Board of Governors

Regular Meeting

Friday, May 10th, 2024
12:00 p.m. – 2:00 p.m.

Video Conference Call and

1240 South Loop Road, Alameda, CA 94502

ALAMEDA Alliance FOR HEALTH
Health care you can count on.
Service you can trust.

AGENDA

BOARD OF GOVERNORS
Regular Meeting
Friday, May 10th, 2024
12:00 p.m. – 2:00 p.m.

In-Person and Video Conference Call

1240 S. Loop Road
Alameda, CA 94502

and

7830 MacArthur Blvd.
Oakland, CA 94605

PUBLIC COMMENTS: Public Comments can be submitted for any agendized item or for any item not listed on the agenda, by mailing your comment to: “Attn: Clerk of the Board,” 1240 S. Loop Road, Alameda, CA 94502 or by emailing the Clerk of the Board at brmartinez@alamedaalliance.org. You may attend meetings in person or by computer by logging in to the following link: Click here to join the meeting. You may also listen to the meeting by calling in to the following telephone number: 1-510-210-0967 conference 728716599#. If you use the link and participate via computer, you may use the chat function, and request an opportunity to speak on any agendized item, including general public comment. Your request to speak must be received before the item is called on the agenda. If you participate by telephone, please submit your comments to the Clerk of the Board at the email address listed above or by providing your comments during the meeting at the end of each agenda item. Oral comments to address the Board of Governors are limited to three (3) minutes per person. Whenever possible, the board would appreciate it if public comment communication was provided prior to the commencement of the meeting.

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

1. CALL TO ORDER

(A regular meeting of the Alameda Alliance for Health Board of Governors will be called to order on May 10th, 2024, at 12:00 p.m. in Alameda County, California, by Rebecca Gebhart, Presiding Officer. This meeting is to take place in person and by video conference call)

2. ROLL CALL

3. AGENDA APPROVAL

4. INTRODUCTIONS

5. CONSENT CALENDAR

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

a) MARCH 8th, 2024, COMPLIANCE ADVISORY COMMITTEE MEETING MINUTES

b) MARCH 8th, 2024, BOARD OF GOVERNORS MEETING MINUTES

6. BOARD MEMBER REPORTS

a) COMPLIANCE ADVISORY COMMITTEE

b) FINANCE COMMITTEE

7. CEO UPDATE

8. BOARD BUSINESS

a) REDETERMINATION PRESENTATION

b) HEDIS DATA PRESENTATION

c) REVIEW AND APPROVE MARCH 2024 AND APRIL 2024 MONTHLY FINANCIAL STATEMENTS

d) REVIEW AND APPROVE HOSPITAL COUNCIL OF NORTHERN AND CENTRAL CA HOSPITAL SEAT NOMINEE(S)

e) REVIEW AND APPROVE RESOLUTION NOMINATING WENDY PETERSON FOR APPOINTMENT TO DESIGNATED LONG TERM SERVICES AND SUPPORTS (LTSS) SEAT

f) REVIEW AND APPROVE RESOLUTION ESTABLISHING THE COMMUNITY ADVISORY SELECTION COMMITTEE, SEATS AND CHARTER.

9. STANDING COMMITTEE UPDATES

a) PEER REVIEW AND CREDENTIALING COMMITTEE

b) QUALITY IMPROVEMENT HEALTH EQUITY COMMITTEE

10. STAFF UPDATES

11. UNFINISHED BUSINESS

12. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS

13. PUBLIC COMMENT (NON-AGENDA ITEMS)

14. ADJOURNMENT

NOTICE TO THE PUBLIC

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

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

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

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

Supplemental Material Received After the Posting of the Agenda: Any supplemental materials or documents distributed to a majority of the Board regarding any item on this agenda after the posting of the agenda will be available for public review. To obtain a document, please call the Clerk of the Board at (510) 747-6160.

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

Americans With Disabilities Act (ADA): It is the intention of the Alameda Alliance for Health to comply with the Americans with Disabilities Act (ADA) in all respects. If, as an attendee or a participant at this meeting, you will need special assistance beyond what is normally provided, the Alameda Alliance for Health will attempt to accommodate you in every reasonable manner. Please contact the Clerk of the Board, Brenda Martinez, at (510) 747-6160 at least 48 hours prior to the meeting to inform us of your needs and to determine if accommodation is feasible. Please advise us at that time if you will need accommodations to attend or participate in meetings on a regular basis.

I hereby certify that the agenda for the Board of Governors was posted on the Alameda Alliance for Health's web page at www.alamedaalliance.org by May 7th, 2024, by 12:00 p.m.

Brenda Martinez, Clerk of the Board

EXECUTIVE SUMMARY APPENDIX

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

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PRESENTATIONS APPENDIX

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

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HEDIS DATA PRESENTATION PAGE 94

SUPPORTING MATERIALS APPENDIX

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

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Consent Calendar

Compliance Advisory Committee Meeting Minutes

ALAMEDA Alliance FOR HEALTH
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COMPLIANCE ADVISORY COMMITTEE
Regular Meeting Minutes
Friday, March 8th, 2024
10:30 a.m. – 11:30 a.m.

Video Conference Call and

1240 S. Loop Road
Alameda, CA 94502

CALL TO ORDER

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

Committee Members Remote: None

Committee Members Excused: None

1. CALL TO ORDER

The regular Compliance Advisory Committee meeting was called to order by Dr. Kelley Meade at 10:30 am.

2. ROLL CALL

A roll call was taken of the Committee Members, quorum was confirmed.

3. AGENDA APPROVAL OR MODIFICATIONS

There were no modifications to the agenda.

4. PUBLIC COMMENT (NON-AGENDA ITEMS)

None

5. CONSENT CALENDAR

a) December 8th, 2023, COMPLIANCE ADVISORY COMMITTEE MEETING MINUTES

Motion: A motion was made by Richard Golfin, III and seconded by Byron Lopez to approve Consent Calendar Agenda Item (a).

Vote: Motion unanimously passed.

No opposition or abstentions.

6. COMPLIANCE MEMBER REPORTS

a) COMPLIANCE ACTIVITY REPORT

i. Plan Audits and State Regulatory Oversight

1. Status Updates on State Audit Regulatory Oversight
    a. 2024 DHCS Routine Medical Survey Audit
        - The audit is scheduled for June 2024, and the virtual interview sessions are scheduled to be conducted from June 17 – June 28, 2024.
        - The Plan is expecting to receive a formal audit notification the week of March 11, 2024.
        - The lookback period is expected to cover April 1, 2023 – March 31, 2024. The following areas will be included:
            i. Utilization management;
            ii. Case management;
            iii. In-care coordination;
            iv. Access and availability;
            v. Member's rights and responsibilities;
            vi. Quality improvement system;
            vii. Organization and administration;
            viii. Transportation;
            ix. Behavioral health
        - 2024 Mock Audits
            - The Plan will hold 2024 Moch Audit interviews with subject matter experts in preparation for the 2024 DHCS audit.
            - Our Mock Audits are scheduled for April 22, 2024 – May 3, 2024, and will cover all sections of the DHCS audit.
            - The Mock Audit schedule and questions are provided.
                1. Sample questions provided.
                2. Sample answers provided.

        Question: The line up of items covered in the actual survey in the mock survey—do they overlap, and the mock survey will have more items, or will they be equal?

        Answer: They will be equal.

        Question: I got a mock audit schedule that has these categories, and the categories mentioned for the actual audit were smaller in number. So will these be put into larger categories.

        Answer: Yes. When we get the final audit findings, the report will have eight categories—utilization management, administrative management, administration, etc.—but the categories that are listed are more refined, so there are sections within the greater categories.

    b. 2023 DHCS Routine Medical Survey
        - The onsite interview took place April 17, 2023 – April 28, 2023.
        - There were 15 findings and four identified repeat findings.
        - The Plan submitted its Corrective Action Plan to the department in November.

- Internal meetings have been held with stakeholders to review CAP plans and implementation efforts to eliminate repeat findings and lower the number of overall deficiencies year over year.
- The DHCS is requesting a monthly update of the CAP progress.
    - A January update was submitted was submitted on January 18, 2024.
    - The Plan received the DHCS response to the January update on February 12.
    - DHCS has additional questions for eight out of 15 findings and the Plan submitted the February update timely on February 26, and we are currently waiting for a response.

2. Compliance Dashboard

- Findings have been received for the 2022 DMHC Behavioral Health Investigation.
    - There were two findings, which were added to the dashboard. That brings the total overall findings that we are tracking on the dashboard to 183.
    - The Audit Review Period for the 2022 DMHC Behavioral Health Investigation was April 1, 2022 - April 30, 2022. DMHC came on site virtually from September 7, 2022 – September 8, 2022.
    - The final report was received January 5, 2024, and the Corrective Action Plan was submitted to DMHC on February 4, 2024.
    - Along with the two identified findings, there were also three barriers to care, which have been added to the dashboard as well.
    - Findings involved two provisions of the Knox-Keene Act:
        - The first area is Utilization Management: The Plan failed to timely implement the requirements of Sections 1374.72 and 1374.721 (SB 855).
            - Among these requirements was the obligation to conduct utilization review for behavioral health services, applying the criteria and guidelines set forth in the most recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty.
            - The specific issue was with policy UM-063 Gender Affirmation Surgery and Transgender Services, which wasn't in compliance with the World Professional Association of Transgender Health (WPATH) criteria when DMHC reviewed it back in 2022. The policy was updated to bring it into compliance in September 2022.
            - Additionally, the Alliance has contracted with the WPATH to provide training for standards of care. All training for UM reviewers will be complete by Q4 2024.
            - The Alliance also conducts annual Interrater Reliability Studies, or IRRs, with all UM decision makers to ensure that documented criteria are being applied consistently. The next IRR will be completed by Q3 2024.

Question: So this is state oversight; is there anything that meets up at a federal level for this particular item?

Answer: This is something we have been working on since 2021. We have UM-063, which is one of our global health management policies and clinical services, clinical delivery. Dr. Mendoza, Dr. Juan, have worked extensively at shaping that policy to match the transgender, gender-diverse, and intersex guidelines. DMHC has gone back and forth with us on what they wanted to see with that policy, and the types of parity-centric language they wanted to see for our population. Last summer, we finally got approval of this filing, under SB 855, just as a sort of overall state legislation that polices plans in delivering these services, but then we received additional comments because the WPATH guidelines have been updated to a new standard, and that new standard is different than what California laws are. The last guidance that we received was they would like us to be on the latest standards of WPATH, which we did, but then WPATH came out with new requirements that were different, so then we had a question: do we comply with the latest updates to WPATH and be out of compliance with the law, or do we not update to WPATH and be out of compliance with what was asked of us? Legal services has recently updated the policy. We have actually updated the policy in coordination with Dr. Mendoza and SB 855, which incorporates WPATH, so we were able to make revisions that we think comply with all, and this was done last week or the week before.

Question: Just so I understand this, the Corrective Action Plan that was submitted on February 4 now has a companion policy document that is in compliance with all jurisdictions.

Answer: That is what we are shooting for. We engaged Legal to see how we can comply with both.

- The second finding is in the area of 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 a follow-up is planned where indicated.
  - As of April 1, 2023, Alameda Alliance for Health (AAH) has terminated its contract with Beacon Health Options, so we no longer have the delegate that this finding refers to.
  - 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.

Question: Do we submit a Corrective Action Plan for that item, or do we just insource and say that was our corrective action plan?

Answer: Yes. So what we are reviewing are findings from a BHI parity audit, which the State said there wouldn't be findings for; back in 2021 and 2022 they said they would issue group results for five plans, and do five plans each year, so we expected to get group findings from their findings of the five plans that they had reviewed. But instead, we

received individual plan results. We since terminated our NBHL partnership, so the findings we received in 2022 are not reflective of the current state of our business in managing behavioral health services, so for most of these we plan to highlight we no longer have a behavioral health delegate, as those services are administrated in-house, and then plan to talk about how we administer behavioral health here, and we have a collection of professionals, under Dr. Carey's leadership, that manage our behavioral health services here.

- In addition to the findings, DMHC also found the Alliance had unaddressed barriers to care. These are not Knox-Keene Act violations.
    - According to the DMHC, barriers to care may create delays in a member's ability to obtain behavioral health services, however they do not rise to the level of a Knox-Keene Act violation.
    - The barriers to care are basically recommendations from DMHC. There were three found, in the following three areas:
        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.
        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.
        3. Enrollee Experience: Enrollees experience difficulties obtaining appointments.
    - Since these are not findings, we did not need to provide a CAP response to DMHC, however, Internal Audit will be adding these barriers to care to the Internal Audit Plan, where we will review plan processes in order to risk asses, much like we have with other comparison audits. This will allow us to determine areas of possible weakness that lead to these barriers to care, so we can partner with the Alliance departments to strengthen any weaknesses and continue to improve the Plan.

Question: Will the mock audit incorporate these items, or will that be a separate internal audit process?

Answer: It will be a separate internal audit process.

ii. Compliance Risk Assessment Results and Plan Progress

1. Update Presented at March 8th Board of Governors

    a. An update will be provided on the Compliance Risk Assessment and Internal Review which was conducted in 2022 and 2023, and updates on plan progress which has an overview of our internal audit program as well as some of our plans for future development in Compliance.

b) DELEGATION ACTIVITY AND OVERSIGHT

None

c) MEDI-CAL PROGRAM UPDATES

None

7. COMPLIANCE ADVISORY COMMITTEE BUSINESS

a) 2024 Compliance Advisory Committee Calendar

8. STAFF UPDATES

None

9. UNFINISHED BUSINESS

None

10. STAFF ADVISORIES ON COMPLIANCE BUSINESS FOR FUTURE MEETINGS

None

11. ADJOURNMENT

Chair Dr. Kelley Meade adjourned the meeting at 11:30 am.

Board of Governors Meeting Minutes

Alameda Alliance for Health
Health care you can count on.
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BOARD OF GOVERNORS
Regular Meeting Minutes
Friday, March 8th, 2024
12:00 p.m. – 2:00 p.m.

Video Conference Call and

1240 S. Loop Road
Alameda, CA 94502

1. CALL TO ORDER

Board of Governors Present: Rebecca Gebhart (Chair), Dr. Noha Aboelata (Vice Chair), Aarondeep Basrai, Colleen Chawla, Dr. Rollington Ferguson, Andrea Ford, Byron Lopez, Andie Martinez Patterson, Dr. Kelley Meade, Andrea Schwab-Galindo, Supervisor Lena Tam, Natalie Williams

Board of Governors Remote (Traditional Brown Act): James Jackson

Board of Governors Excused: Dr. Marty Lynch, Jody Moore, Yeon Park, Dr. Evan Seevak

Alliance Staff Present: Matthew Woodruff, Dr. Steve O'Brien, Gil Riojas, Anastacia Swift, Ruth Watson, Sasi Karaiyan, Tiffany Cheang, Michelle Lewis, Lao Paul Vang

Chair Gebhart called the regular Board of Governors meeting to order at 12:00 p.m.

2. ROLL CALL

Roll call was taken and a quorum was established.

3. AGENDA APPROVAL OR MODIFICATIONS

There were no modifications to the agenda.

4. INTRODUCTIONS

Tome Meyers was welcomed and introduced as the Executive Director of Medicare Programs.

5. CLOSED SESSION

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

After roll call and quorum was established, the Board convened into Closed Session.

6. CONSENT CALENDAR

a) DECEMBER 5th, 2023, FINANCE COMMITTEE MEETING MINUTES

b) FEBRUARY 6th, 2024, FINANCE COMMITTEE MEETING MINUTES

c) DECEMBER 8th, 2023, COMPLIANCE ADVISORY COMMITTEE MEETING MINUTES

d) DECEMBER 8th, 2023, BOARD OF GOVERNORS MEETING MINUTES

e) JANUARY 26th, 2024, BOARD OF GOVERNORS RETREAT MINUTES

Motion: A motion was made by Supervisor Lena Tam and seconded by Dr. Rollington Ferguson to approve the Consent Calendar Agenda Items 5a through 5e.

Vote: The motion was passed unanimously.

Ayes: Aarondeep Basrai, Colleen Chawla, Dr. Rollington Ferguson, Andrea Ford, James Jackson, Byron Lopez, Andie Martinez Patterson, Dr. Kelley Meade, Andrea Schwab-Galindo, Supervisor Lena Tam, Natalie Williams, Chair Rebecca Gebhart and Vice Chair Dr. Noha Aboelata.

No opposition or abstentions.

7. BOARD MEMBER REPORTS

a) BOARD CHAIR REPORT

i. FORM 700 SUBMISSION

Chair Rebecca Gebhart reminded Board members that their Form 700 is due by April 2nd , 2024, and can be submitted online or by mail.

ii. TRAININGS

b) COMPLIANCE ADVISORY COMMITTEE

Dr. Kelley Meade provided a brief update on the Compliance Advisory Committee meeting that was held on March 8th, 2024.

c) FINANCE COMMITTEE

Dr. Rollington Ferguson provided a brief update on the Finance Committee meeting held on February 6th, 2024.

8. CEO UPDATE

Matt Woodruff provided an update on the following areas:

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

	February	YTD
Medi-Cal	($7.4M)	$26.6M
Group Care	($648K)	$751K
Total	($8.0M)	$27.4M

  - **Revenue was $166.7 million in January 2024 and $989.8 million Year-to-Date (YTD)**.
    - Medical expenses were $168.6 million in January and $928.1 million for the fiscal year-to-date; the medical loss ratio is 101.2% for the month and 93.8% for the fiscal year-to-date.
    - Administrative expenses were $8.3 million in January and $53.8 million year-to-date; the administrative loss ratio is 5.0% of net revenue for the month and 5.4% of net revenue year-to-date.
  - **Tangible Net Equity (TNE)**: Financial reserves are 612% of the required DMHC minimum, representing $293.9 million in excess TNE.
  - **Total enrollment in January 2024 was 400,518**, an increase of 48,538 Medi-Cal members compared to December.

- **Key Performance Indicators:**
  - **Regulatory Metrics:**
    - All Regulatory Metrics were met.
  - **Non-Regulatory Metrics:**
    - The member services team did not meet internal metrics for service. The team's speed to answer was at 79%, and the abandonment rate was at 9%, compared to internal metrics of 80% and 5%, respectively.

- **Program Implementations:**
  - **Single Plan Model**
    - Good news. The Alliance enrollment as of January 25th, 2024, is 400,518.

- Member Services had their second largest call volume in its history, almost surpassing 24,000 calls, compared to nearly 30,000 calls in January.
- Member Services had their second largest Walk-In volume in its history, with 64 members coming onsite for help. That equates to over 3 members onsite per day. For comparison, we averaged just 1 per day for the first six months of the Fiscal year.
- The Health Care Services Department had its second largest volume of authorizations ever in February 2024. The team received over 7,637 authorization requests in February, compared to 8,519 in January 2024. These numbers encompass authorizations for all categories, not just outpatient.

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

- **Recruiting Incentives for our Network**
  - Process and application currently under development.

- **Proposed Board of Governors Community Investment Program**
  - Process and application currently under development.

- **Medicare Overview**
  - **<u>D-SNP Readiness</u>**

    Alameda Alliance for Health (AAH) Medicare Advantage Duals Special Needs Plan (DNSP) will begin serving members on January 1st, 2026.

    Key milestones and dates the Alliance is working toward for January 1st, 2026, include the following:

    - D-SNP Feasibility Study (ProForma) – January 2024 - completed
    - Core System (Claims, Medical Management, Grievance & Appeals) Review – January 2024 – completed
    - DHCS & DMHC Material Modification Submission 1 – March 1st, 2024 - completed
    - DHCS & DMHC Material Modification Submission 2 (Financials) – April 15th, 2024
    - Provider Network Development and Recruitment – February 2024 thru February 2025
    - CMS Notice of Intent to Apply – November 2024

- CMS Application (Model of Care (MOC), Provider Network, & DMHC Approval) – February 2025
- CMS Formulary and Bid Submission (Benefit Determination) – June 2025
- Operational Readiness Assessment, Training, and Audit – June through December 2025
- Annual Enrollment Period – October thru December 2025

- **Accomplishments in Greater Detail**

2023 Q2 (May)

- In May 2023, AAH entered into a Consultant Services Agreement with Rebellis Group to provide the Subject Matter Expertise (SME) to support the development of the D-SNP program.

2023 Q3 (July thru September)

- In July 2023, AAH and Rebellis completed the project kickoff, introducing D-SNP to AAH project stakeholders and the Executive Team, and began the review and development of the project plan, defining the work and timeline required to meet the project milestones and the successful launch of D-SNP on January 1st, 2026.
- Rebellis, with the support of AAH stakeholders, began the development of the Proforma.
- Rebellis met with AAH IT and Business stakeholders to evaluate the viability of our Claims (HEALTHsuite), Medical Management (TruCare), and Grievance & Appeals (QualitySuite) systems to support D-SNP.

2023 Q4 (October thru December)

- AAH received the initial draft Proforma for review and feedback.
- AAH received the Final DRAFT System Evaluation for review, feedback, and AAH's decision on the platforms to support Claims, Medical Management, and Grievance and Appeals.

2024 Q1 (January thru March)

- Tome Meyers, Executive Director of Medicare, started March 4th, 2024, and serves as the Project Driver supporting Ruth Watson as the project's Executive Sponsor.
- Executive Leadership confirmed the decision to use the existing Claims (HEALTHsuite), Medical Management (TruCare), and Grievance & Appeals (QualitySuite) platforms for D-SNP and for IT to initiate discussions with each system vendor (Ram and Zyter) to evaluate and confirm the enhancements available to support D-SNP.
- Completed user training and provided user access to Rebellis Academy, the online, self-directed training content for Medicare

- Advantage and Part D organizations (including DSNP) offered by Rebellis Group.
- Completed the DHCS & DMHC Material Modification Submission 1 as required by March 1st, 2024.

- **Next Steps**

  2024 Q2 (April thru June)

  AAH and Rebellis will complete the kickoff and initial review and development for the following:

  - Review of current Policy & Procedures (all business areas).
  - Model of Care. The Model of Care includes four parts, MOC 1 Description of the SNP Population, MOC 2 Care Coordination, MOC 3 Provider Network, MOC 4 Quality Measurement & Performance Measurement. The initial focus is on MOC part 1.
  - Clinical services for Utilization Management, Quality, Stars, and HEDIS.
  - Sales and Marketing Planning.
  - Product Management with a focus on Benefit Pre-Planning.
  - Member Experience with a focus on Member Call Center Planning.
  - Oversight of Rebellis Academy user training.
  - DHCS & DMHC Material Modification Submission 2 (Financials) for submission by April 15th, 2024.
  - Receipt and review of the Quest GeoAccess report for network adequacy required to support the development of the Provider Network Recruitment / Engagement Strategy.

9. BOARD BUSINESS

a) REVIEW AND APPROVE STAFF REPORT NOMINATING JAMES JACKSON FOR VICE CHAIR OF THE FINANCE COMMITTEE

Motion: A motion was made by Dr. Rollington Ferguson and seconded by Natalie Williams to approve the nomination of James Jackson for Vice Chair of the Finance Committee.

Vote: The motion was passed unanimously.

Ayes: Aarondeep Basrai, Colleen Chawla, Dr. Rollington Ferguson, Andrea Ford, Byron Lopez, Andie Martinez Patterson, Dr. Kelley Meade, Andrea Schwab-Galindo, Supervisor Lena Tam, Natalie Williams, Chair Rebecca Gebhart and Vice Chair Dr. Noha Aboelata.

Abstain: James Jackson

No oppositions.

b) COMPLIANCE PRESENTATION

Informational item only.

c) REDETERMINATION PRESENTATION

Due to time constraints, the balance of the redetermination presentation was postponed to the May 10th, 2024 Board of Governors meeting.

Motion: A motion was made by Dr. Kelley Meade and seconded by Andrea Ford to postpone redetermination balance and discussion with the exception of Gil's items (September 2023, December 2023 and January 2024 monthly financial statements)

Vote: The motion was passed unanimously.

Ayes: Aarondeep Basrai, Colleen Chawla, Dr. Rollington Ferguson, Andrea Ford, James Jackson, Byron Lopez, Andie Martinez Patterson, Dr. Kelley Meade, Andrea Schwab-Galindo, Supervisor Lena Tam, Natalie Williams, Chair Rebecca Gebhart and Vice Chair Dr. Noha Aboelata.

No opposition or abstentions.

d) REVIEW AND APPROVE SEPTEMBER 2023, DECEMBER 2023 AND JANUARY 2024 MONTHLY FINANCIAL STATEMENTS

Motion: A motion was made by Supervisor Tam and seconded by Dr. Rollington Ferguson to approve the September 2023, December 2023 and January 2024 monthly financial statements.

Vote: The motion was passed unanimously.

Ayes: Aarondeep Basrai, Colleen Chawla, Dr. Rollington Ferguson, Andrea Ford, James Jackson, Byron Lopez, Andie Martinez Patterson, Dr. Kelley Meade, Andrea Schwab-Galindo, Supervisor Lena Tam, Natalie Williams, Chair Rebecca Gebhart and Vice Chair Dr. Noha Aboelata.

No opposition or abstentions.

e) FISCAL YEAR 2024 SECOND QUARTER FORECAST

Gil Riojas shared a brief update on the Fiscal Year 2024 second quarter forecast.

10. STANDING COMMITTEE UPDATES

Due to time constraints, the standing committee updates were postponed to the May 10th, 2024 Board of Governors meeting.

a) PEER REVIEW AND CREDENTIALING COMMITTEE

b) PHARMACY & THERAPEUTICS COMMITTEE

c) QUALITY IMPROVEMENT HEALTH EQUITY COMMITTEE

d) COMMUNITY ADVISORY COMMITTEE

11. STAFF UPDATES

There were no staff updates.

12. UNFINISHED BUSINESS

None.

13. STAFF ADVISORIES ON BOARD BUSINESS FOR FUTURE MEETINGS

None.

14. PUBLIC COMMENT (NON-AGENDA ITEMS)

There were no public comments for non-agenda items.

15. ADJOURNMENT

Chair Gebhart adjourned the meeting at 2:03 p.m.

CEO Update

Matthew Woodruff

To: Alameda Alliance for Health Board of Governors

From: Matthew Woodruff, Chief Executive Officer

Date: May 10th, 2024

Subject: CEO Report

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

	March	YTD
Medi-Cal	($3.45M)	$26.4M
Group Care	$137K	$3.1M
Total	($3.3M)	$29.5M

  - **Revenue was $169.7 million in March 2024 and $1.3 billion Year-to-Date (YTD)**.
    - Medical expenses were $163.3 million in March and $1.2 billion for the fiscal year-to-date; the medical loss ratio is 96.2% for the month and 93.9% for the fiscal year-to-date.
    - Administrative expenses were $9.8 million in March and $69.2 million year-to-date; the administrative loss ratio is 5.8% of net revenue for the month and 5.2% of net revenue year-to-date.
  - **Tangible Net Equity (TNE)**: Financial reserves are 628% of the required DMHC minimum, representing $297.2 million in excess TNE.
  - **Total enrollment in March 2024 was 403,941**, an increase of 1,682 Medi-Cal members compared to February.

- **Key Performance Indicators:**
  - **Regulatory Metrics:**
    - All Regulatory Metrics were met.
  - **Non-Regulatory Metrics:**
    - The member services team did not meet one internal metric for service. The team's abandonment rate was at 9%, compared to the internal metric of 5%.
    - The Alliance IT team missed an internal metric of 100% up time for all internal systems. The Alliance systems went down for a few hours one day in April due to a clerical oversight.

- **Program Implementations:**
  - **Single Plan Model**
    - Good news. The Alliance enrollment as of March 2024, is 403,941.
    - Enrollment continues to rise in the first three months of the calendar year versus our original estimates of declining enrollment based on redetermination data. The Alliance in conjunction with the ACSSA, believe our enrollment continues to expand as the County implemented State approved procedures last Fall and the County is offering overtime to all employees to work on the redeterminations.
  - **DHCS Audit**
    - The teams are preparing for our June DHCS audit. Our goal is to have no repeat findings and bring down the overall number of findings from previous years.
  - **Pay Equity Salary Survey**
    - The Alliance received our latest report from our contracted vendor. We will work to implement the needed changes during our annual review process this July.

- **Medicare Overview**
  - **D-SNP Readiness**
    - Alameda Alliance for Health (AAH) Medicare Advantage Duals Special Needs Plan (D-SNP) will begin serving members on January 1st, 2026.
    - The Alliance met with CMS, DHCS and DMHC to review D-SNP readiness and filings, and the agencies were pleased with the Alliance progress. DMHC confirmed that the Medicare Provider Amendment will be submitted for informational purposes only, which is favorable to the Alliance contracting timeline to start contracting earlier.
    - The Alliance is making strides on the following: network strategy, Model of Care (MOC) development, and analysis of delegates/supplemental vendors. In the month of June, the Board will receive a complete Medicare update that will be done quarterly from June forward.
    - In the month of June, the Board will receive a complete Medicare update that will be done quarterly from June forward.

Executive Dashboard

OPERATIONS DASHBOARD — MAY 2024

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Financials

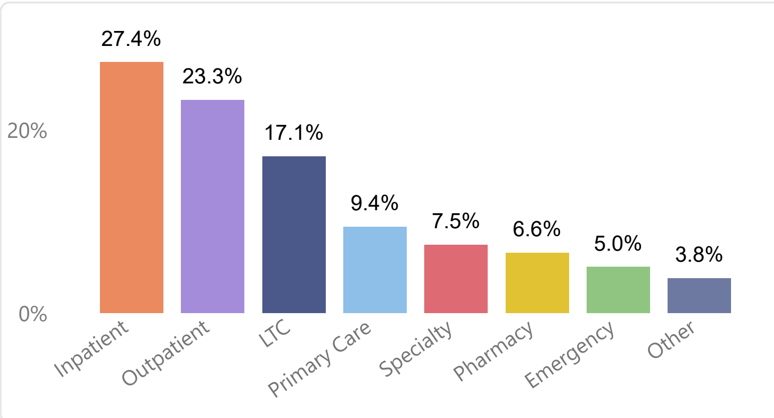
Income & Expenses

	MARCH 2024	FISCAL YTD
REVENUE	$ 283.3 M	$ 1.6 B
MEDICAL EXPENSE	$ (163.3) M	$ (1.2) B
ADMIN EXPENSE	$ (9.8) M	$ (69.2) M
OTHER/TAX	$ (113.5) M	$ (256.1) M
NET INCOME	$ (3.3) M	$ 29.5 M

Medical Loss % (Fiscal YTD)

93.9%

Medical Expenses



Liquid Reserves

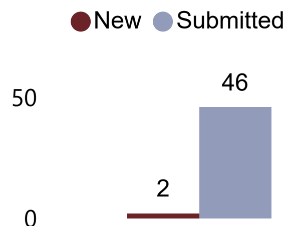
TNE %

628.3%

TNE $

$353.4M

Reinsurance Cases



Balance Sheet

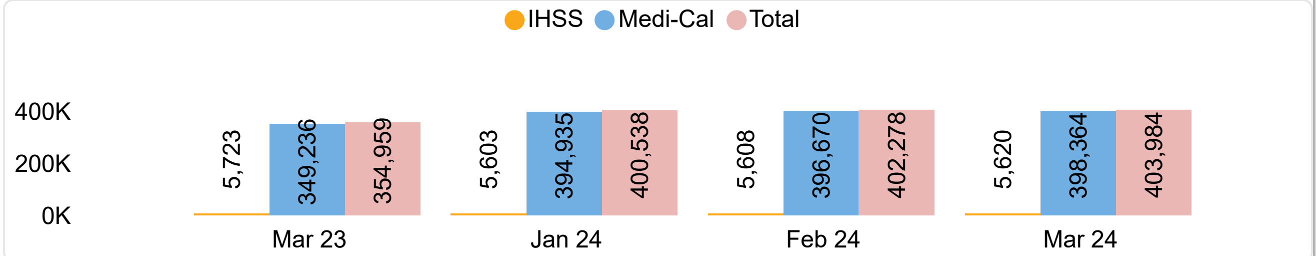
Cash Equivalents	**$765.4M**
Pass-Through Liabilities	**$257.2M**
Uncommitted Cash	**$508.2M**
Working Capital	**$338.0M**

Current Ratio

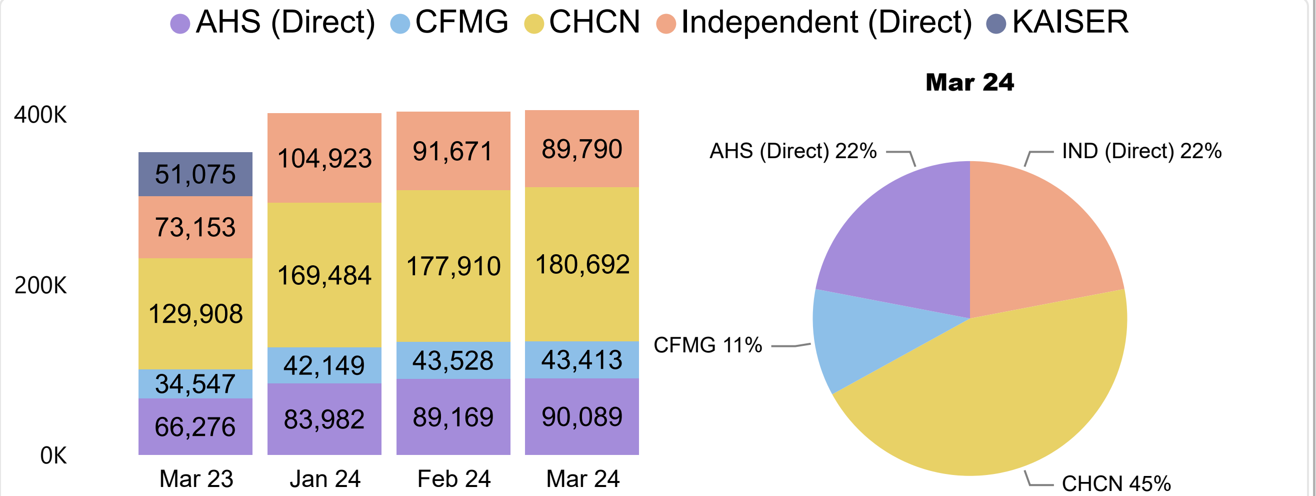
1.58

Membership

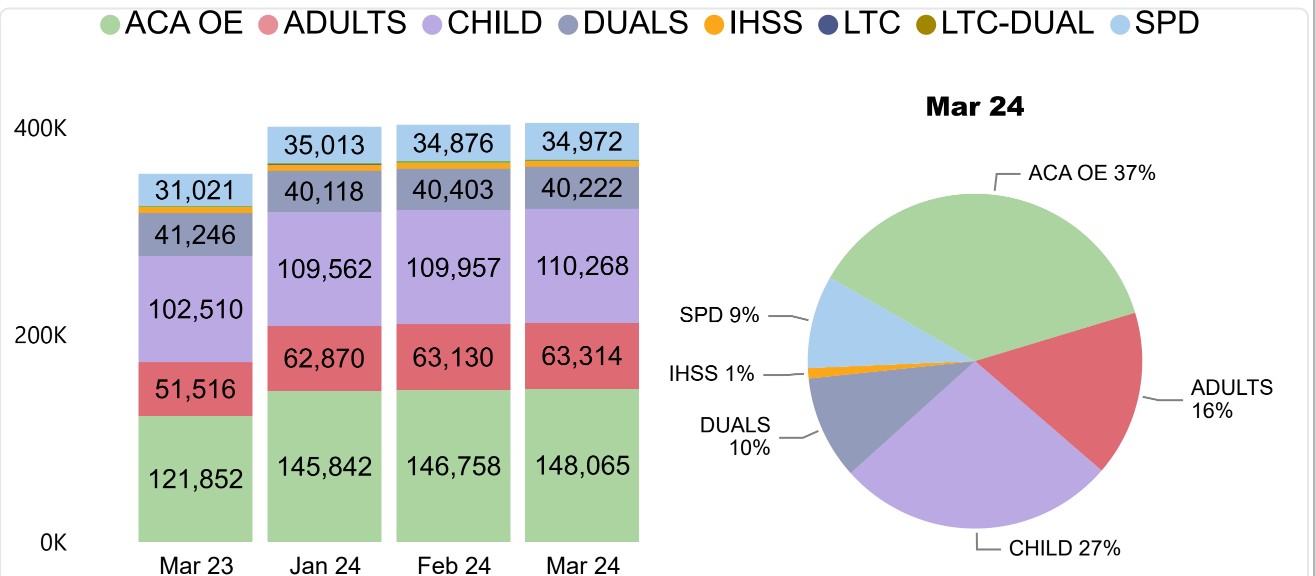
By Plan



By Network

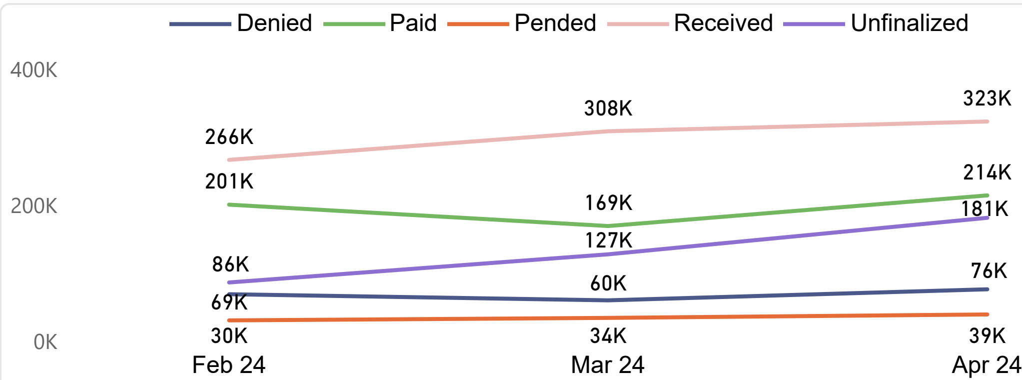


By Category

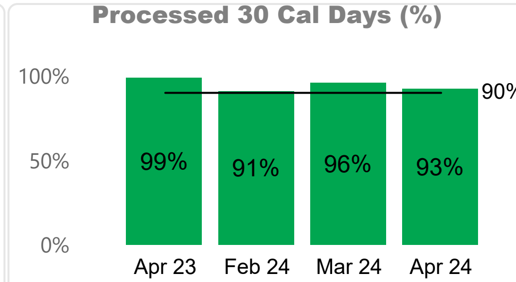


Claims

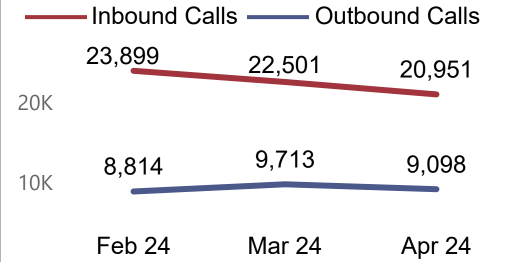
Claims Processing

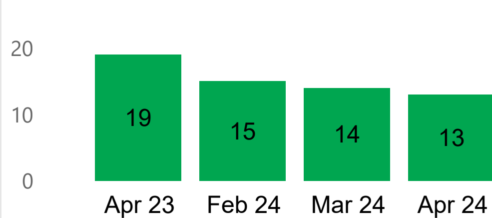


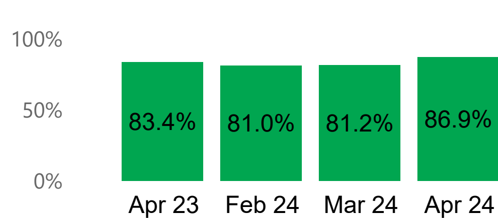
Claims Compliance

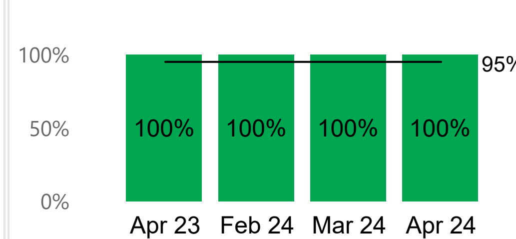


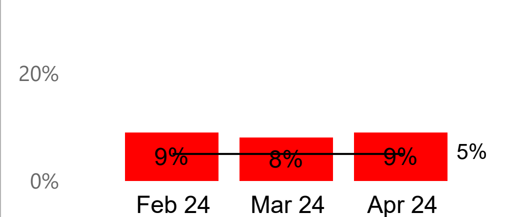
Member Services

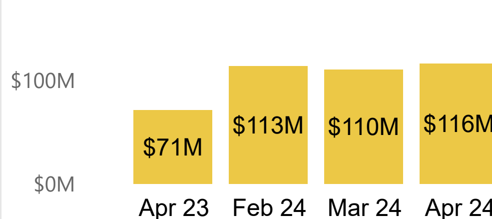


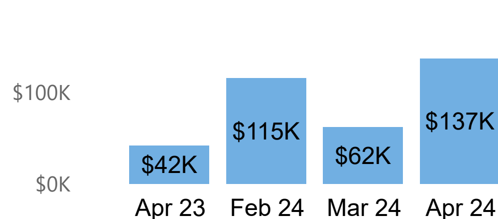




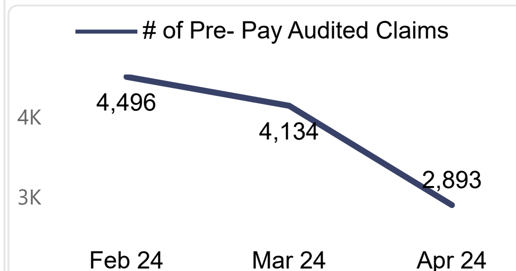


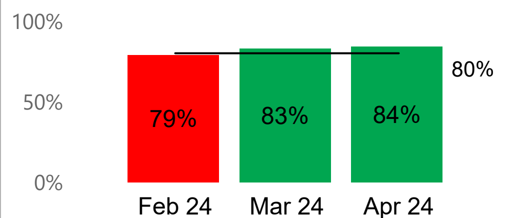






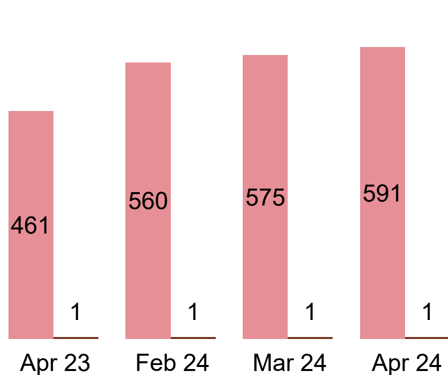
Claims Auditing



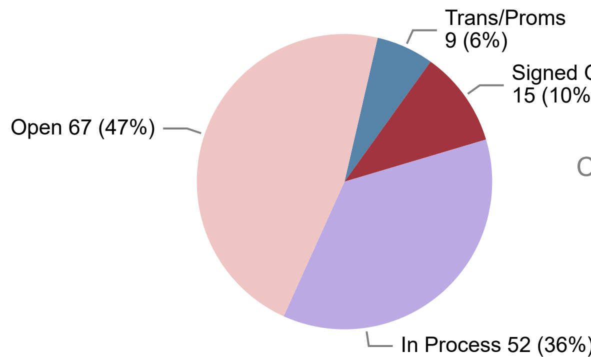


Average Call Times	Feb 24	Mar 24	Apr 24
Wait Time	00:58	00:49	00:50
Call Duration	06:49	07:02	06:57

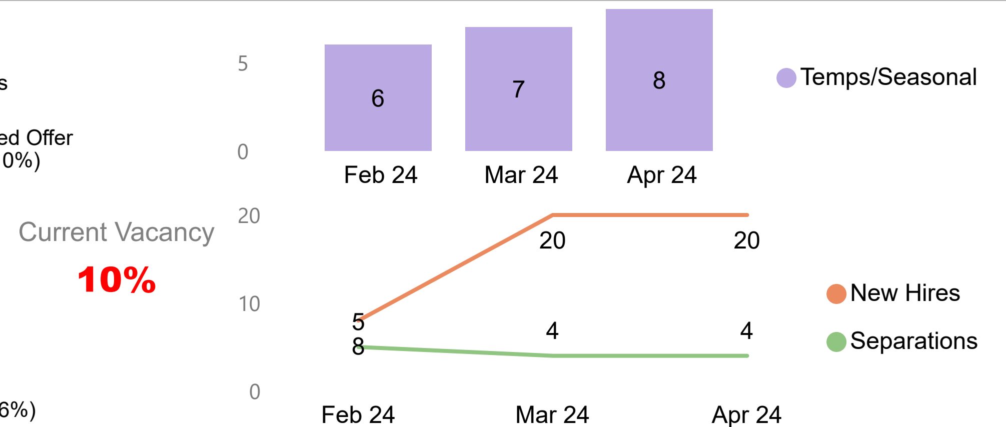
Human Resources



Recruiting Status



Current Vacancy
10%



Provider Services

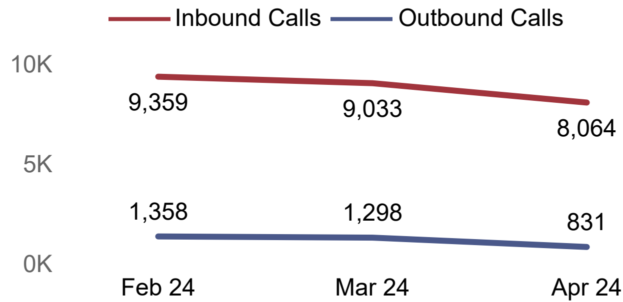
Provider Network

Hospital	17
Specialist	9,941
Primary Care Physician	793
Skilled Nursing Facility	104
Urgent Care	7
Health Centers (FQHCs and Non-FQHCs)	68
TOTAL	**10,930**

Provider Credentialing

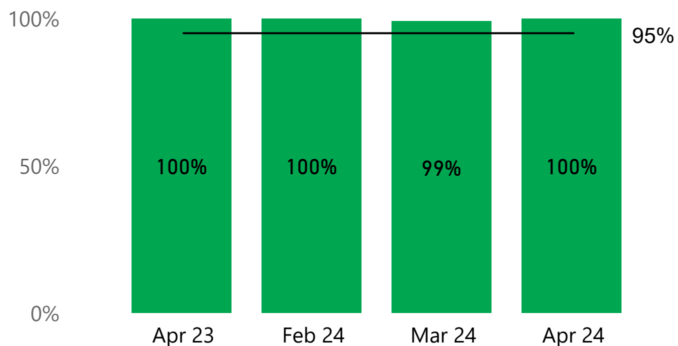
3,396

Provider Call Center



Provider Disputes & Resolutions

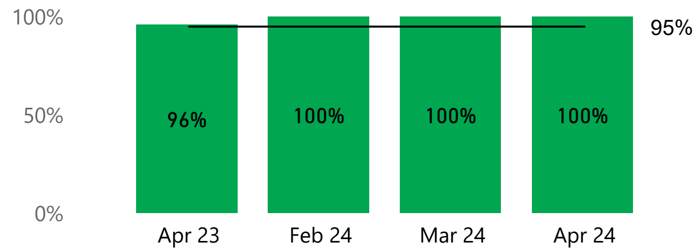
Turnaround Compliance (45 business days)



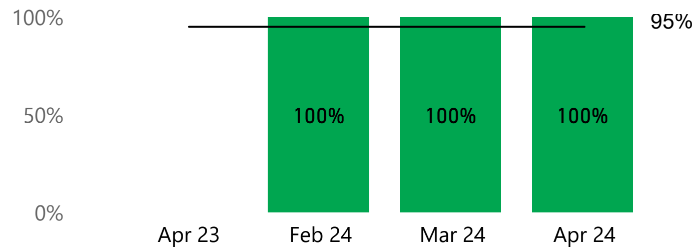
Compliance

Member Grievances

Standard (30 calendar days)

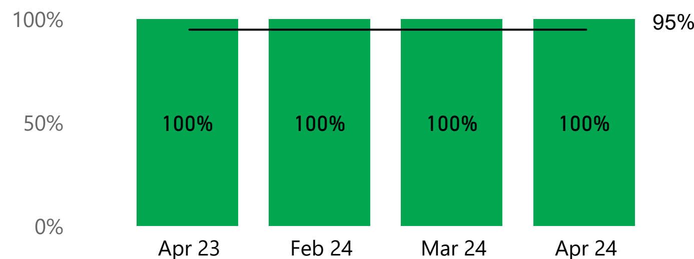


Expedited (3 calendar days)

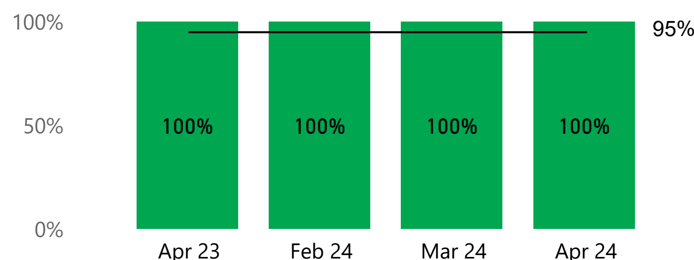


Member Appeals

Standard (30 calendar days)

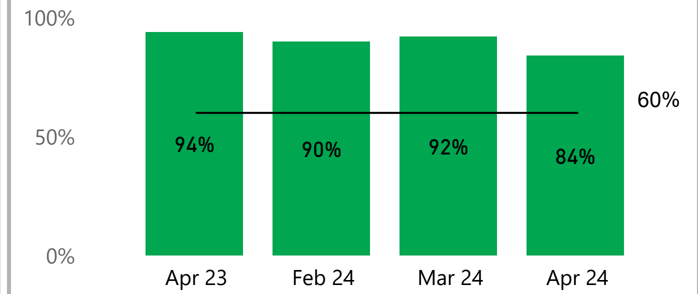


Expedited (3 calendar days)

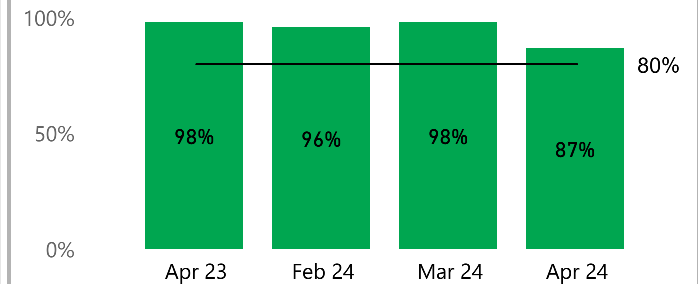


Encounter Data

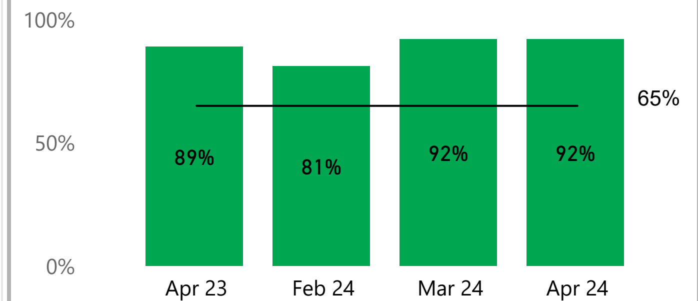
Institutional 0-90 days



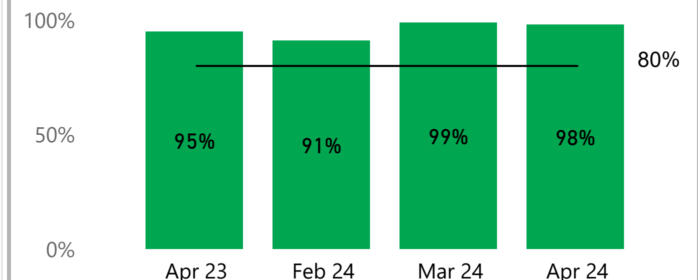
Institutional 0-180 days



Professional 0-90 days



Professional 0-180 days



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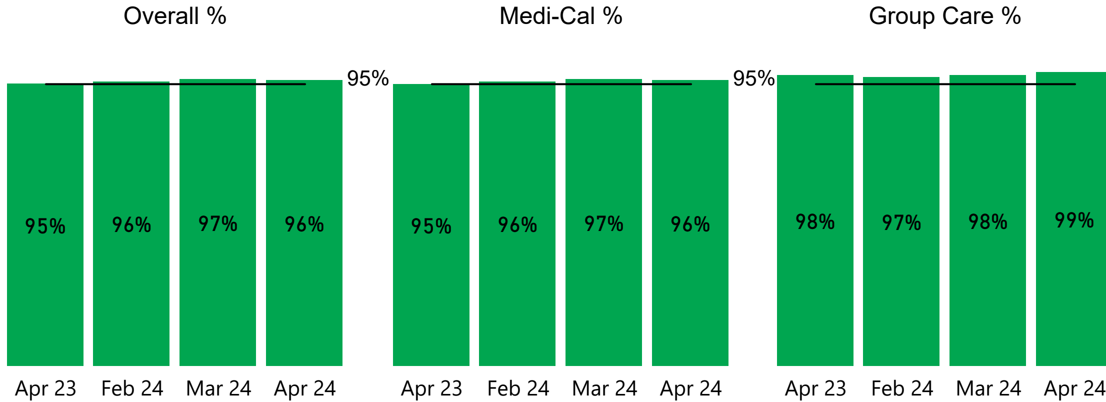
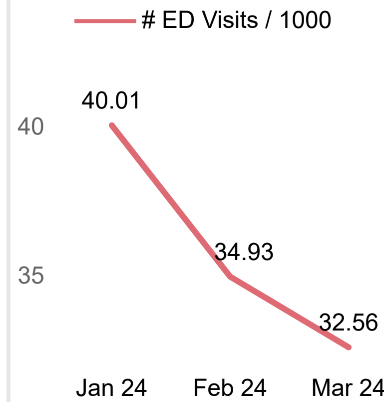
Health Care Services

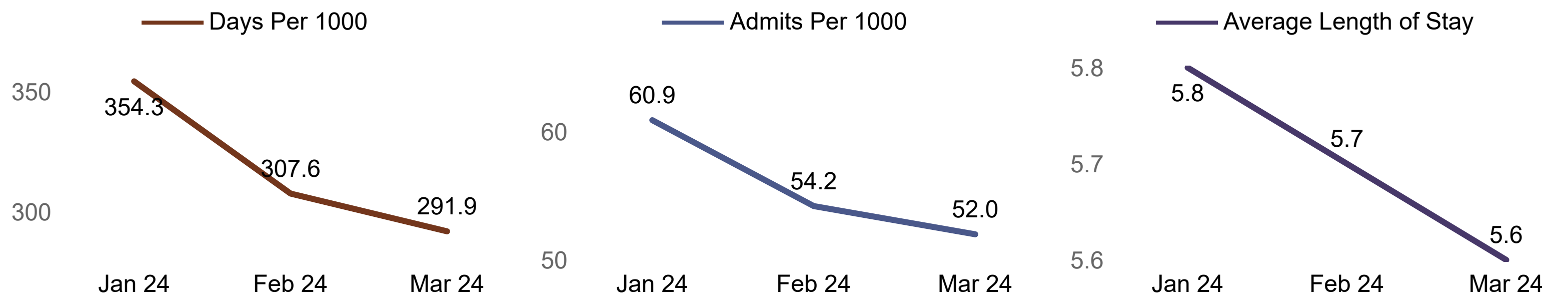
Authorization Turnaround



ED Utilization

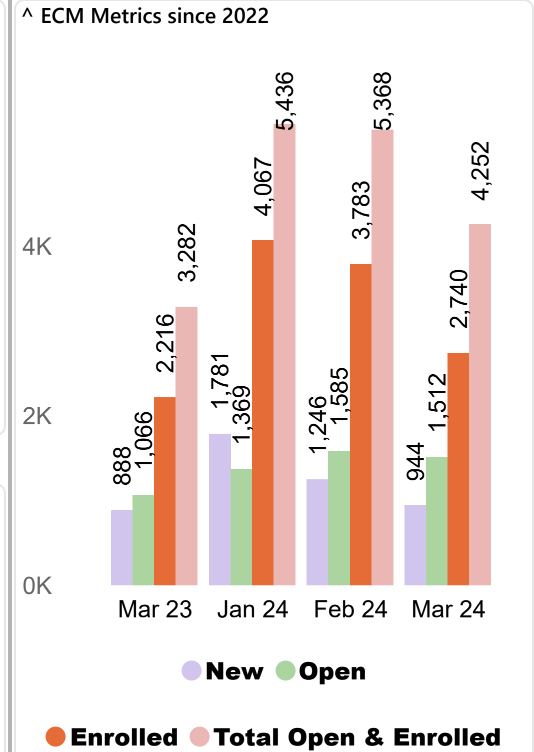


Inpatient Utilization



Case Management

Total Cases^

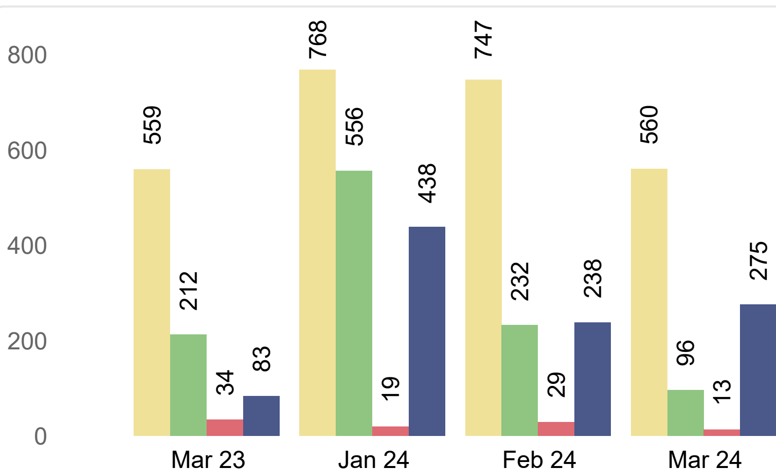


Case Management^

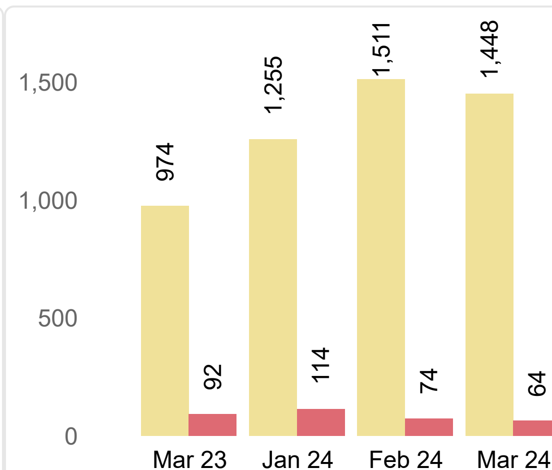
Care Coordination · Community Supports · Complex Cases · Enhanced Case Management

^ ECM Metrics since 2022

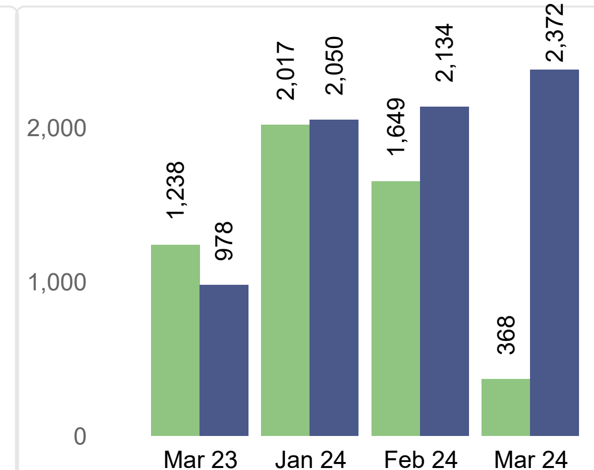
New Cases



Open Cases



Enrolled Cases



Technology (Business Availability)

Applications	Apr 23	Feb 24	Mar 24	Apr 24
HEALTHsuite System	100.0%	100.0%	100.0%	97.8%
Other Applications	100.0%	100.0%	100.0%	100.0%
TruCare System	100.0%	100.0%	100.0%	98.0%

Outpatient Authorization Denial Rates *

OP Authorization Denial Rates	Apr 23	Feb 24	Mar 24	Apr 24
Denial Rate Excluding Partial Denials (%)	3.5%	4.0%	3.4%	2.7%
Overall Denial Rate (%)	3.8%	4.2%	3.7%	2.9%
Partial Denial Rate (%)	0.3%	0.3%	0.4%	0.2%

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

Pharmacy Authorizations

Authorizations	Apr 23	Feb 24	Mar 24	Apr 24
Approved Prior Authorizations	37	35	34	35
Closed Prior Authorizations	95	91	109	76
Denied Prior Authorizations	43	36	80	43
Total Prior Authorizations	175	162	223	154

Legislative Tracking

ALAMEDA Alliance FOR HEALTH

2024 Legislative Tracking List

The 2024 California State Legislative Session has kept legislators busy during the entire month of April. Lawmakers have discussed hundreds of bills at policy committee hearings, and the deadline for bills with fiscal impacts to be heard has now passed. As additional key bill deadlines approach, some bills did not survive committee hearings while other bills were diluted to remain alive. The following is a list of state bills tracked by the Public Affairs and Compliance Departments. These bills are of interest to and could have a direct impact on Alameda Alliance for Health and its membership.

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

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

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

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

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

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

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

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

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

Location: 1/12/2024-A. DEAD

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

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

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

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

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

Location: 1/18/2024-A. DEAD

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

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

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

AB 236 (**Holden** D) **Health care coverage: provider directories.**
Current Text: Amended: 1/22/2024 html pdf
Status: 5/1/2024-Referred to Com. on HEALTH.
Location: 5/1/2024-S. HEALTH

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

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

AB 365 (**Aguiar-Curry** D) **Medi-Cal: diabetes management.**
Current Text: Amended: 9/8/2023 html pdf
Status: 9/14/2023-Failed Deadline pursuant to Rule 61(a)(14). (Last location was INACTIVE FILE on 9/12/2023)(May be acted upon Jan 2024)
Location: 9/14/2023-S. 2 YEAR

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

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

AB 412 **(Soria D) Distressed Hospital Loan Program.**
Current Text: Amended: 4/24/2023 html pdf
Status: 6/14/2023-Referred to Com. on HEALTH.
Location: 6/14/2023-S. HEALTH

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

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

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

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

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

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

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

Summary: Current law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. Current law requires the Director of Health Care Services to develop and implement standards for the timely processing and payment of each

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

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

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

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

AB 815 (**Wood** D) **Health care coverage: provider credentials.**
Current Text: Amended: 4/20/2023 html pdf
Status: 7/14/2023-Failed Deadline pursuant to Rule 61(a)(10). (Last location was HEALTH on 6/7/2023)(May be acted upon Jan 2024)
Location: 7/14/2023-S. 2 YEAR

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

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

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

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

Summary: Current federal law establishes the Program of All-Inclusive Care for the Elderly (PACE), which provides specified services for older individuals at a PACE center so that they may continue living in the community. Federal law authorizes states to implement PACE as a Medicaid state option. Current state law establishes the California Program of All-Inclusive Care for the Elderly (PACE program) to provide community-based, risk-based, and capitated long-term care services as optional services under the state's Medi-Cal state plan. Current law requires the department to develop

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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) **Vessels: equipment.**
Current Text: Amended: 5/1/2024 html pdf
Status: 5/1/2024-From committee chair, with author's amendments: Amend, and re-refer to committee. Read second time, amended, and re-referred to Com. on RLS.
Location: 9/14/2023-S. RLS.

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. This bill would require any equipment installed, or modification to accommodate that equipment, that could limit engine power or operational ability of specified commercial harbor craft, to be approved by at least one authorized classification society, as defined, and not void any existing warranty provided by the manufacturer of the engine or propulsion system. The bill would require aftermarket equipment that could limit a harbor craft's engine power to include an override or bypass feature that ensures the vessel can be operated at full power. The bill would require the owner or operator to report the use of the override or bypass feature during operation, 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 1338 (**Petrie-Norris** D) **Medi-Cal: community supports.**
Current Text: Amended: 4/20/2023 html pdf
Status: 2/1/2024-From committee: Filed with the Chief Clerk pursuant to Joint Rule 56.
Location: 1/18/2024-A. DEAD

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

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

AB 1359 (**Schiavo** D) **Paid sick days: health care employees.**
Current Text: Amended: 6/26/2023 html pdf
Status: 9/14/2023-Failed Deadline pursuant to Rule 61(a)(14). (Last location was INACTIVE FILE on 9/11/2023)(May be acted upon Jan 2024)
Location: 9/14/2023-S. 2 YEAR

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

							year	Conc.			
1st House				2nd House							

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

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

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

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

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

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

Summary: The Lanterman Developmental Disabilities Services Act makes the State Department of Developmental Services responsible for providing various services and supports to individuals with developmental disabilities, and for ensuring the appropriateness and quality of those services and supports. Current law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Current law establishes the California Advancing and Innovating Medi-Cal (CalAIM) initiative, subject to receipt of any necessary federal approvals and the availability of federal financial participation, in order to, among other things, improve quality outcomes, reduce health disparities, and increase flexibility. Current law authorizes the department to standardize those populations that are subject to mandatory enrollment in a Medi-Cal managed care plan across all aid code groups and Medi-Cal managed care models statewide, subject to a Medi-Cal managed care plan readiness, continuity of care transition plan, and disenrollment process developed in consultation with stakeholders, in

accordance with specified requirements and the CalAIM Terms and Conditions. Existing law, if the department standardizes those populations subject to mandatory enrollment, exempts certain dual and non-dual beneficiary groups, as defined, from that mandatory enrollment. This bill would additionally exempt dual and non-dual-eligible beneficiaries who receive services from a regional center and use a Medi-Cal fee-for-service delivery system as a secondary form of health coverage.

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

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

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

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

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

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

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

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

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

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

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

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

AB 1842 **(Reyes D) Health care coverage: Medication-assisted treatment.**
Current Text: Introduced: 1/16/2024 html pdf
Status: 4/29/2024-Read third time. Passed. Ordered to the Senate. (Ayes 73. Noes 0.) In Senate. Read first time. To Com. on RLS. for assignment.
Location: 4/29/2024-S. RLS.

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

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

AB 1895 **(Weber D) Public health: maternity ward closures.**
Current Text: Amended: 3/18/2024 html pdf
Status: 5/1/2024-In committee: Set, first hearing. Referred to suspense file.
Location: 5/1/2024-A. APPR. SUSPENSE FILE

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

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

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AB 1926 (**Connolly** D) **Health care coverage: regional enteritis.**

Current Text: Amended: 3/19/2024 html pdf

Status: 4/17/2024-In committee: Set, first hearing. Referred to suspense file.

Location: 4/17/2024-A. APPR. SUSPENSE FILE

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

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

AB 1943 (**Weber** D) **Medi-Cal: telehealth.**

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

Status: 5/1/2024-From committee: Do pass. To Consent Calendar. (Ayes 14. Noes 0.) (May 1).

Location: 5/1/2024-A. CONSENT CALENDAR

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

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

AB 1970 (**Jackson** D) **Mental Health: Black Mental Health Navigator Certification.**

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

Status: 5/1/2024-In committee: Set, first hearing. Referred to suspense file.

Location: 5/1/2024-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, within the Health and Welfare Agency, the Department of Health Care Access and Information, which is responsible for, among other things, administering various health professions training and development programs. Current law requires the department 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.

ALAMEDA **Alliance** FOR HEALTH

AB 1975 (**Bonta** D) **Medi-Cal: medically supportive food and nutrition interventions.**

Current Text: Introduced: 1/30/2024 html pdf

Status: 5/1/2024-In committee: Set, first hearing. Referred to suspense file.

Location: 5/1/2024-A. APPR. SUSPENSE FILE

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

Summary: Current law 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, effective July 1, 2026, subject to federal approval and the issuance of final guidance by the department. The bill would require those interventions to be covered if determined to be medically necessary by a health care provider or health care plan, as specified. The bill would require the provision of interventions for 12 weeks, or longer if deemed medically necessary. The bill would require a Medi-Cal managed care plan to offer at least 3 of 6 listed interventions, with certain conditions for a 7th intervention.

AB 1977 (**Ta** R) **Health care coverage: behavioral diagnoses.**

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

Status: 4/25/2024-Read second time. Ordered to Consent Calendar.

Location: 4/24/2024-A. CONSENT CALENDAR

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

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

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

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

Status: 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: 4/24/2024-In committee: Set, first hearing. Referred to suspense file.
Location: 4/24/2024-A. APPR. SUSPENSE FILE

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

Summary: Current law 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: Introduced: 2/1/2024 html pdf
Status: 5/1/2024-In committee: Set, first hearing. Referred to suspense file.
Location: 5/1/2024-A. APPR. SUSPENSE FILE

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

Summary: Current law 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 with enrollment of more than 100,000 lives, notwithstanding the fee-for-service requirement as described, 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 extend that repeal date to January 1, 2030. The bill would extend the period of time authorized for those pilot programs to operate from December 31, 2025, to December 31, 2027. The bill would extend the deadline for the department to report the findings to the Legislature from January 1, 2027, to January 1, 2029.

AB 2105 (**Lowenthal** D) **Coverage for PANDAS and PANS.**
Current Text: Amended: 4/18/2024 html pdf
Status: 5/1/2024-In committee: Set, first hearing. Referred to suspense file.
Location: 5/1/2024-A. APPR. SUSPENSE FILE

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

Summary: Would require 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: 5/1/2024-In committee: Set, first hearing. Referred to suspense file.
Location: 5/1/2024-A. APPR. SUSPENSE FILE

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

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

AB 2115 (**Haney** D) **Controlled substances: clinics.**
Current Text: Amended: 4/1/2024 html pdf
Status: 4/24/2024-From committee: Do pass and re-refer to Com. on APPR. (Ayes 16. Noes 0.) (April 23). Re-referred to Com. on APPR.
Location: 4/23/2024-A. APPR.

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

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

AB 2129 (**Petrie-Norris** D) **Immediate postpartum contraception.**
Current Text: Amended: 4/11/2024 html pdf
Status: 4/25/2024-Read second time. Ordered to Consent Calendar.
Location: 4/24/2024-A. CONSENT CALENDAR

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

Summary: 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 accredited birthing center. The bill would prohibit that provider contract from considering those devices, implants, or services to be part of a payment for a general obstetric procedure. Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.

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

Current Text: Amended: 2/27/2024 html pdf
Status: 4/10/2024-In committee: Set, first hearing. Referred to suspense file.
Location: 4/10/2024-A. APPR. SUSPENSE FILE

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

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

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

Current Text: Amended: 3/21/2024 html pdf
Status: 4/24/2024-In committee: Set, first hearing. Referred to suspense file.
Location: 4/24/2024-A. APPR. SUSPENSE FILE

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

Summary: Current law 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: 5/1/2024-Re-referred to Com. on APPR.
Location: 4/23/2024-A. APPR.

Desk	Policy	Fiscal	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: 4/29/2024 html pdf
Status: 4/30/2024-Re-referred to Com. on APPR.
Location: 4/23/2024-A. APPR.

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 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 final federal rules are implemented, whichever is later.

AB 2200 (**Kalra** D) **Guaranteed Health Care for All.**

Current Text: Amended: 4/30/2024 html pdf
Status: 5/1/2024-Re-referred to Com. on APPR.
Location: 4/23/2024-A. APPR.

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 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: 4/11/2024 html pdf
Status: 4/15/2024-Re-referred to Com. on HUM. S. Re-referred to Com. on APPR. pursuant to Assembly Rule 96.
Location: 4/15/2024-A. APPR.

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

Summary: Under current law, specialty mental health services include federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services provided to eligible Medi-Cal beneficiaries under 21 years of age. This bill would require, when a child or youth 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: 5/1/2024-From committee: Do pass. To Consent Calendar. (Ayes 14. Noes 0.) (May 1).
Location: 5/1/2024-A. CONSENT CALENDAR

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: Introduced: 2/8/2024 html pdf
Status: 5/1/2024-In committee: Set, first hearing. Referred to suspense file.
Location: 5/1/2024-A. APPR. SUSPENSE FILE

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

Summary: Current law requires health care service plans and health insurers to include coverage for screening for various conditions and circumstances, including adverse childhood experiences. Current law provides for the Medi-Cal program, administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2027, to include coverage for screenings for social determinants of health, as defined. The bill would require providers to use specified tools or protocols when documenting patient responses to questions asked in these screenings. The bill would require a health care service plan or health insurer to provide physicians who provide primary care services with adequate access to peer support specialists, lay health workers, social workers, or community health workers in counties where the plan or insurer has enrollees or insureds, as specified. The bill would authorize the respective departments to adopt guidance to implement its provisions.

AB 2258 **(Zbur D) Health care coverage: cost sharing.**
Current Text: Amended: 4/1/2024 html pdf
Status: 5/1/2024-In committee: Set, first hearing. Referred to suspense file.
Location: 5/1/2024-A. APPR. SUSPENSE FILE

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

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

AB 2271 **(Ortega D) St. Rose Hospital.**
Current Text: Amended: 4/18/2024 html pdf
Status: 4/24/2024-From committee: Do pass and re-refer to Com. on APPR. (Ayes 15. Noes 0.) (April 23). Re-referred to Com. on APPR.
Location: 4/23/2024-A. APPR.

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

Summary: The California Health Facility Construction Loan Insurance Law establishes, without cost to the state, an insurance program for health facility construction, improvement, and expansion loans in order to stimulate the flow of private capital into health facilities construction, improvement, and expansion and in order to rationally meet the need for new, expanded, and modernized public and nonprofit health facilities necessary to protect the health of all the people of this state. 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 requires the Department of Health Care Access and Information to administer both of these programs. This bill would require the department to approve the forgiveness of both of these loans for the St. Rose Hospital in the City of Hayward.

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

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

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

implement these provisions and would require the department to make any state plan amendments or waiver requests public 45 days prior to submitting them to the federal Centers for Medicare and Medicaid Services.

AB 2319 (**Wilson** D) **California Dignity in Pregnancy and Childbirth Act.**
Current Text: Amended: 3/21/2024 html pdf
Status: 5/1/2024-In committee: Set, first hearing. Referred to suspense file.
Location: 5/1/2024-A. APPR. SUSPENSE FILE

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

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

AB 2332 (**Connolly** D) **Corrections: health care.**
Current Text: Amended: 3/21/2024 html pdf
Status: 5/1/2024-In committee: Set, first hearing. Referred to suspense file.
Location: 5/1/2024-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 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.

ALAMEDA Alliance FOR HEALTH

AB 2339 (**Aguiar-Curry** D) **Medi-Cal: telehealth.**
Current Text: Introduced: 2/12/2024 html pdf
Status: 4/17/2024-In committee: Set, first hearing. Referred to suspense file.
Location: 4/17/2024-A. APPR. SUSPENSE FILE

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: 4/17/2024-From committee: Do pass and re-refer to Com. on APPR. with recommendation: To Consent Calendar. (Ayes 16. Noes 0.) (April 16). Re-referred to Com. on APPR.
Location: 4/16/2024-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. 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
1st House				2nd House							

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: 4/29/2024-Re-referred to Com. on APPR.

Location: 4/23/2024-A. APPR.

Desk	Policy	Fiscal	Floor	Desk	Policy	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: 4/10/2024-From committee: Do pass and re-refer to Com. on APPR. with recommendation: To Consent Calendar. (Ayes 16. Noes 0.) (April 9). Re-referred to Com. on APPR.

Location: 4/9/2024-A. APPR.

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

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

ALAMEDA **Alliance** FOR HEALTH

AB 2376 (**Bains** D) **Chemical dependency recovery hospitals.**
Current Text: Amended: 3/21/2024 html pdf
Status: 4/17/2024-From committee: Do pass and re-refer to Com. on APPR. with recommendation: To Consent Calendar. (Ayes 16. Noes 0.) (April 16). Re-referred to Com. on APPR.
Location: 4/16/2024-A. APPR.

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

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

AB 2446 (**Ortega** D) **Medi-Cal: diapers.**
Current Text: Amended: 4/4/2024 html pdf
Status: 4/17/2024-In committee: Set, first hearing. Referred to suspense file.
Location: 4/17/2024-A. APPR. SUSPENSE FILE

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

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

AB 2449 (**Ta** R) **Health care coverage: qualified autism service providers.**
Current Text: Introduced: 2/13/2024 html pdf
Status: 4/25/2024-Read third time. Passed. Ordered to the Senate. (Ayes 72. Noes 0.) In Senate. Read first time. To Com. on RLS. for assignment.
Location: 4/25/2024-S. RLS.

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

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

Alameda Alliance for Health

AB 2466 (**Carrillo, Wendy** D) **Medi-Cal managed care: network adequacy standards.**

Current Text: Amended: 4/18/2024 html pdf
Status: 4/22/2024-Re-referred to Com. on APPR.
Location: 4/16/2024-A. APPR.

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

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: 4/25/2024 html pdf
Status: 4/29/2024-Re-referred to Com. on APPR.
Location: 4/23/2024-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 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 treatment of 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: 4/4/2024 html pdf
Status: 4/25/2024-Read second time. Ordered to Consent Calendar.
Location: 4/24/2024-A. CONSENT CALENDAR

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

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

AB 2668 (**Berman** D) **Coverage for cranial prostheses.**

Current Text: Introduced: 2/14/2024 html pdf
Status: 4/24/2024-Coauthors revised. From committee: Do pass and re-refer to Com. on APPR. (Ayes 16. Noes 0.) (April 23). Re-referred to Com. on APPR.
Location: 4/24/2024-A. APPR.

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

1st House				2nd House				Conc.			

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

AB 2699 (**Carrillo, Wendy** D) **Hazardous materials: reporting: civil liability.**
Current Text: Amended: 4/1/2024 html pdf
Status: 4/16/2024-From committee: Do pass and re-refer to Com. on APPR. (Ayes 9. Noes 3.) (April 16). Re-referred to Com. on APPR.
Location: 4/16/2024-A. APPR.

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

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

AB 2701 (**Villapudua** D) **Medi-Cal: dental cleanings and examinations.**
Current Text: Introduced: 2/14/2024 html pdf
Status: 4/10/2024-From committee: Do pass and re-refer to Com. on APPR. (Ayes 16. Noes 0.) (April 9). Re-referred to Com. on APPR.
Location: 4/9/2024-A. APPR.

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

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

AB 2703 (**Aguiar-Curry** D) **Federally qualified health centers and rural health clinics: psychological associates.**
Current Text: Introduced: 2/14/2024 html pdf
Status: 4/17/2024-In committee: Set, first hearing. Referred to suspense file.
Location: 4/17/2024-A. APPR. SUSPENSE FILE

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

1st House				2nd House				Conc.			

Summary: Current law requires the State Department of Health Care Services to 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: 4/29/2024-Re-referred to Com. on APPR.
Location: 4/23/2024-A. APPR.

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

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: 4/17/2024-In committee: Set, first hearing. Referred to suspense file.
Location: 4/17/2024-A. APPR. SUSPENSE FILE

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

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

AB 2843 (**Petrie-Norris** D) **Health care coverage: rape and sexual assault.**
Current Text: Introduced: 2/15/2024 html pdf
Status: 4/24/2024-From committee: Do pass and re-refer to Com. on APPR. with recommendation: To Consent Calendar. (Ayes 16. Noes 0.) (April 23). Re-referred to Com. on APPR.
Location: 4/23/2024-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 or health insurance policy that is issued, amended, renewed, or delivered on or after January 1, 2025, to provide coverage without cost sharing for emergency room medical care and follow-up health care treatment for an enrollee or insured who is treated following a rape or sexual assault. The bill would prohibit a health care service plan or health insurer from requiring, as a condition of providing coverage, (1) an enrollee or insured to file a police report, (2) charges to be brought against an assailant, (3) or an assailant to be convicted of rape or sexual assault. Because a violation of the bill by a health care service plan would be a crime, the bill would impose a state-mandated local program.

AB 2914 (**Bonta** D) **Health care coverage: essential health benefits.**
Current Text: Amended: 4/10/2024 html pdf
Status: 4/24/2024-From committee: Do pass and re-refer to Com. on APPR. (Ayes 16. Noes 0.) (April 23). Re-referred to Com. on APPR.
Location: 4/23/2024-A. APPR.

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

Summary: Current law requires the 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: 4/24/2024 html pdf
Status: 4/25/2024-Re-referred to Com. on APPR.
Location: 4/23/2024-A. 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. This bill would, among other things, require 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 first using it and annually thereafter, and with respect to an automated decision tool that a deployer first used before January 1, 2025, the bill would require the deployer to perform an impact assessment on that automated decision tool before January 1, 2026, 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 Civil Rights Department within 7 days of a request by the department 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 Civil Rights Department.

AB 2956 (**Boerner** D) **Medi-Cal eligibility: redetermination.**
Current Text: Amended: 4/18/2024 html pdf
Status: 4/22/2024-Re-referred to Com. on APPR.
Location: 4/16/2024-A. APPR.

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

1st House		2nd House		Conc.			

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: 2/17/2024-From printer. May be heard in committee March 18.
Location: 2/16/2024-A. PRINT

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

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

AB 3030 **(Calderon D) Health care services: artificial intelligence.**

Current Text: Amended: 4/25/2024 html pdf
Status: 4/29/2024-Re-referred to Com. on APPR.
Location: 4/24/2024-A. APPR.

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

Summary: Would require a health facility, clinic, physician's office, or office of a group practice that uses generative artificial intelligence to generate written or verbal patient communications 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 permitting a patient to communicate with a human health care provider. Because a violation of these requirements would be a crime, this bill would impose a state-mandated local program.

AB 3059 **(Weber D) Human milk.**

Current Text: Amended: 3/11/2024 html pdf
Status: 4/24/2024-Coauthors revised. From committee: Do pass and re-refer to Com. on APPR. (Ayes 16. Noes 0.) (April 23). Re-referred to Com. on APPR.
Location: 4/23/2024-A. 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. Existing law exempts a "mothers' milk bank," as defined, from paying a licensing fee

to be a tissue bank. 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 human milk that was obtained from a mothers' milk bank.

AB 3129 (**Wood** D) **Health care system consolidation.**
Current Text: Amended: 4/24/2024 html pdf
Status: 4/25/2024-Re-referred to Com. on APPR.
Location: 4/23/2024-A. APPR.

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

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

AB 3149 (**Garcia** D) **Promotores and Promotoras Advisory and Oversight Workgroup.**
Current Text: Amended: 4/18/2024 html pdf
Status: 4/22/2024-Re-referred to Com. on APPR.
Location: 4/16/2024-A. APPR.

Desk	Policy	Fiscal	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: beneficiaries with other primary coverage.**
Current Text: Amended: 4/25/2024 html pdf
Status: 4/29/2024-Re-referred to Com. on APPR.
Location: 4/23/2024-A. APPR.

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

1st House				2nd House				Conc.			

Summary: Under current federal law, in accordance with third-party liability rules, Medicaid is generally the payer of last resort if a beneficiary has another source of health care coverage in addition to Medicaid coverage. Under this bill, in the case of an enrollee of a Medi-Cal managed care plan who has other health care coverage and for whom the Medi-Cal program is a secondary payer, the State Department of Health Care Services 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. The bill, in the case of an enrollee of a Medi-Cal managed care plan who has coverage under the federal Medicare Program or another primary form of health care coverage and for whom the Medi-Cal program is a secondary payer, would prohibit a provider participating in the Medi-Cal fee-for-service delivery system or in the federal Medicare Program from being required to contract with the Medi-Cal managed care plan in order to provide services to that enrollee and to bill the managed care plan.

AB 3215 (**Soria** D) **Medi-Cal: mental health services for children.**
Current Text: Introduced: 2/16/2024 html pdf
Status: 2/17/2024-From printer. May be heard in committee March 18.
Location: 2/16/2024-A. PRINT

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

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

AB 3221 (**Pellerin** D) **Department of Managed Health Care: review of records.**
Current Text: Amended: 4/1/2024 html pdf
Status: 5/1/2024-From committee: Do pass. (Ayes 14. Noes 0.) (May 1).
Location: 4/16/2024-A. APPR.

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

Summary: Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (hereafter the act), provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law requires the records, books, and papers of a health care service plan and other specified entities to be open to inspection by the director of the department during normal business hours.This bill would instead require the records, books, and papers of a health care service plan and other specified entities to be open to inspection by the director, including through electronic means. The bill would require a plan and other specified entities to furnish in electronic media records, books, and papers that are possessed in electronic media and to conduct a diligent review of records, books, and papers and make every effort to furnish those responsive to the director's request. The bill would require records, books, and papers to be furnished in a format that is digitally searchable, to the greatest extent feasible. The bill would require records, books, and papers to be preserved until furnished, if requested by the department. The bill would authorize the director to inspect and copy these records, books, and papers, and to seek relief in an administrative law proceeding if, in the director's determination, a plan or other specified entity fails to fully or timely respond to a duly authorized request for production of records, books, and papers. Because a willful violation of these requirements would be a crime, the bill would impose a state-mandated local program.

AB 3245 (**Patterson, Joe** R) **Coverage for colorectal cancer screening.**
Current Text: Amended: 4/25/2024 html pdf
Status: 4/29/2024-Read second time. Ordered to third reading.
Location: 4/29/2024-A. THIRD READING

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

Summary: Current law generally 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.

AB 3260 (Pellerin D) **Health care coverage: reviews and grievances.**
Current Text: Amended: 4/1/2024 html pdf
Status: 4/17/2024-From committee: Do pass and re-refer to Com. on APPR. (Ayes 13. Noes 1.) (April 16). Re-referred to Com. on APPR.
Location: 4/16/2024-A. APPR.

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

Summary: (1)Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law generally authorizes a health care service plan or disability insurer to use utilization review, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. Existing law requires these decisions to be made within 30 days, or less than 72 hours when the enrollee faces an imminent and serious threat to their health. Existing law requires a health care service plan to establish a grievance system to resolve grievances within 30 days, but limits that timeframe to 3 days when the enrollee faces an imminent and serious threat to their health. Existing law requires a plan to provide a written explanation for its grievance decisions, as specified.This bill would require that utilization review decisions be made within 72 hours from the health care service plan's receipt of the clinical information reasonably necessary to make the determination when the enrollee's condition is urgent, and would make a determination of urgency by the enrollee's health care provider binding on the health care service plan. If the plan lacks the information reasonably necessary to make a decision regarding an urgent request, the bill would require the plan to notify the enrollee and provider about the information necessary to complete the request within 24 hours of receiving the request. The bill would require the plan to notify the enrollee and the provider of the decision within a reasonable amount of time, but not later than 48 hours after specified circumstances occur. If a health care service plan fails to make a utilization review decision, or provide notice of a decision, within the specified timelines, the bill would require the health care service plan to treat the request for authorization as a grievance and provide notice with specified information to the enrollee that a grievance has commenced.

AB 3275 (Soria D) **Health care coverage: claim reimbursement.**
Current Text: Amended: 4/18/2024 html pdf
Status: 4/22/2024-Re-referred to Com. on APPR.
Location: 4/16/2024-A. APPR.

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

Summary: Current law provides for the regulation of health insurers by the Department of Insurance. Current law requires a health 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 existing 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 existing law, if a claim is not reimbursed, contested, or denied pursuant to these timelines, as specified, interest accrues at a rate of 15% per annum for a health care service plan and 10% per annum for a health insurer. This bill would increase that interest accrual rate for a health insurer to 15% per annum. The bill, notwithstanding the above-described timelines, would require a health care service plan or health insurer to reimburse a claim for a small and rural provider, critical access provider, or distressed provider within 10 business days after receipt of the claim, or, if the health care service plan or health insurer contests or denies the claim, to notify the claimant within 5 business days that the claim is contested or denied. Under the bill, if a claim for

reimbursement to a small and rural provider, critical access provider, or distressed provider is contested on the basis that the health care service plan or health insurer has not received all information necessary to determine payer liability for the claim and notice has been provided, the health care service plan or health insurer would have 15 business days after receipt of the additional information to complete reconsideration of the claim. Under the bill, if a claim is not reimbursed, contested, or denied pursuant to these timelines, as specified, interest would accrue at a rate of 15% per annum for health care service plans and health insurers.

SB 70 **(Wiener D) Prescription drug coverage.**
Current Text: Amended: 6/29/2023 html pdf
Status: 9/1/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/16/2023)(May be acted upon Jan 2024)
Location: 9/1/2023-A. 2 YEAR

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

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

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

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

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

SB 238 **(Wiener D) Health care coverage: independent medical review.**
Current Text: Amended: 6/19/2023 html pdf
Status: 9/1/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/23/2023)(May be acted upon Jan 2024)
Location: 9/1/2023-A. 2 YEAR

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

Summary: Current law provides for the regulation of disability insurers by the Department of Insurance. Current law establishes the Independent Medical Review System within each department, under which an enrollee or insured may seek review if a health care service has been denied, modified, or delayed by a health care service plan or disability insurer and the enrollee or insured has previously filed a grievance that remains unresolved after 30 days. This bill, commencing July 1, 2024, would require a health care service plan or a disability insurer that modifies, delays, or denies a health care service, based in whole or in part on medical necessity, to automatically submit within 24 hours a decision regarding a disputed health care service to the Independent Medical Review System, as well as the information that informed its decision, without requiring an enrollee or insured to submit a grievance, if the decision is to deny, modify, or delay specified services relating to mental health or substance use disorder conditions for an enrollee or insured up to 26 years of age. The bill would require a health care service plan or disability insurer, within 24 hours after submitting its decision to the Independent Medical Review System to provide notice to the appropriate department, the enrollee or insured or their representative, if any, and the enrollee's or insured's provider. The bill would require the notice to include notification to the enrollee or insured that they or their representative may cancel the independent medical review at any time before a determination, as specified. The bill would apply specified existing provisions relating to mental health and substance use disorders for purposes of its provisions, and would be subject to relevant provisions relating to the Independent Medical Review System that do not otherwise conflict with the express requirements of the bill. With respect to health care service plans, the bill would specify that its provisions do not apply to Medi-Cal managed care plan contracts.

SB 282 (**Eggman** D) **Medi-Cal: federally qualified health centers and rural health clinics.**
Current Text: Amended: 3/13/2023 html pdf
Status: 9/1/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/16/2023) (May be acted upon Jan 2024)
Location: 9/1/2023-A. 2 YEAR

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

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

SB 294 (**Wiener** D) **Health care coverage: independent medical review.**
Current Text: Amended: 1/11/2024 html pdf
Status: 4/29/2024-Referred to Com. on HEALTH.
Location: 4/29/2024-A. HEALTH

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

Summary: Would, commencing July 1, 2025, require a health care service plan or a disability insurer that upholds its decision to modify, delay, or deny a health care service in response to a grievance or has a grievance that is otherwise pending or unresolved upon expiration of the relevant timeframe to automatically submit within 24 hours a decision

regarding a disputed health care service to the Independent Medical Review System, as well as the information that informed its decision, if the decision is to deny, modify, or delay specified services relating to mental health or substance use disorder conditions for an enrollee or insured up to 26 years of age. The bill would require a health care service plan or disability insurer, within 24 hours after submitting its decision to the Independent Medical Review System to provide notice to the appropriate department, the enrollee or insured or their representative, if any, and the enrollee's or insured's provider. The bill would require the notice to include notification to the enrollee or insured that they or their representative may cancel the independent medical review at any time before a determination, as specified.

SB 339 (**Wiener** D) **HIV preexposure prophylaxis and postexposure prophylaxis.**

Current Text: Chaptered: 2/6/2024 html pdf

Status: 2/6/2024-Chaptered by Secretary of State - Chapter 1, Statutes of 2024

Location: 2/6/2024-S. CHAPTERED

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

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

SB 363 (**Eggman** D) **Facilities for inpatient and residential mental health and substance use disorder: database.**

Current Text: Amended: 5/18/2023 html pdf

Status: 9/1/2023-September 1 hearing: Held in committee and under submission.

Location: 8/23/2023-A. APPR. SUSPENSE FILE

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

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

SB 424 (**Durazo** D) **Medi-Cal: Whole Child Model program.**

Current Text: Amended: 5/25/2023 html pdf

Status: 7/14/2023-Failed Deadline pursuant to Rule 61(a)(10). (Last location was HEALTH on 6/8/2023)(May be acted upon Jan 2024)

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

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

Summary: Current law establishes the California Children's Services (CCS) Program, administered by the State Department of Health Care Services and a designated agency of each county, to provide medically necessary services for persons under 21 years of age who have any of specified medical conditions and who meet certain financial eligibility requirements. Current law establishes the Medi-Cal program, which is administered by the department and under which

qualified low-income individuals receive health care services. Current law requires the department to establish a statewide Whole Child Model program stakeholder advisory group that includes specified persons, including CCS case managers, and to consult with that advisory group on prescribed matters. Current law terminates the advisory group on December 31, 2023. This bill would extend the operation of the advisory group until December 31, 2026.

SB 427 (Portantino D) **Health care coverage: antiretroviral drugs, drug devices, and drug products.**

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

Status: 4/11/2024-Read third time. Passed. Ordered to the Senate. In Senate. Concurrence in Assembly amendments pending.

Location: 4/11/2024-S. CONCURRENCE

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

Summary: Current law generally prohibits a health care service plan, excluding a Medi-Cal managed care plan, or health insurer from subjecting antiretroviral drugs that are medically necessary for the prevention of HIV/AIDS, including preexposure prophylaxis or postexposure prophylaxis, to prior authorization or step therapy. Under current law, a health care service plan or health insurer is not required to cover all the therapeutically equivalent versions of those drugs without prior authorization or step therapy if at least one is covered without prior authorization or step therapy. This bill would prohibit a health care service plan, excluding a Medi-Cal managed care plan, or health insurer from subjecting antiretroviral drugs, drug devices, or drug products that are either approved by the United States Food and Drug Administration (FDA) or recommended by the federal Centers for Disease Control and Prevention (CDC) for the prevention of HIV/AIDS, to prior authorization or step therapy, but would authorize prior authorization or step therapy if at least one therapeutically equivalent version is covered without prior authorization or step therapy and the plan or insurer provides coverage for a noncovered therapeutic equivalent antiretroviral drug, drug device, or drug product without cost sharing pursuant to an exception request. The bill would require a plan or insurer to provide coverage under the outpatient prescription drug benefit for those drugs, drug devices, or drug products, including by supplying participating providers directly with a drug, drug device, or drug product, as specified.

SB 516 (Skinner D) **Health care coverage: prior authorization.**

Current Text: Amended: 9/13/2023 html pdf

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

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

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

Summary: Would, on or after January 1, 2026, prohibit a health care service plan or health insurer from requiring a contracted health professional to complete or obtain a prior authorization for any covered health care services if the plan or insurer approved or would have approved not less than 90% of the prior authorization requests they submitted in the most recent completed one-year contracted period. The bill would set standards for this exemption and its denial, rescission, and appeal. The bill would authorize a plan or insurer to evaluate the continuation of an exemption not more than once every 12 months, and would authorize a plan or insurer to rescind an exemption only at the end of the 12-month period and only if specified criteria are met. The bill would require a plan or insurer to provide an electronic prior authorization process. The bill would also require a plan or insurer to have a process for annually monitoring prior authorization approval, modification, appeal, and denial rates to identify services, items, and supplies that are regularly approved, and to discontinue prior authorization on those services, items, and supplies that are approved 95% of the time. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

SB 551 (Portantino D) **Beverage containers: recycling.**

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

Status: 3/21/2024-Read second time and amended. Re-referred to Com. on APPR.

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

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

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

SB 729 (Menjivar D) **Health care coverage: treatment for infertility and fertility services.**
Current Text: Amended: 8/14/2023 html pdf
Status: 9/1/2023-Failed Deadline pursuant to Rule 61(a)(11). (Last location was APPR. SUSPENSE FILE on 8/23/2023)(May be acted upon Jan 2024)
Location: 9/1/2023-A. 2 YEAR

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

Summary: Would require large and small group health care service plan contracts and disability insurance policies issued, amended, or renewed on or after January 1, 2024, to provide coverage for the diagnosis and treatment of infertility and fertility services. With respect to large group health care service plan contracts and disability insurance policies, the bill would require coverage for a maximum of 3 completed oocyte retrievals, as specified. The bill would revise the definition of infertility, and would remove the exclusion of in vitro fertilization from coverage. The bill would also delete a requirement that a health care service plan contract and disability insurance policy provide infertility treatment under agreed-upon terms that are communicated to all group contractholders and policyholders. The bill would prohibit a health care service plan or disability insurer from placing different conditions or coverage limitations on fertility medications or services, or the diagnosis and treatment of infertility and fertility services, than would apply to other conditions, as specified. The bill would make these requirements inapplicable to a religious employer, as defined, and specified contracts and policies.

SB 966 (Wiener D) **Pharmacy benefits.**
Current Text: Amended: 4/29/2024 html pdf
Status: 4/29/2024-Read second time and amended. Re-referred to Com. on APPR.
Location: 4/25/2024-S. APPR.

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

Summary: The Knox-Keene Act requires a pharmacy benefit manager under contract with a health care service plan to, among other things, register with the Department of Managed Health Care. Current law provides for the regulation of health insurers by the Department of Insurance. This bill would additionally require a pharmacy benefit manager, as defined by the bill, to apply for and obtain a license from the Department of Insurance to operate as a pharmacy benefit manager on and after January 1, 2026. 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 Fund to be available to the department for use, upon appropriation by the Legislature, for costs related to licensing and regulating pharmacy benefit managers.

SB 980 (**Wahab** D) **Medi-Cal: dental crowns and implants.**
Current Text: Amended: 3/21/2024 html pdf
Status: 4/8/2024-April 8 hearing: Placed on APPR suspense file.
Location: 4/8/2024-S. APPR. SUSPENSE FILE

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

Summary: Under current law, early and periodic screening, diagnostic, and treatment (EPSDT) services are covered under Medi-Cal for an individual under 21 years of age in accordance with certain federal provisions. Under existing law, for persons 21 years of age or older, laboratory-processed crowns on posterior teeth are a covered benefit when medically necessary to restore a posterior tooth back to normal function based on the criteria specified in the Medi-Cal Dental Manual of Criteria. This bill, for purposes of the above-described Medi-Cal coverage for laboratory-processed crowns, would remove the condition that the tooth be posterior and would apply the coverage to persons 13 years of age or older. Under the bill, this provision would not be construed to exclude Medi-Cal coverage for laboratory-processed crowns on teeth if otherwise required under EPSDT services.

SB 999 (**Cortese** D) **Health coverage: mental health and substance use disorders.**
Current Text: Amended: 4/8/2024 html pdf
Status: 4/26/2024-Set for hearing May 6.
Location: 4/25/2024-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 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: 4/30/2024-Set for hearing May 6.
Location: 4/25/2024-S. APPR.

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

Summary: Would require an individual or group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, to include 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: 4/15/2024-April 15 hearing: Placed on APPR suspense file.
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: 3/21/2024 html pdf
Status: 4/29/2024-April 29 hearing: Placed on APPR suspense file.
Location: 4/29/2024-S. APPR. SUSPENSE FILE

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

Summary: This bill, subject to any necessary federal approvals and the availability of federal funding, would require the State Department of Health Care Services and the State Department of Social Services to develop a model memorandum of understanding (MOU), and would require the department to require Medi-Cal managed care plans and alternative payment agencies to enter an MOU that includes, at a minimum, the provisions included in the model.

SB 1120 (Becker D) **Health care coverage: utilization review.**
Current Text: Amended: 4/15/2024 html pdf
Status: 4/22/2024-April 22 hearing: Placed on APPR suspense file.
Location: 4/22/2024-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 authorizes a health care service plan or health insurer to use prior authorization and other utilization review or utilization management functions, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. Current law requires a health care service plan or health insurer, including those plans or insurers that delegate utilization review or utilization management functions to medical groups, independent practice associations, or to other contracting providers, to comply with specified requirements and limitations on their utilization review or utilization management functions. Current law authorizes the Director of the Department of Managed Health Care or the Insurance Commissioner to assess an administrative penalty to a health care service plan or health insurer, as applicable, for failure to comply with those requirements. This bill would require algorithms, artificial intelligence, and other software tools used for utilization review or utilization management decisions to comply with specified requirements, including that they be fairly and equitably applied.

SB 1131 (Gonzalez D) **Medi-Cal providers.**
Current Text: Amended: 4/8/2024 html pdf
Status: 4/15/2024-April 15 hearing: Placed on APPR suspense file.
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: The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under current law, services provided by a certified nurse practitioner are covered under the Medi-Cal program to the extent authorized by federal law, and current law requires the department to permit a certified nurse practitioner to bill Medi-Cal independently for their services. This bill would similarly make services provided by a licensed physician assistant covered under the Medi-Cal program and would require the department to permit a certified nurse practitioner to bill Medi-Cal independently for their services.

SB 1180 (**Ashby** D) **Health care coverage: emergency medical services.**
Current Text: Amended: 4/29/2024 html pdf
Status: 4/30/2024-Set for hearing May 6.
Location: 4/25/2024-S. 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 and triage paramedic assessments. This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, to 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. The bill would require those plans and policies to require an enrollee or insured who receives covered services from a noncontracting program to pay no more than the same cost-sharing amount they would pay for the same covered services received from a contracting program. The bill would specify the reimbursement process and amount for a noncontracting program. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. The bill would also make services provided by these programs covered benefits under the Medi-Cal program.

SB 1213 (**Atkins** D) **Health care programs: cancer.**
Current Text: Amended: 4/8/2024 html pdf
Status: 4/15/2024-April 15 hearing: Placed on APPR suspense file.
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 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: 4/30/2024-Set for hearing May 6.
Location: 4/25/2024-S. APPR.

Desk	Policy	Fiscal	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: 4/15/2024-April 15 hearing: Placed on APPR suspense file.
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: 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
1st House				2nd House							

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: 4/15/2024-April 24 set for second hearing canceled at the request of author.
Location: 2/29/2024-S. HEALTH

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

ALAMEDA Alliance FOR HEALTH

1st House				2nd House				Conc.			

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

SB 1290 **(Roth D) Health care coverage: essential health benefits.**
Current Text: Introduced: 2/15/2024 html pdf
Status: 4/23/2024-Read second time. Ordered to third reading.
Location: 4/23/2024-S. THIRD READING

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

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

SB 1300 **(Cortese D) Health facility closure: public notice: inpatient psychiatric and maternity services.**
Current Text: Amended: 4/8/2024 html pdf
Status: 4/16/2024-Read second time. Ordered to third reading.
Location: 4/16/2024-S. THIRD READING

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

Summary: Current law requires the State Department of Public Health to license, regulate, and inspect health facilities, as specified, including general acute care hospitals. Under current law, a general acute care hospital is required to provide certain basic services, including medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services. Current law authorizes a general acute care hospital to provide various special or supplemental services if certain conditions are met. Current regulations define a supplemental service as an organized inpatient or outpatient service that is not required to be provided by law or regulation. Current law requires a health facility to provide 90 days of public notice of the proposed closure or elimination of a supplemental service, and 120 days of public notice of the proposed closure or elimination of an acute psychiatric hospital. This bill would change the notice period required before proposed closure or elimination of the supplemental service of inpatient psychiatric service or maternity service from 90 days to 120 days. By changing the definition of a crime, this bill would impose a state-mandated local program.

SB 1339 **(Allen D) Supportive community residences.**
Current Text: Amended: 4/29/2024 html pdf
Status: 4/30/2024-Set for hearing May 6.
Location: 4/25/2024-S. APPR.

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

Summary: 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 that does not provide medical care or a level of support for activities of daily living that require state licensing. 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.

SB 1354 **(Wahab D) Long-term health care facilities: payment source and resident census.**
Current Text: Amended: 4/29/2024 html pdf
Status: 4/30/2024-Set for hearing May 6.
Location: 4/25/2024-S. APPR.

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

Summary: Current law provides for the licensing and regulation of long-term health care facilities, including, among others, skilled nursing facilities and intermediate care facilities, by the State Department of Public Health. A violation of those provisions is generally a crime. 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: 4/26/2024-Set for hearing May 6.
Location: 4/23/2024-S. APPR.

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

Summary: Current law generally requires a county to redetermine a Medi-Cal beneficiary's eligibility to receive Medi-Cal benefits every 12 months and whenever the county receives information about changes in a beneficiary's circumstances that may affect their eligibility for Medi-Cal benefits. Current law provides for the In-Home Supportive Services (IHSS) program, administered by the State Department of Social Services and counties, under which qualified aged, blind, and disabled persons are provided with supportive services in order to permit them to remain in their own homes. Current law authorizes certain Medi-Cal beneficiaries to receive IHSS as a covered Medi-Cal benefit. This bill would, to the extent that any necessary federal approvals are obtained, and federal financial participation is available and not otherwise jeopardized, require an IHSS recipient to be continuously eligible for Medi-Cal for 3 years, if they have a fixed income, and would prohibit a redetermination of Medi-Cal eligibility before 3 years, except as specified. The bill would make the implementation of its provisions contingent upon the department obtaining all necessary federal approvals, the department determining that systems have been programmed to implement these provisions, and the Legislature has appropriated funding to implement these provisions after a determination that ongoing General Fund resources are available to support the ongoing implementation of these provisions.

SB 1397 **(Eggman D) Behavioral health services coverage.**
Current Text: Amended: 4/15/2024 html pdf
Status: 4/22/2024-April 22 hearing: Placed on APPR suspense file.
Location: 4/22/2024-S. APPR. SUSPENSE FILE

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, 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: critical access hospitals.**
Current Text: Amended: 4/29/2024 html pdf
Status: 4/30/2024-Set for hearing May 6.
Location: 4/25/2024-S. APPR.

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

Summary: Under current law, each hospital designated by the State Department of Health Care Services as a critical access hospital, and certified as such by the Secretary of the United States Department of Health and Human Services under the federal Medicare rural hospital flexibility program, is eligible for supplemental payments for Medi-Cal covered outpatient services rendered to Medi-Cal eligible persons. Current law conditions those payments on receipt of federal financial participation and an appropriation in the annual Budget Act for the nonfederal share of those payments, with supplemental payments being apportioned among critical access hospitals based on their number of Medi-Cal outpatient visits. This bill would require that each critical access hospital that elects to participate receive a base reimbursement at 100% of the hospital's projected reasonable and allowable costs for covered Medi-Cal services, as defined, furnished in the Medi-Cal fee-for-service and managed care delivery systems for each subject calendar year, effective for dates of service on or after January 1, 2026. The bill would require the department to develop and maintain one or more reimbursement methodologies, or revise one or more existing reimbursement methodologies applicable to participating critical access hospitals, or both, to implement the cost-based payment levels.

SB 1428 (**Atkins** D) **Health care coverage: triggering events.**
Current Text: Amended: 3/18/2024 html pdf
Status: 4/29/2024-Referred to Com. on HEALTH.
Location: 4/29/2024-A. HEALTH

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

Summary: Current law provides for the regulation of health insurers by the Department of Insurance. Current law requires a health care service plan or a health insurer to allow an individual to enroll in or change individual health benefit plans as a result of specified triggering events, including a loss of minimum essential coverage, as defined, gaining a dependent or becoming a dependent, or being mandated to be covered as a dependent pursuant to a valid state or federal court order. Current law allows an individual 60 days from the date of a triggering event to apply for subsequent coverage. This bill would allow an individual 60 days before or and after the date of a triggering event to apply for subsequent coverage. coverage, to the extent no conflicts with the availability and length of specified special enrollment periods exist. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

SB 1492 (**Menjivar** D) **Medi-Cal reimbursement rates: private duty nursing.**
Current Text: Amended: 4/15/2024 html pdf
Status: 4/26/2024-Set for hearing May 6.
Location: 4/25/2024-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 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.

Board Business

Alameda County Social Services (ACSSA) Medi-Cal Re-Evaluations

Alameda Alliance for Health Board of Governors
May 10, 2024

Andrea Ford, Agency Director, ACSSA

Tammy Lue, Medi-Cal Program Specialist, ACSSA-WBA

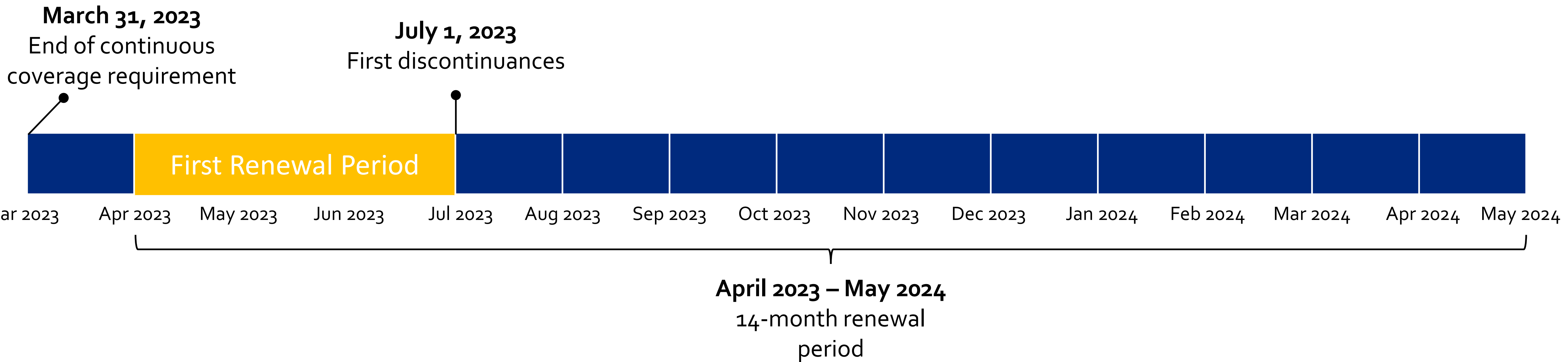
Juan Ventanilla, Medi-Cal Program Specialist, ACSSA-WBA

Alameda County
Social Services Agency

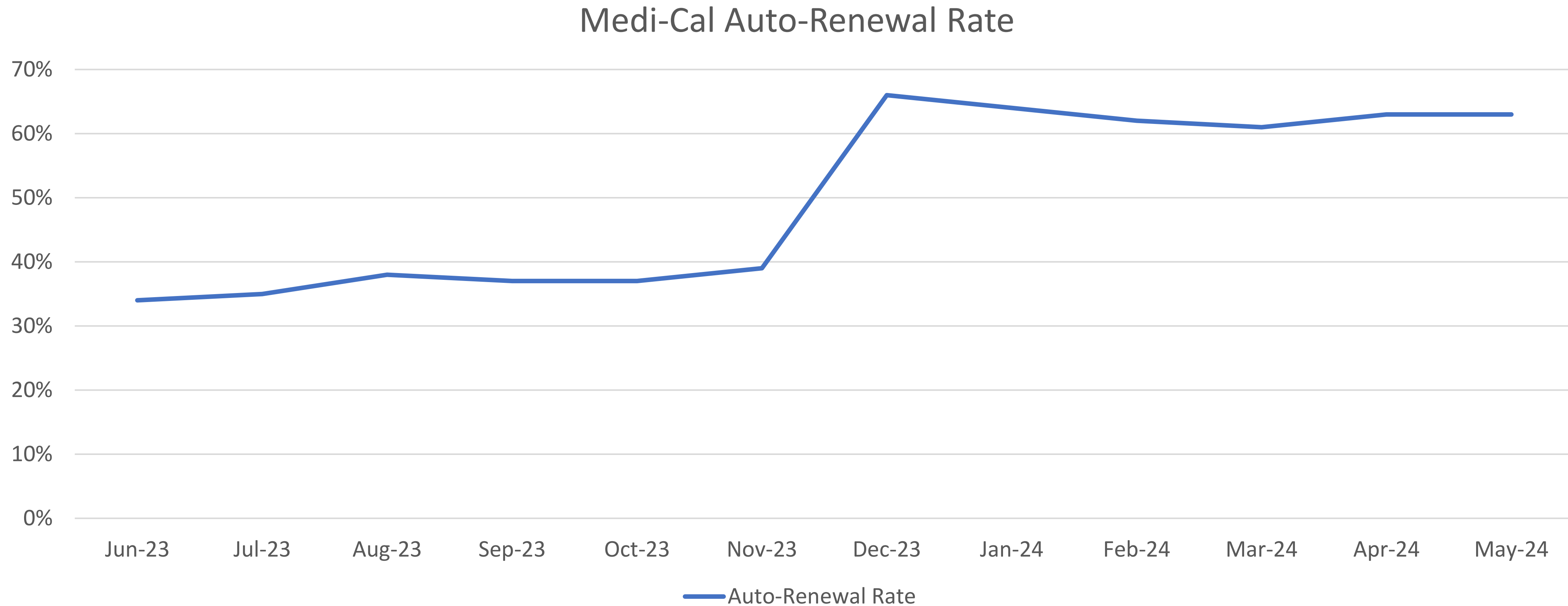
Overview

1. Medi-Cal Re-Evaluation Data
2. Alliance Net Change Enrollment
3. ACSSA Plan for Re-Evaluation Process
4. Medi-Cal Re-Evaluation Waivers
5. Alliance & ACSSA Collaboration

Continuous Coverage Unwinding



Medi-Cal Re-Evaluation (RE) Data



Alameda County
Social Services Agency

Medi-Cal Re-Evaluation (RE) Data – cont.

- June 2023-March 2024*
  - # of packets sent: 138,091
  - # of REs received: 117,139
    - # of REs processed: 91,158
    - # of REs not processed: 25,981
  - # of REs not received: 51,426
  - # of cases discontinued: 39,293
    - # of cases discontinued for no RE: 31,090

*data as of 04/05/2024

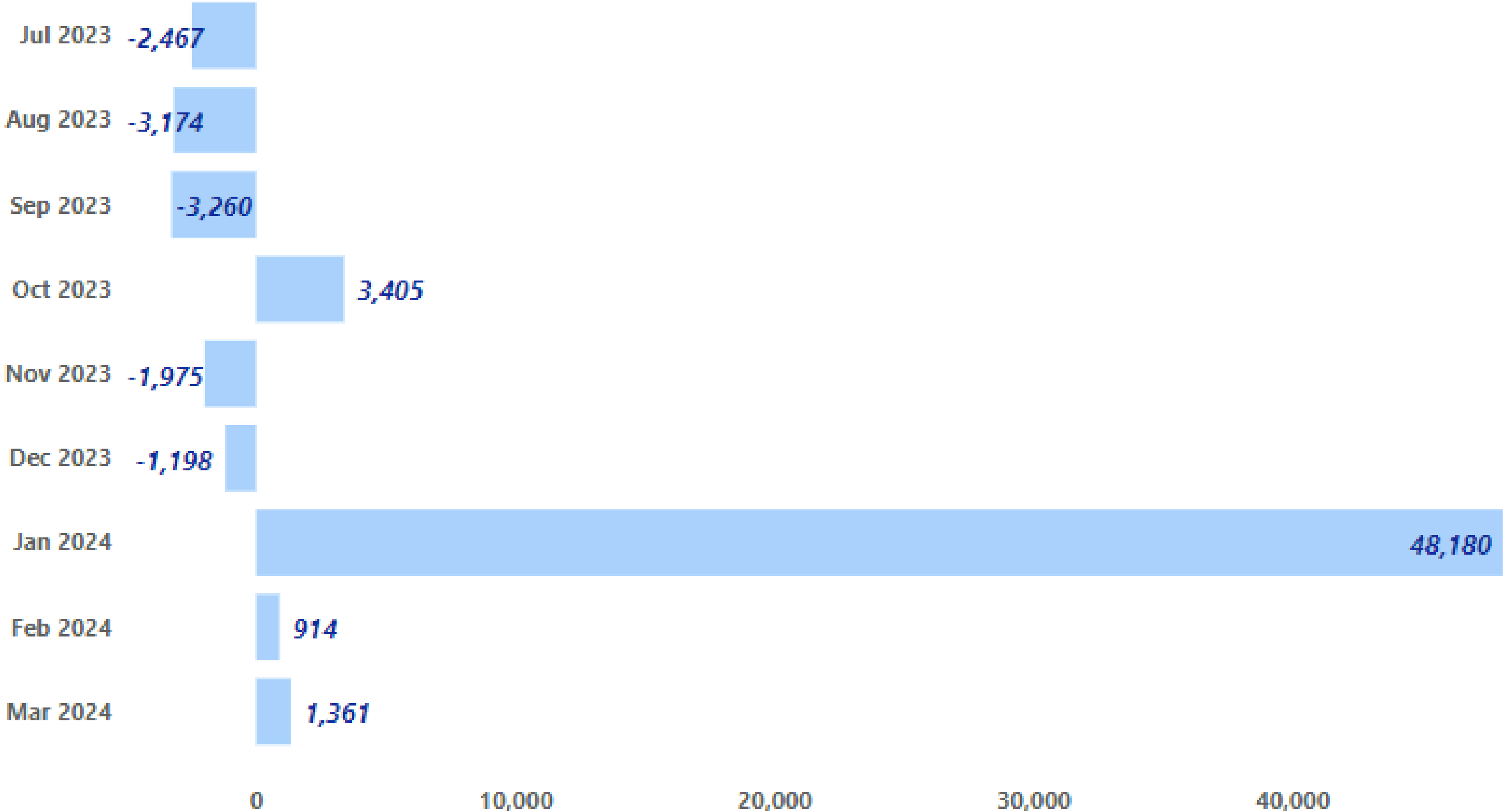
Alliance Medi-Cal Member Redetermination

- Less than 10% of Alliance members had a renewal date from the California Department of Health Care Services during the unwinding period through March 2024.

Source: California Department of Health Care Services (DHCS)

Alliance Medi-Cal Membership Net Change Enrollment

ALAMEDA Alliance FOR HEALTH



- In January 2024, we transitioned to a Single Plan model in Alameda County.
- The Anthem members transitioned to the Alliance.

Alliance Net Change Enrollment by Aid Category

Aid Category	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Total
ACA OE	-1,264	-1,849	-1,735	1,203	-1,330	-1,271	25,514	278	771	**20,317**
ADULT	-480	-434	-526	689	-228	-88	14,257	400	468	**14,058**
CHILD	-344	-506	-502	1,455	390	546	4,971	554	700	**7,264**
DUALS	-189	-159	-254	-209	-648	-319	-1,091	-277	-613	**-3,759**
LTC	-5	-4	4	-1	-5	-4	79	0	-2	**62**
LTC-DUAL	-5	-11	-16	-4	-25	-22	352	6	-45	**230**
SPD	-180	-211	-231	272	-129	-40	4,098	-47	82	**3,614**
Total	**-2,467**	**-3,174**	**-3,260**	**3,405**	**-1,975**	**-1,198**	**48,180**	**914**	**1,361**	**41,786**

Alameda Alliance for Health

Alliance Net Change Enrollment by Ethnicity

Ethnicity	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Total
HISPANIC	-775	-879	-986	1,419	-146	0	27,886	864	1,133	**28,516**
UNKNOWN	59	70	113	623	743	791	7,246	701	1,366	**11,712**
BLACK	-417	-524	-432	410	-268	-213	7,134	-147	-165	**5,378**
WHITE	-373	-457	-454	350	-409	-336	3,105	-24	-35	**1,367**
ASIAN OR PACIFIC ISLANDER	-83	-48	-41	63	71	75	737	53	199	**1,026**
ASIAN INDIAN	-57	-88	-69	132	-133	-58	790	121	-32	**606**
AMERICAN INDIAN OR ALASKAN NATIVE	3	-8	4	24	-11	-10	129	-4	-7	**120**
SAMOAN	3	-3	-14	2	11	2	85	2	-6	**82**
KOREAN	13	-26	-15	34	-33	-33	149	-4	-19	**66**
LAOTIAN	-2	-4	-11	-1	1	-1	54	4	1	**41**
JAPANESE	-4	-9	-8	4	-10	-7	62	-4	8	**32**
GUAMANIAN	2	-2	-4	1	1	-3	3	-2	3	**-1**
HAWAIIAN	-12	-1	-3	-4	-1	-2	17	-2	-3	**-11**
CAMBODIAN	-7	-9	-25	-14	13	-1	13	-8	-15	**-53**
FILIPINO	-128	-101	-121	-43	-103	-86	171	23	-66	**-454**
VIETNAMESE	-81	-101	-103	-3	-61	-94	47	-24	-44	**-464**
CHINESE	-207	-220	-272	84	-322	-166	2	45	-63	**-1,119**
OTHER	-401	-764	-819	324	-1,318	-1,056	550	-680	-894	**-5,058**
Total	**-2,467**	**-3,174**	**-3,260**	**3,405**	**-1,975**	**-1,198**	**48,180**	**914**	**1,361**	**41,786**

ACSSA Plan for Re-Evaluation Process – cont.

- ACSSA continues implementation of the Health Enrollment Navigators Project until June 2025 via Senate Bill (SB) 154 by partnering with 7 CBOs to conduct outreach and assist community members with completing Medi-Cal applications or re-evaluation.

- ACSSA has integrated unwinding activities into the CBO partners' implementation of the project as well as into the targeted multimedia marketing campaign.

Medi-Cal Re-Evaluation Waivers

- Re-Evaluation Waivers
  - **Reasonable Compatibility Threshold Increase:** Threshold for the Medi-Cal auto-renewal process has increased to 20%.
  - **Hard-to-Reach Population Waiver:** The renewal can be processed if information about a hard-to-reach individual is received, and enough information is available to complete a re-evaluation.
  - **Reasonable Explanation:** Ability to provide verification through verbal or written explanation that resolves the discrepancy between self-attested income and income received through electronic data sources.
  - **100% FPL Waiver:** The renewal can be processed if the most recent income determination was at or below 100% FPL, no electronic data is received, and no contradictory information is on file.
  - **Stable Income Waiver:** The renewal can be processed if the most recent income determination was no earlier than 12 months prior to March 2019, if the individual only receives stable income, and no contradictory information is on file.

Alliance & ACSSA Collaboration

- Coordination with Alameda Alliance for Health
- Memorandum of Understanding between ACSSA and Alliance was finalized and ACSSA is currently sharing Medi-Cal renewal due dates for outreach to plan members.
- Alliance has provided funding of $50,000 to each of ACSSA's partnering CBOs and $75,000 to ACSSA to assist with renewal efforts.

Alliance & ACSSA Collaboration

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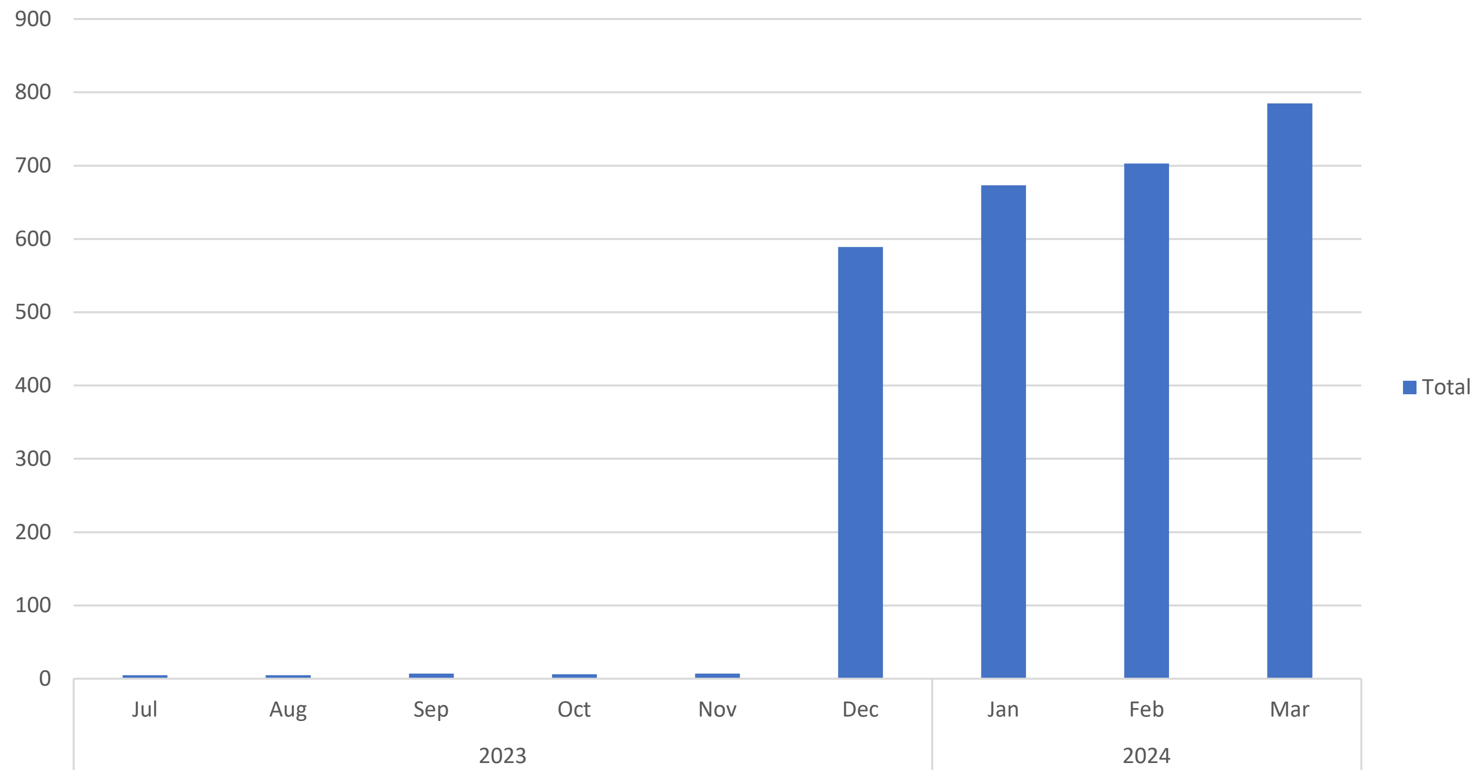

Enrollment Assistor Sites:
Family Bridges
East Bay Agency for Children
Asian Health Services
Axis Community Health
Bay Area Community Health
East Oakland Health Center
LifeLong Medical Care
La Clinica de la Raza
Native American Health Center
Tiburcio Vasquez Health Center
West Oakland Health Center

Thank You!

Questions?

HEDIS Update

Board of Governors Meeting
May 10, 2024

ALAMEDA Alliance FOR HEALTH

Alameda Alliance for Health

What is HEDIS?

- **Healthcare Effectiveness Data and Information Set (HEDIS)**
  - NCQA standard metrics designed to measure quality improvement and performance
  - National benchmarks to compare health plan performance
    - Updated annually for evidence-based guidelines, benchmarks, and revised quality measures
  - 90+ measures across 6 dimensions of quality of care and service
    - Effectiveness
    - Access/Availability
    - Experience of Care
    - Utilization
    - Descriptive Information
    - Electronic systems

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Oversight & Accountability

- DHCS Medi-Cal Accountability Set (MCAS)
  - AQFS
  - Quality Component Withhold & Incentive Program
  - Sanctions
  - Auto-Assignment
- DMHC Health Equity & Quality Measure Set (HEQMS)
- NCQA Accreditation – Health Plan
- NCQA Accreditation – Health Equity
- Future: CMS and Stars Measures

DHCS Medi-Cal Accountability Set (MCAS)

- Measures held to MPL fall into 5 domains:
  - Behavioral Health
  - Children's Health
  - Chronic Disease
  - Reproductive Health
  - Cancer Prevention

Measurement Year (MY)	Measures Reported	Measures Held to MPL
MY 2021	36	15
MY 2022	39	15
MY 2023	42	18
MY 2024	41	18

- Report Only measures includes 3 new LTC measures
- Majority of the measures are NCQA HEDIS, but also include several from other measure stewards.

Minimum Performance Level (MPL) is the 50th percentile.

DMHC Health Equity & Quality Measure Set (HEQMS)

- HEQMS includes:
  - 15 HEDIS measures
  - CAHPS Health Plan survey results
- MY 2023 and MY 2024: All measures overlap with DHCS MCAS except one
- Potential corrective action and/or administrative penalties not until 2027

AAH MCAS Performance – MY2022

- Five (5) measures did not meet MPL
  - Controlling High Blood Pressure
  - Cervical Cancer Screening
  - Lead Screening in Children
  - Well Child Visits in the First 15 Months
  - 30-day follow-up After ED Visit for Mental Illness
- Comparison to MY 2021
  - Rates improved in 9 of the measures
  - MY 2021 had 3 measures that did not meet MPL
- DHCS sanction imposed ($80,000)
  - Triggered by 2 measures within a single domain (Children's Health)

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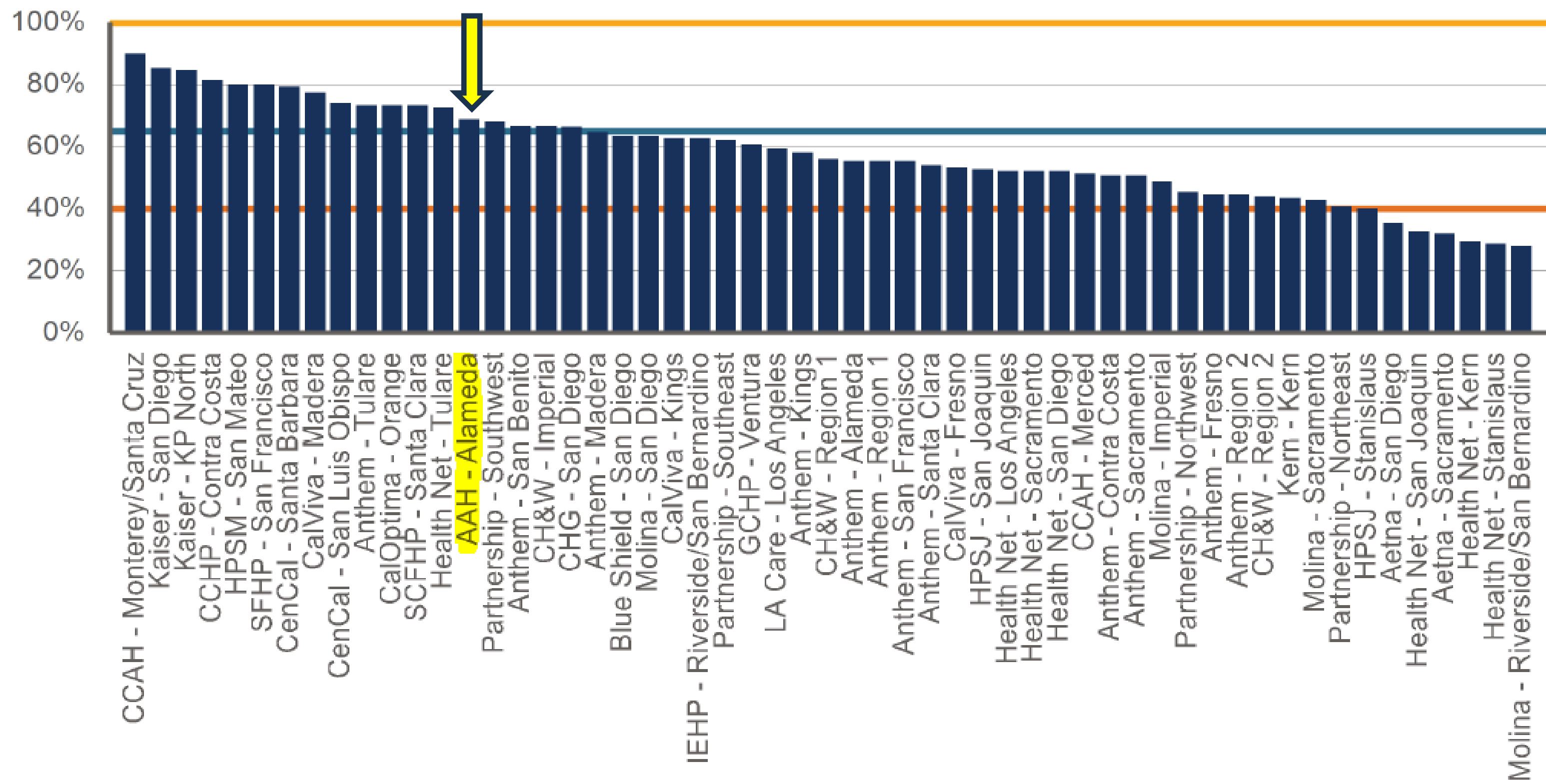
Statewide Comparison

Managed Care Performance Monitoring Dashboard Report
Released April 2024

2023 HEDIS® Aggregated Quality Factor Score (AQFS)

HPL - 100% | Weighted Average - 60% | MPL - 40%

By HEDIS® Reporting Unit



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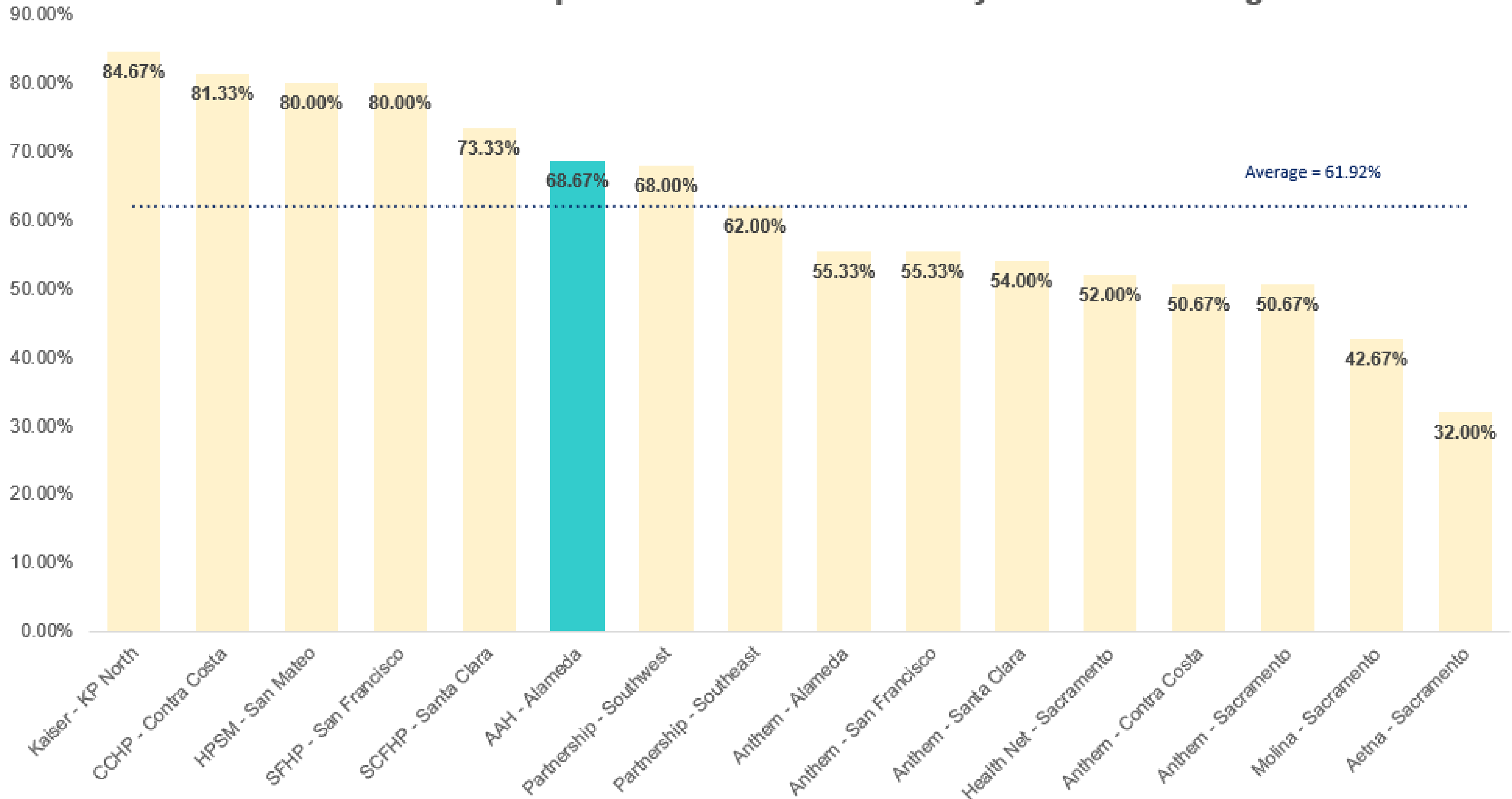
Regional Comparison



AAH Aggregated Quality Factor Score (AQFS) Trend

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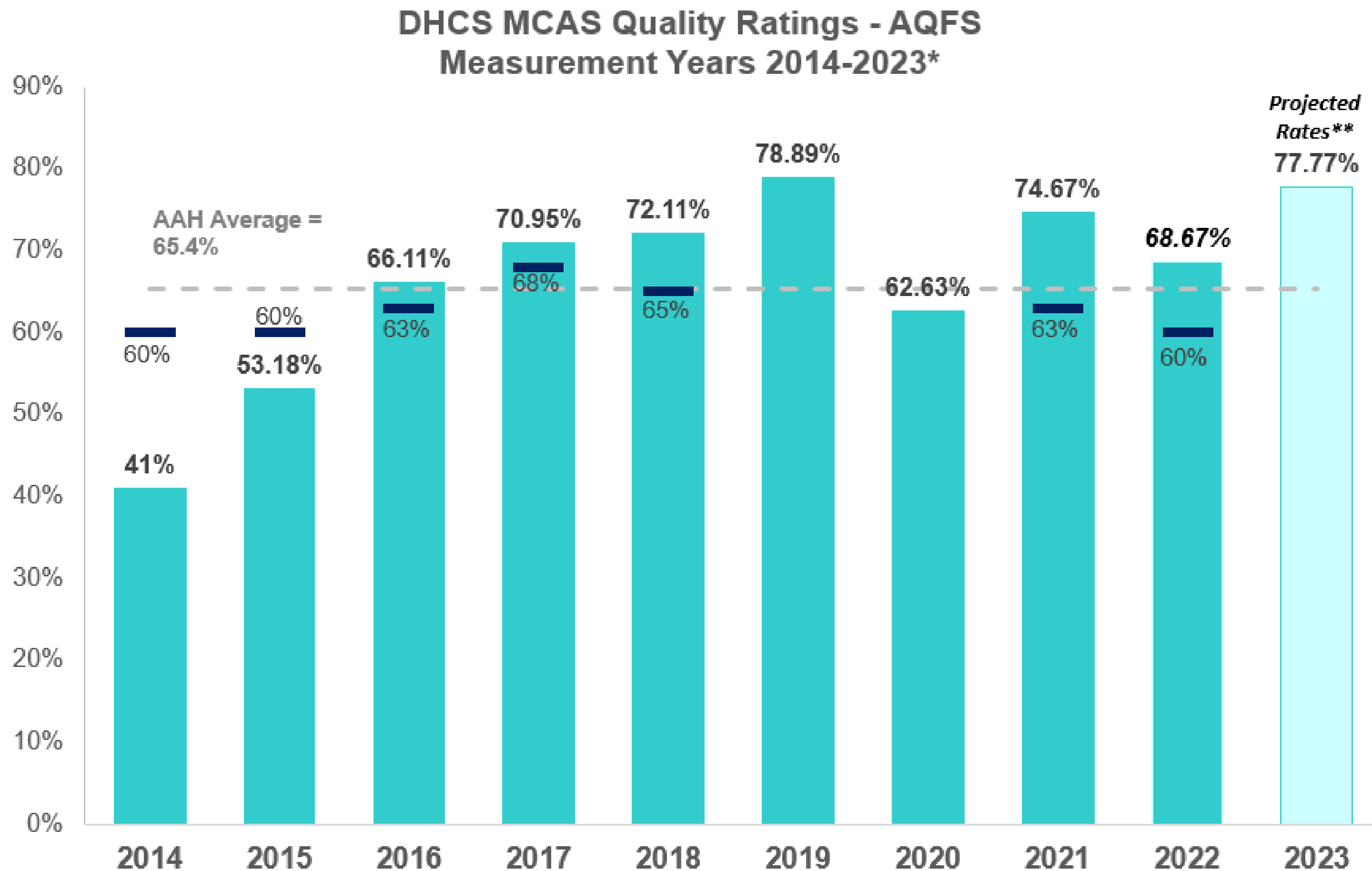

* DHCS did not report AQFS in 2019 and 2020 due to the PHE. Rates reported are based on AAH estimates.

** MY 2023 is still in progress and has not been finalized. Rate reported is based on AAH estimate as of 4/26/2024.

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AAH MCAS Performance – MY2023

- As of 4/26/2024, 3 measures are not meeting MPL
  - Lead Screening in Children
  - Topical Fluoride in Children
  - 30-day follow-up After ED Visit for Mental Illness
- Medical Record Retrievals (MRR) are 96% closed
- Comparison to MY 2022
  - Rates improved in 14 out of 18 measures
- NCQA and DHCS HEDIS audits passed successfully
- Change Healthcare impact on abstraction process mitigated
- Rates will be finalized in June 2024
- Anticipate a DHCS sanction based on current methodology
  - 2 measures within a single domain (Children's Health)

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MCAS Performance

	Measure Description	MY2022	MY2023 As of 4/26/2024	50th Pctl (MPL)
Behavioral Health	Follow-Up After Emergency Department Visit for Substance Use (30-Day)	29.82%	38.01%	36.34%
	Follow-Up After Emergency Department Visit for Mental Illness (30-Day)	49.03%	51.10%	54.87%
Children's Health	Childhood Immunization Status—Combination 10	63.26%	45.01%	30.90%
	Developmental Screening in the First Three Years of Life	44.24%	54.38%	34.70%
	Immunizations for Adolescents—Combination 2	50.61%	47.69%	34.31%
	Lead Screening in Children	60.58%	60.83%	62.79%
	Topical Fluoride for Children	12.18%	14.07%	19.30%
	Well-Child Visits in the First 15 Months - Six or More Well-Child Visits	46.56%	58.67%	58.38%
	Well-Child Visits for Age 15 Months to 30 Months -Two or More Well-Child Visits	69.01%	74.03%	66.76%
	Child and Adolescent Well-Care Visits	49.69%	56.28%	48.07%
Chronic Disease Management	Asthma Medication Ratio	74.71%	69.85%	65.61%
	Controlling High Blood Pressure	54.74%	64.48%	61.31%
	Hemoglobin A1c Control for Patients with Diabetes—HbA1c Poor Control >9%	29.20%	31.36%	37.96%
Reproductive Health	Chlamydia Screening in Women	64.14%	67.11%	56.04%
	Prenatal and Postpartum Care - Timeliness of Prenatal Care	87.50%	90.87%	84.23%
	Prenatal and Postpartum Care - Postpartum Care	85.42%	90.41%	78.10%
Cancer Prevention	Breast Cancer Screening	56.08%	59.59%	52.60%
	Cervical Cancer Screening	53.83%	60.58%	57.11%

ALAMEDA Alliance FOR HEALTH

Initiatives/Activities

Added in 2023

- **Member Mailers ->** ***Birthday cards, Breast Cancer Screening (BCS) flyers***
- **Member Outreach calls ->** ***Cervical Cancer Screening (CCS), BCS***
- **On-hold messages**
- **Provider webinars**
- **Provider incentives ->** ***After hours, Office staff***
- **Non-utilizer pilot**
- **Expanded year-round record retrievals**
- **Additional data specifications approved by auditors ->** ***Other coverage exclusions, Mom/newborn linkages***
- **EHR extract improvements**
- **Provider collaborations ->** ***Mobile mammography, Pap clinics***

New for 2024

- **Addition of HIE NCQA DAV certified data**
- **Provider Support ->** ***Practice Facilitation, Coding Support, Workflow Optimization, Enhanced reporting***
- **Provider incentives ->** ***Fluoride varnish, Health Equity Pilot***
- **Campaigns ->** ***Well child, Colorectal cancer screening (COL) home kits, Community health fair education on health screenings with focus on African American community***
- **Participation in DHCS/IHI child health equity collaborative**
- **Provider collaborations ->** ***Controlling Blood Pressure (CBP) PDSA, CHW navigators for ED follow-up, Lead screening point of care testing***

Continued from prior years

- **Member Outreach calls ->** ***First 5***
- **Member Incentives ->** ***HEDIS Crunch, Well-child, CCS, BCS***
- **Provider incentives ->** ***P4P, grant funded QI projects***
- **Actionable care gap reports**

Questions??

ALAMEDA Alliance FOR HEALTH

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Definitions

- MY = Measurement Year
- HEDIS = Healthcare Effectiveness Data and Information Set
- MCAS = Medi-Cal Accountability Set (DHCS)
- HEQMS = Health Equity and Quality Measure Set (DMHC)
- AQFS = Aggregated Quality Factor Score (DHCS)
- MPL = Minimum Performance Level
- HPL = High Performance Level
- NCQA = National Committee for Quality Assurance
- P4P = Pay for Performance
- MRR = Medical Record Retrieval

Hospital Seat Nominations:

Discussion & Resolution

Tosan O. Boyo

[redacted] & [redacted]

Born in Nigeria, raised in Jersey, then backpacking across all seven continents shaped Tosan's views on how intersections across culture, policy and healthcare impact vulnerable communities. He believes access to affordable high-quality care is a cornerstone for a thriving society and he's on a life-long journey to eliminate disparities. Tosan specializes in utilizing Lean Six Sigma to advance quality outcomes, operational effectiveness and health equity. He's a mission-driven executive with a track record of leading teams in Academic, Safety-Net and Community Medical Centers through successful growth, innovation and turnaround initiatives. Tosan is prolific keynote speaker on Health Equity and an elected board member of the Institute of Healthcare Improvement - Serving as Governance Chair. For decades, IHI has spearheaded best practices to advance high-quality outcomes and zero harm world-wide.

President – East Bay Market. Sutter Health, CA. 2023 – Present

Oversee all aspects of Sutter Health's East Bay Market including strategy development, operational management, capital allocation, financial performance, service line development, medical group alignment and community partnerships.

- Sutter East Bay encompasses: Alta Bates Medical Center - 393 beds, Summit Medical Center - 325 beds, Delta Medical Center - 140 beds, Eden Medical Center - 130 beds, Solano Medical Center - 106 beds, Herrick Psychiatric Hospital - 68 beds, 15 Ambulatory Centers and 4 Surgery Centers, $2.5 Billion in operating revenue, 600,000 lives served, 45,000 acute discharges, 1 million outpatient visits, 4,500 births and 200,000 emergency encounters annually.
- Responsible for managing the market's operations improvement, continuous growth, profit and loss (P&L), and support services. Provides strategic direction to all clinical and business entities of the markets' hospitals, ambulatory centers and surgery centers while ensuring highest quality of care, patient access and cost-effective services are provided to communities served.

Senior Vice President – Hospital Operations. John Muir Health, CA. 2020 – 2023

Oversee operations of Walnut Creek Medical Center – 554 beds, Concord Medical Center – 244 beds, JMH Psychiatric Hospital – 73 beds, Service Line Strategies and Enterprise Ancillaries. John Muir Health encompasses $2 Billion in operating revenue, 35,000 acute discharges, 800,000 outpatient visits, 3,300 births, 2,300 trauma activations and 120,000 emergency encounters annually.

- Executive Sponsor of LEAN Management System: Spearheaded continuous performance improvement principles enterprise-wide to drive consistent executive visibility, clinical integration, prioritization, and problem solving.
  - Created System Performance Huddle gathering all VPs on daily basis with a discipline to maximize quality, flow and volume.
  - Deployed True North and balanced scorecard with visual management to align strategy, tactics and frontline.
  - Built curriculum and facilitated workshops for >90% of management staff on PDSA Cycles and Leader Standard Work.
- Incident Commander of COVID-19: Redesigned the Health System's pandemic response plan with detailed standard work, surge indicators, iterative scenarios and thresholds to ensure optimal capacity utilization.
  - Increased COVID-19 unit from 30 beds to 168 beds to support >45% of the county's hospitalized COVID-19 population. Established routine testing for high-risk workers and maintained workforce exposure positivity rate at <0.5%.
  - Executed vaccination strategy: within 45 days of go-live, administered 75% of staff and physicians with 1st and 2nd dose. Immediately pivoted to vaccinating the community at 3,000/week then doubling to 6,000/week after 3 weeks.
  - Directed partnership with county to deploy teams to skilled-nursing facilities, residential care facilities, farm workers and school districts in vulnerable zip codes to manage outbreaks, vaccine administration, information and guidance.
  - Assembled leaders of color across 10 health systems in the Bay Area to develop a vaccination campaign to ramp uptake among communities of color. Ensured high-prevalence regions had greater access to vaccines and testing.
- Executive Sponsor of Service Lines: Drive growth, standardization, cost control, quality outcomes, bundled payment initiatives across Oncology, Digestive Health, Obstetrics, Pediatrics, Cardiovascular, Orthopedics, Spine, Trauma, Surgical Specialties and Neurosciences generating >$500 Million contribution margin annually.
  - Chair programming and operationalization of Outpatient Specialty Center ~$300 Million and 154,000 sqft. joint venture with UCSF. Services included: Radiation Oncology, Medical Oncology, Infusion, Pharmacy, Genetic Counseling and Research.
  - Maximized savings across pharmaceuticals, supply chain and purchased services by standardizing clinical preferences, consolidating contracts, and deploying a fully integrated 340b program resulting in $35 Million in annual savings.
  - Increased robotic surgery adoption rates to reduce time to treatment, length of stay and re-admission rates and executed plans to attain center of excellence for stroke, bariatric program, total joint replacements and digestive health.
- Executive Sponsor of Medi-Cal Strategy: JMH is the largest provider of Acute Care to Medi-Cal enrollees in the County. 34% of emergency encounters are Medi-Cal, 50% of that were ESI level 4/5, yet only 7% of outpatient visits were Medi-Cal. Utilized

Safety-Net relationships deep experience with elected officials to establish inaugural Medi-Cal strategy to support vulnerable populations with an aim to reduce $129 Million shortfall. Led operational deployment, contract negotiations, payer partnerships and alignment of community benefit programs to attain right care, time and place across the care continuum.

- Executive Sponsor of Health Equity: Develop and deploy strategies with stratified quality data to facilitate systemic and institutional measurable changes in patient outcomes. Lead Black Maternal Health (In the US, Black women are 243% more likely to die from childbirth-related causes). Established governance and operational infrastructure to ramp-up organizational readiness quantify, assess and mitigate this disparity at JMH while ensuring alignment with County and State.
- Executive Sponsor of Behavioral Health: Managed Psychiatric Hospital turnaround with revitalized staff engagement and attained profitability in 15 months. Increased average daily census by 45% and outpatient volume by 30%. Integrated tele-psychiatry workflows into Primary Care to improve access, care experience and recidivism reduction.
- Executive Sponsor of Government Affairs: Foster and maintain close working relationships with State officials, County officials, trade associations and business groups. Identify timely new legislative, regulatory, and ballot proposals which could significantly impact JMH. Develop advocacy plans that address (i) the specific legislative, regulatory, and ballot proposals that warrant allocation of JMH advocacy efforts, (ii) the rationale for prioritizing such identified matters; and (iii) the recommended tactics, strategies, and messages for each such effort.

Chief Operating Officer. San Francisco General Hospital, CA. 2017 – 2020

Oversee operations of Academic Medical Center encompassing $1 Billion in operating revenue, 397 beds, 18,000 acute discharges, 600,000 outpatient visits, 1,200 births, 3,100 trauma activations and 85,000 emergency encounters annually. Manage $185 Million affiliation agreement with UCSF School of Medicine establishing physician partnerships across the enterprise. SFGH is the City's only Level 1 Trauma Center, only Psychiatric Emergency Center, largest Primary Care Center and home to 20 Research Centers.

- Chief of Operations of San Francisco's COVID-19 Command Center: Appointed by the Director of Public Health to lead a team of over 2,000 staff focused on optimizing contact tracing, case investigation, hospital surge capacity management, testing assets, PPE inventory, quarantine processes, first responders, public transportation, shelters and nutrition services for the entire City.
  - At the height of the pandemic, of the most densely populated cities in the US, San Francisco achieved the lowest COVID-19 death-rates, new case-rates and highest testing-rates. Successfully procured >100 days' inventory of most critical PPE.
  - Built 3 critical teams (advanced analytics, medical operations and community outreach) from the ground-up to control outbreaks, create alternative care sites and expand surveillance testing in SNFs and congregate settings.
  - Directed transition into Phase 2 as "shelter in place" gradually lifted. Supported City and Health Officials to develop guidelines for economic recovery, resume elective procedures, routine medical/dental appointments and re-open schools.
- Executive Sponsor of Health Equity: Established institutional vision, governance structure, system charter, communications campaign and strategic alignment with daily operations to eliminate health disparities and promote inclusion system-wide.
  - Expanded analytics framework to advance population health management by collecting data for REAL (race, ethnicity and language) and SOGI (sexual orientation and gender identity) at 95% completeness.
  - Created disparities assessment protocol and increased utilization from 6% to 77% by permeating principles of implicit bias awareness, relationship-centered communication and trauma-informed systems across Patient Safety Committee.
  - Headed inaugural diversity and inclusion survey then facilitated town halls evaluating organization's baseline and progress. Determined resources and tactics needed to build an inclusive culture with measurable outcomes for workforce.
- Executive Sponsor of Capital Planning: Optimize clinical infrastructure, technology strategy, real estate portfolio, facilities management and equipment administration. Integrated LEAN 3P strategies across projects to control cost, time-slippage and unplanned work. Campus encompasses 15 buildings, 1.8 Million sqft, 12,000 medical devices and 25,000 work-orders annually.
  - Chaired EPIC Activation: Scope consolidated 62 disparate systems into one patient-centered record ~$377 Million Project. Exceeded Go-Live KPIs and shut down command center within 2 weeks. Deemed "one of the best Go-Lives ever" by EPIC.
  - Chaired programming, design and operationalization of Ambulatory Center ~$315 Million and 617,000 sqft and Research Center ~$275 Million and 175,000 sqft. Services included across both projects: Urgent Care, Primary Care, Specialty Care, Core Lab, Rehab Center, Psychiatric Emergency Center, HIV/AIDS Center and Trauma Research Center.
- Executive Sponsor of Ancillary Services: Drive continuous improvement across Patient Throughput, Urgent Care, Supply Chain, Diagnostic Imaging, Rehabilitation (OT/PT/ST), Clinical Laboratories, Anatomic Pathology, Behavioral Health Center, Nutrition, Utilization Management, Biomedical Engineering, Environmental Services, Occupational Safety, Sheriff's Department, Telecom and Emergency Management. Oversight encompasses 1,400 staff and providers with ~$120 Million operating budget.

- Chaired Alignment of Ambulatory Care and Emergency Department: Increased Urgent Care throughput by 20%, controlled ED left-without-being-seen at 3% and proactively redirected 50% of ESI-level 4/5 to Primary Care setting. Achieved TNAA <10 days across outpatient therapeutics, increased volume >10% and controlled registry costs at <5%.
- Chaired Utilization Management: Restructured task-force to address root-causes of hospital throughput bottlenecks. Spearhead PDSAs focused on reducing inappropriate length of stay, eliminating barriers to discharge by noon, providing social determinants for high-utilizers, refining observation services and partnering with external agencies for safe placement.
- Chaired Workplace Violence Prevention: Created Behavioral Emergency Response Team to reduce batteries and assaults. Instituted Code Tan – A multidisciplinary response team for victims of violence, tragedies and volatile situations.
- Engaged Orthopedic Institute and Birth Center to establish first commercial insurance contract in SFGH history.

Director – Ambulatory Network. San Mateo Medical Center, CA. 2014 – 2017

Oversee operations of Primary Care Clinics, Specialty Care Clinics, Urgent Care Clinics, Dental Care Clinics, Behavioral Health Clinics, School-based Clinics, Managed Care Programs, Telemedicine and Interpreter Services across Redwood City, Half Moon Bay, Daly City, South San Francisco and San Mateo. Oversight encompassed 500 staff and physicians supporting 260,000 outpatient visits annually.

- Executive Sponsor of Patient Centered Medical Homes: Deployed LEAN Management System transforming Care-Team structure, primary care capacity, specialty care referral workflows, staffing ratios, care access paths, inreach and outreach standard work.
  - Surpassed budget target by >10,000 outpatient visits annually, increased patient satisfaction scores from 81% to 88% and maximized utilization of clinic appointments to ~95% capacity daily.
  - Created Patient Connection Center: Empaneling newly assigned members, creating continuity for recently hospital-discharged patients, unempaneled specialty care and ED follow-up visits. Reduced unmet needs from 54% to 7%.
  - Launched Express Care Clinics and implemented Phone-Based Care protocols to reduce inappropriate ED utilization, improve same-day access and care-continuity across the Network. Reduced average TNAA to <10 days and no-show rates to ~11%.
  - Redesigned Telecommunications by centralizing call centers, upgrading IT systems, defining standard work, staffing ratios and patient-centered trainings. Achieved ~10% abandoned rate with <100 sec wait time across the Network.
- Executive Sponsor of Value-Based Care: Transitioned operations from fee-for-service to fee-for-value with a goal to optimize quality outcomes, risk stratification and cost control of 56,000 lives at 60% capitation.
  - Created Office of Managed Care from the ground up establishing contract agreement and consolidation of data infrastructure from health plan and referring providers. Developed job descriptions, recruited and ramped-up team responsible for financial planning and analysis, business development, risk stratification and population health analytics.
  - Headed collaboration with Health Plan of San Mateo to establish Joint Tactics Committee to improve performance of utilization management, HEDIS scores, regulatory standards and resolution of care coordination challenges.
  - Operationalized Medicaid Waiver programs - Delivery System Reform Incentive Payments, Dental Transformation, Whole Person Care, Public Hospital Redesign and Incentives in Medi-Cal and Healthcare for Homeless and Farmworkers.
  - Successfully expanded Endocrinology, Pain, Cardiology and Musculoskeletal services to meet specialty needs by region.
- Executive Sponsor of Health Equity: Led training, validation and implementation initiative to collect and stratify accurate race, ethnicity and language data. Successfully expanded interpreter access with new mobile devices to close disparities in outcomes.

Manager – Primary Care Clinics. Alameda Health System, CA. 2013 – 2014

Oversee operations of Urgent Care, Internal Medicine, Pediatrics, Geriatrics and OB/GYN Practices at Highland Hospital in Oakland. Oversight encompassed 150 staff and physicians supporting 70,000 outpatient visits annually.

- Successfully licensed, transitioned and operationalized new 80,000 sqft Outpatient Center. Defined growth strategy, financial forecast, staffing model and workflows to improve access, care continuity and reduce inappropriate ED utilization.
- Led LEAN initiative aligning Ambulatory Care and Emergency Department to ensure low-acuity patients received the right care, at the right place and the right time. Proactively redirected 25% of ESI-level 4/5 ED encounters to clinic setting.
- Led LEAN initiative integrating Behavioral Health teams into Primary Care to improve care coordination and quality outcomes.
- Led LEAN initiative in Internal Medicine to reduce overtime by $1.5 Million and achieve 95% charge reconciliation in 6 months.
- Led LEAN initiative in OB/GYN to optimize door-to-doc lead time by 30% and reduce no-show rates to 15%.

Manager – Specialty Care Clinics. UC San Diego Health System, CA. 2011 – 2013

Tosan O. Boyo

&

Oversee operations of Abdominal Transplantation and Hepatobiliary Diseases Clinics across San Diego, Riverside and Las Vegas. Oversight encompassed 50 staff and physicians supporting 15,000 outpatient visits and 110 transplants annually.

- Appointed by COO to establish inaugural cohort of LEAN training to optimize performance of system-wide programs.
- Led LEAN initiative to deploy group visits increasing throughput by 30% and reduced TNAA from 4 months to 2 weeks.
- Led LEAN initiative across Clinical Laboratories to reduce cycle time by 35%.
- Led LEAN initiative to reduce no-show rate to 5% and successfully increased patient experience to cross 95th percentile.
- Built Nurse Practitioner post-transplant clinics into practice which increased access capacity by >25%.
- Developed and implemented business plan to head expansion into Riverside County increasing market share by >20%.
- Dissolved operations of Las Vegas Clinic eliminating projected losses of >$200,000 annually.
- Consolidated Liver Program with Hillcrest Specialty Clinic resulting in >$120,000 over-head savings annually.

Awards

40 under 40, San Francisco Business Times, 2024
Executive of the Year, California Association of Healthcare Leaders, 2021.
Resolution 20-11 Honor, San Francisco Health Commission, 2020.
Values in Action, San Francisco Department of Public Health, 2019.
Best Equity Initiative, Disparities Solutions Center, 2018.
Performance Excellence in Ambulatory Care, California Association of Public Hospitals, 2016.

Boards

Health Evolution, 2020 - Present
Institute for Healthcare Improvement, 2021 - Present
East Bay Economic Development Alliance, 2023 - Present
Oakland Chamber of Commerce, 2024 - Present
Walnut Creek Chamber of Commerce, 2020 - 2023
Fred Finch Family Services, 2015 - 2020

Education

Board Certified Fellow, American College of Healthcare Executives.
Master's Degree in Public Health, Montclair State University.
Bachelor's Degree in Clinical Psychology, The College of New Jersey.

Publications

ttps://www.egonzehnder.com/from-clarity-to-courage-five-leadership-traits-and-competencies-to-drive-equity-in-healthcare/tosan-boy
https://www.healthevolution.com/insider/leadership-profile-sutterhealth-tosan-boyo/
https://www.ncqa.org/videos/quality-talks-2022-tosan-boyo-mph-on-how-equity-work-validates-verifies-quality-work/
https://youtu.be/ES0ughzmlpo
https://www.healthevolution.com/insider/trauma-the-tyrannical-time-traveler/#health-equity
https://youtu.be/viJcFEzL4_o
http://www.ihi.org/communities/blogs/facing-down-denial-and-data-challenges-when-addressing-equity
https://www.careinnovations.org/resources/tackling-bias-fear-inequality-and-disrespect-tosan-boyos-blueprint-for-a-successful-
https://www.healthevolution.com/insider/the-multiple-worlds-of-black-health-workers/#leadership
https://vimeo.com/196026150

Keynotes

"Health Equity Trailblazers: Where Vision Meets Commitment " National Committee of Quality Assurance, 2024
"Community Partnerships and Investments to Eliminate Health Disparities" Healthcare CEO Strategy Summit, 2024
"Community-based investments and partnerships to advance health equity" Health Evolution Forum, 2024
"Northern California Leadership Series" National Association of Health Service Executives, 2024

"Unlocking Opportunities for Improved Health" UCSF Rosenman Institute's 7th Annual Symposium, 2023.
"The Art & Science of Leading Hospital Turnarounds" National CXO Summit, 2023.
"Leveraging Lean to Advance Strategic Goals" Lean Research Symposium, 2023.
"Equity is a Moral and Business Imperative" Equity Innovation Summit, 2022.
"Looking Outside The Hospital: Integrating Health System With Public Health" National CXO Summit, 2022.
"Building an Equitable Digital Health Ecosystem" National Committee of Quality Assurance, 2022.
"Creating Breakthroughs – Improvement as Part of Daily Work" Institute for Healthcare Improvement, 2022.
"Staffing: During and Beyond the Pandemic" California Association of Healthcare Leaders, 2022.
"Equity Work Verifies Quality Work" National Committee of Quality Assurance, 2022.
"Reaching the New Frontier – Creating 21st Century Health Care." Population Health Colloquium, 2021.
"Closing Health Disparities - Prioritizing Investments and Measuring Progress" Health Evolution, 2021.
"Roundtable on Community Health & Health Equity." Health Evolution, 2021.
"The Year of Inequities" Patient Experience Digital Series, A Cleveland Clinic & HIMSS Event, 2021.
"Overcoming Disparities in Healthcare." Black Caucus, 2021.
"Equity Interventions That Make a Difference." Oregon Primary Care Association, 2020.
"Developing the Integrated Health System of the Future." California Association of Healthcare Leaders, 2020.
"Leadership in the Era of COVID-19." Schwartz Center Compassion in Action Healthcare Conference, 2020.
"Caring for Patients Against the Backdrop of COVID-19 and Systemic Racism." Center for Care Innovations, 2020.
"Responding to a Pandemic, Rebuilding our Public Health System." Stanford Center of Philanthropy and Civil Society, 2020.
"Equity: A Dimension of Quality, Workforce Well-being and Joy in Work." Institute for Healthcare Improvement, 2020.
"Deploying Equity Strategies across the Health System." America's Essential Hospitals VITAL Conference, 2020.
"Deploying Equity Strategies across the Health System." Safety Net Institute, 2019.
"Deploying Equity Strategies across the Health System." Massachusetts General Hospital, 2019.
"Deploying Equity Strategies across the Health System." Boston Children's Hospital, 2019.
"Advancing Health Equity." The #PopHealth Show, 2019.
"Advancing Health Equity." UCSF School of Medicine, 2019.
"Advancing Health Equity." Disparities Solutions Center, 2018.
"Why Immigrant Stories in Healthcare Matter." Schwartz Center Rounds, 2018.
"Learning from Leaders." California Association of Healthcare Leaders, 2018.
"Goals and Challenges of the Capitation Preparedness Program." Safety Net Institute, 2015.

Clifford Wong, M.D.

Certifications

American Board of Internal Medicine
Nephrology and Hypertension, 2003-present
Internal Medicine, 2000-present

Medical Board of California
Medical license, 4/1999-present

Experience

West Coast Kidney Institute (formerly Chabot Nephrology Medical Group), San Leandro, CA
Board member, 11/2020-present
Vice President, Chabot division, 8/2020-present
Secretary, Chabot division, 8/2010-7/2020
Partner, 8/2010-present
Associate, 3/2003-1/2006

Lunny, Ahn, Wong M.D.s, Fremont, CA
Partner, 10/2009-8/2010

Mission Nephrology, Fremont, CA
Associate, 1/2006-10/2009

Dialysis Access Center, Oakland, CA
Interventional nephrologist, 11/2003-1/2006

DaVita Mission Hills Dialysis, Hayward, CA
Medical Director, 2013-present

DaVita Fremont Home Dialysis, Fremont, CA
Medical Director, 2013-present

Hospital Affiliations

St. Rose Hospital, Hayward, CA, 3/2003-present
Chief of Medical Staff, 10/2015-10/2020
Member, Board of Trustees (ex officio), 10/2015-10/2020
Medical Director, Acute Dialysis Service, 1/2018-present

Member, Medical Executive Committee, 2008-present
Chair, Quality Improvement Committee, 2008-9/2015
Member, Physician Peer Review Committee, 2007-present

Washington Hospital, Fremont, CA, 1/2006-present
Member, Dialysis Committee, 2006-present
Member, Clinical Evaluation Committee, 2007-2009

Past Hospital Affiliations
San Leandro Hospital, San Leandro, CA, 3/2003-1/2006, 2014-5/2022
Kindred Hospital, San Leandro, CA, 3/2003-1/2006, 2014
Eden Medical Center, Castro Valley, CA, 3/2003-1/2006
Summit Medical Center, Oakland, CA, 3/2003-1/2006
Valley Care Medical Center, Pleasanton, CA, 3/2003-1/2006
San Ramon Medical Center, San Ramon, CA, 3/2003-1/2006

Education
Post-Fellowship
Dialysis Access Center, Oakland, CA
Interventional Nephrology training program, 7/2003-10/2003

Fellowship
University of California, San Diego Medical Center, San Diego, CA
Division of Nephrology and Hypertension, 2000-2002

Residency
University of California, San Diego Medical Center, San Diego, CA
Division of Medicine, 1997-2000

Medical School
University of California, San Diego School of Medicine, La Jolla, CA
Doctor of Medicine degree, 1997

Undergraduate
Stanford University, Stanford, CA,
Department of Biological Sciences
Bachelor of Science degree, with departmental honors, 1993

Memberships
American Society of Nephrology

Alameda-Contra Costa Medical Association
Secretary/Treasurer, 11/2023-present
Councilor, District 6 (Hayward/Castro Valley), 1/2020-11/2023
Alternate Councilor, District 6, 11/2017-1/2020
Member, California Medical Association Council on Legislation, 12/2021-2023
Chair, Legislative Committee, 1/2019-1/2024 (member since 11/2017)
Nominating Committee, 5/2021-present

RESOLUTION NO. 2024-XX

A RESOLUTION OF ALAMEDA ALLIANCE FOR HEALTH APPROVING ALAMEDA COUNTY HOSPITAL SEAT NOMINEE FOR BOARD OF GOVERNORS MEMBERSHIP, AND RECOMMENDING THAT THE ALAMEDA COUNTY BOARD OF SUPERVISORS MAKE AN APPOINTMENT TO THE BOARD OF GOVERNORS OF ALAMEDA ALLIANCE FOR HEALTH

WHEREAS, The Alameda Alliance for Health (“Alliance”) Board of Governors (“Board”) has a vacancy of the Alameda County Hospital Seat (Regular # 9); and

WHEREAS, pursuant to Section 3.D.3 of the Alliance *Bylaws*, the Hospital Council of Northern and Central California has recommended nominees to fill this vacancy; and

WHEREAS, pursuant to Section 3.C of the Alliance *Bylaws* the Alliance Executive Committee has reviewed the nominees and has provided their recommendations to the Alliance Board; and

WHEREAS, pursuant to Sections 3.C of the Alliance *Bylaws*, the Alliance Board has reviewed the Executive Committee’s recommendation and have approved by majority vote Tosan Boyo to fill the vacant seat; and

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

WHEREAS, upon receipt of the resolution, the Alameda County Board of Supervisors may choose to adopt the resolution, by majority vote, appointing the member to the Alliance Board.

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

SECTION 1. That the Alliance Board approves Tosan Boyo to fill the Alameda County Hospital Seat (Regular # 9) on the Alliance Board, as created pursuant to Section 3.D.3 of the Alliance *Bylaws*.

SECTION 2. The Alliance Board hereby recommends that the Alameda County Board of Supervisors adopt a resolution by majority vote appointing Tosan Boyo as a member in the Alameda County Hospital Seat (Regular # 9) of the Alliance Board.

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

PASSED AND ADOPTED by the Board at a meeting held on the 10th day of May 2024.

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CHAIR, BOARD OF GOVERNORS

ATTEST:

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Secretary

RESOLUTION NO. 2024-XX

A RESOLUTION OF ALAMEDA ALLIANCE FOR HEALTH APPROVING ALAMEDA COUNTY HOSPITAL SEAT NOMINEE FOR BOARD OF GOVERNORS MEMBERSHIP, AND RECOMMENDING THAT THE ALAMEDA COUNTY BOARD OF SUPERVISORS MAKE AN APPOINTMENT TO THE BOARD OF GOVERNORS OF ALAMEDA ALLIANCE FOR HEALTH

WHEREAS, The Alameda Alliance for Health ("Alliance") Board of Governors ("Board") has a vacancy of the Alameda County Hospital Seat (Regular # 9); and

WHEREAS, pursuant to Section 3.D.3 of the Alliance *Bylaws*, the Hospital Council of Northern and Central California has recommended nominees to fill this vacancy; and

WHEREAS, pursuant to Section 3.C of the Alliance *Bylaws* the Alliance Executive Committee has reviewed the nominees and has provided their recommendations to the Alliance Board; and

WHEREAS, pursuant to Sections 3.C of the Alliance *Bylaws*, the Alliance Board has reviewed the Executive Committee's recommendation and have approved by majority vote, Dr. Clifford Wong to fill the vacant seat; and

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

WHEREAS, upon receipt of the resolution, the Alameda County Board of Supervisors may choose to adopt the resolution, by majority vote, appointing the member to the Alliance Board.

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

SECTION 1. That the Alliance Board approves Dr. Clifford Wong to fill the Alameda County Hospital Seat (Regular # 9) on the Alliance Board, as created pursuant to Section 3.D.3 of the Alliance *Bylaws*.

SECTION 2. The Alliance Board hereby recommends that the Alameda County Board of Supervisors adopt a resolution by majority vote appointing Dr. Clifford Wong as a member in the Alameda County Hospital Seat (Regular # 9) of the Alliance Board.

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

PASSED AND ADOPTED by the Board at a meeting held on the 10th day of May 2024.

____
CHAIR, BOARD OF GOVERNORS

ATTEST:

____
Secretary

Designated Long-Term Services & Supports (LTSS) Seat

Nomination & Resolution

WENDY PETERSON

[redacted]. | Oakland, CA
[redacted] | [redacted]

Wendy Peterson has worked in the field of aging policy and services for 28 years, after leaving the computer industry where she managed a technology development start-up. Since 2002, Ms. Peterson has directed the Senior Services Coalition of Alameda County, representing providers of home and community-based services for older adults throughout the county. The Coalition and its members advance policy change and collaborative initiatives to improve the lives of older adults and their families. Together, Coalition members serve over 90,000 older adults.

EXPERIENCE

DIRECTOR

Senior Services Coalition of Alameda County

2002 – PRESENT

- Led a diverse coalition of nonprofit and public organizations in its mission to strengthen and improve the network of support for older people in Alameda County, securing investments in aging services, prompting policy improvements and collaborative initiatives, and bringing aging expertise to decision making forums.
- Worked closely with member organizations to develop a working knowledge of their care-delivery, program and business models, and client and community profiles
- Facilitated participatory annual planning processes to identify and address emerging issues, and develop strategic priorities and policy agenda that reflect the interests of member organizations and the older adults they serve.
- Worked collaboratively across sectors and siloes to cultivate and strengthen relationships with stakeholders, and build awareness of policy and system issues that affect the well-being of older adults and the community-based organizations that serve them.
- Liaised with policy makers and government agencies at the federal, state and local level to build awareness, develop champions, and advance strategic priorities.
- Served on leadership team for Alameda County Council for Age-Friendly Communities, helping to develop the 2016 and 2020 Countywide Area Plan, advance the Board resolution designating Alameda County an Age-Friendly County, developing the Alameda County Age-Friendly Plan, and developing the Council recommendations for addressing housing insecurity and homelessness among older adults.
- Led a day-in-the-life field study of older adults in Alameda County in partnership with Greater Good Studios and the SCAN Foundation to inform the development of the California Master Plan for Aging.
- Conducted field studies, data and policy analyses, authoring impact reports, policy briefs, fact sheets, newsletters and other communications to inform stakeholders and policy makers of issues impacting older adults.
- Managed multiple collaborative projects, including design and implementation of a pilot with local Kaiser Permanente hospitals and community-based organizations.
- Managed budget and fund development, hired and managed staff and project consultants.

CONSULTANT

Fund Development | Planning | Special Projects

2000 – 2009

- Served as Project Planner for Clear Path to Coverage initiative at LifeLong Medical Care, a CHCF funded initiative in partnership with the Public Policy Institute, training community health centers in California to provide comprehensive health coverage screening and assistance to older patients.
- Served as Interim Director for East Bay Benefits Initiative, at LifeLong Medical Care, managing implementation of an initiative to prepare older adults, community-based organizations, and community health centers for roll-out of

Medicare Part D. Acquired comprehensive and detailed knowledge of Part D benefit, Medi-Cal, Medicare, and intersecting health insurance coverage.

- Completed over 40 successful grantwriting projects for nonprofit clients, primarily in aging services.

MARKETING & DEVELOPMENT DIRECTOR

Center for Elders' Independence

1996 – 2000

- Established a marketing department for this community-based Program of All-Inclusive Care for the Elderly.
- Hired, trained and supervised outreach and intake manager, benefits specialists and support staff, helping census grow from 120 to 210.
- Interfaced with Department of Health Services re monitoring of marketing activities and annual audits.
- Planned and implemented marketing plan to establish brand awareness in the professional community and public.
- Served as primary grant writer and launched donor development program, raising over $420,000 from private foundations and individuals over two years.

OTHER EXPERIENCE

PRESIDENT/CEO

A-Squared Systems | Oakland, CA

1985 - 1996

Co-founded and piloted a small computer technology company through start-up, product development, and acquisition.

MARKETING & PROMOTIONS MANAGER

Sierra On-Line, Inc. | Coursegold, CA

1983 - 1984

MARKETING MANAGER

Edu-Ware Services, Inc. | Agoura Hills, CA

1980 – 1983

EDUCATION

BACHELOR OF ARTS, ENGLISH

University of California, Los Angeles

JUNE 1980 | CUM LAUDE

President's Fellowship Grantee

UCLA Writing Program Intern

HONORS

RECOGNITION, U.S. House of Representatives, 2007 Congressional Record Vol. 153 No. 82

COMMENDATION, California Senate, 2009

COMMENDATION, Alameda County Board of Supervisors, 2011

HONOREE, Kenneth Hoh Advocacy Award, 2010

COMMUNITY SERVICE

PRESIDENT, Board of Directors, DayBreak Adult Care | 2014 – PRESENT

MEMBER, Board of Directors, California Collaborative for Long-Term Services & Supports | 2019 - PRESENT

MEMBER, Board of Trustees, East Bay Foundation on Aging | 2013-2017

VICE CHAIR, Advisory Board, Tri-City Elders Coalition | 2013-2015 (Member 2008 – 2015)

MEMBER, Advisory Committee, Ashby Village | 2010 – 2012

MEMBER, Board of Directors, Archway School | 2012 – 2015

PRESIDENT, Board of Trustees, Chaparral House (Skilled Nursing Facility) | 2003-2005 (Member 1999 – 2007)

MEMBER, Board of Directors, League of Women Voters of Oakland | 1991-1993

RESOLUTION NO. 2024-XX

A RESOLUTION OF ALAMEDA ALLIANCE FOR HEALTH APPROVING LONG TERM SERVICES AND SUPPORTS SEAT NOMINEE FOR BOARD OF GOVERNORS MEMBERSHIP, AND RECOMMENDING THAT THE ALAMEDA COUNTY BOARD OF SUPERVISORS MAKE AN APPOINTMENT TO THE BOARD OF GOVERNORS OF ALAMEDA ALLIANCE FOR HEALTH

WHEREAS, on September 19, 2023, the Alameda County Board of Supervisors adopted Ordinance No 2023-32, which became effective on October 19, 2023, adding four additional seats to the Alameda Alliance for Health (“Alliance”) Board of Governors (“Board”), including a seat to represent Long Term Services and Supports in a subject matter expertise capacity (“LTSS Seat”); and

WHEREAS, pursuant to Ordinance No 2023-32, the Alliance Executive Committee recommends that the Alliance Board nominate Wendy Peterson to fill the vacant LTSS Seat; and

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

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

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

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

SECTION 1. That the Alliance Board approves Wendy Peterson to fill the LTSS Seat (Regular # 19) on the Alliance Board, as created pursuant to Section 6.96.040 L. of Alameda County Ordinance No. 2023-32.

SECTION 2. The Alliance Board hereby recommends that the Alameda County Board of Supervisors adopt a resolution by majority vote appointing Wendy Peterson as a member in the LTSS Seat (Regular # 19) of the Alliance Board.

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

PASSED AND ADOPTED by the Board at a meeting held on the 10th day of May 2024.

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CHAIR, BOARD OF GOVERNORS

ATTEST:

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Secretary

RESOLUTION NO. 2024-XX

A RESOLUTION OF THE BOARD OF GOVERNORS CREATING THE COMMUNITY ADVISORY SELECTION COMMITTEE

WHEREAS, the Alameda Alliance for Health ("Alliance") Board of Governors has adopted *Bylaws*, Article 7 of which, allow for the creation of committees by way of resolution to carry out the purposes of the Board of Governors; and

WHEREAS, Resolution #2023-11, approved by the Alliance Board of Governors on December 8, 2023, established the Community Advisory Committee in accordance with Exhibit A, Attachment III, Section 5.2.11(E) of Contract #**23-30212** ("the Contract") between Alameda Alliance for Health and the Department of Health Care Services; and

WHEREAS, the Contract requires that the Community Advisory Committee have a Selection Committee, responsible for selecting its members; and

WHEREAS the Alliance has determined that the creation of a committee is most appropriate to carry out the duties of the Selection Committee.

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

SECTION 1. The Community Advisory Selection Committee tasked with selecting members of the Community Advisory Committee and ensuring the Alliance's service area is represented, shall be created pursuant to this Resolution #2024-XX.

SECTION 2. The Community Advisory Selection Committee shall, in accordance with the Contract, be composed of person(s) on the Alliance Board of Governors, including representation in the following areas: Safety Net Providers including Federally Qualified Health Centers (FQHC), Behavioral Health, Regional Center (RC), Local Education Agency (LEAs), Dental Provider, Indian Health Care Provider (IHCPs), and Home and Community-Based Service (HCBS) program provider.

SECTION 3. The meeting schedule of the Community Advisory Selection Committee shall be determined by its members and scheduled on an as-needed basis. The membership will serve for a term of two (2) years and may be reappointed to serve additional terms.

PASSED AND ADOPTED by the Alameda Alliance Board of Governors at a meeting held on the 10th of May 2024.

CHAIR, Board of Governors

ATTEST:

Secretary

ALAMEDA ALLIANCE FOR HEALTH

COMMUNITY ADVISORY SELECTION COMMITTEE (SC) CHARTER

Purpose:
The Community Advisory Selection Committee “Selection Committee” (SC) is a committee reporting to the Alameda Alliance for Health (Alliance) Board of Governors. The SC is comprised of a representative sample of individuals who provide different perspectives, ideas, and views to the Community Advisory Committee (CAC), and includes persons on the Alliance Board of Governors, Safety Net Provider(s) from Federally Qualified Health Centers, Regional Center(s), Local Education Agency, dental provider(s), as well as other persons and community-based organizations representing Alameda County, in accordance with the Alliance’s contract with the Department of Health Care Services (DHCS).

Policy/Scope:
The Alliance shall maintain the SC in accordance with its contract with DHCS.

The SC is tasked with the following:

a) Ensuring the CAC membership reflects the general Medi-Cal Member population in Alameda County, including representatives from Individualized Health Care Plans, adolescents and/or parents and/or caregivers of children, including foster youth.
b) Making appropriate modifications to the CAC as the population the Alliance serves for the purpose of ensuring the Alliance’s community is represented and engaged.
c) Making good-faith efforts to include representatives from diverse and hard-to-reach populations on the CAC, with a specific emphasis on persons who are representatives of or serving populations that experience Health disparities, considering individuals with diverse racial and ethnic backgrounds, gender identity, sexual orientation, and physical disabilities.
d) Promptly replacing vacant seats on the CAC within 60 calendar days of the CAC vacancy when a member resigns, is asked to resign, or is otherwise unable to serve *on the CAC.*

Membership of the CAC Selection Committee:

The SC shall consist of voting members, including the Chair and Vice Chair. The membership of the SC will serve in accordance with applicable laws as well as procedures set forth by the Alliance *Bylaws*. The terms for SC members will be for two (2) years and established by resolution. Members may be reappointed to serve, pending approval by the Board of Governors.

The SC will include the following representations within the membership, in accordance with the contract between the State and the Alliance:

i) Persons who sit on the Alliance's Governing Board, including representation in the following areas: Safety Net Providers including Federally Qualified Health Centers (FQHC), Behavioral Health Providers, Regional Centers (RC), Local Education Agencies (LEAs), dental providers, Indian Health Care Providers (HCPs), program providers; and

ii) Persons and community-based organizations who are representatives within the Alliance's Service Area, adjusting for changes in membership diversity. *The Chair and Vice Chair of the CAC shall represent persons who are representatives within the Alliance's Service Area in the SC.*

Officers of the Selection Committee:

Officers of the SC shall consist of:

a) Chair
b) Vice-Chair

The Chair and Vice Chair of the SC shall be filled by the Chair and Vice-Chair of the Board of Governors.

If both the Chair and Vice Chair of the SC are absent or unable to act at a meeting where a quorum is present and the Chair has not selected an individual to act as Chair, the Committee shall select an attending committee member to act as Chair pro tempore, with all the authority appurtenant thereto.

Meeting Materials:

a) SC meeting agendas shall be developed dependent on the needs of the meeting(s) and the input from SC members.
b) At least 72 hours prior to a regular meeting, an agenda and meeting materials shall be posted on the Alliance website in a centralized location.
c) The agenda shall be posted at the main entrance of the Alliance's principal offices and/or any other location freely accessible to members of the public.
d) Meetings will be conducted in accordance with applicable law, including the *Brown Act* and best practices as outlined in *Robert's Rules of Order*.

Voting & Quorum:

a) Items warranting a vote, such as the review and approval of a member nomination to the CAC, must be reviewed when there is a quorum of the membership present.
b) Members attending virtually must have an approved basis under Assembly Bill 2449 (AB 2449) or *Traditional Brown Act*, to be determined by the AAH Legal Department.

Meeting Schedule:

a) The SC shall meet on an as-needed basis.

Public Comment:

a) Every agenda for a regular meeting shall provide an opportunity for members of the public to directly address the SC on any agenda items.
b) Where a member of the public raises an issue which has not yet come before the committee, the item may be briefly discussed and placed on the next meeting agenda for further discussion, but no action may be taken at that meeting.

Finance

Gil Riojas

To: Alameda Alliance for Health, Board of Governors

From: Gil Riojas, Chief Financial Officer

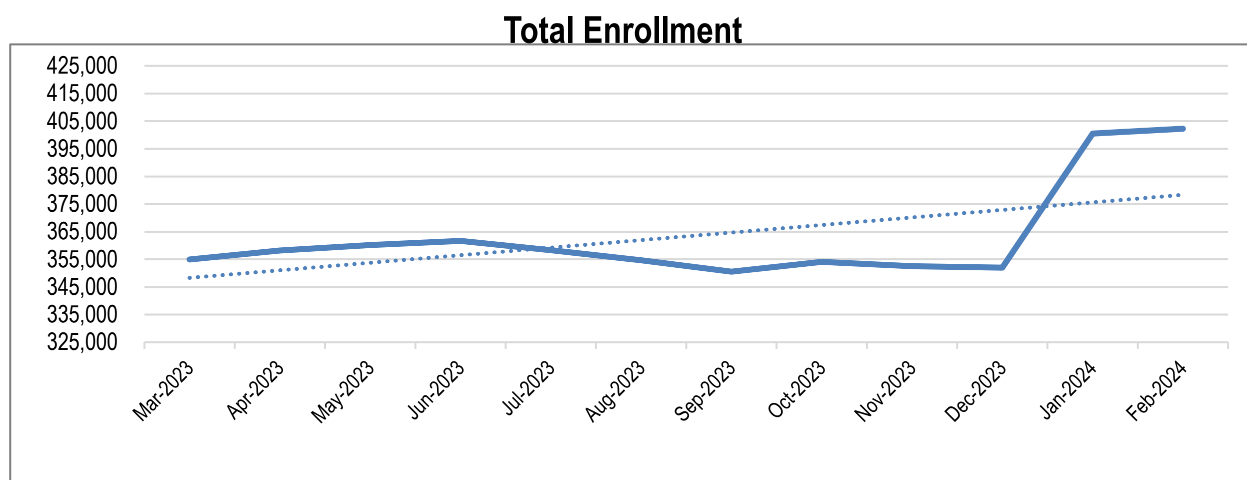
Date: May 10th, 2024

Subject: Finance Report – February 2024 Financials

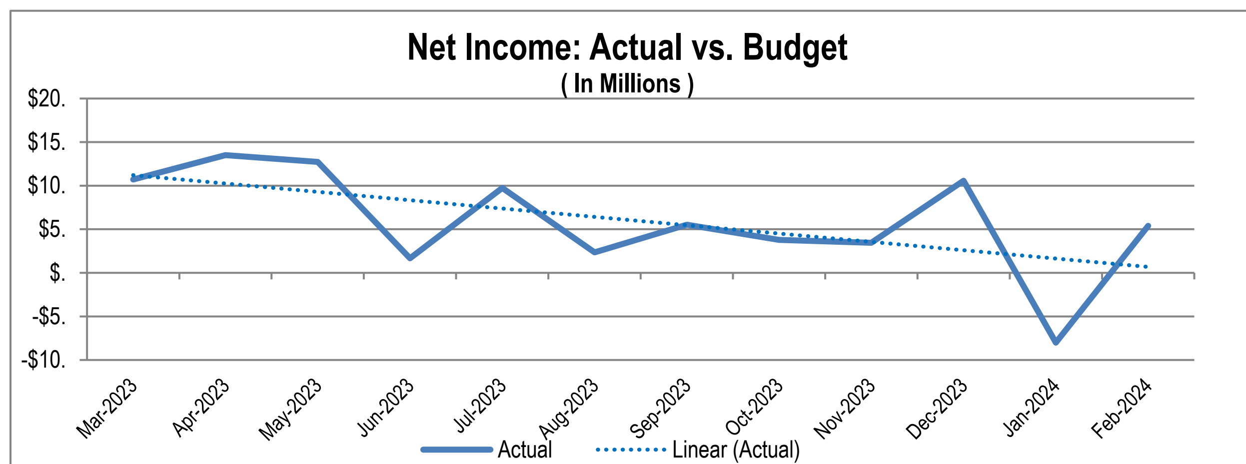
Executive Summary

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

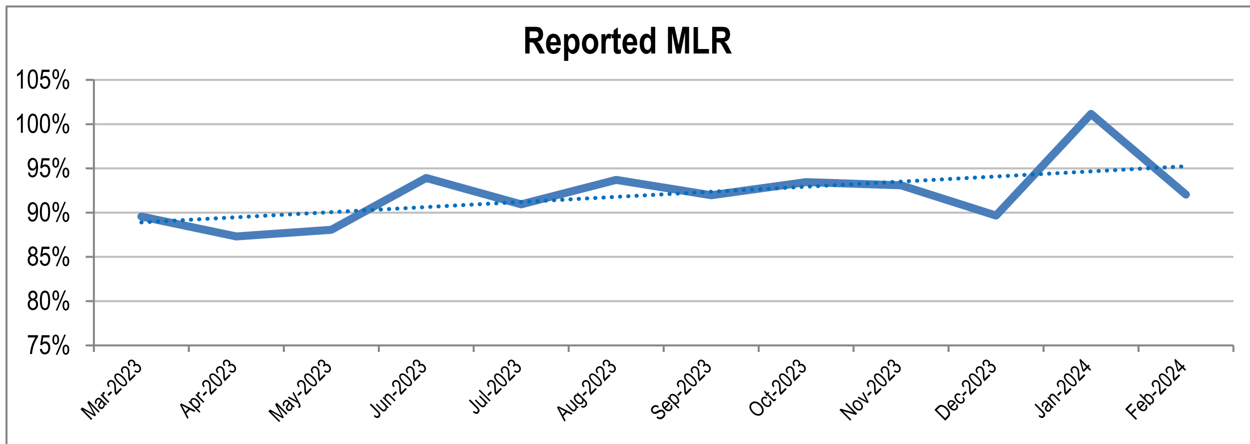
Enrollment – In February, Enrollment increased by 1,741 members.



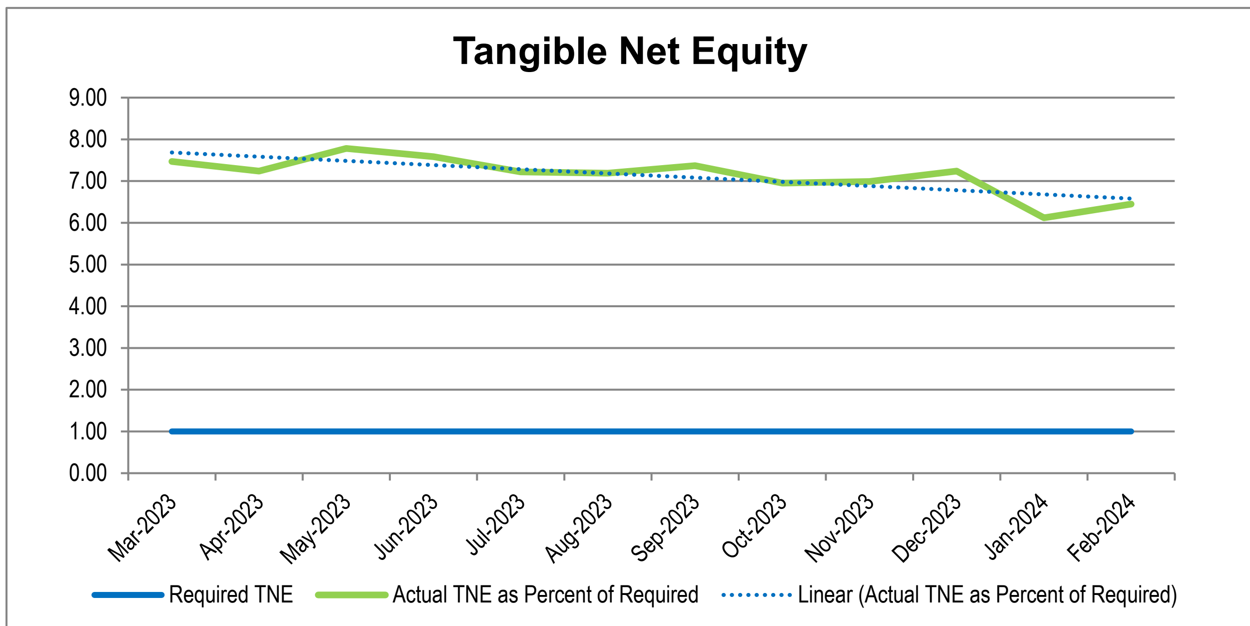
Net Income – For the month ended February 29th, 2024, actual Net Income was $5.4 million vs. budgeted Net Income of $3.4 million. Fiscal year-to-date actual Net Income was $32.8 million vs. Budgeted Net Income of $20.0 million. For the month, Premium revenue was 2.7% favorable to Budget.



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



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



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

Finance

Supporting Documents

To: Alameda Alliance for Health, Board of Governors

From: Gil Riojas, Chief Financial Officer

Date: May 10th, 2024

Subject: Finance Report – February 2024

Executive Summary

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

Overall Results: (in Thousands)

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

Net Income by Program: (in Thousands)

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

*Includes consulting cost for Medicare implementation.

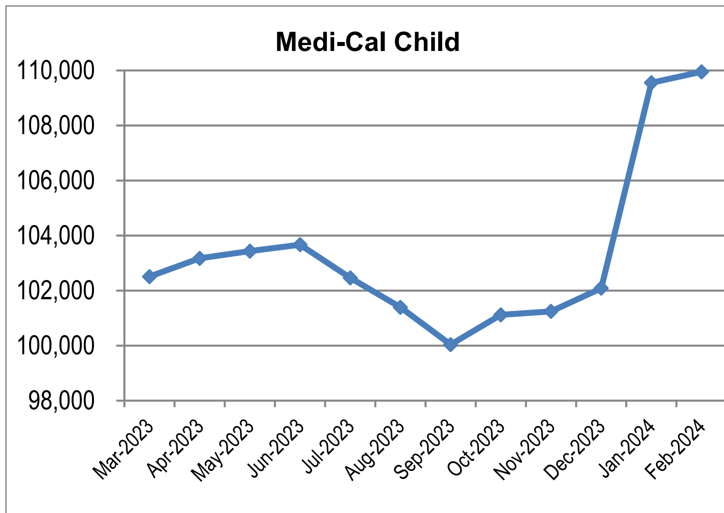
Enrollment

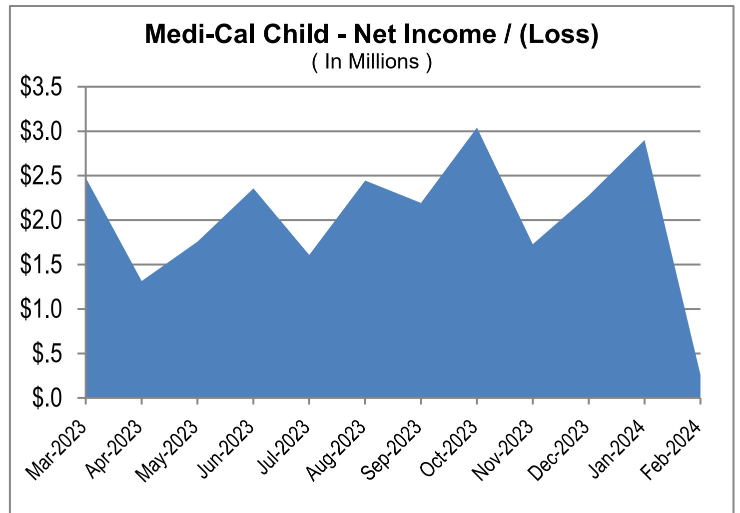
- Total enrollment increased by 1,741 members since January 2024.
- Total enrollment increased by 40,574 members since June 2023.

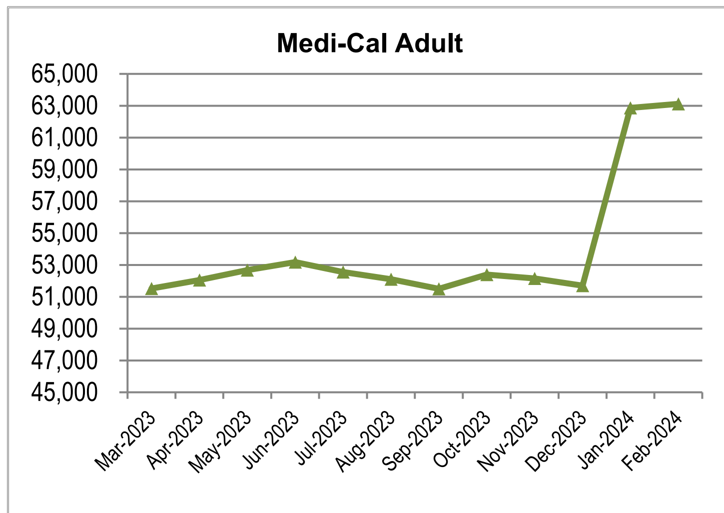
Monthly Membership and YTD Member Months
Actual vs. Budget
For the Month and Fiscal Year-to-Date

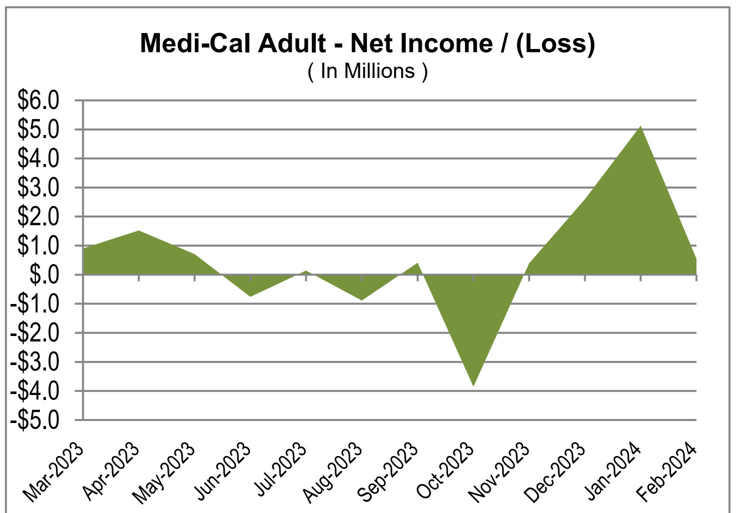
Enrollment					Member Months			
Current Month					Year-to-Date			
Actual	Budget	Variance	Variance %		Actual	Budget	Variance	Variance %
				Medi-Cal:				
63,117	56,788	6,329	11.1%	Adult	438,371	425,986	12,385	2.9%
109,953	100,933	9,020	8.9%	Child	827,851	807,223	20,628	2.6%
34,875	42,133	(7,258)	-17.2%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

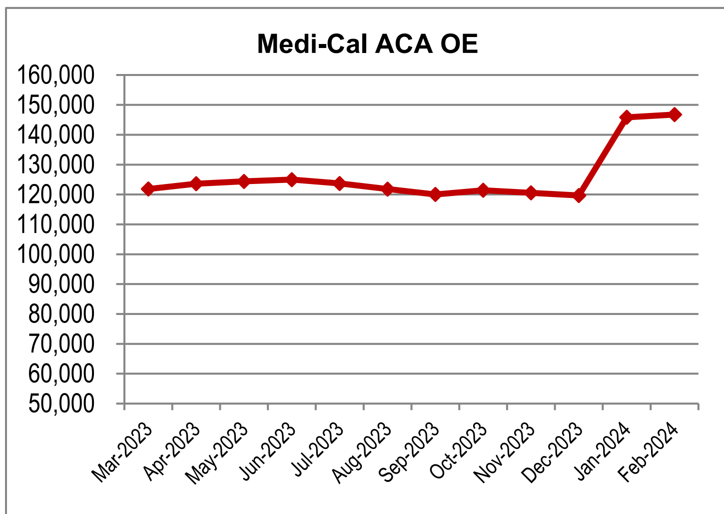
Enrollment and Profitability by Program and Category of Aid

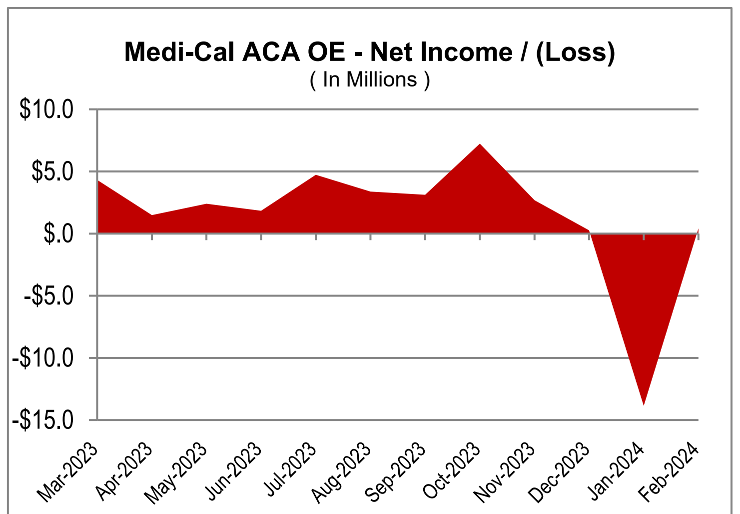




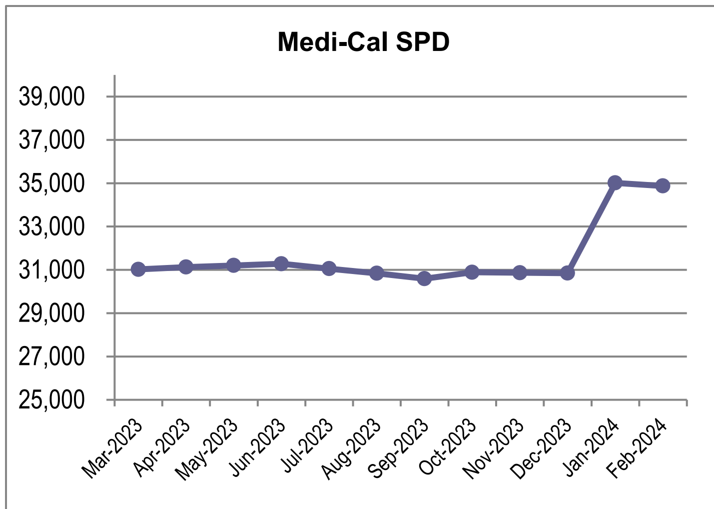


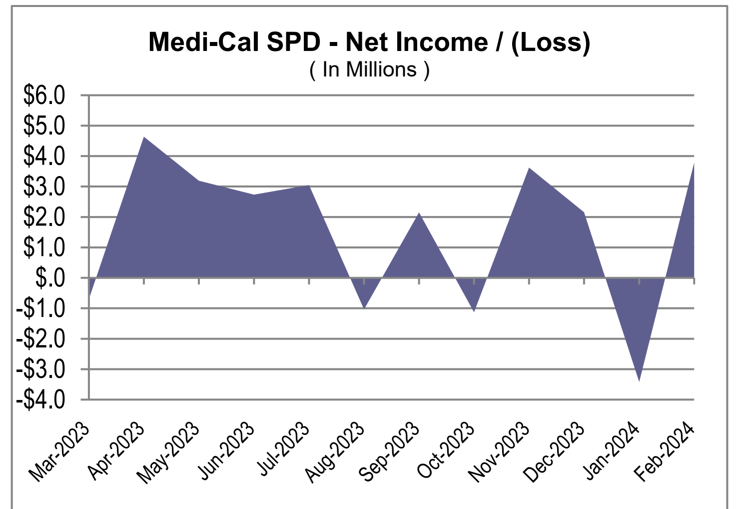


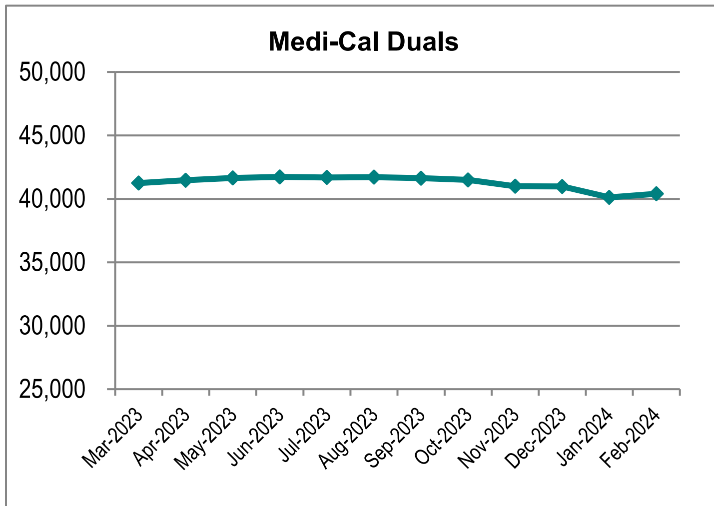


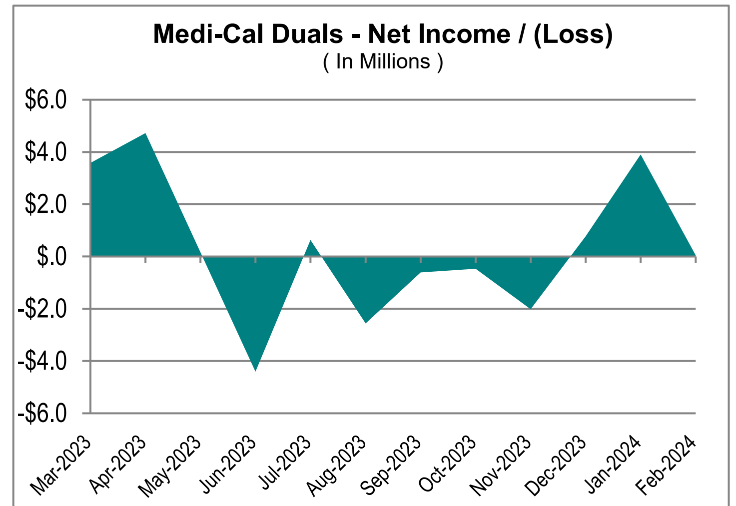


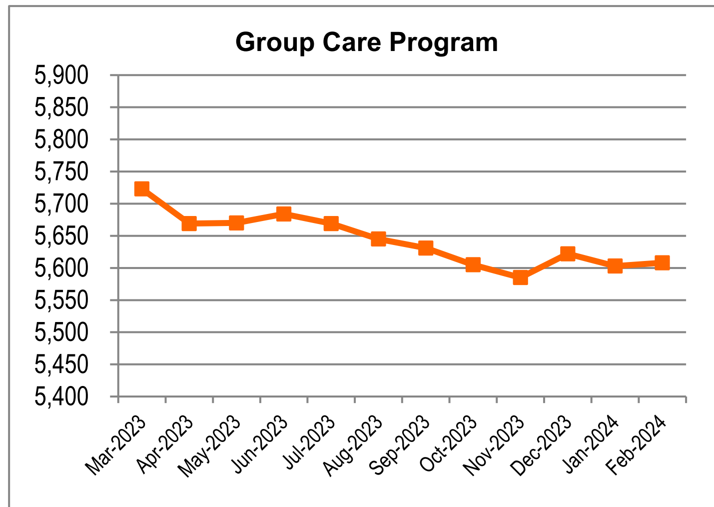
Enrollment and Profitability by Program and Category of Aid

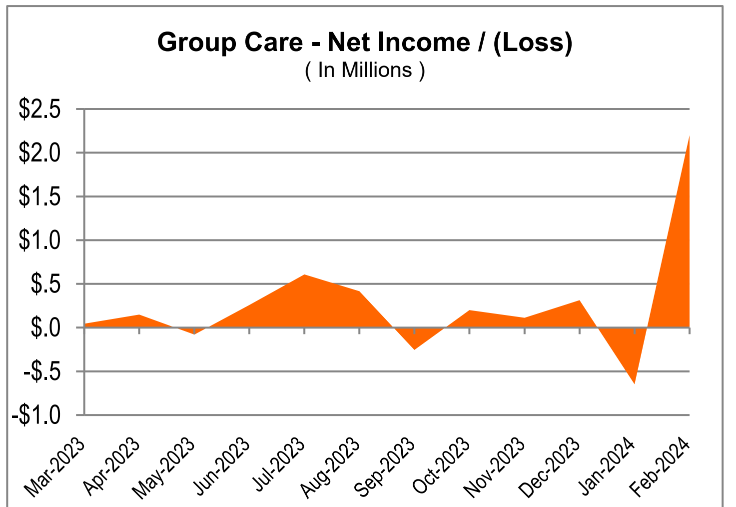




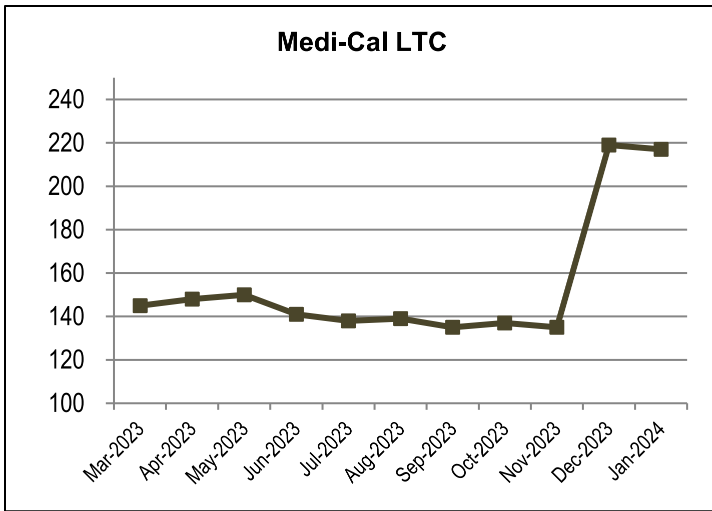


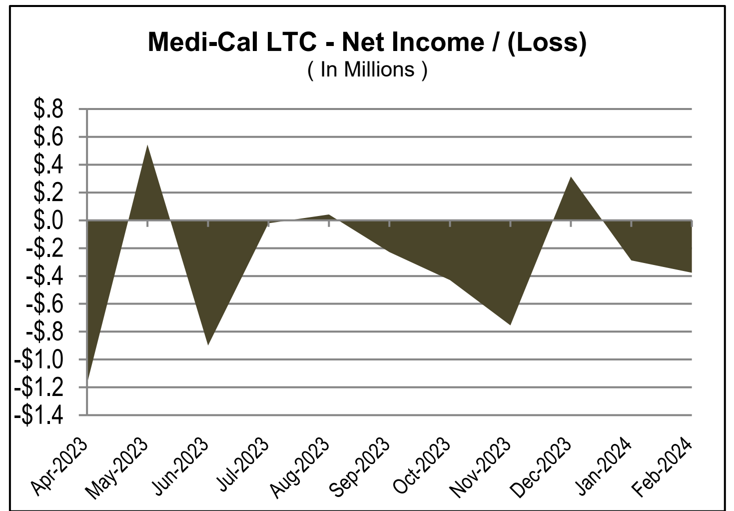


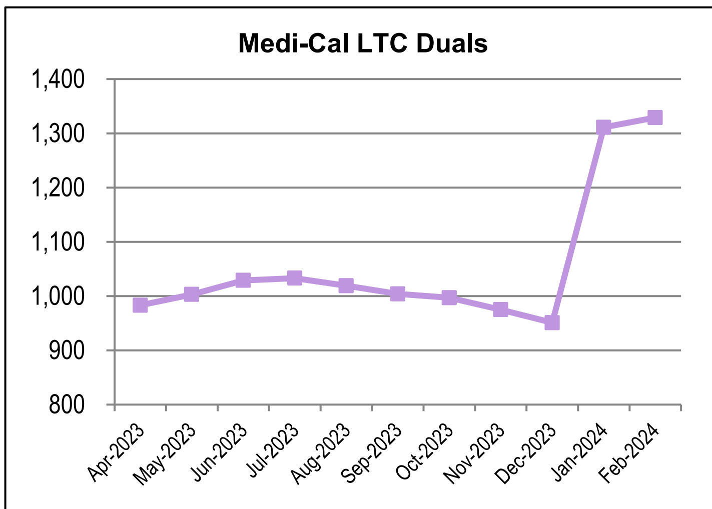


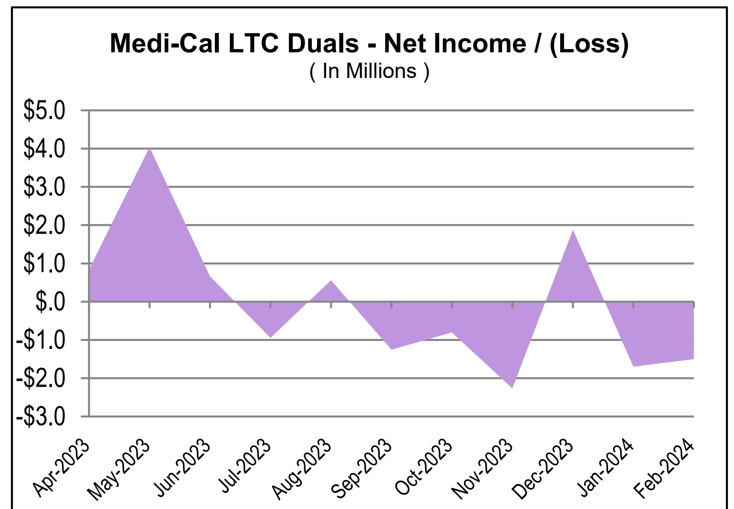


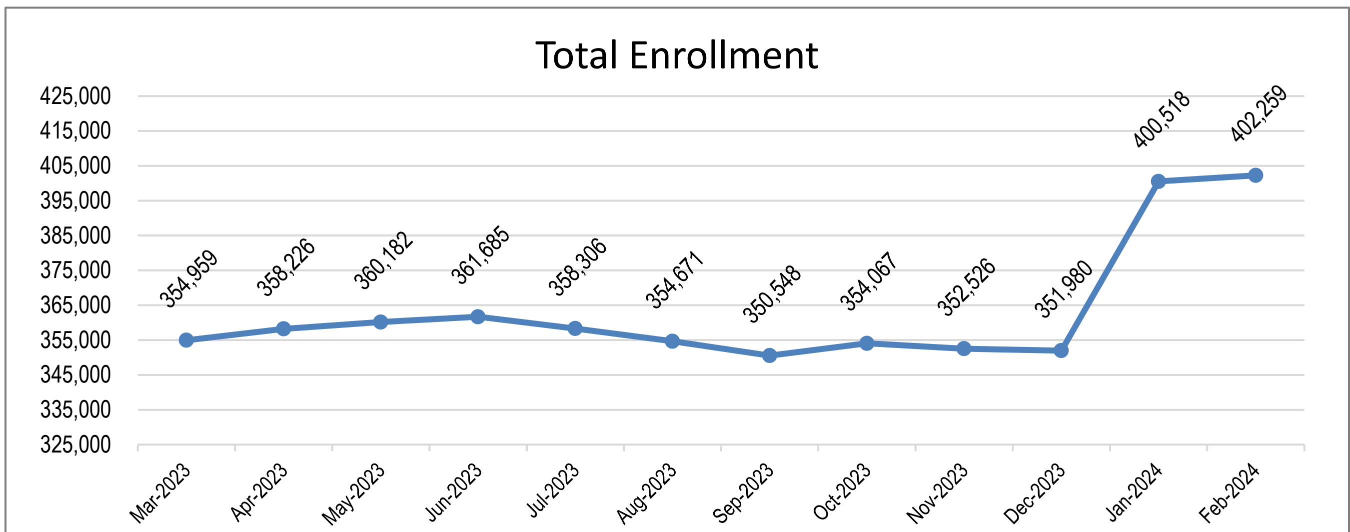
Enrollment and Profitability by Program and Category of Aid

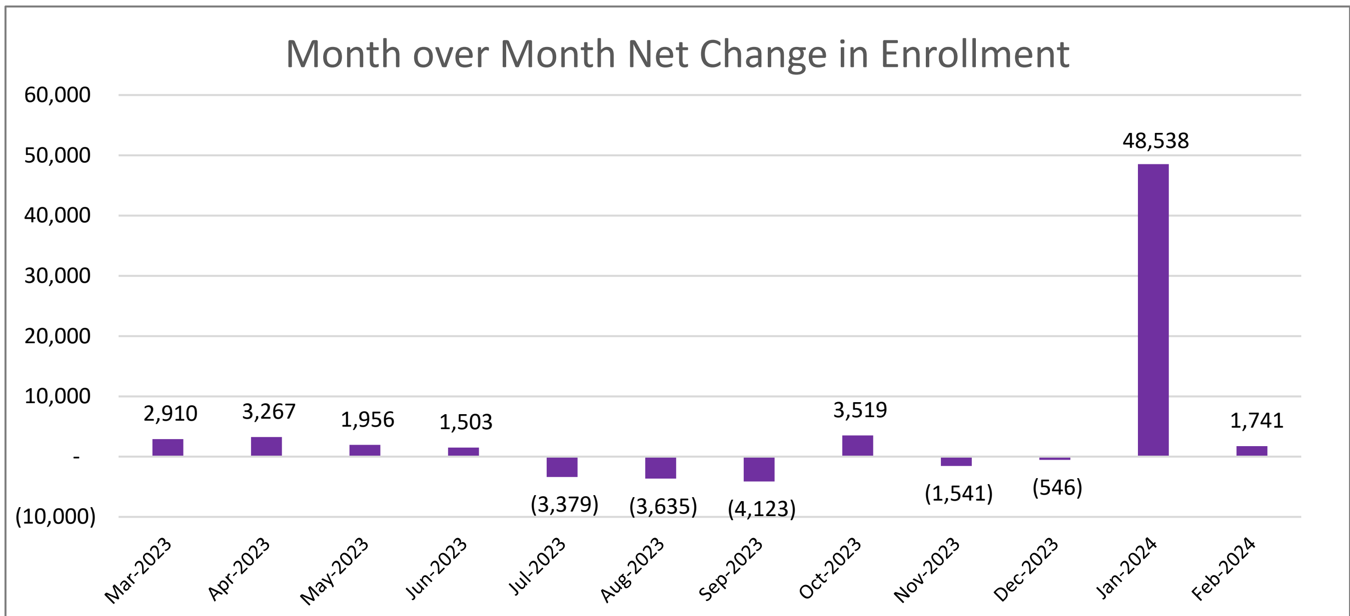










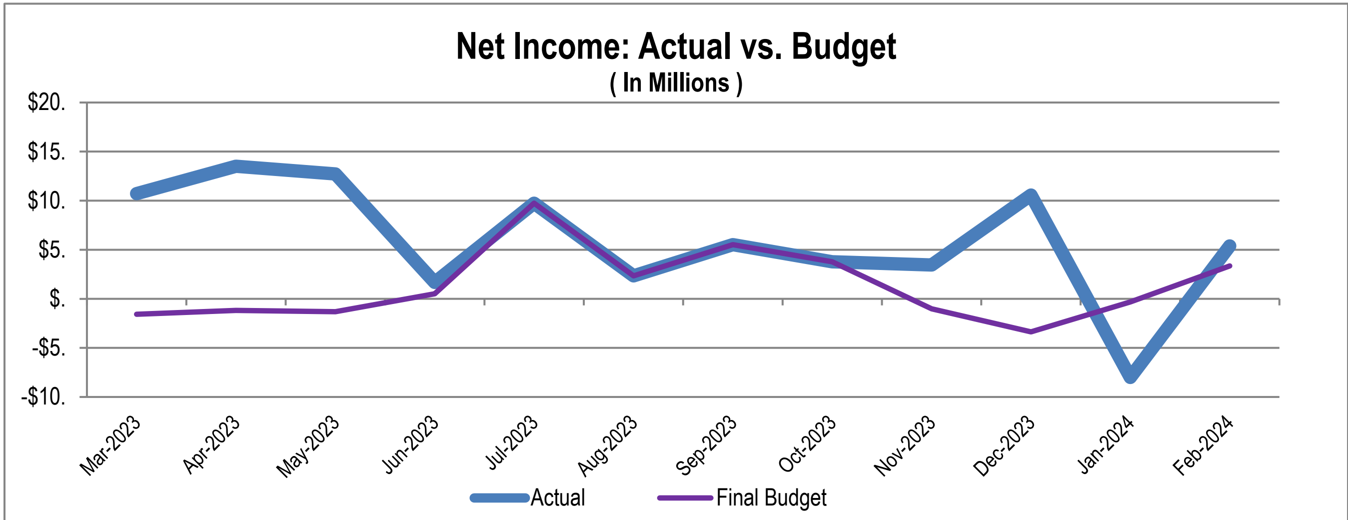


- The Public Health Emergency (PHE) ended May 2023. Disenrollments related to redetermination started July 2023 and will continue through May 2024. In preparation for the Single Plan Model, effective October 2023 DHCS no longer assigned members to Anthem, and instead new members were assigned to the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

<u>Net Income</u>

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

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

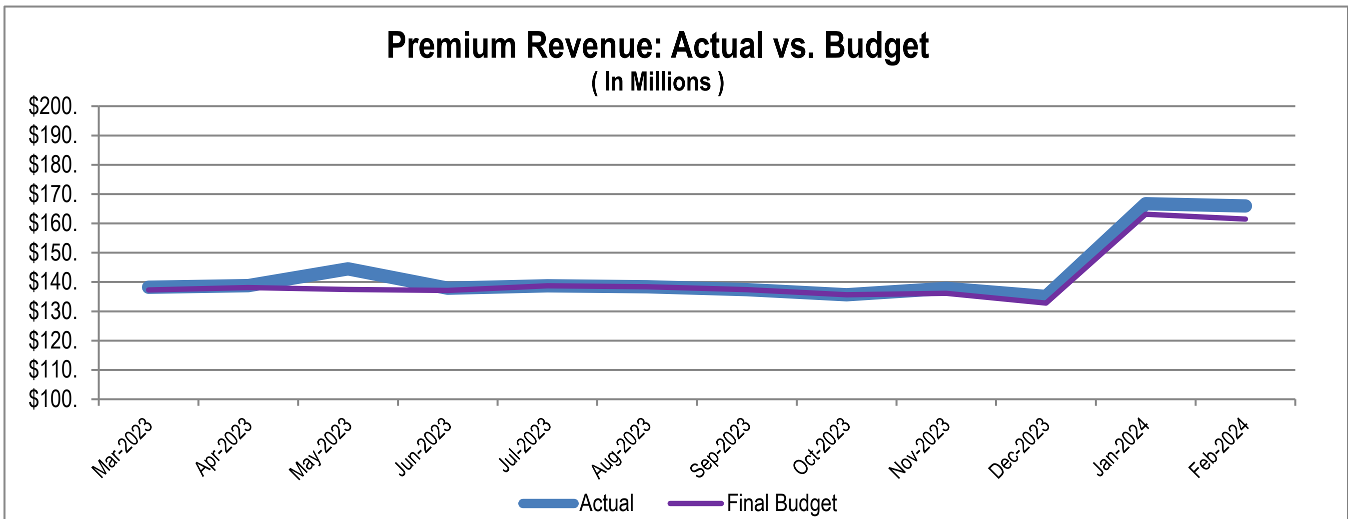


- The favorable variance of $2.0 million in the current month is primarily due to:
  - Favorable $4.4 million higher than anticipated Premium Revenue.
  - Unfavorable $500,000 higher than anticipated Medical Expense.
  - Favorable $2.1 million lower than anticipated Administrative Expense.
  - Unfavorable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

Premium Revenue

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

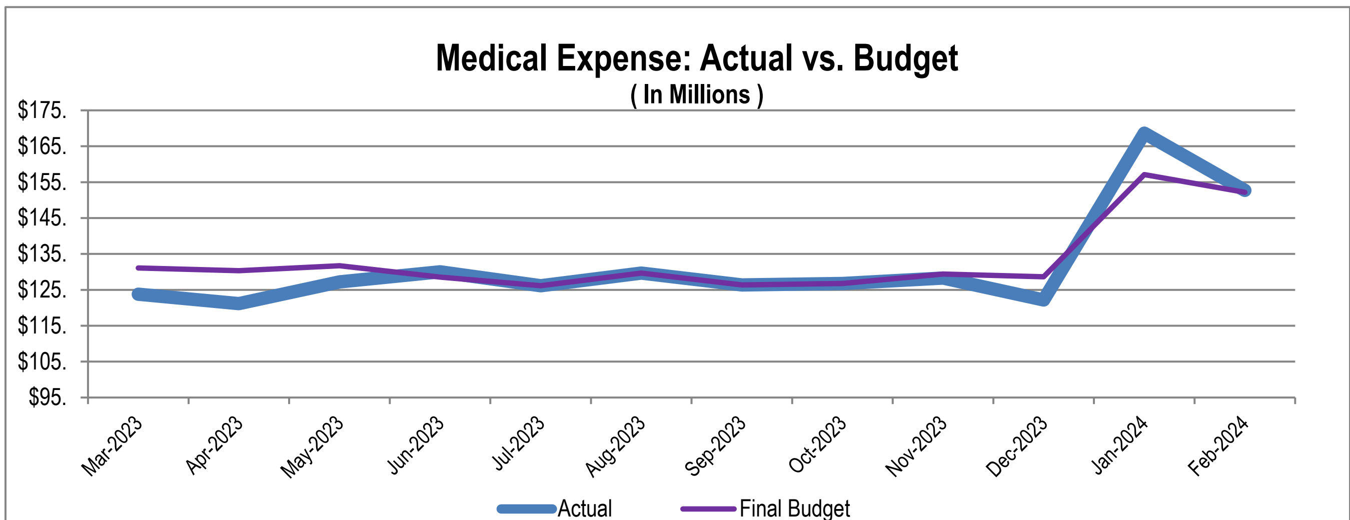
- For the fiscal YTD ended February 29th, 2024:
  - Actual Revenue: $1.2 billion.
  - Budgeted Revenue: $1.1 billion.



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

Medical Expense

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



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

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

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

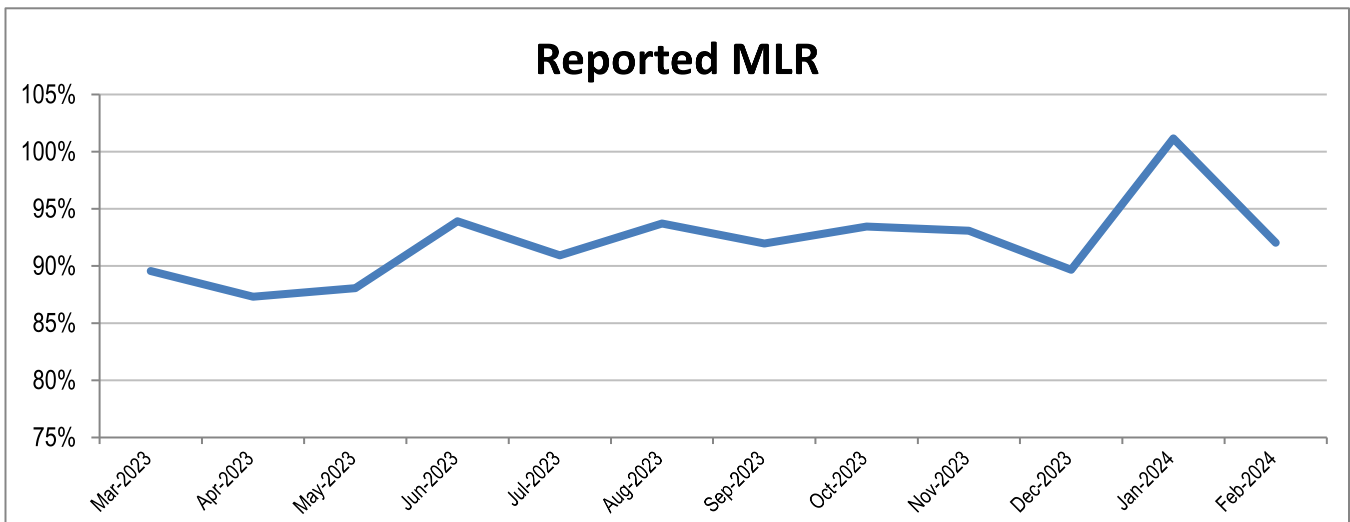
Medical Expense - Actual vs. Budget (Per Member Per Month) Adjusted to Eliminate the Impact of Prior Year IBNP Estimates						
	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$65.74	$0.00	$65.74	$64.27	($1.48)	-2.3%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

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

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

Medical Loss Ratio (MLR)

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



Administrative Expense

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

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

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

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

The year-to-date variances include:

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

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

Other Income / (Expense)

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

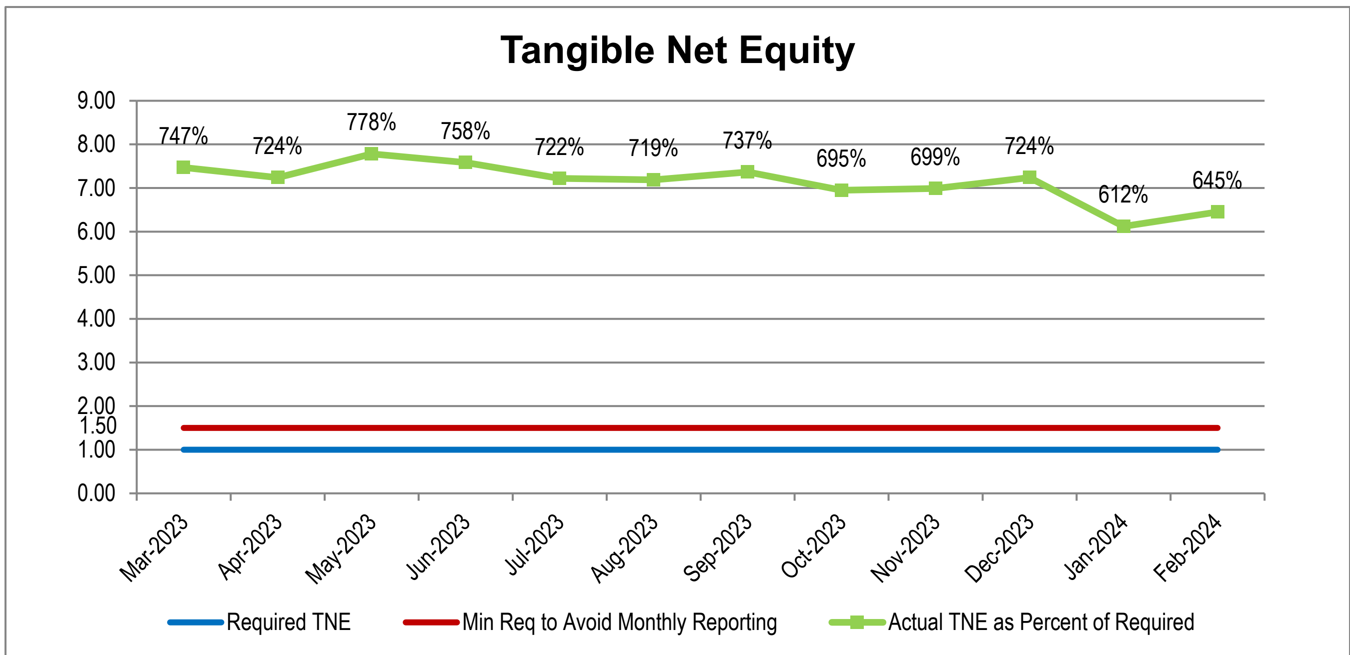
- Fiscal year-to-date net investments show a gain of $20.4 million.
- Fiscal year-to-date claims interest expense, due to delayed payment of certain claims, or recalculated interest on previously paid claims is $493,000.

Managed Care Organization (MCO) Provider Tax

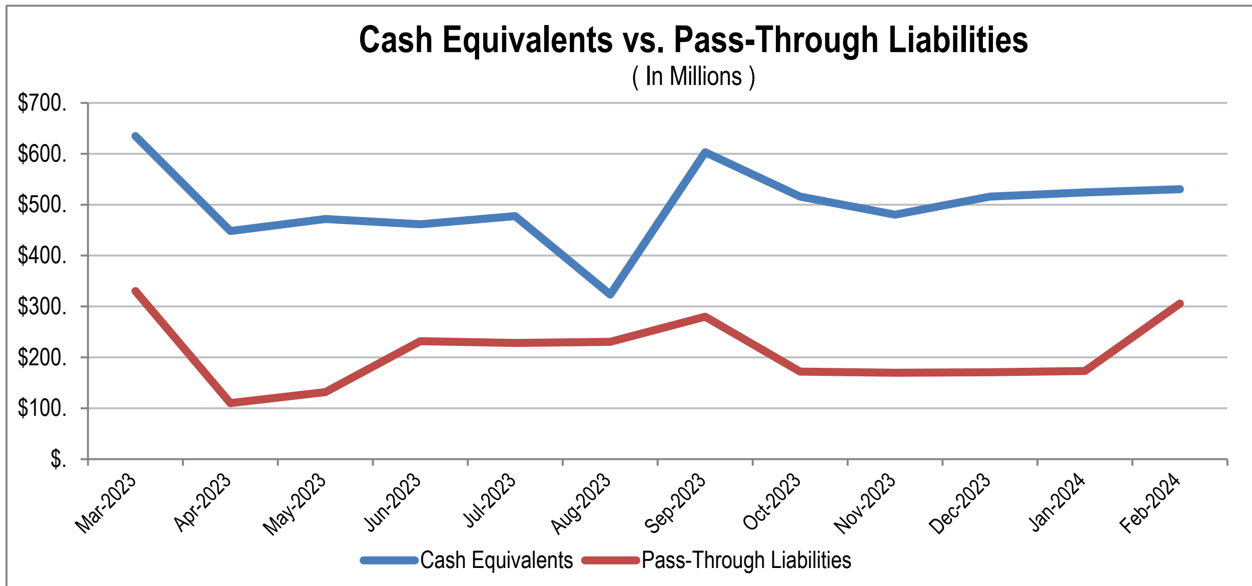
- For the month ended February 29th, 2024:
    - $159.8 million unbudgeted MCO Tax Revenue.
    - $162.5 million unbudgeted MCO Tax Expense.

Tangible Net Equity (TNE)

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



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



Capital Investment

- Fiscal year-to-date capital assets acquired: $1.2 million.
- Annual capital budget: $1.6 million.
- A summary of year-to-date capital asset acquisitions is included in this monthly financial statement package.

Caveats to Financial Statements

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

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

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

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

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

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

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

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

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

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

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

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

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

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE MONTH OF FEBRUARY 2024

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

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE FISCAL YEAR TO DATE FEBRUARY 2024

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

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

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

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

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

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

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

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

		Project ID	Prior YTD Acquisitions	Current Month Acquisitions	Fiscal YTD Acquisitions	Capital Budget Total	$ Variance Fav/(Unf.)
1. Hardware:							
	Cisco Catalyst 9300 - Catalyst Switches	IT-FY24-01	$ -	$ -	**$ -**	$ 50,000	$ 50,000
	Cisco Catalyst 8500 - Routers	IT-FY24-02	$ -	$ -	**$ -**	$ 60,000	$ 60,000
	Cisco AP-9166 - Access Point	IT-FY24-03	$ -	$ -	**$ -**	$ 10,000	$ 10,000
	Cisco UCS-X M6 or M7 Blades x 6	IT-FY24-04	$ 426,471	$ -	**$ 426,471**	$ 426,371	$ (100)
	PURE Storage array	IT-FY24-05	$ -	$ -	**$ -**	$ 300,000	$ 300,000
	PKI management	IT-FY24-06	$ -	$ -	**$ -**	$ 20,000	$ 20,000
	IBM Power Hardware Upgrade	IT-FY24-07	$ 560,652	$ -	**$ 560,652**	$ 288,629	$ (272,023)
	Misc Hardware	IT-FY24-08	$ 7,119	$ -	**$ 7,119**	$ 15,000	$ 7,881
	Network / AV Cabling	IT-FY24-09	$ 107,600	$ -	**$ 107,600**	$ 30,000	$ (77,600)
	Training Room Projector	IT-FY24-10	$ 1,359	$ -	**$ 1,359**	$ 13,000	$ 11,641
	Conference room upgrades	IT-FY24-11	$ -	$ -	**$ -**	$ 107,701	$ 107,701
Hardware Subtotal			**$ 1,103,201**	**$ -**	**$ 1,103,201**	**$ 1,320,701**	**$ 217,500**
2. Software:							
	Zerto renewal and Tier 2 add	AC-FY24-01	$ -	$ -	**$ -**	$ 126,000	$ 126,000
Software Subtotal			**$ -**	**$ -**	**$ -**	**$ 126,000**	**$ 126,000**
3. Building Improvement:							
	Appliances over 1k new/replacement (all buildings/suites)	FA-FY24-01	**$ -**	$ -	**$ -**	$ -	$ -
	ACME Security: Readers, HID boxes, Cameras, Doors (planned/unplanned	FA-FY24-02	$ -	$ -	**$ -**	$ 20,000	$ 20,000
	HVAC: Replace VAV boxes, duct work, replace old equipment	FA-FY24-03	$ 18,295	$ -	**$ 18,295**	$ 20,000	$ 1,705
	Electrical work for projects, workstations requirement	FA-FY24-04	$ -	$ -	**$ -**	$ 10,000	$ 10,000
	1240 Interior blinds replacement	FA-FY24-05	**$ -**	$ -	**$ -**	$ 25,000	$ 25,000
	EV Charging stations, if not completed in FY23 and carried over to FY24	FA-FY24-06	**$ 35,399**	$ -	**$ 35,399**	$ 50,000	$ 14,601
Building Improvement Subtotal			**$ 53,694**	**$ -**	**$ 53,694**	**$ 125,000**	**$ 71,306**
4. Furniture & Equipment:							
	Office desks, cabinets, shelvings (all building/suites: new or replacement)	FA-FY24-17	$ 3,860	$ -	**$ 3,860**	$ 10,000	$ 6,140
	Replace, reconfigure, re-design workstations	FA-FY24-18	$ -	$ -	**$ -**	$ 20,000.00	$ 20,000
Furniture & Equipment Subtotal			**$ 3,860**	**$ -**	**$ 3,860**	**$ 30,000**	**$ 26,140**
GRAND TOTAL			**$ 1,160,755**	**$ -**	**$ 1,160,755**	**$ 1,601,701**	**$ 440,946**
5. Reconciliation to Balance Sheet:							
	Fixed Assets @ Cost - 2/29/24				**$ 38,855,851**		
	Fixed Assets @ Cost - 6/30/23				**$ 37,695,096**		
	Fixed Assets Acquired YTD				**$ 1,160,755**		

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

TANGIBLE NET EQUITY (TNE)

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

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

LIQUID TANGIBLE NET EQUITY

	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Net Assets	$333,703,974	$336,047,435	$341,561,770	$345,338,268	$348,779,178	$359,342,945	$351,333,888	$356,726,008
Fixed Assets at Net Book Value	(5,169,098)	(5,539,264)	(5,608,622)	(5,653,388)	(6,079,010)	(5,997,733)	(7,085,899)	(6,961,780)
Net Lease Assets/Liabilities/Interest	(711,429)	(475,037)	(1,115,074)	(727,353)	(662,463)	(1,135,481)	(1,193,576)	(1,033,509)
CD Pledged to DMHC	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)
Liquid TNE (Liquid Reserves)	**$328,184,876**	**$330,158,171**	**$335,603,148**	**$339,334,880**	**$342,350,168**	**$352,995,212**	**$343,897,989**	**$349,414,228**
Liquid TNE as Multiple of Required	**7.10**	**7.06**	**7.24**	**6.83**	**6.86**	**7.11**	**5.99**	**6.31**

REPORT #8

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

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

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

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

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

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

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING

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

ALAMEDA ALLIANCE FOR HEALTH
TRENDED ENROLLMENT REPORTING

FOR THE FISCAL YEAR 2024	FINAL BUDGET												
	Budget Jul-23	Budget Aug-23	Budget Sep-23	Budget Oct-23	Budget Nov-23	Budget Dec-23	Budget Jan-24	Budget Feb-24	Budget Mar-24	Budget Apr-24	Budget May-24	Budget Jun-24	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted													
Directly Contracted (DCP)	74,547	73,027	72,504	78,530	78,174	77,543	103,987	103,154	102,341	101,536	100,739	99,949	1,066,031
Alameda Health System	66,089	65,344	64,133	63,271	62,977	62,254	86,850	85,925	85,022	84,129	83,245	82,371	891,610
	140,636	138,371	136,637	141,801	141,151	139,797	190,837	189,079	187,363	185,665	183,984	182,320	1,957,641
Delegated:													
CFMG	34,810	34,649	34,144	34,035	33,709	33,339	43,104	42,595	42,131	41,671	41,217	40,767	456,171
CHCN	130,230	129,183	127,430	126,705	125,969	124,637	170,082	168,328	166,633	164,957	163,297	161,657	1,759,108
Kaiser	52,630	52,468	52,337	51,526	51,188	50,639	0	0	0	0	0	0	310,788
Delegated Subtotal	217,670	216,300	213,911	212,266	210,866	208,615	213,186	210,923	208,764	206,628	204,514	202,424	2,526,067
Total	**358,306**	**354,671**	**350,548**	**354,067**	**352,017**	**348,412**	**404,023**	**400,002**	**396,127**	**392,293**	**388,498**	**384,744**	**4,483,708**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted													
Directly Contracted (DCP)	305	(1,520)	(523)	6,026	(356)	(631)	26,444	(833)	(813)	(805)	(797)	(790)	25,707
Alameda Health System	(1,244)	(745)	(1,211)	(862)	(294)	(723)	24,596	(925)	(903)	(893)	(884)	(874)	15,038
	(939)	(2,265)	(1,734)	5,164	(650)	(1,354)	51,040	(1,758)	(1,716)	(1,698)	(1,681)	(1,664)	40,745
Delegated:													
CFMG	(441)	(161)	(505)	(109)	(326)	(370)	9,765	(509)	(464)	(460)	(454)	(450)	5,516
CHCN	(1,721)	(1,047)	(1,753)	(725)	(736)	(1,332)	45,445	(1,754)	(1,695)	(1,676)	(1,660)	(1,640)	29,706
Kaiser	(278)	(162)	(131)	(811)	(338)	(549)	(50,639)	0	0	0	0	0	(52,908)
Delegated Subtotal	(2,440)	(1,370)	(2,389)	(1,645)	(1,400)	(2,251)	4,571	(2,263)	(2,159)	(2,136)	(2,114)	(2,090)	(17,686)
Total	**(3,379)**	**(3,635)**	**(4,123)**	**3,519**	**(2,050)**	**(3,605)**	**55,611**	**(4,021)**	**(3,875)**	**(3,834)**	**(3,795)**	**(3,754)**	**23,059**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted													
Directly Contracted (DCP)	20.8%	20.6%	20.7%	22.2%	22.2%	22.3%	25.7%	25.8%	25.8%	25.9%	25.9%	26.0%	23.8%
Alameda Health System	18.4%	18.4%	18.3%	17.9%	17.9%	17.9%	21.5%	21.5%	21.5%	21.4%	21.4%	21.4%	19.9%
	39.3%	39.0%	39.0%	40.0%	40.1%	40.1%	47.2%	47.3%	47.3%	47.3%	47.4%	47.4%	43.7%
Delegated:													
CFMG	9.7%	9.8%	9.7%	9.6%	9.6%	9.6%	10.7%	10.6%	10.6%	10.6%	10.6%	10.6%	10.2%
CHCN	36.3%	36.4%	36.4%	35.8%	35.8%	35.8%	42.1%	42.1%	42.1%	42.0%	42.0%	42.0%	39.2%
Kaiser	14.7%	14.8%	14.9%	14.6%	14.5%	14.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6.9%
Delegated Subtotal	60.7%	61.0%	61.0%	60.0%	59.9%	59.9%	52.8%	52.7%	52.7%	52.7%	52.6%	52.6%	56.3%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

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

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

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

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

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

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

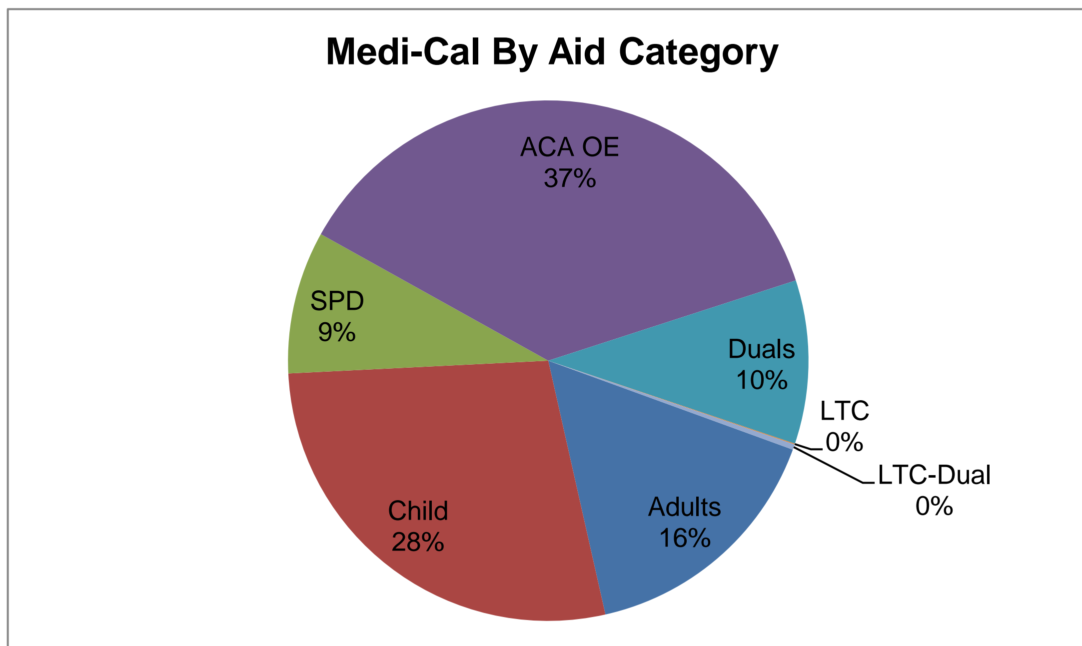
ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED FEBRUARY 29, 2024

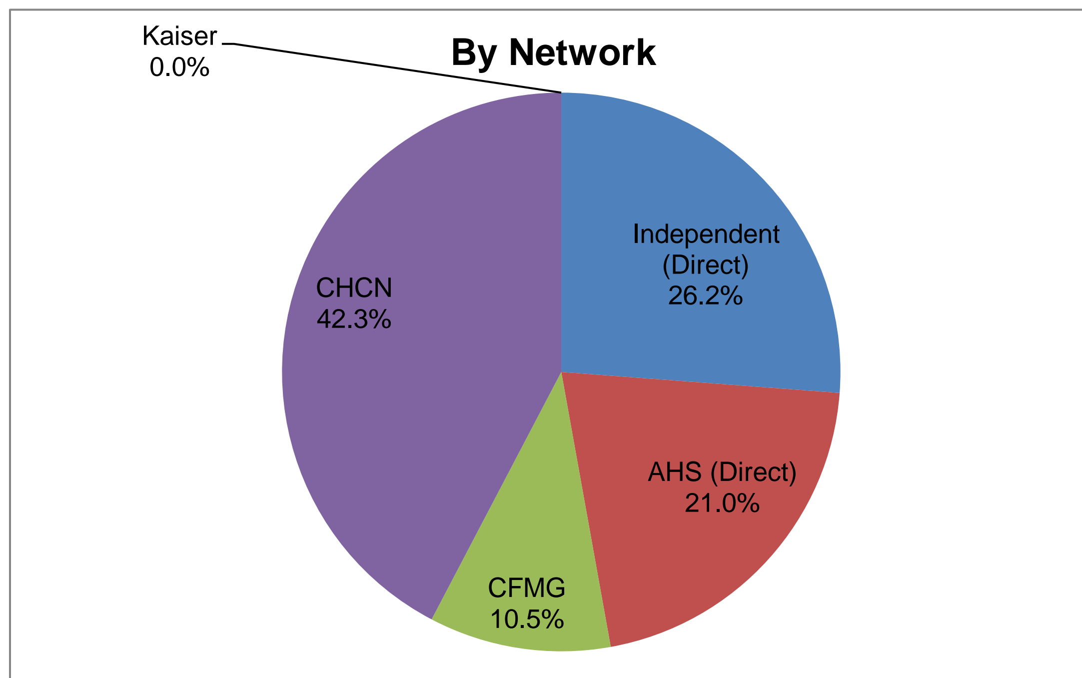
CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
776,061	1,037,266	261,205	25.2%	Quality Management Department Total	6,034,539	8,521,770	2,487,231	29.2%
406,234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

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend

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

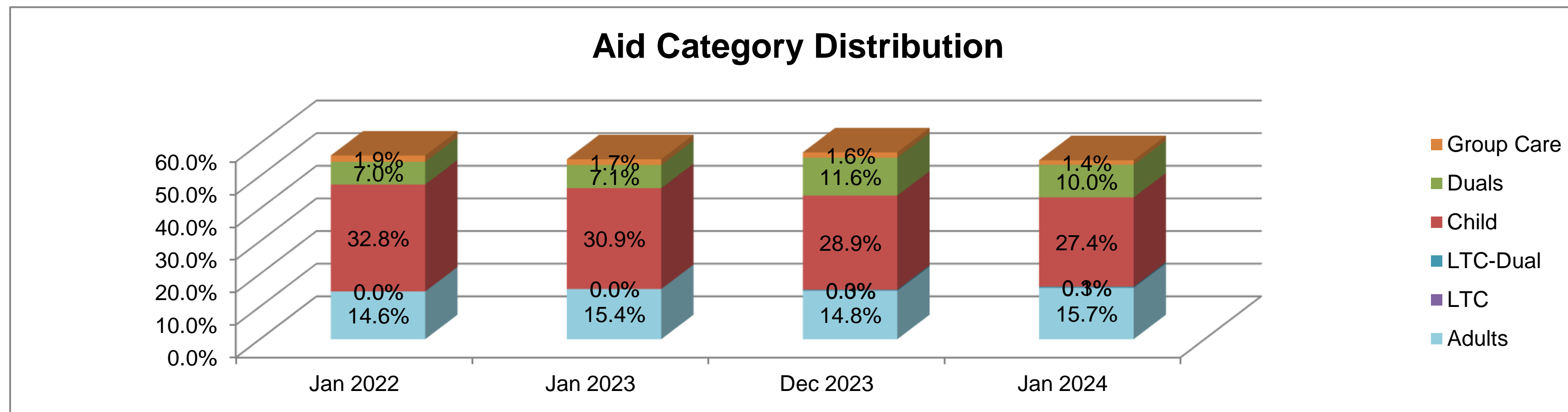




Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

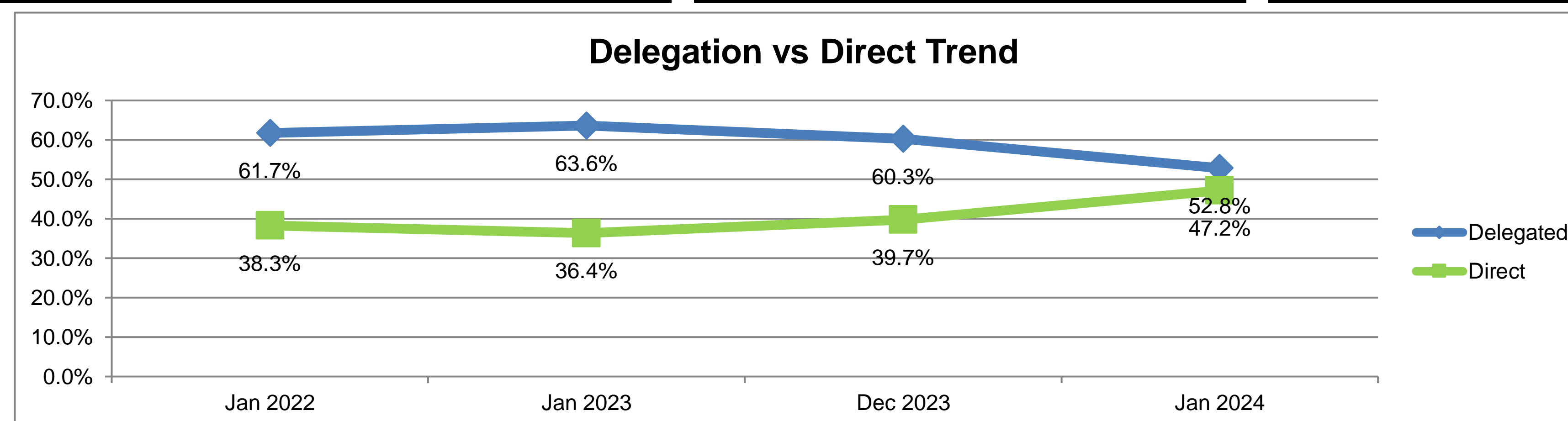
Category of Aid Trend

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



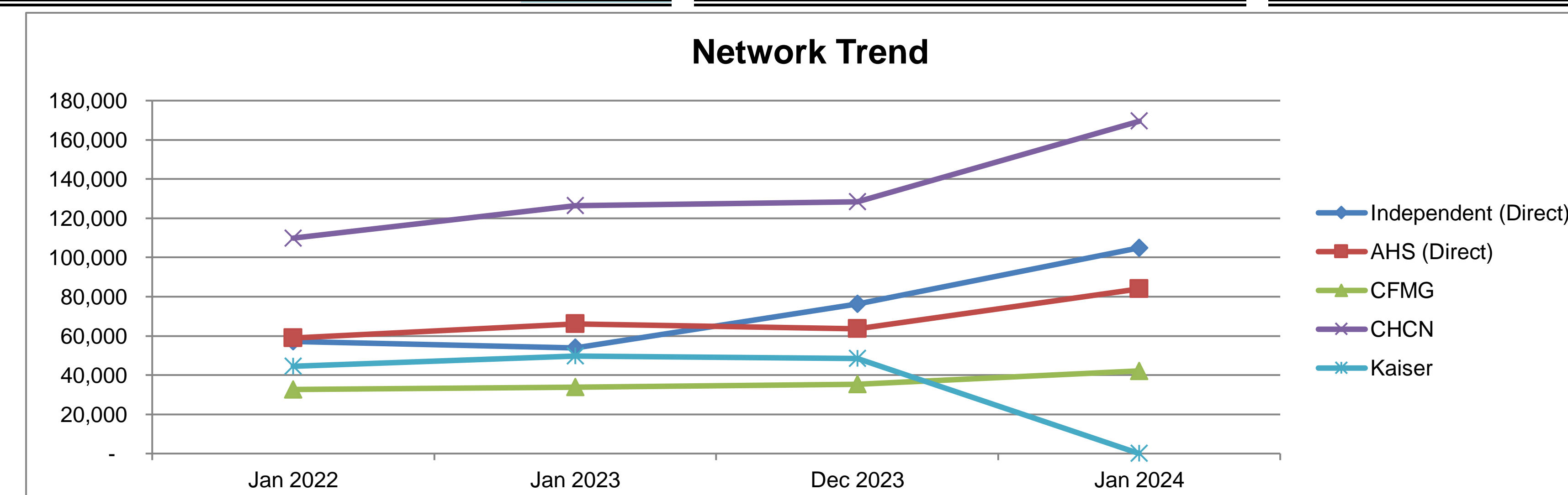
Delegation vs Direct Trend

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



Network Trend

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



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

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

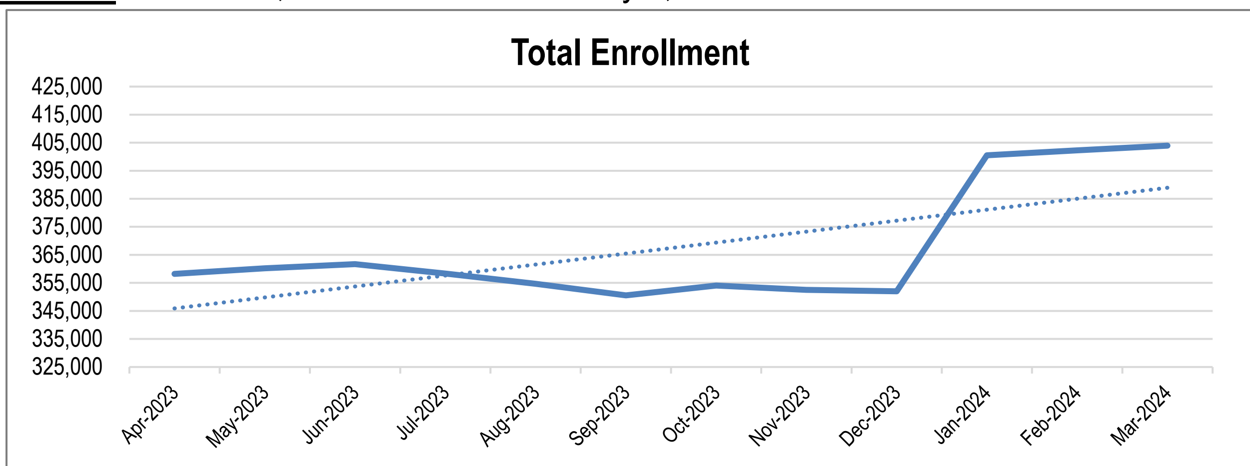
Date: **May 10th, 2024**

Subject: Finance Report – March 2024 Financials

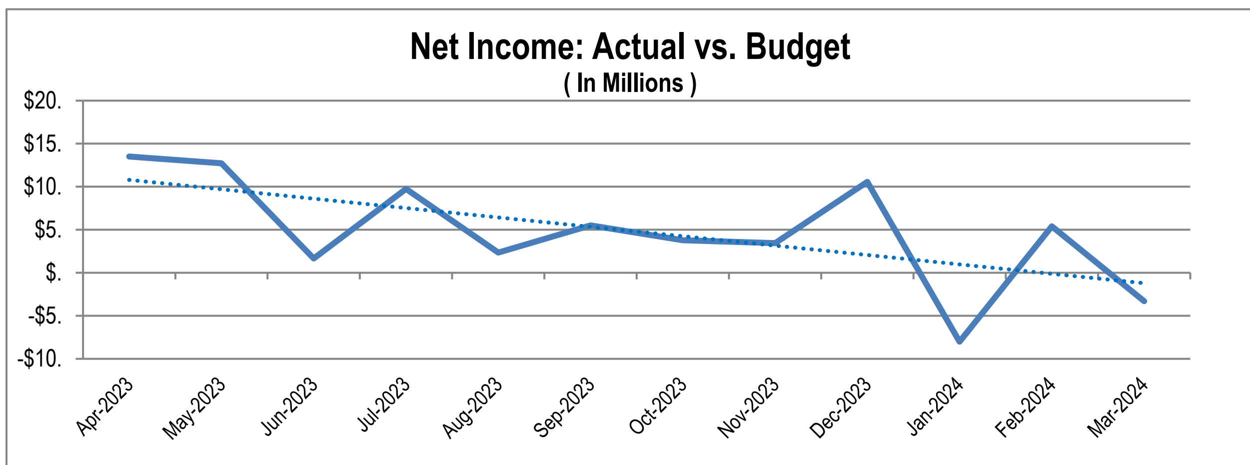
Executive Summary

For the month ended March 31st, 2024, the Alliance continued to experience increases in enrollment, bringing total enrollment to 404K members. A Net Loss of $3.3 million was reported in March. The Plan's Medical Expenses represented 96.2% of revenue. Alliance reserves decreased to 628% of required and remain well above minimum requirements.

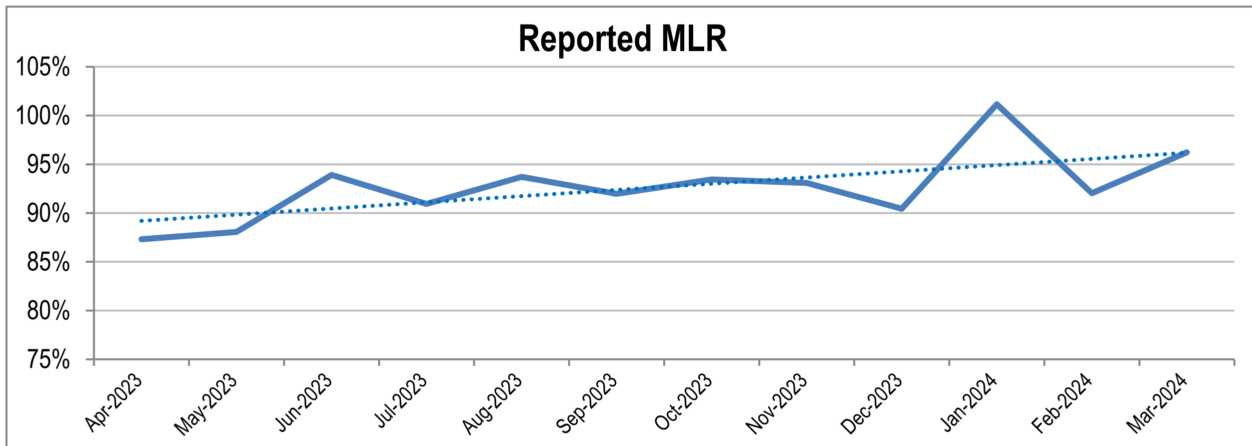
Enrollment – In March, Enrollment increased by 1,682 members.



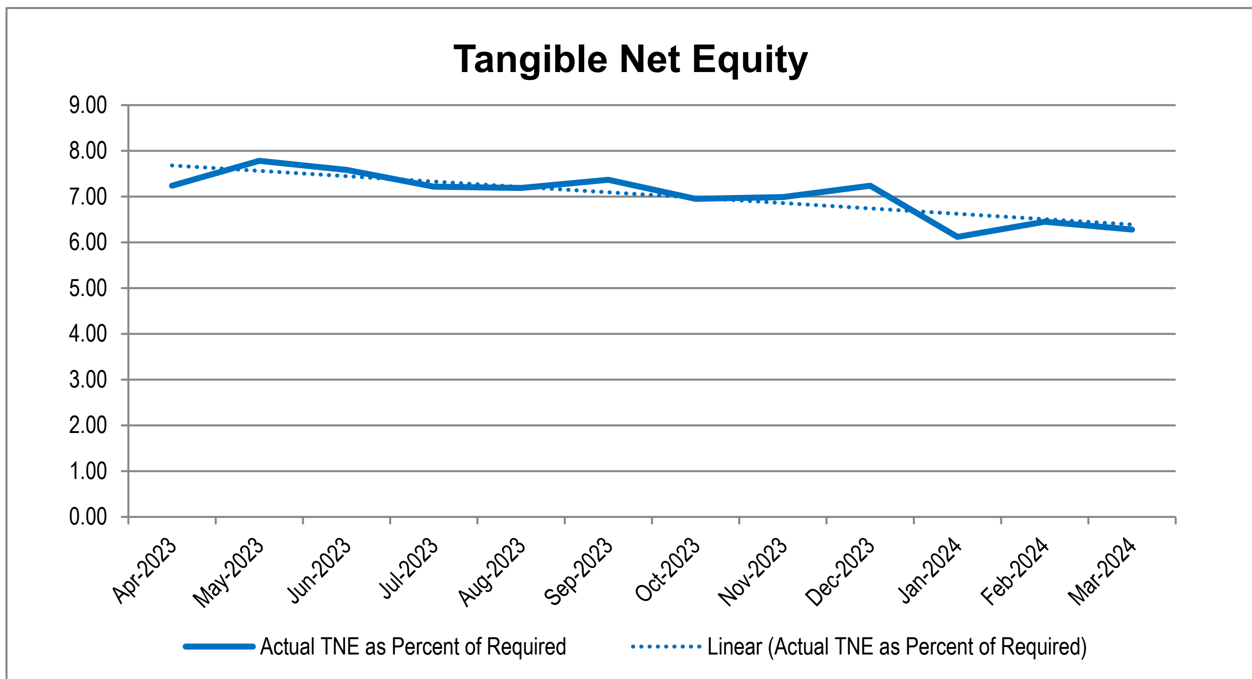
Net Income – For the month ended March 31st, 2024, actual Net Loss was $3.3 million vs. budgeted Net Loss of $2.3 million. Fiscal year-to-date actual Net Income was $29.5 million vs. Budgeted Net Income of $17.7 million. For the month, Premium revenue was 5.8% favorable to Budget.



Medical Loss Ratio (MLR) – The Medical Loss Ratio was 96.2% for the month and 93.9% for the fiscal year-to-date. MLR percentages above 95% may result in net losses for the plan.



Tangible Net Equity (TNE) - The Department of Managed Health Care (DMHC) required $56.3M in reserves, we reported $353.4M. Our overall TNE remains healthy at 628%.



The Alliance continues to benefit from increased non-operating income. For March we reported returns of $2.9M, and year-to-date $23.3M, in the investment portfolio.

Finance

Supporting Documents

To: Alameda Alliance for Health, Board of Governors

From: Gil Riojas, Chief Financial Officer

Date: May 10th, 2024

Subject: Finance Report – March 2024

Executive Summary

- For the month ended March 31st, 2024, the Alliance had enrollment of 403,941 members, a Net Loss of $3.3 million and 628% of required Tangible Net Equity (TNE).

Overall Results: (in Thousands)

	Month	YTD
Revenue	$283,273	$1,598,808
Medical Expense	163,283	1,244,046
Admin. Expense	9,845	69,227
MCO Tax Expense	116,267	278,804
Other Inc. / (Exp.)	2,809	22,724
Net Income	**($3,314)**	**$29,455**

Net Income by Program: (in Thousands)

	Month	YTD
Medi-Cal*	($3,451)	$26,366
Group Care	137	3,089
	($3,314)	**$29,455**

*Includes consulting cost for Medicare implementation.

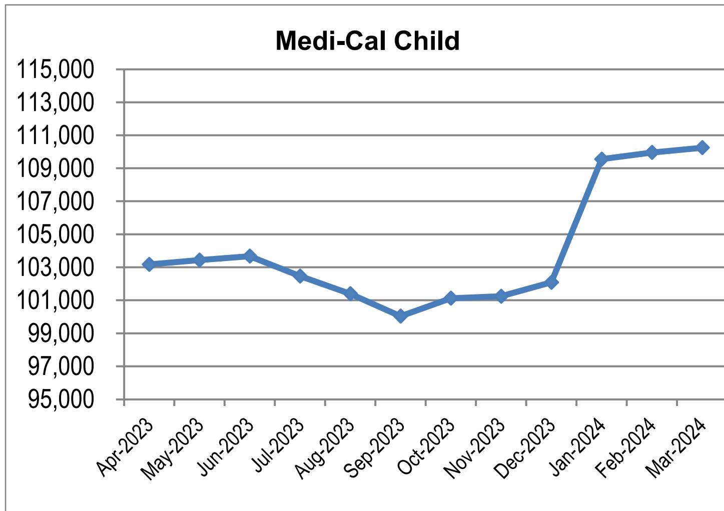
Enrollment

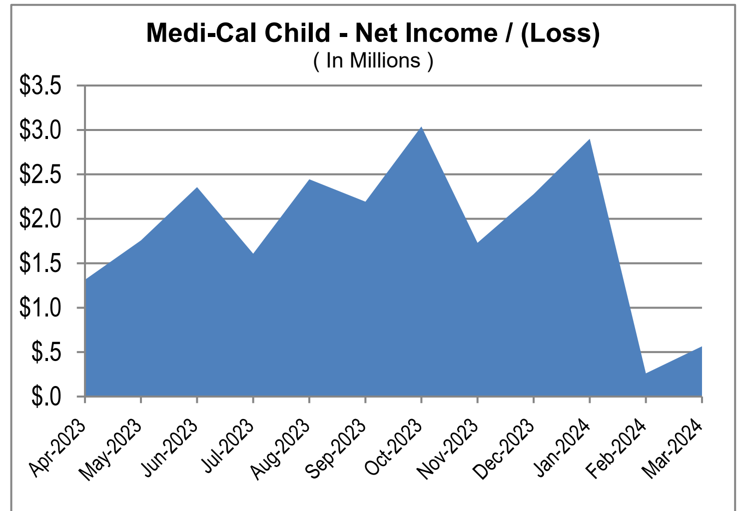
- Total enrollment increased by 1,682 members since February 2024.
- Total enrollment increased by 42,256 members since June 2023.

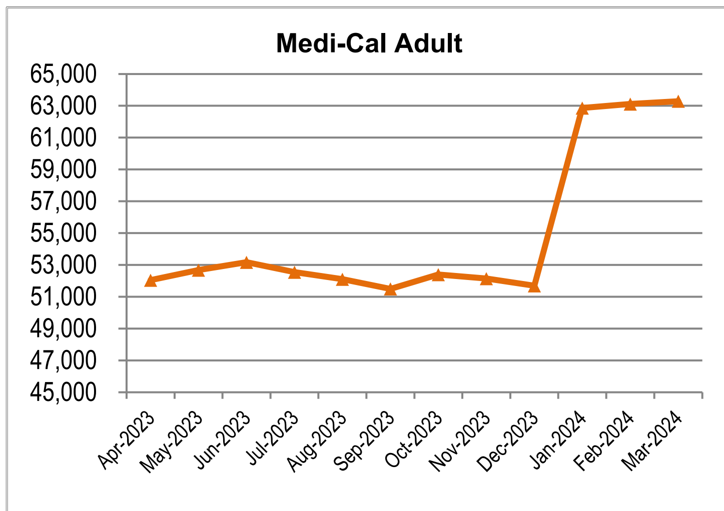
Monthly Membership and YTD Member Months
Actual vs. Budget
For the Month and Fiscal Year-to-Date

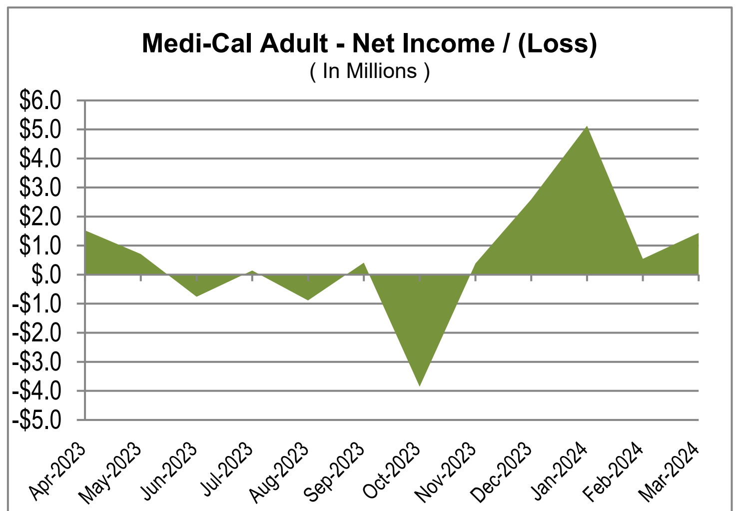
Enrollment					Member Months			
Current Month					Year-to-Date			
Actual	Budget	Variance	Variance %		Actual	Budget	Variance	Variance %
				Medi-Cal:				
63,293	56,107	7,186	12.8%	Adult	501,664	482,093	19,571	4.1%
110,250	99,823	10,427	10.4%	Child	938,101	907,046	31,055	3.4%
34,972	41,796	(6,824)	-16.3%	SPD	289,946	310,999	(21,053)	-6.8%
40,222	45,600	(5,378)	-11.8%	Duals	369,241	386,344	(17,103)	-4.4%
148,061	145,933	2,128	1.5%	ACA OE	1,167,873	1,170,443	(2,570)	-0.2%
216	174	42	24.1%	LTC	1,477	1,345	132	9.8%
1,307	1,159	148	12.8%	LTC Duals	9,926	9,538	388	4.1%
398,321	**390,592**	**7,729**	**2.0%**	**Medi-Cal Total**	**3,278,228**	**3,267,808**	**10,420**	**0.3%**
5,620	5,535	85	1.5%	Group Care	50,588	50,365	223	0.4%
403,941	**396,127**	**7,814**	**2.0%**	**Total**	**3,328,816**	**3,318,173**	**10,643**	**0.3%**

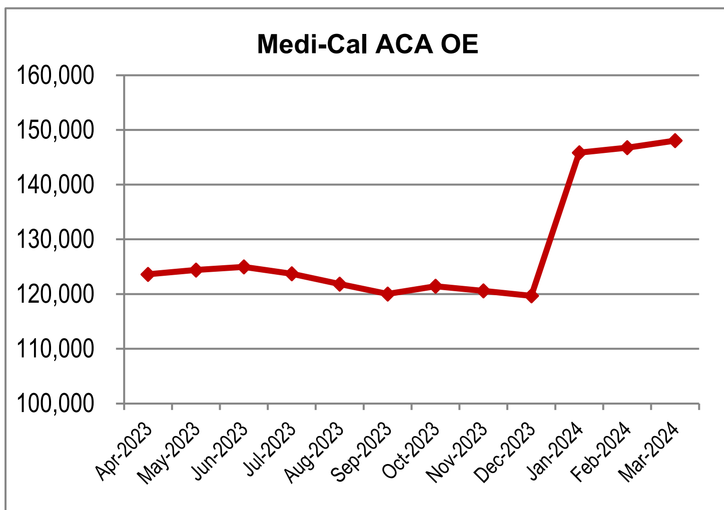
Enrollment and Profitability by Program and Category of Aid

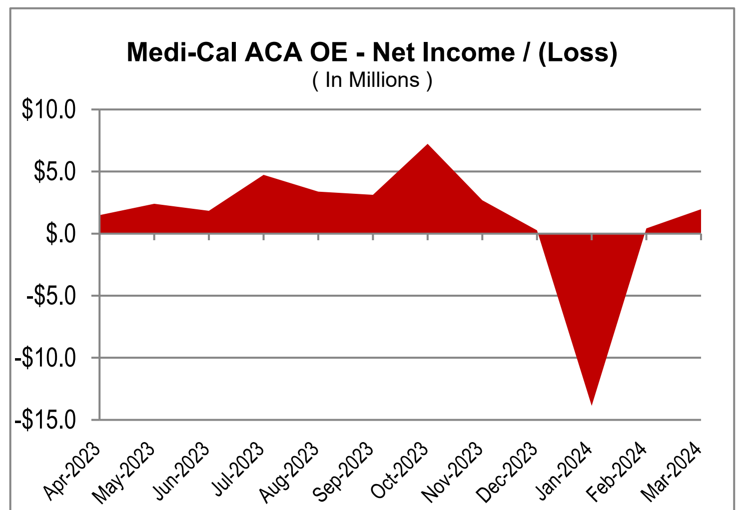




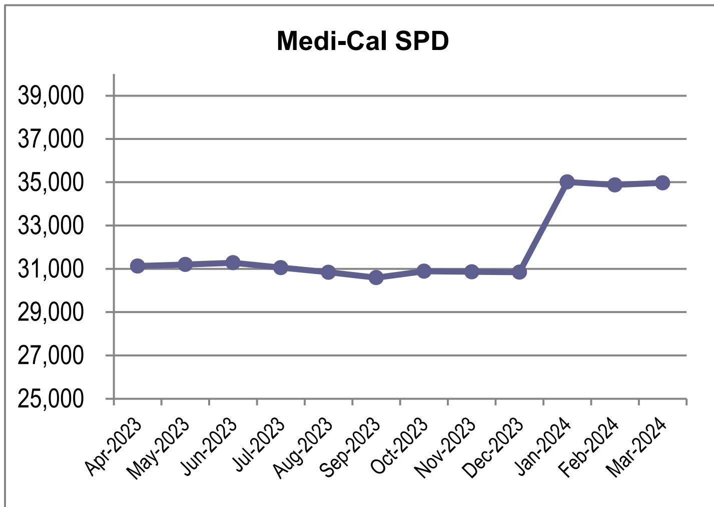


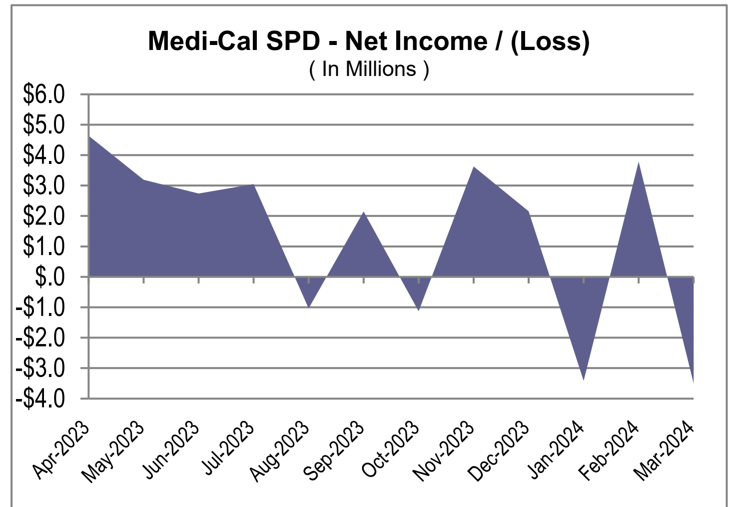


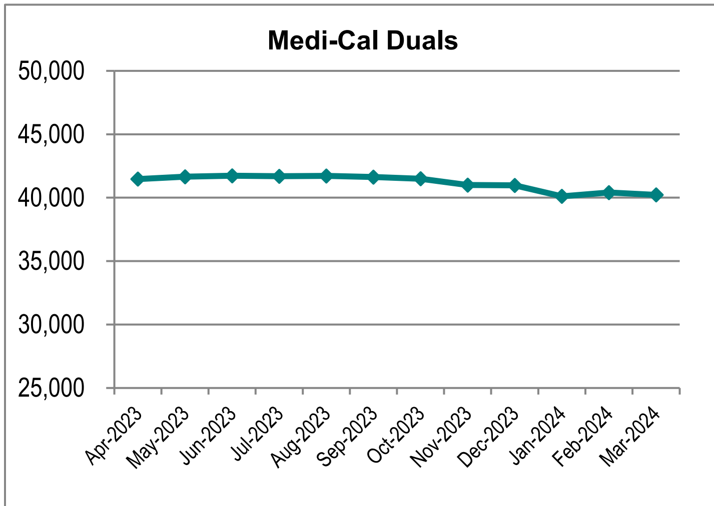


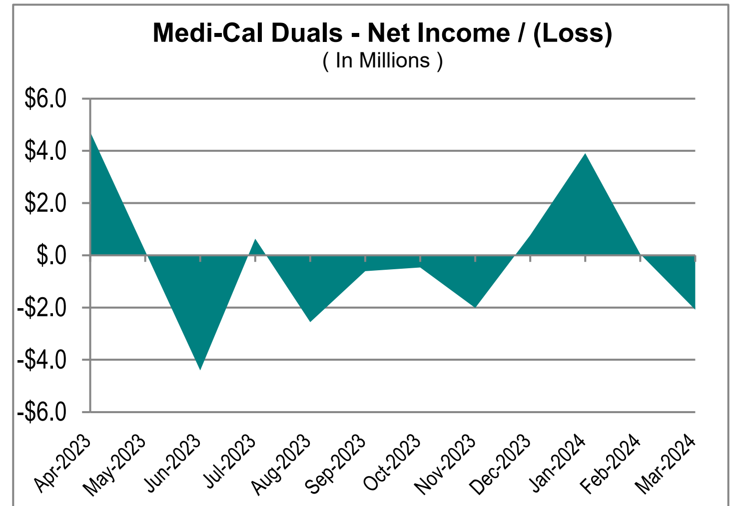


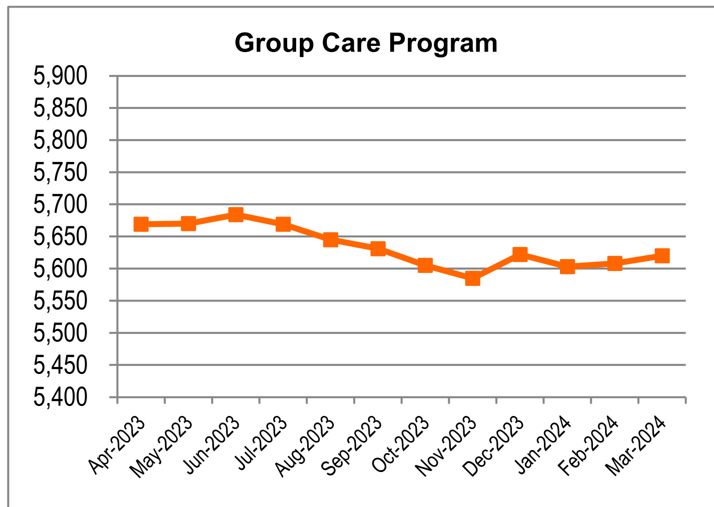
Enrollment and Profitability by Program and Category of Aid

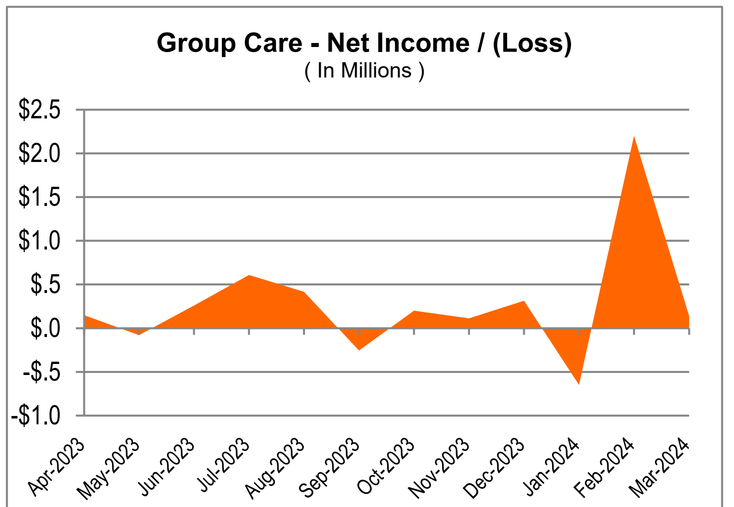




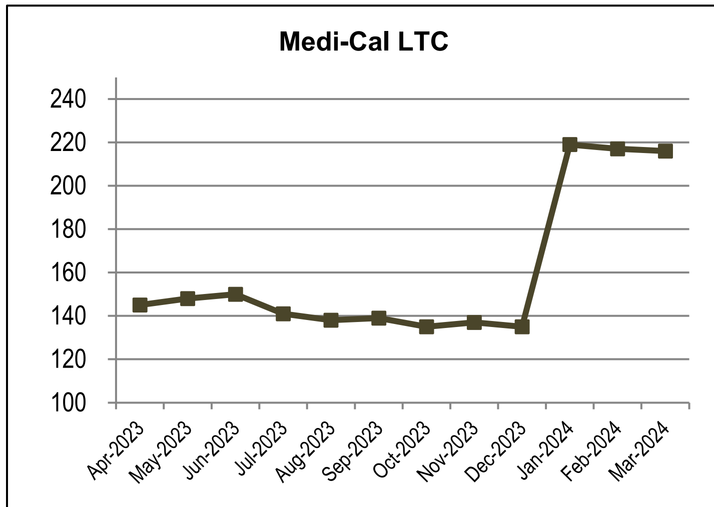


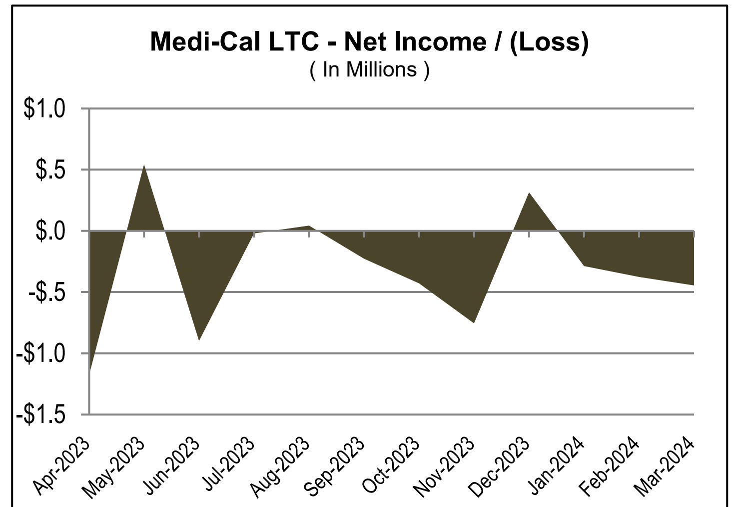


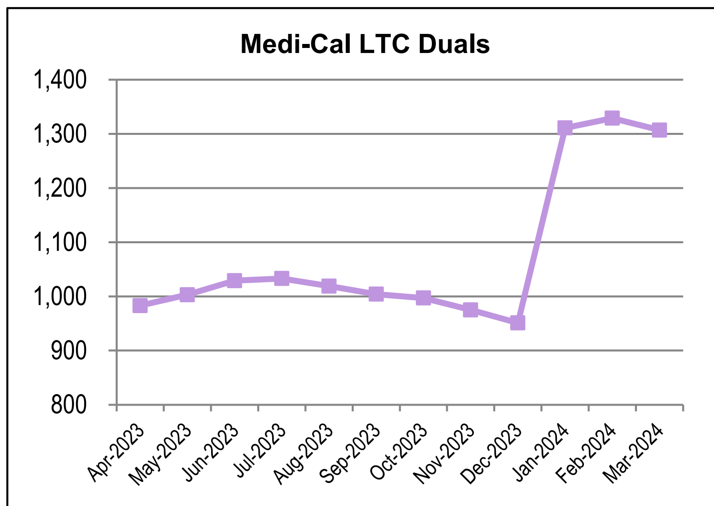


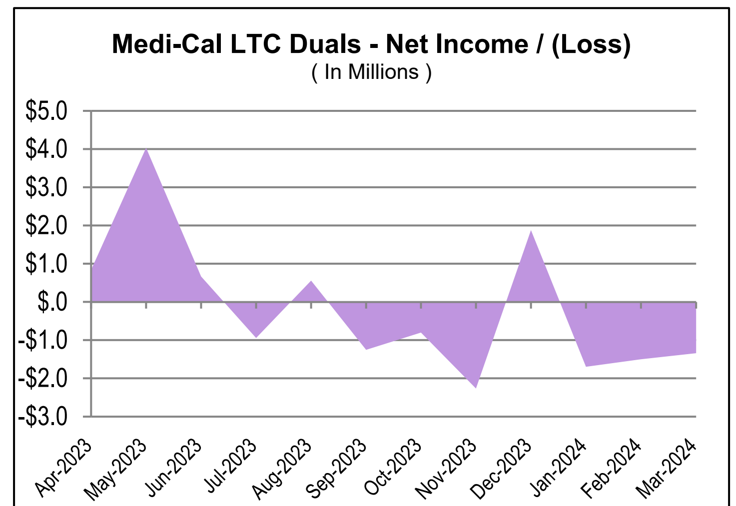


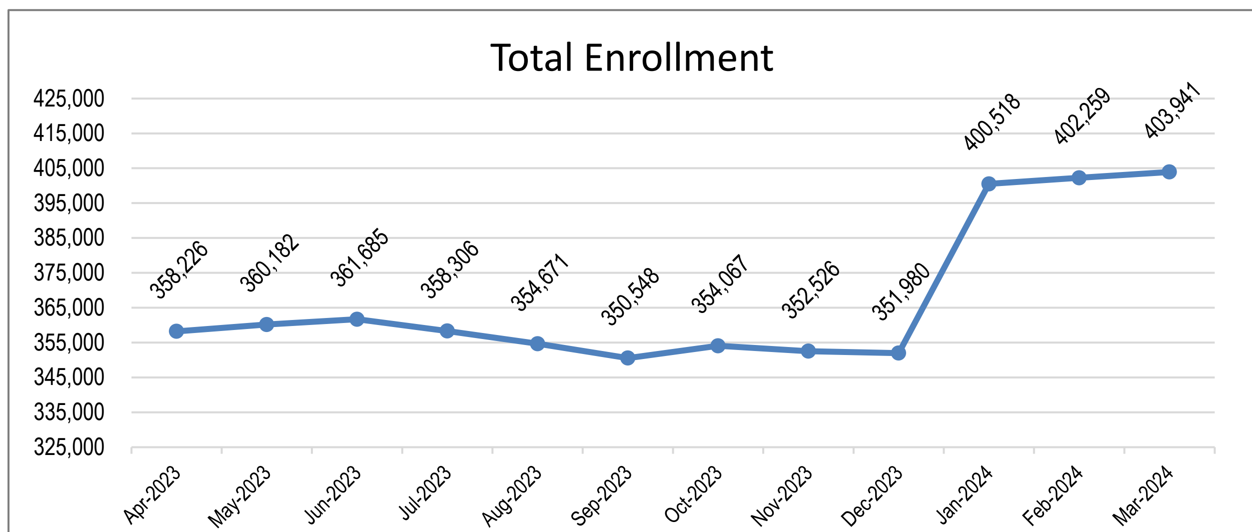
Enrollment and Profitability by Program and Category of Aid

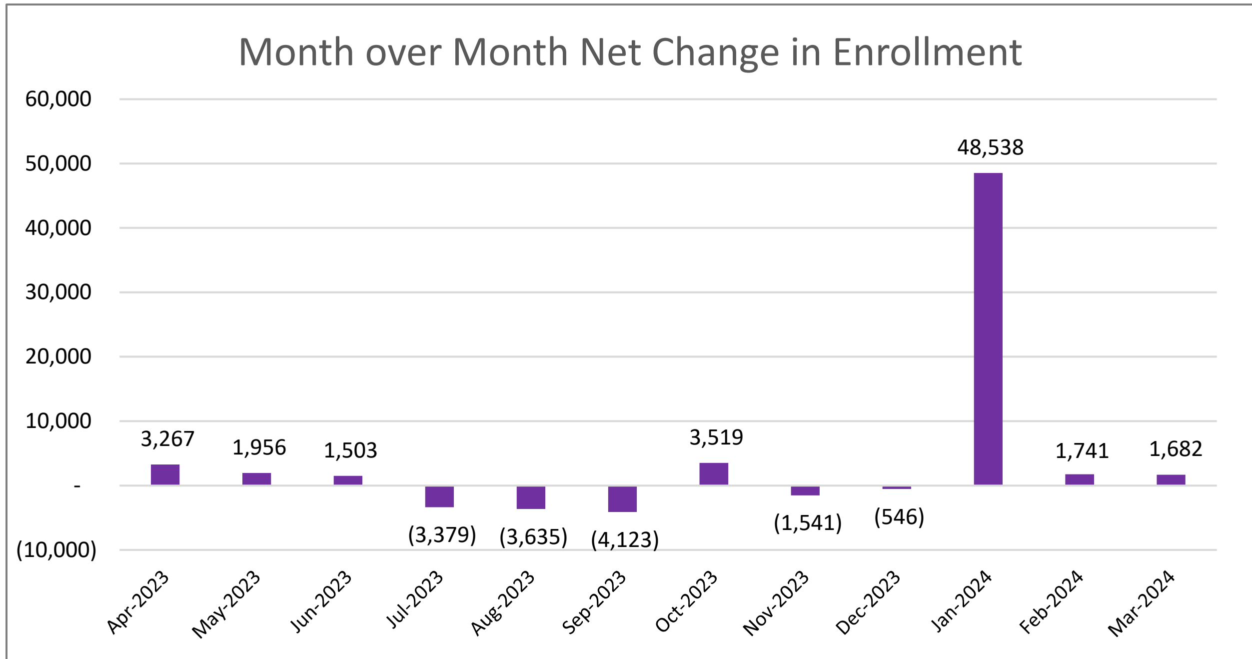










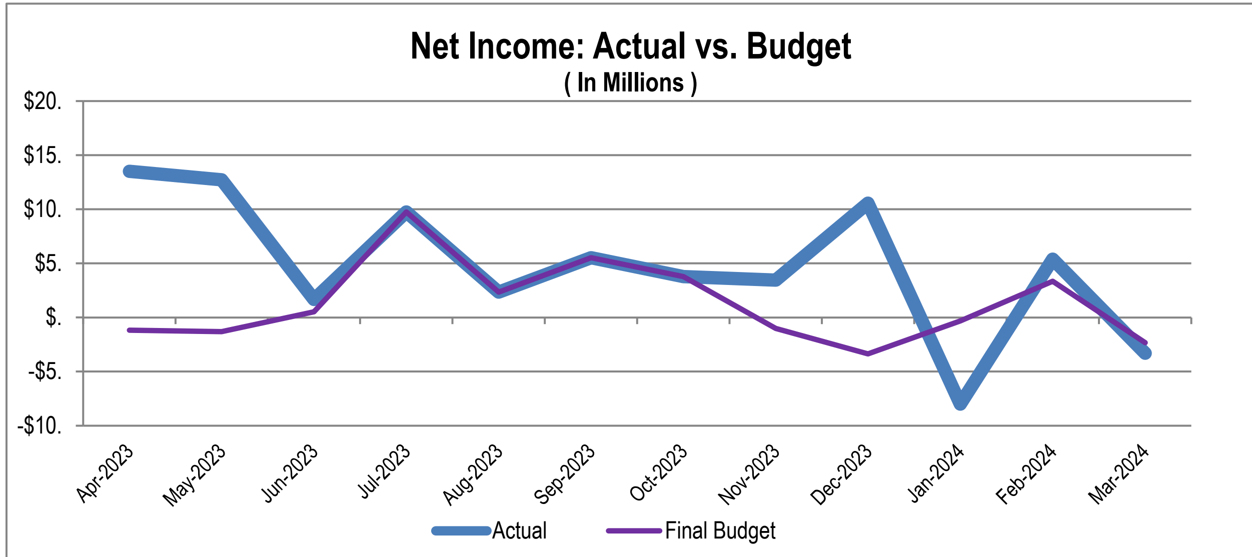


- The Public Health Emergency (PHE) ended May 2023. Disenrollments related to redetermination started July 2023 and will continue through May 2024. In preparation for the Single Plan Model, effective October 2023 DHCS no longer assigned members to Anthem, and instead new members were assigned to the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

Net Income

- For the month ended March 31st, 2024:
    - Actual Net Loss $3.3 million.
    - Budgeted Net Loss $2.3 million.

- For the fiscal YTD ended March 31st, 2024:
    - Actual Net Income $29.5 million.
    - Budgeted Net Income $17.7 million.

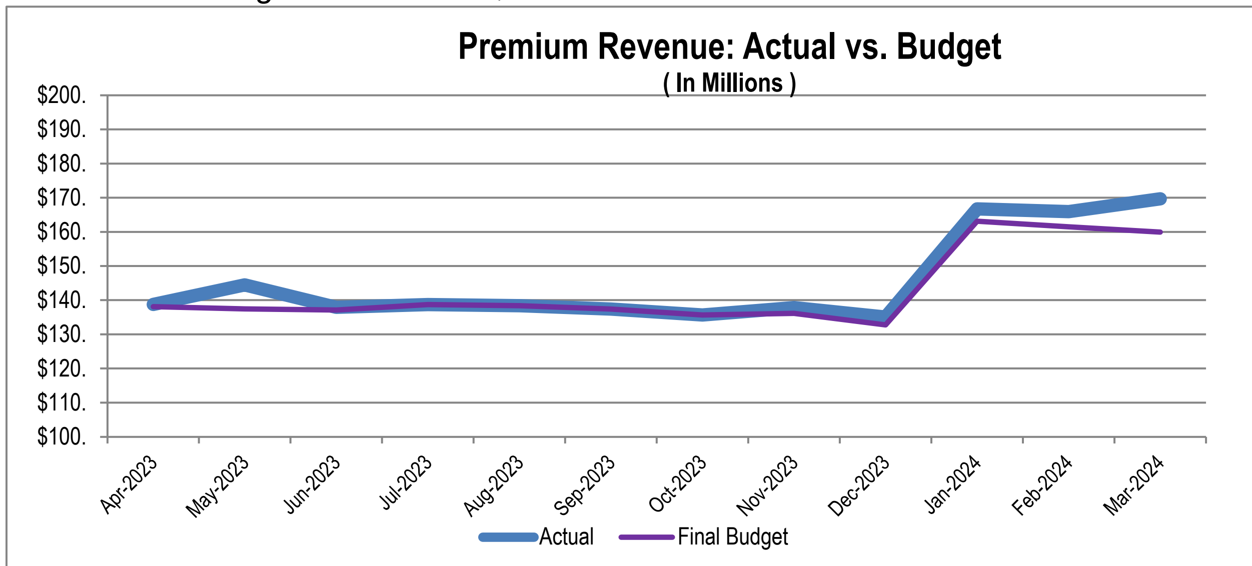


- The unfavorable variance of $979,000 in the current month is primarily due to:
  - Favorable $9.8 million higher than anticipated Premium Revenue.
  - Unfavorable $7.1 million higher than anticipated Medical Expense.
  - Unfavorable $1.3 million higher than anticipated Administrative Expense.
  - Favorable $359,000 higher than anticipated Other Income/Expense.
  - Unfavorable $2.7 million for unbudgeted net MCO Tax.

Premium Revenue

- For the month ended March 31st, 2024:
  - Actual Revenue: $169.7 million.
  - Budgeted Revenue: $159.9 million.

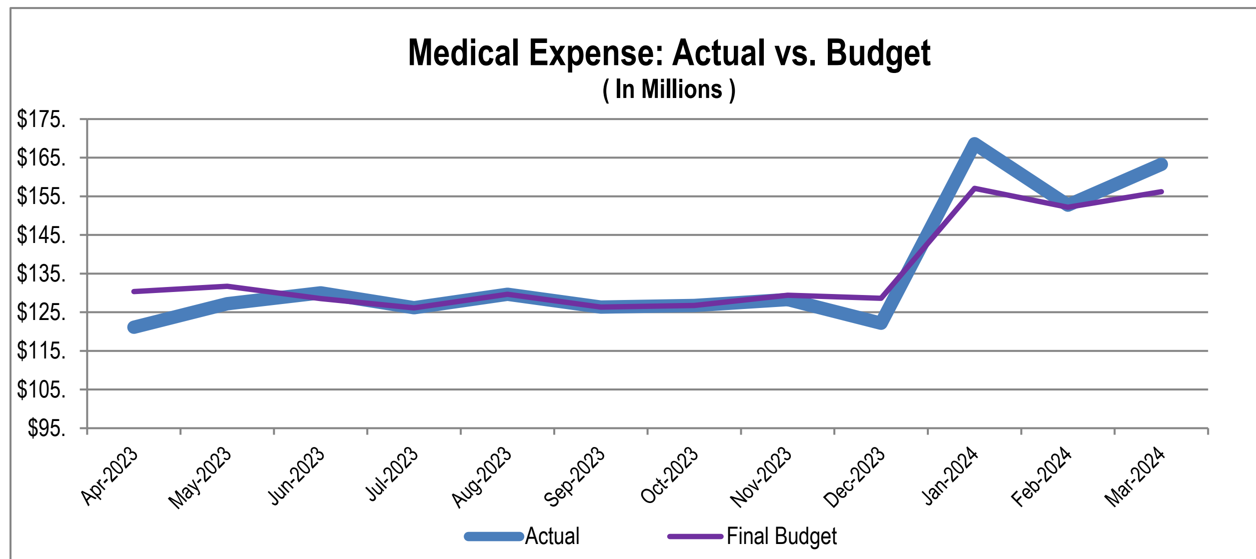
- For the fiscal YTD ended March 31st, 2024:
  - Actual Revenue: $1.3 billion.
  - Budgeted Revenue: $1.3 billion.



- For the month ended March 31st, 2024, the favorable Premium Revenue variance of $9.8 million is primarily due to the following:
  - Favorable Medi-Cal Capitation Rate variance. Rates were not available at time of budget and the magnitude of new Targeted Rate Increase (TRI) revenue and expense was unknown and therefore not budgeted.
  - Favorable CalAIM Incentive revenue primarily due to an additional award for HHIP.
  - Unfavorable enrollment volume variance for February 2024.
  - The 2022 Acuity Adjustment reserve was released, making an unfavorable impact on capitation revenue.

Medical Expense

- For the month ended March 31st, 2024:
  - Actual Medical Expense: $163.3 million.
  - Budgeted Medical Expense: $156.2 million.
- For the fiscal YTD ended March 31st, 2024:
  - Actual Medical Expense: $1.2 billion.
  - Budgeted Medical Expense: $1.2 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 March, updates to Fee-For-Service (FFS) increased the estimate for prior period unpaid Medical Expenses by $1.8 million. Year to date, the estimate for prior years increased by $8.3 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	$211,715,963	$0	$211,715,963	$203,843,575	($7,872,388)	-3.9%
Primary Care FFS	$50,487,831	$12,446	$50,500,276	$53,549,768	$3,061,937	5.7%
Specialty Care FFS	$51,333,721	$57,795	$51,391,516	$54,127,143	$2,793,422	5.2%
Outpatient FFS	$78,032,248	$414,943	$78,447,191	$85,235,879	$7,203,631	8.5%
Ancillary FFS	$106,281,729	$751,606	$107,033,336	$107,795,870	$1,514,141	1.4%
Pharmacy FFS	$81,442,634	$478,192	$81,920,826	$88,785,334	$7,342,700	8.3%
ER Services FFS	$62,709,957	$11,692	$62,721,648	$57,378,375	($5,331,582)	-9.3%
Inpatient Hospital & SNF FFS	$334,989,609	$5,295,391	$340,285,000	$344,730,080	$9,740,470	2.8%
Long Term Care FFS	$211,451,132	$1,304,257	$212,755,389	$186,897,812	($24,553,320)	-13.1%
Other Benefits & Services	$44,637,159	$0	$44,637,159	$45,118,225	$481,066	1.1%
Net Reinsurance	($361,921)	$0	($361,921)	$1,963,631	$2,325,552	118.4%
Provider Incentive	$3,000,000	$0	$3,000,000	$3,000,000	$0	0.0%
	$1,235,720,063	**$8,326,322**	**$1,244,046,385**	**$1,232,425,693**	**($3,294,370)**	**-0.3%**

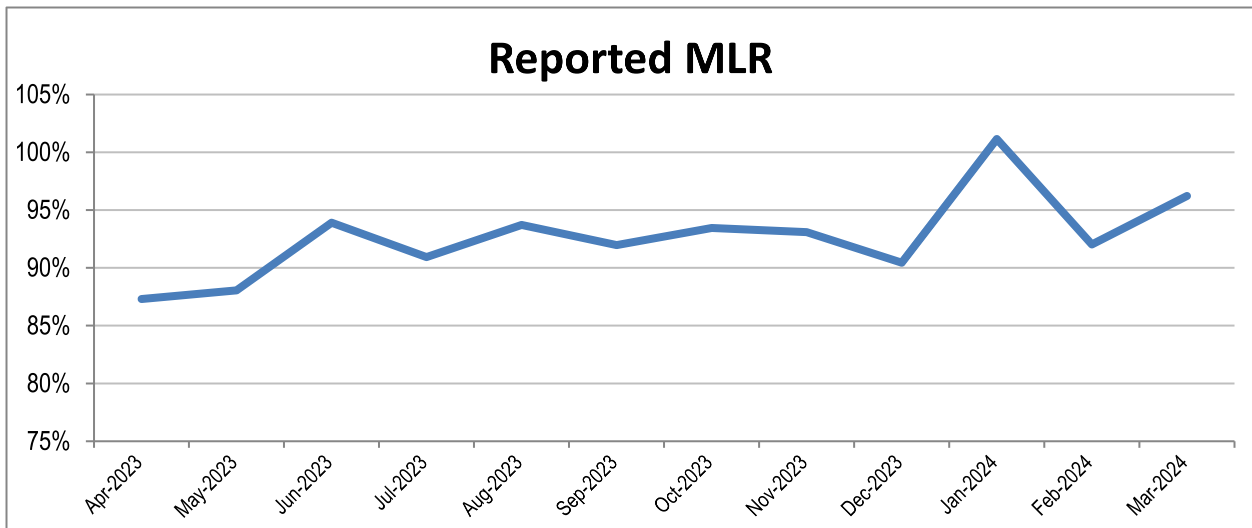
Medical Expense - Actual vs. Budget (Per Member Per Month) Adjusted to Eliminate the Impact of Prior Year IBNP Estimates						
	Actual			Budget	Variance Actual vs. Budget Favorable/(Unfavorable)	
	Adjusted	Change in IBNP	Reported		$	%
Capitated Medical Expense	$63.60	$0.00	$63.60	$61.43	($2.17)	-3.5%
Primary Care FFS	$15.17	$0.00	$15.17	$16.14	$0.97	6.0%
Specialty Care FFS	$15.42	$0.02	$15.44	$16.31	$0.89	5.5%
Outpatient FFS	$23.44	$0.12	$23.57	$25.69	$2.25	8.7%
Ancillary FFS	$31.93	$0.23	$32.15	$32.49	$0.56	1.7%
Pharmacy FFS	$24.47	$0.14	$24.61	$26.76	$2.29	8.6%
ER Services FFS	$18.84	$0.00	$18.84	$17.29	($1.55)	-8.9%
Inpatient Hospital & SNF FFS	$100.63	$1.59	$102.22	$103.89	$3.26	3.1%
Long Term Care FFS	$63.52	$0.39	$63.91	$56.33	($7.20)	-12.8%
Other Benefits & Services	$13.41	$0.00	$13.41	$13.60	$0.19	1.4%
Net Reinsurance	($0.11)	$0.00	($0.11)	$0.59	$0.70	118.4%
Provider Incentive	$0.90	$0.00	$0.90	$0.90	$0.00	0.3%
	$371.22	**$2.50**	**$373.72**	**$371.42**	**$0.20**	**0.1%**

- Excluding the impact of prior year estimates for IBNP, year-to-date medical expense variance is $3.3 million unfavorable to budget. On a PMPM basis, medical expense is 0.1% favorable to budget. For per-member-per-month expense:
    - Capitated Expense is slightly over budget, due to inception of Provider Targeted Rate Increases (TRI), partially offset by favorable FQHC expense.

- Primary Care Expense is slightly under budget driven mostly by the lower ACA OE, SPD and Child utilization.
- Specialty Care Expense is below budget, driven mostly by lower SPD utilization.
- Outpatient Expense is under budget due to lower lab and radiology utilization and facility other unit cost across most populations.
- Ancillary Expense is under budget mostly due to lower utilization in the Child Categories of Aid.
- Pharmacy Expense is under budget mostly due to lower Non-PBM expense driven by lower utilization in the SPD and ACA OE Categories of Aid.
- Emergency Room Expense is over budget driven mostly by higher utilization in the ACA OE, Adult and Child populations.
- Inpatient Expense is under budget mostly driven by lower utilization and unit cost in the SPD and Adult populations.
- Long Term Care Expense is over budget mostly due to higher utilization and unit cost in the SPD, ACA OE and Duals populations.
- Other Benefits & Services is under budget, due to favorable community relations, other purchased, professional and interpreter services offset in Mar-24 by unexpected HHIP and IPP 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 96.2% for the month and 93.9% for the fiscal year-to-date.



Administrative Expense

- For the month ended March 31st, 2024:
    - Actual Administrative Expense: $9.8 million.

- Budgeted Administrative Expense: $8.5 million.

- For the fiscal YTD ended March 31st, 2024:
  - Actual Administrative Expense: $69.2 million.
  - Budgeted Administrative Expense: $75.8 million.

Summary of Administrative Expense (In Dollars) For the Month and Fiscal Year-to-Date Favorable/(Unfavorable)								
Current Month					**Year-to-Date**			
Actual	**Budget**	**Variance $**	**Variance %**		**Actual**	**Budget**	**Variance $**	**Variance %**
$5,375,654	$5,238,791	($136,864)	-2.6%	Employee Expense	$44,748,035	$47,941,203	$3,193,168	6.7%
360,531	73,023	(287,508)	-393.7%	Medical Benefits Admin Expense	1,675,722	1,396,660	(279,062)	-20.0%
2,970,612	864,663	(2,105,949)	-243.6%	Purchased & Professional Services	10,650,413	9,685,867	(964,546)	-10.0%
1,138,226	2,353,681	1,215,454	51.6%	Other Admin Expense	12,152,431	16,774,164	4,621,733	27.6%
$9,845,024	$8,530,158	($1,314,867)	-15.4%	Total Administrative Expense	$69,226,600	$75,797,893	$6,571,293	8.7%

The year-to-date variances include:
- Unfavorable impact of timing of start dates for Consulting for new projects and Computer Support Services.
- Favorable Employee and Temporary Services variances and delayed Training, Travel, Recruitment, and other employee-related expenses.
- Unfavorable Purchased and Professional Services expense realized as result of asset definition change.

The Administrative Loss Ratio (ALR) is 5.8% of net revenue for the month and 5.2% 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 $23.3 million.
- Fiscal year-to-date claims interest expense, due to delayed payment of certain claims, or recalculated interest on previously paid claims is $555,000.

Managed Care Organization (MCO) Provider Tax

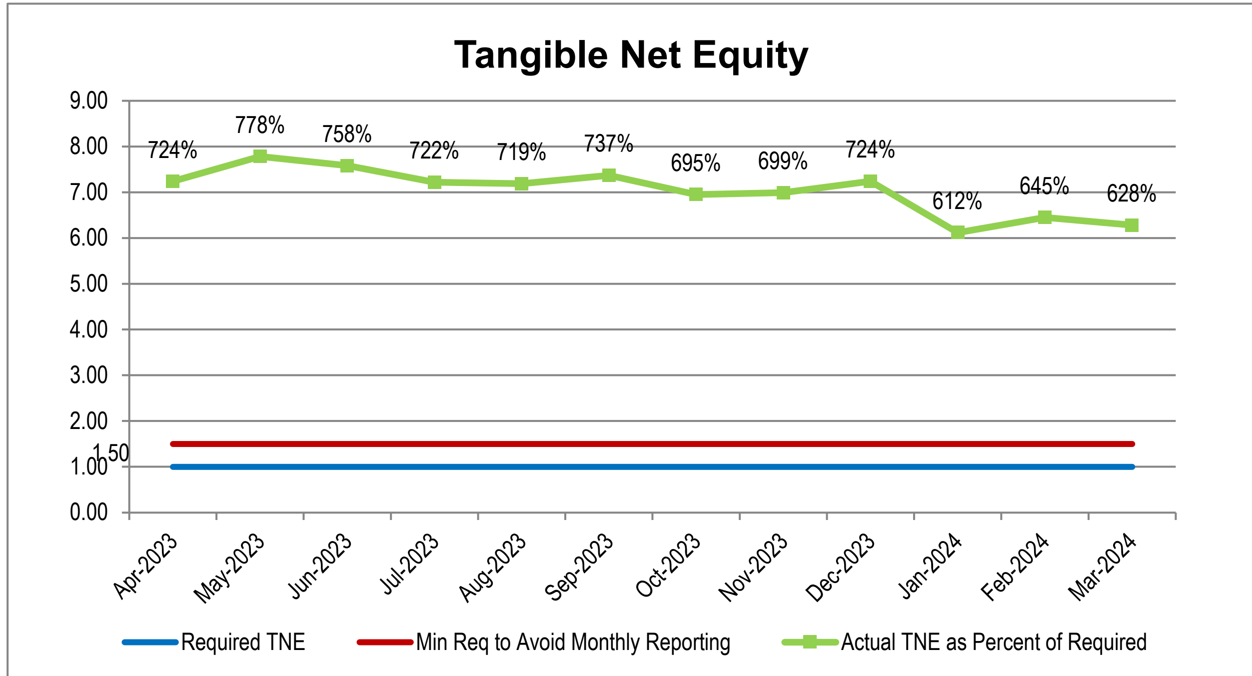
- For the month ended March 31st, 2024:
  - $113.6 million unbudgeted MCO Tax Revenue.
  - $116.3 million unbudgeted MCO Tax Expense.

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

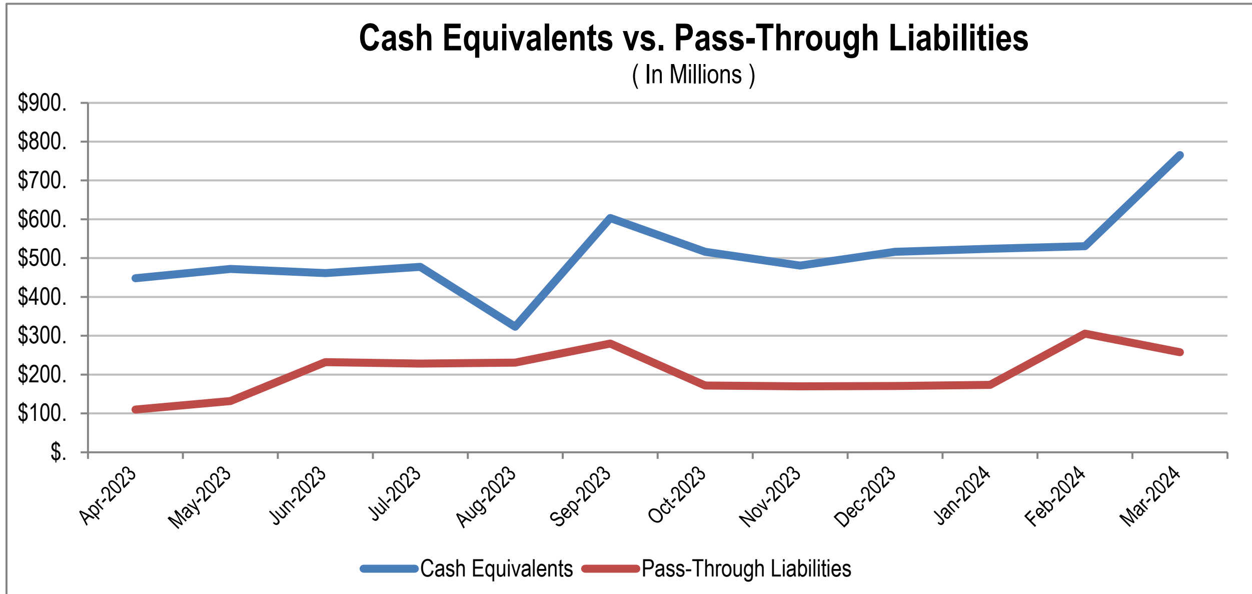
percentage of fee-for-service medical expenses. The Alliance exceeds DMHC's required TNE.

- Required TNE $56.3 million
- Actual TNE $353.4 million
- Excess TNE $297.2 million
- TNE % of Required TNE 628%



- To ensure appropriate liquidity and limit risk, the majority of Alliance financial assets are kept in short-term investments.
- Key Metrics
  - Cash & Cash Equivalents $765.4 million
  - Pass-Through Liabilities $257.2 million
  - Uncommitted Cash $508.2 million
  - Working Capital $338.0 million

- Current Ratio 1.58 (regulatory minimum is 1.00)



Capital Investment

- Fiscal year-to-date capital assets acquired: $1.2 million.
- Annual capital budget: $1.6 million.
- A summary of year-to-date capital asset acquisitions is included in this monthly financial statement package.

Caveats to Financial Statements

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

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

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

ALAMEDA ALLIANCE FOR HEALTH
BALANCE SHEETS
CURRENT MONTH VS. PRIOR MONTH
FOR THE MONTH AND FISCAL YTD ENDED MARCH 31, 2024

	3/31/2024	2/28/2024	Difference	% Difference
CURRENT ASSETS:				
Cash & Equivalents				
Cash	($11,347,297)	$163,524,058	($174,871,355)	-106.94%
Short-Term Investments	776,723,919	366,969,217	409,754,702	111.66%
Interest Receivable	2,503,458	2,571,146	(67,688)	-2.63%
Premium Receivables	140,446,549	403,732,995	(263,286,446)	-65.21%
Reinsurance Receivables	6,927,005	6,023,597	903,408	15.00%
Other Receivables	1,478,194	781,572	696,622	89.13%
Prepaid Expenses	295,422	2,503,896	(2,208,474)	-88.20%
CalPERS Net Pension Assets	(5,286,448)	(5,286,448)	0	0.00%
Deferred Outflow	14,099,056	14,099,056	0	0.00%
TOTAL CURRENT ASSETS	**$925,839,858**	**$954,919,089**	**($29,079,231)**	**-3.05%**
OTHER ASSETS:				
Long-Term Investments	5,191,724	2,327,040	2,864,684	123.10%
Restricted Assets	350,000	350,000	0	0.00%
GASB 87-Lease Assets (Net)	1,004,664	1,070,577	(65,913)	-6.16%
GASB 96-SBITA Assets (Net)	4,250,151	4,623,846	(373,696)	-8.08%
TOTAL OTHER ASSETS	**$10,796,538**	**$8,371,463**	**$2,425,075**	**28.97%**
PROPERTY AND EQUIPMENT:				
Land, Building & Improvements	10,167,264	10,167,264	0	0.00%
Furniture And Equipment	12,960,779	12,962,138	(1,359)	-0.01%
Leasehold Improvement	902,447	902,447	0	0.00%
Internally Developed Software	14,824,002	14,824,002	0	0.00%
Fixed Assets at Cost	$38,854,491	$38,855,851	($1,359)	0.00%
Less: Accumulated Depreciation	($33,028,320)	($32,964,648)	($63,672)	0.19%
NET PROPERTY AND EQUIPMENT	**$5,826,171**	**$5,891,203**	**($65,031)**	**-1.10%**
TOTAL ASSETS	**$942,462,567**	**$969,181,755**	**($26,719,188)**	**-2.76%**
CURRENT LIABILITIES:				
Accounts Payable	3,886,653	3,796,710	89,943	2.37%
Other Accrued Liabilities	31,874,325	29,660,135	2,214,190	7.47%
GASB 87 ST Lease Liabilities	918,888	913,444	5,444	0.60%
GASB 96 ST SBITA Liabilities	2,232,804	2,445,307	(212,503)	-8.69%
Claims Payable	34,420,590	34,919,508	(498,918)	-1.43%
IBNP Reserves	237,048,314	214,216,150	22,832,164	10.66%
Pass-Through Liabilities	257,208,099	305,400,471	(48,192,372)	-15.78%
Risk Sharing - Providers	6,629,337	6,629,337	0	0.00%
Payroll Liabilities	8,602,659	8,167,535	435,124	5.33%
Deferred Inflow	5,004,985	5,004,985	0	0.00%
TOTAL CURRENT LIABILITIES	**$587,826,655**	**$611,153,582**	**($23,326,927)**	**-3.82%**
LONG TERM LIABILITIES:				
GASB 87 LT Lease Liabilities	240,057	318,596	(78,540)	-24.65%
GASB 96 LT SBITA Liabilities	983,568	983,568	0	0.00%
TOTAL LONG TERM LIABILITIES	**$1,223,625**	**$1,302,165**	**($78,540)**	**-6.03%**
TOTAL LIABILITIES	**$589,050,280**	**$612,455,747**	**($23,405,467)**	**-3.82%**
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)	29,455,246	32,768,967	(3,313,721)	-10.11%
TOTAL NET WORTH	**$353,412,287**	**$356,726,008**	**($3,313,721)**	**-0.93%**
TOTAL LIABILITIES AND NET WORTH	**$942,462,567**	**$969,181,755**	**($26,719,188)**	**-2.76%**
Cash Equivalents	$765,376,622	$530,493,275	$234,883,347	44.28%
Pass-Through	$257,208,099	$305,400,471	($48,192,372)	-15.78%
Uncommitted Cash	$508,168,523	$225,092,804	$283,075,719	125.76%
Working Capital	$338,013,203	$343,765,507	($5,752,304)	-1.67%
Current Ratio	157.5%	156.2%	1.3%	0.8%

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED March 31, 2024

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM OPERATING ACTIVITIES				
Commercial Premium Cash Flows				
Commercial Premium Revenue	$2,572,833	$7,698,382	$15,386,704	$23,133,094
GroupCare Receivable	(7,316)	(2,743)	2,598,435	(2,548,146)
Total	2,565,517	7,695,639	17,985,139	20,584,948
Medi-Cal Premium Cash Flows				
Medi-Cal Revenue	280,699,927	768,063,292	1,168,933,565	1,575,675,291
Premium Receivable	263,293,761	86,616,352	68,125,802	158,464,018
Total	543,993,688	854,679,644	1,237,059,367	1,734,139,309
Investment & Other Income Cash Flows				
Other Revenues	622,330	311,655	1,733,271	2,601,099
Interest Income	2,263,731	6,260,976	15,017,310	20,846,592
Interest Receivable	67,688	1,483,298	(2,053,320)	(1,788,882)
Total	2,953,749	8,055,929	14,697,261	21,658,809
Medical & Hospital Cash Flows				
Total Medical Expenses	(163,283,393)	(484,634,350)	(861,878,434)	(1,244,046,386)
Other Health Care Receivables	(1,599,421)	(3,457,510)	(5,745,719)	(4,566,475)
Capitation Payable	-	-	-	(7,387,555)
IBNP Payable	22,832,164	68,905,818	80,153,089	72,543,912
Other Medical Payable	(51,170,682)	56,699,921	(44,066,297)	3,765,878
Risk Share Payable	-	-	2,000,000	1,022,154
New Health Program Payable	-	-	11,640	-
Total	(193,221,332)	(362,486,121)	(829,525,721)	(1,178,668,472)
Administrative Cash Flows				
Total Administrative Expenses	(9,921,701)	(24,826,508)	(48,537,794)	(69,950,343)
Prepaid Expenses	2,195,648	3,427,591	5,206,590	4,568,420
Other Receivables	12,216	12,601	73,562	57,216
CalPERS Pension	-	-	-	-
Trade Accounts Payable	(111,429)	(3,120,957)	(1,680,510)	(905,924)
Payroll Liabilities	435,124	1,891,205	1,521,870	2,672,772
GASB Assets and Liabilities	154,010	255,984	(640,484)	(374,561)
Depreciation Expense	63,672	191,967	382,898	551,195
Total	(7,172,460)	(22,168,117)	(43,673,868)	(63,381,225)
MCO Tax AB119 Cash Flows				
MCO Tax Expense AB119	(116,267,449)	(278,804,104)	(278,804,104)	(278,804,104)
MCO Tax Liabilities	4,894,953	42,847,894	43,252,522	43,252,522
Total	(111,372,496)	(235,956,210)	(235,551,582)	(235,551,582)
Net Cash Flows from Operating Activities	**237,746,666**	**249,820,764**	**160,990,596**	**298,781,787**

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED March 31, 2024

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOWS FROM INVESTING ACTIVITIES				
Investment Cash Flows				
Long Term Investments	(2,864,684)	(453,497)	1,835,840	6,368,813
Total	(2,864,684)	(453,497)	1,835,840	6,368,813
Restricted Cash & Other Asset Cash Flows				
Restricted Assets-Treasury Account	-	-	-	-
Total	-	-	-	-
Fixed Asset Cash Flows				
Fixed Asset Acquisitions	1,365	(20,408)	(600,448)	(1,159,393)
Purchases of Property and Equipment	1,365	(20,408)	(600,448)	(1,159,393)
Net Cash Flows from Investing Activities	**(2,863,319)**	**(473,905)**	**1,235,392**	**5,209,420**
Net Change in Cash	**234,883,347**	**249,346,859**	**162,225,988**	**303,991,207**
Rounding	0	0	-	0
Cash @ Beginning of Period	530,493,275	516,029,763	603,150,634	461,385,415
Cash @ End of Period	**$765,376,622**	**$765,376,622**	**$765,376,622**	**$765,376,622**
Variance	-	-	-	-

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED March 31, 2024

	MONTH	3 MONTHS	6 MONTHS	YTD
NET INCOME RECONCILIATION				
Net Income / (Loss)	($3,313,722)	($5,930,658)	$11,850,517	$29,455,243
Add back: Depreciation & Amortization	63,672	191,967	382,898	551,195
Receivables				
Premiums Receivable	263,293,761	86,616,352	68,125,802	158,464,018
Interest Receivable	67,688	1,483,298	(2,053,320)	(1,788,882)
Other Health Care Receivables	(1,599,421)	(3,457,510)	(5,745,719)	(4,566,475)
Other Receivables	12,216	12,601	73,562	57,216
GroupCare Receivable	(7,316)	(2,743)	2,598,435	(2,548,146)
Total	261,766,928	84,651,998	62,998,760	149,617,731
Prepaid Expenses	2,195,648	3,427,591	5,206,590	4,568,420
Trade Payables	(111,429)	(3,120,957)	(1,680,510)	(905,924)
Claims Payable and Shared Risk Pool				
IBNP Payable	22,832,164	68,905,818	80,153,089	72,543,912
Capitation Payable & Other Medical Payable	(51,170,682)	56,699,921	(44,066,297)	(3,621,677)
Risk Share Payable	-	-	2,000,000	1,022,154
Claims Payable				
Total	(28,338,518)	125,605,739	38,086,792	69,944,389
Other Liabilities				
CalPERS Pension	-	-	-	-
Payroll Liabilities	435,124	1,891,205	1,521,870	2,672,772
GASB Assets and Liabilities	154,010	255,984	(640,484)	(374,561)
New Health Program	-	-	11,640	-
MCO Tax Liabilities	4,894,953	42,847,894	43,252,522	43,252,522
Total	5,484,087	44,995,083	44,145,548	45,550,733
Rounding	-	1.00	1.00	-
Cash Flows from Operating Activities	**237,746,666**	**249,820,764**	**160,990,596**	**298,781,787**
Variance	-	-	-	-

ALAMEDA ALLIANCE FOR HEALTH
CASH FLOW STATEMENT
FOR THE MONTH AND FISCAL YTD ENDED March 31, 2024

	MONTH	3 MONTHS	6 MONTHS	YTD
CASH FLOW STATEMENT:				
Cash Flows from Operating Activities:				
Cash Received				
Capitation Received from State of CA	$543,993,688	$854,679,644	$1,237,059,367	$1,734,139,309
Medicare Revenue	$0	$0	$0	$0
GroupCare Premium Revenue	2,565,517	7,695,639	17,985,139	20,584,948
Other Income	622,330	311,655	1,733,271	2,601,099
Interest Income	2,331,419	7,744,274	12,963,990	19,057,710
Less Cash Paid				
Medical Expenses	(193,221,332)	(362,486,121)	(829,525,721)	(1,178,668,472)
Vendor & Employee Expenses	(7,172,460)	(22,168,117)	(43,673,868)	(63,381,225)
MCO Tax Expense AB119	(111,372,496)	(235,956,210)	(235,551,582)	(235,551,582)
Net Cash Flows from Operating Activities	**237,746,666**	**249,820,764**	**160,990,596**	**298,781,787**
Cash Flows from Investing Activities:				
Long Term Investments	(2,864,684)	(453,497)	1,835,840	6,368,813
Restricted Assets-Treasury Account	0	0	0	0
Purchases of Property and Equipment	1,365	(20,408)	(600,448)	(1,159,393)
Net Cash Flows from Investing Activities	**(2,863,319)**	**(473,905)**	**1,235,392**	**5,209,420**
Net Change in Cash	**234,883,347**	**249,346,859**	**162,225,988**	**303,991,207**
Rounding	0	0	-	0
Cash @ Beginning of Period	530,493,275	516,029,763	603,150,634	461,385,415
Cash @ End of Period	**$765,376,622**	**$765,376,622**	**$765,376,622**	**$765,376,622**
Variance	$0	-	-	-
RECONCILIATION OF NET INCOME TO NET CASH FLOW FROM OPERATING ACTIVITIES:				
Net Income / (Loss)	($3,313,722)	($5,930,658)	$11,850,517	$29,455,243
Add Back: Depreciation	63,672	191,967	382,898	551,195
Net Change in Operating Assets & Liabilities				
Premium & Other Receivables	261,766,928	84,651,998	62,998,760	149,617,731
Prepaid Expenses	2,195,648	3,427,591	5,206,590	4,568,420
Trade Payables	(111,429)	(3,120,957)	(1,680,510)	(905,924)
Claims Payable, IBNP and Risk Sharing	(28,338,518)	125,605,739	38,086,792	69,944,389
Deferred Revenue	0	0	0	0
Other Liabilities	5,484,087	44,995,083	44,145,548	45,550,733
Total	237,746,666	249,820,763	160,990,595	298,781,787
Rounding	-	1	1	-
Cash Flows from Operating Activities	**$237,746,666**	**$249,820,764**	**$160,990,596**	**$298,781,787**
Variance	$0	-	-	-

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE MONTH OF MARCH 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	110,250	63,293	34,972	148,061	40,222	216	1,307	398,321	5,620	-	403,941
Revenue	$47,385,539	$41,231,172	$53,345,698	$97,788,979	$26,372,852	$2,407,424	$12,168,262	$280,699,925	$2,572,833	$0	$283,272,758
Medical Expense	13,199,889	21,183,208	44,427,908	51,876,400	14,897,254	2,699,742	12,683,832	160,968,233	2,310,159	5,000	$163,283,392
Gross Margin	$34,185,650	$20,047,964	$8,917,790	$45,912,579	$11,475,598	($292,319)	($515,571)	$119,731,692	$262,674	($5,000)	$119,989,366
Administrative Expense	$557,409	$1,129,433	$3,065,644	$3,216,862	$836,365	$143,049	$682,041	$9,630,803	$167,285	$46,936	$9,845,024
MCO Tax Expense	$33,202,013	$17,804,053	$10,251,807	$41,649,856	$12,954,522	$53,417	$351,782	$116,267,449	$0	$0	$116,267,449
Operating Income / (Expense)	$426,229	$1,114,478	($4,399,661)	$1,045,861	($2,315,288)	($488,785)	($1,549,394)	($6,166,560)	$95,389	($51,936)	($6,123,107)
Other Income / (Expense)	$138,929	$322,308	$900,662	$919,699	$236,290	$43,287	$206,165	$2,767,340	$42,046	$0	$2,809,386
Net Income / (Loss)	$565,158	$1,436,786	($3,498,999)	$1,965,560	($2,078,998)	($445,498)	($1,343,229)	($3,399,219)	$137,434	($51,936)	($3,313,721)
PMPM Metrics:											
Revenue PMPM	$429.80	$651.43	$1,525.38	$660.46	$655.68	$11,145.48	$9,310.07	$704.71	$457.80	$0.00	$701.27
Medical Expense PMPM	$119.73	$334.68	$1,270.39	$350.37	$370.38	$12,498.81	$9,704.54	$404.12	$411.06	$0.00	$404.23
Gross Margin PMPM	$310.07	$316.75	$255.00	$310.09	$285.31	($1,353.33)	($394.47)	$300.59	$46.74	$0.00	$297.05
Administrative Expense PMPM	$5.06	$17.84	$87.66	$21.73	$20.79	$662.27	$521.84	$24.18	$29.77	$0.00	$24.37
MCO Tax Expense PMPM	$301.15	$281.30	$293.14	$281.30	$322.08	$247.30	$269.15	$291.89	$0.00	$0.00	$287.83
Operating Income / (Expense) PMPM	$3.87	$17.61	($125.81)	$7.06	($57.56)	($2,262.89)	($1,185.46)	($15.48)	$16.97	$0.00	($15.16)
Other Income / (Expense) PMPM	$1.26	$5.09	$25.75	$6.21	$5.87	$200.40	$157.74	$6.95	$7.48	$0.00	$6.95
Net Income / (Loss) PMPM	$5.13	$22.70	($100.05)	$13.28	($51.69)	($2,062.49)	($1,027.72)	($8.53)	$24.45	$0.00	($8.20)
Ratio:											
Medical Loss Ratio	88.2%	88.9%	102.5%	90.9%	108.4%	114.6%	107.3%	96.3%	89.8%	0.0%	96.2%
Administrative Expense Ratio	3.7%	4.7%	7.1%	5.6%	6.1%	6.1%	5.8%	5.8%	6.5%	0.0%	5.8%
Net Income Ratio	1.2%	3.5%	-6.6%	2.0%	-7.9%	-18.5%	-11.0%	-1.2%	5.3%	0.0%	-1.2%

ALAMEDA ALLIANCE FOR HEALTH
OPERATING STATEMENT BY CATEGORY OF AID

GAAP BASIS
FOR THE FISCAL YEAR TO DATE MARCH 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	938,101	501,664	289,946	1,167,873	369,241	1,477	9,926	3,278,228	50,588	-	3,328,816
Revenue	$203,193,604	$214,650,172	$362,962,702	$544,246,672	$149,622,209	$15,759,913	$85,240,018	$1,575,675,289	$23,133,095	$0	$1,598,808,383
Medical Expense	103,967,486	160,704,256	318,176,001	419,188,094	117,055,022	17,177,489	88,711,654	1,224,980,002	19,061,383	5,000	$1,244,046,385
Gross Margin	$99,226,118	$53,945,916	$44,786,701	$125,058,578	$32,567,186	($1,417,576)	($3,471,636)	$350,695,287	$4,071,712	($5,000)	$354,761,999
Administrative Expense	$4,219,962	$7,482,267	$21,874,900	$22,013,089	$6,407,042	$971,173	$4,624,139	$67,592,571	$1,365,043	$268,986	$69,226,600
MCO Tax Expense	$79,259,087	$42,983,506	$24,611,830	$100,306,054	$30,650,506	$132,718	$860,404	$278,804,104	$0	$0	$278,804,104
Operating Income / (Expense)	$15,747,068	$3,480,143	($1,700,028)	$2,739,435	($4,490,362)	($2,521,466)	($8,956,179)	$4,298,612	$2,706,669	($273,986)	$6,731,294
Other Income / (Expense)	$1,272,824	$2,429,296	$7,378,891	$7,225,830	$2,118,624	$334,634	$1,581,537	$22,341,637	$382,315	$0	$22,723,952
Net Income / (Loss)	$17,019,893	$5,909,439	$5,678,863	$9,965,266	($2,371,738)	($2,186,832)	($7,374,643)	$26,640,248	$3,088,984	($273,986)	$29,455,246
PMPM Metrics:											
Revenue PMPM	$216.60	$427.88	$1,251.83	$466.02	$405.22	$10,670.22	$8,587.55	$480.65	$457.28	$0.00	$480.29
Medical Expense PMPM	$110.83	$320.34	$1,097.36	$358.93	$317.02	$11,629.99	$8,937.30	$373.67	$376.80	$0.00	$373.72
Gross Margin PMPM	$105.77	$107.53	$154.47	$107.08	$88.20	($959.77)	($349.75)	$106.98	$80.49	$0.00	$106.57
Administrative Expense PMPM	$4.50	$14.91	$75.44	$18.85	$17.35	$657.53	$465.86	$20.62	$26.98	$0.00	$20.80
MCO Tax Expense PMPM	$84.49	$85.68	$84.88	$85.89	$83.01	$89.86	$86.68	$85.05	$0.00	$0.00	$83.75
Operating Income / (Expense) PMPM	$16.79	$6.94	($5.86)	$2.35	($12.16)	($1,707.15)	($902.29)	$1.31	$53.50	$0.00	$2.02
Other Income / (Expense) PMPM	$1.36	$4.84	$25.45	$6.19	$5.74	$226.56	$159.33	$6.82	$7.56	$0.00	$6.83
Net Income / (Loss) PMPM	$18.14	$11.78	$19.59	$8.53	($6.42)	($1,480.59)	($742.96)	$8.13	$61.06	$0.00	$8.85
Ratio:											
Medical Loss Ratio	82.8%	93.2%	93.9%	94.0%	97.9%	109.9%	105.1%	94.1%	82.4%	0.0%	93.9%
Administrative Expense Ratio	3.4%	4.3%	6.5%	4.9%	5.4%	6.2%	5.5%	5.2%	5.9%	0.0%	5.2%
Net Income Ratio	8.4%	2.8%	1.6%	1.8%	-1.6%	-13.9%	-8.7%	1.7%	13.4%	0.0%	1.8%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED March 31, 2024

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				ADMINISTRATIVE EXPENSE SUMMARY				
$5,375,654	$5,238,791	($136,864)	(2.6%)	Personnel Expenses	$44,748,035	$47,941,205	$3,193,171	6.7%
360,531	73,023	(287,508)	(393.7%)	Benefits Administration Expense	1,675,722	1,396,660	(279,062)	(20.0%)
2,970,612	864,663	(2,105,949)	(243.6%)	Purchased & Professional Services	10,650,413	9,685,867	(964,546)	(10.0%)
251,783	507,624	255,841	50.4%	Occupancy	3,845,558	4,513,855	668,296	14.8%
(282,379)	839,598	1,121,977	133.6%	Printing Postage & Promotion	2,850,786	5,147,849	2,297,063	44.6%
1,171,892	977,362	(194,529)	(19.9%)	Licenses Insurance & Fees	5,276,621	6,883,414	1,606,792	23.3%
(3,069)	29,097	32,166	110.5%	Supplies & Other Expenses	179,465	229,047	49,581	21.6%
$4,469,370	$3,291,367	($1,178,003)	(35.8%)	Total Other Administrative Expense	$24,478,566	$27,856,690	$3,378,125	12.1%
$9,845,024	$8,530,158	($1,314,867)	(15.4%)	Total Administrative Expenses	$69,226,600	$75,797,896	$6,571,295	8.7%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED March 31, 2024

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				Personnel Expenses				
3,346,975	3,174,948	(172,027)	(5.4%)	Salaries & Wages	28,946,199	28,763,681	(182,517)	(0.6%)
262,376	347,357	84,981	24.5%	Paid Time Off	2,873,019	3,076,210	203,191	6.6%
468	4,300	3,832	89.1%	Compensated Incentives	15,386	1,934,097	1,918,711	99.2%
0	0	0	0.0%	Severance Pay	6,160	842,000	835,840	99.3%
61,097	52,469	(8,629)	(16.4%)	Payroll Taxes	574,710	574,636	(74)	0.0%
25,364	19,467	(5,898)	(30.3%)	Overtime	294,695	232,328	(62,367)	(26.8%)
302,632	268,859	(33,773)	(12.6%)	CalPERS ER Match	2,488,180	2,448,444	(39,736)	(1.6%)
868,023	1,000,447	132,424	13.2%	Employee Benefits	6,739,954	7,184,861	444,908	6.2%
(5,084)	0	5,084	0.0%	Personal Floating Holiday	175,010	169,701	(5,309)	(3.1%)
17,019	23,000	5,981	26.0%	Premium Bi/Multilingual Pay	113,461	109,000	(4,461)	(4.1%)
26	0	(26)	0.0%	Prizes	154	0	(154)	0.0%
2,750	0	(2,750)	0.0%	Med Ins Opted Out Stipend	10,000	0	(10,000)	0.0%
261,000	0	(261,000)	0.0%	Holiday Bonus	1,402,961	0	(1,402,961)	0.0%
30,145	0	(30,145)	0.0%	Sick Leave	57,226	0	(57,226)	0.0%
9,551	29,698	20,148	67.8%	Compensated Employee Relations	55,998	251,262	195,265	77.7%
17,510	22,950	5,440	23.7%	Work from Home Stipend	148,300	170,395	22,095	13.0%
2,506	3,758	1,252	33.3%	Mileage, Parking & LocalTravel	9,419	25,181	15,762	62.6%
16,917	24,477	7,559	30.9%	Travel & Lodging	96,539	186,094	89,555	48.1%
73,190	190,482	117,291	61.6%	Temporary Help Services	427,591	1,376,167	948,576	68.9%
58,389	45,548	(12,841)	(28.2%)	Staff Development/Training	207,517	378,187	170,670	45.1%
24,799	31,031	6,232	20.1%	Staff Recruitment/Advertising	105,557	218,961	113,404	51.8%
$5,375,654	**$5,238,791**	**($136,864)**	**(2.6%)**	**Total Employee Expenses**	**$44,748,035**	**$47,941,205**	**$3,193,171**	**6.7%**
				Benefit Administration Expense				
32,536	21,527	(11,010)	(51.1%)	RX Administration Expense	191,780	189,106	(2,673)	(1.4%)
275,719	0	(275,719)	0.0%	Behavioral Hlth Administration Fees	1,093,429	817,710	(275,719)	(33.7%)
52,276	51,497	(779)	(1.5%)	Telemedicine Admin Fees	390,514	389,844	(670)	(0.2%)
$360,531	**$73,023**	**($287,508)**	**(393.7%)**	**Total Benefit Administration Expenses**	**$1,675,722**	**$1,396,660**	**($279,062)**	**(20.0%)**
				Purchased & Professional Services				
140,044	270,235	130,191	48.2%	Consultant Fees - Non Medical	2,037,982	3,098,434	1,060,452	34.2%
1,630,013	319,363	(1,310,650)	(410.4%)	Computer Support Services	4,345,008	3,211,442	(1,133,566)	(35.3%)
11,875	12,500	625	5.0%	Audit Fees	106,875	110,000	3,125	2.8%
0	33	33	100.0%	Consultant Fees - Medical	0	167	167	100.0%
119,937	24,339	(95,598)	(392.8%)	Other Purchased Services	1,350,927	743,462	(607,465)	(81.7%)
0	1,574	1,574	100.0%	Maint.& Repair-Office Equipment	10,176	10,526	350	3.3%
0	0	0	0.0%	Maint.&Repair-Computer Hardware	1,180	1,180	0	0.0%
91,834	117,835	26,001	22.1%	Medical Refund Recovery Fees	768,363	1,004,066	235,703	23.5%
818,170	0	(818,170)	0.0%	Software - IT Licenses & Subsc	1,005,050	0	(1,005,050)	0.0%
73,961	21,870	(52,091)	(238.2%)	Hardware (Non-Capital)	557,986	774,651	216,665	28.0%
43,823	44,565	741	1.7%	Provider Relations-Credentialing	256,139	337,324	81,185	24.1%
39,811	52,350	12,540	24.0%	Legal Fees	186,764	394,616	207,852	52.7%
1,145	0	(1,145)	0.0%	Interpretive Services	23,964	0	(23,964)	0.0%
$2,970,612	**$864,663**	**($2,105,949)**	**(243.6%)**	**Total Purchased & Professional Services**	**$10,650,413**	**$9,685,867**	**($964,546)**	**(10.0%)**
				Occupancy				
63,672	53,678	(9,994)	(18.6%)	Depreciation	551,195	500,331	(50,864)	(10.2%)
(9,448)	62,639	72,087	115.1%	Building Lease	491,660	561,589	69,930	12.5%

ALAMEDA ALLIANCE FOR HEALTH
ADMINISTRATIVE EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED March 31, 2024

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
3,275	5,870	2,595	44.2%	Leased and Rented Office Equipment	21,494	61,769	40,275	65.2%
23,575	17,932	(5,643)	(31.5%)	Utilities	170,472	176,098	5,627	3.2%
(26,245)	86,510	112,755	130.3%	Telephone	527,606	744,971	217,365	29.2%
(7,856)	31,859	39,715	124.7%	Building Maintenance	193,079	283,154	90,075	31.8%
204,810	249,136	44,326	17.8%	SBITA Amortization Expense-GASB 96	1,890,053	2,185,942	295,888	13.5%
$251,783	**$507,624**	**$255,841**	**50.4%**	**Total Occupancy**	**$3,845,558**	**$4,513,855**	**$668,296**	**14.8%**
				Printing Postage & Promotion				
1,158	43,451	42,293	97.3%	Postage	387,605	700,839	313,234	44.7%
4,322	5,300	979	18.5%	Design & Layout	31,080	43,416	12,336	28.4%
(138,399)	48,707	187,106	384.1%	Printing Services	690,835	1,028,323	337,487	32.8%
(12,000)	6,910	18,910	273.7%	Mailing Services	59,807	84,771	24,964	29.4%
676	9,997	9,321	93.2%	Courier/Delivery Service	76,147	85,380	9,233	10.8%
0	0	0	0.0%	Pre-Printed Materials and Publications	1,038	500	(538)	(107.6%)
0	1,250	1,250	100.0%	Promotional Products	7,541	24,121	16,581	68.7%
1,450	150	(1,300)	(866.7%)	Promotional Services	197	5,200	5,003	96.2%
(270,931)	700,500	971,431	138.7%	Community Relations	872,412	2,940,639	2,068,228	70.3%
48,178	23,333	(24,845)	(106.5%)	Translation - Non-Clinical	223,957	234,659	10,702	4.6%
83,167	0	(83,167)	0.0%	Community Reinvestment Expense	500,167	0	(500,167)	0.0%
($282,379)	**$839,598**	**$1,121,977**	**133.6%**	**Total Printing Postage & Promotion**	**$2,850,786**	**$5,147,849**	**$2,297,063**	**44.6%**
				Licenses Insurance & Fees				
0	250,000	250,000	100.0%	Regulatory Penalties	80,000	750,000	670,000	89.3%
24,000	29,000	5,000	17.2%	Bank Fees	266,098	250,587	(15,511)	(6.2%)
309,071	89,101	(219,971)	(246.9%)	Insurance Premium	957,944	756,322	(201,622)	(26.7%)
714,066	439,723	(274,343)	(62.4%)	Licenses, Permits and Fees	2,810,883	3,501,841	690,958	19.7%
124,754	169,539	44,785	26.4%	Subscriptions and Dues - NonIT	1,161,697	1,624,664	462,967	28.5%
$1,171,892	**$977,362**	**($194,529)**	**(19.9%)**	**Total Licenses Insurance & Postage**	**$5,276,621**	**$6,883,414**	**$1,606,792**	**23.3%**
				Supplies & Other Expenses				
7,349	5,729	(1,620)	(28.3%)	Office and Other Supplies	74,327	64,455	(9,872)	(15.3%)
0	9,600	9,600	100.0%	Furniture and Equipment	12,364	35,753	23,389	65.4%
(20,026)	1,300	21,326	1,640.5%	Ergonomic Supplies	17,975	19,825	1,850	9.3%
4,858	6,901	2,043	29.6%	Meals and Entertainment	42,699	63,683	20,984	33.0%
1	0	(1)	0.0%	Miscellaneous Expense	22,500	27,948	5,447	19.5%
4,750	4,850	100	2.1%	Member Incentive Expense	9,600	14,550	4,950	34.0%
0	100	100	100.0%	Covid-19 IT Expenses	0	500	500	100.0%
0	617	617	100.0%	Covid-19 Non IT Expenses	0	2,333	2,333	100.0%
($3,069)	**$29,097**	**$32,166**	**110.5%**	**Total Supplies & Other Expense**	**$179,465**	**$229,047**	**$49,581**	**21.6%**
$9,845,024	**$8,530,158**	**($1,314,867)**	**(15.4%)**	**TOTAL ADMINISTRATIVE EXPENSE**	**$69,226,600**	**$75,797,896**	**$6,571,295**	**8.7%**

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

		Project ID	Prior YTD Acquisitions	Current Month Acquisitions	Fiscal YTD Acquisitions	Capital Budget Total	$ Variance Fav/(Unf.)
1. Hardware:							
	Cisco Catalyst 9300 - Catalyst Switches	IT-FY24-01	$ -	$ -	**$ -**	$ 50,000	$ 50,000
	Cisco Catalyst 8500 - Routers	IT-FY24-02	$ -	$ -	**$ -**	$ 60,000	$ 60,000
	Cisco AP-9166 - Access Point	IT-FY24-03	$ -	$ -	**$ -**	$ 10,000	$ 10,000
	Cisco UCS-X M6 or M7 Blades x 6	IT-FY24-04	$ 426,471	$ -	**$ 426,471**	$ 426,371	$ (100)
	PURE Storage array	IT-FY24-05	$ -	$ -	**$ -**	$ 300,000	$ 300,000
	PKI management	IT-FY24-06	$ -	$ -	**$ -**	$ 20,000	$ 20,000
	IBM Power Hardware Upgrade	IT-FY24-07	$ 560,652	$ -	**$ 560,652**	$ 288,629	$ (272,023)
	Misc Hardware	IT-FY24-08	$ 7,119	$ -	**$ 7,119**	$ 15,000	$ 7,881
	Network / AV Cabling	IT-FY24-09	$ 96,413	$ (1,359)	**$ 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
Hardware Subtotal			**$ 1,103,201**	**$ (1,359)**	**$ 1,101,842**	**$ 1,320,701**	**$ 218,859**
2. Software:							
	Zerto renewal and Tier 2 add	AC-FY24-01	$ -	$ -	**$ -**	$ 126,000	$ 126,000
Software Subtotal			**$ -**	**$ -**	**$ -**	**$ 126,000**	**$ 126,000**
3. Building Improvement:							
	Appliances over 1k new/replacement (all buildings/suites)	FA-FY24-01	**$ -**	$ -	**$ -**	$ -	$ -
	ACME Security: Readers, HID boxes, Cameras, Doors (planned/unplanned	FA-FY24-02	$ -	$ -	**$ -**	$ 20,000	$ 20,000
	HVAC: Replace VAV boxes, duct work, replace old equipment	FA-FY24-03	$ 18,295	$ -	**$ 18,295**	$ 20,000	$ 1,705
	Electrical work for projects, workstations requirement	FA-FY24-04	$ -	$ -	**$ -**	$ 10,000	$ 10,000
	1240 Interior blinds replacement	FA-FY24-05	**$ -**	$ -	**$ -**	$ 25,000	$ 25,000
	EV Charging stations, if not completed in FY23 and carried over to FY24	FA-FY24-06	**$ 35,399**	$ -	**$ 35,399**	$ 50,000	$ 14,601
Building Improvement Subtotal			**$ 53,694**	**$ -**	**$ 53,694**	**$ 125,000**	**$ 71,306**
4. Furniture & Equipment:							
	Office desks, cabinets, shelvings (all building/suites: new or replacement)	FA-FY24-17	$ 3,860	$ -	**$ 3,860**	$ 10,000	$ 6,140
	Replace, reconfigure, re-design workstations	FA-FY24-18	$ -	$ -	**$ -**	$ 20,000.00	$ 20,000
Furniture & Equipment Subtotal			**$ 3,860**	**$ -**	**$ 3,860**	**$ 30,000**	**$ 26,140**
GRAND TOTAL			**$ 1,160,754**	**$ (1,359)**	**$ 1,159,395**	**$ 1,601,701**	**$ 442,306**
5. Reconciliation to Balance Sheet:							
	Fixed Assets @ Cost - 3/31/24				**$ 38,854,491**		
	Fixed Assets @ Cost - 6/30/23				**$ 37,695,096**		
	Fixed Assets Acquired YTD				**$ 1,159,395**		

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

TANGIBLE NET EQUITY (TNE)

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

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

LIQUID TANGIBLE NET EQUITY

	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Net Assets	$333,703,974	$336,047,435	$341,561,770	$345,338,268	$348,779,178	$359,342,945	$351,333,888	$356,726,008
Fixed Assets at Net Book Value	(5,169,098)	(5,539,264)	(5,608,622)	(5,653,388)	(6,079,010)	(5,997,733)	(7,085,899)	(6,961,780)
Net Lease Assets/Liabilities/Interest	(711,429)	(475,037)	(1,115,074)	(727,353)	(662,463)	(1,135,481)	(1,193,576)	(1,033,509)
CD Pledged to DMHC	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)	(350,000)
Liquid TNE (Liquid Reserves)	**$328,184,876**	**$330,158,171**	**$335,603,148**	**$339,334,880**	**$342,350,168**	**$352,995,212**	**$343,897,989**	**$349,414,228**
Liquid TNE as Multiple of Required	**7.10**	**7.06**	**7.24**	**6.83**	**6.86**	**7.11**	**5.99**	**6.31**

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

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

	Actual Jul-23	Actual Aug-23	Actual Sep-23	Actual Oct-23	Actual Nov-23	Actual Dec-23	Actual Jan-24	Actual Feb-24	Actual Mar-24	Actual Apr-24	Actual May-24	Actual Jun-24	YTD Member Months
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				938,101
Adult	52,550	52,102	51,499	52,396	52,151	51,696	62,860	63,117	63,293				501,664
SPD	31,055	30,840	30,592	30,888	30,865	30,846	35,013	34,875	34,972				289,946
ACA OE	123,707	121,819	120,016	121,430	120,573	119,668	145,842	146,757	148,061				1,167,873
Duals	41,688	41,715	41,629	41,496	40,997	40,974	40,117	40,403	40,222				369,241
MCAL LTC	141	138	139	135	137	135	219	217	216				1,477
MCAL LTC Duals	1,033	1,019	1,004	997	975	951	1,311	1,329	1,307				9,926
Medi-Cal Program	352,637	349,026	344,917	348,462	346,941	346,358	394,915	396,651	398,321				3,278,228
Group Care Program	5,669	5,645	5,631	5,605	5,585	5,622	5,603	5,608	5,620				50,588
Total	**358,306**	**354,671**	**350,548**	**354,067**	**352,526**	**351,980**	**400,518**	**402,259**	**403,941**				**3,328,816**
Month Over Month Enrollment Change:													
Medi-Cal Monthly Change													
Child	(1,207)	(1,070)	(1,355)	1,082	123	845	7,465	400	297				6,580
Adult	(624)	(448)	(603)	897	(245)	(455)	11,164	257	176				10,119
SPD	(225)	(215)	(248)	296	(23)	(19)	4,167	(138)	97				3,692
ACA OE	(1,260)	(1,888)	(1,803)	1,414	(857)	(905)	26,174	915	1,304				23,094
Duals	(43)	27	(86)	(133)	(499)	(23)	(857)	286	(181)				(1,509)
MCAL LTC	(9)	(3)	1	(4)	2	(2)	84	(2)	(1)				66
MCAL LTC Duals	4	(14)	(15)	(7)	(22)	(24)	360	18	(22)				278
Medi-Cal Program	(3,364)	(3,611)	(4,109)	3,545	(1,521)	(583)	48,557	1,736	1,670				42,320
Group Care Program	(15)	(24)	(14)	(26)	(20)	37	(19)	5	12				(64)
Total	**(3,379)**	**(3,635)**	**(4,123)**	**3,519**	**(1,541)**	**(546)**	**48,538**	**1,741**	**1,682**				**42,256**
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%				28.6%
Adult % of Medi-Cal	14.9%	14.9%	14.9%	15.0%	15.0%	14.9%	15.9%	15.9%	15.9%				15.3%
SPD % of Medi-Cal	8.8%	8.8%	8.9%	8.9%	8.9%	8.9%	8.9%	8.8%	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%				35.6%
Duals % of Medi-Cal	11.8%	12.0%	12.1%	11.9%	11.8%	11.8%	10.2%	10.2%	10.1%				11.3%
Medi-Cal Program % of Total	98.4%	98.4%	98.4%	98.4%	98.4%	98.4%	98.6%	98.6%	98.6%				98.5%
Group Care Program % of Total	1.6%	1.6%	1.6%	1.6%	1.6%	1.6%	1.4%	1.4%	1.4%				1.5%
Total	**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

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

	Actual Jul-23	Actual Aug-23	Actual Sep-23	Actual Oct-23	Actual Nov-23	Actual Dec-23	Actual Jan-24	Actual Feb-24	Actual Mar-24	Actual Apr-24	Actual May-24	Actual Jun-24	YTD Member Months
Current Direct/Delegate Enrollment:													
Directly-Contracted													
Directly Contracted (DCP)	74,547	73,027	72,504	78,530	75,141	76,228	104,906	91,656	89,759				736,298
Alameda Health System	66,089	65,344	64,133	63,271	63,903	63,545	83,981	89,168	90,086				649,520
	140,636	138,371	136,637	141,801	139,044	139,773	188,887	180,824	179,845				1,385,818
Delegated:													
CFMG	34,810	34,649	34,144	34,035	35,105	35,399	42,148	43,527	43,412				337,229
CHCN	130,230	129,183	127,430	126,705	127,641	128,331	169,483	177,908	180,684				1,297,595
Kaiser	52,630	52,468	52,337	51,526	50,736	48,477	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				1,942,998
Total	**358,306**	**354,671**	**350,548**	**354,067**	**352,526**	**351,980**	**400,518**	**402,259**	**403,941**				**3,328,816**
Direct/Delegate Month Over Month Enrollment Change:													
Directly-Contracted	(939)	(2,265)	(1,734)	5,164	(2,757)	729	49,114	(8,063)	(979)				38,270
Delegated:													
CFMG	(441)	(161)	(505)	(109)	1,070	294	6,749	1,379	(115)				8,161
CHCN	(1,721)	(1,047)	(1,753)	(725)	936	690	41,152	8,425	2,776				48,733
Kaiser	(278)	(162)	(131)	(811)	(790)	(2,259)	(48,477)	0	0				(52,908)
Delegated Subtotal	(2,440)	(1,370)	(2,389)	(1,645)	1,216	(1,275)	(576)	9,804	2,661				3,986
Total	**(3,379)**	**(3,635)**	**(4,123)**	**3,519**	**(1,541)**	**(546)**	**48,538**	**1,741**	**1,682**				**42,256**
Direct/Delegate Enrollment Percentages:													
Directly-Contracted	39.3%	39.0%	39.0%	40.0%	39.4%	39.7%	47.2%	45.0%	44.5%				41.6%
Delegated:													
CFMG	9.7%	9.8%	9.7%	9.6%	10.0%	10.1%	10.5%	10.8%	10.7%				10.1%
CHCN	36.3%	36.4%	36.4%	35.8%	36.2%	36.5%	42.3%	44.2%	44.7%				39.0%
Kaiser	14.7%	14.8%	14.9%	14.6%	14.4%	13.8%	0.0%	0.0%	0.0%				9.3%
Delegated Subtotal	60.7%	61.0%	61.0%	60.0%	60.6%	60.3%	52.8%	55.0%	55.5%				58.4%
Total	**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				31,055
Adult	0	0	0	0	279	395	5,382	6,329	7,186				19,571
SPD	0	0	0	0	131	358	(7,460)	(7,258)	(6,824)				(21,053)
ACA OE	0	0	0	0	(607)	63	(3,355)	(799)	2,128				(2,570)
Duals	0	0	0	0	(413)	(351)	(5,670)	(5,291)	(5,378)				(17,103)
MCAL LTC	0	0	0	0	1	(2)	47	44	42				132
MCAL LTC Duals	0	0	0	0	(10)	(20)	117	153	148				388
Medi-Cal Program	0	0	0	0	515	3,523	(3,545)	2,198	7,729				10,420
Group Care Program	0	0	0	0	(6)	45	40	59	85				223
Total	**0**	**0**	**0**	**0**	**509**	**3,568**	**(3,505)**	**2,257**	**7,814**				**10,643**
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)				(27,509)
Alameda Health System	0	0	0	0	926	1,291	(2,869)	3,243	5,064				7,655
	0	0	0	0	(2,107)	(24)	(1,950)	(8,255)	(7,518)				(19,854)
Delegated:													
CFMG	0	0	0	0	1,396	2,060	(956)	932	1,281				4,713
CHCN	0	0	0	0	1,672	3,694	(599)	9,580	14,051				28,398
Kaiser	0	0	0	0	(452)	(2,162)	0	0	0				(2,614)
Delegated Subtotal	0	0	0	0	2,616	3,592	(1,555)	10,512	15,332				30,497
Total	**0**	**0**	**0**	**0**	**509**	**3,568**	**(3,505)**	**2,257**	**7,814**				**10,643**

ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED MARCH 31, 2024

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
				CAPITATED MEDICAL EXPENSES:				
$5,175,801	$1,408,515	($3,767,287)	(267.5%)	PCP Capitation	$22,408,166	$11,163,462	($11,244,705)	(100.7%)
6,082,985	6,228,140	145,155	2.3%	PCP Capitation FQHC	44,166,249	45,362,936	1,196,686	2.6%
377,440	365,810	(11,630)	(3.2%)	Specialty-Capitation	2,926,849	2,885,374	(41,474)	(1.4%)
5,305,351	5,594,932	289,581	5.2%	Specialty-Capitation FQHC	38,447,308	40,068,010	1,620,702	4.0%
911,602	712,144	(199,457)	(28.0%)	Laboratory Capitation	5,346,529	5,215,976	(130,553)	(2.5%)
338,693	329,894	(8,799)	(2.7%)	Vision Cap	2,534,276	2,513,541	(20,735)	(0.8%)
109,806	106,545	(3,260)	(3.1%)	CFMG Capitation	851,407	840,102	(11,305)	(1.3%)
262,486	273,344	10,858	4.0%	Anc IPA Admin Capitation FQHC	1,904,764	1,973,361	68,597	3.5%
0	0	0	0.0%	Kaiser Capitation	83,773,193	84,015,590	242,397	0.3%
0	0	0	0.0%	BHT Supplemental Expense	4,672	0	(4,672)	0.0%
(18,635)	0	18,635	0.0%	Maternity Supplemental Expense	2,423,784	2,311,103	(112,681)	(4.9%)
879,920	1,035,284	155,364	15.0%	DME Cap	6,928,766	7,494,122	565,356	7.5%
$19,425,449	**$16,054,609**	**($3,370,840)**	**(21.0%)**	**5 - TOTAL CAPITATED EXPENSES**	**$211,715,963**	**$203,843,575**	**($7,872,388)**	**(3.9%)**
				FEE FOR SERVICE MEDICAL EXPENSES:				
2,226,366	0	(2,226,366)	0.0%	IBNR Inpatient Services	10,727,898	(2,306,298)	(13,034,196)	565.2%
66,790	0	(66,790)	0.0%	IBNR Settlement (IP)	321,836	(69,188)	(391,024)	565.2%
178,110	0	(178,110)	0.0%	IBNR Claims Fluctuation (IP)	858,234	(184,504)	(1,042,738)	565.2%
40,565,004	49,045,927	8,480,922	17.3%	Inpatient Hospitalization FFS	298,798,545	334,220,311	35,421,766	10.6%
2,328,079	0	(2,328,079)	0.0%	IP OB - Mom & NB	18,848,234	7,462,632	(11,385,601)	(152.6%)
467,818	0	(467,818)	0.0%	IP Behavioral Health	1,708,949	895,483	(813,465)	(90.8%)
791,647	0	(791,647)	0.0%	IP Facility Rehab FFS	9,021,305	4,711,642	(4,309,663)	(91.5%)
$46,623,815	**$49,045,927**	**$2,422,112**	**4.9%**	**6 - Inpatient Hospital & SNF Expense**	**$340,285,000**	**$344,730,080**	**$4,445,079**	**1.3%**
280,368	0	(280,368)	0.0%	IBNR PCP	617,981	46,983	(570,998)	(1,215.3%)
8,410	0	(8,410)	0.0%	IBNR Settlement (PCP)	18,538	1,409	(17,129)	(1,215.7%)
22,428	0	(22,428)	0.0%	IBNR Claims Fluctuation (PCP)	49,440	3,759	(45,681)	(1,215.2%)
3,630,474	2,722,845	(907,629)	(33.3%)	Primary Care Non-Contracted FF	23,710,072	19,610,057	(4,100,016)	(20.9%)
205,886	323,154	117,268	36.3%	PCP FQHC FFS	3,816,084	3,487,664	(328,420)	(9.4%)
0	0	0	0.0%	Phys Extended Hours Incentive	3,500	6,000	2,500	41.7%
6,577	3,672,168	3,665,591	99.8%	Prop 56 Physician	13,892,264	26,721,808	12,829,544	48.0%
16,232	0	(16,232)	0.0%	Prop 56 Hyde	225,081	58,257	(166,824)	(286.4%)
73,487	0	(73,487)	0.0%	Prop 56 Trauma Screening	698,125	316,945	(381,180)	(120.3%)
78,065	0	(78,065)	0.0%	Prop 56 Develop. Screening	799,035	383,782	(415,253)	(108.2%)
778,399	0	(778,399)	0.0%	Prop 56 Family Planning	6,669,583	2,905,675	(3,763,908)	(129.5%)
0	0	0	0.0%	Prop 56 VBP	573	7,428	6,856	92.3%
$5,100,326	**$6,718,167**	**$1,617,841**	**24.1%**	**7 - Primary Care Physician Expense**	**$50,500,276**	**$53,549,768**	**$3,049,492**	**5.7%**
1,585,157	0	(1,585,157)	0.0%	IBNR Specialist	2,101,750	(704,271)	(2,806,021)	398.4%
315,443	0	(315,443)	0.0%	Psychiatrist FFS	2,497,724	927,497	(1,570,227)	(169.3%)
2,244,961	7,648,123	5,403,161	70.6%	Specialty Care FFS	21,590,437	42,800,167	21,209,730	49.6%
153,137	0	(153,137)	0.0%	Specialty Anesthesiology	1,566,781	733,088	(833,693)	(113.7%)
1,118,564	0	(1,118,564)	0.0%	Specialty Imaging FFS	10,162,050	4,332,553	(5,829,497)	(134.6%)
18,358	0	(18,358)	0.0%	Obstetrics FFS	169,065	71,825	(97,240)	(135.4%)
260,141	0	(260,141)	0.0%	Specialty IP Surgery FFS	2,521,133	1,146,377	(1,374,756)	(119.9%)
610,802	0	(610,802)	0.0%	Specialty OP Surgery FFS	5,617,717	2,380,160	(3,237,557)	(136.0%)
406,068	0	(406,068)	0.0%	Spec IP Physician	4,272,780	1,804,945	(2,467,835)	(136.7%)
20,304	104,193	83,889	80.5%	SCP FQHC FFS	660,886	712,272	51,386	7.2%
47,555	0	(47,555)	0.0%	IBNR Settlement (SCP)	63,055	(21,127)	(84,182)	398.5%
126,814	0	(126,814)	0.0%	IBNR Claims Fluctuation (SCP)	168,139	(56,342)	(224,481)	398.4%
$6,907,304	**$7,752,316**	**$845,011**	**10.9%**	**8 - Specialty Care Physician Expense**	**$51,391,516**	**$54,127,143**	**$2,735,627**	**5.1%**
1,147,543	0	(1,147,543)	0.0%	IBNR Ancillary	4,865,449	2,122,555	(2,742,894)	(129.2%)
34,426	0	(34,426)	0.0%	IBNR Settlement (ANC)	145,966	63,677	(82,289)	(129.2%)
91,803	0	(91,803)	0.0%	IBNR Claims Fluctuation (ANC)	389,235	169,805	(219,430)	(129.2%)
94,056	0	(94,056)	0.0%	IBNR Transportation FFS	260,679	45,720	(214,959)	(470.2%)
1,371,910	0	(1,371,910)	0.0%	Behavioral Health Therapy FFS	11,471,516	4,951,126	(6,520,389)	(131.7%)
1,231,277	0	(1,231,277)	0.0%	Psychologist & Other MH Prof.	10,133,132	4,215,464	(5,917,668)	(140.4%)
327,481	0	(327,481)	0.0%	Acupuncture/Biofeedback	2,588,116	1,075,338	(1,512,777)	(140.7%)
155,453	0	(155,453)	0.0%	Hearing Devices	1,092,606	381,525	(711,081)	(186.4%)
103,907	0	(103,907)	0.0%	Imaging/MRI/CT Global	410,676	141,544	(269,132)	(190.1%)
34,451	0	(34,451)	0.0%	Vision FFS	444,849	164,593	(280,256)	(170.3%)
10	0	(10)	0.0%	Family Planning	69	30	(40)	(133.3%)
552,167	0	(552,167)	0.0%	Laboratory-FFS	4,555,540	1,917,612	(2,637,927)	(137.6%)
86,681	0	(86,681)	0.0%	ANC Therapist	851,373	395,200	(456,173)	(115.4%)
1,200,310	0	(1,200,310)	0.0%	Transportation (Ambulance)-FFS	9,845,517	3,746,485	(6,099,032)	(162.8%)
1,926,377	0	(1,926,377)	0.0%	Transportation (Other)-FFS	14,374,541	5,929,067	(8,445,474)	(142.4%)
1,424,132	0	(1,424,132)	0.0%	Hospice	12,691,003	5,779,983	(6,911,020)	(119.6%)

ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED MARCH 31, 2024

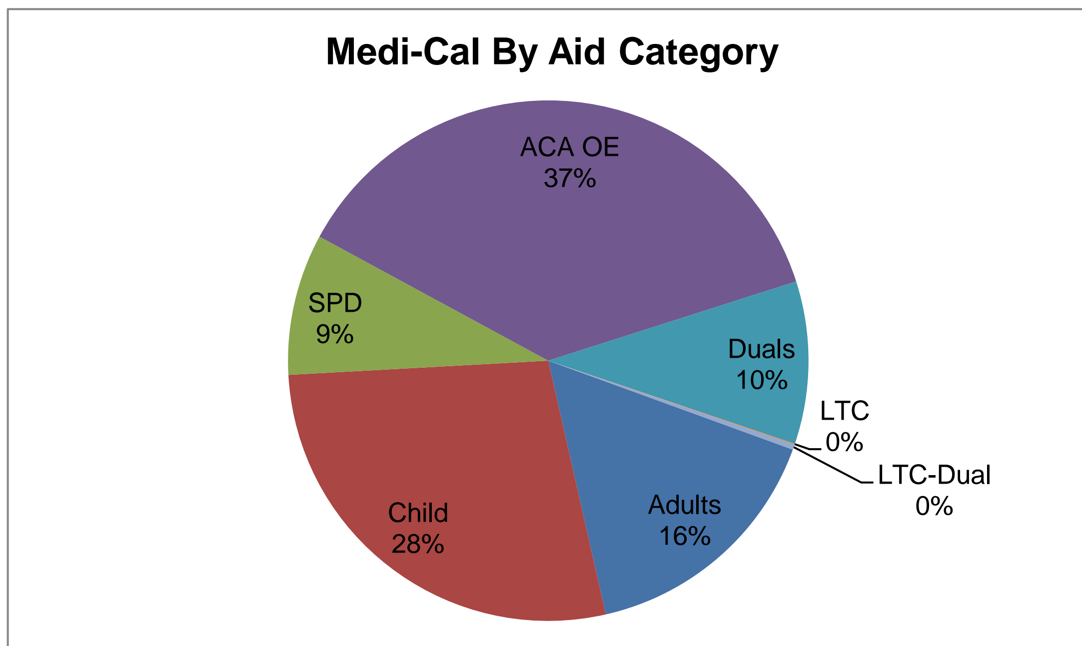
CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	**Budget**	**$ Variance (Unfavorable)**	**% Variance (Unfavorable)**	**Account Description**	**Actual**	**Budget**	**$ Variance (Unfavorable)**	**% Variance (Unfavorable)**
1,570,828	0	(1,570,828)	0.0%	Home Health Services	11,532,887	4,994,036	(6,538,850)	(130.9%)
603	12,494,312	12,493,709	100.0%	Other Medical-FFS	11,474	55,469,659	55,458,185	100.0%
(4,981)	0	4,981	0.0%	Medical Refunds through HMS	40,019	(309,963)	(349,982)	112.9%
(2,006)	0	2,006	0.0%	Medical Refunds	(585,418)	(565,083)	20,335	(3.6%)
27,875	0	(27,875)	0.0%	DME & Medical Supplies	227,384	116,689	(110,694)	(94.9%)
0	0	0	0.0%	GEMT FFS	(373,988)	(373,988)	0	0.0%
1,791,598	1,846,454	54,856	3.0%	ECM Base/Outreach FFS Anc.	13,949,707	13,594,721	(354,985)	(2.6%)
(4,395,728)	0	4,395,728	0.0%	CS Housing Deposits FFS Ancillary	(4,190,028)	135,985	4,326,012	3,181.3%
4,219,838	0	(4,219,838)	0.0%	CS Housing Tenancy FFS Ancillary	6,243,804	1,183,089	(5,060,715)	(427.8%)
(598,340)	0	598,340	0.0%	CS Housing Navigation Services FFS Ancillary	(95,817)	257,647	353,464	137.2%
1,066,889	0	(1,066,889)	0.0%	CS Medical Respite FFS Ancillary	1,700,053	377,892	(1,322,161)	(349.9%)
(617,126)	0	617,126	0.0%	CS Medically Tailored Meals FFS Ancillary	(315,738)	128,446	444,184	345.8%
(280,646)	0	280,646	0.0%	CS Asthma Remediation FFS Ancillary	(248,159)	11,648	259,807	2,230.5%
0	10,000	10,000	100.0%	MOT Wrap Around (Non Medical MOT Cost)	0	50,000	50,000	100.0%
1,457,743	0	(1,457,743)	0.0%	CS Personal Care & Homemaker Services FFS Ancillary	1,457,743	0	(1,457,743)	0.0%
11,347	0	(11,347)	0.0%	CS Caregiver Respite Services FFS Ancillary	11,347	0	(11,347)	0.0%
437,983	0	(437,983)	0.0%	Community Based Adult Services (CBAS)	3,510,337	1,425,263	(2,085,074)	(146.3%)
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	37,463	23,701	(13,762)	(58.1%)
0	0	0	0.0%	Justice Involved Pilot	0	161,111	161,111	100.0%
$14,467,859	**$14,350,766**	**($117,093)**	**(0.8%)**	**9 - Ancillary Medical Expense**	**$107,033,336**	**$107,795,870**	**$762,534**	**0.7%**
1,870,799	0	(1,870,799)	0.0%	IBNR Outpatient	4,817,089	422,626	(4,394,463)	(1,039.8%)
56,124	0	(56,124)	0.0%	IBNR Settlement (OP)	144,510	12,677	(131,833)	(1,039.9%)
149,664	0	(149,664)	0.0%	IBNR Claims Fluctuation (OP)	385,366	33,811	(351,555)	(1,039.8%)
2,086,224	12,455,794	10,369,571	83.3%	Out Patient FFS	15,225,295	59,841,026	44,615,731	74.6%
2,015,689	0	(2,015,689)	0.0%	OP Ambul Surgery FFS	15,625,729	6,937,396	(8,688,333)	(125.2%)
2,052,477	0	(2,052,477)	0.0%	OP Fac Imaging Services FFS	15,668,019	6,670,623	(8,997,397)	(134.9%)
18,313	0	(18,313)	0.0%	Behav Health FFS	99,127	(21,966)	(121,093)	551.3%
612,936	0	(612,936)	0.0%	OP Facility Lab FFS	5,043,973	2,081,864	(2,962,109)	(142.3%)
167,395	0	(167,395)	0.0%	OP Facility Cardio FFS	1,384,454	608,098	(776,356)	(127.7%)
158,784	0	(158,784)	0.0%	OP Facility PT/OT/ST FFS	1,388,787	270,230	(1,118,557)	(413.9%)
1,296,322	0	(1,296,322)	0.0%	OP Facility Dialysis FFS	18,664,842	8,379,495	(10,285,347)	(122.7%)
$10,484,727	**$12,455,794**	**$1,971,067**	**15.8%**	**10 - Outpatient Medical Expense Medical Expense**	**$78,447,191**	**$85,235,879**	**$6,788,688**	**8.0%**
2,236,374	0	(2,236,374)	0.0%	IBNR Emergency	3,036,043	30,260	(3,005,783)	(9,933.2%)
67,091	0	(67,091)	0.0%	IBNR Settlement (ER)	91,082	910	(90,172)	(9,909.0%)
178,911	0	(178,911)	0.0%	IBNR Claims Fluctuation (ER)	242,890	2,423	(240,467)	(9,924.3%)
675,261	0	(675,261)	0.0%	Special ER Physician FFS	7,511,921	3,056,795	(4,455,126)	(145.7%)
6,479,344	7,766,576	1,287,233	16.6%	ER Facility	51,839,712	54,287,987	2,448,275	4.5%
$9,636,980	**$7,766,576**	**($1,870,404)**	**(24.1%)**	**11 - Emergency Expense**	**$62,721,648**	**$57,378,375**	**($5,343,273)**	**(9.3%)**
(191,044)	0	191,044	0.0%	IBNR Pharmacy OP	2,675,224	(204,308)	(2,879,532)	1,409.4%
(5,730)	0	5,730	0.0%	IBNR Settlement (RX) OP	80,254	(6,133)	(86,387)	1,408.6%
(15,284)	0	15,284	0.0%	IBNR Claims Fluctuation (RX) OP	214,018	(16,345)	(230,363)	1,409.4%
569,141	373,361	(195,780)	(52.4%)	Pharmacy FFS	4,491,011	3,789,919	(701,092)	(18.5%)
66,234	12,085,379	12,019,145	99.5%	Pharmacy Non-PBM FFS-Other Anc	1,085,323	53,755,283	52,669,960	98.0%
7,173,395	0	(7,173,395)	0.0%	Pharmacy Non-PBM FFS-OP FAC	51,884,871	21,975,503	(29,909,368)	(136.1%)
192,386	0	(192,386)	0.0%	Pharmacy Non-PBM FFS-PCP	1,932,948	615,362	(1,317,586)	(214.1%)
2,143,326	0	(2,143,326)	0.0%	Pharmacy Non-PBM FFS-SCP	19,706,634	8,807,902	(10,898,732)	(123.7%)
2,758	0	(2,758)	0.0%	Pharmacy Non-PBM FFS-FQHC	97,196	41,158	(56,037)	(136.2%)
17,790	0	(17,790)	0.0%	Pharmacy Non-PBM FFS-HH	78,410	27,987	(50,423)	(180.2%)
0	0	0	0.0%	RX Refunds HMS	(63)	(63)	0	0.0%
(25,000)	32,128	57,128	177.8%	Pharmacy Rebate	(325,000)	(931)	324,069	(34,805.0%)
$9,927,972	**$12,490,867**	**$2,562,895**	**20.5%**	**12 - Pharmacy Expense**	**$81,920,826**	**$88,785,334**	**$6,864,508**	**7.7%**
7,315,612	0	(7,315,612)	0.0%	IBNR LTC	22,666,674	4,802,539	(17,864,135)	(372.0%)
219,468	0	(219,468)	0.0%	IBNR Settlement (LTC)	680,002	144,077	(535,925)	(372.0%)
585,250	0	(585,250)	0.0%	IBNR Claims Fluctuation (LTC)	1,813,333	384,202	(1,429,131)	(372.0%)
1,505,636	0	(1,505,636)	0.0%	LTC - ICF/DD	2,314,832	0	(2,314,832)	0.0%
18,107,437	0	(18,107,437)	0.0%	LTC Custodial Care	156,173,826	63,392,176	(92,781,649)	(146.4%)
3,858,019	23,934,451	20,076,432	83.9%	LTC SNF	29,106,722	118,174,818	89,068,096	75.4%
$31,591,422	**$23,934,451**	**($7,656,971)**	**(32.0%)**	**13 - Long Term Care Expense**	**$212,755,389**	**$186,897,812**	**($25,857,576)**	**(13.8%)**
$134,740,406	**$134,514,864**	**($225,541)**	**(0.2%)**	**14 - TOTAL FFS MEDICAL EXPENSES**	**$985,055,183**	**$978,500,261**	**($6,554,922)**	**(0.7%)**
0	(334,796)	(334,796)	100.0%	Clinical Vacancy Department Total	0	(1,560,473)	(1,560,473)	100.0%
65,298	130,346	65,048	49.9%	Quality Analytics Department Total	712,197	1,300,379	588,183	45.2%
909,630	1,087,822	178,192	16.4%	Utilization Management Department Total	7,509,585	8,539,082	1,029,497	12.1%

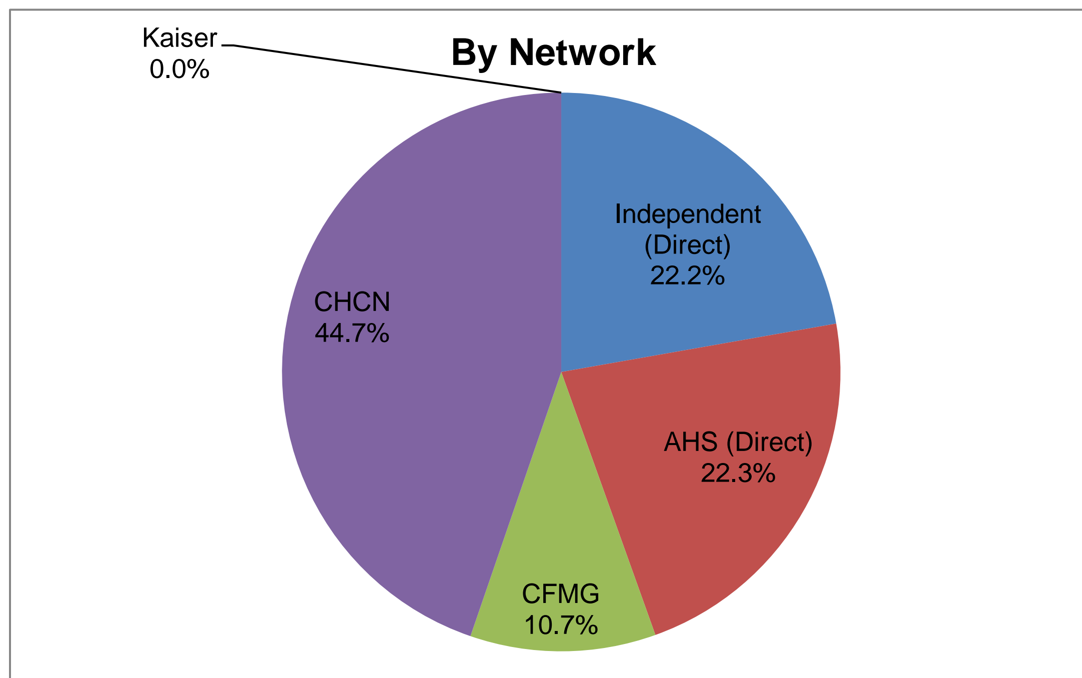
ALAMEDA ALLIANCE FOR HEALTH
MEDICAL EXPENSE DETAIL
ACTUAL VS. BUDGET
FOR THE MONTH AND FISCAL YTD ENDED MARCH 31, 2024

CURRENT MONTH					FISCAL YEAR TO DATE			
Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)	Account Description	Actual	Budget	$ Variance (Unfavorable)	% Variance (Unfavorable)
694,744	684,552	(10,192)	(1.5%)	Case/Disease Management Department Total	5,461,964	5,644,530	182,567	3.2%
5,461,174	1,534,108	(3,927,067)	(256.0%)	Medical Services Department Total	19,408,099	16,502,581	(2,905,518)	(17.6%)
1,226,924	1,616,749	389,825	24.1%	Quality Management Department Total	7,261,463	10,138,519	2,877,056	28.4%
280,564	327,185	46,621	14.2%	HCS Behavioral Health Department Total	2,459,217	2,639,812	180,595	6.8%
141,097	150,293	9,195	6.1%	Pharmacy Services Department Total	1,270,402	1,319,352	48,950	3.7%
58,815	61,931	3,116	5.0%	Regulatory Readiness Total	554,232	594,443	40,211	6.8%
$8,838,247	**$5,258,190**	**($3,580,057)**	**(68.1%)**	**15 - Other Benefits & Services**	**$44,637,159**	**$45,118,226**	**$481,066**	**1.1%**
(1,118,000)	(1,083,971)	34,029	(3.1%)	Reinsurance Recoveries	(10,909,311)	(8,548,228)	2,361,083	(27.6%)
1,397,291	1,445,295	48,004	3.3%	Reinsurance Premium	10,547,390	10,511,859	(35,531)	(0.3%)
$279,291	**$361,324**	**$82,033**	**22.7%**	**16- Reinsurance Expense**	**($361,921)**	**$1,963,631**	**$2,325,552**	**118.4%**
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%**
$163,283,392	**$156,188,986**	**($7,094,406)**	**(4.5%)**	**18 - TOTAL MEDICAL EXPENSES**	**$1,244,046,385**	**$1,232,425,693**	**($11,620,691)**	**(0.9%)**

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend							
Category of Aid	**Mar 2024**	**% of Medi-Cal**	**Independent (Direct)**	**AHS (Direct)**	**CFMG**	**CHCN**	**Kaiser**
Adults	63,314	16%	13,366	14,286	5	35,657	-
Child	110,268	28%	9,679	13,409	40,473	46,707	-
SPD	34,972	9%	11,344	5,488	1,431	16,709	-
ACA OE	148,065	37%	25,272	53,178	1,499	68,116	-
Duals	40,222	10%	26,477	2,860	5	10,880	-
LTC	216	0%	201	6	-	9	-
LTC-Dual	1,307	0%	1,305	-	-	2	-
Medi-Cal	398,364		87,644	89,227	43,413	178,080	-
Group Care	5,620		2,146	862	-	2,612	-
Total	**403,984**	**100%**	**89,790**	**90,089**	**43,413**	**180,692**	**-**
Medi-Cal %	98.6%		97.6%	99.0%	100.0%	98.6%	0%
Group Care %	1.4%		2.4%	1.0%	0.0%	1.4%	0.0%
		Network Distribution	*22.2%*	*22.3%*	*10.7%*	*44.7%*	*0.0%*
			% Direct:	**45%**		**% Delegated:**	**55%**

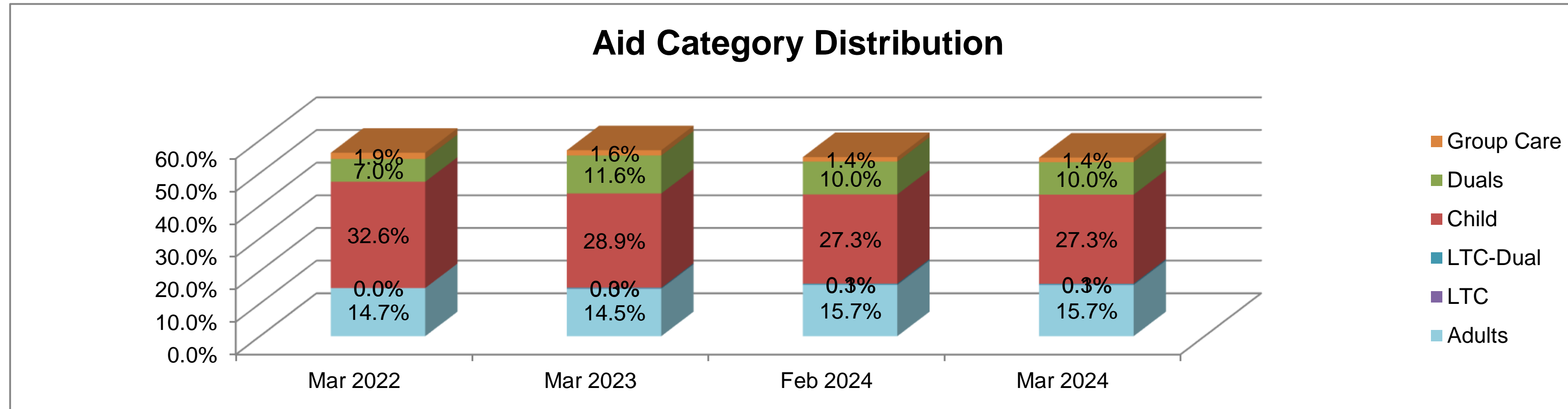




Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

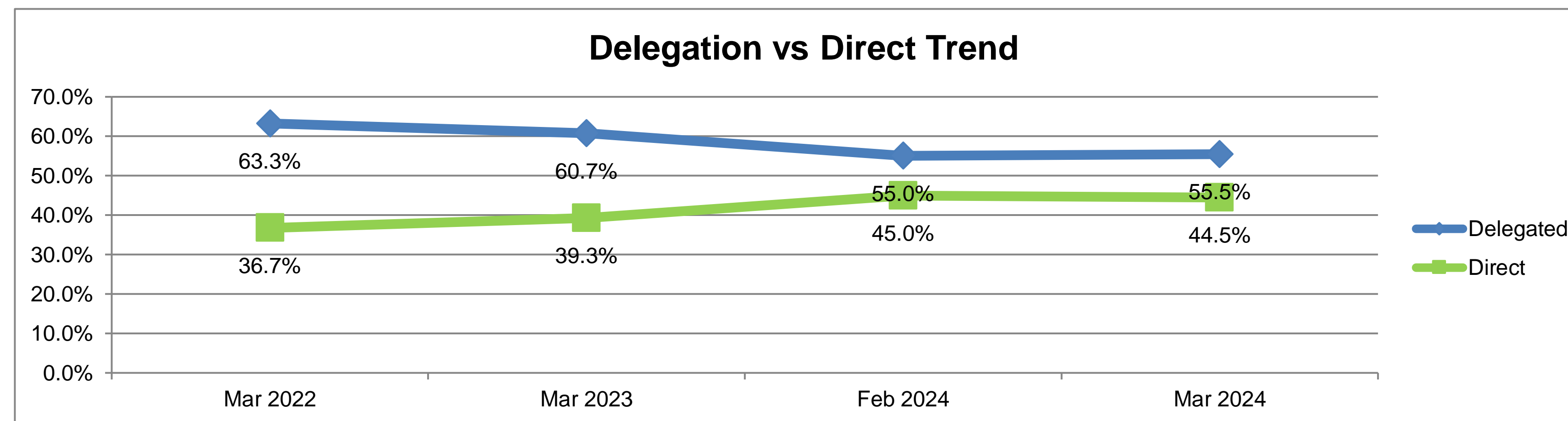
Category of Aid Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Category of Aid	Mar 2022	Mar 2023	Feb 2024	Mar 2024	Mar 2022	Mar 2023	Feb 2024	Mar 2024	Mar 2022 to Mar 2023	Mar 2023 to Mar 2024	Feb 2024 to Mar 2024
Adults	45,228	51,516	63,130	63,314	14.7%	14.5%	15.7%	15.7%	13.9%	22.9%	0.3%
Child	99,888	102,510	109,957	110,268	32.6%	28.9%	27.3%	27.3%	2.6%	7.6%	0.3%
SPD	26,823	31,021	34,876	34,972	8.7%	8.7%	8.7%	8.7%	15.7%	12.7%	0.3%
ACA OE	107,648	121,852	146,758	148,065	35.1%	34.3%	36.5%	36.7%	13.2%	21.5%	0.9%
Duals	21,350	41,246	40,403	40,222	7.0%	11.6%	10.0%	10.0%	93.2%	-2.5%	-0.4%
LTC	-	143	217	216	0.0%	0.0%	0.1%	0.1%	0.0%	51.0%	-0.5%
LTC-Dual	-	948	1,329	1,307	0.0%	0.3%	0.3%	0.3%	0.0%	37.9%	-1.7%
Medi-Cal Total	300,937	349,236	396,670	398,364	98.1%	98.4%	98.6%	98.6%	16.0%	14.1%	0.4%
Group Care	5,850	5,723	5,608	5,620	1.9%	1.6%	1.4%	1.4%	-2.2%	-1.8%	0.2%
Total	**306,787**	**354,959**	**402,278**	**403,984**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**15.7%**	**13.8%**	**0.4%**



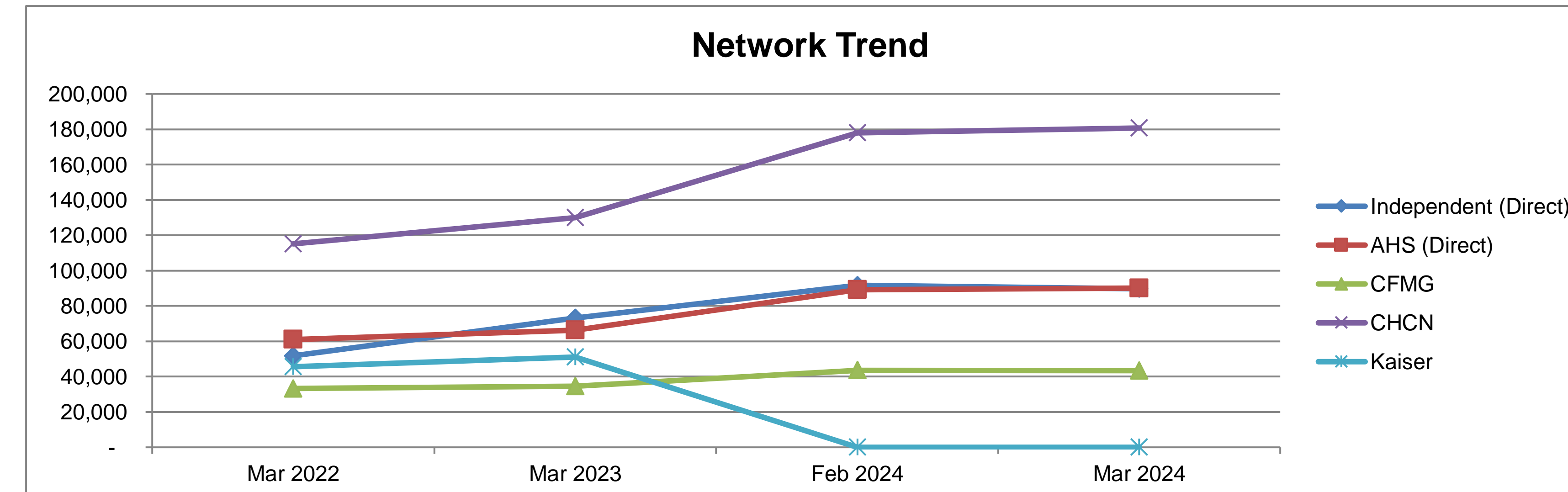
Delegation vs Direct Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Members	Mar 2022	Mar 2023	Feb 2024	Mar 2024	Mar 2022	Mar 2023	Feb 2024	Mar 2024	Mar 2022 to Mar 2023	Mar 2023 to Mar 2024	Feb 2024 to Mar 2024
Delegated	194,046	215,530	221,438	224,105	63.3%	60.7%	55.0%	55.5%	11.1%	4.0%	1.2%
Direct	112,741	139,429	180,840	179,879	36.7%	39.3%	45.0%	44.5%	23.7%	29.0%	-0.5%
Total	**306,787**	**354,959**	**402,278**	**403,984**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**15.7%**	**13.8%**	**0.4%**



Network Trend

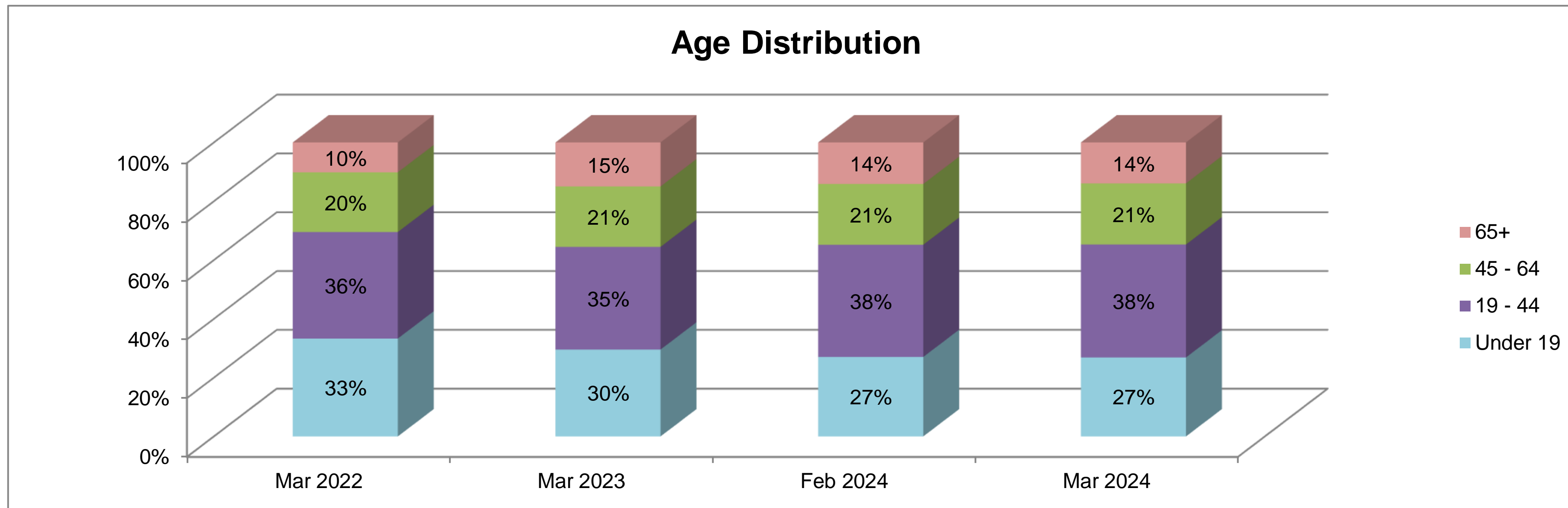
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Network	Mar 2022	Mar 2023	Feb 2024	Mar 2024	Mar 2022	Mar 2023	Feb 2024	Mar 2024	Mar 2022 to Mar 2023	Mar 2023 to Mar 2024	Feb 2024 to Mar 2024
Independent (Direct)	51,767	73,153	91,671	89,790	16.9%	20.6%	22.8%	22.2%	41.3%	22.7%	-2.1%
AHS (Direct)	60,974	66,276	89,169	90,089	19.9%	18.7%	22.2%	22.3%	8.7%	35.9%	1.0%
CFMG	33,293	34,547	43,528	43,413	10.9%	9.7%	10.8%	10.7%	3.8%	25.7%	-0.3%
CHCN	115,125	129,908	177,910	180,692	37.5%	36.6%	44.2%	44.7%	12.8%	39.1%	1.6%
Kaiser	45,628	51,075	-	-	14.9%	14.4%	0.0%	0.0%	11.9%	-100.0%	0.0%
Total	**306,787**	**354,959**	**402,278**	**403,984**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**15.7%**	**13.8%**	**0.4%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

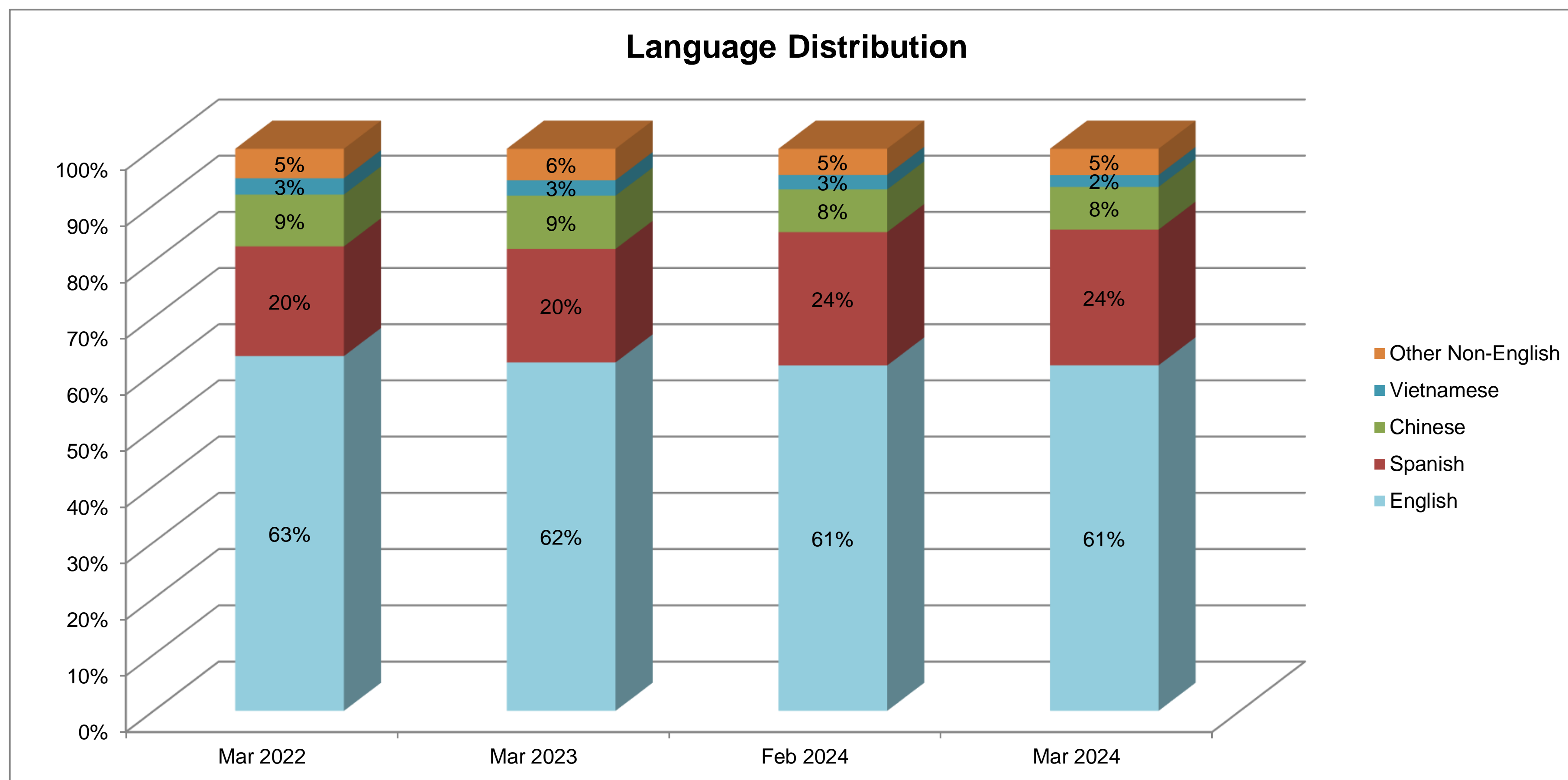
Age Category Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Age Category	**Mar 2022**	**Mar 2023**	**Feb 2024**	**Mar 2024**	**Mar 2022**	**Mar 2023**	**Feb 2024**	**Mar 2024**	**Mar 2022 to Mar 2023**	**Mar 2023 to Mar 2024**	**Feb 2024 to Mar 2024**
Under 19	102,146	104,866	109,248	108,522	33%	30%	27%	27%	3%	3%	-1%
19 - 44	111,172	124,034	154,277	155,233	36%	35%	38%	38%	12%	25%	1%
45 - 64	62,347	72,979	83,583	83,951	20%	21%	21%	21%	17%	15%	0%
65+	31,122	53,080	57,113	56,278	10%	15%	14%	14%	71%	6%	-1%
Total	**306,787**	**354,959**	**404,221**	**403,984**	**100%**	**100%**	**100%**	**100%**	**16%**	**14%**	**0%**



Language Trend

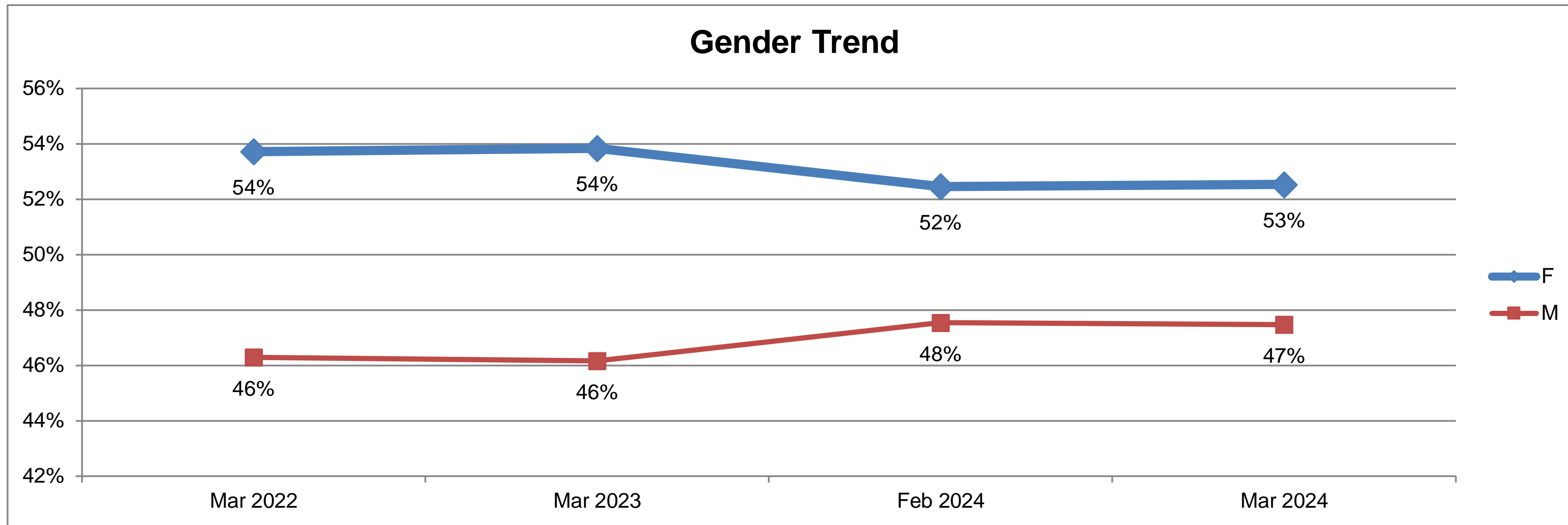
	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Language	**Mar 2022**	**Mar 2023**	**Feb 2024**	**Mar 2024**	**Mar 2022**	**Mar 2023**	**Feb 2024**	**Mar 2024**	**Mar 2022 to Mar 2023**	**Mar 2023 to Mar 2024**	**Feb 2024 to Mar 2024**
English	193,534	219,911	248,268	248,207	63%	62%	61%	61%	14%	13%	0%
Spanish	59,913	71,737	95,947	97,569	20%	20%	24%	24%	20%	36%	2%
Chinese	28,316	33,645	30,706	30,760	9%	9%	8%	8%	19%	-9%	0%
Vietnamese	8,888	9,773	10,459	8,536	3%	3%	3%	2%	10%	-13%	-18%
Other Non-English	16,136	19,893	18,841	18,912	5%	6%	5%	5%	23%	-5%	0%
Total	**306,787**	**354,959**	**404,221**	**403,984**	**100%**	**100%**	**100%**	**100%**	**16%**	**14%**	**0%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

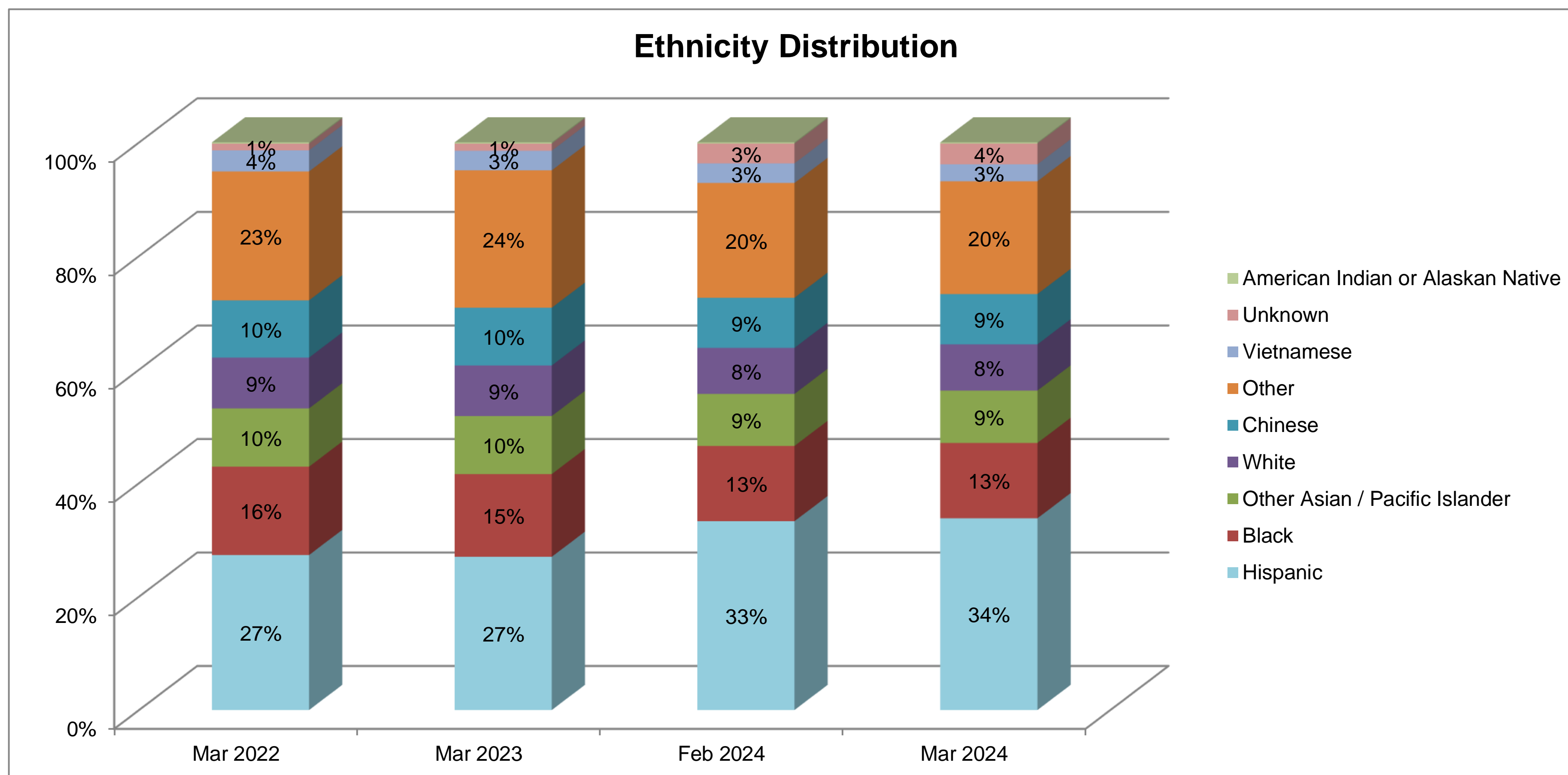
Gender Trend

Gender	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Mar 2022	Mar 2023	Feb 2024	Mar 2024	Mar 2022	Mar 2023	Feb 2024	Mar 2024	Mar 2022 to Mar 2023	Mar 2023 to Mar 2024	Feb 2024 to Mar 2024
F	164,784	191,101	212,039	212,211	54%	54%	52%	53%	16%	11%	0%
M	142,003	163,858	192,182	191,773	46%	46%	48%	47%	15%	17%	0%
Total	**306,787**	**354,959**	**404,221**	**403,984**	**100%**	**100%**	**100%**	**100%**	**16%**	**14%**	**0%**



Ethnicity Trend

Ethnicity	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Mar 2022	Mar 2023	Feb 2024	Mar 2024	Mar 2022	Mar 2023	Feb 2024	Mar 2024	Mar 2022 to Mar 2023	Mar 2023 to Mar 2024	Feb 2024 to Mar 2024
Hispanic	83,813	95,858	134,527	136,557	27%	27%	33%	34%	14%	42%	2%
Black	47,769	51,755	53,620	53,627	16%	15%	13%	13%	8%	4%	0%
Other Asian / Pacific Islander	31,540	36,336	37,048	37,287	10%	10%	9%	9%	15%	3%	1%
White	27,426	31,596	32,783	32,857	9%	9%	8%	8%	15%	4%	0%
Chinese	30,921	36,098	35,685	35,796	10%	10%	9%	9%	17%	-1%	0%
Other	69,621	85,859	81,682	80,230	23%	24%	20%	20%	23%	-7%	-2%
Vietnamese	11,419	12,260	13,958	12,036	4%	3%	3%	3%	7%	-2%	-14%
Unknown	3,633	4,460	14,108	14,794	1%	1%	3%	4%	23%	232%	5%
American Indian or Alaskan Native	645	737	810	800	0%	0%	0%	0%	14%	9%	-1%
Total	**306,787**	**354,959**	**404,221**	**403,984**	**100%**	**100%**	**100%**	**100%**	**16%**	**14%**	**0%**



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

Medi-Cal By City

City	Mar 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	161,344	41%	24,531	42,483	17,380	76,950	-
Hayward	62,986	16%	12,500	16,578	7,334	26,574	-
Fremont	36,195	9%	14,911	6,799	1,985	12,500	-
San Leandro	33,074	8%	8,094	5,691	4,293	14,996	-
Union City	14,628	4%	5,410	2,629	848	5,741	-
Alameda	14,092	4%	3,441	2,538	2,070	6,043	-
Berkeley	15,465	4%	4,384	2,101	1,759	7,221	-
Livermore	12,640	3%	2,006	709	2,170	7,755	-
Newark	9,177	2%	2,730	4,011	467	1,969	-
Castro Valley	9,407	2%	2,425	1,689	1,373	3,920	-
San Lorenzo	7,261	2%	1,448	1,620	820	3,373	-
Pleasanton	7,222	2%	1,792	454	775	4,201	-
Dublin	7,336	2%	1,982	463	887	4,004	-
Emeryville	2,747	1%	619	612	440	1,076	-
Albany	2,550	1%	700	270	550	1,030	-
Piedmont	495	0%	130	191	53	121	-
Sunol	87	0%	25	15	6	41	-
Antioch	52	0%	13	19	6	14	-
Other	1,606	0%	503	355	197	551	-
Total	**398,364**	**100%**	**87,644**	**89,227**	**43,413**	**178,080**	**-**

Group Care By City

City	Mar 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	1,767	31%	367	326	-	1,074	-
Hayward	623	11%	291	138	-	194	-
Fremont	626	11%	437	59	-	130	-
San Leandro	583	10%	239	86	-	258	-
Union City	300	5%	190	44	-	66	-
Alameda	292	5%	94	23	-	175	-
Berkeley	162	3%	49	14	-	99	-
Livermore	103	2%	35	3	-	65	-
Newark	134	2%	79	33	-	22	-
Castro Valley	191	3%	79	30	-	82	-
San Lorenzo	134	2%	45	21	-	68	-
Pleasanton	60	1%	15	2	-	43	-
Dublin	112	2%	37	5	-	70	-
Emeryville	37	1%	14	5	-	18	-
Albany	21	0%	11	1	-	9	-
Piedmont	11	0%	3	-	-	8	-
Sunol	2	0%	2	-	-	-	-
Antioch	22	0%	7	4	-	11	-
Other	440	8%	152	68	-	220	-
Total	**5,620**	**100%**	**2,146**	**862**	**-**	**2,612**	**-**

Total By City

City	Mar 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	163,111	40%	24,898	42,809	17,380	78,024	-
Hayward	63,609	16%	12,791	16,716	7,334	26,768	-
Fremont	36,821	9%	15,348	6,858	1,985	12,630	-
San Leandro	33,657	8%	8,333	5,777	4,293	15,254	-
Union City	14,928	4%	5,600	2,673	848	5,807	-
Alameda	14,384	4%	3,535	2,561	2,070	6,218	-
Berkeley	15,627	4%	4,433	2,115	1,759	7,320	-
Livermore	12,743	3%	2,041	712	2,170	7,820	-
Newark	9,311	2%	2,809	4,044	467	1,991	-
Castro Valley	9,598	2%	2,504	1,719	1,373	4,002	-
San Lorenzo	7,395	2%	1,493	1,641	820	3,441	-
Pleasanton	7,282	2%	1,807	456	775	4,244	-
Dublin	7,448	2%	2,019	468	887	4,074	-
Emeryville	2,784	1%	633	617	440	1,094	-
Albany	2,571	1%	711	271	550	1,039	-
Piedmont	506	0%	133	191	53	129	-
Sunol	89	0%	27	15	6	41	-
Antioch	74	0%	20	23	6	25	-
Other	2,046	1%	655	423	197	771	-
Total	**403,984**	**100%**	**89,790**	**90,089**	**43,413**	**180,692**	**-**

Operations

Ruth Watson

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

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

Date: **May 10th, 2024**

Subject: **Operations Report**

Member Services

- 12-Month Trend Blended Summary:
  - The Member Services Department received a twenty-three percent (23%) increase in calls in April 2024, totaling twenty thousand nine hundred fifty-one (20,951) compared to sixteen thousand two hundred twenty-nine (16,229) in April 2023.
  - The abandonment rate for April 2024 was nine percent (9%), compared to eighteen percent (18%) in April 2023.
  - The Department's service level was eighty-four percent (84%) in April 2024, compared to sixty-nine percent (69%) in April 2023. The average speed to answer (ASA) was fifty seconds (00:50) compared to one minute and forty-eight seconds (01:48) in April 2023. The Department continues to recruit to fill open positions. Customer Service support service vendor continues to provide overflow call center support.
  - The average talk time (ATT) was six minutes and fifty-seven seconds (06:57) for April 2024 compared to six minutes and one second (06:01) for April 2023.
  - Ninety-eight percent (98%) of calls were answered within 10 minutes for April 2024 compared to ninety-seven percent (97%) in April 2023.
  - Outbound calls totaled nine thousand and ninety-eight (9098) in April 2024 compared to six thousand four hundred and seventy-one (6471) in April 2023.
  - The top five call reasons for April 2024 were: 1). Change of PCP, 2). Eligibility/Enrollment, 3). Benefits, 4). Provider Network, 5). ID card requests. The top five call reasons for April 2023 were: 1). Change of PCP, 2). Benefits, 3)., Eligibility/Enrollment, 4). Kaiser, 5). ID Card Requests.
  - Utilization for the member automated eligibility IVR system totaled one thousand four hundred ninety-two (1492) in April 2024 compared to one thousand one hundred and forty-seven (1147) in April 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 three hundred ninety-five (1395) web-based requests in April 2024 compared to eight hundred fifty-four (854) in April 2023. The top three web reason requests for April 2024 were: 1). Change of PCP, 2). ID Card Requests, 3). Update Contact Information. Forty-two (42) members were assisted in-person in April 2024.

- Member Services Behavioral Health:

  - The Member Services Behavioral Health Unit received a total of one thousand six hundred sixty-one (1661) calls in April 2024.
  - The abandonment rate was twenty-seven percent (27%).
  - The service level was fifty-seven percent (57%).
  - The average speed to answer (ASA) was three minutes six seconds. (3:06).
  - Calls answered in 10 minutes were ninety percent (90%).
  - The Average Talk Time (ATT) was nine minutes and thirty-four seconds (09:34). ATT are impacted by the DHCS requirements to complete a screening for all members initiating MH services for the first time.
  - One thousand four hundred forty-six (1446) outbound calls were completed in April 2024.
  - Three hundred twelve (312) outreach campaigns were completed in April 2024, including twenty-five (25) BH/ABA screenings.
  - One hundred sixty-nine (169) screenings were completed in April 2024.
  - Fifty-two (52) referrals were made to the County (ACCESS) in April 2024.
  - Nineteen (19) members were referred to Center Point for SUD services in April 2024.

Claims

- 12-Month Trend Summary:

  - The Claims Department received 322,786 claims in April 2024 compared to 218,296 in April 2023.
  - The Auto Adjudication was 86.9% in April 2024 compared to 83.4% in April 2023.
  - Claims compliance for the 30-day turn-around time was 92.5% in April 2024 compared to 98.6% in April 2023. The 45-day turn-around time was 100% in April 2024 compared to 99.9% in April 2023.

- Monthly Analysis:

  - In the month of April, we received a total of 322,786 claims in the HEALTHsuite system. This represents an increase of 4.65% from the prior month and is higher, by 104,490 claims, than the number of claims received in April 2023; the higher volume of received claims remains attributed to the increased membership.
  - We received 89.59% of claims via EDI and 10.41% of claims via paper.
  - During the month of April, 100% of our claims were processed within 45 working days.
  - The Auto Adjudication rate was 86.9% for the month of April.

Provider Services

- 12-Month Trend Summary:
  - The Provider Services department's call volume in April 2024 was 8,064 calls compared to 6,245 calls in April 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 199 calls/visits during April 2024.
  - The Provider Services department answered 5,789 calls for April 2024 and made 831 outbound calls.

Credentialing

- 12-Month Trend Summary:
  - At the Peer Review and Credentialing (PRCC) meeting held on April 16, 2024, there were one hundred and fourteen (114) initial network providers approved; seven (7) primary care providers, nine (9) specialists, nine (9) ancillary providers, ten (10) midlevel providers, and eighty (80) behavioral health providers. Additionally, forty (40) providers were re-credentialed at this meeting; eight (8) primary care providers, twenty-three (23) specialists, one (1) ancillary provider, and eight (8) midlevel providers.

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

Provider Dispute Resolution

- 12-Month Trend Summary:
  - In April 2024, the Provider Dispute Resolution (PDR) team received 1,925 PDRs versus 1,618 in April 2023.
  - The PDR team resolved 1,601 cases in April 2024 compared to 685 cases in April 2023.
  - In April 2024, the PDR team upheld 67% of cases versus 72% in April 2023.
  - The PDR team resolved 99.6% of cases within the compliance standard of 95% within 45 working days in April 2024 compared to 99.7% in April 2023.

- Monthly Analysis:
    - AAH received 1,925 PDRs in April 2024.
    - In the month of April 1,601 PDRs were resolved. Out of the 1,601 PDRs, 1,078 were upheld and 523 were overturned.
    - The overturn rate for PDRs was 33%, which did not meet our goal of 25% or less.
    - Below is a breakdown of the various causes for the 523 overturned PDRs. Please note that there were two primary areas that caused the Department to miss their goal of 25% or less. The first was due to the Member Other Health Coverage (OHC) corrections, with 105 cases that had been denied incorrectly. The second was due to 106 physical therapy claims denied incorrectly for no authorization. The combined volumes of these two primary overturn reasons prevented us from achieving the goal of 25% or less overturned PDRs during April.

        - System Related Issues 16% (83 cases)
            - 61 cases: General configuration issues, i.e., Not Covered, Modifier, Eligibility. (12%)
            - 7 cases: LTC SOC Recoupment (1%)
            - 15 cases: CES (3%)

        - OHC Related Issues 21% (105 cases)
            - 105 cases: OHC Member TPL data, incorrect primary EOB not matching, incorrect manual entry. (21%)

        - Authorization Related Issues 39% (206 cases)
            - 43 cases: Processor errors when auth on file. (8%)
            - 8 cases: System (2%)
            - 106 cases: PTPN (physical therapy) (20%)
            - 7 cases: CFMG (1%)
            - 42 cases: UM/retro review (8%)

        - Additional Documentation Provided 3% (18 cases)
            - 13 cases: Duplicate claim documentation that allows for claims to be adjusted. (2%)
            - 5 cases: Timely Filing (1%)

        - Incorrect Rates 10% (49 cases)
            - 9 cases: System (2%)
            - 35 cases: Hospice (7%)
            - 5 cases: LOA (1%)

        - Claim Processing Errors 11% (62 cases)
            - 18 cases: Duplicate (3%)
            - 44 cases: Various Processor errors. (8%)

- 1,596 out of 1,601 cases were resolved within 45 working days resulting in a 99.6% compliance rate.
- The average turnaround time for resolving PDRs in April was 43 days.
- There were 3,808 PDRs pending resolution as of 04/30/2024 with no cases older than 45 working days.

Community Relations and Outreach

- 12-Month Trend Summary:
    - In April 2024, the Alliance completed 975 member orientation outreach calls and 142 member orientations by phone.
    - The C&O Department reached 586 people (87% identified as Alliance members) during outreach activities, compared to 320 individuals (40% identified as Alliance members) in April 2023.
    - The C&O Department spent $0 in donations, fees, and/or sponsorships, compared to $25.00 in April 2023.
    - The C&O Department reached members in12 cities/unincorporated areas throughout Alameda County, the Bay Area, and the U.S., compared to 12 cities in April 2023.
- Monthly Analysis:
    - In April 2024, the C&O Department completed 975 member orientation outreach calls, 142 member orientations by phone, 3 member education events, and 1 Alliance website inquiry.
    - Among the 586 people reached, 87% identified as Alliance members.
    - In April 2024, the C&O Department reached members in 12 locations throughout Alameda County, the Bay Area, and the U.S.
    - Please see attached **Addendum A**.

Operations

Supporting Documents

Member Services

Blended Call Results

Blended Results	April 2024
Incoming Calls (R/V)	20,951
Abandoned Rate (R/V)	9%
Answered Calls (R/V)	19,165
Average Speed to Answer (ASA)	00:50
Calls Answered in 30 Seconds (R/V)	84%
Average Talk Time (ATT)	06:57
Calls Answered in 10 minutes	98%
Outbound Calls	9098

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

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

Member Services

MSBH	April 2024
Incoming Calls (R/V)	1614
Abandoned Rate (R/V)	27%
Answered Calls (R/V)	1175
Average Speed to Answer (ASA)	03:06
Calls Answered in 30 Seconds (R/V)	57%
Average Talk Time (ATT)	09:34
Calls Answered in 10 minutes	90%
Outbound Calls	1446
Screenings Completed	169
ACBH Referrals	52
SUD referrals to Center Point	19

Claims Department
March 2024 Final and April 2024 Final

METRICS

Claims Compliance	Mar-24	Apr-24
90% of clean claims processed within 30 calendar days	95.6%	92.5%
95% of all claims processed within 45 working days	100.0%	100.0%

Claims Volume (Received)	Mar-24	Apr-24
Paper claims	36,087	33,587
EDI claims	272,366	289,199
Claim Volume Total	**308,453**	**322,786**

Percentage of Claims Volume by Submission Method	Mar-24	Apr-24
% Paper	11.70%	10.41%
% EDI	88.30%	89.59%

Claims Processed	Mar-24	Apr-24
HEALTHsuite Paid (original claims)	169,061	214,097
HEALTHsuite Denied (original claims)	59,799	76,034
HEALTHsuite Original Claims Sub-Total	**228,860**	**290,131**
HEALTHsuite Adjustments	3,000	15,177
HEALTHsuite Total	**231,860**	**305,308**

Claims Expense	Mar-24	Apr-24
Medical Claims Paid	$110,283,537	$115,809,477
Interest Paid	$62,198	$136,578

Auto Adjudication	Mar-24	Apr-24
Claims Auto Adjudicated	185,783	25,218
% Auto Adjudicated	81.2%	86.9%

Average Days from Receipt to Payment	Mar-24	Apr-24
HEALTHsuite	14	13

Pended Claim Age	Mar-24	Apr-24
0-29 calendar days	32,840	38,453
HEALTHsuite		
30-59 calendar days	1,122	572
HEALTHsuite		
Over 60 calendar days	24	3
HEALTHsuite		

Overall Denial Rate	Mar-24	Apr-24
Claims denied in HEALTHsuite	59,799	76,034
% Denied	25.8%	24.9%

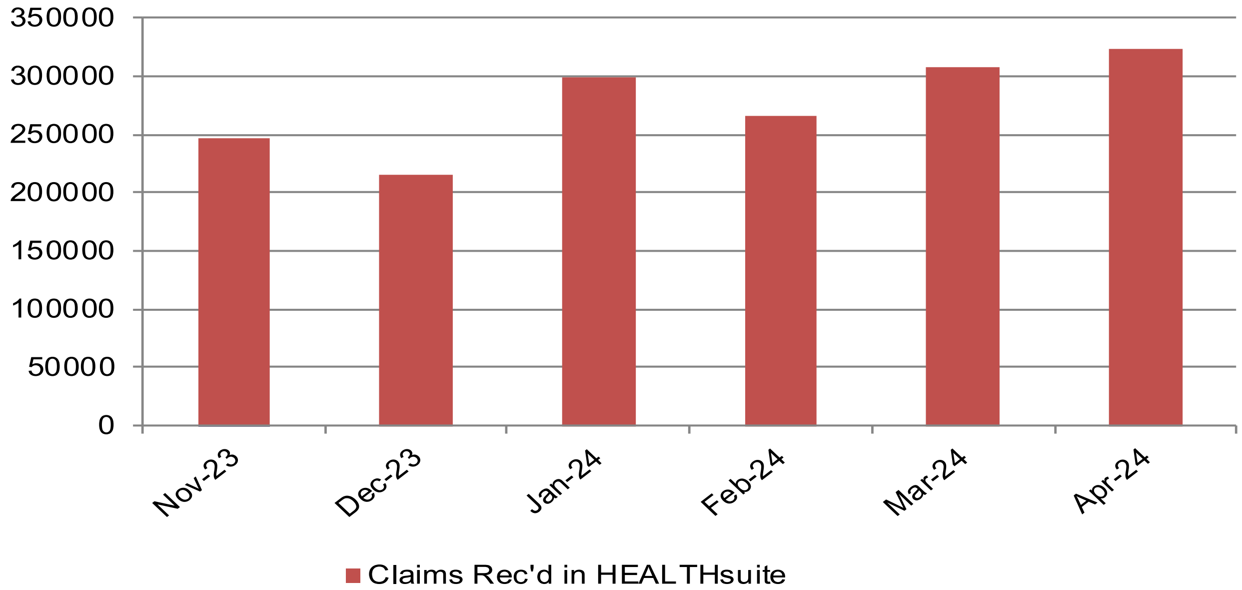
Claims Department
March 2024 Final and April 2024 Final

Apr-24

Top 5 HEALTHsuite Denial Reasons	% of all denials
Responsibility of Provider	23%
Duplicate Claims	19%
No Benefits Found For Dates of Service	11%
Non-Covered Benefit For This Plan	11%
Must Submit Paper Claim With Copy of Primary Payor EOB	8%
% Total of all denials	**72%**

Claims Received By Month

Run Date	12/1/2023	1/1/2024	2/1/2024	3/1/2024	4/1/2024	5/1/2024
Claims Received Through	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**Apr-24**
Claims Rec'd in HEALTHsuite	247,537	215,246	298,465	266,339	308,453	322,786



Claims Year Over Year Summary

Monthly Results	Regulatory Requirement	AAH Goal
Claims Compliance - comparing April 2024 to April 2023 as follows: 30 Days - 92.5% (2024) vs 98.6% (2023) 45 Days - 100% (2024) vs 99.9% (2023) 90 Days - 99.9% (2024) vs 99.9% (2023)	90% of clean claims in 30 calendar days 95% of all claims in 45 working days 99% of all claims in 90 calendar days	90% of clean claims in 30 calendar days 95% of all claims in 45 working days 99% of all claims in 90 calendar days
Claims Received - AAH received 322,786 claims in April 2024 vs 218,296 in April 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 290,131 in April 2024 (22 working days) vs 189,022 in April 2023 (20 working days).	N/A	N/A
Medical Claims Expense - the amount of paid claims in April 2024 was $115,809,477 (4 check runs) vs $71,220,841 in April 2023 (4 check runs).	N/A	N/A
Interest Expense - the amount of interest paid in April 2024 was $136,578 vs $41,843 in April 2023.	N/A	< $496,000 per fiscal year or $30,000 per month
Auto Adjudication - the AAH rate in April 2024 was 86.9% vs 83.4% in April 2023.	N/A	85% or higher
Average Days from Receipt to Payment - the average # of days from receipt to payment in April 2024 was 13 days vs 19 days in April 2023.	N/A	<= 25 days

Claims Year Over Year Summary

Pended Claim Age - comparing April 2024 to April 2023 as follows: 0-30 calendar days - 38,453 (2024) vs 28,436 (2023) 30-59 calendar days - 572 (2024) vs 936 (2023) Over 60 calendar days - 3 (2024) vs 225 (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 April 2024 to April 2023.	N/A	N/A

Provider Relations Dashboard April 2024

Alliance Provider Relations Staff	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Incoming Calls (PR)	10695	9359	9033	8064								
Abandoned Calls	4806	4325	3272	2275								
Answered Calls (PR)	5889	5034	5761	5789								
Recordings/Voicemails	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Incoming Calls (R/V)	413	2551	1970	1595								
Abandoned Calls (R/V)												
Answered Calls (R/V)	413	2551	1970	1595								
Outbound Calls	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Outbound Calls	1140	1358	1298	831								
N/A												
Outbound Calls	1140	1358	1298	831								
Totals	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Total Incoming, R/V, Outbound Calls	11835	13268	12301	10490								
Abandoned Calls	4806	4325	3272	2275								
Total Answered Incoming, R/V, Outbound Calls	7442	8993	9029	8215								

Provider Relations Dashboard April 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%								
Benefits	4.3%	3.6%	2.4%	3.0%								
Claims Inquiry	38.5%	41.7%	45.4%	40.1%								
Change of PCP	3.3%	3.9%	2.6%	3.6%								
Check Tracer	1.1%	1.1%	1.2%	1.0%								
Complaint/Grievance (includes PDR's)	4.4%	4.3%	6.1%	5.8%								
Contracts/Credentialing	1.1%	1.0%	1.5%	1.4%								
Demographic Change	0.0%	0.0%	0.0%	0.0%								
Eligibility - Call from Provider	23.0%	20.5%	17.5%	20.9%								
Exempt Grievance/ G&A	0.6%	0.1%	0.1%	0.0%								
General Inquiry/Non member	0.0%	0.0%	0.0%	0.0%								
Health Education	0.0%	0.0%	0.0%	0.0%								
Intrepreter Services Request	0.5%	0.6%	0.7%	1.1%								
Provider Portal Assistance	3.7%	3.8%	3.2%	3.2%								
Pharmacy	0.1%	0.1%	0.1%	0.2%								
Prop 56	0.2%	0.4%	0.3%	0.3%								
Provider Network Info	0.0%	0.0%	0.1%	0.0%								
Transportation Services	0.2%	0.2%	0.1%	0.1%								
Transferred Call	0.0%	0.0%	0.0%	0.1%								
All Other Calls	13.4%	13.1%	13.1%	13.1%								
TOTAL	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								
Contracting/Credentialing	9	21	50	26								
Drop-ins	27	49	29	30								
JOM's	3	2	2	2								
New Provider Orientation	104	103	140	101								
Quarterly Visits	0	0	0	0								
UM Issues	0	0	0	0								
Total Field Visits	156	231	259	199	0	0	0	0	0	0	0	0

ALLIANCE NETWORK SUMMARY - CURRENTLY CREDENTIALED PRACTITIONERS						
Practitioners		BH/ABA 1,722	AHP 542	PCP 386	SPEC 713	PCP/SPEC 13
AAH/AHS/CHCN Breakdown			AAH 2,183	AHS 273	CHCN 585	COMBINATION OF GROUPS 355
Facilities	**420**					

VENDOR SUMMARY **Credentialing Verification Organization, Symplyr CVO**	**Number**	**Time to Process - 30 Calendar Days**	**Goal - 25 Business Days**	**Goal - 98% Accuracy**	**Compliant**
Initial Files in Process	119	Y	Y	Y	Y
Recred Files in Process	101	Y	Y	Y	Y
Expirables updated **Insurance, License, DEA, Board Certifications**					Y
Files currently in process	**220**				

April 2024 Peer Review and Credentialing Committee Approvals	
Initial Credentialing	**Number**
PCP	7
SPEC	8
ANCILLARY	9
MID-LEVEL/ALLIED HEALTH	10
BH/ABA	80
Sub-total	**114**
Recredentialing	
PCP	8
SPEC	23
ANCILLARY	1
MID-LEVEL/ALLIED HEALTH	8
Sub-total	**40**
TOTAL	**154**

April 2024 Facility Approvals	
Initial Credentialing	**3**
Recredentialing	**13**
Sub-total	**16**
Facility Files in Process	**32**

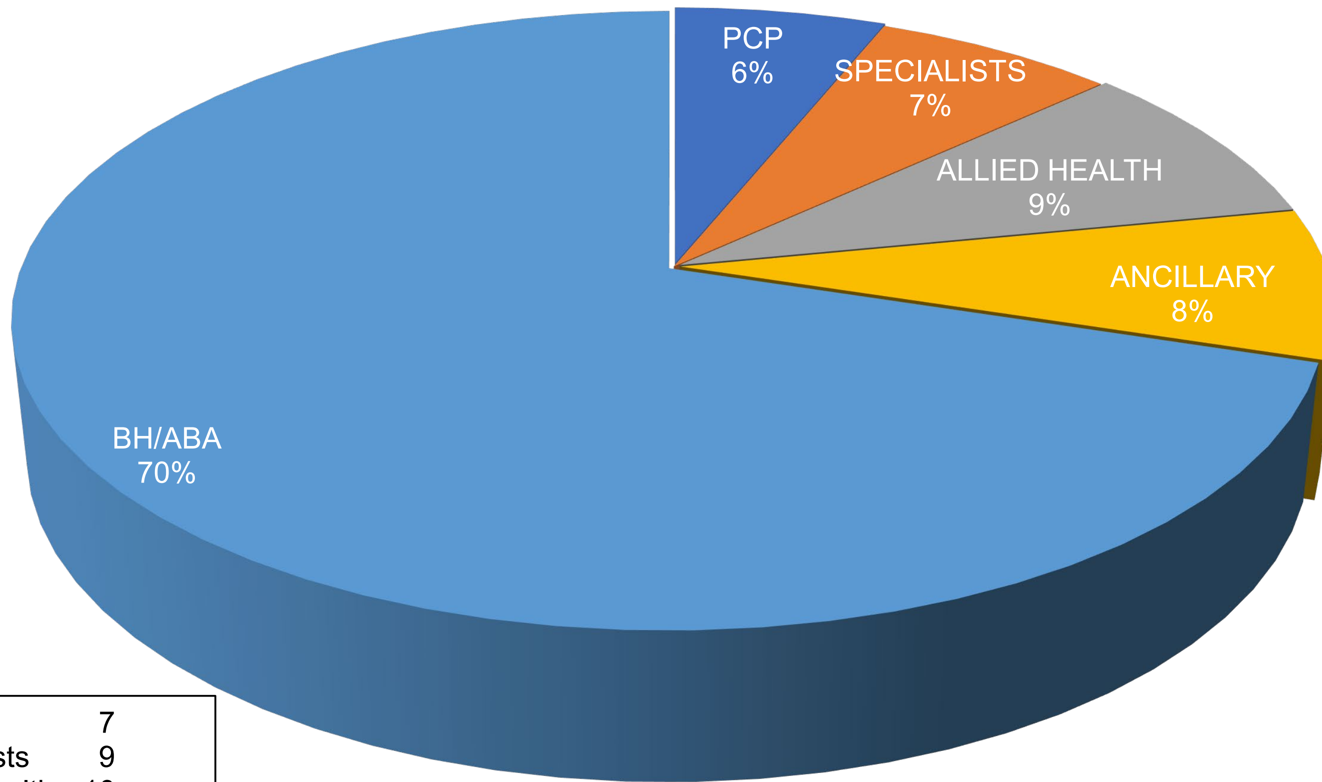
April 2024 Employee Metrics (5 FTEs)	**Goal**		**Met (Y/N)**
File Processing	Timely processing within 3 days of receipt		Y
Credentialing Accuracy	<3% error rate		Y
DHCS, DMHC, CMS, NCQA Compliant	98%		Y
MBC Monitoring	Timely processing within 3 days of receipt		Y

LAST NAME	FIRST NAME	CATEGORY	INITIAL/RE-CRED	CRED DATE
Adedayo	Kehinde	BH/ABA-Telehealth	INITIAL	4/16/2024
Akramian	Wendy	BH/ABA	INITIAL	4/16/2024
Alvarez	Ilian	BH/ABA	INITIAL	4/16/2024
Anderson	Karyn	BH/ABA	INITIAL	4/16/2024
Arellano	Leah	BH/ABA	INITIAL	4/16/2024
Arriaga	Amber	BH/ABA-Telehealth	INITIAL	4/16/2024
Atwal	Monique	BH/ABA-Telehealth	INITIAL	4/16/2024
Bagga-Malhotra	Shagun	Primary Care Physician	INITIAL	4/16/2024
Bairos	Rene	BH/ABA-Telehealth	INITIAL	4/16/2024
Bakker	Danica	BH/ABA-Telehealth	INITIAL	4/16/2024
Ballard	April	BH/ABA-Telehealth	INITIAL	4/16/2024
Barrera	Jennifer	Allied Health	INITIAL	4/16/2024
Bauerle	Brittany	BH/ABA-Telehealth	INITIAL	4/16/2024
Beck	Alexandra	BH/ABA-Telehealth	INITIAL	4/16/2024
Borromeo	Christian	BH/ABA-Telehealth	INITIAL	4/16/2024
Bradshaw	Jamison	BH/ABA	INITIAL	4/16/2024
Brennan	Catherine	BH/ABA-Telehealth	INITIAL	4/16/2024
Busby	Rachelle	BH/ABA-Telehealth	INITIAL	4/16/2024
Carrera	William	Specialist	INITIAL	4/16/2024
Celosse	Karin	BH/ABA	INITIAL	4/16/2024
Charles	Wilbert	Primary Care Physician	INITIAL	4/16/2024
Chi	Oneida	Ancillary	INITIAL	4/16/2024
Chrisman	Patrick	BH/ABA	INITIAL	4/16/2024
Delgadillo	Karen	BH/ABA-Telehealth	INITIAL	4/16/2024
Demarte	Chelsea	BH/ABA	INITIAL	4/16/2024
Dixon	Tiana	BH/ABA-Telehealth	INITIAL	4/16/2024
Ejaz	Ehsan	Allied Health	INITIAL	4/16/2024
Estrella	Leland	BH/ABA-Telehealth	INITIAL	4/16/2024
Fatoorechi	Sarah	BH/ABA-Telehealth	INITIAL	4/16/2024
Gentry	Yvette	Ancillary	INITIAL	4/16/2024
Ghanbarzadeh	Nicole	BH/ABA	INITIAL	4/16/2024
Gibbs	Paul	Allied Health	INITIAL	4/16/2024
Gin	McKenna	Allied Health	INITIAL	4/16/2024
Gold	Sarah	BH/ABA-Telehealth	INITIAL	4/16/2024
Golly	Jessica	BH/ABA-Telehealth	INITIAL	4/16/2024
Gordon	Dawn	Allied Health	INITIAL	4/16/2024
Gurung	Nabinta	BH/ABA-Telehealth	INITIAL	4/16/2024
Gustafson	Jennifer	BH/ABA-Telehealth	INITIAL	4/16/2024
Gutierrez	Jasmine	BH/ABA-Telehealth	INITIAL	4/16/2024
Hanson	Heidi	Specialist	INITIAL	4/16/2024
Hawkins	Mitzi	Doula	INITIAL	4/16/2024
Hayes	Krista	Allied Health	INITIAL	4/16/2024
Hernandez	Alexandra	BH/ABA-Telehealth	INITIAL	4/16/2024
Hernandez	Ariana	BH/ABA-Telehealth	INITIAL	4/16/2024
Honeck	Noel	BH/ABA-Telehealth	INITIAL	4/16/2024
Huggins	Jennifer	BH/ABA	INITIAL	4/16/2024
Huynh	Nhu	BH/ABA-Telehealth	INITIAL	4/16/2024
Jauregui	Jesus	BH/ABA	INITIAL	4/16/2024
Jimenez	Zo	BH/ABA	INITIAL	4/16/2024
Jordan	Danielle	BH/ABA	INITIAL	4/16/2024
Josephson	Jacqueline	BH/ABA-Telehealth	INITIAL	4/16/2024
Kalili	Megan	Allied Health	INITIAL	4/16/2024
Kaur	Jagveer	BH/ABA-Telehealth	INITIAL	4/16/2024
Kechedjian	Armine	Specialist	INITIAL	4/16/2024
Kim	Christopher	BH/ABA	INITIAL	4/16/2024
Kohner	Melissa	Primary Care Physician	INITIAL	4/16/2024

LAST NAME	FIRST NAME	CATEGORY	INITIAL/RE-CRED	CRED DATE
Kooturu	Shruthi	BH/ABA-Telehealth	INITIAL	4/16/2024
Kyei	Abigail	BH/ABA	INITIAL	4/16/2024
Lacey	Savauna	BH/ABA	INITIAL	4/16/2024
Ladner	Laura	BH/ABA-Telehealth	INITIAL	4/16/2024
Landaker	Patricia	BH/ABA-Telehealth	INITIAL	4/16/2024
Lawson	Alexandria	BH/ABA	INITIAL	4/16/2024
Lee	Helen	BH/ABA-Telehealth	INITIAL	4/16/2024
Leonhart	Juliana	BH/ABA-Telehealth	INITIAL	4/16/2024
Leskin	Lorraine	BH/ABA-Telehealth	INITIAL	4/16/2024
Lewis	Emily	BH/ABA-Telehealth	INITIAL	4/16/2024
Liao	Xing	BH/ABA-Telehealth	INITIAL	4/16/2024
Mash	Jaime	Doula	INITIAL	4/16/2024
McGuire	Caroline	Specialist	INITIAL	4/16/2024
Merkow	Maxwell	Allied Health	INITIAL	4/16/2024
Mosley	Amy	Allied Health	INITIAL	4/16/2024
Munksgard	Fletcher	BH/ABA	INITIAL	4/16/2024
Murray	Patrick	BH/ABA-Telehealth	INITIAL	4/16/2024
Nguyen	Giao	BH/ABA	INITIAL	4/16/2024
Noble	Venus	BH/ABA	INITIAL	4/16/2024
Nugent	Ryan	BH/ABA-Telehealth	INITIAL	4/16/2024
O'Brien	Colleen	BH/ABA-Telehealth	INITIAL	4/16/2024
Oco	Sheila Marie	Ancillary	INITIAL	4/16/2024
Orton-Cheung	Nicole	BH/ABA-Telehealth	INITIAL	4/16/2024
Pauley	Heather	BH/ABA-Telehealth	INITIAL	4/16/2024
Phillips	PK	BH/ABA	INITIAL	4/16/2024
Plaza	Lorena	BH/ABA-Telehealth	INITIAL	4/16/2024
Preciado	Luz	BH/ABA	INITIAL	4/16/2024
Qadir	Abdul	BH/ABA-Telehealth	INITIAL	4/16/2024
Ricciardelli	Nicole	Primary Care Physician	INITIAL	4/16/2024
Richter	Jacqueline	Primary Care Physician	INITIAL	4/16/2024
Rikhy	Seema	BH/ABA-Telehealth	INITIAL	4/16/2024
Roark	Rufus	BH/ABA-Telehealth	INITIAL	4/16/2024
Rogachevsky	Michael	BH/ABA-Telehealth	INITIAL	4/16/2024
Roy	Cecilia	Primary Care Physician	INITIAL	4/16/2024
Saberinia	Hooman	Specialist	INITIAL	4/16/2024
Samizay	Sadaf	Specialist	INITIAL	4/16/2024
Shah	Gaurav	BH/ABA	INITIAL	4/16/2024
Sharifnia	Panid	Ancillary	INITIAL	4/16/2024
Shek	Cheuk Fung	Ancillary	INITIAL	4/16/2024
Simpson	Tiffany	BH/ABA	INITIAL	4/16/2024
Slater	Naomi	Primary Care Physician	INITIAL	4/16/2024
Smith	Casey	Ancillary	INITIAL	4/16/2024
Smith	Danielle	BH/ABA-Telehealth	INITIAL	4/16/2024
Sohrabian	Garni	BH/ABA-Telehealth	INITIAL	4/16/2024
Solorio De Alvarez	Yesica	BH/ABA-Telehealth	INITIAL	4/16/2024
Tipton	Cheyenne	BH/ABA-Telehealth	INITIAL	4/16/2024
Travers	Danielle	BH/ABA	INITIAL	4/16/2024
Vengel	David	BH/ABA-Telehealth	INITIAL	4/16/2024
Venturi	Coury	Specialist	INITIAL	4/16/2024
Wai	Karen	BH/ABA-Telehealth	INITIAL	4/16/2024
Waite	Erin	BH/ABA	INITIAL	4/16/2024
Weaver	Eric	Allied Health	INITIAL	4/16/2024
Wilborn	Briana	Ancillary	INITIAL	4/16/2024
Wilson	Jessica	BH/ABA-Telehealth	INITIAL	4/16/2024
Wing	Lauren	Specialist	INITIAL	4/16/2024
Yim	Benjamin	BH/ABA	INITIAL	4/16/2024
Zacharia	Elizabeth	BH/ABA-Telehealth	INITIAL	4/16/2024

LAST NAME	FIRST NAME	CATEGORY	INITIAL/RE-CRED	CRED DATE
Zavala	Monica	BH/ABA-Telehealth	INITIAL	4/16/2024
Zonca	Courtney	Specialist	RE-CRED	4/16/2024
Auker	Todd	Specialist	RE-CRED	4/16/2024
Agarwal	Nikhil	Allied Health	RE-CRED	4/16/2024
Braddock	Jennifer	Specialist	RE-CRED	4/16/2024
Brimmer	Jenna	Allied Health	RE-CRED	4/16/2024
Brown-Lechner	Mindy	Allied Health	RE-CRED	4/16/2024
Chan	Naomi	Specialist	RE-CRED	4/16/2024
Chard	Paul	Specialist	RE-CRED	4/16/2024
Chawla	Varun	Specialist	RE-CRED	4/16/2024
Chen	Alycia	Specialist	RE-CRED	4/16/2024
Chen	Ya-Kuan	Allied Health	RE-CRED	4/16/2024
De Leon	Stephanie	Specialist	RE-CRED	4/16/2024
Dierks	Ole	Specialist	RE-CRED	4/16/2024
Entwisle	Christopher	Allied Health	RE-CRED	4/16/2024
Freitas	Rachel	Specialist	RE-CRED	4/16/2024
Gladstone	Hayes	Specialist	RE-CRED	4/16/2024
Griffin	Michael	Specialist	RE-CRED	4/16/2024
Gwynn	Robert	Primary Care Physician	RE-CRED	4/16/2024
Hoffman	David	Specialist	RE-CRED	4/16/2024
Holman	Herbert	Allied Health	RE-CRED	4/16/2024
Huffner	Christine	Specialist	RE-CRED	4/16/2024
Ingegno	Michael	Primary Care Physician	RE-CRED	4/16/2024
Kallem	Priyanka	Specialist	RE-CRED	4/16/2024
Kirman	Christian	Primary Care Physician	RE-CRED	4/16/2024
Kumar	Suksham	Specialist	RE-CRED	4/16/2024
Loman	Jane	Specialist	RE-CRED	4/16/2024
Mandel	Mark	Primary Care Physician	RE-CRED	4/16/2024
Mogri	Durriyah	Primary Care Physician	RE-CRED	4/16/2024
Nazneen	Nikhat	Primary Care Physician	RE-CRED	4/16/2024
Ng	Christina	Specialist	RE-CRED	4/16/2024
Ng	Ramford	Allied Health	RE-CRED	4/16/2024
Nishiike	Yui	Specialist	RE-CRED	4/16/2024
Reddy	Thirupathi	Primary Care Physician and Specialist	RE-CRED	4/16/2024
Reen	Gurcharan	Primary Care Physician	RE-CRED	4/16/2024
Shein	May	Specialist	RE-CRED	4/16/2024
Snyder	Barry	Specialist	RE-CRED	4/16/2024
Splitter	Amy	Allied Health	RE-CRED	4/16/2024
Van Braden	Sonia	Specialist	RE-CRED	4/16/2024
Wong	Samuel	Specialist	RE-CRED	4/16/2024
Wright	Randolph	Ancillary	RE-CRED	4/16/2024
Zhong	Qinghui			

APRIL PEER REVIEW AND CREDENTIALING INITIAL APPROVALS BY SPECIALTY



PCP	7
Specialists	9
Allied Health	10
Ancillary	9
BH/ABA	80
Total	114

Provider Dispute Resolution
March 2024 and April 2024

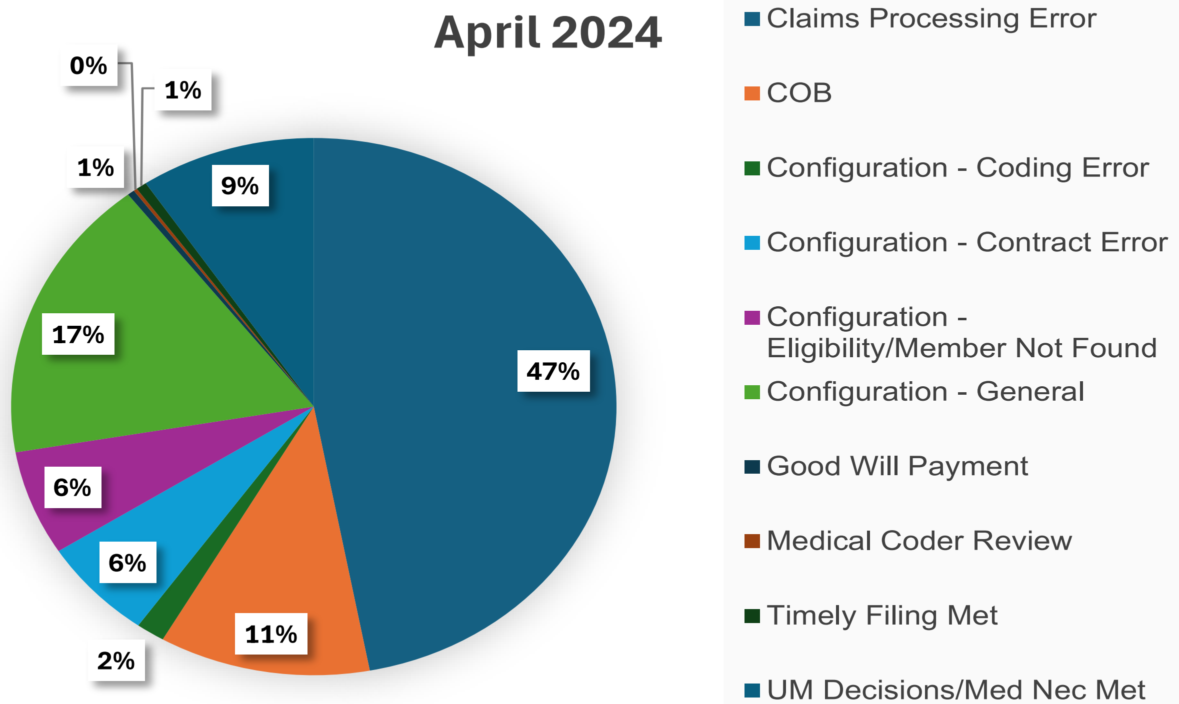
METRICS

PDR Compliance	Mar-24	Apr-24
# of PDRs Resolved	1,701	1,601
# Resolved Within 45 Working Days	1,691	1,596
% of PDRs Resolved Within 45 Working Days	99.4%	99.6%
PDRs Received	**Mar-24**	**Apr-24**
# of PDRs Received	2,274	1,925
PDR Volume Total	**2,274**	**1,925**
PDRs Resolved	**Mar-24**	**Apr-24**
# of PDRs Upheld	1,059	1,078
% of PDRs Upheld	62%	67%
# of PDRs Overturned	642	523
% of PDRs Overturned	38%	33%
Total # of PDRs Resolved	**1,701**	**1,601**
Average Turnaround Time	**Mar-24**	**Apr-24**
Average # of Days to Resolve PDRs	43	43
Oldest Resolved PDR in Days	70	89
Unresolved PDR Age	**Mar-24**	**Apr-24**
0-45 Working Days	3,531	3,808
Over 45 Working Days	0	0
Total # of Unresolved PDRs	**3,531**	**3,808**

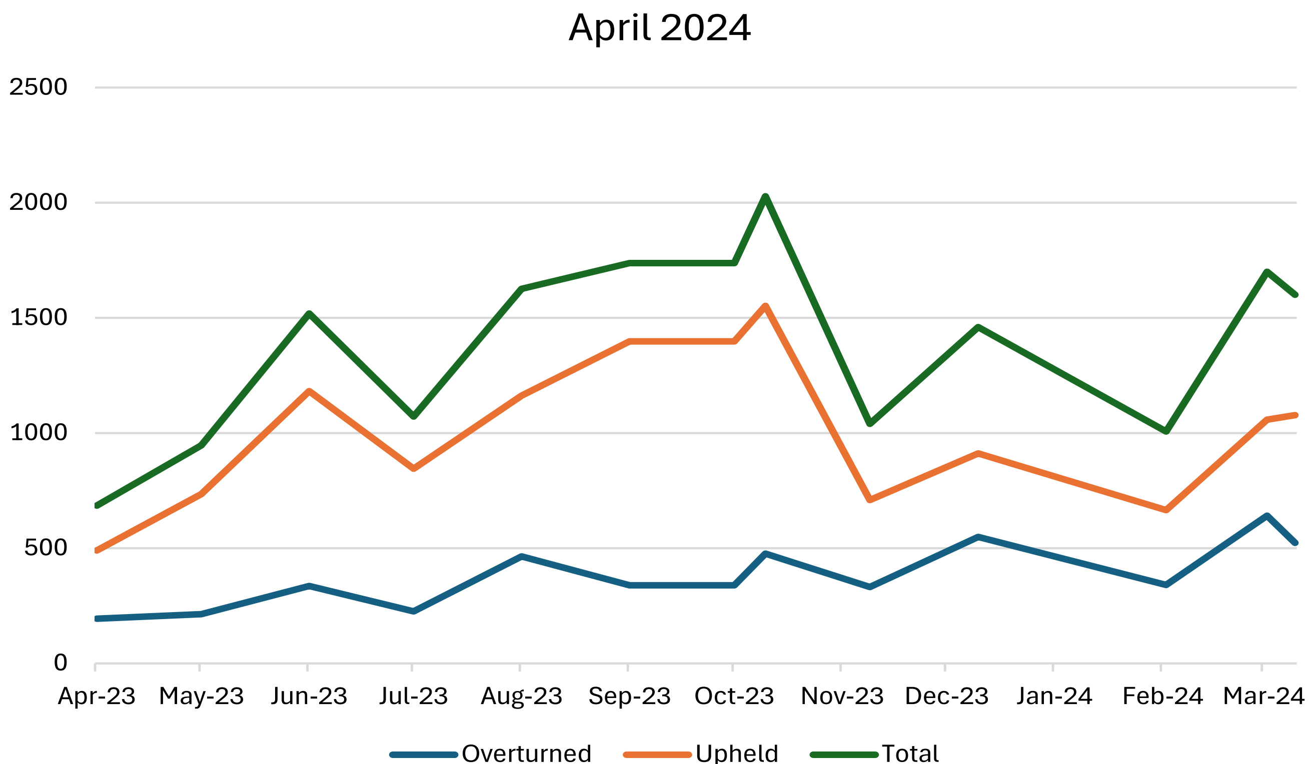
Provider Dispute Resolution
March 2024 and April 2024

Apr-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 - 1,601 in April 2024 vs 685 in April 2023	N/A	N/A
# of PDRs Received - 1,925 in April 2024 vs 1,618 in April 2023	N/A	N/A
# of PDRs Resolved within 45 working days - 1,596 in April 2024 vs 683 in April 2023	N/A	N/A
% of PDRs Resolved within 45 working days - 99.6% in April 2024 vs 99.7% in April 2023	95%	95%
Average # of Days to Resolve PDRs - 43 days in April 2024 vs 34 days in April 2023	N/A	30
Oldest Resolved PDR in Days - 89 days in April 2024 vs 45 days April 2023	N/A	N/A
# of PDRs Upheld - 1,078 in April 2024 vs 491 in April 2023	N/A	N/A
% of PDRs Upheld - 67% in April 2024 vs 72% in April 2023	N/A	> 75%
# of PDRs Overturned - 523 in April 2024 vs 194 in April 2023	N/A	N/A
% of PDRs Overturned - 33% in April 2024 vs 28% in April 2023	N/A	< 25%

Provider Dispute Resolution Year Over Year Summary		
PDR Overturn Reasons: Claims processing errors - 47% (2024) vs 63% (2023) Configuration errors - 31% (2024) vs 16% (2023) COB -11% (2024) vs 10% (2023) Clinical Review/UM Decisions/Medical Necessity Met - 9% (2024) vs 8% (2023)	N/A	N/A

COMMUNICATIONS & OUTREACH DEPARTMENT

ALLIANCE IN THE COMMUNITY

FY 2023-2024 | **APRIL 2024 OUTREACH REPORT**

ALLIANCE IN THE COMMUNITY

FY 2023-2024 | APRIL 2024 OUTREACH REPORT

During April 2024, the Alliance completed **975** member orientation outreach calls among net new members and non-utilizers and conducted **142** member orientations (**15%** member participation rate). In addition, in April 2024, the Outreach team completed **1** Alliance website inquiry, **9** service requests, **1** social media inquiry, and **3** member education events. The Alliance reached a total of **444** people at the Black Women's Health Forum, Diaper Distribution, and Asian Health Services Monthly Food Distribution community outreach activities.*

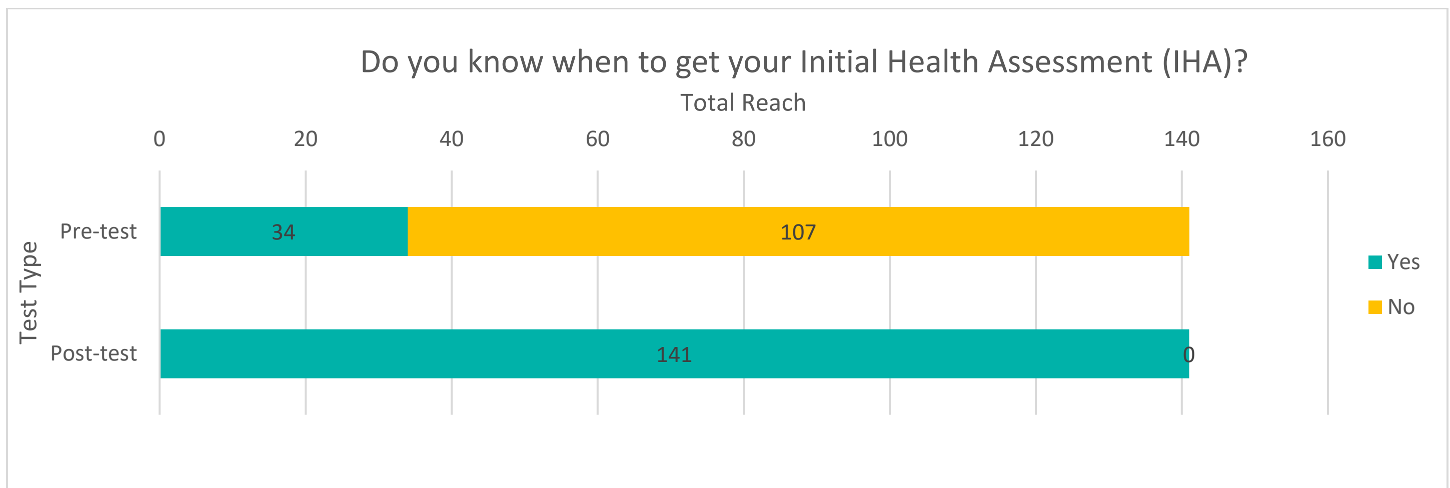
The Communications & Outreach Department began reporting the number of members reached during outreach activities in late February 2018. Since July 2018, **32,226** self-identified Alliance members have been reached during outreach activities.

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 April 30, 2024, the Outreach Team completed **35,481** member orientation outreach calls and conducted **8,372** member orientations (**24%** member participation rate).

The Alliance Member Orientation (MO) program has been in place since August 2016. In 2019, the program was recognized as a promising practice to increase member knowledge and awareness about the Initial Health Appointment (IHA) by the Department of Health Care Services (DHCS), Managed Care Quality and Monitoring Division (MCQMD). We have steadily increased program participation. Our 2019 6-month average participation rate was **111** members per month. Between April 1, through April 30, 2024 (21 working days) – **142** members completed an MO by phone.

After completing a MO **100%** of members who completed the post-test survey in April 2024 reported knowing when to get their IHA, compared to only **24.1%** of members knowing when to get their IHA in the pre-test survey.

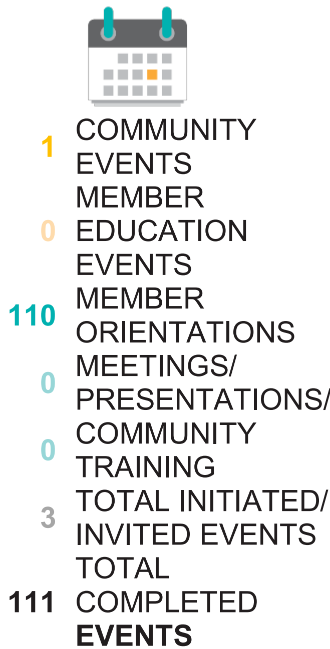


All report details can be reviewed at: **W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Outreach Reports\FY 23-24\Q4\1. April 2024**

ALLIANCE IN THE COMMUNITY

FY 2023-2024 | APRIL 2024 OUTREACH REPORT

FY 2022-2023 APRIL 2023 TOTALS



Count	Events
1	COMMUNITY EVENTS
0	MEMBER EDUCATION EVENTS
110	MEMBER ORIENTATIONS
0	MEETINGS/ PRESENTATIONS/
0	COMMUNITY TRAINING
3	TOTAL INITIATED/ INVITED EVENTS
111	TOTAL COMPLETED **EVENTS**

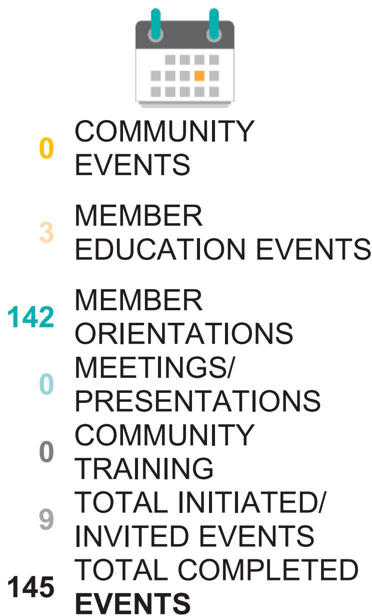
12 CITIES

Alameda
Berkeley
Castro Valley
Dublin
Fremont
Hayward
Livermore
Oakland
Pleasanton
San Leandro
San Lorenzo
Union City

Count	Reached
210	TOTAL REACHED AT COMMUNITY EVENTS
0	TOTAL REACHED AT MEMBER EDUCATION EVENTS
110	TOTAL REACHED AT MEMBER ORIENTATIONS
0	TOTAL REACHED AT MEETINGS/PRESENTATIONS
0	TOTAL REACHED AT COMMUNITY TRAINING
127	MEMBERS REACHED AT ALL EVENTS
320	**TOTAL REACHED AT ALL EVENTS**

$25.00
TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

FY 2023-2024 APRIL 2024 TOTALS



Count	Events
0	COMMUNITY EVENTS
3	MEMBER EDUCATION EVENTS
142	MEMBER ORIENTATIONS
0	MEETINGS/ PRESENTATIONS
0	COMMUNITY TRAINING
9	TOTAL INITIATED/ INVITED EVENTS
145	TOTAL COMPLETED **EVENTS**

12 CITIES**

Alameda
Berkeley
Castro Valley
Dublin
Fremont
Hayward
Livermore
Newark
Oakland
Pleasanton
San Leandro
San Ramon

Count	Reached
0	TOTAL REACHED AT COMMUNITY EVENTS
444	TOTAL REACHED AT MEMBER EDUCATION EVENTS
142	TOTAL REACHED AT MEMBER ORIENTATIONS
0	TOTAL REACHED AT MEETINGS/PRESENTATIONS
0	COMMUNITY TRAINING
509	MEMBERS REACHED AT ALL EVENTS
586	**TOTAL REACHED AT ALL EVENTS**

$0.00
TOTAL SPENT IN DONATIONS, FEES & SPONSORSHIPS*

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

COMMUNICATIONS & OUTREACH DEPARTMENT

SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2023-2024 | **April 2024**

The Alliance Communications and Outreach (C&O) Department created the social media and website activity (SM&WA) Report to provide a high-level overview of stakeholder engagement through various digital media platforms. Between **April 1, 2024**, and **April 30, 2024**:

1. Alliance Website:
   - Received **25,000** unique visits
   - Received **22,000** new user visits
   - The top **10** website page visits were:
     1. Homepage
     2. Provider Page
     3. Find a Doctor
     4. Benefits and Services
     5. Careers
     6. Medi-Cal Members
     7. Contact Us
     8. Members
     9. Get a New ID Card
     10. About Us
2. Facebook Page:
   - Maintained Fans at **631**
   - Did not receive any reviews in **April 2024**
3. Glassdoor Page:
   - **3** out of a **5-star** overall rating
   - Received 1 review in **April 2024**
4. Instagram Page:
   - Page debuted **June 10, 2021**
   - Increased in followers from **509** to **526**
5. Twitter Page:
   - Maintained followers at **357**
6. LinkedIn Page:
   - Increased followers from **5.2k to 5.3k**
   - Received **215-**page clicks
7. Yelp Page:
   - Page visits **70**
   - Appeared in Yelp searches **112** times
   - Did not receive any reviews in **April 2024**
8. Google Page:
   - **4,786** website clicks made from the business profile
   - **1,521** calls made from the business profile
   - Did not receive any reviews in **April 2024**
   - Received **10** chat messages in **April 2024**

ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2023-2024 | April 2024

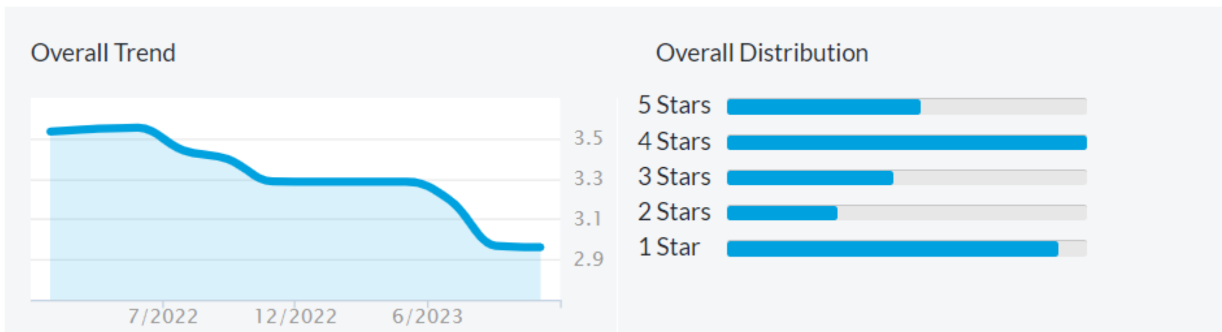
GLASSDOOR OVERVIEW

Alameda Alliance for Health Ratings and Trends

About Glassdoor ratings

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

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

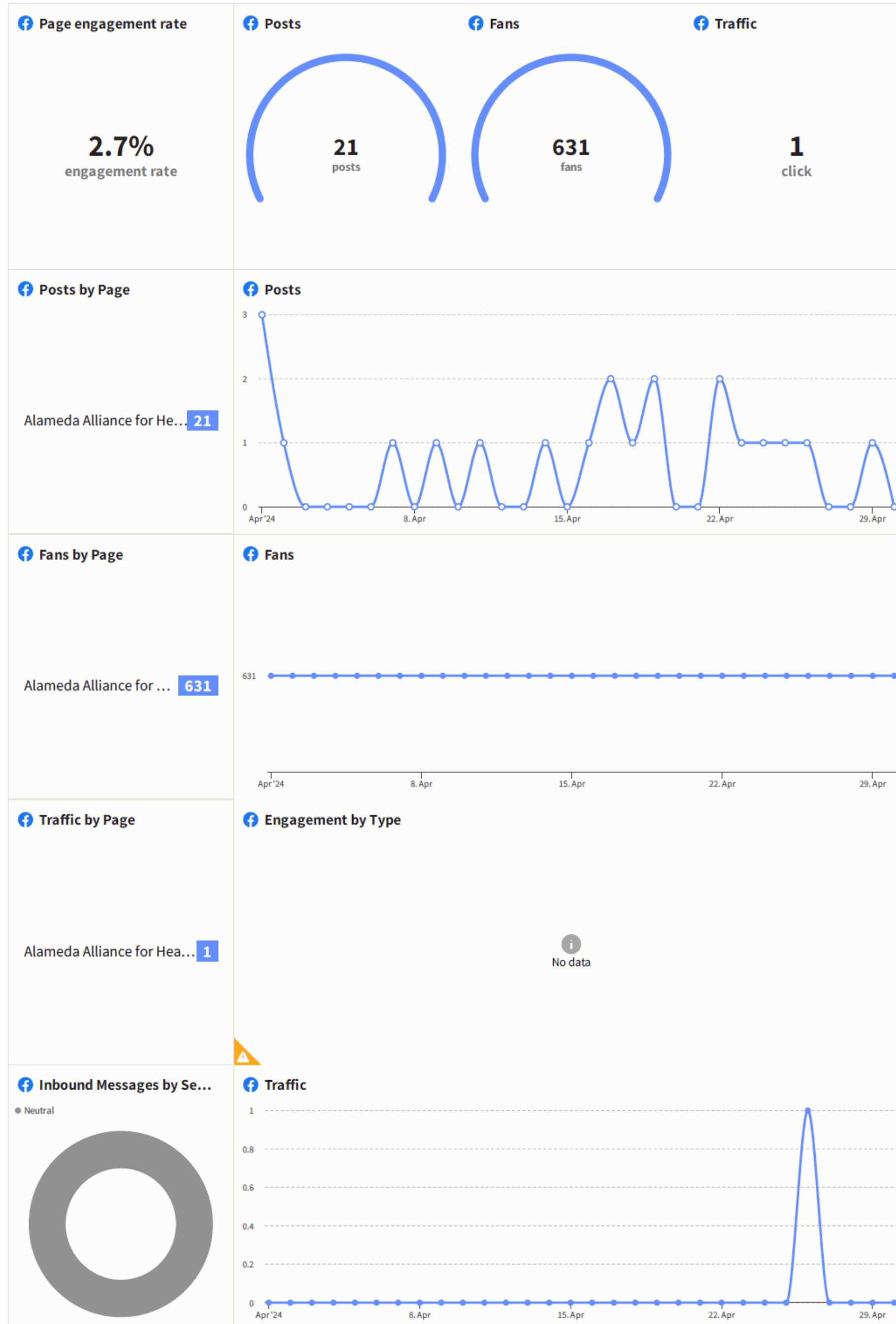


All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2023-2024\Q4\1. April 2024

ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2023-2024 | April 2024

FACEBOOK OVERVIEW



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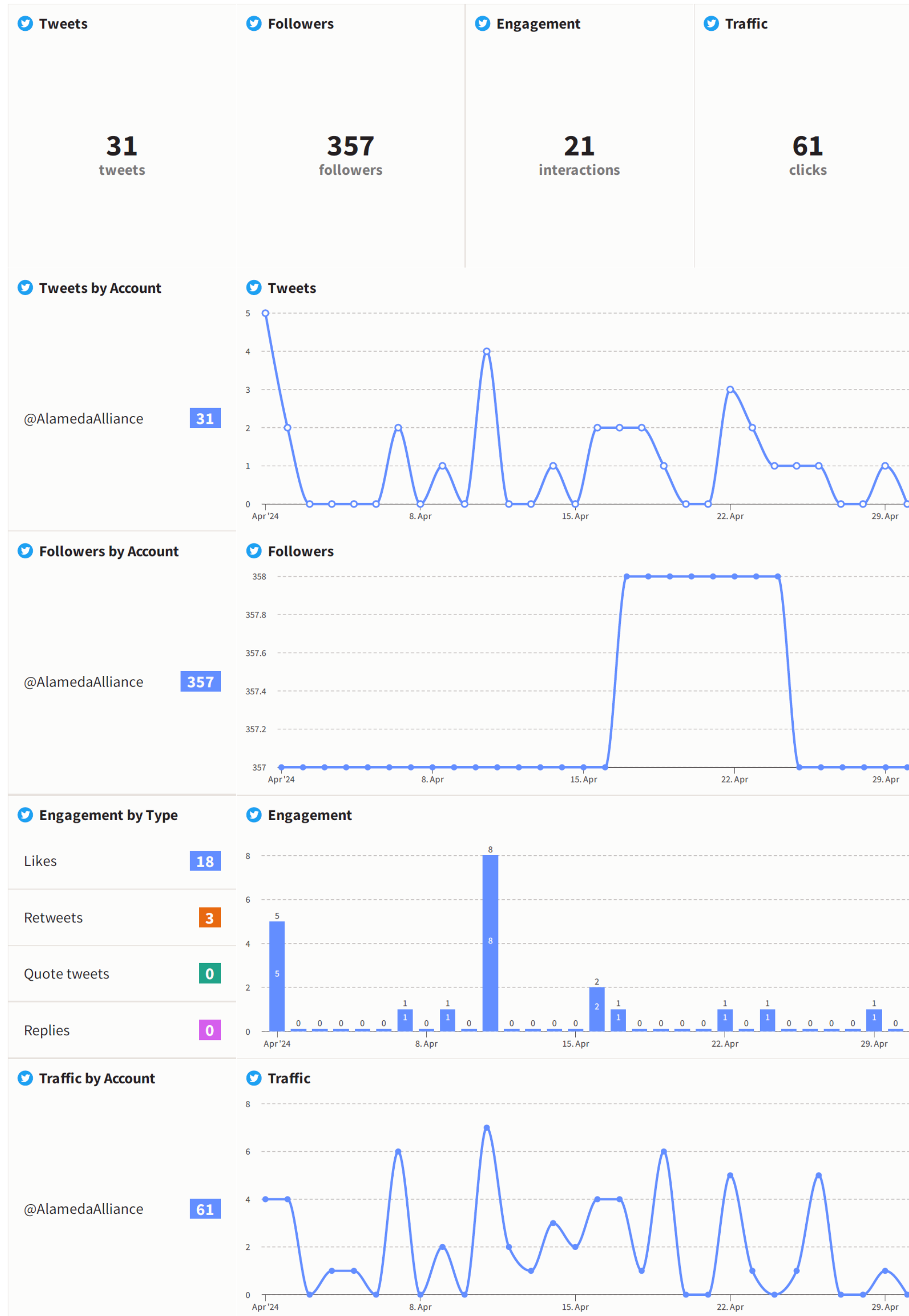
ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2023-2024 | April 2024

TWITTER OVERVIEW



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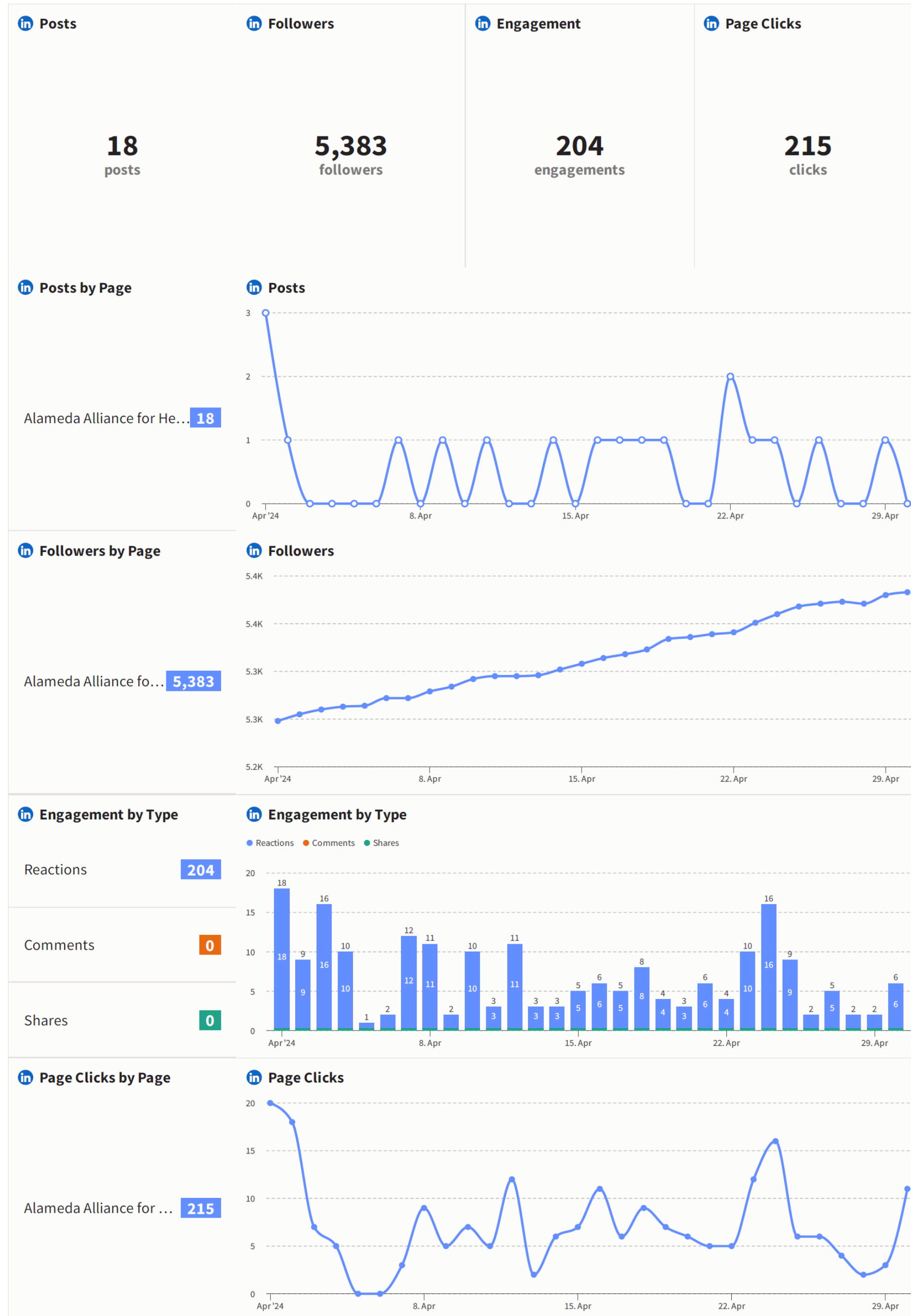
ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2023-2024 | April 2024

LINKEDIN OVERVIEW

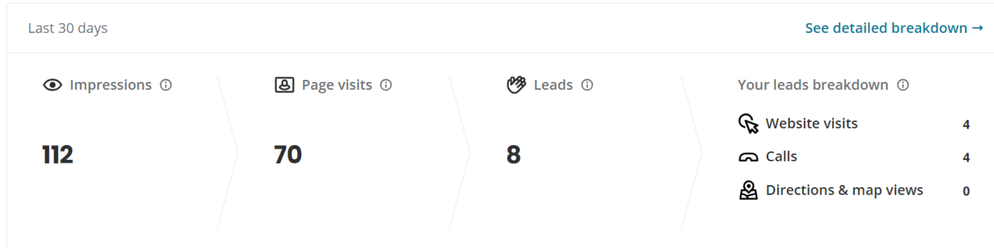


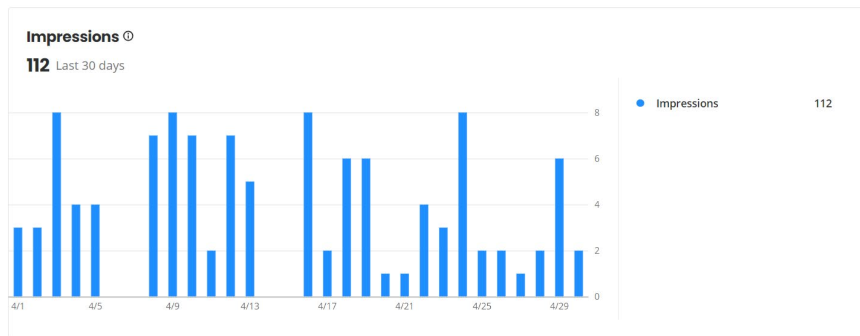
All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2023-2024\Q4\1. April 2024

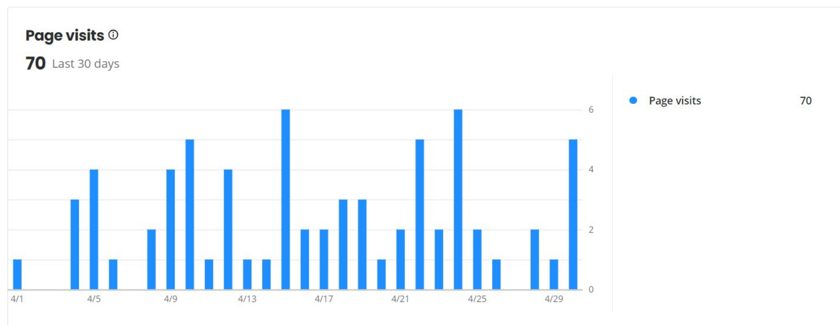
ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

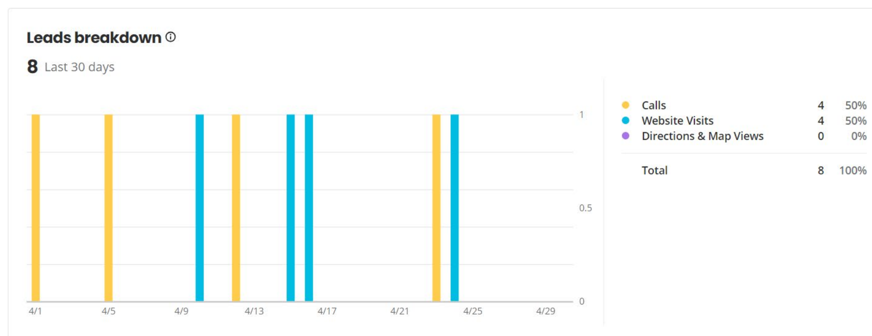
FY 2023-2024 | April 2024

YELP OVERVIEW







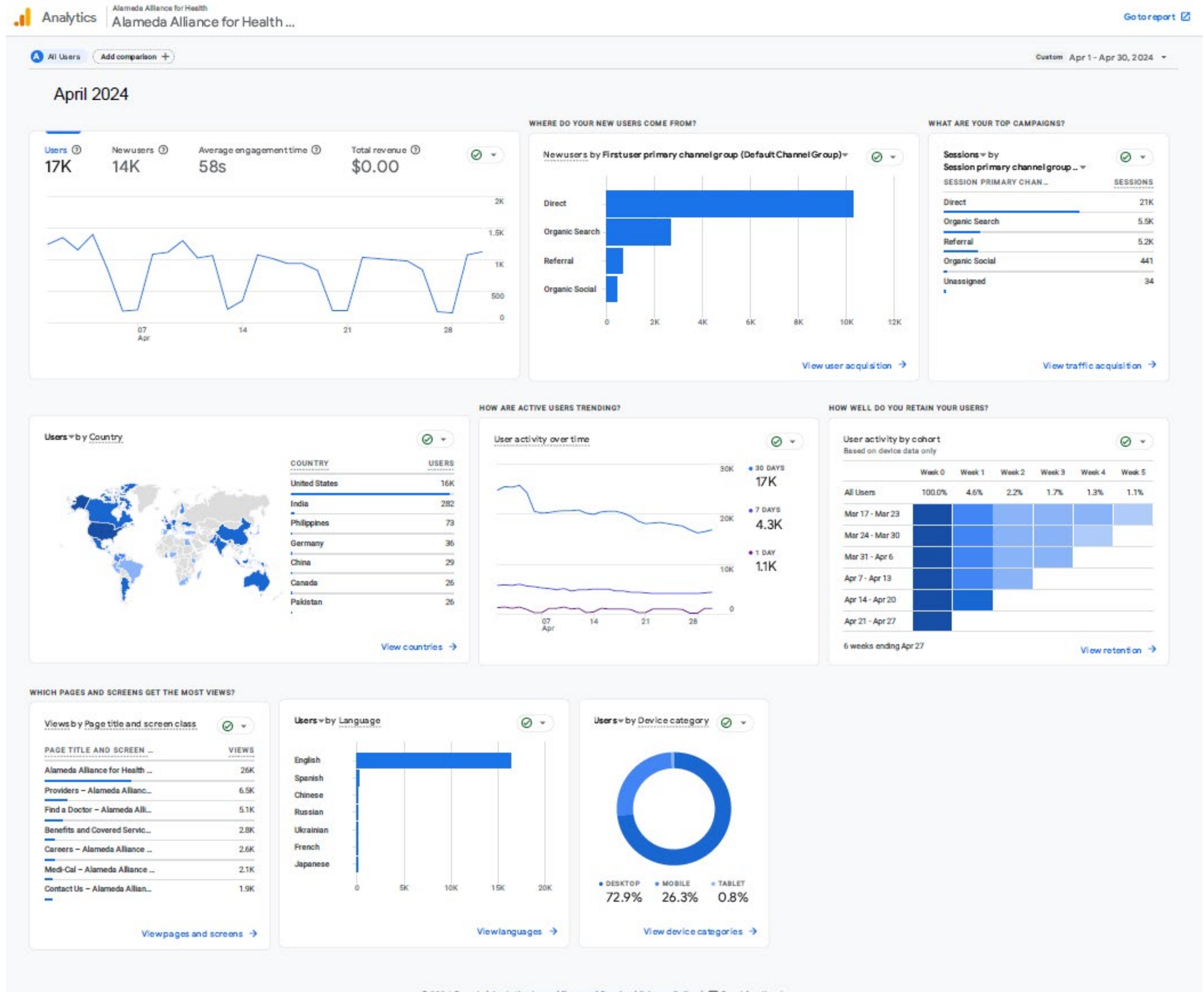


All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2023-2024\Q4\1. April 2024

ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2023-2024 | April 2024

ALLIANCE WEBSITE OVERVIEW:



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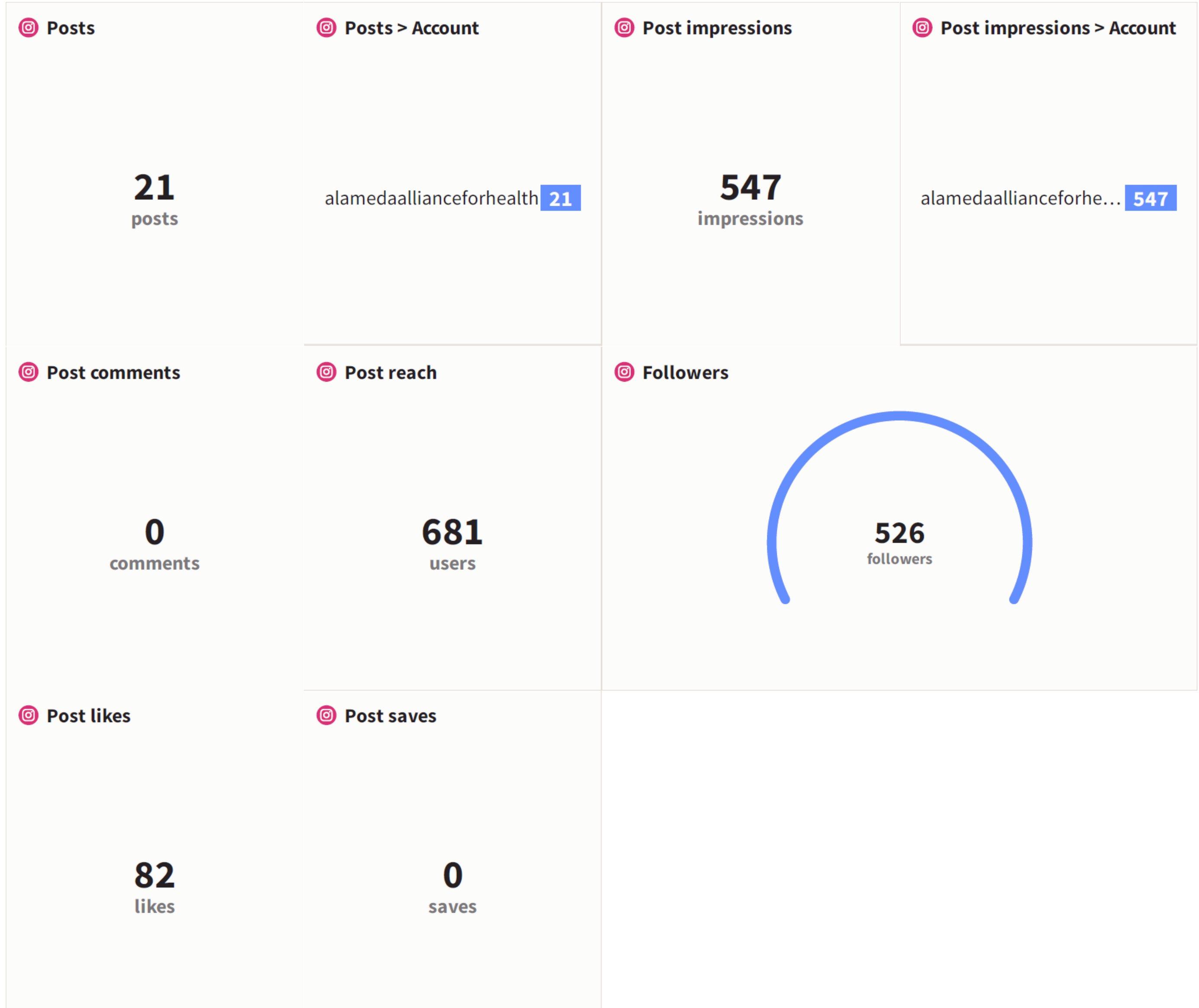
ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2023-2024 | April 2024

Instagram OVERVIEW:



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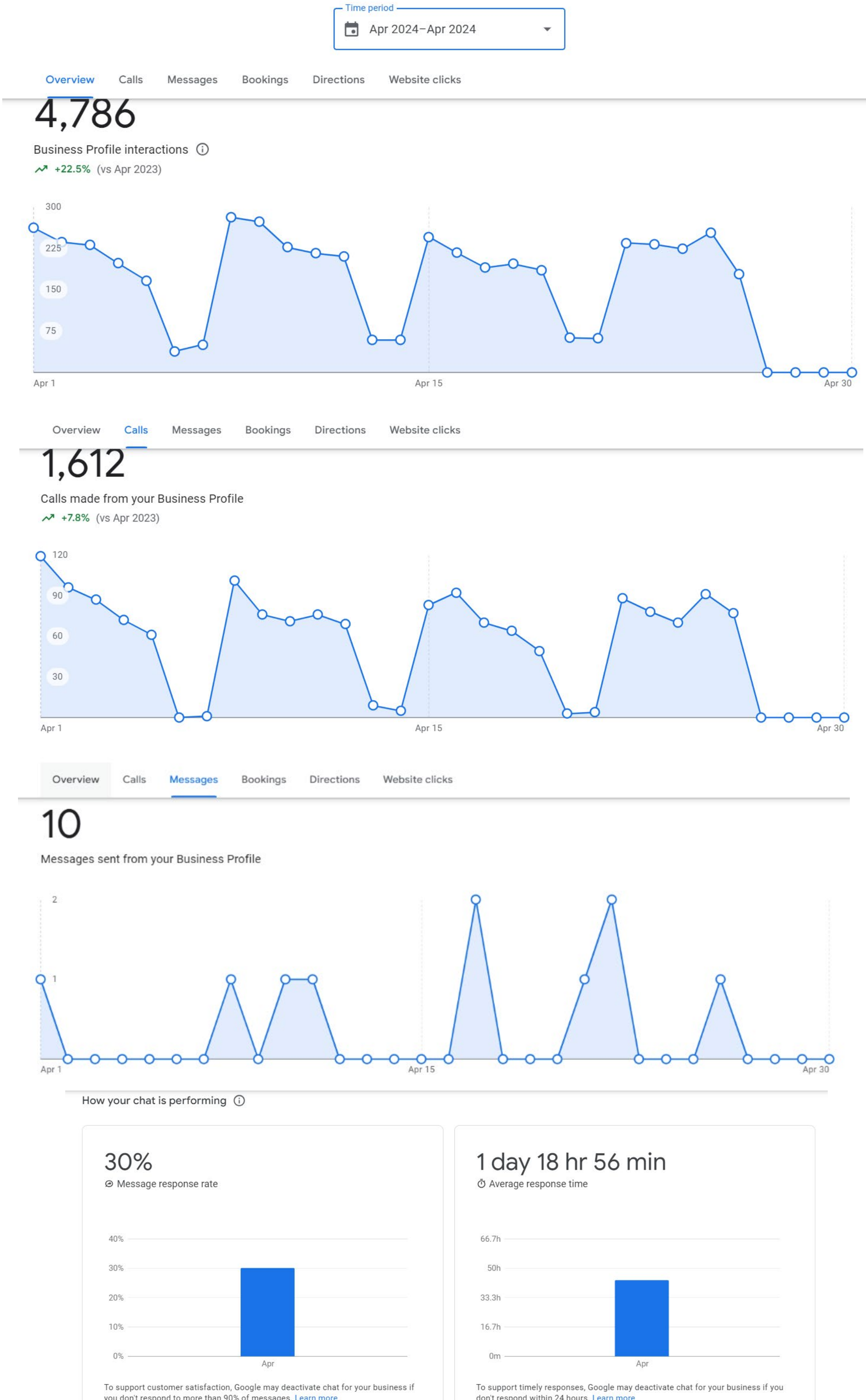
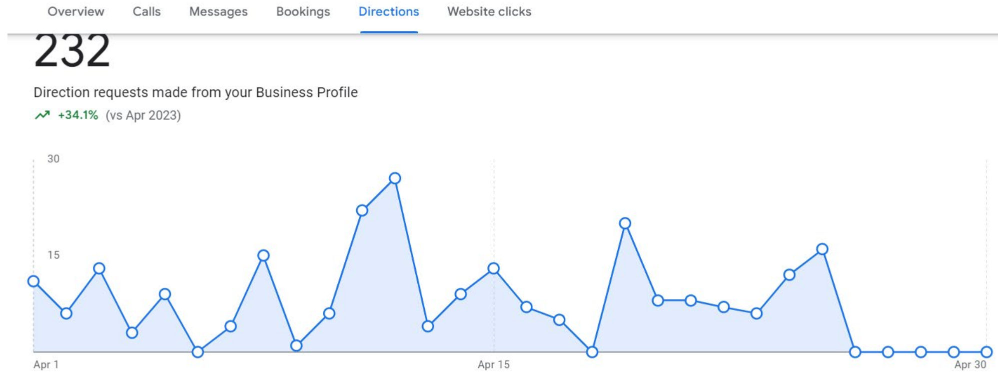
ALLIANCE SOCIAL MEDIA AND WEBSITE ACTIVITY REPORT

FY 2023-2024 | April 2024

Google OVERVIEW:



Google OVERVIEW cont.:



All details can be reviewed at: W:\DEPT_Operations\COMMUNICATIONS & MARKETING_OFFICIAL FOLDER\Reports\C&O Reports\Social Media Reports\FY 2023-2024\Q4\1. April 2024

To: Alameda Alliance for Health Board of Governors

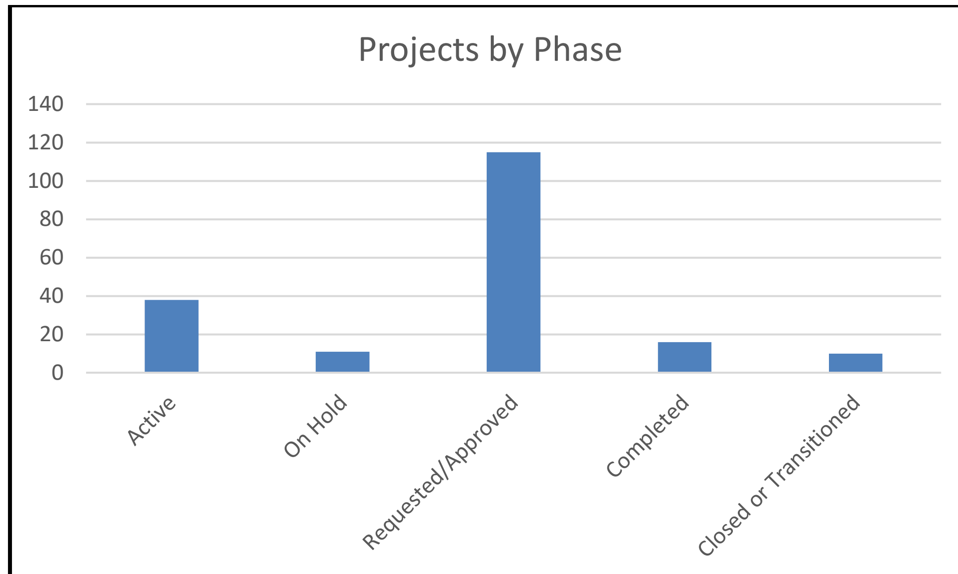
From: Ruth Watson, Chief Operating Officer

Date: May 10th, 2024

Subject: Integrated Planning Division Report – April 2024 Activities

Project Management Office

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



Integrated Planning

- **D-SNP**
    - D-SNP Key Initiatives and Dates
        - DMHC Material Modification Submission – MA Service Area Expansion – March 2024
        - DMHC Material Modification Submission – DSNP Product – August 2024
        - CMS Notice of Intent to Apply – November 2024
        - CMS Application Submission including MOC, Provider Network Adequacy & DMHC Approval – February 2025
        - CMS Formulary & Bid Submission (Benefit Determination) – June 2025
        - CMS SMAC Submission – July 7, 2025
        - Rebate Allocation with CMS and Health Plan – July / August 2025

        - Annual Enrollment Period (AEP) – October thru December 2025
        - IT System Readiness – December 15, 2025
        - Open Enrollment Period (OEP) Begins – January 1, 2026
    - D-SNP Activities – April 2024
        - Participated in Local Plan D-SNP Readiness Meeting attended by DHCS, DMHC, and CMS

          Developed Medicare Provider Contracting Rates Grid
        - Developed Medicare Vendor Analysis Grid
        - Continued development of Model of Care (MOC) responses for MOC 1, 3, and 4
        - Completed updates to the Provider Contract Amendments to support Sequestration, Medical Education, Disproportionate Share Hospital, Risk Adjustment (Coding Accuracy), and STARS
        - Submitted Medicare License Expansion Amendment Financial Filing to DMHC
        - Staffing Updates
            - Posted Two Contract Specialist Positions
        - CEO, COO, & ED, Medicare Programs presented to CHCN on April 30th regarding Medicare Advantage D-SNP 101 and engaged in a dialogue with FQHC leadership on concerns and questions.
        - 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 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.

- **CalAIM Initiatives:**
    - Community Supports (CS):
        - The following new services are live as of January 1st, 2024:
            - Nursing Facility Transition/Diversion to Assisted Living Facilities
            - Community Transition Services/Nursing Facility to a Home
            - Asthma Remediation (expanded to include adults and new providers)
            - Medically Tailored Meals (expanded to include new providers)
            - Caregiver Respite, Personal Care & Homemaker Services, and Environment Accessibility Adaptations – Home Mods (expanded to include new providers)
        - Sobering Centers service is on track to go live by July 1st, 2024
        - The final two CS services are expected to launch by January 2025:
            - Day Habilitation Programs
            - Short-Term Post-Hospitalization Housing
        - An updated MOC will need to be submitted to DHCS to align with these two new services

- Justice-Involved (JI) Initiative:
    - CalAIM Re-entry
        - Go-live date for the CalAIM Re-Entry initiative is October 1st, 2024, for all MCPs
            - Correctional facilities will have the ability to select their go-live date within a 24-month phase-in period (10/1/2024 – 9/30/2026)
            - Santa Rita Jail is targeting to go-live on 7/1/2026 with pre-release services; Juvenile Justice Center's go-live is TBD
            - Managed Care Plans (MCPs) must be prepared to coordinate with correctional facilities as of October 1st, 2024, even if facilities in their county will go-live at a later date
        - Bi-weekly workgroup meetings with Alameda County Sheriff's Office, Probation, Alameda County Behavioral Health, Social Security Administration, Kaiser Permanente and AAH continue to support collaboration on the strategy for this initiative
            - Workgroup is developing workflows and strategies to support behavioral health linkages, care plans, and the pre-release warm hand-off
        - Additional meetings will be held internally to further define the data requirements for AAH to share with external agencies in support of the JI initiatives
        - AAH 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
        - AAH JI project team met with Alameda County Collaborative Courts on April 12 to discuss progress on JI re-entry, in partnership with Kaiser Permanente
        - AAH JI project team attended a tour of the Juvenile Justice Center in collaboration with the Probation department on April 26

- AAH/Roots JI Pilot Project:
    - AAH's pilot for post-release services began in July 2023 in preparation for the 2024 programs related to this population
        - The team continues to track and trend the monthly data received from Roots to support the development of our strategy for the re-entry initiative that commences in 2024
        - Initial data analysis has shown a disparity between the number of males vs. females seeking help upon release (roughly 10% of males vs. near 100% females)
        - Housing assistance is also a top need for this population
        - 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
        - Monthly check-ins with Roots will continue through the remainder of the pilot term, ending in July 2024

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

- 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 1, 2024 to July 1, 2024

Recruiting and Staffing

- Integrated Planning Open position(s):
  - Backfill for Sr. PM – requisition posted and will begin screenings & interviews
  - Business Process Analyst – job description drafted and currently under HR review.
- Recruitment for new positions effective February 2024 – pending
- Backfill for Business Analyst – Integrated Planning

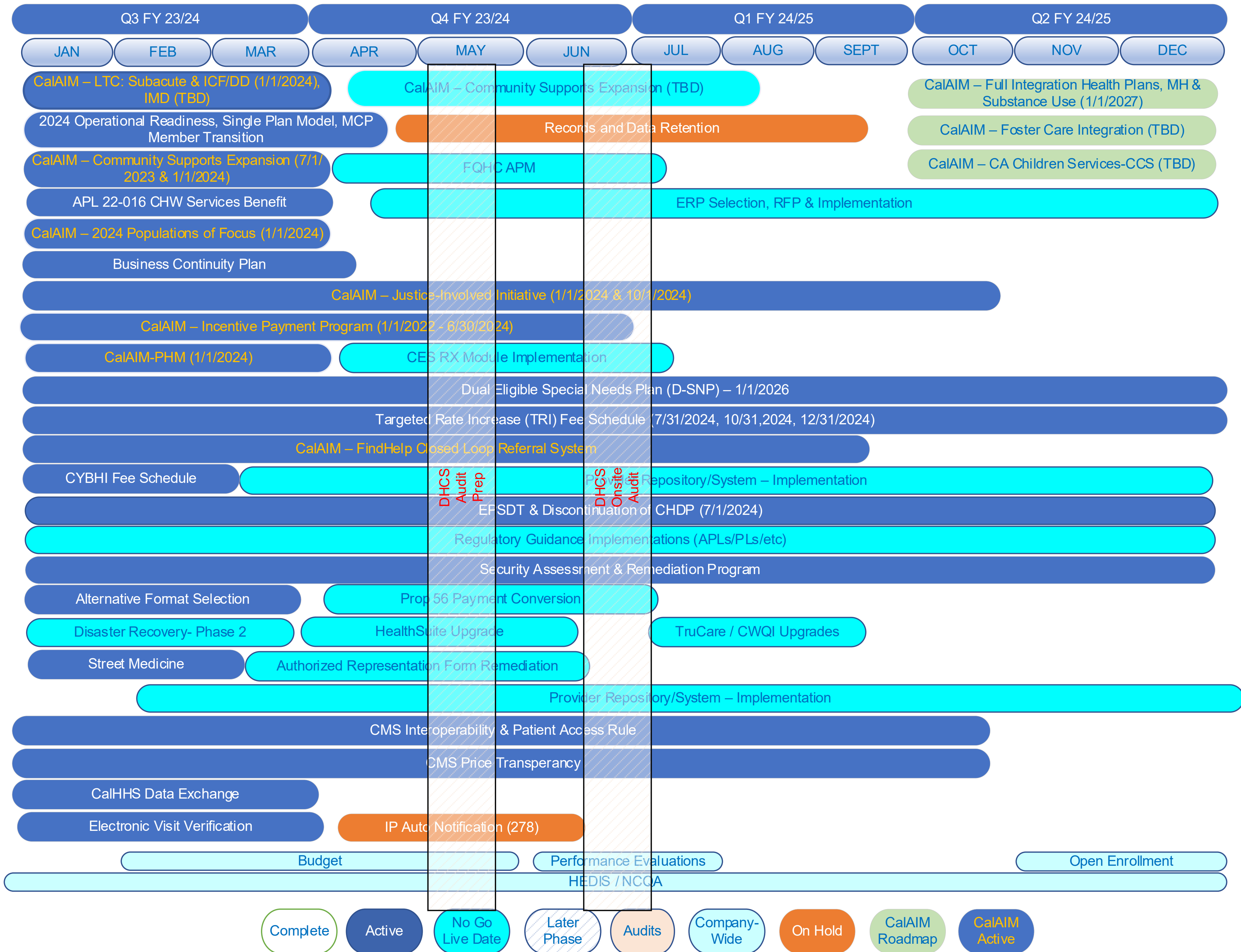
Integrated Planning

Supporting Documents Project Descriptions

Key projects currently in-flight: AJ / Lori / Todd / Corry

- 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) CS 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
    - Long Term Care - benefit was carved into all MCPs effective January 1st, 2023, with the exception of Subacute and ICF-DD facilities which are scheduled for implementation January 1st, 2024; IMD facilities implementation date TBD
    - Justice Involved Initiative – adults and children/youth transitioning from incarceration or juvenile facilities will be enrolled into Medi-Cal upon release
        - DHCS is finalizing policy and operational requirements for MCPs to implement the CalAIM Justice-Involved Initiative
            - MCPs must be prepared to go live with ECM for the Individuals Transitioning from Incarceration as of January 1st, 2024
            - MCPs must be prepared to coordinate with correctional facilities to support reentry of members as the return to the community by October 1st, 2024
            - Correctional facilities will have two years from 10/1/2024-9/30/2026 to go live based on readiness
    - Population Health Management (PHM) – all Medi-Cal managed care plans were required to develop and maintain a whole system, person-centered population health management strategy effective January 1st, 2023. PHM is a comprehensive, accountable plan of action for addressing Member needs and preferences, and building on their strengths and resiliencies across the continuum of care that:
        - Builds trust and meaningfully engages with Members;

        - Gathers, shares, and assesses timely and accurate data on Member preferences and needs to identify efficient and effective opportunities for intervention through processes such as data-driven risk stratification, predictive analytics, identification of gaps in care, and standardized assessment processes;
        - Addresses upstream factors that link to public health and social services;
        - Supports all Members staying healthy;
        - Provides care management for Members at higher risk of poor outcomes;
        - Provides transitional care services for Members transferring from one setting or level of care to another; and
        - Identifies and mitigates social drivers of health to reduce disparities
    - Dual Eligible Special Needs Plan (D-SNP) Implementation – All Medi-Cal MCPs will be required to operate Medicare Medi-Cal Plans (MMPs), the California-specific program name for Exclusively Aligned Enrollment Dual Eligible Special Needs Plans (EAE D-SNPs) by January 2026 in order to provide better coordination of care and improve care integration and person-centered care. Additionally, this transition will create both program and financial alignment, simplify administration and billing for providers and plans, and provide a more seamless experience for dual eligible beneficiaries by having one plan manage both sets of benefits for the beneficiary.
- Community Health Worker Services Benefit – Community Health Worker (CHW) services became a billable Medi-Cal benefit effective July 1st, 2022. CHW services are covered as preventive services on the written recommendation of a physician or other licensed practitioner of the healing arts within their scope of practice under state law for individuals who need such services to prevent disease, disability, and other health conditions or their progression; prolong life; and promote physical and mental health and well-being
- 2024 Single Plan Model
    - 2024 Managed Care Plan Contract Operational Readiness – new MCP contract developed as part of Procurement RFP; all MCPs must adhere to new contract effective January 1st, 2024
        - Business Continuity Plan required as part of Operational Readiness
        - MOUs with third parties required as part of Operational Readiness
    - MCP Member Transition
        - Anthem members will transition to AAH effective January 1st, 2024
        - Members currently delegated to Kaiser will transition to Kaiser as part of their direct contract with DHCS effective January 1st, 2024
- CYBHI Statewide Fee Schedule – The Department of Health Care Services (DHCS), in collaboration with the Department of Managed Health Care (DMHC), has developed 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.



Q3 FY 23/24
Q4 FY 23/24
Q1 FY 24/25
Q2 FY 24/25
JAN
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DEC
CalAIM – LTC: Subacute & ICF/DD (1/1/2024), IMD (TBD)
CalAIM – Community Supports Expansion (TBD)
CalAIM – Full Integration Health Plans, MH & Substance Use (1/1/2027)
2024 Operational Readiness, Single Plan Model, MCP Member Transition
Records and Data Retention
CalAIM – Foster Care Integration (TBD)
CalAIM – Community Supports Expansion (7/1/2023 & 1/1/2024)
FQHC APM
CalAIM – CA Children Services-CCS (TBD)
APL 22-016 CHW Services Benefit
ERP Selection, RFP & Implementation
CalAIM – 2024 Populations of Focus (1/1/2024)
Business Continuity Plan
CalAIM – Justice-Involved Initiative (1/1/2024 & 10/1/2024)
CalAIM – Incentive Payment Program (1/1/2022 - 6/30/2024)
CalAIM-PHM (1/1/2024)
CES RX Module Implementation
Dual Eligible Special Needs Plan (D-SNP) – 1/1/2026
Targeted Rate Increase (TRI) Fee Schedule (7/31/2024, 10/31,2024, 12/31/2024)
CalAIM – FindHelp Closed Loop Referral System
CYBHI Fee Schedule
Provider Repository/System – Implementation
DHCS Audit Prep
DHCS Onsite Audit
EPSDT & Discontinuation of CHDP (7/1/2024)
Regulatory Guidance Implementations (APLs/PLs/etc)
Security Assessment & Remediation Program
Alternative Format Selection
Prop 56 Payment Conversion
Disaster Recovery- Phase 2
HealthSuite Upgrade
TruCare / CWQI Upgrades
Street Medicine
Authorized Representation Form Remediation
Provider Repository/System – Implementation
CMS Interoperability & Patient Access Rule
CMS Price Transparency
CalHHS Data Exchange
Electronic Visit Verification
IP Auto Notification (278)
Budget
Performance Evaluations
Open Enrollment
HEDIS / NCQA
Complete
Active
No Go Live Date
Later Phase
Audits
Company-Wide
On Hold
CalAIM Roadmap
CalAIM Active

Integrated Planning

Ruth Watson

To: Alameda Alliance for Health Board of Governors

From: Ruth Watson, Chief Operating Officer

Date: May 10th, 2024

Subject: Incentives & Reporting Board Report – April 2024 Activities

Current Incentive Programs

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

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

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

- The second Bi-Quarterly Report (BQR) for the measurement period of July – December 2023, was submitted to DHCS on December 21st, 2023, and approved for payment on March 13th, 2024; AAH received $1.1M on April 18th, 2024, which was 100% of the eligible funds for this reporting period
- Partner meetings continued with Local Education Agencies (LEAs) regarding project plan activities for successful completion of the milestones
- 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 $5.5M 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

- The Submission 2 (S2) Report for the final reporting period of January – October 2023 was submitted to DHCS on December 27th, 2023, and approved by DHCS on March 6th, 2024; AAH received $17.6M on April 16th, 2024, which is 79% of the eligible funds for the S2 report
- $38M out of a possible $44M has been awarded to the Alliance by DHCS, and a total of $17.6M has been paid to HHIP partners to date
- Alameda County Health (formerly HCSA) continues to complete deliverables and milestones outlined in the December 2022 MOU:
    - To date, Alameda County Health (AC Health) has completed deliverables related to:
        - HHIP data reporting
        - Housing Financial Supports Progress Report
        - Street Medicine Data and Program Model as well as Contracting recommendations
        - 2023 Q1 and Q2 Housing Community Supports Capacity Building progress reports
        - Housing Community Supports Legal Services Pilot grant agreement execution with a legal services provider, hiring of 1.0 FTE staff attorney, and completion of progress report(s)
        - An executed contract with a Data Reporting firm and Project Manager for the 2024 Point-in-Time (PIT) Count
    - As of April 20th, $12.8M in total payments has been paid to AC Health for HHIP milestone completion
- Internal and external workgroup meetings continue to plan for and implement initiatives related to HHIP program goals including:
    - A new opportunity available to SBHIP LEAs to address the challenges of students experiencing homelessness and associated behavioral health needs (i.e., anxiety, depression, etc.)
        - The application has been released and responses are due May 3rd, 2024
    - Development of an application process to increase partnerships within the community to support HHIP program goals of reducing and preventing homelessness utilizing funds earned from the S2 report
        - The application has been developed and is scheduled to be released June 1st, 2024

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

- Of the 14 practices that submitted program applications, Alameda Health System was the only applicant selected by DHCS for this initial cohort

- The MCP Initial Planning Incentive Payment Program milestone documentation was submitted to DHCS on January 4th, 2024, and AAH was notified on March 18th, 2024 that our submitted deliverables were reviewed and approved; the associated payment of $442K was received April 22nd, 2024

New Programs in Development

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

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

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

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

- Expanding the Alameda Alliance Provider network by approximately 10 to 15 providers a year
- Improving member access to Primary Care Providers, Specialists, and Behavioral Health professionals
- Promoting diverse and culturally inclusive care reflective of Alliance members

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

Recruiting and Staffing

Incentives & Reporting Open position(s):

- There are no open positions at this time

Incentive Program Descriptions

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

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

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

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

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

Equity and Practice Transformation (EPT) Payments Program – new program released by DHCS in August 2023 and is a one-time $700M primary care provider practice transformation program designed to advance health equity, reduce COVID-19-driven care disparities, and prepare practices to participate in alternative payment models

- EPT is for primary care practices, including Family Medicine, Internal Medicine, Pediatrics, Primary Care 0B/GYN, and/or Behavioral Health in an integrated primary care setting
- Medi-Cal Managed Care Plan (MCP) Initial Provider Planning Incentive Payments
    - $25 million over one (1) year to incentivize MCPs to identify and work with small-to medium-sized independent practices as they develop practice transformation plans and applications to the larger EPT Provider Directed Payment Program

- EPT Provider Directed Payment Program
    - $650 million over five (5) years to support delivery system transformation, specifically targeting primary care practices that provide primary care pediatrics, family medicine, internal medicine, primary care OB/GYN services, or behavioral health services that are integrated in a primary care setting to Medi-Cal members; $200 million of the $650 million will be dedicated to preparing practices for value-based care
    - The Statewide Learning Collaborative
        - $25 million over five (5) years to support participants in the Provider Directed Payment Program in implementation of practice transformation activities, sharing and spread of best practices, practice coaching activities, and achievement of stated quality and equity goal

To: Alameda Alliance for Health Board of Governors

From: Ruth Watson, Chief Operating Officer

Date: May 10th, 2024

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

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

Program Year 1 Update

Infrastructure Development

Projects in Progress:

- Designing a Housing Inventory worksheet to learn about expanded community housing providers
- Curriculum development for Housing Learning Symposium
- Finalized Housing Community Services department Charter
- Housing and Community Services Logic Model – Phase 2 (creating Health Equity opportunities)

Staffing:

- Community Health Worker (CHW) Program Manager – position pending AAH final approval
- Developed CHW job descriptions and interview questions

Budget:

- Developed and submitted Housing budget

Metrics Development:

- Finalized Housing performance metrics

Community Networks & Partnerships Development:

- Alameda Alliance and Continuum of Care (CoC) collaboration:
    - Racial Equity Committee:

        - AAH Housing Department also co-facilitated the Racial Equity Framework presentation
- Community Education on CalAIM Community Supports:
    - Began discussion with East Bay Asian Local Development Corporation on the expansion of Community Supports and unit availability
- Participation in the following Community Networks:
    - Attended The Supreme Court and Criminalization of Homelessness discussions
    - Attended the Health Housing Data Symposium to align health data quality strategies
    - Attending Doing Research Together: The nuts and bolts of doing collaborative research with persons with lived experiences, hosted by UCSF

Interdepartmental Collaboration:

- Health Equity Department – AAH Housing Team and Health Equity Team participated in the Oakland, Berkeley/Alameda County CoC Spring Community conference
- HHIP/Housing and Community Services Program – project updates:
    - Completion of HHIP and Housing Application process content to reflect the Housing Bridge the Gap model and support HHIP program goals of reducing and preventing homelessness

Compliance

Richard Golfin III

To: Alameda Alliance for Health Board of Governors

From: Richard Golfin III, Chief Compliance & Privacy Officer

Date: May 10th, 2024

Subject: Compliance Division Report

Compliance Audit Updates

- 2024 DHCS Routine Full Medical Survey:
  - The DHCS has confirmed the 2024 Routine Full Medical Survey is scheduled for June 2024. The virtual interview sessions are scheduled from June 17th, 2024, through June 28th, 2024. The Plan received the formal audit notification letter on March 13th, 2024. The lookback period spans June 1st, 2023, through May 31st, 2024. The Plan submitted the pre-audit materials on April 24th, 2024, with an additional Addendum (Addendum E) submitted on April 29th, 2024. The DHCS has reached out to the Plan with clarifying questions related to the pre-audit submission and the Plan is in the process of providing responses.
- 2024 Plan Internal Mock Audits:
  - The Compliance Division held Mock interviews with subject matter experts (SMEs) in preparation for the 2024 Routine Full Medical Survey. Sixteen (16) Mock interviews were held from April 22nd, 2024, through May 3rd, 2024. Mock interviews include select Plan delegates and downstream partner/subcontractors. The interviews will cover all sections of the Full Medical Survey.
- 2023 DHCS Routine Full Medical Survey:
  - The 2023 virtual interviews took place from April 17th, 2023, through April 28th, 2023. There were 15 findings and 4 repeat findings identified following the review. The Plan submitted its Corrective Action Plan to the DHCS on November 22nd, 2023. Internal meetings were held with internal stakeholders in Q4 to review Corrective Action Plan and coordinate implementation efforts across the enterprise in efforts to reduce or eliminate repeat findings and lower the number of overall deficiencies year-over-year. In November 2023, the DHCS implemented a new process requiring monthly updates on Corrective Action Plans. The Plan submitted its final update on April 15th, 2024. The DHCS accepted and closed the 2023 Routine Full Medical Survey Corrective Action Plans on April 26th, 2024.

- 2024 HSAG Network Adequacy Validation Audit (NAV)
    - On March 15th, 2024, Health Services Advisory Group, Inc. (HSAG) informed the Plan that it will conduct a Network Adequacy Validation (NAV) Audit. HSAG is a third-party contractor of DHCS, an External Quality Review Organization, conducting the audit on behalf of DHCS. The NAV Audit will evaluate the Plan's data, systems and methods used to calculate results for each network adequacy indicator, as defined by the state's standards. HSAG will specifically validate network related data reported to DHCS in November 2023. Internal meetings began on April 8th, 2024, to discuss details of the request and review the timeline. Impacted departments include Analytics, IT, QI, Provider Services and Compliance. Pre-audit deliverables are due to HSAG on May 15th, 2024. A virtual onsite systems walkthrough and subsequent interview are scheduled for July 15th, 2024, and July 17th, 2024.

- 2024 TRI Subcapitation SDR Audit
    - On April 19th, 2024, the DHCS informed the Plan of its intent to audit a Plan sub-contractual agreement. The Plan must provide contract documentation such as: a List of Covered Services (DOFR); Contract Payment Rate Information, and; specific contract pages, among other items specifically requested by the DHCS. All audit material must be provided within 10 business days of the audit notification. The required materials span the SFY 2021-22 time period (July 1st, 2021, through June 30th, 2022).

Compliance Activity Updates

- DMHC Material Modification – 2024 RFP Readiness Submission:
    - On March 5th, 2024, the Department of Managed Health Care (DMHC) provided additional comments to Filing #20234323 to which the Plan provided responses on April 2nd, 2024. The Plan expects to receive DMHC's response or notice of closure on or around May 2nd, 2024.

- HIPAA Final Rule to Support Reproductive Health Care Privacy:
    - On April 26th, 2024 the Department of Health and Human Services (HHS) released changes to the HIPAA Final Rule by prohibiting uses and disclosures of PHI for criminal, civil, or administrative investigations or proceedings against individuals, covered entities or their business associates (collectively, ''regulated entities''), or other persons for seeking, obtaining, providing, or facilitating reproductive health care that is lawful under the circumstances in which it is provided. The Plan must comply with these changes by December 23rd, 2024.

- 42 CFR Part 2 – Confidentiality of Substance Use Disorder (SUD) Patient Records:
    - On April 16th, 2024, the following changes to 42 CFR Part 2 became effective. The major changes allow HIPAA covered entities to use a single consent for all future uses and disclosures for Treatment, Payment, and Health Care Operations (TPO), and allows HIPAA covered entities and business associates that receive records under this consent to redisclose the records in accordance with HIPAA regulations. The Plan must comply with these updates by February 16th, 2026.
- DMHC Medicare Licensure 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 (LOB). The DMHC issued an Order of Postponement and comments on March 28th, 2024. The Plan provided responses to the DMHC on April 25th, 2024. In addition, the Plan has developed a Plan for transitioning its current Policy & Procedure template for Medicare policies.
- Protiviti Enterprise Risk Management (ERM) Assessment Implementation:
    - The Plan has engaged a third-party consultant, Protiviti, to assist with its roll out of holistic approaches to risk management and risk stratification across the enterprise. Weekly status meetings are held with the Protiviti team to review progress and milestones. Nineteen (19) stakeholder interviews are scheduled with leaders across the Plan with a final report anticipated in June 2024.
- DMHC Timely Access Report/Annual Network Review (TAR/ANR):
    - The Plan is required to annually submit a Timely Access Compliance Report (TAR) that includes information related to monitoring the Plans' network compliance with timely access standards, including network rates of compliance with the appointment wait-time standards during the previous year. The Plan is also required to annually submit information confirming the status of each network and its enrollment, including a complete list of the plan's contracted providers, hospitals, and enrollees within each network. These materials were submitted timely on May 1st, 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 to the Department's satisfaction.

Undertaking Compliance Chart			
Undertaking #	**Deliverable**	**Next Milestone**	**Progress**
No. 6	Submit electronically an Amendment filing to demonstrate compliance with the federal Mental Health Parity and Addiction Equity Act ("MHPAEA") (42 USC § 300 gg-26) and its regulations (45 CFR § 146.136) and Section 1374.76 of the Act.	May 30, 2024	The Plan received a comment table on March 7, 2024. Due to the extensive number of comments (153), the Plan obtained assistance from outside counsel and requested an extension to submit a response on April 30th, 2024. The Plan submitted its responses and updated Non-Quantitative Treatment Limitations (NQTL) Tables on April 30th, 2024.

Compliance

Supporting Documents

COMPLIANCE DASHBOARD SUMMARY										
	Resource	Type	2018	2019	2020	2021	2022	2023	TOTAL	% Completed
OVERALL FINDINGS	DHCS	Total State Audit Findings	38	28	7	33	15	15	136	
		Total Self-Identified Issues	12	0	0	2	0	2	16	
		Total Findings	**50**	**28**	**7**	**35**	**15**	**17**	**152**	
		Total In Progress	0	0	0	0	0	0	0	
		Total Completed	50	28	7	35	15	17	152	**100%**
		Total Findings	**50**	**28**	**7**	**35**	**15**	**17**	**152**	
	DMHC	Total State Audit Findings			5	6	8		19	
		Total Self-Identified Issues			3	0	0		3	
		Total Findings			**8**	**6**	**8**		**22**	
		Total In Progress			0	0	1		1	
		Total Completed			8	6	7		21	**95%**
		Total Findings	**NA**	**NA**	**8**	**6**	**8**	**NA**	**22**	
	DMHC Financial Services	Total State Audit Findings		5			4		9	
		Total Self-Identified Issues		0			0		0	
		Total Findings		**5**			**4**		**9**	
		Total In Progress		0			0		0	
		Total Completed		5			4		9	**100%**
		Total Findings	**NA**	**5**	**NA**	**NA**	**4**	**NA**	**9**	
STATE AUDIT FINDINGS		In Progress	0	0	0	0	1	0	1	
		Completed	38	33	12	39	26	15	163	**99%**
		Total Findings	**38**	**33**	**12**	**39**	**27**	**15**	**164**	
SELF-IDENTIFIED FINDINGS		In Progress	0	0	0	0	0	0	0	
		Completed	12	0	3	2	0	2	19	**100%**
		Total Findings	**12**	**0**	**3**	**2**	**0**	**2**	**19**	
TOTAL OVERALL FINDINGS			**50**	**33**	**15**	**41**	**27**	**17**	**183**	

COMPLIANCE DASHBOARD SUMMARY			
	Type	TOTAL	%
OVERALL FINDINGS	Total State Audit Findings	164	90%
	Total Self-Identified Issues	19	10%
	Total Findings	**183**	
	Total In Progress	1	1%
	Total Completed	182	99%
	Total Findings	**183**	
STATE AUDIT FINDINGS	In Progress	1	1%
	Completed	163	99%
	Total Findings	**164**	
SELF-IDENTIFIED FINDINGS	In Progress	0	0%
	Completed	19	100%
	Total Findings	**19**	

2023 DHCS Audit Summary			
	Type	TOTAL	%
OVERALL FINDINGS	Total State Audit Findings	15	88%
	Total Self-Identified Issues	2	12%
	Total Findings	**17**	
	Total In Progress	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			
	Type	TOTAL	%
OVERALL FINDINGS	Total State Audit Findings	3	100%
	Total Self-Identified Issues	0	0%
	Total Findings	**3**	
	Total In Progress	0	0%
	Total Completed	3	100%
	Total Findings	**3**	

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

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

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

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

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

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

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

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

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

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

ALAMEDA ALLIANCE FOR HEALTH
COMPLIANCE DASHBOARD

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2023 DHCS Audit - *Audit Review Period 4/1/2022 - 3/31/2023* *Audit Onsite Dates - April 17, 2023 - April 28, 2023*							INTERNAL AUDITS		
#	**Category**	**Deficiency**	**Corrective Action Plan (CAP)**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**State/Self Identified**	**Agency**	**Year**
1	UM	(1.5.1) Notice of Action (NOA) Letters The Plan did not ensure a delegate sent NOA letters to providers and members.	The Plan received the delegate's Root Cause Analysis (RCA) and CAP on 04/14/2023. After review and evaluation of the delegate's document the Plan issued a formal CAP on 05/31/2023 and received the delegate's CAP response on 06/27/2023. The initial corrective actions completed by the delegate includes updating their IT script and ensuring the identified missing NOA letters were sent out to the member and that outreach was completed to confirm that services approved or had denial modification authorizations were utilized by members. The delegate also developed workflows to detect and mitigate failures. The CAP includes the delegate's implementation of a remediation plan. The remediation plan includes updates in their workflow, training, and an internal monthly audit- with results submitted to The Alliance for review. The Plan reviewed and evaluated the delegate's CAP implementation and progress during the interim and provided guidance. The CAP was approved and closed on 09/25/2023. (Completed) The delegate is expected to continue its internal monthly audit for the NOA letters and fax confirmation. The Plan will continue to monitor the audit results for compliance. Please see document 1.5.1_AAH Response for full details. (On Track) Additionally, the Plan will review the UM delegates' P&P's to ensure that preventative, detective, and oversight measures are in place for internal NOA letter generation and fax confirmation and these will be evaluated annually at minimum. (On Track) 1a. Monitoring of the delegate's monthly internal audit is ongoing. (On Track) 2. Review the UM delegates' policies and procedures to ensure that preventative, detective, and oversight measures are in place for internal NOA letter generation and fax confirmation. (On Track) Update 3/8/2024 P&P review complete and P&P deemed adequate. Review of the delegate's P&P regarding NOAs is ongoing and The Alliance will continue to meet with the delegate to have P&P appropriately updated. **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

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#	**Category**	**Deficiency**	**Corrective Action Plan (CAP)**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**State/Self Identified**	**Agency**	**Year**
2	QI	(2.1.1) Provision of an Initial Health Assessment (IHA) The Plan did not ensure the provision of a complete IHA for new members.	1. Update IHA policy QI-124 (On Track) **Update 4/5/2024:** Policy updated and approved at Compliance Committee on 3/19/2024 1a. Update IHA policy 124 to include requirement regarding outreach attempts (On Track) **Update 4/5/2024**: Policy updated and approved at Compliance Committee on 3/19/2024 2. Provider education and feedback through Joint Operational Meetings (On going) Update 4/5/2024: Presented at JOMs with delegates in December 2023 2a. Deliver provider education webinars with information about IHA requirements (On Track) **Update 4/5/2024**: Webinars with delegates scheduled through May 2024 2b. Develop a "Measure Highlights" tool for providers. This tool will encompass outreach requirements, IHA elements, USPSTF screenings, and claim codes used to account for IHA completion 3. Expand code set to include additional codes for capturing IHA-related activities (On Track) Update 3/8/2024: Codes updated and included in policy QI-124. 3a. Communicate and provide code sets to providers (On Track) **Update 4/5/2024:** Codes updated and included in policy QI-124 4. Monitor IHA rates (Ongoing) **Update 4/5/2024**: Non-compliance providers and missing elements identified, CAPs issued. 5. Enhance the volume of medical records subjected to review for completeness, including review of USPSTF requirements. (On Track)	**3/31/2024**	Completed	Quality	State	DHCS	2023

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#	**Category**	**Deficiency**	**Corrective Action Plan (CAP)**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**State/Self Identified**	**Agency**	**Year**
3	BHT	(2.3.1) Behavioral Health Treatment (BHT) Plan Elements The Plan did not ensure members' BHT treatment plans contained all the required elements.	1. The Behavioral Heath team developed the attached Treatment Plan Guidelines for our ABA Providers (please see attachment). This document outlines the treatment plan elements that are listed in APL 23-010. All treatment plans and prior-authorization requests for ABA services are reviewed by Board Certified Behavior Analysts (BCBA).The guidelines were emailed to all providers and will also be available on-line for providers to access. In addition to the document, the ABA clinicians worked with the Provider communication team to send out updates/reminders to providers regarding the treatment plan guidelines. Our team is also available to meet with providers and educate them on how to apply the guidelines to their treatment plan templates. (Completed) 1a. Pending Project: We are currently developing an on-line treatment plan template/form that will be utilized by our ABA providers when completing the initia 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 submited 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
4	Access and Availability	(3.1.1) First Prenatal Visit The Plan's policies and procedures for a first prenatal visit for a pregnant member is not compliant with the standard of two weeks upon request.	The Plan has edited Timely Access Standard table, policy QI-107 and QI-114 to reflect the first prenatal visit standard within 2 weeks of the request. (Completed)	Q4 2023	Completed	Quality	State	DHCS	2023
5	Family Planning and State Supported Services	(3.6.1) Non-contracted Provider Payments The Plan did not pay non-contracted providers at the appropriate Medi-Cal fee-for-service rate.	A Change Request was entered to change non-contract mid-level providers reimbursements to 100% of the Medi-Cal rate moving forward. (Completed)	11/16/2023	Completed	Claims	State	DHCS	2023
6	Family Planning and State Supported Services	(3.6.2) Proposition 56 Family Planning Payments The Plan did not distribute add-on payments for institutional family planning service claims as required by APL 22-011.	1. P&P has been revised to ensure that Family Planning services paid on institutional claims are paid As part of Prop 56 payments. 1a. The Plan's Analytics Team is in the midst of preparing the payment details for the retro payment on the FP institutional data and looking to complete by 11/30/2023 timeline. (On Track) 2. The Analytics dept has calculated the retroactive payments due to facilities as a result of finding 3.6.2, APL 22-011 and APL 23-008. (On Track) 2a. Payments will be distributed to providers prior to or latest by Nov 30, 2023. (On Track) 2b. Facility providers with qualifying Family Planning services as per APL 23-008 will be included as part of our monthly Prop 56 payment processing going forward starting Dec 2023. (On Track)	1/15/2024	Completed	Claims	State	DHCS	2023

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#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	State/Self Identified	Agency	Year
7	NMT & NEMT	(3.8.1) **R** Physician Certificate Statement (PCS) Forms The Plan did not ensure PCS forms were on file for members receiving NEMT services.	1.The Plan made the decision to no longer allow courtesy NEMT trips for members without a PCS form on file and the decision to insource PCS form acquisition to the Plan's Case Management Department beginning 3/1/23. Working alongside the Plan's transportation subcontractor, the Plan created new workflows to ensure the transportation subcontractor was not scheduling NEMT trips for members unless there was a confirmed valid PCS form on file, or the Plan provided a verbal authorization due to a trip being of an urgent nature. The Plan hired two transportation coordinators to focus on PCS acquisition leveraging the Plan's preexisting relationships with the provider network and access to EHR's. Through the end of 2022 and beginning of 2023, the Plan's transportation subcontractor trained its call center agents on the new workflow. On 2/14/23, the Plan trained its transportation coordinators on PCS acquisition. On 2/21/23, the Plan trained its entire case management team, that participates in phone shifts for the Plan's case management phone line, on the parameters for verbal authorizations for NEMT trips of an urgent nature. The Plan continues to report on the success of the new workflows at the Plan's UM Committee. (On Track) 1a.The Plan is working with its analytics team to create a report using PCS data elements to match up against subcontractor's report of all NEMT trips taken each month. This report will assist in finding any gaps in PCS compliance. The Plan estimates this report to go live 12/1/2023. (On Track)	12/15/2023	Completed	Case Management	State	DHCS	2023
8	NMT & NEMT	(3.8.2) Transportation Providers' Medi-Cal Enrollment Status The Plan did not ensure all transportation providers were enrolled in the Medi-Cal program.	The Plan has updated the P&P VMG-005 from reviewing the Transportation Providers (TP) on a quarterly review to a monthly review. Attached for reference is the updated P&P. The Plan began reviewing the TP monthly for the utilization from April 2023 to current. (Completed and Ongoing)	4/1/2023	Completed	Vendor Management	State	DHCS	2023
9	Member Rights	(4.1.1) **R** Grievance Acknowledgement and Resolution Letter Timeframes The Plan did not send acknowledgement and resolution letters within the required timeframes.	A grievance processing timeline was created to outline the grievance 30 calendar day process, day by day. The timeline outlines that by day 5, acknowledgement letters will be sent out. We will continue to monitor the daily aging report to ensure that acknowledgement letters are sent in a timely manner. The timeline also outlines that on Day 20, "If response is not received, after at least two follow-up attempts, task to a Medical Director in Quality Suite." Complying with this process will ensure that the Medical Director has sufficient time to reach out to the provider or facility to assist in obtaining a response. The Grievance and Appeals staff were trained on the new timeline on 8/1/2023, copies of the timeline were distributed to the department. (Completed and Ongoing)	8/1/2023	Completed	G&A	State	DHCS	2023

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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
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 nee 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 us 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 1: 013.	The claims system configuration team has corrected the fee schedule for the provider and adjusted the impacted claims to pay the correct rate. (Completed)	4/26/2023	Completed	Claims	State	DHCS	2023
16	CM	(2.2) PCP and members are not consistently notified of Case Management case closures	Configuration made in TruCare to ensure consistent notification	4/26/2023	Completed	Case Management	Self	DHCS	2023
17	Fraud and Abuse	(6.2) The Plan did not report preliminary investigations of all suspected cases of fraud and abuse to DHCS within 10 working days of the Plan receiving notification of the incident.	The Plan has created an interdepartmental team working in collaboration to develop a reporting process for timely submissions of possible HIPAA and FWA incidents to Compliance. Six points of entry for possible incidents have been identified. The team is utilizing technological improvements as well as developing staff training to be able to identify a possible incident for immediate reporting to compliance. At the initiation of the Reporting Process Enhancement, the FWA Specialist will conduct training designed for each department identified as a point of entry. The FWA Specialist will be responsible to track and monitor all privacy related referrals to the compliance department for timeliness Training provided to staff and new tools being used consistently	4/26/2023	Completed	Compliance	Self	DHCS	2023

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2022 DMHC Behavioral Health Investigation - *Audit Review Period* 4/1/2020 - 4/30/2022 *Audit Onsite Dates - September 7, 2022 - September 8, 2022*							INTERNAL AUDITS	
#	**Category**	**Deficiency**	**Corrective Action Plan (CAP)**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**State/Self Identified**	**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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2022 DMHC RBO Audit: Delegate - *Audit Review Period* 1/1/2022 - 3/31/2022							INTERNAL AUDITS			
#	**Category**	**Deficiency**	**Corrective Action Plan (CAP)**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**
1	Claims Payment Accuracy	The Department's examination disclosed that one of 30 high dollar claims were not reimbursed correctly. The claims billed with Current Procedural Terminology (CPT) codes 93005 were underpaid. This deficiency was noted in high dollar claim sample number 28.	The RBO is reprocessing all claims with code 93005 underpaid from January 2021 to present and will upload corrected explanations of benefits upon completion. Corrected explanations of benefits showing additional payment (plus interest and penalty where applicable) as well as the requested report and policies will be submitted to DMHC on or before 1/30/2023.	1/30/2023	Completed	Claims Compliance		State	DMHC	2022
2	Misdirected Claims	The Department's examination disclosed that five out of 40 denied claims were not forwarded. This deficiency was noted in the following denied claims sample numbers: 3, 6, 20, 34, and 37. This deficiency was also noted in the high dollar claim sample numbers: 3, 5, 9, 10, and 25.	There is a system limitation (i.e. mapping issue) where some of the claims (837I encounters) are not being forwarded through our claims processing system. Because of this issue, 837I claims are not being forwarded to health plans. 837I misdirected claims are denied as health plan responsibility and providers are notified via weekly explanations of benefits. The mapping issue was discovered Q1 2022 and tests began at that time with health plans and clearinghouses. 837P files continue to be submitted successfully. The delegate is working with IT to upgrade the server so that updates provided by our software vendors can be implemented for the mapping issue to be resolved. The expected compliance date will be on or before 2/28/2023. 1/26/2023: server updates completed, system updates happening this week. 1/27/2023: system consultant met with the software vendor and their development team to identify and resolve issues so that system updates can happen successfully. 1/30/2023: all system updates completed successfully on test environment	1/30/2023	Completed	Claims Compliance		State	DMHC	2022
3	Reimbursement of Claims Overpayments	The Department's examination disclosed that the RBO failed to send a written request for overpayment reimbursement to the provider. This deficiency was noted in the following late claim sample numbers: 16, 32, and 35.	Examiner error. When the claims examiner reprocessed these claims, the overpayment was reversed instead of a refund request letter being sent to the provider. Compliance met September 27, 2022 when the claims examiner was reminded in a verbal meeting of the above rule as well as the Delegate's internal policy on overpayments. Also, there is a report run prior to the weekly check run to ensure compliance. Because the overpayment was reversed in the adjusted claims, a refund request was not sent for the original claims.	1/30/2023	Completed	Claims Compliance		State	DMHC	2022

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

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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 2023Update 03/10/2023: Delegate has submitted an updated form and delegate is currently working toward completion of the form for submission to the Plan. Provider Services and Compliance will review to validate all fields are complete once all forms are received Update 4/15/2023: The other delegate's form received on 3/2/2023, and two levels of review completed 3/10/2023.	3/10/2023	Completed	Provider Relations		State	DHCS	2022

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2022 DHCS AUDIT FINDINGS: *Audit Review Period 1/1/2021 - 3/31/2022*							INTERNAL AUDITS			
#	**Category**	**Deficiency**	**Corrective Action Plan (CAP)**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**
4	QI	(2.1.1) The Plan did not document attempts to contact members and schedule the IHA.	1. The plan will continue to inform members of the IHA through the EOC, welcome letters to all new members, and videos. - In addition, all members are eligible for a new member orientation (including a financial incentive). - Information regarding the IHA will be included in the member newsletter. The Alliance will initiate a new phone campaign where all new members will receive a phone call encouraging the member to receive an IHA. This phone log will be appropriately documented. The Alliance will create a call script for new member phone calls. 2. The plan will create a report to identify new plan membersUpdate 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 workflowsUpdate 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 approvalUpdate 3/10/2023: Awaiting DHCS approval of script. Update 6/9/2023: Final documents submitted to DHCS for review. Awaiting DHCS response. The Plan will continue to ensure accurate documentation of IHA outreach attempts via providers, by reviewing documentation as part of FSRs.	9/8/2023	Completed	QI		State	DHCS	2022
5	CM	**R** (2.5.1) The Plan's MOU with the county MHP did not include the responsibility for the review of disputes between the Plan and the MHP.	1. The Alliance has made several updates to the MOU and incorporated APL 18-015, as well as APL 21-013 Dispute Resolution Process Between Mental Health Plans and Medi-Cal Managed Care Health Plans. The Alliance has had a series of meetings with the MHP to review redline changes to the MOU. The MHP is currently under review of the redline changes and will notify the Alliance when they can move forward with signing the MOU. The MHP MOU vetting process includes County Board of Supervisor (BOS) approval. Therefore, the Alliance is hoping to execute the MOU by the end of 2022.	12/31/2023	Completed	Provider Relations		State	DHCS	2022
6	Provider Relations	**R** (3.1.1) The Plan did not monitor the network providers' compliance with requirements for when appointments were extended.	1. The Provider Manual was edited to update the requirements, providers were advised in the Quarterly Provider Packet, and The Alliance Provider Representatives advised providers during PCP visits. Additionally, fax blasts were sent to providers regarding the updated requirements, and the Provider Education document was updated to reflect the requirements. 2. Edit P&P and Quality of Access Workflow to ensure all cases are reviewed by a QI Nurse. If a case is determined to be related to access, QI / A&A staff will review data for ED / Inpatient Stays as a result of delay in appointment. If the member does have an ED / IP Claim, the QI RN will then work the case up as a PQI / Quality of Care. This will be reviewed by the Medical Director and follow the PQI process. Finally, all QOA cases with available MRs will be reviewed to ensure the appropriate provider documentation. Update 03/10/2023: Policy QI-114 has been updated and is awaiting approval at committee Update 4/14/2023: P&P Q1-114 was approved at Compliance Committee 3/21/2023	3/21/2023	Completed	Provider Relations QI		State	DHCS	2022

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2022 DHCS AUDIT FINDINGS: *Audit Review Period 1/1/2021 - 3/31/2022*							INTERNAL AUDITS			
#	**Category**	**Deficiency**	**Corrective Action Plan (CAP)**	**Completion Date**	**Internal CAP Status**	**Department Responsible**	**Validation Status**	**State/Self Identified**	**Agency**	**Year**
7	Claims	(3.6.1) The Plan improperly denied emergency services claims.	1. Case #7 – The claim was paid on 8/11/2021. The vendor was notified of the finding on 5/19/2022 and asked to review their internal process to ensure that codes on claims are captured correctly. They acknowledged they reviewed their internal processes and stated that poor claim imaging may have cause the issue, but they will increase the resolution to help ensure better results in the future. 2. Case #20 –The vender was notified of the issue on 5/19/2022 and asked to review their internal process to ensure that dates on clams are captured correctly. They acknowledged they reviewed their internal processes and stated that poor claim imaging may have cause the issue, but they will increase the resolution to help ensure better results in the future. In addition, an edit was enhanced to ensure that the date range order is correct. 3. The claim was paid on 1/5/2022 correctly. The Claims Processor was shown the claim finding for review along with the correct workflow document that shows the correct process to help ensure moving forward this does not occur again. This workflow was also reviewed by the Claim Processor team and training occurred.	10/11/2022	Completed	Claims		State	DHCS	2022
8	Access and Availability	**R** (3.8.1) The Plan did not use PCS forms for NEMT services.	1. The Plan will educate providers on PCS requirements. Update 3/10/2023: Provider Alert PCS Form Reminder and Form was sent out to Providers in a fax blast on Tuesday, 12/27/22. 2. Refine PCS workflows to meet all regulatory requirements. Update 3/10/2023: Workflow updated. 3. The Plan will conduct staff trainings on process workflow changes Update 4/15/2023: Training completed 1/31/2023. 4. The Plan will ensure that the transportation subcontractor trains their staff on the PCS process workflow changes. The transportation subcontractor will provide training materials and sign in sheets Update 4/15/2023: Training completed 1/31/2023. 5. The Plan will develop reports on PCS form outcomes using both transportation subcontractor information and the Plan's process to obtain PCS forms. Update 4/15/2023: Reports developed and presented at UM Committee Q4 2022. 6. The Plan will monitor process workflows from the transportation subcontractor and the Plan to obtain missing PCS forms Update 4/15/2023: Reports developed and presented at UM Committee Q4 2022. 7. The Plan will analyze trends in provider practices and provide feedback to providers regarding PCS form requirements. Update 4/15/2023: Reports developed and presented at UM Committee Q4 2022, where trends analyzed. 8. The plan will evaluate whether to continue having the transportation subcontractor manage the PCS forms or take the direct management of PCS forms back into the Plan. Update 4/15/2023: Reports developed and presented at UM Committee Q4 2022. Will continue to analyze quarterly. 9. The Plan will provide a quarterly report to UM Committee Update 4/15/2023: Reports developed and presented at UM Committee Q4 2022.	4/1/2023	Completed	UM		State	DHCS	2022
9	Member Rights	**R** (4.1.1) The Plan did not send acknowledgement and resolution letters within the required timeframes.	1. The G & A Department Leadership and Quality Assurance Specialist will reference the daily reports to ensure the acknowledgment and resolution letters are sent timely 2. The Plan provided training to the Grievance & Appeals staff to review the regulatory requirements for mailing of acknowledgement and resolution letters. 3. The Quality Assurance Specialist will audit 5 appeals cases and 5 grievances cases per Grievance & Appeals Coordinator per month.	10/1/20222	Completed	G&A		State	DHCS	2022

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

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

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2021 DHCS JOINT AUDIT FINDINGS: *Audit Review Period 6/1/2019 - 3/31/2021*								INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Risk Category (High, Medium, Low)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	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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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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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

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

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

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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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2019 DHCS AUDIT FINDINGS - *Audit Review Period: 6/1/2018-5/31/2019*						INTERNAL AUDITS						
#	Category	Deficiency	Corrective Action Plan (CAP)	Repeat Finding (Yes/No)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
1	UM Delegation	The Plan did not ensure a delegate complied with all contractual and regulatory requirements. The delegate required PA for an initial visit with a mental health provider to determine if the member had mild-to-moderate mental health issues, which the contract does not allow.	The Alliance scheduled a meeting with the delegate to discuss the findings and will put a corrective action plan in place. Update as of 12/5/2019: The delegate has revised policy, and submitted to The Alliance for review. The Alliance will review and discuss changes with the delegate on the next Operations call. Update as of 1/8/2020: Plan reviewed documents and agree with the changes for member self-referral process. Discussing with DHCS prior to final CAP submission.	No	1/8/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed
2	UM Delegation	The Plan did not ensure a delegate complied with all contractual and regulatory requirements. The delegate required a two-step prior authorization (PA) process for BHT services, which is allowed, but did not send written notification when it denied services at the first step. The delegate did not consistently apply criteria for approving BHT.	The Alliance scheduled a meeting with the delegate to discuss the findings and will put a corrective action plan in place. Update as of 12/5/2019: The delegate has revised policy, and submitted to The Alliance for review. The Alliance will review and discuss changes with the delegate on the next Operations call. Update as of 1/8/2020: Plan reviewed documents and still have open items not documented. Plan will be meeting with the delegate to discuss criteria and procedures for further documentation needed. Update as of 2/7/2020: Met with the delegate to review their criteria and approval process. Requested policy language changes to meet the regulatory requirements. Policy was approved by Committee on 1/27/20. Updated CAP response submitted to DHCS on 2/7/2020.	No	2/7/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed
3	UM Delegation	(1.1.3) The Plan did not review ownership and control disclosure information for their Utilization Management (UM) delegates	The Plan will ensure that its delegated providers complete the Ownership and Control disclosure forms. The Plan will create a tracking log and document any follow up attempts made with the delegate to ensure accuracy. Update as of 12/2/2019: PR has created a tracking log and is working on a desktop procedure.	Yes	1/1/2020	Completed	Provider Services	✓	State	DHCS	2019	Completed
4	UM Delegation	The Plan did not ensure receipt of all contractual and regulatory reports during the audit period.	The Plan will conduct staff retraining of delegation reporting procedures to ensure all are tracked and monitored for receipt and review. Update as of 12/5/2019: Staff training was conducted on 12/3/2019.	Yes	12/1/2019	Completed	Compliance	✓	State	DHCS	2019	Completed
5	UM Delegation	The Plan's oversight of its delegate did not identify unclear NOA letters, and incorrect appeal and SFH information	The Alliance scheduled a meeting with the delegate to discuss the findings and will put a corrective action plan in place. Update as of 12/5/2019: The delegate has developed on a new process regarding NOA letters, appeal rights and SFH Information. The Alliance will review and discuss changes with the delegate on the next Operations call. Update as of 1/8/2020: Plan reviewed documents and agreed with changes of procedure checklist and training materials.	No	1/15/2020	Completed	Utilization Management		State	DHCS	2019	Completed
6	Referral Tracking process	The Plan did not track all approved PAs; the specialty referral tracking process did not include modified PAs and in-network approved services.	The UM Department is working with analytics to expand the routine referral tracking report to include all approved authorizations. Update as of 12/5/19: Clarity is being sought from DHCS on the scope of specialty referral tracking. Update as of 1/8/20: An updated referral tracking report is being developed to include all decision types and specialty services that require authorization. Update as of 2/7/20. Updated report sample generated and submitted to DHCS. Working with Analytics to create routine report that captures all needed data elements. Update as of 3/5/2020 UM met with Analytics to create the routine report capturing all needed elements. Report is in development. Update as of 5/8/20 Specialty Tracking Report has been created by Analytics, including all required elements, and will now be routinely reported quarterly through UMC and HCQC. Reported at HCQC on 5/21/20. Update as of 6/12/20: Report sent to HCQC on 5/21/20 and reviewed at UMC at 5/29/20.	Yes	5/21/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed
7	Prior Authorizations	A review of PA data showed non-qualified Plan staff denied retrospective cases for administrative reasons other than non-eligibility for membership. The Plan denied retrospective service requests without review by a medical director if the provider submitted the request more than 30 days after the service delivery date, or if requests did not meet Plan-imposed conditions. The Plan's contract did not specify submission timeframes or other conditions that, if not met, allowed eliminating medical necessity review of retrospective requests for covered services.	Policy and procedure UM-001 Utilization Management will be updated to comply with the contractual requirements. Workflows will be updated to have all retrospective requests reviewed by a medical director. Workflows have been updated to have all retrospective requests reviewed by a medical director. Update as of 12/5/2019: Clarity is being sought from DHCS on allowing a time limit of 30 days. Update as of 1/8/2020: Plan received clarity from DHCS and is updating internal procedures. Update as of 2/7/2020: P&Ps updated to reflect that only an MD can deny retro PA requests. P&Ps approved at HCQC on 1/16/2020.	Yes	1/16/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed
8	Prior Authorizations	(1.2.2) The Plan did not ensure it used appropriate processes to review and approve medically necessary covered services when it did not ensure that qualified medical personnel rendered medical decisions. Dependent practitioners reviewed, assessed and approved requests for continued hospital stays	The process for ensuring LVNs perform only within their scope of practice was updated and implemented on 10/2/2019. Additional changes to the UM systems to better track the change in process are being developed. Update as of 12/5/2019: Changes to the UM systems to better track the RN oversight role with the LVNs completed. Other Managed Medi-Cal plans have LVNs performing UM. Clarity is being sought from DHCS on the use of LVNs in UM. Policies and procedures and job descriptions are being reviewed to be aligned with the updated oversight process. Update as of 1/8/2020: Plan received clarity from DHCS and updated procedures for RN oversight.	No	1/8/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed
9	Prior Authorizations (UM and Rx)	The Plan's notice of action (NOA) letters did not follow specifications in Health and Safety Code Section 1367.01. Provider letters in medical cases did not include the decision makers' direct phone number or contained the incorrect number. Letters did not explain the reasons for the denial. Pharmacy NOAs were not concise.	Accurate phone numbers for the decision makers are on the NOA, monitoring will be conducted through internal audits. UM NOA template letters were updated and implemented on 11/4/2019, internal auditing will be conducted monthly to ensure that the letters are clear and concise and explain the reasons for denial. Pharmacy NOA template letters were updated and implemented in April 2019, internal auditing will be conducted at least monthly to ensure that the letters are clear and concise and explain the reasons for denial. The pharmacy team also meets with the PBM on a weekly basis to optimize PA review process, NOA letter language and reasons for denial.	Yes	11/4/2019	Completed	Utilization Management /Pharmacy		State	DHCS	2019	Completed

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10	Prior Authorizations	The Plan did not ensure that all contracting practitioners were aware of the procedures for orthotic items; the Plan provided inaccurate information about authorization requirements for orthotic items	The Alliance's Authorization Grid will be updated to include the accurate information about authorization requirements for orthotics. The updated grid will be uploaded on the website. Update as of 12/5/2019: A meeting will be scheduled the week of 12/9 to discuss changes. Update as of 1/8/2020: Meeting was conducted and PA grid will be updated to reflect corrections. Update as of 2/7/2020. PA grid is being updated for all services requiring PA, so that MDs do not receive repeat communication about changes to the PA grid. Orthotics will be included in the comprehensive update. Update as of 3/5/2020 Prior Auth requirement for Orthotics was added to the PA grid on the Provider Portal	No	3/2/2020	Completed	Utilization Management	✓	State	DHCS	2019	Completed
11	Appeals	The Plan's appeal notification letters did not comply with contractual regulations. NAR letters were not clear or concise, and contained inaccurate information	The G&A staff will attend additional training to review contractual regulations. Internal audits will be conducted monthly by the manager or director to monitor compliance. Update as of 12/5/2019: Training conducted on 11/14/2019.	No	11/22/2019	Completed	G&A		State	DHCS	2019	Completed
12	Case Management & Care Coordination - HRAs	The Plan did not follow the specified timeframes required for completion of the HRAs for newly enrolled SPD members. The Plan did not ensure that HRAs were completed within 45 calendar days of enrollment for those identified by the risk stratification mechanism as higher risk, and within 105 calendar days of enrollment for those identified as lower risk.	HRA tracking had been implemented in early 2019, and continues at present. HRAs are sent out within the required timeframes. Robo calls are made to low risk members to encourage them to complete and send in the HRA within the timeframe. Direct calls are made by CM staff on high risk members to encourage them to complete and send in the HRA within the timeframe. A tracking log is kept to ensure that the required timelines are met.	No	9/16/2019	Completed	Case Management		State	DHCS	2019	Completed
13	Case Management & Care Coordination - Initial Health Assessment (IHA)	The Plan did not ensure that all providers documented all required components of an IHA. Preventive services identified as USPSTF "A" and "B" recommended services were not provided, or status of these recommended services was not documented	The QI Department revised its provider medical record request letter to include: all categories that support IHA completion; a hyperlink and/or copy of the SHA/IHEBA form; and sample documentation of a compliant SHA/IHEBA. Providers were re-educated on the SHA/IHEBA requirements.	No	9/30/2019	Completed	Quality		State	DHCS	2019	Completed
14	Complex Case Management (CCM)	2.2.1 The Plan did not implement its monitoring of the CCM program to address member needs. The Plan did not close its CCM cases after 90 days, or present them at Case Rounds as stated in its policy	Existing aging reports are being utilized by the Case Management Department in CCM Rounds to ensure that members' cases are either reviewed and closed, or extended past 90 days.	Yes	10/14/2019	Completed	Case Management	✓	State	DHCS	2019	Completed
15	Access & Availability	3.1.1 The Plan did not maintain an accurate provider directory.	The Plan will continue to verify 10 providers per week and has added the following two processes to continuously maintain an accurate provider directory: 1. Provider Data Comparison to manually review provider data received from our delegates started September 2019 and 2. Provider Data Validation Yearly Project to review directly contracted providers who appear in the Provider Directory. In addition, the Provider Relations Department includes a Provider Demographic form in all provider quarterly packets and work with providers to obtain the completed forms during provider visits.	Yes	11/1/2019	Completed	Provider Services	✓	State	DHCS	2019	Completed
16	Emerg Family Planning Claims/SSS	The Plan paid non-contracted family planning services at less than the Medi-Cal Fee-For-Service rate. The Plan's claim system misclassified non-contracted family services as non-billable. The Plan is required to pay all covered family planning services regardless if these services are contracted with the Plan.	This finding is specific to one provider based on the list of services identified in the contract. No other provider was impacted by this issue. The claims system has been re-configured to reimburse services as follows: * services listed in the provider contract will be reimbursed at the contracted rate * covered Medi-Cal services not listed in the contract will be reimbursed at 100% of the prevailing Medi-Cal rate	No	9/5/2019	Completed	Claims	✓	State	DHCS	2019	Completed
17	Emerge Family Planning Claims	The Plan did not inform members of the correct minor consent provision for family planning services in its Evidence of Coverage (EOC).	The Plan has updated its 2020 EOC to include the appropriate minor consent provisions. The EOC was submitted to DHCS for review and approval on 10/7/2019.	No	10/7/2019	Completed	Compliance	✓	State	DHCS	2019	Completed
18	Access to Pharm Services	The Plan did not monitor the provision of drugs prescribed in emergency situations.	The Pharmacy Department is working with the PBM to create routine monitoring reports of drugs prescribed in emergency situations. Update as of 1/8/20: Internal meeting was conducted to ensure requirements are clear and next steps for updating policy and monitoring reports. Update as of 2/11/2020: Draft P&P and monitoring log have been created and are under review. Update as of 4/10/2020: The P&P and monitoring log were approved at the most recent P&T Committee meeting.	Yes	3/17/2020	Completed	Pharmacy	✓	State	DHCS	2019	Completed
19	Grievances	4.1.1 The Plan did not document review and final resolution of clinical grievances by a qualified health care professional	The G&A workflow for Quality of Care review was updated and implemented on 4/15/2019 to include the CMOs review and final resolution.	Yes	4/15/2019	Completed	G&A	✓	State	DHCS	2019	Completed
20	Grievances	4.1.2 The Plan's grievance system did not capture all complaints and expressions of dissatisfaction reported by members.	The G&A staff will attend additional training to review contractual regulations. Internal audits will be conducted monthly by the manager or director to monitor compliance. Update as of 12/5/2019: Training was conducted on 11/14/2019.	No	11/22/2019	Completed	G&A		State	DHCS	2019	Completed
21	Grievances	The Plan's grievance system did not capture all complaints and expressions of dissatisfaction filed through Plan providers.	The Plan provided training to its delegated entities of the Plan's grievance process to ensure the Plan's system receives and resolves all complaints of dissatisfaction. Clinics will be trained by the delegate to ensure that the Alliance is capturing all complaints. Update as of 1/8/2020: Medical group provided training sign in sheet. The delegate is working on next steps of educating providers. Update as of 2/7/2020: the delegate provided an attestation to complete its provider training by the end of Q1 2020. Update as of 4/10/2020: Meeting medical group week of 4/6 to discuss implementation. Update as of 4/20/2020: Process for forwarding complaints received by medical group has been implemented as of 4/20/2020.	Yes	~~3/31/2020~~ 5/1/2020	Completed	G&A/Provider Services/ Compliance	✓	State	DHCS	2019	Completed
22	Grievances	4.1.4 The Plan sent member resolution letters without completely resolving all complaints.	The G&A staff will attend additional training to review contractual regulations. Internal audits will be conducted monthly by the manager or director to monitor compliance. Update as of 12/5/2019: Training was conducted on 11/14/2019.	Yes	11/22/2019	Completed	G&A		State	DHCS	2019	Completed

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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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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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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
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

ALAMEDA ALLIANCE FOR HEALTH
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2018 DHCS FINAL AUDIT REPORT FINDINGS - *Audit Review Period: 6/1/2017-5/31/2018*								INTERNAL AUDITS			
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
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

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2018 DHCS FINAL AUDIT REPORT FINDINGS - *Audit Review Period: 6/1/2017-5/31/2018*					INTERNAL AUDITS						
#	Category	Deficiency	Corrective Action Plan (CAP)	Completion Date	Internal CAP Status	Department Responsible	Validation Status	State/Self Identified	Agency	Year	Status
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

#	Regulatory Agency	APL/PL #	Date Released	APL/PL Title	LOB	APL Purpose Summary
Q4 2023 - Present APL IMPLEMENTATION TRACKING LIST						
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.
12	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.

May 2024

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Background

- The CRA was conducted from December 2022 through May 2023 by RGP, a third-party consultant.
  - The report includes 14 areas of opportunities with 22 findings.
  - Details on the audit and our initial assessment were presented at the December 2023 Compliance Advisory Committee meeting.
- 52% of the recommendations have been completed.
  - Including programs and policies already developed and not accounted for in the CRA.
- 48% of the recommendations are in process.
  - Compliance has created an implementation plan and started working with impacted areas to address the findings.

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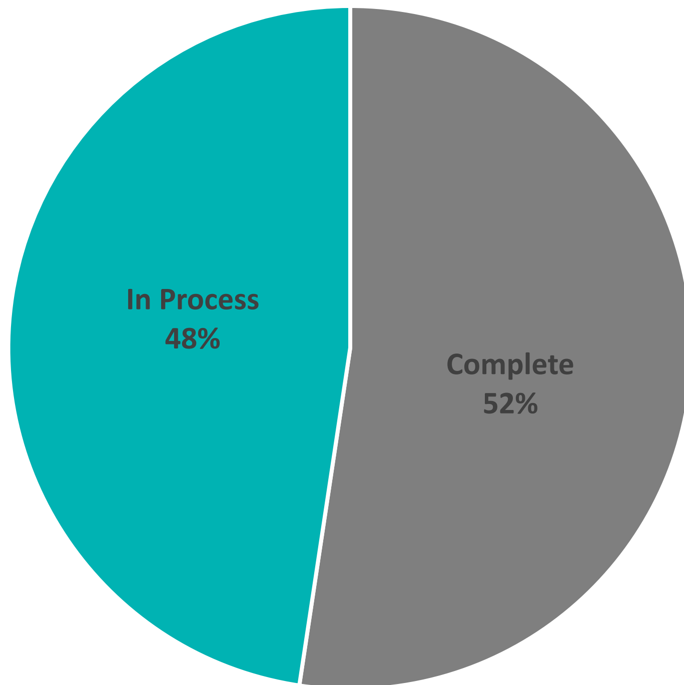
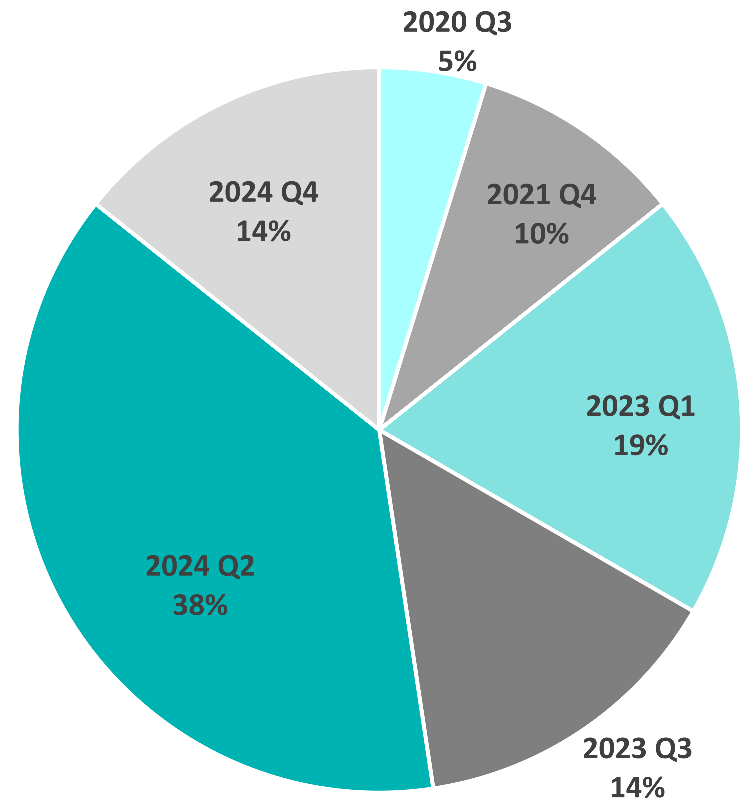
Implementation Status





Recommendations Completed

Completed	Quantity	Description
2024 Q2	1	• 6.1 Developed Compliance Hotline Triage behavioral health triage protocols.

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Additional Actions

- The Compliance Division developed additional actions beyond RGP's recommendations to mature the compliance program.
  - 22 additional actions for the 14 areas of opportunity.

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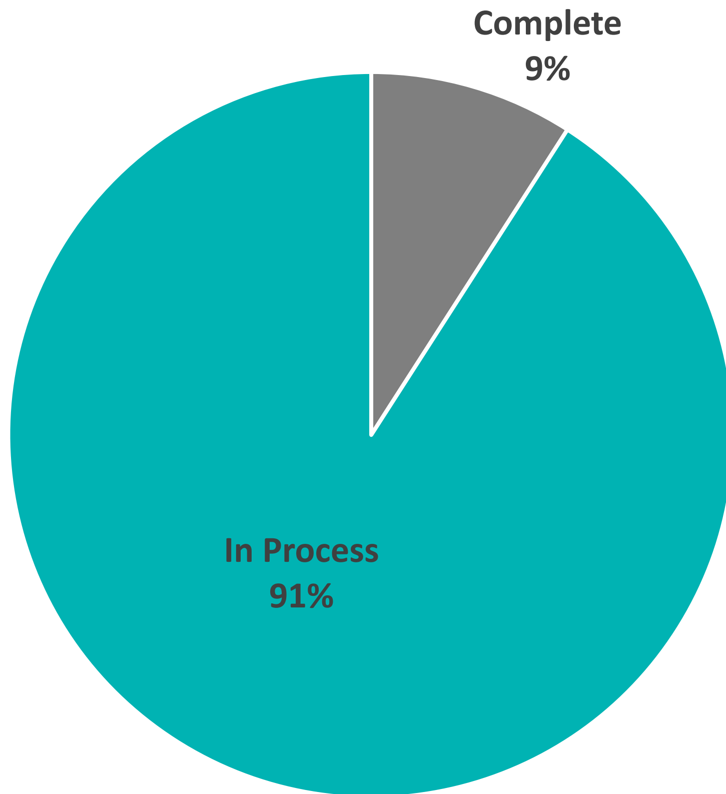
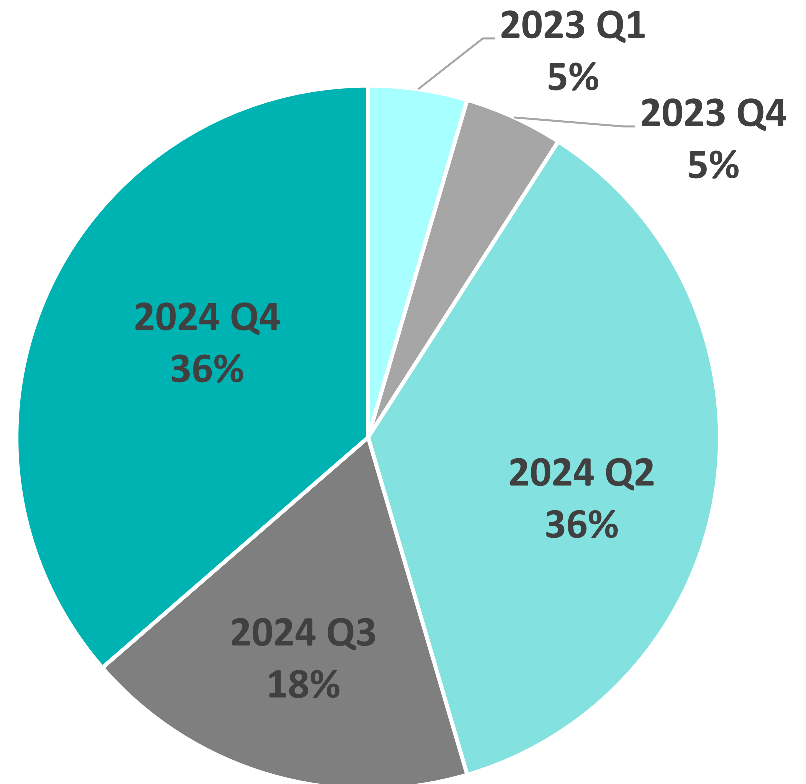
Additional Actions Status





Additional Actions Completed

Completed	Quantity	Description

2023 Q3	2	• 5 AA - Regulatory Affairs partners with IPD on ongoing projects and implementation processes.
		• 12 AA - The following was developed as on-going training resources for Policies and Procedures.
		    • The Policy and Procedure Template provides guidance/ training to employees on the format of the Alliance's policies.
		    • The P&P WOC Workflow provides an overview of the development, review, and approval process.

Recommendations In Process (Highlights)

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Estimated Completion	Quantity	Description
2024 Q2	2	• 3.1 Internal Audit Procedures • Desktop procedures for conducting audits and reporting internal audit findings have been developed and are under review by management. • 6.2 Human Resource Hotline • The Alliance is determining if a Human Resource Hotline will be obtained.
2024 Q4	1	• 4.1 Establish an enterprise risk management program. • The enterprise-wide corporate risk assessment kicked off on March 26, 2024.

Additional Actions In Process (Highlights)

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Completed	Quantity	Description

2024 Q4	4	• 4 AA - Stakeholders from various departments are being interviewed to ensure they are actively involved in the risk assessment process. Interviews began May 1, 2024.
		• 8AA - Compliance is gathering feedback from Subcontractor and Delegation Oversight Committee stakeholders on the CAP process and Delegation Dashboard. Also, Dashboard reporting is being enhanced.
		• 11 AA - A continued FWA training plan and workflows are being developed so incidents are reported timely from other departments.
		• 13 AA - Privacy has started partnering with Vendor Management on:
		  • Various agreements such as Data Sharing Agreements
		  • Privacy/security incident investigations
		  • Development of a Vendor Playbook

Questions?

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Health Care Services

Donna Carey, MD

To: Alameda Alliance for Health Board of Governors

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

Date: May 10th, 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 March to April 2024, with the largest month-over-month increase in outpatient authorization volumes.

Total Authorization Volume (Medical Services)			
Authorization Type	**February 2024**	**March 2024**	**April 2024**
Inpatient	2,283	2,176	2,317
Outpatient	3,916	4,033	4,395
Long-Term Care	1,114	879	1,068
Total	**7,313**	**7,088**	**7,780**

***Source**: #02569_AuthTAT_Summary*

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

Utilization Management: Outpatient

- Anthem CoC volume is consistently running at 10-15% of all incoming authorizations at any given time.

- For process improvement, OP UM completed an analysis of our radiology requests over the last 15 months and identified services that were being approved at 90% or more and moved them to an automated authorization process. Further assessment will be done by our Physicians to evaluate if certain radiology services may ultimately be removed from our prior authorization process. Improvements to our reporting are being made to further evaluate at a code level other services where we may be able to automate the decision process or remove from PA.

- Annual evaluation of our PA coding on prior authorization has begun. Impact analysis of updated coding is being done in the following areas: acupuncture, allergy, EEG, sleep study, blood products and radiology.

- 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 4,395 authorizations in the month of April. The top 5 categories remain radiology, OP Rehab, TQ, Home Health and Outpatient facility.

Total Outpatient Authorization Volume			
Authorization Status	**February 2024**	**March 2024**	**April 2024**
Approvals	3680	3798	4219
Partial Approvals	17	24	15
Denials	219	211	161
Total	**3916**	**4033**	**4395**

Source: *#02569_AuthTAT_Summary*

Outpatient Authorization Denial Rates			
Denial Rate Type	**February 2024**	**March 2024**	**April 2024**
Overall Denial Rate	**4.2%**	**3.7%**	**2.9%**
Denial Rate Excluding Partial Denials	**4.0%**	**3.4%**	**2.7%**
Partial Denial Rate	**0.3%**	**0.4%**	**0.2%**

Source: *#03690_Executive_Dashboard*

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

Source: *#02569_AuthTAT_Summary*

Utilization Management: Inpatient

- The Inpatient UM team processed a total of 2,317 reviews in the month of April. This is a 10% increase from the volume reported in March 2024, markedly higher than December 2023 before the integration of the Anthem and Adult Expansion members in addition to the seasonal influx in acute admissions during the typical Winter Flu

Season Months. We continue to see an increase in the SNF Admissions related to 2023 volume increases from both the Long-Term Care carve-in and the dually eligible (MediCare and Medi-Cal) population throughout Q4 and into Q1 of this year. These new populations have a higher hospitalization rate, which contributed to increases in acute inpatient admissions.

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

- Auth TAT compliance was 97% for February, 99% in March and 96% in March. Despite the increase in auth volume, IP UM Team still exceeded the benchmark TAT of 95% for both our Medical and Commercial Lines of Business.

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

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

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

Total Inpatient Authorization Volume			
Authorization Status	**February 2024**	**March 2024**	**April 2024**
Approvals	2215	2101	2249
Partial Approvals	0	0	0
Denials	68	75	68
Total	**2283**	**2176**	**2317**

***Source**: #02569_AuthTAT_Summary*

Inpatient Med-Surg Utilization			
Total All Aid Categories			
Actuals (excludes Maternity)			
Metric	**January 2024**	**February 2024**	**March 2024**
Authorized LOS	**5.8**	**5.7**	**5.6**
Admits/1,000	**60.9**	**54.2**	**52.0**
Days/1,000	**354.3**	**307.6**	**291.9**

***Source**: #01034_AuthUtilizationStatistics*

Inpatient Authorization Denial Rates			
Denial Rate Type	**January 2024**	**February 2024**	**March 2024**
Full Denials Rate	**0.8%**	**0.7%**	**1.6%**
Partial Denials	**1.4%**	**1.5%**	**1.4%**
All Types of Denials Rate	**2.3%**	**2.2%**	**3.0%**

***Source**: #01292_AllAuthDenialsRates*

Turn Around Time Compliance			
Line of Business	**February 2024**	**March 2024**	**April 2024**
Overall	**97%**	**99%**	**96%**
Medi-Cal	**97%**	**99%**	**96%**
IHSS	**100%**	**100%**	**97%**
Benchmark	*95%*	*95%*	*95%*

***Source**: #02569_AuthTAT_Summary*

Utilization Management: Long-Term Care

- New Long Term Care Manger will start 05/06/2024.

- LTC census during April 2024 was 2,879 members. This is an increase of 15.25% from March 2024.

- Month to Month in Q1 2024 the admissions, days and readmissions are decreasing. From January to March the admissions decreased by 53.68%, the days decreased by 60.75% and the readmissions decreased by 50%. Some of this could be due to a lag in claims, but we are seeing a decrease.

Totals	January 2024	February 2024	March 2024
Admissions	136	106	63
Days	777	706	305
Readmissions	26	16	13

***Source**: #14236_LTC_Dashboard*

- LTC Deliverables all submitted, approved by DHCS

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

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

- Having virtual rounds with AHS and Eden LTC facilities

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

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

- Authorization volume has increased by 21.5% in April 2024 compared to March 2024.

Total LTC Authorization Volume			
Authorization Status	**February 2024**	**March 2024**	**April 2024**
Approvals	1095	870	1036
Partial Approvals	0	0	0
Denials	19	9	32
Total	**1114**	**879**	**1068**

Source: *#02569_AuthTAT_Summary*

Turn Around Time Compliance			
Line of Business	**February 2024**	**March 2024**	**April 2024**
Medi-Cal	**96%**	**96%**	**98%**
Benchmark	*95%*	*95%*	*95%*

Source: *#02569_AuthTAT_Summary*

- Authorization processing turn-around time (TAT) **exceeds** benchmark

- LTC team continues the following activities to manage increased production volumes and maintain TAT compliance:
    - Hiring additional staff to assist with the increase in volume

- Continue staff education so that TAT is calculated correctly
- Working with analytics to help capture line level TAT correctly

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.

- CM continues to work with UM on Continuity of Care requests for former Anthem members that transitioned over to the Alliance on January 1, 2024.

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

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

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

Case Type	Cases Opened in March 2024	Total Open Cases as of March 2024	Cases Opened in April 2024	Total Open Cases as of April 2024
Care Coordination	560	1448	642	1472
Complex Case Management	13	64	7	45
Transitions of Care (TCS)	1103	1734	1202	2154

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

Behavioral Health

Mental Health Turnaround Times

MH TAT			
**Goal ≥95%*	**24-Feb**	**24-Mar**	**24-Apr**
Determination TAT%	99%	99%	98%
Notification TAT%	81%	75%	89%

- On April 16, 2024, the IT department fixed the letter automation for approved authorizations in the Provider Portal, resulting in a 14% increase in notification TAT efficiency.

Behavioral Health Treatment Turnaround Times

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

Behavioral Health Denial Rates

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

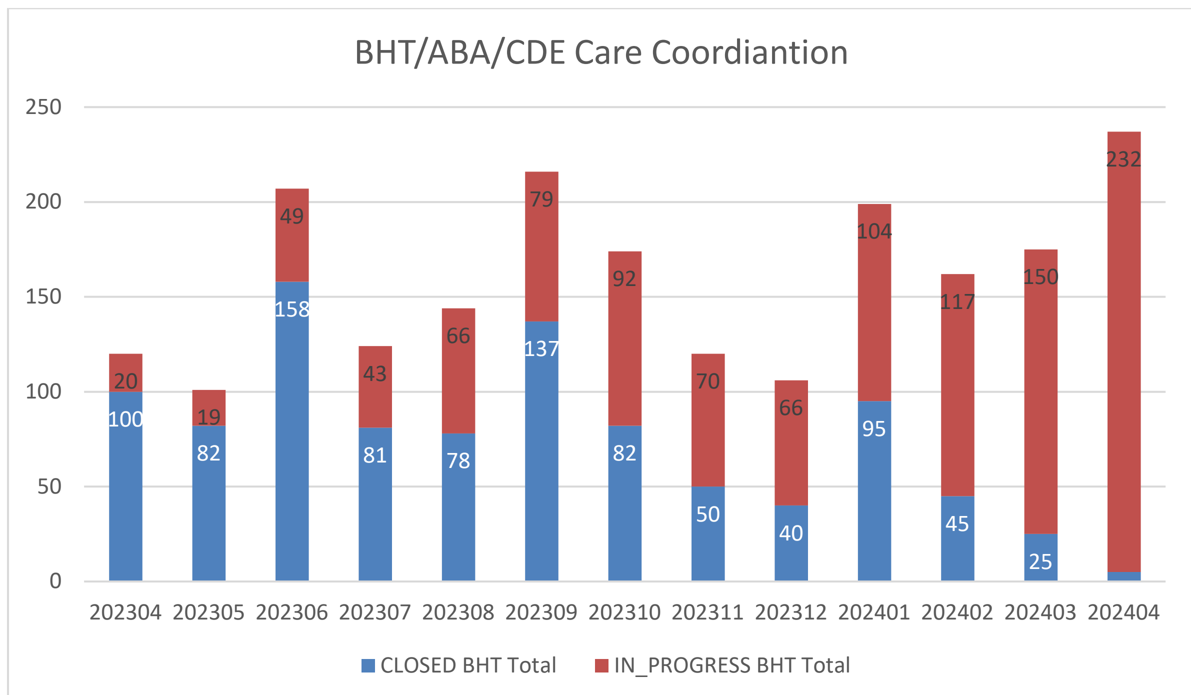
***Source: 14939_BH_AuthTAT**

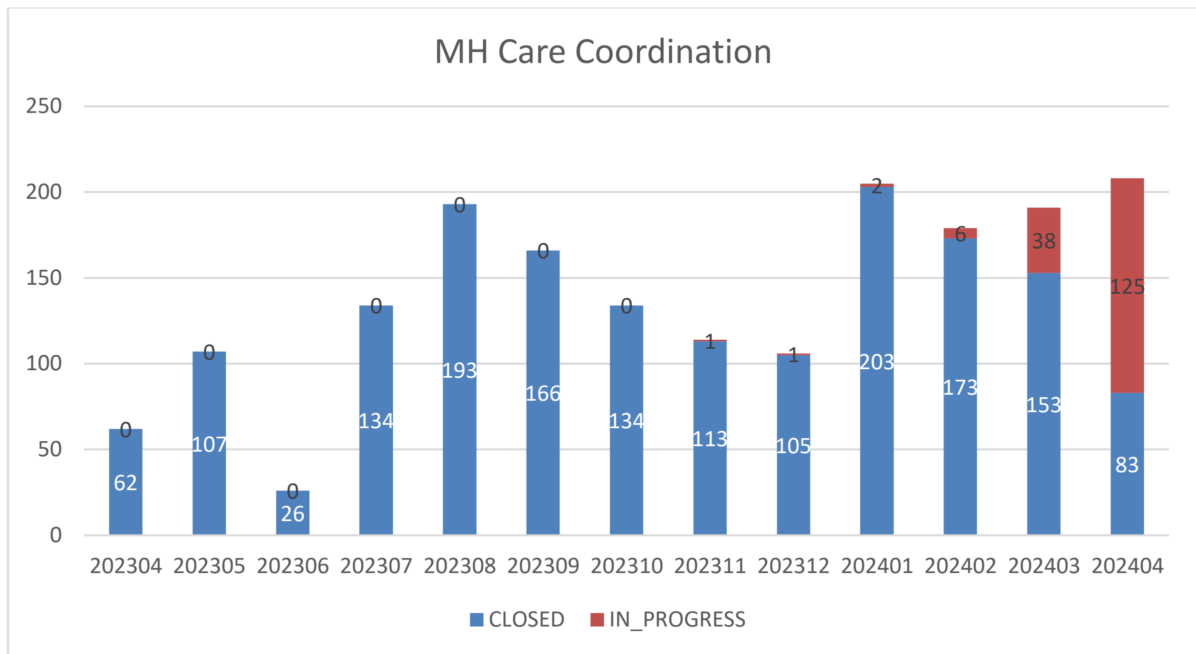
BH Case Management

BH Care Coordination

Total # Medi-Cal Screening Tools			
	Feb-24	**Mar-24**	**Apr-24**
Youth Screenings	63	44	46
Adults Screenings	111	97	119

***Source: PBI_14460 – MLS BH TruCare Assessments**





***Source: 14665_BH_Cases**

Additional Initiatives

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

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

- DHCS Audit CAP Finding 2.3.1 (Month 6):
    - BH-004 has been fully implemented as of 04/10/2024.
    - AAH is developing an online BHT Treatment Authorization Request, which is currently being reviewed by the Medical Director and ABA clinical team.

The BHT treatment plan audit has been fully accepted by DHCS with no further questions. The next audit period (Q2) will go through June 2024.

Pharmacy

- Pharmacy has completed the project potential under-utilizers for **2,417** Medi-Cal & **41** GroupCare members with Hepatitis C and **129** Medi-Cal & **5** GroupCare members with chronic hepatitis B at Alameda Alliance for Health. Pharmacy had top **10** PCP fax blasts (Hep C: 1135, Chronic Hep B: 116) . Also, Pharmacy completed the targeted top 10 PCP for academic detailing meetings. General member education for members is in progress. Pharmacy have so far reviewed **151** chart reviews. **118** members did not require any interventions while **2** specialists referral/follow-up, **1** lab order, **3** new drug recommendation and **27** PCP follow up are to take place.
- 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. 9 members were identified for potential care coordination outreaching.

MME	IHSS	MCAL	Total
January 2024			**364**
50-89	5	283	288
90-119	1	22	23
120-199	2	29	31
200-299	0	12	12
300-399	0	5	5
>400	0	5	5
February 2024			**326**
50-89	4	260	264
90-119	0	19	19
120-199	1	28	29
200-299	0	9	9
300-399	0	2	2
>400	0	3	3
March 2024			**362**
50-89	3	296	299
90-119	1	22	23
120-199	1	23	24
200-299	0	9	9
300-399	0	1	1
>400	0	6	6

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 assists them working through challenging issues such as appropriate billing.

- AAH continues to collaborate with Health Care Services Agency (HCSA) 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 Outreach in January 2024	Total Open Cases as of January 2024	ECM Outreach in February 2024	Total Open Cases as of February 2024	ECM Outreach in March 2024	Total Open Cases as of March 2024
2335	2339	2072	2434	937	2610

***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 the 6-month continuity of care timeline is ending.

- The AAH CS team is working collaborative with HCSA to assist HCSA with catching up on Housing CS services for the FY ‘23-’24. This includes correcting authorization dates and continuing authorizations for members who have received services from HCSA since 7/1/23.

- The new manager for Community Supports will start Monday, May 13, 2024.

- CS services are focused on offering services or settings that are medically appropriate and cost-effective alternatives. The Alliance offers the following community supports:
  - Housing Navigation
  - Housing Deposits
  - Tenancy Sustaining Services

- Medical Respite
- Medically Tailored/Supportive Meals
- Asthma Remediation
- (Caregiver) Respite Services
- Personal Care & Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Nursing Facility Transition/Diversion to Assisted Living Facilities
- Community Transition Services/Nursing Facility Transition to a Home
- Sobering Centers (Coming July 2024)
- Short term Post Hospitalization Housing (coming Jan 2025)
- Day Habilitation (coming Jan 2025)

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

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

Community Supports	Services Authorized in January 2024	Services Authorized in February 2024	Services Authorized in March 2024
Housing Navigation	1056	997	985
Housing Deposits	148	146	136
Housing Tenancy	1400	1269	1032
Asthma Remediation	63	77	90
Meals	1033	1150	1260
Medical Respite	96	102	109
Transition to Home	5	6	5
Nursing Facility Diversion	24	27	24
Home Modifications	5	5	3
Homemaker Services	181	232	283
Caregiver Respite	3	6	5

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

Grievances & Appeals

- All cases were resolved within the goal of 95% of regulatory timeframes.
- Total grievances resolved in March were 7.64 complaints per 1,000 members.
- The Alliance's goal is to have an overturn rate of less than 25%, for the reporting period of March 2024; we met our goal at 23% overturn rate.

March 2024 Cases	Total Cases	TAT Standard	Benchmark	Total in Compliance	Compliance Rate	Per 1,000 Members*
Standard Grievance	1,409	30 Calendar Days	95% compliance within standard	1,408	99.9%	3.15
Expedited Grievance	1	72 Hours	95% compliance within standard	1	100.0%	0.00
Exempt Grievance	2,121	Next Business Day	95% compliance within standard	2,120	99.9%	4.84
Standard Appeal	48	30 Calendar Days	95% compliance within standard	48	100.0%	0.11
Expedited Appeal	0	72 Hours	95% compliance within standard	N/A	N/A	0.00
Total Cases:	3,579		95% compliance within standard	3,577	99.9%	7.64

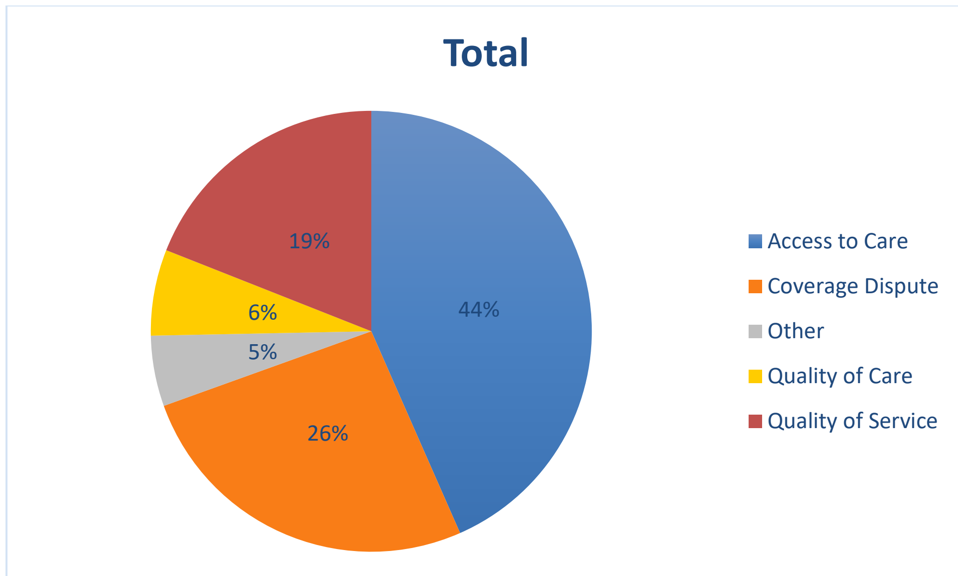
*Calculation: the sum of all unique grievances for the month divided by the sum of all enrollment for the month multiplied by 1000.

Grievances

- 612 of 1,410 (44%) cases were related to Access to Care, the top 3 grievance categories are:
  - (317) Timely Access
  - (121) Technology/Telephone
  - (87) Provider Availability

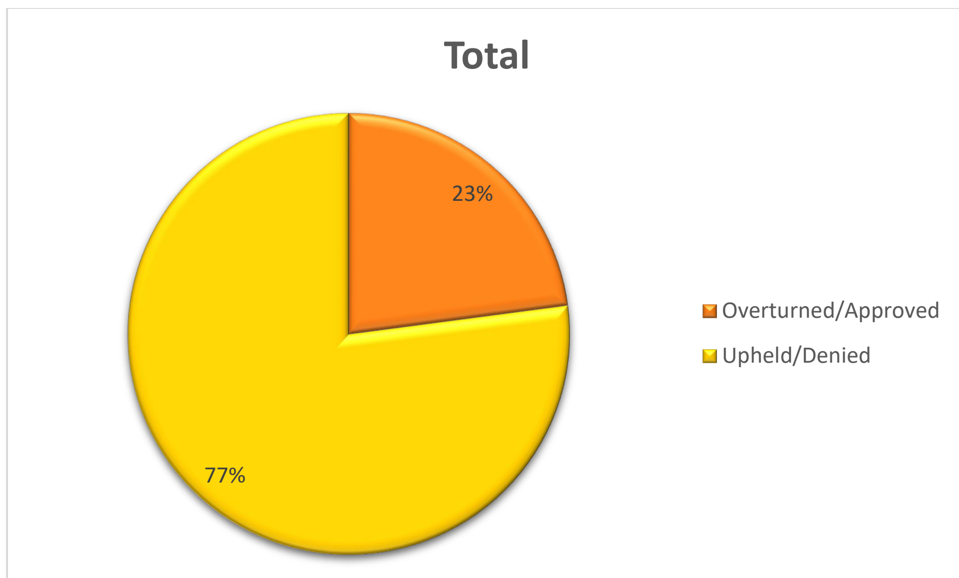
- 368 of 1,410 (26%) cases were related to Coverage Dispute, the top 3 grievance categories are:
  - (152) Provider Balance Billing
  - (419) Provider Direct Member Billing
  - (42) Reimbursement

- 268 of 1,410 (19%) cases were related to Quality of Service, the top 3 categories are:
  - (72) Plan Customer Service
  - (45) Transportation
  - (43) Provider/Staff Attitude



Appeals:

- 11 out of 48 (23%) cases were overturned for the month of March 2024:
  - (6) Disputes Involving Medical Necessity
  - (4) Out of network
  - (1) Coverage Disputes



Quality

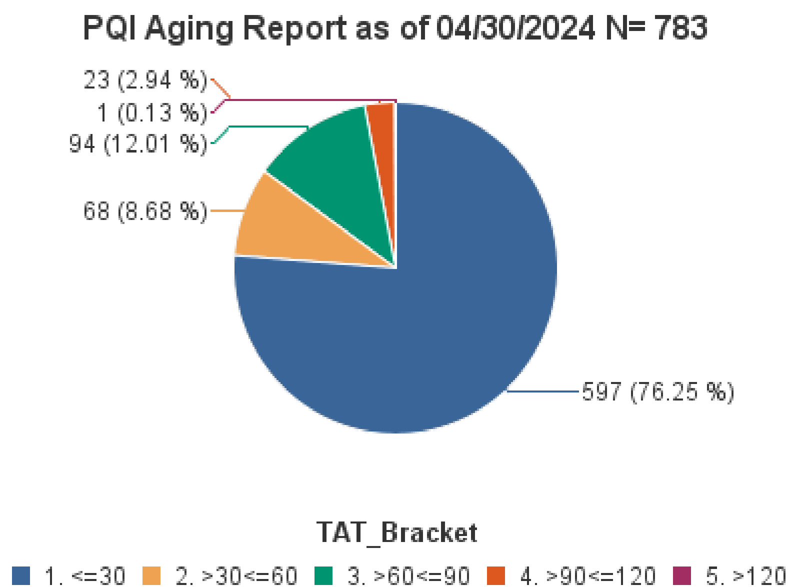
- Quality Improvement continues to track and trend PQI Turn-Around-Time (TAT) compliance. Our goal is closure of PQIs cases within 120 days from receipt to resolution via nurse investigation and procurement of medical records and/or provider responses followed by final MD review when applicable.

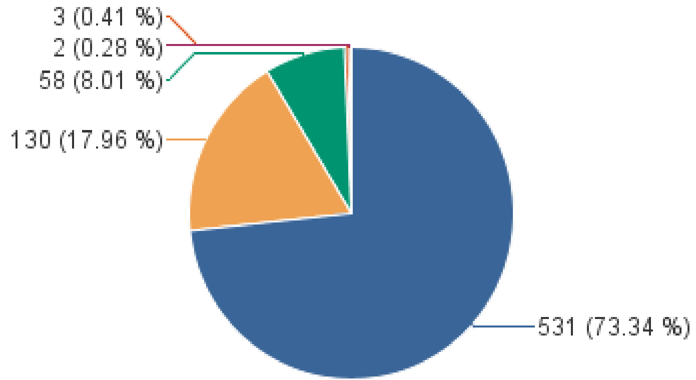
- As part of an effort to streamline the PQI review process, Quality of Access issues are reviewed by the Access & Availability team and Quality of Language issues by the Cultural & Linguistics team after they are triaged by the QI Clinical team. Quality of Care and Service issues continue to be reviewed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

- 0.28% of cases in March and 0.13% in April were still open past the 120-day TAT. Therefore, turnaround times for case review and closure remain well within the benchmark of 95% per PQI P&P QI-104 for this lookback period.

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

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




PQI Aging Report as of 03/31/2024 N= 724
3 (0.41 %)
2 (0.28 %)
58 (8.01 %)
130 (17.96 %)
531 (73.34 %)
TAT_Bracket
1. <=30
2. >30<=60
3. >60<=90
4. >90<=120
5. >120

Health Equity

Lao Paul Vang

Health Equity

Lao Paul Vang

To: Alameda Alliance for Health Board of Governors

From: Lao Paul Vang, Chief Health Equity Officer

Date: May 10th, 2024

Subject: Health Equity Report

<u>**Internal Collaboration:**</u>

- **Meetings and check-ins with Division Chiefs Update** –

  - ➢ Alliance division chiefs 1x1 monthly check-ins to update on Health Equity (HE) and Diversity, Equity, and Inclusion (DEI) activities and seek opportunities to collaborate and assist each other with any hurdles or concerns.

- **Population Health Management (PHM), Quality Improvement (QI), and Utilization Management (UM) Update** –

  - ➢ The committee discussed the following topics:

    - LGBTQ Center - Outreach Collaboration
    - PHM Strategy - Staff DEI Training
    - Cultural Sensitivity Training
    - PHM Strategy Review
    - Population Needs Assessment – ACPH

- **Vendor Management (VM) Update – Supplier Diversity Project:**

  - ➢ Continued work with the vendor management team, which includes supplier diversity program strategy and implementation.
  - ➢ Deliverables include a review of initiative positioning copy and content for informational content, oversight of the association membership selection process, and review of the new policy.

<u>**External Collaboration**</u>

- **Bi-weekly meetings with Local Health Plans' Chief Health Equity Officers (CHEOs) Update –**

  - ➢ Discussed the work surrounding SOGI data collection challenges and lessons learned.
  - ➢ Continued discussion regarding the building and implementation of the DEI Training Program.

- **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, particularly on DEI training as required by APL 23-025.
  - DHCS has completed town hall meetings to gather community voices for its Health Equity and DEI Roadmap, which has been officially published.

- **Alameda Co Public Health Department CHIP Kickoff –**

  - Attended the Alameda County Public Health Department's (ACPHD) Community Health Improvement Plan (CHIP) for 2023-2025, with stakeholders, local residents, CBOs, public sector reps, and staff in attendance. The CHIP selected 3 priority areas:
    1) Access to Care,
    2) Economic Security & Opportunities, and
    3) Promoting Peaceful Families & Communities.
  - We collaborated with other organizations and community members to gain valuable insight & perspective into the communities' needs.

- **County Data on Health Equity –**

  - In collaboration with our CEO, Matt, and Alameda County, we met to discuss data sharing. We are presently reviewing and analyzing the County's data to assist in understanding the communities we serve and how we can improve our services and relationships.

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

- **Leadership Enrichment Sessions –**

  - The first of two Leadership Enrichment Sessions was conducted with the SLT (the second session is scheduled for May).

- **Alliance Strategic Roadmap Update –**

  - Finalized the Strategic Planning Committee membership list.
  - The first session is confirmed for mid-May.
  - Communication touchpoint options for committee members (including the committee invite, pre-work, etc.) were shared with the HE Team.

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

  DEI Curriculum Training Activities –

  - DEI transcript modules were received from Human Resources and are currently under review.
  - The newly developed Health Equity module outlines were presented for review and approval to the Health Equity Team.
    - Project moving forward to 'storyboarding' to provide HE with a visual outlay of the module (due May 15).
  - Working with the Vendor Management team in the review of the identified vendors' DEI/Health Equity training curriculum (3 vendor reviews conducted to date).
  - HE began working on the provider training modules with the outline slated for delivery in May for review and approval.
  - Began working with project management to meet curriculum deadlines.

  DEI Training Curriculum Timeline –

    - Mid-July first draft,
    - Mid-August final draft,
    - Mid-September submission to DHCS for approval.
    - We are on track to meet our deadlines.

- **Communications Update –**

  - The HE Department developed an intranet page for the staff that went live in April.
  - At the April 28th All Staff Meeting, the Health Equity Department provided an update on the Curriculum Training and the Alliance Health Equity Roadmap activities.

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

- **DEIB Committee Update –**

  - In April, the DEIB Committee was canceled.

- **VIA Committee Update** –

  - The VIA Committee was canceled in April.
  - Yemaya emailed the members with any updates regarding the May 9th Spring Social Event.
  - Jeanette emailed the members regarding agenda items for the All Staff Meeting.

Information Technology

Sasikumar Karaiyan

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

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

Date: **May 10th, 2024**

Subject: **Information Technology Report**

Call Center System Availability

- AAH phone systems and call center applications performed at 97.81% availability during the month of April 2024 despite supporting 97% of staff working remotely.

- On Friday, April 18th at 10:00am, the Alliance experienced a certificate issue that affected partial access to the Call Center.
  - The access issue was resolved within four hours.

- The scheduled Cisco Call Center software upgrade has been completed successfully without any issues.

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.

- Successfully deployed server patches to 95% of our server environment. This includes security vulnerability patches.

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 is currently collecting procedural documentations, server inventory lists, and diagrams and submitting them to the disaster recovery technical writer for review and clean-up.

- Procurement of additional replication licenses has been processed.

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 is currently in the midst of a product “Proof of concept” which is set to be completed by mid-May 2024.

- Product selection and contract processing for both services and licenses will soon follow to proceed with the implementation phase of the project.

Encounter Data

- In the month of April 2024, the Alliance submitted 212 encounter files to the Department of Health Care Services (DHCS) with a total of 457,676 encounters.

Enrollment

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

HealthSuite

- The Alliance received 322,786 claims in the month of April 2024.
- A total of 290,131 claims were finalized during the month out of which 252,218 claims auto adjudicated. This sets the auto-adjudication rate for this period to 86.9%.
- HEALTHsuite application encountered an outage on April 18th, 2024, which lasted 4 hours. This sets the uptime to 97.81% for the application.

TruCare

- A total of 18,561 authorizations were loaded and processed in the TruCare application.
- TruCare application encountered an outage on April 18th, 2024, which lasted 4 hours. This sets the uptime to 98.00% for the application.

Information Technology

Supporting Documents

Enrollment

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

Month	Total MC[1]	MC[1] - Add/ Reinstatements	MC[1] - Terminated	Total GC[2]	GC[2] - Add/ Reinstatements	GC[2]- Terminated
March	399,414	9,548	9,645	5,644	143	121

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 April 2024

Auto-Assignments	Member Count
Auto-assignments MC	2,876
Auto-assignments Expansion	2,803
Auto-assignments GC	51
PCP Changes (PCP Change Tool) Total	5,234

TruCare Application

- See Table 2-1 “Summary of TruCare Authorizations for the month of April 2024”.
- There were 18,561 authorizations processed within the TruCare application.
- TruCare Application Uptime – 98.50%.
- 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 April 2024*

Transaction Type	Inbound automated Auths	Errored	Total Auths Loaded in TruCare
Paper Fax to Scan (DocuStream)	2948	2391	1652
Provider Portal Requests (Zipari)	5216	1012	5153
EDI (CHCN)	5592	1569	5451
Provider Portal to AAH Online (Long Term Care)	13	6	11
ADT	1137	572	675
Behavioral Health COC Update - Online	38	27	35
Behavioral initial evaluation - Online	66	39	58
HCSA (Health Care Service Agencies)	1251	89	1167
Manual Entry (all other not automated or faxed vs portal use)	N/A	N/A	2906
Total			17108

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 March 2024

Group	Individual User Accounts	Individual User Accounts Accessed	Total Logins	New Users
Provider	7,060	5,303	402,889	771
MCAL	109,743	4,578	11,298	1,778
IHSS	3,654	86	73	30
Total	120,457	9,967	414,260	2,579

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

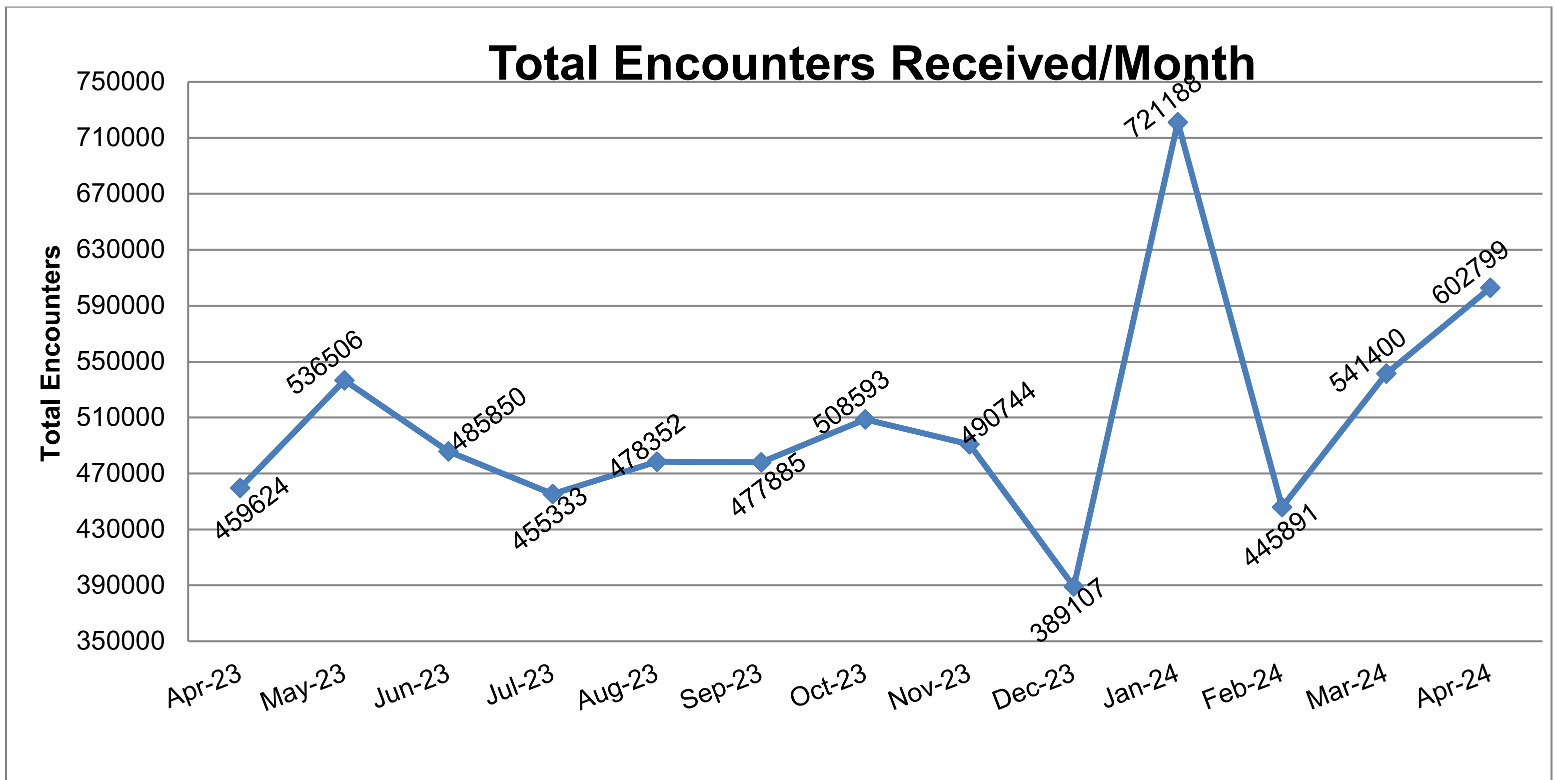
Category	Page Name	Page Views
Provider - eligibility/claim	Member Eligibility	1417417
Provider - Claims	Claim Status	226381
Provider - eligibility/claim	Claim Status	22712
Provider - authorizations	Auth Submit	17983
Member Config	Provider Directory	8601
Provider - authorizations	Auth Search	8325
Member My Care	Member Eligibility	5823
Directory Config	Provider Directory	5526
Provider - Claims	Submit professional claims	5253
Provider - eligibility/claim	Member Roster	5240
Member Help Resources	Find a Doctor or Hospital	4381
Member Help Resources	ID Card	2836
Member Help Resources	Select or Change Your PCP	2562
Member Home	MC ID Card	1599
Member My Care	My Claims Services	1512
Provider - Provider Directory	Provider Directory 2019	1174
Provider - reports	Reports	951
Member My Care	Authorization	914
Member My Care	My Pharmacy Medication Benefits	529
Provider - Home	Forms	471
Provider - Home	Behavior Health Forms SSO	450
Member Help Resources	Forms Resources	427
Member Help Resources	FAQs	416
Member My Care	Member Benefits Materials	362
Provider - Provider Directory	Manual	337
Member Help Resources	Authorizations Referrals	325
Provider - Provider Directory	Instruction Guide	300
Member Help Resources	Contact Us	268

Encounter Data From Trading Partners 2024

- **AHS**: April weekly files (6,573 records) were received on time.
- **BAC**: April monthly files (64 records) were received on time.
- **Beacon**: April weekly files (0 records)
  - No longer receiving encounter files.
- **CHCN**: April weekly files (170,653 records) were received on time.
- **CHME**: April monthly files (7,969 records) were received on time.
- **CFMG**: April weekly files (16,394 records) were received on time.
- **Docustream**: April monthly files (302 records) were received on time.
- **EBI**: April monthly files (1,700 records) were received on time.
- **FULLCIR**: April monthly files (2,261 records) were received on time.
- **HCSA**: April monthly files (7,118 records) were received on time.
- **IOA**: April monthly files (1,925 records) were received on time.
- **Kaiser**: April bi-weekly files (2,286 records) were received on time.
- **LAFAM**: April monthly files (105 records) were received on time.
- **LogistiCare**: April weekly files (32,632 records) were received on time.
- **March Vision**: April monthly files (3,633 records) were received on time.
- **MED**: April monthly files (633 records) were received on time.
- **OMATOCHI**: April monthly files (29 records) were received on time.
- **PAIRTEAM**: April monthly files (5,344 records) were received on time.
- **Quest Diagnostics**: April weekly files (18,000 records) were received on time.
- **SENECA**: April monthly files (159 records) were received on time.
- **TITANIUM**: April monthly files (2,233 records) were received on time.
- **Magellan**: April monthly files (413,936 records) were received on time.

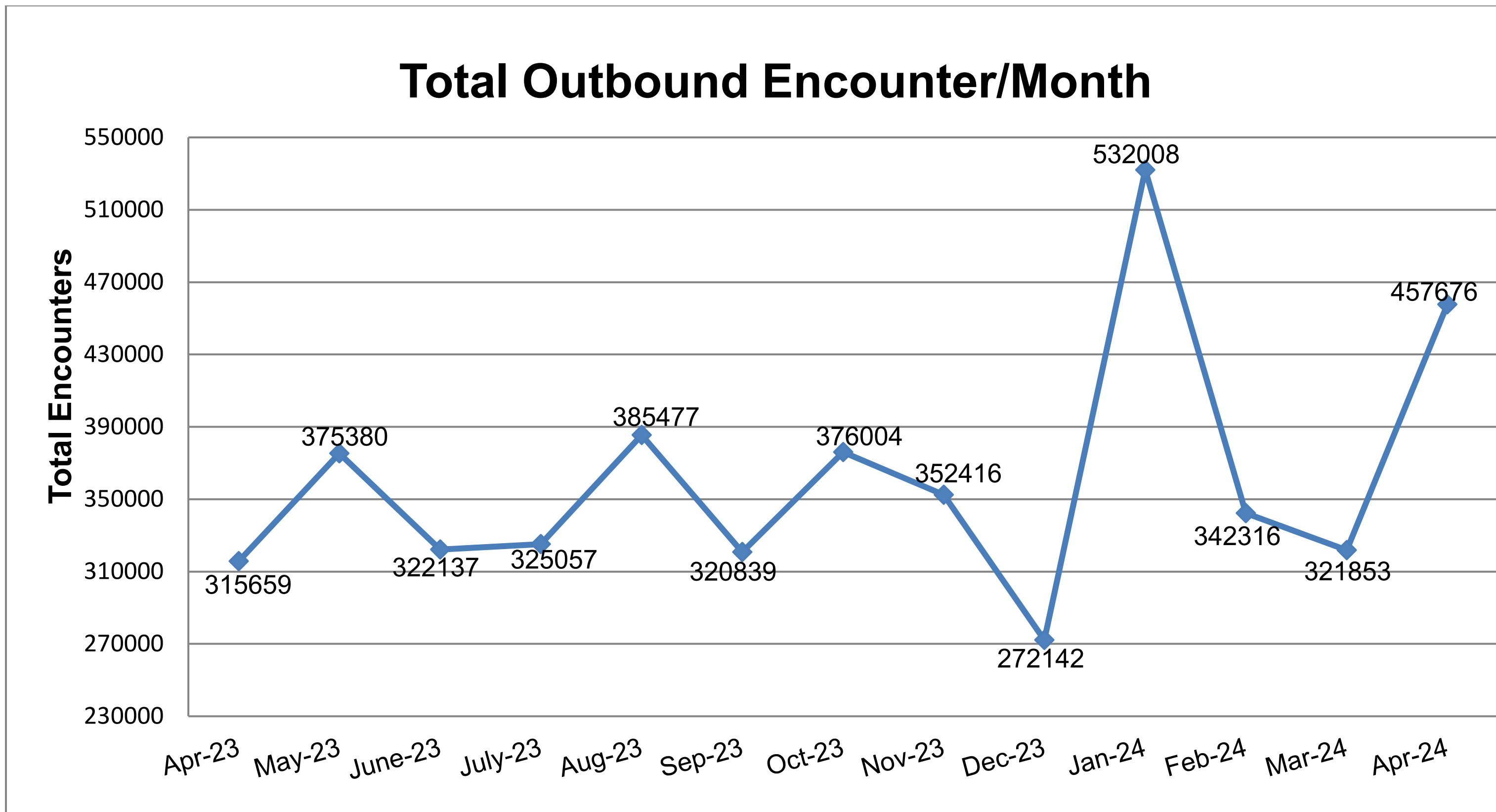
Trading Partner Encounter Inbound Submission History

Trading Partners	Apr-23	May-23	Jun-23	July-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Health Suite	218296	251858	267437	224540	244907	247423	241298	247537	215246	298465	266339	308453	322786
AHS	6353	5380	6250	4363	4380	5479	5371	5243	6284	4570	7736	7005	6573
BAC	38	40	37	39	38	38	57	73	55	59	57	55	64
Beacon	15799	5822	4559	620									
CHCN	84654	117764	90418	102081	85836	77060	111275	87839	58566	96124	103674	122217	170653
CHME	5277	4987	5692	5706	5704	6212	7609	6445	5694	5843	5560	6022	7969
Claimsnet	16155	12526	9986	12379	8946	12302	12167	11670	18995	12043	10557	12651	16394
Docustream	865	575	607	567	744	562	400	705	476	930	814	698	302
EBI	976	15	910	1664	814	867	718	823	811	1047	2903	1625	1700
FULLCIR							888	598	177	828	1586	213	2261
HCSA	78	72	5573	3824	3466	2490	1913	2403	2087	2223	2097	2822	7118
IOA	201	325	974	424	673	1086	967	1073	1250	1453	1233	1054	1925
Kaiser	68883	91196	53820	56673	76278	79751	81985	87005	26208	77407	3725	9966	2286
LAFAM							24				60	39	105
Logisticare	20558	28628	20859	22235	27129	22456	25509	20781	32181	182822	20774	35600	32632
March Vision	4275	3647	5101	4468	4563	4933	4427	4428	4562	9693		6183	3633
MED				9	11	144	194	523	532	535	742	683	633
OMATOCHI													29
PAIRTEAM													5344
Quest	17216	13671	13627	15741	14859	17008	13712	13077	15834	27022	17658	22306	18000
SENECA					4	74	79	56	52	124	222	112	159
TITANIUM								465	97		154	3696	2233
Total	459624	536506	485850	455333	478352	477885	508593	490744	389107	721188	445891	541400	602799



Outbound Encounter Submission

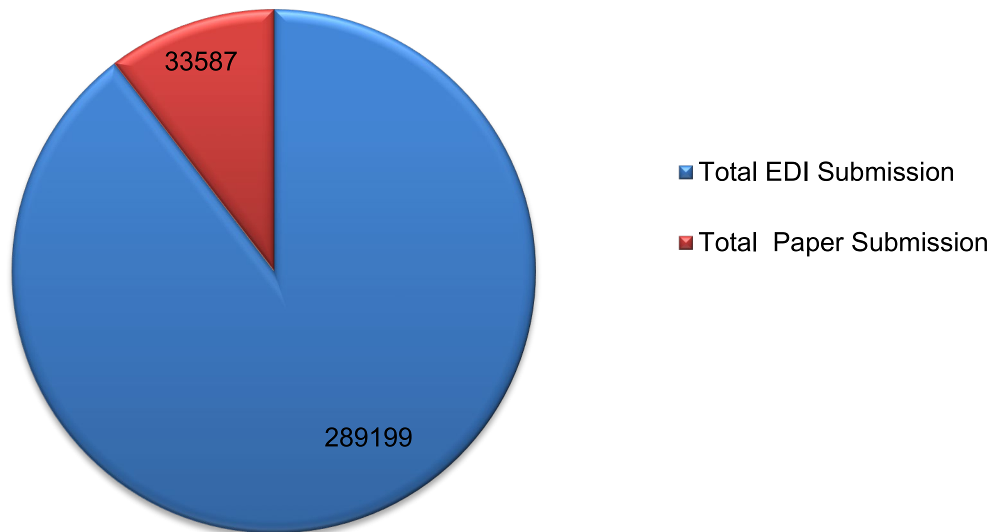
Trading Partners	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Health Suite	117823	151866	126674	147199	170751	127465	163149	134823	136233	172386	177658	147776	250835
AHS	7300	5236	5070	5318	4251	4253	6355	5147	4936	5667	7497	6968	6524
BAC	38	40	37	39	37	38	52	67	53	55	55	47	59
Beacon	11927	2879	2233	318									
CHCN	60373	79256	65595	56593	74313	55365	62962	73866	39846	67063	74336	80498	104625
CHME	5159	4864	5577	5595	5546	6063	7475	6321	5588	5703	5470	5889	7558
Claimsnet	9834	10891	7445	8849	6386	7075	7452	8031	11581	10145	7730	6757	13467
Docustream	481	411	378	347	529	441	270	573	404	387	600	377	267
EBI	906	15	872	1574	804	855	710	794	802	987	1347	1002	1589
FULLCIR							806	516	124	653	540	116	1636
HCSA	52	55	1781	3778	3405	2349	1876	2342	1991	2142	2013	2769	4710
IOA	45	276	751	410	654	984	65	934	1228	1378	1156	1000	1868
Kaiser	65652	72893	68887	55988	75591	78162	81165	85807	26113	76335	3542	9650	1905
LAFAM							2					16	92
LogistiCare	20411	28455	20787	21686	26670	22142	24497	25951	31546	157548	40529	34931	32247
March Vision	3006	2366	3408	2720	2737	2992	2863	2661	2752	2700	2616	3736	2407
MED				9	11	126	145	438	428	446	624	528	518
OMATOCHI													56
PAIRTEAM													4279
Quest	12652	15877	12642	14634	13788	12456	16082	3655	8394	28299	16589	16333	20983
SENECA					4	73	78	52	48	114	14	199	140
TITANIUM								438	75			3261	1911
Total	315659	375380	322137	325057	385477	320839	376004	352416	272142	532008	342316	321853	457676



HealthSuite Paper vs EDI Claims Submission Breakdown

Period	Total EDI Submission	Total Paper Submission	Total claims
24-Apr	289199	33587	322786

Key: EDI – Electronic Data Interchange

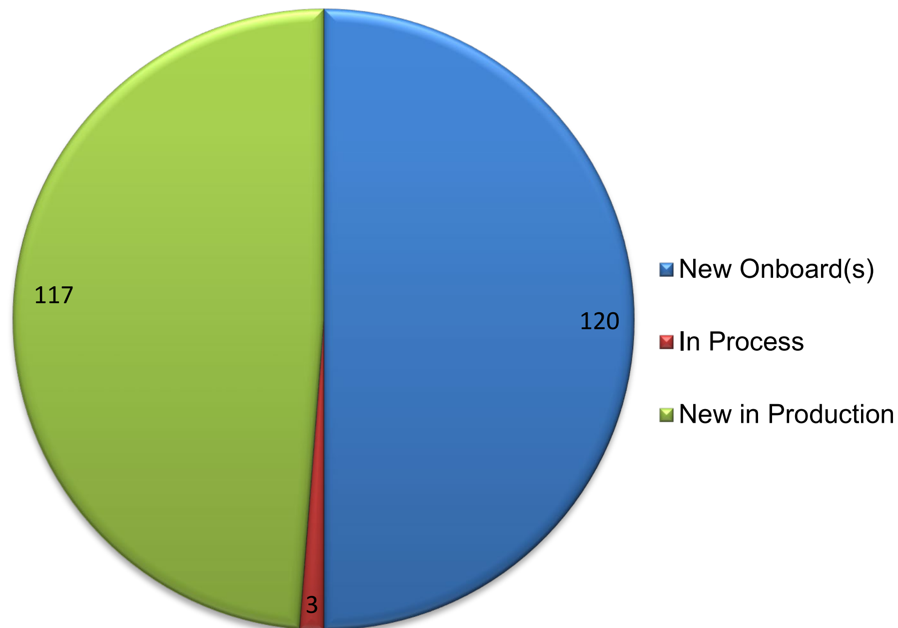


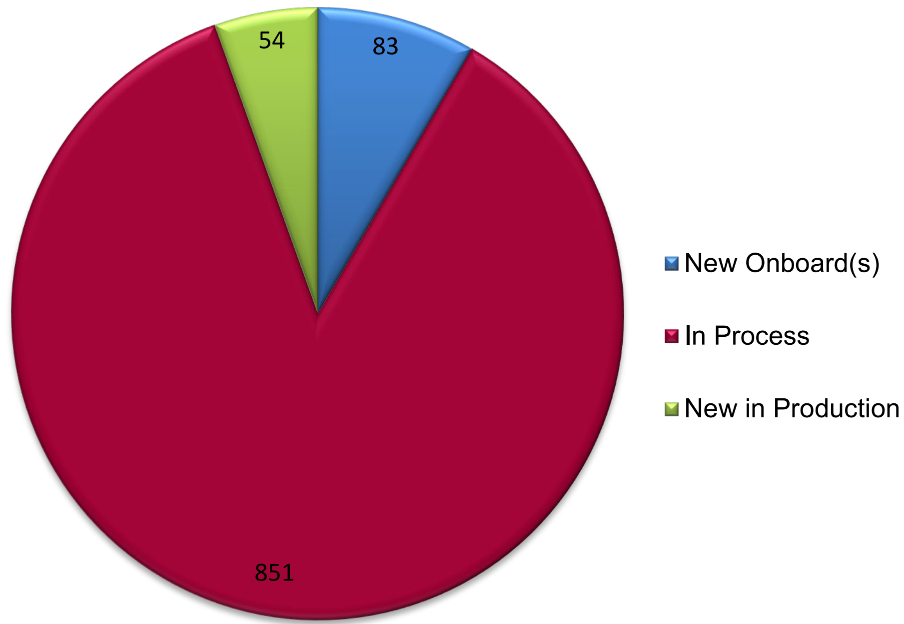
Onboarding EDI Providers – Updates

- April 2024 EDI Claims:
  - A total of 2277 new EDI submitters have been added since October 2015, with 117 added in April 2024.
  - The total number of EDI submitters is 3017 providers.

- April 2024 EDI Remittances (ERA):
  - A total of 996 new ERA receivers have been added since October 2015, with 54 added in April 2024.
  - The total number of ERA receivers is 1012 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
May-23	35	5	30	2400	44	527	8	722
Jun-23	79	7	72	2472	58	544	41	763
Jul-23	48	2	46	2518	62	583	23	786
Aug-23	44	1	43	2561	41	602	22	808
Sep-23	70	0	70	2631	46	621	27	835
Oct-23	36	2	34	2665	21	640	2	837
Nov-23	47	2	45	2710	45	679	6	843
Dec-23	25	2	23	2733	63	716	26	869
Jan-24	63	2	61	2794	76	751	41	910
Feb-24	37	17	20	2814	59	783	27	937
Mar-24	111	25	86	2900	60	822	21	958
Apr-24	120	3	117	3017	83	851	54	1012





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 **April** 2024.

File Type	APR-24
837 I Files	42
837 P Files	170
Total Files	212

Lag-time Metrics/Key Performance Indicators (KPI)

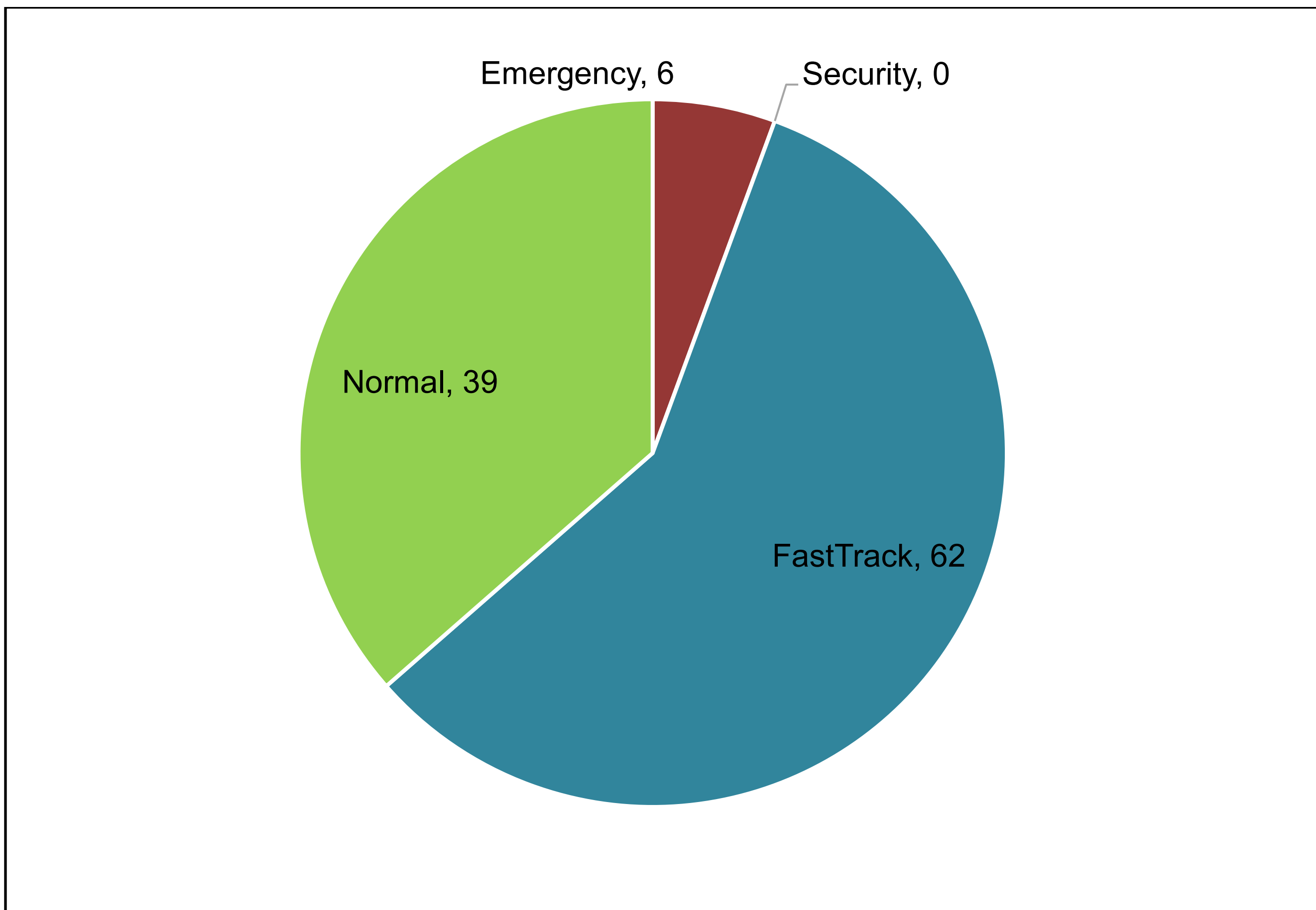
AAH Encounters: Outbound 837	Apr-24	Target
Timeliness-% Within Lag Time - Institutional 0-90 days	84%	60%
Timeliness-% Within Lag Time - Institutional 0-180 days	87%	80%
Timeliness-% Within Lag Time - Professional 0-90 days	92%	65%
Timeliness-% Within Lag Time – Professional 0-180 days	98%	80%

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

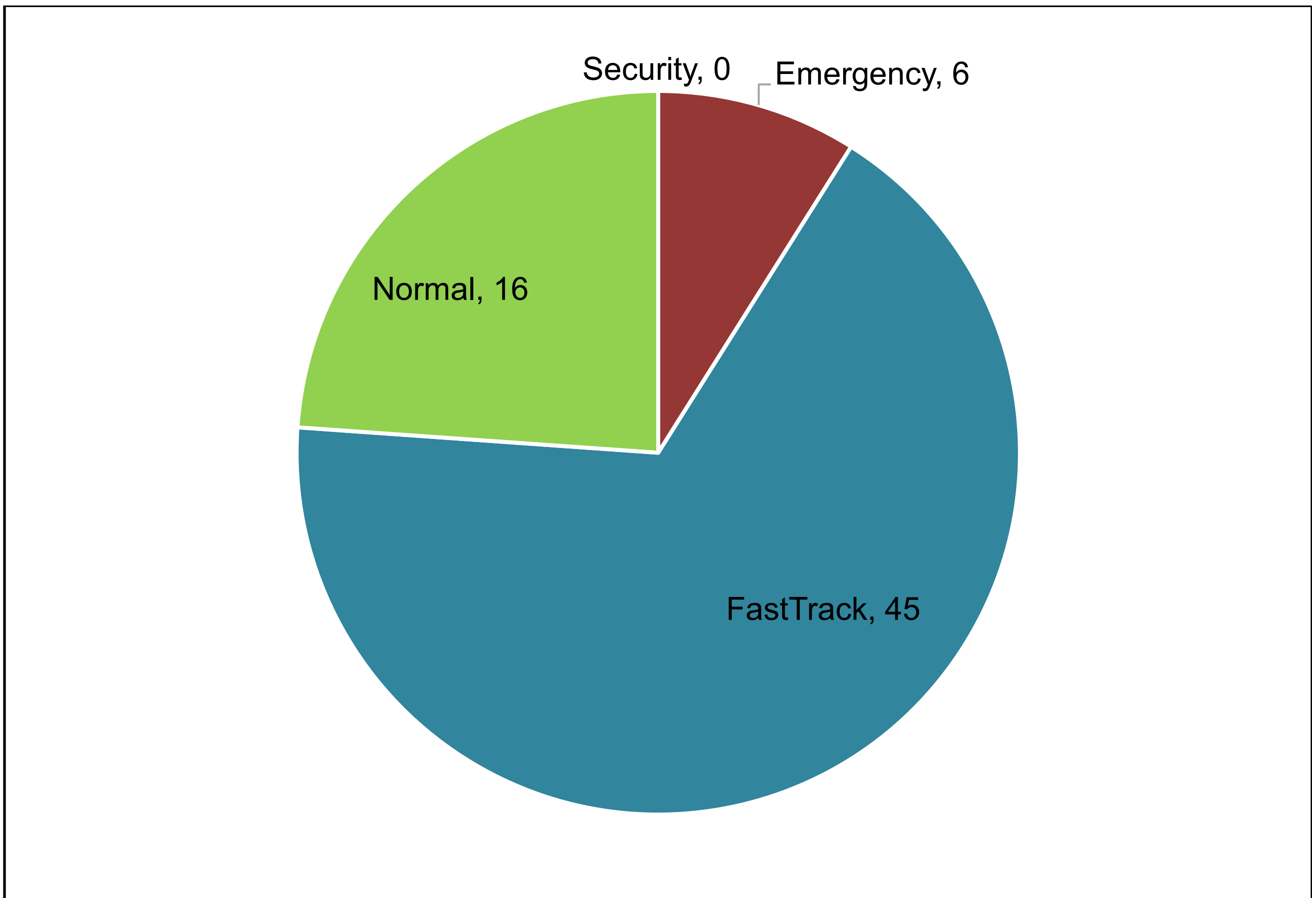
Change Management Key Performance Indicator (KPI)

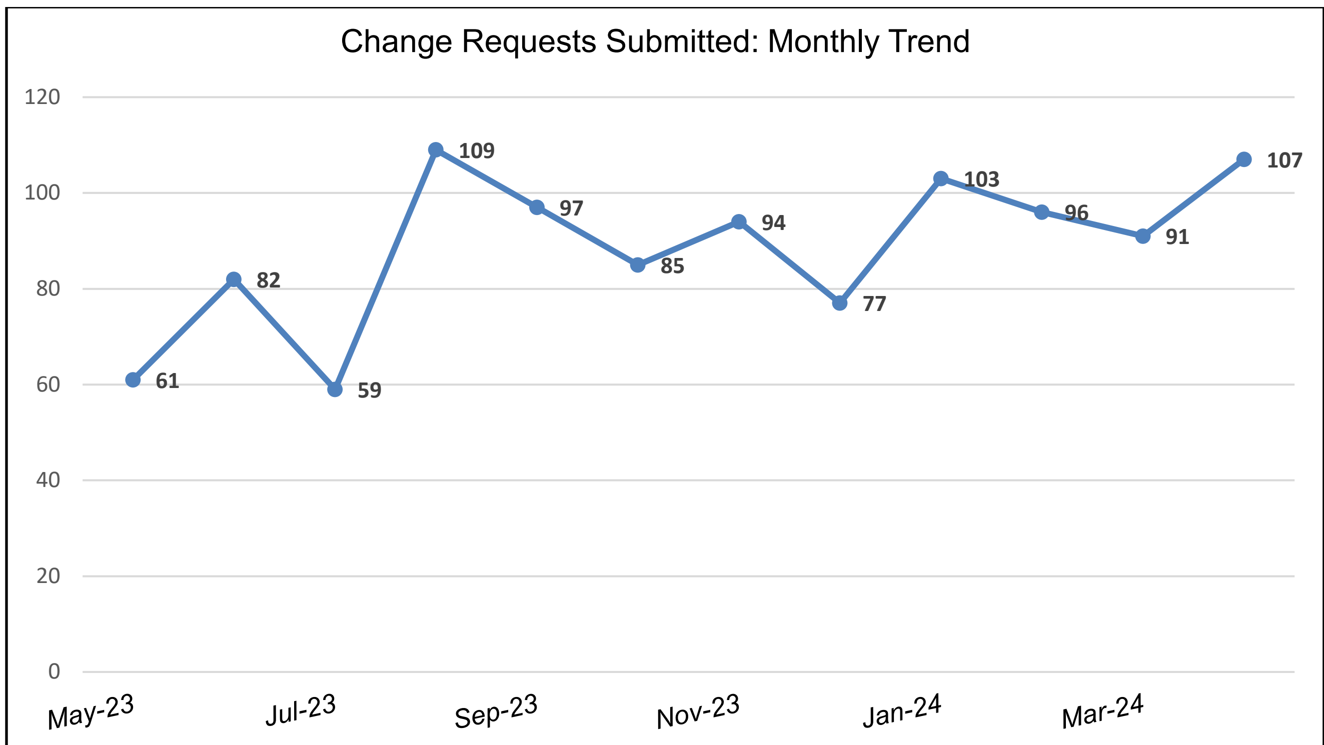
- Change Request Overall Summary in the month of April 2024 KPI:
    - 107 Changes Submitted.
    - 67 Changes Completed and Closed.
    - 178 Active Change Requests in pipeline.
    - 18 Change Requests Cancelled or Rejected.

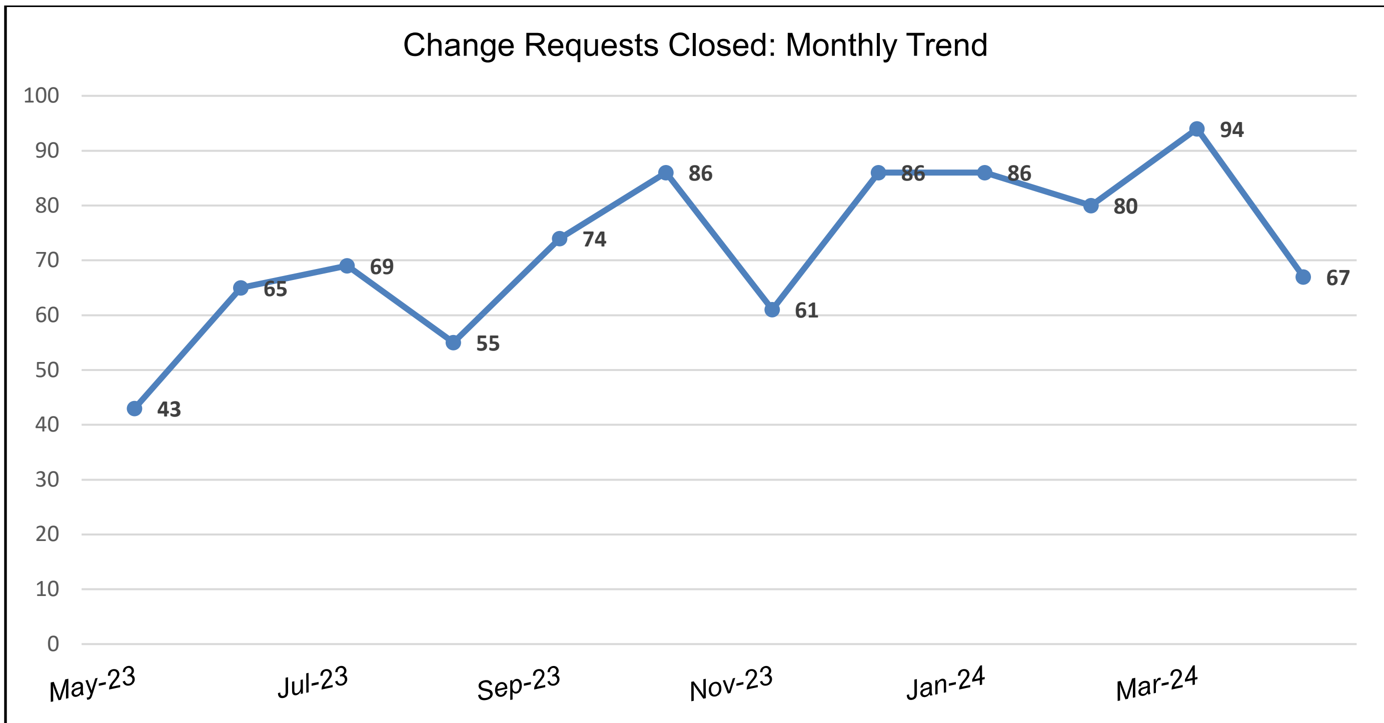
- 107 Change Requests Submitted/Logged in the month of April 2024



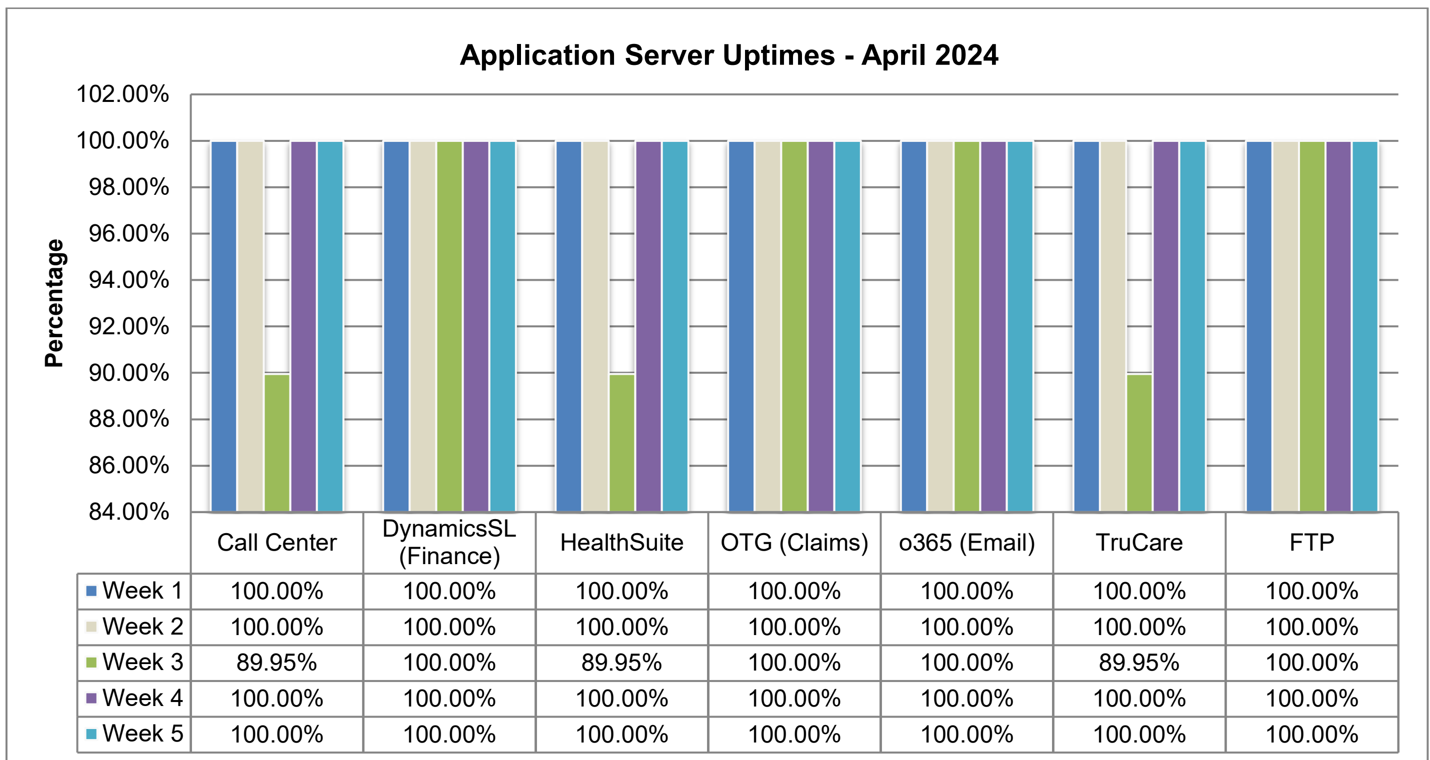
- 67 Change Requests Closed in the month of April 2024





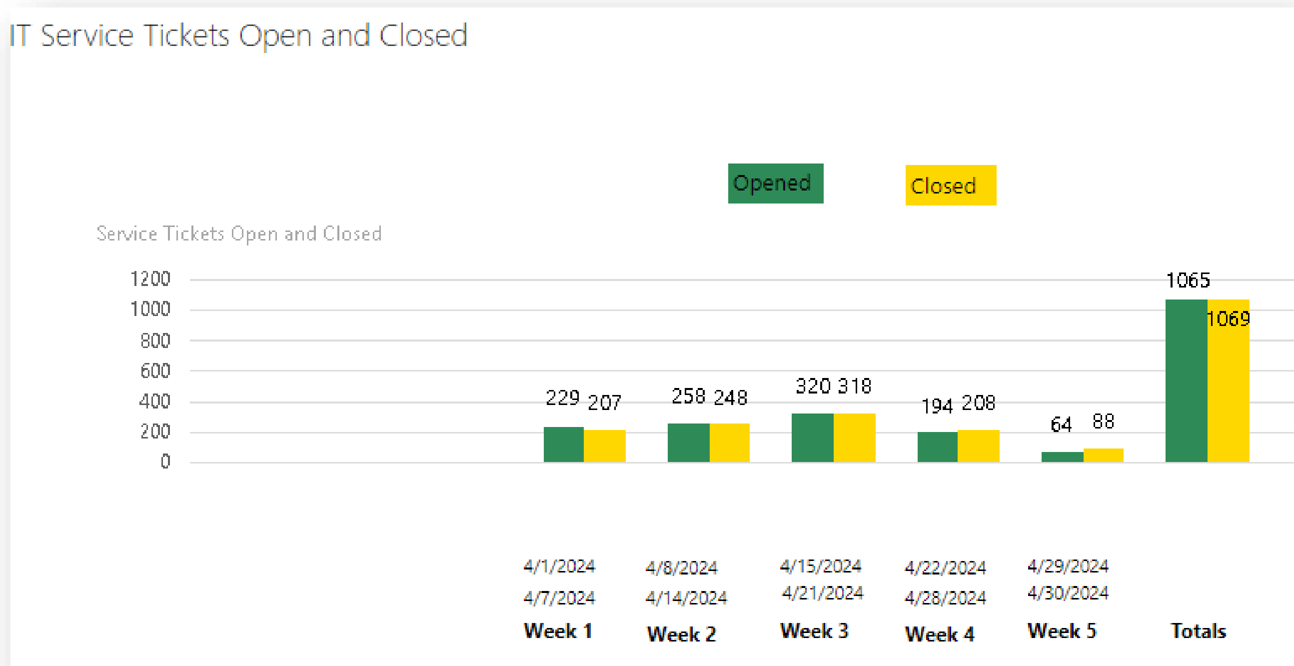


T Stats: Infrastructure



	Call Center	DynamicsSL (Finance)	HealthSuite	OTG (Claims)	o365 (Email)	TruCare	FTP
Week 1	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Week 2	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Week 3	89.95%	100.00%	89.95%	100.00%	100.00%	89.95%	100.00%
Week 4	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Week 5	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

- All mission critical applications are monitored and managed thoroughly.
- On Friday, April 19th at 10:00am, the Alliance experienced a certificate issue that affected partial access to three major applications (HealthSuite, TruCare and Call Center).
  - The access issue was resolved within four hours.



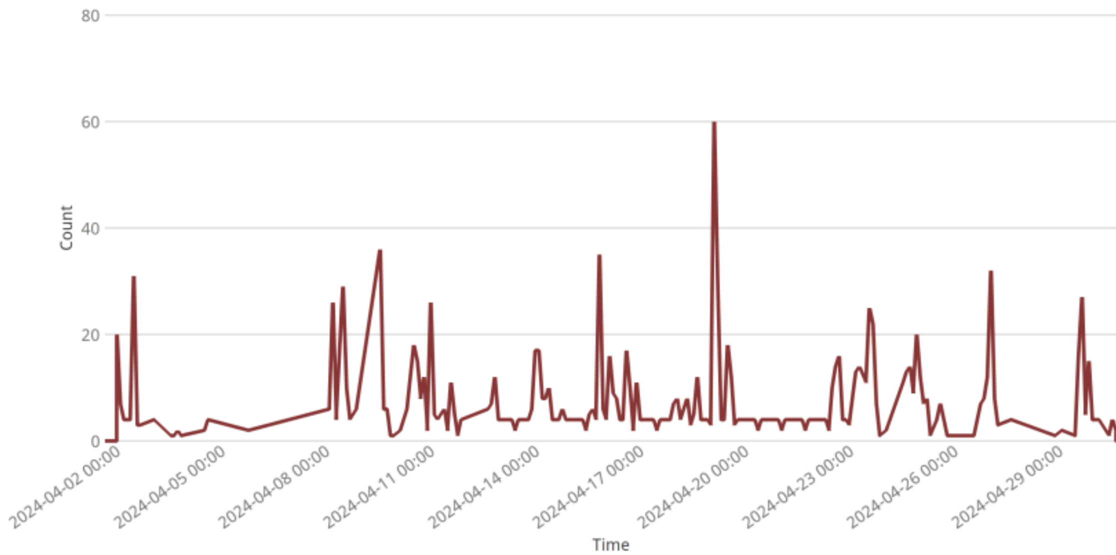
- 1065 Service Desk tickets were opened in the month of April 2024, which is 5.44% higher than the previous month (1007) and 14.36% higher than the previous 3-month average of 912.

- 1069 Service Desk tickets were closed in the month of April 2024, which is 0.37% higher than the previous month (1065) and 14.49% higher than the previous 3-month average of 914.

April 2024

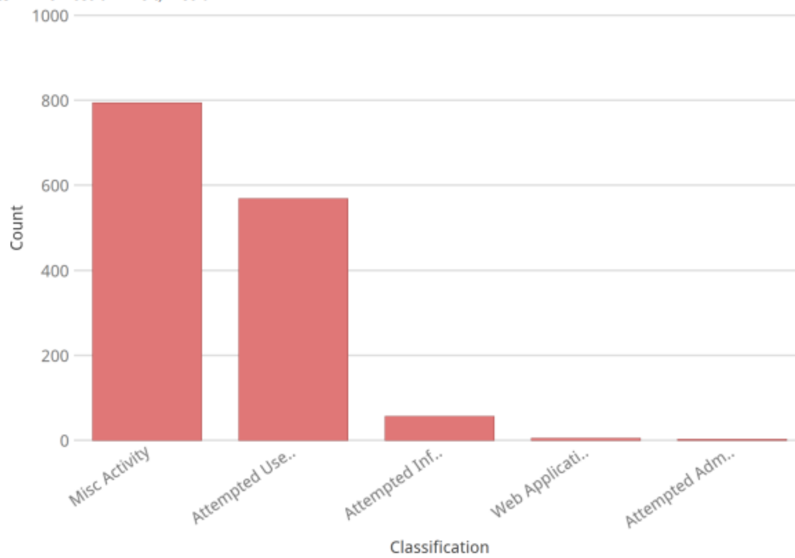
All Intrusion Events

Time Window: *2024-04-01 09:29:00 - 2024-04-30 09:29:00*



Dropped Intrusion Events

Time Window: *2024-04-01 09:30:00 - 2024-04-30 09:30:00*
Constraints: *Inline Result = !Alert,!Would **



Classification	Count
Misc Activity	795
Attempted User Privilege Gain	569
Attempted Information Leak	57
Web Application Attack	5
Attempted Administrator Privilege Gain	3

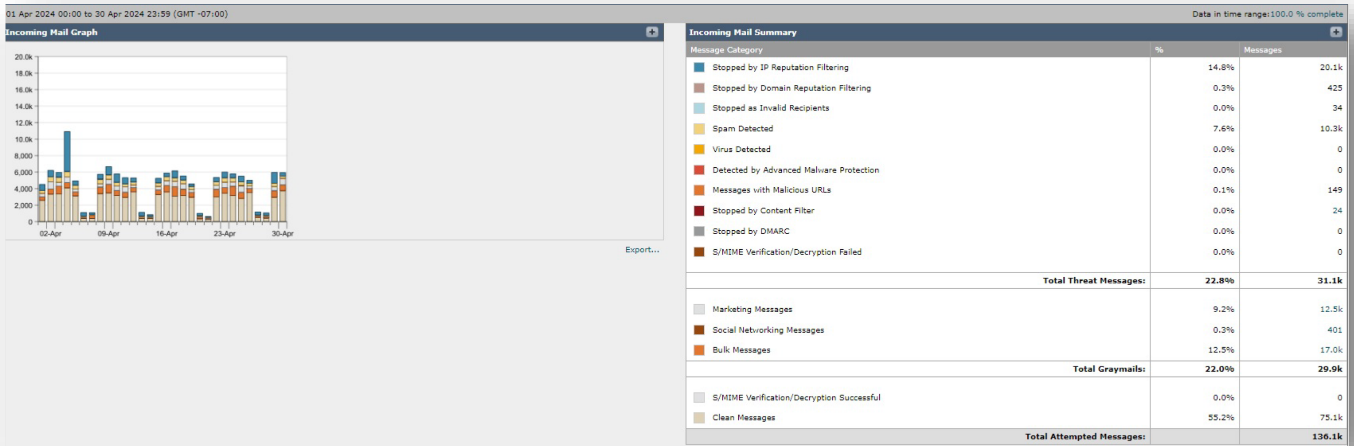
IronPort Email Security Gateways

Email Filters

April 2024

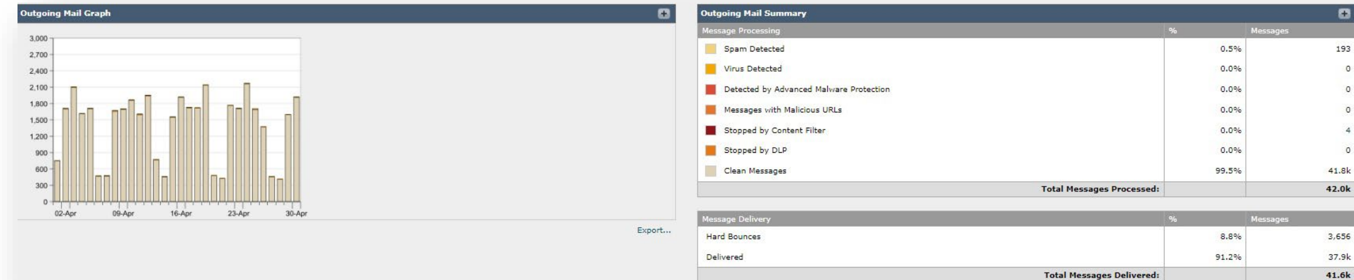
MX4

Inbound Mail



Message Category	%	Messages
Stopped by IP Reputation Filtering	14.8%	20.1k
Stopped by Domain Reputation Filtering	0.3%	425
Stopped as Invalid Recipients	0.0%	34
Spam Detected	7.6%	10.3k
Virus Detected	0.0%	0
Detected by Advanced Malware Protection	0.0%	0
Messages with Malicious URLs	0.1%	149
Stopped by Content Filter	0.0%	24
Stopped by DMARC	0.0%	0
S/MIME Verification/Decryption Failed	0.0%	0
Total Threat Messages:	22.8%	31.1k
Marketing Messages	9.2%	12.5k
Social Networking Messages	0.3%	401
Bulk Messages	12.5%	17.0k
Total Graymails:	22.0%	29.9k
S/MIME Verification/Decryption Successful	0.0%	0
Clean Messages	55.2%	75.1k
Total Attempted Messages:		136.1k

Outbound Mail



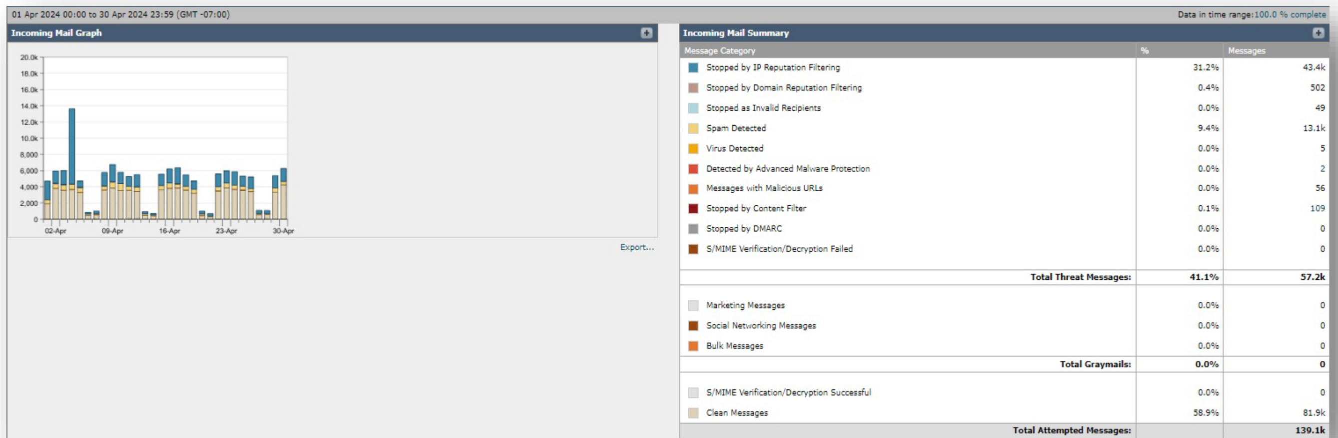
Message Processing	%	Messages
Spam Detected	0.5%	193
Virus Detected	0.0%	0
Detected by Advanced Malware Protection	0.0%	0
Messages with Malicious URLs	0.0%	0
Stopped by Content Filter	0.0%	4
Stopped by DLP	0.0%	0
Clean Messages	99.5%	41.8k
Total Messages Processed:		42.0k

Message Delivery	%	Messages
Hard Bounces	8.8%	3,656
Delivered	91.2%	37.9k
Total Messages Delivered:		41.6k

April 2024

MX9

Inbound Mail



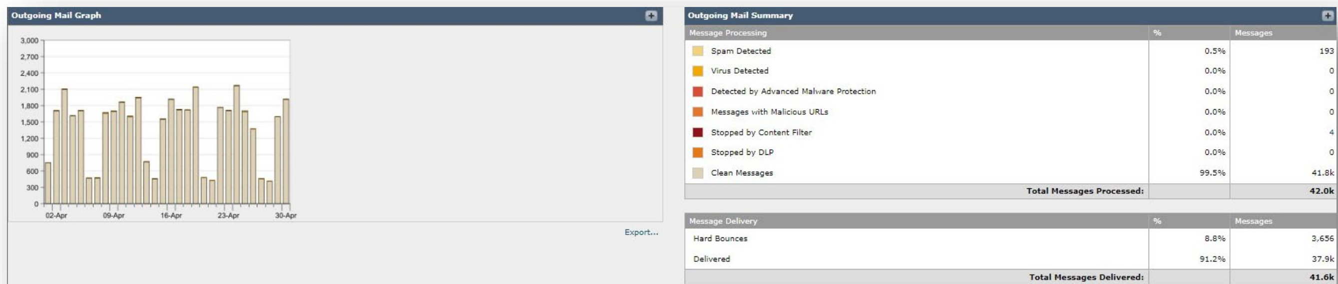
01 Apr 2024 00:00 to 30 Apr 2024 23:59 (GMT -07:00)

Data in time range: 100.0 % complete

Incoming Mail Summary

Message Category	%	Messages
Stopped by IP Reputation Filtering	31.2%	43.4k
Stopped by Domain Reputation Filtering	0.4%	502
Stopped as Invalid Recipients	0.0%	49
Spam Detected	9.4%	13.1k
Virus Detected	0.0%	5
Detected by Advanced Malware Protection	0.0%	2
Messages with Malicious URLs	0.0%	56
Stopped by Content Filter	0.1%	109
Stopped by DMARC	0.0%	0
S/MIME Verification/Decryption Failed	0.0%	0
Total Threat Messages:	**41.1%**	**57.2k**
Marketing Messages	0.0%	0
Social Networking Messages	0.0%	0
Bulk Messages	0.0%	0
Total Graymails:	**0.0%**	**0**
S/MIME Verification/Decryption Successful	0.0%	0
Clean Messages	58.9%	81.9k
Total Attempted Messages:		**139.1k**

Outbound Mail



Outgoing Mail Summary

Message Processing	%	Messages
Spam Detected	0.5%	193
Virus Detected	0.0%	0
Detected by Advanced Malware Protection	0.0%	0
Messages with Malicious URLs	0.0%	0
Stopped by Content Filter	0.0%	4
Stopped by DLP	0.0%	0
Clean Messages	99.5%	41.8k
Total Messages Processed:		**42.0k**

Message Delivery	%	Messages
Hard Bounces	8.8%	3,656
Delivered	91.2%	37.9k
Total Messages Delivered:		**41.6k**

Item / Date	Apr-23	May-23	Jun-23	Jul-23	Aug-23	*Sep-23*	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	*Apr-24*
Stopped By Reputation	31.7k	33.2k	27.1k	30.4k	59.1k	*99.7k*	74k	74.1k	58k	91.9k	51k	84.7k	***63.5k***
Invalid Recipients	97	113	92	82	79	*98*	86	88	73	81	87	185	***83***
Spam Detected	14.5k	13.7k	14.1k	12.5k	27.9k	*33.1*	28.7k	25.8k	20.6k	26.9k	22.6k	27.6k	***23.4k***
Virus Detected	2	9	1	5	3	*22*	10	29	6	11	9	12	***5***
Advanced Malware	0	3	1	0	1	*55*	37	78	24	29	8	4	***2***
Malicious URLs	6	478	233	170	6	*50*	97	11	57	57	43	33	***205***
Content Filter	115	127	162	56	39	*110*	114	333	66	108	376	116	***133***
Marketing Messages	15.5k	18.5k	16.1k	15.7k	16.2k	*8.4k*	9.5k	8.9k	8.1k	9.4k	10.1k	10.1k	***12.5k***
Attempted Admin Privilege Gain	170	4	50	173	51	*250*	6	0	1	7	4	48	***3***
Attempted User Privilege Gain	428	42	66	162	47	*329*	146	48	48	69	330	526	***569***
Attempted Information Leak	24.4k	5	1	18	53	*118*	71	51	50	65	51	72	***57***
Potential Corp Policy Violation	0	4	2	0	0	*0*	0	0	0	0	3	4	***0***
Network Scans Detected	0	0	0	0	0	*0*	0	0	0	0	0	0	***0***
Web Application Attack	2	7	1	8	0	*15*	7	4	4	1	0	0	***5***
Attempted Denial of Service	109	0	0	1	0	*4*	0	0	0	0	0	0	***0***
Misc. Attack	521	2	3	1,862	151	*2,901*	1,023	347	2,146	1	424	332	***795***

- 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 63.5k.
- Attempted information leaks detected and blocked at the firewall is at 57 for the month of **April 2024.**
- Network scans returned a value of 0, which is in line with previous month's data.
- Attempted User Privilege Gain increased at 569 from a previous six-month average of 265.

Analytics

Tiffany Cheang

To: Alameda Alliance for Health Board of Governors

From: Tiffany Cheang, Chief Analytics Officer

Date: May 10th, 2024

Subject: Performance & Analytics Report

Member Cost Analysis

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

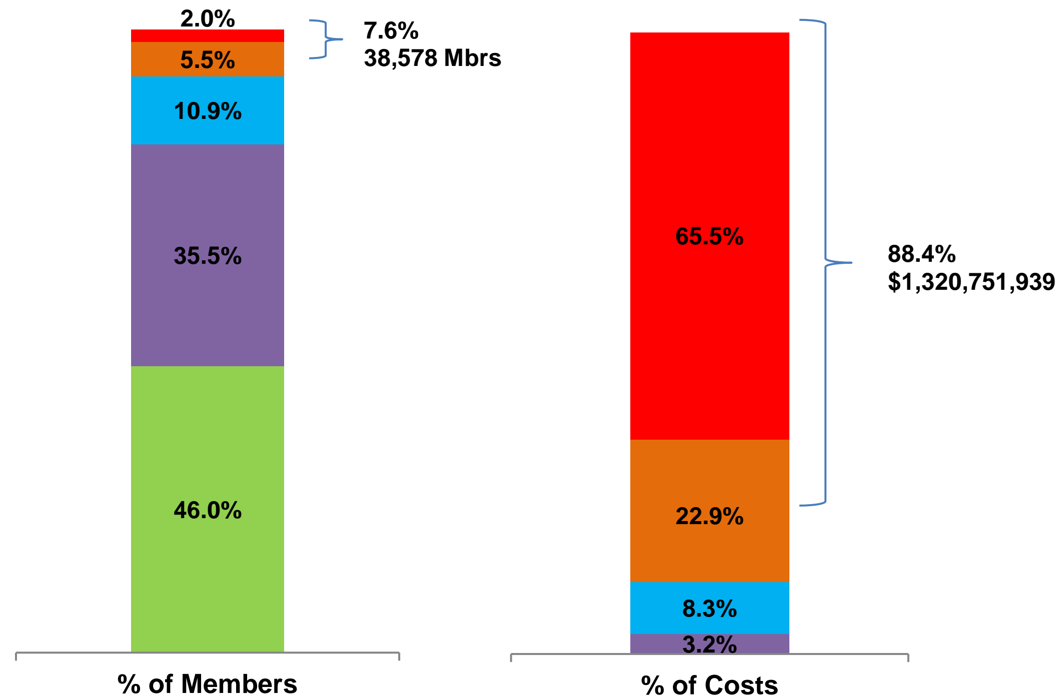
Current reporting period: Feb 2023 – Jan 2024 dates of service
Prior reporting period: Feb 2022 – Jan 2023 dates of service
(Note: Data excludes Kaiser membership data.)

- For the Current reporting period, the top 7.6% of members account for 88.4% 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 53.4% of the members, with SPDs accounting for 22.5% and ACA OE's at 30.9%.
    - The percent of members with costs >= $30K slightly decreased from 2.2% to 2.0%.
    - 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 32.9%.
    - 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 7.6% is more concentrated in the 45-66 year old category (38.2%) compared to the overall population (20.8%).

Analytics

Supporting Documents

Alameda Alliance for Health - Analytics Supporting Documentation: Member - Cost Analysis
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Feb 2023 - Jan 2024
Note: Data incomplete due to claims lag
Run Date: 04/28/2024



Cost Range	Members	% of Members	Costs	% of Costs
$30K+	10,282	2.0%	$ 978,005,739	65.5%
$5K - $30K	28,296	5.5%	$ 342,746,200	22.9%
$1K - $5K	55,737	10.9%	$ 124,682,063	8.3%
< $1K	181,534	35.5%	$ 48,488,514	3.2%
$0	235,012	46.0%	$ -	0.0%
Totals	**510,861**	**100.0%**	**$ 1,493,922,515**	**100.0%**

Top 7.6% of Members = 88.4% of Costs

Cost Range	Members	% of Total Members	Costs	% of Total Costs
$100K+	2,887	0.6%	$ 577,057,996	38.6%
$75K to $100K	1,392	0.3%	$ 121,103,124	8.1%
$50K to $75K	2,142	0.4%	$ 130,865,131	8.8%
$40K to $50K	1,554	0.3%	$ 69,201,436	4.6%
$30K to $40K	2,307	0.5%	$ 79,778,051	5.3%
SubTotal	***10,282***	***2.0%***	***$ 978,005,739***	***65.5%***
$20K to $30K	3,899	0.8%	$ 94,802,486	6.3%
$10K to $20K	10,748	2.1%	$ 150,005,302	10.0%
$5K to $10K	13,649	2.7%	$ 97,938,413	6.6%
SubTotal	***28,296***	***5.5%***	***$ 342,746,200***	***22.9%***
Total	**38,578**	***7.6%***	**$ 1,320,751,939**	***88.4%***

Enrollment Status	Members	Total Costs
Still Enrolled as of Jan 2024	302,734	$ 1,234,516,608
Dis-Enrolled During Year	53,242	$ 142,385,395
Totals	**355,976**	**$ 1,376,902,003**

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

Alameda Alliance for Health - Analytics Supporting Documentation: Member - Cost Analysis
7.6% of Members = 88.4% of Costs
Lines of Business: MCAL, IHSS; Excludes Kaiser Members
Dates of Service: Feb 2023 - Jan 2024
Note: Data incomplete due to claims lag
Run Date: 04/28/2024

7.6% of Members = 88.4% of Costs
22.5% of members are SPDs and account for 27.2% of costs.
30.9% of members are ACA OE and account for 30.5% of costs.
12.5% of members disenrolled as of Jan 2024 and account for 13.8% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Members	% of Members
IHSS	IHSS	146	631	777	2.0%
MCAL	MCAL - ADULT	854	4,559	5,413	14.0%
	MCAL - BCCTP	-	-	-	0.0%
	MCAL - CHILD	402	2,112	2,514	6.5%
	MCAL - ACA OE	2,919	9,000	11,919	30.9%
	MCAL - SPD	2,969	5,725	8,694	22.5%
	MCAL - DUALS	632	2,520	3,152	8.2%
	MCAL - LTC	113	62	175	0.5%
	MCAL - LTC-DUAL	699	402	1,101	2.9%
Not Eligible	Not Eligible	1,548	3,285	4,833	12.5%
Total		**10,282**	**28,296**	**38,578**	**100.0%**

Cost Breakout by LOB

LOB	Eligibility Category	Members with Costs >=$30K	Members with Costs $5K-$30K	Total Costs	% of Costs
IHSS	IHSS	$ 10,946,377	$ 7,336,862	$ 18,283,239	1.4%
MCAL	MCAL - ADULT	$ 76,564,618	$ 52,763,029	$ 129,327,647	9.8%
	MCAL - BCCTP	$ -	$ -	$ -	0.0%
	MCAL - CHILD	$ 28,293,867	$ 24,465,744	$ 52,759,611	4.0%
	MCAL - ACA OE	$ 292,646,775	$ 110,200,263	$ 402,847,037	30.5%
	MCAL - SPD	$ 285,830,892	$ 73,916,197	$ 359,747,089	27.2%
	MCAL - DUALS	$ 54,483,534	$ 28,980,095	$ 83,463,629	6.3%
	MCAL - LTC	$ 16,962,728	$ 816,598	$ 17,779,327	1.3%
	MCAL - LTC-DUAL	$ 69,671,860	$ 4,798,606	$ 74,470,466	5.6%
Not Eligible	Not Eligible	$ 142,605,089	$ 39,468,805	$ 182,073,894	13.8%
Total		**$ 978,005,739**	**$ 342,746,200**	**$ 1,320,751,939**	**100.0%**

Highest Cost Members; Cost Per Member >= $100K
28.9% of members are SPDs and account for 31.6% of costs.
26.2% of members are ACA OE and account for 33.3% of costs.
14.0% of members disenrolled as of Jan 2024 and account for 11.2% of costs.

Member Breakout by LOB

LOB	Eligibility Category	Total Members	% of Members
IHSS	IHSS	31	1.1%
MCAL	MCAL - ADULT	179	6.2%
	MCAL - BCCTP	-	0.0%
	MCAL - CHILD	50	1.7%
	MCAL - ACA OE	755	26.2%
	MCAL - SPD	835	28.9%
	MCAL - DUALS	207	7.2%
	MCAL - LTC	91	3.2%
	MCAL - LTC-DUAL	334	11.6%
Not Eligible	Not Eligible	405	14.0%
Total		**2,887**	**100.0%**

Cost Breakout by LOB

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

% of Total Costs By Service Type

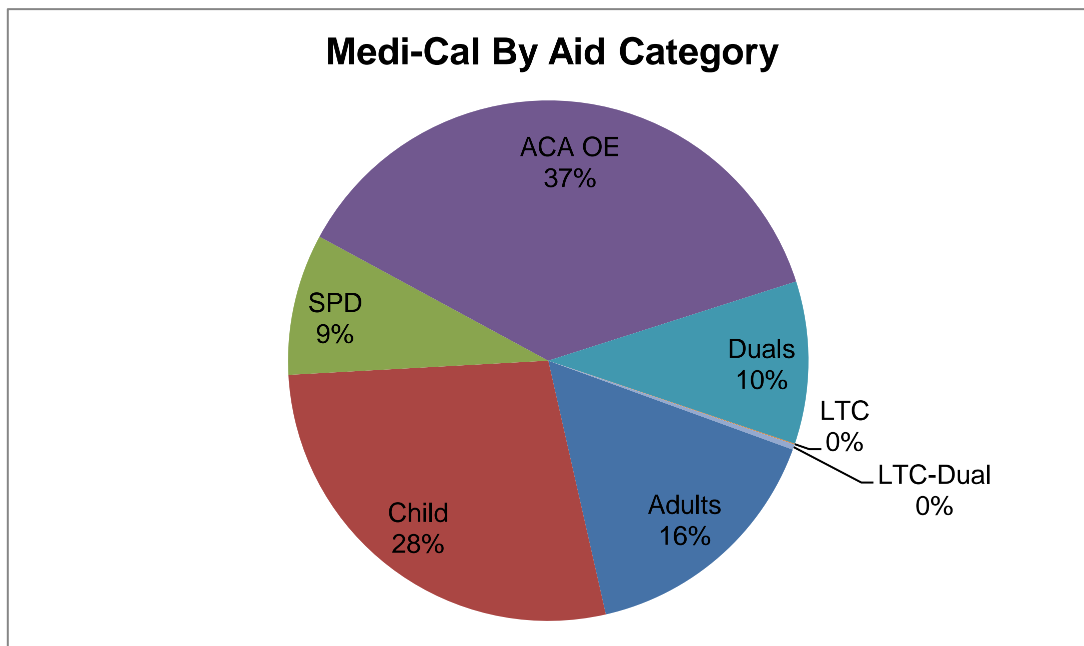
				Breakout by Service Type/Location						
Cost Range	Trauma Costs	Hep C Rx Costs	Pregnancy, Childbirth & Newborn Related Costs	Pharmacy Costs	Inpatient Costs (POS 21)	ER Costs (POS 23)	Outpatient Costs (POS 22)	Office Costs (POS 11)	Dialysis Costs (POS 65)	Other Costs (All Other POS)
$100K+	7%	0%	1%	0%	41%	1%	11%	3%	1%	26%
$75K to $100K	3%	0%	1%	0%	24%	2%	5%	3%	4%	44%
$50K to $75K	4%	0%	2%	0%	28%	3%	6%	5%	5%	29%
$40K to $50K	4%	0%	2%	1%	30%	5%	5%	5%	2%	20%
$30K to $40K	10%	0%	2%	0%	23%	12%	5%	5%	1%	17%
$20K to $30K	3%	1%	3%	1%	24%	6%	7%	6%	1%	18%
$10K to $20K	0%	0%	8%	1%	24%	5%	9%	7%	2%	17%
$5K to $10K	0%	0%	11%	1%	22%	6%	9%	9%	1%	23%
Total	**5%**	**0%**	**2%**	**0%**	**33%**	**3%**	**8%**	**4%**	**2%**	**25%**

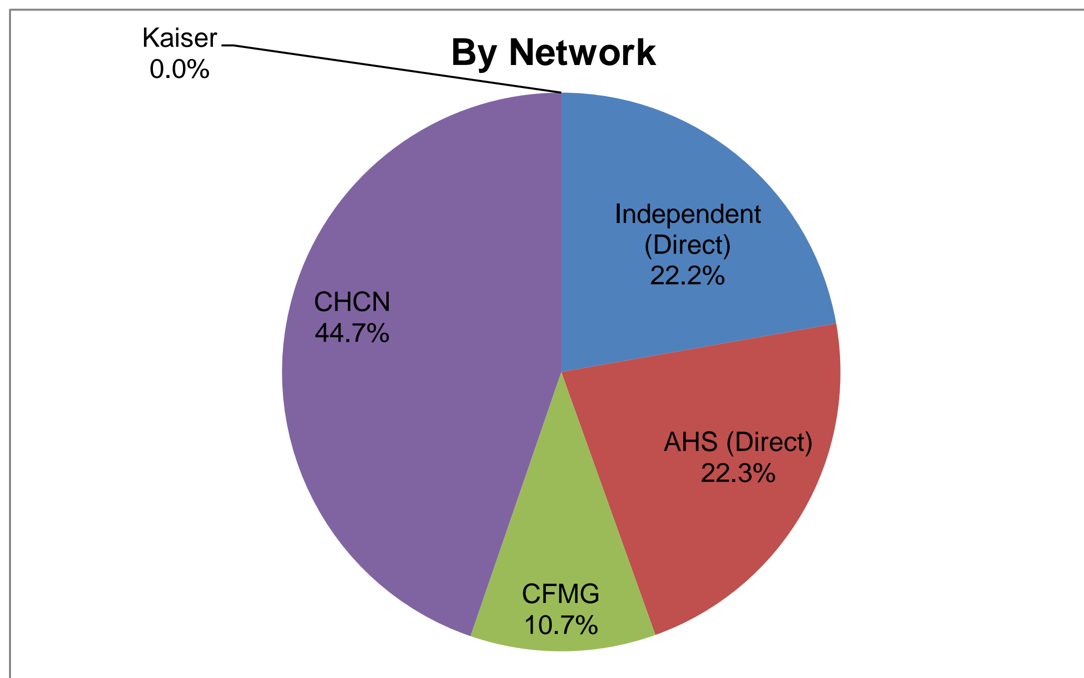
Notes:
- Report includes medical costs (HS & Diamond Claims, Beacon, Logisticare FFS, CHCN FFS Preventive Services, CHME) and pharmacy costs. IBNP factors are not applied.
- CFMG and CHCN encounter data has been priced out.
- Report excludes Capitation Expense

Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

Category of Aid Trend

Category of Aid	Mar 2024	% of Medi-Cal	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Adults	63,314	16%	13,366	14,286	5	35,657	-
Child	110,268	28%	9,679	13,409	40,473	46,707	-
SPD	34,972	9%	11,344	5,488	1,431	16,709	-
ACA OE	148,065	37%	25,272	53,178	1,499	68,116	-
Duals	40,222	10%	26,477	2,860	5	10,880	-
LTC	216	0%	201	6	-	9	-
LTC-Dual	1,307	0%	1,305	-	-	2	-
Medi-Cal	398,364		87,644	89,227	43,413	178,080	-
Group Care	5,620		2,146	862	-	2,612	-
Total	**403,984**	**100%**	**89,790**	**90,089**	**43,413**	**180,692**	**-**
Medi-Cal %	98.6%		97.6%	99.0%	100.0%	98.6%	0%
Group Care %	1.4%		2.4%	1.0%	0.0%	1.4%	0.0%
		Network Distribution	*22.2%*	*22.3%*	*10.7%*	*44.7%*	*0.0%*
			% Direct:	**45%**		**% Delegated:**	**55%**

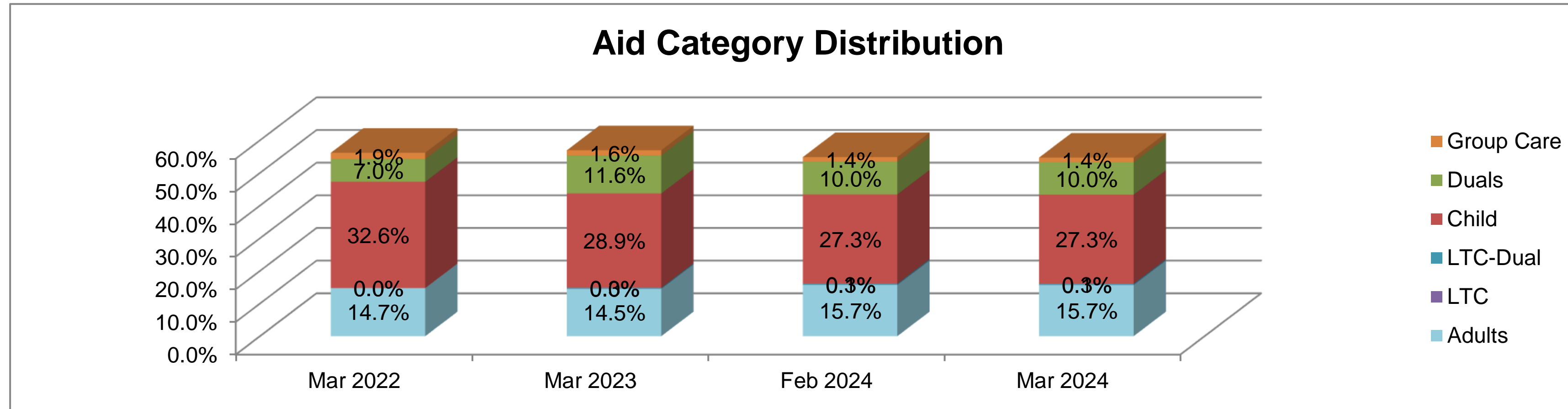




Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

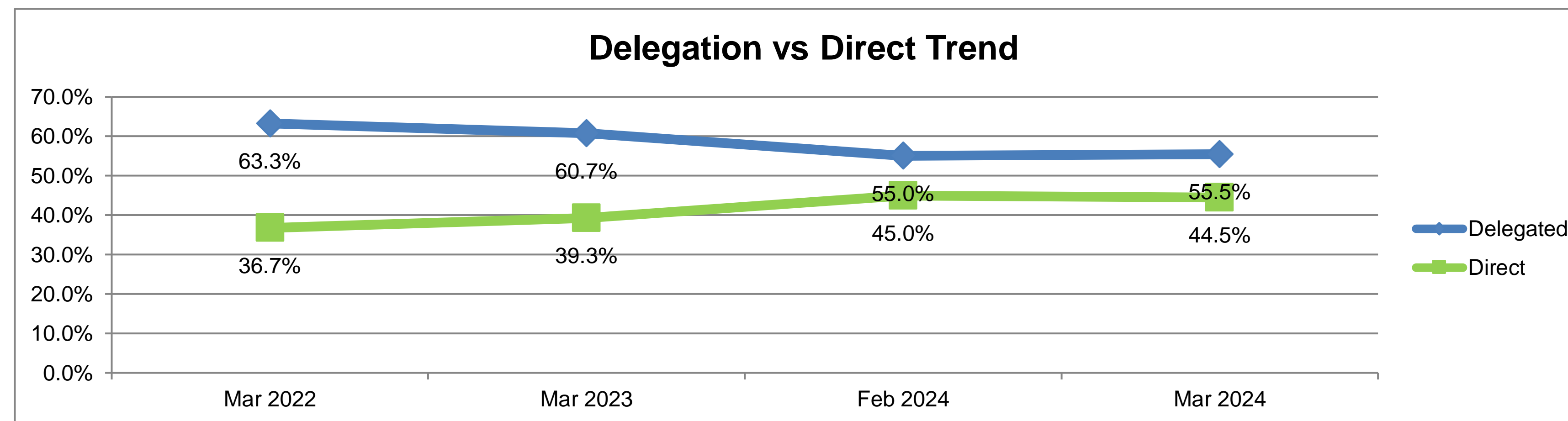
Category of Aid Trend

Category of Aid	Members Mar 2022	Members Mar 2023	Members Feb 2024	Members Mar 2024	% of Total (ie.Distribution) Mar 2022	% of Total Mar 2023	% of Total Feb 2024	% of Total Mar 2024	% Growth (Loss) Mar 2022 to Mar 2023	% Growth (Loss) Mar 2023 to Mar 2024	% Growth (Loss) Feb 2024 to Mar 2024
Adults	45,228	51,516	63,130	63,314	14.7%	14.5%	15.7%	15.7%	13.9%	22.9%	0.3%
Child	99,888	102,510	109,957	110,268	32.6%	28.9%	27.3%	27.3%	2.6%	7.6%	0.3%
SPD	26,823	31,021	34,876	34,972	8.7%	8.7%	8.7%	8.7%	15.7%	12.7%	0.3%
ACA OE	107,648	121,852	146,758	148,065	35.1%	34.3%	36.5%	36.7%	13.2%	21.5%	0.9%
Duals	21,350	41,246	40,403	40,222	7.0%	11.6%	10.0%	10.0%	93.2%	-2.5%	-0.4%
LTC	-	143	217	216	0.0%	0.0%	0.1%	0.1%	0.0%	51.0%	-0.5%
LTC-Dual	-	948	1,329	1,307	0.0%	0.3%	0.3%	0.3%	0.0%	37.9%	-1.7%
Medi-Cal Total	300,937	349,236	396,670	398,364	98.1%	98.4%	98.6%	98.6%	16.0%	14.1%	0.4%
Group Care	5,850	5,723	5,608	5,620	1.9%	1.6%	1.4%	1.4%	-2.2%	-1.8%	0.2%
Total	**306,787**	**354,959**	**402,278**	**403,984**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**15.7%**	**13.8%**	**0.4%**



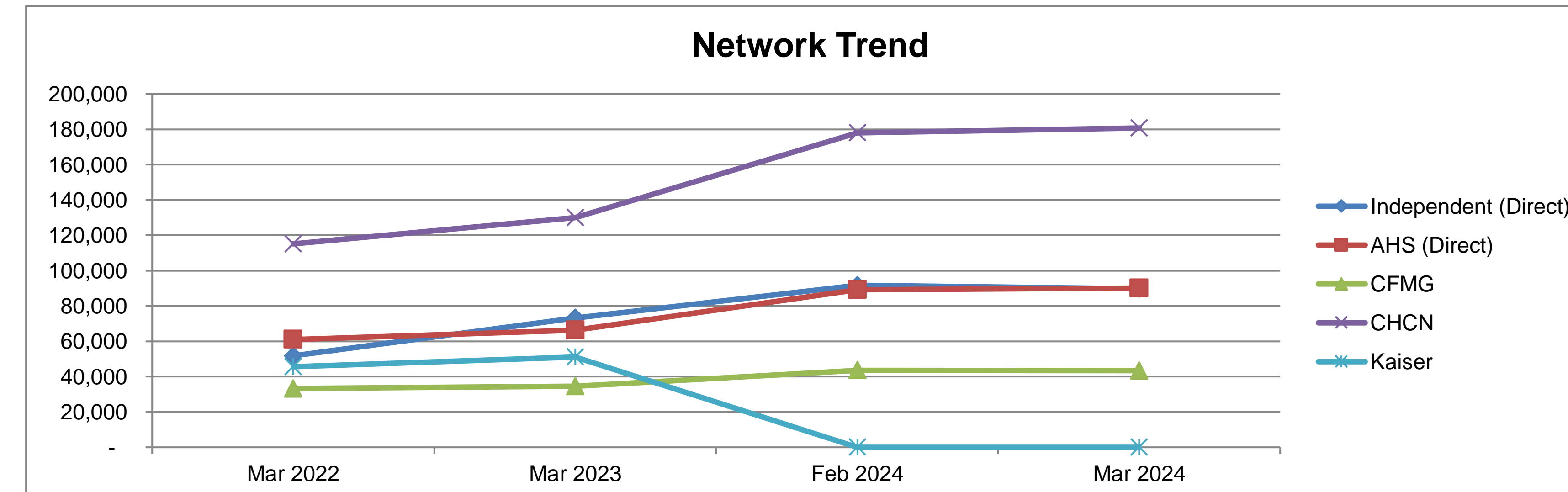
Delegation vs Direct Trend

Members	Members Mar 2022	Members Mar 2023	Members Feb 2024	Members Mar 2024	% of Total (ie.Distribution) Mar 2022	% of Total Mar 2023	% of Total Feb 2024	% of Total Mar 2024	% Growth (Loss) Mar 2022 to Mar 2023	% Growth (Loss) Mar 2023 to Mar 2024	% Growth (Loss) Feb 2024 to Mar 2024
Delegated	194,046	215,530	221,438	224,105	63.3%	60.7%	55.0%	55.5%	11.1%	4.0%	1.2%
Direct	112,741	139,429	180,840	179,879	36.7%	39.3%	45.0%	44.5%	23.7%	29.0%	-0.5%
Total	**306,787**	**354,959**	**402,278**	**403,984**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**15.7%**	**13.8%**	**0.4%**



Network Trend

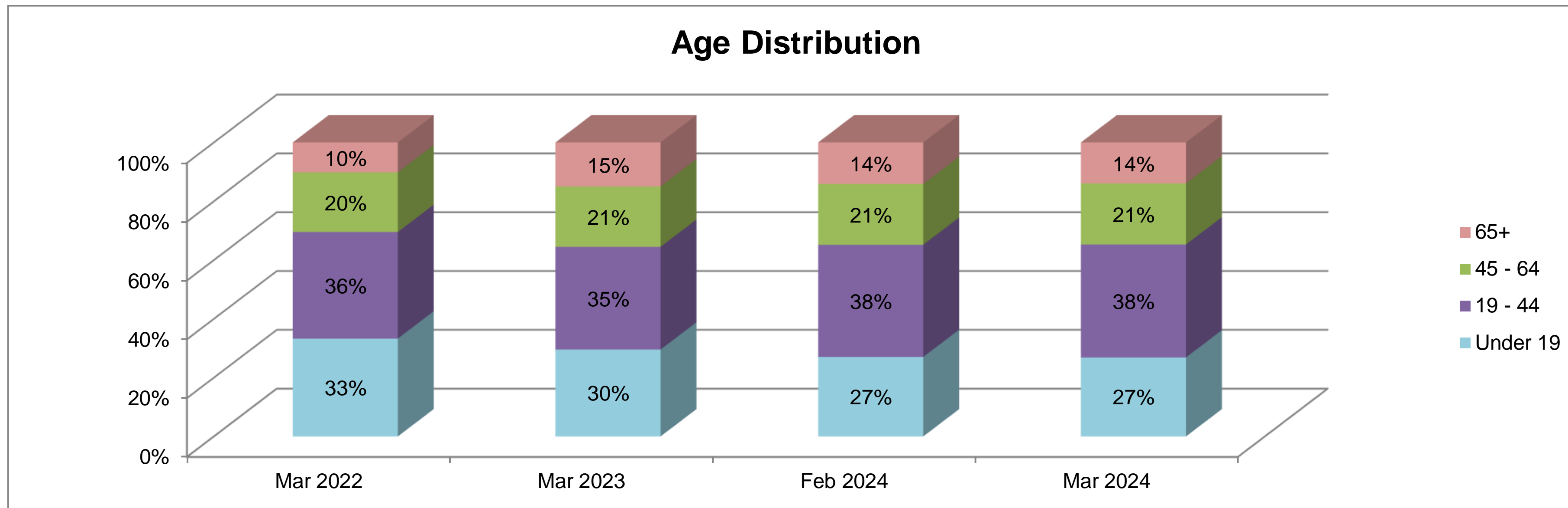
Network	Members Mar 2022	Members Mar 2023	Members Feb 2024	Members Mar 2024	% of Total (ie.Distribution) Mar 2022	% of Total Mar 2023	% of Total Feb 2024	% of Total Mar 2024	% Growth (Loss) Mar 2022 to Mar 2023	% Growth (Loss) Mar 2023 to Mar 2024	% Growth (Loss) Feb 2024 to Mar 2024
Independent (Direct)	51,767	73,153	91,671	89,790	16.9%	20.6%	22.8%	22.2%	41.3%	22.7%	-2.1%
AHS (Direct)	60,974	66,276	89,169	90,089	19.9%	18.7%	22.2%	22.3%	8.7%	35.9%	1.0%
CFMG	33,293	34,547	43,528	43,413	10.9%	9.7%	10.8%	10.7%	3.8%	25.7%	-0.3%
CHCN	115,125	129,908	177,910	180,692	37.5%	36.6%	44.2%	44.7%	12.8%	39.1%	1.6%
Kaiser	45,628	51,075	-	-	14.9%	14.4%	0.0%	0.0%	11.9%	-100.0%	0.0%
Total	**306,787**	**354,959**	**402,278**	**403,984**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**15.7%**	**13.8%**	**0.4%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

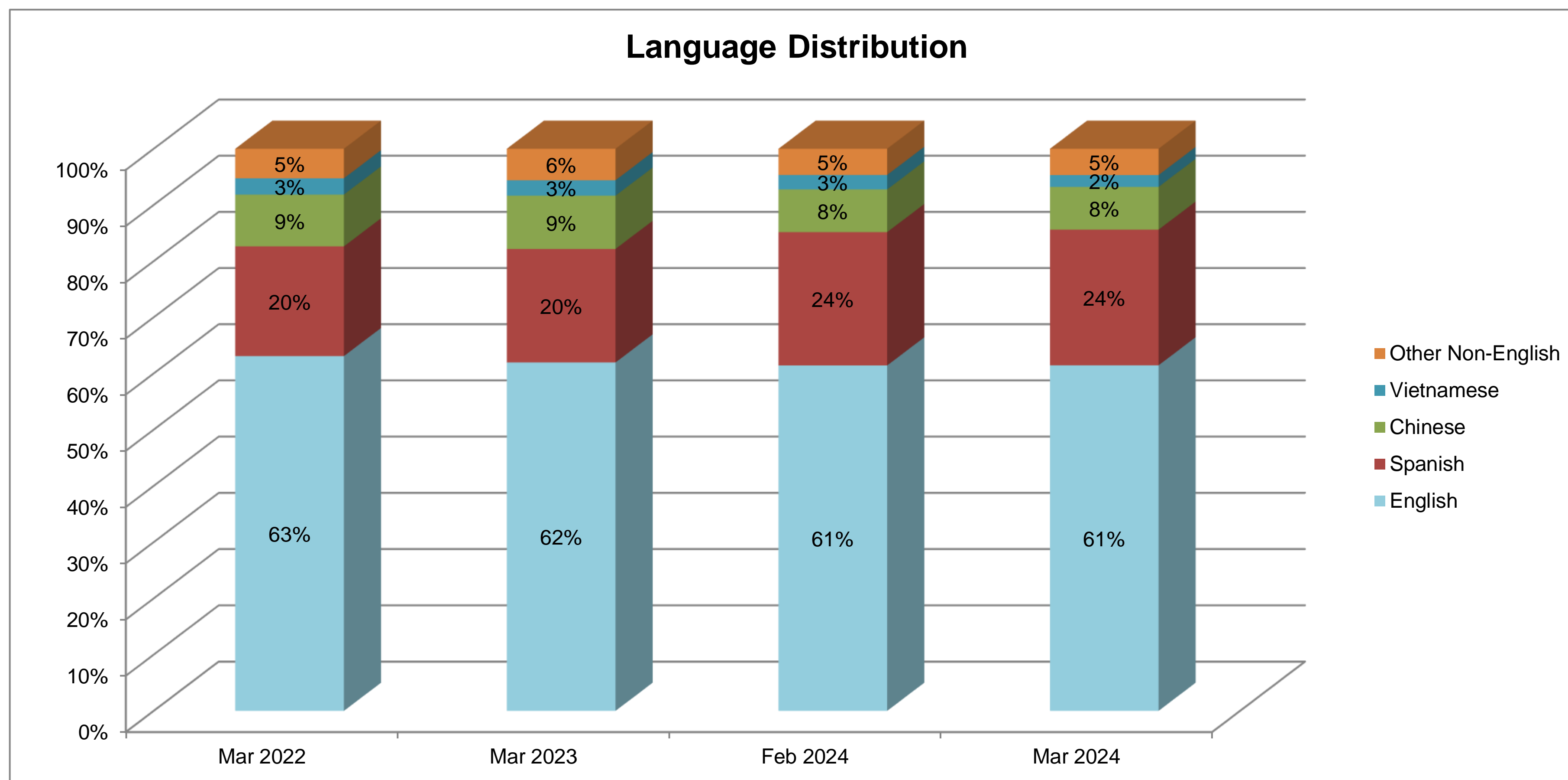
Age Category Trend

Age Category	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Mar 2022	Mar 2023	Feb 2024	Mar 2024	Mar 2022	Mar 2023	Feb 2024	Mar 2024	Mar 2022 to Mar 2023	Mar 2023 to Mar 2024	Feb 2024 to Mar 2024
Under 19	102,146	104,866	109,248	108,522	33%	30%	27%	27%	3%	3%	-1%
19 - 44	111,172	124,034	154,277	155,233	36%	35%	38%	38%	12%	25%	1%
45 - 64	62,347	72,979	83,583	83,951	20%	21%	21%	21%	17%	15%	0%
65+	31,122	53,080	57,113	56,278	10%	15%	14%	14%	71%	6%	-1%
Total	**306,787**	**354,959**	**404,221**	**403,984**	**100%**	**100%**	**100%**	**100%**	**16%**	**14%**	**0%**



Language Trend

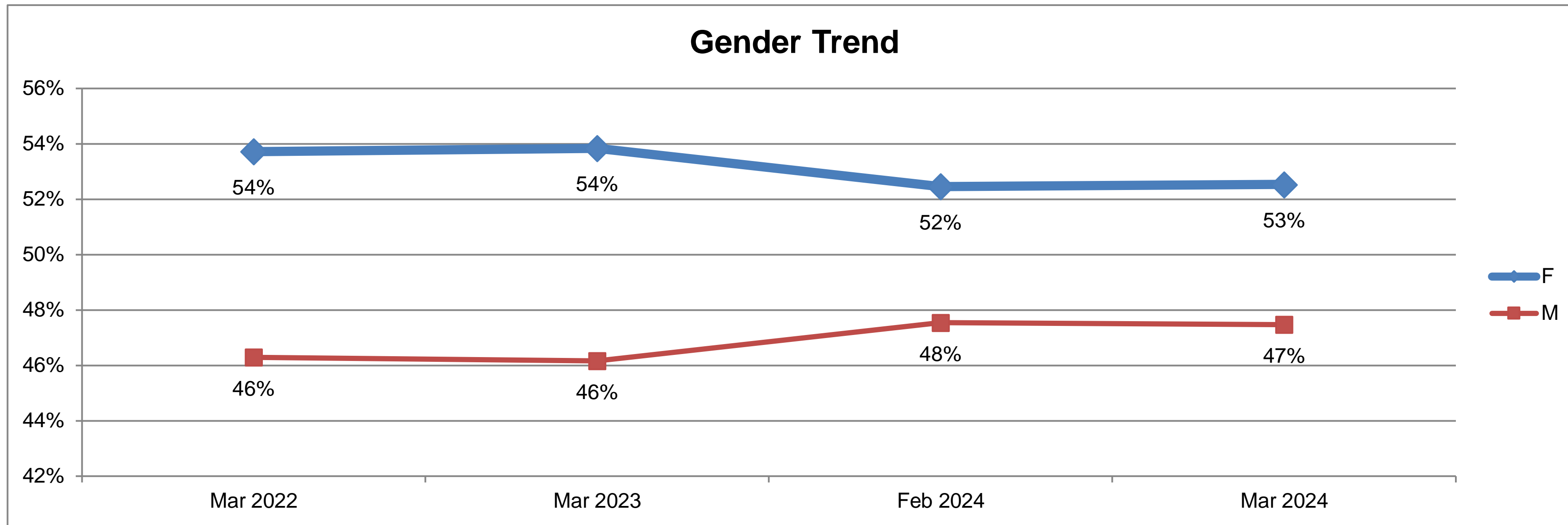
Language	Members				% of Total (ie.Distribution)				% Growth (Loss)		
	Mar 2022	Mar 2023	Feb 2024	Mar 2024	Mar 2022	Mar 2023	Feb 2024	Mar 2024	Mar 2022 to Mar 2023	Mar 2023 to Mar 2024	Feb 2024 to Mar 2024
English	193,534	219,911	248,268	248,207	63%	62%	61%	61%	14%	13%	0%
Spanish	59,913	71,737	95,947	97,569	20%	20%	24%	24%	20%	36%	2%
Chinese	28,316	33,645	30,706	30,760	9%	9%	8%	8%	19%	-9%	0%
Vietnamese	8,888	9,773	10,459	8,536	3%	3%	3%	2%	10%	-13%	-18%
Other Non-English	16,136	19,893	18,841	18,912	5%	6%	5%	5%	23%	-5%	0%
Total	**306,787**	**354,959**	**404,221**	**403,984**	**100%**	**100%**	**100%**	**100%**	**16%**	**14%**	**0%**



Alameda Alliance for Health - Analytics Supporting Documentation: Membership Profile

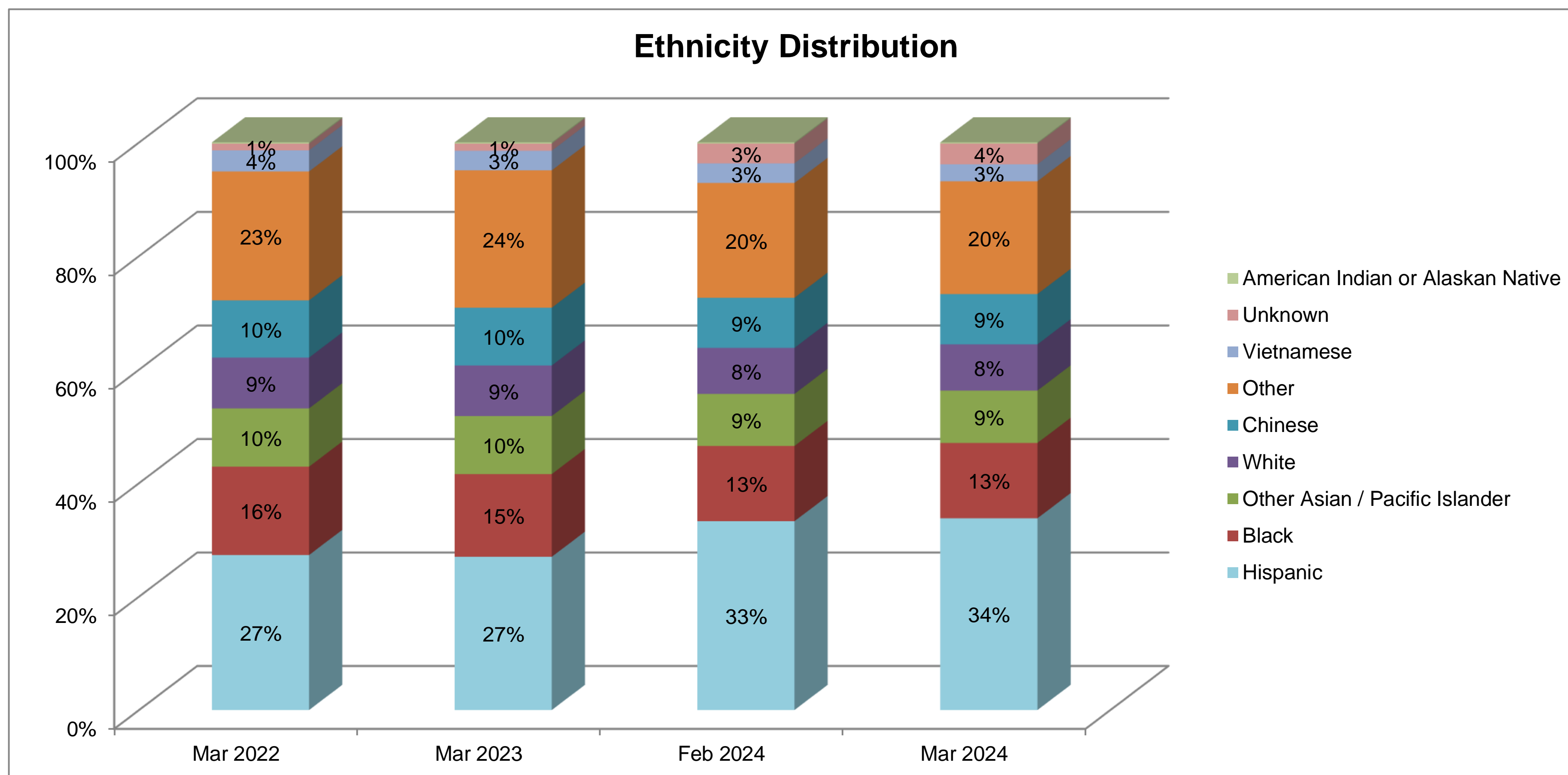
Gender Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Gender	Mar 2022	Mar 2023	Feb 2024	Mar 2024	Mar 2022	Mar 2023	Feb 2024	Mar 2024	Mar 2022 to Mar 2023	Mar 2023 to Mar 2024	Feb 2024 to Mar 2024
F	164,784	191,101	212,039	212,211	54%	54%	52%	53%	16%	11%	0%
M	142,003	163,858	192,182	191,773	46%	46%	48%	47%	15%	17%	0%
Total	**306,787**	**354,959**	**404,221**	**403,984**	**100%**	**100%**	**100%**	**100%**	**16%**	**14%**	**0%**



Ethnicity Trend

	Members				% of Total (ie.Distribution)				% Growth (Loss)		
Ethnicity	Mar 2022	Mar 2023	Feb 2024	Mar 2024	Mar 2022	Mar 2023	Feb 2024	Mar 2024	Mar 2022 to Mar 2023	Mar 2023 to Mar 2024	Feb 2024 to Mar 2024
Hispanic	83,813	95,858	134,527	136,557	27%	27%	33%	34%	14%	42%	2%
Black	47,769	51,755	53,620	53,627	16%	15%	13%	13%	8%	4%	0%
Other Asian / Pacific Islander	31,540	36,336	37,048	37,287	10%	10%	9%	9%	15%	3%	1%
White	27,426	31,596	32,783	32,857	9%	9%	8%	8%	15%	4%	0%
Chinese	30,921	36,098	35,685	35,796	10%	10%	9%	9%	17%	-1%	0%
Other	69,621	85,859	81,682	80,230	23%	24%	20%	20%	23%	-7%	-2%
Vietnamese	11,419	12,260	13,958	12,036	4%	3%	3%	3%	7%	-2%	-14%
Unknown	3,633	4,460	14,108	14,794	1%	1%	3%	4%	23%	232%	5%
American Indian or Alaskan Native	645	737	810	800	0%	0%	0%	0%	14%	9%	-1%
Total	**306,787**	**354,959**	**404,221**	**403,984**	**100%**	**100%**	**100%**	**100%**	**16%**	**14%**	**0%**



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

Medi-Cal By City

City	Mar 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	161,344	41%	24,531	42,483	17,380	76,950	-
Hayward	62,986	16%	12,500	16,578	7,334	26,574	-
Fremont	36,195	9%	14,911	6,799	1,985	12,500	-
San Leandro	33,074	8%	8,094	5,691	4,293	14,996	-
Union City	14,628	4%	5,410	2,629	848	5,741	-
Alameda	14,092	4%	3,441	2,538	2,070	6,043	-
Berkeley	15,465	4%	4,384	2,101	1,759	7,221	-
Livermore	12,640	3%	2,006	709	2,170	7,755	-
Newark	9,177	2%	2,730	4,011	467	1,969	-
Castro Valley	9,407	2%	2,425	1,689	1,373	3,920	-
San Lorenzo	7,261	2%	1,448	1,620	820	3,373	-
Pleasanton	7,222	2%	1,792	454	775	4,201	-
Dublin	7,336	2%	1,982	463	887	4,004	-
Emeryville	2,747	1%	619	612	440	1,076	-
Albany	2,550	1%	700	270	550	1,030	-
Piedmont	495	0%	130	191	53	121	-
Sunol	87	0%	25	15	6	41	-
Antioch	52	0%	13	19	6	14	-
Other	1,606	0%	503	355	197	551	-
Total	**398,364**	**100%**	**87,644**	**89,227**	**43,413**	**178,080**	**-**

Group Care By City

City	Mar 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	1,767	31%	367	326	-	1,074	-
Hayward	623	11%	291	138	-	194	-
Fremont	626	11%	437	59	-	130	-
San Leandro	583	10%	239	86	-	258	-
Union City	300	5%	190	44	-	66	-
Alameda	292	5%	94	23	-	175	-
Berkeley	162	3%	49	14	-	99	-
Livermore	103	2%	35	3	-	65	-
Newark	134	2%	79	33	-	22	-
Castro Valley	191	3%	79	30	-	82	-
San Lorenzo	134	2%	45	21	-	68	-
Pleasanton	60	1%	15	2	-	43	-
Dublin	112	2%	37	5	-	70	-
Emeryville	37	1%	14	5	-	18	-
Albany	21	0%	11	1	-	9	-
Piedmont	11	0%	3	-	-	8	-
Sunol	2	0%	2	-	-	-	-
Antioch	22	0%	7	4	-	11	-
Other	440	8%	152	68	-	220	-
Total	**5,620**	**100%**	**2,146**	**862**	**-**	**2,612**	**-**

Total By City

City	Mar 2024	% of Total	Independent (Direct)	AHS (Direct)	CFMG	CHCN	Kaiser
Oakland	163,111	40%	24,898	42,809	17,380	78,024	-
Hayward	63,609	16%	12,791	16,716	7,334	26,768	-
Fremont	36,821	9%	15,348	6,858	1,985	12,630	-
San Leandro	33,657	8%	8,333	5,777	4,293	15,254	-
Union City	14,928	4%	5,600	2,673	848	5,807	-
Alameda	14,384	4%	3,535	2,561	2,070	6,218	-
Berkeley	15,627	4%	4,433	2,115	1,759	7,320	-
Livermore	12,743	3%	2,041	712	2,170	7,820	-
Newark	9,311	2%	2,809	4,044	467	1,991	-
Castro Valley	9,598	2%	2,504	1,719	1,373	4,002	-
San Lorenzo	7,395	2%	1,493	1,641	820	3,441	-
Pleasanton	7,282	2%	1,807	456	775	4,244	-
Dublin	7,448	2%	2,019	468	887	4,074	-
Emeryville	2,784	1%	633	617	440	1,094	-
Albany	2,571	1%	711	271	550	1,039	-
Piedmont	506	0%	133	191	53	129	-
Sunol	89	0%	27	15	6	41	-
Antioch	74	0%	20	23	6	25	-
Other	2,046	1%	655	423	197	771	-
Total	**403,984**	**100%**	**89,790**	**90,089**	**43,413**	**180,692**	**-**

Human Resources

Anastacia Swift

To: Alameda Alliance for Health Board of Governors

From: Anastacia Swift, Chief Human Resources Officer

Date: May 10th, 2024

Subject: Human Resources Report

Staffing

- As of May 1st, 2024, the Alliance had 591 full time employees and 1-part time employee.
- On May 1st, 2024, the Alliance had 67 open positions in which 15 signed offer acceptance letters have been received with start dates in the near future resulting in a total of 52 positions open to date. The Alliance is actively recruiting for the remaining 52 positions and several of these positions are in the interviewing or job offer stage.
- Summary of open positions by department:

Department	Open Position May 1st	Signed Offers Accepted by Department	Remaining Recruitment Positions
Healthcare Services	9	6	3
Operations	36	4	32
Healthcare Analytics	2	1	1
Information Technology	9	2	7
Finance	3	0	3
Compliance & Legal	4	2	2
Human Resources	3	0	3
Health Equity	1	0	1
Executive	0	0	0
Total	67	15	52

- Our current recruitment rate is 10%.

Employee Recognition

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

  5 years:
  - Natalie Ho (Utilization Management)
  - Jessica Pedden (Quality Analytics)
  - Jennifer Svoboda (Case/ Disease Management)

  6 years:
  - Idy Vong (Member Services)
  - Bobby Hendrix (Quality Management)

  7 years:
  - Ramon Tran Tang (Pharmacy Services)

  8 years:
  - Sonia Spears (Quality Analytics)
  - Kristel Rusiana (Utilization Management)
  - Maria Adoracion Radona (Utilization Management)
  - Tanisha Lipscomb-Shepard (Quality Management)
  - Junaid Godil (IT-Ops and Quality Apps Mgt)

  9 years:
  - Paris Hawkins (Claims)
  - Christine Marie Rosal (Utilization Management)

  12 years:
  - Christine Rattray (Quality Management)
  - Elsa Guzman (Case/ Disease Management)

  14 years:
  - Marlowe West (Claims)
  - Latrina Brodnax (Claims)

  15 years:
  - Tyisha Pierce (Claims)

  16 years:
  - Ed Sanares (IT Infrastructure)
  - Kristy Nguyen (Finance)

  22 years:
  - Mandy Gutierrez (Marketing & Communications)

  23 years:
  - Teresa Corral (Claims)