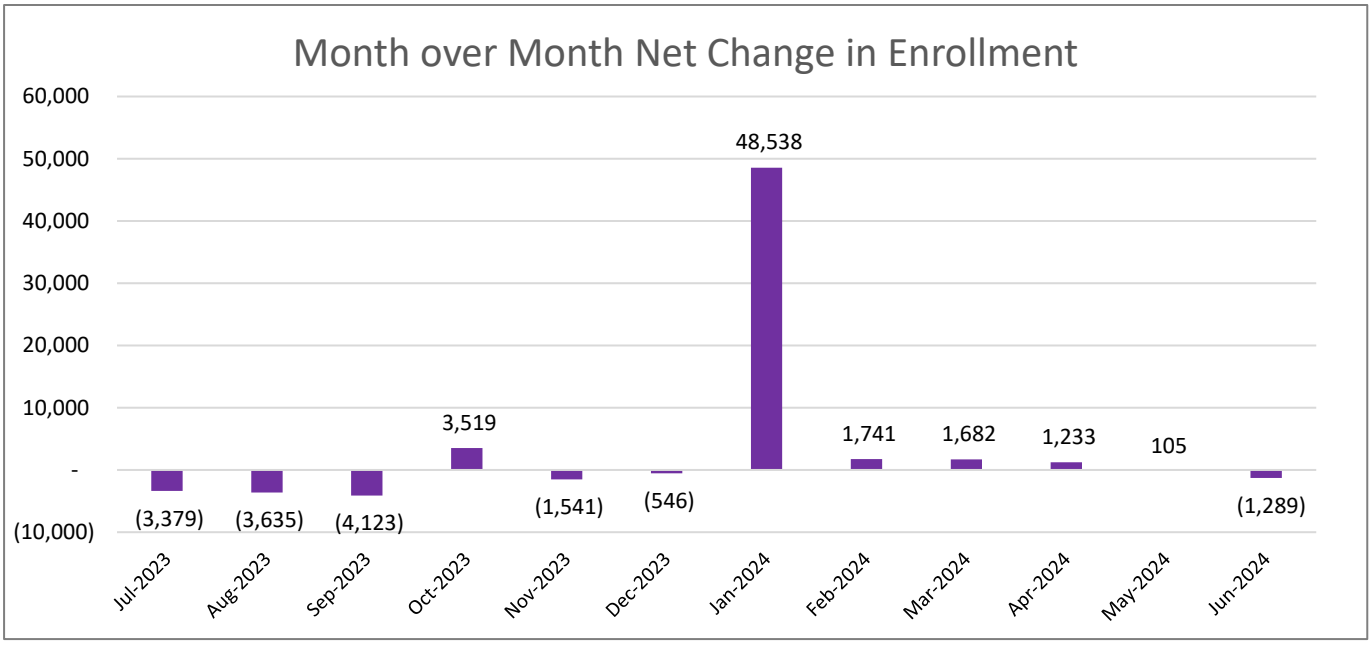








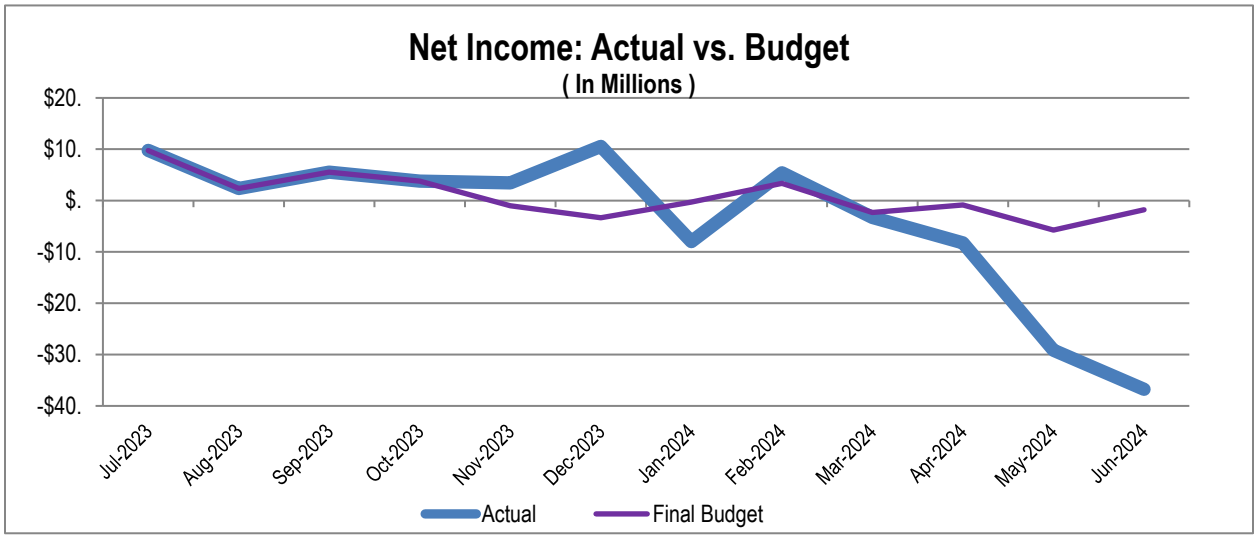




- The Public Health Emergency (PHE) ended May 2023. Disenrollments related to redetermination started July 2023 and ended May 2024. In preparation for the Single Plan Model, effective October 2023 DHCS no longer assigned members to Anthem, and instead new members were assigned to the Alliance.
- In January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

Net Income

- For the month ended June 30th, 2024:
  - Actual Net Loss $36.7 million.
  - Budgeted Net Loss $1.8 million.

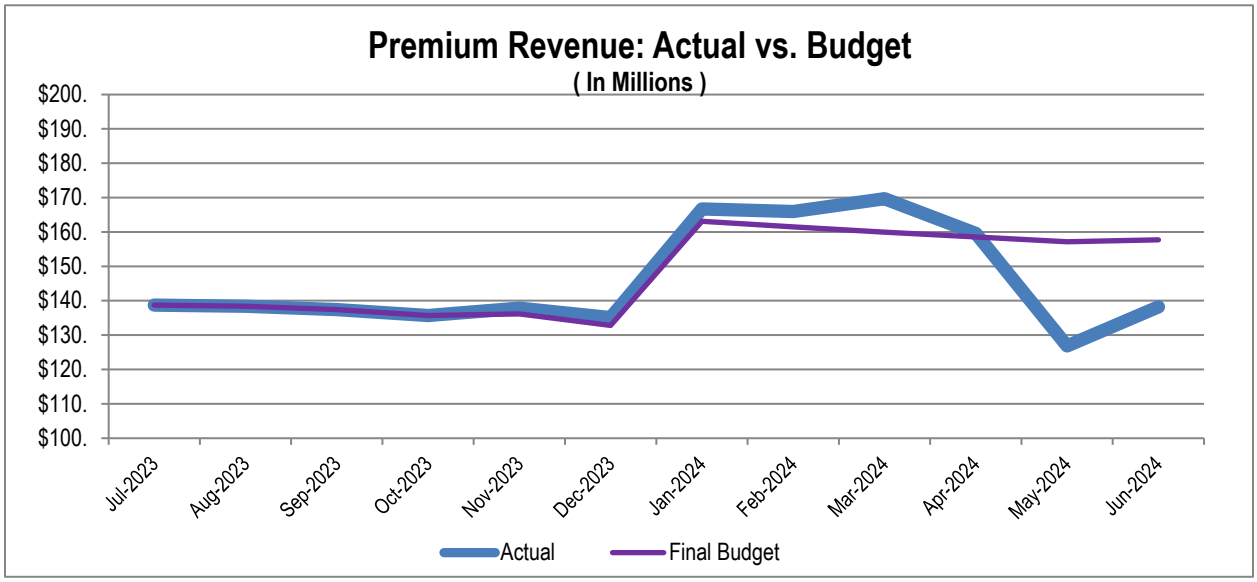


- For the fiscal YTD ended June 30th, 2024:
  - Actual Net Loss $44.7 million.
  - Budgeted Net Income $9.3 million.
- The unfavorable variance of $34.9 million in the current month is primarily due to:
  - Unfavorable $19.5 million lower than anticipated Premium Revenue.
  - Unfavorable $16.2 million higher than anticipated Medical Expense.

Premium Revenue

- For the month ended June 30th, 2024:
  - Actual Revenue: $138.2 million.
  - Budgeted Revenue: $157.7 million.

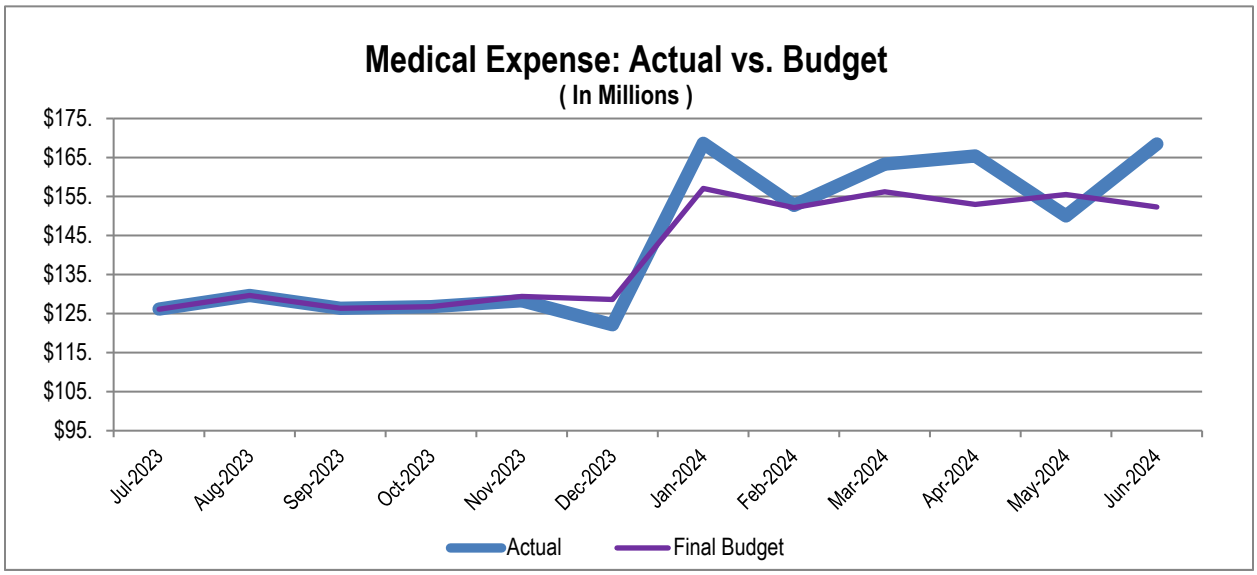
- For the fiscal YTD ended June 30th, 2024:
  - Actual Revenue: $1.8 billion
  - Budgeted Revenue: $1.8 billion.



- For the month ended June 30th, 2024, the unfavorable Premium Revenue variance of $19.5 million is primarily due to the following:
  - Unfavorable Medi-Cal Rate Acuity adjustment for CY2023 with greatly lower rates than anticipated.
  - Unfavorable accrual for the estimated 2023 Major Organ Transplant risk corridor payback to DHCS.
  - Medi-Cal Rate Acuity adjustment for CY2024
  - Favorable Medi-Cal Capitation Rate variance. Rates were not available at the time of budget and the magnitude of upcoming Targeted Rate Increase (TRI) revenue and expense was unknown and therefore not budgeted.
  - Favorable adjustment of historical Medical Loss Ratio (MLR) reserve.
  - Favorable retroactive Capitation payments for CY2022 Kaiser Contract.

Medical Expense

- For the month ended June 30th, 2024:
  - Actual Medical Expense: $168.5 million.
  - Budgeted Medical Expense: $152.3 million.
- For the fiscal YTD ended June 30th, 2024:
  - Actual Medical Expense: $1.7 billion.
  - Budgeted Medical Expense: $1.7 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 June, updates to Fee-For-Service (FFS) increased the estimate for prior period unpaid Medical Expenses by $5.9 million. Year to date, the estimate for prior years increased by $10.5 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	$266,148,714	$0	$266,148,714	$251,048,563	($15,100,151)	-6.0%
Primary Care FFS	$57,657,217	$29,291	$57,686,508	$73,334,806	$15,677,589	21.4%
Specialty Care FFS	$73,321,194	$111,224	$73,432,418	$76,995,468	$3,674,274	4.8%
Outpatient FFS	$111,819,436	$424,914	$112,244,351	$121,862,351	$10,042,915	8.2%
Ancillary FFS	$158,786,303	$1,173,171	$159,959,474	$150,178,558	($8,607,745)	-5.7%
Pharmacy FFS	$115,091,207	$508,144	$115,599,352	$125,550,416	$10,459,209	8.3%
ER Services FFS	$92,140,394	$17,479	$92,157,874	$80,304,222	($11,836,172)	-14.7%
Inpatient Hospital & SNF FFS	$481,912,414	$4,327,381	$486,239,794	$489,017,992	$7,105,578	1.5%
Long Term Care FFS	$308,081,192	$3,939,397	$312,020,589	$257,634,255	($50,446,937)	-19.6%
Other Benefits & Services	$51,030,763	$0	$51,030,763	$61,271,381	$10,240,618	16.7%
Net Reinsurance	($1,602,160)	$0	($1,602,160)	$3,027,462	$4,629,622	152.9%
Provider Incentive	$3,000,000	$0	$3,000,000	$3,000,000	$0	0.0%
	$1,717,386,673	**$10,531,002**	**$1,727,917,675**	**$1,693,225,473**	**($24,161,201)**	**-1.4%**

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	$58.58	$0.00	$58.58	$55.99	($2.59)	-4.6%
Primary Care FFS	$12.69	$0.01	$12.70	$16.36	$3.67	22.4%
Specialty Care FFS	$16.14	$0.02	$16.16	$17.17	$1.03	6.0%
Outpatient FFS	$24.61	$0.09	$24.71	$27.18	$2.57	9.4%
Ancillary FFS	$34.95	$0.26	$35.21	$33.49	($1.46)	-4.3%
Pharmacy FFS	$25.33	$0.11	$25.44	$28.00	$2.67	9.5%
ER Services FFS	$20.28	$0.00	$20.28	$17.91	($2.37)	-13.2%
Inpatient Hospital & SNF FFS	$106.07	$0.95	$107.02	$109.07	$2.99	2.7%
Long Term Care FFS	$67.81	$0.87	$68.68	$57.46	($10.35)	-18.0%
Other Benefits & Services	$11.23	$0.00	$11.23	$13.67	$2.43	17.8%
Net Reinsurance	($0.35)	$0.00	($0.35)	$0.68	$1.03	152.2%
Provider Incentive	$0.66	$0.00	$0.66	$0.67	$0.01	1.3%
	$378.01	**$2.32**	**$380.33**	**$377.64**	**($0.37)**	**-0.1%**

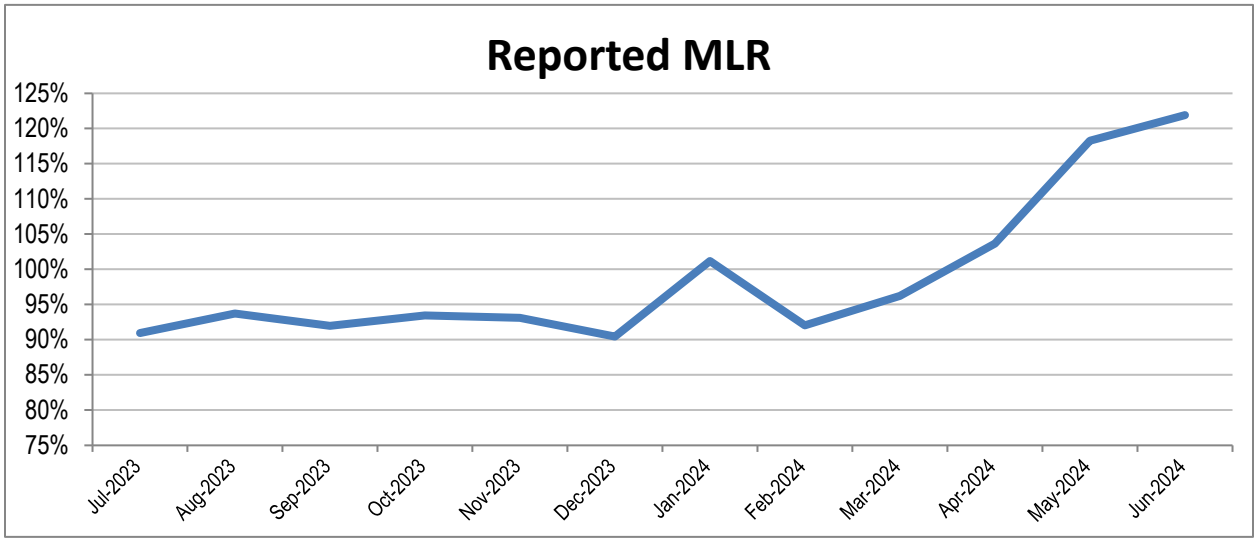
- Excluding the impact of prior year estimates for IBNP, year-to-date medical expense variance is $24.2 million unfavorable to budget. On a PMPM basis, medical expense is -0.1% unfavorable to budget. For per-member-per-month expense:
    - Capitated Expense is slightly over budget, largely driven by unfavorable PCP Capitation expense due to inception of Provider Targeted Rate

Increases (TRI), partially offset by favorable FQHC expense and favorable Global subcontract expense related to prior fiscal year rate adjustment.

- Primary Care Expense is under budget driven by the low utilization in the ACA OE, SPD, Adult and Child aid code categories and a surplus of Prop 56 revenue.
- Specialty Care Expense is below budget, driven mostly by less than expected SPD and Dual aid code category utilization.
- Outpatient Expense is under budget due to lower than expected lab and radiology utilization and facility other unit cost in all populations except for Child and LTC populations.
- Ancillary Expense is over budget mostly due to higher than expected utilization in all populations except for the Child category of aid.
- Pharmacy Expense is under budget due to low Non-PBM expense driven by lower utilization in the ACA OE, SPD, Adult and Dual aid code categories.
- Emergency Room Expense is over budget driven by high utilization in all populations except for LTC-Duals and Group Care.
- Inpatient Expense is over budget driven by high utilization and unit cost in the ACA OE aid code category.
- Long Term Care Expense is over budget due to high utilization and unit cost in the SPD, ACA OE and Duals categories of aid.
- Other Benefits & Services is under budget, due to lower than expected Community Relations, Other Purchased Professional Services, and CalAIM Incentive expense partially offset by higher HHIP and Other Employee Expense.
- Net Reinsurance year-to-date is under budget because more recoveries were received than expected.

Medical Loss Ratio (MLR)

The Medical Loss Ratio (total reported medical expense divided by Premium revenue) was 121.9% for the month and 98.7% for the fiscal year-to-date.



Administrative Expense

- For the month ended June 30th, 2024:
  - Actual Administrative Expense: $9.5 million.
  - Budgeted Administrative Expense: $9.7 million.

- For the fiscal YTD ended June 30th, 2024:
  - Actual Administrative Expense: $97.7 million.
  - Budgeted Administrative Expense: $104.2 million.

Summary of Administrative Expense (In Dollars)
For the Month and Fiscal Year-to-Date
Favorable/(Unfavorable)

Current Month					Year-to-Date			
Actual	Budget	Variance $	Variance %		Actual	Budget	Variance $	Variance %
$4,422,056	$5,863,602	$1,441,546	24.6%	Employee Expense	$60,138,340	$66,271,689	$6,133,349	9.3%
75,167	71,455	(3,712)	-5.2%	Medical Benefits Admin Expense	2,001,755	1,612,583	(389,172)	-24.1%
1,307,911	1,075,118	(232,793)	-21.7%	Purchased & Professional Services	15,213,956	12,372,079	(2,841,877)	-23.0%
3,694,618	2,668,963	(1,025,655)	-38.4%	Other Admin Expense	20,301,157	23,973,926	3,672,769	15.3%
$9,499,752	$9,679,138	$179,387	1.9%	Total Administrative Expense	$97,655,208	$104,230,277	$6,575,069	6.3%

The year-to-date variances include:

- Favorable Employee and Temporary Services and delayed training, travel, Recruitment and other employee-related expenses.
- Favorable Building Occupancy costs.
- Favorable Licenses, Insurance & Fees
- Favorable Consulting Fees
- Unfavorable impact of timing for Computer Support Services, Other Purchased Services; Medical Benefit Admin fees, Community Relation fees; as well as the change in account bookings for IT-related Licenses and Subscriptions.

The Administrative Loss Ratio (ALR) is 6.9% of net revenue for the month and 5.6% of net revenue year-to-date.

Other Income / (Expense)

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

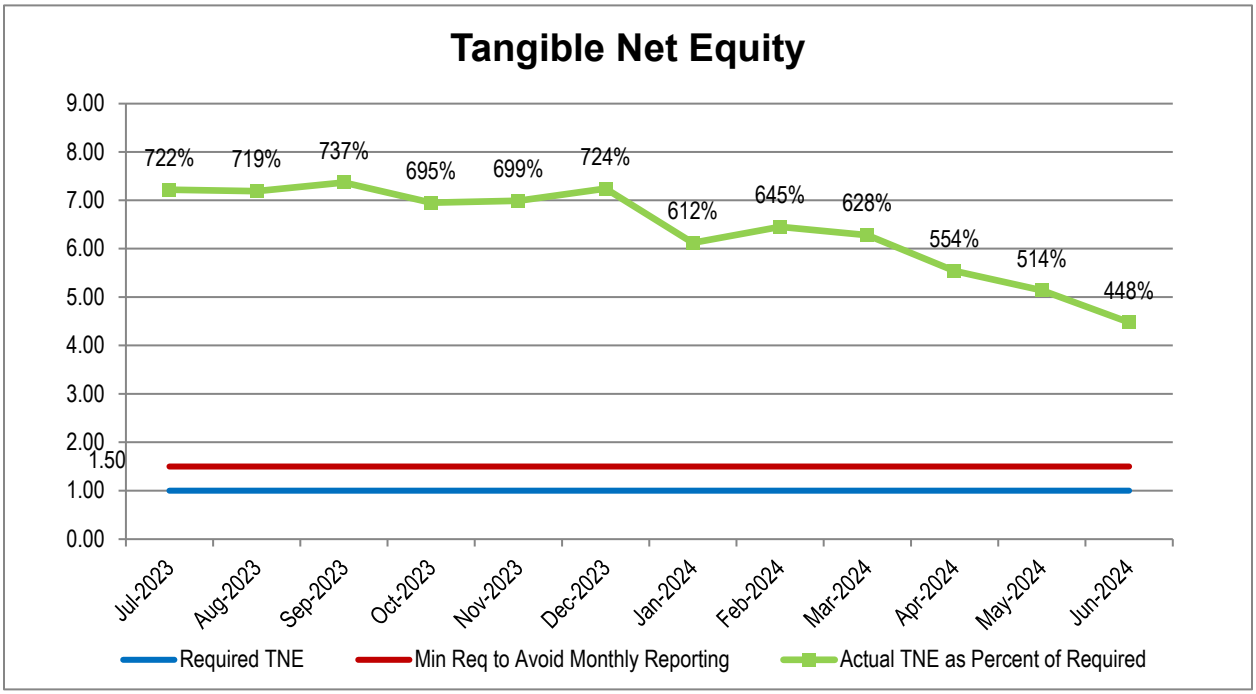
- Fiscal year-to-date net investments show a gain of $31.7 million.
- Fiscal year-to-date claims interest expense, due to delayed payment of certain claims, or recalculated interest on previously paid claims is $865,000.

Managed Care Organization (MCO) Provider Tax

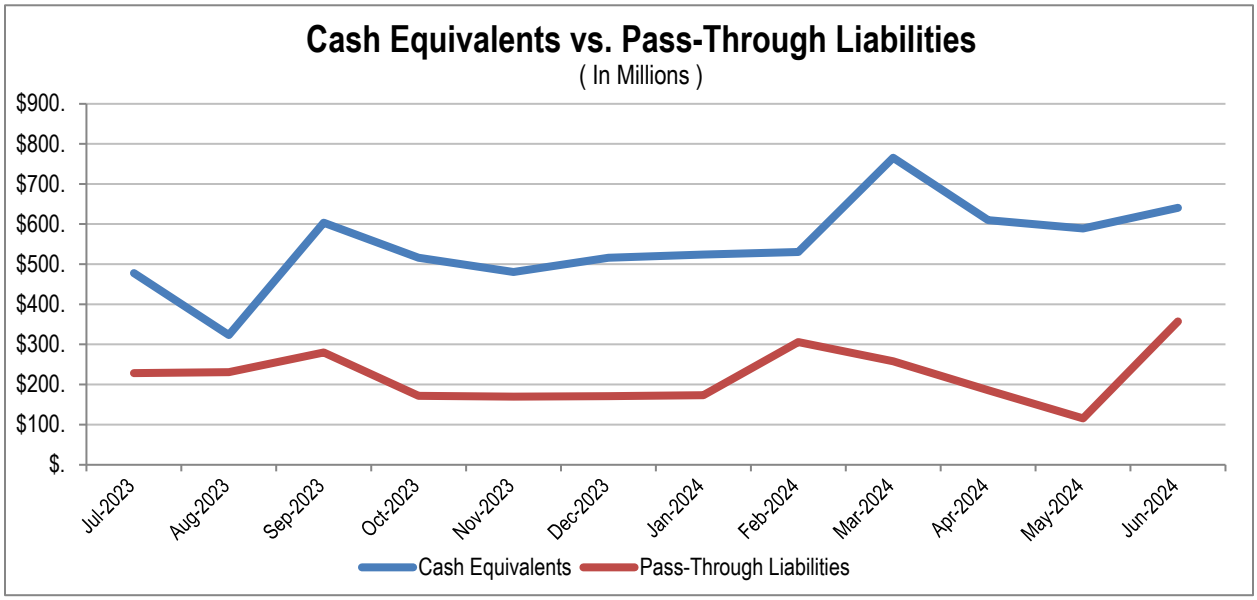
- For the month ended June 30th, 2024:
  - $114.8 million unbudgeted MCO Tax Revenue.
  - $114.8 million unbudgeted MCO Tax Expense.

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 $62.4 million
    - Actual TNE $279.2 million
    - Excess TNE $216.8 million
    - TNE % of Required TNE 448%



- To ensure appropriate liquidity and limit risk, the majority of Alliance financial assets are kept in short-term investments.
- Key Metrics
    - Cash & Cash Equivalents $640.3 million
    - Pass-Through Liabilities $357.5 million
    - Uncommitted Cash $282.9 million
    - Working Capital $236.5 million
    - Current Ratio 1.30 (regulatory minimum is 1.00)



Capital Investment

- Fiscal year-to-date capital assets acquired: $415,000.
- 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.

Finance

Supporting Documents

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

CURRENT MONTH					FISCAL YEAR TO DATE			
		$ Variance	% Variance				$ Variance	% Variance
Actual	Budget	(Unfavorable)	(Unfavorable)	Account Description	Actual	Budget	(Unfavorable)	(Unfavorable)
				MEMBERSHIP				
398,332	379,251	19,081	5.0%	1. Medi-Cal	4,475,730	4,416,822	58,908	1.3%
5,658	5,493	165	3.0%	2. GroupCare	67,529	66,886	643	1.0%
403,990	**384,744**	**19,246**	**5.0%**	**3. TOTAL MEMBER MONTHS**	**4,543,259**	**4,483,708**	**59,551**	**1.3%**
				REVENUE				
138,178,166	157,721,756	(19,543,590)	(12.4%)	4. Premium Revenue	1,750,002,982	1,777,122,514	(27,119,532)	(1.5%)
114,754,580	0	114,754,580	0.0%	5. MCO Tax Revenue AB119	615,623,026	0	615,623,026	0.0%
$252,932,746	**$157,721,756**	**$95,210,990**	**60.4%**	**6. TOTAL REVENUE**	**$2,365,626,008**	**$1,777,122,514**	**$588,503,495**	**33.1%**
				MEDICAL EXPENSES				
				Capitated Medical Expenses:				
$19,351,023	$15,576,865	($3,774,157)	(24.2%)	7. Capitated Medical Expense	$266,148,714	$251,048,563	($15,100,151)	(6.0%)
				Fee for Service Medical Expenses:				
$45,555,861	$47,623,940	$2,068,079	4.3%	8. Inpatient Hospital Expense	$486,239,794	$489,017,992	$2,778,198	0.6%
$5,122,607	$6,533,868	$1,411,261	21.6%	9. Primary Care Physician Expense	$57,686,508	$73,334,806	$15,648,298	21.3%
$7,558,568	$7,558,321	($248)	(0.0%)	10. Specialty Care Physician Expense	$73,432,418	$76,995,468	$3,563,051	4.6%
$22,862,010	$14,016,325	($8,845,685)	(63.1%)	11. Ancillary Medical Expense	$159,959,474	$150,178,558	($9,780,916)	(6.5%)
$11,768,346	$12,086,307	$317,961	2.6%	12. Outpatient Medical Expense	$112,244,351	$121,862,351	$9,618,000	7.9%
$10,799,461	$7,579,788	($3,219,674)	(42.5%)	13. Emergency Expense	$92,157,874	$80,304,222	($11,853,652)	(14.8%)
$12,483,871	$12,137,822	($346,049)	(2.9%)	14. Pharmacy Expense	$115,599,352	$125,550,416	$9,951,064	7.9%
$32,827,326	$23,401,431	($9,425,895)	(40.3%)	15. Long Term Care Expense	$312,020,589	$257,634,255	($54,386,334)	(21.1%)
$148,978,050	$130,937,801	($18,040,249)	(13.8%)	16. Total Fee for Service Expense	$1,409,340,358	$1,374,878,067	($34,462,292)	(2.5%)
($24,594)	$5,427,665	$5,452,259	100.5%	17. Other Benefits & Services	$51,030,763	$61,271,381	$10,240,618	16.7%
$148,695	$351,286	$202,591	57.7%	18. Reinsurance Expense	($1,602,160)	$3,027,462	$4,629,622	152.9%
$0	$0	$0	0.0%	19. Risk Pool Distribution	$3,000,000	$3,000,000	$0	(0.0%)
$168,453,174	**$152,293,617**	**($16,159,557)**	**(10.6%)**	**20. TOTAL MEDICAL EXPENSES**	**$1,727,917,675**	**$1,693,225,473**	**($34,692,202)**	**(2.0%)**
$84,479,572	**$5,428,139**	**$79,051,433**	**1,456.3%**	**21. GROSS MARGIN**	**$637,708,333**	**$83,897,041**	**$553,811,292**	**660.1%**
				ADMINISTRATIVE EXPENSES				
$4,422,056	$5,863,602	$1,441,546	24.6%	22. Personnel Expense	$60,138,340	$66,271,692	$6,133,352	9.3%
$75,167	$71,455	($3,712)	(5.2%)	23. Benefits Administration Expense	$2,001,755	$1,612,583	($389,172)	(24.1%)
$1,307,911	$1,075,118	($232,793)	(21.7%)	24. Purchased & Professional Services	$15,213,956	$12,372,079	($2,841,877)	(23.0%)
$3,694,618	$2,668,963	($1,025,655)	(38.4%)	25. Other Administrative Expense	$20,301,157	$23,973,926	$3,672,769	15.3%
$9,499,752	**$9,679,139**	**$179,387**	**1.9%**	**26. TOTAL ADMINISTRATIVE EXPENSES**	**$97,655,208**	**$104,230,280**	**$6,575,072**	**6.3%**
$114,754,580	**$0**	**($114,754,580)**	**0.0%**	**27. MCO TAX EXPENSES**	**$615,599,026**	**$0**	**($615,599,026)**	**0.0%**
($39,774,760)	**($4,251,000)**	**($35,523,760)**	**(835.7%)**	**28. NET OPERATING INCOME / (LOSS)**	**($75,545,901)**	**($20,333,239)**	**($55,212,662)**	**(271.5%)**
				OTHER INCOME / EXPENSES				
$3,024,840	**$2,450,000**	**$574,840**	**23.5%**	**29. TOTAL OTHER INCOME / (EXPENSES)**	**$30,828,113**	**$29,588,843**	**$1,239,270**	**4.2%**
($36,749,919)	**($1,801,000)**	**($34,948,919)**	**(1,940.5%)**	**30. NET SURPLUS (DEFICIT)**	**($44,717,789)**	**$9,255,603**	**($53,973,392)**	**(583.1%)**
121.9%	96.6%	-25.3%	-26.2%	31. Medical Loss Ratio	98.7%	95.3%	-3.4%	-3.6%
6.9%	6.1%	-0.8%	-13.1%	32. Administrative Expense Ratio	5.6%	5.9%	0.3%	5.1%
-14.5%	-1.1%	-13.4%	-1,218.2%	33. Net Surplus (Deficit) Ratio	-1.9%	0.5%	-2.4%	-480.0%

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

	6/30/2024	5/31/2024	Difference	% Difference
CURRENT ASSETS:				
Cash & Equivalents				
Cash	($6,756,723)	$17,969,861	($24,726,584)	-137.60%
Short-Term Investments	647,097,949	571,035,527	76,062,422	13.32%
Interest Receivable	1,916,063	1,526,874	389,189	25.49%
Premium Receivables	366,943,520	162,334,975	204,608,545	126.04%
Reinsurance Receivables	5,610,158	5,300,879	309,279	5.83%
Other Receivables	5,326,985	5,268,678	58,307	1.11%
Prepaid Expenses	296,016	904,521	(608,506)	-67.27%
CalPERS Net Pension Assets	(6,144,132)	(5,286,448)	(857,684)	16.22%
Deferred Outflow	14,319,532	14,099,056	220,476	1.56%
TOTAL CURRENT ASSETS	**$1,028,609,368**	**$773,153,923**	**$255,455,445**	**33.04%**
OTHER ASSETS:				
Long-Term Investments	32,992,246	26,748,669	6,243,578	23.34%
Restricted Assets	350,000	350,000	0	0.00%
GASB 87-Lease Assets (Net)	806,923	872,837	(65,913)	-7.55%
GASB 96-SBITA Assets (Net)	4,089,460	4,311,777	(222,317)	-5.16%
TOTAL OTHER ASSETS	**$38,238,629**	**$32,283,282**	**$5,955,347**	**18.45%**
PROPERTY AND EQUIPMENT:				
Land, Building & Improvements	9,842,648	9,842,648	0	0.00%
Furniture And Equipment	12,541,393	12,541,393	0	0.00%
Leasehold Improvement	902,447	903,599	(1,153)	-0.13%
Internally Developed Software	14,824,002	14,824,002	0	0.00%
Fixed Assets at Cost	$38,110,489	$38,111,641	($1,153)	0.00%
Less: Accumulated Depreciation	($32,662,672)	($32,612,126)	($50,546)	0.15%
NET PROPERTY AND EQUIPMENT	**$5,447,816**	**$5,499,516**	**($51,699)**	**-0.94%**
TOTAL ASSETS	**$1,072,295,814**	**$810,936,720**	**$261,359,094**	**32.23%**
CURRENT LIABILITIES:				
Accounts Payable	5,304,306	2,409,177	2,895,129	120.17%
Other Accrued Liabilities	80,257,691	72,173,398	8,084,293	11.20%
GASB 87 ST Lease Liabilities	777,289	922,283	(144,994)	-15.72%
GASB 96 ST SBITA Liabilities	2,621,143	2,380,680	240,464	10.10%
Claims Payable	36,144,921	34,543,423	1,601,498	4.64%
IBNP Reserves	272,440,149	245,687,493	26,752,656	10.89%
Pass-Through Liabilities	357,458,504	115,807,452	241,651,052	208.67%
Risk Sharing - Providers	6,629,337	6,629,337	0	0.00%
Risk Corridor Reserves	19,000,000	0	19,000,000	0.00%
Payroll Liabilities	8,099,226	8,189,492	(90,266)	-1.10%
Deferred Inflow	3,327,530	5,004,985	(1,677,455)	-33.52%
TOTAL CURRENT LIABILITIES	**$792,060,096**	**$493,747,720**	**$298,312,376**	**60.42%**
LONG TERM LIABILITIES:				
GASB 87 LT Lease Liabilities	78,600	71,130	7,470	10.50%
GASB 96 LT SBITA Liabilities	917,866	1,128,698	(210,832)	-18.68%
TOTAL LONG TERM LIABILITIES	**$996,466**	**$1,199,828**	**($203,362)**	**-16.95%**
TOTAL LIABILITIES	**$793,056,562**	**$494,947,548**	**$298,109,014**	**60.23%**
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)	(44,717,789)	(7,967,869)	(36,749,919)	461.23%
TOTAL NET WORTH	**$279,239,252**	**$315,989,172**	**($36,749,920)**	**-11.63%**
TOTAL LIABILITIES AND NET WORTH	**$1,072,295,814**	**$810,936,720**	**$261,359,094**	**32.23%**
Cash Equivalents	$640,341,226	$589,005,388	$51,335,838	8.72%
Pass-Through	$357,458,504	$115,807,452	$241,651,052	208.67%
Uncommitted Cash	$282,882,722	$473,197,936	($190,315,214)	-40.22%
Working Capital	$236,549,272	$279,406,203	($42,856,931)	-15.34%
Current Ratio	129.9%	156.6%	-26.7%	-17.0%

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

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM OPERATING ACTIVITIES				
Commercial Premium Cash Flows				
Commercial Premium Revenue	$2,587,465	$7,744,562	$15,442,943	$30,877,657
GroupCare Receivable	2,537,169	2,544,485	2,541,742	(3,661)
Total	5,124,634	10,289,047	17,984,685	30,873,996
Medi-Cal Premium Cash Flows				
Medi-Cal Revenue	250,345,281	759,073,063	1,527,136,355	2,334,748,351
Premium Receivable	(207,145,716)	(229,041,456)	(142,425,104)	(70,577,438)
Total	43,199,565	530,031,607	1,384,711,251	2,264,170,913
Investment & Other Income Cash Flows				
Other Revenues	(228,928)	(373,264)	(61,609)	2,227,835
Interest Income	3,352,279	8,833,283	15,094,260	29,679,875
Interest Receivable	(389,189)	587,394	2,070,692	(1,201,488)
Total	2,734,162	9,047,413	17,103,343	30,706,222
Medical & Hospital Cash Flows				
Total Medical Expenses	(168,453,180)	(483,871,291)	(968,505,641)	(1,727,917,676)
Other Health Care Receivables	(366,754)	(2,533,393)	(5,990,904)	(7,099,868)
Capitation Payable	-	-	-	(7,387,555)
IBNP Payable	26,752,656	35,391,835	104,297,653	107,935,747
Other Medical Payable	158,792,784	69,858,994	126,558,915	73,624,872
Risk Share Payable	-	-	-	1,022,154
New Health Program Payable	-	-	-	-
Total	16,725,506	(381,153,855)	(743,639,977)	(1,559,822,326)
Administrative Cash Flows				
Total Administrative Expenses	(9,598,263)	(28,784,466)	(53,610,974)	(98,734,806)
Prepaid Expenses	705,952	56,502	3,484,093	4,624,922
Other Receivables	(98,278)	(55,646)	(43,045)	1,570
CalPERS Pension	637,208	637,208	637,208	637,208
Trade Accounts Payable	(302,074)	970,796	(2,150,162)	64,872
Payroll Liabilities	(1,767,722)	(2,180,889)	(289,684)	491,884
GASB Assets and Liabilities	180,337	378,013	633,996	3,450
Depreciation Expense	50,546	(365,647)	(173,681)	185,548
Total	(10,192,294)	(29,344,129)	(51,512,249)	(92,725,352)
MCO Tax AB119 Cash Flows				
MCO Tax Expense AB119	(114,754,580)	(336,794,922)	(615,599,026)	(615,599,026)
MCO Tax Liabilities	114,741,263	99,945,965	142,793,859	143,198,487
Total	(13,317)	(236,848,957)	(472,805,167)	(472,400,539)
Net Cash Flows from Operating Activities	**57,578,256**	**(97,978,874)**	**151,841,886**	**200,802,914**

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

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM INVESTING ACTIVITIES				
Investment Cash Flows				
Long Term Investments	(6,243,571)	(27,800,524)	(28,254,020)	(21,431,710)
Total	(6,243,571)	(27,800,524)	(28,254,020)	(21,431,710)
Restricted Cash & Other Asset Cash Flows				
Restricted Assets-Treasury Account	-	-	-	-
Total	-	-	-	-
Fixed Asset Cash Flows				
Fixed Asset Acquisitions	1,153	744,002	723,597	(415,393)
Purchases of Property and Equipment	1,153	744,002	723,597	(415,393)
Net Cash Flows from Investing Activities	**(6,242,418)**	**(27,056,522)**	**(27,530,423)**	**(21,847,103)**
Net Change in Cash	**51,335,838**	**(125,035,396)**	**124,311,463**	**178,955,811**
Rounding	-	-	-	-
Cash @ Beginning of Period	589,005,389	765,376,623	516,029,764	461,385,416
Cash @ End of Period	**$640,341,227**	**$640,341,227**	**$640,341,227**	**$640,341,227**
Variance	-	-	-	-

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

	MONTH	3 MONTHS	6 MONTHS	YTD
NET INCOME RECONCILIATION				
Net Income / (Loss)	($36,749,926)	($74,173,035)	($80,103,693)	($44,717,790)
Add back: Depreciation & Amortization	50,546	(365,647)	(173,681)	185,548
Receivables				
Premiums Receivable	(207,145,716)	(229,041,456)	(142,425,104)	(70,577,438)
Interest Receivable	(389,189)	587,394	2,070,692	(1,201,488)
Other Health Care Receivables	(366,754)	(2,533,393)	(5,990,904)	(7,099,868)
Other Receivables	(98,278)	(55,646)	(43,045)	1,570
GroupCare Receivable	2,537,169	2,544,485	2,541,742	(3,661)
Total	(205,462,768)	(228,498,616)	(143,846,619)	(78,880,885)
Prepaid Expenses	705,952	56,502	3,484,093	4,624,922
Trade Payables	(302,074)	970,796	(2,150,162)	64,872
Claims Payable and Shared Risk Pool				
IBNP Payable	26,752,656	35,391,835	104,297,653	107,935,747
Capitation Payable & Other Medical Payable	158,792,784	69,858,994	126,558,915	66,237,317
Risk Share Payable	-	-	0	1,022,154
Claims Payable				
Total	185,545,440	105,250,829	230,856,568	175,195,218
Other Liabilities				
CalPERS Pension	637,208.00	637,208.00	637,208.00	637,208.00
Payroll Liabilities	(1,767,722)	(2,180,889)	(289,683)	491,884
GASB Assets and Liabilities	180,337	378,013	633,996	3,450
New Health Program	-	-	-	-
MCO Tax Liabilities	114,741,263	99,945,965	142,793,859	143,198,487
Total	113,791,086	98,780,297	143,775,380	144,331,029
Rounding	-	-	-	-
Cash Flows from Operating Activities	**57,578,256**	**(97,978,874)**	**151,841,886**	**200,802,914**
Variance	-	-	-	-

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

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOW STATEMENT:				
Cash Flows from Operating Activities:				
Cash Received				
Capitation Received from State of CA	$43,199,565	$530,031,607	$1,384,711,251	$2,264,170,913
Medicare Revenue	$0	$0	$0	$0
GroupCare Premium Revenue	5,124,634	10,289,047	17,984,685	30,873,996
Other Income	(228,928)	(373,264)	(61,609)	2,227,835
Interest Income	2,963,090	9,420,677	17,164,952	28,478,387
Less Cash Paid				
Medical Expenses	16,725,506	(381,153,855)	(743,639,977)	(1,559,822,326)
Vendor & Employee Expenses	(10,192,294)	(29,344,129)	(51,512,249)	(92,725,352)
MCO Tax Expense AB119	(13,317)	(236,848,957)	(472,805,167)	(472,400,539)
Net Cash Flows from Operating Activities	**57,578,256**	**(97,978,874)**	**151,841,886**	**200,802,914**
Cash Flows from Investing Activities:				
Long Term Investments	(6,243,571)	(27,800,524)	(28,254,020)	(21,431,710)
Restricted Assets-Treasury Account	0	0	0	0
Purchases of Property and Equipment	1,153	744,002	723,597	(415,393)
Net Cash Flows from Investing Activities	**(6,242,418)**	**(27,056,522)**	**(27,530,423)**	**(21,847,103)**
Net Change in Cash	**51,335,838**	**(125,035,396)**	**124,311,463**	**178,955,811**
Rounding	-	-	-	-
Cash @ Beginning of Period	589,005,389	765,376,623	516,029,764	461,385,416
Cash @ End of Period	**$640,341,227**	**$640,341,227**	**$640,341,227**	**$640,341,227**
Variance	$0	-	-	-
RECONCILIATION OF NET INCOME TO NET CASH FLOW FROM OPERATING ACTIVITIES:				
Net Income / (Loss)	($36,749,926)	($74,173,034)	($80,103,694)	($44,717,790)
Add Back: Depreciation	50,546	(365,647)	(173,681)	185,548
Net Change in Operating Assets & Liabilities				
Premium & Other Receivables	(205,462,768)	(228,498,616)	(143,846,619)	(78,880,885)
Prepaid Expenses	705,952	56,501	3,484,094	4,624,922
Trade Payables	(302,074)	970,796	(2,150,162)	64,872
Claims Payable, IBNP and Risk Sharing	185,545,440	105,250,829	230,856,568	175,195,218
Deferred Revenue	0	0	0	0
Other Liabilities	113,791,086	98,780,297	143,775,380	144,331,029
Total	57,578,256	(97,978,874)	151,841,886	200,802,914
Rounding	-	-	-	-
Cash Flows from Operating Activities	**$57,578,256**	**($97,978,874)**	**$151,841,886**	**$200,802,914**
Variance	$0	-	-	-

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE FISCAL YEAR TO DATE JUNE 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	1,269,266	691,282	394,719	1,615,790	488,782	2,143	13,748	4,475,730	67,529	-	4,543,259
Revenue	$340,509,368	$320,015,948	$497,475,114	$812,750,198	$223,868,704	$21,721,704	$118,407,316	$2,334,748,352	$30,877,656	$0	$2,365,626,008
Medical Expense	141,502,390	215,307,220	456,231,244	578,140,859	162,636,314	25,672,507	120,895,677	1,700,386,212	27,524,463	7,000	$1,727,917,675
Gross Margin	$199,006,978	$104,708,728	$41,243,870	$234,609,339	$61,232,390	($3,950,803)	($2,488,362)	$634,362,140	$3,353,193	($7,000)	$637,708,333
Administrative Expense	$5,751,877	$10,658,145	$30,932,280	$31,095,774	$8,742,673	$1,387,269	$6,607,981	$95,175,998	$1,896,956	$582,254	$97,655,208
MCO Tax Expense	$175,748,796	$94,089,415	$54,400,864	$220,882,584	$68,314,938	$277,622	$1,884,808	$615,599,026	$0	$0	$615,599,026
Operating Income / (Expense)	$17,506,305	($38,831)	($44,089,275)	($17,369,019)	($15,825,221)	($5,615,694)	($10,981,150)	($76,412,884)	$1,456,237	($589,254)	($75,545,901)
Other Income / (Expense)	$1,681,648	$3,368,829	$10,012,654	$9,894,322	$2,769,413	$455,868	$2,129,575	$30,312,310	$515,803	$0	$30,828,113
Net Income / (Loss)	$19,187,953	$3,329,998	($34,076,621)	($7,474,697)	($13,055,808)	($5,159,826)	($8,851,575)	($46,100,575)	$1,972,040	($589,254)	($44,717,789)
PMPM Metrics:											
Revenue PMPM	$268.27	$462.93	$1,260.33	$503.00	$458.01	$10,136.12	$8,612.69	$521.65	$457.25	$0.00	$520.69
Medical Expense PMPM	$111.48	$311.46	$1,155.84	$357.81	$332.74	$11,979.70	$8,793.69	$379.91	$407.59	$0.00	$380.33
Gross Margin PMPM	$156.79	$151.47	$104.49	$145.20	$125.28	($1,843.58)	($181.00)	$141.73	$49.66	$0.00	$140.36
Administrative Expense PMPM	$4.53	$15.42	$78.37	$19.24	$17.89	$647.35	$480.65	$21.26	$28.09	$0.00	$21.49
MCO Tax Expense PMPM	$138.46	$136.11	$137.82	$136.70	$139.77	$129.55	$137.10	$137.54	$0.00	$0.00	$135.50
Operating Income / (Expense) PMPM	$13.79	($0.06)	($111.70)	($10.75)	($32.38)	($2,620.48)	($798.75)	($17.07)	$21.56	$0.00	($16.63)
Other Income / (Expense) PMPM	$1.32	$4.87	$25.37	$6.12	$5.67	$212.72	$154.90	$6.77	$7.64	$0.00	$6.79
Net Income / (Loss) PMPM	$15.12	$4.82	($86.33)	($4.63)	($26.71)	($2,407.76)	($643.84)	($10.30)	$29.20	$0.00	($9.84)
Ratio:											
Medical Loss Ratio	85.9%	95.3%	103.0%	97.7%	104.6%	119.7%	103.8%	98.9%	89.1%	0.0%	98.7%
Administrative Expense Ratio	3.5%	4.7%	7.0%	5.3%	5.6%	6.5%	5.7%	5.5%	6.1%	0.0%	5.6%
Net Income Ratio	5.6%	1.0%	-6.8%	-0.9%	-5.8%	-23.8%	-7.5%	-2.0%	6.4%	0.0%	-1.9%

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE MONTH OF JUNE 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	110,124	62,746	34,920	149,324	39,748	222	1,248	398,332	5,658	-	403,990
Revenue	$46,400,777	$35,376,993	$42,941,451	$88,438,988	$24,393,132	$1,780,514	$11,013,426	$250,345,281	$2,587,465	$0	$252,932,746
Medical Expense	14,361,978	20,479,893	42,606,674	59,723,287	14,143,126	3,028,004	11,206,818	165,549,780	2,903,394	-	$168,453,174
Gross Margin	$32,038,799	$14,897,100	$334,777	$28,715,701	$10,250,006	($1,247,490)	($193,392)	$84,795,501	($315,929)	$0	$84,479,572
Administrative Expense	$473,873	$1,072,171	$3,001,878	$3,066,500	$788,542	$140,490	$669,843	$9,213,297	$206,979	$79,476	$9,499,752
MCO Tax Expense	$33,167,131	$17,074,944	$10,250,398	$40,753,921	$13,110,601	$40,928	$356,657	$114,754,580	$0	$0	$114,754,580
Operating Income / (Expense)	($1,602,205)	($3,250,015)	($12,917,500)	($15,104,719)	($3,649,136)	($1,428,908)	($1,219,892)	($39,172,375)	($522,908)	($79,476)	($39,774,760)
Other Income / (Expense)	$151,227	$343,667	$979,662	$984,781	$250,672	$46,292	$215,591	$2,971,892	$52,949	$0	$3,024,840
Net Income / (Loss)	($1,450,978)	($2,906,348)	($11,937,838)	($14,119,938)	($3,398,464)	($1,382,616)	($1,004,301)	($36,200,483)	($469,960)	($79,476)	($36,749,919)
PMPM Metrics:											
Revenue PMPM	$421.35	$563.81	$1,229.71	$592.26	$613.69	$8,020.33	$8,824.86	$628.48	$457.31	$0.00	$626.09
Medical Expense PMPM	$130.42	$326.39	$1,220.12	$399.96	$355.82	$13,639.66	$8,979.82	$415.61	$513.15	$0.00	$416.97
Gross Margin PMPM	$290.93	$237.42	$9.59	$192.30	$257.87	($5,619.32)	($154.96)	$212.88	($55.84)	$0.00	$209.11
Administrative Expense PMPM	$4.30	$17.09	$85.96	$20.54	$19.84	$632.84	$536.73	$23.13	$36.58	$0.00	$23.51
MCO Tax Expense PMPM	$301.18	$272.13	$293.54	$272.92	$329.84	$184.36	$285.78	$288.09	$0.00	$0.00	$284.05
Operating Income / (Expense) PMPM	($14.55)	($51.80)	($369.92)	($101.15)	($91.81)	($6,436.52)	($977.48)	($98.34)	($92.42)	$0.00	($98.45)
Other Income / (Expense) PMPM	$1.37	$5.48	$28.05	$6.59	$6.31	$208.52	$172.75	$7.46	$9.36	$0.00	$7.49
Net Income / (Loss) PMPM	($13.18)	($46.32)	($341.86)	($94.56)	($85.50)	($6,228.00)	($804.73)	($90.88)	($83.06)	$0.00	($90.97)
Ratio:											
Medical Loss Ratio	108.5%	111.9%	130.3%	125.2%	125.4%	174.1%	105.2%	122.1%	112.2%	0.0%	121.9%
Administrative Expense Ratio	3.6%	5.9%	9.2%	6.4%	7.0%	8.1%	6.3%	6.8%	8.0%	0.0%	6.9%
Net Income Ratio	-3.1%	-8.2%	-27.8%	-16.0%	-13.9%	-77.7%	-9.1%	-14.5%	-18.2%	0.0%	-14.5%

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				ADMINISTRATIVE EXPENSE SUMMARY				
$4,422,056	$5,863,602	$1,441,546	24.6%	Personnel Expenses	$60,138,340	$66,271,692	$6,133,352	9.3%
75,167	71,455	(3,712)	(5.2%)	Benefits Administration Expense	2,001,755	1,612,583	(389,172)	(24.1%)
1,307,911	1,075,118	(232,793)	(21.7%)	Purchased & Professional Services	15,213,956	12,372,079	(2,841,877)	(23.0%)
480,190	522,532	42,342	8.1%	Occupancy	4,091,346	6,044,874	1,953,528	32.3%
2,857,913	1,077,950	(1,779,963)	(165.1%)	Printing Postage & Promotion	9,346,962	8,167,043	(1,179,919)	(14.4%)
225,696	1,040,113	814,418	78.3%	Licenses Insurance & Fees	6,183,761	9,467,793	3,284,032	34.7%
130,819	28,368	(102,451)	(361.1%)	Supplies & Other Expenses	679,088	294,216	(384,872)	(130.8%)
$5,077,696	$3,815,537	($1,262,159)	(33.1%)	Total Other Administrative Expense	$37,516,868	$37,958,588	$441,720	1.2%
$9,499,752	$9,679,139	$179,387	1.9%	Total Administrative Expenses	$97,655,208	$104,230,280	$6,575,072	6.3%

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				Personnel Expenses				
3,217,216	3,371,768	154,552	4.6%	Salaries & Wages	39,315,222	39,305,046	(10,176)	0.0%
484,246	370,678	(113,567)	(30.6%)	Paid Time Off	4,052,050	4,344,296	292,246	6.7%
435	5,150	4,715	91.6%	Compensated Incentives	20,731	1,949,082	1,928,351	98.9%
0	0	0	0.0%	Severance Pay	139,537	842,000	702,463	83.4%
56,809	54,287	(2,522)	(4.6%)	Payroll Taxes	751,068	761,382	10,314	1.4%
25,093	19,467	(5,627)	(28.9%)	Overtime	415,763	291,728	(124,035)	(42.5%)
(543,469)	285,651	829,120	290.3%	CalPERS ER Match	2,603,404	3,426,368	822,964	24.0%
864,552	1,062,878	198,326	18.7%	Employee Benefits	9,393,708	10,403,267	1,009,559	9.7%
(892)	0	892	0.0%	Personal Floating Holiday	171,551	169,701	(1,850)	(1.1%)
17,220	23,500	6,280	26.7%	Premium Bi/Multilingual Pay	171,813	191,250	19,437	10.2%
0	0	0	0.0%	Prizes	231	0	(231)	0.0%
4,050	0	(4,050)	0.0%	Med Ins Opted Out Stipend	16,650	0	(16,650)	0.0%
139,000	0	(139,000)	0.0%	Holiday Bonus	1,541,961	0	(1,541,961)	0.0%
40,667	0	(40,667)	0.0%	Sick Leave	212,684	0	(212,684)	0.0%
4,635	32,105	27,470	85.6%	Compensated Employee Relations	63,368	345,708	282,341	81.7%
19,880	23,200	3,320	14.3%	Work from Home Stipend	204,140	239,895	35,755	14.9%
820	5,383	4,563	84.8%	Mileage, Parking & LocalTravel	13,106	38,467	25,360	65.9%
7,706	33,322	25,615	76.9%	Travel & Lodging	120,965	265,728	144,763	54.5%
19,437	173,922	154,485	88.8%	Temporary Help Services	497,498	1,914,492	1,416,994	74.0%
56,920	314,927	258,007	81.9%	Staff Development/Training	301,013	1,322,228	1,021,215	77.2%
7,730	87,365	79,635	91.2%	Staff Recruitment/Advertising	131,878	461,055	329,176	71.4%
$4,422,056	**$5,863,602**	**$1,441,546**	**24.6%**	**Total Employee Expenses**	**$60,138,340**	**$66,271,692**	**$6,133,352**	**9.3%**
				Benefit Administration Expense				
22,902	21,438	(1,464)	(6.8%)	RX Administration Expense	260,736	253,510	(7,226)	(2.9%)
0	0	0	0.0%	Behavioral Hlth Administration Fees	1,193,429	817,710	(375,719)	(45.9%)
52,265	50,017	(2,248)	(4.5%)	Telemedicine Admin Fees	547,590	541,364	(6,227)	(1.2%)
$75,167	**$71,455**	**($3,712)**	**(5.2%)**	**Total Benefit Administration Expenses**	**$2,001,755**	**$1,612,583**	**($389,172)**	**(24.1%)**
				Purchased & Professional Services				
448,406	375,941	(72,465)	(19.3%)	Consultant Fees - Non Medical	3,503,298	4,084,085	580,788	14.2%
356,891	276,389	(80,502)	(29.1%)	Computer Support Services	4,952,228	3,794,214	(1,158,014)	(30.5%)
3,875	12,500	8,625	69.0%	Audit Fees	134,500	147,500	13,000	8.8%
(1,800)	33	1,833	5,500.5%	Consultant Fees - Medical	(1,800)	267	2,067	775.0%
60,464	95,771	35,306	36.9%	Other Purchased Services	1,887,816	956,291	(931,526)	(97.4%)
2,713	1,576	(1,137)	(72.1%)	Maint.& Repair-Office Equipment	11,710	15,250	3,540	23.2%
0	0	0	0.0%	Maint.&Repair-Computer Hardware	1,180	1,180	0	0.0%
(133,512)	126,966	260,478	205.2%	Medical Refund Recovery Fees	858,287	1,375,835	517,548	37.6%
350,483	10,000	(340,483)	(3,404.8%)	Software - IT Licenses & Subsc	1,967,928	10,000	(1,957,928)	(19,579.3%)
106,451	79,028	(27,423)	(34.7%)	Hardware (Non-Capital)	1,105,621	964,774	(140,847)	(14.6%)
39,739	44,565	4,826	10.8%	Provider Relations-Credentialing	414,273	471,018	56,745	12.0%
74,202	52,350	(21,852)	(41.7%)	Legal Fees	354,951	551,666	196,715	35.7%
0	0	0	0.0%	Interpretive Services	23,964	0	(23,964)	0.0%
$1,307,911	**$1,075,118**	**($232,793)**	**(21.7%)**	**Total Purchased & Professional Services**	**$15,213,956**	**$12,372,079**	**($2,841,877)**	**(23.0%)**
				Occupancy				
50,546	52,722	2,176	4.1%	Depreciation	185,548	659,372	473,825	71.9%
63,791	64,863	1,072	1.7%	Building Lease	678,970	751,730	72,760	9.7%

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
9,226	5,870	(3,356)	(57.2%)	Leased and Rented Office Equipment	42,087	79,379	37,292	47.0%
24,764	15,482	(9,282)	(60.0%)	Utilities	212,836	224,044	11,209	5.0%
74,641	86,510	11,869	13.7%	Telephone	865,834	1,004,501	138,667	13.8%
34,903	47,949	13,046	27.2%	Building Maintenance	681,261	392,499	(288,762)	(73.6%)
222,317	249,136	26,819	10.8%	SBITA Amortization Expense-GASB 96	1,424,811	2,933,348	1,508,537	51.4%
$480,190	**$522,532**	**$42,342**	**8.1%**	**Total Occupancy**	**$4,091,346**	**$6,044,874**	**$1,953,528**	**32.3%**
				Printing Postage & Promotion				
177,987	117,321	(60,666)	(51.7%)	Postage	899,219	972,902	73,684	7.6%
7,387	5,300	(2,087)	(39.4%)	Design & Layout	40,056	84,316	44,260	52.5%
401,590	155,772	(245,818)	(157.8%)	Printing Services	1,827,518	1,373,133	(454,386)	(33.1%)
26,071	6,910	(19,161)	(277.3%)	Mailing Services	119,975	105,501	(14,474)	(13.7%)
2,896	13,330	10,435	78.3%	Courier/Delivery Service	105,310	123,871	18,561	15.0%
0	333	333	100.0%	Pre-Printed Materials and Publications	1,038	1,500	462	30.8%
0	0	0	0.0%	Promotional Products	6,594	25,371	18,777	74.0%
0	150	150	100.0%	Promotional Services	(1,253)	5,650	6,903	122.2%
2,208,516	755,500	(1,453,016)	(192.3%)	Community Relations	6,042,792	5,170,139	(872,653)	(16.9%)
33,467	23,333	(10,134)	(43.4%)	Translation - Non-Clinical	305,712	304,659	(1,053)	(0.3%)
$2,857,913	**$1,077,950**	**($1,779,963)**	**(165.1%)**	**Total Printing Postage & Promotion**	**$9,346,962**	**$8,167,043**	**($1,179,919)**	**(14.4%)**
				Licenses Insurance & Fees				
0	250,000	250,000	100.0%	Regulatory Penalties	80,000	1,000,000	920,000	92.0%
83,070	29,000	(54,070)	(186.4%)	Bank Fees	401,168	337,587	(63,582)	(18.8%)
0	89,101	89,101	100.0%	Insurance Premium	1,057,904	1,023,624	(34,280)	(3.3%)
28,462	501,834	473,372	94.3%	Licenses, Permits and Fees	3,374,930	4,965,361	1,590,431	32.0%
114,164	170,179	56,015	32.9%	Subscriptions and Dues - NonIT	1,269,758	2,141,221	871,463	40.7%
$225,696	**$1,040,113**	**$814,418**	**78.3%**	**Total Licenses Insurance & Postage**	**$6,183,761**	**$9,467,793**	**$3,284,032**	**34.7%**
				Supplies & Other Expenses				
5,219	5,859	640	10.9%	Office and Other Supplies	106,436	78,452	(27,984)	(35.7%)
0	2,000	2,000	100.0%	Furniture and Equipment	21,300	41,753	20,453	49.0%
62,809	1,300	(61,509)	(4,731.4%)	Ergonomic Supplies	119,959	23,525	(96,434)	(409.9%)
7,581	13,593	6,012	44.2%	Meals and Entertainment	96,405	98,605	2,201	2.2%
29,864	0	(29,864)	0.0%	Miscellaneous Expense	52,223	27,948	(24,276)	(86.9%)
4,850	4,850	0	0.0%	Member Incentive Expense	14,450	19,400	4,950	25.5%
20,497	0	(20,497)	0.0%	Equity & Practice Transformation (EPT)	268,315	0	(268,315)	0.0%
0	100	100	100.0%	Covid-19 IT Expenses	0	800	800	100.0%
0	667	667	100.0%	Covid-19 Non IT Expenses	0	3,733	3,733	100.0%
$130,819	**$28,368**	**($102,451)**	**(361.1%)**	**Total Supplies & Other Expense**	**$679,088**	**$294,216**	**($384,872)**	**(130.8%)**
$9,499,752	**$9,679,139**	**$179,387**	**1.9%**	**TOTAL ADMINISTRATIVE EXPENSE**	**$97,655,208**	**$104,230,280**	**$6,575,072**	**6.3%**

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	$ 95,054	$ -	**$ 95,054**	$ 30,000	$ (65,054)
	Training Room Projector	IT-FY24-10	$ 12,546	$ -	**$ 12,546**	$ 13,000	$ 454
	Conference room upgrades	IT-FY24-11	$ -	$ -	$ -	$ 107,701	$ 107,701
	Fixed Asset Reclass due to new policy (FN-601)		$ (387,427)	$ -	**$ (387,427)**	$ -	$ 387,427
Hardware Subtotal			**$ 714,414**	**$ -**	$ 714,414	**$ 1,320,701**	**$ 606,287**
2. Software:							
	Zerto renewal and Tier 2 add	AC-FY24-01	$ -	$ -	$ -	$ 126,000	$ 126,000
	Fixed Asset Reclass due to new policy (FN-601)		$ (28,099)	$ -	**$ (28,099)**	$ -	$ 28,099
Software Subtotal			**$ (28,099)**	**$ -**	$ (28,099)	**$ 126,000**	**$ 154,099**
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
	Fixed Asset Reclass due to new policy (FN-601)		**$ (324,617)**	$ -	**$ (324,617)**		$ 324,617
Building Improvement Subtotal			**$ (270,923)**	**$ -**	$ (270,923)	**$ 125,000**	**$ 395,923**
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
	Fixed Asset Reclass due to new policy (FN-601)		$ (3,860)	$ -	**$ (3,860)**		$ 3,860
Furniture & Equipment Subtotal			**$ -**	**$ -**	$ -	**$ 30,000**	**$ 30,000**
5. Leasehold Improvement							
	ExacqVision NVR Upgrade, Cameras/Video System upgrade	FA-FY24-02	$ 1,153	$ (1,153)	$ -	$ -	$ -
			$ -	$ -	$ -	$ -	$ -
			$ -	$ -	$ -	$ -	$ -
Leasehold Improvement Subtotal			**$ 1,153**	**$ (1,153)**	$ -	**$ -**	**$ -**
GRAND TOTAL			**$ 416,545**	**$ (1,153)**	$ 415,393	**$ 1,601,701**	**$ 1,186,308**

6. Reconciliation to Balance Sheet:

Fixed Assets @ Cost - 6/30/24	**$ 38,110,489**
Fixed Assets @ Cost - 6/30/23	**$ 37,695,096**
Fixed Assets Acquired YTD	**$ 415,393**

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**	**QTR. END Mar-24**	**Apr-24**	**May-24**	**QTR. END Jun-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	($3,313,721)	($8,258,822)	($29,164,293)	($36,749,919)
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	$29,455,245	$21,196,423	($7,967,870)	($44,717,789)
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	$353,412,287	$345,153,466	$315,989,172	$279,239,253
Subordinated Debt & Interest	$0	$0	$0	$0	$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**	**$353,412,287**	**$345,153,466**	**$315,989,172**	**$279,239,253**
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	($3,313,721)	($8,258,822)	($29,164,293)	($36,749,919)
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**	**$56,252,051**	**$62,358,321**	**$61,532,891**	**$62,398,585**
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	$84,378,076	$93,537,481	$92,299,337	$93,597,878
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	$297,160,236	$282,795,145	$254,456,281	$216,840,668
Actual TNE as a Multiple of Required	**7.22**	**7.19**	**7.37**	**6.95**	**6.99**	**7.24**	**6.12**	**6.45**	**6.28**	**5.54**	**5.14**	**4.48**

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	$353,412,287	$345,153,466	$315,989,172	$279,239,253
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)	(5,826,171)	(5,763,018)	(5,499,516)	(5,447,816)
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)	(879,498)	(859,354)	(681,823)	(501,485)
CD Pledged to DMHC	(350,000)	(350,000)	(350,000)	(350,000)	(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**	**$347,236,116**	**$339,040,448**	**$310,139,656**	**$273,441,437**
Liquid TNE as Multiple of Required	**7.10**	**7.06**	**7.24**	**6.83**	**6.86**	**7.11**	**5.99**	**6.31**	**6.17**	**5.44**	**5.04**	**4.38**

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	110,250	110,502	110,539	110,124	1,269,266
Adult	52,550	52,102	51,499	52,396	52,151	51,696	62,860	63,117	63,293	63,507	63,365	62,746	691,282
SPD	31,055	30,840	30,592	30,888	30,865	30,846	35,013	34,875	34,972	34,888	34,965	34,920	394,719
ACA OE	123,707	121,819	120,016	121,430	120,573	119,668	145,842	146,757	148,061	149,168	149,425	149,324	1,615,790
Duals	41,688	41,715	41,629	41,496	40,997	40,974	40,117	40,403	40,222	39,951	39,842	39,748	488,782
MCAL LTC	141	138	139	135	137	135	219	217	216	224	220	222	2,143
MCAL LTC Duals	1,033	1,019	1,004	997	975	951	1,311	1,329	1,307	1,291	1,283	1,248	13,748
Medi-Cal Program	352,637	349,026	344,917	348,462	346,941	346,358	394,915	396,651	398,321	399,531	399,639	398,332	4,475,730
Group Care Program	5,669	5,645	5,631	5,605	5,585	5,622	5,603	5,608	5,620	5,643	5,640	5,658	67,529
Total	**358,306**	**354,671**	**350,548**	**354,067**	**352,526**	**351,980**	**400,518**	**402,259**	**403,941**	**405,174**	**405,279**	**403,990**	**4,543,259**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	(1,207)	(1,070)	(1,355)	1,082	123	845	7,465	400	297	252	37	(415)	6,454
Adult	(624)	(448)	(603)	897	(245)	(455)	11,164	257	176	214	(142)	(619)	9,572
SPD	(225)	(215)	(248)	296	(23)	(19)	4,167	(138)	97	(84)	77	(45)	3,640
ACA OE	(1,260)	(1,888)	(1,803)	1,414	(857)	(905)	26,174	915	1,304	1,107	257	(101)	24,357
Duals	(43)	27	(86)	(133)	(499)	(23)	(857)	286	(181)	(271)	(109)	(94)	(1,983)
MCAL LTC	(9)	(3)	1	(4)	2	(2)	84	(2)	(1)	8	(4)	2	72
MCAL LTC Duals	4	(14)	(15)	(7)	(22)	(24)	360	18	(22)	(16)	(8)	(35)	219
Medi-Cal Program	(3,364)	(3,611)	(4,109)	3,545	(1,521)	(583)	48,557	1,736	1,670	1,210	108	(1,307)	42,331
Group Care Program	(15)	(24)	(14)	(26)	(20)	37	(19)	5	12	23	(3)	18	(26)
Total	**(3,379)**	**(3,635)**	**(4,123)**	**3,519**	**(1,541)**	**(546)**	**48,538**	**1,741**	**1,682**	**1,233**	**105**	**(1,289)**	**42,305**
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%	27.7%	27.7%	27.7%	27.6%	28.4%
Adult % of Medi-Cal	14.9%	14.9%	14.9%	15.0%	15.0%	14.9%	15.9%	15.9%	15.9%	15.9%	15.9%	15.8%	15.4%
SPD % of Medi-Cal	8.8%	8.8%	8.9%	8.9%	8.9%	8.9%	8.9%	8.8%	8.8%	8.7%	8.7%	8.8%	8.8%
ACA OE % of Medi-Cal	35.1%	34.9%	34.8%	34.8%	34.8%	34.6%	36.9%	37.0%	37.2%	37.3%	37.4%	37.5%	36.1%
Duals % of Medi-Cal	11.8%	12.0%	12.1%	11.9%	11.8%	11.8%	10.2%	10.2%	10.1%	10.0%	10.0%	10.0%	10.9%
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

	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	89,759	89,551	88,353	88,040	1,002,242
Alameda Health System	66,089	65,344	64,133	63,271	63,903	63,545	83,981	89,168	90,086	90,631	91,108	90,864	922,123
	140,636	138,371	136,637	141,801	139,044	139,773	188,887	180,824	179,845	180,182	179,461	178,904	1,924,365
Delegated:													
CFMG	34,810	34,649	34,144	34,035	35,105	35,399	42,148	43,527	43,412	43,700	44,076	43,991	468,996
CHCN	130,230	129,183	127,430	126,705	127,641	128,331	169,483	177,908	180,684	181,292	181,742	181,095	1,841,724
Kaiser	52,630	52,468	52,337	51,526	50,736	48,477	0	0	0	0	0	0	308,174
Delegated Subtotal	217,670	216,300	213,911	212,266	213,482	212,207	211,631	221,435	224,096	224,992	225,818	225,086	2,618,894
Total	**358,306**	**354,671**	**350,548**	**354,067**	**352,526**	**351,980**	**400,518**	**402,259**	**403,941**	**405,174**	**405,279**	**403,990**	**4,543,259**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	(939)	(2,265)	(1,734)	5,164	(2,757)	729	49,114	(8,063)	(979)	337	(721)	(557)	37,329
Delegated:													
CFMG	(441)	(161)	(505)	(109)	1,070	294	6,749	1,379	(115)	288	376	(85)	8,740
CHCN	(1,721)	(1,047)	(1,753)	(725)	936	690	41,152	8,425	2,776	608	450	(647)	49,144
Kaiser	(278)	(162)	(131)	(811)	(790)	(2,259)	(48,477)	0	0	0	0	0	(52,908)
Delegated Subtotal	(2,440)	(1,370)	(2,389)	(1,645)	1,216	(1,275)	(576)	9,804	2,661	896	826	(732)	4,976
Total	**(3,379)**	**(3,635)**	**(4,123)**	**3,519**	**(1,541)**	**(546)**	**48,538**	**1,741**	**1,682**	**1,233**	**105**	**(1,289)**	**42,305**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	39.3%	39.0%	39.0%	40.0%	39.4%	39.7%	47.2%	45.0%	44.5%	44.5%	44.3%	44.3%	42.4%
Delegated:													
CFMG	9.7%	9.8%	9.7%	9.6%	10.0%	10.1%	10.5%	10.8%	10.7%	10.8%	10.9%	10.9%	10.3%
CHCN	36.3%	36.4%	36.4%	35.8%	36.2%	36.5%	42.3%	44.2%	44.7%	44.7%	44.8%	44.8%	40.5%
Kaiser	14.7%	14.8%	14.9%	14.6%	14.4%	13.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.8%
Delegated Subtotal	60.7%	61.0%	61.0%	60.0%	60.6%	60.3%	52.8%	55.0%	55.5%	55.5%	55.7%	55.7%	57.6%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING

FOR THE FISCAL YEAR 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	10,427	11,777	12,900	13,559	69,291
Adult	0	0	0	0	279	395	5,382	6,329	7,186	8,073	8,596	8,634	44,874
SPD	0	0	0	0	131	358	(7,460)	(7,258)	(6,824)	(6,574)	(6,165)	(5,881)	(39,673)
ACA OE	0	0	0	0	(607)	63	(3,355)	(799)	2,128	4,840	6,685	8,154	17,109
Duals	0	0	0	0	(413)	(351)	(5,670)	(5,291)	(5,378)	(5,555)	(5,570)	(5,570)	(33,798)
MCAL LTC	0	0	0	0	1	(2)	47	44	42	49	44	45	270
MCAL LTC Duals	0	0	0	0	(10)	(20)	117	153	148	149	158	140	835
Medi-Cal Program	0	0	0	0	515	3,523	(3,545)	2,198	7,729	12,759	16,648	19,081	58,908
Group Care Program	0	0	0	0	(6)	45	40	59	85	122	133	165	643
Total	**0**	**0**	**0**	**0**	**509**	**3,568**	**(3,505)**	**2,257**	**7,814**	**12,881**	**16,781**	**19,246**	**59,551**
Current Direct/Delegate Enrollment Variance - Favorable/(Unfavorable)													
Directly-Contracted													
Directly Contracted (DCP)	0	0	0	0	(3,033)	(1,315)	919	(11,498)	(12,582)	(11,985)	(12,386)	(11,909)	(63,789)
Alameda Health System	0	0	0	0	926	1,291	(2,869)	3,243	5,064	6,502	7,863	8,493	30,513
	0	0	0	0	(2,107)	(24)	(1,950)	(8,255)	(7,518)	(5,483)	(4,523)	(3,416)	(33,276)
Delegated:													
CFMG	0	0	0	0	1,396	2,060	(956)	932	1,281	2,029	2,859	3,224	12,825
CHCN	0	0	0	0	1,672	3,694	(599)	9,580	14,051	16,335	18,445	19,438	82,616
Kaiser	0	0	0	0	(452)	(2,162)	0	0	0	0	0	0	(2,614)
Delegated Subtotal	0	0	0	0	2,616	3,592	(1,555)	10,512	15,332	18,364	21,304	22,662	92,827
Total	**0**	**0**	**0**	**0**	**509**	**3,568**	**(3,505)**	**2,257**	**7,814**	**12,881**	**16,781**	**19,246**	**59,551**

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				CAPITATED MEDICAL EXPENSES:				
$5,168,313	$1,363,679	($3,804,634)	(279.0%)	PCP Capitation	$37,893,253	$15,299,003	($22,594,250)	(147.7%)
6,134,407	6,037,922	(96,485)	(1.6%)	PCP Capitation FQHC	62,652,001	63,665,560	1,013,559	1.6%
374,061	353,957	(20,104)	(5.7%)	Specialty-Capitation	4,061,646	3,959,010	(102,636)	(2.6%)
5,369,484	5,427,719	58,234	1.1%	Specialty-Capitation FQHC	54,616,999	56,517,220	1,900,220	3.4%
706,569	692,140	(14,429)	(2.1%)	Laboratory Capitation	7,471,564	7,312,260	(159,304)	(2.2%)
338,567	320,130	(18,437)	(5.8%)	Vision Cap	3,551,898	3,483,625	(68,273)	(2.0%)
108,829	103,093	(5,736)	(5.6%)	CFMG Capitation	1,181,563	1,152,808	(28,755)	(2.5%)
265,196	265,110	(86)	0.0%	Anc IPA Admin Capitation FQHC	2,703,411	2,776,867	73,456	2.6%
0	0	0	0.0%	Kaiser Capitation	80,008,718	84,015,590	4,006,872	4.8%
0	0	0	0.0%	BHT Supplemental Expense	4,672	0	(4,672)	0.0%
9,318	0	(9,318)	0.0%	Maternity Supplemental Expense	2,442,419	2,311,103	(131,317)	(5.7%)
876,280	1,013,116	136,837	13.5%	DME Cap	9,560,570	10,555,518	994,948	9.4%
$19,351,023	**$15,576,865**	**($3,774,157)**	**(24.2%)**	**5 - TOTAL CAPITATED EXPENSES**	**$266,148,714**	**$251,048,563**	**($15,100,151)**	**(6.0%)**
				FEE FOR SERVICE MEDICAL EXPENSES:				
4,550,555	0	(4,550,555)	0.0%	IBNR Inpatient Services	26,044,346	(2,306,298)	(28,350,644)	1,229.3%
136,518	0	(136,518)	0.0%	IBNR Settlement (IP)	781,331	(69,188)	(850,519)	1,229.3%
1,327,293	0	(1,327,293)	0.0%	IBNR Claims Fluctuation (IP)	2,083,549	(184,504)	(2,268,053)	1,229.3%
35,176,548	47,623,940	12,447,392	26.1%	Inpatient Hospitalization FFS	414,538,117	478,508,224	63,970,107	13.4%
3,089,769	0	(3,089,769)	0.0%	IP OB - Mom & NB	27,730,380	7,462,632	(20,267,747)	(271.6%)
11,942	0	(11,942)	0.0%	IP Behavioral Health	2,178,477	895,483	(1,282,993)	(143.3%)
1,263,236	0	(1,263,236)	0.0%	IP Facility Rehab FFS	12,883,595	4,711,642	(8,171,953)	(173.4%)
$45,555,861	**$47,623,940**	**$2,068,079**	**4.3%**	**6 - Inpatient Hospital & SNF Expense**	**$486,239,794**	**$489,017,992**	**$2,778,198**	**0.6%**
17,590	0	(17,590)	0.0%	IBNR PCP	508,260	46,983	(461,277)	(981.8%)
527	0	(527)	0.0%	IBNR Settlement (PCP)	15,246	1,409	(13,837)	(982.0%)
(9,163)	0	9,163	0.0%	IBNR Claims Fluctuation (PCP)	40,661	3,759	(36,902)	(981.7%)
4,497,867	2,663,317	(1,834,551)	(68.9%)	Primary Care Non-Contracted FF	38,190,460	27,659,529	(10,530,931)	(38.1%)
(223,275)	315,652	538,927	170.7%	PCP FQHC FFS	4,781,906	4,442,113	(339,793)	(7.6%)
(6,000)	0	6,000	0.0%	Phys Extended Hours Incentive	(2,500)	6,000	8,500	141.7%
(1,817)	3,554,900	3,556,717	100.1%	Prop 56 Physician	10,119,533	37,502,924	27,383,390	73.0%
(72,148)	0	72,148	0.0%	Prop 56 Hyde	185,552	58,257	(127,295)	(218.5%)
75,019	0	(75,019)	0.0%	Prop 56 Trauma Screening	784,000	316,945	(467,054)	(147.4%)
80,884	0	(80,884)	0.0%	Prop 56 Develop. Screening	857,377	383,782	(473,594)	(123.4%)
763,818	0	(763,818)	0.0%	Prop 56 Family Planning	6,512,355	2,905,675	(3,606,680)	(124.1%)
(696)	0	696	0.0%	Prop 56 VBP	(4,306,341)	7,428	4,313,770	58,071.9%
$5,122,607	**$6,533,868**	**$1,411,261**	**21.6%**	**7 - Primary Care Physician Expense**	**$57,686,508**	**$73,334,806**	**$15,648,298**	**21.3%**
929,560	0	(929,560)	0.0%	IBNR Specialist	1,229,643	(704,271)	(1,933,914)	274.6%
264,491	0	(264,491)	0.0%	Psychiatrist FFS	3,492,221	927,497	(2,564,724)	(276.5%)
2,991,039	7,456,794	4,465,755	59.9%	Specialty Care FFS	31,683,870	65,361,254	33,677,384	51.5%
196,614	0	(196,614)	0.0%	Specialty Anesthesiology	2,292,197	733,088	(1,559,109)	(212.7%)
1,189,455	0	(1,189,455)	0.0%	Specialty Imaging FFS	14,404,540	4,332,553	(10,071,986)	(232.5%)
22,229	0	(22,229)	0.0%	Obstetrics FFS	265,989	71,825	(194,165)	(270.3%)
370,212	0	(370,212)	0.0%	Specialty IP Surgery FFS	3,825,638	1,146,377	(2,679,261)	(233.7%)
794,933	0	(794,933)	0.0%	Specialty OP Surgery FFS	8,755,122	2,380,160	(6,374,963)	(267.8%)
627,470	0	(627,470)	0.0%	Spec IP Physician	6,214,542	1,804,945	(4,409,597)	(244.3%)
110,907	101,527	(9,380)	(9.2%)	SCP FQHC FFS	1,133,392	1,019,509	(113,882)	(11.2%)
27,886	0	(27,886)	0.0%	IBNR Settlement (SCP)	36,893	(21,127)	(58,020)	274.6%
33,773	0	(33,773)	0.0%	IBNR Claims Fluctuation (SCP)	98,371	(56,342)	(154,713)	274.6%
$7,558,568	**$7,558,321**	**($248)**	**0.0%**	**8 - Specialty Care Physician Expense**	**$73,432,418**	**$76,995,468**	**$3,563,051**	**4.6%**
2,412,077	0	(2,412,077)	0.0%	IBNR Ancillary	5,984,925	2,122,555	(3,862,370)	(182.0%)
72,363	0	(72,363)	0.0%	IBNR Settlement (ANC)	179,550	63,677	(115,873)	(182.0%)
253,961	0	(253,961)	0.0%	IBNR Claims Fluctuation (ANC)	478,794	169,805	(308,989)	(182.0%)
115,438	0	(115,438)	0.0%	IBNR Transportation FFS	713,540	45,720	(667,820)	(1,460.7%)
1,533,903	0	(1,533,903)	0.0%	Behavioral Health Therapy FFS	16,614,052	4,951,126	(11,662,926)	(235.6%)
1,520,118	0	(1,520,118)	0.0%	Psychologist & Other MH Prof.	15,053,567	4,215,464	(10,838,103)	(257.1%)
320,977	0	(320,977)	0.0%	Acupuncture/Biofeedback	3,668,470	1,075,338	(2,593,131)	(241.1%)
122,821	0	(122,821)	0.0%	Hearing Devices	1,450,933	381,525	(1,069,407)	(280.3%)
53,827	0	(53,827)	0.0%	Imaging/MRI/CT Global	589,562	141,544	(448,018)	(316.5%)
69,931	0	(69,931)	0.0%	Vision FFS	710,757	164,593	(546,164)	(331.8%)
20	0	(20)	0.0%	Family Planning	109	30	(79)	(266.7%)
915,198	0	(915,198)	0.0%	Laboratory-FFS	7,512,705	1,917,612	(5,595,093)	(291.8%)
112,155	0	(112,155)	0.0%	ANC Therapist	1,290,289	395,200	(895,089)	(226.5%)
1,728,272	0	(1,728,272)	0.0%	Transportation (Ambulance)-FFS	14,930,889	3,746,485	(11,184,404)	(298.5%)
2,265,766	0	(2,265,766)	0.0%	Transportation (Other)-FFS	20,865,269	5,929,067	(14,936,202)	(251.9%)
1,745,128	0	(1,745,128)	0.0%	Hospice	18,342,339	5,779,983	(12,562,356)	(217.3%)

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

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
1,638,637	0	(1,638,637)	0.0%	Home Health Services	16,488,445	4,994,036	(11,494,408)	(230.2%)
0	12,209,826	12,209,826	100.0%	Other Medical-FFS	12,077	92,383,214	92,371,137	100.0%
0	0	0	0.0%	Medical Refunds through HMS	(160,659)	(309,963)	(149,303)	48.2%
0	0	0	0.0%	Medical Refunds	(768,260)	(565,083)	203,177	(36.0%)
35,692	0	(35,692)	0.0%	DME & Medical Supplies	377,498	116,689	(260,808)	(223.5%)
0	0	0	0.0%	GEMT FFS	(373,988)	(373,988)	0	0.0%
(220,093)	1,796,499	2,016,592	112.3%	ECM Base/Outreach FFS Anc.	17,268,099	19,033,853	1,765,754	9.3%
172,785	0	(172,785)	0.0%	CS Housing Deposits FFS Ancillary	(3,978,952)	135,985	4,114,936	3,026.0%
2,601,453	0	(2,601,453)	0.0%	CS Housing Tenancy FFS Ancillary	9,404,369	1,183,089	(8,221,280)	(694.9%)
1,207,794	0	(1,207,794)	0.0%	CS Housing Navigation Services FFS Ancillary	1,368,022	257,647	(1,110,375)	(431.0%)
1,864,749	0	(1,864,749)	0.0%	CS Medical Respite FFS Ancillary	3,959,001	377,892	(3,581,109)	(947.7%)
871,287	0	(871,287)	0.0%	CS Medically Tailored Meals FFS Ancillary	754,554	128,446	(626,108)	(487.4%)
57,293	0	(57,293)	0.0%	CS Asthma Remediation FFS Ancillary	(177,759)	11,648	189,407	1,626.1%
0	10,000	10,000	100.0%	MOT Wrap Around (Non Medical MOT Cost)	0	80,000	80,000	100.0%
1,177,566	0	(1,177,566)	0.0%	CS Personal Care & Homemaker Services FFS Ancillary	2,885,416	0	(2,885,416)	0.0%
7,575	0	(7,575)	0.0%	CS Caregiver Respite Services FFS Ancillary	20,322	0	(20,322)	0.0%
205,318	0	(205,318)	0.0%	Community Based Adult Services (CBAS)	4,452,723	1,425,263	(3,027,460)	(212.4%)
0	0	0	0.0%	CS Pilot LTC Diversion Expense	0	15,291	15,291	100.0%
0	0	0	0.0%	CS Pilot LTC Transition Expense	42,815	23,701	(19,114)	(80.6%)
0	0	0	0.0%	Justice Involved Pilot	0	161,111	161,111	100.0%
$22,862,010	**$14,016,325**	**($8,845,685)**	**(63.1%)**	**9 - Ancillary Medical Expense**	**$159,959,474**	**$150,178,558**	**($9,780,916)**	**(6.5%)**
1,890,318	0	(1,890,318)	0.0%	IBNR Outpatient	5,318,225	422,626	(4,895,599)	(1,158.4%)
56,710	0	(56,710)	0.0%	IBNR Settlement (OP)	159,546	12,677	(146,869)	(1,158.5%)
156,991	0	(156,991)	0.0%	IBNR Claims Fluctuation (OP)	425,454	33,811	(391,643)	(1,158.3%)
1,927,524	12,086,307	10,158,783	84.1%	Out Patient FFS	21,952,477	96,467,498	74,515,021	77.2%
1,811,676	0	(1,811,676)	0.0%	OP Ambul Surgery FFS	22,294,097	6,937,396	(15,356,702)	(221.4%)
2,321,145	0	(2,321,145)	0.0%	OP Fac Imaging Services FFS	22,958,419	6,670,623	(16,287,797)	(244.2%)
30,227	0	(30,227)	0.0%	Behav Health FFS	178,131	(21,966)	(200,097)	910.9%
579,946	0	(579,946)	0.0%	OP Facility Lab FFS	7,085,017	2,081,864	(5,003,153)	(240.3%)
166,424	0	(166,424)	0.0%	OP Facility Cardio FFS	2,044,255	608,098	(1,436,157)	(236.2%)
100,915	0	(100,915)	0.0%	OP Facility PT/OT/ST FFS	1,754,635	270,230	(1,484,404)	(549.3%)
2,726,471	0	(2,726,471)	0.0%	OP Facility Dialysis FFS	28,074,095	8,379,495	(19,694,600)	(235.0%)
$11,768,346	**$12,086,307**	**$317,961**	**2.6%**	**10 - Outpatient Medical Expense Medical Expense**	**$112,244,351**	**$121,862,351**	**$9,618,000**	**7.9%**
1,658,930	0	(1,658,930)	0.0%	IBNR Emergency	3,608,324	30,260	(3,578,064)	(11,824.4%)
49,768	0	(49,768)	0.0%	IBNR Settlement (ER)	108,252	910	(107,342)	(11,795.8%)
206,638	0	(206,638)	0.0%	IBNR Claims Fluctuation (ER)	288,671	2,423	(286,248)	(11,813.8%)
1,297,109	0	(1,297,109)	0.0%	Special ER Physician FFS	11,534,581	3,056,795	(8,477,786)	(277.3%)
7,587,016	7,579,788	(7,228)	(0.1%)	ER Facility	76,618,045	77,213,834	595,789	0.8%
$10,799,461	**$7,579,788**	**($3,219,674)**	**(42.5%)**	**11 - Emergency Expense**	**$92,157,874**	**$80,304,222**	**($11,853,652)**	**(14.8%)**
1,422,876	0	(1,422,876)	0.0%	IBNR Pharmacy OP	2,751,320	(204,308)	(2,955,628)	1,446.7%
42,686	0	(42,686)	0.0%	IBNR Settlement (RX) OP	82,536	(6,133)	(88,669)	1,445.8%
137,619	0	(137,619)	0.0%	IBNR Claims Fluctuation (RX) OP	220,108	(16,345)	(236,453)	1,446.6%
604,379	365,502	(238,877)	(65.4%)	Pharmacy FFS	6,312,823	4,894,270	(1,418,552)	(29.0%)
139,480	11,740,808	11,601,328	98.8%	Pharmacy Non-PBM FFS-Other Anc	1,583,753	89,320,863	87,737,111	98.2%
7,725,980	0	(7,725,980)	0.0%	Pharmacy Non-PBM FFS-OP FAC	75,718,464	21,975,503	(53,742,961)	(244.6%)
208,772	0	(208,772)	0.0%	Pharmacy Non-PBM FFS-PCP	2,680,536	615,362	(2,065,174)	(335.6%)
2,223,521	0	(2,223,521)	0.0%	Pharmacy Non-PBM FFS-SCP	26,601,109	8,807,902	(17,793,208)	(202.0%)
9,415	0	(9,415)	0.0%	Pharmacy Non-PBM FFS-FQHC	143,302	41,158	(102,143)	(248.2%)
23,145	0	(23,145)	0.0%	Pharmacy Non-PBM FFS-HH	128,512	27,987	(100,525)	(359.2%)
0	0	0	0.0%	RX Refunds HMS	(494)	(63)	430	(680.6%)
(54,000)	31,512	85,512	271.4%	Pharmacy Rebate	(622,617)	94,219	716,836	760.8%
$12,483,871	**$12,137,822**	**($346,049)**	**(2.9%)**	**12 - Pharmacy Expense**	**$115,599,352**	**$125,550,416**	**$9,951,064**	**7.9%**
6,009,729	0	(6,009,729)	0.0%	IBNR LTC	26,865,175	4,802,539	(22,062,636)	(459.4%)
180,292	0	(180,292)	0.0%	IBNR Settlement (LTC)	805,958	144,077	(661,881)	(459.4%)
1,000,731	0	(1,000,731)	0.0%	IBNR Claims Fluctuation (LTC)	2,149,213	384,202	(1,765,011)	(459.4%)
1,414,878	0	(1,414,878)	0.0%	LTC - ICF/DD	6,809,538	0	(6,809,538)	0.0%
18,047,026	0	(18,047,026)	0.0%	LTC Custodial Care	229,709,058	63,392,176	(166,316,882)	(262.4%)
6,174,671	23,401,431	17,226,761	73.6%	LTC SNF	45,681,646	188,911,260	143,229,614	75.8%
$32,827,326	**$23,401,431**	**($9,425,895)**	**(40.3%)**	**13 - Long Term Care Expense**	**$312,020,589**	**$257,634,255**	**($54,386,334)**	**(21.1%)**
$148,978,050	**$130,937,801**	**($18,040,249)**	**(13.8%)**	**14 - TOTAL FFS MEDICAL EXPENSES**	**$1,409,340,358**	**$1,374,878,067**	**($34,462,292)**	**(2.5%)**
0	(160,447)	(160,447)	100.0%	Clinical Vacancy Department Total	0	(2,293,245)	(2,293,245)	100.0%
166,942	162,249	(4,694)	(2.9%)	Quality Analytics Department Total	1,051,281	1,783,947	732,666	41.1%
1,072,540	1,076,310	3,769	0.4%	Utilization Management Department Total	10,826,559	12,216,313	1,389,754	11.4%

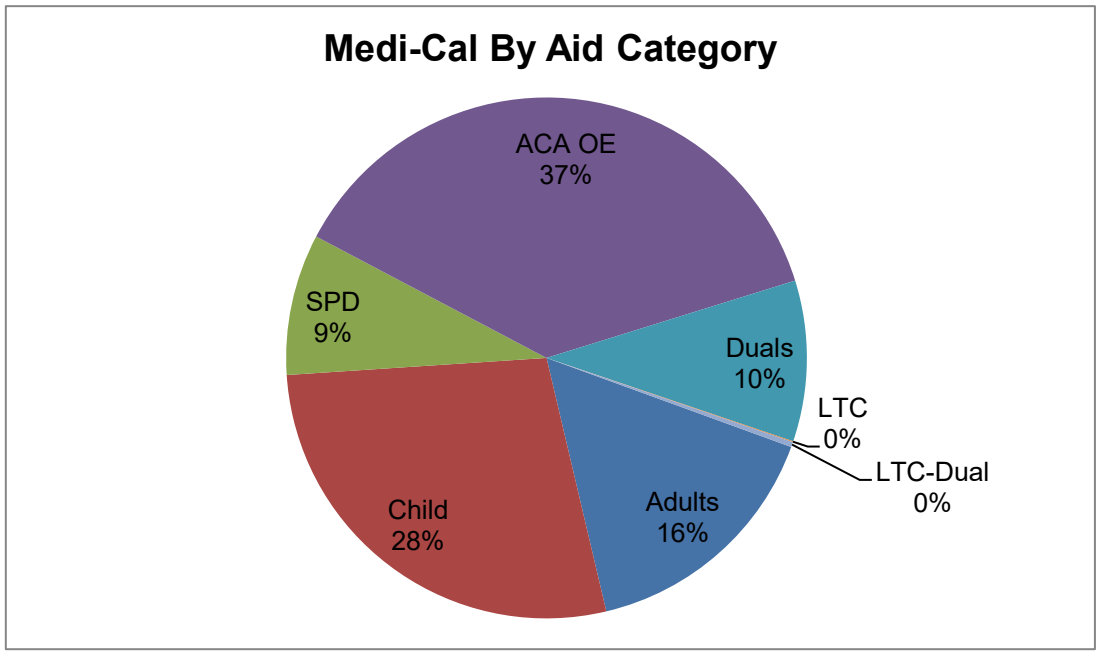
ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED JUNE 30, 2024

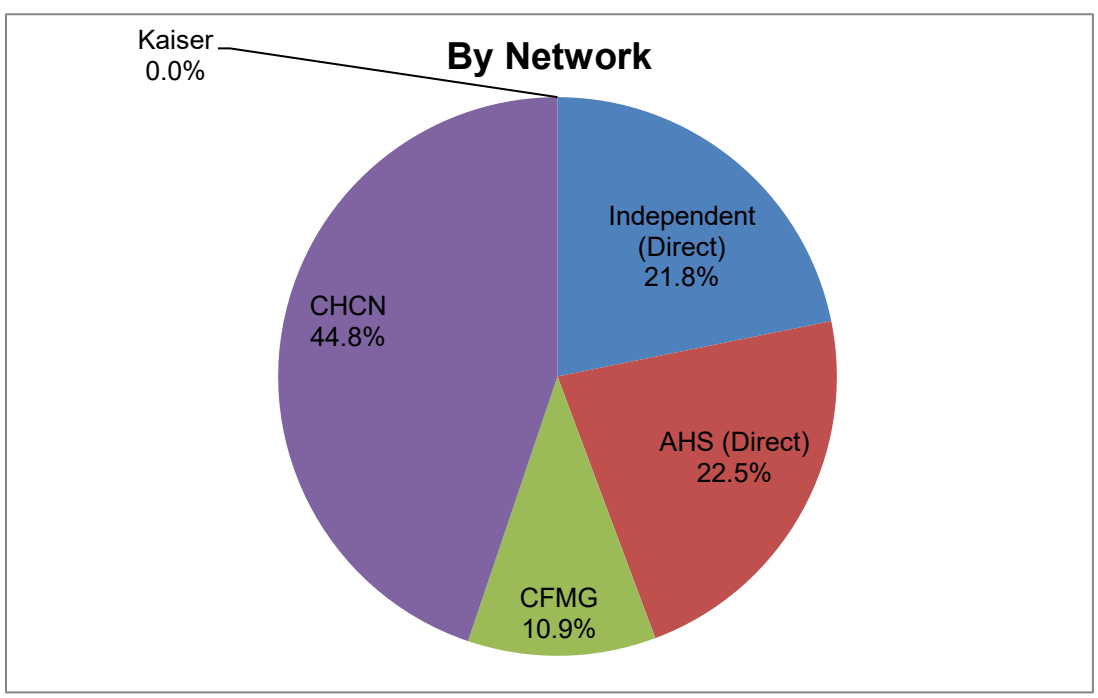
CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
675,879	683,792	7,913	1.2%	Case/Disease Management Department Total	7,566,501	7,964,396	397,895	5.0%
(3,269,425)	1,531,952	4,801,377	313.4%	Medical Services Department Total	15,447,498	21,182,254	5,734,756	27.1%
842,229	1,597,846	755,617	47.3%	Quality Management Department Total	10,267,082	14,027,846	3,760,764	26.8%
302,905	324,489	21,584	6.7%	HCS Behavioral Health Department Total	3,451,085	3,737,952	286,867	7.7%
128,940	149,543	20,604	13.8%	Pharmacy Services Department Total	1,677,468	1,848,333	170,865	9.2%
55,395	61,931	6,536	10.6%	Regulatory Readiness Total	743,289	803,585	60,296	7.5%
($24,594)	**$5,427,665**	**$5,452,259**	**100.5%**	**15 - Other Benefits & Services**	**$51,030,763**	**$61,271,381**	**$10,240,618**	**16.7%**
(1,253,257)	(1,053,858)	199,399	(18.9%)	Reinsurance Recoveries	(16,356,865)	(11,739,721)	4,617,144	(39.3%)
1,401,953	1,405,144	3,191	0.2%	Reinsurance Premium	14,754,705	14,767,184	12,478	0.1%
$148,695	**$351,286**	**$202,591**	**57.7%**	**16- Reinsurance Expense**	**($1,602,160)**	**$3,027,462**	**$4,629,622**	**152.9%**
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%**
$168,453,174	**$152,293,617**	**($16,159,557)**	**(10.6%)**	**18 - TOTAL MEDICAL EXPENSES**	**$1,727,917,675**	**$1,693,225,473**	**($34,692,202)**	**(2.0%)**

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend

Category of Aid	Jun 2024	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Adults	62,786	16%	12,794	14,436	10	35,546	-
Child	110,164	28%	9,092	13,607	41,039	46,426	-
SPD	34,935	9%	11,366	5,529	1,437	16,603	-
ACA OE	149,359	37%	25,256	53,589	1,501	69,013	-
Duals	39,789	10%	26,114	2,818	4	10,853	-
LTC	224	0%	209	7	-	8	-
LTC-Dual	1,250	0%	1,248	-	-	2	-
Medi-Cal	398,507		86,079	89,986	43,991	178,451	-
Group Care	5,658		2,127	882	-	2,649	-
Total	**404,165**	**100%**	**88,206**	**90,868**	**43,991**	**181,100**	**-**
Medi-Cal %	98.6%		97.6%	99.0%	100.0%	98.5%	0%
Group Care %	1.4%		2.4%	1.0%	0.0%	1.5%	0.0%
	Network Distribution		*21.8%*	*22.5%*	*10.9%*	*44.8%*	*0.0%*
			% Direct:	**44%**		**% Delegated:**	**56%**

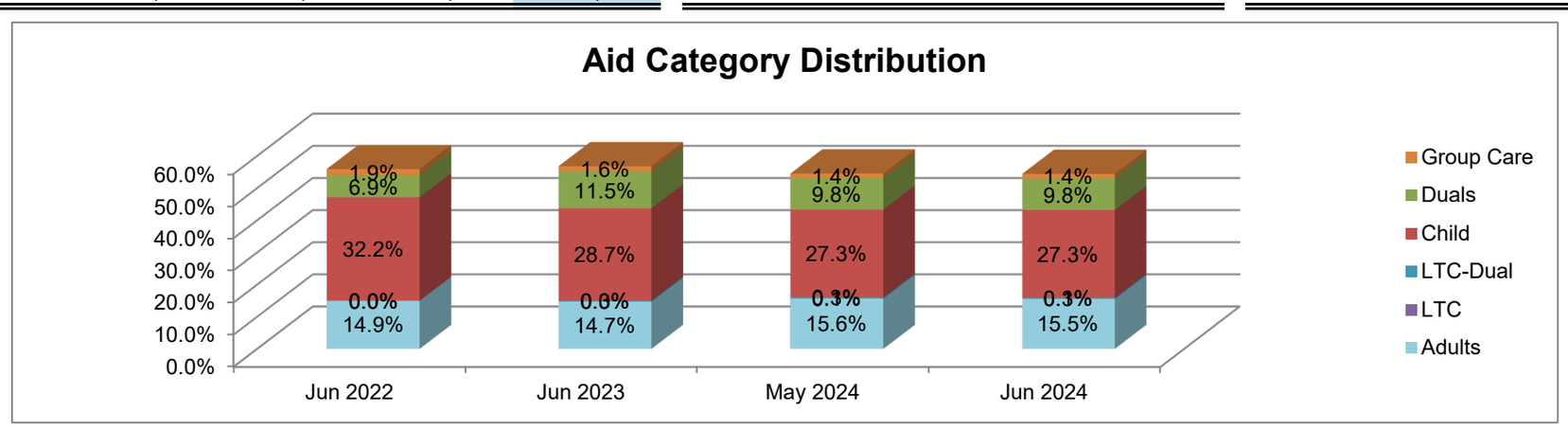




Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

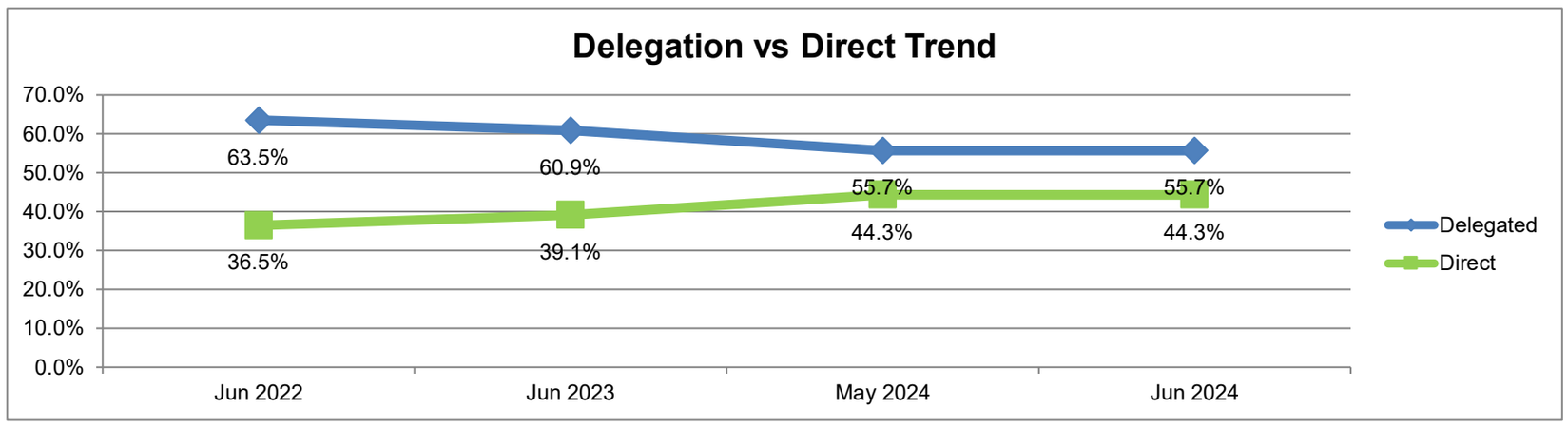
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Jun 2022	Jun 2023	May 2024	Jun 2024	Jun 2022	Jun 2023	May 2024	Jun 2024	Jun 2022 to Jun 2023	Jun 2023 to Jun 2024	May 2024 to Jun 2024
Adults	46,761	53,174	63,405	62,786	14.9%	14.7%	15.6%	15.5%	13.7%	18.1%	-1.0%
Child	100,772	103,670	110,561	110,164	32.2%	28.7%	27.3%	27.3%	2.9%	6.3%	-0.4%
SPD	27,105	31,280	34,965	34,935	8.7%	8.6%	8.6%	8.6%	15.4%	11.7%	-0.1%
ACA OE	110,938	124,967	149,427	149,359	35.4%	34.6%	36.9%	37.0%	12.6%	19.5%	0.0%
Duals	21,685	41,731	39,842	39,789	6.9%	11.5%	9.8%	9.8%	92.4%	-4.7%	-0.1%
LTC	-	150	220	224	0.0%	0.0%	0.1%	0.1%	0.0%	49.3%	1.8%
LTC-Dual	-	1,029	1,283	1,250	0.0%	0.3%	0.3%	0.3%	0.0%	21.5%	-2.6%
Medi-Cal Total	307,261	356,001	399,703	398,507	98.1%	98.4%	98.6%	98.6%	15.9%	11.9%	-0.3%
Group Care	5,795	5,684	5,640	5,658	1.9%	1.6%	1.4%	1.4%	-1.9%	-0.5%	0.3%
Total	**313,056**	**361,685**	**405,343**	**404,165**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**15.5%**	**11.7%**	**-0.3%**



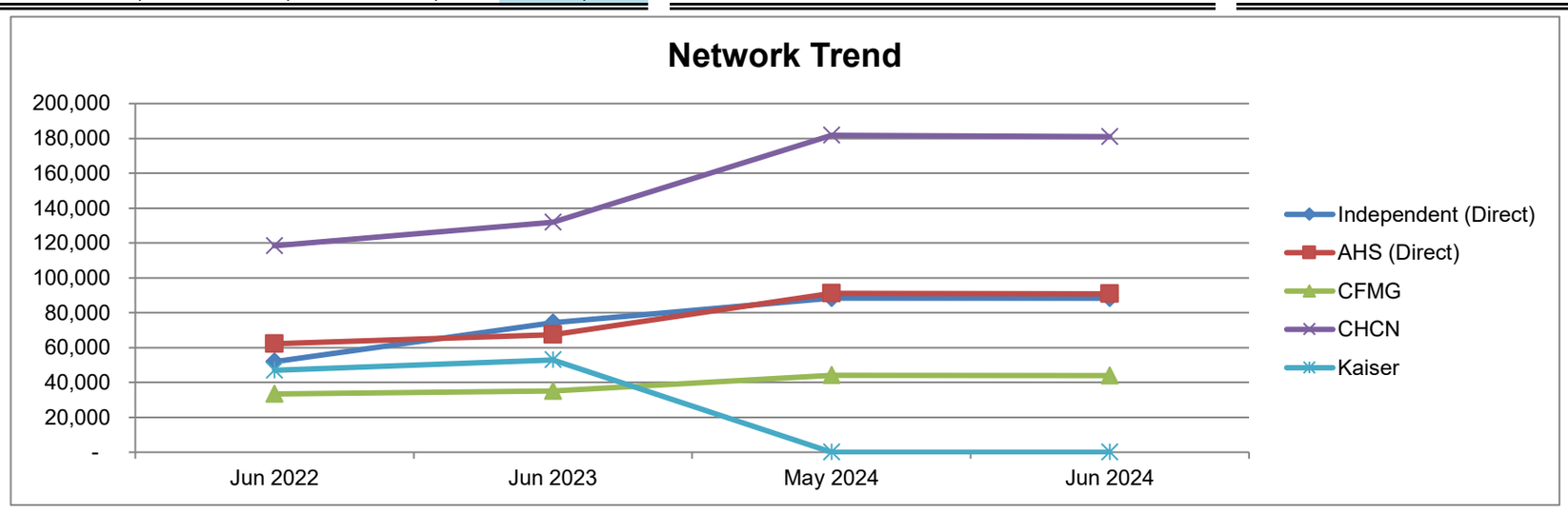
Delegation vs Direct Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	Jun 2022	Jun 2023	May 2024	Jun 2024	Jun 2022	Jun 2023	May 2024	Jun 2024	Jun 2022 to Jun 2023	Jun 2023 to Jun 2024	May 2024 to Jun 2024
Delegated	198,905	220,110	225,844	225,091	63.5%	60.9%	55.7%	55.7%	10.7%	2.3%	-0.3%
Direct	114,151	141,575	179,499	179,074	36.5%	39.1%	44.3%	44.3%	24.0%	26.5%	-0.2%
Total	**313,056**	**361,685**	**405,343**	**404,165**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**15.5%**	**11.7%**	**-0.3%**



Network Trend

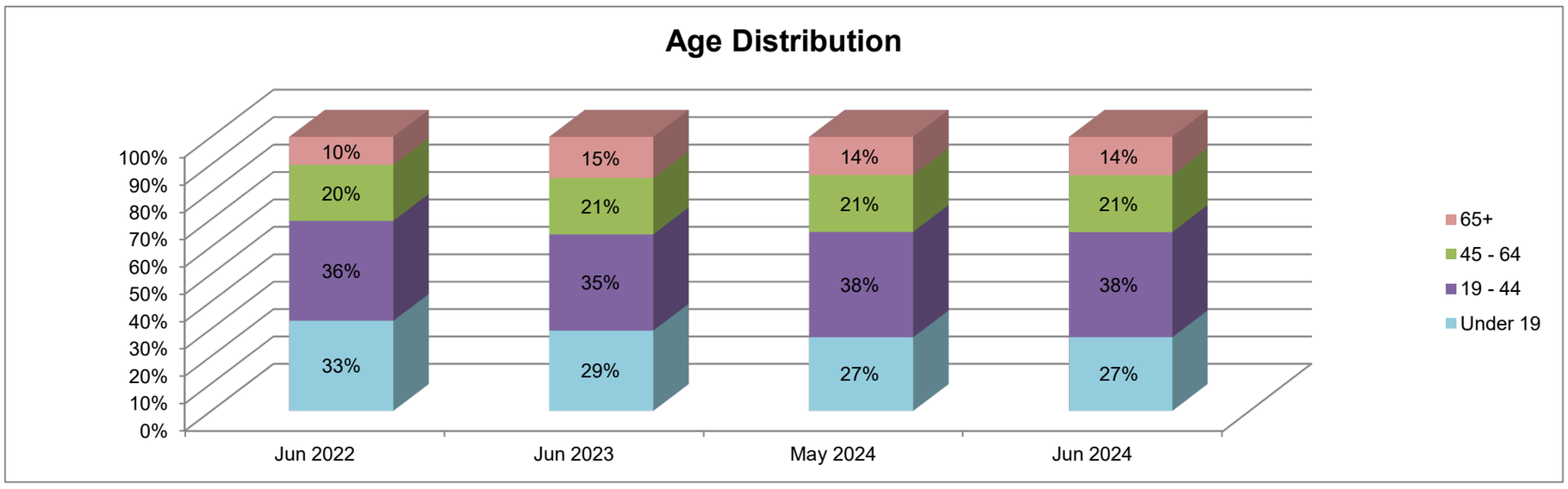
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Jun 2022	Jun 2023	May 2024	Jun 2024	Jun 2022	Jun 2023	May 2024	Jun 2024	Jun 2022 to Jun 2023	Jun 2023 to Jun 2024	May 2024 to Jun 2024
Independent (Direct)	51,936	74,242	88,381	88,206	16.6%	20.5%	21.8%	21.8%	42.9%	18.8%	-0.2%
AHS (Direct)	62,215	67,333	91,118	90,868	19.9%	18.6%	22.5%	22.5%	8.2%	35.0%	-0.3%
CFMG	33,408	35,251	44,083	43,991	10.7%	9.7%	10.9%	10.9%	5.5%	24.8%	-0.2%
CHCN	118,411	131,951	181,761	181,100	37.8%	36.5%	44.8%	44.8%	11.4%	37.2%	-0.4%
Kaiser	47,086	52,908	-	-	15.0%	14.6%	0.0%	0.0%	12.4%	-100.0%	0.0%
Total	**313,056**	**361,685**	**405,343**	**404,165**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**15.5%**	**11.7%**	**-0.3%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

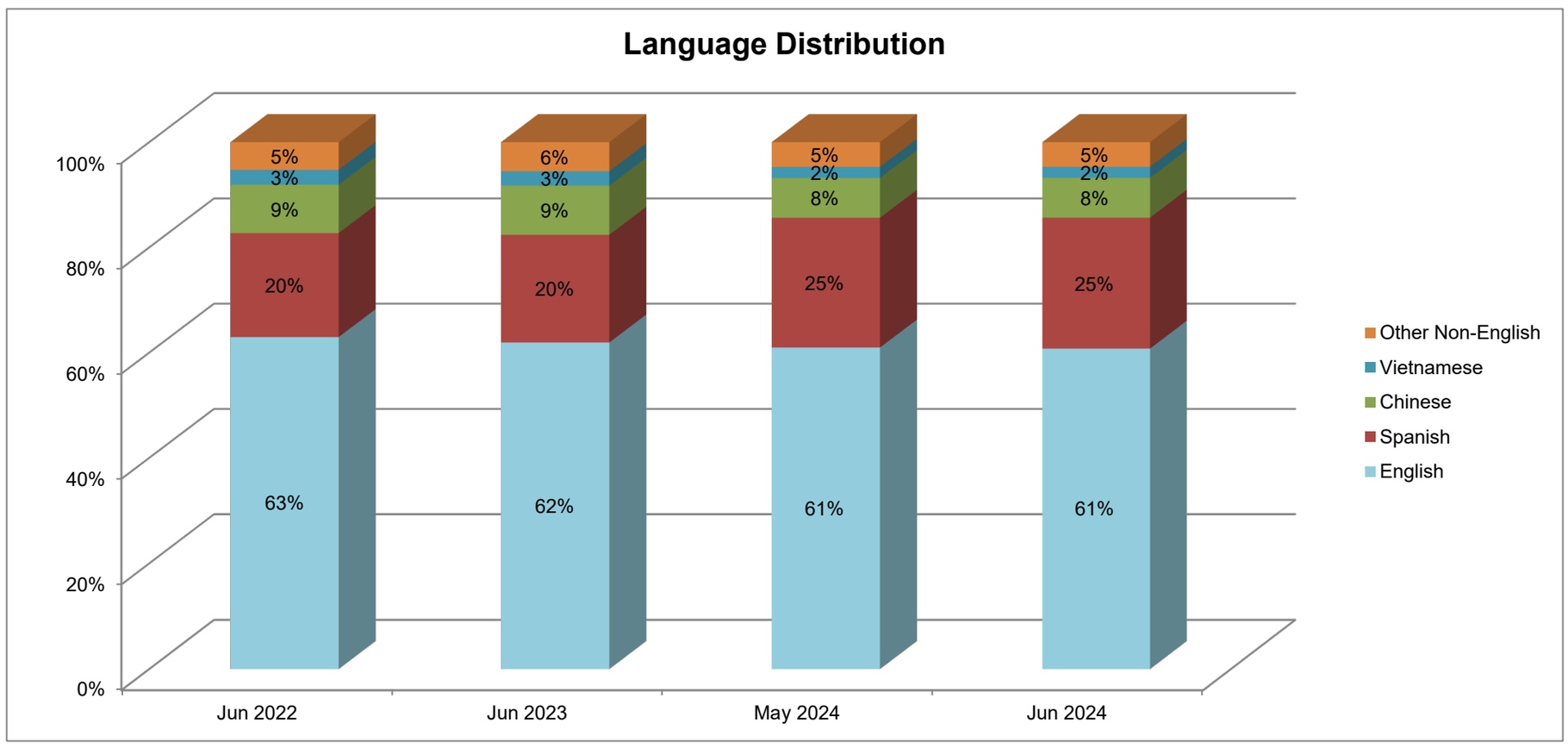
Age Category Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Jun 2022	Jun 2023	May 2024	Jun 2024	Jun 2022	Jun 2023	May 2024	Jun 2024	Jun 2022 to Jun 2023	Jun 2023 to Jun 2024	May 2024 to Jun 2024
Under 19	103,026	106,040	108,994	108,701	33%	29%	27%	27%	3%	3%	0%
19 - 44	114,184	127,085	155,914	155,198	36%	35%	38%	38%	11%	22%	0%
45 - 64	63,899	74,391	84,121	83,870	20%	21%	21%	21%	16%	13%	0%
65+	31,947	54,169	56,314	56,396	10%	15%	14%	14%	70%	4%	0%
Total	**313,056**	**361,685**	**405,343**	**404,165**	**100%**	**100%**	**100%**	**100%**	**16%**	**12%**	**0%**



Language Trend

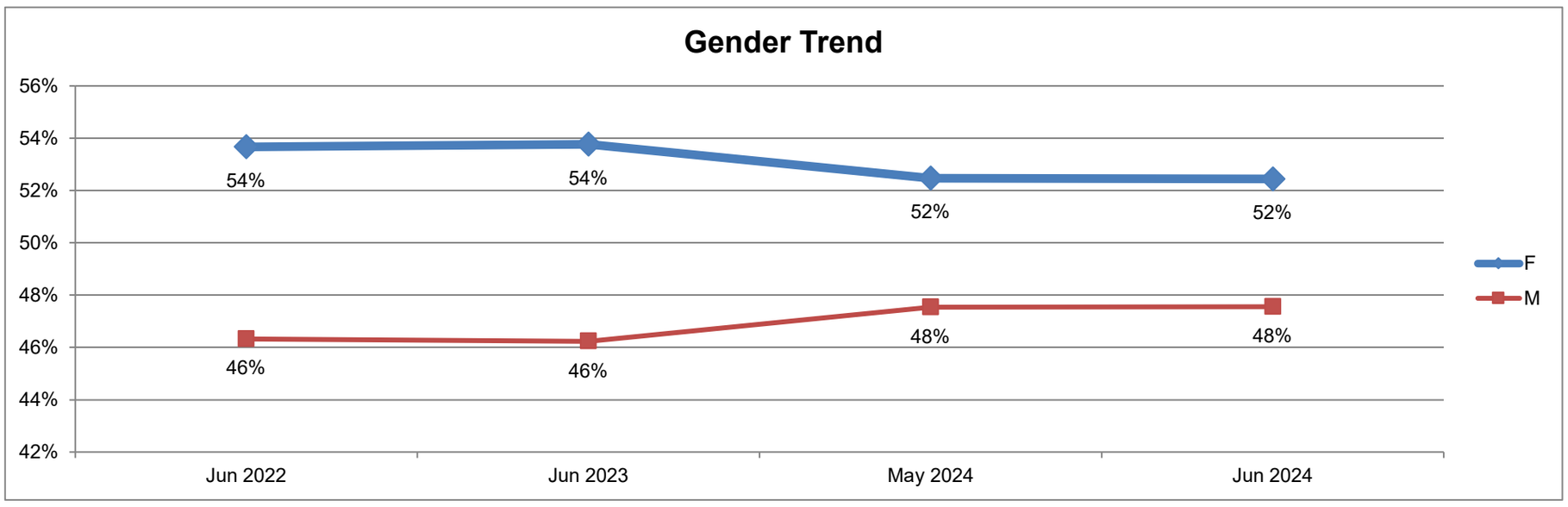
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	Jun 2022	Jun 2023	May 2024	Jun 2024	Jun 2022	Jun 2023	May 2024	Jun 2024	Jun 2022 to Jun 2023	Jun 2023 to Jun 2024	May 2024 to Jun 2024
English	197,106	223,993	247,134	245,593	63%	62%	61%	61%	14%	10%	-1%
Spanish	61,849	74,012	99,964	100,576	20%	20%	25%	25%	20%	36%	1%
Chinese	28,802	33,860	30,741	30,660	9%	9%	8%	8%	18%	-9%	0%
Vietnamese	8,868	9,838	8,461	8,386	3%	3%	2%	2%	11%	-15%	-1%
Other Non-English	16,431	19,982	19,043	18,950	5%	6%	5%	5%	22%	-5%	0%
Total	**313,056**	**361,685**	**405,343**	**404,165**	**100%**	**100%**	**100%**	**100%**	**16%**	**12%**	**0%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

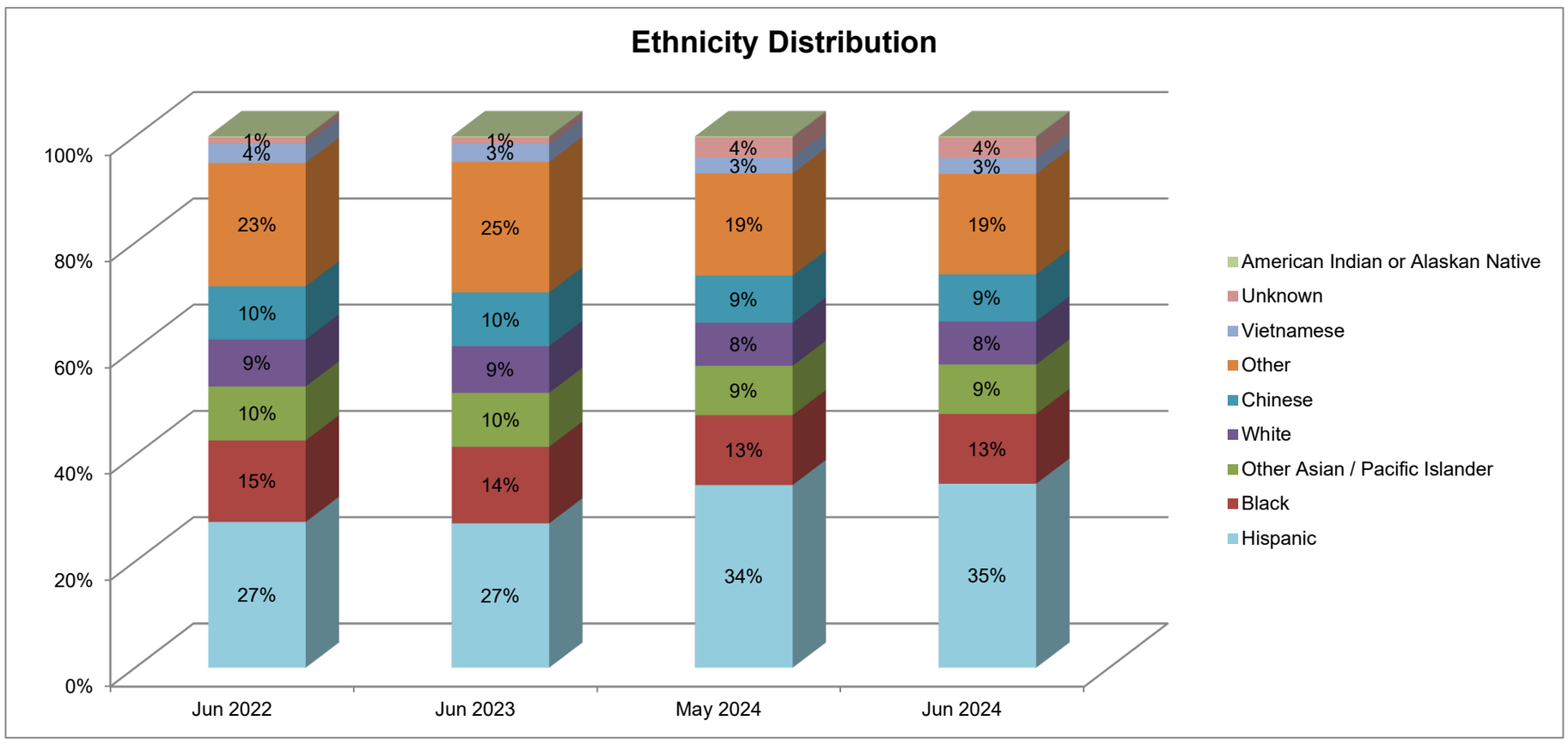
Gender Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Jun 2022	Jun 2023	May 2024	Jun 2024	Jun 2022	Jun 2023	May 2024	Jun 2024	Jun 2022 to Jun 2023	Jun 2023 to Jun 2024	May 2024 to Jun 2024
F	168,023	194,470	212,650	211,959	54%	54%	52%	52%	16%	9%	0%
M	145,033	167,215	192,693	192,206	46%	46%	48%	48%	15%	15%	0%
Total	**313,056**	**361,685**	**405,343**	**404,165**	**100%**	**100%**	**100%**	**100%**	**16%**	**12%**	**0%**



Ethnicity Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Jun 2022	Jun 2023	May 2024	Jun 2024	Jun 2022	Jun 2023	May 2024	Jun 2024	Jun 2022 to Jun 2023	Jun 2023 to Jun 2024	May 2024 to Jun 2024
Hispanic	85,824	98,185	139,254	139,887	27%	27%	34%	35%	14%	42%	0%
Black	48,031	52,097	53,353	53,044	15%	14%	13%	13%	8%	2%	-1%
Other Asian / Pacific Islander	31,777	36,735	37,596	37,615	10%	10%	9%	9%	16%	2%	0%
White	27,666	31,823	32,881	32,738	9%	9%	8%	8%	15%	3%	0%
Chinese	31,360	36,522	35,951	35,855	10%	10%	9%	9%	16%	-2%	0%
Other	72,720	88,825	77,966	76,430	23%	25%	19%	19%	22%	-14%	-2%
Vietnamese	11,426	12,366	11,993	11,893	4%	3%	3%	3%	8%	-4%	-1%
Unknown	3,570	4,397	15,550	15,906	1%	1%	4%	4%	23%	262%	2%
American Indian or Alaskan Native	682	735	799	797	0%	0%	0%	0%	8%	8%	0%
Total	**313,056**	**361,685**	**405,343**	**404,165**	**100%**	**100%**	**100%**	**100%**	**16%**	**12%**	**0%**



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

Medi-Cal By City

City	Jun 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	160,572	40%	23,498	42,614	17,528	76,932	-
Hayward	63,652	16%	12,550	17,165	7,487	26,450	-
Fremont	36,669	9%	15,047	6,734	2,102	12,786	-
San Leandro	33,083	8%	8,112	5,715	4,277	14,979	-
Union City	14,574	4%	5,437	2,609	840	5,688	-
Alameda	13,876	3%	3,347	2,480	2,082	5,967	-
Berkeley	15,058	4%	4,030	2,291	1,753	6,984	-
Livermore	12,825	3%	1,859	655	2,231	8,080	-
Newark	9,278	2%	2,696	4,109	501	1,972	-
Castro Valley	9,466	2%	2,491	1,656	1,396	3,923	-
San Lorenzo	7,298	2%	1,465	1,647	846	3,340	-
Pleasanton	7,391	2%	1,743	416	817	4,415	-
Dublin	7,391	2%	1,979	440	879	4,093	-
Emeryville	2,784	1%	607	619	455	1,103	-
Albany	2,520	1%	660	288	563	1,009	-
Piedmont	490	0%	112	196	57	125	-
Sunol	86	0%	24	15	6	41	-
Antioch	47	0%	11	18	7	11	-
Other	1,447	0%	411	319	164	553	-
Total	**398,507**	**100%**	**86,079**	**89,986**	**43,991**	**178,451**	**-**

Group Care By City

City	Jun 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	1,785	32%	344	331	-	1,110	-
Hayward	630	11%	294	149	-	187	-
Fremont	638	11%	427	70	-	141	-
San Leandro	592	10%	242	87	-	263	-
Union City	297	5%	188	47	-	62	-
Alameda	294	5%	93	23	-	178	-
Berkeley	156	3%	53	10	-	93	-
Livermore	101	2%	30	4	-	67	-
Newark	133	2%	81	29	-	23	-
Castro Valley	191	3%	86	27	-	78	-
San Lorenzo	137	2%	44	21	-	72	-
Pleasanton	67	1%	21	3	-	43	-
Dublin	117	2%	39	6	-	72	-
Emeryville	31	1%	11	4	-	16	-
Albany	22	0%	12	2	-	8	-
Piedmont	10	0%	2	1	-	7	-
Sunol	2	0%	2	-	-	-	-
Antioch	25	0%	7	5	-	13	-
Other	430	8%	151	63	-	216	-
Total	**5,658**	**100%**	**2,127**	**882**	**-**	**2,649**	**-**

Total By City

City	Jun 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	162,357	40%	23,842	42,945	17,528	78,042	-
Hayward	64,282	16%	12,844	17,314	7,487	26,637	-
Fremont	37,307	9%	15,474	6,804	2,102	12,927	-
San Leandro	33,675	8%	8,354	5,802	4,277	15,242	-
Union City	14,871	4%	5,625	2,656	840	5,750	-
Alameda	14,170	4%	3,440	2,503	2,082	6,145	-
Berkeley	15,214	4%	4,083	2,301	1,753	7,077	-
Livermore	12,926	3%	1,889	659	2,231	8,147	-
Newark	9,411	2%	2,777	4,138	501	1,995	-
Castro Valley	9,657	2%	2,577	1,683	1,396	4,001	-
San Lorenzo	7,435	2%	1,509	1,668	846	3,412	-
Pleasanton	7,458	2%	1,764	419	817	4,458	-
Dublin	7,508	2%	2,018	446	879	4,165	-
Emeryville	2,815	1%	618	623	455	1,119	-
Albany	2,542	1%	672	290	563	1,017	-
Piedmont	500	0%	114	197	57	132	-
Sunol	88	0%	26	15	6	41	-
Antioch	72	0%	18	23	7	24	-
Other	1,877	0%	562	382	164	769	-
Total	**404,165**	**100%**	**88,206**	**90,868**	**43,991**	**181,100**	**-**

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: **August 9th, 2024**

Subject: **Operations Report**

Member Services

- 12-Month Trend Blended Summary:
    - The Member Services Department received a twelve percent (12%) decrease in calls in July 2024, totaling eighteen thousand five hundred forty-six (18,546) compared to sixteen thousand two hundred seventy-six (16,276) in July 2023.
    - The abandonment rate for July 2024 was four percent (4%), compared to fourteen percent (14%) in July 2023.
    - The Department's service level was ninety-four percent (94%) in July 2024, compared to sixty-three percent (63%) in July 2023. The average speed to answer (ASA) was fourteen seconds (00:14) compared to one minute and thirty-seven seconds (01:37) in July 2023. The Department continues to recruit to fill open positions. A Customer Service support service vendor continues to provide overflow call center support.
    - The average talk time (ATT) was six minutes and fifty-eight seconds (06:58) for July 2024 compared to six minutes and thirty-five seconds (06:35) for July 2023.
    - One hundred percent (100%) of calls were answered within ten (10) minutes for July 2024 compared to ninety-seven percent (97%) in July 2023.
    - Outbound calls totaled seven thousand six hundred and thirteen (7,613) in July 2024 compared to six thousand eight hundred and thirty-seven (6,837) in July 2023.
    - The top five call reasons for July 2024 were: 1). Change of PCP, 2). Eligibility/Enrollment, 3). Benefits, 4). Provider Network, 5). ID Card Requests. The top five call reasons for July 2023 were: 1). Eligibility/Enrollment, 2). Change of PCP, 3). Benefits, 4). Kaiser, 5). Appeals & Grievances.
    - Utilization for the member automated eligibility IVR system totaled one thousand three hundred eighty-two (1,382) in July 2024 compared to one thousand three hundred twenty-one (1,321) in July 2023.
    - The Department continues to service members via multiple communication channels (telephonic, email, online, web-based requests and in-person) while honoring the organization's policies. The Department responded to one thousand two hundred twenty-eight (1,228) web-based requests in July 2024 compared to eight hundred ninety-seven (897) in July 2023. The top three web reason requests for July 2024 were: 1). Change of PCP, 2). ID Card Requests, 3). Update Contact Information. Sixty-nine (69) members

were assisted in-person in July 2024 compared to twenty (20) in July, 2023.

- Member Services Behavioral Health:

    - The Member Services Behavioral Health Unit received a total of one thousand three hundred seventy-eight (1,378) calls in July 2024 compared to one thousand eighty-five (1,085) in July 2023.
    - The abandonment rate was twelve percent (12%) in July 2024 compared to fourteen percent (14%) in July 2023.
    - The service level was seventy-five percent (75%) in July 2024 compared to eighty percent (80%) in July 2023.
    - The average speed to answer (ASA) was one minute nine seconds (1:09) in July 2024 compared to one minute thirteen seconds (1:13) in July 2023.
    - Calls answered in ten (10) minutes were ninety-nine percent (99%) in July 2024 compared to ninety-nine percent (99%) in July 2023.
    - The Average Talk Time (ATT) was seven minutes and fifty-eight seconds (07:58) in July 2024 compared to nine minutes and twenty-five seconds (09:25) in July 2023. MS BH Team utilizes the DHCS age-appropriate screening tools for Medi-Cal Mental Health Services to determine the appropriate delivery system for members who are not currently receiving mental health services when they contact the plan.
    - One hundred twelve (112) screenings were completed in July 2024.
    - Forty (40) referrals were made to the County (ACCESS) in July 2024.
    - One thousand one hundred forty-six (1,146) outbound calls were completed in July 2024.
    - One hundred four (104) outreach campaigns were completed in July 2024, including fifteen (15) BH/ABA screenings.
    - Twenty (20) members were referred to Center Point for SUD services in July 2024.

Claims

- 12-Month Trend Summary:

    - The Claims Department received three hundred thirty-two thousand one hundred fifty (332,150) claims in July 2024 compared to two hundred twenty-four thousand five hundred forty (224,540) in July 2023.
    - The Auto Adjudication was eighty-five point four percent (85.4%) in July 2024 compared to eighty point nine percent (80.9%) in July 2023.
    - Claims compliance for the thirty (30) day turn-around time was eighty-six point seven percent (86.7%) in July 2024 compared to ninety point one percent (90.1%) in July 2023. The forty-five (45) day turn-around time was ninety-nine point eight percent (99.8%) in July 2024 compared to ninety-nine point nine percent (99.9%) in July 2023.

- Monthly Analysis:

    - In the month of July, we received a total of three hundred twenty-two one hundred fifty (322,150) claims in the HEALTHsuite system. This represents an increase of eleven point seven percent (11.7%) from June 2024, and is higher, by one hundred seven thousand six hundred ten (107,610) claims, than the number of claims received in July 2023. The higher volume of received claims remains attributed to an increased membership and corresponding utilization of services.
    - We received eighty-eight point twenty-one percent (88.21%) of claims via EDI and eleven point seventy-nine percent (11.79%) of claims via paper.
    - During the month of July, ninety-nine point eight percent (99.8%) of our claims were processed within forty-five (45) working days.
    - The Auto Adjudication rate was eighty-five point four percent (85.4%) for the month of July.

Provider Services

- 12-Month Trend Summary:

    - The Provider Services department's call volume in July 2024 was eight thousand ninety-three (8,593) calls compared to nine thousand six hundred twenty-three (9,623) calls in July 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 four hundred twenty-two (422) calls/visits during July 2024.
    - The Provider Services department answered six thousand eight hundred six (6,806) calls for July 2024 and made one thousand sixty-six (1,066) outbound calls.

Credentialing

- 12-Month Trend Summary:

    - At the Peer Review and Credentialing (PRCC) meeting held on July 16, 2024, there were one hundred twenty-eight (128) initial network providers approved; zero (0) primary care providers, seven (7) specialists, six (6) ancillary providers, eight (8) midlevel providers, and one hundred seven (107) behavioral health providers. Additionally, eighteen (18) providers were re-credentialed at this meeting; six (6) primary care providers, seven (7) specialists, one (1) ancillary provider, and four (4) 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 July 2024, the Provider Dispute Resolution (PDR) team received two thousand three hundred seventy-five (2,375) PDRs versus one thousand seven hundred sixty-four (1,764) in July 2023.
  - The PDR team resolved one thousand nine hundred seventy-six (1,976) cases in July 2024 compared to one thousand seventy-two (1,072) cases in July 2023.
  - In July 2024, the PDR team upheld seventy-five percent (75%) of cases versus seventy-nine percent (79%) in July 2023.
  - The PDR team resolved ninety-nine point eight percent (99.8%) of cases in July 2024 compared to ninety-nine point nine percent (99.9%) in July 2023; the compliance standard is ninety-five percent (95%) within forty-five (45) working days.

- Monthly Analysis:
  - AAH received two thousand three hundred seventy-five (2,375) PDRs in July 2024.
  - In the month of July, one thousand nine hundred seventy-six (1,976) PDRs were resolved. Out of the one thousand nine hundred seventy-six (1,976) PDRs, one thousand four hundred seventy-three (1,473) were upheld and five hundred three (503) were overturned.
  - The overturn rate for PDRs was twenty-five percent (25%), which met our goal of twenty-five percent (25%) or less.
  - one thousand nine hundred seventy-one (1,971) out of one thousand nine hundred Ssventy-six (1,976) cases were resolved within forty-five (45) working days resulting in a ninety-nine point eight percent (99.8%) compliance rate.
  - The average turnaround time for resolving PDRs in July was forty-two (42) days.
  - There were four thousand three hundred eighty-nine (4,389) PDRs pending resolution as of 07/31/2024, with no cases older than forty-five (45) working days.

Community Relations and Outreach

- 12-Month Trend Summary:

    - In July 2024, the Alliance completed one thousand four hundred seventeen (1,417) member orientation outreach calls and one hundred twenty-seven (127) member orientations by phone.
    - The C&O Department reached one thousand four (1,004) people, (forty-four percent (44%) identified as Alliance members) during outreach activities, compared to approximately five hundred eighty-two (582) individuals (seventy-three percent (73%) self-identified as Alliance members) in July 2024.
    - The C&O Department spent a total of zero dollars ($0) in donations, fees, and/or sponsorships, compared to zero dollars ($0) in July 2024.
    - The C&O Department reached members in twelve (12) cities/unincorporated areas throughout Alameda County, compared to fourteen (14) cities in July 2024.

- Monthly Analysis:

    - In July 2024, the C&O Department completed one thousand four hundred seventeen (1,417) member orientation outreach calls and one hundred twenty-seven (127) member orientations by phone, forty-four (44) Alliance website inquiries, fifteen (15) service requests, two (2) social media inquiries and seven (7) community events.
    - Among the one thousand four (1,004) people reached, forty-four percent (44%) identified as Alliance members.
    - In July 2024, the C&O Department reached members in twelve (12) locations throughout Alameda County.
    - Please see attached **Addendum A**.

Operations

Supporting Documents

Member Services

Blended Call Results

Blended Results	July 2024
Incoming Calls (R/V)	18,546
Abandoned Rate (R/V)	4%
Answered Calls (R/V)	17,890
Average Speed to Answer (ASA)	00:14
Calls Answered in 30 Seconds (R/V)	94%
Average Talk Time (ATT)	06:58
Calls Answered in 10 minutes	100%
Outbound Calls	7613

Top 5 Call Reasons (Medi-Cal and Group Care) July 2024
Change of PCP
Eligibility/Enrollment
Benefits
Provider Network Info
ID Card Requests

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

MSBH	JULY 2024
Incoming Calls (R/V)	1378
Abandoned Rate (R/V)	12%
Answered Calls (R/V)	1213
Average Speed to Answer (ASA)	01:09
Calls Answered in 30 Seconds (R/V)	75%
Average Talk Time (ATT)	07:58
Calls Answered in 10 minutes	99%
Outbound Calls	1146
Screenings Completed	112
ACBH Referrals	40
SUD referrals to Center Point	20

Claims Department
June 2024 Final and July 2024 Final

METRICS

Claims Compliance	Jun-24	Jul-24
90% of clean claims processed within 30 calendar days	89.7%	86.7%
95% of all claims processed within 45 working days	99.8%	99.8%
Claims Volume (Received)	**Jun-24**	**Jul-24**
Paper claims	31,510	39,153
EDI claims	265,757	292,997
Claim Volume Total	**297,267**	**332,150**
Percentage of Claims Volume by Submission Method	**Jun-24**	**Jul-24**
% Paper	10.60%	11.79%
% EDI	89.40%	88.21%
Claims Processed	**Jun-24**	**Jul-24**
HEALTHsuite Paid (original claims)	225,484	266,214
HEALTHsuite Denied (original claims)	80,044	87,460
HEALTHsuite Original Claims Sub-Total	**305,528**	**353,674**
HEALTHsuite Adjustments	6,030	18,703
HEALTHsuite Total	**311,558**	**372,377**
Claims Expense	**Jun-24**	**Jul-24**
Medical Claims Paid	$115,671,347	$166,789,642
Interest Paid	$84,231	$183,683
Auto Adjudication	**Jun-24**	**Jul-24**
Claims Auto Adjudicated	267,304	302,158
% Auto Adjudicated	87.5%	85.4%
Average Days from Receipt to Payment	**Jun-24**	**Jul-24**
HEALTHsuite	14	16
Pended Claim Age	**Jun-24**	**Jul-24**
0-29 calendar days	40,621	36,877
HEALTHsuite		
30-59 calendar days	17,365	21,302
HEALTHsuite		
Over 60 calendar days	10	14
HEALTHsuite		

Overall Denial Rate	Jun-24	Jul-24
Claims denied in HEALTHsuite	80,044	87,460
% Denied	25.7%	23.5%

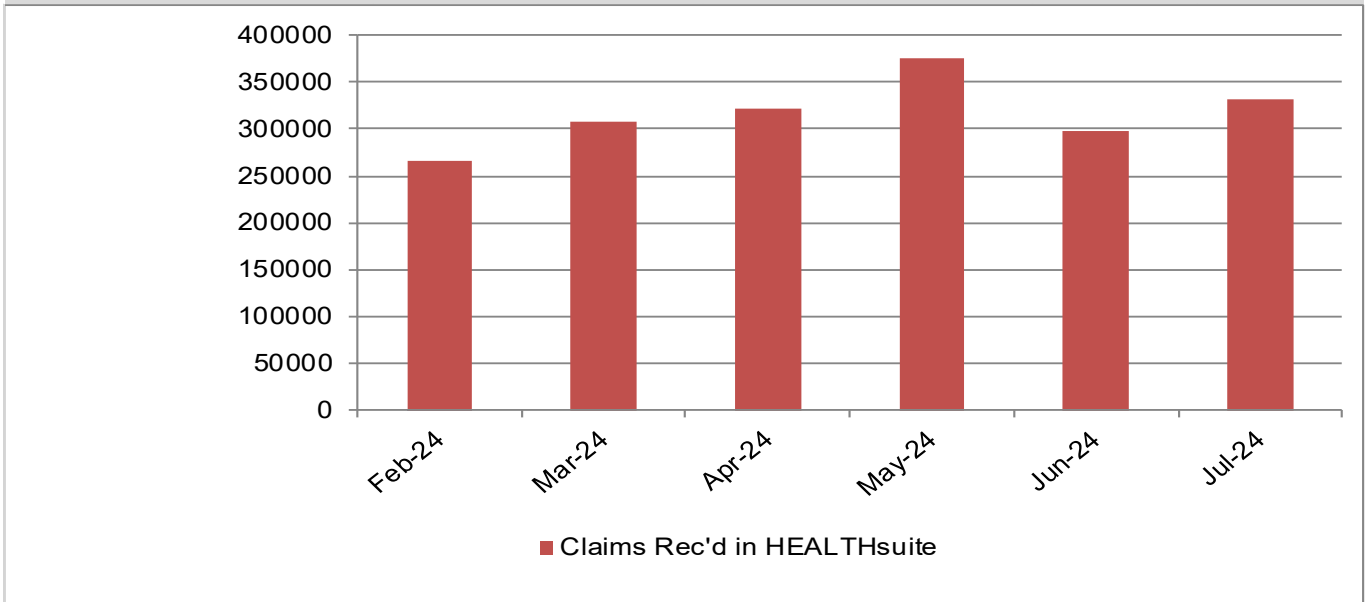
Claims Department
June 2024 Final and July 2024 Final

Jul-24

Top 5 HEALTHsuite Denial Reasons	% of all denials
Responsibility of Provider	23%
No Benefits Found For Dates of Service	12%
Non-Covered Benefit For This Plan	11%
Duplicate Claim	10%
Must Submit Paper Claim With Copy of Primary Payor EOB	9%
% Total of all denials	**65%**

Claims Received By Month

Run Date	3/1/2024	4/1/2024	5/1/2024	6/1/2024	7/1/2024	8/1/2024
Claims Received Through	**Feb-24**	**Mar-24**	**Apr-24**	**May-24**	**Jun-24**	**Jul-24**
Claims Rec'd in HEALTHsuite	266,339	308,453	322,786	375,454	297,267	332,150



Claims Year Over Year Summary

Monthly Results	Regulatory Requirement	AAH Goal
Claims Compliance - comparing July 2024 to July 2023 as follows: 30 Days - 86.7% (2024) vs 90.1% (2023) 45 Days - 99.8% (2024) vs 99.9% (2023) 90 Days - 99.9% (2024) vs 99.9% (2023)	90% of clean claims in 30 calendar days 95% of all claims in 45 working days 99% of all claims in 90 calendar days	90% of clean claims in 30 calendar days 95% of all claims in 45 working days 99% of all claims in 90 calendar days
Claims Received - AAH received 332,150 claims in July 2024 vs 224,540 in July 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 353,674 in July 2024 (23 working days) vs 210,001 in July 2023 (20 working days).	N/A	N/A
Medical Claims Expense - the amount of paid claims in July 2024 was $166,789,642 (5 check runs) vs $79,733,440 in July 2023 (4 check runs).	N/A	N/A
Interest Expense - the amount of interest paid in July 2024 was $183,683 vs $42,793 in July 2023.	N/A	< $496,000 per fiscal year or $30,000 per month
Auto Adjudication - the AAH rate in July 2024 was 85.4% vs 80.9 in July 2023.	N/A	85% or higher
Average Days from Receipt to Payment - the average # of days from receipt to payment in July 2024 was 16 days vs 20 days in July 2023.	N/A	<= 25 days

Claims Year Over Year Summary

Pended Claim Age - comparing July 2024 to July 2023 as follows: 0-30 calendar days - 36,877 (2024) vs 26,674 (2023) 30-59 calendar days - 21,302 (2024) vs 1,293 (2023) Over 60 calendar days - 14 (2024) vs 5 (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 July 2024 to July 2023.	N/A	N/A

Provider Relations Dashboard July 2024

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

Provider Relations Dashboard July 2024

Call Reasons (Medi-Cal and Group Care)

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

Field Visit Activity Details

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

ALLIANCE NETWORK SUMMARY, CURRENTLY CREDENTIALED PRACTITIONERS						
Practitioners		BH/ABA 2,055	AHP 543	PCP 370	SPEC 718	PCP/SPEC 13
AAH/AHS/CHCN Breakdown			AAH 2,529	AHS 272	CHCN 539	COMBINATION OF GROUPS 359
Facilities	**424**					

VENDOR SUMMARY Credentialing Verification Organization, Symplyr CVO				
	Number	**Average Calendar Days in Process**	**Goal - 25 Business Days***	**Goal - 98% Accuracy**	**Compliant**
Initial Files in Process	64	5	Y	Y	Y
Recred Files in Process	42	5	Y	Y	Y
Expirables updated Insurance, License, DEA, Board Certifications					Y
Files currently in process	**106**				
					*** 25 business days = 35 calendar days**

July 2024 Peer Review and Credentialing Committee Approvals	
Initial Credentialing	**Number**
PCP	0
SPEC	7
ANCILLARY	14
MIDLEVEL/AHP	0
BH/ABA	107
Sub-total	**128**
Recredentialing	
PCP	6
SPEC	7
ANCILLARY	1
MIDLEVEL/AHP	4
Sub-total	**18**
TOTAL	**146**

July 2024 Facility Approvals	
Initial Credentialing	**2**
Recredentialing	**6**
Sub-total	**8**
Facility Files in Process	**65**

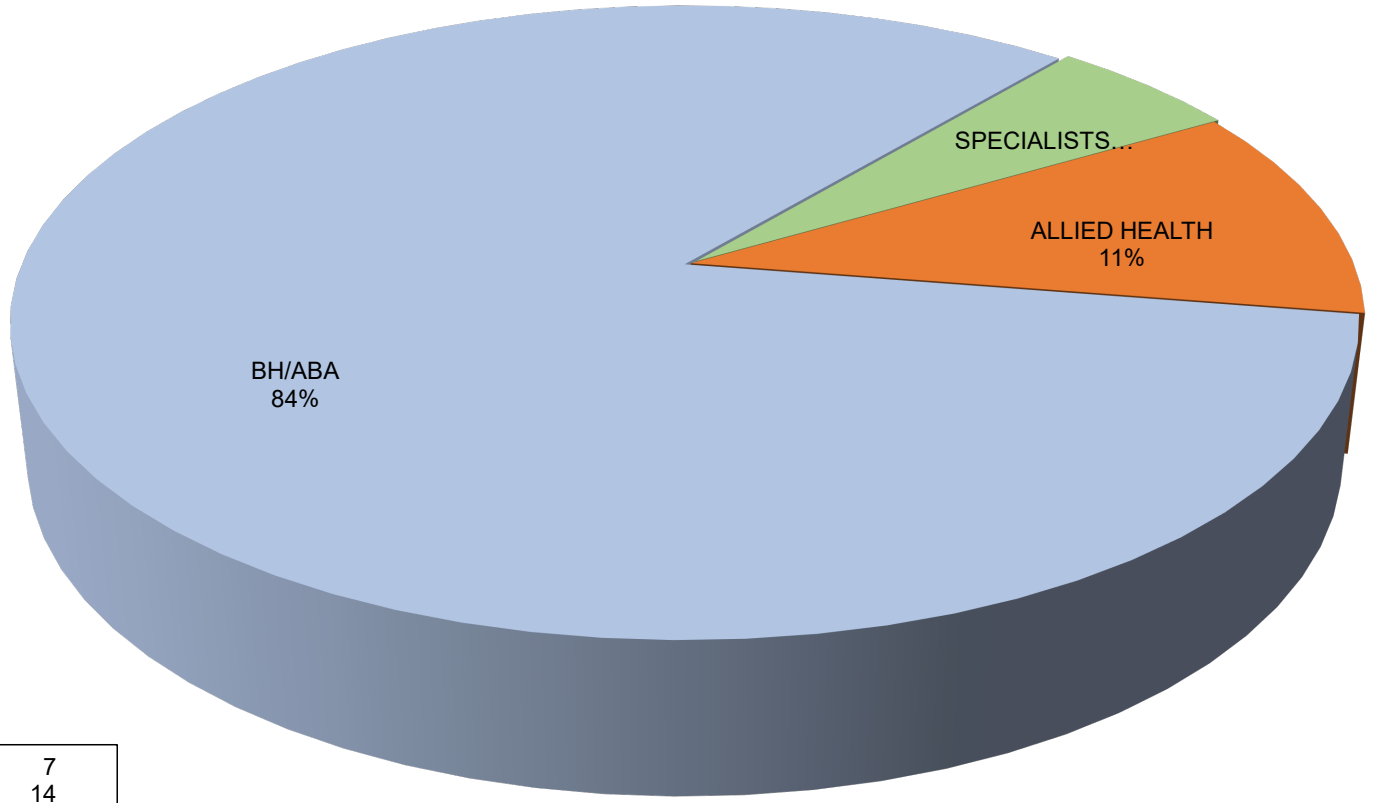
July 2024 Employee Metrics (5 FTEs)	Goal		Met (Y/N)	
File Processing	Timely processing within 3 days of receipt		Y	
Credentialing Accuracy	<3% error rate		Y	
DHCS, DMHC, CMS, NCQA Compliant	98%		Y	
MBC Monitoring	Timely processing within 3 days of receipt		Y	

LAST NAME	FIRST NAME	CATEGORY	INITIAL/RE-CRED	CRED DATE
Aasen	Elise	ABA-Telehealth	INITIAL	7/16/2024
Abadi	Steven	Specialist	INITIAL	7/16/2024
Aguilar	Jacqueline	BH	INITIAL	7/16/2024
Alcocer	Melissa	ABA	INITIAL	7/16/2024
Alvarado	Heather	BH-Telehealth	INITIAL	7/16/2024
Andarza	Lisa	ABA-Telehealth	INITIAL	7/16/2024
Angel	Gabryelle	ABA-Telehealth	INITIAL	7/16/2024
Anjo	Benjamin	BH-Telehealth	INITIAL	7/16/2024
Arreguin	Sonia	BH	INITIAL	7/16/2024
Asher	Xanthe	BH	INITIAL	7/16/2024
Avendano Machuca	Karla	ABA-Telehealth	INITIAL	7/16/2024
Ayala	Jocelyn	ABA-Telehealth	INITIAL	7/16/2024
Bancroft	Lisa	ABA	INITIAL	7/16/2024
Benjamin	Karen	BH	INITIAL	7/16/2024
Billings	Caitlin	BH	INITIAL	7/16/2024
Blum	Frederick	BH-Telehealth	INITIAL	7/16/2024
Bong	Cindy	ABA-Telehealth	INITIAL	7/16/2024
Carrera	Cherie	BH	INITIAL	7/16/2024
Cerna	Louise	BH	INITIAL	7/16/2024
Chavez	Diana	BH	INITIAL	7/16/2024
Chen	Isabelle	ABA-Telehealth	INITIAL	7/16/2024
Childers	Amy	BH	INITIAL	7/16/2024
Cooper	Ami	BH-Telehealth	INITIAL	7/16/2024
Cordova	Rex Anne	Ancillary	INITIAL	7/16/2024
Cuen	Ashli	ABA-Telehealth	INITIAL	7/16/2024
Davila	Paul	BH	INITIAL	7/16/2024
Dharma	Kalamani	Specialist	INITIAL	7/16/2024
Diggs	Jovona	Ancillary	INITIAL	7/16/2024
Dominguez	Kristin	BH-Telehealth	INITIAL	7/16/2024
Dunlap	Kendra	BH	INITIAL	7/16/2024
Dyer	Andrea	BH-Telehealth	INITIAL	7/16/2024
Eduvala	Loree Anne	ABA	INITIAL	7/16/2024
Edwards	Michelle	Allied Health	INITIAL	7/16/2024
Fabillar	Rose Anne	ABA-Telehealth	INITIAL	7/16/2024
Farris	Tatyana	ABA-Telehealth	INITIAL	7/16/2024
Fernandez	Hannia	BH	INITIAL	7/16/2024
Feyzbakhsh	Natali	Allied Health	INITIAL	7/16/2024
Fitzpatrick	Moira	BH-Telehealth	INITIAL	7/16/2024
Fleming	Shanna	BH	INITIAL	7/16/2024
Fox	Catherine	Ancillary	INITIAL	7/16/2024
Fuhrmeister	Madison	ABA-Telehealth	INITIAL	7/16/2024
Gamad	Fiel	BH-Telehealth	INITIAL	7/16/2024
Gilbert	Nicole	BH-Telehealth	INITIAL	7/16/2024
Gonzalez Tapia	Yesenia	BH	INITIAL	7/16/2024
Gorewitz	Janet	BH-Telehealth	INITIAL	7/16/2024
Gruenewald	Brayden	ABA-Telehealth	INITIAL	7/16/2024
Gutierrez	Angelina	BH	INITIAL	7/16/2024
Harouni	Gabriel	BH-Telehealth	INITIAL	7/16/2024
Hechtman	Sara	BH-Telehealth	INITIAL	7/16/2024
Henderson	Andrea	BH-Telehealth	INITIAL	7/16/2024
Hernandez	Alondra	BH	INITIAL	7/16/2024
Hertz	Haley	BH	INITIAL	7/16/2024
Hester	Angela	ABA	INITIAL	7/16/2024
Higgins	Isaac	BH	INITIAL	7/16/2024
Huang	Jean	Specialist	INITIAL	7/16/2024
Jahan	Farhana	BH	INITIAL	7/16/2024

LAST NAME	FIRST NAME	CATEGORY	INITIAL/RE-CRED	CRED DATE
Jaswal	Jessica	Specialist	INITIAL	7/16/2024
Jauregui	Elizabeth	BH	INITIAL	7/16/2024
Kaminker	Jacob	BH	INITIAL	7/16/2024
Kanska	Katarzyna	BH	INITIAL	7/16/2024
Kassai	Shabnam	BH	INITIAL	7/16/2024
Kim	Sue	Allied Health	INITIAL	7/16/2024
Kiritsis	Paul	BH-Telehealth	INITIAL	7/16/2024
Korkoian	Laura	BH-Telehealth	INITIAL	7/16/2024
LaCroix	Jori	ABA-Telehealth	INITIAL	7/16/2024
LaFave	Lisa	BH-Telehealth	INITIAL	7/16/2024
Litwin	Tracey	BH	INITIAL	7/16/2024
Louie	Lung	Allied Health	INITIAL	7/16/2024
Maheux	Colleen	BH-Telehealth	INITIAL	7/16/2024
Marcelo	Joanne	Allied Health	INITIAL	7/16/2024
Marchevsky	Thomas	BH	INITIAL	7/16/2024
Marenco	Flavio	BH-Telehealth	INITIAL	7/16/2024
Mason	Brandon	BH-Telehealth	INITIAL	7/16/2024
Mathis	Rene	BH	INITIAL	7/16/2024
McNabola	Iris	BH-Telehealth	INITIAL	7/16/2024
Meshach	Alyssa	ABA-Telehealth	INITIAL	7/16/2024
Milstein	Matthew	BH-Telehealth	INITIAL	7/16/2024
Monclus	Brittany	ABA-Telehealth	INITIAL	7/16/2024
Moore	Brian	BH-Telehealth	INITIAL	7/16/2024
Moxley	Caroline	BH-Telehealth	INITIAL	7/16/2024
Muniz	Marissa	BH-Telehealth	INITIAL	7/16/2024
Muradian	Regine	BH-Telehealth	INITIAL	7/16/2024
Nasserian	Negin	BH-Telehealth	INITIAL	7/16/2024
Nelson	Paige	ABA-Telehealth	INITIAL	7/16/2024
Nervo	Gabriel	BH	INITIAL	7/16/2024
Newman	Shelli	Ancillary	INITIAL	7/16/2024
Nourshahi	Masoumeh	BH-Telehealth	INITIAL	7/16/2024
Oranuba	Chiamaka	ABA-Telehealth	INITIAL	7/16/2024
Paulitsch-Buckingha	Andrea	BH	INITIAL	7/16/2024
Prasad	Roselyn	BH	INITIAL	7/16/2024
Ramos	Sasha	ABA	INITIAL	7/16/2024
Ramos	Taylor	ABA-Telehealth	INITIAL	7/16/2024
Rawan	Katerina	ABA-Telehealth	INITIAL	7/16/2024
Reichling	Jennifer	BH-Telehealth	INITIAL	7/16/2024
Rieff	Leah	Allied Health	INITIAL	7/16/2024
Riggs	Kathryn	BH-Telehealth	INITIAL	7/16/2024
Rivas	Monica	ABA-Telehealth	INITIAL	7/16/2024
Roca	Victoria	BH	INITIAL	7/16/2024
Russell	Judith	BH-Telehealth	INITIAL	7/16/2024
Sabado	Amberly	BH-Telehealth	INITIAL	7/16/2024
Salera	Christine	Allied Health	INITIAL	7/16/2024
Samonte	Kimberly Claire	ABA	INITIAL	7/16/2024
Savery	Dyan	BH-Telehealth	INITIAL	7/16/2024
Sawka	Bobette	BH-Telehealth	INITIAL	7/16/2024
Scoles	William	BH	INITIAL	7/16/2024
Serlin	Ilene	BH-Telehealth	INITIAL	7/16/2024
Silva	Adina	BH	INITIAL	7/16/2024
Siy	Grechell	BH-Telehealth	INITIAL	7/16/2024
Spencer	Jacob	BH-Telehealth	INITIAL	7/16/2024
Steidinger	Joan	BH-Telehealth	INITIAL	7/16/2024
Stidham	Kalle	Specialist	INITIAL	7/16/2024
Tabib	Shirin	BH-Telehealth	INITIAL	7/16/2024
Tan	Linda	ABA-Telehealth	INITIAL	7/16/2024

LAST NAME	FIRST NAME	CATEGORY	INITIAL/RE-CRED	CRED DATE
Tanna	Renuka	BH-Telehealth	INITIAL	7/16/2024
Taylor	Simone	BH	INITIAL	7/16/2024
Taylor	Yoseya	BH	INITIAL	7/16/2024
Tehrani	David	Specialist	INITIAL	7/16/2024
Trichter	Stephen	BH	INITIAL	7/16/2024
Vaze	Aditya	Specialist	INITIAL	7/16/2024
Verango	Jeremy	Allied Health	INITIAL	7/16/2024
Visser	Tammy	BH	INITIAL	7/16/2024
Vo	David	BH	INITIAL	7/16/2024
Williams	Samantha	BH	INITIAL	7/16/2024
Wolff	Linda	Ancillary	INITIAL	7/16/2024
Younessi	Arielle	BH-Telehealth	INITIAL	7/16/2024
Zapata	Parthena	BH-Telehealth	INITIAL	7/16/2024
Zembruski	Joy	BH-Telehealth	INITIAL	7/16/2024
Zereh	Reema	Ancillary	INITIAL	7/16/2024
Besh	Basil	Specialist	RECRED	7/16/2024
Distefano	James	Specialist	RECRED	7/16/2024
Ferguson	Susan	Primary Care Phy	RECRED	7/16/2024
Henley	Eric	Primary Care Phy	RECRED	7/16/2024
Kale	Ashay	Specialist	RECRED	7/16/2024
Kaplan	Daniel	Specialist	RECRED	7/16/2024
LaRock	Kristi	Allied Health	RECRED	7/16/2024
Lenoir	Denise	Allied Health	RECRED	7/16/2024
Mann	Barry	Specialist	RECRED	7/16/2024
Martin	Jenny	Allied Health	RECRED	7/16/2024
McMillan	Eugene	Primary Care Phy	RECRED	7/16/2024
Minahan	Sara	Allied Health	RECRED	7/16/2024
Morris	Kelly	Primary Care Phy	RECRED	7/16/2024
Pirnia	Nicholas	Specialist	RECRED	7/16/2024
Reinking	Jason	Primary Care Phy	RECRED	7/16/2024
Singh	Harpriya	Specialist	RECRED	7/16/2024
Wait	Cecily	Primary Care Phy	RECRED	7/16/2024
Weir	Sierra	Ancillary	RECRED	7/16/2024

JULY PEER REVIEW AND CREDENTIALING
INITIAL APPROVALS BY SPECIALTY



Specialists	7
Allied Health	14
BH/ABA	107
Total	128

Provider Dispute Resolution
June 2024 and July 2024

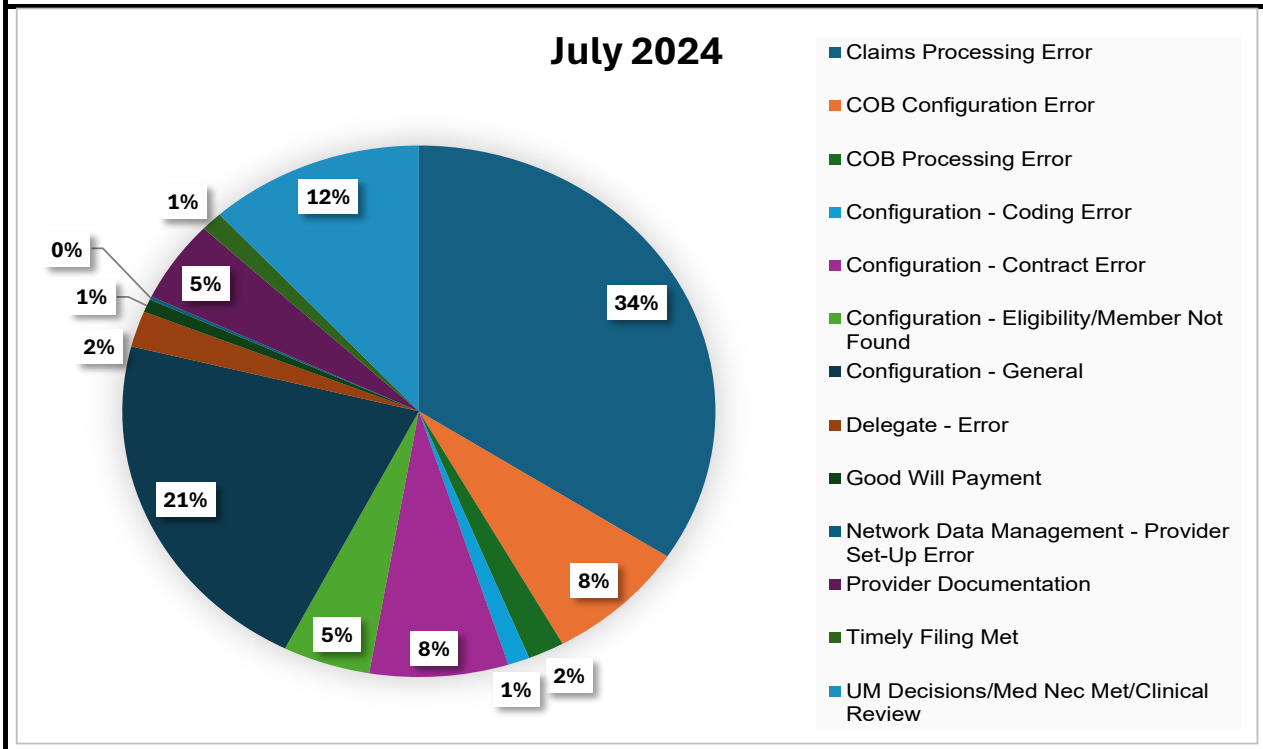
METRICS

PDR Compliance	Jun-24	Jul-24
# of PDRs Resolved	1,613	1,976
# Resolved Within 45 Working Days	1,609	1,971
% of PDRs Resolved Within 45 Working Days	99.8%	99.8%
PDRs Received	**Jun-24**	**Jul-24**
# of PDRs Received	3,792	2,375
PDR Volume Total	**3,792**	**2,375**
PDRs Resolved	**Jun-24**	**Jul-24**
# of PDRs Upheld	1,127	1,473
% of PDRs Upheld	70%	75%
# of PDRs Overturned	486	503
% of PDRs Overturned	30%	25%
Total # of PDRs Resolved	**1,613**	**1,976**
Average Turnaround Time	**Jun-24**	**Jul-24**
Average # of Days to Resolve PDRs	42	42
Oldest Resolved PDR in Days	61	62
Unresolved PDR Age	**Jun-24**	**Jul-24**
0-45 Working Days	4,505	4,389
Over 45 Working Days	0	0
Total # of Unresolved PDRs	**4,505**	**4,389**

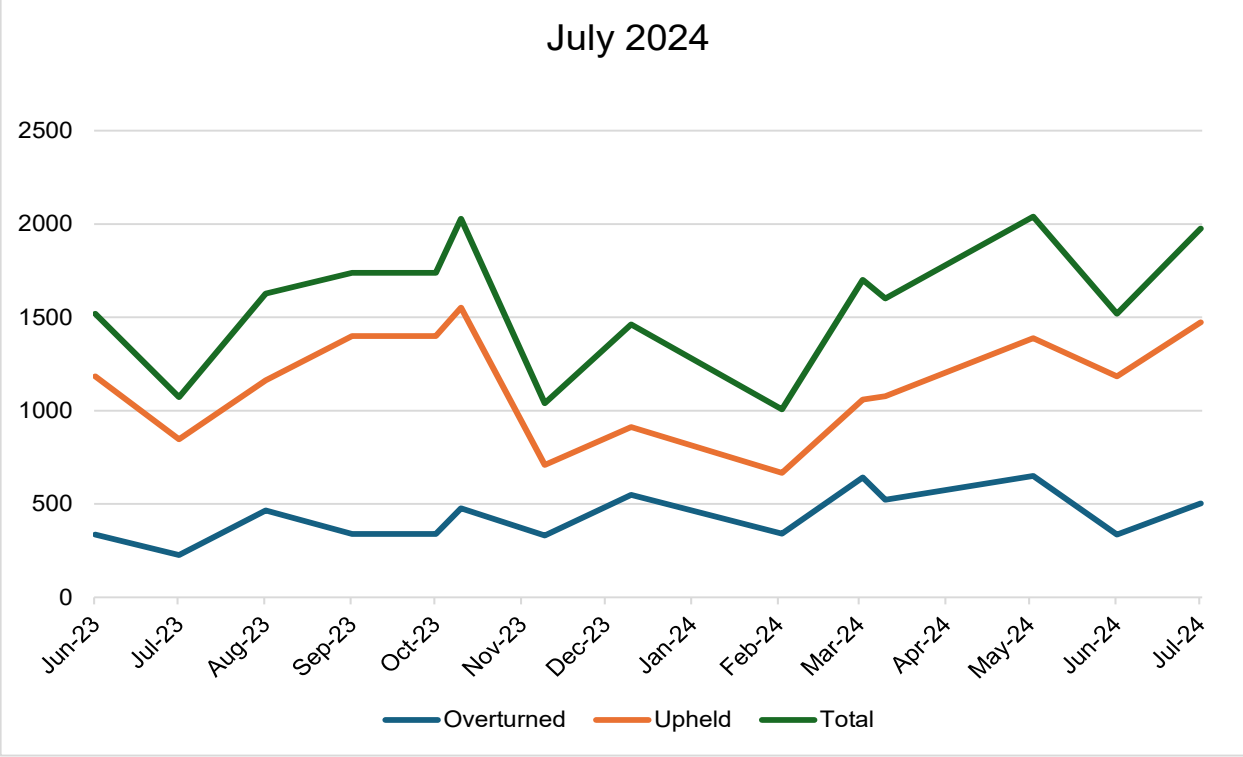
Provider Dispute Resolution
June 2024 and July 2024

Jul-24

PDR Resolved Case Overturn Reasons



Rolling 12-Month PDR Trend Line



Provider Dispute Resolution Year Over Year Summary

Monthly Results	Regulatory Requirements	AAH Goal
# of PDRs Resolved - 1,976 in July 2024 vs 1,072 in July 2023	N/A	N/A
# of PDRs Received - 2,375 in July 2024 vs 1,764 in July 2023	N/A	N/A
# of PDRs Resolved within 45 working days - 1,971 in July 2024 vs 1,071 in July 2023	N/A	N/A
% of PDRs Resolved within 45 working days - 99.8% in July 2024 vs 99.99% in July 2023	95%	95%
Average # of Days to Resolve PDRs - 42 days in July 2024 vs 39 days in July 2023	N/A	30
Oldest Resolved PDR in Days - 62 days in July 2024 vs 44 days July 2023	N/A	N/A
# of PDRs Upheld - 1,473 in July 2024 vs 846 in July 2023	N/A	N/A
% of PDRs Upheld - 75% in July 2024 vs 79% in July 2023	N/A	> 75%
# of PDRs Overturned - 503in July 2024 vs 226 in July 2023	N/A	N/A
% of PDRs Overturned - 25% in July 2024 vs 21% in July 2023	N/A	< 25%

Provider Dispute Resolution Year Over Year Summary		
PDR Overturn Reasons: Claims processing errors - 36% (2024) vs 37% (2023) Configuration errors -35% (2024) vs 38% (2023) COB -8% (2024) vs 17% (2023) Clinical Review/UM Decisions/Medical Necessity Met -12% (2024) vs 7% (2023)	N/A	N/A

During July 2024, the Alliance completed **1,417** member orientation outreach calls among net new and non-utilizer members and conducted **127** member orientations (**9%** member participation rate). In addition, in July 2024, the Outreach team completed **44** Alliance website inquiries, **15** service requests, **2** social media inquiries, and **7** community events. The Alliance reached a total of **1,004** people and spent a total of $0 in donations, fees, and/or sponsorships at the 44th Annual Holistic Health Fair, Housing Authority of the County of Alameda (HACA) Annual Resource Fair, Homeless Resources & Job Fair, Market Street Seventh Day Adventist Church, Safe Kids Day, and St. Anne Catholic Church Summer Festival.*

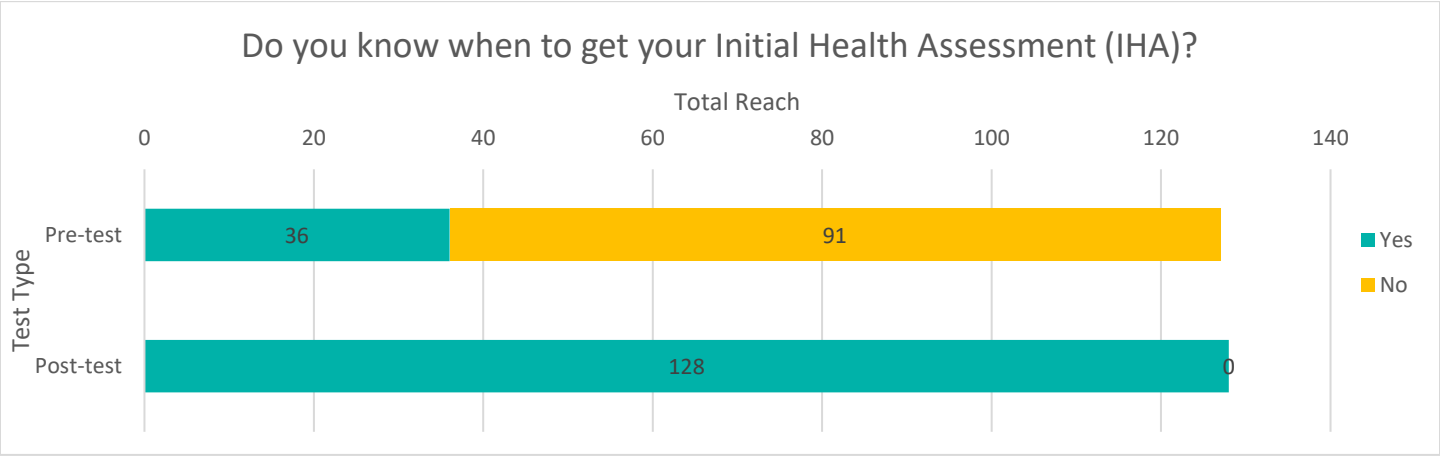
The Communications & Outreach Department began reporting the number of members reached during outreach activities in late February 2018. Since July 2018, **33,598** self-identified Alliance members have been reached during outreach activities.

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

On **Wednesday, March 18, 2020,** the Alliance began conducting member orientations by phone. As of July 31, 2024, the Outreach Team completed **38,920** member orientation outreach calls and conducted **8,749** member orientations (**22.5%** member participation rate).

The Alliance Member Orientation (MO) program has existed since August 2016. In 2019, the program was recognized as a promising practice to increase member knowledge and awareness about the Initial Health Appointment (IHA) by the Department of Health Care Services (DHCS), Managed Care Quality and Monitoring Division (MCQMD). We have steadily increased program participation. Our 2019 6-month average participation rate was **111** members per month. Between July 1, through July 31, 2024 (22 working days) – **127** members completed an MO by phone.

After completing a MO **100%** of members who completed the post-test survey in July 2024 reported knowing when to get their IHA, compared to only **28.3%** of members knowing when to get their IHA in the pre-test survey.



All report details can be reviewed at: **W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Outreach Reports\FY 24-25\Q1\1. July 2024**

FY 2023-2024 JULY 2023 TOTALS

- 1 COMMUNITY EVENTS
- 2 MEMBER EDUCATION EVENTS
- 100 MEMBER ORIENTATIONS
- 0 MEETINGS/ PRESENTATIONS/
- 0 COMMUNITY TRAINING
- 3 TOTAL INITIATED/ INVITED EVENTS
- **103 TOTAL COMPLETED EVENTS**

14 CITIES

Alameda
Albany
Berkeley
Castro Valley
Dublin
Fremont
Hayward
Madera
Newark
Oakland
Pleasanton
San Leandro
San Lorenzo
Union City

- 114 TOTAL REACHED AT COMMUNITY EVENTS
- 368 TOTAL REACHED AT MEMBER EDUCATION EVENTS
- 100 TOTAL REACHED AT MEMBER ORIENTATIONS
- 0 TOTAL REACHED AT MEETINGS/PRESENTATIONS
- 0 TOTAL REACHED AT COMMUNITY TRAINING
- 423 MEMBERS REACHED AT ALL EVENTS
- **582 TOTAL REACHED AT ALL EVENTS**

$0.00
TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

FY 2024-2025 JULY 2024 TOTALS

- 7 COMMUNITY EVENTS
- 0 MEMBER EDUCATION EVENTS
- 127 MEMBER ORIENTATIONS
- 0 MEETINGS/ PRESENTATIONS
- 0 COMMUNITY TRAINING
- 11 TOTAL INITIATED/ INVITED EVENTS
- 134 TOTAL COMPLETED **EVENTS**

12 CITIES**

Alameda
Berkeley
Castro Valley
Dublin
Fremont
Hayward
Newark
Oakland
San Jose
San Leandro
San Lorenzo
Union City

- 1004 TOTAL REACHED AT COMMUNITY EVENTS
- 0 TOTAL REACHED AT MEMBER EDUCATION EVENTS
- 127 TOTAL REACHED AT MEMBER ORIENTATIONS
- 0 TOTAL REACHED AT MEETINGS/PRESENTATIONS
- 0 COMMUNITY TRAINING
- 442 MEMBERS REACHED AT ALL EVENTS
- **1131 TOTAL REACHED AT ALL EVENTS**

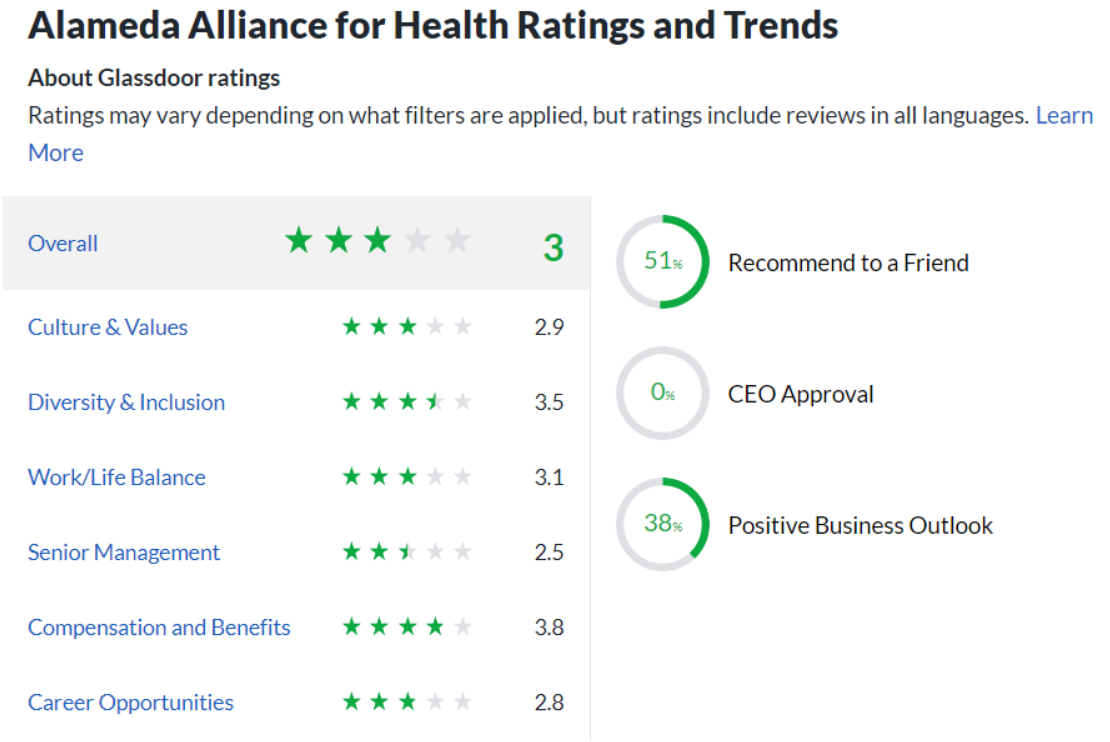
$0.00
TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

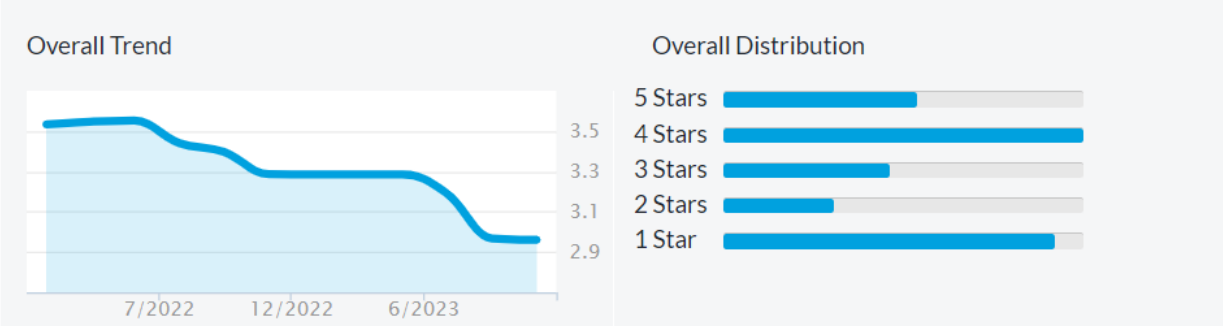
***Cities represent the mailing address designations for members who completed a member orientation by phone and community event. The italicized cities are outside of Alameda County. The C&O Department started including these cities in the Q3 FY21 Outreach Report.*

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

1. Alliance Website:
    - Received **15,000** unique visits
    - Received **12,000** new user visits
    - The top **10** website page visits were:
        i. Homepage
        ii. Provider Page
        iii. Find a Doctor
        iv. Benefits and Covered Services
        v. Careers
        vi. Contact Us
        vii. Medi-Cal
        viii. Members
        ix. Get a New ID Card
        x. About Us
2. Facebook Page:
    - Maintained Fans at **631**
    - Did not receive any reviews in **July 2024**
3. Glassdoor Page:
    - **3** out of a **5-star** overall rating
    - Received 1 (one) review in **July 2024**
4. Instagram Page:
    - Page debuted **June 10, 2021**
    - Increased in followers from **554** to **559**
5. Twitter Page:
    - Slight Increase in followers from **360** to **361**
6. LinkedIn Page:
    - Increased followers from **5.6k** to **5.7k**
    - Received **230-**page clicks
7. Yelp Page:
    - Page visits **104**
    - Appeared in Yelp searches **91** times
    - Did not receive any reviews in **July 2024**
8. Google Page:
    - **2,492** website clicks made from the business profile
    - **1,402** calls made from the business profile
    - Received **1** (one) review in **July 2024**
    - Received **4** (four) chat messages in **July 2024**

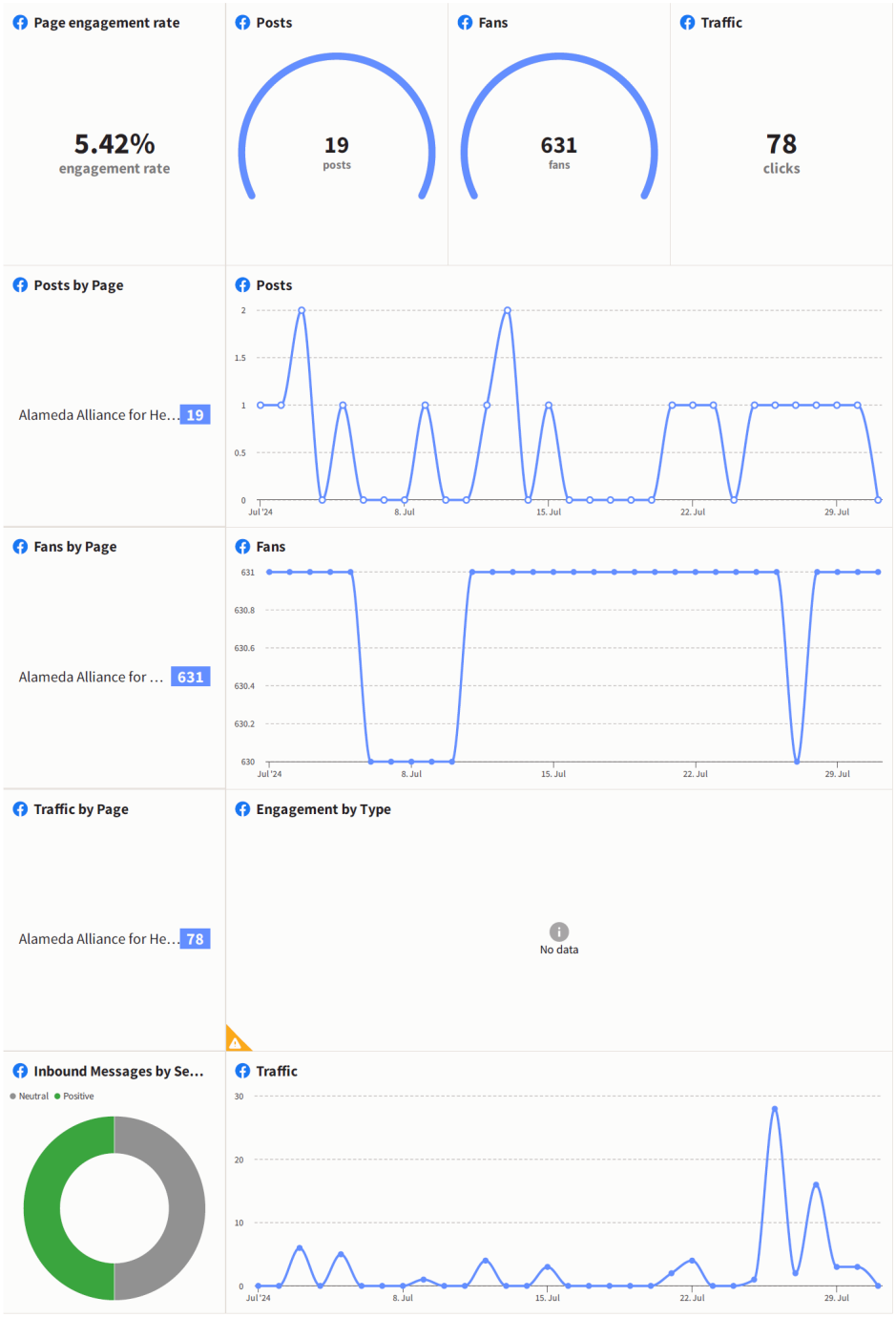
GLASSDOOR OVERVIEW





All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2024-2025\Q1\1. July 2024

FACEBOOK OVERVIEW



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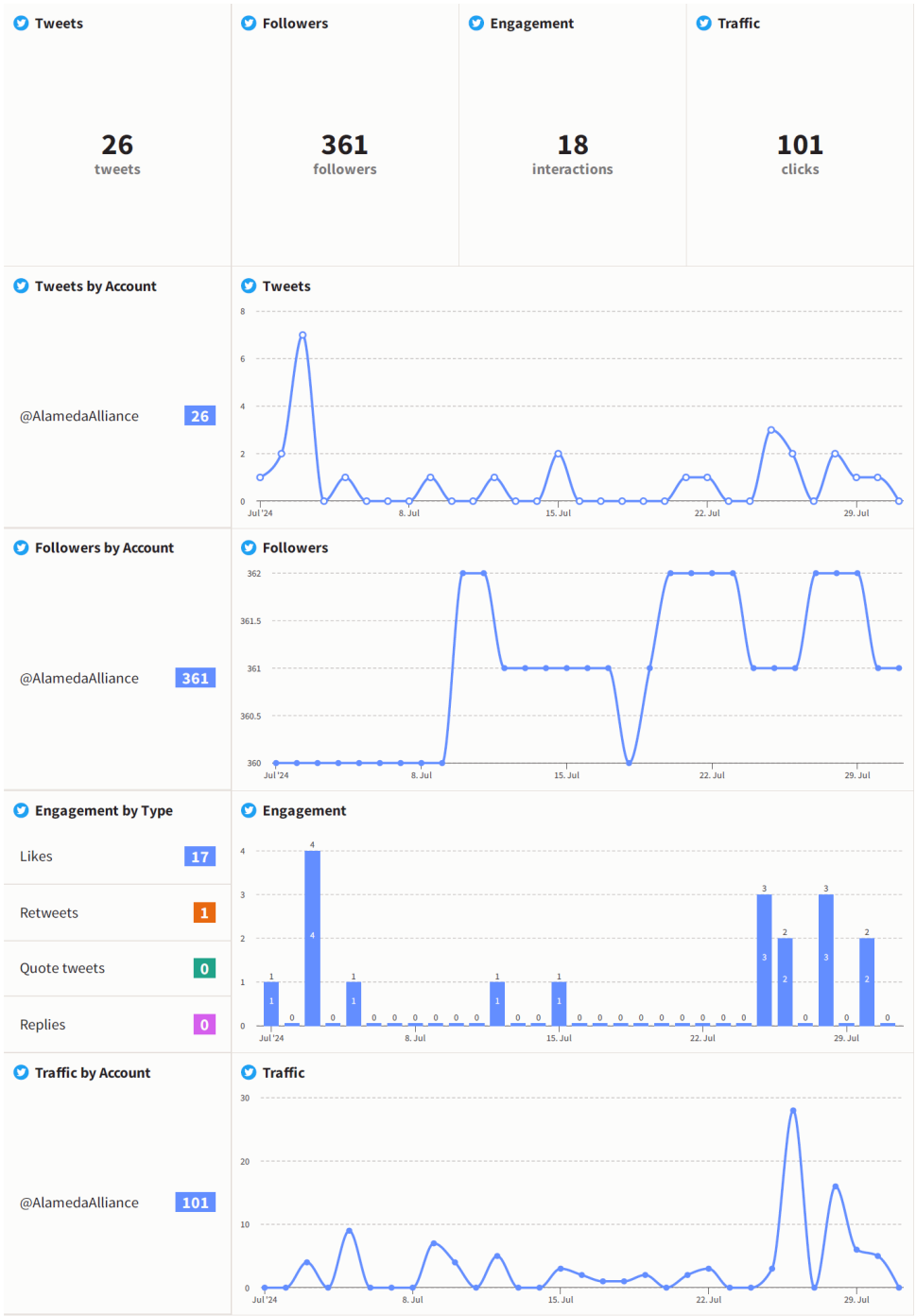
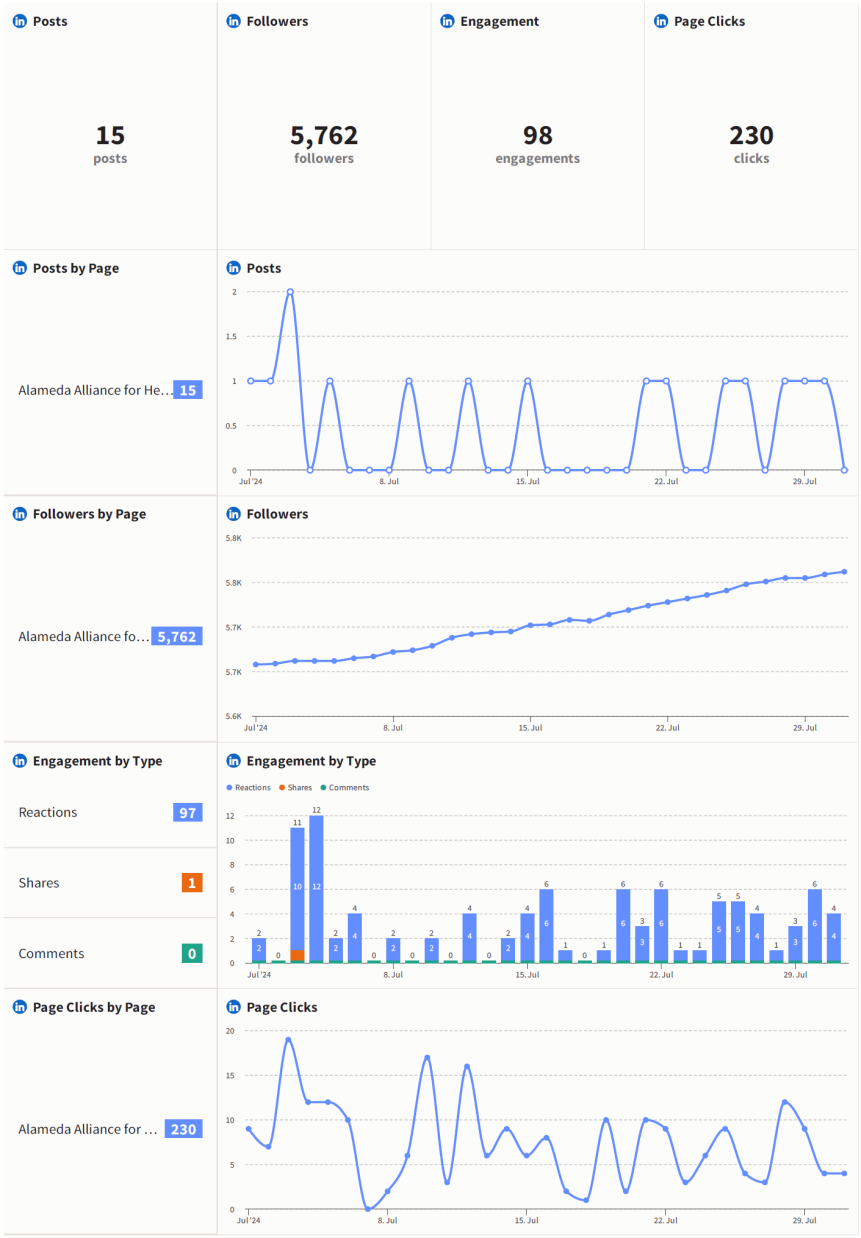
TWITTER OVERVIEW



All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2024-2025\Q1\1. July 2024

LINKEDIN OVERVIEW



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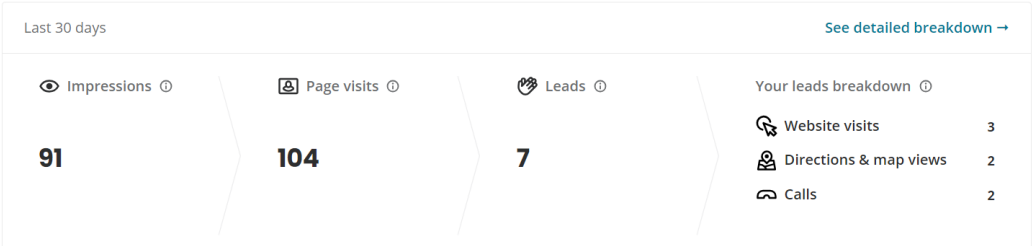
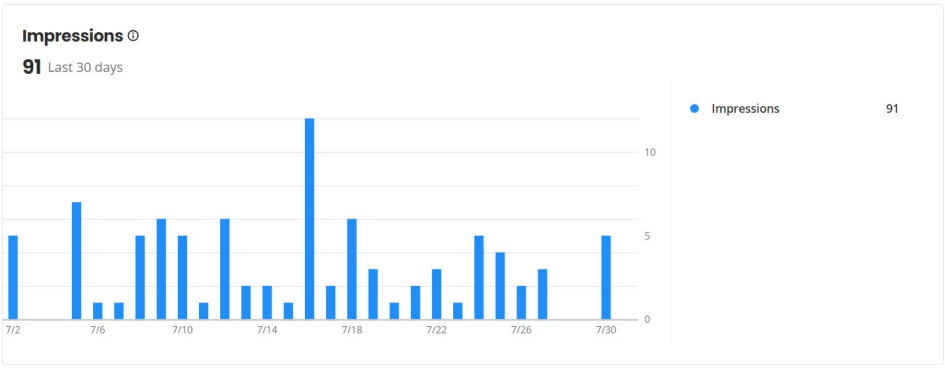
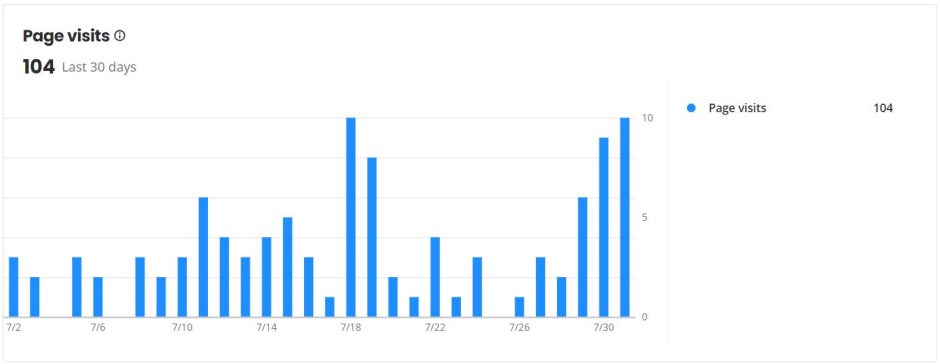
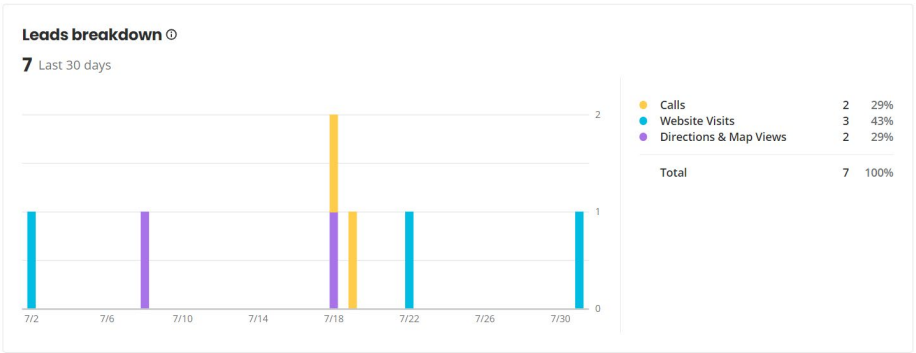
YELP OVERVIEW









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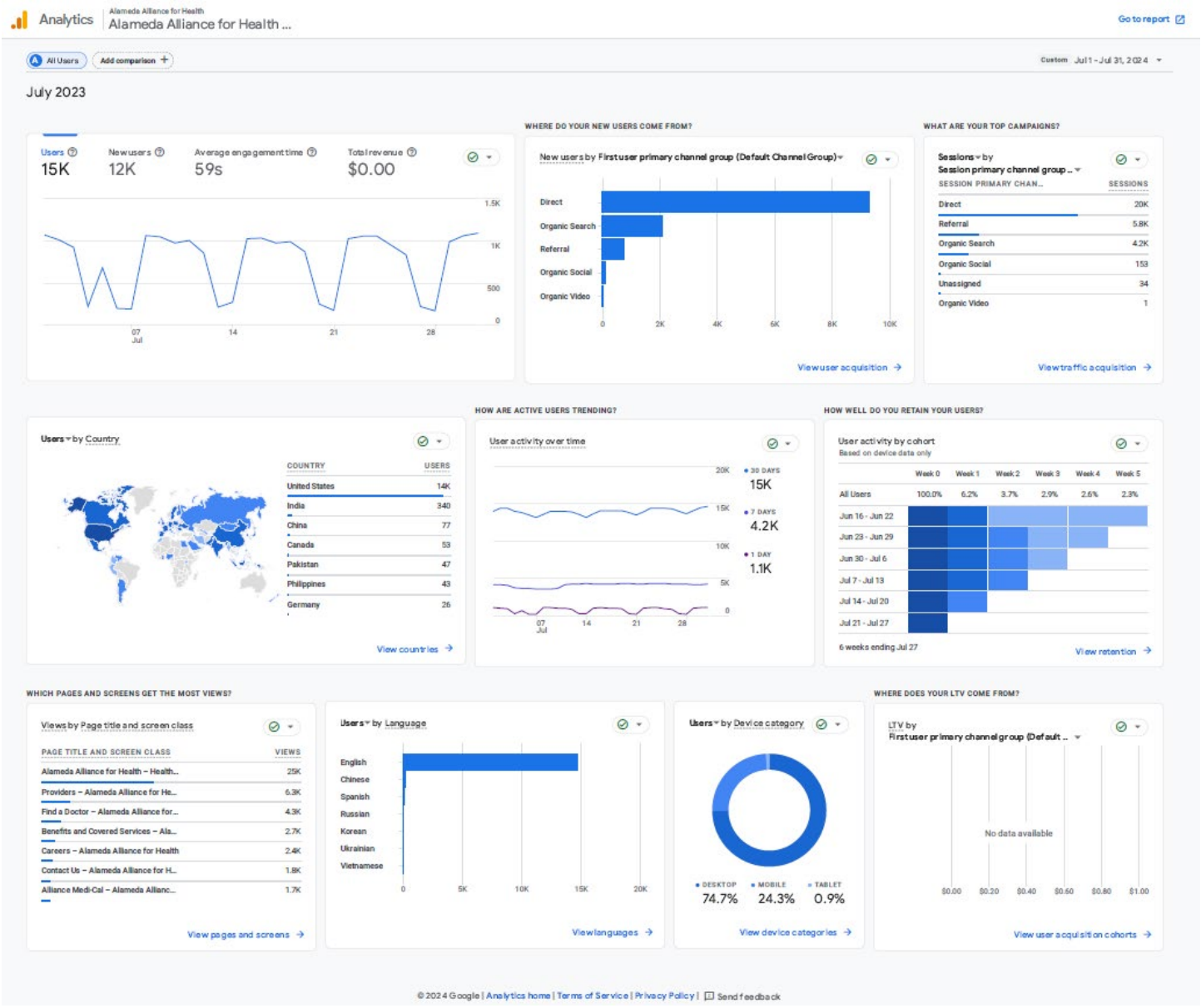
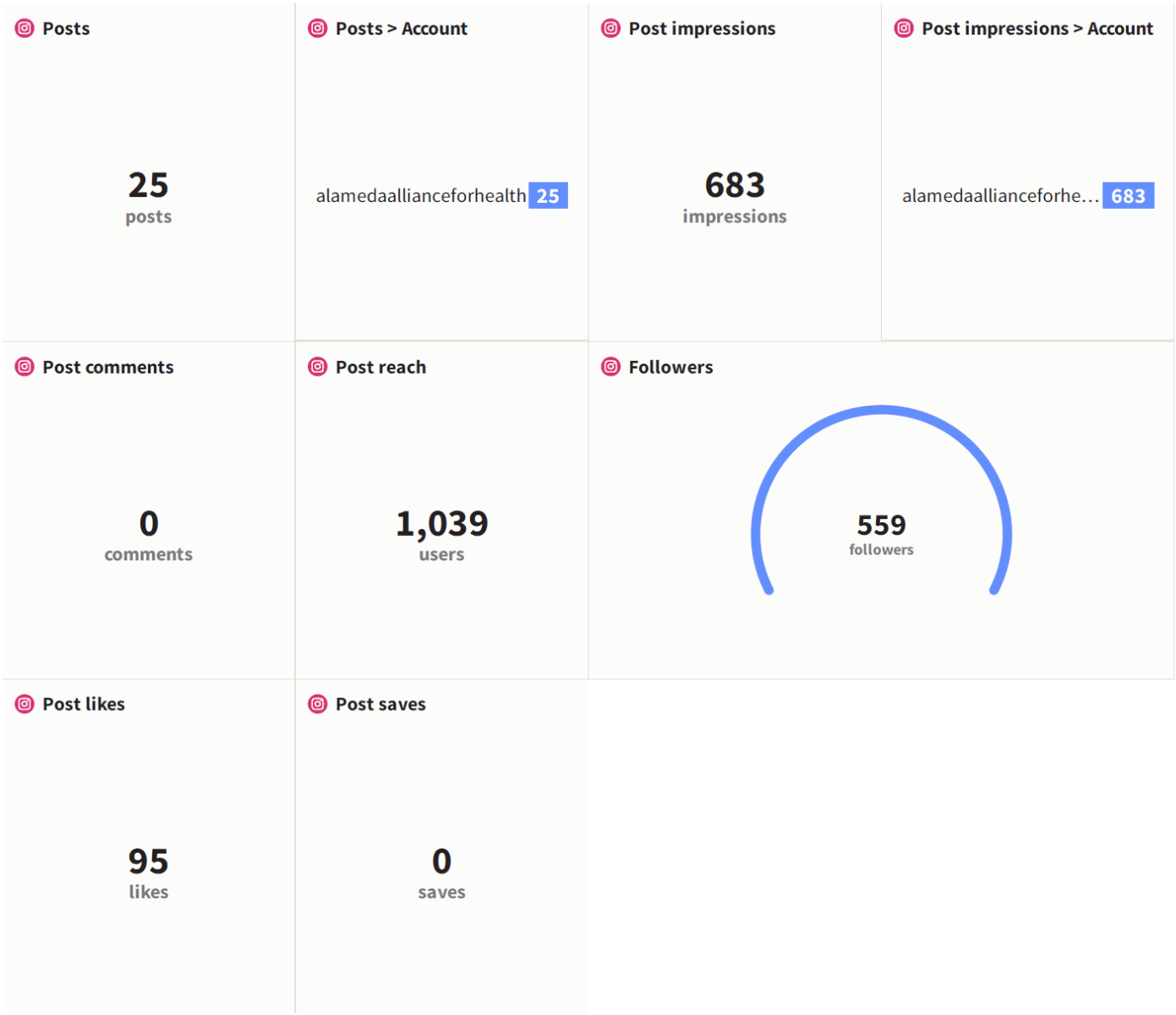
ALLIANCE WEBSITE OVERVIEW:



All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2024-2025\Q1\1. July 2024

Instagram OVERVIEW:



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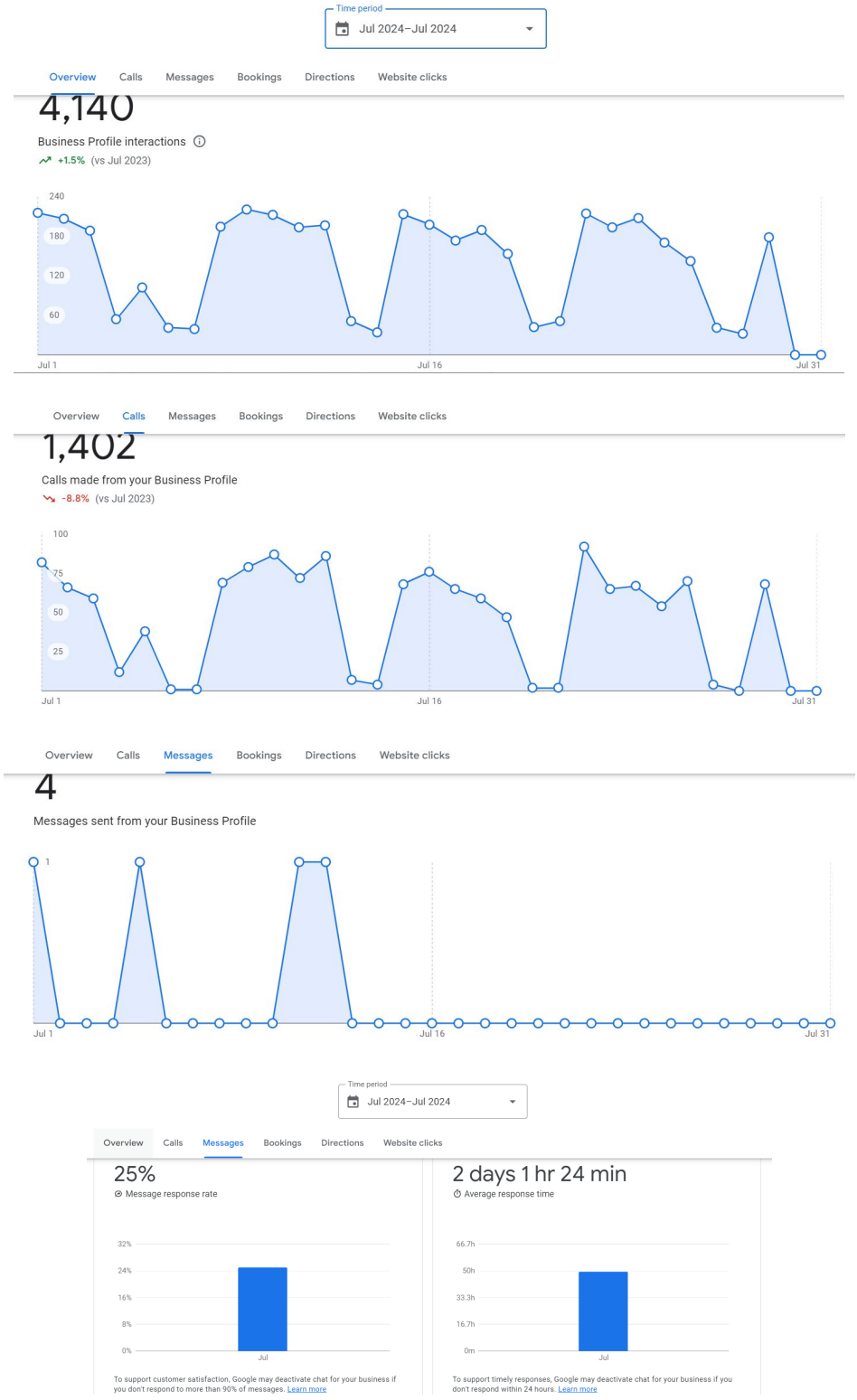
Google OVERVIEW:



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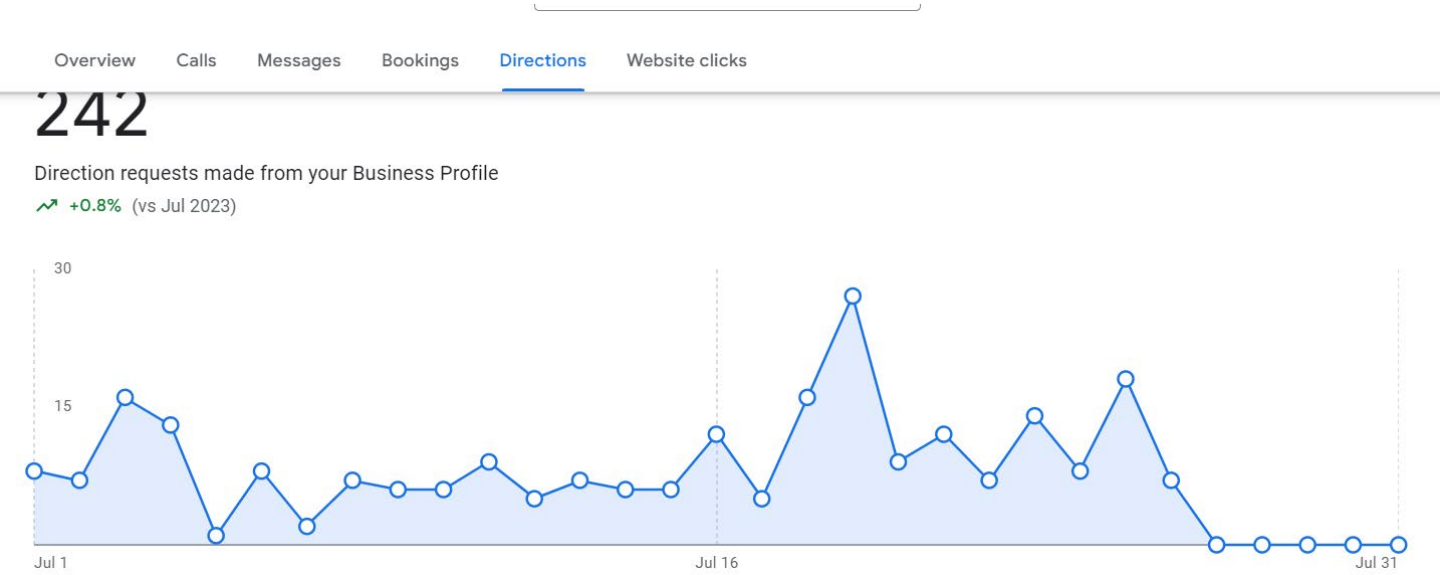

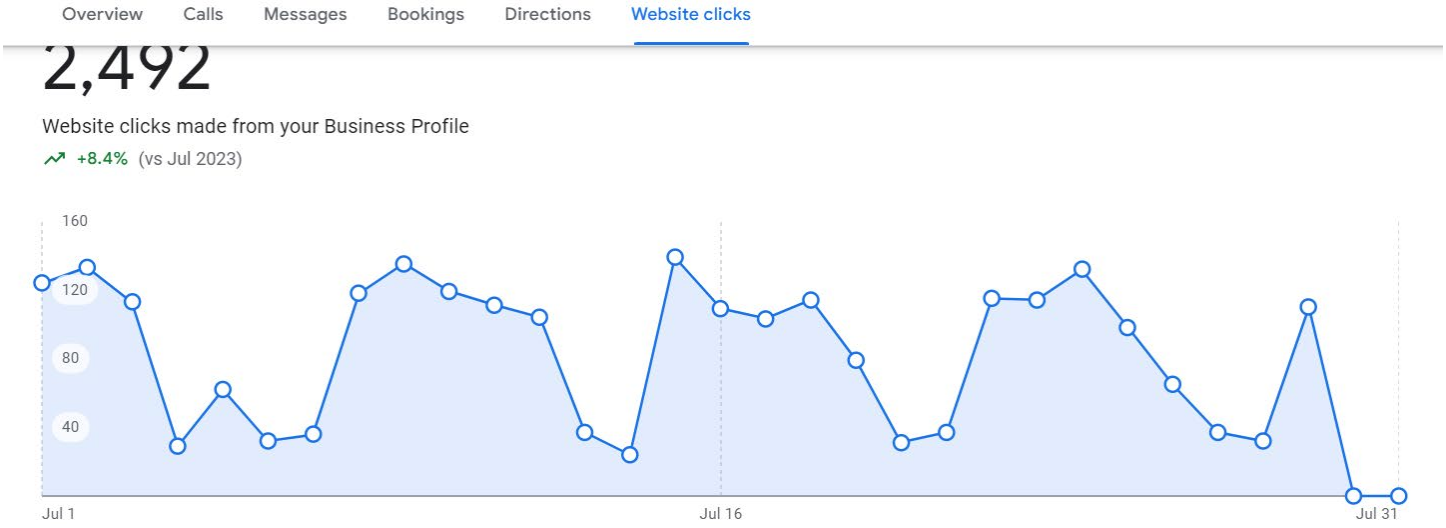

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Integrated Planning

Ruth Watson

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

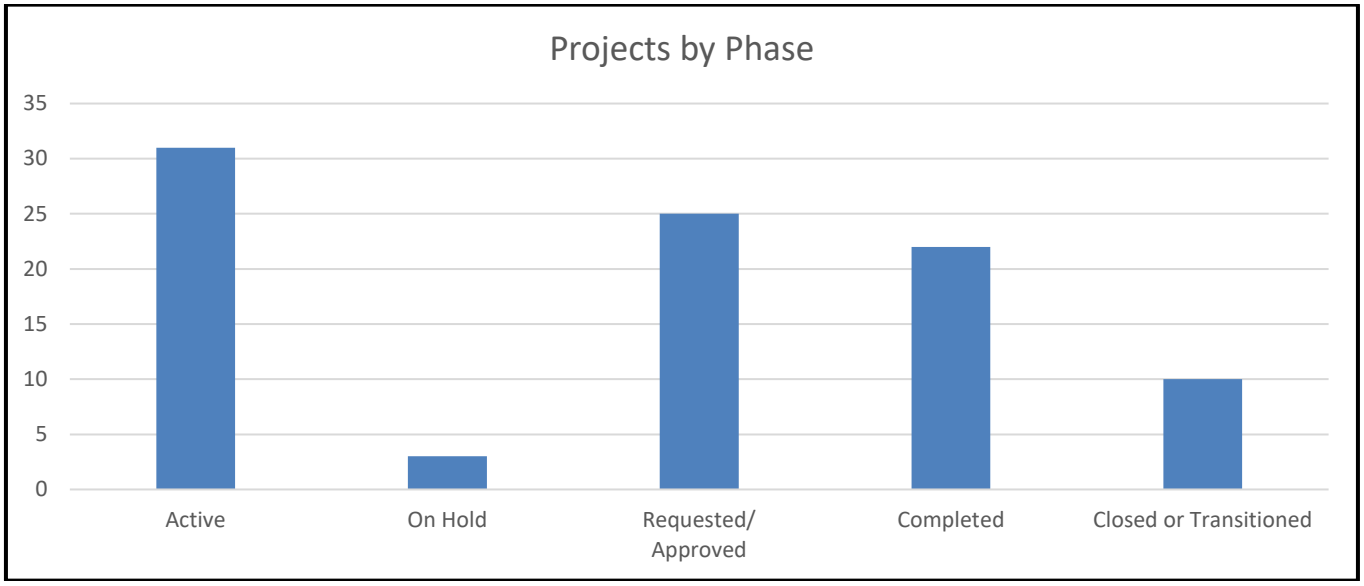
From: **Ruth Watson, Chief Operating Officer**

Date: **August 9th, 2024**

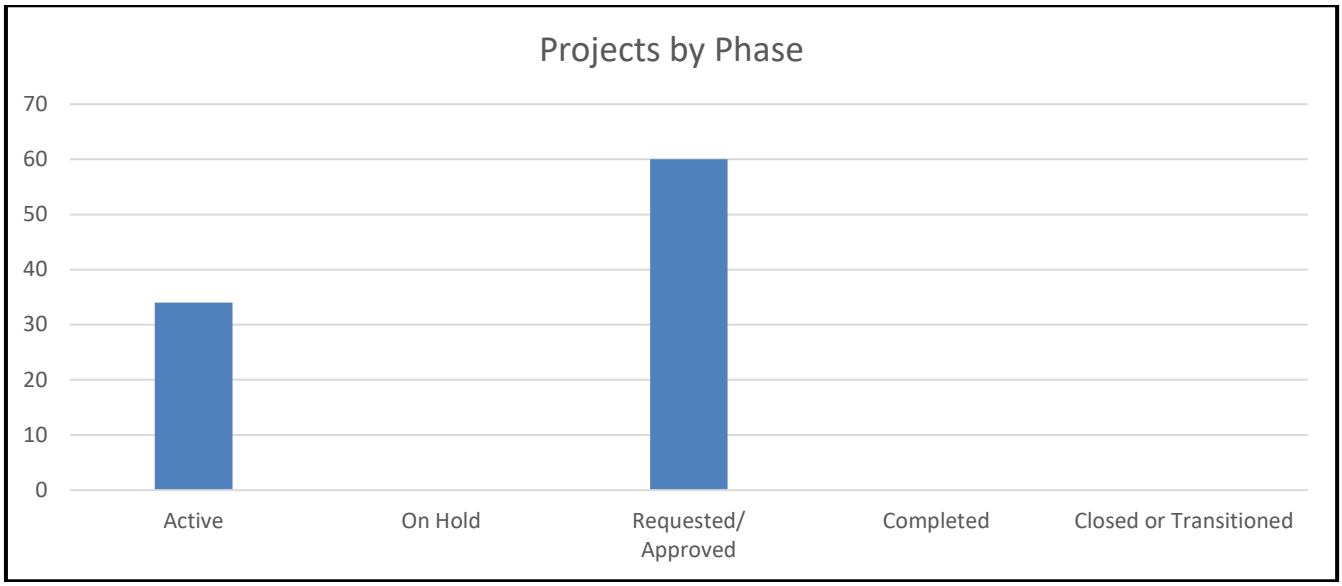
Subject: **Integrated Planning Division Report – July 2024 Activities**

Integrated Planning Division

- Enterprise Portfolio
  - 77 projects currently on the Alameda Alliance for Health (AAH) enterprise-wide portfolio
    - 31 Active projects (discovery, initiation, planning, execution, warranty)
    - 3 On Hold projects
    - 25 Requested and Approved Projects
    - 22 Complete projects
    - 10 Closed/Transitioned to Department or IT Led



- D-SNP Portfolio
    - 93 projects currently on the Alameda Alliance for Health (AAH) enterprise-wide portfolio
        - 34 Active projects (discovery, initiation, planning, execution, warranty)
        - 60 Requested and Approved Projects



    - D-SNP Key Initiatives and Dates
        - DMHC Material Modification Submission – MA Service Area Expansion – March 2024
        - DMHC Material Modification Submission – DSNP Product – August 2024
        - CMS Notice of Intent to Apply – November 2024
        - CMS Application Submission including MOC, Provider Network Adequacy & DMHC Approval – February 2025
        - CMS Formulary & Bid Submission (Benefit Determination) – June 2025
        - CMS SMAC Submission – July 7th, 2025
        - Rebate Allocation with CMS and Health Plan – July / August 2025
        - Annual Enrollment Period (AEP) – October thru December 2025
        - IT System Readiness – December 15th, 2025
        - Open Enrollment Period (OEP) Begins – January 1st, 2026

    - D-SNP Activities – July 2024
        - Provider Services & Contracting
            - Provider Contracting started July 22nd, 2024
            - D-SNP provider amendment rates were approved
            - Developed Provider D-SNP Awareness Campaign supporting the Provider Outreach and Engagement webinar scheduled for August 20th, 21st, and 29th
            - Staffing Update:
                - Posted Two Contract Specialist Positions
                - One open position. Hiring is in process
                - One position hired. Started July 29th, 2024

- Product
  - 3 Vendors replied to the Dental Benefit RFP
  - Vision Benefit RFP released
  - OTC Flex Card meetings occurring
  - Medicare Vendor Analysis and Supplemental Benefit Grid in development
  - Development of the First Tier, Downstream or Related Entity (FDR) Oversight Policy Selected the Creative Department for Branding Consultant – SOW review in progress
  - Medicare Organizational Structure Exercise kick off
  - Staffing Update:
    - Director, Stars Strategy & Program Management – pending offer
    - Manager, Medicare Marketing, Communications, and Branding - posted
- Quality
  - Continued development of Model of Care (MOC) responses for MOC 1, 2, 3, and 4
- Health Care Services / Quality / Behavioral Health
  - UM – CMS, DHCS, and NCQA determination requirements documented
  - CM – CMS, DHCS, NCQA ICT, F2F, ECM – Like Services requirements documented
  - Draft CM Program Structure Documented
  - BH UM – CMS, DHCS, and NCQA determination requirements documented
  - BH CM – Draft Preliminary Program Structure
  - Quality – MOC 1, 2, 3, 4 in progress (42% with completed draft)
- Finance
  - Continued review of CMS D-SNP regulations and development of requirements
- Compliance
  - Three comments received on the DMHC Material Modification – MA Service Area Expansion (filing #20241128) on July 8th. Responses due August 8th.
  - DMHC Material Modification – DSNP Product prefiling meeting with DMHC on July 24th.
- Pharmacy
  - Pre-delegation audit template completed
  - Pre-delegation Mock audit in process with Pharmacy staff
  - Medicare PBM services proposal in review
  - Development of curriculum supporting Pre-delegation audit tool in process
  - Submitted Pharmacy Business Case for temporary Director, Pharmacy
- Operations (Claims / Member Services / Mailroom / IVR Payment Integrity / COBA)
  - Assigned Project Manager.

- IT
    - Zipari on-site kick off occurred on 7/30/2024
    - IT project management plan strategy approved. IT project plans for TruCare (Zyter), HEALTHsuite (RAM Technologies), and QualitySuite are in development.
- P&Ps / SOPs / KPIs
    - Initial development of the Standard Operating Procedure (SOP) process flow to support SOP enterprise training.

- Program Decisions
    - Delegate Provider Credentialing – UCSF, Physical Therapy PN, Lucille Packard, Teledoc, PerformRx
    - Delegate most PBM functions to PerformRX
    - Delegate Provider Training to CHCN
    - Delegate Bid Preparation & Development to Milliman
    - Extend current Medi-Cal contract for Medicare within DME to CHME, Transportation to ModivCare, Telehealth to Teladoc, NAL to Optum, and CAHPS to Press Ganey
    - Delegate Health Risk Assessment (HRA) to a vendor
    - No member delegation
    - DoFR for CHCN for Capitation
    - One HMO PBP for 1/1/26

- **CalAIM Initiatives:**
    - Community Supports (CS):
        - Sobering Centers launch has been rolled into the January 2025 CS expansion
        - Along with Sobering Centers, the final two CS services expected to launch by January 2025 are:
            - Day Habilitation Programs
            - Short-Term Post-Hospitalization Housing
        - The CS Model of Care (MOC) was submitted to DHCS on June 28th, 2024, in support of the two additional CS services
        - Health Care Services has been working to review CS provider scorecards and narrow down the selection of providers for the upcoming expansion
        - In addition to the final two services launching, we are also looking into providers to expand the network for Asthma Remediation and Caregiver Respite Services
        - Once the new providers have been selected, we will begin contracting, credentialing, and site certification

    - 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
    - DHCS has indicated they intend to release a revised JI Policy Guide by end of July 2024; impacts to project scope and schedule will be assessed once this is released.
    - DHCS has announced that MCPs will be notified of individuals who are eligible for pre-release services and therefore eligible for ECM through the daily/monthly 834 file with the JI indicator starting in September 2024
        - Internal working sessions to document use cases for this JI indicator have been initiated with IT, Analytics, ECM, and other impacted departments
    - 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 meets monthly with the local Wellpath team (clinical provider within Santa Rita Jail) to continue discussions about data sharing and to learn about discharge planning
        - Wellpath corporate is now hosting monthly meetings with MCPs to define data sharing requirements and workflows
    - Alameda County Behavioral Health, Wellpath, and Alameda County Sheriff's office are creating a draft care plan for adults at Santa Rita Jail. They expect to share this draft with AAH by the end of July for MCP review
        - Youth population will have a separate care plan created by Probation. This work is anticipated to continue into July, with partnership between Probation and Alameda County Behavioral Health.

- 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
        - A final analysis of the data from July 2023 through June 2024 is in development to demonstrate trends in the key data metrics identified by the project team
        - 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
        - Discussions about sustainability for the Roots programs funded through this pilot have been initiated. Roots is looking to AAH for guidance around billing for ECM and CHW services provided in the 90-day pre-release period
        - Roots is proposing an extension to the pilot period. The proposal from Roots is still under review with senior leadership as of July 30th, 2024

- Community Health Worker (CHW) Benefit – Medi-Cal benefit effective July 1st, 2022, designed to promote the MCP's contractual obligations to meet DHCS broader Population Health Management standards and as adjunctive services as part of the interventions to positively impact health outcomes
    - Provider Recruitment – the Alliance is working or meeting with several organizations in order to grow the CHW network
        - Alameda Health Systems – working with internal teams to create pathways for CHW emergency department services
        - Building Futures – pre-contract phase
        - East Bay Asian Local Development Corporation (EBALDC) – pre-contract phase
        - Family Resource Navigators – pre-contract phase
        - First 5 of California – pre-contract phase
        - Journey Health – contract fully executed
        - Pair Team – awaiting returned agreement from provider
        - Roots – contract amendment to add CHW services in review with provider.
        - Save DV – pre-contract phase
        - Youth Alive, West Oakland Collaborative, Alta Bates Medical – conducted CHW presentation with these groups
    - CHW Workgroup Activities:
        - APL 24-006 – DHCS released an updated CHW APL on May 13th; assessing operational impacts; revised P&Ps addressing this APL's requirements are due to DHCS in August

- CYBHI Fee Schedule – Effective January 1st, 2024, the Alliance is partnering with Carelon (formerly known as Beacon) to implement the CYBHI Fee Schedule
    - Cohort 1 is intended to be a "learning" cohort
    - DHCS continues holding a series of meetings with Cohort participants; these include Onboarding Sessions for the LEAs as well as Technical Office Hours each Thursday of the month
        - The meetings held have been heavily focused on the LEA process
    - The Alliance will utilize Carelon as the Third Party Administrator (TPA)
    - The Claims submission date has been extended from April 1st, 2024 to July 1st, 2024
        - It may not be true that all MCPs or LEAs have systems set up, however, LEAs may submit claims for up to 180 days from the date of service
        - Claims may be submitted retroactively back to July 1st, 2024 as long as it is submitted by end of the year

- MCPs have expressed concern over the initial TPA model and DHCS is considering two options, requesting MCP feedback.
- DHCS has developed a new engagement model for the Health Plan Work Group (HPWG and will meet every week, Fridays between August and September 10 -11am.
    - An email will be shared each Monday with recaps and agendas for subsequent meetings

Recruiting and Staffing

- Integrated Planning Open position(s):
    - Business Process Analyst – 1 Position filled – Started July 1st, 2024, 2nd Position - Pending
- Business Analyst – Integrated Planning – Position filled – started July 15th, 2024
- Backfill Business Analyst – Integrated Planning – Position - Pending

Projects and Programs

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 became effective on January 1st, 2024
    - Community Supports (CS) effective January 1st, 2022 – menu of optional services, including housing-related and flexible wraparound services, to avoid costlier alternatives to hospitalization, skilled nursing facility admission and/or discharge delays
        - As of January 1st, 2024, AAH will offer twelve (12) of the fourteen (14) DHCS-designated CS services
            - January 1st, 2022 – Six (6) Community Supports were implemented
            - July 1st, 2023 – Three (3) additional CS services went live
            - January 1st, 2024
                - Two (2) CS services that support the LTC PoFs that were effective January 2023 are being piloted in 7/1-12/31/2023 and went live in January
                - One (1) additional CS service is also targeted for implementation in July 2024
    - Justice Involved Initiative – adults and children/youth transitioning from incarceration or juvenile facilities will be enrolled into Medi-Cal upon release
        - DHCS is finalizing policy and operational requirements for MCPs to implement the CalAIM Justice-Involved Initiative
            - MCPs must be prepared to go live with ECM for the Individuals Transitioning from Incarceration as of January 1st, 2024
            - MCPs must be prepared to coordinate with correctional facilities to support reentry of members as the return to the community by October 1st, 2024
            - Correctional facilities will have two years from 10/1/2024-9/30/2026 to go live based on readiness
    - Dual Eligible Special Needs Plan (D-SNP) Implementation – All Medi-Cal MCPs will be required to operate Medicare Medi-Cal Plans (MMPs), the California-specific program name for Exclusively Aligned Enrollment Dual Eligible Special Needs Plans (EAE D-SNPs) by January 2026 in order to provide better coordination of care and improve care integration and person-centered care. Additionally, this transition will create both program and financial alignment, simplify administration and billing for providers and plans, and provide a more seamless experience for dual eligible beneficiaries by having one plan manage both sets of benefits for the beneficiary

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

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

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

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

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

Date: **August 9th, 2024**

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

Current Incentive Programs

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

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

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

- Partner meetings continued with the Local Education Agencies (LEAs) regarding project plan activities for successful completion of the milestones
- The Alliance worked with LEAs to complete the Bi-Quarterly Report (BQR) submission for the reporting period of January – June 2024; the report was submitted to DHCS on June 27th, 2024
- The Alameda County Office of Education (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, $7.4M has been awarded to the Alliance by DHCS for completed deliverables, and a total of $6.6M has paid to LEA and SBHIP partners

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

- Total earnable dollars by the Alliance under this program was $44M
- The Alliance received a total of $38M based on submission of deliverables and achievement of DHCS-defined metrics
    - $17.9M has been awarded to our HHIP partners to date
- A HHIP funding opportunity was released earlier this year to SBHIP LEAs to address the challenges of students experiencing homelessness and associated behavioral health needs (i.e., anxiety, depression, etc.)
    - The Alliance received applications from ten (10) LEAs totaling $1.3M and all submitted applications were approved; LEAs were notified of funding decisions on May 31st, 2024
    - Completion of LEA MOU amendments are in progress
- A program to increase partnerships within the community to support HHIP program goals of reducing and preventing homelessness utilizing funds earned from the S2 report is now live
    - The program application was released on June 3rd, 2024, and eight (8) informational sessions have been conducted for twelve (12) interested organizations
    - Up to $10M is available to partners through this program; ten (10) applications were received totaling $19.9M in funding requests related to capacity building, innovation, diversity and health equity, and housing stability

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

- Of the fourteen (14) practices that submitted program applications, Alameda Health System was the only Alliance-associated applicant selected by DHCS to participate
- The original funding was $700 million over five (5) years; however, due to state budget constraints, the funding has been reduced to $140 million over three (3) years
    - One impact related to the funding reduction is that DHCS has delayed the initial program payment for practices to March 2025

New Programs

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

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

The Alliance finalized program materials, including provider-facing program overview documents, application materials, evaluation criteria, governance structure, and policy and procedures. The program launched on June 1st, 2024, and was announced via a press release on May 29th, 2024. Since June 1st, seven (7) informational sessions have been conducted for fifteen (15) different practices.

Recruiting and Staffing

Incentives & Reporting Open position(s):

- The Grants & Incentives Program Manager position was filled via an internal promotion on July 30th, 2024
- Recruitment for the Business Analyst, Incentives & Reporting is underway

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

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

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

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

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

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

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

Date: **August 9th, 2024**

Subject: **Housing and Community Services – July 2024 Activities**

Housing Program Updates

Program Status:

- Continued participation with various stakeholders throughout Alameda County including the Continuum of Care (CoC) Racial Equity Committee, Outreach Access & Coordination Committee, Healthcare for the Homeless Oakland Monthly Regional Housing Meeting, HMIS Committee, CoC Leadership Board, and CoC Notice of Funding Opportunity (NOFO) committee

Projects Status:

- Developing curriculum for Housing Learning Symposium
- ROI project for Housing Related Community Supports
- Housing Department internal restructuring – in progress

Community Health Worker Program Updates

Program Status:

- Benefit presentations – continued to provide CHW presentations to various stakeholders during July
- Network Building/Provider Recruitment
    - Contracting
        - Roots – expanding existing contract to add CHW services
    - Pre-Contracting
        - On-going meetings with Alameda Health Systems, Alta Bates Medical, Building Futures, Family Resource Navigators, First 5 of California, SAVE DV, and West Oakland Collaborative

Projects Status

- Developing curriculum for CHW Learning Cohort
- Developing CHW internal referral process
    - Developing strategy with internal stakeholders for compliance with APL 24-006, including CHW Supervising Provider credentialing requirements and oversight for Emergency Department CHW personnel
- Updating CHW Policies and Procedures (P&P) based on APL 24-006 requirements
    - Updated P&P is due to DHCS by 08/09/2024
- Development of a CHW Supervising Provider workflow – in progress
- Development of public website content in partnership with the Communications & Outreach team – in progress

Staffing

- Recruitment is currently underway for the following positions:
    - Housing and Community Services Housing Program Coordinator (2)

Compliance

Richard Golfin III

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

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

Date: **August 9th, 2024**

Subject: **Compliance Division Report**

Compliance Audit Updates

- 2024 Department of Health Care Services (DHCS) Routine Full Medical Survey

    - The 2024 DHCS Routine Full Medical Survey began on June 17th, 2024, and ended on June 28th, 2024. To date, the Plan has received three hundred and forty-one (341) document requests; 311 end-of-day requests and an additional thirty (30) post-audit requests. The Plan has addressed 99% of the additional requests. The Preliminary Report has not been provided. Once received, the Plan will have fifteen (15) days to respond to the agency with mitigating information.

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

    - On June 20th, 2024, the Plan received the 2023 DHCS Focused Audit Draft Report and Notice Letter. The 2023 DHCS Focused Audit was conducted concurrently with the 2023 DHCS Routine Survey. The Preliminary Report outlined nine (9) findings: four (4) findings under Behavioral Health Services; and five (5) findings under Transportation Services, Non-Medical and Non-Emergent Medical Transportation (NMT/NEMT). The Plan reviewed the findings and did not have objections to the State's report. The Plan confirmed its acceptance of the Draft report on July 3rd, 2024. The Plan submitted its response to the Draft report timely on July 19th, 2024. The Plan is working with internal leads to collect CAP responses.

- 2024 Health Services Advisory Group, Inc. (HSAG) Network Adequacy Validation Audit (NAV)

    - On March 15th, 2024, HSAG informed the Plan of its 2024 NAV Audit. The virtual NAV Audit was held on July 15th and July 17th, 2024. On July 22nd, 2024, the Plan received the *post virtual review IS Tracking Grid* from HSAG to respond to follow-up requests post-audit. The log contained 19 follow-up items, including five (5) post-onsite requests. The Plan submitted the response timely to HSAG on July 30th, 2024. The Plan is awaiting further instruction from HSAG auditors.

Compliance Activity Updates

- DMHC Medicare Filings – 2026 Medicare Launch

    - Medicare License Expansion Filing: On March 1st, 2024, the Plan submitted Material Modification (E-Filing No. 20241128) to expand its Knox-Keene license to include the Medicare Line of Business by January 1, 2026. The DMHC issued an Order of Postponement on March 28th, 2024. To address remaining comments, the Plan met with DMHC's Office of Financial Review (OFR) for additional guidance. The Plan will provide an additional response to DMHCs remaining comments by August 2nd, 2024. The Plan expects that the filing will be approved by the agency within the coming months.

    - D-SNP (Dual Eligible Special Needs Plan) Product Filing: In preparation for submitting a second Material Modification (proposed E-Filing, no filing number yet assigned) to add a D-SNP product to the Plan's current State License, the Plan held a pre-filing meeting with DMHC on Wednesday, July 24th, 2024. During this call, the Plan received DMHC's guidance related to documents to include in the submission. The Plan has identified August 9th, 2024, as the target filing date.

- California Department of Managed Health Care (DMHC) Material Modification – 2024 RFP Readiness, Single Plan County Model Transition Submission:

    - The DMHC requested status of DHCS' post-transition monitoring of the Plan, including a description of the monitoring reports and other closing documents. The Plan compiled a report that outlines the Plan's post-transition activities. The Plan submitted its response and report to DMHC on Monday, July 29th, 2024. The Plan anticipates that this filing will close within the coming months.

- 2024 Corporate Compliance Annual Training:

    - On Monday, September 9th, 2024, Staff will be assigned Annual Compliance Trainings. Annual training covers the following areas: HIPAA, FWA, and Cultural Sensitivity. Staff will have ninety (90) days to complete the assigned trainings.

- Justice-Involved Populations of Focus Pre-CAP Letter

    - On January 26th, 2023, DHCS approved to offer a targeted set of services to youth and eligible adults in state prisons, county jails, and youth correctional facilities for up to ninety (90) days prior to release. The Plan submitted documentation to support how to integrate this initiative into our current scope of services. On February 1st, 2024, the Plan received a pre-CAP letter from DHCS indicating the Plan scored "inadequate" on the below requirements:

        - Contract with at least 1 experienced JI ECM Provider in each county of operation.

        - Develop network sufficiency to meet estimated ECM capacity needs.

    - The Plan submitted the additional documentation on March 22nd, 2024. DHCS stated it had completed its review of the Plan's written responses to the Justice-Involved Population of Focus Pre-CAP Letter and determined that no formal CAP is warranted at this time. This item is now closed.

- 2024 Long Term Care Intermediate Care Facilities/ Intermediate Care Facility for the Developmentally Disabled (LTC-ICF/DD) Phase I Corrective Action Plan (CAP)

    - Effective January 1st, 2024, the Plan is contractually required to cover LTC-ICF/DD Services. To demonstrate its readiness to provide services at this level of care, the Plan must attempt to contract with *all* California Department of Public Health (CDPH) licensed and certified LTC-ICF/DDs within California and specific care-homes within the County. On July 3rd, 2024, DHCS deemed the Plan to be out of compliance with this requirement. The Contracting Department has vigorously attempted to contract with facilities outside of Alameda County and statewide and continues to report its efforts to DHCS. The Plan is prepared to submit its first CAP response report due August 1, 2024.

- 2022 Behavioral Health Insourcing: Material Modification

    - On March 23rd, 2023, the Plan received a conditional order of approval from the Department of Managed Health Care (DMHC). The DMHC's conditional approval was subject to the Plan's full performance of eight (8) Undertakings (UTs). Undertaking No. 6 remains outstanding. The current status is detailed in the chart below:

Undertaking No. 6 Status Chart		
Deliverable	**Next Milestone**	**Progress**
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.	August 21st, 2024	Due to the DHCS audit, the Plan requested and received an extension to respond to the DMHC's latest round of comments by July 22nd, 2024. With support from outside counsel, the Plan filed its substantive responses on July 22nd, 2024. The Plan anticipates closing this filing within the next 90 days.

Compliance

Supporting Documents

Q4 2023 - Present APL IMPLEMENTATION TRACKING LIST						
#	Regulatory Agency	APL/PL #	Date Released	APL/PL Title	LOB	APL Purpose Summary
56	DHCS	23-028	10/3/2023	Dental Services – Intravenous Sedation and General Anesthesia Coverage	MEDI-CAL	The purpose of this All Plan Letter (APL) is to describe the requirements for Medi-Cal managed care health plans (MCPs) to cover intravenous (IV) moderate sedation and deep sedation/general anesthesia services provided by a physician in conjunction with dental services for MCP Members in hospitals, ambulatory surgical settings, or dental offices. This APL supersedes APL 15-012.1 This APL identifies information that MCPs must review and consider during the prior authorization process as described and detailed in the attached guidelines for IV moderate sedation and deep sedation/general anesthesia for dental procedures (Attachment A).
57	DHCS	23-029	10/11/2023	Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities	MEDI-CAL	The purpose of this All Plan Letter (APL) is to clarify the intent of the Memorandum of Understanding (MOU) required to be entered into by the Medi-Cal managed care plans (MCPs) and Third Party Entities (defined below) under the Medi-Cal Managed Care Contract (MCP Contract) with the Department of Health Care Services (DHCS), and to specify the responsibilities of MCPs under those MOUs. In addition, this APL contains an MOU template with general provisions required to be included in all MOUs (Base Template) that the MCPs must execute pursuant to the MCP Contract and MOU templates tailored for certain programs, which contain the required general MOU provisions and program-specific provisions (Bespoke Templates). Further, this APL addresses DHCS' expectations and oversight of MCP obligations under this APL and the MOUs, including MCP reporting requirements.
58	DHCS	23-030	10/24/2023	Medi-Cal Justice-Involved Reentry Initiative-Related State Guidance	MEDI-CAL	The purpose of this All Plan Letter (APL) is to announce the release of the "Policy and Operational Guide for Planning and Implementing CalAIM Justice-Involved Reentry Initiative" for county welfare departments, state prisons, county correctional facilities, county youth correctional facilities, and/or their designated entity(ies). The Policy and Operational Guide (herein referred to as "The Guide") memorializes policy and operational requirements for implementing the Medi-Cal Justice-Involved Reentry Initiative.
59	DMHC	23-020	10/26/2023	Amendments to Rule 1300.67.2.2 and Incorporated Annual Network Submission Instruction Manual and Annual Network Report Forms for Reporting Year 2024	GROUP CARE	The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) to inform health care service plans (health plans) of new amendments to 28 CCR § 1300.67.2.2 and the incorporated Annual Network Submission Instruction Manual and Annual Network Report Forms for the reporting year (RY) 2024 Annual Network Report submission. These amendments are made in accordance with Senate Bill (SB) 221 (Wiener, Chapter 724, Statutes of 2021) and SB 225 (Wiener, Chapter 601, Statutes of 2022) which provided the DMHC with two exemptions from the Administrative Procedure Act (APA) to develop mandatory reporting methodologies and standards for the Annual Network Report and Timely Access Compliance submission.
60	DMHC	23-021	11/14/2023	Payment of COVID Claims for COVID-19 Tests Delivered Between March 4, 2020 and December 31, 2021	MEDI-CAL & GROUP CARE	The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 23-021, which provides information in regards to payment of COVID claims for COVID-19 tests delivered between March 4, 2020 and December 31, 2021.
61	DHCS	23-012	12/4/2023	Enforcement Actions: Administrative and Monetary Sanctions (REVISED)	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide clarification to Medi-Cal managed care health plans (MCPs) of the Department of Health Care Services' (DHCS) policy regarding the imposition of administrative and monetary sanctions, which are among the enforcement actions DHCS may take to enforce compliance with MCP contractual provisions and applicable state and federal laws. This APL supersedes APL 22-015.
62	DMHC	23-022	12/13/2023	Compliance with Senate Bill 1419 - Health Information	MEDI-CAL & GROUP CARE	The Department of Managed Health Care (Department) issues this All Plan Letter (APL) 23-022, delaying the January 1, 2024 effective date of SB 1419 (2022) until January 1, 2025.
63	DMHC	23-023	12/14/2023	Notice of Amendments to Rules 1300.51 and 1300.67.2 and Incorporated Documents – Network Adequacy Requirements and Mental Health Standards and Methodology for RY 2024	MEDI-CAL & GROUP CARE	The Department of Managed Health Care (Department) issues this All Plan Letter (APL) 23-022, delaying the January 1, 2024 effective date of SB 1419 (2022) until January 1, 2025.
1	DHCS	24-001	1/12/2024	Street Medicine Provider: Definitions and Participation in Managed Care	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care plans (MCPs) on opportunities to utilize street Medicine providers to address clinical and non-clinical needs of their Medi-Cal Members experiencing unsheltered homelessness.

#	Regulatory Agency	APL/PL #	Date Released	APL/PL Title	LOB	APL Purpose Summary
2	DMHC	24-001	1/12/2024	Amendment to Rule 1300.71.31 regarding calculation of the “Average Contracted Rate” for AB 72 (2016) purposes	MEDI-CAL & GROUP CARE	The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 24-001 to provide guidance to plans on the Amendment to section 1300.71.31 of title 28 of the California Code of Regulations (Rule 1300.71.31).
3	DMHC	24-002	1/22/2024	Large Group Renewal Notice Requirements	GROUP CARE	The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 24-002 to provide guidance to plans on the timing and content requirements for renewal notices to large group contract holders under HSC section 1374.21 and HSC section 1385.046.
4	DMHC	24-003	1/29/2024	Plan Year 2025 QHP, QDP, and Off-Exchange Filing Requirements	N/A	The Department of Managed Health Care (Department) issues this All Plan Letter (APL) 24-003 to assist in the preparation of Plan Year 2025 regulatory submissions, in compliance with the Knox- Keene Act at California Health and Safety Code sections 1340 et seq. (Act) and regulations promulgated by the Department at California Code of Regulations, title 28 (Rules).
5	DHCS	24-002	2/8/2024	Medi-Cal Managed Care Plan Responsibilities for Indian Health Care Providers and American Indian Members	MEDI-CAL	The purpose of this All Plan Letter (APL) is to summarize and clarify existing federal and state protections and alternative health coverage options for American Indian Members enrolled in Medi-Cal managed care plans (MCPs). Additionally, this APL consolidates various MCP requirements pertaining to protections for Indian Health Care Providers (IHCPs), including requirements related to contracting with IHCPs and reimbursing claims from IHCPs in a timely and expeditious manner. This APL also provides guidance regarding MCP tribal liaison requirements and expectations in relation to their role and responsibilities.
6	DMHC	24-004	2/22/2024	Coverage of Over-the Counter FDA Approved Contraceptives	GROUP CARE	The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 24-004 to remind health plans, effective January 1, 2024, the rules changed regarding health plan coverage of over-the-counter (OTC) contraceptive drugs, devices, and products approved by the federal Food and Drug Administration (FDA).
7	DMHC	24-005	3/11/2024	Change Healthcare Cyberattack	MEDI-CAL & GROUP CARE	The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 24-005 to encourage health plans to be flexible to ensure stability of the health care system following the cyberattack of Change Healthcare
8	DMHC	24-006	3/20/2024	Provider Directory Annual Filing Requirements	MEDI-CAL & GROUP CARE	This All Plan Letter (APL) reminds health care service plans of California Health and Safety Code section 1367.27, subdivision (m)’s requirement to annually submit provider directory policies and procedures to the Department of Managed Health Care (Department).
9	DHCS	24-003	3/28/2024	Abortion Services	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCP) with information regarding their responsibility to provide Members with timely access to abortion services.
10	DMHC	24-007	4/3/2024	Implementation of Senate Bill 855 Regulation, Mental Health and Substance Use Disorder Coverage	GROUP CARE	The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 24-007 to provide guidance regarding implementation of the regulation as well as filing and compliance requirements for commercial full-service health plans and specialized health care service plans (plan or plans) offering behavioral health services.
11	DHCS	24-004	4/8/2024	Quality Improvement and Health Equity Transformation Requirements	MEDI-CAL	The purpose of this All Plan Letter (APL) is to notify Medi-Cal managed care plans (MCPs), including MCPs delivering services to Members with specialized health care needs under the Population-Specific Health Plan (PSP) model, of requirements for quality and health equity improvement. Unless otherwise noted, all MCP requirements set forth in this APL apply to PSPs.
12	DMHC	24-008	4/15/2024	2024 Health Plan Annual Assessments	GROUP CARE	The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 24-008 to provide information to health care service plans (health plans) pertaining to the DMHC’s fiscal year (FY) 2024-25 annual assessments.
13	DHCS	24-005	4/29/2024	California Housing and Homelessness Incentive Program	MEDI-CAL	The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCP) with guidance on the incentive payments linked to the Housing and Homelessness Incentive Program (HHIP) implemented by the California Department of Health Care Services (DHCS) in accordance with the Medi-Cal Home and Community-Based Services (HCBS) Spending Plan.
14	DMHC	24-008	4/15/2024	2024 Health Plan Annual Assessments	GROUP CARE	The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 24-008 to provide information to health care service plans (health plans) pertaining to the DMHC’s fiscal year (FY) 2024-25 annual assessments.
15	DMHC	24-009	5/6/2024	Change Healthcare Cyberattack Response Filing	MEDI-CAL & GROUP CARE	The Department of Managed Health Care (DMHC) hereby issues this All Plan Letter (APL) 24-009 to request information from plans regarding their response and outreach to enrollees potentially impacted by the Change Healthcare cyberattack.

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

COMPLIANCE DASHBOARD SUMMARY

	Resource	Type	2018	2019	2020	2021	2022	2023	2024	TOTAL	% Completed
OVERALL FINDINGS	DHCS	Total State Audit Findings	38	28	7	33	15	24	TBD	145	
		Total Self-Identified Issues	12	0	0	2	0	2	23	39	
		Total Findings	**50**	**28**	**7**	**35**	**15**	**26**	**23**	**184**	
		Total In Progress	0	0	0	0	0	9	23	32	
		Total Completed	50	28	7	35	15	17	0	152	**94%**
		Total Findings	**50**	**28**	**7**	**35**	**15**	**26**	**23**	**161**	
	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	9	0	10	
		Completed	38	33	12	39	26	15	0	163	**94%**
		Total Findings	**38**	**33**	**12**	**39**	**27**	**24**	**0**	**173**	
SELF-IDENTIFIED FINDINGS		In Progress	0	0	0	0	0	0	23	23	
		Completed	12	0	3	2	0	2	0	19	**45%**
		Total Findings	**12**	**0**	**3**	**2**	**0**	**2**	**23**	**42**	
TOTAL OVERALL FINDINGS			**50**	**33**	**15**	**41**	**27**	**26**	**23**	**215**	

COMPLIANCE DASHBOARD SUMMARY			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	Total State Audit Findings	173	80%
	Total Self-Identified Issues	42	20%
	Total Findings	**215**	
	Total In Progress	33	15%
	Total Completed	182	85%
	Total Findings	**215**	
STATE AUDIT FINDINGS	In Progress	10	6%
	Completed	163	94%
	Total Findings	**173**	
SELF-IDENTIFIED FINDINGS	In Progress	23	55%
	Completed	19	45%
	Total Findings	**42**	

2024 DHCS Audit Summary			
	Type	**TOTAL**	**%**
OVERALL FINDINGS	Total State Audit Findings	0	0%
	Total Self-Identified Issues	23	100%
	Total Findings	**23**	
	Total In Progress	23	100%
	Total Completed	0	0%
	Total Findings	**23**	

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

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	0	0%
	Total Completed	17	100%
	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			
OVERALL FINDINGS	**Type**	**TOTAL**	**%**
	Total State Audit Findings	3	100%
	Total Self-Identified Issues	0	0%
	Total Findings	**3**	
	Total In Progress	0	0%
	Total Completed	3	100%
	Total Findings	**3**	

2022 DMHC 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
R = Repeat Observation

2024 DHCS Audit ***- Audit Review Period*** **6/1/2023 - 5/31/2024** ***Audit Onsite Dates - June 17, 2024 - June 28, 2024***			
#	**Category**	**Plan Observations and Potential Findings**	**Department Responsible**
1	UM	(1.2) Prior Authorization Procedures The Plan did not authorize referrals to transplant programs within 72 hours of the member's specialist identifying the member as eligible for Major Organ Transplant (MOT)	UM
2	UM	(1.2) Prior Authorization Procedures The Plan did not ensure all MOT procedures, including bone marrow, were performed in a medically approved center of excellence (COE) as described in APL 21-015	UM
3	UM	(1.3) Prior Authorization Appeals The Plan did not obtain written consent from members prior to appeal when the provider filed the appeal in accordance with APL 21-011	G&A
4	UM	(1.3) Prior Authorization Appeals The Plan did not send updated non-discrimination notice with tagline to appeal notification as described in APL 21-004	G&A
5	CM and CoC	(2.1) California Childrens Services (CCS) The Plan did not monitor CCS referral program pathways to identify members who may be eligible for CCS	Case Management
6	CM and CoC	(2.1) Initial Health Assessment (IHA) The Plan did not ensure reasonable member outreach attempts for the IHA document	QI
7	CM and CoC	(2.1) **R** Initial Health Assessment (IHA) The Plan did not ensure the provision of Initial Health Assessments for members	QI
8	CM and CoC	(2.1) Initial Health Assessment (IHA) The Plan did not ensure the provision of blood lead screenings for pediatric members	QI

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2024 DHCS Audit ***- Audit Review Period*** **6/1/2023 - 5/31/2024** ***Audit Onsite Dates - June 17, 2024 - June 28, 2024***			
#	**Category**	**Plan Observations and Potential Findings**	**Department Responsible**
9	CM and CoC	(2.1) Initial Health Assessment (IHA) The Plan did not ensure the member outreach attempts were conducted and documented for IHAs for pediatric members	QI
10	CM and CoC	(2.3) Behavioral Health Therapy (BHT) The Plan did not ensure timely access to Behavioral Health Therapy services	Behavioral Health
11	CM and CoC	(2.3) Behavioral Health Therapy (BHT) The Plan did not ensure provision of BHT services	Behavioral Health
12	CM and CoC	(2.3) Behavioral Health Therapy (BHT) The Plan did not ensure care coordination for members needing BHT services	Behavioral Health
13	CM and CoC	(2.4) Continuity of Care The Plan did not ensure the notice of action (NOA) letters regarding continuity of care (CoC) denials were clear and concise	UM
14	Access and Availability	(3.1) Access The Delegate subcontractor placed members on appointment waitlists and did not provide timely appointments	QI
15	Access and Availability	(3.1) Access The Plan did not monitor appointment wait times and appointment availability for specialists and behavioral health specialists	QI
16	Member Rights	(4.1) Grievance Resolution The Plan did not ensure the decision maker for grievances involving clinical issues was a healthcare expert with clinical expertise for the condition as described in APL 21-011	G&A
17	Member Rights	(4.1) Grievance Resolution The Plan did not completely resolve quality of care and quality of service grievances	G&A

ALAMEDA ALLIANCE FOR HEALTH
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2024 DHCS Audit ***- Audit Review Period*** **6/1/2023 - 5/31/2024** ***Audit Onsite Dates - June 17, 2024 - June 28, 2024***			
#	**Category**	**Plan Observations and Potential Findings**	**Department Responsible**
18	Member Rights	(4.1) Grievance Resolution The Plan did not ensure resolution letters contained clear and concise explanations for quality of care and quality of service decisions	G&A
19	Member Rights	(4.1) Grievance Resolution The Plan did not send updated non-discrimination and language assistance information with grievance letters	G&A
20	Member Rights	(4.2) Cultural and Linguistic Services (CLS) The Plan did not monitor the linguistic performance of vendors that provider interpreter services	Cultural and Linguistic Services
21	Member Rights	(4.3) Confidentiality The Plan did not notify DHCS within 24 hours of a breach or HIPAA incident	Compliance
22	Fraud, Waste, and Abuse	(6.2) Fraud, Waste, and Abuse The Plan does not have a regular method of reviewing services have been delivered by network providers or received by members	Compliance Claims UM
23	State Supported Services	(3.6) State Supported Services The Plan did not distribute minimum payments for State Supported Services claims as described in APL 23-015	Claims

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 Focused Audit ***- Audit Review Period*** **4/1/2022 - 3/31/2023**
Audit Onsite Dates - April 17, 2023 - April 28, 2023

#	Category	Deficiency	Department Responsible
1	UM	(2.1) Case Management and Care Coordination The Plan did not ensure the provision of coordination of care to deliver mental health care services to its members.	UM Provider Services
2	BH	(2.2) Information Exchange with the County Mental Health Plan (MHP) The Plan did not follow the written policies and procedures in its MOU for the timely sharing of medical information with the MHP.	UM Privacy IT
3	BHT	(2.3) Confirmation of Referred Treatments for Substance Use Disorder (SUD) The Plan did not make good faith efforts to confirm whether members received referred treatment for SUD and document when and where treatment was received, and any next steps following treatment.	UM Continuity of Care Behavioral Health
4	BH	(2.4) Follow Up for Referred Substance Use Disorder Treatments The Plan did not follow up with members who did not receive referred treatments to understand barriers and make subsequent adjustments to referrals.	UM Case Management Behavioral Health
5	NMT & NEMT	(3.1) Door-to-Door Assistance The Plan did not have a process in place to ensure that door-to-door assistance was provided for all members receiving NEMT services.	Vendor Management
6	NMT & NEMT	(3.2) Monitoring of Door-to-Door Assistance The Plan did not conduct monitoring activities to verify NEMT providers were providing door-to-door assistance for members receiving NEMT services, per APL 22-008	Vendor Management
7	NMT & NEMT	(3.3) Transportation Liaison The Plan did not have a direct line to the transportation liaison that it provided to providers and members, and the transportation liaison did not process authorizations after business hours.	UM

ALAMEDA ALLIANCE FOR HEALTH
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2023 DHCS Focused Audit ***- Audit Review Period 4/1/2022 - 3/31/2023***
Audit Onsite Dates - April 17, 2023 - April 28, 2023

#	Category	Deficiency	Department Responsible
8	NMT & NEMT	(3.4) **R** Physician Certification Statement Forms The Plan did not ensure that members had the required PCS forms for NEMT services, nor did the Plan ensure that PCS forms contained all required components. A verification study of 14 samples revealed ten NEMT trips did not include the required PCS forms. The verification study also revealed for three samples that required the PCS form, there was not a place for start and end dates for NEMT services. The Plan updated the PCS form in March 2023; however, the start and end dates still were not included. Instead, the form had boxes for the prescriber to check off for durations of time; 3, 6, 9, and 12 months.	UM
9	Member Rights	(3.5) Ambulatory Door-to-Door The Plan did not ensure its delegate, provided the appropriate level of service for members requiring ambulatory door-to-door service.	UM Continuity of Care Vendor Management

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

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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
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2023 DHCS Audit - *Audit Review Period* 4/1/2022 - 3/31/2023 *Audit Onsite Dates - April 17, 2023 - April 28, 2023*							INTERNAL AUDITS		
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2	QI	(2.1.1) Provision of an Initial Health Assessment (IHA) The Plan did not ensure the provision of a complete IHA for new members.	1. Update IHA policy QI-124 (On Track) **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
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. **Update 5/10/2024:** Policy BH-004 was approved at Compliance Committee on 4/10/2024. 1b. The Plan intends to conduct audits on our Treatment Review documentation to ensure that all required elements are covered in the review process in compliance with the requirements in the APL. The expected implementation date of this audit is Q1 of 2024. **Update 5/10/2024**: Q1 2024 treatment plan audits are in progress pending completion at end of March. The next audit period (Q2) will go through June. 1c. The Provider/PCP Manual is also pending updates that will include a FAQ for PCPs, provider education regarding the prior authorization process, and the referral process. This is currently under review-pending completion. **Update 5/10/2024:** Provider Manual revised and submitted to DHCS Plan Communications Department, who is reviewing proposed revisions and once completed will be made available via the provider portal	**5/10/2024**	**Completed**	Behavioral Health	State	DHCS	2023

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

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

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

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2022 DMHC Behavioral Health Investigation - *Audit Review Period* 4/1/2020 - 4/30/2022 *Audit Onsite Dates - September 7, 2022 - September 8, 2022*							INTERNAL AUDITS	
#	**Category**	**Deficiency**	**Corrective Action Plan (CAP)**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**State/Self Identified**	**Agency**
1	UM	The Plan failed to timely implement the requirements of Sections 1374.72 and 1374.721 (SB 855)	The Alliance reviews and/or updates all policy and procedures at least annually, to ensure our policy and procedures content is reflective of current regulatory requirements. All UM policy and procedures including any updates and the UM Program Description, are reviewed in the Utilization Management Committee (UMC), subsequently reviewed, and approved at our Board Delegated Quality Improvement Health Equity Committee (QIHEC) which reports directly to the Alliance Board of Governors. In response and in compliance with SB 855, The Alliance has updated UM-063 - Gender Affirmation Surgery and Transgender Services and the Alliance UM Program Description. Both bodies of work are aligned with current WPATH Standards of Care. The Alliance is contracted with WPATH to provide training on WPATH Standards of Care - all UM decision makers (including RNs and physicians) are required to complete WPATH training to ensure the most current WPATH standards required by SB 855 are used for medical necessity decision-making. 100% of current UM reviewers will complete WPATH Training by Q2 2024 & 100% of newly hired UM reviewers will complete WPATH Training within 90-days of their start date 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	DMHC
2	Quality Assurance	The Plan does not ensure its delegate consistently documents quality of care provided is being reviewed, problems are being identified, effective action is taken to improve care where deficiencies are identified, and follow-up is planned where indicated.	As of 4/1/2023, The Alliance has terminated its contract with the delegate. Since termination, The Alliance has insourced all mental and behavioral health services and processes all quality of care issues identified. The Alliance follows its internal policy and procedures and workflows to ensure that all quality of care problems are identified, reviewed and further, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.	4/1/2023	Completed	UM Quality Assurance Behavioral Health Compliance	State	DMHC

#	**Category**	**Barriers to Care**	**Plan Response**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**State/Self Identified**	**Agency**
1	Pharmacy Services	The Plan has limited ability to provide Office Based Opioid Treatment (OBOT) and Opioid Treatment Program (OTP) therapy and lacks policies and procedures for these treatments.	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	DMHC
2	Cultural Competency and Health Equity	Neither the Plan nor its delegate conduct assessments pertaining to cultural competency and health equity specific to the Plan's enrollee population.	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	DMHC
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	DMHC

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2022 DMHC RBO Audit: Delegate - *Audit Review Period* 1/1/2022 - 3/31/2022							INTERNAL AUDITS			
#	**Category**	**Deficiency**	**Corrective Action Plan (CAP)**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**
1	Claims Payment Accuracy	The Department's examination disclosed that the RBO failed to reimburse one paid claim correctly due to a systematic error. The claims system failed to classify the provider as a contracted provider. The claim was paid incorrectly at the non-contracted rate, which was less than the contracted rate. The RBO represented to the Department that this deficiency was due to a contract amendment, effective February 1, 2021, that was not updated in their claims system. This deficiency was noted in paid claims sample number P-18.	Delegate updated claims system to accurately reflect all providers listed on the provider roster as contracted with the effective date of 2/1/2021 to align with the contract amendment. A claims sweep was completed with a lookback to 2/1/2021. All claims previously paid noncontracted were reprocessed as contract and have been paid with any accrued interest and/or penalties associate with each claim reprocessed on 10/12/2022. Evidence of the complete claims audit sweep associated with members was sent to The Alliance on 1/19/2023 via secure email. Draft policy was created to ensure provider contracts and rosters are appropriately loaded within delegate's claims system. Draft policy will be presented to the delegate's Compliance Committee on 3/29/2023 for review and approval. 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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#	**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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#	**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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2022 DHCS AUDIT FINDINGS: *Audit Review Period 1/1/2021 - 3/31/2022*							INTERNAL AUDITS			
#	**Category**	**Deficiency**	**Corrective Action Plan (CAP)**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**
1	G&A	(1.3.1) The Plan did not send acknowledgement letters for standard appeals within the required timeframe of five calendar days.	1. The Daily Clerk Report is received daily by Grievance & Appeals Clerks and Leadership. The report will be reviewed by the Grievance & Appeals Leadership team to ensure acknowledgment letters are mailed timely. 2. The Plan provided training to the Grievance & Appeals staff to review the regulatory requirements for mailing of acknowledgement letters.	10/1/2022	Completed	G&A		State	DHCS	2022
2	G&A	(1.3.2) The Plan did not comply with existing APLs to notify members receiving a NAR that upholds an adverse benefit determination that they have an additional 120 days in addition to the initial 120 days allowed to request a SFH.	1. Your Rights enclosure was updated to reflect enrollees have 240 days to request a State Fair Hearing 2. Policy & Procedure G&A-007 State Hearings has been updated to reflect the member has 240 calendar days to request a State Hearing. The policy will go to committee for review and approval in December. 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

ALAMEDA ALLIANCE FOR HEALTH
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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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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

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#	**Category**	**Deficiency**	**Corrective Action Plan (CAP)**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**
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
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

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

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

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

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

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

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

ALAMEDA ALLIANCE FOR HEALTH
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
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

ALAMEDA ALLIANCE FOR HEALTH
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2020 DHCS STATE AUDIT FINDINGS - *Audit Review Period: 10/01/2018 - 9/30/2020*					INTERNAL AUDITS						
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
4	UM	The Plan did not notify members and the hospital of continued denial of long term acute care (LTAC) services through NOA letters and "Your Rights" attachments for each concurrent review throughout the members' hospital stays	1. The Plan reviewed and revised the following P&P: a. UM-003 Concurrent Review and Discharge Planning Process to reflect frequency of reviews throughout the members' hospital stay, including after a NOA is sent, and the use of standard Utilization Review procedures. Policy and Procedure will be approved at the HCQC on 5/20/2021. b. The Plan's standard review procedures include applying written criteria for each review. The Plan's standard utilization review procedures are reflected in Plan's P&P UM-057 and in UM-054 Notice of Action. 2. The Plan will train its Utilization Management staff involved in the Concurrent Review process of the change. The training will be documented with training materials and attendance records. Update 5/14/21: Training was completed on 3/31/21 3. The Plan will audit the Concurrent review process after Q2 2021 to ensure that process are followed and implemented accordingly. Update 5/14/21: Manual audit in place, automated report in development. Update 7/9/2021: Manual tracking continues, nearing completion of automated report. 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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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

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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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#	**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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#	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
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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#	**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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#	**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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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: **August 9th, 2024**

Subject: **Health Care Services Report**

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

- There was a month-over-month increase in total authorization volume from June to July 2024.

Total Authorization Volume (Medical Services)			
Authorization Type	**May 2024**	**June 2024**	**July 2024**
Inpatient	2,147	1,911	1,997
Outpatient	4,437	3,815	4,172
Long-Term Care	820	688	926
Total	**7,404**	**6,414**	**7,095**

***Source**: #02569_AuthTAT_Summary*

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

Utilization Management: Outpatient

- Anthem CoC volume continues at 10-15% 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.

- Reporting requirements for DHCS are continuing through 12/31/2024 as part of the DHCS monitoring and oversight process.

- OP processed a total of 4,172 authorizations in the month of July.

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

Total Outpatient Authorization Volume			
Authorization Status	**May 2024**	**June 2024**	**July 2024**
Approvals	4,288	3,737	4,096
Partial Approvals	9	4	4
Denials	140	74	72
Total	**4,437**	**3,815**	**4,172**

***Source**: #02569_AuthTAT_Summary*

Outpatient Authorization Denial Rates			
Denial Rate Type	**May 2024**	**June 2024**	**July 2024**
Overall Denial Rate	**3.1%**	**2.6%**	**2.2%**
Denial Rate Excluding Partial Denials	**2.9%**	**2.3%**	**2.1%**
Partial Denial Rate	**0.2%**	**0.2%**	**0.1%**

***Source**: #03690_Executive_Dashboard*

Outpatient Turn Around Time Compliance			
Line of Business	**May 2024**	**June 2024**	**July 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

- Total inpatient auth volume and denials increased slightly from June to July.

- There continues to be a decrease in average LOS month to month, along with a decrease in days per thousand, conversely a slight increase in admits per thousand overall.

- IP Auth TAT compliance continues to surpass benchmark, with overall TAT of 99% in July.

- IP UM is receiving ADT feed for Authorization automation from Alameda Health System'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. The team continues to pursue ADT feeds at Stanford and UCSF, and is working with IT to increase SNF ADT feeds.

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

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

Total Inpatient Authorization Volume			
Authorization Status	**May 2024**	**June 2024**	**July 2024**
Approvals	2,103	1,854	1,944
Partial Approvals	0	0	0
Denials	44	57	53
Total	**2,147**	**1,911**	**1,997**

Source: #02569_AuthTAT_Summary

Inpatient Med-Surg Utilization			
Total All Aid Categories			
Actuals (excludes Maternity)			
Metric	**April 2024**	**May 2024**	**June 2024**
Authorized LOS	**5.9**	**5.3**	**5.4**
Admits/1,000	**50.5**	**53.7**	**50.2**
Days/1,000	**297.6**	**287.0**	**269.4**

Source: #01034_AuthUtilizationStatistics – data only available through June 2024

Inpatient Authorization Denial Rates			
Denial Rate Type	**May 2024**	**June 2024**	**July 2024**
Full Denials Rate	**0.8%**	**0.6%**	**0.9%**
Partial Denials	**1.3%**	**1.0%**	**0.7%**
All Types of Denials Rate	**2.1%**	**1.5%**	**1.6%**

Source: #01292_AllAuthDenialsRates

Inpatient Turn Around Time Compliance			
Line of Business	**May 2024**	**June 2024**	**July 2024**
Overall	**97%**	**98%**	**99%**
Medi-Cal	**97%**	**98%**	**99%**
IHSS	**100%**	**100%**	**100%**
Benchmark	*95%*	*95%*	*95%*

Source: #02569_AuthTAT_Summary

Utilization Management: Long-Term Care

- Transition of the long-term care staff to the new manager will be effective 09/30/24, to allow for yearly evaluations to be completed.

- Health Navigator position was posted to assist with difficult placement from acute admissions and transitions of care.

- LTC census during July 2024 was 2510 members. This is a decrease of 11.21% from June 2024.

- Month to Month, the admissions, days and readmissions are decreasing. From April to June the admissions decreased by 25.56%, the days decreased by 27.18% and the readmissions stayed the same. Some of this could be due to a lag in claims data being available, but we are seeing a decrease, overall. July data is not available at time of this report.

Totals	April 2024	May 2024	June 2024
Admissions	134	133	99
Days	1,043	813	592
Readmissions	39	34	34

Source: #14236_LTC_Dashboard

- COC is ending for DME for members in long-term care. LTC team is coordinating with CHME and reaching out to facilities/providers that have been using out-of-network venders. CHME is assisting with obtaining new orders to ensure no disruption in services for members.

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

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

- Social Workers continue visiting LTC facilities in person, on monthly and quarterly basis depending on census.

- Continue referrals to TCS and other internal/external programs to provide wraparound support to members preparing to discharge from an LTC custodial facility.

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

- Authorization volume had an increase in July by 34.59%, compared to June 2024.

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

Total LTC Authorization Volume			
Authorization Status	**May 2024**	**June 2024**	**July 2024**
Approvals	796	660	878
Partial Approvals	0	0	0
Denials	24	28	48
Total	**820**	**688**	**926**

Source: #02569_AuthTAT_Summary
****Numbers change month over month based on the void and copy process to adjust authorizations for bed holds***

LTC Turn Around Time Compliance			
Line of Business	**May 2024**	**June 2024**	**July 2024**
Medi-Cal	**97%**	**96%**	**97%**
Benchmark	*95%*	*95%*	*95%*

Source: #02569_AuthTAT_Summary

Behavioral Health

- In July, Behavioral Health processed 551 authorizations, 445 Care Coordination cases, and 445 Medi-Cal Mental Health Screenings and maintained a turnaround time performance level above 95%.

Total BH Authorization Volume			
	24-May	**24-June**	**24-July**
Approvals	469	339	552
Partial Approval	1	0	0
Denials	1	1	1
Total	471	440	551

Source: 14939_BH_AuthTAT

Mental Health Turnaround Times

MH TAT			
**Goal ≥95%*	**24-May**	**24-June**	**24-July**
Determination TAT%	97%	98%	95%
Notification TAT%	95%	98%	98%

Source: 14939_BH_AuthTAT

Behavioral Health Treatment Turnaround Times

BHT TAT			
**Goal ≥95%*	**24-May**	**24-June**	**24-July**
Determination TAT%	99%	100%	99%
Notification TAT%	100%	100%	100%

Source: 14939_BH_AuthTAT

Behavioral Health Denial Rates

**Goal ≤ 5%*	BH Denial Rates	
24-May	**24-June**	**24-July**
0.01%	0.01%	0.01%

Source: 14939_BH_AuthTAT

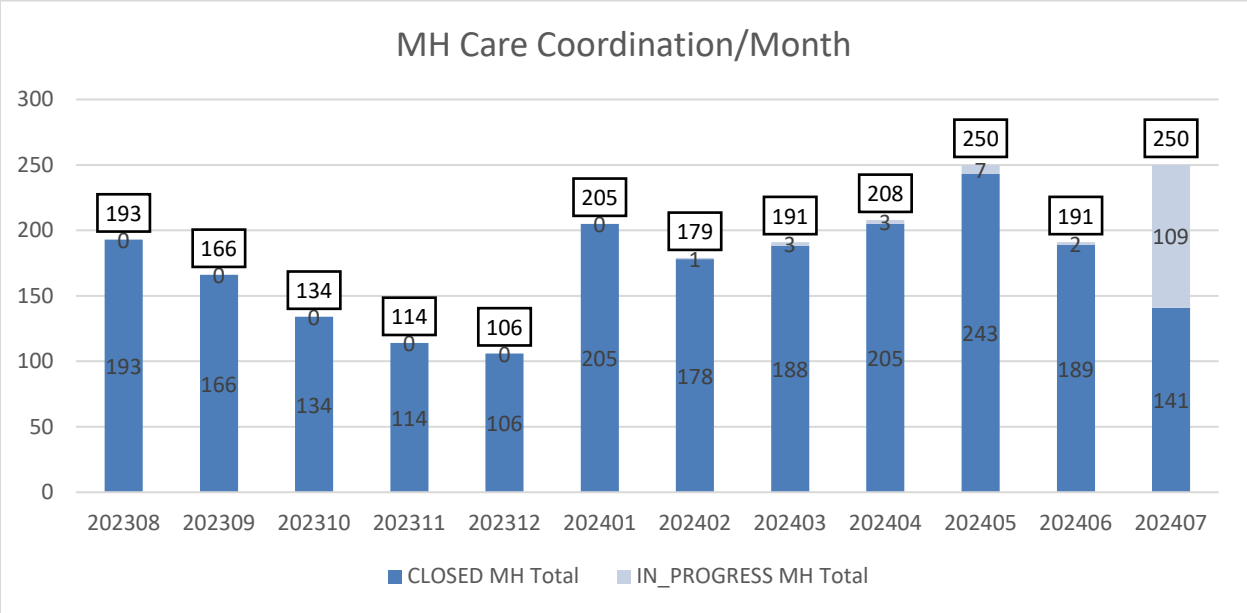
Mental Health Care Coordination

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

Total # Medi-Cal Screening Tools			
	24-May	24-June	24-July
Youth Screenings	57	77	66
Adults Screenings	118	154	160

Source: PBI_14460 – MLS BH TruCare Assessments

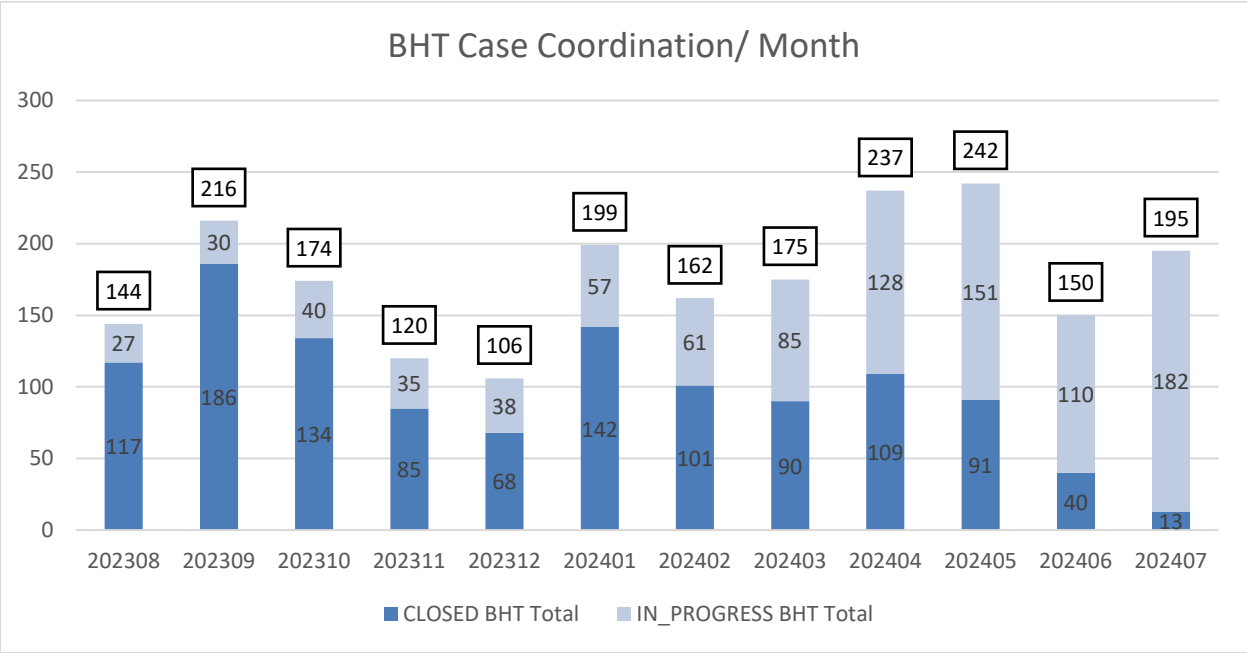
- Alliance licensed mental health clinicians, psychiatric nurses, and behavioral health navigators provide care coordination for members who need assistance accessing the mental health treatment services they need.



Source: 14665_BH_Cases

Behavioral Health Treatment (BHT)

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

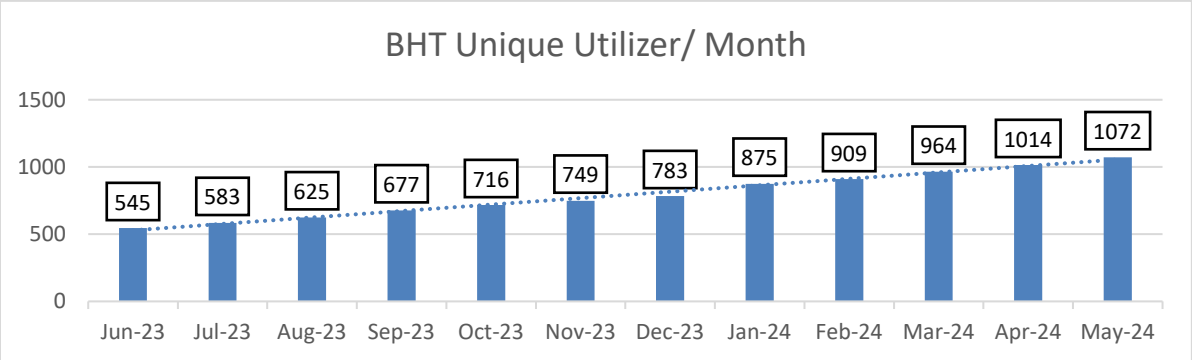


Source: 14665_BH_Cases

Behavioral Health Utilization

- Removing barriers to access Behavioral Health services remains a primary goal for the Alliance Behavioral Health team.

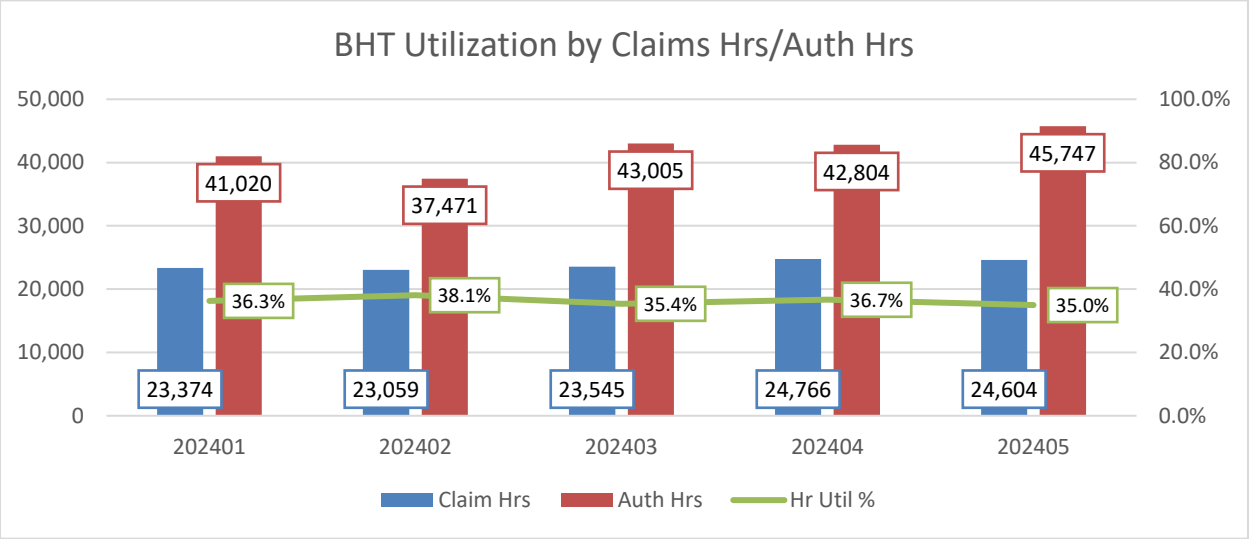
- We observed a consistent rise in unique utilizers of BHT/ABA services, with a 5.7% increase from April 2024 to May 2024.



Source: PBI 14621 BHT Utilization Report

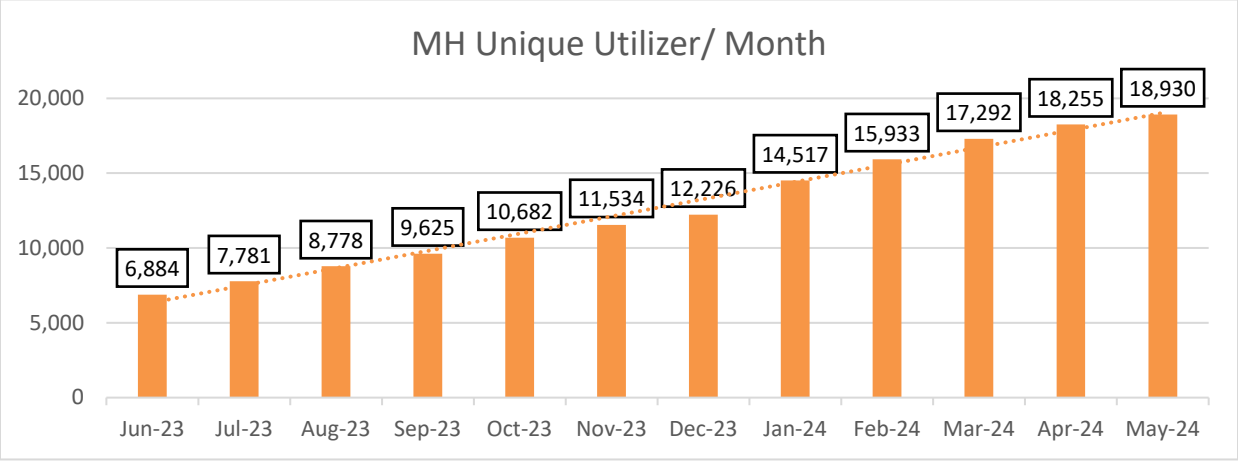
- “BHT Utilization by Claims Hrs/Auth Hrs” graph comprehensively analyzes the total authorized hours and the total claims paid by the hour submitted from January 2024 through May 2024.

- BHT Utilization the percentage of authorized hours that were utilized as evidenced by billed claims within the matching authorization period, reveals that the volume of services authorized are not actually utilized. This pattern of underutilization of authorized services may be due to multiple factors including the child’s availability, provider availability and network limitations.



Source: PBI 14621 BHT Utilization Report

- The utilization of mental health services has steadily risen, showing a 3.7% increase in unique utilizers from April 2024 to May 2024.



Source: PBI 14637 BH12M Report

Pharmacy

- Pharmacy is collaborating with population health, QI, and disease management on creating clinical programs for HEDIS measures for high blood pressure, asthma, and diabetes.
- Pharmacy continues to monitor members on use of opioids. Pharmacy, CM and BH have developed a new referral process for SUD CM referral to BRIDGE Clinic and BH Referral for MH services.

MME	IHSS	MCAL	Total
April			**350**
50-89	4	274	278
90-119	0	20	20
120-199	1	33	34
200-299	0	13	13
300-399	0	2	2
>400	0	3	3
May			**348**
50-89	2	284	286
90-119	0	14	14
120-199	1	33	34
200-299	0	10	10
300-399	0	1	1
>400	0	3	3
June			**375**
50-89	11	274	285
90-119	6	22	28
120-199	6	41	47
200-299	0	10	10
300-399	1	0	1
>400	1	3	4

Case and Disease Management

- The CM team has been working diligently to assist all members with Transitional Care Services (TCS) as they transition from one level of care to another. The CM team continues to collaborate with clinic partners to ensure the TCS requirements are met, including (but not limited to) scheduling and ensuring follow up appointments for members, informing members of CM services, notifying appropriate individuals of TCS services (hospital discharge planners, members/caregivers/support teams, etc).

- CM is collaborating with UM and LTC to work on members with long lengths of (hospital) stays in hopes of successful and safe discharges and referrals as appropriate. (Referrals include Community Supports, ECM and other community resources, as needed.)

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

- 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.

Case Type	Cases Opened in June 2024	Total Open Cases as of June 2024	Cases Opened in July 2024	Total Open Cases as of July 2024
Care Coordination	616	1,317	642	1,343
Complex Case Management	3	24	13	38
Transitions of Care (TCS)	995	2,087	1,359	2,488

***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 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.

- The ECM team meets with each ECM provider twice a month: once to discuss specific cases and once to discuss operational issues. This has created greater rapport with our providers and has led to assisting ECM providers with working through challenging issues such as appropriate billing.

- The ECM team is working closely with current ECM providers to expand serving additional ECM Populations of Focus as appropriate. This expansion is preparation for additional provider expansion for Jan 1, 2025.

- AAH continues to collaborate with Alameda County (AC) Health to discuss Street Medicine alignment. All 4 of the Street Medicine teams have finalized their contracts for ECM. As the number of authorizations continues to increase for Street Medicine, the ECM team will continue to work closely with the Street Team providers to make sure encounters are submitted smoothly.

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

ECM Outreach in April 2024	Total Open Cases as of April 2024	ECM Outreach in May 2024	Total Open Cases as of May 2024	ECM Outreach in June 2024	Total Open Cases as of June 2024
1,210	2,962	942	3,171	1,049	3,348

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

Community Supports (CS)

- 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 their Continuity of Care comes to an end.

- The team is currently re-evaluating authorization processes to improve operational efficiencies while minimizing provider administrative burden.

- 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 *(Model of Care submitted to DHCS for Jan 2025 launch)*
    - Short term Post Hospitalization Housing *(Model of Care submitted to DHCS for Jan 2025 launch)*
    - Day Habilitation *(Model of Care submitted to DHCS for Jan 2025 launch)*

- AAH CS staff continue 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.

- The CS leadership team in process of reviewing Provider Entity Interest Forms for the below CS services:
    - Short-Term Post-Hospitalization Housing
    - Day Habilitation Program

Community Supports	Services Authorized in April 2024	Services Authorized in May 2024	Services Authorized in June 2024
Housing Navigation	1,189	1,191	1,188
Housing Deposits	254	265	272
Housing Tenancy	1,434	1,400	1,370
Asthma Remediation	100	93	100
Meals	1,376	1,345	1,130
Medical Respite	121	124	134
Transition to Home	12	13	13
Nursing Facility Diversion	31	32	33
Home Modifications	3	6	7
Homemaker Services	278	258	213
Caregiver Respite	5	5	6

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

Grievances & Appeals

- All cases except **expedited appeals** were resolved within the goal of 95% of regulatory timeframes.

- We did not meet our goal of 95% of regulatory timeframes for expedited appeals because 1 expedited appeal case was not closed timely.

- Total Unique grievances resolved in July were 7.23 complaints per 1,000 members.

July 2024 Cases	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate	Per 1,000 Members*
Standard Grievance	1,399	30 Calendar Days	95% compliance within standard	1,397	99.8%	3.11
Expedited Grievance	2	72 Hours	95% compliance within standard	2	100.0%	0.004
Exempt Grievance	1,939	Next Business Day	95% compliance within standard	1,938	99.9%	4.11
Standard Appeal	28	30 Calendar Days	95% compliance within standard	28	100.0%	0.07
Expedited Appeal	4	72 Hours	95% compliance within standard	3	75.0%	0.00
Total Cases:	3,372		95% compliance within standard	3,368	99.8%	7.23

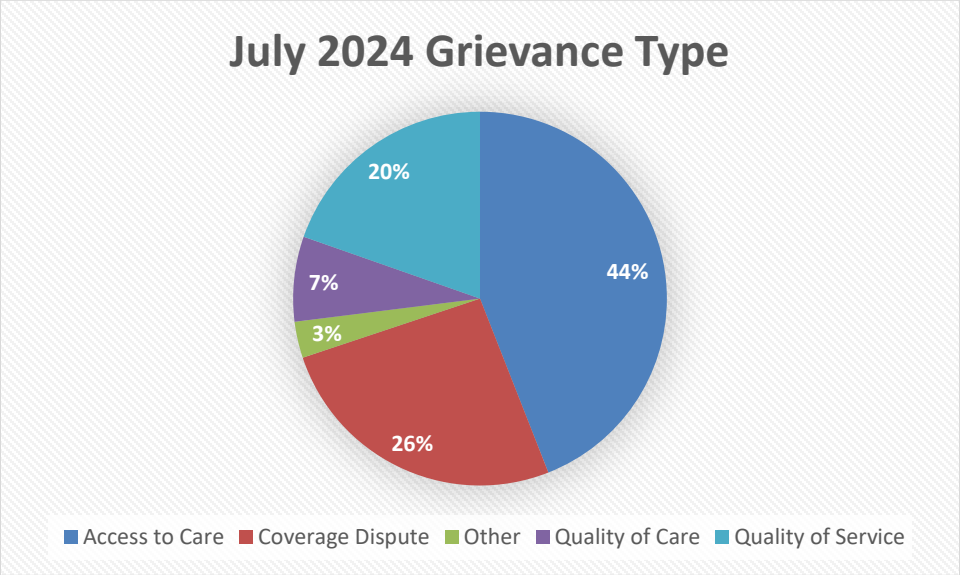
*Calculation: the sum of all unique grievances for the month divided by the sum of all enrollment for the month multiplied by 1000.

Grievances

- **617** of 1,399 (44%) cases were related to Access to Care, the top 3 grievance categories are:
  - (264) Timely Access
  - (128) Technology/Telephone
  - (85) Provider Availability

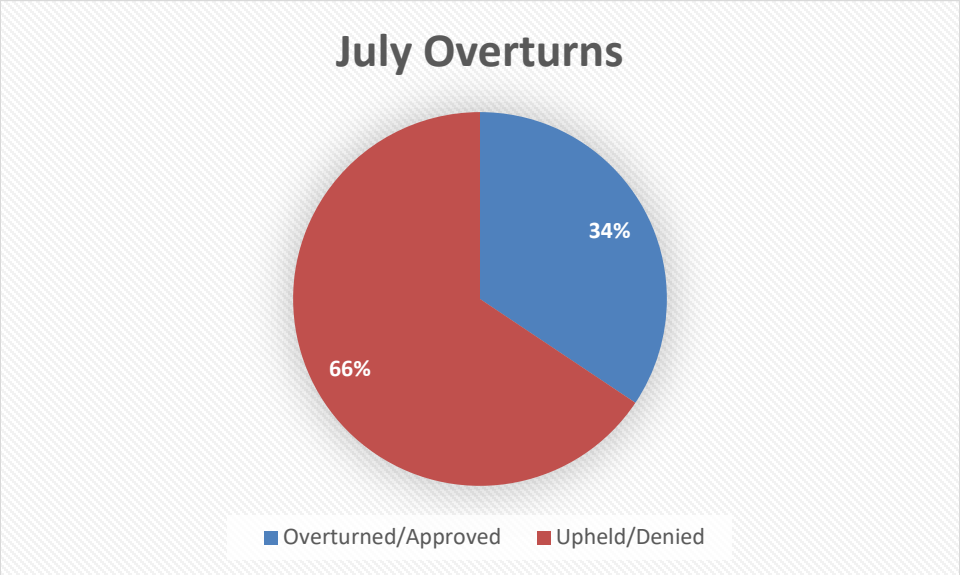
- **362** of 1,399 (26%) cases were related to Coverage Dispute, the top 3 grievance categories are:
  - (182) Provider Direct Member Billing
  - (101) Provider Balance Billing
  - (39) Reimbursement

- **275** of 1,399 (20%) cases were related to Quality of Service, the top 3 categories are:
  - (77) Plan Customer Service
  - (53) Provider/Staff Attitude
  - (40) Transportation



Appeals:

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



- **11** out of 32 (34%) cases were overturned for the month of July 2024:
  - (5) Out of network
  - (5) Disputes Involving Medical Necessity
  - (1) Coverage Disputes

Quality

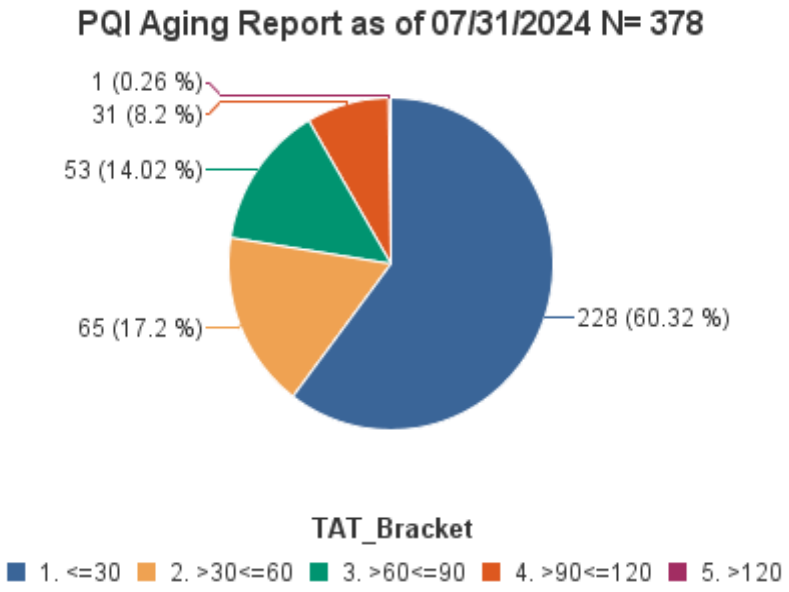
- Quality Improvement continues to track and trend PQI Turn-Around-Time (TAT) compliance. Our goal is closure of PQIs cases within 120 days from receipt to resolution via nurse investigation and procurement of medical records and/or provider responses followed by final MD review when applicable.

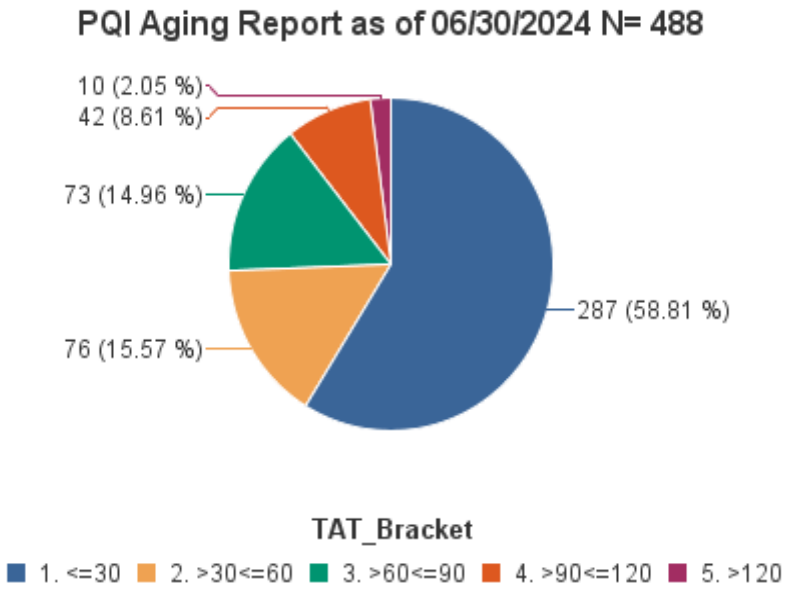
- As part of an effort to streamline the PQI review process, Quality of Access issues are reviewed by the Access & Availability team and Quality of Language issues by the Cultural & Linguistics team after they are triaged by the QI Clinical team. Quality of Care and Service issues continue to be reviewed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

- 2.05% cases in June and 0.26% in July 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.

- Total number of PQIs from all categories decreased by 110 from June to July. TATs are closely monitored to ensure timely closure of cases within the standard 95%.




PQI Aging Report as of 06/30/2024 N= 488
10 (2.05 %)
42 (8.61 %)
73 (14.96 %)
287 (58.81 %)
76 (15.57 %)
TAT_Bracket
1. <=30
2. >30<=60
3. >60<=90
4. >90<=120
5. >120

2023 Final HEDIS Rates – Managed Care Accountability Set

Measure Acronym	Measure Description	2022 Admin Rate	2022 Hybrid Rate	2023 Admin Rate	2023 Hybrid Rate	MPL - 50th %ile
	Behavioral Health					
FUA1	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 30 Day	29.82%		38.90%		36.34%
FUM1	Follow-Up After Emergency Department Visit for Mental Illness - 30 Day	49.03%		54.69%		54.87%
	Disease Management					
AMR	Asthma Medication Ratio	74.71%		69.88%		65.61%
CBP	Controlling High Blood Pressure	41.77%	54.74%	48.85%	65.21%	61.31%
HBD2	HbA1c Poor Control (>9.0%)	37.06%	29.20%	32.46%		37.96%
	Well Child					
CIS	Childhood Immunization Status - Combo 10	45.20%	52.80%	41.24%	45.74%	30.90%
IMA	Immunizations for Adolescents - Combo 2	49.36%	50.61%	49.27%	47.69%	34.31%
DEV	Developmental Screening in the First Three Years of Life Total	44.24%		54.39%		34.70%
LSC	Lead Screening in Children	57.52%	60.58%	60.78%	61.31%	62.79%
TFLCH1	Topical Fluoride for Children Rate1 - dental or oral health services	12.18%		14.13%		19.30%
W15	Well-Child Visits in the First 15 Months of Life - 6 or More Visits	46.56%		58.67%		58.38%
W30	Well-Child Visits for Age 15 Months to 30 Months - Two or More Visits	69.01%		74.03%		66.76%
WCV	Child and Adolescent Well-Care Visits	49.69%		56.30%		48.07%
	Women's Health					
BCSE	Breast Cancer Screening - ECDS	56.08%		59.59%		52.60%
CCS	Cervical Cancer Screening	52.44%	53.83%	58.33%	60.58%	57.11%
CHL	Chlamydia Screening in Women	64.14%		67.14%		56.04%
PPC1	Timeliness of Prenatal Care	85.36%	87.50%	85.90%	90.87%	84.23%
PPC2	Timeliness of Postpartum Care	81.72%	85.42%	86.74%	89.95%	78.10%

- The chart above provides a summary of the 2023 Managed Care Accountability (MCAS) measures held to the minimum performance level (MPL). Out of the 18 measures that Alameda Alliance was accountable for against the MPL/50th percentile, 15 measures achieved or exceeded the goal. Three measures fell below the MPL but showed improvement over MY2022.

- Several factors contributed to the increase in rates, including provider education through webinar offerings, 1:1 meetings with providers/delegates, and tools to gain knowledge of MCAS measure specifications and best practice sharing. Additionally, internal staffing improvements allowed for more coordination of member outreach and incentive programs. Data sharing, expansion of medical record retrieval, and other coverage exclusions also helped the Alliance achieve MCAS goals.

- While we met goals for most MCAS measures, three measures fell below the MPL: Follow-up After Emergency Department Visit for Mental Illness (FUM) – 30 days, Lead Screening in Children (LSC), and Topical Fluoride for Children (TFL). Barriers we encountered include data sharing challenges between the County and Plan for the FUM measure, challenges with DHCS payment for TFL, and member reluctance to complete lab measures for LSC.

- To address these shortcomings, the Quality Department has undertaken several quality improvement initiatives aimed at increasing rates for measures currently below the MPL. These efforts include working closely with the County to overcome data sharing challenges, integrating the use of Community Health Workers (CHWs) to conduct follow-up for members in the ED for mental illness, providing financial support for providers to obtain Point of Care Testing for in-clinic lead testing, offering provider incentive payments for in-clinic fluoride application, and conducting a deeper dive into the TFL data to check for accuracy. We are encouraged that these additional activities will improve the three measures and help us meet or exceed the MPL.

Health Equity

Lao Paul Vang

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

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

Date: **August 9th, 2024**

Subject: **Health Equity Report**

Internal Collaboration

- **Meetings and check-ins with Division Chiefs Update**
    - The Alliance division chiefs meet 1x1 monthly to update on Health Equity (HE) and Diversity, Equity, and Inclusion (DEI) activities.
- **Population Health Management (PHM), Quality Improvement (QI), and Utilization Management (UM) Update**
    - PHM is working directly with Elevated Diversity to ensure the new design of the DEI Training meets APL 23–025.

External Collaboration

- **Bi-weekly meetings with Local Health Plans' Chief Health Equity Officers (CHEOs) Update**
    - Ongoing discussions regarding DEI training curriculum and other Health Equity related issues.
- **Monthly Meetings with DHCS' Chief Health Equity Officer (DHCS CHEO) Update**
    - DHCS CHEO and MCPs CHEOs met to collaborate on Health Equity and DEI initiatives.
    - The meeting consisted of DHCS and CHEO Updates, MCP Health Equity and Quality Think Tank Recap, and the Use of Healthy Places Index for Risk Adjustment Discussion.

Advancing Health Equity Initiative (AHEI)

- **Alliance Strategic Roadmap Update**
    - Conducted Strategic Planning Committee session, with work focused on developing a strategic roadmap.
    - The fourth Roadmap meeting was held on August 2nd, and the fifth meeting will be on August 14th.

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

  DEI Curriculum Development

  - Secured approvals on foundational elements for the DEI
  - Training will include images, design approach, course interactivity, etc.
  - Met with various internal stakeholders to determine how additional mandated/required content can be included within new modules.
  - Presented client storyboard for the staff Health Equity module and conducted multiple review sessions with key Human Resources and Health Equity staff.
  - Conducted weekly meetings with project management personnel.

- **DEI Training Curriculum Timeline**

  - Mid-August - Final draft,
  - Mid-September - Submission to DHCS for approval.
  - Mid-November - Select a provider for the pilot training process.
  - January 2025 – Launch pilot training process.
  - April – June, completion of pilot training and launch of all training to all providers and downstream networks.

- **Communications Update**

  - The Curriculum training attestation form is in the branding process.
  - A communication from the CHEO introducing the DEI Training Curriculum is being prepared in August.

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

- **DEIB Committee Update**

  - The Committee approved the meeting minutes.
  - Response to comment during the Pride Presentation at the All-Staff Meeting. A discussion ensued about what were the next steps to be taken. Lao is arranging staff training with the Oakland LGBTQIA+.
  - The inequities of the performance reviews were discussed. It was concluded this was an HR issue and should be brought to their attention.
  - Delta Dental – This was discussed with the CEO, but no decision was made on the next steps.

- **VIA Committee Update**

  - The VIA Committee discussed and planned our summer staff event, which is on August 8th. All arrangements have been made.

ALAMEDA Alliance FOR HEALTH

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

Information Technology

Sasikumar Karaiyan

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

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

Date: **August 9th, 2024**

Subject: **Information Technology Report**

Call Center System Availability

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

Encounter Data

- In the month of July 2024, the Alliance submitted 217 encounter files to the Department of Health Care Services (DHCS) with a total of 434,555 encounters.

Enrollment

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

HealthSuite

- The Alliance received 332,150 claims in the month of July 2024.

- A total of 353,674 claims were finalized during the month of July, out of which 302,158 claims auto adjudicated. This sets the auto-adjudication rate for this period to 85.4%.

- HealthSuite application encountered an outage for 38 minutes on 26th of July. This sets the uptime to 99.62% for the application.

TruCare

- A total of 18,264 authorizations were loaded and processed in the TruCare application.

- TruCare Application Uptime – 99.99%.

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 report has been delivered by our vendor and the project team is currently prioritizing the critical items from the report which will be addressed immediately.

- Microsoft Intune deployment kicked off in July.

    - **Microsoft Intune** is a cloud-based service that focuses on mobile device management (MDM) and mobile application management (MAM). It will allow the Alliance to manage and secure access to corporate information on mobile devices, while also protecting the Alliance's data. With Intune, the Alliance can manage devices and apps, protect data, and ensure compliance with your organization's policies.

    - The engineering team have completed the foundational technical configurations and are now focused on user testing and documentation.

    - Email communications to all staff have been sent to start the campaign and inform the organization of what to expect.

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.

- Project team completed collecting the final procedural documentations for tier 2/3 applications.

- Tabletop testing has been completed to finalize the procedural documentations in the run book.

- IT leadership review of the runbook has been completed and project closure activities is now underway.

Data Retention Project (Phase 1)

- One of the Alliance major goals for fiscal year 2024 is to complete the first phase of the implementation of an enterprise Data Retention program that will focus on structured data.

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

- The project team completed the POV (proof of value) with BigID and was presented with the results and best use cases.

- Contract processing for both implementation services and licenses has been completed.

- The project kick-off meeting and resource onboarding have been completed. Weekly project meeting sessions have been scheduled and are ongoing.

Information Technology

Supporting Documents

Enrollment

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

Month	Total MC[1]	MC[1] - Add/ Reinstatements	MC[1] - Terminated	Total GC[2]	GC[2] - Add/ Reinstatements	GC[2]- Terminated
July	404,456	6,461	6,601	5,676	152	137

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 July 2024

Auto-Assignments	Member Count
Auto-assignments MC	2,357
Auto-assignments Expansion	2,125
Auto-assignments GC	48
PCP Changes (PCP Change Tool) Total	4,530

TruCare Application

- See Table 2-1 “Summary of TruCare Authorizations for the month of July 2024”.
- There were 18,264 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 July 2024*

Transaction Type	Inbound automated Auths	Errored	Total Auths Loaded in TruCare
Paper Fax to Scan (DocuStream)	2,677	2,169	1,581
Provider Portal Requests (Zipari)	5,274	1072	5,228
EDI (CHCN)	5,957	1,637	5,801
Provider Portal to AAH Online (Long Term Care)	14	12	13
ADT	1,217	716	689
Behavioral Health COC Update - Online	53	42	50
Behavioral initial evaluation - Online	55	27	53
HCSA (Health Care Service Agencies)	N/A	N/A	N/A
Manual Entry (all other not automated or faxed vs portal use)	N/A	N/A	3,017
Total			16,432

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 June 2024

Group	Individual User Accounts	Individual User Accounts Accessed	Total Logins	New Users
Provider	7,472	5,338	397,849	582
MCAL	114,401	3669	8,434	1,266
IHSS	3,763	75	113	25
Total	125,636	9,082	406,396	1,873

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

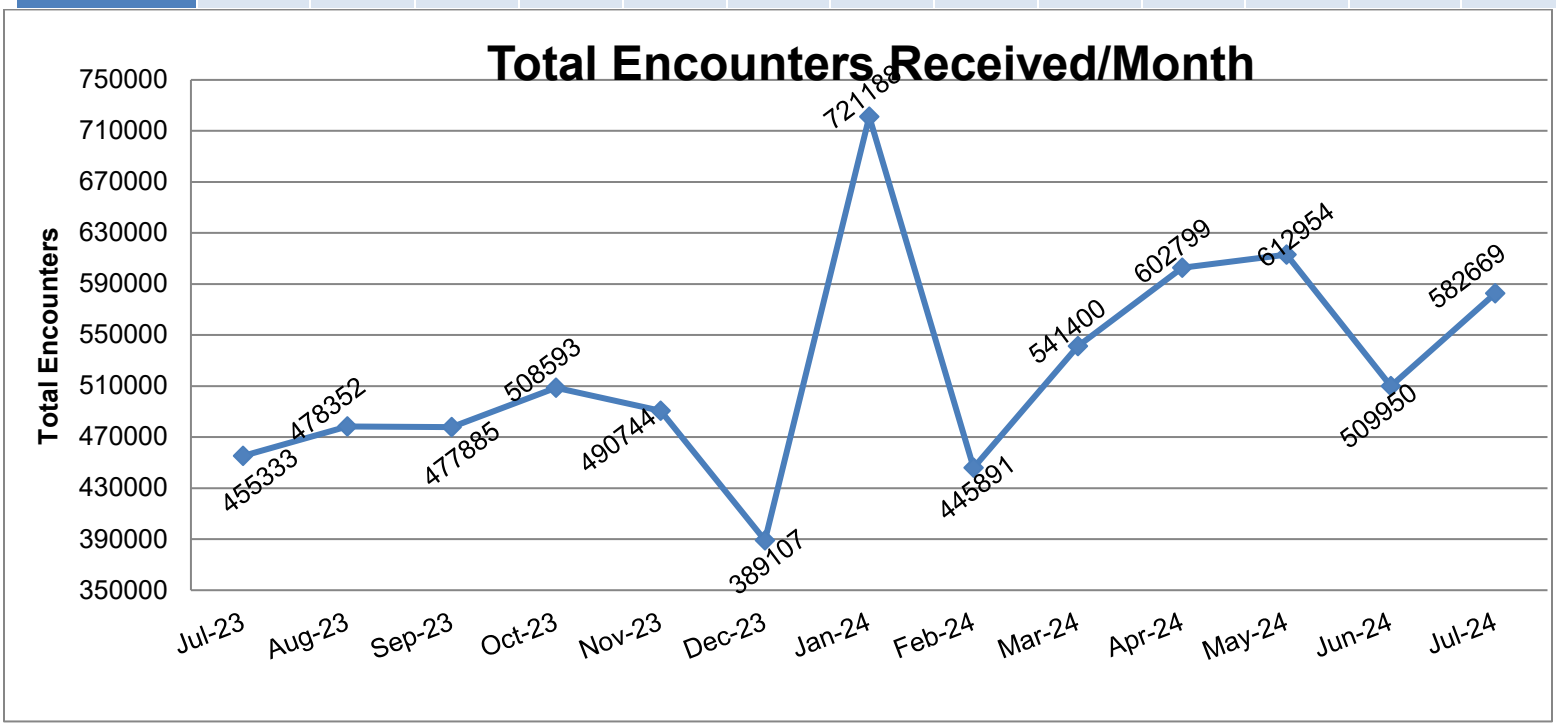
Category	Page Name	Page Views
Provider - eligibility/claim	Member Eligibility	1402716
Provider - Claims	Claim Status	224257
Provider - eligibility/claim	Claim Status	26339
Provider - authorizations	Auth Submit	15475
Provider - authorizations	Auth Search	7840
Provider - Claims	Submit professional claims	4526
Member My Care	Member Eligibility	4266
Member Help Resources	Find a Doctor or Hospital	3204
Member Help Resources	ID Card	2452
Provider - eligibility/claim	Member Roster	2094
Member Help Resources	Select or Change Your PCP	1956
Member Home	MC ID Card	1443
Member My Care	My Claims Services	1235
Provider - Provider Directory	Provider Directory 2019	1039
Provider - reports	Reports	851
Member My Care	Authorization	610
Member My Care	My Pharmacy Medication Benefits	431
Provider - Home	Behavior Health Forms SSO	422
Provider - Home	Forms	401
Member Help Resources	FAQs	387
Member My Care	Member Benefits Materials	343
Provider - Provider Directory	Instruction Guide	315
Member Help Resources	Forms Resources	309
Member Help Resources	Authorizations Referrals	307
Provider - Provider Directory	Manual	290

Encounter Data From Trading Partners 2024

- **AHS**: July weekly files (7,296 records) were received on time.
- **BAC**: July monthly files (88 records) were received on time.
- **Beacon**: July weekly files (0 records)
    - No longer receiving encounter files.
- **CHCN**: July weekly files (135,444 records) were received on time.
- **CHME**: July monthly files (7,242 records) were received on time.
- **CFMG**: July weekly files (10,776 records) were received on time.
- **Docustream**: July monthly files (934 records) were received on time.
- **EBI**: July monthly files (1,623 records) were received on time.
- **FULLCIR**: July monthly files (1,362 records) were received on time.
- **HCSA**: July monthly files (6,841 records) were received on time.
- **IOA**: July monthly files (847 records) were received on time.
- **Kaiser**: July bi-weekly files (2,052 records) were received on time.
- **LAFAM**: July monthly files (70 records) were received on time.
- **LIFE**: July monthly files (0 records) were received on time
- **LogistiCare**: July weekly files (43,038 records) were received on time.
- **March Vision**: July monthly files (6,404 records) were received on time.
- **MED**: July monthly files (615 records) were received on time.
- **OMATOCHI**: July monthly files (0 records) were received on time.
- **PAIRTEAM**: July monthly files (5,763 records) were received on time.
- **Quest Diagnostics**: July weekly files (18,000 records) were received on time.
- **SENECA**: July monthly files (109 records) were received on time.
- **TITANIUM**: July monthly files (2015 records) were received on time.
- **Magellan**: July monthly files (415,314 records) were received on time.

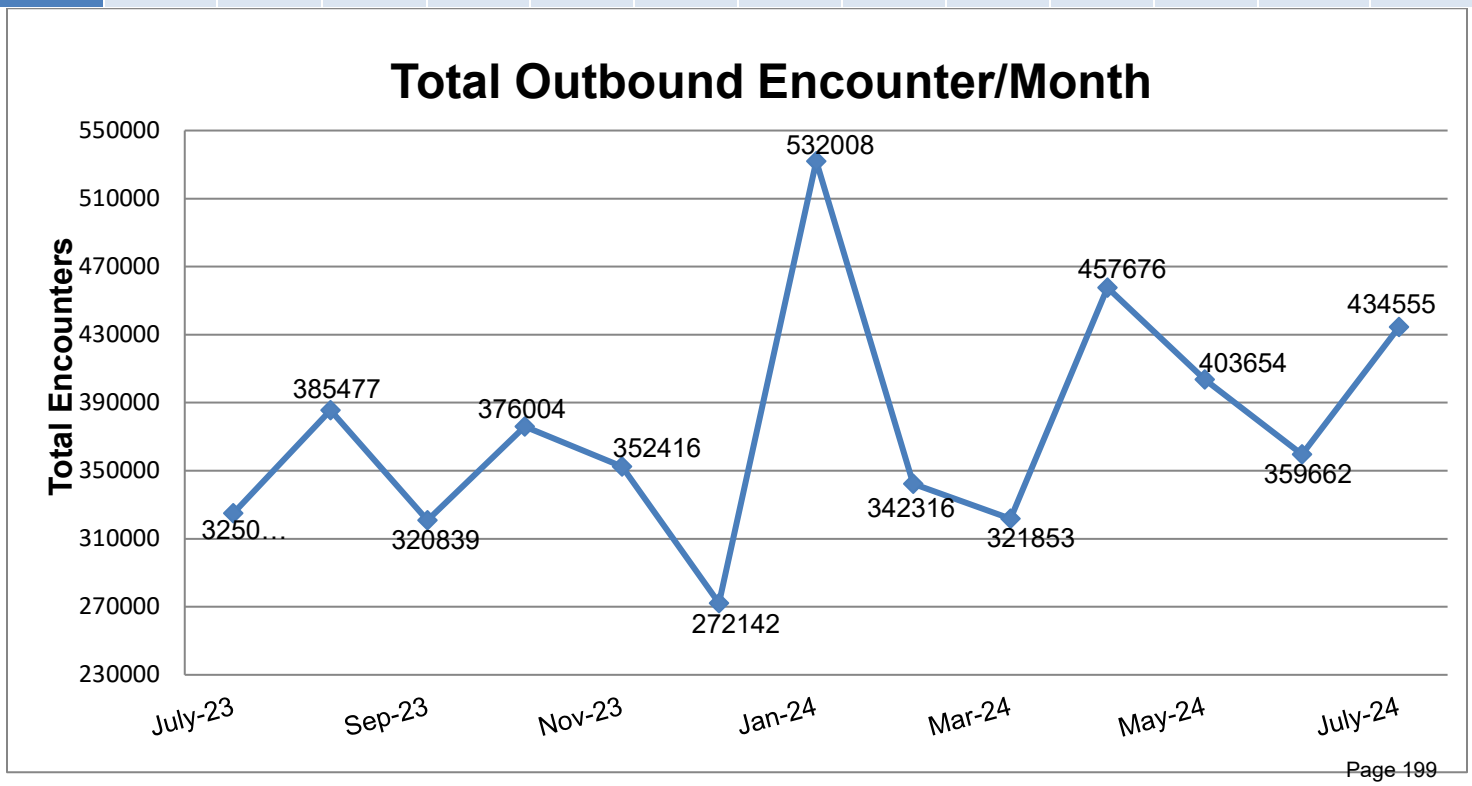
Trading Partner Encounter Inbound Submission History

Trading Partners	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Health Suite	224540	244907	247423	241298	247537	215246	298465	266339	308453	322786	375454	297267	332150
AHS	4363	4380	5479	5371	5243	6284	4570	7736	7005	6573	8412	13316	7296
BAC	39	38	38	57	73	55	59	57	55	64	70	77	88
Beacon	620												
CHCN	102081	85836	77060	111275	87839	58566	96124	103674	122217	170653	122445	110650	135444
CHME	5706	5704	6212	7609	6445	5694	5843	5560	6022	7969	7107	7449	7242
Claimsnet	12379	8946	12302	12167	11670	18995	12043	10557	12651	16394	15934	21143	10776
Docustream	567	744	562	400	705	476	930	814	698	302	1589	749	934
EBI	1664	814	867	718	823	811	1047	2903	1625	1700	184	2043	1623
FULLCIR				888	598	177	828	1586	213	2261	8478	2842	1362
HCSA	3824	3466	2490	1913	2403	2087	2223	2097	2822	7118	5535	3663	6841
IOA	424	673	1086	967	1073	1250	1453	1233	1054	1925	1163	1280	847
Kaiser	56673	76278	79751	81985	87005	26208	77407	3725	9966	2286	886	1079	2052
LAFAM				24				60	39	105	116	86	70
LIFE												1694	
LogistiCare	22235	27129	22456	25509	20781	32181	182822	20774	35600	32632	27531	16205	43038
March Vision	4468	4563	4933	4427	4428	4562	9693		6183	3633	8546	7092	6404
MED	9	11	144	194	523	532	535	742	683	633	722	744	615
OMATOCHI										29			
PAIRTEAM										5344	7582		5763
Quest	15741	14859	17008	13712	13077	15834	27022	17658	22306	18000	18001	22500	18000
SENECA		4	74	79	56	52	124	222	112	159	113	71	109
TITANIUM					465	97		154	3696	2233	3086		2015
Total	455333	478352	477885	508593	490744	389107	721188	445891	541400	602799	612954	509950	582669



Outbound Encounter Submission

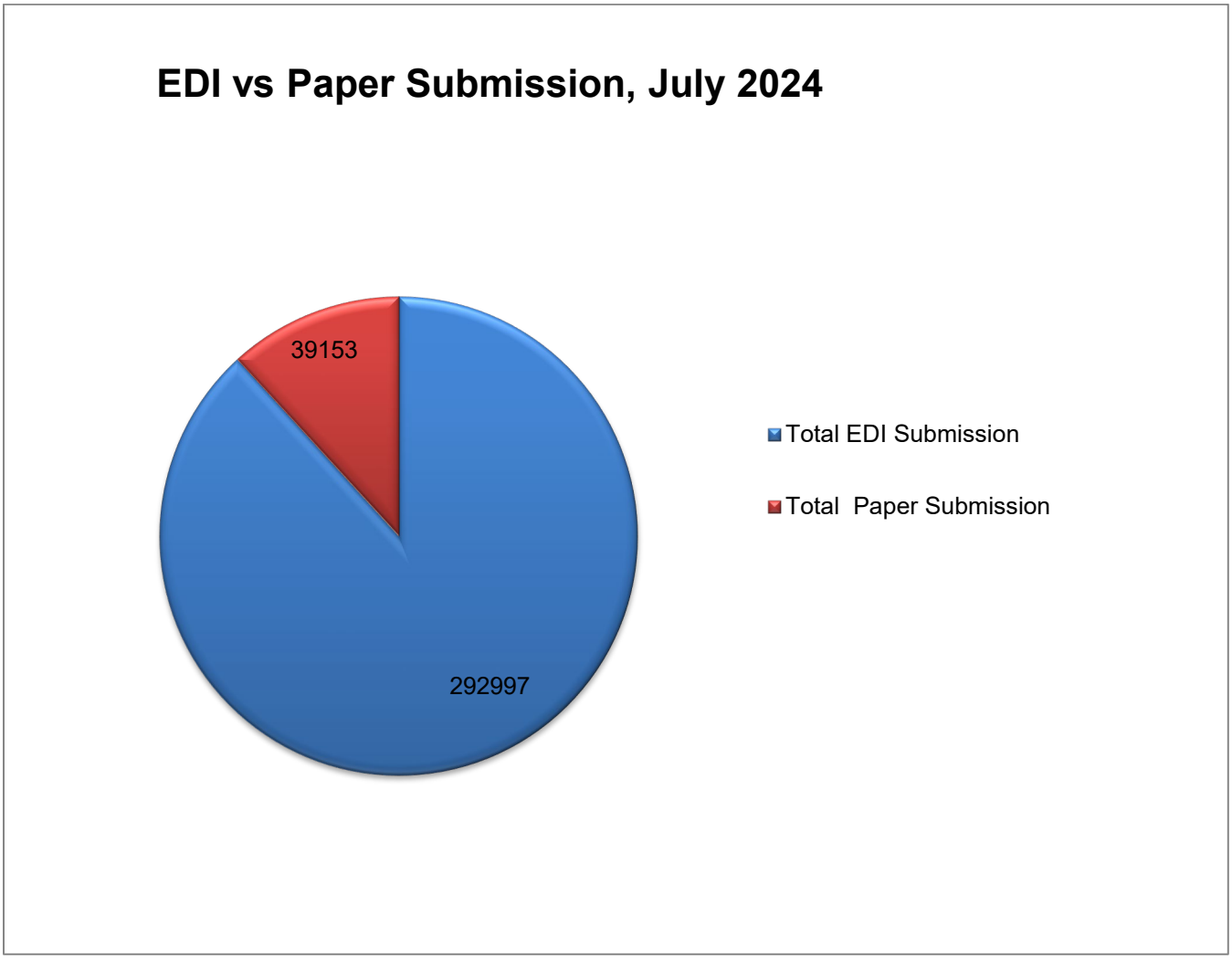
Trading Partners	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Health Suite	147199	170751	127465	163149	134823	136233	172386	177658	147776	250835	198595	204068	230706
AHS	5318	4251	4253	6355	5147	4936	5667	7497	6968	6524	7002	10684	6703
BAC	39	37	38	52	67	53	55	55	47	59	66	72	80
Beacon	318												
CHCN	56593	74313	55365	62962	73866	39846	67063	74336	80498	104625	107577	77200	94476
CHME	5595	5546	6063	7475	6321	5588	5703	5470	5889	7558	6749	7310	7095
Claimsnet	8849	6386	7075	7452	8031	11581	10145	7730	6757	13467	11561	11506	9994
Docustream	347	529	441	270	573	404	387	600	377	267	839	570	725
EBI	1574	804	855	710	794	802	987	1347	1002	1589	60	1835	1443
FULLCIR				806	516	124	653	540	116	1636	5401	2410	1084
HCSA	3778	3405	2349	1876	2342	1991	2142	2013	2769	4710	5363	3493	6757
IOA	410	654	984	65	934	1228	1378	1156	1000	1868	1029	1221	749
Kaiser	55988	75591	78162	81165	85807	26113	76335	3542	9650	1905	1292	812	1404
LAFAM				2					16	92	103	58	66
LIFE												28	
LogistiCare	21686	26670	22142	24497	25951	31546	157548	40529	34931	32247	27487	16221	43019
March Vision	2720	2737	2992	2863	2661	2752	2700	2616	3736	2407	5719	4553	3766
MED	9	11	126	145	438	428	446	624	528	518	579	654	552
OMATOCHI										56			
PAIRTEAM										4279	4422		3246
Quest	14634	13788	12456	16082	3655	8394	28299	16589	16333	20983	16912	16898	20898
SENECA		4	73	78	52	48	114	14	199	140	109	69	108
TITANIUM					438	75			3261	1911	2789		1684
Total	325057	385477	320839	376004	352416	272142	532008	342316	321853	457676	403654	359662	434555



HealthSuite Paper vs EDI Claims Submission Breakdown

Period	Total EDI Submission	Total Paper Submission	Total claims
24-June	265757	31510	297267

Key: EDI – Electronic Data Interchange

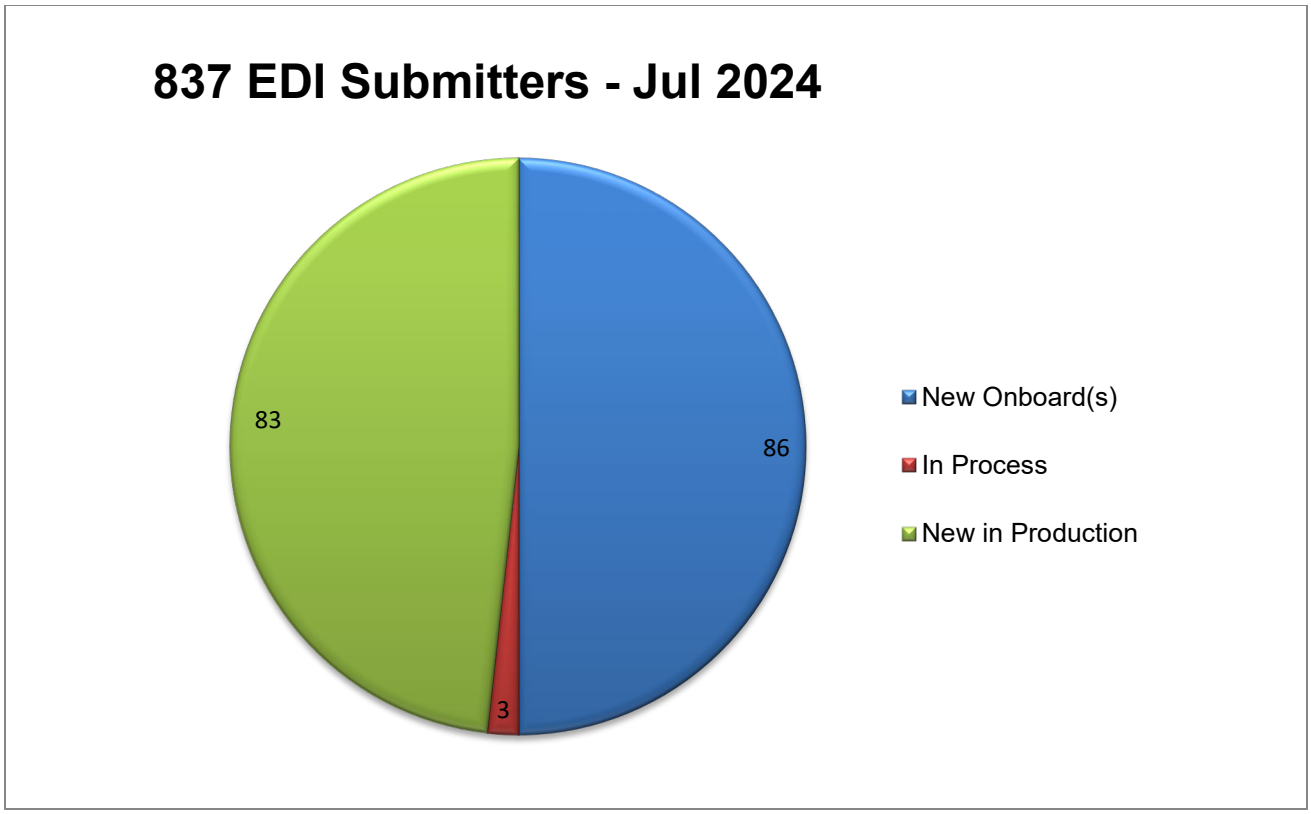


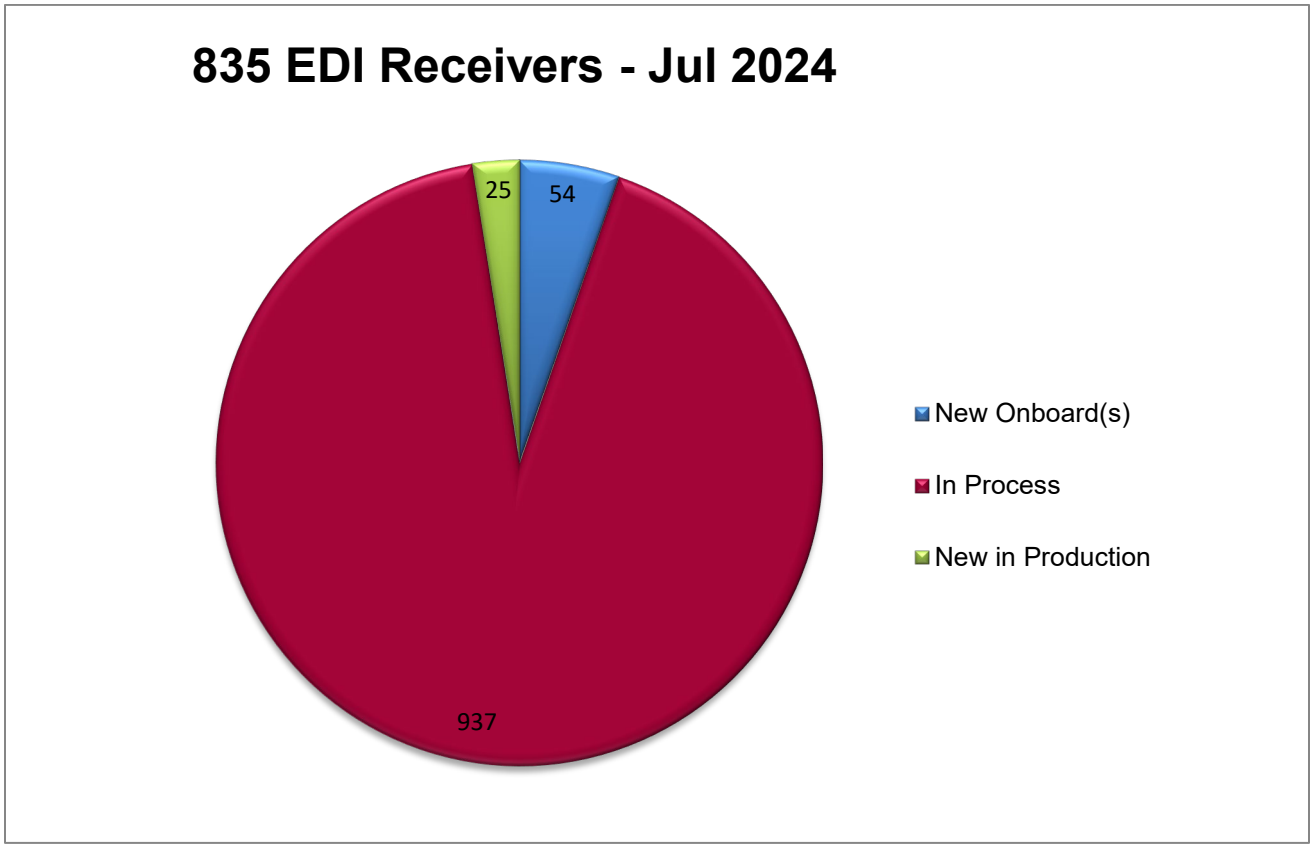
Onboarding EDI Providers – Updates

- July 2024 EDI Claims:
  - A total of 2463 new EDI submitters have been added since October 2015, with 83 added in July 2024.
  - The total number of EDI submitters is 3203 providers.

- July 2024 EDI Remittances (ERA):
  - A total of 1077 new ERA receivers have been added since October 2015, with 25 added in July 2024.
  - The total number of ERA receivers is 1093 providers.

	837				835			
	New on Boards	In Process	New In Production	Total in Production	New on Boards	In Process	New In Production	Total in Production
Aug-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
Apr-24	120	3	117	3017	83	851	54	1012
May-24	81	13	68	3085	63	874	40	1052
Jun-24	39	4	35	3120	50	908	16	1068
Jul-24	86	3	83	3203	54	937	25	1093


837 EDI Submitters - Jul 2024
83
86
3
New Onboard(s)
In Process
New in Production


835 EDI Receivers - Jul 2024
25
54
937
New Onboard(s)
In Process
New in Production

Encounter Data Submission Reconciliation Form (EDSRF) and File Reconciliations

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

File Type	Jul-24
837 I Files	46
837 P Files	171
Total Files	217

Lag-time Metrics/Key Performance Indicators (KPI)

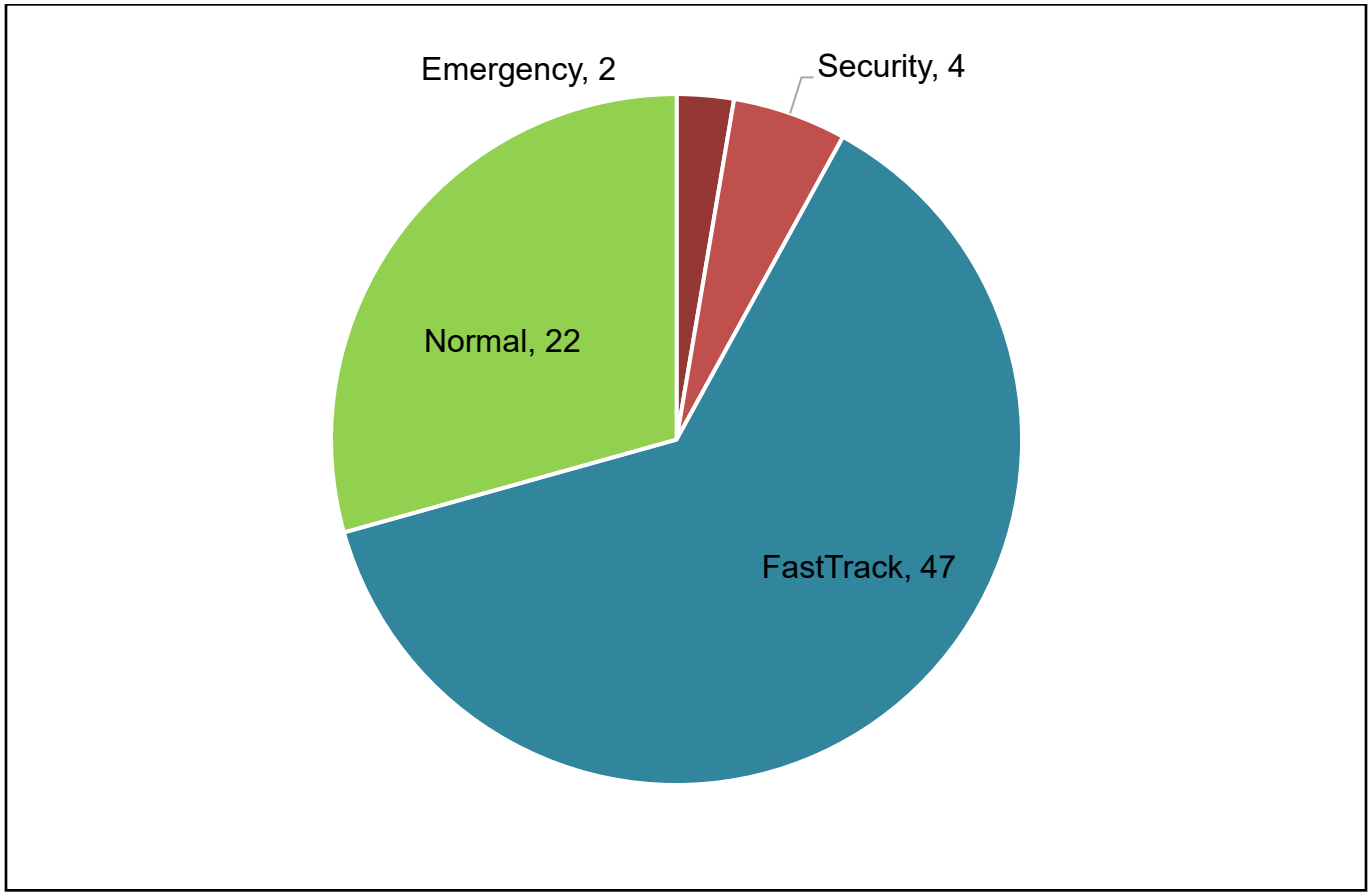
AAH Encounters: Outbound 837	Jul-24	Target
Timeliness-% Within Lag Time - Institutional 0-90 days	88%	60%
Timeliness-% Within Lag Time - Institutional 0-180 days	95%	80%
Timeliness-% Within Lag Time - Professional 0-90 days	91%	65%
Timeliness-% Within Lag Time – Professional 0-180 days	98%	80%

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

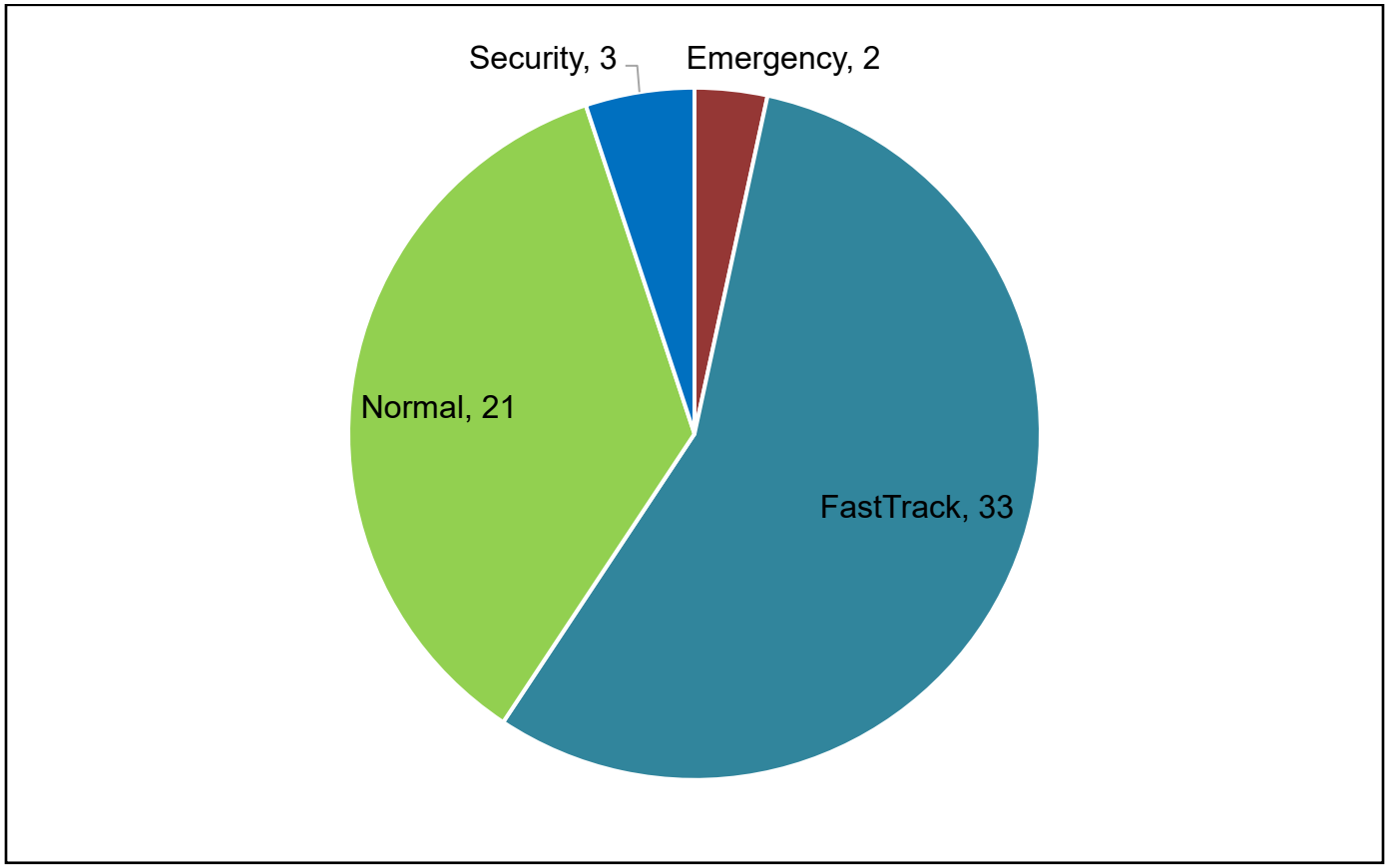
Change Management Key Performance Indicator (KPI)

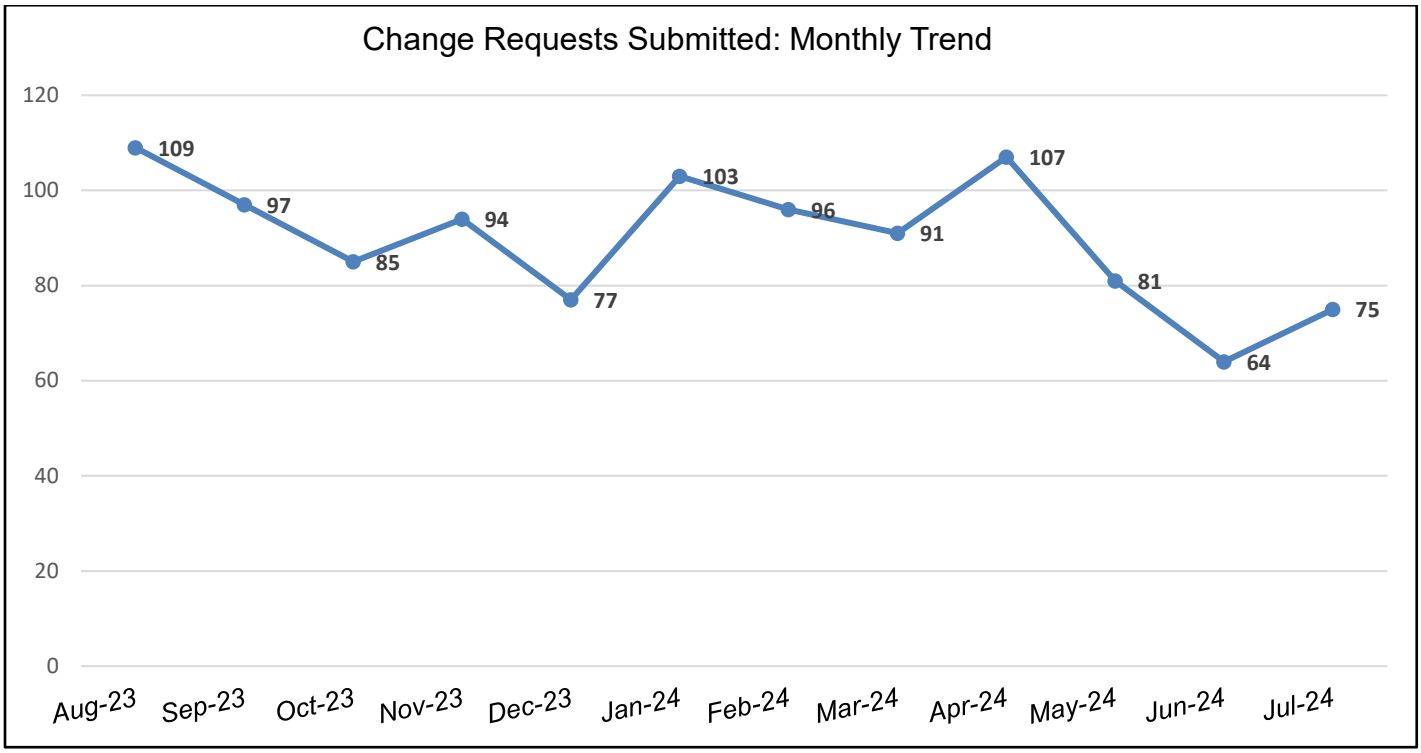
- Change Request Overall Summary in the month of July 2024 KPI:
  - 75 Changes Submitted.
  - 59 Changes Completed and Closed.
  - 142 Active Change Requests in pipeline.
  - 21 Change Requests Cancelled or Rejected.

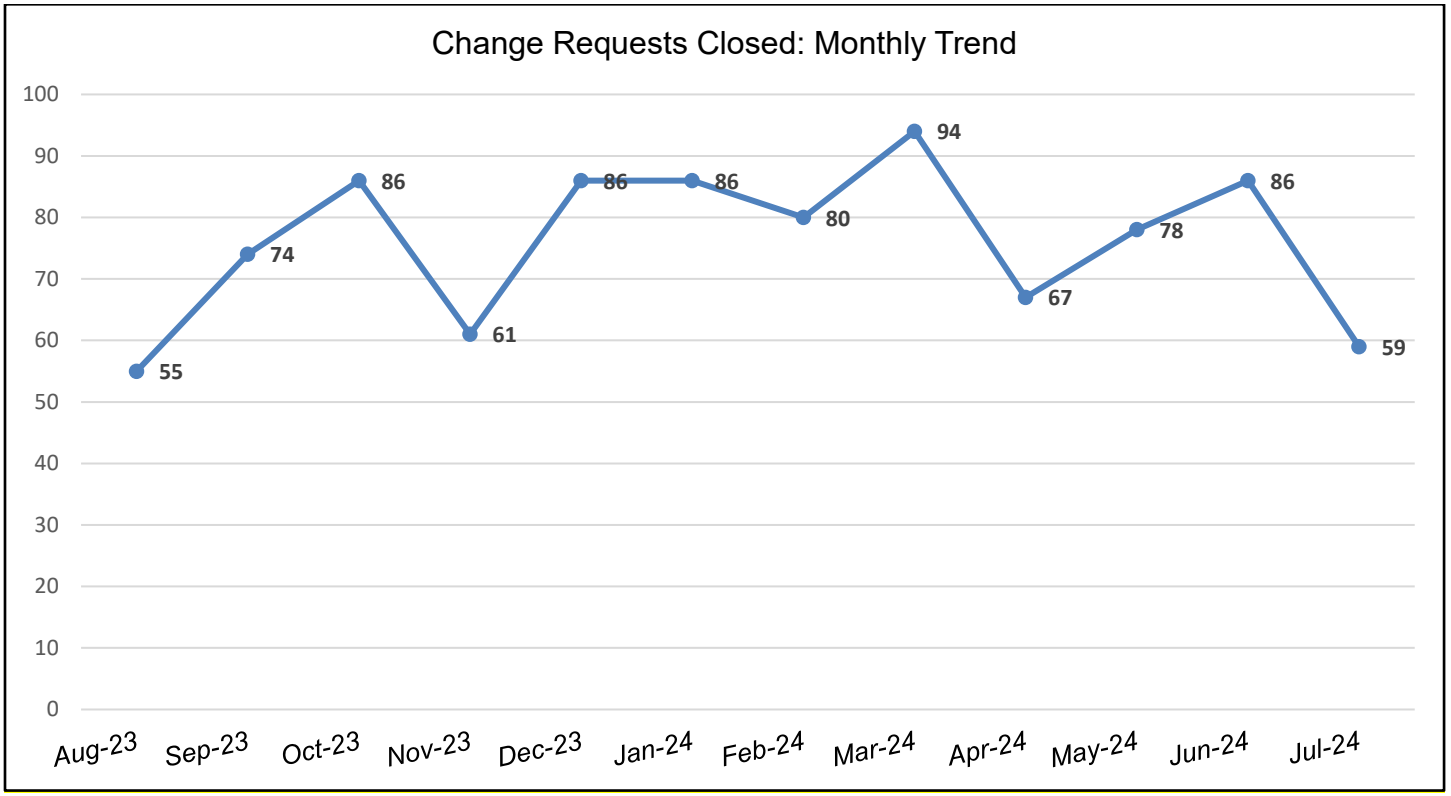
- 75 Change Requests Submitted/Logged in the month of July 2024



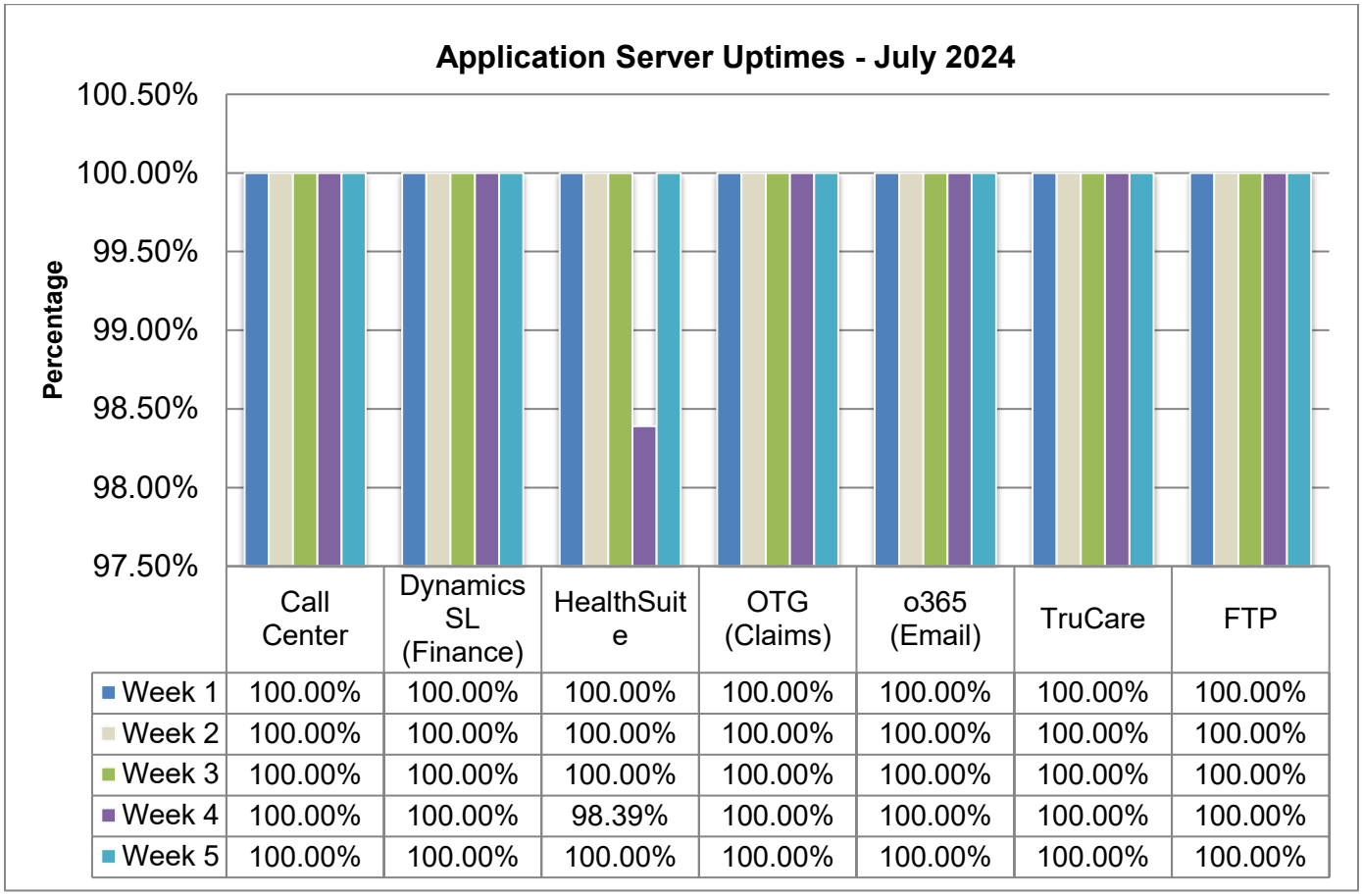
- 59 Change Requests Closed in the month of July 2024




Change Requests Submitted: Monthly Trend
120
100
80
60
40
20
0
109
97
85
94
77
103
96
91
107
81
64
75
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24


Change Requests Closed: Monthly Trend
100
90
80
70
60
50
40
30
20
10
0
55
74
86
61
86
86
80
94
67
78
86
59
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24

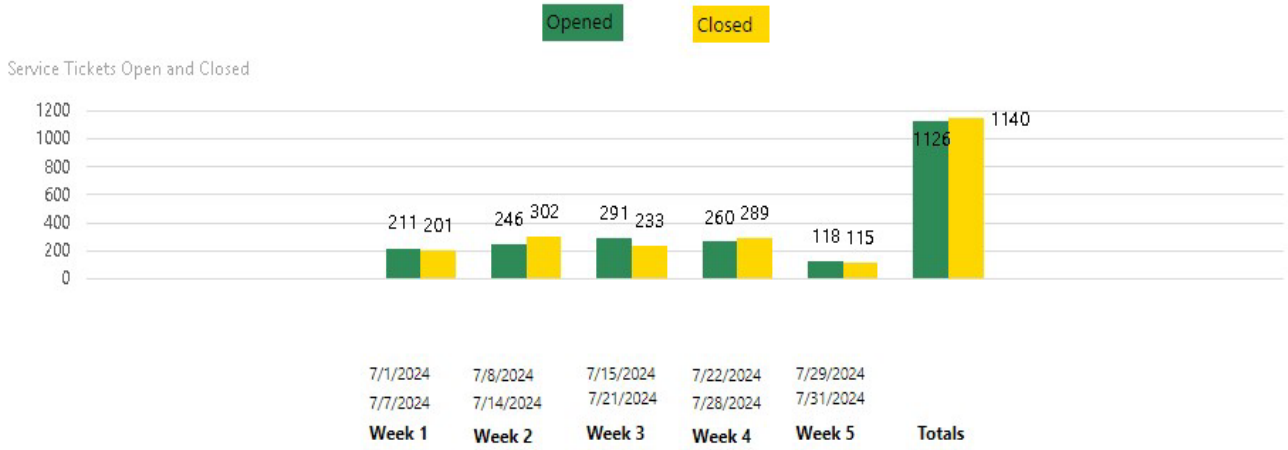
IT Stats: Infrastructure



	Call Center	Dynamics SL (Finance)	HealthSuite	OTG (Claims)	o365 (Email)	TruCare	FTP
Week 1	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Week 2	100.00%	100.00%	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%	98.39%	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.
- July 26, 2024, at 4:09pm our HealthSuite application experienced an outage that lasted for 38 minutes.
    - The issue was resolved at 4:47pm on July 26, 2024

IT Service Tickets Open and Closed

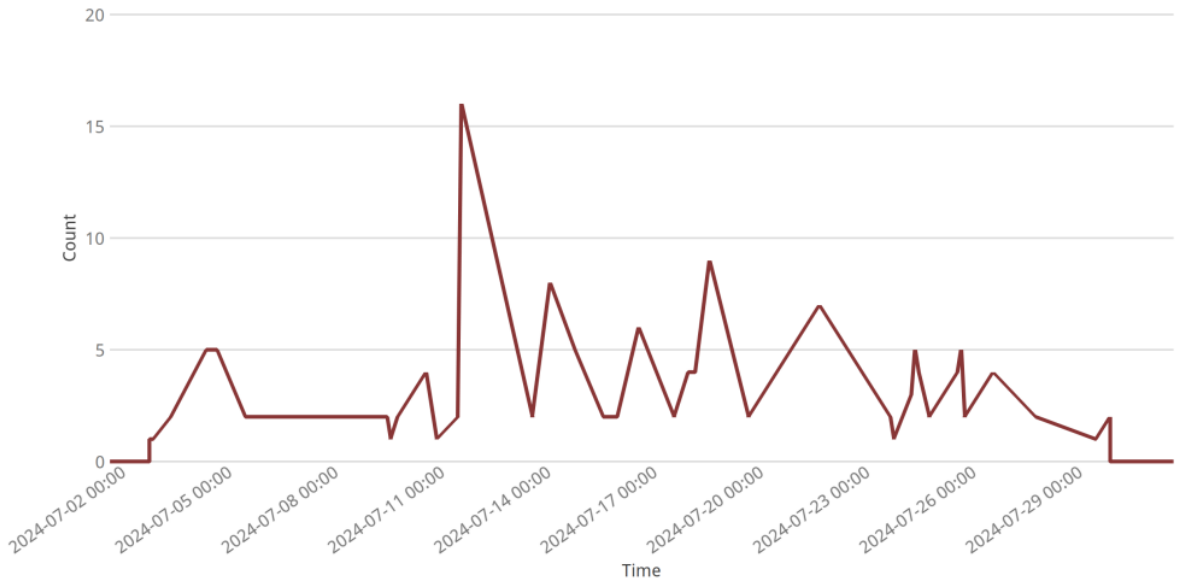


- 1126 Service Desk tickets were opened in the month of July 2024, which is 17.76% higher than the previous month (926) and 12.17% higher than the previous 3-month average of 989.

- 1140 Service Desk tickets were closed in the month of July 2024, which is 20.35% higher than the previous month (908) and 14.47% higher than the previous 3-month average of 975.

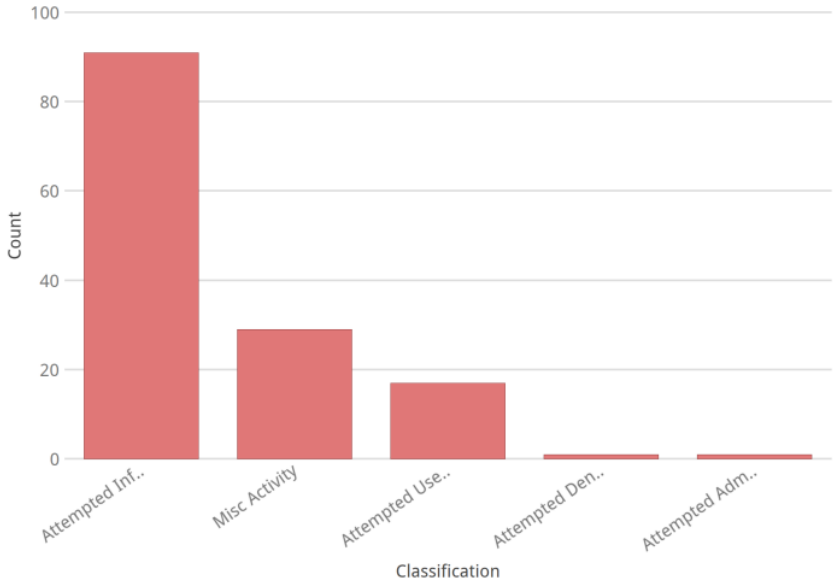
All Intrusion Events

Time Window: *2024-07-01 09:29:00 - 2024-07-31 09:29:00*



Dropped Intrusion Events

Time Window: *2024-07-01 09:30:00 - 2024-07-31 09:30:00*
Constraints: *Inline Result = !Alert,!Would **



Classification	Count
Attempted Information Leak	91
Misc Activity	29
Attempted User Privilege Gain	17
Attempted Denial of Service	1
Attempted Administrator Privilege Gain	1

IronPort Email Security Gateways

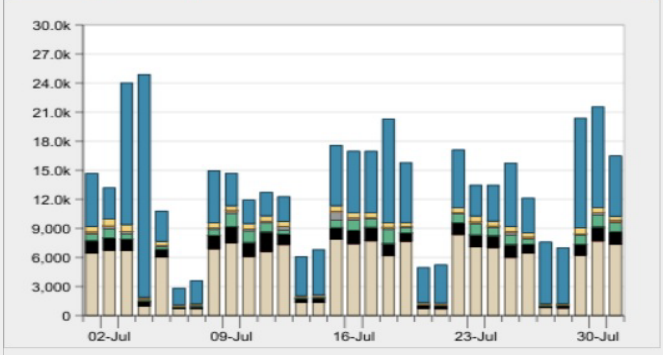
Email Filters

July 2024

Inbound Mail

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

Incoming Mail Graph



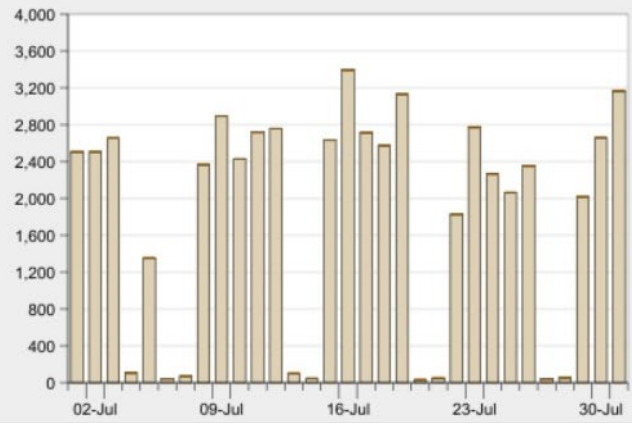
Export...

Incoming Mail Summary

Message Category	%	Messages
Stopped by IP Reputation Filtering	44.9%	183.8k
Stopped by Domain Reputation Filtering	0.0%	78
Stopped as Invalid Recipients	0.0%	122
Spam Detected	3.1%	12.9k
Virus Detected	0.0%	3
Detected by Advanced Malware Protection	0.0%	0
Messages with Malicious URLs	0.0%	123
Stopped by Content Filter	0.0%	86
Stopped by DMARC	1.5%	5,951
S/MIME Verification/Decryption Failed	0.0%	0
Total Threat Messages:	**48.1%**	**197.1k**
Marketing Messages	4.8%	19.5k
Social Networking Messages	0.2%	853
Bulk Messages	7.3%	29.9k
Total Graymails:	**12.3%**	**50.2k**
S/MIME Verification/Decryption Successful	0.0%	0
Clean Messages	39.6%	162.4k
Total Attempted Messages:		**409.7k**

Outbound Mail

Outgoing Mail Graph



Export...

Outgoing Mail Summary

Message Processing	%	Messages
Spam Detected	0.0%	0
Virus Detected	0.0%	6
Detected by Advanced Malware Protection	0.0%	0
Messages with Malicious URLs	0.0%	0
Stopped by Content Filter	0.0%	0
Stopped by DLP	0.0%	0
Clean Messages	100.0%	56.3k
Total Messages Processed:		**56.3k**

Message Delivery	%	Messages
Hard Bounces	2.9%	1,614
Delivered	97.1%	54.3k
Total Messages Delivered:		**55.9k**

Item / Date	Jul-23	Aug-23	*Sep-23*	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	*May-24*	Jun-24	***Jul-24***
Stopped By Reputation	30.4k	59.1k	*99.7k*	74k	74.1k	58k	91.9k	51k	84.7k	63.5k	27.5k	2.7k	***183.8k***
Invalid Recipients	82	79	*98*	86	88	73	81	87	185	83	93	54	***122***
Spam Detected	12.5k	27.9k	*33.1*	28.7k	25.8k	20.6k	26.9k	22.6k	27.6k	23.4k	15.1k	2.2k	***12.9k***
Virus Detected	5	3	*22*	10	29	6	11	9	12	5	13	22	***3***
Advanced Malware	0	1	*55*	37	78	24	29	8	4	2	9	0	***0***
Malicious URLs	170	6	*50*	97	11	57	57	43	33	205	209	1	***123***
Content Filter	56	39	*110*	114	333	66	108	376	116	133	100	1	***86***
Marketing Messages	15.7k	16.2k	*8.4k*	9.5k	8.9k	8.1k	9.4k	10.1k	10.1k	12.5k	8.4k	18.4k	***19.5k***
Attempted Admin Privilege Gain	173	51	*250*	6	0	1	7	4	48	3	1	4	***1***
Attempted User Privilege Gain	162	47	*329*	146	48	48	69	330	526	569	554	474	***17***
Attempted Information Leak	18	53	*118*	71	51	50	65	51	72	57	46	66	***0***
Potential Corp Policy Violation	0	0	*0*	0	0	0	0	3	4	0	0	0	***0***
Network Scans Detected	0	0	*0*	0	0	0	0	0	0	0	0	0	***0***
Web Application Attack	8	0	*15*	7	4	4	1	0	0	5	3	4	***0***
Attempted Denial of Service	1	0	*4*	0	0	0	0	0	0	0	1	0	***1***
Misc. Attack	1,862	151	*2,901*	1,023	347	2,146	1	424	332	795	145	64	***29***

- 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 with a return to a reputation-based block for a total of 183.8k.
- Attempted information leaks detected and blocked at the firewall is at 0 for the month of **July 2024.**
- Network scans returned a value of 0, which is in line with previous month's data.
- Attempted User Privilege Gain is at 17 from a previous six-month average of 411.

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: **August 9th, 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: May 2023 – April 2024 dates of service
Prior reporting period: May 2022 – April 2023 dates of service
(Note: Data excludes Kaiser membership data.)

- For the Current reporting period, the top 8.5% of members account for 87.8% of total costs.

- In comparison, the Prior reporting period was slightly higher at 9.7% 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 54.1% of the members, with SPDs accounting for 21.8% and ACA OE's at 32.3%.
    - The percent of members with costs >= $30K slightly increased from 2.2% to 2.3%.
    - Of those members with costs >= $100K, the percentage of total members has slightly increased to 0.6%.
        - For these members, non-trauma/pregnancy inpatient costs continue to comprise the majority of costs, decreasing to 33.4%.
    - 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 8.5% is more concentrated in the 45-66 year old category (37.3%) compared to the overall population (20.8%).

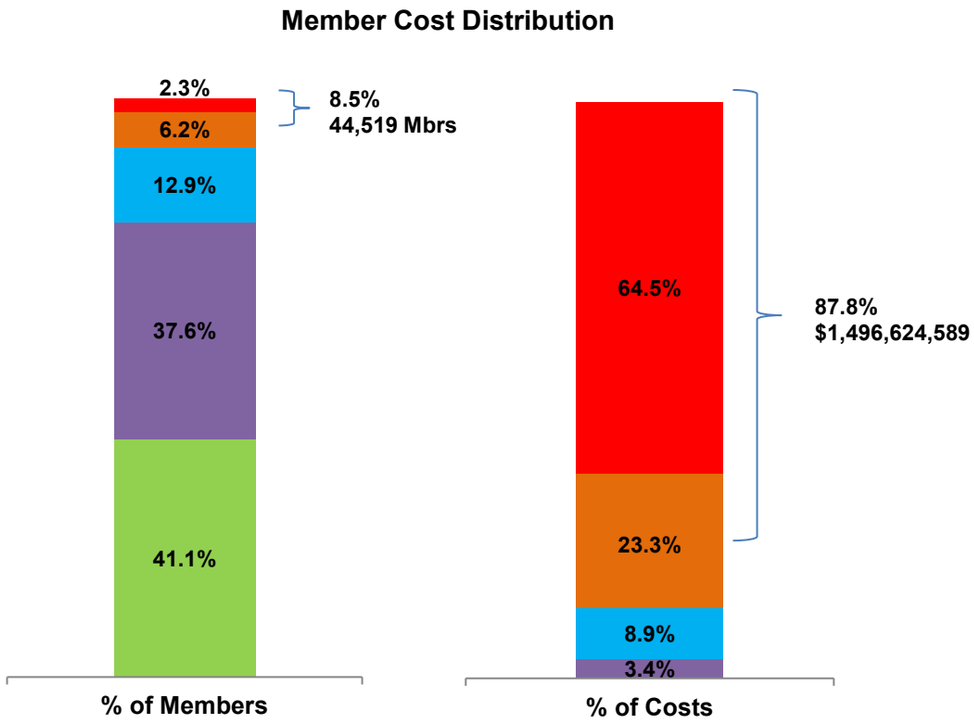
Analytics

Supporting Documents

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

Note: Data incomplete due to claims lag

Run Date: 07/29/2024



Cost Range	Members	% of Members	Costs	% of Costs
$30K+	11,912	2.3%	$ 1,099,471,074	64.5%
$5K - $30K	32,607	6.2%	$ 397,153,516	23.3%
$1K - $5K	67,779	12.9%	$ 151,220,612	8.9%
< $1K	197,787	37.6%	$ 57,367,930	3.4%
$0	216,603	41.1%	$ -	0.0%
Totals	**526,688**	**100.0%**	**$ 1,705,213,131**	**100.0%**

Top 8.5% of Members = 87.8% of Costs

Cost Range	Members	% of Total Members	Costs	% of Total Costs
$100K+	3,215	0.6%	$ 633,194,449	37.1%
$75K to $100K	1,538	0.3%	$ 133,818,956	7.8%
$50K to $75K	2,457	0.5%	$ 149,980,529	8.8%
$40K to $50K	1,936	0.4%	$ 86,223,936	5.1%
$30K to $40K	2,766	0.5%	$ 96,253,204	5.6%
SubTotal	***11,912***	***2.3%***	***$ 1,099,471,074***	***64.5%***
$20K to $30K	4,725	0.9%	$ 115,230,018	6.8%
$10K to $20K	12,113	2.3%	$ 169,735,315	10.0%
$5K to $10K	15,769	3.0%	$ 112,188,182	6.6%
SubTotal	***32,607***	***6.2%***	***$ 397,153,516***	***23.3%***
Total	**44,519**	***8.5%***	**$ 1,496,624,589**	***87.8%***

Enrollment Status	Members	Total Costs
Still Enrolled as of Apr 2024	405,233	$ 1,502,546,280
Dis-Enrolled During Year	121,455	$ 202,666,851
Totals	**526,688**	**$ 1,705,213,131**

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
8.5% of Members = 87.8% of Costs
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: May 2023 - Apr 2024
Note: Data incomplete due to claims lag
Run Date: 07/29/2024

8.5% of Members = 87.8% of Costs
21.8% of members are SPDs and account for 26.9% of costs.
32.3% of members are ACA OE and account for 31.5% of costs.
10.9% of members disenrolled as of Apr 2024 and account for 12.1% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Members	% of Members
IHSS	IHSS	164	744	908	2.0%
MCAL	MCAL - ADULT	959	5,584	6,543	14.7%
	MCAL - BCCTP	-	-	-	0.0%
	MCAL - CHILD	454	2,832	3,286	7.4%
	MCAL - ACA OE	3,437	10,959	14,396	32.3%
	MCAL - SPD	3,314	6,385	9,699	21.8%
	MCAL - DUALS	867	2,663	3,530	7.9%
	MCAL - LTC	175	15	190	0.4%
	MCAL - LTC-DUAL	992	132	1,124	2.5%
Not Eligible	Not Eligible	1,550	3,293	4,843	10.9%
Total		**11,912**	**32,607**	**44,519**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Costs	% of Costs
IHSS	IHSS	$ 12,577,680	$ 8,562,633	$ 21,140,313	1.4%
MCAL	MCAL - ADULT	$ 85,987,418	$ 65,685,285	$ 151,672,704	10.1%
	MCAL - BCCTP	$ -	$ -	$ -	0.0%
	MCAL - CHILD	$ 32,818,312	$ 32,119,140	$ 64,937,452	4.3%
	MCAL - ACA OE	$ 338,368,674	$ 132,741,610	$ 471,110,284	31.5%
	MCAL - SPD	$ 320,179,270	$ 83,025,789	$ 403,205,059	26.9%
	MCAL - DUALS	$ 66,602,661	$ 31,713,412	$ 98,316,073	6.6%
	MCAL - LTC	$ 20,267,538	$ 290,084	$ 20,557,622	1.4%
	MCAL - LTC-DUAL	$ 82,033,642	$ 2,604,358	$ 84,638,000	5.7%
Not Eligible	Not Eligible	$ 140,635,877	$ 40,411,205	$ 181,047,082	12.1%
Total		**$ 1,099,471,074**	**$ 397,153,516**	**$ 1,496,624,589**	**100.0%**

Highest Cost Members; Cost Per Member >= $100K
29.2% of members are SPDs and account for 30.3% of costs.
28.0% of members are ACA OE and account for 32.6% of costs.
11.2% of members disenrolled as of Apr 2024 and account for 11.5% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Total Members	% of Members
IHSS	IHSS	37	1.2%
MCAL	MCAL - ADULT	212	6.6%
	MCAL - BCCTP	-	0.0%
	MCAL - CHILD	62	1.9%
	MCAL - ACA OE	900	28.0%
	MCAL - SPD	938	29.2%
	MCAL - DUALS	259	8.1%
	MCAL - LTC	94	2.9%
	MCAL - LTC-DUAL	352	10.9%
Not Eligible	Not Eligible	361	11.2%
Total		**3,215**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Total Costs	% of Costs
IHSS	IHSS	$ 5,913,826	0.9%
MCAL	MCAL - ADULT	$ 47,841,351	7.6%
	MCAL - BCCTP	$ -	0.0%
	MCAL - CHILD	$ 14,129,849	2.2%
	MCAL - ACA OE	$ 206,663,010	32.6%
	MCAL - SPD	$ 191,846,400	30.3%
	MCAL - DUALS	$ 34,282,393	5.4%
	MCAL - LTC	$ 15,787,969	2.5%
	MCAL - LTC-DUAL	$ 43,629,743	6.9%
Not Eligible	Not Eligible	$ 73,099,907	11.5%
Total		**$ 633,194,449**	**100.0%**

% of Total Costs By Service Type

Breakout by Service Type/Location

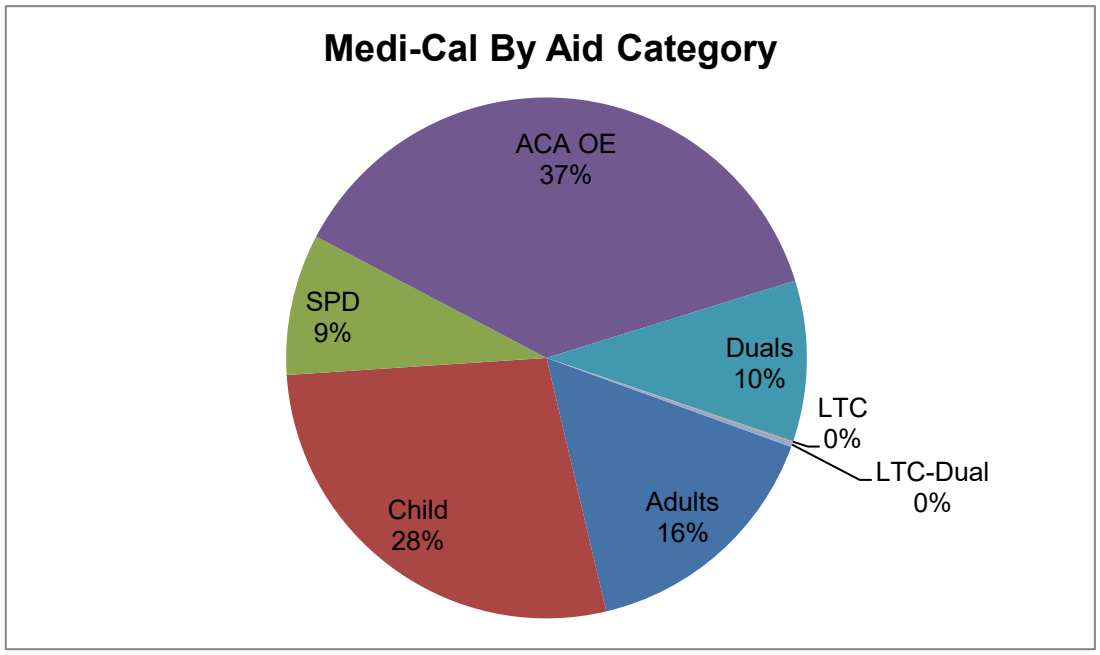
Cost Range	Trauma Costs	Hep C Rx Costs	Pregnancy, Childbirth & Newborn Related Costs	Pharmacy Costs	Inpatient Costs (POS 21)	ER Costs (POS 23)	Outpatient Costs (POS 22)	Office Costs (POS 11)	Dialysis Costs (POS 65)	Other Costs (All Other POS)
$100K+	6%	0%	1%	0%	41%	1%	11%	3%	2%	26%
$75K to $100K	3%	0%	1%	0%	24%	2%	6%	3%	5%	44%
$50K to $75K	4%	0%	2%	0%	27%	3%	6%	5%	4%	32%
$40K to $50K	5%	0%	1%	1%	25%	6%	5%	5%	1%	30%
$30K to $40K	9%	0%	2%	0%	20%	11%	5%	5%	1%	27%
$20K to $30K	3%	1%	4%	0%	23%	6%	7%	7%	2%	19%
$10K to $20K	0%	0%	10%	1%	25%	6%	9%	9%	2%	15%
$5K to $10K	0%	0%	6%	1%	14%	9%	12%	13%	1%	17%
Total	**5%**	**0%**	**3%**	**0%**	**30%**	**4%**	**9%**	**5%**	**2%**	**26%**

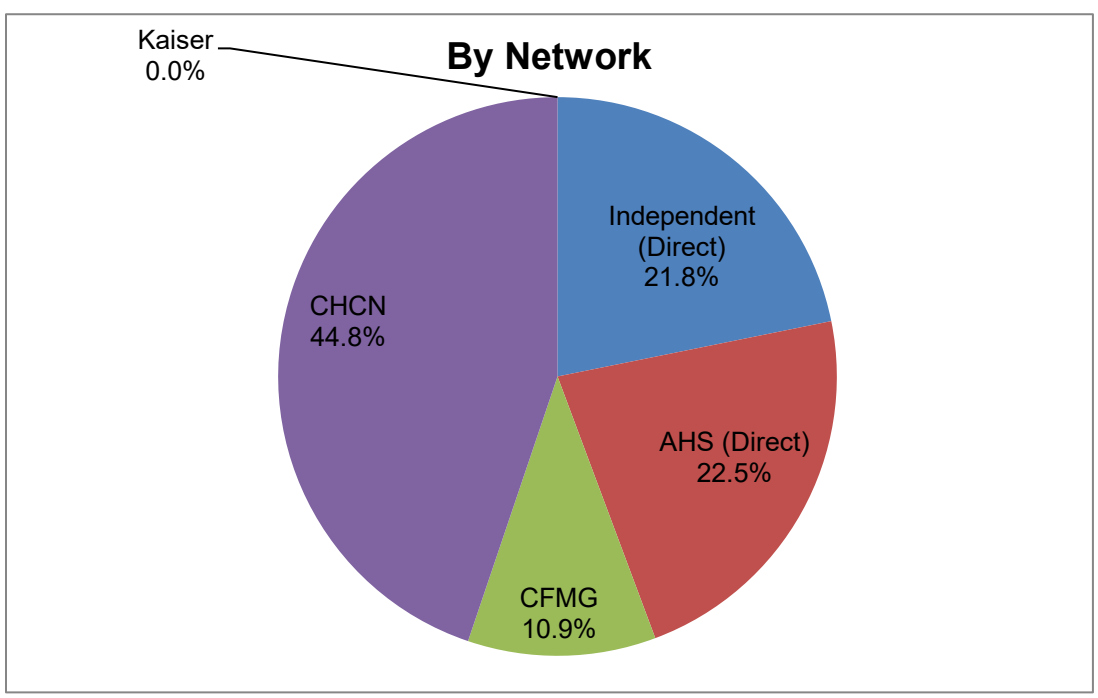
Notes:
- Report includes medical costs (HS & Diamond Claims, Beacon, Logisticare FFS, CHCN FFS Preventive Services, CHME) and pharmacy costs. IBNP factors are not applied.
- CFMG and CHCN encounter data has been priced out.
- Report excludes Capitation Expense

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend

Category of Aid	Jun 2024	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Adults	62,786	16%	12,794	14,436	10	35,546	-
Child	110,164	28%	9,092	13,607	41,039	46,426	-
SPD	34,935	9%	11,366	5,529	1,437	16,603	-
ACA OE	149,359	37%	25,256	53,589	1,501	69,013	-
Duals	39,789	10%	26,114	2,818	4	10,853	-
LTC	224	0%	209	7	-	8	-
LTC-Dual	1,250	0%	1,248	-	-	2	-
Medi-Cal	398,507		86,079	89,986	43,991	178,451	-
Group Care	5,658		2,127	882	-	2,649	-
Total	**404,165**	**100%**	**88,206**	**90,868**	**43,991**	**181,100**	**-**
Medi-Cal %	98.6%		97.6%	99.0%	100.0%	98.5%	0%
Group Care %	1.4%		2.4%	1.0%	0.0%	1.5%	0.0%
	Network Distribution		*21.8%*	*22.5%*	*10.9%*	*44.8%*	*0.0%*
			% Direct:	**44%**		**% Delegated:**	**56%**

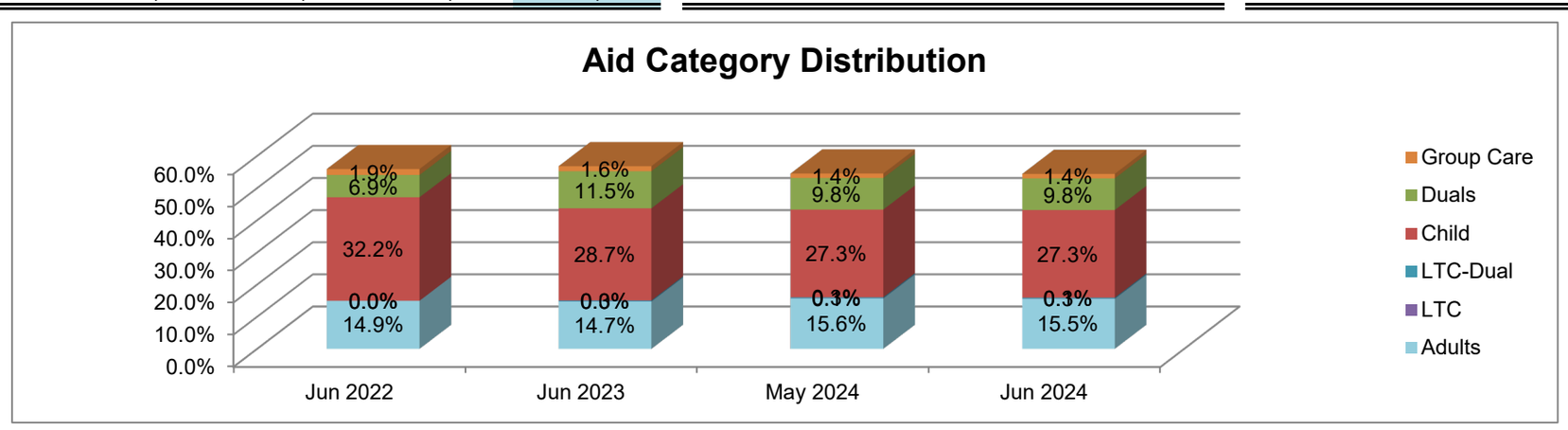




Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

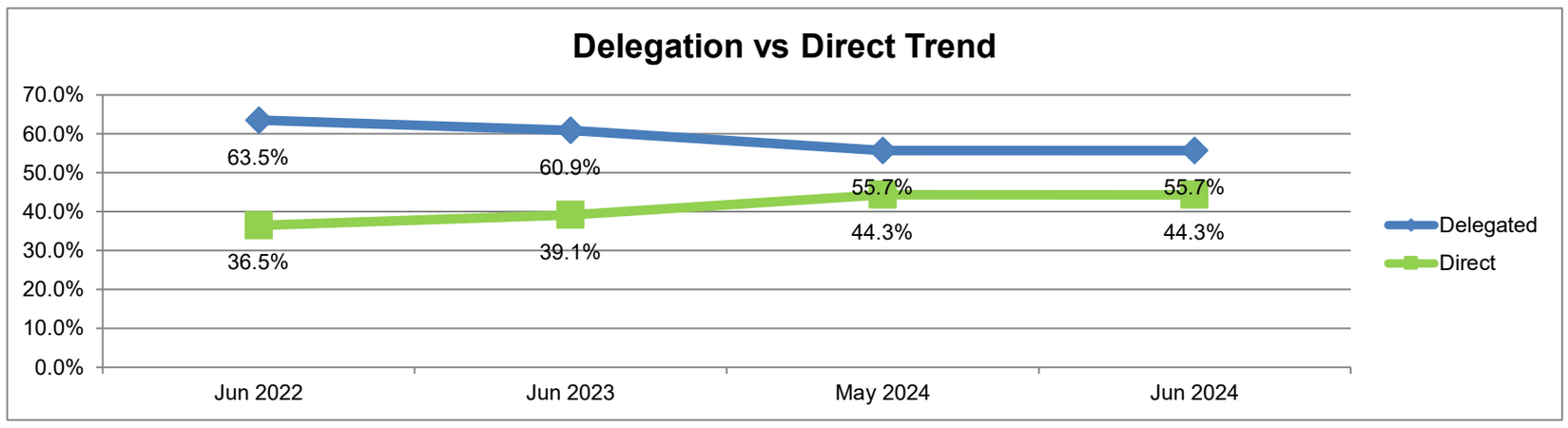
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Jun 2022	Jun 2023	May 2024	Jun 2024	Jun 2022	Jun 2023	May 2024	Jun 2024	Jun 2022 to Jun 2023	Jun 2023 to Jun 2024	May 2024 to Jun 2024
Adults	46,761	53,174	63,405	62,786	14.9%	14.7%	15.6%	15.5%	13.7%	18.1%	-1.0%
Child	100,772	103,670	110,561	110,164	32.2%	28.7%	27.3%	27.3%	2.9%	6.3%	-0.4%
SPD	27,105	31,280	34,965	34,935	8.7%	8.6%	8.6%	8.6%	15.4%	11.7%	-0.1%
ACA OE	110,938	124,967	149,427	149,359	35.4%	34.6%	36.9%	37.0%	12.6%	19.5%	0.0%
Duals	21,685	41,731	39,842	39,789	6.9%	11.5%	9.8%	9.8%	92.4%	-4.7%	-0.1%
LTC	-	150	220	224	0.0%	0.0%	0.1%	0.1%	0.0%	49.3%	1.8%
LTC-Dual	-	1,029	1,283	1,250	0.0%	0.3%	0.3%	0.3%	0.0%	21.5%	-2.6%
Medi-Cal Total	307,261	356,001	399,703	398,507	98.1%	98.4%	98.6%	98.6%	15.9%	11.9%	-0.3%
Group Care	5,795	5,684	5,640	5,658	1.9%	1.6%	1.4%	1.4%	-1.9%	-0.5%	0.3%
Total	**313,056**	**361,685**	**405,343**	**404,165**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**15.5%**	**11.7%**	**-0.3%**



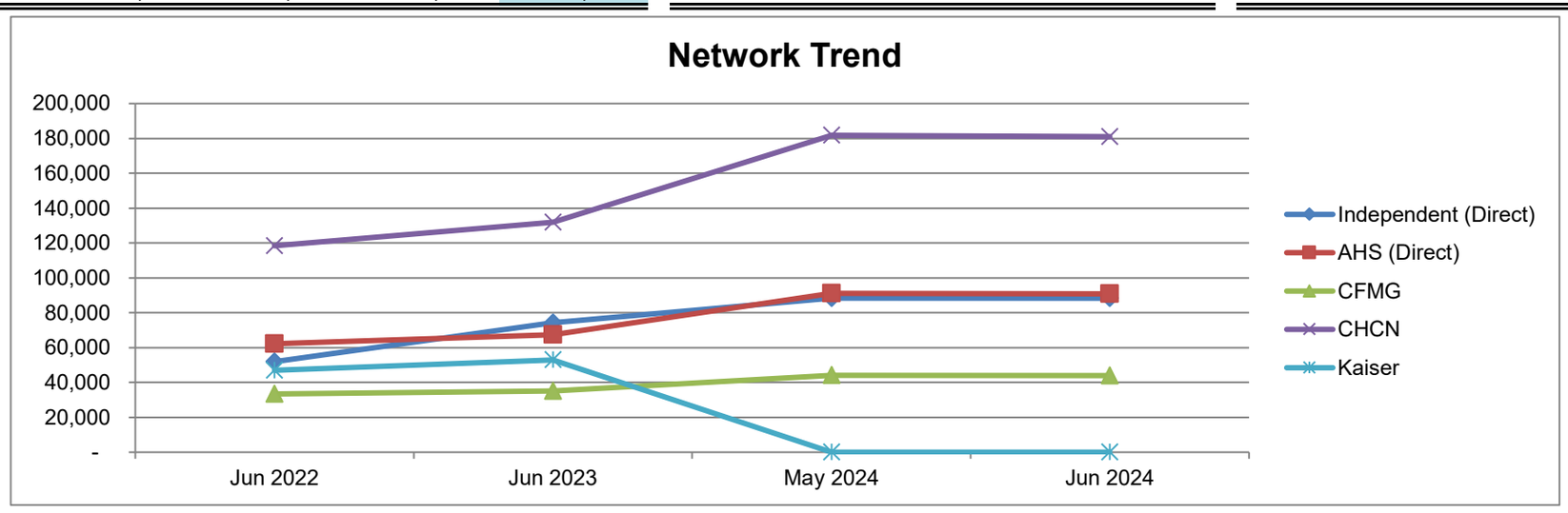
Delegation vs Direct Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	Jun 2022	Jun 2023	May 2024	Jun 2024	Jun 2022	Jun 2023	May 2024	Jun 2024	Jun 2022 to Jun 2023	Jun 2023 to Jun 2024	May 2024 to Jun 2024
Delegated	198,905	220,110	225,844	225,091	63.5%	60.9%	55.7%	55.7%	10.7%	2.3%	-0.3%
Direct	114,151	141,575	179,499	179,074	36.5%	39.1%	44.3%	44.3%	24.0%	26.5%	-0.2%
Total	**313,056**	**361,685**	**405,343**	**404,165**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**15.5%**	**11.7%**	**-0.3%**



Network Trend

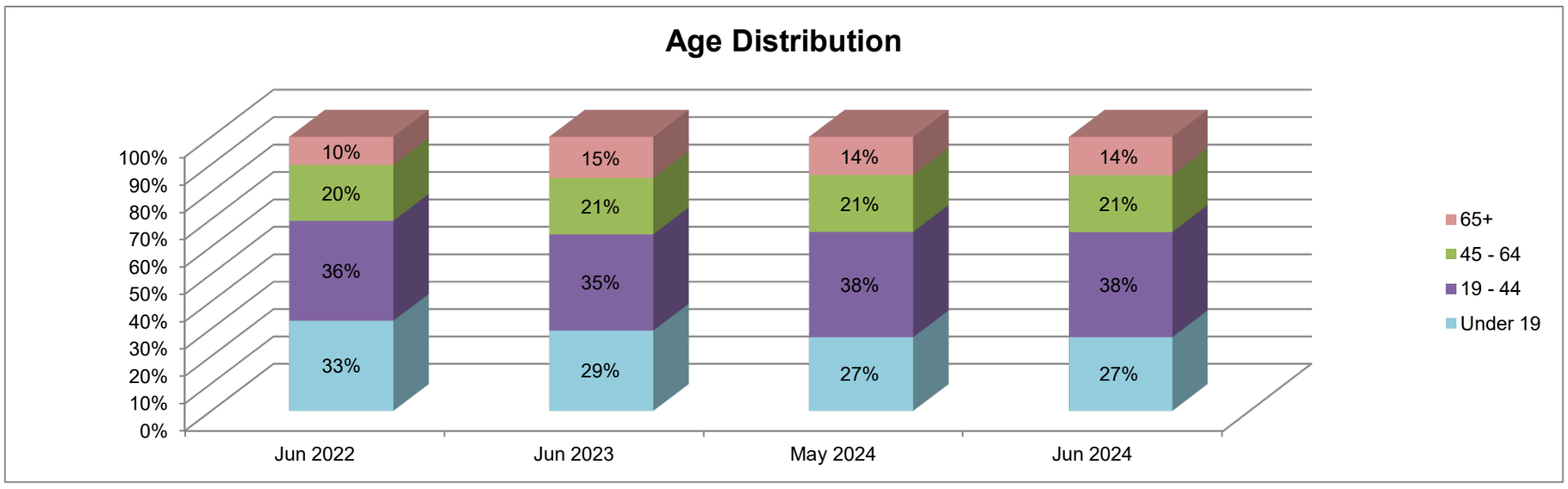
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Jun 2022	Jun 2023	May 2024	Jun 2024	Jun 2022	Jun 2023	May 2024	Jun 2024	Jun 2022 to Jun 2023	Jun 2023 to Jun 2024	May 2024 to Jun 2024
Independent (Direct)	51,936	74,242	88,381	88,206	16.6%	20.5%	21.8%	21.8%	42.9%	18.8%	-0.2%
AHS (Direct)	62,215	67,333	91,118	90,868	19.9%	18.6%	22.5%	22.5%	8.2%	35.0%	-0.3%
CFMG	33,408	35,251	44,083	43,991	10.7%	9.7%	10.9%	10.9%	5.5%	24.8%	-0.2%
CHCN	118,411	131,951	181,761	181,100	37.8%	36.5%	44.8%	44.8%	11.4%	37.2%	-0.4%
Kaiser	47,086	52,908	-	-	15.0%	14.6%	0.0%	0.0%	12.4%	-100.0%	0.0%
Total	**313,056**	**361,685**	**405,343**	**404,165**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**15.5%**	**11.7%**	**-0.3%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

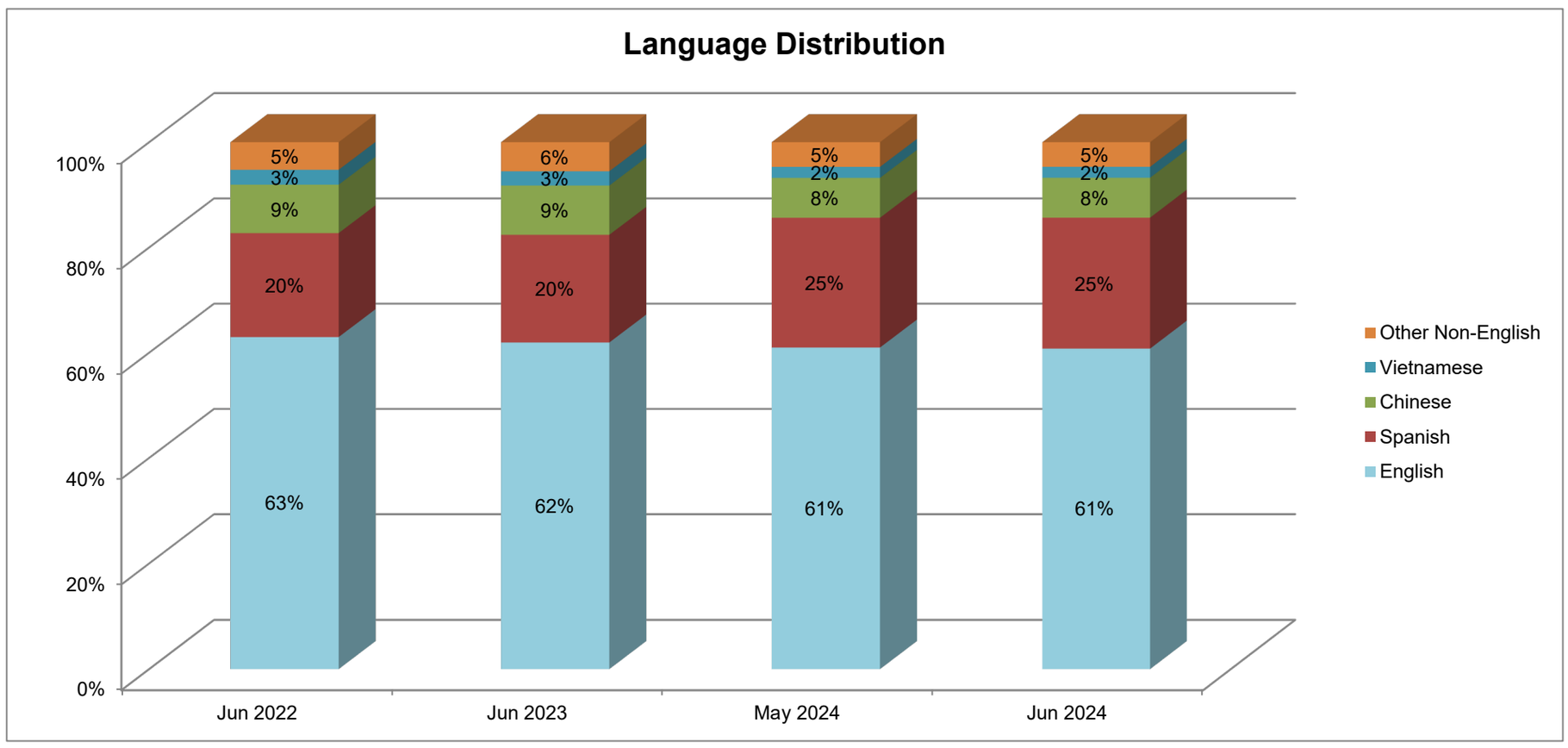
Age Category Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	Jun 2022	Jun 2023	May 2024	Jun 2024	Jun 2022	Jun 2023	May 2024	Jun 2024	Jun 2022 to Jun 2023	Jun 2023 to Jun 2024	May 2024 to Jun 2024
Under 19	103,026	106,040	108,994	108,701	33%	29%	27%	27%	3%	3%	0%
19 - 44	114,184	127,085	155,914	155,198	36%	35%	38%	38%	11%	22%	0%
45 - 64	63,899	74,391	84,121	83,870	20%	21%	21%	21%	16%	13%	0%
65+	31,947	54,169	56,314	56,396	10%	15%	14%	14%	70%	4%	0%
Total	**313,056**	**361,685**	**405,343**	**404,165**	**100%**	**100%**	**100%**	**100%**	**16%**	**12%**	**0%**



Language Trend

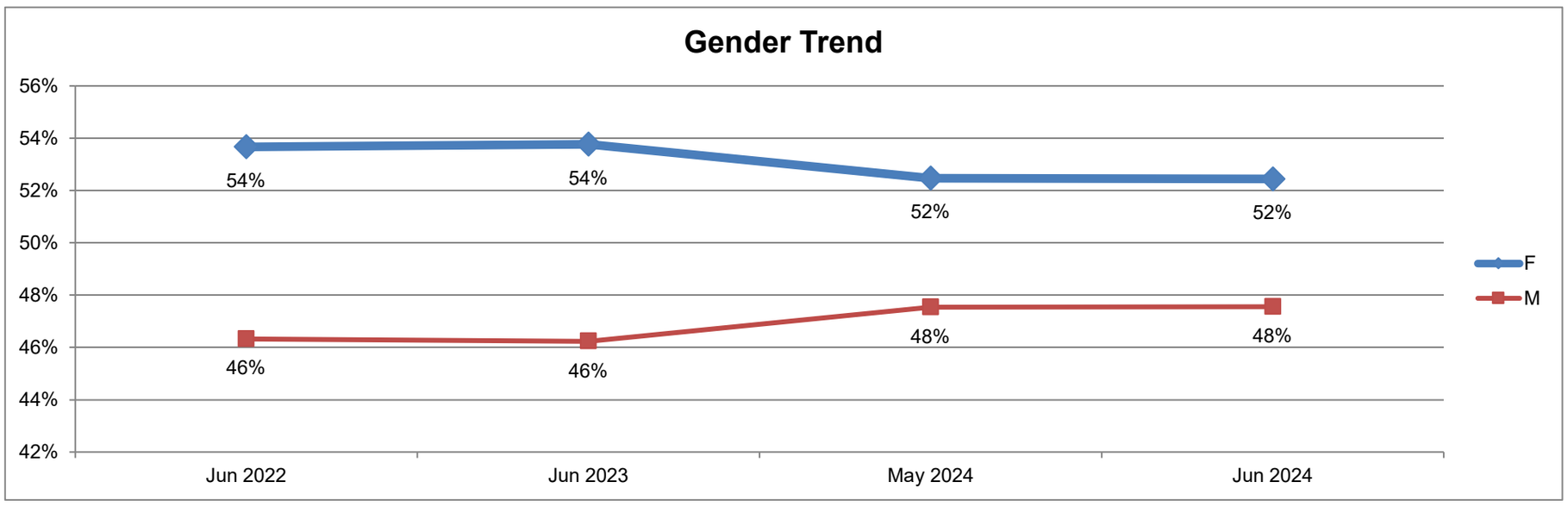
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	Jun 2022	Jun 2023	May 2024	Jun 2024	Jun 2022	Jun 2023	May 2024	Jun 2024	Jun 2022 to Jun 2023	Jun 2023 to Jun 2024	May 2024 to Jun 2024
English	197,106	223,993	247,134	245,593	63%	62%	61%	61%	14%	10%	-1%
Spanish	61,849	74,012	99,964	100,576	20%	20%	25%	25%	20%	36%	1%
Chinese	28,802	33,860	30,741	30,660	9%	9%	8%	8%	18%	-9%	0%
Vietnamese	8,868	9,838	8,461	8,386	3%	3%	2%	2%	11%	-15%	-1%
Other Non-English	16,431	19,982	19,043	18,950	5%	6%	5%	5%	22%	-5%	0%
Total	**313,056**	**361,685**	**405,343**	**404,165**	**100%**	**100%**	**100%**	**100%**	**16%**	**12%**	**0%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

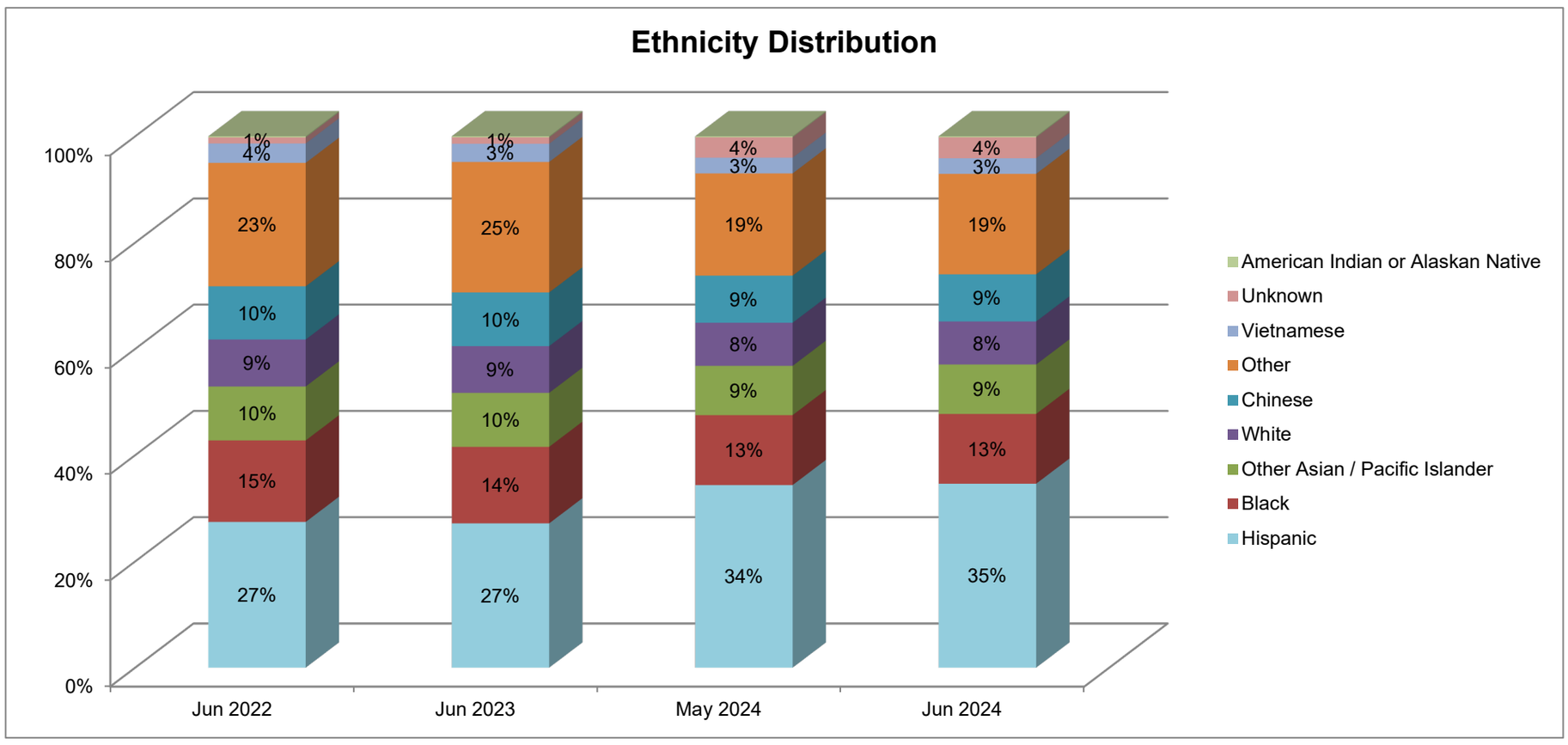
Gender Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Jun 2022	Jun 2023	May 2024	Jun 2024	Jun 2022	Jun 2023	May 2024	Jun 2024	Jun 2022 to Jun 2023	Jun 2023 to Jun 2024	May 2024 to Jun 2024
F	168,023	194,470	212,650	211,959	54%	54%	52%	52%	16%	9%	0%
M	145,033	167,215	192,693	192,206	46%	46%	48%	48%	15%	15%	0%
Total	**313,056**	**361,685**	**405,343**	**404,165**	**100%**	**100%**	**100%**	**100%**	**16%**	**12%**	**0%**



Ethnicity Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Jun 2022	Jun 2023	May 2024	Jun 2024	Jun 2022	Jun 2023	May 2024	Jun 2024	Jun 2022 to Jun 2023	Jun 2023 to Jun 2024	May 2024 to Jun 2024
Hispanic	85,824	98,185	139,254	139,887	27%	27%	34%	35%	14%	42%	0%
Black	48,031	52,097	53,353	53,044	15%	14%	13%	13%	8%	2%	-1%
Other Asian / Pacific Islander	31,777	36,735	37,596	37,615	10%	10%	9%	9%	16%	2%	0%
White	27,666	31,823	32,881	32,738	9%	9%	8%	8%	15%	3%	0%
Chinese	31,360	36,522	35,951	35,855	10%	10%	9%	9%	16%	-2%	0%
Other	72,720	88,825	77,966	76,430	23%	25%	19%	19%	22%	-14%	-2%
Vietnamese	11,426	12,366	11,993	11,893	4%	3%	3%	3%	8%	-4%	-1%
Unknown	3,570	4,397	15,550	15,906	1%	1%	4%	4%	23%	262%	2%
American Indian or Alaskan Native	682	735	799	797	0%	0%	0%	0%	8%	8%	0%
Total	**313,056**	**361,685**	**405,343**	**404,165**	**100%**	**100%**	**100%**	**100%**	**16%**	**12%**	**0%**



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

Medi-Cal By City

City	Jun 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	160,572	40%	23,498	42,614	17,528	76,932	-
Hayward	63,652	16%	12,550	17,165	7,487	26,450	-
Fremont	36,669	9%	15,047	6,734	2,102	12,786	-
San Leandro	33,083	8%	8,112	5,715	4,277	14,979	-
Union City	14,574	4%	5,437	2,609	840	5,688	-
Alameda	13,876	3%	3,347	2,480	2,082	5,967	-
Berkeley	15,058	4%	4,030	2,291	1,753	6,984	-
Livermore	12,825	3%	1,859	655	2,231	8,080	-
Newark	9,278	2%	2,696	4,109	501	1,972	-
Castro Valley	9,466	2%	2,491	1,656	1,396	3,923	-
San Lorenzo	7,298	2%	1,465	1,647	846	3,340	-
Pleasanton	7,391	2%	1,743	416	817	4,415	-
Dublin	7,391	2%	1,979	440	879	4,093	-
Emeryville	2,784	1%	607	619	455	1,103	-
Albany	2,520	1%	660	288	563	1,009	-
Piedmont	490	0%	112	196	57	125	-
Sunol	86	0%	24	15	6	41	-
Antioch	47	0%	11	18	7	11	-
Other	1,447	0%	411	319	164	553	-
Total	**398,507**	**100%**	**86,079**	**89,986**	**43,991**	**178,451**	**-**

Group Care By City

City	Jun 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	1,785	32%	344	331	-	1,110	-
Hayward	630	11%	294	149	-	187	-
Fremont	638	11%	427	70	-	141	-
San Leandro	592	10%	242	87	-	263	-
Union City	297	5%	188	47	-	62	-
Alameda	294	5%	93	23	-	178	-
Berkeley	156	3%	53	10	-	93	-
Livermore	101	2%	30	4	-	67	-
Newark	133	2%	81	29	-	23	-
Castro Valley	191	3%	86	27	-	78	-
San Lorenzo	137	2%	44	21	-	72	-
Pleasanton	67	1%	21	3	-	43	-
Dublin	117	2%	39	6	-	72	-
Emeryville	31	1%	11	4	-	16	-
Albany	22	0%	12	2	-	8	-
Piedmont	10	0%	2	1	-	7	-
Sunol	2	0%	2	-	-	-	-
Antioch	25	0%	7	5	-	13	-
Other	430	8%	151	63	-	216	-
Total	**5,658**	**100%**	**2,127**	**882**	**-**	**2,649**	**-**

Total By City

City	Jun 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	162,357	40%	23,842	42,945	17,528	78,042	-
Hayward	64,282	16%	12,844	17,314	7,487	26,637	-
Fremont	37,307	9%	15,474	6,804	2,102	12,927	-
San Leandro	33,675	8%	8,354	5,802	4,277	15,242	-
Union City	14,871	4%	5,625	2,656	840	5,750	-
Alameda	14,170	4%	3,440	2,503	2,082	6,145	-
Berkeley	15,214	4%	4,083	2,301	1,753	7,077	-
Livermore	12,926	3%	1,889	659	2,231	8,147	-
Newark	9,411	2%	2,777	4,138	501	1,995	-
Castro Valley	9,657	2%	2,577	1,683	1,396	4,001	-
San Lorenzo	7,435	2%	1,509	1,668	846	3,412	-
Pleasanton	7,458	2%	1,764	419	817	4,458	-
Dublin	7,508	2%	2,018	446	879	4,165	-
Emeryville	2,815	1%	618	623	455	1,119	-
Albany	2,542	1%	672	290	563	1,017	-
Piedmont	500	0%	114	197	57	132	-
Sunol	88	0%	26	15	6	41	-
Antioch	72	0%	18	23	7	24	-
Other	1,877	0%	562	382	164	769	-
Total	**404,165**	**100%**	**88,206**	**90,868**	**43,991**	**181,100**	**-**

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: **August 9th, 2024**

Subject: **Human Resources Report**

Staffing

- As of August 1st, 2024, the Alliance had 617 full time employees and 1-part time employee.

- On August 1st, 2024, the Alliance had 62 open positions in which 15 signed offer acceptance letters have been received with start dates in the near future resulting in a total of 47 positions open to date. The Alliance is actively recruiting for the remaining 47 positions and several of these positions are in the interviewing or job offer stage.

- Summary of open positions by division:

Division	Open Position August 1st	Signed Offers Accepted by Department	Remaining Recruitment Positions
Healthcare Services	15	0	15
Operations	34	12	22
Healthcare Analytics	1	0	1
Information Technology	5	1	4
Finance	2	0	2
Compliance	3	2	1
Human Resources	2	0	2
Health Equity	0	0	0
Executive	0	0	0
Total	62	15	47

- Our current recruitment rate is 9%.

Employee Recognition

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

  5 years:
  - Alan Zhang (Claims)

  6 years:
  - Trina Chung (Claims)
  - Nancy Tran (Member Services)
  - Cathy Cortez Ledesma (Grievance & Appeals)

  7 years:
  - Rubeen Samra (Member Services)
  - Jasmine Cornn (Provider Services)

  8 years:
  - Cindy Delos Santos-Dalanon (Credentialing)
  - Alex Alvarez (Marketing & Communications)
  - Roberta Robertson (Privacy & SIU)

  9 years:
  - Matthew Woodruff (Executive)

  10 years:
  - Evelyn Waters-Glover (Case & Disease Management)

  11 years:
  - Julia Kim (Healthcare Analytics)
  - Jennifer Reyes (Utilization Management)

  13 years:
  - Lorraine Valdivia (Claims)

  14 years:
  - Daniel McKay (IT Infrastructure)

  19 years:
  - Felicia Alexander-Samuels (Claims)

ALAMEDA Alliance FOR HEALTH

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Legislative Tracking

2024 Legislative Tracking List

The California State Legislature returned to Sacramento after their summer recess this week for the final month of the 2023-2024 legislative session. Lawmakers will have until August 31st to pass bills and send them to the Governor's desk. The Governor will then have until September 30th to sign or veto bills passed by the legislature.

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: 6/27/2024 html pdf
Status: 6/27/2024-Read second time and amended. Re-referred to Com. on APPR.
Location: 6/26/2024-S. 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 and a health insurer that contracts with providers for alternative rates of payment to publish and maintain a provider directory or directories with information on contracting providers that deliver health care services enrollees or insureds and requires a health care service plan and health insurer to regularly update its printed and online provider directory or directories, as specified. Current law authorizes the departments to require a plan or insurer to provide coverage for all covered health care services provided to an enrollee or insured who reasonably relied on materially inaccurate, incomplete, or misleading information contained in a health plan's provider directory or directories. This bill would require a plan or insurer to annually verify and delete inaccurate listings from its provider directories and would require a provider directory to be 60% accurate on July 1, 2025, with increasing required percentage accuracy benchmarks to be met each year until the directories are 95% accurate on or before July 1, 2028. The bill would subject a plan or insurer to administrative penalties for failure to meet the prescribed benchmarks. The bill would require a plan or insurer to arrange care and provide coverage for all covered health care services provided to an enrollee or insured who reasonably relied on inaccurate, incomplete, or misleading information contained in a health plan or policy's provider directory or directories and to reimburse the provider the contracted amount for those services. The bill would prohibit a provider from collecting an additional amount from an enrollee or insured other than the applicable in-network cost sharing. The bill would require a plan or insurer to provide information about in-network providers to enrollees and insureds upon request and would limit the cost-sharing amounts an enrollee or insured is required to pay for services from those providers under specified circumstances.

AB 365 **(Aguiar-Curry D) Medi-Cal: diabetes management.**
Current Text: Amended: 9/8/2023 html pdf
Status: 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 551 **(Bennett D) Public Utilities Commission.**
Current Text: Amended: 7/3/2024 html pdf
Status: 7/3/2024-Read second time and amended. Re-referred to Com. on APPR.
Location: 7/2/2024-S. APPR.

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

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

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

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

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1st House				2nd House							

Summary: Current law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. Current law requires the Director of Health Care Services to develop and implement standards for the timely processing and payment of each claim type. Current law requires that the standards be sufficient to meet minimal federal requirements for the timely processing of claims. Current law states the intent of the Legislature that claim forms for use by physicians and hospitals be the same as claim forms in general use by other payors, as specified. This bill would require the department to allow a provider to submit an electronic signature for a claim or remittance form under the Medi-Cal program, to the extent not in conflict with federal law.

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

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

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

AB 815 **(Wood D) Health care coverage: physician and provider credentials.**
Current Text: Amended: 7/3/2024 html pdf
Status: 7/3/2024-From committee: Amend, and do pass as amended and re-refer to Com. on APPR. (Ayes 9. Noes 1.) (July 3). Read second time and amended. Re-referred to Com. on APPR.
Location: 7/3/2024-S. APPR.

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

Summary: Current law establishes the California Health and Human Services Agency, which includes departments charged with the administration of health, social, and other human services. Current law provides for the licensure and regulation of health care service plans by the Department of Managed Health Care under the Knox-Keene Health Care Service Plan Act of 1975, and the regulation of health insurers by the Department of Insurance. Current law sets forth requirements for provider credentialing by a health care service plan or health insurer. This bill would require the California Health and Human Services Agency to create and maintain a physician credentialing board, with specified membership, and would require the board, on or before July 1, 2027, to develop a standardized credentialing form to be used by all health care service plans and health insurers. The bill would require every health care service plan or health insurer to use the standardized credentialing form, as specified. The bill would not apply the standardized form requirements to specified Medi-Cal managed care contracts with the State Department of Health Care Services.

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

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

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

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

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

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

AB 1092 **(Wood D) Health care service plans: consolidation.**
Current Text: Amended: 6/28/2023 html pdf
Status: 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 1122 **(Bains D) Commercial harbor craft: equipment.**
Current Text: Amended: 7/3/2024 html pdf
Status: 7/3/2024-From committee: Amend, and do pass as amended and re-refer to Com. on APPR. (Ayes 7. Noes 0.) (July 3). Read second time and amended. Re-referred to Com. on APPR.
Location: 7/3/2024-S. APPR.

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

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

AB 1157 **(Ortega D) Rehabilitative and habilitative services: durable medical equipment and services.**
Current Text: Amended: 7/13/2023 html pdf
Status: 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 year	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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 1316 **(Irwin D) Emergency services: psychiatric emergency medical conditions.**
Current Text: Amended: 6/17/2024 html pdf
Status: 6/25/2024-Read second time. Ordered to third reading.
Location: 6/25/2024-S. THIRD READING

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

Summary: The Lanterman-Petris-Short Act provides for the involuntary commitment and treatment of a person who is a danger to themselves or others or who is gravely disabled, as defined. The Medi-Cal program 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. Pursuant to a schedule of covered benefits, current law requires Medi-Cal coverage for inpatient hospital services, subject to utilization controls, and with respect to fee-for service beneficiaries, coverage for emergency services and care necessary for the treatment of an emergency medical condition and medical care directly related to the emergency medical condition, as specified.

Current law provides for the licensing and regulation of health facilities by the State Department of Public Health and makes a violation of those provisions a crime. Current law defines "psychiatric emergency medical condition," for purposes of providing treatment for emergency conditions, as a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either an immediate danger to the patient or to others, or immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder. Current law includes various circumstances under which a patient is required to be treated by, or may be transferred to, specified health facilities for treatment that is solely necessary to relieve or eliminate a psychiatric emergency medical condition. This bill would revise the definition of "psychiatric emergency medical condition" to make that definition applicable regardless of whether the patient is voluntary, or is involuntarily detained for evaluation and treatment, under prescribed circumstances. The bill would make conforming changes to provisions requiring facilities to provide that treatment. By expanding the definition of a crime with respect to those facilities, the bill would impose a state-mandated local 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 **(Papan D) California Environmental Quality Act: geothermal exploratory projects: lead agency.**
Current Text: Amended: 6/20/2024 html pdf
Status: 7/3/2024-From committee: Do pass and re-refer to Com. on APPR. (Ayes 7. Noes 0.) (July 3). Re-referred to Com. on APPR.
Location: 7/3/2024-S. APPR.

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

Summary: Current law establishes the Geologic Energy Management Division in the Department of Conservation, under the direction of the State Oil and Gas Supervisor, who is required to supervise the drilling, operation, maintenance, and abandonment of wells so as to permit the owners or operators of those wells to utilize all methods and practices known to the industry for the purpose of increasing the ultimate recovery of geothermal resources, as provided. Current law requires the division to be the lead agency for all geothermal exploratory projects for purposes of the California Environmental Quality Act (CEQA), as specified. This bill would repeal the requirement that the division be the lead agency for all geothermal exploratory projects for purposes of CEQA. This bill would declare that it is to take effect immediately as an urgency statute.

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

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

Summary: Current law requires the Medical Board of California, in determining its continuing education requirements, to consider including a course in integrating mental and physical health care in primary care settings, especially as it pertains to early identification of mental health issues and exposure to trauma in children and young adults and their appropriate care and treatment. Current law requires a physician and surgeon to provide notice to patients at an initial

office visit regarding a specified database. Current law requires the State Department of Public Health to license and regulate health facilities, including general acute care hospitals. Current law requires a general acute care hospital to establish and adopt written policies and procedures to screen patients who are 12 years of age and older for purposes of detecting a risk for suicidal ideation and behavior. The Knox-Keene Health Care Service Plan Act of 1975 provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Current law provides for the regulation of health insurers by the Department of Insurance. This bill would require a physician and surgeon, a general acute care hospital, a health care service plan, and a health insurer to provide to each legal guardian of a patient, enrollee, or insured, 10 to 18 years of age, a written or electronic notice regarding the benefits of a behavioral health and wellness screening. The bill would require the providers to provide the notice at least once every 2 years in the preferred method of the legal guardian.

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

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

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

AB 1644 **(Bonta D) Medi-Cal: medically supportive food and nutrition services.**
Current Text: Amended: 4/27/2023 html pdf
Status: 2/1/2024-From committee: Filed with the Chief Clerk pursuant to Joint Rule 56.
Location: 1/18/2024-A. DEAD

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

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

AB 1690 **(Kalra D) Universal health care coverage.**

Current Text: Introduced: 2/17/2023 html pdf
Status: 2/1/2024-Died at Desk.
Location: 1/18/2024-A. DEAD

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

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

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

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

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

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

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

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

AB 1842 **(Reyes D) Health care coverage: Medication-assisted treatment.**
Current Text: Amended: 5/20/2024 html pdf
Status: 6/11/2024-Read second time. Ordered to third reading.
Location: 6/11/2024-S. THIRD READING

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: 6/24/2024 html pdf
Status: 7/3/2024-From committee: Do pass and re-refer to Com. on APPR. (Ayes 9. Noes 2.) (July 3). Re-referred to Com. on APPR.
Location: 7/3/2024-S. APPR.

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

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 operates a perinatal unit and expects challenges in the next 6 months that may result in a reduction or loss of perinatal services, to provide specified information to the Department of Health Care Access and Information, including, but not limited to, the number of medical staff and employees working in the perinatal unit and the hospital's prior performance on financial metrics. The bill would require the Department of Health Care Access and Information to forward the provided information to various entities, including the State Department of Health Care Services. The bill would require this information be kept confidential to the extent permitted by law. The bill would require, within 3 months of receiving this notice from the hospital, the Department of Health Care Access and Information, in conjunction with the State Department of Public Health and the State Department of Health Care Services, to conduct a community impact assessment to identify the 3 closest hospitals operating a perinatal unit, their distance from the challenged facility, and whether those hospitals have any restrictions on their reproductive health services. The bill would require the Department of Health Care Access and Information to provide the community impact assessment to specified entities and would require these entities to keep the community impact assessment confidential. If the hospital closes its perinatal unit, the bill would require the hospital to provide public notice of the closure, including the results of the community impact assessment, and other specified information on the hospital's internet website 90 days in advance of the closure.

AB 1926 **(Connolly D) Health care coverage: regional enteritis.**
Current Text: Amended: 3/19/2024 html pdf
Status: 6/24/2024-In committee: Referred to suspense file.
Location: 6/24/2024-S. APPR. SUSPENSE FILE

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

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

AB 1943 **(Weber D) Medi-Cal: telehealth.**
Current Text: Amended: 6/6/2024 html pdf
Status: 6/17/2024-In committee: Referred to suspense file.
Location: 6/17/2024-S. APPR. SUSPENSE FILE

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

Summary: Under current law, in-person, face-to-face contact is not required under the Medi-Cal program when covered health care services are provided by video synchronous interaction, audio-only synchronous interaction, remote patient monitoring, or other permissible virtual communication modalities, when those services and settings meet certain criteria. This bill would require the State Department of Health Care Services to, by October 1, 2025, produce a public report on telehealth in the Medi-Cal program that includes analyses of, among other things, (1) telehealth access and

utilization, (2) the effect of telehealth on timeliness of, access to, and quality of care, and (3) the effect of telehealth on clinical outcomes, as specified. The bill would authorize the department, in collaboration with the California Health and Human Services Agency, to issue policy recommendations based on the report's findings.

AB 1970 **(Jackson D) Mental Health: Black Mental Health Navigator Certification.**
Current Text: Amended: 6/18/2024 html pdf
Status: 6/24/2024-In committee: Referred to suspense file.
Location: 6/24/2024-S. APPR. SUSPENSE FILE

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. The bill would make these provisions subject to an appropriation by the Legislature.

AB 1975 **(Bonta D) Medi-Cal: medically supportive food and nutrition interventions.**
Current Text: Amended: 6/5/2024 html pdf
Status: 6/24/2024-In committee: Referred to suspense file.
Location: 6/24/2024-S. APPR. SUSPENSE FILE

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

Summary: Current law requires the State Department of Health Care Services to establish the Medically Tailored Meals Pilot Program and the Short-Term Medically Tailored Meals Intervention Services Program, to operate in specified counties and during limited periods for the purpose of providing medically tailored meal intervention services to eligible Medi-Cal beneficiaries with certain health conditions, including congestive heart failure, cancer, diabetes, chronic obstructive pulmonary disease, or renal disease. Current law, subject to implementation of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, authorizes a Medi-Cal managed care plan to elect to cover community supports approved by the department as cost effective and medically appropriate in a comprehensive risk contract that are in lieu of applicable Medi-Cal state plan services. Under current law, community supports that the department is authorized to approve include, among other things, medically supportive food and nutrition services, including medically tailored meals. This bill would make medically supportive food and nutrition interventions, as defined, a covered benefit under the Medi-Cal program, through both the fee-for-service and managed care delivery systems, no sooner than July 1, 2026, upon appropriation and subject to federal approval and the issuance of final guidance by the department. The bill would require those interventions to be covered if determined to be medically necessary by a health care provider or health care plan, as specified. The bill would require the provision of interventions for 12 weeks, or longer if deemed medically necessary. 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: 6/24/2024 html pdf
Status: 6/25/2024-Read second time. Ordered to third reading.
Location: 6/25/2024-S. THIRD READING

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

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

disorder or autism to be reevaluated or receive a new behavioral diagnosis to maintain coverage for behavioral health treatment for their condition. The bill would require a treatment plan to be made available to the plan or insurer upon request. Because a willful violation of this provision by a health care service plan would be a crime, the bill would impose a state-mandated local program.

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

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

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

AB 2043 **(Boerner D) Medi-Cal: nonmedical and nonemergency medical transportation.**
Current Text: Amended: 4/1/2024 html pdf
Status: 6/24/2024-In committee: Referred to suspense file.
Location: 6/24/2024-S. APPR. SUSPENSE FILE

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

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

AB 2063 **(Maienschein D) Health care coverage.**
Current Text: Amended: 6/17/2024 html pdf
Status: 6/24/2024-In committee: Referred to suspense file.
Location: 6/24/2024-S. APPR. SUSPENSE FILE

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

Summary: Current law exempts a health care service plan from the requirements of the Knox-Keene Health Care Service Plan Act of 1975 if the plan is operated by a city, county, city and county, public entity, political subdivision, or public joint labor management trust that satisfies certain criteria, including that the plan requires providers to be reimbursed solely on a fee-for-service basis. Current law authorizes the Director of the Department of Managed Health Care, no later than May 1, 2021, to authorize 2 pilot programs, one in northern California and one in southern California, under which providers approved by the department may undertake risk-bearing arrangements with a voluntary employees' beneficiary association (VEBA) with enrollment of more than 100,000 lives, notwithstanding the fee-for-

service requirement described above, or a trust fund that is a welfare plan and a multiemployer plan with enrollment of more than 25,000 lives, for independent periods of time beginning no earlier than January 1, 2022, to December 31, 2025, inclusive, if certain criteria are met. Current law requires the association or trust fund and each health care provider participating in each pilot program to report to the department information regarding cost savings and clinical patient outcomes compared to a fee-for-service payment model, and requires the department to report those findings to the Legislature no later than January 1, 2027. Current law repeals these provisions on January 1, 2028. This bill would instead authorize the director to authorize one pilot program in southern California, under which providers approved by the department may undertake risk-bearing arrangements with a VEBA, as specified above, if certain criteria are met. The bill would extend that repeal date to January 1, 2030. The bill would extend the period of time authorized for the pilot program to operate from December 31, 2025, to December 31, 2027.

AB 2105 **(Lowenthal D) Coverage for PANDAS and PANS.**
Current Text: Amended: 6/17/2024 html pdf
Status: 6/25/2024-Set for Hearing 7/31/2024
Location: 6/25/2024-S. THIRD READING

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

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

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

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

AB 2115 **(Haney D) Controlled substances: clinics.**

Current Text: Amended: 6/17/2024 html pdf
Status: 7/3/2024-From committee: Do pass and re-refer to Com. on APPR. (Ayes 9. Noes 0.) (July 3). Re-referred to Com. on APPR.
Location: 7/3/2024-S. APPR.

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

AB 2129 **(Petrie-Norris D) Immediate postpartum contraception.**
Current Text: Amended: 7/3/2024 html pdf
Status: 7/3/2024-Action rescinded whereby the bill was read third time, passed, and to Assembly. Ordered to third reading. Read third time and amended. Ordered to second reading.
Location: 7/3/2024-A. SECOND READING

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

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

AB 2132 **(Low D) Health care services: tuberculosis.**
Current Text: Amended: 6/25/2024 html pdf
Status: 7/3/2024-From committee: Do pass and re-refer to Com. on APPR. (Ayes 11. Noes 0.) (July 2). Re-referred to Com. on APPR.
Location: 7/3/2024-S. APPR.

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

Summary: Would require a patient who is 18 years of age or older receiving health care services in a facility, clinic, center, office, or other setting, where primary care services are provided, to be offered the 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 care coverage, except as specified. 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. The bill would prohibit a health care provider that fails to comply with these provisions from being subject to any disciplinary action related to their licensure or certification, or to any civil or criminal liability, for that failure. The bill would require the State Department of Public Health to work with stakeholders to implement these provisions, and to notify primary care facilities about these provisions. The bill would make related findings and declarations.

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

Current Text: Amended: 3/21/2024 html pdf
Status: 6/26/2024-From committee: Do pass and re-refer to Com. on APPR. (Ayes 10. Noes 0.) (June 26). Re-referred to Com. on APPR.
Location: 6/26/2024-S. APPR.

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

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

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

Summary: Current law generally prohibits a person who manufactures a prescription drug from offering in California any discount, repayment, product voucher, or other reduction in an individual's out-of-pocket expenses associated with the individual's health insurance, health care service plan, or other health coverage, including, but not limited to, a copayment, coinsurance, or deductible, for any prescription drug if a lower cost generic drug is covered under the individual's health insurance, health care service plan, or other health coverage on a lower cost-sharing tier that is designated as therapeutically equivalent to the prescription drug manufactured by that person or if the active ingredients of the drug are contained in products regulated by the federal Food and Drug Administration, are available without prescription at a lower cost, and are not otherwise contraindicated for the condition for which the prescription drug is approved. This bill would require a health care service plan, health insurance policy, or pharmacy benefit manager that administers pharmacy benefits for a health care service plan or health insurer to apply any amounts paid by the enrollee, insured, or a third-party patient assistance program for prescription drugs toward the enrollee's or insured's cost-sharing requirement, and would only apply those requirements with respect to enrollees or insureds who have a chronic disease or terminal illness. The bill would limit the application of the section to health care service plans and health insurance policies issued, amended, delivered, or renewed on or after January 1, 2025. The bill would repeal those provisions on January 1, 2035.

AB 2198 **(Flora R) Health information.**
Current Text: Amended: 6/17/2024 html pdf
Status: 6/25/2024-Read second time. Ordered to third reading.
Location: 6/25/2024-S. THIRD READING

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

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, except for Medi-Cal dental managed care contracts, exclude a specialized plan or insurer that issues, sells, renews, or offers a contract or policy covering dental or vision services from the above-

described API requirements, and would instead require a specialized plan or insurer that issues, sells, renews, or offers a contract or policy covering dental or vision services and meets specified enrollment requirements to comply with the above-described API requirements beginning January 1, 2027, or when the final federal rules for impacted payers are implemented, whichever is later.

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

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

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

AB 2237 **(Aguiar-Curry D) Children and youth: transfer of specialty mental health services.**
Current Text: Amended: 6/26/2024 html pdf
Status: 6/26/2024-Read second time and amended. Re-referred to Com. on APPR.
Location: 6/25/2024-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, specialty mental health services include federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services provided to eligible Medi-Cal beneficiaries under 21 years of age. This bill would require, when a child or youth 21 years of age or younger who is receiving Medi-Cal specialty mental health services changes residence from one county to another, the receiving county to provide specialty mental health services to the child or youth, if the transfer of those services from one county to another is not otherwise governed by a process established in statute. The bill also would require the State Department of Health Care Services to collect specified data related to the receipt of specialty mental health services by children and youth who move outside of the county where they originally received specialty mental health services, and to include the data in the department's Medi-Cal specialty mental health services performance dashboard. The bill would require the department to issue guidance, as specified, to define the requirements on a receiving county for the continued provision of specialty mental health services, to coordinate and expedite the transfer of services from one county to another, and reduce the burden on children and youth and their caregivers to reestablish services in the receiving county. The bill would authorize the department to implement, interpret, or make specific its provisions by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, until regulations are adopted, as specified.

AB 2246 **(Ramos D) Medical Practice Act: health care providers: qualified autism service paraprofessionals.**
Current Text: Amended: 3/18/2024 html pdf
Status: 6/27/2024-In committee: Hearing postponed by committee.

Location: 6/17/2024-S. APPR.

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

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: Amended: 6/6/2024 html pdf
Status: 6/17/2024-In committee: Referred to suspense file.
Location: 6/17/2024-S. APPR. SUSPENSE FILE

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

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 until regulations are adopted, and would require the departments to coordinate in the development of guidance and regulations.

AB 2258 **(Zbur D) Health care coverage: cost sharing.**
Current Text: Amended: 6/24/2024 html pdf
Status: 7/1/2024-In committee: Referred to suspense file.
Location: 7/1/2024-S. APPR. SUSPENSE FILE

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

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

AB 2271 **(Ortega D) St. Rose Hospital.**
Current Text: Amended: 6/24/2024 html pdf
Status: 7/1/2024-In committee: Referred to suspense file.
Location: 7/1/2024-S. APPR. SUSPENSE FILE

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

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

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

Desk	Dead	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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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: 6/27/2024 html pdf
Status: 7/3/2024-From committee: Do pass and re-refer to Com. on APPR. (Ayes 10. Noes 1.) (July 2). Re-referred to Com. on APPR.
Location: 7/3/2024-S. 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. Existing law makes legislative findings relating to implicit bias and racial disparities in maternal mortality rates. Current law requires a hospital that provides perinatal care, and an alternative birth center or a primary clinic that provides services as an alternative birth center, to implement an evidence-based implicit bias program, as specified, for all health care providers involved in perinatal care of patients within those facilities. Current law requires the health care provider to complete initial basic training through the program and a refresher course every 2 years thereafter, or on a more frequent basis if deemed necessary by the facility. Current law requires the facility to provide a

certificate of training completion upon request, to accept certificates of completion from other facilities, and to offer training to physicians not directly employed by the facility. Current law requires the 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 specified health care providers at hospitals that provide perinatal care, alternative birth centers, or primary care clinics, as specified. The bill would require an implicit bias program to include recognition of intersecting identities and the potential associated biases. The bill would require initial basic training for the implicit bias program to be completed by June 1, 2025, for current health care providers, and within 6 months of their start date for new health care providers, unless exempted.

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

Desk	Policy	Dead	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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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: 7/2/2024-Read second time. Ordered to third reading.
Location: 7/2/2024-S. THIRD READING

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

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: 6/25/2024-Read second time. Ordered to third reading.
Location: 6/25/2024-S. THIRD READING

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: 4/25/2024-Failed Deadline pursuant to Rule 61(b)(5). (Last location was HEALTH on 2/26/2024)
Location: 4/25/2024-A. DEAD

Desk	Dead	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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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) Mental health and psychiatric advance directives.**
Current Text: Amended: 4/25/2024 html pdf
Status: 7/2/2024-Failed Deadline pursuant to Rule 61(b)(13). (Last location was JUD. on 5/29/2024)
Location: 7/2/2024-S. DEAD

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

Summary: Current law establishes the requirements for executing a written advance health care directive that is legally sufficient to direct health care decisions. Current law provides a form that an individual may use or modify to create an advance health care directive. Under existing law, a written advance health care directive is legally sufficient if specified requirements are satisfied, may be revoked by a patient having capacity at any time, and is revoked to the extent of a conflict with a later executed directive. Current law requires a supervising health care provider who knows of the existence of an advance health care directive or its revocation to record that fact in the patient's health record. Existing law sets forth requirements of witnesses to a written advance health care directive. A written advance health care directive or similar instrument executed in another jurisdiction is valid and enforceable in this state under existing law. A person who intentionally falsifies, forges, conceals, defaces, or obliterates an individual's advance health care directive or its revocation without the individual's consent is subject to liability of up to $10,000 or actual damages, whichever is greater, plus reasonable attorney's fees. Current law authorizes an appeal of specified orders relating to an advance health care directive. Current law generally prohibits involuntary civil placement of a ward, conservatee, or person with capacity in a mental health treatment facility, subject to a valid and effective advance health care directive. Under current law, an advance psychiatric directive is a legal document, executed on a voluntary basis by a person who has the capacity to make medical decisions and in accordance with the requirements for an advance health care directive, that allows a

person with mental illness to protect their autonomy and ability to direct their own care by documenting their preferences for treatment in advance of a mental health crisis. An individual may execute both an advance health care directive and a voluntary standalone psychiatric advance directive. This bill would extend the above-described advance health care directive provisions to psychiatric advance directives and would make conforming changes. The bill would specify that a psychiatric advance directive is a legal written or digital document, executed as specified, that allows a person with behavioral health illness to document their preferences for treatment and identify a health care advocate in advance of a behavioral health crisis.

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

Desk	Policy	Dead	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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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: 7/3/2024 html pdf
Status: 7/3/2024-From committee: Amend, and do pass as amended and re-refer to Com. on APPR with recommendation: To Consent Calendar. (Ayes 11. Noes 0.) (July 3). Read second time and amended. Re-referred to Com. on APPR.
Location: 7/3/2024-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 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. Current 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. The bill would delete the requirement for chemical dependency recovery as a supplemental service to be provided in a distinct part of a general acute care hospital or acute psychiatric hospital, and instead would authorize those facilities to provide chemical dependency recovery services within the same building or in a separate building on campus that meets specified structural requirements of a

freestanding chemical dependency recovery hospital.

AB 2446 **(Ortega D) Medi-Cal: diapers.**
Current Text: Amended: 5/16/2024 html pdf
Status: 6/26/2024-From committee: Do pass and re-refer to Com. on APPR. (Ayes 11. Noes 0.) (June 26). Re-referred to Com. on APPR.
Location: 6/26/2024-S. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed by, and funded pursuant to, federal Medicaid program provisions. Existing law establishes a schedule of covered benefits under the Medi-Cal program, including incontinence supplies.This bill would add to the schedule of Medi-Cal benefits diapers for infants or toddlers with certain conditions, such as a urinary tract infection and diseases of the skin. 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 limit the diapers provided pursuant to these provisions to an appropriate supply based on the diagnosed condition and the age of the beneficiary. 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: Amended: 6/3/2024 html pdf
Status: 6/17/2024-In committee: Referred to suspense file.
Location: 6/17/2024-S. APPR. SUSPENSE FILE

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 another national accrediting entity approved by the Secretary of California Health and Human Services.

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

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

information establishing that the plan was unable to deliver timely, available, or accessible health care services to enrollees, as specified. Under the bill, failure to comply with the appointment time standard may result in contract termination or the issuance of sanctions as described above.

AB 2467 **(Bauer-Kahan D) Health care coverage for menopause.**
Current Text: Amended: 6/26/2024 html pdf
Status: 7/3/2024-From committee: Do pass and re-refer to Com. on APPR. (Ayes 9. Noes 0.) (July 3). Re-referred to Com. on APPR.
Location: 7/3/2024-S. APPR.

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, except for a specialized contract or policy, that is issued, amended, or renewed on or after January 1, 2025, to include coverage for evaluation and treatment options for perimenopause and menopause. The bill would require a health care service plan or health insurer to annually provide clinical care recommendations, as specified, for hormone therapy to all contracted primary care providers who treat individuals with perimenopause and menopause. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

AB 2556 **(Jackson D) Behavioral health and wellness screenings: notice.**
Current Text: Amended: 6/11/2024 html pdf
Status: 6/20/2024-Read third time. Passed. Ordered to the Assembly. (Ayes 36. Noes 0.). In Assembly. Concurrence in Senate amendments pending. May be considered on or after June 22 pursuant to Assembly Rule 77.
Location: 6/20/2024-A. CONCURRENCE

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, except as specified, or health insurer to provide to enrollees and insureds a written or electronic notice regarding the benefits of a behavioral health and wellness screening, as defined, for children and adolescents 8 to 18 years of age. The bill would require a health care service plan or insurer to provide the notice annually. Because a violation of the bill's requirements relative to a health care service plan would be crimes, the bill would impose a state-mandated local program.

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

Desk	Policy	Dead	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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: 5/16/2024-Failed Deadline pursuant to Rule 61(b)(8). (Last location was APPR. SUSPENSE FILE on 5/15/2024)
Location: 5/16/2024-A. DEAD

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

AB 2701 **(Villapudua D) Medi-Cal: dental cleanings and examinations.**
Current Text: Amended: 6/17/2024 html pdf
Status: 6/24/2024-In committee: Referred to suspense file.
Location: 6/24/2024-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, one dental prophylaxis cleaning per year and one initial dental examination by a dentist are covered Medi-Cal benefits for beneficiaries 21 years of age or older. Under existing law, 2 dental prophylaxis cleanings per year and 2 periodic dental examinations per year are covered Medi-Cal benefits for beneficiaries under 21 years of age. Current law conditions implementation of those provisions on receipt of any necessary federal approvals, the availability of federal financial participation, and, for beneficiaries 21 years of age or older, funding in the annual Budget Act. This bill would expand the above-described dental benefits, for beneficiaries 21 years of age or older, to at least 2 cleanings and at least 2 examinations per year when medically necessary, as specified in the Medi-Cal Dental Manual of Criteria. The bill would, for purposes of these provisions, include an individual's inability to maintain daily oral hygiene habits, susceptibility to oral health disease or decay, preoperative dental care, or as required by other specified provisions of law, in the definition of "medically necessary," and require the department to update the Medi-Cal Dental Manual of Criteria to conform with this inclusion.

AB 2703 **(Aguiar-Curry D) Federally qualified health centers and rural health clinics: psychological associates.**
Current Text: Introduced: 2/14/2024 html pdf
Status: 7/1/2024-In committee: Referred to suspense file.
Location: 7/1/2024-S. APPR. SUSPENSE FILE

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

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

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

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

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

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: Amended: 7/3/2024 html pdf
Status: 7/3/2024-From committee: Amend, and do pass as amended and re-refer to Com. on APPR with recommendation: To Consent Calendar. (Ayes 11. Noes 0.) (July 3). Read second time and amended. Re-referred to Com. on APPR.
Location: 7/3/2024-S. APPR.

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

Summary: Current law requires a victim of sexual assault who seeks a medical evidentiary examination to be provided with one, as specified. Current law prohibits costs incurred by a qualified health care professional, hospital, clinic, sexual assault forensic examination team, or other emergency medical facility for the medical evidentiary examination portion of the examination of the victim of a sexual assault, as described in a specified protocol, when the examination is performed as specified, from being charged directly or indirectly to the victim of the assault. This bill 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 followup 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 2914 **(Bonta D) Health care coverage: essential health benefits.**
Current Text: Amended: 4/10/2024 html pdf
Status: 7/3/2024-From committee: Do pass and re-refer to Com. on APPR with recommendation: To Consent Calendar. (Ayes 11. Noes 0.) (July 3). Re-referred to Com. on APPR.
Location: 7/3/2024-S. APPR.

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

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

AB 2930 **(Bauer-Kahan D) Automated decision tools.**
Current Text: Amended: 7/3/2024 html pdf
Status: 7/3/2024-From committee: Amend, and do pass as amended and re-refer to Com. on APPR. (Ayes 9. Noes 2.) (July 2). Read second time and amended. Re-referred to Com. on APPR.
Location: 7/3/2024-S. APPR.

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

Summary: The Unruh Civil Rights Act provides that all persons within the jurisdiction of this state are free and equal and, regardless of their sex, race, color, religion, ancestry, national origin, disability, medical condition, genetic information, marital status, sexual orientation, citizenship, primary language, or immigration status, are entitled to the full and equal accommodations, advantages, facilities, privileges, or services in all business establishments of every kind whatsoever. The California Fair Employment and Housing Act establishes the Civil Rights Department within the Business, Consumer Services, and Housing Agency and requires the department to, among other things, bring civil actions to enforce the act. Existing law, the California Consumer Privacy Act of 2018 (CCPA), grants to a consumer various rights with respect to personal information, as defined, that is collected by a business, as defined, including the right to request that a business delete personal information about the consumer that the business has collected from the consumer. This bill would, among other things, require, as prescribed, a deployer, as defined, and a developer of an automated decision tool, as defined, to perform an impact assessment on any automated decision tool before the tool is first deployed and annually thereafter that includes, among other things, a statement of the purpose of the automated decision tool and its intended benefits, uses, and deployment contexts. The bill would require a deployer or developer to provide the impact assessment to the California Privacy Protection Agency within 30 days of a request by the agency and would punish a violation of that provision with an administrative fine of not more than $10,000 to be recovered in an administrative enforcement action brought by the agency. The bill would exempt an impact assessment from the California Public Records Act, as specified. This bill would require the California Privacy Protection Agency to, by January 1, 2027, establish a staggered schedule that identifies when each state government deployer, as defined, is required to comply with specified deployer requirements for each deployed automated decision tool.

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

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

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

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

Dead	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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: 6/27/2024 html pdf
Status: 6/27/2024-Read second time and amended. Re-referred to Com. on APPR.
Location: 6/26/2024-S. APPR.

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

Summary: The Medical Practice Act establishes the Medical Board of California for the licensing, regulation, and discipline of physicians and surgeons. The Osteopathic Act, enacted by an initiative measure, establishes the Osteopathic Medical Board of California for the licensing and regulation of osteopathic physicians and surgeons. This bill would require a health facility, clinic, physician's office, or office of a group practice that uses generative artificial intelligence to generate written or verbal patient communications pertaining to patient clinical information, as defined, to ensure that those communications include both (1) a disclaimer that indicates to the patient that a communication was generated by generative artificial intelligence, as specified, and (2) clear instructions describing how a patient may contact a human health care provider, as specified. The bill would exempt from this requirement a communication read and reviewed by a human licensed or certified health care provider. Under the bill, a violation of these provisions by a physician would be subject to the jurisdiction of the Medical Board of California or Osteopathic Medical Board of California, as appropriate.

AB 3059 **(Weber D) Human milk.**
Current Text: Amended: 6/17/2024 html pdf
Status: 6/26/2024-From committee: Do pass and re-refer to Com. on APPR. (Ayes 11. Noes 0.) (June 26). Re-referred to Com. on APPR.

Location: 6/26/2024-S. APPR.

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

Summary: Current law licenses and regulates tissue banks and generally makes a violation of the requirements applicable to tissue banks a crime. This bill would specify that a general acute care hospital is not required to have a license to operate a tissue bank to store or distribute pasteurized donor human milk that was obtained from a tissue bank licensed by the State Department of Public Health.

AB 3129 **(Wood D) Health care system consolidation.**
Current Text: Amended: 6/27/2024 html pdf
Status: 7/3/2024-From committee: Do pass and re-refer to Com. on APPR. (Ayes 9. Noes 2.) (July 2). Re-referred to Com. on APPR.
Location: 7/3/2024-S. APPR.

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

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

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

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

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

lived experience with using and navigating Promotores or Promotoras services and the Medi-Cal program.

AB 3156 **(Patterson, Joe R) Medi-Cal managed care plans: regional center services: beneficiaries with other primary coverage.**
Current Text: Amended: 7/3/2024 html pdf
Status: 7/3/2024-From committee: Amend, and do pass as amended and re-refer to Com. on APPR. (Ayes 11. Noes 0.) (July 3). Read second time and amended. Re-referred to Com. on APPR.
Location: 7/3/2024-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 federal law, in accordance with third-party liability rules, Medicaid is generally the payer of last resort if a beneficiary has another source of health care coverage in addition to Medicaid coverage. Under the bill, in the case of a Medi-Cal managed care plan enrollee who has other health coverage, as specified, the department would be required to ensure that a provider billing the managed care plan for allowable costs not paid by the other health care coverage does not face administrative requirements significantly in excess of the administrative requirements for billing those same costs to the Medi-Cal fee-for-service delivery system.

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

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

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

AB 3221 **(Pellerin D) Department of Managed Health Care: review of records.**
Current Text: Amended: 6/17/2024 html pdf
Status: 6/25/2024-Read second time. Ordered to third reading.
Location: 6/25/2024-S. THIRD READING

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

Summary: The Knox-Keene Health Care Service Plan Act of 1975 provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Current law requires the records, books, and papers of a health care service plan and other specified entities to be open to inspection by the director of the department during normal business hours. This bill would instead require the records, books, and papers of a health care service plan and other specified entities to be open to inspection by the director, including through electronic means. The bill would require a plan and other specified entities to furnish in electronic media records, books, and papers that are possessed in electronic media and to conduct a diligent review of records, books, and papers and make every effort to furnish those responsive to the director's request. The bill would require records, books, and papers to be furnished in a format that is digitally searchable, to the greatest extent feasible. The bill would require records, books, and papers to be preserved until furnished, if requested by the department. 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.

AB 3245 **(Patterson, Joe R) Coverage for colorectal cancer screening.**
Current Text: Amended: 6/10/2024 html pdf
Status: 6/17/2024-In committee: Referred to suspense file.
Location: 6/17/2024-S. APPR. SUSPENSE FILE

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

Summary: Current law provides for the regulation of health insurers by the Department of Insurance. Current law generally requires a health care service plan contract or a health insurance policy issued, amended, or renewed on or after January 1, 2022, to provide coverage without cost sharing for a colorectal cancer screening test, and for a colorectal cancer screening examination in specified circumstances, assigned either a grade of A or a grade of B by the United States Preventive Services Task Force. This bill would additionally require that coverage if the test or screening examination is assigned either a grade of A or a grade of B, or equivalent, in accordance with the most current recommendations established by another accredited or certified guideline agency approved by the California Health and Human Services Agency.

AB 3260 **(Pellerin D) Health care coverage: reviews and grievances.**
Current Text: Amended: 6/27/2024 html pdf
Status: 6/27/2024-Read second time and amended. Re-referred to Com. on APPR.
Location: 6/26/2024-S. APPR.

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

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

AB 3275 **(Soria D) Health care coverage: claim reimbursement.**
Current Text: Amended: 6/27/2024 html pdf
Status: 6/27/2024-Read second time and amended. Re-referred to Com. on APPR.
Location: 6/26/2024-S. APPR.

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

Summary: Current law requires a health insurer or health care service plan, including a specialized health care service plan, to reimburse a claim or portion of a claim no later than 30 working days after receipt of the claim, unless the plan contests or denies the claim, in which case the plan is required to notify the claimant within 30 working days that the claim is contested or denied. Under current law, if a claim or portion thereof is contested on the basis that a health insurer or health care service plan has not received all information necessary to determine payer liability for the claim or portion thereof and notice has been provided, the health insurer or health care service plan has 30 working days after receipt of the additional information to complete reconsideration of the claim. Current law extends these timelines to 45 working days for a health care service plan that is a health maintenance organization. Under current law, if a claim is not reimbursed, contested, or denied pursuant to these timelines, as specified, interest accrues at a rate of 15% per annum for a health care service plan and 10% per annum for a health insurer. Commencing January 1, 2026, this bill instead would require a health care service plan or health insurer to reimburse a clean claim or a portion thereof within 30 calendar days

after receipt of the claim, or, if a claim does not meet the criteria for a clean claim, to notify the claimant within 30 calendar days that the claim is contested or denied. The bill would require the Department of Managed Health Care and the Department of Insurance to determine the criteria for a clean claim, as specified, no later than July 31, 2025. The bill would authorize the departments to issue guidance and amend regulations related to these provisions. The bill would exempt the guidance and amendments from the Administrative Procedure Act until December 31, 2027.

SB 70 **(Wiener D) Prescription drug coverage.**
Current Text: Amended: 6/29/2023 html pdf
Status: 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-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	Floor	Conf.	Enrolled	Vetoed	Chaptered

						year		Conc.			
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: 5/24/2024 html pdf
Status: 7/2/2024-July 2 set for first hearing. Placed on suspense file.
Location: 7/2/2024-A. APPR. SUSPENSE FILE

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 disability insurers by the Department of Insurance. Current law establishes the Independent Medical Review System within each department, under which an enrollee or insured may seek review if a

health care service has been denied, modified, or delayed by a health care service plan or disability insurer and the enrollee or insured has previously filed a grievance that remains unresolved after 30 days. This bill, commencing January 1, 2026, would require a health care service plan or a disability insurer that upholds its decision to modify, delay, or deny a health care service in response to a grievance or has a grievance that is otherwise pending or unresolved upon expiration of the relevant timeframe to automatically submit within 24 hours a decision regarding a disputed health care service to the Independent Medical Review System, as well as the information that informed its decision, if the decision is to deny, modify, or delay specified services relating to mental health or substance use disorder conditions for an enrollee or insured up to 26 years of age. The bill would require a health care service plan or disability insurer, within 24 hours after submitting its decision to the Independent Medical Review System to provide notice to the appropriate department, the enrollee or insured or their representative, if any, and the enrollee's or insured's provider.

SB 299 **(Limón D) Voter registration: California New Motor Voter Program.**
Current Text: Amended: 6/27/2024 html pdf
Status: 7/2/2024-From committee: Do pass and re-refer to Com. on APPR. (Ayes 10. Noes 4.) (July 1). Re-referred to Com. on APPR.
Location: 7/2/2024-A. APPR.

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

Summary: Current law requires, in conformance with federal law, that the Secretary of State and the Department of Motor Vehicles establish and implement the California New Motor Voter Program for the purpose of increasing opportunities for voter registration for qualified voters. Current law requires the department to transmit to the Secretary of State specified information related to a person's eligibility to vote, which the person provides when applying for a driver's license or identification card or when the person notifies the department of an address change. Current law requires that if this information transmitted to the Secretary of State constitutes a completed affidavit of registration, the Secretary of State must register or preregister the person to vote, as applicable, unless the person affirmatively declines to register or is ineligible to vote, as specified. This bill would require the Secretary of State and the department to develop a process for the department to use information from the statewide voter registration database to determine whether a person who submits a driver's application is already registered or preregistered to vote in the state. The bill would require the department, based upon this determination, to transmit specified information provided by the person during their transaction with the department to the Secretary of State for the purpose of registering or preregistering that person to vote or to update their registration information. The bill would prohibit the department from providing a person the opportunity to attest to meeting voter eligibility requirements when they submit a driver's license application, if the person provides a document to the department during the transaction demonstrating that the person is not a United States citizen.

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) The Broadband Infrastructure Grant Account and Federal Funding Account.**
Current Text: Amended: 7/2/2024 html pdf
Status: 7/2/2024-Read second time and amended. Re-referred to Com. on APPR.
Location: 6/26/2024-A. APPR.

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

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

SB 427 **(Portantino D) Health care coverage: antiretroviral drugs, drug devices, and drug products.**
Current Text: Amended: 4/4/2024 html pdf
Status: 5/13/2024-Ordered to the Assembly. In Assembly. Held at Desk.
Location: 5/13/2024-A. DESK

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-Re-referred to Com. on APPR. pursuant to Assembly Rule 96. (Set for hearing on 08/07/2024)
Location: 8/1/2024-A. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	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 537 **(Becker D) Department of General Services: memorial to forcibly deported Mexican Americans and Mexican immigrants.**
Current Text: Amended: 6/10/2024 html pdf
Status: 7/2/2024-Failed Deadline pursuant to Rule 61(b)(13). (Last location was G.O. on 6/10/2024)
Location: 7/2/2024-A. DEAD

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

Summary: Current law, the Apology Act for the 1930s Mexican Repatriation Program, makes findings and declarations regarding the unconstitutional removal and coerced emigration of United States citizens and legal residents of Mexican descent, between the years 1929 and 1944, to Mexico from the United States during the 1930s "Mexican Repatriation" Program. Current law expresses the apology of the State of California to those individuals who were illegally deported and coerced into emigrating to Mexico and requires that a plaque to commemorate those individuals be installed and maintained by the Department of Parks and Recreation in an appropriate public place in Los Angeles. This bill would authorize a nonprofit organization representing Mexican Americans or Mexican immigrants, in consultation with the Department of General Services, to plan, construct, and maintain a memorial to Mexican Americans and Mexican immigrants who were forcibly deported from the United States during the Great Depression, as provided. The bill would require the nonprofit organization to submit a plan for the memorial to the department for its review and approval. The bill would require the memorial to be located at an appropriate public place in Los Angeles.

SB 551 **(Portantino D) Beverage containers: recycling.**
Current Text: Amended: 3/21/2024 html pdf
Status: 6/19/2024-June 19 set for first hearing. Placed on suspense file.
Location: 6/19/2024-A. APPR. SUSPENSE FILE

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-September 1 hearing postponed by committee. (Set for hearing on 08/15/2024)
Location: 8/1/2024-A. APPR. SUSPENSE FILE

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	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: Amended: 7/3/2024 html pdf
Status: 7/3/2024-From committee: Do pass as amended and re-refer to Com. on APPR. (Ayes 10. Noes 0.) (July 2). Read second time and amended. Re-referred to Com. on APPR.
Location: 7/2/2024-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 (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. This bill would additionally require a pharmacy benefit manager, as defined, to apply for and obtain a license from the Department of Insurance to operate as a pharmacy benefit manager no later than January 1, 2027. The bill would establish application qualifications and requirements, and would require initial license and renewal fees to be collected into the newly created Pharmacy Benefit Manager Account in the Insurance Fund, to be available to the department for use, upon appropriation by the Legislature, as specified, for costs related to licensing and regulating pharmacy benefit managers. This bill would require a pharmacy benefit manager to file with the department at specified annual intervals 2 reports, one of which discloses product benefits specific to the purchaser, and the other of which includes information about categories of drugs and the pharmacy benefit manager's contracts and revenues.

SB 980 **(Wahab D) The Smile Act.**
Current Text: Amended: 6/10/2024 html pdf
Status: 6/19/2024-From committee: Do pass and re-refer to Com. on APPR. (Ayes 16. Noes 0.) (June 18). Re-referred to

Com. on APPR.
Location: 6/18/2024-A. APPR.

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 current law, for persons 21 years of age or older, laboratory-processed crowns on posterior teeth are a covered benefit when medically necessary to restore a posterior tooth back to normal function based on the criteria specified in the Medi-Cal Dental Manual of Criteria. This bill, The Smile Act, for purposes of the above-described Medi-Cal coverage for laboratory-processed crowns, would remove the condition that the tooth be posterior and would apply the coverage to persons 13 years of age or older. The bill would also add, as a covered Medi-Cal benefit for persons of any age, subject to prior authorization, a dental implant if tooth extraction or removal is medically necessary or if the corresponding tooth is missing. The bill would condition this coverage on there being no other covered functional alternatives for prosthetic replacement to correct the person's dental condition, as specified, on the person being without medical conditions for which dental implant surgery would be contraindicated, on receipt of any necessary federal approvals, and on the availability of federal financial participation.

SB 999 **(Cortese D) Health coverage: mental health and substance use disorders.**
Current Text: Amended: 4/8/2024 html pdf
Status: 6/12/2024-From committee: Do pass and re-refer to Com. on APPR. (Ayes 14. Noes 1.) (June 11). Re-referred to Com. on APPR.
Location: 6/11/2024-A. APPR.

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: 4/29/2024 html pdf
Status: 5/16/2024-Failed Deadline pursuant to Rule 61(b)(8). (Last location was APPR. SUSPENSE FILE on 5/6/2024)
Location: 5/16/2024-S. DEAD

Desk	Policy	Dead	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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 specified coverage for the treatment of obesity, including coverage for at least one FDA-approved antiobesity medication.

SB 1017 **(Eggman D) Available facilities for inpatient and residential mental health or substance use disorder treatment.**
Current Text: Introduced: 2/5/2024 html pdf
Status: 5/16/2024-May 16 hearing: Held in committee and under submission.
Location: 4/15/2024-S. APPR. SUSPENSE FILE

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 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: 5/16/2024 html pdf
Status: 6/26/2024-From committee: Do pass and re-refer to Com. on APPR. with recommendation: To consent calendar. (Ayes 6. Noes 0.) (June 25). Re-referred to Com. on APPR.
Location: 6/25/2024-A. APPR.

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

Summary: Current law establishes a system of childcare and development services, administered by the State Department of Social Services, for children from infancy to 13 years of age. Existing law authorizes, upon departmental approval, the use of appropriated funds for alternative payment programs to allow for maximum parental choice. Current law authorizes those programs to include, among other things, a subsidy that follows the family from one childcare provider to another, or choices among hours of service. Current law requires the department to contract with local contracting agencies for alternative payment programs so that services are provided throughout the state. Under existing law, early and periodic screening, diagnostic, and treatment (EPSDT) services are covered Medi-Cal benefits for individuals under 21 years of age. 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 authorize 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: 7/8/2024 html pdf
Status: 7/8/2024-From committee: Do pass as amended and re-refer to Com. on APPR. with recommendation: To consent calendar. (Ayes 11. Noes 0.) (July 2). Read second time and amended. Re-referred to Com. on APPR. (Amended text released 7/10/2024)
Location: 7/2/2024-A. APPR.

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

Summary: Current law generally authorizes a health care service plan or disability insurer to use prior authorization and other utilization review or utilization management functions, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. Current law requires a health care service plan or disability insurer, including those plans or insurers that delegate utilization review or utilization management functions to medical groups, independent practice associations, or to other contracting providers, to comply with specified requirements and limitations on their utilization review or utilization management functions. Current law 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 disability insurer, as applicable, for failure to comply with those requirements. This bill would require a health care service plan or disability insurer, including a specialized health care service plan or specialized health insurer, that uses an artificial intelligence, algorithm, or other software tool for the purpose of utilization review or utilization management functions, or that contracts with or otherwise works through an entity that uses that type of tool, to ensure compliance with specified requirements, including that the tool bases its determination on specified information and is 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.

SB 1131 **(Gonzalez D) Medi-Cal providers: family planning.**
Current Text: Amended: 5/16/2024 html pdf
Status: 6/19/2024-June 19 set for first hearing. Placed on suspense file.
Location: 6/19/2024-A. APPR. SUSPENSE FILE

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, the Family Planning, Access, Care, and Treatment (Family PACT) Program, administered by the Office of Family Planning within the department. Under Family PACT, comprehensive clinical family planning services are provided to a person who has a family income at or below 200% of the federal poverty level and who meets other eligibility criteria to receive those services. Current law makes the Family PACT Program inoperative if the program is determined to no longer be cost effective, as specified. If the program becomes inoperative, existing law requires all persons who have received, or are eligible to receive, comprehensive clinical family planning services pursuant to Family PACT to receive family planning services under other specified provisions of the Medi-Cal program or under the State-Only Family Planning Program, which is also established within the department. Current law requires enrolled providers in the Family PACT Program or the State-Only Family Planning Program to attend a specific orientation approved by the department and requires providers who conduct certain services to have prior training in those services. This bill would, for both of the above-described programs, require the department to allow a provider a minimum of 6 months from the date of enrollment to complete the orientation. The bill would, for the Family PACT Program, require a site certifier of a primary care clinic or affiliate primary care clinic, as those terms are defined, to be a clinician who oversees the provision of Family PACT services and would authorize certain clinic corporations to enroll multiple service addresses under a single site certifier. The bill would require any orientation or training that the department requires of a site certifier to comply with specified requirements, including, among others, being offered through a virtual platform and being offered at least once per month.

SB 1180 **(Ashby D) Health care coverage: emergency medical services.**
Current Text: Amended: 6/24/2024 html pdf
Status: 6/24/2024-Read second time and amended. Re-referred to Com. on APPR.
Location: 6/18/2024-A. APPR.

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

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

SB 1213 **(Atkins D) Health care programs: cancer.**
Current Text: Amended: 4/8/2024 html pdf
Status: 6/5/2024-From committee: Do pass and re-refer to Com. on APPR. (Ayes 14. Noes 0.) (June 4). Re-referred to Com. on APPR.
Location: 6/4/2024-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 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: Amended: 4/29/2024 html pdf
Status: 5/16/2024-Failed Deadline pursuant to Rule 61(b)(8). (Last location was APPR. SUSPENSE FILE on 5/13/2024)
Location: 5/16/2024-S. DEAD

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

Summary: Current federal law specifies different parts of Medicare that cover specific services, such as Medicare Part B, which generally covers medically necessary services and supplies and preventive services. The Knox-Keene Health Care Service Plan Act of 1975 provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Current federal law additionally provides for the issuance of Medicare supplement policies or certificates, also known as Medigap coverage, which are advertised, marketed, or designed primarily as a supplement to reimbursements under the Medicare Program for the hospital, medical, or surgical expenses of persons eligible for the Medicare Program, including coverage of Medicare deductible, copayment, or coinsurance amounts, as specified. Current law, among other provisions, requires supplement benefit plans to be uniform in structure, language, designation, and format with the standard benefit plans, as prescribed. Current law prohibits an issuer from denying or conditioning the offering or effectiveness of any Medicare supplement contract, policy, or certificate available for sale in this state, or discriminating in the pricing of a contract, policy, or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application that is submitted prior to or during the 6-month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Current law requires an issuer to make available specified Medicare supplement benefit plans to a qualifying applicant under those circumstances who is 64 years of age or younger who does not have end stage renal disease. This bill would delete the exclusion of otherwise qualified applicants who have end stage renal disease, thereby making the specified Medicare supplement benefit plans available to those individuals. The bill, on and after January 1, 2025, would prohibit an issuer of Medicare supplement coverage in this state from denying or conditioning the issuance or effectiveness of any Medicare supplement coverage available for sale in the state, or discriminate in the pricing of that coverage because of the health status, claims experience, receipt of health care, medical condition, or age of an applicant, if an application for coverage is submitted during an open enrollment period, as specified in the bill.

SB 1258 **(Dahle R) Medi-Cal: unrecovered payments: interest rate.**
Current Text: Amended: 4/8/2024 html pdf
Status: 6/26/2024-From committee: Do pass and re-refer to Com. on APPR. with recommendation: To consent calendar. (Ayes 16. Noes 0.) (June 25). Re-referred to Com. on APPR.
Location: 6/25/2024-A. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Current law requires the Director of Health Care Services to establish administrative appeal processes to review grievances or complaints arising from the findings of an audit or examination. Under current law, if recovery of a disallowed payment has been made by the department, a provider who prevails in an appeal of that payment is entitled to interest at the rate equal to the monthly average received on investments in the Surplus Money Investment Fund, or simple interest at the rate of 7% per annum, whichever is higher. Under current law, with exceptions, interest at that same rate is assessed against any unrecovered overpayment due to the department. In the case of an assessment against any unrecovered overpayment due to the department, this bill would authorize the department to waive the interest, as part of a repayment agreement entered into with the provider, if the unrecovered overpayment occurred 4 or more years before the issuance of the first statement of account status or demand for repayment, after taking into account specified factors, including the impact of the repayment amounts on the fiscal solvency of the provider, and whether the overpayment was caused by a policy change or departmental error that was not the fault of the billing provider.

SB 1268 **(Nguyen R) Medi-Cal managed care plans: contracts with safety net providers.**

Current Text: Amended: 4/15/2024 html pdf
Status: 4/25/2024-Failed Deadline pursuant to Rule 61(b)(5). (Last location was HEALTH on 4/3/2024)
Location: 4/25/2024-S. DEAD

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

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

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

SB 1290 **(Roth D) Health care coverage: essential health benefits.**
Current Text: Introduced: 2/15/2024 html pdf
Status: 6/26/2024-From committee: Do pass and re-refer to Com. on APPR. with recommendation: To consent calendar. (Ayes 16. Noes 0.) (June 25). Re-referred to Com. on APPR.
Location: 6/25/2024-A. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Would express the intent of the Legislature to review California's essential health benefits benchmark plan and establish a new benchmark plan for the 2027 plan year. The bill would limit the applicability of the current benchmark plan benefits to plan years on or before the 2027 plan year. This bill contains other related provisions and other existing laws.

SB 1300 **(Cortese D) Health facility closure: public notice: inpatient psychiatric and maternity services.**
Current Text: Amended: 6/20/2024 html pdf
Status: 7/3/2024-Read second time. Ordered to third reading.
Location: 7/3/2024-A. THIRD READING

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

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law provides for the regulation of disability insurers by the Department of Insurance. Current law requires a health care service plan contract or disability insurance policy issued, amended, or renewed on or after January 1, 2021, to provide coverage for medically necessary treatment of mental health and substance use disorders, as defined, under the same terms and conditions applied to other medical conditions. This bill would require a plan or insurer subject to the above-described coverage requirement, and its delegates, to establish a process to reimburse providers for mental health and substance use disorder treatment services that are integrated with primary care services and provided under a contract or policy issued, amended, or renewed on or after July 1, 2025. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

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

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

SB 1354 **(Wahab D) Long-term health care facilities: payment source and resident census.**
Current Text: Amended: 6/17/2024 html pdf
Status: 6/26/2024-Coauthors revised. From committee: Do pass and re-refer to Com. on APPR. (Ayes 16. Noes 0.) (June 25). Re-referred to Com. on APPR.
Location: 6/25/2024-A. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Current law prohibits a long-term health care facility that participates as a provider under the Medi-Cal program from discriminating against a Medi-Cal patient on the basis of the source of payment for the facility's services that are required to be provided to individuals entitled to services under the Medi-Cal program. Current law prohibits that facility from seeking to evict out of the facility, or transfer within the facility, any resident as a result of the resident changing their manner of purchasing the services from private payment or Medicare to Medi-Cal, except as specified. This bill would require the facility 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: 4/25/2024 html pdf
Status: 5/16/2024-Failed Deadline pursuant to Rule 61(b)(8). (Last location was APPR. SUSPENSE FILE on 5/6/2024)
Location: 5/16/2024-S. DEAD

Desk	Policy	Dead	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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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: 4/15/2024 html pdf
Status: 6/19/2024-From committee: Do pass and re-refer to Com. on APPR. with recommendation: To consent calendar. (Ayes 16. Noes 0.) (June 18). Re-referred to Com. on APPR.
Location: 6/18/2024-A. APPR.

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

SB 1423 **(Dahle R) Medi-Cal: Rural Hospital Technical Advisory Group.**
Current Text: Amended: 6/27/2024 html pdf
Status: 6/27/2024-Read second time and amended. Re-referred to Com. on APPR.
Location: 6/25/2024-A. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	Fiscal	Floor	Conf. Conc.	Enrolled	Vetoed	Chaptered
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Summary: Would require the State Department of Health Care Services to convene a Rural Hospital Technical Advisory Group, with a certain composition of stakeholders, at least bimonthly during the 2025 calendar year. The bill would set forth the purposes of the advisory group, including, among other things, analyzing the continued ability of small, rural, or critical access hospitals, as defined, to remain financially viable under existing Medi-Cal reimbursement methodologies, to provide related recommendations, and to identify key contributors to the financial challenges of those hospitals, as specified.The bill would require, by March 31, 2026, the department, in consultation with the advisory group, to report to the Legislature on the findings and recommendations arising out of the convenings, as specified.

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

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

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

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

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